azara
USER CONFERENCE
APR 29–MAY 1
BOSTON, MA
2025

Navigating the Data Maze

Strategies for Quality Improvement to Enhance Patient Outcomes

Today’s Presenters

Sydney Benton
Ambulatory Quality Manager
Eskenazi Health Center

Amanda Horton
Quality Improvement Specialist
Cherry Health Services

Kristin Batts
Director of Quality and Informatics
Cherry Health Services

Today’s Agenda

Quality Action Plans (QAPs)
Eskenazi Health Center

Expanding Quality Using DRVS
Cherry Health Services

Q&A
Ask away!

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Quality Action Plans (QAPs) at Eskenazi Health Center

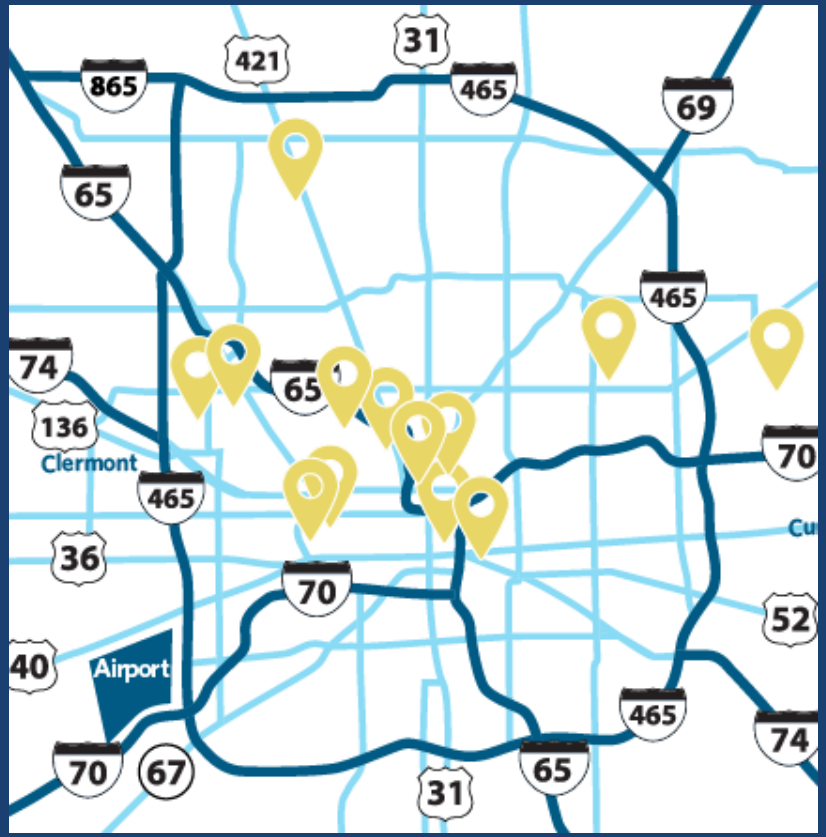
PRESENTED BY

Sydney Benton

Ambulatory Quality Manager

Eskenazi Health Centers

- Patients: 111,196 (UDS 2024)
- Encounters: 397,793 (2024)
- 13 FQHC sites, 2 School-Based Health
- Services offered:
  - Primary Care
  - OBGYN
  - Teen Care
  - Dental
  - Optometry



Ambulatory Quality Team

Health centers and service lines are split amongst QI Coordinators/Analyst.

Quality measures are divided so that each team member has their “specialty”.

The QI team member is point person for QI in their assigned clinics and metrics.

Left to Right: Sydney (Ambulatory Quality Manager), Jenn (Chief Data Officer), McKenna (QI Coordinator), Derek (QI Coordinator), Courtnie (Clinical QI Coordinator), Tammy (QI Analyst), Rhea (QI Intern)

Quality Before QAP

Quarterly meetings with health centers' Quality Champion Teams (multidisciplinary team of leadership, physician leader, nurses, and medical assistants)

Posted data on announcement boards in health centers

Monthly newsletter with data attached

Quality Best Practice guide

Quality Action Plan

I. Quality Measures

Metric	YTD Avg	Current Month	Notes	Action Recommended (including Best Practice Reinforcement)	Action Performed
Kudos			Increases from last quarter, celebrate improved understanding from the clinic teams, etc.		
Measure Opportunities					

II. Utilization (Pulled from Azara)

Pull Azara TOC report for past 30 days for the specific clinic.

Patient	DX	# of Encounters (Last 6 months)	Notes	Action Recommended	Action Performed
Patient MRN and Name			Last PCP appointment, any previous patient outreach attempts, etc.		

III. Incentive Program Status

Metric	Goal	YTD	Notes: Specific patients that have opportunity to meet goal with quick action	Action Recommended (including Best Practice Reinforcement)	Action Performed
SDOH- Food Insecurity Screening					
Colorectal Cancer Screening					
Childhood Immunization Status					

I | Quality Measures

- ☑ Kudos – celebrate the wins!
- ☑ Opportunities for Improvement (OFIs) with recommended actions
- ☑ Monitoring data of current QI interventions
- ☑ General QI recommendations
  - Best practice reinforcement
  - Rounding with staff
  - Elbow-to-elbow training
  - Staff meeting education

Identifying Kudos and OFIs

Report: UDS 2024 CQMs filtered by Rendering Location

MEASURE	RESULT	CHANGE	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS
Childhood Immunization Status (CMS 117v12)	35.8%	+ 4.5% ▲	42.1%	190	531	0
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v12)	71.8%	+ 54.3% ▲	96.1%	2,527	3,519	8
BMI Screening and Follow-Up 18+ Years (CMS 69v12)	69.5%	+ 34.2% ▲	96.2%	3,177	4,574	1,012
Depression Remission at Twelve Months (CMS 159v12)	6.1%	+ 2.3% ▲	23.1%	6	98	14
Screening for Depression and Follow-Up Plan (CMS 2v13)	85.7%	+ 11.6% ▲	94.3%	5,837	6,813	98
Tobacco Use: Screening and Cessation (CMS 138v12)	90.8%	- 0.3% ▼	99.0%	5,078	5,594	0
Colorectal Cancer Screening (CMS 130v12)	69.0%	+ 4.3% ▲	68.3%	1,716	2,488	49
Cervical Cancer Screening (CMS 124v12)	80.1%	+ 2.6% ▲	79.2%	2,456	3,068	251
Breast Cancer Screening Ages 50-74 (CMS 125v12)	73.0%	+ 5.0% ▲	80.3%	732	1,003	19
Hypertension Controlling High Blood Pressure (CMS165v12)	48.1%	+ 31.5% ▲	83.7%	905	1,883	148
Diabetes A1c > 9 or Untested (CMS 122v12)	32.1%	+ 0.7% ▲	11.6%	418	1,301	17
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v7)	56.3%	- 0.6% ▼	89.8%	1,548	2,752	53
IVD Aspirin Use (CMS 164v7.2)	80.6%	- 1.2% ▼	91.5%	141	175	30
HIV Screening (CMS 349v6)	80.4%	+ 5.9% ▲	94.3%	4,643	5,778	37

Quality Action Plan

I. Quality Measures

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Colorectal Cancer Screening					
Childhood Immunization Status					

II | Utilization

Identify patients who have:

High ED/IP utilization
High risk stratification
Poorly managed chronic conditions
Not seen their PCP in over 1 year

Data from:

Azara Transition of Care (TOC) Report
Epic chart search
    SDOH and Care Gap Analysis

Finding Patients for Outreach

Report: Transitions of Care (TOC) - ED/IP

ADMISSION EVENT					
TYPE	ADMISSION	DISCHARGE ↑	FACILITY	ED VISITS LAST 6 MONTHS	IP VISITS LAST 6 MONTHS
ER Visit	2/1/25 6:34 pm	2/2/25 1:25 am	Eskenazi Health	3	1
ER Visit	2/2/25 1:23 am	2/2/25 4:58 am	Eskenazi Health	1	0
ER Visit	2/2/25 2:30 am	2/2/25 5:26 am	Eskenazi Health	2	0
ER Visit	2/2/25 6:17 am	2/2/25 8:24 am	Eskenazi Health	2	0
ER Visit	2/2/25 6:58 am	2/2/25 8:46 am	IU Health	1	0
ER Visit	2/2/25 9:14 am	2/2/25 10:18 am	Eskenazi Health	3	0
ER Visit	2/2/25 8:27 am	2/2/25 11:15 am	Eskenazi Health	1	0
ER Visit	2/2/25 10:40 am	2/2/25 11:54 am	Riverview Hospital	2	0
ER Visit	2/2/25 10:31 am	2/2/25 12:01 pm	IU Health	2	0
ER Visit	2/2/25 10:32 am	2/2/25 12:33 pm	Eskenazi Health	1	0
ER Visit	2/2/25 3:00 am	2/2/25 12:37 pm	IU Health	14	1
ER Visit	2/2/25 9:21 am	2/2/25 1:51 pm	Eskenazi Health	2	0

TOC ED/IP Report Cont.

