

# Data in Action

Optimizing DRVS to Support Value-Based Care

azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



# Presenters



**Camilla Adams**  
Population Health Director  
Canyonlands Community  
Healthcare



**Thanh Nguyen**  
Data Analytics & Research  
Manager  
Louisiana Primary Care  
Association





## Every Role Matters

Using DRVS to Empower Team-Based Value Care



## Azara at the Network Level

Less Guesswork, More Groundwork



## Questions & Discussion



# Every Role Matters: Using DRVS to Empower Team-Based Value Care

Camilla Adams, Population Health Director  
Canyonlands Healthcare



**Canyonlands**  
*Healthcare*

# Canyonlands *Healthcare*



**11 Sites**



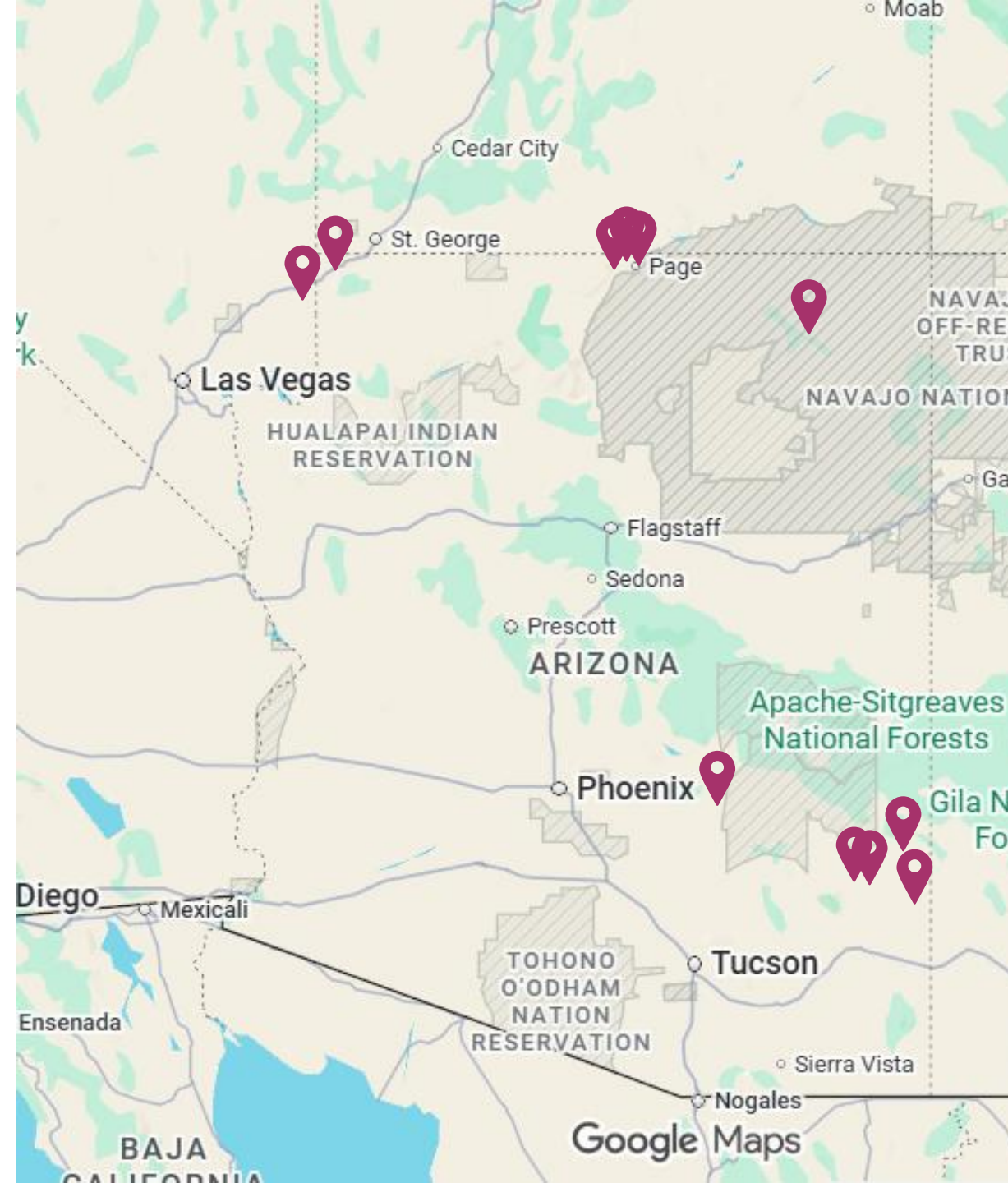
**~200 Employees**

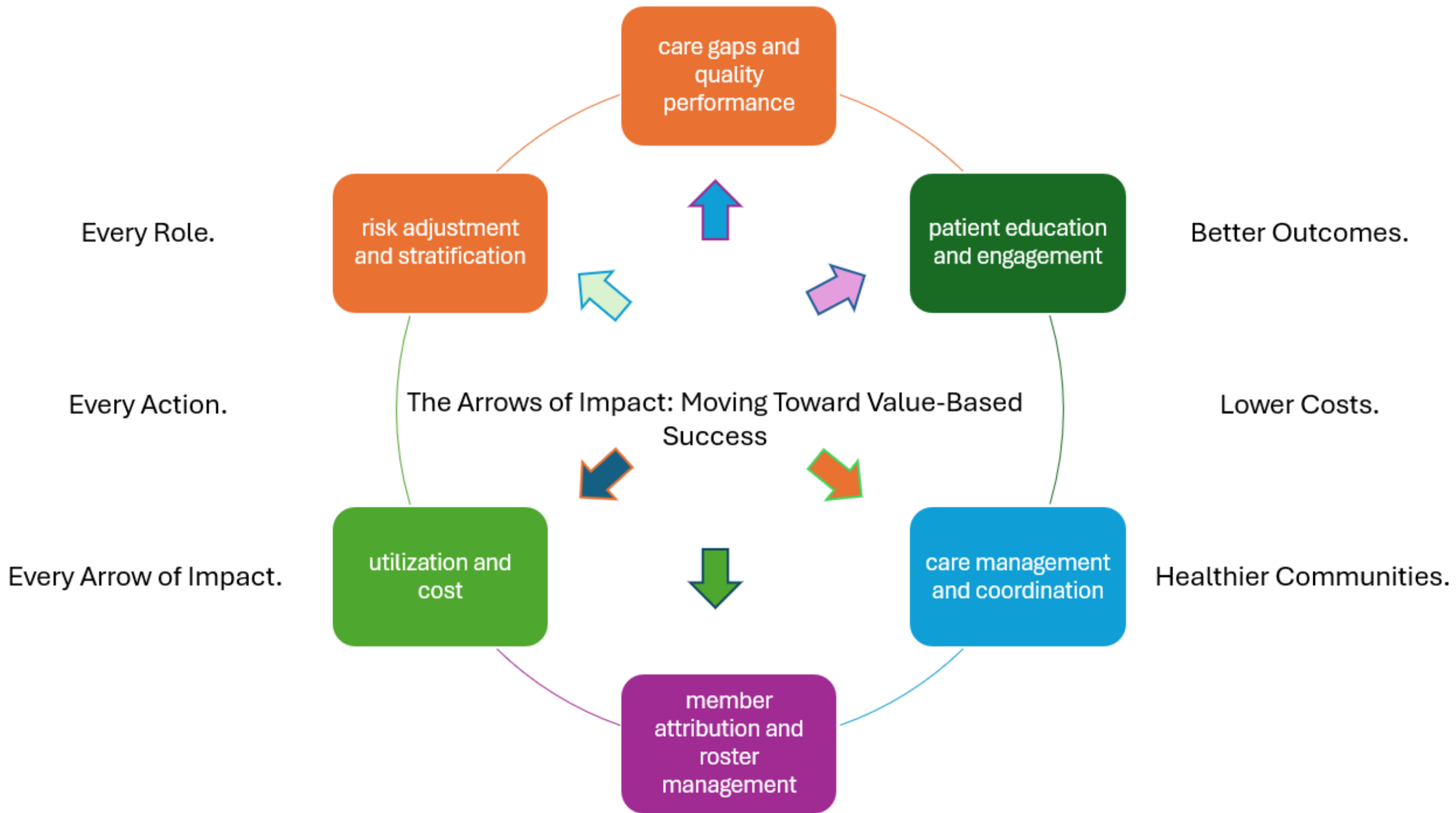


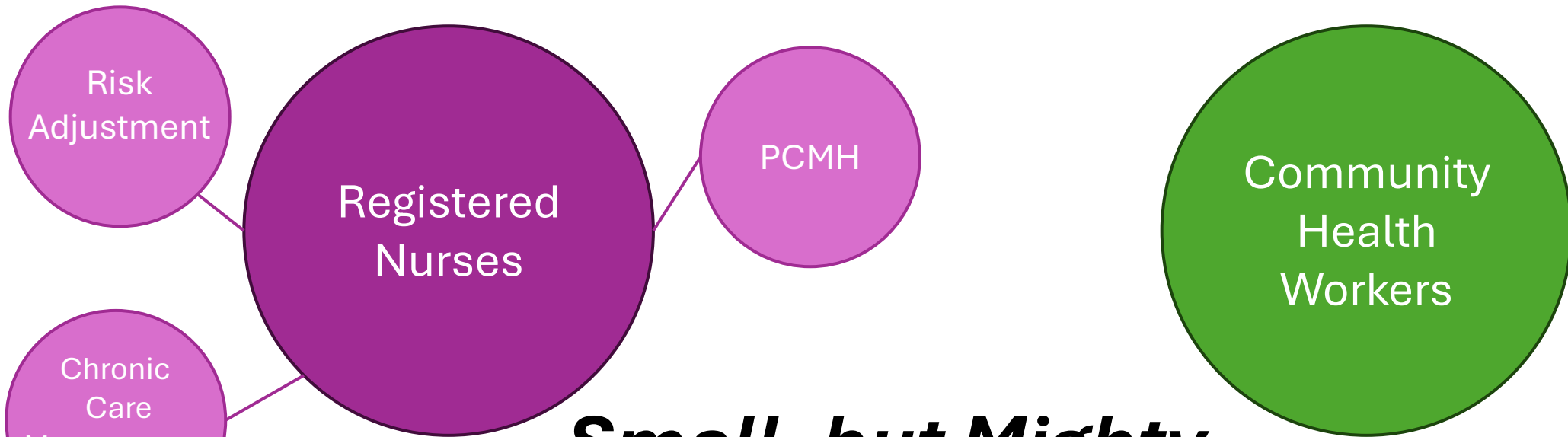
**20,000+ patients**



**Primary Care, OB, Dental,  
Chiro, Behavioral Health,  
& Pharmacy**

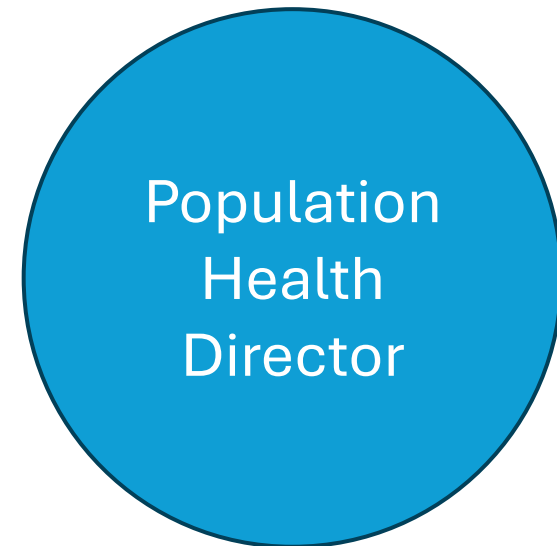






***Small, but Mighty***

# **Population Health Team**



# Meet Brittany



**Key Strengths:** Kindness,  
Forgiveness, Love,  
Spirituality, Gratitude



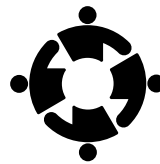
Former ER Nurse;  
current CCM Nurse



High intrinsic motivation



Very competitive, Type A



Active in the community



Give her a list and she  
will knock it out!

# Patient Visit Planning - PVP



Useful for morning huddles, identifying patient needs and planning next steps.



See all of the patients scheduled each day – strategically identify opportunities.

**Patient Visit Planning (PVP)** ⓘ  
PVP 🔒 PVPVIEW

DATE RANGE: 03/11/2026-03/11/2026 📅  
RENDERING PROVIDERS: All Rendering Provid... ▾

A	B	C	D	E	F	G	H	I
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⬇️ ▾ Augustine, Greg

⬇️ ▾ Black, Ronda

⬇️ ▾ Bridgewater, Bill

⬇️ ▾ Crowley, Patrick

⬇️ ▾ Decelles, Larry

⬇️ ▾ Doe, Jane

# Chronic Care Management - Registered Nurse

8:18 AM Wednesday, March 11, 2026

Visit Reason: **Mental Health and Counseling No Show**

<b>Wesolick, Ashanti</b> <span>PNP</span> MRN: 1103912 DOB: 11/15/1999 (26)	<b>Sex at Birth:</b> F (She/Her/Hers) <b>GI:</b> Female <b>SO:</b> Choose not to disclose	<b>Phone:</b> 857-478-4536 <b>Lang:</b> German <b>Risk:</b> Low (20)	<b>Portal Access:</b> 04/08/2025 <b>Cohort:</b> At Risk Patients - DM & HTN, Diabetes Aduti List 2026	<b>PCP:</b> Doe, Jane <b>Payer:</b> Medicare <b>CM:</b> Paula Silvia
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DIAGNOSES (6)		
ASCVD	Cancer	CP
DM I or II	HIV	HTN-E

RISK FACTORS (3)		
ANTICOAG	Chronic Opioid Tx	TOB

SDOH (13)		
CLOTHING	EDU	EMPLOYMENT
FOOD	FPL<200%	HISP/LAT
HOUSING	LANGUAGE	MATERIAL-SECURITY
MIGRANT	RACE	RENT/MORTGAGE
TRANSPORT-MED		

ALERT	MESSAGE	DATE	RESULT
Pap HPV	Missing		Demo Data

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Ga			
Ga			

Uses PVP to identify potential candidates for chronic care management.

Looks at the alerts, diagnoses, and risk factors.

Engages patients when they visit with the provider that day to share about the program & enroll them.

# Patient's Story

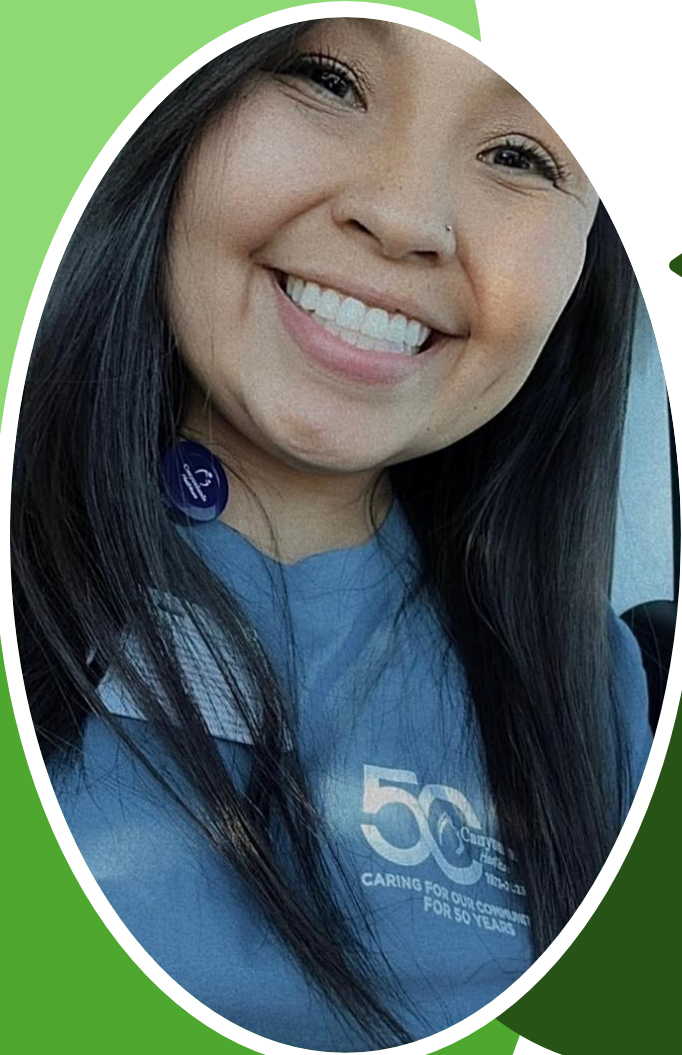
In the months leading up to CCM enrollment, our first CCM patient was **in the ER every 1.5 days**.

