Hypertension Management

Emily Holzman, MPH
Director, Clinical Transformation

February 28, 2024

CONFIDENTIAL

This file contains information that is confidential to Azara healthcare, LLC.
Do not view, copy, distribute, or disclose without prior consent.

Today’s Agenda

HYPERTENSION BACKGROUND

HYPERTENSION TOOLS IN DRVS

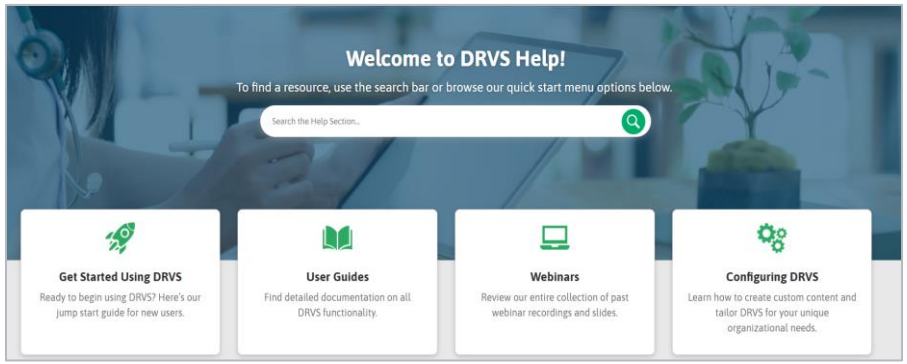
AMA MAP BP™ AND POPULATION IMPACT

WHAT’S NEW IN DRVS

azara healthcare

Resources in DRVS Help Section

Utilize the Help section in DRVS for the most current information.



Click the question mark icon and select Help Documentation. Enter your search criteria (i.e., scorecards).

User Guides are available for all topics covered today (and many more!)

azara healthcare

Hypertension Background

Hypertension in the U.S. and Montana

In 2021, hypertension was a primary or contributing **cause of 691,095 deaths in the United States.**

Nearly half of adults have hypertension (48.1%, 119.9 million), defined as a systolic blood pressure greater than 130 mmHg or a diastolic blood pressure greater than 80 mmHg or are taking medication for hypertension.

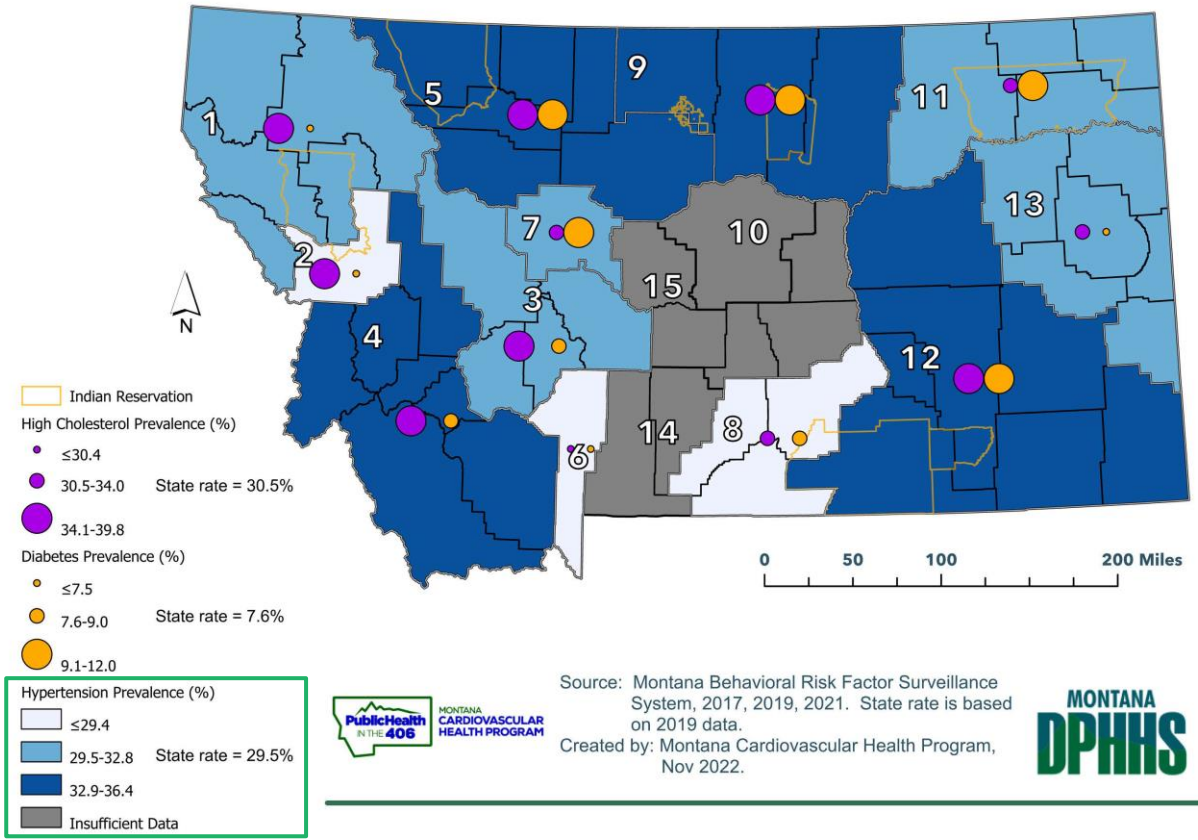
The percentage of **Montana adults reporting high blood pressure** has remained **at about 30% since 2011**.

Source: Centers for Disease Control and Prevention, Facts About Hypertension: https://www.cdc.gov/bloodpressure/facts.htm#:~:text=In%202021%2C%20hypertension%20was%20a,deaths%20in%20the%20United%20States.&text=Nearly%20half%20of%20adults%20have,are%20taking%20medication%20for%20hypertension.

https://dphhs.mt.gov/assets/publichealth/Cardiovascular/Resources/HTNFactSheet2021.pdf

azara healthcare

Prevalence of Hypertension, High Cholesterol, and Diabetes among Adults Aged 18 Years and Older, by Chronic Disease Regions, Montana, 2017-2021



Source: Montana Behavioral Risk Factor Surveillance System, 2017, 2019, 2021. State rate is based on 2019 data.
Created by: Montana Cardiovascular Health Program, Nov 2022.

Hypertension Tools in DRVS

azara healthcare

DRVS Tools

Measures	Million Hearts AMA MAP BP™ UDS – HTN Controlling High Blood Pressure
Reports / Scorecards	Million Hearts AMA MAP BP™ Care Effectiveness
Dashboards	AMA MAP BP™
Registries	Hypertension ASCVD Risk Registry

