Purpose

The Care Coordinator’s Handbook will provide you with:

- Enhanced Personal Health Care Transformation Team member role descriptions
- Definitions of terms commonly used
- Self-guided learning activities using Milestone-focused topics
- Quick links to frequently referenced sites
- Information on special topics - for example, pediatric resources

Top Three Actions for the Care Coordinator

- Take action based on findings in the clinical reports
- Submit referrals to internal programs
- Reach out to members to schedule follow-up appointments

How to Use This Handbook

- Review it as an introduction and overview of Enhanced Personal Health Care.
- Follow the “Milestone” user-friendly lessons to boost your Care Coordination skills and understanding.
- Relate transformation activities at your practice to the ACP Practice Advisor® modules and Practice Biopsies.
- Use links to quickly find key Enhanced Personal Health Care resources such as the Recorded Learning Library, Collaborative Learning Opportunities, Virtual Office Hours, Pharmacist Consultant resources and Provider Toolkit.
- Use links to locate and use information about Anthem care management programs - there are many benefits and resources available for Anthem members, but resources vary by plan. Your Provider Clinical Liaison will assist you with any referral or resource questions.

Quick Links

Terminology

Lessons and Special Topics
Quick Links

Availity
Log in to access Enhanced Personal Health Care reports

MMH+ Member Medical History Plus
Link to Anthem’s MMH+ individual patients’ medical claims records

Anthem.com Enhanced Personal Health Care
Link to California website Provider home page

Anthem Care Management Referral Form
Link to email-ready form
Enhanced Personal Health Care Support Team Roles

The Provider Clinical Liaison will assist you with:
- Clinical review of patients
- Development of care planning and care coordination skills
- Referrals to Anthem Care Management programs
- Access to Referral Specialist and Pharmacist Consultant

The Care Consultant Senior will assist you with:
- Work Process Redesign
- Clinical Data Management
- Medical Home Building
- Learning Collaboratives, Virtual Office Hours and other learning opportunities
- Program reports progress updates
- Community Resources
Lesson Plans for Care Coordinators: Toolkit Topic Focus Areas

**Care Coordination**
Milestone 1

**Risk Stratifying Populations**
Milestone 2

**Care Planning**
Milestone 3

**Population Health Management and Registries**
Milestone 4

**Health Information Technology**
Milestone 5

**Patient -Centered Care**
Milestone 6

**Enhanced Access to Care**
Milestone 7

**The Medical Neighborhood**
Milestone 8

**Improved Clinical and Utilization Outcomes**
Milestone 9

**Medical Home Recognition and Other Advanced Activities**
Milestone 10

**Special Topics:**
**Pediatric Resources, Pediatric Behavioral Health Resources**

**Special Topics:**
**Behavioral Health Resources – Integration and Adult Resources**

**Special Topics:**
**Anthem Care Management Programs and Resources**

**Special Topics:**
**Pharmacist Consultant**

**Terminology**
Care Coordination

Milestone 1: Establish internal infrastructure to coordinate care

Questions:
- How do you follow up on patients with missed appointments or missed screenings?
- How are you notified when a patient has been to the ER or admitted to the hospital?
- Does your practice team have established workflows to assess medication reconciliation and adherence? Is any training needed?
- Do you have a pre-visit huddle? How do you flag charts? What is your post-visit process?
- Do you have adequate time to devote to care coordination?
- What do you want to improve?

Basic Ideas:
You are transitioning to a patient-centered medical home, which means you are assuming responsibility for coordinating the preventive and chronic care needs of your patients. Your task is to be a point of contact for patients and families, improve communication, and ensure that medical information is accurate. There are many resources to help you learn about care coordination in the Provider Toolkit. As you adjust your workflows and incorporate new tools, remember that you have a team of consultants that will help you every step of the way. Your goal is to achieve the best possible health outcomes for your patients.

