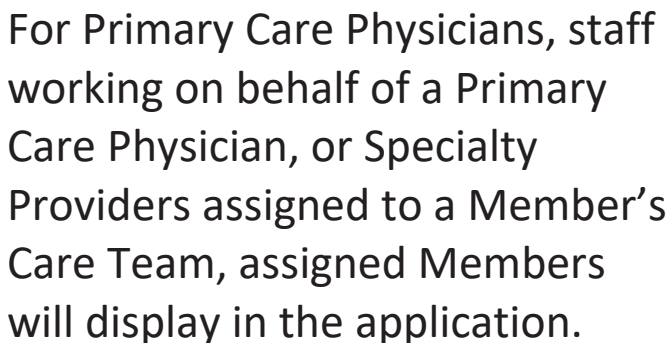
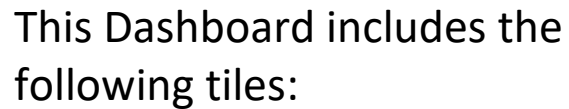


Users with an Optum Link can click the CommunityCare 2.0 tile to launch the application:



Upon launching CommunityCare, you will be directed to the Population Dashboard which will provide quick access to new information about your Member population.



- Care Plan
- Activities
- My Members
- Quality Measures
- Inpatient Admissions & Discharges
- Emergency Department Discharges

Identifies:







- Care Plans recently revised
- Care Plan pending review by the logged in Care Team Member

Click the **hyperlink** to access Care Plans pending review



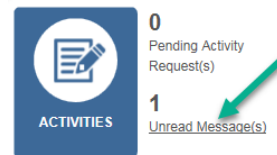
Request Received

Care Plan Rev... Member Name Refer/Acknowledged Date Refer Date From Date To Date Pending

	Member Name	Activity Type	Scheduled Date	Refer Date	Refer by	Acknowledged by	Acknowledged Date	Priority	Status
	 [redacted]	Care Plan Review	02/29/2018	02/29/2018	 [redacted]	N/A	N/A	N/A	Pending
	 [redacted]	Care Plan Review	02/14/2018	02/14/2018	 [redacted]	N/A	N/A	N/A	Pending

4. Activities

Click the hyperlink to view **Messages** sent by a Member of the Care Team



VIEW CARE PLAN

UnitedHealthcare®
Community Plan

CARE PLAN

MEMBER PRIMARY INFORMATION

Member Name : [Redacted] Gender : [Redacted]
Member DOB : [Redacted] Age : [Redacted]
Primary Care Manager : [Redacted] Address : [Redacted]
Care Staff Phone Number : [Redacted] City, State, Zip : [Redacted]
Medicare ID : [Redacted]

CONDITIONS

SNO	Condition	Category	Level	Created On
1	Diabetes	Medical	Primary	1/20/2017
2	Diabetes	Medical	Primary	1/20/2017
3	Hypertension	Medical	Secondary	8/28/2017
4	Hypertension	Medical	Secondary	1/20/2017

MEDICATIONS

SNO	Medication	Dosage	Start Date	End Date	Frequency	Source
No Records						

CARE TEAM

SNO	Name	Clinic/Organization	Role/Type	Specialty	Phone	Fax	Start Date
1	[Redacted]	C&S	NT: Manager/Supervisor	Not Available	[Redacted]	[Redacted]	10/18/2017
2	[Redacted]	Not Available	Not Available	Family Practice	[Redacted]	[Redacted]	1/1/2018
3	[Redacted]	ABC Clinic	EXT: Nurse	Family Nurse Practitioner	[Redacted]	[Redacted]	1/1/2018

