General SRC #05, Attachment 2: Cancer Disease Management Program
Table of Contents

Introduction .......................................................................................................................... 2
Program Goals..................................................................................................................... 3
Program Content................................................................................................................ 4
Cancer Disease Management Program - Core Process Overview ........................................ 4
Cancer Disease Management Program - Core Components Overview .............................. 5
Identifying Enrollees for the Cancer DM Program.............................................................. 6
Frequency of Enrollee Identification.................................................................................. 6
Providing Enrollees with Information ................................................................................. 8
Interventions Based on Assessment.................................................................................... 10
General Interventions .......................................................................................................... 10
Intervention: Symptom and Chronic Condition Self-Management ....................................... 11
Intervention: Medication and Safety .................................................................................. 12
Intervention: Emotional Support and Engagement............................................................... 12
Interventions: Condition-Specific ..................................................................................... 12
Cancer DM Program............................................................................................................ 12
Eligible Enrollee Active Participation.................................................................................. 14
Individual-Level Approaches .............................................................................................. 14
Neighborhood-Level Approaches......................................................................................... 15
Informing and Educating Providers..................................................................................... 15
Integrating Enrollee Information ........................................................................................ 16
Health Information Systems for Disease Management.......................................................... 16
Provider Communication .................................................................................................... 17
Satisfaction with Disease Management.............................................................................. 17
Measuring Effectiveness ..................................................................................................... 17
Appendix ............................................................................................................................... 19
Introduction

Magellan Complete Care is an integrated whole health plan designed for the total care of individuals including medical and behavioral health needs. Magellan Complete Care is a Medicaid specialty plan as part of the Statewide Medicaid Managed Care program specializing in the care of those with a Serious Mental Illness (SMI). Our members are both eligible for Medicaid and have been diagnosed with a Serious Mental Illness.

Our clinical and operational model of care allows us to offer our members access to high-quality, clinically appropriate, affordable healthcare, tailored to each individual’s needs to ultimately improve healthcare outcomes and the overall quality of life for our members and their families. This document outlines the scope, structure and activities of Magellan Complete Care’s Cancer Disease Management (DM) program. Detailed standards of the DM program are located in applicable policies and procedures. The clinical basis for our program was established by the American Cancer Society, Centers for Disease Control (CDC), National Cancer Institute, and the American Journal of Clinical Oncology, focusing on a comprehensive and general approach to the management of cancer.

The term “enrollee” is used to represent an individual who is the recipient of healthcare benefits, interchangeable with “consumer” and “member”.

Our mission is to help our members find their way through the health care system by giving them a dedicated Care Coordination Team. This team keeps track of how the member is doing, helps make and keep appointments, coordinates with community agencies and resources, and understands what the member is going through. The Care Coordination Team acts as a conduit between members, their doctors, counselors, family, and caregivers to set goals for feeling better and enjoying a healthier life. Our goal is to ensure that all members receive personalized, high-quality health care tailored to their physical, mental, and social needs.

Cancer is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. Cancer cells can spread to other parts of the body through the blood and lymph systems. Cancer is not just one disease, but many diseases. There are more than 100 different types of cancer. Additional information regarding the different types of cancer can be found within the National Cancer Institute’s What Is Cancer?

The number of new cancer cases can be reduced, and many cancer deaths can be prevented. Research shows that screening for cervical and colorectal cancers as recommended helps prevent these diseases by finding precancerous lesions so they can be treated before they become cancerous. Screening for cervical, colorectal, and breast cancers also helps find these diseases at an early, often highly treatable stage. The Center for Disease Control (CDC) offers free or low-cost mammograms, nationwide Pap tests, and free or low-cost colorectal cancer screening in 25 states and four tribes.

Vaccines also help reduce cancer risk. The human papillomavirus (HPV) vaccine helps prevent most cervical cancers, some vaginal and vulvar cancers, and more recently tonsillar cancer in men. The hepatitis B vaccine can help reduce liver cancer risk. Making cancer screenings, information, and referral services available and accessible to all Americans can reduce cancer incidence and deaths.

A person’s cancer risk can be reduced in other ways by receiving regular medical care, avoiding tobacco, limiting alcohol use, avoiding excessive exposure to ultraviolet rays from the sun and tanning beds, eating a diet rich in fruits and vegetables, maintaining a healthy weight, and being physically active.
Because there are so many different types of cancers and even more types of treatment modalities, the focus of this Cancer Disease Management program is to assist enrollees in managing the long list of symptoms and side effects that enrollees typically experience due to the disease and the corresponding treatments. The purpose of the Cancer Disease Management Program is to support and empower enrollees and their caregivers (with the enrollee’s permission) to effectively receive and manage their ongoing condition(s), manage symptoms and side effects and prevent complications by working with their providers. This includes assisting enrollees in finding appropriate and accessible cancer treatment providers. Once providers and treatment are accessed, the Magellan Complete Care team assists the enrollee in adhering to treatment and medication regimens. This includes ongoing monitoring of applicable labs/vital signs, adopting a healthy lifestyle, and care coordination among behavioral health and medical providers.

Our Cancer Disease Management program supports the physician or provider/patient relationship and treatment plan, emphasizing prevention of complications through evidence based practice guidelines, helping enrollees access and engage in care, and evaluating clinical and psychosocial outcomes on an ongoing basis.

The program includes population-based, group, and individual approaches for general cancer management in combination with tailored approaches for managing enrollees’ behavioral health conditions. These activities promote a holistic approach to improve the enrollee’s physical and mental well-being through easy to use tools, coaching and outreach.

**Program Goals**

A significant proportion of Magellan Complete Care’s population will require some form of support for managing chronic conditions. In the specialty plan, nearly half (48 percent) of the SMI population experiences them. The Cancer Disease Management program is aimed at helping enrollees access appropriate care and focuses on improving the health outcomes and symptom management for people with cancer. The program uses a holistic approach to achieve the best possible therapeutic outcomes based on assessment of enrollee needs, ongoing care monitoring, evaluation and tailored enrollee and practitioner interventions.

