Winning in Value-Based Care with Aledade:

Essential ACO Success Strategies

Aledade.com

Aledade

Contents

WHO WE ARE

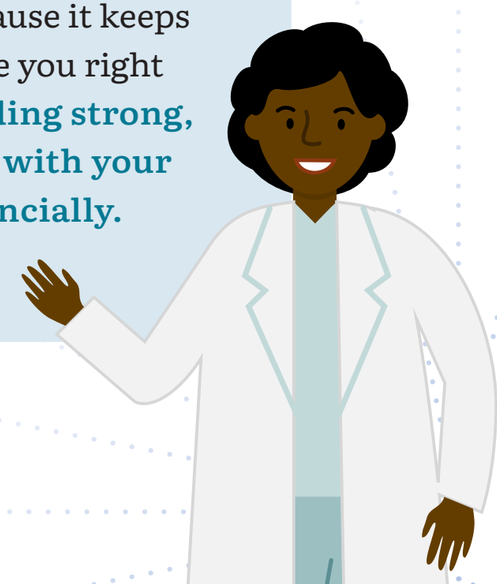
A mission to do what's good for patients, doctors and society

Since Aledade was founded in 2014, we have focused on its core beliefs and mission: to **empower primary care clinicians with the resources, tools and support necessary to improve patient care while reducing costs.**

> "One of the things unique about Aledade is, they work alongside me, teaching me, training me, encouraging me, reminding me, and giving me tools that I can use to do the right thing in medicine. The finances have been great, giving me greater strength to function and survive as a practice."

Dr. Tim Martindale,
Woodway, Tx

Our proven model of primary care is rapidly gaining ground because it keeps primary care physicians like you right where you want to be: **building strong, meaningful relationships with your patients and thriving financially.**



WHO WE ARE

Experience and Consistency

Since the onset of the national shift toward a healthcare system based on value rather than volume, **Aledade has shown that properly resourced, financially aligned, and empowered primary care can deliver exponential cost savings while significantly improving care.**

Our continuous success is founded on the trusted relationship we build with our members. We don't own or operate practices and clinics - we partner with them - and give them the data, tools and support they need to prioritize what's most important in keeping their patients healthy and succeeding financially in value-based care.

For primary care organizations like yours, our local and nationwide accountable care organizations (ACOs) deliver a business model that truly rewards you with reliable, sustainable growth, ensuring that together, **we are doing more good for patients, doctors and society, year after year.**

27K+
Clinicians

2.5M+
Patients

$2.28B+
Savings achieved

** Past performance is not a guarantee of future performance.*

BY THE NUMBERS

Proven Success

The hallmark of our strong, physician-led ACOs is a track record of consistent, year-over-year improvements in shared savings payments and quality metrics. Our performance is both predictable and industry-leading across value-based programs.

$205,121
Average shared savings earned per primary care organization

685,497
AWVs delivered

1,900+
Practices and health centers

200+
Value-based contracts across Traditional Medicare, Medicare Advantage, Medicaid and Commercial payers

** Past performance is not a guarantee of future performance.*

Multi-payer arrangements include value-based contracts with payers including Commercial, Medicare Advantage and Medicaid. Multi-payer figures are estimates and pending payer reconciliation. Amounts shown are per unique TIN participating in an health plan ACO.

WHAT WE DO

A Proven Model for Primary Care

Developed by physicians, for physicians, the Aledade Core 4 serves as the "roadmap" to success for our members; it's our data-driven, proven formula to help organizations like yours deliver quality primary care to patients, reduce costs of care and earn shared savings.

Built on a foundation of nearly a decade of experience from more than a thousand practices and community health centers (CHCs) nationwide, the Core 4 simplifies the complex goals of population health improvement and value-based care into four targeted initiatives.

Over the past decade, our year-over-year performance has consistently proven that when organizations like yours excel in these four competencies, they tend to improve health outcomes for their patients and achieve savings revenues for their organizations.

> "Aledade understands the role we play, and they've made Medicare understand the role we play. To be rewarded for our good work is very powerful, and that's why most Aledade physicians see more shared savings year after year."

