Maximizing Value-Based Care

with

Clinical Lab Insights

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Atlantic Division

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VIRGINIA COMMUNITY HEALTHCARE ASSOCIATION

ADVOCATE™
EDUCATE
ELEVATE

Unlock The Power of Lab Data

Our portfolio of analytics solutions is powered by **45 billion lab results**, generating actionable insights to help reach the quadruple aim.

Quality Care

Backed by clinical guidelines and real-world evidence, our digital solutions provide actionable insights to power quality patient care.

Lower Costs

Our solutions identify the right test for the right patient at the right time, reducing costs while meeting quality metrics.

Labcorp solutions

Patient Experience

Identify care gaps in your community and close these gaps with tailored programs designed to meet patients where they are.

Provider Experience

Our solutions seamlessly integrate into clinical workflows, allowing providers to focus on what matters most.

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Labcorp's data can be a powerful tool

Labcorp data offers national scale, frequent patient touchpoints, historical result values, as well as demographics and payer coding

Labcorp data provides direct value

1. Gain visibility into lab results and patient visits outside of the health system and throughout the U.S.
2. Identify and monitor high-risk and high-cost patients including those with diabetes, CKD and CVD
3. Target lab-based care gaps associated with payer quality incentives
4. Assess appropriate patient coding against laboratory results
5. Access community-based lab data for disease trending, benchmarking and to identify underserved populations

Fill gaps that exist in other available data sources

EHR capabilities

- Does not aggregate lab data at a population level
- Excludes lab results ordered by outside providers
- Data from EMRs not easily integrated or comparable

Payer claims data

- Excludes actual lab result values per patient
- Payer coding offers limited clinical data
- Often significant time delay of few months

Health Information Exchange (HIE)

- Limited to specific regions
- Significant time delays
- Data formats often inconsistent and not comparable

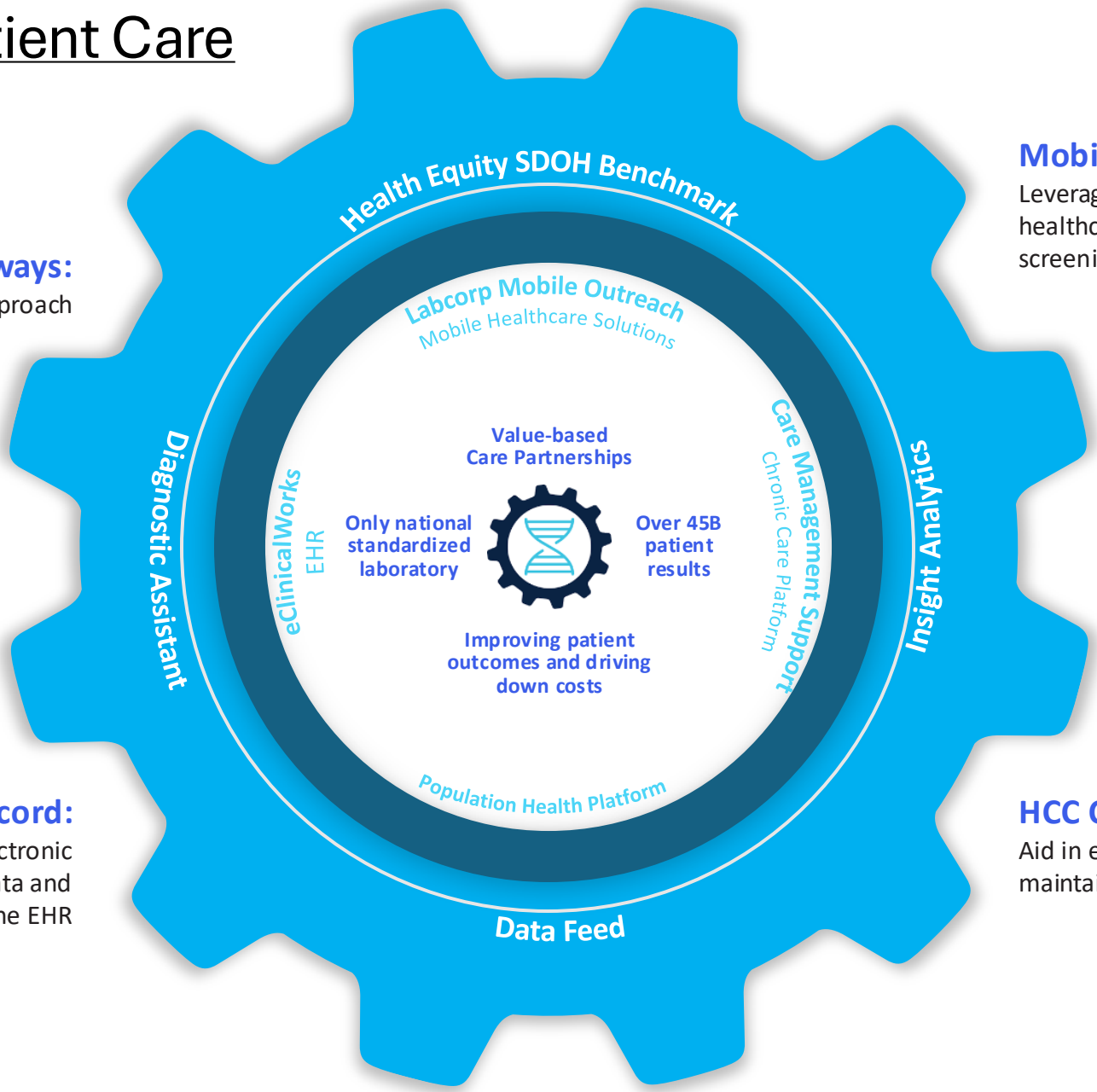
Transforming Patient Care

Advancing healthcare access within reach for ALL patients

Clinical Pathways:
Guideline Based Algorithmic Approach

Streamlined Patient Care:
Diagnostic Assistant is a point of care tool within the NextGen that enables add-on orders and reduces duplicate orders

Complete View of Patient Record:
Labcorp *Diagnostic Assistant* connects electronic health record (EHR) data with Labcorp data and provides insights directly into the EHR