Cancer is recognized as one of the leading causes of death and disability in the United States. In 2016, there will be an estimated 1,685,210 new cancer cases diagnosed and 595,690 cancer deaths in the US. Cancer remains the second most common cause of death in the US, accounting for nearly 1 of every 4 deaths. There are over 100 different forms of cancer, 1 in 17 deaths are due to lung cancer with lung cancer as the most common cancer in men. Breast cancer is the most common cancer in women. The American Cancer Society estimates that 12,990 new cases of cervical cancer will be diagnosed by the end of 2016. In the year of 2016 an average of 4,120 women will die from cervical cancer.

The absence of effective preventive care for many individuals with SMI creates an environment that leads to a very high prevalence of modifiable risk factors such as tobacco use, lack of physical activity and poor nutrition. Effective coordination and care management is needed to address the reality that the mental illness itself is a barrier to management of physical health conditions. Mental illness makes it harder for people to access care, adhere to a therapeutic regimen, keep follow up appointments and navigate the health care system.

Magellan Complete Care’s approach to Cancer Disease Management is different from that found in traditional coaching programs. We address co-occurring medical and behavioral health conditions as well as substance abuse by combining health care, social support, and peer support with care coordination tools that foster communication and shared treatment planning among providers.
While population-based, our Cancer Disease Management Program’s approach is individualized and includes peer support to help members engage and embrace self-care, healthy behaviors, working with providers, and adherence to treatment.

The goals of the Cancer Disease Management Program include utilizing evidence-based and team approaches to:

▲ Maintain and improve the health of Magellan Complete Care enrollees with Cancer by increasing their health knowledge about their condition and their ability to engage in treatment and shared decision making with their providers.
▲ Improve Magellan Complete Care enrollees’ engagement in their health and ability to self-manage the side effects and symptoms related to their cancer diagnosis and treatment. This will be accomplished with support of the DM team and providers through structured coaching, tools and outreach based on evidence based guidelines, enrollee empowerment strategies, and tools to prevent and manage exacerbations of their condition.
▲ Improve coordination of care for enrollees with cancer including medication reconciliation and evaluation of medication safety.
▲ Support Magellan Complete Care providers (both physical and behavioral) in their plan of care and efforts to educate the enrollee about cancer, and in delivering care which is consistent with national guidelines and evidence-based practice.
▲ Monitor and implement interventions to improve performance on outcome measures such as the Healthcare Data and Effectiveness Data and Information (HEDIS®) cancer related measures, enrollee surveys to evaluate the clinical and patient perspectives, and the effect on overall cost and health care service utilization.
▲ Reduce morbidity and mortality related to cancer for Magellan Complete Care enrollees whenever possible.

Data Sources:
▲ [http://www.cdc.gov/cancer](http://www.cdc.gov/cancer) (Cancer Prevention and Control)
▲ American Journal of Clinical Oncology

**Program Content**

Magellan Complete Care’s Cancer Disease Management Program is offered to all eligible enrollees diagnosed with cancer. Our Cancer Disease Management Program incorporates education, motivational and emotional support, easy to read materials, and group and individual resources in alignment with the enrollee’s conditions, needs, and readiness for behavior change.

**Cancer Disease Management Program - Core Process Overview**

Magellan Complete Care’s Cancer Disease Management processes:

1. Identifies enrollees who meet criteria for the Cancer DM program
2. Identifies the enrollee’s caregiver, who with the enrollee’s consent, is permitted to engage and receive information on the enrollee’s care and participation in the Cancer DM program
3. Stratifies enrollees into low, moderate, high, or ultra high-risk categories based upon medical and behavioral health conditions and issues
4. Promotes self-management of cancer through personalized enrollee interventions
5. Coordinates care with providers to reinforce treatment plans
6. Completes referrals to other departments, support groups and community resources based upon acuity, medical status, or member needs
7. Reinforces evidence-based practice guidelines
8. Completes an annual enrollee satisfaction survey for process improvement purposes
9. Refer to the DM program description and desktop procedure

**Cancer Disease Management Program - Core Components Overview**

Magellan Complete Care’s Cancer Disease Management program includes the following core components:

- **Disease management staff known as Wellness Specialists who educate and support moderate risk members (Integrated Care Case Managers work with the high risk population).** Wellness Specialists are registered nurses or have a combination of health education credentials and training and expertise in disease management.

- **Community-based teams including Health Guides (navigators) and Peer Support Specialists (individuals with lived experience with SMI who have been certified to deliver support to others) who identify and connect enrollees to resources that support the enrollees’ disease management goals.**

- **Cancer-specific and wellness engagement and education interventions including:**

  - **One on One wellness coaching** is facilitated by our Wellness Specialists and/or Peer Specialists. These techniques are facilitated by specialists who have learned to cope with their own mental illnesses, and who are trained to share their experience through healthy living activities such as group workshops. A main goal of these interactions is to help enrollees and their families regain hope, learn wellness self-management, and work with their providers to improve both mental and physical health. Lifestyle issues that may be addressed include tobacco use, being sedentary, obesity, substance use, early screenings, sun exposure, and healthy eating.

  - **Health education written materials** with appropriate reading level, cultural appropriateness, and based on current health standards and evidence;

  - **Magellan Complete Care member website** containing a health and medication library and interactive assessments and health tools for self-management of cancer conditions and symptoms, in English and Spanish;

  - **Online, interactive courses from Healthwise™** on managing Cancer and the health behaviors and lifestyle choices that affect the path of Cancer disease (tobacco, weight, exercise, early screenings, sun exposure). The online programs are used in the manner best suited to the enrollee: independently, with orientation from the Wellness Specialist, Health Guide, or Peer Support Specialist; as part of a group class on self management of conditions; or individually when a Wellness Specialist or case manager engages with moderate or high risk enrollees. The course content is engaging and evidence-based, and it allows enrollees and the multidisciplinary Care Coordination Team to measure understanding and track progress and completion. The display is appealing and appropriate for lower literacy levels.

