Molina Healthcare of California

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

April, 2015

MOLINA® HEALTHCARE

Your Extended Family.

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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 CPG's 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 CPG's 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)

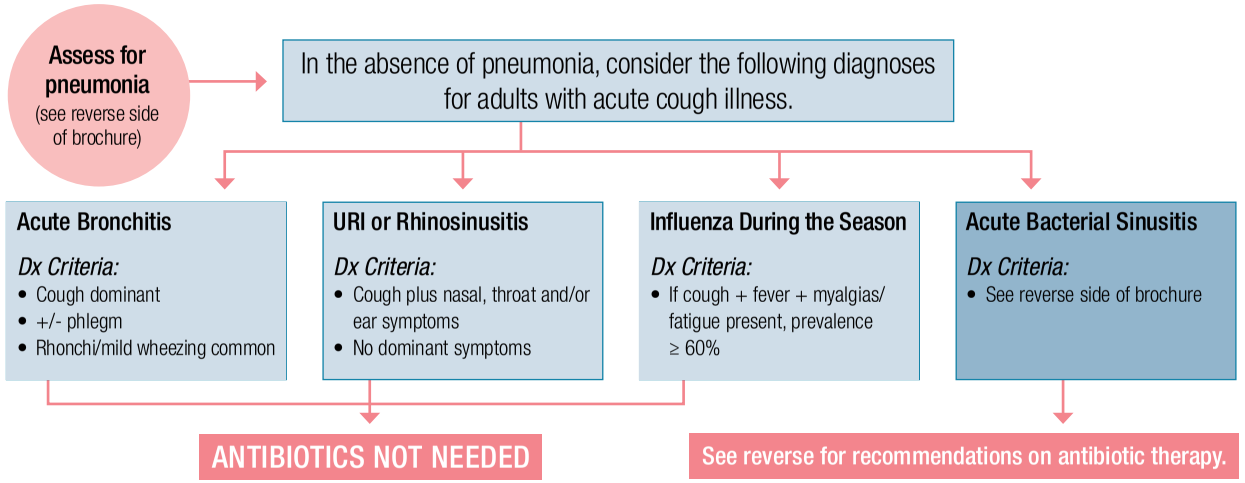
Molina also utilizes internal data (i.e. ED and IP claims, pharmacy, and encounter data) to identify members who would benefit from more intense supervision and management. These members are evaluated for possible inclusion into our Case Management or Complex Case Management Programs. Those members identified 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

Evidence-Based Management of Acute Respiratory Tract Infections

Repeated studies and meta-analyses have demonstrated no significant benefit from antibiotics in otherwise healthy persons. Antibiotic administration is associated with allergic reactions, C. difficile infection and future antibiotic resistance in the treated patient and the community.



**Adapted from Gonzales R, et al. A cluster randomized trial of decision support strategies for reducing antibiotic use in acute bronchitis. Jama Intern Med. Published online, January 14, 2013. doi:10.1001/jamainternmed.2013.1589*

Educate and Advise Patients

Most patients want a diagnosis, not necessarily antibiotics. Explain to the patient that most bronchitis is a viral illness, and coughs are either viral or reactive airway disease. It is important to emphasize that antibiotics may have serious side effects and may create resistance to antibiotics in the patient or their family. This strategy is associated with equal or superior patient satisfaction.

Set appropriate expectations for the duration of symptoms, e.g., cough may last for up to four weeks.

Give symptomatic relief such as codeine-based cough suppressants, NSAIDS, multi-symptom OTC medications, and possibly bronchodilators if there is any bronchospasm.

Caution patients regarding symptoms (such as high fevers and shortness of breath) that indicate more severe disease.

Recommend Vaccination

Prevent respiratory infections by vaccination:

- Influenza vaccination for all persons >6 months of age, particularly older and younger patients and those with concomitant significant illnesses.
- Pneumococcal vaccination for those with concomitant significant illnesses and all persons >65 years old who have not had a prior vaccination within 5 years.
- Pertussis immunization for all pregnant women of any age with each pregnancy, between 27 and 36 weeks (but CAN be given at any time). Prompt vaccination is recommended for those who have or will have close contact with an infant <12 months of age (e.g., parents, grandparents, childcare providers, and healthcare practitioners). For all others vaccinate once during the routine every-10-year tetanus booster.

FOR MORE INFORMATION OR ADDITIONAL MATERIALS, VISIT WWW.AWARE.MD.

Reference Articles

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2. Chow AW, et al. IDSA Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults. *Clin Infect Dis*. 2012;54(8): e72-e112.
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2. Gerber GA, et al. Prevention of Rheumatic Fever and Diagnosis and Treatment of Acute Streptococcal Pharyngitis. Circulation. 2009;119:1541-1551.

Nonspecific Cough Illnesses/Acute Bronchitis/Pertussis:

1. Gonzales 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. Gonzales R, et al. Principles of Appropriate Antibiotic Use for Treatment of Uncomplicated Acute Bronchitis: Background. *Ann Intern Med*. 2001;134:521-29.
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5. Centers for Disease Control and Prevention. Recommended antimicrobial agents for the treatment and postexposure prophylaxis of pertussis: 2005 CDC guidelines. *MMWR* 2005;54(No. RR-14):1-16.

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1. Gonzales 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. Gonzales 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. Revised January 2013. Accessed August 2014.

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(1266):62-64.

