

azara

USER CONFERENCE

APR 29–MAY 1

BOSTON, MA

2025

# Data Validation to Transformation

HCCNS Supporting Health Centers

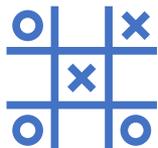


# Today's Speaker



**Amber King**  
Data Strategies Director  
Alabama Primary Health Care Association

# Today's Objectives



## Initial project:

Data validation strategies and lessons learned



## Data hygiene hurdles!

Health center challenges with ongoing data hygiene and DRVS



## ID, please

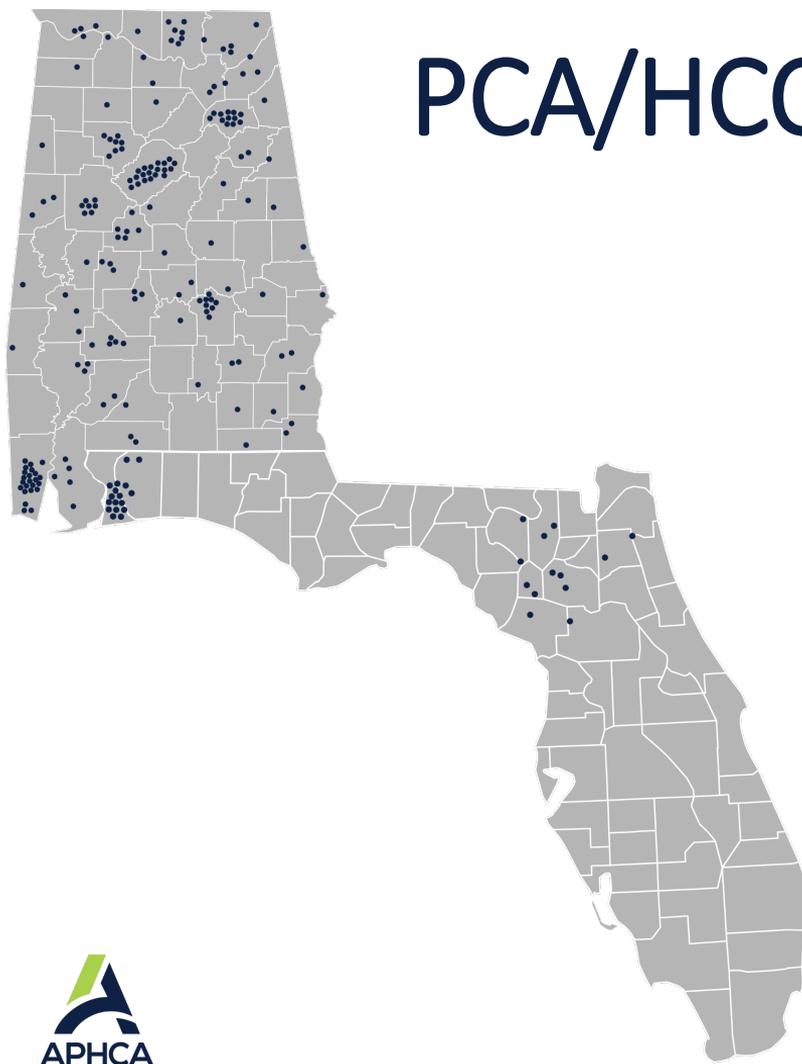
Strategy for identifying health centers under-utilizing DRVS



## Plan of action

(and lessons learned along the way!)

# PCA/HCCN Members



- Alabama Regional Medical Services
- Aletheia House
- AltaPointe Health Systems
- Bayou La Batre Area Health Development Board
- Cahaba Medical Care
- Capstone Rural Health Center
- Central North Alabama Health Services
- Christ Health Center
- Community Health Northwest Florida
- Family Health/MCHD
- Franklin Primary Health Center
- HAPPI Health Services
- Northeast Alabama Health Services
- Physicians Care of Clarke
- Quality of Life Health Services
- Rural Health Medical Program
- Southeast Alabama Rural Health Associates
- Thrive Alabama
- Trenton Medical Center
- Whatley Health Services



# APHCA | Quality Connect Network



21 Health Center Organizations  
across 2 states

- 206 care delivery sites
- Representing over 450,000 patient lives

Began partnering with Azara in  
2021/2022

- Currently have 19 out of 21 organizations live
- 1 center in implementation process

HCCN staff (4 primary members)  
built relationships through:

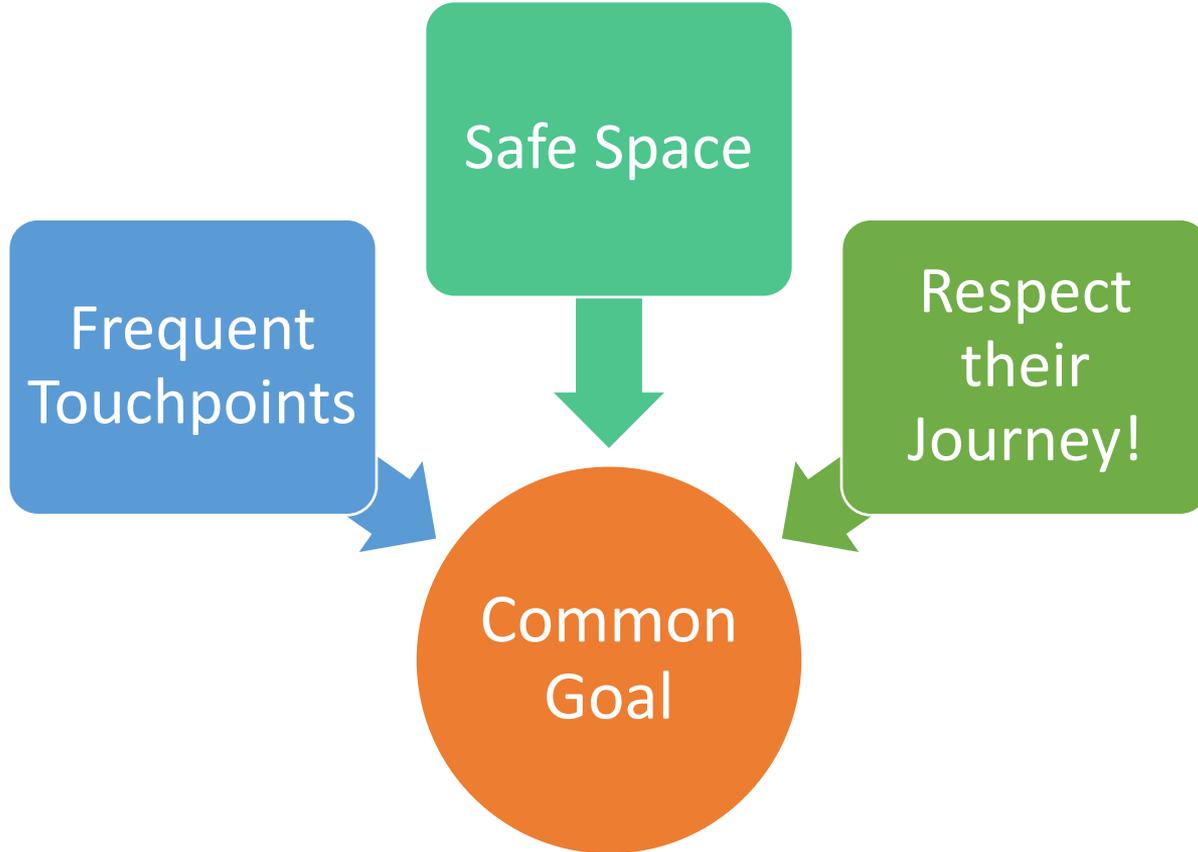
- Quality Connect monthly meetings
- User Groups – EHR and Azara
- CLIMB - quarterly in person, quality work group

# APHCA | Quality Connect Network



- Identify challenges seen in centers
- Share best practices through collaborative learning
- Provide training forums monthly for EHR use, Azara best practices, and workflow challenges
- Provided **55** trainings and **658** technical assistance sessions in 2024!