DIAGNOSIS		NEXT APPOINTMENT				
CODE	DESCRIPTION	NEXT APPOINTMENT	TYPE	RISK	HIE	RISKSCORE
I71.43	Infrarenal abdominal aortic aneurysm, without rupture			Moderate	IHIE	13
N30.00	Acute cystitis without hematuria	4/1/2025	RETURN GYN	Low	IHIE	0
R07.9	Chest pain, unspecified	4/23/2025	NEW ADULT	Low	IHIE	1
R20.0	Anesthesia of skin	5/12/2025	RETURN ADULT	Moderate	IHIE	11
				Low	IHIE	0
L73.9	Follicular disorder, unspecified			High	IHIE	26
H66.009	Acute suppurative otitis media without spontaneous rupture ...	4/16/2025	RETURN PEDIATRIC	Low	IHIE	0
N30.00	Acute cystitis without hematuria			Low	IHIE	5
		5/23/2025	RETURN GYN	Low	IHIE	0
J06.9	Acute upper respiratory infection, unspecified				IHIE	
				Moderate	IHIE	11
N20.1	Calculus of ureter			High	IHIE	22
B20	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE	5/9/2025	PC MH MD FOLLO...	High	IHIE	19
Z48.89	Encounter for other specified surgical aftercare			Low	IHIE	5
H57.89	OTHER SPECIFIED DISORDERS OF EYE AND ADNEXA	3/26/2025	NEW GYN	Low	IHIE	7

SDOH and Care Gaps *(Epic)*

Actions Recommended

Available at Eskenazi Health

- Mental health services
- Social work referrals
- Community health workers
- Ancillary services

Outside Resources

- Transportation
- Food pantry referrals
- WIC and other MCPHD referrals
- MCE programs

Utilization | Patient Example

High risk- 17: Hypertension, Hyperlipidemia, Cirrhosis, Diabetes, SAD/SUD, Severe Mental Illness, Depression, 1-3 SDOH risk factors, elevated LDL, PHQ-9 >=16

17 ED visits, 1 IP in last 6 months: Epigastric pain, UTI, Abdominal Pain, Elevated WBC, Diabetes, Hyperlipidemia

Outreach	Preparation	Outcome
Last PCP visit over 1 year ago, visit scheduled with PCP	Prioritize “robust call” and pre-visit planning for upcoming visit	Optometry referral Glucose monitor ordered Labs completed Depression screen Medications Updated Visited ED only 2 times since PCP visit

Quality Action Plan

I. Quality Measures					
Metric	**YTD Avg**	**Current Month**	**Notes**	**Action Recommended (including Best Practice Reinforcement)**	**Action Performed**
Kudos			Increases from last quarter, celebrate improved understanding from the clinic teams, etc.		
Measure Opportunities					
II. Utilization (Pulled from Azara)			**Pull Azara TOC report for past 30 days for the specific clinic.**		
Patient	**DX**	**# of Encounters (Last 6 months)**	**Notes**	**Action Recommended**	**Action Performed**
Patient MRN and Name			Last PCP appointment, any previous patient outreach attempts, etc.		

III. Incentive Program Status					
Metric	**Goal**	**YTD**	**Notes: Specific patients that have opportunity to meet goal with quick action**	**Action Recommended (including Best Practice Reinforcement)**	**Action Performed**
SDOH- Food Insecurity Screening					
Colorectal Cancer Screening					
Childhood Immunization Status					

