AI for Care Management

How Palm Beach ACO Scales Patient Engagement with Zynix AI

An executive discussion on AI-enabled outreach, EMR integration, and care-management at scale.

Speakers

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Educational Webinar Series

RUN OF SHOW

Today’s 60-minute discussion

1. the problem
2. PBACO operating reality
3. Initial use cases
4. Scale + integration
5. Roadmap + lessons
6. Q&A

Discussion flow

0–5 min	**David McDonald**	Opening, introductions, objective
5–15 min	**Jay + David K.**	Why care management needs a new operating model
15–35 min	**Jay + David K.**	PDV/TCM, AWV, outreach, scheduling, and Zynix workflows
35–48 min	**Jay + David K.**	EMR complexity, operations, cost-of-care, quality, HCC capture
48–55 min	**Jay + David K.**	Future roadmap: AI scribe + after-hours answering / triage
55–60 min	**David McDonald**	Audience Q&A and close

01

Why care management needs a new operating model

--the operational problem is scaling execution, not just finding more help.

WHY THIS MATTERS

The value-based care execution gap

What ACOs must do

- TCM / PDV follow-up
- AWV scheduling
- Quality gap closure
- Risk capture support
- Documentation + reporting

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What teams can absorb

- Manual call lists
- Staffing constraints
- Fragmented workflows
- Incomplete follow-up
- After-hours leakage

Core thesis

The winning model is AI-enabled execution with human oversight — not simply more manual labor.

POLL

Audience poll #1 (Answer one or more that apply)

What is the hardest patient-engagement problem to scale today?

- A Post-discharge follow-up within the right window
- B AWV outreach and scheduling at scale
- C Quality-gap outreach and closure
- D After-hours access and leakage

PBACO CONTEXT

Palm Beach ACO: operating at scale

Network scale

Large ACO environment with broad provider participation and significant patient-engagement volume.

EMR complexity

1,500+ EMR instances create workflow, integration, reporting, and consistency challenges.

Execution need

Timely outreach, follow-up scheduling, write-backs, and performance tracking across fragmented operations.

“What made patient engagement and care-management execution especially Challenging at PBACO’s scale?”

FROM WORKLOAD TO BOTTLENECK

Why manual care-management outreach breaks

1. List created
2. Call attempts
3. Patient reached
4. Appointment booked
5. Visit kept
6. Loop closed

Manual model failure points

- Repeated outreach attempts are labor intensive
- Scheduling and handoffs vary by practice
- Documentation can lag behind the work
- No-show rescue is inconsistent
- After-hours calls create leakage and staff burden

Implication

Adding more manual labor may help briefly, but it does not create a scalable or repeatable operating model.

USE CASE

Initial focus area #1: PDV / TCM follow-up

Goal: timely post-discharge engagement + follow-up scheduling

1. Discharge trigger
2. AI outreach
3. Status check
4. PCP follow-up
5. EMR note
6. Care team escalation

Operational value

Standardized 48-hour outreach and timely follow-up booking without scaling call-center labor.

Clinical value

Earlier issue detection, medication adherence checks, and escalation of red flags.

VBC value

Designed to support

- lower readmissions,
- fewer avoidable ER visits, and
- better shared-savings potential.

VIDEO ILLUSTRATION

PDV / TCM outreach and scheduling

What to listen for: patient status check, medication / red-flag prompts, follow-up booking, and handoff-ready documentation.

PLAY AUDIO

“The point is not just that a call happened — the workflow moves toward closure.”

USE CASE

Initial focus area #2: AWV outreach and scheduling

AWVs are not just visits — they support quality, relationship, documentation, and risk capture.

1. AWV eligible
2. AI outreach
3. Schedule visit
4. Reminders
5. No-show rescue
6. Visit completed

Quality impact

More timely preventive care and quality-gap identification.

HCC impact

Risk recapture opportunities.