  - **Care coordination activities** based upon enrollee’s needs and status, such as helping members choose a provider, make an appointment, or arrange transportation. It also facilitates sharing of information among treating providers including multiple specialists involved in a member’s care.

  - **Whole person and condition specific health coaching activities**

  - **Milliman Chronic Condition and Healthwise enrollee materials and interactive modules are utilized to support enrollees learn about their Cancer and self-management activities.**

  - **Recovery and resiliency principles.**
Identifying Enrollees for the Cancer DM Program
Magellan Complete Care’s model of care involves having a robust presence in the community, promoting interaction with our enrollees on a regular basis. Any of those interactions can lead to the identification of enrollees eligible for the Cancer disease management program. Review of sources and reports to identify enrollees with Cancer occurs at least monthly. Enrollees will be identified as eligible for the Cancer Disease Management Program through a variety of additional sources, including:

▲ **Claims/encounter data:** Claims data will be used to identify enrollees who have diabetes.

▲ **Pharmacy data:** Pharmacy data is used to identify enrollees who are prescribed medications for Cancer management.

▲ **Health Risk Assessment (HRA) data:** The HRA is a proprietary assessment tool developed by Magellan’s medical and behavioral health experts. This assessment is comprised of medical, preventive, behavioral, psychosocial, and lifestyle questions that are tailored to the SMI population. On this questionnaire, enrollees self-identify whether they have any chronic conditions, such as Cancer and other comorbid conditions.

▲ **Lab results:** Lab data is used to identify risk levels for enrollees with Cancer in the population, based on certain lab result values related to Cancer and its side effects and symptoms.

▲ **Data collected through Magellan Complete Care Utilization Management or Case Management programs:** Enrollees may be identified as eligible for the Magellan Complete Care Cancer DM Programs based on case management program referrals, discharge planner referrals, concurrent review referrals, transition reports, prior authorization requests, among other referral sources.

▲ **Information from health management, wellness or coaching programs:** Data from Magellan’s clinical information system is used to identify enrollees with Cancer and with gaps in care.

▲ **Information from patients and providers:** Enrollees may self-refer or be referred by their provider into the Magellan Complete Care Cancer DM program.

▲ **Refer to the revised DM program description and desk top procedure**

Frequency of Enrollee Identification
Our program uses a combination of administrative data and predictive modeling as well as ‘real time’ referral sources to identify members with Cancer who are eligible for the Cancer Disease Management program. Administrative data is produced through regular reporting procedures that are followed each month, and the data is reviewed at least monthly to identify individuals with cancer.

Magellan Complete Care has licensed ImpactPro® to enhance our predictive modeling capabilities. The commercially available tool has been modified by Magellan Complete Care to incorporate behavioral health conditions, social support status and other issues that are unique to our populations. The tool assigns each member a likelihood of hospital admission and other health service utilization based on previous claims and other data, including enrollee reported information. The model relies on the use of a more robust data set than most models, including:

- Enrollment information (age, gender);
- Medical and behavioral claims (diagnoses, cost of care, events);
- Outpatient pharmacy claims; and,
- Health and Wellness Questionnaire data.

In addition to identifying members with targeted diseases and their risk levels, ImpactPro® also identifies gaps in care according to about 800 rules that imbed evidence based care. Closure of these gaps in care can improve clinical care and outcomes and mitigate the risk of increased utilization.
We have found that risk identification and stratification cannot be done solely through claims analysis, particularly when claims data are unavailable or there is a lack of an extensive history of claims. Additionally, there are critical components of information for Cancer DM Program approaches and interventions that can only be provided by self report from enrollees. These include health habits, living situation and social connectedness, which are all important predictors of outcomes. Therefore, Magellan Complete Care uses information captured via a Health Risk Assessment (HRA) to further identify the key areas of risks and needs of the SMI population.

The core domains of the HRA include:
- Living Situation;
- Hospital/Office Visit History;
- Substance Abuse and Tobacco Use History;
- Social Activity;
- Physical Activity;
- Nutrition Habits;
- Preventive Test History;
- Depression Screening;
- Chronic Condition and Behavioral Health History;
- Rating of Health; and
- Confidence and Readiness Rating for Behavior Change.

Magellan Complete Care’s HRA can be administered in person or telephonically. Once Magellan Complete Care’s case management team is informed that an individual is enrolled in the plan, staff reaches out to the enrollee through written materials, telephonically and face to face, to welcome them to the plan, and gather the HRA as well as documenting our New Enrollee interview. Together, these tools are used for a baseline understanding of the member’s recent health history and current needs. All enrollees in an institutional setting receive a face to face evaluation, if possible. Our goal is to complete an initial assessment for most enrollees living in the community within 30 days of enrollment and 15 days for enrollees living in an Assisted Living Facility or other institution. We utilize Health Guides and Peer Support Specialists to help locate individuals who are homeless or otherwise hard to find.

The baseline information collected through administration of the HRA allows MCC to stratify the population and identify those who are at greatest risk. Relying on a unique scoring system that assigns different values to higher risk elements, such as ER use and presence of chronic and disease specific conditions such as cancer, MCC stratifies the population into four risk tiers (Ultra High, High, Moderate and Low) risk based on the self-reported responses on the HRA. The risk level guides the level of optimal care management that addresses each person’s specific needs. Members who are stratified as moderate, high and ultra high risk will have additional clinical needs assessment completed to determine if they meet criteria for participation in the Cancer DM Program and to provide information for care planning.

HRAs, which are updated on an annual basis, provide important insights to identifying the needs of members and opportunities to support members in managing their conditions. This information supplements the monthly data identified through our predictive modeling process and the ongoing, real-time identification through utilization management, member and provider referrals, and other referral sources. Enrollees who are newly identified as eligible for the Cancer DM Program are then referred to the Wellness Specialist via the clinical information system for follow-up and outreach.
Once an enrollee has been identified for the Cancer DM Program, the member is welcomed to the program. Magellan Complete Care follows an opt-out model, and a member may decline or disenroll from the program at any time. Enrollees who decline or disenroll are re-approached after six months and asked to participate, and enrollees are provided contact information about the program and informed that they are able to re-enroll at any time. When a member is contacted about the program, the Magellan Complete Care staff member will share with the member the source of information used to identify the member with Cancer (claims, HRA, etc.). If a member has been identified incorrectly with cancer, this information is noted in the clinical system and the member is removed from the program listing and is not sent follow up materials or other outreach for the Cancer DM Program.

