



Clinical Practice Guidelines (CPGs) summarize national recommendations and focus on key clinical points useful for the busy practitioner. They have been reviewed by practicing New Mexico physicians and are meant to serve as general guidelines, but are not intended to substitute for clinical judgment in individual cases. **Bold, underlined elements are considered core elements, which may be monitored annually.** CPGs are incorporated into our *Blue Care Connection*[®] Disease Management programs. CPGs are available online at: www.bcbsnm.com/provider. Note: Inclusion of a service does not imply that the service is necessarily a covered benefit and is not a guarantee of payment.

ASTHMA	
Endorsed Guidelines	<p><i>Guidelines for the Diagnosis and Management of Asthma</i>, National Heart, Lung, and Blood Institute (NHLBI) Expert Panel Report 3 (EPR3), October 2007</p> <p><i>How to obtain full guideline: If you are reading this electronically, click on the link below. Otherwise, enter the Web address into your browser (e.g., Internet Explorer, Safari, Firefox).</i></p> <p>www.nhlbi.nih.gov/guidelines/asthma/asthdln.htm</p> <p>To order hard copies of <i>EPR3</i>, call (301) 592-8573.</p>
Guiding Principles	<p>Goals of asthma control:</p> <ol style="list-style-type: none"> 1. Prevent chronic and troublesome symptoms. 2. Infrequent use (≤ 2 days a week) of short-acting beta agonists (“rescue inhalers”). 3. Near normal pulmonary function and activity levels. 4. Prevent recurrent exacerbations of asthma and the need for ER visits or hospitalizations. 5. Prevent progressive loss of lung function; for children, prevent reduced lung growth. 6. Step-down therapy: minimum medication necessary to maintain control.
Core Elements	<ol style="list-style-type: none"> 1. <u>Medical history assesses severity of asthma</u>, exercise tolerance, triggers, history of hospitalizations, and ER visits. 2. <u>Physical examination of lungs includes inspection, percussion, and auscultation</u> to document presence or absence of wheezing and other signs of airflow obstruction. 3. <u>Drug therapy of other than mild intermittent asthma includes inhaled corticosteroids</u> unless contraindicated. Step-down approach is used to identify minimum necessary doses of medications to maintain asthma control. 4. Patient has a <u>Written Action Plan</u> that addresses what to do if symptoms worsen. 5. Testing/monitoring includes: <ul style="list-style-type: none"> ▪ <u>Baseline and periodic spirometry</u> ▪ <u>Peak flow meter or symptom monitoring</u> ▪ <u>An in-office evaluation q 2-6 wks during initiation of therapy, q 1-6 mth for follow-up, and at least annually</u>

ADULT TYPE 2 DIABETES	
Endorsed Guidelines	<p><i>New Mexico Adult Diabetes Practice Guideline</i>, New Mexico Health Care Takes On Diabetes, 2009</p> <p><i>How to obtain full guideline: If you are reading this electronically, click on the link below. Otherwise, enter the Web address into your browser (e.g., Internet Explorer, Safari, Firefox).</i></p> <p>www.nmtod.com or www.diabetes.org</p> <p>To order hard copies of <i>ADA guidelines</i>, call (800) 342-2383.</p>
Guiding Principles	<ol style="list-style-type: none"> 1. Long-term control of glucose (as measured by A1C) reduces the risk of microvascular damage. 2. Control of blood pressure and cholesterol levels are important therapeutic goals to reduce cardiovascular risk. 3. Minimizing complications warrants consistent monitoring for early signs of retinal, kidney, and foot disease. 4. Team approach to care and patient self-management is critical to success.
Core Elements	<ol style="list-style-type: none"> 1. Medical history assesses results of self-administered blood glucose monitoring and symptoms suggesting complications of diabetes. 2. Physical examination assesses: <ul style="list-style-type: none"> ▪ <u>Blood pressure</u>, weight, and tobacco status at each visit ▪ Foot examination (bare feet) for skin, sensation, and pulses at least annually but preferably at each visit 3. Testing/management includes: <ul style="list-style-type: none"> ▪ An <u>in-office evaluation at least annually</u> ▪ Use of medications: glucose control, blood pressure control, ACEI/ARB, lipid control, aspirin prophylaxis ▪ <u>A1C four times a year (or twice a year if in good control)</u> ▪ Annual estimate of GFR by serum creatinine ▪ <u>Annual screen for microalbuminuria</u> (unless patient already has nephropathy) ▪ <u>Annual lipid screening</u> ▪ <u>Referral to ophthalmologist/optometrist for yearly retinal exam (nonmydriatic camera acceptable alternative)</u> 4. Coordination of Care: providing – directly or by referral – training in self-care, nutrition, and foot care, at a minimum.