azara healthcare

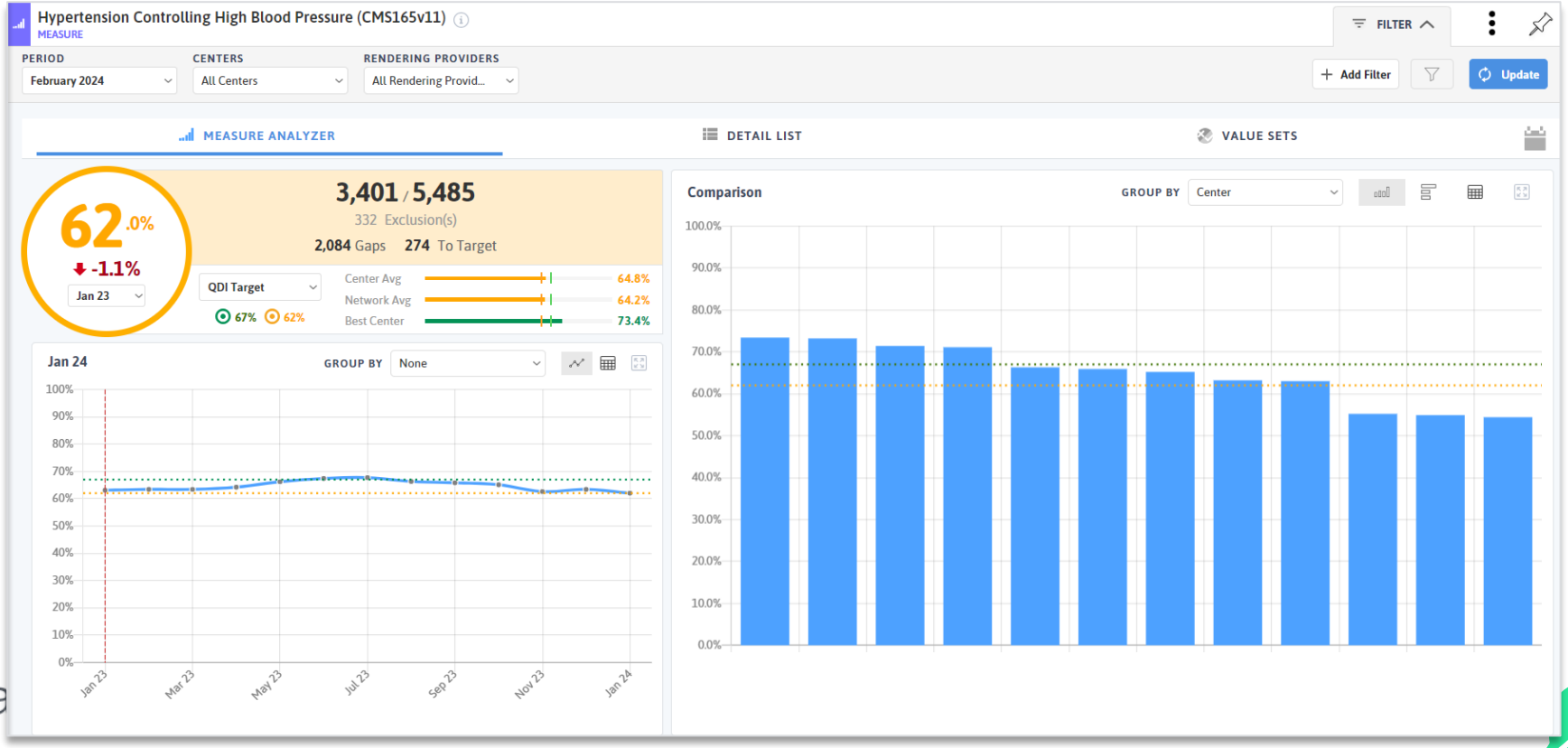
Million Hearts Measures

Measure	Description
Undiagnosed HTN – Million Hearts	Patients age 18-85 who do not have a hypertension diagnosis but had at least one Stage 2 HTN Blood Pressure reading or at least two Stage 1 HTN Blood Pressure readings in the last year. Note: Patient with a diagnosis of R03.0 - Elevated blood-pressure reading, without diagnosis of hypertension will be noted in the detail. They will still be included in the numerator.
HTN Prevalence	Patients age 18-85 with Hypertension.
Essential HTN Prevalence	Percentage of patients age 18-85 that were seen for at least 1 medical visits in the last 12 months with Essential (primary) Hypertension.
Uncontrolled HTN on No Anti-HTN Medications	Patients with uncontrolled essential hypertension (defined as most recent blood pressure of >=140 OR >=90) in the measurement period who are NOT prescribed anti-hypertension therapy at (or up to 7 days after) their most recent **encounter**.
Uncontrolled HTN on Monotherapy	Patients with uncontrolled essential hypertension (defined as most recent blood pressure reading of >=140 OR >=90) in the measurement period who are on monotherapy at (or up to 7 days after) their most recent **encounter**.
Uncontrolled HTN Prescribed a Guideline Recommended Therapy	Patients with uncontrolled essential hypertension (defined as most recent blood pressure of >=140 OR >=90) in the measurement period who are prescribed a guideline recommended therapy.
Statin Therapy for Prevention & Treatment of Cardiovascular Disease (CMS 347v3 Modified/Million Hearts	Patients considered at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period: - Adults aged 21 years and older who were previously diagnosed with or currently have an active diagnosis of clinical, Million Hearts has modified this measure to not include patients with active diagnosis of familial or pure hypercholesterolemia in this measure
BP at Every Visit	Primary care visits with blood pressure documented.

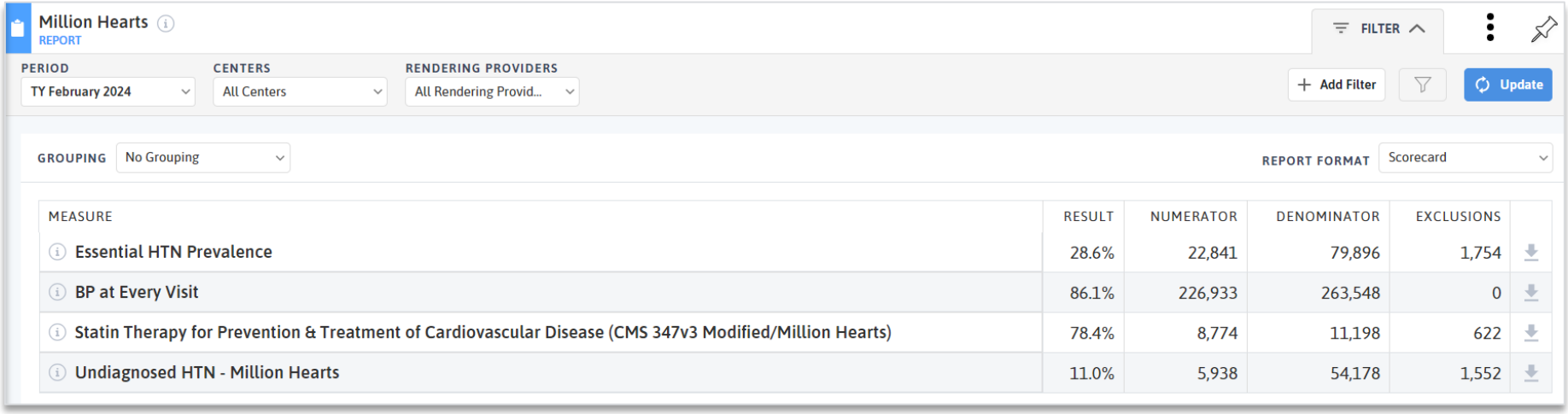
AMA MAP BP™ Measures

Measure Name	Description
Controlling High Blood Pressure (CMS165v8, NQF 0018, ACO 28)	**Patients** 18-85 years of age who had an active diagnosis of hypertension during the measurement period and whose most recent blood pressure during the measurement period was adequately controlled (<140/90mmHg).
HTN - Confirmatory Repeated Blood Pressure Measurement	**Encounters** in the measurement period where patients with essential hypertension and uncontrolled blood pressure (>140/90) had a confirmatory blood pressure measured at the visit.
HTN - Medication Intensification	**Encounters** in the measurement period where patients with essential hypertension and uncontrolled BP (>140/90) had a new class of BP medication prescribed.
HTN - Average Systolic BP Reduction After Medication Intensification	The average systolic blood pressure reduction for **patients** with uncontrolled blood pressure after receiving medication intensification at an encounter in the period.

Hypertension Controlling High Blood Pressure (CMS165v11)

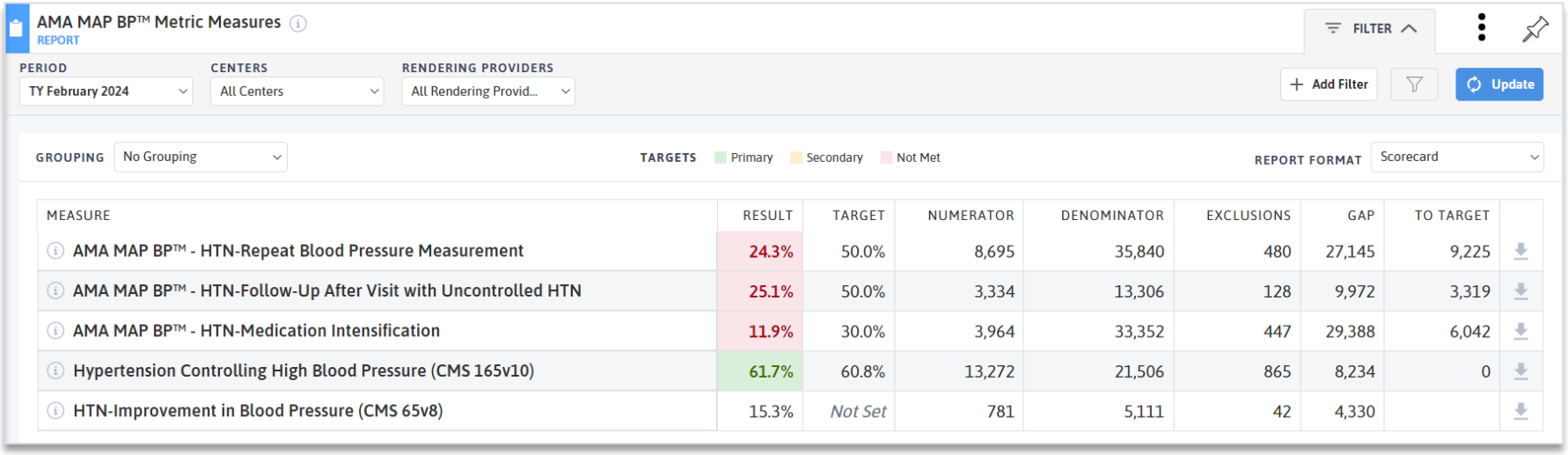


Million Hearts Scorecard



azara healthcare

AMA MAP BP™ Scorecard



AMA MAP BP™ Metric Measures
REPORT

FILTER

PERIOD: TY February 2024 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid...

