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April 24, 2024

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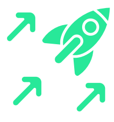
Today’s Agenda

INTEGRATED BEHAVIORAL HEALTHCARE

DRVS TOOLS TO SUPPORT BEHAVIORAL HEALTH & PRIMARY CARE

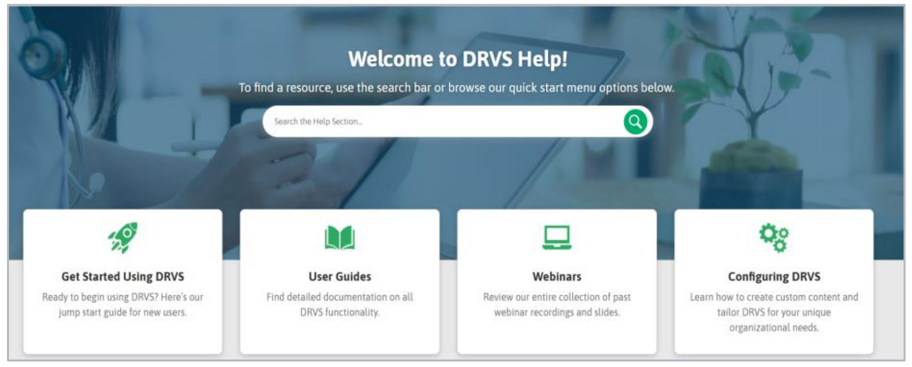
CONTROLLED SUBSTANCE MODULE FEATURES



WHAT’S NEW IN DRVS

Resources in DRVS Help Section

Utilize the Help section in DRVS for the most current information.



Click the question mark icon and select Help Documentation. Enter your search criteria (i.e., scorecards).

User Guides are available for all topics covered today (and many more!)

Integrated Behavioral Healthcare

Chronic Illness & Mental Health

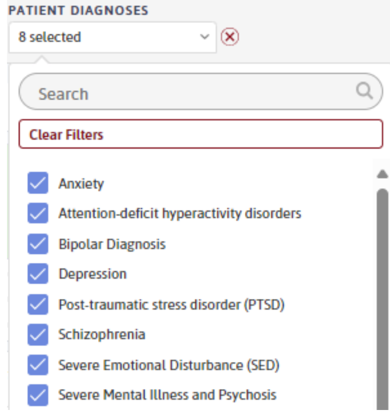
NIH Source

Patients with chronic medical conditions are at higher risk of depression

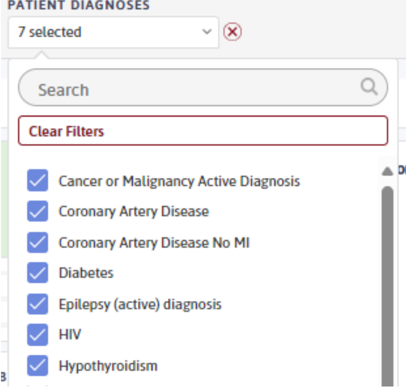
Research suggests those with depression & another medical illness results in more severe symptoms of both

Pts may have difficulty adapting to their medical condition

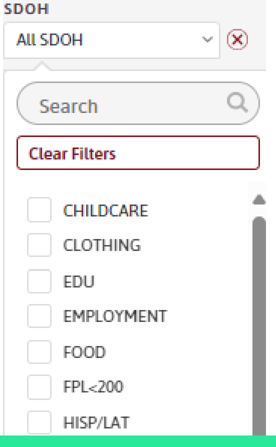
Pts may also have higher medical costs



Patient Diagnosis Filter for **Behavioral Health Dx**

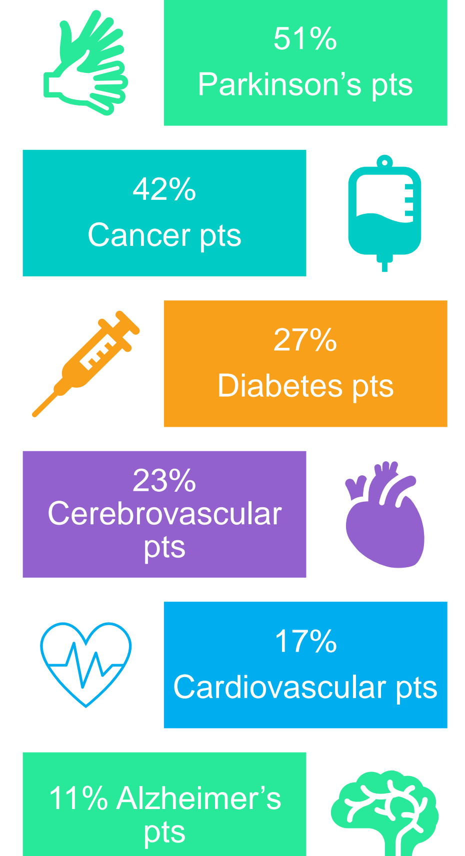


Patient Diagnosis Filter for **Chronic Condition Dx**



Filter for **SDOH** factors

Depression and Chronic Illness



Identify any of these conditions in DRVS through **pt diagnosis or risk filter**

https://publichealth.jhu.edu/2021/the-intersection-of-mental-health-and-chronic-disease

Case Example | Diabetes (DM)

Pts w/ DM are 2-3x more likely to develop depression than those w/o DM

→46% increased risk for mortality

Only 25%- 50% of DM pts with depression get diagnosed AND treated

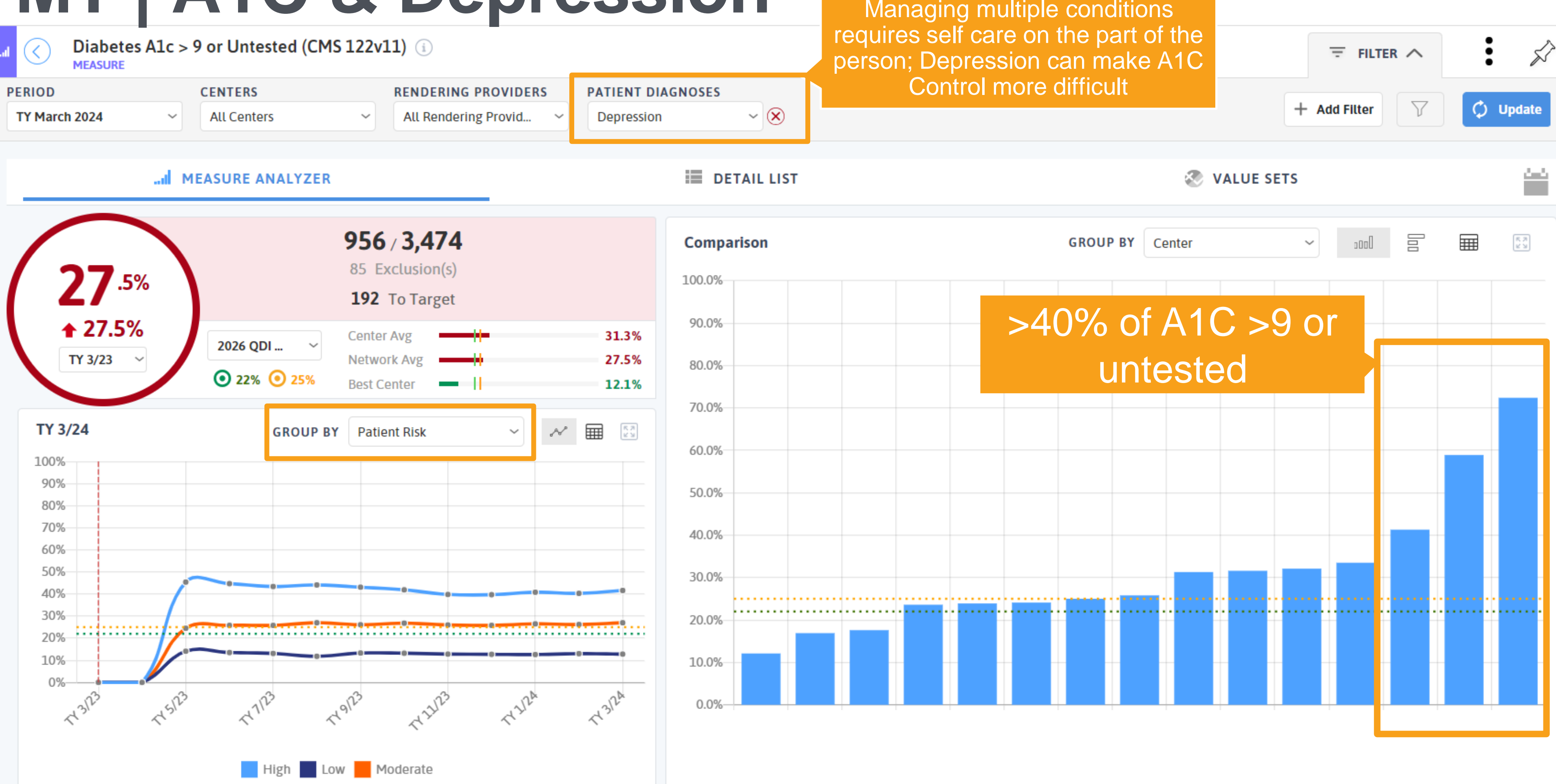
DM pts w/ Depression show:

