# Due, Doing, Done! Optimizing Clinical Workflows with the PVP

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UPPER GREAT LAKES
FAMILY HEALTH

# Introduction

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# UPPER GREAT LAKES FAMILY HEALTH (UGL)

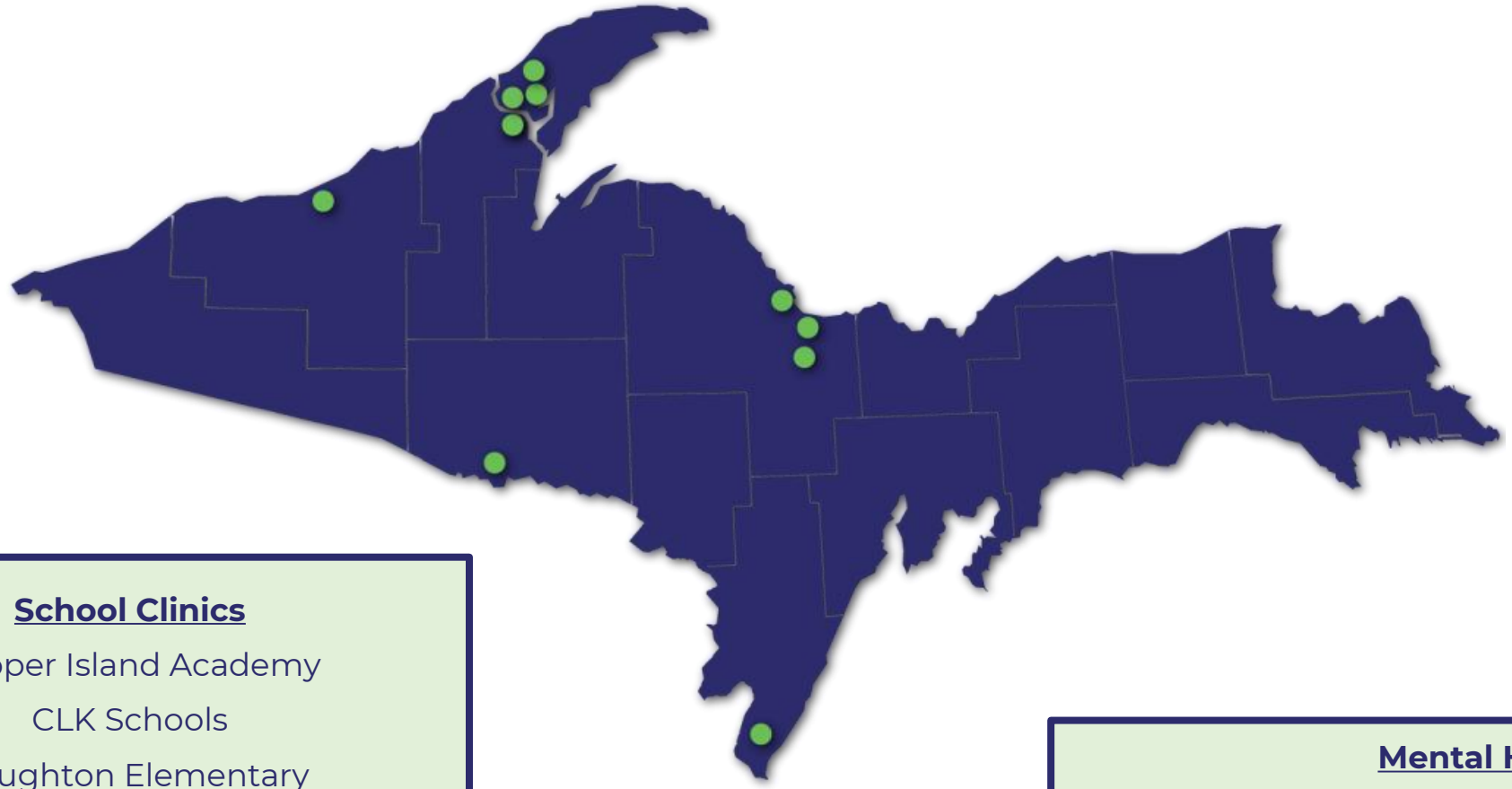
UGL began in 2009 as a vision of Dr. Catherine Kroll, an Upper Peninsula family practice provider of 40+ years.