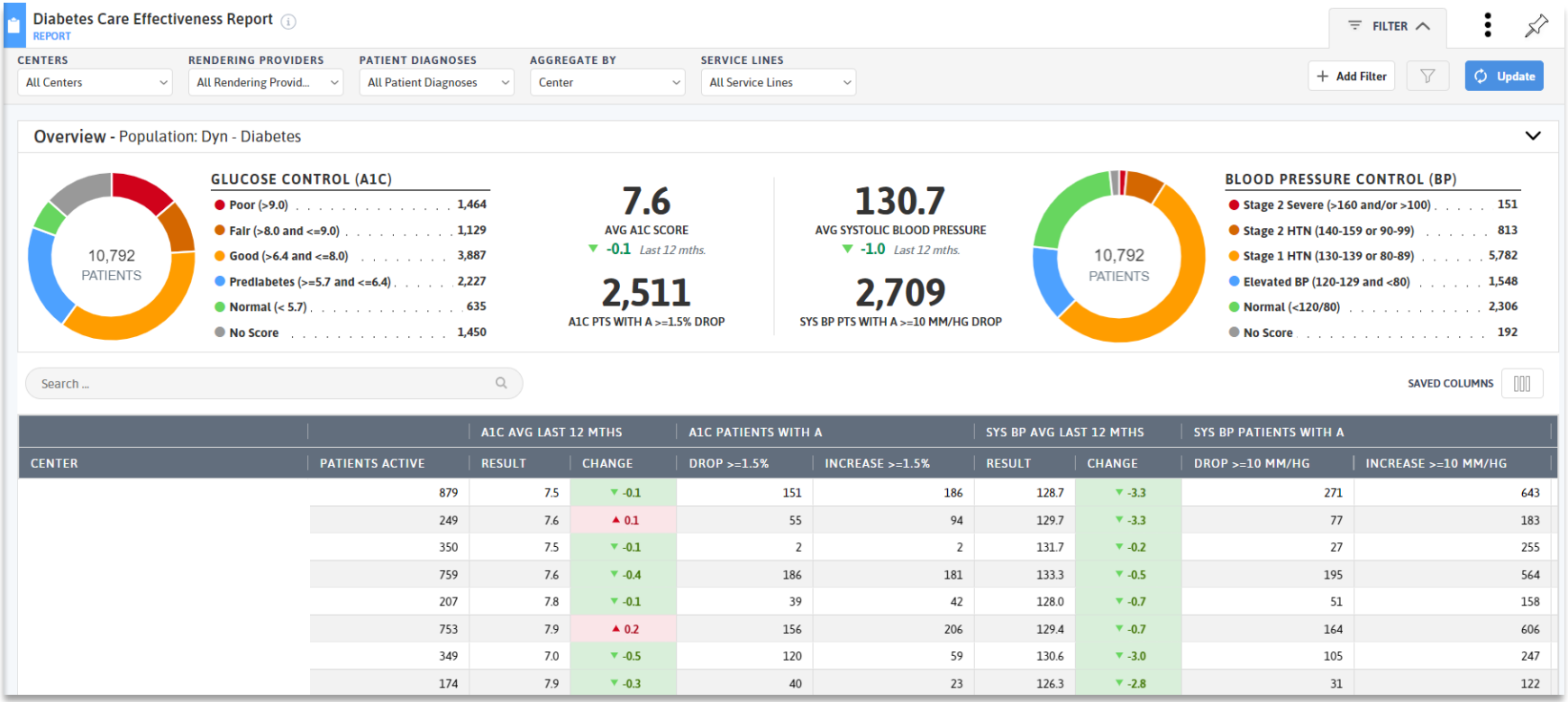
Add Filter | Update

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

MEASURE	RESULT	TARGET	NUMERATOR	DENOMINATOR	EXCLUSIONS	GAP	TO TARGET
AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement	24.3%	50.0%	8,695	35,840	480	27,145	9,225
AMA MAP BP™ - HTN-Follow-Up After Visit with Uncontrolled HTN	25.1%	50.0%	3,334	13,306	128	9,972	3,319
AMA MAP BP™ - HTN-Medication Intensification	11.9%	30.0%	3,964	33,352	447	29,388	6,042
Hypertension Controlling High Blood Pressure (CMS 165v10)	61.7%	60.8%	13,272	21,506	865	8,234	0
HTN-Improvement in Blood Pressure (CMS 65v8)	15.3%	*Not Set*	781	5,111	42	4,330	

azara healthcare

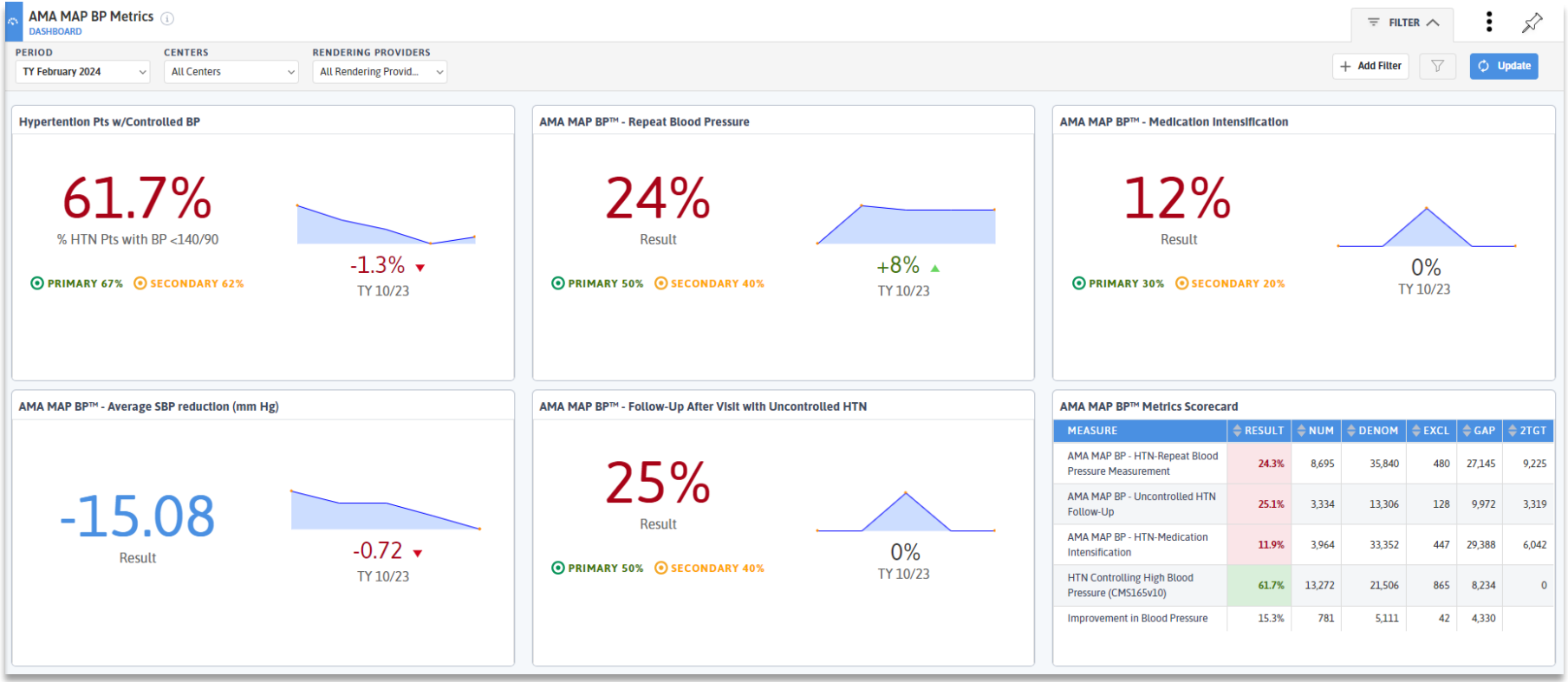
Care Effectiveness Report



		A1C AVG LAST 12 MTHS		A1C PATIENTS WITH A		SYS BP AVG LAST 12 MTHS		SYS BP PATIENTS WITH A	
CENTER	PATIENTS ACTIVE	RESULT	CHANGE	DROP >=1.5%	INCREASE >=1.5%	RESULT	CHANGE	DROP >=10 MM/HG	INCREASE >=10 MM/HG
	879	7.5	▼ -0.1	151	186	128.7	▼ -3.3	271	643
	249	7.6	▲ 0.1	55	94	129.7	▼ -3.3	77	183
	350	7.5	▼ -0.1	2	2	131.7	▼ -0.2	27	255
	759	7.6	▼ -0.4	186	181	133.3	▼ -0.5	195	564
	207	7.8	▼ -0.1	39	42	128.0	▼ -0.7	51	158
	753	7.9	▲ 0.2	156	206	129.4	▼ -0.7	164	606
	349	7.0	▼ -0.5	120	59	130.6	▼ -3.0	105	247
	174	7.9	▼ -0.3	40	23	126.3	▼ -2.8	31	122

