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USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

A Treasure Map to Success

Creating a Plan to Maximize DRVS Usage

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Today's Presenters

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Agenda

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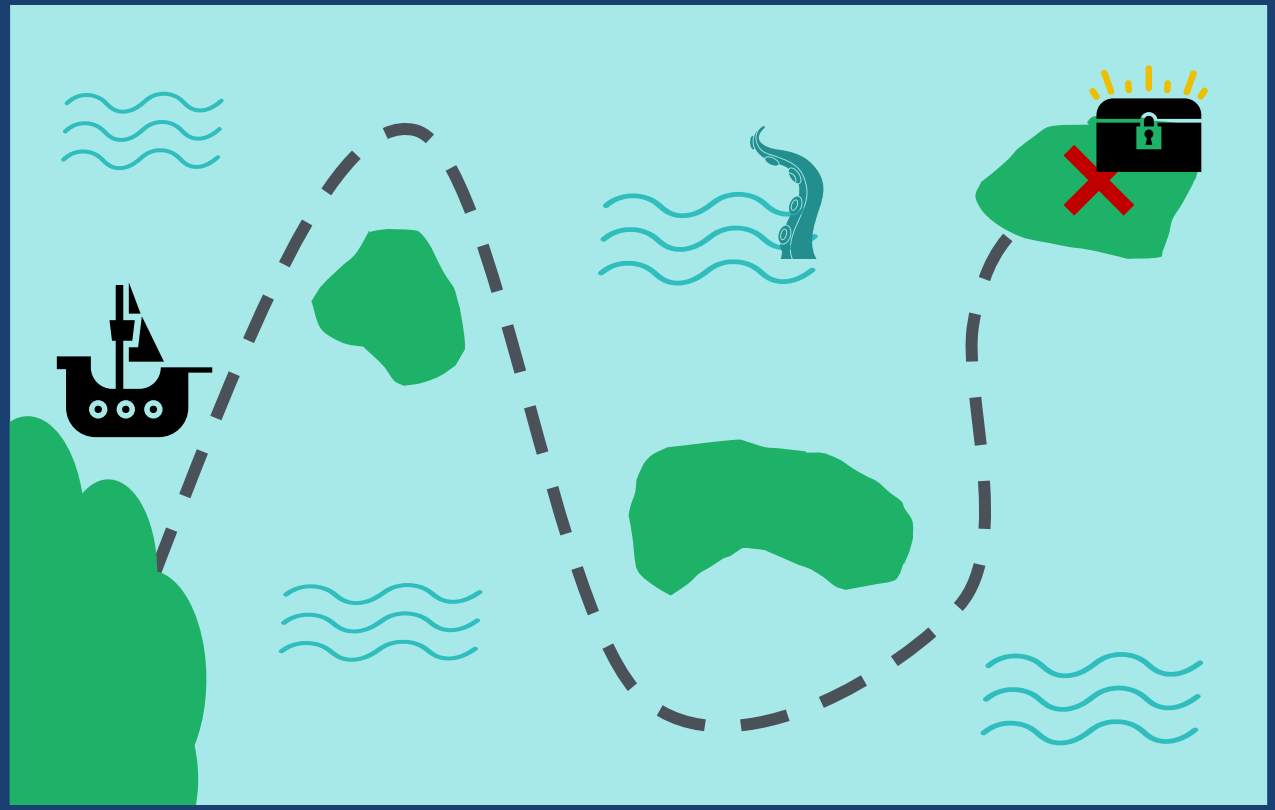
LOCATE YOUR PORT

DEFINE YOUR SUCCESS

PLAN YOUR COURSE

FIND YOUR TREASURE



Locating Your Port

Define the Starting Point

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Where are you starting?

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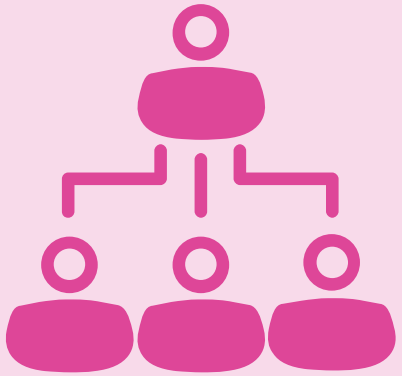

Organization Structure

Current Performance

Data Literacy

Organization Structure

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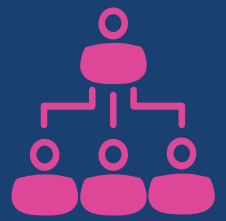
1. Leadership Buy In → Top-down engagement can help drive the project
2. DRVS Ownership → Define internal DRVS project manager
3. Subject Matter Experts → Collaborate with clinical and EHR experts



Current Performance

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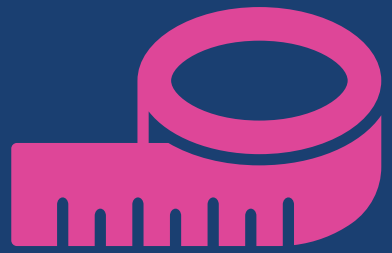

What are you measuring?

What policies do you have?

What are your strengths?

Data Literacy

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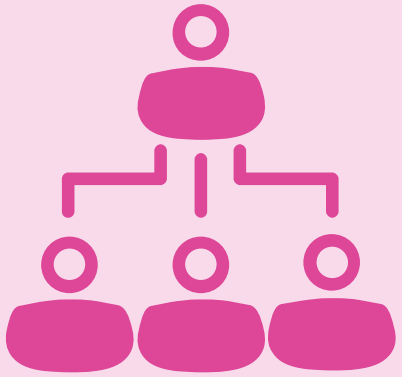
Understand how EHR data translates into technology, into quality improvement

Where are you starting?



Organization Structure

Current Performance

Data Literacy

Orienting

Define Your Success

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Where are you going?

Measure Name	UDS 2024	HRSA	PCA/HCCN	ACO	Payer Contracts/P4P
DM A1c	X	X		X	X
Cervical Cancer Screening	X		X		X
Childhood Immunizations	X		X	X	
HTN BP Control	X	X			
Child Weight Screening and Counseling	X			X	
Colorectal Cancer Screening	X	X	X		X
Depression Screening and Follow-up	X				
Depression Remission at 12 months	X				
Adult Weight Screening and Follow-up	X				X
Child Dental Sealants	X				
Tobacco Assessment and Cessation Advice	X				
Breast Cancer Screening	X		X	X	X
Statin Therapy - Prev&Tx CAD	X				
IVD Use of Aspirin	X				

Department	Name	Title	Expectations for Using DRVS
Quality Improvement			
Providers (primary care)			
Support Staff (MA, LPN, etc.)			
Care Management			
Administrative			
Behavioral Health			
Dental			

Role	Goals	DRVS Tool
Care Coordinators	• Uses data at the point of care to close care gaps • Conduct research on patient care gaps	• PVP & CMP • Measures
Community Health Worker	• Identify patients with social care needs & connect to additional resources	• PVP • Registries
MA/Nurse	• Uses data at the point of care to close care gaps	• PVP & CMP
Provider	• Uses data at the point of care to close care gaps	• PVP & CMP
Care Teams	• Uses data at the point of care to close care gaps	• PVP & CMP • EHR Plug In
Referral Team	• Uses the Referral module to identify open referrals needing action • Reviews referrals ordered as an organization and by specific site/provider/specialty	• Referral Reports • Referral Dashboard • Referral Measures
Pop Health Team	• Uses ACC to track patients in Care Management and to document CQM outreaches • Identify patients for grant participation & additional care opportunities • Track health outcomes of key patient populations	• Azara Care Connect • Registries • Cohorts
Clinical Pharmacy	• Identifies patients with chronic conditions like diabetes or hypertension, their control, and medications	• Registries • Care Effectiveness Reports
Behavioral Health Program	• Reviews trends of screenings for general and BH populations	• Registries • Measures
Diabetes Team	• Identifies patients in diabetes program • Tracks medications, screenings, A1c control, and visits	• Cohorts • Registries
School Based Health	• Identify CHC patients seen at SBHC • Tracks screening & preventive care for SBHC kids	• Location Filters / Cohorts • Immunization & Well Child Management Reports
Grant Reporting	• Report on outcomes for grant metrics • Identify areas of DRVS to support writing grants	• Measures • Registries
Quality Team	• Understand trends in key quality measures (like UDS) • Uses data to plan & track PDSAs and other QI projects • Maintains DRVS to support other users • Create scorecards & dashboards for leadership team	• Measures • Scorecards • Dashboards • Admin
Leadership	• Make data-driven decisions as an organization • Understand trends and needs of population served • Review operational trends	• Dashboards • Scorecards

