

# Section 6

## Clinical Programs

---

<b>Care Management Programs</b>	<b>6-1</b>
Regional Care Management	6-1
Care Partnership Program	6-1
Social Care Management	6-2
Smoking Cessation	6-2
HIV/AIDS	6-2
Maternal and Child Health	6-2
Text4baby	6-3
Pediatric Care Management	6-3
<b>Disease Management Programs</b>	<b>6-3</b>
Diabetes Disease Management	6-3
Outcome Measurements and Effectiveness	6-4
Asthma Disease Management	6-5
Chronic Obstructive Pulmonary Disease	6-6
Cardiovascular Disease	6-6
<b>Other Programs</b>	<b>6-6</b>
Proactive Well-Child Care	6-6
School-based Health Center Program	6-7
Organ Transplants	6-7
<b>Nurse Advice Line</b>	<b>6-7</b>
<b>Online Clinical Reports</b>	<b>6-8</b>

## Section 6 Clinical Programs

### Care Management Programs

AllWays Health Partners Care Management and Disease Management programs serve members across physical, behavioral and psychosocial conditions. Our Care Management programs are designed to provide comprehensive, multidisciplinary, and fully integrated care management services that complement and support the care delivered by providers as they help their patients make effective use of available health care resources.

Our holistic and culturally sensitive model is intended to support member adherence to provider's recommended treatment and facilitate self-management. Program participants are identified through our member health needs assessment, medical and pharmacy utilization resource data, or clinician, provider and self-referrals.

In addition to obtaining and sustaining the most appropriate, accessible, and cost-effective health care for AllWays Health Partners members, our care managers:

- Collaborate with practitioners, members, families, providers, social service agencies, and community organizations in developing and executing care management plans for members with complex health care needs
- Support and reinforce members in their efforts to adhere to treatment interventions recommended by their providers through motivational coaching
- Advocate for members to obtain the most appropriate health care services available, through education, referral, and negotiation
- Educate members, families, and health care providers regarding benefits, availability of services, community resources, entitlement programs, and health care alternatives
- Educate members and families regarding health risks, preventative health measures, treatment plans, and medications
- Identify and facilitate access to social service agencies, community organizations, patient support groups, and other adjunct services
- Participate, as needed, in case conferences, family meetings, and informational sessions

- Work with members on their unique discharge planning needs throughout the continuum of care, and specialized equipment needs to maximize their independence in the community
- Provide in home care management to our neediest members with highly complex, unstable, or chronic high-end medical, behavioral health and psychosocial conditions

For more information or to refer a member to Care Management, contact AllWays Health Partners Clinical Services department at 855-444-4647, or send an email\* to [caremanagement@allwayshealth.org](mailto:caremanagement@allwayshealth.org).

\*Please do not send Protected Health Information (PHI) through unsecured email.

### Regional Care Management

Regional Care Managers are assigned to primary practice sites throughout the service area. Regional Care Managers blend traditional utilization management with a progressive, episodic care management approach, sustaining the most appropriate and cost-effective accessible health care for members while coordinating such health care needs as home care and outpatient therapies.

AllWays Health Partners Regional Care Managers collaborate with providers, members, families, health care providers and community agencies and organizations to ensure members with specialized needs receive the care they need.

### Care Partnership Program

In addition to AllWays Health Partners' traditional care and disease management programs, AllWays Health Partners offers a specialized program, called Care Partnership. Through multiple referral sources and the use of predictive modeling software, AllWays Health Partners is able to reach out to members whose complex medical conditions or challenges with effective self-management require more intensive support in order to prevent more serious complications and disease progression.

Because these members typically lack a well-coordinated care plan, have multiple comorbidities, and may face a multitude of psychosocial challenges, our program employs a comprehensive approach focused on medical, social, and behavioral health care management services. Our Care Managers partner with members, their families, their PCPs, and other health care personnel to develop patient centered goals, promote effective self-management, assist in the coordination of care, and facilitate supportive relationships. Care

Managers use motivational and coaching techniques in their care planning and interventions to both improve health status and to avoid hospitalizations.

## Social Care Management

We recognize that often the primary barrier to effective medical care for our members is not medical in nature. Some of the most pressing concerns for many members are income, housing, food, utilities, clothing, and finding transportation.

