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azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



Advancing Population Health

Chronic Disease Management & Cancer
Screening Optimization Using Azara DRVS

Dr. Ann-Marie John, PhD, MSN, BSN, RN

Director of Prevention & Wellness /
Population Health

Community Health Center of Buffalo, Inc.

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Today's Presenter

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Dr. Ann-Marie John, PhD, MSN, BSN, RN
Director of Prevention & Wellness / Population Health
Community Health Center of Buffalo, Inc.
Buffalo, New York



Learning Objectives

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1. Leverage Azara DRVS to optimize chronic disease & screening.
2. Integrate SDOH into population level decision-making.
3. Embed analytics into workflows to sustain measurable improvement.
4. Align quality strategy with value-based payment and equity goals.



The Population Health Challenge for FQHCs

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High prevalence of hypertension & diabetes burden



Preventable cancer morbidity



Social & structural barriers (transportation, food insecurity, housing instability)



Workforce strain & documentation burden



Multiple reporting demands (UDS, CMS, ACOs)

Challenge: No single operational “source of truth”



Prior State

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Data lived in multiple places (e.g., EHR, billing, excel spreadsheets), leading to multiple versions of the truth



No data infrastructure to be proactive



Unable to track data continuously or by provider



Inconsistent naming conventions led to inaccurate data



No navigation workflow



Adopting a Data-Driven Infrastructure

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MEASURE ANALYZER DETAIL LIST VALUE SETS

Search Patients ... Measure Investigation Tool

VIEW: All Gaps Num Excl Simple Full SAVED COLUMNS

CENTER NAME	MRN	DEMOGRAPHICS >	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL	PROVIDER	LOCATION	INACTIV
Family Health Center	1103758	Locantore, Dane	M	7/5/2003	9176791		Branchburg, Tom	FHC - Needs Update	N
Family Health Center	1103759	Hallo, Sheba	M	2/5/1954	6311320		House, Gregory	FHC - Needs Update	N
Family Health Center	1103760	Gudis, Shaina	F	12/6/1976	1055944		Cote, David	FHC - Needs Update	N
Family Health Center	1103765	Upadhyaya, Major	M	10/12/1948	5787061		Mejido, Daniel	FHC - Needs Update	N

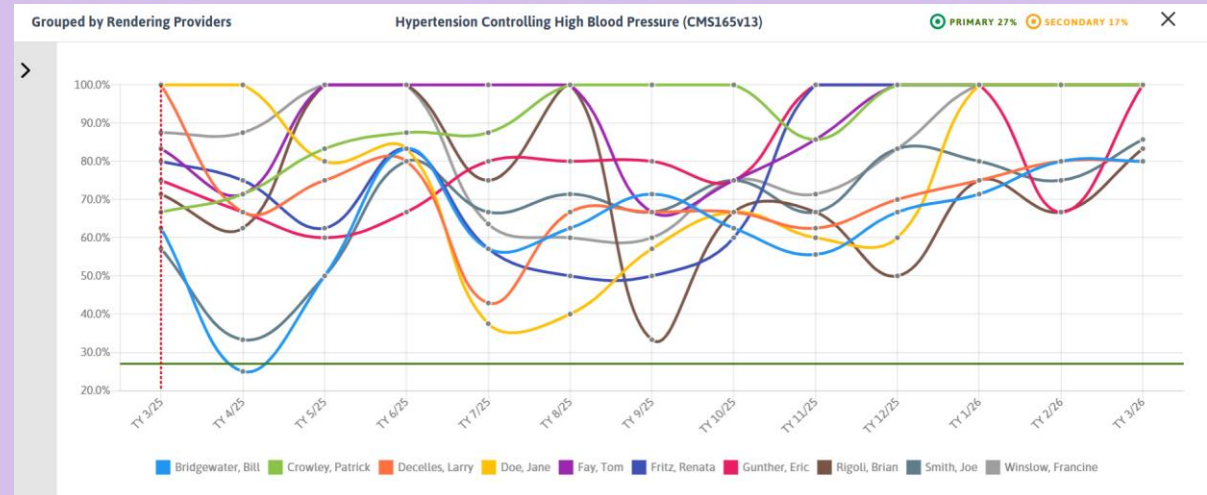
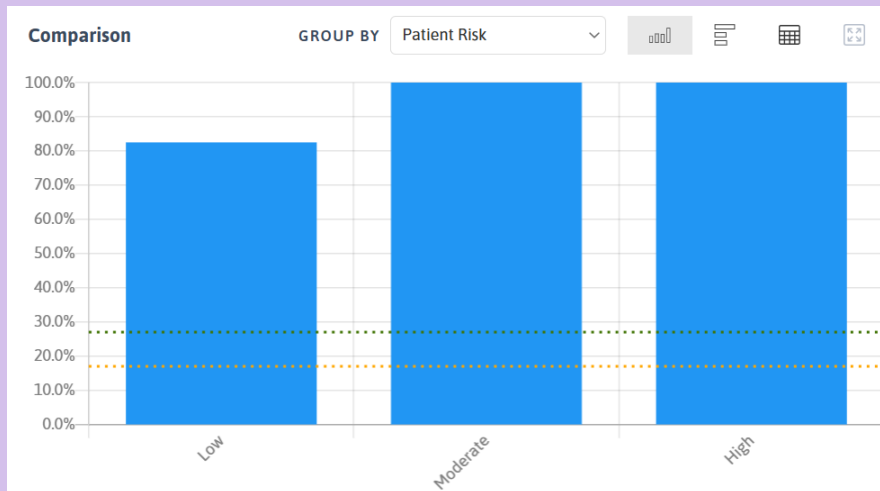
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RENDERING LOCATIONS

