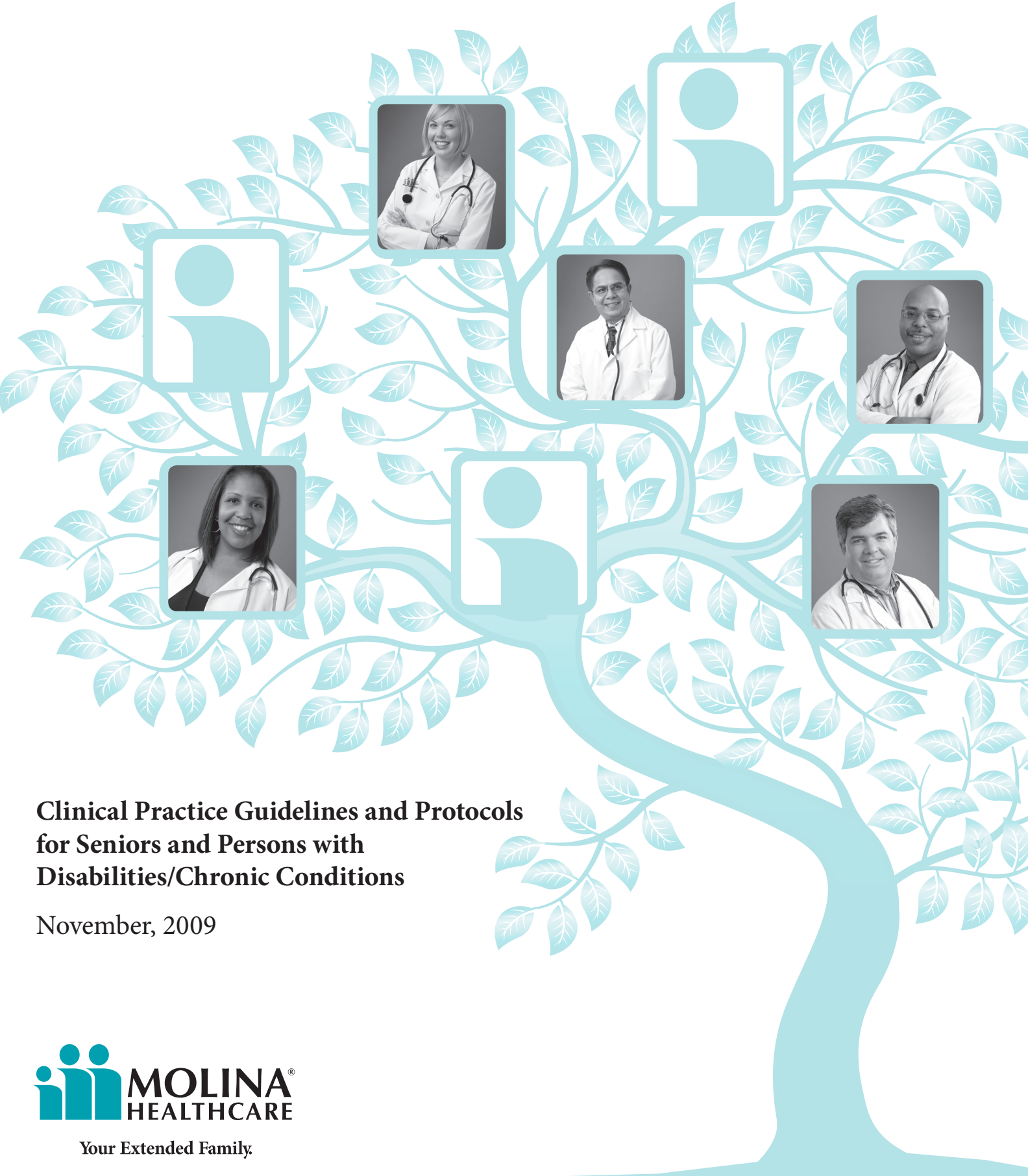


Molina Healthcare of California



Clinical Practice Guidelines and Protocols for Seniors and Persons with Disabilities/Chronic Conditions

November, 2009



Your Extended Family.

Molina Healthcare of California

**Clinical Practice Guidelines and Protocols
for Seniors and Persons with
Disabilities/Chronic Conditions**

November, 2009

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INTRODUCTION

As Molina's membership grows, we are seeing increased numbers of seniors and persons with disabilities (SPD) voluntarily select Molina as their health plan. To ensure that we are effectively meeting their needs, we are carefully reviewing all areas of our operations.

This booklet contains five clinical practice guidelines (CPG): asthma, acute respiratory tract infection, diabetes, high blood pressure and depression. Also included are Molina's adult preventive health guidelines which are updated annually. While these CPGs are not specific to the seniors and persons with disabilities, we have selected these clinical areas for inclusion in this booklet because they represent chronic conditions that are prevalent within the adult and senior populations. Practitioners should consider adapting these guidelines when and if necessary based upon the unique needs of their patients with disabilities and activity limitations. Primary and preventive care is fundamental in the overall management of health for people with chronic conditions and disabilities and can mitigate or prevent secondary or related problems. We hope that these CPGs will be a useful resource in providing care for your Molina members.

We would also like to make you aware of some additional resources that are available to you, and your Molina members, that are particularly relevant for seniors and persons with disabilities. These include:

- Molina's Nurse Advice Line that is available to members 24 hours a day, 7 days a week
- Non-emergency transportation to medical appointments
- Free interpreter services including American Sign Language
- Alternative format materials (large font, Braille, audio)

Molina also utilizes internal data (i.e. ED and IP claims, pharmacy, and encounter data) to identify members who would benefit from more intense supervision and management. These members are evaluated for possible inclusion into our Case Management or Complex Case Management Programs. Those members identified with certain disease states are also enrolled in our disease management programs. Currently these programs include asthma, diabetes, COPD and CVD. Providers can always directly refer their Molina members into any of these programs.

Molina Healthcare looks forward to partnering with our providers to ensure that our seniors and persons with disabilities members have full access to high quality medical care. By working together we can eliminate real and potential disparities of care that are the result of the many barriers that these members routinely experience.