Primary Care Quality Measure Report

REPORT

FILTER 2

FILTERS: TY April 2024 Primary Care Practices

REPORT | CARE GAPS

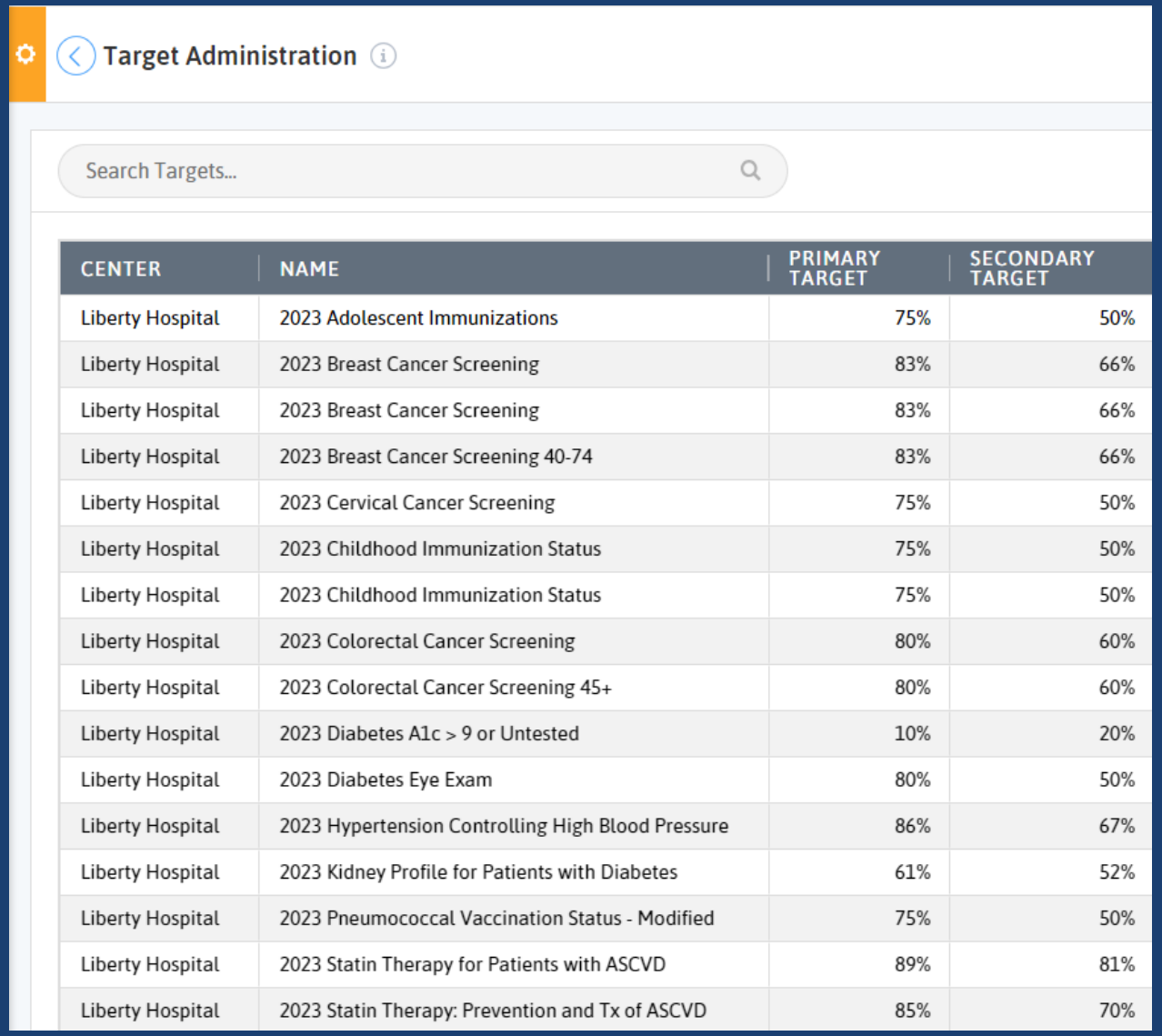
GROUPING No Grouping

TARGETS Primary Secondary Not Met

REPORT FORMAT Scorecard

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	TO TARGET
Colorectal Cancer Screening (CMS 130v11)	59.6%	80.0%	9,778	16,394	229	3,338
Breast Cancer Screening Ages 40-74 (CMS 125v9 modified)	65.7%	83.0%	6,631	10,099	145	1,752
Cervical Cancer Screening (CMS 124v11)	43.4%	75.0%	4,499	10,376	1,657	3,283
Hypertension Controlling High Blood Pressure (CMS165v11)	73.2%	86.0%	6,529	8,923	342	1,145
Diabetes A1c > 9 or Untested (CMS 122v11)	17.2%	10.0%	635	3,692	35	266
Kidney Profile for Patients with Diabetes	54.4%	61.0%	2,389	4,393	172	291
Diabetes: Eye Exam (CMS 131v9)	32.2%	80.0%	1,188	3,689	34	1,764
Statin Therapy ASCVD (CMS 347v6 Breakout)	83.6%	89.0%	3,390	4,054	163	219
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS347v6)	78.3%	85.0%	6,113	7,811	283	527
Childhood Immunization Status - DTP, IPV, MMR, HIB, HEPB, VZV, PCV (CMS 117v11 Breakout)(CMS 117v10 Breakout)	70.6%	75.0%	204	289	0	13
Adolescent Immunizations	18.4%	75.0%	71	386	0	219
Pneumococcal Vaccination Status for Older Adults - CDC Schedule (CMS 127v10 Modified)	64.6%	75.0%	5,294	8,201	45	857

Where do you want to go?

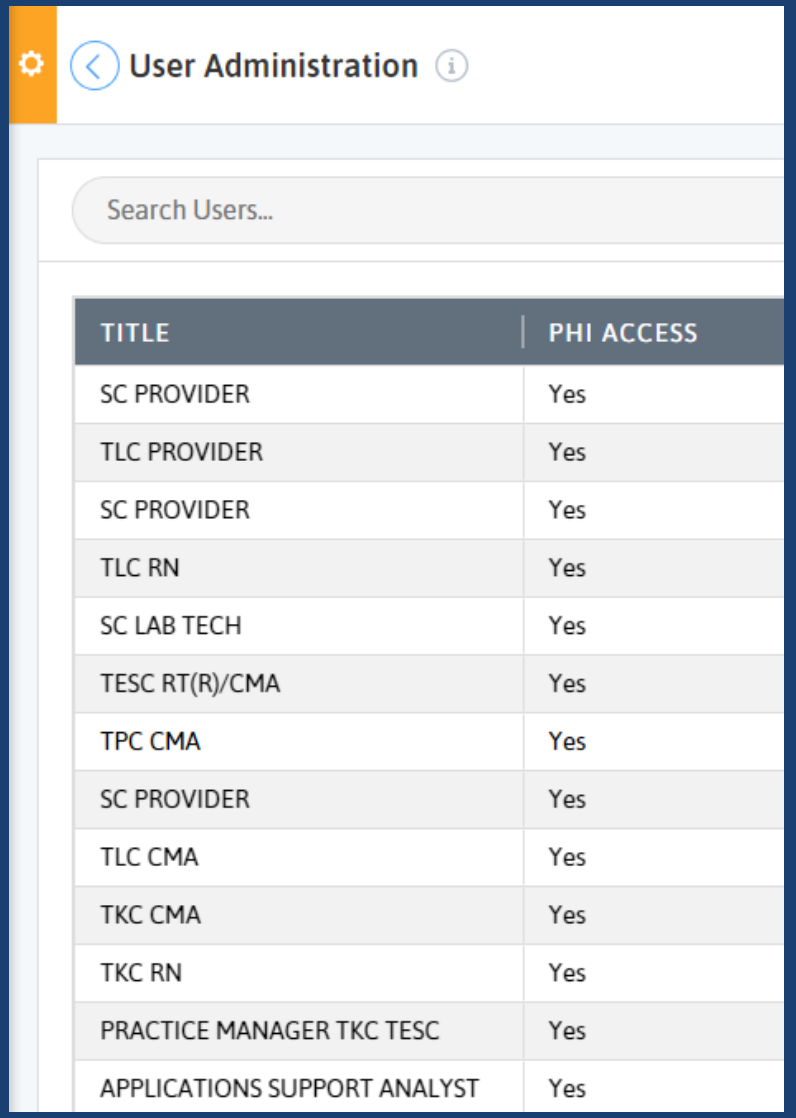


CENTER	NAME	PRIMARY TARGET	SECONDARY TARGET
Liberty Hospital	2023 Adolescent Immunizations	75%	50%
Liberty Hospital	2023 Breast Cancer Screening	83%	66%
Liberty Hospital	2023 Breast Cancer Screening	83%	66%
Liberty Hospital	2023 Breast Cancer Screening 40-74	83%	66%
Liberty Hospital	2023 Cervical Cancer Screening	75%	50%
Liberty Hospital	2023 Childhood Immunization Status	75%	50%
Liberty Hospital	2023 Childhood Immunization Status	75%	50%
Liberty Hospital	2023 Colorectal Cancer Screening	80%	60%
Liberty Hospital	2023 Colorectal Cancer Screening 45+	80%	60%
Liberty Hospital	2023 Diabetes A1c > 9 or Untested	10%	20%
Liberty Hospital	2023 Diabetes Eye Exam	80%	50%
Liberty Hospital	2023 Hypertension Controlling High Blood Pressure	86%	67%
Liberty Hospital	2023 Kidney Profile for Patients with Diabetes	61%	52%
Liberty Hospital	2023 Pneumococcal Vaccination Status - Modified	75%	50%
Liberty Hospital	2023 Statin Therapy for Patients with ASCVD	89%	81%
Liberty Hospital	2023 Statin Therapy: Prevention and Tx of ASCVD	85%	70%

Create targets that guide improvement, but are also achievable

Where do you want to go?

Build your DRVS crew



Wayfinding

Create your plan for success

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Training as Part of a System

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Structure: the *interrelationships* of a system's parts

System

- Goals
- Roadmap
- Why Are We Using DRVS?