Mobile Community Outreach:
Leveraging g-coded density heat map to provided healthcare services, patient education, and screening events in underserved communities

Clinical Case Study & Publication:
Co-development of white paper

High Risk Stratification:
Identify high risk and rise in risk patient for chronic conditions

HCC Coding:
Aid in enhancing coding practices and maintaining the accuracy of medical records

A high-value partnership

Preferred Provider agreements establish a foundation for transitioning into full-risk contracts where financial partnerships are critical for success

A Labcorp preferred agreement includes:

- Laboratory values data feed
- Diagnostic Assistant at the point of care
- Care Gap Summary Report
- Insight Analytics® reports
- HCC Coding reports
- Health Equity planning support
- Open orders and care gap closure programs

Knowledge at the Point of Care

Diagnostic Assistant

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How Diagnostic Assistant™ Works –All in Real-Time

1

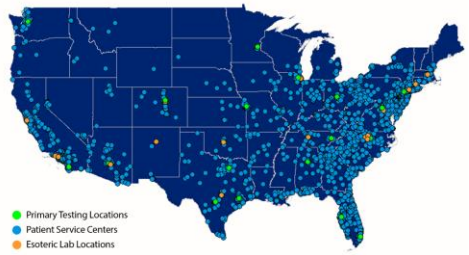
Log into EHR

Patient medical record sent to Diagnostic Assistant via FHIR

2

Labcorp Look Up

Identify any additional lab results for the patient with unified data platform



Data/Insight Delivered

Available to provider directly at the point of care via CDS Hooks

4

3

Connected Data

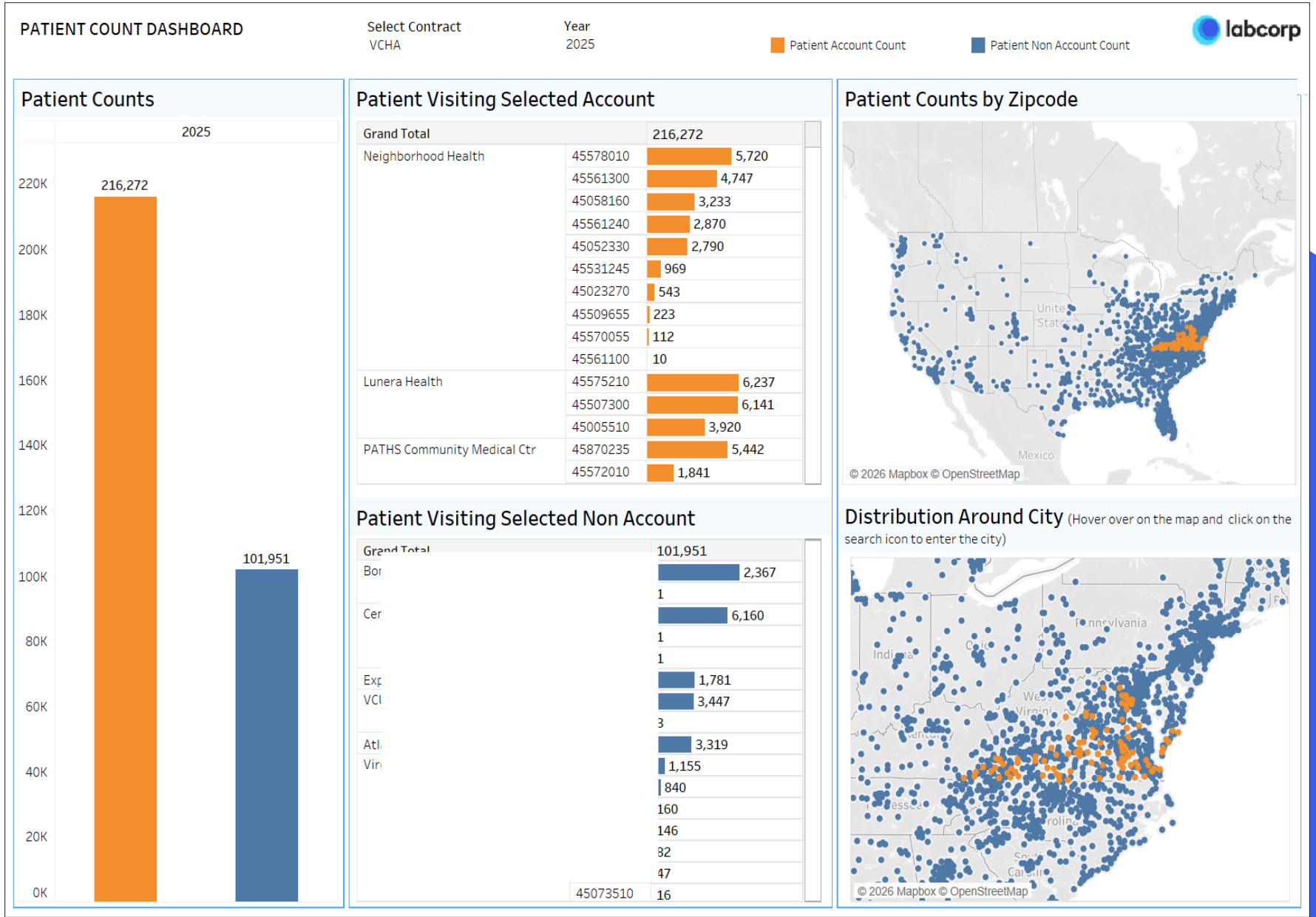
Patient's EHR and Labcorp data connected into a single patient record

Bringing lab results from outside of your network to your providers

- In 2025, LabCorp has processed at least one order/result for **216,272 unique patients** that came from your practice
- Of the 216,272 patients, **101,951 patients** had at least one order/result that originated **from practices outside of your practice**

With Diagnostic Assistant, these out of network results become available to your providers at the point of care!

In 2025, 47% of VCHA Patients had at least one Labcorp order/result ordered by a provider outside the walls of VCHA Centers!



