Quality Improvement

Oversight of Contracted Vendors
Guidelines for Treating Tobacco Use and Dependence
Guidelines for the Diagnosis and Management of Asthma
Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus
Guidelines for the Diagnosis and Treatment of Patients with Depression in the Primary Care Setting
BCBSIL Clinical Practice Guidelines
Shared Decision-Making
Guidelines for Heart Failure in the Adult
Guidelines for Primary and Secondary Prevention of Atherosclerotic Cardiovascular Disease
Preventive Health Care Guidelines
Screening Adults for Depression Clinical Practice Guideline
Provider Manual
Quality Improvement
POLICY:

The HCM Quality and Research Department is responsible for conducting oversight of services Blue Cross and Blue Shield of Illinois (BCBSIL) delegates to Contracted Vendors. These delegated services include, but are not limited to:

- Credentialing
- Quality Improvement
- Utilization Management/Case Management
- Member Rights and Responsibilities
- Member Connections

This policy applies to oversight performed for HMO products on all delegated services to contracted vendors. This policy also applies to the oversight of delegated services for PPO/FEP products for the following vendors:

- Mental Health (Magellan)
- Prescription Drug (Prime Therapeutics)

PURPOSE/OBJECTIVES:

To ensure that members are receiving care and service across all networks that are performed in accordance with contract requirements and mutually agreed upon standards, including but not limited to, URAC Utilization Management standards, URAC Case Management Organization Standards (if applicable), and the National Committee for Quality Assurance (NCQA) standards.

GUIDELINES:

The following are required of a Contracted Vendor:

- A dated and signed contract, business associate agreement and delegation agreement clearly defining reporting and performance expectations for both BCBSIL and the Contracted Vendor

- Annual submission of all policies and procedures including but not limited to, confidentiality policy, complaint and appeal policy and credentialing/recredentialing policy, if applicable

- All Contracted Vendors must attend and present semi-annually at the Managed Care Quality Improvement Committee meetings. (BCBSIL reserves the right to periodically participate in Contracted Vendors’ Quality Improvement Committee meetings.)

The following defines the required components of each delegated service. All or some services may be delegated; therefore those not delegated are not applicable for evaluation and scoring purposes as defined by the contracted vendor’s delegation agreement.
1. Where Quality Improvement is delegated, the following are required:
   - Submission of an annual Quality Improvement Program Description
   - Submission of an annual Quality Improvement Plan listing annual goals and/or objectives
   - Annual submission of QI Program evaluation
   - Submission of quarterly and annual reports, which document activities and results for all delegated activities (Credentialing, Quality Improvement, Utilization Management/Case Management, Member Rights and Responsibilities)
   - Quarterly submission of Quality Improvement Committee minutes
   - Annual submission of member and provider satisfaction survey results (if applicable)

2. Where Utilization/Case Management is delegated, the following are required:
   - Submission of a Utilization Management Program Description and Case Management Program Description (if applicable)
   - Quarterly submission of Utilization Management statistics and Case Management statistics (if applicable)
     Utilization Statistics will include:
     - the number of UM cases handled by type (pre-service, urgent concurrent, or post-service) and by service (inpatient or outpatient),
     - number of denials made,
     - number of cases appealed
   - Undergo an annual onsite audit conducted by BCBSIL to review UM and CM files (If the Contracted Vendor is URAC and/or NCQA accredited, the required level of oversight is reduced. No annual onsite evaluation is required as long as the Contracted Vendor remains NCQA and/or URAC accredited.)
   - Provide a copy of the Contracted Vendor’s URAC and/or URAC Case Management accreditation award, if accredited.

3. Where Member Rights and Responsibilities is delegated, the following are required:
   - Quarterly submission of member complaint data by number, type and action taken and turn around times
   - Quarterly submission of member appeal data by number, type and disposition and turn around times
   - Quarterly submission of telephone statistics including average speed of answer and call abandonment rate
   - Submission of copies of member communications such as Member Newsletters, brochures, etc. (if available)

4. Where Credentialing/Recredentialing are delegated, the following are required:
   - Annual submission of a roster of practitioners and providers credentialed and recredentialed
   - Annual submission of quality onsite visit standards, tools and network summary report
   - Analysis of data
   - Credentialing Committee meeting minutes
5. **Where Member Connections is delegated, the following are required:**

- **Web Site and Pharmacy Benefit Updates**
  - Annual submission of policy and standard operating procedure
  - Submission of screenshots of Web site functionality
  - Documentation of formulary changes
- **Telephone**
  - Annual submission of training modules used by Member Services
- **Web site functionality and Telephone training modules will include:**
  - Estimation of financial responsibility for pharmaceuticals
  - Exception process
  - Mail-order prescription refill
  - Location of in-network pharmacy
  - Conduct a proximity search by zip code
  - Determine potential drug-drug interactions
  - Determine a drug’s common side effects and significant risks
  - Availability of generic substitutes
- **QI Process on Accuracy of Information: Website and Telephone**
  - Annual submission of policy and standard operating procedure
  - Quarterly submission of audit results. Audit will include:
    - Estimation of financial responsibility for pharmaceuticals
    - Exception process
    - Mail-order prescription refill
    - Location of in-network pharmacy
    - Conduct a proximity search by zip code
    - Determine potential drug-drug interactions
    - Determine a drug’s common side effects and significant risks
    - Availability of generic substitutes
PROCEDURE

1. The HCM Quality & Research staff will review the vendor’s policies, procedures and all required submissions prior to delegation.

2. The BCBSIL HCM Quality & Research staff reviews the required submissions from the Contracted Vendor for compliance with BCBSIL criteria and provides the Contracted Vendor with the results of the audit. The results of the audit are presented semi-annually at the Managed Care QI Workgroup and semi-annually at the Managed Care QI Committee for feedback, recommendations, and approval where applicable.

   • The Contracted Vendor is required to respond to areas of deficiency within 30 days. The oversight review tools include mechanisms for corrective action and follow-up requests. Non-compliance requires a corrective action plan or response within 30 days of receipt of the audit results. Failure to provide the requested information or to implement a corrective action plan may result in further action including termination as specified in the Delegation Agreement.

   Any follow-up or necessary action that needs to be taken relating to the above items will be documented by the BCBSIL HCM Quality & Research staff and reviewed by the Managed Care QI Committee.

3. Where Case Management is delegated, HCSC staff will conduct an onsite audit annually to assess compliance with URAC CM standards, if applicable. The Contracted Vendor will be provided with the results of the audit. The results of the audit are presented at the QI Workgroup and at the Managed Care QI Committee for feedback and recommendations. If the Contracted Vendor is URAC and/or NCQA accredited, the required level of oversight is reduced. No annual onsite evaluation is required as long as the Contracted Vendor remains NCQA and/or URAC accredited.

   • The Contracted Vendor is required to respond to areas of deficiency within 30 days. The oversight review tools include mechanisms for corrective action and follow-up requests. Non-compliance requires a corrective action plan or response within 30 days of receipt of the audit results. Failure to provide the requested information or to implement a corrective action plan may result in further action including termination as specified in the Delegation Agreement.

   • Any follow-up or necessary action that needs to be taken relating to the above items will be documented by the BCBSIL HCM Quality & Research staff and reviewed by the Managed Care QI Committee.

4. The BCBSIL HCM Quality & Research staff and the Network Management Staff will assess and monitor the effectiveness of communication and coordination of processes between BCBSIL and the Contracted Vendor. Meetings may be conducted with the vendor to discuss items such as:

   • Compliance with the applicable standards
   • Clinical and service quality improvement projects/activities
   • Performance and plans for improvement related to annual goals and objectives
   • Member complaint and appeal issues
   • Findings from case management files
   • Communication with vendors may be done via phone, fax, e-mail, regular mail, or electronically
*See Attachments 1-6 for audit tools used to assess the above. Applicable attachments are provided on an as-needed basis.

- UM Program Description Evaluation (Annual)
- QI Program Description Evaluation (Annual)
- Annual Report Review
- Delegated Submissions Tool (Quarterly)
- Delegated FEP Case Management Record Audit Tool (Annual, if not URAC Accredited)
- Delegated Case Management Audit Tool (Annual, if not URAC Accredited)
2009 Annual and Prospective UM Plan Compliance Report for the HMOs* of BCBSIL

IPA Name: ______________________ # of Revisions until Passing: ____________
Initial Review Date: ____________ Passing Date: ______________
Reviewer: ______________________

BOLDED ITEMS LISTED ARE NEW

STANDARDS FOR 2009

UM PROGRAM / PLAN

☐ 1. The UM Plan is reviewed and revised yearly with acceptance documented in UM Committee Meeting Minutes
   Must state that the UM Plan is reviewed, revised and approved on an annual basis. Must include case management (cm) as noted in multiple sites in the HMO UM plan. Must be approved through the UM Committee. Must include behavioral health or submit BH UM Plan.

☐ 2. Scope and Goals includes objective and purpose of IPA UM Program
   (specific goals must be identified).

☐ 3. Description of MG process for its UM Plan development (including staff involved in review, revision and final approval) and submission to the HMO by the required date. Description of UM Committee structures, meeting schedule and physician representation, including specialist representation. Include list of membership.

☐ 4. UM Staff and accountability includes responsibilities of and staff level for
   a) Medical Director
   b) Physician Advisor
   c) List of Board Certified Specialist/Consultant, including BH practitioners
   d) UM Coordinator

☐ 5. Description of Services that are delegated including CMF, hospital UR department, Behavioral Health/ Mental Health facility or group
   a) Discussion, documentation of approval of delegate’s UM Plan annually
   b) Description of BH aspects of UM Program
   c) Review, approval, submission to HMOs the BH UM Plan

☐ 6. Nationally recognized medical criteria selected by the MG for medical necessity review and LOS determinations. Include process for any

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additional criteria, guidelines, etc. Must be current version. Document the process for selection, approval, application, and annual process for criteria update and review (including BH) 12, 14 Pg ______

Describe your process for notifying practitioners of the availability, method of requesting the criteria and format in which it will be provided. Include any additional criteria. A sample of this annual written statement is to be attached. 15 Pg ______

Describe your process and information utilized in making medical necessity and benefit determinations 15 Pg ______

Describe your process if nationally recognized criteria is not available and additional criteria created by the IPA is utilized Board certified specialist, including BH must be available as needed to assist in making determinations and approving criteria. 13 Pg ______ making criteria.

Include reference to BH for criteria. Include approval process through committee. If additional MG criteria is used, must describe process for selection, approval and include in statement to practitioners. Include process for notifying practitioners of criteria availability. Attach sample. Describe process for review determinations and information utilized in making decisions. Describe process for use of consultants in decision-making.

☐ 7. Description of process for UM reviews performed on-site at facilities. 12 Pg ______

Must include the following:

a) Guidelines for identification of IPA staff at the facility in accordance with facility policy 12 Pg ______

b) Process for scheduling the on-site reviews in advance 13 Pg ______

c) A process for ensuring that IPA staff follow facility rules 13 Pg ______

d) Hospitalist program, if applicable 13 Pg ______

Include all components in description, if applicable. Include hospitalist program, if applicable. If hospitalist program, Hospitalist / PCP signatures must be provided prior to the audit.) If no on-site review is performed, this must be documented.

IPA PHYSICIAN and UM STAFF

☐ 8. An annual list of all Medical Directors, Physician Advisors, RNs, LPNs is to be submitted in the UM Plan (include license numbers for physicians and RNs). 14 Pg ______

Must include license numbers to be verified in HMO credentialing or by the HMO. Physician and Registered Nurse licenses must be submitted to the HMO annually.

☐ 9. Written job descriptions with qualifications for practitioners who review denials, including a behavioral health practitioner job description. 13, 14, 15 Pg ______

The job description must include the responsibilities for that position. Page 13 of HMO UM plan under Medical Director a), include “supervises all UM decision-making and CM activities.” Must include a job description for at least one BH (in BH or IPA plan).

☐ 10. All physicians practicing/participating within an IPA must be currently licensed to practice medicine in the state of practice and must be currently credentialed by BCBSIL. 14 Pg ______

Include this statement in plan.

☐ 11. Written procedures for training, orientation and ongoing performance monitoring of clinical and non-clinical utilization staff submitted annually 14 Pg ______

Must state somewhere in Plan and be a policy and procedure. Must include performance monitoring.
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12. Inter-rater reliability criteria testing semi-annually for UM decision makers (including PA, Medical Directors, and UM staff)

Statement of performing inter-rater semi-annually for all parties listed – peer to peer review.

Every physician and UM staff member involved in UM decision-making must be included in the testing.

13. Affirmation statement distributed to all staff involved in UM decision making including a statement regarding conflict of interest.

Include the statement with all components. Does not need to be signed. Must be distributed annually. Does not need to be distributed to all existing members, as HMO will distribute via a newsletter. Must be distributed to all new members via memo, welcome letter. A general posting in PCP office meets this requirement.

ACCESS TO IPA STAFF

14. The IPA must provide the following communications services for practitioners and members:

a) at least 8 hrs a day, during normal bus. hrs, staff must be available for inbound calls regarding UM issues;

b) UM staff must have the ability to receive inbound after business hrs communication regarding UM issues;

c) there must be outbound communication from staff regarding UM inquiries during normal business hours;

d) calls must be returned within one business day of receipt of communication;

e) staff must identify themselves by name, title and organization name when initiating or returning calls;

f) there must be a toll free number or staff that accepts collect calls regarding UM issues; and

g) callers must have access to UM staff for questions

IPA must document inbound and outbound communication process in the annual UM Plan. Method for receiving after hours communication must be included.

Must include all components. Must state if they will have a toll free number OR accept collect calls.

REQUIREMENTS FOR UM DECISION MAKING: Non-behavioral and Behavioral Health

15. Description of the Prospective/Pre-certification/Pre-Service process including determination of medical necessity and appropriateness of service and site for inpt/outpt services, performed by the UR Coordinator and/or PA using the nationally recognized medical criteria selected by the IPA. IPA may determine procedures that do not require pre-certification via written policy and procedure attached to UM Plan. The policy may include diagnoses, procedures and/or physicians that do not require prior authorization and/or concurrent review based on historical UM data.

Pre-certification/Pre-service includes documentation of the following:

a) sources of relevant clinical information utilized (list sources)

b) estimated length of stay (admission)

c) medical criteria met including criteria code (admission)

d) non-urgent Pre-service determination (approval and denial) and member/provider notification within 5 calendar days of receipt of request, including the collection of all necessary information

e) urgent pre-service determination (approval and denial) and member/practitioner notification within 72 hrs of receipt of request, including the collection of all necessary information

Must include all components. If pre-cert and/or concurrent are not required in certain instances, this must be documented in policy and procedure. There must be a description in UM Plan of how
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it was determined that the diagnoses, procedures, physicians, etc would not be reviewed. Describe method of checking if non reviewed admission was discharged in a timely manner. Describe member notification.

16. For practitioner notification, if initial notification is made by telephone, IPA must:
   - record time and date of call, AND document name of IPA employee who made the call

   Must include this statement.

17. For all denials, confirmation of the decision must be provided by Mail, fax, or e-mail

   Must include this statement.

CERTIFICATION / INITIAL REVIEW PROCESS:

18. All admissions must be included on admission log

   Must include - Submit sample log with required elements.

19. Emergent Admissions
   - Timeframes for UM decision making, notification to member and practitioner
   - Application of nationally recognized criteria
   - Assigned LOS
   - Discharge Planning/Case Management

   Must include all components.

20. Certification form meets all of HMOs required Standards

   Check submitted forms for all required elements. Include social, family, home assessment.

21. Initial review for pre-cert/pre-service non-urgent (elective) admission may be deferred until ALOS has reached its limit

   Must include checked day before discharge or end of anticipated LOS.

22. Written policy and procedure for closure of a case due to insufficient information decision-making must be included with UM Plan submission and must meet time-frames

   Must be a policy.

23. IPA cannot reverse a certification decision unless it receives new information not available at time of initial determination.

   Must include this statement.

24. Semi-annual review of staff adherence to all time frames for making UM decisions

   Must include above statement. Every UM staff member must be included in the testing.

CONCURRENT REVIEW PROCESS

25. Describe concurrent review process (including BH). Include sources of relevant clinical information utilized, the criteria used, UM decisions made and practitioner notification within 24 hrs of receipt of request. The case review is done one day prior to expiration of the current certification, or one day prior to the anticipated discharge date to determine need for continued stay. Additional assigned LOS, and discharged planning/case management needs addressed. PA review every 7 days. Social, family, home assessment documented.

   Document process, include timeframes, include all components. Include reference to checking case before LOS expired or day before discharge.

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26. Describe process if pre-service, initial review, concurrent stay doesn’t meet nationally recognized medical criteria. Document PA referrals and resulting denials.

Describe process. Include documentation of PA referrals and resulting denials.

CASE MANAGEMENT / DISCHARGE PLANNING/Complex Case Management

27. Describe discharge planning/case management process and document written protocols. Include complex case management components:

1. Describe how cases are identified for complex case management cases
2. Describe method of communication to the member and the primary physician for complex case management cases.
3. Include all of the elements for complex case management cases, as noted on page 18&19 of the BCBS UM plan, in either a policy or in your IPA um plan.

IPA must provide HMO CM survey to all participants when case closed.

Describe process for both. Must state that upon admission, both are performed. Must include all new items for complex case management (complex CM).

The goal is to help these Members regain optimal health or improved functional capability.

28. Describe behavioral health follow-up process

Describe process. Appointment should be scheduled within 7 days.

RETROSPECTIVE REVIEW PROCESS / POST-SERVICE PROCESS

29. Describe process including timeframe for decision making, and member/practitioner notification

Describe process, check timeframe.

ILLINOIS DEPT. OF INSURANCE REQUIREMENT

30. Report to HMO if IPA is a registered URO or identify delegated entity. Include plan and timeframe for seeking registration. Proof of current registration/ renewal must be submitted with UM Plan. IPAs delegating to a CMF must also register.

Describe when approved, submit letter, submit renewal, if applicable.

IPA REFERRAL PROCESS

31. Describe process for referrals to Specialists, therapies, DME, labs Compliance with decision making timeframes for all referral types, within 5 calendar day of receipt of request, including any request for additional information.

Include the process for denied referrals by notifying the member and practitioner must be notified in writing or electronically within 5 calendar days. All referrals must follow the timeframes identified by type i.e. pre-service, initial, concurrent review and post-service. Include referral inquiry process, if no denials. PCP communication and agreement must be documented.

Must describe process, include all required elements, timeframe, check referral forms submitted.

32. Describe process for standing referrals (Submit policy and procedure).

Must be policy and procedure.
33. Describe transition of care process

Describe process, must meet UM Plan requirements.

34. Describe the process for Exhaustion of limited benefits (includes rehab, therapies, infertility and BH).

Describe process, must meet UM Plan requirements, must notify HMO Behavioral Health Liaison (or Nurse Liaison) to review letter prior to sending letter to member. In your UM Plan, you need to add “HMO Provider” in front of “Network Consultant”. (Ex: HMO Provider Network Consultant)

DENIALS

35. Description of process for behavioral health and non-behavioral health denials.

Process must include:

- Physicians signature, email documentation identify the physician, or unique electronic identifier co-signed by the physician/BH practitioner.
- Expedited appeals process for all denied cases, within appropriate time frame
- Relevant clinical information supporting decision and source(s), PCP communication and agreement must be documented.
- Notification to practitioners of policy for making reviewer available to discuss UM denial
- Denial/appeal log maintained monthly clearly identifying type, also document on log if none
- Submission to HMO Nurse Liaison as outlined, including BH.

Must include all components, meet required timeframes as outline in pre-service, concurrent review, etc.
Must include BH denial requirements, must include submission of logs and files to NL.
Must change dates in UM Plan to 2009 and 2010 as noted on page 22 of HMO UM Plan.

WRITTEN DENIAL NOTIFICATION

36. Description of Behavioral health and non-behavioral health denial decisions process including appropriate timeframes. The HMO sample letters must be used for denials and include all the required elements.

Check to make sure denial letters are exactly like HMO and have all the required components.

IPA APPEAL PROCESS

37. Description of process for explaining all levels of appeal (Pre-service and Post-service) appeals:

a) documentation of the substance of the appeal and action taken;

b) full investigation of the appeal;

c) the opportunity for the Member to submit written comments, documents or other information relating to the appeal;

d) appointment of a new person for review of the appeal who was not involved in, or a subordinate to anyone involved in the previous review;

e) for medical necessity appeals, the case must be reviewed by a practitioner of the same or similar specialty as the managing practitioner;

f) the decision and notification to the Member must be made within 15 calendar days of the receipt of the request (this timeframe includes both clinical/non-clinical appeals if first level is performed at the IPA);

g) there must be notification about further appeal rights including the appeal process;

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h) there must be procedures for providing the Member access and copies of all documents relevant to the appeal, upon request; and

i) an authorized representative must be able to act on the Member's behalf.

Expedited appeal:

If the Member is hospitalized, the member may continue to receive services with no Financial liability until notified of the decision.

Procedures for registering and responding to expedited pre-service appeals include:

a) allowance of oral or written initiation of an expedited appeal by the Member or practitioner acting on behalf of the Member;

b) decision and notification to the Member and practitioner as quickly as the medical condition requires, within 24 hours of receipt if information is complete, but no later than 72 hours after the request is made; and

c) electronic or written confirmation of the decision must be made within this timeframe.

The HMO letter that includes instructions about appeal rights and resources must be used for all denials and for all appeals for which the denial was maintained.

External appeal:

Requests from the Practitioner(s) and/or Member for an external appeal should be directed to the Customer Assistance Unit of HMO.

Must include all components. Should state appeal can come to MG or HMO for first level.

Should not mention second level of appeal. Include number to Customer Assistance Unit (312) 653-6600.

As noted in the HMO UM Plan on page 24, change time frame under appeals to 15 calendar days. This timeframe includes both clinical and non-clinical appeals if first level is performed at the IPA.

☐ 38. Describe new and existing medical technology process

Must contact the HMO

☐ 39. Describe process for emergency services

Must follow prudent layperson and MSA.

☐ 40. Describe process for ensuring appropriate utilization, include tracking at least four of the outcomes listed noting potential utilization issues when identified.

Include a policy for obtaining corrective action from IPA physicians with identified avoidable days.

MG must describe four elements for tracking utilization, including 1 BH. Must be reported in committee minutes at least semi-annually. Include comparison of at least six months of data.

Also must describe method of tracking avoidable inpatient days. Include policy on avoidable days and corrective action for physicians with repeat non-compliance issues.

TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTH

☐ 41. Describe member process for obtaining behavioral health services and coordination of services. Any delegation of BH must be described in the UM Plan.

Describe triage and referral protocols which include:

a) addressing level of urgency and appropriate setting

b) protocols based on sound clinical evidence, currently accepted practices, reviewed and revised annually

c) decisions are made by lic. BH practitioners with appropriate experience

d) staff are supervised by a lic. BH care practitioner with min. master's degree and 5 yrs

e) post-master's clinical experience

Confidential i.e. must refer to BH Plan if they delegate. Otherwise describe how members obtain BH services, protocols used, decisions must be made by BH practitioner.