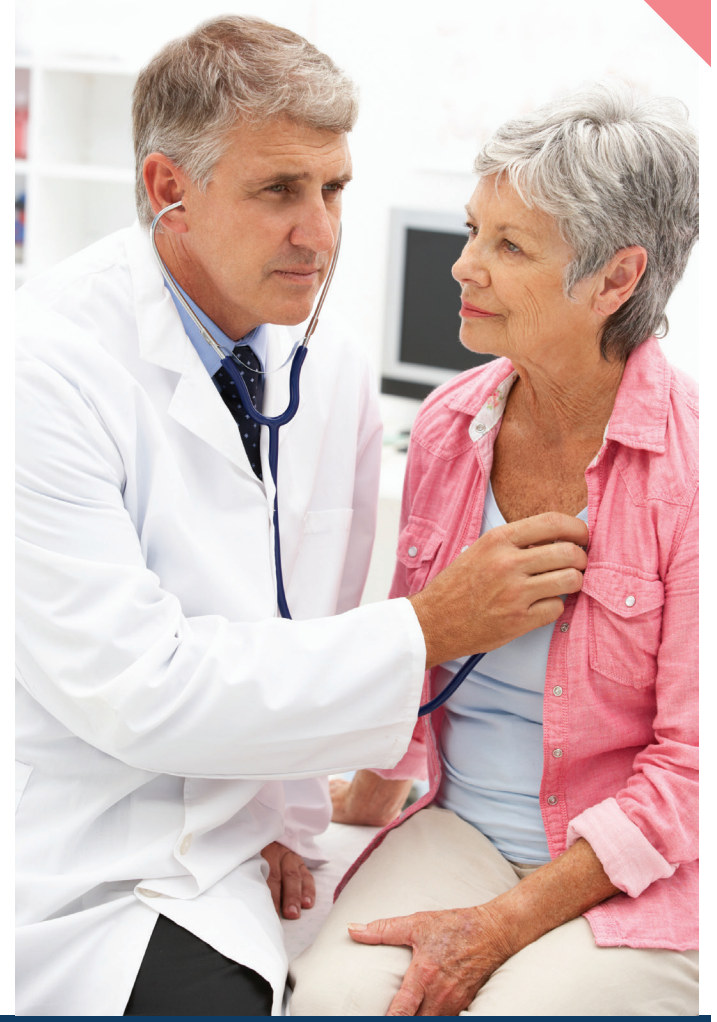
Cellulitis and Abscesses:

1. Stevens DL, et al. Practice Guidelines for the Diagnosis and Management of Skin and Soft-Tissue Infections. *Clin Infect Dis* 2005; 41:1373-406.
2. Swartz MA., Cellulitis. *N Engl J Med* 2004; 350:904-912
3. Liu, et al. Clinical Practice Guidelines by the Infectious Diseases Society of America for the Treatment of Methicillin-Resistant Staphylococcus Aureus Infections in Adults and Children. *Clin Infect Dis* 2011; 52:1-38.

ADULT

Acute Infection Guideline Summary

2015



Supporting Organizations

Alameda Alliance for Health
Anthem Blue Cross
CalOptima
Care1st Health Plan
CenCal Health
Health Net of California
Health Plan of San Joaquin
Inland Empire Health Plan
Kaiser Permanente
L.A. Care Health Plan
Molina Healthcare of California

Endorsing Organizations

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

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Adopted by Molina Healthcare of California Clinical Quality Improvement Committee 12/10/14

