Making Headway

Population Health Improvement with DRVS

PRESENTED BY:

Dr. Annemarie Witmer
Chief Health Services Officer
Central North Alabama Health Services

Jaime DiFalco
Quality Improvement Coordinator
Pendleton Community Care

Jessica Daily Haas
Director of Clinical Transformation
West Virginia Primary Care Association

azara 2024
USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

Today’s Presenters

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Dr. Annemarie Witmer

Central North Alabama Health Services

Jessica Daily Haas

West Virginia Primary Care Association (WVPCA)

Jamie DiFalco

Pendleton Community Care

Agenda

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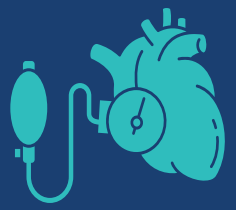


HYPERTENSION AND QUALITY INITIATIVES

Dr. Annmarie Witmer | Central North Alabama Health Services, Inc.

GOING FOR THE CUP! USING DRVS FOR IMPROVEMENT IN DIABETIC OUTCOMES

Jessica Daily Haas | WVPCA

Jamie DiFalco | Pendleton Community Care

QUESTIONS

Hypertension and Quality Initiatives

Dr. Annmarie Witmer, MSN, MSHA, DNP, CRNP
Clinical Services Officer
Central North Alabama Health Services, Inc.

Central North Alabama Health Services, Inc.

Your Health, Our Mission

1982
Incorporated as a 2-physician family practice in North Alabama.

16,000
Patients served in 2022

98%
Patients at or below 200% of the FPL

50%
Patients uninsured

27%
Patients with a diagnosis of hypertension

1st & 2nd
Quartile performance for more than half of CQMs

Patients with Low Income and Poverty Levels in our Clinics

Clinics	% Poverty	% Low income
Huntsville	27%	51%
Athens	23%	41%
New Market	9%	30%
Toney	9%	30%

Population served by Health Centers

82%

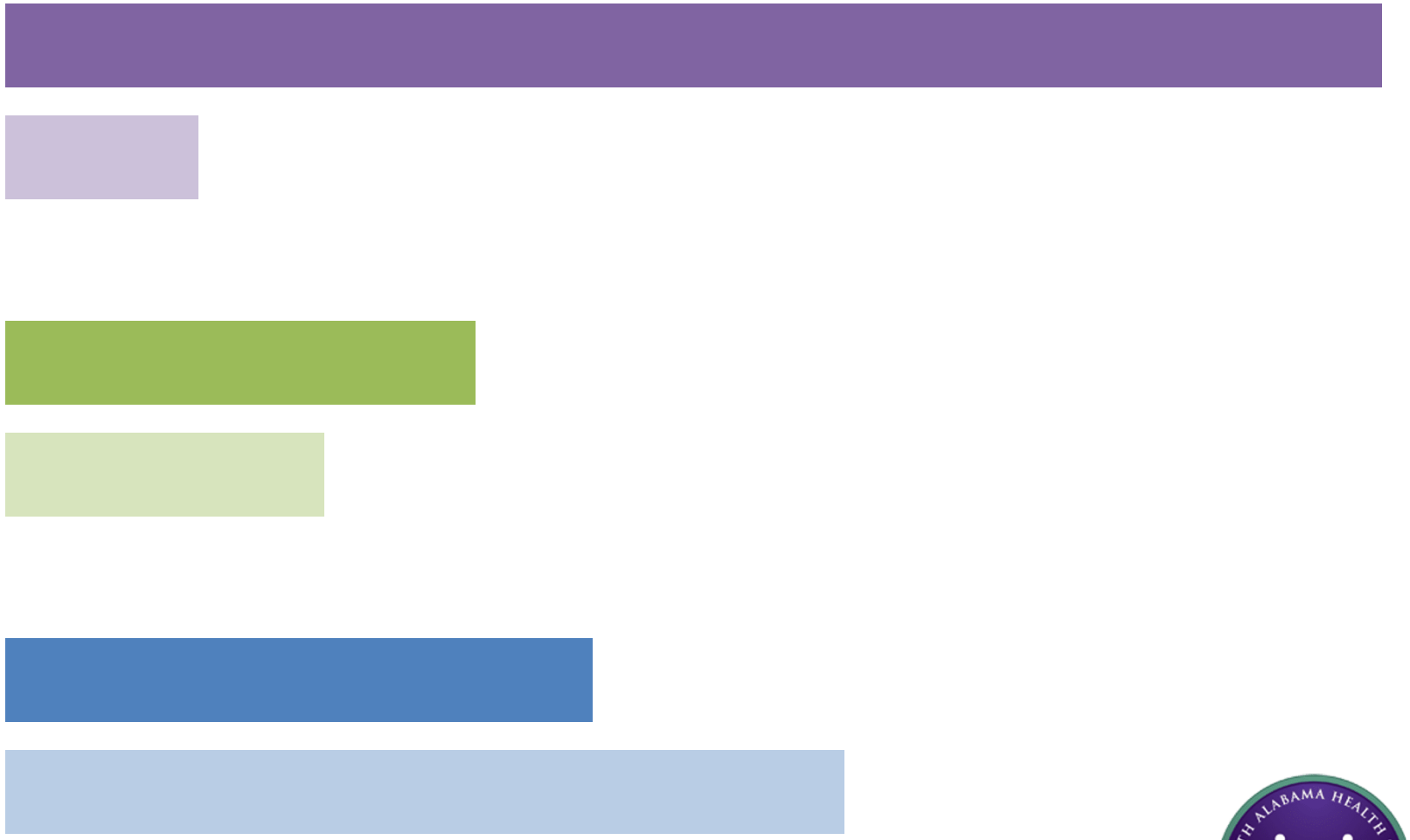
Live at or people FPL, compared to 11.5% nationally

28%

Are without health insurance, compared to 19% nationally

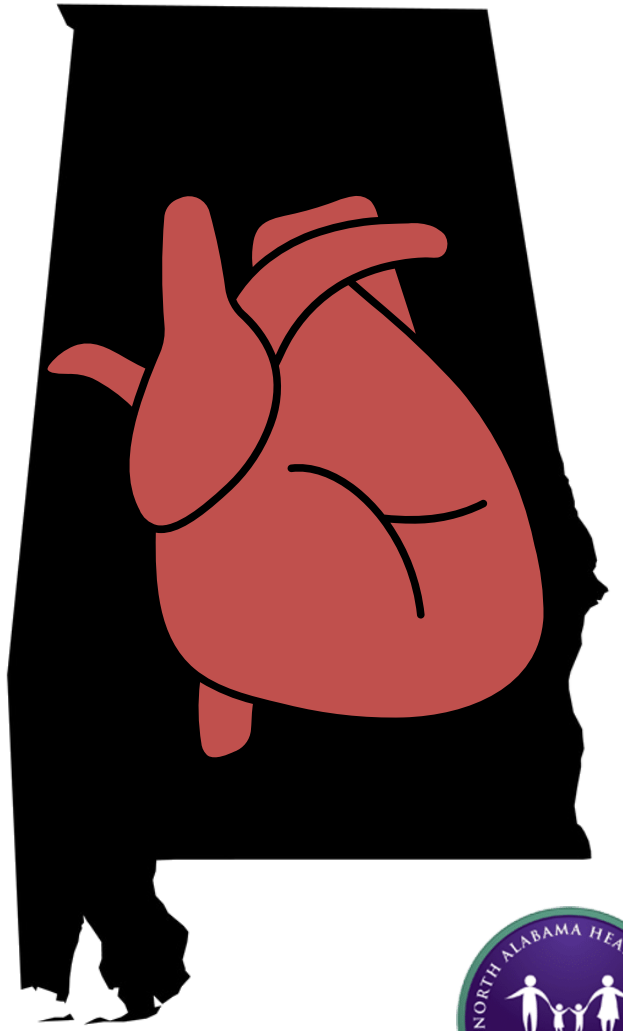
35%

Have Medicaid coverage, compared to 50% nationally



Alabama

- 7th poorest state
- 3rd poorest health outcomes
- 2nd lowest life expectancy
- 1st highest level of mortality related to CVD and stroke
- 1st highest level of mortality for heart disease



Hypertension in Alabama

Heart disease **is the leading cause of death in Alabama.**

15,173 deaths from heart disease in 2022

Hypertension in CNAHSI

Hypertension is the leading monthly diagnosis across CNAHSI from 2019 to date

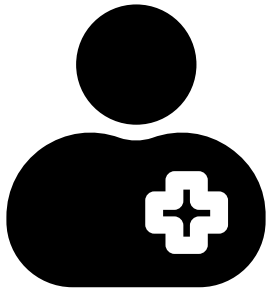
3,423 patients 18-45 with HTN in 2019

53.19% BP Control rate in 2019

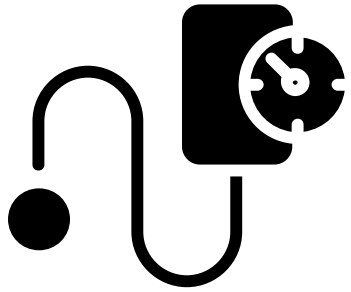
- Patients routinely ran out of meds
- Had no way to check blood pressure, so if they had no symptoms, they did not consider it a priority

Hypertension in CNAHSI

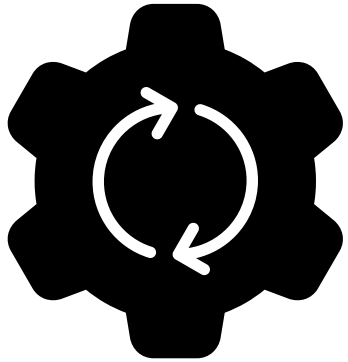
In 2021 received HRSA HTN Grant to:



- Conduct outreach and engage patients with HTN
- Provide patient education



- Purchase Bluetooth and wireless-enabled SMBP devices
- Implement clinical processes that support use of SMBP devices
- Develop case management to support engagement and use of SMBP device

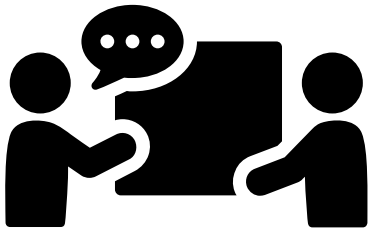


- Train for staff on new workflows
- Contract with Chronic Care IQ Care Management Platform for Remote Patient Monitoring in Q4 2021

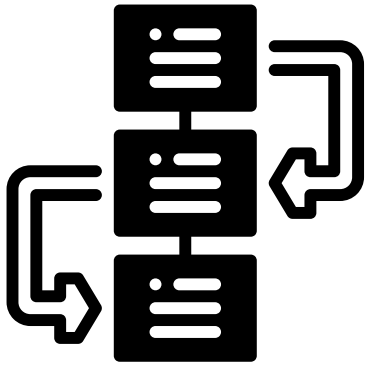
HRSA
Health Resources & Services Administration

CENTRAL NORTH ALABAMA HEALTH SERVICES, INC.
Caring About People
1982

Hypertension Grant Work



Enabling Services Case Managers did **education for staff** on the importance of proper **blood pressure technique**

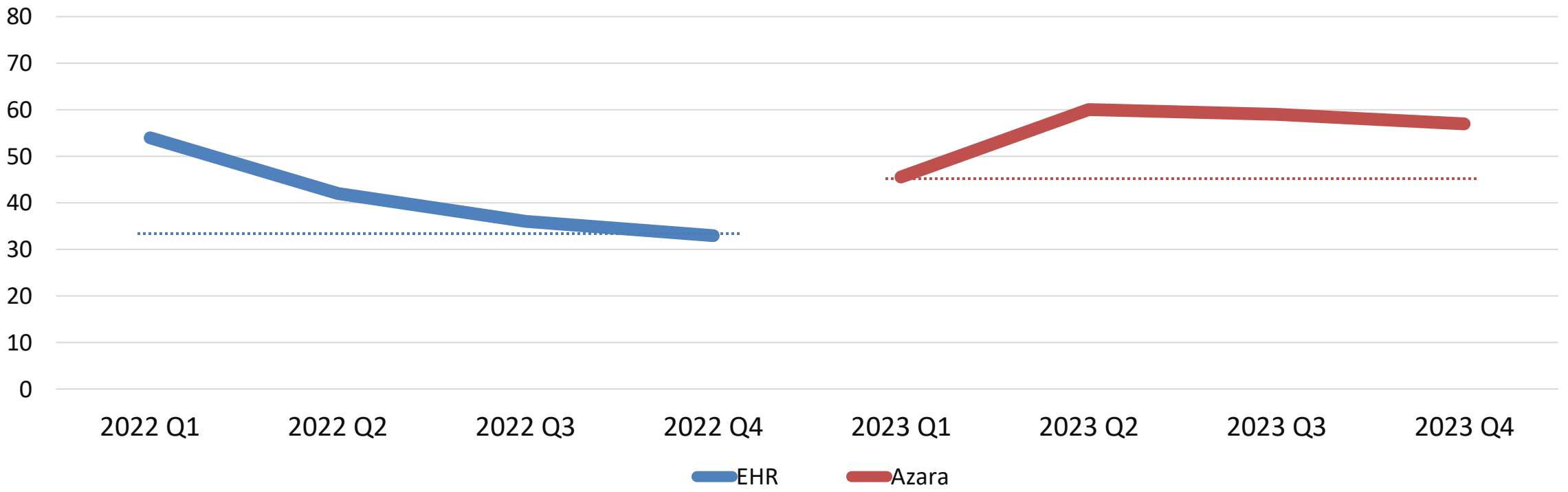


Developed hypertension protocols to assist in case management

Developed patient education booklet with tips on properly taking blood pressure, diet, exercise, and logs for patient to complete and bring to health visits

Case managers **prioritized the stage 2 uncontrolled patients** placed on Remote Patient Monitoring (RPM) at the beginning

UDS HTN Performance



Numbers in the EMR were anywhere from 6% to 40% different from the Azara numbers.

