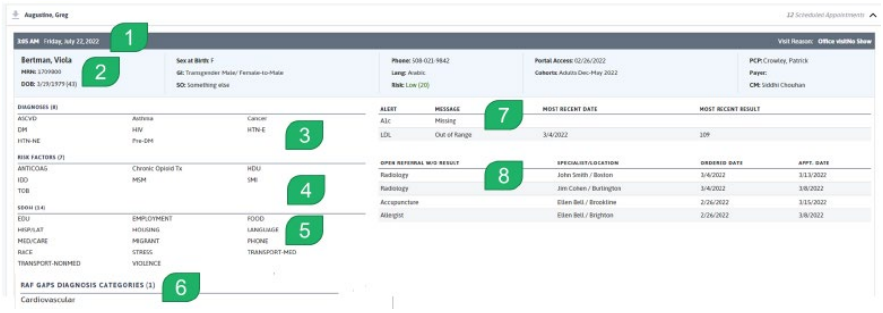
Patient Visit Planning (PVP)

The Patient Visit Planning Report is a tool designed to make it easier to manage the care of your patients.



Features:

- Allows “walk-in” patients to be added to the providers daily schedule.
- Highlight’s the patient’s active chronic diagnoses (Please note that the diagnosis filter in DRVS looks for a diagnosis active at any time in last 12 months.) Examples of diagnoses included with the PVP are diabetes, hypertension, asthma, depression, HIV, COPD, CHF, CAD, and IVD.
- Highlights the patient’s risk factors. Examples of risk factors include tobacco use, BMI, and pregnancy.
- Social Determinants of Health (SDOH) factors are displayed, with the total number noted in parentheses.
- 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.
- 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.
    - 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.
    - 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 our organizations-defined acceptable range.
- Some POC alerts can be closed at the end of a visit.
- Open referrals without results displays referrals that have been ordered but a consult note or report from the referral has not yet been received.
- Filters can be utilized with PVP.
- PVPs can be printed or used online.

Updated: 2/16/2023