

Switching Tracks: On The Road to DRVS

azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



Today's Presenters

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i2i Merger with Azara



Following the acquisition of Azara Healthcare in December of 2024, Insight Partners acquired i2i in February of 2025 to combine best in class resources, delivery solutions and technology to the Safety Net Marketplace with an already vibrant community of users. Azara DRVS will remain the flagship product to support both Networks and affiliated FQHCs with Population Health and Value Based Care Reporting and Analytics.



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Today's Agenda

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- ➔ **Tracks to DRVS Journey:**
High Level Overview
- ➔ **Guest Speakers:**
Talk about their journey over to DRVS





Transitioning to DRVS

Making it Simple



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DRVS Platform Key Benefits

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Unlimited Users: Scale access across organization.



Intuitive Experience: Easy log-in and navigation.



Flexible Learning: Multiple self-paced training resources.



Proven Onboarding: Robust process ensures data accuracy.



Comprehensive Library: Over 200 ready to use reporting tools.

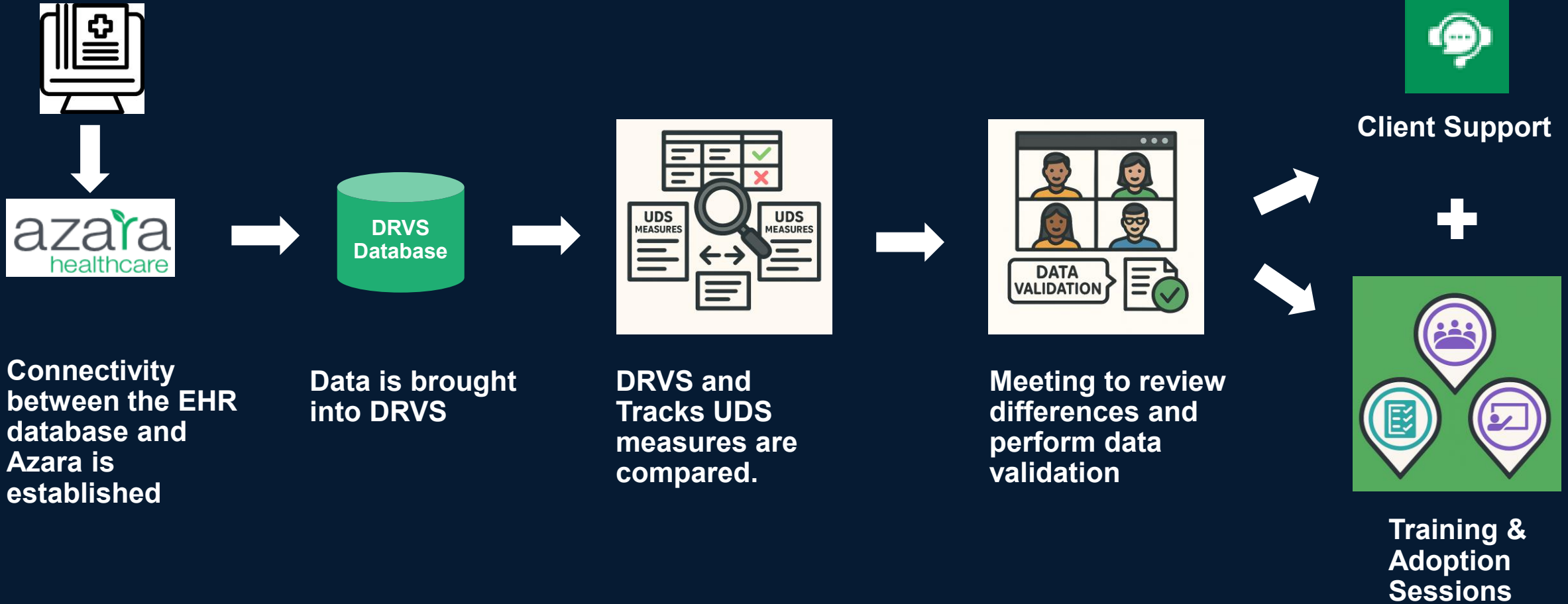


Web-Based Platform: No local installation required.



The Process of Transitioning to DRVS

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Training & Adoption Program at Azara

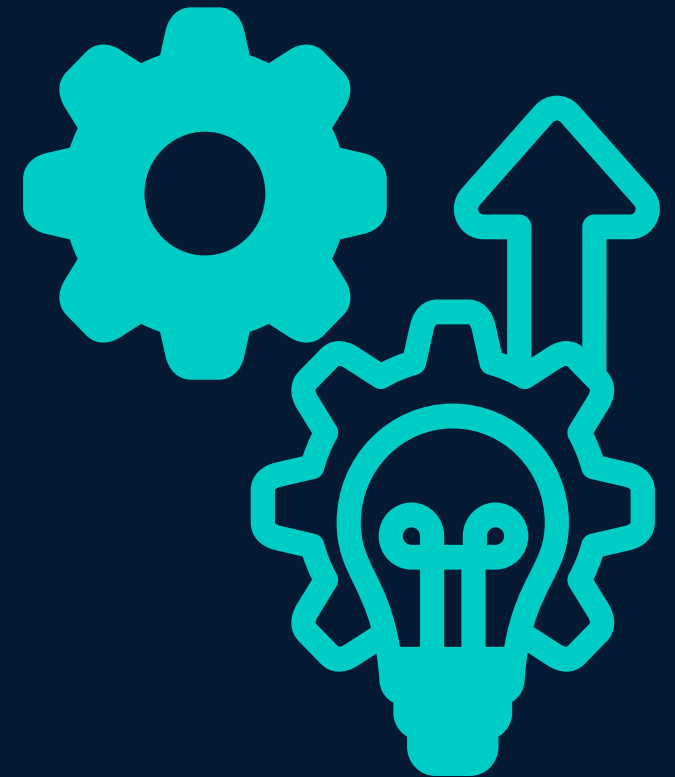
15

Post-implementation engagement with Azara's Clinical Transformation team designed to provide you with knowledge and tools to integrate population health and analytics platform into the organization.

Learn core features of DRVS functionality & **configure** tools to align with organization needs.



Develop strategic plans to incorporate DRVS across organization initiatives.



Training & Adoption Program Approach

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Hands-on learning to maximize knowledge and use of DRVS

Functional Training

- Explores the core features and functionality of DRVS.
- Highlights common users and use cases of different tools.
- Offers hands-on practice in configuring DRVS.

Adoption Series

- Furthers use & knowledge of DRVS with 1-hour learning sessions.
- Builds on fundamentals to help ensure long-term success of DRVS.
- Incorporates organizational initiatives into sessions to align content with goals.



Help Documentation



azara healthcare

Support Portal Contact Support Log in to DRVS

Welcome to DRVS Help!

To find a resource, use the search bar or browse our quick start menu options below.

Search the Help Section...

- Get Started Using DRVS**
Ready to dive in? This guide helps new users get up to speed!
- User Guides**
Detailed documentation on all DRVS features.
- Azara Events and Webinars**
Register for events and view past recordings.
- UDS - Uniform Data System**
Access resources for UDS+ and UDS submissions.
- Quick Tip Clips**
Get the key DRVS insights you need—fast! These quick, targeted clips walk you through essential features and functionality.
- Configuring DRVS**
Create custom content and tailor DRVS to your needs.

Return to Top



Azara Academy

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Azara Academy

Learn how to incorporate Azara tools to support patient care delivery, population health management, and performance improvement. Check out new and exciting resources to take your knowledge and use of Azara tools to the next level!

My Trainings 4 Home New Users Role-Based Resources Events

Home > Home

New & Exciting Courses

Intro to DRVS
Review this course to understand how DRVS can support population health initiatives.

COLLECTION 2 items

Transitioning to DRVS
This course is designed for users transitioning from i2i Tracks to DRVS.

COLLECTION 1 item

DRVS Quality Tools
Explore how to visualize your data in DRVS, examine trends across your organization, and identify opportunities for improvement...

PATH 3 modules

View



azara
ACADEMY

Now Live!

Azara Academy, our new Learning Management System, offers users the ability to jumpstart and deepen their DRVS knowledge, whenever they what!



Available Support – Portal, Live Chat, Call



The screenshot displays the Azara dashboard interface. On the left, a sidebar contains navigation icons for Home, Pins, PVP, CMP, Reports, Dashboards, Measures, Registries, and Admin. The main content area is divided into three sections:

- UDS 2024 CQMs:** A table listing 17 measures with their results for TY July 2024.
- Network Overview:** A summary card showing 283,988 Patients and 1,122,574 Visits, along with a gauge chart for 'DM A1c > 9 or Untested (CMS 122v12)' at 28%.
- Events & Announcements:** A list of upcoming events, including 'APO Message Schedule Enhancement' and 'August Webinars'.

A blue callout box on the right side of the dashboard highlights a support menu with the following options:

- Help Documentation
- Visit Support Portal
- Email Support: support@azarahealthcare.com
- Call Support: 781-365-2213 (Monday-Friday 7AM-6PM EST)

A blue text box at the bottom left states: "The Azara Support team is available to answer questions related to data, customization, access, and more!". A blue arrow points from this text box to a live chat icon in the bottom right corner of the dashboard.



Home Page: i2iTracks



The screenshot shows the i2iTracks home page. At the top, there is a menu bar with 'FILE', 'SETUP', 'PATIENTS', 'FIND', 'REPORTS', 'WINDOWS', and 'HELP'. Below the menu is a header area with the i2iTracks logo and a title 'i2iTracks Today'. A sidebar on the left contains navigation icons for home, up, search, user, and other functions. The main content area is divided into two sections. The left section, titled 'MY STATISTICS', contains a table of key metrics:

Metric	Value
Patients Admits - Yesterday	2085
Admission - Heart Failure in the last 1 week	6
Admission - Sepsis in the last 1 week	2005
Hospital Discharge Log - Follow-Up Required	75
***Diabetes pts with A1c >9	235

The right section, titled '01: AREA 1.6.2 (NQF 2372) BREAST CANCER SCREENING', features a line chart showing the percentage of women aged 52-74 screened in the prior 27 months. The x-axis represents 'Time in Months' from 12 to 0, and the y-axis represents '% Women 52-74 Screened in Prior 27 Mths' from 0 to 100. The chart shows a steady increase in screening rates over the 12-month period, peaking at approximately 90% in month 4. Below the chart, there is a 'Show Values' link and a '02: AREA 1.6.3 (NQF 0032) CERVICAL CANCER SCREENING' section header. To the right of the chart are 'Refresh' and 'Customize' buttons.



Home Page: Azara DRVS



The screenshot shows the Azara DRVS home page dashboard. It features a search bar at the top, a navigation sidebar on the left, and several data visualization components. The main content area is divided into three columns: a table of UDS 2025 CQMs, a network overview with patient and visit counts, and a list of events and announcements. A gauge chart for 'DM A1c or GMI > 9 or Untested' shows a 58% completion rate.

MEASURE	RESULT
Childhood Immunization Status (CMS 117v13)	0.0%
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v13)	51.6%
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	84.6%
Depression Remission at Twelve Months (CMS 159v13)	3.2%
Screening for Depression and Follow-Up Plan (CMS 2v14)	80.5%
Tobacco Use: Screening and Cessation (CMS 138v13)	73.3%
Colorectal Cancer Screening (CMS 130v13)	69.4%
Cervical Cancer Screening (CMS 124v13)	31.4%
Breast Cancer Screening Ages 50-74 (CMS 125v13)	68.1%
Hypertension Controlling High Blood Pressure (CMS165v13)	94.5%
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	57.8%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v8)	87.5%
Initiation of Substance Use Disorder Treatment (CMS137v13a)	89.3%
Initiation and Engagement of Substance Use Disorder Treatment	

Network Overview
TY October 2025
3,353 PATIENTS | 7,105 VISITS

DM A1c or GMI > 9 or Untested (CMS 122v13)
TY October 2025
58%

Events & Announcements

- ANNOUNCEMENT** Streamlined Measure Details, Powerful Export Control
New toggle and export features on select measures. This update makes the detail list faster and...
- ANNOUNCEMENT** Update: AMA MAP™ Hypertension Measures
Update: AMA MAP™ Hypertension Measures Azara has updated two measures from the AMA MAP™ Hyperten...
- ANNOUNCEMENT** Update: UDS 2025 Table 7b and 7c
Update: UDS 2025 Table 7b and 7c Azara has updated UDS Table 7b as follows: Prior Update Based o...
- EVENT** November Webinars
Join us for our November webinars! Drive Shared Savings. Enhance MSSP.

DRVS



MH (Morning Huddle): i2iTracks



The screenshot displays the i2iTracks software interface. At the top, there is a menu bar with options: FILE, SETUP, PATIENTS, FIND, REPORTS, WINDOWS, HELP. Below the menu, the main header includes the i2iTRACKS logo, the text "i2iTracks Today", and "Demo Data". A navigation sidebar on the left contains icons for home, search, and user management. The main content area shows a "Care Team Huddle" section with tabs for "Care Team Intelligence", "Empanelment", "Performance Measures", and "Care Coordination". An "Appointment Filter" is set to "Dr. Jonathan Smith, Dr. Phil Franklin, Dr. Bobby Jones, Dr. Tim Ellis". The "Appointments Scheduled For" section is set to "Today". A table lists appointments for "Dr. Bobby Jones". The first appointment is at 8:30 AM, a "Checkup" by "Dr. Bobby Jones" for "Larry Lassen" (DOB: 9/3/2010, Patient ID: 102). The patient's medical history is shown below the appointment, including "Reason: Asthma", "Smoker: No", and "Due: Asthma Treatment, Annual Exam" (highlighted with a red box). The second appointment is at 9:20 AM, a "Checkup" by "Dr. Bobby Jones" for "Susan Morris" (DOB: 5/7/1961, Patient ID: 106). The patient's medical history for this appointment includes "Reason: DM Check" and "Outstanding Referrals: 4".