AllWays Health Partners has a team of social care managers with extensive experience in the field of social and human services. Social Care Managers help members identify and procure community-based services. They conduct comprehensive health needs assessments and collaborate with other care managers to help minimize barriers so that members can meet their medical, behavioral, and psychosocial goals. The social care management team also oversees the Smart Neighbor Resource Database, an online directory of over 450 community, state, and nationally based resources. These resources are relevant to the populations AllWays Health Partners serves and help improve the overall health and wellbeing of our members in need.

## Smoking Cessation

The smoking cessation program at AllWays Health Partners is designed to provide members with information about methods to quit and to help members decide on the method that is most appropriate for them. The AllWays Health Partners Tobacco Treatment Specialist helps members develop behavior change strategies for dealing with cravings and facilitate access to prescription and over-the-counter cessation medications (both covered under AllWays Health Partners' pharmacy program). AllWays Health Partners members who obtain a prescription for over-the-counter nicotine replacement therapy (such as the patch, gum, or inhaler) pay only the pharmacy copayment. Only members with pharmacy coverage qualify for nicotine replacement therapy.

Individuals may be identified for the program through a health needs assessment, self-referral and referral by a care manager or a provider.

For more information about AllWays Health Partners' Smoking Cessation program, please contact AllWays Health Partners' Provider Service Center (8:00 a.m. to 6:00 p.m. Monday through Friday) at 1-855-444-4647 or send an email to the Smoking Cessation counselor at [quitsmoking@allwayshealth.org](mailto:quitsmoking@allwayshealth.org).

## HIV/AIDS

The evolution of HIV/AIDS treatment has placed greater emphasis on proactive identification, treatment and chronic needs management as hallmarks of care excellence. AllWays Health Partners is committed to providing individualized care management services to at-risk populations and conducts proactive screening for HIV/AIDS during the following routine assessments:

- Prenatal risk assessments
- Social care management assessments
- General care management assessments for each member involved in care management

In addition, the diagnoses categories related to HIV/ AIDS are incorporated into the proactive high-risk case identification in AllWays Health Partners' predictive modeling techniques.

AllWays Health Partners provides network providers with information regarding the latest treatment approaches, including new technologies and bio-pharmaceuticals, by providing online access to the HIV/AIDS Treatment Information Service Guidelines, developed by the U.S. Department of Health and Human Services. The HIV treatment guidelines are periodically reviewed and updated by panels of HIV experts from the Department of Health and Human Services.

## Maternal and Child Health

AllWays Health Partners' "For You Two" program provides care management services to pregnant members at high risk for adverse birth outcomes.

AllWays Health Partners is strongly committed to making these services available to women with medical or psychosocial conditions that render them vulnerable to pre-term or low birth-weight delivery. Members are referred to the program from a variety of sources including clinician and member self-referral.

AllWays Health Partners' obstetric nurse care managers work closely with obstetric providers to maximize access to and the efficacy of prenatal care. If enrolled in the "For You Two" program, the care manager is able to ensure a member's comprehensive access to such services as behavioral health or substance abuse services, direct referral to AllWays Health Partners' smoking cessation counselor, and full coverage of breast pumps and postpartum home visits.

## Text4baby

“Text4baby” is a free program that sends health-related text messages to expectant mothers and mothers of infants.

Each year in the U.S. more than 500,000 babies are born prematurely, and an estimated 28,000 children die before their first birthday. In response to this national public health crisis, the National Healthy Mothers, Healthy Babies (HMHB) Coalition launched text4baby to help new mothers care for their health and give their babies the best possible start in life.

Women who sign up for the service by texting BABY to 511411 (or BEBE in Spanish) receive free SMS text messages each week, timed to their due date or baby’s date of birth. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources.

### *Outreach Partners*

The National HMHB Coalition is working with a broad range of partners to encourage the women they reach to take advantage of this free service. Outreach partners include state and local health departments, community health centers, WIC programs, health plans, retail partners, community organizations, major medical associations, and non-profit organizations.

Text4baby is made possible through a broad, public-private partnership that includes government, corporations, academic institutions, professional associations, tribal agencies and non-profit organizations. Founding partners are HMHB, Voxiva, CTIA–The Wireless Foundation, and WPP. U.S. government partners include the White House Office of Science and Technology Policy and the Department of Health and Human Services. The mobile health platform is provided by Voxiva and free messaging services are generously provided by participating wireless service providers. Implementation partners include BabyCenter, Danya International, Syniverse, Keynote Systems, and The George Washington University.