So many things contributing to this including poor medication management, loneliness, schizophrenia, no familial support, or transportation.

Upon enrolling in CCM, this patient went **42 days without an ER visit**.



# Meet Toni



**Key Strengths: Fairness,  
Prudence, Teamwork,  
Honesty, Kindness**



Shy



Wants to remain anonymous  
& behind the scenes



Prefers phone calls over in  
person interactions



Calm & compassionate



No stranger to life's challenges

FILTERS: 2025 CCS - Cervical Cancer Screening

**PAYER REPORTED SCORE**

# 39.08%

OPPORTUNITY +2.92%

**LEGEND**

**MEASURE COMPLIANCE**

- Compliant
- Non-Compliant (Gap)

**COMPLIANCE**

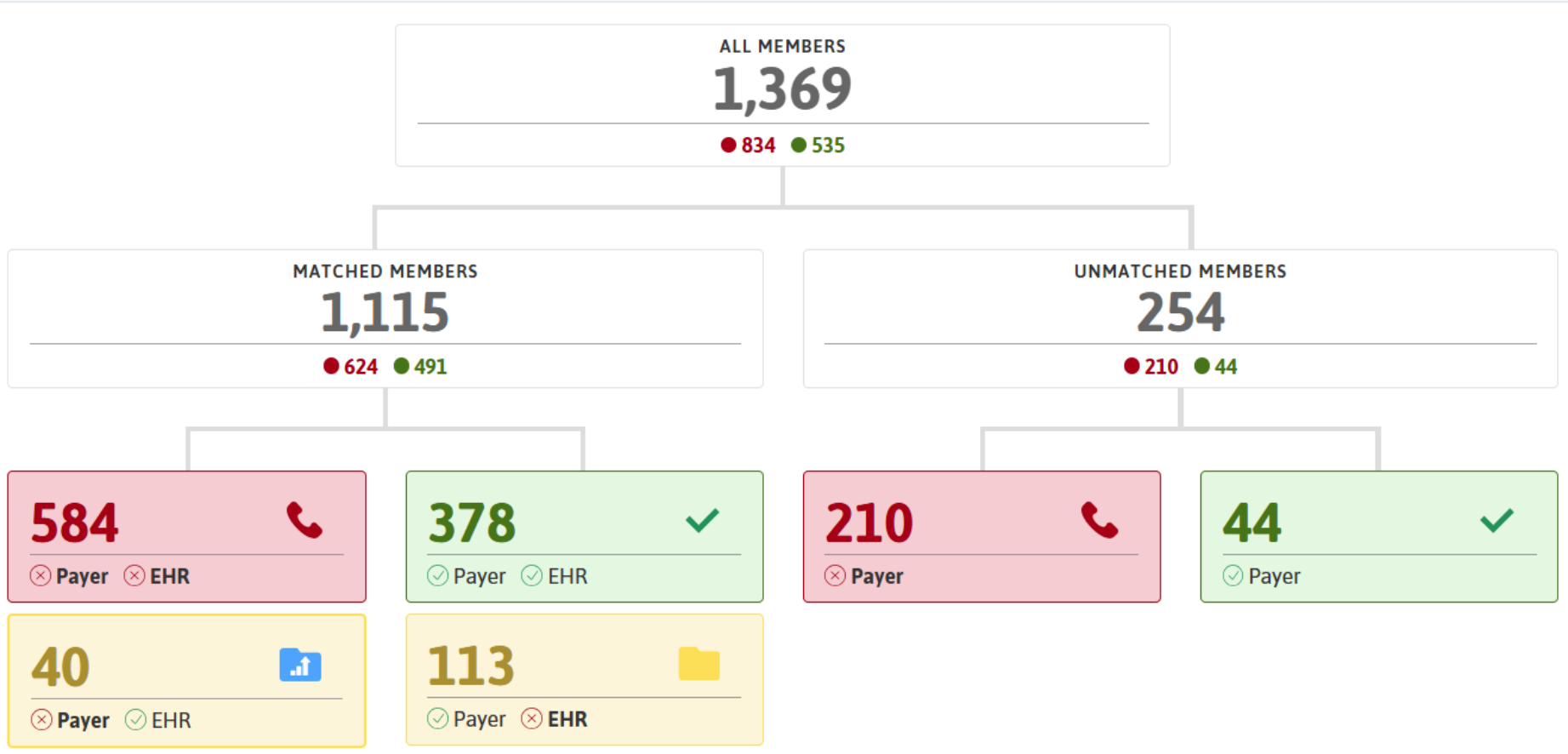
- Non-Compliant (Gap)
- Data Reconciliation
- Compliant

**ACTION REQUIRED**

- Data Reconciliation
- Member Outreach
- No Action

**DISPLAY**

SHOW DETAILS Disabled Enabled



Last Received 1/7/2026

**Contributing to the team behind the scenes**

FILTERS: 2025 CCS - Cervical Cancer Screening

PAYER REPORTED SCORE

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LEGEND

MEASURE COMPLIANCE

- Compliant
- Non-Compliant (Gap)

COMPLIANCE

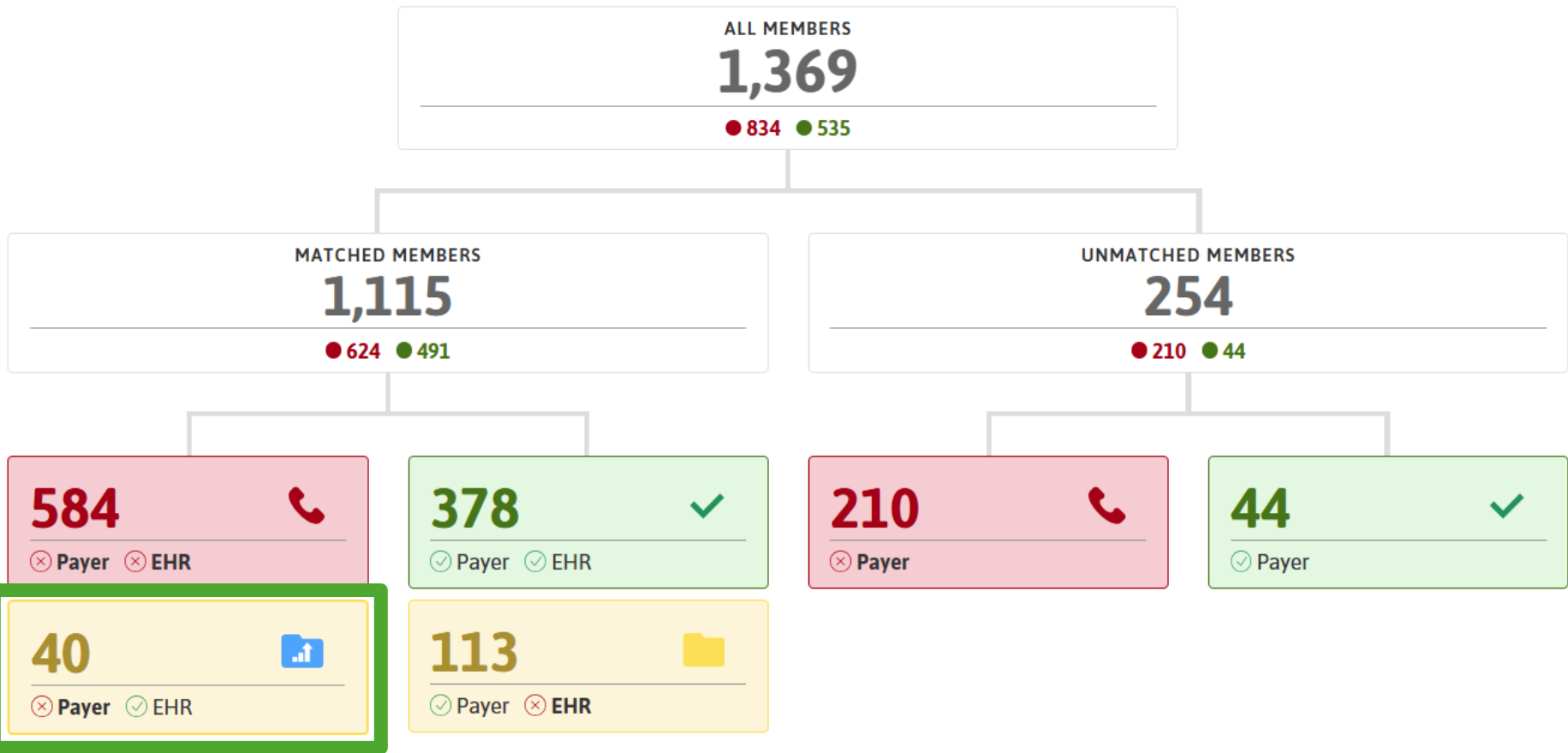
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ACTION REQUIRED

- Data Reconciliation
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- No Action

DISPLAY

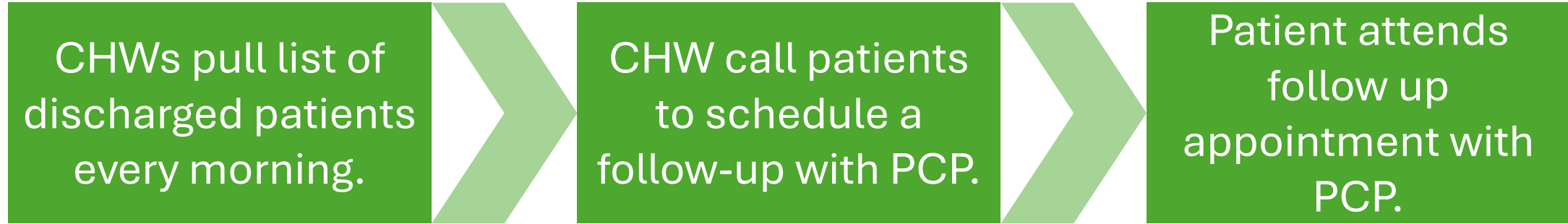
SHOW DETAILS Disabled Enabled



Last Received 1/7/2026

Toni uses the Care Gap Reconciliation report to submit supplemental data. Her work led to a **40% improvement** in open care gaps in 2025.

# Transition of Care Workflow



Transitions of Care (TOC) - ED/IP REPORT FILTER 2

FILTERS: 03/16/2025-03/16/2026 Discharge

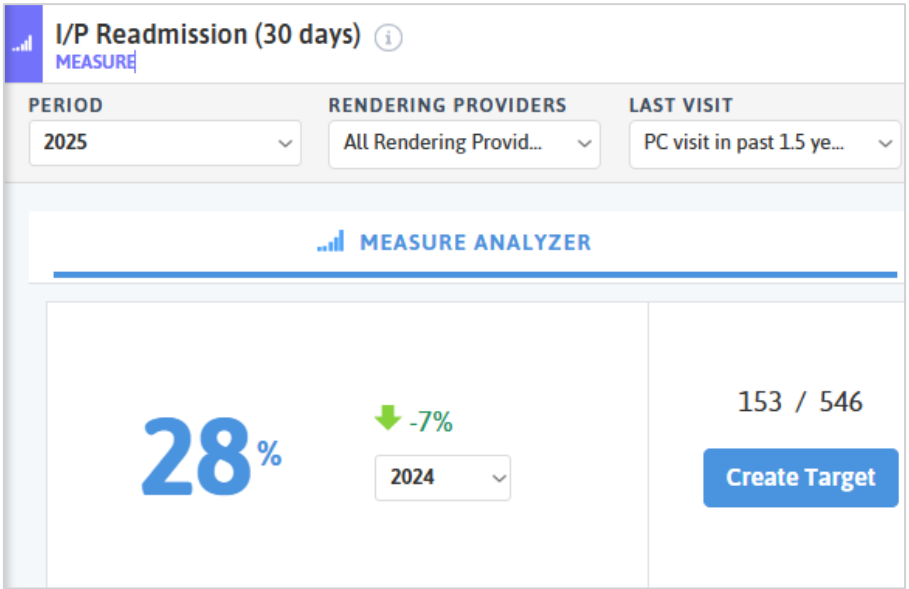
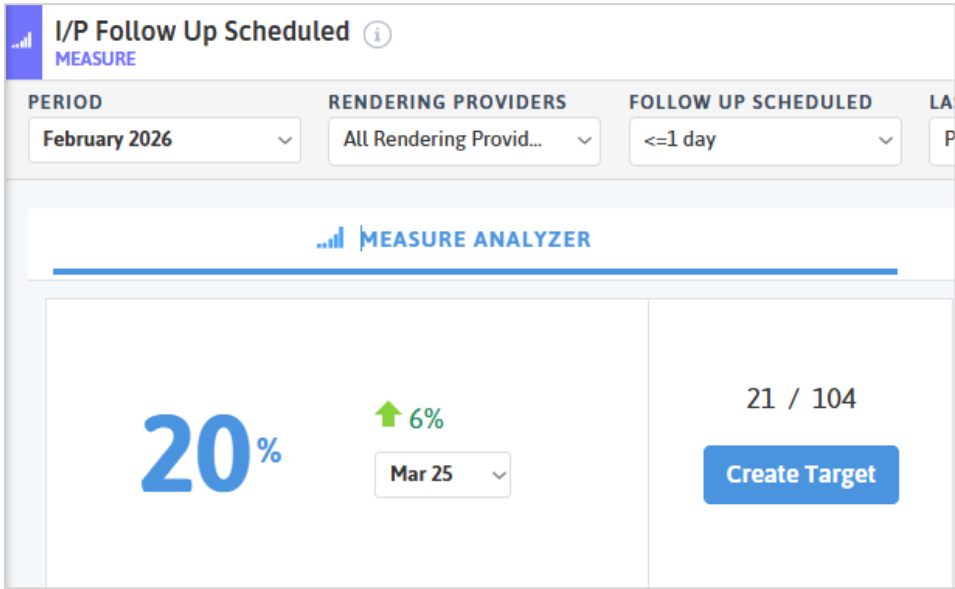
REPORTS