Information on tax incentives to improve accessibility in your office or clinic can be found by visiting the web site of Center for Disability Issues and the Health Professions:

<http://www.cdihp.org/briefs/brief6-tax-incentives.html>

The Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommend annual vaccination from September through May.¹

Recommendations for Adult Influenza Vaccination	Recommendations for Pneumococcal Vaccine (polysaccharide)
<ul style="list-style-type: none"> • Vaccinate any adult at high risk for influenza complications, or in close contact with persons at higher risk. • Vaccinate health care workers and caregivers. • Trivalent inactivated influenza (TIV) and live, attenuated influenza vaccine (LAIV) are available, each with different routes of administration, indications, populations, and side effects. • Should influenza occur symptomatic care is the standard; early diagnosis of influenza prevents inappropriate use of antibiotics unless there is a secondary bacterial infection. 	<ul style="list-style-type: none"> • Pneumococcal vaccine is appropriate for: <ul style="list-style-type: none"> • Individuals \geq 65 years of age; • Individuals 2-64 years of age with chronic medical conditions. • Revaccination: <ul style="list-style-type: none"> • One time, 5 years after primary vaccination for individuals with functional or anatomic asplenia or immunocompromised persons. • Individuals \geq 65 years of age who received first dose < 65 years of age and at least 5 years has past since first dose.
<p>Acute Bronchitis</p> <ul style="list-style-type: none"> • Repeated studies have documented that antibiotic therapy has no benefit for acute bronchitis. • Antibiotics are not only associated with allergic reactions, but also with other adverse events such as <i>Clostridium difficile</i> (<i>C. difficile</i>) infections, which may lead to increased morbidity and mortality. 	
<p>Antiviral Therapy</p> <p>Viral epidemiologic resistance patterns are changing. Please refer to the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/flu for the most current antiviral recommendations.</p>	
<p>Symptomatic Relief</p> <ul style="list-style-type: none"> • Discuss with patients non-pharmacological interventions to prevent, appropriately manage, and treat viral respiratory infections. • Review over-the-counter medications and home remedies that may offer future symptomatic relief and may prevent unnecessary office visits for antimicrobial therapies. 	
<p>AWARE</p> <p>The CMA Foundation's Alliance Working for Antibiotic Resistance Education (AWARE) Project is your partner in decreasing antibiotic resistance. For the past decade, AWARE has developed clinical and patient education resources to help champion appropriate antibiotic use.</p>	

¹Centers for Disease Control and Prevention. Prevention and Control of Influenza. MMWR Early Release, July 17, 2008. At www.cdc.gov/mmwr/preview/mmwrhtml/r57e717a1.htm.

For more information or to download additional materials, visit www.aware.md.

Supporting Organizations

- Alameda Alliance for Health
- Antean Blue Cross
- Blue Shield of California
- CalOptima
- Centrist Health Plan
- Central Health
- Health Net of California
- Health Plan of San Joaquin
- Inland Empire Health Plan
- Kaiser Permanente
- Kerr Family Health Care
- L.A. Care Health Plan
- Molina Healthcare

Endorsing Organizations

- American Academy of Pediatrics, California District
- American Academy of Urgent Care Medicine
- Association of California Nurse Leaders
- California Academy of Physician Assistants
- California Association of Nurse Practitioners
- California Pharmacists Association
- California Society of Health-System Pharmacists
- Urgent Care Association of America

Acute Bacterial Sinusitis:

1. The Sinus and Allergy Health Partnership. Antimicrobial Treatment Guidelines for Acute Bacterial Rhinosinusitis. *Otolaryngol Head Neck Surg*. January, Supplement 2004;130:1-45.
2. Piccirillo JF. Clinical Practice: Acute Bacterial Sinusitis. *NEJM*. August 2004; 351:902-910.
3. Snow V, et al. Principles of Appropriate Antibiotic Use for Acute Sinusitis in Adults: Background. *Ann Intern Med* 2001; 134:498-505.
4. Swain RG, et al. The Diagnosis and Management of Sinusitis: A Practice Parameter Update. *J Allergy Clin Immunol*; 2005;116:S13-47.

Pharyngitis:

1. Gerber GA, et al. Prevention of Rheumatic Fever and Diagnosis and Treatment of Acute Streptococcal Pharyngitis. *Circulation*. 2009;119:1541-1551.

Non-specific Cough Illnesses/Acute Bronchitis:

1. Gonzalez R, et al. Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults. *Ann Emerg Med*. 2001; 37:690-97. (Reprinted from *Ann Intern Med*. 2001)
2. Gonzalez R, et al. Principles of Appropriate Antibiotic Use for Treatment of Uncomplicated Acute Bronchitis: Background. *Ann Intern Med*. 2001; 134:521-29.
3. Hooton T. Antimicrobial Resistance: A Plan of Action for Community Practice. *AFP*. 2001;63:1034-39.
4. Wenzel RP, et al. Acute Bronchitis. *NEJM*. 2006;355:2125-30.

Non-specific URI:

1. Gonzalez R, et al. Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults: Background, Specific Aims and Methods. *Ann Intern Med*. 2001; 134:479-86.
2. Gonzalez R, et al. Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults: Background. *Ann Intern Med*. 2001; 134:490-94.
3. Institute for Clinical Systems Improvement. Health Care Guideline: Diagnosis and Treatment of Respiratory Illness in Children and Adults. Available at: www.icsi.org. Accessed June 2009.

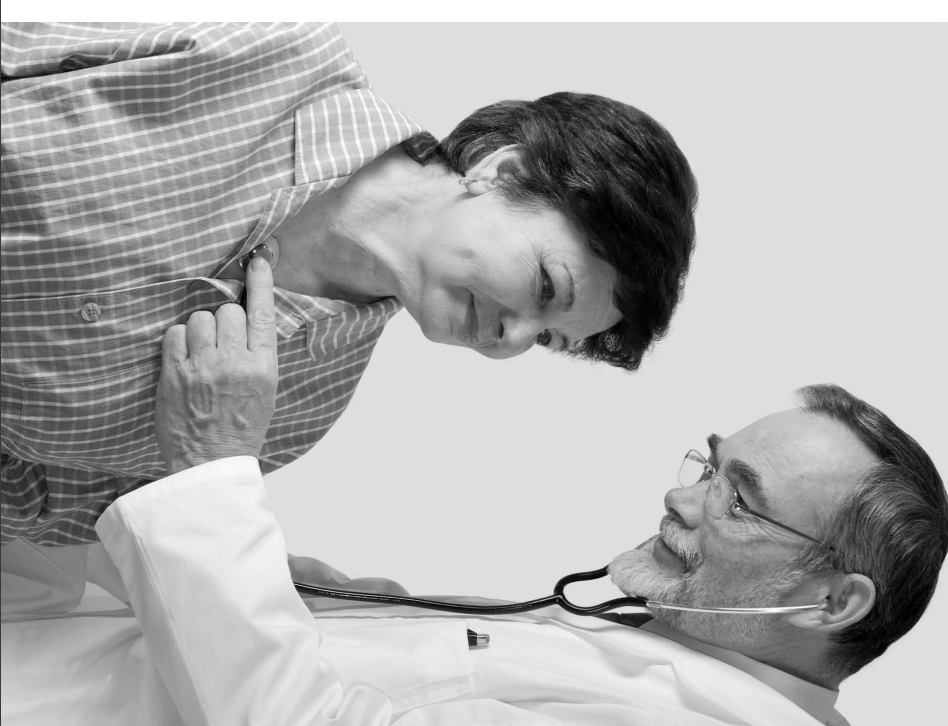
Community Acquired Pneumonia:

1. Mandell LA, et al. Infectious Diseases Society of America/American Thoracic Society Consensus Guidelines on Management of Community-Acquired Pneumonia in Adults. *CID*. 2007;44:S27-72.
2. Drugs for Community-Acquired Bacterial Pneumonia. *Med Lett Drugs Ther*. 2007;49(1269):62-64.