Patterns

- Staff Meetings
- Individual Meetings
- Quality Initiatives

Events

- Specific Training Topics
- Data Hygiene + Ad-Hoc Issues
- Feedback + Other Communication

Peter Senge, *What is a System*

Adopting DRVS

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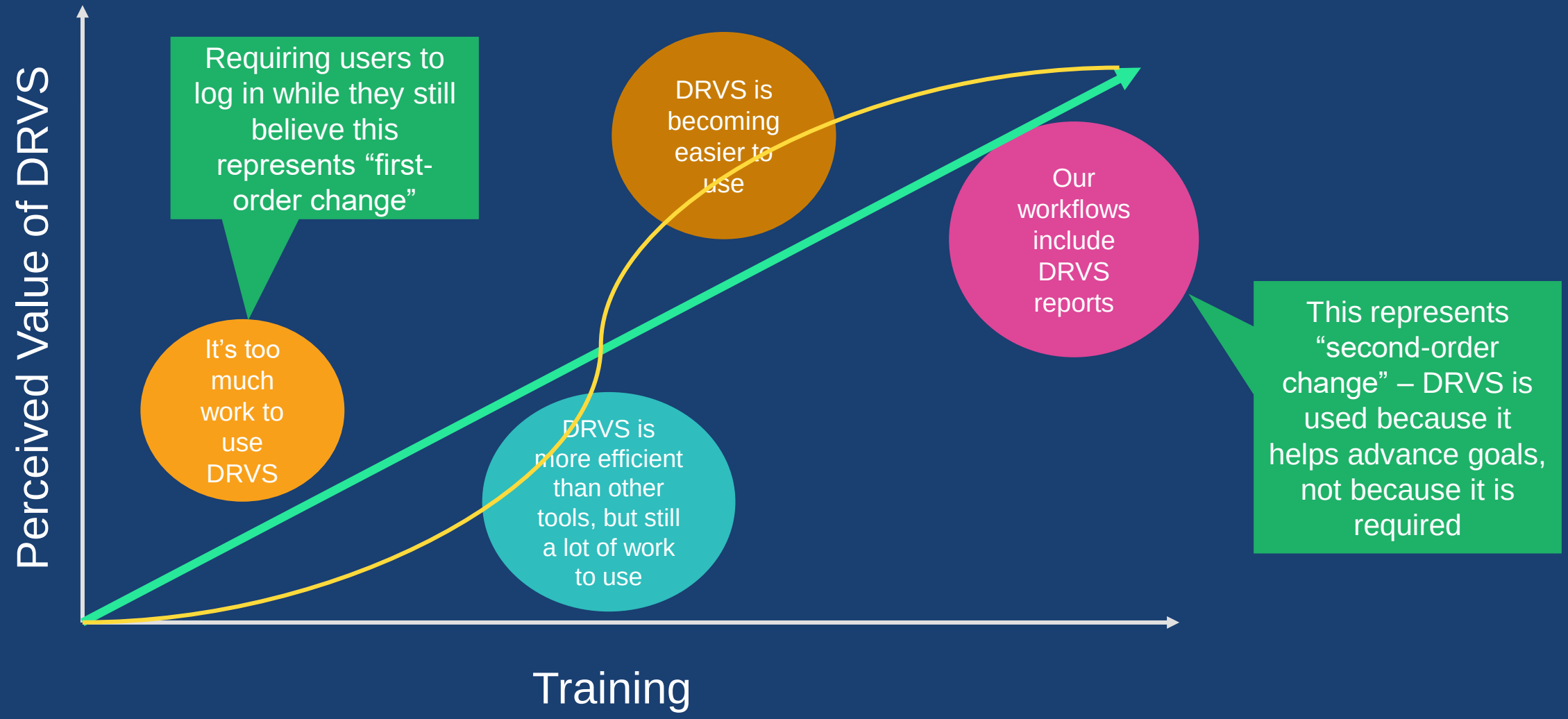

Roles and Responsibilities

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Role	Responsibilities	Accountable
Front Desk	❑ Generates the PVP for same-day appointments ❑ Reviews assigned alerts (FPL, SOGI, etc.)	Practice Manager
MA/LPN	❑ Runs the PVP each morning & prints for all members of the care team ❑ Marks the PVP with notes for the huddle ❑ Reviews and closes assigned alerts ❑ Disposes of PVP print outs in HIPPAA secure manner (keeping 1 copy to scan for PCMH evidence)	Clinical Support Staff Supervisor
Provider	❑ Participates in the huddle ❑ Reviews and closes assigned alerts ❑ Identifies RAF gaps and updates patients' chart appropriately ❑ Empowers support staff	Medical Director

If your practice has the DRVS EHR plug in, consider how care teams will into their workflows.

Create a Timeline

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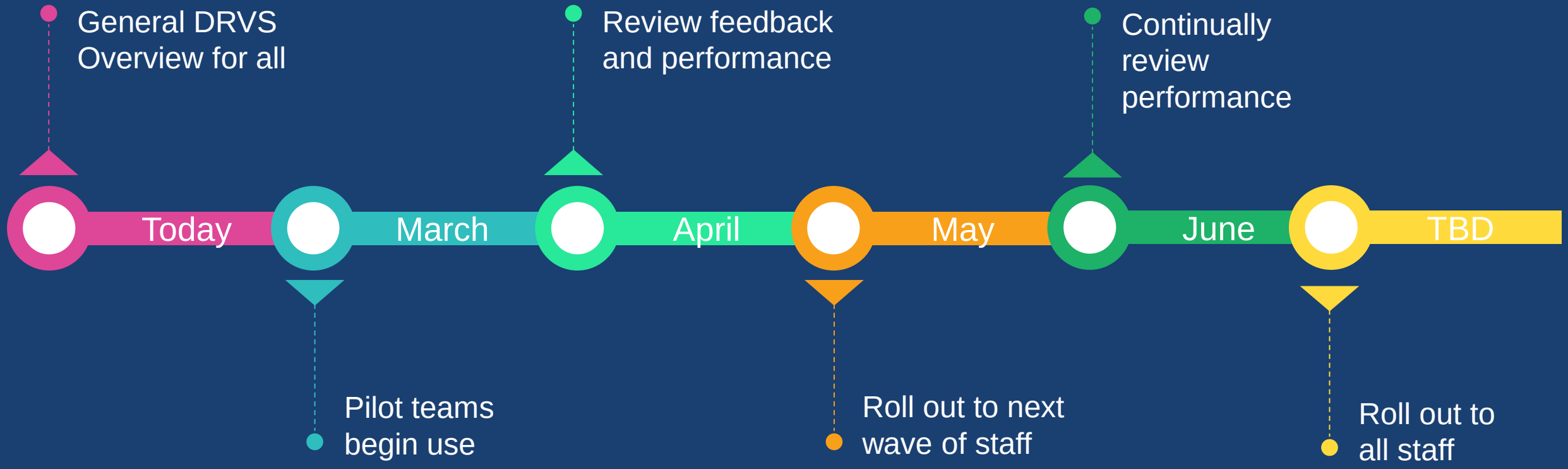
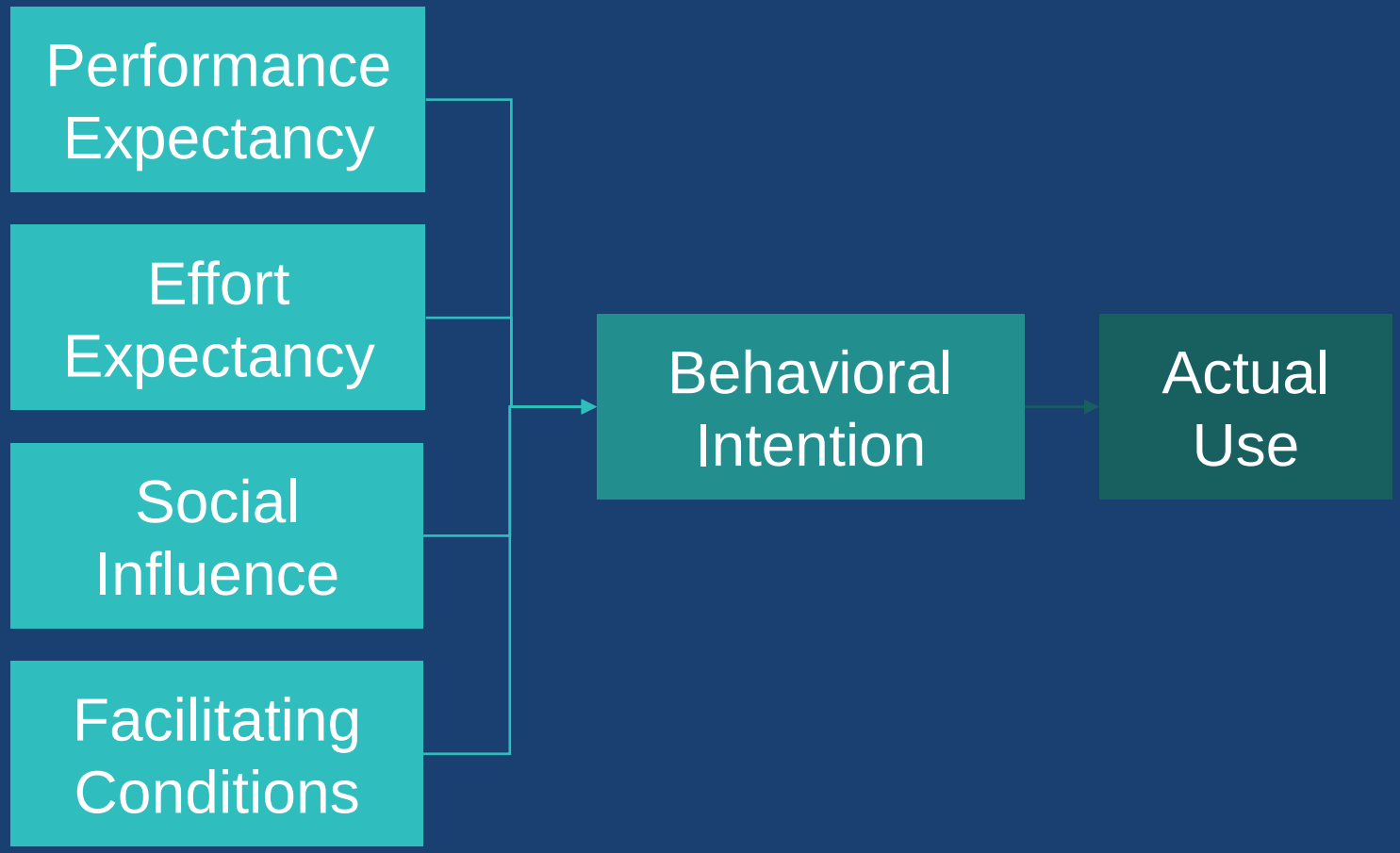


