AmeriHealth Caritas
District of Columbia

To:	**All AmeriHealth Caritas DC Providers**
Date:	**October 19, 2020**
Subject:	Clinical Practice Guidelines Update—Adult Depression, Diabetes Mellitus, and Hemophilia
Summary:	As a part of AmeriHealth Caritas District of Columbia's commitment to providing quality care to our enrollees, we are updating some of our Clinical Practice Guidelines (CPG) so that they are current with industry best practices. Please review the summaries of the updated guidelines and reference the attached documents for the full CPG.

Adult Depression (Michigan Quality Improvement Consortium, *updated January 2020*)

Eligible population:

- Adults eighteen years or older, including pregnant and postpartum women

Detection and Diagnosis:

- Assess for other causes of symptoms and comorbid conditions that might impact treatment (e.g. medical or medication induced conditions, drug or alcohol abuse, bipolar disorder, anxiety disorders, and psychosis).

Frequency:

- Screen annually. More often if high risk.
- Pregnant and postpartum women
    - At the first prenatal visit; on postpartum visits (within 3-8 weeks of discharge) and if symptoms or signs raise suspicion using Edinburgh Postnatal Depression Scale.

Individuals diagnosed with depressive disorder: Treatment and Follow Up

- If initiating antidepressant medication, follow manufacturer's recommended doses. Avoid underdosing. If inadequate responses after 2-4 weeks, increase dosage as tolerated not to exceed the highest recommended dose unless directed by a psychiatrist. If discontinuing an antidepressant, be aware of need to taper some medications.
- Monitoring: if medication prescribed, continue treatment and monitoring for at least 9-12 months after acute symptoms resolve. Patients with recurring major depressive and/or persistent depression disorder (≥ 2 years) usually require lifelong treatment.

Diabetes Mellitus (Michigan Quality Improvement Consortium, *updated June 2020*)

Eligible Population:

- Adults ages eighteen through seventy-five (18-75) with type 2 diabetes mellitus.

Assessment (at least every six months, more frequently if needed as support management of weight, blood pressure, glycemia, or secondary prevention methods).

- Weight: recent weight trend. Goal for overweight patients is weight loss. Weight gain is a red flag and should prompt aggressive interventions for weight stabilization or weight loss. Record BMI annually.
- Blood Pressure: goal is <140/90.
- Glycemia: usually measured with A1c, fasting blood glucose or continuous glucose monitoring can be used. Individualized A1c goal depends on patient's health and frailty status.
- Social Determinants of Health: especially food insecurity, housing stability, and financial barriers.

Weight Loss:

- For those patients who are obese or gaining weight over time, consider referral to a comprehensive weight loss program if available, or to a diabetes educator.
- Nutritional counseling should focus on: increasing daily intake of low glycemic vegetables, moderate consumption of protein, and heart healthy nuts.

Hypertension:

- Evidence-based non pharmacologic interventions for high blood pressure include weight loss, regular exercise, salt reduction, and alcohol reduction.

Hemophilia (National Hemophilia Association, *updated August 2020*)

Recommendations for healthcare providers and physicians treating patients with Hemophilia A, Hemophilia B, von Willebrand Disease, and other congenital bleeding disorders.

View here: https://www.hemophilia.org/Researchers-Healthcare-Providers/Medical-and-Scientific-Advisory-Council-MASAC/MASAC-Recommendations/MASAC-Recommendations-Concerning-Products-Licensed-for-the-Treatment-of-Hemophilia-and-Other-Bleeding-Disorders

A. Treatment of Hemophilia A
    a. Recombinant (r) FVIII products are the recommended treatment of choice for patients with Hemophilia A. A possible exception to this recommendation is a newly diagnosed individual, who should also consider with their healthcare providers initiating treatment with a plasma-derived factor VIII, von Willebrand VWF factor.
    b. Desmopressin (DDAVP) can be used to treat those with mild Hemophilia A who have been documented by a DDAVP trial to have a significant rise in FVIII.
B. Treatment of Hemophilia B
    a. Recombinant factor IX products are recommended treatment for patients with Hemophilia B.
C. Treatment of von Willebrand Disease

a. Desmopressin: Most Persons with VWD type 1 may be treated with desmopressin, given either parenterally or by a highly concentrated nasal spray
b. Recombinant VWF Concentrate: Recombinant VWF is available to treat patients with type 2B and type 3 VWD; it can also be used in type 1, 2A, 2M, and 2N VWD who are not responsive to DDAVP or are children under two.

