Treating Depression to Remission in the Primary Care Setting

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Goals of this “mini-training”:

• 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

How Common Is Depression In Primary Care?

• **B**etween 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

• **D**epression costs $17 billion in lost workdays each year

• **T**hose most at risk for depression include women, those with a family history of depression, the unemployed, and persons with chronic disease

• **D**espite 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?

• 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

- 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
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

- 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?

• **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 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

- 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

- 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

#### Recommended Antidepressants

<table>
<thead>
<tr>
<th>Drug/Class</th>
<th>Brand Name</th>
<th>Initial Dose</th>
<th>Dosage Range (mg/day)</th>
<th>Contraindications: Avoid Combining any of these Antidepressants with MAOIs</th>
<th>Considerations</th>
<th>Compliance and Adequacy of Response</th>
</tr>
</thead>
</table>
| Selective Serotonin Reuptake Inhibitors (SSRIs) | | | | | Management of insomnia, effect as a side effect or serious symptom: consider trazodone 25-100 mg or zopiclone 5-10 mg at bedtime, or try drugging dose at night. Serious side effects involved in about 30% (delayed myalgia, delayed rigidity) manage dry swallowing in time. | If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.
| Citalopram | Cipramil | 20 mg qAM | 20-50 | | | |
| Escitalopram | Lexapro | 10 mg qAM | 5-20 | | | |
| Fluoxetine | Prozac | 20 mg qAM | 20-60 | | | |
| Paroxetine | Paxil | 20 mg qAM | 10-60 | | | |

#### Trazodone (LCAs)

- Avoid in patients low dose trazodone and nortriptyline (LCs) persistence.
- If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.

#### Other Antidepressants

- **Nortriptyline**
  - **Sezarine**
  - **50 mg qID**
  - **50-300 mg**
  - Management of insomnia, effect as a side effect or serious symptom: consider trazodone 25-100 mg or zopiclone 5-10 mg at bedtime, or try drugging dose at night. Serious side effects involved in about 30% (delayed myalgia, delayed rigidity) manage dry swallowing in time. | If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.

- **Bupropion SR**
  - **Wellbutrin SR**
  - **100 mg qID**
  - **100-300 mg**
  - | If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.

- **Venlafaxine SR**
  - **Effexor**
  - **75-225 mg qID**
  - | If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.

- **Sertraline**
  - | If noncompliance persists after temporary dose decrease and is side-effect related, consider switching to another from or other antidepressant with less side effects.

#### Notes

1. Antidepressants should be used with caution during pregnancy. SSRIs and the most studies are the safest. Avoid combining any of these with MAOIs.
2. The use of antidepressants should be avoided in patients with a history of serious side effects.
3. Compliance and adequacy of response may be affected by other medications, age, and other medical conditions.
4. Other antidepressants: **Citalopram (Citalomax), escitalopram (Lexapro)**. Consult a specialist for these medications.

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HEDIS goals for antidepressant medication management

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

• 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

- 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

• 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

• 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

• 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