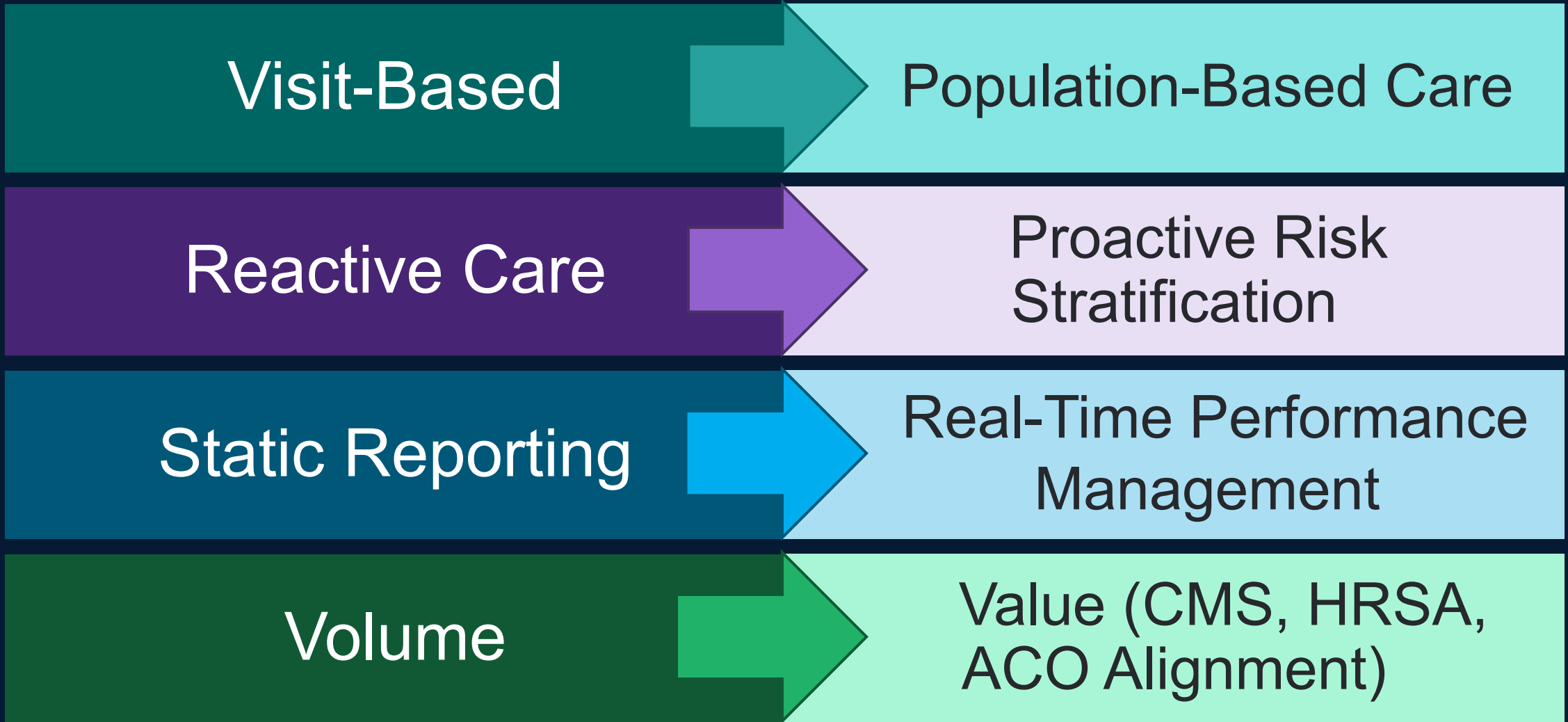
Main Office ✖

COHORTS

Dyn-Diabetes ✖



Why This Works



Embedding Analytics into Workflows

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✓ Pod communication & huddles

✓ Open order review

✓ Outreach lists

✓ Quality improvement meetings



Advancing Population Health Outcomes Using DRVS

Focus Areas for Optimization:

- 1 Chronic Disease Management Optimization
- 2 Cancer Screening
- 3 Age-Friendly Health Systems Integration
- 4 Social Care Integration



Chronic Disease Management Optimization

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Focus Area: Hypertension & Diabetes Outcomes

Levers for success:

- Risk stratified dynamic cohorts
- Standardized pathways
- Culturally tailored outreach
- Remote Patient Monitoring
- Nurse-led follow-up protocols



Chronic Disease Optimization | Prioritize High-Risk Patients



Hypertension Controlling High Blood Pressure (CMS165v13) MEASURE

PERIOD: TY March 2026 | RENDERING PROVIDERS: All Rendering Provid... | COHORTS: CHCB AF Geri Progra... **Layer cohort to scope to high-risk patients.**

MEASURE ANALYZER | **DETAIL LIST** | VALUE SETS

Search Patients ... **Prioritize patients who haven't been in practice recently.** Measure Investigation Tool | All | **Gaps** | Num | Excl | VIEW | Simple | **Who have particularly high BPs?**

MOST RECENT ENCOUNTER		HTN E 1ST DX		MULTIPLE BP LOWEST			ACTIVE PREGN	
DATE	After	DATE	CODE	DATE	SYSTOLIC	DIASTOLIC	VAL... ↓	ONSET DATE
9/23/2025	ffalo	9/23/2025	I10	10/6/2025	187	101	187/101	
11/4/2025	ffalo	5/23/2016	I10	11/4/2025	186	106	186/106	
1/2/2026	ffalo	2/27/2024	I10	8/7/2025	181	84	181/84	
1/21/2026	ffalo	11/27/2023	I10	1/21/2026	169	102	169/102	

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Despite high performance, dashboards allow us to isolate remaining gaps and focus resources on patients who are not yet optimized. DRVS transforms static data into actionable workflows that drive targeted intervention, improve outcomes, and sustain high performance.

Chronic Disease Management DASHBOARD

PERIOD: TY March 2026 | RENDERING PROVIDERS: All Rendering Provid...

