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# TIPS FOR VALUE-BASED CARE OFFICES

- **ACO Champion:** Assign one clinic staff member to oversee all ACO activities. This includes outreach to ACO patients, ensuring workflows for closing quality and care gaps, monitoring alerts from ER and hospital notifications, and coordinating transitions of care for ACO patients.
- **AWV Eligibility Checks:** These should be done on every Medicare patient who is on the schedule for the next day. This ensures that a standard office visit may be adjusted to an AWV for eligible patients already on the schedule.
- **Closed Loop System:** Implement a "closed loop system" which means patients are scheduled for a follow up visit ***before*** they leave the office. High Cost/Risk patients must be seen sooner rather than later.
  - An average Medicare patient is seen 5+ times per year in the USA. Data shows practices who see Medicare patients 6-8x per year have highest quality scores and lower overall cost!
- **No Shows:** Call & reschedule no shows within 24 hours.
- **Med Reconciliation with Reminder Calls:** When doing appointment reminder calls, be sure to remind patients to bring an accurate list of medications or ALL their medication bottles.
- **Post-Acute Management**
  - Home Health: Request Home Health services to notify your office of all your Medicare patients on their service. Schedule those patients for an in-office visit before recertification of services – This ensures medical necessity of Home Health services. Follow-up with the patient within 7 days of Home Health discharge to ensure they have all necessary resources for a smooth transition.
  - Skilled Nursing Facilities (SNF): Have an open line of communication with Attending Providers at SNFs your patients are staying with. Be sure to complete a Transitional Care Management visit for your patient as they are discharged from SNF back to home.

## CONTACT US

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