

Patient Visit Planning

Innovative Ways to Leverage the PVP

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Transformation

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Today's Agenda



OVERVIEW OF THE PVP



CONSIDERATIONS AND SET UP



USE CASES

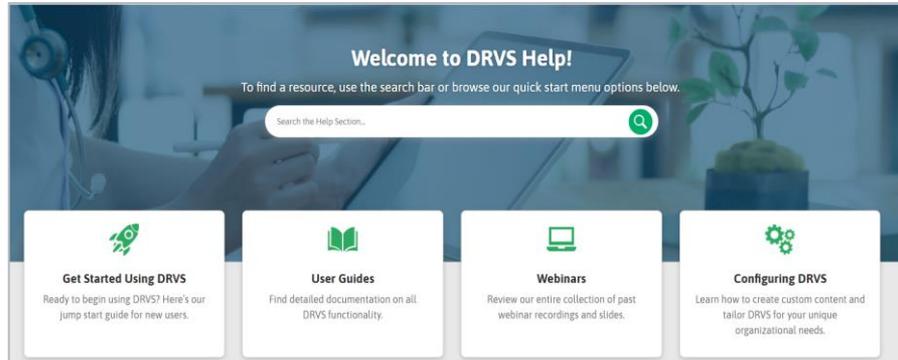


WHAT'S NEW IN DRVS



Resources in DRVS Help Section

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

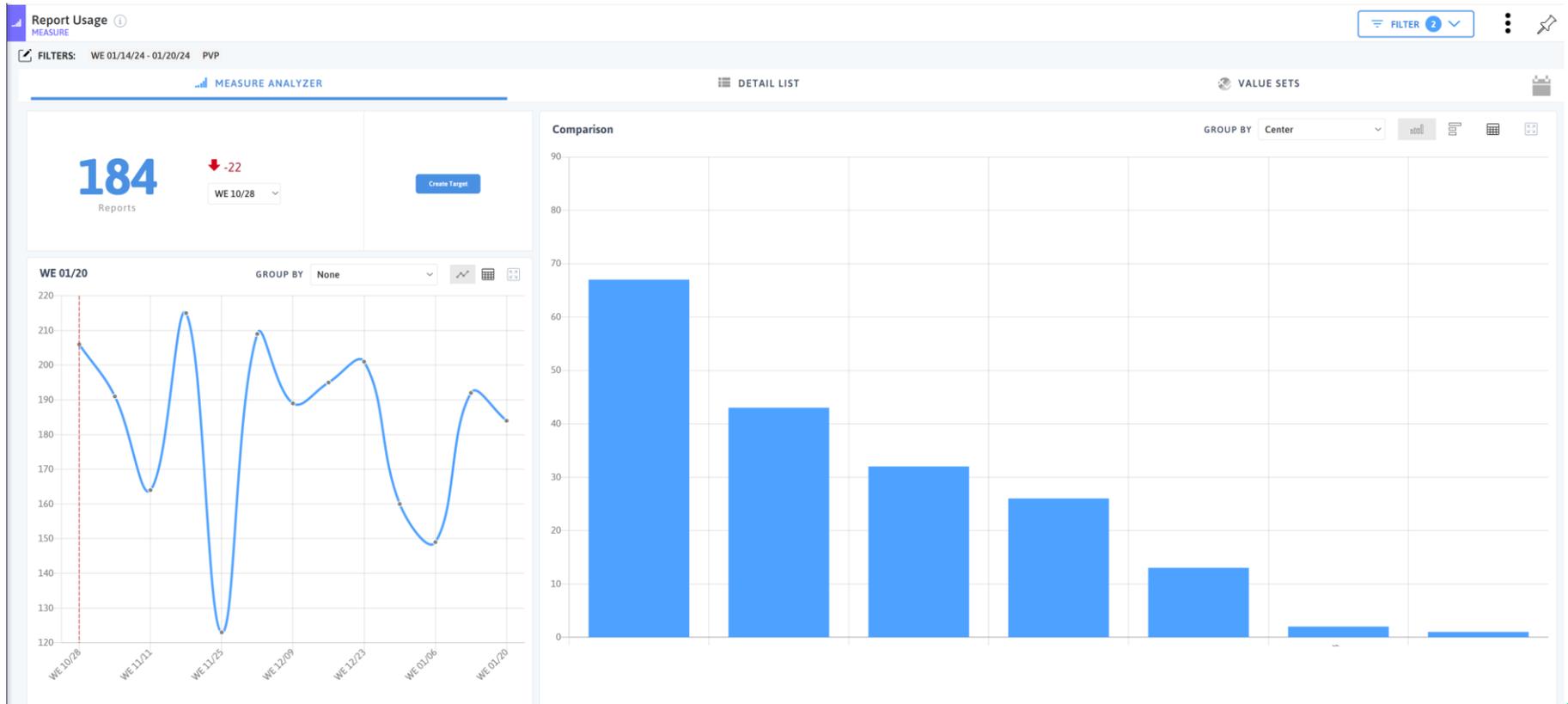


Click the question mark icon and select Help Documentation. Enter your search criteria (i.e., scorecards).