HCCN 2025-2029 Objectives

Objectives	Objective Description
1. Data Management & Analytics	Increase the percentage of PHCs that advance and optimize clinical, financial, and operations data to improve clinical quality, health outcomes, and operations.
2. Interoperability & Data Sharing	Increase the percentage of PHCs that improve bidirectional interoperability with health care providers and community-based organizations by strengthening care coordination, reducing unnecessary medical testing and data duplication, and implementing more efficient and effective referral and information sharing processes to improve health outcomes and reduce provider burden.
3. Data Modernization Implementation	Increase the percentage of PHCs that have implemented at least one FHIR-based application in their EHR or data systems.
4. Artificial Intelligence	Increase the percentage of PHCs participating in T/TA designed to support the implementation on AI practices that adhere to industry ethical guidelines and established protocols. These efforts aim to help PHCs address health disparities and improve patient care by using health IT AI solution that support data-driven care practices.
5. Additional Value-Based Care	Increase the percentage of PHCs that use data to update operational processes in health IT systems to support value-based care that enhances the patient and provider experience, improves health outcomes, and reduces health disparities.

**first 3 required by HRSA, objective 4 and 5 voted by PHCs for Network to cover*

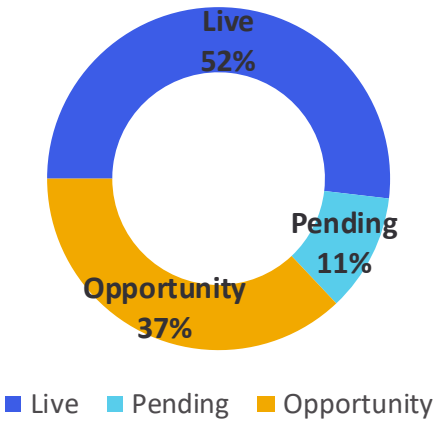
https://lpca.net/programs-services/hccn/

Diagnostic Assistant adoption across VCHA

14 centers are live, supporting 526 users and 431,178 events

Centers live on Diagnostic Assistant	Users	Events
Blue Ridge Medical Center	5	4,468
Central Virginia Health Services	316	360,829
Clinch River Health Services, Inc.	1	50
Community Access Network	16	6,443
Daily Planet Health Services	21	3,821
Eastern Shore Rural Health System, Inc.	23	7,637
Greater Prince William Area Community Health Center, Inc.	32	7,447
Hampton Roads Community Health Center	18	10,200
Healthworks	2	337
Healthy Communities Health Centers	9	1,367
Rockbridge Area Health Center	10	1,944
Southern Dominion Health System, Inc.	9	1,152
Southwest Virginia Community Health Systems	49	17,556
Stone Mountain Health	15	7,927

52% of VCHA centers are live



Pending implementation (3)

Neighborhood Health
Johnson Health Centers
Community Health Center of NRV

Centers available to connect (10)

Bland County
Capital Area Health Network
Connect Health + Wellness
Highland
Horizon Health Services
Monroe Health Center
New Horizons
PATHS
SEVHS
Tri Area

Percentages reflect the 27 VCHA centers represented on this slide.