Her dream was to provide quality healthcare for all people in the Upper Great Lakes region, regardless of their ability to pay.

Since then, UGL has grown from a single location to 17 FQHC clinics across the Upper Peninsula, serving more than 24,000 patients a year.

UPPER GREAT LAKES FAMILY HEALTH

# Locations



**Primary Care**

Calumet
Lake Linden
Hancock
Houghton
Ontonagon
Iron River
Menominee
Marquette
Sawyer
Gwinn

**Dental**

Calumet
Sawyer
Iron River

**School Clinics**

Copper Island Academy
CLK Schools
Houghton Elementary
Houghton Middle/High
Lake Linden Schools

**Mental Health**

Available via telehealth through
entire UGL region, some in-person availability

# Agenda

- Why Do Care Gaps Exist?
- Making the Right Thing the Easy Thing
- Putting the Pieces Together
- Framework for Utilizing PVP Effectively
- Quality Playbook, Screening Report Cards, To Do Lists
- The Impact of Patient Facing Tools
- Lessons We’ve Learned
- How Can You Get Started?

THE CHALLENGE

# Why do care gaps exist?

### The Hard Truth

Dashboards don't change behavior—**systems do**.

**Patients don't understand what they're due for**

Clinical terminology, confusing insurance, and changing guidelines create confusion and missed opportunities

**Providers communicate intent, but it doesn't stick**

Verbal instructions get lost without systematic follow-through

**Staff juggle too many competing lists**

Multiple data sources create cognitive overload and inefficiency

**Population health data lives outside of daily work**

Information exists in systems that aren't integrated into workflows

THE CHALLENGE

# Where We Started (August 2025)

| Kidney Health Evaluation | Hemoglobin A1C > 9 or Untested | Breast Cancer Screening | Colon Cancer Screening |
|---|---|---|---|
| 54.1% ↓ | 76.1% ↓ | 72.9% ↓ | 69.1% ↓ |

OUR PHILOSOPHY

# Make the Right Thing the Easy Thing

## Create one source of truth

DRVS serves as our **single source** of truth, so teams are working from the same, trusted information (and mapping stays as UTD as possible).

## Translate data into plain language

Replace clinical jargon with clear, actionable messages patients and staff understand.

## Build redundancy on purpose

Strategic repetition ensures critical information reaches the right people at the right time