azara healthcare

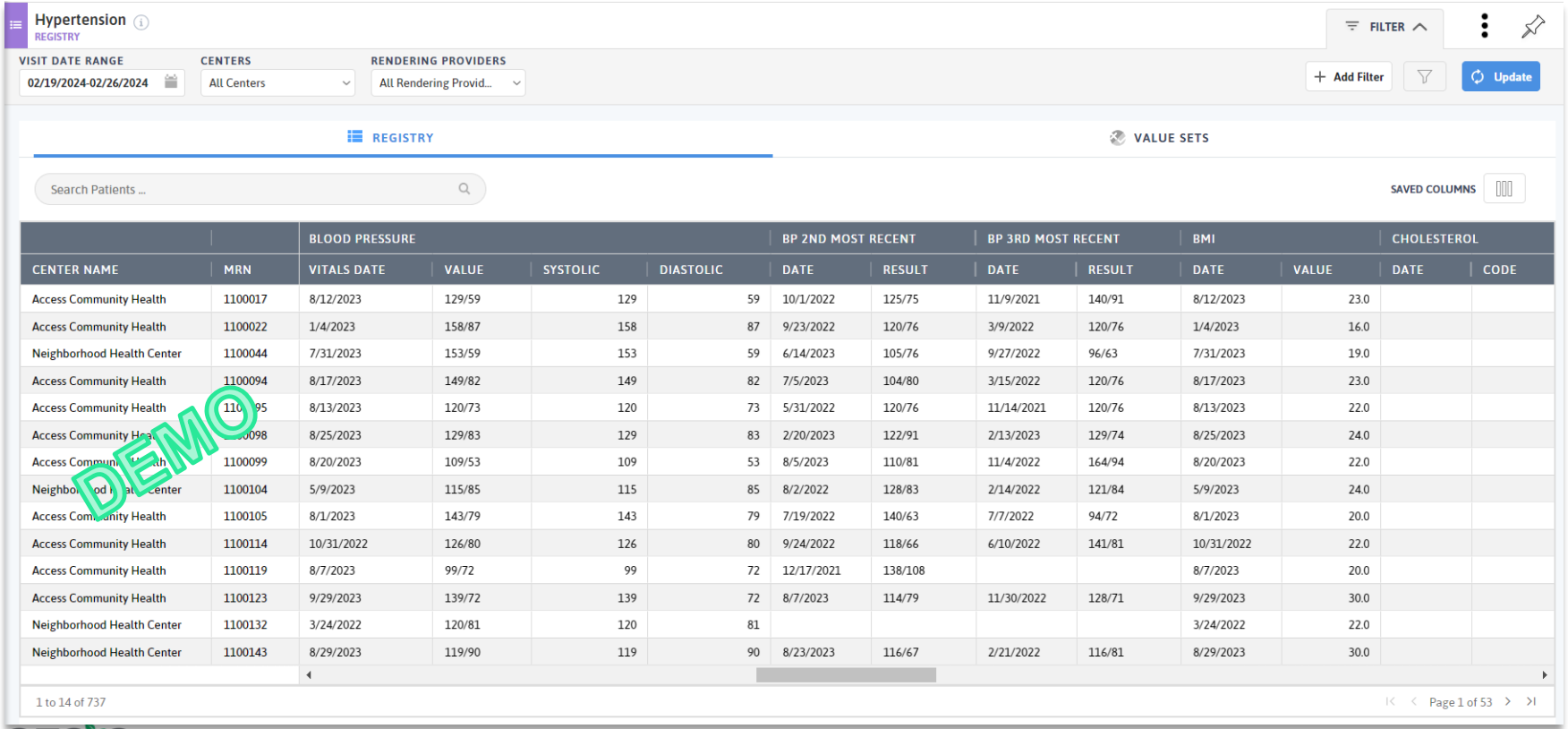
AMA MAP BP™ Metrics Dashboard



MEASURE	RESULT	NUM	DENOM	EXCL	GAP	2TGT
AMA MAP BP - HTN-Repeat Blood Pressure Measurement	24.3%	8,695	35,840	480	27,145	9,225
AMA MAP BP - Uncontrolled HTN Follow-Up	25.1%	3,334	13,306	128	9,972	3,319
AMA MAP BP - HTN-Medication Intensification	11.9%	3,964	33,352	447	29,388	6,042
HTN Controlling High Blood Pressure (CMS165v10)	61.7%	13,272	21,506	865	8,234	0
Improvement in Blood Pressure	15.3%	781	5,111	42	4,330	

azara healthcare

Hypertension Registry



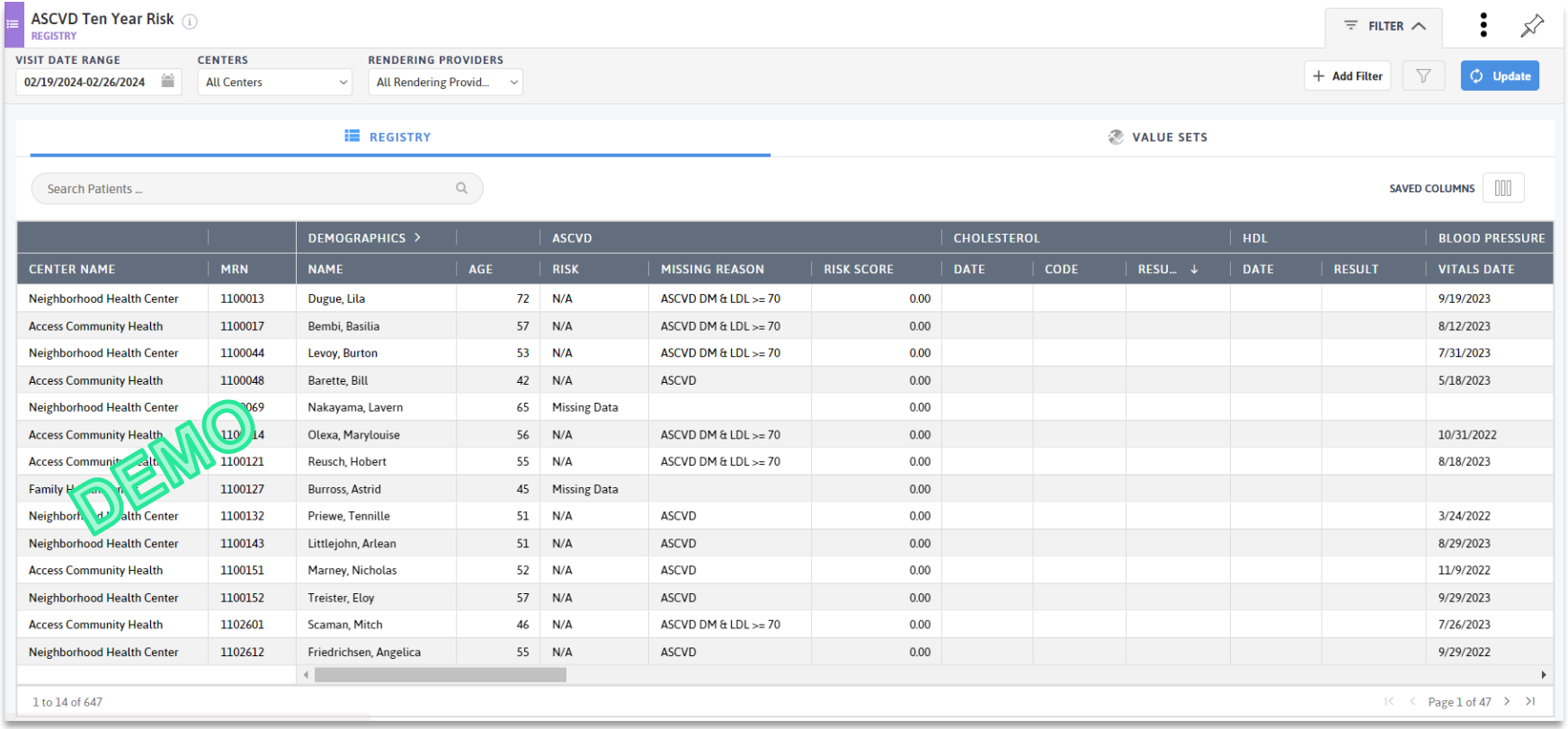
		BLOOD PRESSURE				BP 2ND MOST RECENT		BP 3RD MOST RECENT		BMI		CHOLESTEROL	
CENTER NAME	MRN	VITALS DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	RESULT	DATE	RESULT	DATE	VALUE	DATE	CODE
Access Community Health	1100017	8/12/2023	129/59	129	59	10/1/2022	125/75	11/9/2021	140/91	8/12/2023	23.0		
Access Community Health	1100022	1/4/2023	158/87	158	87	9/23/2022	120/76	3/9/2022	120/76	1/4/2023	16.0		
Neighborhood Health Center	1100044	7/31/2023	153/59	153	59	6/14/2023	105/76	9/27/2022	96/63	7/31/2023	19.0		
Access Community Health	1100094	8/17/2023	149/82	149	82	7/5/2023	104/80	3/15/2022	120/76	8/17/2023	23.0		
Access Community Health	1100095	8/13/2023	120/73	120	73	5/31/2022	120/76	11/14/2021	120/76	8/13/2023	22.0		
Access Community Health	1100098	8/25/2023	129/83	129	83	2/20/2023	122/91	2/13/2023	129/74	8/25/2023	24.0		
Access Community Health	1100099	8/20/2023	109/53	109	53	8/5/2023	110/81	11/4/2022	164/94	8/20/2023	22.0		
Neighborhood Health Center	1100104	5/9/2023	115/85	115	85	8/2/2022	128/83	2/14/2022	121/84	5/9/2023	24.0		
Access Community Health	1100105	8/1/2023	143/79	143	79	7/19/2022	140/63	7/7/2022	94/72	8/1/2023	20.0		
Access Community Health	1100114	10/31/2022	126/80	126	80	9/24/2022	118/66	6/10/2022	141/81	10/31/2022	22.0		
Access Community Health	1100119	8/7/2023	99/72	99	72	12/17/2021	138/108			8/7/2023	20.0		
Access Community Health	1100123	9/29/2023	139/72	139	72	8/7/2023	114/79	11/30/2022	128/71	9/29/2023	30.0		
Neighborhood Health Center	1100132	3/24/2022	120/81	120	81					3/24/2022	22.0		
Neighborhood Health Center	1100143	8/29/2023	119/90	119	90	8/23/2023	116/67	2/21/2022	116/81	8/29/2023	30.0		

1 to 14 of 737

Page 1 of 53

azara healthcare

ASCVD Risk Registry



Hypertension Management at the Point of Care

azara healthcare

Activities by Role| Summary

Role	Activities
 **MA/LPN**	• Pre-visit plan for telehealth /face to face patient visits • **Take confirmatory BPs for any BP >140/90** • **Discuss alerts** in huddle – Elevated BP and no HTN dx – Missing ASCVD criteria – No Statin – No Self-Management
 **RN**	• **Schedule BP follow up within 2 weeks of medication change** • Conduct virtual BP check (visit or home BP monitoring results) • **Provide home BP monitoring instruction/teach back** • Evaluate/Identify clinical inertia when conducting prescription refills
 **Front Office or Call Center**	• Schedule visits for hypertensive patients with no follow up appointments (or others as identified by Care Coordinator/CHW/Care Manager)
 **Medical Provider**	• Utilize evidence-based guidelines for treatment intensification • **Diagnose the undiagnosed** • **Review MAP hypertension management dashboard** • Review uncontrolled patients on panel • **Use ASCVD Risk Registry** to guide treatment when labs returned • Collaborate with care team and facilitate warm hand-offs for more in-depth education

Activities by Role| Summary (con't)

Role	Activities
 Care Manager	• Actively oversee/manage patients with changes in medication (cohort) • Provide home BP monitoring instruction/teach back • Self management goal setting / care planning • Conduct SDOH screens • Provide education or enabling resources • Participate in Care Team huddles
 Registered Dietitian	• Self management focus on nutrition and weight loss • Identify patients with out of range BMI • Participate in Care Team huddles
 Care Coordinator/ CHW	• Identify patients with undiagnosed hypertension, high risk ASCVD without treatment, hypertensive tobacco users
 Pharmacist	• **Review/discuss/manage patients with treatment inertia** • Participate in **Care Team huddles**
 Quality Improvement Team	• Review panel reports with providers (academic detailing) • Monitor practice, team, provider performance • Create cohorts based on focus for intensification, pharmacy intervention, care manager engagement

