

azara2025

USER CONFERENCE APR 29-MAY 1 | BOSTON, MA

DRVS' Best Kept Secrets

Optimizing DRVS for Patient, Performance, and Population Health Management



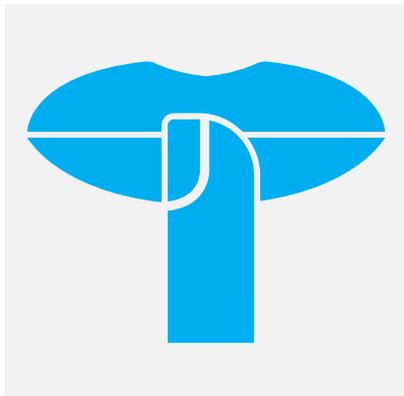
Today's Presenters



Danielle Harvey
Sr. Clinical Improvement
Specialist, Clinical
Transformation

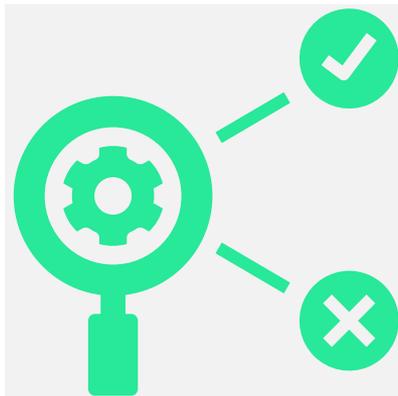


Shannon Gallant
Product Manager,
Product Management



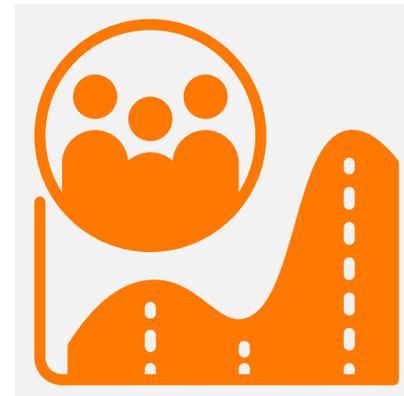
COMING CLEAN

These are not secrets we're intentionally keeping but secrets we're eager to share with the world!



PERFORMANCE MANAGEMENT

Highlight backend configuration opportunities that can streamline your reporting processes.



POPULATION MANAGEMENT

Track health outcomes over time for populations of your choice with custom Care Effectiveness Reports.

Coming Clean



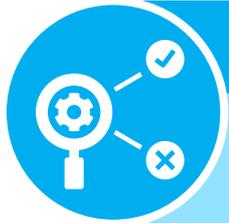
**Secrets secrets
are no fun...**



**Unless you share
with everyone!**

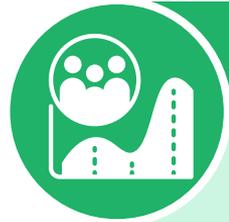


Overview



Performance Management

YTD Progression, Dynamic Baseline Periods, Saved Filters, Saved Columns, Pins, Group Admin, Dashboard Updates



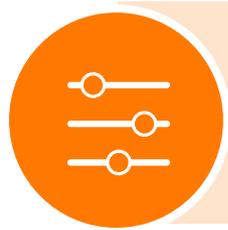
Population Health Management

Custom Care Effectiveness Reports & Cohort Basics

Performance Management



Tools to Review



Dynamic
Baseline Periods



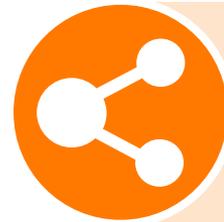
Pins



Saved
Columns



Saved & Default
Filters



Group
Admin

Dynamic Baseline Periods:

Available on Scorecards & Dashboards!

- Allows users to lock in a “lookback” and to compare the period against it in both saved filters and email subscriptions
- As new periods are processed, the baseline period moves as well

BASELINE PERIOD

None

DYNAMIC PERIODS

- 1 Period Back
- 2 Periods Back
- 3 Periods Back
- 4 Periods Back
- 5 Periods Back
- 6 Periods Back
- 7 Periods Back
- 8 Periods Back
- 9 Periods Back
- 10 Periods Back

Baseline Periods | Static vs. Dynamic

UDS 2024 CQMs REPORT

PERIOD: Q1 2025 RENDING PROVIDERS: 4 selected

GROUPING: No Grouping

MEASURE

- Childhood Immunization Status (CMS 115v12)
- Child Weight Assessment / Counseling for Obesity (CMS 155v12)
- BMI Screening and Follow-Up 18+ Years (CMS 155v12)
- Depression Remission at Twelve Months (CMS 155v12)
- Screening for Depression and Follow-Up (CMS 155v12)
- Tobacco Use: Screening and Cessation (CMS 155v12)
- Colorectal Cancer Screening (CMS 130v12)
- Cervical Cancer Screening (CMS 124v12)
- Breast Cancer Screening Ages 50-74 (CMS 125v12)
- Hypertension Controlling High Blood Pressure (CMS165v12)
- Diabetes A1c > 9 or Untested (CMS 122v12)

STATIC PERIODS

- Q1 2025
- Q4 2024
- Q3 2024
- Q2 2024
- Q1 2024
- Q4 2023
- Q3 2023
- None

DYNAMIC PERIODS

- 1 Period Back
- 2 Periods Back
- 3 Periods Back
- 4 Periods Back

TARGETS: Primary Not Met

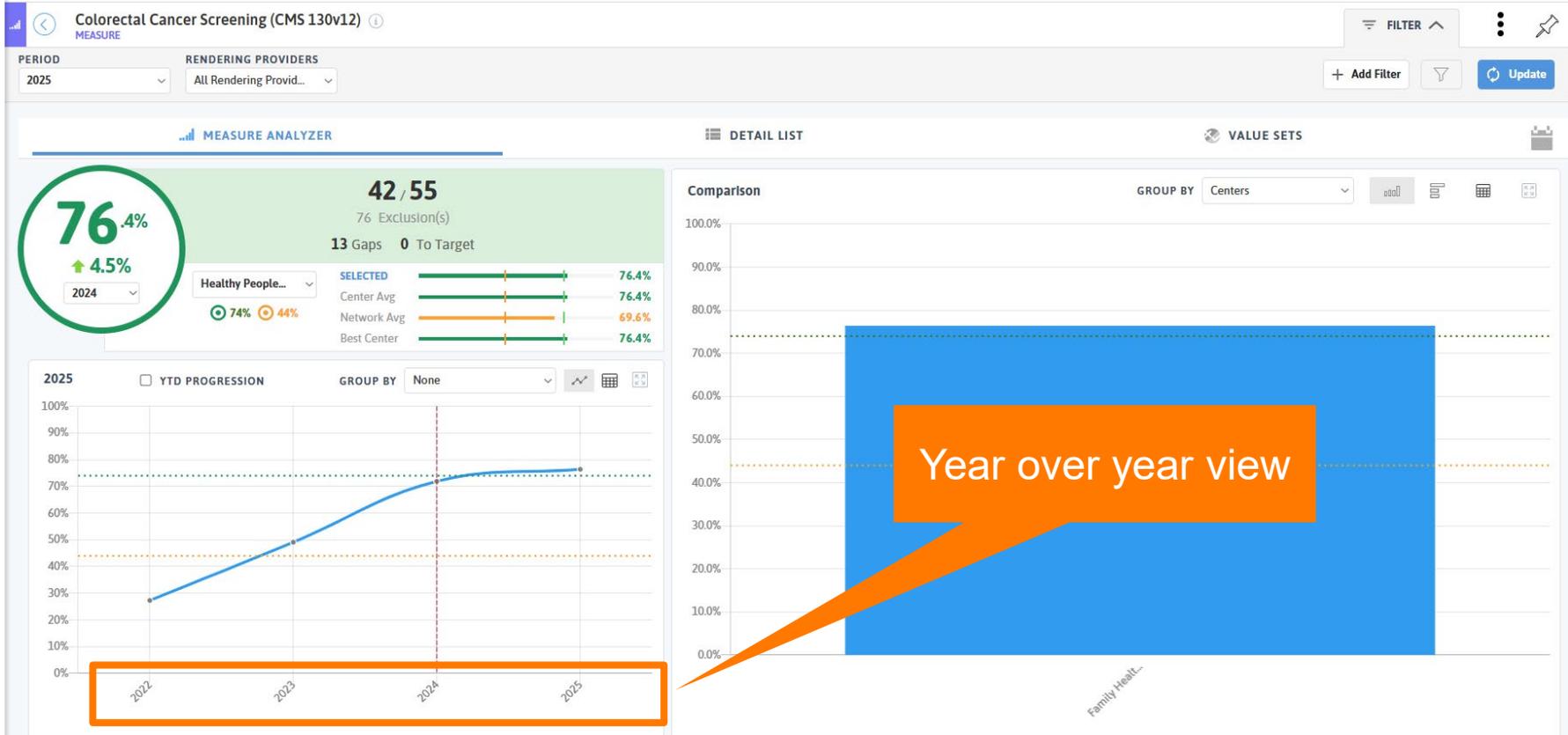
REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (CMS 115v12)	0.0%	0.0%	35.0%	0	0	1
Child Weight Assessment / Counseling for Obesity (CMS 155v12)	76.0%	- 4.8% ▼	30.0%	19	25	17
BMI Screening and Follow-Up 18+ Years (CMS 155v12)	91.4%	+ 9.3% ▲	36.0%	32	35	69
Depression Remission at Twelve Months (CMS 155v12)	15.4%	+ 15.4% ▲	47.0%	2	13	2
Screening for Depression and Follow-Up (CMS 155v12)	92.5%	+ 6.5% ▲	76.0%			
Tobacco Use: Screening and Cessation (CMS 155v12)	81.0%	- 0.8% ▼	20.0%			
Colorectal Cancer Screening (CMS 130v12)	90.0%	+ 25.0% ▲	38.0%			
Cervical Cancer Screening (CMS 124v12)	100.0%	+ 75.0% ▲	63.0%			
Breast Cancer Screening Ages 50-74 (CMS 125v12)	100.0%	+ 50.0% ▲	53.0%			
Hypertension Controlling High Blood Pressure (CMS165v12)	100.0%	0.0%	79.0%			
Diabetes A1c > 9 or Untested (CMS 122v12)	48.9%	- 9.8% ▼	60.0%			

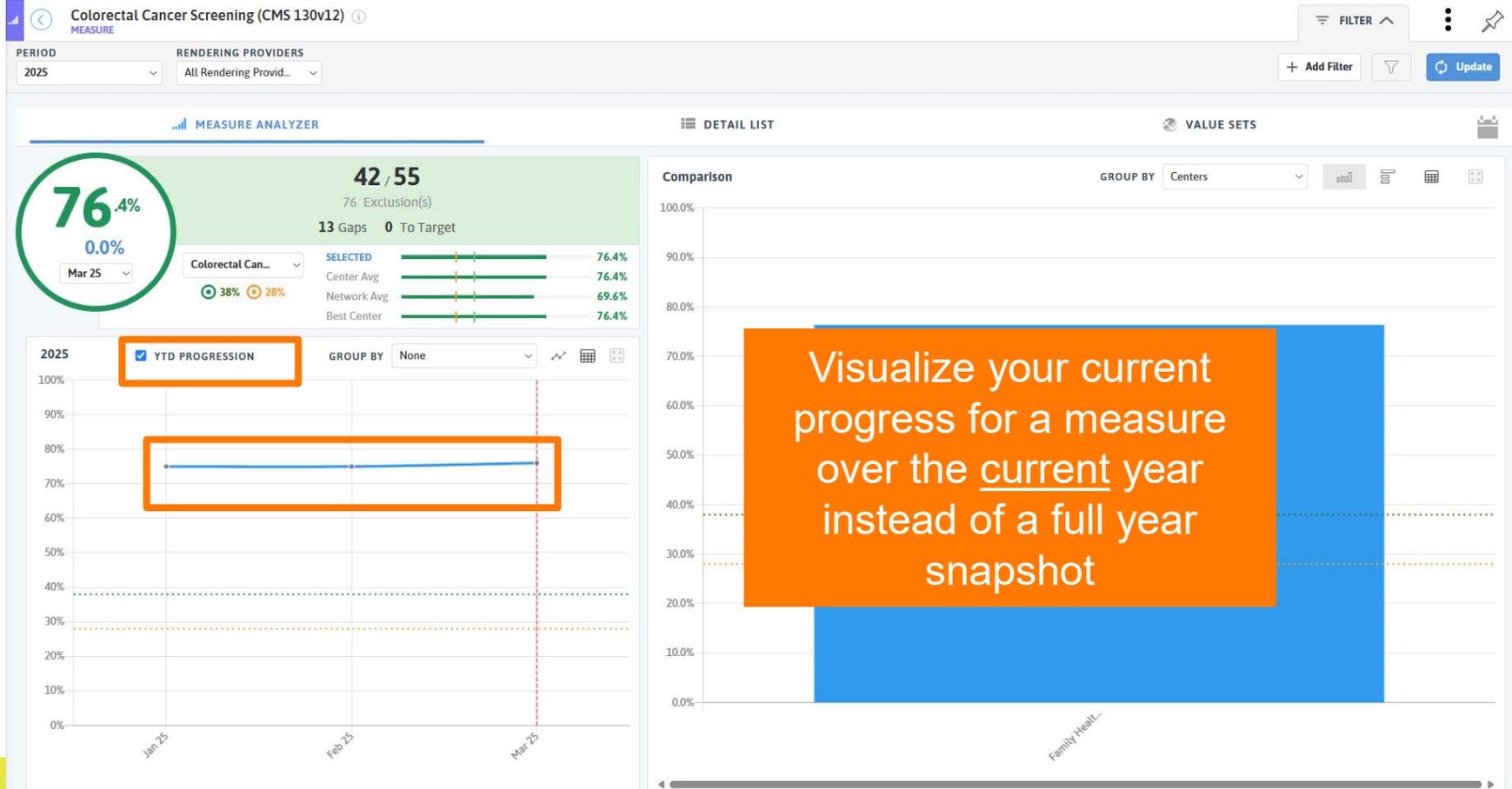
Choose from a static (fixed) comparison point or one that moves forward as new periods are processed

