Anthem is providing this information as a general educational tool to assist Provider Organizations with compliance. Anthem does not represent this information as legal advice. Provider Organizations are responsible for conducting final research regarding health plan and regulatory requirements.
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Guideline Workbook Online Access Process

1. Go to http://www.anthem.com/ca/home-providers.html:

2. Left click on center of screen “To enter site click here”:
3. Left click “Answers @Anthem” scroll down to “More” and left click:

4. Select the Guideline Workbook you would like to access and left click on it:

5. The Guideline Workbook will open as a PDF file that you can view or download and save.
EXTERNAL RESOURCES

Anthem Resources

Anthem
Web site:  https://www.anthem.com/ca
Address:  21555 Oxnard St., Woodland Hills, CA 91367

Anthem Clinical Practice Guidelines Resources
Copies of the CPGs may be obtained by calling (877) 273-4189 or visiting AnthemWeb site –
http://www.anthem.com/ca/home-providers.htm
➢ Click on “To enter site click here”
➢ Click on “Health and Wellness” tab then click on “Practice Guidelines”.
➢ You will see a list of CPGs, click on desired CPG.

HMO and Senior Secure Operations Manual
Web site:  www.Anthem.com/ca
➢ Click on “provider” tab and then click enter on Anthem site
➢ Go to Answers@anthem Tab, on the drop down, click on Provider Access

Questions:  For Operation Manual: Contact Network Relations at (855) 238-0095 Monday through Thursday between the hours of 9:00 am -12:30 pm and 1:30 pm - 4:00 pm) or e-mail inquiries to networkrelations@wellpoint.com.

For technical questions or support concerning Provider Access, please call (866) 829-4545.

If you have any questions regarding how to use the CD or to request additional copies, please e-mail your inquiries to prov.communications@wellpoint.com, or you may fax them to (818) 234-8959.

General Questions:  Carol Louck (818) 234-3441 or Carol.Louck@wellpoint.com

Preventive Care Guidelines and Clinical Practice Guidelines
Web site:  http://www.anthem.com/ca
(click on “Provider” at bottom of page, click on “Enter” under “Welcome to Anthem Blue Cross”, click on “Preventive Health Guidelines” under “Health & Wellness” (toward the bottom of the page)]

Phone:  (877) 273-4189

External Sources for Preventive Care Guidelines

American Academy of Family Physicians
Web site:  http://www.aafp.org/
Address:  PO Box 11210 Shawnee Mission, KS 66207-1210
Phone:  (800) 274-2237
Fax:  (913) 906-6075
American Academy of Pediatrics  
Web site: [http://www.aap.org](http://www.aap.org)  
Address: Department of Federal Affairs, 601 13th Street, N.W., Suite. 400 North, Washington, DC 20005  
Phone: (202) 347-8600  
Fax: (202) 393-6137

American Cancer Society  
Phone: (800) ACS-2345 or (800) 227-2345

American College of Obstetrics and Gynecology  
Web site: [http://www.acog.org](http://www.acog.org)  
Address: P.O. Box 70620 Washington, DC 20002-9998  
Phone: (800) 673-8444 or (202) 638-5577

American College of Physicians- Internal Medicine  
Web site: [http://www.acponline.org/](http://www.acponline.org/)  
Address: 190 N. Independence Mall West, Philadelphia, PA 19106-1572  
Phone: (800) 523-1546 or (215) 351-2400

American College of Surgeons  
Address: 633 North Saint Clair Street, Chicago, IL 60611-3211  
Phone: (800) 621-4111 or (312) 202-5000  
Fax: (312) 202-5001

Office of Disease Prevention and Health Promotion  
Web site: [http://www.odphp.osophs.dhhs.gov](http://www.odphp.osophs.dhhs.gov)  
Address: 1101 Wootton Parkway Suite LL100  
Rockville, MD 20852  
Phone: (240) 453-8280  
Fax: (240) 453-8282

Health Services/Technology Assessment Text (HSTAT)  
(CPG’s, evidence reports, publications, NIH Clinical Studies, Preventive Services, Treatment Improvement Protocols)  
Address: National Information Center on Health Services Research and Health Care Technology (NICHSR)  
National Library of Medicine  
Building 38A, Mail Stop 20  
8600 Rockville Pike, Bethesda, MD 20894  
Phone: (301) 496-6308  
Fax: (301) 496-4450  
Email: publicinfo@nlm.nih.gov
Accreditation/Oversight/Regulatory and Related Agencies

**Health Plan Employer Data and Information Set (HEDIS)**
Standardized performance measures sponsored, supported, maintained, overseen and published by NCQA; HEDIS was initiated as a national cooperative project between several health plans and leading employers such as GTE, Digital and Xerox with the goal being to create a standard set of health plan quality indicators, covering preventive care processes and outcomes, with accompanying technical specifications for collection with resulting national benchmark comparison that allow employers to make more discriminating purchase decisions and give health plans a standard set of performance indicators. Contracted PGs can obtain HEDIS updates by contacting the Anthem QI Department Provider Line at (877) 273-4189, choose option #3.

**Industry Collaboration Effort (ICE) Health Plans/Providers/Associations**
Email: admin@iceforhealth.org
Fax: (714) 763-4340
Address: PO Box 6270 Newport Beach CA 92658

**National Committee for Quality Assurance (NCQA)**
Web site: [http://www.NCQA.org](http://www.NCQA.org)
Phone: (202) 955-3500 or (888) 275-7585
Fax: (202) 955-3599
Address: 1100 13th St. NW Suite 1000. Washington, D.C.20005

Health Agency Contacts and Information

**Health Management Corporation**
Specializes in the following: Disease Management/Advanced Care Management/Health Education/Risk Identification/Health Needs Assessment (AccuStrat)/24 hour nurse line/On-Site Health Screenings and Worksite Wellness/Maternity Management/Health Coaching and Health Support Programs/Interactive Voice Response/Advanced Predictive Modeling/Individualized Intervention Plan
Phone: (800) 523-9279
Fax: (804) 662-5372
Website: [http://www.linkedin.com/company/health-management-corporation](http://www.linkedin.com/company/health-management-corporation)

**Health Improvement Programs**

**Anthem Condition Care and Complex Care Program**
(For questions regarding the following Health Improvement Programs:CHF, Cardiovascular, Diabetes, Asthma, Depression, Musculoskeletal, Pregnancy, Tobacco Cessation)
Phone: (888) 200-0916 or (800) 522-5560
Fax: (888) 252-6840
**Hearing Impaired Services**
WCI in Santa Monica, Calif. offers assistive devices/equipments for the hearing-impaired.

Web site: www.weitbrecht.com

Phone: (800) 233-9130 (V/TTY)
(310) 665-4924 (Direct)
Fax: (310) 450-9918

Address: 1500 Olympic Boulevard
Santa Monica, CA 90404

**Resources for the Aged**

**California Department of Aging**

Web site: http://www.aging.ca.gov/

Address: 1300 National Drive Suite 200, Sacramento, CA 95834-1992

Phone: (800) 510-2020 or (916) 419-7500
Fax: (916) 928-2267
TDD: (800)735-2929

**Eldercare Locator**

Web site: http://www.eldercare.gov

Phone: (800) 677-1116

**National Association of Area Agencies on Aging**

Web site: http://www.n4a.org

Address: 1730 Rhode Island Ave, NW, Suite 1200, Washington, D.C. 20036

Phone: (202) 872-0888
Fax: (202) 872-0057

**Health Insurance Counseling and Advocacy Program (HICAP)**
(The California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP) provides personalized counseling, community education and outreach events for Medicare beneficiaries.)

Web site: http://www.aging.ca.gov/hicap/default.aspx

Phone: Phone: (800) 434-0222

**Health Care Decisions Resources**

**American Association of Retired Persons (AARP)**

Web site: http://www.aarp.org

Phone: (888) 687-2277
Address: 601 E Street N.W.
Washington, DC 20049
**Caring Connections**

Web site:  [http://www.caringinfo.org](http://www.caringinfo.org)
Phone:  (800) 658-8898
Multilingual Line: 877.658.8896

**Healthcare and Elder Law Programs Corporation (H.E.L.P.)**

Address:  1404 Cravens Ave., Torrance, CA 90501
Phone:  (310) 533-1996

**Elder Abuse Resources**

**Adult Protective Services**

Website:  [http://www.cdss.ca.gov/agedblinddisabled](http://www.cdss.ca.gov/agedblinddisabled)
Phone:  (According to county APS office (follow directions on site)

**California Department of Aging**

Website:  [https://www.aging.ca.gov/](https://www.aging.ca.gov/)
Address:  1300 National Drive, Suite 200
Sacramento, CA 95834-1992
Phone:  (916) 419-7500 or (800) 510-2020
TTY:  (800) 735-2929
Fax:  (916) 928-2267

**Services and Financial Support to Low-Income, Aged, Blind and Disabled**

Website:  [http://www.cdss.ca.gov/agedblinddisabled](http://www.cdss.ca.gov/agedblinddisabled)
Address:  California Health and Human Services
1600 Ninth Street, Room 460
Sacramento, CA 95814
Phone:  (916) 654-3454
Long-Term Care Ombudsman
Website:  http://www.aging.ca.gov/Programs/LTCOP/Contacts/
or for contacts by county
http://www.aging.ca.gov/programs/ombudsman.asp
Phone:  (916) 419-7500
          TDD: (800) 735-2929
Fax:  (916) 928-2267

National Committee for the Prevention of Elder Abuse
Website:  http://www.preventelderabuse.org
Address:  1730 Rhode Island Avenue, NW, Suite 1200, Washington, DC 20036
Phone:  (202) 464-9481
Fax:  (202) 872-0057

Social Security Administration
Website:  http://www.ssa.gov
Phone:  (800) 772-1213 (earnings/benefits status, referrals to local offices)
TTY:  (800) 325-0778

Child Abuse Resources

California Department of Social Services, Office of Child Abuse Prevention
Website:  http://www.childworld.ca.gov/PG2289.htm
Address:  744 P Street, MS 8-11-82, Sacramento, CA 95814
Phone:  (916) 651-6960 or (877)-846-1602

California Youth Crisis Line
Website:  http://www.youthcrisisline.org/
Phone:  (800) 843-5200

Child Abuse Prevention Network
Website:  http://www.child-abuse.com/capn.shtml

Childhelp National Child Abuse Hotline
Website:  http://www.childhelpusa.org
Phone:  (800) 4-A-CHILD or (800)-422-4453
          TDD: (800)-2-A-CHILD or (800) 222-4453

Parent Education Classes
Website:  http://www.positiveparenting.com
Address:  P.O. Box 1312, Ventura, CA 93002
Phone:  (805) 648-6846

Prevent Child Abuse America
Website:  http://www.preventchildabuse.org
Phone:  (312) 663-3520 or (800) 244-5373
Prevent Child Abuse California
Web site: http://www.pca-ca.org/
Phone: (916) 244-1900

Rape, Abuse and Incest National Network Hotline (RAINN)
Web site: http://www.rainn.org/
Phone: (800) 656-4673

Domestic Violence Abuse Resources

California Partnership to End Domestic Violence (CPEDV) (merger of the California Alliance Against Domestic Violence and Statewide California Coalition for Battered Women)
Web site: http://www.cpedv.org/
Address: P.O. Box 1798, Sacramento, CA 95812-1798
Phone: (916) 444-7163, or (800) 524-4765
Fax: (916) 444-7165

National Center for Victims of Crime
Web site: http://www.victimsofcrime.org/
Address: 2000 M Street NW, Suite 480, Washington, DC 20036
Phone: (202) 467-8700

National Coalition Against Domestic Violence
Web site: http://www.ncadv.org
Phone: (303) 839-1852 or (800) 799-7233
TTY(303) 839-8459

U.S. Department of Justice, Violence Against Women Office
Web site: http://www.usdoj.gov/ovw/
Address: 145 N Street, NE, Suite 10W.121, Washington, D.C. 20530
Phone: (202) 307-6026
TTY: (202) 307-2277

Medical Web site Resources

Health Information on the Web
(Patient 101 How to Find Reliable Health Information)
Web site: http://www.jointcommission.org/Patient_101_How_to_Find_Reliable_Health_Information/
Address: The Joint Commission
One Renaissance Blvd, Oakbrook Terrace, IL 60181
Phone: (630)-792-5800

WebMD
Web site: http://www.webmd.com

California Distance Learning Health Network (CDLHN)
Web site: http://www.cdln.com

Revised 10/29/2015
Health Services/Technology Assessment Text (HSTAT)
(for practice guidelines, evidence reports, publications, National Institute of Health Clinical Studies, Preventive Services, Treatment Improvement Protocols)

Case Management and Disease Management Resources

Case Management Society of America
Web site: http://www.cmsa.org/
Address: 6301 Ranch Drive, Little Rock, AR 72223
Phone: (501) 225-2229 or Toll-Free: (800) 216-2672
Fax: (501) 221-9068 or (501) 227-5444

National HIV/AIDS Information
Web site: http://www.kff.org/hivaids/hiv100104pkg.cfm
REQUIRED CCM AND DM HEALTH PLAN SUBMISSIONS
Required CCM and DM Health Plan Submissions

Provider Organization must develop, maintain and submit to contracted Health Plans, the following written and committee approved required submissions per timelines outlined in the attached, “Anthem Provider Organization Reporting and Documentation Requirements”.

Complex Case Management:
- CCMPlan
- CCMWorkplan
- CCMSemi-Annual Reports
- CCMAnnual Program Evaluation
- CCMCorrective Action Plans (CAPs) (addressing identified CCM audit deficiencies in Anthem Audit Summation Letter for achievement of Status B or C in CCM)

Disease Management:
- DM Plan
- DMWorkplan
- DM Semi-Annual Reports
- DM Annual Program Evaluation
- DM Corrective Action Plans (CAPs) (addressing identified DM audit deficiencies in Anthem Audit Summation Letter for achievement of Status B or C in DM)

All submissions must be submitted timely and completely. Oversight will be conducted to assess compliance and corrective action taken, if needed.

Attachments:
- Anthem Provider Organization Reporting and Documentation Requirements
- Outline for Sample CCM, DM Plan
- Sample CCM, DM Plan/Program Review Signature Page
- Outline for Sample CCM, DM CAP
Anthem Provider Organization
Reporting and Documentation Requirements

The following table lists each required program report, due dates, and reporting content. The last column identifies the specific sections within each report template that must be completed; sections not listed are optional.

All reports are to be sent to your assigned Auditor. An evaluation of each report will be completed and sent to you within 30 calendar days of receipt. The evaluations are based on timeliness of submitting the report and content comprehensiveness per the enclosed report instructions. The results of your report evaluations will be reflected on your annual audit score summary report.

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<th>Report Type</th>
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<th>Required Report Content</th>
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<tr>
<td>2014 2(^{nd}) Semi-Annual Report</td>
<td>2/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
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<td>and Annual Evaluation</td>
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<td>2015UM Program Plan</td>
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<tr>
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<td>2015UM Work Plan</td>
<td>2/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
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<tr>
<td>20151(^{st}) Semi-Annual Report</td>
<td>8/15/15</td>
<td>Tabs 1-6, and contact/signature page</td>
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<td>and Annual Evaluation</td>
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<td><strong>Credentialing</strong></td>
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<td>20142(^{nd}) Semi-Annual Report</td>
<td>2/15/15</td>
<td>Entire Submission Form and complete report</td>
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<td>8/15/15</td>
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<td><strong>Corrective Action Plan</strong></td>
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<td>Corrective Action Plan</td>
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Revised 10/29/2015
COMPLEX CASE MANAGEMENT PLAN

I. Purpose
The purpose of Complex Case Management is to empower members to take control of their health care needs across the care continuum by coordinating quality health care services and the optimization of benefits through a realistic, cost-effective, and timely case management plan. The value of case management will be evidenced by best practices and quality outcomes that contribute to the optimal health, function, safety, and satisfaction of our members. The CCM Program clearly defines the structure, goals, organization, objectives and processes, functional areas, reporting relationships and assignment of responsibilities to appropriate individuals.

