Patient Outreach for Scheduling Support

Aledade

Scheduling and attending a wellness or follow-up visit for patients is an important step in managing overall health, to review preventive screenings, diagnosis documentation and medication management. By scheduling and attending these appointments, patients can proactively manage their health while your organization improves shared savings and Medicare Advantage (MA) quality performance.

Wellness Visits

Annual Wellness Visits (AWVs), Medicare Age In (MAI) and Well-Child Visits (WCV) ensure a checkpoint for a comprehensive overview of patient health and preventive care needs.

Transitions of Care (ToC)

Connected, interactive outreach through outbound calling is key to support patients navigating the discharge process after transitioning home from a hospital stay. Through early outreach in the post-discharge timeframe and a discharge review, you can gain an overall view of patient well-being to reduce readmissions.

Post-Discharge Assessment

Where applicable, eligible patients will receive a post-discharge assessment following a hospital stay which will be documented in the Aledade App and submitted by provider. The post-discharge assessment can assist with closing the Medication Reconciliation Post-Discharge (MRP) care gap.

ED Follow-Up for High Risk Patients

Ensuring your patients with multiple chronic conditions receive the right care at the right time means proactive follow-up care following an ED discharge.

Hypertension (HTN)

We can provide support to your patients diagnosed with hypertension (HTN) who have had an uncontrolled blood pressure (BP) reading at their most recent visit to schedule a follow-up appointment via phone outreach, complementary texts and a mailed letter.

Wellness Visits

Outreach support to schedule wellness visits ensures timely preventive care while strengthening the clinician-patient relationship through in-office visits.

Wellness visits are vital to discuss preventive services and to identify unrecognized diagnoses, which can lead to improved patient health. Scheduling and attending a wellness visit for patients is an important step in managing overall health, to review preventive screenings, diagnosis documentation and medication management. These visits include Annual Wellness Visits (AWVs), Medicare Age In (MAI) and Well-Child Visits (WCVs).

Success Spotlight

*Camarena Health, an Aledade member Community Health Center (CHC) said they were able to accomplish a **54% AWV completion rate** for Medicare patients, compared to the 45% average among Aledade CHCs nationwide.*

What's included?

- We reach out to eligible patients to schedule their Wellness Visit through phone outreach
- To schedule appointments, we need EHR access. From there, all outreach outcomes are documented in the Aledade App so that you maintain insight into your patient's preferences and responses to Wellness Visit scheduling requests

How to participate?

Opt-in or opt-out to Wellness Visit Scheduling in My Practice in the Aledade App under Direct Scheduling.

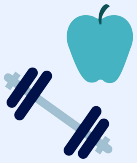
We can reach your patients where they are to support improving overall health outcomes.

Patient Journey

Your patient visits you regularly or hasn't ever scheduled a Wellness Visit

Eligible patients are contacted via phone outreach to schedule a Wellness Visit

Your patient attends their in-office Wellness Visit, serving as a touchpoint for you to provide preventive care and review their overall health



Patients can continue to manage their health at home through lifestyle changes or necessary follow-ups for any concerns that may arise

Transitions of Care (ToC)

with Post-Discharge Assessment support

Aledade

Outreach to your patients following a hospital discharge with a full post-discharge assessment and scheduling for a TCM appointment.

Connected, interactive outreach through outbound calling is key to support patients navigating the discharge process after transitioning home from a hospital stay. Through early outreach in the post-discharge timeframe, a discharge review and TCM appointment, you can gain an overall view of patient well-being to reduce readmissions Eligible patients will also be referred for advanced care planning, if applicable.

Success Spotlight

*Camarena Health, an Aledade member Community Health Center (CHC), saw a **95%** Transitional Care Management (TCM) outreach rate for Medicare patients compared to the average **67%** among all Aledade CHCs nationwide.*

What's included?

- Eligible patients are contacted via telephone, receive a comprehensive Post-Discharge Assessment and scheduled for a follow-up appointment.
- Practices will still be responsible for completing the full medication recommendation.
- All outreach is documented within the EHR.

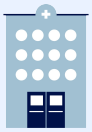
How to participate?

Opt-in via My Practice in the Aledade App under TOC/TCM Transitions of Care.

Reduce the risk of readmissions through follow-up care with Aledade's patient outreach.

Patient Journey

Your patient is in good health or managing a condition



An unforeseen event occurs leading your patient to a hospital visit and discharge

Within 2 days of discharge, your patient is followed-up with, completes a post-discharge assessment and scheduled within 14-days for a TCM follow-up appointment

Your patient attends their TCM follow-up appointment and you submit their post-discharge assessment to close the MRP case gap

Post-Discharge Assessment

Following a hospital discharge, an assessment will be administered to eligible patients during telephonic outreach.

Aledade

To support continuity of care and improve outcomes, our assessment includes reviewing the following information with patients:

Medication Reconciliation

- Newly prescribed medications
- Discontinued medications
- Current medication list

Medication & Equipment Support

- Assistance needed to take medications
- Durable Medical Equipment (DME) prescribed

Post Acute Care Needs

- Home healthcare needs
- Reason for recent hospitalization

Care Coordination

- Understanding who assists the patient with appointments
- Identifying barriers to attending appointments or accessing care

Patient Support

Aledade's patient support is intended to compliment the care you're already providing while improving health outcomes.