D. Treatment of patients with Inherited Hemophilia A or B and Inhibitors to Factor VIII or Factor IX
   a. Inhibitor development is the most severe complication of treatment for patients with inherited hemophilia A or B. Choice of product depends on multiple factors including type of inhibitor, current titer of inhibitor, location of the bleed, previous response to these products, availability of clinical trial data supporting use of these products, and concomitant medications.
   b. For high-titer inhibitors, immune intolerance induction (ITI) is the best option for inhibitor eradication.
   c. Consultation with a Hemophilia treatment center is highly recommended.

Michigan Quality Improvement Consortium Guideline

Primary Care Diagnosis and Management of Adults with Depression

The following guideline recommends screening for depression, assessing suicide risk, following diagnostic criteria, shared decision-making and treatment planning, monitoring and adjusting treatment.

<table>
<tr><th>Eligible Population</th><th>Recommendation and Level of Evidence</th><th>Frequency</th></tr>
<tr><td>Adults 18 years or older, including pregnant and postpartum women</td><td>Detection and Diagnosis:
Screen for depression, using a validated screening tool (e.g. PHQ-2 or 9, Edinburgh Scale) with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. [B]
Assess for other causes of symptoms, and comorbid conditions that might impact treatment (e.g., medical and medication-induced conditions, drug or alcohol abuse, bipolar disorder, anxiety disorders, psychosis).
Assess if criteria are met using DSM-5 criteria. [A] Criteria A, B, C and D must be met.
<table>
<tr><th>DSM-5 criteria</th><th>Major Depression</th><th>Persistent Depressive Disorder</th></tr>
<tr><td>A. Symptoms</td><td>5 total for ≥ 2 weeks and must include symptom #1 or #2</td><td>3 total for ≥ 2 years. Must include symptom #1. Never > 2 months symptom-free</td></tr>
<tr><td>1. Depressed mood</td><td>x</td><td>x</td></tr>
<tr><td>2. Marked diminished interest/pleasure</td><td>x</td><td></td></tr>
<tr><td>3. Significant weight gain/loss, appetite decrease/increase</td><td>x</td><td>x</td></tr>
<tr><td>4. Insomnia/hypersomnia</td><td>x</td><td>x</td></tr>
<tr><td>5. Psychomotor agitation/retardation noticeable by others</td><td>x</td><td></td></tr>
<tr><td>6. Fatigue/loss of energy</td><td>x</td><td>x</td></tr>
<tr><td>7. Feelings of worthlessness or inappropriate guilt</td><td>x</td><td>x</td></tr>
<tr><td>8. Diminished concentration or indecisiveness</td><td>x</td><td>x</td></tr>
<tr><td>9. Recurrent thoughts of death or suicidal ideation</td><td>x</td><td></td></tr>
<tr><td>10. Hopelessness</td><td></td><td>x</td></tr>
<tr><td colspan="3">B. Symptoms cause clinically significant distress or impairment in functioning</td></tr>
<tr><td colspan="3">C. Symptoms not attributed to a substance or other medical condition</td></tr>
<tr><td colspan="3">D. Lack of psychotic disorder or history of manic or hypomanic symptoms</td></tr>
</table></td><td><u>Pregnant and postpartum women</u>
At the first prenatal care visit; on post-partum visits (within 3-8 weeks of discharge) and if symptoms or signs raise suspicion using the Edinburgh Postnatal Depression Scale[1].

