Automation with Accountability

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Educational Webinar Series

How ACOs Can Scale Patient Engagement Without Burning Out Teams

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zynix.ai

YOUR PRESENTERS

Built by operators who have lived value-based care

JC

Jay Chowdappa, MD

Co-Founder & CEO

- Founded 6 Medicare ACOs across Florida
- $300M+ in shared savings under MSSP
- 700+ participating physicians
- Board-certified Internal Medicine
- Co-founded Assurity DCE
- National leader in population health & VBC

GC

Gautam Chowdary

Co-Founder & CTO

- Built AI/ML platforms from 0 → 1 in healthcare
- CEO, Medvise AI — clinical AI documentation
- Ex-Zendar (autonomous vehicle perception)
- Ex-Esper (enterprise device infrastructure)
- MS Computer Science, Arizona State University
- Forbes Technology Council member

CONTEXT

Why this matters now

ACOs are under pressure to do more outreach, faster, with less operational slack.

AUDIENCE POLL *Answer one or more that apply*

What is the biggest patient engagement bottleneck in your organization today?

- **A** Reaching patients reliably
- **B** Converting outreach into booked care on time
- **C** Getting patients to complete visits or tests
- **D** Closing the loop with follow-up and documentation

OPERATIONAL REALITY

The ask keeps growing. Teams are already stretched.

What ACOs are asked to do

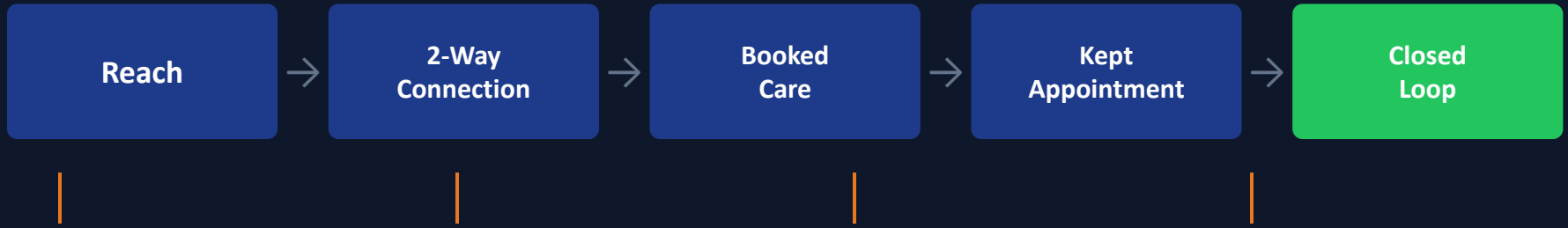
- Close more care gaps
- Hit post-discharge windows
- Drive preventive care
- Improve patient engagement
- Prove closure and defensibility

What teams actually have

- Limited staff capacity
- Fragmented work queues
- Manual call lists
- Incomplete documentation
- High turnover risk

THE PROBLEM

Why patient engagement breaks at scale



SCALE PROBLEM

Why manual outreach fails at scale

Human effort is precious — use it where judgment matters.

What coordinators are juggling

- Large daily call lists
- Repeated voicemail loops
- Manual scheduling and rescheduling
- Documentation after every touchpoint
- Escalation follow-up and callbacks

The result

- Outreach volume grows faster than staffing
- Each missed step creates another queue
- After-hours leakage adds low-yield work
- Quality programs become labor-heavy and brittle

HOW IT WORKS

What accountable automation actually does-

Automation Handles Volume

- First-touch outreach
- Reminder cadence
- Scheduling prompts
- EMR status updates
- Audit-ready logging

Humans Handle Exceptions

- Clinical judgment
- Safety escalations
- Complex counseling
- Medication decisions
- High-risk coordination

