Patient Visit Planning

Innovative Ways to Leverage the PVP

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Today’s Agenda

OVERVIEW OF THE PVP

CONSIDERATIONS AND SET UP

USE CASES

WHAT’S NEW IN DRVS

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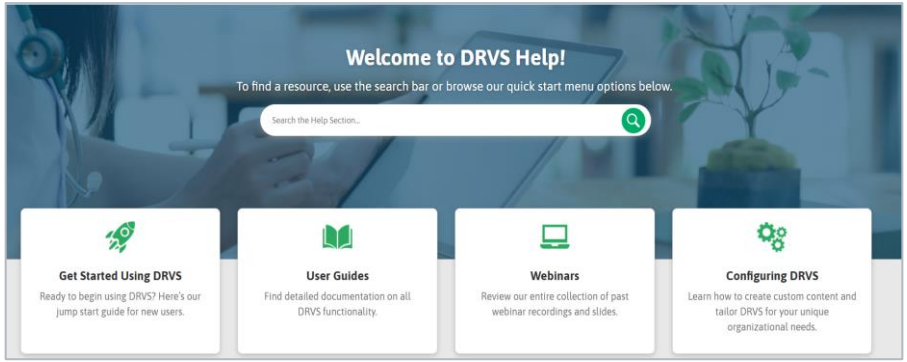
Resources in DRVS Help Section

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!)

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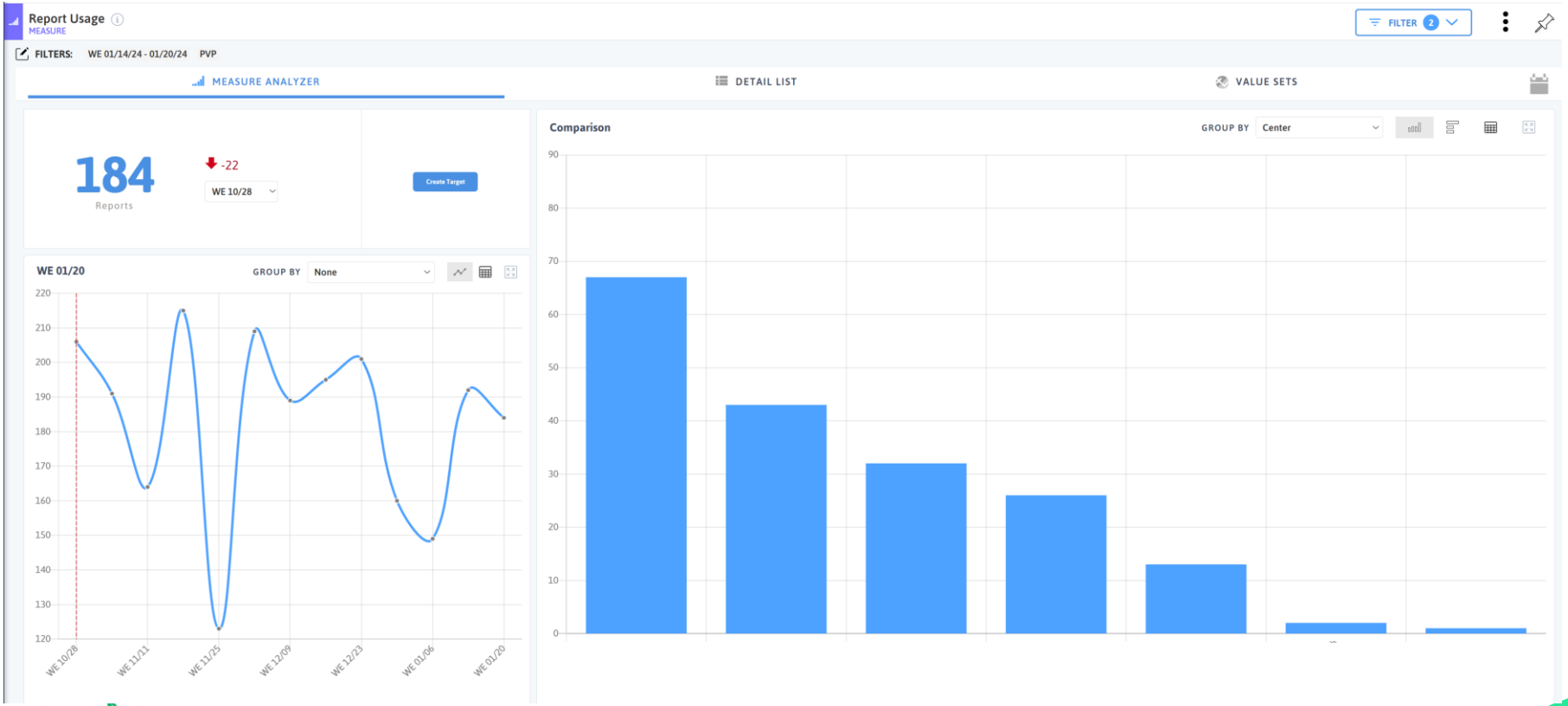
PVP Usage Across Montana



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Introduction to the Patient Visit Planning Report

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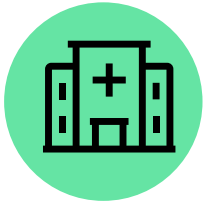
More Care to Deliver, Less Time


SOGI Documentation

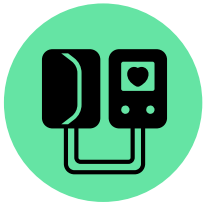

Cancer Screenings


Diabetes Care


SDOH Assessment


Hospital Discharges


Behavioral Health Screenings


Blood Pressure


Immunizations


Open Referrals

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Common Challenges with Pre-Visit Planning

Sticky notes in the EHR

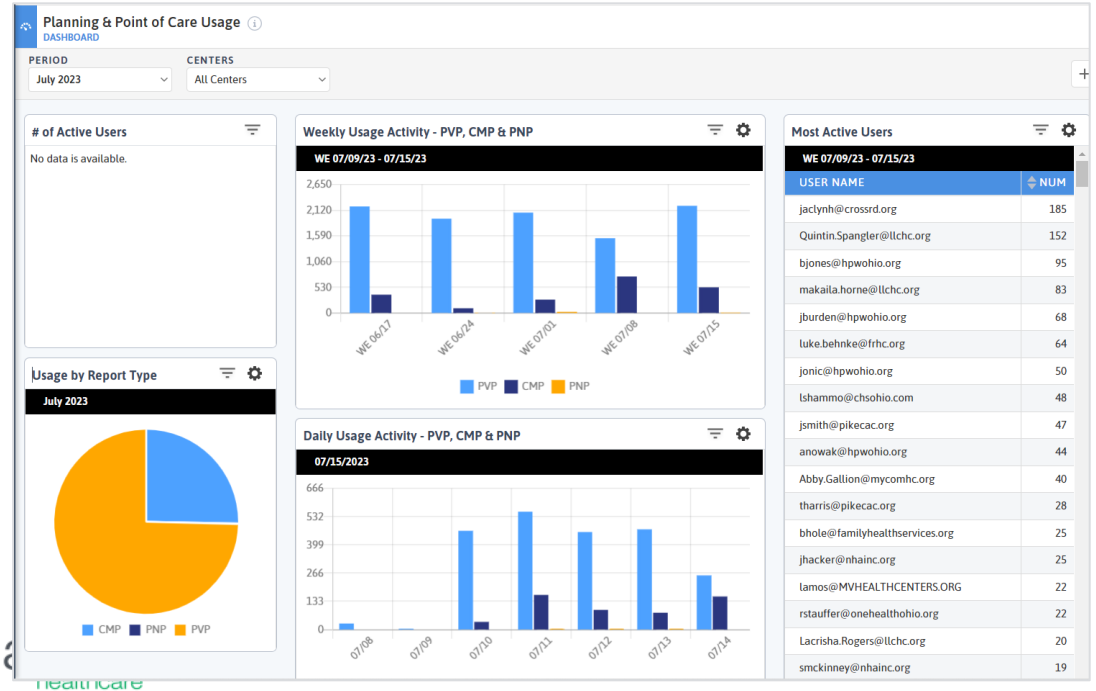
Manual & time-consuming scrubbing

High variability amongst care teams

Huddles as PCMH requirement

PVP & PCMH

AR-TC 1: The practice continues to use a **team-based approach to provide coordinated care**.



Can demonstrate by:

- Providing PVPs you have exported & annotated
- Planning & Point of Care Dashboard

Patient-Visit Planning Report

Efficient, actionable to-do list of alerts and other meaningful patient information that can be used to facilitate huddling & high-quality care delivery. Benefits include:

Automated chart scrubbing to identify care gaps

Displays relevant information beyond clinical factors

Highly configurable to align with practice’s unique priorities, workflows, and populations

Can be generated for same-day/walk-in patients

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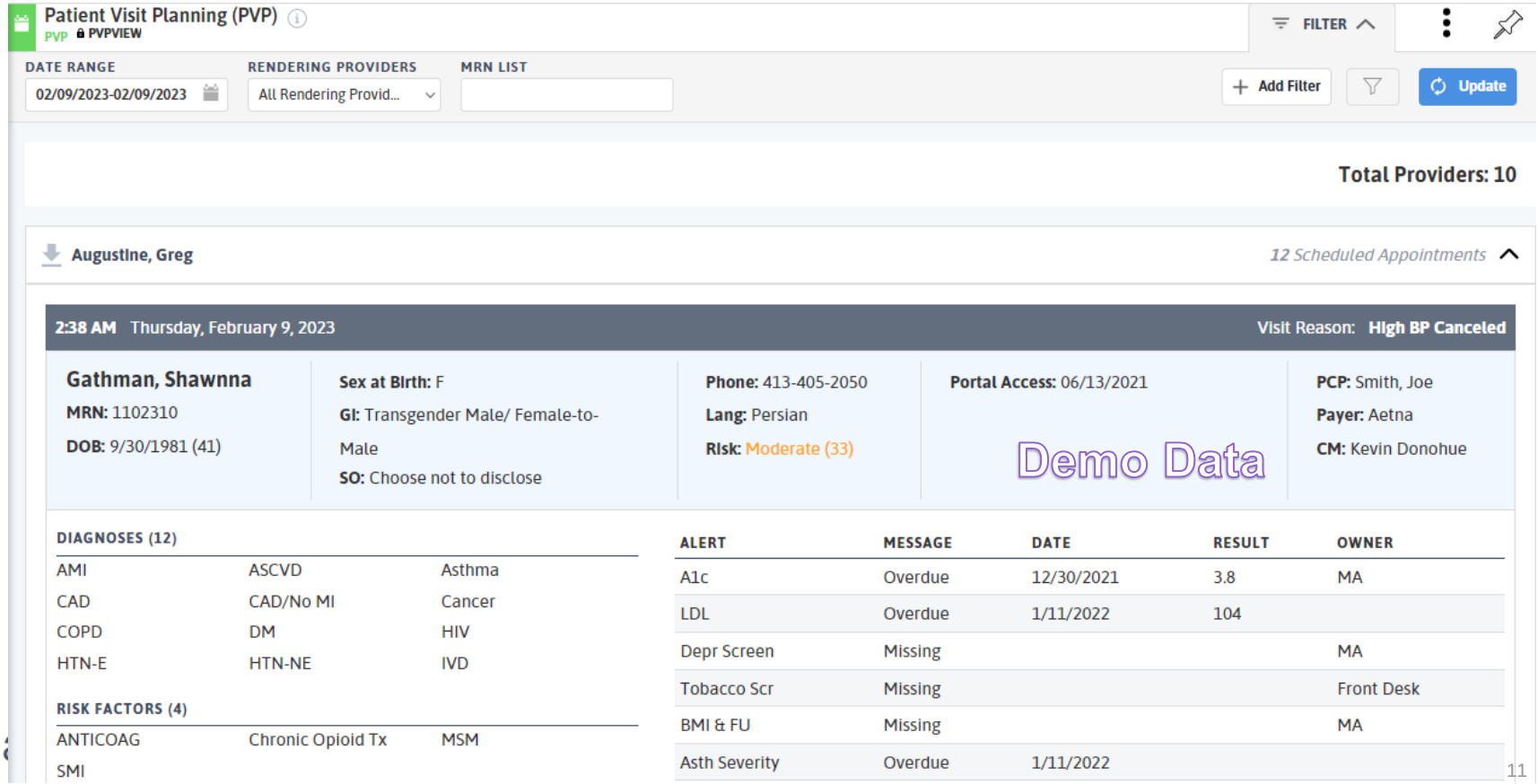
Patient Visit Planning Report