ADULT

Acute Respiratory Tract Infection Guideline Summary

2010



Adult Clinical Practice Guidelines Compendium Summary

Illness	Indications for Antibiotic Treatment	Pathogen	Antimicrobial Therapy	Antibiotic	Guidelines Reviewed
Acute Bacterial Sinusitis	<p>When to Treat with an Antibiotic: Diagnosis of acute bacterial sinusitis may be made in adults with symptoms of a viral URI that have not improved after 10 days or that worsen after 5-7 days.</p> <p>Diagnosis may include some or all of the following symptoms or signs: Nasal drainage, nasal congestion, facial pressure/pain (especially when unilateral and focused in the region of a particular sinus), postnasal discharge, anosmia, fever, cough, maxillary dental pain, ear pressure/fullness. Less frequent signs and symptoms include hyposmia and fatigue, in conjunction with some or all of the above.</p>	<p><i>Streptococcus pneumoniae</i></p> <p>Nonlyneable <i>Haemophilus influenzae</i></p> <p><i>Moraxella catarrhalis</i></p>	<p>Antibiotic Duration: 7 to 10 days</p> <p>Failure to respond after 72 hours of antibiotics: Reevaluate patient and switch to alternate antibiotic.</p>	<p>1st Line:</p> <ul style="list-style-type: none"> Amoxicillin <p>Alternatives:</p> <ul style="list-style-type: none"> Amoxicillin-clavulanate Oral cephalosporins: not first generation and not cefixime (i.e. cefpodoxime, cefuroxime, cefdinir, etc.) Respiratory quinolones (levofloxacin, moxifloxacin) <p>For β-Lactam Allergy:</p> <p>Trimethoprim-sulfamethoxazole, doxycycline, azithromycin, clarithromycin</p>	<p>American Academy of Allergy, Asthma & Immunology (AAAAI)</p> <p>American Academy of Family Physicians (AAFP)</p> <p>American College of Physicians (ACP)</p> <p>Centers for Disease Control and Prevention (CDC)</p> <p>Sinus and Allergy Health Partnership (SAHP)</p>
	<p>When NOT to Treat with an Antibiotic: Nearly all cases of acute sinusitis resolve without antibiotics. Antibiotic use should be reserved for moderate symptoms that are not improving after 10 days, or that are worsening after 5-7 days, and severe symptoms.</p>	Mainly viral pathogens		<p>1st Line:</p> <ul style="list-style-type: none"> Penicillin V <p>Alternatives:</p> <ul style="list-style-type: none"> Benzathine penicillin G Amoxicillin Oral cephalosporins Clindamycin <p>For β-Lactam Allergy:</p> <ul style="list-style-type: none"> Erythromycin Clindamycin 	<p>ACP, CDC</p> <p>Infectious Diseases Society of America (IDSA)</p> <p>Institute for Clinical Systems Improvement (ICSI)</p>
Pharyngitis	<p>When to Treat with an Antibiotic: <i>Streptococcus pyogenes (Group A Strep)</i> Symptoms of sore throat, fever, headache.</p> <p>Physical Findings include: Fever, tonsillopharyngeal erythema and exudates, palatal petechiae, tender and enlarged anterior cervical lymph nodes, and absence of cough. Confirm diagnosis with throat culture or rapid antigen detection before using antibiotics.</p> <p>When NOT to Treat with an Antibiotic: Most pharyngitis cases are viral in origin. The presence of the following is uncommon with Group A Strep, and point away from using antibiotics: conjunctivitis, cough, rhinorrhea, diarrhea, and absence of fever.</p>	<p><i>Streptococcus pyogenes</i></p> <p>Routine respiratory viruses</p>	<p>Group A Strep: Treatment reserved for patients with positive rapid antigen detection or throat culture.</p> <p>Antibiotic Duration: Generally 10 days</p>	<p>1st Line:</p> <ul style="list-style-type: none"> Penicillin V <p>Alternatives:</p> <ul style="list-style-type: none"> Amoxicillin Oral cephalosporins Clindamycin <p>For β-Lactam Allergy:</p> <ul style="list-style-type: none"> Erythromycin Clindamycin 	<p>ACP, CDC</p> <p>Infectious Diseases Society of America (IDSA)</p> <p>Institute for Clinical Systems Improvement (ICSI)</p>
Non-specific Cough Illness / Acute Bronchitis	<p>When to Treat with an Antibiotic: Antibiotics not indicated in patients with uncomplicated acute bacterial bronchitis. Sputum characteristics not helpful in determining need for antibiotics. Treatment is reserved for patients with acute bacterial exacerbation of chronic bronchitis and COPD, usually smokers. In patients with severe symptoms, rule out other more severe conditions, e.g. pneumonia. Testing is recommended either prior to or in conjunction with treatment for pertussis.</p> <p>When NOT to Treat with an Antibiotic: 90% of cases are nonbacterial. Literature fails to support use of antibiotics in adults without history of chronic bronchitis or other co-morbid conditions.</p>	<p><i>Chlamydia pneumoniae</i></p> <p><i>Mycoplasma pneumoniae</i></p> <p><i>Bordetella pertussis</i></p>	<p>Uncomplicated: Not indicated</p>	<p>Uncomplicated: Not indicated</p> <p>Chronic COPD:</p> <ul style="list-style-type: none"> Amoxicillin, trimethoprim-sulfamethoxazole, tetracyclines <p>Other:</p> <ul style="list-style-type: none"> <i>Bordetella pertussis</i>, <i>Chlamydia pneumoniae</i>, <i>Mycoplasma pneumoniae</i> - macrolide or doxycycline 	<p>AAFP, ACP, CDC, IDSA</p>
	<p>When NOT to Treat with an Antibiotic: Antibiotics not indicated; however, nonspecific URI is a major cause of acute respiratory illnesses presenting to primary care practitioners. Patients often present expecting some treatment. Attempt to discourage antibiotic use and explain appropriate non-pharmacologic treatment.</p>	Mainly viral pathogens		<p>Not indicated.</p>	<p>Not indicated.</p>
Nonspecific URI		Viral	Not indicated.	Not indicated.	AAFP, ACP, CDC, ICSI, IDSA
Outpatient Community Acquired Pneumonia	<p>When to Treat with an Antibiotic as an Outpatient: Perform CXR to confirm the diagnosis of pneumonia. Evaluate for outpatient management. Consider pre-existing conditions, calculate Pneumonia Severity Index (PSI \leq 90 for outpatient management) or CURB-65 (0 or 1 for outpatient management). Visit www.idsociety.org for more information.</p> <p>Sputum gram stain and culture are recommended if active alcohol abuse, severe obstructive/structural lung disease, or pleural effusion.</p> <p>When NOT to Treat with an Antibiotic as an Outpatient: Consider inpatient admission if PSI score $>$ 90, CURB-65 \geq 2, unable to tolerate orals, unstable social situation, or if clinical judgment so indicates.</p>	<p><i>Streptococcus pneumoniae</i></p> <p><i>Mycoplasma pneumoniae</i></p> <p><i>Haemophilus influenzae</i></p> <p><i>Chlamydia pneumoniae</i></p>	<p>Empiric Therapy*:</p> <p>Healthy with no DRSP** risk factors: Macrolide; consider doxycycline</p> <p>Presence of co-morbidity, antibiotic use within 3 months***, or risk of DRSP: Respiratory quinolone or combination of a β-lactam plus a macrolide Antibiotic duration: Minimum of 5 days; discontinue once afebrile for 48 - 72 hours.</p> <p>* Consider alternative agents for macrolide-resistant <i>S. pneumoniae</i> in any patient including those without co-morbidities</p> <p>** DRSP: Drug-resistant <i>S. pneumoniae</i></p> <p>*** Choose a class of antibiotic that differs from the prior antibiotic</p>	<p>1st Line:</p> <ul style="list-style-type: none"> Macrolide (azithromycin, clarithromycin, or erythromycin) Doxycycline <p>β-Lactam Alternatives:</p> <p>(to be given with a macrolide)</p> <ul style="list-style-type: none"> High dose amoxicillin or amoxicillin-clavulanate Cephalosporins (cefprozil, cefuroxime, cefprozil, cefuroxime) <p>Other Alternative:</p> <ul style="list-style-type: none"> Respiratory quinolone (moxifloxacin, levofloxacin) 	<p>Infectious Diseases Society of America / American Thoracic Society (IDSA/ATS)</p> <p>ICSI</p>