Baseline Period filter powers the Change column

YTD Progression | Measure Analyzer



YTD Progression | Measure Analyzer

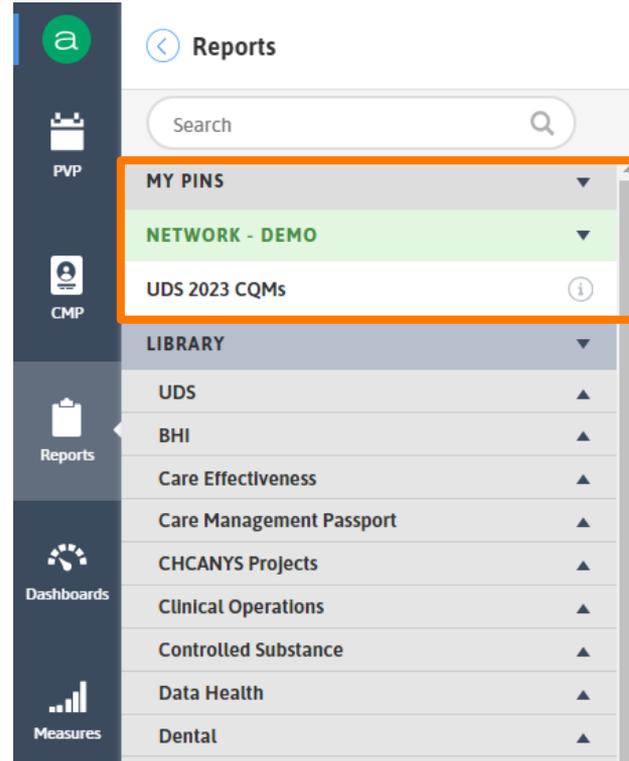


Visualize your current progress for a measure over the current year instead of a full year snapshot

Save the Searching & Sifting



Your favorites are
just **one click**
away!



Pinning Reports, Registries, & Dashboards

1 Start by click the thumbtack icon in the upper righthand corner

Pin to Menu

Location | Select Menu

Shared Pins

My Pins

Cancel

Add Pin

2 You'll see "Shared Pins" if you have pin admin. This will pin the resource for all DRVS users in your organization.

Saving to "My Pins" will put the resource in your pinned folder.

Saved Filters

Diabetes DASHBOARD

PERIOD: August 2023 | RENDERING PROVIDERS: All Rendering Provid... | COHORTS: DM Lifestyle Program

1. Apply all filters

2. Select "funnel" icon

3. Give filter a name

4. Click "Save"

Patients with Diabetes
TY August 2023
32
Pts w/ Diabetes

A1c < 7%

A1c > 9% / Untested
August 2023
60.0%, 69.2%, 53.8%, 53.3%, 58.8%, 58.8%

A1c Cascade
TY August 2023

PTS W/ DIABETES	Count	Percentage
DM A1c < 7	8	25%
DM A1c >= 7 and A1c <= 8	4	12.5%
DM A1c > 8 and A1c <= 9	1	3.1%

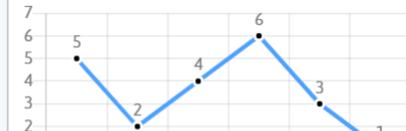
LDL Cascade
TY August 2023

PTS W/ DIABETES	Count	Percentage
DM LDL < 100	8	25%
DM LDL >= 100 AND < 130	6	19%
DM LDL >= 130	9	28%

A1c Uncontrolled by Age
TY August 2023



August 2023



Saved Filters
+ Add New

Save the set of currently set filters for easy and fast re-use.

FILTER NAME*
DM Lifestyle

Share this Filter
Shared filters can be set as defaults for reports

Save

Saved Filters

Diabetes DASHBOARD

PERIOD: August 2023 | RENDERING PROVIDERS: All Rendering Provid... | COHORTS: DM Lifestyle Program

Patients with Diabetes
TY August 2023
32 Pts w/ Diabetes
+8 ▲
TY 3/23

A1c < 7%
TY August 2023
25%

A1c Cascade
TY August 2023

PTS W/ DIABETES	32	
DM A1c < 7	8	25%
DM A1c >= 7 and A1c <= 8	4	12.5%
DM A1c > 8 and A1c <= 9	1	3.1%

LDL Cascade
TY August 2023

PTS W/ DIABETES	32	
DM LDL < 100	8	25%
DM LDL >= 100 AND < 130	6	19%
DM LDL >= 130	9	28%

A1c Uncontrolled by Age
TY August 2023

DM Pts with Primary Care Visits
August 2023

Filters Panel:

- Filter: FILTER
- + Add Filter
- Update
- Saved Filters + Add New
- MY FILTERS: DM Lifestyle
- SHARED FILTERS: Test filter

Annotation: By clicking "DM Lifestyle", filters will automatically be applied to the dashboard

Saved Filters | Default Filter

Select to lock in applied filters as the default filter on custom reports & dashboards

Saved Filters

Save the set of currently set filters for easy and fast re-use.

FILTER NAME*

Share this Filter
Shared filters can be set as defaults for reports

Set as Default Filter
This will override the previous default filter

Saved Filters | Updating the Filter

UDS 2024 CQMs REPORT

PERIOD: Q1 2025 | RENDERING PROVIDERS: 4 selected | BASELINE PERIOD: Q4 2024

SEARCH: [Search] [Clear Filters]

MEASURE: [Childhood Immu] [Child Weight As] [BMI Screening a] [Depression Rem] [Screening for De] [Tobacco Use: Sc] [Colorectal Canc]

GROUPING: No Grouping

TARGETS: Primary Secondary Not Met

MEASURE	RESULT	CHANGE	TARGET
/ Physical Activity (CMS 155v12)	70.0%	+ 5.5% ▲	30.0%
2)	82.5%	+ 6.6% ▲	36.0%
12)	8.3%	+ 1.6% ▲	47.0%
2v13)	91.5%	+ 8.8% ▲	76.0%
)	73.2%	- 6.1% ▼	20.0%
	68.8%	- 7.7% ▼	38.0%

Filter Panel:

- MY FILTERS: DMH Test
- SHARED FILTERS: Test, Family Medicine Providers, OB/GYN Providers

- Branchburg, Tom
- Cote, David
- Plant, Robert
- Weixel, Evan

Family Medicine Providers filter consisting of 4 providers

Saved Filters | Updating the Filter

UDS 2024 CQMs REPORT

PERIOD: Q1 2025

RENDERING PROVIDERS: 5 selected

BASELINE PERIOD: Q4 2024

PATIENT DIAGNOSES: Diabetes Type I or T...

Search: []

Clear Filters

GROUPING: No Grouping

TARGETS: Primary Secondary Not Met

MEASURE	RESULT	CHANGE	TARGET
Childhood Immunization (CMS 155v12)	0.0%	0.0%	3
Child Weight Assessment (CMS 155v12)	70.0%	+ 5.5% ▲	3
BMI Screening and Assessment (CMS 155v12)	82.5%	+ 6.6% ▲	3
Depression Remission (CMS 155v12)	8.3%	+ 1.6% ▲	4
Screening for Depression (CMS 155v13)	91.5%	+ 8.8% ▲	7
Tobacco Use: Screened (CMS 155v12)	73.2%	- 6.1% ▼	2
Colorectal Cancer Screening (CMS 155v12)			3

MEASURE

- Branchburg, Tom
- Cote, David
- Plant, Robert
- Weixel, Evan
- House, Gregory
- Houser, Dougie
- Jones, James

MY FILTERS

- DMH Test

SHARED FILTERS

- Test
- Family Medicine Providers
- OB/GYN Providers

Update Filter

Delete Filter

11

Easily update saved filters

Creating Saved Columns

SAVED COLUMNS



- 1 Hold down your cursor and select the column that you want to get rid of.
- 2 Drag the column off the registry and release. Repeat this for all the columns you want to remove.
- 3 Select “Saved Columns” in the righthand corner and give your “view” a name.

The screenshot shows a web application interface for a Diabetes Registry. At the top, there's a header with 'Diabetes REGISTRY' and a search bar. Below the header, there are filters for 'VISIT DATE RANGE' (12/20/2023-12/27/2023) and 'RENDERING PROVIDERS' (All Rendering Provid...). A table of patient data is displayed with columns for DEMOGRAPHICS, INSURANCE, and MOST RECENT ENCOUNTER. A dialog box titled 'Saved Columns' is open on the right, allowing the user to name the saved columns. The dialog includes a 'Reset Columns' button, a 'Saved Columns' header, a '+ Add New' button, a text input field containing 'Amelia's View', and a 'Save' button.

DEMOGRAPHICS >		INSURANCE		MOST RECENT ENCOUNTER	
NAME	MRN	FINANCIAL CLASS	PRIMARY PAYER	DATE	PROVIDER
Lieng, Alessandra	1104141	Medicaid	Medicaid	9/26/2023	Bridgewater, Bill
Shippy, Gabriel	1104154	Private Insurance	Coventry	8/11/2023	Fritz, Renata
Kietar, Bebe	1104155	Private Insurance	Aetna	9/11/2022	Smith, Joe
Palomo, Merrill	1104181	Medicare	Medicare	8/7/2023	Winslow, Francine
Willenbring, Wanita	1104182	Medicare	Medicare	2/26/2022	Black, Ronda
Dziadek, Nellie	1104206	Private Insurance	Aetna	8/8/2023	Crowley, Patrick
Mora, Annamae	1104230	Medicaid	Medicaid	6/28/2022	Crowley, Patrick
Economy, Terrilyn	1104241	Medicaid	Medicaid	4/6/2023	Fritz, Renata
Stehly, Jesse	1101839	Medicare	Medicare	6/17/2023	Smith, Joe

Reset to Personalized View with Two Clicks!

Diabetes REGISTRY FILTER + Add Filter Update

VISIT DATE RANGE: 12/20/2023-12/27/2023
 RENDERING PROVIDERS: All Rendering Provid...

REGISTRY **VALUE SETS**

Search Patients ...

DEMOGRAPHICS		INSURANCE		MOST RECENT ENCOUNTER			NEXT APPOINTMENT	
NAME	MRN	FINANCIAL CLASS	PRIMARY PAYER	DATE	PROVIDER	LOCATION	DATE	PROVIDER
Lleng, Alessandra	1104141	Medicaid	Medicaid	9/26/2023	Bridgewater, Bill	Main St. Office	9/22/2023	Bridge
Shippy, Gabriel	1104154	Private Insurance	Coventry	8/11/2023	Fritz, Renata	70 Blanchard Rd.	12/26/2023	Decel
Kielar, Bebe	1104155	Private Insurance	Aetna	9/11/2022	Smith, Joe	1400 Cambridge St.	10/19/2023	Augustine, Gre
Palomo, Merrill	1104181	Medicare	Medicare	8/7/2023	Winslow, Francine	1400 Cambridge St.	9/20/2023	Decelles, Larr
Willenbring, Wanita	1104182	Medicare	Medicare	2/26/2022	Black, Ronda	Main St. Office	10/20/2023	Augustine, Gre
Dziadek, Nettie	1104206	Private Insurance	Aetna	8/8/2023	Crowley, Patrick	Main St. Office	10/1/2023	Crowley, Patri
Mora, Annamae	1104230	Medicaid	Medicaid	6/28/2022	Crowley, Patrick	70 Blanchard Rd.	9/17/2023	Decelles, Larr
Economy, Terrilyn	1104241	Medicaid	Medicaid	4/6/2023	Fritz, Renata	70 Blanchard Rd.	11/2/2023	Bridgewater, Bill
Stehly, Jesse	1101839	Medicare	Medicare	6/17/2023	Smith, Joe	70 Blanchard Rd.	12/17/2023	Black, Ronda

1 **SAVED COLUMNS**

Saved Columns + Add New

2 **MY COLUMNS**

Amelia's View

SHARED COLUMNS

None available

Demo Data

1 to 9 of 375 Page 1 of 42

**How many of you
have explored
Group Admin
before?**



Group Admin

Group admin gives users the ability to create groups to **simplify filtering**. Grouping data can help you to focus on the set of values you want, while ignoring irrelevant values.

