Physician Services

System Adult and Adolescent Depression Pathway

Providence St. Joseph Health

Adult and Adolescent Depression Pathway

Step by Step to excellent depression care

SCREEN FOR DEPRESSION EVERY YEAR

Step 1: Administer the PHQ-2

Administer to all patients 12 years and older annually (with translator if appropriate). A positive PHQ-2 screen is a score of 3 or higher. **Enter into Doc Flowsheet in Visit Navigator.**

TOOLKIT:
LINK to suggested Rooming Process (Adult)
LINK to Adult Screening Workflow
LINK to Adolescent Screening Workflow
LINK to EPIC PHQ-2 Tips and Tricks

Step 2: Administer the PHQ-9

For patients who screen positive on the PHQ-2, administer the PHQ-9 or appropriate next level screener with translator if appropriate (Geriatric Depression Scale, Edinburgh Postnatal Depression Scale, PHQ-A, etc.) **Enter into Doc Flowsheet in Visit Navigator.** Review precipitating medical conditions, medications, and abused substances.

TOOLKIT:
LINK to screener comparison
LINK to site for translated screeners
LINK to EPIC Depression SmartSet Tips and Tricks
LINK to system screening metric
LINK to system follow up metric

See Appendix A: screening/assessment decision tree

Step 2a: Suicide Risk

If there is a positive answer to the ***suicide risk question number 9 on the PHQ-9***, physician must review with patient and implement a regional Suicide Assessment and Management Policy. Suggested to administer the Columbia Suicide Severity Rating Scale to assess the severity and immediacy of suicide risk.

TOOLKIT:
LINK to Columbia Suicide Severity Rating Scale

Step 3: Stage Depression Severity and Triage to Treatment

TRIAGE TO TREATMENT

The chart below quantifies depression severity based on the PHQ-9 score and provides guidance for recommended treatment, appropriate coding per ICD-10 guidelines, but does not supersede clinical judgment. See Appendix B: triage of positive second level screen (PHQ-9, GDS, etc.) decision tree.

ADULT AND ADOLESCENT (12-17) TREATMENT RECOMMENDATION

PHQ-9 Score **Depression Severity**		5-9 **Mild Depression**	10-14 **Major Depressive Disorder Mild**	15-19 **Major Depressive Disorder Moderate Severe**	20-27 **Severe Depression**
Psychotherapy	Adolescent (12-17) Population		**Psychotherapy is recommended as <u>first-line treatment</u> for adolescents at all MDD severity levels**		
	Adult Population		**X**	**X**	**X**
Pharmacotherapy	All Populations			**X**	**X**
Additional Recommended Treatment	*Self-Management Tools*	**X**	**X**	**X**	**X**
	Patient Education	**X**	**X**	**X**	**X**
ICD-10		Potential codes R45.X & F43.X	F33.0 and F32.0	F33.1 and F32.1	F33.2 and F32.2
Next Steps		Go to step 4	Go to step 4	Go to steps 4, 5 and 6	Go to steps 4,5, and 6

Step 4: Positive Screen Management

Step 4a: Patient Education and Self-Management Tools

Share patient education and self-management tools with the patient and/or parents of adolescents (12-17) with a positive screen.

TOOLKIT:

- **LINK** to patient education for adults
- **LINK** to patient education for adolescents
- **LINK** to self-management tools and resources from NIMH

Step 4b: Pharmacotherapy

Evidence-based antidepressant prescribing aims to achieve the maximum target dose of antidepressant. Dose adjustments are made based on response rates. Recommended medication follow up for adults is 4-6 weeks for Major Depressive Disorder (MDD) Mild and Moderate Severe. Follow up for adults is 2-4 weeks for MDD Severe. Re-assess with a PHQ-9 (or alternate screener). Target is remission.