# Relationship with Health Centers



# Quality Connect Monthly Meetings



**When?:** Once a month at a consistent day and time



**Who?:** Quality, Data/IT, and Clinical Staff (this includes CMO for some centers)



**What?:** Review workplan activities, identify QI projects for center, include in various areas. Technical needs include: Azara Training, Practice Facilitation, Policy and Compliance, and PCMH



**Woah!:** Participation rate above 85%



# Azara User Groups & Office Hours

## Azara User Groups

- 18–20 attendees from 10-12 health centers (on average)
- Primarily used to identify needs across network, collaborative discussion, and targeted technical assistance
- Larger scale training: Risk Stratification, Hep C, HIV, Transitions of Care, Admin Functionality

## Azara Office Hours

- 8-10 attendees from 6-8 health centers (on average)
- Open discussion time
- Short, targeted assistance
- Reminders of upcoming trainings



# EHR User Groups



 athenahealth

10  
centers

**Greenway**  
Health™

2 centers

**Epic**

3 centers

*eClinicalWorks*

4 centers

HENRY SCHEIN  
**MicroMD**

1 center

**nextgen**  
healthcare

1 center



All EHR User Groups are a platform for peer learning and discussion as well as training opportunities!

# Additional Learning Groups



## HIV Work Group

- 25-30 attendees from 16-18 centers
- Developed as part of Ending the Epidemic Initiative
- Found that connecting with each other was more beneficial than training and lectures
- Completed comprehensive assessment for challenges and barriers
- Used feedback to develop topics for HIV Training

## Referral Work Group

- 20-25 attendees from 17-18 health centers
- Developed as a combination of Azara User Groups and EHR User Groups
- Consistent challenges with both EHR and Azara
- 2025 is planned with PDSA cycles in mind
- Identified challenges across network as we work collaboratively to clean up and close outstanding referrals

# CLIMB Quality Workgroup





# Data Validation Phase

# Biggest Data Hurdles



Biggest Challenge: Data “Trust”



No ongoing hygiene plan



Understanding how to validate



Expecting data to always be “right”

# More Validation & Hygiene Challenges



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Competing Priorities – both HCCN and PHC

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Staff turnover

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Understanding of practically “how” to validate

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Identification of responsible parties

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How to report issues and when

---

Level setting and expectations



# Deep Dive the Data!



- 1 Identify areas of concern
- 2 Compare DRVS data to EHR data
  - Understand each EHR's specific requirements
  - Validate challenges found with each center on same EHR
- 3 Training how to enter Azara Support tickets
- 4 See one, do one, teach one



# Azara Support Ticket | Best Practices



	Help Documentation	
	Visit Support Portal	
	Email Support <a href="mailto:support@azarahealthcare.com">support@azarahealthcare.com</a>	
	Call Support 781-365-2213	Monday-Friday 7AM-6PM EST

[Training in Help Section \(linked here!\)](#)

## Visit Support Portal

- Network helps with sign up challenges
- Network trains center on how to manage when employees leave

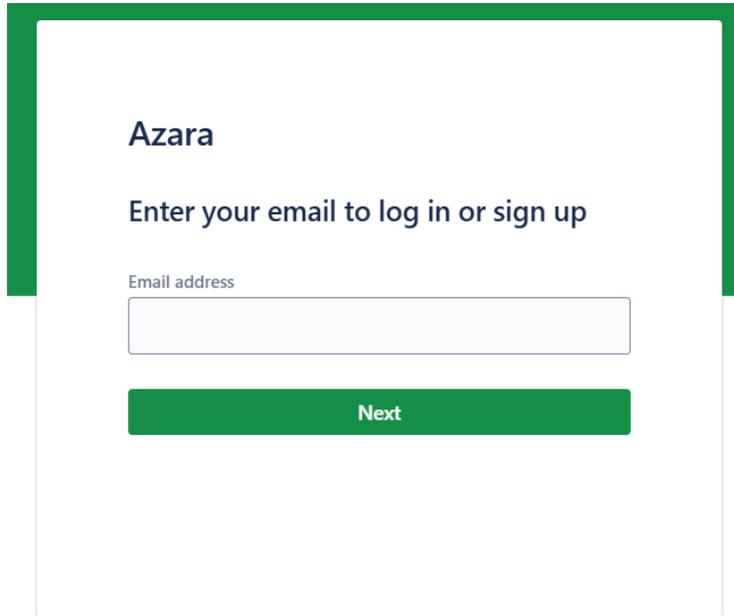
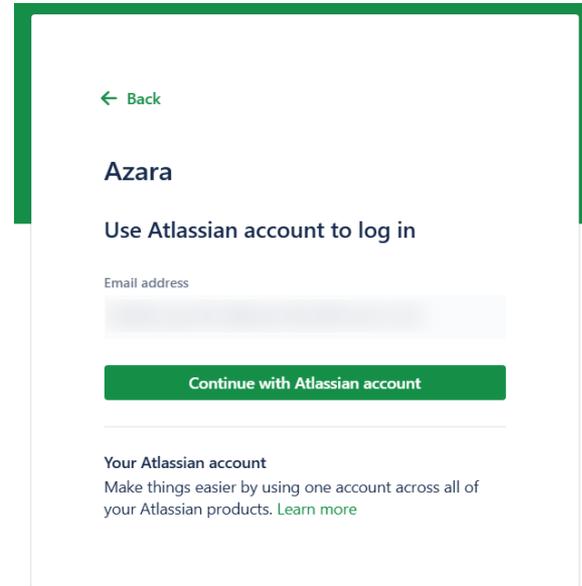
## Email Support

- Not encrypted
- Tracking challenges

## Call Support

- Great for trouble logging in
- Simple requests

# Creating a Jira/Atlassian Account

A screenshot of the Azara login/sign-up page. The page has a white background with a green border. At the top, the word "Azara" is displayed in a dark blue font. Below it, the text "Enter your email to log in or sign up" is centered. Underneath, there is a label "Email address" followed by a white input field with a light gray border. At the bottom, there is a prominent green button with the word "Next" written in white.A screenshot of the Azara account confirmation page. The page has a white background with a green border. At the top left, there is a green arrow pointing left followed by the text "Back". Below that, the word "Azara" is displayed in a dark blue font. Underneath, the text "Use Atlassian account to log in" is centered. Below this, there is a label "Email address" followed by a white input field with a light gray border. At the bottom, there is a prominent green button with the text "Continue with Atlassian account" written in white. Below the button, there is a section titled "Your Atlassian account" with the text "Make things easier by using one account across all of your Atlassian products. [Learn more](#)".

1 [Go to Azara Customer Support Portal \(linked here!\)](#)

2 Enter your email to log in or sign up, and click “Next”

3 Confirm your email address and click “Continue with Atlassian account”



When a user leaves your organization, don't forget to disable their account through a Support Ticket!

# Azara Support Ticket | Challenges



Not understanding how measure code value sets are defined in Azara.



Not providing patient examples with screen shots.

Took 8 weeks to resolve due to missing information



raised this on 05/Feb/25 12:38 PM

[Hide details](#)

## Description

Please capture codes 81528 and 82274 (Cologuard) to the UDS Colorectal Cancer Screening. Thank you!