PVP | Use Cases

	Role	Action
	MA/LPN	Runs PVP as part of the morning huddle to prepare care team for that day's patients.
	Provider	Uses the alerts on the PVP to close patients' care gaps.
	Front Desk	Generates the PVP for same-day or walk-in patients so care teams can easily see what the patients' care gaps are.
	Practice/Site Manager	Configures the alerts to match practice workflows and uses the *Alert Closure – Point of Care* measure to ensure care teams are using the PVP.

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Highlight | RAF Gaps

8:30 AM Wednesday, January 10, 2024 ✓ — **Visit Reason:**

Doe, John **MRN:** 000123456 **DOB:** 3/8/1976 (47)	**Sex at Birth:** M **GI:** M **SO:** Straight	**Phone:** 012-234-5678 **Lang:** Spanish	**Portal Access:** N	**PCP:** Augustine, Greg **Payer:** **CM:** Unassigned

Demo Data

DIAGNOSES (5)

ASCVD	DM	HTN-E
HyLip	IVD	

RISK FACTORS (0)

SDOH (4)

FPL<200%	HISP/LAT	INSURANCE
LANGUAGE		

RAF GAPS DIAGNOSIS CATEGORIES (4)

Cardiovascular	Diabetes	Metabolic
Hematological		

ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Missing		
A1c	Out of Range	12/22/2023	7.0
HIV	Overdue	2/9/2021	negative
AUDIT	Missing		

RAF GAPS DIAGNOSIS CATEGORIES (4)

Cardiovascular	Diabetes	Metabolic
Hematological		

			APPT. DATE
Vascular Surgery	Dr. Fritz	4/10/2023	5/1/2023

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Highlight | RAF Gaps on the CMP

Social Drivers of Health (4)

FPL<200%	HISP/LAT	INSURANCE
LANGUAGE		

Allergies (0)

No active allergies

Demo Data

Medications (Last 10 of 16)

ACTIVE AS OF	NAME	SOURCE
9/20/23	atorvastatin 40 MG Oral Tablet	
9/20/23	lisinopril 10 MG Oral Tablet	
9/20/23	metformin hydrochloride 1000 MG Oral Tablet	
9/20/23	empagliflozin 10 MG Oral Tablet [Jardiance]	
11/14/22	hydrocortisone 10 MG/ML / neomycin 3.5 MG/ML / polymyxin B 10000 UNT/ML Otic Suspension	
9/13/21	LANCETS	
9/13/21	Blood Glucose Test	
2/9/21	lisinopril	
2/9/21	metformin hydrochloride 500 MG Oral Tablet	
5/13/20	fish oils	

RAF Gaps (4)

DIAGNOSIS CATEGORY	CONTEXT	BILLED CY	UNBILLED CY	ACTIONS TO CONSIDER
Cardiovascular	Dx Not Billed		EHR: I10 (12/20/23)	Add to Chg Next Visit
Diabetes	Dx Not Billed		EHR: E11.9 (12/20/23)	Add to Chg Next Visit
Metabolic	Dx Not Billed		EHR: E80.4 (12/20/23)	Add to Chg Next Visit
Hematological	Dx Not Billed		EHR: D69.6 (04/25/23)	Add to Chg Next Visit

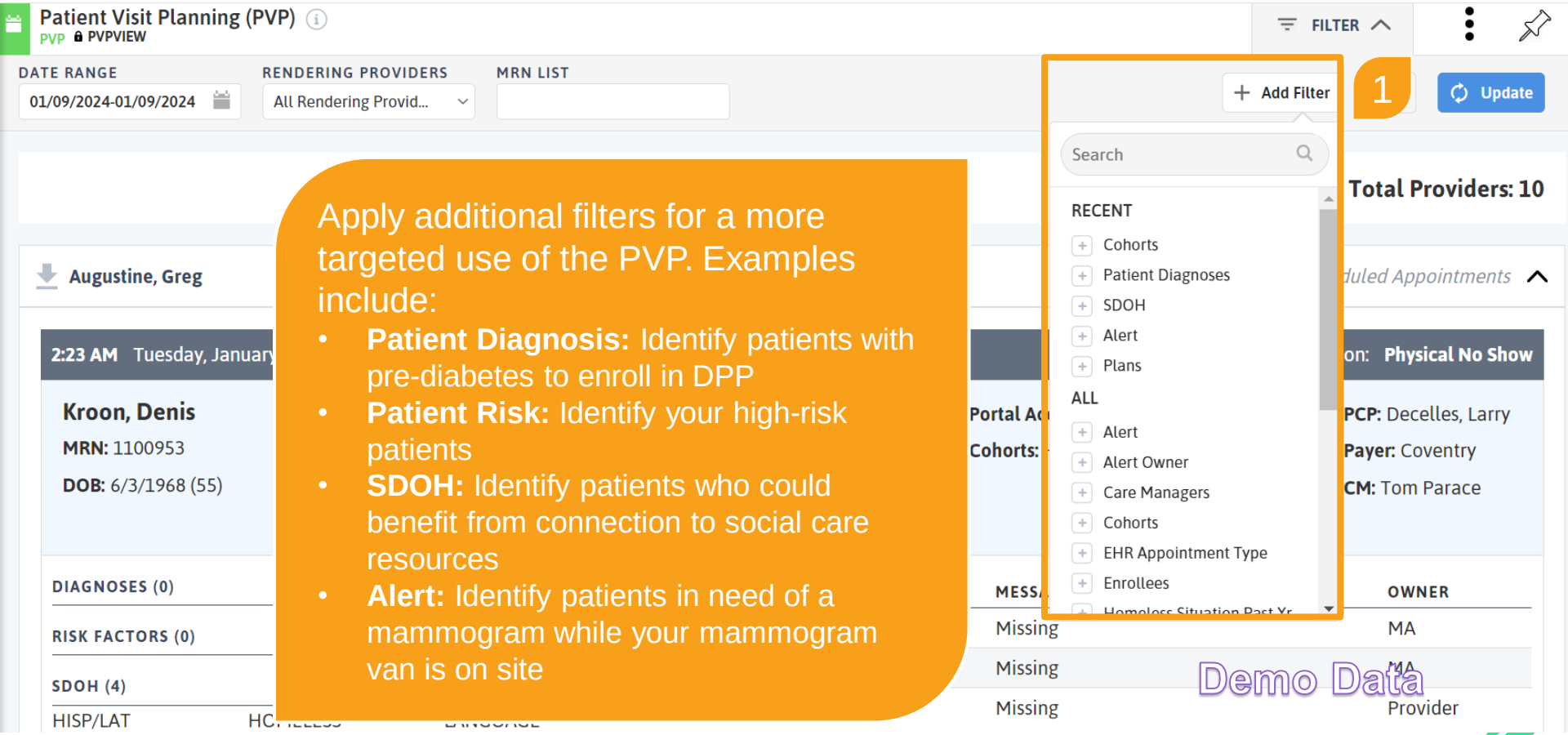
Total RAF Risk Score

No RAF Score

Open Referrals w/o Result (3)

TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Dermatology	University Hospital, 47 Blanchard	9/20/23	

Highlight | Leveraging Filters

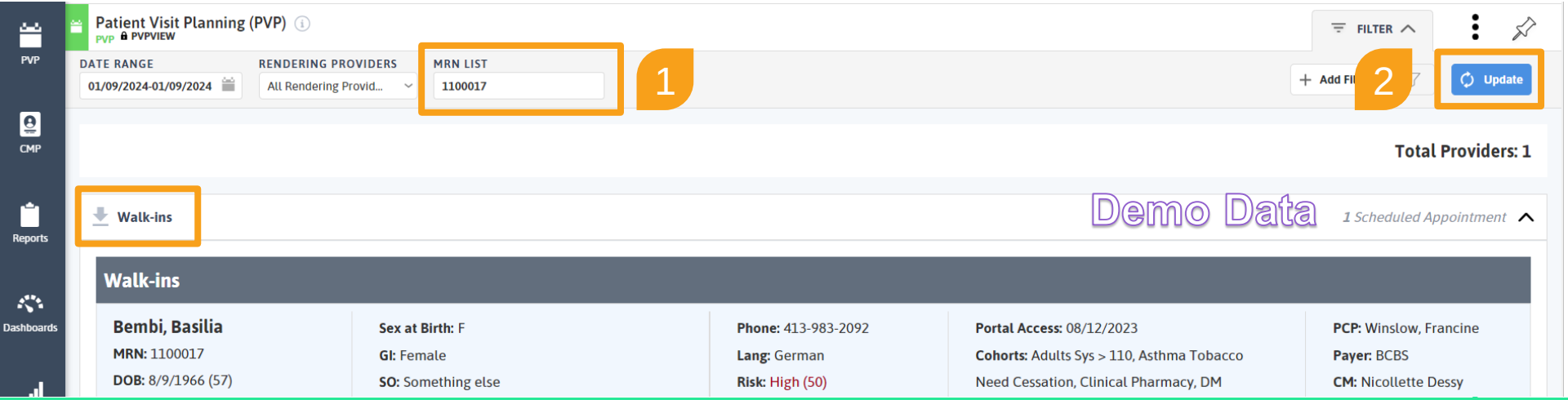


Apply additional filters for a more targeted use of the PVP. Examples include:

- **Patient Diagnosis:** Identify patients with pre-diabetes to enroll in DPP
- **Patient Risk:** Identify your high-risk patients
- **SDOH:** Identify patients who could benefit from connection to social care resources
- **Alert:** Identify patients in need of a mammogram while your mammogram van is on site

Highlight | Same-Day / Walk-In Patients

1. Enter MRN for patient(s).
   - Use wildcard ‘%’ if you only know part of the MRN
   - Use wildcard ‘%’ if there may be zeros preceding the MRN
   - If looking for more than one patient, separate MRNs with comma
2. Click ‘Update’ – DRVS will create a separate walk-in report



Considerations and Set Up

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Importance of Configuring Alerts

The biggest challenge with pre-visit planning tools like alerts includes workflow disruption and alert fatigue. To ensure CDS is an effective tool, alerts must be designed to provide…

The right **information**

To the right **person**

In the right **format**

Through the right **channel**

At the right time during task execution

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Considerations for Configuration

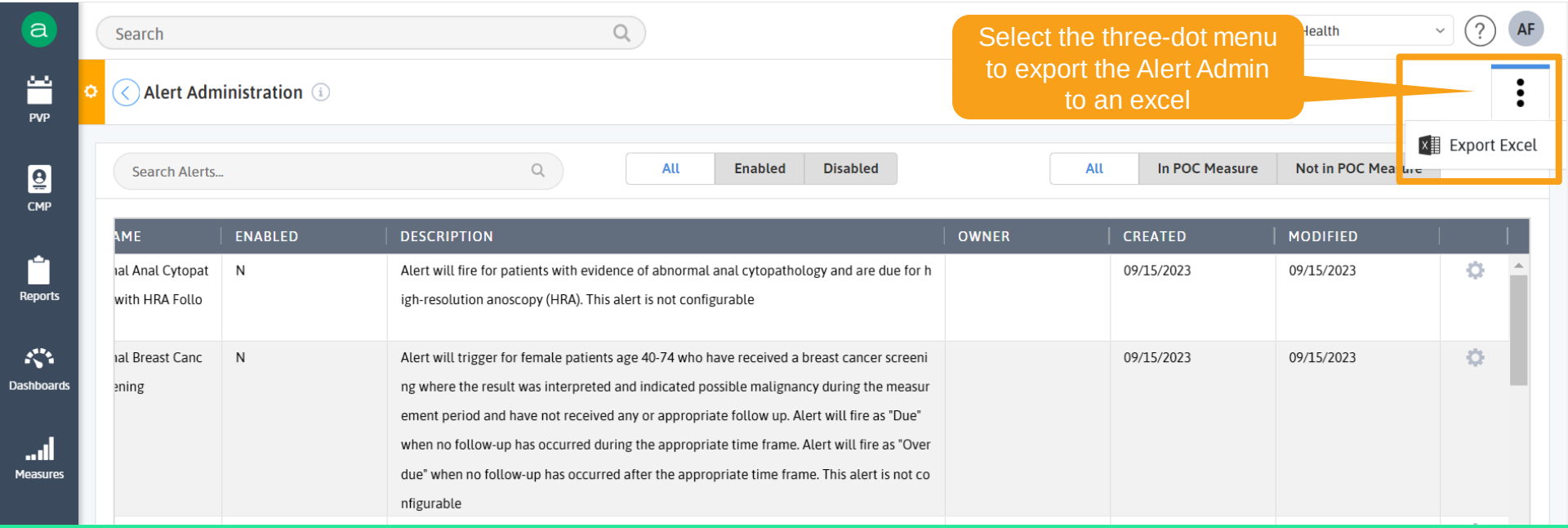
Consider the following questions for each alert as you plan for configuration.

Alerts cannot currently be customized by user. Configuration changes affect all users equally.

Category	Question	Response
Purpose	What is the intent of enabling or changing the configuration of this alert?	
Alert Owner	Who will be responsible for addressing this alert / closing this care gap?	
Frequency/ Date Criteria	How often do you want this alert to appear? Should it be aligned with a measure or more often for better care?	
Result Criteria	Are there any numeric or alphanumeric phrase parameters needed to satisfy this alert?	
Inclusion criteria	What specific criteria triggers the alert for patients? Are there any measure criteria, numerator, denominator or exclusions to follow?	
Exclusion criteria	Are they any patients you don't want triggered for this alert?	

Recommended Approach

- Have one person export the alert list and take notes.
- Have another person logged in to DRVS to adjust alerts: enable/disable, change display name, assign owners, and for configurable alerts change the logic.
- All alert configurations will take effect the following day after nightly processing



Sample Standing Actions

PVP Name	Responsible (MA, RN, P	Description	Action
Asthma Rx	MA	Alert will trigger if patient age 5-64 has been identified as having persistent asthma but has not been prescribed asthma control medication. Will not trigger if patient has an active diagnosis of Emphysema, COPD, Obstructive Chronic Bronchitis, Cystic Fibrosis, or Acute Respiratory Failure. This alert is not configurable. This alert is not configurable	Perform medication reconciliation and add long-acting asthma med to med module if patient is taking long-acting asthma med. If no long-acting asthma med being taken alert provider.
Dental	MA	Alert will trigger if Dental Visit has not occurred in the last 1 years.	Verify no dental visit and add needs to reason for f/u. CAA will, schedule with NW Dental or refer to personal dentist.
Fluoride Varnish	MA	Alert will trigger if Fluoride Varnish Application for Children has not occurred in the last 1 years. Alert only applies to patients >= 9 mths old and <= 240 mths old.	Place order and last person to touch patient applies varnish.
Well Visit	MA	Alert will trigger if Physical Exam has not occurred in the last 1 years. Alert only applies to patients >= 7 yrs old and <= 18 yrs old.	Schedule future appointment when rooming the patient
Well Child 3-6	MA	Alert will trigger if Physical Exam has not occurred in the last 1 years. Alert only applies to patients >= 3 yrs old and <= 6 yrs old.	Schedule future appointment when rooming the patient
Dental Sealant	Dental	rt will trigger if UDS Child Dental Sealant has not occurred in the last 1 years. Alert only applies to patients >= 6 yrs old and <= 9 yrs old. Patient must not have UDS Child Dental Sealant Exclusions.	Apply sealant and/or document exceptions.
Bill NEW E&M code	Provider	Alert will trigger if Medical Encounter has not occurred in the last 3 years. Alert only applies to patients >= 3 yrs old.	Bill with a NEW patient E&M code.
Depr Follow-Up	Provider	Alert will trigger if patient depression screen results are positive OR PHQ-2 >=3 with no subsequent PHQ-9 OR PHQ-9 >= 10 AND no depression follow-up performed at a qualifying encounter the same day or within 14 days after the positive screening. Patient must not have Depression/Bipolar. This alert is not configurable	Document medication, referral to BH, or "intervention" item from list on HPI.
Hep C - Baby Boomer	Provider	Alert will trigger if patient birth year is between the years 1945 - 1965 and have not had a Hep C Screening This alert is not configurable	Discuss with patient and order if patient agrees.

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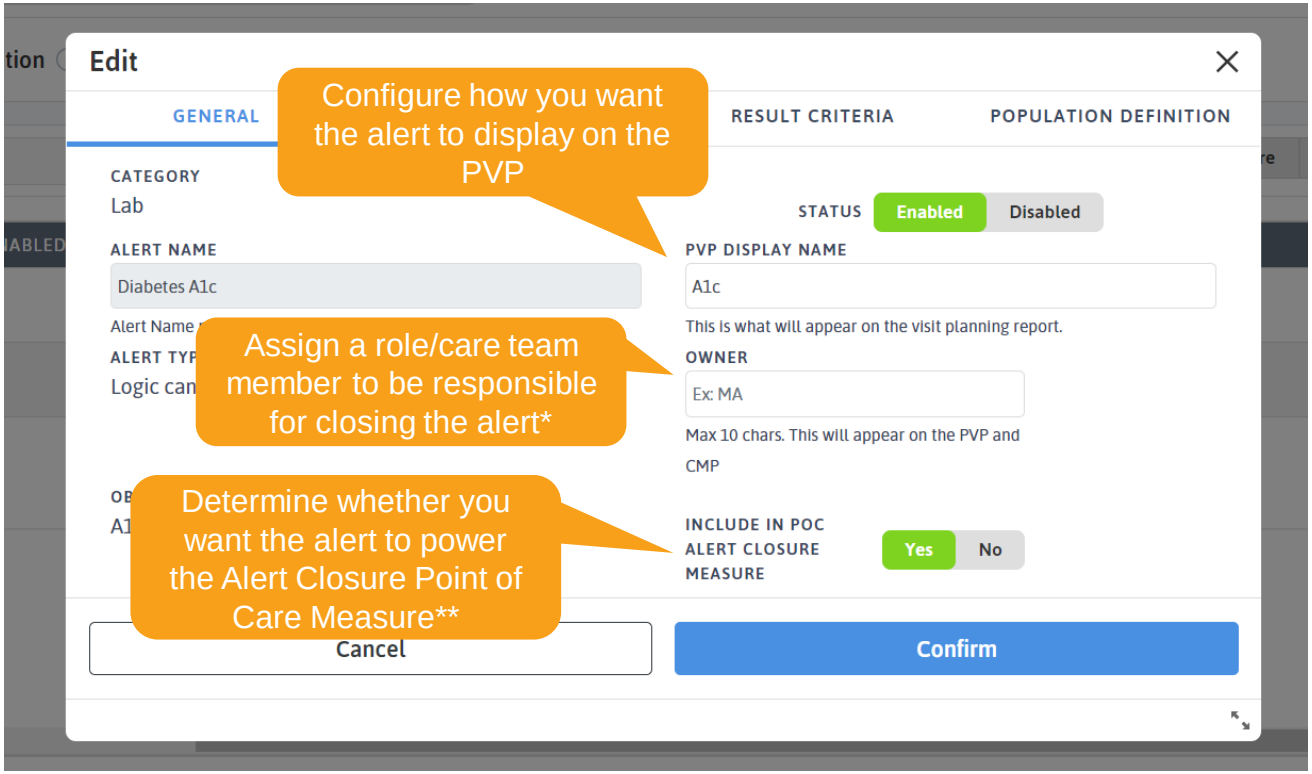
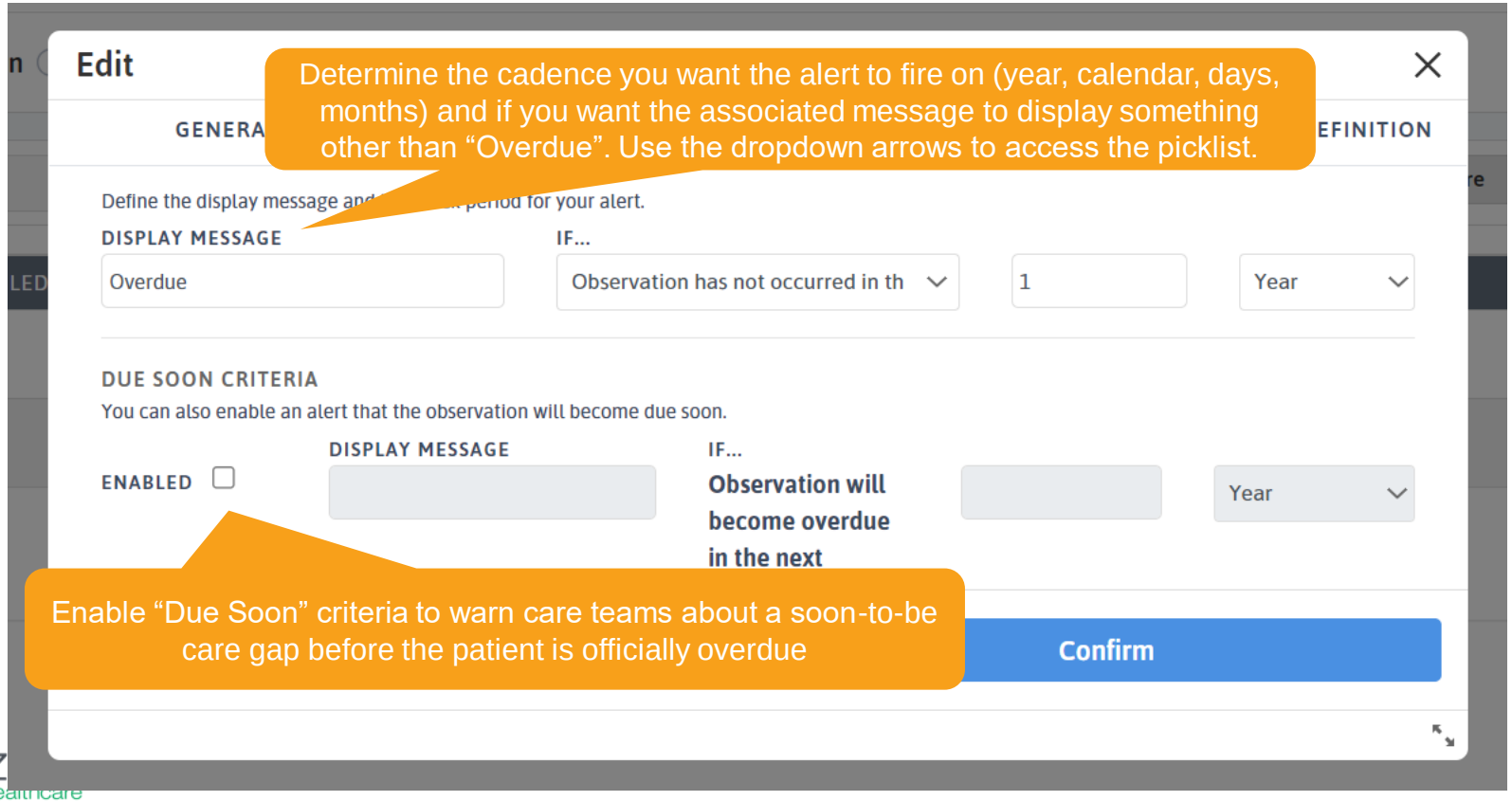
Alert Configuration | General Tab



