POLICY: QualCare will adopt and disseminate clinical practice guidelines to assist QualCare staff and practitioners to make decisions about appropriate health care for specific clinical circumstance.

EXCEPTIONS: None unless specified

WARNINGS: The Plan specific Summary Plan Description will supersede policy criteria.

ADMINISTRATIVE STATEMENT:

1. The types of guidelines will include:
   - Guidelines for medical and for mental health/substance abuse conditions
   - Guidelines for preventive health including guidelines for perinatal care, care for children up to 24 months and for 2-19 years old, for adults 20-64 and adults 65 years and older.

2. At least two medical and two behavioral guidelines will be the basis for the Case and/or Disease Management (Health Promotion) Program. (Attachment D, E)

3. The guidelines will be evidence-based, will be updated at least every (2) two years unless legislature or regulatory change indicate a need for an earlier change, and will be made available to practitioners via Newsletter and/or website portal.

DEFINITION:

Evidence-based guidelines are clinical practice guidelines known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence; or by professional standards, in the absence of scientific evidence; or by expert opinion, in the absence of professional standards.

The organization may adopt guidelines in the following ways:
   - From recognized sources, or
   - From involvement of board-certified practitioners from appropriate specialties.

PROCEDURE:

1. Process for Guideline Adoption:
   a. Guidelines may be adopted from recognized sources (see Attachment A for listing and links, the Preventative Health Guidelines are located in UM SOP 4.09 Preventative and Wellness)
   b. Current refereed literature will be reviewed.
c. Consultation with experts in the relevant disciplines will be done.

d. Standards and/or practice guidelines established by nationally recognized professional organizations shall be used in assessing the applicability of new programs to QualCare policies.

e. New Programs and Clinical Practice Guidelines shall be presented to the Care Management Committee (CMC) for review prior to presentation to the Quality Management Committee (QMC). Recommended revisions shall be incorporated into the appropriate policies before proceeding to the next level of review.

f. The QMC, which is comprised of licensed physicians representing the following medical specialties: pediatrician, obstetrician-gynecologist, internist or family practitioner, general surgeon or surgical specialist and psychiatrist, shall review new policies and its recommended revisions shall be incorporated into these policies before proceeding to the next level of review.

g. Final review and approval of new programs and clinical practice guidelines shall be the responsibility of the QualCare Board of Directors.

2. Requirement for Review of Guidelines:

   a. Adopted guidelines must be reviewed and updated at least every (2) two years. The review will be documented in the meeting minutes of the CMC meeting. The CMC may amend or withdraw a guideline based on the review.

   b. If relevant and new scientific evidence becomes available, or changes are made in guidelines adopted from recognized sources, the CMC must initiate a review and amendment or updating of an adopted guideline.

3. Dissemination of Guidelines:

   a. Guidelines adopted by the QMC will be published to QualCare’s Provider Portal, website. When guidelines are revised or updated, notifications are sent to practitioners in a newsletter.

   b. When adopted, guidelines may be distributed to practitioners using the following methods:

      • In writing by mail, or where the practitioner has such access, by fax or e-mail.

      • On the QualCare website, through a portal for practitioners. If using the website for distribution, practitioners will be notified through the provider newsletter from QualCare.

4. Evaluation of Performance in Relation to Guidelines:

   a. Annually, starting in the fourth quarter of the year, QualCare will evaluate data on a sample of members with the acute or chronic condition for clinical practice guidelines and the target populations for preventative health guidelines to determine whether the screening or treatment members receive follow the outlined guidelines:

      • A clinic practice guideline for (2) separate and distinct acute or chronic medical condition.

      • A clinical practice guideline for (2) separate and distinct mental health/substance abuse condition.

      • A clinical practice guideline for (2) separate and distinct preventative health guidelines.

   b. The CMC will report to the QMC the results of the evaluation and any recommendation for guidelines updates, performance improvement programs and/or quality improvement initiatives indicated by analysis. The CMC will initiate the appropriate action to improve performance.

