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Value-Based Care Playbook

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Preface

This playbook is designed to integrate the entire office staff into the **Value-Based Care (VBC)** process through educational essentials and application. All staff should have a basic VBC understanding to ease the burden of the provider and ultimately enhance patient care. This **team approach** is crucial in the successful implementation of Value-Based Care.

Acknowledgements

We'd like to acknowledge and thank the following people for their valuable contributions to the development of this playbook.

- Alexis Mojica (B.S. in Health Education): literature review on the history and concept of value-based care
- Danielle Webb, MHA (MSPB Chief Operating Officer): guidance on payment models
- Patricia Platt, CPC (MSPB Director of Coding and Risk Adjustment): insight and recommendations for coding documentation guidelines
- Claudia Honan, JD (General Counsel - Chief Legal Officer): for legal review and counsel

Lastly, we'd like to thank Dr. Carlos Lira (MSPB Chief Medical Officer) for his vision to create this playbook.

1. Value-Based Care History and Concept

1.1 History

The term **Value-Based Care** was first introduced around 2004 [1] as part of a larger conversation to reform the U.S. healthcare system through an alternative payment model [2]. Centers for Medicare & Medicaid Services (CMS) realized that the current **fee-for-service** model was not sustainable. [3]

Medicare was spending excessive healthcare funds, which could impact the availability of Medicare for future generations. To avoid unnecessary spending on Medicare services, **value-based care payment models** were created as a **cost saving alternative** with a focus on **higher quality of care** while **reducing expenses**. To do this, CMS needed to assess the state of its population, which led to the development of **Medicare risk adjustment**.

1.2 Medicare Risk Adjustment

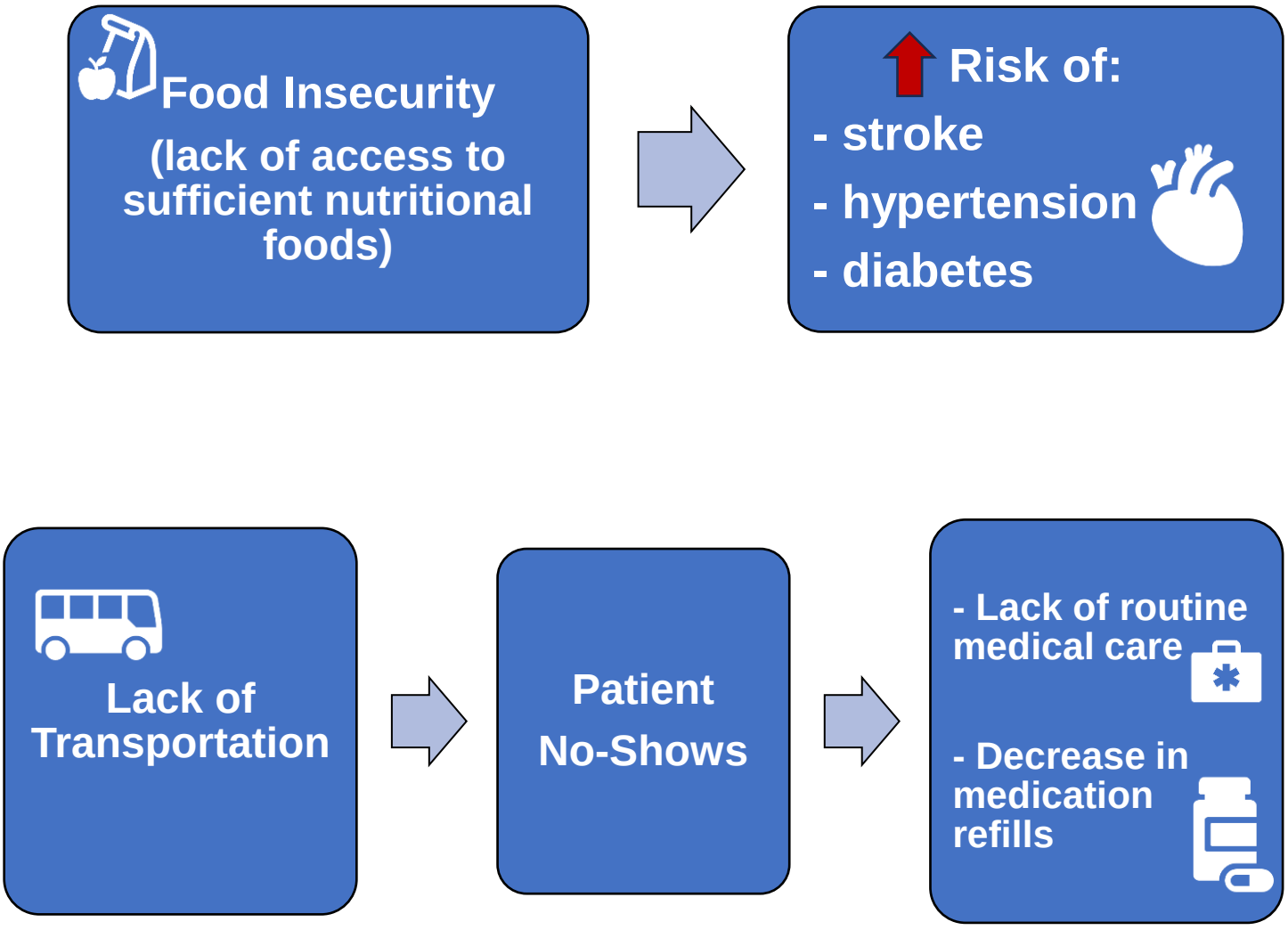
The **Medicare risk adjustment (MRA)** model was created using demographics and diagnoses. Collecting data from over 1 million Medicare beneficiaries helped **anticipate healthcare costs** needed for specific populations [4]. **Risk adjustment factor** (**RAF**) scores were then assigned to specific diagnoses associated with higher costs [5]. These RAF values are used today as a quantifiable representation of the disease burden for the patient based on the individual patient's demographics and diagnoses. The basic concept is: the **higher** the RAF, the **sicker** the patient, and the **more reimbursement** provided by CMS for anticipated medical expenses.