## Design for humans, not perfection

Create workflows that accommodate real-world constraints and human behavior

FRAMEWORK

# How Do the Pieces Fit Together?

PVP

## DRVS Patient Visit Planning

Prioritize patients using actionable intelligence

## Quality Playbook

Define why actions matter & set rules

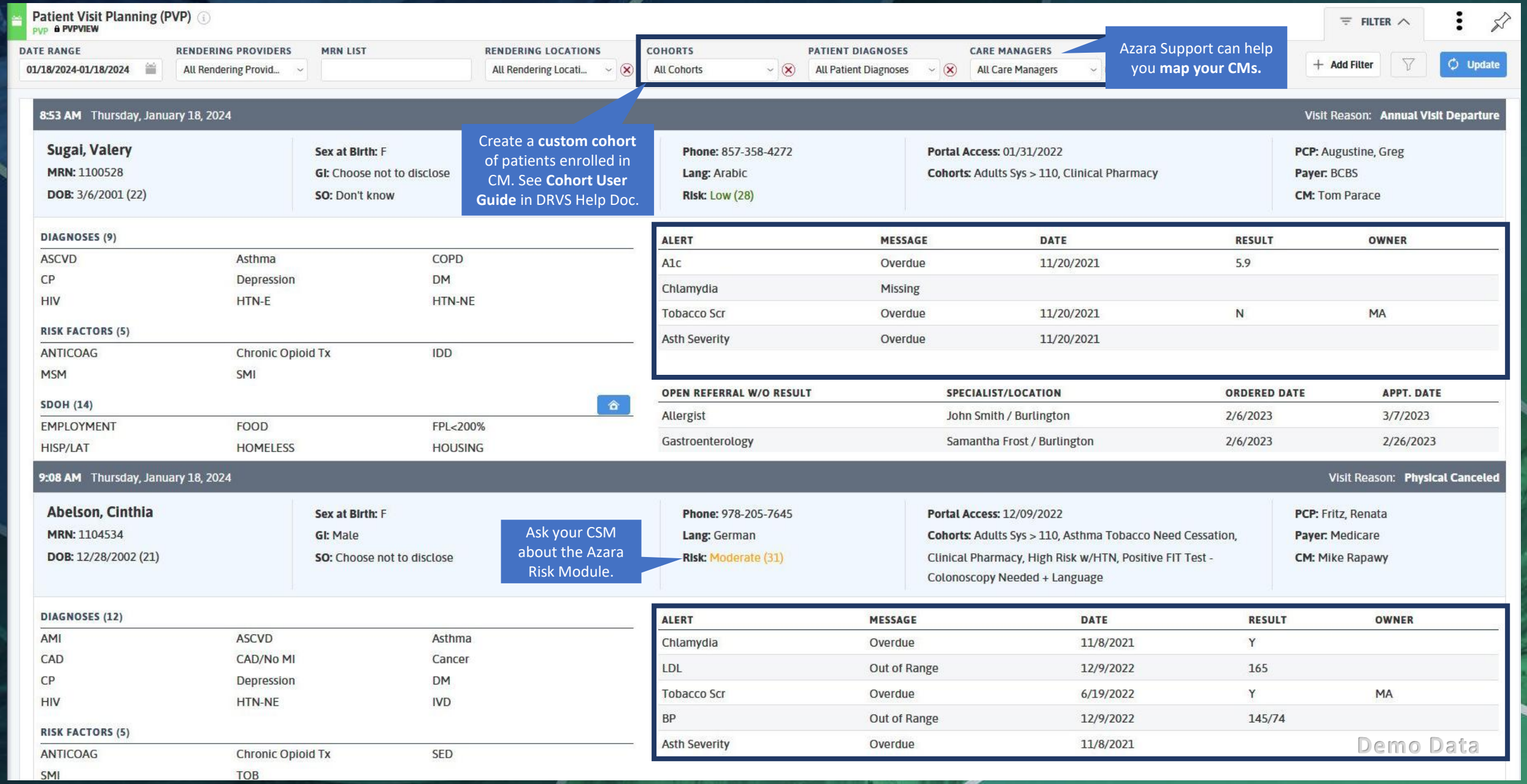
## Screening Cards

Engage patients with report-backed reminders

## Check-Out Forms

Execute tasks via forms & to-do lists

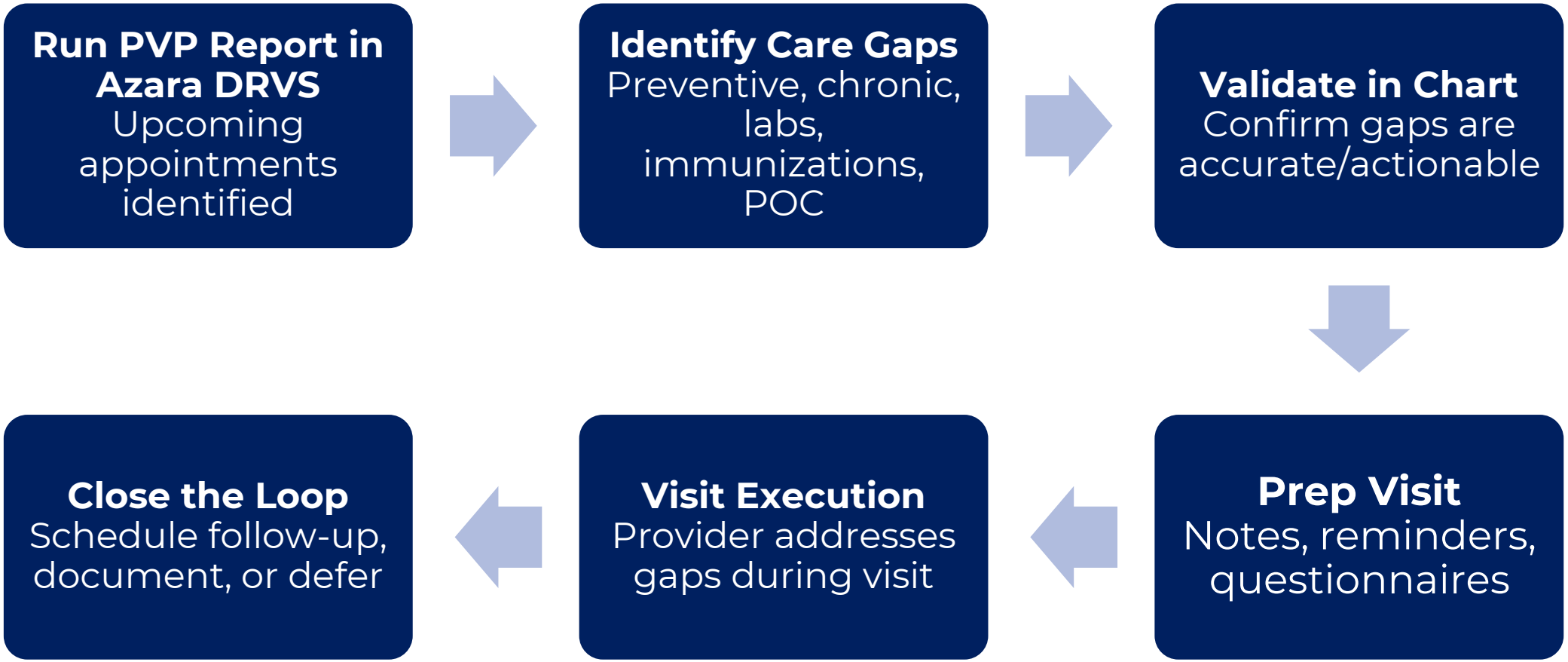
# DRVS PVP


Patient Visit Planning (PVP)
PVP
PVPVIEW
FILTER
DATE RANGE
01/18/2024-01/18/2024
RENDERING PROVIDERS
All Rendering Provid...
MRN LIST
RENDERING LOCATIONS
All Rendering Locati...
COHORTS
All Cohorts
PATIENT DIAGNOSES
All Patient Diagnoses
CARE MANAGERS
All Care Managers
Add Filter
Update
Azara Support can help you map your CMs.
Create a custom cohort of patients enrolled in CM. See Cohort User Guide in DRVS Help Doc.
8:53 AM Thursday, January 18, 2024
Visit Reason: Annual Visit Departure
Sugai, Valery
MRN: 1100528
DOB: 3/6/2001 (22)
Sex at Birth: F
GI: Choose not to disclose
SO: Don't know
Phone: 857-358-4272
Lang: Arabic
Risk: Low (28)
Portal Access: 01/31/2022
Cohorts: Adults Sys > 110, Clinical Pharmacy
PCP: Augustine, Greg
Payer: BCBS
CM: Tom Parace
DIAGNOSES (9)
ASCVD
Asthma
