Subject: Care Management at VMG

Valley Medical Group is fortunate to have two care management groups embedded in our practice to support the work to care for our most chronically ill or vulnerable patients. A referral to either team is as simple as sending a patient case to the appropriate team member for your center.

BAYCARE
AMC: Laurie Runkle, RN Care Manager, Ashlea Aubrey, MA Care Coordinator
EHC: Louise Whitworth, RN Care Manager, Tanya Ringer, MA Care coordinator
GHC: Galina Agapov, RN Care Manager, Lorrie McGrath, RN Care Manager, Ashlea Aubrey, MA Care coordinator
NHC: Jess LaMontagne, RN Care Manager, Tanya Ringer, MA Care Coordinator

The Baycare Care Management team provides support to VMG patients in specific value-based contracts including: Medicare (MSSP), Blue Cross Blue Shield, HNE, and Unicare GIC.

The embedded RN Care Managers and Medical Assistant Care Coordinators focus on high-risk patients with complex medical or social situations. They meet with patients in both the office and at home to provide education, support, care coordination, and to address barriers to care.

The teams follow patients closely after hospital, nursing facility, and emergency room discharges to review discharge instructions, address barriers to care, and coordinate follow up appointments for TCMS.

The Baycare team also works on the quality program for Blue Cross Blue Shield to address patients with hypertension, diabetes, or in need of certain preventive health screenings.

The team works closely with VMG providers and the entire care team. If unsure if a patient qualifies for Baycare care management, please refer them via a patient case and they will screen. If the patient is not in a Baycare contract, many times they can offer advice on where else to refer.

CDH iCMP
Nurse Care Manger: Sara White, RN
Social Workers:
AMC and GHC: Nancy Delabarre, LCSW
EHC and NHC: Kevin Verni, LICSW

Integrated Care Management (iCMP) is a primary-care based care management program available to Mass General Brigham ACO (MassHealth) patients at Valley Medical Group. This program provides care coordination and support to complex patients in collaboration with their PCP.

Patients who are most appropriate for this program have multiple chronic conditions, chronic/complex medical or psychosocial conditions, at-risk for high utilization of acute care services, and frequent ED utilization.
The goals of iCMP include improving clinical outcomes, enhancing quality of life, enhancing provider and staff satisfaction, and reducing cost of care.

Patients are identified in different ways including provider referrals. Other sources of patient identification include a generated “High Risk List’ which utilizes an algorithm based on claims data including chronic disease and utilization. iCMP also utilizes high utilization reports and Cooley Dickinson Hospital post discharge lists as additional sources of patient identification.

iCMP is a voluntary program and if the patient/family is agreeable to the support, an initial assessment will be completed to develop patient centered goals. iCMP maintains regular contact with the patient either telephonically or with face-to-face visits in the community. Patients are discharged from the program when their needs have been met or if a patient is no longer reachable.

iCMP Plus is an enhanced care management program which provides home based care and care coordination to the highest risk Mass General Brigham ACO patients. iCMP Plus is a collaboration with Commonwealth Care Alliance which has a team made up of Nurse Practitioners, Nurse, Social Worker, and Health Outreach Worker.

To refer a patient to iCMP or iCMP Plus, please send any of the team members a patient case and they will review for eligibility.