Benchmark impact

Improved risk re-capture can support more accurate spending benchmarks.

Practice impact

More scheduled visits and less manual outreach burden.

VIDEO ILLUSTRATION

AWV outreach and scheduling

What to listen for: patient-friendly explanation, appointment conversion, reminder logic, and low-lift handoff to the practice.

PLAY AUDIO

POLL

Audience poll #2

Which workflow would create the most near-term value for your organization?

- A PDV / TCM outreach and follow-up scheduling
- B AWV outreach and scheduling
- C Quality-gap outreach: A1c, kidney, CRC, mammography
- D After-hours answering / triage and ER diversion

ZYNIX AIs ROLE

What Zynix automates in the PBACO operating model

Patient identification

Eligible cohorts from claims, EMR, ADT, or gap lists

AI outreach

Voice + SMS outreach, retry logic, opt-out handling

Scheduling support

PCP follow-up, AWV booking, reminders, no-show rescue

Documentation

Call summary, structured fields, EMR write-back where integrated

Reporting

Operational dashboards, KPIs, audit trails, reconciliation support

Core idea: automate repetitive execution; escalate exceptions to care teams.

INTEGRATION

The EMR challenge: scale without standardization

1,500+

EMR instances across the PBACO environment

Why this matters

Workflow consistency is hard when data, scheduling, and documentation are distributed across many systems.

Integration strategy

Start with high-value workflows and prioritize scalable read/write pathways where available.

Operational principle

Do not wait for perfect integration everywhere to create value.

End state

Closed-loop outreach with increasing EMR write-back and structured reporting over time.

OPERATING MODEL

Closed-loop execution: from trigger to EMR write-back

1. Trigger
2. Outreach
3. Assessment
4. Scheduling
5. Escalation
6. Write-back
7. Dashboard

Examples of triggers

Hospital discharge
AWV eligibility
Unclosed quality gap
After-hours inbound call
Abnormal result / missed referral

What “closed loop” means

Patient reached or attempts documented
Next step booked or routed
Human escalation when needed
Action appears in dashboard / EMR
Performance is measurable

Why leaders care

Lower variance
Higher accountability
Better audit readiness
More predictable operating cost
Faster scaling across network

VBC ECONOMICS

How AWV execution supports quality and risk capture

1. AWV scheduled
2. Patient seen
3. Gaps reviewed
4. HCCs documented
5. Care plan updated
6. Risk accurately captured

Quality score impact

More preventive gaps identified and acted on
Better annual engagement with primary care
Opportunity to address chronic disease measures

Risk-adjustment impact

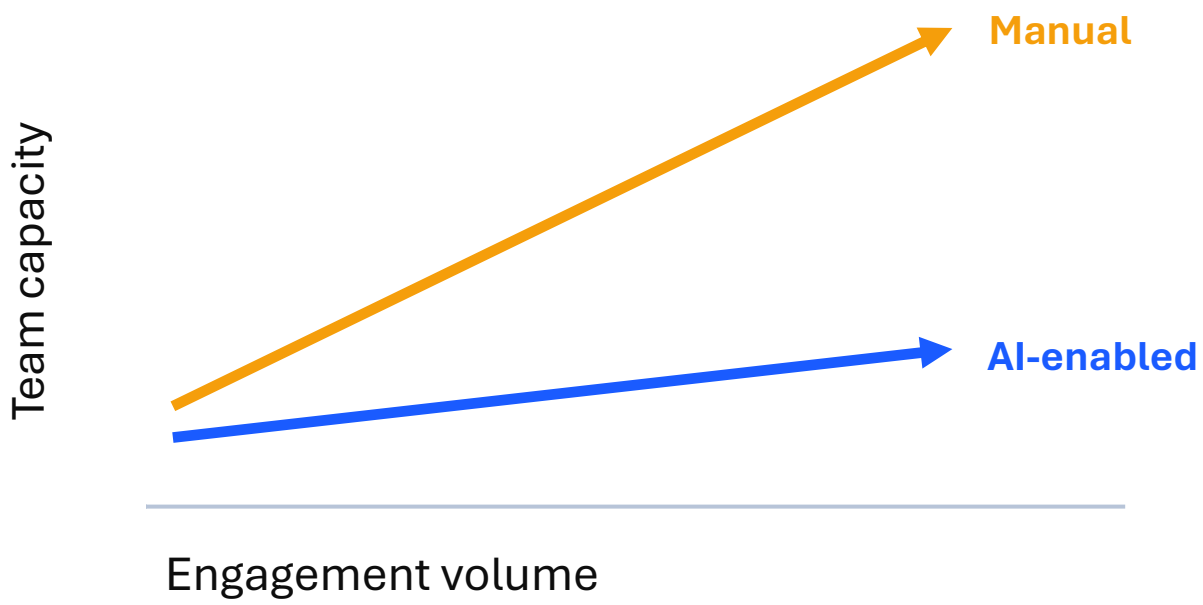
More complete condition documentation
Better recapture of chronic conditions
More accurate spending benchmarks over time