Point Of Care | Visit Planning

9:53 AM Wednesday, February 15, 2023 — **Visit Reason:** **Annual Visit Departure**

Henzler, Janett
MRN: 1101321
DOB: 4/27/1965 (57)

Sex at Birth: F
GI: Male
SO: Don't know

Phone: 413-702-0565
Lang: English
Risk: Low (12)

Portal Access: N

PCP: Augustine, Greg
Payer: Aetna
CM: Mike Bomber

DIAGNOSES (8)

ASCVD	CAD	CAD/No MI
Cancer	DM	HIV
HTN-NE	IVD	

RISK FACTORS (5)

Chronic Opioid Tx	IDD	MSM
SMI	TOB	

SDOH (7)

CLOTHING		FPL<200%
HISP/LAT	HOME	
STRESS		

DEMO

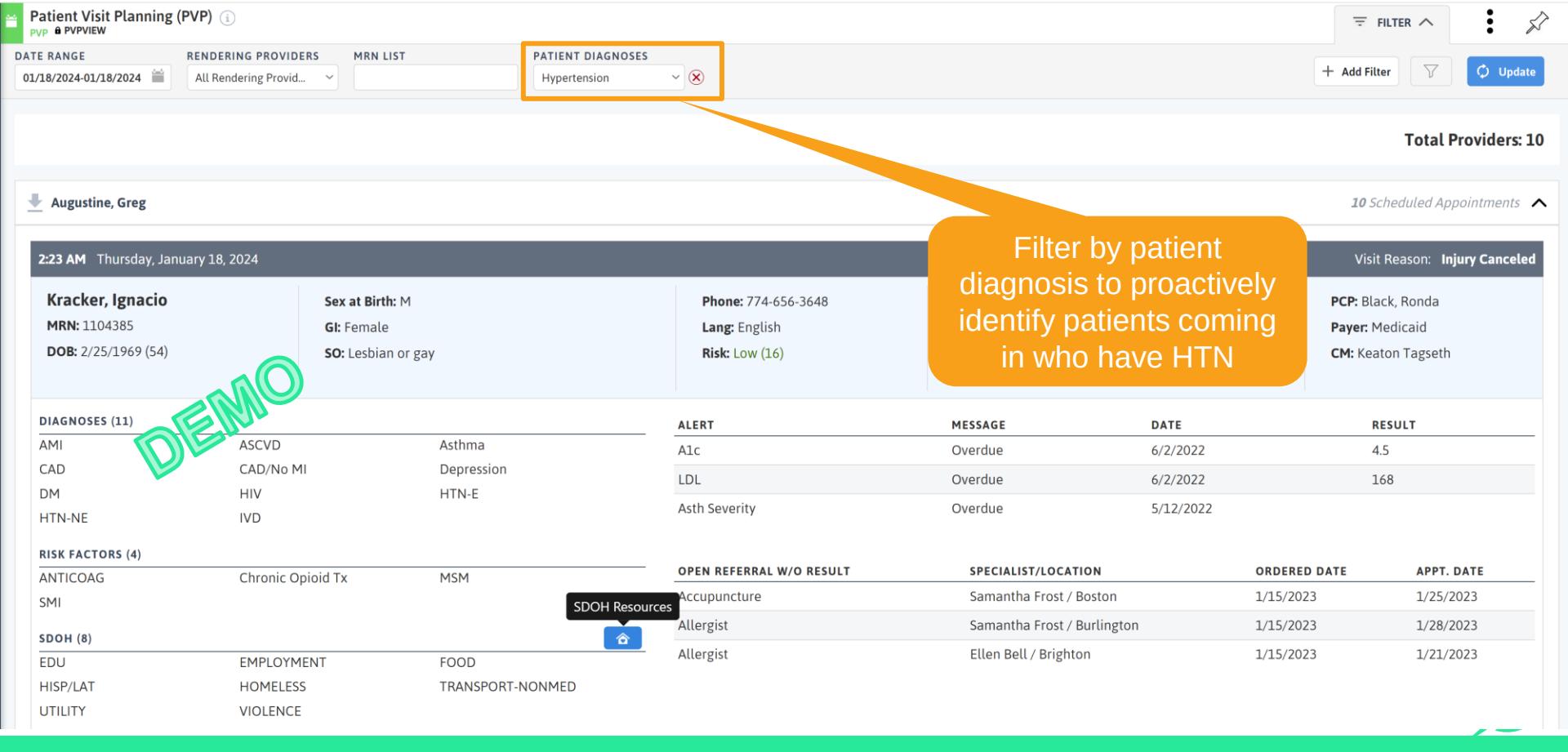
ALERT	MESSAGE	DATE	RESULT	OWNER
A1c	Missing			MA
LDL	Missing			
BP	Out of Range	1/23/2023	142/98	MA
Eye	Missing			
I/P Encounter	Occurred	2/1/2023		Care Cor

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
stroenterology	Jim Cohen / Boston	1/23/2023	1/31/2023
oenterology	Samantha Frost / Burlington	1/23/2023	1/25/2023
tionist	Ellen Bell / Burlington	1/23/2023	2/15/2023
tionist	Samantha Frost / Boston	1/23/2023	
ology	John Smith / Brighton	1/23/2023	1/27/2023

Using the PVP, identify patients that have a diagnosis of Hypertension and a BP that is out of range.

azara healthcare

Point Of Care | Visit Planning



Point of Care | Care Management Passport

Assessments (Last 10 of 34)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	2/9/23	1
N18.3	Chronic kidney disease, stage 3 (moderate)	2/9/23	1
E55.9	Vitamin D deficiency, unspecified	2/9/23	1
Z91.89	Other specified personal risk factors, not elsewhere classified	1/6/22	0
B02.9	Zoster without complications	1/6/22	0
Z28.21	Immunization not carried out because of patient refusal	1/6/22	0
I10	Essential (primary) hypertension	8/20/21	0

Active Problems (7)

CODE	DESCRIPTION	MOST RECENT
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease	4/22/19
Z79.4	Long term (current) use of insulin	4/22/19
N18.3	Chronic kidney disease, stage 3 (moderate)	1/9/19
E78.2	Mixed hyperlipidemia	1/9/19
M85.88	Other specified disorders of bone density and structure, other site	6/19/18
E55.9	Vitamin D deficiency, unspecified	11/16/15
I10	Essential (primary) hypertension	10/12/15

Medications (8)

ACTIVE AS OF	NAME	SOURCE
2/9/23	amlodipine 5 MG Oral Tablet	
2/9/23	cloNIDine HCl 0.1 MG 12HR Extended Release Oral Tablet	
2/9/23	atorvastatin 40 MG Oral Tablet	
2/9/23	hydrochlorothiazide 12.5 MG / lisinopril 20 MG Oral Tablet	
2/9/23	empagliflozin 25 MG Oral Tablet [Jardiance]	
2/9/23	pantoprazole 40 MG Delayed Release Oral Tablet	
9/10/20	ergocalciferol 1.25 MG Oral Capsule	
1/27/20	hydrochlorothiazide 25 MG / triamterene 37.5 MG Oral Tablet	

The Numbers

BMI	1/6/22	**26.79** lb/m2
Systolic	8/20/21	**152** mmHg
Diastolic	8/20/21	**55** mmHg
LDL	5/6/21	**99** mg/dL
A1c	8/6/21	**9.8** %
PHQ-9 (or 2)	6/8/21	**0**
Risk	2/28/23	**19 (H)**

AMA MAP BP™ and Population Impact

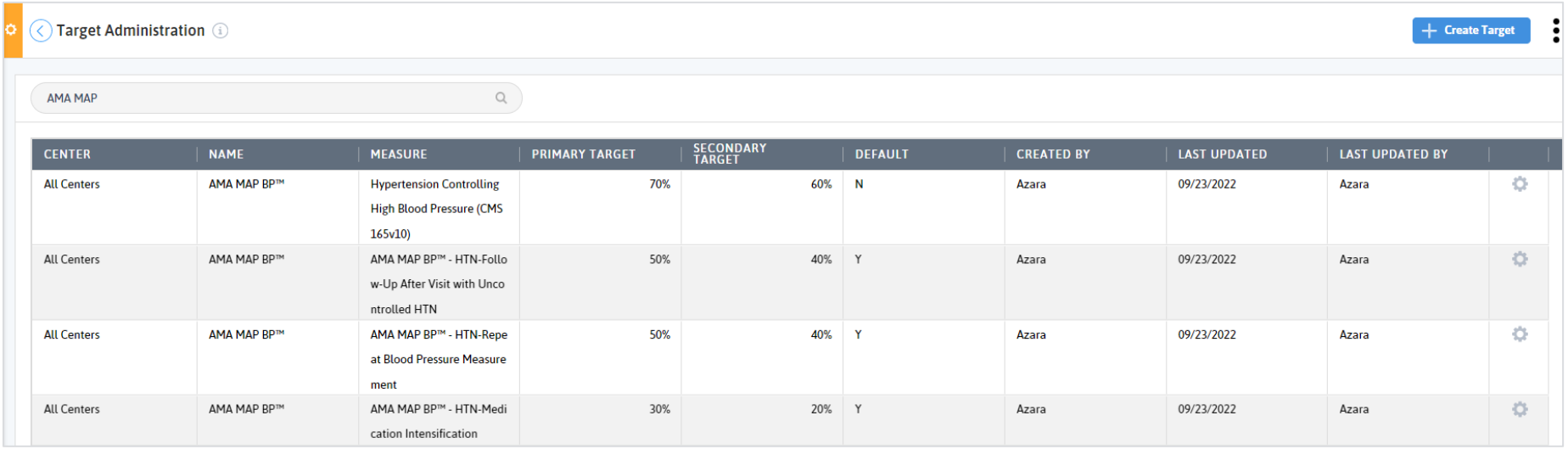
azara healthcare

Operationalizing AMA MAP BP™ Tools

Tool	What Tool Measures	When to Use	How to Use
AMA MAP BP™ Measures	Are we improving care and quality long term?	Weekly to assess trends	Measures > HTN > AMA MAP BP™ Measures > Use comparison chart to group by provider > Use detail list for specific examples
AMA MAP BP™ Scorecard	Are we improving care and meeting are targets?	Monthly	AMA MAP BP™ scorecard > Group by provider groups > Add default filters for baseline period and baseline > Evaluate changes over time
AMA MAP BP™ Dashboard	Are we improving care and meeting are targets?	Monthly	Dashboards > Custom > AMA MAP BP™ Metrics Dashboard > Evaluate changes over time
Usage Measures	Are the AMA MAP BP™ metrics being run, and how frequently?	Daily or weekly in initial stages; once adoption is solid, can scale back and use as needed	Measures > Usage > Reports by User > Filter to previous week and AMA MAP BP