Mapping was the key to the difference - Azara pulled from the entire patient record, not just one specific area.

Creating Data Driven Change

DRVS implemented in 2022

PVP

Leveraged the Patient Visit Planning report to support pre-visit planning

Visit Reason: **Hypertension 3m f/u**

Phone:
Lang: English
Risk: Low (8)

Portal Access: N
Cohorts: Dyn - Uncontrolled HTN, Hypertension

PCP:
Payer: SLIDING FEE SCHEDULE - DISCOUNT
CM: Unassigned

ALERT	MESSAGE	DATE	RESULT
Mammo	Missing		
Pap HPV	Missing		
LDL	Overdue	12/16/2022	74
BP	Out of Range	1/22/2024	140/94
Hypertension Medication Intensification	Missing		

AMA MAP™ measures, reports, and dashboards, used to track process and outcome improvements

AMA MAP™ Hypertension

AMA MAP BP™ Metric Measures
REPORT

MEASURE	RESULT	TARGET
AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement	27.7%	50.0%
AMA MAP BP™ - HTN-Follow-Up After Visit with Uncontrolled HTN	13.1%	50.0%
AMA MAP BP™ - HTN-Medication Intensification	20.8%	30.0%
Hypertension Controlling High Blood Pressure (CMS 165v10)	53.7%	70.0%
HTN-Improvement in Blood Pressure (CMS 65v8)	12.6%	*Not Set*

Continued Hypertension Initiatives

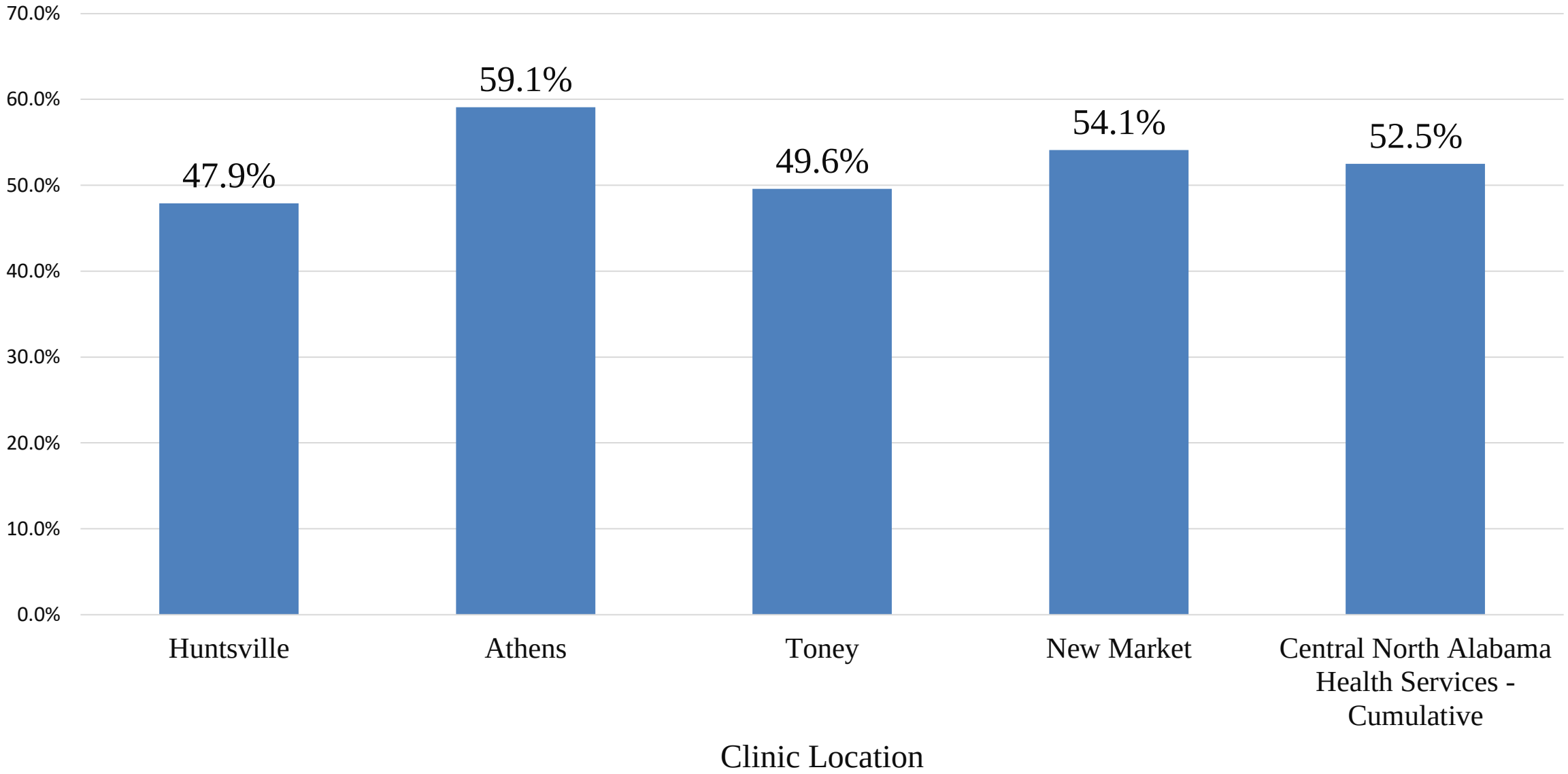
Alabama Cardiovascular Cooperative
Heart Health Improvement Project

The project concentrated on:

- Patients who were not enrolled in the RPM program
- Staff understanding and engagement

Focus on patient education, lifestyle changes, medication adherence, medication intensification, self-management goals, and patient follow up

Baseline Data (08/01/21 – 07/31/22) Controlled HTN (CMS 165)



Alabama Cardiovascular Cooperative (ALCC)

Heart Health Improvement Project (HHIP)

Funded by Agency for Healthcare Research and Quality (AHRQ)

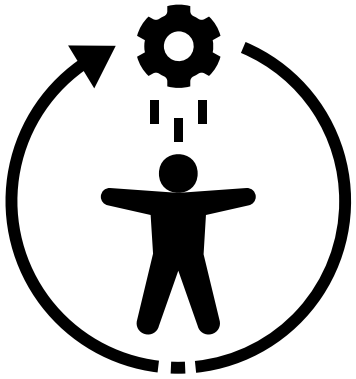
Tools for Success:

- Practice Facilitation & Technical Assistance
- Data Transparency
- Onsite & e-Learning

Commitments:

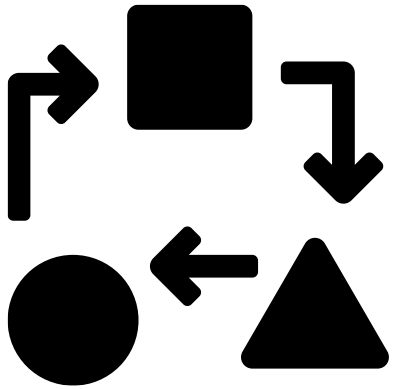
- Assign Practice Champion for each clinic location
- Monthly in-person and/or virtual meetings over the course of one year
- Complete one PDSA per quarter

Four Domains



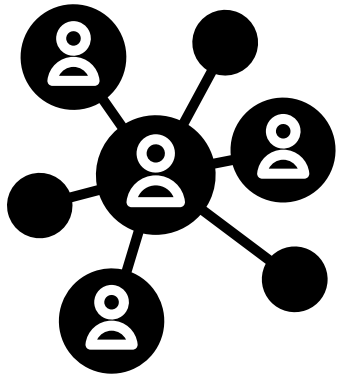
Self-Management Support

Implementation of self-management goals for all qualifying HTN patients (18 – 85 with pre-HTN or HTN) that were not enrolled in the Remote Patient Monitoring (RPM) program



Standardized Care Processes

Implementation of the Hill-Bone BP Compliance Scale for all patients presenting for an appointment with a know diagnosis of HTN



Team Engagement, Optimized Care, & Outreach

Standardization (and implementation where necessary) of daily patient-centered huddles to include all members of the care team

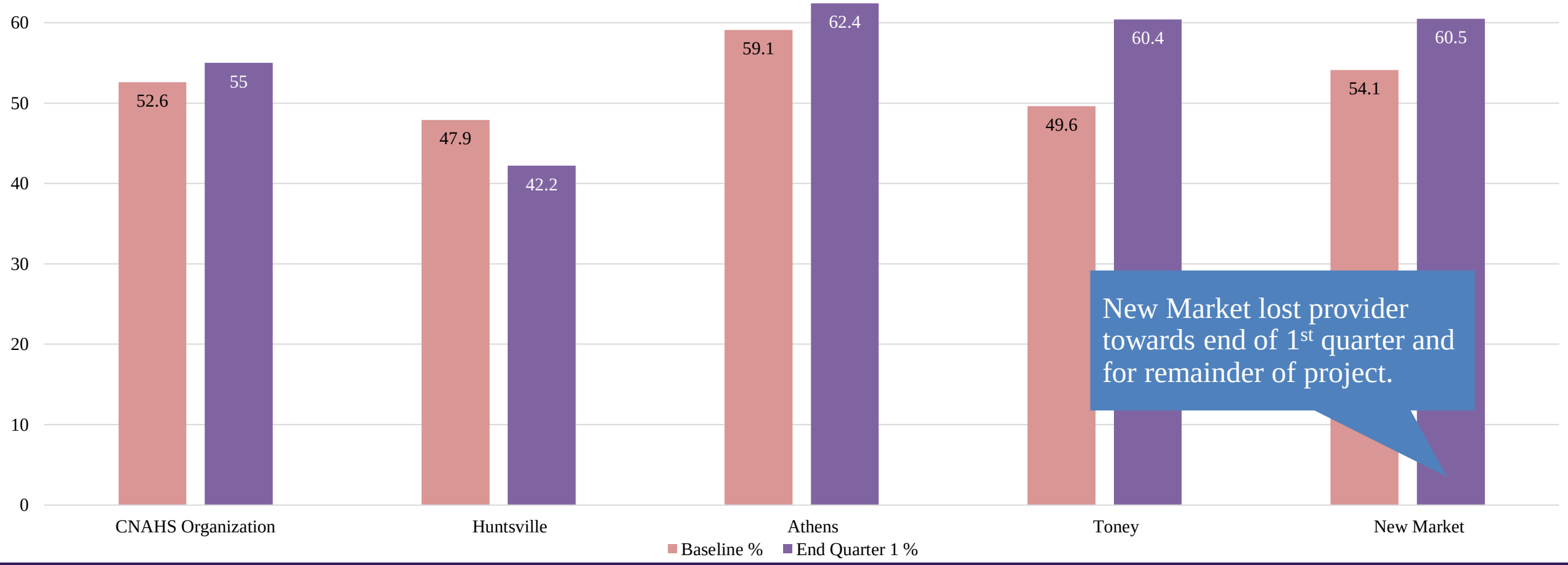
Clinical Information Systems

Use of AMA MAP™ resources in DRVS to target repeat blood pressure measurement and medication intensification