Use careful language in the webinar: “designed to support,” “intended to improve,” and “can help create the conditions for.”

BUSINESS CASE

Operational efficiency: scaling without proportional headcount

Illustrative capacity curve



Manual model

Capacity grows mostly by adding people, call lists, and management overhead.

AI-enabled model

Automation absorbs repetitive outreach while humans focus on exceptions.

Leadership outcome

More consistent execution, better staff leverage, and lower marginal cost per engagement.

POLL

Audience poll #3 (Answer 1 or more)

Which value driver matters most for AI-enabled care management?

- A Lower operational cost / less staffing pressure
- B Timely follow-up and better patient access
- C Reduced avoidable readmissions / ER visits
- D Quality, HCC recapture, and shared savings potential

FINANCIAL LOGIC

Cost-of-care logic: from timely engagement to shared savings potential

1. Timely outreach
2. Follow-up booked
3. Issues surfaced early
4. Avoidable utilization reduced
5. Shared savings potential

PDV / TCM impact logic

Earlier contact and PCP follow-up are designed to support lower readmissions and avoidable ER use.

AWV impact logic

More timely annual visits support quality closure, HCC recapture, and better care planning.

Operating leverage

AI-enabled workflows help increase engagement volume without equivalent headcount growth.

EXPANSION

Future roadmap: AI scribe across the provider network

Why AI scribe matters in the same operating model

Provider adoption

Reduces documentation burden and creates a practical provider-facing AI entry point.

Data capture

Supports better structured documentation, problem-list hygiene, and follow-up triggers.

Care execution

Visit documentation can trigger care-gap outreach, referral follow-up, or care-plan actions.

How can PBACO use scribe adoption to create a broader AI-enabled care-execution layer?

EXPANSION

Future roadmap: after-hours answering, triage, and ER diversion

1. After-hours call
2. AI answer
3. Routine request handled
4. Red flag escalated
5. Next-day follow-up
6. ED leakage reduced

Patient access

Patients receive timely, structured responses instead of voicemail-only pathways.

Team protection

Routine after-hours volume is absorbed before it becomes staff burden.

ACO economics

Appropriate triage and timely follow-up can support ER diversion and lower avoidable cost.

VIDEO ILLUSTRATION

After-hours answering and triage

What to listen for: routine request handling, escalation language, and how the workflow protects teams while preserving access.