Poorer glycemic control

Decreased physical activity

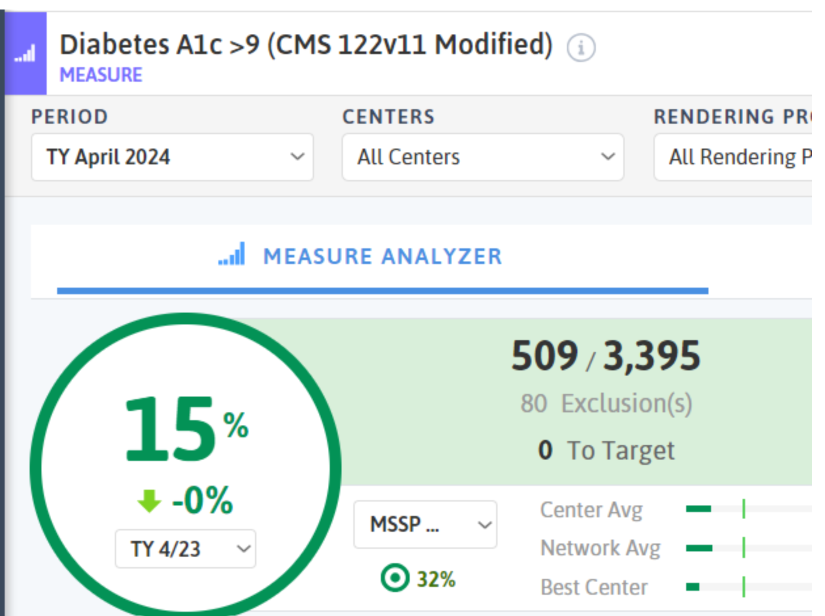
Higher obesity

MT | A1C & Depression

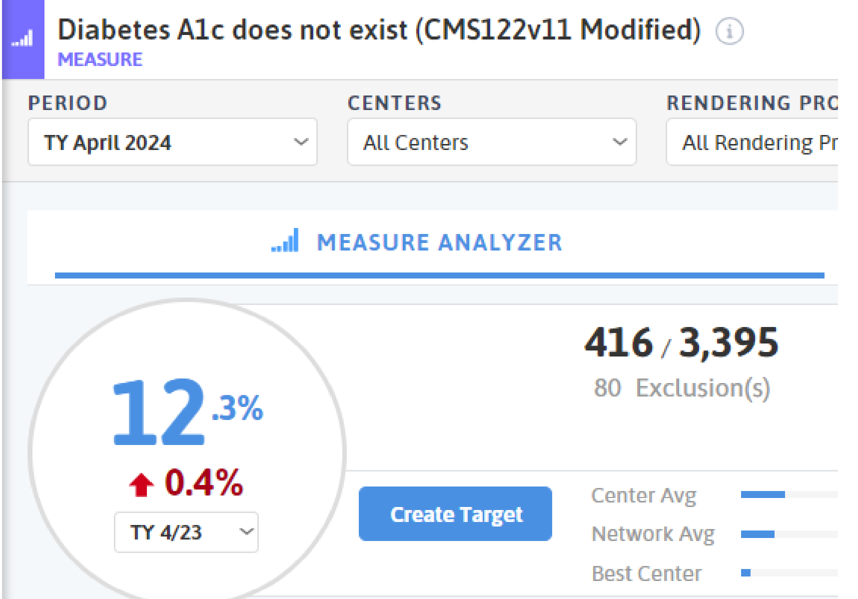


MT | Breakout A1C >9 & Untested

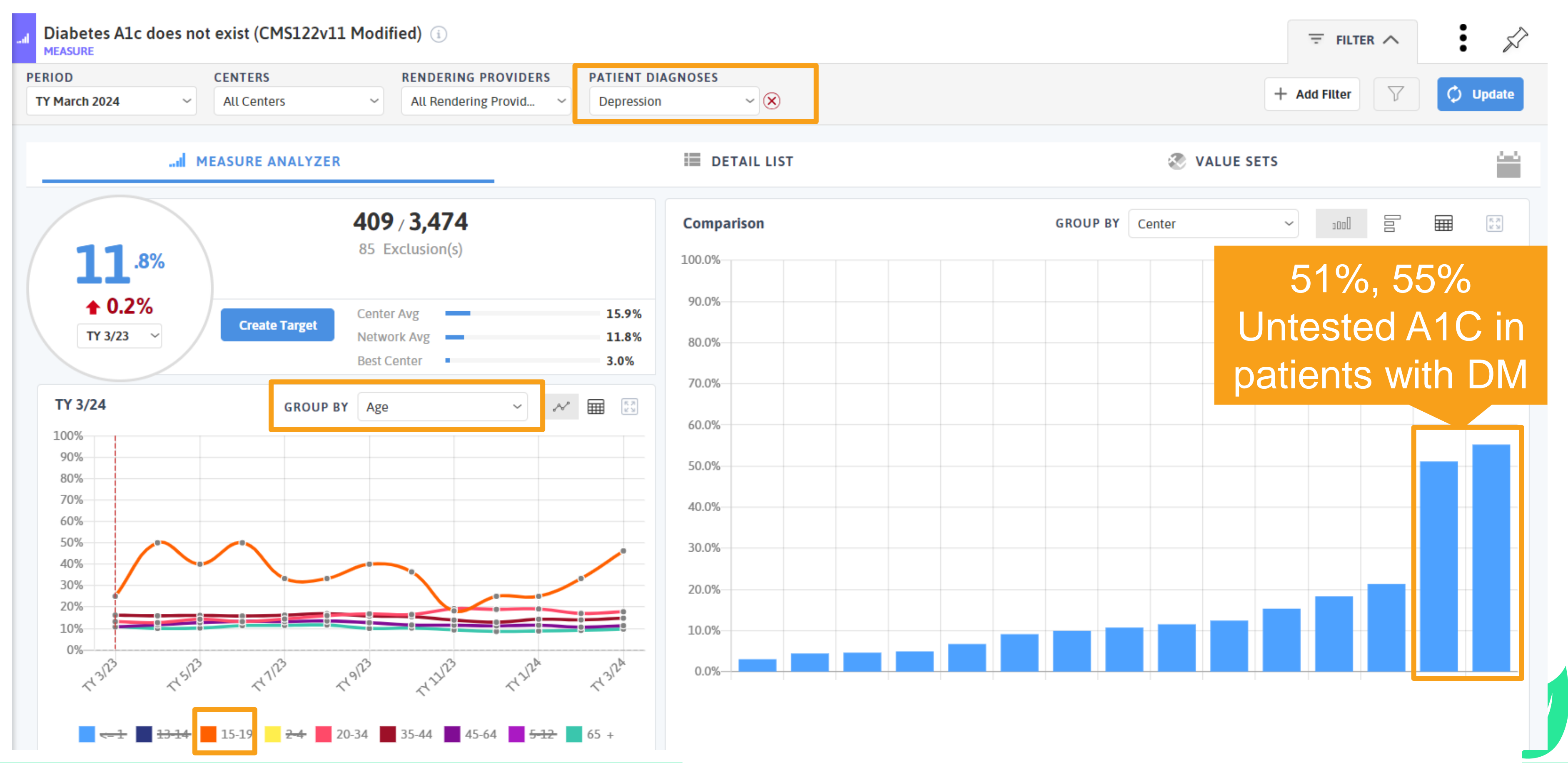
DIABETES A1C >9 & DEPRESSION

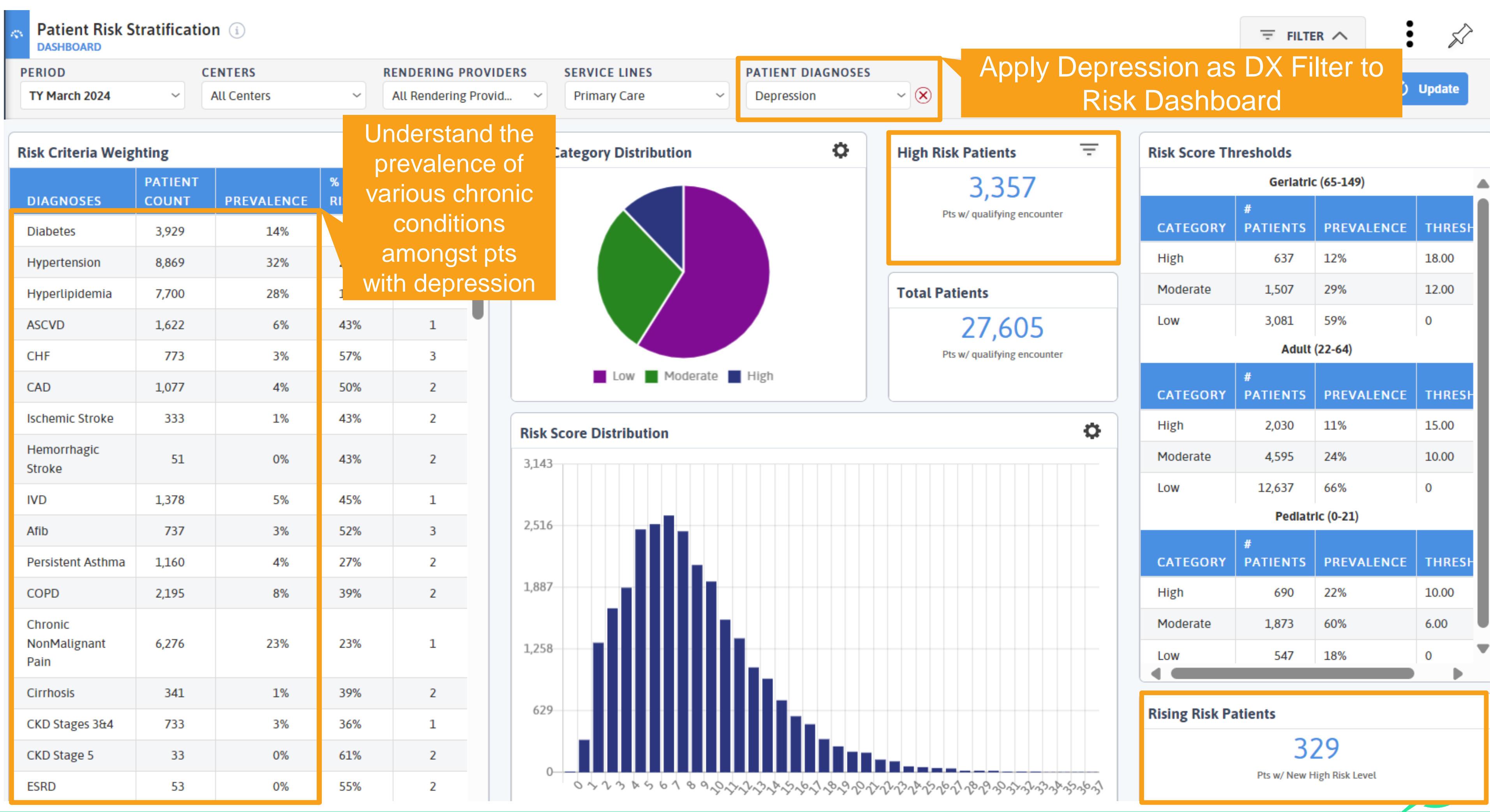


DIABETES A1C DOES NOT EXIST & DEPRESSION



MT | A1C Untested & Depression Dx

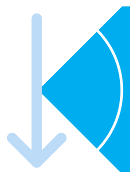




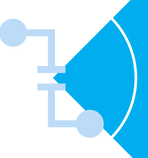
Patient Risk Stratification
DASHBOARD
FILTER
PERIOD
TY March 2024
CENTERS
All Centers
RENDERING PROVIDERS
All Rendering Provid...
SERVICE LINES
Primary Care
PATIENT DIAGNOSES
Depression
Apply Depression as DX Filter to Risk Dashboard
Update
Risk Criteria Weighting
DIAGNOSES
PATIENT COUNT
PREVALENCE
Understand the prevalence of various chronic conditions amongst pts with depression
Diabetes 3,929 14%
Hypertension 8,869 32%
Hyperlipidemia 7,700 28%
ASCVD 1,622 6% 43% 1
CHF 773 3% 57% 3
CAD 1,077 4% 50% 2
Ischemic Stroke 333 1% 43% 2
Hemorrhagic Stroke 51 0% 43% 2
IVD 1,378 5% 45% 1
Afib 737 3% 52% 3
Persistent Asthma 1,160 4% 27% 2
COPD 2,195 8% 39% 2
Chronic NonMalignant Pain 6,276 23% 23% 1
Cirrhosis 341 1% 39% 2
CKD Stages 3&4 733 3% 36% 1
CKD Stage 5 33 0% 61% 2
ESRD 53 0% 55% 2
Category Distribution
Low
Moderate
High
High Risk Patients
3,357
Pts w/ qualifying encounter
Total Patients
27,605
Pts w/ qualifying encounter
Risk Score Distribution
3,143
2,516
1,887
1,258
629
0
Risk Score Thresholds
Geriatric (65-149)
CATEGORY # PATIENTS PREVALENCE THRESH
High 637 12% 18.00
Moderate 1,507 29% 12.00
Low 3,081 59% 0
Adult (22-64)
CATEGORY # PATIENTS PREVALENCE THRESH
High 2,030 11% 15.00
Moderate 4,595 24% 10.00
Low 12,637 66% 0
Pediatric (0-21)
CATEGORY # PATIENTS PREVALENCE THRESH
High 690 22% 10.00
Moderate 1,873 60% 6.00
Low 547 18% 0
Rising Risk Patients
329
Pts w/ New High Risk Level

Behavioral Health Challenges

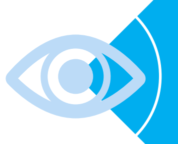
Referral process



Low treatment initiation rates



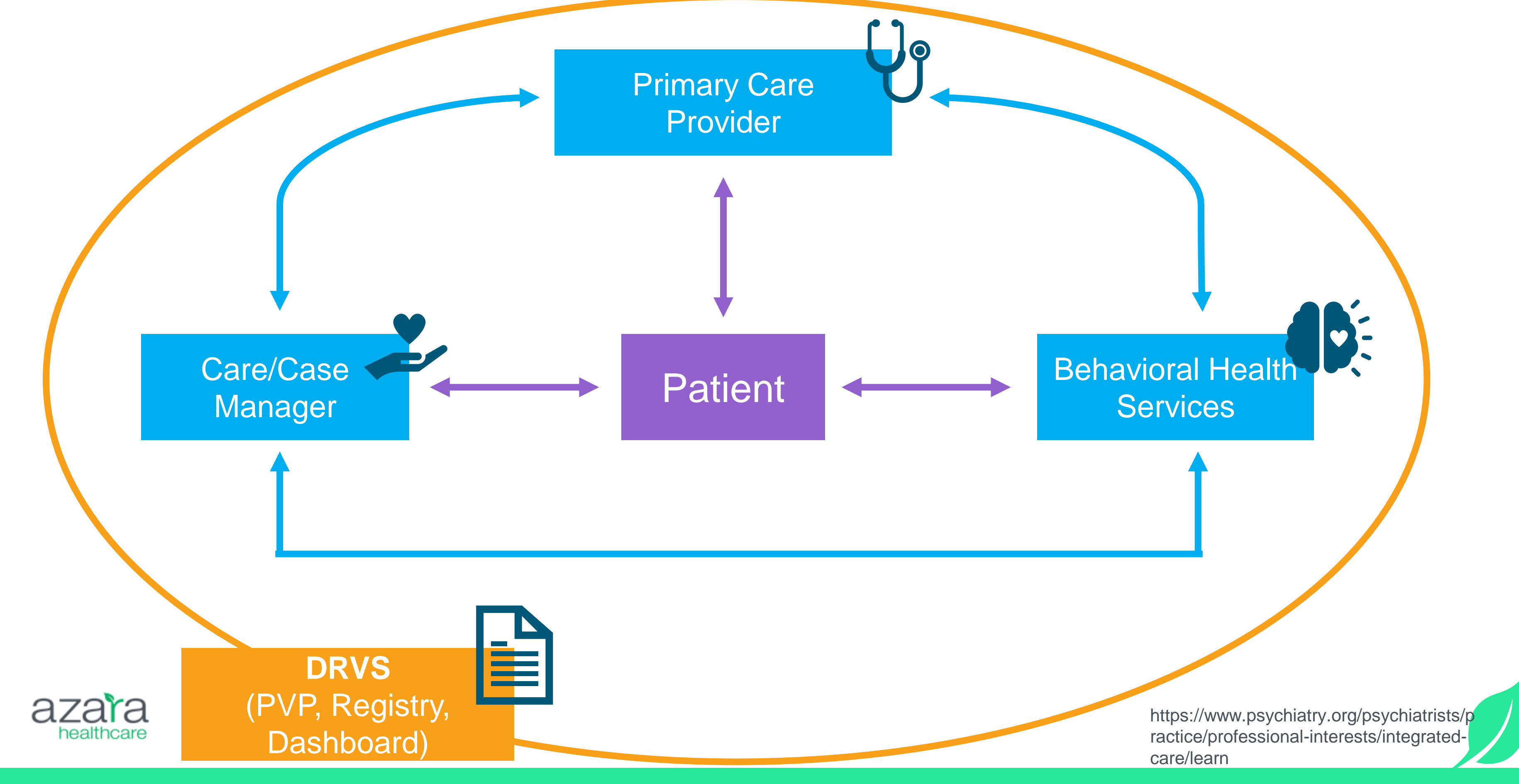
Fragmented communication amongst providers



Perceived stigma of seeing a mental health specialist

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7945346/

Integrated Behavioral Health Care



azara healthcare

Integration Benefits

Patients (with BH + PC Needs)

Convenience
Trusted relationship with PCP
Easier to improve all conditions

Providers

Holistic care
Meeting patients where they are
Increased efficiency using shared patient information

Studies show integrated care improves health and patient experience, while reducing costs and barriers to care.
It all starts with screening!

What is Integrated Behavioral Health? | The Academy (ahrq.gov)