Anticipate Rough Waters



- Define how DRVS will help in their work
- Highlight the ease of using DRVS
- Get buy in from key staff
- Communicate data hygiene efforts

Getting On Board

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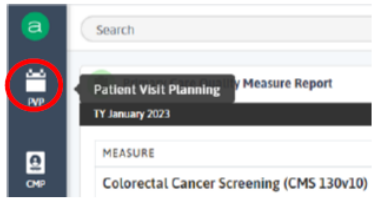
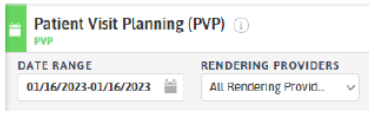
Accessing DRVS Pre-Visit Planning Reports

Website: drvs.azarahealthcare.com

Username: your Liberty Hospital email

Use the PVP icon in the top left to access Pre-Visit Planning Reports and Care Management Passports.





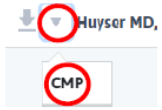
- To change the date, click in the "Date Range" box. If using the "Custom Range" option from the drop-down menu, you must select a start and stop date from the calendar. If you only want one day, click on that day twice.
- Select the Provider you are pre-visit planning for from the "Rendering Providers" drop-down menu.

After selecting the date(s) and Provider(s), hit Update towards the right side of the screen. A collapsed report will generate below.

To view the report, use the down arrow towards the right. To export the report to PDF, use the download arrow on the left. Once downloaded, the PVP report will appear at the top or bottom of your screen depending on your device.

The DRVS PVP can also be viewed within NextGen. A DRVS account is required for this link to work.

Another PVP format is the Care Management Passport (CMP). This format includes additional information and prints only one patient per page. To download CMPs, click the triangle located between the PVP download arrow and Provider's name and then on the CMP pop-up.



The CMP will load to the download queue (bell icon in top right). You will be alerted when the CMP download is complete. Click into the bell to access the report.

Individual CMPs can be obtained using the CMP icon located on the left side navigation menu.

PVP Name	Description
Colorectal Cancer Screening Results	Alert will trigger for patients aged 45-75 to report the status of routine colorectal cancer screening activities. Includes the most recent result(s), if no screening is on record, or if screening is not indicated.
Cervical Cancer Screening Results	Alert will fire for female patients aged 21-64 to report the status of routine cervical cancer screening activities. Includes the most recent result(s), if no screening is on record, or if screening is not indicated.
Mammo	Alert will trigger if Mammogram has not occurred in the last 2 years, or is due in the next 2 years. Alert only applies to female patients >= 40 yrs old and <= 85 yrs old. Patient must not have Palliative Care Services or Mastectomy or Mammogram Alert Addendum or Hospice Care.
Bone Density - Female	Alert will trigger if DEXA Bone Density Scan has not occurred in the last 2 years, or is due in the next 2 years. Alert only applies to female patients >= 65 yrs old.
A1c	Alert will trigger if A1c has not occurred in the last 1 years, or if the A1c value is >= 7. Alert only applies to patients <= 85 yrs old. Patient must have Diabetes.
CKD Screening - DM	Alert will trigger if Kidney Profile has not occurred in the last 1 years. Alert only applies to patients >= 18 yrs old and <= 85 yrs old. Patient must have Diabetes. Patient must not have Palliative Care or hospice care or Kidney Profile or Hospice Care or End Stage Renal Disease (ESRD) & CKD Stage 5 or Dialysis Services.
DM Eye Exam	Alert will trigger if DM Eye Exam has not occurred in the last 2 years. Alert only applies to patients >= 18 yrs old and <= 75 yrs old. Patient must have Diabetes. Patient must not have Hospice Care or Diabetic Retinopathy.
DM Eye Exam Retinopathy	Alert will trigger if DM Eye Exam has not occurred in the last 1 years. Alert only applies to patients >= 18 yrs old and <= 75 yrs old. Patient must have Diabetic Retinopathy and Diabetes. Patient must not have Hospice Care.
DM Foot Exam	Alert will trigger if Foot Exam has not occurred in the last 1 years. Alert only applies to patients <= 85 yrs old. Patient must have Diabetes. Patient must not have 2 Unilateral Amputation Above or Below Knee or Bilateral Amputation of Leg Below or Above Knee.
Diabetes Risk	Alert will trigger if patient had an A1c >= 5.7 OR a Glucose Tolerance Test >= 140 in the past year. Alert only applies to patients 18 - 75 years old. Excludes patients which have pregnancy, ESRD, diabetes , pre-diabetes, or gestational diabetes.

Getting On Board

- Consider goal and current workflow
- Compare pros & cons
- Create opportunity for conversation
- Create a plan for roll out & monitoring

Anticipate choppy waters

Advance Care Planning

Background: Advance Care Planning helps patients plan for their care if they become unable to make decisions or communicate their care preferences. Early conversations with patients about serious illness can help ensure care is consistent with patients' goals and reduce distress for families.

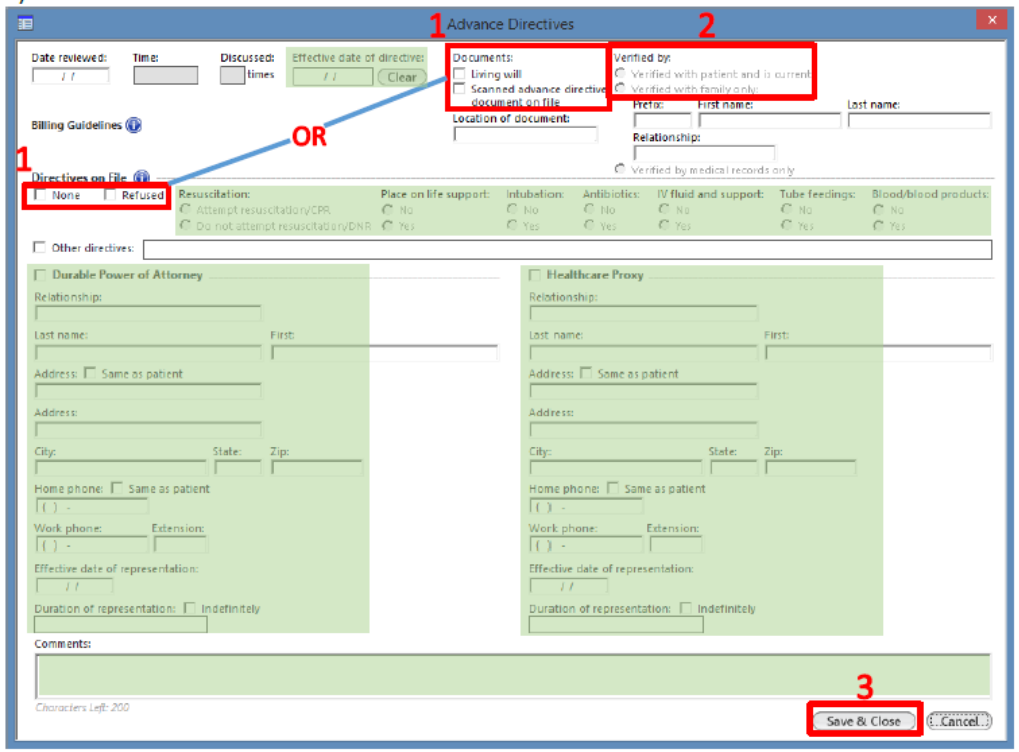
Who: Advance Care Planning can occur with any patient. Advance Care Planning is measured and reported for patients age 65 and older with Medicare.

When: Annually or more often as appropriate.

Intake Workflow:
Navigate to the template using the Advance Directives link on the Patient Information Bar.
1) If Advance Directives are on file or the patient has documentation with them, update the *Documents* section of the template and corresponding shaded fields shown below. Obtain a copy of records for our file.

- If the patient does not have Advance Directives in place or is not able to provide documentation, make a selection from the *None/Refused* section and use the *Comments* box at the bottom of the template to document relevant information (e.g. Liberty Hospital "Who Speaks for You" brochure provided, patient plans to bring Advance Directive documents to next visit)

2) Verify the status of what is on file is current (this selection will update the Date Reviewed field),
3) Save and Close.



Getting On Board

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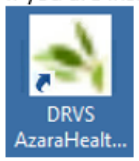
Website: drvs.azarahealthcare.com

If you are inside of Citrix, there is a shortcut on the desktop.