Promoting prenatal and post-partum health is one of AllWays Health Partners’ major health and quality initiatives, and a priority in our efforts to address health disparities in our State. Our partnership with text4baby is a natural extension of our work in these areas.

## Pediatric Care Management

The Pediatric Care Management program addresses the health care needs of children and infants with serious illness and unique health care needs including medical, behavioral, developmental, psychosocial concerns and conditions and complications arising from the newborn period. The role of the Pediatric Care Manager is to educate, coordinate and facilitate care, emphasizing collaboration with the provider, the member’s parents or guardians, other health care providers, social service agencies, and community organizations in developing and executing a care management plan for the member.

Many of the cases involve children with special health care needs, enabling us to link families with special resources and programs available for this population. AllWays Health Partners is committed to working with providers for children with special health care needs. We promote the American Academy of Pediatrics “medical home” model of care to develop supportive and collaborative partnerships with our providers to improve the care and quality of life for these members.

### *Parent Advisor*

In addition to traditional care management approaches, AllWays Health Partners has created a staff role performed by an individual who shares the personal experience of parenting special needs children. In this non-clinical role, the parent advisor offers detailed guidance with the special education process. In addition, the parent advisor provides information that links parents to support groups and resources.

---

## Disease Management Programs

### Diabetes Disease Management

AllWays Health Partners’ Diabetes Disease Management Program strives to help AllWays Health Partners members take control of their diabetes through member and provider-oriented outreach strategies and interventions. The program rests on the assumption that, for most patients diabetes is a controllable illness and that much of diabetes morbidity is preventable.

Using the *American Diabetes Association Clinical Practice Recommendations* as a framework, the goal of AllWays Health Partners’ comprehensive Diabetes Disease Management Program is to promote optimal member/provider management to help minimize disease-related complications. The multi-pronged approach attempts to improve member’s self-management skills while increasing member

knowledge of the disease process. The varied components on the Diabetes Disease Management Program are all geared to assisting the primary care provider (PCP) to more effectively manage their AllWays Health Partners patients with diabetes in a more proactive fashion. The aim of AllWays Health Partners' diabetes program is early detection and optimal member/provider management and control.

AllWays Health Partners' Diabetes Disease Program is intended to provide outreach to members at varying levels of intensity on a stratification of clinical data to help members more effectively manage their diabetes, reduce the risk for short- and long-term complications, enhance member understanding of diabetes and good self-management practice and improve their self-assessed "quality of life." In addition, the diabetes program delivers cultural competent education meeting the member's individual needs.

Members are identified for the program through multiple sources including: inpatient; outpatient; ER and pharmacy utilization claims data; direct referrals from health care providers; member self-referral; and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program any time.

#### *Member Resources*

Members identified as being higher risk receive outreach phone calls from a Diabetes Care Manager, who conducts assessments and develops individualized care plans based on the needs of members, including:

- Disease-specific education on the importance of glucose monitoring, the connection with dental health, medication adherence, timely preventative screenings, disease signs and complications, weight management, dietary needs, and the importance of communicating with their providers
- Referral to AllWays Health Partners' tobacco treatment specialist for quitting smoking and our on-site behavioral health care managers for managing depression
- Collaboration with the member/family, PCP, and other health care providers to implement a care management plan
- Reimbursement for outpatient diabetes educators and registered dietitians

#### *Provider Resources*

##### REPORTING MEMBER UTILIZATION

AllWays Health Partners provides practice site quarterly specific reports derived from health plan claims data to support providers in managing a patient's outcome. These

reports are available through [allwaysprovider.org](http://allwaysprovider.org) and include:

- *Diabetes Member Utilization Report*—Member-level information over a 12-month period that includes:
  - » Number of diabetic related hospitalizations
  - » Number of diabetic related visits to the ER
  - » Receipt of HbA1c test
  - » Receipt of LDL test
  - » Receipt of retinal screening examination
  - » Presence of a cardiovascular comorbidity
  - » Last dispensed ACE/ARB
  - » Last dispensed statin
- *Diabetes Screening Rates*—A graphic report showing the screening rates of recommended tests for diabetes for your site compared to a benchmark rate of AllWays Health Partners overall for a specific reporting time period, including:
  - » Two or more HbA1c tests
  - » Four or more HbA1c tests
  - » LDL-C screening
  - » Retinal eye exam
- *Diabetes Screening Rate Trend*—A graphic report showing the screening rates for recommended tests for diabetes for your site compared to benchmark rate of AllWays Health Partners overall. This report presents the same results as the Diabetes Screening Rates Report for up to 12 months
- Clinical Practice Guidelines
- American Diabetes Association Clinical Practice Recommendations

In addition to the reports available on [allwaysprovider.org](http://allwaysprovider.org), AllWays Health Partners mails to primary care practice sites Diabetes Gap Reports, a member specific utilization report that identifies which recommended screening(s) their patient may have missed based on claims information and other relevant information related to cardiovascular comorbidity.