Illness	Indications for Antibiotic Treatment	Pathogen	Antimicrobial Therapy	Antibiotic	Guidelines Reviewed
Acute Bacterial Sinusitis	***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.	**Mainly viral pathogens**	**Not indicated**	**1st Line:** • Amoxicillin-clavulanate (875 mg/ 125 mg po bid) **Alternatives:** • Amoxicillin-clavulanate (high dose 2000 mg/125 mg po bid), Doxycycline, Respiratory quinolone (levofloxacin, moxifloxacin)* **For ß-Lactam Allergy:** • Doxycycline, Respiratory quinolone (levofloxacin, moxifloxacin)*	American Academy of Allergy, Asthma & Immunology (AAAAI) American Academy of Family Physicians (AAFP) American Academy of Otolaryngology – Head and Neck Surgery American College of Physicians (ACP) Centers for Disease Control and Prevention (CDC) Infectious Diseases Society of America (IDSA)
	When to Treat with an Antibiotic: Diagnosis of acute bacterial sinusitis may be made in adults with symptoms of acute rhinosinusitis (nasal obstruction or purulent discharge, facial fullness or pain, fever, or anosmia) who have any of the three following clinical presentations: Symptoms lasting > 10 days without clinical improvement. Severe illness with high fever (>39°C [102.2° F]) and purulent nasal discharge or facial pain for >3 consecutive days at the beginning of illness Worsening symptoms or signs (new onset fever, headache or increase in nasal discharge) following typical URI that lasted 5-6 days and were initially improving	*Streptococcus pneumoniae* Nontypeable *Haemophilus influenzae* *Moraxella catarrhalis*	**Antibiotic Duration:** 5 to 7 days Failure to respond after 72 hours of antibiotics: Re-evaluate patient and switch to alternate antibiotic.		
Pharyngitis	***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.	**Routine respiratory viruses**	**Group A Strep:** Treatment reserved for patients with positive rapid antigen detection or throat culture. **Antibiotic Duration:** 10 days	**1st Line:** • Penicillin V, Benzathine penicillin G, Amoxicillin **Alternatives:** • Oral cephalosporins **For ß-Lactam Allergy:** • Azithromycin*, Clindamycin, Clarithromycin*	ACP, AAFP, CDC, IDSA Institute for Clinical Systems Improvement (ICSI)
	When to Treat with an Antibiotic: Streptococcus pyogenes (Group A Strep) Symptoms of sore throat, fever, headache. 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.	*Streptococcus pyogenes*			
Nonspecific Cough Illness / Acute Bronchitis	***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.	**Mainly viral pathogens**	**Uncomplicated:** Not Indicated	**Uncomplicated:** Not indicated **Chronic COPD:** • Amoxicillin, Trimethoprim-sulfamethoxazole (TMP/SMX), Doxycycline **Other:** • *Chlamydophila pneumoniae, Mycoplasma pneumoniae* - macrolide* (azithromycin or clarithromycin) or doxycycline	AAFP, AC, CDC
	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. Testing for pertussis is recommended particularly during outbreaks and according to public health recommendations (see below).	*Chlamydophila pneumoniae* *Mycoplasma pneumoniae*			
Pertussis	Testing for pertussis is recommended particularly during outbreaks and according to public health recommendations, particularly those at high risk – teachers, day care and healthcare workers. Persons with exposure to infants (parents, child care workers or family members) should be vaccinated and tested if they have symptoms. Vaccination per ACIP recommendations is highly encouraged to prevent outbreaks. All pregnant women should be vaccinated during every pregnancy.	*Bordetella pertussis*	Treatment is required for all cases and close contacts or as directed by health officer	Azithromycin* 2nd line: TMP/SMX	CDC
Nonspecific URI	***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.	**Viral**	Not indicated.	Not indicated.	AAFP, ACP, CDC, ICSI
Outpatient Community Acquired Pneumonia	***When NOT to Treat with an Antibiotic as an Outpatient:*** Consider inpatient admission if PSI score > 90, CURB-65 ≥ 2, unable to tolerate orals, unstable social situation, or if clinical judgment so indicates.	*Streptococcus pneumoniae* *Mycoplasma pneumoniae* *Haemophilus influenzae* *Chlamydophila pneumoniae*	**Empiric Therapy**: Healthy with no recent antibiotic use risk factors: Macrolide*; consider doxycycline Presence of co-morbidity or antibiotic use within 3 months Respiratory quinolone ß-lactam plus a macrolide* (or doxycycline as an alternative to the macrolide). **Antibiotic duration:** • Quinolones – 5 days • All other regimens – 7 days	**Uncompliicated without comorbidities:** • Macrolide (azithromycin or clarithromycin)* • Doxycycline (alternative to macrolide) **With comorbidities:** **ß-Lactam Alternatives:** (to be given with a macrolide* or doxycycline) • High dose amoxicillin or amoxicillin-clavulanate • Cephalosporins (cefpodoxime, cefuroxime) **Other Alternative:** • Respiratory quinolone (moxifloxacin, levofloxacin 750mg QD)*	Infectious Diseases Society of America / American Thoracic Society (IDSA/ATS) ICSI
	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 ≤ 90 for outpatient management) or CURB-65 (0 or 1 for outpatient management). Visit www.idsociety.org for more information. Sputum gram stain and culture are recommended if active alcohol abuse, severe obstructive/structural lung disease, or pleural effusion. Pneumococcal vaccination should be done following current ACIP recommendations which have been recently updated. Selective use of PCV 13 (conjugated pneumococcal vaccine) is now recommended in some situations for adults in conjunction with regular pneumococcal vaccine (PPSV23).				
Cellulitis and Abscesses	***Cellulitis*** is almost always secondary to streptococcal species. Treatment can be directed narrowly. ***Abscesses*** are often secondary to Staph – including MRSA. The treatment is primarily drainage and this is required for larger abscesses. If surrounding cellulitis, treatment should be broadened to cover MRSA. Cultures should be obtained.	*Streptococcus pyogenes* *Staphylococcus aureus (Methicillin sensitive and Methicillin resistant)*	Indicated Incision and drainage. If significant associated cellulitis, add antibiotics	• Cephalexin, Cefadroxil, Dicloxacillin **For Penicillin Allergy:** Clindamycin If significant cellulitis add either doxycycline/ minocycline, or TMP/SMX to the above.	IDSA

** Macrolides and quinolones cause QT prolongation and have an increased risk of cardiac death.*

Adopted by Molina Healthcare of California Clinical Quality Improvement Committee 12/10/14

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

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	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	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		• Maintain current step • Regular follow-ups every 1-6 months to maintain control. • Consider step down if well controlled for at least 3 months.	• Step up 1 step • Reevaluate in 2-6 weeks • For side effects, consider alternative treatment options	• Consider short course of oral systemic corticosteroids • Step up 1 – 2 steps • Reevaluate in 2 weeks • For side effects, consider alternative treatment options

Adopted by Molina Healthcare of California Clinical Quality Management Committee 11/4/09, 12/8/10, 3/21/12. Adopted by Molina Healthcare of California Clinical Quality Improvement Committee 12/12/12, 12/11/13, 12/10/14.

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 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	• >80% predicted/ personal best • >80% predicted	• 60- 80% predicted/ personal best • 75-80% predicted	• < 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		• Maintain current step • Regular follow-ups every 1-6 months • Consider step down if well controlled for at least 3 months.	• Step up at least 1 step • Reevaluate in 2-6 weeks • For side effects, consider alternative treatment options	• 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