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Insight Analytics

Care Gap Summary Report

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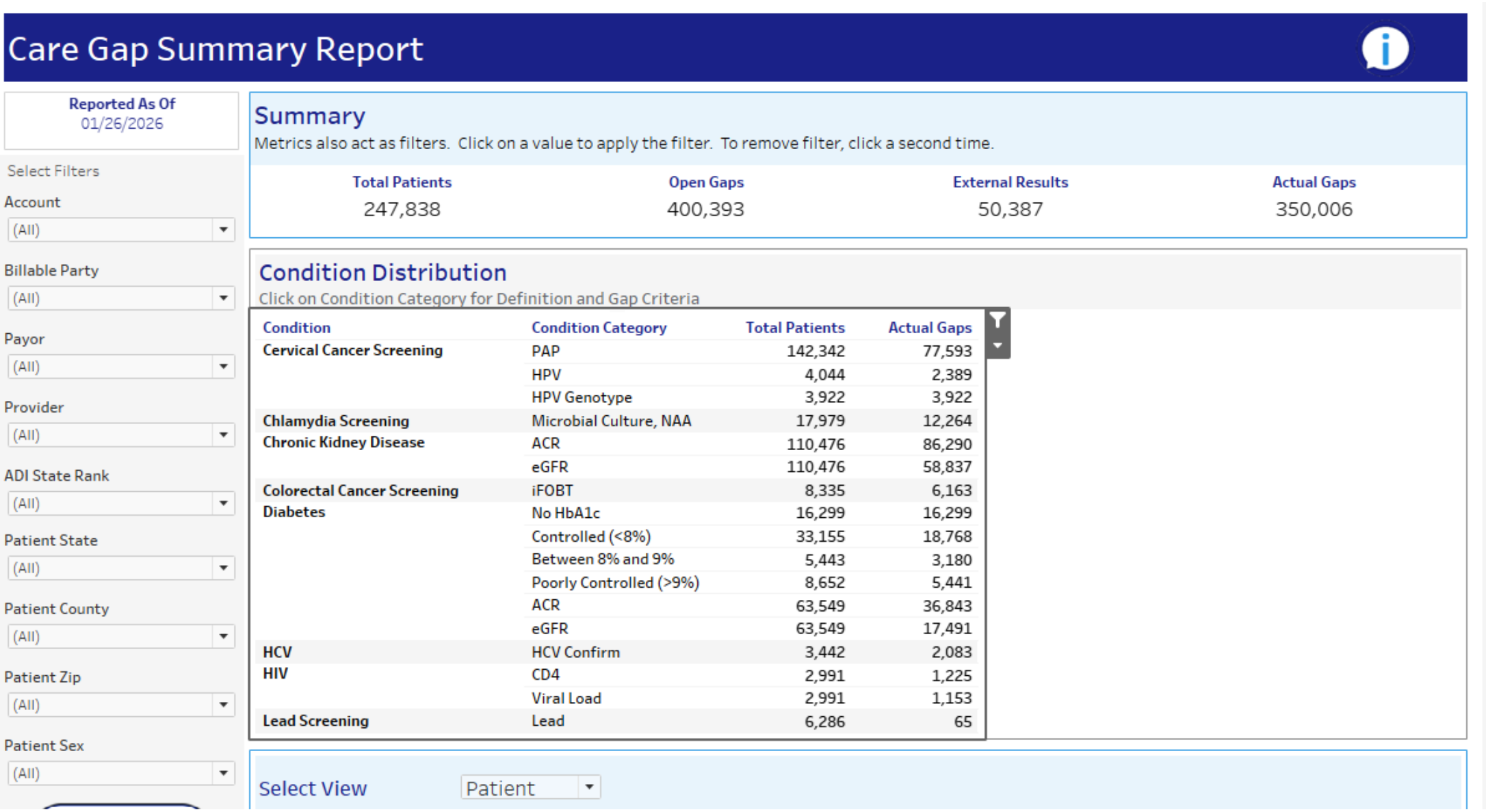
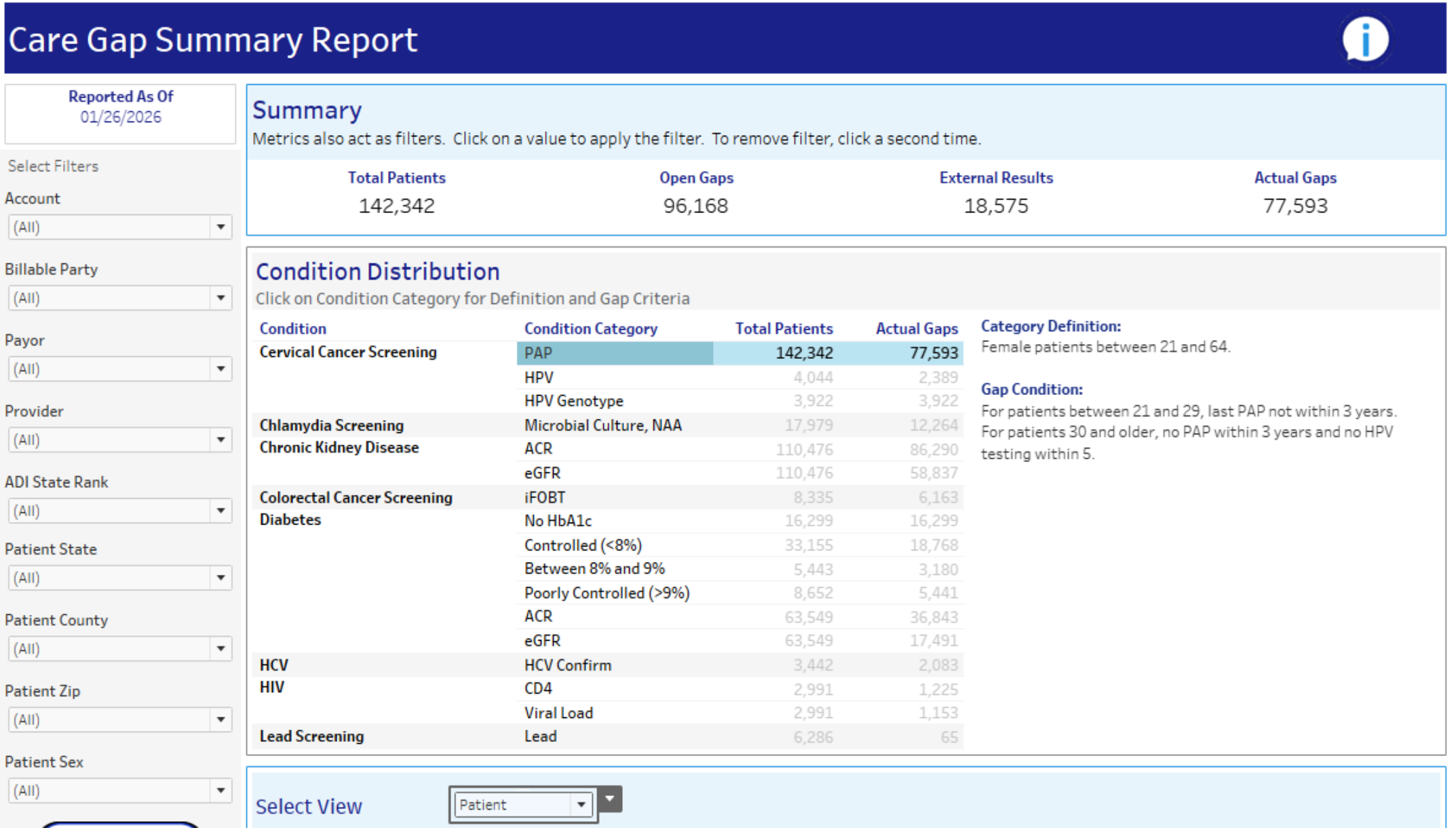
VCHA Care Gap Summary



VCHA Cervical Cancer Care Gap Summary



Care Gap Summary Report

Reported As Of
01/26/2026

Select Filters

Account: (All)

Billable Party: (All)

Payor: (All)

Provider: (All)

ADI State Rank: (All)

Patient State: (All)

Patient County: (All)

Patient Zip: (All)

Patient Sex: (All)

Summary

Metrics also act as filters. Click on a value to apply the filter. To remove filter, click a second time.

Total Patients	Open Gaps	External Results	Actual Gaps
142,342	96,168	18,575	77,593

Condition Distribution

Click on Condition Category for Definition and Gap Criteria

Condition	Condition Category	Total Patients	Actual Gaps
Cervical Cancer Screening	PAP	142,342	77,593
	HPV	4,044	2,389
	HPV Genotype	3,922	3,922
Chlamydia Screening	Microbial Culture, NAA	17,979	12,264
Chronic Kidney Disease	ACR	110,476	86,290
	eGFR	110,476	58,837
Colorectal Cancer Screening	iFOBT	8,335	6,163
Diabetes	No HbA1c	16,299	16,299
	Controlled (<8%)	33,155	18,768
	Between 8% and 9%	5,443	3,180
	Poorly Controlled (>9%)	8,652	5,441
	ACR	63,549	36,843
	eGFR	63,549	17,491
HCV	HCV Confirm	3,442	2,083
HIV	CD4	2,991	1,225
	Viral Load	2,991	1,153
Lead Screening	Lead	6,286	65

Category Definition:
Female patients between 21 and 64.