The enrollee’s responses on the HRA are an important source of high level information about the enrollee and a vehicle for initial engagement in the Cancer DM Program. Other sources of information about the enrollee’s strengths and opportunities will be gathered from among several sources, including:

- ImpactPro® will be used for identifying members with comorbid conditions, predicting and stratifying risk, and identifying gaps in care specifically related to cancer prevention and care (e.g. mammograms, cervical cancer screenings, etc.)
- Evidence-based assessments utilizing Milliman Care Guidelines’ disease condition management tools for Cancer disease management.
- Magellan Complete Care’s proprietary integrated care guidelines, which address condition/condition and drug/condition interplay specific to conditions common in the SMI population.
- Interview with the enrollee as well as their family and supports, if indicated and agreed by the enrollee.
- Discussion with the enrollee’s treating providers for physical and behavioral health care.

Providing Enrollees with Information

The Magellan Complete Care staff coordinating the Cancer DM Program activities are allocated and located to best meet the program needs of our population and to comply with the state’s contract. The staff members involved in Cancer DM Program activities include Wellness Specialists (disease managers), Integrated Care Case Managers (Case Managers), Health Guides, Peer Support Specialists, Care Workers (clerical), Medical Directors, and Clinical Pharmacists. These staff members are part of the Care Coordination Team which works with each member and the member’s providers. If the enrollee provides consent for the caregiver to receive information related to the member’s treatment and care coordination activities, the Magellan Complete Care program staff also engages with the member’s caregiver during the member’s participation in the Cancer DM Program. In addition to Wellness Specialists, Peer Support Specialists, and Case Managers delivering individual and group education and support to enrollees, other members of the Care Coordination Team do the practical work of assisting members to engage in care, adhere to their provider’s treatment plan, and attend scheduled appointments. Peer Support Specialists and Health Guides, interacting with enrollees where they live and work, are trained to recognize, support, and refer when an enrollee seems to be stressed or in crisis, isolated or lacking social support, or not taking medications appropriately or safely.

The Care coordination Team will work closely with the enrollee using various tools and approaches to manage risk factors such as:

- Gaps in care;
- Changes in health status;
- Social risk factors;
- Crisis and safety risk;
- Over utilization of the emergency department;
Lack of compliance with treatment plans;
- Medication non-compliance;
- Need for coordination of services and resources;
- Educational needs; and,
- Need to be connected to a provider.

Within each of these areas a “whole-person” approach is taken, meaning that, regardless of the member being enrolled in the Cancer DM Program, his or her psychosocial assessment, lifestyle habits, behavioral health status, and presence of specific disease conditions and co-morbidities are taken into account when designing an enrollee-driven self-management plan of care. Integrated care guidelines are used as a resource to identify potential problems, risk or interactions between the different conditions. For example, some drugs used to treat behavioral conditions can have an effect on blood sugar levels in regards to cancer. Enrollees on drugs for both Cancer and behavioral health conditions will need more active monitoring of their levels.

The member’s Care Coordination Team supports the enrollee in understanding his/her condition and provide the tools and programmatic support for improved self-management of his/her Cancer, using various outreach and engagement approaches. Participants will be helped to develop symptom response plans which demonstrate they know how to identify an exacerbation of their condition and have a plan to deal with it, including knowing who and when to call for help.

General awareness about the Cancer DM Program will occur through:
- Mailing of introductory material to enrollees upon enrollment in the plan
- 24/7 access to the MCC Florida website
- Enrollees can call the 24/7 Care Line for any health question or concern they may have
- Information in the Enrollee Handbook
- Information in the Provider Handbook and provider orientation sessions

Targeted engagement activities for enrollees identified as eligible for the program will occur through:
- Mailing of a Welcome Letter to introduce them to the program
  - For enrollees under the age of 18 identified as eligible for the Cancer DM Program, the enrollee’s parent or legal guardian will be provided with the introductory program materials.
- Contacting the enrollee to participate either in-person or by phone
  - After two attempts, if the staff member is not able to reach an enrollee by telephone, an “unable to reach” letter will be mailed.
  - If the staff member is able to reach an enrollee, he or she will also establish whether the enrollee has been participating in a Cancer DM Program offered outside of Magellan Complete Care. For enrollees who were previously participating in a Cancer DM Program offered outside of Magellan Complete Care, the staff member will seek information from the previous Cancer program provider to ensure continuity of care planning.
If the enrollee does not decline to participate in a Magellan Complete Care Cancer DM Program, a designated member of the member’s Care Coordination Team (i.e. ICCM or Wellness Specialist) will provide education about the program and its benefits, and how to use program services, through in-person contact, internet connectivity and/or telephone calls.

Enrollees are notified that they are able to opt-out of the program at any time, and will be provided information on how to opt-out if they choose to do so.

The Magellan Complete Care team tracks eligible enrollees in the clinical information system. Cancer DM Program enrollment is maintained as is information on ongoing engagement through analysis of members’ care coordination plans. Enrollee participation data, including frequency and forms of contact, is tracked by the Health Services Department.

Interventions Based on Assessment

For members participating in the Cancer Disease Management program, general and specific interventions will be used based upon completion and review of assessments with the member. Magellan Complete Care takes a whole person approach when identifying and applying interventions that are tailored to the member’s specific needs. Diagnosis of Cancer alone does not drive risk stratification of the member - all factors related to the member, including behavioral health conditions, living situation, social factors, motivation, and other factors identified through assessment will determine the interventions identified for the member and frequency of follow up. Therefore, a full set of both general and disease-specific interventions is available and used for the member, depending on the member’s risks and needs. Magellan Complete Care follows the approach that members identified as higher risk will have a higher frequency of contact and follow up from the Care Coordination Team on interventions. These approaches will be driven based on the direction of the member’s Wellness Specialist and input from other individuals on the member’s Care Coordination Team.