VALUE SETS

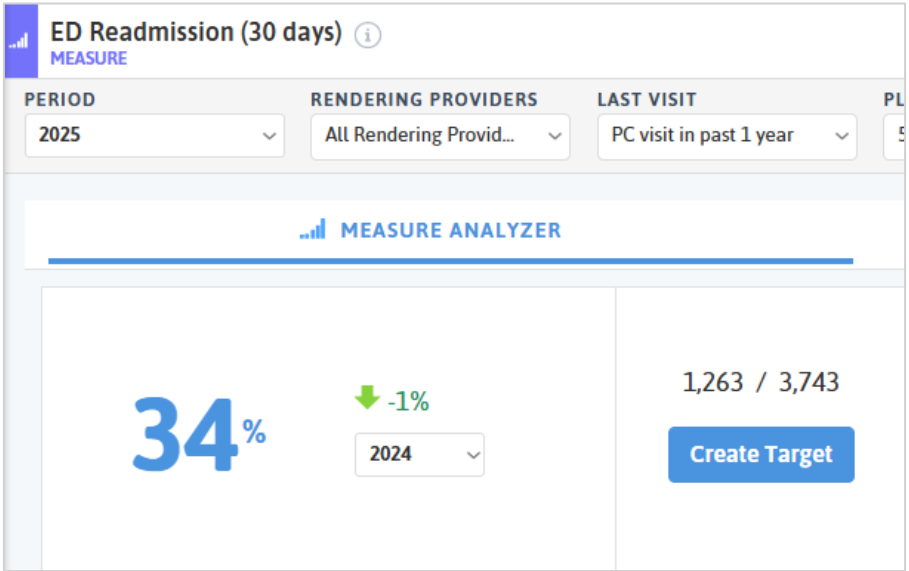
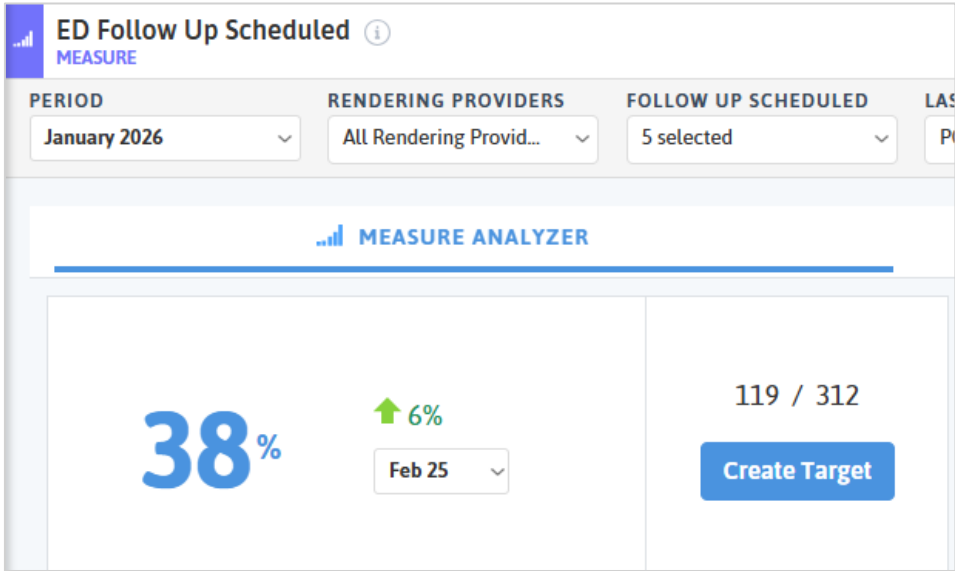
Search ... NEXT APPT All No Appt Upcoming Appt SAVED COLUMNS

DEMOGRAPHICS >					ADMISSION EVENT					
NAME	MRN	DATE OF BIRTH	PATIENT (Y/N)	INACTIVE	TYPE	ADMISSION ↓	DISCHARGE	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6
Stieg, Chester	1103147	6/5/1946	Y	N	ER Visit	3/13/26 9:03 am	3/13/26 11:33 am	Sacred Heart Hospital	1	
Cable, Jeffery	1102376	11/8/1977	Y	N	ER Visit	3/12/26 9:48 am	3/12/26 4:33 pm	St. Marys Hospital	1	
Neubacher, Garfield	1100766	9/15/1972	Y	N	ER Visit	3/12/26 8:03 am	3/12/26 10:18 am	Burlington General Hospital	1	
Tabian, Jeffery	1102457	3/8/2009	Y	N	Inpatient Stay	3/9/26 8:18 am	3/12/26 8:33 pm	St. Josephs Hospital	0	
Logrono, Timothy	1103248	5/20/1973	Y	N	Inpatient Stay	3/9/26 4:18 am	3/13/26 2:18 pm	Burlington General Hospital	0	
Cheaney, Benny	1101309	4/18/1980	Y	N	Inpatient Stay	3/1/26 3:33 am	3/7/26 5:18 pm	Trinity Hospital	0	
Anagnost, Ollie	1101388	3/1/1999	Y	N	ER Visit	2/28/26 10:18 am	2/28/26 5:18 pm	Sacred Heart Hospital	1	
Dori, Auzenne	1101102	5/29/1998	Y	N	ER Visit	2/28/26 10:03 am	2/28/26 2:33 pm	Burlington General Hospital	1	
Serafine, Adrian	1100785	11/24/1978	Y	N	ER Visit	2/28/26 10:03 am	2/28/26 2:18 pm	St. Marys Hospital	1	

Demo Data



Met goals for Hospital Follow Up and Readmission value-based measures!



# Meet Ellee



**Key Strengths:** Kindness, Love, Fairness, Judgement, Appreciation of Excellence and Beauty



Motivated to do well



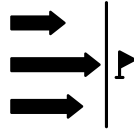
Peer leadership skills



Experienced in varying types of CHW work



Understands complex patients & their struggles



Competitive & persistent

# Care Management Passport



**06:03 AM** Friday, March 20, 2026 **PROVIDER:** Augustine, Greg **VISIT REASON:** Canceled

<b>Mangrum, Demetrius</b> MRN: 1102152 DOB: 1/1/2005 (21)	<b>Sex at Birth:</b> M <b>GI:</b> Male <b>SO:</b> Don't know	<b>Phone:</b> (857) 860-5079 <b>Language:</b> English <b>Risk:</b> Low (29)	<b>Last Phys:</b> 12/24/2024 <b>Portal Access:</b> Y	<b>PCP:</b> Doe, Jane <b>Payer:</b> Aetna <b>CM:</b> Chris Ryan	<b>Demo Data</b>
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Assessments (Last 10 of 20)			
CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
R05	Cough	6/17/26	2
Z30.019	Encounter for initial prescription of contraceptives, unspecified	6/17/26	1
R06.03	Acute respiratory distress	6/17/26	1
307.80	Psychogenic pain, site unspecified	6/17/26	1

Active Problems (Last 10 of 18)		
CODE	DESCRIPTION	MOST RECENT
Z59.1	Inadequate housing	6/17/26
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease	6/17/26
R50.9	Fever, unspecified	6/17/26
J06.0	Acute laryngopharyngitis	6/17/26

Gives staff a holistic picture of each patient and their history

# CMP - Generate Summary

1. Brand new addition
2. Gives AI Generated summary
3. Lists actionable steps for the staff

## Smart Summary

This is a 30-year-old transgender male patient with multiple chronic conditions including hypertension, diabetes, COPD, HIV, and a history of stroke and mental health disorders.

1. The patient has a history of severe mental illness, illicit drug use disorder, and tobacco use, with a recent behavioral health encounter in Sep 2025 and multiple missed mental health appointments.
2. Recent labs show **elevated A1c at 9.9** (Jun 2024), indicating poorly controlled diabetes; blood pressure readings have been variable but recent systolic is 108 and diastolic 89 (Sep 2025).
3. There are multiple hospitalizations including an inpatient stay in Feb 2026 for vomiting and prior stays for psychiatric and respiratory issues.
4. The patient has several open referrals for radiology, acupuncture, nutritionist, and allergist with appointments scheduled in Oct 2025 and beyond.
5. There is a significant history of missed appointments across various service lines including primary care, mental health, and injury visits, with no appointments scheduled for today or the near future.

### Today's Recommended Action Items

1. Reach out to the patient to reschedule missed appointments, especially for mental health and chronic disease management, to improve care engagement.
2. Coordinate with care team to address diabetes management urgently given the elevated A1c and ensure blood pressure control is optimized.
3. Review and update social determinants of health support, focusing on housing instability and poverty, to assist with care adherence and overall health outcomes.

*AI-generated content — please review for accuracy*

03:18 AM Monday, March 10, 2026

PROVIDER: Augustine, Greg VISIT REASON: No Show

Stober, Eliana

Sex at Birth: F

Phone: (781) 679-3038

Last Phys: 9/8/2025

PCP: Black, Ronda

MRN: 1101627

GI: Female

Language: English

Portal Access: 05/25/2024

Payer: Coventry

DOB: 10/4/1995 (30)

SO: Straight (not lesbian or gay)

Risk: Low (24)

Cohorts: Diabetes Aduti List 2026

CM: Chris Ryan

Gest Wks: 29\_0

Demo Data

# Patient's Story

“Patient A” started out with **every alert** you can imagine on their CMP.

Ellee kept **building a relationship** with the patient for months and months.

One visit, when she looked at the CMP, she saw showed no alerts open, but the more important story was the **bond she had created with the patient.**



# Conclusion



**Align team strengths** with workflows and technology.



**Celebrate wins** for patients, staff, and health center.

# Azara at the Network Level

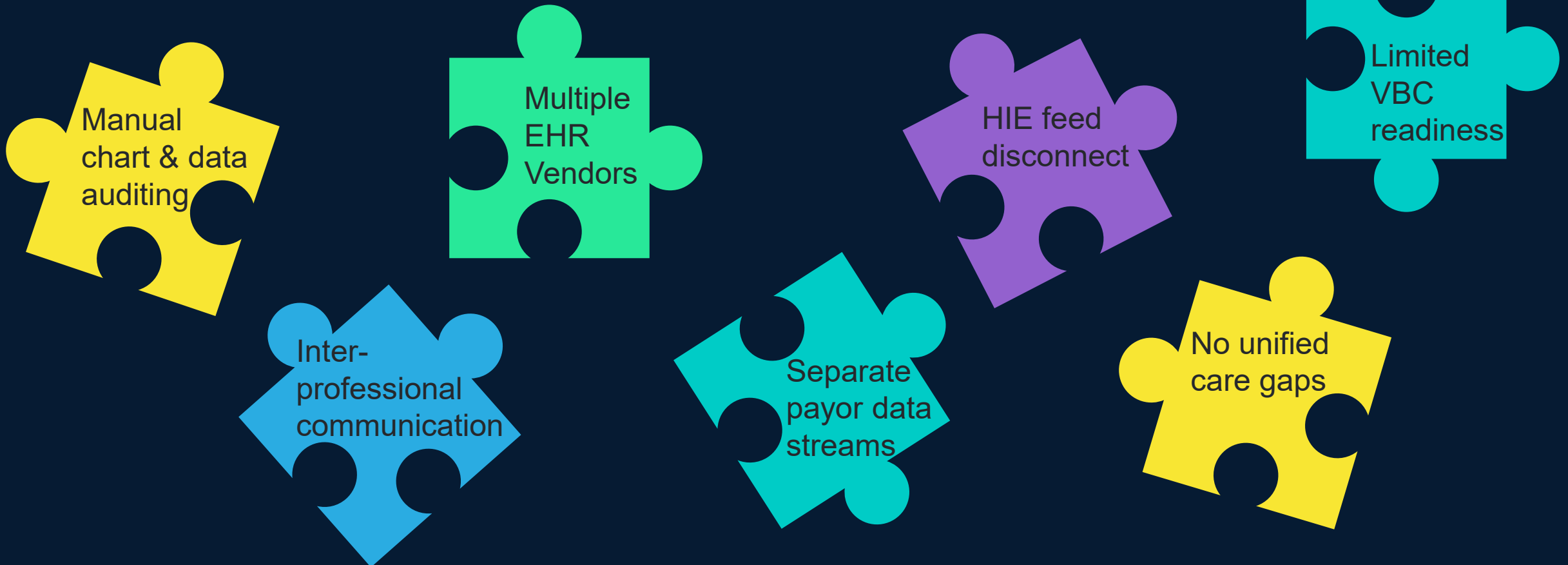
Less Guesswork, More Groundwork



# The Network Before DRVS (pre-2017)

15

## Fragmented Data Environment

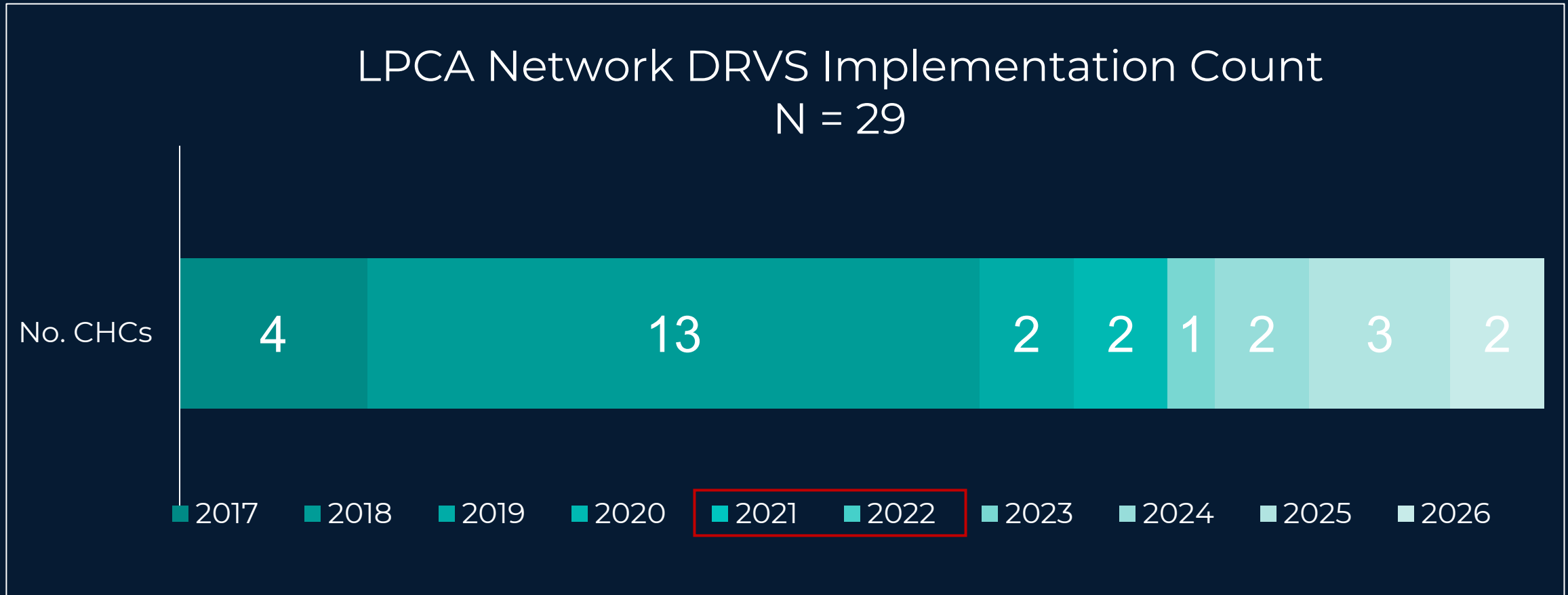




# The Growth (est. 2017 – present)

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Multi-vendor alignment achieved