II. Goals and Objectives
A. To help members regain optimum health or improved functional capability in the right setting and in a cost effective manner through the following:
   - Align identified members with the intensity of case management services determined by their individual needs
   - Integrate with all existing Clinical Programs and find the best program for the member
   - Comprehensive assessment of member population, including a cultural and linguistic diverse membership
   - Identification of members with CCM conditions and needs
   - Assist members who meet defined criteria to ensure continuity and continued access to care when their current provider leaves the network and the member is in an active course of treatment, where applicable.
   - Provide education for condition self management
   - Promote and facilitate member behavior change
   - Collaborate and communicate with the member/family, the physician and other health care providers
   - Development and implementation of CCM treatment plans with performance goals, utilizing evidence-based clinical guidelines
   - Achieve the goals in the individual member’s case management plan
   - Development and implementation of CCM self-management plans, tools
   - Educate and involve the member and family in the coordination of services
   - Provide comprehensive initial and ongoing member assessments
   - Assist members in determining available benefits and resources and optimize use of available benefits
   - Assist members with transition to care available in community or other resources, if necessary, when benefits end and the member still requires care.
     - Improve member and provider satisfaction
     - Promote member safety
   - Assure timely interventions that increase effectiveness and efficiency of care/services provided to the member
   - Integration, coordination and collaboration with and referrals to and from other programs
   - Promote the health, independence, and optimal functioning of members in the most proactive and effective way
     - Monitor and improve behavioral healthcare, if applicable

B. CCM Program meets objectives and goals, and includes functional areas and their responsibilities, and reporting relationships for departmental staff.
   - Case Managers must have at least an RN licensure. LVNs do not qualify without supervision and LCSWs would not be able to assess medical issues.
   - Non-RNs may process referrals to CM Program, communicate CCM Program Information to members and practitioners, obtain member demographic data and
member consents, determine member eligibility and benefits, and administer Quality of Life Assessments

C. Patient safety and improvement is addressed

IIII. Organizational Structure and Responsibilities

A. Governing Body responsibilities/functions:
   1. Responsible for establishing, maintaining and supporting the CCM Program
   2. Delegates ongoing responsibility for the development and implementation of the Program to the CCM Committee
   3. Complex Case Management and its program are accountable to the governing body.
   4. Provides oversight of the CCM and its activities, and participate indirectly with CCM issues.
   5. Evaluates, approves and makes recommendations on the CCM Plan at least annually and at time of any revision.
   6. Discuss reports, requests additional information when required, and provide resolution to improve care and service.

B. Medical Director/CMO
   1. Designated physician must hold a current, unrestricted license to practice in the state of California.
   2. Designated physician has substantial involvement in the CCM Program
   3. More than one practitioner is involved in Program activities.
   4. Oversees compliance with contracted health plan, accrediting agency, state and federal requirements.
   5. Participates in or advises the CCM Committee or subcommittee that reports to the CCM Committee.
   6. A designated behavioral health care practitioner is involved in the behavioral health care aspects of the CCM Program. The designated behavioral health care practitioner may be a medical director, clinical director or participating practitioner from the organization or behavior health delegate.

C. Frequency and Schedule of Meetings
   The CCMC will meet as stated in policy, but at least quarterly. Urgent issues will be addressed separately by the designated senior physician and/or a subcommittee.

D. The Complex Case Management Committee
   The CCMC is an interdisciplinary committee of the Governing Body, with membership appointed by the CEO/President/Executive Director and the CMO/Medical Director. It includes administrative staffs who are involved in Complex Case Management services. Physician members are representative of the Practitioner Panel. The committee is responsible for conducting oversight of all functions, including delegated activities, if applicable

Committee Composition: If the committee is a staff committee with no participating practitioners, there should be practitioner involvement in clinical subcommittees. Staff committees may be comprised of staff or practitioners or both.

Clinical Committees: A minimum of 3 practitioners (representing a broad spectrum of specialties as appropriate). Only licensed practitioners have voting rights on issues involving clinical decisions. At least 3 practitioners make up a quorum. Subcommittees of the CCMC will report to the CCMC at least quarterly. The CCMC will report to the Governing Body at least quarterly. The CCMC recommends policy decisions, reviews and evaluates the results of CCM activities; institutes needed actions, and ensures follow-up, as appropriate.

E. CCM processes and activities
   1. Responsibilities of the Committee and Subcommittees (including reporting relationships)
   2. Responsibilities of the Committee Chairperson
3. Committee composition (Clinical) – physician chairperson, CEO/President/Executive Director or designee, CMO/Medical Director, CCM Manager/Director, and a minimum of 3 practitioners.

4. Health Plan representatives may attend CCMC meetings.

5. Description of mechanism for communicating to practitioners and members.

6. Departmental data collection systems are used to monitor and evaluate care and service in relation to specific aspects of each department (staff, analytical capabilities and data resources are adequate to meet program needs).

7. Description of mechanism for integration into functions of Provider Organization operations, and reporting CCM activities to all appropriate staff in order to keep them informed of ongoing monitoring and evaluation activities and related outcomes.

8. Confidentiality/Privacy/Security
   a. Description of Confidentiality/Privacy/Security standards – separate P&Ps may be referenced.
   b. CCMC Members will sign a confidentiality agreement annually and the agreement will be kept in the practitioner or employee file.
   c. All health plan representative guests of the Committee will also sign a confidentiality agreement.
   d. Peer review records and proceedings will be kept confidential according to Section 1157 of the California Evidence Code.
   e. A description of how correspondence and meeting minutes will be handled/stored.
   f. A description of how member information is protected.

9. The CCM Program’s policies and procedures will be reviewed and approved, and if necessary, revised on at least an annual basis, and submitted to the Provider Organization’s Governing Body and any requesting contracted health plan within 15 calendar days of Program approval.

10. The CCM Annual Summary and Evaluation Report of CCM activities will be submitted annually to the Governing Body and any requesting contracted health plan by 2/15 of the following year. Upon member/practitioner request, a description of the CCM Program and report of the progress made in meeting goals will be provided.

11. CCM Semi-Annual Reports will be reviewed and approved on a semi-annual basis, and submitted to the Provider Organization’s Governing Body and any requesting contracted health plan by 8/15 of the current year and 2/15 of the following year. The 2nd Semi-Annual report may be incorporated into the Annual QM Program Evaluation (as long as separate statistics are shown for the timeframes).

12. CM Workplan
   a. Developed and implemented each year by the CCMC.
   b. Reviewed and approved by the Governing Body and includes the following: scope, goals, objectives, projects and plans for the year (including follow-up on issues identified previously).
   c. Describes a process in which responsibility and time frames can be delineated and annual reviews, evaluations and revisions to the Plan can be accomplished.
   d. Reports on effectiveness, outcomes and recommendations are prepared for the CEO/President/Executive Director and/or the Governing Body.

IV. CCM Committee Meeting Minutes
   A. Minutes are documented, contemporaneous (created at the time the activity is conducted), and produced by the date of the next meeting. It must be dated and signed by the CCM Chairperson (electronic signature is acceptable). Minutes must be current and available for review by contracted health plan.
   B. Attendance must be documented.
   C. Minutes are maintained in a secure location and are not reproduced in order to maintain confidentiality.
   D. Reflect the CCM process such as committee decisions, action plan implementation and evaluation/follow-up. CCMM activities may include but are not limited to the following:
1. Reviews and approves CCM Policies and Procedures, CCM Plan, CCM Workplan, CCM Semi-Annual Reports, CCM Program Evaluation, subcommittee reports, delegated activities (as applicable)
2. Develops and ensure implementation of corrective action plan
3. Reports to Governing Body and health plan (per health plan submission requirement)
4. Analyzes, evaluates and reports the results of CCM activities
5. Institutes needed actions and ensures follow-up as needed
6. Documents CCM case review.
7. Documents practitioner representation and participation during meeting discussion

E. Audits, Surveys and Studies
   - There must be evidence of presentation to CCM for analysis, determination of performance goals thresholds and identified opportunities for intervention. Applicable corrective action plan implementation and measurement of effectiveness.
   - There must be target dates of completion of audits/studies and surveys and method of informing practitioners and members.
   - All audit/study/survey results will be made available upon request to the contracted health plan
1. Member Satisfaction review of complaints is conducted annually to provide opportunity to monitor and evaluate activities

V. Patient Safety
A. Description of process on improving patient safety of clinical care
   Examples:
   - Evaluate clinical practices against aspects of evidence-based practice guidelines that improve safe practices
   - Improve continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes
   - Improve continuity and coordination of care between sites of care, such as hospitals and nursing homes, to ensure timely and accurate communication
   - Implement pharmaceutical management practices that require safeguards to enhance patient safety
   - Track and trend adverse-event reporting to identify systems issues that contribute to poor safety
   - Distribute to members information that improves their knowledge about clinical safety in their own care
   - Questions to ask surgeons prior to surgery
   - Questions to ask about drug-drug interactions
   - Research findings that facilitate decision-making
   - Distribute to members information that facilitates informed decisions based on safety examples include:
     - Facilitates with computerized pharmacy order-entry systems
     - Hospitals that use physicians specifically trained in intensive care
     - Provider Organizations that have best practices or outcomes often based on volume
     - Pharmacies that provide counseling and research on proven safe clinical practices
       - Conduct in-service training focused on improving knowledge of safe practices
       - Combine data on adverse outcomes or polypharmacy issues
       - Distribute research on proven safe clinical practice
       - Develop incentives for achieving safer clinical practices

VI. The CCM Plan will be annually reviewed, updated, approved, signed and dated by the CCM Chairperson and annually approved by the Governing Body.
Disease Management Plan

I. Purpose
The purpose of the Disease Management (DM) Program is to guarantee the delivery of the highest quality possible in the level of care and service provided to Anthem members. To ensure this level is achieved and/or surpassed, programs/activities having a direct or indirect influence on the quality and outcome of clinical care and service delivered to all Anthem members are consistently and systematically monitored and evaluated. The evaluation process is fully documented, issues are relevant to the enrolled member population, responsibility is assigned to appropriate individuals, and when opportunities for improvement are noted, recommendations are provided. The DM Program clearly defines the structure, goals, organization, objectives and processes, functional areas, reporting relationships and assignment of responsibilities to appropriate individuals.

II. Goals and Objectives
A. To help members regain optimum health or improved functional capability in the right setting and in a cost effective manner through the following:
   ➢ Identification of members with DM conditions/needs
   ➢ Interventions are based on an assessment according to stratification
   ➢ Development and implementation of DM Self-Management Plans/Tools
   ➢ System integration, coordination and collaboration with and referrals to and from other Programs
   ➢ Member specific information is processed in accordance with Federal HIPAA and State confidentiality requirements
   ➢ Process for the DM Program impact and effectiveness evaluation annually
B. DM Program meets objectives and goals, and includes functional areas and their responsibilities, and reporting relationships for departmental staff.
   ➢ System integration, coordination and collaboration with and referrals to and from other Programs Disease Managers must have at least an RN licensure. LVNs do not qualify without supervision and LCSWs would not be able to assess medical issues.
   ➢ Non-RNs may process referrals to DM Program, communicate DM Program availability to members and practitioners, identify member eligibility and benefits, apply disease stratification, obtain member demographic data, consents and Opt In/Opt Out determinations and administer Health Appraisals (HA), Lifestyle Issues and Health Assessments.
C. DM Behavioral Healthcare is monitored and improved, if applicable.
D. Patient safety and improvement is addressed.
E. Objectives for Serving a Culturally and Linguistically Diverse Membership.

III. Organizational Structure and Responsibilities
A. Governing Body responsibilities/functions:
   1. Responsible for establishing, maintaining and supporting the DM Program.
   2. Delegate’s ongoing responsibility for the development and implementation of the Program to the Committee.
   3. Disease Management and its program are accountable to the governing body.
   4. Provides oversight of the activities, and participate indirectly with DM issues.
   5. Evaluates, approves and makes recommendations on the DM Plan at least annually and at time of any revision.
   6. Receives regular quarterly written reports from the DMC delineating identified opportunities to improve care and service, actions taken, and improvements resulting from monitoring and evaluation activities.
   7. Discuss reports, requests additional information when required, and provide resolution to improve care and service.

B. Medical Director/CMO
1. Designated physician must hold a current, unrestricted license to practice in the state of California.
2. Designated physician has substantial involvement in the DM program and who directs the implementation of the Quality Improvement process.
3. Participates in or advises the DM Committee or subcommittee that reports to the DM Committee.
4. Oversees compliance with contracted health plan, accrediting agency, state and federal requirements.
5. Develops recommendations to improve health care services and oversees the committee.
6. A designated behavioral health care practitioner is involved in the behavioral health care aspects of the DM Program. The designated behavioral health care practitioner may be a medical director, clinical director or participating practitioner from the organization or behavior health delegate.

C. Frequency and Schedule of Meetings
The DMC will meet as stated in the policy, but at least quarterly. Urgent issues will be addressed separately.

D. The Disease Management Committee
The DMC is an interdisciplinary committee of the Governing Body, with membership appointed by the CEO/President/Executive Director and the CMO/Medical Director. It includes administrative staffs who are involved in the quality of care and services. Physician members are representative of the Practitioner Panel.

Committee Composition: If the committee is a staff committee with no participating practitioners, there should be practitioner involvement in clinical subcommittees. Staff committees may be comprised of staff or practitioners or both.

Clinical Committees: A minimum of 3 practitioners (representing a broad spectrum of specialties as appropriate). Only licensed practitioners have voting rights on issues involving clinical decisions. At least 3 practitioners make up a quorum. Subcommittees of the DMC will report to the DMC at least quarterly. The DMC will report to the Governing Body at least quarterly. The DMC recommends policy decisions, reviews and evaluates the results of QI activities; institutes needed actions, and ensures follow-up, as appropriate.

E. DMC processes and activities
1. Responsibilities of the Committee and Subcommittees (including reporting relationships)
2. Responsibilities of the Committee Chairperson
3. Committee composition (Clinical) – physician chairperson, CEO/President/Executive Director or designee, CMO/Medical Director, DM Manager/Director, and a minimum of 3 practitioners. Health Plan representatives may attend DMC meetings.
4. Description of mechanism for communicating to practitioners and members
5. Departmental data collection systems are used to monitor and evaluate care and service in relation to specific aspects of each department (staff, analytical capabilities and data resources are adequate to meet program needs)
6. Description of mechanism for integration into functions of Provider Organization operations, and reporting DM activities to all appropriate staff in order to keep them informed of ongoing monitoring and evaluation activities and related outcomes
7. Confidentiality/Privacy/Security (HIPAA)
   a. Description of Confidentiality/Privacy/Security standards – separate P&Ps may be referenced
   b. DMC members will sign a confidentiality agreement annually and the agreement will be kept in the practitioner or employee file
   c. All health plan representative guests of the Committee will also sign a confidentiality agreement
   d. Peer review records and proceedings will be kept confidential according to Section 1157 of the California Evidence Code
   e. A description of how correspondence and meeting minutes will be handled/stored
f. A description of how member information is protected

8. The DM Program’s plan, policies and procedures will be reviewed and approved, and if necessary, revised on at least an annual basis, and submitted to the Provider Organization’s Governing Body and any requesting contracted health plan within 15 calendar days of Program approval.

9. The DM Annual Summary and Evaluation Report of DM activities will be submitted annually to the Governing Body and any requesting contracted health plan by 2/15 of the following year. 10.DM Semi-Annual Reports will be reviewed and approved on a semi-annual basis, and submitted to the medical group’s Governing Body and any requesting contracted health plan by 8/15 of the current year and 2/15 of the following year. The 2nd Semi-Annual report may be incorporated into the Annual DM Program Evaluation (as long as separate statistics are shown for the timeframes).