CLINICAL INTERVENTIONS

SNO	Opportunity	Goal Group	Goal	Intervention	Status	Start Date	Target Date	Term
1	Self Reported Chronic Disease	Self Management	Member is engaged with PCP or other care provider in management of their diabetes over the next year	Take your medications as prescribed****	Member Agrees to Goal - In Progress	8/25/2017	9/25/2018	Long Term
Notes: 8/28/2017 8:37:55 AM								
2	Self Reported Chronic Disease	Self Management	Member is engaged with PCP or other care provider in management of their heart condition over the next year	Take your medications as prescribed**	Member Agrees to Goal - In Progress	8/25/2017	9/25/2018	Long Term
Notes: 8/28/2017 8:36:44 AM								
3	Personal Goals Medical	Advance Directives	Members end of life wishes are documented in an Advance Directive. Living Will and shared with family and PCP over the next year.	Educate member and family on value of having Advance Directives completed	Member Agrees to Goal - In Progress	8/25/2017	9/25/2018	Long Term
Notes: 8/28/2017 8:37:27 AM								
4	Barriers to Medication Adherence	Self Management	Member takes medication as prescribed during the next year	Educate member about the purpose of the medication and importance of compliance	In Progress	2/20/2018	8/20/2018	Long Term
Notes:								

Acknowledge Cancel

Click “**Acknowledge**” to enter a Note and indicate the care plan has been reviewed and acknowledged

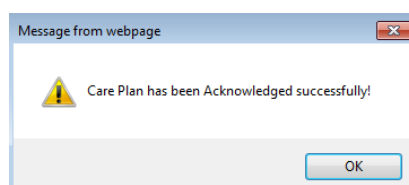
ACKNOWLEDGE REVIEW CARE PLAN

Primary Care Manager : [Redacted]
Request From : [Redacted]
Care Member : [Redacted]

Notes :
Care Plan has been reviewed and acknowledged by a this care team member.

Send Close

A confirmation message will appear, and an activity will be recorded in the Member’s record that the care plan has been **acknowledged**



Request Received

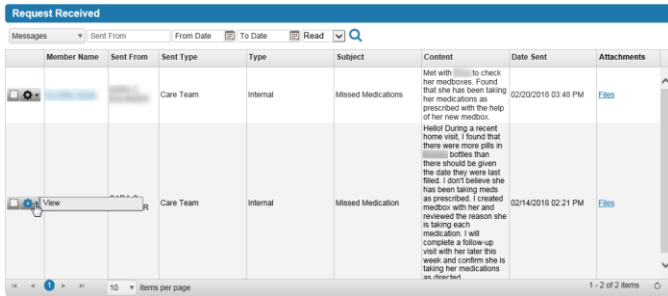
Member Name	Sent From	Sent Type	Type	Subject	Content	Date Sent	Attachments
[Redacted]	Care Team	Internal	Missed Medication	Missed Medication	Hi! During a recent home visit, I found that there were more pills in [Redacted] bottles than there should be given the date they were last filled. I don't believe she has been taking meds as prescribed. I created medicine with her and reviewed the reason she is taking each medication. I will complete a follow-up visit with her later this week and confirm she is taking her medications as directed.	8/21/2018 02:21 PM	Files

1 - 1 of 1 items

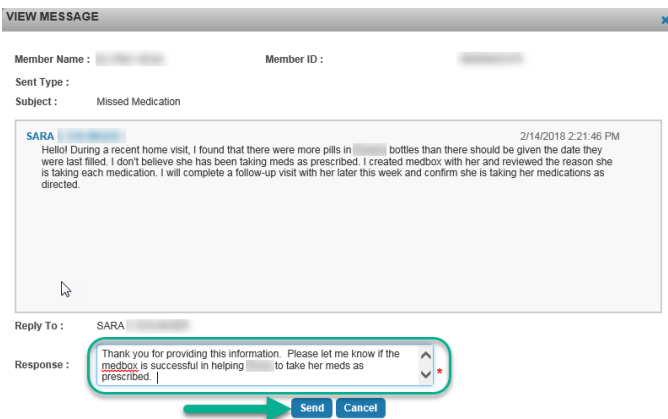
Change the display to “**Read**,” click the search button, and view previously read messages



To send a reply, click the widget and select **“View”**:

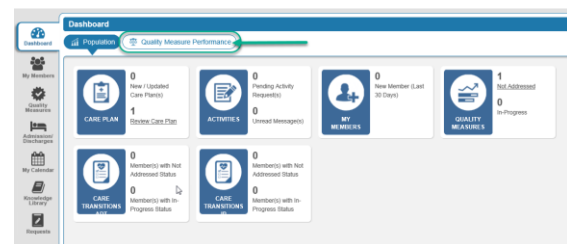


Enter the response and select **“Send”**:

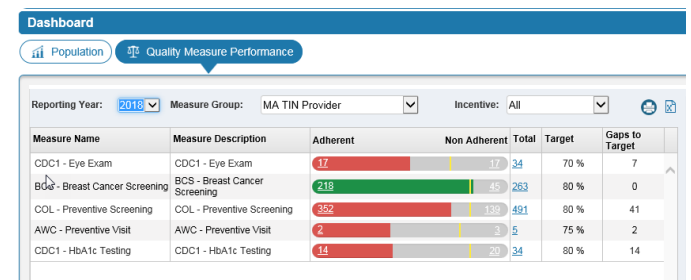


5. Quality Measure Performance Dashboard

From the Dashboard, change the display from Population to **Quality Measure Performance**:



This section displays a group of Quality Measures targeted for a specific State or Provider Practice:



Measure Name: displays the name of the Quality Measure

Measure Description: displays the short description associated with the measure

Adherent: identifies the total

number of Members for whom this measure has been completed

Non Adherent: identifies the total number of Members for whom this measure remains to be closed

Total: identifies the total number of Members for whom this measure applies (both Adherent and Non Adherent)

Target: identifies the desired target percentage for completion

Gaps to Target: indicates the number of outstanding measures to be completed in order to meet the identified Target

Click the hyperlink to display the detailed Member information:

Dashboard

Population Quality Measure Performance

Reporting Year: 2018 Measure Group: MA TIN Provider Incentive: All

Measure Name	Measure Description	Adherent	Non Adherent	Total	Target	Gaps to Target
CDC1 - Eye Exam	CDC1 - Eye Exam	17	17	34	70 %	7
BDC - Breast Cancer Screening	BCS - Breast Cancer Screening	218	45	263	80 %	0
COL - Preventive Screening	COL - Preventive Screening	352	139	491	80 %	41
AWC - Preventive Visit	AWC - Preventive Visit	2	5	7	75 %	2
CDC1 - HbA1c Testing	CDC1 - HbA1c Testing	14	20	34	80 %	14

The detailed Member information will display in the Quality Measures window:

Source: Performance dashboard

Scorecard	Last Name	First Name	DOB	Atlanta ID	Client Name	RISK SCORE	PBS SCORE	AWC - Preventive...
						0	N/A	
						0	N/A	
						0	N/A	

Total Care Opportunities: 3

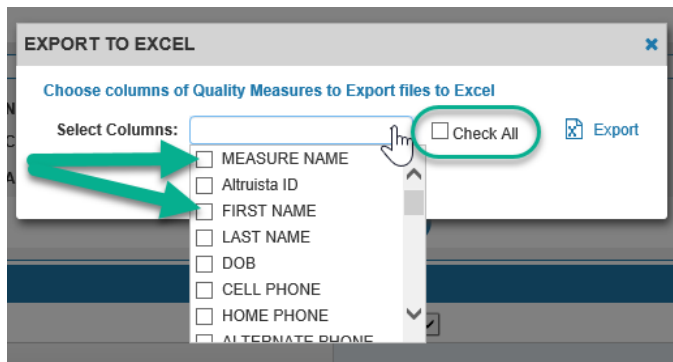
This list can be exported to an Excel document, with customized data elements:

Source: Performance dashboard

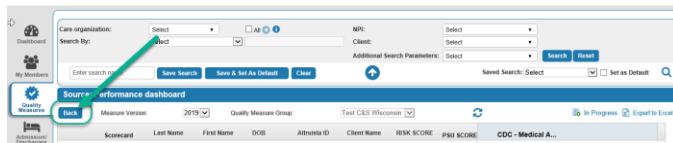
Scorecard	Last Name	First Name	DOB	Atlanta ID	Client Name	RISK SCORE	PBS SCORE	AWC - Preventive...
						0	N/A	
						0	N/A	
						0	N/A	