Gap Condition:
For patients between 21 and 29, last PAP not within 3 years. For patients 30 and older, no PAP within 3 years and no HPV testing within 5.

Select View: Patient

COMING SOON...

A statewide initiative powered by VCHA + Labcorp

Virginia Care Gap Accelerator Project

From a pioneering legacy in medicine to accelerating the future of care.

IDENTIFY → ACT → CLOSE → ELEVATE

Use external data to uncover opportunities, focus outreach, close care gaps and strengthen UDS performance across Virginia's community health centers.

THE CHALLENGE IS ON
An award will recognize the center that closes the most care gaps!

Honoring the past. Accelerating progress. Rewarding impact.

Insight Analytics

Identifying high-risk patients and implementing more effective clinical practices

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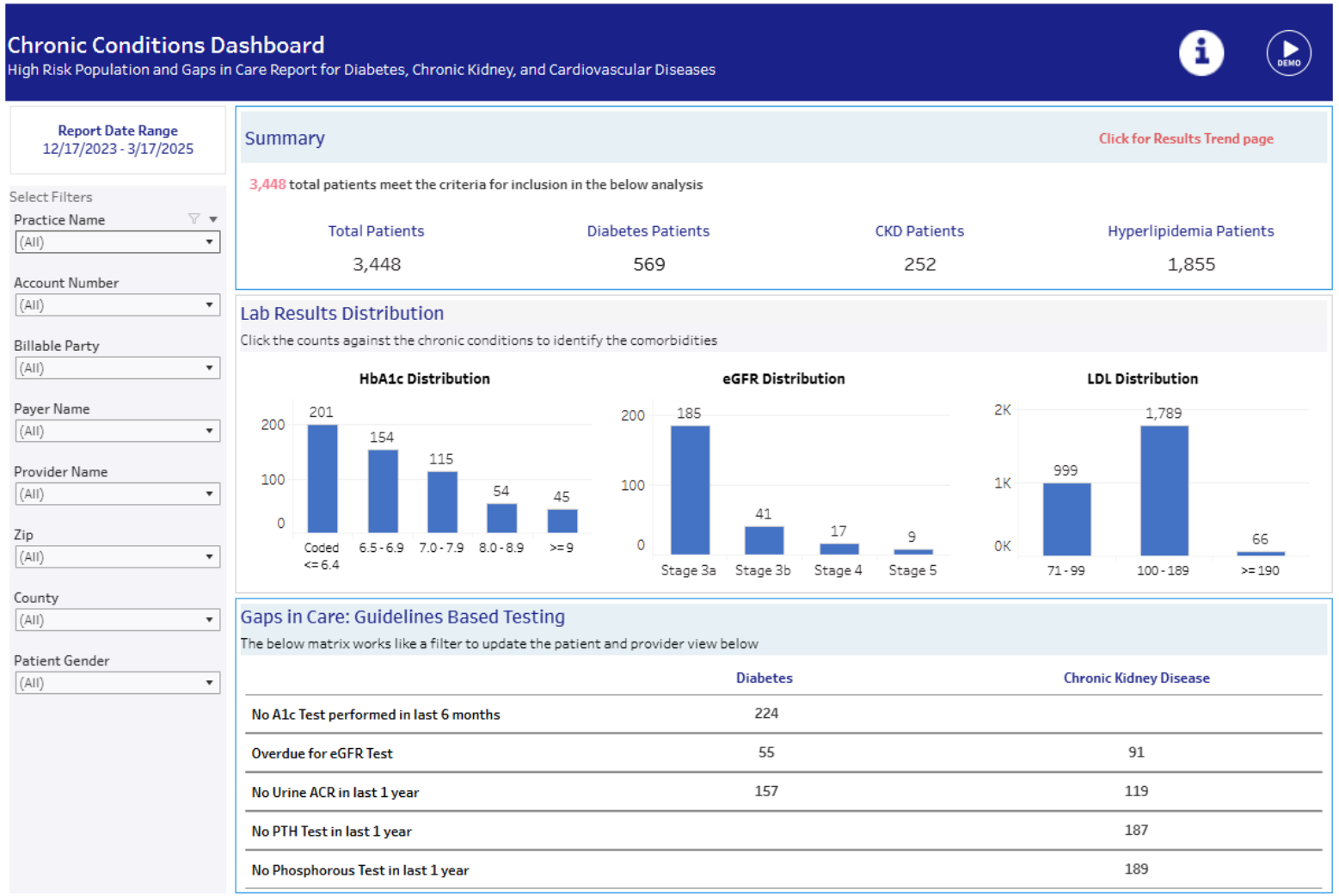
Labcorp can provide prebuilt, lab-based population health analytics as a tool to define targeted opportunities

Example of Labcorp Insight Analytics™ – *Chronic Conditions*

- Review patient population & target gaps-in-care

Interactive population analytics dashboards

- Utilizes Labcorp patient and results data
- Includes built-in filters
- Reveal details when hovering over visuals
- Provide ability to drill down to the provider or patient level
- Available on demand via Labcorp Link portal