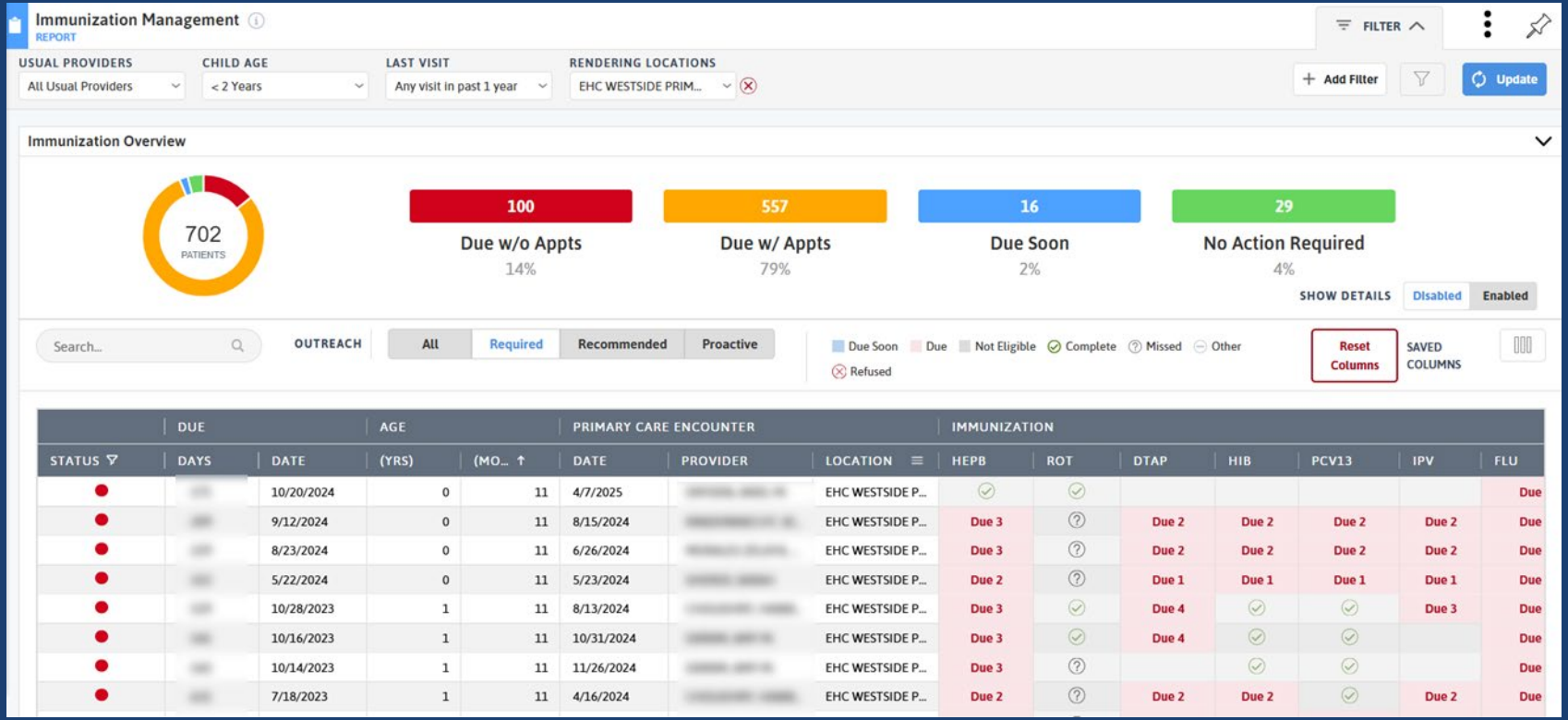
III | Prioritized Metrics

Monthly progress monitoring & manageable outreach lists

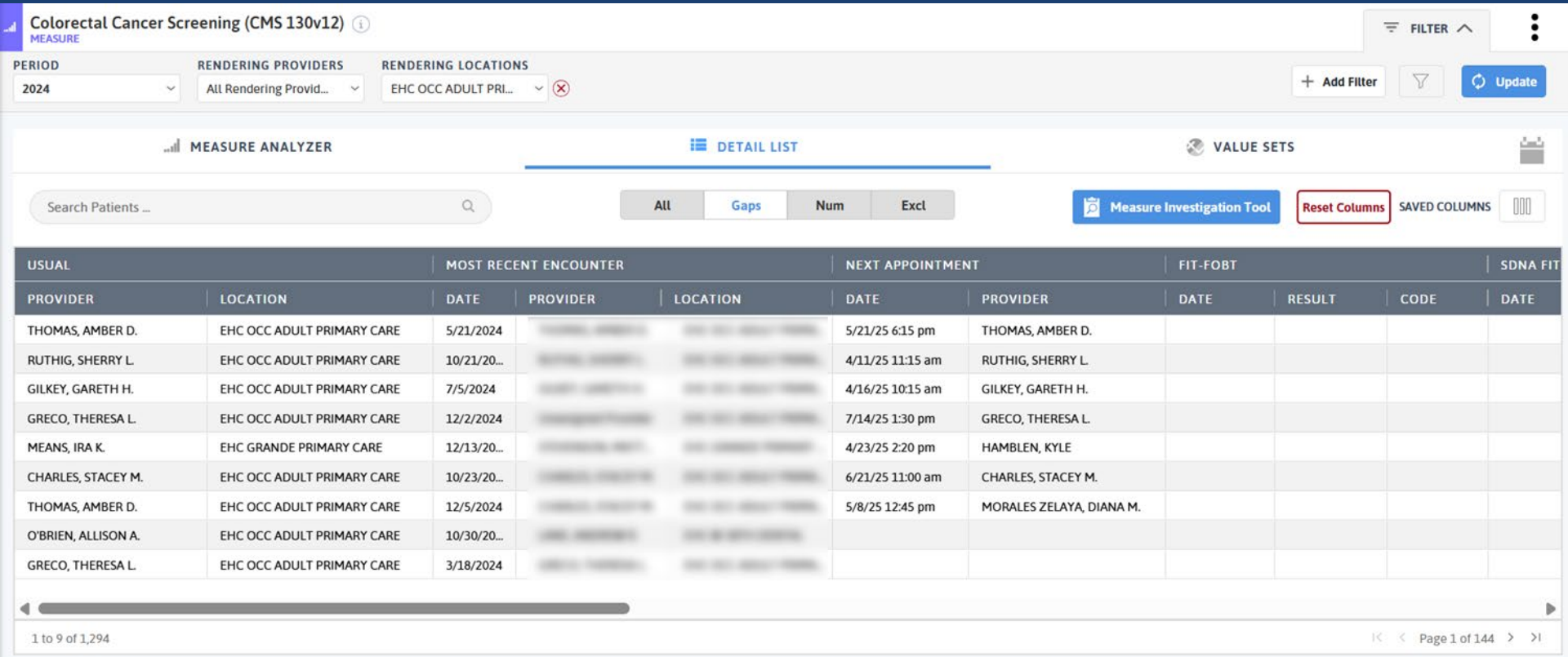
2024	2025
CMS 117 Childhood Immunization Status	Adult Access to Preventative Care
CMS 130 Colorectal Cancer Screening	Well Child Visit 0-15 months
SDOH Food Insecurity Screening	SDOH Food Insecurity Z-Code Added

Immunizations

Report: Immunization Management

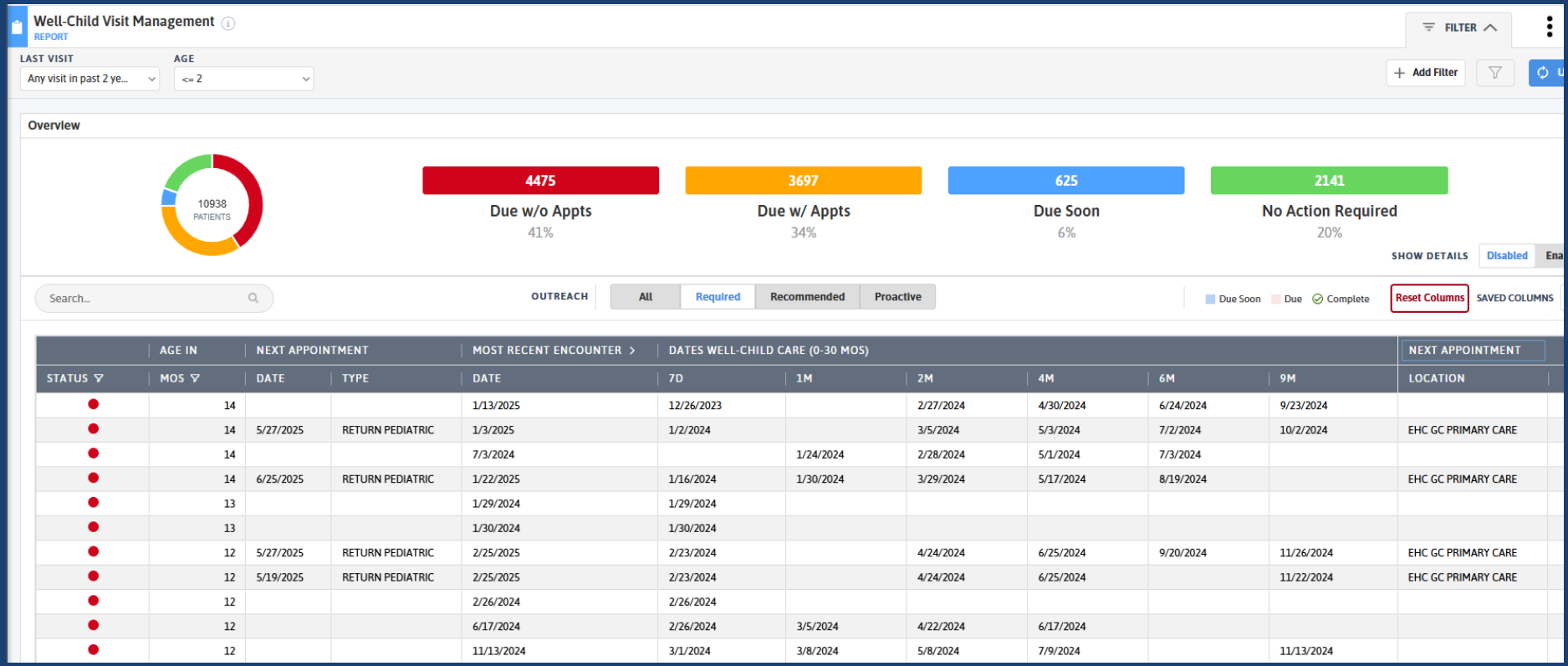


Colorectal Cancer Screening



Well Child Visits (0-15mos)

Report: Well-Child Visit Management



	AGE IN	NEXT APPOINTMENT		MOST RECENT ENCOUNTER >	DATES WELL-CHILD CARE (0-30 MOS)						NEXT APPOINTMENT
STATUS	MOS	DATE	TYPE	DATE	7D	1M	2M	4M	6M	9M	LOCATION
●	14			1/13/2025	12/26/2023		2/27/2024	4/30/2024	6/24/2024	9/23/2024	
●	14	5/27/2025	RETURN PEDIATRIC	1/3/2025	1/2/2024		3/5/2024	5/3/2024	7/2/2024	10/2/2024	EHC GC PRIMARY CARE
●	14			7/3/2024		1/24/2024	2/28/2024	5/1/2024	7/3/2024		
●	14	6/25/2025	RETURN PEDIATRIC	1/22/2025	1/16/2024	1/30/2024	3/29/2024	5/17/2024	8/19/2024		EHC GC PRIMARY CARE
●	13			1/29/2024	1/29/2024						
●	13			1/30/2024	1/30/2024						
●	12	5/27/2025	RETURN PEDIATRIC	2/25/2025	2/23/2024		4/24/2024	6/25/2024	9/20/2024	11/26/2024	EHC GC PRIMARY CARE
●	12	5/19/2025	RETURN PEDIATRIC	2/25/2025	2/23/2024		4/24/2024	6/25/2024		11/22/2024	EHC GC PRIMARY CARE
●	12			2/26/2024	2/26/2024						
●	12			6/17/2024	2/26/2024	3/5/2024	4/22/2024	6/17/2024			
●	12			11/13/2024	3/1/2024	3/8/2024	5/8/2024	7/9/2024		11/13/2024	

