



Access to Patient Prioritization Data Ensures Comprehensive, Proactive Care

Dr. Sharon Nickell-Olm
Eustis, Florida

CHALLENGE

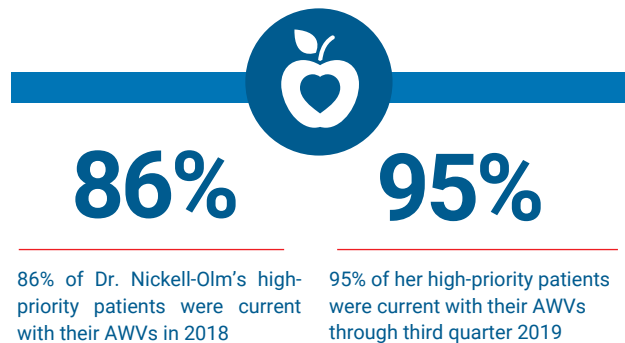
Even in a small practice, managing patients with escalating needs can be a significant challenge. Medicare Annual Wellness Visits (AWVs) can help set a risk benchmark for individuals and offer an opportunity to close gaps in care. But primary care providers need to develop a targeted outreach program to ensure high-priority patients are receiving AWVs each year.

For Dr. Sharon Nickell-Olm, a solo physician in Eustis, Florida, creating a structured approach for conducting AWVs depended on getting access to actionable patient data at the point of care. Using the Aledade App for preventive, proactive care has helped Nickell-Olm accurately assess each patient for risk and address individualized needs accordingly.



“As a small practice, it’s not easy keeping up with all of the changes happening to healthcare. I needed guidance and support to navigate value-based care, and that is exactly what Aledade provides. The App has helped us make the most of time and resources. It’s hard to overstate how important that is for us.”

—Dr. Sharon Nickell-Olm



SOLUTION

Nickell-Olm joined the Aledade Florida 2016 ACO in 2017. With the wellness worklist in the Aledade App, Nickell-Olm can identify her highest priority patients and ensure that these individuals are scheduled for their AWVs.

Dedicated practice staff conduct outreach and schedule appointments. They can also see if a patient is scheduled for a different type of visit and can add an AWV to that existing appointment to save time for the patient and make sure all services are provided.

Thanks to these patient prioritization tools, 86 percent of Nickell-Olm’s high-priority patients were current with their AWVs in 2018. Through the third quarter of 2019, that number increased to 95 percent.

Once a patient is scheduled for an AWV, the practice’s two licensed practical nurses (LPNs) use the Aledade Daily Huddle feature to conduct pre-visit planning. The Daily Huddle includes information on the individual’s specialist utilization, recent hospital events, clinical risks, and preventive care needs.

On the day of the appointment, Nickell-Olm and nurse practitioner Debbie Boyd receive a printed Daily Huddle to inform their clinical conversations with each of their patients and complete any outstanding action items.

Enhanced visibility into specialist utilization is particularly helpful, Nickell-Olm said, especially for patients with complex needs who may be under the care of multiple physicians. The ability to access this information at a glance empowers Nickell-Olm to quarterback her patients' care and easily keep track of the patient's activities, such as medication changes or upcoming tests.

"AWVs are an important opportunity to focus on quality improvement and be sure that we have a complete picture of the patient's health," said Nickell-Olm. "That's good for the patient, because they're receiving more coordinated, comprehensive care. But it's also important for us as a practice to ensure we are capturing the complexity of our patients as completely and accurately as possible."

In addition to identifying potential gaps in care, the Daily Huddle encourages appropriate risk coding by highlighting key patient information from the practice's integrated electronic health record, lab data, and other connected data sources. As a result, Nickell-Olm can be confident that her patients' diagnoses are complete and correct, leading to better overall care and more accurate reimbursements.

In 2018, the Aledade Florida Central ACO, centered in the greater Orlando area, reduced inpatient hospitalizations by 8 percent, saved Medicare \$3.4 million, and earned a quality score of 96 percent as a participant in the Medicare Shared Savings Program.

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BY THE NUMBERS: 2018 ALEDADE FLORIDA CENTRAL ACO

8% // 96% // \$3.4M

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hospitalizations

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Medicare savings

PATIENT CASE-STUDY

Identifying High-Priority Patients Makes a Difference

"Dave" is a diabetic patient who only spends part of the year in Florida. In 2017, this snowbird was struggling to manage his diabetes and incurred high costs for the healthcare system due to noncompliance with recommended care. In March of 2018, Dr. Nickell-Olm used the Aledade App to identify Dave as a high-priority candidate for enhanced chronic care management due to his clinical risks. She enrolled him in the practice's diabetes program.

Working closely with Dave's spouse, Nickell-Olm provided education about portion control and dietary changes that could help to improve Dave's control over his diabetes. Armed with new information about the importance of disease management, the spouse also helped to remind Dave to take his medications on time and in the correct manner.

When he isn't in Florida, Dave now calls Nickell-Olm every month to provide updates on his health. Unlike previous years, Dave did not experience an ED visit or hospitalization in 2018 or the first half of 2019.

For more information about value-based care, visit aledade.com.