Objectives:
- Access Provider Care Management Solutions (PCMS)
- Establish care team duties and workflows and define your role as care coordinator
- Develop a process to identify and intervene with high-risk patients
- Identify and close patient care gaps
- Outreach to patients with recent hospitalizations and coordinate care transitions
- Develop a process for medication reconciliation and adherence at each visit
- Reach out to patients who have missed appointments
- Coordinate referrals and test results

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 1
  Resources, including toolkits, to support establishment of infrastructure to coordinate care.
- Four Pillars - from the Care Plan Playbook Milestone 3
  Guide to post-discharge risk reduction
- Virtual Office Hours with Enhanced Personal Health Care Team
  Attend for guidance on special topics each month or request a topic
- Recorded Webinars
  - Care Team Huddle
  - Care Coordination
  - Establishing a Care Team
  Collaborative Learning Opportunities Recording Library

I want to learn more:
- ACP Practice Advisor Modules and Biopsies - Building the Foundation
  - Organize Your Practice
  - Work as a Team
  - Coordinate Care
Risk Stratifying Populations

Milestone 2: Establish Internal Process to Review and Use Reports and MMH+ for Population Health Management and High-Risk Patient Stratification

Objectives:

- Implement a workflow process for MMH+ and Enhanced Personal Health Care reports
- Demonstrate use of resources for high-risk patient stratification
- Use reports to review cost of care implications

Questions:

- Can you identify your target population?
- What data do you have that can help you identify and stratify your high-risk population (utilization, diagnoses, pharmacy data, reports, etc.)?
- How will you need to deliver care differently to meet the needs of this group of patients?
- How will this help your practice and your patients? Impact cost of care?

Basic Ideas:

Stratifying your patient population is one way to identify patients who can most benefit from additional guidance and attention from the practice care team. Patients may be identified and prioritized using information from PCMS Hot Spotter report, the Emergency Room Report, the Inpatient Authorization Report and the Care Opportunities Report. MMH+ provides additional detailed patient information to assist you. You will need to develop a process for using this information to reach out to patients with chronic conditions, conduct pre-visit planning, and close care gaps. Your goal is to demonstrate improved trends for chronic disease clinical outcome measures.

Resources on Anthem.com Enhanced Personal Health Care:

- Provider Toolkit Milestone 2
  Resources, including Anthem materials, to assist you in establishing processes and workflows to utilize reports and MMH+ for population health management and high-risk patient stratification.
- Risk Stratified Care Management – Milestone 2
  American Academy of Family Physicians
- MMH+ Guide and request form
  How to use MMH+ and access request form
- Acute and Chronic Care Measures
  Scorecard Measures

I want to learn more:

- ACP Practice Advisor Biopsies - Building the Foundation
  - Use of Technology I & II
  - Manage Populations
Care Planning

Milestone 3: Establish sustainable process for shared care planning including self-management support/goal setting/action planning

Objectives:
- Establish a routine process for care plan development
- Demonstrate proactive care planning and begin to incorporate self-management support
- Develop a workflow to support annual comprehensive assessment
- Implement a process to include medication adherence and reconciliation at each visit and care transition

Questions:
- Why do we need to do care plans?
- How does a care plan impact the patient’s treatment plan?
- Is there a guide or “template” that we need to use for care plans?

Basic Ideas:
A care plan is a detailed approach to care customized to an individual patient’s needs. Care plans are called for when a patient can benefit from personalized instruction and feedback to help manage a health condition or multiple conditions. A care plan enhances a patient’s plan of care by providing steps to meet identified health goals. The format will vary based on your charting process and electronic capabilities and should not require duplicate documentation.

There is no single template that must be followed, but there are critical elements that should be included:
- Collaborative approaches to health, including patient and family participation in care plan
- Prioritized goals for a patient’s health status
- Established timeframes for reevaluation
- Resources that might benefit the patient, including a recommendation as to the appropriate level of care
- Planning for continuity of care, including assistance making the transition from one care setting to another

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 3
  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. Includes: Patient Care Plan Template Care Plan Playbook Assessment Domains
- Recorded Webinars – Self-Management Support
  Collaborative Learning Opportunities Recording Library

I want to learn more:
- ACP Practice Advisor Modules and Biopsies – Building the Foundation
  Coordinate Care
- Tools
  - Partnering in Self-Management Support: A Toolkit for Clinicians
    Institute for Healthcare Improvement
  - Video with Techniques for Effective Patient Self-Management
    California Healthcare Foundation
  - Integrating Comprehensive Medication Management
    Patient Centered Primary Care Collaborative
Population Health Management and Registries