Consider:

- Financial Class
- Interactions
- Race
- Ethnicity
- Language

The screenshot shows the 'Group Admin' interface. At the top, there is a navigation bar with a gear icon, a back arrow, the text 'Group Admin', a 'VALUE CATEGORY' dropdown menu set to 'Interactions', a '+ Create Group' button, and a three-dot menu icon. Below the navigation bar, there are two tabs: 'VALUES 11' (active) and 'GROUPS 2'. A search bar labeled 'Search Values...' is positioned above the table. Below the search bar are three filter buttons: 'All' (selected), 'Grouped', and 'Ungrouped'. The table has three columns: 'VALUE', 'GROUPS', and 'COUNT TY'. The table contains the following data:

VALUE	GROUPS	COUNT TY
Office visit	No-Show Appointments	19,537
High BP	No-Show Appointments	14,509
Sick Visit	No-Show Appointments	14,435
Annual Visit	No-Show Appointments	14,421
Injury	No-Show Appointments	14,404
Physical	No-Show Appointments	14,345
Mental Health and Counseling	No-Show Appointments	14,288
Medical		5,535

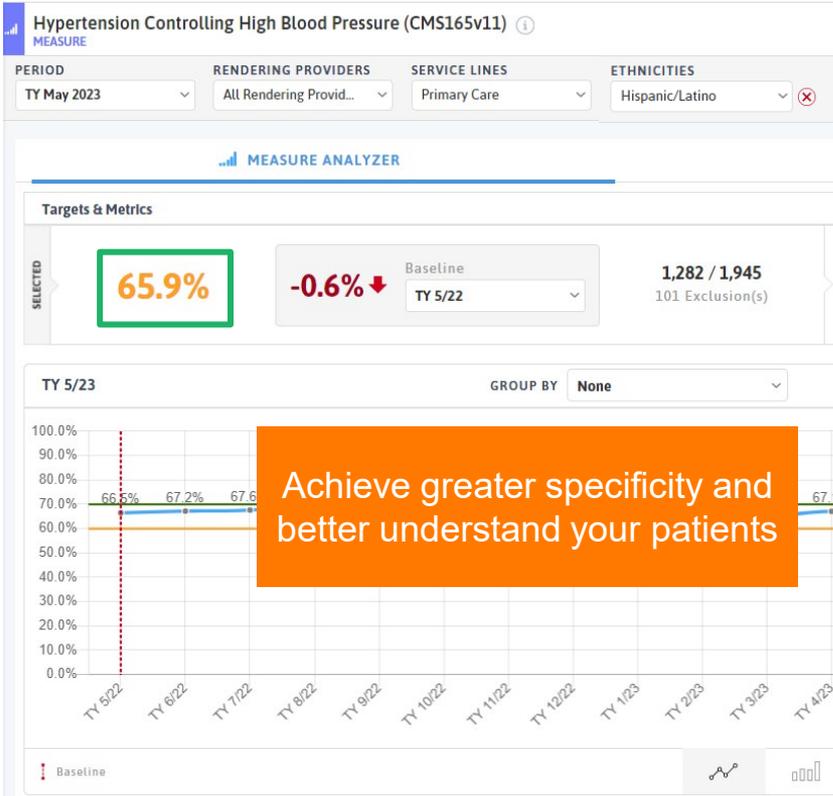
At the bottom of the table, there is a pagination bar showing '1 to 8 of 11' and navigation arrows. The page number 'Page 1 of 2' is also visible.

Group Admin | Examples

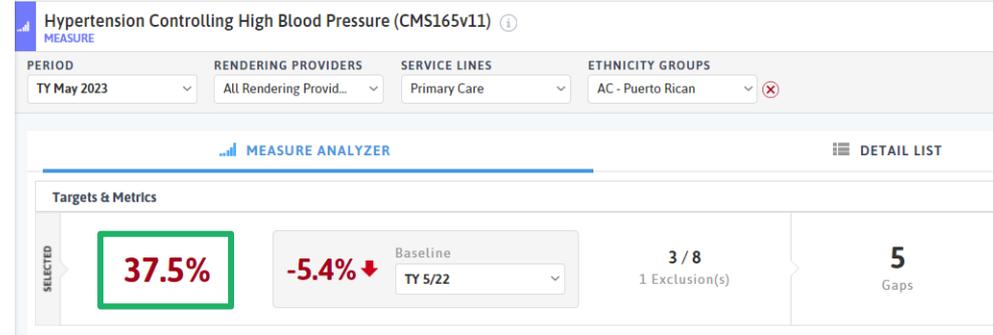
- 1 Defining a single **financial class** “Medicaid group” that includes all the different Medicaid plans found in your EHR.
- 2 Creating an **interactions group** called “Behavioral Health” to look at all types of behavioral health visits, including both appointments and encounters.
- 3 Creating Dominican and Puerto Rican **ethnicity groups** to get a more granular perspective on your patient population as opposed to relying on the broader “Hispanic/Latino” UDS ethnicity group.

Race, Ethnicity & Language Groups

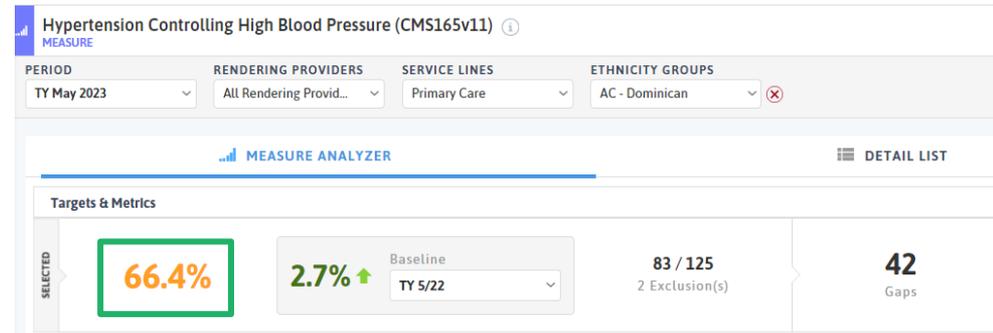
Hispanic/Latino



Puerto Rican



Dominican



No Show Appointments ⓘ

MEASURE

FILTER ^



PERIOD

RENDERING PROVIDERS

February 2025

All Rendering Provid...

+ Add Filter



Update

MEASURE ANALYZER

DETAIL LIST

VALUE SETS

16.4%

↑ 3.1%

1,411 / 8,591

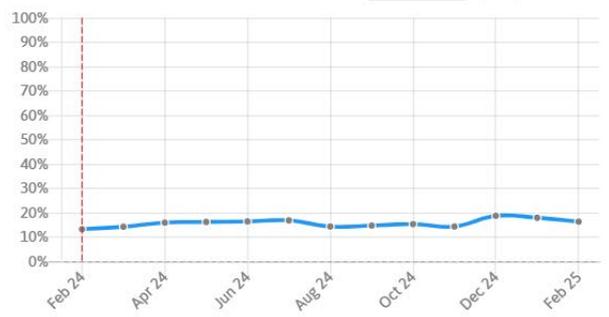
2,323 Exclusion(s)

Feb 24

Create Target

Feb 25

GROUP BY None

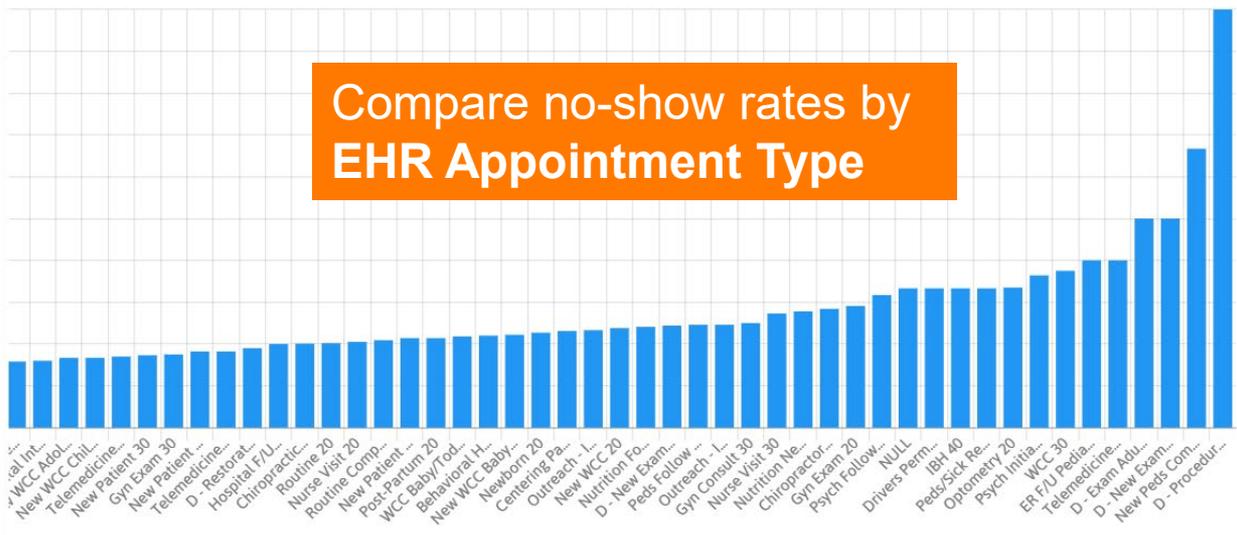


Comparison

GROUP BY EHR Appointment Type



Compare no-show rates by EHR Appointment Type



No Show Appointments ⓘ
MEASURE

FILTER ^

+ Add Filter ▼ ↻ Update

PERIOD: February 2025 ▼

RENDERING PROVIDERS: All Rendering Provid... ▼

MEASURE ANALYZER

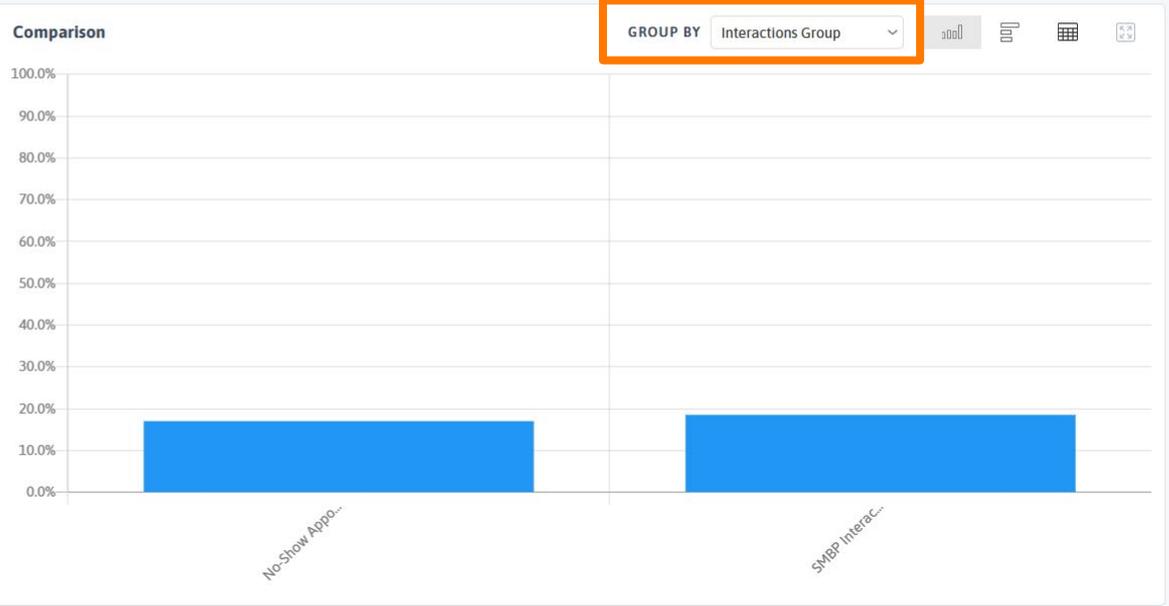
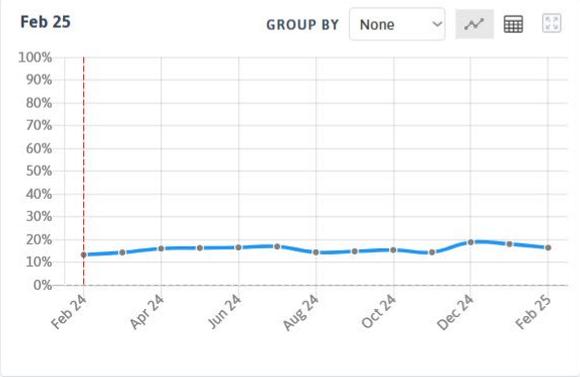
DETAIL LIST