## Outcome Measurements and Effectiveness

Some of the key measures that AllWays Health Partners looks at to assess the program include:

- HEDIS measure: Comprehensive Diabetes Care;

Central to the program is improving screening rates (HgbA1C, retinal eye exams, lipid screening, micro-albuminuria) for at-risk members in an effort to improve health outcomes.

- Member satisfaction with diabetes educational tools
- Member satisfaction with Care Management intervention

## Asthma Disease Management

AllWays Health Partners has a multifaceted Asthma Disease Management program that focuses on improving our adult and child members' understanding of what controlled asthma means, understand their medications, proper way to use an inhaler, environmental triggers, and managing exacerbations. Our program provides outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the AllWays Health Partners patient with asthma.

Members targeted for enrollment in the asthma disease management program include those who are at high risk for ineffective management of their asthma disease process as manifested by frequent utilization of the emergency room for asthma related problems, asthma related inpatient admissions, and high recent and chronic use of symptom-relief and crisis asthma medications.

Built on the NHLBI Asthma Management Guidelines, our program reinforces the provider's treatment plan.

Members are identified for the program through multiple sources, including: inpatient, outpatient, emergency room services, and pharmacy claims data, direct referrals from health care providers, member self-referral and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program at any time.

### Member Resources

Members identified as being at the highest risk may receive additional educational material mailings to help them manage their asthma. An Asthma Care Manager conducts an assessment to evaluate asthma control, employing the asthma control test, and provides a personalized care plan that includes the following interventions to minimize exacerbations and reduce impairment:

- Education about the disease process, necessary lifestyle changes
- Provides resources and strategies to eliminate and avoid factors that may exacerbate asthma

- Makes referrals to support groups, community resources, the AllWays Health Partners smoking cessation counselor and other health and social agencies
- Makes provision for covered benefits such as a mattress encasing, smoking cessation, allergy treatments

### Provider Resources

#### REPORTING MEMBER UTILIZATION

AllWays Health Partners provides primary care sites with quarterly specific reports derived from health plan claims data to support providers in managing a patient's outcome. These reports are available through [allwaysprovider.org](http://allwaysprovider.org) and include:

- *Quarterly Site based Asthma Registry:* These reports are issued quarterly and provide a risk stratified summary of relevant asthma related utilization for each member identified with asthma at the practice site during the prior 12 months of the member's AllWays Health Partners enrollment. The following variables are included in these reports:
  - » Summary of asthma related hospitalization and readmissions
  - » Summary of asthma-related emergency room visits
  - » Summary of specialist visits
  - » Summary of pulmonary function tests
  - » Dispensed medications
  - » Number of inhaled and oral steroid prescriptions
  - » Number of combined inhaler prescriptions
  - » Number of leukotriene modifier prescriptions
  - » Number of inhaled steroid/long-acting beta agonist prescriptions
  - » Number of systemic steroid prescriptions
- *Asthma Care Quality Measure Trend Report:* This report provides a site level profile of the quarterly Asthma Disease Management Program measures. A primary care site can compare how it is doing against the AllWays Health Partners benchmark among primary care sites with 75 or more AllWays Health Partners members in the asthma population for any quarter during the past 12 quarters. A site may also look for trends in asthma care at their site that show improvement or identify areas where an action may be taken to improve care and utilization.
- A primary care site bi-weekly *Asthma Trigger Reports:* These reports identify individual members

with evidence of current problematic asthma control as evidenced by high use of bronchodilators or systemic steroids or asthma related emergency department use. The following variables are included in these reports:

- » An asthma related ER visit in the past 2 weeks OR a paid claim for an asthma ER visit in the past 6 weeks;
- » A systemic steroid dispensing in the past 2 weeks AND have received at least 3 systemic steroids in the past 4 months and at least 1 beta agonist dispensing in the past 4 months;
- » A beta-agonist dispensing in the past 2 weeks AND have received at least 3 beta-agonists in the past 4 months;
- » Have seen a specialist with the diagnosis of asthma

## Chronic Obstructive Pulmonary Disease

AllWays Health Partners' Chronic Obstructive Pulmonary Disease (COPD) Program offers personalized health support to participants affected with COPD.