Delivery

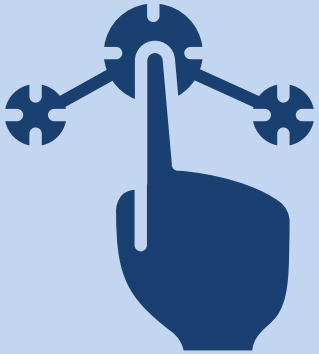
Who is typically involved in monthly meetings?

- Health center leadership
- QI Coordinator

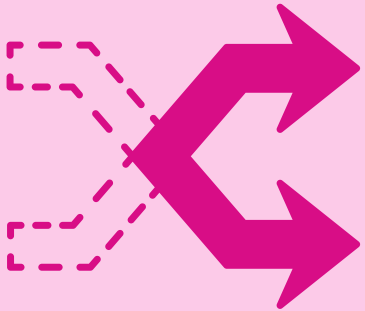
Delegation of Action Items:

- Distributing outreach lists to staff
- Secure chat to MAs/nurses to schedule patients or place referrals
- Scheduling time to do staff education
- Adding “sticky note” reminders onto charts of patients with upcoming appts

Customization



Addition of pre-birth selection patients



Changing “utilization” to “outreach”

Including additional staff in the delivery meetings

Adding the QAP to Quality SharePoint page

Quality Measures

Metric	Goal	Current Month	Notes	Action(s) Taken
Developmental Screening	87.00%	88.50%	Kudos! Throughout 2024 screening rates continued to improve and now for January (QTD) clinic has met	
Depression Screening and Follow Up	95.00%	66.00%	From my audit, it seems there needs to be training for the whole clinic not just specific MAs. Screenings are not being done for multple provider teams. PHQ 2 needs to be done every visit. Discuss intervention methods (rounding, staff meeting,	Quality Champion Team MA will discuss this measure at the staff meeting on 3/4

Utilization (Pulled from Azara TOC)

Patient	DX	# of Encounters	Notes	Action(s) Taken
MRN: 1	BH, Flu, Abdominal Pain	28 ED	Patient assigned to Dr. J through Anthem Medicaid. Last PC visit was 3/21/2022 seen for a - PC appt scheduled for 1/14/2025. Has multiple HM topics due (CCS, BCS, vaccines). Multiple SDOH concerns present. Most visits are with BH.	Pt was seen by Dr. S. Pt has a specific insurance where there can only be 1 provider and 1 pharmacy. That provider will send the medication to the approved pharmacy. Dr. S is not the assigned provider, but SW helped the patient navigate insurance to change the pcp to Dr. S. PCP-General still says Dr. J Recommend changing the PCP-General to Dr. . **Update 2/19/25**: looks like Dr. S will be the pt's PCP. Next appt scheduled in March '25 with Dr. S
MRN: 2	ESRD, HTN	11 IP	Pt has multiple SDOH concerns. There is no PCP-General identified. Discharge 1/13/25 - no follow-up appt with PCP made.	Outreach to patient via our Spanish interperter - patient scheduled for 2/10 at 1:30pm - patient confirmed appointment date/time. **Update 2/19**: patient was a no-show. Pt. in the ED again on 2/14/25
MRN: 3	COPD Acute Exacerbation	4 ED/ 10 IP	Has not been seen in PC since 2023. Has multiple HM topics due (CRC, A1c, vaccines), chronic conditions, SDOH (food, transportation) Clinic to focus PVP around patient. Transportation needs present. Scheduled for 6/12 in PC, 6/7 in cardiology, 5/16 in pulmonology.	PT was connected with transportation resources for appts.
MRN: 4	DM	1 ED / 1 IP	Pt was seen postpartum in Sept 2024, in ED Dec 2024 for epigastric pain-ED recs PCP follow up. Multiple social needs present (financial, depression). Schesdule ED follow up and consider nurse/dietitian/PharmD visit for DM mgmt	Outreach was attempted 3 times without success.

Incentive Program Status

Metric	Goal	YTD	Notes	Action(s) Taken
Well Child Visits 0-15 mo	85.00%	31.60%	**MRN**:5 - 12 mo old with 5 WCV's the 6th visit is scheduled after the patient turns 15 mo. If possible reschedule prior to 3/29/2025. Last WCV 1/2/25.	MRN: 5 - scheduled for 3/26/25
			MRN: 6 - 14 mo old with 5 WCV's. Has is an acute appt on 1/21/25. If patient keeps appt will be within the 15 mo timeframe. Recommend robust confirm this appt is with pt and adding in WCV components if appropriate.	MRN: 6 - visit for 1/21 was No Showed. Patient scheduled for 2/27 with PCP for WCC 15mo
Adult Access to Preventive Care	64.00%	27.72%	Quality sent the list of patients who haven't had a visit yet in 2025 and who did not already have an appt scheduled.	Outreach lists sorted by provider and given to their MA to complete.
SDOH- Food Insecurity Screening	70.00%	95.2% English 93.9% Non-English	Keep up the great work!	
SDOH- Food Insecurity Z Codes	50.00%	38.80%	This workflow seems to be done more consistently!	QI coordinator will check in with staff when rounding to see if they have any
Childhood Immunization Status	42.10%	24.50%	MRN: 0 (needs 1 Dtap before 4/30);	All pts are up to date on WCVs. List sent to Floor Captain to schedule nurse visit for catch up.
			MRN: 1 (needs 1 flu before 5/31); has nuse visit 3/15- watch for cancel/no show	
			MRN: 2 (needs 1 Dtap, 1 IPV, 1 PCV before 4/25);	
			MRN: 3 (needs 1 Dtap, 1 Hib, 1 flu before 4/24),	
			MRN: 4 (needs 1 Dtap, 1 Hib before 3/30)	
			MRN: 5 (needs 1 Dtap, 1 MMR, 1 Hib, 1 VCV, 1 PCV, 1 Hep A, 1 flu before 5/6)	

Lessons Learned

1. Be Flexible
   - Adapting the tool to the health centers' needs
     - Outreach lists vs. a handful of patients
   - Adapting the tool to the patients' needs
     - Communication preferences, SDOH needs, payer
2. Continuously communicate → continuous quality improvement
3. Share the "why" behind the importance of the QAP
4. Celebrate the quality wins

Gaining Clinic Buy In

Explain the “Why”