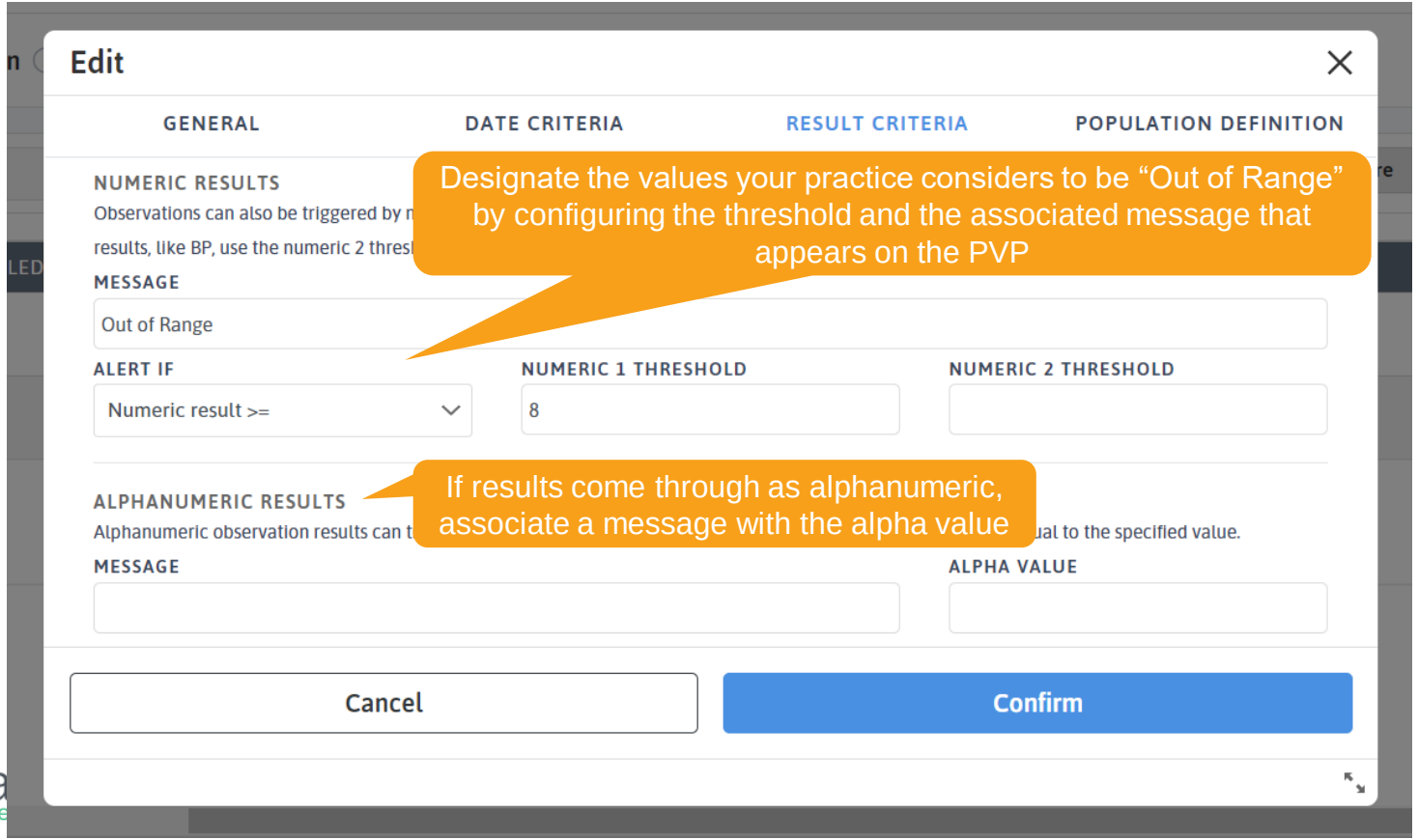
* Determine a standardized nomenclature – e.g. always use “MA” instead of “Medical Assistant”

** Recommend toggling to “yes” only for alerts that you expect the care team to close within the visit

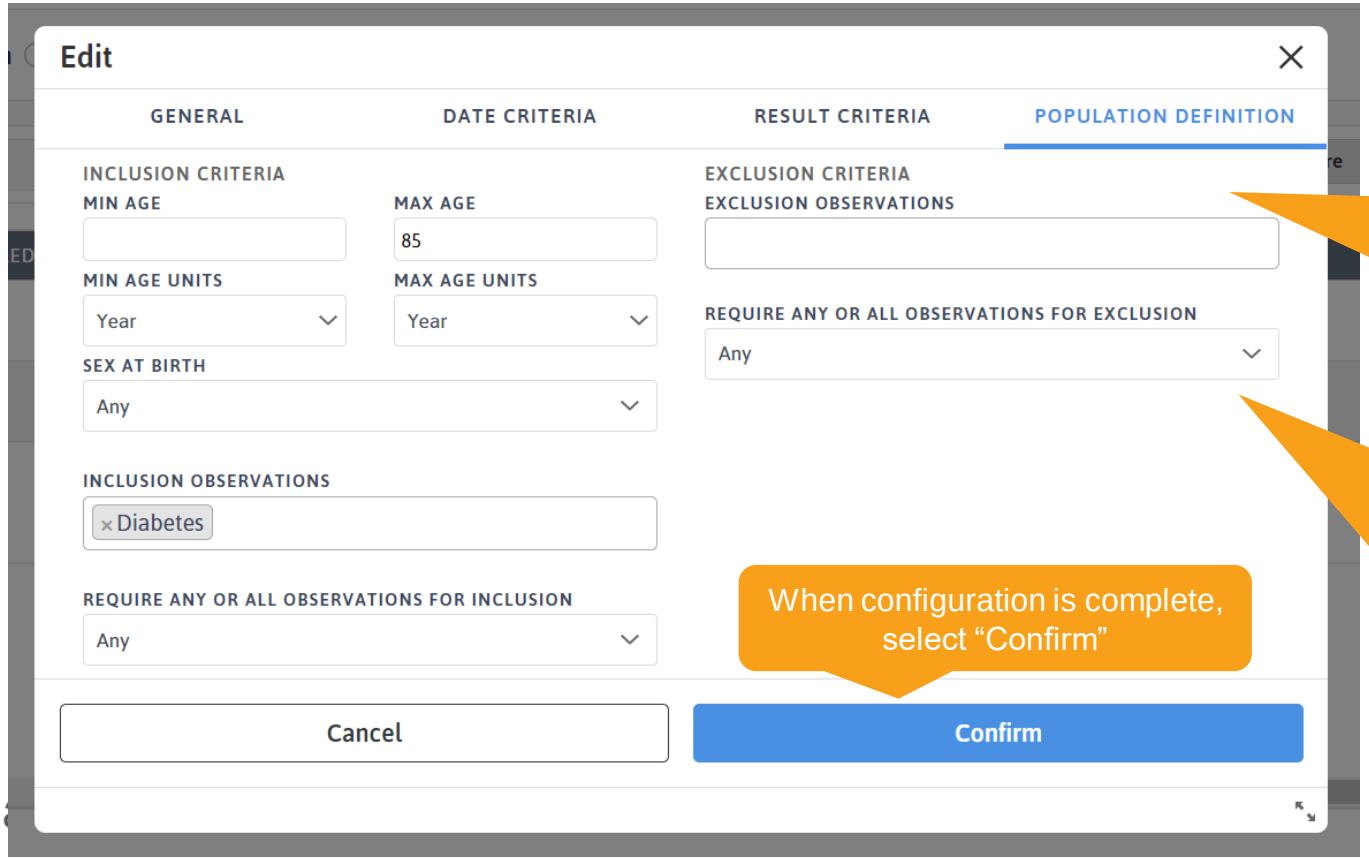
Alert Configuration | Date Criteria Tab



Alert Configuration | Result Criteria Tab



Alert Configuration | Population Definition



Determine who you want this alert to fire for, including age, sex at birth, and inclusion or exclusion observations

When configuration is complete, select “Confirm”

If you’re including multiple inclusion or exclusion criteria, pay attention to the “Any” or “All” configuration.