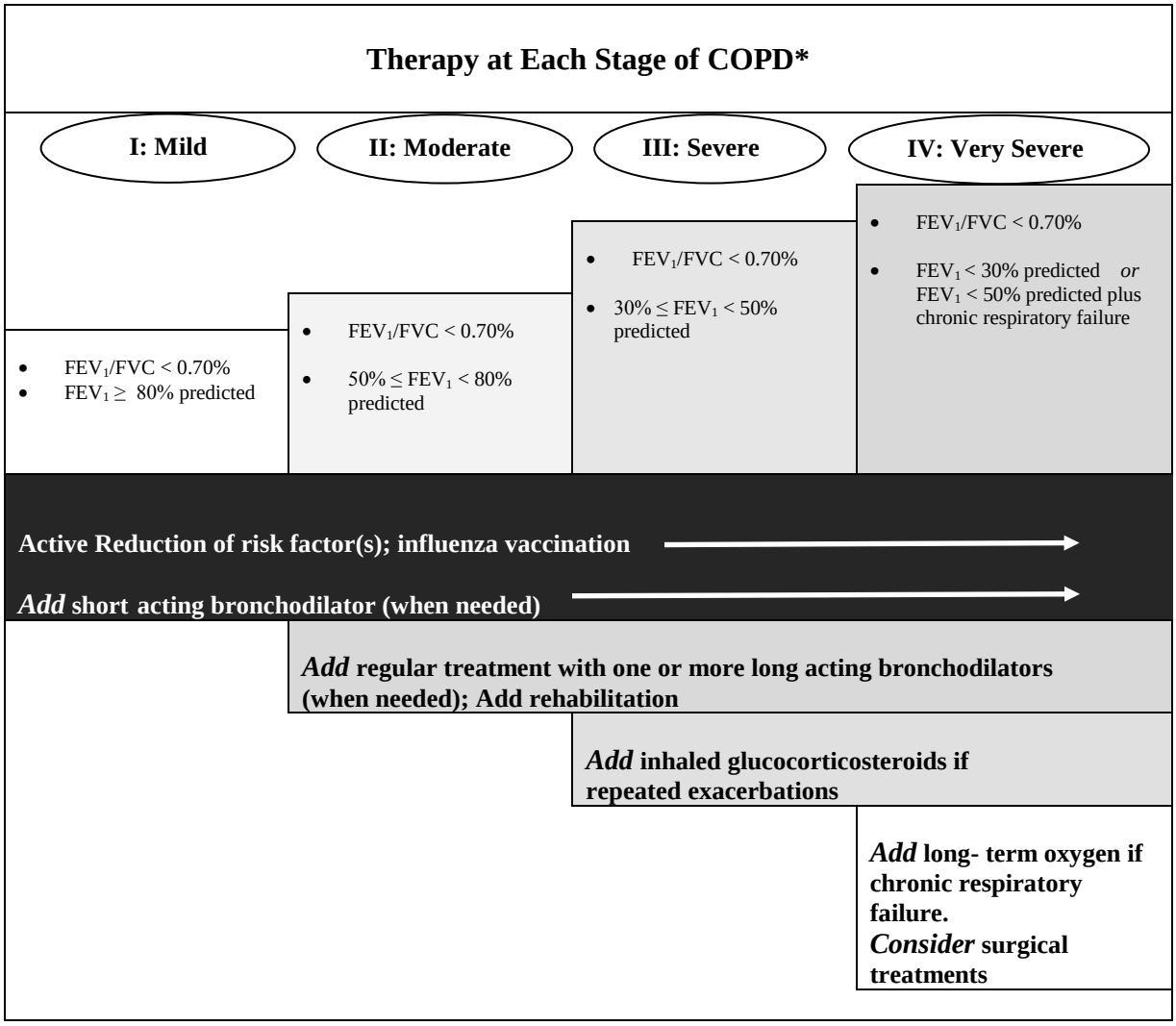
The following are extracted from the NHLBI_NAEPP 2007 Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. (www.nhlbi.nih.gov/guidelines/asthma/index.htm)

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		• Maintain current treatment • Regular follow-ups every 1-6 months. • Consider step down if well controlled for at least 3 months.	• 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	• 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
COPD Summary of Characteristics and Recommended Treatment



**** Postbronchodilator FEV_1 is recommended for the diagnosis and assessment of severity of COPD.***

Summary for Treatment of COPD, 11/12/11
Adapted from Global Initiative for Chronic Obstructive Lung Disease, Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, November 2009, updated 2011. www.goldcopd.org
Adopted by Molina Healthcare of California CQMC 12/9/09, 12/8/10, 3/21/1203/03/14. Adopted by Molina Healthcare of California CQIC 12/12/12, 12/11/13, 12/10/14.

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, 38:S4-S69, 2015(www.diabetes:org), and Basic Guidelines for Diabetes Care, developed by the Diabetes Coalition of California and California Diabetes Program, 2012 (www.caldiabetes.org).

1. Criteria for diagnosis of diabetes in nonpregnant adults

Multiple 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.

1. A1C ≥ 6.5%. The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.* **OR**
2. FPG ≥126 mg/dl (7.0 mmol/l). Fasting is defined as no caloric intake for at least 8 h.* **OR**
3. 2-hour plasma glucose ≥200 mg/dl (11.1 mmol/l) during an OGTT. The test should be performed as described by the World Health Organization, using a glucose load containing the equivalent of 75g anhydrous glucose dissolved in water.* **OR**
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥200 mg/dl (11.1 mmol/l)

*In the absence of unequivocal hyperglycemia, criteria 1 – 3 should be confirmed by repeat testing.

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 all diabetic patients.

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

A screening lipid profile should be performed at the time of first diagnosis, at initial medical evaluations, and/or at age 40 and every 1-2 years thereafter .