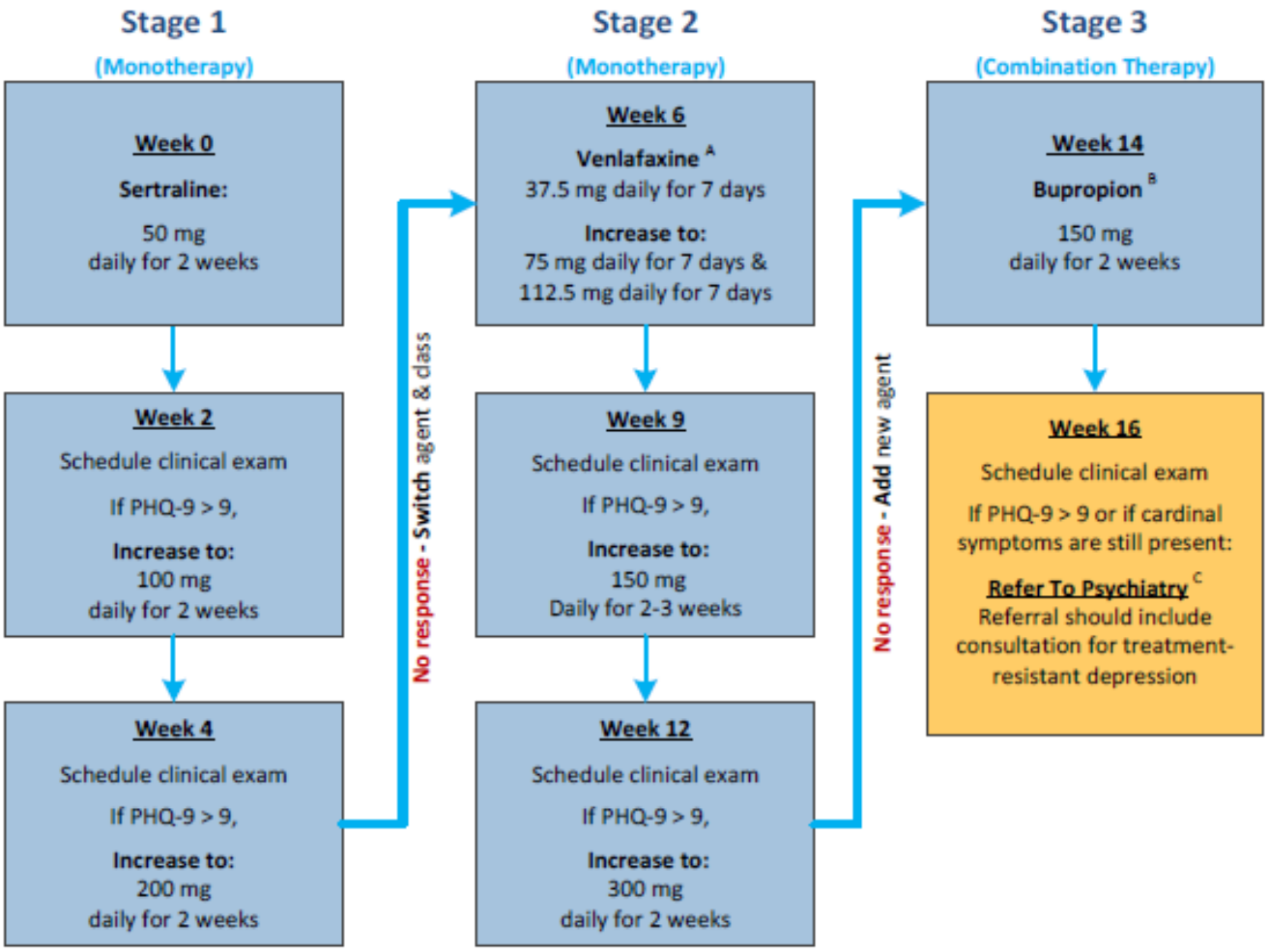
TOOLKIT:

- Recommend Bipolar assessment:
  - Is there a history of bipolar disorder in your family?
  - At any point in your life, have you gone through periods when you felt the opposite of being depressed – very "high" or "hyper" with lots of energy? Didn't need to sleep? Felt you could do anything?
- Follow up questionnaires:
  - Mood disorder questionnaire
  - GAD-7 questionnaire

- **LINK** to Adult Antidepressant Algorithm (page 5)
- **LINK** to Adult Antidepressant Dosing Table (page 6)
- Adult Follow Up Algorithm (page 12)
- **LINK** to Adolescent Antidepressant Algorithm (page 7)
- **LINK** to Adolescent Antidepressant Dosing Table (page 8)