Milestone 4:
Establish and maintain population health registry and reports for patient outreach, closing gaps in care, and managing prevention and chronic disease needs of patients

Objectives:
- Refine the system you use to identify high-risk and complex patients in the practice’s population
- Identify specific steps that can be implemented to assist patients in setting goals and improving healthcare outcomes
- Identify registry resources and current gaps, for both prevention and chronic care measures

Questions:
- Are there ways in which you think your practice could use information systems to improve care?
- Do you wait for patients to come in for care or do you have a way to track which patients may be due for preventive care?
- How are evidence-based guidelines used to guide patient care in this practice?
- What tools, resources and support do you have available at the point of care when you need to make a clinical decision?

Basic Ideas:
Population Management is based on stratifying patients—from low-risk, to complex, high-risk, and uncontrolled chronic conditions. Evidence based guidelines (EBGs) are used to monitor prevention and disease management of patients. Your task is to understand the pattern and processes for how care for this population has been provided in the past and to develop new care processes for tracking, monitoring and follow-up on a more pro-active basis to maintain people at the highest level of wellness.

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit: Milestone 4
  Population health registry guides and other materials to help you set-up and maintain a registry and use its functionality for patient outreach, closing gaps in care and managing prevention and chronic disease needs of patients.

I want to learn more:
- ACP Practice Advisor Modules and Biopsies
  - Building the Foundation
    - Use of Technology I and II
    - Manage Populations
  - Improving Clinical Care
    - Manage Diabetes Mellitus
- Tools
  - Population Health Management in the Medical Neighborhood
    Patient Centered Primary Care Collaborative
- Guidelines
  - 2015 HEDIS Measures
Health Information Technology

Milestone 5: Maximize e-health record and/or available health Information technology (HIT) for evidence-based care delivery and relevant clinical decision support

Objectives:
- Use evidence-based resources to determine interventions for patients
- Develop processes for exchange of information to decrease gaps in care
- Use available technology to improve coordination of care
- Incorporate resources such as a Personal Health Record or WebMD for patient self-care management

Questions:
- Are there ways in which you think your practice could use information systems to improve patient care?
- How does your practice identify patients who need visits, labs, or other services?
- How do you currently link patients to resources?

Basic Ideas:
Health Information Technology includes all the digital tools you use to manage patient health, such as an electronic medical record (EMR), patient portal, e-prescribing, registries with embedded evidence based guidelines, and clinical alerts. Improved use of technology will impact clinical outcomes and cost of care. Your task is to utilize Availity, MMH+ and other web-based resources to minimize gaps in care and improve continuity of care. Your goal is to facilitate information exchange.

Examples:
- EMR - document diagnoses, vital signs, tests and treatments, populate registries
- Registry - for patient monitoring, patient outreach, point-of-care reminders, care management, health risk stratification, care gap identification, quality reporting, performance evaluation, and other purposes
- Risk stratification - classify patients by their current health status and their health risk
- Automated Outreach - generate automated messaging to patients who need preventive or chronic disease care (according to standardized clinical protocols) and keep track of referrals to other providers, receive results

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 5
  Materials to assist your practice maximize EHR or other available HIT for evidence-based care delivery and relevant clinical decision support.
- Guidelines
  - Practice Guidelines
  - Health and Wellness
- E-Prescribing
  - E-Prescribing
  - Plans and Benefits

I want to learn more:
- ACP Practice Advisor Module and Biopsies - Building the Foundation
  - Use of Technology II
- Creating a Personal Health Medical Record (4min Audio/Video)
  - Agency for Healthcare Research and Quality
Patient-Centered Care

Milestone 6: Transition to a culture of patient-centered care

Objectives:
- Empower patients to claim their place at the center of our health care system
- Engage patients so that they understand and embrace your culture of patient-centered care

Questions:
- How can you motivate patients to achieve their health care goals?
- How can you develop collaborative partnerships with patients and their caregivers?
- What tools are available to promote patients’ self-management?

Basic Ideas:
Your practice will begin to holistically evaluate patients for strengths and barriers, not just looking at the medical condition but at every aspect of a patient’s mind and body, including social/family support networks. Your task is to reduce the impact of culture, language, lack of resources and other limitations in the care planning process, and to include patient experience in quality improvement processes. Your goal is to empower patients with the right resources and processes for shared decision-making.

