



Hoosier Alliance Is An AmeriHealth Mercy Company

MDwise Hoosier Alliance
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MDwise Hoosier Alliance Complex Case/ Care Management Program

Purpose

To identify members with complex health care needs which may be due to an individual's catastrophic, high-risk, comorbid and/or chronic health condition; to evaluate for care management through the development and implementation of a coordinated, member-focused and multidisciplinary plan of care aimed at meeting the specific health needs of the member while promoting optimal health outcomes.

MDwise Hoosier Alliance (MDHA) has approved for the following diseases/conditions:

1. Diabetes
2. Asthma
3. COPD
4. Chronic Kidney Disease
5. Congestive Heart Failure
6. Coronary Artery Disease
7. Children with Special Health Care Needs
8. Pregnancy
9. Depression
10. ADHD
11. PDD/Autism

Additional disease/conditions will be identified within the "Other" case/care management category. As there are no specific program descriptions, those conditions designated as "Other" will fall within the general Complex Case/Care Management Program (CCM). The goals, objectives, identification, stratification, outreach and outcome process fall parallel with the other case/care management programs, which have been implemented by MDHA.

MDHA supports NCQA Standard QI 7, which identifies that all members with a disease or condition that meets the criteria for CCM should be included within a complex case/care management program.

MDHA assesses the characteristics and needs of its member population and relevant subpopulations relying on eligibility categories, Hoosier Healthwise and Healthy Indiana Plan member demographics, self-referral services, specialty services, specific utilization patterns such as members enrolled in the Right Choices Program.



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The process includes activities to:

- Monitor treatment plan and outcomes
- Coordinate access to care and services
- Evaluate progress toward goals as the levels of interventions are implemented
- Report health, quality and utilization outcomes

MDHA has adopted the definition of Case Management from the Case Management Society of America (see Attachment A).

Key Elements

1. Program Objectives

- **Member:** to improve the health and quality of life for our members with complex health conditions by encouraging self-management techniques and improving the member's understanding of the condition(s). This includes assisting members with development and implementation of self-management plans. This includes all aspects of NCQA QI 7 and 8 requirements.
- **Provider Goal:** to enhance provider understanding of and compliance with MDHA's CCM Program and the Standards of Practice for Case Management. Providers will be an active participant in the care of the member through collaboration with the care and/or case manager and through direct member contact.

2. Program Goals

- Identify, provide and coordinate services for members with complex co-morbid conditions
- Facilitate processes to actively assist members and providers with the management of complex conditions
- Facilitate access to needed resources
- Systematically assess the characteristics of our member population and sub-populations
- Maintain, review and update as needed case management processes and resources to address members' needs
- Identify processes which specifically outline sources of information to identify members for case management
- Identify appropriate referral avenues for members to be referred to case management and other resources
- Maintain a case management system which supports the case management program by providing necessary evidenced-based clinical guidelines, algorithms, assessments, documentation, automatic prompts for case management follow-up and automatic documentation of staff demographics, (i.e., staff member's name, title, date and time of input or activity)



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- Ensure case management activities address the assessment of individualized development of case management plans which identify the members' health status, history, medications, condition-specific issues, activities of daily living, cognitive and mental health status, life-planning activities, cultural and physical preferences and limitations, identification of barriers and how to overcome, progress assessment, prioritization of goals, follow-up, communication and self-management plan, as well as involvement of caregivers and referrals to resources

Additionally, a case management plan will include goals for not only the member, but the caregiver, including caregiver preferences and the level of involvement the caregiver has in the member's case management plan.

- Ensure documented case management processes are followed for assessments, including ongoing monitoring and evaluation of case management activities
- Provide a process to obtain feedback from members regarding satisfaction, complaints and inquiries
- Analyze and evaluate the program at least annually
- Identify and have systems in place to set performance goals, measure outcomes or effectiveness and to analyze results
- Provide interventions to support opportunities for improvement and remeasurement