Note: Not all diagnoses have a RAF score

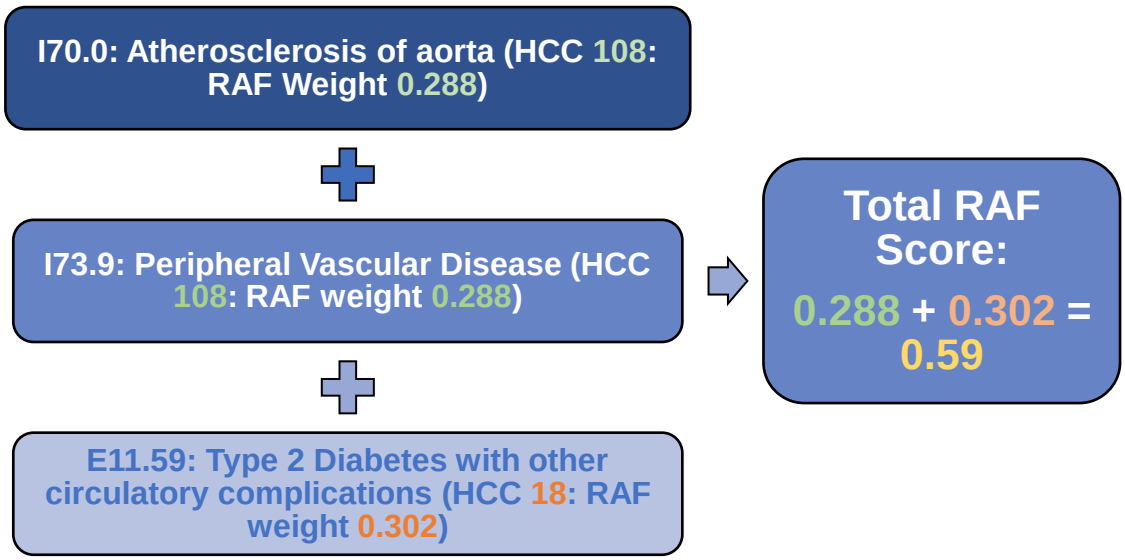
1.21 Social Determinants of Health

Value-Based Care involves proactivity and prevention. With the goal of improving **population health** and providing more **holistic** patient care, **social determinants of health** (**SDOH**) have become fundamental in identifying patients negatively impacted by **environmental circumstances**. These are social risk factors such as zip code and insurance status, which can impact patient health outcomes [6]. As more data is collected on SDOH, this information is expected to impact risk adjustment models over time to reflect more accurate reimbursement needed for patient care [7].

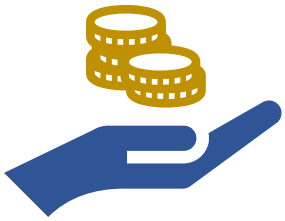
Below are a few examples of how SDOH can impact patient health [8,9].



All diagnoses with a RAF score fall within **Hierarchical Condition Categories (HCCs)**. There are currently **86** categories in the **2020 model**, which **group similar diagnoses** together based on disease symptoms, risk, or burden [10]. For example, **diastolic heart failure** and **pulmonary hypertension** are grouped under **HCC 85**, which is the category for **congestive heart failure**. Each HCC has an assigned RAF score based on the predicted costs that CMS has assigned for the care of that condition. Medicare beneficiaries with diagnoses from separate HCCs are captured by providers during the calendar year and are reported to CMS. These diagnoses provide an additional RAF score to the patient's demographics. The example below shows that although there are **three** risk adjusted diagnoses, only the RAF scores with **unique HCCs** are added together.



CMS is regularly fine-tuning the risk adjustment model as continuous data collection reflects updated **cost** and **utilization** patterns [11]. Therefore, please note that some risk adjusted diagnoses may not carry the same risk adjusted weight from one year to the next. Some diagnoses may eventually not carry any value at all.



To understand the sources of reimbursement for Value-Based Care, it is important to remember that it was created to **assess patient population risk** and compensate physicians for the individualized, condition-specific care needed for each patient. This tailored, higher quality of care will increase patient satisfaction and keep unnecessary expenses down [12].

VBC Reimbursement/Expenses

There are two main sources of VBC reimbursement: **MRA** and **Star** quality measures.

Medicare Risk Adjustment, once more, predicts patients' **healthcare costs** for medical care needed in the coming year. In other words, data collected for 2023 will predict healthcare costs and reimbursement for 2024.

Star measures include preventive/managed care services (HEDIS) and patient satisfaction (surveys). For more information on these measures, refer to the **VBC HEDIS Quick Guide**.

Major expenses include **hospital admissions** and **readmissions**. Page **14** in the **Provider Essentials** section provides more in-depth information on VBC reimbursement and expenses.