Any: Patient must have at least one of the conditions
All: Patient must have all of the conditions (comorbid)

Alerts & Mapping Admin

If there are workflows, templates, and fields that are not mapped to DRVS, **your alerts will misfire**.

To prevent this, review your mapping admin on a frequent cadence to ensure that all your workflows are captured. This should be built into your data hygiene checklist.

Ensure that there is an open line of communication between care teams and quality when an alert misfires. This will help the quality team identify and rectify the issue.

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Tips

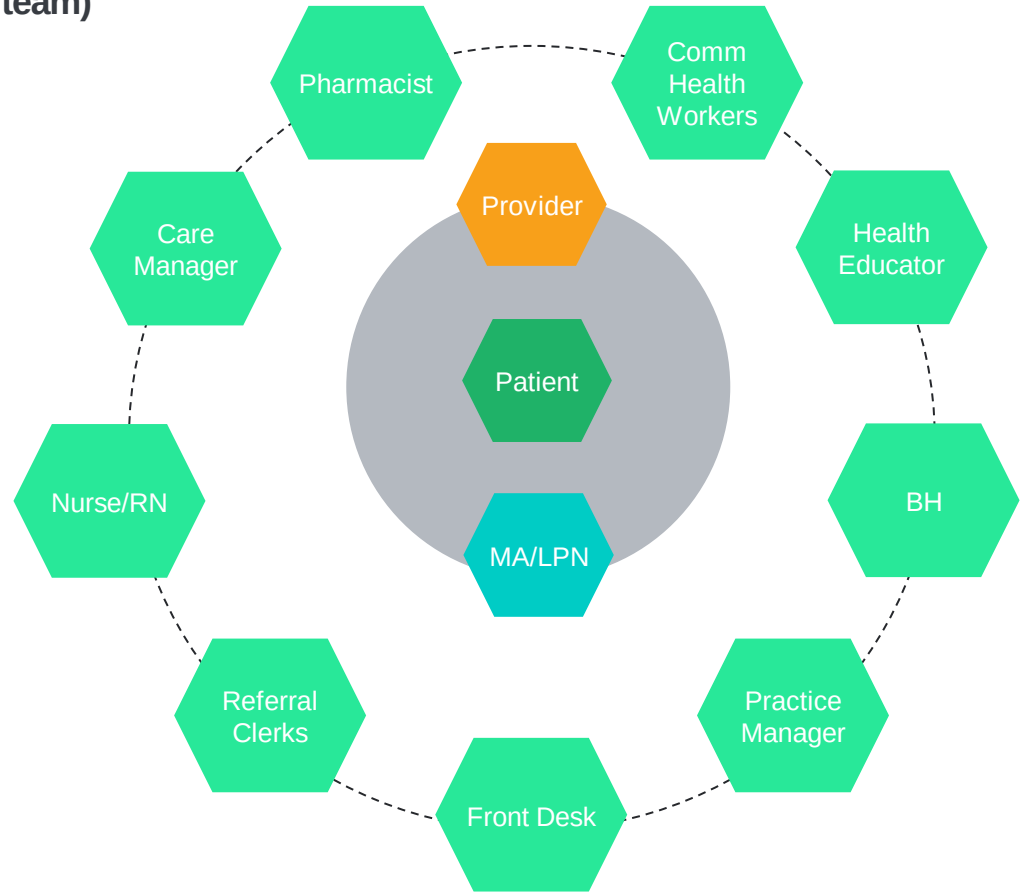
- Only enable alerts when you want care teams to **focus on those alerts**
  - Example: only enable flu alerts when you have flu vaccines in stock
- Get **provider buy-in** on alert configuration
  - Example: only enable alerts that providers have reviewed and helped validate.
- **Start small**
  - Example: only enable UDS-related alerts to start, then expand

Less is more when it comes to alerts on the PVP

Use Cases for the PVP

Care Team Members

(Customize for your team)



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Roles and Responsibilities

Sample

Role	Responsibilities	Accountable
Front Desk	❑ Generates the PVP for same-day appointments ❑ Reviews assigned alerts (FPL, SOGI, etc.)	Practice Manager
MA/LPN	❑ Runs the PVP each morning & prints for all members of the care team ❑ Marks the PVP with notes for the huddle ❑ Reviews and closes assigned alerts ❑ Disposes of PVP print outs in HIPPAA secure manner (keeping 1 copy to scan for PCMH evidence)	Clinical Support Staff Supervisor
Provider	❑ Participates in the huddle ❑ Reviews and closes assigned alerts ❑ Identifies RAF gaps and updates patients' chart appropriately ❑ Empowers support staff	Medical Director

If your practice has the DRVS EHR plug in, consider how care teams will integrate that information in their workflows.

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Roles and Responsibilities

Sample

Role	Responsibilities	Accountable
Case Manager	❑ Identifies care managed patients on the schedule ❑ Creates plan to check in during visits as needed ❑ Reviews the PVP to identify patients eligible for care management services	Population Health Supervisor
Behavioral Health	❑ Reviews schedule with primary care to plan for potential warm hand offs ❑ Assists BH patients in scheduling primary care visits	Behavioral Health Director
Dental Staff	❑ Reviews schedule with primary care to plan for potential warm hand offs ❑ Assists patients in scheduling primary care visits ❑ Reviews CMP to identify key medical concerns in relation to dental outcomes	Dental Director
Quality Team	❑ Assures accuracy of PVP information	Quality Director
All users	❑ Reports PVP inconsistencies to dedicated resource	All staff

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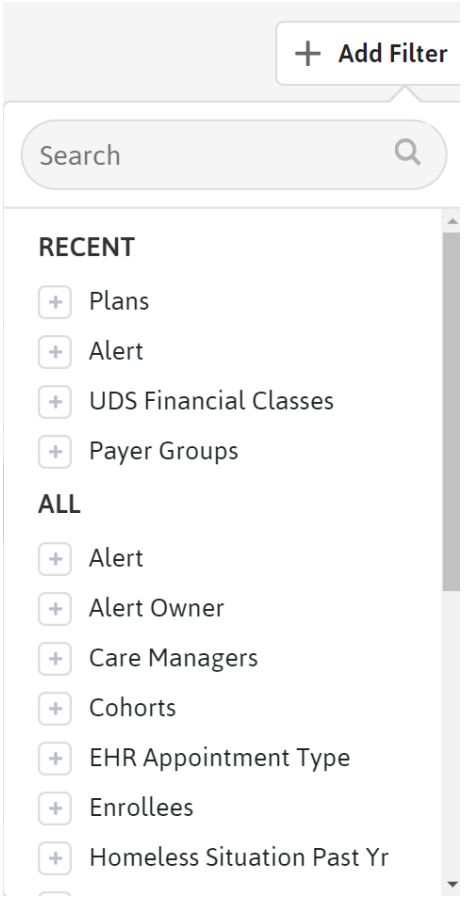
Filtering the PVP

- **Compliance**
  - Plan (Medicaid, Medicare MSSP, Mountain Health Co-op)
  - Alert (care corresponding to HEDIS measures)
- **Operational**
  - Alert in advance (1 week ahead)
  - EHR Appointment Type
- **Clinical**
  - SDOH/Demographics
  - Diagnosis
  - Cohorts
  - Care Manager



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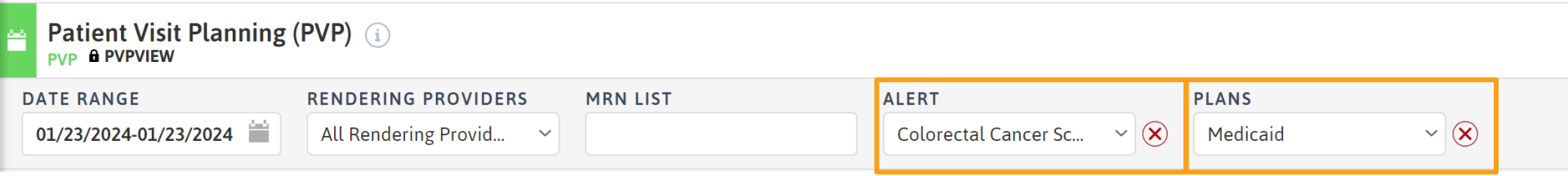
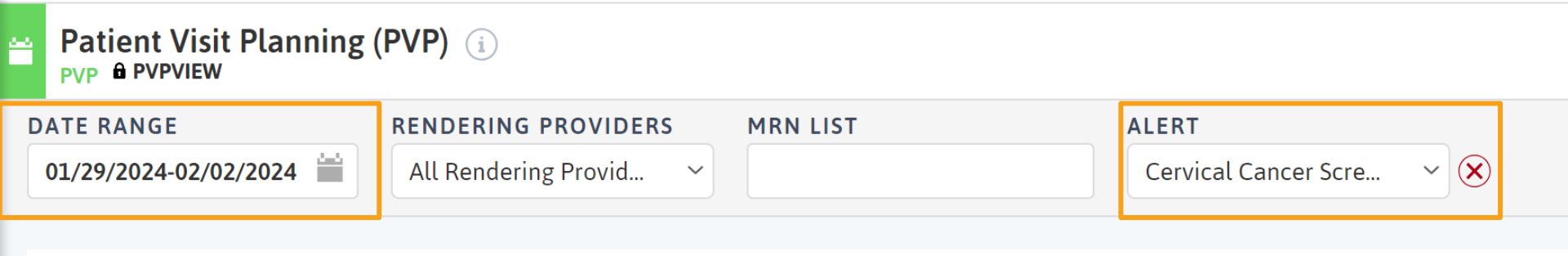
Compliance

- Filters:
  - Plan: Medicaid
  - Alert: Colorectal Cancer Screening
- Use Case: Colorectal cancer screening is a Medicaid measure of interest. Identifying which patients are enrolled on the Medicaid rosters sent to Azara who need a colorectal cancer screening can help prioritize work.



Operational

- Filters:
  - Date Range: Next week
  - Rendering Provider: Primary care/medical provider group
  - Alert: Cervical Cancer Screening
- Use Case: Appointments with paps/HPV tests take longer than routine visits. Finding visits where the appointment could be extended to include a screening and having front desk call patients to prep them can save time and an additional visit. Can also use EHR Appointment Type filter to find visits where this would be appropriate.



Clinical

- Filters:
  - Date Range: Current or next week
  - Diagnosis: Diabetes
  - SDOH: Transportation (Med or Non-Med)
- Use Case: Patients with chronic condition diagnoses like diabetes may have more difficulty managing medications and lifestyle changes if they have certain SDOH triggers, like transportation. Patients with diagnoses of diabetes and transportation insecurity could benefit from Uber/Lyft vouchers, remote glucose monitoring devices, grocery programs, etc. that can be discussed during a visit.