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



PVP Usage Across Montana



Introduction to the Patient Visit Planning Report



More Care to Deliver, Less Time



SOGI
Documentation



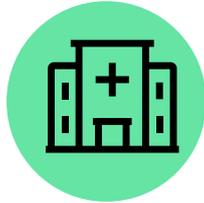
Cancer
Screenings



Diabetes
Care



SDOH
Assessment



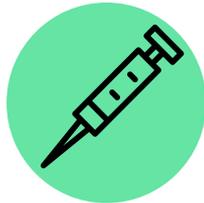
Hospital
Discharges



Behavioral
Health
Screenings



Blood Pressure



Immunizations



Open
Referrals



Common Challenges with Pre-Visit Planning

Sticky notes in the EHR

Manual & time-consuming scrubbing

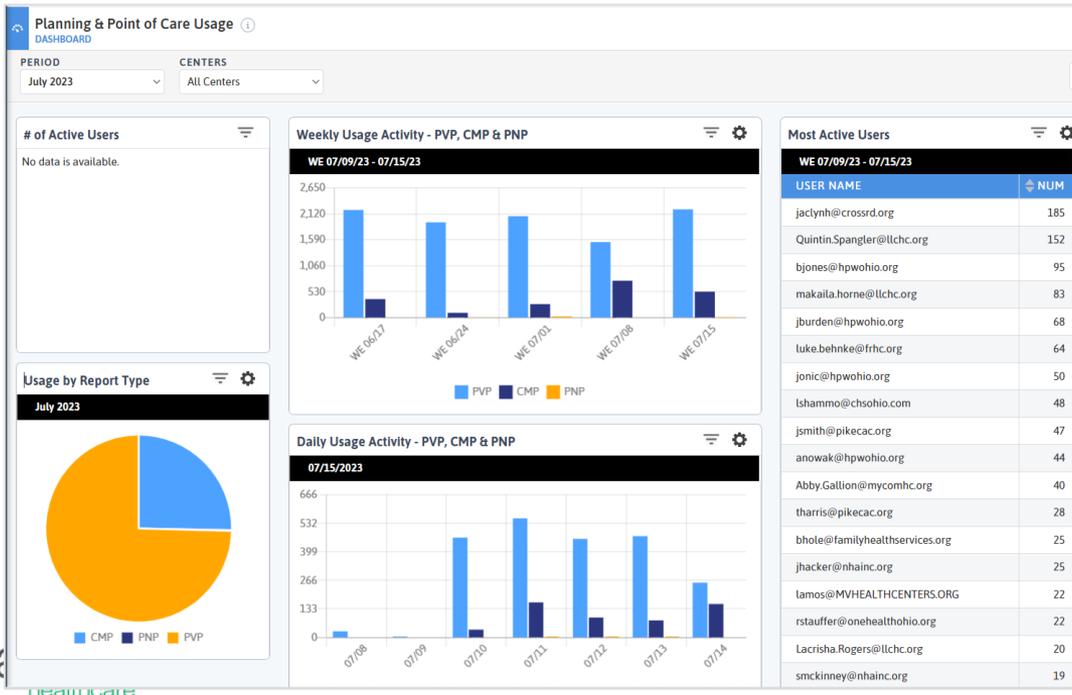
High variability amongst care teams

Huddles as PCMH requirement



PVP & PCMH

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



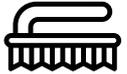
Can demonstrate by:

- 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



Patient Visit Planning Report

Patient Visit Planning (PVP) ⓘ
PVP PVPVIEW

☰ FILTER ^

⋮ 📌

DATE RANGE: 02/09/2023-02/09/2023 📅

RENDERING PROVIDERS: All Rendering Provid... ▾

MRN LIST:

+ Add Filter ▾

🔄 Update

Total Providers: 10

⏴ Augustline, Greg

12 Scheduled Appointments ^

2:38 AM Thursday, February 9, 2023

Visit Reason: High BP Canceled

Gathman, Shawwna

MRN: 1102310

DOB: 9/30/1981 (41)

Sex at Birth: F

GI: Transgender Male/ Female-to-Male

SO: Choose not to disclose

Phone: 413-405-2050

Lang: Persian

Risk: Moderate (33)

Portal Access: 06/13/2021

Demo Data

PCP: Smith, Joe

Payer: Aetna

CM: Kevin Donohue

DIAGNOSES (12)

AMI	ASCVD	Asthma
CAD	CAD/No MI	Cancer
COPD	DM	HIV
HTN-E	HTN-NE	IVD

RISK FACTORS (4)

ANTICOAG	Chronic Opioid Tx	MSM
SMI		

ALERT

MESSAGE	DATE	RESULT	OWNER
A1c	12/30/2021	3.8	MA
LDL	1/11/2022	104	
Depr Screen	Missing		MA
Tobacco Scr	Missing		Front Desk
BMI & FU	Missing		MA
Asth Severity	Overdue	1/11/2022	



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 <i>Alert Closure – Point of Care</i> measure to ensure care teams are using the PVP.



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

Demo Data

PCP: Augustine, Greg
 Payer:
 CM: Unassigned

DIAGNOSES (5)			ALERT	MESSAGE	DATE	RESULT
ASCVD	DM	HTN-E	Colon CA 45+	Missing		
HyLip	IVD		A1c	Out of Range	12/22/2023	7.0
RISK FACTORS (0)			HIV	Overdue	2/9/2021	negative
SDOH (4)			AUDIT	Missing		
FPL<200%	HISP/LAT	INSURANCE	RAF GAPS DIAGNOSIS CATEGORIES (4)			
LANGUAGE			Cardiovascular	Diabetes	Metabolic	
RAF GAPS DIAGNOSIS CATEGORIES (4)			Hematological			
Cardiovascular	Diabetes	Metabolic				
Hematological						
						APPT. DATE
			Dermatology	University Hospital, 47 Blanchard	7/20/2023	
			Vascular Surgery	Dr. Fritz	4/10/2023	5/1/2023