3. Program Content

- Condition monitoring to include, but not be limited to, a member's self-management skills, inclusive of self-monitoring and medical testing, and documented self-reported information
- Development of and monitoring adherence to treatment plans, including but not limited to, medications, self-monitoring activities, making needed appointments with PMP and specialist(s), and care gaps
- Identification of medical and behavioral health comorbidities on an individual basis to allow implementation of the most effective treatment/care plan and self-monitoring plan. This includes referrals to specialists.
- Identify possible health behaviors that may impede a member's ability to manage his or her condition. Promote healthy lifestyle practices such as exercise, nutrition and smoking cessation efforts through education and resources.
- Identification of psychosocial issues that may play a part in a member's adherence to a treatment plan. These issues may include, but not limited to, perceived barriers such as access to care issues, transportation and financial limitations, and cultural, religious and ethnic beliefs.
- Completed depression screening during the first (thirty) 30 calendar days of enrollment into care management



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- Identification of member's caregiver, if appropriate, and with consent of the member, provide the caregiver information related to the condition and treatment plan for the member
- Encourage and assist with communication between the member and provider related to his or her health concerns and treatment. By doing so, establishing a Medical Home for the member.
- Increase the administration of influenza and pneumonia vaccinations
- Provide members with a list of external resources specific to their need(s)

Interventions to Achieve Program Content

- Educate members about adherence to medication regimen and preventive care to be included within an individualized self-management plan through telephonic outreach
- Assist members in executing a healthy lifestyle by educating them about smoking cessation, the importance of staying active, weight management, nutrition and the dangers of substance abuse, as appropriate for each member
- Assist members in communicating with their provider about their health conditions, treatments and self-management plans
- Upon consent of member, supply the member's caregiver with information about the member's condition and treatment plan and provide resources to support the caregiver's role (i.e., About Special Kids, Indiana Family Helpline, Agency on Aging, among others)
- Assist members in taking action to modify smoking or start a smoking cessation program by providing information by phone and/or mail related to the Indiana Tobacco Quitline program
- Educate members about their disease state(s), future implications and comorbidities (including mental health) through phone contact, interactive phone response and disease specific mailings, per MDwise Policy MM-10.
- Coordinate care gaps with the member and provider through ongoing telephonic contacts and/or phone reminders
- Assist members in receiving influenza and pneumococcal vaccinations, as appropriate
- Coordinate with external resources as needed such as, but not limited to, 211, Indiana Family Helpline, Indiana Tobacco Quitline program, and Agency on Aging
- Assist members with the identification of psychosocial issues that are creating barriers to the members achieving their goals for treatment and self-management

4. Population Identification and Integration of Member Information

All members identified as having complex conditions are eligible for the program. The following methods, while not an all-inclusive list, will be utilized to identify members for the CCM Program:

- NURSEon-call encounters
- ER visit
- Health Risk Screenings
- Provider referrals (*HA416-Case Management Referral Form HHW-HIP P0017*)



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- Initial Complex Assessment Tool
- Claims (medical and pharmacy)
- MDwise Corporate referrals
- Diagnostic Cost Group (DxCG) Scores
- Utilization Management (UM)/Prior Authorization (PA) Department
- Medical Director
- Hospital Census and Discharge Planning
- ManagedCare.com
- Disease Management Program Referral
- Self-referrals

MDHA integrates member information from the following systems to facilitate continuity of care:

- Disease and Case/Care Management System (Pre-certification, Concurrent, Hospital, Discharge and Claims Data)
- Utilization Management System (Pre-certification, Concurrent Review and Discharge Data)
- ManagedCare.com
- Claims (Hospital Admission and Discharge Data) DxCG risk scoring

5. Population Stratification

Once identified, members are stratified into three risk groups (high – care management, moderate – case management and low – population based).

- Population-based members (Low risk): Members with DxCG scores of ≤ 299
- Case Management members (Moderate risk): Members with DxCG scores of 300 to 499
- Care Management members (High risk): Members with DxCG scores ≥ 500

Upon intake into the case management program an additional stratification occurs when the initial complex assessment has been completed within the first thirty (30) calendar days of identification. Members may risk higher or lower than the initial stratification received via the Program Management Tool (PMT). Members who have urgent case management needs are assigned to a case manager within one (1) business day of receipt of referral. Within ten (10) business days, the member will receive an initial outreach attempt by a case manager to obtain an assessment.



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6. Levels of Activity for Member Outreach

The stratification risk group drives the level of interventions.

• **Low-Population Based**

Criteria: Members who meet Low risk level as outlined in the Stratification Section.

Members with complex conditions having a Low risk score are flagged for population-based intervention, but members can move from one classification to another based on changes in their severity or exacerbation of symptoms.