10. DM Workplan
   a. Developed and implemented each year by the DMC
   b. Reviewed and approved by the Governing Body and includes the following: scope, goals, objectives, projects and plans for the year (including follow-up on issues identified previously)
   c. Describes a process in which responsibility and time frames can be delineated and annual reviews, evaluations and revisions to the Plan can be accomplished
   d. Reports on effectiveness, outcomes and recommendations are prepared for the CEO/President/Executive Director and/or the Governing Body

IV. DMC Meeting Minutes
   A. Minutes are documented, contemporaneous (created at the time the activity is conducted), and produced by the date of the next meeting. It must be dated and signed by the DM Chairperson (electronic signature is acceptable). Minutes must be current and available for review by contracted health plan.
   B. Attendance must be documented.
   C. Minutes are maintained in a secure location and are not reproduced in order to maintain confidentiality.
   D. Reflect the DM process such as committee decisions, action plan implementation and evaluation/follow-up. DM activities may include but are not limited to the following:
      1. Reviews and approves DM Policies and Procedures, DM Plan, DM Workplan, DM Semi-Annual Reports, DM Program Evaluation (formats follow ICE), subcommittee reports, delegated activities (as applicable)
      2. Develops and ensures implementation of corrective action plan
      3. Reports to Governing Body and health plan (per health plan submission requirement)
      4. Analyzes, evaluates and reports the results of DM activities
      5. Institutes needed actions and ensures follow-up as needed
      6. Evidence of ongoing education and communication with practitioners and/or members
      7. Documents practitioner representation and participation during meeting discussion
   E. Audits, Surveys and Studies
      - There must be evidence of presentation to DMC for analysis, determination of performance goals thresholds and identified opportunities for intervention. Applicable corrective action plan implementation and measurement of effectiveness.
      - There must be target dates of completion of audits/studies and surveys and method of informing practitioners and members.
      - All audit/study/survey results will be made available upon request to the contracted health plan
      1. Member Satisfaction review of complaints, and inquiries is conducted annually to provide opportunity to monitor and evaluate activities
      2. Clinical Practice Audits
      3. The Provider Organization employs and tracks one performance measure for each DM Program measurement that addresses a relevant process or outcome, produces a quantitative result that captures processes or outcomes for which Provider
Organization can establish benchmarks or goals, is population based, uses data and methodology that are valid for the process or outcome being measured for internal tracking and Quality Improvement and has been analyzed in comparison with a benchmark or goal and past performance.

4. Annual measurement of active participation rates.
5. Annual Clinical Practice Guideline Performance Measurement

F. Description of Health Management Systems for Commercial and Medicare, as applicable (may reference separate P&Ps) – to include goals, objectives, protocols and interventions

1. System by which the Provider Organization improves the health status of members with at least 2 chronic conditions (includes the integration of the health education activities with disease management and case management programs).
2. Two clinical practice guidelines for two chronic medical conditions (4 measures)
3. Communication of Provider Organization’s health management programs/activities to practitioners/members
4. Program member attendance kept on file and in patient medical record
5. Analysis of effectiveness of programs. Method for measuring outcomes using at least 12 months of program data.

V. Patient Safety

A. Description of process on improving patient safety of clinical care

Examples:

- Evaluate clinical practices against aspects of evidence-based practice guidelines that improve safe practices
- Improve continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes
- Improve continuity and coordination of care between sites of care, such as hospitals and nursing homes, to ensure timely and accurate communication
- Implement pharmaceutical management practices that require safeguards to enhance patient safety
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  - Questions to ask surgeons prior to surgery
  - Questions to ask about drug interactions
  - Research findings that facilitate decision-making
- Distribute to members information that facilitates informed decisions based on safety - examples include:
  - Facilities with computerized pharmacy order-entry systems
  - Hospitals that use physicians specifically trained in intensive care
  - Provider Organization’s that have best practices or outcomes often based on volume
  - Pharmacies that provide member counseling and research on proven safe clinical practices
- Conduct in-service training focused on improving knowledge of safe practices (e.g., improving medical record legibility; establishing systems for timely follow-up of lab results)
- Combine data on adverse outcomes or polypharmacy issues
  - Distribute research on proven safe clinical practice
  - Develop incentives for achieving safer clinical practices

VI. The DM Plan will be annually updated, reviewed, approved, signed and dated by the DMC Chairperson and annually approved by the Governing Body.
CCM Program/Plan Signature Page

Provider Organization Name:

________________________________________

Review and approval of the attached CCM Program/Plan Description performed by:

SIGNATURE OF CCM CHAIRPERSON:

_______________________________________DATE__________________________

SIGNATURE OF AUTHORIZED GOVERNING BOARD REPRESENTATIVE:

_______________________________________DATE__________________________

SUBMITTED BY:

_______________________________________DATE__________________________

It is mandatory that this signature page (or one containing the above information) be submitted along with the Annual Program/Plan Description to each contracted Health Plan within 15 calendar days after committee approval.

FOR HEALTH PLAN USE ONLY

PROGRAM/PLAN REVIEWED

BY______________________________________________________________

DATE________________________
DM Program/Plan Signature Page

Provider Organization Name:

_________________________________________

Review and approval of the attached DM Program/Plan Description performed by:

SIGNATURE OF DM CHAIRPERSON:

_______________________________________DATE________________________

SIGNATURE OF AUTHORIZED GOVERNING BOARD REPRESENTATIVE:

_______________________________________DATE________________________

SUBMITTED BY:

_______________________________________DATE________________________

It is mandatory that this signature page (or one containing the above information) be submitted along with the Annual Program/Plan Description to each contracted Health Plan within 15 calendar days after committee approval.

FOR HEALTH PLAN USE ONLY

PROGRAM/PLAN Reviewed
BY____________________________________________

DATE________________________
### SAMPLE CORRECTIVE ACTION PLAN

<table>
<thead>
<tr>
<th>Provider Organization Name</th>
<th>Audit Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrective Action Plan (CAP) Date</td>
<td>Audit Conversion Year and Type</td>
</tr>
<tr>
<td>Auditor</td>
<td>Re-evaluation Date</td>
</tr>
</tbody>
</table>

Date CAP Sent to Anthem:____________ CAP Completed By:________________________

<table>
<thead>
<tr>
<th>Audit Category</th>
<th>Audit Indicator &amp; Applicable Indicator Header</th>
<th>Audit Score</th>
<th>Area For Improvement</th>
<th>Corrective Action</th>
<th>Timeframe for CAP Implementation</th>
<th>Responsible Provider Organization Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Returning the CAP timely is essential for maintaining a passing score on the next audit.
COMPLEX CASE MANAGEMENT (CCMC) AND DISEASE MANAGEMENT COMMITTEE (DMC)
Documentation of CCM-DM Meeting Minutes

PURPOSE

- To maintain a clear and accurate record, in a standardized format, of decision-making process, discussion, provider's participation, analysis and resolution of the Complex Case Management and or Disease Management activities.
- To promote continuity from meeting to meeting and accountability to follow through on the decisions, actions and recommendations in a timely manner.
- To ensure that meeting minutes will be contemporaneous, dated and signed by the chairperson.
- To establish priorities for the improvement or resolution of potential issues that directly or indirectly impact patient safety, medical and/or behavioral health care and service and all potential liabilities.

PROCEDURE

1. A standardized agenda and minutes format must be used for CCM and or DM meeting minutes. The following headings are recommended:
   a. Agenda Item/Issue
   - The issue or subject to be reviewed by the Committee
   b. Discussion/Findings/Recommendations
   - What was reviewed and within what timeframe?
   - Was the performance standard met?
   - Is there need for improvement?
   - Were any problems caused by defects in the established systems or in performance?
   - What is the severity of the problem?
   - Does this represent a trend?
   - Does further study or monitoring need to be done?
   c. Plan of Action
   - Provide what action is appropriate even if no action is taken based on the conclusions
   - Construct a time frame for the development and implementation of the action
   - Assign responsibility to appropriate person for action and follow-up
   d. Follow-up
   - Provide information on when further information will be presented and who is responsible for presenting it.
   - Provide information on what type of information is expected, what trended information is gathered and what actions are developed.

2. All CCM and or DM attendees and guests must sign the meeting attendance sign in sheets. Physician attendance by teleconference or web-ex is acceptable as long as it is documented within the minutes and the Medical Director's signature confirms the attendance.

3. There must be a written meeting agenda in place and made available for the attendees.

4. All attendees must sign confidentiality statements.

5. Practitioner and member names and PHI must be de-identified. Unique identifiers must be used for practitioners and members when documenting peer review activity, grievances, quality issues or other sensitive discussions.

6. Members of the CCMC and or DMC, guests and Health Plan representatives must sign confidentiality statements.

7. There must be adequate PCP and SCP representation.

8. There must be at voting quorum (3 licensed practitioners at a minimum) present at each meeting.

9. Meetings must be held at least quarterly, with urgent issues addressed separately.
10. The CCMC and or DMC must report to the governing body/board of directors at least quarterly.

11. Minutes should be taken simultaneously during the meeting and reflect all discussion from each agenda item including committee discussions and actions. Reference materials must be attached to the minutes and referenced in the minutes.

12. Meeting minutes must be contemporaneous, accurate, provide accountability for follow-up, and promote continuity from meeting to meeting.

13. Meeting minutes must be produced within 30 calendar days prior to the subsequent meeting, and must be dated and signed by the QMC Chairperson.

14. Minutes of the meeting must be numbered, dated, and include but not be limited to discussion of the following:
   - Approval of Policies and Procedures, CCM and DM
   - Approval of plan/program, work plan, semi-annual reports and annual evaluation, CCM and DM
   - Identification of members for CCM and or DM Programs
   - Review of Member Self Management Tool, CCM and DM
   - Review of annual Member Satisfaction, CCM and DM
   - Health Appraisal Review, CCM and DM
   - CCM and or DM case review
   - Review of any delegated functions, CCM and DM
   - Identification of issues, corrective action plan formulation, follow-up and remeasurement as applicable, CCM and DM
   - Review of results of CCM activities
   - Quality audit outcomes, CCM
   - Adoption and distribution of two Medical Clinical Practice GuidelinesDM
   - Informing and educating practitioners about the DM Program
   - Disease Management resources, DM
## Provider Organization CCMC Meeting Minutes

The regularly scheduled CCMC meeting was held on [insert date and time]. The following members were in attendance: [insert member names]

<table>
<thead>
<tr>
<th>AGENDA ITEM/ISSUE</th>
<th>DISCUSSION/RECOMMENDATIONS</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intro &amp; Confidentiality Agreements</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Guests introduced. Confidentiality Agreements distributed and signed</td>
<td></td>
</tr>
<tr>
<td>2. Review of Previous Minutes</td>
<td>Minutes of previous CCMC meeting, January 12, 2015, reviewed. Minutes accepted with the following revision to Item #3: wording changed from 'Dr. [Name] presented…' to “Dr. [Name] presented…”</td>
<td>None</td>
</tr>
<tr>
<td>3. Old Business</td>
<td>3. Discussion of items/issues requiring follow-up from previous meeting. Brief narrative required providing meaningful information to committee members. For example:</td>
<td>a. Analyze complaints and report opportunities for improvement of member satisfaction back to the CCMC next meeting.</td>
</tr>
<tr>
<td></td>
<td>a. Member Satisfaction with CCM</td>
<td>b. Call the hospital Case Management Department to access community resources</td>
</tr>
<tr>
<td></td>
<td>b. Case review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Analyze complaints and report opportunities for improvement of member satisfaction back to the CCMC next meeting.</td>
</tr>
<tr>
<td></td>
<td>b. 1 complex case management cases reviewed. TC is a 65 y/o diabetic male s/p CVA with right sided paralysis occurring 10/1/14. Rehab is complete and member now going to OP rehab. Daughter stays with him and helps him while his wife is at work during the day. Plan is to enroll him in adult day care during the day and wife to care for him at night and during the weekends. Wife needs a referral to a care giver support group and the American Diabetes Association. Medical Director, Dr. Jones suggested calling the hospital for care giver resources and support groups.</td>
<td></td>
</tr>
<tr>
<td>4. New Business</td>
<td>a. Reports reviewed. All goals were met on the 2nd semi annual report except for average duration of case load. On an average cases are being left open for 9 months without monthly member touch.</td>
<td>a. Case Manager education will take place regarding member touch at least monthly, or more often to assess progress towards meeting prioritized goals.</td>
</tr>
<tr>
<td>b. Case Review</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
gunshot wound to the head. Trach and g-tube will be placed this week. The family would like the member to be transferred to a facility near their/her home so they can visit and be more involved in her care and discharge plans. CCM Medical Director, Dr. Jones will call the hospitalist to discuss stability to transfer her to a contracting facility closer to her home and family.

planning will take place at the next meeting.

<table>
<thead>
<tr>
<th>5. Adjournment</th>
<th>All business for CCMC meeting concluded and adjourned at 9:00 AM.</th>
</tr>
</thead>
</table>

Respectfully Submitted,

_______________________  __________________________  _______________

CCMC Chairperson Signature  CCMC Chairperson Printed Name  Date
Provider Organization DMC Meeting Minutes

The regularly scheduled DMC meeting was held on [insert date and time]. The following members were in attendance: [insert member names]

<table>
<thead>
<tr>
<th>AGENDA ITEM/ISSUE</th>
<th>DISCUSSION/RECOMMENDATIONS</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intro &amp; Confidentiality Agreements</td>
<td>Guests introduced. Confidentiality Agreements distributed and signed</td>
<td>None</td>
</tr>
<tr>
<td>2. Review of Previous Minutes</td>
<td>Minutes of previous DMC meeting, January 12, 2015, reviewed. Minutes accepted with the following revision to Item #3: wording changed from &quot;Dr. [Name] presented...&quot; to &quot;Dr. [Name] presented...&quot;</td>
<td>None</td>
</tr>
<tr>
<td>3. Old Business</td>
<td>3. Discussion of items/issues requiring follow-up from previous meeting. Brief narrative required providing meaningful information to committee members. For example:</td>
<td>a. Analyze complaints, compliments, inquiries and report opportunities for improvement of member satisfaction.</td>
</tr>
<tr>
<td>a. Member Satisfaction with DM</td>
<td>a. Member Satisfaction surveys for the 4th quarter completed. 2014 results were stratified and analyzed. 5 complaints received and 2 compliments received.</td>
<td>b. Plan to distribute the 2015 adopted CPGs to all practitioners via e-blast before the next meeting.</td>
</tr>
<tr>
<td>b. Clinical Practice Guideline Adoption</td>
<td>b. Annual review and adoption of Anthem Blue Cross's adopted CPGs of Diabetes and CAD (which are the two chronic conditions identified from member population health status). Oncology, Obesity and Overweight Adults were also adopted.</td>
<td></td>
</tr>
<tr>
<td>4. New Business</td>
<td>a. Reports reviewed. All goals were met on the 2nd semi annual report. Total number of members identified for DM has increased every quarter.</td>
<td>a. Monitor DM case loads over the next quarter and assess for adequate staffing ratio</td>
</tr>
<tr>
<td>a. Approval of 2015 DM Plan, Workplan and 2014 2nd Semi Annual Reports</td>
<td>b. 47 year old male, newly diagnosed diabetic with coronary artery disease. Diabetic blood sugar monitoring log and caloric intake diary given to member. Logs reviewed weekly by the Disease Manager. Blood sugars are normalizing. Food log shows improved choices. Dr. Lee suggests the dietician call the member for additional diet education.</td>
<td>b. Dietician to call member and blood sugar and caloric logs will be re-evaluated at the next meeting.</td>
</tr>
<tr>
<td>b. Case Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Adjournment</td>
<td>All business for DMC meeting concluded and adjourned at 9:00 AM.</td>
<td></td>
</tr>
</tbody>
</table>

Respectfully Submitted,

DMC Chairperson Signature   DMC Chairperson Printed Name   Date
As a member of the Complex Case Management Committee, I recognize that confidentiality is vital to the Complex Case Management process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection within Complex Case Management Committee activities, and to make no voluntary disclosure of such information except to persons authorized to receive it.