## Activity



05/Feb/25 2:00 PM

Good Afternoon

Thank you for reaching out to Support! We are not able to add codes to the value set of this measure because we are not the measure steward, you would need to reach out to the NCOA directly to have those codes added. However, this measure does allow for us to capture certain items using structured data. If you send a screenshot of how these codes are documented for patient examples I can see if we would be able to capture them that way to pull patients into the measure.

Please let me know if you have any questions!

# Azara Support Ticket | Challenges



✘ Although patient example MRNs provided, did not provide screenshots.

✘ Screen shots once attached cut off the MRN for patient and the date the values were entered.

Table 4 UDS Error Unknow Income

 raised this on 07/Feb/24 1:46 PM [Hide details](#)

**Description**

DRVS shows 4K patients with unknow income but Athena reports around 3K. I pulled the patient data from both systems and found the following patients that have income 100% below the poverty line in Athena and reporting unknown income in DRVS:



Took 2 months to resolve due to missing information

# Azara Support Ticket | Almost There...



Provided both specific EHR and Azara reports as attachments.



Did not provide screenshots from EHR of the patients missing in Azara.

### Description

Hello

Our Azara's UDS patient count is only showing 20,927 patient. The Athena report is showing 36,452.

Attached is "Patients by Zip code from both vendors.

### Activity

 15/Jan/24 4:11 PM



Azara UDS 2023 ... PM.xlsx  
16 Mar 2024, 02:11 AM

(24 kB)



UDS Patients by ... (1).csv  
16 Mar 2024, 02:11 AM

(2 kB)

# Azara Support Ticket | Success!



Specific measure identified



EHR Screen shots – best practices:

- For missing patients, show the encounter AND the codes billed/charged/documentated on the encounter
- For missing data, show how the documentation occurred in EHR – specific workflow if possible
- For new mapping, workflow is key to show exactly where documentation occurs and how it appears in chart
- Ideally can provide both a “positive” example and “negative”



This ticket was resolved within a few weeks

raised this on 08/Jan/25 10:28 AM [Hide details](#)

**Description**

Please map the Annual Family Planning Screening Measure to this social history question that we have turned on in Athena.

We have been documenting these.

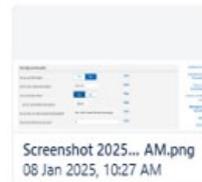
Example of a patient: documented in chart under Social Hx

ID: [REDACTED]

DOB [REDACTED]

## Activity

08/Jan/25 10:28 AM





# Optimization

# Identify the Need



# Requests for Support



Using filters

How to find specific patients

Navigation to find the data

Azara Office Hours

Dashboard vs. Scorecards

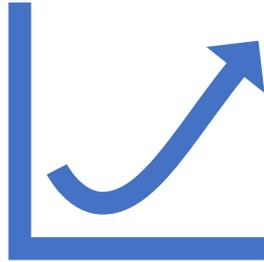
# Needs Assessment



# Clinical Staff



Not using data  
at point of  
service



Clinical staff  
unsure how to use  
data to drive  
change



Data was not  
relevant –“How  
does this help  
me?”

# Usage Reports



Primary reports utilized: CQM scorecards or UDS reports

Breaking out by center and then by user helped to identify trends

Using the module filters!

While CMP and PVP usage were higher, the other aspects of DRVS were underutilized

Primarily quality staff utilizing DRVS

# Network Usage Dashboard



APHA Usage Dashboard

FILTER

+ Add Filter

Update

PERIOD: March 2025

CENTERS: All Centers

RENDERING PROVIDERS: All Rendering Provid...

