Palmetto Health Quality Collaborative

Care Map

Management of Depressive Disorders in Primary Care

IMPORTANCE OF FOCUS

Up to 10% of patients seen in the primary care setting meet the criteria for major depressive disorder. The prevalence may be 30%-40% among patients with such chronic medical illnesses as coronary artery disease (CAD), cerebrovascular disease, diabetes mellitus, obesity, and human immunodeficiency virus (HIV). Untreated depression my help explain poor adherence to appointment keeping and prescribed treatments.

Research has shown that %45 of patients who commit suicide visited their primary care doctor in the month leading up to their death while only %19 had seen a mental health provider.

Appropriate recognition and treatment of depressive disorders in the primary care setting can significantly improve patient outcomes and decrease mortality.

GOALS

The overall goal of this Care map is to improve the care of adults entering the primary care setting with major depression by increasing compliance with evidence-based practice guidelines.

The ultimate treatment goal for the patient is to achieve remission, return to optimal level of psychosocial functioning, and to prevent the relapse and recurrence of depression.

KEY RECOMMENDATIONS

- Initial assessment should include a thorough diagnostic evaluation including consideration of medical conditions or substance use disorders which can mimic depression.
- Utilize standardized measures to screen for initial symptoms and monitor the patient's response to treatment.
- Referral for psychotherapy or counseling is appropriate to consider at any stage of treatment.
- Therapeutic benefits of antidepressants are often not apparent for several weeks and full benefits may not be fully realized for up to 12 weeks.
- Assess for suicide risk at each visit and counsel patient on ways to access emergency care.
- Avoid use of short-acting benzodiazepines like alprazolam, particularly in patients who use alcohol or patients taking opioid pain medications.

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CARE PATHWAY COMPONENTS

Initial Visit

- Diagnostic Evaluation
  - Establish diagnosis, review DSM-5 criteria
  - PHQ-9 (record initially ratings in the record)
  - MDQ
    - If positive:
      - Carefully screen for history of mania (Please note that mania is a sustained period of elevated or irritable mood lasting days, weeks, or even months. Sudden, brief "mood swings" or a situational irritability are not suggestive of Bipolar Disorder.
      - Consider psychiatry referral
  - Screen for co-morbidities (substance use, medical conditions)
  - Suicide risk assessment (Columbia Scale)
- Initial Treatment Plan
  - Consider referral to counselor/therapist for psychotherapy(alone for less severe cases or in combination with medications)
  - Start antidepressant
    - SSRI (see list) is first choice
    - Consider patient's preference and prior response to medication
    - Take caution if MDQ or patient history is suggestive of mania
  - Counsel patient on expected time to onset of action for medication and the importance of taking the medication **every day** as prescribed
  - Provide suicide hotline number and other educational resources.
  - Schedule follow up in 2 weeks

Follow Up Visit #1

- Re-assessment
  - PHQ-9
  - Suicide risk assessment
  - Inquire about side effects

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- Treatment Plan
  - Continue initial medication if tolerated (Do not stop medication due to lack of efficacy at this point)
  - If initial medication not tolerated, consider switch to a different SSRI
  - Schedule follow up in 2-4 weeks (depending on severity)

Follow Up Visit #2

- Re-assessment
  - PHQ-9
  - Suicide risk assessment
  - Inquire about side effects and patient's perception of symptom improvement
- Treatment Plan
  - If no response
    - Consider switch to different SSRI, SNRI, or Bupropion*
  - If partial response
    - Maximize dose as tolerated
    - Refer to counselor/therapist for psychotherapy if not already done
    - Consider referral to psychiatrist to re-evaluate medication regimen
  - Schedule follow up in 2-4 weeks (depending on severity)

Subsequent Follow Up Visits

- Re-assessment
  - PHQ-9
  - Suicide risk assessment
  - Inquire about side effects and patient's perception of symptom improvement
- Treatment Plan
  - If no response or partial response
    - Consider trial of mirtazepine
    - If 2 or more failed trials of monotherapy, consider venlafaxine combined with mirtazepine
    - Consider referral to psychiatry
  - Schedule follow up in 2-4 weeks (depending on severity) until patient reports resolution of symptoms.

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Antidepressant Classes:

SSRI: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertaline

SNRI: venlafaxine, desvenlafaxine, duloxetine, levomilnacipram

NDRI: bupropion

Other:
mirtazepine (antagonist/inverse agonist at serotonin and noradrenergic receptors)
vortioxetine, vilazodone (serotonin modulators)
Tricyclic Antidepressants (i.e. amitriptyline)*
MAOI's (i.e. selegiline)*

***Special Considerations:**

- All antidepressants have similar efficacy, although there is substantial variation in response from one patient to the next
- **Fluoxetine** has a very long half-life, requiring a washout period of at least 5 weeks. Slower dose titration may be required when switching to another serotonergic medication
- **Buproprion** may lower seizure threshold and **should not be used** in patients with a history of seizures or eating disorder

- **Venlafaxine** may cause elevation in blood pressure and should be used with caution in patients with a history of severe hypertension or cardiovascular risk factors
- **Mirtazepine** can be sedating and tends to promote appetite (with resulting weight gain)
- **Milnacipram** is an SNRI approved for the treatment of Fibromyalgia. It is not approved for the treatment of depression, but has a very similar mechanism of action compared to other SNRI's. Please note that combining this with SSRI's or SNRI could result in serotonin syndrome.
- TCA's and MAOI's require increased caution due to the potential for serious side effects and drug interactions. These medications are typically reserved for patient who have failed to respond to lower risk medications.