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. 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)

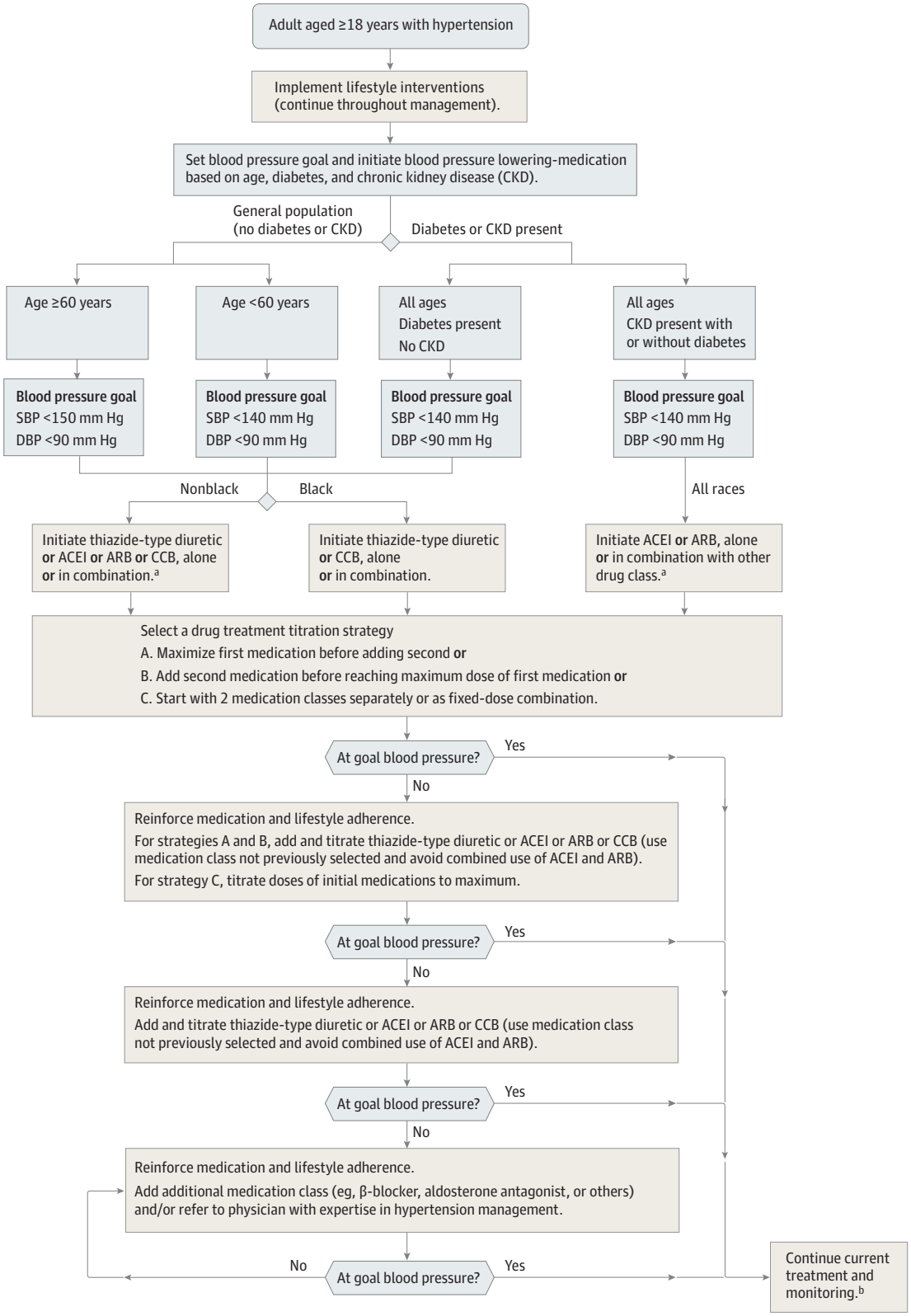
All nonpregnant patients with diabetes and hypertension should be treated with a regimen that includes either an ACE Inhibitor or an ARB. Along with controlling hypertension, these drugs also have been shown to delay the progression of nephropathy.

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.
C. Administer Hepatitis B vaccination to unvaccinated adults with diabetes who are age 19 through 59 years. Consider administering Hepatitis B vaccination to unvaccinated adults with diabetes who are age ≥ 60 years.

4/25/01. Revised and adopted by Clinical Quality Management Committee 6/12/02, 8/14/02, 8/6/03, 8/4/04, 4/6/05, 4/5/06, 4/4/07, 3/12/08, 3/11/09, 3/10/10, 3/16/11, 3/21/12. Revised and adopted by Clinical Quality Improvement Committee 3/13/13, 2/12/14, 3/11/2015.

Figure. 2014 Hypertension Guideline Management Algorithm



SBP indicates systolic blood pressure; DBP, diastolic blood pressure; ACEI, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; and CCB, calcium channel blocker.

[a] ACEIs and ARBs should not be used in combination.

[b] If blood pressure fails to be maintained at goal, reenter the algorithm where appropriate based on the current individual therapeutic plan.

Evidence – Based Dosing for Antihypertensive Drugs			
Antihypertensive Medication	**Initial Daily Dose, mg**	**Target Dose in RCTs Reviewed, mg**	**No. of Doses per day**
ACE inhibitors			2
Captopril	50	150-200	1-2
Enalapril	5	20	1
Lisinopril	10	40	
Angiotensin receptor blockers			
Eprosartan	400	600-800	1-2
Candesartan	4	12-32	1
Losartan	50	100	1-2
Valsartan	40-80	160-320	1
Irbesartan	75	300	1
ß- Blockers			
Atenolol	25-50	100	1
Metoprolol	50	100-200	1-2
Calcium Channel Blockers			
Amlodipine	2.5	10	1
Diltiazem extended release	120-180	360	1
Nitrendipine	10	20	1-2
Thiazide – type diuretics			
Bendroflumethiazide	5	10	1
Chlorthalidone	12.5	12.5-25	1
Hydrochlorothiazide	12.5-25	25-100[a]	1-2
Indapamide	1.25	1.25-2.5	1

Abbreviations: **ACE**: angiotenisin – converting enzyme; **RCT**: randomized controlled trial.
[a] Current recommended evidence-based dose that balances efficacy and safety is 25-50 mg daily.