Utilizing PVP For Depression Remission

Health Partners of Western Ohio

Health Partners of Western Ohio

CHALLENGES

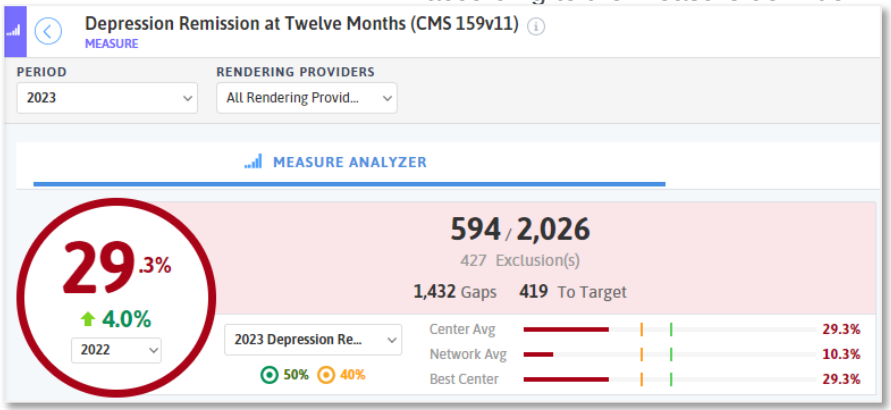
The organization identified the Depression Remission measure as an area of clinical focus for 2022/2023. The prediction of the PHQ-9 re-screening and follow-up window was determined the primary driver as to why CHC targets were not being met.

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

IMPACT

- 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%**

16% positive percentage improvement from 2022 - 2023

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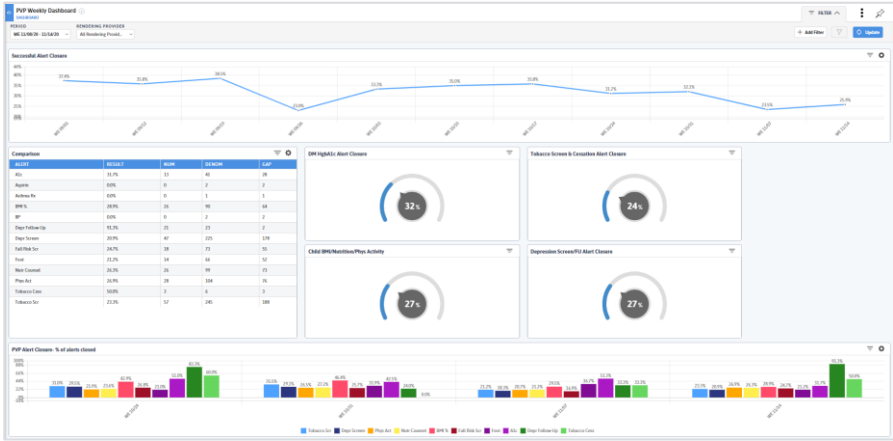
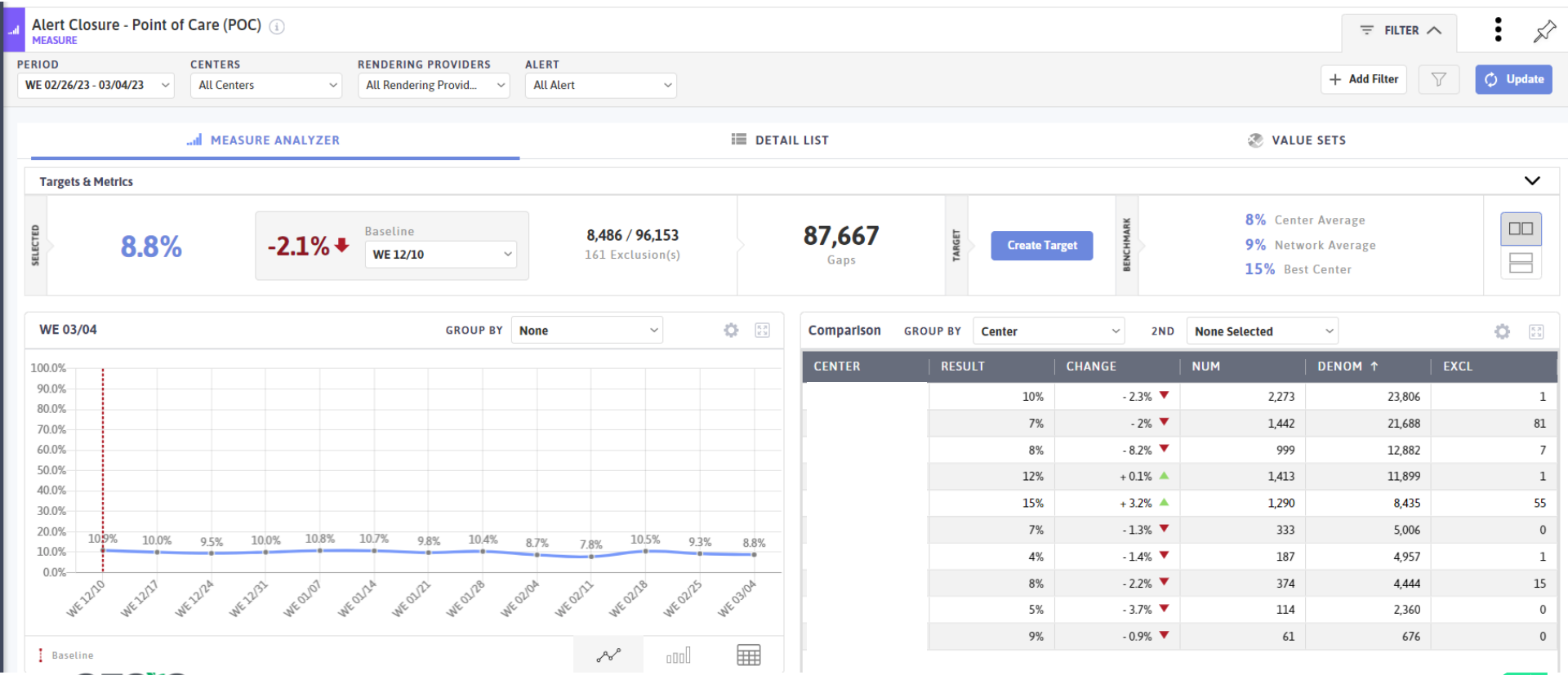
Using the Alert Closure Measure

- Use with Patient Visit Planning Report
  - Monitor team efficiency in closing alerts
  - Remember to filter by provider/provider group when running report
- Leverage details
  - Expose missed opportunities with Detail List
  - Build custom dashboard to track progress



Alert Closure Measure Performance



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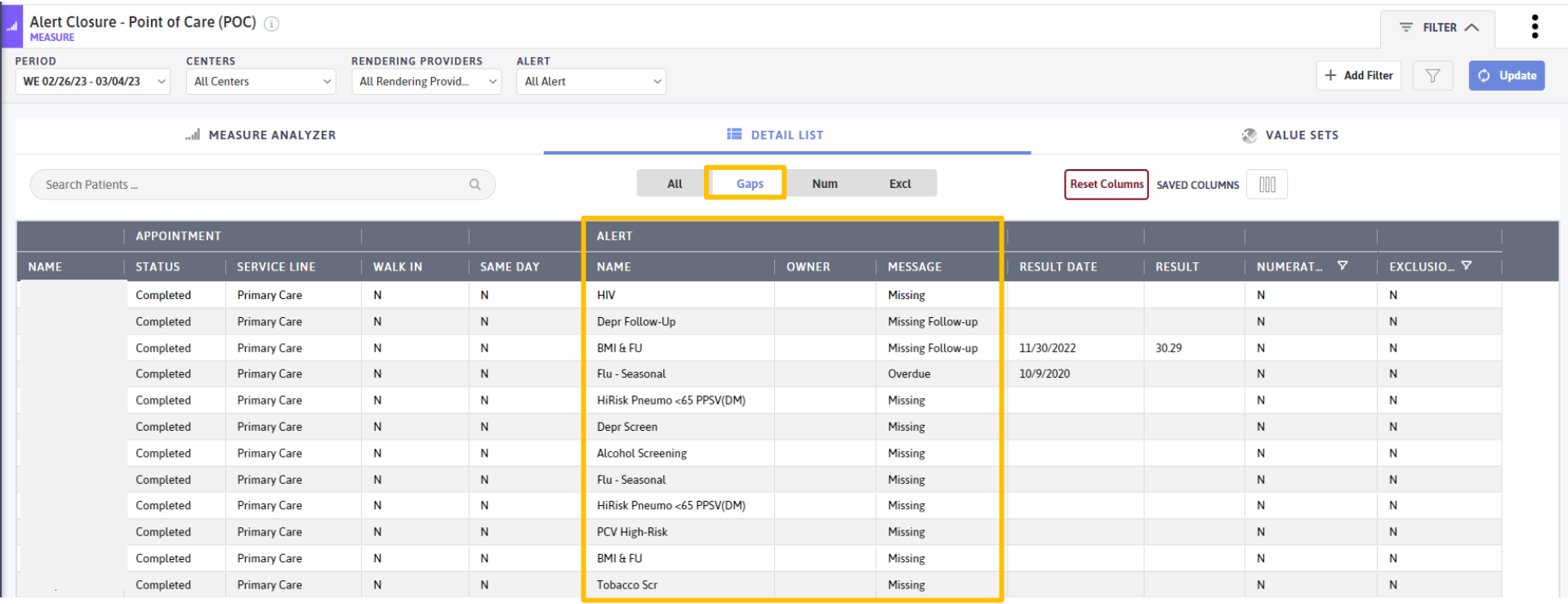
Alert Closure Gaps



	APPOINTMENT				ALERT						
NAME	STATUS	SERVICE LINE	WALK IN	SAME DAY	NAME	OWNER	MESSAGE	RESULT DATE	RESULT	NUMERAT...	EXCLUSIO...
	Completed	Primary Care	N	N	HIV		Missing			N	N
	Completed	Primary Care	N	N	Depr Follow-Up		Missing Follow-up			N	N
	Completed	Primary Care	N	N	BMI & FU		Missing Follow-up	11/30/2022	30.29	N	N
	Completed	Primary Care	N	N	Flu - Seasonal		Overdue	10/9/2020		N	N
	Completed	Primary Care	N	N	HiRisk Pneumo <65 PPSV(DM)		Missing			N	N
	Completed	Primary Care	N	N	Depr Screen		Missing			N	N
	Completed	Primary Care	N	N	Alcohol Screening		Missing			N	N
	Completed	Primary Care	N	N	Flu - Seasonal		Missing			N	N
	Completed	Primary Care	N	N	HiRisk Pneumo <65 PPSV(DM)		Missing			N	N
	Completed	Primary Care	N	N	PCV High-Risk		Missing			N	N
	Completed	Primary Care	N	N	BMI & FU		Missing			N	N
	Completed	Primary Care	N	N	Tobacco Scr		Missing			N	N