Net  
Mo

stem

15



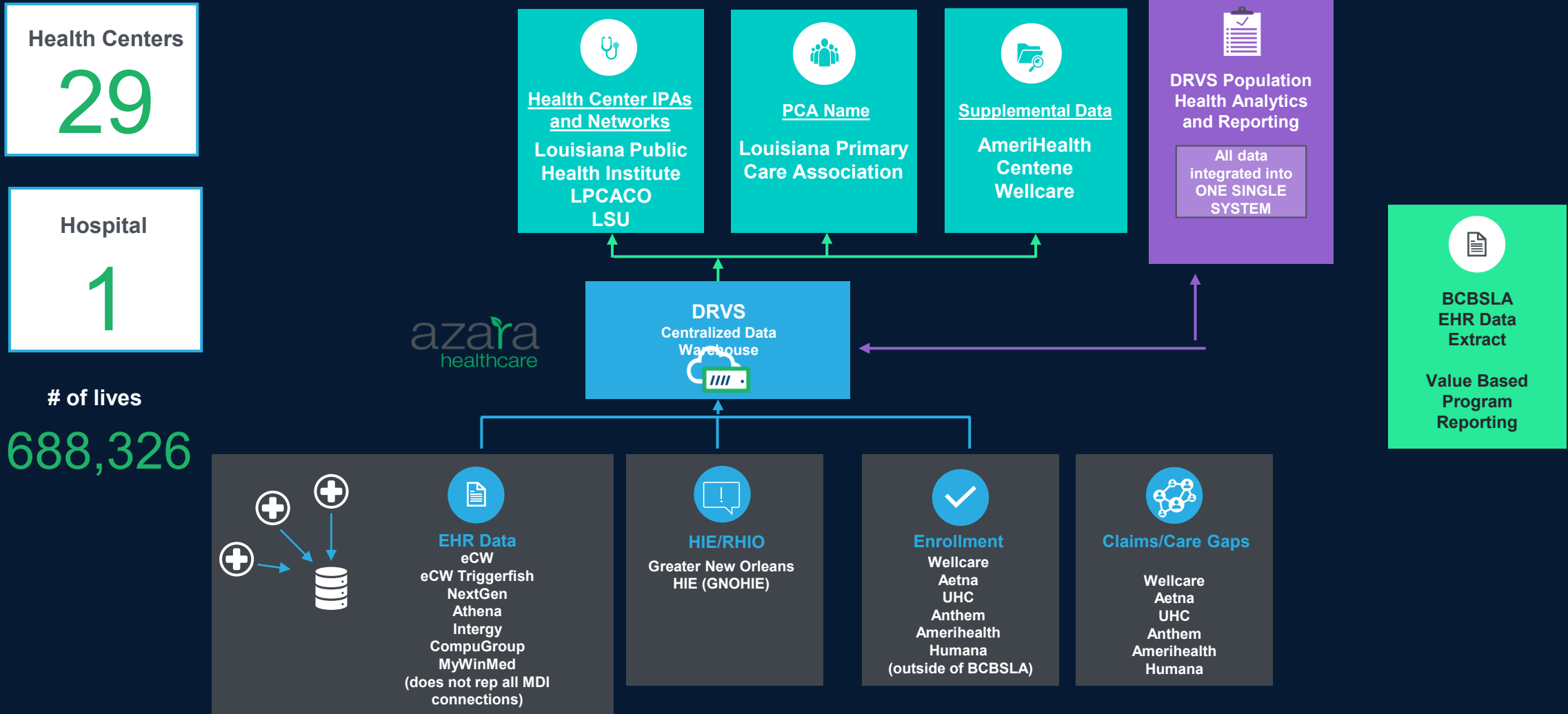
azara USER

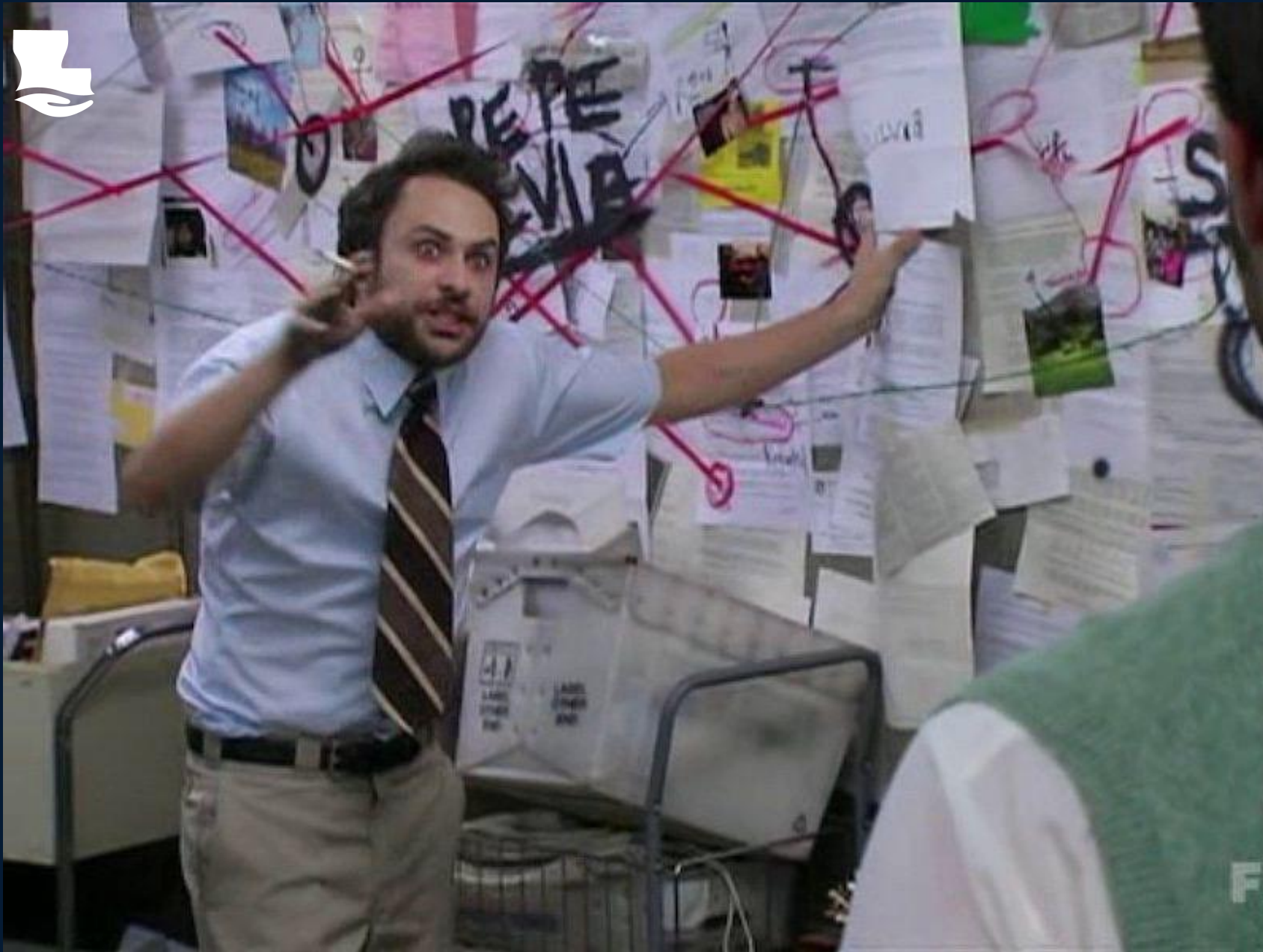




# Network-Level Data Ecosystem Model

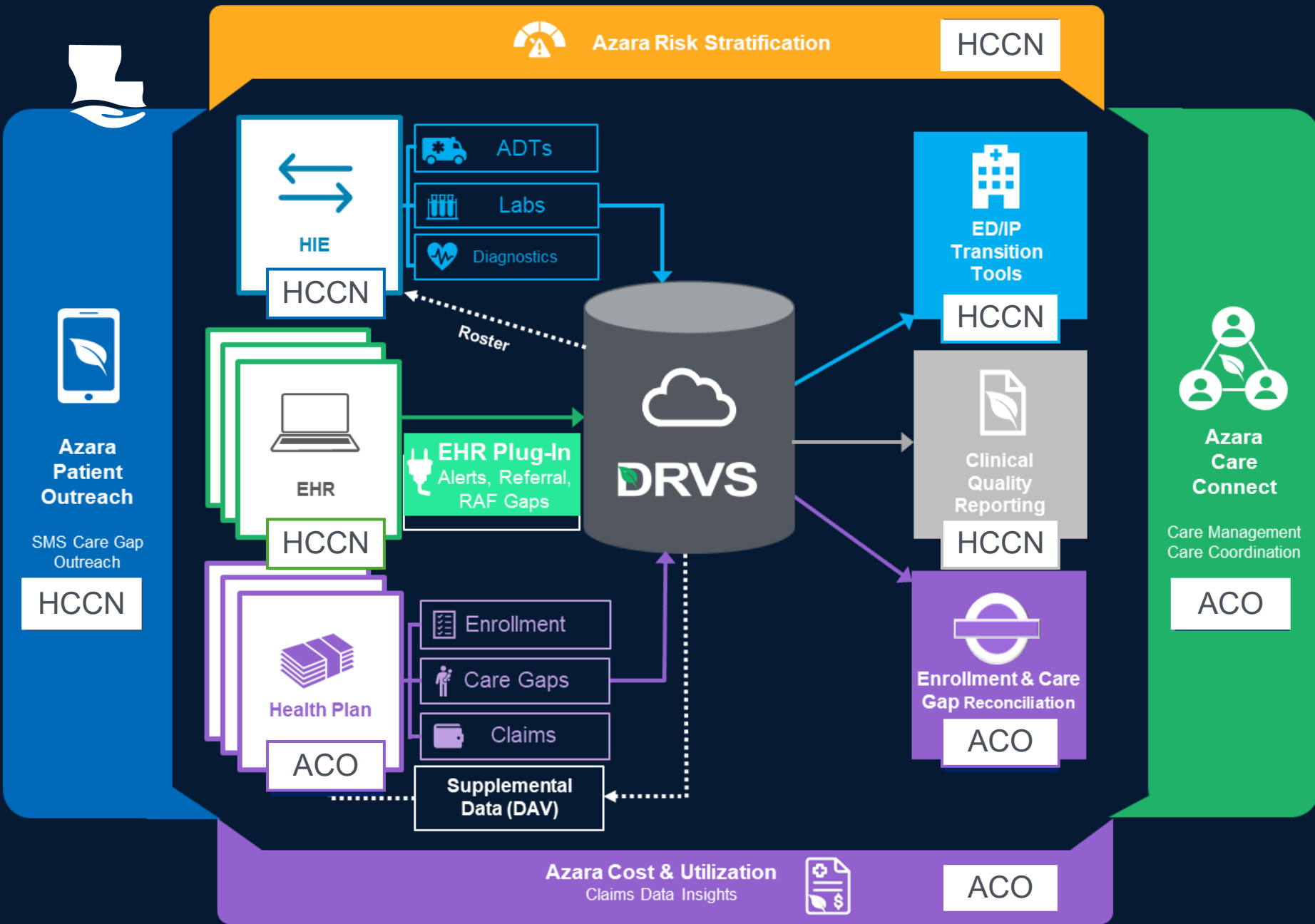
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# “Cross Divisional” Network- Level Data Ecosystem Model





“Cross Divisional” Network-Level Data Ecosystem Model





HCCN Support / Lead

Azara DRVS

EHR Plug In

Obstetrics / Maternal Care

Upstream

Patient Surveys

15

Referral Management

FinOps

Controlled Substance

Azara Patient Outreach

SDOH

Dental

Hep C & HIV

LPCACO Support / Lead

Value Based Care Reporting

Risk Stratification

Azara Care Connect

Transitions of Care

Azara Cost Utilization (ACU)

Team approach to supporting DRVS





# Partnership Infrastructure

Gearing up to “DRV” Azara across Louisiana





# Cross-Vendor EHR Alignment

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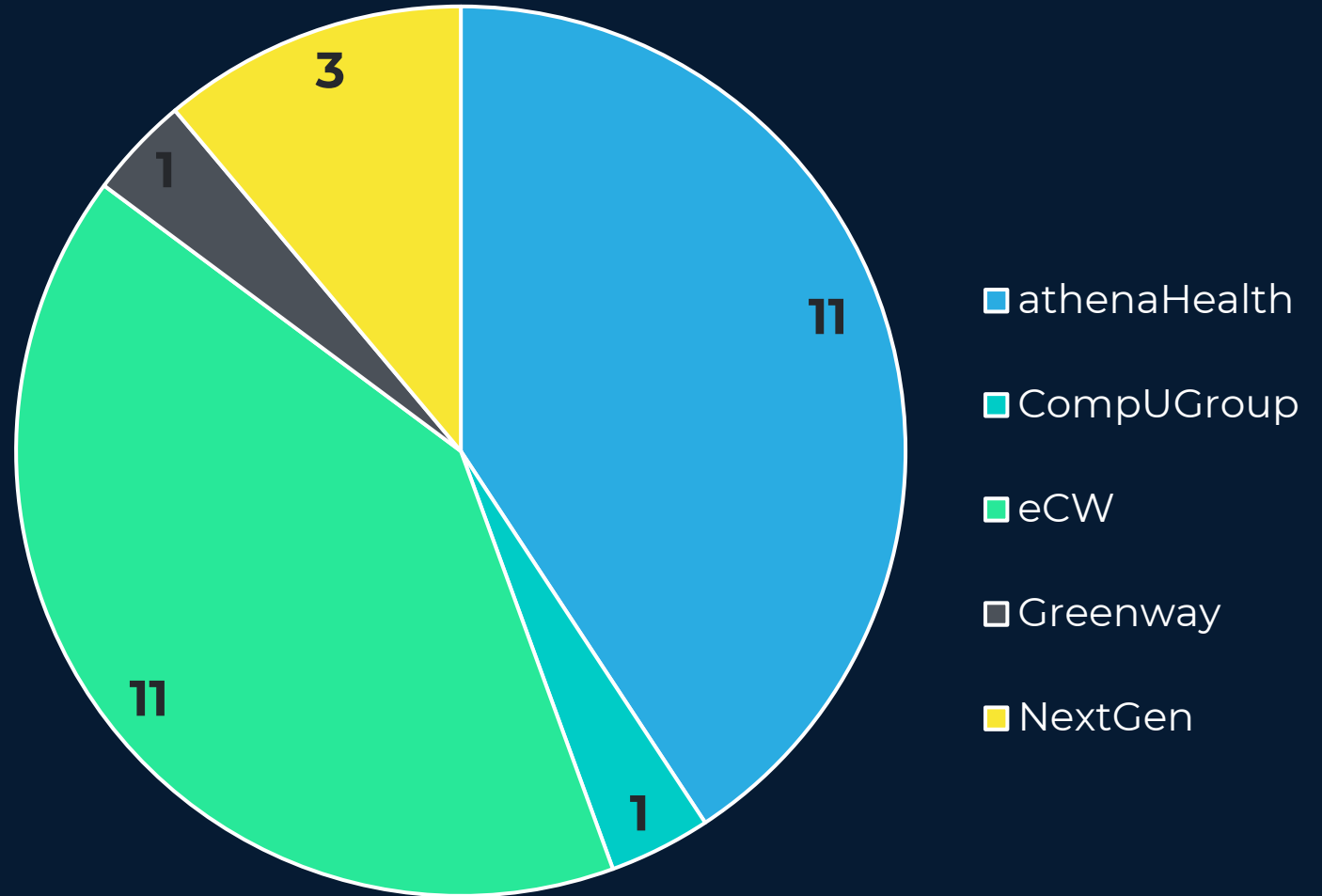
## EHR Vendors Integrated:

26/41 = 63%

Network on DRVS

## Top EHR Vendors

- athenaHealth
- eCW





# Cross-Vendor EHR Alignment

## Network-Level Support:



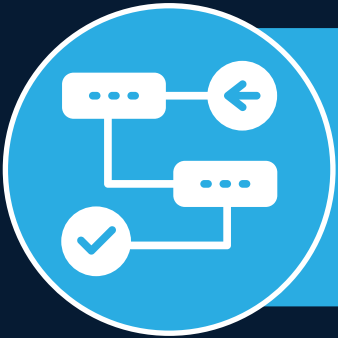
### Standardized measure mapping

EHR Specific Roundtable  
EMR-specific DRVS Dashboards



### Template-based mapping playbooks

Similar workflow to DRVS Implementation Workbook



### Data validation workflows

Validation Workbook



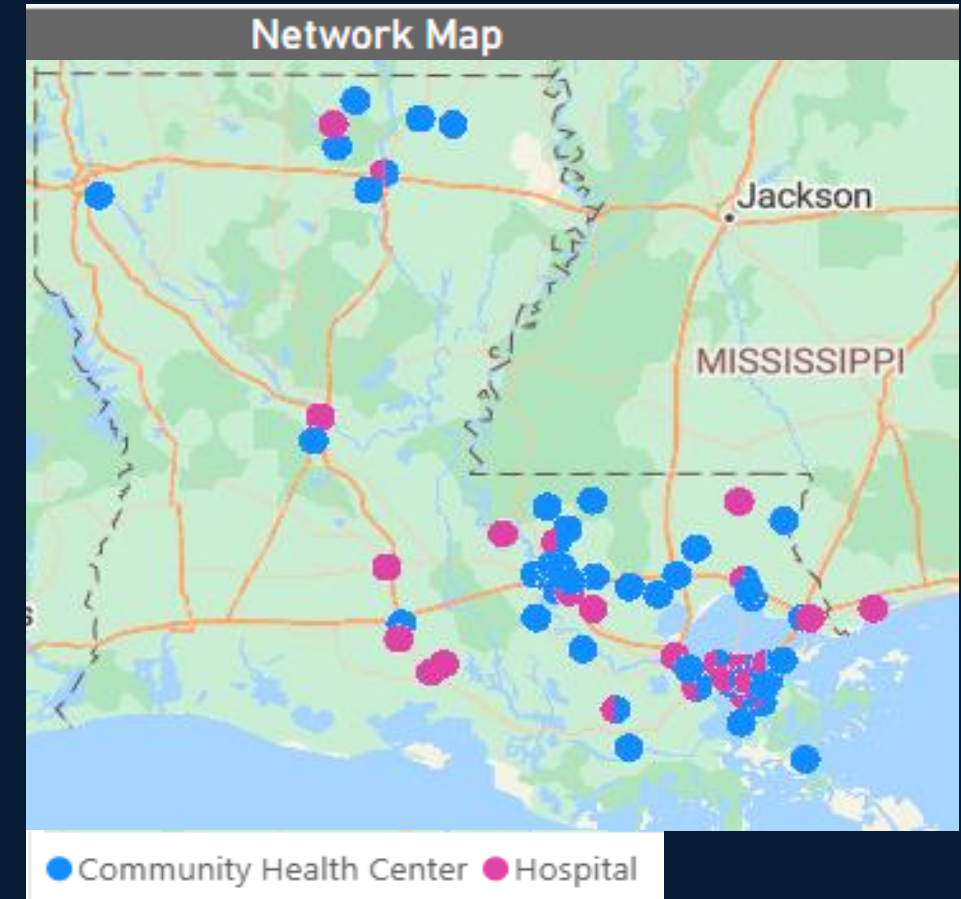
### Pre-UDS review processes

Measure of the month



# Strategic Partnerships That Power the Ecosystem

- **HIE integration** through LPHI
- Receive **daily ED/IP notifications**
- Includes **diagnosis-level details** for care management



# Strategic Partnerships That Power the Ecosystem

## Insurance Payer Plans

- ACO Contract Participation Crosswalk
- HEDIS Measure Crosswalk across multiple contracts
- 9 → 17 contracts
- > 24 measures

LPCACO, LLC MY 2026 VBCs / VBAs
MSSP (Medicare)
Wellcare (Medicare Adv.)
AmeriHealth Caritas (Medicaid)
Aetna (Medicaid)
<b>Aetna (Medicare Adv.)* new for 2026</b>
Healthy Blue ICCM (Medicaid)
<b>LA Blue - Stellar Health (Med. Adv)* new for 2026</b>
<b>LA Blue - Stellar Health (Com. / ACA)* new for 2026</b>
<b>LA Healthcare Connections - COC Form (Medicaid) * new for 2026</b>
<b>LA Healthcare Connections - EQH (Medicaid) * new for 2026</b>
<b>UHC - EQH (Medicaid) *+ new for 2026, pending 2026 MCO status</b>





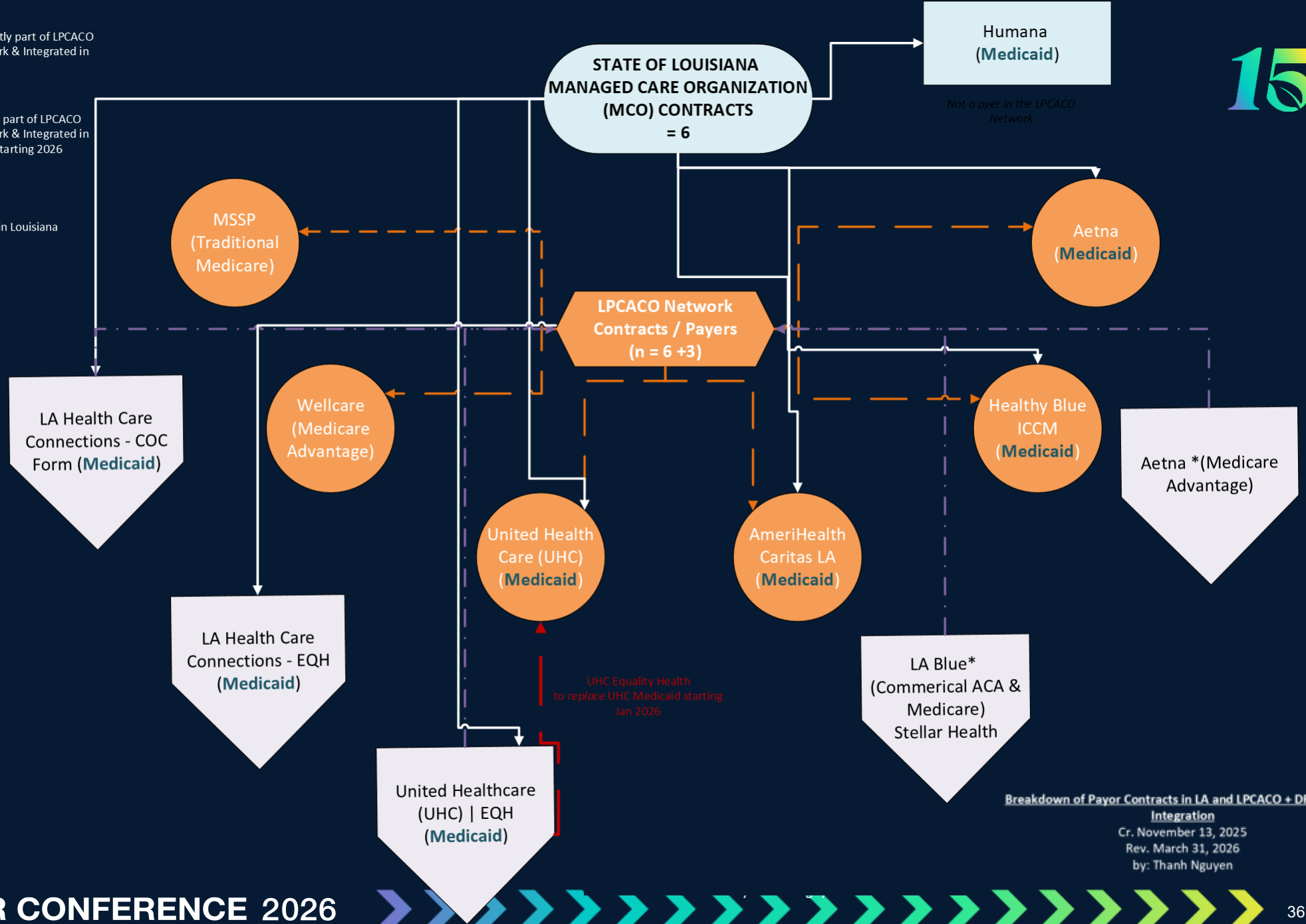
Currently part of LPCACO Network & Integrated in DRVS



Will be part of LPCACO Network & Integrated in DRVS starting 2026



(MEDICAID) MCOs in Louisiana



**Breakdown of Payor Contracts in LA and LPCACO + DRVS Payer Integration**  
 Cr. November 13, 2025  
 Rev. March 31, 2026  
 by: Thanh Nguyen

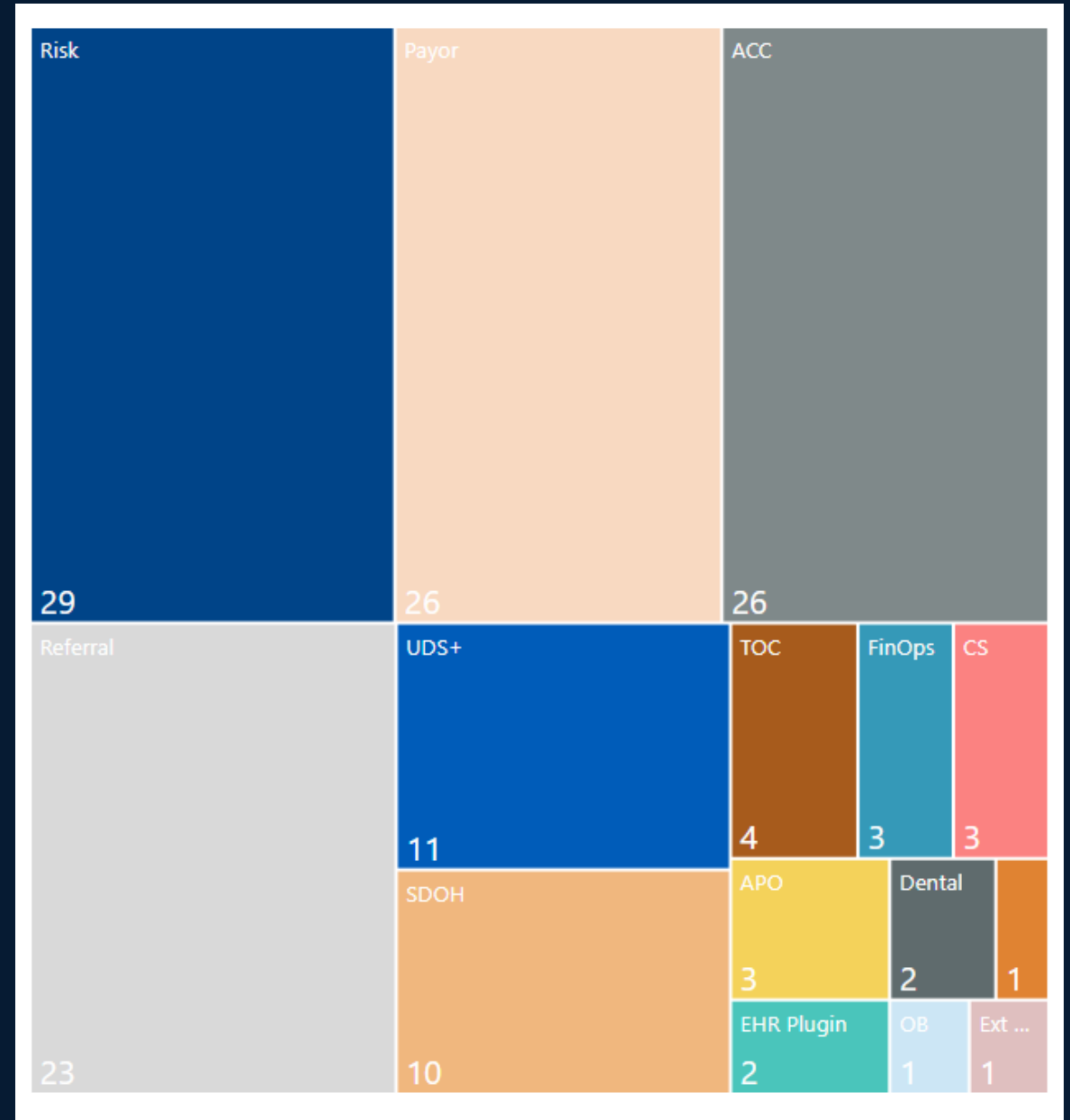




# Strategic Partnerships Use Case

## Crosswalk Development:

- CQMs across multiple projects (i.e., Measure Matrix – UDS, PCA, HCCN, NCQA, AHA/AMA, etc.)
- Center Grants
  - H80
  - LAL
  - Statewide Initiatives
  - HPSA
  - HIV / AIDS
  - Education





# Operationalizing DRVS at Network Level

DRVing Azara Across LA





# Governance-Driven Data Strategy

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## Network Governance Components:

- HCCN Management Panel
- Data Governance Committee
- DRVS Super User / Data Champs
- SME Networks
- Vendor touchpoints
- Quarterly iPWP reviews

## Outcomes:

- Elevated analytic literacy
- Shared accountability
- Reduced duplication
- Bi-directional communication feeds between Network and health center staff





# TA Infrastructure

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## LPCA Network Support Model

- Individualized Health Center Workplans
- One-on-One Mapping Sessions
- UDS Readiness Reviews
- Measure Validation Walkthroughs
- Enrollment Reconciliation
- Claims Gap Reconciliation

## Support Mechanisms

- TA Calendar
- Smartsheet TA tracker
- Formal evaluations
- Ad hoc qualitative feedback
- Continuous QI loops & PDSAs
- myLPCA Resources Page
- Mailchimp Promos





# User Groups & Roundtables

15

**Purpose:** Move from tool usage  
→ to analytic ownership.



## Structure

- Vendor-specific EHR roundtables
- DRVS Roundtables
- Data Champs sessions (super users)
- SME peer-to-peer learning
- Feedback loops to vendors
- Hands-on learning labs



## Impact

- Shared solutions
- Reduced isolation
- Standardized workflows
- Increased DRVS adoption





# Data Hygiene as a Network Standard

## Stabilizing the System

### Current State:

- Questionable data integrity leads to unreliable patient information, making it difficult for care teams to trust and act on reported gaps in care.
- Inconsistent workflows and fragmented patient data.
- Staff turnover erodes DRVS expertise, creating gaps in data accuracy and workflow continuity.
- Frustration grows as staff spend extra time reconciling conflicting data instead of focusing on patient care.



### Actives and Outcomes:

- **Data Validation** - Faith in DRVS data and EHR correlation.
- **Documented Workflows** – Ensures accurate mapping, consistency and knowledge retention.
- **Data Dictionary** – Repository of mapped data for periodic baseline reference.
- **Cross Training** – Removes bottlenecks and single points of failure.
- **Executive Involvement** - Promotes tools are properly utilized and frustrations are valid operational concerns vs. Individual/institutional learning curves.



### Network Standardization Improves Success:

- Validated data using consistent methodologies improves:
- HCCN performance reporting.
- ACO quality scores.





# Sustainability Model

Three Pathways:

- Technical Infrastructure
- Governance & Oversight
- Workforce Development





# Team –Based Sustainability Infrastructure



## Three Supporting Teams:

- Clinical Staff (2)
- Operational Staff (2)
- Quality (2)





# Ensuring Success

## Commitment is Essential:

- Network-wide participation establishes **consistent data-quality practices** that support accurate HCCN reporting to HRSA and reliable ACO performance benchmarking. **Any gaps in participation weaken both goals.**
- Executive championing communicates **organizational priority** and ensures staff have the **protected time needed to carry out data-quality** work in resource-constrained FQHC settings.
- Board-level monitoring of DRVS usage **reinforces governance commitment** to HCCN objectives during HRSA site visits and positions the ACO for proactive, **continuous quality improvement** rather than reactive crisis response.