Our goal is to empower participants to make smarter life choices that help slow inevitable disease progression and allow them to maximize their functional independence. It strives to improve the participant's quality of life while reducing hospitalizations and emergency room visits, resulting in lower COPD-related healthcare costs.

Our program provides outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the AllWays Health Partners patient with COPD.

Members targeted for enrollment in the COPD disease management program include those who are at high risk for ineffective management based on progressive or severe COPD, emergency room visits and inpatient admissions for COPD exacerbations.

Members are identified for the program through multiple sources including: outpatient, emergency, hospital setting, pharmacy claims data, direct referrals from health care providers, member self-referral, and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program at any time.

The program also encourages participants to stay

connected to their provider's plan of care.

## Cardiovascular Disease

AllWays Health Partners' Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF) Programs offer personalized health support to participants affected by CAD and CHF.

Our programs encouraging participants to collaborate with their physician and prevent disease progression disability, as well as the development of other chronic conditions.

Our programs empower participants to improve their health status and increase compliance with their provider's treatment regimen.

Our programs provide outreach to members at varying levels of intensity based on a stratification of medical and pharmacy claims data and assists the provider with information to proactively manage the AllWays Health Partners patient.

Members targeted for enrollment in the CAD and CHF disease management programs include those who are at high risk for ineffective management of their disease process as manifested by frequent utilization of the emergency room and inpatient admissions for related problems.

Members are identified for the program through multiple sources, including: inpatient, outpatient, emergency room services, pharmacy claims data, direct referrals from health care providers, member self-referral, and other sources of referral. Participation is voluntary and at no cost. Members may opt out of the program at any time.

---

## Other Programs

### Proactive Well-Child Care

AllWays Health Partners provides a comprehensive program to deliver proactive well child care services by establishing expectations regarding the importance and content of well-child care; and by communicating these to enrollees and providers. AllWays Health Partners endorses the Massachusetts Health Quality Partners' (MHQP) Pediatric Preventive Care Guidelines. Clinical programs are designed to support and collaborate with primary care practices and school based programs. The objectives of proactive well-child care are:

- To provide comprehensive and continuous health care designed to prevent illness and disability

- To foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage
- To create an awareness of the availability and value of preventive health care services

Information regarding the MHQP guidelines for pediatric preventive care is available to all pediatric providers. These guidelines are accessible on [allwaysprovider.org](http://allwaysprovider.org) and include comprehensive clinical instruction on health maintenance visits, routine lab work, sensory screening, infectious disease screening, cancer screening, and general counseling and guidance. Health maintenance visits include the following:

- History and physical exam
- Developmental assessment
- Nutritional assessment
- Dental assessment and referral
- Head circumference (until 24 months)
- Immunization assessment
- Behavioral health screening

For detailed information on documentation standards for these services, please refer to the “Quality Management Programs” section of this manual.

## School-based Health Center Program

AllWays Health Partners contracts with school-based health centers (SBHCs) to facilitate better access to quality health care for children and adolescents. Contracted SBHCs provide HMO covered services to school-aged AllWays Health Partners members within the school setting. During the school year, students can easily access the services that each center provides.

### *Covered Services*

To facilitate access to primary care and urgent care services for students at SBHCs, AllWays Health Partners will reimburse for those services delivered provided all other claim processing rules are met. Examples of covered services include:

- Comprehensive physical examinations
- Immunizations
- Treatment of minor illness or minor injuries
- Pregnancy testing
- Sexually transmitted disease testing and treatment
- HIV/AIDS testing and counseling

SBHCs do not make direct referrals to specialists. Rather, the SBHC must refer the member back to the PCP except for emergencies.

### *Coordination of Care Form*

The child or adolescent’s PCP is notified of services rendered at the school-based health center through the use of the Coordination of Care correspondence form. The Coordination of Care form helps to establish a link between health care providers whose ultimate goal is to ensure timely access and proper follow-up to care delivered at SBHCs.

## Organ Transplants

For members requiring transplant services, AllWays Health Partners has partnered with OptumHealth Care Solutions for the use of its comprehensive transplant network.