VALUE SETS

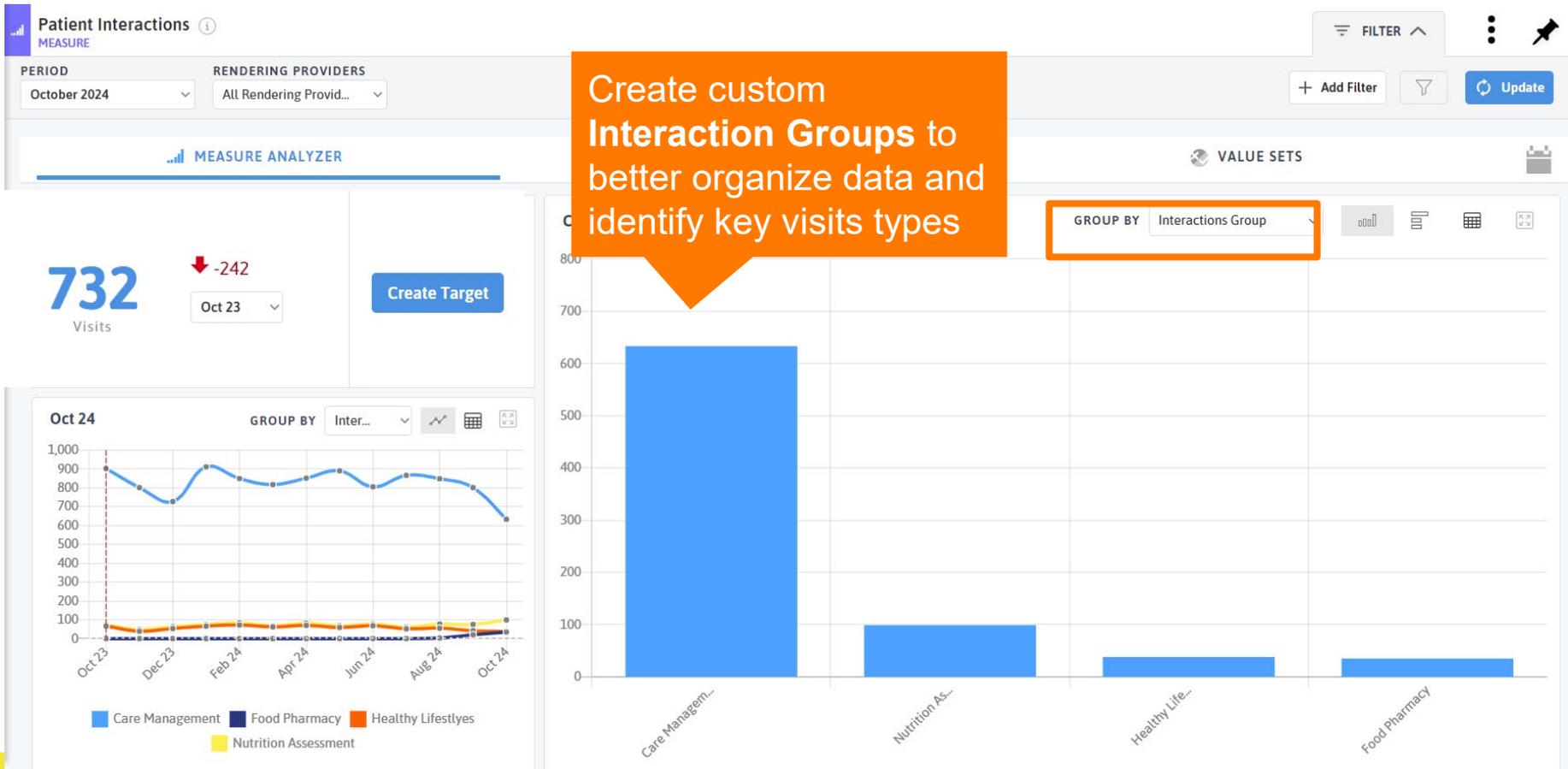
16.4% ↑ 3.1%

1,411 / 8,591
2,323 Exclusion(s)

Feb 24 ▼ Create Target



Interactions Groups



Create custom Interaction Groups to better organize data and identify key visits types

Visit Group Admin

1

Select *Groups* from the Administration landing page.

The screenshot shows the Azara Administration interface. On the left is a dark sidebar with icons and labels for various sections: 'a' (top), 'PVP', 'CMP', 'Reports', 'Dashboards', 'Measures', 'Registries', and 'Admin'. The main content area is titled 'Administration' and contains a list of menu items: Alerts, Care Effectiveness, Care Managers, Cohorts, Dashboards, Email Subscriptions, Force Match, Groups, Locations, Mappings, Patient Outreach, Providers, and Registries. The 'Groups' item is highlighted with an orange border. Each menu item has a right-pointing chevron icon.

- Administration
 - Alerts
 - Care Effectiveness
 - Care Managers
 - Cohorts
 - Dashboards
 - Email Subscriptions
 - Force Match
 - Groups**
 - Locations
 - Mappings
 - Patient Outreach
 - Providers
 - Registries

Select Category

2

Select the *Value Category* from the dropdown.

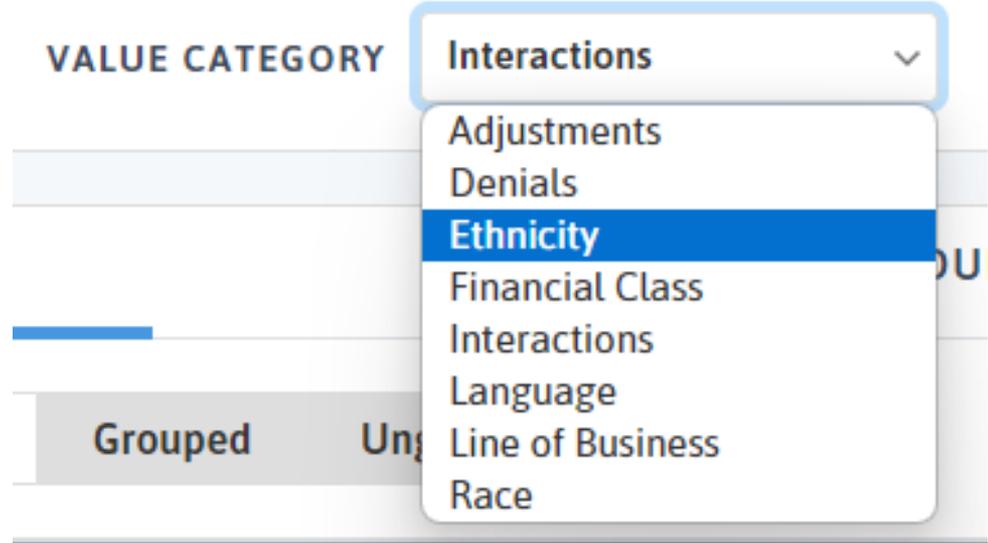
VALUE CATEGORY

Interactions

- Adjustments
- Denials
- Ethnicity**
- Financial Class
- Interactions
- Language
- Line of Business
- Race

Grouped Un

DU





Group Admin ⓘ

VALUE CATEGORY

Race



+ Create Group

VALUES 3157

Search Values...



All

Grouped

Ungrouped

PERIOD TYPE

All Time

Last Year

CENTER	VALUE	GROUPS	COUNT	TY
Access Community Health	Black/African American	AC - Black or African American , AC - Black/African American	1,327	
Access Community Health	White	White	1,245	
Access Community Health	Unreported/Chose Not to Disclose Race	Unreported/Chose Not to Disclose Race	965	
Access Community Health	More than One Race	More than One Race	889	
Access Community Health	Hispanic/Latino		378	
Access Community Health	Hispanic		360	
Access Community Health	Other Pacific Islander	AC - Other Pacific Islander	147	
Access Community Health	American Indian/Alaska Native	AC - American Indian/Alaska Native	127	

Search values by key word or phrase. The column will list the values that match the search criteria.

Toggle between All, Grouped, and Ungrouped to quickly filter to only the values that are assigned to a group or not assigned to a group

Search Values...



All

Grouped

Ungrouped

PERIOD TYPE

All Time

Last Year

CENTER	VALUE	GROUPS	COUNT TY
Access Community Health	Black/African American	AC - Black or African American , AC - Black/African American	17
Access Community Health	White	AC - White	
Access Community Health	Unreported/Refused To Report Race.	AC - Unreported/Chose Not to Disclose Race	
Access Community Health	Unknown/Undetermined		
Access Community Health	More Than One Race	AC - More than One Race	
Access Community Health	Hispanic/Latino		
Access Community Health	Hispanic		
Access Community Health	Other Pacific Islander	AC - Other Pacific Islander	
	American Indian/Alaska Native	AC - American Indian/Alaska Native	127

Toggle between **All Time** or **Last Year** to quickly filter to only the values that had counts in the last year (Count TY greater than zero.)

+ Create Group

Group Admin VALUE CATEGORY Race

VALUES 78

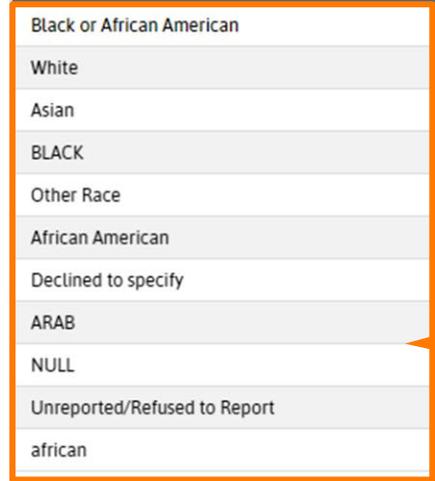
GROUPS 1

Search Values...

All Grouped Ungrouped

PERIOD TYPE All Time Last Year

VALUE	GROUPS	COUNT	TY
Black or African American	AC - Black or African American , AC - Black/African American, Test	10,566	
White	AC - White	3,526	
Asian	AC - Asian	1,540	
BLACK	AC - Black or African American	1,386	
Other Race	AC - Other Race	955	
African American	AC - Black or African American	387	
Declined to specify	Other Race	366	
ARAB		232	
NULL		201	
Unreported/Refused to Report	Other Race	135	
african		74	



Value column lists all the options for values pulled directly from the EHR

VALUES 78

GROUPS 1

Search Values...

All Grouped Ungrouped

PERIOD TYPE All Time Last Year

VALUE	GROUPS	COUNT	TY
Black or African American	AC - Black or African American , AC - Black/African American, Test	10,566	
White	AC - White	3,526	
Asian	AC - Asian	1,540	
BLACK	AC - Black or African American	1,386	
Other Race	AC - Other Race	955	
African American	AC - Black or African American	387	
Declined to specify	AC - Unreported/Chose Not to Disclose Race	366	
ARAB		232	
NULL		201	
Unreported/Refused to Report	AC - Unreported/Chose Not to Disclose Race	135	
african	AC - Black or African American	74	

Once created, the **Groups** column is where you see the groups the raw EHR values have been assigned to by either the practice or the network. Values may be assigned to multiple groups and will be separated by a comma.

VALUES **78**

GROUPS **1**

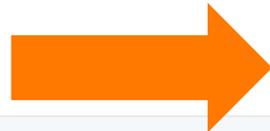
Search Values... 🔍

All Grouped Ungrouped

PERIOD TYPE All Time Last Year

VALUE	GROUPS	COUNT TY
Black or African American	AC - Black or African American , AC - Black/African American, Test	10,566
White	AC - White	3,526
Asian	AC - Asian	1,540
BLACK	AC - Black or African American	1,386
Other Race	AC - Other Race	955
African American	AC - African American	387
Declined to specify	AC - Declined to specify	366
ARAB	AC - ARAB	232
NULL	AC - NULL	201
Unreported/Refused to Report	AC - Unreported/Refused to Report	135
african	AC - african	74

To help you judge the impact of adding a value to a group, **Count TY** lists the number of patient records containing the value in the trailing year



To create a group, select the blue + *Create Group* button in the upper righthand corner of the Group Admin page

VALUES 24

Search Values...