Highlight | RAF Gaps on the CMP

Social Drivers of Health (4)		
FPL<200%	HISP/LAT	INSURANCE
LANGUAGE		

Allergies (0)	
<i>No active allergies</i>	

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
<i>No RAF Score</i>

Open Referrals w/o Result (3)			
TYPE	SPECIALIST/LOCATION	ORDER DATE	APPT DATE
Dermatology	University Hospital, 47 Blanchard	9/20/23	

Highlight | Leveraging Filters

Patient Visit Planning (PVP) ⓘ
PVP PVPVIEW

DATE RANGE: 01/09/2024-01/09/2024 📅 RENDERING PROVIDERS: All Rendering Provid... MRN LIST:

Augustine, Greg

2:23 AM Tuesday, January

Kroon, Denis
MRN: 1100953
DOB: 6/3/1968 (55)

DIAGNOSES (0)
RISK FACTORS (0)
SDOH (4)
HISP/LAT

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

Filter Panel:

+ Add Filter

Search

RECENT

- + Cohorts
- + Patient Diagnoses
- + SDOH
- + Alert
- + Plans

ALL

- + Alert
- + Alert Owner
- + Care Managers
- + Cohorts
- + EHR Appointment Type
- + Enrollees
- + Homeless Situation Past Yr

Total Providers: 10

Physical No Show

PCP: Decelles, Larry
Payer: Coventry
CM: Tom Parace

OWNER

MA

MA

Provider

Missing

Missing

Missing

Demo Data

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

The screenshot displays the Patient Visit Planning (PVP) interface. At the top, the title 'Patient Visit Planning (PVP)' is visible. Below it, there are search filters for 'DATE RANGE' (01/09/2024-01/09/2024), 'RENDERING PROVIDERS' (All Rendering Provid...), and 'MRN LIST' (1100017). A blue 'Update' button is located to the right of the MRN list. Below the filters, there is a 'Walk-ins' button with a download icon. The main content area shows a patient record for 'Bembi, Basilia' with various details including MRN, DOB, sex, language, risk level, portal access, cohorts, PCP, payer, and CM.

Patient Visit Planning (PVP)

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

RENDERING PROVIDERS: All Rendering Provid...

MRN LIST: 1100017

Update

Walk-ins

Demo Data | 1 Scheduled Appointment

Walk-ins				
Bembi, Basilia MRN: 1100017 DOB: 8/9/1966 (57)	Sex at Birth: F GI: Female SO: Something else	Phone: 413-983-2092 Lang: German Risk: High (50)	Portal Access: 08/12/2023 Cohorts: Adults Sys > 110, Asthma Tobacco Need Cessation, Clinical Pharmacy, DM	PCP: Winslow, Francine Payer: BCBS CM: Nicollette Dessy

Considerations and Set Up



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



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

Select the three-dot menu to export the Alert Admin to an excel

NAME	ENABLED	DESCRIPTION	OWNER	CREATED	MODIFIED	
Anal Anal Cytopat with HRA Follow	N	Alert will fire for patients with evidence of abnormal anal cytopathology and are due for high-resolution anoscopy (HRA). This alert is not configurable		09/15/2023	09/15/2023	⚙️
Anal Breast Canc ening	N	Alert will trigger for female patients age 40-74 who have received a breast cancer screening where the result was interpreted and indicated possible malignancy during the measurement period and have not received any or appropriate follow up. Alert will fire as "Due" when no follow-up has occurred during the appropriate time frame. Alert will fire as "Over due" when no follow-up has occurred after the appropriate time frame. This alert is not configurable		09/15/2023	09/15/2023	⚙️

Sample Standing Actions

VVP 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	Alert 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.



Alert Configuration | General Tab

Edit [X]

GENERAL | RESULT CRITERIA | POPULATION DEFINITION

CATEGORY
Lab

ALERT NAME
Diabetes A1c

Alert Name

ALERT TYPE
Logic can...

STATUS **Enabled** Disabled

PVP DISPLAY NAME
A1c

This is what will appear on the visit planning report.

OWNER
Ex: MA

Max 10 chars. This will appear on the PVP and CMP

INCLUDE IN POC ALERT CLOSURE MEASURE **Yes** No

Cancel **Confirm**

Callout 1: Configure how you want the alert to display on the PVP

Callout 2: Assign a role/care team member to be responsible for closing the alert*

Callout 3: Determine whether you want the alert to power the Alert Closure Point of Care Measure**



Alert Configuration | Date Criteria Tab

Edit ✕

GENERAL **DEFINITION**

Define the display message and the period for your alert.

DISPLAY MESSAGE **IF...**

Overdue Observation has not occurred in th

DUE SOON CRITERIA

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

ENABLED **DISPLAY MESSAGE** **IF...**

Observation will become overdue in the next

Confirm

Determine the cadence you want the alert to fire on (year, calendar, days, months) and if you want the associated message to display something other than "Overdue". Use the dropdown arrows to access the picklist.

Enable "Due Soon" criteria to warn care teams about a soon-to-be care gap before the patient is officially overdue

Alert Configuration | Result Criteria Tab

Edit

GENERAL DATE CRITERIA **RESULT CRITERIA** POPULATION DEFINITION

NUMERIC RESULTS
Observations can also be triggered by numeric results, like BP, use the numeric 2 threshold

MESSAGE
Out of Range

ALERT IF
Numeric result >=

NUMERIC 1 THRESHOLD
8

NUMERIC 2 THRESHOLD

ALPHANUMERIC RESULTS
Alphanumeric observation results can trigger an alert when the value is equal to the specified value.