## Active DRVS Users

526

Count of Users

-72

Feb 25

## Monthly Report Type Runs



## Monthly Report & Measure Runs

CENTERS	REPORTS
	2,961
	1,077
	842
	661
	596
	569
	527
	447
	431
	426
	408
	391
	387
	331
	301
	203
	169
	21

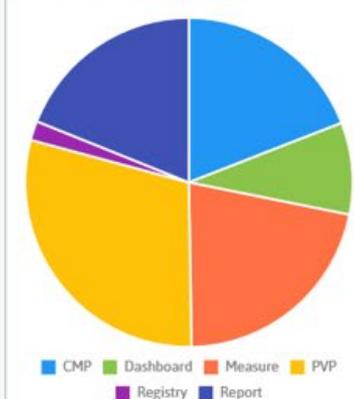
## PVP and CMP Usage Trend



## Alert Closure Trend



## Monthly Report Type Runs

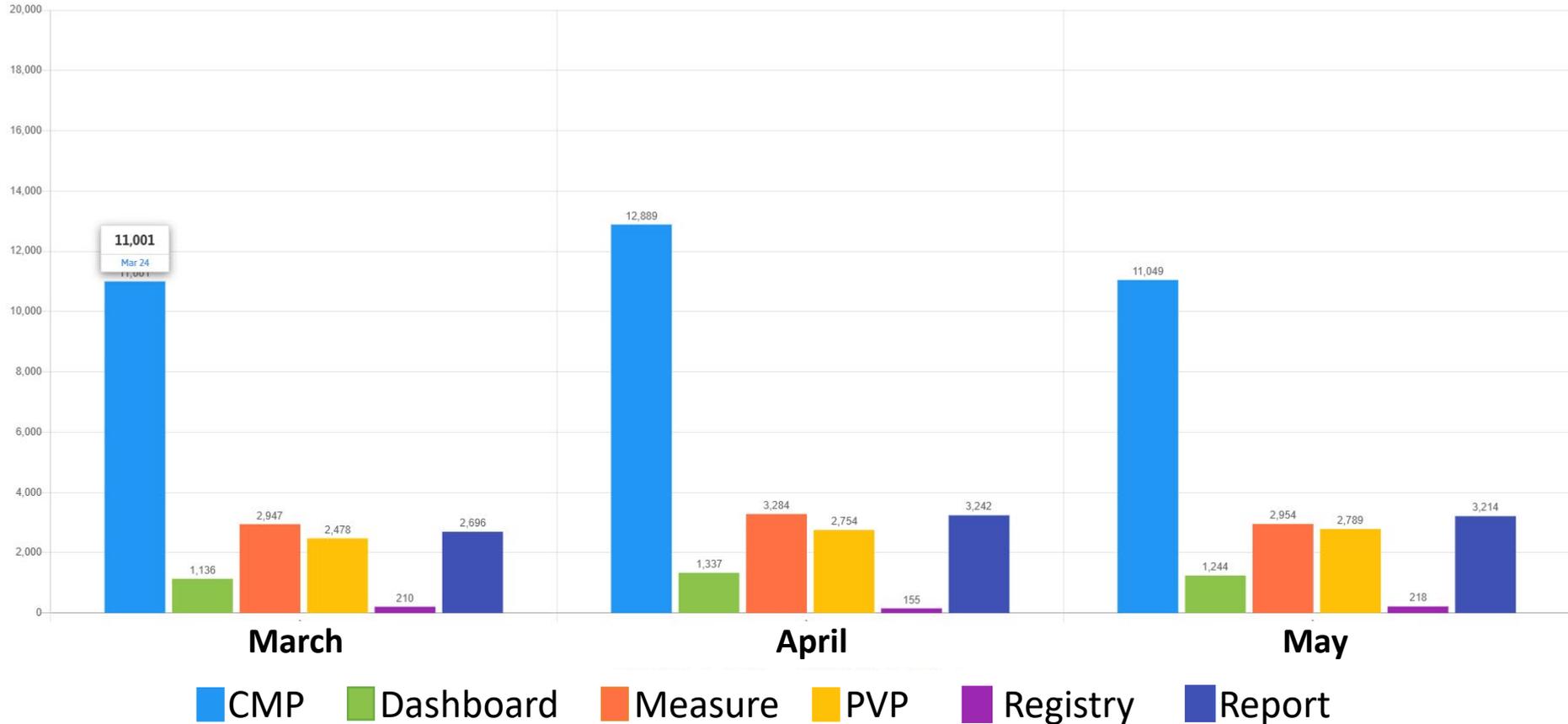


# Starting Out



Grouped by Report Type

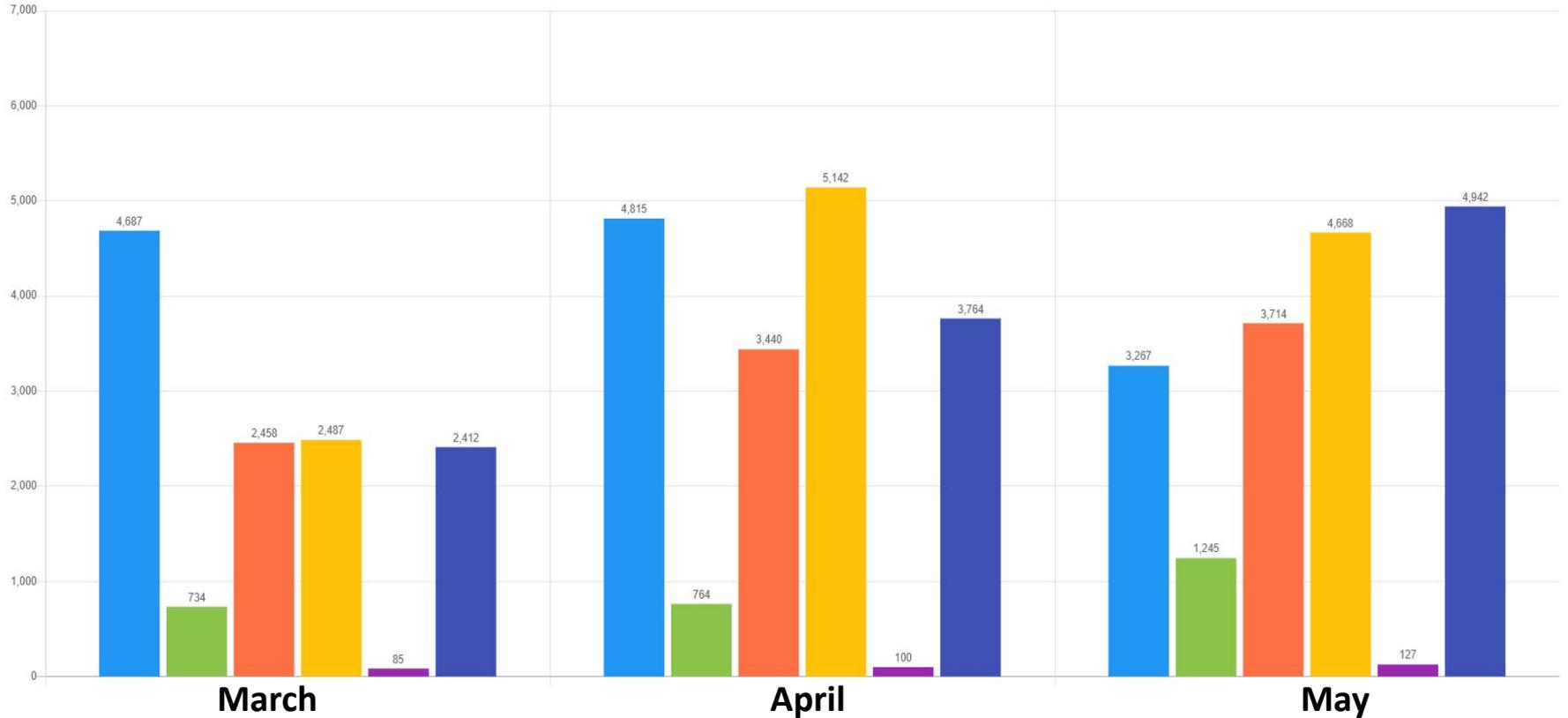
Report Usage



# Making Progress



>



**CMP**   **Dashboard**   **Measure**   **PVP**   **Registry**   **Report**

# Reporting to Leadership



## APHCA Azara Board Dashboard

Active DRVS Use

575

Count of Users



Oct 24

Active C Suite Use

30

Count of Users



Oct 24

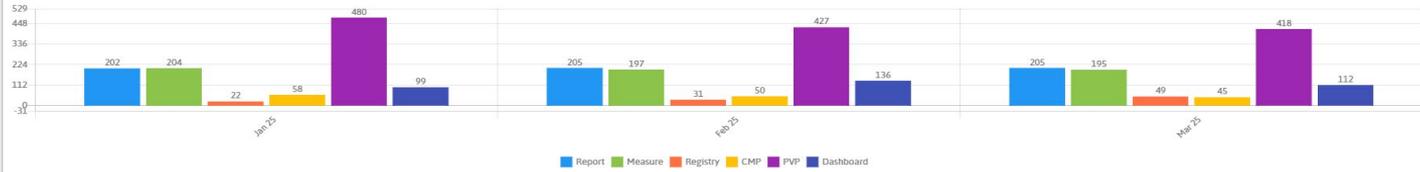
PVP & CMP Usage Tren



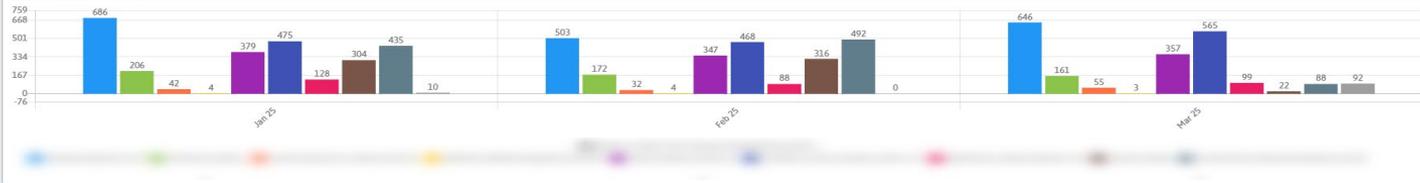
Alert Closure Tren



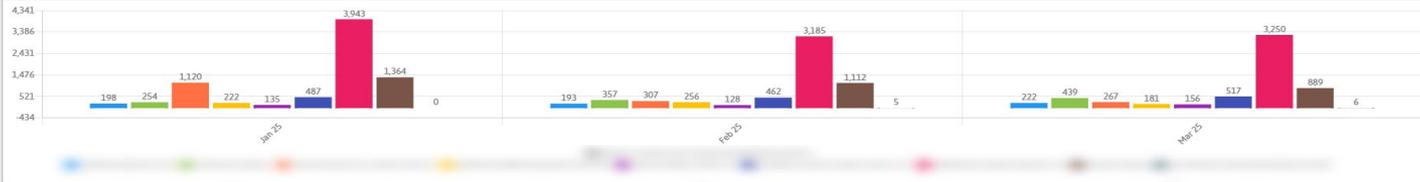
Overall DRVS Usage by Report Ty



PVP and CMP Usage by Cen



PVP and CMP Usage by Cente

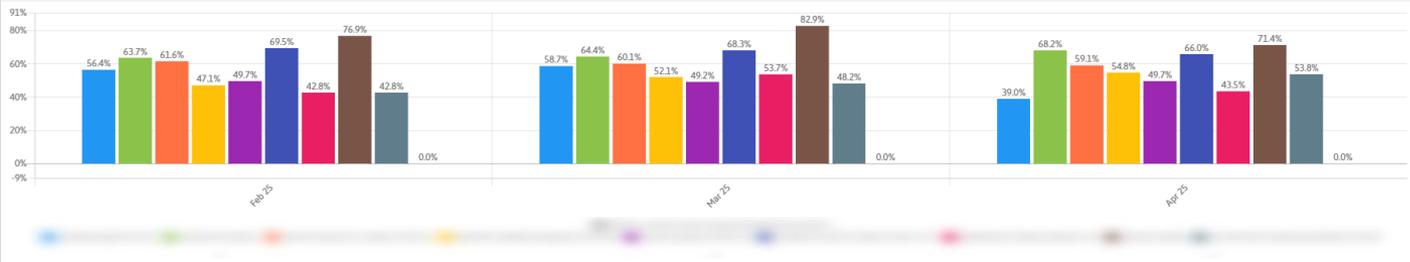


# Leadership Alert Closure



## APHA Alert Closure Board Dashboard

Alert Closure by Cent



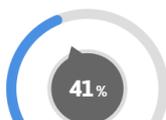
Alert Closure by Cent



Child/Adult BMI Alert Closure Performance



Depression Screening Alert Closure Performance



Depression Remission Alert Closure Performance



Tobacco Screening Alert Closure Performance



Diabetes A1C Alert Closure Performance



Statin Therapy Alert Closure Performance



HRSN Alert Closure Performance



# DRVS Usage Reports | By Type



TYPE	NAME	FIRST RUN	LAST RUN	DISTINCT USERS ↑	REPORTS GENERATED
Report	Patient Visit Planning (PVP)	10/01/2024	10/31/2024	293	4,446
Report	UDS 2024 CQMs	10/01/2024	10/31/2024	61	1,114
Report	Care Management Passport (CMP)	10/01/2024	10/31/2024	49	6,837
Measure	Cervical Cancer Screening (CMS 124v12)	10/01/2024	10/31/2024	37	126
Measure	Breast Cancer Screening Ages 50-74 (CMS 125v1...	10/01/2024	10/31/2024	36	262
Measure	Colorectal Cancer Screening (CMS 130v12)	10/02/2024	10/31/2024	31	100
Measure	Diabetes A1c > 9 or Untested (CMS 122v12)	10/01/2024	10/29/2024	27	83