Date: ____________________  Signed: ______________________

Print Name: _________________________

CCM Confidentiality Statement
DM Confidentiality Statement

As a member of the Disease Management Committee, I recognize that confidentiality is vital to the Disease Management process. Therefore, I agree to respect and maintain the confidentiality of all discussions, records, and information generated in connection within Disease Management Committee activities, and to make no voluntary disclosure of such information except to persons authorized to receive it.

Date: _______________  Signed: ______________________

Print Name: _________________________
Conflict of Interest Agreement

As a member of the Complex Case Management (CCM) and or Disease Management (DM) Committee, I agree to report any conflict of interest with respect to matters under review to the chairperson of the committee and refrain from completing the review.

Conflict of interest is defined as having any involvement with the beneficiary involved in the review, having any fiduciary relationship with the provider in question, or having any other involvement in the case which impairs judgment in performing the review.

I have read and understand the above Conflict of Interest Agreement, and promise to abide by its terms.

Date: ____________________  Signed:_________________________

Print Name: _________________________
Agreement Regarding Confidential or Proprietary Information

As a condition of my employment at "X" Provider Organization, I agree to the following:

1. I will not disclose or use at any time, either during or subsequent to my employment, any confidential or proprietary information of "X" Provider Organization of which I have become aware during my employment, except as required in performing my duties as an employee of "X" Provider Organization. I further agree that I will not appropriate any such confidential or proprietary information for my own use, or use in any way inconsistent with the interest of "X" Provider Organization.

2. I understand that confidential or proprietary information may be available to me in order that I may perform the duties of my job. I agree not to seek to acquire confidential or proprietary information beyond that which is reasonably necessary for me to effectively perform my job.

3. I agree that confidential and proprietary information includes, but is not limited to, the following:
   - Medical information, personal information regarding Medicare or other employees, practitioners, providers, patient accounting, billing or payroll information.
   - Information that "X" Provider Organization is required by law, regulation, or policy to maintain as confidential.
   - All financial information concerning "X" Provider Organization, its members, practitioners, or providers, disseminated solely for internal use.
   - Personnel records and information contained in those records.
   - Information, which could aid others to commit fraud, sabotage, or otherwise misuse "X" Provider Organization’s products or services, or damage their business.
   - Trade secrets such as product design, computer hardware/software, computer systems and programs, processing techniques and generated outputs, and all information received that is marked “Confidential – Do Not Copy.”

4. I agree that all "X" Provider Organization files and other records or data in any form are the exclusive property of "X" Provider Organization, even if I have written, created or otherwise been involved in the development of such information. I agree that upon termination of my employment, I will return to my employer all manuals, letters, notes, notebooks, reports, lists, data, information, or files which were in my possession or control during the term of my employment. I agree that any and all work product, materials, software and programs, including any intellectual property I develop in the course of my employment at "X" Provider Organization shall be the sole and exclusive property of my employer.

5. I agree that I will not engage in any outside activities from which I or a third party may gain at the expense of "X" Provider Organization or otherwise have an adverse impact on "X" Provider Organization. I agree to fully disclose to "X" Provider Organization any potential conflicts of interest and to fully and truthfully respond to any questions concerning possible conflicts of interest.

6. I agree to report any apparent violation of terms of the Agreement by another employee to appropriate management.

7. I understand this Agreement is a condition of my employment, and if I violate the terms of this Agreement my employment may be immediately terminated. Such remedy shall not be exclusive but shall be cumulative with all other remedies at law or in equity.

8. I have read this Agreement and I understand its contents. I agree to be bound by this Agreement and have signed it below to signify my agreement.

_______________________________  __________________________
Employee Name                  Employee Signature

_______________________________  __________________________
Employee Social Security Number  Date
Provider Organization Name:

________________________________________

_______ Attestation

Year

☐ Complex Case Management  ☐ Disease Management

☐ Review and approval of Policies & Procedures performed by:
  (Include table of contents of approved policies)

☐ DM Clinical Practice Guidelines
  (Include list of approved guidelines)

Signature of Senior Physician Reviewer:

________________________________________

Date __________

________________________________________

Date __________

Signature of Authorized Governing Board Representative:

________________________________________

Date __________

Submitted by:

________________________________________

Date __________
Complex Case Management Program Evaluation

Measuring Effectiveness of the Complex Case Management Program

The Provider Organization measures the Complex Case Management Program annually using three measures. For each measure there will be evidence of the following subsets:

**Identifies a Relevant Process or Outcome**
- The Provider Organization must select measures or processes that have significant and demonstrable bearing on a defined portion (which can include the entire CCM population) or subset of the CCM population or process so that appropriate interventions would result in significant improvement for the population. (Because inclusion criteria for CCM Programs vary from program to program, participation rates cannot be consistently measured and are not measures of effectiveness). Examples:
  - Measures of effectiveness for chronic conditions based on HEDIS, with specifications adapted to draw a denominator from the case management population only (e.g., cholesterol management, appropriate use of medication for asthma, comprehensive diabetes care)
  - Measures for care of chronic conditions based on National Quality Forum (NQF) measures, with specifications adapted to draw a denominator from the CCM population at the plan level (e.g., angiotensin converting enzyme [ACE] inhibitor use in people with heart failure)
  - Health status (e.g., SF-8®, SF-36® or SF-12® results) – if utilizing this measurement, the Provider Organization can utilize two measures of effectiveness – one each for physical and mental health functioning.
  - Satisfaction with CCM services. The three patient experiences measures may not all be satisfaction with the CCM Program operations, such as satisfaction with the frequency of contact or satisfaction with the case manager. Examples of other measures of patient experience include:
    - Improved quality of life
    - Pain management
    - Health status - If measuring health status using the Health Institute’s SF-12® (single page scannable, shorter Health Survey that is a subset of the SF-36®, or SF-36® (longer Health Institute Health Survey), and given that these tools are designed to facilitate the assessment of health status on physical and mental dimensions of care, Provider Organization may use the results for two measures of effectiveness - one each for physical and mental health functioning. Provider Organization may also use the activities conducted in the population assessment to measure effectiveness.
  - Use of service measures for specific populations for which there is consensus that an increase or decrease represents improvement (e.g., inpatient days/1,000; emergency department visits, admissions/1,000; medication compliance; total cost per member per month [PMPM]).
  - Readmission rates
  - Measures of ambulatory-care-sensitive admission, which are those conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or severe disease. Examples can be found at the following citation: Preventable Hospitalizations, Window Into Primary and Preventive Care, 2000, Health Care Cost and Utilization Project (HCUP) Fact Book No. 5, Agency for Healthcare Quality and Research http://www.ahrq.gov/data/hcup/factbk5/.

**Uses Valid Methods that Provide Quantitative Results**
- Measurement of CCM effectiveness must include the use of quantitative information derived from valid methodology. The following criteria must be included when evaluating a measure’s validity:
  - Numerator and denominator
  - Sampling methodology
  - Sample size calculation
  - Measurement periods and seasonality effects
Sets an Explicit, Quantifiable Performance Goal

- A performance goal must be established for each of the three measures.
  - A performance goal is the desired level of achievement that the Provider Organization sets for itself.
  - Provider Organization may base its goal on external benchmarks, which are known levels of best performance.

Clearly Identifies Measure Specifications

- The organization describes the data source, the eligible population, coding or other means of identifying the clinical process or outcome and any adaptation of HEDIS Effectiveness of Care measures used. The intent is to provide measure specifications that have enough detail to guide valid measurement.

Collects Data and Analyzes Results

- Analysis of findings must include a comparison of results against goals and an analysis of the causes of any deficiencies (if appropriate) to establish a basis for sound outcomes measurement.
  - Analysis must go beyond data display or simple reporting of results.
  - Provider Organization must use qualitative and quantitative analysis of findings that includes a comparison of results against goals.
  - Conducts a causal analysis if stated goals were not met.
  - The intent of this element is to establish a basis for sound outcomes measurement while acknowledging that different programs have widely varying population bases, enrollment methods and data access.

Identifies Opportunities for Improvement, if Applicable

- Provider Organization uses results of its analysis to prioritize opportunities for improvement.
- Opportunities may be different each time Provider Organization measures and analyzes the data.

Action and Re-Measurement

- Provider Organization implements at least one intervention, that addresses one or more opportunities identified to improve performance.
- Implementation of at least one intervention that addresses one or more opportunities identified to improve satisfaction.
- Provider Organization re-measures using methods consistent with initial measurements to determine impact on performance.
- Re-measurement using methods consistent with initial measurements to determine impact on satisfaction.

Reference Sources:
NCQA QI 7.H.1, I, J

Attachment(s):
None
Disease Management Program Evaluation
Measuring Effectiveness of Disease Management Program

The Provider Organization tracks one performance measure for each DM Program:

- Population may be members or practitioners.
  - An example of measuring practitioner effectiveness would be to look at their rates for doing dilated retinal exams for diabetic members.
- Measures must include entire population for which the Provider Organization has responsibility for DM. DM effectiveness may be measured by drawing a representative sample from the entire population.
  - Participation rates do not meet the intent of this indicator
- Audited HEDIS results specifically relevant to the condition addressed are considered appropriate measures even though the HEDIS population may not match the population of the DM Program exactly.
  - If the Provider Organization uses SF-8, SF-12 or SF-36 to measure health status, the results may count for two measures of effectiveness, one each for physical and mental health functioning.
  - Participation rates do not meet the intent of this indicator.
- Other examples of potential areas of measurement:
  - Delivery of health care services and results of these services
  - Relevant member behaviors
    - Adherence to prescribed medical treatment regimens
    - Weight loss
    - Smoking cessation
    - Member functioning (SF 36® and/or Quality-of-life measures)
    - UM
    - Clinical measures
- Addresses a relevant process or outcome
- Produces a quantitative result that captures processes or outcomes for which Provider Organization can establish benchmarks or goals
- Is population based
- Uses data and methodology that are valid for the process or outcome being measured for internal tracking and Quality Improvement
- Has been analyzed in comparison with a benchmark or goal and past performance

Reference Sources:
NCQA QI 8. K. 1-5

Attachment(s):
None
DELEGATION OF COMPLEX CASE AND DISEASE MANAGEMENT
Delegation

**What is delegation?**
Delegation occurs when the Provider Organization gives another entity the authority to carry out a function that it would otherwise perform. This authority includes the right to decide what to do and how to do it, within the parameter agreed on by the Provider Organization and the other entity. When delegation exists, the health plan requires the presence of a mutual agreement between the delegating organization and its delegate that is performing specific functions related to its own and NCQA standards. Although the Provider Organization does not directly perform delegated functions, it must oversee them to ensure that the delegate is properly performing the functions. The Provider Organization may reclaim the right to carry out its delegated functions at any time.

*The Provider Organization’s responsibility:*
The Provider Organization is ultimately accountable for all functions performed within its purview, whether they are performed by the Provider Organization, by a delegate or by a sub-delegate. A Provider Organization that delegates activities associated with any of the categories of NCQA standards must demonstrate that it has not compromised its ability to evaluate structures and processes and to achieve improved (or consistent, high-quality) performance across its network and membership.

**What is Sub-Delegation?**
Sub-delegation occurs when the Provider Organization’s delegate gives a third entity the authority to carry out a delegated function. For example, the Provider Organization may delegate credentialing (CR) Complex Case Management (CCM) or Disease Management (DM) activities to an MSO, which then delegates some of those activities to a specialized company (vendor). In this case, the specialized company (vendor) is the sub-delegate.

*Oversight of sub-delegates:*
When a delegate sub-delegates to a third entity, either the delegate or the organization oversees the sub-delegate’s work. The delegation agreement between the organization and the delegate specifies the entity responsible for overseeing sub-delegates. If the delegate oversees the sub-delegate, it must report to the organization regarding the sub-delegate’s performance. The Provider Organization must ensure that work performed meets the Provider Organization standards, governmental agency (CMS and DMHC), URAC and NCQA standards. The Provider Organization is ultimately accountable for all activities performed by both the delegate and sub-delegate on its behalf.
Guide to Delegation

<table>
<thead>
<tr>
<th>Ownership issues</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSO and group wholly owned by the same organization (e.g. hospital, integrated health system, business corporation)</td>
<td>Activities conducted by ‘sister’ organizations does not constitute a delegation arrangement</td>
<td>Wholly owned means 100%, anything less is not wholly owned</td>
</tr>
<tr>
<td>MSO wholly owns medical group</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group wholly owns MSO</td>
<td>No delegation</td>
<td></td>
</tr>
<tr>
<td>MSO partially owned by medical group</td>
<td>Delegation</td>
<td></td>
</tr>
<tr>
<td>Medical group partially owned by MSO</td>
<td>Delegation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Product</th>
<th>Activity</th>
<th>Delegation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product Utilization Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSO</td>
<td>P&amp;P development, approved by group</td>
<td>No delegation</td>
<td>No delegation agreement or oversight required</td>
</tr>
<tr>
<td></td>
<td>P&amp;P development, not approved by group</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required (annual review for compliance with MCO requirements)</td>
</tr>
<tr>
<td></td>
<td>Collection of information needed to make a decision</td>
<td>No delegation</td>
<td>No delegation or oversight required</td>
</tr>
<tr>
<td></td>
<td>Any decision made by MSO – either an approval or a denial</td>
<td>Delegation</td>
<td>Delegation agreement and oversight required</td>
</tr>
</tbody>
</table>
Delegating to an NCQA-Accredited or NCQA-Certified Entity

When a Provider Organization delegates defined activities to an NCQA-Accredited or NCQA-Certified organization, the expectation of a formal pre-delegation evaluation, annual evaluation and annual audit, as applicable, and the determination of meeting NCQA standards are satisfied for activities covered within the delegate’s NCQA-Accreditation or NCQA-Certification survey.

The Health Plan waives the pre-delegation assessment and annual oversight requirements of NCQA-Accredited or NCQA-Certified delegates. Oversight relief is not available for activities that are not covered—including NA activities, within the scope of a delegate’s NCQA-Accreditation or NCQA-Certification survey.

NCQA Accreditation Programs

NCQA Certification Programs
- Disease Management (DM) [www.ncqa.org/tabid/73/Default.aspx]
Delegation Example

Does someone other than the treating physician make decisions about what care the Provider Group pays for or what care a patient may have?

Yes → Delegation

No → Does an entity other than the Provider Group have the authority to perform some or all CM or DM functions (e.g. another entity provides the Health Appraisal services for members?)

Yes → Delegation

No → No Delegation
Sample Policies and Procedures and Informational Attachments

The following templates may be utilized by the Provider Group to assist with the development of policies. The templates are based on Anthem requirements and may not be specific to other health plan requirements, including the ICE Credentialing Shared Audit.
Purpose:
Clinical practice guidelines are systematically developed descriptive tools or standardized specifications used for the provision of non-preventive acute and chronic medical services to assist practitioners and members make decisions about appropriate healthcare for specific clinical circumstances.

“X” Provider Organization may adopt the guidelines adopted and/or developed by Anthem (available at www.anthem.com/ca or in the Anthem DM Guideline Workbook) or nationally recognized organizations such as the American Diabetes Association (ADA), Academy of Pediatrics, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American College of Obstetrics and Gynecology, American Cancer Society, American College of Surgeons and American Health Care Policy Review are acceptable clinical practice guidelines.

Clinical practice guidelines do not include:
- UM criteria or guidelines that primarily address medical necessity decisions (e.g., Milliman)

Policy:
It is the policy of “X” Provider Organization to review and approved Clinical Practice Guidelines for its Disease Management (DM) programs every two years or more frequently if guidelines change within the two year period.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will use the following data sources in adopting clinical practice guidelines:
  - “X” Provider Organization will adopt 2 clinical practice guidelines for at least 2 medical conditions (4 measures).
  - X Provider Organization uses practice guidelines for the provision of non-preventive acute and chronic medical services to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances.

- “X” Provider Organization establishes the clinical basis for the guidelines:
  - Evidence-based guidelines are clinical practice guidelines known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert opinion, in the absence of professional standards.
  - “X” Provider Organization will review and approve Clinical practice guidelines that are based on reasonable medical evidence, from recognized sources and that have a sound scientific basis, e.g., clinical literature and expert consensus in the absence of professional standards.