MESSAGE

ALPHA VALUE

Cancel Confirm

Designate the values your practice considers to be "Out of Range" by configuring the threshold and the associated message that appears on the PVP

If results come through as alphanumeric, associate a message with the alpha value



Alert Configuration | Population Definition

Edit

GENERAL DATE CRITERIA RESULT CRITERIA **POPULATION DEFINITION**

INCLUSION CRITERIA

MIN AGE:

MIN AGE UNITS:

SEX AT BIRTH:

INCLUSION OBSERVATIONS:

REQUIRE ANY OR ALL OBSERVATIONS FOR INCLUSION:

DATE CRITERIA

MAX AGE:

MAX AGE UNITS:

RESULT CRITERIA

EXCLUSION CRITERIA

EXCLUSION OBSERVATIONS:

REQUIRE ANY OR ALL OBSERVATIONS FOR EXCLUSION:

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.



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

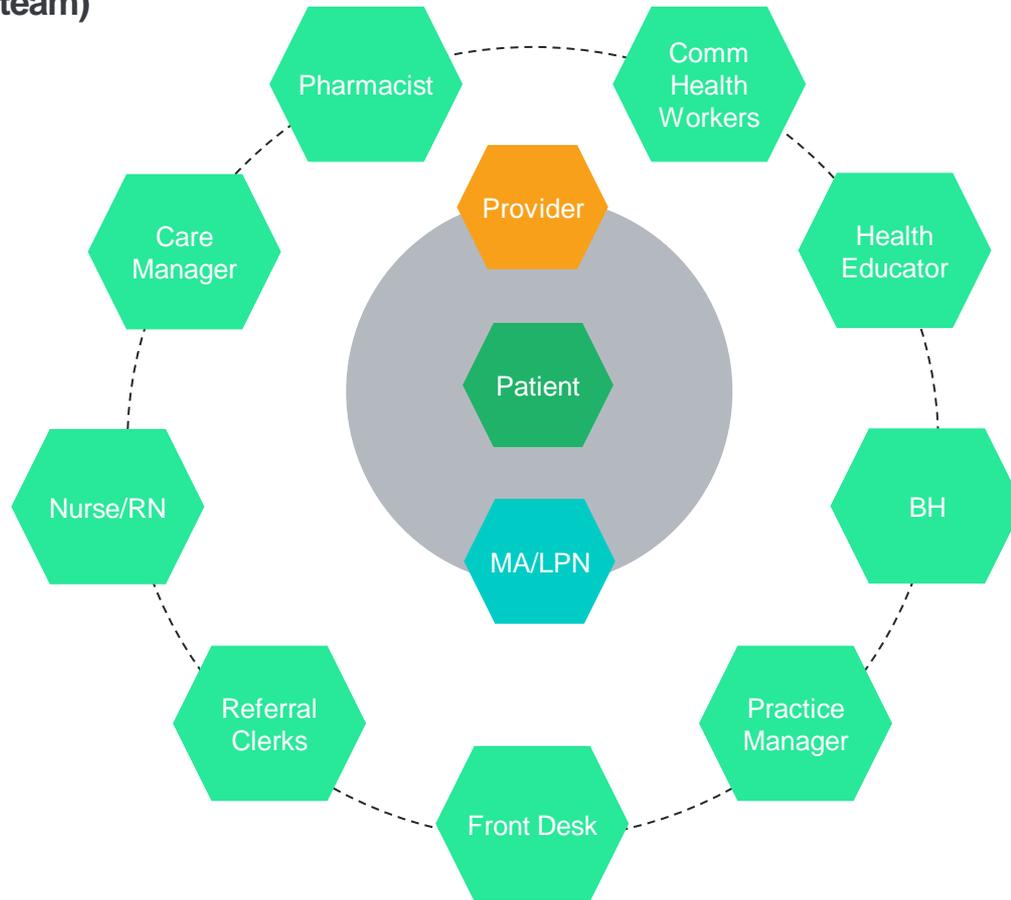


Use Cases for the PVP



Care Team Members

(Customize for your team)



Roles and Responsibilities

Role	Responsibilities	Accountable
Front Desk	<ul style="list-style-type: none"> <input type="checkbox"/> Generates the PVP for same-day appointments <input type="checkbox"/> Reviews assigned alerts (FPL, SOGI, etc.) 	Practice Manager
MA/LPN	<ul style="list-style-type: none"> <input type="checkbox"/> Runs the PVP each morning & prints for all members of the care team <input type="checkbox"/> Marks the PVP with notes for the huddle <input type="checkbox"/> Reviews and closes assigned alerts <input type="checkbox"/> Disposes of PVP print outs in HIPPPAA secure manner (keeping 1 copy to scan for PCMH evidence) 	Clinical Support Staff Supervisor
Provider	<ul style="list-style-type: none"> <input type="checkbox"/> Participates in the huddle <input type="checkbox"/> Reviews and closes assigned alerts <input type="checkbox"/> Identifies RAF gaps and updates patients' chart appropriately <input type="checkbox"/> 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.