COPD
CP
Depression
DM
HIV
HTN-E
HTN-NE
RISK FACTORS (5)
ANTICOAG
Chronic Opioid Tx
IDD
MSM
SMI
SDOH (14)
EMPLOYMENT
FOOD
FPL<200%
HISP/LAT
HOMELESS
HOUSING
ALERT
MESSAGE
DATE
RESULT
OWNER
A1c
Overdue
11/20/2021
5.9
Chlamydia
Missing
Tobacco Scr
Overdue
11/20/2021
N
MA
Asth Severity
Overdue
11/20/2021
OPEN REFERRAL W/O RESULT
SPECIALIST/LOCATION
ORDERED DATE
APPT. DATE
Allergist
John Smith / Burlington
2/6/2023
3/7/2023
Gastroenterology
Samantha Frost / Burlington
2/6/2023
2/26/2023
9:08 AM Thursday, January 18, 2024
Visit Reason: Physical Canceled
Abelson, Cinthia
MRN: 1104534
DOB: 12/28/2002 (21)
Sex at Birth: F
GI: Male
SO: Choose not to disclose
Ask your CSM about the Azara Risk Module.
Phone: 978-205-7645
Lang: German
Risk: Moderate (31)
Portal Access: 12/09/2022
Cohorts: Adults Sys > 110, Asthma Tobacco Need Cessation, Clinical Pharmacy, High Risk w/HTN, Positive FIT Test - Colonoscopy Needed + Language
PCP: Fritz, Renata
Payer: Medicare
CM: Mike Rapawy
DIAGNOSES (12)
AMI
ASCVD
Asthma
CAD
CAD/No MI
Cancer
CP
Depression
DM
HIV
HTN-NE
IVD
RISK FACTORS (5)
ANTICOAG
Chronic Opioid Tx
SED
SMI
TOB
ALERT
MESSAGE
DATE
RESULT
OWNER
Chlamydia
Overdue
11/8/2021
Y
LDL
Out of Range
12/9/2022
165
Tobacco Scr
Overdue
6/19/2022
Y
MA
BP
Out of Range
12/9/2022
145/74
Asth Severity
Overdue
11/8/2021
Demo Data

