Treating Depression to Remission in the Primary Care Setting

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Goals of this "mini-training":

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- Understand why it's important to take the time to screen for depression and prepare patients adequately for depression treatment
- Understand how practices engage and track patients in getting their depression to remission
- Learn how to access resources that can improve the care of your patients and ideally make your practice more efficient
- Identify opportunities to consult on clinical situations that may be more complex than what you commonly treat on your own

Importance of treating depression in the primary care setting

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How Common Is Depression In Primary Care?

- Between 5 percent and 9 percent of adult patients in primary care suffer from depression and up to 2 percent of children and 4 percent of adolescents suffer from this illness
- Depression costs $17 billion in lost workdays each year
- Those most at risk for depression include women, those with a family history of depression, the unemployed, and persons with chronic disease
- Despite a relatively high prevalence in primary care and its substantial economic impact, depression often goes unrecognized in the primary care setting

What are the virtues of the various depression screening tools?

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- Depression assessment scales, which ask patients to rate the severity or frequency of various symptoms
- Depression symptom count instruments, which are based on depression criteria
- Advantage of assessment scales is that they can give a sense of severity of symptoms and their functional impact
- Advantage of symptom count instruments is that they help to establish more firmly whether a clinical picture "meets the criteria" for a depression diagnosis, but may not fully take into account its functional impact
- PHQ-9 incorporates the best elements of both approaches

For when time is limited: using a two-question test

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- Over the past 2 weeks, have you ever felt down, depressed, or hopeless?
- Over the past 2 weeks, have you felt little interest or pleasure in doing things?
- Predictive value positive measured at up to 30 percent
- May be helpful in practices where time is limited
- Allows the practitioner to drill down with more detail if a positive screen or other mood symptoms are apparent

Drilling down: PHQ-9 Prime MD questionnaire

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Over the past 2 weeks, how often have you been bothered any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Trouble falling/staying asleep, sleeping too much
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself – or that you are a failure or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- 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.
- Thoughts that you would be better off dead or of hurting yourself in some way.

Drilling down with the PHQ-9

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- Rated by 0-3 point scale (not at all, several days, more than half the time, nearly every day)
- Score less than 4 not suggestive of depressive illness
- Score 15 or greater suggestive of depressive illness, specifically recommends psychotherapy, medication or both in combination
- In between, suggests that clinicians use their best judgment in the context of symptom duration and level of functional impairment
- Scoring: Predictive value positive up to 55%
- May be more effective than simple "symptom count" screens in that it combines the symptoms with a severity rating
- May be easily incorporated into review of systems
- Helps to distinguish depression from other psychiatric illness
- Assists PCPs to quickly incorporate depression treatment with their treatment of other acute or chronic medical illness

How does the data inform your practice?

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- Important to strategize in advance on how you plan to use the data, rather than just keep it for its own sake
- Most successful practices use the screening score as the first data point in a depression registry
- Health plans support registries by uploading data for new antidepressant medication starts in a secure website
- May choose to do serial PHQ-9 measurements over time to determine if improvement has occurred
- Patients may get outreach calls (CPT code 99371-99373) from nurses or other staff to ensure that there are not questions about the medicine, or to check for side-effects early in the medication trial
- May choose to focus efforts of your staff in handling medically "high risk" patients (e.g. may choose to focus on depressed diabetic or cardiac patients first)

How to incorporate screening into your practice

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How should a busy clinician implement screening?

- Ease of administration and interpretation of the test are key
- Ideally, a depression screen should function similarly to a vital sign, providing an easy-to-assess yet reliable marker of the need to address a patient's depression
- It is not enough to know that formal depression criteria are met; it is also important to know whether a patient's functioning is impaired
- It is difficult in primary care to "clinically" assess functioning in the face of numerous competing demands, even when clinicians know from a screening test that a patient meets criteria for depression
- For this reason, even watchful waiting for the "positive screening/low impairment" patients may be difficult to put into practice
- Certain patients may expect you to "do something" with a positive test, even though impairment may be relatively mild
- Certain other patients may resist any treatment at all, in spite of clear functional impairment and likely benefit of treatment

Clinical situations where it is important to treat depression

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- Chronic pain or other somatoform illness
- Endocrinologic illness (e.g. diabetes, thyroid)
- Post myocardial infarction
- Post stroke
- Depression as a side-effect of a treatment for another disorder
- Depression the context of a physical disability
- Depression in the context of a life-threatening illness (cancer, COPD)
- Depression in the context of addiction
- *(And many other clinical situations that you will encounter…)*