Primary Responsibility: MDwise

Interventions focus on:

Members will be engaged through disease specific and preventive care population-based interventions, including educational materials, appointment and preventive care reminders. Pregnant members shall receive standard pregnancy care educational materials. Members will receive tobacco cessation materials about the Indiana Tobacco Quitline and access information for MDwise 24-hour NURSEon-call line. All members in population-based management will receive some or all of the above-mentioned interventions bi-annually per MDwise Policy MM-10.

• **Moderate-Case Management**

Criteria: Members who meet Moderate risk level as outlined in the Stratification Section.

Members are outreached to by automated voice response, United States Postal Service (USPS) and/or telephonically at least quarterly. Automated prompts are created in the documentation system to alert case managers when outreaches are scheduled.

Primary Responsibility: MDHA Case Management Technicians and Nurse Case Manager Level 1.

Interventions include, but not limited to:

- Welcome letter providing the member with information about case management and how to contact the Case Management Department in order to speak with a nurse. (*HA333-New Member Welcome Letter HHW-HIP M0001*)
- Resource letter providing the member with MDwise Member Services information, including transportation services and 24 hour NURSEon-call line, transportation benefit information and community resource information, including Indiana Tobacco Quitline, 211, and Indiana Family Helpline. (*HA426 Case Management Resource Letter HHW-HIP M0008*)
- Preventive care reminders
- Assistance with transportation issues
- Assistance with setting up appointments with PMP and/or specialists
- Assistance with pharmacy issues
- Appointment reminders, as need



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- **High-Care Management**

Criteria: Members who meet High risk level as outlined in the Stratification Section. These members are outreached to telephonically and/or via USPS at least quarterly. Automated prompts are created in the documentation system to alert the case manager when outreaches are scheduled.

Primary Responsibility: MDHA Case Manager

Interventions focus on, but are not limited to:

- All interventions under Low-Population Based and Moderate-Case Management
- Member participation letter sent to PMP (*HA058-Praticiatption in Case Management P0268*)
- Goals letter sent to the member and PMP (*HA061-Case Management Intro Letter M0367*)
- An initial complex health risk assessment will be completed within thirty (30) calendar days of identification including, but not limited to:
 - Initial assessment of members' health status, including condition-specific issues
 - Documentation of clinical history, including medications
 - Initial assessment of the activities of daily living
 - Initial assessment of mental health status, including cognitive functions
 - Initial assessment of life-planning activities, including the presence of health care power of attorney or Do Not Resuscitate (DNR) orders, if applicable
 - Evaluation of cultural and linguistic needs, preferences or limitations
 - Evaluation of visual and hearing needs, preferences or limitations
 - Evaluation of caregiver resources and involvement
 - Evaluation of available benefits within the organization and from community resources
 - Development of an individualized case management plan, including prioritized goals, that considers the member's and caregiver's goals, preferences and desired level of involvement in the case management plan
 - Identification of barriers to meeting goals or complying with the plan
 - Facilitation of member referrals to resources and follow-up to determine whether members act on referrals
 - Development of a schedule for follow-up and communication with member
 - Process to assess progress toward care management planned interventions
 - Review of the member's claim history
 - Contact with the member's family and health care providers
 - Development and communication of member self-management plans
 - A process to assess progress or course changes against the member's care management plan



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- Identifying the member's needs related to the diagnosis
- Evaluate the member's care gaps and coordinate services to achieve all preventive care with the provider
- Education regarding medication and self-management adherence, exercise, proper nutrition, and smoking cessation
- Evaluate the appropriateness of a specialty referral
- Coordination with the provider regarding member education, self-management and use of appropriate medications, modifications to care plan and change in member classification from High-Moderate risk to Low risk
- Depression Screening completed within thirty (30) calendar days of enrollment
- Disease-specific assessments, as appropriate
- Condition monitoring to include comorbidities

7. Complex Case Management Program Outcome Measurements for Restratification

After six (6) months, the member's progress towards his or her self-management/treatment plan is evaluated using outcome measurements. Based on the outcome measures listed below, the member will be reassessed and re-stratified according to, but not limited to, Section 5 Population Stratification:

- Medication adherence
- Progress and/or success with smoking cessation by member self-report
- Reduction in ER visits/costs related to complex conditions as identified by claims and utilization information
- Reduction in inpatient hospitalizations/costs related to complex conditions as identified by claims and utilization information
- Routine office visits at least two (2) times a year as identified by member and provider communication, care gaps and claims information
- Documented annual influenza vaccination as identified by claims and/or care gap information
- Care gap issues addressed within thirty (30) days of gaps being identified
- Care plan goals are met and documentation supporting achievement of goals is gathered

Evaluation of member's outcomes will continue every six (6) months while engaged in case/care management activities. Based on this evaluation, the member can be moved to population-based case management, or remain in care management.