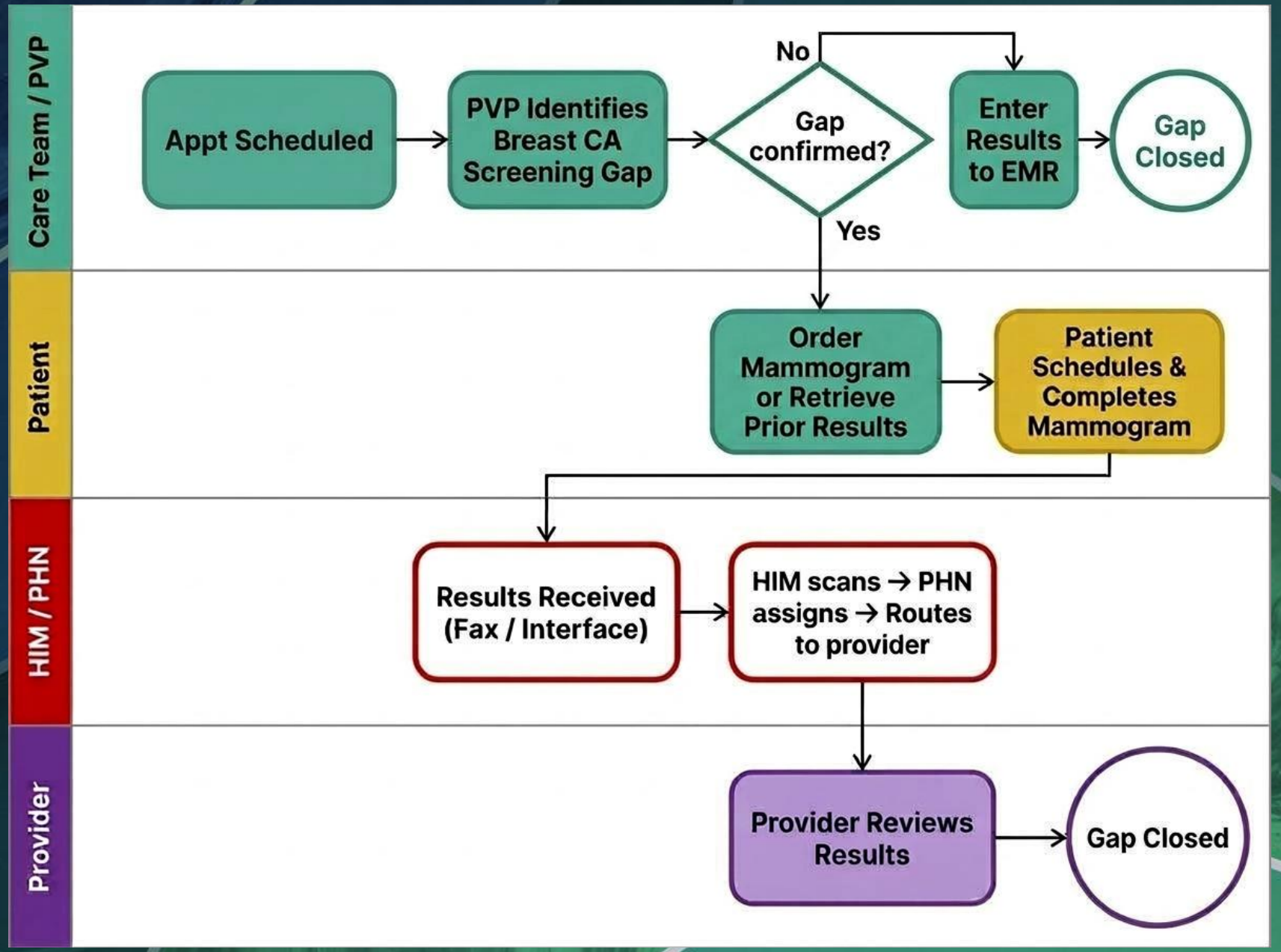
# DRVS PVP Report as the Backbone

- Identifies care gaps
- Prepares the visit
- Aligns team focus
- Supports metric performance