Medical policies and criteria are used as guidelines. Coverage is dependent on the benefits outlines in the Plan’s Summary Plan Description.
General National Clinical Evidence Based Standard Links


National Institutes of Health - http://nih.gov/


American College of Cardiology - http://www.cardiosource.org/acc (Attachment C Sample)

The American Congress of Obstetricians and Gynecologists - http://www.acog.org/


___________________________________________________________________________________________________________________

Specific Disease/Condition Links

Acute Conditions

- Myocardial Infarction - http://www.heart.org
- Asthma - http://www.lung.org/lung-disease/asthma/

- CHF - http://www.heart.org

- Stroke –
  ✓ http://www.stroke.org
  ✓ http://www.heart.org

Preventive Health

- Hyperlipidemia - http://www.heart.org

- Prostate Screening
  ✓ http://www.cancer.gov/cancertopics/pdq/screening/prostate/Patient/page1
  ✓ http://www.cdc.gov/cancer/prostate/basic_info/screening.htm
  ✓ http://www.uspreventiveservicestaskforce.org/prostatecancerscreening.htm

- Colorectal Screening –
- Breast Cancer Screening
  ✓ http://www.cancer.org/healthy/findcancerearly/cancerscreeningguidelines/american-cancer-society
  ✓ http://www.cdc.gov/cancer/breast/basic_info/screening.htm
  ✓ http://www.cancer.gov/cancertopics/pdq/screening/breast/Patient/page1

- Cervical Cancer Screening
  ✓ http://www.cdc.gov/cancer/cervical/basic_info/screening.htm
  ✓ http://www.uspreventiveservicestaskforce.org/uspstf/uspscfv.htm
  ✓ http://www.cdc.gov/hpv/Screening.html

**Chronic**
- Pain Management
  ✓ http://www.guideline.gov/content.aspx?id=36064
  ✓ http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

- Hypertension –
  ✓ http://www.nhlbi.nih.gov/guidelines/hypertension/

- CKD/ CRF –
  ✓ http://www.renal.org
  ✓ http://www.kidney.org/

- Asthma – http://www.lung.org/lung-disease/asthma/


Guideline Summary NGC-8116

Guideline Title

VA/DoD clinical practice guideline for the management of diabetes mellitus.

Bibliographic Source(s)


Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Veterans Health Administration, Department of Defense. VA/DoD clinical practice guideline for the management of diabetes mellitus. Washington (DC): Veterans Health Administration, Department of Defense; 2003 Sep. Various p.

Scope

Disease/Condition(s)

- Diabetes mellitus (type 1 and type 2)
- Pre-diabetes
- Complications of diabetes mellitus, including hypertension, dyslipidemia, kidney disease, retinopathy, and foot problems

Guideline Category

Counseling
Diagnosis
Evaluation
Management
Prevention
Risk Assessment
Screening
Treatment

Clinical Specialty

Cardiology
Endocrinology
Family Practice
Internal Medicine
Nephrology
Nutrition
Ophthalmology
Optometry
Podiatry
Preventive Medicine

**Intended Users**
Advanced Practice Nurses
Dietitians
Health Care Providers
Nurses
Optometrists
Pharmacists
Physician Assistants
Physicians
Podiatrists
Social Workers
Students

**Guideline Objective(s)**

- To provide recommendations for the management of diabetes mellitus
- To provide education and guidance to primary care clinicians and coordinate and standardize care within subspecialty teams and to serve as a teaching tool for students and house staff

**Target Population**
Adult patients (18 years or older) with diabetes mellitus receiving treatment in the Department of Veterans Affairs (VA) or Department of Defense (DoD) healthcare system

**Interventions and Practices Considered**

**Core Assessment**

1. Biochemical tests for diagnosis, including fasting blood glucose (FBG) and hemoglobin marker (HbA₁c)
2. Evaluation of symptoms and risk factors
3. Assessment of the risk of maternal fetal complications and screening of pregnant women for autoimmune thyroid disease, hypertension, and renal disease
4. Identification of comorbid conditions and/or complications requiring special attention
5. Referral of pediatric patients
6. Patient stabilization (medically, psychologically, and socially)
7. Annual medical evaluation (including patient/family history, physical examination, laboratory tests, nutritional assessment, educational assessment)
8. Determination of diabetes type (Type 1 or 2, age, body mass index [BMI], urinary ketones)
9. Consideration of aspirin therapy to prevent cardiovascular disease
10. Management of hypertension*
   - Angiotensin-converting enzyme inhibitor (ACEI)
• Angiotensin receptor blockers (ARBs)
• Calcium channel blockers
• Beta-blockers
• Diuretics