Use of Benzodiazepines

- Anxiety is a very common symptom in patients suffering from depressive illness
- Although benzodiazepines provide short-term relief of anxiety, they are poor long-term options

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- Benzodiazepines are strongly associated with both physiologic and psychological dependence
- Over-time, these medications may decrease your patient's ability to cope with anxiety
- Once tolerance and physiologic dependence develop, withdrawal symptoms can be mistaken for anxiety
- Short-acting benzodiazepines like alprazolam are most problematic and should be avoided
- Use of benzodiazepines in combination with opioid pain medications or alcohol is associated with **potentially fatal** side effects and should be avoided whenever possible

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WHEN TO REFER

Emergency Referral (Either direct admission or ED referral):

1. Physician concern about immediate risk of suicide.
2. Presence of delusions or hallucinations which are directly impacting patient's behavior (for example, the patient is not eating due to command hallucinations).
3. Inability to care for basic needs (as evidenced by objective signs of self-neglect).

Routine Referral:

1. Failure to respond to 2 or more adequate antidepressant trials.
2. History of suspected manic symptoms.
3. Presence of (or suspicion of) psychosis (hallucinations, delusions, disorganized thoughts).
4. Patients with co-morbid conditions (substance use, personality disorders, etc)

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REFERENCE MATERIALS

STABLE RESOURCE TOOLKIT

The Mood Disorder Questionnaire (MDQ) - Overview

The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers and consumer advocates to address the need for timely and accurate evaluation of bipolar disorder.

Clinical Utility

- The MDQ is a brief self-report instrument that takes about 5 minutes to complete.
- This instrument is designed for *screening purposes only* and is not to be used as a diagnostic tool.
- A positive screen should be followed by a comprehensive evaluation.

Scoring

In order to screen positive for possible bipolar disorder, all three parts of the following criteria must be met:

- "YES" to 7 or more of the 13 items in Question 1 **AND**
- "Yes" to Question number 2 **AND**
- "Moderate Problem" or "Serious Problem" to Question 3

Psychometric Properties

The MDQ is best at screening for bipolar I (depression and mania) disorder and is not as sensitive to bipolar II (depression and hypomania) or bipolar not otherwise specified (NOS) disorder.

Population /type	Sensitivity & Specificity
Out-patient clinic serving primarily a mood disorder population[1]	Sensitivity 0.73 Specificity 0.90
General Population[2]	Sensitivity 0.28 Specificity 0.97
37 Bipolar Disorder patients 36 Unipolar Depression patients[3]	Overall Sensitivity 0.58 (BDI 0.58-BDII/NOS 0.30) Overall Specificity 0.67
Primary care patients receiving treatment for depression[4]	Sensitivity 0.58 Specificity 0.93

1. *Hirschfeld RMA. et, al. Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire, Am J of Psychiatry, 2000, 157:1873-1875.*
2. *Hirschfeld RMA. The mood disorder Questionnaire: A simple, patient-rated screening instrument for bi-polar disorder. Journal of Clinical Psychiatry Primary Care Companion 2002; 4: 9-11.*
3. *Miller CJ et al, Sensitivity and specificity of the Mood Disorder Questionnaire for detecting bipolar disorder. J Affect Disorder 2004. 81: 167-171.*
4. *Hirschfeld RMA, et al. Screening for bipolar disorder in patients treated for depression in a family medicine clinic. JABFP 2005, 18: 233-239.*

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STABLE RESOURCE TOOLKIT

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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 _____

A2663B 10-04-2005

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Visit	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
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RESOURCES

DSM-V, American Psychiatric Association

MDQ

PHQ9

Columbia Suicide Risk Scale (Also available in CERNER)

STAR*D Treatment Algorithm 2011 (http://www.edc.gsph.pitt.edu/stard/public/)

American Psychiatric Association (APA). Practice guideline for the treatment of patients with major depressive disorder. 3rd ed. Arlington (VA): American Psychiatric Association (APA); 2010 Oct.

For Additional Information

Palmetto Health Assessment and Referral 434-4813

National Suicide Hotline 1-800-273-8255

National Alliance on Mental Illness: www.nami.org

American Psychiatric Association: www.psychiatry.org

For additional information on this clinical pathway, please contact Dr. Jeffery Raynor at Jeffery.raynor@palmettohealth.org

Reviewed/Updated 9/24/15