Time	Type	Provider	Name	DOB	Patient ID	Resource	Med Rec #	Age	PCP
8:30 AM	Checkup	Dr. Bobby Jones	Larry Lassen	9/3/2010	102	Registered Nurse		15	Dr. Juan Gomez
Reason: Asthma History (12 Mo.): Canceled: 1 No Shows: 3 Visits: 2 ER: 0 Admits: 0 Last Visit DR: Dr. Juan Gomez Outstanding Referrals: 2									
Smoker: No									
Last Weight: Last BMI #: 3.9 (8/10/25) Last BP: 115/65 (4/12/25) Last PHO-2: Last PHO-9: 7 (2/26/25)									
Due: Asthma Treatment, Annual Exam									
9:20 AM	Checkup	Dr. Bobby Jones	Susan Morris	5/7/1961	106	Registered Nurse		64	Dr. Juan Gomez
Reason: DM Check History (12 Mo.): Canceled: 2 No Shows: 1 Visits: 6 ER: 2 Admits: 3 Last Visit DR: Dr. Bobby Jones Outstanding Referrals: 4									
Last DR: 7451234 Last M... 04/2024 Last S... 4/10/2024 PCP: 11 (3/28/24) 11 (3/28/24) 11 (3/28/24)									



PVP (Patient Visit Planning): Azara DRVS



4:33 AM Wednesday, March 25, 2026

Visit Reason: Physical Departure

Schwipps, Samual

MRN: 1100420

DOB: 09/13/1995 (30)

Sex at Birth: M (He/Him/His)

GI: Other

SO: Don't know

Phone: 508-127-7627

Lang: German

Risk: High (44)

Portal Access: 03/25/2025

Cohort: At Risk Patients - DM & HTN,
Diabetes Aduti List 2026

PCP: Augustine, Greg

Payer: Aetna

CM: Alex Shvarts

DIAGNOSES (10)

ASCVD	Asthma	CAD
CAD/No MI	CP	DM I or II
HCV	HIV	HTN-NE
IVD		

RISK FACTORS (6)

ANTICOAG	Chronic Opioid Tx	IDD
MSM	SMI	TOB

SDOH (12)

CHILDCARE	EDU	FPL<200%
ISOLATION	LANGUAGE	MED/CARE
PHONE	RACE	SAFETY
TRANSPORT-MED	UTILITY	VIOLENCE

RAF GAP DISEASE GROUPS

Pregnancy	Pulmonary	DD
CNS	Infectious	Cerebrovascular
Cardiovascular	Diabetes	



ALERT	MESSAGE	DATE	RESULT	OWNER
AUDIT	Missing			Front Desk
Flu - Seasonal	Due Seasonal		Due Date: 2025-10-01	

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Allergist	Samantha Frost / Burlington	2/11/2026	2/26/2026
Allergist	Samantha Frost / Boston	2/11/2026	3/11/2026
Gastroenterology	Jim Cohen / Brighton	2/11/2026	3/13/2026
Nutritionist	Ellen Bell / Brighton	2/11/2026	3/31/2026
Nutritionist	Ellen Bell / Brookline	11/28/2025	12/23/2025
Radiology	Ellen Bell / Boston	11/28/2025	12/12/2025

Demo Data



PVS (Patient Visit Summary): i2iTracks



Date Printed: 9/18/2025

Patient Visit Summary (Diabetes)

Patient ID: 2996	MR: []	Age: 52 Yrs	DOB: 10/16/1972	Sex: F	Date: 9/17/2025	Last Vitals	This Visit
Name: Richardson, Anna		Race: HISPANIC			Blood Pressure: 112/78		
Address 1: 822 East Valley		Language: English			Weight (lbs): 194		
Address 2: []		Phone: 707-385-2371			Height (inches): 63		
City: Santa Rosa		PCP: Mike Green, MD			BMI: 34.36		
State: CA	ZIP: 95403	Insurance: Medicaid			Pain Score: []		
		Next Appt: []			PHQ-9: 22		

PROBLEMS: Asthma; Asthma, Any; Asthma, Persistent; Asthma, Persistent (eCOM); Benign essential hypertension; Diabetes - Problem List Only; Diabetes mellitus without mention of complication.; Diabetes Type 1 or 2; DVT History; Family History of Breast Cancer; Hyperlipidemia; Hypertension, Any; Hypertension, Essential; Leg Ulcers; Tobacco User, Current

Alerts:

Due: Procedure / Referral: Alcohol Use Screening	Due: Procedure / Referral: Anxiety Screening
Due: Procedure / Referral: Eye: Retinal Exam	Due: Procedure / Referral: HIV Screening
Due: Procedure / Referral: Mammogram, Historical	Due: Procedure / Referral: Retinal Eye Exam
Follow-Up Required: Call Patient	Follow-Up Required: Ensure patient enrolled in DSMES: DSMES (DM Education Class)
Follow-Up Required: Follow Up: Referral	Follow-Up Required: Requested Claim - FIU?: Referral

Upcoming Items:

Procedures / Referrals	C	Date	N	Labs	C	Date	N
Depression Screening	Received	8/21/2025		HbA1c	9	8/22/2025	
Due: Eye: Retinal Exam				LDL	87	9/17/2025	
Foot Screening	Received	9/12/2025 2:		Microalb/Creat Ratio			
Other Values	C	Date	N	Educations	C	Date	N
Self Monitoring Blood Glucose				Diabetes Education	Received	9/17/2025	
Tobacco Status (Current/Past)	Current	9/17/2025		Diet/Nutrition Counseling	Received	4/15/2025	
Treatment Plans	C	Date	N	Exercise/Physical Activity Cour			
Daily Weighing Plan				Immunizations	C	Date	N
Diet Plan	Prescribed	4/15/2025		Vaccine: COVID-19			
Diet/Exercise Alone Plan				Vaccine: Influenza	Received	9/17/2025 1:	
				Vaccine: Pneumovax	Received	6/17/2025	
				Goals	C	Date	N
				Self Management Goal, Any			

Blood Pressure	HbA1c	LDL	ACE Inhibitor	ARB					
Date	Val	Date	Val	Date	Dosage	Date	Dosage		
9/17/25	112/78	6/22/25	9	9/17/25	87	1/17/25	Unknown	5/8/21	Unknown
9/17/25	114/80	5/3/25	6.3	7/9/25	138	11/22/22	Discontinued	8/3/20	Unknown
6/19/25	118/77	5/3/25	9.3	6/22/25	142	11/12/22	Unknown		
6/19/25	138/96	5/3/25	9.3	3/25/25	150	8/3/20	Discontinued		
6/1/25	135/95	2/22/25	9.2	2/4/25	114	1/8/20	Unknown		
5/4/25	122/68	2/22/25	9.2	1/25/25	124				

Aspirin	Statin		
Date	Dosage	Date	Dosage
2/8/24	Unknown	7/18/25	Unknown
11/12/22	Unknown	3/6/25	Discontinued
12/13/21	Discontinued	1/30/25	Unknown
8/3/20	Discontinued	5/23/23	Discontinued
1/6/20	Unknown	11/12/22	Unknown
		8/3/20	Unknown

Demo Data

Current Referrals:

i2i C = Current N = New D = Discontinue R = Referred E = Received F = Refused L = Enrolled U = Un-Enrolled
S = Scheduled SR = See Results CI = Contraindication

Page 1 of 2
i2iTracks™



CMP (Care Management Passport): Azara DRVS



Assessments (Last 10 of 34)				Active Problems (7)																														
CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY	CODE	DESCRIPTION	MOST RECENT																												
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	2/9/23	1	E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	4/22/19																												
N18.3	Chronic kidney disease, stage 3 (moderate)	2/9/23	1	Z79.4	Long term (current) use of insulin	4/22/19																												
E55.9	Vitamin D deficiency, unspecified	2/9/23	1	N18.3	Chronic kidney disease, stage 3 (moderate)	1/9/19																												
Z91.89	Other specified personal risk factors, not elsewhere classified	1/6/22	0	E78.2	Mixed hyperlipidemia	1/9/19																												
B02.9	Zoster without complications	1/6/22	0	M85.88	Other specified disorders of bone density and structure, other site	6/19/18																												
Z28.21	Immunization not carried out because of patient refusal	1/6/22	0	E55.9	Vitamin D deficiency, unspecified	11/16/15																												
I10	Essential (primary) hypertension	8/20/21	0	I10	Essential (primary) hypertension	10/12/15																												
Z13.9	Encounter for screening, unspecified	8/20/21	0	<h3>The Numbers</h3> <h2>Demo Data</h2> <table border="1"> <tbody> <tr> <td>BMI</td> <td>1/6/22</td> <td>26.79 lb/m2</td> <td></td> </tr> <tr> <td>Systolic</td> <td>8/20/21</td> <td>152 mmHg</td> <td></td> </tr> <tr> <td>Diastolic</td> <td>8/20/21</td> <td>55 mmHg</td> <td></td> </tr> <tr> <td>LDL</td> <td>5/6/21</td> <td>99 mg/dL</td> <td></td> </tr> <tr> <td>A1c</td> <td>8/6/21</td> <td>9.8 %</td> <td></td> </tr> <tr> <td>PHQ-9 (or 2)</td> <td>6/8/21</td> <td>0</td> <td></td> </tr> <tr> <td>Risk</td> <td>2/28/23</td> <td>19 (H)</td> <td></td> </tr> </tbody> </table>			BMI	1/6/22	26.79 lb/m2		Systolic	8/20/21	152 mmHg		Diastolic	8/20/21	55 mmHg		LDL	5/6/21	99 mg/dL		A1c	8/6/21	9.8 %		PHQ-9 (or 2)	6/8/21	0		Risk	2/28/23	19 (H)	
BMI	1/6/22	26.79 lb/m2																																
Systolic	8/20/21	152 mmHg																																
Diastolic	8/20/21	55 mmHg																																
LDL	5/6/21	99 mg/dL																																
A1c	8/6/21	9.8 %																																
PHQ-9 (or 2)	6/8/21	0																																
Risk	2/28/23	19 (H)																																
Z79.4	Long term (current) use of insulin	8/6/21	0																															

Medications (8)		
ACTIVE AS OF	NAME	SOURCE
2/9/23	amlodipine 5 MG Oral Tablet	
2/9/23	acetaminophen 300 MG / codeine phosphate 30 MG Oral Tablet	
2/9/23	atorvastatin 40 MG Oral Tablet	
2/9/23	hydrochlorothiazide 12.5 MG / lisinopril 20 MG Oral Tablet	
2/9/23	empagliflozin 25 MG Oral Tablet [Jardiance]	
2/9/23	pantoprazole 40 MG Delayed Release Oral Tablet	
9/10/20	ergocalciferol 1.25 MG Oral Capsule	
1/27/20	hydrochlorothiazide 25 MG / triamterene 37.5 MG Oral Tablet	



AI Summaries in MIT & CMP: Now Available! | 2



Care Management Passport (CMP): View a summary of the patient and recommended action items.

Smart Summary **Demo Patient Data**

This is an 84-year-old male patient with complex chronic conditions including diabetes, severe mental illness, and multiple recent hospital and emergency visits.

1. The patient has a history of type 1 diabetes with chronic complications and a critically elevated **A1c of 12.6** as of Sep 2025, indicating poor glycemic control.
2. Recent vital signs show **low blood pressure (62/44 mmHg)** recorded on Sep 12, 2025, which may require urgent evaluation.
3. The patient has multiple behavioral health diagnoses including severe mental illness and psychosis, with a recent mental health and counseling encounter on Sep 12, 2025.
4. There are overdue screenings including a depression screen and A1c test, with the last depression screen showing a moderate score of 6 on Sep 12, 2025.
5. The patient has a history of homelessness and social determinants of health challenges including housing, transportation, and violence concerns documented as of Jan 2026.

Today's Recommended Action Items

1. Prioritize scheduling a comprehensive diabetes management visit to address the elevated A1c and review current medications and adherence.
2. Arrange for blood pressure monitoring and evaluation given the recent low readings to rule out hypotension causes.
3. Coordinate behavioral health follow-up and ensure depression screening is completed and addressed in care planning.

AI-generated content — please review for accuracy



i2iTracks: Patient Searches



i2iTRACKS FILE SETUP PATIENTS FIND REPORTS WINDOWS HELP

Search for Patients Demo Data

Pre-Filters | Patient Searches | ***Diabetes pts with A1c >9

Patient Search Results: *Diabetes pts with A1c >9 (Group: Default)**

Location: (All) Provider: (All)

Patients | Overdue Care Items

Drag a column here to group by this column.									
Name	DOB	Home Phone	HbA1c (Last R...	HbA1c (Last D...	Diabetes Typ...	Diabetes Typ...	NextApptDate	LastVisitDO	
<input type="checkbox"/> Aguilar, Martha	7/6/1962	707-385-4367	9.3	9/17/2025				9/17/2025	
<input type="checkbox"/> Aguilar, Miguel	12/12/1963	707-526-4049	11.2	9/17/2025				9/17/2025	
<input type="checkbox"/> Aguilar, Veronica	9/16/1981	707-526-5904	9.3	9/17/2025				9/17/2025	
<input type="checkbox"/> Aguilera, Issa F	5/23/2001	707-526-4534	9.7	9/17/2025				9/17/2025	
<input type="checkbox"/> Aguirre, Jose	6/21/1974	707-385-2996	10.7	3/20/2020				9/17/2025	
<input type="checkbox"/> Alejandro, Rogelio	9/23/1972	707-526-0805	9.4	7/21/2025				9/17/2025	

Search Criteria

Pre-Filter: Include Registered Patients
Active
AND
(
 Have Problem: 'Diabetes Type I (NQF)' or 'Diabetes Type 1 or 2' (Period = Any period)
 OR Have Tracking Type: 'Diabetes - High Risk' or 'Diabetes Tracking' or 'Diabetes Tracking (i2i)' (Entered During Period = Any period)
)
AND Have HbA1c (Value: Greater than 9 (Most Recent); Period = Any period; Min Count = 1)

Select All
Select None
Actions
Patient Info
Report
Report Selected

Count: 235
 Show Criteria



Azara DRVS: Registries



Hypertension REGISTRY

VISIT DATE RANGE: 09/01/2024-09/30/2024

RENDERING PROVIDERS: All Rendering Provid...