A1C Break Down Calendar Year

A1C LEVEL	RESULT	NUM
No A1c	13.6%	157
8% to 8.99%	8.5%	98
7% to 7.99%	14.8%	171
0% to 6.99%	48.0%	554
>9%	15.0%	173
<9%	0.1%	1

>9/Untested Prior Year Comparison: 28.6% (-0.4% TY 2/26)

% >9 or Untested Calendar Year: 29%

>9 or Untested Calendar Year Gaps: 330

% DM Kidney Evaluation Calendar Year: 34%

Kidney Eval. Diabetes- Provider Gaps (High to Low)

RENDERING PROVIDERS	RESULT	NUM	DENOM	GAP
Bharti, Rachna	16.3%	37	227	190
Mayo, Kaylan	42.6%	123	289	166
Green, Nicholas	33.0%	72	218	146
Palwa, Anisha	36.3%	77	212	135
DAO, TINH	58.1%	176	303	127
YUSUF, EMILY	37.6%	41	109	68
Durham, Madison	21.6%	16	74	58
Ahmad, Shahla	34.2%	27	79	52
Unassigned Provider	45.5%	40	88	48
Davis, Kenyani	31.8%	21	66	45
Czach, Selene	11.9%	5	42	37
Simon, Carol	48.5%	32	66	34
Park, Song	45.9%	28	61	33

% HTN BP Control Prior Year Comparison: 73.3% (+0.1% TY 2/26)

% HTN Controlled Calendar Year: 73%

HTN Gaps Calendar Year: 810

% Statin Therapy Prior Year Comparison: 79.7% (+0.6% TY 2/26)

% Statin Calendar Year: 80%

Statin Gaps Calendar Year: 304

% IVD Aspirin Prior Year Comparison: 84.0% (+0.5% TY 2/26)

% IVD Aspirin Calendar Year: 84%

IVD Aspirin Gaps Calendar Year: 41

Chronic Disease Management Outcomes



Hypertension Controlling High Blood Pressure (CMS165v13)
MEASURE

PERIOD: TY March 2026
RENDERING PROVIDERS: All Rendering Provid...

Aligned with:
HRSA UDS benchmarks
AHA Hypertension standards
Value-based incentive contracts

FILTER ^

+ Add Filter

Update

MEASURE ANALYZER

73.3%

2,225 / 3,035

172 Exclusion(s)

810 Gaps 0 To Target

↑ 0.1%
TY 2/26

AMA M...
70% 60%

SELECTED 73.3%
Center Avg 73.3%
Network Avg 66.5%
Best Center 100.0%

TY 3/26

GROUP BY: None

Comparison

GROUP BY: Race

RACE	RESULT	CHANGE	NUM	DENOM	EXCL
Black/African A...	72.9%	- 0.2% ▼	1,687	2,314	142
White	72.2%	+ 1.9% ▲	337	467	15
Other Asian	82.7%	- 0.9% ▼	139	168	12
Unreported/Cho...	71.9%	+ 1.1% ▲	46	64	2
American Indian...	75%	0%	12	16	1
Native Hawaiian	75%	- 25% ▼	3	4	0
Vietnamese	100%	0%	1	1	0
Asian Indian	0%	0%	0	1	0

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Cancer Screening Optimization

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Focus Area: Breast & Colorectal Cancer Screening

Levers for Success:

- Open order gap lists
- Navigation tracking
- Site-level comparisons
- Standing orders
- Outreach campaigns



Active Tracking of Open Lab Orders



Open Lab Orders MEASURE FILTER Update

PERIOD: March 2026 | RENDERING PROVIDERS: All Rendering Provid... | ORDER TYPE: 4 selected

MEASURE ANALYZER

Search Patients ...

DEMOGRAPHICS > MEMBER

NAME	MRN	PLAN
[blurred]	[blurred]	[blurred]
[blurred]	[blurred]	[blurred]

Search

Clear Filters

- FIT DNA Lab Order
- FOBT/FIT Lab Order
- Cervical Cytopathology (Pap) Lab Order
- Cervical HPV Lab Order
- COVID-19 Diagnostic Testing Order
- A1C Lab Order
- Influenza Lab Order
- CRC Biomarker

VALUE SETS

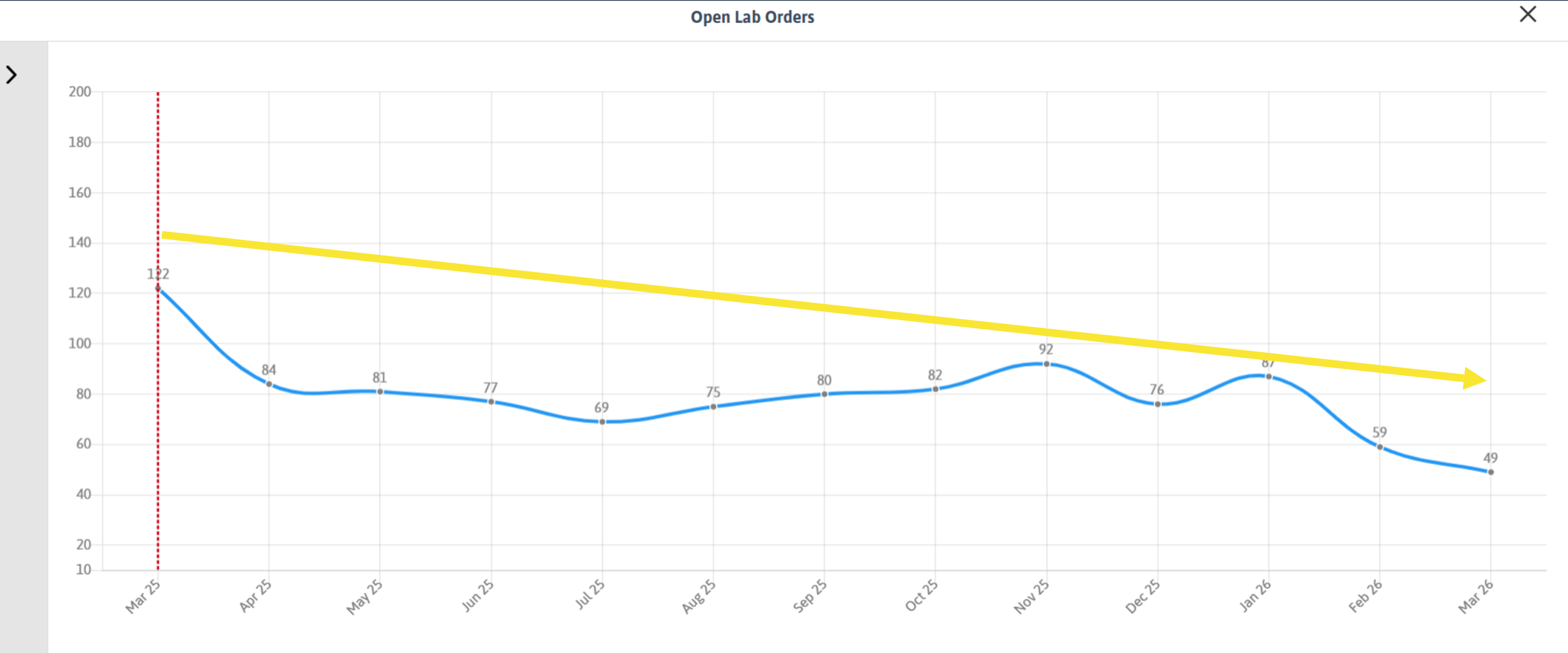
LABORATORY ORDER

EXCLUSION	ORDERED DATE	COMPLETED DATE	RESULTS RECEIVED DATE
N	3/10/2026		
N	3/3/2026		

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Reduction in Open Lab Volume