Understand & address health centers’ priorities

Set realistic expectations

Successes

Increased **collaboration** between QI and health center teams

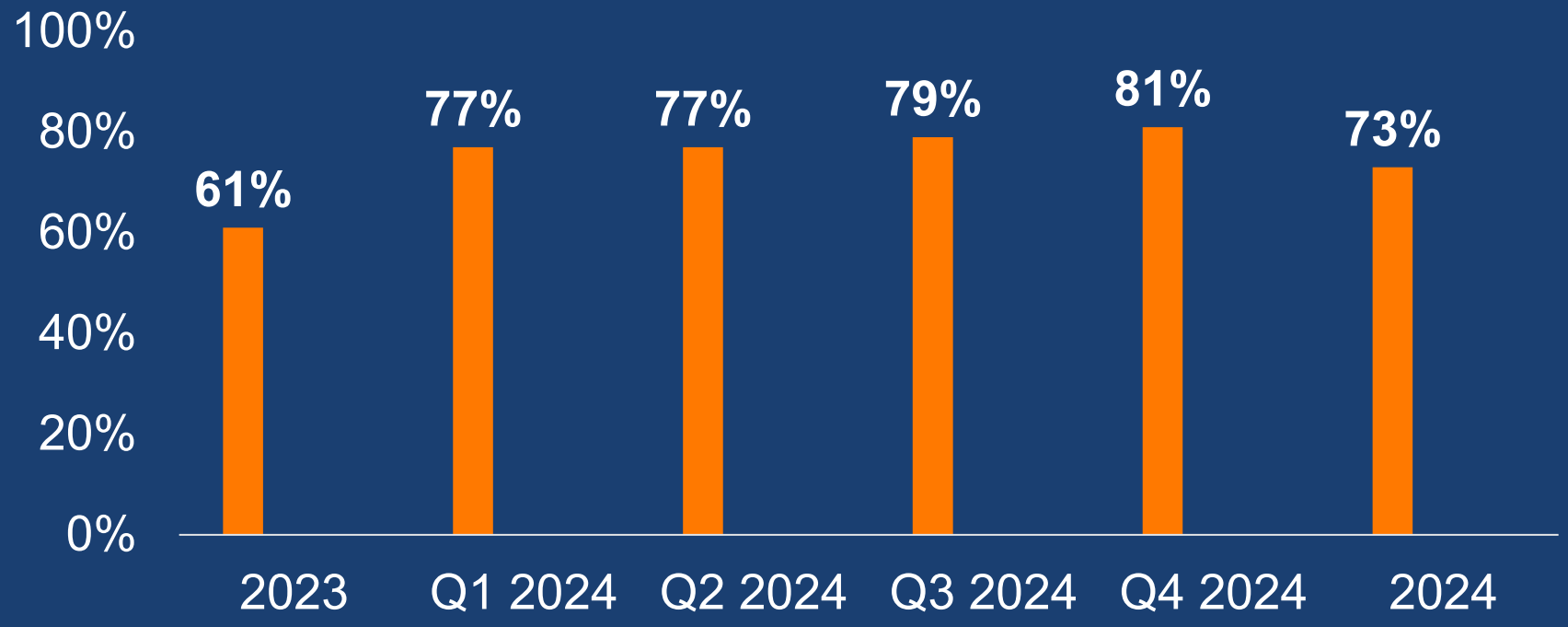
Increased **awareness** of barriers and opportunities to QI

Improved **coordination** of wrap-around services

Improved **patient outcomes**

Success in Numbers

CMS 69: Body Mass Index (BMI) Screening and Follow-Up Plan



Staff Feedback

"The monthly meetings keep us engaged. It is nice to have the monthly check in on how we are doing so we can make changes to the clinic workflows in real time. I know [QI Coordinator] will be back next month, so that keeps us accountable for making improvements."
- Health Center Manger

"I was initially assuming it was just another meeting, but [QI Coordinator] showed that there are patients we need to give more care to. We see some hospital notes in Epic from other hospitals, but I had no idea some patients had been to multiple EDs over 60 times in the past few months… Oftentimes they have SDOH needs in addition to their healthcare needs. I am glad we are able to identify and help them with all of their needs."
- Physician

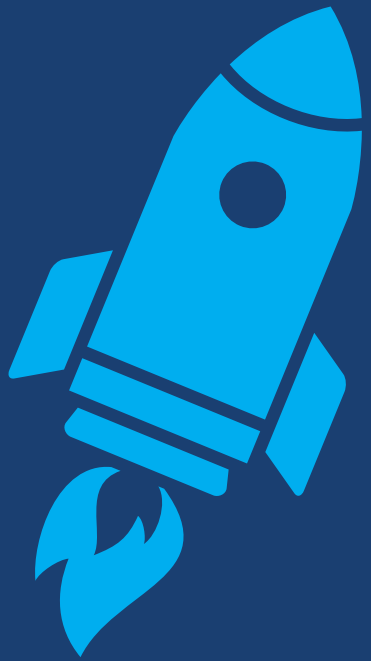
From the Quality Team

“QAP allows me to conceptualize the small, actionable steps for clinic teams to improve quality outcomes. With this tool, I can outline clearly our shared responsibilities to the quality metrics and also show the strength of our collaboration over time, since I am always building on what we did the previous month.”

“I like the High Utilizer section because it identifies patients who are at high risk for many health conditions and allows us to reach out to address all the issues whether that's scheduling them for a PCP appt, having a CHW come to the home, or having a SW help them with transportation etc. It is a way for me to do something that leads to helping better a patient’s wellbeing”

“I like that QAPs help me and the clinics visualize quality as individual patient care, rather than just percentages and goals. I feel like so often the clinics see quality as just numbers when really each of those "numbers" is a patient that didn't get the care they needed/deserved from us”

Future Growth Opportunities



Using Azara **cohorts** to track high ED/IP utilizers who have been on past QAPs

QAP expansion to **more service lines**

- Optometry
- Dental
- Teen Care
- Behavioral Health
- OB/GYN
- Podiatry

Expanding Quality at Cherry Health

PRESENTED BY

Amanda Horton
Quality Improvement Specialist

Kristin Batts, LMSW
Director of Quality and Informatics

Who We Are | Cherry Health

Michigan’s largest FQHC, located in Grand Rapids

20 locations across 6 counties

Services provided:

- Primary Care
- Behavioral Health
- Dental
- Vision
- Women’s Health
- Pediatrics
- School-Health Programs
- Pharmacy

Prior State | Quality at Cherry Health

Managing many different reporting requirements, population health priorities, and value-based care contracts:

Quality Work & Stakeholders

- HRSA
- NCQA PCMH
- MPCA
- AAAHC

Population Health & Health Plans

- Priority Health
- United Healthcare
- Blue Cross Blue Shield
- Meridian
- Molina
- McLaren
- Humana

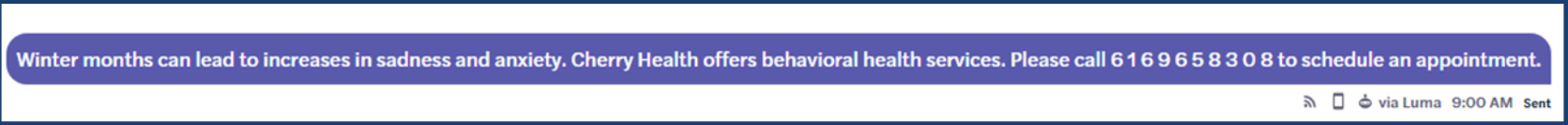
Current State | Advancing Quality Using DRVS

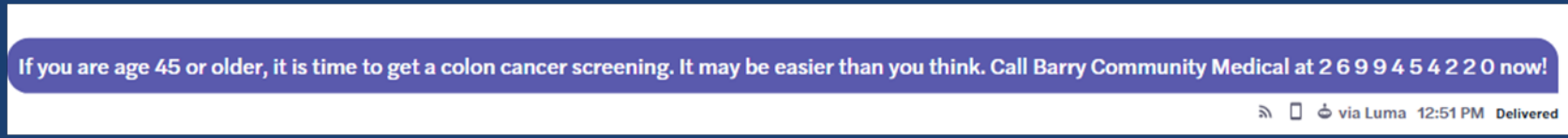
- [x] Not Met Lists – Patient Outreach
- [x] Quality Scorecards
- [x] Clinician Report Cards
- [x] Benchmarking across the state

