

Scaling Care Management with ACC and ACU

A Two-Tier Coordination Model

azara2026

USER CONFERENCE APRIL 13-15 | BOSTON, MA



Introduction

15



Katie Brehm, MPH
Population Health Program Manager



Marki Anderson, MHSA, PCMH CCE, PMP
Value-Based Contract Analyst



FQHC in Southwest Ohio

42,421 patients, 188,410 encounters

Medical, dental, behavioral health,
vision, women's health, chiro, cardio

Implemented Azara in 2022 through the
Ohio Association of Community Health
Centers





Background

Care Coordination vs Care Management

15

Care Coordination

Deliberately **organizing** patient care activities.

Sharing information among all the participants concerned with a patient's care.

Achieve safer and more effective care.

Care Management

Identifying at risk patient populations.

Managing their care between office visits.

Focused on **decreasing risk**.

Appropriate interventions and whole-person care



The Business Case – You Need Both

15

Patients need assistance beyond the standard processes that close the loop

SDOH

- Barrier to care
- Connection to resources

“Process help” versus Clinical help

Care Coordinators = CHW, MAs, experienced patient service reps

Each care team member should be working at the top of their license

Nurses - Clinical care vs. scheduling appointments

Nurses with a Provider like schedule (Medicare Chronic Care Management).

Care Managers = LPNs, RNs



Azara Care Connect is Designed for Both

15

Care Coordination

Patients identified through contact reasons

- CQM or TOC

Patient “list” where patients are identified at one point in time then come off the list when they are no longer in the gap.

Care Management

Patients identified through cohorts

- Clinical criteria - certain diagnosis, etc
- Can create manual cohorts

This is a patient “list” where patients remain on the list until they no longer meet the criteria.



Azara Care Connect



Care Management
(Cohorts)

Care Coordination
(Contact Reason)

The screenshot displays the Azara Care Connect interface. At the top, there is a navigation bar with tabs for Home, Patients, Tasks, Reports, and Care Coordination. A search bar for 'Search ACM Patients...' is located on the right. Below the navigation bar, there are three summary cards: 'UTILIZATION' showing 'Inpatient Last 7 Days' (12) and 'Emergency Last 7 Days' (35); 'TASKS' showing 'Overdue' (0), 'Flagged' (0), 'Due Today' (0), and 'Assigned' (0); and 'PATIENTS' showing 'With Appts Today' (57), 'Starred' (0), 'New' (260), and 'Assigned' (0). Below these cards is a section for 'Starred Patients' with tabs for 'Starred Patients', 'Flagged Tasks', and 'Coordination Tasks'. A search bar for 'Search starred patients' is present. The main area shows a table with columns: NAME, MRN, DOB, NEXT APPT, CARE MANAGER, and COHORTS. The table currently displays 'No Patients to Display' and 'Showing 0 to 0 of 0 entries'.



Problems ACC Solved for PHS (Primary Health Solutions) **15**

Need for a 2-tier workflow.

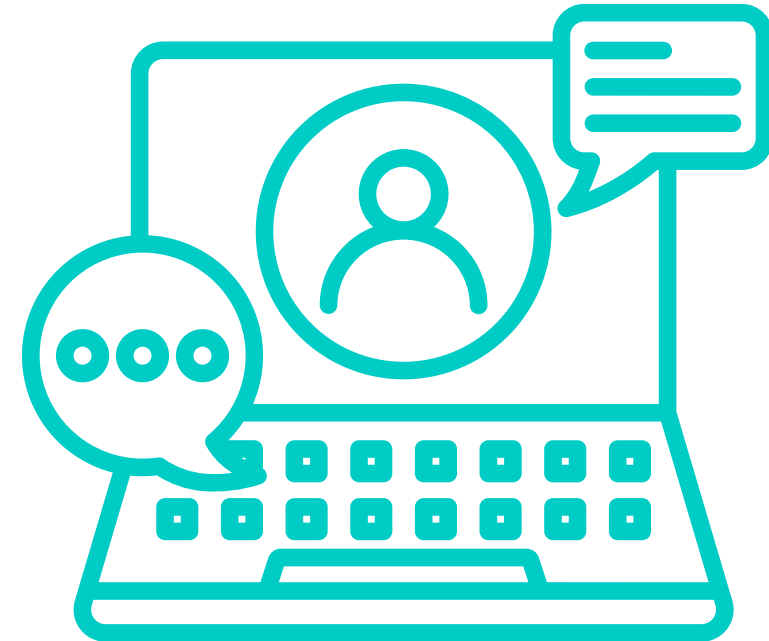
Identifying patients via a population health strategy.