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 6
  Methods to engage your patients and support your practice in transitioning to a culture of patient-centered care.
- Improving the Patient Experience Change Package - Milestone 6
  California Quality Collaborative
- Patient Brochure
  - Describes the basic elements of a medical home, what they should expect from their medical home, and gives a brief checklist of what to bring to appointments. English and Spanish Versions. Milestone 6

I want to learn more:
- ACP Practice Advisor Module and Biopsies - Building the Foundation
  - Building the Foundation
    - Engage Patients
  - Improving Clinical Care
    - Motivational Interviewing
- Tools
  - Partnering in Self-Management Support: A Toolkit for Clinicians
    Institute for Healthcare Improvement
  - Encourage Participation in Self-Management Programs
    CDC two-page guide for providers
  - How to Implement Self-Management Support
    California Healthcare Foundation
- Guidelines
  - Implementation Guide Part I: Measuring Patient Experience
  - Part II: Engaging Patients in Their Health and Care
  - Part III: Communicating -Patient-Centered Experience
    Safety Net Medical Home Initiative
Enhanced Access to Care

Milestone 7: Provision of enhanced access for patients

Objectives:
- Provide patients with options for communication such as email or texting
- Have clinical staff or alternative available 24-7
- Make arrangements for 24/7 electronic access to personal health information and MMH+, including after-hours personnel or on-call providers
- Move toward open access (same day) scheduling of appointments
- Plan appointment types and standing orders to streamline care
- Develop a process for documentation and follow up on scheduling and clinical advice
- Provide patients with a documented process for choosing a PCP
- Develop a process for timely appointments for new patients

Questions:
- What are the current options for patients to schedule appointments?
- Do all on-call providers have access to patients’ health information?
- What are the barriers to open access scheduling?

Basic Ideas:
You are being asked to focus on patient needs and preferences as you guide your patients to the right care at the right time in the right setting. New approaches such as e-mail exchange, after hours care and patient portals can help you achieve these goals without having to keep the practice open 24-7, but allowing for 24-7 service availability.

Open access scheduling allows for patients to see a provider-preferably their own provider-on the day they call to set an appointment, regardless of the reason for the visit. Practices that have adopted this method have reported improved patient satisfaction, increased productivity and higher physician compensation.

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 7
  Resources to establish expanded office hours, cross-coverage arrangements after hours, and online communication and visits for your patients within the patient-centered care model.
- Ten Steps to Enhance Patient Satisfaction in Your Practice - Milestone 7
  American Medical Association

I want to learn more:
- ACP Practice Advisor Modules and Biopsies - Building the Foundation
  - Communicate with Patients
  - Enhance Patient Access
  - Specialty Practice Recognition
    - Provide Access and Communication
The Medical Neighborhood

Milestone 8: Establish external processes/infrastructure to achieve coordination of care with the medical neighborhood and community

Objectives:
- Establish relationships with medical and community providers outside the practice
- Develop tools and procedures to communicate and coordinate patient care
- Incorporate medication reconciliation and care plan updates for all care transitions
- Refine your process for tracking referrals and test results

Questions:
- What arrangements do you have with other providers in your area?
- How satisfied are you with access to care for your patients?
- What protocols are in place for transitions of care and medication reconciliation?
- What is your process to track referrals?
- Do you include patient preferences and concerns in the referral process?

Basic Ideas:
A patient-centered medical home provides continuity between settings and collaboration among everyone involved in a patient’s care. Shared decision-making with the patient and family and care coordination promotes better health outcomes - fewer readmissions and medication issues, better patient safety and patient satisfaction, reduction in duplication of services and increased delivery of preventive services. Your task is to avoid mistakes, reduce delays in accessing services, and improve processes for getting and using information and recommendations from specialists, hospitals and other service providers. Your goal is to develop more sophisticated relationships with outside providers and community resources over time.

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 8
  Resources to support the setting up of external processes and infrastructure to sustain coordination of care outside of the medical home.