Annually. More often if high risk.</td></tr>
<tr><td>Individuals diagnosed with a depressive disorder</td><td>Assess risk of suicide by direct questioning about suicidal ideation, and if present, suicidal planning, potential means, and personal/family history of suicidal attempts. [D] See established clinical tools for risk assessment and suicide prevention[2,3].
■ If patient at moderate to severe risk for suicide, refer to emergency department or crisis intervention center. Develop safety plan.</td><td>At each encounter addressing depression until patient is treated to remission.</td></tr>
<tr><td></td><td>Treatment and follow-up:
Educate and engage patient. Include self-management support and life-style modifications (e.g., behavioral activation, healthy sleep and diet, exercise, stress-management, social support, spiritual support, online resources). [C]
Utilize shared decision-making in treatment planning. [A] Consider onset and severity of symptoms, impairment, past episodes, psychosocial stressors, medical and psychiatric comorbidities, patient preference, resource accessibility. For mild to moderate symptoms consider pharmacotherapy and/or evidence-based psychotherapy. [A] For severe symptoms consider both pharmacotherapy and evidence-based psychotherapy. [A]
Monitor response to treatment using standardized scale (e.g., PHQ-9) at least every 4 months until remission is obtained. On PHQ-9, adequate response is 50% reduction in score, remission=total score <5.
Consider referral to behavioral health specialist when additional counseling is desired, primary physician is not comfortable managing patient's depression, diagnostic uncertainty, complex symptoms or social situation, pregnancy, response to medication at therapeutic dose is not optimal, considering prescribing multiple agents, or more extensive interventions are warranted. [D]
If initiating antidepressant medication, follow manufacturer's recommended doses. Avoid underdosing. If inadequate response after 2-4 weeks, increase dosage as tolerated not to exceed the highest recommended dose unless directed by a psychiatrist. If discontinuing antidepressant, be aware of need to taper some medications.
If limited or no response to treatment, assess for non-adherence, inadequate dosing, diagnostic inaccuracy or comorbid conditions exacerbating symptoms. Consider: increased doses of medication or frequency of psychotherapy, switching treatments or augment treatment with other medications or psychotherapeutic interventions, consultation.
Monitoring: If medication prescribed, continue treatment and monitoring for at least 9-12 months after acute symptoms resolve. [A] Patients with recurrent major depression and/or persistent depressive disorder (≥ 2 years) usually require lifelong treatment.</td><td>Schedule sufficient follow-up visits to assess response to treatment and titrate dose (typically every two weeks, monthly at a minimum). [D]</td></tr>
</table>

[1] Edinburgh Postnatal Depression Scale
[2] Suicide Prevention for Primary Care Toolkit
[3] Suicide Assessment Five-step Evaluation and Triage

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline is based on several sources, including: Final Update Summary: Depression in Adults: Screening. U.S. Preventive Services Task Force, January 2016; American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fifth Edition - DSM-5; Nonpharmacological Versus Pharmacological Treatments for Adult Patients with Major Depressive Disorder, AHRQ Publication No. 15(16)-EHC031-EF, AHRQ, December 2015; Trangle, M, et. al. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated March 2016; and Suicide Prevention Toolkit for Primary Care; Suicide Assessment Five-Step Evaluation and Triage - SAFE-T. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Management of Type 2 Diabetes Mellitus

The following guideline applies to patients aged 18-75 years with type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

Key Components

Assessment (at least every 6 months, more frequently as needed to support management of weight, blood pressure, glycemia or secondary prevention interventions)

Weight **[A]**: recent weight trend. Goal for overweight patients is gradual weight loss. Weight gain is a red flag and should prompt aggressive interventions to support weight stabilization or weight loss. Record BMI annually.

Blood pressure **[A]**: Goal <140/90. If high cardiovascular disease (CVD) risk (10-year ASCVD risk ≥ 15%) or known CVD, <130/80. Calculate ASCVD risk. Record BP and risk results.
Refer to treatment algorithm (p. 124/S116) for patients with diabetes.