All Grouped Ungrouped

VALUE	GROUPS	COUNT	TY
NULL			
Black/African American			
Don't know		2,090	
White		1,927	
Other Asian		234	
More than one race		110	
Native Hawaiian		106	
Other Pacific Islander		92	
Filipino		91	
Chose Not To Disclose		74	
American Indian		38	
Guamanian or Chamorro		38	
Asian Indian		30	
Chinese		5	

Create Group

GROUP NAME 1

Native Hawaiian or Pacific Islander

VALUE CATEGORY 2

Race

PERIOD TYPE 3

All Time

AVAILABLE VALUES 5

Search

4

Filipino
Unreported/Choose Not to Disclose Race
Black/African American
Korean
More than One Race
Ignore
Japanese
White
Chinese
Vietnamese Other Asian

Guamanian or Chamorro
Samoan
Other Pacific Islander
Native Hawaiian

Cancel

Confirm 6

1. **Name your group.** This name will identify your group in the group filter in reports and measures, and in the list on the Groups Admin page. Put your practice's name or initials at the beginning of the group. For example, "ACH Ukrainian" for Access Community Health.
2. Select a **Value Category** from the dropdown (Race, Ethnicity, or Language)
3. Select a **Period Type** of the last year or for all time.
4. The **Available Values** lists all the options for values from your EHR. Add value to your group by double clicking, dragging and dropping, or using arrows (do the same to remove values).
5. Start typing a phrase in the search box to **search** the list for all values with that phrase in them.
6. Once you have selected all the values you want in your group, click **Confirm**. The new group will be saved and listed on the Groups Admin page.

Success!

Group Admin ⓘ VALUE CATEGORY Race

+ Create Group

VALUES 17

GROUPS 1

Search Groups...

GROUP NAME	VALUE COUNT	CREATED DATE	CREATED BY	UPDATED DATE	LAST UPDATED BY	
Native Hawaiian and Pacific Islander	4	4/17/2025	Azara	4/17/2025	Azara	⚙️

Columns

Dashboards | Text Widget!



TEXT WIDGET
The Text Widget is used to add text, images, or links.



Add Widget - Text Widget



TEXT

A ▾	 ▾	↶ ↷	System Font ▾	12pt ▾	Paragraph ▾
B	<i>I</i>	<u>U</u>	☰ ☱ ☲	☳ ☴ ☵	  ▾ <> 
0 WORDS					

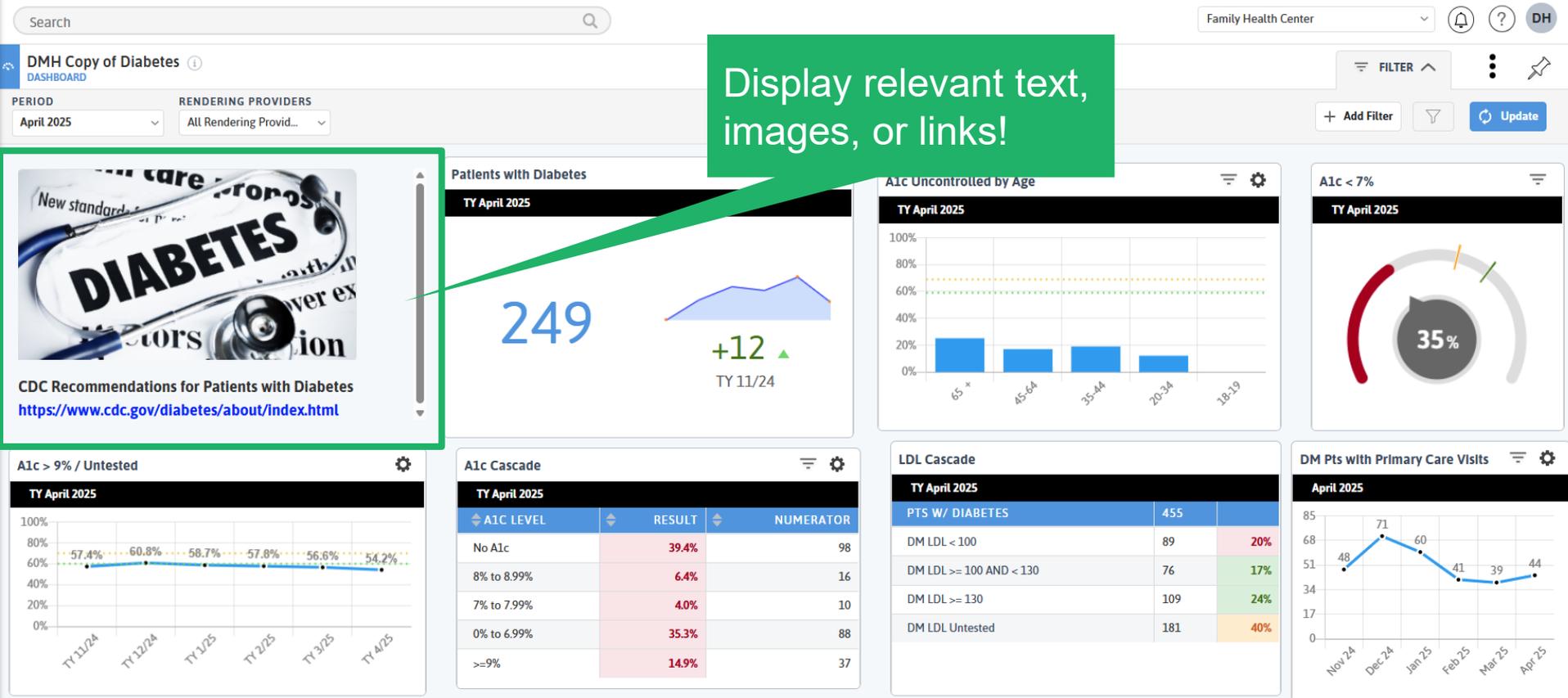
Cancel

Confirm



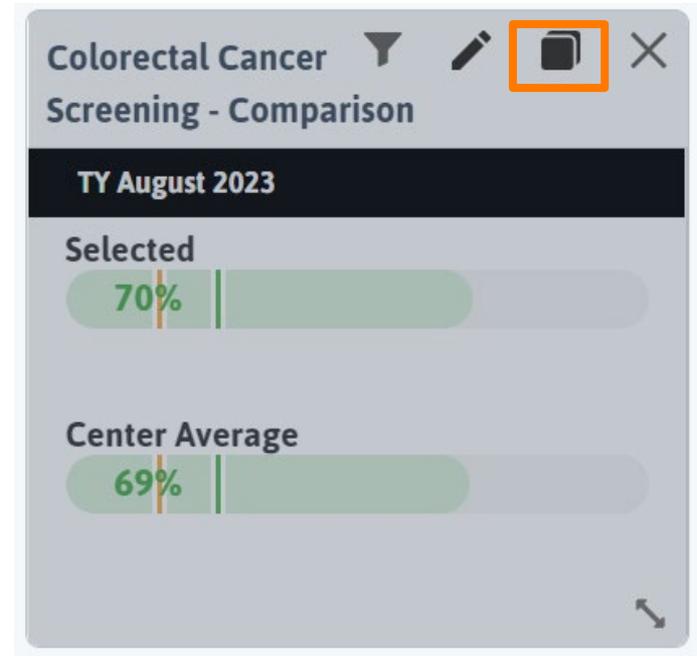
Supports text, html, images, and links!

Dashboards | Text widget



Dashboards | Copy Widget

- Make a copy of a widget on a dashboard while in edit mode
-  When a user clicks on this icon, an exact copy of the current widget will be created and added to the upper left-hand corner of the dashboard



Performance Management



The Measure Conundrum

Traditional measures, measure
ACCOUNTABILITY
to tell others how we are doing based on a
threshold established at a national level.

Traditional measures **don't tell us**
how **EFFECTIVE**
we are at treating / managing our patients.

Care Effectiveness Reporting (CER) in DRVS



Reporting designed for a specific identified population.



Evaluate clinical improvement-patient & program level

- Any improvement
- Clinically significant improvement
- Remission



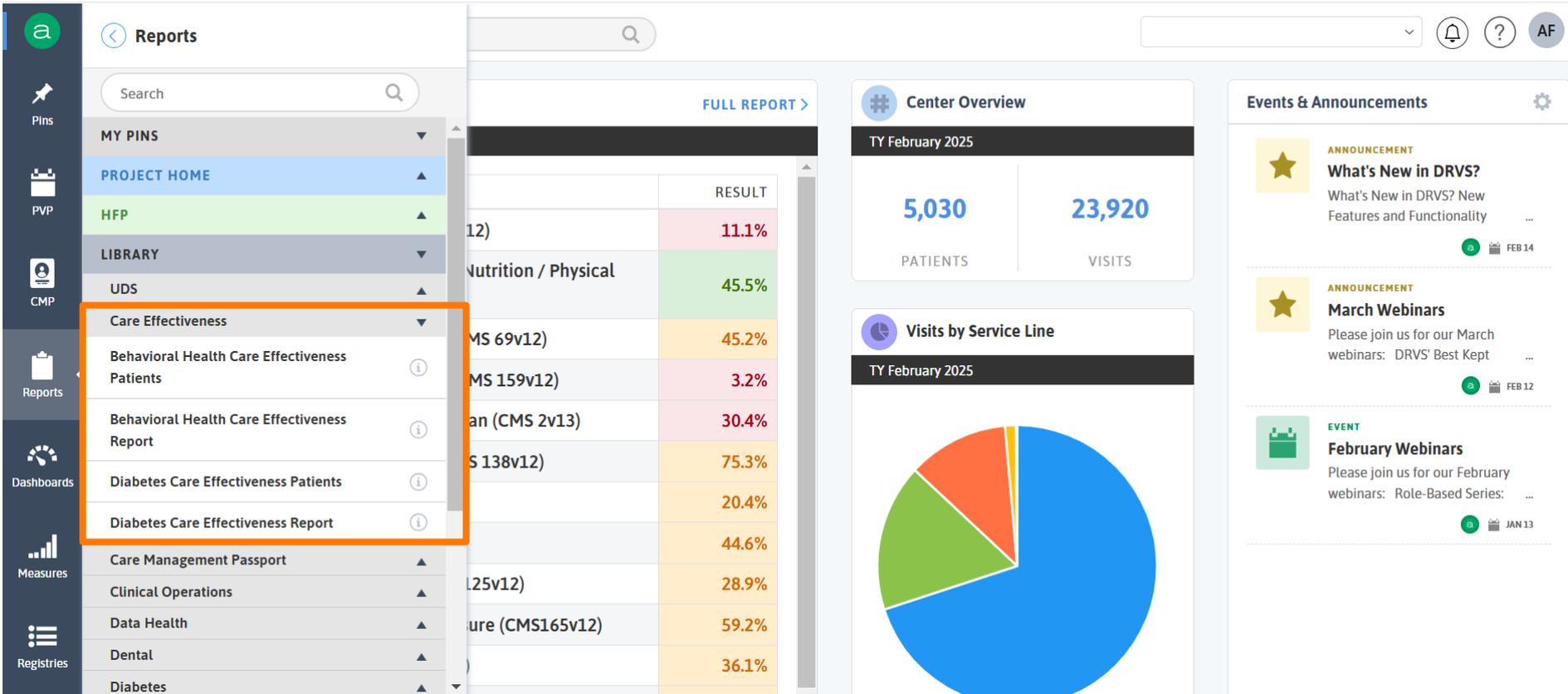
Identify patients who need action taken / interventions



Evaluate program operations

- Are patients getting a re-evaluation?
- Appropriate access / encounters

Care Effectiveness Reports



The screenshot shows a dashboard for Care Effectiveness Reports. On the left is a navigation sidebar with icons for Pins, PVP, CMP, Reports, Dashboards, Measures, and Registries. The main content area is titled 'Reports' and includes a search bar and a 'FULL REPORT >' link. A table displays various care effectiveness metrics with columns for patient groups and results. A pie chart titled 'Visits by Service Line' is shown for February 2025. On the right, there are sections for 'Center Overview' (showing 5,030 patients and 23,920 visits for February 2025) and 'Events & Announcements' (listing 'What's New in DRVS?', 'March Webinars', and 'February Webinars').

