mpca THE VOICE OF COMMUNITY HEALTH CENTERS

AN AZARA DRVS USER GUIDE FOR MPCA MEMBERS

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I. INTRODUCTION

This User Guide intends to provide the foundations of using Azara Healthcare's Data Reporting and Visualization System, or DRVS features and tools at a basic level. This Guide can be used to onboard new staff at your health center and/or serve as a refresher on how to use any of the features for staff already trained on using DRVS. From the Table of Contents, if you hold down the control button and click on the page number for the corresponding section, you can jump directly to that section in this document. Throughout this User Guide, you will find references to Azara's quick tip clips from their website for each of the features presented and screenshots of navigating through the features of DRVS.

Disclaimer: the screenshots of patient-level detail accompanying the features throughout this Guide come from the DRVS demo environment, which contains no real patient data, so it remains HIPAA compliant.

Several MPCA staff helped contribute to the writing of this User Guide. Our data team, consisting of Cheryl Gildner, Data Manager (cgildner@mpca.net), Ashley Wozniak, Clinical Data Specialist (awozniak@mpca.net), and Halli Rennaker, Clinical Data Specialist (hrennaker@mpca.net) all contributed to the contents of this guide. Technical questions regarding DRVS features should be directed to them. In addition to MPCA's data team review, this guide was reviewed by Amy Alward, Director of Population Health (aalward@mpca.net), and Dr. Faiyaz Syed, Chief Medical Officer (fsyed@mpca.net). Many thanks to all of MPCA's contributors for making this guide possible!

A HISTORY OF DRVS

Azara Healthcare, LLC is a health information technology (HIT) company that was founded in 2011 and developed the cloud based DRVS population health platform to support healthcare organizations, including federally qualified health centers (FQHCs), hospitals, primary care associations (PCAs), and health center control networks (HCCNs) with their data reporting and analytics needs.

MPCA selected DRVS as their integrated data system (IDS) in 2016, with the first group of Michigan FQHCs going live on the platform in July 2017. To date, 39 of the 40 FQHCs in Michigan have signed contracts with Azara. The decision to endorse DRVS as its IDS over competitors in the marketplace came down to several factors: our clinically integrated network's (CIN) need for network-level data, the capabilities DRVS features offered, timeliness of data imported, data visualization components, and its ability to integrate with electronic health record (EHR) systems. To make the subscription to DRVS more lucrative to health centers, MPCA was able to cover 75% of the costs associated with implementing DRVS through HCCN funding. The power of DRVS to take clinical and operational data and make it actionable and meet the needs of its subscribers has grown over the years, with continual enhancements, often at the request of healthcare organization staff.

Since 2020 alone, Michigan's patient population in DRVS has grown by 300,000. With knowing your patient population and what their preventive and chronic disease management needs are, the ability to improve their health outcomes has never been more important. DRVS can affect the way health care is delivered and improve patient outcomes while reducing health care costs for some of the most vulnerable populations in the community.

DRVS DATA

The main source of data in DRVS comes directly from structured clinical and operational data in your EHR. Structured data is data that has coding behind it, such as LOINC, diagnosis, G, or CPT codes, or date fields. DRVS scans your EHR nightly and updates whether patients receive age and gender-appropriate care, based on established clinical guidelines. Non-structured data includes free text, such as when a patient self-reports having a colonoscopy done and the date is documented in a progress note, but not recorded in a date field or obtaining results and attaching them to an order with procedure codes. DRVS will not be able to read these fields and credit the health center for making sure the patient was compliant with their preventive cancer screening because DRVS can only "read" structured data. For the most accurate reporting in DRVS, documenting patient data in your EHR should always be captured in structured fields. Otherwise, you

will not get a true picture of how you are performing across different measures or have a reliable account of which patients have care gaps, which can lead to missed opportunities to improve their health outcomes. The summary table below lists sources of structured vs. unstructured data.

STRUCTURED DATA IN YOUR EHR	UNSTRUCTURED DATA IN YOUR EHR
• Date fields (ie. in a health maintenance record, immunization record, surgical history) • Data tables (ie. a health maintenance record) • Data with codes behind it (ie. lab orders, referrals) • Completed orders or referrals that have results attached	• Free text in a progress note (ie. "Patient reports having completed service") • Scanned documents not attached to an order or referral

The structured data DRVS reads are mapped from your EHR during the implementation process when DRVS is programmed how to read patient data. Any time there are changes to where structured data is captured in your EHR or you use different codes, these changes need to be reported to Azara, so they can update their mappings. A support ticket can be created from Azara's Support Portal here: Azara Support Portal.

ONBOARDING WITH DRVS

Every healthcare entity with a subscription to DRVS will identify a Super User at the beginning of implementation. The Super User is often an IT or Quality department staff member and will be your gatekeeper to your organization's DRVS account. If you are going to be using DRVS in any capacity, they will be the one to set you up with log-in credentials by adding you as a user and assigning which DRVS privileges you have access to. If you are in a more limited clinical role within your organization, you may not have access or capabilities to some of the more advanced features, like creating cohorts or exporting patient lists. As your role changes within your organization, your Super User can change these privileges.

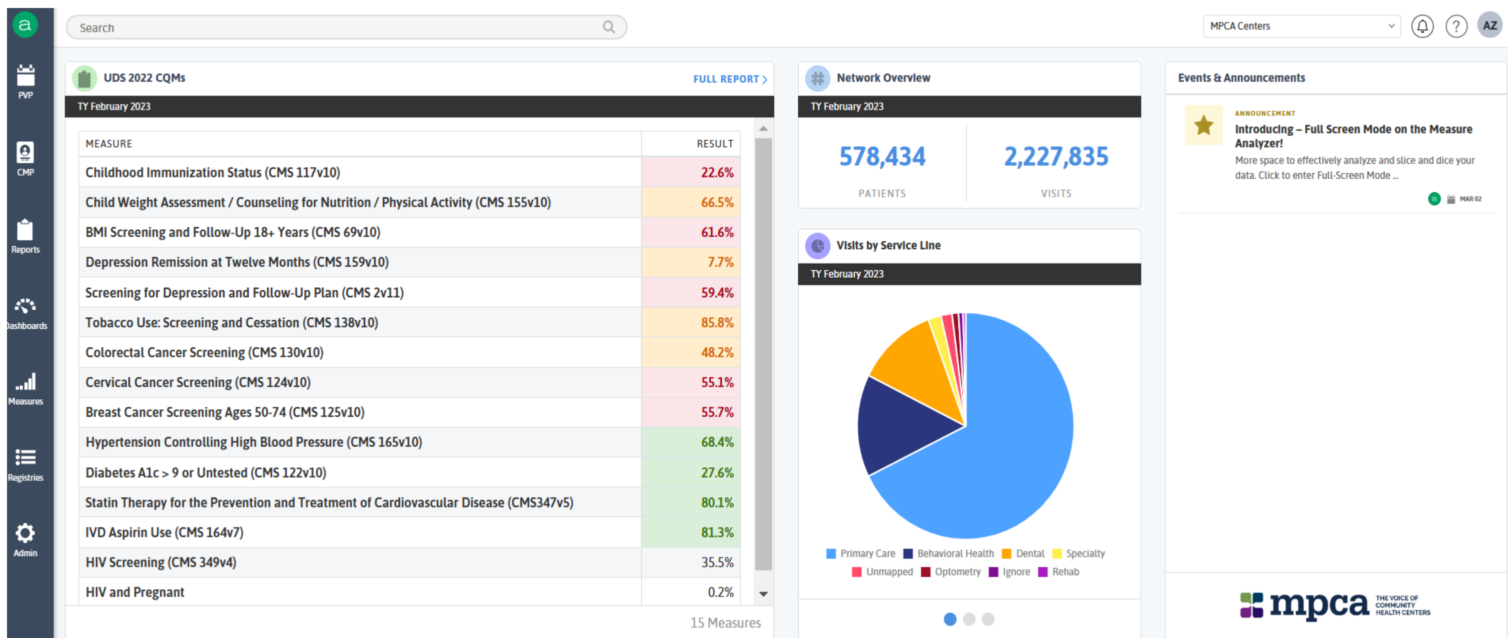
In addition to designating a Super User, it is worthwhile to assign Administrative or Admin privileges to other staff in your organization, who can assist with functionality if the Super User is unavailable. Some responsibilities of someone with Admin privileges may include adding user accounts, resetting passwords, or assigning privileges to other staff. Anyone can be assigned Admin privileges, but it is recommended that only someone who is competent in all DRVS functionality be assigned these privileges. This may include Quality Specialists, IT staff, or your CMO/Medical Director and COO.

It is recommended that when onboarding new staff, include DRVS training with training in the IT systems you use (ie. EHR, patient outreach platforms, HR system). The Super User will often be the one to train you on the features of DRVS you will be using. MPCA's data team will often train the Super User, but they can also assist with general staff training. Requests can be made to the data team using the e-mails in the Introduction section of this User Guide. Azara Healthcare's website has reference videos for each of the features in DRVS that staff should watch at least once. They can be found here: Get Started Using DRVS.

Now that you understand how DRVS became the preferred IDS in Michigan and how data is reported, let us dive into the features DRVS offers!

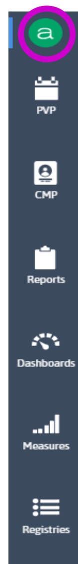
II. THE DRVS LANDING PAGE

The first page you view once you log in to your DRVS account is called the landing page. In this section, you will learn about the data contained in the landing page and how to navigate to different features of DRVS. Below is a screenshot of the full landing page from DRVS's MPCA user account.



THE LEFT NAVIGATION BAR

On the far left of the DRVS landing page, you will find the Navigation Bar. This bar contains clickable icons that take you to different features of DRVS. They include the PVP, CMP, Reports, Dashboards, Measures, Registries, and Admin. Depending on the level of access each user's DRVS account is set up with, some of these features may not be available to you. This Guide will demonstrate how to use each of these features in subsequent sections. The Navigation Bar is static, so it will always be displayed in all features of DRVS. At any point you want to go back to the Landing Page, you can click on the first icon, the "A" (for Azara) in the green circle. Below is a close-up of the Navigation Bar.



THE SEARCH BAR AND WIDGETS

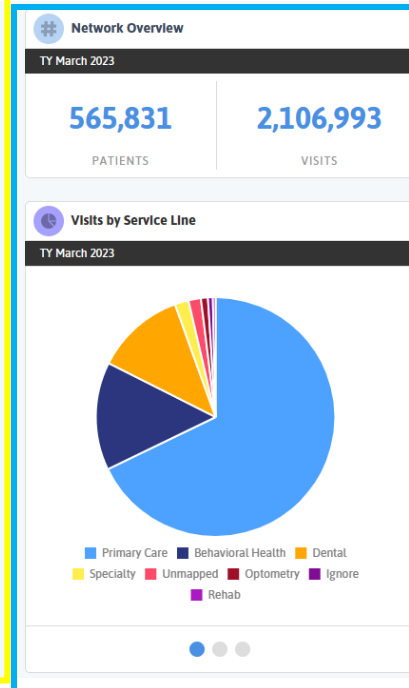
The middle section of the Landing Page consists of the search bar and 3 different widgets, or boxes of clinical and/or operational data, with different visual presentations, seen below.

UDS 2022 CQMs — FULL REPORT >

TY March 2023

MEASURE	RESULT
Childhood Immunization Status (CMS 117v10)	22.3%
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v10)	65.9%
BMI Screening and Follow-Up 18+ Years (CMS 69v10)	62.0%
Depression Remission at Twelve Months (CMS 159v10)	7.9%
Screening for Depression and Follow-Up Plan (CMS 2v11)	58.1%
Tobacco Use: Screening and Cessation (CMS 138v10)	86.1%
Colorectal Cancer Screening (CMS 130v10)	48.0%
Cervical Cancer Screening (CMS 124v10)	55.0%
Breast Cancer Screening Ages 50-74 (CMS 125v10)	55.9%
Hypertension Controlling High Blood Pressure (CMS 165v10)	68.4%
Diabetes A1c > 9 or Untested (CMS 122v10)	28.1%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v5)	81.4%
IVD Aspirin Use (CMS 164v7)	82.1%
HIV Screening (CMS 349v4)	35.7%
HIV and Pregnant	0.2%

15 Measures



The search bar outlined in red can be used at any point to quickly find information within the DRVS tool, such as a particular measure or scorecard. The leftmost widget in yellow defaults to the UDS scorecard for the most current trailing year (TY) measurement period. A definition of the different measurement periods will be provided in the Measures and Appendix sections of this User Guide. This widget is customizable. Instructions on how to change this widget will be provided momentarily. Scorecards will be discussed in greater detail in the Reports section of this User Guide.

The top widget of the two stacked widgets in the above blue box displays performance for the total number of unique patients seen within your health center and the total number of visits those patients had in the most current TY measurement period. Below it is a rotating widget that toggles between displays of the visits by service line pie chart, percent of patients with a type II diabetes diagnosis who have their most recent A1C >9 or who have never had an A1C test done at your center, and the percent of patients who have a diagnosis of hypertension and have it controlled. In the visits by service line display, if you hover your mouse/touchpad arrow over a section in the pie chart, you will be able to see the total number of patient visits for that service line. When you hover over the percentages in the middle of the dial for the A1C and hypertension clinical quality measures, you will see the number of patients who fall into the numerator for the measure out of the total population in the denominator for those measures. More about the numerator and denominator of measures will be discussed in the Measures section. The clinical quality measures in the bottom widget also display a green and yellow line in the dial, which represent your center's primary and secondary targets, respectively. If no targets have been set, the primary and secondary targets will default to MPCA's value-based performance goals. These two widgets are not customizable because they are high-priority measures for MPCA's members.

EVENTS AND ANNOUNCEMENTS

The events and announcements section of the Landing Page contains information regarding DRVS product updates, upcoming Azara webinars and conferences, and MPCA events and announcements, such as the monthly IDS User Group meeting. Below is a close-up of the events and announcements section.

Events & Announcements

ANNOUNCEMENT NEW

Recording Link IDS User Group Super User 101

https://nam04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvimeo.com%2F806790688%2F96

MAR 14

EVENT

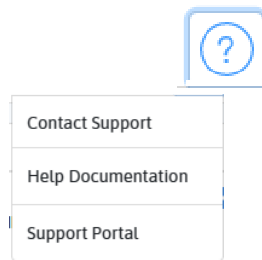
March Webinars

Please join us for our March webinars: Thursday, March 9th 2pm ET - DRVS 101: New User Overview ...

FEB 23

HELP AND USER PROFILE

Should you find yourself having trouble using DRVS and your health center's Super User is unable to resolve the issue, you can contact the Azara support team by clicking on the question mark in the circle in the top right corner of the Landing Page. When you click it, you will see a drop-down of options to choose from, shown below.

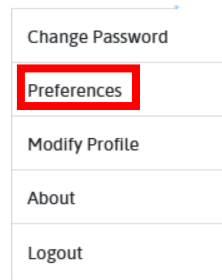


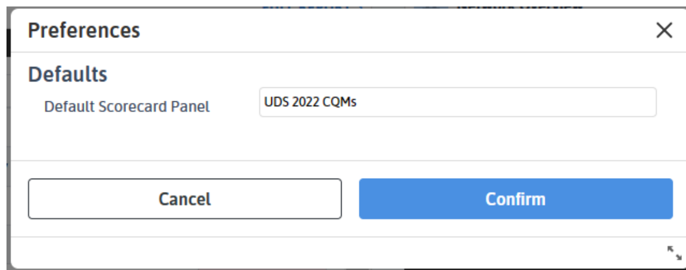
Clicking Contact Support opens an Outlook e-mail window to send a support ticket to Azara's customer support team. This e-mail is not secure, nor is it HIPAA compliant, so do not include patient data when submitting a ticket this way. If you are going to submit a ticket this way, it is best to only report functionality problems, such as missing data, or an account problem that does not involve patient-level data. Be sure to include as much detail as possible in describing the problem you are having with DRVS and include a saved image or copy and paste a screenshot of where the problem is.

To submit a ticket directly to the customer support team, click on Support Portal. This will take you directly to Azara's ticket reporting system. Support tickets submitted this way are secure and HIPAA compliant, so patient-level examples of issues can be included in your supporting information. This is the preferred method of submitting all tickets to Azara's customer support team. You can also easily check back on the ticket's status with the generated ticket number. The same guidance for documenting the problem you are experiencing in the ticket is advised.

The Help Documentation option takes you to an external website where you can access guides on how to use the general features of DRVS, watch clips on using the different features, access past recordings of webinars, see upcoming Azara events, and more. Many of the features in DRVS for MPCA's subscribers are customized, so you may not be able to find the solution you are looking for in these sections. Instead, reaching out to MPCA's data team for assistance is recommended. MPCA has developed its own playbooks in collaboration with Azara that can help you understand and use DRVS to its fullest capability.

Next to the help features on the Landing Page, you will see your initials in a circle. Clicking on this lets you change your password, update your name and/or job title, see what features you have access to, and, as mentioned earlier, change the scorecard displayed on your Landing Page. To do so, click on Preferences. A box will pop up that lets you search for a different scorecard to make your personal default. You will need to know the name or part of the name of an existing scorecard to search for it. Make sure you hit confirm for the change to take effect.



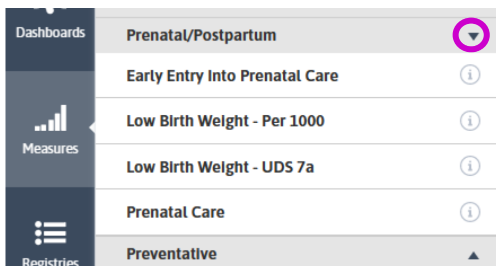


To watch a video of navigating the Landing Page, you can access it here: General Navigation.

III. MEASURES AND THE MEASURE ANALYZER

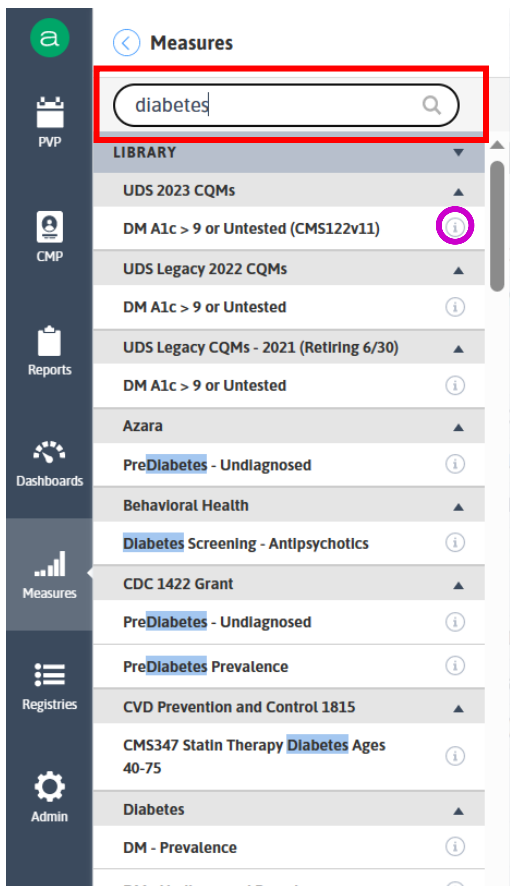
ACCESSING MEASURES

Measures are the foundation of many of the other features in this guide, so we will start with a basic understanding of what measures are and the patient population included and excluded from a measure. As you may recall, you can access any measure within DRVS from the Left Navigation Bar by clicking on the Measures button. This opens a drop-down of measure categories. Clicking the arrow to the right of the measure category opens it up and displays all measures that belong to that category, which you can then click on to open the Measure Analyzer, described later in this section. Some measures may be found under multiple measure categories, such as the Diabetes A1C>9 or untested being found under the UDS and Diabetes measure categories. They are the same measure, however.



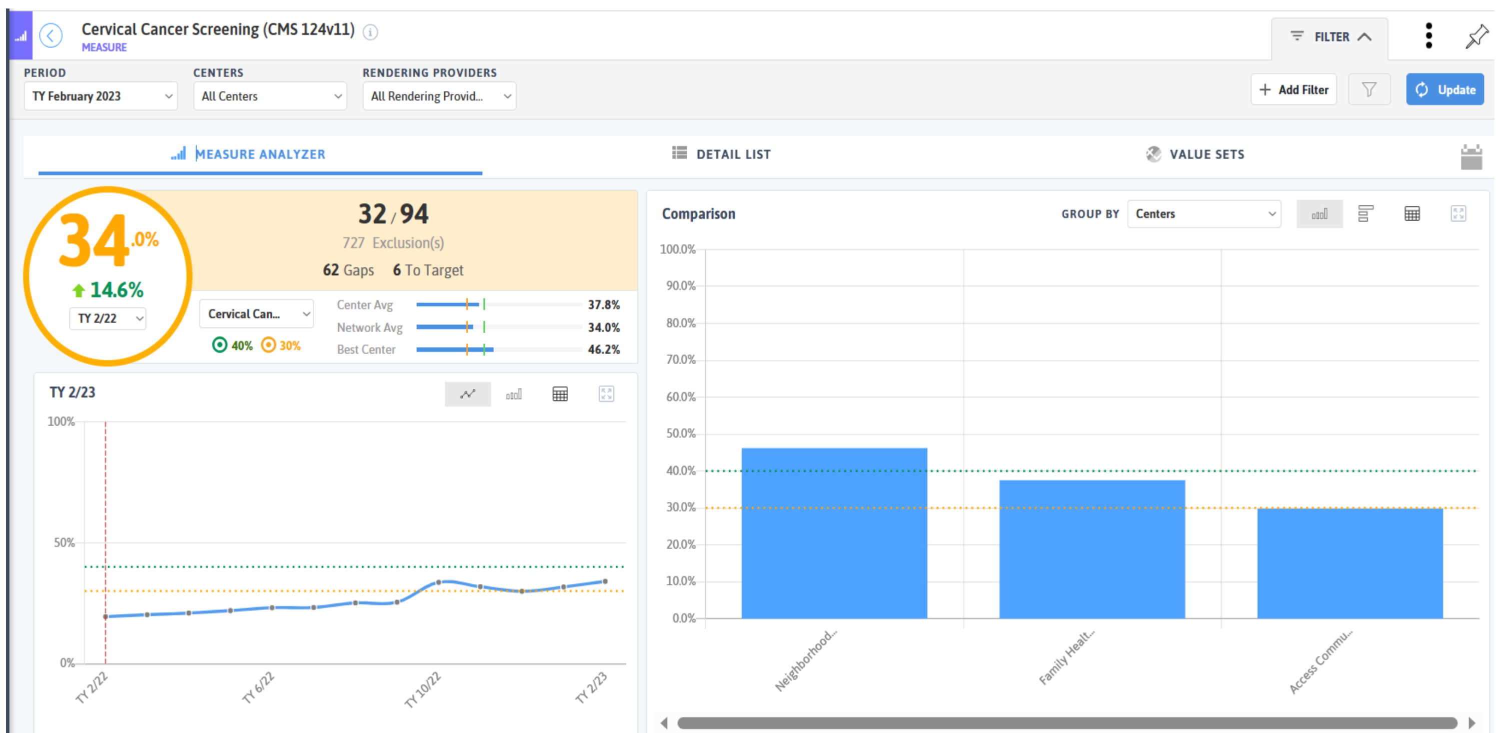
The easiest way to navigate to a particular measure in the Measure Analyzer is to use the search bubble above the list of measure categories and locate the measure that way. In the example below, the search is for diabetes measures. If you were not sure which diabetes measure you wanted to investigate, or which category the diabetes measure you want to investigate belongs to, typing diabetes into the search bubble would show you all diabetes measures within each measure category.

MPCA has many grant-funded projects aimed at improving specific measures, so some of the measure categories and measures would not be available if you were part of another state's PCA. To further help you in selecting which measure you want to investigate, or to understand what the measure means, hovering your mouse/touchpad pointer over the "i" in the circle to the right of the measure name pops up a box that tells you the measure definition.



THE MEASURE ANALYZER

Once you have identified which measure you want to explore, clicking on the measure name in the Measures list opens the Measure Analyzer. In the below example, the Cervical Cancer Screening measure was selected under the UDS 2023 CQMs measure category. We will now go through each of the sections in the Measure Analyzer, starting at the top.



Measure Name. The full measure name is displayed at the top of the Measure Analyzer page, along with the measure endorsing body and endorsement iteration. Most of the time, the measure endorsing body will be CMS, the Centers for Medicare and Medicaid Services. From the Measure Analyzer, when you click on the information "i" in the circle next to the measure name, a box containing the full measure details pops up, seen below.

Search

Cervical Cancer Screening (CMS 124v10)
MEASURE

Cervical Cancer Screening (CMS 124v10)

Endorser: None
Steward: NCQA

Women 21-64 years of age who were screened for cervical cancer using either of the following criteria: -Women age 21-64 who had cervical cytology performed within the last 3 years OR -Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

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

- Cervical cytology (pap test) performed during the measurement period or the two years prior to the measurement period for women who are >= 21 years old at the time of the test
- Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are >=30 years old at the time of the test

Denominator:
Women 23-64 years of age with a visit during the measurement period.

- Age >=23 and <64 at start of the measurement period*
- Measure qualifying visit in the last 12 months (see value set tab and technical specifications for qualifying visit codes)

*Age range begins at age 23, not 21, to accommodate for the look back period described in the numerator.

Exclusions:
- Hysterectomy with no residual cervix, or cervical stump excision anytime in the patient's history before the end of the measurement period
- Congenital absence of cervix anytime in the patient's history before the end of the measurement period
- Hospice Care for any part of the measurement period
- Palliative Care received during the measurement period

Codes related to Inpatient event are not included.

Technical Specifications

Value Set Dictionary

CMS eCQM Library

The measure definition is described first. The numerator of a measure describes how a patient satisfies or is compliant with the measure. The denominator describes how a patient qualifies for inclusion in the total population eligible to meet the measure. Exclusions and exceptions are reasons why a patient would not be included in the denominator of the measure. For the purposes of this Guide, we will not go into technical specifications, the value set dictionary, or the CMS electronic clinical quality measure (eCQM) library. To learn about these aspects of the measure information, reach out to your organization's Super User or watch Azara's quick tip clip at the end of this section.

To save measures you frequently run, once in the Measure Analyzer, click the pin icon to the right of the measure name, check the box for My Pins, and click the blue 'Add Pin' button.

Cervical Cancer Screening (CMS 124v11)
MEASURE

FILTER

PERIOD: TY February 2023
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER | DETAIL LIST

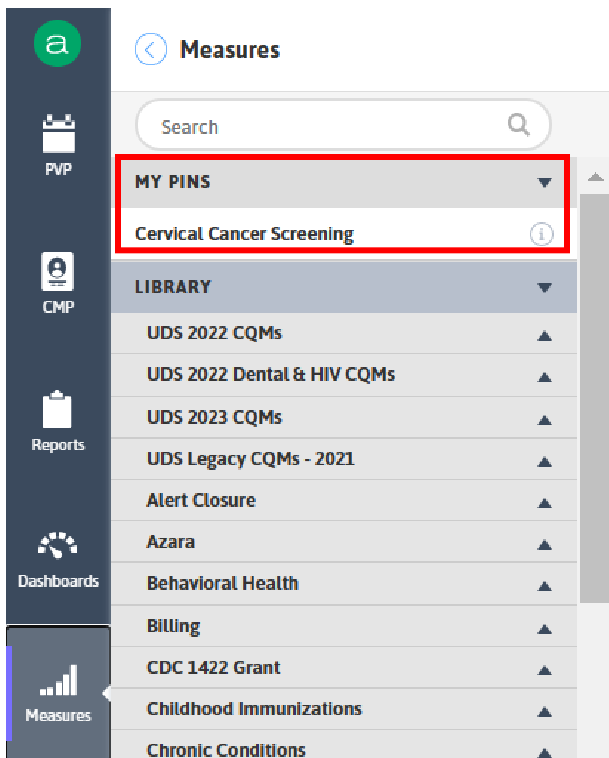
34.0%
14.6%

32 / 94
727 Exclusion(s)
62 Gaps 6 To Target

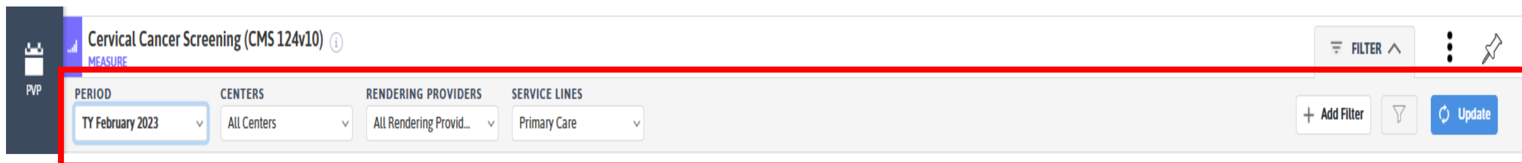
Comparison
100.0%
90.0%

Pin to Menu
Location | Select Menu
My Pins
Cancel | Add Pin

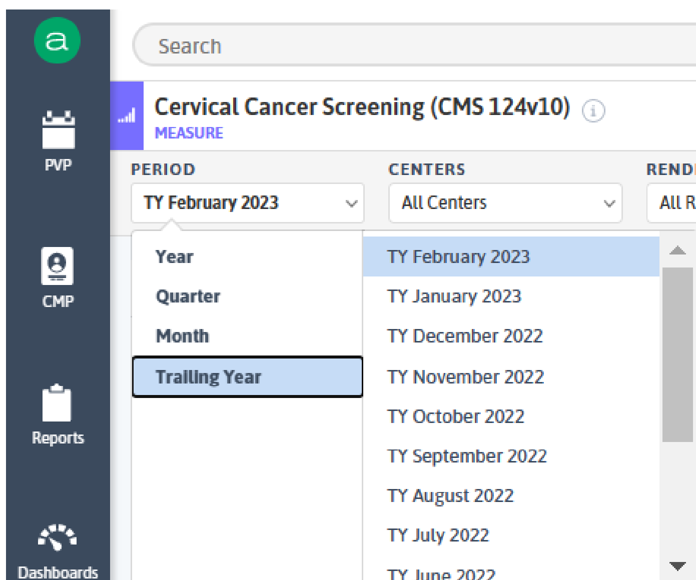
When you go back to the Measures button, your saved pins will be the first category of measures in the list, as seen below.



The Filters Bar. Below the measure name is the filters bar. The filters bar lets you focus in on the patient population using default settings. The default settings vary from measure to measure, but at a minimum include the period and rendering providers.



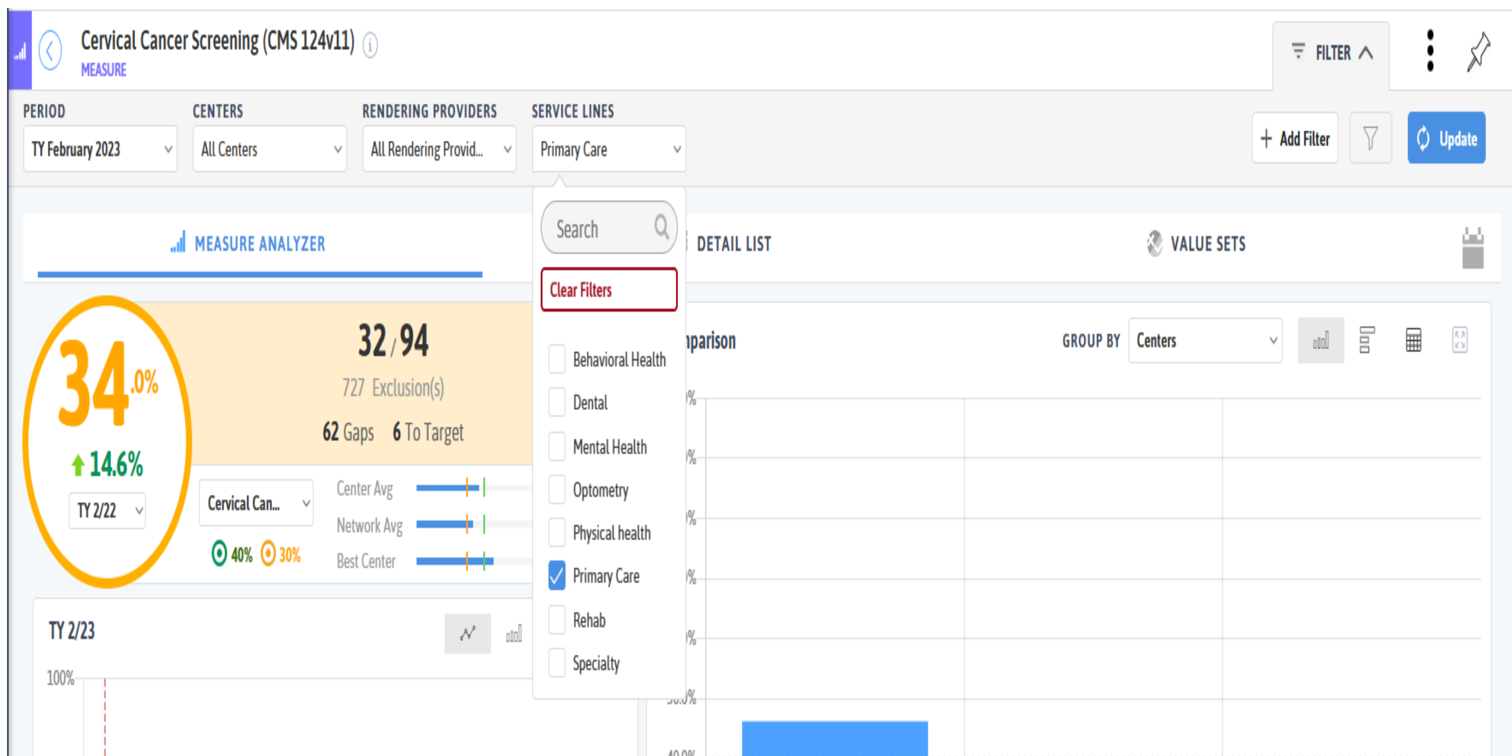
Depending on the measure, you can apply different measurement period options. The TY period, which is also the default for most measures, stands for trailing year. The trailing year period is the current measurement period and 11 months prior. In the above screenshot, the TY February 2023 period reflects patient data from March 2022 through February 2023. Below is the list of additional periods for the Cervical Cancer Screening Measure.



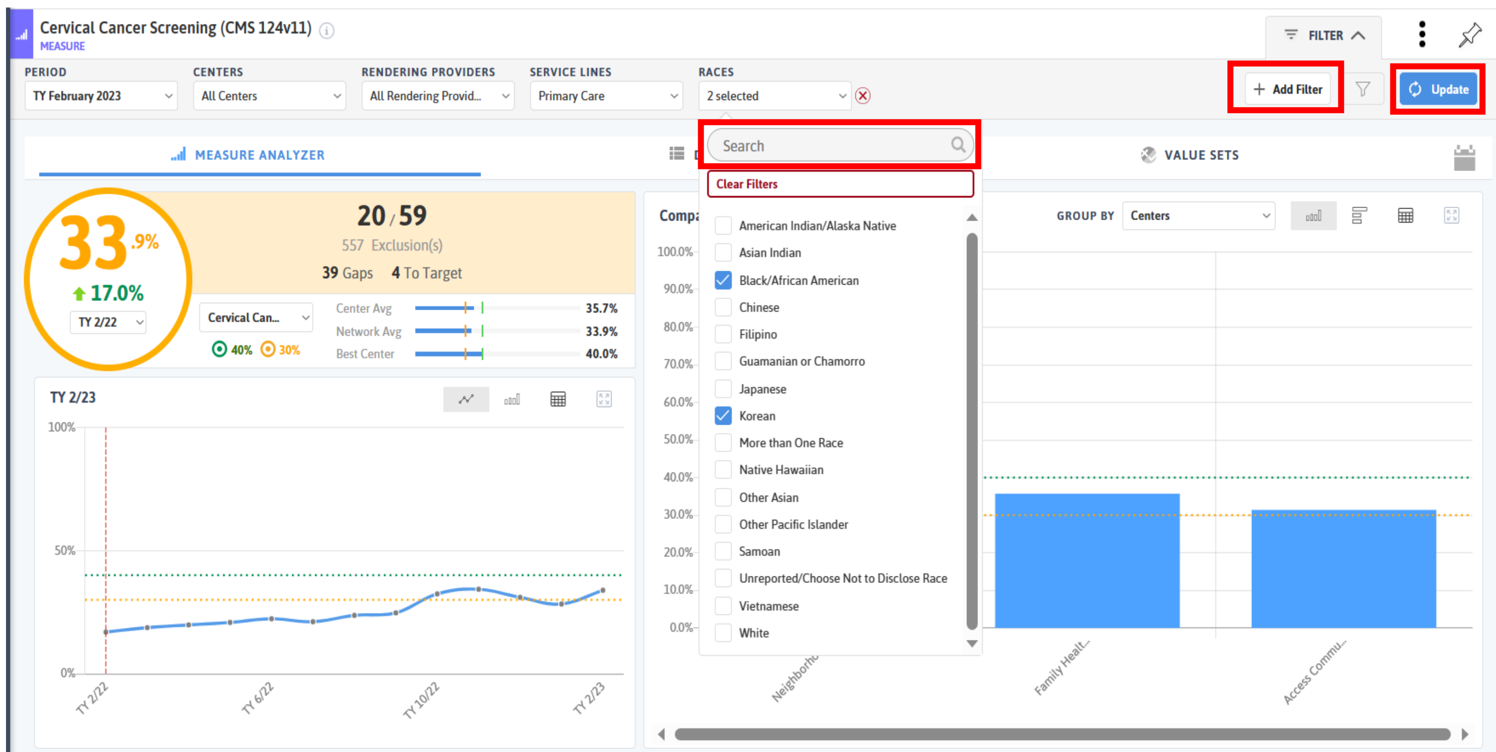
As a side note, in the DRVS demo version, the filter for Centers has been applied. MPCA staff with user accounts in both the live and demo versions of DRVS have the option to filter by center name because we have access to all our health centers' data. Individual health centers cannot see other health center data at the patient level because this would be a violation of HIPAA regulations, so this filter is not available.

Providers can be one of two types in DRVS: rendering or usual. As mentioned above, rendering provider is one of the default filter bar settings. A rendering provider is the last provider a patient saw. The usual provider is the provider a patient most often sees. In the context of Medicaid plans, this is usually the patient's assigned primary care provider (PCP). When selecting a rendering provider or providers from the drop-down list, you will narrow the data for the measure to just the providers selected. Depending on your role at your health center, filtering for a rendering provider may be beneficial to you. If you only work with a specific provider or providers, you may want to filter the measure analyzer to just the provider(s) you work with.

The service line filter for many measures defaults to primary care, but DRVS is not limited to just the primary care setting. Many FQHCs offer services in addition to primary care, and those departments also have use for understanding their patient populations and quality measures of significance to their disciplines, so DRVS provides data for these specialties. If your center does not have a particular specialty from the list in the screenshot below, there will not be data displayed for that service line.

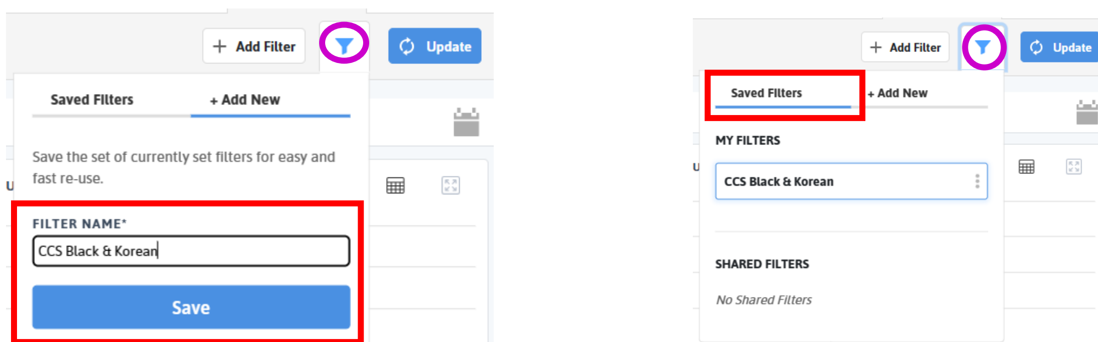


In addition to the default filters in the filters bar, you can add filters to narrow the patient population in the Measure Analyzer by clicking the 'add filter' button. This adds a drop-down of characteristics you can filter by. Some of the more commonly used filters are service line (when not a default for the measure), languages, ethnicities, races, and payers. Multiple filters can be added to the filters bar by clicking each category one at a time. Each filter applied adds a drop-down list to further narrow patient characteristics. You can also use the search bubble to look up a characteristic in the category. This becomes useful when the drop-down has a lengthy list of options you would have to scroll through, such as the patient diagnosis category. Once you apply your intended filters, make sure to click the blue 'Update' button for the data to reflect the filters selected. To remove the filter, click the red "x" in the circle next to the filter drop-down and click the update button again. You will not be able to remove any of the default filters. In the below screenshot, the races category is applied, and Black and Korean races have been selected.



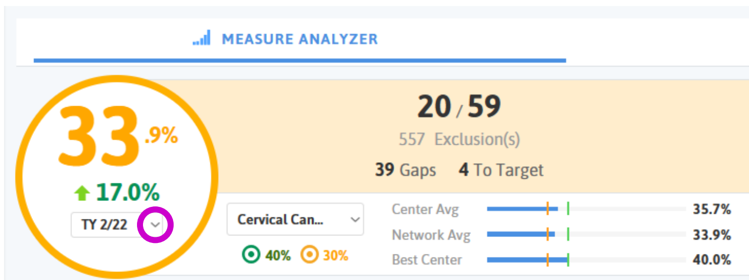
DRVS reads the measure categories themselves going across the filters bar as "And," and selections within categories read as "Or." The only exception to this is the patient diagnosis category, which will always apply the selections as "And." In the above screenshot, DRVS will display data for cervical cancer screening performance in TY February 2023 AND all centers AND all rendering providers AND primary care service lines AND Asian OR African American races.

As you use the measure analyzer to filter your patient population across various measures and apply different filters to those measures, you will see a list of recently used filters when you click the 'add filter' button. If you regularly run a measure with the same filters, you can save these settings with the funnel button. Each new setting requires naming it and clicking the blue 'Save' button. The next time you run the measure again, you can choose from the saved filters settings you just created. The settings saved will only apply to the measure you save them in; you will need to save filter settings for each measure you run, separately.



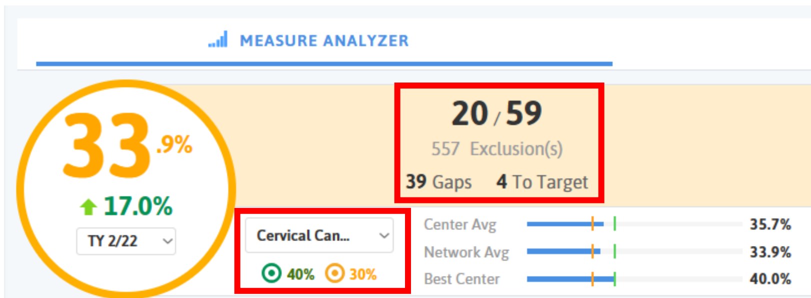
Measure Performance. Below the Filters Bar contains your health center's performance on the measure based on the filters applied in the filter's bar, in the bubble. This will be the largest percentage number you see. When the bubble and percent are yellow, as seen below, this means the center met the secondary target set for the measure. If it were green, the primary target was met, and if it were red, they were below the secondary target. More on measure targets will be discussed further later in this section. Below your center's performance is the percent change from the measurement period one year prior, the default setting (TY 2/22). When the number is green with an up arrow in green, this shows your center improved by that percent over the comparison measurement period. A decrease in performance will be

indicated in red, with a red down arrow. If you want to change the comparison period, you can click the down arrow in the measurement period box and select a different measurement period. The furthest back you can look, however, is a measurement period one year prior.

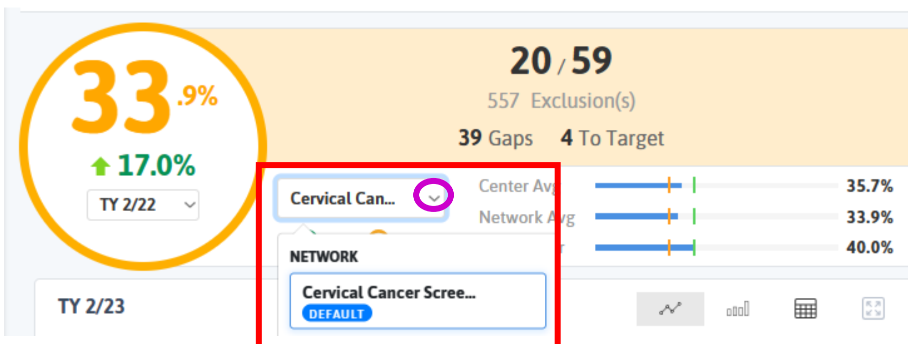


One thing to keep in mind when analyzing performance on a measure is that you want to see an inverse relationship to demonstrate improvement in certain measures. An example of this includes the Diabetes A1C >9 or Untested measure. In this case, the change compared to the baseline would show a green arrow pointing down. For this measure, you want your diabetic patients to have an A1C below 9, which signifies their diabetes is under control. You also want to make sure as many patients as possible with a diabetes diagnosis have a test at least once per year, so they would not be defined as untested.

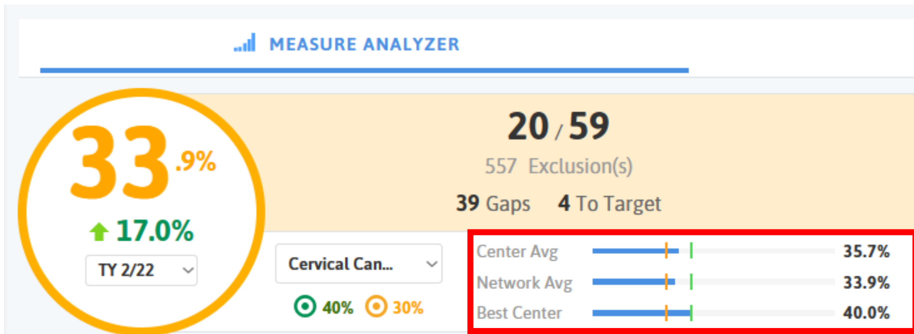
Next to your performance bubble are the number of patients in the numerator and denominator; exclusions, which are the number of patients who do not meet the measure criteria; the number of patients with a care gap for the measure, which is calculated by subtracting the number of patients in the numerator from the denominator; and number of patients needing to meet the measure to satisfy the primary goal determined by your Chief Medical Officer (CMO) and/or Quality Director and set by your DRVS Super User. Again, these numbers are determined based on the filters selected in the filters bar for the measure.



Below the raw numbers for the measure is a drop-down box for the measure target and the primary (green) and secondary (yellow) targets for the measure target, seen above. In this example, when you expand the measure target drop-down, you can see that the network target is how performance is being measured against. In the live DRVS environment, you might see targets for other measure body endorsing targets, such as HEDIS or Healthy People 2030 that you can switch to. If your health center has not set its own targets, the default will be set as the MPCA network target.

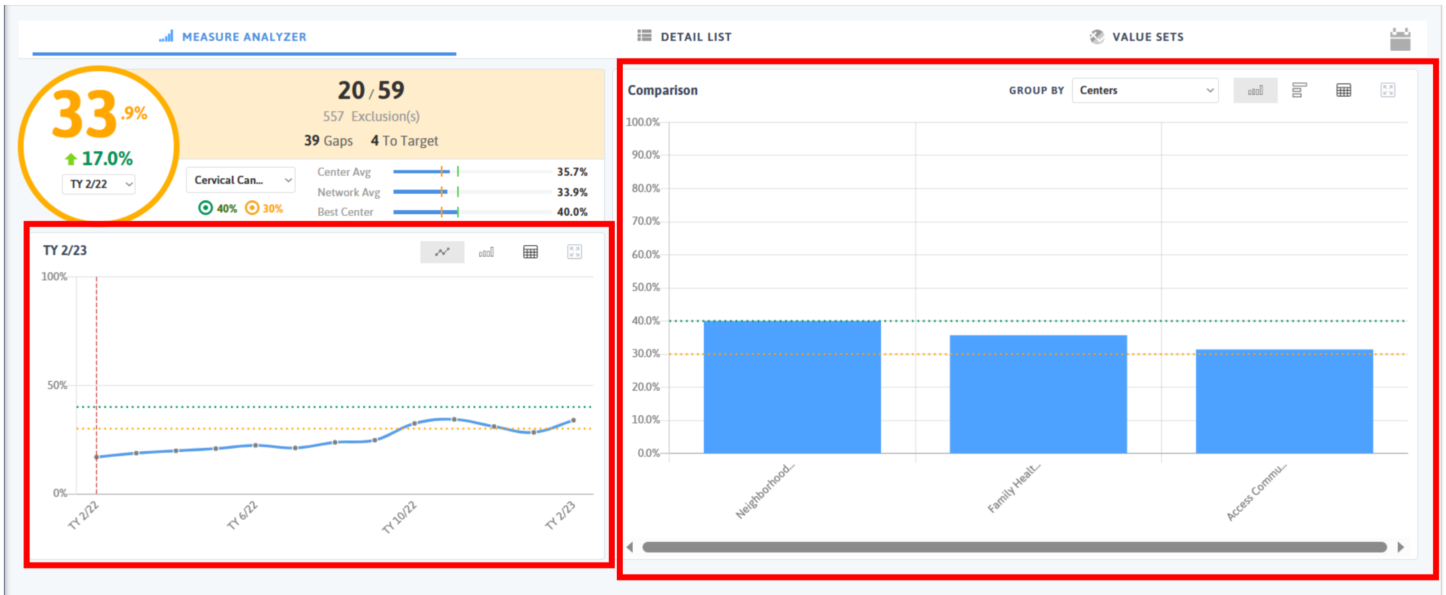


Some centers like to know how they are performing in comparison to other centers, so next to measure target comparison information, you will see a comparison of your center's performance against the MPCA network average and the highest performing, or best center. The green primary and yellow secondary target lines will be indicated in the performance bar, along with the blue bar representing actual performance for each metric comparison.



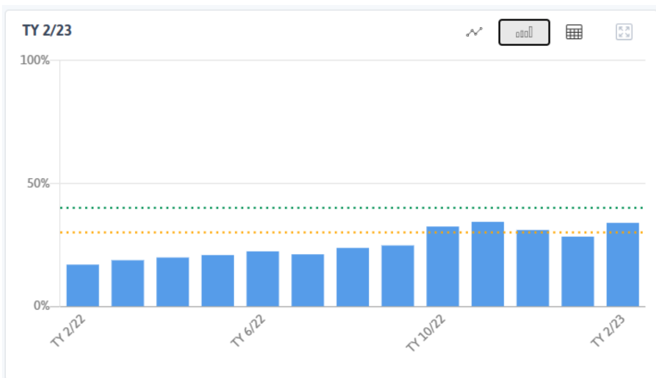
Next to your performance on the measure is the targets set for the measure and the number of additional patients who would need to satisfy the measure to meet the primary target. Both the primary and secondary targets are displayed. The drop-down box lets you change the measure target steward if your center follows national or network standards. This may change both percentile targets. You can also set your own center's targets for the measure. The Super User will have the ability to do so with their Admin privileges.

Data Visualization in the Measure Analyzer. One of the most powerful aspects of using DRVS for quality improvement lies in the ability to measure performance over time. DRVS offers compelling data visualization capabilities that help inform current performance and allow you to identify opportunities for improvement when performance is lower than your quality targets. The side-by-side data visualization components of the Measure Analyzer include a run chart below the measure performance and a comparison bar graph on the right, seen below.



The run chart shows performance on the measure over the measurement period with any filters applied from the filters bar, along with the primary and secondary target lines in green and yellow, respectively. Since the measurement period is a TY period, the lookback includes the 12 TY measure periods prior to the current TY period. If the measurement period in the filters bar were a monthly period, you would see performance on the measure for the current month and 12 months prior. Hovering your mouse/touchpad pointer over each dot in the measurement period allows you to see

the numerator, denominator, and exclusions for that period. You also can view this data as a bar graph or in a data table by clicking the top right icons, shown below.



TY 2/23

PERIOD	RESULT	NUM	DENOM	EXCL
TY 2/22	17%	37	219	589
TY 3/22	19%	40	214	591
TY 4/22	20%	40	202	610
TY 5/22	21%	38	183	637
TY 6/22	22%	39	175	656
TY 7/22	21%	35	166	676
TY 8/22	24%	37	156	684
TY 9/22	25%	36	146	700
TY 10/22	32%	23	71	545
TY 11/22	34%	24	70	554
TY 12/22	31%	18	58	569
TY 1/23	28%	17	60	552
TY 2/23	34%	20	59	557

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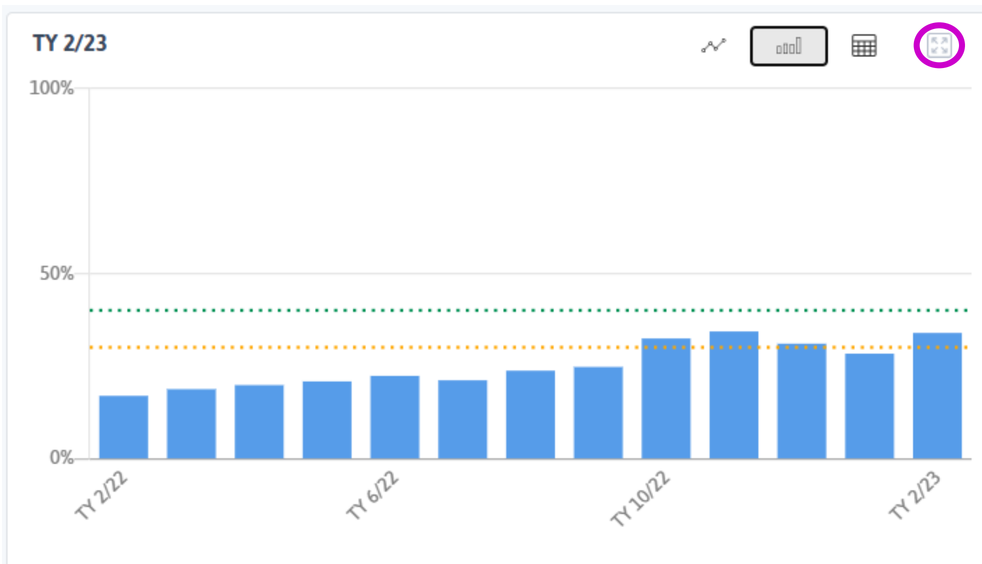
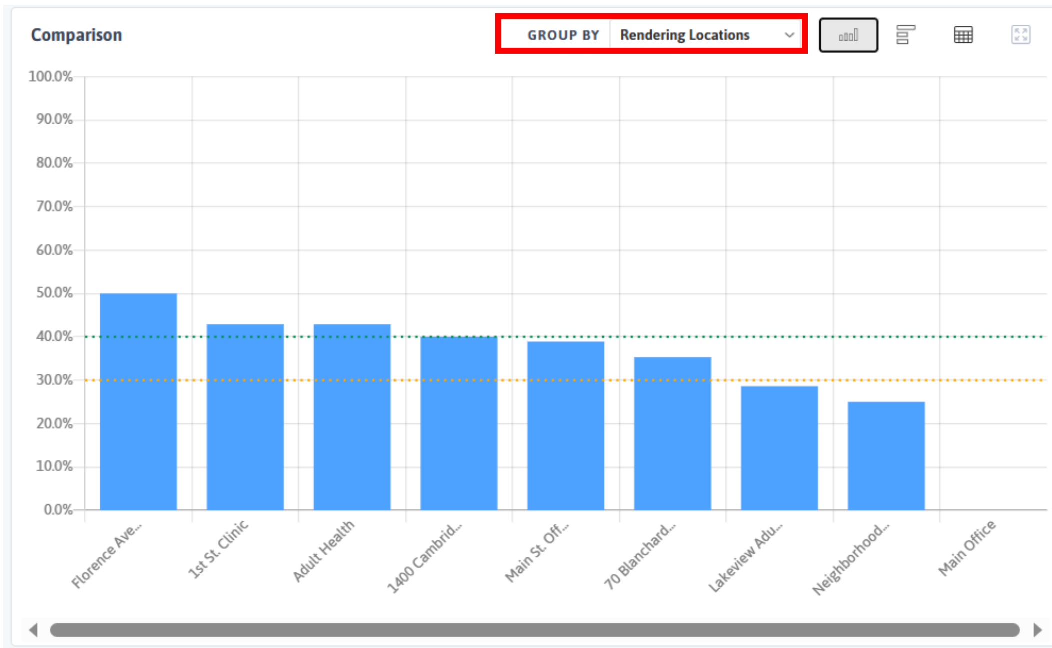
Hovering over each bar graph lets you see the same numerator, denominator, and exclusions you would in the run chart and how close to meeting the primary or secondary targets you are. In the data table, when you have reached a target for the primary or secondary targets in any of the measurement periods, the result will be highlighted in green or yellow, respectively. The red indicates the target set for the measure has not been reached in that measurement period.

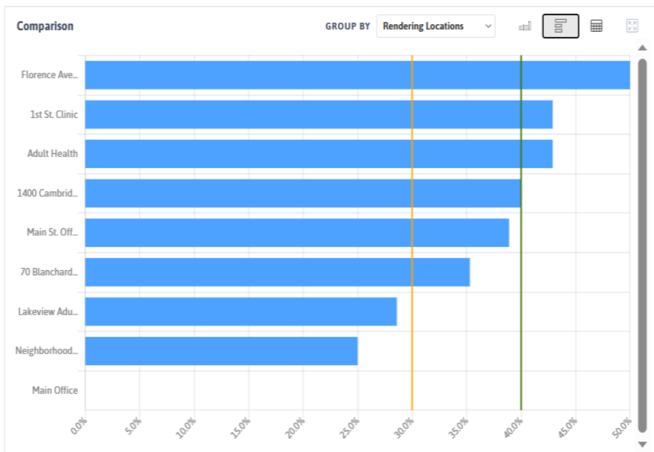
Clicking on the far-right icon in the top right of the run chart will open the run chart full screen for the display you have set.



In the comparison bar graph, the DRVS demo environment and the MPCA user environment default to comparing performance with all health centers in the network. The default setting will show your center performance on the measure for the current measurement period. If you want to compare performance on the measure across different filters, you can do so by selecting a characteristic in the Group By drop-down box. A common comparison is to see how different sites are performing and target the lower-performing sites for improvement interventions. In the Group By drop-down, you would select rendering location. The screenshot below shows how this grouping was applied. Hovering over the measurement bars will pop up the numerator, denominator, and exclusion information.



Like the run chart, the comparison data can also be viewed in different ways by clicking on the icons in the top right of the box, seen below. The middle icon shows the bar graph with the bars stacked vertically and jutting out to the right, while the right icon displays a data table as with the run chart. Also, note that the primary and secondary target lines are displayed on the bar graphs. You can also use the far-right icon to show the data in the visualization selected in full-screen mode.



Comparison GROUP BY Rendering Locations

RENDERING LOCATIONS	RESULT	CHANGE	NUM	DENOM	EXCL
Florence Ave. Center	50%	+ 34.2% ▲	2	4	81
1st St. Clinic	43%	+ 34.1% ▲	3	7	105
Adult Health	43%	+ 21.8% ▲	3	7	68
1400 Cambridge St.	40%	+ 18.2% ▲	4	10	163
Main St. Office	39%	+ 15.1% ▲	7	18	167
70 Blanchard Rd.	35%	+ 15.7% ▲	6	17	162
Lakeview Adult Med...	29%	+ 8% ▲	2	7	92
Neighborhood Medi...	25%	+ 3.6% ▲	1	4	63
Main Office	0%	- 27.3% ▼	0	2	65

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DETAIL LIST

The Detail List within the Measures section of DRVS shows patient-level detail of who is contributing to performance on a measure (ie. part of the numerator) and who has a gap in that measure. To access the detail list from a measure, click the ‘Detail List’ tab in the top middle of the screen, next to the ‘Measure Analyzer’ tab. The below screenshot of the Detail List is from the DRVS demo environment, which does not contain real patient data.

Cervical Cancer Screening (CMS 124v10)
MEASURE

FILTER

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

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...

All | Gaps | Num | Excl

Measure Investigation Tool | SAVED COLUMNS

		DEMOGRAPHICS >							MOST RECENT ENCOUNTER		
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION
Neighborhood Health Center	1103270	Grimstead, Thomasine	F	12/9/1998	2823505	Parker, Philip	N	N	9/24/2022	Cranston, Bill	Main Office
Neighborhood Health Center	1100259	Lacina, Monet	F	10/20/1993	4138828	Parker, Philip	N	N	3/5/2022	Parker, Philip	Adult Health
Access Community Health	1103215	Horikoshi, Antoinette	F	3/11/1974	1970872	Doe, Jane	N	N	1/18/2023	Doe, Jane	Main St. Office
Access Community Health	1101910	Wade, Lorrine	F	5/3/1997	3607755	Crowley, Patrick	N	N	7/3/2022	Fritz, Renata	Main St. Office
Family Health Center	1101380	Deleonardo, Chrissy	F	2/21/1968	6503276	Houser, Dougie	N	N	2/17/2023	Rigoli, Brian	Lakeview Adult Medici
Family Health Center	1103140	Silquero, Yong	F	12/31/1978	5306684	Branchburg, Tom	N	N	1/2/2023	Cote, David	1st St. Clinic
Family Health Center	1101444	Maffey, Barb	F	9/3/1997	4412692	Mejido, Daniel	N	N	2/27/2023	Houser, Dougie	Florence Ave. Center
Access Community Health	1101330	Neubacher, Awilda	F	7/28/1975	6794276	Bridgewater, Bill	N	N	10/9/2022	Black, Ronda	1400 Cambridge St.
Access Community Health	1100298	Bruk, Gertude	F	2/25/1980	8907292	Winslow, Francine	N	N	2/23/2023	Winslow, Francine	70 Blanchard Rd.
Access Community Health	1100680	Gillock, Sidney	F	7/30/1973	6644147	Fritz, Renata	N	N	5/24/2022	Bridgewater, Bill	70 Blanchard Rd.
Access Community Health	1102732	Terwillegar, Julene	F	12/28/1982	3985488	Augustine, Greg	N	N	12/21/2022	Augustine, Greg	1400 Cambridge St.
Access Community Health	1102407	Sines, Adrianna	F	2/18/1973	7348860	Smith, Joe	N	N	10/10/2022	Augustine, Greg	Main St. Office
Neighborhood Health Center	1100526	See, Tennille	F	11/18/1973	1035711	Bar, Samuel	N	N	6/16/2022	Pane, Janet	Neighborhood Medica
Family Health Center	1101953	Briner, Louann	F	6/3/1991	4536710	Plant, Robert	N	N	9/18/2022	Houser, Dougie	1st St. Clinic
Access Community Health	1101962	Bouley, Johnson	F	7/26/1979	8117792	Decelles, Larry	N	N	1/22/2023	Black, Ronda	1400 Cambridge St.
Access Community Health	1102606	Welchman, Xiao	F	8/13/1968	7086564	Decelles, Larry	N	N	1/17/2023	Smith, Joe	70 Blanchard Rd.
Access Community Health	1101361	Frakes, Brittni	F	12/22/1971	2020064	Gunther, Eric	N	N	12/30/2022	Gunther, Eric	Main St. Office

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Notice that the filter bar from the Measure Analyzer has not changed. If you decide you want to add additional filter(s) to the measure, you can select what you want to add, then click update. This will change the data in the Measure Analyzer and Detail List tabs.

The patient detail box contains patient demographic and clinical information, organized like a registry. More detailed information about registries will be covered in a later section of this guide. Using the scroll bar at the bottom of the patient detail box lets you see the full scope of clinical information provided. The columns will depend on the measure you are looking at. It will generally include the patient's most recent encounter, next appointment, most recent documented history of completing the measure, and any exclusionary information. A close-up of some of the columns in the patient detail box is seen below.

		PAP			HPV SCREENING			HYSTERECTOMY		CERVICAL ABSENCE DX		HOSPICE CARE
CENTER NAME	MRN	DATE	RESULT	CODE	DATE	RESULT	CODE	DATE	CODE	DATE	CODE	DATE
Neighborhood Health Center	1103270	4/4/2021	Y	Pap	1/24/2022	Y	38372-9	4/4/2021	Hysterectomy Partial Ovaries Remain			
Family Health Center	1102667	9/27/2021	Y	Pap				9/27/2021	Cervical Stump Excision			
Access Community Health	1103215				1/18/2023	Y	38372-9	8/23/2022	Cervical Stump Excision			
Family Health Center	1104633											
Family Health Center	1102701				4/28/2022	Y	38372-9	4/28/2022	Hysterectomy Partial Ovaries Remain			
Access Community Health	1104284							11/30/2022	Hysterectomy Partial Ovaries Remain			
Family Health Center	1103901	4/12/2021	Y	Pap				2/22/2023	Hysterectomy Partial Ovaries Remain			
Neighborhood Health Center	1103418	2/26/2021	Y	19766-5	2/26/2021	Y	38372-9	10/16/2022	Hysterectomy Partial Ovaries Remain			
Access Community Health	1101546	2/1/2023	Y	Pap	2/1/2023	Y	38372-9	2/1/2023	Cervical Stump Excision			
Family Health Center	1104810							7/1/2022	Cervical Stump Excision			
Family Health Center	1101627				12/3/2022	Y	38372-9	11/8/2022	Hysterectomy Partial Ovaries Remain			
Family Health Center	1102825	6/17/2022	Y	19766-5	12/12/2022	Y	38372-9	12/12/2022	Cervical Stump Excision			
Access Community Health	1100518				6/19/2022	Y	38372-9	11/14/2022	Cervical Stump Excision			
Access Community Health	1102375				8/16/2022	Y	38372-9	11/28/2022	Hysterectomy Partial Ovaries Remain			

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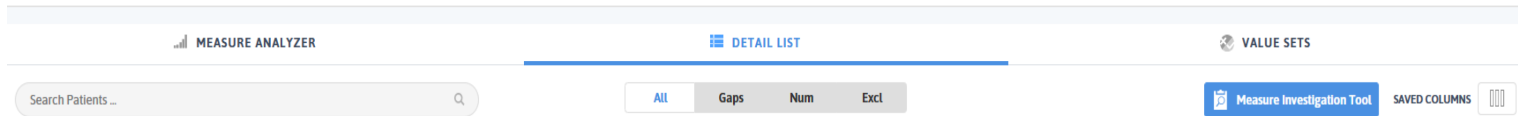
Below the Detail List tab, you have a search bubble to the left that allows you to search patients by name or MRN if you want to look up details on an individual patient. Directly below the Detail List button is a set of boxes for All, Gaps, Num, and Excl. To the right, you have the Measure Investigation Tool and Saved Columns buttons; for the purposes of this guide, we will not get into detail about the functionality of these buttons, nor will the Value Sets tab be discussed. Azara's Quick-Tip Clip at the end of this section icnludes information about these features. A close-up is seen below.



The default when you click on the Detail List tab is the highlighted All button, seen above. This means that all patients who were eligible for meeting the measure in the measurement period and based on the filters applied are shown in the patient details list. In this example, any patient who was eligible for a cervical cancer screening in the measurement period TY Feb 2023, based on age and gender criteria from the measure definition minus exclusion criteria, is seen in the patient detail list. Essentially, the All button refers to the denominator for the measure.

In the bottom left of the patient detail list box, outlined in red below, you have the actual number of patients counted in the measure and the number of patients that can be visible on one page at a time. The number of patients displayed on a single page cannot be changed. To scroll through the list of patients, use the right arrow circled in purple below, at the bottom right of the patient detail box.

The Gaps button, next to the All button, is one of the most useful features of DRVS. When a patient has a care gap, they have not received an age and gender-recommended health care service. The Gaps button shows you the list of patients who were eligible for the service in the measurement period with the filters applied from the filters bar, and who did not meet the criteria for completing the measure. By clicking on the Gaps button, you will see how the patient list changes, most notably with the number of patients making up the total number of patient gaps in the bottom left and the number of pages in the Patient Detail List in the bottom right. Note that this number is the same number in the Gaps box in the Measure Analyzer tab.

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ... | All | Gaps | Num | Excl | Measure Investigation Tool | SAVED COLUMNS

		DEMOGRAPHICS ›							MOST RECENT ENCOUNTER		
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION
Access Community Health	1101910	Wade, Lorrine	F	5/3/1997	3607755	Crowley, Patrick	N	N	7/3/2022	Fritz, Renata	Main St. Office
Access Community Health	1102606	Welchman, Xiao	F	8/13/1968	7086564	Decelles, Larry	N	N	1/17/2023	Smith, Joe	70 Blanchard Rd.
Family Health Center	1104633	Lapham, Johnsie	F	5/13/1986	5065745	Plant, Robert	N	N	8/9/2022	Branchburg, Tom	Lakeview Adult Medici...
Family Health Center	1104397	Methe, Arlene	F	10/8/1986	2018463	Ryan, Frank	N	N	7/23/2022	Weixel, Evan	Lakeview Adult Medici...
Access Community Health	1101005	Brierton, Tran	F	9/24/1978	1852443	Fritz, Renata	N	N	6/24/2022	Gunther, Eric	1400 Cambridge St.
Access Community Health	1103515	Bisaillon, Willena	F	9/28/1988	6978174	Fritz, Renata	N	N	1/23/2023	Smith, Joe	70 Blanchard Rd.
Access Community Health	1100836	Hebden, Dotty	F	12/31/1995	2611160	Bridgewater, Bill	N	N	12/25/2022	Black, Ronda	Main St. Office
Access Community Health	1103454	Smyre, Aide	F	3/20/1988	5369707	Doe, Jane	N	N	9/14/2022	Crowley, Patrick	70 Blanchard Rd.
Access Community Health	1102490	Burtle, Eusebia	F	7/14/1976	4334537	Doe, Jane	N	N	6/30/2022	Crowley, Patrick	Main St. Office
Family Health Center	1103898	Hans, Berry	F	9/11/1998	8924297	Jones, James	N	N	12/25/2022	Weixel, Evan	Lakeview Adult Medici...
Access Community Health	1102985	Daubenspeck, Raylene	F	9/3/1991	7338171	Decelles, Larry	N	N	1/30/2023	Fritz, Renata	Main St. Office
Neighborhood Health Center	1104021	Terepka, Sixta	F	1/8/1966	6201285	Paul, Jessica	N	N	2/24/2023	Parker, Philip	Neighborhood Medical...
Family Health Center	1100139	Boger, Dayna	F	4/13/1989	4307658	Ryan, Frank	N	N	1/28/2023	Rigoli, Brian	1st St. Clinic
Neighborhood Health Center	1100038	Reh, Orville	F	3/17/1997	8484353	Reddington, Robert	N	N	3/27/2022	Pane, Janet	Neighborhood Medical...
Access Community Health	1101299	Uvalle, Angie	F	11/19/1987	6392894	Doe, Jane	N	N	1/12/2023	Black, Ronda	1400 Cambridge St.
Family Health Center	1103664	Sievel, Jacqueline	F	3/19/1983	4250724	Ryan, Frank	N	N	5/17/2022	Weixel, Evan	Lakeview Adult Medici...
Access Community Health	1101042	Applin, Laureen	F	9/11/1982	7122309	Winslow, Francine	N	N	11/5/2022	Winslow, Francine	70 Blanchard Rd.

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To see the list of patients who have completed the measure, click on the Num button. Ideally, you want to have more patients in the Num display, as seen below, than in the Gaps display above. In this demo version, there are, in fact, more patients who have a cervical cancer screening care gap than there are who have completed the measure at any of the health centers that are part of this account. This means that more work needs to be done to get the screening rate up to the target either the health center set for themselves or the target they are using based on center, national, or VBC standards.

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...   All | Gaps | Num | Excl   Measure Investigation Tool   SAVED COLUMNS

		DEMOGRAPHICS >							MOST RECENT ENCOUNTER			N
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION	D
Family Health Center	1101411	Zylka, Tama	F	4/4/1965	6193414	Ryan, Frank	N	N	5/6/2022	Branchburg, Tom	Lakeview Adult Medici...	
Access Community Health	1102245	Pistone, Alda	F	9/24/1989	9032368	Bridgewater, Bill	N	N	10/16/2022	Crowley, Patrick	70 Blanchard Rd.	4
Neighborhood Health Center	1103196	Lesniewski, Justin	F	12/9/1979	6751483	Paul, Jessica	N	N	7/7/2022	Crane, Vince	Neighborhood Medical...	
Access Community Health	1100754	Duos, Loria	F	4/4/1982	2834636	Augustine, Greg	N	N	12/20/2022	Black, Ronda	1400 Cambridge St.	
Family Health Center	1101618	Dambrose, Shavon	F	10/11/1988	5263957	Weixel, Evan	N	N	3/5/2022	Branchburg, Tom	Lakeview Adult Medici...	
Access Community Health	1101792	Reddicks, Meghan	F	8/26/1964	2850419	Doe, Jane	N	N	1/26/2023	Black, Ronda	70 Blanchard Rd.	
Access Community Health	1101196	Perciful, Devora	F	4/15/1969	1854300	Bridgewater, Bill	N	N	9/6/2022	Smith, Joe	Main St. Office	
Neighborhood Health Center	1103531	Bawer, Michiko	F	12/15/1979	8388894	Fay, Tom	N	N	9/24/2022	Crane, Vince	Adult Health	4
Access Community Health	1100673	Feeley, Coreen	F	7/22/1972	7329249	Smith, Joe	N	N	11/22/2022	Fritz, Renata	Main St. Office	
Neighborhood Health Center	1101242	Yeske, Estelle	F	1/12/1965	5767711	Green, Leslie	N	N	10/3/2022	Bar, Samuel	Adult Health	
Family Health Center	1104935	Byfield, Lonnie	F	1/17/1964	9999785	Plant, Robert	N	N	2/1/2023	Branchburg, Tom	1st St. Clinic	
Access Community Health	1103081	Bentancourt, Gabriella	F	3/11/1985	7468714	Crowley, Patrick	N	N	2/15/2023	Bridgewater, Bill	1400 Cambridge St.	
Family Health Center	1102982	Kivel, Madeleine	F	8/21/1965	3858103	Branchburg, Tom	N	N	1/3/2023	Houser, Dougie	Florence Ave. Center	
Access Community Health	1103643	Vainio, Makeda	F	9/28/1992	7787286	Fritz, Renata	N	N	2/9/2023	Decelles, Larry	Main St. Office	
Family Health Center	1103202	Weafer, Jazmin	F	9/27/1986	5275584	Ryan, Frank	N	N	9/4/2022	Jones, James	1st St. Clinic	
Access Community Health	1100215	Sanislo, Stephaine	F	11/17/1971	8509723	Gunther, Eric	N	N	1/14/2023	Black, Ronda	Main St. Office	4
Access Community Health	1102255	Crabtree, Guadalupe	F	3/1/1981	1042777	Winslow, Francine	N	N	11/13/2022	Bridgewater, Bill	Main St. Office	

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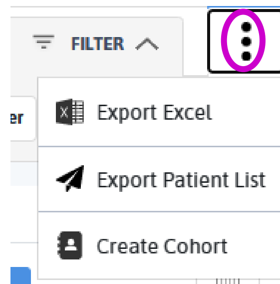
To see details on patients who are excluded from the measure, clicking the Excl button will display these details, as seen below. It is worth mentioning here that the DRVS demo environment does not always contain data that logically makes sense, as is the case for the patient exclusions of this measure. The number of exclusions for a measure is usually much smaller, in comparison to the numerator and gaps. Scrolling all the way over in the Patient Detail List will show the reason the patient was excluded from the measure, which will match the measure description discussed earlier. In the case of cervical cancer screening, having a hysterectomy excludes patients from the denominator.

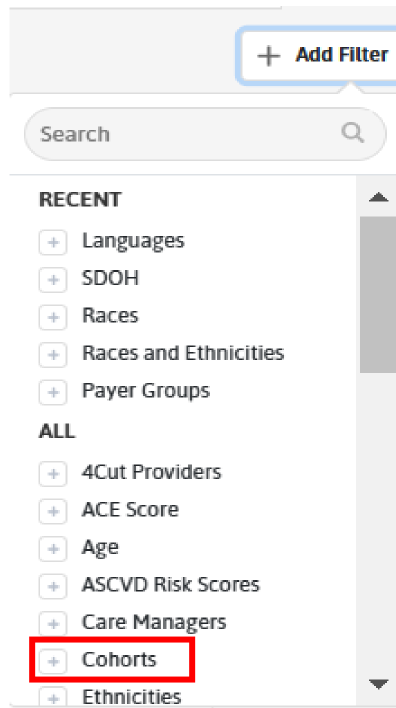
				HYSTERECTOMY		CERVICAL ABSENCE DX		HOSPICE CARE		PALLIATIVE CARE SERVICES	
CENTER NAME	MRN	ULT	CODE	DATE	CODE	DATE	CODE	DATE	CODE	DATE	CODE
Neighborhood Health Center	1103270		38372-9	4/4/2021	Hysterectomy Partial Ovaries Remain					9/12/2022	Palliative Care Services
Access Community Health	1100253			1/13/2023	Hysterectomy Partial Ovaries Remain					1/13/2023	FACIT Palliative Care Questionnaire
Access Community Health	1103215		38372-9	8/23/2022	Cervical Stump Excision					1/18/2023	Palliative Care Services
Access Community Health	1101764			6/19/2022	Hysterectomy Partial Ovaries Remain						
Access Community Health	1101365			7/27/2022	Hysterectomy Partial Ovaries Remain					7/27/2022	FACIT Palliative Care Questionnaire
Neighborhood Health Center	1101827			4/21/2022	Hysterectomy Partial Ovaries Remain						
Neighborhood Health Center	1102624			1/8/2023	Hysterectomy Partial Ovaries Remain					10/24/2022	FACIT Palliative Care Questionnaire
Neighborhood Health Center	1101597			1/24/2022	Cervical Stump Excision						
Access Community Health	1103795		38372-9	8/1/2021	Hysterectomy Partial Ovaries Remain			1/16/2023	Hospice Care	2/18/2023	FACIT Palliative Care Questionnaire
Family Health Center	1102623			4/13/2022	Hysterectomy Partial Ovaries Remain						
Access Community Health	1103946		38372-9	12/4/2022	Hysterectomy Partial Ovaries Remain					9/11/2022	FACIT Palliative Care Questionnaire
Family Health Center	1102666			12/9/2022	Hysterectomy Partial Ovaries Remain						
Access Community Health	1104076		38372-9							11/22/2022	FACIT Palliative Care Questionnaire
Family Health Center	1100007			5/12/2022	Hysterectomy Partial Ovaries Remain						

1 to 14 of 557   Page 1 of 40

The patient detail list is an actionable list: using the 3 stacked dots at the top right of the page, you can either export the patient list to Excel, to a patient outreach platform or create a cohort of the patients from the filters applied in the filters bar and in the patient detail list.



Exporting the patient list to Excel opens each column from the patient details data table into its own column in Excel. The Export Patient List option exports the list to a patient outreach platform that is integrated with DRVS. In Michigan, the two patient outreach platforms integrated with DRVS are Luma Health and Care Message. The Create Cohort option is an advanced option that requires privileges assigned by your Super User. A cohort is a static list of patients who fall in the measurement period and other filters set for the measure. Managing the patient gaps list with this option allows you to track whether these patients comply with performance measures over time. When a cohort is created, it becomes an option in the filters bar to add to future measurement periods.



PRACTICAL APPLICATIONS

One of the most common ways DRVS users incorporate the functionality of the Measures feature into clinical operations is to export the care gap patient detail list to their patient outreach platform and send patients messages requesting they call the clinic to schedule an appointment to have the care gap addressed. To export the patient care gap list, select the Detail List and highlight Gaps. Within the patient list, we recommend you filter for patients who do not have upcoming appointments in the Next Appointment date column, seen below. When the care gap message you send asks patients to call the clinic to schedule an appointment, patients who already have an appointment will presumably have their care gaps addressed at their next appointment when care teams huddle to discuss patient needs for the day. Further discussion into effectively using DRVS to plan for patient visits is discussed later in this User Guide.

PERIOD: TY February 2023 | CENTERS: Family Health Center | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care | + Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ... | All | Gaps | Num | Excl | Measure Investigation Tool | SAVED COLUMNS

					MOST RECENT ENCOUNTER			NEXT APPOINTMENT			
CENTER NAME	MRN	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION	DATE	PROVIDER	LOCATION	APPOINTMEN
Family Health Center	1100296	Plant, Robert	N	N	9/1/2022	Mejido, Daniel	Florence Ave. Center				
Family Health Center	1103664	Ryan, Frank	N	N	5/17/2022	Weixel, Evan	Lakeview Adult Medicine				
Family Health Center	1104106	Weixel, Evan	N	N	11/26/2022	Ryan, Frank	Lakeview Adult Medicine				
Family Health Center	1100596	Mejido, Daniel	N	N	10/14/2022	Weixel, Evan	1st St. Clinic				
Family Health Center	1104397	Ryan, Frank	N	N	7/23/2022	Weixel, Evan	Lakeview Adult Medicine				
Family Health Center	1100139	Ryan, Frank	N	N	1/28/2023	Rigoli, Brian	1st St. Clinic				
Family Health Center	1103898	Jones, James	N	N	12/25/2022	Weixel, Evan	Lakeview Adult Medicine	6/24/23 8:0...	Jones, James	FHC - Needs Upd...	Annual Visit
Family Health Center	1104633	Plant, Robert	N	N	8/9/2022	Branchburg, Tom	Lakeview Adult Medicine				
Family Health Center	1104709	Houser, Dougie	N	N	11/14/2022	Cote, David	1st St. Clinic				

To remove patients who have upcoming appointments from the patient details data table to the right of the Date sub-column header, click the 3 stacked bars to open a pop-up window. In the drop-down box that defaults to After, select No Date. You will notice the number of patients in the bottom left change of the page adjust. From there, click the 3 stacked dots at the top right of the page and select Export Patient List. This will open a window to name the patient care gap list. It is recommended you provide enough detail so there is no ambiguity with what patient population you are providing outreach to. Standard nomenclature should include the measurement period and measure name, along with any other filters you may have applied (ie. language, rendering site, rendering provider, etc.) In this example of cervical cancer screening patient care gaps, a good name would be 'TY Feb 2023 cervical cancer care gaps.' The steps for exporting the patient list are shown sequentially, below.

PERIOD: TY February 2023 | CENTERS: Family Health Center | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care | + Add Filter

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ... | All | 1. Gaps | Num | Excl | Measure Investigation Tool

					MOST RECENT ENCOUNTER			NEXT APPOINTMENT
CENTER NAME	MRN	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION	2 DA... 3 No Date / Clear
Family Health Center	1100296	Plant, Robert	N	N	9/1/2022	Mejido, Daniel	Florence Ave. Center	
Family Health Center	1103664	Ryan, Frank	N	N	5/17/2022	Weixel, Evan	Lakeview Adult Medicine	
Family Health Center	1104106	Weixel, Evan	N	N	11/26/2022	Ryan, Frank	Lakeview Adult Medicine	
Family Health Center	1100596	Mejido, Daniel	N	N	10/14/2022	Weixel, Evan	1st St. Clinic	
Family Health Center	1104397	Ryan, Frank	N	N	7/23/2022	Weixel, Evan	Lakeview Adult Medicine	
Family Health Center	1100139	Ryan, Frank	N	N	1/28/2023	Rigoli, Brian	1st St. Clinic	
Family Health Center	1104633	Plant, Robert	N	N	8/9/2022	Branchburg, Tom	Lakeview Adult Medicine	
Family Health Center	1104709	Houser, Dougie	N	N	11/14/2022	Cote, David	1st St. Clinic	

FILTER 4

Export Excel

5 Export Patient List

Create Cohort

Export Patient List

You have reqested 2182 records to be sent to your SFTP folder.

We'll follow up shortly with an email containing the results of your request.

Name 6

Please provide a friendly name that can be used to identify the transfer.

Cancel | 7 Confirm

Once you confirm the export, when you log in to your patient outreach platform, you will be able to send your care gap message. If your center does not have a patient outreach platform that is integrated with Azara, you can export the patient list to Excel, save it in the appropriate format, and upload it to the system you use.

MPCA created the below recommended monthly outreach calendar that health centers can follow or adapt to their own needs. It is recommended that you limit sending care gap messages to one or two types per month because sending too many can cause patients to ignore or opt out of the messages altogether. This resource can be e-mailed to you by contacting Amy Zarr-McDonagh at azarr@mpca.net.

	January	February	March	April	May	June	July	August	September	October	November	December
Gap in Care Focus Measure(s)	Cervical Cancer Screening HbA1C Testing	Controlling High Blood Pressure	Colorectal Cancer Screening	BMI Screening and Follow-Up / Counseling HbA1C Testing	Child and Adolescent Immunizations	Chlamydia Screening	HbA1C Testing	Controlling High Blood Pressure	Child and Adolescent Immunizations	Breast Cancer Screening HbA1C Testing	Tobacco Use Screening and Cessation Counseling	
Other Suggested Measures		Statin Therapy for Cardiovascular Disease Use of Aspirin or Another Antiplatelet for IVD		Diabetes Care-Eye Exam		HIV Screening		Dental Sealants for Children 6-9 Lead Screening	Influenza Vaccination	Depression Screening/Follow-Up/Remission		

You will notice in the above calendar there are no care gap outreach messages for December. This is because health center efforts are focused on getting ready for UDS submission at the beginning of the new year by making sure data is correctly documented within the EHR for ease of reporting.

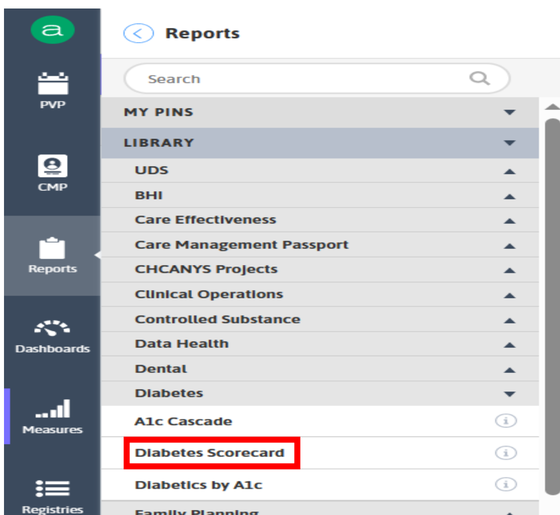
The Quick-Tip Clip for the Measure Analyzer can be viewed here: DRVS Measure Analyzer.

Using the Measures feature in DRVS is a useful tool to help you familiarize yourself with how different measures are satisfied and what it means for a patient to be compliant on a measure or have a care gap. When you want to look at multiple measures at the same time, using the Reports feature will accomplish this task.

IV. REPORTS

ACCESSING REPORTS

Reports in DRVS are groups of related measures that can be viewed at the same time. They are organized into a scorecard. To access Reports in DRVS, simply click on the Reports button on the Left Navigation Bar. This opens a list of report categories; expanding a category allows you to select a report, like the Measures button, seen below. Hovering your mouse/touchpad pointer over the “i” in the circle to the right of the report name provides a description of the report. Some of the more commonly used reports by our health centers include the universal data system (UDS), patient-centered medical home (PCMH), and transitions of care (TOC) reports. Any reports you have pinned will be at the top of the list. You can also search for a report in the search bubble. Some of the report categories are custom to MPCA's network and are not available to other DRVS PCA networks. Once you select the report you would like to view, it displays the data in scorecard format. For demonstrating how to use a report, we will use the diabetes report as an example.



THE REPORTS SCORECARD

Clicking on the diabetes scorecard report takes you to a new page with the diabetes scorecard.

Diabetes Scorecard
REPORT

PERIOD: TY February 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Diabetes: Eye Exam (CMS 131v9)	89.4%	50.0%	1,456	1,629	17
Diabetes Foot Exam (NQF 0056)	64.8%	37.0%	1,075	1,659	17
Diabetes BP < 130/80	45.1%	37.0%	734	1,629	17
Diabetes BP < 140/90	81.0%	24.0%	1,320	1,629	17
Diabetes Depression Screening	100.0%	48.0%	992	992	654
Diabetes Tobacco Use Assessment and Cessation	75.2%	27.0%	1,197	1,591	55
Diabetes: Medical Attention for Nephropathy (CMS 134v9)	99.3%	48.0%	1,617	1,629	17

Note that in the filters bar, the primary care service line is not a default setting when accessing reports. If you want to know which primary care (or any other service line) patients are and are not compliant with the measure in the scorecard, you will need to add the filter and update the scorecard, as described in the Measures section. Otherwise, patients receiving any type of service at your health center, including patients who may only see your dental or behavioral health providers, will be included in the scorecard. The new scorecard with the primary care service line is displayed below:

Diabetes Scorecard
REPORT

PERIOD: TY February 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Diabetes: Eye Exam (CMS 131v9)	92.2%	50.0%	1,140	1,236	11
Diabetes Foot Exam (NQF 0056)	67.7%	37.0%	854	1,261	11
Diabetes BP < 130/80	46.0%	37.0%	569	1,236	11
Diabetes BP < 140/90	82.8%	24.0%	1,023	1,236	11
Diabetes Depression Screening	100.0%	48.0%	732	732	515
Diabetes Tobacco Use Assessment and Cessation	78.6%	27.0%	949	1,208	39
Diabetes: Medical Attention for Nephropathy (CMS 134v9)	99.3%	48.0%	1,227	1,236	11

Each diabetes care measure has its own line in the scorecard. Clicking on any of the measures will take you to the Measure Analyzer. In the next column over, the Result column is the performance on the measure after filters are applied in the filters bar. If performance has met the 90th percentile target, the result will be highlighted in green. If the result is between the 75th and 89th percentile target, it will be highlighted yellow. When the result has not met the measure target, it will be highlighted in red. The Target column represents the 90th percentile target. The remaining columns in the scorecard display the numerator, denominator, and exclusions for each measure. Clicking the down arrow next to any of the Exclusions will download the patient detail list for that measure and allow you to open it in Excel. You can export the entire scorecard to Excel or as a pdf by clicking the 3 stacked dots at the top right of the

screen. The scorecard will display in Excel exactly as you see it, with each data element occupying its own cell. You can save the scorecard to your pins by clicking the pin at the top right of the screen and checking the box to save to My Pins.

CARE GAPS

To see details on patients who have multiple care gaps across scorecard measures, click on the care gaps tab next to the report tab. The default setting displays patients with care gaps who do not have an upcoming appointment. They represent the most actionable aspects of the scorecard. These are patients you will want to reach out to via phone call, text, or e-mail with a patient outreach platform to encourage them to schedule a follow-up with their PCP to ensure all their healthcare needs are met.

Diabetes Scorecard
REPORT

PERIOD: TY February 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care

FILTER | Add Filter | Update

REPORT | CARE GAPS

Search ... | GAPS: Gaps Present | All | Has Appt | No Appt | SAVED COLUMNS

	DEMOGRAPHICS >		GAP		MEASURES				
CENTER NAME	NAME	MRN	COUNT	DESCRIPTION	DM EYE EXAM	DM FOOT EXAM	DM BP < 130/80	DM BP < 140/90	DM DEPRESSIO
Family Health Center	Vermeulen, Nedra	1100134	3	DM Foot, BP outside range		gap	gap		
Neighborhood Health Center	Corbell, Hubert	1101419	3	DM Foot, BP outside range		gap	gap		
Family Health Center	Deflorio, Rudolf	1102851	2	BP outside range			gap	gap	
Neighborhood Health Center	Scharmann, Joellen	1100002	2	DM Foot, BP outside range		gap	gap		
Family Health Center	Calverley, Hayden	1101530	1	BP outside range			gap		
Family Health Center	Malekan, Kami	1102742	1						
Family Health Center	Coopage, Ezequiel	1104011	1	DM Foot		gap			
Neighborhood Health Center	Glas, Lonnie	1100475	1	BP outside range			gap		

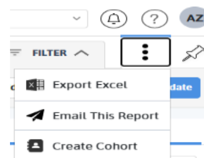
As you scroll across the care gaps table, each measure has its own column and gaps are indicated in red, as seen above. You will also see when each patient's last appointment was, as seen below. If you want to see all patients in the scorecard with care gaps, or just patients with care gaps and an upcoming appointment, you can select the All or Has Appt buttons, respectively.

REPORT | CARE GAPS

Search ... | GAPS: Gaps Present | All | Has Appt | No Appt | SAVED COLUMNS

	DEMOGRAPHICS >		GAP		MEASURES				
CENTER NAME	NAME	MRN	COUNT	DESCRIPTION	DM EYE EXAM	DM FOOT EXAM	DM BP < 130/80	DM BP < 140/90	DM DEPRESSION
Family Health Center	Vermeulen, Nedra	1100134	3	DM Foot, BP outside range		gap	gap		
Neighborhood Health Center	Corbell, Hubert	1101419	3	DM Foot, BP outside range		gap	gap		
Family Health Center	Deflorio, Rudolf	1102851	2	BP outside range			gap	gap	
Neighborhood Health Center	Scharmann, Joellen	1100002	2	DM Foot, BP outside range		gap	gap		
Family Health Center	Calverley, Hayden	1101530	1	BP outside range			gap		
Family Health Center	Malekan, Kami	1102742	1						
Family Health Center	Coopage, Ezequiel	1104011	1	DM Foot		gap			
Neighborhood Health Center	Glas, Lonnie	1100475	1	BP outside range			gap		

When viewing the scorecard's care gaps, you have options for distributing the scorecard. Clicking the stacked 3 dots at the top right of the page gives you the option to export the scorecard to Excel, e-mail it, or create a cohort if you have cohort privileges.



Exporting the scorecard to Excel displays each data column and data element in its own cell. Often, Quality Improvement staff at health centers will e-mail the scorecard report to providers on a monthly or quarterly basis to help providers focus on groups of measures they need to improve their performance on. Creating a cohort from the patient care gap list Reports feature in DRVS allows you to track patients with one or more care gaps in the scorecard at a fixed point in time and whether those care gaps get closed at a later point in time by adding the cohort to the filters bar when the report is run in the future.

CUSTOMIZATION

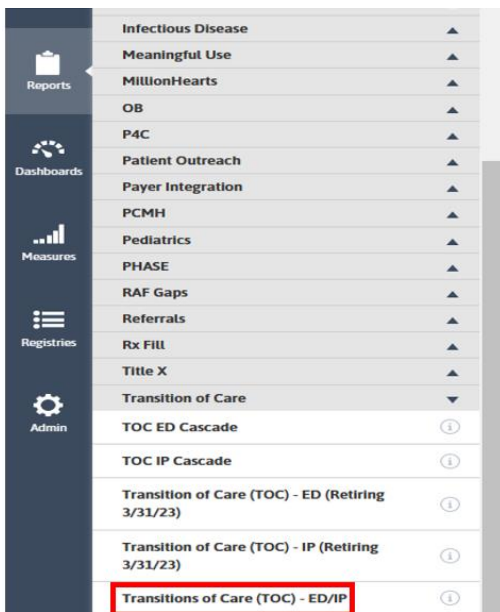
If you are looking through the existing reports in DRVS and find that a report with all the measures you want to compare performance on does not currently exist, Azara allows for the customization of reports. Creating a custom report requires special administrative privileges that your health center's Super User will have. Alternatively, for help creating a custom scorecard report, MPCA's data team (Cheryl Gildner, Ashley Wozniak, and Hallie Rennaker) can assist.

PRACTICAL APPLICATIONS

With the many reports and the ability to create customized reports in DRVS, managing the healthcare needs of patients with multiple care gaps becomes much easier. Many of the existing reports in DRVS are focused on eCQMs. Other types of reports exist in DRVS, including operational, financial, and transitions of care (TOC) reports. For this section, we will focus on how using the transitions of care reports can help improve patient outcomes while reducing healthcare costs and increasing revenue through the transitional care management (TCM) billing process and meeting VBC performance goals. For more information about care management practices, please refer to the Care Management User Guide developed by Shelly Hathaway, MPCA's Nurse Care Consultant.

When one of your patients receives care in an emergency department (ED) and/or is admitted as an inpatient (IP), DRVS receives information through the hospital's admission, discharge, and transfer (ADT) feed through the state's health information exchange (HIE). Standard practice dictates that once a patient is sent home from the hospital, they have a timely follow-up with their primary care provider to ensure continuity of care and patient conditions are effectively managed. The Transitions of Care (TOC)-ED/IP report can be used to identify which patients have been released and which ones need to be scheduled with their primary care provider.

To access the Transitions of Care (TOC)- ED/IP report, click the Reports button in the left navigation panel, scroll the Reports categories list to the bottom to open the Transitions of Care category, and click on the Transitions of Care (TOC)-ED/IP report name.



From there, TOC outreach staff can view the list of patients who do not have upcoming appointments and initiate the TCM process by calling the patients to help them schedule an appointment with their PCP. Many health centers will employ RN Care Managers (CMs) to serve this function because they are credentialed to submit enhanced billing codes for reimbursement.

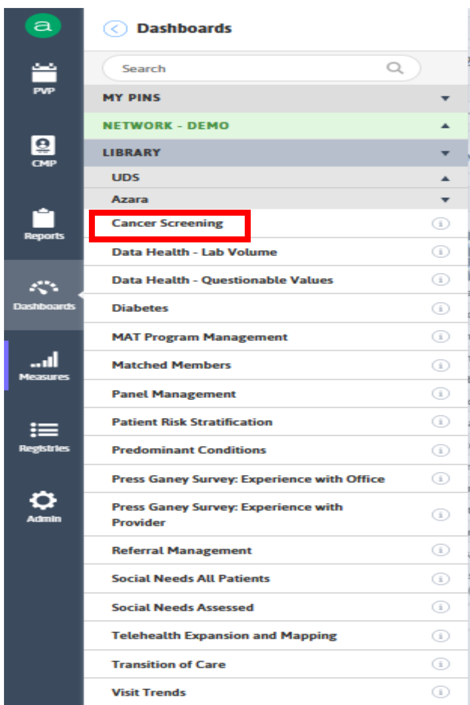
To see the Quick Tip Clip for Using the Reports feature in DRVS, you can access it at the following link: DRVS Scorecards.

V. DASHBOARDS

The dashboards feature in DRVS contains performance on measures related to one another that are visualized in different ways. Each measure within a dashboard has its own widget, and each dashboard has its own unique widgets.

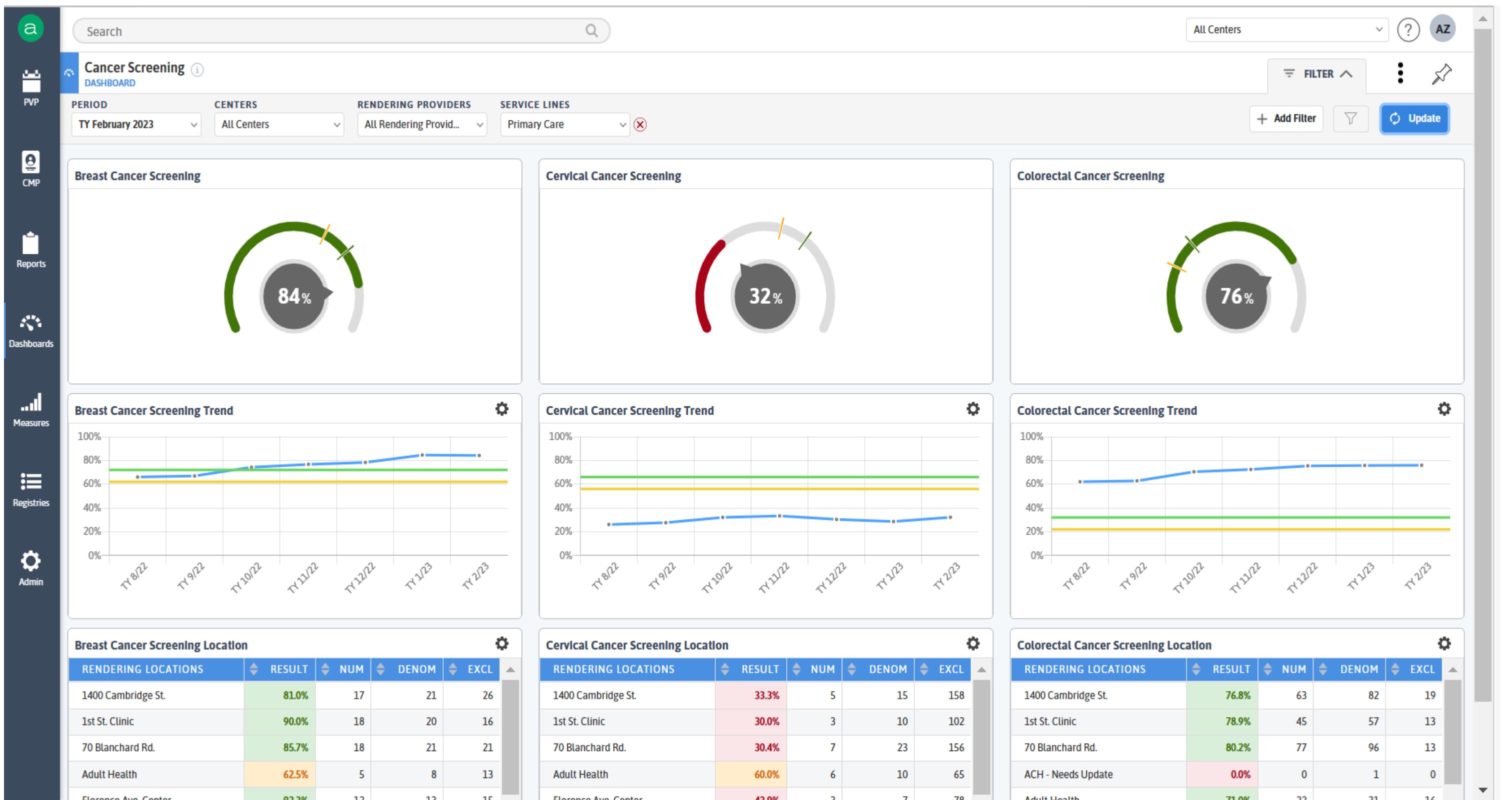
ACCESSING DASHBOARDS

To access dashboards in DRVS, click the Dashboards button on the Left Navigation Bar. This will open the categories of dashboards available in DRVS. Clicking the arrow to the right of the dashboard category name opens the category to show the list of dashboards within that category. Your pinned dashboards will be at the top of the list. Most dashboards will be found under the Azara category and are available to all MPCA health centers. In 2022, Michigan FQHCs most frequently used Patient Risk Stratification, Referral Management, Panel Management, Transitions of Care, and UDS Adult Preventive dashboards. You can also search for a dashboard using the search bubble above the list of dashboard categories. Hovering over the circle “i” next to the dashboard name will give you a description of the widgets in the dashboard, what measures are associated with the dashboard, and examples of how you might want to use the dashboard as part of your center’s clinical operations. In the following example, we will use the Cancer Screening dashboard to demonstrate how the measures are visualized in different ways.



DASHBOARDS DISPLAY

Once you click on the Cancer Screening dashboard under the Azara category, a new page opens with the filters bar at the top and the different widgets that make up the Cancer Screening dashboard below. The Dashboards feature default filters bar does not include a service line, so the primary care service line has been added in the screenshot below. Additional filters are also available to narrow performance on the metrics within the dashboard. To save a dashboard and make it easily accessible for later use, click the pin at the top right of the page and save it to My Pins.



Within a dashboard, clicking on the circled "i" next to the dashboard name opens a pop-up window with the dashboard description. The description for the Cancer Screening dashboard is below.

Cancer Screening

Created By: Azara
Created On: 2/3/2023 10:22:09 PM

Modified By: Azara
Modified On: 2/3/2023 10:22:09 PM

Cancer Screening

This dashboard provides an overview of performance on three cancer screening measures: breast cancer, cervical cancer, and colorectal cancer.

The gauge widget shows the status for the selected period. The trend lines shows measure performance for the period selected. To change the display of the trend line to a table, column, or bar chart, click the gear icon on the widget. The location widgets display performance on the measure by location. To change the display of the location table to a table, column or bar chart, click the gear icon on the widget.