TREATMENT OF ADULT HYPERTENSION

Endorsed Guidelines	<p><i>The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VII)</i>, National Heart, Lung, Blood Institute, NIH, 2003</p> <p>How to obtain full guideline: If you are reading this electronically, click on the link below. Otherwise, enter the Web address into your browser (e.g., Internet Explorer, Safari, Firefox).</p> <p>www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm</p> <p>To order hard copies of <i>JNC VII</i> from the NHLBI Information Center, call (301) 592-8573.</p>																				
Guiding Principles	<p>1. The Blood Pressure categories are:</p> <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>Category</th> <th>SBP mmHg</th> <th>AND</th> <th>DBP mmHg</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td><120</td> <td></td> <td><80</td> </tr> <tr> <td>Prehypertension</td> <td>120-139</td> <td>OR</td> <td>80-89</td> </tr> <tr> <td>Stage 1 HTN</td> <td>140-159</td> <td>OR</td> <td>90-99</td> </tr> <tr> <td>Stage 2 HTN</td> <td>≥160</td> <td>OR</td> <td>≥100</td> </tr> </tbody> </table> <p>2. Treating essential hypertension greatly reduces risk for MI, stroke, kidney failure, and premature mortality.</p> <p>3. Treat to goal: BP < 140/90 or <130/80 if diabetes or chronic kidney disease.</p> <p>4. The majority of patients will need TWO medications to reach goal.</p> <p>5. Use of self-monitoring may be considered in an attempt to improve patient adherence.</p>	Category	SBP mmHg	AND	DBP mmHg	Normal	<120		<80	Prehypertension	120-139	OR	80-89	Stage 1 HTN	140-159	OR	90-99	Stage 2 HTN	≥160	OR	≥100
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Core Elements	<p>1. When clinically indicated because of atypical presentation, comorbid conditions, or response to therapy, rule out secondary hypertension.</p> <p>2. The patient with controlled hypertension should be evaluated by the clinician at least annually. The patient with uncontrolled hypertension should be evaluated frequently until BP is controlled.</p> <p>3. Attention should be paid to:</p> <ul style="list-style-type: none"> ▪ Evidence of end-organ damage: heart, kidney, retina, brain ▪ Medication adherence and lifestyle modification progress ▪ Side effects of medications <p>4. Examination should include:</p> <ul style="list-style-type: none"> ▪ Retinal exam ▪ Cardiovascular exam (EKG only if clinically indicated) ▪ Periodic test of renal function ▪ Periodic check of electrolytes, especially potassium if on diuretics or ACEI <p>5. Treatment should be to a goal of <140/90 (<130/80 if diabetes or chronic kidney disease).</p> <p>6. Treatment approaches should be consistent with JNC VII recommendations, summarized below:</p> <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>BP</th> <th>Treatment</th> </tr> </thead> <tbody> <tr> <td>Pre HTN (120-139 syst or 80-89 diast)</td> <td>Lifestyle modification should be instituted</td> </tr> <tr> <td>Stage 1 (140-159 syst or 90-99 diast)</td> <td>For Most: Thiazide diuretic. Consider: ACEI, ARB, BB, CCB, or combination</td> </tr> <tr> <td>Stage 2 (≥160 syst or ≥100 diast)</td> <td>For Most: Two-drug combination Usual regimen: Thiazide diuretic PLUS ACEI, ARB, BB, or CCB</td> </tr> </tbody> </table> <p>Approaches if BP not at goal</p> <ul style="list-style-type: none"> ○ Optimize doses ○ Add additional medications: ACEI, ARB, BB, CCB, or alpha blocker ○ If on diuretic plus two additional drugs at adequate doses, consult with hypertension specialist <p>Abbreviations</p> <p>ACEI: Angiotensin Converting Enzyme Inhibitor ARB: Angiotensin Receptor Blocker BB: Beta-Blocker CCB: Calcium Channel Blocker</p>	BP	Treatment	Pre HTN (120-139 syst or 80-89 diast)	Lifestyle modification should be instituted	Stage 1 (140-159 syst or 90-99 diast)	For Most: Thiazide diuretic. Consider: ACEI, ARB, BB, CCB, or combination	Stage 2 (≥160 syst or ≥100 diast)	For Most: Two-drug combination Usual regimen: Thiazide diuretic PLUS ACEI, ARB, BB, or CCB												
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INITIAL PHARMACOLOGIC TREATMENT IN ADULT MAJOR DEPRESSION	
Endorsed Guidelines	<p>Major Depression in Adults in Primary Care, Institute for Clinical Systems Improvement (ICSI), 2008</p> <p>How to obtain full guideline: <i>If you are reading this electronically, click on the link below. Otherwise, enter the Web address into your browser (e.g., Internet Explorer, Safari, Firefox).</i></p> <p>www.icsi.org/guidelines_and_more/depression_major_in_adults_in_primary_care_3.html</p>
Guiding Principles	<ol style="list-style-type: none"> 1. Major depression is a serious disease that can be managed with antidepressant medication in a primary care setting, combined with, or as an alternative to, psychotherapy. 2. The diagnosis of major depression should be made based on objective criteria. 3. Because improvement may be gradual, initial pharmacologic management of major depression requires that antidepressants be continued for up to 3 months (12 weeks) to determine effectiveness. An algorithmic approach is described in the ICSI guideline. 4. Choice of antidepressants should be tailored to the individual, based on co-existing conditions and other medications. 5. Patients treated with antidepressants should have follow-up visits at least monthly. 6. Referral to behavioral health specialists should be made for atypical or high-risk cases or cases unresponsive to trials of antidepressants.
Core Elements	<ol style="list-style-type: none"> 1. Clinical evaluation should rule out other medical and psychiatric conditions that are similar to, or can mimic, major depression. 2. Depending on severity, the patient should be offered antidepressant medication, psychotherapy, or both. 3. When antidepressants are used, the choice is individualized based on concomitant medical and behavioral conditions and known drug effects, side effects, and drug-drug interactions. 4. <u>An initial course of antidepressants is given for a sufficient period, up to twelve (12) weeks, to establish efficacy.</u> 5. The patient is monitored for increased agitation or suicidality when starting antidepressants. 6. <u>The patient is evaluated at least monthly during the initial course of therapy.</u> 7. If antidepressant treatment is not successful, or if there are atypical or high-risk features, the patient should be referred to an appropriate mental health provider to consider further options and augmentative therapy.
NOTE	Continuation therapy and relapse prevention are beyond the scope of this brief guideline, but are discussed in detail in the complete ICSI guideline.