Total Care Opportunities: 3

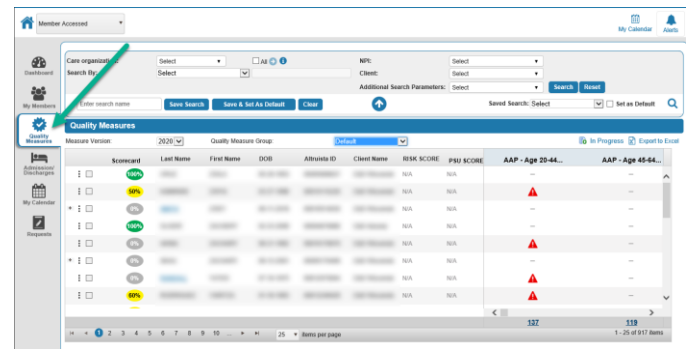
Check the box to “Select Columns” to be included in the export, or click the “Check All” box to export all available data fields:



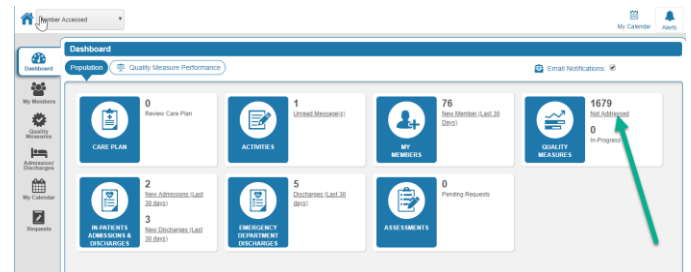
Click the “Back” button to return to the Quality Measure Dashboard display:



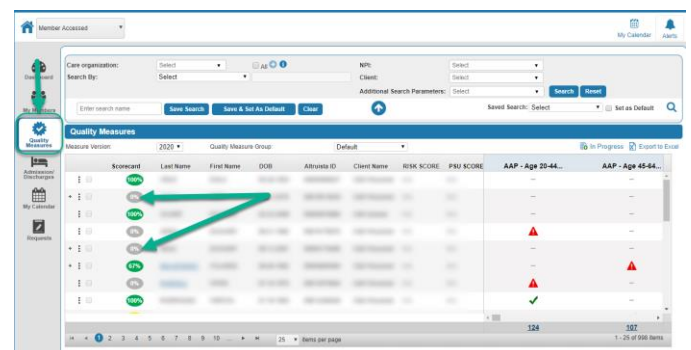
A complete list of ALL Quality Measure Data can be accessed by clicking the side bar icon “Quality Measures”

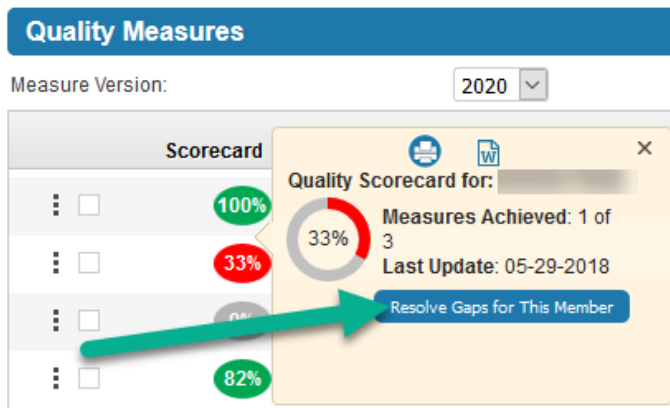


A complete list of all Quality Measures to be addressed can be also be accessed by clicking “Not Addressed” hyperlink from the Quality Measures tile of the Population Dashboard



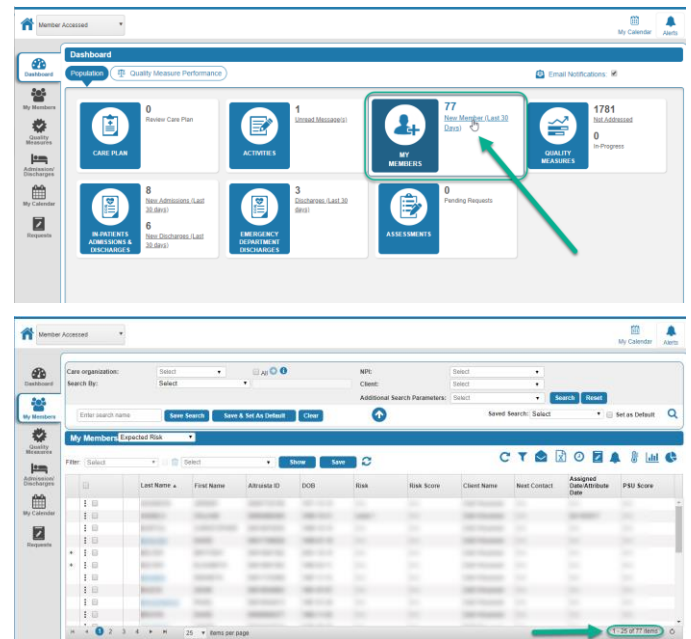
Clicking the “Scorecard” icon will display the gap-closure progress for an individual Member