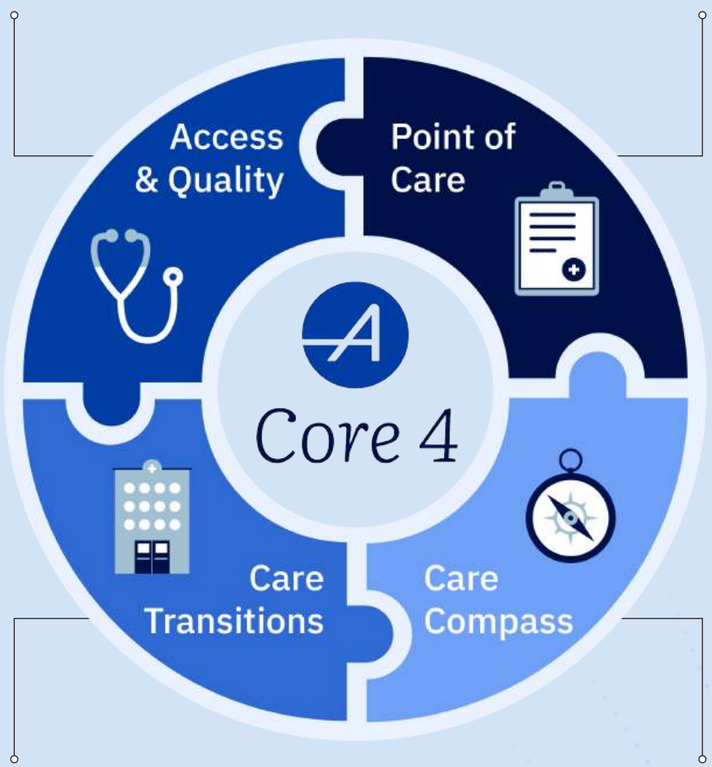
Dr. Daljeet Saluja,
Baltimore, MD

Access & Quality

Data to prioritize patients in need of services and to manage care gap closures, wellness and preventive care

Point of Care

Access to targeted clinical insights, including potential diagnoses for review, for each scheduled patient



Care Transitions

Post-discharge support with user-friendly workflows and insights into ED and inpatient facility utilization

Care Compass

Clinical services tailored to patient needs, such as medication adherence and specialized care management

CORE 4

Why Access and Quality Are Critical to Patient Outcomes and Shared Savings

Our ACO model proves that more coordinated, proactive, and comprehensive care can keep patients in better health. Year after year, clinicians like you have demonstrated the value of Annual Wellness Visits (AWVs) in improving patient health, reducing costs of care and achieving shared savings goals.

According to an American Journal of Preventive Medicine study, although patients were up to date with 80% of recommended preventive clinical services after wellness visits, only 0.5% of patients were up to date with all the recommended clinical preventive services. **When patients receive recommended preventive care, they are healthier and spend less on annual medical care, which improves potential shared savings goals.**

Given the clear correlation between regular preventive care, improved outcomes and increased cost savings, AWVs are a central component of the Core 4, and we prioritize them in our proprietary data tool, the Aledade App.

> “These visits grant us the opportunity to look at the whole person in front of us—answering their questions, offering preventive service, and developing a plan to address any areas of concern. Wellness visits help us transition from a reactive to a proactive mindset in addressing our patients’ healthcare needs.”

Dr. Richard Shorter,
Princeton, West Virginia

$0 cost for patients receiving an AWV

685,497 AWVs delivered in 2023 by Aledade member ACOs

83% average quality score across all Aledade ACOs

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Reimbursement rates are based on a national average and may vary depending on your location.

How to Prioritize the Right Patients, at the Right Time

The Aledade App combines data from Electronic Health Record (EHR) systems, Admit-Discharge-Transfer (ADT) data, hospital event notifications, health information exchanges (HIEs), labs and pharmacies, and insights from practice-generated and payer claims into a single solution to deliver up-to-date data about your patients - including their need for an AWV.

The App integrates with your existing EHR to help you identify the three factors that determine AWV priority status: complex care needs, diagnosis documentation and attribution. This surfaces patients in need of preventive care services, making it easier for you and your staff to prioritize and close care gaps.