(Change specialists to practitioner as noted in HMO UM Plan page 25) (Continued on next page)
If IPA changes contract management firms, the Nurse Liaison and HMO Provider Network Consultant must be notified at least 30 days in advance of the date the new firm will assume the delegation as noted in the HMO UM Plan page 27. Also note the multiple CM additions on this page that needs to be added to the IPA UM Plan.

☐ 42. BH services must be provided in accordance with HMO access standards 26 Pg _______

Must state they meet all required access standards or list the access standards as noted in UM plan. Access to urgent care in now within "24" hours. (See HMO UM Plan page 26 near middle)

☐ 43. Describe process for submitting telephone reports quarterly to the HMO QI Department 26 Pg _______

If they delegate to BH vendor, must state they will submit these to HMO. Any BH organization or IPA providing BH services must submit telephone reports quarterly to the HMO QI Department.

PROTECTED HEALTH INFORMATION

☐ 44. IPA must follow the provisions for the use of Protected Health Information 26 Pg _______
   a) use Protected Health Information to provide or arrange for the provision of medical and BH benefits administration and services Pg _______
   b) provide a description of appropriate safeguards to protect the information from inappropriate use or further disclosure Pg _______
   c) ensure that sub-delegates have similar safeguards Pg _______
   d) provide individuals with access to their Protected Health Information Pg _______
   e) inform the IPA if inappropriate uses of the PHI occur, and Pg _______
   f) ensure that Protected Health Information is returned, destroyed, or protected if the contract ends Pg _______

Must include all above components in policy and procedure.

PROCESS FOR DELEGATION AND OVERSIGHT OF UM 26-27 Pg _______

☐ 45. Mechanisms for oversight must include, but are not limited to:
   a) Annual approval of the sub-delegate UM Plan Pg _______
   b) Annual evaluation of sub-delegate against HMO & IPA requirements Pg _______
   c) Review of quarterly submissions and any reports, and Pg _______
   d) Identification of any deficiencies w/corrective action Pg _______

A pre-delegation evaluation of the proposed delegate must be performed prior to delegation to ensure compliance w/HMO and IPA UM Plan 27 Pg _______

Must state all of the above if they delegate. If they do not delegate, refer to #5, do not have to repeat again.

HMO OVERSIGHT OF IPA – ANNUAL AUDIT REQUIREMENTS

☐ 46. UM Committee meets at least monthly to review and discuss UM activities. Minutes to include date, chairman and members present (including specialist representation), minutes signed by Medical Director/Chair within 5 weeks of meeting. 28 Pg _______

Must include. Note the timeframe change for corrective action plan if IPA fails audit. (Page 28 in the HMO UM Plan)

☐ 47. Committee minutes must consist of the following additional requirements:

   Annually
   a) Review and approval of the IPA UM Plan/including BH 28 Pg _______
   b) Review and acceptance of medical criteria (including BH and any additional criteria) 28 Pg _______

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   Evaluation of the UM program and progress in meeting determined 28 Pg _______
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goals. All goals identified for the year must be discussed. Interventions implemented, results of interventions (outcomes), and further opportunities for improvement should be discussed.

Review and revision of all UM related policies and procedures (all must be in a format which minimally includes: IPA name, name of policy, effective date, review date and most current revision date, signature of reviewing and approving authority).

Include Policy & Procedure for Complex Case Management. In minutes, state policies and date they were reviewed. A listing of policies may be submitted to the HMO for the annual submissions requirement. The list must include all required policies, the date of review or revision, and the Medical Director’s signature. If a policy does not have any revisions, it does not have to be submitted to the HMO. If the policy is new or has been revised, then it needs to be submitted with the UM Plan.

Review of annual HMO PCP and Member survey results with specific reference to referrals and interventions if referral question scores < 83%.

Referral score must be documented for both surveys. If score <83% need to document intervention.

Semi-Annually
a) Identification, analysis, development of interventions for improvement related to utilization stats. IPAs are required to track at least 4 (including BH), of inpt.days/1000, admits or discharges/1000, BH days/1000, ALOS, rates for types of procedures, and include a comparison of past quarters (at least 6 months of data arrayed in table or graph). Interventions noted.

b) Inter-rater reliability testing for criteria utilization (Medical Director, PA and UM Staff) and decision making timeframes (UM Staff). A summary of the results and number of cases by reviewer must be included in the minutes. Include any corrective action.

c) Summary/discussion of six months of avoidable inpatient days and reason for delayed discharge. IPA Physicians identified with avoidable day practice patterns identified in UM Committee with corrective action according to MG UM policy.

d) Discussion of referral statistics (including BH) with a two quarter referral comparison, trending, analysis, and discussion documented in the minutes (at least 6 months of data arrayed in table or graph). Interventions must be documented for any trends noted.

Quarterly
Quarterly review and discussion any complaints received by the group and
Resolved timely. These may be discussed in summary format using categories of complaints. A monthly log must be maintained including documentation of no complaints.

Quarterly review and discussion of any submissions, reports from sub-delegates.

Quarterly discussion of HMO review of IPA denial files, any non-compliance and corrective action, if required.

Monthly
Review and discussion of all denied/appealed services to include a summary of categories of denials (BH, non-BH, medical necessity, OON etc.), member in each category, timeframes compliance and resolution. Include number of PA referrals and the number resulting in denials.

Must state committee will communicate in minutes all components above and required timeframes.
### 48. ADDITIONAL UM REQUIREMENTS / ACTIVITIES

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<td>31</td>
</tr>
<tr>
<td>Organ transplant program/process</td>
<td>31</td>
</tr>
<tr>
<td>Out of area admissions program/process</td>
<td>31</td>
</tr>
<tr>
<td>Out of network program/process</td>
<td>31</td>
</tr>
<tr>
<td>Termination of benefits process description</td>
<td>31-33</td>
</tr>
</tbody>
</table>

*Must include all components above and required timeframes.*

Termination of benefits applies to Medical as well as Behavioral Health Admissions.

A diagnosis, clinical summary and patient status must be sent to the HMO Nurse Liaison along with the IPA's termination of benefit letter and the written statement from the PCP.

On page 32 of the HMO UM Plan, note that Provider is added to the HMO Provider Network.

## Notes:

Policy and Procedures format:
- MG name
- Policy Name
- Effective date
- Review and revision date (policies are required to be reviewed annually)
- Signature of reviewing and approving authority

**HMO Illinois and BlueAdvantage HMO**

*Revised 6/1/09*

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CASE INFORMATION

IPA # and NAME: _____________________________________________
Document # and name for IPA with complex case management case (CM).

Member Initials (FN, LN)/ ID #: ________________________________________________
Document Member first and last initial, unique ID number.

Date case opened: ________________ Date case closed or NA: ________________
Document date opened as COMPLEX CM case. Document date when closed or NA if still open in complex case management.

Diagnosis (es): _________________________________________________
Document complex or multiple diagnoses for complex case managed Member.

Goal for Member’s Case:
Check appropriate box for overall goal for this Member.

☐ Regain optimal health
☐ Improved functional capability

COMPLEX CASE IDENTIFICATION PROCESS

IPA must demonstrate each of the methods below and how they are utilized to identify POSSIBLE complex CM cases:

1. Claims data – any type of claims report, re-admission report
2. Hospital discharge data – UM report, hospital report
3. Pharmacy data - # medications, high dollar
4. Data collected from UM process – initial, concurrent, discharge planning
5. D2 Hawkeye report – covers all above, except data collected from the UM process

Optional sources – health information line referral, disease management program referral, discharge planner referral, PCP, PSP, Member self-referral.

1. How was case identified for Complex Case Management (CM)?
Check all that apply ONLY IF demonstrated in written report format, D2, or UM form.

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1. Claims data</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 2. Hospital discharge data</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 3. Pharmacy data</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 4. Data collected through UM process</td>
<td>.5</td>
</tr>
<tr>
<td>☐ 5. D2 Hawkeye report or demonstration</td>
<td>2 pts (covers 1, 3)</td>
</tr>
</tbody>
</table>

Extra 1 pt for ANY of the optional sources. Total 4 pts
COMPLEX CASE MANAGEMENT CONSENT
2. Documentation of Member’s verbal or written consent for complex case management.
Must be documentation of Member’s consent to be involved in complex case management. May be verbal consent.

COMPLEX CASE MANAGEMENT FILE DOCUMENTATION

3. Are the following elements documented in file?

1. Evidence-based clinical guideline
   There is documentation of the name of the guideline and the source.

2. Member or Member related contact
   Documentation of each Member or Member related contact. Documentation must include: recording of interaction, date, time, ID of individual making contact. Example: ‘SNS, RN 12/4/08 1PM - Spoke with Dorothy Jones at Healthy Home Health Care regarding patients compliance with wound care treatment. Ms Jones will re-inforce the need for the wound care in the AM AND PM. Will check on Member for compliance in one week.’

3. Date to follow-up with Member
   Documented date for follow-up. Example – ‘Call Member on 12/11/08 – one week follow-up for wound care compliance’.

4. Initial assessment
   Documentation of current health status, co-morbidities, diagnoses, procedures, history or progression of illness, medications, treatment history, medications, assessment of ability to perform activities of daily living, mental status, and ability to communicate and understand.

5. Life planning activities
   Documentation of existence of any will, living will, advance directives, power-of-attorney. Document ‘none’, or ‘not applicable’, depending on the case.

6. Cultural and linguistic needs
   Documentation of language spoken and any cultural preferences, needs that may affect the Member’s care. If no cultural specifics, document ‘none’.

7. Available benefits
   Documentation of any specific benefit limitations or specifics. Example: ‘Patient has a limitation of 20 home health visits.’ If not applicable, document ‘standard HMO benefits’.

8. Caregiver resources
   Documentation of any possible caregivers, family members, decision-makers regarding health care.
9. □ Individualized care plan
Documentation of at least one short and long term goal for Member. Goals must be specific with explanation of goal, measurable, expected timeframe, when goal re-measurement will occur. Goals may be used from guidelines, but must be identified or documented.

10. □ Barriers
Documentation of Member barriers to achieve goals. Examples: Member non-compliance, visual impairment, lack of understanding, language barrier, physical impairment, psychological impairment.

11. □ Follow-up schedule
Documentation of a schedule for contact with Member, any referrals, education, self-management support.

Documentation of communication of self-management activities. May include: special diet, chart daily readings, (blood sugar, BP), peak flows, wound care, etc.

13. □ Assessment of Member progress
Documentation of Member’s progress toward documented goals, including self-management progress.

14. □ Estimated inpatient days saved
Documentation of any estimated inpatient days saved or ‘none’.

15. □ CM survey given or completed, if case closed
Documentation of CM survey given, completed, refused or ‘not applicable, if case remains open’.

A. □ All 4 sources demonstrated (or D2 and 2 other sources) and NO complex case management cases identified.
   Total: 14 pts

B. □ All 4 sources demonstrated (or D2 and 2 other sources) AND 12/15 elements in at least one case documented
   Total: 14 pts

C. □ 12/15 elements in at least one case documented without demonstrating data sources
   Total: 10 pts

D. □ All 4 sources presented without demonstration of review for potential complex case management cases and no cases
   Total: 4 pts

Check A, B, C or D above to determine points.
A. Approval of QI Program Description

| Date <Current Year> QI Program Description approved by delegate QI Committee: | <Current Year> | 5 | □ |
| Date <Current Year> QI Program Description approved by Plan QI Committee: | <Current Year> | 5 | □ |

B. Evaluation of QI Program Description Elements:

<table>
<thead>
<tr>
<th>QI Program Description Elements</th>
<th>Scoring</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Description of QI Program purpose and mission</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>2. Description of QI Program structure and content</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>3. Designation of a practitioner in the appropriate specialty to be actively involved in implementing the QI Program</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>4. Organization structure including relevant committees</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>5. Designation of a committee to oversee QI activities • Specifies the role, structure and meeting frequency of the QI Committee • Includes representation from network providers and/or practitioners</td>
<td>10</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>6. Scope and processes of the Clinical and Non-Clinical (Service) QI Projects</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>7. Quality indicators that reflect important aspects of care or service</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>8. Develops a QI Workplan that includes: • The objectives, scope and planned projects for the year • Designated personnel responsibilities • Planned monitoring of previously identified issues</td>
<td>10</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>9. Member rights and responsibilities: • Policies and procedures for member inquiries, complaints and appeals • Access standards • Member satisfaction survey</td>
<td>10</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>10. Policies and procedures for credentialing and recredentialing</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>11. Allocate sufficient resources to meet the needs of the QI Program</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>12. How the QI Program is annually evaluated, approved, and revised and by whom</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
<tr>
<td>13. A description of all delegated QI arrangements that addresses all of the above</td>
<td>5</td>
<td>□ Pg.</td>
</tr>
</tbody>
</table>

*Total Score | 90 (Maximum Points Possible) | (Delegate Score) | % Percentage |

Comments and follow-up:
Reviewed 6/1/09
Confidential
<<Product>>
Delegate Oversight Materials Audit Tool
<<Year>> ANNUAL REPORT REVIEW

Date of Review: 
Score:

Date of Annual Report:

Date Annual Report Approved by <<Vendor Organization>> QI Committee:

Annual report includes: <<Vendor Organization>> QI Workgroup:

Quality Improvement

<table>
<thead>
<tr>
<th>QI STUDY (Clinical and Service)</th>
<th>PREVIOUS RESULT</th>
<th>GOAL</th>
<th>RESULT</th>
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<tbody>
<tr>
<td>Clinical:</td>
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<td></td>
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<tr>
<td>Service:</td>
<td></td>
<td></td>
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</tbody>
</table>

Quality Improvement Opportunities noted:

Interventions noted:

Member Service

<table>
<thead>
<tr>
<th>Member Service Opportunities noted:</th>
</tr>
</thead>
</table>

Interventions noted:

Confidential

Page 1
Credentialing/ Recredentialing

Roster of practitioners credentialed and re-credentialed

Credentialing Opportunities noted:

Interventions noted:

Utilization Management

UM statistics and review summary
Inter-rater reliability results
Denials analysis
Under/ Over utilization method developed

Utilization Management Opportunities noted:

Interventions noted:

Pharmacy (Member Connections)

QI Process on Accuracy of Information: Website and Telephone
Policy and standard operating procedures
Audit results
Pharmacy Benefit Information-Website:
Standard operating procedure
Screenshots of Web site functionality
Pharmacy Benefit Information-Telephone
Training modules
Pharmacy Benefit Updates: Web site and Telephone
Policy and standard operating procedure
Documentation of Updates

Member Connections Opportunities noted:

Interventions noted:


*Total Score

(Maximum Points Possible)

(Delegate Score)

% Percentage

*The total points possible will vary depending on the services delegated to the vendor. Therefore, the delegate score will be divided by the maximum points possible for a final percentage.

Comments and follow-up:
### DELEGATE SUBMISSIONS TOOL

<table>
<thead>
<tr>
<th>Document</th>
<th>Timeframe</th>
<th>Date Received</th>
<th>Points Possible</th>
<th>Points Earned</th>
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<tbody>
<tr>
<td><strong>REPORTING</strong></td>
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<tr>
<td>1. Quarterly Reports</td>
<td>Quarterly</td>
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<td>5 Points</td>
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</tr>
<tr>
<td>• First Quarter Report</td>
<td>1ST</td>
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<tr>
<td>• Second Quarter Report</td>
<td>2ND</td>
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<tr>
<td>• Third Quarter Report</td>
<td>3RD</td>
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<tr>
<td>• Fourth Quarter Report (includes Annual)</td>
<td>4TH</td>
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<td>2. Presentation to the BCBSIL Managed Care QI Committee</td>
<td>Semi-Annually</td>
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<td>• First semi-annual report</td>
<td>1ST HALF</td>
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<td>• Second semi-annual report</td>
<td>2ND HALF</td>
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<td><strong>CONTRACTUAL</strong></td>
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<td>1. Signed contract</td>
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<td>2. Signed delegation agreement</td>
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<td><strong>WHERE QUALITY IMPROVEMENT IS DELEGATED:</strong></td>
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<td>(If not a delegated service, points in this section are not applicable.)</td>
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<tr>
<td>1. QI Program Description-Annual</td>
<td>Annually</td>
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<td>5 Points</td>
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<tr>
<td>2. QI Workplan-Annual</td>
<td>Annually</td>
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<td>5 Points</td>
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<tr>
<td>3. QI Committee-Quarterly (meets at least quarterly with meeting minutes)</td>
<td>Quarterly</td>
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<td>5 Points</td>
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<tr>
<td>• First Quarter Report</td>
<td>1ST</td>
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<tr>
<td>• Fourth Quarter Report (includes Annual)</td>
<td>4TH</td>
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<tr>
<td>4. QI Study Summaries-Annual</td>
<td>Annually</td>
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<td>5 Points</td>
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<td>5. QI Indicators-Quarterly</td>
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<td>5 Points</td>
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<td>• First Quarter Report</td>
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<tr>
<td>• Fourth Quarter Report (includes Annual)</td>
<td>4TH</td>
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<td>6. Provider Satisfaction Survey Results</td>
<td>Annually</td>
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<td>5 Points</td>
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<tr>
<td><strong>WHERE MEMBER RIGHTS AND RESPONSIBILITIES ARE DELEGATED:</strong></td>
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<td>(If not a delegated service, points in this section are not applicable.)</td>
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<td>1. Member satisfaction survey</td>
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<tr>
<td>2. Member inquiry, complaint and appeal policies and procedures</td>
<td>Annually</td>
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<td>5 Points</td>
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<tr>
<td>3. Confidentiality policy and procedure</td>
<td>Annually</td>
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<td>5 Points</td>
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</tr>
<tr>
<td>4. Member rights and responsibilities indicators</td>
<td>Quarterly</td>
<td></td>
<td>5 Points</td>
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<tr>
<td>• Complaints/1000</td>
<td>1ST</td>
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<tr>
<td>• Number of member appeals by type and disposition</td>
<td>2ND</td>
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<tr>
<td>• Number of member complaints by type and action taken</td>
<td>3RD</td>
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<td></td>
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<tr>
<td>• Fourth Quarter Report</td>
<td>4TH</td>
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### DELEGATE SUBMISSIONS TOOL - CONT’D

<table>
<thead>
<tr>
<th>Document</th>
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<th>Points Possible</th>
<th>Points Earned</th>
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<td><strong>WHERE CREDENTIALING AND REREDENTIALING ARE DELEGATED:</strong> <em>(If not a delegated service, points in this section are not applicable.)</em></td>
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<tr>
<td>1. Credentialing and Recredentialing policy and procedure</td>
<td>Annually</td>
<td>5 Points</td>
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</tr>
<tr>
<td>2. Roster of practitioners and providers credentialed and recredentialed</td>
<td>Annually</td>
<td>5 Points</td>
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<tr>
<td>3. Credentialing audit results (if applicable)</td>
<td>Annually</td>
<td>5 Points</td>
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<td><strong>WHERE UTILIZATION MANAGEMENT IS DELEGATED:</strong> <em>(If not a delegated service, points in this section are not applicable.)</em></td>
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<td>1. UM Program Description</td>
<td>Annually</td>
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<td>2. UM Statistics</td>
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<td>• ALOS</td>
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<td>5 Points</td>
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<tr>
<td>• Days/1000</td>
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<td>• Admits/1000</td>
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<td>• Inpatient readmission rate</td>
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<td></td>
<td>4TH</td>
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<tr>
<td>3. UM Indicators</td>
<td>Quarterly</td>
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<tr>
<td>• Inter-rater reliability test results</td>
<td>1ST</td>
<td>5 Points</td>
<td></td>
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<tr>
<td>• Timeliness of UM decisions</td>
<td>2ND</td>
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<tr>
<td>• Denials/1000</td>
<td>3RD</td>
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<td>4TH</td>
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<td><strong>WHERE MEMBER CONNECTIONS IS DELEGATED:</strong> <em>(If not a delegated service, points in this section are not applicable.)</em></td>
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<tr>
<td>1. Policy and Standard Operating Procedures and Other Documented Materials:</td>
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<tr>
<td>• Quality Assurance (Accuracy of Information)</td>
<td>Annually</td>
<td>5 Points</td>
<td></td>
</tr>
<tr>
<td>• Pharmacy Benefit Information: Web site</td>
<td></td>
<td>5 Points</td>
<td></td>
</tr>
<tr>
<td>• Screenshots of Web site Functionality</td>
<td></td>
<td>5 Points</td>
<td></td>
</tr>
<tr>
<td>• Telephone Training Modules</td>
<td></td>
<td>5 Points</td>
<td></td>
</tr>
<tr>
<td>2. Reporting for QI Process on Accuracy of Information:</td>
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</tr>
<tr>
<td>Web Site Audit Results:</td>
<td>Quarterly</td>
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</tr>
<tr>
<td>• First Quarter Report</td>
<td>1ST</td>
<td>5 Points</td>
<td>(awarded at the end of the reporting year if all four quarters are received)</td>
</tr>
<tr>
<td>• Second Quarter Report</td>
<td>2ND</td>
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<tr>
<td>Telephone Audit Results:</td>
<td>Quarterly</td>
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</tr>
<tr>
<td>• Fourth Quarter Report</td>
<td>4TH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pharmacy Benefit Updates for Web site and Telephone (including but not limited to recalls, formulary changes, withdrawals, etc.)</td>
<td>Annually</td>
<td>5 Points</td>
<td></td>
</tr>
<tr>
<td>• Documentation of Updates</td>
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</tbody>
</table>

**Total Score** *(Maximum Points Possible)*

*(Delegate Score)*

% Percentage

*The total points possible will vary depending on the services delegated to the vendor. Therefore, the delegate score will be divided by the maximum points possible for a final percentage. Comments and follow-up:
<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM 13</td>
<td>Protection of Welfare/Safety</td>
</tr>
<tr>
<td>CM 13</td>
<td>Advance Directive - was the question asked</td>
</tr>
<tr>
<td>CM 14</td>
<td>Member’s Rights</td>
</tr>
<tr>
<td>CM 16</td>
<td>Obligation to Monitor/Assist Provider/Vendor Selection</td>
</tr>
<tr>
<td>CM 17</td>
<td>Criteria for Opening CM Services</td>
</tr>
<tr>
<td>CM 18(a)</td>
<td>Nature of CM Relation (3rd Party)</td>
</tr>
<tr>
<td>CM 18(b)</td>
<td>Disclosure to 3rd Party</td>
</tr>
<tr>
<td>CM 18(c)</td>
<td>Written Notification of Action &amp; Recommendation</td>
</tr>
<tr>
<td>CM 18(d)</td>
<td>Complaint Process &amp; Access</td>
</tr>
<tr>
<td>CM 18(e)</td>
<td>Rational for Selecting Member, if Requested</td>
</tr>
<tr>
<td>CM 19(a)</td>
<td>Consent - Oral</td>
</tr>
<tr>
<td>CM 19(b)</td>
<td>Attempt to Obtain Written Consent</td>
</tr>
<tr>
<td>CM 19(c)</td>
<td>Consent Timeframe to be Obtained</td>
</tr>
<tr>
<td>CM 19(d)</td>
<td>Consent Duration of Validity</td>
</tr>
<tr>
<td>CM 21</td>
<td>Information/ Tools Used During CM Process (P&amp;Ps, Assessment forms…)</td>
</tr>
<tr>
<td>CM 22</td>
<td>CM Assessment</td>
</tr>
<tr>
<td>CM 24(a)</td>
<td>CM Plan, Collaboration w/ Member &amp; Team</td>
</tr>
<tr>
<td>CM 24(b)</td>
<td>Short-term Goals</td>
</tr>
<tr>
<td>CM 24(c)</td>
<td>Long-term Goals</td>
</tr>
<tr>
<td>CM 24(d)</td>
<td>Re-evaluation/Follow Up Timeframes</td>
</tr>
<tr>
<td>CM 24(e)</td>
<td>Resources Utilized</td>
</tr>
<tr>
<td>CM 25</td>
<td>Collaborative Approaches w/ Family/Physician</td>
</tr>
<tr>
<td>CM 27(a)</td>
<td>Discharge Criteria</td>
</tr>
<tr>
<td>CM 27(b)</td>
<td>CM Aware of Discharge Criteria</td>
</tr>
<tr>
<td>CM 27(c)</td>
<td>Discharge Date</td>
</tr>
<tr>
<td>CM 27(d)</td>
<td>Discharge Rationale</td>
</tr>
</tbody>
</table>

Score %: Percent (%) in Compliance

- Depression 1*: Screen Member for Depression** 0%
- Depression 2*: Member’s Response** 0%
- Depression 3*: Intervention for “Positive” Screen** 0%
- Depression 4*: Reassessed within 30 Days** 0%
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<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression 5* Treatment Effectiveness</td>
<td>0%</td>
</tr>
<tr>
<td>Depression 6* Recommendation of Referral</td>
<td>0%</td>
</tr>
<tr>
<td>Depression Screening Compliance</td>
<td>0%</td>
</tr>
<tr>
<td>Medication Adherence Questions asked at case opening</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Questions asked at case closure</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Questions asked at annual assessment</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Member's responses documented</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Interventions documented for questions answered &quot;Yes&quot;</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Follow up documented Q30 days</td>
<td>0</td>
</tr>
<tr>
<td>Medication Adherence Medication Adherence Compliance</td>
<td>0</td>
</tr>
<tr>
<td>Mem Involvement Member Concerns Documented</td>
<td>0</td>
</tr>
<tr>
<td>Mem Involvement Plan of Care Reflects Needs</td>
<td>0</td>
</tr>
<tr>
<td>Mem Involvement Goals Reflect Concerns</td>
<td>0</td>
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<tr>
<td>Mem Involvement Appropriate Short Term Goals</td>
<td>0</td>
</tr>
<tr>
<td>Mem Involvement Addressing Barriers</td>
<td>0</td>
</tr>
<tr>
<td>Mem Involvement Support for Case Continuance</td>
<td>0</td>
</tr>
<tr>
<td>Member Involvement Compliance</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Screening for Depression QIP**

* Measures for GI Projects / " Plan must use an evidence-based screening tool. Refer to the full screening for depression questions below.