Click the “Resolve Gaps for This Member” icon to view a complete list of gaps to be closed

Member (Last 30 days)” will display all Members assigned to the Provider within the past 30 days



Definitions

Altruista ID: A CommunityCare application unique member identifier

Risk: Risk indicates the likelihood of a patient admission or re-admission within a specific time span.

Risk Score: A score helps with the determination of how risky a patient is for admission/re-admission compared to others based on lifestyle characteristics and past events.

Next Contact Date: Date of next “scheduled” outreach to

6. My Members

Clicking the hyperlink on the My Members tile from the Population Dashboard “New

member. An Activity has a completion date scheduled in the future.

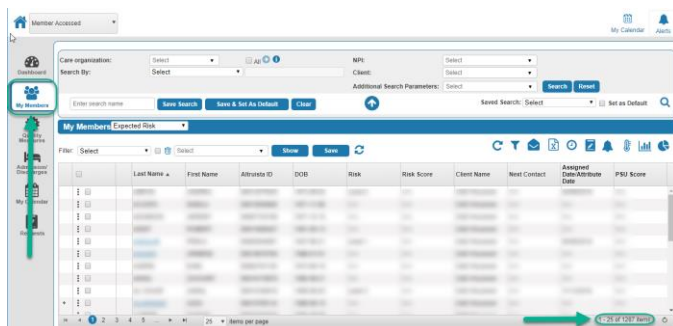
Assigned Date/Attribute Date:

The date the member was assigned to a Care Manager

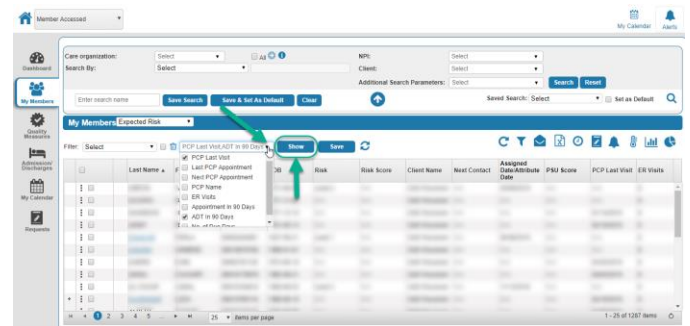
PSU (Persistent Super Utilizer)

Score: Persistent super utilizer is a risk score determined from multiple data sources, i.e. claims, diagnosis, inpatient events, etc. that suggests a member is at risk over a period of time (persistently high risk). These members have chronic health conditions and/or have had multiple inpatient re-admissions within a specific time frame and have been targeted for care management services.

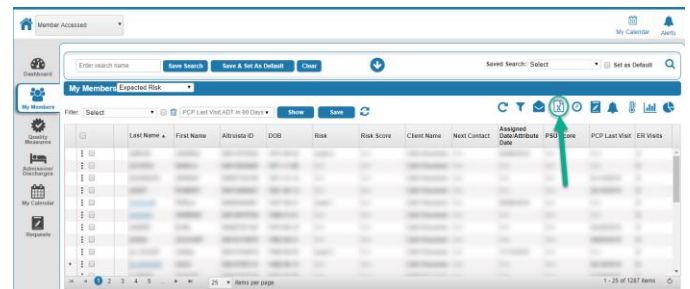
A complete list of ALL Members can be accessed by clicking the side bar icon “My Members”