General Interventions

All enrollees in the Cancer Disease Management program will receive:

- Initial and ongoing Cancer condition assessments, education, assistance in goal setting, and support for skills development in self-management of Cancer
- Interventions that remind the enrollee to participate:
  - In condition self monitoring activities
  - Health screenings
  - Immunization (e.g. annual flu, pneumovax, etc.)
- Self-direction and skill development in the area of independent administering of medication and medication adherence;
- Self-management support and development of self-management plans and/or relapse prevention plans so individuals can attain personal health goals;
- Closing identified gaps in care
- Encouragement to participate in the development and ongoing review of the care coordination plan. Interventions will be identified for each enrollee based on risk level, strengths, and opportunities, and a member of the Care Coordination Team will be assigned to be responsible for following through on each intervention.

The intensity and frequency of interventions for enrollees enrolled in the Cancer DM Program will shift as an enrollee’s condition or circumstances changes. Enrollees will be regularly assessed for health literacy, skills in self-management,
screening for depression, level of confidence, and motivation for making a behavior change throughout their participation in the Cancer DM Program. The findings from these ongoing assessments as well as information shared by the enrollee’s providers will inform the enrollee’s goals and interventions as documented in the care coordination plan. The care coordination plan includes short and long-term goals and interventions that are tailored to the enrollee’s conditions, risks, and readiness for behavior change. For many enrollees in this population, social isolation is a key concern, so goals and interventions may include a focus on identifying friends and families who are able to support the enrollee in managing his/her cancer. Additionally, many care coordination plans developed for enrollees in this population will address topics of recovery and resiliency, and highlight the importance of creating crisis and/or safety plans.

When an enrollee meets with his/her doctor to discuss cancer treatment options, they should be instructed to bring their personal medical record (complete medical history), which should outline any other chronic conditions they may have; the medications they are taking, including the dosage, how often he/she takes the medication, and any side effects they have experienced; drug allergies (and any other allergies they may have), including what they have experienced when they have taken a medication they are allergic to; previous surgeries or medical procedures; medical tests and results; and the names of other doctors, including contact information. This information will help the doctor better coordinate care and minimize the risk of complications.

Some enrollees may be asked to temporarily stop taking some of their current medications because of potential interactions with cancer treatments or supportive care. Sometimes the side effects of cancer treatment can make it unsafe to take specific medications. If an enrollee is unsure about which medications they should be taking, they should talk with their doctor or pharmacist.

It is also important to ask questions to learn more about how chronic conditions may affect the cancer and cancer treatment. Enrollees should consider asking the following questions:

- What are my treatment options?
- What is the goal of each treatment?
- What treatment plan do you recommend and why?
- How will this treatment affect my chronic condition(s)? Will it make the condition(s) worse?
- What is the best way for me to manage my chronic condition(s) during treatment?
- Will I need additional or different medications, tests, or screenings during treatment to control my chronic condition(s)?
- How can I reduce potential side effects or health problems related to my cancer treatment?
- How will you work with my other health care providers to share health information and manage my care?

**Intervention: Symptom and Chronic Condition Self-Management**

The care coordination plan and the educational components of the program address symptom identification and ongoing condition management. For example: the use of appropriate pain medication for cancer pain management, treatment of nausea, anorexia, and dietary management, energy conservation for fatigue due to chemotherapy and/or radiation therapy treatment. Coaching to sensitize enrollees to the importance of annual cancer screenings, such as mammograms, cervical cancer screens, etc., is critical to self-empowerment and mitigation of problems.
**Intervention: Medication and Safety**

Both the initial assessment and follow up interactions with the enrollee will include assessment of medication adherence. Since there are so many potential interactions and risks, we expect that many of the participants will have medication regimen evaluation by our clinical pharmacist. Outreach to the treating physicians to discuss potential changes occurs when member safety issues are identified. We support adherence to drug regimens by encouraging treating providers to simplify them whenever possible. Peer Support Specialists are able to work with enrollees to encourage medication adherence.

The care coordination plan is used to track the enrollee’s progress, focusing not only on symptom management and adherence to treatment for the enrollee’s Cancer condition, but also behavior change and progress to reducing lifestyle risk factors.

**Intervention: Emotional Support and Engagement**

We recognize the value of and need for addressing the emotional needs and support of our enrollees. All enrollees in the Cancer DM Program will be screened for depression. The Care Coordination Team will engage with the enrollee in-person, via telephone, and with online tools, as indicated by the enrollee’s preferences and needs. All staff members working with members will be trained in motivational techniques. With their experience living with SMI, Peer Support Specialists often bring team enrollees important and timely insights about the enrollee’s motivation. They also model recovery, resiliency and healthy lifestyles for enrollees. By coordinating and engaging all participants in the enrollees’ care, we can help provide consistent messages and emotional support. Additionally, community support groups and classes will be a source of learning and support for members with cancer.

**Interventions: Condition-Specific**

Wellness Specialists (disease managers), ICCMs, and other members of the Care Coordination Team support enrollees as they learn to self-manage their cancer. The following section includes examples of evidence based care enrollees are encouraged to incorporate into their daily lives for managing cancer.

**Cancer DM Program**

**What Enrollees should know:**

- Survival statistics can help estimate prognosis (chance of recovery) and determine the treatment options
- Survival statistics are different based on the type of cancer, the stage, age, and length of time after diagnosis
- Although statistics can provide an *estimate* of survival, they are based on large groups of patients and cannot tell a person exactly how long he or she will live after a cancer diagnosis

When people are diagnosed with cancer, one of the first things they may want to know is their chance of survival and recovery. Understanding survival statistics becomes extremely important, yet it can also be confusing.