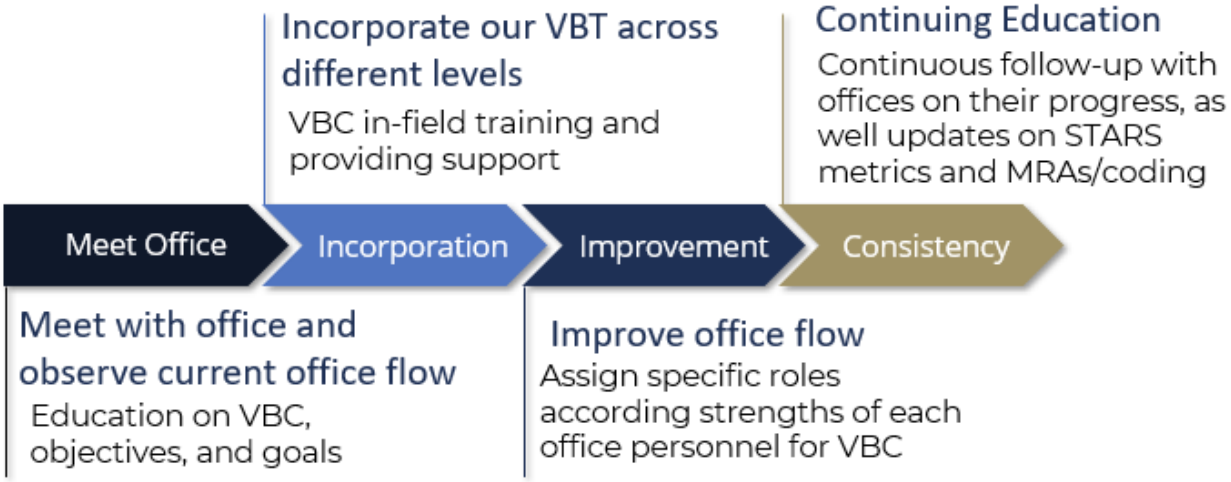
1.3 VBC Team Introduction

The **Value-Based Care Team** was created to **support** and **facilitate** VBC **education** and **training** at **all levels** within the office setting.

Our team has a variety of educational backgrounds and experience in the field that allow for objective, well-rounded office trainings: Our MD, NP, RN, Medical Assistant, Office Manager, Public Health, and Health Education professionals have collaborated to develop a simple way of educating and implementing VBC at all levels.

We understand that the level of value-based care knowledge at every practice is different. Therefore, we offer a **menu** of topics to choose from for further training and continuing education. Based on your selection of training topics, the VBC Team will integrate themselves into your practice to provide support for improving office flow efficiency.

Below is the **VBC team's action plan**.



2. Provider Essentials

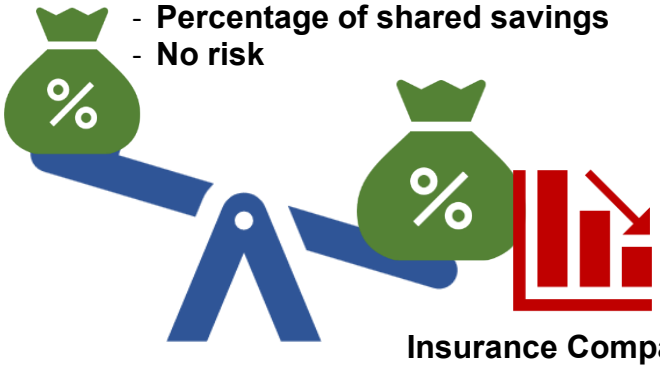
2.1 Payment Models

The most common VBC payment models are **Shared Savings** Programs and **Full Risk** contracts.

In **Share Savings Programs**, insurance companies share overall savings with the physician while either assuming full or shared risk with the physician depending on the type of contract.

Shared Savings Programs: Upside

Physician
- **Percentage of shared savings**
- **No risk**



Insurance Company
- **Full risk**

- Insurance company assumes **full risk** (Covers losses)
- Provider shares in a **percentage** of the savings

Shared Savings Programs: Downside

Physician
- **Shared risk**
- **Larger % of shared savings**

Insurance Company
- **Shared risk**

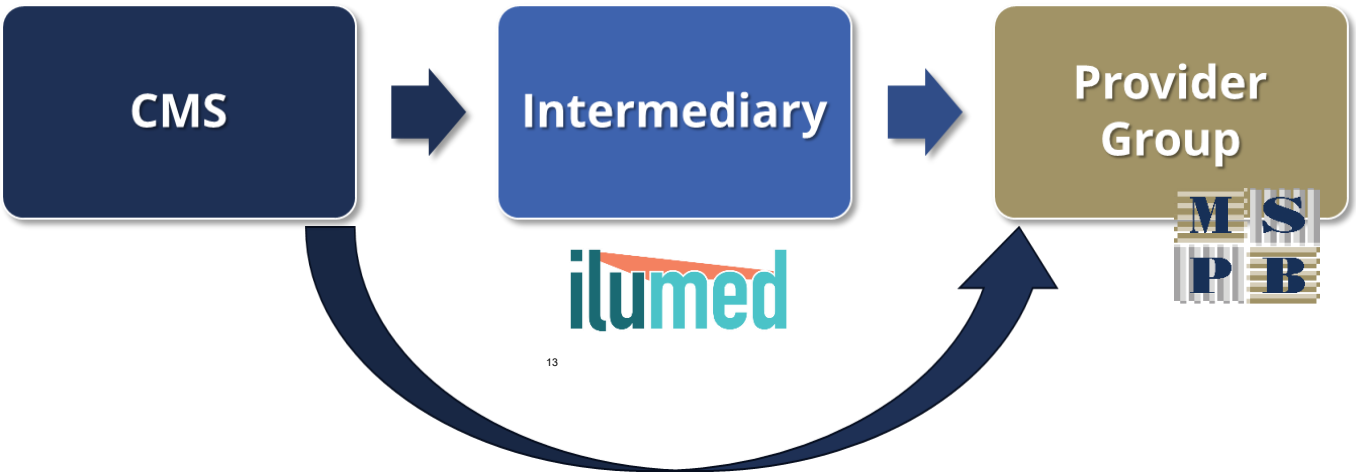
- Insurance company and provider **share** the **risk**
- Physician shares in a **larger percentage** of the **savings** compared to "upside only".