“X” Provider Organization will involve board-certified practitioners from appropriate specialties in the development or adoption of clinical practice guidelines that are not from recognized sources. “X” Provider Organization that does not use clinical practice guidelines from recognized sources must provide an opportunity for board-certified practitioners that would use the Guideline to give advice during its development.

Practitioners are involved in the adoption of clinical practice guidelines. Practitioner involvement may come through participation on a committee or through the Provider Organization’s consideration of comments from practitioners to whom guidelines were circulated.
- Recognized sources are organizations that develop or promulgate evidence-based clinical practice guidelines and include professional medical associations, voluntary health organizations and NIH Centers and Institutes. Clinical practice guidelines do not exist from recognized sources for all conditions and all interventions.

- Evidence-based guidelines may be obtained through the National Guideline Clearinghouse at www.guideline.gov.

- Other recognized Guideline sources include:
  - Professional medical associations such as:
    - American Medical Association
    - American College of Cardiology
    - American Orthopedic Association
    - American Academy of Pediatrics
  - Voluntary health organizations such as:
    - American Diabetes Association
    - American Heart/Stroke Association
    - American Lung Association
  - National Institutes of Health (NIH) Centers and Institutes such as:
    - National Heart Lung and Blood Institute
    - National Cancer Institute

- “X” Provider Organization DM Committee reviews, updates and approves the Clinical Practice Guidelines:
  - Initially, then every two years, or more frequently if national guidelines change within the two year period as often as they are updated, revised, or adopted.

- “X” Provider Organization distributes the four Clinical Practice Guidelines to the appropriate practitioners as follows:
  - Distribution of at least 4 medical clinical practice guidelines and any revision, to all practitioners who are likely to use them as appropriate to area of practice.
  - To all practitioners that are likely to use them
  - To new practitioners as they are added
  - When adopted
  - When updated or revised
  - By one of the following methods:
    - In writing by mail, fax or e-mail.
    - On the Web, if it notifies practitioners that information is available.

- “X” Provider Organization conducts annual Clinical Practice Guidelines performance measurement as follows:
  - “X” Provider Organization annually measures performance against at least two important aspects (for a total of four measures) of the following:
    - Two clinical practice guidelines for two medical conditions respectively
    - Performance measurement must relate to the clinical process of care found within the guidelines that is most likely to affect care.
    - Outcome measures will be directly related to the clinical practice guidelines (such as utilization measures). “X” Provider Organization may also use utilization measures whose performance directly correlates with the clinical process of care. If the Provider Organization uses such a measure “X” Provider Organization will demonstrate that research exists to correlate the measure with the clinical process of care.
    - “X” Provider Organization must collect and analyze data to determine practitioner adherence to adopted guidelines and improve practitioners’ performance.
    - Data collection methodology will be sound and produce valid and reliable results that include whole or parts of the guidelines that are not utilized.
    - The methodology that “X” Provider Organization implements must provide it with results to improve practitioner performance with Guideline use. The methodology must allow “X” Provider Organization to aggregate results and analyze areas or parts of the guidelines that are not being used.
    - Assessment may be populated based or practice based.
• If assessment is population based, “X” Provider Organization may evaluate data on a sample of members with the acute or chronic condition to determine whether the treatment members receive follows the guidelines.

• If assessment is practice based, “X” Provider Organization identifies a sample of practitioners or practices and evaluates a sample of their treatment records for non-preventive acute or chronic conditions. If performed correctly, the methodology allows the “X” Provider Organization to draw conclusions about the performance of individual practitioners or practices.

• If “X” Provider Organization is involved in collaborative Guideline activities, measurement of Guideline performance may occur at the collaborative level, using aggregate data.
  • Performance measurement must relate to the clinical process of care found within the guidelines that is most likely to affect care.
  • Outcome measures not directly related to the clinical practice guidelines (such as utilization measures) are not acceptable; however, “X” Provider Organization may use utilization measures whose performance directly correlates with the clinical process of care to meet the intent of this element. If “X” Provider Organization uses such a measure it must demonstrate that research exists to correlate the measure with the clinical process of care. (for a total of four measures)

Reference Sources:

Attachments:
Clinical Practice Guideline Information
Clinical Practice Guidelines

Adopting Clinical Practice Guidelines assists practitioners and members in making decisions about appropriate care for specific clinical circumstances and to improve patient outcomes.

The Provider Organization should utilize its practitioners to develop/adopt/implement Clinical Practice Guidelines for non-preventive acute or chronic medical conditions and preventive and non-preventive based on reasonable medical evidence and sound scientific basis, in consideration of needs of member population, and the recommendations of regionally or nationally recognized organizations, to assist practitioners/members in decisions about appropriate care for specific circumstances. Clinical Practice Guidelines may be referred to as treatment protocols, practice parameters or clinical pathways.

Areas of concern that the Provider Organization should implement and thus be able to produce evidence are listed below:

- Two written Clinical Practice Guidelines (for at least 2 medical conditions or 4 measures) will be reviewed/approved, documented and updated as necessary annually by the DMC and/or the CMC. The Provider Organization will initiate guidelines review when new scientific evidence or national standards are published before the annual review date.
- Clinical Practice Guidelines will address the patient population, evidence based, with a sound scientific basis such as clinical literature and expert consensus. The development of Clinical Practice Guidelines may incorporate recommendations from one or more of the following: Anthem (available at www.anthem.com/ca or in the Anthem DM Guideline Workbook) or nationally recognized organizations such as American Diabetes Association, American Academy of Pediatrics, American Academy of Family Physicians, American Society of Internal Medicine, American College of Physicians, American College of Obstetrics and Gynecology, American Cancer Society, American College of Surgeons and American Health Care Policy Review, and Anthem. If Clinical Practice Guidelines are not developed from recognized sources, board certified practitioners from appropriate specialties pertinent to their level of expertise will be involved in the development of the guidelines.
- Practitioners are involved in the adoption of Clinical Practice Guidelines. Involvement may come through participation on a committee or through the Provider Organization’s consideration of comments from practitioners to whom guidelines were circulated.
- Medical Clinical Practice Guidelines will be distributed to all contracted practitioners who are likely to use them as appropriate to their area of practice including new practitioners as they are added, new guidelines when adopted and when updated or revised.
- Clinical Practice Guidelines will be utilized as a clinical basis in the Provider Organization’s Disease Management Program.
- The Provider Organization will identify and implement opportunities/interventions for improvement and measure the effectiveness of those interventions.

Anthem considers clinical practice guidelines to be an important component of our medical care delivery system. Anthem performs an assessment of the disease prevalence of our membership every two years. Our disease prevalence based, health management programs have adopted nationally published clinical practice guidelines that are developed by relevant specialty physician organizations, and designed to monitor and improve the treatment outcomes for high-volume/high-risk diseases. Accreditation bodies, such as the National Committee for Quality Assurance (NCQA), require health plans to adopt clinical practice guidelines and to measure performance against at least four practice guidelines. Similarly, Anthem requires the contracted Provider Medical Groups/Independent Physician Associations (PMG/IPA) to adopt the Anthem Clinical Practice Guidelines.

Copies of the CPGs may be obtained by calling 1-877-273-4189 or visiting Anthem Web site http://www.anthem.com/ca/home-providers.html: Click on “Provider” then Click the “Enter” tab, then Click on Health and Wellness top tab then click on “Practice Guidelines”. You will see a list of CPGs, click on desired CPG.

List of (Medical) Clinical Practice Guidelines
- Asthma – National Asthma Education and Prevention Programs
• CAD (general population and for women) – AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with CAD and other Atherosclerotic Vascular Disease; Effectiveness-Based Guideline for the Prevention of Cardiovascular Disease in Women
• Chlamydia/Human Papillomavirus (HPV) – Sexually Transmitted Disease Guidelines 2010
• Chronic Obstructive Pulmonary Disease (COPD) – Global initiative for COPD
• Diabetes – 2015 American Diabetes Association Standards of Care
• Hepatitis C – Infectious Diseases Society of America (IDSA) American Association for the Study of Liver Disease
• HIV/AIDS – Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America
• Heart Failure – Guideline for the Management of Heart Failure: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on the Practice Guidelines
• Hypertension in Child and Adolescent – Hypertension in Child and Adolescent; The Fourth Report on Diagnosis, Evaluation and Treatment of High Blood Pressure in Children and Adolescents
• Maternity / Perinatal Care Summary Based on the Guidelines; American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) - Perinatal Guideline Summary based on the Guidelines for Perinatal Care, 7th Edition. 2012.
• Obesity in Adults – 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report to the American College of cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society
• Sickle Cell Anemia – National Heart, Lung, Blood Institute (NHBLBI)
• Vascular at Risk – 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults
**Purpose:** To ensure that the complex case management program lists all information and interventions.

**Policy:** The complex case management program content includes all information and interventions that directs a member, practitioner or provider to improve health care delivery and management and promote quality, cost effective outcomes. This information is available to other providers involved in the member’s care. The policies and procedures include the following:

- Initial assessment includes an evaluation of the member’s health status and identifies condition specific issues. Example of likely co-morbidities:
  - High-risk pregnancy and heart disease for member’s with diabetes

- There should be documentation of member clinical history. Examples include:
  - Disease onset
  - Key events (e.g., acute phases)
  - Inpatient stays
  - Treatment history
  - Current and past medications

- An initial assessment helps in the evaluation of the member’s functional status, in relation to activities of daily living (ADLs).

- The complex case management care plan includes an initial behavioral health status assessment, including cognitive functions, mental health conditions and substance use disorders.

- Initial assessment of psychosocial issues [NCQA QI 7.F.5]
  - Examples may include:
    - Beliefs and concerns about the condition or treatment
    - Perceived barriers to meeting treatment requirements
    - Access, transportation and financial barriers to obtaining treatment

- Initial assessment of life-planning activities
  - This may not be appropriate for all members (e.g., children). The complex case management provider determines if such a discussion is appropriate during the first contact based on the member’s experience.
  - Providing life-planning information (e.g., brochure, pamphlet) to all members in complex case management will meet the intent.
  - Life-planning activities include Wills, Living Wills, Advance Directives and Health Care Powers of Attorney.

- An evaluation must be performed of cultural, linguistic, visual and hearing needs, preferences or limitations

- An evaluation must be performed of caregiver resources and involvement.
  - Adequacy of caregiver resources including family involvement and decision-making about the care plan.

- Eligibility for health benefits and other pertinent financial information regarding benefits is included in the evaluation.
  - Refers to benefits within the Provider Organization and from community resources (e.g., community mental health, Employee Assistance Program [EAP], Disease Management
and Wellness organizations, palliative care programs and other national or community resources

- There should be development of an individualized complex case management care plan including prioritized goals that considers members and caregiver’s goals, preferences and desired level of involvement in the plan. The plan is personalized to meet member specific needs.

- There will be identification of barriers to meeting goals or complying with the care
  - The complex case management care plan must include documentation that barriers were addressed, even if no barriers were identified.

- There should be development of a schedule for follow-up after referrals to health resources to determine whether member acted upon the referral
  - May specify that follow-up is not applicable in all situations

- There should be development of a schedule for follow-up of care plan and communication with members
  - Examples may include; counseling, referral to a DM Program, education and self-management support.

- Instructions or materials provided to members or caregivers to help them manage their conditions (Self-Management activities are components of the care plan and do not require a separate plan or specific format). Member Self-Management activities may include, but are not limited to:
  - Maintaining a prescribed diet
  - Charting daily readings (e.g., weight, blood sugar)
  - Changing a wound dressing as directed

- Progress assessment of meeting goals and/or overcoming barriers, which can be met by re-adjustment of care plan and goals as needed.

Reference Sources:
NCQA QI 7.E

Attachment(s):
Sample CCM File Review
CCM FILE REVIEW ASSESSMENT

I. **Health Status**
   Initiated and completed within 30 calendar days from the determination that a member is eligible for CCM services. During initial assessment, case managers evaluate the member's health status specific to identified health conditions and likely co-morbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes).

   **Helpful Hints**
   - Assessment may be completed in multiple visits
   - Assessment components may be completed by other members of the care team and with the assistance of member’s family or caregiver
   - Three or more attempts, to reach the member, should be made via;
     - Telephone
     - Regular mail
     - E-mail
     - Fax

   **Example:**
   33 y.o. female, weight 256.2 lb, height 5’4.5, BMI 43.3. Hx of Morbid Obesity with unsuccessful multiple weight loss attempts, Dyslipidemia, Pain in weight bearing joints, back, dyspnea on exertion, craniotomy for resection of arteriovenous malformation 1999

II. **Clinical History**
   The case management file document the member's clinical history, including Disease onset; key events such as acute phases; and inpatient stays, treatment history and current and past medications.

   **Examples:**
   - Clinical History: Member is a 42 year old female, weight 216 lb, height 5’8, BMI 32.8. Hx of lap band surgery 7/29/08, Obesity, Hypertension, tubal ligation. Current Treatment Plan: lap revision of adjustable gastric restrictive device component only with planned date 11/10/10 at (Name) Heart Hospital. List of current medications/dosages: Atenolol 20 mg qd, HCTZ 12.5 mg qd, chew multiVitqd, calc+Dqd, Vit 12 qd.
   - Obesity with slow onset during four pregnancies from the years 2000-2008. Member gained 100 lbs total over 5 years. HTN was diagnosed 2008, Diabetes was diagnosed in 2009. Dyspnea and joint pain have also been a slow onset, but worse in the last year. Member has had one hospitalization for a craniotomy for resection of AV malformation in 1999 which is completely resolved now. Member was also hospitalized in 2009 with diabetic ketoacidosis. Blood Sugar was 620 and member was diagnosed with diabetes during the admission. Member is on a 1400 ADA diabetic diet which she admits that she does not follow. She overeats when she is stressed and eats fast food frequently. She checks her blood sugars daily. Blood sugars usually run 140-200. Current medications: Atenolol 25 mg QD, 10 units Regular insulin and 20 units NPH Insulin QD, diet pills that she buys at the drug store called Dexatrim, Advil and Aleve for her joint pain PRN. No past medications.

III. **Activities of Daily Living (ADLS)**
   Case management file evaluates the member's functional status related to activities of daily living such as eating, bathing and mobility.
   Activities of daily living:
   - Grooming
   - Dressing
• Bathing
• Toileting
• Eating
• Meal preparation
• Laundry
• Light housekeeping
• Shopping
• Using the telephone
• Managing money
• Managing medications

**Examples:**
- Member does not need any assistance with ADLs. When doing household chores, member must rest between chores. She feels she is recovering slower than she did 13 yrs ago when she had surgery, but realize she is older now. She has no impairments.
- Member has no ADL difficulties. Member feels his current functional status is normal. Member has no impairments that affect his ability to care for himself.
- Member denies needing any help with ADLs. She does not climb 13 steps in home at this time R/T doctor's pre-op orders. She feels her current function status is stable. Member has no impairments that prevent her ability to care for herself.
- He is independent with ADL’s, but is not allowed to drive at this time. No problems with his memory or understanding directions. No visual or hearing deficits. Fatigues easily.
- The member states he is independent for self-care. He is able to ambulate independently in the home. He has a problem with walking for long period of time due to pain.
- Member is able to perform ADLs without assistance, but needs therapy to get back to his baseline. He continues to work on his strength and endurance.
- The member has weakness on the left side. He needs assistance with all ADL’s due to lack of movement in his left hand. He has some feeling in his left arm. No problems related to Speech, Hearing or Vision. Poor reading skills, and inability to write.
- The member states he is independent for self care. He is able to ambulate independently in the home. No problems related to Speech, Hearing, Vision or Sensory impairment of the extremities.
- Independent with ADL’s at this time. Member reports getting winded easily and requires frequent rest breaks. No issues with vision or hearing.

