DENVER HEALTH MEDICAL PLAN INC. DENVER HEALTH MEDICAID CHOICE

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_CG1011	**Effective Date: 11/2021**
Guideline Subject: Treatment of Depression in Adults in Primary Care Guideline	**Revision Date: 11/2022**
Page 1 of 6	**Obsoletes:**

Gregg Kamas — 10/13/2021

Quality Management Committee Chair **Date**

I. PURPOSE: To define recommended patterns of care for treatment of adult depression. Depression is a medical condition impacting patients, families, employers, and health care systems. Depression can worsen the prognosis for other medical conditions.

II. POPULATION: Adults 18 years of age and older.

III. GUIDELINE:

A. Consider the diagnosis of major depression based on chronic conditions and common presentations, even if the member does not initially complain of a depressed mood.
Conditions and symptoms considered high risk for depression include:
1. Chronic conditions (CVD, Diabetes, cognitive impairment), chronic pain, geriatrics, tobacco use, alcohol/substance misuse/abuse, chronic anxiety, history of abuse/trauma/PTSD, combat veteran, persistent anger/irritability, recent loss. (APA, 2019, pg. 14)
2. Presentations: Mood manifestations such as sadness, emotional distress, emotional numbness, or sometimes anxiety or irritability. Neurovegetative symptoms such as loss of energy, changes in sleep, appetite, or weight. Cognitive changes. Or somatic symptoms such as headache, abdominal or pelvic pain, back pain or other physical complaints. (Up To Date, Aug 2020). Symptoms of depression are commonly known by SIGECAPS or: sleep disorders; interest deficit; guilt; energy decrease; concentration deficit; appetite disorder; psychomotor retardation or agitation; suicidality (Maurer, Raymond, Davis, 2018).

B. Screening/diagnosing depression (Health Team Works, 2011):
Consider the use of universal screening for all patients, screening is required in cases of clinical suspicion for depression.

Screening

- Use Patient Health Questionnaire (PHQ)-2 or PHQ-9. PHQ-9 has been shown to be more effective in those with chronic disease.
- "In the past 2 weeks: Have you had little interest or pleasure in doing things? Have you felt down, depressed or hopeless?"
- If "yes" on either question, or a score ≥ 3, complete full PHQ-9. (The PHQ-9 is a validated tool for both detecting and monitoring depression in primary care settings. The tool is available in other languages at http://www.phqscreeners.com.

Further Assessment

Further assessment may be necessary to rule out bipolar disorder by asking:

- Have you ever had a period of time when you were feeling 'up' or 'high' or 'hyper' and so full of energy that you got into trouble or that other people thought you were not your usual self? (excluding alcohol or drug intoxication)
- Have you ever had periods of time where for several days you have had increased energy and have been persistently irritable so that you had arguments or verbal or physical fights, or shouted at people outside your family? (excluding alcohol or drug intoxication)

Other considerations:

- Recent life events (Why now?)
- History of depression/bipolar disorder or alcohol/substance misuse
- Patient's perception of problem: beliefs and knowledge about depression; cultural considerations
- Consider medical and medication causes
- Family history of depression, bipolar disorder
- Suicide risk
- Assess risk of harming others
- Screen for co-morbid psychiatric disorders
- Complementary/Alternative Medicine or other treatments currently used

C. Clinicians should use the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) criteria to determine diagnosis of major depression, persistent depressive disorder, other specified depressive disorder, and unspecified depressive disorder.
    1. Major depression can be diagnosed by having 5 of the following symptoms for 2 weeks (must include a and b)
        a. Depressed mood
        b. Marked Diminished interest and/or pleasure
        c. Significant weight loss or gain, appetite decrease or increase
        d. Insomnia or hypersomnia
        e. Psychomotor agitation or retardation
        f. Fatigue or loss of energy
        g. Feelings of worthlessness or inappropriate guilt
        h. Diminished concentration or indecisiveness
        i. Suicidal ideation: thoughts, plans, means, intent
        j. Hopelessness (Health Team Works, 2011)