ADULT ANTIDEPRESSANT ALGORITHM

(MDD Severe Depression Titration schedule Example)



At any point in treatment

Consult/refer to psychiatry if:

- Adverse effects are too severe after 4-6 weeks
- There have been 2 unsuccessful SSRI trials
- Depressed and psychotic symptoms are present without homicidal or suicidal thoughts
- Suspicion of bipolar disorder

Send to ER if:

- Depressed and acutely suicidal or grossly psychotic

Tapering is not needed when switching from one class to another

A. IR, ER available for Venlafaxine.
B. IR, SR and XL available for Bupropion – may cause anxiety in some patients due to its activating properties.
C. Red flags to trigger early referral; psychosis, mixed symptoms and suicidal ideation.

Reference to evidence-based algorithm for antidepressants:

- Comparative efficacy and acceptability of 12 new-generation antidepressants: a multiple-treatment meta-analysis. **2009** Lancet Depression SSRI Meta Analysis
- Comparative benefits and harms of second generation antidepressants for treating major depressive disorder. **2011** Annals of Internal Medicine

Although there is no significant difference in efficacy between second generation antidepressants, the agents cannot be considered identical, especially with regard to side-effect profile and potential drug-interactions. The pathway team selected sertraline and escitalopram based on least potential for side effects, drug interactions and cost.