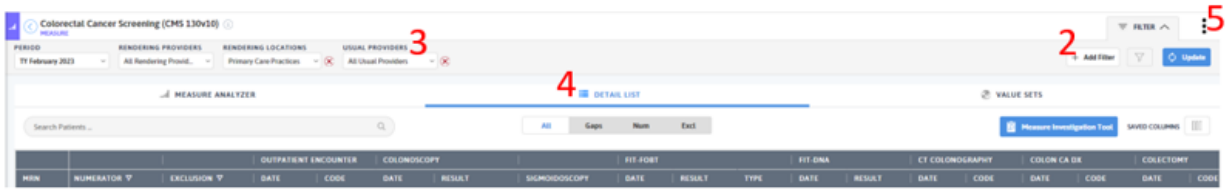


There are two ways to get your patient care gap lists.

Option One:

1) Click on the measure name from the home screen (1).

2) Add the "Usual Provider" Filter (2), then pick the Provider (3). Click over to the "Detail List" tab (4), then use the three dots on the right to access the "Export Excel" option (5). Once the report is exported, patients with an "N" in the Numerator Column and an "N" in the Exclusion Column are your care gaps, generally speaking. There is some variation to this rule due to individual measure specifications, like for the A1c measure where care gaps = Numerator "Yes," or the immunization measures where Exclusions are part of the Numerator.
    a. If you are using filters to narrow down your list, and choose to filter before exporting, you will want to verify selections held with the Export; otherwise, they'll need to be reapplied.



Setting Sail

DRVS Roll Out

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Building a Foundation for Data Trust

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How seaworthy is your data?

Prioritize Validation

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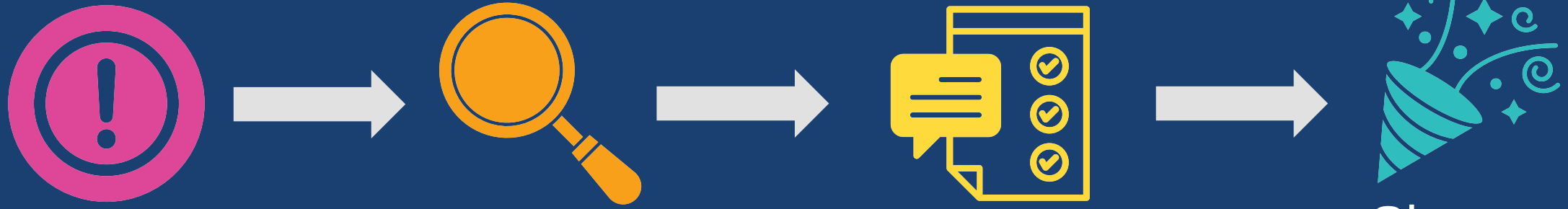

Identify the issue

Investigate Concerns

Provide Follow Up

Share Success

Resolve & Educate on Documentation

Review Updated Data

DRVS Validation Resources

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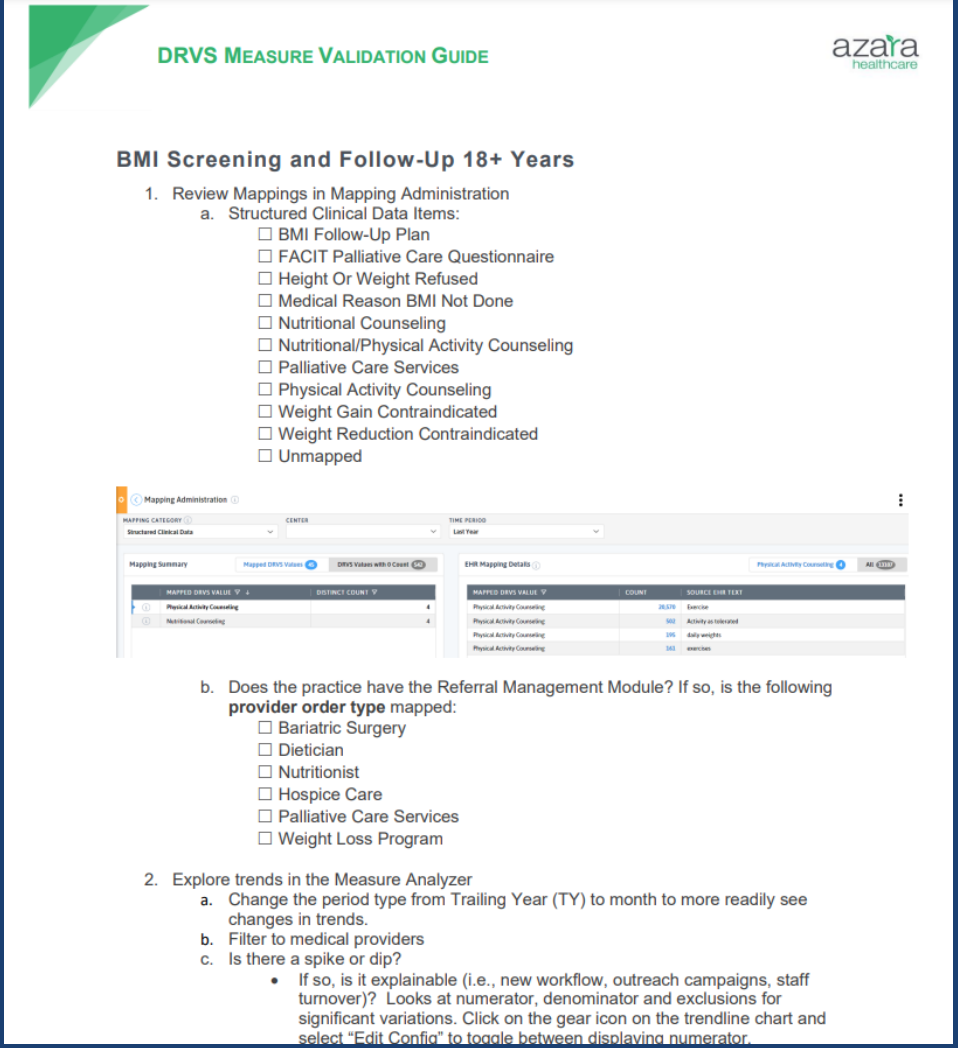
Measure Validation Guides



DRVS MEASURE VALIDATION GUIDE

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BMI Screening and Follow-Up 18+ Years

1. Review Mappings in Mapping Administration
   a. Structured Clinical Data Items:
      - ☐ BMI Follow-Up Plan
      - ☐ FACIT Palliative Care Questionnaire
      - ☐ Height Or Weight Refused
      - ☐ Medical Reason BMI Not Done
      - ☐ Nutritional Counseling
      - ☐ Nutritional/Physical Activity Counseling
      - ☐ Palliative Care Services
      - ☐ Physical Activity Counseling
      - ☐ Weight Gain Contraindicated
      - ☐ Weight Reduction Contraindicated
      - ☐ Unmapped

   b. Does the practice have the Referral Management Module? If so, is the following **provider order type** mapped:
      - ☐ Bariatric Surgery
      - ☐ Dietician
      - ☐ Nutritionist
      - ☐ Hospice Care
      - ☐ Palliative Care Services
      - ☐ Weight Loss Program

2. Explore trends in the Measure Analyzer
   a. Change the period type from Trailing Year (TY) to month to more readily see changes in trends.
   b. Filter to medical providers
   c. Is there a spike or dip?
      - If so, is it explainable (i.e., new workflow, outreach campaigns, staff turnover)? Looks at numerator, denominator and exclusions for significant variations. Click on the gear icon on the trendline chart and select "Edit Config" to toggle between displaying numerator,

Structured Mapping Guides

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How to Map Structured Clinical Data - Colon Related Mappings

By Lori Lynes, Director of Data Quality

DRVS has 7 Structured Clinical Data Items available in Mapping Admin that are used in the colorectal cancer screening measures and alert. They fall into 3 categories – surgical history, screenings and other colorectal mappings. They are:

Surgical History

- Colectomy

Screenings

- Colonoscopy
- CT Colonography
- Sigmoidoscopy

Other Colorectal Mappings

- Colorectal Cancer Screening Refusal Reason
- Colonoscopy Due Date
- Colonoscopy Referral

New!

The following section provides descriptions of each of the above items and example mappings from DRVS users.

Surgical History

- **Colectomy** is used as an exclusion for the colorectal cancer screening alert and measures. There are many types of colectomies. Only colectomies that remove the entire colon may be mapped. In the diagram below, the only two that would count as an exclusion are total proctocolectomy and total abdominal colectomy. All other types should be mapped to archive. Mappings typically come from surgical history. The problem list is the ideal place to record colectomies.

Strategies for Success
Use Multiple Measures

Select measures that can help depict an accurate picture of the effects on the systems of change you're making:

Outcome Measures: How is the system performing? What is the result?

Process Measures: Are the parts/steps in the system performing as planned?

Balancing Measures: Are changes designed to improve one part of the system causing new problems in other parts?

Measure Considerations

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Outcome

- UDS CQMs
- HEDIS
- Prevalence
- Operational
- A1c/BP/PHQ-9/GAD-7
- TOC - Readmissions

Process

- Lab volume
- Referral
- Usage
- Alert Closure
- Repeat BP
- A1c untested
- Care Plan
- TOC – follow-up calls and visits
- Annual Wellness Visit

Balancing

- UDS CQMs filtered by race, SDOH
- Open lab order
- Operational (interactions per patient)
- TOC - Readmissions

Balancing Measures

Mitigating the butterfly effect

The Butterfly Effect:

The phenomenon whereby **minute localized change** complex system can have **large effects elsewhere**

Anchor Your Activities

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Schedule Regular Meetings

- Quality
- Providers
- Nursing

Share Team Performance

- Top trends
- Opportunities
- Peer review

Have Open Conversations

- Discuss trends
- Listen & verify
- Follow up after

Identify Opportunities for Improvement

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Aggregate

Use of Appropriate Medications for Asthma

Numerator:
Patients who were ordered at least one prescription for a preferred therapy during the measurement period (last 12 months)

- Corticosteroids (QVAR, Pulmicort, Flovent)
- Long-acting bronchodilators (Serevent, Foradil)
- Leukotriene modifiers (Singulair)

Denominator:
Patients 5-64 years of age with Persistent Asthma and a visit during the measurement period.