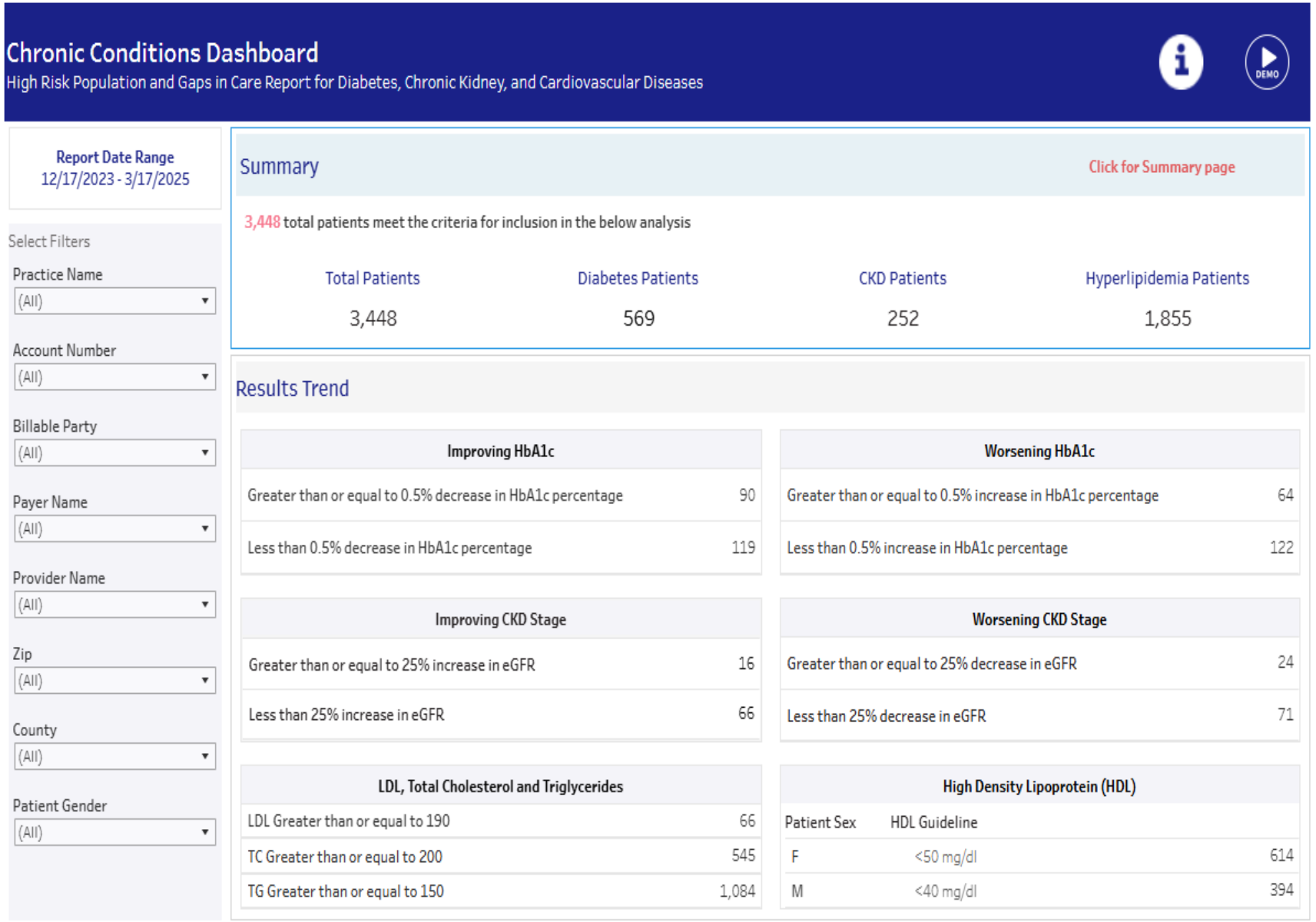


Labcorp Insight Analytics™ – *Chronic Conditions*

- **Focusing on key lab indicators of chronic diseases can help providers extend care and improve outcomes**

- **Identify high risk populations**
  - Diabetes: from prediabetes to poorly controlled
  - Chronic Kidney Disease: patients in stages 3-5
  - Various comorbidities

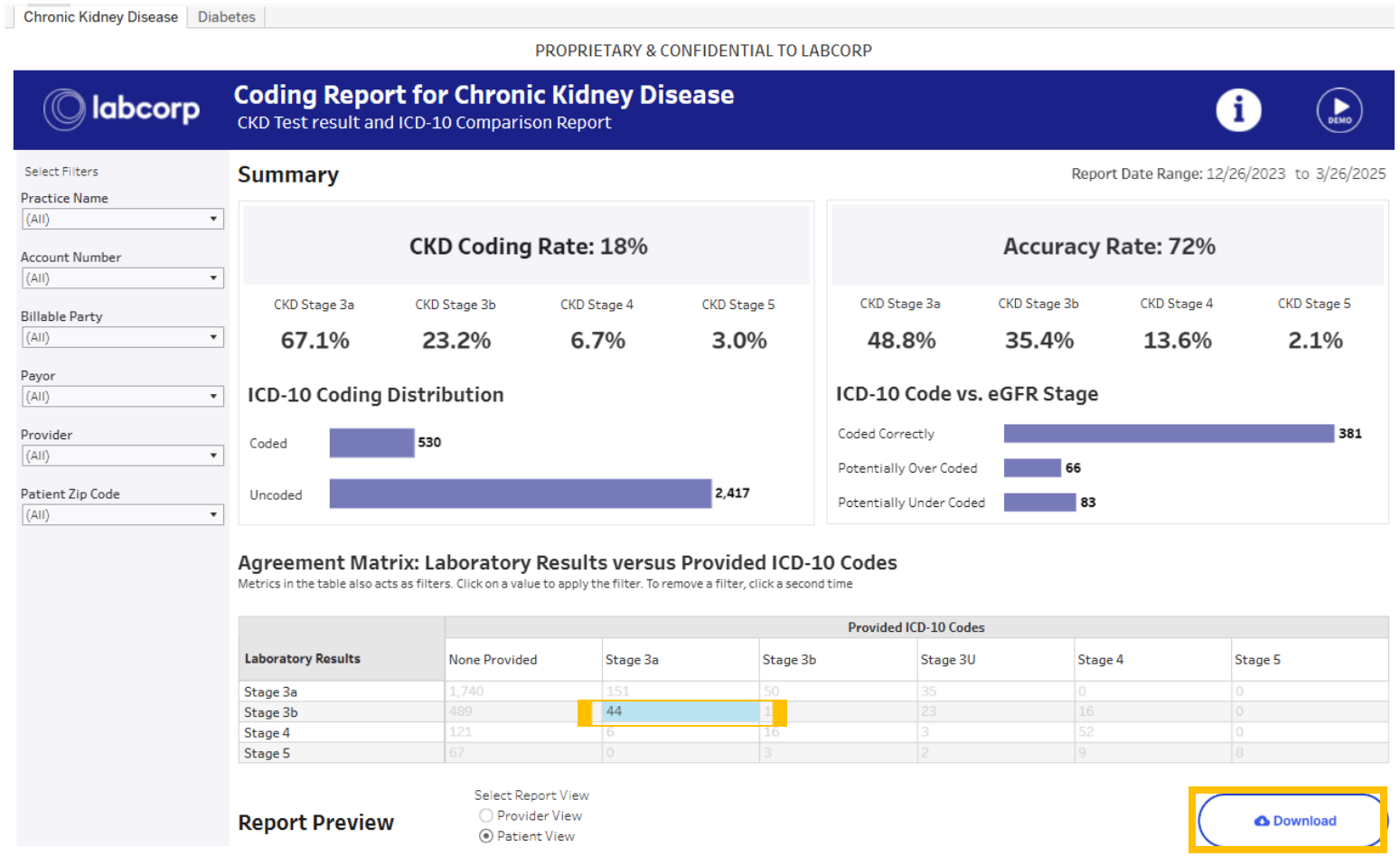
- **Target gaps in care**
  - Diabetic Patients
  - Chronic Kidney Disease Patients
  - Patients with Hyperlipidemia