Demo Data

REGISTRY VALUE SETS

Search Patients ...

BP VALUES 1ST				BP VALUES 2ND				BP VALUES 3RD		
DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	VALUE	SYSTOLIC
5/22/24 6:30 pm	115/81	115	81							
9/4/24 12:30 pm	129/77	129	77							
9/10/24 11:15 am	136/83	136	83	9/10/24 11:15 am	113/75	113	75			
9/9/24 9:30 am	160/116	160	116	9/9/24 9:30 am	153/95	153	95			
9/13/24 8:15 am	126/85	126	85							
9/4/24 10:00 am	153/88	153	88	9/4/24 10:00 am	147/87	147	87			
10/16/24 8:00 am	166/74	166	74	10/16/24 8:00 am	152/78	152	78	10/16/2024	135/78	
10/9/24 8:00 am	200/105	200	105	10/9/24 8:00 am	134/86	134	86			
9/30/24 8:00 am	158/74	158	74	9/30/24 8:00 am	144/76	144	76			
10/15/24 12:00 am	139/86	139	86							
9/9/24 12:00 am	157/105	157	105							
9/9/24 10:45 am	151/98	151	98	9/9/24 10:45 am	139/76	139	76			
9/19/24 10:45 am	144/77	144	77	9/19/24 10:45 am	133/75	133	75			
9/18/24 10:00 am	186/112	186	112	9/18/24 10:00 am	128/84	128	84			
9/26/24 12:00 am	137/96	137	96							

1 to 15 of 2,076

Pre-built searches.

No more having to learn about the And/Or/“” functions.



DEM (Data Element Manager): i2iTracks



The screenshot shows the i2iTracks Data Element Manager interface. The top menu includes FILE, SETUP, PATIENTS, FIND, REPORTS, WINDOWS, and HELP. The main window is titled "Data Element Manager" and features a left-hand navigation pane with a tree view of categories such as Allergy, Discharge Status, Education, Ethnicity, Event, Goal, Immunization, Medication, and Status. The main area displays a table of data elements with columns for Name, Type, User-Defined, Favorite, Enabled, # Occurrences, and Last Date. A filter box and checkboxes for "Show Disabled" and "Patient Level" are also visible.

Name	Type	User-Defined	Favorite	Enabled	# Occurrences	Last Date
On ACE or ARB	Medication	Yes	No	Yes	95641	11/18/2025 1:
ACE or ARB Therapy	Medication	Yes	No	Yes	95641	11/18/2025 1:
Aspirin	Medication	No	Yes	Yes	82124	11/18/2025 1:
ACE Inhibitor	Medication	No	Yes	Yes	81517	11/18/2025 1:
Lipid Lowerer	Medication	Yes	No	Yes	60816	11/18/2025 1:
Statin	Medication	No	Yes	Yes	59568	11/18/2025 1:
Lipid Lowerer	Medication	Yes	No	Yes	58289	11/18/2025 1:
Sulfonylurea, Any	Medication	No	Yes	Yes	23757	11/18/2025 1:
Glucophage	Medication	No	Yes	Yes	22687	6/28/2021 12:
Visit: UDS Visit	Event	No	No	Yes	21540	11/18/2025 2:
ARB	Medication	No	Yes	Yes	21176	11/18/2025 1:
Had a visit	Event	Yes	No	Yes	20216	11/18/2025 1:
Visit: Ambulatory	Event	No	No	Yes	20095	11/18/2025 2:
Drugs to be avoided in the elderly	Medication	Yes	No	Yes	18903	11/18/2025 1:



DRVS Mapping Admin



Under Mapping Administration, you can see elements that require mapping attention and DRVS displays the unmapped values.

MAPPING CATEGORY	UNMAPPED EHR VALUES
Ethnicity	0
Gender Identity	0
Homelessness Status	1
Immunizations	0
Lab Results	
Language	
Migrant Status	
Race	
Service Line	
Sexual Orientation	
Structured Clinical Data	
Telehealth Encounter	
UDS F2F Qualifying Encounter	

MAPPING CATEGORY	UNMAPPED EHR VALUES
Appointment Status	
Billable Encounter	
Homelessness Status	
Prenatal Visit	
Provider Order Type	
Race	
Service Line	

MAPPED DRVS VALUE	COUNT	SOURCE EHR TEXT
Unmapped	4,479	Open
Unmapped	1,502	Radiology
Unmapped	1,455	Allergist
Unmapped	1,447	Accupuncture
Unmapped	1,417	Gastroenterology
Unmapped	1,406	Nutritionist



iPHA Reports: i2iTracks



2025 CUSTOM UDS REPORT 6B 7

Run Date: 3/23/2026 5:52:55 AM
Date Range: 1/1/2025 - 12/31/2025

2025 CUSTOM UDS REPORT 6B & 7

Item	Target	Value	%	
2. CMS124-v13 CERVICAL CANCER SCREENING				
A. [DENOMINATOR]: Women 24-64 years of age by the end of the measurement period with a visit during the measurement period		1042	100 %	
1. [NUMERATOR]: Patients who received age appropriate screening for cervical cancer	> 40%	290	27.83 %	↓
3. CMS125-v13 BREAST CANCER SCREENING				
A. [DENOMINATOR]: Women 52-74 years of age by the end of the measurement period with a visit during the measurement period		298	100 %	
1. [NUMERATOR]: Women who received at least one screening for breast cancer within the last 27 months	> 40%	0	0%	↓
4. CMS155-v13 WEIGHT ASSESSMENT & COUNSELING FOR CHILDREN/ADOLESCENTS				
A. [DENOMINATOR]: Patients 3-17 years of age by the end of the measurement period, with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period		65	100 %	
1. BMI% - During Calendar Year		46	70.77 %	
2. Nutrition Counseling - During Calendar Year		43	66.15 %	



DRVS Scorecards



Measures already built out for you in DRVS based on CQM specifications.

Ability to display in Crosstab format for enhanced visibility

UDS 2025 CQMs REPORT

PERIOD: TY September 2025 | RENDERING PROVIDERS: All Rendering Provid... | BASELINE PERIOD: TY May 2025

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (CMS 117v13)	0.0%	0.0%	55.0%	0	7	10
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v13)	51.8%	-2.7% ▼	40.0%	115	222	111
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	83.9%	-1.8% ▼	95.0%	360	429	670
Depression Remission at Twelve Months (CMS 159v13)	4.8%	+2.6% ▲	30.0%	5	105	152
Screening for Depression and Follow-Up Plan (CMS 2v14)	75.6%	+1.2% ▲	62.0%	1,055	1,396	4
Tobacco Use: Screening and Cessation (CMS 138v13)	69.5%	-1.2% ▼	85.0%	928	1,335	12

Demo Data

GROUPING: Rendering Providers | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: CrossTab

RENDERING PROVIDERS	CHILDHOOD IMMZ STATUS (CMS 117V13)	CHILD WEIGHT ASSESSMENT (CMS 155V13)	BMI SCREEN & FOLLOW-UP 18+ (CMS 69V13)	DEPR REMISSION AT 12 MONTHS (CMS 159V13)	DEPR SCRIN & FOLLOW-UP (CMS 2V14)	TOBACCO USE: SCREENING & CESSATION (CMS 138V13)	COLORECTAL CANCER SCREENING (CMS 130V13)	CERVICAL CANCER SCREENING (CMS 124V13)	BREAST CANCER SCREENING (CMS 125V13)	HTN CONTROLLING HIGH BP (CMS 165V13)	DM A1C OR GMI > 9 OR UNTESTED (CMS 122V13)	ST... (CMS 34...)
Augustine, Greg	0.0%	61.0%	90.6%	0.0%	85.1%	79.0%	69.0%	0.0%	80.0%	66.7%	63.1%	74
Bar, Samuel	0.0%	83.3%	84.6%	0.0%	90.9%	88.0%	0.0%	0.0%	0.0%	100.0%	46.2%	83
Black, Ronda	0.0%	51.5%	84.9%	7.1%	80.5%	78.5%	76.9%	37.5%	100.0%	100.0%	50.0%	73



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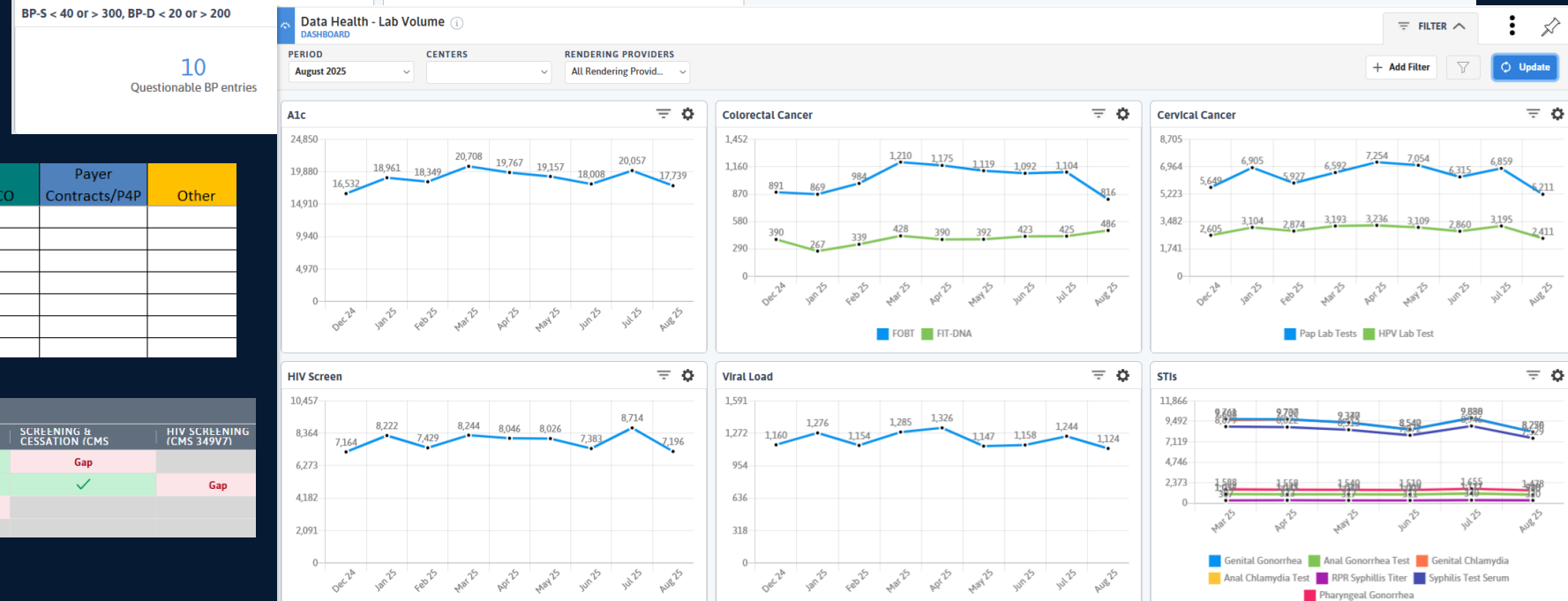
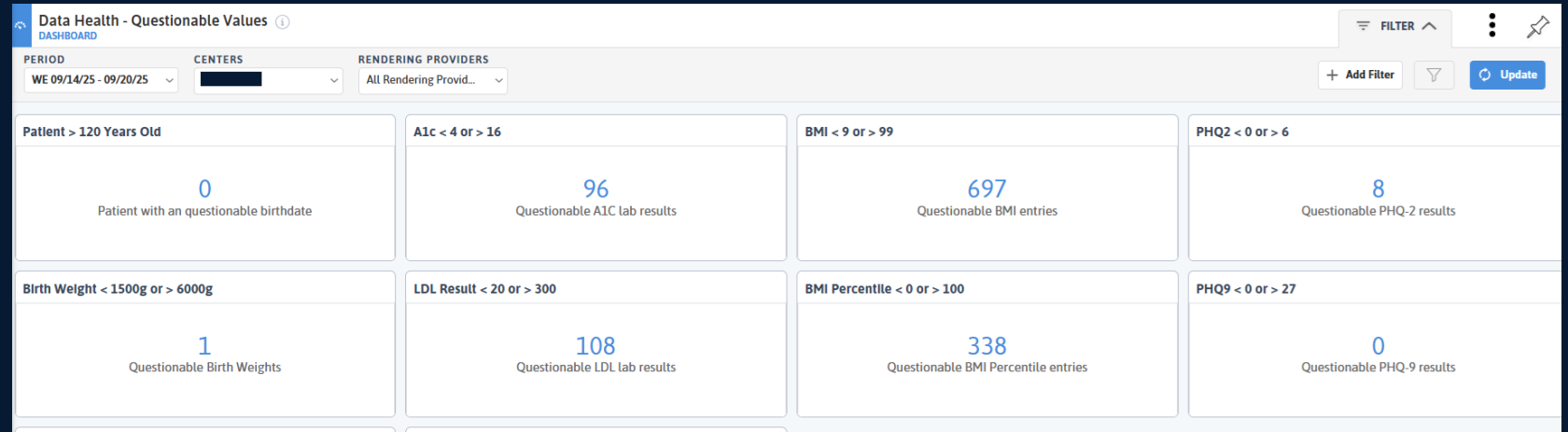
DRVS Advanced Features



Data Hygiene Tools



MAPPING CATEGORY	UNMAPPED EHR VALUES
Ethnicity	1
Gender Identity	0
Homelessness Status	0
Immunizations	0
Lab Results	0
Language	0
Migrant Status	0
Race	0
Service Line	5
Sexual Orientation	0
Structured Clinical Data	4
Telehealth Encounter	25
UDS F2F Qualifying Encounter	0
UDS Service Category	17
Veteran Status	0