This guideline summary is intended for physicians and healthcare professionals to consider in managing the care of their patients for acute respiratory tract infections. While the summary describes recommended courses of intervention, it is not intended as a substitute for the advice of a physician or other knowledgeable healthcare professional. These guidelines represent best clinical practice at the time of publication, but practice standards may change as more knowledge is gained.

Important Points from Asthma Clinical Guidelines

The following are extracted from the NHLBI_NAEPP 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. (www.nlm.nih.gov/guidelines/asthma/index.htm)

MONITORING CONTROL DETERMINES ONGOING THERAPY

Asthma control is achieved by:

1) Reducing impairment, which includes:

- a) Prevention of chronic and troublesome symptoms
- b) Reducing need for inhaled short-acting bronchodilator to relieve symptoms
- c) Maintenance of near normal lung function
- d) Maintenance of normal activity levels
- e) Patient and family satisfaction

2) Reducing risk, which includes:

- a) Prevention of recurrent exacerbations
- b) Prevention of progressive loss of lung function
- c) Avoidance of adverse effects of pharmacotherapy for asthma

Components of Control (≥ 12 years of Age and Adults)		Classification of Asthma Control (≥ 12 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout The day
	Nighttime awakenings	≤2x/month	1-3x/week	≥4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV ₁ or peak flow	>80% predicted/ personal best	60 – 80% predicted/ personal best	< 60% predicted/ personal best
	Validated questionnaires ATAQ ACQ ACT	0 ≤0.75 ≥20	1 – 2 ≥1.5 16 - 19	3 – 4 N/A ≤ 15
Risk	Exacerbations requiring oral systemic corticosteroids	0 – 1 / year	≥2 / year	
	Progressive loss of lung function	Consider severity and interval since last exacerbation		
	Treatment-related adverse effects	Evaluation requires long-term follow-up care		
Recommended Action for Treatment		Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
		<ul style="list-style-type: none"> • Maintain current step • Regular follow-ups every 1-6 months to maintain control. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up 1 step • Reevaluate in 2-6 weeks • For side effects, consider alternative treatment options 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids • Step up 1 – 2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options

Important Points from Asthma Clinical Guidelines

The following are extracted from the NHLBI_NAEPP 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. (www.nlm.nih.gov/guidelines/asthma/index.htm)

MONITORING CONTROL DETERMINES ONGOING THERAPY

Components of Control (Children 5–11 Years of Age)		Classification of Asthma Control (Children 5-11 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout The day
	Nighttime awakenings	≤ 1x/month	≥2x/month	≥2x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function • FEV1 or peak flow • FEV1/FVC	<ul style="list-style-type: none"> • >80% predicted/ personal best • >80% predicted 	<ul style="list-style-type: none"> • 60- 80% predicted/ personal best • 75-80% predicted 	<ul style="list-style-type: none"> • < 60% predicted/ personal best • < 75% predicted
Risk	Exacerbations requiring oral systemic corticosteroids	0 – 1 /year	≥2 / year	
		Consider severity and interval since last exacerbation		
	Reduction in lung growth	Evaluation requires long-term follow-up care		
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment		<ul style="list-style-type: none"> • Maintain current step • Regular follow-ups every 1-6 months • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up at least 1 step • Reevaluate in 2-6 weeks • For side effects, consider alternative treatment options 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids • Step up 1- 2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options

Important Points from Asthma Clinical Guidelines

The following are extracted from the NHLBI_NAEPP 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. (www.nhlbi.nih.gov/guidelines/asthma/index.htm)

MONITORING CONTROL DETERMINES ONGOING THERAPY

Components of Control Children 0-4 Years of Age)		Classification of Asthma Control (Children 0-4 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	>1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year	2-3/year	>3/year
	Treatment-related adverse effects	Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.		
Recommended Action for Treatment		<ul style="list-style-type: none"> • Maintain current treatment • Regular follow-ups every 1-6 months. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up 1 step • Reevaluate in 2-6 weeks • If no clear benefit in 4-6 weeks, consider alternative diagnoses or adjusting therapy • For side effects, consider alternative treatment options 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids • Step up 1- 2 steps • Reevaluate in 2 weeks • If no clear benefit in 4-6 weeks, consider alternative diagnoses or adjusting therapy • For side effects, consider alternative treatment options