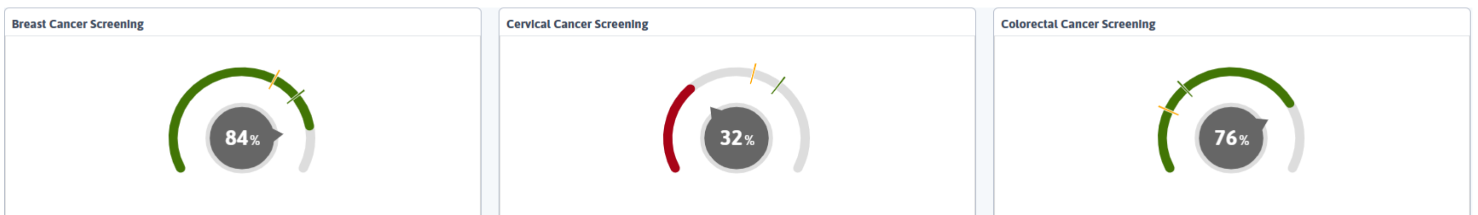
The measures utilized in this dashboard are:

- Breast Cancer Screening Ages 50-74 (NQF 2372)
- Cervical Cancer Screening (NQF 0032)
- Colorectal Cancer Screening (NQF 0034)

Uses for this dashboard:

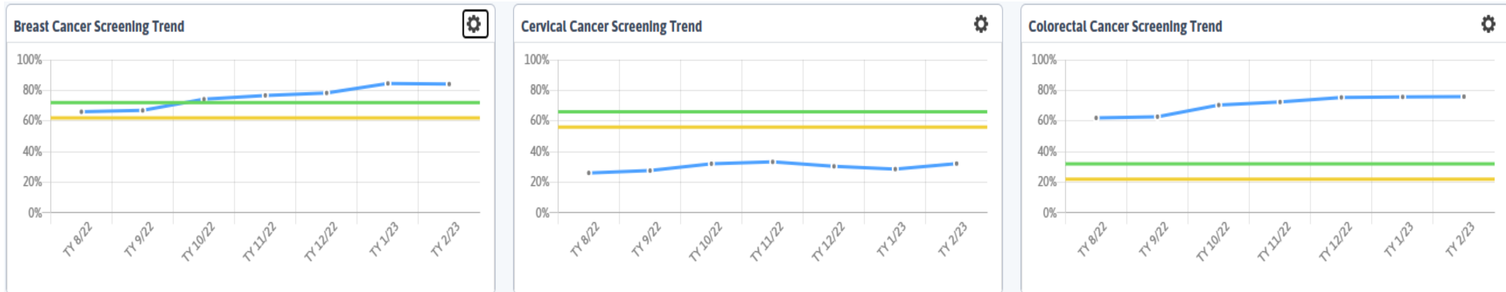
- Monitor how you are screening your population for breast, cervical, and colorectal cancer.
- Identify locations that are screening better or worse than others and utilize that information for performance improvement activities.
- Distribute the dashboard to the clinical leadership team to keep them informed of current screening statuses.

Within the Cancer Screening dashboard, there are 3 rows of widgets, containing 3 widgets each, 1 for each cancer screening measure. The top row of widgets contains the overall performance of the health centers in the Demo environment, displayed as a dial, as seen below.



The green and yellow primary and secondary goals, respectively, are indicated to show how close to meeting those goals your center is. If you hover over the performance rate in the middle of the dial, performance to the nearest 1/10th of a decimal place and the numerator, denominator, and exclusions for the measure pops up.

The next row of widgets in the Cancer Screening dashboard are run charts for each of the cancer screening measures. The look-back period in for the run charts in the Dashboards is shorter than the look-back period in the Measure Analyzer.



Hovering over each data point in the run chart shows the performance to the nearest 1/10th of a decimal place and the numerator, denominator, and exclusions for the measure. The green and yellow primary and secondary performance targets, respectively, are also displayed in the run charts.

The last row of widgets in the Cancer Screening dashboard shows a data table of performance on each measure for each site within a healthcare organization. Each site has its own line in the data table. The numerator, denominator, and exclusions for the measure are shown next to each site.

Breast Cancer Screening Location

RENDERING LOCATIONS	RESULT	NUM	DENOM	EXCL
1400 Cambridge St.	80.0%	20	25	31
1st St. Clinic	90.9%	20	22	17
70 Blanchard Rd.	89.7%	26	29	26
Adult Health	62.5%	5	8	14
Florence Ave. Center	88.9%	16	18	17
Lakeview Adult Medicine	87.5%	14	16	19

Cervical Cancer Screening Location

RENDERING LOCATIONS	RESULT	NUM	DENOM	EXCL
1400 Cambridge St.	29.6%	8	27	188
1st St. Clinic	33.3%	6	18	121
70 Blanchard Rd.	30.8%	12	39	185
Adult Health	64.3%	9	14	80
Florence Ave. Center	53.8%	7	13	96
Lakeview Adult Medicine	36.8%	7	19	101

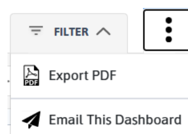
Colorectal Cancer Screening Location

RENDERING LOCATIONS	RESULT	NUM	DENOM	EXCL
1400 Cambridge St.	78.3%	83	106	19
1st St. Clinic	74.6%	50	67	16
70 Blanchard Rd.	76.3%	90	118	17
ACH - Needs Update	0.0%	0	1	0
Adult Health	73.0%	27	37	18
Florence Ave. Center	75.0%	45	60	15

Clicking on the measure name in any of the widgets will take you to the Measure Analyzer, where you can delve into patient-level detail on who is compliant with the screening and who has a screening gap. Any filters applied in Dashboards will carry over to the Measure Analyzer. To go back to the dashboard without having to reapply your settings, click the left-pointing arrow next to the measure name in the Measure Analyzer.

DISTRIBUTING DASHBOARDS

Clicking the 3 stacked dots next to the pin in the top right of the page allows you to see your options for distributing the dashboard: exporting as a pdf and e-mailing the dashboard. Selecting to e-mail the dashboard creates a pop-up to set how often and to whom the dashboard will be sent. Typically, staff from your QI department will arrange this.



CUSTOMIZATION

As with Reports, the Dashboards feature in DRVS also has the option for customization. A customized dashboard may be warranted if the groups of measures you want to look at are not part of an existing dashboard. To create your own dashboard, you will need administrative privileges, so your Super User and/or anyone else with those privileges at your center can help create a customized dashboard. Customizing a dashboard lets you choose the types of widgets and how the data is displayed in the widgets. You can also e-mail MPCA's Data Team for support in creating a customized dashboard.

PRACTICAL APPLICATIONS

As mentioned earlier in this section, the dashboard description provides practical use examples. Following these guidelines will help ensure that the Dashboards feature is utilized effectively and contribute to performance improvement. For example, any of the dashboards containing eCQMs can be e-mailed to providers, so they are aware of their performance on your center's priority measures. Distributing other dashboards, such as the Matched Members, Panel Management, and Transitions of Care dashboards, can help improve access to care, provide better continuity of care, allow providers and other clinical and non-clinical support staff to better manage patients' health care needs, and increase revenue for your organization.

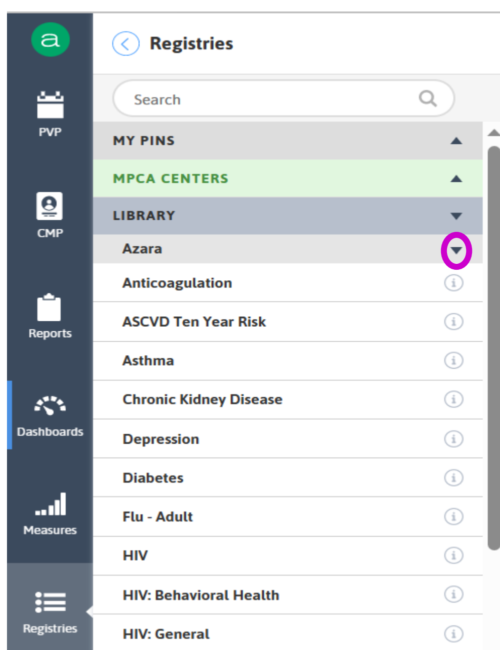
The Quick-Tip Clip for the Dashboards feature can be viewed at the following link: DRVS Dashboards.

VI. REGISTRIES

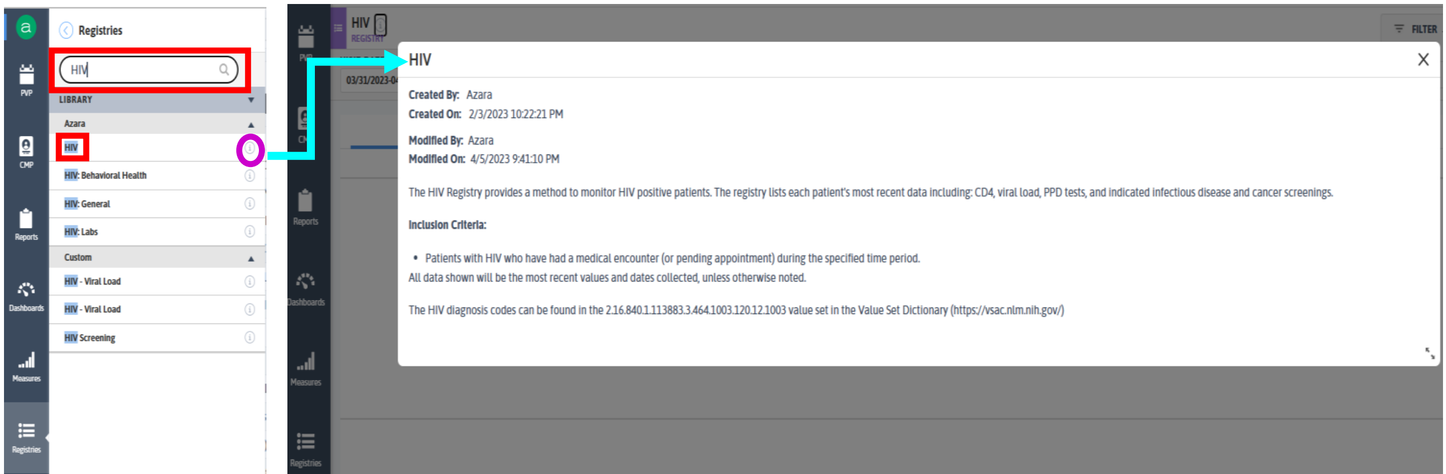
The Registries feature in DRVS displays all patients seen within the same measurement period and their clinical information across clinical measures within the registry type. Registries are useful for learning about your patients' entire care needs that may not otherwise be related. For example, in the Adult Primary Care Registries, you will see clinical information for how recently a patient received services for the UDS measures, whereas a condition specific registry will only contain clinical information for those related measures.

ACCESSING REGISTRIES

To access the Registries feature in DRVS, click the Registries button in the Left Navigation Bar. This will open the list of registry categories, with any pinned registries at the top. Most pre-loaded registries created by Azara are found under the Azara category. Scrolling down within the category will allow you to see the full list of registries.



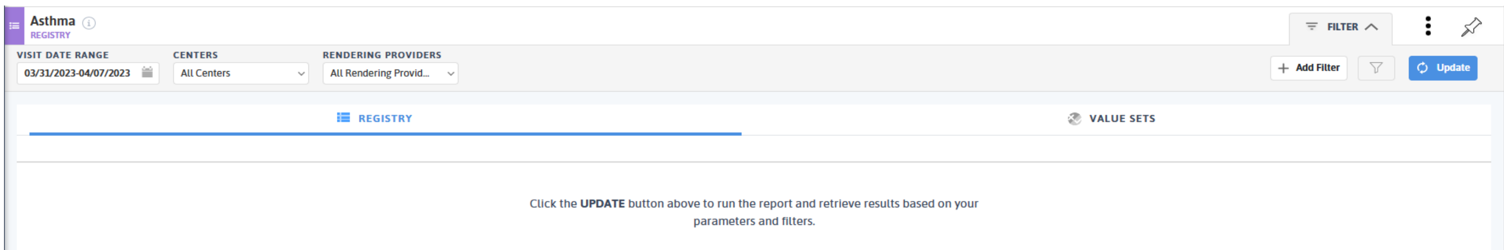
You can also search for an existing registry using the search bubble, as seen below. Hovering over the “i” to the right of the registry name pops up a window with the registry description, inclusion, and exclusion criteria. You can also view this information by clicking the “i” next to the registry name when you are in the registry itself.



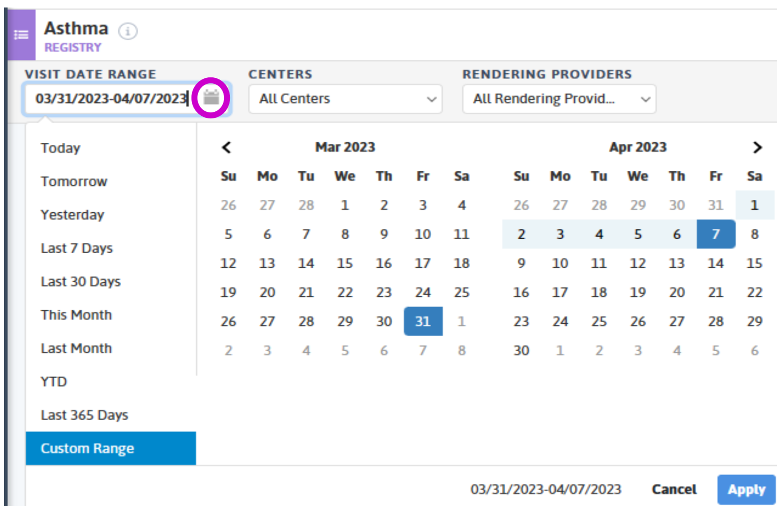
REGISTRIES DISPLAY

Now, let us look at a registry within DRVS and see the patient and clinical data elements contained in it. We will use the asthma registry for our example. Again, the patient details you will see are from DRVS’ demo environment, so they are not real patients.

When you click on the asthma registry under the Azara category, patient data does not appear, initially; you first must set any filters you want to apply and click the blue update button.



The visit date range will default to the current date plus the previous 7 days. When you click on the calendar icon in the visit date range box in the filters bar, it opens date range options to choose from, including setting a custom date range. The registries feature is the only feature in DRVS which allows you to set a custom date range.



Registries can be run retrospectively, looking at patients who had visits in the past, or prospectively, to see clinical information on patients who have upcoming appointments. In the following screenshots, we will look at patients who were seen the previous day and identify the care needs these patients have. You can search for a specific patient by name, MRN number, or Medicaid number to view clinical information for a single patient in the registry using the search bubble below the blue registry button.

PVP
CMP
Reports
Dashboards
Measures
Registries
Admin

Asthma
REGISTRY

FILTER

VISIT DATE RANGE 04/06/2023-04/06/2023
CENTERS All Centers
RENDERING PROVIDERS All Rendering Provid...

+ Add Filter
Update

REGISTRY
VALUE SETS

Search Patients ...

SAVED COLUMNS

		DEMOGRAPHICS ›	INSURANCE		MOST RECENT ENCOUNTER			NEXT APPOINTMENT			
CENTER NAME	MRN	NAME	FINANCIAL CLASS	PRIMARY PAYER	DATE	PROVIDER	LOCATION	DATE	PROVIDER	LOCATION	APPOINTMENT TY
Neighborhood Health Center	1100174	Miccio, Keneth	Private Insurance	BCBS	2/23/2023	Cranston, Bill	Neighborhood Medical Center	2/22/2023	Cranston, Bill	NHC - Needs Update	Injury
Access Community Health	1100191	Hickox, Reyes	Medicare	Medicare	5/23/2022	Winslow, Francine	1400 Cambridge St.	3/4/2023	Fritz, Renata	ACH - Needs Update	Mental Health and C
Neighborhood Health Center	1100210	Adamcik, Guy	Private Insurance	BCBS	10/12/2022	Parker, Philip	Main Office	2/21/2023	Bar, Samuel	NHC - Needs Update	Physical
Family Health Center	1100231	Kostic, Bart	Medicare	Medicare	1/19/2022	Weixel, Evan	1st St. Clinic	3/6/2023	Plant, Robert	FHC - Needs Update	Office visit
Access Community Health	1101437	Pollen, Neta	Private Insurance	Aetna	2/25/2022	Decelles, Larry	1400 Cambridge St.	2/10/2023	Smith, Joe	ACH - Needs Update	Office visit
Family Health Center	1101463	Kittrell, Valentin	Medicaid	Medicaid	3/28/2021	Branchburg, Tom	Florence Ave. Center	2/12/2023	Mejido, Daniel	FHC - Needs Update	Physical
Family Health Center	1101469	Kehres, Alfredo	Private Insurance	Coventry	12/7/2022	House, Gregory	1st St. Clinic	4/4/2023	Cote, David	FHC - Needs Update	High BP
Neighborhood Health Center	1102608	Tanigawa, Pat	Private Insurance	Aetna	12/8/2021	Crane, Vince	Adult Health	2/18/2023	Parker, Philip	NHC - Needs Update	Sick Visit
Family Health Center	1102666	Ahuna, Rosemarie	Medicare	Medicare	12/9/2022	Houser, Dougie	Lakeview Adult Medicine	2/21/2023	Ryan, Frank	FHC - Needs Update	Injury
Access Community Health	1103807	Staubin, Jeremiah	Medicaid	Medicaid	12/2/2022	Bridgewater, Bill	1400 Cambridge St.	2/9/2023	Bridgewater, Bill	ACH - Needs Update	Mental Health and C
Neighborhood Health Center	1103852	Rothenberg, Valentine	Private Insurance	BCBS	3/1/2022	Green, Leslie	Main Office	3/6/2023	Bar, Samuel	NHC - Needs Update	Office visit
Access Community Health	1103856	Sergi, Darby	Private Insurance	Coventry	2/24/2023	Crowley, Patrick	1400 Cambridge St.	2/11/2023	Augustine, Greg	ACH - Needs Update	Injury
Family Health Center	1103870	Sendro, Ernestina	Private Insurance	Coventry	8/4/2022	Jones, James	1st St. Clinic	3/17/2023	Jones, James	FHC - Needs Update	Mental Health and C
Neighborhood Health Center	1103907	Rongstad, Antony	Medicare	Medicare	10/31/2022	Cranston, Bill	Adult Health	3/27/2023	Cranston, Bill	NHC - Needs Update	Annual Visit
Neighborhood Health Center	1100335	Mcgirr, Vaughn	Private Insurance	Coventry	9/23/2022	Cranston, Bill	Neighborhood Medical Center	2/16/2023	Crane, Vince	NHC - Needs Update	Mental Health and C
Access Community Health	1100351	Cornelison, Emery	Private Insurance	Coventry	10/1/2022	Smith, Joe	Main St. Office	3/12/2023	Decelles, Larry	ACH - Needs Update	Annual Visit

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In the patient data table, you will first find information about the patient, their most recent encounter, and their next scheduled appointment. If this were a live registry that contained real patient data, the 'Most Recent Encounter' date column would have dates only for the visit date range matching the measurement period in the filters bar; the dates you see in the above registry is another example of the Demo environment not always presenting logically. The exception to this would be if the provider had not closed out the encounter in the EMR, so DRVS would not recognize the visit as complete.

Above the patient's name column is the heading for 'Demographics.' When you click the right-facing arrow, it expands additional columns containing patient demographic information, as seen below. You can use the scroll bar at the bottom of the table to see patient contact information.

Asthma
REGISTRY

VISIT DATE RANGE: 04/06/2023-04/06/2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

FILTER | Add Filter | Update

REGISTRY | VALUE SETS

Search Patients ... | SAVED COLUMNS

		DEMOGRAPHICS								
CENTER NAME	MRN	NAME	USUAL PROVIDER	SEX AT BIRTH	DATE OF BIRTH	RACE	ETHNICITY	LANGUAGE	ADDRESS	CITY
Neighborhood Health Center	1100174	Miccio, Keneth	Parker, Philip	M	10/24/1976	American Indian/Alaska Native	Non-Hispanic/Latino	English	80 North St.	Mancheste
Access Community Health	1100191	Hickox, Reyes	Decelles, Larry	F	2/26/1975	Unreported/Refused to Report Race	Non-Hispanic/Latino	Spanish	741 West St.	Milton
Neighborhood Health Center	1100210	Adamcik, Guy	Bar, Samuel	F	10/23/1973	Pacific Islander	Hispanic/Latino	German	446 Second St.	Ashland
Family Health Center	1100231	Kostic, Bart	Houser, Dougie	F	8/13/1966	American Indian/Alaska Native	Unreported/Refused to Report Ethnicity	German	755 Main St.	Fairfield
Access Community Health	1101437	Pollen, Neta	Bridgewater, Bill	M	9/9/1979	Black/African American	Hispanic/Latino	Arabic	500 Lake St.	Waltham
Family Health Center	1101463	Kittrell, Valentin	Branchburg, Tom	M	6/27/2000	White	Hispanic/Latino	German	538 Elm St.	Madison
Family Health Center	1101469	Kehres, Alfredo	Cote, David	F	4/22/1994	White	Hispanic/Latino	Spanish	492 Park St.	Salem
Neighborhood Health Center	1102608	Tanigawa, Pat	Green, Leslie	M	8/28/1989	Pacific Islander	Hispanic/Latino	French	508 West St.	Winchester
Family Health Center	1102666	Ahuna, Rosemarie	Mejido, Daniel	F	12/8/1965	White	Non-Hispanic/Latino	German	562 Fourth St.	Newport
Access Community Health	1103807	Staubin, Jeremiah	Gunther, Eric	M	10/8/2001	American Indian/Alaska Native	Unreported/Refused to Report Ethnicity	English	465 North St.	Clinton
Neighborhood Health Center	1103852	Rothenberg, Valentine	Paul, Jessica	M	11/13/1945	American Indian/Alaska Native	Non-Hispanic/Latino	German	822 North St.	Ashland
Access Community Health	1103856	Sergi, Darby	Decelles, Larry	F	11/7/2001	Asian	Unreported/Refused to Report Ethnicity	English	216 Elm St.	Franklin
Family Health Center	1103870	Sendro, Ernestina	Rigoli, Brian	F	6/2/1975	Black/African American	Non-Hispanic/Latino	English	341 Third St.	Georgetow
Neighborhood Health Center	1103907	Rongstad, Antony	Paul, Jessica	M	3/21/1985	Asian	Hispanic/Latino	German	209 Fourth St.	Burlington
Neighborhood Health Center	1100335	Mcgirr, Vaughn	Green, Leslie	M	5/14/1973	Unreported/Refused to Report Race	Unreported/Refused to Report Ethnicity	English	124 South St.	Waterbury
Access Community Health	1100351	Cornelison, Emery	Black, Ronda	M	6/29/1999	Native Hawaiian	Unreported/Refused to Report Ethnicity	English	269 Main St.	Riverside

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As you scroll past the 'Next Appointment' information, you will see each patient's clinical information related to the asthma measures. The asthma registry contains dates, codes, and additional clinical information for asthma diagnosis and severity, preferred treatment, persistent asthma diagnosis, BMI, Flu shot, and PCV (not seen below). Each clinical registry will contain the clinical data elements specific to the health care services related to each registry.

Asthma
REGISTRY

VISIT DATE RANGE: 04/06/2023-04/06/2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

FILTER | Add Filter | Update

REGISTRY | VALUE SETS

Search Patients ... | SAVED COLUMNS

		ASTHMA DX			ASTHMA SEVERITY			ASTHMA PREFERRED TX			PERSISTENT ASTHMA DX		BMI		
CENTER NAME	MRN	DATE	CODE	SELF MGMT	DATE	CODE	DETAIL	DATE	CODE	NAME	DATE	CODE	DATE	VALUE	FLU DATE
Neighborhood Health Center	1100174	2/23/2023	J45.30	2/23/2023	2/23/2023	J45.30		2/23/2023	313306		2/23/2023	J45.30	2/23/2023	33.0	
Access Community Health	1100191	12/14/2021	493.20	5/23/2022				5/23/2022	313306				5/23/2022	28.0	
Neighborhood Health Center	1100210	10/12/2022	493.20	5/17/2022				10/12/2022	313306				10/12/2022	20.0	
Family Health Center	1100231	6/23/2021	J45.30		6/23/2021	J45.30		6/23/2021	313306		6/23/2021	J45.30	6/23/2021	20.0	
Access Community Health	1101437	5/16/2021	J45.30	2/25/2022	5/16/2021	J45.30		2/25/2022	313306		5/16/2021	J45.30	2/25/2022	28.0	
Family Health Center	1101463	3/28/2021	493.02	3/28/2021	3/18/2021	J45.30		3/28/2021	313306		3/18/2021	J45.30	3/28/2021	20.0	
Family Health Center	1101469	5/11/2022	J45.30	8/1/2022	5/11/2022	J45.30		8/1/2022	313306		5/11/2022	J45.30	8/1/2022	14.0	
Neighborhood Health Center	1102608	12/8/2021	493.20	12/8/2021				12/8/2021	153892				12/8/2021	22.0	
Family Health Center	1102666	12/9/2022	493.02	12/9/2022	4/2/2022	J45.30		12/9/2022	153892		4/2/2022	J45.30	12/9/2022	18.0	
Access Community Health	1103807	12/2/2022	493.02	12/2/2022				12/2/2022	153892				12/2/2022	16.0	
Neighborhood Health Center	1103852	3/1/2022	J45.30	3/1/2022	3/1/2022	J45.30		3/1/2022	153892		3/1/2022	J45.30	3/1/2022	34.0	
Access Community Health	1103856	4/14/2022	493.02	1/12/2022				7/29/2022	313306				7/29/2022	25.0	
Family Health Center	1103870	10/30/2021	493.20	10/30/2021				8/4/2022	313306				8/4/2022	22.0	
Neighborhood Health Center	1103907	10/31/2022	493.02	10/31/2022				8/24/2022	313306				10/31/2022	27.0	
Neighborhood Health Center	1100335	8/8/2022	J45.30	8/8/2022	8/8/2022	J45.30		9/23/2022	313306		8/8/2022	J45.30	9/23/2022	23.0	
Access Community Health	1100351	10/1/2022	J45.30	10/1/2022	10/1/2022	J45.30		11/13/2021	313306		10/1/2022	J45.30	10/1/2022	23.0	

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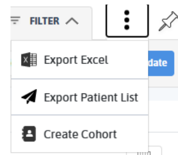
In a live registry with real patient data, you would see a more complete registry. For example, in the 'Asthma Preferred TX' box, under the 'Name' column, you would see the name of the primary medication each patient takes to control their asthma.