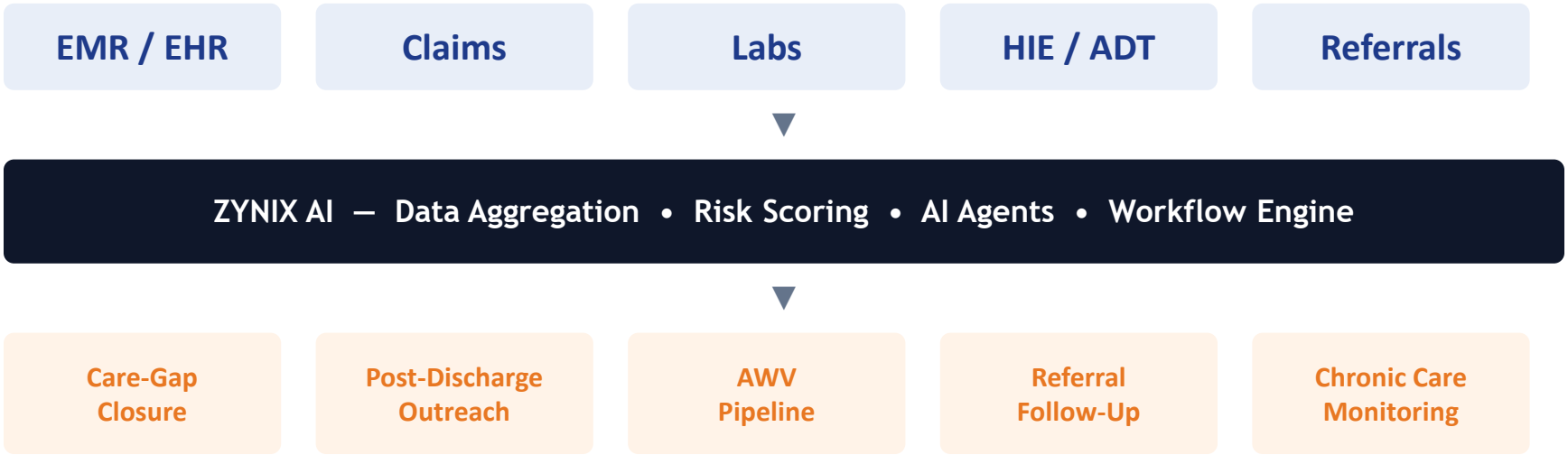
Governance Makes It Defensible

- Consent & opt-out controls
- Role-based access
- Escalation rules
- Traceable audit trails
- Transparent handoffs

PLATFORM

The Zynix AI platform

One engagement layer across all ACO workflows.



MODEL

Automation + human-in-the-loop is the winning model

Let the technology absorb repetitive volume.

AI-supported functions

- Initial outreach and reminders
- Basic scheduling and no-show rescue
- Routine care-gap explanations
- Simple status checks and structured questions
- After-hours first-line coverage

Human-owned functions

- Clinical judgment and care-plan
- Complex counseling
- Urgent escalation and red-flag response
- Relationship-based conversations
- Final accountability for patient care

AUDIENCE POLL *Answer one or more that apply*

Where can automation create the most immediate value in your organization?

- **A** First-touch outreach (AWV / TOC / quality gaps)
- **B** Scheduling and reminders
- **C** Documentation in EMR
- **D** After-hours coverage and triage

TWO ENGINES

Two outreach engines every ACO needs

Do not think only in terms of TOC.

Engine 1

Care-gap / preventive / chronic maintenance

Designed to move patients from open gaps to test or visit completion.

Engine 2

Post-diagnostic / event-driven follow-up

Designed to respond to events, discharges, abnormal results, and missed follow-through.

ENGINE 1

Care-gap closure outreach

Examples that matter every day to ACO operations.

Typical workflow triggers

- A1c overdue
- Renal profile overdue: uACR / eGFR
- FIT / stool occult / CRC screening overdue
- Mammography overdue
- AWV not yet scheduled
- BP recheck or diabetic eye exam overdue

What the workflow must accomplish

- Explain why the test or visit matters
- Capture site / lab preference when relevant
- Place or route the order / appointment
- Send reminders until completion
- Document closure back to the team

ENGINE 2

Post-diagnostic and event-driven follow-up

Same backbone, different triggers.

Typical event triggers

- Post-discharge outreach window
- Abnormal lab or imaging follow-up
- ED visit requiring PCP touchpoint
- Missed specialist referral or follow-up
- Positive depression screen needing response

What the workflow must accomplish

- Reach the patient quickly
- Assess status and red flags
- Book or route the next step
- Escalate when symptoms or risk warrant it
- Close the loop with documentation

AUDIENCE POLL *Answer one or more that apply*

Which workflow is the highest priority for automation in your organization over the next 12 months?

- **A** Post-discharge follow-up
- **B** AWV pipeline
- **C** Diabetes / renal care-gap closure
- **D** Preventive screening outreach

CARE GAPS

From gap list to closed loop

Workflow	Outreach Motion	Completion Event	Closure Definition
A1c overdue	Explain diabetic monitoring; route to lab	Lab drawn	Result posted and chart updated
Renal profile	Explain kidney monitoring; schedule uACR/eGFR	Lab completed	Result available, PCP notified
FIT / stool occult	Outreach + order/ship + reminder cadence	Kit returned	Result documented, gap closed
Mammography	Schedule imaging + reminders + no-show rescue	Study completed	Report posted, closure documented

LIVE illustration

Demo: A1c + kidney function outreach

POST-EVENT

From trigger to closed loop — post-event examples

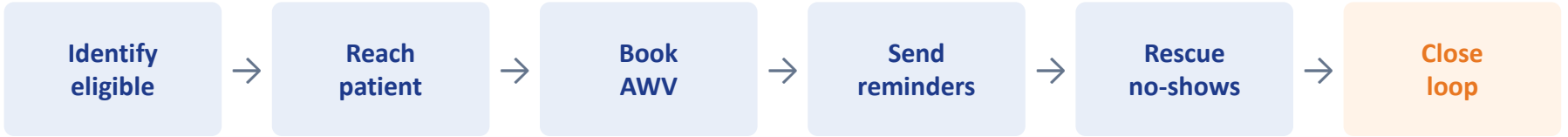
Workflow	Outreach Motion	Completion Event	Closure Definition
Post-discharge	72-hr outreach + 7-day follow-up booking	Visit scheduled / completed	TOC loop closed and documented
Abnormal lab	Notify patient, assess urgency, route next step	Patient reached, action taken	Escalation or visit documented
Missed referral	Re-engage patient, route back to scheduling	Referral completed or rescheduled	Referral loop closed

LIVE illustration

Demo: PDV / post-discharge follow-up

AWV PIPELINE

High-value workflow: AWV pipeline automation



- Use automation to absorb first-touch outreach and reminder burden.
- Keep staff focused on exceptions, questions, and rescheduling edge cases.
- Tie the workflow to kept visit rate and closure — not just calls placed.