# Performance Alignment Roadmap

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Phase	Timeline	Activity	HCCN Objective	ACO Benefit
<b>Phase 1: Preparation</b>	Two Weeks	Program overview; executive commitments; staff designation; technical readiness	Governance engagement; workforce capacity building	Leadership accountability for quality performance
<b>Phase 2: Network Data Validation</b>	Four Weeks	EHR-to-DRVS mapping, standardized validation protocols; workflow documentation	Data Management & Analytics; UDS readiness; network-wide standardization	Accurate patient attribution; reliable ACO quality measure calculations
<b>Phase 3: HCCN Spring Learning</b>	Three Days	DRVS 101 fundamentals; Quality/Operations workshops	Workforce technical proficiency; interoperability foundations	Independent performance monitoring; reduced consultant dependency
<b>Phase 4: Local Hands-On Training</b>	One Week	Value-based care reporting; care coordination; risk; risk adjustment and recapture	Data-driven clinical decision support; care coordination optimization	Higher quality capture rates; expenditure reduction through proactive outreach





# Data in Action: Value-Based Care Through DRVS

VBC – now in cruise control





# From Data Aggregation to Clinical Action

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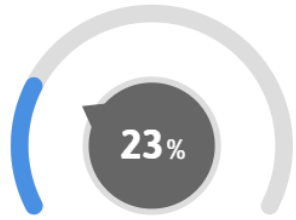
## DRVS Enables

- Clinical Quality Measure surveillance
- Risk stratification (RAF GAPS)
- Whole-person care analysis
- **SDOH integration**
- Pre-visit planning workflows + CMP
- Care team coordination (ACC/ACU)
- Measure investigation

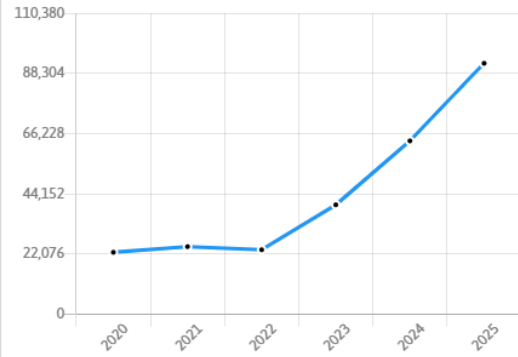


# Social Needs Assessed

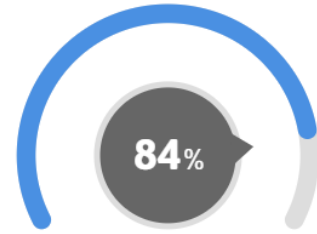
## Social Needs Assess



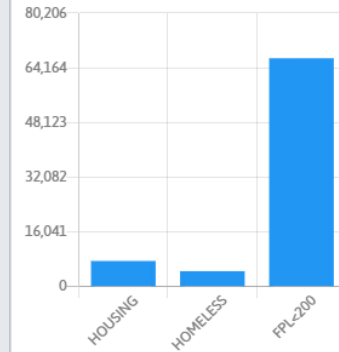
## Needs Assessed Tre



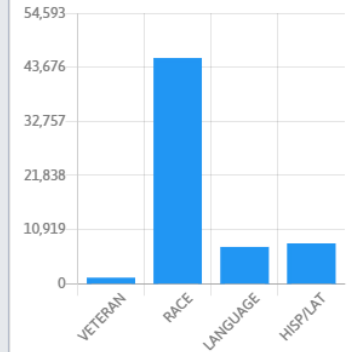
## Core Criteria Assess



## Housing & Incom



## Personal Characteristi



## >12 SDOH



## 8-12 SDOH



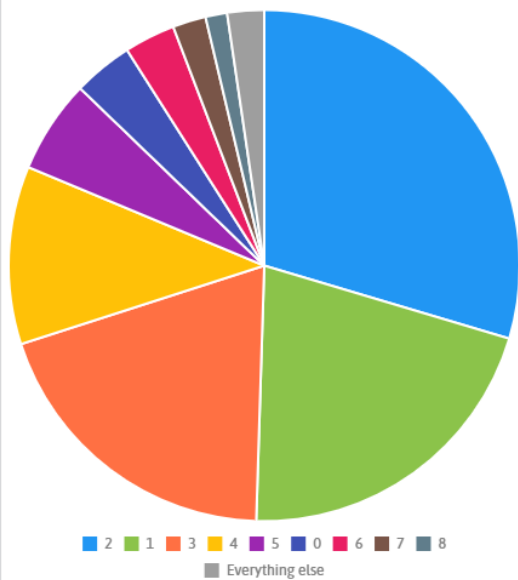
## 4-7 SDOH



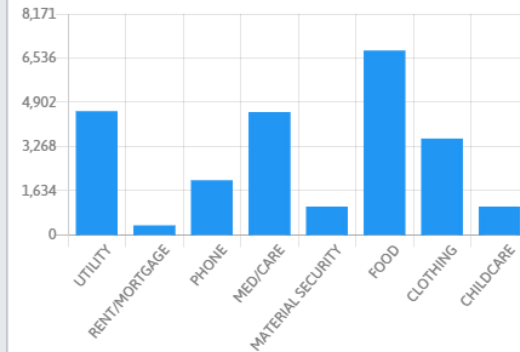
## <4 SDOH



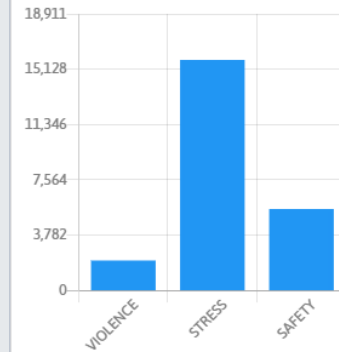
## SDOH Count Distributi



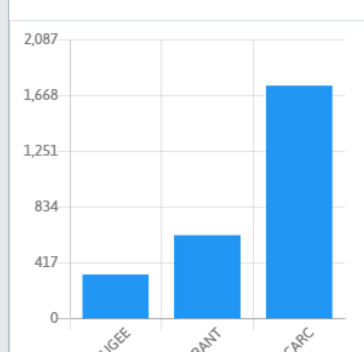
## Material Securit



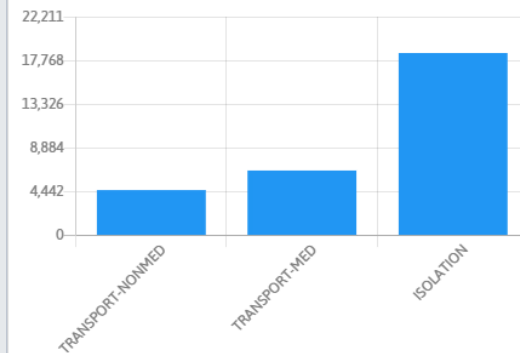
## Violence & Stre:



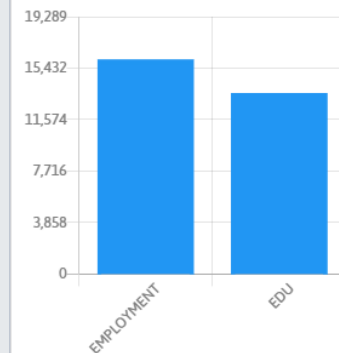
## Migrant-Incarc-Refugee (Situati



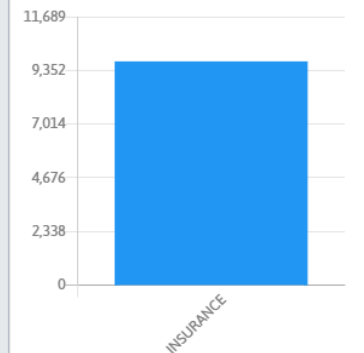
## Transportation & Isolati



## Education & Emplo



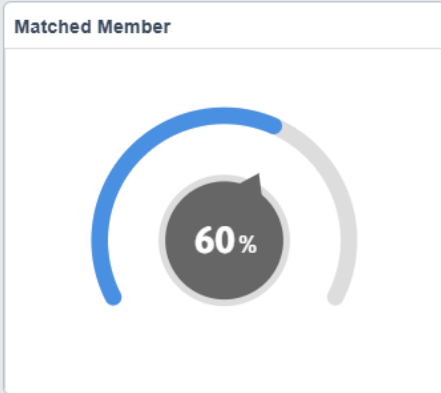
## Insuranc





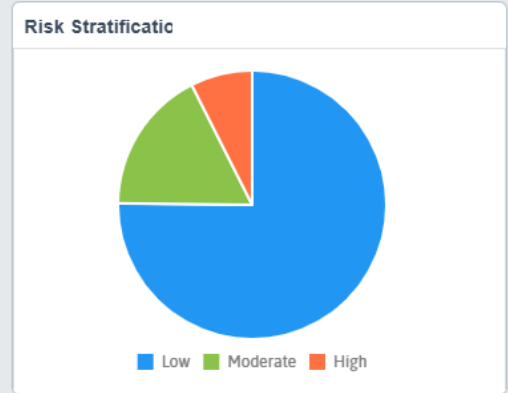
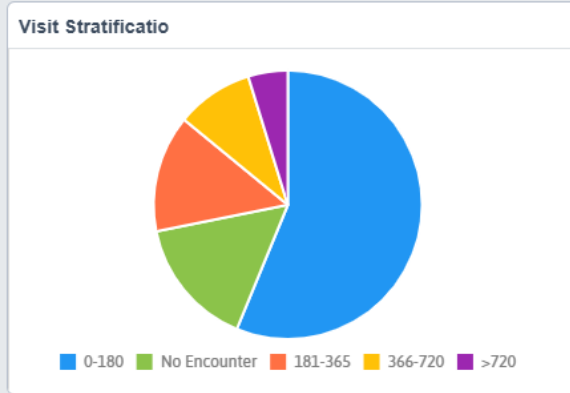
### Health Plan Enrollment

# Member:  
  
**67,974**



Unmatched Member  
  
**26,006**

Soft Matche  
  
**1,168**

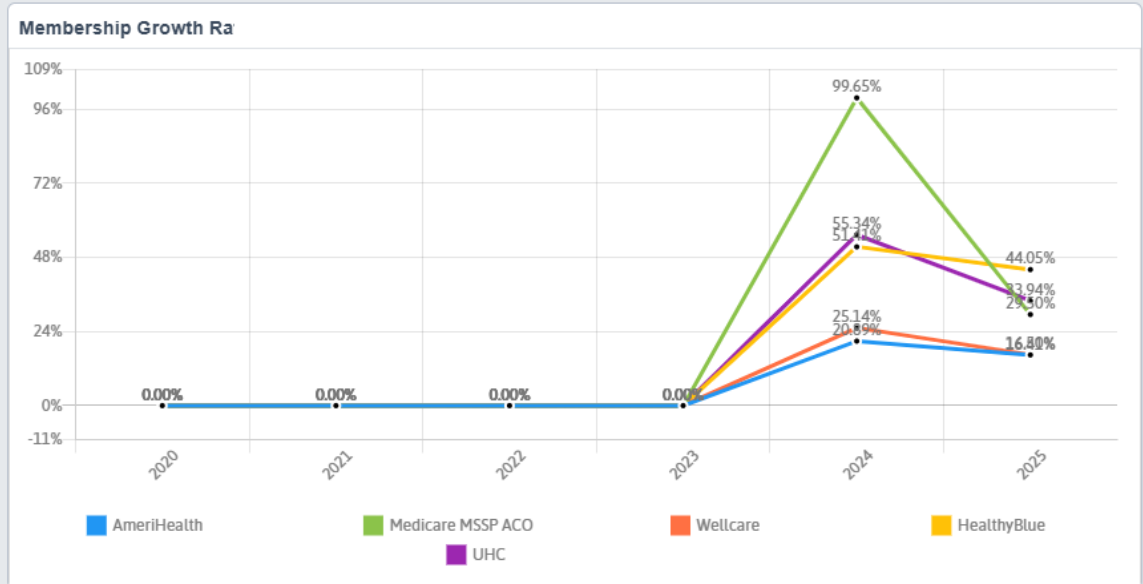


Membership by Pla

PLANS	MATCH RATE	MEMBERS
AmeriHealth	77%	16,393
HealthyBlue	63%	10,766
Medicare MSSP ACO	99%	5,550
UHC	44%	34,332
Wellcare	88%	933

Cost Stratificatio

COST GROUP	MATCH RATE	MEMBERS	GAP
No Cost Data	63%	24,237	8,975
\$0-5K	55%	33,301	15,037
\$5-10K	68%	4,507	1,444
\$10-25K	72%	3,900	1,090
\$25-50K	73%	1,303	354
\$50-100K	65%	526	184
>\$100K	65%	200	70





# of Active Users

106  
Count of Users



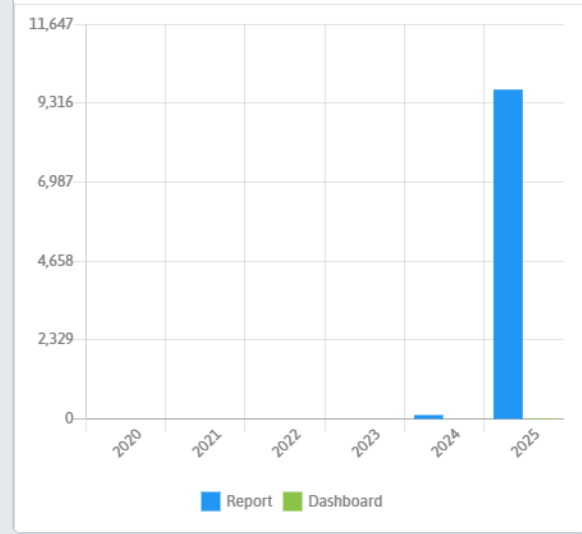
Active User Count by Cen'

CENTERS	USERS
Teche Health	9
SWLA Center for Health Services	9
Winn Community Health Center, Inc.	8
David Raines Community Health Centers	7
CommuniHealth Services	6
DePaul Community Health Center	6
EXCELth, Inc.	6
Iberia Comprehensive Community Health Center	6
NOELA	6
Catahoula Parish Hospital District #2	5
RKM Primary Care	5
CareSouth (Capitol City Family Health Center)	4
Priority Health Care	4

Active User

USER NAME	USERS
bpressley@excelth.com	1
Christina.Foster@rkmcare.org	1
christopher.sins@startcorp.org	1
harkeisha.young@dcsno.org	1
csterling@swlahealth.org	1
dboudreaux@swlahealth.org	1
jchappell@cphd2.org	1
sriedel@caresouth.org	1
agnesf@icchc.org	1
avilo@tabhealth.org	1
dcotton@cphd2.org	1
jflores@noelachc.org	1
LShelton@davidraineschc.org	1

Monthly Usage Trend



Top Report

REPORT NAME	REPORTS
Members	2,504
Wellcare Medicare Plan Calculated - 2/3 Star	2,345
Wellcare Medicare Plan Calculated - 4/5 Star	1,658
Plan Data Latency	1,080
Amerihealth Plan Calculated - LDH	922
Amerihealth Plan Calculated 2% Increase	703
Soft Matching	494

Top Measure

REPORT NAME	REPORTS
-------------	---------

Top Dashboard

REPORT NAME	REPORTS
MSSP Focus Measures	3





### MSSP Focus Measures

#### AWV Member-Based (EHR + Claims data):

##### AWV (EHR & Claim)

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Medicare AWV Member Based	56.1%	3,059	5,457	0	2,398	1,034

##### AWV Performanc

**56.1%**  
% of eligible members w/Annual Well Visit  
PRIMARY 75%

#### MSSP Quality Measures (EHR data):

##### MSSP Quality Measur

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
DMA1c > 9	9.0%	143	1,583	65	143	0
HTN Controlling High BP (CMS 165v13)	68.8%	2,614	3,800	360	1,186	46
Depr Scrn & Follow-Up (CMS 2v14)	88.0%	5,779	6,566	508	787	0
Breast Cancer Screening (CMS 125v13)	57.4%	1,139	1,983	98	844	51

##### MSSP Quality Measures

TARGET ACHIEVEMENT

**2** PRIMARY      **0** SECONDARY      **2** NOT MET

4 Total Measures

#### Additional ACO Focus Measures (EHR data):

##### Additional ACO Focus Measu

MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
Colorectal Cancer Screening (CMS 130v13)	51.4%	2,203	4,285	213	2,082	154
Depr Remission at 12 Months (CMS 159v13)	18.2%	50	274	89	224	33
Falls Screening for Future Fall Risk	60.3%	2,832	4,697	18	1,865	691
Influenza Immunization (Yr Only)	26.7%	1,459	5,473	84	4,014	183
Statin Therapy CVD (CMS 347v8)	80.4%	2,479	3,085	124	606	298
Tobacco Use: Screening & Cessation (CMS 138v13)	89.6%	6,020	6,717	23	697	26