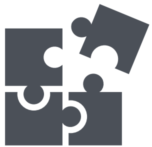
DRVS Tools to Support Integrated Care

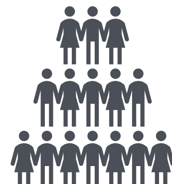
DRVS Tools To Support Integration

Point of Care

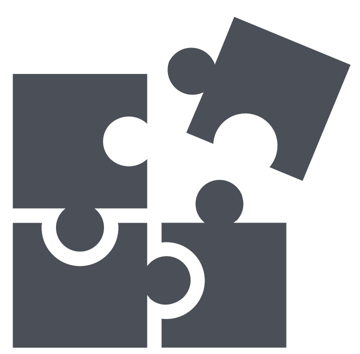
Population Health

Performance Management

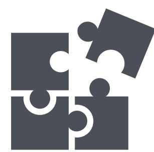




Integrated behavioral health care blends care for medical conditions and related behavioral health factors that affect health and well-being **into one setting**.



Patient Visit Planning Report



7:15 AM Tuesday, April 16, 2024 — Visit Reason: **EXT-DIABET Diabetic w/ fasting labs**

Sex at Birth: F
GI:
SO: straight or heterosexual

Phone:
Lang: English
Risk: Low (8)

Portal Access: Y

DIAGNOSES (4)

Anxiety	Depression	DM
HTN-E		

RISK FACTORS (1)

TOB

SDOH (1)

RACE

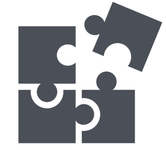
RAF GAPS DIAGNOSIS CATEGORIES (3)

Cardiovascular	Psychiatric	Diabetes

ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Overdue	4/7/2023	Negative
Hep C - Baby Boomer	Missing		
Drug Screening	Overdue	1/16/2023	
SBIRT	Overdue	1/16/2023	0
Flu - Seasonal	Overdue	9/2/2020	
Statin Rx	Missing		DM
Preventive Care Visit	Overdue	7/8/2022	
Well Visit 19+	Overdue	7/8/2022	
Anxiety Screen w/Dx	Missing		

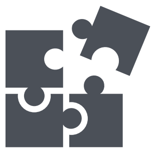
Alerts | Depression

PVP Alert Administration User Guide



Alert	Description
Depression Remission (10 Centers enabled)	Alert will trigger if patient has a diagnosis of depression or dysthymia and has not had a follow-up PHQ9, or has had a follow-up PHQ9 >=5. Alert will begin firing 1 month before the follow-up period starts (i.e., 9 mo. After the initial screen), and will be capped by 12 months after the follow-up period closes (i.e., 26 mo. After initial screen). This alert is not configurable.
Depression Screen with Diagnosis (1 Center enabled)	Alert will trigger if Depression Screen has not occurred in the last 1 year. Alert only applies to patients >12 yrs old. Patients must have active diagnosis of Depression. This alert is not configurable.
Depression Screening (13 Centers enabled)	Alert will trigger if Depression Screen Result has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression Screen Refused or Depression Screen Contraindicated or Depression or Bipolar Dx.
Depression Screening Follow-up (13 Centers enabled)	Alert will trigger if patient had positive depression screen results AND had a qualifying encounter on the same day of or within 14 days after the positive screening, AND had no depression follow-up performed on the same day of the encounter. Patient must not have Depression/Bipolar. This alert is not configurable

Depression Screening & Follow-Up Workflow



START

Patient 12+ arrives

Use Patient Visit Planning report to review care alerts daily.