# PATIENT VISIT PLANNING WORKFLOW



# Driving Breast Cancer Gap Closure



# CHECK OUT FORMS

# UGL Check Out Form

**Patient Name** _____

**Provider** _____ **Date** _____

| | |
|---|---|
| **Schedule follow up:**<br>☐ 1wk ☐ 1mo ☐ 3mo ☐ 6mo ☐ PRN<br>☐ Other _____ ☐ Already Scheduled<br>☐ Pending Results<br>Reason _____ | **Referral sent to:**<br>**Internal** ☐ Care Team ☐ Pharmacist<br>**External** ☐ _____ |
| **Schedule Annual:**<br>☐ AWV ☐ Annual PE/Well Child | ☐ **Rx(s) Sent** |
| **Obtain Labs**<br>☐ Today ☐ _____ ☐ Fasting | **Obtain Xray/Other Diagnostics**<br>☐ Today ☐ Call to Schedule ☐ Await Call |
| ☐ Action Created (if appt not scheduled) | |

**DM Reminders:**

**Most recent A1C > 7 = Repeat every 3 mo**

**Most recent A1C ≤ 7 = Repeat every 6 mo**

**BMP & Urine Microalbumin annually**

**OV every 6 months (at minimum)**

Configure alerts in DRVS to meet your clinical strategies.

# QUALITY PLAYBOOK

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# QUALITY
*Playbook*



# BREAST CANCER SCREENING

## GUIDELINES

| | |
|---|---|
| Women of Avg Risk 40-44 | Optional Annual Mammograms |
| Women of Avg Risk 45-54 | Annual Mammograms |
| Women of Avg Risk 55+ | Biennial Mammograms; Annual, if desired |

*Note: UGL's recommendations are for annual mammograms for age 45-54, but the measure only requires biennial*

## EXCLUSIONS

| | |
|---|---|
| Bilateral Mastectomy | Surgical History: Bilateral Mastectomy *or* L Mastectomy + R Mastectomy |
| Hospice Care | Any Hospice Code |
| Palliative Care | Z51.5 |
| Age > 66 & living in an nursing home long-term | Documentation of admission to LTC or SNF |
| Age >66 & Evidence of Frailty + >1 Visit w/ dx of Advanced Illness OR active med for dementia | ICD10 Codes, Meds, etc. **See Appendix** |