**Estimating how long people live after a cancer diagnosis:**

Survival statistics, usually given as rates, describe the percentage of people with a certain type of cancer who will be alive a certain time after the cancer is detected. Survival rates can be given for any length of time. Cancer statistics are
usually given as a five-year relative survival rate; this describes the percentage of people with cancer who will be alive five years after diagnosis, excluding those who die from other diseases. Sometimes, survival statistics are calculated to include all people with a specific type of cancer, regardless of stage. This is called an overall rate:

**Example:** Overall, the five-year relative survival rate for women with cervical cancer is 68%, which means that about 68 out of every 100 of women with cervical cancer will still be living five years after diagnosis.

Other survival statistics are calculated for specific cancer stages (the stage is an indication of the size of the tumor, and whether and how far the cancer has spread) as survival statistics can vary by stage.

**Example:** The five-year relative survival rate for early-stage cervical cancer is 91%. This means that 91 out of every 100 women diagnosed with early-stage cervical cancer will be living five years after diagnosis.

**Calculating how many people are cancer free or have cancer that is not growing or spreading:**

Five-year relative survival rates include all people who are alive five years after a cancer diagnosis, including those who are in remission (temporary or permanent absence of disease) or still being treated. Disease-free survival (sometimes abbreviated as DFS) statistics and progression-free survival statistics (sometimes abbreviated as PFS) are more specific survival statistics that are often used when evaluating cancer treatments.

Disease-free survival rates refer only to the percentage of people who experience a complete remission after finishing treatment.

Progression-free survival rates describe the percentage of people who do not experience any new tumor growth or cancer spread during or after treatment, including those whose disease has either completely or partially responded to treatment, or those whose disease is stable (the cancer is still present but not growing or spreading).

**The concept of “cure”:**

In medicine, a disease is considered cured when it has been successfully treated and does not return. The concept of “cure” is difficult to apply to cancer because undetected cancer cells can sometimes remain in the body after treatment, causing the cancer to return later (referred to as a recurrence or relapse). Many cancers are considered “cured” when there is no cancer detected five years after diagnosis. However, recurrence after five years is still possible.

**Determining prognosis:**

Among the first questions often asked when a person is diagnosed with cancer is whether the cancer can be treated successfully. This is called a prognosis—the likely course and outcome of the cancer and the chances of recovery. Doctors use survival statistics to make predictions about prognosis.

**Example:** A man diagnosed with testicular cancer may be said to have a favorable prognosis, as the overall five-year relative survival rate for testicular cancer is 95%.
Similar to survival statistics, prognosis also depends on the stage of the cancer at diagnosis—how early the cancer is detected and if or how far it has spread.  

*Example:* If detected early, the five-year relative survival rate for colorectal cancer is 90%. For advanced stage colorectal cancer that has spread to distant parts of the body, the five-year relative survival rate is about 13%.

**Points to remember:**

- Statistics are estimates that describe trends in large numbers of people. Statistics *cannot* be used to predict what will actually happen to an individual.
- Survival statistics for different cancer types, stages of cancer, age groups, or time periods can vary dramatically. People are encouraged to ask their doctor for the most appropriate statistics based on their individual medical condition.
- As with any medical information, ask your doctor for clarification if cancer-related statistics seem unclear.

**Evaluating treatment options:**

Five-year relative survival rates are commonly used as a way to evaluate and compare different treatment options. Although someone who has survived five years after a cancer diagnosis is not necessarily “cured,” the five-year relative survival statistic is considered a good indication that the cancer is responding to treatment and that the treatment is successfully extending the life of the person with cancer. Survival statistics help doctors determine which treatments provide the most benefit to people with cancer and whether the benefits outweigh any risks (such as unpleasant side effects) associated with the treatment.

Cancer is a chronic condition that requires ongoing management related to treatment parameters and side effects, and overall symptoms of the cancer condition itself. This program helps enrollees understand how to control their Cancer to prevent complications. Many drugs used to treat SMI conditions can both worsen or improve cancer treatment and side effects. For example, for women with Estrogen receptive breast cancer, the use of Tamoxifen along with shutting down the Estrogen supply, can cause sever hot flashes. Medications typically prescribed for the treatment of Depression, such as SSRIs, can help decrease hot flashes.

One of the goals of this program is to increase the number of enrollees who adhere to their medication regimen and reduce their lifestyle risks through behavioral change. The program also seeks to decrease the emergency room and inpatient visits for condition and treatment complications.

**Eligible Enrollee Active Participation**

**Individual-Level Approaches**

Our experience has shown that enrollees with SMI respond well to engaging in their health care when trusted health care relationships exist, and that our enrollees prefer telephonic and face-to-face contact when interacting with their health care team. Accordingly, for moderate and high risk members, we use face-to-face interventions and a high frequency of telephonic contact or progress reporting to ensure that enrollees are receiving the support they need to manage their diabetes. These approaches include telephonic outreach and onsite coaching interaction with a Care Coordination Team member, as well as referral to group classes offered by program staff and regular follow up with their treating providers.
Neighborhood-Level Approaches
Our Health Guides and Disease Management staff will connect our enrollees to community resources where possible. One example of this outreach would be to encourage healthy eating through connections to community gardens and Farm Share programs.

Informing and Educating Providers
Primary Care Providers (PCP’s) and Oncology providers play a leadership role in the care of cancer. Magellan Complete Care supports providers in delivering evidence based care through education, monitoring of the enrollee’s condition and treatment plan, and feedback as well as supporting patient engagement in care and coordinating different components of the treatment plan. We place particular emphasis on closing gaps in care and medication management, given the special considerations and medication-related risks for the SMI population.

For high volume practices or health homes, Magellan Complete Care will designate resources including Wellness Specialists and case managers who will work with providers and their patients. For enrollees who have Cancer and other chronic conditions or special needs requiring ongoing care from a specialist, Magellan Complete Care will provide authorization for “standing referrals” to reduce any barriers or administrative burden for the provider and the enrollee.

The Magellan Complete Care Provider Manual includes information regarding how we work with providers to support enrollees with cancer. Any provider is welcome to refer a member to the program. Providers receive information about their patient’s progress via shared documents including the care coordination plan.