MA/LPN Rooms Patient, performs vitals on Intake form.

MA/LPN open Social History Template. Perform PHQ-2.

If patient answers no to both questions, then patient does not need follow-up.

If patient answers yes to either question, then patient needs follow-up.

MA/LPN completes additional 7 questions of PHQ-9 with the patient and document results in the EHR.

Provider reviews with patient and assesses need for further follow up. PHQ-9 Score >9 or scoring 2 or greater on question 9. Otherwise, no follow up.

NO FOLLOW UP

Continue with visit.

FOLLOW-UP NEEDED

Patient agrees to pursue BH. Provider ensures warm handoff made and orders a referral OR if BH not needed, schedules a follow up primary care appt.

Patient agrees to try medication for depression. Provider prescribes using the medication module.

Patient refuses BH and/or medications. Provider document refusal using structured data such as a check box.

END

Depression Screen & f/u Complete

Utilizing PVP For Depression Remission

Health Partners of Western Ohio

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

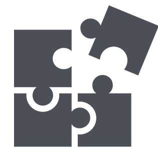
- CHC ran the PVP report by month allowing visibility into all patients on the schedules who fell into the measure denominator, along with the corresponding lookback period.
- Behavioral Health teams used these lists as a means to ensure screenings were captured during the necessary date ranges according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

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

2022 Network average **8.1%**

2022 HPWO **25.3%**

Depression Remission | Alert



Turn On!

Alert Administration

depression remission

All | Enabled | Disabled

All | In POC Measure | Not in POC Measure

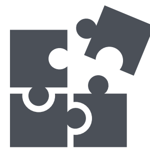
CATE...	NAME	PVP NAME	ENABLED	DESCRIPTION	OWNER
Screening	Depression Remission	Depression Remission	Y	Alert will trigger if a patient has a diagnosis of depression or dysthymia and has not had a follow-up PHQ9, or has had a follow-up PHQ9 >=5. Alert will begin firing 1 month before the follow-up period starts (i.e. 9 months after the initial screen), and will be capped by 12 months after the follow-up period closes (i.e. 26 months after the initial screen). This alert is not configurable	MA

10 Centers have Enabled

What workflow(s) have you put in place for this alert?

How do you move the needle on this population?

Depression Remission Workflow



START

Patients12 years of age or older w/ Depression or Dysthymia and PHQ-9 >=9

Use Patient Visit Planning report to know if patient needs follow up PHQ-9.

MA/LPN Rooms Patient, performs vitals on Intake form.

MA/LPN opens Screening Tools link or Intake Template and completes PHQ-9.

NUMERATOR SATISFIED

If patient's PHQ-9 is <5 and taken between 10 and 14 months after the initial elevated PHQ-9.

NUMERATOR NOT SATISFIED

If patient's PHQ-9 is >=5 and taken between 10 and 14 months after the initial elevated PHQ-9.

MA/LPN lets provider know; provider review with patient and assess current approach to depression or dysthymia:

- Medication adjustment with pharm D. on staff
- Warm handoff to BH or LCSW on staff

NO ADDITIONAL FOLLOW UP

REPEAT SCREENING RECOMMENDED

Continue with visit.

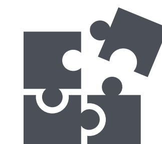
Provider records plan in checkout template and front office will schedule follow up visit that includes PHQ-9 screening.

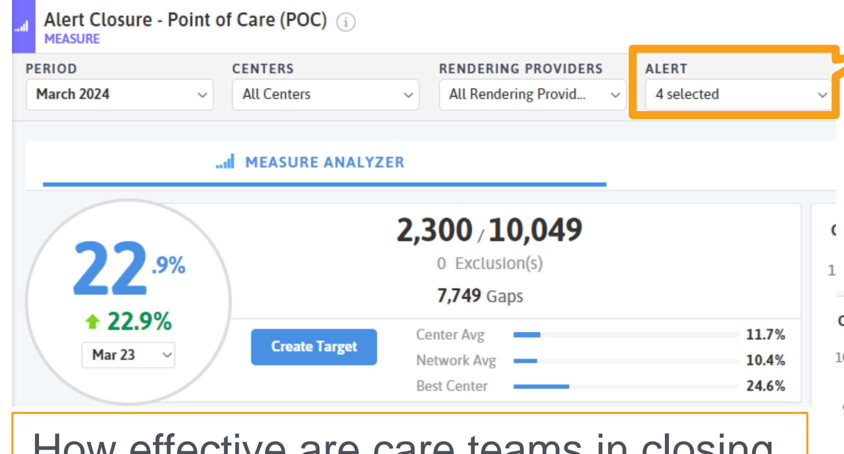
END

Depression Remission Complete

The Depression Remission measure requires that a follow up PHQ-9 screening be conducted 10-14 months after the initial positive screen and, to meet the numerator criteria, that follow up screening result must be < 5. While patients with depression may be screened more frequently, to satisfy the measure it is recommended to schedule a primary care appointment in this 10-14-month window to ensure compliance.

POC Alert Closure Measure





ALERT

4 selected

Search

Clear Filters

- Depression Screening (Depression Screen)
- Depression Screening (PHQ2-Depression Screen)
- Depression Screening Primary Care (Depression Screen by PC)
- Depression Screening Primary Care (PHQ-9 in Medical Due)

Comparison

GROUP BY Service Line

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

37.8%
1,910 / 5,052
0 Exclusions
Primary Care

25.5%
226 / 885
0 Exclusions
Behavioral Health

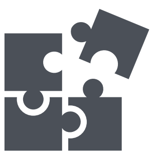
Primary Care
Specialty
Behavioral H...
Ignore
Unmapped
Optometry
Dental
Rehab

How effective are care teams in closing care gaps?

How are new/enabled alerts being closed?

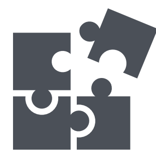
Are care teams across service lines closing gaps?

Alerts | PHQ9



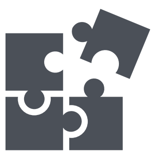
Alert	Description
PHQ-9 Follow-Up (2 Centers enabled)	Alert will trigger if a patient PHQ-9 screen is >=10 and there is no follow-up on the same day as the positive screening. Patient must not have Depression/Bipolar. This alert is not configurable.
PHQ-9 Screen (5 Centers enabled)	Alert will trigger if PHQ-9 Depression Screen has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression or Bipolar Dx.
PHQ-9 Utilization (2 Centers enabled)	Alert will trigger if a patient has a diagnosis of depression or dysthymia and has not completed a PHQ9 during each applicable 3 month period in which there was a qualifying visit. This alert is not configurable.
Positive PHQ-9 Follow-Up (2 Centers enabled)	Alert will trigger for patients age >=18 with a diagnosis of depression whose last PHQ9 was positive and was over 90 days to 1 year old, but has not had a recurrent PHQ9 to follow up. This alert is not configurable.

Alerts | Behavioral Health



Alert	Description
Diabetes Screen – Antipsychotics (1 Center enabled)	Alert will trigger if A1C has not occurred in the last 1 years. Patient must have Antipsychotic Medications. Patient must not have Palliative Care or hospice care.
Metabolic Monitoring – Antipsychotics (2 Centers enabled)	Alert will trigger for patients prescribed an antipsychotic medication in the last year who have not had metabolic testing (CMP, TSH, CBC w/dif AND LDL) within the last 12 months. This alert is not configurable.
Anxiety Screen (4 Centers enabled)	Alert will trigger if Anxiety Screen has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must not have Anxiety,
Anxiety Screen with Diagnosis (1 Center enabled)	Alert will trigger if GAD-7 Score has not occurred in the last 1 years. Alert only applies to patients >=16 yrs old. Patient must have Anxiety.

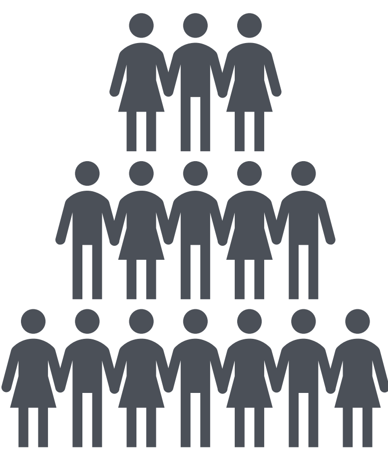
Alerts | Suicide Assessments



Alert	Description
MDD Suicide Risk Assessment (No centers enabled)	Alert will trigger if Suicide Risk Assessment has not occurred in the last 0 days. Alert only applies to patients >=6 yrs old and <=17 yrs old. Patient must have Major Depressive Disorder.
Suicide Risk Assessment Ages 10-17 (No centers enabled)	Alert will trigger if Suicide Risk Assessment has not occurred in the last 6 months. Alert only applies to patients >=10 yrs old and <=17 yrs old. Patient must have Suicide Risk Assessment.
Suicide Risk Assessment Ages 18+ (No centers enabled)	Alert will trigger if Suicide Risk Assessment has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must have Suicide Risk Assessment.

Population health is defined as the **health outcomes** of a group of individuals, including the distribution of such outcomes within the group.

--Institute for Healthcare Improvement (IHI)



https://www.ihi.org/insights/populations-population-health-and-evolution-population-management-making-sense-terminology

Registry Use Cases | Tip of the Iceberg

Identify patients due for depression screening (and/or follow-up)

Identify patients with chronic condition(s) AND behavioral health diagnoses (or PHQ-9 score)

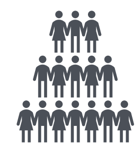
Identify patients seen by both primary care and behavioral health

Track patients' clinical outcomes: A1C, BP, PHQ-9, GAD-7, etc.

Stratify patients for care coordination and/or for care management

More information about Registries

Registry | Depression (stock)



Depression
REGISTRY

Consider additional filters to apply: Age, Diagnosis, Risk, SDOH

FILTER

VISIT DATE RANGE: 04/11/2023-04/10/2024
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

REGISTRY | VALUE SETS

Search Patients ...