GAUTAM: PLAY VIDEO

Future PBACO Implementation

Quality Gap Reminder Outreach by Sofia

Expanding PBACO's AI-enabled outreach beyond PDV and AWV into scalable quality gap closure workflows

Priority Quality Gaps

A1c reminders

Kidney function labs: uACR / eGFR

CRC / FIT / stool occult outreach

Mammogram reminders

Diabetic eye exams

BP rechecks / preventive follow-up

How Sofia Helps

Proactive outbound voice outreach

Patient-friendly education

Scheduling or routing support

Reminder cadence until completion

Closed-loop status tracking

Workflow visibility for PBACO teams

Why It Matters

Improves preventive and chronic care closure

Supports quality scores

Helps scale without proportional headcount growth

Creates more operational consistency

Supports risk capture and value-based care performance

Same engagement infrastructure → more quality gap closure at PBACO scale

Illustration

Sofia Quality Gap Outreach Demo

What this illustration shows

Open quality gap identified
Sofia engages the patient
Clear explanation of why the test or screening matters
Reminder or scheduling support
Progress toward completion

Possible examples:
Overdue A1c
Overdue CRC / FIT / stool occult
Overdue mammogram

What to listen for

Natural, patient-friendly conversation
Clear explanation and education
Low-friction next step
Consistent outreach process
Support for PBACO teams rather than replacing them

From open gap → patient engagement → action → completion

GOVERNANCE

Governance and trust: the model has to be safe and defensible

Human-in-the-loop

Automation handles repetitive workflow; clinical teams own decisions and escalations.

Security posture

HIPAA-aligned data handling, access controls, and enterprise security expectations including SOC 2 Type II.

Auditability

Traceable outreach, handoffs, escalation rules, write-backs, and operational KPIs.

Trust equation

1. **Transparency**
2. **Governance**
3. **Security**
4. **Human oversight**
5. **Scale with confidence**

ENTERPRISE COMPLIANCE & STANDARDS

HIPAA-Aligned	SOC 2 Type II	BAA-Ready	Access & Encryption
PHI handling & safeguards	Independently audited controls	Business Associate Agreements	RBAC + end-to-end encryption

ROLLOUT

Implementation roadmap: start focused, then expand

Phase 1

PDV / TCM outreach + follow-up scheduling

High-value, time-sensitive workflow

Phase 2

AWV outreach + scheduling

Quality, risk capture, primary-care engagement

Phase 3

EMR write-backs + dashboards

Scalable reporting and workflow accountability

Phase 4

Scribe + after-hours triage

Provider adoption + ER diversion support

Design principle: prove value in focused workflows, then reuse the same operating layer across the network.

MEASUREMENT

KPIs that will matter in this PBACO × Zynix rollout

Reach

pickup rate, valid contact rate, attempt cadence

Conversion

2-way connection, appointment booked, scheduling turnaround

Completion

kept visit, lab/test completed, gap closed

Clinical routing

red flags escalated, response time, closure of routed tasks

Economics

readmission/ER trend, AWV completion, quality/HCC impact

Operations

staff hours saved, cost per completed engagement, EMR write-back rate

POLL

Audience poll #4

What is the biggest barrier to scaling AI-enabled care-management workflows?

- A Provider trust and adoption
- B EMR integration complexity
- C Compliance / security concerns
- D Proving ROI and operational value

TAKEAWAYS

Takeaways for other ACOs

1. Start with workflows that matter

PDV/TCM and AWV are high-value because they connect operations to utilization, quality, and risk capture.

2. Build an operating layer

The strategic asset is not one call script; it is repeatable outreach, scheduling, write-back, and measurement.

3. Keep humans in control

Automation should absorb repetitive volume while care teams own judgment, escalation, and relationships.

Core takeaway: AI for care management is most powerful when it is tied to closed-loop execution.

AUDIENCE QUESTIONS

Stop by our VBCExhibitHall.com Virtual Booth

[Visit the Zynix AI exhibit booth]

Closing thought

AI-enabled care management is not about replacing teams.

It is about giving ACOs/MSOs/CINs a scalable execution layer for outreach, scheduling, documentation, and closed-loop care coordination.

Next step: continue the conversation with Zynix.AI -- *dmcdonald@zynix.ai*

Thank you

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