You and your staff can then use our customizable, multi-channel patient outreach programs to engage with patients in need of preventive care with compelling wellness reminders, leading to improved outcomes for patients and greater potential shared savings for your organization.

> “One of the biggest data points we’ve been able to leverage since joining Aledade, is to take that sick patient and really put our arms around them to make sure they’re getting the care they need. We want to provide great care so that they don’t have to utilize those more expensive services, and ultimately save money for the system as a whole.”

Andrew Pieleck, D.O.,
FAOASM, FACOFP,
Forest, Va.

32% increase in patient utilization of medically necessary primary care services due to our direct mail service

17% increase in patients who scheduled an AWV within 7 days of receiving a reminder

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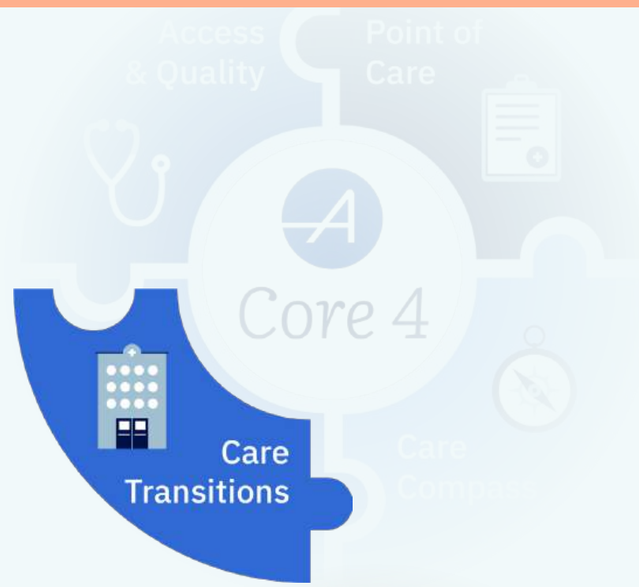
CORE 4

Why Timely Follow-up is Key to Lowering Costs and Earning Shared Savings



When you have access to integrated timely data for patients who have recently been in the emergency department (ED), hospital or skilled nursing facility (SNF), paired with easy-to-use post-discharge workflows, you can better embrace your most vulnerable patients.

Transitional Care Management (TCM) services are evidence-based interventions intended to embrace vulnerable patients after emergency department (ED), hospital or SNF visits. **Research has shown that patients who receive TCM services have lower rehospitalization rates, lower total Medicare spending and additional healthy days at home.**

By calling patients promptly after an ED visit, you and your staff can address their health needs, coordinate care and schedule follow-up medical services for those who need it. It's also an opportunity to identify any barriers to getting care at the office, and provide education around any same-day or after-hours clinic services.

$2,713
average savings for one future readmission

$14,000
approximate savings generated to the ACO for each prevented readmission

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How to Reduce Stress and Confusion Between Care Settings

The Aledade App aggregates data from various sources and helps identify patients who have recently been discharged from the ED, enabling you and your staff to engage with those patients and address their needs before they become more serious and costly.

Timely follow-up after an ED visit involves calling patients soon after the visit to address health needs, coordinate care, and schedule follow-up medical services for those who need it. These calls allow you to demonstrate concern for patients, provide triage support, and prevent ED visit recurrence. The call is also an opportunity to identify patients' barriers to getting care at your clinic and provide education around your same-day and after-hours services.

SUCCESS STORY:

Williamson Health & Wellness Center

In 2012, Dr. Dino Beckett at Williamson Health and Wellness Center in West Virginia used the Aledade App to implement a team-based Chronic Care Management Program to help address chronic conditions for patients at his practice.

"One of our patients who was recently enrolled in the program has seen exceptional success. This patient with chronic obstructive pulmonary disease (COPD) had a habit of seeking care at the ED once or twice a week. They had serious anxiety about their COPD and saw emergency care as their only option when he had trouble breathing.

Once enrolled, the patient received additional care services, including weekly home visits from community health workers who reduced their anxiety, taught them to better manage their COPD with breathing exercises, and helped them learn to navigate resources other than the ED.