ADULT ANTIDEPRESSANT DOSING TABLE

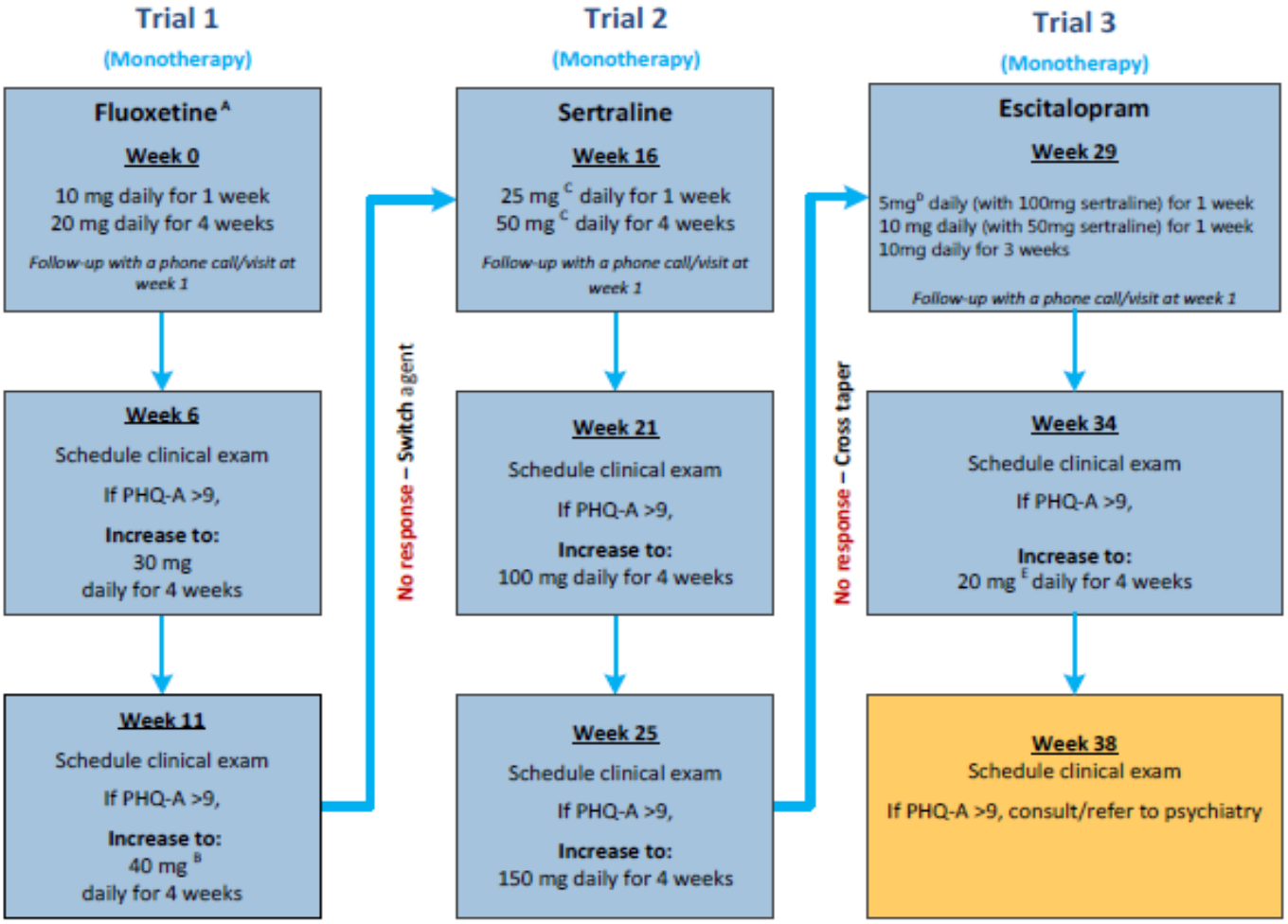
Drug class	Generic (trade)	Usual starting dose (mg/day)	Usual dose range (mg/day)	Max dose (mg/day)	Frequency	Common side effects/comments	CYP P450 inhibition	Cash price (generic)
SSRI	Sertraline (Zoloft®)	50	50-200	200	Qday	May be mildly activating Some GI upset; jitteriness; possibly mild headache	Dose-dependent 2D6 inhibitor; weak 3A4 inhibitor	$
	Escitalopram (Lexapro®)	10	10-20	20	Qday	Tends to have less side effects and is generally well tolerated	Modest 2D6 inhibitor with 20mg dose	$-$$
SNRI	Venlafaxine IR(Effexor®)	37.5	75-375	375	IR:BID-TID	Monitor BP in uncontrolled HTN Warn patients of abrupt withdrawal symptoms May have more GI upset than other SSRIs; can increase agitation; jitteriness; possibly mild headache	Weak 2D6 inhibitor	$-IR
	Venlafaxine ER (Effexor®)	37.5	75-225	225	ER: Qday			$$-ER
DNRI	Bupropion IR (Wellbutrin®)	200	300-450	IR: 450	IR: BID (initial dose)-TID	More stimulating; less sexual side effects; may worsen anxiety and jitteriness When using the IR formulation, second dose should be taken no later than 2 p.m. SR formulation, doses should be 8 hours apart. Taking it late in the day interferes with sleep. XL formulation is taken all in the morning. Contraindication: history of seizures or TBI At higher doses, monitor BP in uncontrolled HTN	2D6 inhibitor	$-IR
	Bupropion SR (Wellbutrin SR®)	150	300-400	SR: 400	SR: Qday (initial dose) - BID			$$-SR
	Bupropion XL (Wellbutrin XL®)	150	150-300	XL: 450	XL: Qday			$$-XL

ADOLESCENT (12-17) ANTIDEPRESSANT ALGORITHM

Families and caregivers of patients being treated with antidepressants for major depressive disorder should be alerted about the need to monitor patients for the emergence of agitation, irritability, and other symptoms, as well as the emergence of suicidality, and to report such symptoms immediately to healthcare providers.

Begin Antidepressant Therapy

(Psychotherapy needs to continue during pharmacotherapy)



At any point in treatment

Consult/refer to psychiatry if:

- Adverse effects are too severe after 4-6 weeks
- There have been 2 unsuccessful SSRI trials
- Depressed and psychotic symptoms are present without homicidal or suicidal thoughts
- Suspicion of bipolar disorder

Send to ER if:

- Depressed and acutely suicidal or grossly psychotic

Footnote:

A. Fluoxetine starting and target dose may be 10mg/day. Dosage increases depending on age and weight of child. Dosage in adolescents and higher weight children should be increased to 20 mg/day after 2 weeks.
B. Recommended dosage is beyond FDA recommended dose.
C. Sertraline starting dose may be 25 mg daily in lower weight or younger adolescents.
D. Escitalopram starting dose may be 5 mg daily in lower weight or younger adolescents.
E. Increase Escitalopram dose to 20 mg/day only after a minimum of 3 weeks, if improvement is not satisfactory, based on the PHQ-A/9 score.