Full Risk

Physician
- Assumes **full risk**
- **Larger percentage** of the **savings** compared to shared savings contracts.

ACO REACH Model

The **ACO REACH Model** (previously known as Direct Contracting Entities) allows physician groups to interact directly with Medicare to bypass insurance companies. Most physician groups unfortunately do not have adequate funds in escrow to cover potential losses with this type of contract. Contracts with entities such as **ilumed**, were created as an intermediary to provide these funds.



2.2 Best Practices for Clinical Documentation

Once **chronic conditions** are identified by the provider, it is important to **properly document** them using the following guidelines:

- Documentation should be **concise**, **clear**, and **consistent**.
- Support documentation for diagnoses using the **MEAT** criteria.
- Document a status on all conditions in assessment/plan.

Suggestion: Get familiar with the Hierarchical Chronic Conditions list.

M: Monitor	**signs, symptoms, disease progression, disease regression**
E: Evaluate	**test results, medication effectiveness, response to treatment**
A: Assess/Address	**ordering tests, discussion, review records, counseling**
T: Treat	**medications, therapies, other modalities**

Abbreviations and Acronyms

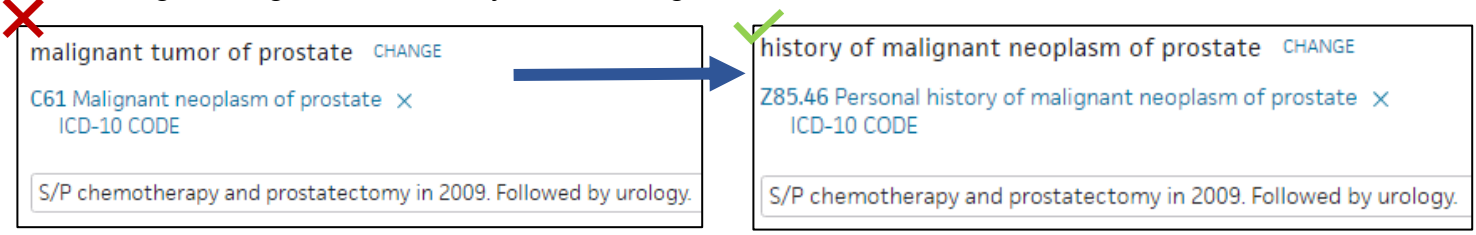
Avoid the use of **abbreviations** and **acronyms**, using only industry standards. It is recommended to spell out the diagnosis initially. Sometimes acronyms may have multiple meanings. (E.g., CAD could be coronary artery disease or carotid artery disease).

Dates and Timelines

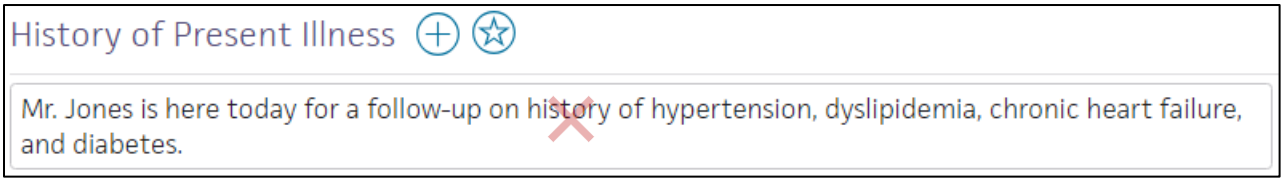
Document **important dates** in the **History of Present Illness (HPI)**, including hospital admission/discharge dates and surgery dates. (E.g., “Patient went to the JFK ER for abdominal pain, is here for a hospital follow up. He was admitted 5/14/23 and discharged on 5/19/23, s/p laparoscopic appendectomy on 5/15/23.”)

Historical vs Present

Change a diagnosis to 'history of' if no longer active.



If the patient has an **active** diagnosis, do **NOT** document "history of" in the patient note.



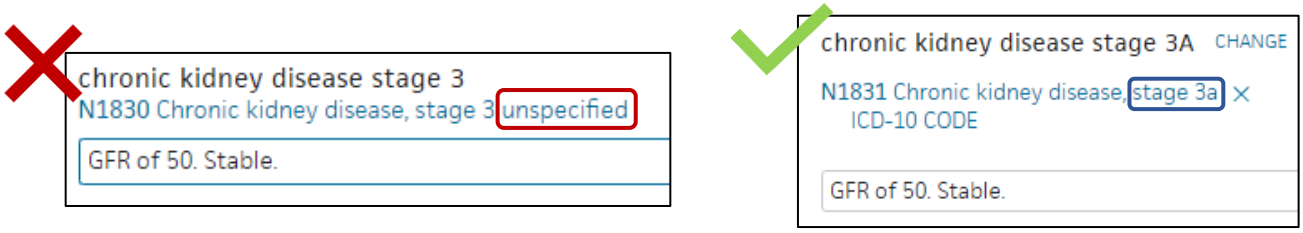
Documenting "history of" implies that the diagnosis is **no longer active**.

Consistency

Confirm that documentation in the patient note **does not** have any contradictions. (E.g., If a patient has a right leg ulcer, the physical exam should not document "skin intact"). There should be supporting documentation throughout the HPI and Physical Exam (PE) for diagnoses.

Specificity

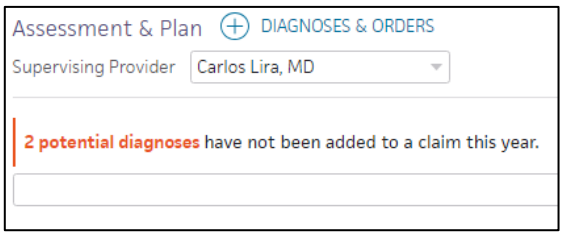
Document the highest specificity when coding diagnoses (E.g., CKD3A or CKD3B should be used instead of CKD3 unspecified).