D. Treatment and management (Health Team Works, 2011):

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Shared Decision Making	Promote Health Behaviors	Additional Considerations:	Consider Referral or Consult:
•Tailor treatment to individual patient •Provide education on diagnosis •Review treatment options (based on PHQ-9 score) •Discuss treatement barriers: family/work responsibilities, insurance, transportation •Negotiate Treatment Plan •Set Timeline: response, side effects and treatment duration •Educate on importance of adherence •Develop safety plan for suicidal ideation	•Exercise •Social Support •Faith/spiritual support •Healthy sleep pattern •Healthy diet •Alcohol only in moderation •Cessation of tobacco and illict drug use •Engagement in positive activities •Stress management •Educational books and online resources •Handouts to aid in patient education about depression, medications and counseling are attached in Appendix A	•Current or planned pregnancy: psychotherapy preferred if symptoms tolerable •Start with lower dose for anxiety or elderly •Cultural factors that influence treatment choice •SNRI or tricyclic for chronic pain •Level of functioning/activities of daily living •Discuss safety with the patient •Need for emergency services •Psychiatry referral, including ECT evaluation •Complementary/Alternative Medicine •Educate patients under age 25 about the risk of sucicial ideation with intitation of SSRIs	•Consider psychiatry consult/referral for the following: •Suicidal/Homicidal Patient •Bipolar Disorder •Co-occuring substance abuse •Psychotic features •Multiple medications •Consider referral to telphonic counseling for depression and anxiety as appropriate •Referral to appropriate disease management program as indicated

- For initial treatment it is recommended through shared decision making with the patient psychotherapy and/or second-generation antidepressants be offered. Always assess barriers to treatment, whether it be structural or attitudinal barriers. (APA, 2019, pg. 52 and 60)
- When using combined treatments of psychotherapy and pharmacotherapy it is important to consider the costs, risk of side effects and demands on the patient (APA, 2019, pg. 54).

Initial recommendations based on PHQ-9 are listed in the following table (Health Team Works, 2011).

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendations
5-9	Minimal Symptoms	Support, educate to call if worse; return in 1 month
10-14	Major Depression (mild)	Evidence-based psychotherapy equally effective as anti-depressant
15-19	Major Depression moderately severe	Evidence-based psychotherapy and/or anti-depressant
≥ 20	Major Depression, severe	Anti-depressant and psychotherapy (esp. if not improved on monotherapy)

See Attachment A for list of common antidepressant medications used at Denver Health.

E. Follow-up, Management, and Treatment Phases: Monitor and adjust treatment, monitor side effects:

1. Initial follow up should occur at 1-2 weeks (Health Team Works, 2011). The goal is to complete a medication and treatment plan evaluation(addressing the following issues) and provide an opportunity for the member to discuss any other concerns relating to treatment:
    a. Adherence to treatment plan
    b. Monitoring of adverse effects and adjustment of medications as necessary
    c. Assessment of mood/vegetative symptoms
    d. Assessment of suicidality or other at risk behavior (risk may increase during early treatment phase) (APA, 2010)
2. Subsequent follow up will occur every 4-8 weeks until remission or minimal symptoms (Health Team Works, 2011).
3. Acute Phase (Months 1-4)(Health Team Works, 2011):
    a. Treatment in the acute phase is aimed at inducing remission and achieving a full return to baseline level of functioning. Selection of initial treatment should be influenced by clinical features:
        - Severity of symptoms and presence of co-occurring disorders
        - Patient preference
        - Prior treatment experiences
    b. Medication:
        Selection of medication is based largely on anticipated adverse effects, safety and tolerability, pharmacologic properties, etc. Once an antidepressant has been selected, it should be titrated based on age, treatment setting, and presence of co-occurring disorders, concomitant pharmacotherapy, or adverse effects.

Incomplete response to treatment is associated with poor functional outcomes. The acute phase should not be concluded prematurely for those who do not fully respond (APA, 2010).

(Health Team Works, 2011)

Response	PHQ-9 score after 4-6 weeks	Treatment Recommendations
Responsive	Drop ≥ 5 points from baseline	No treatment change needed. Follow-up again after 4 weeks.
Partially Responsive	Drop 2-4 points from baseline	Often warrants increase in dose, possibly no-change needed
Non-Responsive	Drop 1 point or no change or increase	• Consider starting anti-depressant if receiving therapy alone • Review Psychological counseling options and preferences • Informal or formal psychiatric consultation • Medications:

		-Increase dose, Switch medication, or Augmentation (lithium, thyroid, stimulant, 2nd generation anti-psychotic, 2nd anti-depressant

c. Medication response should be assessed at 4 weeks. It takes 4-8 weeks to determine if the patient is only partially responsive or unresponsive to a specific intervention (APA, 2010)
d. If response to antidepressant treatment is inadequate consider the following:
   - Review evidence to ensure the diagnosis is correct
   - Evaluate compliance with medications and determine need for increased dosing or change in medications
   - If the member had 2 inadequate medication trials without good response, consider referral to psychiatry for further psychopharmacological management

