Fast Facts: Ambulatory Care Management

THE WHY

- To deliver the highest quality care while building and maintaining trust with our patients and the practices in our network, we are partnering with our Primary Care Physicians to deliver a program that is frictionless and focuses on targeted lives to have the greatest success on patient outcomes and quality goals, and are instituting a preventive health care initiative.
- To yield the largest impact on increasing revenue, decreasing expense and improving performance, we will have our Care Management team members working at the top of their licenses with the moderate, rising, and highest risk attributed population in our network.
- We will enable a **HEALTHIER** and **HAPPIER** population, while improving **QUALITY** of life for individuals.

THE HOW — Implementation of three evidence-based programs:

- **Complex Care Management** – managing our ***highest*** risk population to improve patient outcomes
- **Transitions of Care** – an embedded model of care, managing our ***rising/higher*** risk population discharging from the inpatient setting
- **Chronic Disease Management** – managing our ***moderate*** risk population, incorporating preventive healthcare solutions while supporting the physician/patient relationship and promoting self-care

CLINICAL GOALS

Complex Care Management	Transitions of Care	Disease Management
✓ Decrease unplanned/ unnecessary admissions and readmissions ✓ Trained with a preventive health care lens ✓ Ensure PCP follow-up ✓ Complete SDOH assessment – close gaps (CHW referral) ✓ Care gap closure	✓ Prevent unplanned/unnecessary readmissions ✓ Ensure all discharge needs are met ✓ Post-discharge assessment and education including medication reconciliation ✓ Ensure PCP post-discharge follow-up ✓ Complete SDOH assessment – close gaps (CHW referral)	✓ Decrease number of not-at-goal/not tested chronic disease management patients ✓ Ensure PCP follow-up ✓ Chronic disease education ✓ Complete SDOH assessment ✓ Care gap closure

ELIGIBILITY CRITERIA

Complex Care Management	Transitions of Care	Disease Management
✓ Highest cost/highest utilizing ✓ Attributed diagnosis of CHF, DM and/or COPD ✓ Approximately top 3% of attributed lives ✓ Active within BCBSMA, TMP, MSSP and United VBC current registry	✓ Discharge from affiliated/non-affiliated hospitals/SNFs ✓ Attributed diagnosis of CHF, DM and/or COPD ✓ Approximately top 3-15% of attributed lives ✓ Active VBC current registry	✓ Active hypertension and/or diabetes diagnosis ✓ ACSVD score 7.5%-19.9% for HTN ✓ Current A1C greater than 9% ✓ Active on the ACO or VBC current registry