Risks of not treating depression to point of remission

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- Risk of under medicating by keeping a patient on a starting dose of an antidepressant
- Risk of discontinuing the medication too soon
- Risk of patient non-adherence to an otherwise effective medication regimen

Example of an antidepressant guide for Primary Care Providers

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Recommended Antidepressants

Drug/Class	Brand Name	Initial Dose	Dosage Range (mg/day)	Contraindications: Avoid Combining any of these Antidepressants with MAOIs.	Considerations	Compliance and Adequacy of Response
Selective Serotonin Reuptake Inhibitors (SSRIs)						
Citalopram	Celexa	20 mg qAM	20-60		Management of insomnia, either as a side effect or residual symptom: consider trazodone 25-100 mg or zolpidem 5-10 mg. If sedation in AM, try giving dose at night. Sexual side effects affect about 30% (delayed ejaculation, decreased libido): manage by switching to non-SSRI or in males may use sildenafil or other similar agents. Avoid paroxetine if weight gain is a concern. Avoid paroxetine and fluoxetine if patient on P450 2D6 substrates such as metoprolol, risperidone. Be aware of small risk of increased suicidality particularly in adolescents, young adults, and the elderly. Risk of osteoporosis from long term use. Monitor anticoagulants more closely in combination with SSRIs.	If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another SSRI or other antidepressant with less of a tendency for that side effect.
Sertraline	Zoloft	50 mg qAM	50-200			
Fluoxetine	Prozac	20 mg qAM	10-80			
Paroxetine	Paxil	20 mg qAM	10-50			
Escitalopram (only SSRI that is non-generic). *May require additional utilization management. Tier 3.*	Lexapro	10 mg qAM	5-20			
Tricyclic Antidepressants (TCAs)						
Amitriptyline	Elavil	25 mg bid	50-300	Significant cardiac abnormalities (acute recovery period after MI, arrhythmias). Patients at high risk of overdosing. First degree AV block, prolonged QT interval, or bundle branch block.	Risks from anticholinergic side effects, especially in the elderly, such as prostatic hypertrophy, constipation, dry mouth (can give severe dental decay with long term use). Check plasma level if many side effects and at least once at full doses to rule out toxic levels due to pharmacogenetic variations. Falls and hypotension significant issue with TCAs.	Most patients tolerate desipramine and nortriptyline best. If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to a less anticholinergic agent (e.g.desipramine); if still not successful, consider switching to another antidepressant. (Amitriptyline has a very high side effect profile, is rarely used as an antidepressant now - but it is still used often in low doses for pain management).
Desipramine	Norpramin	25 mg bid	50-300			
Imipramine	Tofranil	25 mg bid	50-300			
Nortriptyline	Pamelor	10 mg bid	50-200			
Others						
Nefazodone	Serzone	50 mg bid	300--600		Reduced likelihood of sexual dysfunction as a side effect. No weight gain. Rarely causes activation as a side effect the way SSRIs can. May cause severe fulminant hepatitis in rare cases. Increased risk of hepatoxicity makes it second line. Start with lower dose if patient on 2D6 blocking medication like fluoxetine, paroxetine, or bupropion - which might increase level of an anxiogenic metabolite.	If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another antidepressant.
Bupropion SR *May require additional utilization management. Tier 3*	Wellbutrin SR	100 mg QD	100-400	Bulimia, anorexia nervosa, seizure disorder history.	Lower incidence of sexual side effects; slightly less likely to induce mania. Should be taken early in the day; 8 hours between doses; max of 200mg/dose. Constipation most common side effect.	If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another antidepressant. Bupropion XR available for once-daily dosing, in AM: very costly.
Venlafaxine SA *May require additional utilization management. Tier 3*	Effexor	37.5 mg BID	75-225	.	Sexual side effects similar to SSRIs. Costly. Inhibits both serotonin and norepinephrine. Can increase blood pressure, so BP should be monitored. Generally used as second line after failure to improve with or tolerate another antidepressant.	If noncompliance persists after temporary dose decrease and is side-effect related, or is due to moderate response, consider switching to an SSRI, a TCA, nefazodone or buproprion. Effexor XR available for once-daily dosing, in AM.
Mirtazapine	Remeron	15mg qd hs	15-45mg qd		Low incidence of sexual side effects, but is sedating and causes weight gain often. Enhances both noradrenergic and serotonergic activity. Use with caution with patients with hx of leucopoenia and hepatic dysfunction.	Utilize SSRIs prior to mirtazapine because of side effect profiles, unless avoidance of sexual side effects is a high priority and weight gain risk is acceptable.
NOTES:						
1 All antidepressants should be used with caution during pregnancy; SSRIs are the most studied and are reasonably safe regarding teratogenicity but some concerns about pulmonary hypertension in neonates. Sertraline may have less risk with breast feeding. Pregnancy and Lactation may indicate the need for a specialist consultation. Most up to date data should be sought.						
2 Assess at 1,2, and 4 weeks after initiation (phone contact with nurse adequate), and at 6-8 weeks after reaching therapeutic range, assuming treatment compliance.						
3 Duration of Treatment for All Medications: A. If patient experiences full recovery, continue treatment for 6-12 months from point of full remission. Taper medications over 4-6 weeks (especially important with paroxetine, least important with fluoxetine because of very long half-life of active metabolite). B. If this is third depressive episode, maintenance treatment at full dose is recommended. Additional Dosing Information: Tricyclics. Most physically healthy young to middle-aged adults can tolerate an initial dose of 50mg/day if needed. Increase dose 25 mg every 3-4 days as tolerated until full recovery, emergence of significant side effects, or maximum therapeutic range is reached. SSRIs. Suggested dosing: initiate with starting dose for one month except citalopram increase to 40 mg after one week routinely if tolerated. If after a month there is no response of the response has plateaued at an unsatisfactory level, increase daily dose as follows: sertraline, 50 mg, paroxetine,10-20 mg, citalopram, 20 mg, fluoxetine 10-20 mg.						
4 Other antidepressants: Duloxetine (Cymbalta), Selegiline patch, Olanzapine/fluoxetine combination (Symbyax): seek specialist consultation.						