**Recommendations/Comments:**

**Interventions Used:**

*indicate which evidence-based screening tool was used*

---

**Member Involvement QIP -** there are 3 new measures: (1) Appropriate Short Term Goals (Do short term goals represent incremental progress toward Long Term Goal? (2) Addressing Barriers (If Barriers exist, are the goals modified, or new ones added, to support a change in the treatment plan?); (3) Support for Case Continuance (Do current goals on the Plan of Care support keeping the case open until the next evaluation?)
Health Care Management Policy and Procedure

Oversight of Contracted Vendors
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Screening for Depression Questions

1** Did the CM screen the member for depression using an evidence-based tool (see examples above)?
2** Is the member's response to the screening documented?
3** If the response to the screening was "positive" did the CM document the intervention(s)?
4** If the response to the screening was "positive," was the member reassessed within 30 days of the response to follow through with the intervention?
5* If the member is currently receiving treatment or begins treatment during the case management phase, did the CM document the member's response?
6* Did the CM recommend a referral to a qualified provider and document the intervention?

Evidence-based Screening Tool Used: (Indicate which tool was used)

Listed are evidence-based instruments for depression screening for adults. Individuals should receive the appropriate training to use these tools before screening members:

(1) Beck Depression Inventory (BDI), (2) Center for Epidemiologic Study Depression Scale (CES-D), (3) General Health Questionnaire (GHQ), (4) Geriatric Depression Scale (GDS), (5) Medical Outcomes Study Depression Screen (MOS-D), (6) Primary Care Evaluation of Mental Disorders (PRIME-MD), (7) Patient Health Questionnaire (PHQ-9), (8) Symptom Driven Diagnostic System—Primary Care (SDDS-PC), (9) Self Care-D, (10) SF8 or SF12 Quality of Life Health Survey, (11) Whooley Depression Screening Questions, (12) Zung Self-Assessment Depression Scale (Zung SDS), (13) Other behavioral health/mental health evidence-based assessment tools.

Note: The Depression Screening QI Project only applies to adults 18 years and older.

Reviewed 6/1/09
Oversight of Contracted Vendors

Product: <Product Specified>
Vendor: <Vendor Organization>
Date of Audit: <Date>
Number of Elements Scored: <Number>
Number of Elements in Compliance: <Number>
Percentage of Compliance: <Percent>

QI Workgroup: <Date>
Managed Care QI Committee: <Date>
Reviewers: <Name>

Annual Submissions
Copies of UR licensure (if applicable);
UM Program accreditation (URAC/NCQA) (if applicable);
CM Program accreditation (URAC) (if applicable);
Corporate organizational chart;
CM Program Description, Work Plan and Annual Evaluation;
CM Policies and Procedures and Process Flowcharts;
Quality Management Structure Chart;
Quality Improvement/Management Plan;
Quality Management Policies and Procedures and Process Flowcharts;
QI/CM/UM Committee structure;
CM Training Program Description;
Outline of CM Orientation/Training
Risk Management Program Description;
Sample written notification letters;
CM Case Identification Methods and Thresholds;
CM criteria.

Quarterly Submissions
Reporting/oversight:
- Access
- Activity
- Utilization
- Cost Benefit
- Outcomes/survey
- QI studies/initiatives/ URAC QI Projects
- Complaints
- Quality Management results
Timeliness standards (Processes, Decisions, Notification)

Reviewed 6/1/09

Documents to prepare for Case Management On-site Review
Job descriptions of all levels of CM/QM personnel and physician advisors;
Resume/CV for the individuals with overall accountability for the operations of CM;
List of names of individuals that directly supervise CM;
List of case managers and credentials;
List of Physician advisor/consultant and their credentials;
Personnel files (all levels of CM/QM and physician advisors);
Sample performance evaluations;
Statements of Case Managers Practicing within scope of licensure;
Description of Compensation system;
Licensure verification system and documentation;
CM System(s), Tools, Forms and links with other departments;
CM/QM/UM Committee minutes;
Patient/Consumer complaint logs and supporting documentation for events;
Patient surveys;
Relevant sections of state or federal statutes;
Orientation checklist;
Training documentation, i.e. sign in sheets, meeting minutes, attendee lists,
competency evaluation;
Quality measurement/improvement tools;
Quality Audit Documentation, i.e., Tools, meeting minutes, corrective actions;
Patient consent forms;
Medical Record Release of Information form;
Packet of information given to consumers at the onset of CM;
Confidentiality statements;
Annual Ethics Training;
Letter of Attestation;
Incident reports;
Consumer rights;
CM Orientation/Training Manual; and Case files.
### Case Management Policies and Procedures

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance</th>
<th>Score</th>
</tr>
</thead>
</table>
| **Case Management Policies and Procedures** | **Source Documents:**  
  • UR licensure  
  • UM Program accreditation/CM Program accreditation  
  • CM Program Description and Work Plan  
  • CM Policies and Procedures  
  • Corporate Organization chart  
  • Case Management Organizational chart  
  • Quality Management Structure chart | YES | NO | |
| **URAC**  
  CM 1, Core 2  
  CM 4 | CM Program Description and/or written policies include:  
  • CM definition consistent with URAC;  
  • Advocacy role clearly defined if CM is used for making benefits determination;  
  • Mission statement;  
  • Organizational framework for program;  
  • Description of CM services and how delivered;  
  • Population served;  
  • Organizational oversight and reporting requirements of the program;  
  • Program goals;  
  • Staff Qualifications | | | 1 |
| **BCBSIL Requirements** | Written CM policies and procedures which address all aspects of the CM program and interface with other departments within the organization:  
  • Updated at least annually; and  
  • Approved by senior management or QI committee. | | | |
<p>| <strong>BCBSIL Requirements</strong> | CM Program evaluated and approved annually by senior management or QI committee. | | | |</p>
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance FEP Case Management</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CM Staff Structure and Qualifications</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| HCSC annual onsite review | Source Documents:  
- CM policies and procedures  
- Patient/consumer complaint log  
- Case Management supervision and staff list  
- Case Management Case Load Guidelines  
- Physician advisor/consultant list  
- Resume/CV for individuals with overall accountability  
- Evidence of CM certification  
- Statements of Practice within the Scope of Licensure  
- Case files  
- Job descriptions  
- Personnel files  
- Annual performance reviews  
- Training Program Description  
- Orientation/Training Manuals  
- Orientation checklist  
- Training documentation  
- Sample Competency Methods | | | |
| URAC CM 2 | Reasonable Case Manager caseload guidelines with supporting rationale:  
- Severity of cases;  
- Complexity of cases;  
- Role requirements;  
- Applies a process to monitor caseload based on organizational guidelines;  
- Employs/contracts with an adequate number of CM personnel to provide services. | | | |
| URAC CM 3 | Policy and procedure in place for CM staff to consult with or seek advice from licensed physicians with expertise appropriate to the types of health care being managed. | | | |
**CM Staff Structure and Qualifications – cont’d**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance FEP Case Management</th>
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<tbody>
<tr>
<td>URAC</td>
<td><strong>CM Staff Structure and Qualifications</strong></td>
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<tr>
<td>Core 31</td>
<td>Senior clinical staff person requirements:</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td></td>
<td>• Has current unrestricted clinical license(s)</td>
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<td></td>
<td>• Qualifications to perform clinical oversight for services provided</td>
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<td></td>
<td>• Post-graduate experience in direct patient care</td>
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<td>• Board certification (if MD or DO)</td>
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<tr>
<td>Core 32</td>
<td>Senior clinical staff person responsibilities:</td>
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<td></td>
<td>• Provides guidance for all clinical aspects of the program;</td>
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<td></td>
<td>• Is responsible for clinical aspects of program; and</td>
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<td></td>
<td>• Has periodic consultation with practitioners in the field.</td>
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<tr>
<td></td>
<td>• Serves on the Quality Management Committee</td>
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<tr>
<td>CM 6 (a)</td>
<td>Qualification for CM Supervisors include one of the following:</td>
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<td>1</td>
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<tr>
<td></td>
<td>• Bachelors or higher degree in health related field and licensure as a health professional; or</td>
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<td></td>
<td>• Certification as a Case Manager; or</td>
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<td></td>
<td>• Professional certification in a clinical specialty and at least 3 years CM experience</td>
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<td></td>
<td>• Evidence of CM certification for individuals if they have directly supervised case management process for 3 or more years</td>
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<tr>
<td>CM 6 (b)</td>
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<tr>
<td>CM 4 (a)</td>
<td>Qualifications for Case Managers include:</td>
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<tr>
<td></td>
<td>• Bachelors or higher degree in health related field and licensure as health professional; or</td>
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<tr>
<td></td>
<td>• Certification as a Case Manager; or</td>
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<tr>
<td></td>
<td>• RN licensure and 3 years clinical practice experience</td>
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<td></td>
<td>• Practice within the scope of their licensure.</td>
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<tr>
<td>CM 4 (b)</td>
<td></td>
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</tbody>
</table>
When non-case managers are used to support the CM process:
- The case manager is responsible and accountable for the case and has direct supervision over the non-case manager for the CM activities performed.
- The role of the non-case manager is clearly defined by the organization; and
- Performance of the non-case manager is monitored.

Written job descriptions for staff that address:
- Required education, training, and/or professional experience;
- Expected professional competencies;
- Appropriate licensure/certification requirements; and
- Scope and role of responsibilities.

Licensure and credentials verification system that includes:
- Verify current licensing and credentials upon hire and thereafter no less than every 3 years; and
- Require staff to notify organization in a timely manner of an adverse change in licensure or certification status; and
- Implement corrective action in response to adverse changes in licensure and certification status.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance FEP Case Management</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff Management and Development</strong></td>
<td></td>
<td></td>
<td>YES</td>
<td>1</td>
</tr>
<tr>
<td>URAC CM 9</td>
<td>Case Managers are educated in current principles, procedures and knowledge domains of case management based on nationally recognized standards of case management. Education includes: • Organization’s CM process, policies and procedures, state specific requirements, professional roles and resources and clinical/payor specific requirements; • URAC’s CM Organization Standards; and • Relevant professional education on at least an annual basis.</td>
<td></td>
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<tr>
<td>URAC CM 8</td>
<td>Encourage professional development among case managers through: • Providing access to the experience/knowledge needed to apply for professional certification; • Education regarding the quality management program; • Participation through membership in or attendance at meetings of relevant professional organizations; and • Education in cultural diversity appropriate to the populations served.</td>
<td></td>
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<tr>
<td>Standard</td>
<td>Description</td>
<td>Comments</td>
<td>Compliance FEP Case Management</td>
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<tr>
<td>Case Review</td>
<td><strong>Source Documents:</strong> CM Cases</td>
<td></td>
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<tr>
<td>URAC CM 10</td>
<td>Conducts review of Case Management process through case review by Case Management program director, advisor or supervisor to: • Promote achievement of Case Management goals as established in consumer specific case management plans; • Report the findings to the quality management committee.</td>
<td></td>
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<tr>
<td>Information Management</td>
<td><strong>Source Documents:</strong> CM policies and procedures</td>
<td></td>
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<tr>
<td>URAC Core 13 Core 14 Core 15</td>
<td>The organization implements information system(s) (electronic or paper or both) to collect, maintain, and analyze information necessary for organizational management that • Provides for data integrity; • Provides for data confidentiality and security; • Includes a disaster recovery plan that • Is tested at least every 2 years; and • Addresses identified areas for improvement; and • Includes a plan for storage, maintenance, and destruction.</td>
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<tr>
<td>Standard</td>
<td>Description</td>
<td>Comments</td>
<td>Compliance FEP Case Management</td>
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<tr>
<td>Quality Improvement</td>
<td>Source Documents: CM policies and procedures Quality Improvement/Management Plan Quality Audit Tools Quality Audits Quality Improvement studies/initiatives Quality Management Department documentation, i.e., audit forms, minutes, corrective action plans, data collection, performance improvements</td>
<td>YES NO</td>
<td></td>
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<tr>
<td>URAC Core 18</td>
<td>Quality Management Program: The organization maintains a quality management program that promotes objective and systematic measurement, monitoring and evaluation services and implements quality improvement activities based upon findings.</td>
<td>1</td>
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<tr>
<td>URAC Core 19</td>
<td>Quality Management Program Resources: The organization employs staff and provides resources necessary to support the day-to-day operations of the quality management program.</td>
<td>1</td>
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<tr>
<td>URAC Core 20</td>
<td>Quality Management Program Requirements: The organization has written description for its QM Program that: Is approved by the organization’s governing body; Defines the scope, objectives, activities, and structure of the QM Program; Is reviewed and updated at least annually by the QM Committee; Defines the roles and responsibilities of the QM Committee; and Designates a member of senior management with the authority and responsibility for the overall operation of the QM program and who serves on the QM committee.</td>
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</table>
### Quality Improvement – cont’d

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<tr>
<th>Standard</th>
<th>Description</th>
<th>Compliance FEP Case Management</th>
<th>Score</th>
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</thead>
</table>
| URAC Core 21 | Quality Management Committee:  
The organization has a QM Committee that:  
• Is granted authority for QM by the organization’s governing body;  
• Provides on-going reporting to the organization’s governing body;  
• Meets at least quarterly;  
• Maintain approved minutes of all committee meetings;  
• If applicable, includes at least one participating provider or receives input from a participating provider committee (such as a Physician Advisors Group);  
• Provides guidance to staff on quality management priorities and projects;  
• Approves the QI projects to undertake;  
• Monitors progress in meeting QI goals; and  
• Evaluates the effectiveness of the QM program at least annually. | YES | NO | 1 |
### Consumer and Organizational Safety and Education (Organizational Ethics)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Source Documents:</strong></td>
<td></td>
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<tr>
<td>• Letter of attestation</td>
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<tr>
<td>• Confidentiality policy and procedure</td>
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<tr>
<td>• Employee confidentiality statement</td>
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<td>• Personnel files</td>
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<tr>
<td>• CM policies and procedures</td>
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<tr>
<td>• Sample of Incident Report</td>
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<td>• Employee orientation checklist</td>
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<td>• Training documentation</td>
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<tr>
<td>• Personnel files (documentation of orientation process)</td>
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<tr>
<td>• Description of the compensation system for case managers</td>
<td></td>
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<tr>
<td>• Documentation of specific utilization bonuses or incentives (paid/withheld)</td>
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</table>

**URAC CM 13**

Policies and procedures to protect the welfare and safety of consumers and case managers

**For consumer protection:**

• Americans with Disabilities act, worker’s compensation, and other laws protecting rights of consumers;
• Identification and reporting of abuse;
• Informed consent for services, advance medical directives and power of attorney for health care;
• Health benefits and benefits administration;
• Seeking resources for resolution of legal questions; and
• Prevention of suicide

**For consumer protection and case manager protection:**

• Prevention of violence;
• Prevention of infectious diseases; and
• Reporting of incidents and unusual occurrences.

**Score:** 1
### Consumer and Organizational Safety and Education (Organizational Ethics) – cont’d

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
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<th>Compliance FEP Case Management</th>
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</thead>
</table>
| URAC CM 14 | Policies to promote the autonomy of consumers and support consumer and family decision making:  
• Education of consumers on their rights;  
• Process consumers are informed of choices regarding services;  
• Right of consumers to have input into CM plan;  
• Right of consumers to refuse treatment or services, including CM services and implications of such refusal relating to benefit eligibility and/or health outcomes;  
• Use of end of life and advance care directives by organization, as applicable;  
• Right of consumers to obtain information regarding the organization’s criteria for case closure;  
• Right of consumers to receive notification and a rationale when CM services are changed or terminated; and  
• Alternative approaches when the consumer and/or family is unable to fully participate in the assessment phase. |          |                                  | 1     |
<table>
<thead>
<tr>
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</thead>
</table>
| **URAC CM 15** | Case Manager Ethics Training: Establishes and educates CM personnel, no less than annually, on policies and procedures supporting the ethical framework for CM practice, including:  
- Advocacy for consumer needs;  
- Guidance for professional relationships with consumers;  
- Prohibition of relationships that could compromise professional objectivity;  
- Resolution of conflicts of interest between the case manager, consumer, third party payer, provider or any other entity;  
- Business, financial and marketing practices;  
- Resolution of perceived lapses in quality of care resulting from actions by consumers, payers, case managers, providers, organizations, or other entities affecting the CM process;  
- Policies that address the CM’s handling of consumer needs when such needs extend beyond the scope of the organization’s services;  
- Prohibition of discrimination against a consumer or group of consumers by the CM or organization; and  
- Information on how policies regarding the ethical framework will be shared with staff, contractors, clients, and consumers. |          |                               | 1     |
| **URAC CM 16** | Vendor Policy and Procedure  
- The organization establishes and implements policies and procedures addressing its obligations to assist consumers in selecting providers and to monitor vendors to which case managers may make referrals. |          |                               | 1     |
## Oversight of Contracted Vendors

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<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Management Process</strong></td>
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<td>Source Documents:</td>
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<td>CM policies and procedures</td>
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<td>CM criteria</td>
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<td>Quality Committee meeting minutes</td>
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<td>Forms/online information exchanged between departments</td>
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<td>Contract list</td>
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<td>Patient consent form</td>
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<td></td>
<td>Medical record release of information form</td>
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<td></td>
<td>Packet of information given to clients at the onset of CM</td>
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<td></td>
<td>Written notification (letters)</td>
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<td></td>
<td>Copies of information and tools used by Case Managers</td>
<td></td>
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<td></td>
<td>Hours of operation</td>
<td></td>
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<tr>
<td></td>
<td>Risk Management Program Description</td>
<td></td>
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<tr>
<td>URAC Core 5</td>
<td>A mechanism established and implemented mechanisms promote collaboration, coordination and communication across disciplines and departments within the organization, with emphasis on integrating administrative activities, quality improvement, and where present, clinical operations.</td>
<td></td>
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<tr>
<td>URAC CM 17</td>
<td>Criteria for identifying individuals for case management services.</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Standard</td>
<td>Description</td>
<td>Comments</td>
<td>Compliance FEP Case Management</td>
<td>Score</td>
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<tr>
<td><strong>Case Management Process – cont’d</strong></td>
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</tbody>
</table>
| URAC CM 18 | Policy that requires Case Managers to disclose the following information to consumers at the onset of the Case Management relationship:  
- Nature of the case management relationship;  
- Circumstances in which information obtained during CM will be disclosed to third parties;  
- How and when consumers are to be provided with written notifications of CM actions and recommendations;  
- Availability of a complaint process and the method by which to access it; and  
- If requested, a description of the rationale for selecting the consumer for CM services | | | 1 |
| URAC CM 19 | Policy for consent for participation in CM activities that:  
- Requires documentation of oral consent;  
- Requires at minimum an attempt to obtain written consent;  
- Indicates the time frame in which the consent must be obtained; and  
- Indicates the duration of validity of the consent. | | | 1 |
| URAC CM 21 | Make available appropriate tools and information that:  
- Enables case managers to collect information necessary to carry out the case management process  
- Accessible to the Case Manager and others involved in the case management process; and  
- Used in the quality management process. | | | 1 |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Score</th>
</tr>
</thead>
</table>
| **Case Management Process – cont’d** | Policy to conduct and document an assessment of each consumer that at a minimum includes:  
- Cultural barriers considered in psychosocial functioning and health care decision making;  
- Current health status and past medical history;  
- Treatment plan;  
- Resources required to meet immediate needs for health care;  
- Psychosocial status; and  
- Safety concerns.  
Additional elements that may be included:  
- Consumer knowledge and education needs in relation to health status and treatment plan;  
- Consumer/family decision making.  
Review of all potential cases by Psychiatric consultant;  
- Alternate settings licensed by State;  
- Identification of alternative care settings and comparison costs  
- Mechanism to evaluate the need for extension of existing benefits vs. non-covered benefits; and  
- FEP approval of case or ICM program. | YES      | 1     |
| **URAC CM 22**   |                                                                                                                                             |          |       |
| **URAC CM 24**   | Policy to document for every consumer a case management plan specific to the individual consumer that;  
- Is developed in collaboration with the consumer and members of the health care team; and identifies:  
- Short term and long term goals  
- Time frames for re-evaluation (follow-up) and response to services  
- Resources to be utilized  
- Collaborative approaches to be used including family and physician participation. |          | 1     |
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance FEP Case Management</th>
<th>Score</th>
</tr>
</thead>
</table>
| **URAC CM 26** | Policy for resolving disagreements within the Case Management Organization staff regarding consumer care options.  
  - How conflict among health care team members is resolved  
  - When a case should be referred to physician advisors/consultants for clarification  
  - Processes for resolving differences of opinion between case managers and physician advisors/consultants | YES | NO | 1 |
| **URAC CM 27** | Criteria for discharge of consumers or termination of case management services.  
  - Criteria for discharge of consumers or termination of CM Services that are maintained by the organization  
  - CM's are aware of the organization's criteria  
  - Documentation of rational for the discharge of consumers or termination of CM services and the date of discharge from CM | | | 1 |
<p>| <strong>URAC Core 35</strong> | Established standards to assure that the consumer and clients can obtain services; and Defines and monitors its performance with respect to the access standards. | | | 1 |</p>
<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Comments</th>
<th>Compliance FEP Case Management</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBSIL Requirement</td>
<td>Reporting in place to provide monitoring and oversight of CM processes, impact and outcomes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEP II 1-2</td>
<td>• Access</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Activity</td>
<td></td>
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<td></td>
<td>• Utilization</td>
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<td>• Cost Benefit</td>
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<td></td>
<td>• QI studies/initiatives</td>
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<td></td>
<td>• Patient satisfaction surveys</td>
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<tr>
<td></td>
<td>• Complaint tracking and trending</td>
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<td></td>
<td>• QM results, analysis and actions plans</td>
<td></td>
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</tr>
</tbody>
</table>

**Case Management Process – cont’d**

| FEP II 8-9               | Risk Management program in place that identifies, analyze, control, evaluate and prevent liability exposure due to clinical and operational risk factors. | YES | NO |  |

**Onsite Case Management**

| URAC CM 28               | With field and/or on-site CM service, case managers are required to:                                                  | YES | NO | 1 |
|                          | • Carry a picture ID with full name and the name of the organization;                                                |      |    |   |
|                          | • Schedule on-site activities at least 1 business day in advance, unless otherwise agreed upon; and                  |      |    |   |
|                          | • Follow reasonable hospital or facility procedures, including checking in with designated hospital or facility personnel. |      |    |   |
## Complaints

**Source Documents:**
- Policies and procedures for handling complaints
- Complaint logs
- Supporting documentation for events listed in the complaint logs
- Complaint tracking and trending reporting
- Committee minutes

**Policy and procedure through which consumers and providers may submit a complaint that include:**
- A process to determine if the complaint relates to an issue within the scope of CM responsibilities of the organization; and
- A process to refer complaints that are outside the scope of the CM responsibilities of the organization to the appropriate entity.