Reset Columns | SAVED COLUMNS

	MOST RECENT ENCOUNTER		NEXT APPOINTMENT							DEPR SCRN		
MRN	DATE	PROVIDER	DATE	PROVIDER	LOCATION	TYPE	REASON	AGE	MED RECONCILIATION	DATE	TYPE	RESULT
1103865	5/5/2023	Decelles, Larry	10/22/2023	Smith, Joe	ACH - Needs Update	High BP		21	12/29/2021	5/5/2023	PHQ-9 Depression Screen	6
1103866	4/3/2022	Augustine, Greg	11/18/2023	Winslow, Francine	ACH - Needs Update	High BP		72	12/4/2021	4/3/2022	PHQ-9 Depression Screen	27
1103867	4/17/2023	Black, Ronda	10/25/2023	Doe, Jane	ACH - Needs Update	Sick Visit		36	1/9/2023	4/17/2023	PHQ-9 Depression Screen	4
1103868	6/12/2023	Plant, Robert	9/29/2023	Branchburg, Tom	FHC - Needs Update	Office Visit		19	8/28/2022	1/5/2023	PHQ-9 Depression Screen	12
1103869	4/24/2023	Cote, David	9/17/2023	Ryan, Frank	FHC - Needs Update	Office visit		47	4/24/2023	4/24/2023	PHQ-9 Depression Screen	24
1103871	5/2/2023	Fritz, Renata						5		11/28/2022	PHQ-9 Depression Screen	2
1103882	4/20/2023	Decelles, Larry	10/21/2023	Fritz, Renata	ACH - Needs Update	Physical		36	9/5/2021	1/29/2023	PHQ-9 Depression Screen	10
1103890	4/25/2023	Gunther, Eric						20		4/25/2023	PHQ-9 Depression Screen	27
1103901	4/14/2023	Smith, Joe	9/30/2023	Smith, Joe	ACH - Needs Update	Office Visit		1	4/5/2022	4/14/2023	PHQ-9 Depression Screen	26
1103903	2/18/2023	Smith, Joe	9/29/2023	Augustine, Greg	ACH - Needs Update	Office Visit		4	9/14/2021	3/6/2022	PHQ-9 Depression Screen	28
1103904	8/30/2023	Augustine, Greg	9/29/2023	Augustine, Greg	ACH - Needs Update	Office Visit		10	11/28/2021	8/30/2023	PHQ-9 Depression Screen	25
1103907	6/18/2023	Branchburg, Tom	9/28/2023	Plant, Robert	FHC - Needs Update	Sick Visit		57	8/11/2022	6/6/2023	PHQ-9 Depression Screen	8
1103908	3/30/2022	Parker, Philip	9/19/2023	Parker, Philip	NHC - Needs Update	Office visit		74		3/30/2022	PHQ-9 Depression Screen	0
1103912	7/26/2023	Weixel, Evan	11/11/2023	Branchburg, Tom	FHC - Needs Update	Physical		76	7/26/2023	7/26/2023	PHQ-9 Depression Screen	18

Do patients have a next appt scheduled? Identify for outreach

When was their last phq-9? What was the score?

azara healthcare

Registries | Customize by Use + Role

Depression Remission Management (i)
REGISTRY

i.e., Created for Depression & Remission Management

FILTER

VISIT DATE RANGE: 02/18/2024-03/18/2024
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

Add Filter | Update

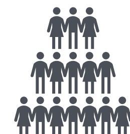
REGISTRY | VALUE SETS

Search Patients ...

Reset Columns | SAVED COLUMNS

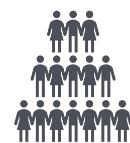
DEPR FOLLOWUP ASMT PERIOD		PHQ-9 RESULT			PHQ9 UTILIZATION Q4 PHQ9			PHQ9 UTILIZATION Q3 PHQ9		
START DATE	END DATE	DATE	VALUE	PHQ9 UTILIZATION Q4 VISIT DATE	DATE	RESULTS	PHQ9 UTILIZATION Q3 VISIT DATE	DATE	RESULTS	PHQ9 UTILIZATI
3/24/2023	7/24/2023	2/20/2024	8	2/20/2024	2/20/2024	8	10/19/2023			9/6/2023
		2/1/2024	4	1/10/2024	1/10/2024	0	12/6/2023	12/6/2023	0	7/11/2023
3/26/2023	7/26/2023	2/20/2024	11	2/20/2024	2/20/2024	11	12/6/2023			8/23/2023
		12/11/2023	5				12/11/2023	12/11/2023	5	7/26/2023
		3/8/2024	9	3/8/2024	3/8/2024	9				
6/24/2023	10/24/2023	2/9/2024	0	2/9/2024	2/9/2024	0	10/26/2023	10/26/2023	0	
		3/11/2024	0				11/7/2023			
		1/10/2024	3	1/10/2024	1/10/2024	3				8/4/2023
1/2/2023	5/2/2023	3/1/2024	17	3/1/2024	3/1/2024	17				
		5/4/2023	3							9/8/2023
1/16/2023	5/16/2023	2/12/2024	13	2/12/2024	2/12/2024	13	10/25/2023	10/25/2023	14	9/21/2023
2/14/2023	6/14/2023	2/29/2024	5	2/29/2024	2/29/2024	5				7/14/2023
		1/17/2024	15	1/17/2024	1/17/2024	15				7/18/2023
		3/11/2024	4	3/11/2024	3/11/2024	4				
		1/29/2024	0	1/29/2024	1/29/2024	0				8/14/2023
		2/28/2024	6	2/28/2024	2/28/2024	6	10/19/2023	10/19/2023	7	9/28/2023

RDEs | Behavioral Health



- **ADHD**
  - ADHD Diagnosis
  - ADHD Medications
  - ADHD Self Management
  - Vanderbilt ADHD Assessment
- **Anxiety**
  - Anxiety
  - Anxiety Disorders
  - Anxiety Screen
  - GAD-2
  - GAD-7
- **Bipolar**
  - Bipolar Diagnosis
  - Bipolar Disorder
- **CAT-MH**
  - CAT-MH ANX Severity
  - CAT-MH DEP Severity
  - CAT-MH MHM Severity
  - CAT-MH PTSD Severity
  - CAT-MH SS Severity
  - CAT-MH SU Severity
- **Depression**
  - Beck Depression Inventory (BDI-II)
  - Beck Depression Inventory – Fast Screen (BDI-FS)
  - Clinically Useful Depression Outcome Scale (CUDOS)
  - Depression Assessment PHQ-9 >9
  - Depression Diagnosis
  - Depression Follow-Up
  - Depression Follow-Up Assessment Period CY
  - Depression Follow-Up Assessment Period for PHQ-9 >9
  - Depression Screen Primary Care
  - Depression Screen Refused
  - Depression Screening
  - Depression Self Management
  - Depression/Bipolar

RDEs | Behavioral Health



- **Geriatrics**
  - Geriatric Depression Scale Long Form
  - Geriatric Depression Scale Short Form
  - Geriatric Depression Screen
- **Major Depressive Disorder in Remission**
- **Medication**
  - Antidepressant Medication
  - Antipsychotic Medications
- **Operational**
  - Next Behavioral Health Appointment
  - Collaborative Care Next Due
  - Collaborative Care Referral
  - Behavioral Health Assessment
  - Behavioral Health Assessment Next Due
  - Behavioral Health Encounter
  - BH Counselor
  - BH Interaction
- **Pediatric**
  - CES-DC
  - Child Adolescent Psychiatry Screen
  - SED
  - Vanderbilt ADHD Assessment
- **PHQ**
  - PHQ-2 Depression Screen
  - PHQ-9 Depression Screen
  - PHQ-2 Question 9
  - PHQ-9 Utilization – Q1, Q2, Q3, Q4
- **Postpartum Depression**
- **PSC**
  - PSC-17 Internalizing
  - PSC-17 Total
- **Psychosocial Assessment**

RDEs | Behavioral Health

- **Psychosocial Assessment**
- **PTSD**
  - PTSD
  - PTSD Checklist for DSM-5
  - PTSD Primary Care Screen for DSM-5
  - PTSD Screen
  - PTSD Severity Short Scale
- **SAD**
- **Schizophrenia**
- **Stress**
  - Stress
  - Stress Disorder
  - Stress ICD-10
- **Suicide**
  - Suicidality
  - Suicide Attempt Self Harm
  - Suicide Risk Assessment
  - Columbia Suicide Severity Score

A Note on Cohorts

A group of people who share a common characteristic or experience within a defined period.

In DRVS - a cohort is a group of patients, that have a record in DRVS, that are linked together for the purpose of comparison and tracking performance.

Cohorts created in DRVS are static; the patient list **will not change** unless manually manipulated

Why a Cohort?

Easy identification, comparison, or tracking performance

Helps measure outcomes for a specific group of patients defined at one point in time

Important to track cohorts when measuring success.

Are the people you're outreaching to coming in?

Are they getting their A1C?

Are those being managed by behavioral health also reducing their A1C value?