	RESULT
12)	11.1%
Nutrition / Physical	45.5%
MS 69v12)	45.2%
MS 159v12)	3.2%
an (CMS 2v13)	30.4%
S 138v12)	75.3%
	20.4%
	44.6%
Care Management Passport	28.9%
25v12)	28.9%
ure (CMS165v12)	59.2%
)	36.1%

Center Overview
TY February 2025

5,030 PATIENTS 23,920 VISITS

Visits by Service Line
TY February 2025



Events & Announcements

- ANNOUNCEMENT**
What's New in DRVS?
What's New in DRVS? New Features and Functionality ... FEB 14
- ANNOUNCEMENT**
March Webinars
Please join us for our March webinars: DRVS' Best Kept ... FEB 12
- EVENT**
February Webinars
Please join us for our February webinars: Role-Based Series: ... JAN 13

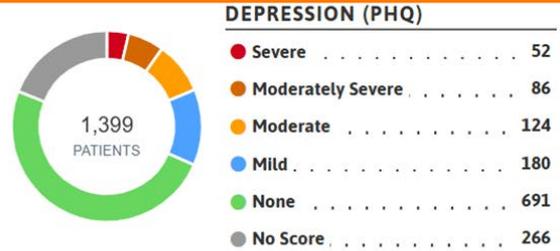
Behavioral Health Care Effectiveness Patients REPORT

FILTER ^ ⋮ 📌

RENDERING PROVIDERS: All Rendering Provid...
 PATIENT DIAGNOSES: All Patient Diagnoses
 SERVICE LINES: All Service Lines

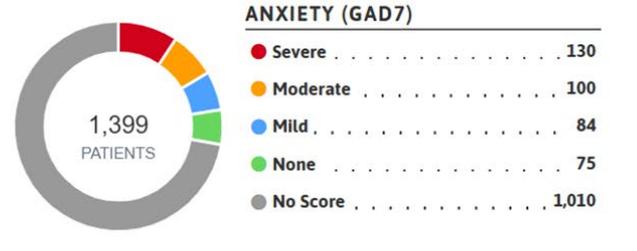
+ Add Filter 🗑 Update

Overview - Population: Dyn - Depression/Anxiety



5.0
AVG PHQ SCORE
▼ -0.7 Last 12 mths.
174
PHQ PTS WITH A >= 5 PT DROP

11.1
AVG GAD7 SCORE
▼ -0.1 Last 12 mths.
16
GAD7 PTS WITH A >= 6 PT DROP



Search Patients ... 🔍

NEXT APPT: All No Appt Upcoming Appt

SAVED COLUMNS ☰

DEMOGRAPHICS >		FIRST PHQ IN LAST 12 MTHS			MOST RECENT PHQ LAST 12 MTHS			FIRST GAD7 IN LAST 12 MTHS		MOST RECENT GAD7 LA	
NAME	MRN	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	STATUS	RESU
[blurred]	[blurred]	0	3/12/2024	●	0	4/15/2024	0			●	
[blurred]	[blurred]	0	3/8/2024	●	0	12/18/2024	0			●	
[blurred]	[blurred]	16	4/8/2024	●	21	1/29/2025	▲ 5			●	
[blurred]	[blurred]	0	3/8/2024	●	0	1/8/2025	0			●	
[blurred]	[blurred]	0	4/18/2024	●	0	1/21/2025	0			●	

Behavioral Health Care Effectiveness Patients REPORT

FILTER ⌵ ⋮ 📌

RENDERING PROVIDERS: All Rendering Provid... ⌵

PATIENT DIAGNOSES: All Patient Diagnoses ⌵

SERVICE LINES: All Service Lines ⌵

+ Add Filter ⌵ 🔄 Update

Overview - Population: Dyn - Depression/Anxiety ⌵



DEPRESSION (PHQ)

● Severe	52
● Moderately Severe	86
● Moderate	124
● Mild	180
● None	691
● No Score	266

5.0
AVG PHQ SCORE
▼ -0.7 Last 12 mths.

174
PHQ PTS WITH A >= 5 PT DROP

11.1
AVG GAD7 SCORE
▼ -0.1 Last 12 mths.

16
GAD7 PTS WITH A >= 6 PT DROP



ANXIETY (GAD7)

● Severe	130
● Moderate	100
● Mild	84
● None	75
● No Score	1,010

Search Patients ... 🔍

NEXT APPT: All No Appt Upcoming Appt

SAVED COLUMNS ☰

DEMOGRAPHICS >		FIRST PHQ IN LAST 12 MTHS			MOST RECENT PHQ LAST 12 MTHS			FIRST GAD7 IN LAST 12 MTHS		MOST RECENT GAD7 LA	
NAME	MRN	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	STATUS	RESU
...	...	0	3/12/2024	●	0	4/15/2024	0			●	
...	...	0	3/8/2024	●	0	12/18/2024	0			●	
...	...	16	4/8/2024	●	21	1/29/2025	▲ 5			●	
...	...	0	3/8/2024	●	0	1/8/2025	0			●	
...	...	0	4/18/2024	●	0	1/21/2025	0			●	

● No Score 266

Search Patients ...

NEXT APPT

[All](#) [No Appt](#) [Upcoming Appt](#)

[Reset Columns](#) SAVED COLUMNS

FIRST PHQ IN LAST 12 MTHS			MOST RECENT PHQ LAST 12 MTHS			FIRST GAD7 IN LAST 12 MTHS			MOST RECENT GAD7 LAST 12 MTHS		
RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	STATUS	RESULT	DATE	CHANGE
3	4/23/2024	●	0	10/1/2024	▼ -3			●			
0	5/22/2024	●	5	2/17/2025	▲ 5	21	2/17/2025	●	21	2/17/2025	0
		●						●			
		●						●			
6	11/12/2024	●	0	1/14/2025	▼ -6	20	11/21/2024	●	21	12/20/2024	▲ 1
13	7/30/2024	●	10	8/26/2024	▼ -3			●			
19	6/28/2024	●	11	8/2/2024	▼ -8	8	6/28/2024	●	10	8/2/2024	▲ 2
18	11/18/2024	●	18	11/18/2024	0			●			
3	6/5/2024	●	6	2/7/2025	▲ 3	3	2/7/2025	●	3	2/7/2025	0
18	4/11/2024	●	0	1/27/2025	▼ -18	14	4/11/2024	●	13	8/12/2024	▼ -1
20	5/1/2024	●	24	6/3/2024	▲ 4			●			
0	7/26/2024	●	3	7/30/2024	▲ 3	6	7/30/2024	●	6	7/30/2024	0
		●						●			
3	4/24/2024	●	0	12/20/2024	▼ -3	19	6/4/2024	●	19	6/4/2024	0
		●						●			

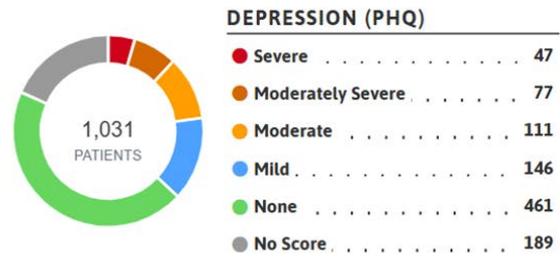
Behavioral Health Care Effectiveness Report REPORT

FILTER ^ ⋮ 📌

RENDERING PROVIDERS: All Rendering Provid... ▼
 PATIENT DIAGNOSES: All Patient Diagnoses ▼
 AGGREGATE BY: Rendering Provider ▼
 SERVICE LINES: Behavioral Health ▼

+ Add Filter ⌵
↻ Update

Overview - Population: Dyn - Depression/Anxiety

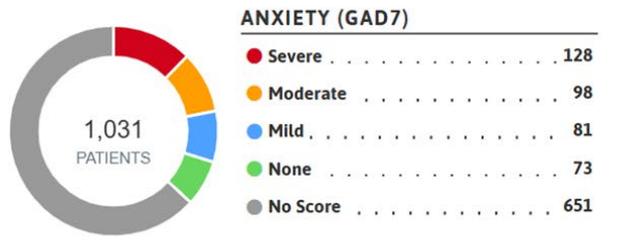


5.9
AVG PHQ SCORE
▼ -0.9 Last 12 mths.

159
PHQ PTS WITH A >= 5 PT DROP

11.1
AVG GAD7 SCORE
▼ -0.0 Last 12 mths.

16
GAD7 PTS WITH A >= 6 PT DROP



Search ... 🔍

SAVED COLUMNS ☰

RENDERING PROVIDER	PATIENTS ACTIVE	↑ ≡	PHQ AVG LAST 12 MTHS		PHQ PATIENTS WITH A >=5 POINT		GAD7 AVG LAST 12 MTHS		GAD7 PATIENTS WITH A >=6 POINT	
			RESULT	CHANGE	DROP	INCREASE	RESULT	CHANGE	DROP	INCREASE
...	288		5.8	0.0	42	41	11.2	▲ 0.1	3	
...	281		6.1	▼ -0.9	49	33	11.9	▼ -0.4	6	
...	276		5.8	▼ -0.4	41	34	12.6	▲ 0.1	3	
...	264		6.7	▼ -1.3	50	28	11.4	0.0	6	
...	177		6.0	▲ 0.6	20	31	11.5	▲ 0.1	1	

Search ...



SAVED COLUMNS



RENDERING PROVIDER	PATIENTS ACTIVE	↑	PHQ AVG LAST 12 MTHS		PHQ PATIENTS WITH A >=5 POINT		GAD7 AVG LAST 12 MTHS		GAD7 PATIENTS WITH A >=6 POINT	
			RESULT	CHANGE	DROP	INCREASE	RESULT	CHANGE	DROP	INCREASE
		288	5.8	0.0	42	41	11.2	▲ 0.1	3	
		281	6.1	▼ -0.9	49	33	11.9	▼ -0.4	6	
		276	5.8	▼ -0.4	41	34	12.6	▲ 0.1	3	
		264	6.7	▼ -1.3	50	28	11.4	0.0	6	
		177	6.0	▲ 0.6	20	31	11.5	▲ 0.1	1	
		175	5.9	▼ -1.6	34	21	10.8	▼ -0.8	5	
		169	6.1	▼ -3.1	52	13	12.4	▲ 0.2	2	
		164	5.6	▼ -1.4	25	10	9.3	▼ -0.4	4	
		148	5.8	▼ -1.3	28	14	11.3	▼ -0.7	5	
		148	5.8	▲ 0.7	10	18	11.0	▲ 0.5	0	
		144	6.5	▼ -1.6	27	12	12.2	▲ 0.1	3	
		134	5.3	▲ 0.3	11	14	12.0	▲ 0.2	3	
		130	5.5	▼ -0.8	22	15	10.6	▼ -0.5	3	
		124	4.9	▼ -3.2	39	9	11.9	▲ 0.2	2	
		120	6.3	▼ -1.9	23	12	11.6	▼ -0.4	5	

Demonstrate how your care teams are doing driving improved health outcomes.

**Have you ever
created a custom
care effectiveness
report before?**



- Pins
- PVP
- CMP
- Reports
- Dashboards
- Measures
- Registries
- Administration

Administration

- Administration
- Alerts
- Care Effectiveness
- Care Managers
- Cohorts
- Dashboards
- Email Subscriptions
- Force Match
- Groups
- Locations
- Mappings
- Measures
- Patient Outreach
- Payers
- Providers



Validation Tools

- Measure Validation

Usage Reports

- Centers
- Generated Reports
- Reports
- Reports By User
- Users

Azara

- Patient Investigation Tool (PIT)

⏪ Care Effectiveness (CER) Administration ⓘ

[+ Create CER Report](#)

Search Care Effectiveness Reports...



All

Enabled

Disabled

NAME	REPORT TYPE	CREATED DATE	CREATED BY	LAST UPDATED DATE	LAST UPDATED BY	COHORT	COHORT TYPE	STATUS	
Diabetes Care Effectiveness Report	Population Overview (Aggregate)	04/27/2021	Azara	01/24/2024	Azara	Dyn - Diabetes	DRVS - Dynamic Cohort	Enabled	⚙️
Diabetes Care Effectiveness Patients	Patient Level	04/27/2021	Azara	01/24/2024	Azara	Dyn - Diabetes	DRVS - Dynamic Cohort	Enabled	⚙️
Behavioral Health Care Effectiveness Report	Population Overview (Aggregate)	04/15/2021	Azara	01/24/2024	Azara	Dyn - Depression/Anxiety	DRVS - Dynamic Cohort	Enabled	⚙️
Behavioral Health Care Effectiveness Patients	Patient Level	04/15/2021	Azara	01/24/2024	Azara	Dyn - Depression/Anxiety	DRVS - Dynamic Cohort	Enabled	⚙️

Columns

Care Effectiveness (CER) Administration

Search Care Effectiveness Re

NAME	REPO	STATUS	Columns
Diabetes Care Effec tiveness Report	Popula w (Agg	abled	⚙️
Diabetes Care Effec tiveness Patients	Patien	abled	⚙️
Behavioral Health Care Effectiveness Report	Popula w (Agg	abled	⚙️
Behavioral Health Care Effectiveness Patients	Patien	abled	⚙️

1 to 4 of 4

Page 1 of 1

⊕ Create CER Report

Create CER Report

GENERAL
COLUMNS
VISUALIZATIONS

⚠️ Please note that this report requires nightly processing. Your report will be ready tomorrow morning.

REPORT NAME*

REPORT TYPE*

Patient Level

Select Report Type

Patient Level

Population Overview (Aggregate)

STATUS
ENABLED
DISABLED

DESCRIPTION

POPULATION DEFINITION

Select a cohort below to define the patients that will populate this report.