Managing lists of patients manually.

Standardizing Care Manager Assignments.

NextGen templates less than ideal.

Providers not able to identify active CM patients.



Problems ACC Solved for PHS

15

Need for a 2-tier workflow.

ACC functionality for care coordination and care management.

Identifying patients via a population health strategy.

Can apply a standard criteria to EVERY patient who needs wrap around services

No longer reliant on provider referrals of high cost/utilization/risk lists from payers

Managing patients lists manually.

Workload report shows panel assignment

Care Manager filter for CMs specific patients



Problems ACC Solved for PHS – Continued

NextGen templates less than ideal.

Custom / editable care plan templates

Diseases/cohorts specific care plans

Providers not able to identify active CM patients.

DRVS EHR Plug In shows care plan with one click from patient information bar & the plugin is a part of the workflow.

No standard way to assign a care manager

CM field is mapped in EHR to pull over into Azara Care Connect



DRVS EHR Plug-In Inside of NextGen

The screenshot displays a web-based EHR interface. At the top, a navigation bar includes links for 'OBGYN Details', 'Screening Tools', 'Azara', 'PHI Log', 'Sticky Note', 'Referring Provider', 'HIPAA', 'Advance Directives', and 'Screening Summary'. Below this is a browser tab labeled 'SevaSSO Azara Demo'. The main content area is divided into several sections:

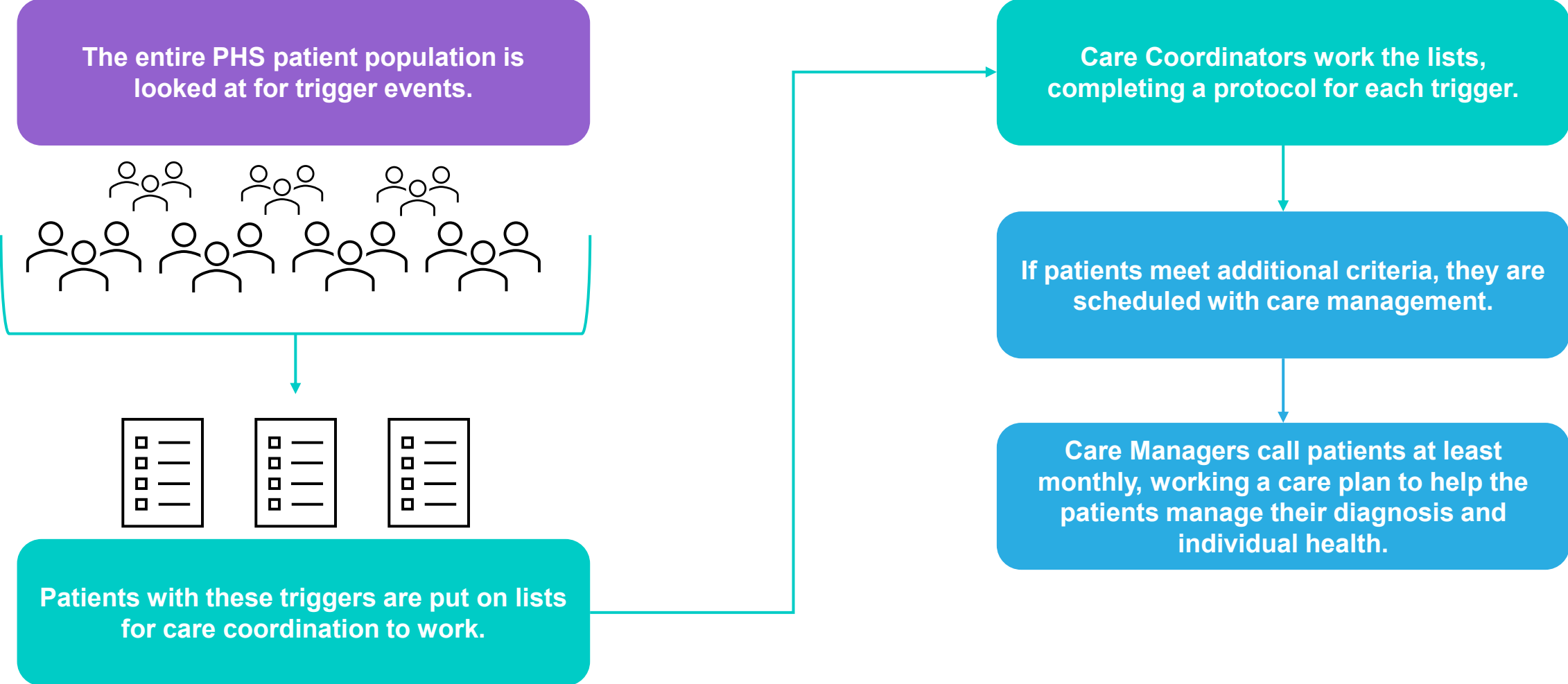
- Tasks:** A table with columns 'Due', 'Action', 'Summary', 'Assignee', and 'Comments'. The table is currently empty, displaying 'no results found'.
- Management Plan:** A section with a large teal placeholder box.
- Patient Consent:** A section with the following text:
 - Date: 11/21/2025
 - Care management program discussed with patient. Consent statement read to patient. Patient gave verbal consent.
 - Consent Statement:
 - As a patient with **two or more ongoing health conditions**, you may benefit from a care management program Primary Health Solutions offers to patients. The services available through our care management program includes:*
 - Helping you manage ongoing health conditions, checking in with you on your health care needs, and helping you understand and take your medications.
 - Making sure you can get in touch with your provider or care team 24-hours-a-day, 7-days-a-week, including by telephone and patient portal
 - Seeing that each time you come to the health center you see a regular provider or care team, whenever possible.
 - Working with you to make a plan for how to best care for your health issues;
 - Helping you work with and coordinate care across different providers and settings, including specialists or other providers, hospitals, and emergency department.
 - Your Rights*
 - As part of the chronic care management services, you will receive a copy of your care plan. You have the right to stop chronic care management services at any time (effective the end of a calendar month). Please contact us at 513-454-1111 to stop your consent.*
- Care Plan Review:** A section with the text: 'Care plan was created 08/28/2025'.