TREATMENT OF ADHD IN CHILDREN AGED 6-12	
Endorsed Guidelines	<p>Clinical Practice Guideline: Treatment of the School-Aged Child with Attention Deficit Hyperactivity Disorder (ADHD), American Academy of Pediatrics as published in: <i>Pediatrics</i>, Vol. 108 (4), October 2001, pp. 1033-1044</p> <p>How to obtain full guideline: <i>If you are reading this electronically, click on the link below. Otherwise, enter the Web address into your browser (e.g., Internet Explorer, Safari, Firefox).</i></p> <p>Diagnosis: pediatrics.aappublications.org/cgi/content/abstract/pediatrics:105/5/1158</p> <p>Treatment: aappolicy.aappublications.org/cgi/content/abstract/pediatrics:108/4/1033</p>
Guiding Principles	<ol style="list-style-type: none"> 1. ADHD in children 6 through 12 years of age requires both a structured approach to diagnosis and the development of a specific treatment plan with concrete goals. 2. The treating clinician should work in collaboration with the child, parents, and school to implement the treatment plan. 3. Based on the available scientific evidence, stimulant medication, behavioral treatment, or both should form the basis of treatment to improve target symptoms. 4. Choice of medications should be tailored to the needs of the child. 5. There are no generally accepted guidelines for optimal duration of psycho- or pharmacotherapy. Once adequate improvement in target symptoms is achieved, the child should be monitored at an interval appropriate to the overall clinical status. 6. Primary care providers should consider referral to behavioral health specialists when target symptoms are not improved despite therapy, or if other risk factors are present.
Core Elements	<ol style="list-style-type: none"> 1. The diagnosis of ADHD is made objectively and includes: <ul style="list-style-type: none"> ▪ The use of explicit criteria for the diagnosis, available from the American Academy of Pediatrics (see “Endorsed Guidelines” above); and ▪ Obtaining information about the child’s symptoms in more than one setting (especially from schools); and ▪ Searching for coexisting conditions that may make the diagnosis more difficult or complicate treatment planning; and ▪ Formulating a treatment plan after consulting with the parents and school that identifies specific target symptoms. 2. <u>Once a diagnosis of ADHD is established, the treating clinician should institute a course of medication, formal behavioral therapy, or both.</u> Stimulants are considered first-line treatment, although in some cases, antidepressants may be indicated as second-line therapy. 3. <u>The treating clinician monitors children placed on stimulant medication for effectiveness and side effects with a face-to-face office visit every three to six months.</u> 4. If an adequate trial of stimulant therapy (including a second agent if needed) is not effective in improving target symptoms, consideration is given to referring the child to a behavioral health specialist.