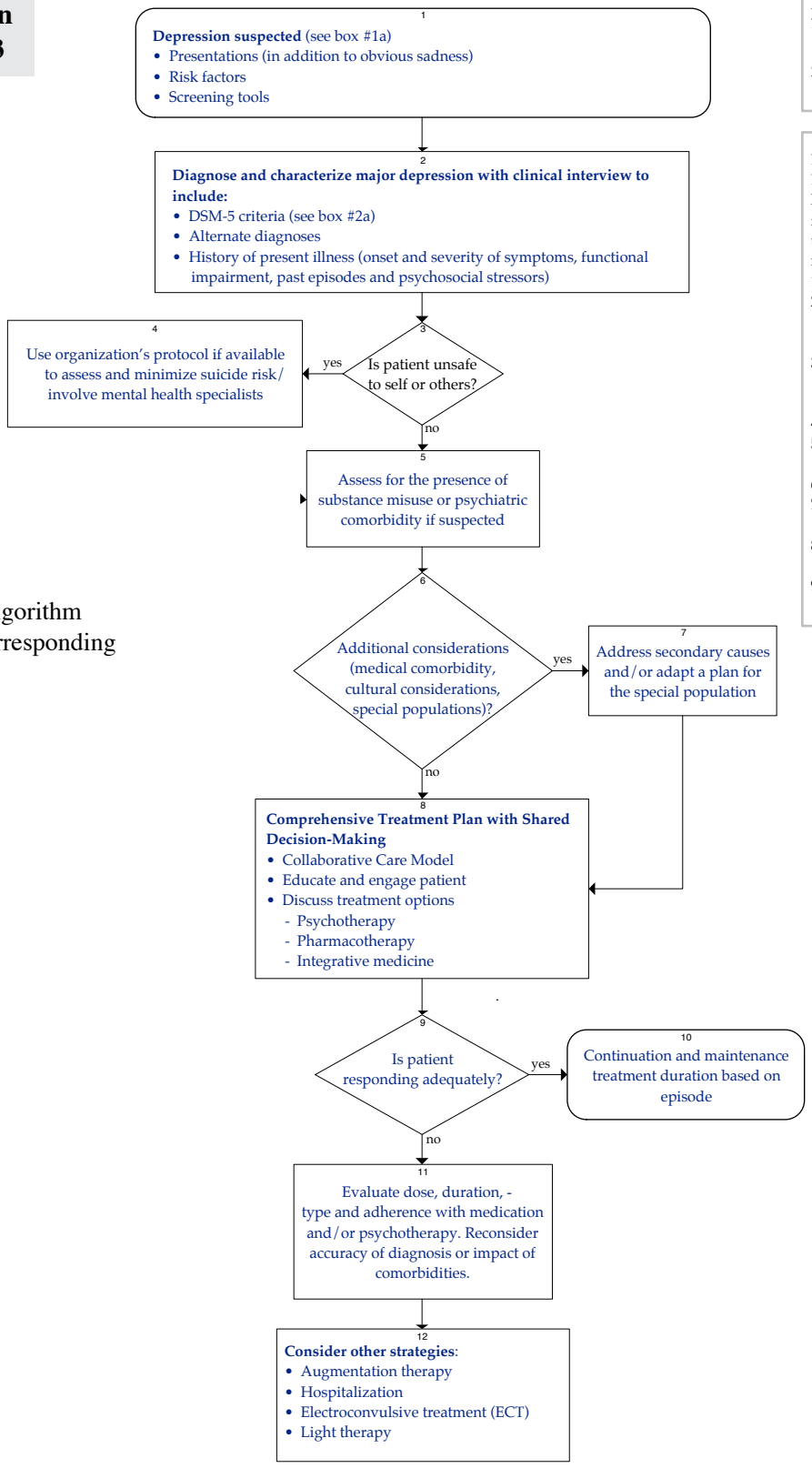
Strategies to Dose Antihypertensive Drugs[a]		
Strategy	**Description**	**Details**
A	Start one drug, titrate to maximum dose, and then add a second drug	• If goal BP is not achieved with the initial drug, titrate the dose of the initial drug up to the maximum recommended dose to achieve goal BP. • If goal BP is not achieved with the use of one drug despite titration to the maximum recommended dose, add a second drug from the list (thiazide-type diuretics, CCB, ACEI, or ARB) and titrate up to the maximum recommended dose of the second drug to achieve goal BP.
B	Start one drug and then add a second drug before achieving maximum dose of the initial drug	• Start with one drug then add a second drug before achieving the maximum recommended dose of the initial drug, then titrate both drugs up to the maximum recommended doses of both to achieve foal BP.
C	Begin with 2 drugs at the same time, either as 2 separate pills or as a single pill combination	Initial therapy with 2 drugs simultaneously, either as 2 separate drugs or as a single pill combination. Some committee members recommend starting therapy with ≥2 drugs when SBP > 160 mm Hg and/or DBP is >100 mm Hg, or if SBP >20 mm Hg above goal and DBP is > 10 mm Hg above goal.
For all strategies:	*If goal BP is not achieved with 2 drugs, select a third drug from the list (thiazide-type diuretics, CCP, ACEI, or ARB), avoiding the combined use of ACEI and ARB. Titrate the third drug up to the maximum recommended dose to achieve goal BP.	

