DENVER HEALTH MEDICAL PLAN INC. DENVER HEALTH MEDICAID CHOICE

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_CG1011

Effective Date: 11/2022

Guideline Subject: Treatment of Depression in Adults in Primary Care Guideline

Revision Date: 11/2023

Obsoletes:

Christine Seals Messersmith MD 11/1/22

Quality Management Committee Chair **Date**

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.

I. POPULATION:

Adults 18 years of age and older.

II. GUIDELINE:

A. Clinicians may need to suspect the diagnosis of depressive disorders based on chronic conditions and common presentations even if patients do 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, geriatric patients, tobacco use, ETOH/substance misuse/abuse, chronic anxiety, history of abuse/trauma/PTSD, combat veterans, persistent anger/irritability, recent loss.
2. Presentations: Multiple (more than five per year) medical visits, multiple somatic complaints, work or relationship dysfunction, dampened affect, changes in interpersonal relationships, poor behavioral follow-through with activities of daily living or prior treatment recommendations, weight gain or loss, sleep disturbance, chronic fatigue, memory/other cognitive complaints such as difficulty concentrating or making decisions, irritable bowel syndrome, volunteered complaints of stress or mood disturbance.

B. Screening/diagnosing depression: If there is suspicion or screening for depression:

1. Either the Patient Health Questionnaire (PHQ)-2 or the PHQ-9 can be used to screen for depression. There is stronger evidence supporting the use of the PHQ-9 in patients with chronic disease. Currently depression screening with the PHQ-2 is being performed on all adult patients at least once annually.
2. PHQ-2, ask patient "Over the past two weeks, have you experienced more days than not." The PHQ-2 is also part performed as part of the screening process for primary care clinics using the PHQ-4 (for depression and anxiety screening).
    a. Little interest or pleasure in doing things?
    b. Feeling down, depressed or hopeless?
    c. A total of 3 points or higher, should complete the PHQ-9 (see attachment A)
3. PHQ-9. The PHQ-9 has been validated for measuring depression severity and is validated as a tool for both detecting and monitoring depression in primary care settings. The tool is available in other languages at http://www.phqscreeners.com.
    a. Further assessment by the provider or behavioral health provider should rule out bipolar disorder before starting medications. The following questions can be asked to help identify.
        1. 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? (Do not consider times when you were intoxicated on drugs or alcohol.)
        2. Have you ever had periods of time where for several days you had increased energy and were persistently irritable so that you had arguments or verbal or physical fights, or shouted at people outside your family? (Do not consider times when you were intoxicated on drugs or alcohol.)
    b. Other considerations:
        1. Recent life events (why now?)
        2. History of depression, or alcohol/substance misuse
        3. Patient's perception of problem: beliefs and knowledge about depression
        4. Cultural considerations (language, stigma, influence on symptom presentation)

NOTE:

This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinicians judgment or to establish a protocol for all patients with a particular condition.

5. Consider medical and medication causes of depression
6. Family history of mental illness
7. Suicide risk (thoughts, plans, means, previous attempts, recent exposure). "Are you thinking of harming or killing yourself?"
8. Assess risk of harming others
9. Screen for co-morbid psychiatric disorders: anxiety, PTSD, panic disorder, tobacco, substance misuse
10. Complementary/alternative medicine or other treatments currently used

C. Treatment and management:

1. Initial treatment:

a. When depression diagnosis has been made, a shared decision-making process should be incorporated.
   1. Shared decision-making is a practice that guides patients, families, and physicians through a reliable process that incorporates patient values, priorities, and goals into discussions of risks and benefits of treatment options.
   2. Methods and patient information handouts to aid in educating the patient about depression, medications and counseling are addressed in Reference C.
   3. Consider referral to your clinic's behavioral health provider or tele-counseling.
   4. Consider referral to DH OBHS or other community mental health resources.

b. Remember to educate patients under 25 about the risk of suicidal ideation that can be seen after the initiation of SSRIs. Consider psychiatry consult or referral for the following conditions: suicidal patient, homicidal patient, bipolar disorder, co-occurring substance abuse, psychotic features, and/or multiple failed psychiatric medications.

c. Initial recommendations based on PHQ-9 are listed in the following table.

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 equaly effective as antidepressant
15-19	Major Depression (moderately severe)	Evidence-based psychotherapy and/or antidepressant
≥20	Major Depression (severe)	Evidence-based psychotherapy and/or antidepressant

*Consider consultation with behavioral health consultant assigned to the clinic to help co-manage the patient.

2. Follow up and management

a. The goal of acute phase treatment is remission (PHQ-9 Score of < 5 points) or minimal symptoms (PHQ-9 Score of 5-9 points). Patients who achieve this goal are considered to reach the "continuation phase of treatment."

b. First follow-up contact at 2-4 weeks to determine compliance with medications, medication side effects and/or clinical response. Subsequent follow up every 4-8 weeks (consider telephone contact in some cases) until remission or minimal symptoms. Perform ongoing suicide risk assessment; risk may increase during early treatment phase. Attachment B lists examples of frequently used medications.

c. Acute Phase (until symptom resolution):