azara healthcare

Performance Management | Targets

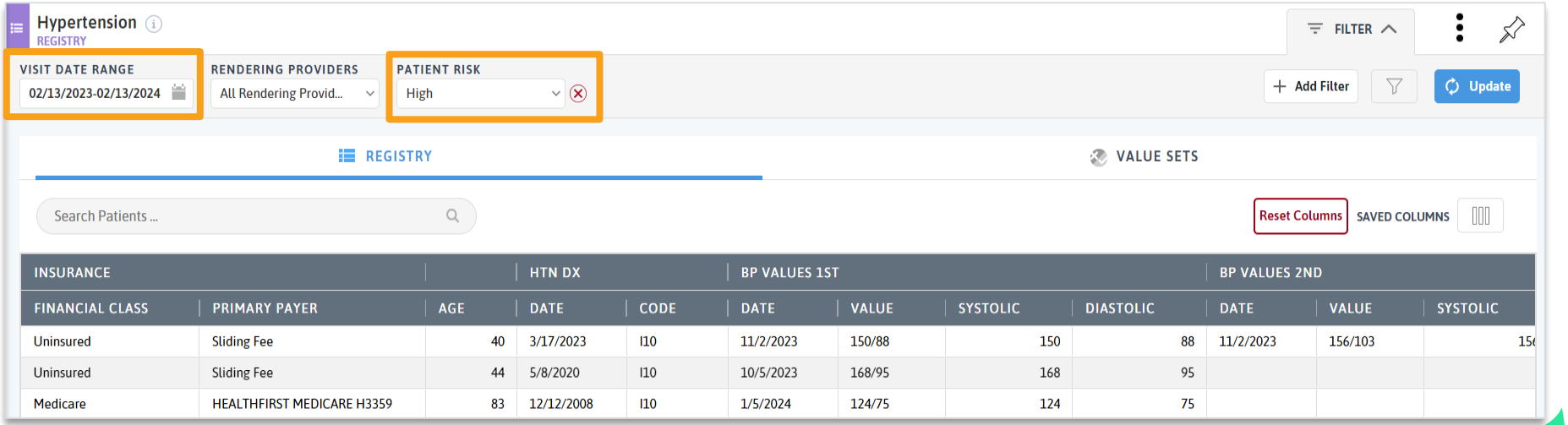


CENTER	NAME	MEASURE	PRIMARY TARGET	SECONDARY TARGET	DEFAULT	CREATED BY	LAST UPDATED	LAST UPDATED BY	
All Centers	AMA MAP BP™	Hypertension Controlling High Blood Pressure (CMS 165v10)	70%	60%	N	Azara	09/23/2022	Azara	
All Centers	AMA MAP BP™	AMA MAP BP™ - HTN-Follow-Up After Visit with Uncontrolled HTN	50%	40%	Y	Azara	09/23/2022	Azara	
All Centers	AMA MAP BP™	AMA MAP BP™ - HTN-Repeat Blood Pressure Measurement	50%	40%	Y	Azara	09/23/2022	Azara	
All Centers	AMA MAP BP™	AMA MAP BP™ - HTN-Medication Intensification	30%	20%	Y	Azara	09/23/2022	Azara	

azara healthcare

Population Impact – Chronic Conditions

- Having hypertension puts you at risk for heart disease and stroke, which are leading causes of death in the United States.
- The use of registries in DRVS can help us identify patients with a higher risk to prioritize their care needs.

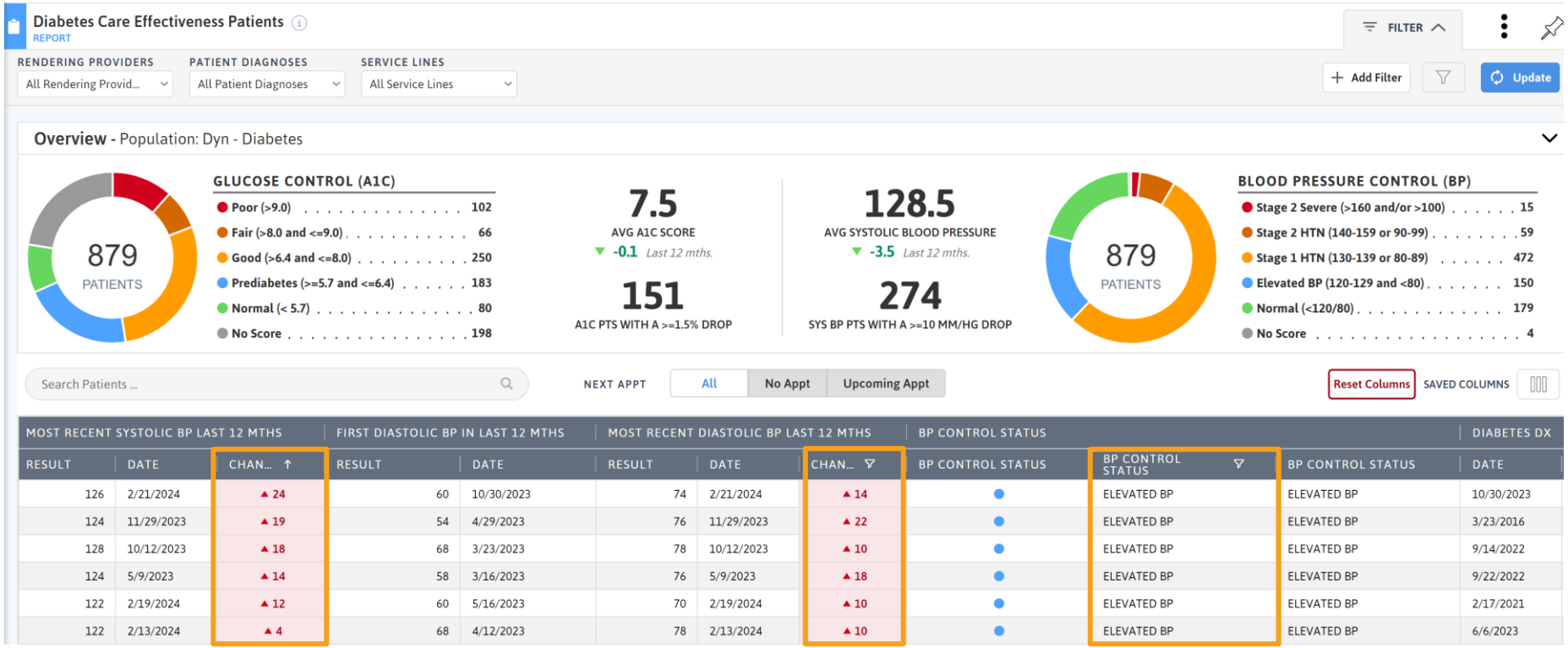


INSURANCE			HTN DX		BP VALUES 1ST				BP VALUES 2ND		
FINANCIAL CLASS	PRIMARY PAYER	AGE	DATE	CODE	DATE	VALUE	SYSTOLIC	DIASTOLIC	DATE	VALUE	SYSTOLIC
Uninsured	Sliding Fee	40	3/17/2023	I10	11/2/2023	150/88	150	88	11/2/2023	156/103	156
Uninsured	Sliding Fee	44	5/8/2020	I10	10/5/2023	168/95	168	95			
Medicare	HEALTHFIRST MEDICARE H3359	83	12/12/2008	I10	1/5/2024	124/75	124	75			