## Financial Incentives

**URAC Core 33**

Utilization based compensation systems for case managers must ensure that client care is not compromised.

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For which some services are not delegated, the points possible will be less than 35. Therefore, the delegate score will be divided by the maximum points possible for a final percentage.

Full compliance – The score for meeting standard with no deficiencies identified is “1”.
Partial or Non Compliance- The score for not meeting the full intent of the standard requiring corrective action is “0”.
Not applicable (NA)-criteria does not apply to the delegated agency.

Reviewer(s):

Reviewed 6/1/09
Health Care Management Policy and Procedure

Policy Name: Guidelines for Treating Tobacco Use and Dependence

BCBSIL Practice Guideline

Policy Number: Quality Improvement - 6

Effective Date: 11/1/01

Revision Date: Review Date: 1/1/2010

Approval Signature:

Medical Director

HMOI, BA HMO, BlueChoice Select, PPO

Approved QI: 1/6/10 CMC: N/A Approved P&P: 12/10/09

Policy:

The Managed Care Products of Blue Cross Blue Shield of Illinois (BCBSIL) will operate under BCBSIL Practice Guidelines for Treating Tobacco Use and Dependence.

Purpose/Objectives:

• To provide recommendations for interventions and system changes to promote the assessment and treatment of tobacco use and dependence.

• This guideline is designed to assist clinicians by providing a framework for evaluation and treatment of patients and is not intended either to replace a clinician’s judgment or establish a protocol for all patients with a particular condition. The final decision regarding medical treatment is made by the physician and the patient.

Guideline:

Treating Tobacco Use and Dependence, which is a U.S. Public Health Service sponsored guideline, should be used to care for adolescents and adults who smoke.

Key recommendations for clinicians, which are based on literature review and expert panel opinion, are:

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.

2. It is essential that clinicians and health care delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a health care setting.

3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in this Guideline.

4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:
a. Practical counseling (problem solving/skills training)
b. Social support delivered as part of treatment

6. Numerous effective medications are available for tobacco dependence, and clinicians should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).
   a. Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
      i. Bupropion SR
      ii. Nicotine gum
      iii. Nicotine inhaler
      iv. Nicotine lozenge
      v. Nicotine nasal spray
      vi. Nicotine patch
      vii. Varenicline
   b. Clinicians also should consider the use of certain combinations of medications identified as effective in this Guideline.

7. Counseling and medication are effective when used by themselves for treating tobacco dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.

8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and health care delivery systems should both ensure patient access to quitlines and promote quitline use.

9. If a tobacco user currently is unwilling to make a quit attempt, clinicians should use the motivational treatments shown in this Guideline to be effective in increasing future quit attempts.

Physicians are urged to incorporate the following steps into daily office care of adults and adolescents to increase the likelihood that tobacco- using patients who visit the clinic will quit:

<table>
<thead>
<tr>
<th>The “5 A’s” model for treating tobacco use and dependence:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask about tobacco use</strong> Identify and document tobacco use status for every patient at every visit.</td>
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<tr>
<td><strong>Advise to quit</strong> In a clear, strong and personalized manner, urge every tobacco user to quit.</td>
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<tr>
<td><strong>Assess willingness to make a quit attempt</strong> Is the tobacco user willing to make a quit attempt at this time?</td>
</tr>
<tr>
<td><strong>Assist in quit attempt</strong> For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the patient quit.</td>
</tr>
<tr>
<td>For patients unwilling to quit at the time, provide interventions designed to increase future quit attempts.</td>
</tr>
<tr>
<td><strong>Arrangement for follow-up</strong></td>
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<tr>
<td><strong>Enhancing motivation to quit tobacco – the “5 R’s”:</strong></td>
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<td><strong>Risks</strong></td>
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<td><strong>Rewards</strong></td>
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<td><strong>Roadblocks</strong></td>
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</table>
Enhancing motivation to quit tobacco – the “5 R’s”:

<table>
<thead>
<tr>
<th>Repetition</th>
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</thead>
<tbody>
<tr>
<td>The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.</td>
</tr>
</tbody>
</table>

Recommendations for children and adolescents include:

1. Clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use.
2. Counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking.
3. Second-hand smoke is harmful to children. Cessation counseling delivered in pediatric settings has been shown to be effective in increasing abstinence among parents who smoke. Therefore, to protect children from secondhand smoke, clinicians should ask parents about tobacco use and offer them cessation advice and assistance.

Copies of the complete U.S. Public Health Service Treating Tobacco Use and Dependence guideline are available on the Internet [http://www.surgeongeneral.gov/tobacco/]. Consumer materials about smoking cessation are available on the same website.

Reference:

**Policy:**

Blue Cross and Blue Shield of Illinois (BCBSIL) will promote the use of the BCBSIL Practice Guidelines for the Diagnosis and Management of Asthma (attached).

**Purpose/Objectives:**

This guideline for the diagnosis and management of asthma is designed to assist clinicians by providing a framework for evaluation and treatment of patients and is not intended to either replace a clinician's judgement or establish a protocol for all patients with a particular condition.

**Guideline:**

This guideline is based upon the recommendations of the National Asthma Education and Prevention Program Expert Panel Report 3, as summarized in Guidelines for the Diagnosis and Management of Asthma Summary Report 2007.

Clinical Issues and Key Clinical Activities from the guideline’s “Summary of Recommended Key Clinical Activities for the Diagnosis and Management of Asthma” are listed below and the entire Summary, taken from the report, follows. Information from the NHLBI on assessing asthma control and sample asthma action plans is also attached.


<table>
<thead>
<tr>
<th>Clinical Issue</th>
<th>Key Clinical Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>Establish asthma diagnosis</td>
</tr>
</tbody>
</table>
| Managing Asthma Long Term | Goal of asthma therapy is asthma control:  
  - Reduce impairment (prevent chronic symptoms, require infrequent use of short-acting beta2-agonist (SABA), maintain (near) normal lung function and normal activity levels).  
  - Reduce risk (prevent exacerbations, minimize need for emergency care or hospitalization, prevent loss of lung function, or for children, prevent reduced lung growth, have minimal or no adverse effects of therapy.) |
| Four Components of Care: |  
  1. Assessment and Monitoring  
     - Assess asthma severity to initiate therapy.  
     - Assess asthma control to monitor and adjust therapy.  
     - Schedule follow-up care. |
Guidelines for the Diagnosis and Management of Asthma

Page 2 of 8

| 2. Education | ▪ Provide self-management education.  
▪ Develop a written asthma action plan in partnership with the patient.  
▪ Integrate education into all points of care where health professionals interact with patients. |
|---|---|
| 3. Control Environmental Factors and Comorbid Conditions | ▪ Recommend measures to control exposures to allergens and pollutants or irritants that make asthma worse.  
▪ Treat comorbid conditions. |
| 4. Medications | ▪ Select medication and delivery devices to meet patient’s need and circumstances. |

**Stepwise Approach**

| General Principles for All Age Groups | ▪ Incorporate four components of care.  
▪ Initiate therapy based on asthma severity.  
▪ Adjust therapy based on asthma control. |
|---|---|
| Ages 0-4 Years | ▪ Consider daily long-term control therapy.  
▪ Monitor response closely, and adjust treatment. |
| Ages 5-11 | ▪ Involve child in developing a written asthma action plan.  
▪ Promote physical activity.  
▪ Monitor for disease progression and loss of lung growth. |
| Ages 12 and Older | ▪ Involve youths in developing written asthma action plan.  
▪ Promote physical activity.  
▪ Assess possible benefit of treatment in older patients.  
▪ Adjust medications to address coexisting medical conditions common among older patients. |
| Exercise-Induced Bronchospasm (EIB) | ▪ Prevent EIB. |
| Pregnancy | ▪ Maintain asthma control through pregnancy. |
| Surgery | ▪ Reduce risks for complications during and after surgery. |
| Home Management | ▪ Incorporate four components of care.  
▪ Develop a written asthma action plan. |
| Management in the Urgent or Emergency Care Setting | ▪ Assess severity.  
▪ Treat to relieve hypoxemia and airflow obstruction; reduce airway inflammation.  
▪ Monitor response.  
▪ Discharge with medication and patient education. |

**Reference:**

### Figure 3-5b. Assessing Asthma Control in Children 5-11 Years of Age

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control (Children 5-11 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well Controlled</td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week but not more than once on each day</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤1x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung function</td>
<td></td>
</tr>
<tr>
<td>• FEV₁ or peak flow</td>
<td>&gt;80% predicted/ personal best</td>
</tr>
<tr>
<td></td>
<td>&gt;80%</td>
</tr>
<tr>
<td>Exacerbations requiring oral systemic corticosteroids</td>
<td>0–1/year</td>
</tr>
</tbody>
</table>

**Risk**

- Reduction in lung growth
- Evaluation requires long-term followup.
- Treatment-related adverse effects: Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.

**Key:** EIB, exercise-induced bronchoconstriction; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.

**Notes:**

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's or caregiver's recall of previous 2–4 weeks and by spirometry/ or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
**FIGURE 3-5c. ASSESSING ASTHMA CONTROL IN YOUTHS ≥12 YEARS OF AGE AND ADULTS**

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control (Youths ≥12 years of age and adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well-Controlled</td>
</tr>
<tr>
<td>Impairment</td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakening</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>FEV&lt;sub&gt;1&lt;/sub&gt; or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
<tr>
<td>Validated Questionnaires</td>
<td></td>
</tr>
<tr>
<td>ATAQ</td>
<td></td>
</tr>
<tr>
<td>ACQ</td>
<td></td>
</tr>
<tr>
<td>ACT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 – 0.75&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>≤0 ≤0 ≤0</td>
</tr>
</tbody>
</table>

*ACQ values of 0.75–1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchoconstriction; FEV<sub>1</sub>, forced expiratory volume in 1 second. See figure 3–8 for full name and source of ATAQ, ACQ, ACT.

**Notes:**

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient’s recall of previous 2–4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
FIGURE 3–6. SAMPLE QUESTIONS FOR ASSESSING AND MONITORING ASTHMA CONTROL

Monitoring Asthma Control

Ask the patient:
- Has your asthma awakened you at night or early morning?
- Have you needed more quick-relief bronchodilator medication (inhaled short-acting beta2-agonist) than usual?
- Have you needed any urgent medical care for your asthma, such as unscheduled visits to your doctor, an urgent care clinic, or the emergency department?
- Are you participating in your usual and desired activities?
- If you are measuring your peak flow, has it been below your personal best?

Actions to consider:
- Assess whether the medications are being taken as prescribed.
- Assess whether the medications are being inhaled with correct technique.
- Assess lung function with spirometry and compare to previous measurement.
- Adjust medications, as needed; either step up if control is inadequate or step down if control is maximized, to achieve the best control with the lowest dose of medication.

FIGURE 3-10a. SAMPLE ASTHMA ACTION PLAN

My Asthma Action Plan

<table>
<thead>
<tr>
<th>Long-Term Control Medicines</th>
<th>How Much To Take</th>
<th>How Often</th>
<th>Other Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>times per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200</td>
<td>times per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>300</td>
<td>times per day</td>
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<td></td>
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<tr>
<td>400</td>
<td>times per day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>500</td>
<td>times per day</td>
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<thead>
<tr>
<th>Quick-Relief Medicines</th>
<th>How Much To Take</th>
<th>How Often</th>
<th>Other Instructions</th>
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Special instructions when I feel: green: good, yellow: not good, red: awful.

I feel good.
- My peak flow is in the GREEN zone.
- My symptoms may include one or more of the following:
  - Tight chest
  - Cough
  - Shortness of breath
  - Waking up at night with asthma symptoms
  - Decreased ability to do usual activities

I do not feel good.
- My peak flow is in the YELLOW zone.
- My symptoms may include one or more of the following:
  - Tight chest
  - Cough
  - Shortness of breath
  - Waking up at night with asthma symptoms
  - Decreased ability to do usual activities

I feel awful.
- My peak flow is in the RED zone.
- Warning signs may include one or more of the following:
  - It's getting harder and harder to breathe
  - Unable to sleep or do usual activities because of trouble breathing

PREVENT asthma symptoms everyday:
- Take my long-term-control medicines (above) every day.
- Before exercise, take 2 puffs of...
- Avoid things that make my asthma worse like...

CAUTION. I should continue taking my long-term-control asthma medications every day AND:
- Take
- Add
- Increase
- Call

MEDICAL ALERT! Get help:
- Take
- Add
- Call
- Call 9-1-1 if you have trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.
FIGURE 3–10b. SAMPLE ASTHMA ACTION PLAN

Child Asthma Action Plan
0–5 years of age

Patient Name: _______________________________________________________
Medical Record #: ___________________________________________________

Health Care Provider's Name: _____________________________________________
DOB: _________________

Health Care Provider’s Phone #: _________________________________________
Completed by: __________________________________________________________
Date: _________________

<table>
<thead>
<tr>
<th>Long-Term Control Medication</th>
<th>How Much To Take</th>
<th>How Often</th>
<th>Other Instructions</th>
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Quick-Relief Medicines
How Much To Take | How Often | Other Instructions
IDR: If new medicine is needed often, call physician.

Child is well and has no asthma symptoms, even during active play.

PREVENT asthma symptoms every day:

- Avoid things that make the child’s asthma worse.
- Avoid tobacco smoke, ask people to smoke outside.

Child is not well and has asthma symptoms that may include:

- Coughing
- Wheezing
- Running nose or other cold symptoms
- Breathing harder or faster
- Awaking due to coughing or difficulty breathing
- Playing less than usual

CAUTION: Take action by continuing to give regular asthma medicine every day/RMD

If the child is not in the Green Zone and still has symptoms after 1 hour, then:

- Give more

Other symptoms that could indicate that your child is having trouble breathing may include:

- Difficulty sleeping
- Poor sound sleep
- Changes in sleep patterns, crying and crying, and decreased appetite

Medications/estimate and frequency

Child feels awful! Warning signs may include:

- Child’s wheeze, cough, or difficulty breathing continues or worsens even after giving yellow zone medications.
- Child’s breathing is so hard that talking, playing, sleeping, and crying is exaggerated.

MEDICAL ALERT! Get help!

- Take the child to the hospital or call 9–1–1 immediately!
- Give more
- Keep child’s chest up
- Call

Danger! Get help immediately!

Call 9–1–1 if:

- If the child’s skin is sanded in around neck and ribs, or
- Lip and/or fingernails are gray or blue, or
- Child doesn’t respond to you.

Adapted and reprinted with permission from the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute.
FIGURE 3-10c. SAMPLE ASTHMA ACTION PLAN

Policy Name: Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus

Policy Number: Quality Improvement - 8
Effective Date: 11/1/01
Revision Date: 1/1/10

Approval Signature: [Signature]
Medical Director

Policy:

Blue Cross and Blue Shield of Illinois (BCBSIL) will promote the use of the BCBSIL Practice Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus.

Purpose/Objectives:

This guideline for the prevention and early detection of complications of diabetes mellitus is designed to assist clinicians by providing a framework for evaluation and treatment of patients and is not intended to either replace a clinician’s judgement or establish a protocol for all patients with a particular condition.

This BCBSIL guideline summarizes portions of the January 2009 American Diabetes Association Position Statement Standards of Medical Care in Diabetes -- 2009. This guideline focuses on routine aspects of diabetes care, particularly prevention and early detection of diabetic complications that apply to all diabetics. Diagnosis of diabetes, prevention/delay of diabetes, pharmacologic management of diabetes, treatment of diabetes in special populations (such as children, adolescents and older adults), management of diabetes in special settings (hospital, school, day care, correctional institutions and disasters) and treatment of complications are beyond the scope of this guideline. Refer to the American Diabetes Association Position Statement for complete recommendations.

Guidelines:

Diabetes is a chronic illness that requires continuing medical care and patient self-management education to prevent acute complications and to reduce the risk of long-term complications. Diabetes care is complex and requires that many issues beyond glycemic control be addressed. A large body of evidence exists that supports a range of interventions to improve diabetes outcomes.

DIABETES CARE

Glycemic control

Clinical considerations:
Glycemic control is fundamental to the management of diabetes. Prospective randomized clinical trials have shown that improved glycemic control is associated with significant decreased rates of retinopathy, nephropathy, and neuropathy. Epidemiological studies show a relationship between A1C control and microvascular complications. The greatest number of complications are averted by taking patients from very poor control to fair or good control.
While there is benefit from further lowering of A1c from 7% to 6% (further reduction in the risk of microvascular complications), the absolute risk reduction from this improvement is smaller and there is substantially increased risk of hypoglycemia. Although epidemiologic studies and meta-analyses show a direct relationship between A1c and cardiovascular disease, the potential of intensive glycemic control to reduce cardiovascular disease is less clearly defined.

Guidelines:

- Perform the A1C test at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control). Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals.
- For microvascular disease prevention, the A1C goal for nonpregnant adults in general is <7%. The general goal of <7% appears reasonable for many adults for macrovascular risk reduction.
- The A1C goal for selected individual patients may be lower than the general goal of <7% if this can be achieved without significant hypoglycemia or other adverse effects of treatment.
- Less stringent treatment goals than the general goal of <7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to obtain despite education, glucose monitoring and effective doses of multiple glucose-lowering agents including insulin.

- Self-monitoring of blood glucose (SMBG):
  - For patients using multiple insulin injections or an insulin pump, SMBG should be done at least three times a day.
  - For patients using less frequent insulin injections, noninsulin therapies or medical nutrition therapy and physical activity alone, SMBG may be useful as a guide to the success of therapy.
  - Instruct the patient in self-monitoring of blood glucose and routinely evaluate the patient’s technique and ability to use data to adjust therapy.

Medical nutrition therapy

Clinical considerations:
Medical nutrition therapy is an integral component of diabetes prevention, management and self-management education. Nutrition is an essential component of an overall healthy lifestyle in addition to its role in preventing and controlling diabetes.

Guidelines:

- People with diabetes should receive individualized medical nutrition therapy as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes medical nutrition therapy.
- Medical nutrition therapy should address weight, dietary fat intake and carbohydrate intake.

Diabetes self-management education (DSME)

Clinical considerations:
DSME helps patients optimize metabolic control, prevent and manage complications and maximize quality of life. Education helps people with diabetes initiate effective self-care when they are first diagnosed. Ongoing DSME helps people with diabetes maintain effective self-management as their diabetes presents new challenges and treatment advances become available.
Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus
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Guidelines:
• People with diabetes should receive DSME according to national standards when their diabetes is diagnosed and as needed thereafter.
• DSME should address psychosocial issues, since emotional well-being is strongly associated with positive diabetes outcomes.

Physical activity

Clinical considerations:
Regular exercise has been shown to improve blood glucose control, reduce cardiovascular risk factors, contribute to weight loss and improve well-being.

Guidelines:
- At least 150 minutes/week of moderate-intensity aerobic physical activity is recommended.
- In the absence of contraindications, people with type 2 diabetes should be encouraged to perform resistance training three times per week.

Psychosocial assessment and care

Psychological and social problems can impair the ability to carry out diabetes care tasks and therefore can compromise health status.

Guidelines:
• Assessment of the psychological and social situation should be included as an ongoing part of the medical management of diabetes.
• When adherence to the medical regimen is poor, screen for psychosocial problems such as depression, anxiety, eating disorders and cognitive impairment.

When treatment goals are not met

For a variety of reasons, some people with diabetes do not achieve the desired goals of treatment. Possible strategies may include rethinking the treatment regimen, assessment of barriers to adherence, culturally appropriate and enhanced diabetes self-management education, co-management with a diabetes team, referral to a medical social worker, change in pharmacological therapy, initiation of or increase in self-monitoring of blood glucose, more frequent contact with the patient, and referral to an endocrinologist.

Immunization

Clinical considerations:
Influenza and pneumonia are common, preventable infectious diseases associated with high mortality and morbidity in the elderly and in people with chronic diseases. Observational studies of patients with a variety of chronic illnesses, including diabetes, show that these conditions are associated with an increase in hospitalizations for influenza and its complications. In a case-control series, influenza vaccine was shown to reduce diabetes-related hospital admission by as much as 79% during flu epidemics.