I want to learn more:
- ACP Practice Advisor Modules and Biopsies
  - Facilitate Transitions I & II
- Building the Foundation
  - Facilitate Transitions I & II
- Specialty Practice Recognition
  - Track and Coordinate Care
- Graphic
  - Welcome to the Medical Home Neighborhood
    Healthcare Intelligence Network
- Guidelines
  - Key Changes and Resources for Care Coordination
  Improving Chronic Illness Care
Improved Clinical and Utilization Outcomes

Milestone 9: Achieve improved clinical and utilization/affordability outcomes

Objectives:
- Use in-network resources that provide cost savings
- Use resources to make better informed referrals
- Decrease utilization, ER visits, and hospitalization
- Implement quality improvement activities using clinical and utilization data
- Measure patient and staff satisfaction to monitor quality

Questions:
- What does quality improvement look like in your practice?
- How do you use quality improvement to make changes?

Basic Ideas:
The best guides for chronic illness care and preventive care outcomes are evidence-based measures. Use of a population health registry will provide you with data about your patients. In the Enhanced Personal Health Care program you are also provided with several reports to help you improve patient outcomes and measure your clinical quality performance. You can track your performance using the Scorecard and see how your Scorecard is linked to Shared Savings. You can view your Scorecard along with other reports on Availity.

There are five composite areas on the Scorecard:
1) Acute and Chronic Care Management
2) Preventive Care
3) Utilization
4) Clinical Quality Improvement
5) Optional NCQA PCMH Recognition

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 9
  Program metrics, report how-to, and options for helping patients to decrease ineffective and unnecessary use of clinical resources are all examples of supports available to help you achieve improved clinical and utilization outcomes.
- HEDIS 101 for Providers
  Health and Wellness>Quality Improvement
- Tools and Resources for Providers
  Health and Wellness>Tools and Resources
- Pharmacy, Specialty and Behavioral Health
  Plans and Benefits>Pharmacy Information
- Quality Improvement Program Brochure and Practice Guidelines
  Health and Wellness>Quality Improvement
- Provider Toolkit - Cost and Quality Resources
  AIM Specialty Solutions, Lab Steerage, Low Back Pain, Quick Care Options (ER alternatives)

I want to learn more:
- ACP Practice Advisor Modules and Biopsies - Building the Foundation
  Improve Quality
Medical Home and other Advanced Activities

Milestone 10: Achieve Level III NCQA Recognition

Objectives:
- Use Quality Improvement tools such as Plan-Do-Study-Act
- Track your progress on milestones and other indicators
- Attend Learning Collaboratives
- Research and understand standards needed for NCQA recognition
- Implement the standards needed for NCQA recognition

Questions:
- Is there support for quality improvement in your practice?

Basic Ideas:
The National Committee for Quality Assurance (NCQA) awards Patient Centered Medical Home recognition to practices that are “functioning as medical homes by using systematic, patient-centered and coordinated care management processes.” We highly recommend and encourage achieving recognition as part of our Enhanced Personal Health Care program, though it is not required. There are resources for NCQA recognition and continuous process improvement including training, in the Provider Toolkit.

Resources on Anthem.com Enhanced Personal Health Care:
- Provider Toolkit Milestone 10
  The American College of Physician’s Practice Advisor and other related resources provide your practice with additional PCMH content to help you achieve Level III NCQA recognition as a medical home, a strongly encouraged but optional milestone.
- Recorded Webinar: Updates to the NCQA PCMH Program
  Collaborative Learning Opportunities Recording Library

I want to learn more:
- ACP Practice Advisor Modules and Biopsies- Building the Foundation
  NCQA Quick Start
- Training
  - NCQA Free Online Training Modules
- Updates on Twitter
  - Follow @NCQA on Twitter for updates about quality and patient-centered medical homes
Special Topics: Pediatric Resources

Resources on Anthem.com>Enhanced Personal Health Care Program

- Preventive Health Guidelines
  Preventive Health Guidelines
- Child and Adolescent Wellness Resource Center
  Health and Wellness> Child and Adolescent Wellness
- Pediatric Learning Collaboratives
  Collaborative Learning Opportunities Recording Library

Web Based Resources

- Family Centered Medical Home Overview
  National Center for Medical Home Implementation- American Academy of Pediatrics
- Building Your Medical Home Toolkit
  National Center for Medical Home Implementation - American Academy of Pediatrics
- NCQA FAQs for Pediatric Practices
  National Committee for Quality Assurance Medical Home Recognition