Measure Name	UDS 2025	HRSA	PCA/HCCN	MU CQM	ACO	Payer Contracts/P4P	Other
DM A1c	X						
Cervical Cancer Screening	X						
Childhood Immunizations	X						
HTN BP Control	X						
Child Weight Screening and Counseling	X						
Colorectal Cancer Screening	X						
Depression Screening and Follow-up	X						

GAP	MEASURES				
DESCRIPTION	CHILD WEIGHT ASSESSMENT (CMS 155V13)	BMI SCREEN & FOLLOW-UP 18+ (CMS 69V13)	DEPR SCRNM & FOLLOW-UP (CMS 2V14)	SCREENING & CESSATION (CMS)	HIV SCREENING (CMS 349V7)
1 Tobacco Scrm	✓		✓	Gap	
1 HIV Scrm	✓		✓	✓	Gap
1 Depr Scrm			Gap		
1 BMI & Follow-Up		Gap			

Data Hygiene Tools



BMI Screening and Follow-Up 18+ Years (CMS 69v13)

Center: Access Community Health | Period: TY September 2025

Name: Gus Aravjo | Sex at Birth: M | DOB: 12/28/1976 (48 years as of 9/30/2025)

BMI LOWEST: 4/20/25 - 22 (Vitals)

Denominator (Y)

Exclusion (Y)

Exception (N)

REASON BMI EXAM OR FOLLOW-UP NOT DONE: 4/20/25 - Medical Reason BMI Follow-Up Not Done (Weight Reduction Contraindicated - Procedure)

1102535	Dinsmoor, Elanor	F	6/9/1974	4451408	Smith, Joe	ACH - Needs Update	N	N	5/25/2025	Decelles, Larry	70 Blanchard Rd.	9/19/25 7:00 am	Doe
1102546	Taliulu, Lloyd	M	5/9/1959	4651263	Augustine, Greg	ACH - Needs Update	N	N	8/15/2025	Winslow, Francine	1400 Cambridge St.	9/25/25 5:45 am	Doe



AI Summaries in MIT & CMP: Now Available! | 1

Azara is excited to roll out powerful new enhancements! Users will see a concise, high-value summary at the top of these tools, surfacing important insights immediately.

These upgrades make it easier than ever for your organization to quickly identify key patient information, understand high-level data, and take timely, informed action.

Measure Investigation Tool (MIT): Access quick, digestible information about why a patient meets or does not meet measure criteria.

BMI Screening and Follow-Up 18+ Years (CMS 69v13) Demo Patient Data X

1102042 Center: Access Community Health Period: TY January 2026

Name: Cletus Loa Sex at Birth: F DOB: 8/1/1968 (57 years as of 1/31/2026)

Smart Summary
The patient is in the numerator because she is 57 years old and has a BMI documented on 06/23/25 with a follow-up plan documented for an abnormal BMI during the measurement period.

AI-generated content — please review for accuracy

Released February 2026

azara healthcare



Immunization Management



Search

All Centers

Immune Management

REPORT

CENTERS: All Centers

USUAL PROVIDERS: All Usual Providers

CHILD AGE: < 2 Years

LAST VISIT: Any visit in past 2 ye...

Dem Data

Filter Update

Immunization Overview

133 PATIENTS

133

Due w/o Appts

100%

0

Due w/ Appts

0%

0

Due Soon

0%

0

No Action Required

0%

SHOW DETAILS Disabled Enabled

Search...

All Required Recommended Proactive

Due Soon Due Not Eligible Complete Missed Other Refused

SAVED COLUMNS

CENTER NAME	STATUS	DEMOGRAPHICS		AGE		PRIMARY CARE ENCOUNTER			IMMUNIZATION			
		NAME	MRN	(YRS)	(MOS)	DATE	PROVIDER	LOCATION	HEPB	ROT	DTAP	HIB
Family Health Center	●	Devito, Charley	1101031	0	0	2/9/2025	Branchburg, Tom	Lakeview Adult Medicine	Due 1		✓	
Neighborhood Health Center	●	Marlene, Badgero	1100878	0	0	2/11/2025	Green, Leslie	Main Office	Due 1		✓	
Access Community Health	●	Mollet, Jacinto	1103848	0	0	1/31/2025	Bridgewater, Bill	Main St. Office	Due 1		✓	
Access Community Health	●	Kulick, Robby	1103472	0	0	9/4/2025	Smith, Joe	70 Blanchard Rd.	Due 1		✓	
Access Community Health	●	Giambruno, Branden	1102412	0	0	12/25/2023	Smith, Joe	Main St. Office	Due 1		✓	
Family Health Center	●	Moralis, Wendolyn	1104878	0	0	1/24/2025	Branchburg, Tom	Florence Ave. Center	Due 1		✓	
Access Community Health	●	Libengood, Jolene	1102422	0	0	4/1/2025	Fritz, Renata	1400 Cambridge St.	Due 1		✓	
Access Community Health	●	Waldhoff, Laticia	1103427	0	0	3/6/2024	Smith, Joe	1400 Cambridge St.	Due 1		✓	
Family Health Center	●	Howey, Beata	1100334	0	1	1/13/2025	Weixel, Evan	Lakeview Adult Medicine	Due 1		✓	
Access Community Health	●	Barnette, Kendra	1103167	0	1	6/21/2025	Crowley, Patrick	Main St. Office	Due 1		✓	
Access Community Health	●	Purtill, Shawn	1104789	0	1	12/8/2023	Augustine, Greg	70 Blanchard Rd.	Due 1		✓	
Access Community Health	●	Shavon, Keye	1102304	0	1	7/24/2025	Bridgewater, Bill	70 Blanchard Rd.	Due 1	Due Soon 1	✓	Due Soon 1
Access Community Health	●	Brainard, Tenesha	1100236	0	1	9/2/2025	Smith, Joe	Main St. Office	Due 1	Due Soon 1	✓	Due Soon 1



Pre-Defined Alerts



Search

Access Community Health

Alert Administration

Search Alerts...

All Enabled Disabled

All In POC Measure Not in POC Measure

CATEGORY	NAME	PVP NAME	ENABLED	CONFIGURABLE	DESCRIPTION	OWNER
Vitals	Adult Weight Screening	BMI & FU	Y	N	Alert will trigger if patient has not had a BMI in the past year, or if most recent BMI was out of range and no follow-up was documented. Out of range is where the BMI < 18.5 OR BMI >= 25 for patients 18+ old. Excludes patients who are pregnant, in hospice care, or receiving palliative care services. This alert is not configurable	MA
Chronic Disease	Asthma Severity	Asth Severity	Y	Y	Alert will trigger if Asthma Severity has not occurred in the last 1 years. Patient must have Asthma.	
Vitals	BMI Child Overweight -Obese	BMI % >85%	Y	N	Alert will trigger if a pediatric patient has BMI % >= 85. Alert applies to children age 2-17 years. This alert is not configurable	
Vitals	BMI Percentile	BMI %	Y	Y	Alert will trigger if BMI Percentile Value has not occurred in the last 1 years. Alert only applies to patients >= 2 yrs old and <= 17 yrs old.	
Vitals	BP	BP	Y	Y	Alert will trigger if Most Recent Blood Pressure has not occurred in the last 1 years, or if numeric_1 value is >= 140 and numeric_2 value is >= 90. Alert only applies to patients <= 85 yrs old. Patient must have IVD or AMI or CABG or PCI or Hypertension or Diabetes Type I or Type II.	
Cancer Screening	Cervical Cancer Screening	Pap HPV	Y	N	Alert will trigger 1) if patient age >= 21 and <= 64 did not have a pap in the last 3 years 2) if patient age >= 20 and <= 64 did not have HPV test in the last 5 years, or is due in the next	Prov

1 to 14 of 28

Page 1 of 2



POC Dashboard



Point of Care Alert Closure DASHBOARD
FILTER ^
⋮ 📌

PERIOD

WE 03/01/26 - 03/07/26

CENTERS

All Centers

RENDERING PROVIDERS

All Rendering Provid...

RENDERING LOCATIONS

All Rendering Locati...

ALERT

All Alert

SERVICE LINES

All Service Lines

+ Add Filter

⌵

Update

Demo Data

% POC Alert Closed

68.3%

% Alerts Closed

● PRIMARY 74%
● SECONDARY 64%

POC Alerts in Period

1,295

Denominator

Closure Performance over Time

Alert Closure by Location

RENDERING LOCATIONS	RESULT	DENOM
FHC - Needs Update	69.5%	453
ACH - Needs Update	68.2%	650
NHC - Needs Update	66.1%	192

Alert Closure by Provider

RENDERING PROVIDERS	RESULT	DENOM
Lynes, Lori	92.3%	13
Pane, Janet	88.0%	25
Plant, Robert	86.1%	36
Paul, Jessica	85.7%	21
Parker, Philip	85.0%	20

Closure by Alert

ALERT	RESULT	NUM	DENOM	GAP
Tobacco Scr	86.3%	207	240	33
BMI & FU	4.7%	9	193	184
A1c	84.4%	151	179	28
Depression Screen	86.5%	154	178	24
Asth Severity	79.2%	137	173	36



Defining A Patient Population: Upcoming



Update Registry Cancel Save

GENERAL

NAME
LuAnn Kimker's Wonderful Azara Conference Presentation

CENTER
All Centers

DESCRIPTION
This is a demonstration of the new registry builder capabilities due to be released in Q2! Get psyched to do things you never thought were possible :-)
Remember to give the Product & Engineering Team big hugs and buy them cookies.

ACCESS SETTINGS
All Centers All Centers

STATUS Enabled Disabled

POPULATION DEFINITION + Create New Population Definition

POPULATION DEFINITION
Epinephrine Edit

POPULATION DESCRIPTION
test

POPULATION CRITERIA RULES SUMMARY

INCLUDE ALL
Patient Poverty Level HHS is 100% and below
AND Patient is greater than 18 Year(s) Old

AND

INCLUDE ANY
Patient has been prescribed Insulin Medication
OR Patient has been prescribed Epinephrine Auto-Injection Rx

DATA ELEMENTS
Select from the options below, double click to add from the left or double click from the right to remove.

TITLE
Search

CATEGORIES
All
Claim
Demographics
Dental
Diabetes
Diagnosis
Encounter
Immunization
Incarceration
Lab

OPTIONS
Actively Pregnant Patient
Bacterial Infection
Care Plan
Developmental Screening
Family Planning Method
Measles IgG Antibody presence
Microalbumin in Urine
SARS-COV-2 (COVID-19) Vaccine Booster Dose
Tobacco Cessation Counseling

SELECTED
A1c
Last Name
Medical Record Number



Defining A Patient Population: Upcoming



Update Registry Cancel Save

Edit Population

GENERAL RULES AND CRITERIA

The information entered here will determine the rules and criteria for including or excluding patients from this population.

TYPE
Select Type Add Rule

INCLUDE ALL

Demographics	POVERTY LEVEL HHS 100% and below ×	Patient Poverty Level HHS is 100% and below AND Patient is greater than 18 Year(s) Old
	AGE Greater than or equal to 18 Years ×	
Primary Payer	Medicaid 7 selected ×	Patient primary payer is one of the 7 selected Medicaid payers

INCLUDE ANY

Medication	INSULIN MEDICATION ×	Patient has been prescribed Insulin Medication OR Patient has been prescribed Epinephrine Auto-Injection Rx
	EPINEPHRINE AUTO-INJECTION RX ×	

Cancel Confirm



Other DRVS Enhanced Features

15

- Provider Empanelment 4 Cut Report
- EMR Plug-in
- Center Usage Reporting
- HEDIS Care Gap Reconciliation
- Ability to add Multiple Targets/Goals to measures
- And so much more!



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Customer Stories

Their Transition Journey





Chesapeake Health Care

Chesapeake Health Care is a non-profit, community-based healthcare organization headquartered in Salisbury, MD, serving communities across the Lower Eastern Shore

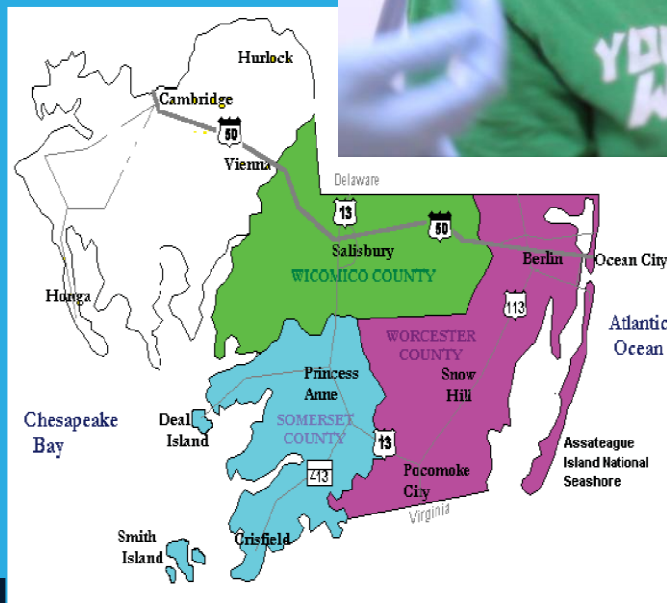
Organization Snapshot

- Founded 1994 (originally known as Three Lower Counties Community Services)
- Patients Served Annually: 61,000+
- Providers: 125
- Care Model: FQHC

Services Offered

- Adult & Family Medicine
- Pediatrics
- Women's Health & OBGYN
- Behavioral Health
- Dental
- Pharmacy

Mission: To provide affordable, culturally competent, patient- and family-centered healthcare, improving access and health outcomes for underserved communities



Total Health Care



Federally Qualified Health Center (FQHC) with 7 locations in Baltimore City and Anne Arundel County, Maryland

Founded: 1968

Mission: To improve health and quality of life in the communities we serve.