Response	PHQ-9 score after 4-8 weeks	Treatment Recommendations
Responsive	Drop ≥5 and overall score <15	No change in medication, support, educate to call if worse; return in 1 month
	Drop >5 and overall score ≥15	Strongly consider increasing dose
Partially Responsive	Drop 2-4 points	If PHQ-9 <15, consider evidence-based psychotherapy If PHQ-9 ≥15, strongly consider increasing dose
Non-Responsive	Drop 1 point or no change or increase	Increase dose if starting with low dose, especially if there is "subjective" improvement stated by patient. Consider switch to another class of antidepressant. At max dose, consider augment with Wellbutrin. Review psychological counseling options and preferences.

d. Continuation Phase (for 6 months following symptom resolution)
   1. Begins after symptom resolution, continue medications at full strength.
   2. Contact every 2-3 months (telephone appropriate in some cases) monitoring for signs of relapse
   3. Generally, use same anti-depressant dose as in acute phase

e. Maintenance Phase for Recurrent Depression (after 6 months of symptom resolution)
   1. For patient with history of 3+ episodes of major depression or persistent depressive disorder
   2. Also consider for patient w/ additional risk factors for recurrence (family history, early age onset, ongoing psychological stressors, co-occurring disorders)
   3. May need to maintain for lifetime
   4. Use PHQ-9 for ongoing monitoring

f. Tapering antidepressant medications, consider for those with 6 months of symptom resolution and a history of 2 or fewer major depressive episodes (examples of common antidepressants are listed in Attachment C).
   1. Taper over 1-2 months with education about side effects and relapse. Generally, decrease the dose by 1/3 to 1/2 every 1 to 2 weeks.
   2. Symptoms can include Flu-like symptoms, SSRIs and SNRIs may also experience anxiety/agitation, sweats, paresthesias.
   3. Severe withdrawal symptoms – consider increasing back to last tolerable dose and tapering more slowly.

4. Diphenhydramine may help with anticholinergic withdrawal symptoms.

3. Depression in pregnancy
   a. In addition to the PHQ-9, the 10-question Edinburgh Postnatal Depression Scale (EPDS, Attachment D) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. Mothers who score above 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 it may be useful to repeat the tool after 2 weeks.
   b. It may be appropriate to continue or start an antidepressant in a pregnant woman.
      1. Micromedex has a function that allows you to access updated information about data/safety concerns for individual meds in pregnancy and breast feeding.
      2. Do not use Paxil as this is now Category D.
      3. Paxil should be used with caution in women of child bearing age who are not on birth control.
   c. Consider consulting with psychiatry or referring to the high risk OB clinic for complicated presentations.

III. ATTACHMENTS:

Attachment A – PHQ-9, Depression Screening Questionnaire
Attachment B – Common Antidepressants (UpToDate)
Attachment C – Suggested Dose Reductions for Tapering Off Common Antidepressants
Attachment D – Edinburgh Perinatal Depression Scale

IV. REFERENCES:

A. Health TeamWorks Guideline, http://www.healthteamworks.org/guidelines/depression.html, January 2011, updated in April 2013.
B. Trangle M, Dieperink B, *et al.*, Major depression in adults in primary care. Institute for Clinical Systems Improvement (ICSI); May 2012
C. Site for patient education material: http://dhpulse.hosp.dhha.org/EducationTraining/pafe/Pages/GeneralTopicBehavioralHealth.aspx with specific handouts for:
   1. What is depression?: http://pulse/clinical/pafe/PDF%20Files/E20-511%20What%20is%20Depression.pdf
   2. What is suicide?: http://pulse/clinical/pafe/PDF%20Files/E20-324%20What%20is%20Suicide.pdf
   3. Medication side effects: http://pulse/clinical/pafe/PDF%20Files/E20-088%20What%20are%20Medication%20Side%20Effects.pdf#search=medication%20side%20effects
   4. Sleep hygiene: http://pulse/clinical/pafe/PDF%20Files/E20-1122%20Sleep%20Hygiene.pdf
   5. What is anger?: http://pulse/clinical/pafe/PDF%20Files/E20-557%20What%20is%20Anger.pdf
D. Community Health Services – Standard Work:
   1. ACS Primary Care Adult Depression Standard Work
   2. ACS Primary Care Adult Depression Process Map

Signature: Christine Seals Messersmith MD
Christine Seals Messersmith MD (Nov 3, 2022 08:05 MDT)

Email: christine.seals@dhha.org

NOTE:
This guideline is designed to assist providers by providing an analytical framework for the evaluation and treatment of patients, and is not intended either to replace a clinicians judgment or to establish a protocol for all patients with a particular condition.

2022 Depression Guidelines - Signature Needed

Final Audit Report 2022-11-03

Created:	2022-11-03
By:	Jacqueline De La Torre (Jacqueline.DeLaTorre@dhha.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAA5Bvox1px3f1-XJfIU6Rb5Dyj25F1RP0O

"2022 Depression Guidelines - Signature Needed" History

Document created by Jacqueline De La Torre (Jacqueline.DeLaTorre@dhha.org)
2022-11-03 - 1:55:40 PM GMT

Document emailed to christine.seals@dhha.org for signature
2022-11-03 - 1:56:46 PM GMT

Email viewed by christine.seals@dhha.org
2022-11-03 - 2:04:38 PM GMT

Signer christine.seals@dhha.org entered name at signing as Christine Seals Messersmith MD
2022-11-03 - 2:04:58 PM GMT

Document e-signed by Christine Seals Messersmith MD (christine.seals@dhha.org)
Signature Date: 2022-11-03 - 2:05:00 PM GMT - Time Source: server

Agreement completed.
2022-11-03 - 2:05:00 PM GMT