Molina Healthcare of California
Clinical Practice Guideline
2010
COPD Summary of Characteristics and Recommended Treatment

Therapy at Each Stage of COPD*			
I: Mild	II: Moderate	III: Severe	IV: Very Severe
<ul style="list-style-type: none"> • FEV₁/FVC < 0.70 • FEV₁ ≥ 80% predicted 	<ul style="list-style-type: none"> • FEV₁/FVC < 0.70 • 50% ≤ FEV₁ < 80% predicted 	<ul style="list-style-type: none"> • FEV₁/FVC < 0.70 • 30% ≤ FEV₁ < 50% predicted 	<ul style="list-style-type: none"> • FEV₁/FVC < 0.70 • FEV₁ < 30% predicted <i>or</i> FEV₁ < 50% predicted plus chronic respiratory failure
Active Reduction of risk factor(s); influenza vaccination →			
Add short-acting bronchodilator (when needed) →			
Add regular treatment with one or more long acting bronchodilators (when needed); Add rehabilitation			
		Add inhaled glucocorticosteroids if repeated exacerbations	
		Add long- term oxygen if chronic respiratory failure. Consider surgical treatments	

* Postbronchodilator FEV₁ is recommended for the diagnosis and assessment of severity of COPD.

Important Points from Diabetes Mellitus Clinical Guidelines

The following are extracted from American Diabetes Association position statements Standards of Medical Care in Diabetes, Diabetes Care, 32:S13-S61, 2009(www.diabetes.org), and Basic Guidelines for Diabetes Care, developed by the Diabetes Coalition of California and California Diabetes Program, 2008 (www.caldiabetes.org).

1. Criteria for diagnosis of diabetes in nonpregnant adults

Three ways to diagnose diabetes are possible, and each, in the absence of unequivocal hyperglycemia, must be confirmed, on a subsequent day, by any one of the three methods. The use of hemoglobin A1C for the diagnosis of diabetes is not recommended at this time.

- A. Symptoms of diabetes and a casual plasma glucose ≥ 200 mg/dl. Casual is defined as any time of day without regard to time since last meal. The classic symptoms of diabetes include polyuria, polydipsia, and unexplained weight loss.,
or
- B. FPG ≥ 126 mg/dl. Fasting is defined as no caloric intake for at least 8 hours, **or**
- C. 2-hour postload glucose ≥ 200 mg/dl during an OGTT. This test should be performed as described by the World Health Organization, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. (OGTT is not recommended for routine clinical use.)

2. Monitoring A1C (Target goal: <7.0% or <1% above lab norms)

The reduction in risk of the complications of diabetes is directly correlated with an A1C level of <7%. Perform A1C tests at least two times a year for patients who are meeting treatment goals (and who have stable glycemic control) and quarterly in patients whose therapy has changed or who are not meeting glycemic goals.

3. Monitoring retinal exams.

Annual comprehensive dilated eye and visual examinations should be performed for patients with diabetes by an ophthalmologist or optometrist who is knowledgeable and experienced in the management of diabetic retinopathy. Examination will be required more frequently if retinopathy is progressing.

4. Monitoring foot care.

Perform a visual inspection of diabetic patients' feet at each routine visit. All individuals with diabetes should receive a thorough foot examination at least once a year to identify high-risk foot conditions. This examination should include an assessment of protective sensation, foot structure and biomechanics, vascular status, and skin integrity. People with one or more high-risk foot conditions should be evaluated more frequently for the development of additional risk factors.

5. Monitoring microalbuminuria

Perform an annual test for the presence of microalbuminuria in type 1 diabetic patients with diabetes duration of ≥ 5 years and in all type 2 diabetic patients, starting at diagnosis.

6. Monitoring lipid levels (Target goals: triglycerides <150 mg/dl; LDL <100 mg/dl; HDL >50 mg/dl)

Adult patients with diabetes should be tested annually for lipid disorders with fasting serum cholesterol, triglyceride, HDL cholesterol, and calculated LDL cholesterol measurements. Children older than two years should be tested after diagnosis of diabetes and when glucose control has been established. If values fall in lower-risk levels, assessment may be repeated every 2 years for adults, and every 5 years for children > 2 years of age.

7. Monitoring hypertension (Target goals: systolic <130 mmHg; diastolic <80 mmHg)

Control of hypertension has been demonstrated conclusively to reduce the complications of diabetic nephropathy, cerebrovascular disease, and cardiovascular disease. Blood pressure should be measured at every routine diabetes visit. In children, blood pressures should be decreased to the corresponding age-adjusted 90th percentile value. If life style modifications do not achieve specific goals, medications should be added in a step-wise fashion until blood pressure goals are reached.

8. ACE Inhibitors/ ARBs (Angiotensin Receptor Blockers)

All nonpregnant patients with diabetes and hypertension should be treated with a regimen that includes either an ACE Inhibitor or an ARB. Along with controlling hypertension, these drugs also have been shown to delay the progression of nephropathy.

9. Immunizations

- A. Annually provide an influenza vaccine for all diabetic patients 6 months of age or older.
- B. Provide at least one lifetime pneumococcal vaccine to all diabetic patients ≥ 2 years of age. A one-time revaccination is recommended for individuals >64 years old when vaccine was administered >5 years ago. Other indications for revaccination include nephrotic syndrome, chronic renal disease and other immunocompromised states.

Molina Healthcare of California
Clinical Practice Guideline
Algorithm for the Treatment of Hypertension

Initial Assessment

- Determine blood pressure stage & lifestyle modification opportunities.
- Determine risk and high-risk conditions with compelling indications.
- Determine treatment recommendations (by using the table below).
- Determine goal blood pressure.
- Consider favorable / unfavorable effects of co-morbid conditions (see table on reverse side).

Begin or Continue Lifestyle Modifications

- Encourage patients to make healthy lifestyle choices:
- Quit smoking to reduce cardiovascular risk.
 - Lose weight, if needed. (Monitor BMI of 18.5 - 24.9)
 - Restrict sodium intake to no more than 100 mmol (2.4 g Na or 6 g NaCl) per day.
 - Limit alcohol intake to no more than 1-2 drinks per day (1 oz or 30 mL ethanol/24 oz beer/10 oz wine/3 oz 80-proof whiskey).
 - Get at least 30-45 minutes of regular aerobic activity on most days of the week (e.g. brisk walking).
 - Maintain adequate potassium intake – about 90 mmol per day.
 - Maintain adequate intakes of calcium and magnesium.
 - Adopt the Dietary Approaches to Stop Hypertension (DASH) eating plan by consuming a diet rich in fruits, vegetables, low-fat dairy products, reduced saturated and total fat.