ICD-10 Coding Alignment Report

Accurate coding ensures financial stability for providers, promotes better patient outcomes, and supports the integrity of value-based care models.

1. Determines appropriate reimbursement and ensures providers are compensated fairly, avoid underpayment for high-risk patients
2. Reflects Patient Risk – Capture the true risk level of a patient population. Risk adjustment calculations ensure that providers managing sicker, more complex patients are compared fairly to those treating healthier populations
3. Improves Quality of Care – Improved care coordination, identification of gaps in care, promotes better outcomes
4. Supports Data Driven Decisions – We know that value-based care relies heavily on data for performance measurement and improvement. Correct coding is essential for analyzing care quality, efficiency, cost-effectiveness and outcomes



2025 ACCELERATING HEALTH EQUITY

Actionable Insights: Utilizing Lab Data for Health Equity Initiatives

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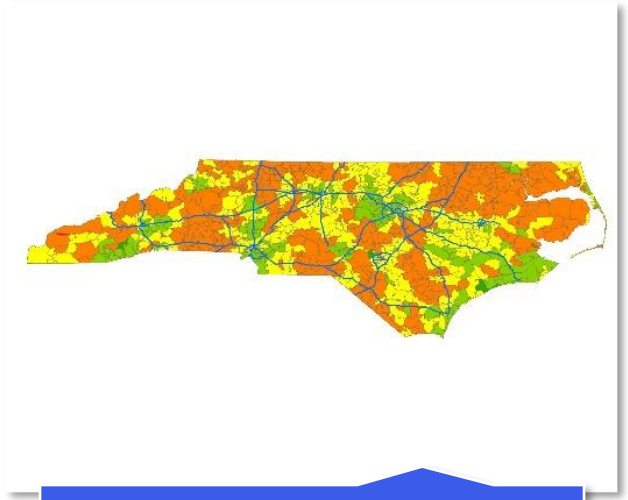
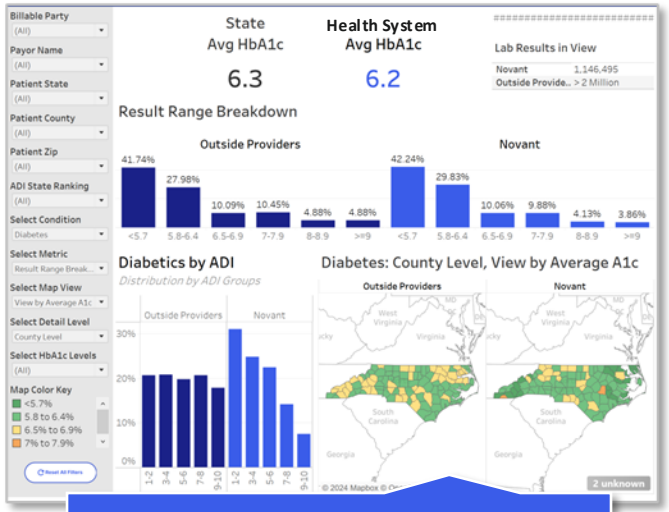
Diabetes: A1C >8 & Untested and/or CKD gap in eGFR

The Diabetes gap closure work team is partnering with Labcorp to layer test results data and set parameters for identifying community "hot spots" – areas of concentration for patients with high diabetes A1C and CKD eGFR test results – and sponsor community events for testing and education in specific areas for socially vulnerable individuals.



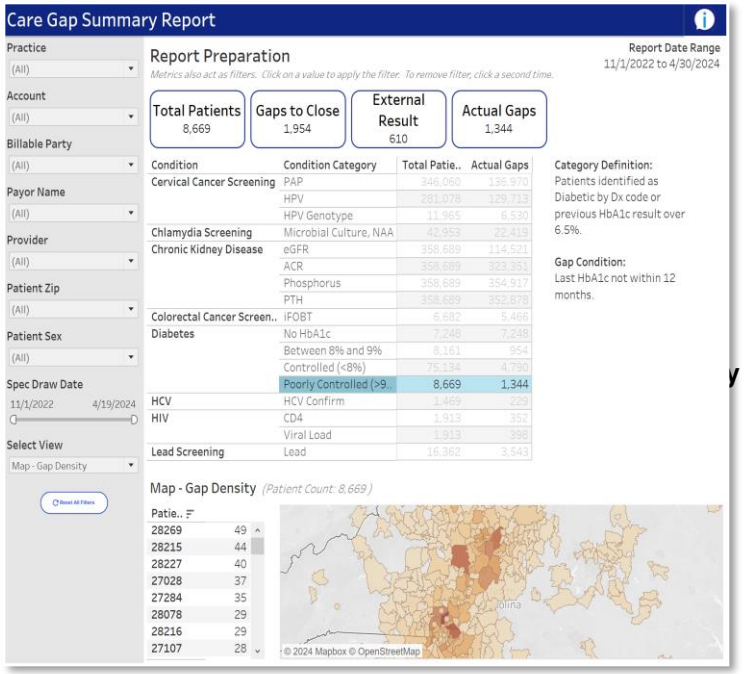
Diabetes A1C poor control or untested

Percent of patients with diabetes (Type 1/Type 2) whose HbA1c is > 8.0% or untested