Roles and Responsibilities

Role	Responsibilities	Accountable
Case Manager	<ul style="list-style-type: none"> <input type="checkbox"/> Identifies care managed patients on the schedule <input type="checkbox"/> Creates plan to check in during visits as needed <input type="checkbox"/> Reviews the PVP to identify patients eligible for care management services 	Population Health Supervisor
Behavioral Health	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews schedule with primary care to plan for potential warm hand offs <input type="checkbox"/> Assists BH patients in scheduling primary care visits 	Behavioral Health Director
Dental Staff	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews schedule with primary care to plan for potential warm hand offs <input type="checkbox"/> Assists patients in scheduling primary care visits <input type="checkbox"/> Reviews CMP to identify key medical concerns in relation to dental outcomes 	Dental Director
Quality Team	<ul style="list-style-type: none"> <input type="checkbox"/> Assures accuracy of PVP information 	Quality Director
All users	<ul style="list-style-type: none"> <input type="checkbox"/> Reports PVP inconsistencies to dedicated resource 	All staff



Filtering the PVP

- **Compliance**

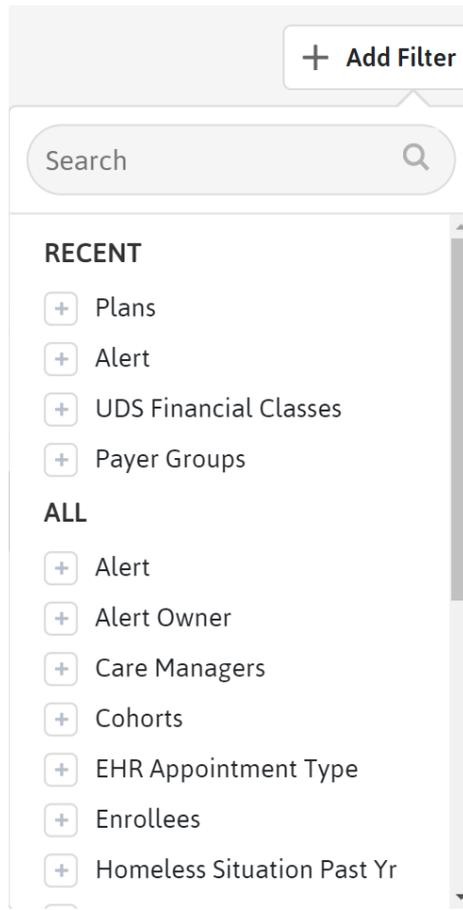
- Plan (Medicaid, Medicare MSSP, Mountain Health Co-op)
- Alert (care corresponding to HEDIS measures)

- **Operational**

- Alert in advance (1 week ahead)
- EHR Appointment Type

- **Clinical**

- SDOH/Demographics
- Diagnosis
- Cohorts
- Care Manager



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.

 Patient Visit Planning (PVP) 
PVP  PVPVIEW

DATE RANGE	RENDERING PROVIDERS	MRN LIST	ALERT	PLANS
01/23/2024-01/23/2024 	All Rendering Provid... 	<input type="text"/>	Colorectal Cancer Sc...  	Medicaid  



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.

 **Patient Visit Planning (PVP)** 

PVP  PVPVIEW

DATE RANGE	RENDERING PROVIDERS	MRN LIST	ALERT
01/29/2024-02/02/2024 	All Rendering Provid... 		Cervical Cancer Scre...  



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.

 Patient Visit Planning (PVP) 
PVP  PVPVIEW

DATE RANGE	RENDERING PROVIDERS	MRN LIST	PATIENT DIAGNOSES	SDOH
01/29/2024-02/02/2024 	All Rendering Provid... 		Diabetes  	TRANSPORT-MED  



Utilizing PVP For Depression Remission

Health Partners of Western Ohio



CHALLENGES

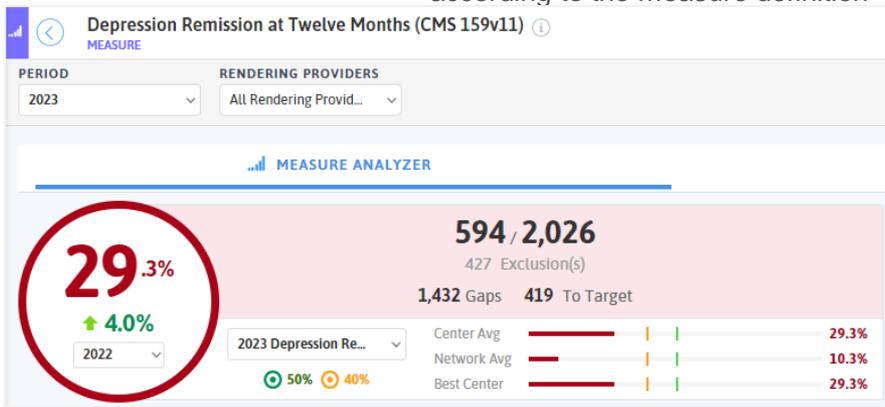
The organization identified the Depression Remission measure as an area of clinical focus for 2022/2023. The prediction of the PHQ-9 re-screening and follow-up window was determined the primary driver as to why CHC targets were not being met.

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

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 \(hrsa.gov\)](https://www.hrsa.gov/uds/clinical-quality-measures-2022).



2022 Network average 8.1%



2022 HPWO 25.3%

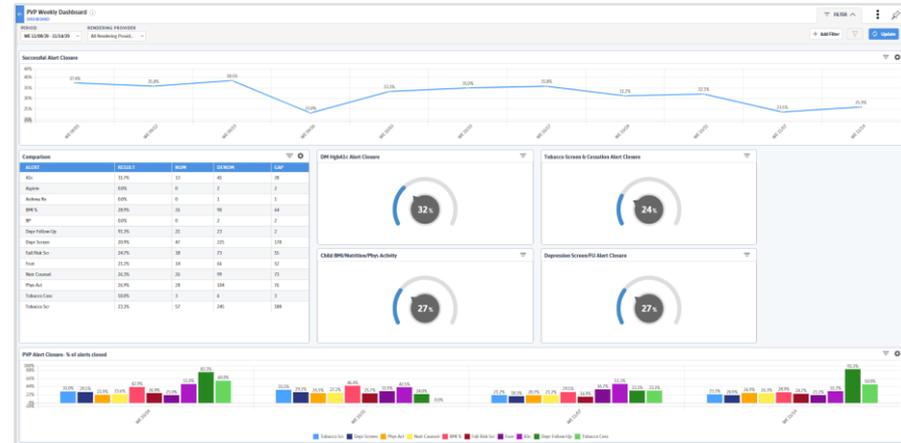


16% positive percentage improvement from 2022 - 2023



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

Alert Closure - Point of Care (POC) MEASURE

FILTER + ⋮ 📌

PERIOD: WE 02/26/23 - 03/04/23
 CENTERS: All Centers
 RENDERING PROVIDERS: All Rendering Provid...
 ALERT: All Alert