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8. Member Participation and Opting Out of the Program

Eligible members are considered enrolled in the program and receive outreach and interventions without a specific request for participation. Participation is voluntary and the member has the right to “opt out” of the program. Following an explanation of case management and reason for the contact, if the member declines to continue with case management, the member is given the case manager’s phone number in case of reconsideration. The member may re-enter the program at any time by contacting the case manager at the number provided.

9. Indiana Tobacco Quitline Information

The Indiana Tobacco Quitline is a free, phone-based counseling service that helps Indiana smokers quit. All members in Case or Care Management will receive information by phone and/or USPS. Services include:

- One-on-one coaching for tobacco users who have decided to quit
- Resources for health care providers who want to improve patient outcomes
- Best practices for employers who want to implement smoke-free policies
- Support for family and friends who want to help loved ones stop smoking
- Tools for tobacco control partners to complement their current programs

Services are available seven (7) days-a-week in more than 170 languages. Members can call 1-800-QUIT-NOW (800-784-8669) or visit <http://www.in.gov/quitline>.

10. Staff Training, Credentials, Certification and Documentation System

- **Staff Training**

It is imperative that our staff have training in the treatment of complex conditions to ensure education continuity. The staff will be trained by the MDHA Medical Director or a designee annually.

- **Credentials and Certification**

The case manager will be a currently licensed RN with at least three (3) years of clinical experience. After initial training, the case manager will review the Clinical Practice Guidelines training annually. The case manager will receive ongoing training through seminars, publications and other education avenues as they become available. The education and training provided will focus on preparing the case manager to become a certified case manager (CCM).

- **Documentation System**

All interaction with the member and provider will be automatically documented in the member’s case file with the staff member’s ID and date and time of the action. Automated prompts for follow-up contacts with the member will be addressed in the member’s plan of care. Clinical Care Guidelines are used to develop assessments with algorithms in the case management documentation system. The staffing ratio for case/care management is 1:200.



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11. Provider Notification and Involvement

In-network providers are notified about the program in several ways:

- The MDwise Provider Manual
- The MDwise Hoosier Alliance Web site, www.hoosieralliance.org
- The MDwise health plan provider Web site, <http://mdwise.org/providers.html>
- Indiana Health Coverage Program (IHCP) Provider Bulletins
- Case management outreach encounters and updates with the provider

Providers receive the following written notification regarding their patients’ participation in the CCM Program:

- Notification of high-risk member enrollment in one-on-one care management, along with a copy of the plan of care goals (*HA058-Participation in Case Management P0268 and HA061- Case Management Intro Letter M0367*)
- Notification of a change in risk level of members enrolled in case/care management (*HA059-Discharge from Case Management M0368*)
- Notification of members who are eligible for complex case management but who the case managers were unable to contact, either initially or for follow-up, to collaborate on patient demographics and update of any relevant clinical findings (*letter to be developed*)
- Notification of members upon graduation from the CCM Program (*HA059-Discharge from Case Management M0368*)

12. Measurements

Cost/ Benefit Measurements	Measurement Capture	Performance Goal
Rate of inpatient admissions for CCM per 1,000 total members	Any claim with ICD9 code other than 491, 492, and/or 496, 493*, 250*, 357.2, 362.0, 366.41, 648.0, 585.9,410.01; 410.11; 410.21; 410.31; 410.41; 410.51; 410.61; 410.71; 410.81; 410.91, 402X1, 428.0, 428.1, 428.2, 428.3, 428.4, 428.9 and a CPT code of 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	3% reduction for members in CCM Care Management during a 12-month period



