The Patient Visit Planning report and Care Management Passport are tools designed to make it easier to manage the care of your patients.

Incorporating these tools into your workflows can result in:

- Improvements in care
- Adherence to evidence-based care guidelines
- Attainment of clinical quality improvement incentive goals
- Support for PCMH huddles and documentation
- Facilitate care gap management
- Improved teamwork for care coordination
- Enhanced provider and staff satisfaction

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Using the patient visit planning report (PVP)

The Patient Visit Planning report (PVP) helps the care team plan, prepare, and review upcoming patient appointments. The PVP displays each patient’s demographic information, chronic conditions and risk factors, as well as actionable items in the form of alerts. The

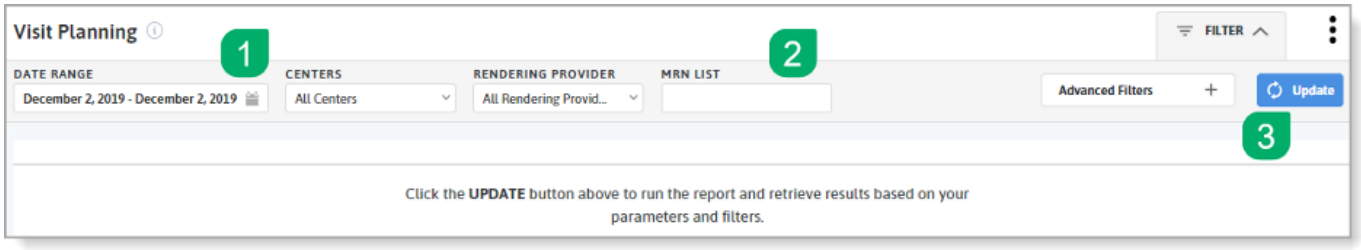
report is in the format of a daily schedule grouped by provider and ordered by appointment time. Filtering can be used to fine tune the group of providers or patients you want to see on the PVP.

Integrating this report into daily care delivery promotes efficient and effective team-based care. Using this report every day is an opportunity for quality improvement (QI) as many practices who use it realize significant measure performance improvement. It also supports data hygiene efforts because every day becomes an opportunity for users to review data from the EHR that may not be accurate due to changed workflows etc.

The PVP can be run prospectively to prepare and plan for patients' upcoming appointments, or historically based on the patients' most recent appointment with a status of 'kept' to review the success of care team planning, preparation, and execution.

Running the report

The PVP is accessed through the Left Nav by clicking the **PVP** icon. When you first navigate to the PVP, you are given the opportunity to change filters (date range, provider, etc.) prior to running the report.