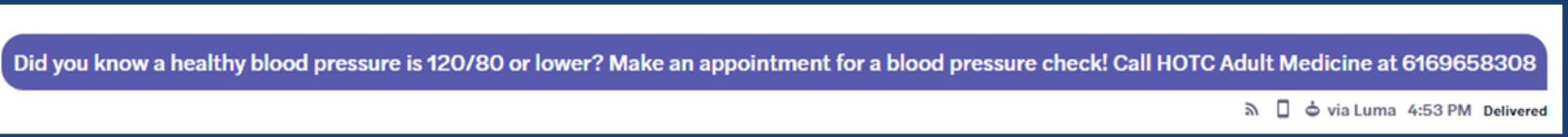
Not Met Lists | Patient Outreach

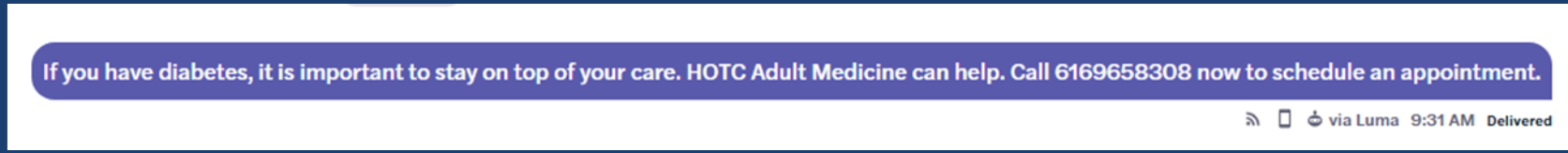
Gap Count	Gap Description	BMI Screen & Follow-Up 18+ (CMS 69v12)	Child Weight Assessment (CMS 155v12)	Depr Scrn & Follow-Up (CMS 2v13)	Childhood Immz Status (CMS 117v12)	HTN Controlling High BP (CMS 165v12)	Cervical Cancer Screening (CMS 124v12)	Colorectal Cancer Screening (CMS 130v12)	DM A1c > 9 or Untested (CMS 122v12)	Tobacco Use: Screening & Cessation (CMS 138v12)	DM Nephropathy	Lead Screening	Chlamydia Screening (CMS 153v12)	Breast Cancer Screening (CMS 125v12)
6	Colo, Tobacco Scrn, DM Urine Protein, Mammo, DM Eye							Gap		Gap	Gap			Gap
5	Colo, DM A1C, DM Eye							Gap	Gap					
5	Depr Scrn, Pap HPV, Colo, Mammo			Gap			Gap	Gap						Gap
5	HTN BP, Colo, DM A1C, Tobacco Scrn, DM Eye					Gap		Gap	Gap	Gap				
4	Colo, DM Eye							Gap						
4	DM A1C, DM Eye								Gap					
4	Pap HPV, Colo, Tobacco Scrn, Mammo						Gap	Gap		Gap				Gap
4	BMI & Follow-Up, Depr Scrn, Colo, Tobacco Scrn	Gap		Gap				Gap		Gap				
4	Colo, DM Eye							Gap						
4	DM A1C, Tobacco Scrn, DM Urine Protein								Gap	Gap	Gap			