Additional support tools for the enrollee’s providers include:

- Materials and information used in the Cancer programs for both enrollees and providers are based on clinical practice guidelines. Evidence-based clinical guidelines for the treatment and management of the core conditions for the programs are reviewed, and modified if necessary, by the Magellan Complete Care Quality Improvement Committee at least every two years. Guidelines are made available to the provider network and medical record reviews are used to confirm use in patient care.

- Evidence based care guidelines that integrate the behavioral and physical health needs of the enrollees, such as guidelines for people with schizophrenia and cancer, are used as considerations by the clinical staff in assessing individual members. Because care for people with both diagnoses requires consideration of both conditions, it is important to integrate the standard guidelines that address only one condition.

Providers:
- May refer their enrollees for additional support to the Cancer DM program;
- Are able to receive notification of enrollee engagement in the program;
- Can assist with developing a comprehensive care plan;
- Can be provided with program and enrollee data; and
- May be engaged to optimize drug regimens for those enrollees with complex regimens for Cancer along with multiple chronic conditions.

Quality improvement activities with providers include development of both systematic interventions for the network and practice specific activities to improve performance. These activities are documented in the annual Quality Work Plan.
Communication with Enrollees’ Providers
Enrollees are encouraged to communicate with their providers about their Cancer DM program enrollment and progress. The Care Coordination Team monitors progress toward goals with regularly scheduled follow-up calls or onsite visits to the enrollee, Primary Care Physician, pediatrician, specialty providers, and/or family and through ongoing monitoring. The goals are modified as the enrollee’s progress/needs change and as the treating providers change their treatment plan and recommendations.

Integrating Enrollee Information
The Magellan Complete Care staff utilizes national evidence based guidelines as a basis for evaluation, quality improvement and analytics, gaps in care identification, enrollee and provider education, key interventions and outcomes measures. Staff has additional resources available to them including:

- Magellan’s proprietary, evidence based integrated care guidelines
- MCG (Milliman) Chronic Care Guidelines
- Magellan’s proprietary behavioral health medical necessity guidelines
- Interqual medical necessity guidelines for physical health topics
- Healthwise and MCG (Milliman) health education materials for members in English and Spanish
- CDC and American Cancer Society website resources

Health Information Systems for Disease Management
Magellan Complete Care utilizes the TruCare clinical information system to coordinate care for all enrollees, including those who are enrolled in the Cancer DM Program. TruCare is the Magellan Complete Care application providing clinical systems support for utilization management, case management, health promotion, disease management, and care coordination activities. TruCare integrates with the claims processing and provider data applications to enable Health Services staff to assess enrollee needs, complete care coordination plans, and authorize services. The system allows contracted Health Home providers to interact with their patient’s care coordination plan if permitted by the enrollee.

TruCare supports the care coordination plan including Cancer DM goals and displays contact information for the enrollee’s providers. The care coordination plan is where short and long term goals, interventions, and progress on those interventions can all be recorded. TruCare maintains automated documentation of the staff enrollee’s identity and the date and time of all actions on the enrollee’s record.

Through a rules-based feature in TruCare, Magellan Complete Care is able to find and outreach to sub-populations of enrollees with Cancer diagnoses and combinations of factors such as age and recency of preventive care services. Once identified, the system supports interventions for the population through tasking, outreach via correspondence, or other processes.

System support for Cancer DM operates seamlessly within TruCare, establishing a single platform for our teams performing across our entire enrollee population. The system incorporates access to the above guidelines into suggested interventions and it includes automatic and manual tasks to prompt staff and assure task completion. For example, staff receives automated prompts for follow-up with their enrollees through:

- The care coordination plan intervention turns red when the review of the goal and intervention is
due.

- TruCare reminds a team enrollee when follow-up is required based upon the diagnosis and completed plan of action

Cancer Disease Management Program data on program enrollment and participation is stored and maintained in a data warehouse for analysis of program activity, staff and enrollee engagement, and outcomes.

Provider Communication
The overall objective of the provider communication and coordination in the disease management program is to facilitate the exchange of important clinical, lifestyle, and related information among all participants in the enrollee’s care. Providers are able to receive a copy of their patient’s care coordination plan and key assessment results. They are encouraged to interact with and contribute to the care coordination plan and assessments in TruCare. For example, for each individual completing a HRA, an individualized, scored report is produced. Once TruCare has sufficient historical data, the predicted risk, gaps in care, and other relevant information for the cancer disease management program (such as medications and service authorizations) are loaded and included within the Member Profile. The member profile is useful for quickly focusing the attention of Wellness Specialist on key information about the enrollee to communicate and share with providers.

Satisfaction with Disease Management
Satisfaction surveys specific to the Cancer DM Program are administered to both Magellan Complete Care enrollee participants and the enrollees’ providers on an annual basis to evaluate the program’s impact on enrollees’ experience of care. Information gathered from ongoing enrollee feedback, complaints and compliments and surveys are analyzed and utilized to enhance staff performance and program processes.

Our Provider Support Specialists gather feedback from treating providers about successes and opportunities for program support and enrollee education. The Provider Support Specialists are nurses who work with providers on clinical patterns of care and help them access our tools such as member profiles and care coordination plans.

Measuring Effectiveness
The Magellan Complete Care Cancer DM Program is reviewed and evaluated on an annual basis to assess program effectiveness. The program is monitored and assessed on an ongoing basis during the program year to track progress towards meeting program goals, national benchmarks and clinical outcomes.

We evaluate the success of the program using a variety of measures. We use HEDIS measures and other measures required by AHCA to evaluate clinical outcomes over time. We expect to see improvements in the health and well-being of program participants. We also compare the rates in gaps in care over time. We measure the gaps using our predictive modeling software that also informs the interventions the Care Coordination Team pursues with the enrollee such as setting up follow up appointments for people with Cancer who have not seen their provider in the last six months. Over time the number of gaps should decrease as enrollees develop regular follow up schedules.

The measures used to evaluate the Magellan Complete Care Cancer DM Program are population-based, and are analyzed in comparison to benchmarks or goals, based on available industry standards. A summary of the proposed
measures used to evaluate the Cancer DM disease management program is listed below.