Note: Psychotherapy is recommended prior to beginning Pharmacotherapy for adolescent patients.

ADOLESCENT (AGE 12-17 YEAR OLD) ANTIDEPRESSANT DOSING TABLE

	Drug Class	Generic (Trade)	Usual starting dose (mg/day)	Usual Dose range (mg/day)	Max dose (mg/day)	Frequency	Common Side Effects / Other precautions	CYP450 inhibition	Cash Price
First Line	SSRI	Fluoxetine (Prozac®)	10	20-60	60	Qday	Headaches, GI upset, insomnia, agitation, anxiety. Low weight children: Dose range 20-30 recommended	Potent CYP2D6 inhibitor; moderate CYP2C9 inhibitor; CYP2C19 and CYP3A4 weak-moderate inhibitor	$
Second Line	SSRI	Sertraline [C] (Zoloft®)	25-50 [A]	25-200	200	Qday	Headaches, GI upset, Insomnia. Lower body weight should be taken into consideration.	Dose-dependent Low-moderate 2D6 inhibitor	$
	SSRI	Escitalopram (Lexapro®)	5-10 [A]	10-20	20 [B]	Qday	Headaches, GI upset, insomnia. Tends to have less side effects and is generally well tolerated	Modest 2D6 with inhibitor with 20mg dose	$-$$
Third Line	SNRI	Venlafaxine ER [C] (Effexor®)	37.5	75-225	225	ER: Qday	May have more GI upset than SSRIs; can increase agitation; jitteriness; possibly mild headache Monitor BP in uncontrolled HTN, warn patients of abrupt withdrawal symptoms	Weak 2D6 inhibitor	$$-ER
	DNRI	Bupropion SR [C, D] (Wellbutrin SR®)	200 [100 BID]	100-150	300	Qday (initial dose) - BID	More stimulating; less sexual side effects; may worsen anxiety and jitteriness SR formulation, doses should be 8 hours apart. Taking it late in the day interferes with sleep. XL formulation is taken all in the morning Contraindication: anorexia and bulimia; history of seizures or TBI, At higher doses, monitor BP in uncontrolled HTN	Moderate CYP2D6 inhibitor	$$-SR
		Bupropion XL [C] (Wellbutrin XL®)	150	150-300	XL: 450	Qday			$$-XL

A. May start at lower dose range for lower weight or younger ages.
B. Cap dose at 20mg/day based on clinical trials with adolescent population.
C. Antidepressant has not been approved for use in treating MDD in the pediatric population. The safety and effectiveness of these antidepressants in patients under 18 years of age has not been established per the FDA.
D. Bupropion SR is twice daily/BID

Step 4c: Psychotherapy

Refer patients with a PHQ-9 score >9 to regional psychotherapy resources. Self-management tools may also be used. Resources available vary by region.

Step 5: Follow-Up and Monitoring of Depressed Patients

<table>
<tr><th>Remission definition</th><th>Response definition</th></tr>
<tr><td>Patients with an initial PHQ-9 score >9 who demonstrate a score of <5 on a monitoring PHQ-9</td><td>A score reduction of 50% or a PHQ-9 score of <10
<table>
<tr><th colspan="2">Response Rates</th></tr>
<tr><td>Good Response:</td><td>PHQ-9 score improves by ≥50%</td></tr>
<tr><td>Partial Response:</td><td>PHQ-9 score improves but by <50%</td></tr>
<tr><td>No Response:</td><td>No or insignificant improvement in PHQ-9</td></tr>
</table></td></tr>
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Adults:

Follow up during acute treatment phase:
Re-assess with the PHQ-9 or other appropriate screener as follows:

At Initial Diagnosis or with Treatment Change:

- Every 4-6 weeks for MDD mild and MDD moderate severe.
- Every 2-4 weeks for MDD severe.

Monitoring [Reached Treatment Goal]:
At a minimum of once a year.