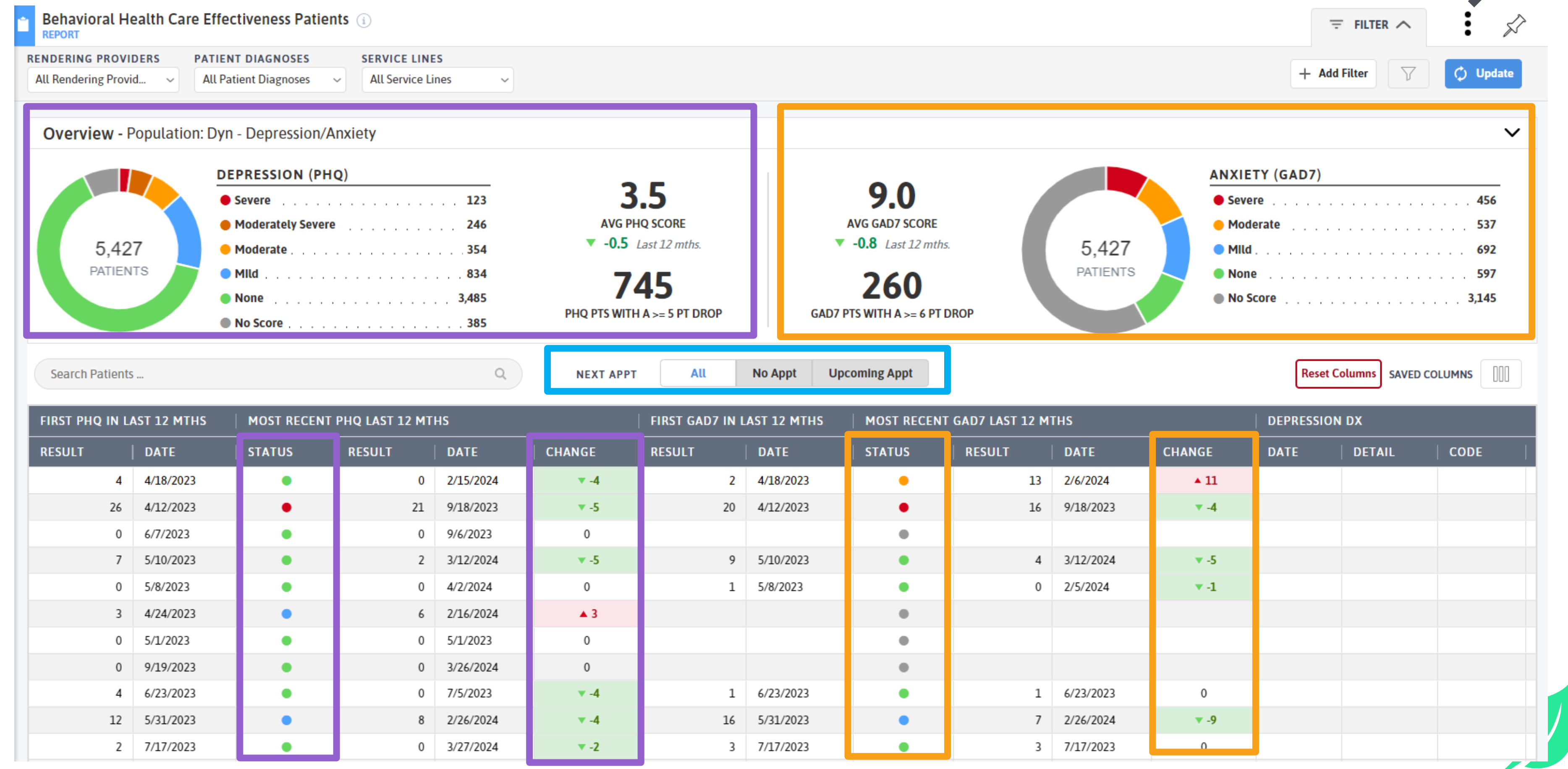
More information on **cohorts**

Available for filtering on any report, dashboard, measure, registry or PVP report

One study shows that clinically, 50% of patients had a greater than 5-point reduction in PHQ-9 depression scores and 32% experienced a ***more than 50% reduction when receiving integrated, whole-person care***.

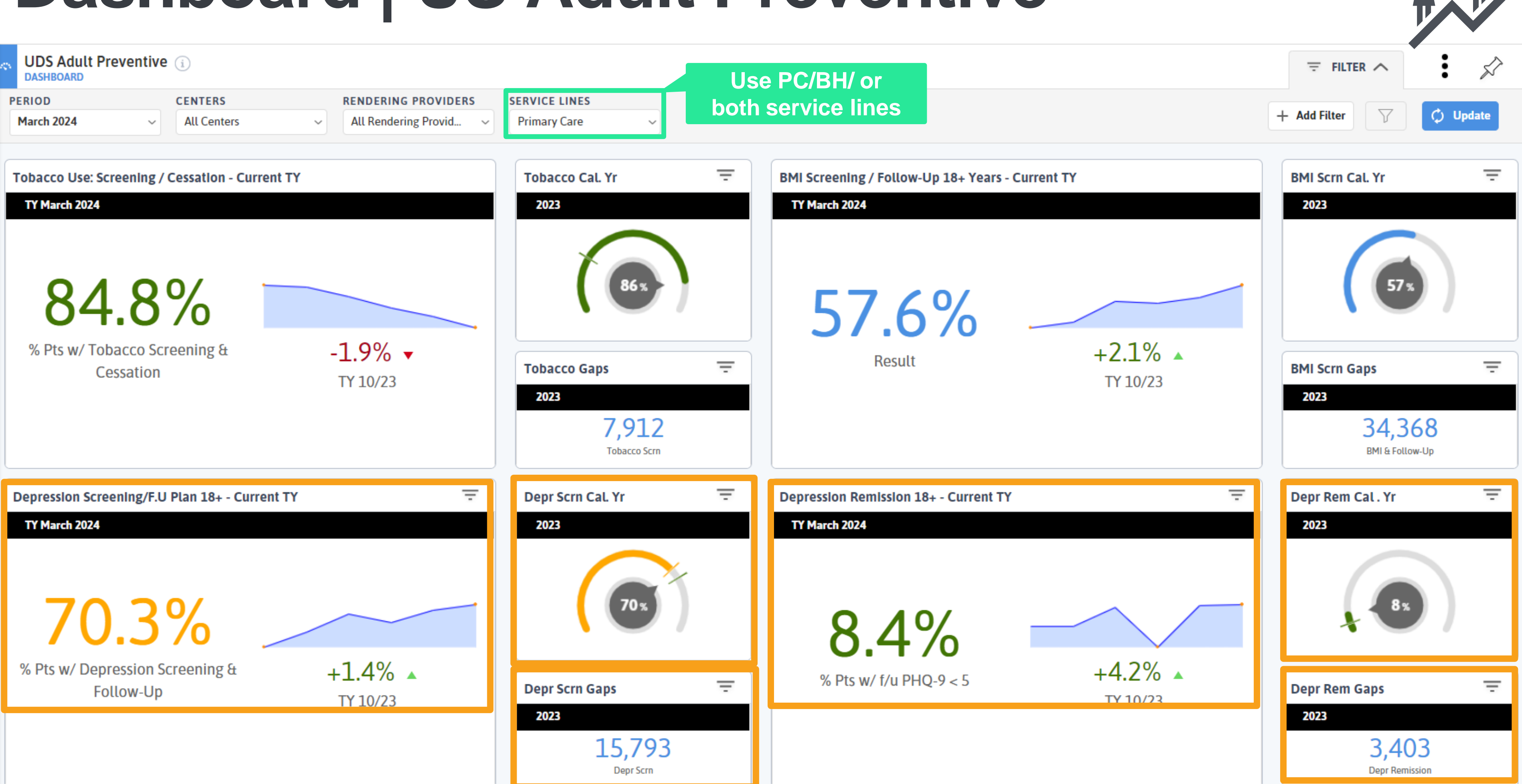
--Outcomes of Integrated Behavioral Health with Primary Care

Care Effectiveness Report (CER)



FIRST PHQ IN LAST 12 MTHS		MOST RECENT PHQ LAST 12 MTHS				FIRST GAD7 IN LAST 12 MTHS		MOST RECENT GAD7 LAST 12 MTHS				DEPRESSION DX		
RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	DATE	DETAIL	CODE
4	4/18/2023		0	2/15/2024	▼ -4	2	4/18/2023		13	2/6/2024	▲ 11			
26	4/12/2023		21	9/18/2023	▼ -5	20	4/12/2023		16	9/18/2023	▼ -4			
0	6/7/2023		0	9/6/2023	0									
7	5/10/2023		2	3/12/2024	▼ -5	9	5/10/2023		4	3/12/2024	▼ -5			
0	5/8/2023		0	4/2/2024	0	1	5/8/2023		0	2/5/2024	▼ -1			
3	4/24/2023		6	2/16/2024	▲ 3									
0	5/1/2023		0	5/1/2023	0									
0	9/19/2023		0	3/26/2024	0									
4	6/23/2023		0	7/5/2023	▼ -4	1	6/23/2023		1	6/23/2023	0			
12	5/31/2023		8	2/26/2024	▼ -4	16	5/31/2023		7	2/26/2024	▼ -9			
2	7/17/2023		0	3/27/2024	▼ -2	3	7/17/2023		3	7/17/2023	0			

Dashboard | US Adult Preventive



Measures – Core Clinical | BH

Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 161v16)
Anxiety Screening for Adults with Anxiety Diagnosis
Diabetes Screening – Antipsychotics
Depression Remission at Twelve Months (CMS159v11)
Child & Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 177v9)
Screening for Depression & Follow-Up Plan (CMS 2v12)
Depression Screen – Adolescents with Depression
Depression Screen – Adults with Depression
Depression Utilization of the PHQ-9 Tool (CMS 160v6)
Antidepressant Medication Management – Effective Acute Phase Treatment
Antidepressant Medication Management – Effective Continuation Phase Treatment

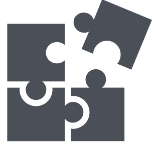
Create **custom scorecards** with any collection of measures

Measures – Core Clinical | BH

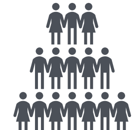
- Screening for Depression & Follow-Up Plan 12-17 yrs (CMS 2v12 Modified)
- Screening for Depression & Follow-Up Plan 18+ years (CMS 2v12 Modified)
- Depression Screen – Positive Result (CMS 2v12 Modified)
- Depression Screen Positive w/Follow-Up (CMS 2v12 Breakout)
- Screening for Depression (CMS 2v12 Modified)
- Annual Anxiety Screen 8+
- Metabolic Testing – Antipsychotics

Behavioral Health Integration & DRVS

Use the Patient Visit Planning Report to provide insight at the point of care.



Use custom registries to identify and track key populations.



Track metrics through measures to monitor operations & workflows

Next Steps

What needle do you want to move?

Understand your patient population

Discuss with your team what support(s) you need

Decide what steps are necessary

Controlled Substance

DRVS Can Help

Identify MAT prescribed patients

Manage MAT patients' clinical and behavioral health

Manage your Programs

Support Primary Care and Behavioral Health

Monitor patients at risk

Report to external stakeholders

Controlled Substance | Measures

Substance Use Disorder and Treatment	• AUD, OUD • Buprenorphine Rx, Naltrexone-Injectable Rx • Controlled Substance Agreement (CNMP & COT) • Substance Use Screening & Intervention Composite
Medication Management	• Medication Assisted Therapy Prescribed for OUD by Provider Reports • Opioid, Benzodiazepine, Opioid & Benzo, Benzodiazepine > 3mg • Naloxone Rx (CNMP & COT)
Initiation/ Engagement Retention in Treatment	• Initiation, Engagement of AOD treatment 13+ • Initiation, Continuity of Pharmacotherapy
Prevention and Screening	• Substance Use Screening & Intervention Composite • Unhealthy Alcohol Use Screening & Counseling • Drug Use Screen & Counseling • Hepatitis C Lifetime Screening (& after OUD Dx)

Controlled Substance | Reports

Controlled Substance

- Collection of Controlled Substance measures
- Quick overview of performance
- Customize for focus measures e.g., HIV/Hep C Screen, Ctrl Sub Agreement, Narcan

MAT Prescribed for OUD by Provider – Report

- Lists prescribing provider and number of unique patients with a prescription for MAT

MAT Prescribed for OUD by Provider – Detail List

- Lists patient details including prescribing provider, medication name, and prescription date

Controlled Substance | Registries

OBOT Registry

- Use to monitor all patients enrolled in an OBOT program.
- Patients who are receiving MAT using Buprenorphine, Naltrexone, or other opioid use treatment medications in the last 12 months.

Opioid – Potential Misuse Registry

- Identify patients at risk of developing opioid addiction.
- Patients with an active opioid medication (excludes buprenorphine) in the last 12 months.

Methadone Medication Registry

- Lists patients with methadone on their medication list.
- Patients with an active methadone medication in the last 12 months.

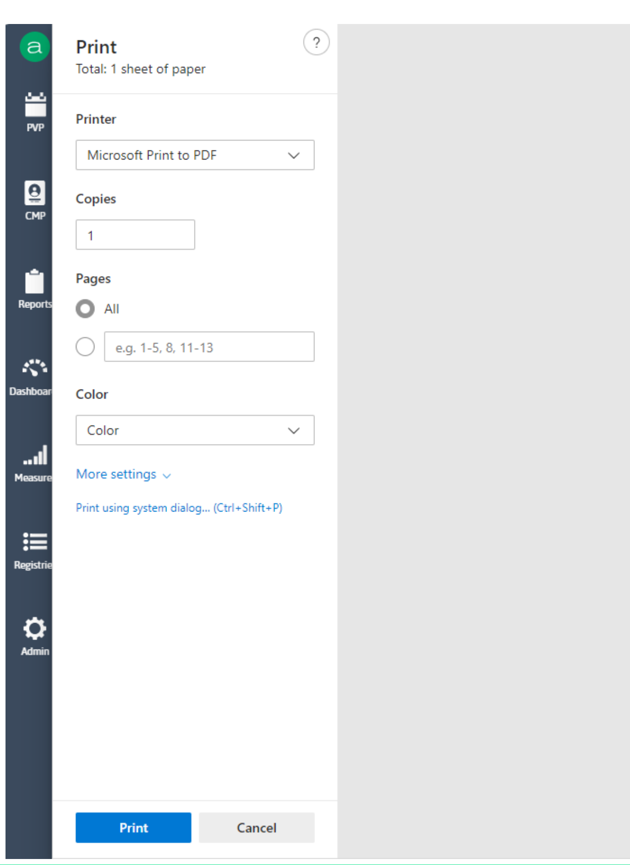
Pain Management Registry

- Use to monitor patients with chronic pain.
- Patients with an active chronic pain diagnosis in the last 12 months.

Super Registries
Copy and edit to make useful for your program needs

What’s New in DRVS?

Printing of PHI Now Restricted From Print Menu



- To protect PHI, users are now restricted from printing out DRVS pages from the browser's print menu that contain PHI.
- This applies to **measures, registries,** and **cohort patient lists.**

FEATURE

Released March 2024

APO: Unmatched Members Campaign Updates

FEATURE

APO ADMINS: Update to Unmatched Members Campaign

New: Specify the members to conduct outreach to based on PLAN

The PLAN variable within the Unmatched Members campaign is now editable within the Campaign Criteria.

To access and edit, navigate to the Unmatched Members campaign Variables section.

By clicking the pencil "edit" icon, you can select the plan(s) you want to include in the campaign criteria.

The default settings are "All Plans". You can change these settings at any time.

Unmatched members

VARIABLES

CAMPAIGN VARIABLES

These are configurable values within the campaign entry/exit criteria or within the messages themselve

VARIABLE	CURRENT SETTINGS	DESCRIPTION	
Plans	All Plans	Health plans to include in campaign	

Edit Variable

These are configurable values within the campaign entry/exit criteria, or within the messages themselves.

VARIABLE NAME

Plans

SELECTED PLANS

2 selected

Health plans to include in campaign

COMMENTS

Search

Select All

AETNA HEALTHCARE

AHMC Healthcare Inc. EPO

Alignment Health Plan

Anthem Blue Cross

Cancel

Available for practices with the APO Module.

Released March 2024

New Filter for Payer Integration Functionality: "Enrollment Status"

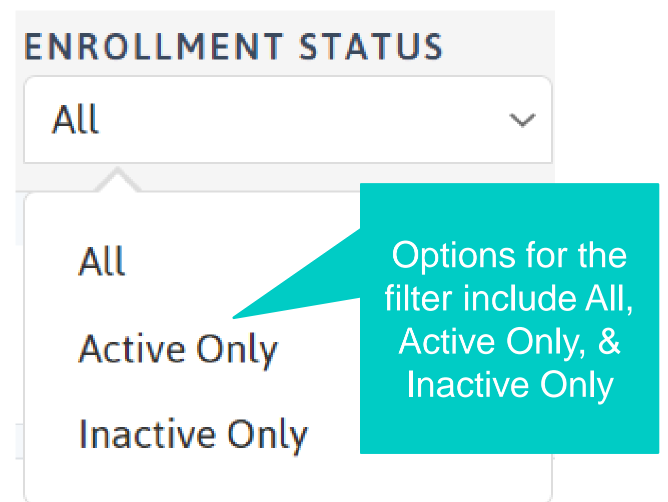
FEATURE

- A filter for "Enrollment Status" is now available for the following:

Care Gap Reconciliation (CGR) Report

Plan Calculated Measures

Plan Calculated Scorecards



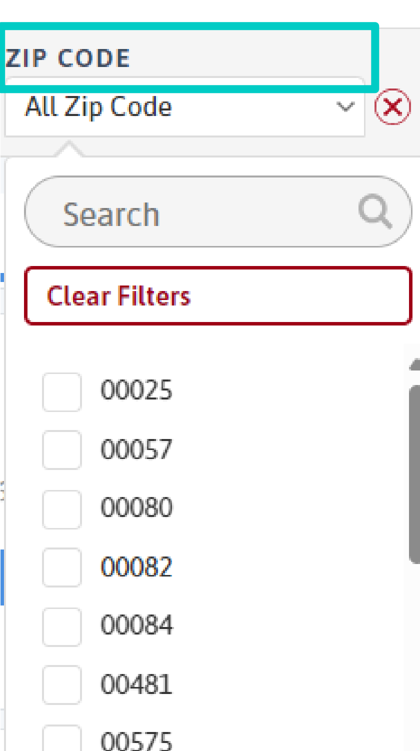
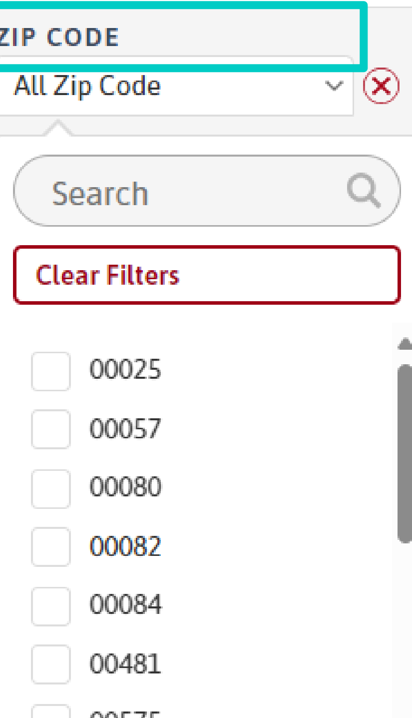
Options for the filter include All, Active Only, & Inactive Only

Available for practices with the Payer Integration Module.

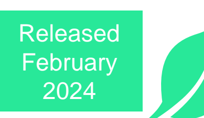
Released February 2024

No Show Appointments Measure
New "Zip Code" Filter

- A "Zip Code" filter is now available in the "No Show Appointments" measure
  - This filter has been added so that users can determine if the distance that patients must travel to the practice has an impact on their no show rate

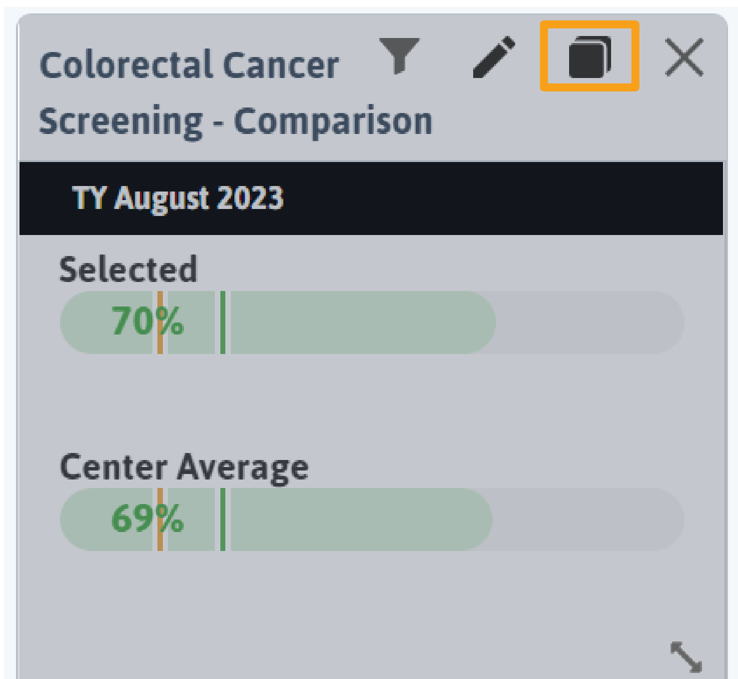
FEATURE



Released February 2024

Dashboard Widget Option Update:
"Copy Widget" Option Now Available!

- Users are now able to make a copy of a widget on a dashboard while in edit mode
- When a user clicks on this icon, an exact copy of the current widget will be created and added to the upper left-hand corner of the dashboard

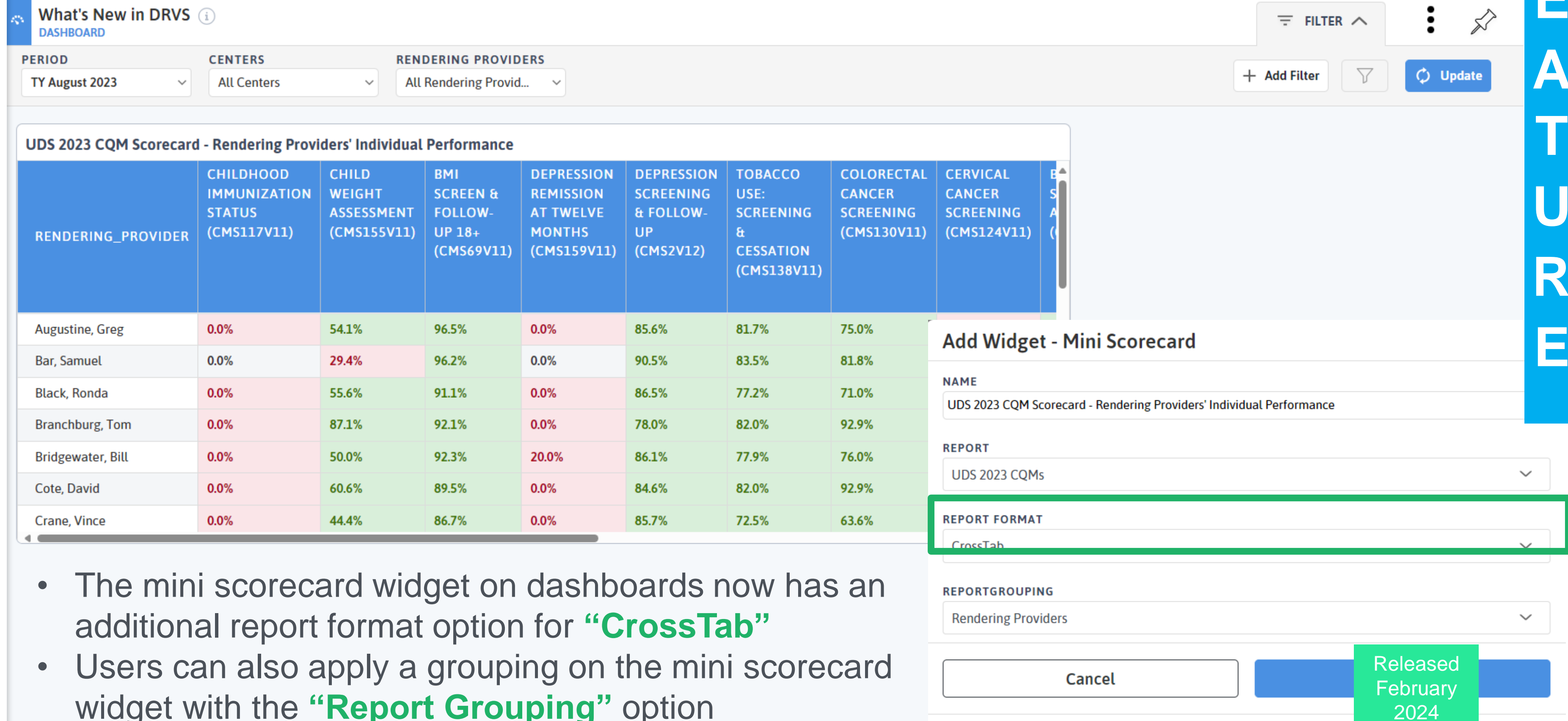


FEATURE

Released February 2024

Dashboard Widget Format Update:

“Crosstab” Now Available for Mini Scorecard Widget!

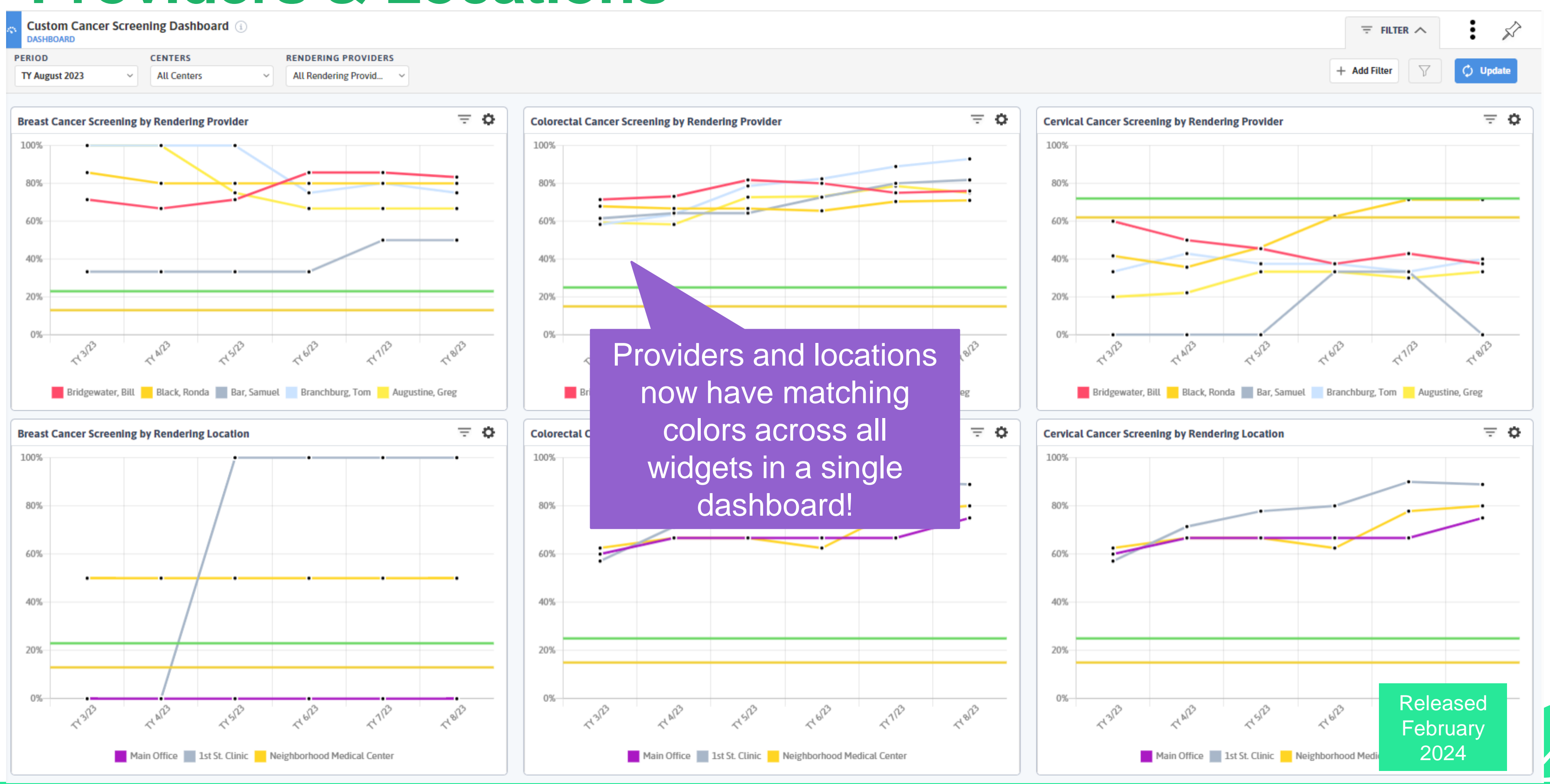


RENDERING_PROVIDER	CHILDHOOD IMMUNIZATION STATUS (CMS117V11)	CHILD WEIGHT ASSESSMENT (CMS155V11)	BMI SCREEN & FOLLOW-UP 18+ (CMS69V11)	DEPRESSION REMISSION AT TWELVE MONTHS (CMS159V11)	DEPRESSION SCREENING & FOLLOW-UP (CMS2V12)	TOBACCO USE: SCREENING & CESSATION (CMS138V11)	COLORECTAL CANCER SCREENING (CMS130V11)
Augustine, Greg	0.0%	54.1%	96.5%	0.0%	85.6%	81.7%	75.0%
Bar, Samuel	0.0%	29.4%	96.2%	0.0%	90.5%	83.5%	81.8%
Black, Ronda	0.0%	55.6%	91.1%	0.0%	86.5%	77.2%	71.0%
Branchburg, Tom	0.0%	87.1%	92.1%	0.0%	78.0%	82.0%	92.9%
Bridgewater, Bill	0.0%	50.0%	92.3%	20.0%	86.1%	77.9%	76.0%
Cote, David	0.0%	60.6%	89.5%	0.0%	84.6%	82.0%	92.9%
Crane, Vince	0.0%	44.4%	86.7%	0.0%	85.7%	72.5%	63.6%

- The mini scorecard widget on dashboards now has an additional report format option for **“CrossTab”**
- Users can also apply a grouping on the mini scorecard widget with the **“Report Grouping”** option

Dashboard Widget Color Update:

Providers & Locations



FEATURE

New Hepatitis B Alert:
Hepatitis B Lifetime Screening

A
L
E
R
T

New alert for Hepatitis B screening

ANNOUNCEMENT

New Hepatitis B Alert

Supports lifetime screening

Azara has created the following alert to assist with identifying adult patients screened at least once in their lifetime with a tests for hepatitis B surface antigen (HBsAg) and antibody to hepatitis B surface antigen (anti-HBs).

Alert name: Hepatitis B Lifetime Screening
PVP name: HepB Lifetime Screening

Description: Alert will trigger if Hepatitis B screening has not occurred in the last 100 years. Alert only applies to patients >= 18 years of age. Does not include patients with HepB diagnosis.

Released
March
2024

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to Achieve measurable results, Celebrate improvement in patient health outcomes, and effectively Engage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:

- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link.

Questions?