Measure	Screening for Depression and Follow-Up Plan (C...	10/01/2024	10/31/2024	23	128
Measure	Hypertension Controlling High Blood Pressure (...)	10/01/2024	10/30/2024	23	57
Measure	Childhood Immunization Status (CMS 117v12)	10/01/2024	10/31/2024	19	69
Measure	BMI Screening and Follow-Up 18+ Years (CMS 6...	10/01/2024	10/31/2024	19	67
Measure	Tobacco Use: Screening and Cessation (CMS 138...	10/01/2024	10/31/2024	18	68
Measure	Patients with Qualifying Encounters	10/01/2024	10/31/2024	17	370
Measure	Depression Remission at Twelve Months (CMS 1...	10/02/2024	10/31/2024	17	56
Measure	HIV Screening (CMS 349v6)	10/01/2024	10/29/2024	17	58
Measure	Child Weight Assessment / Counseling for Nutrit...	10/02/2024	10/31/2024	16	62
Dashboard	UDS Adult Preventive	10/01/2024	10/31/2024	15	21
Dashboard	UDS by Center month to month 2024	10/01/2024	10/30/2024	15	97
Report	Table 4 - Patient Characteristics	10/01/2024	10/30/2024	15	76
Report	QA/QI Quality	10/02/2024	10/31/2024	14	290

# DRVS Usage Reports | Remove PVP + CMP



TYPE	DISPLAY NAME	DATE	COUNT
Report	Provider Quality- Family Practice	10/01/2024	2
Measure	Completed Referrals	10/01/2024	4
Registry	Hep C Screening - Aly	10/01/2024	1
Measure	Early Entry Into Prenatal Care (UDS)	10/01/2024	3
Registry	HIV Screenings - Aly	10/01/2024	1
Report	UDS 2024 CQMs	10/01/2024	21
Registry	OUD pts - Aly	10/01/2024	1
Measure	Annual Family Planning and Contraception Scre...	10/01/2024	2
Measure	Low Birth Weight - UDS 7a	10/01/2024	1
Measure	Childhood Immunization Status (CMS 117v12)	10/01/2024	1
Report	UDS 2024 CQMs	10/01/2024	1
Measure	Diabetes A1c > 9 or Untested (CMS 122v12)	10/01/2024	1
Measure	UDS Qualifying Encounters	10/01/2024	5
Measure	Patients with Qualifying Encounters	10/01/2024	4
Measure	Breast Cancer Screening Ages 50-74 (CMS 125v1...	10/01/2024	19
Report	OB Pregnancy Episode Summary	10/01/2024	1
Measure	Cervical Cancer Screening (CMS 124v12)	10/01/2024	4
Measure	Alert Closure - Point of Care (POC)	10/01/2024	7
Registry	Social Drivers of Health (SDOH)	10/01/2024	1
Measure	Social Drivers of Health Assessment Recorded	10/01/2024	5