Adolescents (12-17):

Follow up during acute treatment phase:
Re-assess with the PHQ-9 or other appropriate screener as follows:

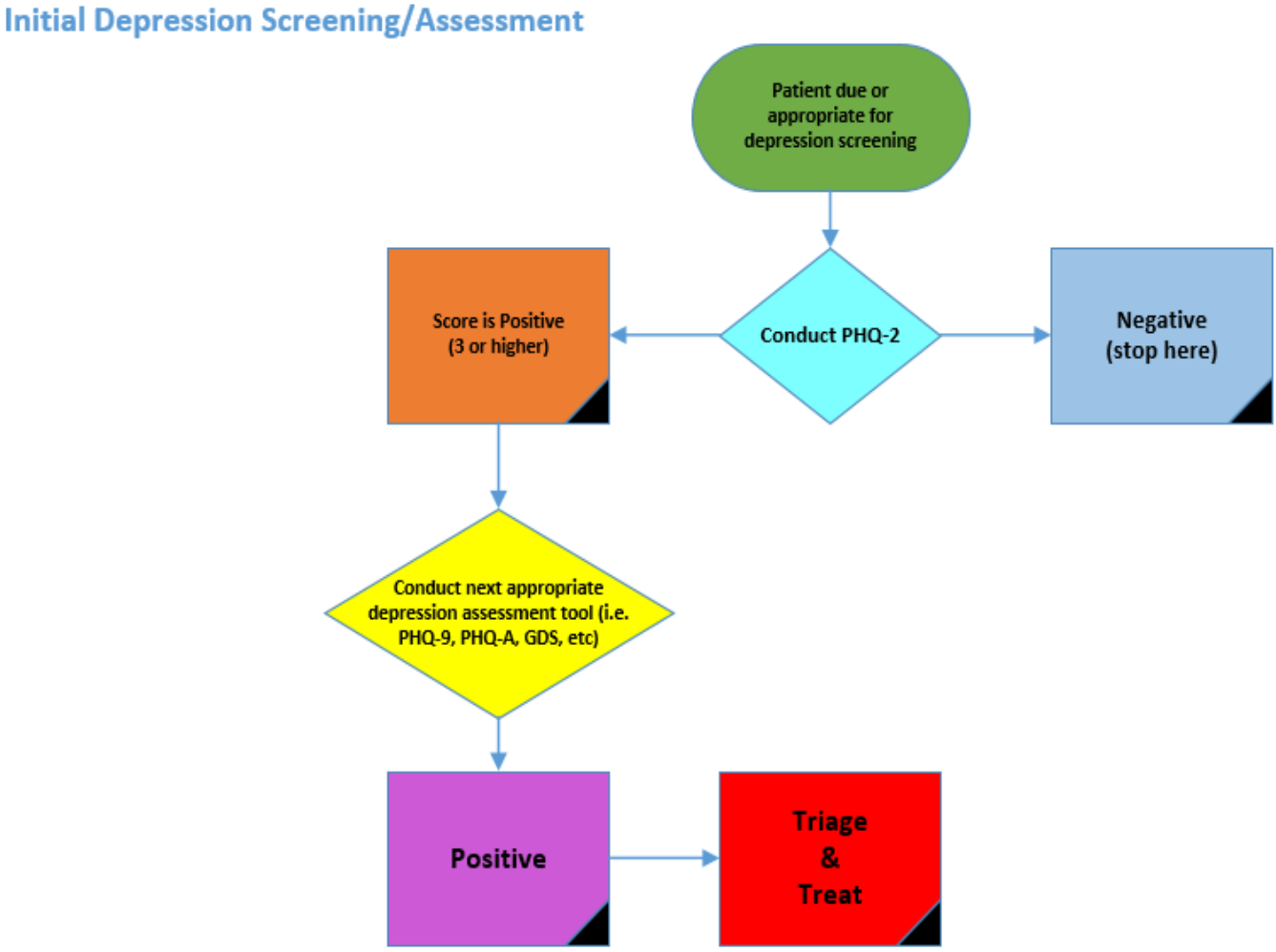
At Initial Diagnosis or with Treatment Change:

- 1-month follow-up visit for adolescent patients referred to psychotherapy, and thereafter every month until depression is improved
- 1-week follow-up phone call/visit for all adolescent patients on an antidepressant, and thereafter every 2-4 weeks follow-up for MDD moderate severe and MDD severe