Not at Goal Blood Pressure (<140/90 mmHg)

- <140/90 mm Hg Uncomplicated hypertension, Risk Group A, Risk Group B, Risk Group C except for the following:
- < 130/80 mm Hg Diabetes, renal failure, heart failure
 - < 125/75 mm Hg Renal failure with proteinuria > 1 gram/24 hours

Initial Drug Choices

Classification	Systolic BP (mmHg)	Diastolic BP (mmHg)	Initial Drug Therapy	
			Without Compelling Indication	With Compelling Indication
Pre-Hypertension	120 – 139	80 – 89	No antihypertensive drug indicated	Use drug(s) for the compelling indications* (see table on reverse side)
Stage 1 Hypertension	140 – 159	90 – 99	Thiazide-Type Diuretics for most. May consider ACEI, ARB, BB, CCB or combination	Use drug(s) for the compelling indications* (see table on reverse side) and add other Antihypertensive drugs (diuretics, ACEI, ARB, BB, CCB) as needed
Stage 2 Hypertension	≥ 160	≥ 100	2-Drug combination for most (usually Thiazide-Type Diuretics and ACEI or BB or CCB)	*Compelling Indications: treat patients with chronic kidney disease or diabetes to BP goal of < 130/80 mmHg.

Not at Goal BP

Optimize Dosages or add Additional Drugs until Goal BP is achieved
 Consider Consultation with Hypertension Specialist

* ACE-I = Angiotension Converting Enzyme Inhibitors BB = Beta Blocker
 ARB = Angiotension Receptor Blocker CCB = Calcium Channel Blocker

(See reverse side for Hypertension treatment compelling favorable / unfavorable co-morbid conditions)

Molina Healthcare of California
Clinical Practice Guideline
Algorithm for the Treatment of Hypertension

Recommended Drugs for Compelling Indications

High-Risk Conditions With Compelling Indications	Diuretic	Beta-Blocker	ACE Inhibitor	ARB	CCB	Aldosterone Antagonist
Heart failure	λ	λ	λ	λ		λ
Post-myocardial infarction		λ	λ			λ
High coronary disease risk	λ	λ	λ		λ	
Diabetes	λ	λ	λ	λ	λ	
Chronic kidney disease			λ	λ		
Recurrent stroke prevention	λ		λ			

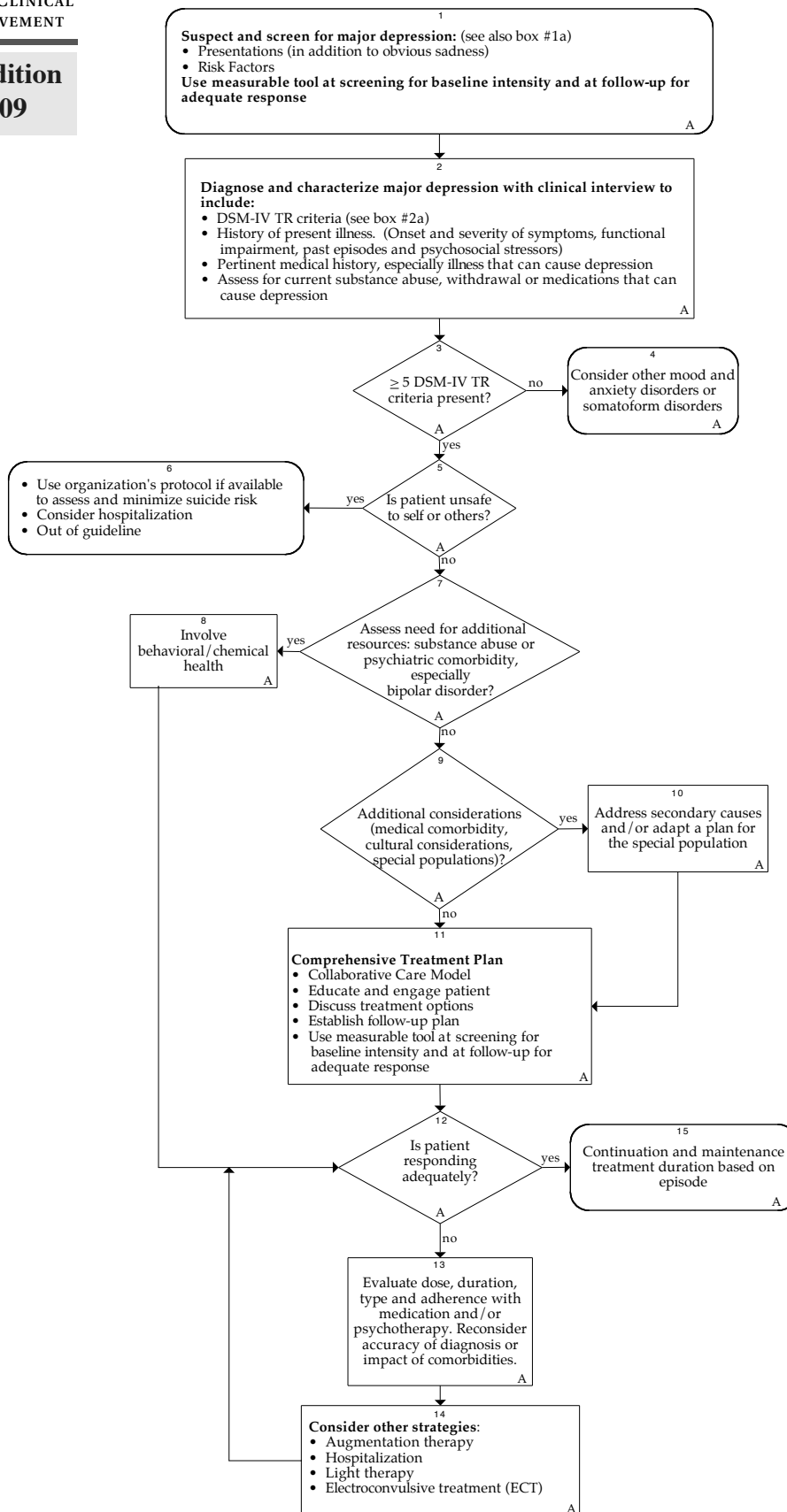
May Have Favorable Effects on Comorbid Condition