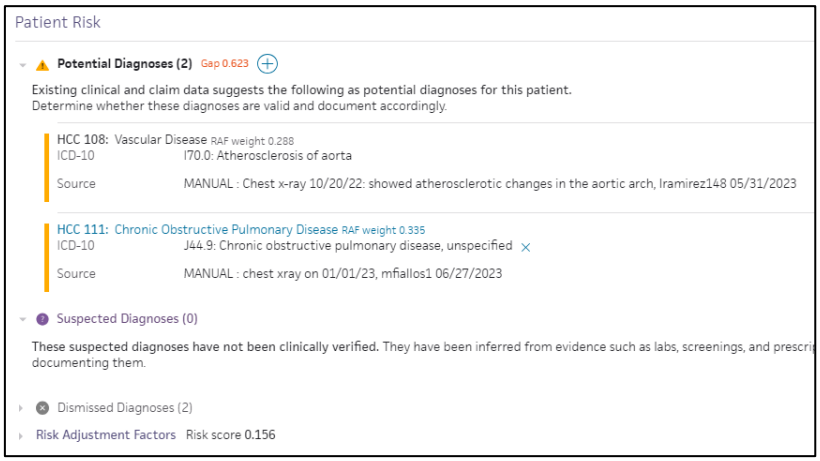


Problem/Medication List

Maintaining an updated problem/medication list will help keep accurate information and avoid inconsistencies within the chart. This will also improve care coordination.

When updating the problem list, assess the **RISK TAB** on Athena for **potential** chronic conditions. This is located on both the problem list and at the top of the assessment & plan section of the patient note within Athena.





Late entries/Addendums

Late entries are designed to make clarifications within the note and should be completed within **72 hours (3 days)** of the patient's visit.

Addendums include updates on specific details that were not available at the time of the visit. Note, addendums cannot be used to add new conditions or information that wasn't already previously in the note. These should be done **within 30 days** of the patient's visit.

These best practices for clinical documentation will create a solid foundation to meet CMS requirements.

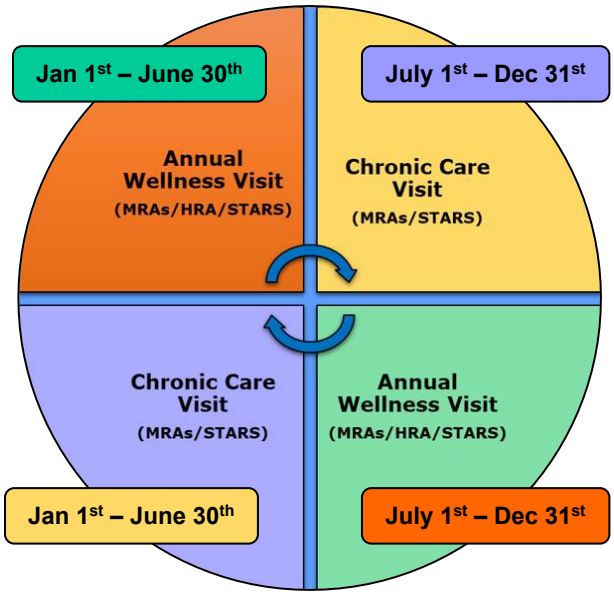
2.3 Value-Based Care Tips

Value-based care was designed to **increase** the **quality** of patient care while **decreasing unnecessary healthcare costs**. The following pages were designed to simplify the intricacies of these concepts and provide further ways to **reduce** the surplus of **expenses**.

2.31 Quality and Care Management for Patients

By **closely following your patients**, you will be able to **anticipate their needs**. Patients with multiple **chronic conditions** are more likely to be **hospitalized**. Proactively seeing higher-risk patients on a frequent basis will help **keep them out of the hospital**. One of the keys to VBC involves **maintenance** and **prevention** to improve patient health outcomes.

Prevention and Maintenance Visits



Medicare requires **Annual Wellness Exams (AWVs)** to be completed **once a year**. AWVs are an opportunity for **HEDIS/Preventive** maintenance and to document all **chronic conditions**. To ensure the best of care, it is recommended to assess and document chronic conditions at **LEAST twice** a year. To differentiate this second visit from regular follow-ups, we have labeled it as a **Chronic Care Visits (CCV)**. This is another opportunity to re-document all conditions and update any changes.

AWVs and **CCVs** are captured between **January 1st – June 30th** and **July 1st – December 31st**, depending on when each are due. **These two visits do NOT have to be 6 months apart**. They simply need to fall within these time frames.

Suggestion: Try to avoid AWVs/CCVs in December. Completing AWVs earlier in the year provides more time for follow-up to meet pending quality measures.

For any other visits scheduled aside from AWVs and CCVs, the provider can choose to solely address diagnoses pertaining to the specific visit (I.e., follow-up on blood pressure or hand pain).

Follow up on a regular basis according to specific needs (3-4x yearly for more complex patients).

2.32 Reimbursement for Care

$$\text{Value} = \frac{Quality}{Cost}$$

Clinical documentation accuracy and **expenses** are two key concepts that if managed correctly, will improve patient satisfaction, drive down healthcare costs, and provide opportunities for the physician to be appropriately compensated for the quality of care provided as opposed to the quantity of services provided (like in fee-for-service).

As previously mentioned, **Medicare Risk Adjustment** is a critical element CMS uses to determine the level of reimbursement a provider should receive to properly care for a patient. Each HCC category captured during the calendar year will provide an additional RAF score to the patient's demographics, which will be used by CMS to anticipate the healthcare spending applicable to the patient.