##### Additional Focus Measure

TARGET ACHIEVEMENT

**0** PRIMARY      **0** SECONDARY      **6** NOT MET

6 Total Measures



PERIOD: 2026 | CENTERS: All Centers | PLANS: All Plans | MEMBER MEASURES: BCS - Breast Cancer ... | RENDERING PROVIDERS: All Rendering Provid... | ENROLLMENT STATUS: Active Only

+ Add Filter Update

PAYER REPORTED SCORE

**1.02%**

OPPORTUNITY +10.54%

LEGEND

MEASURE COMPLIANCE

- Compliant
- Non-Compliant (Gap)

COMPLIANCE

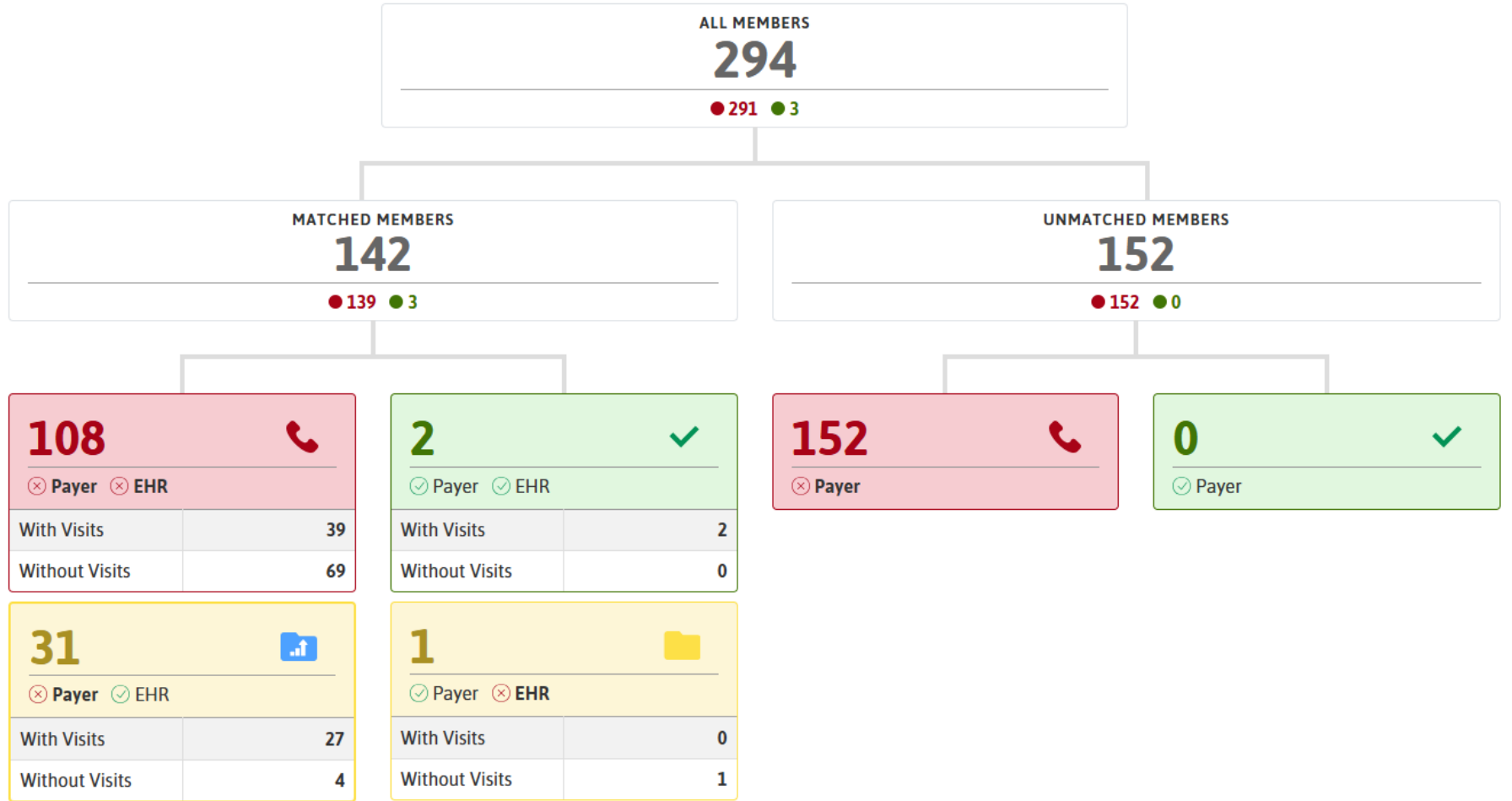
- Non-Compliant (Gap)
- Data Reconciliation
- Compliant

ACTION REQUIRED

- Data Reconciliation
- Member Outreach
- No Action

DISPLAY

SHOW DETAILS  Disabled  Enabled



Last Received 3/20/2026





# Network-Level Impact

## Demonstrated Outcomes

**23 → 26  
PHCs**  
Increased  
DRVS  
Adoption

**92%**  
using pre-  
visit planning  
reports

Increased  
analytic  
literacy  
through  
super-user  
engagement

**Predictive  
Analytics**  
Informing  
care  
coordination  
gaps

**Founda-  
tions**  
for module  
expansion





# Network-Level Impact

## Demonstrated Outcomes

### 2023 DRVS Needs Assessment

- 25 responses from 14 unique CHCs (54% response rate)
- Champion designation (Y/N)
- Usage (Dashboards, PVP/CMP, Registries, Scorecards, Admin, etc.)
- Modules of Interest (SDOH, Risk, CS, TOC, HepC)
- Req. type for TAs to cover: TOC, best way to utilize CS, Payer integration TAs, Data Hygiene, Ryane White HIV/AIDs specific dashboards, referral management





# Network-Level Impact

## Board Feedback Survey Aug 2025



**TA Tracker:**  
2025 – current

332

**Division:** HIT/HCCN & ACO

EHR Customer Service	DRVS Customer Service	Additional
Poor	Excellent	Experienced dental EHR difficulties and had to go to direct connection as opposed to data feed.
I'm not satisfied or impressed but our CEO may see it differently. I'm a proxy	Very satisfied	Highly used in our organization. I feel that this application is more accurate that our EHR
there's a chat support system where you can speak to someone in the very moment that you're having an issue however, most of the time they say that a ticket must be entered and then find out that you're not on the most recent version of the EMR, and therefore	They typically respond within the week and often resolve my issues within 2. I appreciate that if I can't properly articulate the issue via the customer support portal, they will set up a call to further discuss	I wish I knew more of the function of DRVZ/AZARA. I'm not real familiar with the registries and I wish I had the ability to develop my own alert for the PVP report.
Somewhat satisfied	Satisfied	None
	very satisfied	operating well





# Network-Level Feedback

15

Evaluative responses (since Jan 2025) = **336**

- Relevance = 3.75
- Speaker Engagement = 4.04
- Objectives Met = 4.04
- Self-Knowledge of Topic = 3.92
- Confidence to apply knowledge = 3.93
- Recommend TA = 3.98
- Future Attendance = 4.03



**3.95 / 5.00**







# Network Usage | 2025



## Network Usage

### # of Active Users

942

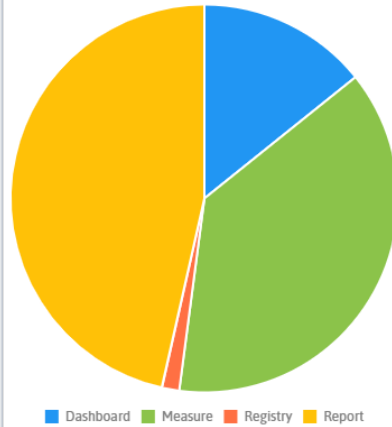
Count of Users



+635

2020

### Usage by Report Type



Dashboard Measure Registry Report

### Report & Measure Runs By Pract

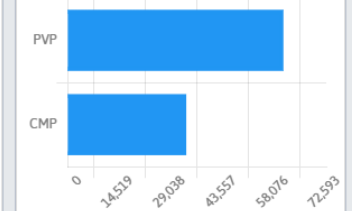
CENTERS	REPORTS
DePaul Community Health Center	32,357
CommuniHealth Services	12,236
Access Health Louisiana	11,796
LPCACO	9,463
Catahoula Parish Hospital District #2	7,844
Teche Health	7,476
Iberia Comprehensive Community Health Center	7,230
Winn Community Health Center, Inc.	5,575
David Raines Community Health Centers	5,296
RKM Primary Care	3,563
SWLA Center for Health Services	3,394
NOELA	3,370
Delhi Community Health Center	3,206

### PVP, CMP & PNP Use

707

Count of Users

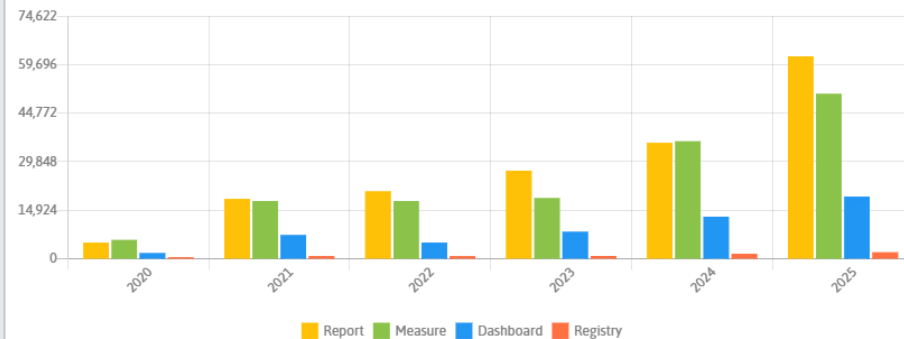
### PVP, CMP & PNP Ru



### Active Users By Pract

CENTERS	USERS
Access Health Louisiana	123
DePaul Community Health Center	106
RKM Primary Care	87
David Raines Community Health Centers	69
Teche Health	66
Winn Community Health Center, Inc.	65
Iberia Comprehensive Community Health Center	48
EXCELth, Inc.	41
CareSouth (Capitol City Family Health Center)	40
CommuniHealth Services	39
InclusivCare	37
Catahoula Parish Hospital District #2	35
Primary Health Services Center	23
START Corporation	22
SWLA Center for Health Services	22

### Monthly Usage Trend



### PVP, CMP & PNP Usage by Pract

CENTERS	USERS
Access Health Louisiana	113
RKM Primary Care	81
Teche Health	60
David Raines Community Health Centers	58
Winn Community Health Center, Inc.	56
Iberia Comprehensive Community Health Center	45
CommuniHealth Services	35
CareSouth (Capitol City Family Health Center)	35
EXCELth, Inc.	33
Catahoula Parish Hospital District #2	31
DePaul Community Health Center	28
InclusivCare	27
Primary Health Services Center	20
START Corporation	15
SWLA Center for Health Services	13
Innis Community Health Center	10





# Network Usage | 2025



Top Dashboard		Top Measure	
REPORT NAME	REPORTS	REPORT NAME	REPORTS
Operations & Quality Report	1,830	Medicare Annual Well Visit	1,735
Operations - Encounters	797	Cervical Cancer Screening (CMS 124v13)	1,615
Referral Management	579	Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	1,606
Enrollment & Attribution	559	Patients with Qualifying Encounters	1,486
Network Usage	535	Alert Closure - Point of Care (POC)	1,467
Data Health - Questionable Values	492	Colorectal Cancer Screening (CMS 130v13)	1,245
LSU - Cancer Screening	483	Patient Interactions	1,244
Visit Trends	397	Panel Match - 4-Cut Provider to PCP	1,185
Cancer Screening	392	Screening for Depression and Follow-Up Plan (CMS 2v14)	1,127
TCHC, Inc. Referral Management	382	Hypertension Controlling High Blood Pressure	1,100

Top Report		Top Registrie	
REPORT NAME	REPORTS	REPORT NAME	REPORTS
UDS 2025 CQMs	12,823	Positive STDs	228
UDS 2024 CQMs	7,750	Primary Care: Adult	207
MSSP Scorecard	6,469	Remote Patient Monitoring	115
Table 5 - Staffing and Utilization	3,456	Hypertension	104
Members	2,504	Diabetes	100
Wellcare Medicare Plan Calculated - 2/3 Star	2,345	SBHC- Uninsured	99
All Referrals	2,149	Social Drivers of Health (SDOH)	78
Wellcare Medicare Plan Calculated - 4/5 Star	1,658	ID Positive STIs	74
Table 6b - Quality of Care Measures	1,544	Depression Care	68
Table 4 - Patient Characteristics	1,431	Tulane Connect Study	60





PLAN	LOB	Membership +1	Total Cost	PMPM	ED Visits/1k	IP Admit/1k	IP 30d Readmit	Quality
+ UHC	Medicaid	27,091 ▼	\$1,004,523 ▼	\$12 ▼	3 ▼	0 ▼	33% ▲	No scorecard is co
+ HealthyBlue	Medicaid	10,388 ▼	\$6,451,203 ▼	\$203 ▼	338 ▼	43 ▼	15% ▼	No scorecard is co
+ Medicare MSSP ACO	Medicare	5,085 ▼	\$2,683,432 ▼	\$173 ▼	247 ▼	93 ▼	24% ▼	No scorecard is co
+ Wellcare	Medicare	480 ▼	\$541,084 ▼	\$377 ▼	142 ▼	33 ▼	75% ▲	● 6 ● 1 ● 13
+ Wellcare	Unmapped	414 ▲	\$588,243 ▲	\$469 ▲	297 ▲	38 ▲	25% ▲	No scorecard is co



