Collaborative Learning Opportunities

If you miss any Collaborative Learning opportunity, you can listen to recordings available online – see page 4 for a link to your Collaborative Learning page.

Reducing Asthma Readmissions and Creating Asthma Action Plans

Online Recording Available

This session is presented in partnership with Cincinnati Children’s Hospital and will cover the hospital’s experience reducing asthma readmissions and ER visits. In addition, attendees will learn about the systematic follow-up of asthma patients and the leading causes of asthma-related pediatric morbidity. Population-level interventions and community connections will also be presented. To complement this presentation, Marjorie Martens, an Enhanced Personal Health Care Program Director, will review the importance and benefits of patient-centered care in the management of asthma. Marjorie will review the Provider Care Management Solutions (PCMS) reporting application and how to identify high-risk patients with care gaps and comorbid conditions. We will also review asthma-related scorecard measures, program expectations and milestones.

How Community Resources Can Help Support Your Practice

Online Recording Available

Knowing how to link patients with community resources helps to extend a patient’s medical home well past a physician’s office and link patients across the continuum of care. Join us to hear about why community resources should be an important part of your medical home strategy, how to locate resources and most importantly how to build relationships with resources in your community.

Susan B. Sigmon will discuss why linking patients to community resources is important and how the Akron-Canton Area Agency on Aging has used community resources to create an integrated approach for their citizens during times of care transitions. She will address the challenges encountered, how a coalition was created, as well as how it has impacted patient outcomes. Deena Terrell will share how her practice, Horizon Medical of Goshen, New York uses community resources as an integrated component of their patient support strategy and steps taken within the clinic to connect with the community.

Our Partnership with the AAP: Making a National Impact on Asthma

Tuesday, Oct. 21, 2014 • Noon – 1 p.m. ET

Richard Ancona, MD, associate professor in Clinical Pediatrics at the State University of NY (SUNY) Stony Brook, Director of Pediatrics at St. John’s Hospital in Smithtown, will present on The AAP’s Medical Home Chapter Champions Program on Asthma (MHCCPA) and how it was organized to meet the need for a high-impact, national initiative focused on improving quality pediatric asthma care. The Program focuses on the dissemination of resources, information, best practices and
advocacy around the National Heart, Lung, and Blood Institute’s asthma guidelines within medical homes at the state level.

To complement this presentation, Kathy Moran, BSN, a Medical Management Lead and Health Coach, will present valuable information for practices on the services offered by our internal Asthma Condition Care program. As a pediatric nurse who has spent many years in the Pediatric Intensive Care Unit at Denver Health Medical Center, Ms. Moran has been managing members in the Condition Care program and as a Health Coach for 7 years. She has the hands-on experience and knowledge to demonstrate the importance of patient-centered care in asthma management. The Care Management department offers providers a Condition Care program for the management of pediatric asthma patients. In addition, our internal nurses support patients and parents through outreach, education, assessments, asthma action plans and potential referrals to community resources as needed.

See page 4 for details on how to register for Collaborative Learning Sessions.

The tools listed below are offered along with many other resources in the Enhanced Personal Health Care Provider Toolkit to help your practice manage and coordinate care for patients with chronic diseases such as asthma.

**Sample Patient Registry Spreadsheet**

A compilation of Excel registries and evidence based guidelines supporting our “Core 5” chronic disease focus areas.

**Registries Made Simple**

This American Academy of Family Physicians (AAFP) article gives readers an idea of the purpose a patient registry serves, and how to use them to guide a practice’s care management activities.

**Registry Evaluation Form**

This self-evaluation form created by Improving Chronic Illness Care (ICIC) can help practices that already have a registry in place identify its strengths and weaknesses.

The tools above and many others are available at www.unicare.com. Select “Providers,” then “Enhanced Personal Health Care,” then “Provider Toolkit.” The resources above are located under Milestone 4: Population Health Management & Registries.

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**PCMS Tip**

**Provider Care Management Solutions**

Provider Care Management Solutions offers providers an intuitive, flexible platform to see clearly the best opportunities for intervention and coordination of care for their patients.

Users may also pull data from PCMS into a Microsoft Excel spreadsheet.

**To Export Data:**

- Click the **Population Management** Tab to access clinical reports. There are four views under Population Management: Attributed Patients; Inactive Patients; Care Opportunities and ER Visits. The Export button is to the right, near the date.

![Image of Export button](file.png)

- Select which columns to include in the export. Some columns are pre-selected, but can be de-selected. Greyed-out columns cannot be de-selected. Choose the Cancel button at any time to exit out of Export.

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**Words Worth Knowing**

A regular feature defining terms, words or concepts that can help practices succeed at delivering patient-centered primary care.

**Continuum of Care**

“A concept involving an integrated system of care that guides and tracks a patient over time through a comprehensive array of health services spanning all levels of intensity of care.”