<table>
<thead>
<tr>
<th>Core DM Program</th>
<th>Process Measures</th>
<th>Clinical Quality Measures</th>
<th>Cost Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>- Participation Rates</td>
<td>Comprehensive Cancer Care (CDC):</td>
<td>- Total Cost</td>
</tr>
<tr>
<td></td>
<td>- Engagement Rates</td>
<td>- Medical attention for symptoms and side effects of cancer diagnosis and treatment</td>
<td>- Rx Cost</td>
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<td>- Medical Cost</td>
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### Cancer HEDIS Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Care, Screening, or test needed</th>
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<tbody>
<tr>
<td>Comprehensive Cancer care</td>
<td>- Breast Cancer Screening</td>
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<tr>
<td>Age 18-75</td>
<td>- Cervical Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>- Annual Monitoring for Patients on Persistent Medications</td>
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<tr>
<td></td>
<td>- Follow-Up After Hospitalization for Mental Illness</td>
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<td></td>
<td>- Antidepressant Medication Management</td>
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</table>
### MCC FL Disease Management Risk Level Interventions

<table>
<thead>
<tr>
<th>Level of Support Needed</th>
<th>Diabetes</th>
<th>Asthma</th>
<th>Hypertension (HTN)</th>
<th>Cancer</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1) Diabetes Educational Information mailed to members</td>
<td>1) Asthma Educational Information mailed to members</td>
<td>1) Hypertension Educational information mailed to members</td>
<td>1) Cancer Educational Information mailed to members</td>
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<td>2) Information provided to members of access and availability of:</td>
<td>2) Information provided to members of access and availability of:</td>
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<td>- 24/7 Telephonic Careline</td>
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<td>- Access to self management tools and education materials on the MCC website</td>
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<td></td>
<td>- Health screenings</td>
<td>- Health screenings</td>
<td>- Self blood pressure monitoring and documentation, daily food and exercise logs</td>
<td>- Health screenings</td>
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<td>- Immunization reminders (e.g. annual flu, pneumovax, etc.)</td>
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<td></td>
<td>3) Encourage best practices including routine monitoring of HbA1c, Diabetic Retinal exams, medications</td>
<td>3) Encourage best practices including medication compliance with inhaler and controller medications as prescribed</td>
<td>3) Encourage best practices including routine monitoring of blood pressure, medication compliance, low salt diet and exercise</td>
<td>3) Encourage best practices including medication compliance, management of treatment side effects and symptom control, knowledge of disease and current treatment, options</td>
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<td></td>
<td>4) Encourage diet and exercise</td>
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<td>Ad hoc targeted campaigns</td>
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<tr>
<td>Level of Support Needed</td>
<td>Diabetes Management Support provided by a Wellness Specialist</td>
<td>Asthma Management Support provided by a Wellness Specialist</td>
<td>Hypertension (HTN) Management Support provided by a Wellness Specialist</td>
<td>Cancer Management Support provided by a Wellness Specialist</td>
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</table>
| **Moderate Risk**       | 1) Disease specific member assessment conducted; member’s diabetic management needs are included in the member’s Care Plan | 2) Ensure appropriate providers are in place or assist to locate | 3) Promotion of:  
- Best practices including regular monitoring of Asthma medications  
  - Review medicine routine: Long term controller use to prevent acute episodes and reliever inhalers  
  - Symptom response plan (red, yellow, and green zones)  
  - Trigger avoidance  
  - Tobacco avoidance  
  - Encourage diet and exercise  
  - Self-direction and skill development to independently administer medication  
  - Self-management support and self-management plan development to attain personal health goals  
  - Access to self management tools and education | 1) Disease specific member assessment conducted; member’s HTN management needs are included in the member’s Care Plan 2) Ensure appropriate providers are in place or assist to locate 3) Promotion of:  
- Best practices including regular monitoring of Hypertension medications  
  - Review medicine routine  
  - Encourage diet and exercise  
  - Self-direction and skill development to independently administer medication  
  - Self-management support and self-management plan development to attain personal health goals  
  - Access to self management tools and education  
  - Hypertension Educational Information mailed to members  
  - Member informed  
  - Access to self management tools and education |
### Level of Support Needed

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<tr>
<th>Diabetes Management Support provided by an ICCM</th>
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<th>Hypertension (HTN) Management Support provided by an ICCM</th>
<th>Cancer Management Support provided by an ICCM</th>
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<tr>
<td><strong>High Risk</strong></td>
<td><strong>Diabetes</strong></td>
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<td><strong>Hypertension (HTN)</strong></td>
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<td>1) Disease specific member assessment conducted; member’s cancer management needs are included in the member’s Care Plan including:</td>
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<tr>
<td>2) Ensure appropriate providers are in place or assist member to locate</td>
<td>2) Ensure appropriate providers are in place or assist member to locate</td>
<td>- Maintain a blood pressure reading log: measure blood pressure at the same time each day</td>
<td>- Symptom identification and ongoing condition management</td>
</tr>
<tr>
<td>3) Assess member understanding of condition and care practices</td>
<td>3) Assess member understanding of condition and care practices</td>
<td>- Support healthy eating – reducing sodium intake, minimize grains and sugars in the diet</td>
<td>- The use of appropriate pain medication for cancer pain management, treatment of nausea, anorexia and dietary management, energy conservation for fatigue due to chemotherapy and/or radiation therapy treatment</td>
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<tr>
<td>4) Assess member needs for equipment / supplies</td>
<td>4) Assess member needs for equipment / supplies</td>
<td>- Create a plan that includes daily activity (i.e., walking)</td>
<td>- Coaching to sensitize enrollees to the importance of annual cancer</td>
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<td>5) Assist member with appointments as needed</td>
<td>5) Assist member with appointments as needed</td>
<td>- Quit smoking</td>
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<td>- Minimize stress in your life</td>
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<td>- Design a plan for medication adherence</td>
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<td>- Limit alcohol</td>
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<td>- Maintain a healthy weight</td>
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<td>- Encourage diet and exercise</td>
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