Kidney Health Evaluations (KED)

Patients CKD Stage 3-5 with a care gap defined by an estimated glomerular filtration rate (eGFR)



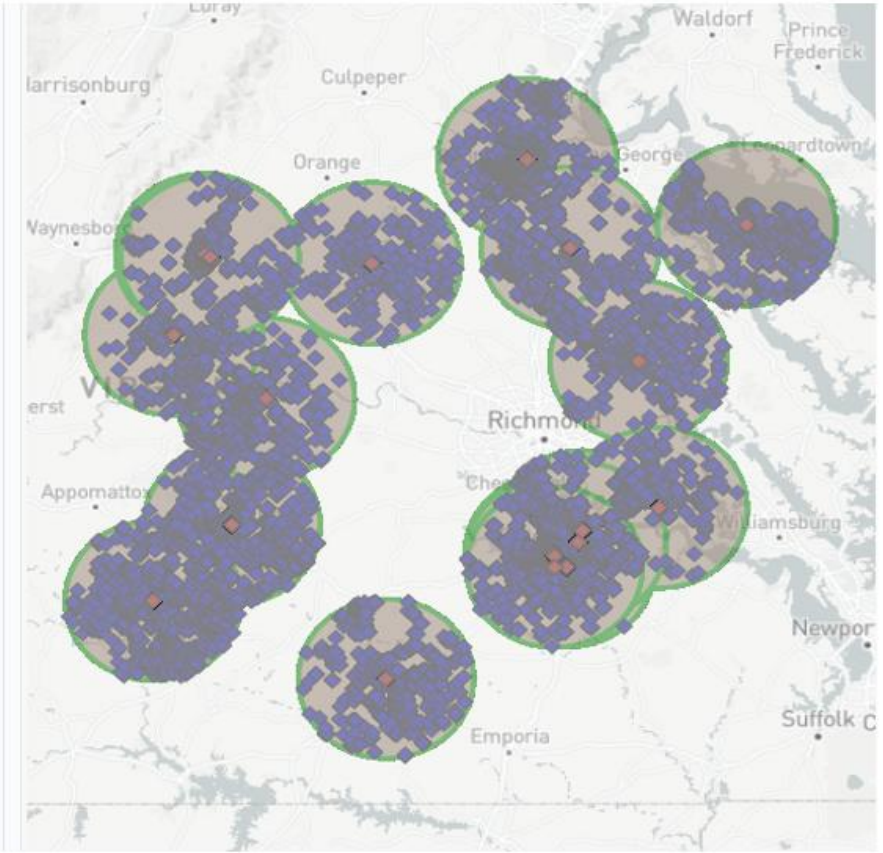
- **Interactive** dashboard of **de-identified** lab data for diabetes and kidney disease
- Includes both internal and external Labcorp results for patients
- **Geographical comparison area** to support community health initiatives
- Patient, provider, or ZIP code views available
- Area Deprivation Index – patient addresses are geocoded

CVHS Community Outreach Discussions

CVHS Hotspotting Map

07/09/2026

Event Location Name	Max_Dist	# Gaps	# Patients	# A1c Gaps	# eGFR gaps	# UACR Gaps	# iFOBT Gaps
CVHS BRUNSWICK	1	29	14	8	8	13	0
CVHS BRUNSWICK	2	60	29	18	16	26	0
CVHS BRUNSWICK	5	234	127	69	68	97	0
CVHS BRUNSWICK	10	532	310	164	168	200	0
CVHS BRUNSWICK	15	1028	594	354	320	354	0
CVHS BUCKINGHAM	1	26	11	8	8	10	0
CVHS BUCKINGHAM	2	46	19	15	15	16	0
CVHS BUCKINGHAM	5	280	129	101	72	102	0
CVHS BUCKINGHAM	10	655	313	242	186	227	0
CVHS BUCKINGHAM	15	1080	674	501	386	471	0
CVHS CAROLINE	1	71	42	22	24	24	1
CVHS CAROLINE	2	139	76	43	46	49	1
CVHS CAROLINE	5	256	149	79	76	100	1
CVHS CAROLINE	10	649	400	224	208	246	1
CVHS CAROLINE	15	996	798	449	434	490	1
CVHS CHARLES CITY	1	6	2	2	2	2	0
CVHS CHARLES CITY	2	35	20	10	9	16	0
CVHS CHARLES CITY	5	214	124	57	65	88	0
CVHS CHARLES CITY	10	435	288	135	155	187	0
CVHS CHARLES CITY	15	524	864	460	472	577	2
CVHS CHARLOTTE	1	59	33	29	14	16	0
CVHS CHARLOTTE	2	93	47	41	24	28	0
CVHS CHARLOTTE	5	325	167	134	91	100	0
CVHS CHARLOTTE	10	858	449	353	231	274	0
CVHS CHARLOTTE	15	1629	967	761	523	573	0
CVHS CHARLOTTESVILLE	1	132	86	53	49	62	0
CVHS CHARLOTTESVILLE	2	188	170	112	102	124	0
CVHS CHARLOTTESVILLE	5	215	289	187	164	210	0
CVHS CHARLOTTESVILLE	10	282	352	224	198	259	0
CVHS CHARLOTTESVILLE	15	373	506	316	278	357	0
CVHS CRIMSON CLINIC	1	100	50	32	33	35	0
CVHS CRIMSON CLINIC	2	164	293	186	182	195	2
CVHS CRIMSON CLINIC	5	252	968	572	578	631	3
CVHS CRIMSON CLINIC	10	321	1642	947	948	1068	4
CVHS CRIMSON CLINIC	15	378	1877	1079	1082	1220	5



COMMUNITY PARTNERSHIP IN ACTION

Bringing essential health services closer to Virginia's Eastern Shore

Labcorp supported Eastern Shore Rural Health with the people and infrastructure needed to deliver accessible community screenings.

MOBILE ACCESS

Deployed Labcorp's mobile unit directly into the community

SCREENING SUPPORT

Provided an on-site phlebotomy team for health screenings

PARTNERSHIP IN ACTION

Worked alongside Eastern Shore Rural Health to expand access for local residents

Thank you.