Vision: Every person in the communities served by Total Health Care will have access to a patient-centered medical home that advances health equity across Maryland.

Staff Count: 288

Unique Patients: 26,976

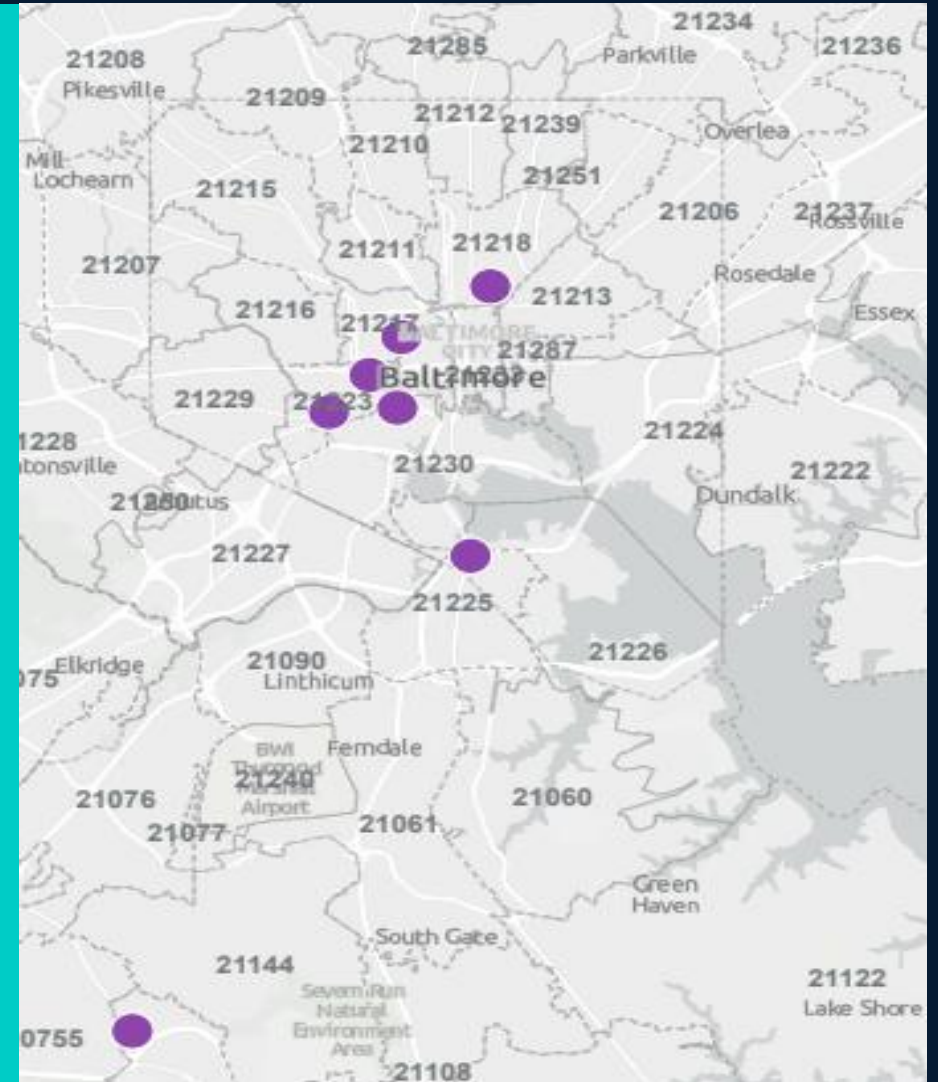
Total Visits: 101,749

Clinic: 81,081; **Virtual:** 21,493

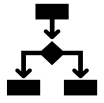
Services: Adult Primary Care, Pediatrics, Behavioral Health, Pharmacy, Dental, Infectious Disease (Hep C/HIV), OB/GYN, Podiatry, Substance Use Services, Telehealth, Mobile Health



Total Health Care
SINCE 1968



Transition Experience: Chesapeake



Outcomes & Impact

- Smooth, well-supported transition
- Strengthened reporting/analytics capabilities
- Reporting continuity during transition
- Improved workflow alignment
- Stronger user adoption across teams
- Ability to support MDPCP reporting



Success Factors

- Strong Collaboration
- Both teams worked closely with Chesapeake
- Provided structured training & guidance
- Facilitated training & ongoing support
- Ensured accurate mapping & validation
- Provided responsive support



Special Shout Out from Chesapeake

Molly Wack

Major component of the transition. Provided structured training and staff guidance

Hannah Paxton

Previously worked with CHC during i2iTracks was uniquely positioned to facilitate training and ongoing support

Lori Lynes

Provided invaluable support during data integration and quality assurance

Matt Paschal

Provided responsive & consistent support by addressing integration questions quickly

Samuel Bar

Supported the integration of MDPCP models within Azara DRVS



Transition Experience: Total Health



15

Value Delivered

- ➔ Great support team providing guidance & resources.
- ➔ Administrative & technical assistance for data transfer/mapping.
- ➔ Comprehensive evaluation conducted to provide valuable workflow recommendations.

Why it was Successful

- ➔ Strong vendor partnership and technical support.
- ➔ Structured roadmap for implementation and training.



Transition Lessons Learned: Chesapeake

15

Open, Clear, and Consistent Communication

- Between internal and external team members
- Ensured questions could be addressed quickly
- Communicating and aligning expectations
- Address potential challenges before they become a problem

Help Documentation Portal

- Documentation library provides step-by-step guidance
- Provides best practices for navigating the platform
- Often, answers questions quickly for those still learning the platform



Transition Lessons Learned: Total Health



- ➔ Ensure key staff are involved in implementation process
- ➔ Have clearly documented workflows
- ➔ Use structured data
- ➔ Have adequate time to review data sets/mapping
- ➔ Learn one functionality at a time/helps to identify how it can integrate into current workflows
- ➔ Spend time navigating the platform to become fully acclimated with the various tools



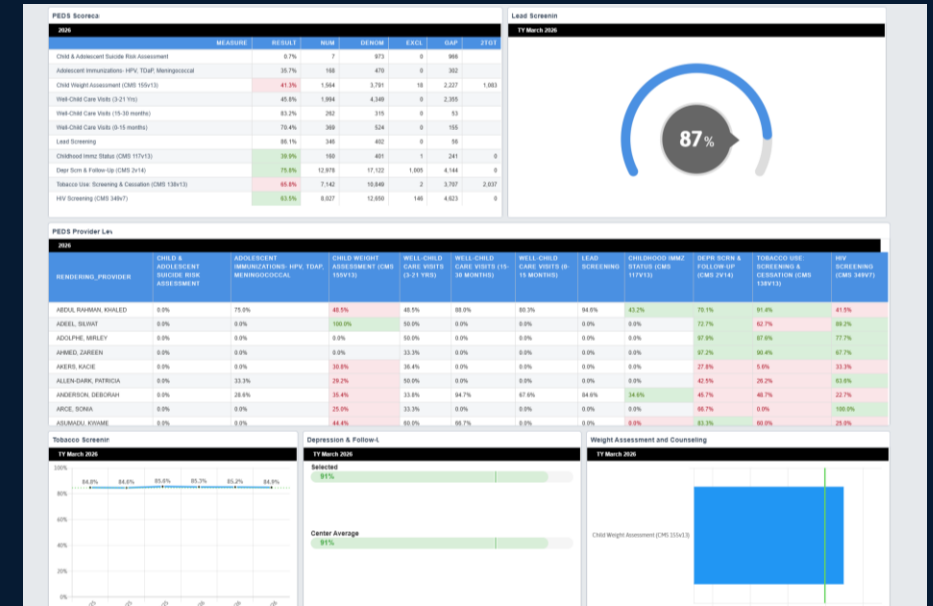
DRVS Functionality | Chesapeake



Dashboards

Most notable is the visualization capabilities of DRVS Dashboards

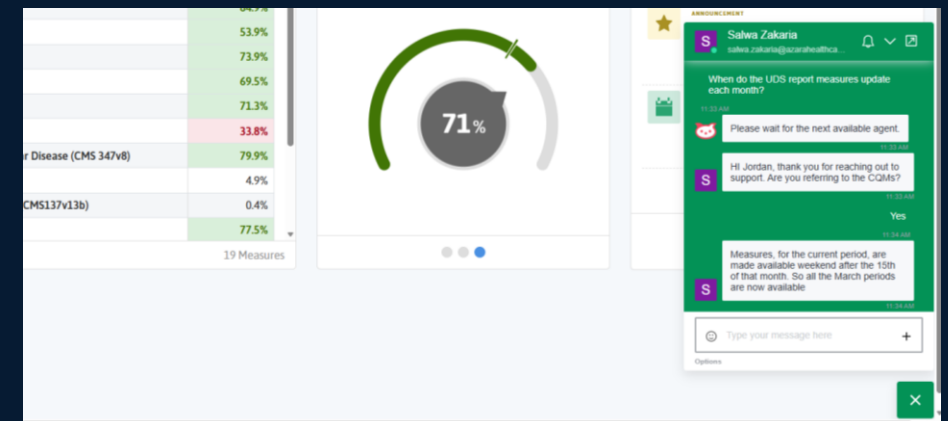
- Clear visual displays of data
- Quickly visualize performance trends
- Identify care gaps



Live Chat

Live Chat support feature has been a standout tool

- Immediate access to support

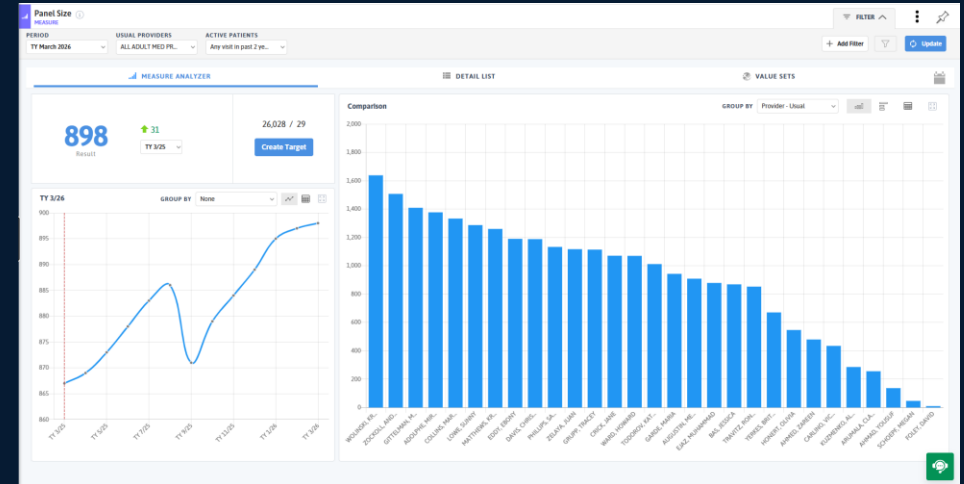


DRVS Functionality | Chesapeake



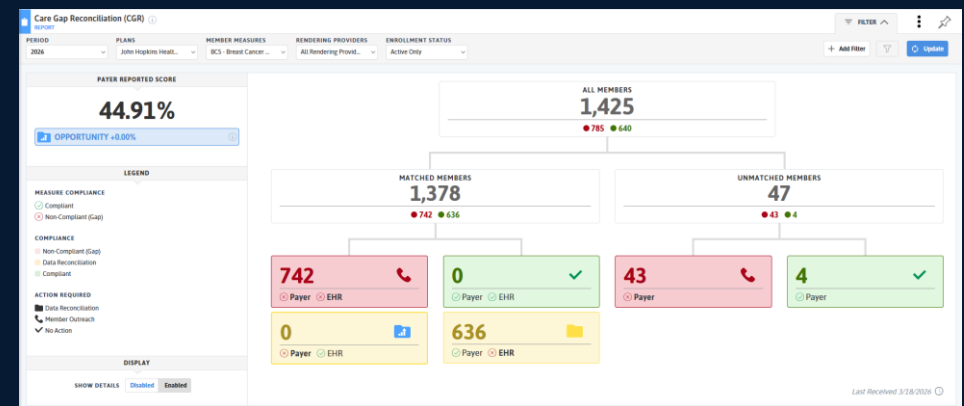
Panel Management

- Ability to identify opportunities to redistribute patients
- Ensures continuity of care and smooth transitions



Care Gap Reconciliation

- Ability to compare internal data with payer-reported care gaps
- Assisting with alignment between EHR documentation and payer information



DRVS Functionality | Total Health



Knowing you are new to DRVS, what functionalities has impressed you the most?

Reporting Tools

- Reports, Dashboards, & Measures
- Standardized
- Benchmarking capabilities

Care Gaps & Data Validation

- PVP & CMP: Streamline workflows with ready to use Care Gap Alerts
- Measure Analyzer: Tracks improvement trends over time
- Drill-down Capabilities: By provider or location



DRVS Functionality | Total Health Care



Specific reports staff find most beneficial?