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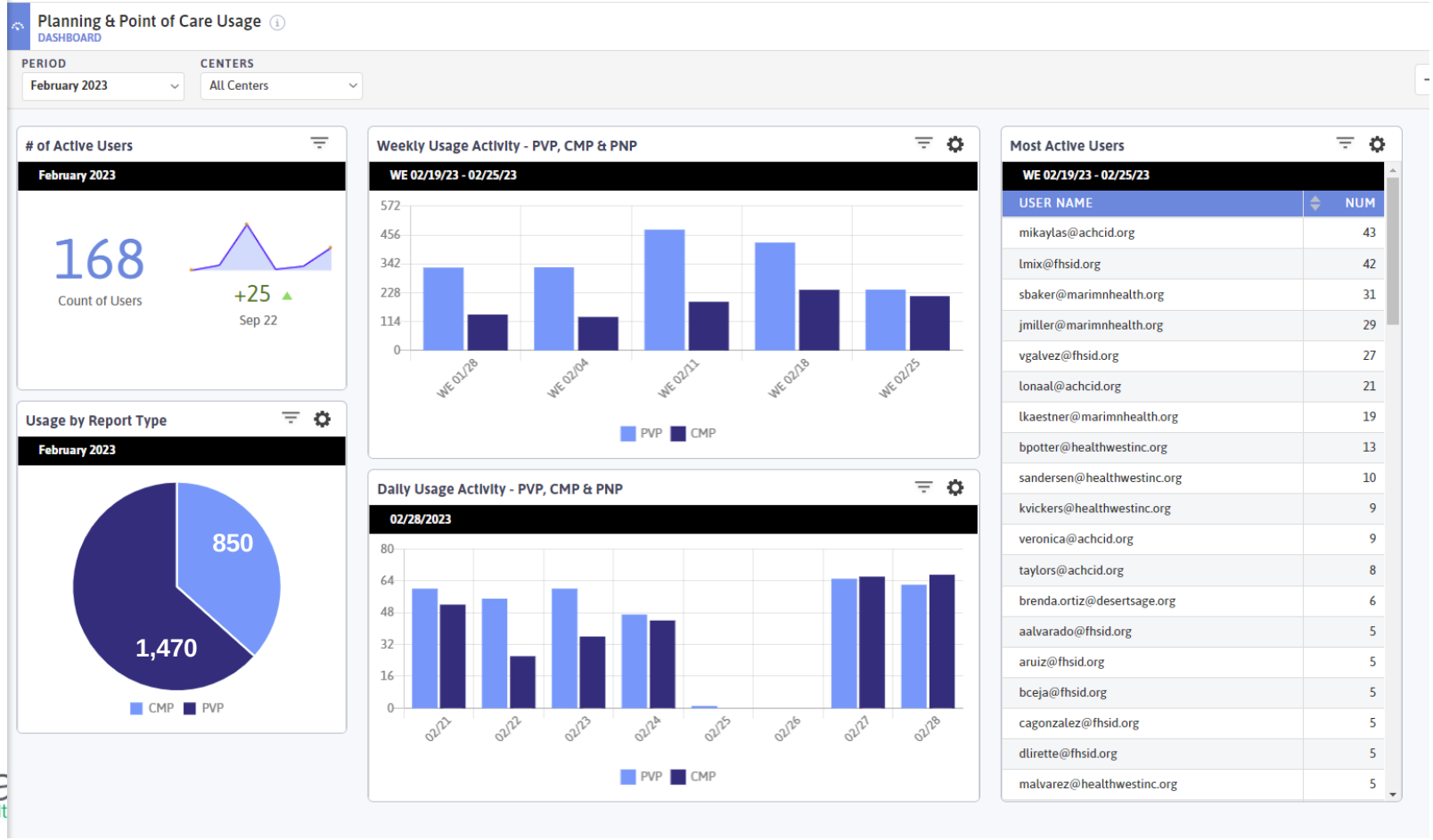
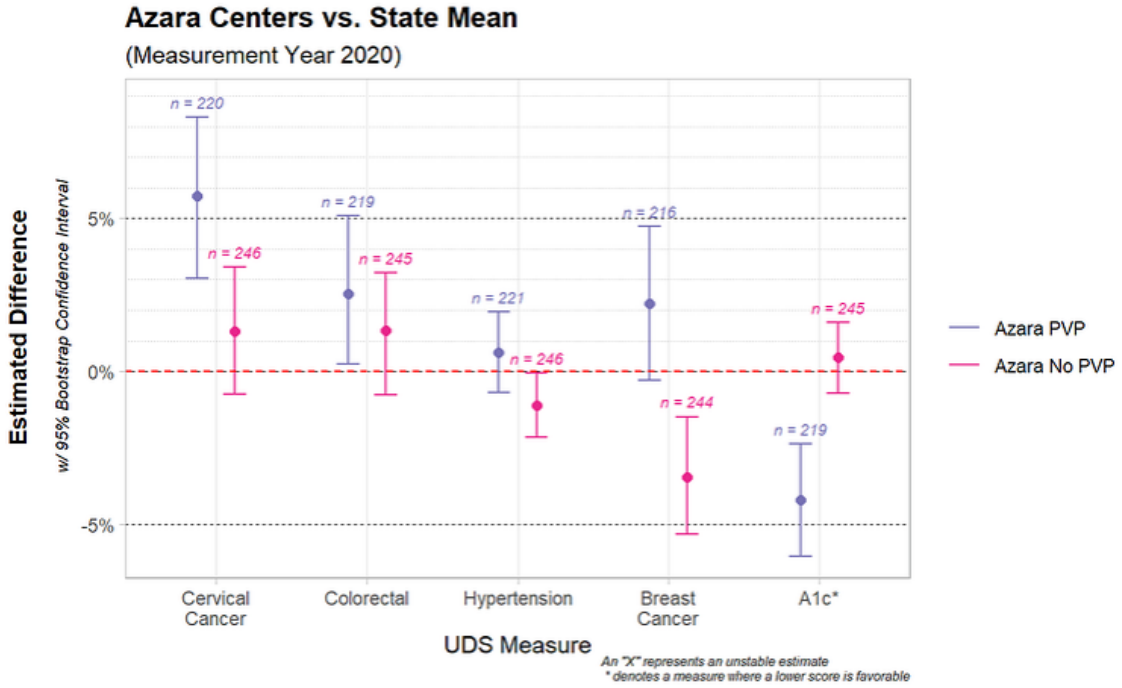
Planning and Point of Care Usage Dashboard



The Azara Effect

Figure 2: Comparison of Measure Performance when using the PVP



Source: https://www.azarahealthcare.com/blog/the-azara-effect

What's New in DRVS?

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2023 Measure Validation Guides:

Now Available in Help!

FEATURE

- Measure-specific guides to assist in validating core CQMs for 2023 are now available in the DRVS Help Section
- Users can access these guides via the following path: DRVS Help (Home) > Population Health Resources > Data Hygiene Resources > Measure Validation Guides
- These guides exist for the following measures:

A1c > 9 or Untested	Adult BMI Screening and Follow Up	Breast Cancer Screening	Cervical Cancer Screening	Childhood Immunization Status	Child Weight Screening / Counseling for Nutrition / Physical Activity	Colorectal Cancer Screening
Dental Sealants	Depression Screening and Follow Up	HIV Screening	Hypertension Controlling High Blood Pressure	IVD Aspirin Use	Statin Therapy for Prevention and Treatment of Cardiovascular Disease	Tobacco Screening and Cessation

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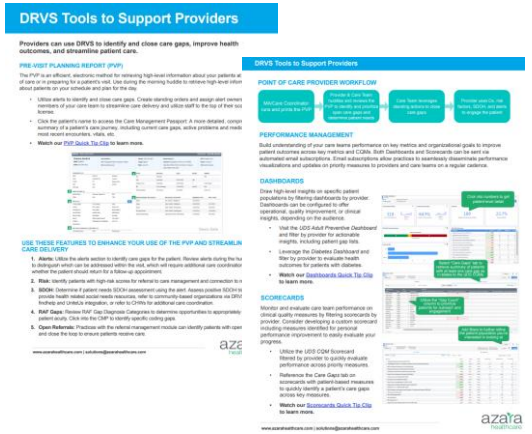
Released Novembe r 2023

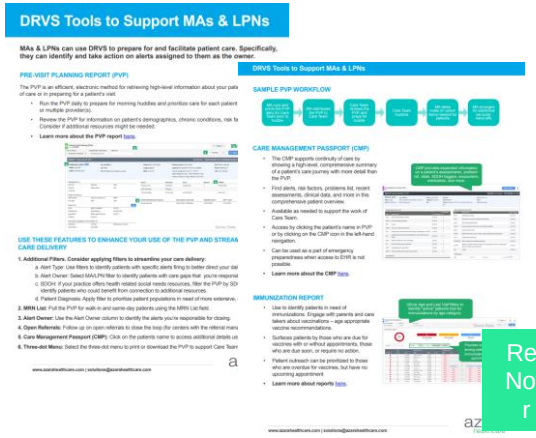
Role Based Guides for DRVS

Now Available in Help!

- Role-based guides for **providers** and **MAs/LPNs** are now available in the DRVS Help Section to provide a better understanding on the DRVS tools and functionality that support the work that you do

- These guides can be accessed via the following path: DRVS Help (Home) > Get Started Using DRVS > Role Based Guides



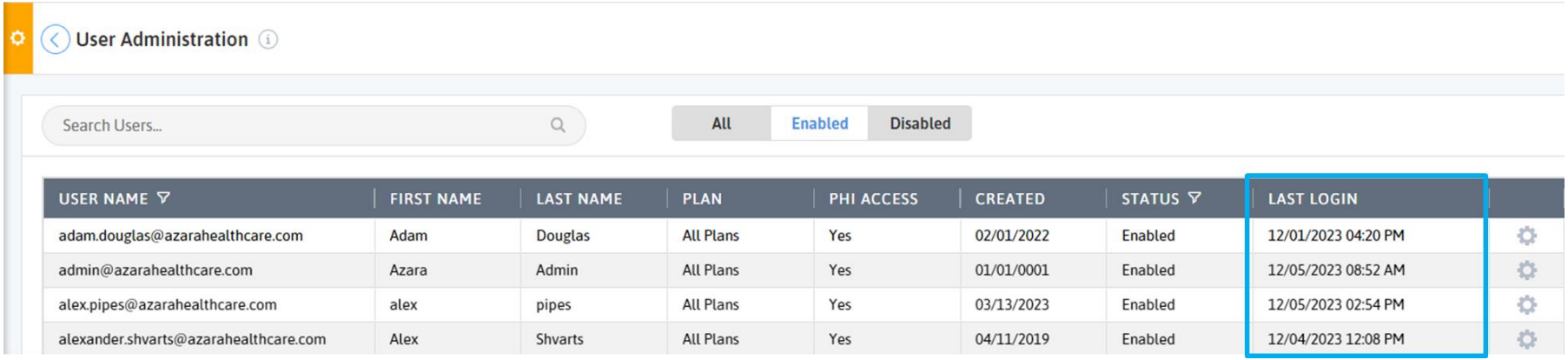


Released November 2023

FEATURE

Users' Last Login:
Now Available in User Administration

- Admin users can now identify each user's last login at their practice in User Administration



FEATURE

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Released November 2023

Two New Stock Dynamic Cohorts:
Tobacco User & Patients on PrEP

FEATURE

Tobacco User

- Patients qualify for this cohort if they answered “Yes” to the most recent tobacco use screening anytime in the last 5 years
- Patients will remain in the cohort until their most recent tobacco use screening is “No.”