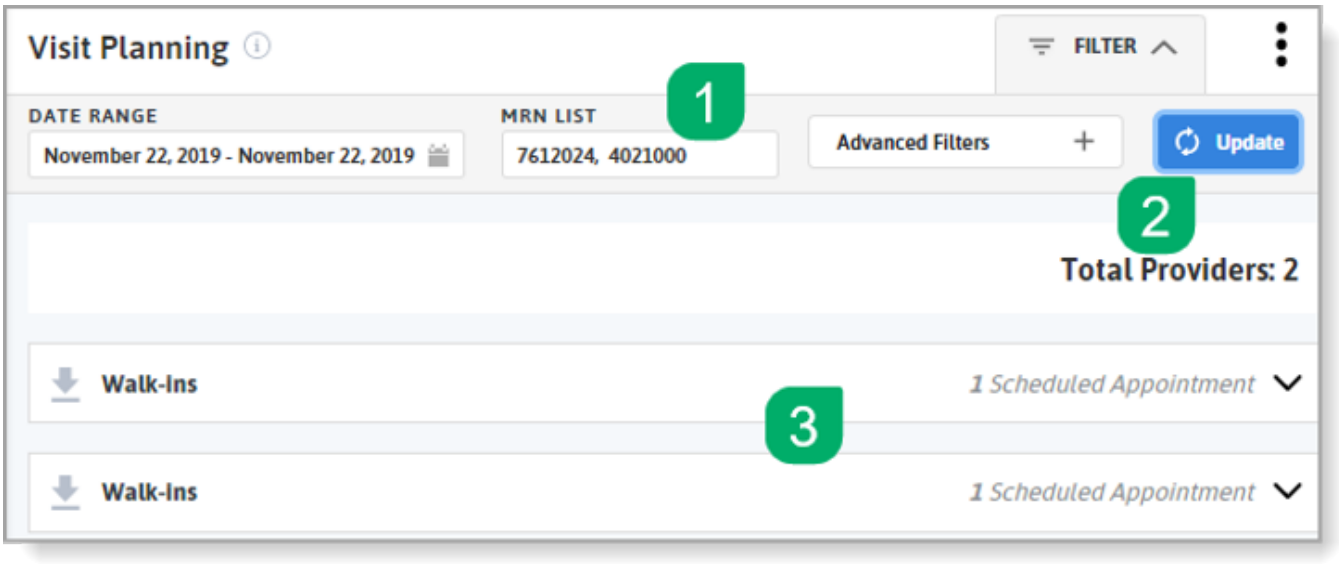


1. Select your date range. The default is to 'Today's' date. Select the time period to reflect your desired time frame for appointments. Appointments will sort by provider and in order of appointment time.

Check with your CHC site administrator or Azara Support to understand the impact of nightly processing. Some practices have additional appointment processing that refreshes appointment data on a more frequent basis. Depending on the data connector, processing of appointments can be every 4-48 hrs.

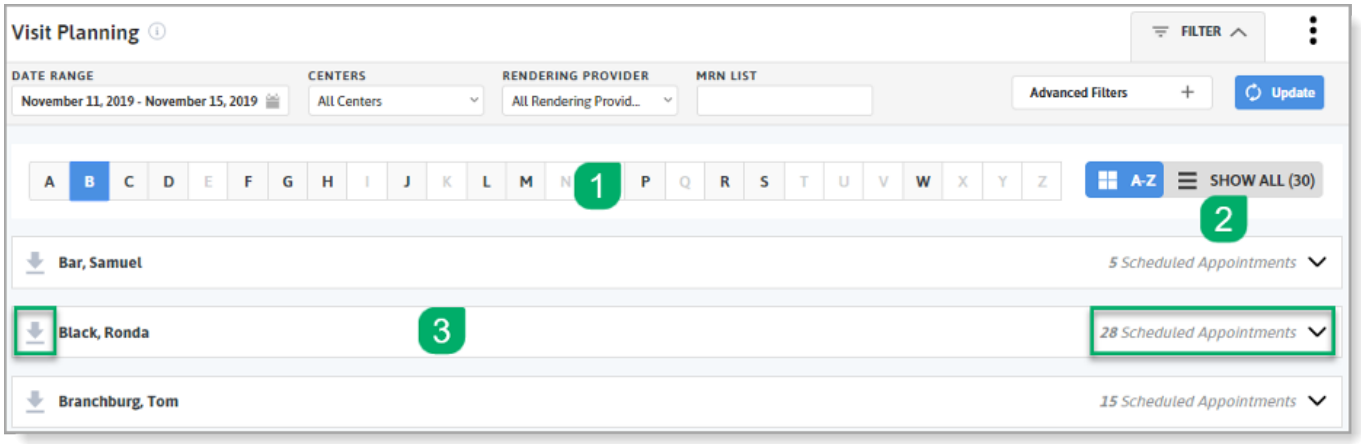
2. Use the filter options to customize your PVP report. When you open the PVP, the default filters are visible. Standard filters can be used to filter patients by condition, risk, or other criteria.
3. Click **Update** to run the report.

Daily schedule and walk-in patients



1. To add walk-in patients (patients whose appointments were scheduled after the last data refresh), use the MRN List box. For one patient per report, run the report for one MRN at a time. For more than one patient in a report, add multiple MRNs separated by commas. Use the wildcard '%' if you only know part of an MRN or for leading zeroes.
2. Click **Update** to run the report.
3. A new report will be generated listing "Walk Ins" as a provider, which can be expanded to view the patient's information.

