Anthem Community Care Coordination expands relationship with Innovative Health Delivery to support commercial members with complex needs

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Effective July 9, 2018, Anthem will integrate Community Health Navigators utilized by Innovative Health Delivery (IHD) into our current care management program to provide enhanced care transition for Anthem members with complex needs. Members will include, but are not limited to, those with the following:

- Hospital readmissions
- Frequent ER visits
- No engagement with PCP within three months or more
- Readmission risk score >24
- Multiple diagnoses
- Identified social determinants of health

IHD does not replace Case Management, the care or the care management provided by PCPs and specialists. Instead provides an extra layer of support with Community Health Navigators as an extension of care management to help our members navigate the complex health care system.

Services are meant to compliment members' efforts to improve health outcomes. IHD will make an initial outreach to identified members to determine the appropriate level of services. IHD will not provide any clinical services.

An IHD Community Health Navigator may reach out to your practice to introduce themselves and establish a relationship with the physician. They may also discuss developing a mechanism by which to share information regarding patients that have been identified for complex care services.

For questions regarding IHD and complex care services, please contact 303-831-3343.

URL: https://providernews.anthem.com/colorado/article/anthem-community-care-coordination-expands-relationship-with-innovative-health-delivery-to-support-commercial-members-with-complex-needs

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