LIVE illustration

Demo: AWV outreach and scheduling

PREVENTIVE

High-value workflow: Preventive screening outreach

Order → schedule → remind → complete → document

Common screening examples

- Mammography
- CRC / FIT / stool occult
- Diabetic eye exam
- BP recheck when visit follow-up is needed

What matters operationally

- Clear explanation of why screening is due
- Frictionless scheduling or routing
- Reminder cadence before completion
- Accurate status update back to care team

Demo: Mammogram reminder and scheduling

AFTER-HOURS

After-hours answering and overflow support

Protect teams from repetitive evening and weekend leakage.

What after-hours automation can do

- Answer routine inbound questions
- Route basic scheduling or callback requests
- Provide clear expectations for next steps
- Escalate urgent symptoms or safety issues

Why ACOs care

- ED diversion
- Faster response experience for patients
- Better containment of low-acuity leakage
- More disciplined escalation to the right humans

Demo: After-hours answering agent

AUDIENCE POLL *Answer one or more that apply*

How is after-hours patient communication handled today in your organization?

- **A** Answering service only
- **B** Internal staff rotation
- **C** Voicemail / mixed model
- **D** Structured automated support with escalation

AUTOMATION

What the platform automates

Automation layer

- Patient identification and worklist generation
- Outreach cadence across voice / messaging
- Structured questions and status capture
- Scheduling support and reminders
- Task routing and audit trail

Shared benefits

- Consistency at scale
- Less manual queue work
- Better visibility into funnel drop-off
- More predictable closure workflows
- Reusable infrastructure across programs

HUMAN LAYER

What the care team still owns

Critical point: automation supports teams — it does not replace them.

Care-team responsibilities

- Clinical decisions and medication changes
- Review of complex or sensitive situations
- Urgent symptom escalation and red flags
- Relationship-based counseling and reassurance

Why this model works

- Uses human time where it matters most
- Improves safety and defensibility
- Avoids over-automation of clinical judgment
- Reduces burnout from repetitive low-yield work

GOVERNANCE

Why accountability matters

Responsible automation must be transparent, governed, and defensible.

Governance essentials

- Consent and disclosure
- Role-based access and queue discipline
- Escalation rules and safety phrases
- Audit trails for action and outcome

Executive value

- Confidence for compliance and leadership
- Defensible workflows when questions arise
- Clear human responsibility boundaries
- Better trust from care teams

OPERATING MODEL

The operational backbone stays the same

Data & Triggers	Claims, EHR gap lists, discharge feeds, abnormal results
Automation Layer	Voice / SMS outreach, scheduling logic, task queues, EMR write-backs
Human Oversight	Clinical review, escalations, medication decisions, complex counseling
Measured Outcomes	Time-to-care, completion rate, closure rate, audit trail

ACCESS Is Forcing a Function for Automation

Low PMPM requires software-driven coordination — not labor-heavy operations

eCKM	CKM	MSK	BH
$6 PMPM	$13.5 PMPM	$6 PMPM	$8.5 PMPM
Cardio-Kidney-Metabolic (Enhanced)	Cardio-Kidney-Metabolic	Musculoskeletal	Behavioral Health

Implication for Operations

The labor-first model doesn't work here. Automate first touch, routing & documentation.

- Reserve humans for exceptions, clinical judgment & relationship-building.
- Winning KPI: reach → 2-way conversation → booked care → completion.

QUALITY REPORTING

Automating MCQM and eCQM data collection at scale

100+

Different EMRs integrated

4

ACOs supported

What Zynix automates for quality reporting

- Centralized data aggregation across heterogeneous EMR environments
- Automated patient matching, deduplication, and clinical record parsing
- QRDA-III file generation and FHIR-based submission to QPP portal
- Real-time gap identification for APP Plus measures (expanding to 8+ in 2026)
- Audit-ready documentation trail for CMS quality reporting compliance

What teams get back

- Fewer repetitive outreach attempts
- Cleaner queues and better prioritization
- More time for escalations and high-value conversations
- Less after-hours burden

What leaders gain

- More scalable engagement operations
- More consistent closure workflows
- Better defensibility and governance
- A clearer path to improvement without adding staff

Automation should not replace care teams.

It should remove the friction that prevents them from Scaling & delivering great care.

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Q&A

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Thank You

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