When we appropriately capture the applicable MRAs and document chronic conditions as specifically as possible, our practice receives the appropriate reimbursement to correspond with the patient's specific disease burden. Below is an example of a patient's reimbursement potential if proper and accurate coding/documentation is achieved.

No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76-year-old female	0.468	76-year-old female	0.468	76-year-old female	0.468
Medicaid Eligible	0.177	Medicaid Eligible	0.177	Medicaid Eligible	0.177
DM Not Coded		DM (No manifestations)	0.118	DM With Vascular Manifestations	0.368
Vascular Disease Not Coded		Vascular Disease Without Complication	0.299	Vascular Disease with Complication	0.41
CHF Not Coded		CHF Not Coded		CHF Coded	0.368
(DM + CHF) Not Coded		(DM + CHF) Not Coded		+ Disease Interaction bonus RAF (DM + CHF)	0.182
Patient Total RAF	0.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	$452	PMPM Payment for Care	$743	PMPM Payment for Care	$1,381
Yearly Reserve for Care	$5,418	Yearly Reserve for Care	$8,921	Yearly Reserve for Care	$16,573

✓ Receive adequate reimbursement for this patient's care.

Note: These values may be outdated compared to new HCC models. This is just an example to get an idea of potential reimbursement.

Star Measures

Another important source of VBC reimbursement comes from **Star** measures which include HEDIS metrics and patient satisfaction surveys. CMS rates Medicare Advantage plans on a scale of **1-5 stars** based on their quality of service. Providers get rated based on their delivery of care.

2.33 Reduce Expenses

The **Medical Loss Ratio (MLR)** is a financial percentage that helps monitor healthcare spending. The goal is for providers to keep this MLR **<80%**. It is essential to recognize the drivers of **cost** and anticipate ways to keep expenses down. Below are some of the main sources of expenses within Value-Based Care.

A major expense is a **hospital admission** that averages **$16,000**. It is imperative to anticipate those at risk for hospitalization and educate all patients on how to avoid unnecessary ER visits. Below are tips on how to keep hospitalizations down.

Patient education: Educate patients to call the office before going to the ER.

Call Service: Make sure there is 24/7 availability so patients can reach providers.

Acute Slots: Allow time in the schedule for acute visits to assess patients in the office.

Routine Visits: Confirm that all patients are scheduled for AWVs/CCVs.

Follow up with high-risk patients frequently.

Develop a **"Micro" subspecialist network** who can see the patient the same day if needed.

Have a list of **Urgent Care centers** in mind to refer to patients. (**Avoid hospital-affiliated** urgent cares)

Ensure that **Front Staff** is trained and efficient in answering **phone calls**.

Preventing readmissions also plays a major role in reducing expenses. See tips below on how to manage this.

Electronic Notifications SuperDocACO2 App: Get updates on patient admission/discharge dates, reason for admissions/etc. Check **Evolv notifications**: (a company that transfers hospital records to Athena directly into the patient chart)

Complete **TCM/Post-Discharge Visit** visits within **72 hours** of the patient's discharge date.

Follow up with patient as frequently as needed.

Utilize **Chronic Care Coordination** using our **MSO**.

Other ways to reduce expenses: use **preferred home health networks**, **avoid unnecessary testing**, and prescribe **generic** and/or **formulary** medications if appropriate.

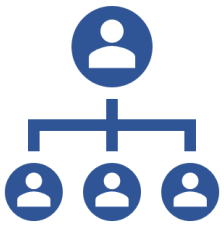
It's impossible to keep up with all Value-Based Care tasks without a support team in the office. Below is a menu of educational training topics the Value-Based Team can provide to your staff.

VBC Training Menu:

- ☐ Concept of Value-Based Care
- ☐ Education on HEDIS measures and health maintenance
- ☐ Education on timing of wellness exams & chronic care visits
- ☐ Education on medications and updating medication list
- ☐ Recognition/Reporting of MRA/HCC diagnoses
- ☐ Education on CPT II Codes (F codes)
- ☐ Education on understanding reports and action plan
- ☐ Education on referral orders
- ☐ Education on TRC/TCM coordination and documentation
- ☐ Education on how to help prepare patient charts the day before
- ☐ Other _____

3. Office Manager Essentials

3.1 Office Flow



Office managers hold a pivotal role within VBC as they can make changes to the office flow to **maximize efficiency** and **improve the delivery of care** for patients. Below are some common topics managers should pay attention to when evaluating their office flow. Roles and responsibilities should be adjusted according to the strengths and skills of each staff member.

DOCPACE

How long are patients waiting to see the provider? Monitor **DOCPACE** to get a better idea of patient wait times.

How long are patients waiting on the phone to speak to staff? How long is staff taking to get to patient voicemails?

Oversee that a **dynamic scheduling** protocol is in place. Identify if rescheduling is appropriate based on clinical priority.

Have a **Triage Protocol** for staff taking calls. If a patient can't be seen the same day, **let the provider know** and **document** thoroughly.

Have a designated staff in charge of the **TCM** protocol to ensure TCMs and ER follow-ups are scheduled appropriately.

Establish/reinforce a **no-show protocol** to ensure proper patient care.

Have a designated staff in charge of **gap reports** for **HEDIS** measures.

Verify that appropriate **CPT codes** are entered in the billing section for **reporting** purposes.

3.12 Closed-Loop Scheduling

It is essential that all patients have a follow-up appointment. This is known as **closed-loop scheduling**. Patients, especially with **chronic conditions,** need consistent follow-up to monitor labs and adjust medications. Providers are **liable** when caring for their patients, which is why **ALL patients should have an appointment scheduled in the future**.