Glycemia: usually measured with A1c **[E]**, fasting glucose or continuous glucose monitoring may be used.
Individualize the A1c goal (pg. 79/S71). Goal depends on patient's health and frailty status. See box below for A1c targets.

Social determinants of health: especially food insecurity, housing stability and financial barriers

Additional assessment and interventions:

CVD: smoking; lipid profile **[E];** statin **[A]**; if confirmed CVD, ASA (75-162 mg/day) unless contraindicated. **[A]**
Tobacco/nicotine cessation **[B]** including second-hand smoke avoidance, offer nicotine replacement therapy and/or non-nicotine medications (varenicline, bupropion, others). **[A]**
Blood pressure control **[A]**, diet and exercise, weight loss, SGLT-2 inhibitors, GLP-1 agonists.

Chronic kidney disease (CKD): microalbuminuria **[B]**, ACE inhibitor or ARB. Serum creatinine for estimated glomerular filtration rate (eGFR) annually. **[B]**
Blood pressure control, glycemic control, limit NSAIDS and other renal-toxic medications.

Retinopathy: fundoscopic exam by an ophthalmologist or optometrist, or fundal photography if no history of retinopathy. **[B]** If retinopathy, repeat eye exam annually. If no retinopathy, every 1-2 years.
Glycemic control.

Foot ulcers: foot exam every visit. **[B]** Review home foot care education including exercise, appropriate footwear, nail and skin care. **[B]** Refer to podiatrist or foot care specialist if high risk feet.

Immunizations **[C]:** ensure appropriate immunization status, especially pneumococcal (PPSV23), influenza and HepB.

Infectious diseases: pneumococcal, influenza and HepB vaccines

Non-alcoholic steatohepatitis (NASH): consider screening with LFTs; treatment is diet, exercise and weight loss

Importance of participation in Diabetes Self-Management Education and Support (DSMES) **[A]** from a collaborative team or diabetic educator. Locate DSMES services.

Preconception counseling for all women capable of pregnancy. **[A]**

Dental care

Weight Loss:

For those patients who are obese or gaining weight over time, consider referral to a comprehensive weight loss program if available, or to a diabetes educator.
Nutritional counseling should focus on: increasing daily consumption of low glycemic index vegetables, moderate consumption of protein and heart health fats, and decreasing or eliminating high glycemic index and highly processed carbohydrates including sugar-sweetened beverages. Consider medical work-up for sleep apnea, hypothyroidism, anemia. Review medication list to eliminate obesogenic medication choices where other options are available. Encourage 30 minutes of walking daily or other exercise program.

Hypertension control:

Evidence-based non-pharmacologic interventions for blood pressure management include weight loss, regular exercise, salt restriction and alcohol reduction.
First-line medication for blood pressure management in patients with diabetes are ACE-I/ARB, thiazide-like diuretic, or dihydropyridine CCB. **[A]**

Glycemic Control:

Most type 2 diabetics benefit from Metformin, if tolerated, as it's been shown to slow progression of the disease and it can help weight loss. For those not well controlled (A1c > 7% for most people) with diet, exercise and metformin, additional medications should be considered. Consider newer medications such as SGLT-2 inhibitors and GLP-1 agonists which have been shown to slow progression of heart disease, heart failure, and CKD, and to induce weight loss in people with diabetes.

Educate on role of self-monitoring of blood glucose in glycemic control. **[A]**

A1c Goals:
<6.5% - women planning pregnancy **[B]**
<6.5% - treated only with lifestyle, metformin-like drugs
<7% - for most patients **[A]**
7-8% - those with a <10 year life expectancy, severe hypoglycemia, severe macrovascular complications or severe CKD

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; E = opinion of expert panel

This guideline lists core management steps. It is based on the American Diabetes Association Standards of Medical Care in Diabetes - 2020 Jan; 43 (Supplemental 1): S1-S212. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors 2000, 2002, 2004, 2006; June 2008, 2010, 2012, 2013, 2014, 2015, 2016, 2018, 2020 **MQIC.ORG**