azara healthcare

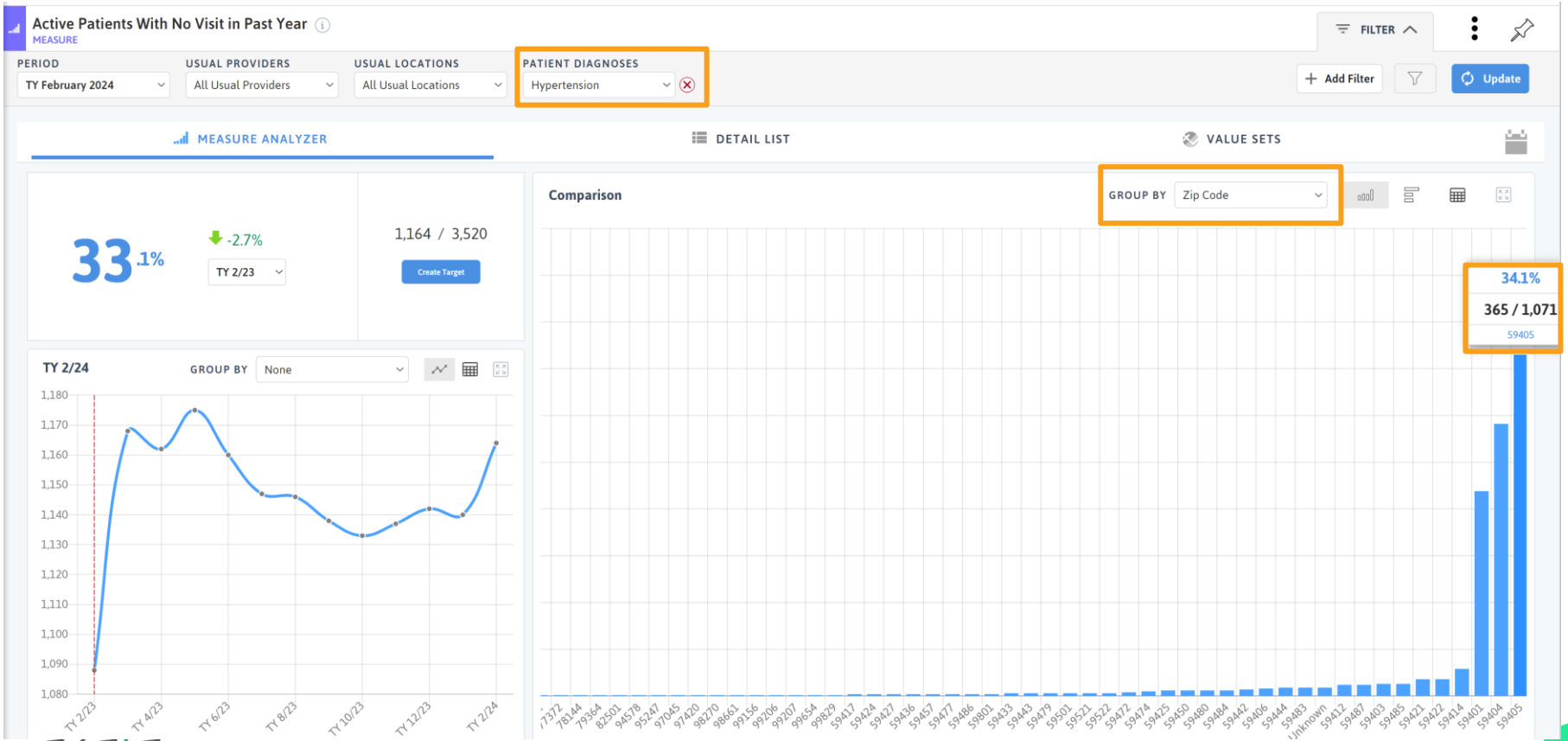
https://www.cdc.gov/bloodpressure/facts.htm

Population Impact – Blood Pressure Control



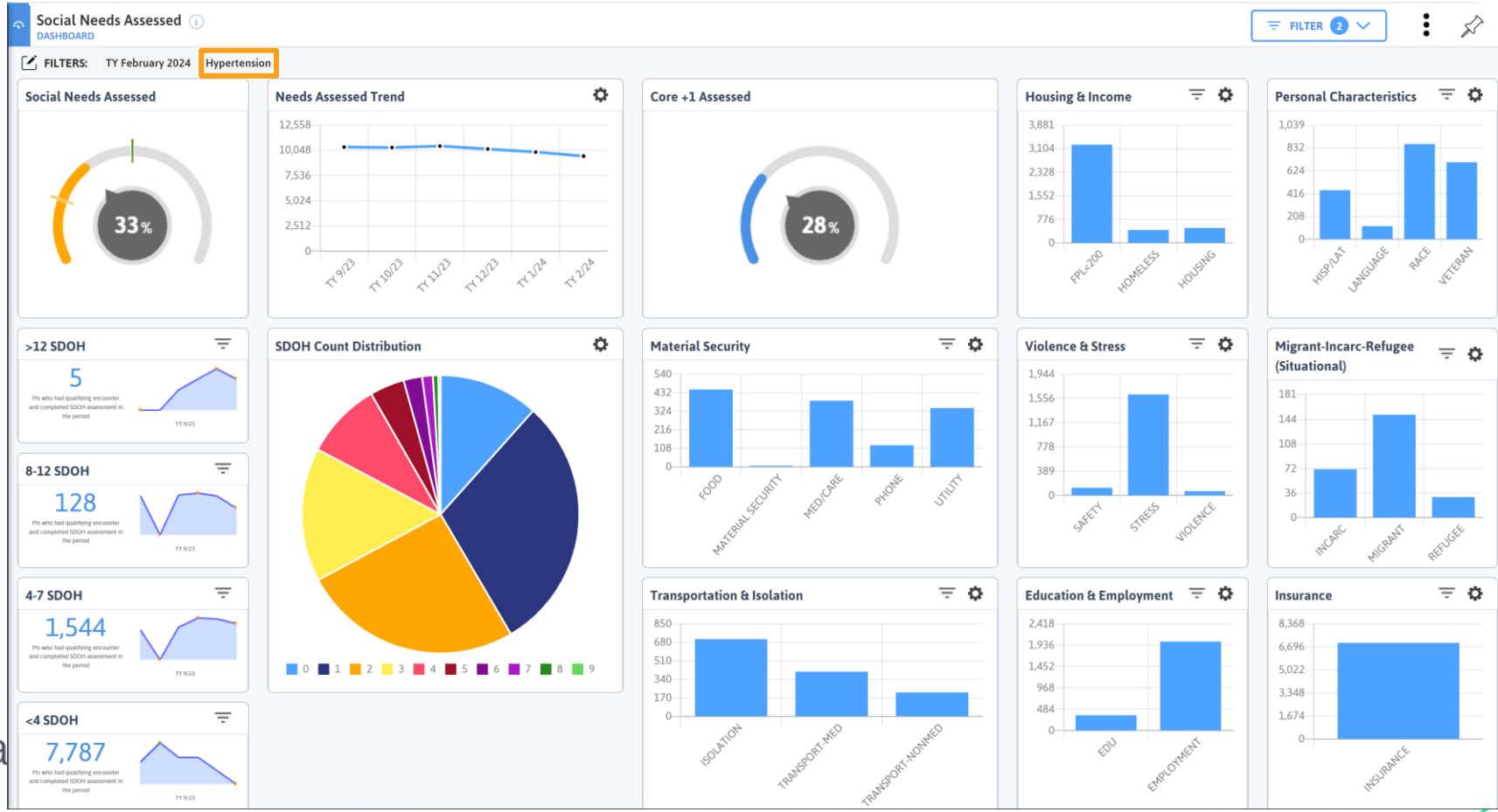
azara healthcare

Population Impact – Patient Engagement



azalea healthcare

Population Impact – SDOH Assessment



What Should I Do Next?

- ❑Review the AMA MAP BP dashboard – how are your numbers? Where can you improve?
- ❑Check alerts on the PVP – can you enable additional ones?
- ❑Assess the resources you have for blood pressure control and hypertension care (home monitoring devices, patient educators, clinical pharmacists, etc.). How do they use DRVS?
- ❑Try out new reporting tools in DRVS and see what they tell you about your population – can you find the highest priority patients? How can you connect them with services?

What's New in DRVS?

azara healthcare

UDS Reporting – Table Updates

FEATURE

ANNOUNCEMENT

Updates to UDS Reporting

New Ethnicity Option for 2023 Reporting

Azara has added the new ethnicity option "Hispanic, Latino/a, or Spanish Origin, Combined" to align with the UDS manual for reporting year 2023. This new ethnicity is present as column A5 in Table 3b and is also available as a new section in Tables 7a, 7b, and 7c.

This new option is intended to help report patients who are considered more than one ethnicity or who self-identify as of Hispanic, Latino/a, or Spanish origin with no distinction within the sub-categories. Please note that it is still acceptable to report patients as "Another Hispanic, Latino/a, or Spanish Origin" if they have not reported a distinction within a sub-category.

Update to Line 21e in Table 6a for PrEP Management

Azara has revised the logic for line 21e "Pre-Exposure Prophylaxis (PrEP)- associated management of all patients on PrEP" to exclude encounters that are reported after the onset date of an HIV diagnosis in order to properly exclude patients who have an existing HIV diagnosis date and are not taking the medication for prevention purposes.

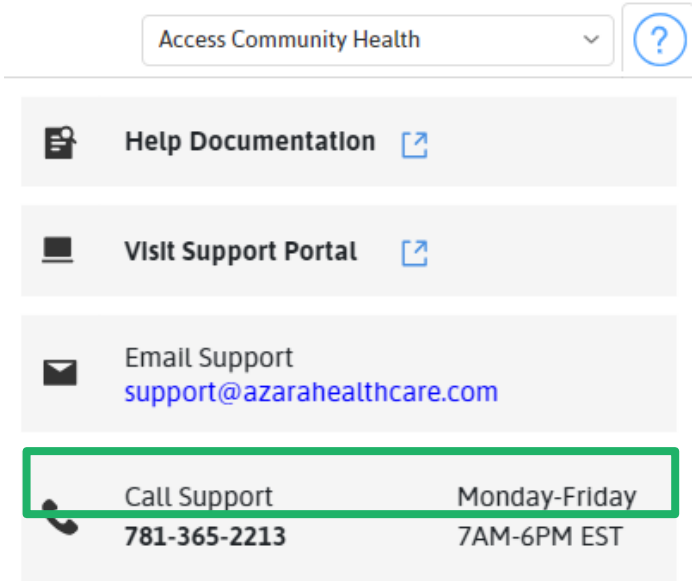
azara healthcare

Released January 2024

Azara Support Phone Number:
Now Easily Accessible for Users!