3. Continuation Phase (Months 4-9):
   Goal: preventing relapse by maintaining antidepressant at acute phase doses, monitoring for adherence and continued efficacy. This phase begins after symptom resolution or with significant symptom reduction toward baseline.
   a. Treatment that was successful in the acute phase is continued, with less frequent monitoring (every 2-3 months)
   b. Continue medications at full strength and generally with the same anti-depressant as in acute phase, monitor for signs of relapse
   c. Depression-focused cognitive behavioral therapy is also recommended as applicable
4. Maintenance Phase for Recurrent Depression (<u>after</u> 6 months of symptom resolution)
   a. Recurrence rates for major depressive episodes are 50% after one episode and after three episodes the risk of recurrence is near 100% without prophylactic treatment (APA, 2010, pg. 81).
   b. Those with 3 or more episodes should be considered a candidate for lifetime antidepressant prophylaxis against recurrent episodes of depression
   c. Consider maintenance phase for those with additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders)
   d. Use PHQ-9 for ongoing monitoring (Health Team Works, 2011)
5. Tapering Anti-Depressant Medications:
   Consider tapering for those with 6 months of symptom resolution and a history of 2 or fewer major depressive episodes.
   a. Taper over several weeks with education about side-effects and relapse
   b. Monitor closely for symptoms of severe withdrawal (SSRIs and SNRIs may experience anxiety/agitation, sweats, paresthesias, in addition to flu-like symptoms) if this occurs, increase back to last tolerable dose and taper more slowly
   c. Diphenhydramine may help with anticholinergic withdrawal symptoms
6. Depression in pregnancy.
   a. In addition to the PHQ-9, the 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. Mothers who score above 9-13 are likely to be suffering from a depressive illness of varying severity but should not override clinical judgment. The scale indicates how the mother has felt during the previous week. In doubtful cases, repeat the tool after 2 weeks according to EPDS attachment instructions.

b. Consider appropriateness of starting/continuing an antidepressant in a pregnant woman
   - Utilize Micromedex to access updated medication information about data/safety concerns for pregnancy and breast feeding.
   - Do not use Paxil with pregnant woman, as this medication is now Category D. Paxil is recommended to be used with caution in women of child bearing age who are not on birth control.

c. Consider consultation with a psychiatrist for more complex presentations

IV. ATTACHMENTS:

Attachment A – List of common antidepressant medications for Denver Health as available on Policy Stat "Ambulatory Care Services Primary Care Adult Depression Guideline" ID #3571192
Attachment B – Edinburgh Postnatal Depression Scale (EPDS)
Attachment C – Patient Health Questionnaire 9 (PHQ-9)

V. REFERENCES:

American Family Physician. (2018, October, 15). *Depression: Screening and Diagnosis.* https://www.aafp.org/afp/2018/1015/p508.html

American Psychiatric Association. (2010, October). *Practice Guideline for the Treatment of Patients With Major Depressive Disorder.* https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

American Psycolological Association. (2019, February 16). *Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts*. https://www.apa.org/depression-guideline/guideline.pdf

Health Team Works. (2011, January 3). *Depression in Adults: Diagnosis and Treatement Guideline.* http://cohealthop.org/wp-content/uploads/2015/01/FINAL-Depression-Guideline_4-9-13.pdf

Common Antidepressant Medications for Denver Health

Drug	Usual total starting dose per day (mg)	Usual total dose per day (mg)	Extreme daily dose range (mg)
Selective serotonin reuptake inhibitors			
Citalopram	20	20 to 40	10 to 40
Fluoxetine	20	20 to 60	10 to 80
Paroxetine	20	20 to 40	10 to 50
Sertraline	50	50 to 200	25 to 300
Serotonin-norepinephrine reuptake inhibitors			
Venlafaxine	37.5 to 75	75 to 375	75 to 450
Venlafaxine XR	37.5	75 to 225	75 to 375
Atypical agents			
Bupropion	200	300 (maximum single dose 150 mg)	100 to 450
Bupropion SR	150	300 (maximum single dose 200 mg)	150 to 400
Bupropion XL	150	300	150 to 450
Mirtazapine	15	15 to 45	7.5 to 60
Serotonin modulators			
Trazodone	100	200 to 500	100 to 600
Tricyclics and tetracyclics			
Amitriptyline	25	150 to 300	10 to 300
Desipramine	25	150 to 300	25 to 300
Doxepin	25	150 to 300	25 to 300
Imipramine	25	150 to 300	10 to 300
Nortriptyline	25	50 to 150	10 to 150

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6 –8 week postpartum examination. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than 5 minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items. Validation studies have utilized various threshold scores in determining which women were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be referred immediately for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel.

Instructions for Users

1. The mother is asked to underline 1 of 4 possible responses that comes the closest to how she has been feeling the previous 7 days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Name:
Date:
Address:
Baby's Age:

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

*3 .I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10. The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J.M. Holden, R. Sagovsky
From: *British Journal of Psychiatry* (1987), 150, 782-786.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