11. Evaluation and management of lipids
   • Screening for lipid abnormalities (fasting lipid profile)
   • Lifestyle counseling
   • Drug therapy when indicted (statins, niacin, bile acid resin, fibrates, ezetimibe)

12. Management of kidney disease
   • Screening for chronic kidney disease (CKD)
   • Screening for proteinuria
   • Assessment of urine albumin/creatinine levels and estimated glomerular filtration rate (eGFR)
   • Lifestyle modifications
   • Pharmacologic interventions (ACEIs, ARBs)

*For complete management, see VA/DoD guideline at [www.osqp.med.va.gov/cpg/cpg.htm](http://www.osqp.med.va.gov/cpg/cpg.htm).

Screening for Diabetes

1. Recognizing risk factors for developing diabetes mellitus
2. Obtaining fasting plasma glucose in patients with risk factors
3. Counseling for interventions to prevent diabetes mellitus (e.g., lifestyle modifications, weight loss)
4. Repeated screening at regular intervals

Glycemic Control

1. Assessment of glycemic control (HbA₁c), and the determination of optimal target HbA₁c using risk stratification criteria
2. Adjustment of HbA₁c target and target range according to individual risk, benefit, and preference
3. Identification of high risk patients and patients requiring insulin therapy
4. Insulin replacement therapy (Type 1)
5. Pharmacological therapy (Type 2)
   • Sulfonylureas
   • Biguanides (metformin)
   • Insulin, including continuous subcutaneous insulin infusion (CSII)
   • Alpha-glucosidase inhibitor (miglitol, acarbose)
   • Meglitinides
   • Thiazolidinediones (rosiglitazone, pioglitazone)
   • GLP-1 agonists
   • Amylin analogs
- Dipeptidyl peptidase-4 (DPP-4) inhibitors

6. Follow-up and patient monitoring
7. Patient education and practices to improve patient adherence
8. Referral to specialist, if necessary
9. Glycemic control for hospitalized patients

Eye Care

1. Assessment of ocular risk factors and referral of high risk patients expediently for a dilated eye examination
2. Follow-up eye examination intervals
3. Patient education, including the need for periodic eye examination, compliance, and the significance of new visual symptoms

Foot Care

1. Visual inspection and peripheral sensation testing at routine primary care visits, and annual foot risk assessment to identify patients at high risk for the development of foot ulcers and lower extremity amputations
2. Assessment of limb threatening conditions (e.g., systematic infection, acute ischemia or rest pain, foot ulceration, puncture wound, ingrown toenail, hemorrhagic callus with or without cellulitis)
3. Wound assessment and the identification of any minor wound or lesion that can be treated by primary care physician
4. Referral to foot care specialist, when necessary
5. Patient and family education for foot care

Self-Management and Education

1. Education on basic concepts, core competency (survival skills), self-management, nutrition, and/or other patient needs
2. Referral for comprehensive diet consultation, risk-focused intervention, or to appropriate specialist
3. Assessment of patient's knowledge and self-management skills

Major Outcomes Considered

- Blood glucose level
- Blood pressure
- Vision change
- Rates of foot wounds
- Lipid levels
- Identification of renal disease
- Level of patient knowledge of disease
American College of Cardiology - http://www.cardiosource.org/acc
ACC/AHA/AMA-PCPI New Performance Measures for Coronary Artery Disease and Hypertension
Home>News/Media>Media Center>News Releases>2011>06> ACC/AHA/AMA-PCPI New Performance Measures for Coronary Artery Disease and Hypertension

June 13, 2011

New performance measures for adults with coronary artery disease (CAD) and hypertension (HTN) were released today by the American College of Cardiology Foundation (ACCF), the American Heart Association (AHA), and the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (PCPI). The measures reflect the standard of care for patients with coronary artery disease and hypertension, and are intended to provide practitioners and institutions with tools to measure and improve care quality.