3.13 Important Patient Visits

The **two most important Medicare visits** of the year are **Annual Wellness Visits (AWVs)** and **Chronic Care Visits (CCVs)**. Depending on specific insurance requirements, staff need to schedule these visits within the appropriate timeframes shown on the right. Try to **avoid AWVs/CCVs** in **December** as it does not give the provider or the staff much time to work on meeting measures.

January 1st – June 30th
July 1st – December 31st

Best practice is to make sure patients get their labs done prior to these important visits.

3.2 Patient Care Coordination

Patient care coordination plays a crucial role in the success of Value-Based Care. The office should be **well organized** for **seamless communication** between PCPs and specialty groups. This will allow for holistic patient care and help avoid medical errors. **MSPB's MSO** is a valuable support system to assist with this. Below are some tips for better coordination.

Staff should be well trained in **facilitating/obtaining medical records**. Everyone should have **access to appropriate facilities**, such as imaging centers, hospitals, and laboratory accounts.

Staff should be trained in **obtaining specialist consult notes**, as well as **sending out the latest primary note** when referring to specialists.

Referrals should be completed in a **timely manner**. Designated staff need to be trained on **appropriate networks/preferred providers/facilities**. The **MSO referral coordinators** can assist with this process if needed.

A **second person** should be **trained for every office task** to avoid delays in patient care coordination (in case the first assigned staff member is unavailable).

4. Office Staff Essentials

4.1 Our Patient Population

Our patient population consists of patients in the following categories:

Medicare Patients	Commercial Patients
Patients who qualify for Medicare: ▪ 65+ ▪ Younger patients with disabilities ▪ Patients with end-stage renal disease	Patients with insurances offered by employers/self-selected

Commercial insurances follow the traditional **fee-for-service (FFS)** model. This means that providers get direct reimbursement for each service provided. **Medicare** also currently works under this model.

Some **Medicare Advantage** plans, along with **ilumed** (our **ACO reach program**), have shifted towards a **value-based care** payment model, which involves **capitation** payments. These are monthly payments for each patient to **cover healthcare expenses** (rather than typical FFS).

Even if a provider does not see the patient in a month or conversely sees them five times a month, they still receive the same capitation payment. These capitation payments encourage providers to be proactive with patient care. Office staff play a key role in scheduling patients for regular visits and following up closely with their care. This continuity of care will serve as a protective factor in keeping patients out of the hospital.

Whether patients have commercial or Medicare insurances, value-based care concepts are still applicable to all our patients. However, each type of insurance involves different reporting requirements. Therefore, it is important to **verify the patient's insurance** to guide staff on preparing for patient visits appropriately.

For more information about the differences between Medicare, Medicare Advantage, and commercial insurance plans, refer to our Value-Based Care Team **Insurances Guide** in our **VBC Tool Book**.

5. Clinical Staff Essentials

5.1 Star (Quality) Measures

Star measures are used by Medicare to rate insurance companies and primary care office's performance on **overall patient care** and **satisfaction**. Clinical staff help with this by verifying screenings are completed based on age requirements and ensuring patients are prepped in the exam room in a timely manner.

For more information about Star measures, refer to our **Value-Based Care Checklist** in our **VBC Tool Book**.

5.2 Annual Wellness Visits/Chronic Care Visits

Annual wellness visits (AWVs) are an opportunity for the provider to assess the patient completely, capture any **chronic conditions** and requirements for **Star** measures. Each office may utilize their clinical staff differently when assisting with AWV requirements at different levels, but it is important to **understand** the **basics**. Requirements include completing the proper **screenings**, **health risk assessment (HRA)** questions, and **CPT II codes (F codes)**.

For more information about **HRA** questions and **F Codes**, refer to our **VBC Checklist** and **HEDIS CPT Codes** in our **VBC Tool Book**.

Chronic Care Visits (CCVs) are another opportunity to re-document all chronic conditions and update any changes to diagnoses and measures (such as getting a new controlled A1C, diabetic eye exam or colorectal screening that might be due).

Coordinate with your provider and office manager regarding your role in these important visits, which may include the following:

- Assist with prepping the AWV using pre-made **VBC templates** in Athena to facilitate the completion of Medicare requirements
- Ask patients **HRA questions** and **screenings**
- Complete CPT II codes (**F codes**): used to report **performance management**
- Create **orders** to meet measures (E.g., mammograms)

If the **AWV** was completed between **January 1st - June 30th**, then the **CCV** should be scheduled between **July 1st - December 31st**, and vice versa. Verify within your workflow that patients have these important visits scheduled within the appropriate time frames. Ensure that required labs/imaging are ordered prior to these visits.

January 1st – June 30th
July 1st – December 31st

5.3 Hospital Follow-Up Visits

Two additional important VBC visits include **hospital follow-ups** (**Transitional Care Management - TCM**) and **ER follow-ups**. The following should be included throughout the TCM process:

- Work on the **ACO App**.
- **Contact** the patient/caregiver within **24-48 hours** of **discharge** and document appropriately.
- Obtain medical records prior to the TCM/ER follow-up visit using resources available within your organization.
- Coordinate with staff to schedule these visits in a timely manner.
- Include the appropriate **CPT II codes (F codes)** necessary to satisfy Medicare requirements:
  - **1111F**: Discharge medications reconciled with the current medication list in outpatient medical record

Coordinate with your provider and office manager regarding your roles and responsibilities with these important visits.

For more information about TCM/ER protocols, refer to our **TCM/ER Follow Up Guidelines** in our **VBC Tool Book**.