The patient also received weekly check-in calls from our practice staff. We also set-up a standing order of Solumedrol, which had proven effective for the patient, at the ED should they seek care there.

The patient who previously went to the ED up to twice a week has now gone six weeks without returning. The Chronic Care Management program has had a huge impact on their life and avoided a dozen ED visits, also easing the strain on hospital providers and slashing the cost of care."

CORE 4

Optimizing Patient Care With Critical Services

At every visit, the Aledade App's Point of Care tools gives you targeted clinical insights across your attributed patient population and curates information such as utilization data and quality and diagnosis gaps. These insights can help you accurately and completely document patient diagnoses, and provide a broad overview of your patients' health, helping to set an accurate financial benchmark for payers.

Using this data, you can connect patients to our focused care services and solutions provided by an interdisciplinary care team, such as assistance with medications, kidney care management (KCM) and comprehensive advance care planning (CACP). These unique programs support you in improving your patients' quality of life and increasing your ACO's savings.

$4.1K
Average savings per CACP-enrolled MSSP patient over 14 months

32%
Reduction in hospitalizations among highly engaged MSSP patients in KCM pilot program

$1.3K
Average incremental organization share of revenue for MSSP patients in CACP program

5.6%
Increase in on-time medication refills for patients enrolled in Medication Adherence program

$5,500
Average reduction in spending per highly engaged MSSP patient in KCM pilot program

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Data-Driven Advance Care Planning Support for Patients

Utilizing our data, you can prioritize high-cost, high-need Medicare patients likely to face significant medical decisions in the near-term and assign Comprehensive Advance Care Planning (CACP) support. Our expert clinical facilitators will collaborate with you and your patient to provide education, establish goals and values, clarify patient preferences and draft customized advance directives. These documents are provided to you and your patient, their loved ones and additional care teams as requested. In partnership with you and your staff, we provide ongoing support to your patients, including reviewing or updating preferences, to ensure their goals of care are met.

> "The CACP program greatly impacts the patient experience for individuals in that situation."

Dr. Laura Theis
Santa Maria, CA

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$292
average PMPM reduction in cost of care for patients when CACP is delivered

$0 cost to your patients

92%
of PCPs in our CACP pilot felt the program beneficial to their practice and patients

9.7 / 10
Average patient satisfaction score

100%
of PCPs in our CACP pilot would continue to refer patients for support

OUR MODEL

Doing More Good: Reinvesting In Your Community

Our primary care partners are successfully leveraging our ACO model and its tools, resources and support to achieve shared savings revenues that enable them to extend services beyond their four walls to do more good within their communities.

SUCCESS STORY:

Batish Family Medicine

In Leland, N.C., Dr. Sanjay Batish, of Batish Family Medicine, recognized that 59% of Black men living in the U.S. have hypertension. As a result, he has medical assistants spend time in a Black-owned barbershop to deliver blood pressure screenings to community members. When elevated blood pressure readings are discovered, the residents are encouraged to make lifestyle changes or seek care from their primary care team.

> We as the Aledade community of clinicians are trying to think creatively about solutions to real problems. Prior to Aledade, I had to think of everything. Being part of this ACO community, I had ready-made resources and materials, experts and encouragement for my idea”

Dr. Sanjay Batish,
Batish Family Medicine,
Leland, N.C.