Exclusions:

- Emphysema
- Chronic Obstructive Pulmonary Disease
- Obstructive Chronic Bronchitis
- Cystic Fibrosis
- Acute Respiratory Failure

Center Average: ___% (#/#)
Best Center: ___%
MO Health Center Average: ___%

ICD-10 Diagnoses	Number of times Dx used 6/1/18-5/31/19	Number of times Dx used 6/1/19-5/31/20
Cough variant asthma J45.991		#
Exercise induced bronchospasm J45.990	#	#
Mild intermittent asthma with (acute) exacerbation J45.21	#	#
Mild intermittent asthma, uncomplicated J45.20	#	#
Mild persistent asthma with (acute) exacerbation J45.31	#	#
Mild persistent asthma, uncomplicated J45.30	#	#
Moderate persistent asthma with (acute) exacerbation J45.41	#	#
Moderate persistent asthma, uncomplicated J45.40	#	#
Other asthma J45.998	#	
Severe persistent asthma with (acute) exacerbation J45.51		
Severe persistent asthma, uncomplicated J45.50	#	
Unspecified asthma with (acute) exacerbation J45.901	#	#
Unspecified asthma, uncomplicated J45.909	#	#

*Highlighted diagnoses are included in the quality measure

Timeframe	Asthma Action Plan Updated within the Last Year for patients in the Measure Denominator	Selection of Unspecified Diagnosis
June 2018-May 2019:	#/#= ___%	#/#= ___%
June 2019-May 2020:	#/#= ___%	#/#= ___%

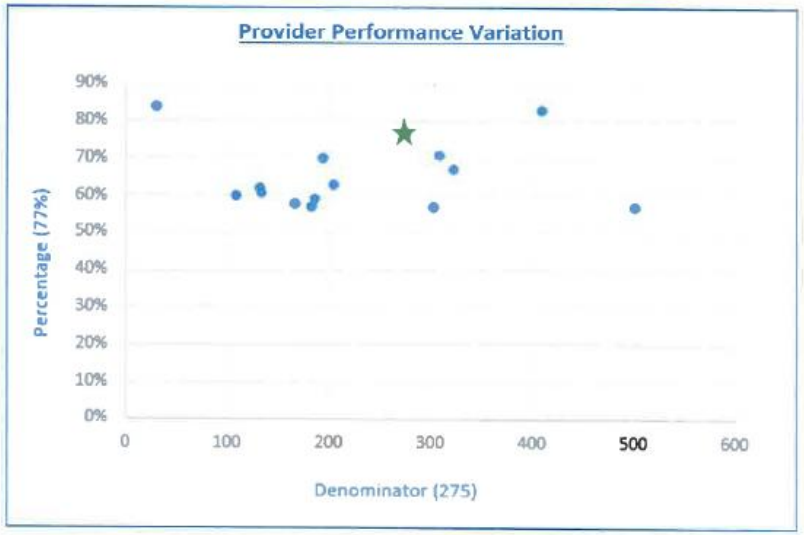
Hypertension Controlling High Blood Pressure (CMS165v8)

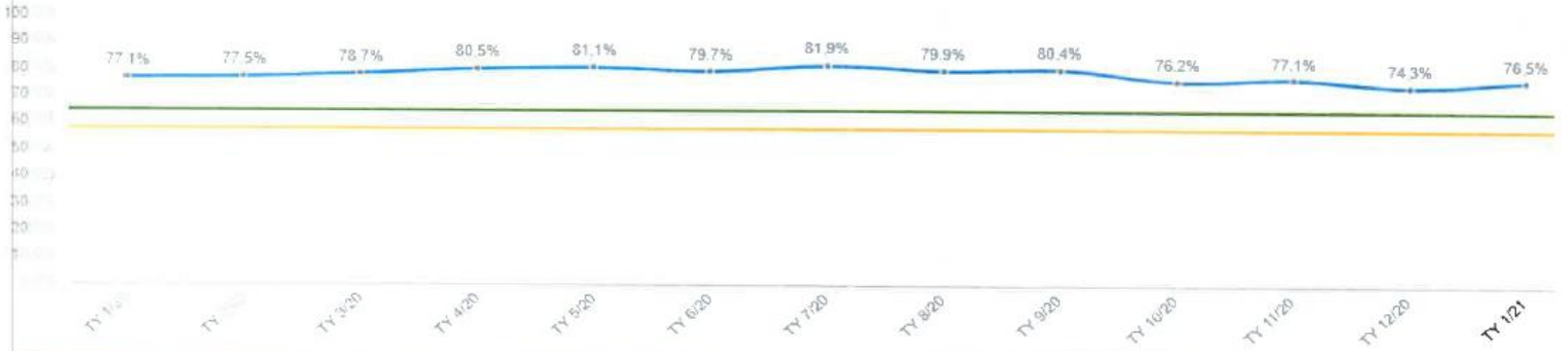
Center Average: __% MO Health Center Average: __% Best Center:

Numerator:
Patients whose blood pressure at the most recent visit is adequately controlled (Blood pressure < 140/90 mmHg) during the measurement period.

Denominator:
Patients 18-85 years of age who had a diagnosis of essential hypertension during the measurement period.

Exclusions:
- Active Pregnancy
- End Stage Renal Disease
- Stage 5 Chronic Kidney Disease
- Dialysis, Kidney Transplant recipient
- Hospice Care





MRN	Provider	Date of Service	1st BP Reading	Was a 2nd BP Reading Taken?	2nd BP Reading	Was a f/u Appt Scheduled?
		##/##/##	##/###	Y/N	###/###	Y/N
		##/##/##	###/###	Y/N	###/###	Y/N
		##/##/##	###/##	Y/N	###/##	Y/N

Sharing Successes

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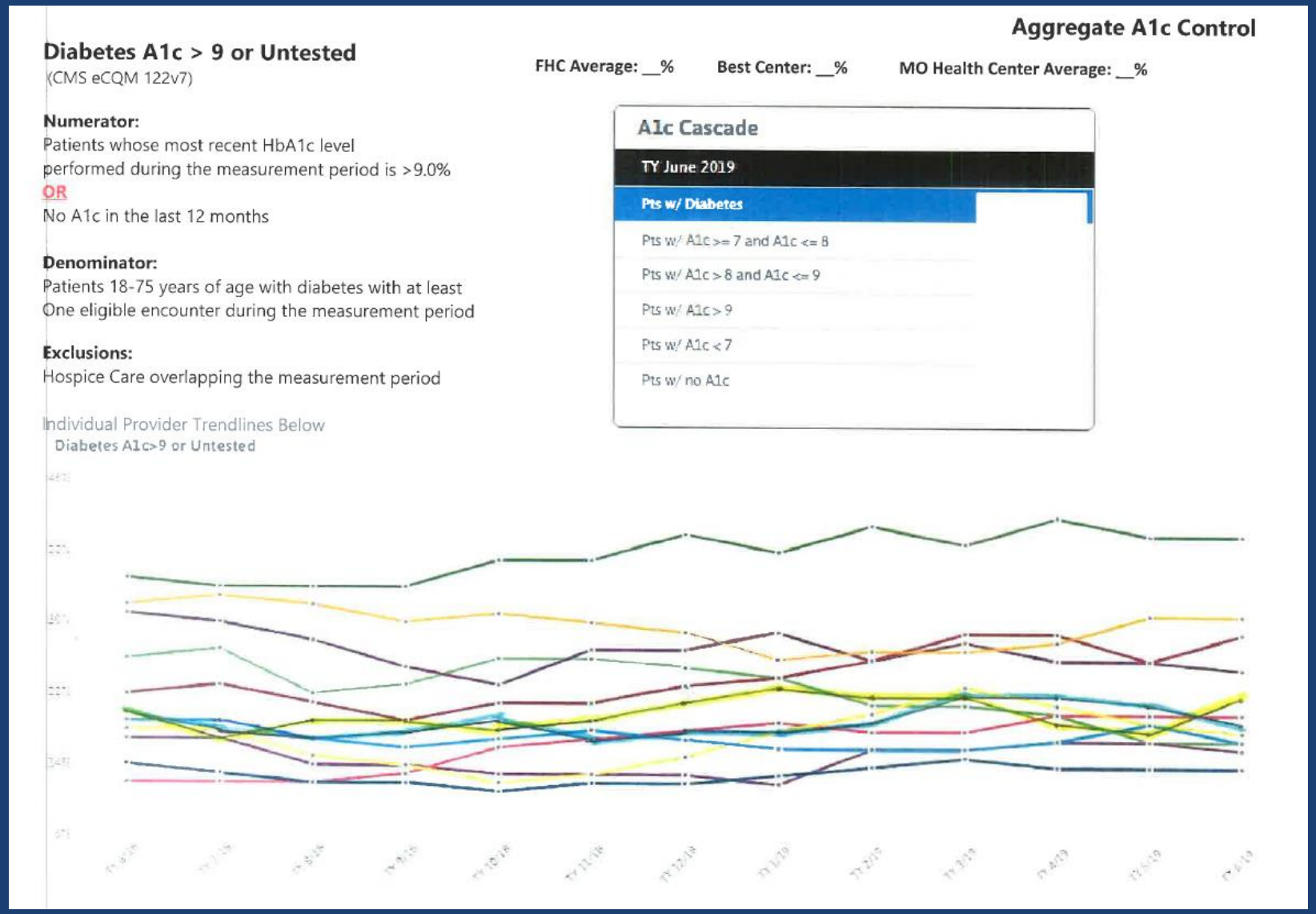