Upstream Initiative: Reports Tracking and Monitoring our Progress



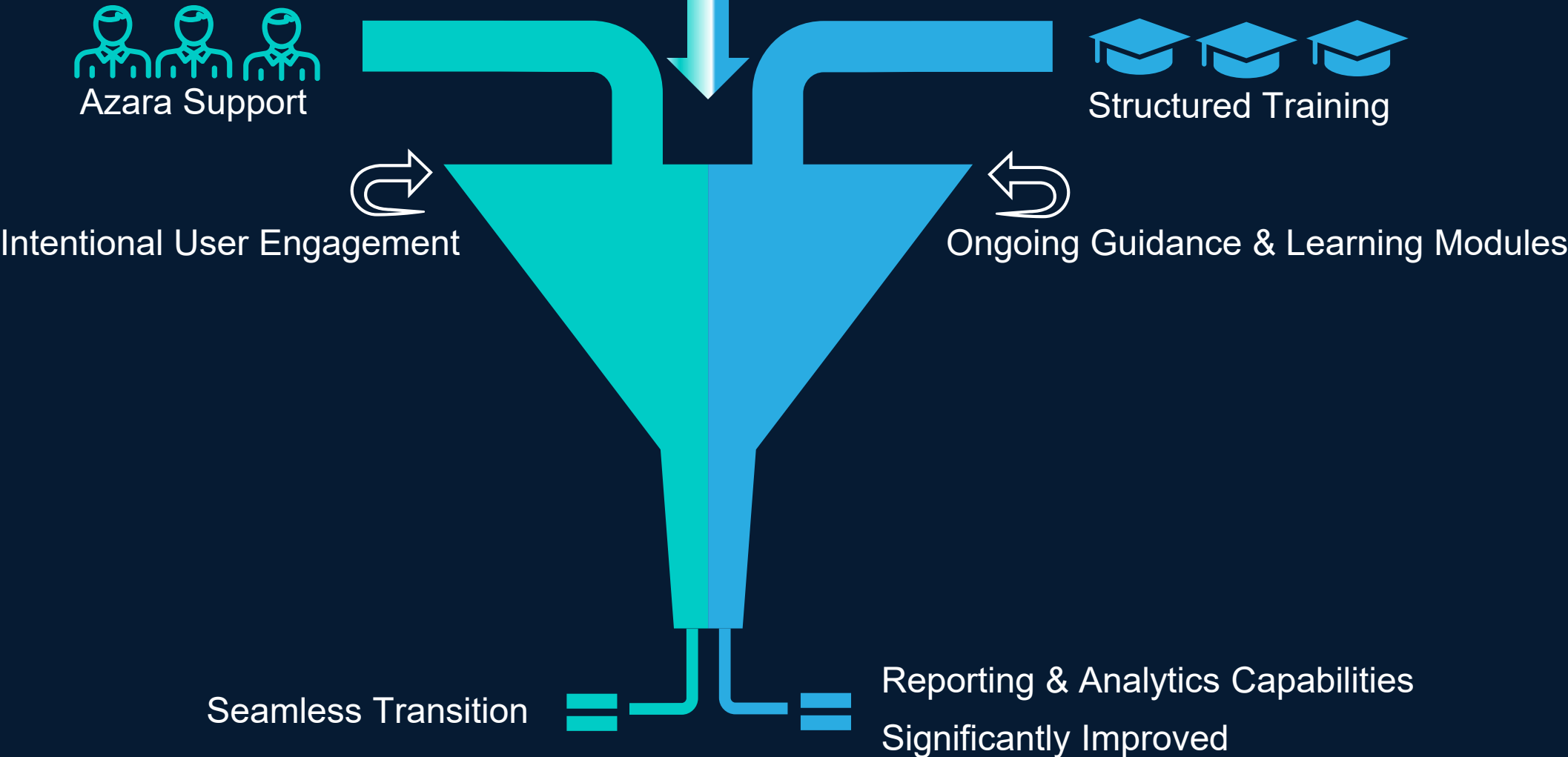
HRSA UDS eCQM's & PCMH Dashboards



PVP (*Patient Visit Planning Report*)




Key Takeaways



Questions?



 azara healthcare

 @AzaraDRVS





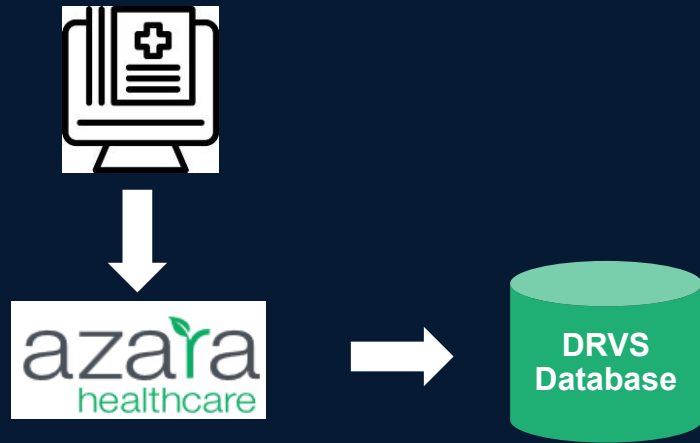
Appendix



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Data Connectivity At a Glance



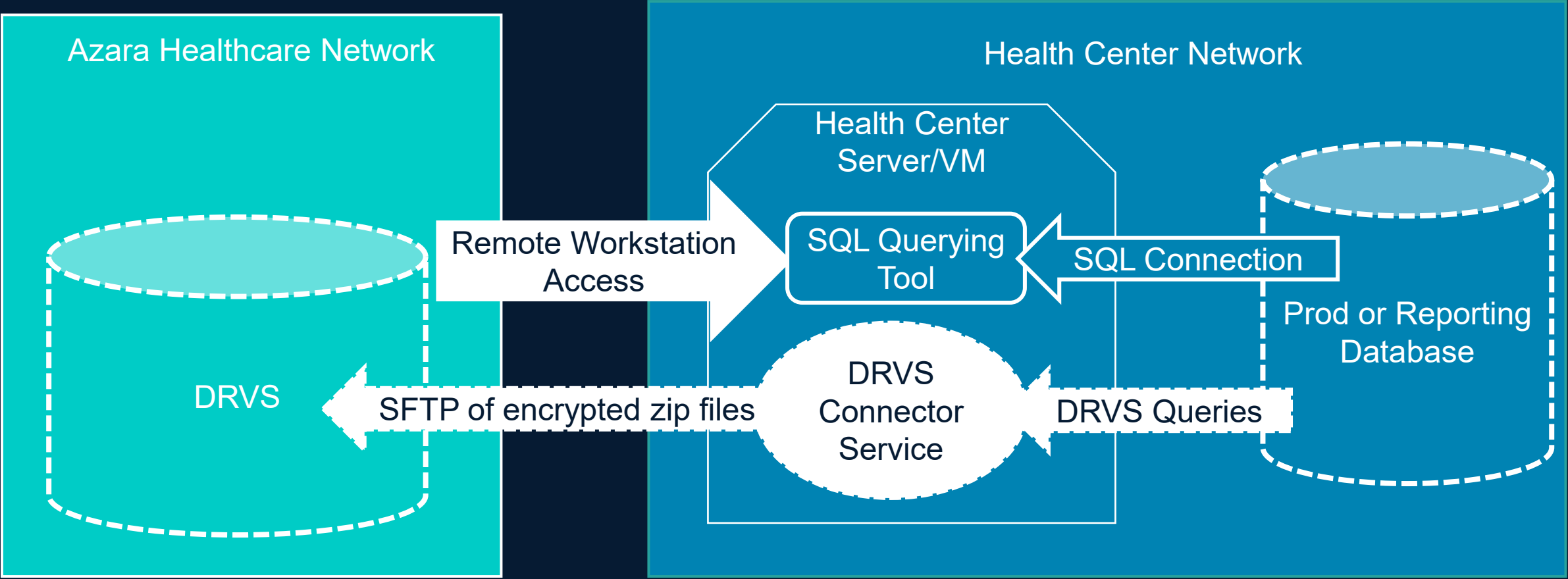
Connectivity between the EHR database and Azara is established

Data is brought into DRVS

- Establish a secure connection and transfer of data (dependent on EMR and hosting)
 - Direct Connection via Azara DRVS Data Connector
 - Pulls Daily incremental data
- OR
- Data Feed
 - Daily extract sent to Azara SFTP
- Azara team monitors the connectors.



Self-Hosted EMR Connectivity



Key

- Maintained by Azara
- Maintained by Health Center IT
- Flow of EHR Data



Utilizing PVP For Depression Remission

Health Partners of Western Ohio



CHALLENGES

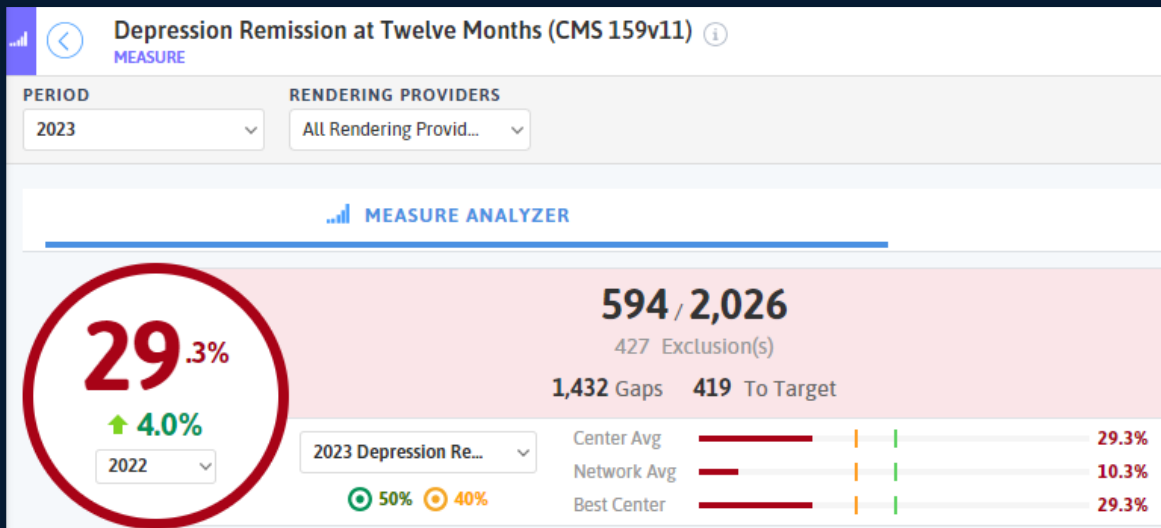
The organization identified the Depression Remission measure as an area of clinical focus for 2022/2023. The prediction of the PHQ-9 re-screening and follow-up window was determined the primary driver as to why CHC targets were not being met.

SOLUTION

- CHC ran the PVP report by month allowing visibility into all patients on the schedules who fell into the measure denominator, along with the corresponding lookback period.
- Behavioral Health teams used these lists as a means to ensure screenings were captured during the necessary date ranges according to the measure definition workflow.

IMPACT

- HPWO is the Ohio network leader for the Depression Remission measure.
- Exceeded the 2022 national average of 13.64% by 11 percentage points according to UDS Clinical Quality Measures 2022 (hrs.gov).



2022 Network average 8.1%



2022 HPWO 25.3%



16% positive percentage improvement from 2022 - 2023



HEDIS Care Gap Reconciliation



Care Gap Reconciliation (CGR) REPORT

MEMBER MEASURES: BCS - Breast Cancer ... PERIOD: 2022 CENTERS: All Centers RENDERING PROVIDERS: All Rendering Provid... PLANS: All Plans

FILTER ^

+ Add Filter ▼ Update

PAYER REPORTED SCORE

53.86 %

OPPORTUNITY +3.81 %

LEGEND

MEASURE COMPLIANCE

- ✔ Compliant
- ✘ Non-Compliant (Gap)

COMPLIANCE

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

ACTION REQUIRED

- Data Reconciliation
- 📞 Member Outreach
- ✔ No Action

DISPLAY

SHOW DETAILS Disabled Enabled

ALL MEMBERS

16,739

● 7,724 ● 9,015

MATCHED MEMBERS

14,875

● 6,373 ● 8,502

UNMATCHED MEMBERS

1,864

● 1,351 ● 513

5,735

✘ Payer ✘ EHR

With Visits	3,039
Without Visits	2,696

6,297

✔ Payer ✔ EHR

With Visits	5,171
Without Visits	1,126

1,351

✘ Payer

513

✔ Payer

638

✘ Payer ✔ EHR

With Visits	551
Without Visits	87

2,205

✔ Payer ✘ EHR

With Visits	1,455
Without Visits	750

Last Received 5/1/2022

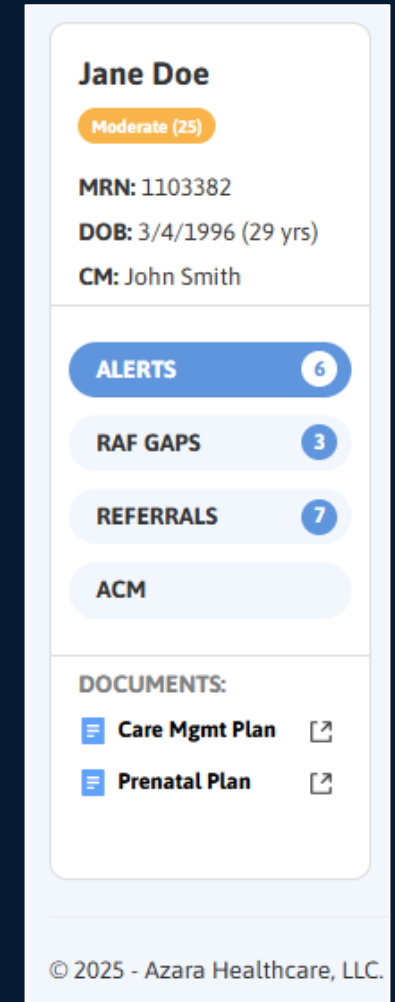
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DRVS EHR Plug-In Overview



- Allows providers and support staff to access Azara DRVS and ACM data from within an EHR at the point-of-care
- Includes:
 - Pre-visit Planning alerts
 - RAF (Risk Adjustment Factor) gaps
 - Open Referrals*
 - Azara Care Management notes*
- Works with Athena One, Epic, NextGen, and both browser (cloud) and desktop application versions of eCW



DRVS Dashboards



Center Overview DASHBOARD

FILTER + Update

PERIOD: August 2025

RENDERING PROVIDERS: All Rendering Provid...