Self Management Support

Change from Baseline

↑ 2.4 | ↓ 5.7 | ↑ 3.3 | ↑ 10.8 | ↑ 6.4

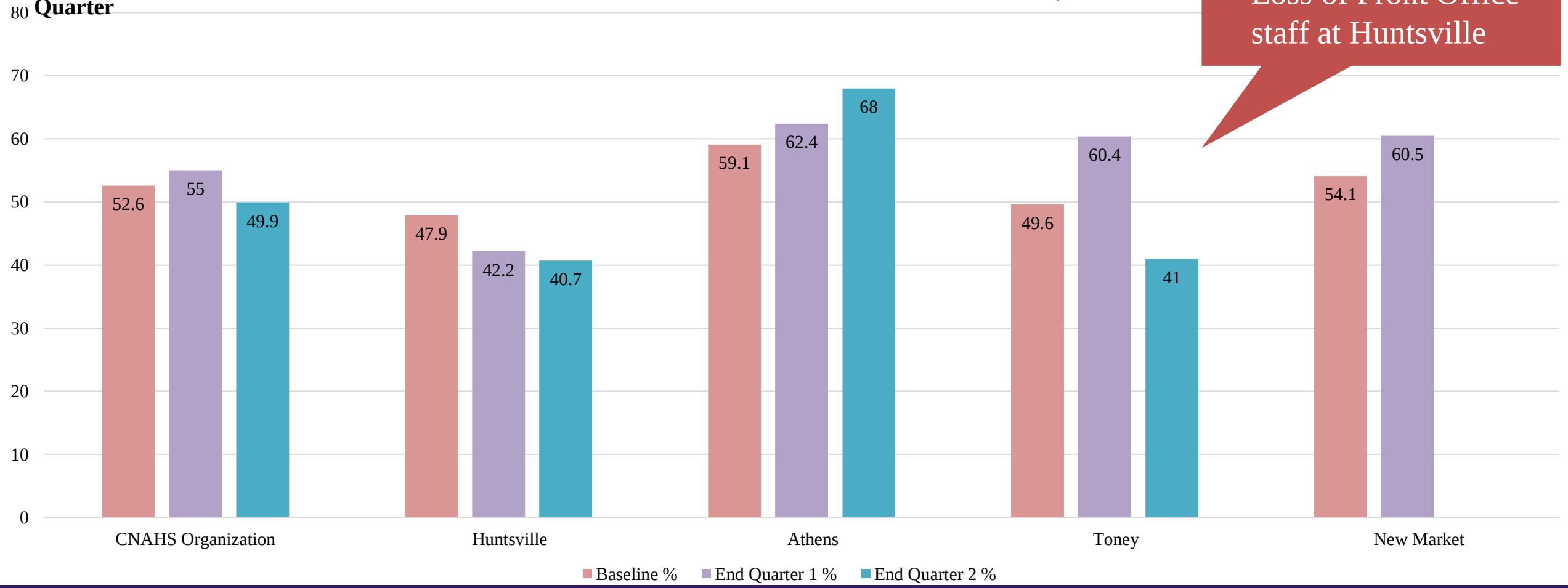


Team Engagement, Optimized Care, & Outreach

	CNAHS Organization	Huntsville	Athens	Toney	New Market
Change from Baseline	↓ 2.7	↓ 7.2	↑ 8.9	↓ 8.5	
Change from Previous Quarter	↓ 5.4	↓ 1.5	↑ 5.6	↓ 19.3	

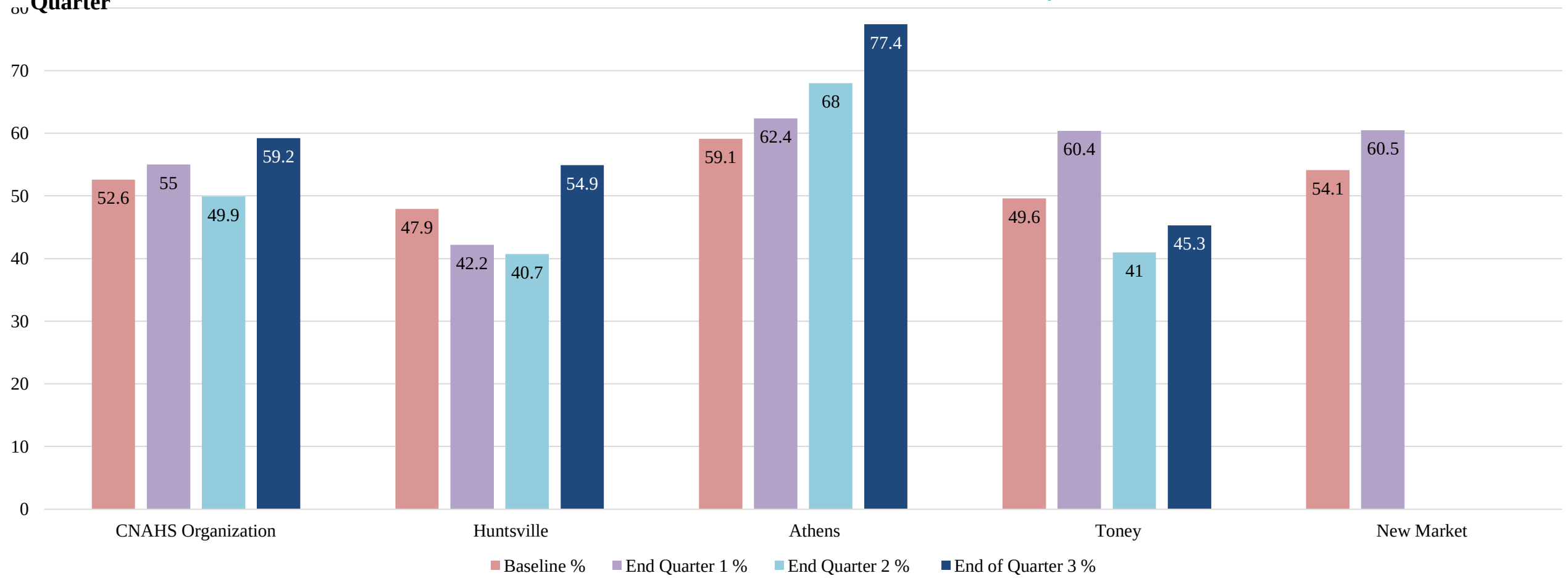
Challenges:

- Loss of MA staff at Huntsville & Toney
- Loss of Front Office staff at Huntsville