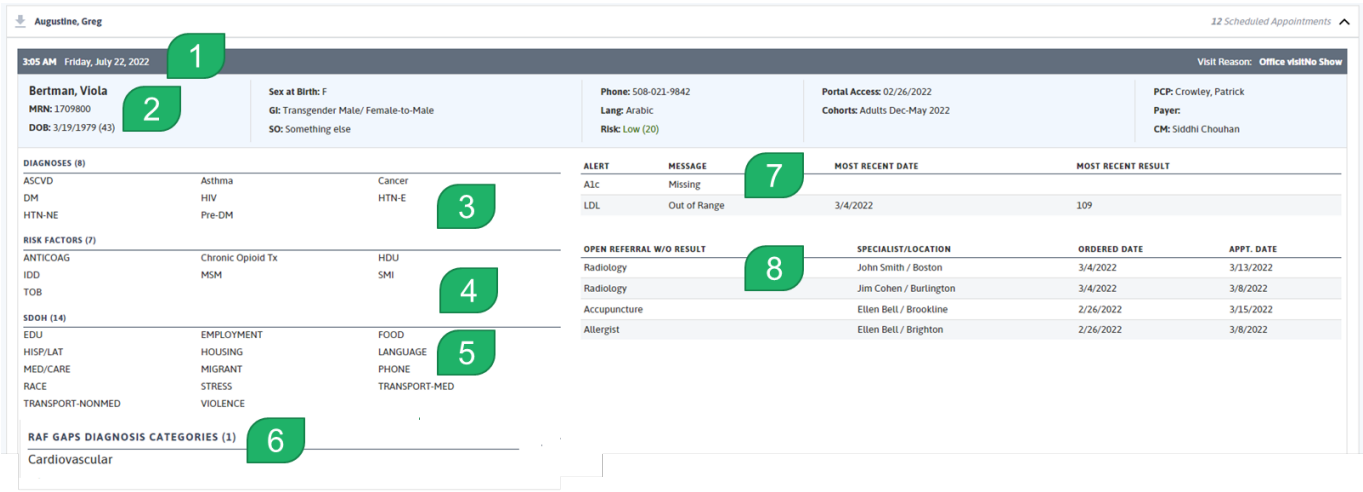
Provider index



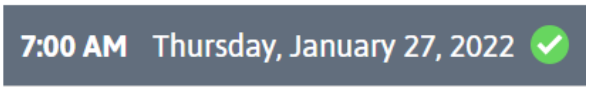
1. When ten or fewer providers are part of the report, they are listed alphabetically by last name. If more than ten providers are part of the report, the provider tabs in the alphabetical index are listed. Providers are organized alphabetically by last name, and a tab is bolded when a provider has patients scheduled.
2. Click **Show All** to list all the providers with appointments in alphabetical order.
3. Each provider is listed with all the patients who have a scheduled appointment during the date range. Click the provider's name to view their visit planning report. Click the

download icon next to the name to download a PDF of the provider's planning report.

Visit planning report



1. For each provider, appointment information is listed that includes the appointment date, time, and reason for visit. Users will also see a green check mark if the appointment has been confirmed. Confirmation is determined by the mapped Appointment Status of "Confirmed" only.



2. The blue patient demographics header includes key patient information including: patients' medical record number, date of birth and age, SOGI data, preferred language, phone number, PCP/usual provider, risk (if available), care manager (if available and assigned), primary payer, last portal access, last well visit, and whether the patient is in an active cohort. Click the patient's name to open the patient's care management passport in a new window.
3. The patient's active chronic diagnoses, with the total number noted in parentheses. Hover over any of the diagnosis abbreviations for a full description. Please note that the diagnosis filter in DRVS looks for a diagnosis active at any time in last 12 months. If a diagnosis filter is applied to the PVP, it is possible that the diagnoses selected in the filter will not match the diagnoses on the PVP. The PVP info snippet also includes a summary of all diagnoses and abbreviations. Examples of diagnoses included with the PVP are diabetes, hypertension, asthma, depression, HIV, COPD, CHF, CAD, and IVD.
4. The patient's risk factors are displayed with the total number noted in parentheses. To view the value sets for each risk factor, navigate to the PVP Risk Factor Detail registry on the left hand navigation under Registries > Azara > Risk Factor Detail. The PVP info snippet includes a summary of all risk factors and abbreviations. Examples of risk factors include tobacco use, BMI, and pregnancy.

