

## Major Depressive Disorders /Suicide Management Clinical Practice Guideline Audit Checklist

<b>REVIEWER INFORMATION</b>
Reviewer Name _____
Date of Review _____ CMC ID _____ Health Plan Code _____
<b>PATIENT INFORMATION</b>
Patient ID _____ Date of Birth _____
<b>PROVIDER INFORMATION</b>
Provider Name (Last, First)/Group Name /Credentials _____
Provider ID (MIS Number) _____
Date of Initial Assessment _____

### DOMAIN 1: DIAGNOSTIC ASSESSMENT

The provider assessed for and found sufficient evidence to support the diagnosis of major depressive disorder (MDD) and determined if complicating medical/psychiatric conditions were present. The initial evaluation included assessment for:

1a. HISTORY AND SYMPTOM PRESENCE AND DURATION that meet DSM-IV criteria for major depressive disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1b. A CO-MORBID SUBSTANCE-INDUCED DISORDER	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1c. OTHER PSYCHIATRIC DISORDERS that could account for the symptoms or complicate treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1d. PSYCHOSOCIAL STRESSORS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1e. MEDICAL CONDITIONS that may cause depression and/or complicate treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1f. PSYCHOTIC FEATURES	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1g. SEVERITY LEVEL OF MDD (E.G., MILD, MODERATE OR SEVERE)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1h. DANGEROUSNESS TO OTHERS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
1i. PAST HISTORY (of depressive episodes and treatment)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<b>2. If provider is a non-M.D., there is documentation of a referral for a medical/psychiatric evaluation if any of the following are present:</b> (psychotic features, complicating medical psychiatric conditions, severity level of moderate or above)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<b>DOMAIN 1 SUBSCORE:</b> _____			
# of items missed (number of "No's") _____			

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### DOMAIN 2: SUICIDE RISK ASSESSMENT AND MANAGEMENT

During the initial evaluation, the provider conducted a thorough suicide risk assessment that, at a minimum, included assessment for:

3a. CURRENT SUICIDAL IDEATION AND PLANS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3b. HISTORY OF SUICIDAL IDEATION AND ATTEMPTS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3c. PRESENCE OF HIGH RISK FACTORS, such as significant behavior change in teens, advanced age/debilitating illness/male senior citizens, insomnia, substance use/abuse, anxiety, recent inpatient discharge, history of violence, and/or gender identity disorder in teens	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3d. Plan for frequent evaluation for suicidal thinking or behavior in patients prescribed ANTI-DEPRESSANT MEDICATIONS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>If suicidal risk was found, the provider implemented a plan to manage the risk, which included:</b>			
3e. Assessment of LETHAL INTENT. Documentation shows interventions to address this with patient and response to measures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
3f. Assessment for access to any weapons or LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4a. Developed plan to DIMINISH ACCESS TO WEAPONS/LETHAL MEANS, if suicidal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4b. Developed PLAN FOR MAINTAINING SOBRIETY and discussed the role of substance use in increasing suicide risk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
4c. Attempted to INVOLVE FAMILY AND OTHER SUPPORT SYSTEM MEMBERS in suicide management plans, or documented why not appropriate	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4d. Documented ACTUAL FAMILY/SUPPORT SYSTEM INVOLVEMENT in suicide management plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<b>DOMAIN 2 SUBSCORE:</b> _____			
# of items missed (number of "No's") _____			

### DOMAIN 3: MAJOR DEPRESSIVE DISORDER THERAPEUTIC INTERVENTIONS

The provider documents in the treatment plan the following:

5. The provider assessed if psychotherapy was indicated	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. If psychotherapy was indicated, the provider specified the therapy type (e.g., CBT) and specific measurable goals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
7. The provider delivered education about MDD and its treatment to the patient, and if appropriate, to the family	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

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8. The psychiatrist delivered education about the medication, including signs of new or worsening suicidality and the high-risk times for this side effect	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
9. If a medical/psychiatric referral had been made (item #2), the provider documented the results of that evaluation and any relevant adjustments to the treatment plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
10. If evidence was found of a comorbid substance use disorder, the provider developed a plan to support sobriety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
11. If psychotic features were found, the treatment plan includes the use of either antipsychotic medication or ECT, or clear documentation why not	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
12. If MDD was of moderate severity or above, the treatment plan uses a combination of psychotherapy and antidepressant medication, or clear documentation why not	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
<b>DOMAIN 3 SUBSCORE:</b> _____			
# of items missed (number of "No's") _____			
<b>TOTAL SCORE:</b> _____			
<b>TOTAL # of items missed (number of "No's")</b> _____			

### Instructions

**1. Treatment Record Selection**

Select medical records with a diagnosis of major depressive disorder.

**2. Audit Process**

Using this audit tool, review the minimum necessary sections of the medical record, including the medication sheet, initial evaluation, progress notes and treatment plans.

**3. Scoring and Intervention Guidelines**

After auditing multiple records per provider, calculate the average total scores of items missed, and then apply the table below.

	Quantitative (Average score from all records reviewed)			Qualitative (if found on any record reviewed)
	0 - 3 average total score	3.1 - 6 average total score	> 6 average total score	
<b>Actions</b>	Essentially compliant, send letter A (unless qualitative applies)	Improvement opportunity, send letter B (unless qualitative applies)	Requires RNCC or designee review and letter C or individualized alternative to letter C (unless qualitative applies)	If item missed is 4a, or if both 4b and 4c are missed, then should go to RNCC or designee review and letter C, or alternative to letter C