On the left side of the interface, there is a sidebar with navigation options: 'Moderate (10)', 'MRN:', 'DOB:', 'CM:', 'PLAN:', 'ALERTS (5)', 'RAF GAPS (4)', 'REFERRALS (4)', 'CARE MGMT', and 'DOCUMENTS: Care Mgmt Plan'.



Program Build Out

Care Connect Program Structure



ACC Workflow

Azara Care Coordination

Patients identified through contact reasons

- Transitions of care – Inpatient discharge only
- Triage from ACU
- Internal care coordination referrals – coming soon (custom contact reason)



List of patients
(Care Coordination Tab)



Care Coordinator

Calls the patient 2 times, works protocol, patient falls off the list

Azara Care Management

Patients identified through cohorts

- Diabetes A1c>9
- New Diabetic (custom build)
- COPD
- Foster Care



List of patients
(Patients Tab)



Care Coordinator

Calls the patient 2 times, documents outreach



IF patient meets CM criteria, assign CM in EHR and schedule



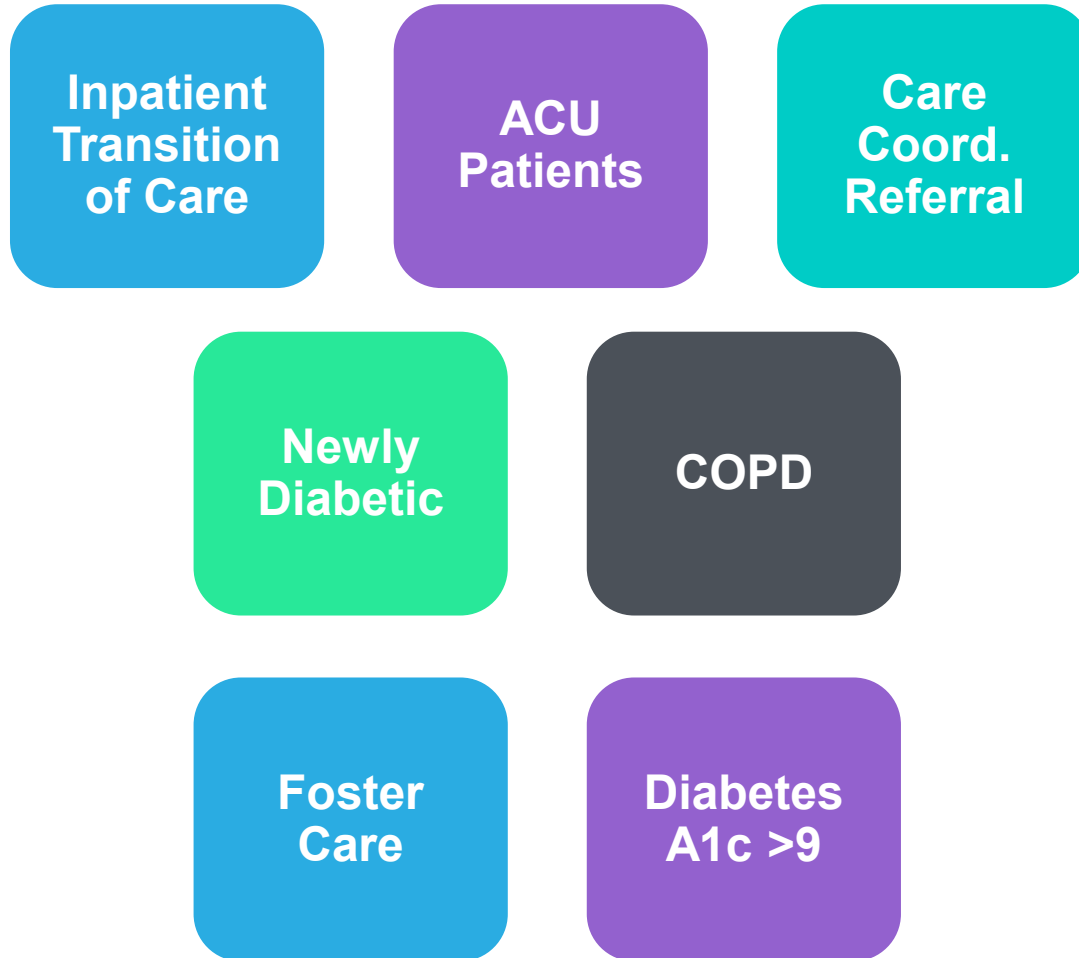
Care Manager

Calls the patient at scheduled time, gets patient consent, creates care plan, patient touch at least once a month



Contact Reasons and Cohort Decisions

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Consider

- Priority quality measures
- Uncontrolled chronic conditions
- Rising risk populations
- Common ED/IP diagnoses
- Regulatory/VBC requirements



ACC and ACU

How Patients Come in From ACU

PHS is in a Medicare Shared Savings Program (MSSP) with our state association. The MSSP made the decision to purchase Azara Cost and Utilization (ACU). Medicare data is input monthly into ACU through the MSSP.

ACU Member Review