From scheduling wellness visits to transitions of care

To pharmacy support, medication adherence and patient campaigns,

Your patient's health journey is supported every step of the way.

What's needed from your practice

The Post-Discharge Assessment assists with closing the MRP care gap.

To close the MRP care gap, practice must submit a claim for TCM 99496 (completed within 7 days of D/C), TCM 99495 (completed within 14 days of D/C) or category II CPT code 1111F (supported by this completed documentation).

ED Follow-Up for High Risk Patients

for Patients with Multiple Chronic Conditions

Aledade

For patients with multiple chronic conditions, follow-up care after an Emergency Department (ED) discharge is critical to reduce readmissions.

Ensuring your patients with multiple chronic conditions receive the right care at the right time means proactive follow-up care following an ED discharge. At no cost to your organization, we're offering additional outreach and scheduling support to your most at-risk Medicare Advantage (MA) patients facilitated by a Registered Nurse (RN) to improve health outcomes and meet quality measures.

"The guidance and support from Aledade has been instrumental in improving the quality of care for our patients. They have been true partners whose goal has been to help us succeed. The programs they have offered have helped us provide things to our patients that we didn't have the resources to accomplish."

- Mike Young, Quality Manager
Boone Medical Group

What's included?

- We outreach to high-risk patients following an ED discharge and perform an assessment with a medication reconciliation facilitated by a RN.
- Aledade submits the completed medication reconciliation on behalf of your practice to the relevant payer within 30-days.

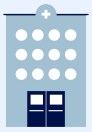
How to participate?

Opt-in via My Practice in the Aledade App under TOC/TCM - Transitions of Care.

Reach your most at-risk patients following an acute event to reduce readmissions.

Patient Journey

Your patient works with you to manage their high-risk chronic conditions



An unforeseen event occurs leading your patient to an Emergency Department (ED) visit and discharge

Within 7 days of discharge, your patient receives a call on behalf of your practice with a medication reconciliation facilitated by a RN

Your patient is scheduled for a follow-up appointment with an in-office visit within 14 days, ensuring upon your patient's visit that the care gap is closed

Hypertension (HTN)

Aledade

Outreach support for your patients with uncontrolled blood pressure at their recent visit or hypertension.

Nearly half of American adults have high blood pressure, which places them at an increased risk for heart disease and stroke. We can provide support to your patients diagnosed with hypertension (HTN) who have had an uncontrolled blood pressure (BP) reading at their most recent visit to schedule a follow-up appointment via phone outreach, complementary texts and a mailed letter.

Success Spotlight

*When Mainline joined Aledade in 2020, their hypertension control rate was **70%**. Numbers only rose from there, up to **81%** in 2022, with their most recent statistics showing an **83%** hypertension control rate in 2024.*

What's included?

- We outreach to eligible patients to schedule an appointment through phone outreach, complimentary texts and a mailed letter.
- If at any point a patient schedules an appointment, text, phone and letter service will cease.

How to participate?

You can opt-in or opt-out of Hypertension Outreach via My Practice in the Aledade App by toggling to Direct Scheduling.

Improve health outcomes through proactive care for hypertension or uncontrolled blood pressure.

Patient Journey

Your patient works with you to manage their hypertension or recently discovers they have uncontrolled blood pressure

Eligible patients are contacted via phone, texts or a mailed letter to schedule a follow-up appointment

Your patient attends their in-office follow up appointment and updates you on their health

Patients can proactively manage their blood pressure at home

*Program is piloted, available on a limited market basis and will be scaled based on practice and patient satisfaction.

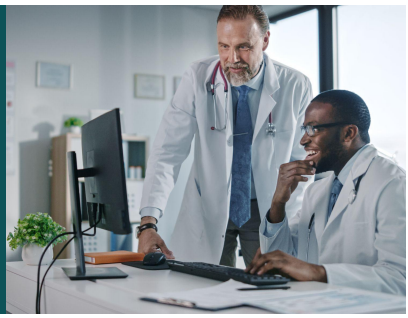
Practice Experience

Aledade is driven by the mission to create a health care system that is good for patients, good for practices and good for society. Through our practice and patient solutions, primary care organizations can thrive in value-based care while delivering better patient care and improving overall health outcomes.

Outreach to your most at-risk patients, and well patients, supports quality performance and increases continuity of care. Our practice and patient solutions are auto opt-in, enabling your practice to focus on what matters most — caring for your patients — while we take care of the rest.

Patient Solutions

- Patient Care Programs
- Patient Engagement & Outreach
- Patient Care Navigation



Practice Solutions

- Business Resources
- Health Plan Network
- Value-based Care Support
- Clinical Coaching

Advocacy

- Education
- Policy

Data & Technology

- Aledade App
- Technology Tools

Better patient care is possible with our support.

Opt-in to Aledade's practice and patient solutions via My Practice in the Aledade App.