| Clinical Practice Guidelines Elements |
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| **Major Depressive Disorder** |
| MDD The provider found sufficient evidence to support the diagnosis of MDD by ruling out medical conditions that might cause depression and/or complicate the treatment. |
| MDD The provider delivered education about MDD and its treatment to the member, and if appropriate, to the family. |
| MDD If psychotic features were found, the treatment plan included the use of either antipsychotic medication or ECT, or clear documentation why not. |
| MDD If MDD was of moderate severity or above, the treatment plan used a combination of psychotherapy and antidepressant medication, or clear documentation why not. |
| MDD The psychiatrist delivered education about the medication, including signs of new or worsening suicidality, and the high risk times for this side effect. |
| MDD If provider was not an M.D., there was documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above. |
| **ADHD** |
| ADHD Diagnosis was determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life. |
| ADHD Record indicated that the medical evaluation was reviewed to rule out medical causes for the signs and symptoms. |
| ADHD Psychoeducation was delivered to all members with ADHD and in the case of minors, to the parents/caregivers. |
| ADHD The treatment plan and rationale as well as available treatments, including medications and their benefits, risks, side effects, were discussed with the member and the parent/caregiver in the case of minors. |
| ADHD Record indicated the use of family interventions that coach parents on contingency management methods. |
| ADHD Record indicated a comprehensive assessment for comorbid psychiatric disorders was conducted. |
| **Substance Use** |
| SA Education was delivered about substance-use disorders. |
| SA A plan for maintaining sobriety, including strategies to address triggers was developed, and the role of substance use in increasing suicide risk was discussed. |
| SA The treatment plan included a referral to self-help groups such as AA, Al-Anon, and NA. |
| SA Evaluation included the consideration of appropriate psychopharmacotherapy. |
| SA For MD providers, evidence that abstinence-aiding medications were considered. |
| SA If provider was not a MD, there was evidence that a referral for abstinence-aiding medication or a diagnostic consultation was considered. |
| **Schizophrenia** |

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| SCHIZOPHRENIA Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment was completed. |
| SCHIZOPHRENIA Education was delivered regarding schizophrenia and its treatment to the member and the family. |
| **SCHIZOPHRENIA If significant risk was found,** the provider implemented a plan to manage the risk, including a plan for diminishing access to weapons/lethal means. |
| SCHIZOPHRENIA If provider was a not an MD, documentation of a referral for a psychiatric evaluation was included in the record. |
| SCHIZOPHRENIA If a psychiatric referral was made, the provider documented the results of that evaluation and any relevant adjustments to the treatment plan. |
| SCHIZOPHRENIA If provider was an MD, and if there was several unsuccessful medication trials and/or severe suicidality, then the member was considered for ECT and/or Clozapine. |
| **Generalized Anxiety Disorder-Adult** |
| GAD Diagnosis for GAD based on DSM-5 criteria |
| GAD Member received education from physician about GAD, options for treatment and general prognosis |
| GAD CBT based psychotherapy and/or psychopharmacotherapy considered as first line treatment. |
| GAD Ongoing monitoring of symptoms that are accessed for severity |
| **Generalized Anxiety Disorder-Children** |
| GAD Diagnosis for GAD based on DSM-5 criteria |
| GAD Member received education from physician about GAD, options for treatment and general prognosis |
| GAD CBT based psychotherapy and/or psychopharmacotherapy considered as first line treatment. |
| GAD Ongoing monitoring of symptoms that are accessed for severity |
| **Bipolar Disorder** |
| BPD Diagnosis is documented by type (acute manic, hypomania, mixed, or acute depressive episode) |
| BPD Complete psychological assessment documented First-line treatment: psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy |
| BPD Psychoeducation, psychotherapy and family intervention provides as indicated |
| BPD Evidence of monitoring medication and managing adverse effects |
| **Suicide Risk** |
| SUICIDE High to intermediate level of acute risk for suicide and Risk Assessment documented |
| SUICIDE Psychosocial evaluation completed |
| SUICIDE Assessment of lethal means and limited access to lethal means, if needed |
| SUICIDE Assessment for indications for inpatient admission |
| SUICIDE Safety plan development if risk is not imminent including social support |
| SUICIDE Continued monitoring of patient status and reassessment of risk in follow-up contacts |

| Oppositional Defiant Disorder |
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| Establish therapeutic alliance with child and family |
| Obtain information directly from the child and parents in assessment activities. |
| Obtain information from multiple outside informants. |
| Use questionnaires and rating scales in assessment and treatment. |
| Consider empirically tested interventions for parents. |
| Consider medications as adjuncts to treatment to address symptoms and comorbid conditions. |
| Consider intensive and prolonged treatment if ODD is severe. |
| **Post-Traumatic Stress Disorder** |
| PSTD Positive screening for PTSD including trauma exposure or previously diagnosed |
| PSTD Assess for severity of symptoms, danger to self or others |
| PSTD First-line treatment: psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy |
| PSTD Adjunctive Treatment: psychosocial therapy, supportive counseling, symptom-specific management, facilitate social or spiritual support. |