| Mark as Needs Review (0) | | | Mark as Pending Engagement (0) | | | Mark as Not Engaged (0) | | | All | Needs Review | Pending Engagement | Engaged | Not Engaged | |
|--------------------------|-------------|--------------------|--------------------------------|--------|---------------|-------------------------|-----|-----|---------------|--------------|--------------------|---------|-------------|------------|
| Status | Status Date | Population | Member Name | Alerts | Plan | LOB | Age | RUB | Chronic Cond. | Eps. | ED Eps. | IP Eps. | Rx Cost | Total Cost |
| <input type="checkbox"/> | 03/01/2026 | High Inpatient ... | [REDACTED] | 0 | Medicare MSSP | Medicare | 26 | 4 | 0 | 19 | 2 | 3 | \$6.12 | \$1,528.91 |
| <input type="checkbox"/> | 02/01/2026 | High Inpatient ... | [REDACTED] | 0 | Medicare MSSP | Medicare | 22 | 4 | 6 | 58 | 4 | 3 | \$24.75 | \$8,808.46 |
| <input type="checkbox"/> | 02/01/2026 | High Emergen... | [REDACTED] | 0 | Medicare MSSP | Medicare | 81 | 5 | 17 | 35 | 6 | 1 | \$48.67 | \$7,943.91 |
| <input type="checkbox"/> | 05/01/2025 | High Emergen... | [REDACTED] | 0 | Medicare MSSP | Medicare | 72 | 5 | 8 | 82 | 8 | 0 | \$174.72 | \$7,395.82 |

Patients flow into ACC care coordination, with the outreach reason of Triage.





Sustainability

Other Things to Think About

Care Management Cohort

- PCMH reporting needs.
- Capturing patients who might fall off dynamic cohorts.

Care Management Billing

- Documentation needs for Medicare CCM Billing.

Graduation Criteria and Declining Services

- Who should be in CM services?
- Who is no longer in CM?

Ongoing Reporting

- Tracking/reporting criteria.
- Center successes?



Making Staff Part of the Process

15

Weekly Tracking (Emailed to project team leads)

Pulled from ACC

- # of patients in each cohort
- Total # of patients identified in cohorts
- # of patients unassigned
- # of patients assigned to each care manager
- # of patients with care plans updated in the last month (manual review)

Calculated in Excel from the above

- % unassigned
- % in care management
- % graduated
- % declined services
- % of patients with care plans (for each care manager panel)



Making Staff Part of the Process

Monthly Data Meeting
(CC, CM, and Project Team Leads)

Care Coordination



Transitions of Care

- Total Reported
- # Completed
- # Attempted
- # Connected

Referrals for Care Coordination

- # Ordered
- # Completed

Appointments Scheduled

- ER/Hosp F/U
- Care Management

Making Staff Part of the Process



Monthly Data Meeting (CC, CM, Project Team Leads)

Care Management

CM Population

- Total patients identified
- # in each cohort
- % unassigned
- % in care management
- % declined
- % graduated

Panels by CM

- Current Panel Number
- # from Target
- # Patients with a Care Plan
- % of Patients with a Care Plan

Panel Composition by Cohorts

Appointments

- Kept Appts
- Cancelled Appts
- No Show Appts
- No Show Rate

Quality Measures



Quality Outcomes

Compare care management panels to entire population and track progress over time

| Care Effectiveness of Care Managed Patients | January | February |
|---|---------|----------|
| Diabetes A1c Control | | |
| Poor (>9) | 81 | 74 |
| Fair (>8 and <=9) | 16 | 15 |
| No Score | 5 | 2 |
| BP Control for Diabetic Patients | | |
| Stage 2 Severe (>=160 or >=100) | 13 | 12 |
| Stage 2 HTN (140-159 or 90-99) | 23 | 24 |
| Stage 1 HTN (130-139 or 80-89) | 65 | 49 |
| Elevated BP (120-129 and <80) | 7 | 10 |

| Measure | January | February |
|--|---------|----------|
| Cervical Cancer Screening (TY) | 48.40% | 47.60% |
| Breast Cancer Screening (TY) | 37.80% | 45.60% |
| Colon Cancer Screening (TY) | 38.30% | 43.20% |
| Total # of 2026 ED Visits (M) | 66 | 58 |
| Average # of ED Visits Per Patient (M) | 1.5 | 1.3 |
| Total # of 2026 IP Visits (M) | 31 | 22 |
| Average # of IP Visits Per Patient (M) | 1.4 | 1.2 |





Next Steps

Looking Ahead



Population

Cohort adjustment to scale population

- Grant programs and tracking

Manual cohorts for patient groups we receive through external data

Add more care managers that serve specific service lines (IE: BH or Woman's health

- Create custom templates for specialty/disease groups

Workflow considerations if other value-based groups add ACU



Staffing

Understand staffing needs through **data**

- Patient reassignment and staff transitions
- Visualizing panel capacity



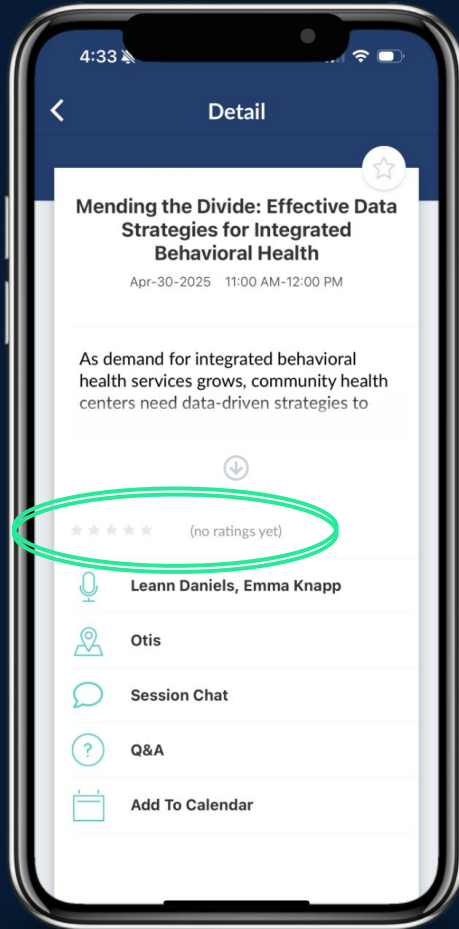


Questions?



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Provide brief feedback or ideas



Rate the session and the speaker(s)



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Thanks for attending!