+ Add Filter Update

Patient Population (3 yr)

TY August 2025

2,208

+15%

▲ TY 2/25

Monthly Visits by Location

August 2025

■ 1400 Cambridge St.
 ■ 70 Blanchard Rd.
 ■ Main St. Office
 ■ 711

Risk Stratification

TY August 2025

■ Low
 ■ Moderate
 ■ High

Rising Risk Patients

August 2025

22

Pts w/ New High Risk Level

Active Patient no Visit Past Year

TY August 2025

457

Patients by Care Manager

TY August 2025

CARE MANAGERS	PATIENTS
Veronica Ariel	131
Kevin Fairley	125
Keaton Tagseth	121

No Show Rate by Appointment Type

August 2025

Provider Continuity

August 2025

10%

UDS Clinical Quality Measures

TY August 2025

MEASURE	RESULT	NUM	DENOM	EXCL
Childhood Immz Status (CMS 117v13)	0.0%	0	8	12
Child Weight Assessment (CMS 155v13)	53.2%	123	231	102
BMI Screen & Follow-Up 18+ (CMS 69v13)	85.4%	352	412	676
Depr Remission at 12 Months (CMS 159v13)	4.2%	4	96	146

SDOH Assessment Rate

August 2025

■ 1400 Cambridge St.
 ■ 70 Blanchard Rd.
 ■ Main St. Office
 ■ 711



DRVS Scorecards



-
-
-
-
-
-
-
-
-

Access Community Health

UDS 2025 CQMs REPORT

PERIOD
TY September 2025

RENDERING PROVIDERS
All Rendering Provid...

BASELINE PERIOD
TY May 2025

+ Add Filter
▼
Update

GROUPING No Grouping

TARGETS ■ Primary ■ Secondary ■ Not Met

REPORT FORMAT Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	
Childhood Immunization Status (CMS 117v13)	0.0%	0.0%	55.0%	0	7	10	⬇
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v13)	51.8%	- 2.7% ▼	40.0%	115	222	111	⬇
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	83.9%	- 1.8% ▼	95.0%	360	429	670	⬇
Depression Remission at Twelve Months (CMS 159v13)	4.8%	+ 2.6% ▲	30.0%	5	105	152	⬇
Screening for Depression and Follow-Up Plan (CMS 2v14)	75.6%	+ 1.2% ▲	62.0%	1,055	1,396	4	⬇
Tobacco Use: Screening and Cessation (CMS 138v13)	69.5%	- 1.2% ▼	85.0%	928	1,335	12	⬇
Colorectal Cancer Screening (CMS 130v13)	68.0%	+ 3.9% ▲	70.0%	104	153	192	⬇
Cervical Cancer Screening (CMS 124v13)	31.4%	+ 3.5% ▲	45.0%	11	35	373	⬇
Breast Cancer Screening Ages 50-74 (CMS 125v13)	61.8%	- 12.4% ▼	87.0%	21	34	56	⬇
Hypertension Controlling High Blood Pressure (CMS165v13)	93.8%	+ 9.2% ▲	80.0%	30	32	299	⬇
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	58.7%	- 3.3% ▼	34.0%	272	463	365	⬇
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v8)	86.5%	+ 1.4% ▲	22.0%	615	711	744	⬇
Initiation of Substance Use Disorder Treatment (CMS137v13a)	90.3%	- 1.4% ▼	22.0%	65	72	0	⬇



DRVS Scorecards – CrossTab View



Search Access Community Health

UDS 2025 CQMs REPORT FILTER

PERIOD: TY September 2025 | RENDERING PROVIDERS: All Rendering Provid... | BASELINE PERIOD: TY May 2025

+ Add Filter | Update

REPORT + CARE GAPS

GROUPING: Rendering Providers | TARGETS: Primary Secondary Not Met | REPORT FORMAT: CrossTab

RENDERING PROVIDERS	CHILDHOOD IMMZ STATUS (CMS 117V13)	CHILD WEIGHT ASSESSMENT (CMS 155V13)	BMI SCREEN & FOLLOW-UP 18+ (CMS 69V13)	DEPR REMISSION AT 12 MONTHS (CMS 159V13)	DEPR SCR N & FOLLOW-UP (CMS 2V14)	TOBACCO USE: SCREENING & CESSATION (CMS 138V13)	COLORECTAL CANCER SCREENING (CMS 130V13)	CERVICAL CANCER SCREENING (CMS 124V13)	BREAST CANCER SCREENING (CMS 125V13)	HTN CONTROLLING HIGH BP (CMS 165V13)	DM A1C OR GMI > 9 OR UNTESTED (CMS 122V13)	STATIN THERAPY CVD (CMS 347V8)	INITIATION OF SUD TREATMENT (CMS137V13A)	ENGAGEMENT OF SUD TREATMENT (CMS137V13B)	IVD ASPIRIN USE	HIV AND PREGNANT	HIV LIN TO CA
Augustine, Greg	0.0%	50.0%	87.9%	0.0%	80.1%	78.1%	82.4%	20.0%	50.0%	100.0%	60.9%	91.0%	94.1%	17.6%	80.0%	95.9%	0.0
Black, Ronda	0.0%	57.4%	81.8%	0.0%	79.6%	74.5%	74.2%	42.9%	77.8%	100.0%	62.1%	91.6%	80.0%	13.3%	100.0%	89.9%	0.0
Bridgewater, Bill	0.0%	70.8%	85.7%	16.7%	81.0%	78.6%	66.7%	50.0%	75.0%	100.0%	59.3%	88.4%	90.9%	18.2%	50.0%	90.9%	0.0
Crowley, Patrick	0.0%	66.0%	89.4%	0.0%	83.6%	80.0%	61.1%	40.0%	100.0%	100.0%	60.0%	90.2%	92.9%	0.0%	60.0%	90.3%	0.0
Decelles, Larry	0.0%	48.8%	77.3%	22.2%	79.8%	78.2%	79.2%	50.0%	33.3%	87.5%	54.9%	85.8%	100.0%	8.3%	33.3%	94.0%	0.0
Doe, Jane	0.0%	61.5%	87.5%	10.0%	81.6%	83.3%	60.9%	33.3%	60.0%	100.0%	54.2%	92.5%	75.0%	12.5%	66.7%	87.1%	0.0
Fritz, Renata	0.0%	62.0%	85.1%	16.7%	81.3%	81.6%	82.8%	50.0%	60.0%	100.0%	56.6%	85.1%	86.7%	0.0%	50.0%	96.7%	0.0
Gunther, Eric	0.0%	57.6%	84.4%	0.0%	83.0%	77.7%	78.3%	50.0%	50.0%	100.0%	62.3%	86.5%	93.3%	13.3%	66.7%	87.1%	0.0
Smith, Joe	0.0%	70.6%	87.3%	13.3%	80.2%	78.6%	75.0%	0.0%	66.7%	100.0%	49.3%	88.2%	89.5%	0.0%	0.0%	94.5%	0.0
Winslow, Francine	0.0%	56.4%	79.7%	16.7%	82.0%	78.2%	76.5%	0.0%	100.0%	75.0%	45.6%	89.7%	93.3%	20.0%	50.0%	92.6%	0.0



Alerts – Due Soon



Edit

GENERAL **DATE CRITERIA** RESULT CRITERIA POPULATION DEFINITION

Define the display message and lookback period for your alert.

DISPLAY MESSAGE IF...
Overdue Observation has not occurred in th 3 Month

DUE SOON CRITERIA
You can also enable an alert that the observation will become due soon.

ENABLED **DISPLAY MESSAGE** IF...
Due Soon Observation will become overdue 30 Day
In the next

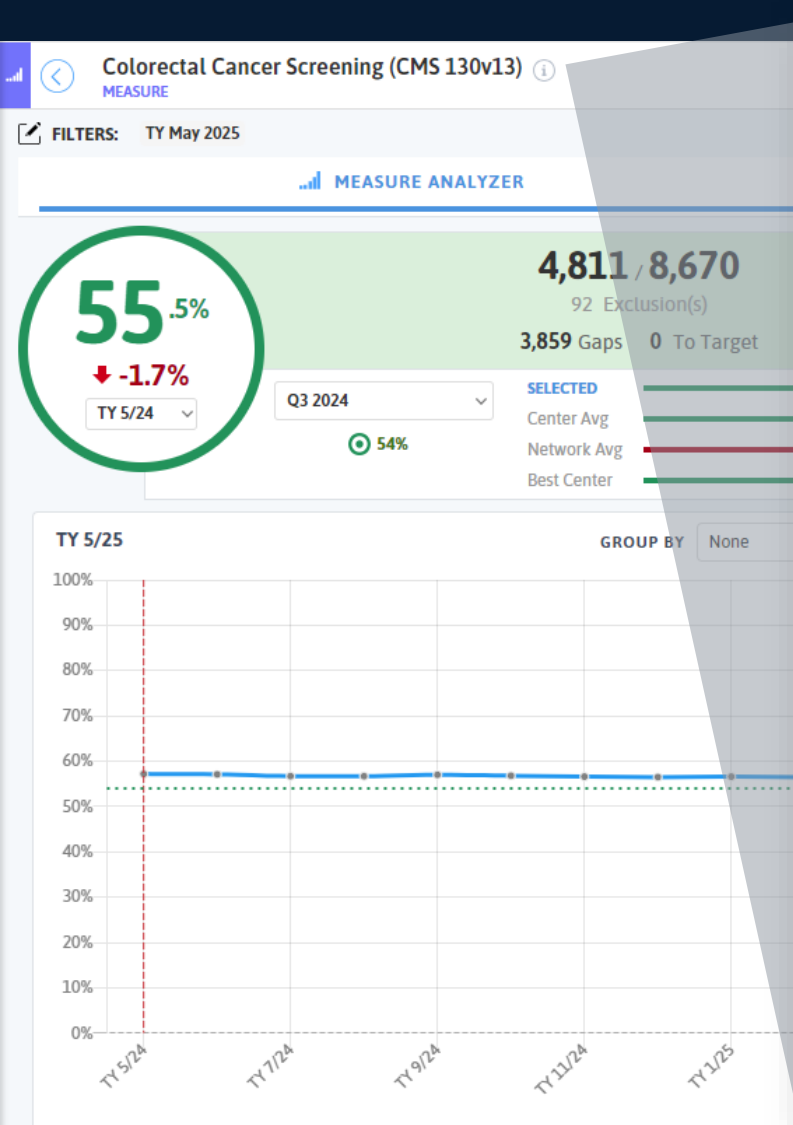
Cancel Confirm



Measure Transparency



Understand the Measure Definition



Colorectal Cancer Screening (CMS 130v13)

Endorser: None
Steward: NCQA

Adults 45-75 years of age who had appropriate screening for colorectal cancer.

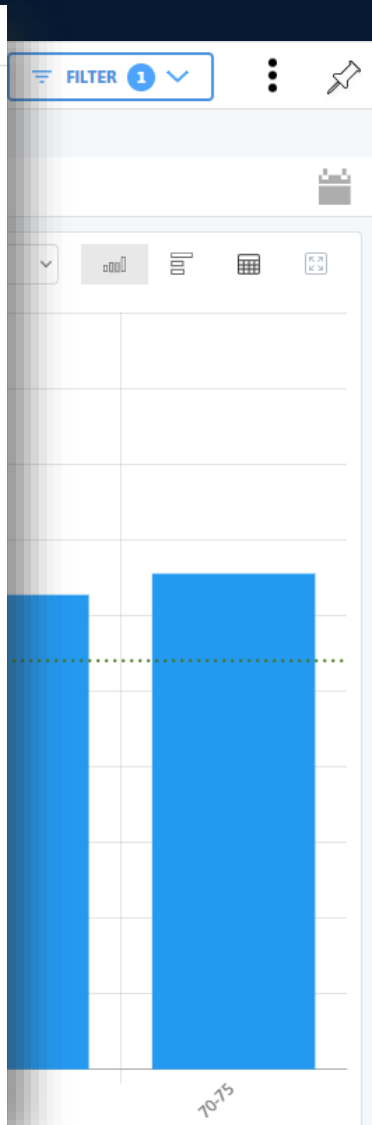
Numerator:
Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal Occult Blood test (FOBT) or FIT result during the measurement period
- OR
- Stool DNA (sDNA) with FIT-DNA test during the measurement period or the 2 years prior to the measurement period
- OR
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
- OR
- CT Colonography during the measurement period or the 4 years prior to the measurement period
- OR
- Colonoscopy during the measurement period or the 9 years prior to the measurement period

*Do not count digital rectal exam or FOBT tests performed in an office setting or performed on a sample collected via digital rectal exam.

Denominator:
Patients 46-75 years of age with a visit during the measurement period

- Age >=46 and <76 by the end of the measurement period
- Measure qualifying visit during the measurement period (see value set tab and technical specifications for qualifying visit codes)



DRVS Benefits – Detail Lists



Search

All Centers

Filter

Update

BMI Screening and Follow-Up 18+ Years (CMS 69v13)

PERIOD: TY September 2025 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER

DETAIL LIST

VALUE SETS

Search Patients ...