MANAGING REGISTRIES

In the top right of the page, you have the stacked 3 dots that allow you to export the registry to Excel, which will take the data from the registry table and assign each data element its own cell, export the patient list, which will transfer the list to either Luma Health or Care Message to send population outreach messages if you have either of those patient outreach platforms integrated with DRVS, or create a cohort of the patients in the registry, if you have Azara privileges to do so. Next to the dots is the pin to save the registry to your pins.



CUSTOMIZING REGISTRIES

The Registries feature in DRVS also allows for customization. For this guide's purposes, we will not detail how to create a custom registry. Your DRVS Super User will have those privileges. MPCA's Data Team can also assist with creating a custom registry for your organization.

PRACTICAL APPLICATIONS

Different staff roles may use the Registries feature in DRVS for different purposes. In the above example of the Asthma registry, we looked at the patients who had a visit the previous day. Quality Department staff might be interested in running a retrospective registry to view which patients had all their care needs met at their most recent office visit and which ones are out of range and require attention to better manage the patient's care needs. To improve health outcomes, Quality Department staff could distribute a provider's list of patients in a clinical registry to care teams to provide additional support and coordinate care, so their conditions are better managed.

A practical application for running registries prospectively is if a Nurse Care Manager runs a clinical registry daily to see which patients coming in have unmet care needs and/or have recent clinical results out of normal range that need to be managed more closely. In the below partial screenshot, the Nurse Care Manager might identify patients to perform an asthma severity before the provider sees the patient. The Nurse Care Manager can also communicate with the patient's provider that the patient needs reinforcement of weight management counseling and/or a referral to weight management programs or nutrition services to control their asthma if the BMI calculated at that visit is out of range. In this practical application, the Registries feature is used to pre-visit plan for upcoming appointments and huddle with the provider for better-coordinated care.

Asthma
REGISTRY

VISIT DATE RANGE: 04/06/2023-04/06/2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

FILTER | Add Filter | Update

REGISTRY | VALUE SETS

Search Patients ...

SAVED COLUMNS

		ASTHMA DX			ASTHMA SEVERITY			ASTHMA PREFERRED TX			PERSISTENT ASTHMA DX	
CENTER NAME	MRN	DATE	CODE	SELF MGMT	DATE	CODE	DETAIL	DATE	CODE	NAME	DATE	CODE
Neighborhood Health Center	1100174	2/23/2023	J45.30	2/23/2023	2/23/2023	J45.30		2/23/2023	313306		2/23/2023	J45.30
Access Community Health	1100191	12/14/2021	493.20	5/23/2022				5/23/2022	313306			
Neighborhood Health Center	1100210	10/12/2022	493.20	5/17/2022				10/12/2022	313306			
Family Health Center	1100231	6/23/2021	J45.30		6/23/2021	J45.30		6/23/2021	313306		6/23/2021	J45.30
Access Community Health	1101437	5/16/2021	J45.30	2/25/2022	5/16/2021	J45.30		2/25/2022	313306		5/16/2021	J45.30
Family Health Center	1101463	3/28/2021	493.02	3/28/2021	3/18/2021	J45.30		3/28/2021	313306		3/18/2021	J45.30
Family Health Center	1101469	5/11/2022	J45.30	8/1/2022	5/11/2022	J45.30		8/1/2022	313306		5/11/2022	J45.30
Neighborhood Health Center	1102608	12/8/2021	493.20	12/8/2021				12/8/2021	153892			

To view the Quick Tip Clip of the Registries feature of DRVS, use the following link: [DRVS Registries](#).

Registries only provide a snapshot of what care needs and care gaps a patient has and are limited to the related services within the registry. In the next section of this User Guide, we will explore the two point of care (POC) tools available to DRVS users, the PVP Report and CMP Passport, which when run prospectively, show all patient care gaps and allow care teams to plan ahead and address patient needs at their visit.

VII. POINT OF CARE (POC) TOOLS: THE PRE-VISIT PLANNING REPORT AND CARE MANAGEMENT PASSPORT

INTRODUCTION

In addition to the data analytics and data visualization components of DRVS covered in the first six sections of this User Guide, DRVS has patient point of care (POC) tools available to DRVS subscribers that help care teams plan for and provide better patient care. These tools are the Pre-Visit Planning Report and Care Management Passport. These tools are valuable for identifying patient care gaps and social service needs and allow for better-coordinated care. Let us examine each of these tools one by one.

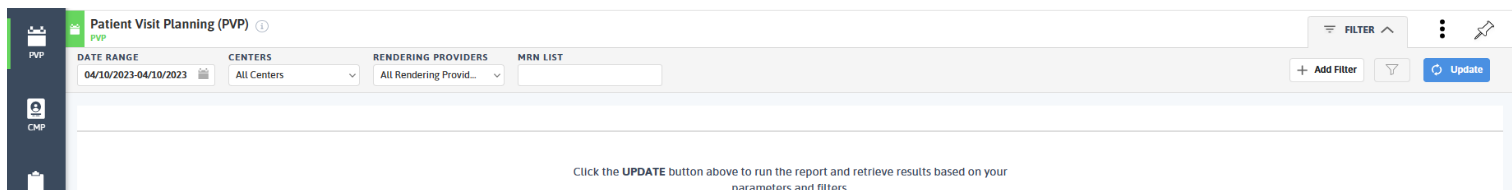
A) THE PRE-VISIT PLANNING (PVP) REPORT

USING THE PVP REPORT TO MEET PATIENT CARE NEEDS

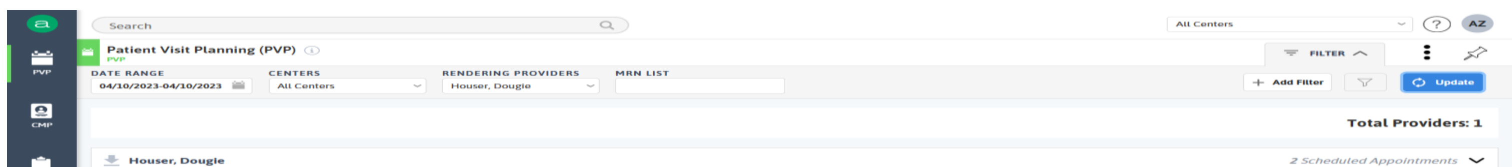
The PVP report is a POC tool that displays patient demographic, clinical, and social drivers information for all patients scheduled on a specific date or date range. The PVP report is used to identify which services a patient is missing, based on age and gender criteria. Its purpose is to help providers and their care teams plan for upcoming patient visits and coordinate care for patients. When patients come in for an office visit, the goal is to ensure multiple care needs are provided at the time of the visit, regardless of the reason for the visit. Identifying your patients' care needs takes the guesswork out of what services to provide and helps care teams provide more efficient care when staff responsibilities are distributed across clinical licenses and skill sets. In turn, when multiple patient care needs are addressed at the time of visit, it reduces the cost to the patient by not having multiple visits and makes patients more likely to access care in the future. Better patient outcomes will also result since more patient preventive and chronic care needs are addressed and better managed.

RUNNING THE PVP REPORT

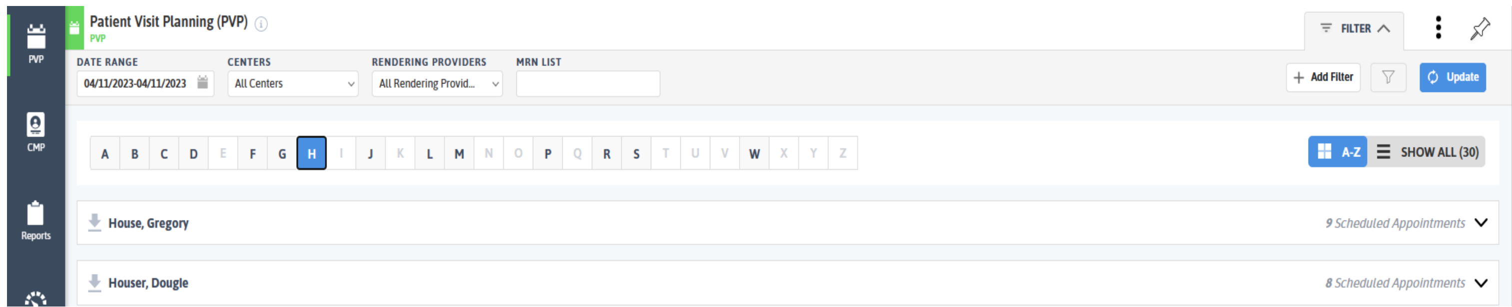
To run the PVP report, click the PVP button at the top of the Left Navigation Bar, once you have logged in to your DRVS account. You will notice from the screenshot below that patient data is not automatically displayed; you first must set your filters in the filters bar and click update.



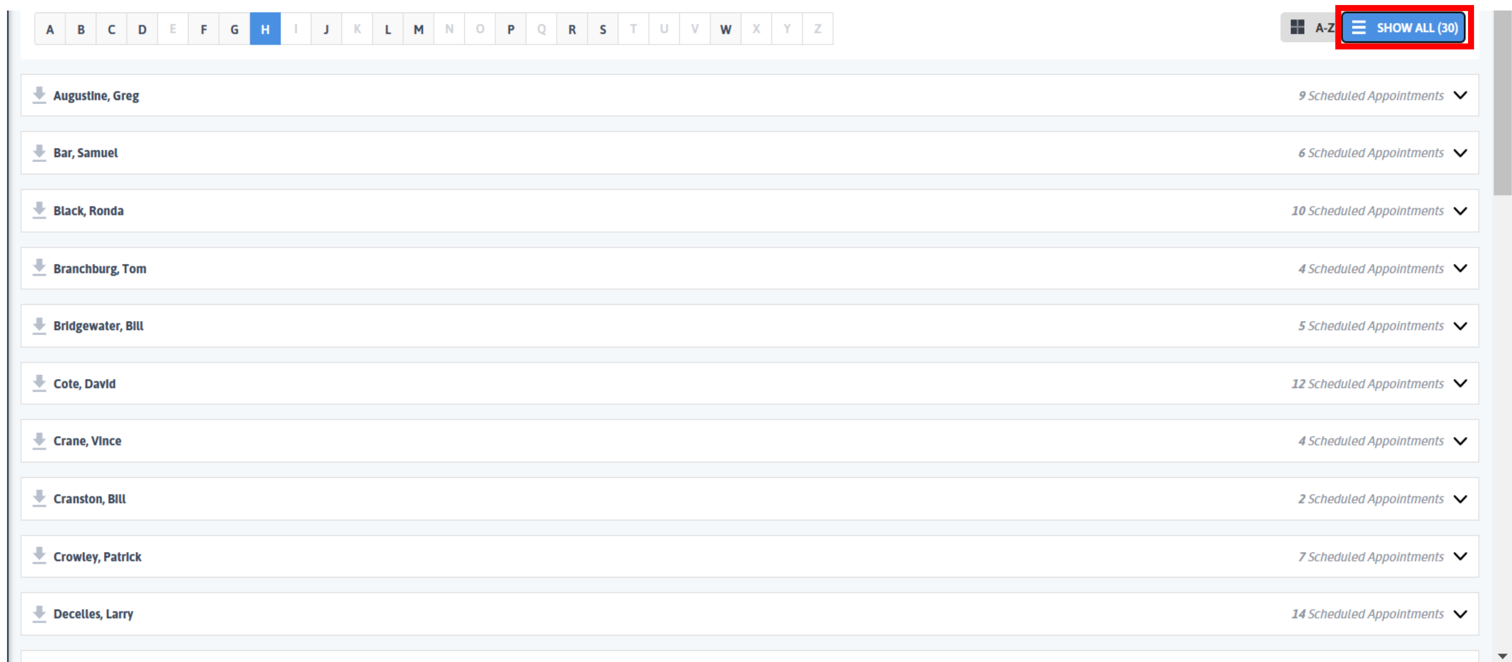
It is recommended you use the PVP report to prepare for patient visits a day ahead of time, when the providers' schedules will be most up to date for the following day's appointments. You can either choose the rendering provider you want to print the PVP report for from the filters bar, seen below, and see how many patient appointments the provider has on the selected date,



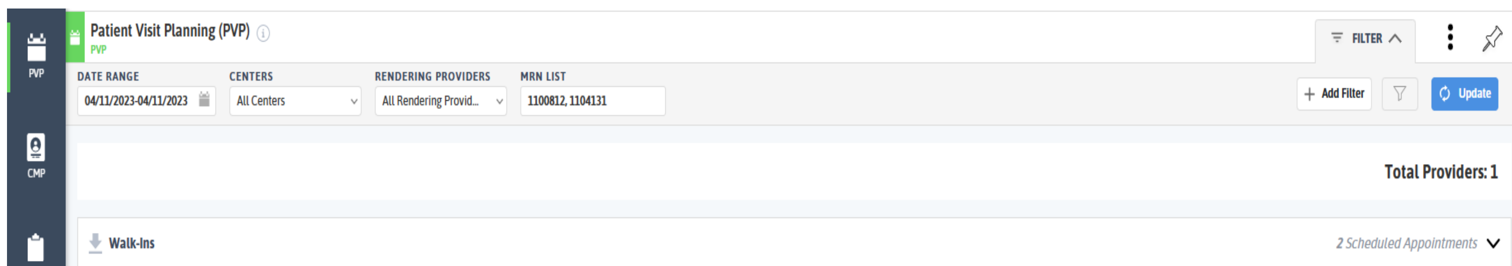
or you can keep the filter to all and see all providers with upcoming appointments on the date selected. Running the PVP report this way, the default setting displays the alphabet for the provider's last initial. Clicking on a letter will display all providers with that initial.



Clicking on the 'Show All' box to the right of the alphabet will list all providers sorted alphabetically.



When running the PVP report a day ahead to prepare for patients coming in for visits, the PVP report will only capture appointments that have been scheduled up to the time you run it. It is common for an appointment to be scheduled late in the day or have same-day appointments added to the provider's schedule. To ensure that these patients' needs are also addressed, you can type the patient's MRN number in the MRN box in the filters bar and click update. Multiple patients can be added by using a comma to separate the MRN numbers.



INFORMATION CONTAINED IN THE PVP REPORT

Either way you choose to locate a provider you want to access the PVP report for, clicking the down carrot next to the number of appointments displays the list of each patient's PVP report.

Search | All Centers | AZ

Patient Visit Planning (PVP)
PVP

FILTER

DATE RANGE	CENTERS	RENDERING PROVIDERS	MRN LIST
04/11/2023-04/11/2023	All Centers	Houser, Dougie	

Add Filter | Update

PVP | CMP | Reports

Total Providers: 1

Houser, Dougie — 4 Scheduled Appointments

Below is an example of a PVP report for a PCP visit in the DRVS demo environment, so this is a fictitious patient and contains no real patient identifying information. We will examine the information in the PVP report, section by section. The colored boxes and circles below were added to show how the PVP report is organized.

9:38 AM Tuesday, April 11, 2023 — Visit Reason: **Physical Departure**

Cermak, Raymundo
MRN: 1104508
DOB: 1/16/1998 (25)
Sex at Birth: F
GI: Transgender Male/ Female-to-Male
SO: Don't know
Phone: 774-515-3512
Lang: French
Risk: Moderate (30)
Portal Access: Y
Cohorts: Test Cohort
PCP: Augustine, Greg
Payer: Aetna
CM: Alex Shvarts

DIAGNOSES (12)

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

RISK FACTORS (6)

ANTICOAG	Chronic Opioid Tx	IDD
MSM	SMI	TOB

SDOH (11)

EDU	FOOD	HOMELESS
HOUSING	ISOLATION	LANGUAGE
RENT/MORTGAGE	SAFETY	STRESS
UTILITY	VIOLENCE	

ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Overdue	12/22/2021	4.5	MA
LDL	Overdue	12/22/2021	174	
BP	Out of Range	5/24/2022	140/93	MA
E/D Encounter	Occurred	12/20/2022		Care Cor
I/P Encounter	Occurred	1/6/2023		Care Cor

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Accupuncture	John Smith / Burlington	5/24/2022	6/2/2022

Starting at the top in the purple box, the date and time of each patient's visit, along with the visit reason, is displayed. This information is pulled from the patient schedule in your EHR. The visit reason will be unique to each organization, based on how their EHR classifies different appointment types. Below the appointment information are patient demographics to the left and PCP, payer, and CM provider information to the right. The patient risk category will be described as it relates to patient diagnoses, risk factors, and SDOH in a moment. Azara also includes whether a patient has access to your organization's patient portal and which cohorts the patient is part of. Ensuring patients have access to their health information is important for Patient-Centered Medical Home (PCMH) and Meaningful Use (MU) federal recognition and incentive payment programs, so identifying whether a patient needs to be offered access to your patient portal will help meet these program standards. Knowing whether a patient is part of a cohort is useful if a patient's clinical outcomes are being tracked as an improvement initiative your health center is part of, so calling attention to this will assist with managing improvement outcomes.

In the green box above, patient diagnoses, risk factors, and SDOH are abbreviated, along with the counts of each in parentheses. The full list of commonly abbreviated diagnoses and risk factors can be found in the Appendix of this User Guide. Patient SDOH are non-medical known contributors to poorer health outcomes. Removing these barriers will help patients improve their health by better managing or eliminating chronic disease burdens. The full list of SDOH factors is listed in the Appendix of this Guide. A new feature of DRVS Azara recently rolled out is the ability to make the patients' SDOH actionable by allowing staff to search and connect patients to community resources that help address their SDOH. This is a separate feature of DRVS that requires a subscription. If your center is connected to this feature, you will see a

house in a blue box to the right of the SDOH category head. Clicking this button takes you to a new page to identify community resources you can connect your patients to.

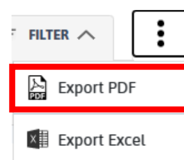
Azara created an algorithm that assigns a risk score to each patient, seen in the blue box with demographic information. Each diagnosis, risk factor, and SDOH are assigned a point value based on the severity of the impact they have on a patient's health. The summation of these point values places patients in a low, medium, or high-risk category, meaning they are likely to have poorer health outcomes and require higher-cost services to meet their medical needs. This is not something that should be overlooked; as we discuss later in this section, a patient's risk will help care teams prioritize their needs and focus on the higher-risk patients when discussing how to manage and coordinate their care during daily huddles.

The orange box in the screenshot above contains patient alerts that are customizable by healthcare organizations. Your organization's DRVS Super User and anyone designated with Admin privileges can determine which alerts to turn on and have displayed on the PVP report. Some alerts also allow for the customization of when alerts are flagged for patients, outside of standard medical recommendations governing the frequency at which services are performed. For example, if your health center wants to be alerted when patients are due for colorectal cancer screening at 45 years old instead of 50, that is a possibility. The alerts are organized by name, whether they are overdue, due soon, out of range, or occurred, the date the service was last performed, the result, and if your center has completed care team roles and responsibilities in the Alerts Administration section of DRVS, the staff member assigned to perform that function. The full list of PVP alerts can be found in the Appendix of this User Guide. The patient alerts will help you plan for the services patients need addressed during their visit by performing them yourself, another staff performing them or coordinating with another department to have those needs addressed.

In the above example, information about any open referrals is shown on the PVP report in the yellow box. Only healthcare organizations that subscribe to Azara's referral management module will see open referrals that do not have results on the PVP. This module comes with an additional cost to implement, since additional mapping is required. The information listed includes the type or specialty the patient was referred to, where they were referred, the date the referral was made, and the date of the patient's appointment. If any of that information is missing, it will be blank. For example, if the patient was asked to call and schedule an appointment for a service they were referred to and never does or does not inform the health center later when that appointment is, the appointment date field will be blank because it was never entered in the EHR. It is best practice to have as much referral information available, as you will see in the Practical Applications section on using the PVP report.

DISTRIBUTING THE PVP

You will notice when utilizing the PVP report the stacked 3 dots appear in the top right of the screen. Clicking on it gives you the option to export the PVP as a pdf file or to Excel. When centers use the PVP to support care team huddles, they will print the PVP as a pdf file and distribute it to care team members, so they can take notes on services they need to address during the huddle. To print multiple providers' PVP report at once, select all providers from the rendering providers filter, click the update button, then export as a pdf.



PRACTICAL APPLICATIONS

As described above, the PVP report contains a lot of useful clinical and non-clinical information about each patient who has scheduled an appointment. The most practical application for using the PVP report is to prepare for daily care team huddles. Care team huddles are short, 10-minute, check-ins between the provider and at minimum one other clinical

support staff member, such as a Medical Assistant (MA), Lead Practical Nurse (LPN), or Nurse (RN). The huddle's purpose is to discuss that day's patients' needs and coordinate care where needed before the provider's patient schedule starts. When possible, additional staff, such as Nurse Care Managers, Care Coordinators, and/or specialty care staff (ie. Behavioral Health support staff) should also attend, to ensure complex patient care needs are met during the visit. If additional staff members are unable to attend, then the MA or whoever leads the huddle should ensure they communicate with staff when their support is needed.

Since the intention of the huddle is to keep it brief, some considerations should be made to maximize time. The focus of the care team huddle should be to discuss only high-need patients who may require additional coordination of services to have their needs met. For routine services, such as assessments or blood pressure checks, the owner of the care alert should perform that service automatically. The huddle leader should remind the provider of the services they need to perform, such as diabetic foot exams or nutritional counseling. This allows all staff to perform to the top of their license and skill set and makes the delivery of care more efficient.

As mentioned, it is best practice to prepare for the huddle a day ahead of time, to allow adequate time to make sure each patient's records are in order, so the huddle can focus on the patients who require the most attention. To help prepare for the huddle, you will want to look to alerts for services that are not performed at your center and ensure these alerts truly reflect patient care gaps. For example, services such as mammograms or colonoscopies may require an outside provider to perform. Often, a patient may have completed these services, but either the place they received these services never sent the results to the PCP, or they are in the patient's EHR, but not documented in a structured way that DRVS can read, so it looks like they did not complete the service when they did.

The first step when seeing an alert for a service that is performed outside your organization is to review the patient's chart in places like scanned documents or recent encounter notes to see if the service was performed or mentioned. If you find a record of the results for that service, it is best practice to create a referral or order in the patient's record, attach the results to the referral, and flag it for the provider to review ahead of the patient's appointment. Once the provider signs off on the result, the PVP will not instantaneously update since the data is refreshed nightly, but you can make a note to yourself that the alert does not need to be discussed during the huddle.

If you find mention of a service being completed in an encounter note or visit summary as free text and a date of when the service was performed is known, you may be able to enter this information as structured data, depending on your EHR. Some EHRs have tables for health maintenance services where date fields are structured data, so if your EHR has this capability, you can enter the date it was performed. Usually, a month and a year is enough to satisfy the completion of the service. You will still want to do your due diligence and request the results of that service from where it was performed by having the patient sign a Release of Information (ROI) form and enter the results in the patient's chart.

Another focus for preparing for the huddle is to review the open referrals section on the PVP if your center has that feature. If the date of the referral appointment has passed, but the alert is still showing on the PVP, that means the referral has not been closed out by the referring provider at your center. This could be because the patient was a no-show to the appointment, or the provider they were referred to has not sent back their records from the service performed. You will want to confirm with the patient whether they attended the appointment, and depending on their response, call the clinic they were referred to and request the results from the service they received. If the patient did not attend their appointment, you can take note of this and mention it to the provider during the huddle.

The quick tip clip for using the PVP report can be viewed here: DRVS Patient Visit Planning (PVP) Report. For guidance on what an effective care team huddle looks like, you can refer to Azara's training video here: DRVS Care Team Huddle. Recommendations for getting your organization started with pre-visit planning and care team huddles are included in the DRVS point of care playbook here: Supporting Huddles: The Patient Visit Planning Report.

B) THE CARE MANAGEMENT PASSPORT (CMP)

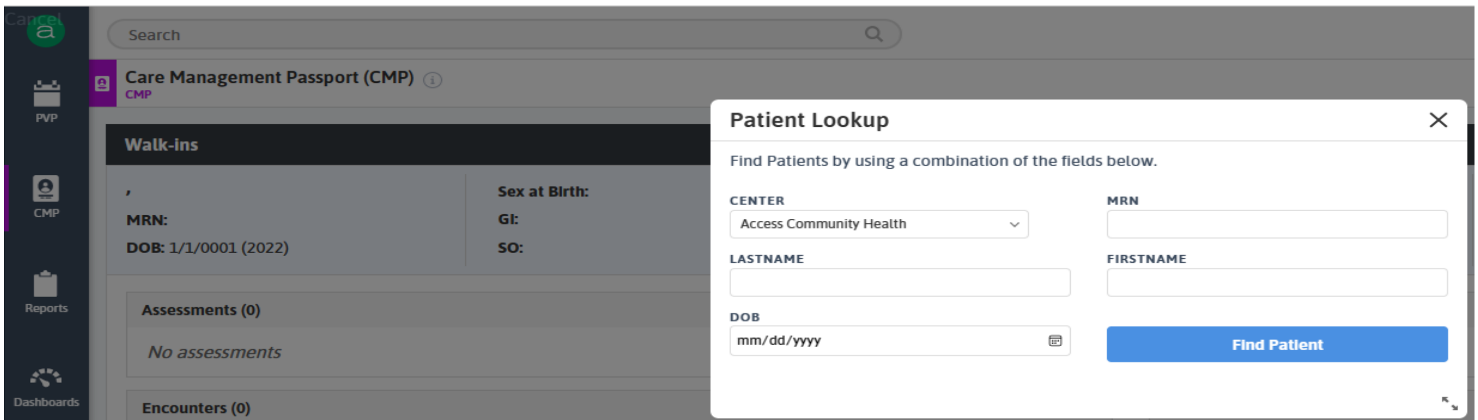
OVERVIEW OF THE CMP

The CMP is another POC tool available in DRVS that typically Care Managers use to review and act on patient needs. Patients in the CMP are viewable individually. The CMP is a standard feature of DRVS, but individuals at a healthcare organization will need to have privileges set by their Super User or anyone with Admin privileges to access the feature.