Finding Your Treasure

Success with DRVS

azara 2024

Uncovering Your Treasure

azara 2024

Celebrate Improvement

Share Your Successes

Eyes on the Prize

Center Usage

DASHBOARD

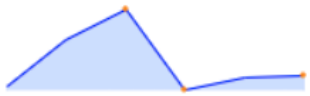
FILTER 0

FILTERS:

of Active Users

43

Count of Users



+7 ▲

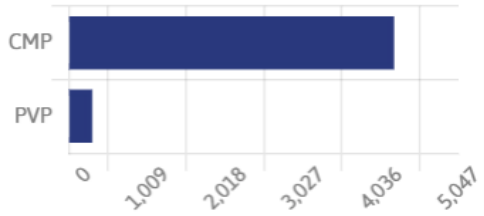
Nov 23

PVP, CMP & PNP Users

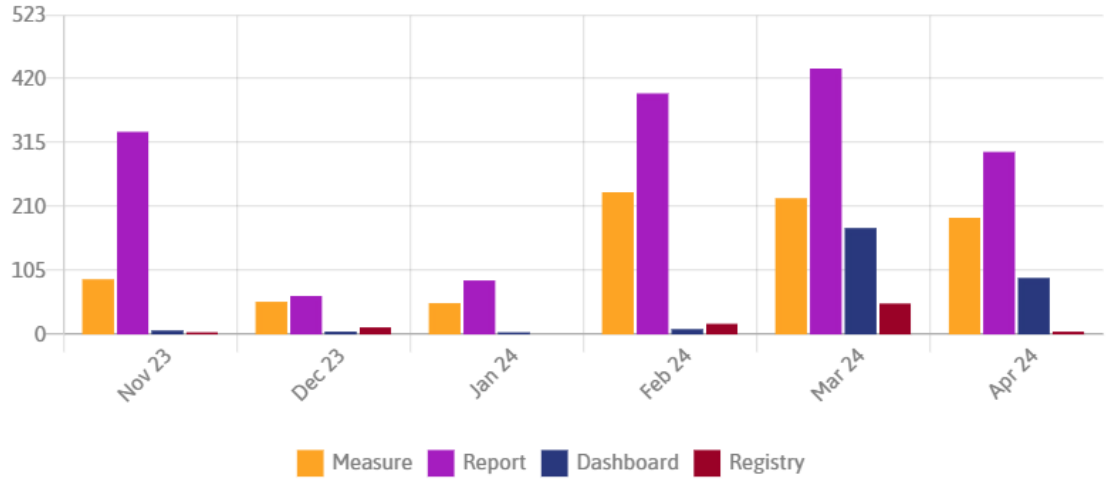
39

Count of Users

PVP, CMP & PNP Runs



Monthly Usage Trends



Top Dashboards

REPORT NAME	REPORTS
Clinical Quality Measure Trends By Location	22
TLC Clinical Quality Measure Trends_ Internal Medicine	21
TLC Clinical Quality Measure Trends_ Family Medicine	13
TESC Clinical Quality Measure Trends	12
TKC Clinical Quality Measure Trends	8

Top Reports

REPORT NAME	REPORTS
Primary Care Quality Measure Report	266
General Practice CQMs	16
Core CQMs	6
Monthly Provider Quality Measure Report	3
Care Management Measures	2
Immunization Management	2

Top Measures

Statin Therapy ASCVD (CMS 347v6 Breakout)	25
Colorectal Cancer Screening (CMS 130v11)	24
Childhood Immunization Status - DTP, IPV, MMR, HIB, HEPB, VZV, PCV (CMS 117v11 Breakout)(CMS 117v10 Breakout)	23
Diabetes A1c > 9 or Untested (CMS 122v11)	12
Statin Therapy for the Prevention and	

Top Registries

REPORT NAME	REPORTS
Immunizations	3
ASCVD Ten Year Risk	1

Celebrate Improvements

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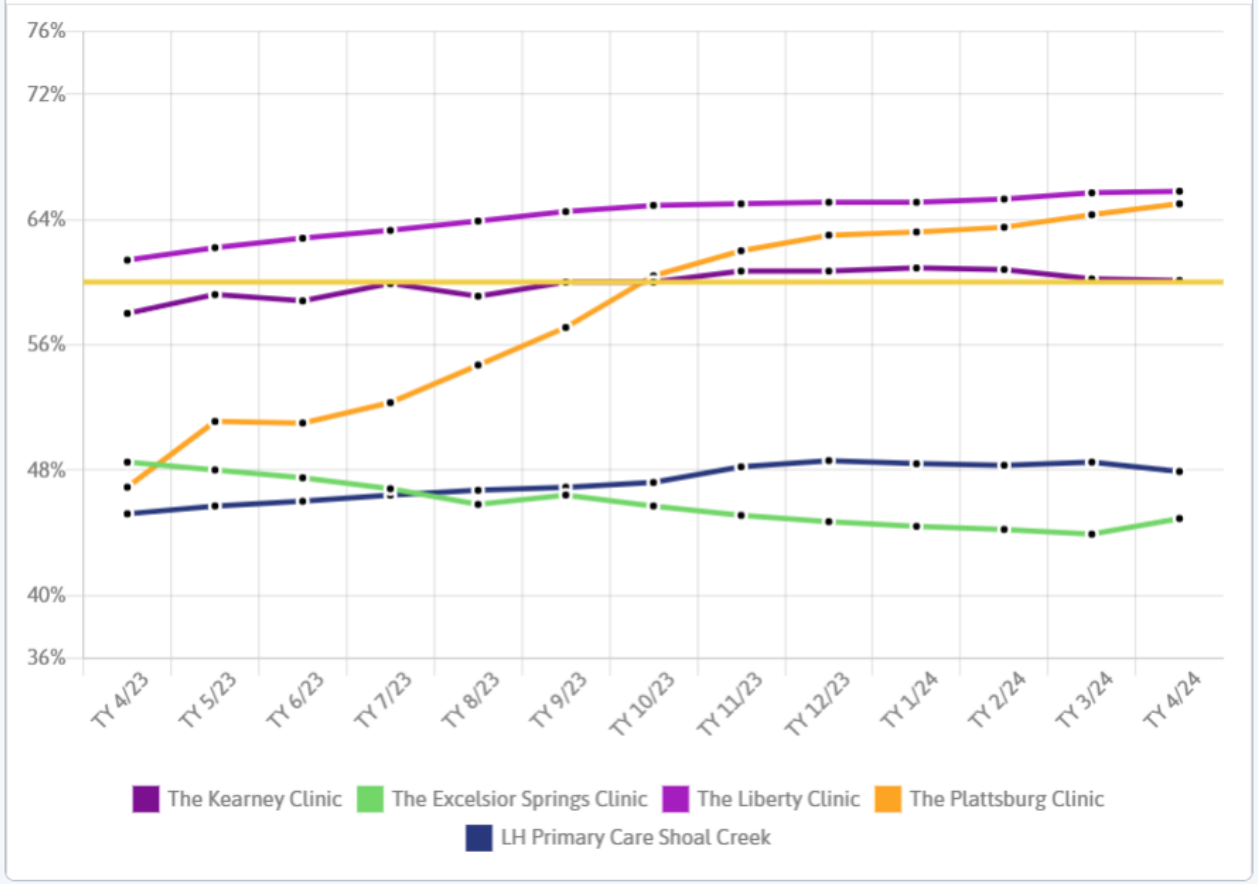
Clinical Quality Measure Trends By Location
DASHBOARD

FILTER

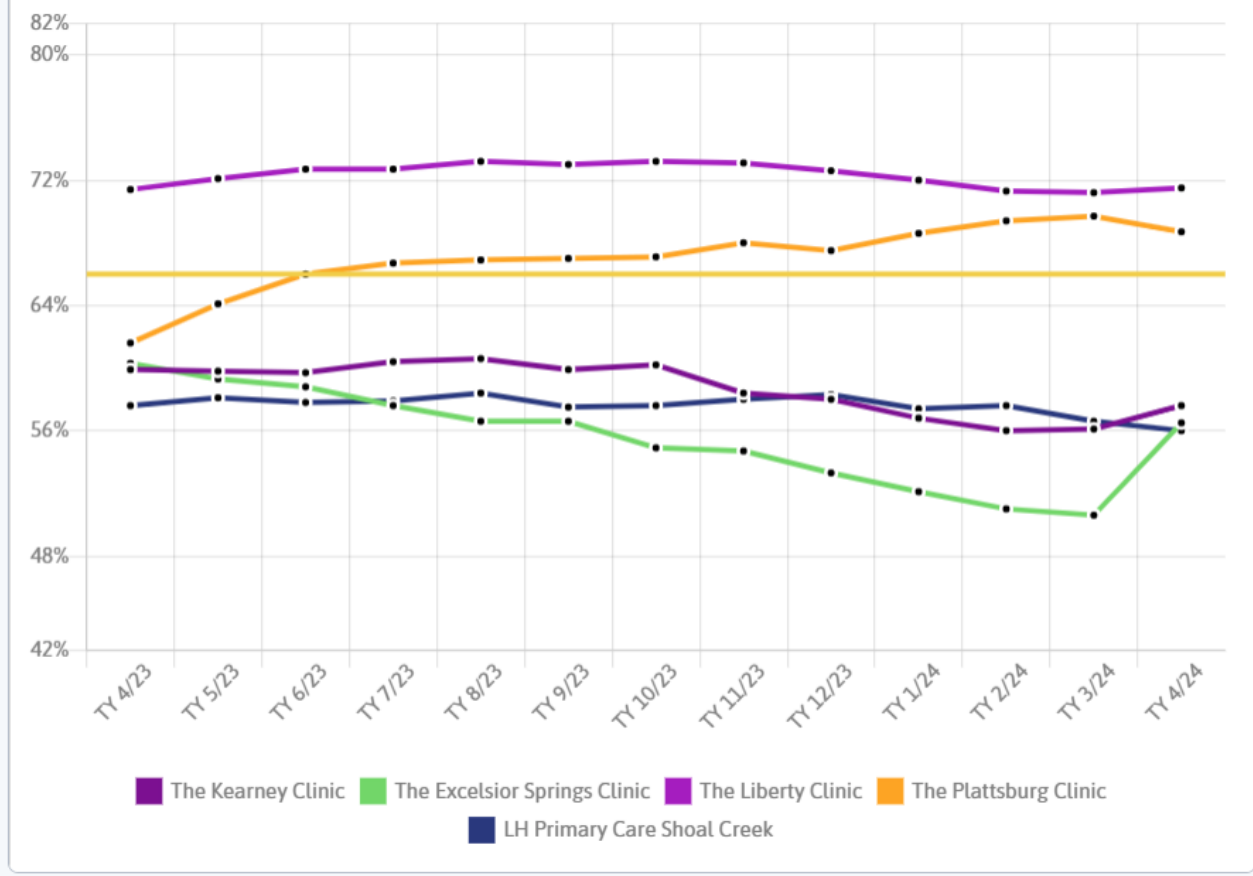
PERIOD: TY April 2024
RENDERING PROVIDERS: All Rendering Provid...
RENDERING LOCATIONS: Primary Care Practices
SERVICE LINES: Primary Care

Add Filter | Update

Colorectal Cancer Screening Ages 45-75 Trend



Breast Cancer Screening Ages 40-74 Trend



Point of Care Tools & Quality Success

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PVP/CMP-using care teams:

21%

Higher point of care alert closure rate

71% more likely to be complete Depression Screenings

64% more likely to have the recommended Advanced Care Discussions

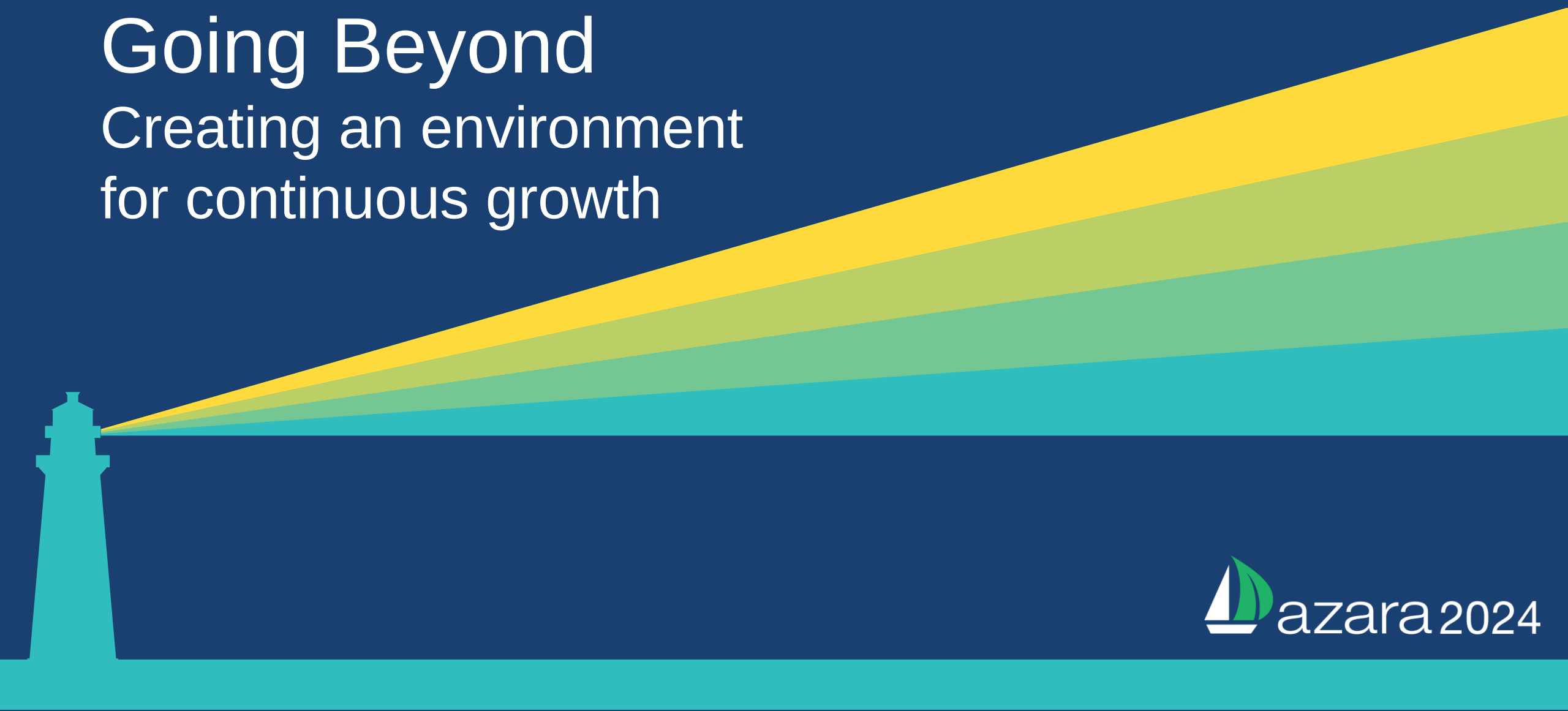
62% more like to complete a Fall Risk Screening

62% more likely to close Diabetic Foot Exam care gaps

37% more likely to complete a comprehensive SDOH Screenings

Going Beyond

Creating an environment for continuous growth



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Staying up-to-date with changing requirements

Always at the drawing board

Go fish!

Stay Up To Date!

Questions?

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Azara healthcare

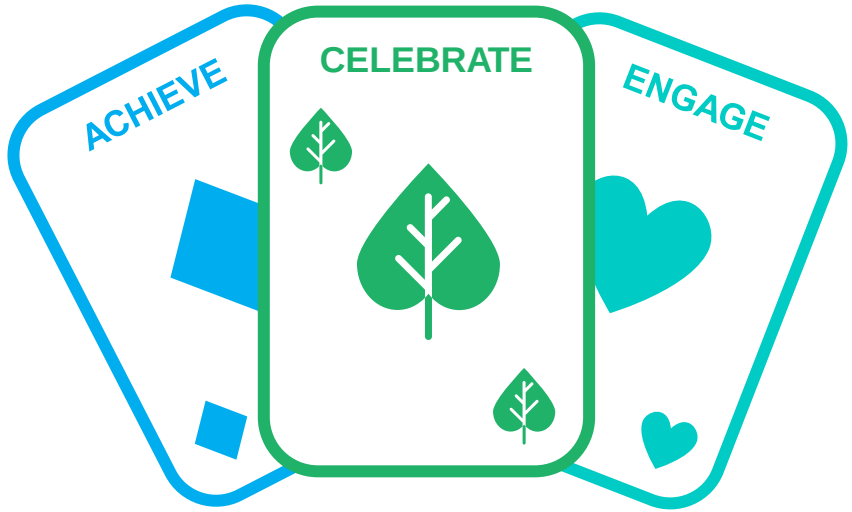
@AzaraDRVS

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

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.

azara
ACE Program



Benefits:

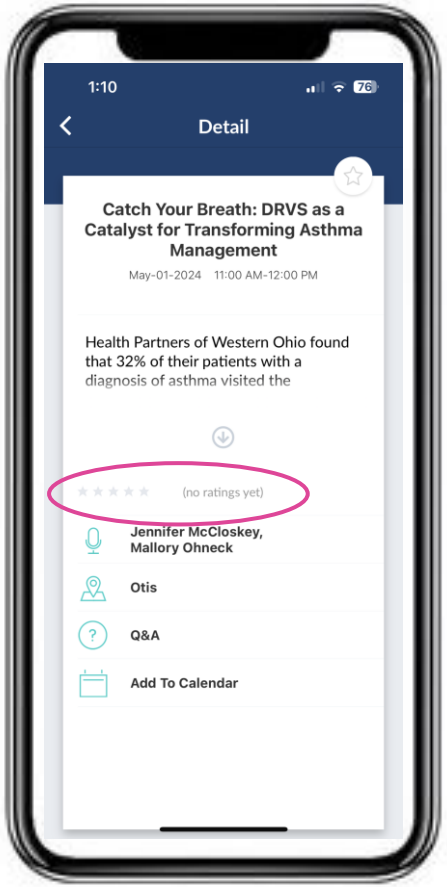
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link or scan our QR code:

See this year's ACE posters in the Ballroom Foyer!

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
USER CONFERENCE
2024

Thanks for attending!