Abbreviations: **ACEI**: angiotensin – converting enzyme; **ARB**: angiotensin receptor blocker; **BP**: blood pressure; **CCP**: calcium channel blockers; **DBP**: diastolic blood pressure; **SBP**: systolic blood pressure

[a] This table is not meant to exclude other agents within the classes of antihypertensive medications that have been recommended but reflects those agents and dosing used in randomized controlled trials that demonstrated improved outcomes.

Sixteenth Edition
September 2013

Text in blue in this algorithm indicates a linked corresponding annotation.



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

2a
DSM-5 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

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ICSI
Institute for Clinical Systems Improvement

Executive Summary – September 2013

Major Depression in Adults in Primary Care Guideline

Scope and Target Population:

The purpose of this guideline is to assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of initial and recurrent major depression and persistent depressive disorder 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 does not address the pediatric population. Diagnoses outside the scope of this guideline include adjustment disorder and bipolar disorder.

This guideline is an evidence-based document based on best care; it 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 of 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, all perinatal patients, as well as those with a history of previous depression.

Aims:

The aims and measures in this guideline are based upon evidence supporting impact of system elements and process elements, and 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 percentage of patients accurately diagnosed with major depression or persistent depressive disorder.
2. Decrease the number of completed suicides in patients with major depression or persistent depressive disorder managed in primary care.
3. Increase the percentage of patients with major depression or persistent depressive disorder who are assessed for the presence and severity (mild to moderate, moderate to high) and dependent on substance use.
4. Increase the assessment for major depression or persistent depressive disorder of primary care patients presenting with additional high-risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women.
5. Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed).
6. Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder.
7. Increase the percentage of patients with major depression or persistent depressive disorder who have a follow-up to assess of response to treatment.

Clinical Highlights:

- 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 that 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.
  - Perinatal depression treatment should involve a thorough risk-benefit assessment in order to minimize the risks of both depression and its treatment to the mother and child.
  - Older persons and the cultural experiences of patients should receive 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 clinician is seeing incremental improvement, continue working with the patient to increase medication dosage or augment with psychotherapy or medication to reach remission. This can take up to three months. Studies have shown that depression can be treated successfully in primary 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, 8-10 weeks of regular and frequent therapy may be required 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

Additional Background:

The U.S. Preventive Services Task Force (USPSTF) recommends routine depression screening for all adults and adolescents (age 12-18) but only in clinical practices that have systems in place with care management, staff assistance or mental health specialist involvement to assure accurate diagnosis, effective treatment and follow-up. Furthermore, the American College of Preventive Medicine (ACPM) supports this recommendation and adds that all primary care practices should have such systems of care in place. 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 reliable process for routine evaluation and documentation of DSM-5 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 are 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 6 to 12 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 to reliably and consistently monitor outcomes of individuals and to improve systemwide 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 clinicians detect major depression in only one-third to one-half 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. Approximately 70-80% of antidepressants are prescribed in primary care, making it critical that clinicians know how to use them and have a system that supports best practices.

At any given time, 9% of the population has a depressive disorder, and 3.4% has major depression. In a 12-month time period, 6.6% of the U.S. population will have experienced major depression, and 16.6 % of the population will experience depression in their lifetime.

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 disabling combination was depression and diabetes.

A recent study showed a relationship between the severity of depression symptoms and work function. Data was analyzed from 771 depressed patients who were currently employed. The data showed that for every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65%. And, even minor levels of depression symptoms were associated with decrements in work function.

Adults (22 – 64 years of age)
Preventive Health Guidelines

Screenings & Testing	Guidelines
Alcohol Misuse Screening	Screen adults ages 18 years or older for alcohol misuse and provide persons who engage in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
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)	At least every 3 years for females who have a cervix.
Chlamydia Screening	For all sexually active women age 24 years and younger and in older women who are at increased risk for infection.
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 if they are at increased risk for coronary heart disease. More frequent screening intervals for men 20 to 35 and women 20 to 45 years of age, if they are at increased risk for coronary heart disease or high lipid level.
Colorectal Cancer Screening	Begin screening for colorectal cancer at age 50 years, using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults. • Fecal occult blood testing (FOBT) every year. • Sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years. • Colonoscopy every 10 years.
Depression Screening	Screen adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes Screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. Recommended 3-year screening interval may vary based on clinician's discretion.
Gonorrhea Screening	For all sexually active women age 24 years and younger and in older women who are at increased risk for infection.
Hepatitis B Screening	Screen all adults at increased risk for infection.
Hepatitis C Screening	Screen all adults at increased risk for infection. Offer one-time screening for adults born between 1945 and 1965.
HIV Testing	Screen adults ages 22 to 65.
Intimate Partner Violence Screening (IPV)	Screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.

Molina's Preventive Health Guidelines are adopted by the Clinical Quality Management Committee on 3/11/15 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**.

Adults (22 – 64 years of age) Preventive Health Guidelines

Lung Cancer Screening	Annually screen for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30-pack-year smoking history and currently smoke or have quit within the past 15 years. Discontinue screening once a person has not smoked for 15 years or develops a health problem that substantially limits life expectance or the ability or willingness to have curative lung surgery.
Obesity/Height/Weight/BMI	Periodically screen for obesity and offer intensive counseling and behavioral interventions to promote sustained weigh loss for obese adults.
Osteoporosis Screening	For women at increased risk, start at age 60.
Syphilis Screening	Adults at increased risk for infection.
Tobacco Use Screening	Ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
Tuberculosis (TB) Screening	For high risk adults.
Vision and Hearing	For high risk adults (elderly and diabetics).
IHEBA - Staying Healthy Assessment (SHA)	**Initial health assessments/education should include the following:** Alcohol misuse; Depression; Physical activity/Healthy diet/Obesity; Tobacco use; Secondhand smoke; STI Violence, Family and partner. Please visit the Molina website to obtain assessment forms and educational tip sheets: **www.molinahealthcare.com** → Providers → California → Forms