Friday Gap List Distribution



Breast Cancer Screening Ages 50-74 (CMS 125v13) MEASURE

PERIOD: TY March 2026 | RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ... | Measure Investigation Tool | ALL | Gaps | Num | Excl | VIEW: Simple | Full | SAVED

Gap lists are downloaded every Friday and filtered to patients coming in next week. Patient lists are distributed to providers.

MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	PROVIDER	LOCATION	INACTIVE		
1100602	Demarais, Marcy	F	5/22/1960	4438499	Decelles, Larry	ACH - Needs Update	N	N	5/24
1104511	Luigi, Elvey	F	9/28/1970	9548267	Decelles, Larry	ACH - Needs Update	N	N	2/10
1101476	Avans, Andre	F	2/27/1969	7613505	Bridgewater, Bill	ACH - Needs Update	N	N	11/7
1102621	Spake, Dalton	F	8/13/1971	4980134	Augustine, Greg	ACH - Needs Update	N	N	11/7
1101246	Vanharlingen, Rayford	F	8/11/1968	7147982	Fritz, Renata	ACH - Needs Update	N	N	12/7
1102729	Witherow, Jennie	F	1/11/1971	6813651	Winslow, Francine	ACH - Needs Update	N	N	8/31

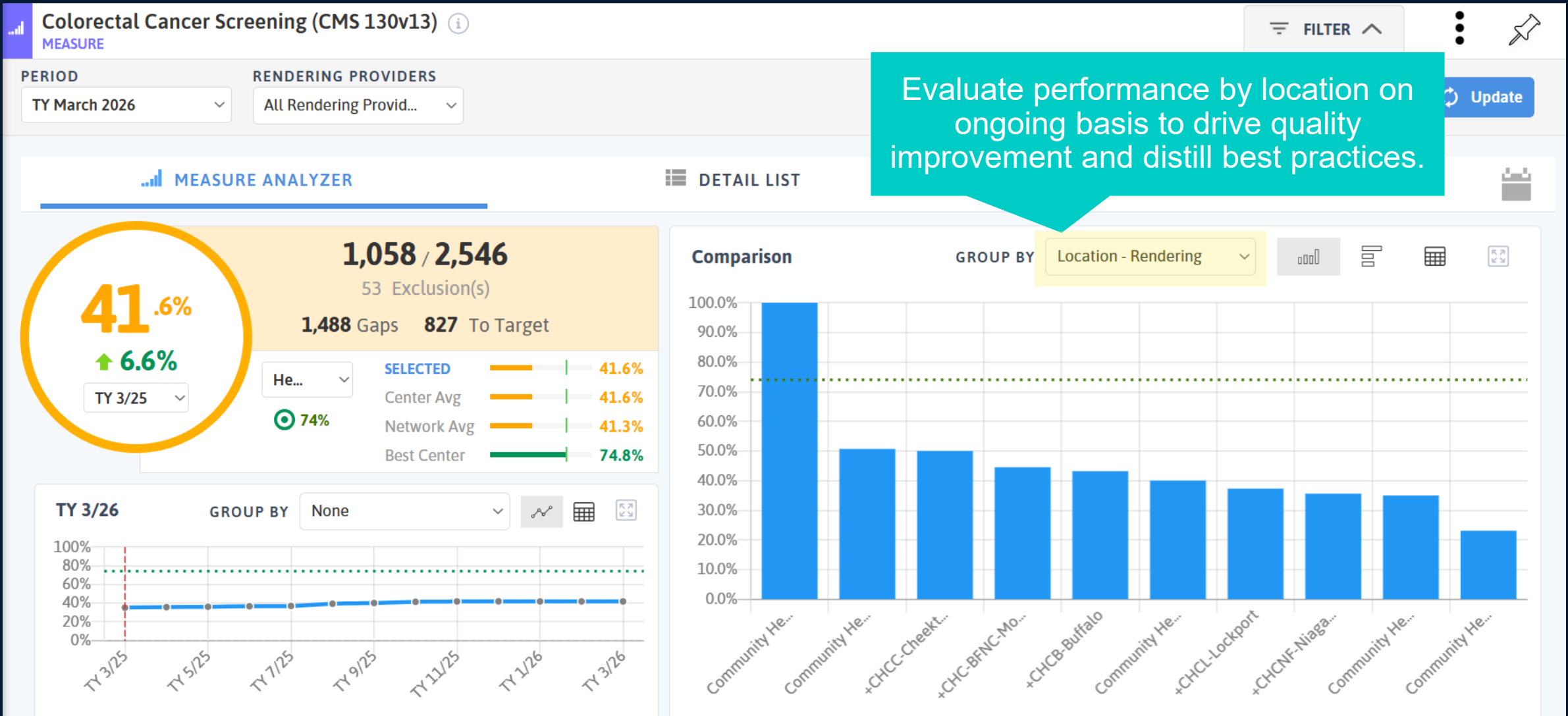
Export Excel All Columns | Export Excel Displayed Columns | Export CSV All Columns | Export CSV Displayed Columns | Create Cohort