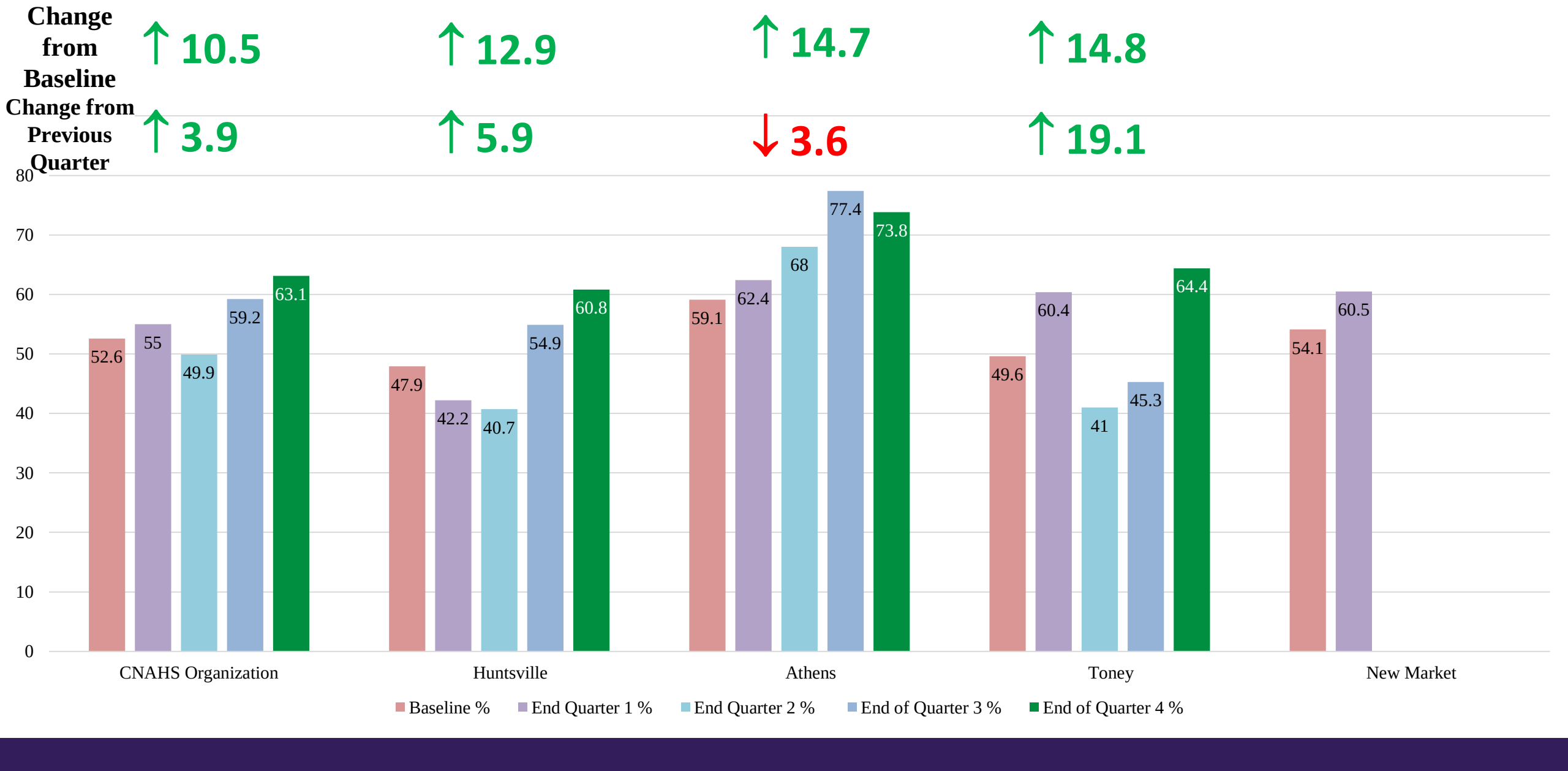


Standardize Care Processes

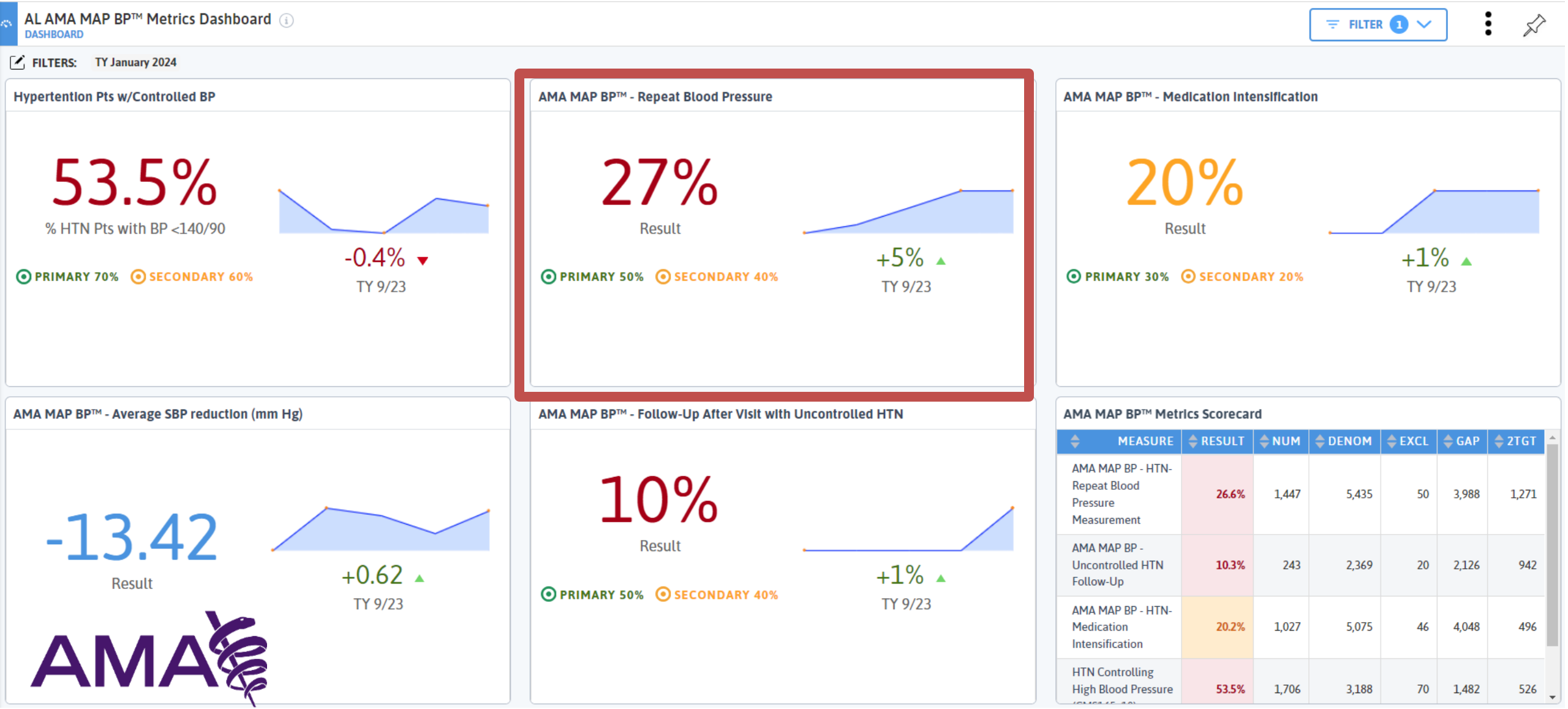
	CNAHS Organization	Huntsville	Athens	Toney	New Market
Change from Baseline	↑ 6.6	↑ 7	↑ 18.3	↓ 4.3	
Change from Previous Quarter	↑ 9.3	↑ 14.2	↑ 9.4	↑ 4.2	



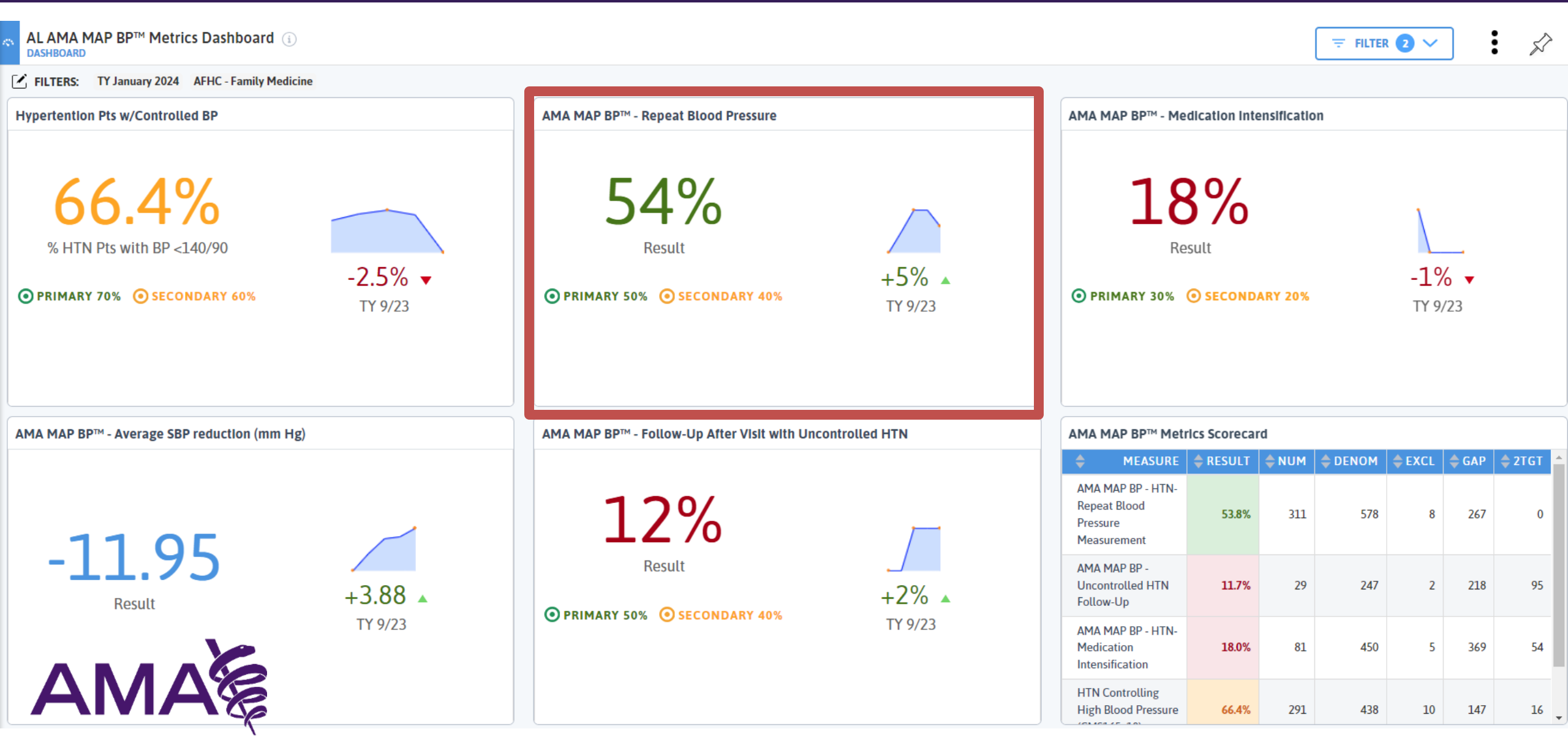
Standardize Care Processes



AMA MAP BP Dashboard - Organization



AMA MAP BP Dashboard – Clinic Level



Medication Intensification Provider Targeting

AMA MAP BP™ - HTN-Medication Intensification

MEASURE

PERIOD: TY March 2024

RENDERING PROVIDERS: All Rendering Provid...

All | Gaps | Num | Excl

SAVED COLUMNS

NEXT APPOINTMENT

In range

03/25/2024

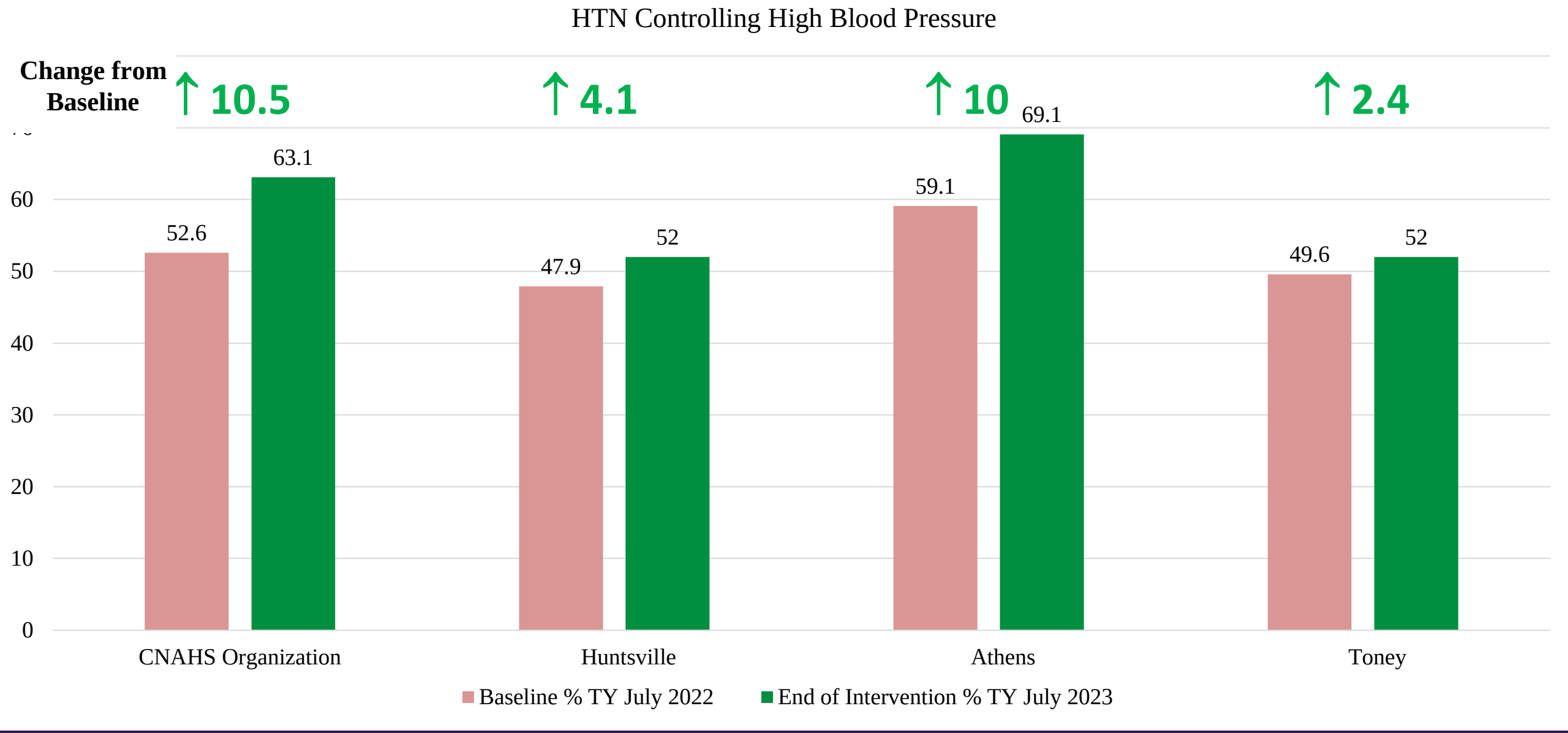
03/31/2024

Clear

HTN

UMERATOR	EXCLUSION	DATE		ON	TYPE	REASON	DIAGNOSIS DATE
	N	3/26/202		dult Medicine	Hypertension	3m f/u	11/26/2018
	N	3/26/202		dult Medicine	Hypertension	3m f/u	11/26/2018
	N	3/26/202		dult Medicine	Hypertension	Hypertension	3/5/2019
	N	3/26/202		dult Medicine	Hypertension	Hypertension	3/5/2019
	N	3/26/202		dult Medicine	Hypertension	Hypertension	3/5/2019
	N	3/26/202		dult Medicine	Hypertension	Hypertension	3/5/2019
	N	3/26/2024	WITMER, ANNEMARIE	HFHC - Adult Medicine	Hyperlipidemia	f/up- Hyperlipidemia	11/3/2016
	N	3/26/2024	WITMER, ANNEMARIE	HFHC - Adult Medicine	Hyperlipidemia	f/up- Hyperlipidemia	11/3/2016
	N	3/26/2024	WITMER, ANNEMARIE	HFHC - Adult Medicine	Hypertension	Hypertension	3/5/2019
	N	3/26/2024	WITMER, ANNEMARIE	HFHC - Adult Medicine	Hypertension	Hypertension	3/5/2019

Year over Year Improvement



AMA MAP BP™ Metric Measures

REPORT

FILTER

PERIOD: TY January 2024

RENDERING PROVIDERS: All Rendering Provid...