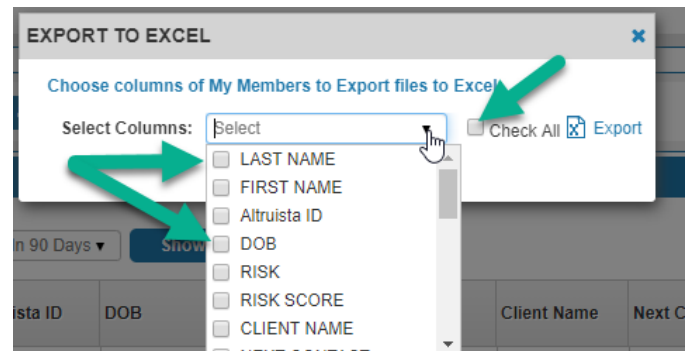
Additional data fields can be added to the display columns by clicking the dropdown arrow, selecting the desired data fields, and clicking on the “Show” button. Clicking the “Save” button will save the display for the user.

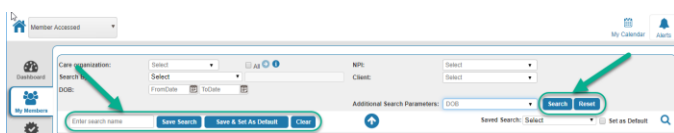


Member information can be exported to Microsoft Excel by clicking the “X” icon

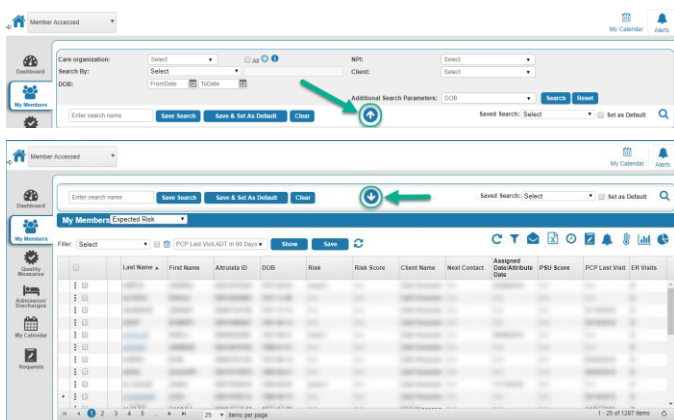


Check the box beside the desired data field to export, or select “Check All” to export all data





Click the arrow icon to close the Search window

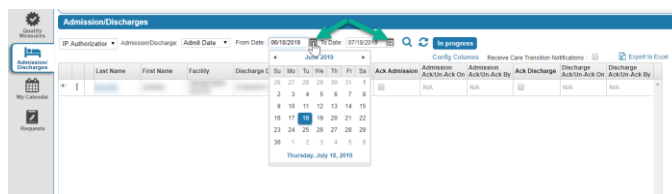


8. Inpatient Admissions & Discharges

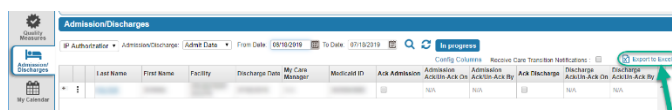
The Inpatient Admissions and Discharges Population Dashboard tile allows for quick access to Members who have been admitted to or discharged from an inpatient facility or nursing home within the past 30 days by clicking the **“New Admissions (Last 30 days)”** and **“New Discharges (Last 30 days)”**



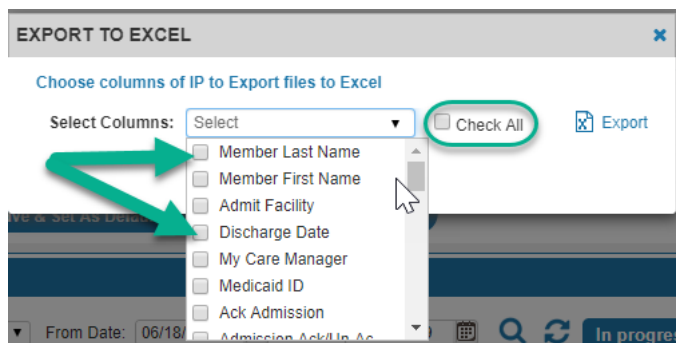
The default 30-day display range can be modified increase or decrease the display range by click on the **“From Date”** or **“To Date”** calendar icons.