The new measures update a set released by the three groups in 2005. According to the writing committee, however, the 2011 set represents a “significant departure” from the earlier document. Specifically, the committee noted that the 2011 measures “break new ground” by examining whether cardiac risk factors are not just “treated” but also “controlled” to target levels and by emphasizing patient-focused outcomes.

“The current measures represent an attempt to resolve some of the methodological issues associated with creating performance measures at the individual practitioner or practice level,” said writing committee co-chair Joseph Drozda, Jr., MD, Director of Outcomes Research at Sisters of Mercy Health System in St. Louis, MO. “These issues arise because of the socioeconomic and clinical heterogeneity of patient populations and the relatively small number of patients treated by any one practitioner or group, prohibiting risk adjustment.”

“This measures set attempts to resolve those issues with the blood pressure and lipid control measures, as well as the symptom assessment and management measures. We believe these represent a significant advance in cardiovascular performance measurement and address issues of importance to policy makers and especially to patients.”

The 10 performance measures comprise both revisions of five measures from the 2005 set and the addition of five new measures. One measure from the previous set—that of screening for diabetes in patients with CAD—was retired. While the writing committee recognized the significance of diabetes as a comorbidity in patients with CAD, there were significant challenges to the implementation of this measure. The measures in the updated set include:

**Coronary Artery Disease Measures**

- **Blood pressure control†**—Patients* should obtain a blood pressure of less than 140/90 mm Hg; if they cannot reach this target, the physician should prescribe at least 2 antihypertensive medications.

- **Lipid control†**—Patients should obtain an LDL cholesterol level of less than 100 mg/dL; if they cannot reach this target, the physician should document a plan of care to lower their LDL level, which includes—at minimum—the prescription of a statin.

- **Symptom and activity assessment**—Physician should evaluate patients’ activity level and the corresponding presence or absence of angina symptoms.

- **Symptom management‡**—Physician should document a plan of care to manage angina symptoms, if present.

- **Tobacco use, screening, cessation, and intervention†**—Physician should screen patients for tobacco use, and patients should receive tobacco-cessation counseling if identified as a user.

- **Antiplatelet therapy†**—Physician should prescribe aspirin or clopidogrel for patients.

- **Beta-blocker therapy (for patients with prior myocardial infarction or a left ventricular ejection fraction of less than 40%)**—Physicians should prescribe beta-blocker therapy for patients.

- **ACE inhibitor/ARB therapy (for patients with diabetes or left ventricular ejection fraction of less than 40%)**—Physicians should prescribe an ACE-inhibitor or ARB therapy.

- **Cardiac rehabilitation patient referral‡**—Physician should refer patients who have had an acute heart attack, a coronary artery bypass graft surgery, stenting, cardiac valve surgery or cardiac transplantation to an early outpatient cardiac rehabilitation program.
Hypertension Measure

- Blood pressure control†—Patients should achieve a blood pressure of less than 140/90 mm Hg; if they are above that threshold, physician should prescribe at least 2 antihypertensive medications.

*Target patient population is defined as those patients who are at least 18 years of age and have had a diagnosis of coronary artery disease or hypertension (for each respective measure category) seen in an outpatient setting across a 12-month period.
† Performance measure that was revised from the 2005 set (two previous measures were combined to form the existing blood pressure control measure)
‡ Performance measure that was added

The performance measures were based on updated practice guidelines and were designed to harmonize with other national measure sets. Before being used in accountability programs, including public reporting or pay-for-performance programs, they will undergo testing developed by the AMA-PCPI and by the ACCF PINNACLE Registry. The recently launched American Cancer Society/American Diabetes Association/AHA The Guideline Advantage will be working to encourage practices to collect the necessary data elements needed to generate reports on the CAD/HTN measure set.

“These measures are primarily intended for the use of individual practitioners and group practices in their efforts to improve the care of patients with hypertension and those with stable coronary disease,” Drozda said. “By adhering to the specifications called for in this measures set, entities operating such accountability programs can be assured of having high quality and clinically meaningful measures.”