BASELINE PERIOD: TY March 2023

Add Filter | Update

GROUPING: No Grouping

TARGETS: Primary | Secondary | Not Met

REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP	TO TARGET
AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement	26.6%	+ 15.1% ▲	50.0%	1,447	5,435	50	3,988	1,271
AMA MAP BP™ - HTN-Follow-Up After Visit with Uncontrolled HTN	10.3%	- 1.5% ▼	50.0%	243	2,369	20	2,126	942
AMA MAP BP™ - HTN-Medication Intensification	20.2%	+ 1.6% ▲	30.0%	1,027	5,075	46	4,048	496
Hypertension Controlling High Blood Pressure (CMS 165v10)	53.5%	+ 9.3% ▲	70.0%	1,706	3,188	70	1,482	526
HTN-Improvement in Blood Pressure (CMS 65v8)	19.2%	+ 1.1% ▲	*Not Set*	175	912	12	737	

CENTRAL NORTH ALABAMA HEALTH SERVICES, INC. 1982

Hypertension Prescribing

REPORT

FILTER

PERIOD: TY January 2024 | RENDERING PROVIDERS: All Rendering Provid... | BASELINE PERIOD: TY March 2023

Add Filter | Update

GROUPING: No Grouping | TARGETS: Primary, Secondary, Not Met | REPORT FORMAT: Scorecard

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR
Adults with HTN Prescribed a Guideline Recommended Therapy	71.0%	+ 71.0% ▲	*Not Set*	2,590	3,648
AMA MAP BP™ - HTN-Average Systolic BP Change After Medication Intensification	-1341.9	- 172.6% ▼	*Not Set*	-9,809	731
AMA MAP BP™ - HTN-Medication Intensification	20.2%	+ 1.6% ▲	30.0%	1,027	5,075
Uncontrolled HTN on Monotherapy	21.3%	- 5.2% ▼	*Not Set*	317	1,485
Uncontrolled HTN on No Anti-HTN Medications	8.9%	- 1.8% ▼	*Not Set*	132	1,485
Uncontrolled HTN Prescribed a Guideline Recommended Therapy	78.6%	+ 15.4% ▲	*Not Set*	1,167	1,485

Abbreviations

ABPM: ambulatory blood pressure monitoring
ACEI: angiotensin-converting enzyme inhibitor
ARB: angiotensin receptor antagonist
ASCVD: atherosclerotic cardiovascular disease
BB: β-blocker
CCB: calcium channel blocker
DBP: diastolic blood pressure
HBPM: home blood pressure monitoring
NSAID: nonsteroidal anti-inflammatory drug
SBP: systolic blood pressure

HTN is defined by JNC 8 as:

Age <60 years: SBP ≥140 mm Hg and/or DBP ≥90 mm Hg at ≥2 visits
Age ≥60 years: SBP ≥150 mm Hg and/or DBP ≥90 mm Hg at ≥2 visits
With diabetes or chronic kidney disease (CKD): SBP ≥140 mm Hg and/or DBP ≥90 mm Hg

Note: BP assessment should be based on an average of at least two readings measured on two or more separate occasions and confirmed in the outpatient setting with multiple readings.

Patients must be instructed to sit quietly in a chair, with feet on the floor and back supported for 5 minutes prior to taking BP.

Consider using HBPM or ABPM to evaluate for white coat hypertension when SBP >130 and <160 mm Hg or DBP >80 and <100 mm Hg.

Goal BP

Age <60 years: SBP <140 mm Hg and DBP <90 mm Hg (for HBPM <135/85 mm Hg)
Age ≥60 years: SBP <150 mm Hg and DBP <90 mm Hg (for HBPM <140/90 mm Hg)
Age ≥60 years with CKD or diabetes: SBP <140 mm Hg and DBP <90 mm Hg (for HBPM <135/85 mm Hg)

Start lifestyle modifications and determine ASCVD risk.*

Weight loss
Healthy diet
Reduced intake of dietary sodium (especially processed foods)
Enhanced intake of dietary potassium
Aerobic exercise (20 minutes, 4 days/week)
Limit alcohol (female ≤1 glass a day, male ≤2 glasses a day).
Smoking cessation
Limit NSAID use.

***ASCVD Risk Estimator Plus**

Available online at:
https://tools.acc.org/ASCVD-risk-estimator-plus

Stage 2 hypertension (SBP ≥140 mm Hg or DBP ≥90 mm Hg)?

No

Stage 1 hypertension with either clinical ASCVD or 10-year ASCVD risk ≥10%?

No

If BP 130–139/80–89 mm Hg

Trial of lifestyle modifications for 3–6 months before reevaluating BP and determining need for pharmacologic therapy

Yes *Yes*

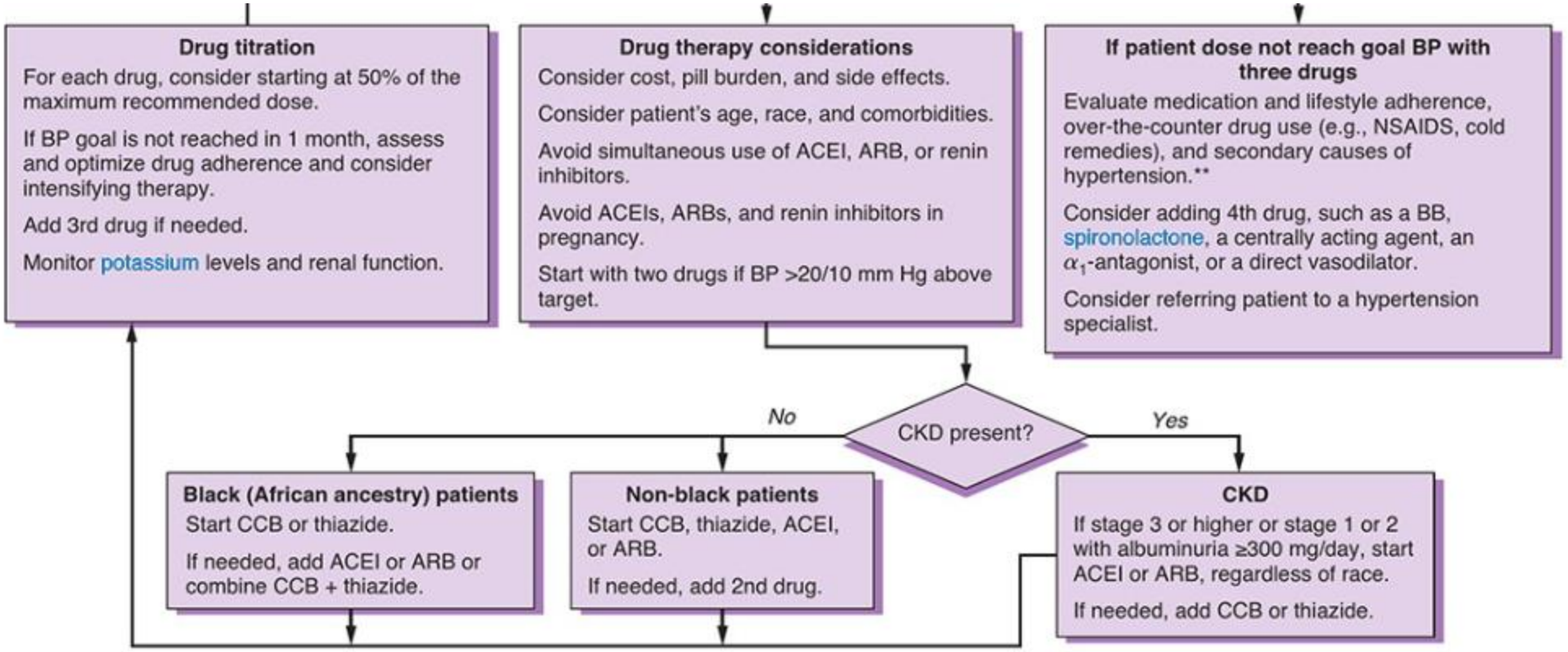
Start pharmacologic treatment.

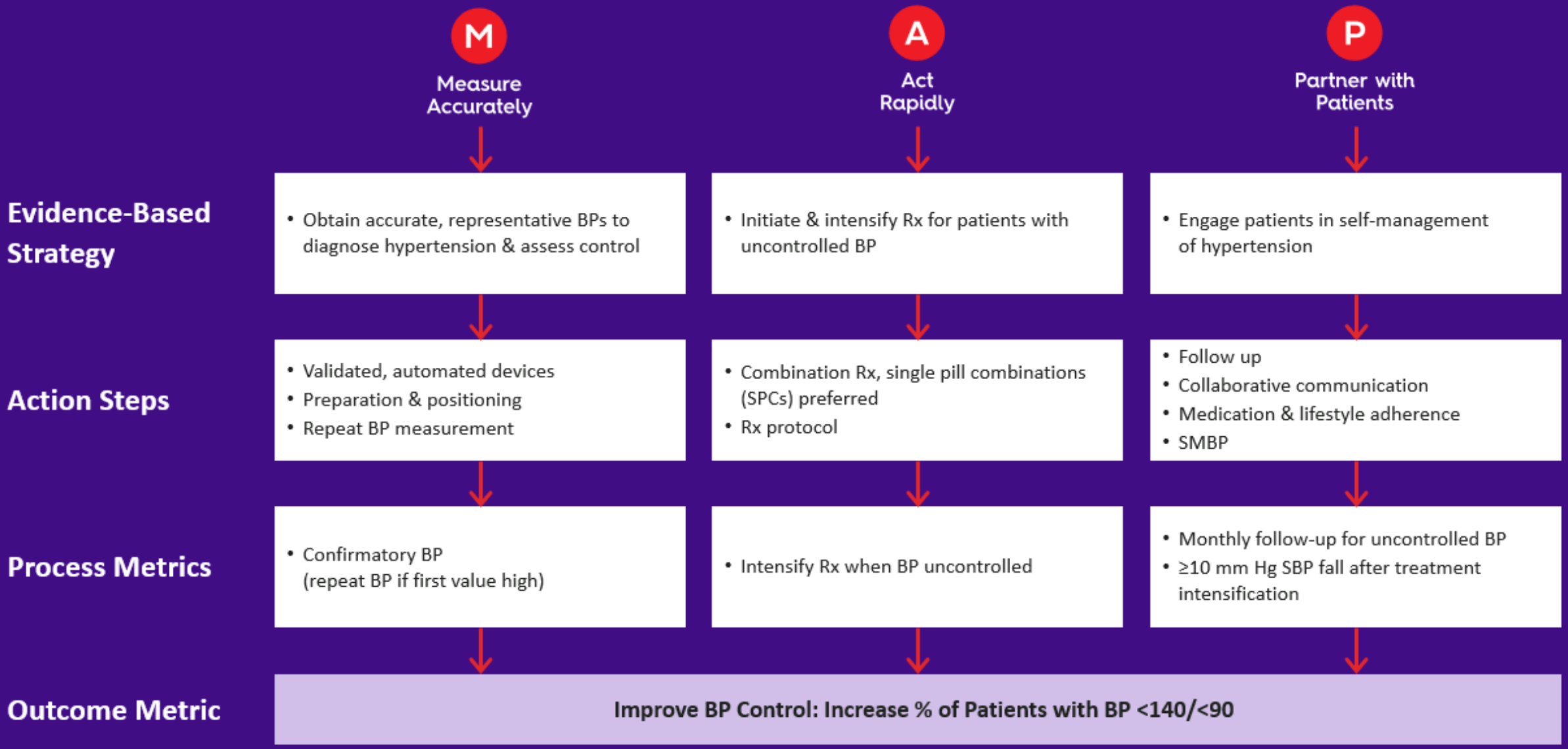
Labs and diagnostics

Fasting blood glucose
Complete blood cell count
Lipids
Basic metabolic panel
Thyroid stimulating hormone
Urinalysis
Ophthalmologic evaluation
Electrocardiogram
Uric acid
Urinary albumin-to-creatinine ratio

Secondary causes of hypertension

CKD
Renovascular disease
Primary aldosteronism
Obstructive sleep apnea
Drug (especially NSAIDs), caffeine, or alcohol-induced hypertension
Pheochromocytoma
Cushing syndrome
Congenital adrenal hyperplasia
Hyperthyroidism or hypothyroidism
Aortic coarctation