FEATURE

- The Azara Support Team's phone number is now available in the Question Mark icon for ease of access

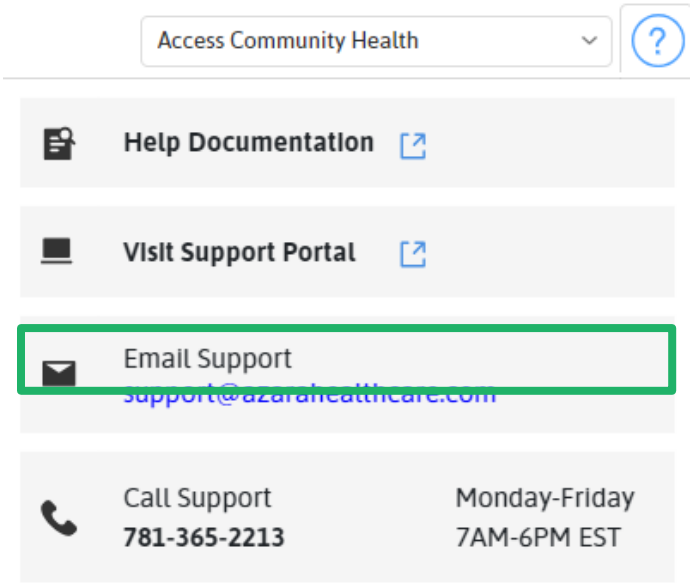


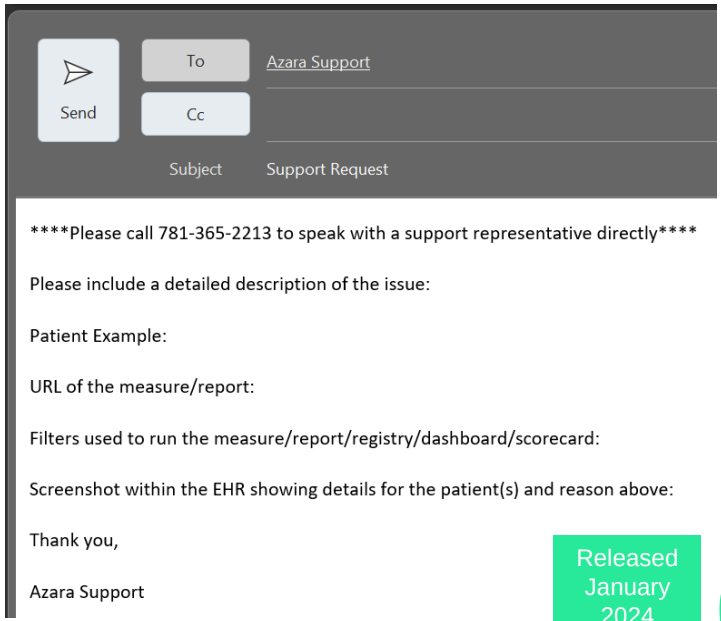
azara healthcare

Released January 2024

“Email Support” Template Enhanced

- The “Email Support” option under the Question Mark icon will now bring users to an updated email template.
- This new template prompts users for key information that Support needs to answer users’ questions as quickly as possible.





FEATURE

Released January 2024

New RDE:
Depression Follow-Up Assessment Period CY

ANNOUNCEMENT

FEATURE

New Depression Remission Follow-Up RDE

Azara has created a new registry data element (RDE) for Depression Remission gap closure

To assist with closing gaps in the measure,"Depression Remission at Twelve Months (CMS 159v11)", Azara has created a new registry data element (RDE) named "Depression Follow-Up Assessment Period CY". The "CY" stands for "calendar year" and the RDE provides the follow-up assessment period as of the current calendar year. This RDE is currently the only reporting element that identifies the assessment period and those patients with possible gaps in the measure for the 2024 reporting period. That is because DRVS does not process the current calendar year period during the month of January.

The RDE returns the start and end date of the follow-up assessment period expected for the patient based on an index screening where the PHQ-9 result was greater than 9. One can use the RDE in a custom registry with the following RDEs to identify patients that need an appointment for a follow-up PHQ-9 screening.

Next Appointment
PHQ-9 Depression Screen

Released January 2024

New COVID-19 Alert Available:
CDC Immunization Adult COVID-19

ANNOUNCEMENT

ALERT

New COVID-19 Alert for Adults

Follows updated CDC schedule for 2023 formulations

Azara has released a new alert to support vaccination of adults against COVID-19. This alert follows the newest CDC guidance for the COVID-19 immunization schedule for patients 19 years of age and older. A new alert for patients under 19 years old will be released in the upcoming months. When that alert is released, all existing COVID-19 alerts will be retired.

COVID-19 Alerts to be retired by end of Q1 2024:
COVID-19 Immunization 3rd Dose
COVID-19 Immunization Booster
COVID-19 Immunization First Dose
COVID-19 Immunization Second Dose

Name: CDC Immunization Adult COVID-19
PVP Name: COVID-19 Adult
Description:
Alert will trigger for patients aged 19 years and older who are eligibl
for a COVID-19 vaccine in the next 14 days or overdue for a vaccine, c
if patient refused the most recent COVID-19 vaccine. This alert is not
configurable

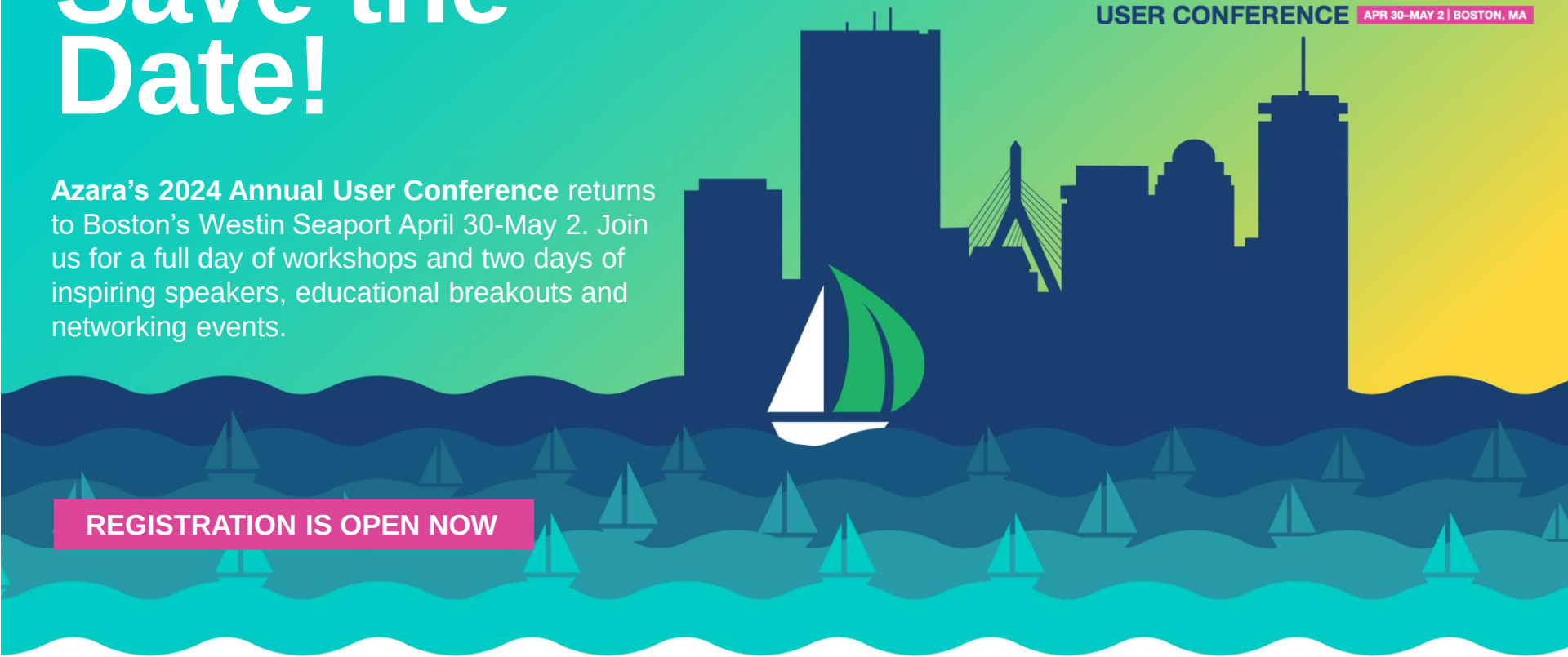
azara healthcare

Released January 2024

Save the Date!

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

Azara's 2024 Annual User Conference returns to Boston's Westin Seaport April 30-May 2. Join us for a full day of workshops and two days of inspiring speakers, educational breakouts and networking events.



REGISTRATION IS OPEN NOW

Learn more at: www.azarahealthcare.com/events/2024-annual-user-conference

Achieve, Celebrate, Engage!

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

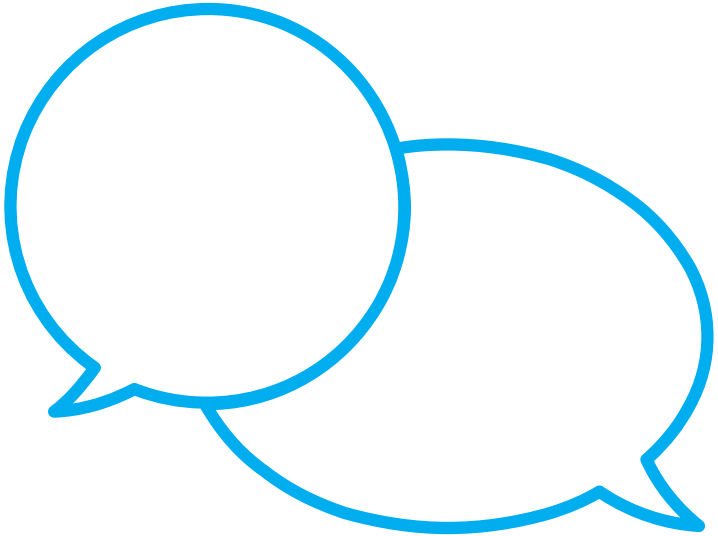
Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement 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
- Win Azara swag!

Submit your success story by completing the form at this link.

Questions?



azara healthcare

azara healthcare

@AzaraDRVS