Immunizations/ Vaccines	Guideline
Tdap (Tetanus, diphtheria, pertussis)	One time dose of Tdap given to adults 64 years and younger who have not previously received Tdap dose, then followed by 1 dose of Td booster every 10 years.
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, including diabetics under age 60.
Haemophilus influenza type b (Hib)	1 to 3 doses for adults at increased risk. For additional Hib vaccination information, visit CDC website: http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm
Human Papillomavirus (HPV)	3 dose series (either HPV4 or HPV2) to all adult females 26 years of age and younger who have not completed the HPV series. Second dose should be given 1-2 months after the first dose and third dose given 6 months after the first dose. 3 dose series (HPV4) recommended for adult males 26 years of age and younger with HIV infection, immunosuppressed, or engaging in high risk sexual activity.
Influenza	1 dose annually during flu season for all adults. For additional influenza vaccination information, visit CDC website: http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm

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Adults (22 – 64 years of age) Preventive Health Guidelines

MMR (Measles, Mumps, Rubella)	1 or 2 doses for adults who lack evidence of immunity and are at increased risk. If dose #2 is recommended, give it no sooner than 4 weeks after dose #1.
Meningococcal	2 doses at least 2 months apart for adults with increased risk. For adults 55 years and younger, MCV4 is preferred over MPSV4 For adults 56 years and older, MPSV4 is preferred. Revaccination with MCV4 every 5 years to adults at increased risk Use MPSV4 if there is a permanent contraindication/precaution to MCV4.
Pneumococcal	For adults ages 19-64 years with underlying conditions: *Prior doses count towards doses recommended below and do not need to be repeated *If PPSAV23 given previously, – wait one year before giving PCV13 – when dose indicated, wait at least five years before giving a second dose of PPSV23 **Smokers, long-term facility resident, or chronic conditions (heart disease, lung disease, liver disease, diabetes, alcoholism):** • Give 1 dose PPSV23 **Immunocompromised (including HIV infection), chronic renal failure, nephrotic syndrome, or Asplenia** • Give one dose PCV13, followed by PPSV 23 at 8 week and 5 year interval. **CSF leaks or Cochlear implants:** • Give one dose PCV 13 followed by one dose PPSV at 8 week interval. *Do not administer PCV13 and PPSV23 at the same visit.
Varicella (Chickenpox)	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.

Seniors (65 years of age and older) Preventive Health Guidelines

Screenings & Testing	Guidelines
Abdominal Aortic Aneurysm (AAA) Screening	One-time screening for AAA by ultrasonography in **men** aged 65 to 75 years who have ever smoked.
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 74 years of age and younger.
Cervical Cancer Screening (Pap smears)	Discontinue routine cervical cancer screening for women older than age 65 if they have had adequate recent screening with normal Pap smear and are not otherwise at high risk for cervical cancer based on clinician's discretion.
Cholesterol/ Lipid Disorder Screening	Routine screening intervals (every 5 years) and more frequent screening if at increased risk for coronary heart disease or high lipid level.
Colorectal Cancer Screening	Continue screening for colorectal cancer until age 75 year, using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults. • Fecal occult blood testing (FOBT) every year. • Sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every 3 years. • Colonoscopy every 10 years.
Diabetes Screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg. Recommended 3-year screening interval may vary based on clinician's discretion.
HIV Testing	Based on clinician's discretion for adults at increased risk
Obesity/Height/Weight/BMI	Periodically screen for obesity and offer intensive counseling and behavioral interventions to promote sustained weigh loss for obese adults.
Osteoporosis Screening	For women 65 years of age and older.
Sexually Transmitted Infections	Based on clinician's discretion for adults at increased risk.
Vision and Hearing	Periodic eye and hearing exams recommended to adults 65 years of age and older.
IHEBA - Staying Healthy Assessment (SHA)	**Initial health assessments/education includes the followings:** Alcohol misuse; Depression; Physical activity/Healthy diet/Obesity; Tobacco use; Secondhand smoke; STI Violence, Family and partner. Please visit the Molina website to obtain assessment forms and educational tip sheets: **www.molinahealthcare.com** → Providers → California → Forms

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Seniors (65 years of age and older) Preventive Health Guidelines

Immunizations/ Vaccines	Guideline
Td/Tdap (Tetanus, diphtheria, pertussis)	One time dose of Tdap for adults 65 years and older who have not previously received Tdap dose, followed by 1 dose of Td booster every 10 years.
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.
Influenza	1 dose annually during flu season. For influenza recommendation, visit CDC website: http://www.cdc.gov/vaccines/vpd-vac/flu/default.htm
MMR (Measles, Mumps, Rubella)	1 or 2 doses for adults who lack evidence of immunity and are at increased risk. If dose #2 is recommended, give the second dose no sooner than 4 weeks after dose #1.
Meningococcal	1 or more doses of MPSV4 at least 2 months apart to senior adults with increased risk (revaccination may be given after 5 years to adults at increased risk).
Pneumococcal	Senior adults with no history of pneumococcal vaccine: • Give 1 dose of PCV 13 followed by 1 dose of PPSV 23 at 6-12 month interval. If PPSV23 received before age 65: • Give PCV 13 after 1 year followed by PPSV 23 at 6-12 month interval (and at least 5 years after prior dose of PPSV23) If PPSAV received at 65 years of age or older: • Give PCV 13 after 1 year *If PCV 13 was given before age 65 years, no additional PCV 13 is needed.
Varicella (Chickenpox)	2 dose series for 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 all senior adults, regardless of a prior episode of herpes zoster.

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Your Extended Family.

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