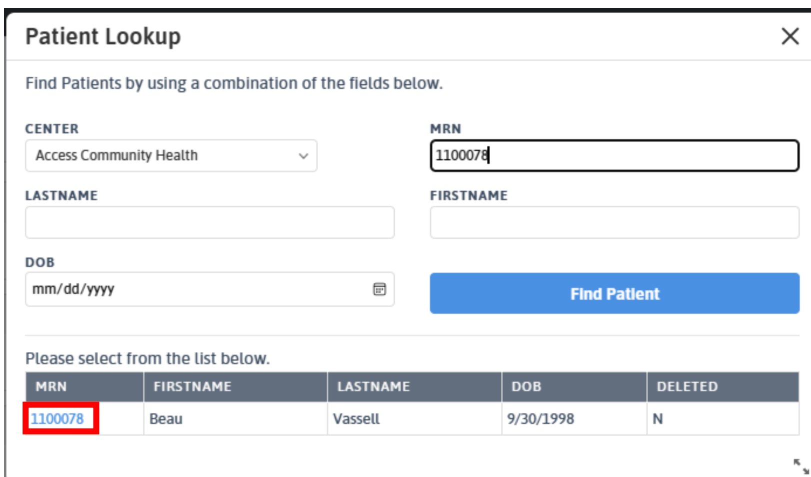
ACCESSING THE CMP AND LOOKING UP A PATIENT

To access the CMP, click the CMP button in the left navigation bar.

This will bring up a box to search for a patient by MRN, name, and/or DOB. The preferred way to look up a patient is by MRN since each patient will have a unique MRN.



Once you enter a patient's MRN number and click the blue 'Find Patient' button, the Patient Lookup box will display all patients matching that MRN number. Again, there should only be one patient displayed when you look up a patient by MRN number. The below screenshot is a fictitious patient from the DRVS demo environment.



Clicking on the blue MRN number from the list will open the patient details in the CMP.

CMP PATIENT DETAILS

Patient details in the CMP are organized by type of information.

Care Management Passport (CMP)
CMP
Patient Lookup

PVP · CMP · Reports · Dashboards · Measures · Registries

03:08 AM Thursday, April 13, 2023 — PROVIDER: Crowley, Patrick — VISIT REASON: Departure

Vassell, Beau	Sex at Birth: M	Phone: 774-018-3714	Last Phys:	PCP: Gunther, Eric
MRN: 1100078	GI: Transgender Female/ Male-to-Female	Language: English	Portal Access: N	Payer: Medicaid
DOB: 9/30/1998 (24)	SO: Bisexual	Risk: Low (7)		CM: Austin Dobson

Assessments (7)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status	1/21/21	0
Z59.1	Inadequate housing	1/21/21	0
G89.12	Acute post-thoracotomy pain	1/21/21	0
295.02	Simple type schizophrenia, chronic	1/21/21	0
308110009	Direct fundoscopy following mydriatic	1/21/21	0
E10.21	Type 1 diabetes mellitus with diabetic nephropathy	1/21/21	0
Z30.019	Encounter for initial prescription of contraceptives, unspecified	1/21/21	0

Active Problems (7)

CODE	DESCRIPTION	MOST RECENT
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status	1/21/21
J45.30	Mild persistent asthma, uncomplicated	1/21/21
Z56.0	Unemployment, unspecified	1/21/21
J80	Acute respiratory distress syndrome	1/21/21
R05	Cough	1/21/21
F73	Profound intellectual disabilities	1/21/21
J16.0	Chlamydial pneumonia	1/21/21

The red demographics bar that you see on the PVP is also present in the CMP. Immediately below the demographics bar outlined in aqua are up to the ten most recent assessments the patient received, the date they received it, and the number of previous times they were assessed in the TY period. In the yellow box is the patient's active problem list. Up to ten active problems will be listed, along with the most recent date the diagnosis was indicated. The total number of assessments and active problems are shown in parenthesis, next to the box title, so there could be more than ten counts in the measurement period.

Below the assessments and active problems are appointment and clinical information.

Encounters (1)

DATE	PROVIDER	TYPE	REASON
1/21/21	Smith, Joe	Medical	Annual Visit

Appointments (Next 5 of 6)

DATE	PROVIDER	TYPE	REASON
4/13/23	Crowley, Patrick	Injury	Departure
4/22/23	Augustine, Greg	Annual Visit	Departure
5/20/23	Augustine, Greg	Physical	Departure
6/5/23	Doe, Jane	High BP	Departure
7/25/23	Bridgewater, Bill	Sick Visit	Departure

The Numbers

BMI	1/21/21	12 lb/m2
Systolic	1/21/21	157 mmHg
Diastolic	1/21/21	85 mmHg
LDL	No data	
A1c	No data	
PHQ-9 (or 2)	1/21/21	27
Risk	3/31/23	7 (L)

To the left in the purple box are the five most recent encounters and the next five scheduled appointments, whom the patient saw or will see, and the type and reason for the visit. The total number of most recent and upcoming appointments will be indicated in parentheses. The number box outlined in orange above contains the most recent key clinical indicator information, the date it was collected, and the patient's risk score, if your organization has the risk module. For the clinical information, if the data has been collected more than once, a line with up to the ten most recent

data points will be displayed next to the most recent result for that clinical indicator. Hovering your mouse/pointer over a data point will display the result. This is a simplified way to see whether a patient's health status is improving.

Below appointment and clinical indicator information are the patient's SDOH, allergies and medications, and risks.

Social Drivers of Health (4)

EMPLOYMENTHISP/LAT INSURANCE
RACE

Allergies (3, last reviewed 1/21/21)

START	DESCRIPTION	REACTION	SEVERITY	SOURCE
1/21/21	ACETAMINOPHEN			
1/21/21	LISINOPRIL			
1/21/21	MILK			

Medications (Last 10 of 12)

ACTIVE AS OF	NAME	SOURCE
1/21/21	1 ML buprenorphine 0.3 MG/ML Cartridge	
1/21/21	1 ML butorphanol tartrate 1 MG/ML Injection	
1/21/21	aliskiren 300 MG / amlodipine 5 MG Oral Tablet	
1/21/21	aspirin 325 MG Oral Capsule	
1/21/21	atomoxetine 100 MG Oral Capsule	
1/21/21	buprenorphine 2 MG / naloxone 0.5 MG Sublingual Film	
1/21/21	calcium carbimide	
1/21/21	chlordiazepoxide hydrochloride 10 MG [Libritabs]	
1/21/21	rivaroxaban	
1/21/21	theophylline 5.33 MG/ML Oral Solution	

Risk

CATEGORY	CRITERIA	POINTS
		0
		0
		0
		0
		0
		0
		0
		0
		0
		0
Diagnoses	HIV	1.00
Diagnoses	HIV	1.00
Diagnoses	Persistent Asthma	3.00
Diagnoses	Persistent Asthma	3.00
Diagnoses	Diabetes	1.00
Diagnoses	Diabetes	1.00
Behavioral Health	Severe Mental Illness and Psychosis	2.00
Behavioral Health	Severe Mental Illness and Psychosis	2.00
Labs & Vitals	Systolic BP 150+	0
Labs & Vitals	Systolic BP 150+	0

The social drivers' information in the green box above comes from the most recent SDOH assessment the patient received, with the total number of drivers in parentheses. If your center is subscribed to the Community Connect feature Azara offers, you will have the ability to click the button with the house in the blue box to open an external site to look up community resources in the patient's area to help mitigate the social drivers of health. The patient's ten most recently recorded allergies and active medications are listed in the pink outlined box, with the total number in parentheses and the date each was last reviewed. The risks in the blue box are listed by risk category, what the risk is, and the number of points assigned to each risk that determines the patient's risk score. In a live environment, you will not see blank lines or duplicate risk information. This is another quirk of working in the DRVS Demo environment.

The last set of information contained in the CMP includes patient alerts, open referrals, and in-patient (IP) and emergency department (ED) utilization. This information is subject to the following: which patient alerts your organization has enabled, whether your organization is subscribed to the referral management module and whether your organization is connected to a health information exchange (HIE) that provides access, discharge, and treatment (ADT) information from hospitals, respectively.

Alerts (9)

ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Missing			MA
LDL	Missing			
Depr Screen	Missing			MA
Tobacco Scr	Missing			Front Desk
BMI & FU	Missing			MA
BP	Overdue	1/21/21	157/85	MA
Asth Severity	Overdue	1/21/21		
Eye	Overdue	1/21/21	Y	
Foot	Missing			

Open Referrals w/o Result (0)

No open referrals

I/P & E/D Utilizations (1)

SOURCE	TYPE	ADMIT DATE	DISCHARGE DATE	LOCATION	DIAGNOSIS	DESCRIPTION
Azara Health HIE	Inpatient Stay	9/11/22	9/14/22	Sacred Heart Hospital	R10.9	

All patient care gap and open referral alerts the patient has will be listed, as displayed on the PVP report, including ED and IP visit information. In the CMP, more information about those visits will be shown, including dates of admission and discharge, what hospital they were seen at, and the diagnosis code and description of the visit. In the above screenshot, the description information is missing. When this happens, it is likely due to the hospital not including what the diagnosis code refers to in the discharge information field DRVS is mapped to in the ADT feed.

PRACTICAL APPLICATIONS

As mentioned previously in this section, access to the CMP requires special privileges set up by your organization's Super User or other staff with Admin privileges. Care Managers or staff with care management responsibilities typically have these privileges. Care Manager best practices for using the CMP include looking up patients coming in for scheduled visits and identifying which patients they need to follow up with for assessments, screenings, and updates to clinical information, among other actions. Often, health centers will hire or assign nurses for this role since they have a clinical license and can provide more services than someone without a clinical license. When available, it is advised that Care Managers attend daily care team huddles between the primary care provider and clinical support staff, to bring awareness to the support patients will need from them. When unable to attend a daily huddle, the Care Manager should communicate with primary care team staff and alert them which patients have needs that require their attention during their visit.

If your organization does not have or offer care management services and would like to know more about how to get started with a care management program, contact Shelly Hathaway, Nurse Care Consultant at shathaway@mpca.net for guidance, technical assistance, and/or MPCA's Care Management Guide.

Azara's Quick-Tip Clip for using the CMP can be viewed here: DRVS Care Management Passport.

VIII. DRVS TROUBLESHOOTING

A) DRVS TROUBLESHOOTING TIPS

Sometimes, DRVS functionality can be interrupted for several reasons. In this section, we will go over some situations you may face when using DRVS, and what you can do to improve usability.

A PAGE WON'T LOAD

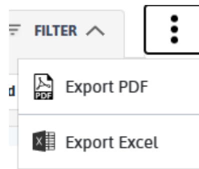
When trying to access a report, dashboard, measure, or other feature in DRVS, sometimes the page may try and process what you are running, but the information takes a long time to load. This will sometimes happen when a patient detail list you are trying to access is large. Other times, there may be a bug in the system or too many DRVS users accessing the system at one time, causing DRVS data to load slow or not at all. If this happens, you have a couple options to try and get DRVS to function properly. One course of action is to log out of your DRVS account and log back in. This usually solves the issue. If not, you may need to stay logged out for a couple of hours before trying to log back in if it is more widespread. You can also try clicking the "A" Azara logo above the Left Navigation Bar to see if that loads the information you are trying to access.

PRINTING THE PVP REPORT

When printing the PVP report as a pdf file for a provider's patient panel, it will take up all room on a single page before going to the next page. This can be problematic because the PVP report for a patient may be split onto two separate pages. Some prefer to have one patient per page because there will be extra room at the bottom to take notes as they prepare for the daily care team huddle and during the care team huddle. Unfortunately, there is no way to change the print setup for the PVP report. The workaround to this would be to enter each patient's MRN number in the filters bar and print one page at a time for each patient.

EXPORT FUNCTIONALITY NOT WORKING

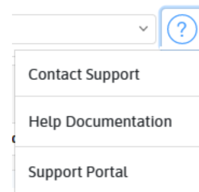
This next troubleshooting workaround applies to staff who have advanced privileges that allow them to distribute patient lists by exporting them and to health centers that have DRVS integrated with patient outreach and engagement platforms. If the export functionality disappears within the three dot drop-down options, the best way to get this functionality restored as quickly as possible is to open a ticket in Azara's Support Portal and include a screenshot of the missing functionality, seen below:



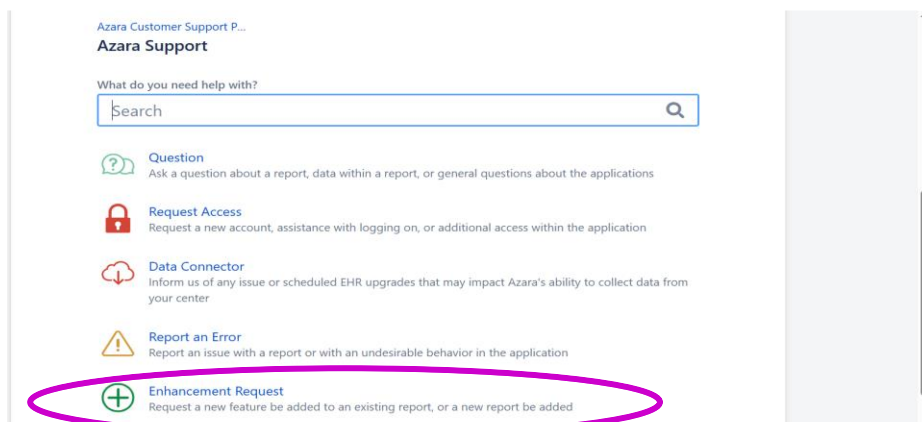
Guidance on how to submit a ticket can be found on pages 6-7 of this User Guide.

DRVS ENHANCEMENT SUGGESTIONS

Azara Healthcare, LLC strives to meet the data reporting and clinical and operational needs of its customers with its DRVS platform. For these reasons, Azara encourages feedback from its users on how to make their product run smoother and operate better. If there is a capability you would like to see added or improved, you can submit a request by clicking the 'Support Portal' button from the question mark drop-down list at the top right of your screen.



This will open a login page in a new web browser window. Once logged in, if you scroll toward the bottom of the page, there will be an option to request a product enhancement.



Clicking on 'Enhancement Request' will take you to a new page with a form to fill out the details of your request.

B) DATA HYGIENE

THE IMPORTANCE OF GOOD DATA HYGIENE

As stated at the beginning of this Guide, the quality and accuracy of data reflected in DRVS are determined in large part by how and where data is entered into your EHR. To improve data hygiene, all staff documenting in the EHR and using DRVS must be aware of how documentation standards must be upheld, to provide optimal patient care. When patients come into your clinic, they feel a sense of trust in their provider and staff that they will receive the care they need, when

they need it. Being able to easily access their records and having confidence that the records are accurate allows providers to deliver timely, appropriate care to their patients.

ENSURING GOOD DATA HYGIENE AND DATA ACCURACY

Most health centers have quality departments with staff whose role is to identify data discrepancies and improve data hygiene. These staff members will perform chart audits to ensure all data systems used are reporting performance as similarly as possible. DRVS offers several tools and resources to assist with data validation, including a measure validation workbook and data health dashboards. For the scope of this User Guide, we will focus on how non-quality department staff can contribute to the overall improvement in data quality. An Azara webinar on the different methods to validate data can be viewed here: Healthy Data Healthy Results. Templates for a measure validation checklist and measure validation calendar can be downloaded in the DRVS playbook section of the Help Documentation website here: Data Hygiene Program Resources.

One way that non-quality improvement staff can improve data quality for your organization is by using the PVP report. As described in the previous section, the PVP report is a valuable tool to help identify and address patient care gaps during a patient's visit. When using the PVP report to prepare for daily care team huddles, reviewing the patient care alerts helps improve overall data hygiene and data quality for your organization, so quality improvement is something all staffing levels have a hand in.

The best way for a non-quality improvement staff member to use the PVP report to improve data hygiene is to identify which alerts require the patient to receive services outside of your healthcare organization to complete and check the patient's chart to see if the records exist. Common services that may show as alerts on the PVP, when they have been completed are mammograms and colonoscopies. Every EHR has different ways of documenting, but one place to look for mammogram and colonoscopy results is in a scanned documents folder or section of the EHR. If records are found, you can then create an order, attach the results, and remind the provider to review them and close the order, so you receive credit for ensuring your patients receive age and gender-appropriate cancer screenings.

It is also worthwhile to check the accuracy of the labs section of your EHR to make sure lab alerts on the PVP report, such as cholesterol or cervical cancer screenings, are true services that need to be addressed at the patient's visit. Depending on what lab you use, labs may end up in your scanned documents section of the EHR, and if they are not attached to an order and signed off by the provider, DRVS will not recognize the services being completed.

If your center subscribes to the referral management module, the Open Referrals section of the PVP report is another place to reconcile records with your EHR for accuracy. Looking for consultation notes where scanned documents are stored in the EHR, attaching them to the referral, and alerting the provider to review will improve closing the loop on open referrals and allow for better data accuracy and continuity of care.

Any data reconciliation changes will not take effect immediately, since it takes time for Azara to refresh the data. Therefore, re-running the PVP report will not show the alerts falling off right away. Using the PVP report to check for data accuracy will still improve the efficiency of daily care team huddles and patient visits by addressing the services patients truly need.

TYPES OF DATA DISCREPANCIES

Once you have determined through data reconciliation between DRVS and your EHR that the records for a patient alert on the PVP do not match, how you respond to the discrepancy will depend on what the source of the discrepancy is. Data discrepancies can be one of two errors: documentation errors or mapping errors. A documentation error is an error that prevents DRVS from recognizing from the EHR that a service was provided because of how it is captured in the EHR. The most common documentation error occurs when a service is provided, but the results from that service are not documented in a structure field within the EHR. Mammogram and colonoscopy reports scanned into the EHR but not

attached to an order are examples of documentation errors. Since DRVS is unable to identify these services as being completed, the patient record will flag them as needing these services until the documentation error is corrected. A mapping error can occur when a healthcare organization goes through an EHR upgrade or a lab interface changes, affecting how types of labs are coded when sending orders. When EHRs are upgraded, there may be new or improved structured fields to collect patient data, but if these fields are not mapped to DRVS, DRVS will not recognize the services as being complete. Labs may also go through a system upgrade and change how orders are coded and identified. Sometimes this is because of a change in clinical guidelines, such as with cervical cancer screening updated recommendations. The results may still be captured in a structured field in your EHR, but if DRVS is not mapped to recognize these new lab interfaces, DRVS will not accurately report services a patient received.

REPORTING DATA DISCREPANCIES

Once you have identified data discrepancies through data validation with the PVP report, the next step is to correct these discrepancies. If you notice that documentation errors are a common occurrence, particularly with mammogram and colonoscopy screenings, this could be a sign of a wider issue that should be addressed at the organizational level. Creating the order and having the patient's provider review the results still needs to occur, but you will also want to bring the pattern to the attention of your Quality and/or Operations Director. Staff training or re-training may be necessary to reinforce good documentation practices.

If the data discrepancy pattern is a result of DRVS not recognizing services as complete when they are documented in the EHR correctly, this error is likely due to a mapping issue and should be reported to Azara for correction. You can either submit a ticket through Azara's Support Portal and provide patient examples (MRN number) that are not being counted as having the service completed, or you can notify quality improvement staff, who can report the discrepancies to Azara, whichever your organizational policy for reporting data discrepancies supports.

IX. APPENDIX

A) PVP AND CMP ABBREVIATIONS, ALERTS, AND SOCIAL DRIVERS

Below is the full list of abbreviations affiliated with the PVP report and CMP. Depending on what alerts your center has enabled, you may or may not see some of these alerts on the PVP and CMP.

Risk factor abbreviations

SHORT NAME	RISK FACTOR NAME
Act Preg	Active Pregnancy
ANTICOAG	Anticoagulant Medications
ASCVD BORDERLINE / INTERMEDIATE /HIGH	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. Watch the ASCVD Overview video here.
BMI	Obesity
Chronic Opioid Tx	Chronic Opioid Therapy
Dev Delay	Developmental Delay, i.e. failure to thrive
HDU	Hard Drug User/Illicit Drug Use Disorders
High ER Ut.	High Emergency Utilization
Low Soc. Spt.	Low Social Support
MSM	Males Having Sex with Males
Pre-DM	Pre-Diabetes/Metabolic Syndrome *(Note: this risk will not trigger if the patient has an active diagnosis of Diabetes)*
Preg-HiR	Pregnancy - High Risk
SED	Severe Emotional Disturbance
SMI	Severe Mental Illness
SUD	Substance Use Disorder
TOB	Tobacco User
Underimm	Under Immunization Status

Chronic conditions and diagnoses abbreviations

ABBREVIATION	CHRONIC CONDITION OR DIAGNOSIS
ADHD	ATTENTION DEFICIT HYPERACTIVITY DISORDER
AMI	ACUTE MYOCARDIAL INFARCTION
ASM	ASTHMA
AUT	AUTISM
BPD	BIPOLAR DISORDER
CAD-NO MI	CORONARY ARTERY DISEASE - NO MYOCARDIAL INFARCTION
CHF	CONGESTIVE HEART FAILURE
CKD-STG5	CHRONIC KIDNEY DISEASE (STAGE 5)
CNMP	CHRONIC NON-MALIGNANT PAIN
COPD	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
CP	CEREBRAL PALSY
DEPRESSION	DEPRESSION
DM	DIABETES
Epilepsy	Epilepsy
HCV	Hepatitis C
HIV	HIV
HTN-NE	HYPERTENSION – NON-ESSENTIAL
HTN-E	HYPERTENSION - ESSENTIAL
HYLIP	HYPERLIPIDEMIA
IVD	ISCHEMIC VASCULAR DISEASE
SCZ	SCHIZOPHRENIA

Social Drivers of Health (SDOH) Abbrieviations

ABBREVIATION	CHRONIC CONDITION OR DIAGNOSIS
HOMELESS	Patient is homeless
HOUSING	Patient has housing insecurity
FPL <200%	Income below 200% of the federal poverty line (FPL) based on their yearly income and household size
FOOD	Insecure access to food
UTIL	Insecure access to utilities
PHONE	Insecure access to a phone
INSURANCE	Patient is uninsured/does not have insurance data recorded, or had Medicare, Medicaid, CHIP Medicaid, or other public insurance (CHIP or non-CHIP)
MATERIAL SECURITY	Rent/other financial strain
MED/CARE	Insecure access to medicine and/or medical care
CHILDCARE	Insecure access to childcare
CLOTHING	Insecure access to clothing
TRANS-MED	Insecure access to transportation for medical needs
TRANS-NONMED	Insecure access to transportation for non-medical needs
ISOLATION	Experiences isolations
SAFETY	Feels unsafe
VIOLENCE	Experiences domestic violence
STRESS	Experiences stress
EMPLOYMENT	Not employed
EDUCATION	Education below high school
RACE	Race other than "White"
HISP/LAT	Ethinicity of "Hispanic/Latino"
LANGUAGE	Language other than "English"
REFUGEE	Refugee status
MIGRANT	Migrant worker
VETERAN	Veteran
INCARC	Has been incarcerated

A hyperlink to the Excel file containing the list of PVP alerts can be viewed at the bottom of the DRVS User Guide page here: Alert Administration.

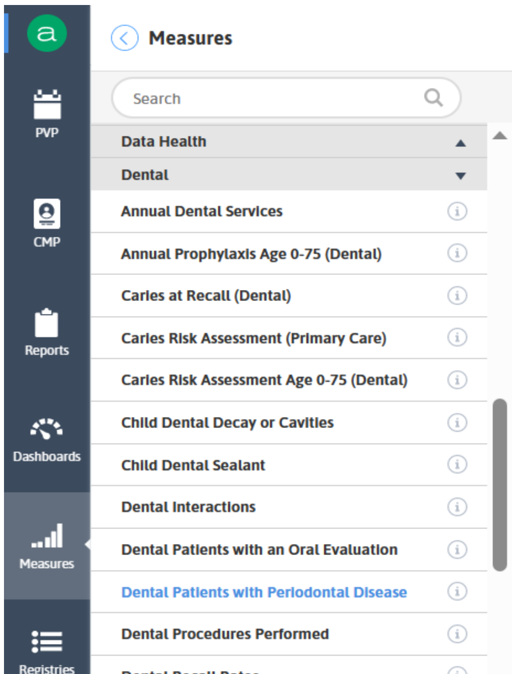
B) DRVS FEATURES UNIQUE TO THE MPCA NETWORK

As mentioned earlier in this User Guide, MPCA has been able to customize many of the features in DRVS to serve our state's and network's specific needs. Below are the clinical, operational, and financial features unique to Michigan's DRVS platform.

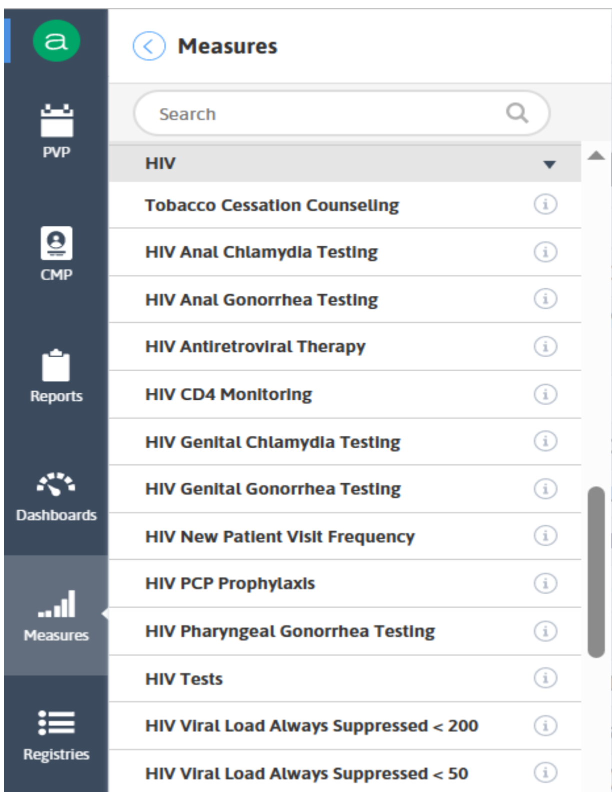
CLINICAL FEATURES

CLINICAL MEASURES There are several measures unique to MPCA's network that are available to our DRVS users. They include dental, HIV, and plan calculated HEDIS measures.