6. Non-Clinical Staff Essentials

6.1 Star (Quality) Measure – Patient Satisfaction

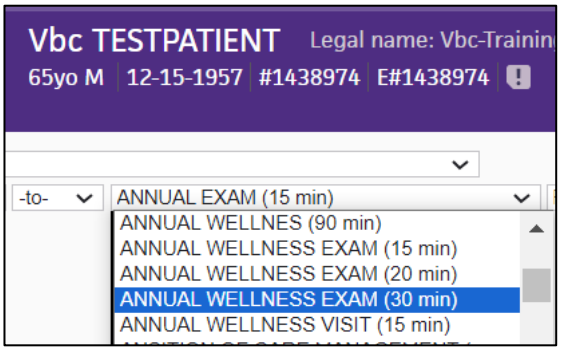
Patient satisfaction surveys are a significant Star measure where patients report how satisfied they are with the care and services provided at their doctor's office. As non-clinical staff, you are the first and last people to provide assistance and support to patients, ultimately giving the final impression of the office. Quality customer service is essential, starting from check-in, all the way to check-out.

6.2 Scheduling/Managing Patient Appointments

It is essential that **all patients leave the office with a follow-up appointment**. This is known as **close-loop scheduling**. Non-clinical staff play a key role in collaboration with the clinical staff to ensure all patients leave the office with a future appointment. Below are some ways to encourage patients to get scheduled:

1. Educate patients on the importance of having a future appointment for continuity of care.
2. If they are resistant to schedule a follow-up, you can create an "**appointment reminder**" that will alert you to call the patient when the future appointment is due.

When scheduling, **appointments should be labeled correctly**. For example, if an appointment is labeled as a regular follow-up, but it should have been an **AWV**, it becomes a **missed opportunity**. The same applies to **TCMs**, **ER visits**, and **CCVs**.



If an appointment is mislabeled, confirm with the clinical staff or office manager to select the appropriate appointment type.

When verifying appointment labels, confirm that each patient has an **AWV** or **Chronic Care Visit (CCV)** scheduled within the time frames below and confirm with clinical staff that required labs/imaging are ordered prior to these visits. If the **AWV** was completed between **January 1st - June 30th**, then the **CCV** should be scheduled between **July 1st - December 31st**, and vice versa. For more information regarding these two visits, refer to page 17 in the clinical staff essentials.

January 1st – June 30th
July 1st – December 31st

Staff should **update the following patient information regularly**:

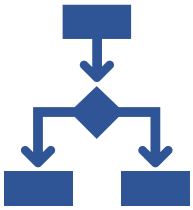
- Demographics (address, phone number, date of birth, etc.)
- Insurance
- Pharmacy

Why is this important? Accurate patient information will improve the quality of care.

When answering patient phone calls, you will come across **urgent situations** that need to be addressed immediately. Talk to your office manager regarding the **triage protocol** for your office. Below are a few examples of complaints that need to be reported to clinical staff and the provider immediately:

- Black stools
- Shortness of breath
- Abdominal pain
- Chest pain
- Headache
- Visual disturbance

6.3 No-Show Protocol



Every office should have a **no-show protocol**. Consult with the office manager regarding the current protocol in place to follow properly.

In the event a patient does not follow office protocol, **discharge letters** are available in Athena. **Document** all non-compliant cases in an appropriate location in the patient's chart.

To summarize, it is important to **educate your patient** on the importance of attending routine appointments. Having patients come to the office consistently allows the provider to stay on top of their chronic conditions and take better care of their health.

6.4 Value-Based Care Training Opportunities

There are many steps to remember, which can be overwhelming. The Value-Based Care team is available to train for **1-1/small group sessions**, offered both **on-site** and at the **corporate** office. The **VBC Tool Book** is also available to reference any additional information and requirements for VBC-related tasks.

Value-Based Care is only successful with a team effort. Together, we can achieve the **best quality of care for all patients**.

7 Value-Based Care Acronyms

- **ACA**: Affordable Care Act
- **ACO**: Accountable Care Organization
- **ACO REACH**: Accountable Care Organization Realizing Equity, Access, and Community Health
- **ADLs**: Activities of Daily Living
- **APM**: Alternative Payment Model
- **AWV**: Annual Wellness Visit
- **CAD**: Coronary Artery Disease
- **CCV**: Chronic Care Visit
- **CKD**: Chronic Kidney Disease
- **CMS**: Centers for Medicare & Medicaid Services
- **CPF**: Conviva Comprehensive Patient Form
- **CPT**: Current Procedural Terminology
- **CVD**: Cerebrovascular Disease
- **DM**: Diabetes Mellitus
- **DRGs**: Diagnosis-Related Groups
- **EHR**: Electronic Health Record
- **ESRD**: End Stage Renal Disease
- **FFS**: Fee for Service
- **FMC**: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions
- **HCC**: Hierarchical Conditions Category
- **HEDIS**: Health Effectiveness Data and Information Set
- **HM**: Health Maintenance
- **HMO**: Health Maintenance Organization
- **HOS**: Health Outcomes Survey
- **HTN**: Hypertension
- **MA**: Medicare Advantage
- **MCO**: Managed Care Organization
- **MSO**: Management Services Organization
- **MI**: Myocardial Infarction
- **MRA**: Medicare Risk Adjustment
- **MSSP**: Medicare Shared Savings Program
- **P4P**: Pay-for-Performance
- **PBP**: Population Based Payment
- **PCCM**: Patient-Centered Care Model
- **PHM**: Population Health Management
- **PPO**: Preferred Provider Organization
- **RAF**: Risk Adjustment Factor
- **SDOH**: Social Determinants of Health
- **SNF**: Skilled Nursing Facility
- **SNP**: Special Needs Plan
- **TCM**: Transitional Care Management
- **TRC**: Transition of Care
- **VBC**: Value Based Care
- **VBT**: Value Based Team

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