# Module Usage & Saved Filters

Saved Filters

+ Add New

MY FILTERS

*No Saved Filters*

SHARED FILTERS

Transitions of Care - Module Usage

Referral Management - Module Usage

Controlled Substance - Module Usage

Fin Ops - Module Usage

HIV - Module Usage

Hep C - Module Usage

Payer Integration - Module Usage

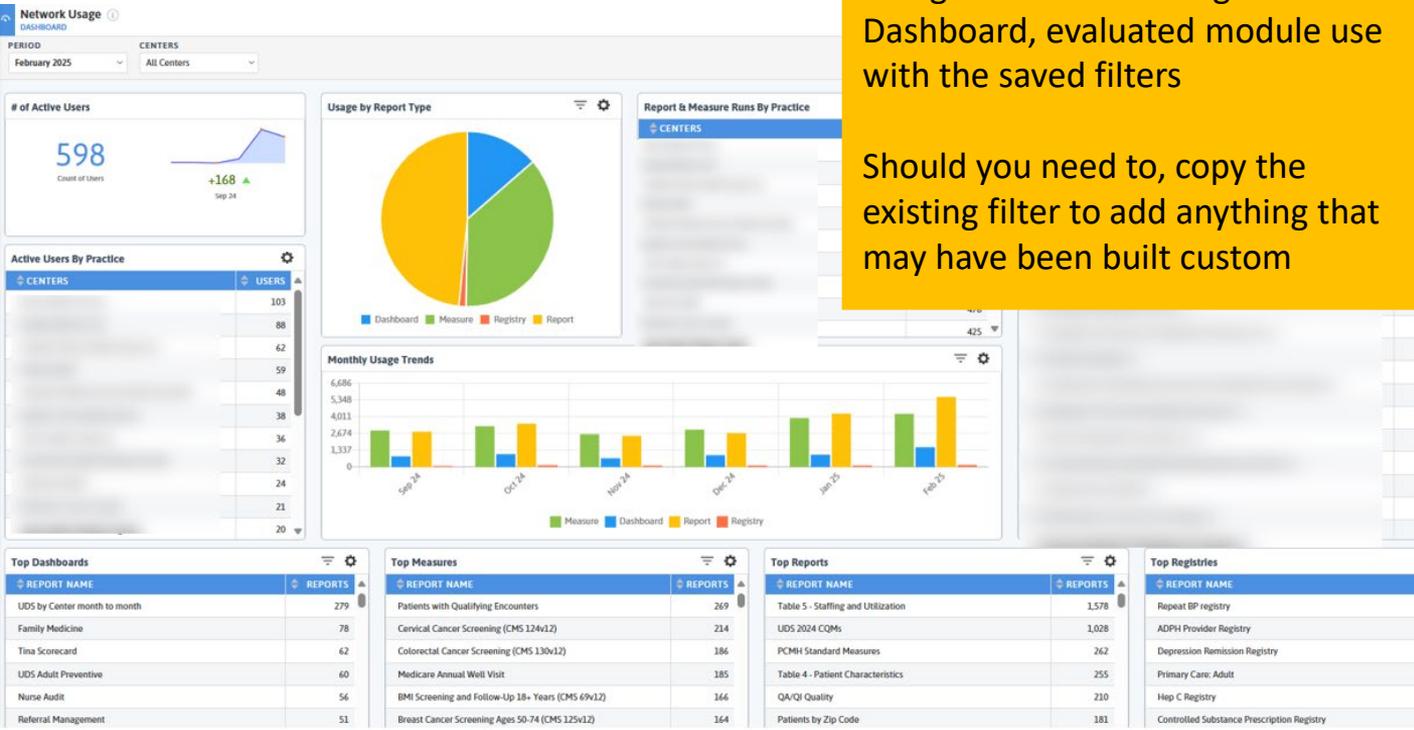
Dental - Module Usage

SDOH - Module Usage

Risk - Module Usage

Using the Network Usage Dashboard, evaluated module use with the saved filters

Should you need to, copy the existing filter to add anything that may have been built custom



# Optimization Process

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Start with wide net

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Drill down to pointed questions

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List and provide a copy of reports they pull routinely

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Discussion group with quality and clinical

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Biggest pain point – what takes the longest?

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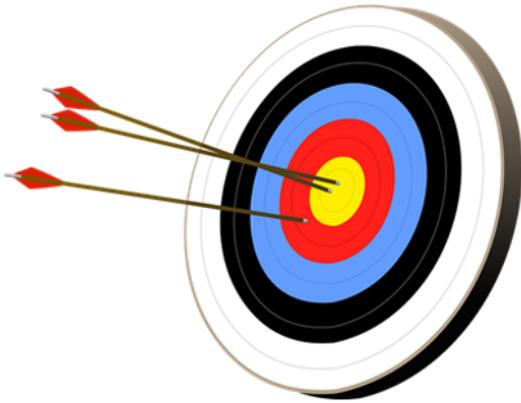
Draw it out

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# Targets and Goal Setting



## GOAL SETTING



TARGETS - Method to our madness?

- Are we setting goals with a plan or just using the path of least resistance?
- Why does specific goal setting planning matter?
  - Setting goals helps us assess where we currently are and to envision the future
  - Provides direction
  - Improves focus
  - Tool for motivation

# Where Do We Start?

## Where are the Gaps?



MEASURE	RESULT	CHANGE
① Childhood Immunization Status (CMS 117v12)	0.0%	0.0%
① Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v12)	18.8%	- 3.2% ▼
① BMI Screening and Follow-Up 18+ Years (CMS 69v12)	89.9%	+ 3.5% ▲
① Depression Remission at Twelve Months (CMS 159v12)	0.0%	0.0%
① Screening for Depression and Follow-Up Plan (CMS 2v13)	0.4%	-0.4% ▼
① Tobacco Use: Screening and Cessation (CMS 138v12)	85.1%	- 0.8% ▼
① Colorectal Cancer Screening (CMS 130v12)	7.4%	+ 1.2% ▲
① Cervical Cancer Screening (CMS 124v12)	4.5%	- 0.2% ▼
① Breast Cancer Screening Ages 50-74 (CMS 125v12)	17.8%	+ 0.3% ▲
① Hypertension Controlling High Blood Pressure (CMS165v12)	70.1%	+ 2.6% ▲
① Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v7)	80.1%	+ 1.0% ▲
① Diabetes A1c > 9 or Untested (CMS 122v12)	19.7%	- 0.5% ▼
① IVD Aspirin Use (CMS 164v7)	71.8%	- 7.9% ▼
① HIV Screening (CMS 349v6)	3.9%	+ 1.6% ▲
① HIV and Pregnant	0.0%	0.0%
① HIV Linkage to Care	0.0%	0.0%
① Dental Sealants for Children between 6-9 Years (CMS 277v0)	0.0%	0.0%

Getting Data into  
Greenway Discussion

Scanning  
Discussion

# Optimization Process



## Discussion Examples:

### Monthly Reports

- Let's list them
- Who is the audience or what do you do with the data?
- How do you display the data?
- How many hours does it take each of you to pull or review monthly reports?

### Weekly Reports

- How much time does it take?
- What are you doing with the data?
- Who is the audience?

### Other Needs

### QI Projects

# Making Data Come to Life



Giving real time  
view and idea of  
what they are  
looking for



In person was key



The “dream” –  
what have you  
always wanted  
to see?



Follow up sessions



# Ongoing Work

# Training and Understanding



Azara data is vast!

Initial Implementation Training  
specifically functional

Easy to use what you are  
comfortable with only

Data can't drive quality if you  
don't explore it!

# Training Plan



## Face to Face

- Initial data validation training
- Walk through questions
- Identify modules under-utilized
- Role based uses

## Ongoing sessions

- Validation
- Training
- Workflow identification

# Role Based Discussions



## Registration Staff

- Discuss workflow – what do they collect, document, scan?
- How is information communicated to clinical staff?
- Do they have appointment type template? (example AWV take longer)
- What feedback on performance do they receive?
- Are they involved with huddles?

## Follow up/Care Coordination

- Discuss workflow – what do they collect, document, scan?
- What is documented in EHR?
- How are referral follow ups documented and scanned?
- What is process for documenting Health Related Social Needs referrals – and how is that ongoing follow up?
- What feedback on performance do they receive?
- Are they involved with huddles?

## Medical Assistant/Intake

- Discuss workflow – what do they collect, document, scan?
- How is “positive” information communicated to clinical staff?
- Do they have template or standard for what to collect? (Health Related Social Needs, Depression, etc)
- Do they have tools to identify care gaps?
- Are they involved with huddles?
- Standing orders?
- What do they do if the patient says they visited ED or another specialist?
- What feedback on performance do they receive?

## Provider Staff

- Discuss workflow – what do they collect, document, review
- How is information communicated to clinical staff?
- Do they have appointment type template? (example AWV take longer)
- What feedback on performance do they receive?
- Are they involved with huddles?

# Custom Builds Based on Center Needs



**2025 Nursing Report Card**

REPORT

PERIOD: March 2025 | RENDERING PROVIDERS: All Rendering Provid...

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

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	GAP	TO TARGET
BMI Calculated	99.6%	Not Set	1,020	1,024	4	
Screening for Depression (CMS 2v12 Modified)	97.6%	75.0%	564	578	14	0
Tobacco Use: Screening and Cessation (CMS 138v12)	99.4%	84.9%	781	786	5	0
Colorectal Cancer Screening (CMS 130v12)	40.2%	41.1%	196	487	291	5
Cervical Cancer Screening (CMS 124v12)						
AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement						
Breast Cancer Screening Ages 50-74 (CMS 125v12)						
Diabetes A1c > 9 or Untested (CMS 122v12)						

Capstone Office Manager D...