Guidelines:
Annually provide an influenza vaccine to all diabetic patients 6 months of age or older.
Administer pneumococcal polysaccharide vaccine to all diabetic patients >2 years of age. A one-time revaccination is recommended for individuals >64 years of age previously immunized when they were < 65 years of age if the vaccine was administered more than 5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease and other immunocompromised states.

PREVENTION AND MANAGEMENT OF DIABETES COMPLICATIONS

Blood pressure control

Clinical considerations:
Hypertension is a common comorbidity of diabetes, with prevalence depending on the type of diabetes, age, obesity, and ethnicity. Hypertension is a major risk factor for cardiovascular disease and microvascular complications. Randomized clinical trials have demonstrated the benefit of lowering blood pressure to <140 mmHg systolic and <80 mmHg diastolic in individuals with diabetes. Epidemiologic analyses show that blood pressure >115/75 is associated with increased cardiovascular event rates and mortality in individuals with diabetes.

Guidelines:
- Blood pressure should be measured at every routine diabetes visit.
- Patients with diabetes should be treated to a systolic blood pressure <130 mmHg.
- Patients with diabetes should be treated to a diastolic blood pressure <80 mmHg.
- Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that contains an ACE inhibitor or an angiotensin receptor blocker.

Dyslipidemia/lipid management

Clinical Considerations:
Patients with type 2 diabetes have an increased prevalence of lipid abnormalities, which contributes to their high risk of cardiovascular disease (CVD). Clinical trials demonstrated significant effects of pharmacologic therapy on CVD outcomes. Clinical trials have shown significant primary and secondary prevention of CVD events in diabetics, with a reduction in CHD death and nonfatal MI more clearly seen in those with high baseline risk.

Guidelines:
- In most adult patients, test for lipid disorders at least annually. In adults with low-risk lipid values (LDL <100 mg/dl, HDL >50 mg/dl and triglycerides <150 mg/dl), lipid assessments may be repeated every 2 years.
- Lifestyle modification focusing on the reduction of saturated fat, trans fat and cholesterol intake, weight loss (if indicated) and increased physical activity should be recommended.
- Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:
  - with overt CVD
  - without CVD who are over the age of 40 and have one or more other CVD risk factors.
- Statin therapy for patients at lower risk should be considered if LDL cholesterol remains >100 mg/dl or in those with multiple CVD risk factors.
- In individuals without overt CVD, the primary goal is an LDL <100 mg/dl.
- In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dl using a high dose of a statin is an option.
Antiplatelet agents

Clinical considerations:
Aspirin has been recommended as a primary and secondary therapy to prevent cardiovascular events in high-risk diabetic and nondiabetic individuals. Many trials have shown an approximate 30% decrease in myocardial infarction and a 20% decrease in stroke in a wide range of patients.

Guidelines:
- Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD.
- Use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or type 2 diabetes at increased cardiovascular risk, including those who are over 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, albuminuria.)
- For patients with CVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used.

Smoking cessation

Clinical considerations:
A large body of evidence provides convincing documentation of the causal link between cigarette smoking and health risks. Cigarette smoking contributes to one of every five deaths in the U.S. and is the most important modifiable cause of premature death. Studies of individuals with diabetes consistently found a heightened risk of CVD and premature death among smokers. Smoking is also related to the premature development of microvascular complications of diabetes. A number of large randomized clinical trials have demonstrated the efficacy and cost-effectiveness of counseling in changing smoking behavior.

Guidelines:
- Advise all patients not to smoke.
- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care.

CHD Screening and Treatment

Clinical considerations
At least annually, cardiovascular risk factors should be assessed. These risk factors include dyslipidemia, hypertension, smoking, a positive family history of premature coronary disease and the presence of micro or macroalbuminuria. Abnormal risk factors should be treated.

Guidelines:
- In asymptomatic patients, evaluate risk factors to stratify patients by 10-year risk and treat risk factors accordingly.
- In patients with known CVD, ACE inhibitor, aspirin and statin therapy (if not contraindicated) should be used to reduce the risk of cardiovascular events.
- In patients with a prior myocardial infarction, beta blockers should be added (if not contraindicated) to reduce mortality.
- In patients >40 years of age with another cardiovascular risk factor, aspirin and statin therapy (if not contraindicated) should be used to reduce the risk of cardiovascular events.
Nephropathy screening

Clinical considerations:
Diabetic nephropathy occurs in 20-40% of patients with diabetes and is the single leading cause of end-stage renal disease (ESRD). Persistent albuminuria in the range of 30-299 mg/24 h (microalbuminuria) has been shown to be the earliest stage of diabetic nephropathy in type 1 diabetes and a marker for development of nephropathy in type 2 diabetes. Microalbuminuria is also a well-established marker of increased CVD risk. While patients with microalbuminuria who progress to macroalbuminuria (>300 mg/24 h) are likely to progress to ESRD, a number of interventions reduce the risk and slow the progression of renal disease.

Guidelines:
- General recommendations:
  - To reduce the risk and slow the progression of nephropathy, optimize glucose control.
  - To reduce the risk and/or slow the progression of nephropathy, optimize blood pressure control.
- Perform an annual test to assess urine albumin excretion in:
  - type 1 diabetic patients who have had diabetes >5 years, and
  - all type 2 diabetic patients starting at diagnosis.
- Serum creatinine should be measured at least annually in all adults with diabetes to estimate GFR and stage the level of chronic kidney disease, if present.
- Reduction in protein intake is recommended for individuals with diabetes and chronic kidney disease.
- In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used.
- Monitor serum creatinine and potassium levels in patients on ACE inhibitors, ARBs or diuretics.
- Continued monitoring of urine albumin excretion is recommended to assess both response to therapy and progression of disease.

Diabetic retinopathy screening

Clinical considerations:
Diabetic retinopathy is a highly specific vascular complication of both type 1 and type 2 diabetes. The prevalence of retinopathy is strongly related to the duration of diabetes. Other factors that increase the risk of, or are associated with, retinopathy include chronic hyperglycemia, the presence of nephropathy, and hypertension. Diabetic retinopathy is the most frequent cause of new cases of blindness among adults aged 20-74 years. Intensive diabetes management with the goal of achieving near normoglycemia has been shown to prevent and/or delay the onset of diabetic retinopathy. Lowering blood pressure has been shown to decrease the progression of retinopathy. Pregnancy in type 1 diabetic patients may aggravate retinopathy.

Guidelines:
- To reduce the risk or slow the progression of retinopathy, optimize glycemic control.
- To reduce the risk of slow the progression of retinopathy, optimize blood pressure control.
- Adults and children aged ten years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes.
Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes.

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2-3 years) may be considered following one or more normal eye exams. Exams will be required more frequently if retinopathy is progressing.

Women who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and should be counseled on the risk of development and/or progression of diabetic retinopathy. Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum.

Neuropathy screening and treatment

Clinical considerations:
Early recognition and appropriate management of neuropathy in the patient with diabetes is important. Specific treatment for the underlying nerve damage is currently not available, other than improved glycemic control, which may slow progression. Effective symptomatic treatments are available for some manifestations of distal symmetric polyneuropathy (DPN) and autonomic neuropathy.

Guidelines:
- All patients should be screened for DPN at diagnosis and at least annually thereafter, using simple clinical tests.
- Electrophysiological testing is rarely ever needed, except in situations where the clinical features are atypical.
- Screening for cardiovascular autonomic neuropathy should be instituted at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes. Special testing is rarely needed.

Foot care

Clinical considerations:
Amputation and foot ulceration, consequences of diabetic neuropathy and/or peripheral arterial disease, are common and major causes of morbidity and disability in people with diabetes. Early recognition and management of risk factors can prevent or delay adverse outcomes.

Guidelines:
- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes or vibration perception threshold).
- Provide general foot self-care education to all patients with diabetes.
- Initial screening for peripheral arterial disease should include a history for claudication and an assessment of the pedal pulses. Consider obtaining an ankle-brachial index.
Preconception care

Clinical considerations:
Major congenital malformations remain the leading cause of mortality and serious morbidity in infants of mothers with type 1 and type 2 diabetes. Observational studies indicate that the risk of malformations increases continuously with increasing maternal glycemia during the first 6-8 weeks of gestation, as defined by first trimester A1C concentrations.

Guidelines:
- A1C levels should be normal or as close to normal as possible (<7%) in an individual patient before conception is attempted.
- **Starting at puberty, preconception counseling should be incorporated in the routine diabetes clinic visit for all women of childbearing potential**
- Women with diabetes who are contemplating pregnancy should be evaluated and, if indicated, treated for diabetic retinopathy, nephropathy, neuropathy, and CVD.
- **Medications used by women contemplating pregnancy should be evaluated before conception.**

Strategies for improving diabetes care

The implementation of the standards of care for diabetes is suboptimal in most clinical settings. The challenge of providing uniformly effective diabetes care has thus far defied a simple solution. Successful programs have published results showing improvement in process measures such as measurement of A1c, lipids and blood pressure. Effects on important intermediated outcomes, such as mean A1c for populations, have been more difficult to demonstrate. Features of successful programs reported in the literature include:
- Improving health care professional education regarding the standards of care through formal and informal education programs.
- Adoption of practice guidelines. Guidelines should be readily accessible at the point of service, such as on patient charts, in examining rooms, in wallet or pocket cards, on PDAs or on office computer systems. Guidelines should begin with a summary of their major recommendations.
- Use of checklists that mirror guidelines, which have been successful at improving adherence to standards of care.
- Tracking systems with either an electronic medical record or patient registry, which have been helpful at increasing adherence to standards of care.
- Other nonautomated systems such as mailing reminders to patients, chart stickers and flowsheets, which have been useful to prompt both providers and patients.
- Systems changes, such as provision of automated reminders to providers and patients, reporting of process and outcome data to providers, and especially identification of patients at risk because of failure to achieve target values or a lack of reported values.
- Quality improvement programs combining cycles of analysis and intervention with provider performance data.
- Practice changes, such as clustering of dedicated diabetes visits into specific times within a primary care practice schedule and/or visits with multiple health care professionals on a single day and group visits.
- Availability of case management or care management services, usually by a nurse. Nurses, pharmacists and other nonphysician health care professionals using detailed algorithms working under the supervision of physicians and nurse education calls have also been helpful. Dieticians using medical nutrition therapy guidelines have been demonstrated to improve glycemic control.
Guidelines for the Prevention and Early Detection of Complications of Diabetes Mellitus

- Availability and involvement of expert consultants, such as endocrinologists and diabetes educators.
- Delivery of diabetes self management education, which has been shown to increase adherence to standard of care.

Because these interventions are generally provided as components of a multifactorial intervention, it is difficult to assess the contribution of each component; however, it is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of health care professionals.

Reference
Policy Name: Guidelines for the Diagnosis and Treatment of Patients with Depression in the Primary Care Setting
Policy Number: Quality Improvement - 9
Effective Date: 11/1/01
Revision Date: 1/1/10
Review Date:

Approval Signature: Medical Director

Policy:
The Managed Care Products of Blue Cross Blue Shield of Illinois will operate under BCBSIL Practice Guidelines for the diagnosis and treatment of patients with depression in the primary care setting. (attached).

Purpose/Objectives:

- In many cases, the diagnosis and treatment of major depressive disorder can be successfully accomplished by primary care practitioners. Referral to a mental health provider may also be an appropriate option, depending upon physician and/or patient preference.

- These guidelines are based primarily on the Institute for Clinical Systems Improvement guideline, Major Depression in Adults in Primary Care, Twelfth Edition.

- These guidelines are intended to assist the Primary Care Physician (PCP) in the diagnosis and treatment of depression. They are not intended either to replace a clinician's judgment or establish a protocol for all patients with a particular condition. The final decision regarding medical treatment is made by the physician and the patient.

Guideline:

1. Suspect and screen for major depression.
   - As the rate of perinatal depression is estimated at 10-15%, additional recommendations for perinatal women include depression screening at the initial prenatal visit, at least once each trimester, at the postpartum follow-up visit and at well-child checks.

2. Diagnose and characterize major depression with a clinical interview. Include:
   - history of present illness
   - medical history
   - medication history
   - substance abuse/dependence.

3. Determine whether DSM-4 diagnostic criteria are met.
Guidelines for the Diagnosis and Treatment of Patients with Depression in the Primary Care Setting

Page 2 of 4

**DSM-4 diagnostic criteria for major depressive disorder:** Symptoms must be present most of the day, nearly daily for at least 2 weeks. At least five of the following symptoms must be identified and one of those must be from the first two symptoms.

1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in almost all activities most of the day nearly every day
3. Significant weight loss or weight gain
4. Insomnia/hypersomnia
5. Psychomotor agitation/retardation
6. Fatigue (loss of energy)
7. Feelings of worthlessness (guilt)
8. Impaired concentration (indecisiveness)
9. Recurrent thoughts of death or suicide

**Evaluate whether:**

1. the symptoms meet criteria for a mixed episode
2. the symptoms cause clinically significant distress or impairment
3. the symptoms are due to a substance (a drug of abuse or medication) or a medical condition
4. the symptoms are better accounted for by bereavement

4. **Consider other mood, anxiety and somatoform disorders.**

5. **Assess whether the patient is unsafe to self or others. Consider asking the following progression of questions:**
   - a) Do you feel that life is worth living?
   - b) Do you wish you were dead?
   - c) Have you thought about ending your life?
   - d) If yes, have you gone so far as to think about how you would do so?
   - e) Do you have access to a way to carry out your plan?
   - f) What keeps you from harming yourself?

6. **If substance abuse or psychiatric comorbidity (including bipolar disorder) is present, assess need for specialty care.**

7. **Immediately involve a behavioral/chemical health provider if there are concerns about the patient’s safety, the safety of others, loss of touch with reality, or inability to care for self/family.**

8. **Consider other factors, including chronic conditions (such as cardiovascular disease, diabetes, chronic pain), cultural considerations, age and dementia.**
9. **Address secondary causes and/or other specific concerns.**

10. **Develop a comprehensive treatment plan.**
    a) Educate and engage the patient. Consider patient self-management, behavioral activation with scheduled pleasant activities and appropriate physical activity.
    b) The patient should be informed of the diagnosis, prognosis and treatment options, including costs, duration, and potential side effects. Points that may be emphasized include:
        1) Depression is a medical illness, not a character defect.
        2) Recovery is the rule, not the exception.
        3) Treatment is effective for nearly all patients.
        4) The aim of treatment is complete remission, not just getting better but staying well.
        5) The risk of recurrence is significant.
        6) Patient and family should be alert to early signs and symptoms of recurrence and seek treatment early if depression returns.
    c) Discuss treatment options, including psychotherapy and pharmacotherapy.
    d) If medications are used, educate the patient about expectations to support medication adherence and completion.
    e) Establish a follow-up plan.

11. **Assess whether patient is responding adequately.**

12. **If remission has not been achieved when re-evaluated, evaluate medication and/or psychotherapy (doses, duration, type and adherence).** Reconsider accuracy of diagnosis or impact of comorbidities. Consider whether consult with a behavioral health provider is needed.

13. **Consider other treatments.**

14. **Continuation and maintenance treatment**
    a) Continuation therapy is the phase during which antidepressants are continued to keep the patient free of symptoms for the duration of the current episode. By definition this is considered to be at least six months long, but may be longer.
    b) Maintenance therapy is designed to prevent recurrence of new or future episodes of major depression. Examples of possible candidates for maintenance therapy include patients who:
        * have had two previous episodes of major depression
        * have had two episodes of major depression with rapid recurrence of episodes
• are more than 60 at onset
• have had severe episodes of major depression
• have a family history of a mood disorder
• have comorbid anxiety disorder or substance abuse
• have a seasonal pattern of major depression

Reference:

1. Institute for Clinical Systems Improvement Health Care Guideline: Major Depression in Adults in Primary Care, Twelfth Edition, May 2009. Available at: 
Policy:

The Plan will operate under the Blue Cross Blue Shield of Illinois (BCBSIL) Policy on Clinical Practice Guidelines. BCBSIL clinical practice guidelines, including both condition-related clinical practice guidelines and preventive care guidelines, are descriptions of recommended approaches to specified clinical conditions or situations.

Purpose:

Blue Cross Blue Shield of Illinois (BCBSIL) sets forth clinical practice guidelines for the following purposes:

- To inform practitioners about current recommendations for care
- To form the basis for quality improvement activities in areas where there may be significant variation in clinical practice
- To provide a basis for criteria that can be used to review care of specific clinical conditions or situations.

Procedure:

I. Development:

A. BCBSIL clinical practice guidelines are to be evidence-based.

B. Clinical practice guidelines set forth by BCBSIL may be derived from either:

1. Recognized sources such as professional medical associations, specialty societies, professional consensus panels, national task forces, national agencies, NIH Centers and NIH Institutes, OR

2. Recommendations of committees convened by BCBSIL that include, at a minimum, both board-certified network practitioners from appropriate specialties and BCBSIL Medical Directors.

C. The manner in which some clinical practice guidelines developed by other entities are presented may not be optimal for the BCBSIL purposes stated above. Therefore, BCBSIL may revise or summarize existing clinical practice guidelines developed by another source.
II. Adoption, Maintenance, and Revision:

A. The following procedure is used for adoption of BCBSIL clinical practice guidelines:

1. The proposed clinical practice guideline is developed by one or more BCBSIL Medical Directors, based on the recommendations of either a recognized source or a BCBSIL committee, as defined above. Input may be solicited from network practitioners board-certified in relevant specialties during this process.

2. The proposed clinical practice guideline is reviewed by the BCBSIL Clinical Management Committee, which includes board-certified network practitioners. The Committee may recommend modification, approval or disapproval, or may refer the clinical practice guideline back to a Medical Director for revision.

3. Final approval of the BCBSIL clinical practice guidelines rests with the BCBSIL Medical Director, Quality Improvement.

B. Practice guidelines are reviewed at least biennially and as needed in response to network feedback or new medical developments.

1. At least annually, a BCBSIL Medical Director reviews the sources for all clinical practice guidelines to be certain that the sources are current.
   i. If the sources for a guideline have not been updated, the guideline may be reviewed biennially.
   ii. If the sources for a guideline have been substantively changed, the guideline will be reviewed within one year of the date that the source was updated.

2. A BCBSIL Medical Director reviews the BCBSIL clinical practice guideline and current literature, and drafts any necessary changes. During this process, input may be solicited from network practitioners who are board-certified in appropriate specialties.

3. The BCBSIL clinical practice guideline, whether modified or unchanged, is then reviewed by the Clinical Management Committee, which includes board-certified network practitioners. The Committee may recommend modification, approval or disapproval, or may refer the clinical practice guideline back to the Medical Director for revision.

4. Final approval of the BCBSIL clinical practice guidelines rests with the BCBSIL Medical Director, Quality Improvement.

III. Use:

A. BCBSIL clinical practice guidelines are disseminated in the following manner:

1. They may be published in their entirety or in summary form in practitioner newsletters, member newsletters or other venues, or may be enclosed in mailings to practitioners and/or providers.

2. The BCBSIL clinical practice guidelines are included in the Provider Manual.

3. The BCBSIL clinical practice guidelines are posted on the BCBSIL web site, with notification to providers in the provider newsletter.

B. BCBSIL clinical practice guidelines may be used differently by specific BCBSIL products. Some products may not use a BCBSIL clinical practice guideline at all. Others may use it only for the purpose of developing practitioner and/or member awareness or sensitivity to a clinical issue. Some products may use the BCBSIL clinical practice guideline in quality improvement, condition management and/or utilization management activities.
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C. BCBSIL clinical practice guidelines are designed to assist clinicians by providing a framework for evaluation and treatment of patients and are not intended to either replace a clinician’s judgement or establish a protocol for all patients with a particular condition. The final decision regarding medical treatment is made by the physician and the patient.

D. BCBSIL clinical practice guidelines are for the purpose of aiding practitioners in making decisions about care. They do not dictate an exclusive course of treatment. Variations in practice may be expected based on the needs of individual patients and other factors, and it is anticipated that a practitioner may elect to not follow a BCBSIL clinical practice guideline in specific cases for appropriate clinical reasons.

E. Network practitioners who disagree with a BCBSIL clinical practice guideline are encouraged to notify any BCBSIL Medical Director regarding the concerns, which will be carefully evaluated.

F. Determination regarding benefit payment is defined by the scope of the member’s contract and is independent of BCBSIL clinical practice guideline recommendations.
Policy Name: Shared Decision-Making
Policy Number: Quality Improvement - 11
Effective Date: 11/1/01
Revision Date: Review Date: 1/1/2009

Approval Signature: [Signature]
Medical Director
HMO, BA, HMO, BlueChoice, BlueChoice Select, PPO
Approved QI: 01/07/09 CMC: 11/18/08 Approved P&P: 12/18/08

Policy:

The Managed Care Products of Blue Cross and Blue Shield of Illinois (BCBSIL) will operate under BCBSIL policy on Shared Decision-Making.

Purpose/Objectives:

To encourage physicians to provide members with complete information about diagnosis, treatment and prognosis in terms that the member understands, in order to enable the member to make an informed decision about proposed medical care.

Procedure:

A. Excellence in health care is strongly dependent upon the relationship between a patient and his/her providers of care. BCBSIL strives to encourage the fullest development of that relationship, and promotes full discussion between patient and practitioner regarding the nature of the patient's concerns/illness, and options for evaluation and treatment, irrespective of benefit structure or health plan design.

B. Prior to any patient receiving non-emergent major treatment, the treating practitioner should document in the medical record that a process of shared decision-making has occurred with the patient or the patient's legally authorized representative. The shared decision making process may include the following:

1. A full description of the condition, including its expected natural course.

2. A description of available treatment options, including:
   - The nature and duration of each treatment.
   - The expected outcome (potential efficacy) of each treatment, including that of observation or non-intervention.
   - Any reasonably foreseeable risks or adverse effects of the treatment.

C. Where available, patient participation in programs designed to enhance shared decision-making is encouraged. Whenever possible, appropriate educational material should be provided to patients prior to, during, and after treatment.
Policy Name: Guidelines for Heart Failure in the Adult  
Policy Number: Quality Improvement - 12  
Effective Date: 11/1/01  
Revision Date: 1/1/10  
Review Date:  

Approval Signature:  
Medical Director  

Replaces Guidelines for Congestive Heart Failure  
Approved QI: 1/6/10  
CMC: 11/10/09  
Approved P&P: 12/10/09

Policy:
The Managed Care Products of Blue Cross Blue Shield of Illinois will operate under BCBSIL Practice Guidelines for Heart Failure in the Adult (attached).

Purpose/Objectives:
To provide guidelines for the treatment of heart failure in the adult. These guidelines are not intended either to replace a clinician's judgment or establish a protocol for all patients with this condition. The final decision regarding medical treatment is made by the physician and the patient.

Guideline:
BCBSIL has adopted the 2009 Focused Update Incorporated into the 2005 American College of Cardiology/American Heart Association Guidelines for the Diagnosis and Management of Heart Failure in Adults. The guideline is available at: http://www.acc.org/clinical/statements.htm

Heart failure is defined as a “complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ability of the ventricle to fill with or eject blood.” Cardinal manifestations are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary congestion and peripheral edema.²

The ACC/AHA guidelines make recommendations for four stages of heart failure (HF):  
- Stage A: at high risk for HF but without structural heart disease or symptoms of HF  
- Stage B: structural heart disease but without signs or symptoms of HF  
- Stage C: structural heart disease with prior or current symptoms of HF  
- Stage D: refractory HF requiring specialized interventions.