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Rate of ER visits for CCM per 1,000 total members	Any claim with ICD9 code other than 491, 492, and/or 496, 493*, 250*, 357.2, 362.0, 366.41, 648.0, 585.9,410.01; 410.11; 410.21; 410.31; 410.41; 410.51; 410.61; 410.71; 410.81; 410.91, 402X1, 428.0, 428.1, 428.2, 428.3, 428.4, 428.9 and a CPT code of 99281-99285	3% reduction for members in CCM Care Management during a 12-month period
PMP office visit every 12 months	Any claim for a PMP office visit with a CPT code of 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 and any ICD9 code other than 491, 492, and/or 496, 493*, 250*, 357.2, 362.0, 366.41, 648.0, 585.9,410.01; 410.11; 410.21; 410.31; 410.41; 410.51; 410.61; 410.71; 410.81; 410.91, 402X1, 428.0, 428.1, 428.2, 428.3, 428.4, 428.9	90% of members in CCM Care Management will have one (1) PMP visit during a 12-month period
Number of members fully engaged in either case or care management in the CCM Disease Management Program for prior 6 months and average time engaged	Informatics report-Dashboard	NA
Documentation of annual Influenza Vaccination	Any claim with ICD9 code other than 491, 492, and/or 496, 493*, 250*, 357.2, 362.0, 366.41, 648.0, 585.9,410.01; 410.11; 410.21; 410.31; 410.41; 410.51; 410.61; 410.71; 410.81; 410.91, 402X1, 428.0, 428.1, 428.2, 428.3, 428.4, 428.9 and a HCPCS of G0008	100% of all members in CCM Care Management will have received an annual Influenza Vaccination during a 12-month period



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13. Annual Evaluation

The Complex Case Management Evaluation is conducted collaboratively by the Senior Director of Clinical Services, Case and Disease Management Supervisor, Supervisor of Quality Improvement and the Chief Medical Officer. The program is evaluated annually and presented in the first quarter of the following year to the Physician Advisory Committee. Quarterly statistics are reported to the Physician Advisory Committee.

Objectives, activities, processes and outcomes are evaluated at a minimum of annually in order to:

- Calculate annual participation rates
- Determine whether the CCM Program has demonstrated improvement in the services and quality of care provided to members.
- Evaluate the overall effectiveness of the CCM Program
- Allow for exploration of barriers and limitations of the CCM Program
- Revise areas as needed to improve effectiveness of the CCM Program
- Obtain feedback from members regarding satisfaction with care management and to analyze member complaints and inquiries
- Implement intervention(s) to improve performance

MDHA also reviews and updates its case management processes and resources to address member needs. Policies are reviewed annually during the Quality Service Committee.



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Attachment A

Case Management Society of America – Standards of Practice for Case Management (2010)

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes.¹

MDwise Hoosier Alliance has adopted the Standards of Practice for Case Management (2010). The following is a list of topics that influence the practice of case management in the current health care environment.

- Addressing the total individual, inclusive of medical, psychosocial, behavioral, and spiritual needs
- Collaborating efforts that focus upon moving the individual to self-care whenever possible
- Increasing involvement of the individual and caregiver in the decision-making process
- Minimizing fragmentation of care within the health care delivery system
- Using evidence-based guidelines, as available, in the daily practice of case management
- Focusing on transitions of care, which includes a complete transfer to the next care setting provider that is effective, safe, timely, and complete
- Improving outcomes by utilizing adherence guidelines, standardized tools, and proven processes to measure a client's understanding and acceptance of the proposed plans, his/her willingness to change, and his/her support to maintain health behavior change
- Expanding the interdisciplinary team to include clients and/or their identified support system, health care providers, including community-based and facility based professionals (e.g., pharmacists, nurse practitioners, holistic care providers, etc.)
- Expanding the case management role to collaborate within one's practice setting to support regulatory adherence
- Moving clients to optimal levels of health and well-being
- Improving client safety and satisfaction
- Improving medication reconciliation for a client through collaborative efforts with medical staff
- Improving adherence to the plan of care for the client, including medication adherence
- These changes advance case management credibility and complement the current trends and changes in health care
- Future case management Standards of Practice will likely reflect the existing climate of health care and build upon the evidence-based guidelines that are proven successful in the coming years²

¹ Case Management Society of America, <http://www.cmsa.org>

² The Standards of Practice for Case Management, <http://www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf>