Scaling Care Management with ACC and ACU

A Two-Tier Coordination Model

azara 2026
USER CONFERENCE APRIL 13–15 | BOSTON, MA

Introduction

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Primary Health Solutions

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

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

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

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

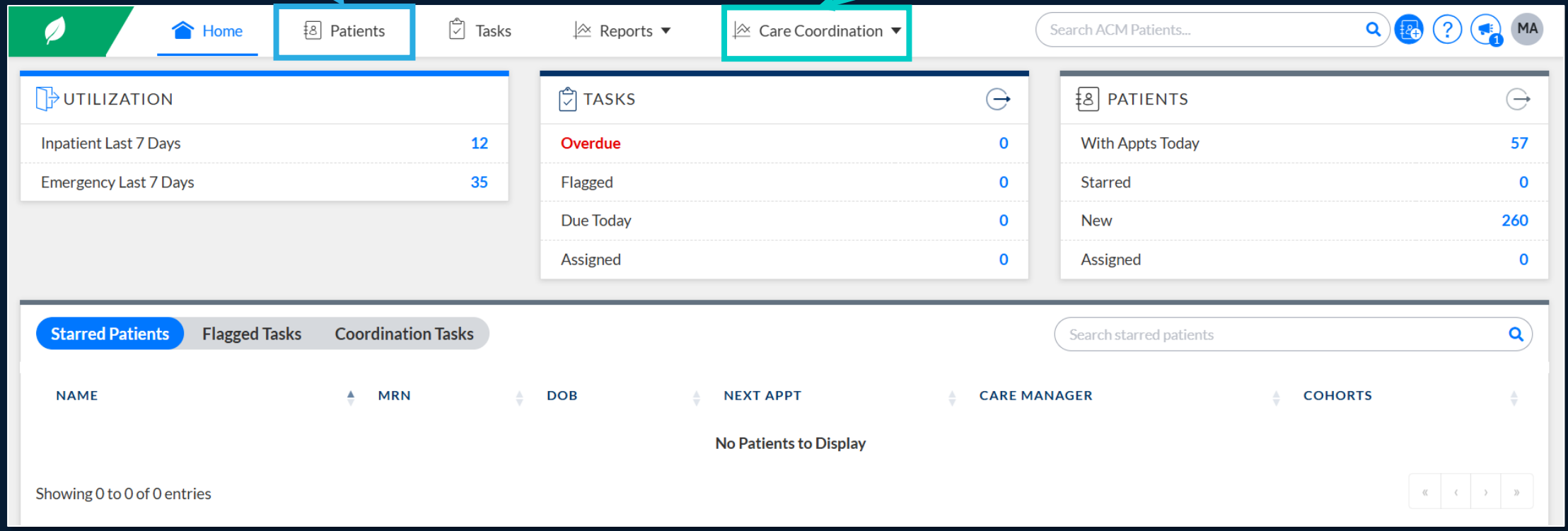
- Clinical criteria - certain diagnosis, etc
- Can create manual cohorts

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)



Problems ACC Solved for PHS (Primary Health Solutions)

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

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

PHS purchased the Azara Care Connect module in summer 2025.

Problems ACC Solved for PHS – Continued

NextGen templates less than ideal.

- Custom / editable care plan templates
- Diseases/cohorts specific care plans

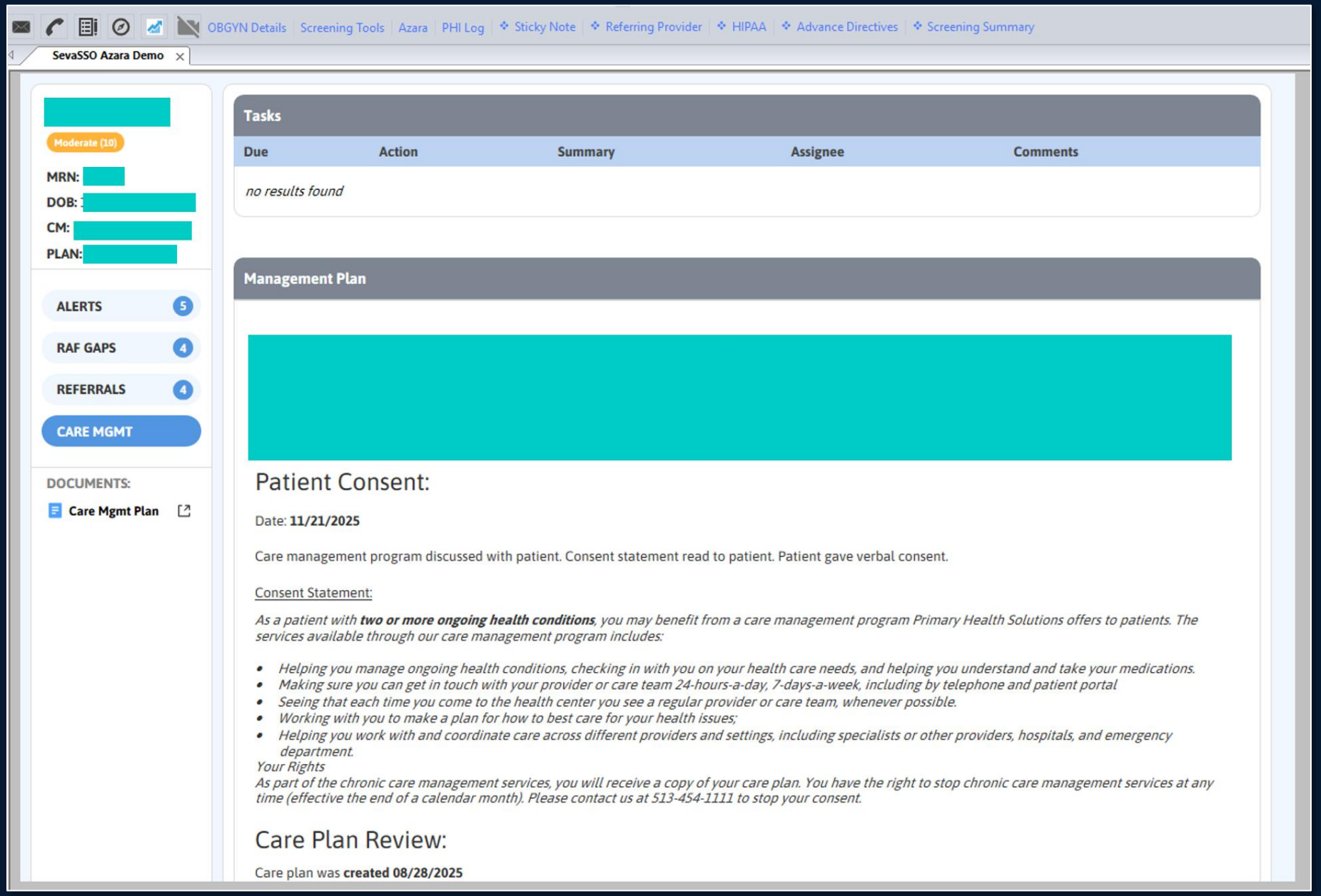
Providers not able to identify active CM patients.

- 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

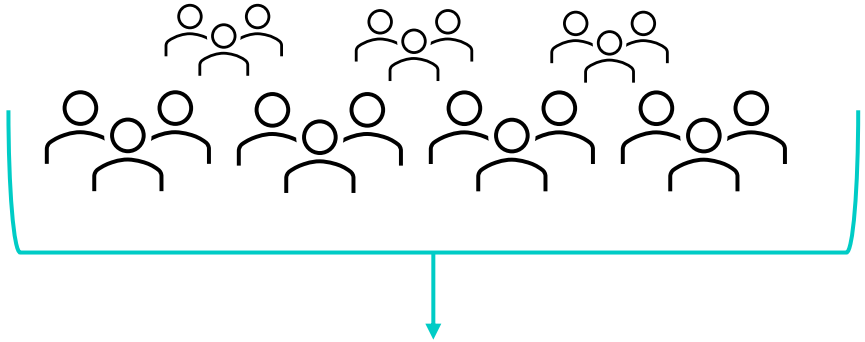
DRVS EHR Plug-In Inside of NextGen

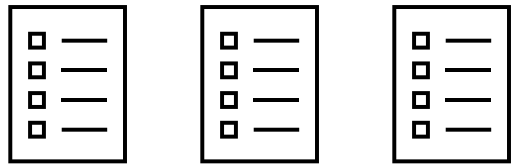


Program Build Out

Care Connect Program Structure

The entire PHS patient population is looked at for trigger events.





Patients with these triggers are put on lists for care coordination to work.

Care Coordinators work the lists, completing a protocol for each trigger.

If patients meet additional criteria, they are scheduled with care management.

Care Managers call patients at least monthly, working a care plan to help the patients manage their diagnosis and individual health.

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

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
	03/01/2026	High Inpatient ...	[redacted]	0	Medicare MSSP	Medicare	26	4	0	19	2	3	$6.12	$1,528.91
	02/01/2026	High Inpatient ...		0	Medicare MSSP	Medicare	22	4	6	58	4	3	$24.75	$8,808.46
	02/01/2026	High Emergen...		0	Medicare MSSP	Medicare	81	5	17	35	6	1	$48.67	$7,943.91
	05/01/2025	High Emergen...		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

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

Next Steps and Scalability

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

Next Steps and Scalability

Staffing

Understand staffing needs through **data**

- Patient reassignment and staff transitions
- Visualizing panel capacity

Questions?

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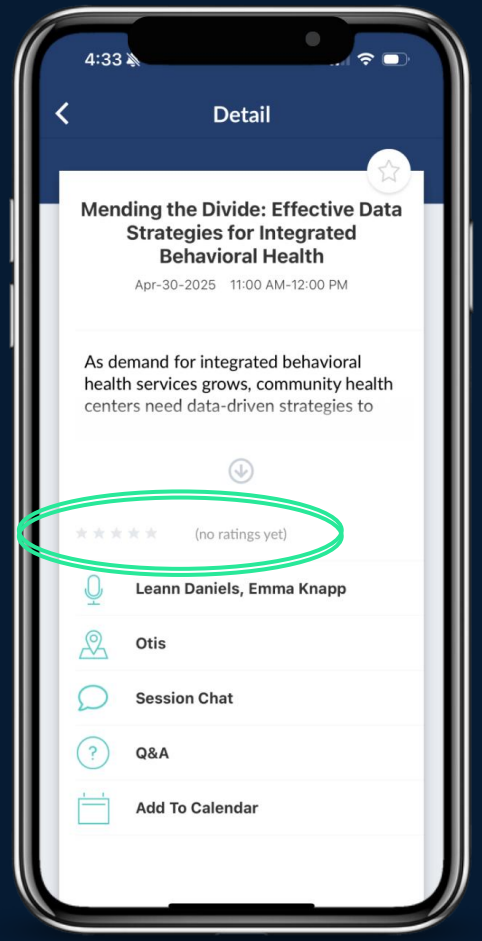

Quick and Easy

Provide brief feedback or ideas

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