Demo Data

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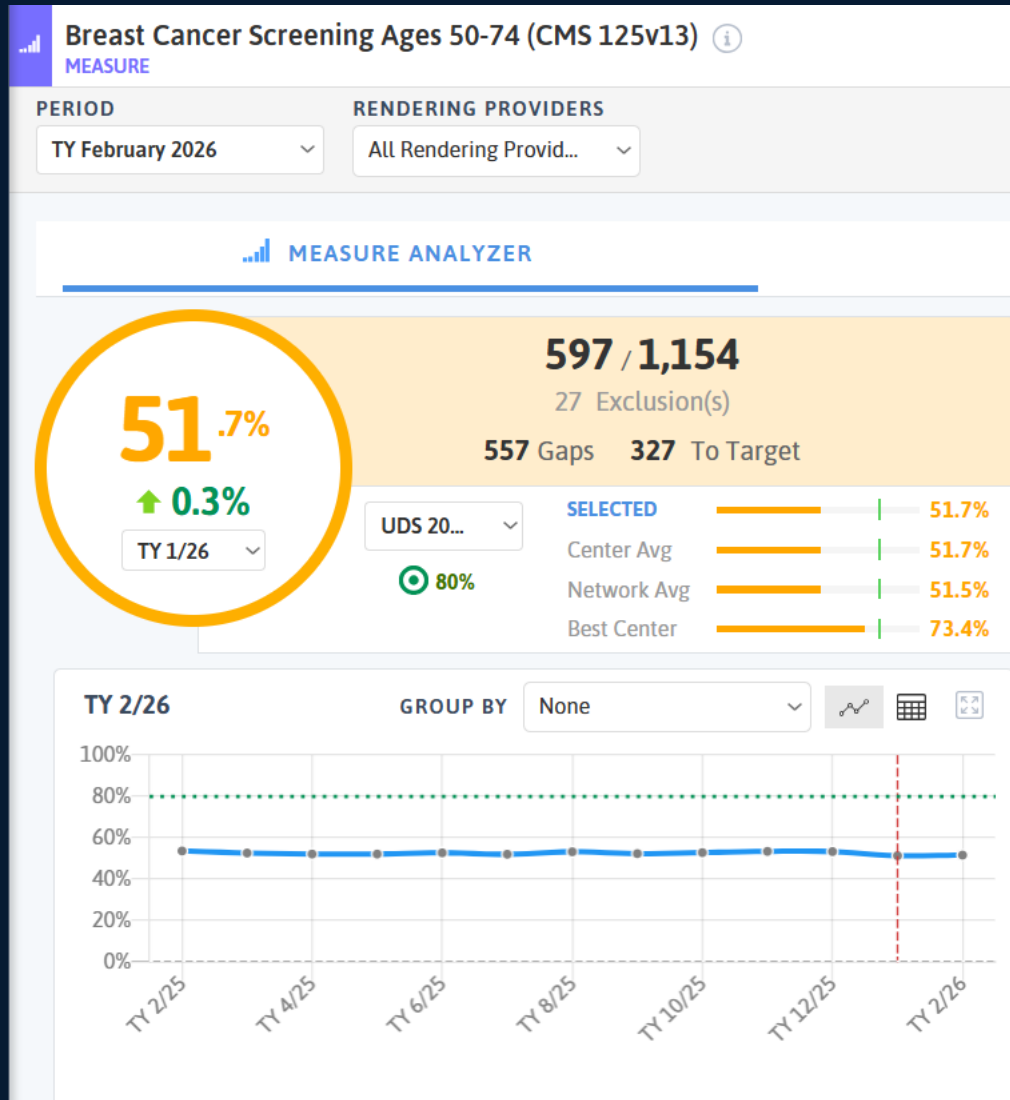
Cancer Screening Optimization



Evaluate performance by location on ongoing basis to drive quality improvement and distill best practices.



Cancer Screening Optimization Outcomes



Age-Friendly Health Systems Integration

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Preventive care aligned with:


- Medicare Annual Wellness Visits
- Chronic disease alignment
- Geriatric consult workflows