Behavioral Health Resources - Pediatric

Resources on Anthem.com>Enhanced Personal Health Care Program

- Pediatric Behavioral Health Learning Collaboratives
  Collaborative Learning Opportunities Recording Library

Online Resources

- Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice
  American Academy of Pediatrics Journal
- Evidence Based Psychosocial Interventions
  American Academy of Pediatrics
- Developmental and Behavioral Screening
  National Center for Medical Home Implementation: Family Centered Medical Home
- American Medical News Article: How to Talk with Families
  American Medical News - discussing mental health with families
Special Topics:
Behavioral Health Resources Integration and Adult Resources

Resources on Anthem.com >
Enhanced Personal Health Care Program

- Behavioral Health Clinical Practice Guidelines
  Health and Wellness ➔ Behavioral Health Clinical Practice Guidelines
- Behavioral Health Management - Clinical Utilization Guidelines
  Plans and Benefits ➔ Behavioral Health Management
- Alcohol and Other Drugs Toolkit and Provider Guidelines
  Health and Wellness ➔ Provider Toolkits

Web based Resources

- Standards for Levels of Integrated Healthcare
  SAMSHA-HSRA Center for Integrated Health Solutions
- Alcohol and Substance Use, Depression Assessment and Guidelines
  HealthTeamWorks
- The Academy: Integrating Behavioral Health and Primary Care - Resources
  US Dept. of Health and Human Services, Agency for Healthcare Research and Policy
- Advancing Care Together
  University of Colorado School of Medicine demonstration projects on integration of primary care and behavioral health
- ACP Practice Advisor: Improving Clinical Care - Depression Screening and Care; Addressing Substance Abuse

Special Topics:
Care Management Programs and Resources

Anthem Care Management Referral Form and User Guide and Care Management Programs At A Glance
Link to email-ready referral form, user guide and a brochure that describes programs

Condition Care

Depending on their benefit plans, some members have additional resources available to help them better manage chronic conditions. The Condition Care program is designed to help participants improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care. A referral to the program allows your patient access to a team of professionals, with guidance and coaching by phone. There is no extra charge for this benefit. You can consult with the Provider Clinical Liaison or the Referral Specialist if you have any questions about the referral process or what to expect when you refer.

The Condition Care program helps members better understand and control certain medical conditions like:

- Diabetes (Type 1 and 2)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure
- Asthma (Pediatric and Adult)
- Coronary Artery Disease
Case Management
Case Management offers telephonic and video chat nursing support following a major hospitalization or procedure due to illness or injury. Cancer, NICU and transplant services are included. Case Management support can help members maximize medical benefits; arrange post discharge care and community resources. Includes a Social Worker to assist with financial and community resources.

Behavioral Health Case Management
Offers immediate and longer term mental health management and information to eligible members.

- Health and Wellness Guidelines and Resources
  Health and Wellness
- 24/7 Nurseline - toll free number to access a nurse anytime - located on the back of the member's insurance card

Resources on Anthem.com

- **Health and Wellness Overview**
  Health assessment, health library, videos, preventive health guidelines+ more
- **Urgent Care Locator**
  Select your state to find local resources for urgent care
- **Forms Library and Glossary**
- **Overview of 360° Health**
  360° Health is a total health solution that helps members become more informed about, and involved in, their health and wellness.
- **Manage a Condition - 360° Health**
  Members with chronic or acute conditions can receive support in adhering to their physician’s care plan and national clinical guidelines. Through ongoing guidance provided by registered nurses and other health care professionals, members can make wiser health care decisions to improve their health and see positive results.
- **Health Care Resources**
  Learn more about Enhanced Personal Health Care, Centers of Medical Excellence
Special Topics: Pharmacist Consultant

The Pharmacist Consultant with the Enhanced Personal Health Care program serves as a member of the clinical support team as the subject matter expert for pharmaceutical management. The Pharmacist Consultant helps identify medication management opportunities and works collaboratively with the Provider Clinical Liaison and primary care provider teams to guide pharmaceutical clinical strategies. The Pharmacist Consultant serves as a resource to facilitate comprehensive medication management services addressing medication reconciliation and medication adherence and can assist with formulary or medication questions.

If you would like to consult with the Pharmacist, ask your Provider Clinical Liaison for assistance.