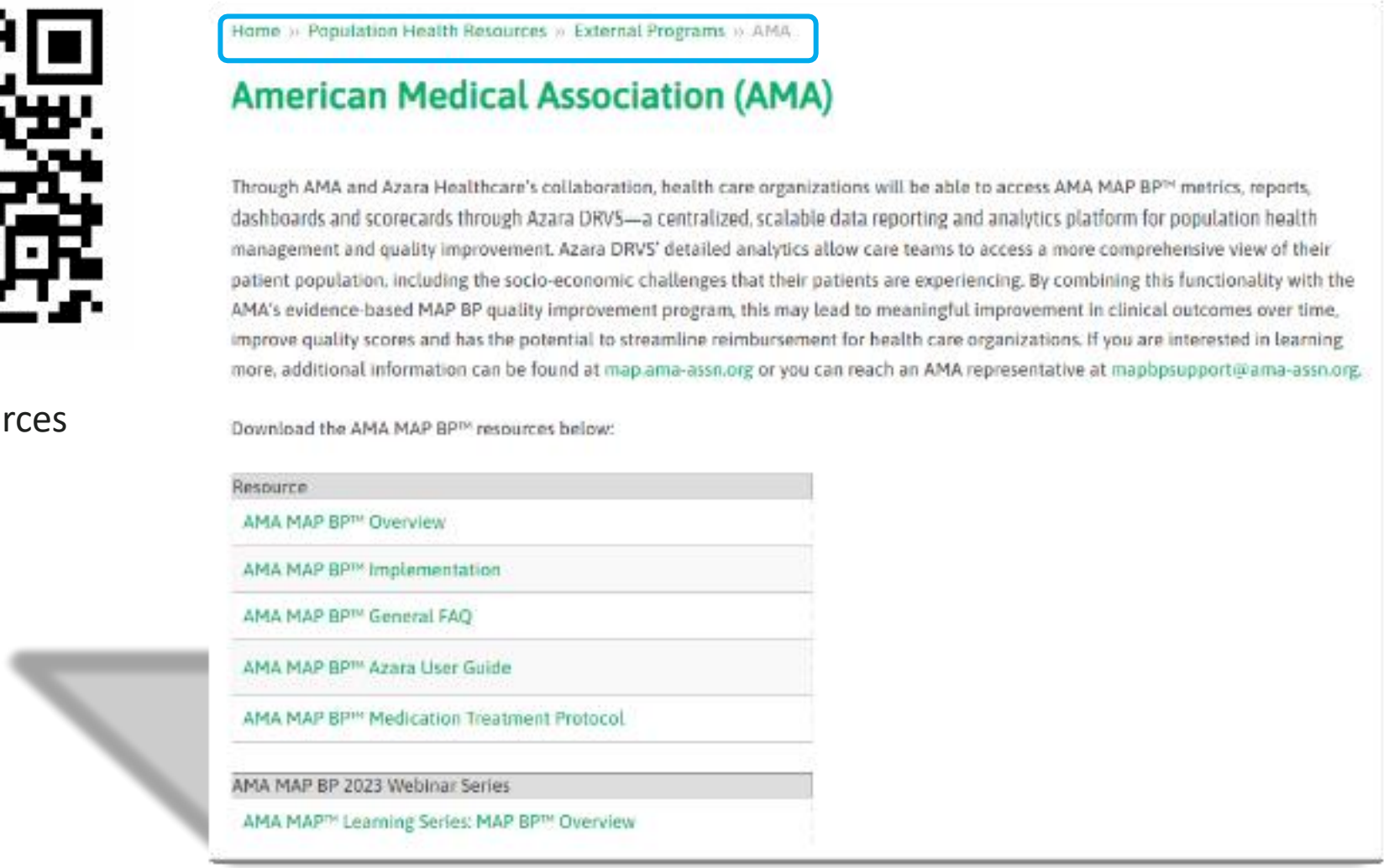

Drug titration
For each drug, consider starting at 50% of the maximum recommended dose.
If BP goal is not reached in 1 month, assess and optimize drug adherence and consider intensifying therapy.
Add 3rd drug if needed.
Monitor potassium levels and renal function.
Drug therapy considerations
Consider cost, pill burden, and side effects.
Consider patient's age, race, and comorbidities.
Avoid simultaneous use of ACEI, ARB, or renin inhibitors.
Avoid ACEIs, ARBs, and renin inhibitors in pregnancy.
Start with two drugs if BP >20/10 mm Hg above target.
If patient dose not reach goal BP with three drugs
Evaluate medication and lifestyle adherence, over-the-counter drug use (e.g., NSAIDS, cold remedies), and secondary causes of hypertension.**
Consider adding 4th drug, such as a BB, spironolactone, a centrally acting agent, an α_1-antagonist, or a direct vasodilator.
Consider referring patient to a hypertension specialist.
CKD present?
No
Yes
Black (African ancestry) patients
Start CCB or thiazide.
If needed, add ACEI or ARB or combine CCB + thiazide.
Non-black patients
Start CCB, thiazide, ACEI, or ARB.
If needed, add 2nd drug.
CKD
If stage 3 or higher or stage 1 or 2 with albuminuria ≥300 mg/day, start ACEI or ARB, regardless of race.
If needed, add CCB or thiazide.



BP = blood pressure; Rx = pharmacotherapy; SMBP = Self-measured BP; SBP = systolic BP

Access AMA MAP™ Resources in Azara DRVS

AMA Resources



Learn About the AMA MAP™ Hypertension Program

AMA MAP™ Hypertension

MAP@ama-assn.org

WV Primary Care Association

One Mission. One Vision. One Voice.

PENDLETON Community Care, Inc.

Franklin ♥ Pendleton Community Care
Riverton ♥ North Fork Primary Care
Harman ♥ Harman Health Center

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APR 30–MAY 2

BOSTON, MA

Going for the Cup!

Utilizing DRVS for Improvement in Diabetic Outcomes

Objectives

FQHCs in West Virginia

Network improvements with DRVS

Pendleton Community Care

Diabetes Quality Project

Project Results

Starting Your Own Project

West Virginia Landscape

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Health of West Virginia Residents

2nd

Highest national prevalence of general health of adults as either **fair or poor**.

26.3%

West Virginia adults considered their health to be either **fair or poor**.

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Demographics

92%
Non-Hispanic, White

88%
Have a high-school diploma

14%
Adults have a disability

17%
Live in poverty

21%
65 years old and over

23%
Enter secondary ed

7%
Veterans

$55,000
Median Income

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Common Barriers

Digital literacy

Literacy

Food insecurities

Age

Transportation

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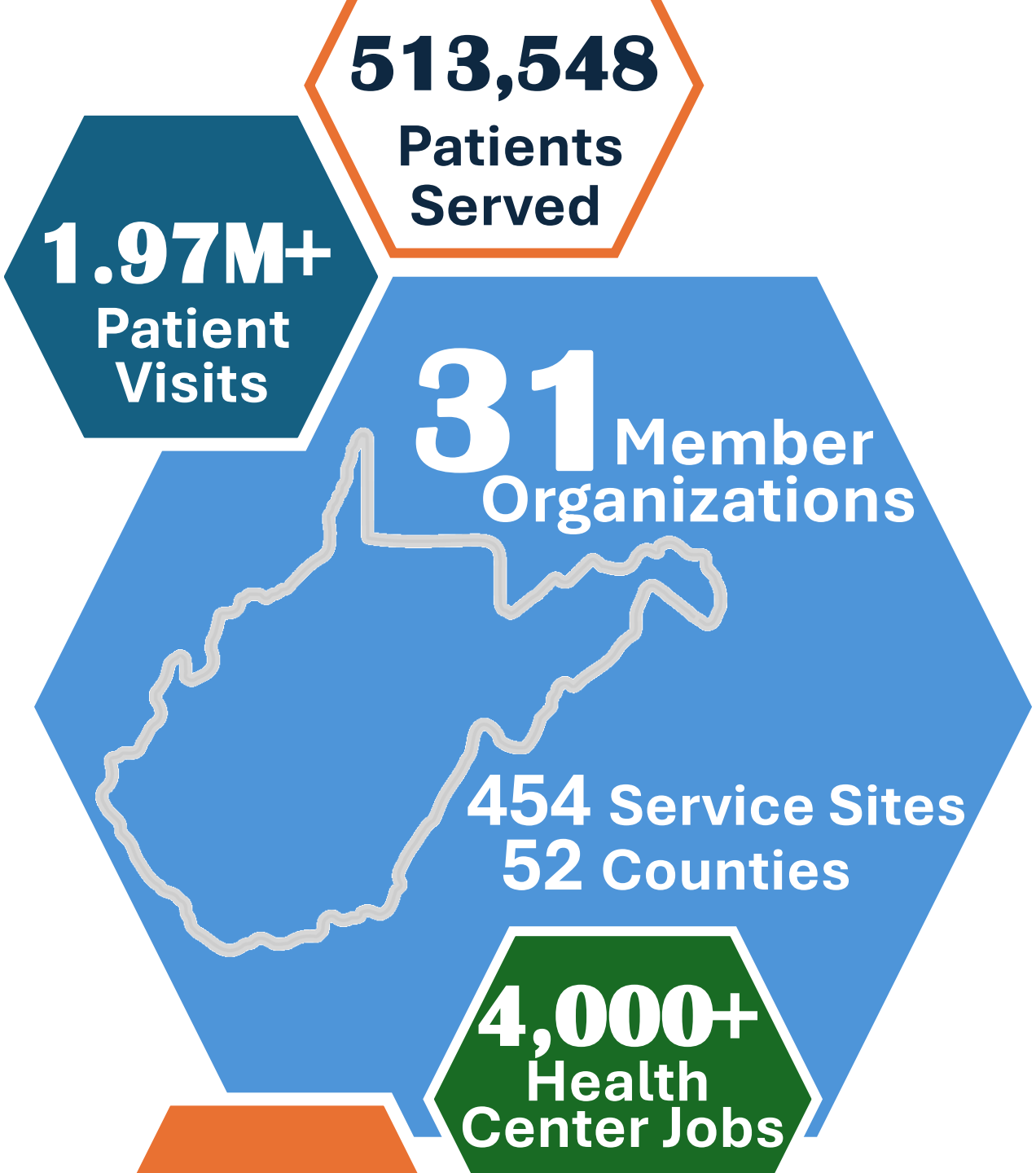
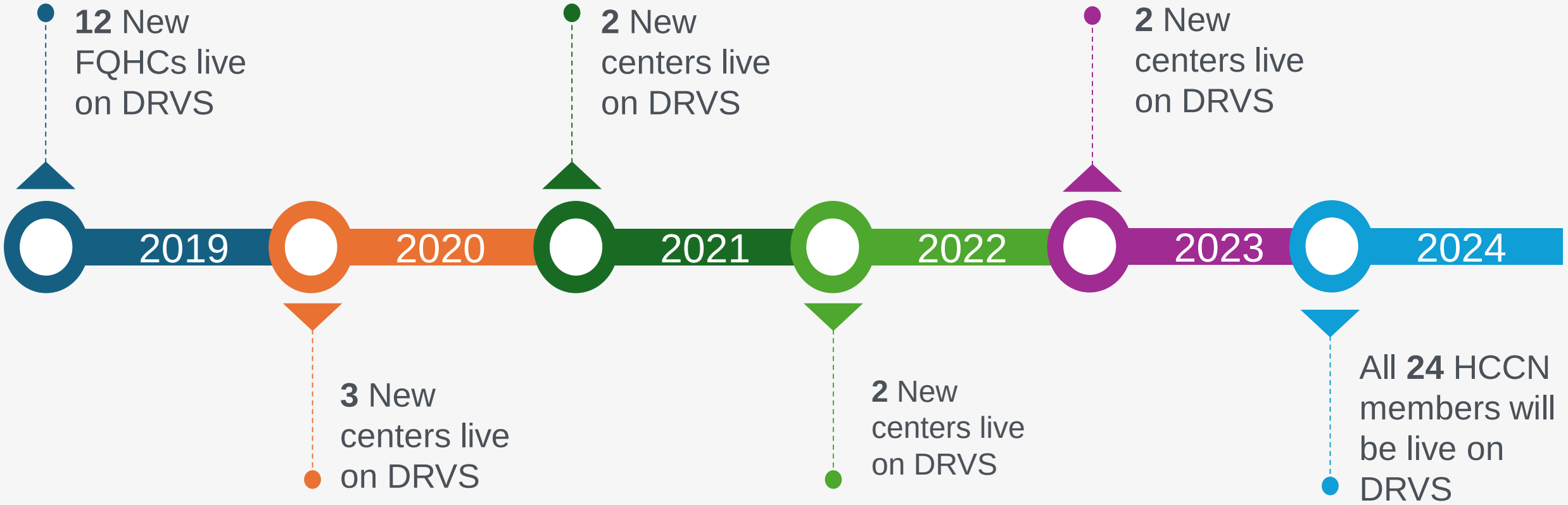
West Virginia Health Centers



Azara Use in West Virginia



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Optimization

Optimization on **peer learning** projects highlighting FQHC work and **leveraging of Azara**