**IV. Initial Assessment of Behavioral Health Status**

During initial assessment, the member's mental health status is evaluated. The evaluation includes:
- Cognitive functions (including members ability to communicate, understand instructions and process information about their illness), mental health conditions and substance abuse disorders.

**Helpful Hints**

Cognitive Functioning Assessment may include the following
- Alert and oriented, able to focus and shift attention, comprehends and recalls directions independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g., on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.
Examples:
- Member stated that his family is supportive, no history of substance abuse. Member is alert and able to communicate. He understands information and answered “no” to all of depression screening questions.
- Member has a history of depression and is currently depressed. He is under the care of a psychiatrist. Family is supportive. No history of substance abuse. Alert and oriented. He is able to recall his doctor’s care instructions.
- Member has some short term memory loss and requires cuing for word recall. Her condition becomes worse during the evening when she is tired, or is in an unfamiliar environment or situation.
- Member does not process information well in groups of people. Education and training is best accomplished with one other person in the room and no outside distractions like the radio or television.
- Member is in a vegetative state and totally dependent. Opens eyes spontaneously but does not follow commands.

V. Initial Assessment of Psychosocial Issues
Initial assessment should include questions that would give the member a chance to verbalize fears or possible barriers to treatment

Example:
- Beliefs and concerns about the condition or treatment
- Perceived barriers to meeting treatment requirements
- Access, transportation and financial barriers to obtaining treatment

VI. Life Planning
The case management file includes an assessment of life planning activities such as Wills, Living Wills, Advance Directives and Health Care Powers of Attorney.

Helpful Hints
- Documentation must demonstrate that it has assessed whether a member has completed life-planning activities.
- May not be appropriate for all members (e.g., children).
- Providing life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement, but it must be documented.

Example:
- Member states that he received an Advance Directive form from the hospital in the past, but decided not to complete it. He declines interest in doing so now. He has a Will and Living Trust. He does not have a Living Will.
- Discussed end of life options with the family. Member has a living will and does not want heroics done under specific situations. Dr. Moore and the hospital have a copy. His wife would like his intention noted in the record and she will scan and e-mail the Living Will to this case manager.
- 32 week premature infant who is in now 40 weeks and in the growing and feeding nursery. Plan is to discharge the baby home with her parents and follow up with her physicians for all the necessary surgeries and care when appropriate. Assessment of Life Planning activities is not applicable.
- Mailed member a brochure that contained information about Wills, Living Wills, Advance Directives and Health Care Powers of Attorney.
VII. **Cultural and Linguistic Needs**
The case management file includes an evaluation of cultural and linguistic needs, preferences or limitations.

**Helpful Hints**
Evaluation may include:
- Any characteristics that make it difficult for the care team to communicate effectively with the member
- Health care treatments or procedures that are religiously or spiritually discouraged or not allowed
- Family traditions related to illness, death and dying

**Examples:**
- The member and member’s family speak only Spanish. The member has a 19 year old niece who lives in the home and speaks English. She translates for the member and family. The family asks that all call be made during the early morning hours before she leaves for school. They decline the use of a language line or certified interpreter.
- The member’s is a Jehovah Witness and cannot receive any blood products.
- The member’s son is an acupuncturist. He seeks Eastern Medicine treatment in addition to his chemotherapy regime. He is currently taking herbs and soups prescribed by his son.

VIII. **Visual and Hearing Needs**
The case management file includes evaluation of visual and hearing needs, preferences or limitations.

**Examples:**
- The member wears glasses for near sightedness. No hearing impairments.
- Child is severely hard of hearing and has a cochlear implant. Since the surgery she has been able to acquire speech and language. No vision impairments.

IX. **Caregiver Resources**
During initial assessment, case managers evaluate caregiver resources and involvement.

**Helpful Hints**
- Resources include family involvement and decision making about the care plan.
- Caregiver assessment may include the following:
  - Member is independent and does not need caregiver assistance
  - Caregiver currently provides assistance
  - Caregiver needs training, supportive services
  - Caregiver is not likely to provide assistance
  - Unclear if caregiver will provide assistance
  - Assistance needed but no caregiver available

**Examples:**
- Member was independent before the accident. His wife works full time and has 3 children under the age of 10. Member will need a caregiver during the day and his wife will try being his caregiver at night.
- Member lives alone. He has no family members that can assist him. He has a neighbor who agreed to bring him occasional meals when she is home.
X. **Benefits**
The case management file includes an evaluation of eligibility for health benefits and other pertinent financial information and referrals to external available resources.

**Helpful Hints**
These could include benefits within the Provider Organization and from community resources. Examples include:
- Community Mental Health
- Employee Assistance Program (EAP)
- Disease Management and Wellness Organizations
- Palliative Care Programs
- National Community Resources

**Examples:**
- Member has a PPO policy. Policy has a $500.00 deductible per member. The mental health benefit is a carve out and the benefit and limited. The member has exhausted the benefit for the year. Referral was made to the member’s employee EAP program and the county mental health department. A referral was also given to the National Alliance on Mental Illness and to the Behavioral Health hospital support group.

XI. **Evaluation of Community Resources**
The case management file addresses whether the member is aware of available resources and/or utilizing these resources already.

**Examples:**
- Community mental health
- Employee Assistance Program (EAP),
- Disease management and wellness organizations
- Palliative care programs
- Other national or community resources

XII. **Individualized Care Plan**
The case management file includes an individualized care plan.

**Helpful Hints**
- Providing education materials alone does not meet the intent
- The care plan considers members and caregiver goals, preferences and the desired level of involvement.
- The care plan is personalized to meets member’s specific needs and identifies:
  - Prioritized goals
  - Timeframe for re-evaluation
  - Resources
  - Planning for continuity of care, including transition of care and transfers
  - Collaborative approaches to be used, including family participation

**Examples:**
- Prioritized goal (formally known as short and long term goals) - Member will be discharged home with his family to a safe environment when rehab is completed in two weeks.
- Time frame for re-evaluation - Rehab case conference is next week. CM will attend the case conference via conference call and re-evaluate the goal at that time.
- Resources to be utilized, including appropriate level of care – Referred member and family to the Amputee Coalition, http://www.amputee-coalition.org/ for information and support
- Planning for continuity of care, including transition of care and transfers - DME of hospital bed, wheelchair, and bed side commode to be arranged and in the home before the member can be discharged. ABC Home Health Care will be arranged to see the member the day after he is discharged to assess and reinforce family training. Member will be transferred home via private car. Pivot transfers will be taught to the member and family in rehab. Member has no stairs to his house or in his house.
- Collaborative approaches to be used, including family participation - Family will provide care 24 hours a day. Family will be independent in wound care at discharge. Home Health will case manage wound care and consult with Dr. James as needed. Home PT and OT will continue until member is no longer home bound and can attend outpatient rehab.

XIII. **Barrier Issues**
The case management file addresses identification of barriers to meeting goals and complying with the plan.

**Helpful Hints**
The file must include documentation that issues of barriers were addressed, even if no barriers were identified. Barrier assessment may include:
- Language or literacy issues
- Lack of or limited access to reliable transportation that may hinder the member from participating in care
- Lack of understanding of a condition or treatment
- Lack of motivation to participate in care plan
- Lack of belief that participation will improve their health
- Financial or insurance issues
- Cultural or spiritual beliefs
- Visual or hearing impairment
- Psychological impairment
- Mental and physical incapacity to participate in care.

**Examples:**
- Barriers were assessed and no barriers to care were identified
- Barrier to care includes a lack of motivation to participate in the care plan. Member is aware of the need to follow his diabetic diet, exercise and avoid alcohol. He refuses to follow his diet and give up drinking alcohol. He is not motivated to exercise and does not think any of these actions will improve his condition.

XIV. **Facilitation of Member Referrals to Resources and Follow-up**
The case management file includes information to determining whether member acted upon the referral

XV. **Development of a Schedule for Follow-Up of Care Plan and Communication with Members**
The case management file includes a schedule for follow-up after a referral to a health resource to confirm member contact

**Helpful Hints**
- Schedule may include, but is not limited to, Counseling referral to a DM program, education and self-management support.
- A follow up may not be applicable in all situations.
**Example:**
- Member was given a referral to the Disease Management’s Diabetes Program. Member will be contacted in two weeks to confirm that contact was made with the program and if enrollment was initiated.

**XVI. Development and Communication of Member Self-Management Plans**
The CCM file includes member Self Management Plans, instructions or materials are provided to members or caregivers to help them manage their conditions.

**Helpful Hints**
- Self-management plans are activities undertaken by members to help them manage their condition, stay healthy and reduce risk, and are based on instructions or materials provided to them by their care givers.
- Self management activities are components of the care plan and do not require a separate plan or specific format.
- Member self-management activities include, but are not limited to:
  - Maintaining a prescribed diet
  - Charting daily readings (e.g., weight, blood sugar)
  - Changing a wound dressing as directed.

**Example:**
- Diabetes management workbook mailed to member by Disease Management. Involvement in self management plan is evidenced by member’s ability to demonstrate self care management of her condition by being knowledgeable of 3 hypoglycemia symptoms to report to her doctor. She is also able to verbalize any changes in blood sugar readings taken daily and asks appropriate questions.

**XVII. Assessment of CCM Plan Progress**
The file includes an assessment of CM progress against CCM Plans and goals for members and modification, as needed.

**Helpful Hints**
- The case management file includes an assessment of the member’s progress toward overcoming barriers to care and meeting treatment goals and includes reassessing and adjusting the care plan and its goals, as needed.

**Examples:**
- Prioritized Goal - Member will be discharged home with his family to a safe environment when rehab is completed in two weeks.
- Assessment of CCM Plan Progress: Attended case conference via conference call today. Member was re-admitted to the acute hospital last weekend with a pseudomonas infection of the stump. Member is on IV antibiotics and is weak and unable to participate in 3 hours of therapy per day. Plan is to transfer member to a lower level of SNF rehab within the facility until the IV antibiotics are complete and member can participate in 3 hours of rehab therapy.
- Care Plan adjusted, new prioritized goal established.
- New Prioritized Goal: Member will return to acute rehab once IV antibiotics are completed in 1 week and the member can tolerate 3 hours of acute rehab.
Purpose: There will be a documented process that describes utilization of support systems for the complex case management program.

Policy**X**Provider Organization utilizes the following types of systems that support the complex case management process:

- Complex case management systems support the use of evidence-based clinical guidelines, algorithms or other prompts to help guide staff through assessment and ongoing management of members.

- Provides automated features that produce accurate, automated documentation of the staff member's ID, date and time of action on the case or when interaction with the member occurred. Examples are:
  
  - Recording actions or interactions with members, practitioners or providers
  - Automatic date, time and user (e.g., user ID or name) stamps may be used.

- Provides automated prompts for follow-up, as required by the CCM File
  
  - To facilitate care planning and management, systems include features to set prompts and reminders for next steps or follow-up contact.

Reference Sources:
NCQA QI 7. D

Attachment(s):
None
SAMPLE DM FILE REVIEW ASSESSMENT

1. The following has been verified:
   - Member eligibility and benefits
   - Consents been obtained
   - Opt In/Opt Out status is determined
   - Communication to member and treating practitioner about the DM Program is documented.

2. Health Assessment has been conducted at initiation of DM.

3. Documentation of the following:
   - Disease stratification is determined
   - Co-morbidities identified
   - Appropriate Clinical Practice Guideline(s) applied
   - Timeframe for DM Program completion threshold established

4. Goals are set and the following identified:
   - DM Treatment Plan
   - Self-Management Tools are applied
   - Contact schedules established
   - Interventions are implemented

5. Documentation of communication with member and member’s treating practitioner during DM process.

6. Member's condition is monitored with multidisciplinary collaboration and integration of member clinical information.

7. Member adherence to the DM Treatment Plan, Self-Management Plan/Tools is assessed and EMRs (or paper medical records) are tracked.

8. Health Assessment has been conducted at DM File closure.

9. Documentation of communication of same to member and member’s treating practitioner about DM file closure.

Reference Sources:
NCQA QI 8.A 1-2,4-6, D, E, MEM 2
Disease Management Member Active Participation Measurement

**Definition** - The active participation rate is the percent of identified eligible members who choose to opt-into or enroll in a Program. This is also referred to as opt-in participation or voluntary participation.

- The active participation rate is derived by the number of members who have received at least one interactive contact in an intervention, divided by the number of members who are identified as eligible for the program.

- The Provider Organization must calculate the Active Participation Rate numerator depending on the type of enrollment they use
  - **Opt-in enrollment** (eligible members choose or volunteer to participate) active participation calculation;
    - Denominator: Total number of identified eligible members
    - Numerator: Total number of identified eligible members that opt into the program.
  - **Opt-out enrollment** (identified eligible members are considered enrolled, regardless of their level of involvement, unless they actively opt out) active participation calculation;
    - Denominator: Total number of identified eligible members
    - Numerator: Total number of identified eligible members with at least one interactive contact

- Provider Organization annually measures DM Program member active participation rates, contact must be interactive.
  - Examples include:
    - Mail-based communication requested by the member, member survey, quiz or assessment of member knowledge gained from reading the communication
    - Phone, including interactive voice response (IVR) module or in person (individual or group)
    - Online contact via Interactive Web-based module, live chat or secure e-mail
  - Interactive contact **does not** include:
    - Completion of a health appraisal
    - Contacts made only to make an appointment, leave a message or acknowledge receipt of materials
    - Receiving only educational mailings or emails does not constitute active participation.
Purpose:
Health Appraisals (HA) are administered and results provided to members annually.

Policy:
It is the policy of “X” Provider Organization to annually administer HAs.

Responsibility: CM/DM Department Staff

Procedure:
“X” Provider Organization will administer HAs annually on all members.
- HA is available to members in language that is easy to understand via one of the following:
  - In print or by telephone for members without Web access
    - Online and through alternative media for members with Web access
    - Inprintor by telephone for members without Web access
- HA is reviewed and updated every two years.
- HA includes an explanation of how the information from the HA will be used, list of organizations and individuals who might receive the information and why, statement that member may consent or decline to have information used and disclosed and explanation of how “X” Provider Organization assesses member understanding of the language used in the HA.

Reference Sources:

Attachments:
Health Appraisals
Examples of Health Appraisals

Examples of Health Appraisals (HAs) include:

Self-perceived health status:
SF-20® questions or other questions where participant rate their health status on a relative scale

Behavioral change strategies:
Prochaska's Stages of Change

Stage 1 - Pre-Contemplation:
- Consciousness Raising (public education using mass media, small groups)
- Dramatic Relief (taking action to decrease anxiety and other negative emotions through role playing, grieving, testimonies, simulations, and other group activities)
- Environmental Re-evaluation (learning how one’s actions affects one’s self/others through guided discussions w/family members, testimonies, story telling)

Stage 2 - Contemplation:
- Self Re-evaluation (re-evaluation of self-image through the following group activities:
  - Values clarification exercises
  - Contact and discussions w/role models
  - Guided imagery where people imagine themselves in the new situation - e.g., committed to abstinence)

Stage 3 - Preparation:
- Self and Social Liberation (belief that one can change and commit to change, and creating social conditions for change by:
  - Changing community norms to favor change
  - Drawing attention to those who have made commitments
  - Organizing events for public commitments)

Stage 4 - Action:
- Using and fostering social support and caring relationships through peer groups
- Contingency Management (reinforcing positive steps towards desired behaviors - e.g., commitments giving group praise and recognition)
- Counter-conditioning (learning to substitute healthy behaviors for problem behaviors - e.g., group activities, outlets)

Stage 5 - Maintenance:
- Continue positive reinforcement and social support through:
  - Continuance of support groups
  - Institutionalization - e.g., through local organizations, of rewards and recognition for keeping commitments
  - Stimulus Control (removing triggers for unhealthy behaviors, role-playing to substitute prompts for healthy behaviors)
  - Maintain Self-efficacy (maintain confidence to resist temptations through regular discussions, accountability system)

Knowledge-Attitude Behavior Model
- Influencing health behavior through informational campaigns, followed by the expectation of attitude change and subsequent desired behavior changes is the basis for this health promotion model. The assumption is of correlations between information level and overt behavior or between attitude and overt behavior.