*Note: Mammo must be entered & resulted in DI tab in eCW.*

Give explicit details

PLAYING THE GAME

# The Quality Playbook

## What counts

Clear criteria for measure numerators & denominators

## When it's complete

Definitions of "done" that align with quality measures

## Who does what

Specific role assignments and responsibilities

## How it ties to resources

Links to PDF workflows, standing orders

# SCREENING REPORT CARDS

# Screening Report Cards

**Supported by Michigan Health Endowment Fund Healthy Aging Grant**

This patient-facing innovation is a standout differentiator in our approach

## Timed with birthdays

High open rate, low friction

## Personalized status

Individual preventive care status in plain language

## Reinforces visits

Sets the stage for productive conversations

## CMP Integration

Filled out using Care Management Passport data

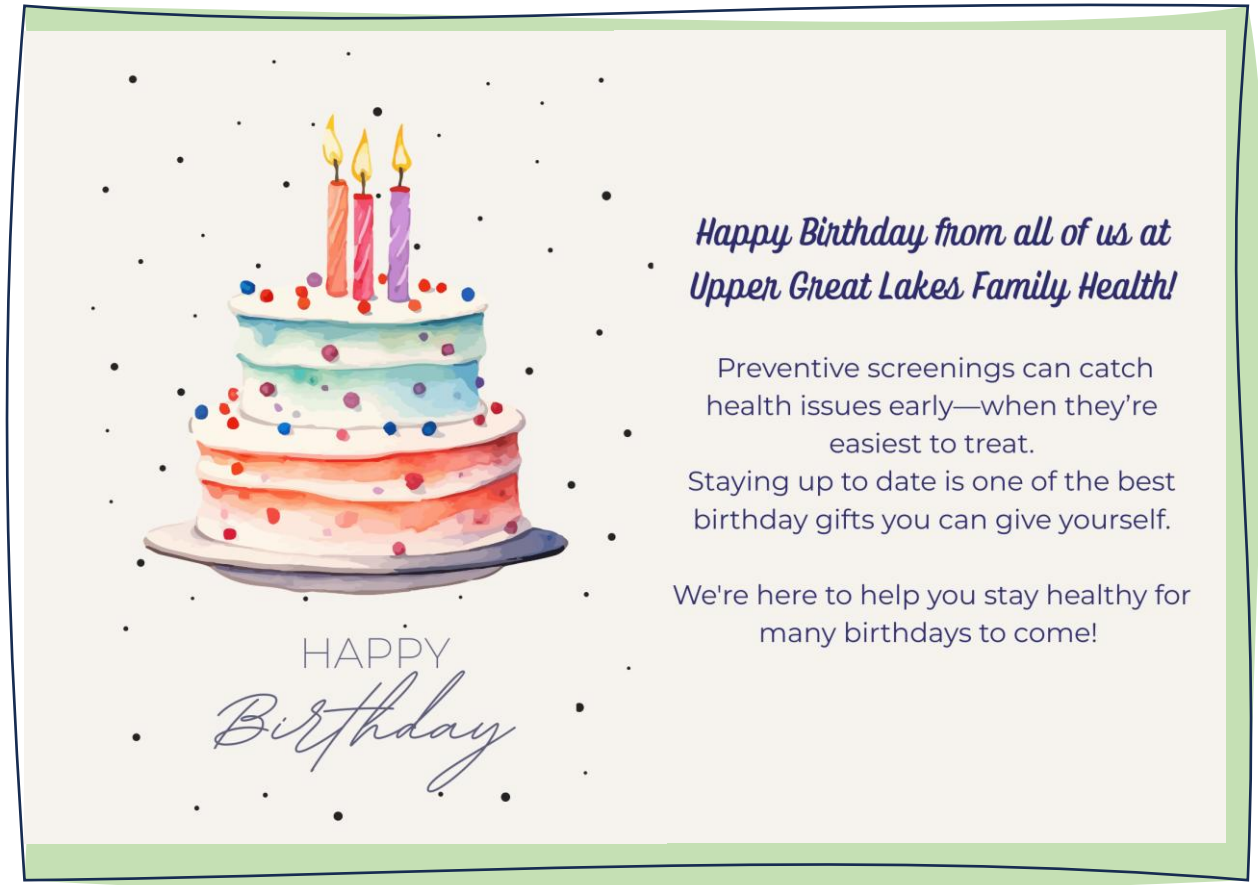
WHY THIS WORKS

# Impact of Patient-Facing Tools

**Patients arrive informed**
They know what to expect and come prepared with questions

**Conversations are faster and clearer**
Shared understanding eliminates time spent explaining basics

**Less defensive outreach**
Proactive communication feels helpful, not nagging




This is population health without sounding like population health.
**It feels personal, not institutional.**

FEMALE

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# PREVENTIVE SCREENING REPORT CARD

Name: Provider:

| SCREENING | LAST DONE | NEXT DUE |
|---|---|---|
| Breast Cancer (Mammogram) | | |
| Cervical Cancer (Pap/HPV) | | |
| Colorectal Cancer (FIT, Cologuard, Colonoscopy) | | |
| Lung Cancer (Current/Former Smokers, Low Dose Chest CT) | | |
| Wellness Visit (Medicare AWV or Annual Physical) | | |

**Let's keep you feeling your best! You're due for:**

**Your next check-in with your PCP is recommended:**

**You have the following outstanding orders & referrals placed:**

MALE

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FAMILY HEALTH

# PREVENTIVE SCREENING REPORT CARD

Name: Provider:

| SCREENING | LAST DONE | NEXT DUE |
|---|---|---|
| Colorectal Cancer (FIT, Cologuard, Colonoscopy) | | |
| Lung Cancer (Current/Former Smokers, Low Dose Chest CT) | | |
| Wellness Visit (Medicare AWV or Annual Physical) | | |