5. Social Determinants of Health (SDOH) factors are displayed, with the total number noted in parentheses. These SDOH factors are determined by the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and other SDOH tools. The PVP info snippet includes a printable, one-page summary of all SDOH factors and abbreviations.
6. RAF Gap Diagnosis Categories are displayed to help organizations alert providers at point of care about existing RAF Gaps for a patient based on the CMS-HCC model or the CDPS Medicaid Model. RAFs (Risk Adjustment Factors) are individual factors that make up a type of risk score that affect how providers are reimbursed for their care. RAF Gaps exist when a code with a high-risk factor has been billed in the past but not in the current year. Please note that RAF Gaps are not enabled by default, and while there is no additional cost, practices and networks need to request that they be enabled through a support ticket to support@azarahealthcare.com.
7. Alerts are used to identify care gaps for the patient. Alerts are based on clinical data such as screenings, labs and vitals and can be enabled or disabled to meet the organizations' needs. Some alerts are configurable, meaning a practice can alter the logic of the alert to meet specific workflow needs. Alerts are grouped and ordered based on similar actions required for the type of alert. The most recent dates and results are listed if available. Each alert is classified with one of the following message types (which is editable for configurable alerts. For more information on configuring alerts, see the Alerts Administration User Guide):
    - Missing: There is no record in DRVS or the EHR of the data pertaining to the alert
    - Overdue: The recommended alert for the patient has not occurred within the organization-defined time period.
    - Due Soon: Triggers when the recommended alert is not yet overdue, but will become due within a defined period, giving the care team time to 'act' on the alert so it does not become overdue.
    - Out of Range: The result recorded from the most recent lab or screening for the patient is not within a organization-defined acceptable range.
8. Open referrals without results displays referrals that have been ordered but a consult note or report from the referral has not yet been received. The referral type, specialist/location, ordered date, and appointment date (if available) are listed. The open referrals listing is only available for practices that have purchased the Referrals Module.

Getting the most of the PVP

Alert Closure – Point of Care

The “Alert Closure – Point of Care” measure can be used to gain insight into the effectiveness of teams using the PVP. Point of Care (POC) alerts are any alerts that are actionable and can be closed by the end of the visit. Some examples of POC alerts are A1c, fall risk screening, nutritional counseling, asthma severity, and tobacco screen. The measure shows the percentage of alerts that were closed out of all alerts from the week. Users can group and filter this data by provider, location, and alert; note that all visits and provider types are represented in the denominator, so the data will need to be filtered by provider or provider group to remove specialty visits such as dental, behavioral health, etc. where a POC alert such as A1c is unlikely to be closed.

Filtering

Filters enable you to tailor the list of patients based on your requirements. Some useful ways to apply filters in the PVP include:

- The filter for **Diagnosis** allows specific teams to run the PVP for patients they are most concerned with. For example, diabetic educators may want to run the PVP for only patients with a DM diagnosis, or a behavioral health team may want to only see patients with a mental health diagnosis such as depression, bipolar, or severe mental illness and psychosis.
- The provider filters may include provider groups or teams, in addition to individual providers. If you are running the PVP report for use in a huddle or to share with providers, use the **Rendering Provider** filter to return the provider the patient is seeing, rather than the provider assigned in the EHR. In the report, the patient’s blue demographic header will list this assigned or **Usual** provider.)
- To view only the patients who have alerts, select FALSE in the **Return All Patients** filter.

To save your filter settings for the PVP, click the filter funnel icon at the right side of the filter bar. Click **Add New**, name your filter, and then click **Save**. The specific set of filters will be added to the **Saved Filters** list. To apply a saved filter, click the filter funnel icon, and select the saved filter from the list. The filter set will be applied to the PVP. You can save multiple sets of filters.
See the Filters User Guide for more details.

Printing or using the PVP online

The PVP can be used and viewed online, as with any of the reports in DRVS.
If you want to use the PVP for a team huddle, to share with provider, or to make notes on it,

you can easily export and print the report. To export the PVP for the filtered list of providers, click the 3-dot menu in the upper right of the page and select Export Excel or Export PDF to download and save the file. To export to PDF for a single provider, use the download icon next to the provider's name. The exported file contains the formatted PVP and a list of all filter settings.

- To print the PVP for use in team huddles, export as a PDF.
- To print the PVP for use in charting, export as an Excel file. The Excel file places each alert on a separate line, which makes it easier for filtering and data validation.

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
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-STGS	**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 Determinants 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)
ABBREVIATION	**CHRONIC CONDITION OR DIAGNOSIS**
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

RAF Gap abbreviations

ABBREVIATION	MEANING	NOTES
CY EHR	Current Year EHR	EHR data joins assessment and problem lists and finds the highest code
PY EHR	Prior Year EHR	EHR data joins assessment and problem lists and finds the highest code
CYB	Current Year Billed	Billed data comes from either charge or CLM data
PYB	Prior Year Billed	Billed data comes from either charge or CLM data
CHG	Charge (from EHR)	Billed EHR data - looks at EHR charge capture (charge dx must match)
CLM	Claim	Billed CLM data - looks at claim line and claim diagnosis * Note: We only show "CLM" when data ONLY exists for CLM (and not charge) for a given RAF gap

Related Topics: Alert Administration Last updated: 11/18/2022