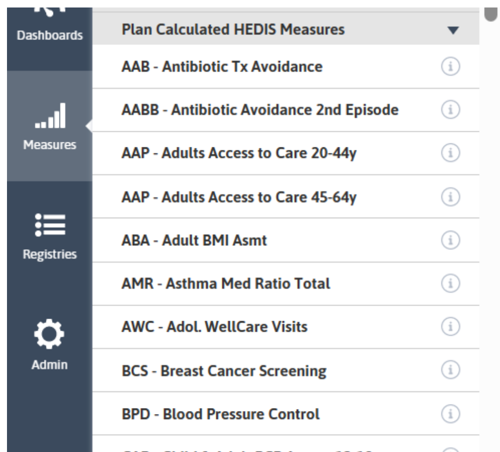
Dental measures: Azara Healthcare has helped MPCA build out a comprehensive set of dental clinical quality measures. Centers which report dental data in their EHR or have DRVS integrated with their electronic dental records (EDR) can add the dental measures module for an additional cost. From the measures button on the left navigation panel, dental is one of the measure categories you can expand to access any of these measures. The screenshot below does not depict the exhaustive list.



Expanded HIV measures: There are three clinical quality HIV measures that are part of the UDS set of measures. MPCA worked with Azara Healthcare to expand on HIV measures as a product enhancement. They can be accessed from the HIV measure category. The below screenshot does not show the exhaustive list of measures.

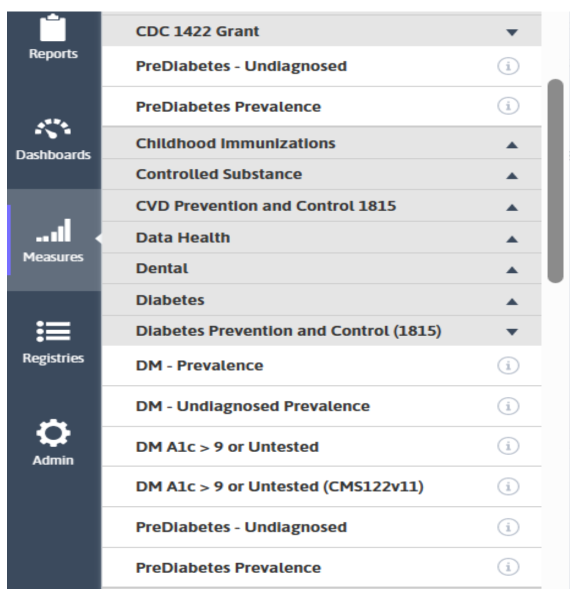


Plan calculated HEDIS measures: Michigan Community Healthy Network (MCHN), MPCA's clinically integrated network (CIN) that negotiates with Michigan Medicaid payers on setting priority measures targets and developing an advanced payment model to reward FQHCs for demonstrating quality in value-based contracts, developed electronic clinical quality measures (eCQMs) based on HEDIS priority measures in DRVS. These measures differ from the standard set of measures in DRVS because they include all patients assigned to a health center or provider at a health center, regardless of whether they have been seen by the center. A patient will be assigned to a provider or health center by the health plan if the patient does not elect a PCP responsible for their care. It is then the health center's responsibility to manage those patients' care, or if they can demonstrate to the payer that the patient is in care elsewhere, the payer can properly re-assign them. The screenshot below shows a portion of the list of plan calculated HEDIS measures in DRVS.

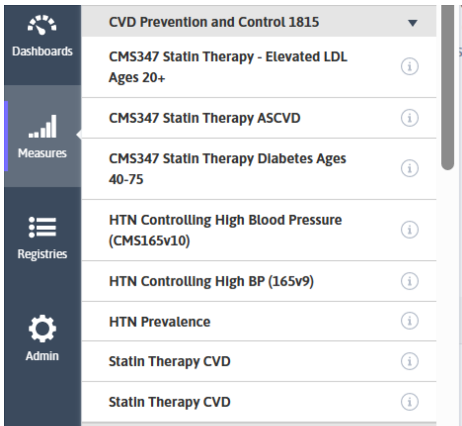


<u>**GRANT-SPECIFIC MEASURES SETS**</u> As an organization that receives grants to deliver quality improvement initiatives to its members, MPCA has been able to work with Azara Healthcare to build measures in DRVS to facilitate the ease of reporting for these grant deliverables. Some of these grant-specific measures include diabetes, hypertension, chronic kidney disease, million hearts, and United Health Foundation measures, each with its own measure categories.

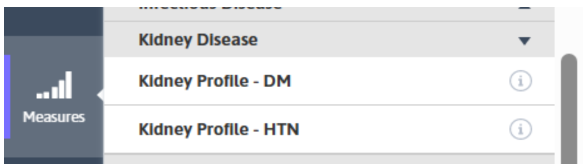
CDC 1422 and Diabetes Prevention and Control (1815): These measures are related to the identification of patients who are and are not diagnosed with pre-diabetes and diabetes. The below screenshot is an expansion of these measure categories and measures included in these categories.



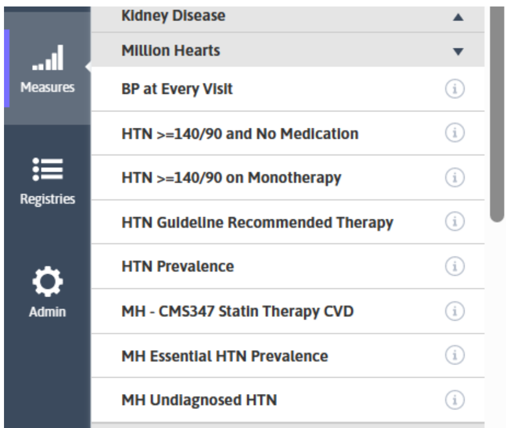
CVD Prevention and Control 1815: Measures for high-risk co-occurring conditions and treatment make up this measure set. Below is a screenshot of the measures included in this measure category.



Kidney Profile: The Kidney Profile measures category contains measures associated with MPCA's chronic kidney disease grant, as seen below.



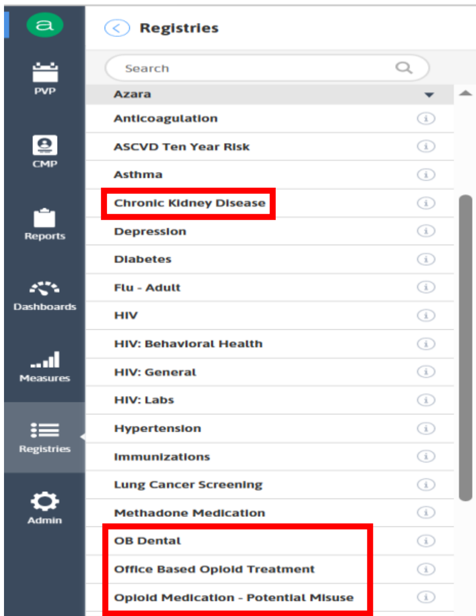
Million Hearts: Directly below the Kidney Profile measure category is the Million Hearts measure category. It contains measures required for reporting hypertension prevalence and treatment rates. Below is the full measure set.



ENHANCED REPORTS Additional reports were added to MPCA's DRVS features, accessible from the left navigation bar. They include behavioral health and diabetes care effectiveness, controlled substance, and OB reports.

Care effectiveness: The behavioral health and diabetes care effectiveness reports are used to show improvements in patients' behavioral health and diabetes outcomes. To access them, expand the Care Effectiveness report category.

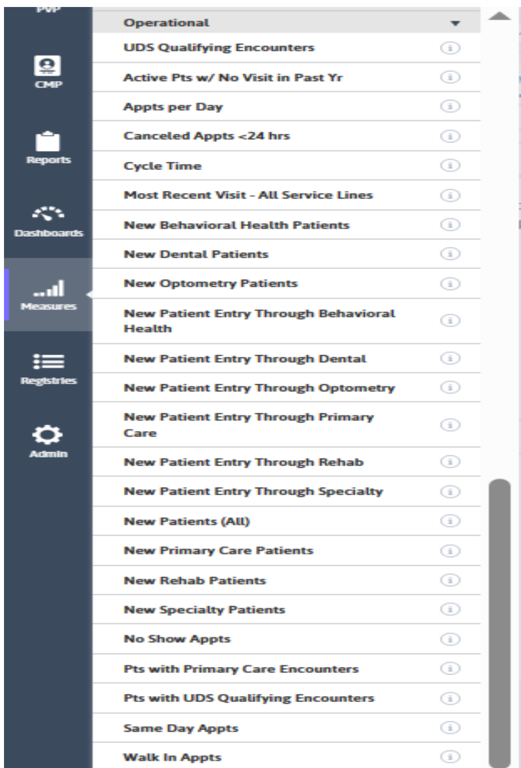
ENHANCED REGISTRIES MPCA offers enhanced registries in DRVS to members of our network. They include chronic kidney disease, OB, and opioid registries. They can be accessed from the Registries button on the left navigation panel, under the Azara registries category.



OPERATIONAL FEATURES

OPERATIONAL MEASURES There are several operational measures unique to MPCA's DRVS user accounts to help improve efficiencies in the delivery of care. They include operational, payer integration, plan calculated, and risk adjustment factors (RAF) measures.

Operational: Expanding the Operational Measures category shows measures related to patient appointments, as seen below.



Payer integration: Operational measures in this category include measures related to your organization's assigned members from health plans, identified below.

CMP
Reports
Dashboards
Measures
Registries
Admin

Payer Integration
- Average Cost PMPM
- Center Membership Growth Rate
- Cost per Member
- ER Utilization Rate
- ER Visits Per Utilizer
- Inpatient Utilization Rate
- Inpatient Visits Per Utilizer
- Matched Members
- Medicare AWV Member Based
- Member A1C Test
- Newly Assigned Members
- Newly Eligible Members
- Newly Ineligible Members
- Newly Unassigned Members
- Plan Membership Growth Rate
- Soft Matched Members
- Unmatched Members
- Usual PCP to Plan PCP Alignment

Plan calculated measures: These measures identify patients who have gaps in certain services that plan-provided Community Health Workers (CHWs) aim to complete by providing patient outreach.

Measures
Registries
Admin

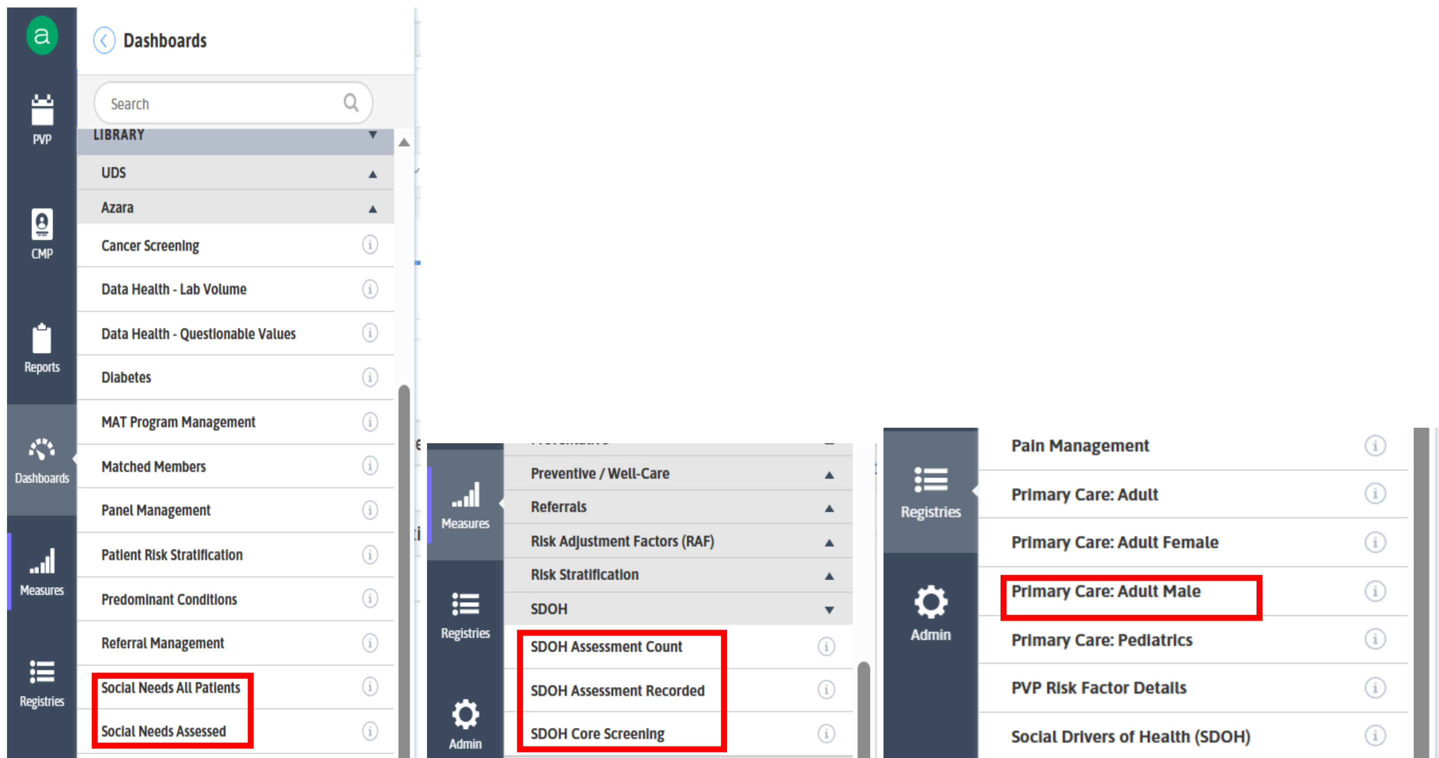
- Patient Outreach
- Payer Integration
- PCHH
- PHASE Measures
- Plan Calculated HEDIS Measures
- Plan Calculated Measures
  - High ED Utilizers
  - Missing HRA
  - No Visit
  - SDOH Required - Plan Calculated

Risk adjustment factors (RAF): The RAF measures provide details on the number of patients with one or more Medicare-designated RAF diagnosis and their RAF score.

Dashboards
Measures
Registries

Risk Adjustment Factors (RAF)
- Average CDPS Medicaid Risk Score
- Average HCC Medicare Risk Score
- Percent of Patients w/ RAF Gap
- RAF Gap Value Per Patient
- RAF Gap Value per Patient w/ Gap
- RAF Gap Value Per RAF Gap
- RAF Gaps Per Patient
- RAF Gaps Per Patient w/ Gap

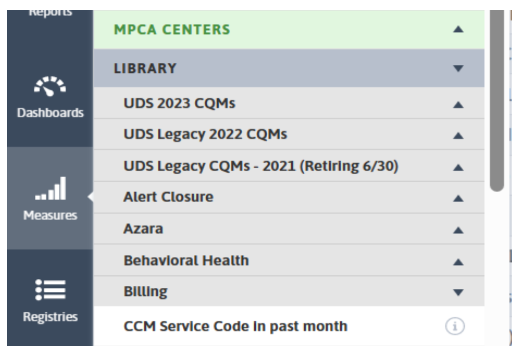
ACC AND SDOH MODULES MPCA members connected to DRVS can add Azara Care Connect (ACC) and SDOH (Social Drivers of Health) modules to your organization's account for an additional charge. ACC is used by CHWs to document and monitor their patient outreach efforts. With access to the SDOH module, MPCA DRVS users gain access to social needs assessment dashboards, measures, and registries. These will allow you to manage and mitigate psychosocial factors that can be detrimental to your patient's health. The SDOH dashboards and registry can be found under the Azara categories in these features, and the SDOH measures have their own category in the measures feature. Additionally, the community linkages add-on module can help facilitate referrals for patients to SDOH services in your area.



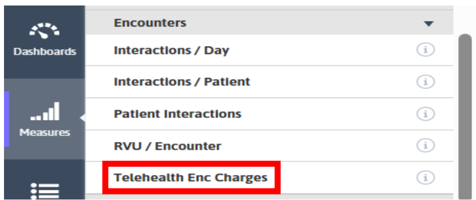
FINANCIAL FEATURES

There are four sets of financial measures in DRVS that will be useful for billing and finance teams to monitor trends for demonstrating increased quality without increased costs.

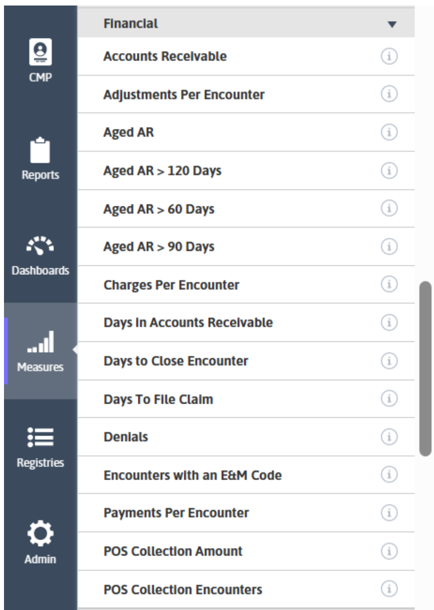
Billing The billing measure available to DRVS users in Michigan tracks the monthly Chronic Care Management (CCM) rate. When patients are released from the hospital, FQHCs can receive enhanced reimbursement for initiating a Transition of Care (TOC) process for Medicare patients that ensures continuity of care and proper follow-up by the patient's PCP. Below is a screenshot of the Billing measure category.



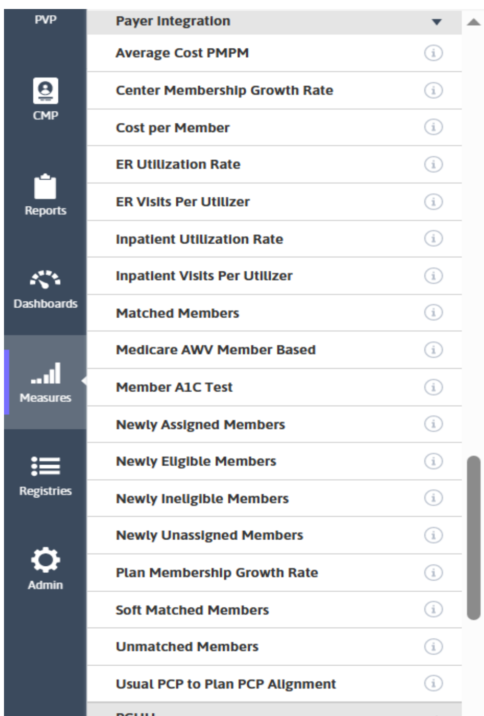
Encounters The encounters measure category contains a financial measure for telehealth charges.



Financial There are many financial measures related to claims filed with payers in the financial measures category, seen below.



Payer integration Payer integration measures are based on monthly patient data Azara receives from health plans. This measure category includes measures related to current and new patients assigned to your health center or provider, costs per member, whether the member matches an EHR record, and ED/IP utilization measures. The full list of measures can be viewed in the screenshot below.



C) DRVS ADD-ON FEATURES

Some of the features in DRVS are available to DRVS users at an additional cost. MPCA has been able to provide financial support in some instances. The add-on features include:

- Azara Care Connect (ACC)
- Azara Patient Outreach (APO)
- Community linkages- this is a service that requires a separate subscription
- Controlled substance modules
- Dental integration
- Financial/Operations module
- EHR plug-in for DRVS
- HIV expanded measures
- Payer integration modules
- Referral management module
- Risk Adjustment Factor (RAF) gaps
- Social Determinants of Health (SDOH) modules

If you are interested in adding features to your DRVS account, you can e-mail Cheryl Gildner, Data Manager at: cgildner@mpca.net.

D) DRVS LINGO- ABBREVIATIONS AND DEFINITIONS

Below is a list of abbreviations and definitions referenced throughout this User Guide.

DRVS: DRVS stands for Data Reporting and Visualization System. It is the cloud-based product Azara Healthcare created to supply healthcare organizations with their data visualization and reporting, population health, and point of care needs.

Network: When comparing your center's performance data, DRVS allows for comparison against national benchmarks, within your organization at the site level, and to MPCA's network. When the network is referenced in this Guide, it refers to the FQHCs that are members of MPCA.

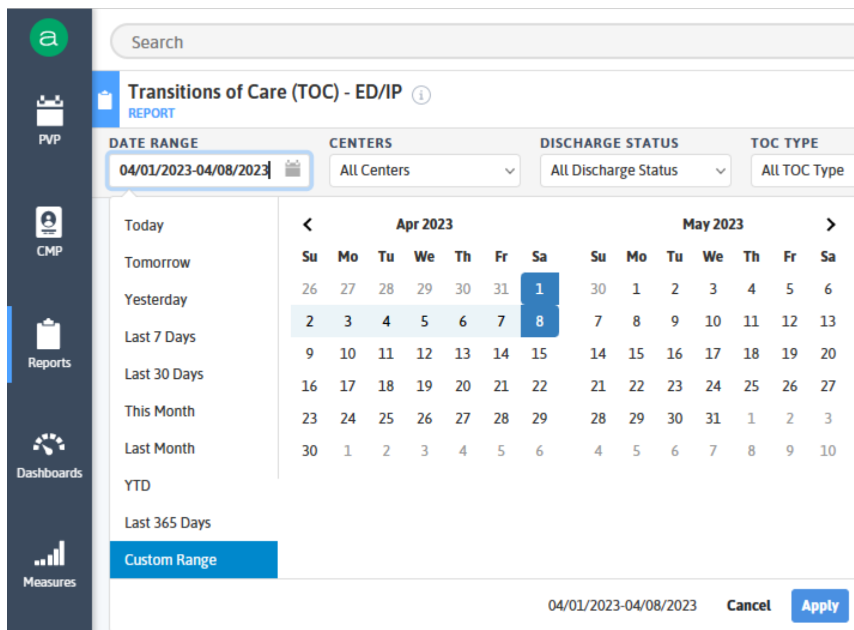
Measure endorsing bodies: In the Measure Analyzer section, it is discussed how measure endorsing bodies set standards of care for whom and how often health care services should be performed for delivery of optimal care. Measure endorsing bodies include the Center for Medicare and Medicaid Services (CMS), the National Association of Quality Assurance (NCQA), the National Quality Forum (NQF), and the US Preventive Services Task Force (USPSTF).

eCQM: Stands for electronic clinical quality measures. They are measures within DRVS to track improvement in patient health outcomes.

Measurement periods: When viewing data in DRVS, you can change the measurement period in the filters bar. Depending on whether you are running a measure, report, registry, or dashboard, you will have different measurement period options to choose from. The **year** measurement period contains data for the entire year you select. If you select the current year, you will see data up to the date you run the data. The **quarter** measurement period contains data for the three-month period selected in the calendar year. Q1 will contain data from January through March, Q2 from April through June, etc. The **month** measurement period contains data from the first day to the last day of the month selected. If selecting the current month, data will be displayed through the date of the month you run the data. The **trailing year (TY)** measurement period is the aggregate, or average performance for the month you are running the data and the 11 TY months prior to that month. The TY measurement period is often used when identifying patients who have care gaps for a given measure because many measures have longer look-back periods to satisfy the measure. For

example, the breast cancer screening measure looks for patients who have had a mammogram in the current measurement period or the 27 months prior, so using the TY measurement period to identify patients with care gaps prevents patients from falling out of the denominator as quickly. This way, you will identify as many patients as possible with care gaps, so the services can be addressed with these patients.

Certain features, such as reports in DRVS will also allow you to filter by **day, week,** and by **custom range**. When filtering by **day**, only data from the date you choose will be displayed. Filtering by **week** prompts you to choose the 7-day week ending date range you want to run data for. Reports and registries allow you to set a **custom range** measurement period. Clicking the date range calendar in the box allows you to set the beginning and end date of the period you want to run data for. Click the blue 'Apply' button to finish setting the date range in the filters bar.



PVP/CMP: The Pre-Visit Planning (PVP) report and Care Management Passport (CMP) are point-of-care tools featured in DRVS that identify patients with care gaps and allow for improved patient care delivery through coordination of care.

CHW: A CHW is a community health worker whom many FQHCs employ to support patient engagement activities, such as care gap outreach.

Rendering vs. usual provider: In the filters bar, one of the default settings for certain measures, reports, registries, and dashboards is to display data by **rendering provider**. This provider type includes any provider a patient has seen in the selected measurement period. You can also include a filter for the **usual provider**, which is the provider a patient most frequently sees. This is often the patient's PCP.

Cohorts: A cohort is a static group of patients that share common characteristics, such as ethnicity, payer, provider, and care gaps. Creating a cohort allows you to track whether the patients included receive age and gender-appropriate care over time.

Widget: A box of data that can be represented in different ways, such as a scorecard, dial, bar chart, pie chart, or run chart. Widgets are the foundational unit within dashboards and on the DRVS landing page.

HIE/ADT: A **health information exchange (HIE)** is a statewide HIT system health centers are connected to, allowing the center to see when and where patients seek care from hospitals across the state. In Michigan, the HIE is the Michigan Health Information Network (MIHIN). Limitations to seeing this data include whether a hospital is connected to the HIE or if there are data feed connection interruptions between Azara, the HIE, and EHRs. When a patient receives care at a hospital that is connected to the HIE, the data is transmitted to Azara in real-time from **admission, discharge, and**

transfer (ADT) feeds. The data includes information for both in-patient and emergency department visits: dates of service, diagnosis codes, and descriptions, and where the patient was discharged to (ie. home, a skilled nursing facility, a rehab center, etc.).

Care teams: As the delivery of care has shifted from provider-driven to patient-driven, the goal in the provision of care should be to focus on multiple, complex needs a patient has in one visit. Care teams of the provider, clinical, and non-clinical support staff can help ensure all patient needs are met by communicating with each other to coordinate medical, behavioral, dental, and social service needs.

MCHN/CIN: The Michigan Community Health Network (MCHN) is the clinically integrated network (CIN) branch of MPCA. Made up of Michigan's FQHCs and community clinics serving our patients, MCHN works with payers to set realistic value-based performance goals for clinical and operational measures. Achieving these goals leads to enhanced payment through value-based contracting with the payers by demonstrating the increased quality of care delivered to patients that improves patient outcomes at reduced costs.

CMS: CMS is the abbreviation for the Centers for Medicare and Medicaid Services, the federal agency that sets measure standards, billing policies, and reimbursement rates for clinics providing services to Medicare and Medicaid recipients.

X. CONCLUSION

We hope this User Guide is helpful for getting started with or refreshing your knowledge of commonly used features in DRVS. Thank you for taking the time to read it and come away with confidence in the product you are using, in whatever capacity. If you have questions about any of the features discussed, contact anyone from MPCA for further help!