**Agpts Per Da**  
WI 02/18/25 02/22/25

**No Show Appointments by We**  
WI 02/18/25 02/22/25

**Copy Collections at Wt**  
February 2025

**Hospital FU by**  
WI 02/18/25

**Encounter Trends - Primary Care**  
February 2025

**No Show Appointments**  
February 2025

**Same Day Appointment**  
February 2025

**Open Referrals Year to Da**  
2025

**Quality Measure Scores**  
February 2025

MEASURE	RESULT	GAP	TO GO
Medicare ADV	18.0%	291	25
Childhood Imritz Status (CMS 117v12)	15.4%	77	0
Breast Cancer Screening (CMS 125v12)	36.7%	331	49
Cervical Cancer Screening (CMS 124v12)	42.4%	543	81
Colorectal Cancer Screening (CMS 130v12)	21.2%	602	0
HIV Screening (CMS 146v4)	72.0%	708	76
Dep Screen & Follow (CMS 2v13)	62.7%	536	0
Tobacco Use Screening & Cessation (CMS 138v12)	86.7%	341	260
DM A1c > 9 or Untested (CMS 122v12)	27.7%	152	28
HTN Controlling High BP (CMS 166v12)	56.7%	379	0
Statin Therapy CVD (CMS 147v12)	88.1%	76	45

**Active Patients No Visits in Last**  
February 2025  
79.8%

**Financial Clas**  
February 2025

FINANCIAL CLASS	VISITS
Medicaid	2,574
Uninsured	1,532
Private Insurance	497
Dual Eligible Medicare and Medicaid	224
Other Public (CHIP)	35

**No Show by Service Li**  
February 2025

**Encounter by Locat**  
February 2025

RENDERING LOCATIONS	VISITS
...	1,066
...	526
...	414
...	416
...	384
...	340
...	291
...	280
...	260
...	267

**Controlled Hypertension Ra**  
2025  
Center Average: 42%  
Network Average: 61%  
Best Center: 72%

**Diabetes A1C over 9**  
2025  
Center Average: 45%  
Network Average: 34%  
Best Center: 34%

**Cervical Cancer Screening R**  
2025  
Center Average: 39%  
Network Average: 34%  
Best Center: 61%

**Colon Cancer Screening R**  
TY February 2025  
Center Average: 39%  
Network Average: 34%  
Best Center: 61%

**Breast Cancer Screening R**  
2025  
Center Average: 32%  
Network Average: 38%  
Best Center: 38%

# Custom Nursing Scorecard



2025 Nursing Report Card REPORT

FILTER ^



PERIOD  
March 2025

RENDERING PROVIDERS  
All Rendering Provid...

+ Add Filter



Update

GROUPING  
No Grouping

TARGETS  
Primary Secondary Not Met

REPORT FORMAT  
Scorecard

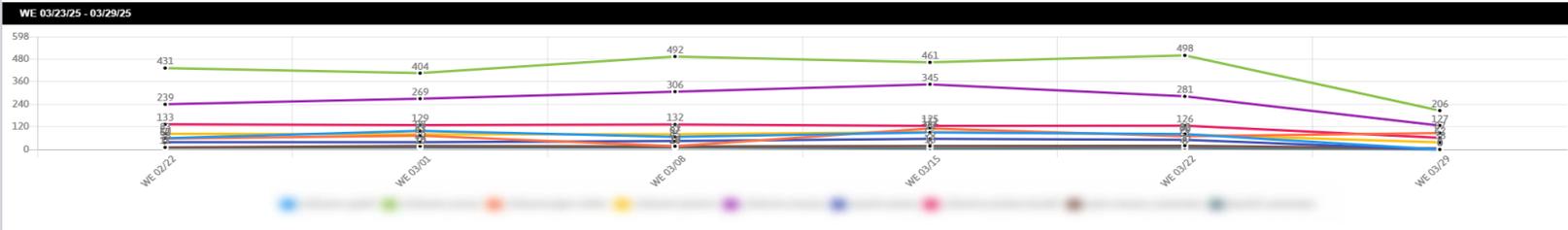
MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	GAP	TO TARGET	
<span>i</span> BMI Calculated	99.7%	Not Set	1,503	1,507	4		
<span>i</span> Screening for Depression (CMS 2v12 Modified)	98.6%	75.0%	821	833	12	0	
<span>i</span> Tobacco Use: Screening and Cessation (CMS 138v12)	99.2%	84.9%	1,155	1,164	9	0	
<span>i</span> Colorectal Cancer Screening (CMS 130v12)	41.0%	41.1%	286	697	411	1	
<span>i</span> Cervical Cancer Screening (CMS 124v12)	56.7%	54.9%	255	450	195	0	
<span>i</span> AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement	84.4%	50.0%	152	180	28	0	
<span>i</span> Breast Cancer Screening Ages 50-74 (CMS 125v12)	59.1%	52.4%	179	303	124	0	
<span>i</span> Diabetes A1c > 9 or Untested (CMS 122v12)	27.0%	29.0%	92	341	92	0	

# Custom Front Desk Dashboard

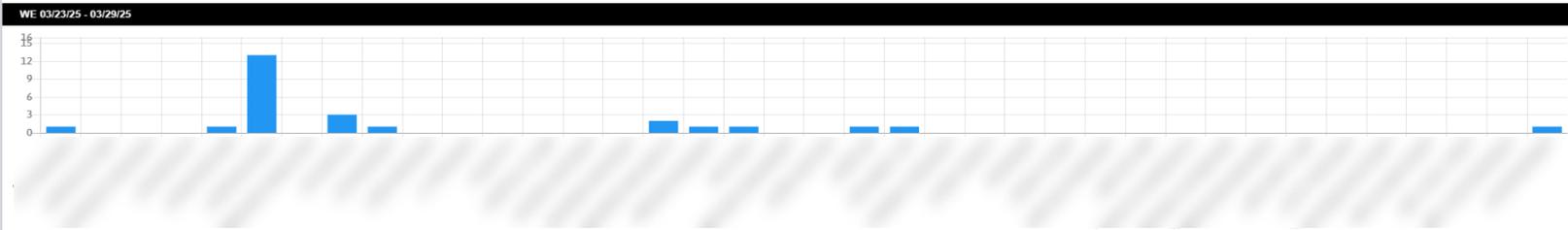
Office Manager Dashboard



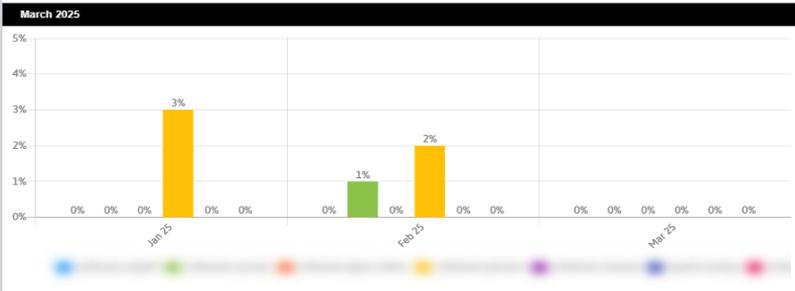
Appts Per Da



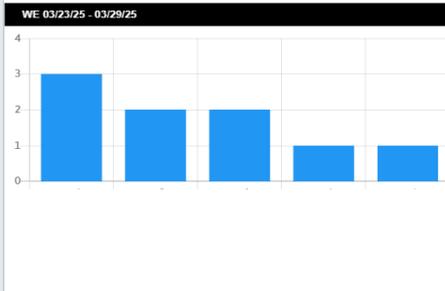
No Show Appointments by We



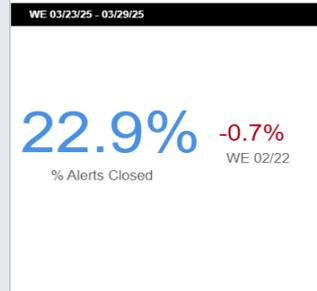
Copy Collections at Vi:



Hospital FU by Wee



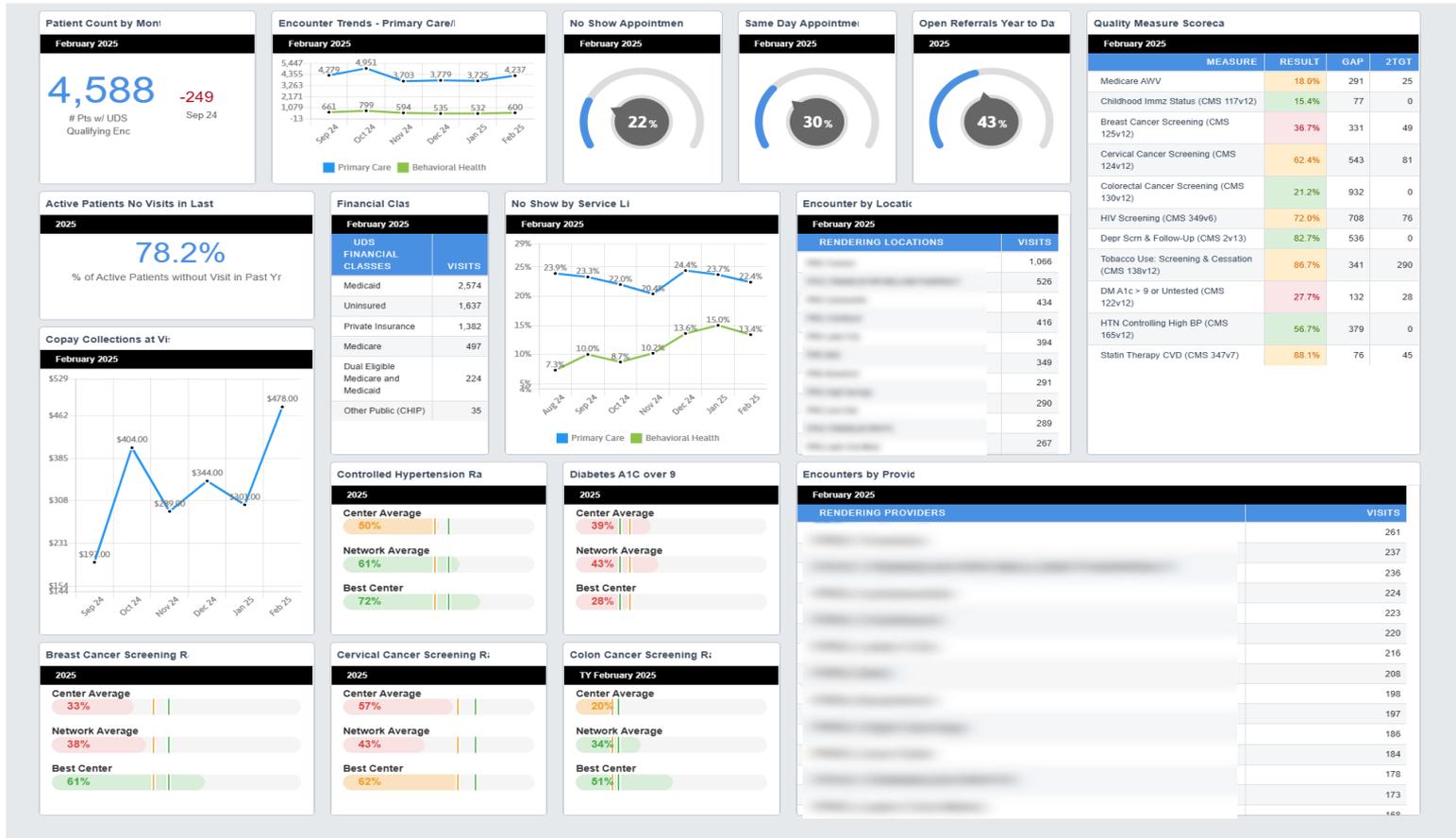
FPL Alert Closure Ra



# Custom CEO Monthly Dashboard



## Dashboard - APHCA

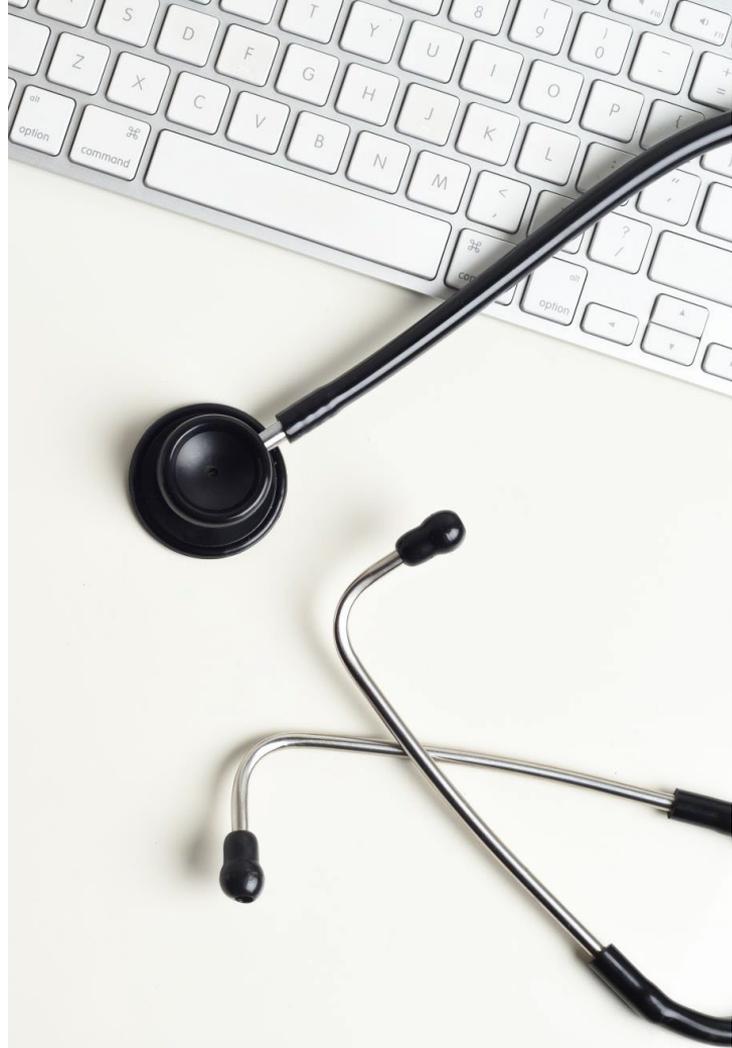




# Lessons Learned

# Lessons Learned

- Train, train, and more train
- Easy to overwhelm staff again
- When possible, face-to-face is best
- Competing priorities will always exist
- Start with low-hanging fruit
- Momentum is built when you can show wins early!





**“Continuous improvement is better than delayed perfection.”**

-Mark Twain



We Are

APHCA

CONTACT US



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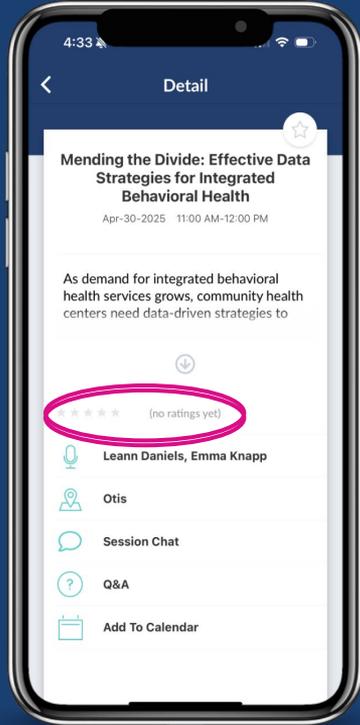
Questions?



# 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)



Help us continue to improve

# 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.

### 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
- Potential to be featured at next year's Azara User Conference
- Win Azara swag!

Submit your success story by completing the form [at this link](#).

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**ACE Program**



# azara2025

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# Thanks for attending!