POPULATION TYPE*

DRVS - Static Cohort

COHORT*

Select Cohort

Cancel

Confirm

Care Effectiveness (CER) Administration

Search Care Effectiveness Reports

NAME	REPORT	STATUS	Columns
Diabetes Care Effectiveness Report	Population w (Agg	Enabled	⚙️
Diabetes Care Effectiveness Patients	Patient	Enabled	⚙️
Behavioral Health Care Effectiveness Report	Population w (Agg	Enabled	⚙️
Behavioral Health Care Effectiveness Patients	Patient	Enabled	⚙️

1 to 4 of 4

+ Create CER Report

< Page 1 of 1 >

Create CER Report

GENERAL
COLUMNS
VISUALIZATIONS

Please note that this report requires nightly processing. Your report will be ready tomorrow morning.

REPORT NAME*

REPORT TYPE*

Patient Level

DESCRIPTION

Select Population Type

EHR - Dynamic Cohort

DRVS - Static Cohort

DRVS - Dynamic Cohort

COST - Static Cohort

DRVS - Static Cohort

CENTER

v

STATUS
ENABLED
DISABLED

COHORT*

Select Cohort
v

Cancel

Confirm

Cohort Basics

-  **What:** A group of patients with a shared characteristic
-  **Who:** Defined by YOUR criteria – all you need is a patient list
-  **How:** Created in the cohort administration
-  **Where:** Displayed on the PVP, in ACC, and anywhere you find the **Cohort** filter

Types of Cohorts

DRVS Static

Manually created in DRVS via patient list or MRN upload

Manually maintained

DRVS Dynamic

Created from data already pulled into DRVS

Set list to choose from & dynamically maintained

EHR Dynamic

Created from custom mapping from your EHR

Requires an SOW



Stock Dynamic Cohorts

Cohort Display Name	Description
Anxiety	Patients who have an Active diagnosis of anxiety in the last 12 months. Patients who are deceased, bipolar disorder, personality disorder, schizophrenia, psychotic disorder or pervasive developmental disorder at the center are excluded from the cohort.
Chronic Obstructive Pulmonary Disease (COPD)	Patients who have a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Congestive Heart Failure (CHF)	Patients who have a diagnosis of Congestive Heart Failure in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Depression	Patients who have an active diagnosis of depression in the last 12 months. Patients who are deceased, bipolar disorder, personality disorder, schizophrenia, psychotic disorder or pervasive developmental disorder at the center are excluded from the cohort.
Depression/Anxiety	Patients who have a depression or anxiety diagnosis. Patients who are deceased are excluded from the cohort.
Diabetes	Patients who have a diagnosis of diabetes. Patients who are deceased or inactive at the center are excluded from the cohort.
DM A1c >9	Patients who have a diagnosis of diabetes and whose most recent hemoglobin A1c lab result is > 9.0%. Patients who are deceased are excluded from the cohort.
DM A1c >8	Patients who have a diagnosis of diabetes and whose most recent hemoglobin A1c lab result is > 8.0%. Patients who are deceased are excluded from the cohort.
DM A1c Untested	Patients who have a diagnosis of diabetes and have not had an A1c result in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
DSMES	Patients in DM Self-Management Education and Support (DSMES) in the last year. Patients who are deceased or inactive at the center are excluded from the cohort.
Hepatitis C	Patients who have a diagnosis of Hepatitis C. Patients who are deceased or inactive at the center are excluded from the cohort.
HIV	Patients who have a diagnosis of HIV. Patients who are deceased or inactive at the center are excluded from the cohort.

Stock Dynamic Cohorts



Cohort Display Name	Description
Hypertension	Patients who have a diagnosis for Hypertension in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Hypertension BP >140/90	Patients who have a diagnosis of hypertension in the last 12 months and whose most recent blood pressure vitals result is > 140/90. If the patient's systolic blood pressure is > 140 mmHg OR their diastolic blood pressure is > 90 mmHg they will be in the cohort. Patients who are deceased or inactive at the center are excluded from the cohort.
Substance Use Disorder (SUD)	Patients who have a diagnosis for Opioid Abuse Disorder in the last 12 months. Patients who are deceased or inactive at the center are excluded from the cohort.
Medication Assistant Treatment (MAT)	Patients who have an opioid use disorder (OUD) medication-assisted therapy (MAT) prescription in the last 90 days. Patients who are deceased or inactive at the center are excluded from the cohort.
Care Management	Patients who are assigned a care manager in DRVS (aka can be from EHR or manually added in ACM). Patients who are deceased or inactive at the center are excluded from the cohort.
CCM	Patients in Chronic Care Management (CCM) through Medicare in the last year. Patients who are deceased or inactive at the center are excluded from the cohort.
ER Visit	Patients who had an emergency room (ER) visit in the last 14 days with the discharge status of home, and who have not had a follow-up call, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.
IP Visit	Patients who had an inpatient (I/P) visit in the last 14 days with a discharge status of home, and do not have an upcoming primary care appointment scheduled. Patients who are deceased or inactive at the center are excluded from the cohort.
High Risk Patients	Patients who have a risk level of High. Patients who are deceased or inactive at the center are excluded from the cohort.
SDOH > 11	Patients who have greater than 11 Social Determinants of Health (SDOH). Patients who are deceased or inactive at the center are excluded from the cohort.

Cancel Care Effectiveness (CER) Administration

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec tiveness Report	Popula w (Agg
Diabetes Care Effec tiveness Patients	Patien
Behavioral Health Care Effectiveness Report	Popula w (Agg
Behavioral Health Care Effectiveness Patients	Patien

1 to 4 of 4

Admin

Create CER Report

GENERAL

⚠ Please note that this report requires nightly processing. Your report will be re

REPORT NAME*

DESCRIPTION

POPULATION DEFINITION
Select a cohort below to define the patients that will populate this report.

POPULATION TYPE*

DRVS - Static Cohort
▼

- Prep 070121_063022
- CM Outreach: New Pts_Casa M.
- CM Cohort
- Prenatal 2024
- TPSSP Popsheet
- BCHN 2022 UDS Cohort
- Shared RV Clients 2022
- HIV Cascade
- Blue-Tooth BP Enroleee
- OTP
- HIV TYMARCH2024
- HIV Cascade 2020_2021
- LCDS PrEP Funded Site Demographic Profile
- BHACS-PrEP HIV Diagnosis Monthly Report
- Blue Tooth Blood Pressure Cuff Enrolees 11.15.23
- LCDS PrEP-BHACS-MSA
- HTN BP Cuff Program Enrollee

Select Cohort
▼

Cancel

Confirm

+ Create CER Report

STATUS		Columns
abled	⚙	

Page 1 of 1

Care Effectiveness (CER) Administration

Search Care Effectiveness Re

NAME	REPO	STATUS	Columns
Diabetes Care Effec tiveness Report	Popula w (Agg	abled	⚙️
Diabetes Care Effec tiveness Patients	Patien	abled	⚙️
Behavioral Health Care Effectiveness Report	Popula w (Agg	abled	⚙️
Behavioral Health Care Effectiveness Patients	Patien	abled	⚙️

1 to 4 of 4

Page 1 of 1

⊕ Create CER Report

Create CER Report

GENERAL COLUMNS VISUALIZATIONS

⚠️ Please note that this report requires nightly processing. Your report will be ready tomorrow morning.

REPORT NAME*
Care Management

REPORT TYPE*
Patient Level

DESCRIPTION
Tracking A1Cs & PHQ-9 of patients enrolled in care management services

CENTER
⌵

STATUS **ENABLED** DISABLED

POPULATION DEFINITION
Select a cohort below to define the patients that will populate this report.

POPULATION TYPE*
DRVS - Static Cohort

COHORT*
CM Cohort

Cancel Confirm

Create CER Report

GENERAL

COLUMNS

VISUALIZATIONS

DATA ELEMENTS

The first two columns on Patient Level reports are always "Full Patient Name" and "MRN". These columns can not be removed. Add additional demographic columns as necessary. Select from the options below. Drag and drop or use the arrow buttons to select columns.

METRIC TYPE

- Encounter
- Laboratory
- Claim
- Prescription
- Social Drivers
- Incarceration
- Dental
- SDOH

METRIC

- SDOH Assessment Status
- SDOH Assistance
- SDOH Controllable Triggers
- SDOH Education Assistance
- SDOH Employment Assistance
- SDOH Refused
- SDOH Triggers
- SDOH-Protection Support

▲

▼

◀

▶

SELECTED

- Full patient name
- Age
- Language
- Race
- Ethnicity
- Date of Birth
- Primary Payer
- Pronouns
- First PHQ in Last 12 Mths
- Most Recent PHQ Last 12 Mths
- First A1c in Last 12 Mths
- Most Recent A1c Last 12 Mths

Cancel

Confirm

Search

Care Effectiveness (C

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec	Popula
tiveness Report	w (Agg
Diabetes Care Effec	Patient
tiveness Patients	
Behavioral Health	Popula
Care Effectiveness	w (Agg
Report	
Behavioral Health	Patient
Care Effectiveness	
Patients	

1 to 4 of 4

+

Create CER Report

STATUS	Columns
abled	⚙️

Page 1 of 1

Create CER Report

GENERAL **COLUMNS** VISUALIZATIONS

DATA ELEMENTS
The first two columns on Patient Level reports are always "Full Patient Name" and "MRN". These columns can not be removed. Add additional demographic columns as necessary. Select from the options below. Drag and drop or use the arrow buttons to select columns.

Search

METRIC TYPE	METRIC
Encounter	SDOH Assessment Status
Laboratory	SDOH Assistance
Claim	SDOH Controllable Triggers
Prescription	SDOH Education Assistance
Social Drivers	SDOH Employment Assistance
Incarceration	SDOH Refused
Dental	SDOH Triggers
SDOH	SDOH-Protection Support

SELECTED

- Full patient name
- Age
- Language
- Race
- Ethnicity
- Date of Birth
- Primary Payer
- Pronouns
- First PHQ in Last 12 Mths
- Most Recent PHQ Last 12 Mths
- First A1c in Last 12 Mths
- Most Recent A1c Last 12 Mths

Cancel Confirm

Track demographics

Search

Care Effectiveness (C)

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec	Popula
tiveness Report	w (Agg
Diabetes Care Effec	Patient
tiveness Patients	
Behavioral Health	Popula
Care Effectiveness	w (Agg
Report	
Behavioral Health	Patient
Care Effectiveness	
Patients	

1 to 4 of 4

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Create CER Report

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Page 1 of 1

Create CER Report

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Laboratory	SDOH Assistance
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- Age
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- Date of Birth
- Primary Payer
- Pronouns
- First PHQ in Last 12 Mths
- Most Recent PHQ Last 12 Mths
- First A1c in Last 12 Mths
- Most Recent A1c Last 12 Mths

Cancel Confirm

Health trajectory data

Search

Care Effectiveness (C

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec	Popula
tiveness Report	w (Agg
Diabetes Care Effec	Patient
tiveness Patients	
Behavioral Health	Popula
Care Effectiveness	w (Agg
Report	
Behavioral Health	Patient
Care Effectiveness	
Patients	

1 to 4 of 4

+ Create CER Report

STATUS	Columns
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abled	
abled	

Page 1 of 1

Create CER Report

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Encounter	SDOH Assessment Status
Laboratory	SDOH Assistance
Claim	SDOH Controllable Triggers
Prescription	SDOH Education Assistance
Social Drivers	SDOH Employment Assistance
Incarceration	SDOH Refused
Dental	SDOH Triggers
SDOH	SDOH-Protection Support

SELECTED

- Qualifying Encounter
- BHI Appointment - Last Encounter
- BHI Appointment - Next Appointment
- Telehealth Visit Types - Last Encounter
- Telehealth Visit Types - Next Appointment
- Diabetes
- Prediabetes
- Hypertension
- Statin
- HTN Guideline Therapy
- Depression Diagnosis

Cancel Confirm

Latest and upcoming encounters across service lines

Search

Care Effectiveness (C

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec	Popula
tiveness Report	w (Agg
Diabetes Care Effec	Patient
tiveness Patients	
Behavioral Health	Popula
Care Effectiveness	w (Agg
Report	
Behavioral Health	Patient
Care Effectiveness	
Patients	

1 to 4 of 4

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Create CER Report

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Page 1 of 1

Create CER Report

GENERAL COLUMNS VISUALIZATIONS

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Search

METRIC TYPE	METRIC
Encounter	SDOH Assessment Status
Laboratory	SDOH Assistance
Claim	SDOH Controllable Triggers
Prescription	SDOH Education Assistance
Social Drivers	SDOH Employment Assistance
Incarceration	SDOH Refused
Dental	SDOH Triggers
SDOH	SDOH-Protection Support

SELECTED

- Qualifying Encounter
- BHI Appointment - Last Encounter
- BHI Appointment - Next Appointment
- Telehealth Visit Types - Last Encounter
- Telehealth Visit Types - Next Appointment
- Diabetes
- Prediabetes
- Hypertension
- Statin
- HTN Guideline Therapy
- Depression Diagnosis

Cancel Confirm

Diagnoses and comorbid conditions

Search

Care Effectiveness (C

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Efficacy Report	Population
Diabetes Care Effectiveness Patients	Patient
Behavioral Health Care Effectiveness Report	Population
Behavioral Health Care Effectiveness Patients	Patient

1 to 4 of 4

AF

Create CER Report

STATUS	Columns
abled	Settings
abled	Settings

Page 1 of 1

Create CER Report

GENERAL **COLUMNS** VISUALIZATIONS

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Search

METRIC TYPE	METRIC
Encounter	SDOH Assessment Status
Laboratory	SDOH Assistance
Claim	SDOH Controllable Triggers
Prescription	SDOH Education Assistance
Social Drivers	SDOH Employment Assistance
Incarceration	SDOH Refused
Dental	SDOH Triggers
SDOH	SDOH-Protection Support

SELECTED

- Depression Diagnosis
- Anxiety
- GAD-7 Score
- Material Security - Food
- SDOH Needs Assessed
- SDOH Food Intervention
- Housing
- SDOH Homelessness Intervention
- SDOH Housing Instability Intervention
- SDOH Inadequate Housing Intervention
- Transportation - Medical
- SDOH Transportation Intervention

Cancel Confirm

Non-clinical drivers of health identified & associated interventions

Search

Care Effectiveness (C

Search Care Effectiveness Re

NAME	REPO
Diabetes Care Effec	Popula
tiveness Report	w (Agg
Diabetes Care Effec	Patien
tiveness Patients	
Behavioral Health	Popula
Care Effectiveness	w (Agg
Report	
Behavioral Health	Patien
Care Effectiveness	
Patients	

1 to 4 of 4

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Create CER Report

STATUS

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III

Page 1 of 1

Create CER Report

GENERAL

COLUMNS

VISUALIZATIONS

VISUALIZATIONS DEFINITION

Pre-defined visualizations for the top of the report. Can have zero, one, or two selected.