Angina	Beta-blockers, CCB
Atrial tachycardia and fibrillation	Beta-blockers, CCB
Cyclosporine-induced hypertension (caution with the dose of cyclosporine)	CCB
Diabetes mellitus (types 1 and 2) with proteinuria	ACE I (preferred), CCB
Diabetes mellitus (type 2)	Low-dose diuretics
Dyslipidemia	Alpha-blockers
Essential tremor	Beta-blockers
Heart failure	Carvedilol, losartan potassium
Hyperthyroidism	Beta-blockers
Migraine	Beta-blockers (non-CS), CCB (non-DHP)
Myocardial infarction	Diltiazem hydrochloride, verapamil hydrochloride
Osteoporosis	Thiazides
Preoperative hypertension	Beta-blockers
Prostatism (BPH)	Alpha-blockers
Renal insufficiency (caution in renovascular hypertension and creatinine >265.2 μ mol/L (3mg/dL))	ACE I

May Have Unfavorable Effects on Comorbid Condition

Bronchospastic disease	Beta-blockers
Depression	Beta-blockers, central alpha-agonists, reserpine
Diabetes mellitus (types 1 and 2)	Beta-blockers, high-dose diuretics
Dyslipidemia	Beta-blockers (non-ISA)* diuretics (high-dose)
Gout	Diuretics
2° or 3° heart block	Beta-blockers, CCB (non-DHP)
Heart failure	Beta-blockers (except carvedilol), CCB (except amlodipine besylate, felodipine)
Liver disease	Labetalol hydrochloride, methyl dopa
Peripheral vascular disease	Beta-blockers
Pregnancy	ACE I, ARB
Renal insufficiency	Potassium-sparing agents
Renovascular	ACE I, ARB

*ISA = Intrinsic Sympathomimetic Activity



1a
The two-question screen:
Over the past month have you been bothered by:
1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

2a
DSM-IV TR Criteria for Major Depressive Episode:
Must have a total of 5 symptoms for at least 2 weeks. One of the symptoms must be depressed mood or loss of interest.
1. Depressed mood.
2. Markedly diminished interest or pleasure in all or almost all activities.
3. Significant (> 5% body weight) weight loss or gain, or increase or decrease in appetite.
4. Insomnia or hypersomnia.
5. Psychomotor agitation or retardation.
6. Fatigue or loss of energy.
7. Feeling of worthlessness or inappropriate guilt.
8. Diminished concentration or indecisiveness.
9. Recurrent thoughts of death or suicide.

A = Annotation

Scope and Target Population:

To assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of new or existing diagnosis of major depression in adults age 18 and over and assist patients to achieve remission of symptoms, reduce relapse and return to previous level of functioning.

This guideline is an evidence-based document based on best care, and has also evolved to include information on best practice systems for implementation. A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations by the U.S. Preventive Services Task Force. Depending on resources and systems, a group or clinic might also consider an interim plan of screening high-risk patients such as those with diabetes, cancer, chronic pain, coronary artery disease and post-stroke, as well as those with a history of previous depression and all perinatal patients.

Clinical Highlights and Recommendations:

- A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment plan and follow-up of major depression is to consider:
 - how well the diagnosis is documented
 - how well the treatment team engages and educates patients/families
 - how reliably the ongoing patient contacts occur and response/remission to treatment are documented
 - how well the outcomes are measured and documented
- Use a standardized instrument to document depressive symptoms. Document baseline symptoms and severity to assist in evaluating future progress, including response and remission rates.
- Additional considerations should be taken into account:
 - Patients with a high risk of common comorbid depression conditions such as substance abuse, diabetes, cardiovascular disease and chronic pain should be screened for depression.
 - Older persons, pregnant women and the cultural experiences of patients require special considerations regarding risk, assessment and treatment of depression.
- Antidepressant medications and/or referral for psychotherapy are recommended as treatment for major depression. Factors to consider in making treatment recommendations are symptom severity, presence of psychosocial stressors, presence of comorbid conditions, and patient preferences. Physical activity and active patient engagement are also useful in easing symptoms of major depression.
- If the primary care provider is seeing incremental improvement, continue working with that patient to augment treatment or increase medication dosage to reach remission. This can take up to three months. Don't give up on the patient whether treating in primary care or referring. Studies have shown that primary care can be just as successful as specialty care.
 - For medication treatment, patients may show improvement at two weeks but need a longer length of time to really see response and remission. Most people treated for initial depression need to be on medication at least 6-12

- months after adequate response to symptoms. Patients with recurrent depression need to be treated for three years or more.
 - For psychotherapy treatment, it can take 8-10 weeks of regular and frequent therapy to show improvement.
- The key objectives of treatment are to:
 - achieve remission of symptoms in the acute treatment phase for major depression
 - reduce relapse and reduction of symptoms
 - return patient to previous level of occupational and psychosocial function

Priority Aims:

The aims and measures in this guideline are based upon evidence supporting impact of system elements, process elements, promoting actual symptom and functional patient improvement and outcomes, and are aligned with MN Community Measurement and the DIAMOND Initiative where there is overlap.

1. Increase the accuracy of diagnosis of major depression.
2. Improve the frequency of assessment of response to treatment in patients with major depression.
3. Improve the outcomes of treatment for major depression.
4. Improve the frequency of assessment of patients with major depression for the presence of substance abuse.
5. Increase the assessment for major depression of primary care patients presenting with additional high risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women.
6. Improve communication between the primary care physician and the mental health care provider (if patient is comanaged).
7. Decrease the number of completed suicides in patients managed for their depression in primary care.

Additional Background:

The U.S. Preventive Services Task Force (USPSTF) recommends routine depression screening for all adults but only in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up. The purpose of this guideline is to assist ICSI members to develop systems that support effective diagnosis and treatment of major depression.

A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment and follow-up of major depression would be to consider the following:

1. **Diagnosis:** The clinic or medical group should have a mechanism to assure that they are routinely evaluating for and documenting the presence for two weeks of at least five vegetative signs and symptoms of major depression (and that one includes sadness or loss of interest or pleasure in usual activities) in order to substantiate that the patient meets the DSM-IV TR criteria for major depression.
2. The clinic or medical group should have a systematic way to provide and document:
 - a. **Engagement Education:** The patient and his/her family is actively engaged and participating in self-management, based on knowledge of the nature of the disease, risk/benefits of treatment options, and consideration of patient preferences.
 - b. **Ongoing Contacts:** A documented system to assure ongoing contacts with the patient during the first six to twelve months of care (scheduled follow-up appointments, phone calls and some way to react and/or reach out if the

patient drops out of treatment) based on use of a standardized, objective tool used at each contact to document and track treatment response.

3. **Outcomes:** The system should have a way of reliably and consistently monitoring outcomes of individuals and systemwide to improve individual care and the effectiveness of the clinical practice overall.