Patients on PrEP

- Patients qualify for this cohort if they had a Pre-Exposure Prophylaxis (PrEP) therapy treatment.
- Patients will remain in the cohort until they are no longer on a PrEP therapy treatment.

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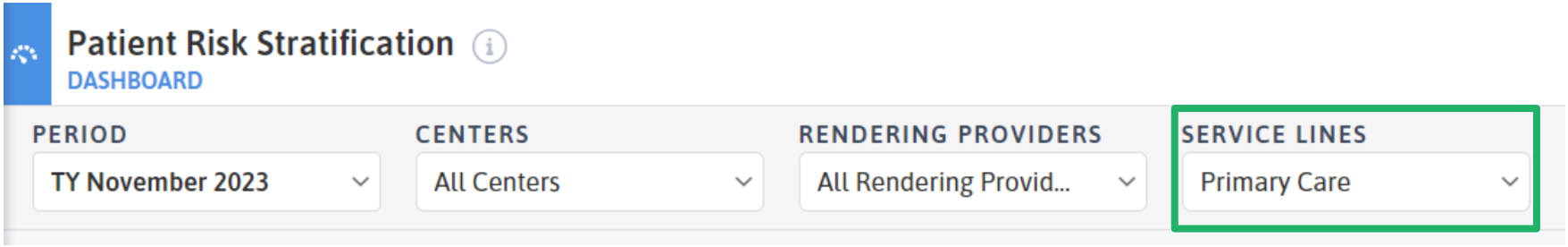
These can be found in Cohort Admin by creating a Dynamic Cohort

Released Novembe r 2023

Patient Risk Stratification Dashboard:
Service Line Filter Updated

FEATURE

- The Patient Risk Stratification Dashboard now has a default Service Line filter in the Global Filter Bar so that users can specify the service line they'd like to see data for



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Available for practices with the Risk module.

Released Novembe r 2023

PVP Enhancement: Pronouns!

Now Available on the PVP

FEATURE

- Contact support at support@azarahealthcare.com for assistance mapping pronouns.
- Please note that pronouns must be captured in a structured field in the EHR to appear on the PVP.

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Released Novembe r 2023

New RDE (Registry Data Element)
"Depression Follow-Up Assessment Period CY"

- A new RDE is now available and can be added to registries to identify patients that will be included in the denominator of the Depression Remission measure for the current calendar year, and describes the expected window of time in which the follow-up PHQ-9 assessment must be documented in order to have a chance of meeting the numerator (thus demonstrating depression remission)
- Note: This RDE is to be used in place of the measure gap list during January when the CQM is not processed for the current calendar year.

DEPR FOLLOWUP ASMT PERIOD	
START DATE	END DATE
11/4/2022	3/4/2023
10/7/2022	2/7/2023
10/3/2022	2/3/2023
9/23/2022	1/23/2023
3/11/2023	7/11/2023

FEATURE

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Released Novembe r 2023

Most Recent Cervical Cancer Routine Screening: Alert Added

ALERT

CATEGORY	NAME	PVP NAME	DESCRIPTION	CREATED
Screening	Cervical Cancer Routine Screening Status	Cervical Cancer Routine Screening Status	Alert will fire for female patients aged 21-64 to report the status of routine cervical cancer screening activities. Includes the most recent result(s), if no screening is on record, or if screening is not indicated. This alert is not configurable	11/01/2023

- A new alert has been added that will fire for 21-64 year old female patients to report the status of their routine cervical cancer screening activities
- This alert includes the following information:

  - Most recent result(s)
  - If no screening is on record
  - If screening is not indicated

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Released November 2023

Group Admin

New Admin Functionality: Groups Admin!

ANNOUNCEMENT

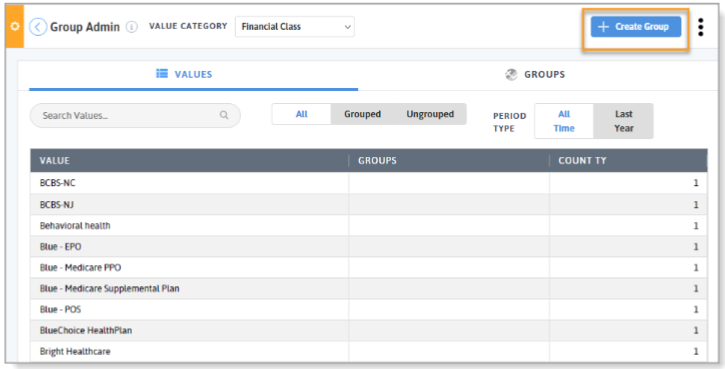
Create Groups to Simplify Filtering in DRVS!

-8 categories of values can be grouped through the Groups Admin including interactions, financial class, line of business (service line), and race.

-Once a group is created, it is displayed in filters for specific reports, measures, dashboards, and registries across DRVS. The interactions group can also play a role in custom care effectiveness reports.

Accessing groups admin and creating groups is based on user permission. Please reach out to your DRVS admin to have permissions adjusted.

Learn More: Groups Admin User Guide



CREATED BY: Azara **PUBLISHED ON:** 01/16/2024

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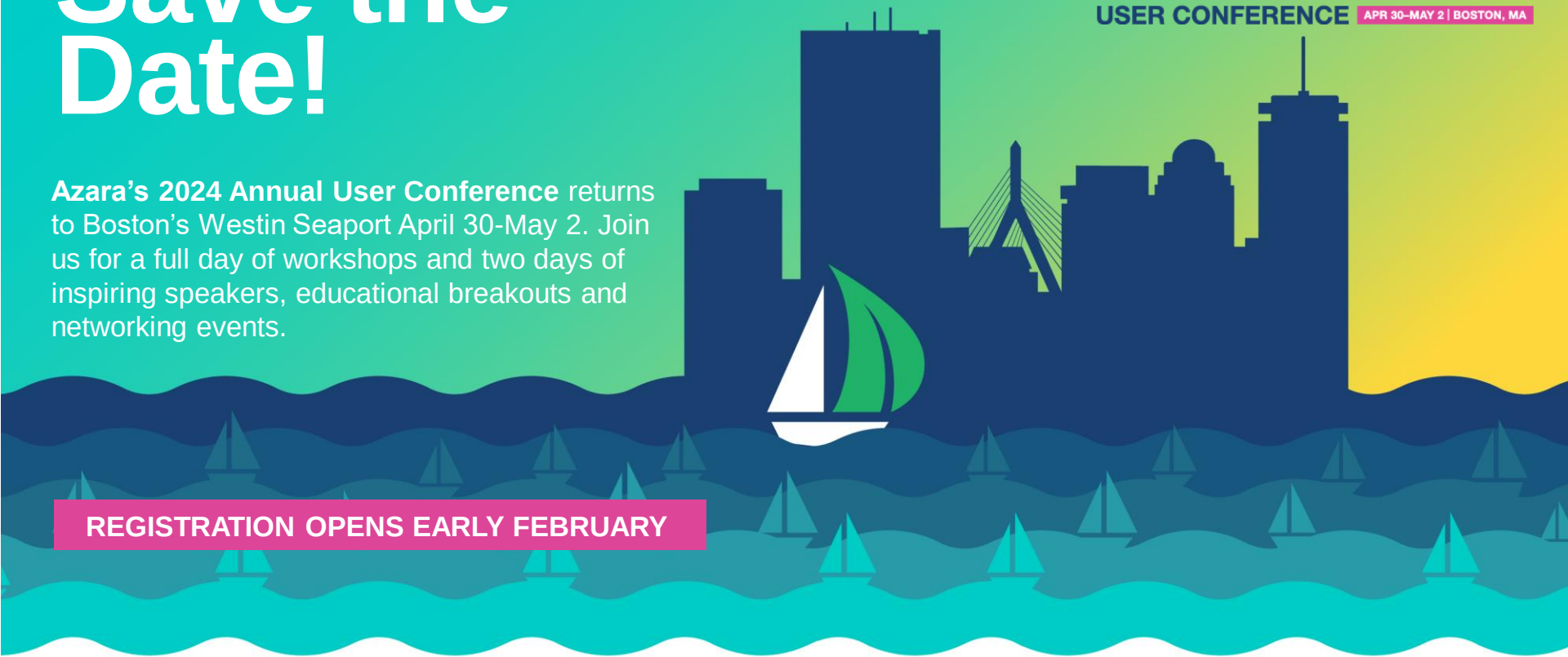
Save the Date!

azara 2024
USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

Azara's 2024 Annual User Conference returns to Boston's Westin Seaport April 30-May 2. Join us for a full day of workshops and two days of inspiring speakers, educational breakouts and networking events.



REGISTRATION OPENS EARLY FEBRUARY

Learn more at: www.azarahealthcare.com/events/2024-annual-user-conference

Achieve, Celebrate, Engage!

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

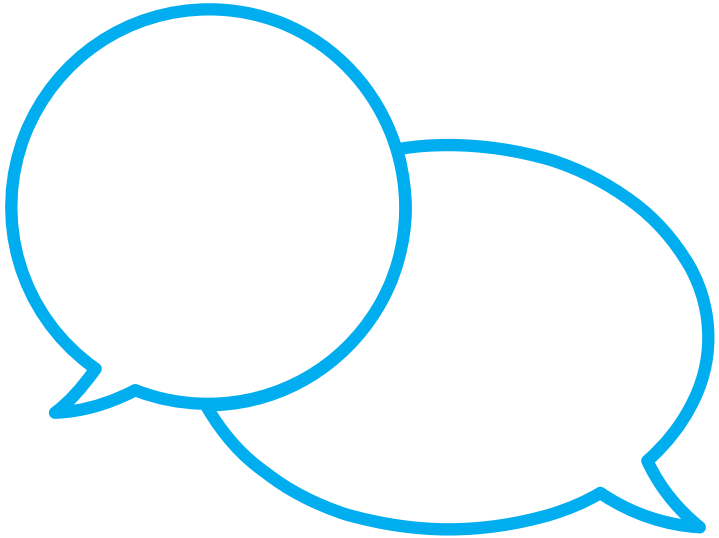
Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement 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?



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