[Measure Investigation Tool](#) | SAVED COLUMNS

		DEMOGRAPHICS >				USUAL				MOST RECENT ENCOUNTER		
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	PROVIDER	LOCATION	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION
Neighborhood Health Center	1104556	Burbage, Roy	M	2/26/1996	1969831	Fay, Tom	NHC - Needs Update	N	N	7/31/2025	Bar, Samuel	Main Office
Access Community Health	1104560	Parkhouse, Mariana	F	3/8/1990	1199021	Bridgewater, Bill	ACH - Needs Update	N	N	5/19/2025	Gunther, Eric	Main St. Offic
Access Community Health	1104563	Ansara, Shana	M	4/8/1994	6128386	Doe, Jane	ACH - Needs Update	N	N	9/6/2025	Smith, Joe	1400 Cambri
Access Community Health	1104576	Kaiama, Kiesha	F	5/22/1995	2035436	Black, Ronda	ACH - Needs Update	N	N	1/3/2025	Smith, Joe	Main St. Offic
Neighborhood Health Center	1102606	Marion, Cerullo	F	9/24/1967	8450446	Pane, Janet	NHC - Needs Update	N	N	3/4/2025	Green, Leslie	Neighborhood
Family Health Center	1102607	Jerry, Mangine	F	4/26/1955	9316357	Cote, David	FHC - Needs Update	N	N	4/19/2025	Rigoli, Brian	Florence Ave
Neighborhood Health Center	1103566	Oleson, Rudy	F	4/12/1968	8420577	Cranston, Bill	NHC - Needs Update	N	N	9/25/2025	Cranston, Bill	Neighborhood
Family Health Center	1103570	Exel, Landon	M	5/27/1955	8866012	House, Gregory	FHC - Needs Update	N	N	9/21/2025	Weixel, Evan	1st St. Clinic
Access Community Health	1103571	Yonke, Loyce	F	1/8/1977	7083450	Gunther, Eric	ACH - Needs Update	N	N	12/5/2024	Augustine, Greg	70 Blancharc
Family Health Center	1103573	Bowdry, Sylvester	M	3/18/1977	1180612	Weixel, Evan	FHC - Needs Update	N	N	3/13/2025	Cote, David	Lakeview Ad
Access Community Health	1103576	Reech, Derek	M	8/31/1983	4031411	Augustine, Greg	ACH - Needs Update	N	N	4/2/2025	Augustine, Greg	1400 Cambri
Access Community Health	1103577	Tupaj, Morris	M	7/4/1980	5211660	Crowley, Patrick	ACH - Needs Update	N	N	9/5/2025	Winslow, Francine	70 Blancharc
Neighborhood Health Center	1103581	Howsare, Devorah	F	2/13/1967	4125205	Bar, Samuel	NHC - Needs Update	N	N	10/13/2024	Pane, Janet	Adult Health
Family Health Center	1103582	Udani, Galen	M	11/21/1966	5637455	Houser, Dougie	FHC - Needs Update	N	N	10/27/2024	Cote, David	Lakeview Ad
Access Community Health	1103605	Kennerty, Britt	F	5/15/1968	1780222	Smith, Joe	ACH - Needs Update	N	N	4/21/2025	Crowley, Patrick	70 Blancharc
Neighborhood Health Center	1103606	Mccumbee, Jackqueline	F	8/22/1986	8004302	Reddington, Robert	NHC - Needs Update	N	N	1/6/2025	Fay, Tom	Neighborhood
Family Health Center	1103608	Ashton, Dealy	M	12/21/1995	1117319	House, Gregory	FHC - Needs Update	N	N	10/24/2024	Houser, Dougie	Lakeview Ad

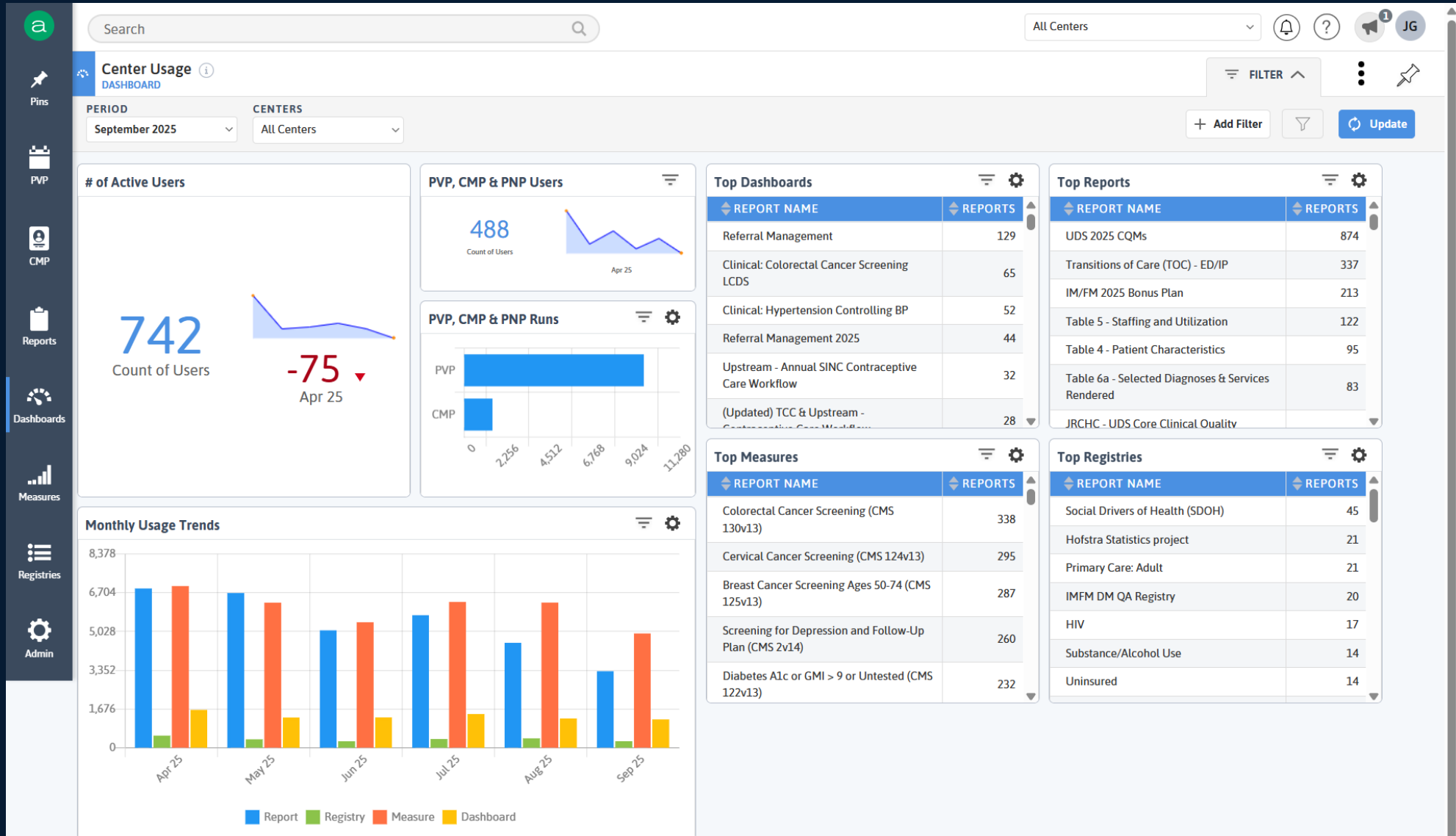
1 to 17 of 2,242

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DEMO DATA



Center Usage / Adoption Monitoring



Example: eCW



The screenshot shows the eClinicalWorks (eCW) interface. A patient record for Jane Doe is visible, including MRN: 1103382, DOB: 3/4/1996 (29 yrs), and CM: John Smith. A 'Third-party Apps' window is overlaid on the patient record, displaying a table of alerts and a list of documents.

Alert	Message	Most Recent Date	Most Recent Result
test	Missing		
A1c	Out of Range	3/15/25	12.6
LDL	Out of Range	3/15/25	185
BMI & FU	Missing Follow-up	3/15/25	Highest BMI: 71.00 (03/15/2025)
Eye	Overdue	3/15/25	Y
Foot	Missing		

DOCUMENTS:

- Care Mgmt Plan
- Prenatal Plan

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Note: eClinicalWorks is not responsible for the accuracy of the data displayed by the third-party app. Data displayed by the third-party app will not be imported into eClinicalWorks.



Member Matching



Health Plan Enrollment Matching ⓘ

DASHBOARD

FILTER ^

+ Add Filter

Update

PERIOD

January 2023

CENTERS

All Centers

RENDERING PROVIDERS

All Rendering Provid...

PLANS

National Health Plan

Matched Members

70%

Mbr Age Stratification ⚙️

AGE	MATCH RATE	NUM	GAP
<= 2	82%	813	182
3-6	81%	1,215	287
7-17	74%	2,273	789
18-25	63%	1,147	662
26-45	63%	2,678	1,603
46-64	69%	1,523	692
65 +	64%	57	32

Soft Matches by Practice ⚙️

CENTERS	SOFTMATCHED MEMBERS	% TOTAL
[REDACTED]	6	6%
[REDACTED]	1	1%
[REDACTED]	0	0%
[REDACTED]	20	22%
[REDACTED]	6	6%
[REDACTED]	20	22%
[REDACTED]	9	10%
[REDACTED]	4	4%
[REDACTED]	9	10%
[REDACTED]	8	9%
[REDACTED]	10	11%
Totals	93	

Members

13,953

Members Eligible During the Period

Mbr Visit Stratification ⚙️

LAST ENCOUNTER	MEMBERS	% TOTAL
No Encounter	4,894	35%
0-180	5,684	41%
181-365	1,940	14%
366-720	1,094	8%

Unmatched Members

4,247

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Multi Measures Care Gaps Outreach



VBC Scorecard REPORT

PERIOD: 2022 CENTERS: All Centers RENDERING PROVIDERS: All Rendering Provid...

REPORT CARE GAPS

Search ...

All Has Appt No Appt
 DATA RECONCILIATION REQUIRED

MEASURE COMPLIANCE
■ Non-Compliant (Gap) ■ Compliant

ACTION REQUIRED
📞 Member Outreach ■ Data Reconciliation

NO ACTION REQUIRED
✓ Compliant

SAVED COLUMNS

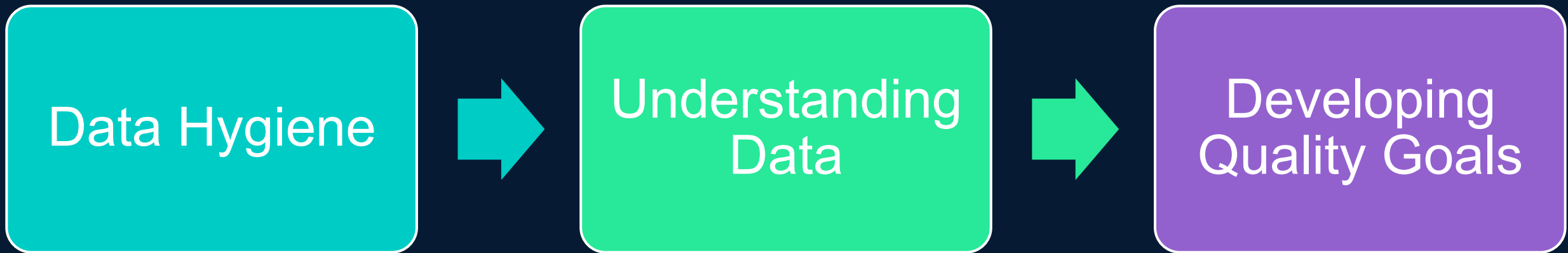
Last Payer Gap File Received 09/23/2022

PLAN	MEMBER NO	MATCH	DEMOGRAPHICS		GAP	DESCRIPTION	MEASURES			
			NAME	MRN			AWC - ADOL. WELLCARE VISITS	BCS - BREAST CANCER SCREENING	CCS - CERVICAL CANCER SCREENING	COL - COLORECTAL CANCER SCREENING
Group Health	2091	✓	Nuffer, Palma	4310731	2	BCS MAMMO, CCS CERV		📞	📞	
Community Health Plan	4153		Kirakosyan, Bruce		2	CCS CERV, COL			📞	📞
Group Health	4189A		Kachel, Kristopher		2	AWC, CCS CERV	📞		📞	
Group Health	66	✓	Mcaulay, Felicidad	5546680	2	AWC, CCS CERV	📞		📞	
United Health Plan	78		Dobrynski, Isabella		2	BCS MAMMO, CCS CERV		📞	📞	
Group Health	82		Bisson, Louisa		2	BCS MAMMO, CCS CERV		📞	📞	
Group Health	167		Kromm, Cedric		2	CCS CERV, COL			📞	📞
Community Health Plan	174		Haning, Guillermo		2	BCS MAMMO, CCS CERV		📞	📞	
United Health Plan	187		Liner, Ivan		2	CCS CERV, COL			📞	📞
Group Health	4240		Oberlies, Coretta		2	AWC, CCS CERV	📞		📞	
United Health Plan	4257		Snook, Kendall		2	AWC, CCS CERV	📞		📞	
Community Health Plan	4364		Caballero, Parker		2	BCS MAMMO, CCS CERV		📞	📞	
United Health Plan	4484		Hulvey, Isaac		2	AWC, CCS CERV	📞		📞	
Community Health Plan	259	✓	Ugaz, Marty	4485655	2	AWC, CCS CERV	📞		■	



Data Hygiene and Quality Improvement

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Data hygiene is about understanding data; understanding data provides the foundation for quality improvement.



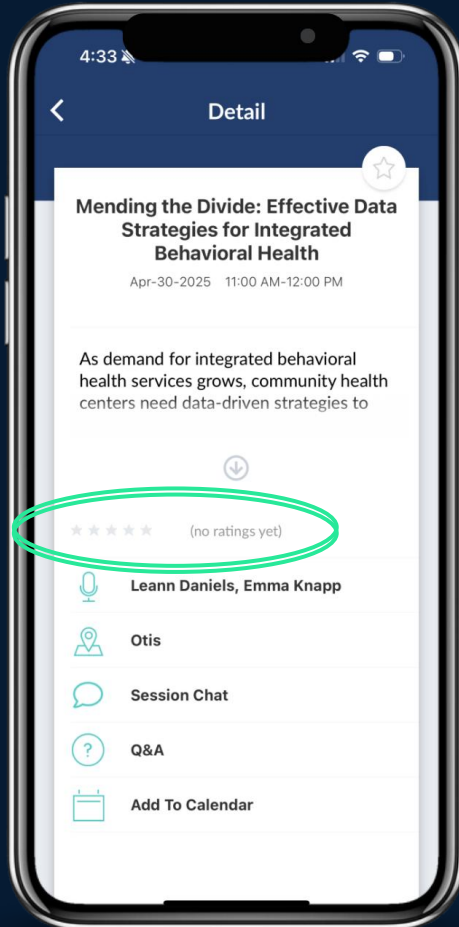


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Quick and Easy



Provide brief feedback or ideas



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