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HEDIS goals for antidepressant medication management

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For patients newly diagnosed with depression:

- 3 follow-up visits with practitioners within a 12 week period (one must be with a prescribing clinician)
- Adherence to medication in the acute treatment phase (initial 12 weeks)
- Adherence to medication in the continuation treatment phase (6 month period)
- Adherence rate is measured by the number of days elapsed between scheduled prescription fills and whether there was a "gap" of time in between

Potential difficulties in medication management for your patient

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- The patient won't come into the office for follow up
- The patient isn't taking the medication according to the prescribed regimen
- The patient isn't taking the medication at all
- The patient may be using alcohol or other drugs that interfere with potential beneficial effects of the medication
- The patient refuses to consider medication for depression

Strategies for assisting patients with medication management

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- Telephonic nurse case management to track visits and medication compliance
- Potential home visits for patients having difficulty coming into the office
- Web-based and telephone-based reminder systems that help patients remember their medication regimens
- Having behavioral health practitioners on-site during certain hours of the week
- Others that local medical practices may have identified that work well for their patients

Reminder on when to change or supplement medication

- May want to consider a second agent when the member has had a partial remission, but still is depressed
- May want to consider another medication when the member has side-effects that are not tolerable
- May want to change medication when a previously effective medication is reported to no longer be helpful

When to seek consultation on a complex clinical situation

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- PCPs should never feel "alone" in managing complex patients
- Suggest consultation when a member has onset of self-destructive or suicidal impulses
- Suggest consultation when a member has onset of aggressive or homicidal impulses
- Suggest consultation when you've treated several approaches to treat a depression that don't appear to be working
- Suggest consultation when treating a member with an unusually complex personality

Risk management suggestions in dealing with depressed patients

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- Important to monitor the patient's response to medication on a regular and frequent basis, especially as you begin treatment
- Important to note any clinically significant changes to the patient's mental status, especially an increase in self-destructive thoughts or behaviors
- Important to note any consultation that you have obtained for complex patients and any subsequent changes in treatment that you've made
- Important to show that you or office staff reached out to patients who have begun treatment, if they have missed an appointment
- Important to show that you are practicing within your "realm of expertise" (e.g. not medicating with a third-line monoamine oxidase inhibitor unless you have significant experience in such treatments)
- Malpractice juries do not expect perfection, but do expect that treatments adhere to the community standard of care
- Your documentation demonstrates adherence to the community standard

  "If you didn't document it, it didn't happen…"

Final Words

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- Depression treatment isn't "rocket science"
- It takes preparation of the patient to improve the likelihood of an effective treatment outcome
- Patients' low motivation may interfere with your efforts to engage them and keep them in treatment
- It is worth the effort
- Effective depression treatment saves lives and allows people to be more productive
- Please don't hesitate to contact me with questions: james.slayton@phs.com