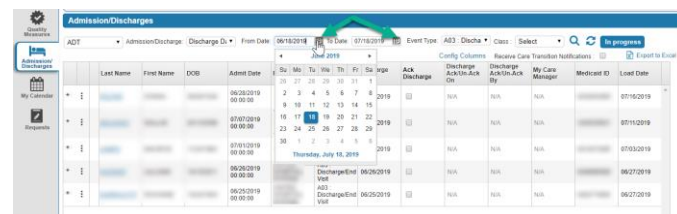
This list can be exported to an Excel spreadsheet, with customized data elements:



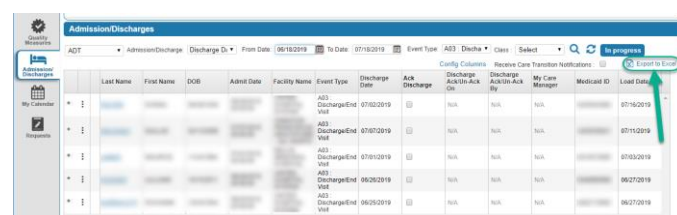
Check the box to **“Select Columns”** to be included in the export, or click the **“Check All”** box to export all available data fields:



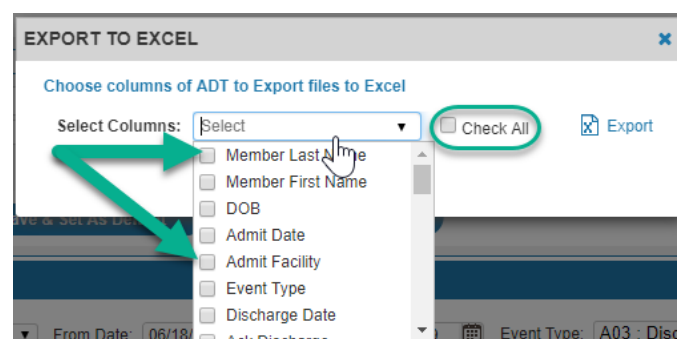
decrease the display range by click on the “From Date” or “To Date” **calendar** icons



This list can be exported to an Excel document, with customized data elements

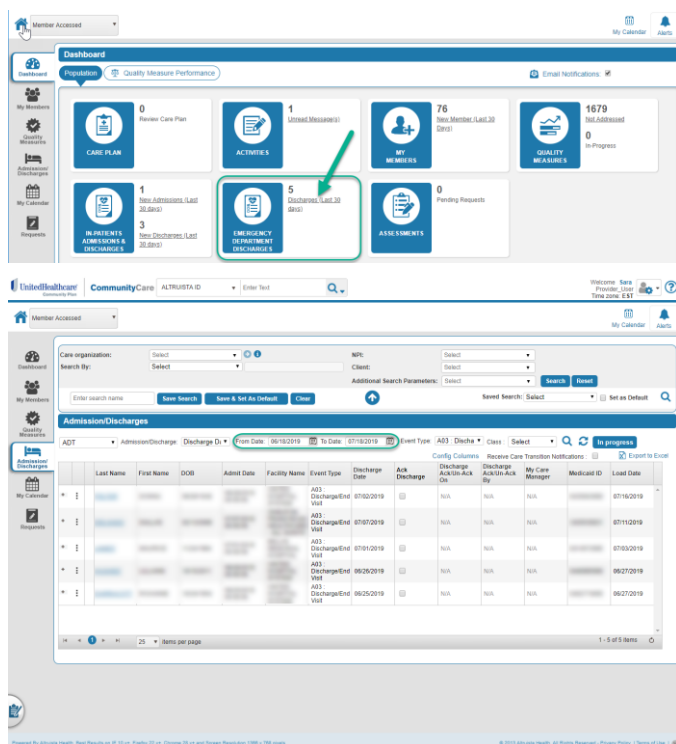


Check the box to “Select Columns” to be included in the export, or click the “Check All” box to export all available data fields:



9. Emergency Department Discharges

The Emergency Department Discharges Population Dashboard tile allows for quick access to Members who have been discharged from an Emergency Department within the past 30 days by clicking the “**New Admissions (Last 30 days)**” and “**New Discharges (Last 30 days)**”



The default 30-day display range can be modified increase or