Guideline Summary

Guideline Title
Practice guideline for the treatment of patients with major depressive disorder, third edition.

Bibliographic Source(s)

Guideline Status
This is the current release of the guideline.

This guideline updates a previous version: American Psychiatric Association practice guideline for the treatment of patients with major depressive disorder. Am J Psychiatry 2000 Apr;157(4 Suppl):1-45. [325 references]

Scope
Disease/Condition(s)
Major depressive disorder

Guideline Category
Evaluation
Management
Treatment

Clinical Specialty
Psychiatry

Intended Users
Physicians

Guideline Objective(s)
To summarize the specific approaches to treatment of individuals with major depressive disorder

Target Population
Individuals with major depressive disorder

Interventions and Practices Considered
Evaluation/Management
1. Establishing and maintaining a therapeutic alliance

2. Psychiatric assessment

3. Safety evaluation including evaluation of suicide risk, level of self-care and dependent care, and risk or harm to self and others

4. Establishing appropriate treatment setting including hospitalization if appropriate

5. Evaluation of functional impairment and quality of life

6. Coordinating care with other clinicians, monitoring status, and tailoring treatment to specific patient needs

7. Assessment of and acknowledgment of potential barriers to treatment

8. Patient and family education

**Treatment**

1. Pharmacotherapy
   - Selective serotonin reuptake inhibitors (SSRI)
   - Serotonin norepinephrine reuptake inhibitors (SNRI)
   - Mirtazapine
   - Bupropion
   - Nonselective monoamine oxidase inhibitors (MAOIs)

2. Somatic therapies such as electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), vagus nerve stimulation

3. Psychotherapy
   - Cognitive-behavioral therapy (CBT)
   - Interpersonal psychotherapy
   - Psychodynamic therapy
   - Marital and family therapy
   - Problem-solving therapy in individual and in group formats

4. Combination of medications and psychotherapy
5. Complementary and alternative therapies
   - St. John's wort
   - S-adenosyl methionine
   - Omega-3 fatty acids
   - Folate
   - Light therapy
   - Acupuncture

Major Outcomes Considered
- Control of depressive symptoms
- Rate of remission, relapse, and recurrence of major depression
- Morbidity and mortality due to major depression
- Side effects of treatment
Postpartum Depression

Overview

Are mood changes common after childbirth?
Yes. After having a baby, many women have mood swings. One minute they feel happy, the next minute they start to cry. They may feel a little depressed, have a hard time concentrating, lose their appetite or find that they can't sleep well even when the baby is asleep. These symptoms usually start about 3 to 4 days after delivery and may last several days.

If you're a new mother and have any of these symptoms, you have what are called the baby blues. The baby blues are considered a normal part of early motherhood and usually go away within 10 days after delivery.

What is postpartum depression?
Some women have more severe symptoms of the baby blues or symptoms that last longer than a few days. This is called postpartum depression. Postpartum depression is an illness, like diabetes or heart disease.

Symptoms

What are the symptoms of postpartum depression?
The symptoms of postpartum depression affect your quality of life and include:

- Feeling sad or down often
- Frequent crying or tearfulness
- Feeling restless, irritable or anxious
- Loss of interest or pleasure in life
- Loss of appetite
- Less energy and motivation to do things
- Difficulty sleeping, including trouble falling asleep, trouble staying asleep or sleeping more than usual
- Feeling worthless, hopeless or guilty
- Unexplained weight loss or gain
- Feeling like life isn't worth living
- Showing little interest in your baby

Although many women get depressed right after childbirth, some women don't begin to feel depressed until several weeks or months later. Depression that occurs within 6 months of childbirth may be postpartum depression.

In rare cases, a woman may develop postpartum psychosis. This is a very serious disease and includes all the symptoms of postpartum depression and thoughts of hurting yourself or hurting the baby. If you have thoughts of hurting yourself or your baby, get help immediately.
How long does postpartum depression last?