Importance of Major Depression Focus in Primary Care

Major depression is a treatable cause of pain, suffering, disability and death, yet primary care providers detect major depression in only 1/3 to 1/2 of their patients with major depression. Additionally, more than 80% of patients with depression have a medical comorbidity. Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated and only 20%-40% showing substantial improvement over 12 months.

In a national survey from the World Health Organization of more than 9,000 adults age 18 and over, the prevalence of major depression was 6.7 percent. Additionally, major depression was second only to back and neck pain for having the greatest effect on disability days, at 386.6 million U.S. days per year.

In another WHO study of more than 240,000 people across 60 countries, depression was shown to produce the greatest decrease in quality of health compared to several other chronic diseases. Health scores worsened when depression was a comorbid condition, and the most disability combination was depression and diabetes.

Work productivity is significantly decreased in employees with major depression with 8.4 hours lost on average per worker per week. This is estimated to cost employers \$44 billion per year in lost productivity.

Adult Preventive Health Guidelines (22 years of age and older)



Screenings & Testing	Guidelines
Blood Pressure/Hypertension	At least every 1 to 2 years or more frequent for those with higher blood pressure.
Breast Cancer Screening (Mammography)	Every 1 to 2 years for women 40 years of age and older.
Cervical Cancer Screening (Pap smears)	Within 3 years of onset of sexual activity, then at least every 3 years thereafter for females who have ever had sex and have a cervix. For women older than age 65 and if they have had adequate recent screening with normal Pap smear and are not otherwise at high risk for cervical cancer, routine screening may be discontinued based on clinician's discretion.
Chlamydia Screening*	For all sexually active females 24 years of age and younger and other asymptomatic females at increased risk, including pregnant women.
Cholesterol/ Lipid Disorder Screening	Every 5 years for men 35 years of age and older. Every 5 years for women 45 years of age and older. More frequent screening for men 20 to 35 and women 20 to 45 years of age, if they have other risk factors for coronary heart disease or high lipid level.
Colorectal Cancer Screening	For all men and women 50 years of age and older. <i>Fecal Occult Blood Testing (FOBT):</i> annually <i>Sigmoidoscopy and double-contrast barium enema:</i> every 5 years <i>Colonoscopy:</i> every 10 years
Diabetes Screening*	Every 3 years for adults with hypertension or hyperlipidemia. For pregnant women during 24 and 28 weeks of pregnancy. Behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care physicians or by referral to other specialists, such as nutritionists or dietitians.
Gonorrhea Screening*	For all sexually active women and men under the age of 25 and individuals at increased risk. For high risk pregnant women during first prenatal visit.
HIV Testing*	For all adults at increased risk for infection. For all pregnant women during first prenatal visit.
Obesity/Height/Weight/BMI	Periodically screen for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
Osteoporosis Screening	For women 65 years of age and older. For women at increased risk, start at age 60.
Syphilis Screening*	Adults at increased risk for infection and all pregnant women. All pregnant women should be tested during first prenatal visit.
Tuberculosis (TB) Screening	For high risk adults
Vision and Hearing	For high risk adults (elderly and diabetics). Periodic eye and hearing exams recommended to elderly adults 65 years of age and older.

Molina's Preventive Health Guidelines are adopted by the Clinical Quality Management Committee on 3/11/09 from the American Academy of Pediatrics, CDC's Advisory Committee of Immunization Practices, the U.S. Preventive Services Task Force, and the American Academy of Family Physicians. Molina recommends that clinical judgments be applied and that the treatments provided to members deviate from the guidelines when individual patient considerations and specific clinical situations dictate. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication; however they should be used with the clear understanding that continued research may result in new knowledge and recommendations. We recommend that the medical records contain appropriate documentation for clinical decisions. This Preventive Health Guideline is also available on the Molina website: www.molinahealthcare.com.

Adult Preventive Health Guidelines (22 years of age and older)



Screenings & Testing	Guidelines
Prenatal Visits* Postpartum Visits*	Prenatal Visits: all pregnant women should receive timely prenatal visit in the first trimester and throughout pregnancy. First Trimester (0 to 13 weeks of pregnancy) Second Trimester (14 to 27 weeks of pregnancy) Third Trimester (28 to 40 weeks of pregnancy) Postpartum Visits: within 21 to 56 days (3 to 8 weeks) after delivery.
IHEBA - Staying Healthy Assessment (SHA)	Initial health assessments/education includes the followings: <ul style="list-style-type: none"> • Alcohol Misuse • Depression • Physical Activity • Tobacco Use • STD/STI • Violence, Family and Partner • Secondhand Smoke Please visit the Molina website to obtain assessment forms and educational tip sheets: www.molinahealthcare.com → Providers → California → Forms

* Inclusive as a part of prenatal and/or postpartum visits.

Immunizations/ Vaccines	Guideline
Td/Tdap* (Tetanus, diphtheria, pertussis)	1 dose of Tdap given to adults 64 years and younger who have not previously received Tdap dose, followed by 1 dose of Td booster every 10 years. 1 dose of Td booster to pregnant women during second or third trimester if previously vaccinated and have not received Td within last 10 years (if pregnant woman received the last Td vaccination less than 10 years previously, administer Tdap during postpartum)
Hepatitis A	2 dose series for adults at increased risk. Second dose given 6 to 18 months after the first dose.
Hepatitis B*	3 dose series for adults at increased risk. All pregnant women should be tested for HBsAg during first trimester. Pregnant women at increased risk should be vaccinated.
Human Papillomavirus (HPV)	3 dose series to all females 26 years of age and younger who have not completed the HPV series. Second dose should be given 2 months after the first dose and third dose given 6 months after the first dose.
Influenza*	Annually during flu season for adults older than 50 years of age or older and adults at increased risk. Inactivated influenza vaccine is recommended for pregnant women in the second and third trimester during the flu season
MMR (Measles, Mumps, Rubella)	1 or 2 doses for adults who lack evidence of immunity and are at increased risk.
Meningococcal	1 dose to adults with increased risk (revaccination may be given after 5 years to adults at increased risk).
Pneumococcal	1 dose for adults 65 years of age and older and one-time revaccination if they were previously vaccinated 5 or more years ago and were younger than 65 years of age at time of primary vaccination.
Chickenpox (Varicella)	2 dose series for all adults without previous immunization or evidence of immunity. Second dose should be administered 4 to 8 weeks after the first dose.
Zoster (herpes zoster)	1 dose for adults 60 years of age and older, regardless of a prior episode of herpes zoster.

* Inclusive as a part of prenatal and/or postpartum visits.

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