The ACC/AHA guideline notes that Stage A and Stage B are not heart failure but are an attempt to help healthcare providers identify patients early who have risk factors that predispose toward the development of HF. **For example**, patients with conditions such as coronary artery disease, hypertension or diabetes **who do not yet demonstrate impaired left ventricular function**, hypertrophy or geometric chamber distortion are considered Stage A while patients with no symptoms who have left ventricular hypertrophy and/or impaired left ventricular function are Stage B.

The guideline outlines the characterization of HF as a clinical syndrome, initial and serial clinical assessment, therapy, treatment of special populations, patients who have concomitant disorders, end-of-life considerations, and implementation of practice guidelines.
Guidelines for Heart Failure in the Adult
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Reference:
Policy:
The Managed Care Products of Blue Cross and Blue Shield of Illinois will operate under BCBSIL Practice Guidelines for the Primary and Secondary Prevention of Atherosclerotic Cardiovascular Disease. (attached).

Purpose/Objectives:
- Many major studies conclude that the incidence and progression of atherosclerotic cardiovascular disease decreases when individuals address modifiable risks, including cigarette smoking, hypertension, high serum cholesterol (including low levels of HDL cholesterol), physical inactivity, obesity and diabetes mellitus. This guideline focuses on risk factor modification, and incorporates recent consensus statements from the American Heart Association. (Please see attachments.)
- This guideline is designed to assist clinicians by providing a framework for evaluation and treatment of patients and is not intended to either replace a clinician's judgment or establish a protocol for all patients with a particular condition. The final decision regarding medical treatment is made by the physician and the patient.

Guideline:

Primary Prevention
Persons with no known atherosclerotic cardiovascular disease should have an assessment of cardiovascular risk factors beginning at age 20. Family history of CHD should be regularly updated. Smoking status, diet, alcohol intake, and physical activity should be assessed at every routine evaluation. Blood pressure, body mass index, waist circumference and pulse should be assessed at least every two years. Every five years, or more frequently if risk factors change, adults should have their risk assessed. Risk factors used in global risk assessment should include age, sex, smoking status, blood pressure, total or LDL cholesterol, HDL cholesterol, and diabetes. Guidance on primary prevention of cardiovascular disease should be based on the risk factor assessment and on the value of healthy life habits, including avoidance of tobacco, healthy dietary patterns, weight control and regular appropriate exercise. Recommendations for primary prevention of cardiovascular disease are summarized in the 2002 American Heart Association table, Guide to Primary Prevention of Cardiovascular Disease and Stroke: Risk Interventions, which is on page 390 in the AHA/ACC primary prevention guideline, available at http://circ.ahajournals.org/cgi/reprint/106/3/388.pdf

The table summarizes recommendations and goals regarding smoking, blood pressure control, dietary intake, aspirin, blood lipid management, physical activity, weight management, diabetes management, and chronic atrial fibrillation.
Secondary Prevention

Secondary prevention guidance should be provided to persons with atherosclerotic cardiovascular disease, including those with coronary artery disease, peripheral arterial disease, atherosclerotic aortic disease and carotid artery disease. Evidence from clinical trials confirms the value of aggressive risk-reduction therapies for these patients. In this population, aggressive comprehensive risk factor management improves survival, improves the quality of life and reduces recurrent events and the need for interventional procedures. Recommended interventions regarding smoking, blood pressure control, lipid management, physical activity, weight management, diabetes management, medications (antiplatelet agents/ anticoagulants, renin-angiotensin-aldosterone system blockers and beta blockers) and influenza vaccination are summarized in the table titled AHA/ACC Secondary Prevention for Patients with Coronary and Other Vascular Disease: 2006 Update, which is on page 2364-2365 in the AHA/ACC secondary prevention guideline, available at http://circ.ahajournals.org/cgi/reprint/113/19/2363

References:

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**Approval Signature:**

Medical Director

HMOI, BA HMO, BlueChoice
Select, PPO

Approved QI: 1/6/10  CMC: N/A  Approved P&P: 12/10/09

**Policy:**

Blue Cross and Blue Shield of Illinois (BCBSIL) will educate members and practitioners about the content of the BCBSIL Preventive Health Care Guidelines (attached) and will assess compliance with targeted guidelines.

**PURPOSE/OBJECTIVES:**

- To increase physician awareness of and compliance with effective methods of preventive care for neonates, for children 0-17 years of age, for adults age 18-64, for adults 65 and older, and for pregnant women.

- To increase member awareness of recommended preventive care services.

The Preventive Health Care Guidelines apply to average risk, asymptomatic and otherwise healthy individuals. Preventive care interventions appropriate for those with other levels of risk (increased or decreased) will vary by individual circumstance, and physicians are encouraged to tailor the approach to these patients as necessary.

The recommended interventions are minimal guidelines. Additional interventions may be useful, except where there is a specific recommendation against routine screening.

*Primary preventive health care services seek to reduce the likelihood of future adverse outcomes in individuals prior to the onset of symptomatic disease. Services such as immunizations, education and counseling, physical examination, and screening tests are primary preventive services.*

Expert groups sometimes disagree on the value of various preventive interventions, and as a consequence recommendations regarding preventive services are not always standard. Despite this lack of universal acceptance, there are numerous areas where reasonable consensus exists, allowing for the formulation of a set of guidelines.

The following guidelines are based on a review of the literature, particularly the recommendations of expert organizations. They have been reviewed by physicians practicing in Blue Cross Blue Shield of Illinois' (BCBSIL) managed care networks, and adopted by the BCBSIL Clinical Management Committee.
The guidelines are organized by age categories: neonatal, pediatric (age 0-17), adults (age 18-64), and adults age 65 and older. Additionally, there is a section pertaining to prenatal preventive services for pregnant women.

In considering the guidelines, several points are to be emphasized:

- Unless specified, stated guidelines are meant to apply to average risk, asymptomatic and otherwise healthy individuals. Preventive care interventions appropriate for those with other levels of risk (increased or decreased) will vary by individual circumstance, and physicians are encouraged to tailor the approach to these patients as necessary.
- The interventions listed are minimal guidelines. Additional interventions may be useful.
- Coverage is based upon member eligibility and the specific benefit plan design. Because there is substantial variation in coverage between benefit programs, inclusion of a service in the BCBSIL Preventive Health Care Guidelines is not a guarantee of payment.
- Sources are cited for each guideline. Where possible, the exact recommendation of the source is used. In some cases, the recommendation or its periodicity has been modified to fit with conflicting recommendations by various sources, or as recommended by BCBSIL network physicians.
- Because the attached guidelines by necessity summarize a large amount of information, all details cannot be provided. The provider is, therefore, encouraged to review the original sources for more complete discussion of indications and contraindications for specified preventive care services, and to verify the accuracy of the summary.
- This guideline is designed to assist clinicians by providing a framework for evaluation and treatment of patients and is not intended to either replace a clinician’s judgment or establish a protocol for all patients. The final decision regarding medical treatment is made by the physician and the patient.

| KEY TO MAJOR PROFESSIONAL ORGANIZATIONS REFERENCED AS GUIDELINE AUTHORITY |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| AAP                                           | American Academy of Pediatrics                                                                                                  |
| ACIP                                          | Advisory Committee on Immunization Practices of the Centers for Disease Control                                                  |
| ACS                                           | American Cancer Society                                                                                                          |
| ACOG                                          | American College of Obstetricians and Gynecologists                                                                             |
| AAFP                                          | American Academy of Family Practice                                                                                               |
| AHA                                           | American Heart Association                                                                                                       |
| ADA                                           | American Diabetes Association                                                                                                |
| AMA                                           | American Medical Association                                                                                                      |
| CDC                                           | Centers for Disease Control                                                                                                      |
| IDPH                                          | Illinois Department of Public Health                                                                                               |
| NCI                                           | National Cancer Institute                                                                                                         |
| USPSTF                                         | U.S. Preventive Services Task Force                                                                                              |
PREVENTIVE HEALTH CARE SERVICES
NEONATES AGE 0-30 days

A. History and Physical Examination (Reference 1, AAP) (Also see Reference 2)
   Perform newborn examination and exam at 3-5 days:
   • History
   • Physical exam
   • Length and weight, weight for length
   • Head circumference
   • Developmental/behavioral assessment
B. Screen for hearing loss (Reference 3 - AAP) (Also see Reference 4)
   • Screen objectively prior to hospital discharge, or before 1 month of age if delivery was in an
     alternative birthing facility.
   • Screen subjectively at 2-4 days
C. Screening Tests (Reference 5, 6 – AAP, 7 – IDPH, 8, 9, 10 – USPSTF)
   Perform screening tests prior to discharge or transfer from the nursery, but no later than 7 days
   of age. In Illinois, tests for the following conditions are mandated:
   • Classical PKU
   • Certain other amino acid, organic acid, and fatty acid oxidation disorders
   • Primary hypothyroidism
   • Classical galactosemia
   • Congenital adrenal hyperplasia due to 21-hydroxylase deficiency
   • Biotinidase deficiency
   • Sickle cell disease/trait
D. Chemoprophylaxis (Reference 11 - USPSTF)
   Administer ocular antibiotic prophylaxis at birth.
E. Immunizations (Reference 12 - ACIP)
   Administer immunizations in accordance with the ACIP Recommended Childhood
   Immunization Schedule for 2008.
F. Counseling/Anticipatory Guidance (Reference 1, 13, 14, 15 – AAP)
   Discuss with parents following delivery and at 2-4 days:
   • Injury prevention/violence prevention/nutrition, AND
   • Sleep positioning
I. **Recommendations**

A. **History and Physical Examination (Reference 1 – AAP) (Also see Reference 2)**
   1. History and initial/interval physical exam
      - Months: 1 2 4 6 9 12 15 18 24 30
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
   2. Height and weight
      - Months: 1 2 4 6 9 12 15 18 24 30
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
   3. **BMI**
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
   4. Head circumference
      - Months: 1 2 4 6 9 12 15 18
   5. Blood pressure
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
   6. Vision screening
      - Years: 3 4 5 6 8 10 12 15
   7. Hearing screen
      - Years: 4 5 6 8 10
   8. Developmental Screening
      - Months: 9 18 30
   9. Psychosocial/Behavioral Assessment
      - Months: 1 2 4 6 9 12 15 18 24 30
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17

B. **Counseling/Anticipatory Guidance**
   1. Anticipatory Guidance, including topics such as nutrition, safety, physical activity, development, behavior (Reference 1, 13, 15 – AAP, 16 – AAFP)
      - Months: 1 2 4 6 9 12 15 18 24
      - Years: 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17
   2. Counseling: Sleep Positioning (Reference 11 - AAP)
      - Months: 1 2 4 6
   3. Adolescent Counseling (Reference 15 – AAP, 16 – AAFP, 17 – AMA)
      Counsel annually between ages 11 and 17 years regarding physical activity, sexual behavior, sexually transmitted diseases and avoidance of tobacco, alcohol and other abusable substances.
C. Laboratory Testing (Reference 1 – AAP) (Also see Reference 18)
   1. Hemoglobin (Hgb) and/or Hematocrit (Hct)
      Measure at 12 months
   2. Urinalysis
      Perform at age 5 and once between 11-17 years of age
      Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
   3. STD Screening: (Reference 19 - AAP) (Also see References 20, 21, 22)
      Perform for all sexually active adolescents

D. Immunizations (Reference 23 - ACIP).
   Administer immunizations in accordance with the ACIP recommended childhood immunization schedule for 2008.

II. Recommendations for select populations at risk

A. Blood lead levels (Reference 24 - IDPH, 25 – AAP, 26-CDC)
   • Children age 6 months to 6 years should be assessed for lead exposure.
   • Those at high risk based upon assessment and those who reside in a high risk area should have a blood lead measurement.

B. Screening for hypercholesterolemia: (Reference 27 - AHA) (Also see Reference 17, 28)
   Perform targeted screening of fasting lipids in children > 2 years of age with a family history of dyslipidemia or premature cardiovascular disease.

C. Tuberculin skin testing (Reference 29, 30 - CDC)
   Targeted tuberculin testing programs should be conducted only among groups at high risk of tuberculosis and discouraged in those at low risk. Factors that correlate highly with risk for latent tuberculosis infection in children include:
   • birth in a foreign country with high prevalence
   • nontourist travel to a high-prevalence country for > 1 week
   • contact with person with TB
   • presence in the home of another person with latent tuberculosis infection.
   Additional factors that are correlated with increased risk of tuberculosis include:
   • being homeless,
   • HIV infection, OR
   • injection drug use.
   In addition, those who reside or work in an institutional setting may have increased risk, depending upon the institution.

D. Papanicolaou Smear (female only) (Reference 31 - ACS) (See References 32, 33, 34)
   • Begin approximately 3 years after onset of vaginal intercourse, but no later than 21 years of age.
   • Screen every year with conventional Pap tests or every 2 years using liquid-based Pap tests.

E. Fluoride supplementation (Reference 35 - USPSTF)
   Oral fluoride supplementation at currently recommended doses should be provided to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
PREVENTIVE HEALTH CARE SERVICES
ADULTS (18 and older)

I. Recommended
   A. History and Physical Examination (See references 36, 37, 38, 39, 40)
      1. Height measurement (See Reference 40, 41, 42)
         Every 1-3 years age 18 and older
      2. Weight measurement and calculation of BMI (See Reference 40, 41, 42)
         Every 1-3 years age 18 and older
      3. Blood pressure measurement (Reference 41 - AHA, and 43 - USPSTF) (Also see Reference 40)
         Every 2 years age 18 and older
      4. Females: Clinical breast exam (Reference 44 - ACS) (Also see References 40, 45, 46, 47, 48)
         • Age 20 to 40: every 3 years
         • Age ≥40: annually
   B. Counseling
      Provide health counseling regarding the following topics (Reference 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59) - USPSTF, AAFP, AHA, ADA, ACS)
      • avoidance of tobacco and/or tobacco cessation,
      • harmful effects of smoking on fetal and child health,
      • STD risk
      • prevention of unintended pregnancy,
      • promotion of healthy diet,
      • alcohol use,
      • benefits of physical activity,
      • prevention of motor vehicle injuries through the use of seatbelts/child safety seats, motorcycle helmets and avoidance of driving while intoxicated,
      • injury prevention,
      • at the time of menopause, women at average risk should be informed about the risks and symptoms of endometrial cancer and strongly encouraged to report any unexpected bleeding or spotting to their physicians, AND
      • the use of aspirin for primary prevention of cardiovascular events for adults who are at increased risk of coronary heart disease.
   C. Screening Tests
      1. Cholesterol (Reference 60 - USPSTF, 61 - ADA) (Also see Reference 62, 63)
         • Screen men age 35 and older and women age 45 and older for lipid disorders and treat abnormal lipids in people who are at increased risk of coronary heart disease.
         • Men age 20 to 35 and women age 20 to 45, who have other risk factors for coronary heart disease should also be screened for lipid disorders.
         • When screening for lipid disorders, include measurement of total cholesterol and HDL-C.
         • Reasonable options for screening interval include: every 5 years; screening at <5 year intervals for people who have lipid levels close to those warranting therapy; and screening at intervals >5 years for low-risk people who have had low or repeatedly normal lipid levels.
         • For adult diabetics, perform a lipid profile at least annually. If lipid values are low-risk, the lipid profile may be performed every two years. (ADA)
2. Breast cancer screening (female only) (Reference 47, 65 - USPSTF) (Also see References 44, 48, 64, 66)
   - Screen with mammography every 1-2 years age 40 and older
   - Consider referring women whose family history is associated with increased risk for deleterious mutations in BRCA1 or BRCA2 genes for genetic counseling and evaluation for BRCA testing.

3. Cervical cancer screening (female only) (Reference 31 – ACS) (See References 32, 33, 34)
   - Begin screening approximately 3 years after onset of vaginal intercourse, but no later than 21 years of age.
   - Screen every year with conventional Pap tests or every 2 years using liquid-based Pap tests.
   - At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years with cervical cytology or every 3 years with an HPV DNA test plus cervical cytology.
   - Women 70 years of age and older who have had 3 or more normal Pap tests and no abnormal Pap tests in the last 10 years may choose to stop cervical cancer screening.
   - Women who have had a total hysterectomy may choose to stop cervical cancer screening.

4. Prostate Cancer Screening (male only) (Reference 67 –AMA) (Also see Reference 68, 69, 70, 71)
   All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making. Prostate cancer screening, if elected by the informed patient, should include both PSA and digital rectal examination. Men most likely to benefit from tests for early detection of prostate cancer should have a life expectancy of at least 10 years and include:
   - Men 40 years of age and older of African American descent
   - Men 40 years of age and older with an affected first-degree relative
   - Men 50 years of age or older.

5. Colorectal Cancer Screening (Reference 72, 73 - ACS) (Also see References 74, 75, 76)
   - Screen both men and women at average risk for colon cancer, beginning at age 50.
   Screening options include:
     - Fecal occult blood test on three specimens collected at home, annually
     - Flexible sigmoidoscopy every 5 years
     - Fecal occult blood annually plus flexible sigmoidoscopy every 5 years
     - Double-contrast barium enema every 5 years
     - Colonoscopy every 10 years
   - Individuals at increased risk or high risk of colon cancer should be screened beginning at an earlier age and according to a different schedule.
D. Immunizations (Reference 77, 79 – ACIP) (Also see Reference 78)

Administer immunizations in accordance with the ACIP Recommended Adult Immunization Schedule for 2007-2008.

II. Recommended for Select Populations at Increased Risk

A. Screening for Diabetes (Reference 80- USPSTF) (Also see Reference 81)
   - Screen adults with hypertension or hyperlipidemia for diabetes.
   - The decision to screen individual patients who do not have hypertension or hyperlipidemia is a matter of clinical judgment.
   - Consider screening at 3-year intervals beginning at age 45, particularly in those with BMI >25kg/m².
   - Consider screening at a younger age in individuals who are overweight or obese and have additional risk factors:
     - are habitually physically inactive
     - have a first-degree relative with diabetes
     - are members of a high-risk ethnic population (African American, Latino, Native American, Asian-American, or Pacific Islander)
     - have delivered a baby weighing >9 lbs or have been diagnosed with gestational diabetes mellitus
     - on previous testing had impaired glucose tolerance or impaired fasting glucose
     - have polycystic ovary syndrome
     - have other conditions associated with insulin resistance
     - have a history of vascular disease

B. HIV Serology (Reference 82 – USPSTF, 83 - CDC)

All pregnant women and all adolescents and adults at increased risk of HIV infection should be screened.
   - HIV screening should be offered to those at increased risk of HIV infection. This includes:
     - Men who have had sex with men after 1975
     - Men and women having unprotected sex with multiple partners
     - Past or present injection drug users
     - Men or women who exchange sex for money or drugs or have sex partners who do
     - Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users
     - Persons being treated for STDs
     - Persons with a history of blood transfusion between 1978 and 1985
     - Persons who request an HIV test despite reporting no individual risk factors. This group may also be at increased risk, since it is likely to include individuals not willing to disclose high risk behaviors.
   - HIV screening should be offered to those who are seen in high-risk or high-prevalence settings, including:
     - STD clinics
     - Correctional facilities
     - Homeless shelters
     - Tuberculosis clinics
     - Clinics serving men who have sex with men
     - Adolescent health clinics with a high prevalence of STDs
C. TB skin test (Reference 29, 30 - CDC)
   Conduct targeted tuberculin testing programs only among groups at high risk for developing tuberculosis and discourage routine testing in those at low risk. Persons with increased risk for developing TB include persons recently infected and persons who have clinical conditions that are associated with an increased risk of infection.
   - Persons who may have recent infection
     - Close contacts of persons with infectious pulmonary TB
     - Persons who have recently immigrated from areas of the world with high rates of TB
   - Groups of people with high rates of TB transmission (homeless persons, those with HIV infection, injection drug users, persons who reside or work in institutional settings)
   - Clinical conditions associated with progression to active TB: HIV infection, injection drug use, pulmonary fibrotic lesions on CXR, underweight, silicosis, chronic renal failure on hemodialysis, diabetes, gastrectomy, jejunoileal bypass, renal and cardiac transplantation, head and neck cancer, other neoplasms, prolonged corticosteroid or immunosuppressive therapy

D. Syphilis serology (Reference 84 - USPSTF)
   - Perform for all pregnant women
   - Perform for those at increased risk:
     - Persons who exchange sex for money or drugs
     - Men who have sex with men and engage in high-risk sexual behavior
     - Persons in adult correctional facilities
     - Persons with other sexually transmitted diseases who may be more likely than others to engage in high risk behavior, putting them at risk for syphilis.

E. Gonorrhea screening (Reference 22 - USPSTF)
   Screen all sexually active women, including those who are pregnant, if they are at increased risk for infection. Risk factors include:
   - age <25
   - prior gonorrhea infection
   - other sexually transmitted infections
   - new or multiple sex partners
   - inconsistent condom use
   - sex work
   - drug use

F. Chlamydia screen (Reference 21 - USPSTF)
   - Annually screen for chlamydial infection all sexually active non-pregnant women aged 24 and younger and older non-pregnant women who are at increased risk.
   - At the first prenatal visit, screen for chlamydial infection all pregnant women aged 24 and younger and older pregnant women who are at increased risk. For pregnant women who remain at increased risk and for those who acquire a new risk factor, such as a new sexual partner, a screening should be conducted during the third trimester.
In addition to the services recommended in the guidelines for adults age 18 and older, the following services are recommended for individuals age 65 and older:

1. Hearing screening  (Reference 85 - USPSTF) (Also see Reference 86)

2. Vision screening  (Reference 85 - USPSTF) (Also see Reference 86)

3. Consider counseling on measures to reduce the risk of falling, including exercise, safety-related skills and behaviors, and environmental hazard reduction.  (Reference 85 - USPSTF)

4. Immunizations (Reference 77 – ACIP)
   Administer immunizations in accordance with the ACIP Recommended Adult Immunization Schedule for 2007-2008.

5. Osteoporosis Screening (Reference 87 – USPSTF)
   - Screen women age 65 and older routinely for osteoporosis, with screening to begin at age 60 for women at increased risk for osteoporotic fractures.

6. Screening for Abdominal Aortic Aneurysm (Reference 88 – USPSTF)
   - Men age 65 to 75 who have ever smoked should be screened one time for abdominal aortic aneurysm, using ultrasonography.
A. Preconceptual Care
Preconceptual care includes identification of those conditions that could affect a future pregnancy or fetus and that may be amenable to intervention.

1. Vaccination
   • Offer rubella immunization to women susceptible to rubella.
   • Offer Hepatitis B vaccine to unimmunized women at risk of acquiring Hepatitis B.
   • Offer varicella vaccine to women susceptible to varicella.

2. Strongly recommend screening for HIV infection.

3. Consider screening tests as specifically indicated:
   • Screening for sexually transmitted diseases
   • Tuberculin test
   • Testing based upon medical or reproductive history
   • Screening for genetic disorders based upon family history and racial/ethnic background

4. Counsel regarding appropriate medical care and behavior to optimize pregnancy outcomes:
   • Nutrition
   • Exercise
   • Weight
   • Preventing HIV infection
   • Use of an accurate menstrual history for determining the time of conception
   • Abstaining from tobacco, alcohol and illicit drug use before and during pregnancy
   • Use of folic acid while attempting pregnancy and in the first trimester
   • Maintaining control of preexisting medical conditions such as diabetes and hypertension

B. Antepartum Care
Woman who receive early and regular prenatal care are more likely to have healthier infants.
Obstetric care should begin early in pregnancy and continue through the postpartum period. ACOG provides detailed recommendations regarding antepartum care.

C. Post Partum Visit
   • See patient 4-6 weeks following delivery
     • An additional visit within 7-14 days of delivery may be advised for patients with a Cesarean section or complications of gestation
   • Postpartum care should include:
     • Interval history
     • Breastfeeding history
     • Physical examination:
       • Weight
       • Blood pressure
       • Breasts
       • Abdomen
       • Pelvic exam
     • Pap smear if needed
     • Review or initiation of birth control, if needed
     • Assessment of emotional status
     • Laboratory testing as indicated
     • Counseling regarding future health and pregnancies
     • Review of immunizations, with administration of those that are indicated
     • Preconceptual counseling, as indicated
**Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008**

*For those who fall behind or start late, see the catch-up schedule*

<table>
<thead>
<tr>
<th>Vaccine ▼</th>
<th>Age ▶</th>
<th>Birth</th>
<th>1 month</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>15 months</th>
<th>18 months</th>
<th>19–23 months</th>
<th>2–3 years</th>
<th>4–6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B vaccine (HepB), (Minimum age: 2 doses)</td>
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<tr>
<td>• Administer monovalent HepB to all newborns prior to hospital discharge.</td>
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<tr>
<td>• If mother is hepatitis B surface antigen (HBsAg) positive, administer HepB and 0.5 ml of hepatitis B immune globulin (HBIG) within 12 hours of birth.</td>
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<tr>
<td>• If mother’s HBsAg status is unknown, administer HepB within 12 hours of birth. Determines HBsAg status as soon as possible and if HBsAg positive, administer HRS (no later than age 1 week).</td>
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<tr>
<td>• If mother is HBsAg negative, the birth dose can be delayed. In rare cases, with a provider’s prior and a copy of the mother’s negative HBsAg laboratory report in the infant’s medical record.</td>
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<tr>
<td>After the birth dose: The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at 2–6 months. The final dose should be administered no earlier than age 4 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB vaccine series at age 0–18 months (generally, at the next well-child visit).</td>
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<tr>
<td>4-month dose: It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.</td>
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<tr>
<td>2. Rotavirus vaccine (Rota), (Minimum age: 6 weeks)</td>
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<tr>
<td>• Do not start the series later than age 12 weeks.</td>
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<tr>
<td>• Administer the first dose in the series by age 12 weeks. Do not administer any dose later than age 32 weeks.</td>
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<tr>
<td>• Data on safety and efficacy outside of these age ranges are insufficient.</td>
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</tr>
<tr>
<td>3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP), (Minimum ages: 5 weeks)</td>
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<tr>
<td>• The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.</td>
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<tr>
<td>• Administer the final dose in the series at age 4–6 years.</td>
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<tr>
<td>4. Haemophilus influenzae type b conjugate vaccine (Hib), (Minimum age: 2 doses)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• If PCV 13 (PedvaxHIB) or ConVax® (Merial) is administered at ages 2 and 4 months, a dose at age 6 months is not required.</td>
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<tr>
<td>• PCV 13 (PedvaxHIB) (Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children at least 12 months of age.</td>
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</tr>
</tbody>
</table>

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the vaccines. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high-risk conditions: www.cdc.gov/vaccines/pubs/ACIP-FactSheet. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB), (Minimum age: 2 doses)
2. Rotavirus vaccine (Rota), (Minimum age: 6 weeks)
3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP), (Minimum ages: 5 weeks)
4. Haemophilus influenzae type b conjugate vaccine (Hib), (Minimum age: 2 doses)
5. Pneumococcal vaccine, (Minimum age: 6 weeks for pneumococcal conjugate vaccine (PCV)), 2 years for pneumococcal polysaccharide vaccine (PPV)
6. Influenza vaccine, (Minimum age: 6 months for trivalent inactivated influenza Vaccine (TIV)), 2 years for live, attenuated influenza vaccine (LAIV)
7. Measles, mumps, and rubella vaccine (MMR), (Minimum age: 12 months)
8. Varicella vaccine, (Minimum age: 12 months)
9. Hepatitis A vaccine (HepA), (Minimum age: 12 months)
10. Meningococcal vaccine, (Minimum age: 2 years for meningococcal conjugate vaccine (MCV4) and for meningococcal polysaccharide vaccine (MPSV4))
### Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2008

*For those who fall behind or start late, see the green bars and the catch-up schedule*

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age</th>
<th>7–10 years</th>
<th>11–12 years</th>
<th>13–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis&lt;sup&gt;1&lt;/sup&gt;</td>
<td>see footnote 1</td>
<td>Tdap</td>
<td>Tdap</td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus&lt;sup&gt;1&lt;/sup&gt;</td>
<td>see footnote 2</td>
<td>HPV (3 doses)</td>
<td>HPV Series</td>
<td></td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;2&lt;/sup&gt;</td>
<td>MCV4</td>
<td>MCV4</td>
<td>MCV4</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;2&lt;/sup&gt;</td>
<td>PPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Influenza (Yearly)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;4&lt;/sup&gt;</td>
<td>HepA Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;4&lt;/sup&gt;</td>
<td>HepB Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus&lt;sup&gt;4&lt;/sup&gt;</td>
<td>IPV Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella&lt;sup&gt;4&lt;/sup&gt;</td>
<td>MMR Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Varicella Series</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2000, for children aged 7–18 years. Additional information is available at [www.cdc.gov/vaccines/recs/schedules](http://www.cdc.gov/vaccines/recs/schedules). Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible. Additional doses may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for high-risk conditions: [http://www.cdc.gov/vaccines/pubs/acip/ha.htm](http://www.cdc.gov/vaccines/pubs/acip/ha.htm). Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™:*
   - Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose.
   - 13–18-year-olds who missed the 11–12 year Tdap or received Td only are encouraged to receive one dose of Tdap 5 years after the last Td/DTaP dose.

2. Human papillomavirus vaccine (HPV). *Minimum age: 9 years:*
   - Administer the first dose of the HPV vaccine series to females at age 11–12 years.
   - Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
   - Administer the HPV vaccine series to females at age 13–16 years if not previously vaccinated.

3. Meningococcal vaccine.
   - Administer MCV4 at age 11–12 years and at age 13–16 years if not previously vaccinated. MCV4 is an acceptable alternative.
   - Administer MCV4 to previously unvaccinated college freshman living in dormitories.
   - MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups.
   - Persons who received MPSV4 3 or more years previously and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

4. Pneumococcal polysaccharide vaccine (PPV).
   - Administer PPV to certain high-risk groups.

5. Influenza vaccine.
   - Administer annually to all close contacts of children aged 6–59 months.
   - Administer annually to persons with certain high-risk factors, health-care workers, and others persons (including household members) in close contact with persons in groups at higher risk.
   - Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season but only received one dose.
   - For healthy nonpregnant persons who do not have underlying medical conditions that predispose them to influenza complications ages 2–49 years, either LAIV or TIV may be used.

6. Hepatitis A vaccine (HepA).
   - Administer the 2 doses in the series at least 6 months apart.
   - HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

7. Hepatitis B vaccine (HepB).
   - Administer the 3-dose series to those who were not previously vaccinated.
   - A 2-dose series of Recombivax HB® is licensed for children aged 11–19 years.

8. Inactivated poliovirus vaccine (IPV).
   - For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

   - If not previously vaccinated, administer 2 doses of MMR during any visit with at least 4 or more weeks between the doses.

10. Varicella vaccine.
    - Administer 2 doses of varicella vaccine to persons younger than 13 years of age at least 3 months apart. Do not repeat the second dose if administered 20 or more days following the first dose.
    - Administer 2 doses of varicella vaccine to persons aged 13 years or older at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/recs/schedules](http://www.cdc.gov/vaccines/recs/schedules)), the American Academy of Pediatrics ([http://www.aap.org](http://www.aap.org)), and the American Academy of Family Physicians ([http://www.aafp.org](http://www.aafp.org)).

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BCBSIL Provider Manual – Rev 6/10

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### Catch-up Immunization Schedule

#### for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine</td>
<td>Dose 1 to Dose 2</td>
<td>Dose 2 to Dose 3</td>
</tr>
<tr>
<td>Hepatitis B&lt;br&gt;Rotavirus&lt;br&gt;Diphtheria, Tetanus, Pertussis</td>
<td>Birth</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Haemophilus influenzae type b</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>6 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 mos</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>12 mos</td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

### Catch-up Schedule for Persons Aged 7–18 Years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccine</td>
<td>Dose 1 to Dose 2</td>
<td>Dose 2 to Dose 3</td>
</tr>
<tr>
<td>Tetanus, Diphtheria</td>
<td>7 yrs**</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td>9 yrs</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>12 mos</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Inactivated Poliovirus Vaccine</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td>Varicella</td>
<td>12 mos</td>
<td>4 weeks</td>
</tr>
</tbody>
</table>

#### Notes
1. Hepatitis B vaccine (HepB).
   - Administer the 3-dose series to those who were not previously vaccinated.
   - If the age is younger than 18 months, the first 2 doses should be given at 2-month intervals.
   - If the age is 12–15 months, the first 2 doses should be given at 1-month intervals.
2. Rotavirus vaccine (Rotarix).
   - If the age is younger than 12 months, the first 2 doses should be given at 2-month intervals.
   - If the age is 12–15 months, the first 2 doses should be given at 1-month intervals.
   - The 3rd dose should be given at age 17–21 months.
3. Mumps, mumps, and rubella vaccine (MMR).
   - The 2nd dose should be given at the same time as the 1st dose.
   - If the age is younger than 12 months, the 2nd dose should be given at age 17–21 months.
4. Haemophilus influenzae type b conjugate vaccine (Hib).
   - A 3rd dose should be given at age 12–15 months.
   - If the age is younger than 12 months, the 3rd dose should be given at age 12–15 months.
5. Measles, mumps, and rubella vaccine (MMR).
   - The 2nd dose should be given at age 4–6 years, and the 1st dose should be given at age 12–15 months.
   - The 2nd dose should be given at age 12–15 months.
7. Human Papillomavirus vaccine (HPV).
   - The 2nd dose should be given at age 12–15 months.
8. Inactivated poliovirus vaccine (IPV).
   - The 3rd dose should be given at age 12–15 months.

#### Additional Information
- The information is based on recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP).
- The schedule is subject to change as new vaccines become available or as recommendations change.

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*Information about reporting reactions after administration is available online at: [www.vaccines.gov](http://www.vaccines.gov) or by telephone at the 24/7 national hotline information line (800)322-6964.**

**Suggested sources of quadrivalent vaccine information should be reported to the state or local health department. Additional information, including procedures and recommendations for administration, is available from the National Center for Immunization and Respiratory Diseases at: [http://www.cdc.gov/vaccines](http://www.cdc.gov/vaccines).**

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### Recommended Adult Immunization Schedule

**Figure 1. Recommended adult immunization schedule, by vaccine and age group**

**United States, October 2007 – September 2008**

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>AGE GROUP</th>
<th>19–49 years</th>
<th>50–64 years</th>
<th>≥65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)*</td>
<td></td>
<td></td>
<td>1 dose Td booster every 10 yrs</td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)*</td>
<td></td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)*</td>
<td></td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td></td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza*</td>
<td></td>
<td>1 dose annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (pneumococcal)*</td>
<td></td>
<td>1-2 doses</td>
<td></td>
<td>1 dose</td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td></td>
<td>2 doses (0, 0–12 mos or 0, 0–18 mos)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td></td>
<td>3 doses (0, 1–2, 4–6 mos)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal*</td>
<td></td>
<td>1 or more doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zoster*</td>
<td></td>
<td></td>
<td></td>
<td>1 dose</td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program.*

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**Recommendation:** For all persons in this category who meet the age recommendations and who lack evidence of immunity (i.e., lack documentation of previous immunization or evidence of prior infection).

**Recommended:** If some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications).

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Report all clinically significant post-vaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at [www.hrsa.gov/tecs/vaccinecompensation](http://www.hrsa.gov/tecs/vaccinecompensation) or by telephone, 866-368-3550. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place N.W., Washington, D.C. 20233; telephone, 202-575-6900.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at [www.cdc.gov/vaccines](http://www.cdc.gov/vaccines) or from the CDC-VAX Information Center at 800-232-0233 in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
### Preventive Health Care Guidelines

**Figure 2. Vaccines that might be indicated for adults based on medical and other indications**

**United States, October 2007 – September 2008**

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>PROPHYLAXIS</th>
<th>DOSAGE/ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/DTap)*</td>
<td>Pregnancy</td>
<td>Immune-compromised patients (including human immunodeficiency virus [HIV], medications, infections)**</td>
<td>1 dose Td booster every 10 yrs</td>
</tr>
<tr>
<td>Human papillomavirus (HPV)*</td>
<td></td>
<td></td>
<td>Substitute 1 dose of Tdap for Td</td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)*</td>
<td></td>
<td></td>
<td>3 doses for females through age 26 yrs (0, 2, 6 mos)</td>
</tr>
<tr>
<td>Varicella*</td>
<td></td>
<td></td>
<td>Contraindicated</td>
</tr>
<tr>
<td>Influenza*</td>
<td></td>
<td></td>
<td>Contraindicated</td>
</tr>
<tr>
<td>Pneumococcal (polyvalent)*</td>
<td></td>
<td></td>
<td>1 dose TIV annually</td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td></td>
<td></td>
<td>1-2 doses</td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td></td>
<td></td>
<td>2 doses (0, 6-12 mos, or 0, 6-18 mos)</td>
</tr>
<tr>
<td>Meningococcal*</td>
<td></td>
<td></td>
<td>2 doses (0, 6-12 mos, or 0, 6-18 mos)</td>
</tr>
<tr>
<td>Zoster*</td>
<td></td>
<td></td>
<td>1 or more doses</td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program.

Recommended if more than risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications).

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines in commonly indicated for adults ages 19 years and older, as of October 1, 2007. Licensed combination vaccines may be used whenever any component of the combination is indicated and when the vaccine’s other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are not included in the schedule, contact the manufacturer’s package insert and the complete statements from the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/pubs/acipltr.htm](http://www.cdc.gov/vaccines/pubs/acipltr.htm))

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).

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**BCBSIL Provider Manual – Rev 6/10**

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Footnotes

Recommended Adult Immunization Schedule • United States, October 2007 – September 2008

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/acip-recs.htm.

1. Tetanus, diphteria, and acellular pertussis (Tdap/Td) vaccination
   Tdap should replace a single dose of Td for adults aged ≥19 years who have not previously received a dose of Tdap. Only one of the Tdap products (Adacel®/PediaSure®) is licensed for use in adults. Adults with documented histories of a complete primary vaccination series with tetanus and diphteria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 1 dose of tetanus and diphteria toxoid-containing vaccine; administered the first dose at 3-6 weeks apart and the third dose 6-12 months after the second dose. However, Td can substitute for any one of the doses of Td in the 3-dose primary series. The booster dose of tetanus and diphteria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received >10 years previously. Td or Tdap vaccine may be used, as indicated.

   If the person is pregnant and received the last Td vaccination ≥16 years previously, administer Td during the second or third trimester. If the person received the last Td vaccination <16 years, administer Tdap during the immediate postpartum period. A one-time administration of 1 dose of Tdap within 4 weeks to 6 months from a previous Td vaccination is recommended for postpartum women, those contacts of infants aged <12 months, and all health-care workers with direct patient contact. In certain situations, Td can be administered during pregnancy see Tdap contraindicated in the immediate postpartum period, or Tdap can be administered instead of Td in pregnant women after an informed discussion with the woman.

   Consult the ACP statement for recommendations for using Td vs prophylaxis in neonatal management.

2. Human papillomavirus (HPV) vaccination
   HPV vaccination is recommended for all females aged ≥26 years who have not completed the vaccine series. History of genital warts, abnormal Pap/colposcopic test, or positive HPV DNA test is not evidence of prior infection with all vaccine HPV types. HPV vaccination is not recommended for these persons.

   Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated. Sexually active females who have not been inoculated with any of the HPV vaccine types receive the full benefit of the vaccines. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types.

   A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose. Although HPV vaccination is not specifically recommended for females with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications," it is not a live virus vaccine and can be administered. However, immune response and vaccine efficacy may be less than in persons who do not have the medical indications described or who are immune competent.

3. Measles, mumps, rubella (MMR) vaccination
   Absolute contraindications: Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication.

   A second dose of MMR is recommended for adults who a) were not recommended for over the age of 12 months, or who are in an institutional setting; b) have been previously vaccinated with killed measles vaccine; or c) have been vaccinated with an unlicensed type of measles vaccine during 1962-1977. All adults in postsecondary educational institutions; 6 or older who work in a health-care facility; or 6 or older who plan to travel internationally.

   Absolute contraindication: Adults born before 1957 can generically be considered immune to mumps. Adults born after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication. History of mumps based on healthcare provider diagnosis, or laboratory evidence of immunity.

   A second dose of MMR is recommended for adults who a) are in an age group that is affected during a mumps outbreak; b) are students in postsecondary educational institutions; c) work in a health-care facility; or 6 or older who plan to travel internationally; or 6 or older who have unexplained health-care worker born before 1997 who have either evidence of immunity, current or previous evidence of immunity, or are in a health-care facility; or 6 or older who have either evidence of immunity, current or previous evidence of immunity, or are in a health-care facility.

   Absolute contraindication: Adults 1 dose of MMR vaccine to persons whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, Part I of the Decision to receive rubella immunity and current vaccine report for congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of exposure at least 4-8 weeks after the first dose.

4. Varicella vaccination
   All adults without evidence of immunity to varicella should receive 2 doses of varicella vaccine unless they have a medical contraindication. Special consideration should be given to those who a) have had contact with persons at high risk for severe illness (e.g., health-care personnel and family contacts of immunocompromised persons) or b) are at risk for exposure or transmission (e.g., teachers, school staff, health-care workers, military personnel, and workers in homeless shelters; restaurant workers; and domestic visitors of institutionalized persons).

   Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) birth before 1990; 3) history of varicella infection; 4) history of varicella vaccination; 5) history of varicella infection; or 6) history of varicella vaccination; or a laboratory-confirmed case of varicella or evidence of immunity by laboratory confirmation, if it was performed at the time of vaccination. 4) History of varicella, based on a health-care provider diagnosis, or laboratory evidence of immunity or laboratory confirmation of disease. Adults with varicella vaccination history should receive an additional dose of varicella vaccine if they have been exposed to varicella or have had exposure to varicella vaccination within the previous 4 weeks. The second dose should be administered 4-8 weeks after the first dose.
5. Influenza vaccination

Medical indications: Chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus; renal or hepatic dysfunction; herpès zoster outbreaks; or immunosuppressive diseases (e.g., malignancy or human immunodeficiency virus [HIV]) or any condition that compromises respiratory function or the handling of respiratory secretions or that increases the risk of infection, e.g., carotid artery disease, or diabetes mellitus (e.g., diabetes mellitus type II); or chronic respiratory infections; or persons with splenectomy; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with splenectomy.

Occupational indications: Healthcare personnel and employees of long-term care and assisted-living facilities.

Other indications: Residents of nursing homes and other long-term care and assisted-living facilities; persons likely to transmit influenza to persons at high risk (e.g., inpatient hospital settings and caregivers of children aged 6-36 months, or persons of all ages with high-risk conditions), and anyone who would like to be vaccinated. Health care recipients aged 65 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special institutions can receive either intramuscularly administered influenza vaccine (Fluzone®) or intranasal vaccine; other persons should receive the inactivated vaccine.

6. Pneumococcal polysaccharide vaccination

Medical indications: Chronic respiratory disease (including asthma); chronic cardiovascular disease; diabetes mellitus; chronic liver disease, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic obstructive pulmonary disease; fibrosing alveolitis; chronic renal failure; nephrotic syndrome; functional or anatomic asplenia, e.g., adult, childhood or splenectomy; or patients with splenectomy if elective splenectomy is planned, vaccinated at least 30 days before surgery; immunocompromised conditions; and coexisting implants and parenteral fluids. Vaccination as close to HIV diagnosis as possible.

Other indications: Adults Native and certain African Indian populations and residents of nursing homes or other long-term care facilities.

7. Rabies vaccination with pneumococcal polysaccharide vaccine

One-time vaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia, e.g., adult, childhood or splenectomy; or immunocompromised conditions.

For persons aged 7-85 years, one-time reimmunization if they were vaccinated ≥6 years previously and were aged >65 years at the time of primary vaccination.

8. Hepatitis A vaccination

Medical indications: Persons with chronic liver disease and persons who are at risk of hepatitis C infection.

Behavioral indications: Men who have sex with men and persons who use illicit drugs.

Occupational indications: Persons working with hepatitis A virus (HAV)-infected patients or with HAV in a research laboratory setting.

Other indications: Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A. A list of countries is available at www.cdc.gov/travel/content/diseases.aspx and any person seeking protection from HIV infection.

Single-agent vaccine formulations should be administered in a 2-dose schedule at least 4 weeks apart (even if ≤8 weeks). If the combined hepatitis A and hepatitis B vaccine (Twinrix®) is used, administer 2 doses at 0, 8-18 months.

9. Hepatitis B vaccination

Medical indications: Persons with chronic renal disease, including patients receiving hemodialysis; persons seeking evaluation or treatment for a sexually transmitted disease (STD); persons with HIV infection; and persons with chronic liver disease.

Occupational indications: Healthcare personnel and patients at risk or patients who are exposed to blood or other potentially infected body fluids.

Behavioral indications: Sexually active persons of all ages, including men who have sex with men and women who have sex with men.

Other indications: Household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infections; clients and staff members of institutions for persons with developmental disabilities; international travelers to countries with high or intermediate endemicity of chronic HBV infection (a list of countries is available at www.cdc.gov/travel/content/diseases.aspx); and any adult seeking protection from HBV infection.

Considering other hepatitis B vaccines is recommended for all adults with STD treatment facilities; HIV testing and treatment facilities; failure to provide chlamydia and gonorrhea testing services; health care settings; and facilities in infectious diseases and sexually transmitted diseases programs and facilities for chronic hepatitis B patients; and institutions and nonresidential day-care facilities for persons with developmental disabilities.

Special vaccination indications: For adult patients receiving hemodialysis and other immunocompromised adults 1 dose of 0.5 µg/mL (Recombivax HB®), or 2 doses of 24 µg/mL (Engerix-B®) administered simultaneously.

10. Measles vaccine

Medical indications: Adults with anatomic or functional asplenia, or terminal complement component deficiencies.

Other indications: First-year college students living in dormitories; middle school students who are not otherwise covered by state or local immunization programs; military recruits; and persons who travel to or live in countries with low-vaccination coverage of measles. Measles is the leading cause of death in children under 5 years of age.

Vaccination is recommended for all adults without evidence of immunity and those with increased risk for infection, e.g., persons residing in areas where disease is endemic.

11. Hepatitis B vaccination

A single dose of hepatitis B vaccine is recommended for adults aged ≥18 years, regardless of whether they report a prior episode of hepatitis C. Persons with chronic medical conditions may be vaccinated unless contraindication or precaution exists for that condition.

12. Selected conditions for which Haemophilus influenzae type b (Hib) vaccine may be used.

Hib conjugate vaccines are licensed for children aged 6 weeks-71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with chronic medical conditions who are at increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have delayed cell immunity, e.g., HIV-infected individuals who have had pneumococcal vaccination or have been treated with chemotherapy, and in patients who have been treated with chemotherapy.

13. Immunocompromised conditions

Vaccines are generally acceptable (e.g., pneumococcal, meningococcal, and influenza [inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immune suppressive conditions. Information on specific conditions is available at www.cdc.gov/vaccines/information.htm.
REFERENCES


103. U.S. Preventive Services Task Force. Screening and supplementation for iron deficiency anemia. September 2007. Available at: http://www.ahrq.gov/clinic/uspstf/uspsiron.htm. Accessed April 14, 2008. USPSTF concludes that evidence is insufficient to recommend for or against routine screening for iron deficiency anemia in asymptomatic children aged 6 to 12 months, but recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia. USPSTF concludes that evidence is insufficient to recommend for or against routine iron supplementation for asymptomatic children aged 6 to 12 months who are at average risk for iron deficiency anemia.


106. US Preventive Services Task Force. Screening for Chlamydial Infection June 2007. Available at: http://www.ahrq.gov/clinic/uspsstf/uspschlm.htm. Accessed April 10, 2008. USPSTF recommends screening for chlamydial infection for: all sexually active non-pregnant young women aged 24 and younger, older non-pregnant women who are at increased risk of infection, all pregnant women aged 24 and younger, and older pregnant women who are at increased risk. USPSTF recommends against routinely providing screening for chlamydial infection for women aged 25 and older, whether or not they are pregnant, if they are not at increased risk. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydial infection for men. Screening for pregnant women who are at increased risk for chlamydial infection is recommended at the first prenatal visit. For pregnant women who remain at increased risk and for those who acquire a new risk factor, such as a new sexual partner, a screening should be conducted during the third trimester. The optimal interval for screening for nonpregnant women is unknown. The CDC recommends at least annual screening for women at increased risk.

107. U.S. Preventive Services Task Force. Screening for gonorrhea May 2005. Available at: http://www.ahrq.gov/clinic/uspsstf/uspsgono.htm. Accessed April 14, 2008. USPSTF recommends screening of sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk of infection. Risk factors include age <25, prior gonorrhea infection, other sexually transmitted infections, new or multiple sex partners, inconsistent condom use, sex work and drug use.

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116. Smith RA, Kokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. ACS recommends that cervical cancer screening begin approximately 3 years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with conventional pap tests or every 2 years using liquid-based Pap tests. At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years with cervical cytology or every 3 years with HPV DNA test plus cervical cytology. Women 70 years of age and older who have had 3 or more normal Pap tests and no abnormal Pap tests in the last 10 years, and women who have had a total hysterectomy, may choose to stop cervical cancer screening.

32. U.S. Preventive Services Task Force. Screening for cervical cancer. January 2003. Available at: http://www.ahrq.gov/clinic/uspsft/uspscerv.htm. Accessed April 10, 2008. The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer and recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease. The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer and concludes that the evidence is insufficient to recommend for or against the routine use of human papillomavirus (HPV) testing as a primary screening test for cervical cancer.

33. National Cancer Institute. Screening for cervical cancer. Available at: http://www.cancer.gov/cancertopics/pdq/screening/cervical/HealthProfessional/page1. Accessed April 15, 2008. NCI summarizes cervical cancer screening recommendations by stating that cervical cancer screening is effective in reducing mortality from cervical cancer when started within three years after first vaginal intercourse. Continued screening in elderly women who have had negative Pap tests is of minimal value. Screening is not helpful in women who do not have a cervix as a result of hysterectomy for a benign condition.

34. American Academy of Family Physicians. Summary of recommendations for clinical preventive services revision 6.4, August 2007. Available at: http://www.aafp.org/online/en/home/clinical/exam.html. Accessed April 14, 2008. AAFP strongly recommends a Pap smear at least every 3 years for women who have ever had sex and have a cervix. AAFP concludes that there is insufficient evidence to recommend for or against routine use of HPV testing as a primary screening test for cervical cancer and that there is insufficient evidence to recommend for or against routine use of new technologies to screen for cervical cancer.


39. Smith RA, Cokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. The ACS recommends that the cancer-related checkup occur on the occasion of a general periodic health examination rather than as a stand-alone examination done at a specific interval based on an individual's age. On the occasion of a periodic health examination, the cancer-related check-up should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity and skin as well as health counseling. No periodicity is recommended.


41. American Heart Association. AHA guidelines for primary prevention of cardiovascular disease and stroke. Circulation 2002;106:388-391. The AHA recommends measurement of blood pressure, body mass index, waist circumference and pulse at each visit (at least every 2 years).


43. U.S. Preventive Services Task Force. Screening for high blood pressure. December 2007. Available at: [http://www.ahrq.gov/clinic/uspstf/uspshype.htm](http://www.ahrq.gov/clinic/uspstf/uspshype.htm). Accessed April 10, 2008. The USPSTF recommends that adults age 18 and older be screened for high blood pressure. USPSTF notes that evidence is lacking to recommend an optimal interval for screening adults for high blood pressure, but that the sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 6) recommends screening every 2 years for persons with SBP and DBP below 120 mm Hg and 80 mm Hg, respectively, and screening every year with SBP of 120-139 or DBP of 80-90 mmHg.

44. Smith RA, Cokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. The American Cancer Society recommends annual screening mammograms for women age 40 and older. Clinical breast exams are recommended, preferably every 3 years between age 20 and 39, and preferably every year after age 40. Women should be informed about the benefits and limitations of breast self-exam.
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47. U.S. Preventive Services Task Force. Screening for breast cancer: recommendations and rationale. February 2002. Available at: [http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm](http://www.ahrq.gov/clinic/uspstf/uspsbrca.htm). Accessed April 10, 2008. USPSTF recommends screening for breast cancer every 1-2 years for women age 40 and older with mammography, with or without clinical breast examination. USPSTF concluded that the evidence for breast cancer screening is generalizable to women age 70 and older if their life expectancy is not compromised by comorbid disease. USPSTF concludes that there is insufficient evidence for or against CBE alone or teaching breast self-examination.

48. American College of Obstetricians and Gynecologists (ACOG). Breast cancer screening. Washington: ACOG; 2003 12 p (ACOG practice bulletin no 42). ACOG recommends that women age 40-49 have screening mammography every 1-2 years and that women age 50 and older have annual screening mammography. Despite a lack of definitive data for or against breast self-examination, BSE has the potential to detect palpable breast cancer and can be recommended. All women should have clinical breast examinations annually.

49. American Academy of Family Physicians. Summary of recommendations for clinical preventive services revision 6.4, August 2007. Available at: [http://www.aafp.org/online/en/home/clinical/exam.html](http://www.aafp.org/online/en/home/clinical/exam.html). Accessed April 14, 2008. AAFP strongly recommends screening all adults for tobacco use and providing tobacco cessation interventions for those who use tobacco, smoking cessation counseling for pregnant smokers, and counseling smoking parents regarding the harmful effects of second hand smoke on children. AAFP strongly recommends that adults at increased risk for coronary heart disease be counseled regarding the risks and benefits of aspirin prophylaxis. AAFP recommends counseling, females age 11 and older regarding adequate calcium intake. Counseling regarding accidental injury prevention (including seatbelt use, motorcycle helmet use and avoidance of driving while intoxicated) and STD risks and prevention are recommended. Behavioral counseling interventions to reduce alcohol misuse by adults including pregnant women, is recommended in primary care settings. Counseling about diet is recommended for adults with hyperlipidemia and other risk factors for cardiovascular and diet-related chronic disease, and behavioral interventions to promote sustained weight loss is recommended for obese adults.


53. Thompson PD, Buchner D, Pina IL et al. Exercise and physical activity in the prevention and treatment of atherosclerotic cardiovascular disease: a statement from the Council on Clinical Cardiology. Circulation 2003;107(24):3109-16. The AHA states that health professionals should take a physical activity history and prescribe physical activity programs commensurate with those recommended by the CDC and the American College of Sports Medicine, with patients encouraged to engage in a variety of physical activities and to progressively increase their activity as tolerated.

54. Haskel WL, Lee IM et al; Physical activity and public health: updated recommendation for adults from the American College of Sports Medicine and the American Heart Association. Circulation. 2007;116:1091-1093. ACSM and AHA recommend that all healthy adults age 18-65 need moderate-intensity aerobic physical activity for a minimum of 30 minutes on five days each week, or vigorous-intensity aerobic physical activity for a minimum of 20 minutes on three days each week. In addition, every adult should perform activities that maintain or increase muscular strength and endurance a minimum of two days each week.

56. American Diabetes Association. Standards of medical care in diabetes 2008. Diabetes Care 2008; 31(Supp 1):S12-S54. The ADA recommends that patients with impaired glucose tolerance or impaired fasting glucose should be given counseling on weight loss as well as instruction for increasing physical activity. Follow up counseling appears to be important for success. In addition to lifestyle counseling, metformin may be considered in those who are at very high risk. Monitoring for the development of diabetes in those with pre-diabetes should be performed every year. The ADA recommends for individuals at high risk for developing type 2 diabetes, structured programs that emphasize lifestyle changes that include moderate weight loss (7% body weight) and regular physical activity (150 minutes/week) with dietary strategies to reduce calories, as these interventions can reduce the risk of developing diabetes.


59. Smith RA, Cokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. The ACS recommends that at the time of menopause, women at average risk should be informed about the risks and symptoms of endometrial cancer and should be strongly encouraged to report unexpected bleeding or spotting to their physicians.


61. American Diabetes Association. Standards of medical care in diabetes 2008. Diabetes Care 2008; 31(Supp 1):S12-S54. Test for lipid disorders at least annually. Lipid assessment may be every two years if lipid values are low-risk (LDL < 100 mg/dl, HDL >50 mg/dl, and triglycerides <150 mg/dl.)


63. National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). Executive summary. NIH Publication No 01-3670, May 2001. The National Cholesterol Education Program recommends that a fasting lipoprotein profile be obtained once every 5 years in all adults age 20 or older. If the testing opportunity is nonfasting, only the total cholesterol and HDL will be usable.
64. American Academy of Family Physicians. Summary of recommendations for clinical preventive services revision 6.4, August 2007. Available at: [http://www.aafp.org/online/en/home/clinical/exam.html](http://www.aafp.org/online/en/home/clinical/exam.html). Accessed April 14, 2008. AAFP recommends mammography every 1-2 years for women age 40 and older, after counseling regarding the potential risks and benefits of the procedure. AAFP concludes that the evidence is insufficient to recommend for or against teaching or performing routine breast self-examination (BSE).


66. Qaseem A, Snow V, et al. Screening mammography for women 40 to 49 years of age: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2007;146:511-515. ACP recommends that clinicians periodically perform individualized assessment of risk for breast cancer in women age 40 to 49 to help guide decisions about screening mammography. Clinicians should inform women 40 to 49 years of age about the potential benefits and harms of screening mammography and base screening mammography decisions on benefits and harms of screening as well as on a woman’s preferences and breast cancer risk profile.

67. American Medical Association. Policy H-425.980 screening and early detection of prostate cancer. Available at [http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-425.980.HTM&s_t=prostate&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&n nth=1&st_p=0&n th=2&]. Accessed April 15, 2008. The launching of mass screening programs for early detection of prostate cancer is premature at this time. Men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making. Prostate cancer screening, if elected by the patient, should include both PSA and DRE.

68. U.S. Preventive Services Task Force. Screening for prostate cancer December 2002. Available at: [http://www.ahrq.gov/clinic/uspsprca.htm](http://www.ahrq.gov/clinic/uspsprca.htm). Accessed April 14, 2008. USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for prostate cancer using prostate specific antigen (PSA) testing or digital rectal examination (DRE). The USPSTF found good evidence that PSA screening can detect early-stage prostate cancer but mixed and inconclusive evidence that early detection improves health outcomes. Screening is associated with important harms, including frequent false-positive results and unnecessary anxiety, biopsies and potential complications of treatment of some cancers that may never have affected a patient’s health. The USPSTF concludes that evidence is insufficient to determine whether the benefits outweigh the harms for a screened population.

69. Smith RA, Cokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. The American Cancer Society recommends that PSA test and digital rectal exam be offered annually starting at age 50 to men who have a life expectancy of at least 10 years. ACS recommends that information be provided to men about the benefits and limitations of testing so that an informed decision about testing can be made with the clinician’s assistance. ACS recommends starting to screen high risk men at a younger age.


71. National Cancer Institute. Prostate cancer screening PDQ. Available at: [http://www.nci.nih.gov/cancertopics/pdq/screening/prostate/healthprofessional](http://www.nci.nih.gov/cancertopics/pdq/screening/prostate/healthprofessional). Accessed April 15, 2008. The evidence is insufficient to determine whether screening for prostate cancer with prostate-specific antigen (PSA) or digital rectal exam (DRE) reduces mortality from prostate cancer. Screening tests are able to detect prostate cancer at an early stage, but it is not clear whether this earlier detection and consequent earlier treatment leads to any change in the natural history and outcome of the disease.
72. Smith RA, Cokkinides V and Eyre HJ. Cancer screening in the United States 2007: a review of current guidelines, practices and prospects. CA Cancer J Clin 2007;57;90-104. The American Cancer Society recommends that beginning at age 50, men and women should have colon cancer screening by means of one of the following screening options: fecal occult blood test or fecal immunochemical test annually, flexible sigmoidoscopy every 5 years, fecal occult blood test annually plus flexible sigmoidoscopy every 5 years, double contrast barium enema every 5 years, colonoscopy every 10 years.


74. U.S. Preventive Services Task Force. Screening for colorectal cancer July 2002. Available at: http://www.ahrq.gov/clinic/uspreventifs/uspscolo.htm. Accessed April 14, 2008. The USPSTF strongly recommends that clinicians screen men and women 50 years of age or older for colorectal cancer. The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from colorectal cancer and concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method.


80. U.S. Preventive Services Task Force. Screening for diabetes mellitus adult type 2 February 2003. Available at: http://www.ahrq.gov/clinic/uspreventifs/uspsdiab.htm. Accessed April 14, 2008. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely screening asymptomatic adults for type 2 diabetes, IGT or IFG. The USPSTF recommends screening for type 2 diabetes in adults with hypertension or hyperlipidemia. The USPSTF notes that in the absence of evidence of direct benefits of routine screening for type 2 diabetes, the decision to screen individual patients is a matter of clinical judgment, and notes that regardless of whether the clinician and patient decide to screen for diabetes, patients should be encouraged to exercise, eat a healthy diet, and maintain a healthy weight.

81. American Diabetes Association. Standards of medical care in diabetes 2008. Diabetes Care 2008; 31(Supp 1):S12-S54. The ADA recommends that screening to detect pre-diabetes and diabetes should be considered in individuals ≥45 years of age with a BMI ≥25kg/m². Screening should also be considered for people <45 years of age and BMI ≥25kg/m² with another risk factor for diabetes. Repeat testing should be carried out at 3-year intervals. Screening should be performed within the health care setting and may be done with fasting plasma glucose or 2-hour oral glucose tolerance test or both.
82. U.S. Preventive Services Task Force. Screening for Human Immunodeficiency Virus Infection July 2005 with April 2007 Amendment. Available at: http://www.ahrq.gov/clinic/uspstf/uspshivi.htm. Accessed April 14, 2008. The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection. The USPSTF makes no recommendation for or against routinely screening for HIV adolescents and adults who are not at increased risk for HIV infection. The USPSTF recommends that clinicians screen all pregnant women for HIV.

83. Centers for Disease Control and Prevention. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health care settings. MMWR 2006;55(RR-14): 1-17. CDC recommends that screening for HIV infection should be performed routinely in all health care settings for all patients aged 13-64, unless the prevalence of undiagnosed HIV infection has been documented to be < 0.1%. Patients initiating treatment for TB and patients seeking treatment for STDs should be screened routinely for HIV. Health care providers should subsequently test all persons likely to be at high risk of HIV at least annually. Screening should be voluntary and undertaken only with the patient’s knowledge and understanding. Patients should be informed orally or in writing that HIV testing will be performed unless they decline.


87. U.S. Preventive Services Task Force. Screening for osteoporosis September 2002. Available at: http://www.ahrq.gov/clinic/uspstf/uspsoste.htm. Accessed April 14, 2008. The USPSTF recommends that women age 65 and older be screened routinely for osteoporosis. The USPSTF recommends that screening begin at age 60 for women at increased risk for osteoporotic fractures. While no specific periodicity is recommended, the USPSTF notes that while a minimum of 2 years may be needed to reliably measure a change in bone mineral density, longer intervals may be adequate and that there are no data on the appropriate age to stop screening.


Policy:

Blue Cross and Blue Shield of Illinois will promote the use of the BCBSIL Screening Adults for Depression Practice Guideline.

Purpose/Objectives:

This guideline for screening adults for depression is designed to assist clinicians by providing a framework for evaluation of patients and is not intended to either replace a clinician’s judgement or establish a protocol for all patients with a particular condition.

This BCBSIL guideline summarizes the 2002 U.S. Preventive Services Task Force (USPSTF) Screening for Depression Guideline.

Guidelines:

Adults should be screened for depression when accurate diagnosis, effective treatment, and careful followup can be assured.

- Screening improves the accurate identification of depressed patients in primary care settings and treatment of depressed adults identified in primary care settings decreases clinical morbidity.
- In studies that simply provide feedback of screening results to clinicians, small benefits have been observed.
- Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment.
- The benefits of screening are likely to outweigh any potential harms.

Clinical Considerations

- Many formal screening tools are available (see Table.) Asking two simple questions about mood and anhedonia (“Over the past 2 weeks, have you felt down, depressed, or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”) may be as effective as using longer instruments. There is little evidence to recommend one screening method over another, so clinicians can choose the method that best fits their personal preference, the patient population served, and the practice setting.
- All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria [such as those from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)] to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and comorbid psychological problems (e.g., anxiety, panic attacks, or substance abuse) should be addressed.
Many risk factors for depression (e.g., female sex, family history of depression, unemployment, and chronic disease) are common, but the presence of risk factors alone cannot distinguish depressed from non-depressed patients.

The optimal interval for screening is unknown. Recurrent screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (e.g., panic disorder or generalized anxiety), substance abuse, or chronic pain.

Clinical practices that screen for depression should have systems in place to ensure that positive screening results are followed by accurate diagnosis, effective treatment and careful follow-up. Benefits from screening are unlikely to be realized unless such systems are functioning well.

Treatment may include antidepressants or specific psychotherapeutic approaches (e.g., cognitive behavioral therapy or brief psychosocial counseling), alone or in combination.

The benefits of routinely screening children and adolescents for depression are not known.

**Background**

In primary care settings, the point prevalence of major depression ranges from 5 percent to 9 percent among adults, and up to 50 percent of depressed patients are not recognized.

Several depression screening instruments are available; most instruments have relatively good sensitivity (80 percent to 90 percent) but only fair specificity (70 percent to 85 percent). Most instruments are easy to use and can be administered in less than 5 minutes.

About 24 percent to 40 percent of patients who screen positive will have major depression. The finding of a positive screen therefore requires further diagnostic questioning by the clinician to establish an appropriate diagnosis and initiate a plan for treatment and follow-up.

Effective treatments are available for patients with depressive illnesses detected in primary care settings. Antidepressant medications for major depression are clearly more effective than placebo. Psychosocial and psychotherapeutic interventions are probably as effective as antidepressant medications for major depression, but they are clearly more time intensive.

Reference

To assist clinicians in identifying depression screening tools, several screening tools are compared in the following table:

### Adult Depression Screening Tools Comparison

<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Number of Items</th>
<th>Ease of Scoring</th>
<th>Clinician</th>
<th>Office Staff</th>
<th>Can be Self Administered</th>
<th>Includes DSM IV diagnostic criteria</th>
<th>Sensitive to change in severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9* Most highly recommended by CCGC committee</td>
<td>9</td>
<td>Easy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>QIDS-SR</td>
<td>16</td>
<td>Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>CES-D</td>
<td>20</td>
<td>Easy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Hamilton</td>
<td>17</td>
<td>More difficult</td>
<td>Yes</td>
<td>Yes (in development)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>Easy</td>
<td>Yes</td>
<td>Untested</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*PHQ-9 has advantage of two pre-screening questions which, if negative, eliminate need to continue. It is also the only tool which can be used as a screening and diagnostic tool. (PHQ-9 is an outgrowth of Prime-MD). Go to [www.coloradoguidelines.org](http://www.coloradoguidelines.org) to download PHQ-9.

**Other instruments in common use include the Zung, Mini Patient Health Survey, HANDS, Prime-MD, and others. These instruments may work well in the hands of health professionals with experience in their use, but are not recommended for those seeking a new instrument.

**Reminder:** These tools should be used in conjunction with a clinician's judgment before determining a diagnosis.

This table was adapted from Colorado Clinical Guidelines Collaborative Depression Guideline Long Form revised 9/12/2006 available at the CCGC Website: [www.coloradoguidelines.org](http://www.coloradoguidelines.org)
To provide a reference guide on contractual responsibilities and administration of the Blue Cross and Blue Shield of Illinois (BCBSIL) products for the HMO, BlueChoice Select and PPO networks.

**Purpose:**

BCBSIL will develop, make available and maintain a Provider Manual for BCBSIL Products.

**Procedure:**

1. BCBSIL developed a Provider Manual which includes, but is not limited to the following information:
   - Member Rights and Responsibilities
   - Contact Personnel
   - Membership Procedures
   - Claims Processing
   - Coordination of Benefits
   - Provider Reimbursement
   - Scope of Benefits
   - Handling Emergencies
   - Inquiries, Complaints, Appeals, and Grievances
   - Contractual Responsibilities
   - Physician Credentialing/Appointment Policy
   - Quality Improvement Program
   - Utilization Management Program
   - Individual Benefit Management Program
   - Policies

2. The Provider Manual is available to the HMO IPAs, BlueChoice Select, and PPO physicians via the Web at [http://www.bcbsil.com/provider/securedpage.htm](http://www.bcbsil.com/provider/securedpage.htm).

3. The Provider Manual will be periodically updated / revised by the designated Health Care Management staff when warranted by changes in policies and/or benefits.