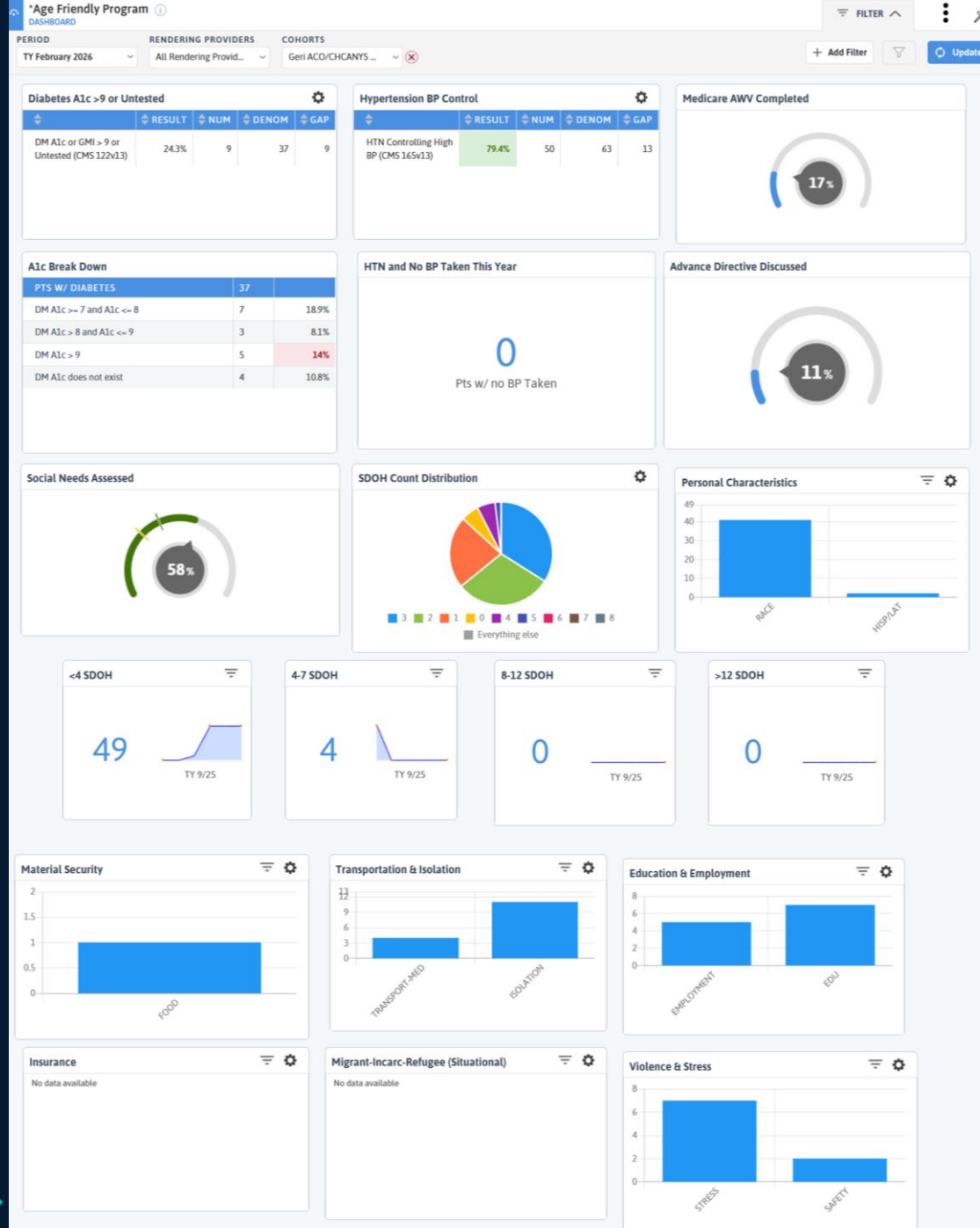


Age-Friendly Quality Tracking

Dashboard demonstrates and facilitates integration between:

- Clinical care (HTN, DM)
- Preventive care (AWV)
- Patient priorities (advance directives)
- Social needs (PRAPARE)

 **Hidden Gem:** Stratify patients based on social risk to prioritize care coordination and resource navigation for those with the highest needs.



Social Care Integration Optimization

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Focus Area: Stop asking, “Why aren’t they compliant”. Start asking, “What barriers are preventing engagement?”

Explore relationship between upstream barriers to care and:

- Missed mammograms
- Poor BP control
- Medication non-adherence
- No-show rates



Aligning SDOH & Clinical Data

Analytics guide **who** to target, **when** to intervene, and **how** to allocate resources.

Applying insights:



Prompting SDOH Screening at Point of Care



10:00 AM Tuesday, March 17, 2026 Visit Reason: TeleHealth Follow up neuropathy, Follow up increase in medication

DIAGNOSES (5)	RISK FACTORS (3)	ALERT	MESSAGE	DATE	RESULT
Asthma		HIV	Missing		
HTN-E		Falls Risk Screening	Missing		
		PHQ9 Utilization	Overdue	1/3/2025	4
		SDOH Needs Assessed	Missing		
		Tobacco Scr	Overdue	12/27/2023	Y
		BP	Out of Range	2/26/2026	124/83
		HepA (Pts >10 mths)	Missing		
		Asth Severity	Missing		
		Adv Care Discussion	Missing		
		Dental	Missing		
		OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
		Cardiology	BGH EKG DEPT., .	6/30/2025	

Edit ✕

GENERAL DATE CRITERIA RESULT CRITERIA POPULATION DEFINITION

INCLUSION CRITERIA

MIN AGE: MAX AGE:

MIN AGE UNITS: MAX AGE UNITS:

SEX AT BIRTH:

EXCLUSION CRITERIA

EXCLUSION OBSERVATIONS:

REQUIRE ANY OR ALL OBSERVATIONS FOR EXCLUSION:

Configured alert to fire specifically for older adults to support healthy aging work



Shared Responsibility | Team-Based Population Health Model

- Providers
- Nurses
- Care managers & Behavioral Health
- Registration & Call Center
- Data & IT teams

***Buffalo Quality Metrics**

PERIOD: TY February 2026 | RENDERING PROVIDERS: All Rendering Provid...

UDS Scorecard

MEASURE	RESULT	NUM	DENOM	EXCL
Childhood Immz Status (CMS 117v12)	0.0%	0	0	0
Child Weight Assessment (CMS 155v12)	91%	3	33	0
BMI Screen & Follow-Up 18+ (CMS 69v12)	38.0%	164	432	7
Depr Remission at 12 Months (CMS 159v12)	0.0%	0	17	0
Depr Scrn & Follow-Up (CMS 2v13)	39.0%	152	390	16
Tobacco Use: Screening & Cessation (CMS 138v12)	12.2%	43	352	0
Colorectal Cancer Screening (CMS 130v12)	47.1%	64	136	0
Cervical Cancer Screening (CMS 124v12)	62.8%	130	207	3
Breast Cancer Screening (CMS 125v12)	66.7%	40	60	0
HTN Controlling High BP (CMS 165v12)	74.0%	128	173	9
Statin Therapy CVD (CMS 347v7)	80.0%	64	80	3
DM A1c > 9 or Untested (CMS 122v12)	30.4%	21	69	0

Medicare AWV

RESULT	NUM	DENOM	GAP	
Medicare AWV	1.16%	3	258	255

Well Child 3y-21y

RESULT	NUM	DENOM	GAP	
Well-Child Care Visits (3-21 Yrs)	62.96%	34	54	20

Well Child 0-15

RESULT	NUM	DENOM	GAP	
Well-Child Care Visits (0-15 months)	0%	0	0	0

Well Child 15-30

RESULT	NUM	DENOM	GAP	
Well-Child Care Visits (15-30 months)	0%	0	0	0

No Shows

RENDERING PROVIDERS	RESULT	NUM	DENOM
Wieland, James	21.2%	158	744
Park, Song	3.8%	1	26
Mustafa, Esra	22.3%	120	537
Matheis, Scott	0.0%	0	0
Koenig, Nicole	36.0%	9	25
Kapoor, Shilpa	18.2%	39	214
EMERSON, CLAUDIA	0.0%	0	0
Davis, Kenyani	0.0%	0	0
Czach, Selene	6.9%	2	29
Chronic Disease Management	0.0%	0	4
Appleby Venezia	0.4%	1	238
Ahmad, Shahla	0.0%	0	58