Cancel

VISUALIZATION SELECTION

× Glucose Control (A1C) × Depression (PHQ)

- Anxiety (GAD7)
- Asthma Control Test (ACT)
- Blood Pressure Control (BP)
- CD4 Monitoring (HIV)
- Depression (PHQ)
- Glucose Control (A1C)
- International Normalised Ratio (INR)
- Viral Load (HIV)

Select which visualizations you want to see at the top of your custom CER

DEPRESSION (PHQ)



● Severe	47
● Moderately Severe	77
● Moderate	111
● Mild	146
● None	461
● No Score	189

5.9

AVG PHQ SCORE

▼ -0.9 Last 12 mths.

159

PHQ PTS WITH A >= 5 PT DROP

11.1

AVG GAD7 SCORE

▼ -0.0 Last 12 mths.

16

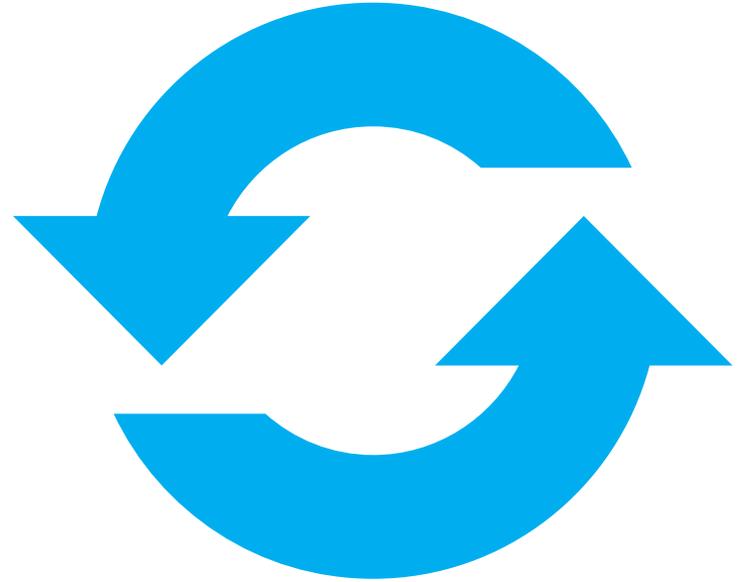
GAD7 PTS WITH A >= 6 PT DROP

ANXIETY (GAD7)



● Severe	128
● Moderate	98
● Mild	81
● None	73
● No Score	651

Nightly Processing



Overview - Population: CM Cohort



GLUCOSE CONTROL (A1C)

● Poor (>9.0)	6
● Fair (>8.0 and <=9.0)	2
● Good (>6.4 and <=8.0)	7
● Prediabetes (>=5.7 and <=6.4)	27
● Normal (< 5.7)	22
● No Score	49



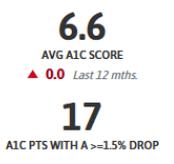
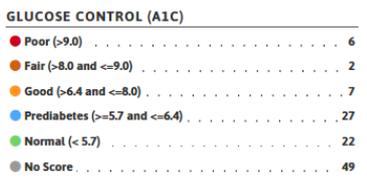
DEPRESSION (PHQ)

● Severe	0
● Moderately Severe	0
● Moderate	0
● Mild	2
● None	75
● No Score	36

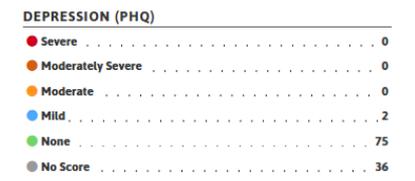
AGE	FIRST PHQ IN LAST 12 MTHS				MOST RECENT PHQ LAST 12 MTHS				FIRST A1C IN LAST 12 MTHS				MOST RECENT A1C LAST 12 MTHS				MOST RECENT ENCOUNTER			BHI APPOI
	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	RESULT	DATE	STATUS	RESULT	DATE	CHANGE	DATE	PROVIDER	LOCATION	DATE				
65	6	7/8/2024	●	3	1/27/2025	▼ -3			●				3/13/2024							
60	0	3/18/2024	●	0	12/24/2024	0	9.9	3/18/2024	●	10.9	12/24/2024	▲ 1.0	12/24/2024							
51			●						●				10/3/2023							
63	0	3/6/2024	●	0	1/28/2025	0	6.4	3/6/2024	●	6.3	10/18/2024	▼ -0.1	2/11/2025							
47	0	6/14/2024	●	0	11/21/2024	0	5.9	8/23/2024	●	5.9	8/23/2024	0.0	2/20/2025							
64	0	3/12/2024	●	0	2/5/2025	0	6.5	6/12/2024	●	6.4	2/5/2025	▼ -0.1	2/5/2025							
47	0	5/3/2024	●	6	8/26/2024	▲ 6	5.8	5/3/2024	●	5.8	5/3/2024	0.0	1/7/2025							
65	7	3/13/2024	●	0	10/29/2024	▼ -7	6.6	3/14/2024	●	6.3	10/29/2024	▼ -0.3	10/29/2024							
40	2	3/2/2024	●	0	2/12/2025	▼ -2	5.5	5/2/2024	●	5.2	2/12/2025	▼ -0.3	2/12/2025							
60	0	4/4/2024	●	0	4/4/2024	0			●											
47	0	3/5/2024	●	1	1/21/2025	▲ 1	6.2	4/17/2024	●	7.2	11/4/2024	▲ 1.0	2/6/2025							
58	0	2/29/2024	●	0	1/22/2025	0	5.0	4/16/2024	●	5.9	1/22/2025	▲ 0.9	1/29/2025							
62	0	3/20/2024	●	0	10/2/2024	0			●				1/15/2025							
61	0	6/25/2024	●	0	1/17/2025	0	5.9	4/9/2024	●	5.6	1/21/2025	▼ -0.3	1/31/2025							
56			●						●				1/31/2023							

Capture health trajectory of patients enrolled in Care Management...

Overview - Population: CM Cohort



...alongside clinical diagnoses & current medications



Search ... 🔍

NEXT APPT All No Appt Upcoming Appt

Reset Columns SAVED COLUMNS ☰

DIABETES DX			PREDIABETES			HTN DX			STATIN MED			
DATE	CODE	CODE DESCRIPTION	DATE	CODE	CODE DESCRIPTION	DATE	CODE	CODE DESCRIPTION	START DATE	NAME	RXNORM	RXNORM DESCRIPTION
12/24/2024	E11.65	TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA				10/25/2016	59621000	Essential hypertension (disorder)	3/13/2024	simvastatin	312961	simvastatin 20 MG Oral Tablet
						11/30/2018	59621000	Essential hypertension (disorder)	12/24/2024	atorvastatin calcium	617310	atorvastatin 20 MG Oral Tablet
			1/22/2025	R73.03	PREDIABETES				1/22/2025	atorvastatin calcium	617312	atorvastatin 10 MG Oral Tablet
8/19/2024	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS				4/16/2024	I10	ESSENTIAL (PRIMARY) HYPERTENSION	11/21/2024	simvastatin	104490	Zocor 10 MG Oral Tablet
2/5/2025	E11.9	TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS										
						9/16/2022	59621000	Essential hypertension (disorder)				
4/9/2019	313436004	Type II diabetes mellitus without complication (disorder)				10/29/2024	I10	ESSENTIAL (PRIMARY) HYPERTENSION	10/29/2024	atorvastatin calcium	617312	atorvastatin 10 MG Oral Tablet
			1/21/2025	R73.03	PREDIABETES	10/31/2024	I10	ESSENTIAL (PRIMARY) HYPERTENSION				
12/23/2024	E13.9	OTHER SPECIFIED DIABETES MELLITUS WITHOUT COMPLICATIONS				7/17/2024	I10	ESSENTIAL (PRIMARY) HYPERTENSION	11/4/2024	atorvastatin calcium	617312	atorvastatin 10 MG Oral Tablet
						7/21/2016	59621000	Essential hypertension (disorder)	6/25/2024	atorvastatin calcium	617314	Lipitor 10 MG Oral Tablet
						10/9/2020	59621000	Essential hypertension (disorder)	11/21/2024	atorvastatin calcium	617312	Amlodipine 2.5 MG / atorvastatin 20 MG Oral Tablet
						9/7/2021	59621000	Essential hypertension (disorder)				

Should any of these patients have diagnoses based on their current vitals?

Are any patients struggling to achieve A1C control & are not currently prescribed a statin?

Overview - Population: CM Cohort



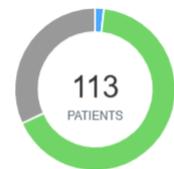
GLUCOSE CONTROL (A1C)

Poor (>9.0)	6
Fair (>8.0 and <=9.0)	2
Good (>6.4 and <=8.0)	7
Prediabetes (>=5.7 and <=6.4)	27
Normal (< 5.7)	22
No Score	49

6.6
AVG A1C
▲ 0.0 Last
17
A1C PTS WITH A

...alongside BH & SDOH information

0.3



DEPRESSION (PHQ)

Severe	0
Moderately Severe	0
Moderate	0
Mild	2
None	75
No Score	36

GAD-7			SOCIAL NEEDS ASSESSMENT		SDOH FOOD INTERVENTION			HOUSING		SDOH HOMELESSNESS INTERVENTION			SDOH HOUSING INSTABILITY IN	
DATE	SCORE	MATERIAL SECURITY FOOD TRIGGER	DATE	SCREENING FORMAT	DATE	CODE	CODE DESCRIPTION	DATE	RESPONSE	DATE	CODE	CODE DESCRIPTION	DATE	CODE
								11/8/2024	Not Homeless					
								1/8/2025	Not Homeless					
								12/21/2023	Not Homeless					
								2/4/2025	Not Homeless					
11/21/2024	0							2/21/2025	Not Homeless					
								11/20/2024	Homeless Shelter					
								2/19/2025	Not Homeless					
		N	2/12/2025	7										
		N	10/23/2024	6										

Are there patients with identified SDOH barriers that haven't received a corresponding intervention?

Wrap Up



**Is there anything you
plan to explore after
today's presentation?**



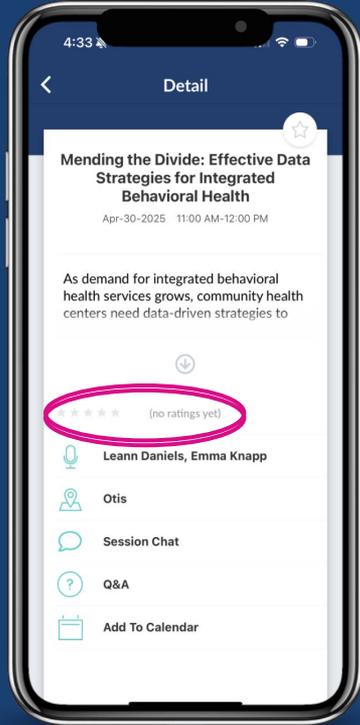
Questions?



We want to hear from you!

Click on the session from your agenda in the conference app.

Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy



Provide brief feedback or ideas



Rate the session and the speaker(s)



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Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:

- Azara will help tell your story and provide a client-branded version for your use
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