+ Add Filter ⌵ 🔄 Update

MEASURE ANALYZER

DETAIL LIST

VALUE SETS

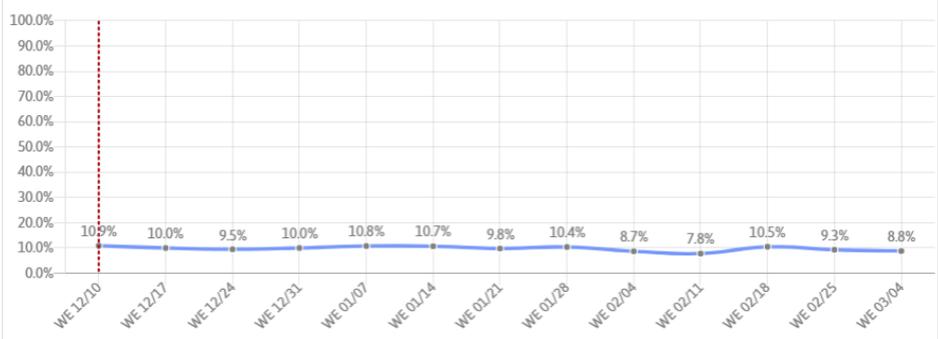
Targets & Metrics

SELECTED **8.8%** **-2.1% ↓** Baseline WE 12/10 **8,486 / 96,153** 161 Exclusion(s) **87,667** Gaps TARGET Create Target BENCHMARK

- 8% Center Average
- 9% Network Average
- 15% Best Center

WE 03/04

GROUP BY: None



Comparison

GROUP BY: Center 2ND: None Selected

CENTER	RESULT	CHANGE	NUM	DENOM ↑	EXCL
	10%	-2.3% ▼	2,273	23,806	1
	7%	-2% ▼	1,442	21,688	81
	8%	-8.2% ▼	999	12,882	7
	12%	+0.1% ▲	1,413	11,899	1
	15%	+3.2% ▲	1,290	8,435	55
	7%	-1.3% ▼	333	5,006	0
	4%	-1.4% ▼	187	4,957	1
	8%	-2.2% ▼	374	4,444	15
	5%	-3.7% ▼	114	2,360	0
	9%	-0.9% ▼	61	676	0



Alert Closure Gaps

Alert Closure - Point of Care (POC) MEASURE

PERIOD: WE 02/26/23 - 03/04/23 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | ALERT: All Alert

+ Add Filter | Update

MEASURE ANALYZER | **DETAIL LIST** | VALUE SETS

Search Patients ...

All | **Gaps** | Num | Excl

Reset Columns | SAVED COLUMNS

APPOINTMENT					ALERT			RESULT DATE	RESULT	NUMERAT...	EXCLUSIO...
NAME	STATUS	SERVICE LINE	WALK IN	SAME DAY	NAME	OWNER	MESSAGE				
	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



Planning and Point of Care Usage Dashboard

Planning & Point of Care Usage DASHBOARD
PERIOD: February 2023
CENTERS: All Centers

of Active Users

February 2023

168

Count of Users +25 ▲
Sep 22

Weekly Usage Activity - PVP, CMP & PNP

WE 02/19/23 - 02/25/23

Week	PVP	CMP
WE 02/19/23	342	114
WE 02/26/23	342	114
WE 03/05/23	456	171
WE 03/12/23	428	228
WE 03/19/23	228	171

Most Active Users

WE 02/19/23 - 02/25/23

USER NAME	NUM
mikaylas@achcid.org	43
lmix@fhsid.org	42
sbaker@marimnhealth.org	31
jmiller@marimnhealth.org	29
vgalvez@fhsid.org	27
lonaal@achcid.org	21
lkaestner@marimnhealth.org	19
bpotter@healthwestinc.org	13
sandersen@healthwestinc.org	10
kvickers@healthwestinc.org	9
veronica@achcid.org	9
taylors@achcid.org	8
brenda.ortiz@desertsage.org	6
aalvarado@fhsid.org	5
aruiz@fhsid.org	5
bceja@fhsid.org	5
cagonzalez@fhsid.org	5
dlirette@fhsid.org	5
malvarez@healthwestinc.org	5