Health Belief Model
- Realistic model that incorporates cues to action (events prompting a desire to make a health change) and self efficacy (a person’s belief in their ability to make a change). It is a tool for predicting health behaviors, based on the theory that a person’s willingness to change their health behaviors is primarily due to the following factors:
  Factor 1 - Perceived Susceptibility:
People will not change their health behaviors unless they believe they are at risk (e.g., those who do not think they are at risk of acquiring HIV from unprotected intercourse, are unlikely to use a condom).

Factor 2 - Perceived Severity:
- The probability that a person will change his/her health behaviors to avoid a consequence depends on how serious he/she considers the consequence to be (e.g., if you are young and in love you are unlikely to avoid kissing your sweetheart if it might give you a cold, however you probably would stop kissing if it might give you Ebola).

Factor 3 - Perceived Benefits:
- It’s difficult to get people to change their health behavior if there isn’t something in it for them (e.g., people are unlikely to stop smoking if they don’t think their life will improve as a result in some way).

Factor 4 - Perceived Barriers:
- One of the major reasons that people don’t change their health behavior is that they think it is going to be hard. Sometimes it’s not just a matter of physical difficulty but social difficulty as well. Changing health behaviors can cost money, effort and time (e.g., if everyone from your office goes out drinking on Friday’s it may be difficult to cut down on your ETOH intake).

Theory of Reasoned Action (TRA):
- Examines the relationship between attitude and behavior with the focus on behavioral intentions rather than attitudes as the main predictors of behavior. According to this theory, attitudes toward a behavior (or more precisely, attitudes toward the expected outcome or result of a behavior) and subjective norms (the influence other people have on a person’s attitudes and behavior) are the major predictors of behavioral intention. TRA works most successfully when applied to behaviors that are under a person’s volitional control. The health-education implications of this theory allow one to identify how and where to target strategies for changing behavior (e.g., prevention of sexually-transmitted diseases and health fitness behaviors).

Bandura’s Social Cognitive Theory
- Based on the idea of vicarious learning - that people learn by observing others, with environment, behavior and cognition as the chief reciprocal factors in influencing development, and that human thought processes are central to understanding personality.

Health Appraisals address the following:
> Member demographics
> Personal health history, including chronic illness and current treatment
> Self-perceived health status
> Identification of effective behavioral change strategies
> Identification of special needs in the areas of hearing impairment, vision impairment and language preference
> Weight and Height
> Smoking
> Physical activity
> Healthy eating
> Stress
> Productivity or absenteeism
> Breast cancer screening
> Colorectal cancer screening
> Cervical cancer screening
> Influenza vaccination
> Risky drinking
> Depressive symptoms
Purpose: To promote health and wellness, Health Education and Promotion Programs must be made available to all members. It must be easily accessible and comprehensible to increase the members adherence to the program.

Policy:  
It is the policy of “X” Provider Organization to develop Health Education and Promotion Programs for its Disease Management (DM) programs.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will use the following data sources in developing the Health Education and Promotion Programs:
  - Self-Management Tools provide members with information on at least the following seven wellness and health promotion areas:
    - Healthy weight (BMI) maintenance
    - Smoking cessation
    - Encouraging physical activity
    - Healthy eating
    - Managing stress
    - Avoiding risky drinking
    - Identifying depressive symptoms
  - For each of the above required seven areas, “X” Provider Organization evaluates the Self-Management Tools for usefulness to members at least every 36 months, with consideration of the following:
    - Usability testing is required.
    - Usability testing with an external audience is not required if internal staff not involved in development of the Self-Management Tool, and shown to be reflective of the population for whom the Tool is meant, are used.
    - Evaluation methods include focus groups, cognitive testing and surveys that focus on specific Tools.
    - Examples of guidelines on usability testing for online Tools may be found at www.usability.gov.
    - Language is easy to understand
    - Member special needs, including vision and hearing
- “X” Provider Organization will demonstrate that it reviews its Self-Management Tools on the above referenced seven areas and updates them every two years, as appropriate.
  - Self-Management Tools must be based on current evidence in the industry.
  - The policy must state how the “X” Provider Organization initiates the review process when new evidence is published before the two-year review date.
- “X” Provider Organization will offer Self-Management Tools online, in print or by telephone for each of the required seven health areas in the scope of review:
  - Example of communication to members of availability to eligible members is:
- Materials describing available Self-Management Tools sent to eligible members.
- Example of an online modality is:
  - Screen shot of online mood log
- Examples of Self-Management Tools include
  - Interactive quizzes
  - Worksheets that can be personalized
  - Online logs of physical activity
  - Caloric intake diary
  - Portion size charts
  - Mood log

**Reference Sources:**
NCQA MEM 1.A,C, MEM 2.A.1-7

**Attachments:**
Health Education and Promotion Information
Health Education and Promotion

This is a guide to assist Provider Organizations with the basic principles associated with developing a robust Health Education program to compliment the Disease Management Program. It includes information detailing current educational resources and how they can be utilized.

Health education programs promote self awareness and responsibility, as well as the importance of developing healthier lifestyles. Benefits may include:

- Increased understanding of personal health, as well as improved compliance with treatment regimens.
- Increase in the early detection of chronic conditions.
- Decrease in costly and extensive services associated with chronic conditions.
- Enhanced patient satisfaction with the comprehensiveness of care received.
- Increase in patient’s confidence regarding the vital role they play in the maintenance and improvement of their own health.
- Positive exposure to a team approach to health care.

All of the above benefit the member, the Provider Organization, and the entire health care system. While the actual positive financial impact of these benefits can only be estimated, positive patient experiences are definitely ranked to patient retention and practice growth.

For information about Anthem services and programs, see the Anthem website.

Program Recommendations

To promote health and wellness, Health Education Programs must be made available to all members. It must be easily accessible and comprehensible to increase member’s adherence to the program.

It is beneficial for Provider Organization’s Health Education Department to collaborate with their Quality Management Department to ensure consistent QI and DM endeavors in Health Education Program effectiveness.

For Provider Organizations lacking the appropriate staffing to offer such programs, community organizations in your area may be able to assist you in providing programs. These organizations offer programs at little or no cost. You may also contact your contracted Health Plan about programs they may have available.

Suggested Topics for Health Education Programs

Health education programs can either be targeted for specific conditions or diseases, or directed to a healthy population. Because different communities may have different educational needs, a Provider Organization’s expertise and familiarity with their patient population is invaluable in appropriate topic selection.

Health Management Programs are secondary and tertiary prevention programs that target specific conditions or diseases. They are best suited for diseases that fall into the following categories:

1. High incidence
2. High treatment cost
3. High treatment variation among doctors
4. High health improvement potential

Health Management Programs use interventions that provide patients with the skills to manage and improve health status, as well as to prevent/decrease future complications. Emphasis is placed on self-management skills, appropriate medication usage, and physician partnering. These programs also promote the most recent acceptable clinical guidelines to providers to educate them about proper management of a patient’s condition.

Health Management Programs follow a four-step process:
1. **Identification** – Members can be identified through utilization data (i.e. emergency room visits, hospitalizations, medications usage, health risk appraisal results, physician referral, or patient referral).

2. **Stratification** – Once the member is identified, the program evaluates the patient to determine their level of risk. This should be done using a pre-determined set of clinical guidelines developed by a national organization (i.e. National heart, Lung and Blood Institute). If there are no national guidelines, Provider Organization clinicians or contracted health plan should be consulted to determine clinically sound risk levels.

3. **Intervention** – Program interventions should be implemented consistent with the patient’s risk level. Patients at high risk require more intense interventions. For example, a well controlled asthmatic may receive educational mailers, while an asthmatic that frequents the emergency room because of asthma attacks may benefit from one-on-one counseling with a nurse.

4. **Outcomes Measurement** – Outcomes should be measured to show the effectiveness of program interventions. Measurable outcomes include changes in utilization, medication usage, and self management skills.

Examples of health management programs include:

- Arthritis Management
- Asthma Management
- Cholesterol Management
- Congestive Heart Failure Management
- Diabetes Management
- Hypertension Management
- Depression Management

**Preventive Health Education Programs** are those programs that are designed to increase awareness about health and the important role the individual plays in disease prevention. Many lifestyle related diseases and conditions, such as heart disease, can be prevented by an individual making changes in his/her lifestyle. Examples of health education programs include:

- Back Care
- Breast Feeding
- Breast Health
- Cancer Awareness
- CPR
- Fitness
- Heart Health
- Men's Health Issues
- Nutrition
- Pediatric Health Issues
- Personal Safety
- Mental Health
- Senior Health Issues
- Smoking Cessation
- Stress Management
- Weight Management
- Women's Health Issues

**Self-Management Tools** are offered to members to help them stay healthy and manage risk. Self-Management Tools provide members with information on at least the following seven wellness and health promotion areas:

- Healthy weight (BMI) maintenance
- Smoking cessation
- Encouraging physical activity
- Healthy eating
- Managing stress
- Avoiding risky drinking
- Identifying depressive symptoms

**Evaluation of Self-Management Tools.** For each of the above required seven areas, the Provider Organization evaluates the Self-Management Tools for usefulness to members, with consideration of the following:

- Usability testing is required. Usability testing with an external audience is not required if internal staff not involved in development of the Self-Management Tool, and shown to be reflective of the population for whom the tool is meant, are used.
- Evaluation methods include focus groups, cognitive testing and surveys that focus on specific Tools.
- Examples of guidelines on usability testing for online Tools may be found at www.usability.gov.
  - Language is easy to understand
  - Member special needs, including vision and hearing

**Review and update of the Self-Management Tools.** The Provider Organization demonstrates that it reviews its Self-Management Tools on the above referenced seven areas and updates them every two years, as appropriate.

- Self-Management Tools must be based on current evidence in the industry.
- The policy must state how the Provider Organization initiates the review process when new evidence is published before the two-year review date.

**Self-Management Tools** are offered online for each of the required seven health areas in the scope of review:

- Example of communication to members of availability to eligible members is:
  - Materials describing available Self-Management Tools sent to eligible members.
  - Example of an online modality is:
    - Screen shot of online mood log

**Attachments:**
Refer to the attached Sample Health Education and Promotion Policy.
Purpose: Health Information Line is offered to assist members with wellness and prevention of illness.

Policy: It is the policy of “X” Provider Organization to offer Health Information Line access to members.

Responsibility: CM/DM Department Staff

Procedure:
- “X” Provider Organization’s Health Information Line is staffed by Registered Nurses or clinicians with the ability to respond to a broad range of health-related questions.
- “X” Provider Organization’s Health Information Line availability, response and information exchange meets the following:
  - Available 24 hours a day by telephone (callers interact with a live person)
  - If a live answering service is utilized for after-hours calls, the answering service informs callers that “X” Provider Organization will return the call within a reasonable time frame (e.g., within one hour)
  - Available via secure transmission of electronic communication with safeguards and with 24-hour turnaround time
    - HIPAA safeguards must be utilized (e.g., safeguards for electronic transmissions)
    - The Health Information Line provides interpretation services for members by telephone
- “X” Provider Organization’s Health Information Line capabilities:
  - Staff utilize the Health Information Line to follow-up on specified cases and contact members
  - Staff utilize the Health Information Line to link member contacts to a contact history
- “X” Provider Organization monitors the Health Information Line by:
  - Tracking telephone and Web statistics at least monthly
  - Tracking member use of the Health Information Line at least quarterly
  - Evaluating member satisfaction with the Health Information Line at least annually
  - Monitoring calls periodically for both daytime and after-hours services
  - Analyzing data at least annually and, if applicable, identifying opportunities and establishing priorities for improvement

Reference Sources:
NCQA MEM 7.A.1-3,7.C

Attachments:
None
**Purpose:**
To identify chronic conditions for Disease Management Programs.

**Policy:**
It is the policy of "X" Provider Organization to annually identifies two chronic conditions that its DM Programs address from available member population health status data (e.g., Health Appraisal).

**Responsibility:** DM Department Staff

**Procedure:**
- "X" Provider Organization will annually evaluate member health data to identify two chronic conditions.

**Reference Sources:**
NCQA QI 8C

**Attachments:**
None
Purpose:
To identify members who qualify for the CCM program.

Policy:
It is the policy of “X” Provider Organization to utilize multiply avenues to proactively identify members for the CCM program.

Responsibility: CCM Department Staff

Procedure:
- “X” Provider Organization will identify members that qualify for the CM program with the following:
  - Claim or encounter data
  - Hospital discharge data
  - Pharmacy data
  - Data collected through the Utilization Management process
  - Data supplied by purchasers:
    - Data supplied by health plan
    - Data supplied by employers
  - Data supplied by members
  - Data supplied by care givers
  - Data supplied by practitioners

Reference Sources:
NCQA QI 7.B.1-7

Attachments:
Sample CM Introduction Letter
Sample: Case Management Introduction ("Welcome") Letter

Provider Organization Name
Address

«firstname» «lastname»
«address1» «address2»
«city», «state» «zip»

Member Name: ______________________
Date of Birth: ______________________
Identification Number: ______________________

Dear «firstname» «lastname»:

Welcome to Case Management!

This letter serves as an introduction of case management services that have been identified on your behalf by <Insert Provider Organization’s Name>. It also confirms your agreement to participate in our Case Management Program. Case Management is a voluntary program designed to help you coordinate health care benefits for your medical conditions or chronic care needs with a goal to help improve your health. Case management services are provided at no additional cost to you.

Licensed health care professionals trained in Case Management and familiar with your benefit plan provide these services. I have been assigned as your Case Manager. My role is to help you and your health care providers optimize your health care benefits. I will work with you and your physician as needed to develop a Case Management Plan that is designed to help meet your needs by using available benefits and resources.

I will stay in contact with you by telephone on a periodic basis. If you have any questions or needs regarding your Case Management Plan, please call me at the number below. You may receive written notifications of Case Management actions and recommendations, such as when a significant change occurs in your care management plan. To assist you with the coordination of health care services, there may be times when certain information needs to be shared with your treating physician or other health care provider.

Please take a moment to read over the attached Member Bill of Rights. Please sign and return the last page of this letter to the address noted on the form within 7 calendar days.

If you would like to give us permission to speak to your family or friends about your case management plan, please ask us for a HIPAA Authorization form.
If you have any questions about the Case Management Program, how you were selected for Case Management services, or reasons for ending Case Management services, please contact me at the number or address listed below. If you have complaints or concerns regarding services provided under the Case Management Program, call the Case Management Department at <insert phone number and hours of operation>.

Sincerely,

Case Manager
Title
Address
Phone #

Enclosures
Member Bill of Rights
Agreement to Participate in the Case Management Program Consent
<Insert Provider Organization Name> Case Management Program

Member Bill of Rights

As a member of <Insert Provider Organization Name>, you have the right to:

- Confidentiality and privacy of health information in accordance with state and federal law.
- Be understood and treated well, even if you have limited English skills, a different cultural background, or a disability.
- Receive information in a language or method you can understand.
- Take part in decisions about your health care treatment with your doctor.
- Designate or authorize another party to act on your behalf.
- Have your advance medical directives (living will and/or medical power of attorney) respected and honored by your health care provider(s).
- Express concerns and complaints about care and services you receive.
- File a complaint without fear of reprisal.

As a participant in <Insert Provider Organization Name> Case Management Program, you have the right to:

- Have Case Management services provided with respect and dignity, and without discrimination.
- Provide input to the Case Management Plan developed by the Case Manager to address your identified health care needs.
- Receive a copy of your Case Management Plan upon request.
- Know and understand the reasoning for selecting cases for Case Management and for ending or closing Case Management services.
- Question how decisions are made regarding your eligibility for Case Management services.
- Receive notification when Case Management services are changed or terminated and the reason(s) why.
- Be informed of choices regarding Case Management services.
- To have others involved in your care to participate in the Case Management assessment.
- Refuse or disenroll from Case Management services, with an explanation provided to you on the implications of refusal in relation to your benefits and health conditions.
Agreement to Participate in the Case Management Program

Please sign and return this page to:
<Insert Provider Organization Name>
Address
City, State, Zip
or
Fax this page to (xxx) xxx-xxxx
or
Scan and e-mail to

- I agree to participate in the Case Management Program offered by <Insert Provider Organization Name>.
- I understand that it is a voluntary program provided at no additional cost to me.
- I have read this letter and understand the information in it.
- I have also read and understand the information listed in the “Member Bill of Rights” section of this letter.