## Summary

Membership

**51.5k** <sup>▼</sup> 6%

Avg RUB

**3.3** <sup>▼</sup> 0

Total Claims Paid

**\$317.8m** <sup>▲</sup> \$37.2m

Cost Per Member

**\$5.6k** <sup>▼</sup> \$282.8

## Top Cost Members



**64.2%** of Cost

**10.5%** of Members

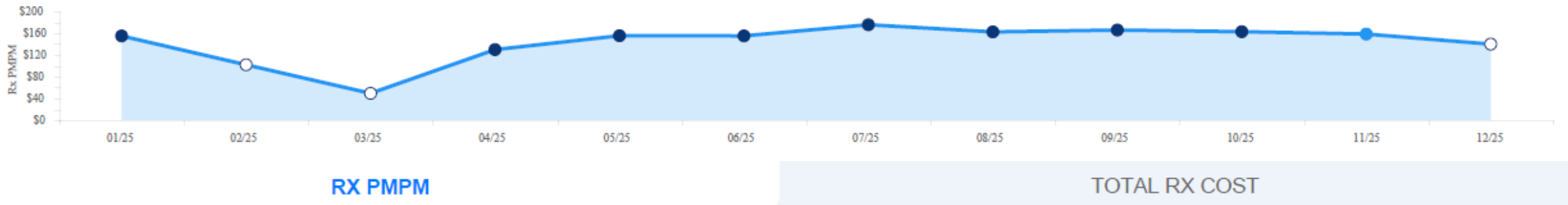
## Rx Utilization

Rx PMPM

**\$141.9** <sup>▼</sup> \$6

Total Rx Cost

**\$97m** <sup>▲</sup> \$12m



## Emergency Utilization

ED Visits/1K

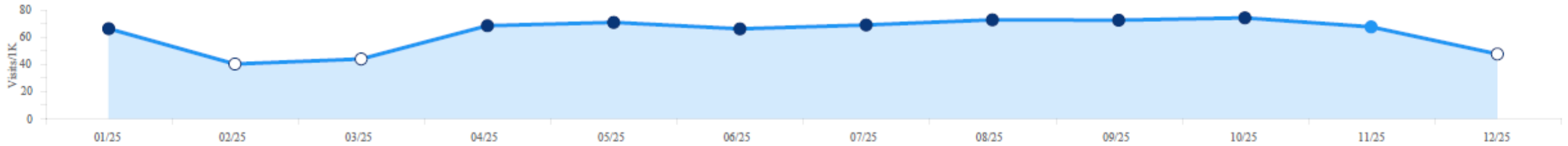
**756** ▼ 9%

Avoidable ED Visits

**63%** ▼ 2%

ED Cost/Visit

**\$716.9** ▲ \$3.7



VISITS/1K

AVOIDABLE ED VISITS

COST/VISIT

## Inpatient Utilization

IP Admits/1K

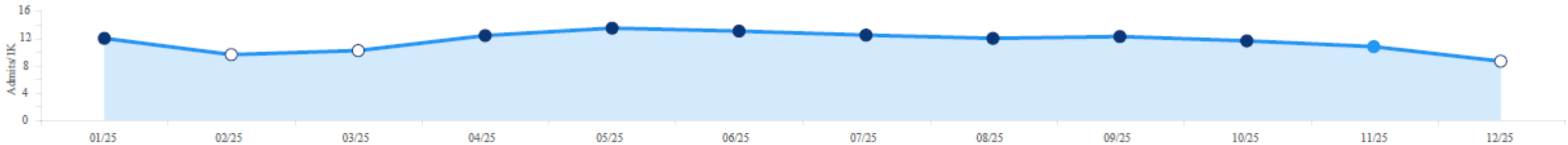
**138** ▼ 3%

Avoidable IP Admits

**17%** ▼ 2%

IP Cost/Admit

**\$6.5k** ▼ \$227.9



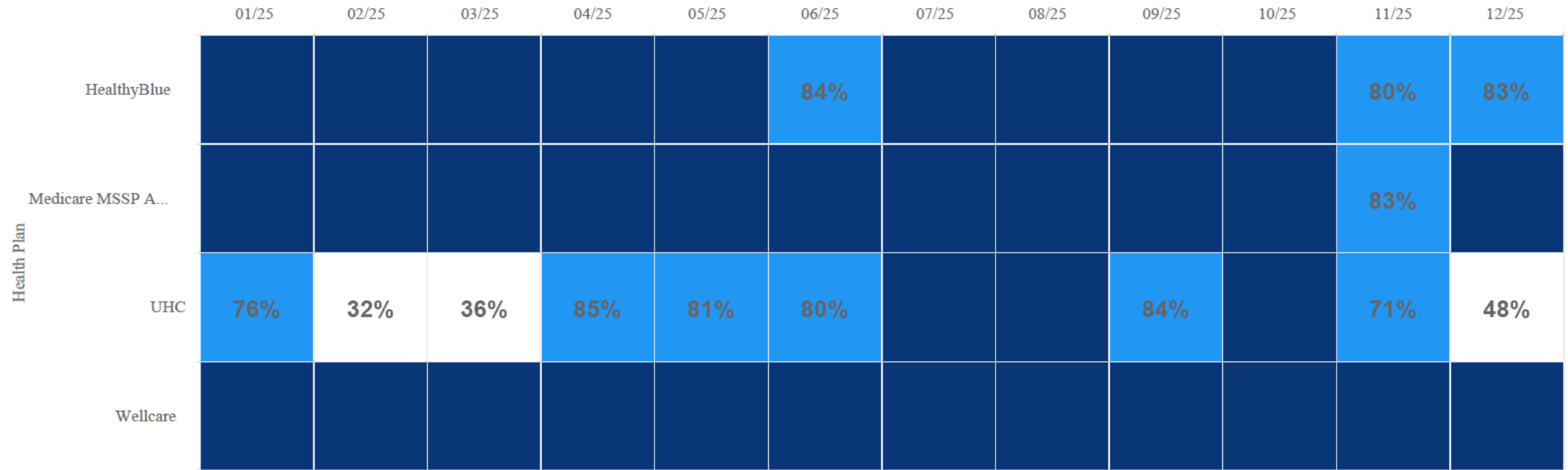
ADMITS/1K

AVOIDABLE IP ADMITS

COST/ADMIT



# Medical Claim Completeness



## Claim Status

- Sufficient
- Semi-Sufficient
- Insufficient
- Not Loaded

## Threshold

- >85%
- 70-85%
- <70%





# Lessons Learned

Insights to Action: What This Taught Us





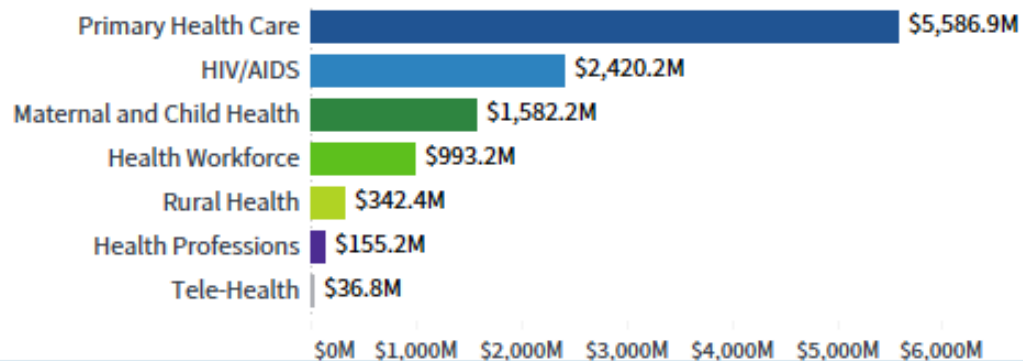
# Data.HRSA – Grants Dashboard

Data as of 10/2/2025 for LA

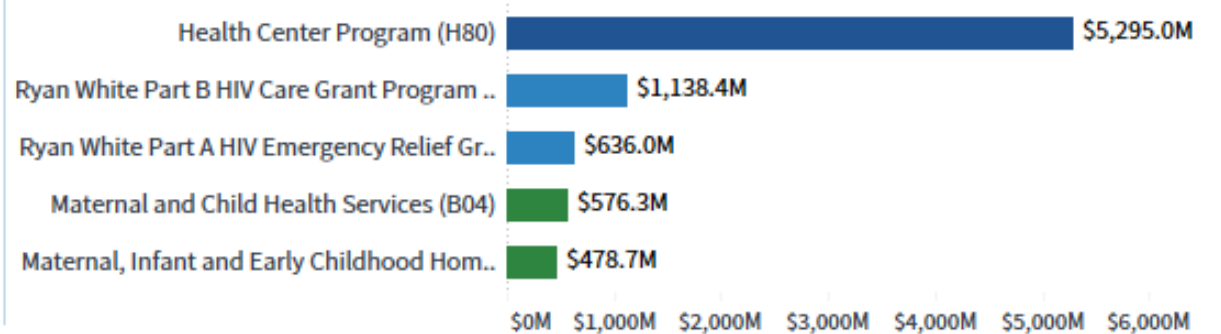
## HRSA Program Area Summary

HRSA Program Area	Unique Awardees	Total Awards	Funding
Health Professions	146	174	\$155,173,726
Health Workforce	567	1,096	\$993,214,910
Healthcare Systems	2	2	\$10,949,200
HIV/AIDS	524	843	\$2,420,173,335
Maternal and Child Health	516	1,067	\$1,582,247,638
Other Programs	6	6	\$7,183,520
Primary Health Care	1,449	1,670	\$5,586,908,435
Rural Health	440	638	\$342,394,025
Tele-Health	63	77	\$36,810,202
<b>Total</b>	<b>2,714</b>	<b>5,573</b>	<b>\$11,135,054,991</b>

HRSA Key Program Area Funding (Dollar Amounts in Millions)



Top Five Programs (Dollar Amounts in Millions)





# What is helping to make this Work

- Intentional partnership
- Vendor accountability
- Rapport & Communication
- Structured TA
- Data hygiene discipline
- Transparent performance tracking
- Shared network culture
- Routine
- Intentional Cross Training



## HCCN 2026 Spring Learning Session

This biannual event hosts expert speakers from key partners, giving you and your team the opportunity to ask questions and engage further with your health center's data needs. This event is perfect for health center leadership as well as information technology and clinical staff. Receive updates directly related to LAHCCN as well as the latest tools and resources from data experts.

### Presentation Topics

Session topics will cover the corresponding (5) HCCN objectives laid out for the project cycle. Our speakers will provide hands-on, tangible learning solutions for health center attendees to take back to apply to their health center organization(s). Topics include:

- HCCN Project Updates,
- AI Security,
- Value-based care,
- Financial and operational preparedness for driving revenue,
- DRVS 101 Bootcamp,
- Network Risk Module,
- EHR Optimization with best practices,
- AMA supported evidence-based practices for controlling HTN, **and more!**

[REGISTER HERE](#)



**Baton Rouge Marriott**  
5500 Hilton Avenue  
Baton Rouge, LA 70808

[Room Block Registration Here](#)

### Dates:

Wednesday, May 20<sup>th</sup>  
8:30 a.m. - 3:30 p.m.

& Thursday, May 21<sup>st</sup>  
8:30 a.m. - 12:00 p.m.

### Registration Costs:

Health Center Member = \$150  
Non-Members = \$200  
Other PCA Members = \$150

CONTACT US

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# MyLPCA LPCA Team



Welcome to our Louisiana Primary Care Association Members Only portal! We'll use this page to provide you with webinar recordings, trainings and power points that are only available to our LPCA Member Community Health Centers. If you need any assistance, please contact Abigail Giroir at [agiroir@lpcanet.net](mailto:agiroir@lpcanet.net) or (225) 927-7662, ext. 327.

- Webinars
- Community Health Worker Registry
- Health Center Controlled Network
- LPCACO
- Value-Based Care Road Map

Economic Impact Reports are here!  
Access your Community Health Center EI Report from CapitalLink below.

Access the 2023 Economic Impact Report

[View this email in your browser](#)



## Monthly Roundtables

1<sup>st</sup> Fridays of the month @ 12PM CT  
-or-  
3<sup>rd</sup> Thursdays of the month @11AM CT

### LPCA invites all Member DRVS Users to our Monthly Roundtables!

At LPCA's Azara Roundtables, attendees can connect with other centers to share strategies and best practices in using Azara DRVS to aid their quality improvement initiatives. These roundtable platforms are exclusive to LPCA members and targeted to QI staff, data analysts, or any staff members who utilize DRVS in their clinical quality efforts. To better accommodate our health centers, we are providing 2 options for the monthly roundtables:

- Option 1: 1st Friday of each month at 12PM, or
- Option 2: 3rd Thursdays of each month at 11AM.

#### DRVS Monthly Roundtable OPTION 1

Date: 1st Fridays of Each Month  
Time: 12 PM CT  
Where: Online (Registration Only)

Register to Attend

#### DRVS Monthly Roundtable OPTION 2

Date: 3rd Thursdays of Each Month  
Time: 11 AM CT  
Where: Online (Registration Only)

Register to Attend

#### What you will get out of these Roundtable(s):

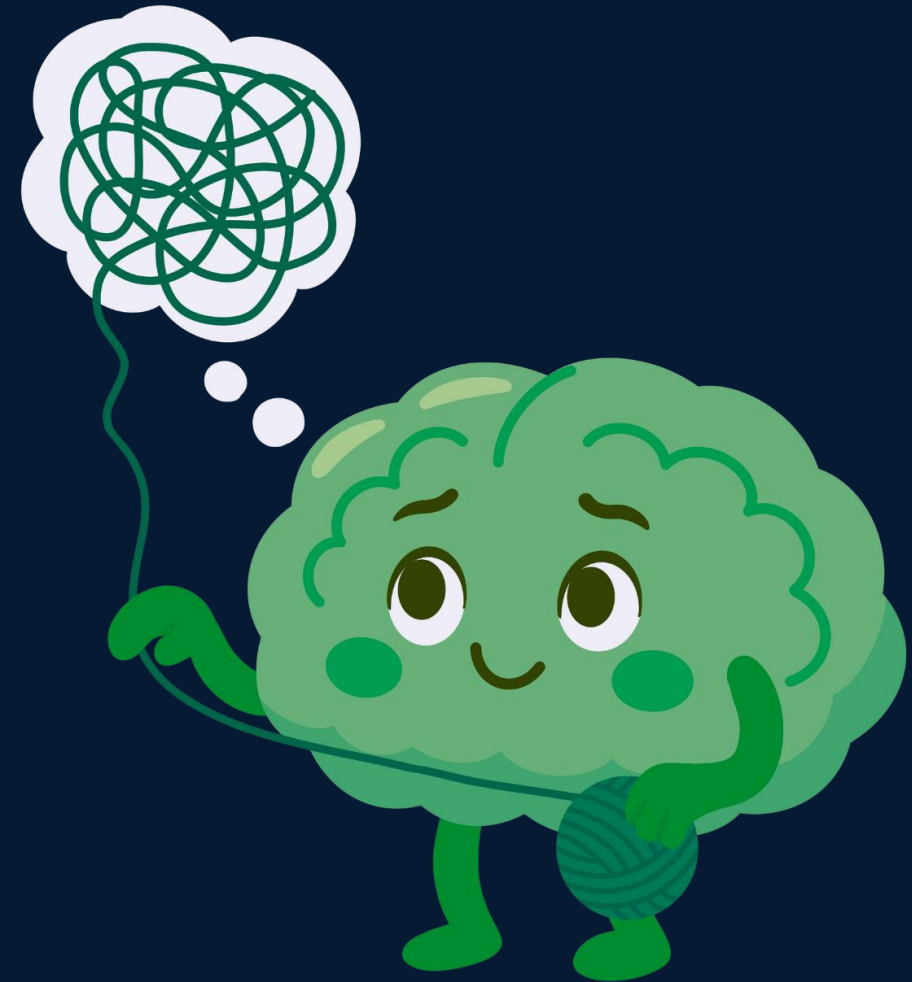
- Discussion led by LPCA Staff and DRVS Super Users,
- Flexibility to have Azara representatives to do highly-requested TAs,
- Better define and identify DRVS Super Users and Data Champions,
- Open forum to share common questions and concerns, and more!



# Food for Thought

15

- Start with governance before dashboards
- Standardize mapping early (SME at Network Level)
- Build super users
- Align payers intentionally
- Don't skip data validation
- Invest in workforce literacy
  - Centralized Knowledge-based System
- Crosswalks!



# DRVS is not a tool. It is a statewide infrastructure.

**Purpose.**  
**Partnership.**  
**Progress.**

- From 4 centers to 26., tentative 29
- From fragmented data to a “semi-unified” warehouse.



# Contacts



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Louisiana Primary Care Association  
[tnguyen@lpca.net](mailto:tnguyen@lpca.net)



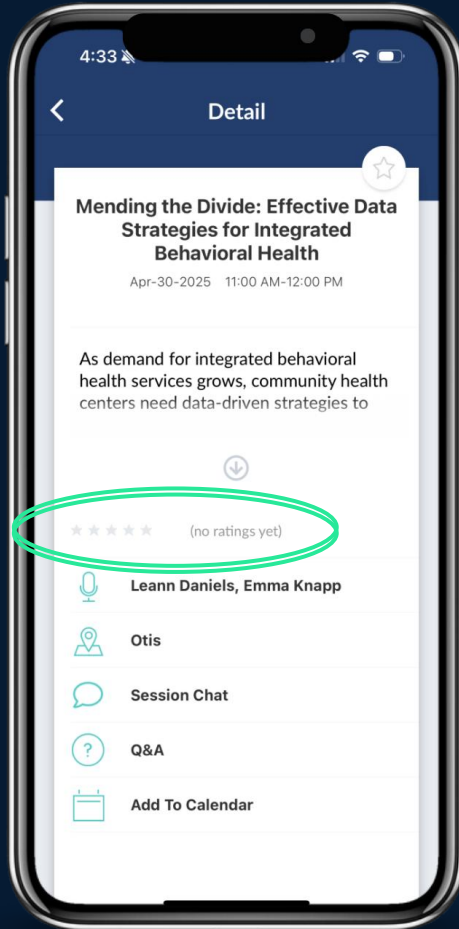


# Questions?



# We want to hear from you!

Click on the session from your agenda in the conference app.  
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



# azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA

# Thanks for attending!