Usage by Report Type

February 2023

Report Type	Count
CMP	1,470
PVP	850

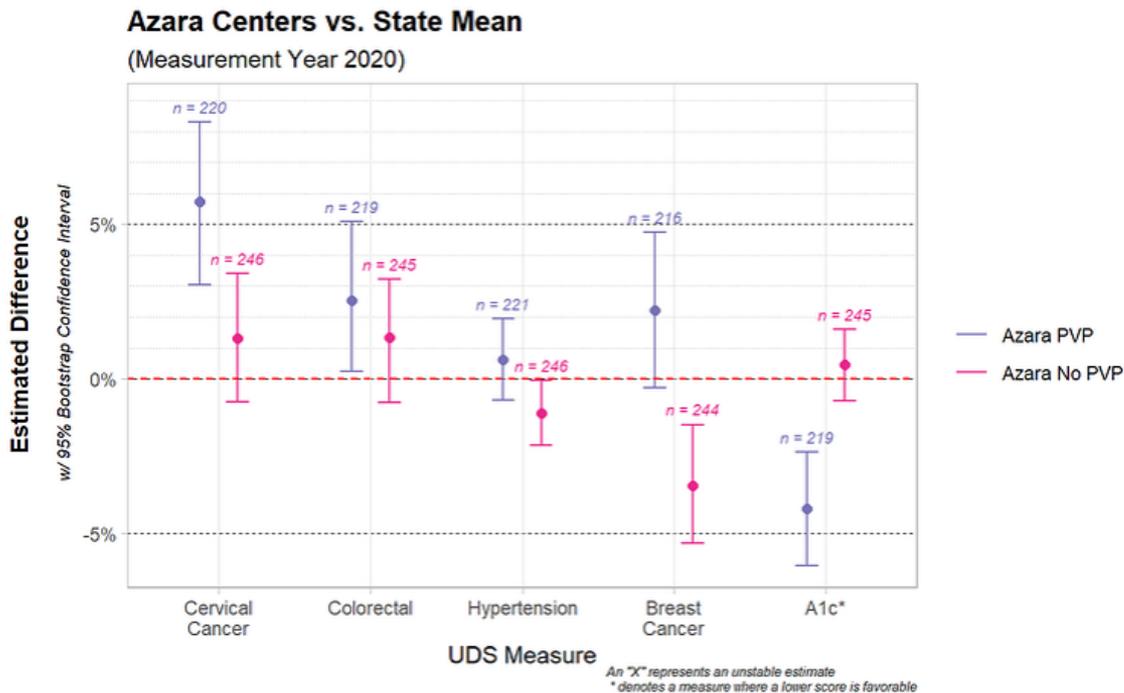
Daily Usage Activity - PVP, CMP & PNP

02/28/2023

Date	PVP	CMP
02/21	64	48
02/22	48	24
02/23	64	32
02/24	48	32
02/25	0	0
02/26	64	64
02/27	48	64
02/28	64	64

The Azara Effect

Figure 2: Comparison of Measure Performance when using the PVP



What's New in DRVS?



2023 Measure Validation Guides: Now Available in Help!



- 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





Role Based Guides for DRVS Now Available in Help!

- Role-based guides for **providers** and **MA/ 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



DRVS Tools to Support Providers

Providers can use DRVS to identify and close care gaps, improve health outcomes, and streamline patient care.

FREE-VISIT PLANNING REPORT (PVP)
The PVP is an efficient, electronic method for reviewing high-level information about your patients at a glance or comparing to a patient's visit. Use during the morning huddle to review high-level visit about patients on your schedule and plan for the day.

- **Visit** - Click to identify and create care gaps. Check identifying criteria and assign visit notes members of your care team to responsible care delivery and follow up to the top of their list.
- **Click** the patient name to access the Care Management Passport. A more detailed, comprehensive view of a patient's care history, including identifying care gaps, visit patterns and notes from other encounters, visit.
- **Watch our PVP Walk-Through** to learn more.



USE THESE FEATURES TO ENHANCE YOUR USE OF THE PVP AND STREAMLINE CARE DELIVERY

1. **Assign** - Click to assign patients to identify care gaps for the patient. Review details during the huddle report which can be addressed within the visit, which will ensure additional care coordination and/or patient follow-up after the normal appointment.
2. **Block** - Identify patients with high-risk scores for relevant care management and coordination in the block.
3. **Block** - Overview of patient needs (SCM) - Review patient care history and associated information to provide health-related medical resources, when a community-based organization or DRVS huddle and create a regular, or one-to-one (COP) for additional care coordination.
4. **Referral** - Review Referral Care Options - Review patient information to appropriately refer patient. Click on the DRVS to identify specific referral.
5. **Care Referrals** - Practice with the referral management module can identify patients with care and those to send to external partners, review care.



DRVS Tools to Support Providers

Providers can use DRVS to identify and close care gaps, improve health outcomes, and streamline patient care.

PERFORMANCE MANAGEMENT
Build consistency of your care team's performance on key metrics and organizational goals to improve patient outcomes across key metrics and COEs. Run Dashboards and Scorecards can be used to monitor overall performance. Final dashboards allow analysis to benchmark performance metrics and identify areas of priority resources to providers and care teams on a regular basis.

DASHBOARDS
Dashboards highlight on specific patient populations for trending dashboard to provider. Dashboards can be configured to offer operational, quality improvement or clinical insight, depending on the audience.

- **Click** the USQ dashboards Dashboard and filter to provide for actionable insight, including patient gap lists.
- **Configure** the Dashboards Dashboard and filter to provide for actionable insight, including patient gap lists.
- **Watch our Dashboards Walk-Through** to learn more.



SCORECARDS
Monitor and compare team performance on clinical quality measures by filtering scorecards by provider. Consider developing a custom report including resources identified for personal professional development to easily evaluate your progress.

- **Click** the USQ COP Scorecard Report to provide to quality evaluate performance across specific measures.
- **Reference** the Care Gap tool on measures with associated measures to identify quality trends in a patient's care gaps across My Resources.
- **Watch our Scorecards Walk-Through** to learn more.



DRVS Tools to Support MAs & LPNs

MAs & LPNs can use DRVS to prepare for and facilitate patient care. Specifically, they can identify and take action on alerts assigned to them as the owner.