DM Eye Exam

RESULT	NUM	DENOM	GAP	
DM Eye Exam	21%	14	68	54

A1c Cascade

A1C LEVEL	RESULT	NUM
No A1c	14.5%	10
8% to 8.99%	4.3%	3
7% to 7.99%	8.7%	6
0% to 6.99%	56.5%	39
>9%	15.9%	11
<=9%	0.0%	0

Shared Dashboards = Shared Ownership

Continuous Quality Improvement

Real-time feedback loops replaced delayed quarterly reports. Monthly review structure consists of:

- ✓ Site-level dashboard
- ✓ Provider-level transparency
- ✓ Numerator/denominator transparency
- ✓ Rapid-cycle PDSA



Measurable Impact

Strong Improvements Across:

- Hypertension control
- Breast cancer screening
- Colorectal cancer screening
- Equity-focused outreach
- Documentation

Strong Alignment With:

- HRSA UDS
- CMS quality measures
- Value-based contracts
- ACO participation
- AHA certification standards



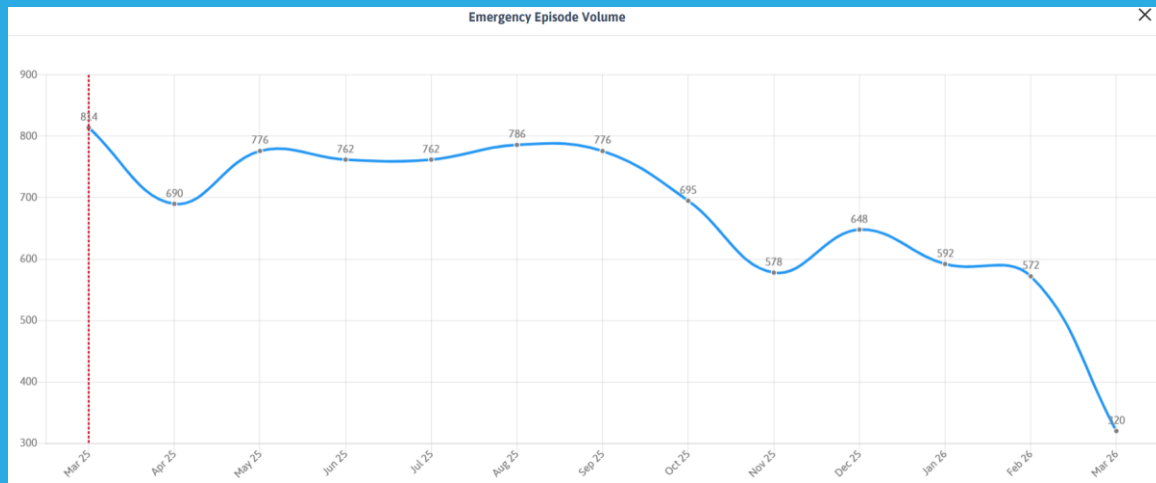
Value-Based Care / ACO / CMS Financial ROI



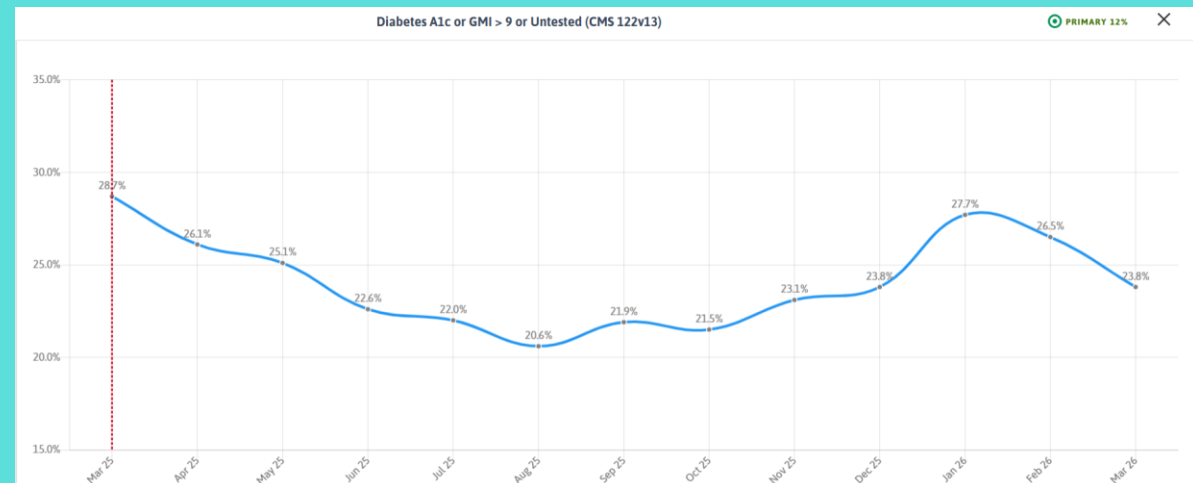
Improved quality scores = higher incentive payments

- Reduced preventable hospitalizations
- Improved HEDIS & UDS performance
- Remote Patient Monitoring (RPM) CPT billing
- Sustainable ROI through proactive care

ED Episode Volume



Diabetes A1C >9 or Untested



Financial Projection | VB Incentives & RPM ROI Modeling



Category	Assumptions	Estimated Annual Impact
Quality Incentives (ACO/CMS)	Improved HTN & screening tied to shared savings	\$150,000 – \$300,000
Avoided Hospitalizations	Reduced preventable admissions (HTN-related)	\$200,000+
RPM 99453 (Setup)	200 pts x \$19	\$3,800
RPM 99454 (Device Supply)	200 pts x \$48 x 12 months	\$115,200
RPM 99457 (Monitoring)	200 pts x \$50 x 12 months	\$120,000
RPM 99458 (Additional Monitoring)	50% eligible x \$40 x 12 months	\$48,000
Estimated Total ROI	Combined quality + RPM revenue	\$636,000 – \$786,000+