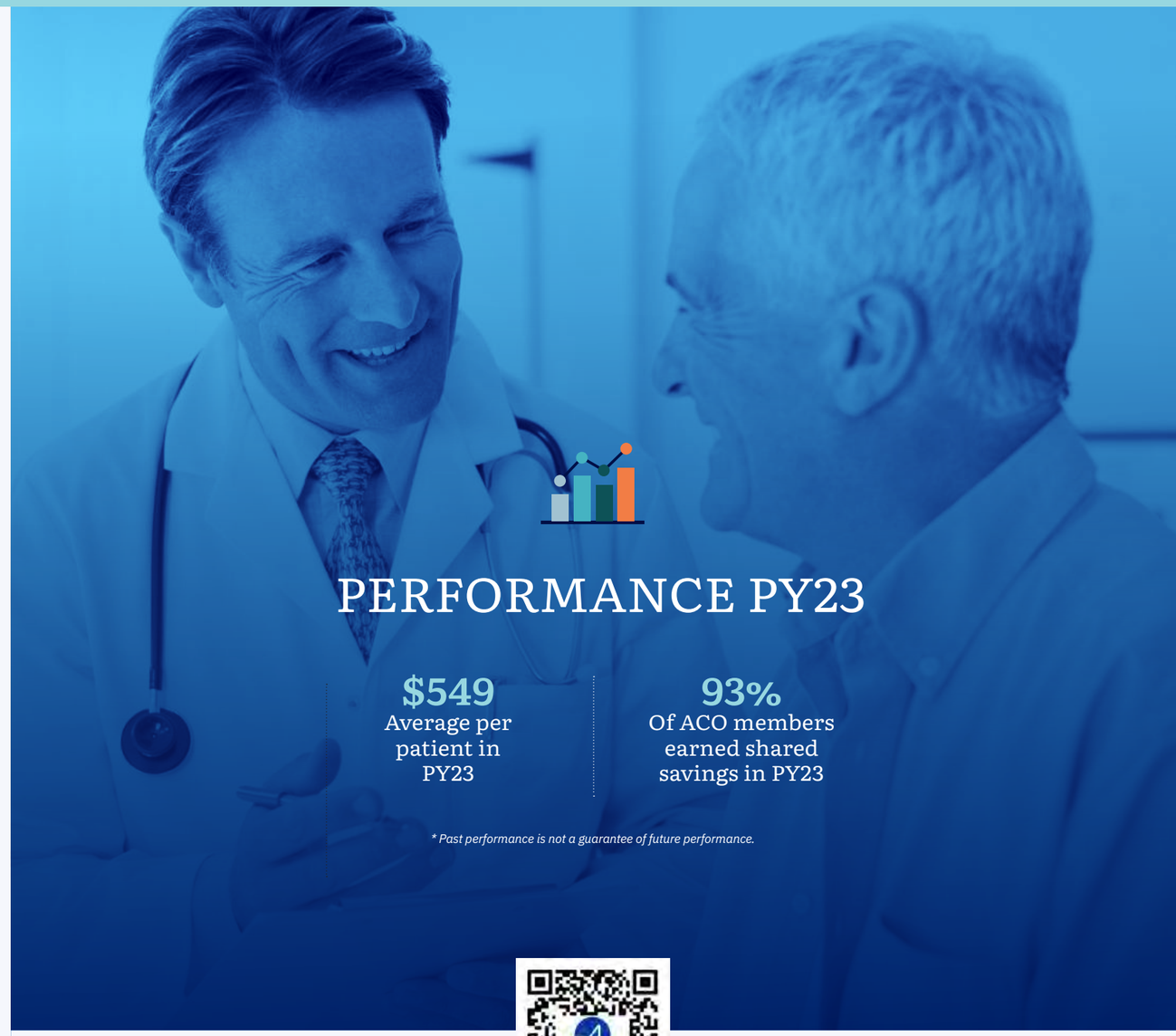
SUCCESS STORY:

Community Clinic NWA

In Northwest Arkansas, Community Clinic NWA, an FQHC, partnered with other groups in the area to launch a meal delivery program for patients in quarantine during the COVID-19 pandemic. The program has since developed into an enhanced case management program that involves working with local growers and participating in a community-supported agriculture (CSA) program to help patients access fresh fruits and vegetables.

> We appreciate the collaborative approach that comes with participating in an Aledade ACO and values learning from similarly missioned organizations working to enhance patient health in Arkansas, while improving quality and reducing costs. Having access to best practices helps us continue our work at a high level.”

Judd Semsingson, COO,
Northwest Arkansas



PERFORMANCE PY23

$549
Average per patient in PY23

93%
Of ACO members earned shared savings in PY23

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Secure your future with expanded tools, resources and support for your staff and patients and year-over-year financial growth for your organization.

Meet with us to get started.


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