Resources on Anthem.com>Enhanced Personal Health Care Program

Located on Milestone 3:
- American Geriatric Society Updated Beers Criteria 2012
  Lists potentially inappropriate medications for use in older adults
- Medication Adherence Flyer
  Includes references for:
  - Adherence to Long Term Therapies Evidence for Action [World Health Organization 2003]
  - Strategies to Enhance Patient Adherence: Making it Simple [National Institutes of Health]
  - Improving Medication Adherence in Older Adults [Adult Medication]

Located on Milestone 8:
  This guide from the Patient-Centered Primary Care Collaborative (PCPCC) discusses the reasons medication management is so important to a functioning patient-centered medical home, and outlines how to adopt a formal process for medication management.
- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation
  This paper from Agency for Healthcare Research and Quality (AHRQ) offers a step-by-step guide to planning and implementing a medication reconciliation process in a health care organization.
- How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation
  Institute for Healthcare Improvement
- Medication Reconciliation Flyer

Web based Resources

- How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation
  Institute for Healthcare Improvement
- Creating a Personal Health Medical Record (4min Audio/Video)
  Agency for Healthcare Research and Quality
- Be a Prepared Patient
  Center for Advancing Health
**Terminology**

**Enhanced Personal Health Care** - Anthem patient-centered care program that includes payment for care coordination and potential shared savings.

**Blue Distinction Total Care** - a national Blue Cross/Blue Shield name for programs such as Enhanced Personal Health Care. Some members such as Blue Card members would recognize the program name as Blue Distinction Total Care.

**NCQA - National Council on Quality Assurance** - NCQA Patient-Centered Medical Home (PCMH) recognition is the most widely-used way to transform primary care practices into medical homes.

**PCMH - Patient Centered Medical Home** - A model for delivering primary care that is patient-centered, comprehensive, coordinated, accessible, and continuously improved through a systems-based approach to quality.

**ACP Practice Advisor** - American College of Physicians (ACP) Practice Advisor is a web-based assessment tool supporting primary care physicians and their practices in patient-centered primary care transformation. With a modular framework that aligns with the 2011 NCQA PCMH Recognition Program, the Practice Advisor provides the primary care physician and team with the opportunities for unlimited practice self-assessments and access to a resource library of over 800 entries. If the practice plans to pursue NCQA, we can provide you with FREE access to Practice Advisor, with complementary consultation & license fee.

**Your Enhanced Personal Health Care Team:**

- **Transformation Team** - The individuals in your practice who participate in transformation activities focused on improving patient care using recognized quality improvement methodology. Ideally this group of individuals should include a representative from each area in the practice.

- **Practice Champion** - The leader of your practice’s transformation approach. This individual has the authority to support the needed activities, resources, and communication with other staff to ensure success of the Enhanced Personal Health Care program.

- **Care Coordinator** - Staff member who facilitates coordination of patient care and care plan creation.

- **Practice Manager** - Staff member who manages day to day activities in your primary care office.

**Registry** - A registry is a mechanism for keeping all pertinent information about a specific group of patients at your fingertips. The information can be used to schedule visits, labs, educational sessions, as well as generate reminders and guidance for the care of patients. Example: all diabetic patients with A1C>7

**Evidence Based Guidelines (Clinical Quality Measures)** - Results of population research used to guide clinical decision making.

**Scorecard** - Providers are scored on five major Composites to allow for shared savings:

1) Acute and Chronic Care Management
2) Preventive Care
3) Utilization
4) Clinical Quality Improvement
5) NCQA PCMH Recognition (optional)

**Population Management** - Comprehensive strategy to improve the quality of care and outcomes for patients with complex, chronic and uncontrolled conditions.

**Risk Management** - Refers to the periodic and systematic assessment of each patient’s health risk status, using criteria from multiple sources to develop a personalized care plan.

**Self-Management Support** - Engaging with and inspiring patients to become informed about their conditions and take an active role in their own treatment.

**Practice Essentials** - Self-paced curriculum for practice transformation supported by live and recorded webinars. Link located on the Enhanced Personal Health Care home page.

**SMART Goals** - When developing care plans with patient and family involvement, use the acronym SMART to define goals that are Specific- Measurable- Assignable- Realistic and Time-related.