It varies for each woman. Some women feel better within a few weeks, but others feel depressed or "not themselves" for many months. Women who have more severe symptoms of depression or who have had depression in the past may take longer to get well. Just remember that help is available and that you can get better.

Causes & Risk Factors

Why do women get postpartum depression?

The exact cause isn't known. Hormone levels change during pregnancy and right after childbirth. Those hormone changes may produce chemical changes in the brain that play a part in causing depression.

Feeling depressed doesn't mean that you are a bad person, that you did something wrong or that you brought this on yourself.

Who gets postpartum depression?

Postpartum depression is more likely if you have had any of the following:

- Previous postpartum depression
- Depression not related to pregnancy
- Severe premenstrual syndrome (PMS)
- A difficult or very stressful marriage or relationship
- Few family members or friends to talk to or depend on
- Stressful life events during pregnancy or after childbirth (such as as severe illness during pregnancy, premature birth or a difficult delivery)
(2) Adopted Medical Clinical Guidelines for Disease Management

(1) Diabetes

Diabetes is a serious health condition that can lead to heart disease, stroke, kidney failure, and blindness. The goal of QualCare’s Diabetes Disease Management Program is to assist members in having better control over their diabetes, leading to fewer complications. The program objectives are based on the American Diabetes Association Standards of Medical Care in Diabetes (ADA, 2014) and National Guideline Clearinghouse.

Program objectives include the following:

HbA1c Testing:
Diabetes Disease Management Program enrollees will obtain hemoglobin A1c (HbA1c) measures based on evidence-based standards and guidelines.

Primary care physician or Endocrinologist visits:
All Diabetes Disease Management Program enrollees will visit their primary care physician or endocrinologist at least twice annually.

Podiatrist visits:
All Diabetes Disease Management Program enrollees will visit their podiatrist annually.

Ophthalmologist visits:
All diabetes Disease Management Program enrollees will visit their ophthalmologist annually.

Dentist visits:
All Diabetes Disease Management Program enrollees will visit their dentist twice annually.

Diabetic associated lab work:
All Diabetes Disease Management Program enrollees will have the following laboratory evaluations annually:
   a. Lipid profile (LDL, HDL, triglyceride, cholesterol)
   b. Liver function tests (AST, ALT)
   c. Microalbuminuria
   d. Serum creatinine
   e. Electrolytes

Diabetes Care Management:

- The Diabetes Disease Nurse Case Managers, registered nurses, focus on collaboration with physicians and support-service providers. This includes contacts with primary and specialty practitioners, arrangements for services such as Diabetic educational programs, home health care, and DME supplies.
- Patient Self-management educational tools that may be provided by the American Diabetes Association, pharmaceutical companies, or DME vendors. These tools may include: educational mailings, preventive care information, behavior modification materials and compliance tracking. Utilization of these tools will empower patients to understand and more effectively manage their disease.
- With these program interventions, outcomes will be tracked and measured on a quarterly and annual basis. Results will be reported to indicate program success as evidenced by program goals and objectives being met.
(2) Coronary Artery Disease

Coronary Artery Disease is a serious health condition that can lead to heart disease, stroke, kidney failure, and blindness. Coronary Artery Disease can be prevented or kept under control by addressing risk factors such as tobacco use, unhealthy diet, physical inactivity, obesity, high blood pressure, diabetes and elevated lipids. The goal of QualCare’s Coronary Artery Disease Management Program is to assist members in having better control over their lifestyles, leading to fewer complications. The program objectives are based on the American Heart Association and National Guideline Clearinghouse.

Program objectives include the following:

Cholesterol Testing:
Coronary Artery Disease Management Program enrollees will obtain Cholesterol measures based on evidence-based standards and guidelines.

Primary care physician or Cardiology visits:
All Coronary Artery Disease Management Program enrollees will visit their primary care physician or endocrinologist at least twice annually.