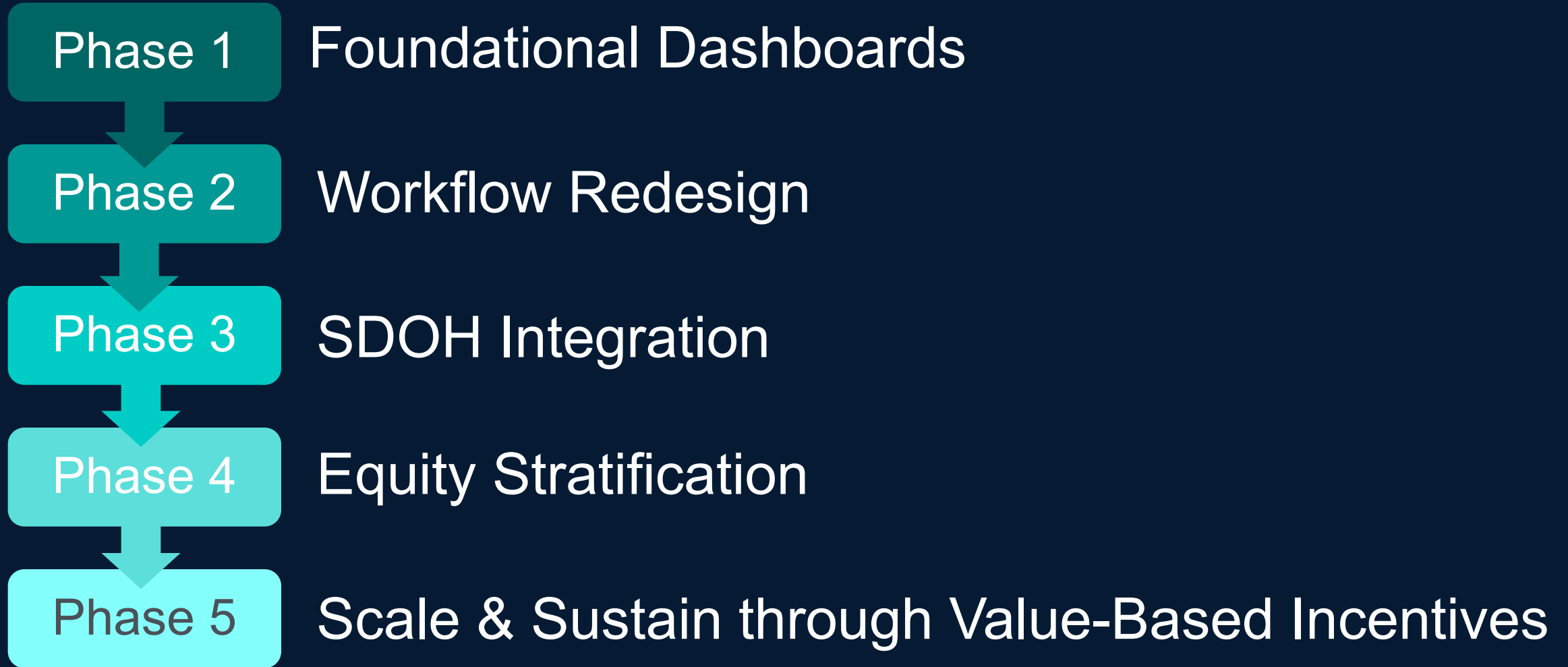
Practical Implementation Lessons

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- 1 Start with one high-impact cohort
- 2 Make data visible to frontline teams
- 3 Standardize documentation before scaling
- 4 Align outreach with SDOH insights
- 5 Tie performance to accountability structures



Implementation Roadmap



Key Takeaways | DRVS Analytics Engine

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Population health drives performance—but **high-risk care management** drives sustainability.

Real-Time Cohort Identification & Risk Stratification
Workflow-Integrated Gap Closure & Targeted Outreach
Improved Quality Metrics (HTN Control, Cancer Screening, AWW)
ACO Shared Savings & CMS Quality Incentives




Identification of Uncontrolled High-Risk Patients
Remote Patient Monitoring (RPM) Enrollment
Billable CPT Revenue (99453, 99454, 99457, 99458)
Recurring Monthly Revenue Stream



Population health success requires:

-  Valid, timely data
-  Intentional workflow design
-  Interdisciplinary discipline

Real-time analytics drive improvement:

-  Workflow design ensures sustainability
-  Equity integration strengthens outcomes
-  Financial alignment secures longevity



Acknowledgment | Strategic Partnership & Support



CHCB gratefully recognizes the AHA and CHCANYS for their continued leadership and investment in equity-driven chronic disease management. Their support has strengthened our ability to operationalize Azara DRVS analytics, advance HTN control, and build sustainable population health infrastructure aligned with VB care. These partnerships have been instrumental in improving outcomes for our most vulnerable communities.



From Reporting to Results.

From Data to Decisions.

From Quality Metrics to Health Equity.



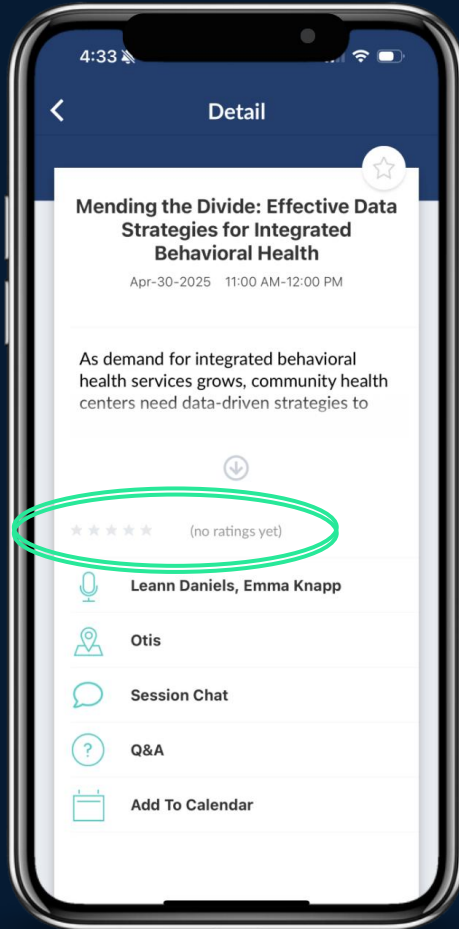


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Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy



Provide brief feedback or ideas



Rate the session and the speaker(s)



Help us continue to improve



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