Gap Lists | Luma Messaging



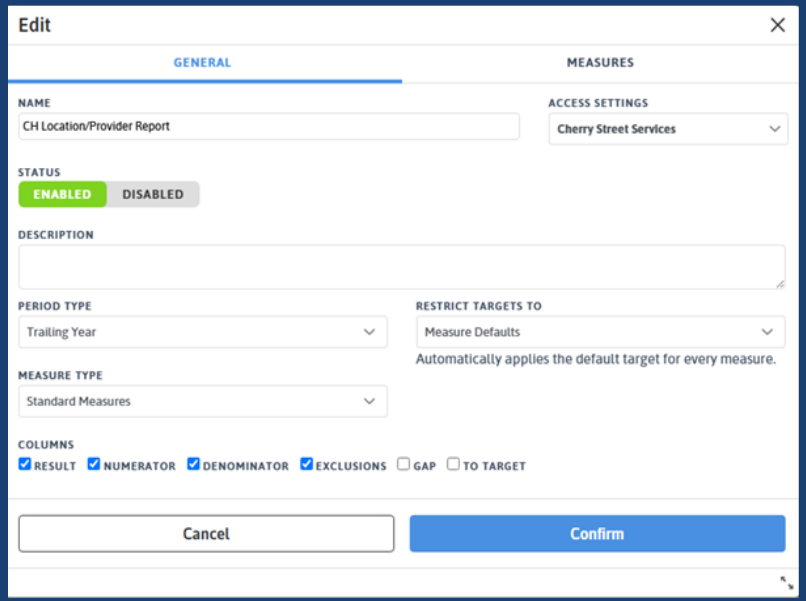


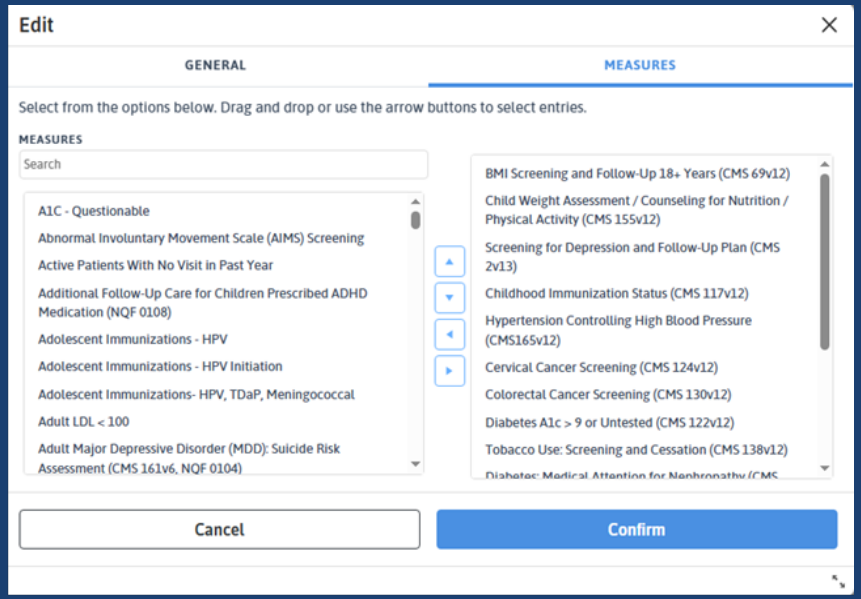




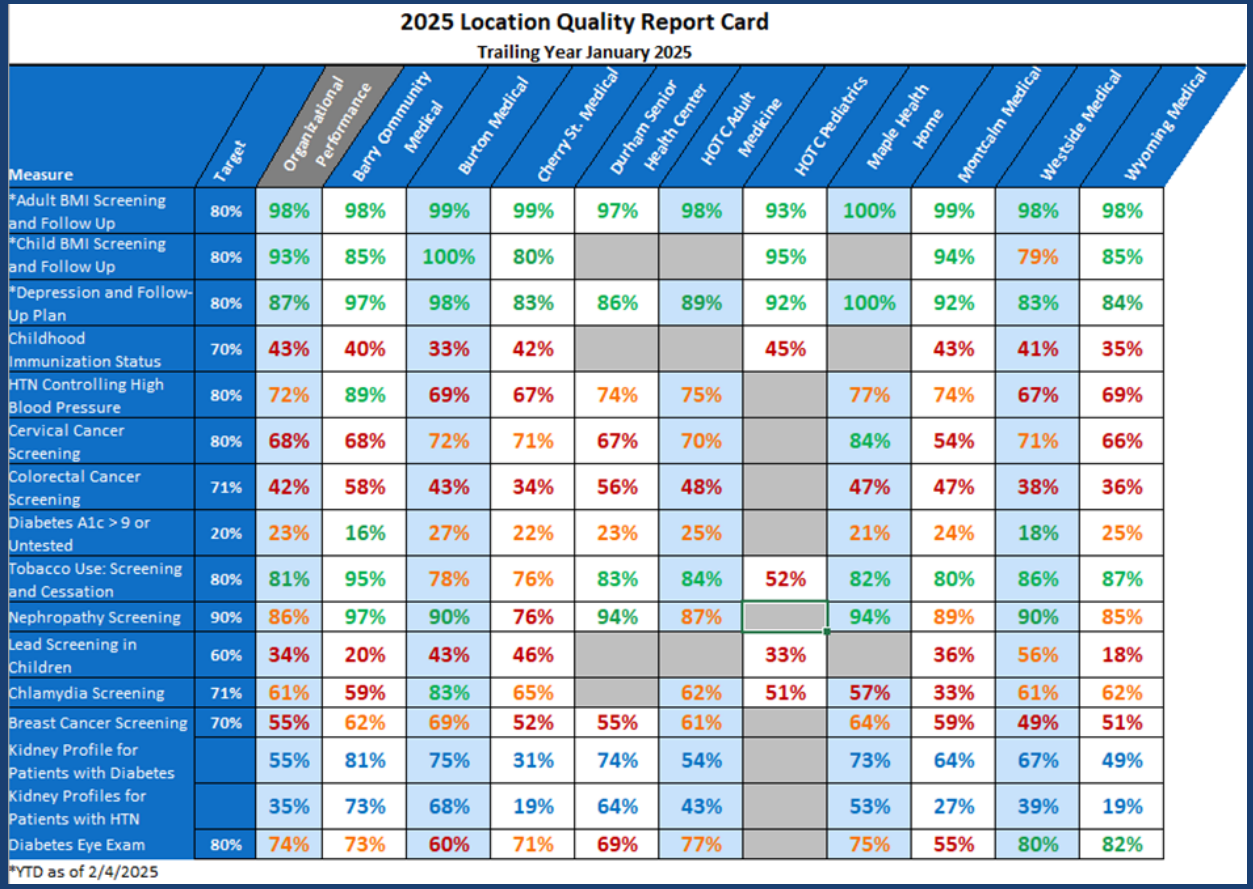
Quality Report Cards

- Created a custom scorecards with prioritized measures
- Distribute monthly to clinical and site leadership





Quality Report Card | Location



2025 Location Quality Report Card

Trailing Year January 2025

Measure	Target	Organizational Performance	Barry Community Medical	Burton Medical	Cherry St. Medical	Durham Senior Health Center	HOT C Adult Medicine	HOT C Pediatrics	Maple Health Home	Montcalm Medical	Westside Medical	Wyoming Medical
*Adult BMI Screening and Follow Up	80%	98%	98%	99%	99%	97%	98%	93%	100%	99%	98%	98%
*Child BMI Screening and Follow Up	80%	93%	85%	100%	80%			95%		94%	79%	85%
*Depression and Follow-Up Plan	80%	87%	97%	98%	83%	86%	89%	92%	100%	92%	83%	84%
Childhood Immunization Status	70%	43%	40%	33%	42%			45%		43%	41%	35%
HTN Controlling High Blood Pressure	80%	72%	89%	69%	67%	74%	75%		77%	74%	67%	69%
Cervical Cancer Screening	80%	68%	68%	72%	71%	67%	70%		84%	54%	71%	66%
Colorectal Cancer Screening	71%	42%	58%	43%	34%	56%	48%		47%	47%	38%	36%
Diabetes A1c > 9 or Untested	20%	23%	16%	27%	22%	23%	25%		21%	24%	18%	25%
Tobacco Use: Screening and Cessation	80%	81%	95%	78%	76%	83%	84%	52%	82%	80%	86%	87%
Nephropathy Screening	90%	86%	97%	90%	76%	94%	87%		94%	89%	90%	85%
Lead Screening in Children	60%	34%	20%	43%	46%			33%		36%	56%	18%
Chlamydia Screening	71%	61%	59%	83%	65%		62%	51%	57%	33%	61%	62%
Breast Cancer Screening	70%	55%	62%	69%	52%	55%	61%		64%	59%	49%	51%
Kidney Profile for Patients with Diabetes		55%	81%	75%	31%	74%	54%		73%	64%	67%	49%
Kidney Profiles for Patients with HTN		35%	73%	68%	19%	64%	43%		53%	27%	39%	19%
Diabetes Eye Exam	80%	74%	73%	60%	71%	69%	77%		75%	55%	80%	82%