Source: Creating a continuum. The goal is to provide an integrated system of care. Evashwick CJ Health Progress. 1989 Jun; 70(5):36-9. 56.
Central Maine Healthcare

Central Maine Healthcare is an integrated health system located in central and western Maine, comprised of three hospitals: Central Maine Medical Center, Bridgton Hospital and Rumford Hospital with 25 primary care practices and several specialty practices. The Central Maine Healthcare team has an attributed membership of 8,379 Enhanced Personal Health Care patients. In addition to Enhanced Personal Health Care, 21 of the 25 primary care practices are also working in the Maine Quality Counts Patient Centered Medical Home and Health Home Pilots.

At the start of their transformation journey in 2009, Central Maine Healthcare implemented the Meridios system to allow for the mining of their Electronic Medical Record (EMR). This system has allowed them to build a database by screening for patients who meet defined criteria. Meridios has also helped with the maintenance of the provider panels and identifying patients with gaps in care.

Central Maine Healthcare also implemented a Care Coordination department and placed a care coordinator in each of their practices. These care coordinators work with the Population Health Management department as well as the providers in the practices to identify the patients who appear to have gaps in care that can be addressed. Understanding the need for standardization, the Care Coordination department started with small tests of change around pre-visit planning and how to recognize these gaps and quickly cover them while the patient is in the office. The care coordinators begin by reviewing providers’ schedules 7 to 10 days ahead of the visit and reach out to the patients regarding any gaps the patients may have, gather missing data (labs, imaging studies, outside referral appointments) for the charts – all while keeping in close communication with the providers.

Providers have found that patient visits are flowing more smoothly and all the information is available in the medical record during the patients’ visits. The practice started this process with one provider in one practice, and has since grown the process through small tests of change and expanded it to a second primary care practice. They plan to continue to support the process and continue the roll out to the remaining practices in the near future.

Since joining the Enhanced Personal Health Care program in July 2013, the team at Central Maine Healthcare has looked for creative ways to incorporate the metrics identified in Enhanced Personal Health Care reports and worked with Meridios to add these metrics to their system, which has allowed for the care coordination department to fully examine the patients under our program.

“We appreciate the way this partnership is transforming the way our PCPs deliver care to patients. Enhanced Personal Health Care demonstrates a commitment to redesigning care delivery through an enhanced payment model,” said Kathi Schandelmeier, director of Central Maine Healthcare’s Primary Care Division.
Massachusetts Notes

Spotlight: Provider Toolkit

At the heart of medical home transformation is a core set of elements that positions a primary care practice to maximize its return on effort investment. These returns are characterized by making progress in sustainable change that favorably impacts patient experience, quality outcomes, and total cost of care.

Some of these “core elements” point to:

• Engaged practice leadership
• Embedded use of QI methodology, including incorporating data use to drive change
• Shifting the practice delivery paradigm to a team-based model

Continue to explore the Provider Toolkit by checking out Milestone 3: Care Planning. You’ll find care planning templates and resources to support establishing a reasonable process in your practice for shared care planning that incorporates self-management support, goal setting and action planning.

Don’t Forget to Connect: Adobe Connect

UniCare can now connect to you and your practice via Adobe Connect. While the Massachusetts UniCare Transformation Team is available to meet with you face-to-face, there are times when it makes sense for both parties to meet virtually. With Adobe Connect, participants can connect into the “classroom” via their computers to share computer screens.

This has proven to be a great resource in assisting with the creation of care plans for members using the HotSpotter report and other clinical reports. We can help you with your access to Availity and MMH+, where you can share your screen and we can help you navigate. The opportunities are endless. If you were hesitating to get assistance from us because you were concerned about the distance we might be driving, please don’t. We can easily meet you at your computer.

You can contact Paulette Ricciardone at paulette.ricciardone@wellpoint.com. We look forward to meeting with you.

New Patient Management Reports Are Here

New reports are now available through Availity from Provider Care Management Solutions (PCMS). This web-based application can help you manage your patients’ health by stratifying your patient population based on risk and chronic conditions. The PCMS reports also alert you to potential gaps in care and flag patients at high risk for readmission.

Are you already using the Availity reports but haven’t re-registered yet? Then please log onto www.Availity.com and link all the users in your practice to the Enhanced Personal Health Care Program. If you are not currently accessing these reports, please reach out to the Transformation Team at UniCarePrimaryCareProgram@wellpoint.com to find out how to register.

Goodbye Ellen Burneika, Community Collaboration Manager

We bid farewell to Ellen Burneika. Over the past year, Ellen has been instrumental in coordinating the efforts of and working with the Transformation Team to establish the Patient-Centered Primary Care Program. We wish Ellen the best of luck in her new adventures in South Carolina.

Mark Your Calendar!

Pediatric Collaboratives:
Making a National Impact on Asthma
Tuesday, Oct. 21, Noon – 1 p.m. ET

Also remember to check out the Patient-Centered Primary Care Program Recording Library

Massachusetts Links

Locate your Patient-Centered Primary Care Program resources following this path: www.unicarestateplan.com > Providers > Patient-Centered Care Program, or click here.

There you’ll find a host of resources, including your:

• Provider Toolkit
• Collaborative Learning Opportunities
• Past issues of Transformation Times

Contact our team at UniCarePrimaryCareProgram@wellpoint.com
Transformation Times, email Emily.Berry@Wellpoint.com

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