FREE-VISIT PLANNING REPORT (PVP)
The PVP is an efficient, electronic method for reviewing high-level information about your patients at a glance or comparing to a patient's visit.

- **Run** the PVP daily to prepare for morning huddles and provide care for each patient on the huddle schedule.
- **Review** the PVP for information on patient demographics, chronic conditions, risk to complete additional resources might be needed.
- **Learn more about the PVP report** link.



USE THESE FEATURES TO ENHANCE YOUR USE OF THE PVP AND STREAMLINE CARE DELIVERY

1. **Additional Filters** - Consider applying filters to streamline your care delivery.
 - **Filter Team** - Use filters to identify patients with specific care gaps to better direct your day.
 - **Filter Care** - Select Care Types to identify patients with care gaps that require support.
 - **SCM** - Filter by patient's health-related medical needs resources. Filter the PVP by SCM to identify patients who could benefit from connection to additional resources.
 - **Filtered Categories** - Apply filters to prioritize patient populations to meet your needs.
2. **Block List** - Put the PVP for walk-in or same-day patients using the Block List tool.
3. **Block Owner** - Use the Block Owner column to identify the care team responsible for closing the care gap.
4. **Care Referrals** - Follow up on open referrals to close the loop for patients with the relevant needs.
5. **Care Management Passport (CMP)** - Click on the patient's name to access additional details on the patient's care history.
6. **Three-Step Alerts** - Select the three-step alerts to print or download the PVP's support care team.



DRVS Tools to Support MAs & LPNs

MAs & LPNs can use DRVS to prepare for and facilitate patient care. Specifically, they can identify and take action on alerts assigned to them as the owner.

CARE MANAGEMENT PASSPORT (CMP)
The CMP supports a variety of uses by allowing a provider, comprehensive summary of a patient's care history with more detail than the PVP.

- **Find** alerts, the history, problems list, report information, visit notes, and the care in the comprehensive patient outcome.
- **Analyze** the patient's care history to identify areas of opportunity.
- **Assess** by clicking the patient's name on the left-hand side of the CMP view the left-hand side of the CMP.
- **Can** be used as part of emergency preparedness or other access to EHR is not possible.
- **Learn more about the CMP** link.



IMMUNIZATION REPORT

- **Identify** patients in need of immunization. Review patient information and care history which includes immunization and care team member recommendations.
- **Support** patients to meet with care team members who will offer appointments, those who are not in a regular appointment.
- **Patient** outreach can be prioritized to those who are not in a regular appointment.
- **Learn more about reports** link.



Released November 2023





Users' Last Login: Now Available in User Administration

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

⚙️ < User Administration ⓘ

Search Users... 🔍

All Enabled Disabled

USER NAME ▾	FIRST NAME	LAST NAME	PLAN	PHI ACCESS	CREATED	STATUS ▾	LAST LOGIN	
adam.douglas@azarahealthcare.com	Adam	Douglas	All Plans	Yes	02/01/2022	Enabled	12/01/2023 04:20 PM	⚙️
admin@azarahealthcare.com	Azara	Admin	All Plans	Yes	01/01/0001	Enabled	12/05/2023 08:52 AM	⚙️
alex.pipes@azarahealthcare.com	alex	pipes	All Plans	Yes	03/13/2023	Enabled	12/05/2023 02:54 PM	⚙️
alexander.shvarts@azarahealthcare.com	Alex	Shvarts	All Plans	Yes	04/11/2019	Enabled	12/04/2023 12:08 PM	⚙️



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



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.



Patient Risk Stratification Dashboard:

Service Line Filter Updated



- 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

Patient Risk Stratification ⓘ
DASHBOARD

PERIOD	CENTERS	RENDERING PROVIDERS	SERVICE LINES
TY November 2023 ▼	All Centers ▼	All Rendering Provid... ▼	Primary Care ▼





PVP Enhancement: Pronouns!

Now Available on the PVP

- 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.

4:14 AM Wednesday, May 25, 2022		Visit Reason: Departure Office visit		
Smith, Susie MRN: 0123456789 DOB: 11/30/1987 (35)	Sex at Birth: F (She/Her/Hers) GI: Female SO: straight or heterosexual	Phone: (123) 456-7890 Language: English Risk: High (8)	Last Phys: 09/04/2020 Portal Access: 05/30/2021	PCP: Doe, Johnathon Payer: BCBS-IN: ANTHEM BLUE CROSS BLUE SHIELD (PPO) CM: Unassigned



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



Most Recent Cervical Cancer Routine Screening: Alert Added



A
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T

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



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](#)

The screenshot shows the 'Group Admin' interface. At the top, there is a breadcrumb 'Group Admin' and a dropdown menu for 'VALUE CATEGORY' set to 'Financial Class'. A blue button labeled '+ Create Group' is highlighted with an orange box. Below this, there are tabs for 'VALUES' and 'GROUPS'. Under 'VALUES', there is a search bar and filter buttons for 'All', 'Grouped', and 'Ungrouped'. Under 'GROUPS', there are filter buttons for 'PERIOD TYPE' with options 'All Time' and 'Last Year'. A table below displays a list of values and their counts.

VALUE	GROUPS	COUNT	TY
BCBS-NC		1	
BCBS-NJ		1	
Behavioral health		1	
Blue - EPO		1	
Blue - Medicare PPO		1	
Blue - Medicare Supplemental Plan		1	
Blue - POS		1	
BlueChoice HealthPlan		1	
Bright Healthcare		1	



Save the Date!

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.

azara 2024

USER CONFERENCE APR 30-MAY 2 | BOSTON, MA

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?