*YTD as of 2/4/2025

Quality Report Card | Clinician

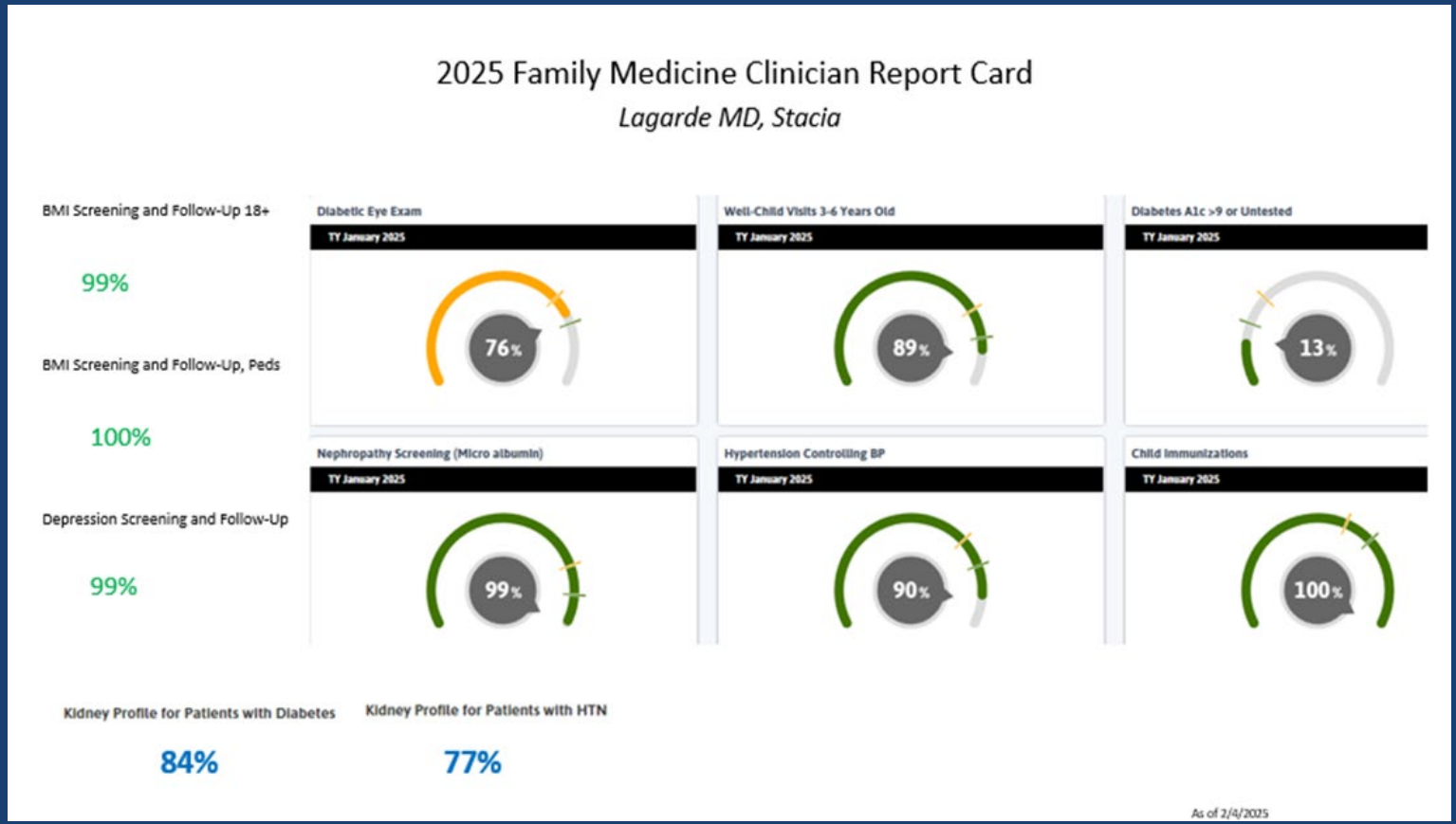
2025 Provider Quality Report Card

Trailing Year January 2025

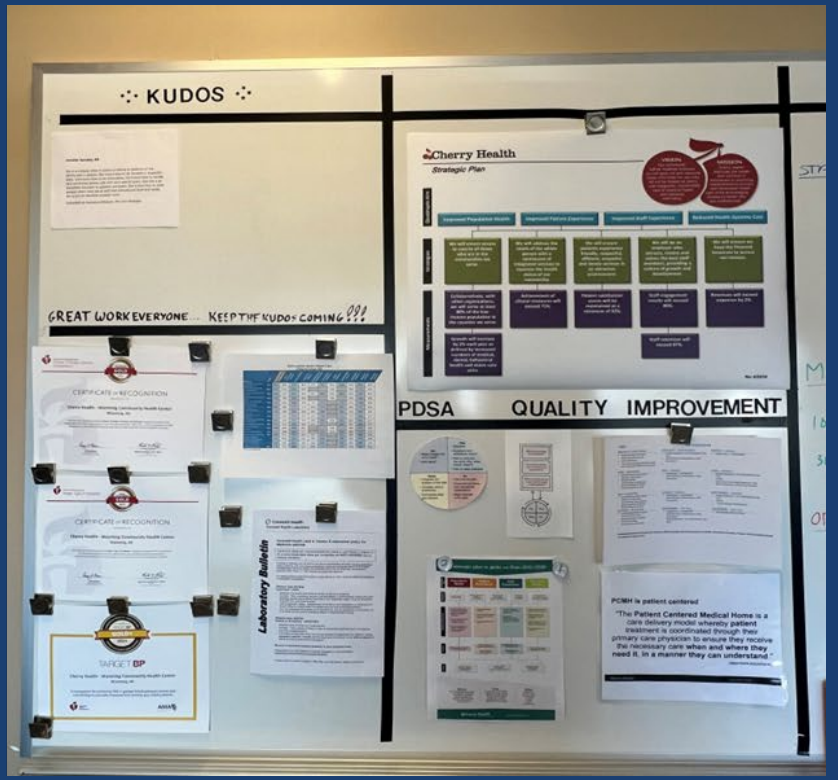
Providers	*Adult BMI Screening and Follow Up Target:80%	*Child BMI Screening and Follow Up Target:80%	*Depression and Follow-Up Plan Target:80%	Childhood Immunizations Target:70%	HTN Controlling High Blood Pressure Target:80%	Cervical Cancer Screening Target:80%	Colorectal Cancer Screening Target:71%	Diabetes A1c > 9 or Untested Target:20%	Tobacco Use: Screening and Cessation	Nephropathy Screening Target:86%	Lead Screening Target:60%	Chlamydia Screening Target-71	Breast Cancer Screening Target-70%	Kidney Profile for Patients with DM	Kidney Profile for Patients with HTN	Diabetes Eye Exam Target: 80%
Organizational Performance	98%	93%	87%	43%	72%	68%	42%	23%	81%	86%	34%	61%	55%	55%	35%	74%
Abbgy, Nicole	99%		85%		68%	63%	37%	27%	80%	77%		47%	51%	32%	27%	77%
Barrett, Kimberly	99%	100%	97%	33%	68%	72%	43%	28%	77%	89%	43%	81%	69%	75%	67%	59%
Bates, Maribel		95%	100%	58%					77%		31%	23%				
Boonstra, Leslie	99%		78%		62%	79%	42%	15%	81%	95%		66%	71%	70%	58%	77%
Bush, Jenny		98%	97%	35%					41%		30%	41%				
Dykstra, Devan	100%	96%	94%	55%	71%	68%	40%	25%	86%	75%	73%	52%	54%	14%	13%	86%
Gary, Ashley	100%	85%	91%	60%	70%	75%	41%	15%	93%	85%	40%	54%	49%	65%	32%	78%
Gerleman, Rachel	98%	73%	80%	11%	67%	78%	31%	31%	66%	80%	25%	63%	56%	62%	29%	69%
Hansen, Lora	100%	94%	96%	71%	76%	50%	46%	15%	84%	92%	43%	31%	58%	63%	26%	56%
Hidalgo, Nicole		94%	90%	45%					18%		34%	70%				
Hoffman, Hannah	99%	93%	86%	50%	71%	60%	50%	34%	76%	84%	50%	26%	64%	67%	27%	53%
Kallio, Jerrica	95%	76%	83%	20%	53%	49%	27%	26%	90%	88%	0%	53%	41%	60%	26%	92%
Kuiper, Kristin	97%		79%		78%	77%	45%	21%	82%	93%		71%	57%	72%	54%	66%
Lagarde, Stacia	99%	100%	99%	100%	90%	75%	63%	13%	97%	99%	50%	68%	68%	84%	77%	76%
Liao, Theodore	99%	83%	83%	41%	68%	69%	28%	29%	79%	83%	22%	58%	46%	32%	10%	73%
Mejeur, Rhonda	92%	100%	84%	0%	66%	53%	20%	36%	73%	96%	0%	71%	26%	40%	13%	32%
Merritt, Mona	99%	48%	58%	20%	59%	68%	29%	25%	70%	75%	20%	62%	44%	23%	7%	61%
ORourke, Susan		100%	93%	40%					64%		31%	38%				
Rahmani, Diba	98%	100%	87%	0%	82%	81%	48%	22%	89%	84%	0%	78%	60%	52%	19%	84%
Ramsahoi, Andrew	99%		93%		71%	69%	52%	22%	83%	92%		0%	53%	73%	62%	69%
Ramsey, Jennifer	100%		94%		84%	82%	63%	22%	89%	86%		69%	81%	50%	43%	88%
Ross, Jodi	99%	100%	96%	82%	73%	85%	38%	13%	88%	77%	42%	77%	56%	34%	18%	72%
Schut, Elizabeth		98%	94%	45%					51%		40%	61%				
Sherwood, Joanne	99%		75%		66%	63%	29%	20%	65%	73%		74%	47%	36%	29%	64%
Stout, Daniel	98%	75%	88%	0%	76%	66%	37%	18%	89%	88%	0%	61%	44%	69%	33%	86%
Stout, Kristin		99%	100%	52%					78%		38%	85%				
Streb, Dylan	95%	81%	69%	25%	51%	59%	30%	28%	77%	91%	63%	71%	31%	66%	36%	74%
VanDuinen, Joni		82%	80%	39%					40%		23%	58%				
Vermeulen, Anne	95%		90%		69%	62%	36%	37%	76%	84%		82%	46%	39%	21%	63%
Zerkle, Katie	98%	82%	95%	0%	86%	58%	49%	22%	93%	90%	0%	50%	46%	75%	65%	65%
Bryant, Paul			91%			88%										
Lewandoski, Anne			80%			87%										
VanValkenburg, Rebecca			74%			88%										

*YTD as of 2/4/2025

Custom Clinician Dashboards



Site Examples



Importance of Benchmarks

Supports **staff engagement** and **goal setting**

Childhood Immunizations, 2024

Why “I Love Azara”

More efficient quality processes

Engagement with quality measures and data

Clinical incentives for quality

Health plan quality rewards

Other Uses of DRVS at Cherry Health

1. Patient Visit Planning (PVP)
2. WiseWoman Registry
3. Transition of Care Reports
4. Risk Registry

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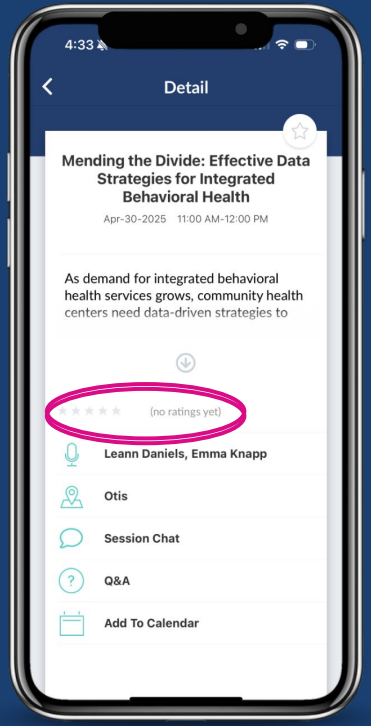
Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



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!

azara healthcare

ACE Program

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
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