Optum has established relationships with medical centers that have demonstrated expertise in various transplant services. Use of transplant services through the Optum network is available to all members. When services within Optum’s network are not available to meet a member’s needs, consideration for the best placement possible will be given outside of Optum’s contracted network.

The member’s appropriate specialty provider or the PCP in cooperation with the member’s specialty provider may initiate authorization requests for all transplant-related services with AllWays Health Partners. All pertinent medical information must be submitted to AllWays Health Partners in writing to obtain authorization for transplant services. Transplants are coordinated through AllWays Health Partners’ Clinical Services Department prior to providing any services, including evaluation. The medical criteria established by AllWays Health Partners will be applied and each potential transplant must be deemed medically necessary, not experimental in nature, and appropriate for the medical condition for which the transplant is proposed.

---

## Nurse Advice Line

AllWays Health Partners offers its members a toll free 24/7 Nurse Advice Line. Patients can speak directly with a registered nurse at any time of the day, seven days a week. Members may also listen to automated information on a wide range of health-related topics, ranging from aging and women’s health to nutrition and surgery. The Nurse Advice Line doesn’t take the place of a primary care visit. It is intended to help our members decide if they should make an appointment with their PCP or go to the emergency



room. The nurse also provides helpful suggestions for how your patients might care for themselves at home.

Your patients may access AllWays Health Partners' Nurse Advice Line at:

- Commercial: 1-800-462-5449
- Partners Plus & Partners Select 1-833-369-5339

## Online Clinical Reports

AllWays Health Partners provides its primary care network with a wealth of clinical resources to help in effectively managing patient care. This provision of timely, actionable site and patient-level data allows PCPs to download electronic versions of various reports and manipulate the data based on the specific needs of their practice.

Access to the data is entirely at the discretion of the provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only and review user permissions regularly.

### Available Reports

- *Asthma Site Summary Report*—Key Measurements for a primary care site for asthma care quality measures compared to the best achievable performance results for the most recent quarter
- *Asthma Care Quality Measure Trend*—Graphs displaying the same results as the Asthma Site
- *Summary Report* for the last 12 quarters
- *Asthma Member Utilization Report*—Asthma related utilization of AllWays Health Partners members assigned to the primary care site
- *Diabetes Screening Rates*—A graphical report showing the screening rates of recommended tests for diabetes for the primary care site compared to a benchmark rate of AllWays Health Partners overall
- *Diabetes Screening Rates Trend*—A graphical report showing the screening rates for the recommended tests for diabetes for the primary care site compared to a benchmark rate of AllWays Health Partners overall for the past 12 quarters
- *Diabetes Member Utilization Report*—A detailed report of utilization by AllWays Health Partners members enrolled at the primary care site
- *ER Site Summary Report*—Summary of ER visits not resulting in an inpatient admission for members

as-signed the primary care site

- *ER Site Summary Trend Report*—Graphs of measures of ER visits not resulting in an inpatient admission for AllWays Health Partners benchmark and for the primary care site
- *Mammography*—A report of female members between the ages of 40 and 74 who have not had a mammogram in the past year
- *Member ER Visit Summary Report*—Summary of ER utilization for members assigned to the primary care site
- *Member ER Visit Detail Report*—A list of each ER visit during the reporting period, by member assigned to the primary care site
- *Seven-month Infants with Fewer Than Three Well Visits*—A report of infants assigned the PCP who are seven months old as of the month end and who have had less than three well child visits between birth to six months of age
- *Have You Seen/Screened Me? Screening Rates*—A graphical report comparing the rate of pediatric well child visits and the rate of MassHealth pediatric behavioral health screens to the AllWays Health Partners benchmark
- *Have You Seen Me? Report*—Detailed report listing members between the ages of 1–18 who did not have a well-child visit in the past year
- *Have You Immunized Me? Report*—Detailed report listing members between the ages of 18 and 24 months of age during the past quarter

Provider offices can also access other administrative reports and conduct many transactions on a self-service basis without assistance from AllWays Health Partners staff.

For a detailed list of [allwaysprovider.org](http://allwaysprovider.org) reports and available transactions, please visit the Member and Provider Management sections of this manual.

To enroll in the provider portal, please visit [allwayprovider.org](http://allwayprovider.org) to follow the easy registration instructions—or consult with your site's appointed User Administrator.

Providers needing additional assistance can email [prweb@allwayshealth.org](mailto:prweb@allwayshealth.org).