**Let's keep you feeling your best! You're due for:**

**Your next check-in with your PCP is recommended:**

**You have the following outstanding orders & referrals placed:**

DIABETES

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# DIABETES SCREENING REPORT CARD

Name: Provider:

| SCREENING | LAST DONE | NEXT DUE |
|---|---|---|
| Hemoglobin A1C | | |
| Kidney Health Evaluation - Urine Microalbumin | | |
| Kidney Health Evaluation - EGFR | | |
| Diabetic Eye Exam | | |
| Diabetic Foot Exam | | |

RESULTS

# What changed for us in 6 months?

| Kidney Health Evaluation | Hemoglobin A1C > 9 or Untested | Breast Cancer Screening | Colon Cancer Screening |
|---|---|---|---|
| 58.7% | 78.2% | 76.6% | 74.0% |
| ↑ 4.6% | ↑ 2.1% | ↑ 3.7% | ↑ 4.6% |

**Better preparedness**

**Cleaner follow-through**

**More meaningful patient conversations**

**Stronger alignment with Azara data**

REFLECTIONS

# Lessons Learned

## Start Small

Pilot with one team or one workflow before scaling across the organization. Perfection is the enemy of progress.

## Over-Communicate

Explain the "why" repeatedly and through multiple channels. People need context to change behavior.

## Standardize Early

Create templates and processes from the beginning—retrofitting is much harder than building it right initially.

## Expect Iteration

Your first version won't be perfect. Build in feedback loops and adjust based on real-world use.

GETTING STARTED

# How to Start This at Your Organization

| Set Yourself Up For Success | |
|---|---|
| Validate your EMR -> DRVS Mapping | Ensure your Standing Orders are UTD with current guidelines |

| Create Your Playbook | |
|---|---|
| Anchor everything to DRVS & PVP | Listen to your staff's needs |

| Choose Your Patient Facing Tool(s) | |
|---|---|
| Consider how to best engage your patient population | Make things personal, not institutional |

# Final Takeaway

Azara shows us the work needed.
Our tools make sure it gets done.

Data alone doesn't close care gaps.

Systems that translate insights into daily workflows, engage patients as partners, and support teams with clear accountability –
that's what drives sustainable improvement.

# Questions?

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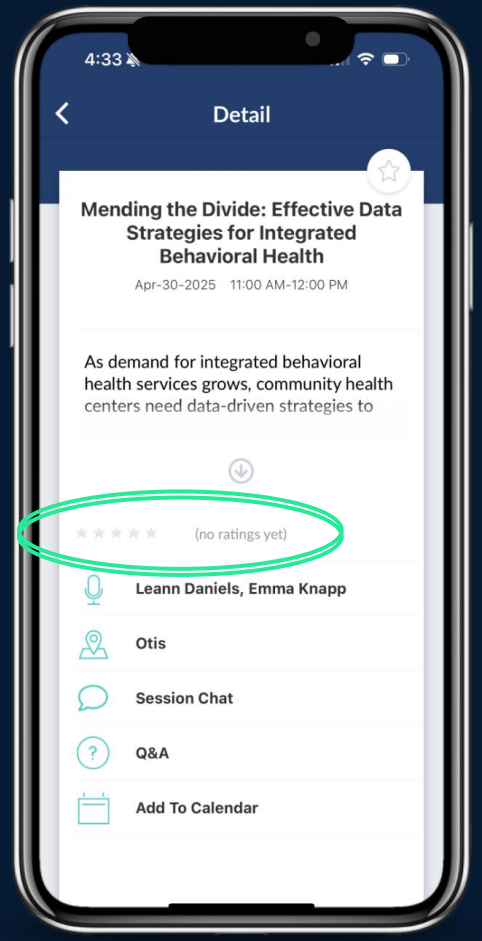
FAMILY HEALTH

Want your own Screening Report Cards? Molly is gifting a **free template**.

Available with this slide deck in the **conference app.**

# 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)

Help us continue to improve

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

# Thanks for attending!