Member’s Name (Please Print): ______________________________________________

Member’s ID Number: _________________ Date of Birth: _________________

Phone Number: __________________________ Best Date/Time to Call: __________

Member’s Signature:
_________________________________________ Date: __________________

Authorized Representative (Complete Only If Applicable)

Name of Authorized Representative (Please Print): __________________________

Relationship to Member: __________________________________________________

Signature of Authorized Representative:
_________________________________________ Date: __________________
Purpose:
To identify members who qualify for the DM program.

Policy:
It is the policy of “X” Provider Organization to utilize multiply avenues to identify members for the DM program.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will identify members that qualify for the DM program with the following:
  - Claim or encounter data
  - Pharmacy data
  - Laboratory results, if applicable
  - Member and Practitioner Referrals
  - Health Appraisal Results
  - Data collected through the UM process, case management process or care management process
  - Data from health management, wellness or health coaching programs
  - Information from Electronic Health Records (EHR)
- “X” Provider Organization will systematically identify members on a monthly basis.
- Members will be provided with the following information about the DM program.
  - How to use the services
  - How members become eligible to participate
  - How to opt in or opt out
- “X” Provider Organization provides interventions to DM Program members based on disease stratification and assessment.
- “X” Provider Organization uses its member identification efforts to provide the following activities to support member wellness:
  - Member-specific reminders for needed care based on condition or risk factor
  - Member-specific reminders about missed services
  - Information about evidence-based care guidelines and diagnostic and treatment options
  - Automated member-specific outreach with links to Web-based Self-Management Tools
  - Information about community based resources
  - Information about Affinity Programs, if applicable

Reference Sources:

Attachments:
Sample DM Welcome Member Letter
NCQA Stratification Example
Sample DM Welcome Member Letter

“X” Provider Organization welcomes you to the Diabetes Management Program. The program will help you better understand your condition, update you on new information about diabetes and provide you with assistance from health professionals to help you manage your health. You do not have to join the program. You are eligible to participate in this program because [insert eligibility criteria].

The Diabetes Management Program is staffed by physicians, nurses and other health care professionals who understand diabetes. They will work with you and keep your doctor informed of your condition and services we are providing you. Program members are entitled to:

- Support from our nurses and other health care staff to make sure you understand the best ways to manage your condition and periodically evaluate your health status.
- Periodic newsletters to keep you informed of the latest information on diabetes and diabetes management.
- Educational materials that can help you understand and manage your medications and plan visits to your doctor, and which give you information on upcoming events such as health fairs.

Your membership in the Diabetes Management Program is voluntary. If at any time you wish to stop participating in the program, just call us at [Provider Organization Phone Number]. We look forward to serving you and helping you stay as healthy as possible.
Stratification

Example:

The organization could use the following classification system to stratify its asthma patient population.

- Step Therapy in Children With Asthma (Refer to the Guidelines for the Treatment and Management of Asthma, National Heart, Lung and Blood Institute [NHLBI])

<table>
<thead>
<tr>
<th>Classification of Asthma Severity</th>
<th>Clinical Features Before Treatment*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong> **</td>
<td></td>
</tr>
<tr>
<td><strong>Step 4: Severe Persistent</strong></td>
<td>• Continual symptoms</td>
</tr>
<tr>
<td></td>
<td>• Limited physical activity</td>
</tr>
<tr>
<td></td>
<td>• Frequent exacerbations</td>
</tr>
<tr>
<td><strong>Step 3: Moderate Persistent</strong></td>
<td>• Daily symptoms</td>
</tr>
<tr>
<td></td>
<td>• Daily use of inhaled short-acting beta 2-agonist</td>
</tr>
<tr>
<td></td>
<td>• Exacerbations affect activity</td>
</tr>
<tr>
<td></td>
<td>• Exacerbations ≥2 times a week; may last days</td>
</tr>
<tr>
<td><strong>Step 2: Mild Persistent</strong></td>
<td>• Symptoms &gt;2 times a week but &lt;1 time a day</td>
</tr>
<tr>
<td></td>
<td>• Exacerbations may affect activity</td>
</tr>
<tr>
<td><strong>Step 1: Mild Intermittent</strong></td>
<td>• Symptoms ≤2 times a week</td>
</tr>
<tr>
<td></td>
<td>• Asymptomatic and normal PEF between exacerbations</td>
</tr>
<tr>
<td></td>
<td>• Exacerbations brief (from a few hours to a few days); intensity may vary</td>
</tr>
</tbody>
</table>

* The presence of one of the features of severity is sufficient to place a patient in that category. An individual should be assigned to the most severe grade in which any feature occurs. The characteristics noted in this figure are general and may overlap because asthma is highly variable. Furthermore, an individual’s classification may change over time.

** Patients at any level of severity can have mild, moderate or severe exacerbations. Some patients with intermittent asthma experience severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.

Interventions based on stratification

For asthma, follow NHBLI recommendations for treatment and education, plus the following.

- **Severe Persistent**: At least one home visit, more frequent doctor visits, frequent follow-up phone calls
- **Moderate Persistent**: Home visit, periodic doctor visits, some follow-up calls depending upon severity of exacerbations
- **Mild Persistent**: Doctor visit, follow-up calls depending upon severity of exacerbations
- **Mild Intermittent**: Doctor visit, follow-up letter

Reference Sources:
NCQA QI 8.F
Purpose:
To integrate member information from multiple systems.

Policy:
It is the policy of “X” Provider Organization to integrate member information from a multiple systems.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will integrate information from the followingsystems:
  - Disease Management Program
  - Case Management Program
  - Utilization Management Program, if applicable
  - Health Information Line
  - Wellness Program, if applicable

Reference Sources:
NCQA QI 8.H

Attachments:
None
Purpose:
Provide practitioners with written information about the DM Program.

Policy:
It is the policy of “X” Provider Organization to provide practitioners with information about the DM Program.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will supply practitioners with information that includes instructions on how to use DM services.
- Information will include how “X” Provider Organization works with a practitioner’s patients in the DM Program.
- Information is distributed by one of the following methods:
  - In writing, by mail, fax or e-mail
  - On the Web, if practitioners are notified via fax, e-mail or mail that the information is available on the Web site

Reference Sources:
NCQA QI 8.G

Attachments:
Sample Practitioner Introduction Letter
DM Practitioner Introduction Letter

“X” Provider Organization This is a letter of introduction to a new disease management program available to your patients with diabetes. “X” Provider Organization has developed the Diabetes Management Program to assist your patients with diabetes to better understand their condition, update them on new information about diabetes and provide them with assistance from our staff to help them manage their disease. The program is designed to reinforce your treatment plan for the patient.

Members of “X” Provider Organization do not have to enroll; they are automatically enrolled when we identify them as diabetics. We will inform you of their participation. If you would like to enroll diabetic patients who are “X” Provider Organization members but are not in the program, please let us know.

The program will provide the following services.

- Support from our nurses and other health care staff to ensure that your patients can understand how to best manage their condition and periodically evaluate their health status.
- Periodic newsletters to keep the patients informed of the latest information on diabetes and diabetes management.
- Educational and informational materials that can assist your patients in understanding and managing the medications you prescribe, how to effectively plan for visits to see you and reminders as to when those visits will occur.
- Information about upcoming events such as health fairs.
- We will also provide you with updates on the results of tests or other information that we collect on your patients. Membership in the Diabetes Management Program is voluntary. If at any time your patients wish to stop participating in the program, they need only call.

Reference Sources:
NCQA QI 8.G

Revised 10/29/2015
Patient Safety

A description of the process for improving patient safety in clinical care must be included as part of the Disease Management Program.

Examples of DM Activities to improve patient safety include:

- Analyze and take action on complaints, inquiries, compliments and satisfaction data that relate to clinical safety
- Implement DM Programs that include follow-up systems to ensure that care is received in a timely manner
- Implement pharmaceutical management practices that require safeguards to enhance patient safety
- Evaluate clinical practices against aspects of evidence-based practice guidelines that improve safe practices
- Improve continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes
- Improve continuity and coordination of care between sites of care, such as hospitals and nursing homes, to ensure timely and accurate communication
- Track and trend adverse-event reporting to identify system issues that contribute to poor safety
- Distributing information to members that improves their knowledge about clinical safety in their own care, such as: questions to ask surgeons prior to surgery, questions to ask about drug to drug interactions, or research findings that facilitate decision making
- Distributing to members information that facilitates informed decisions based on safety such as facilities with computerized pharmacy order-entry systems, hospitals that use physicians specially trained in intensive care, organizations that have best practices or outcomes based on volume or pharmacies that provide patient counseling and research on proven safe clinical practices
- Collaborating with network providers and practitioners to distribute research on proven safe clinical practice (e.g., improving medical record legibility, establishing systems for timely follow-up of lab results), combine data on adverse outcomes or polypharmacy issues, distribute research on proven safe clinical practice, or develop incentives for achieving safer clinical practices
- Conduct in-service training focused on improving knowledge of safe practices (e.g., improving medical record legibility; establishing systems for timely follow-up of lab results)
- Combine data on adverse outcomes or polypharmacy issues
- Distribute research on proven safe clinical practice
- Develop incentives for achieving safer clinical practices
Purpose:
To proactively assess and identify appropriate members for the CCM Program utilizing multiple data sources.

Policy:
It is the policy of “X” Provider Organization to annually assess the characteristics and needs of the member population, including the needs of special populations and identify appropriate members for the CCM Program.

Responsibility: CCM Department Staff

Procedure:
- “X” Provider Organization annually assesses the characteristics and needs of the member population and relevant subpopulations.
- “X” Provider Organization annually assesses the needs of children and adolescents
- “X” Provider Organization annually assesses the needs of individuals with disabilities
- “X” Provider Organization annually assesses the needs of individuals with serious and persistent mental illness
- Annually, “X” Provider Organization reviews and updates the case management processes to address member needs, if necessary.
- Annually, “X” Provider Organization reviews and updates all case management resources to address member needs, if necessary.
- “X” Provider Organization uses the following data sources to proactively identify appropriate members for case management:
  - Claim or encounter data
  - Hospital discharge data
  - Pharmacy data
  - Data collected through the Utilization Management process
  - Data supplied by the Health Plan or employer
  - Data supplied by member or caregiver
  - Data supplied by practitioner

Reference Sources:
NCQA QI 7.A-B

Attachments:
None
Preventive Health Guidelines

It is the responsibility of the Provider Organization to provide timely and appropriate preventive health care to members. Preventive Care Guidelines addressing prevention or early detection interventions, and recommended frequency and conditions under which interventions are required, for all age and sex categories, should be developed based on recommendations of appropriate practitioners or nationally recognized organizations. Preventive Care Guidelines should be reviewed and approved, and updated as necessary, and at least annually by the Case/Disease Management Committee. The Provider Organization initiates review of guidelines when new national standards are published before the annual review date. Preventive Care Guidelines will be distributed to all contracted practitioners and members. Performance is measured annually via participation in the HEDIS project.

Anthem does not require Provider Organizations to write up a Policy and Procedure for Preventive Health Guidelines. Areas that the Provider Organization should implement for Preventive Health Guidelines are:

- Guidelines should be developed for Ages 0 through 65 and over, and for pregnant women.
- Guidelines should address primary and secondary prevention for populations identified as being at high risk for certain health problems.
- Guidelines should include the scientific basis or authority upon which they are based (i.e. US Preventive Services Task Force, the American Academy of Pediatrics or Anthem).
- Appropriate practitioners should be involved in the development or review of preventive care guidelines.
- The Provider Organization should identify specific members who, according to demographic or other identifiable health factors, may be at risk for specific health problems, and urges these members to use appropriate health promotion and prevention services.
- Preventive Care Guidelines for Medicare members must be consistent with Health Care Financing Administration (sources may include US Preventive Health Taskforce, CDC, AAFP, NCI, Anthem, American College of Physicians).
- To monitor practitioner’s compliance and to ensure that preventive care is being offered to all members, the Provider Organization will participate in annual HEDIS project and results of the HEDIS project will be reported to the Quality Management Committee.
- The Provider Organization should identify opportunities for improvement and will implement corrective action plan/interventions. A re-assessment will be conducted to measure the effectiveness of those interventions.
- Anthem Preventive Care Guidelines may be downloaded at: [http://www.anthem.com/ca/provider/f2/s2/t1/pw_a118331.pdf](http://www.anthem.com/ca/provider/f2/s2/t1/pw_a118331.pdf). To obtain a hard copy of the above listed preventive care guidelines, please call (877) 273-4189.
Purpose: To ensure the ability for access to complex case management.

Policy: "X" Provider Organization must have the ability to receive referrals for complex case management from the following sources:

- Discharge planner referral
- Disease Management (DM) Program referral
- Health Information Linereferal
- Member or caregiver self-referral
  - Facilitates member self-referral by communicating the availability of complex case management programs and contact information (e.g., telephone numbers) to members
  - Information may be communicated using printed materials or published on Provider Organization’s Web site.
- Practitioner referral
  - Facilitates practitioner referral by communicating the availability of complex case management programs and contact information (e.g., telephone numbers) to practitioners
  - Information may be communicated using printed materials or published on Provider Organization’s Web site.
- Utilization Management Referral

Reference Sources:
NCQA QI 7.C

Attachment(s):
None
Satisfaction with Complex Case Management/Disease Management Program

At least annually, satisfaction with case management/disease management programs will be evaluated by analyzing member complaints specific to the complex case management/disease management process and obtaining feedback from members via a member satisfaction survey or focus survey groups in order to improve member satisfaction and the overall quality of the program.

Questions for member feedback may include information about:

- The overall CCM/DM Program
- The CCM/DM Program staff
- The usefulness of the CCM/DM information disseminated by the Provider Organization
- The member’s ability to adhere to recommendations

Specific requirements regarding the survey:

- Member feedback must be specific to CCM programs being evaluated.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) and other general survey questions are not allowed to be used.
- Feedback must be from a broad sample of members, not only those who contact the Provider Organization to share feedback.
- Satisfaction surveys may be conducted at the corporate or regional level; however, the results must be stratified at the accreditable entity level for analysis and determination of actions.
- Analysis must consider quantitative and qualitative data to identify patterns of member comments.

Reference Sources:
NCQA QI 7.H, QI 8.I

Attachments:
None
Purpose:
To offer a Wellness Program to promote member wellness and prevention of illness and measure access to wellness and prevention services.

Policy:
It is the policy of “X” Provider Organization to offer a Wellness Program to DM members.

Responsibility: DM Department Staff

Procedure:
- “X” Provider Organization will use the following data sources to identify members eligible for wellness activities following:
  - Claims or encounter data
  - Pharmacy data, if applicable
  - Health Assessment (HA) results
  - Data collected through the Utilization Management (UM) process, if applicable
- “X” Provider Organization will use its member identification efforts to provide the following activities to support member wellness:
  - Member specific reminders for needed care based on condition or risk factor
  - Member specific reminders about missed services
  - Information about evidence based care guidelines and diagnostic and treatment options
  - Automated member specific outreach with links to Web based Self-Management Tools
  - Information about community based resources
  - Information about Affinity Programs
- “X” Provider Organization encourages member health by:
  - Offering incentives to members for completing comprehensive HAs
  - Offering incentives to members for accessing guideline appropriate care
  - Offering incentives to members for using disease specific, Web based tools
  - Measuring the effectiveness of its efforts at least annually

Reference Sources:
NCQA MEM 8.A.1-4, B.1-6, C.1-4

Attachments:
None