Share **policies** and **project information** to other FQHC in learning **webinars** and noodlepod **communication.**

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Going for the STANLEY Cup

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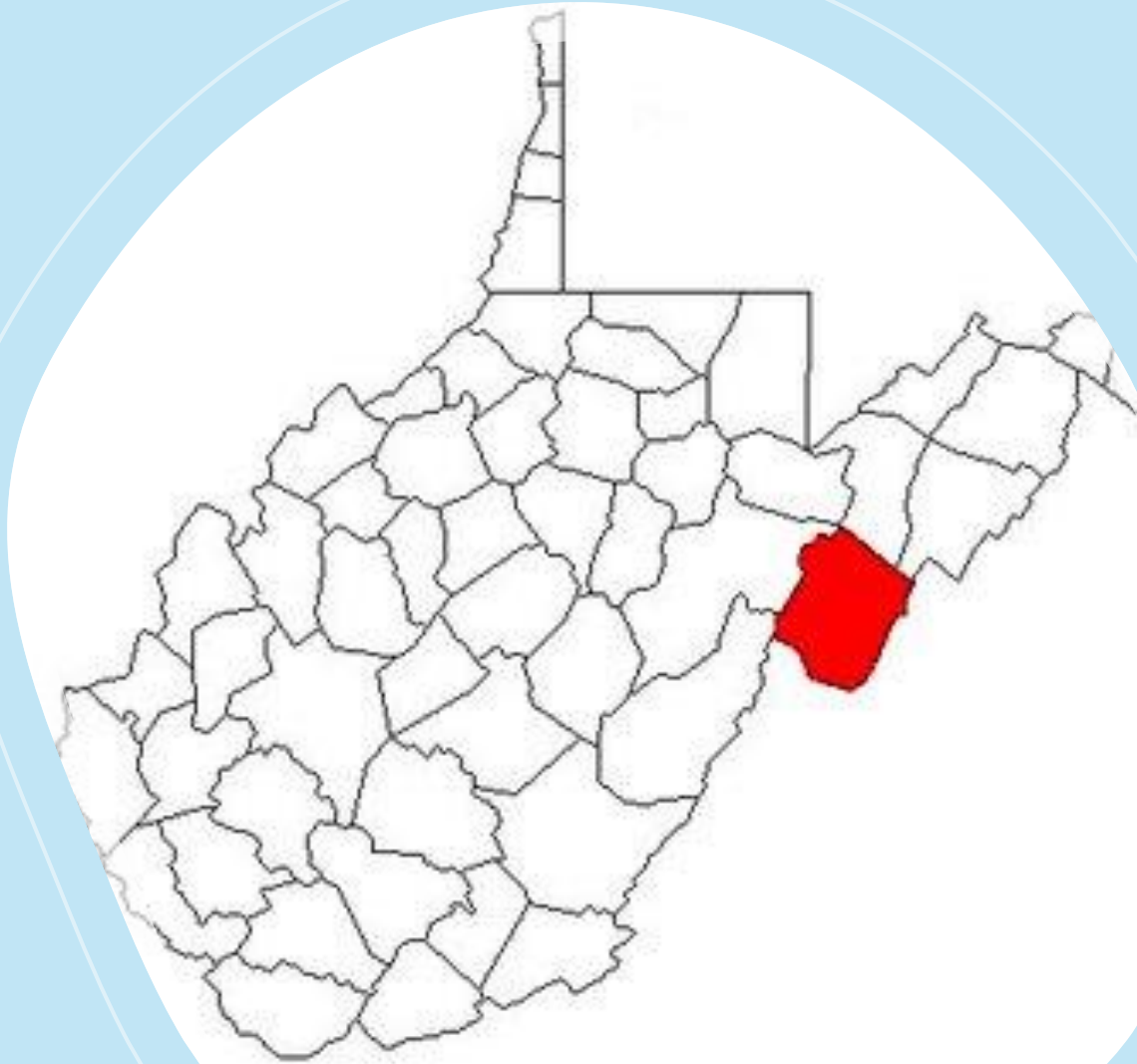

Pendleton Community Care, Inc.

Franklin, West Virginia

PENDLETON Community Care

Demographics

Staffing

2 MDs

9 Mid-levels

Locations

4 School-based Sites

3 Clinic Sites

2 Pharmacies

1 Radiology Site

Patients

5,084

Patients seen in 2023

60%

Chronic Care

10%

Veterans

60%

Medicare / MA

30%

>200% FPL

99.9%

Non-Hispanic, White

In 2022, **0** patients met all **6** diabetes quality measures out of a cohort of **617** patients with diabetes.

Internal Challenge to Diabetes Care

Diabetic care spread throughout the visits, often missing valuable tests in the calendar year.

Staff knowledge of quality measures and associated workflows

Scheduling barriers

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External Challenges to Diabetes Care

Access

- 1 hour to hospital or Wal-Mart
- Food Insecurity
- Low economic area

Patients

- Highest median age in WV
- Reliance on info from family, not medical professionals

Technology

- Lack of cellular or broadband internet
- Low levels of reading and tech literacy

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Background on Project

Aim: Improve the quality outcomes of type 1/type 2 diabetic patients by utilizing Azara DRVS to identify qualified patients for the diabetic incentive project where **10%** of qualified patients will complete all 6 diabetic outcomes by project end January 2024.

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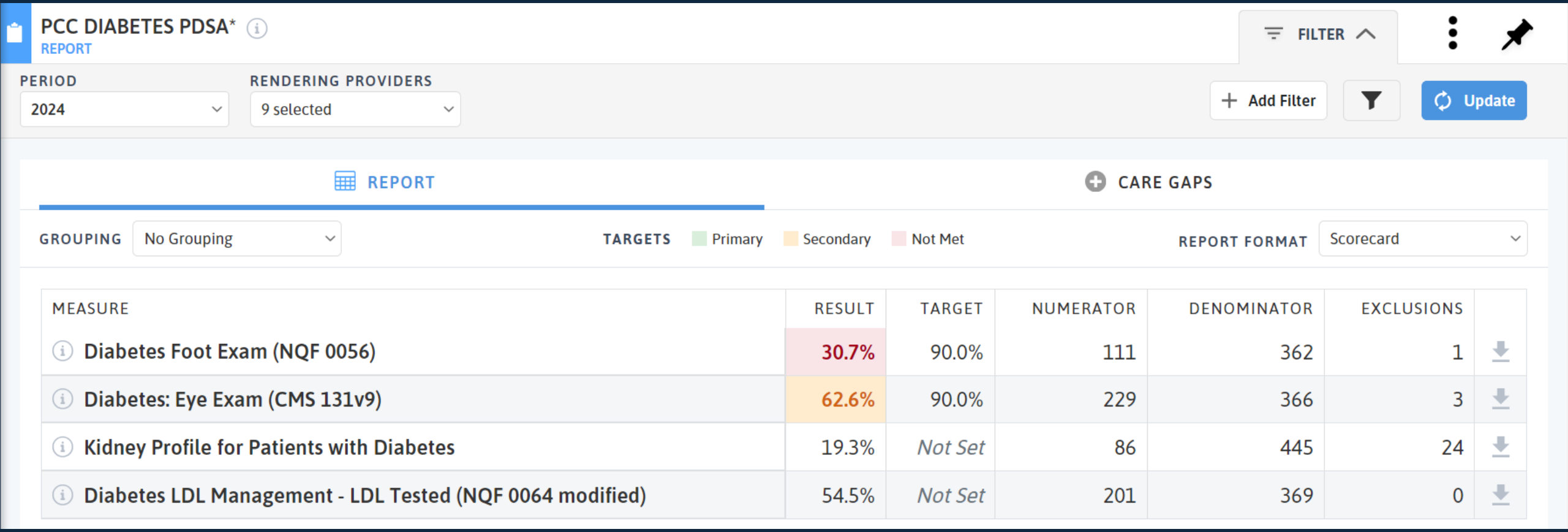
DRVS Tools | Custom Scorecard

- Quick snapshot of measures at a glance
- Set on DRVS homepage for easy access



DRVS Tools | Patient Visit Planning Report

- Made this project much easier to plan.
- Sorting by Cohort made it easier to focus only on patients we were trying to target.

10:00 AM Wednesday, March 27, 2024 — Visit Reason: **ESTABLISHED 30 wants to discuss weight loss meds**

Patient, Name
MRN: 123456
DOB: 6/27/1951 (72)

Sex at Birth: F
GI: Female
SO: straight or heterosexual

Phone: (123) 456-7890
Lang: English

Portal Access: Y
Cohorts: *Diabetes PDSA 2023

PCP: HOUSE, GREGORY
Payer: BCBS-WV
CM: Unassigned

DIAGNOSES (4)

COPD	DM	HTN-E
HyLip		

RISK FACTORS (3)

ASCVD High (26.64)	BMI	TOB

SDOH (2)

EMPLOYMENT	MED/CARE

RAF GAPS DIAGNOSIS CATEGORIES (2)

Diabetes	Lung Diseases and Disorders

ALERT	MESSAGE	DATE	RESULT	OWNER
Colon CA 45+	Overdue	1/3/2023	Negative	
A1c	Due Soon	10/9/2023	5.7	
LDL	Out of Range	10/9/2023	105	
DM Eye Exam No Retinopathy	Overdue	11/15/2019		
Eye	Overdue	11/15/2019		

Demo data

DRVS Tools | Dashboards

Staff Communication

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PCC Diabetes PDSA FAQ's

Who is eligible? Any patient that has a diagnosis of primary diabetes at any time during 2025.

What do we give patients? Patients should be given a packet including an education sheet and goal card at the first visit they are seen. The card should be filled out by clinical staff to include tests already completed in 2025.

What if a patient loses their card? Patients should be given a new card one time with the dates filled out on it.

How do patients get a mug? Patients should be given a mug after completing all activities on the card in 2025, and making a copy of the card for Jamie D (with the patients name on it.)

Can patients get an extra mug? No. Only patients diagnosed with primary diabetes who complete all 6 tests are eligible for one free mug.

What is the timeframe for this PDSA? Patients can complete diabetes tests anytime during 2025. If a service is done outside of PCC patients can provide proof of a service by January 50th, 2024 to be eligible.

Create Patient Education

That reflects YOUR patient demographics

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1 HbA1C

- This test estimates your average blood sugar levels over the past 3 months.
- This is a blood test and can be done with other lab tests
- Depending on your individual results, your provider may recommend this test every 3 months to 6 months.

2 FOOT EXAM

- This exam is done to detect nerve, skin, and vascular foot changes before they become problems.
- This test is best done when wearing easily removeable shoes.
- This test is recommended at least every year.