Coronary Artery Disease associated lab work and treatment monitoring:
All Coronary Artery Disease Management Program enrollees will have the following:
   a. Testing for High Cholesterol: Low Density Lipoprotein (LDL-C) Test performed during the measurement year
   b. Use of persistent medications: received ambulatory ACE/ARB prescription in the measurement year
   c. Monitoring for persistent medications: ACE/ARB; at least 1 Potassium, Creatinine, or BUN test in the measurement year
   d. Persistence of Beta-Blocker: Beta Blocker after a heart attack; beta-blocker treatment for 6 months after discharge
   e. Adhering to Cholesterol Medication: Cholesterol lowering medication (ACG Measure)

Coronary Artery Disease Care Management:

- The Coronary Artery Disease Nurse Case Managers, registered nurses, focus on collaboration with physicians and support-service providers. This includes contacts with primary and specialty practitioners, arrangements for services such as Cardiac educational programs, home health care, and DME supplies.
- Patient Self-management educational tools that may be provided by the American Heart Association, pharmaceutical companies, or DME vendors. These tools may include: educational mailings, preventive care information, behavior modification materials and compliance tracking. Utilization of these tools will empower patients to understand and more effectively manage their disease.
- With these program interventions, outcomes will be tracked and measured on a quarterly and annual basis. Results will be reported to indicate program success as evidenced by program goals and objectives being met.

Additional information related to these Disease Management Programs is contained in SOP UM 7.02 Health Promotion Program.
(2) Adopted Behavioral Health Clinical Guidelines for Disease Management

(1) Depression (Adult and Adolescent)

Depression is a mental illness that can be costly and debilitating to both adults and adolescents. Depression can affect the course and/or outcome of common chronic conditions. The goal of QualCare’s Depression Management Program is to assist members in having better control over their condition, leading to fewer complications. The program objectives are based on the Center for Disease Control and National Guideline Clearinghouse.

Program objectives include the following:

**Depression Health Assessment:**
Depression Management Program enrollees for both adult and adolescent will be given an assessment to identify their risk and immediate areas of concern. The assessment will be based on SF-36. If the member is under the age of 18, the parent or guardian will assist in the completion of the assessment.

**Primary care physician or Behavioral Health Specialist visits:**
All Depression Management Program enrollees will visit their primary care physician or behavioral health specialist as appropriate.

**Depression Management:**

- The Nurse Case Managers, registered nurses, focus on collaboration with physicians and support-service providers. This includes contacts with primary and specialty practitioners, arrangements for services such as counseling and medication.
- Patient Self-management educational tools that may be provided by the National Institute of Health. These tools may include: educational mailings, preventive care information, behavior modification materials and compliance tracking. Utilization of these tools will empower patients to understand and more effectively manage their condition.
- With these program interventions, outcomes will be tracked and measured on a quarterly and annual basis. Results will be reported to indicate program success as evidenced by program goals and objectives being met.
(2) Post-Partum Depression

Post-Partum Depression can begin anytime within the first year after childbirth. The cause is unknown. It is thought that hormonal and physical changes after birth and the stress of caring for a new baby may play a role. Women who had depression prior to pregnancy are at higher risk for developing post-partum depression. The goal is to identify and assist these members with care coordination and behavioral modification. The programs guidelines are structured from the National Institute of Health and the Department of Health and Human Services, Office on Women’s Health.

Program objectives include the following:

Behavioral Health Assessment:
Post-Partum Depression Management Program enrollees will be given an assessment to identify their risk and immediate areas of concern. The assessment will be based on SF-36.

Primary care physician, Obstetrician or Behavioral Health Specialist visits:
All Post-Partum Depression Management Program enrollees will visit their primary care physician, obstetrician (for the post-partum depression) or behavioral health specialist as appropriate.

Post-Partum Depression Management:

- The Nurse Case Managers, registered nurses, focus on collaboration with physicians and support-service providers. This includes contacts with primary and specialty practitioners, arrangements for services such as counseling and medication.
- Patient Self-management educational tools that may be provided by the National Institute of Health. These tools may include: educational mailings, preventive care information, behavior modification materials and compliance tracking. Utilization of these tools will empower patients to understand and more effectively manage their condition.
- With these program interventions, outcomes will be tracked and measured on a quarterly and annual basis. Results will be reported to indicate program success as evidenced by program goals and objectives being met.

Additional information related to these Disease Management Programs is contained in SOP UM 4.01 Case Management Program.