3 EYE EXAM

- Our nurses use a special camera to taka a picture of your eyes for evaluation.
- If you see an eye docter yearly we will have you sign a release to get test information from them.
- This test is recommended yearly

4 MICROALBUMIN

- This test is used to detect increased levels of a blood protein (albumin) in your urine. This helps find early signs of kidney damage so they can be treated.
- The urine sample needed for this test can be done at an exam or at a lab visit.
- This test is recommended at least yearly

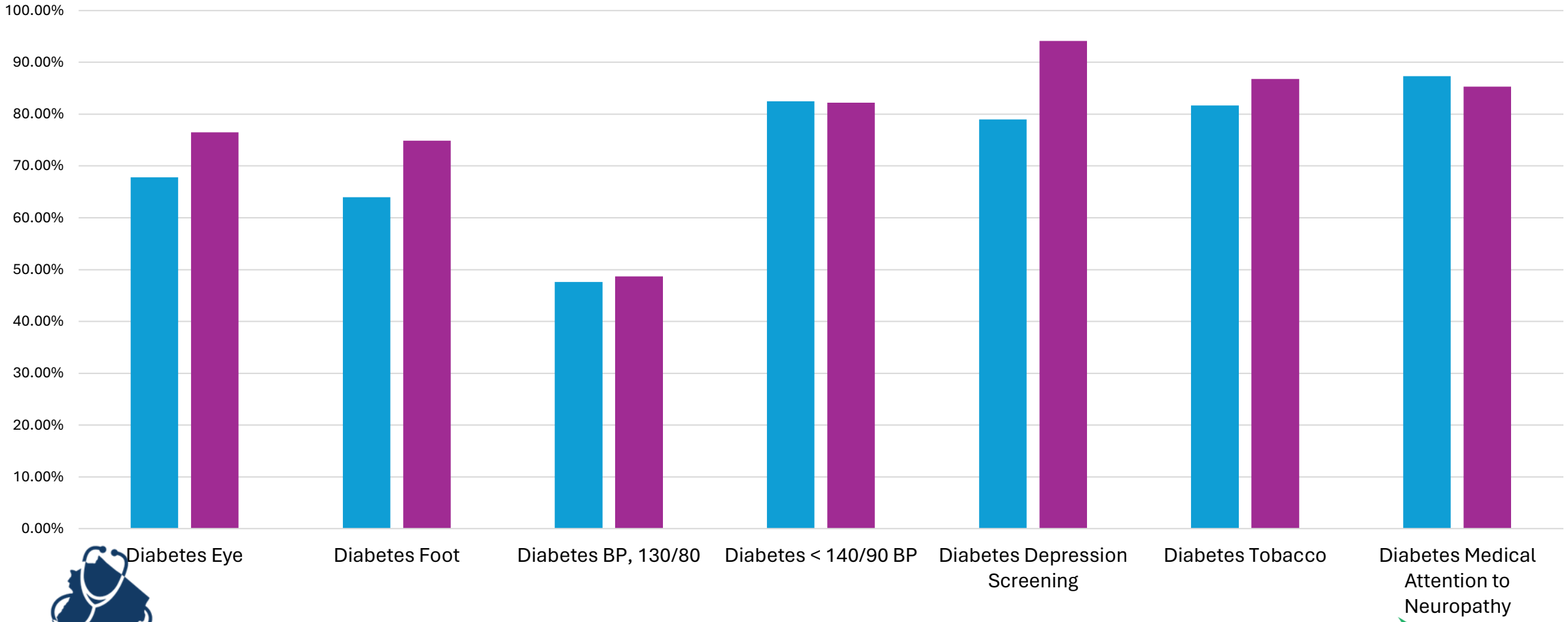
5 eGFR

- This test helps your provider measure your level of kidney function.
- This is a blood test and can be done with other lab tests
- Depending on your individual results, your provider may recommend this test every year.

6 LDL

- This test measures "bad cholesterol" that causes fatty deposits in your arteries which reduces blood flow.
- This is a fasting blood test that can be done with other lab tests
- This test is recommended at least yearly.

2022 vs 2023 Pendleton Diabetic Scorecard



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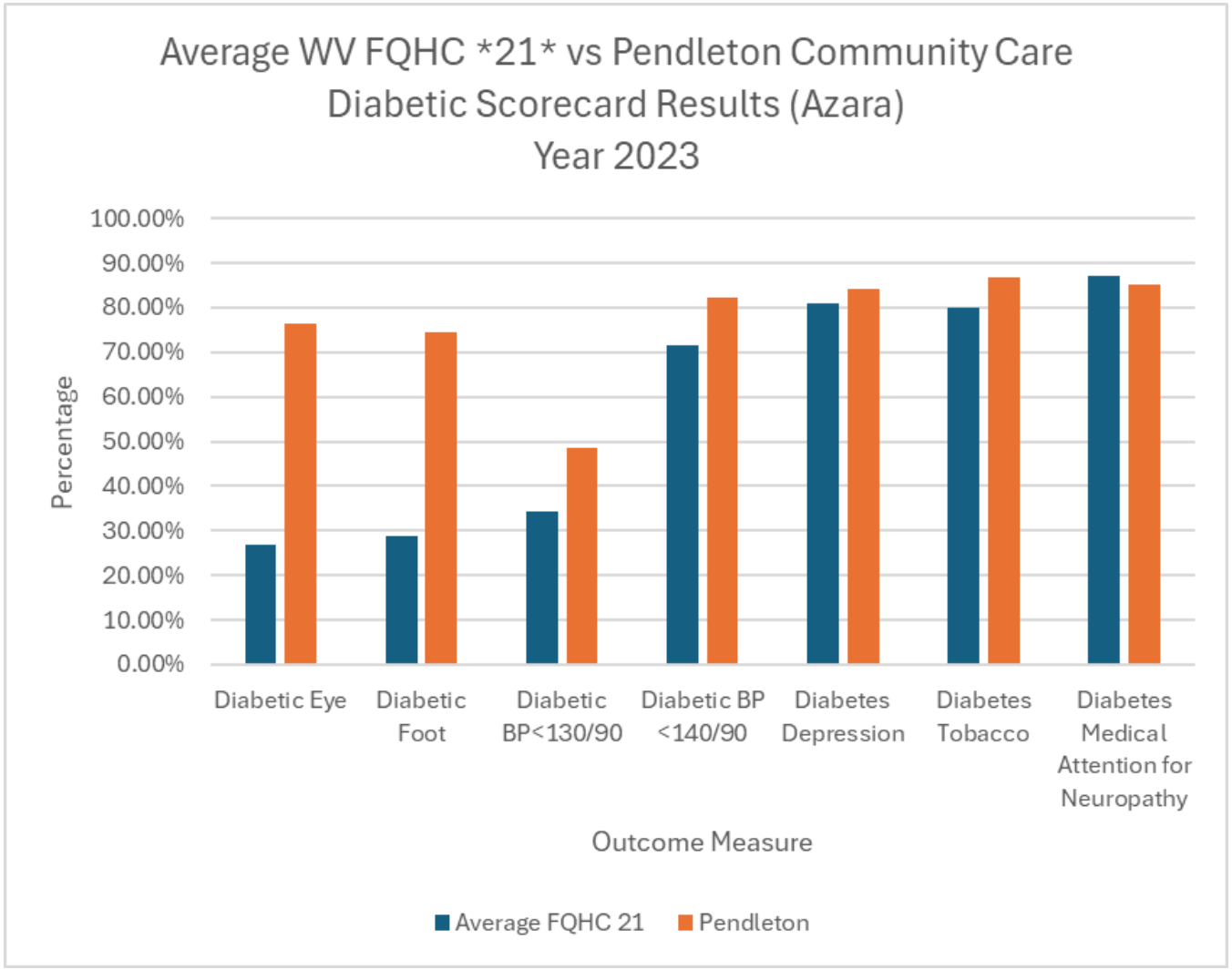
Average WV FQHC vs Pendleton Community Care



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End Result

As of February 2024,

250

patients met all 6 diabetes quality measures!

40%

Of the 617 qualified patients with diabetes

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How you can do a similar project

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BEFORE

- Work with Clinical staff and C-Suite to get buy in.
- Understand the current workflow.
- Think of incentives that matter to YOUR patients.
- Document each expected workflow for the project.
- Train as if staff had never heard of quality measures.

DURING

- Monitor progress often and communicate results.
- Look for problems or changes that can be made throughout the project.
- Cheer on your team!
- Check on staff in person, if possible, and informally. "How's everything going?"

Resources

- Fast Facts (wv.gov)
- Facts About Hypertension | cdc.gov
- U.S. Census Bureau QuickFacts: West Virginia
- WV TRANSIT – WHERE PUBLIC TRANSIT GOES, WEST VIRGINIA GROWS

Contact

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Franklin ♥ Pendleton Community Care
Riverton ♥ North Fork Primary Care
Harman ♥ Harman Health Center

Questions?

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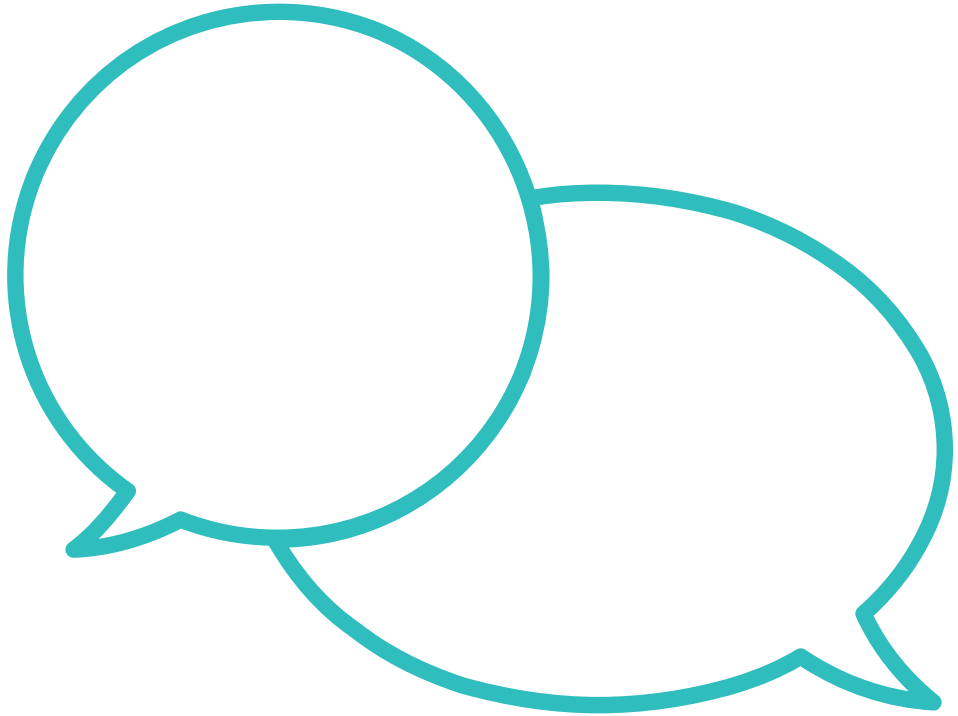

Azara healthcare

@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.

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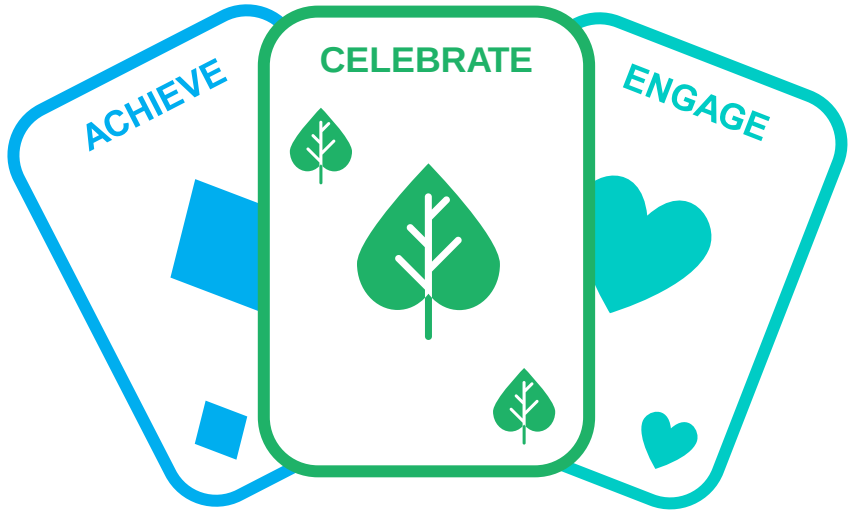
ACE Program



Benefits:

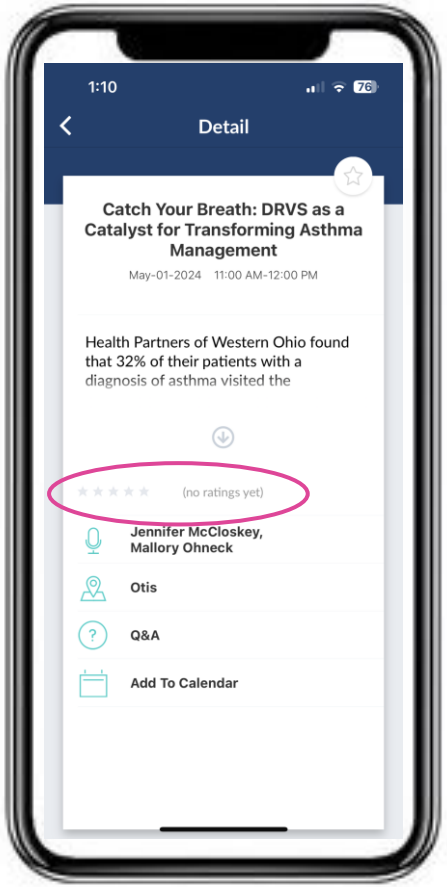
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

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

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USER CONFERENCE
2024

Thanks for attending!