Monitoring [Reached Treatment Goal]:
Follow-up every 3-4 months for both psychotherapy and pharmacotherapy

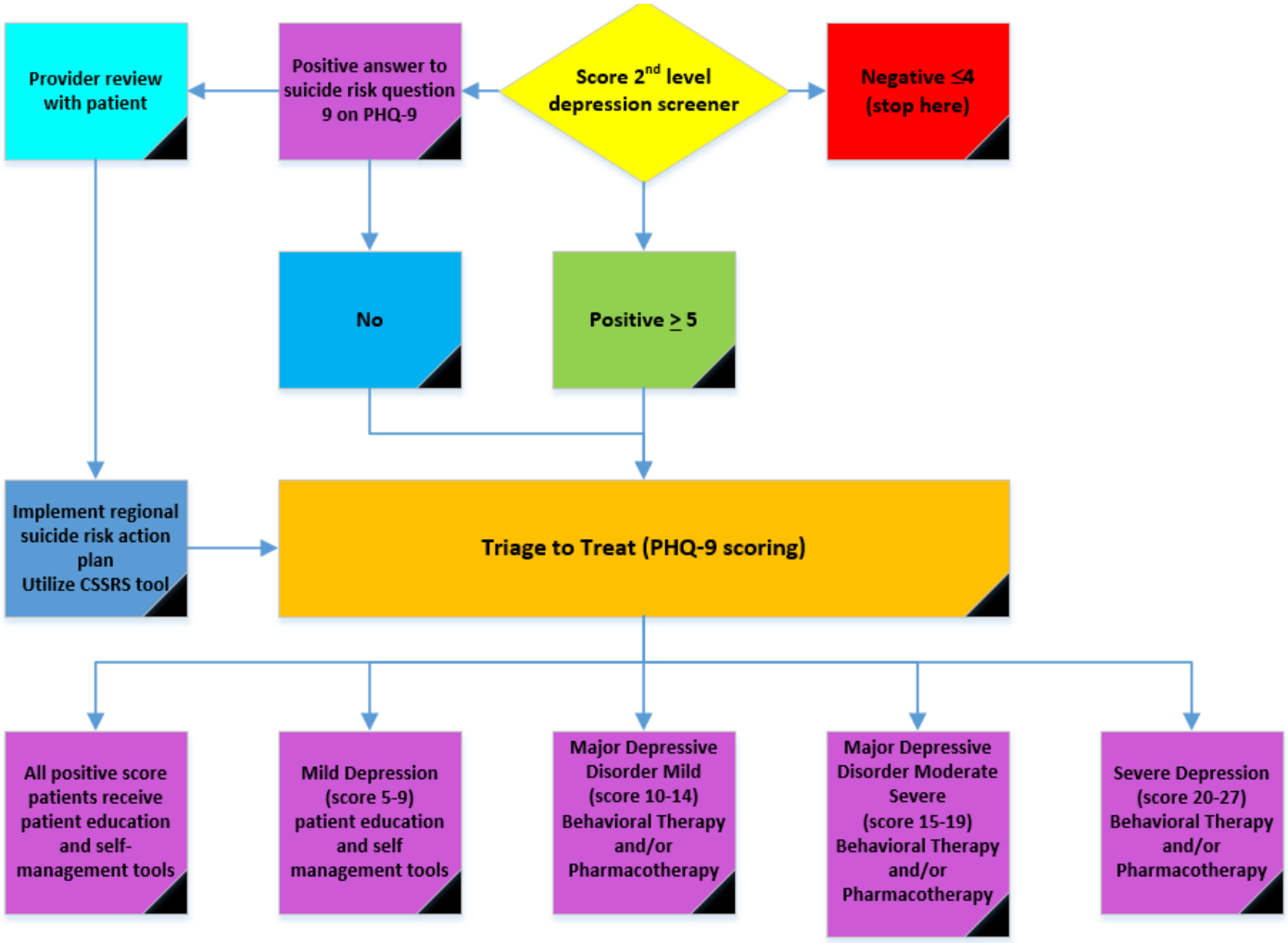
APPENDICES

APPENDIX A: DECISION TREE

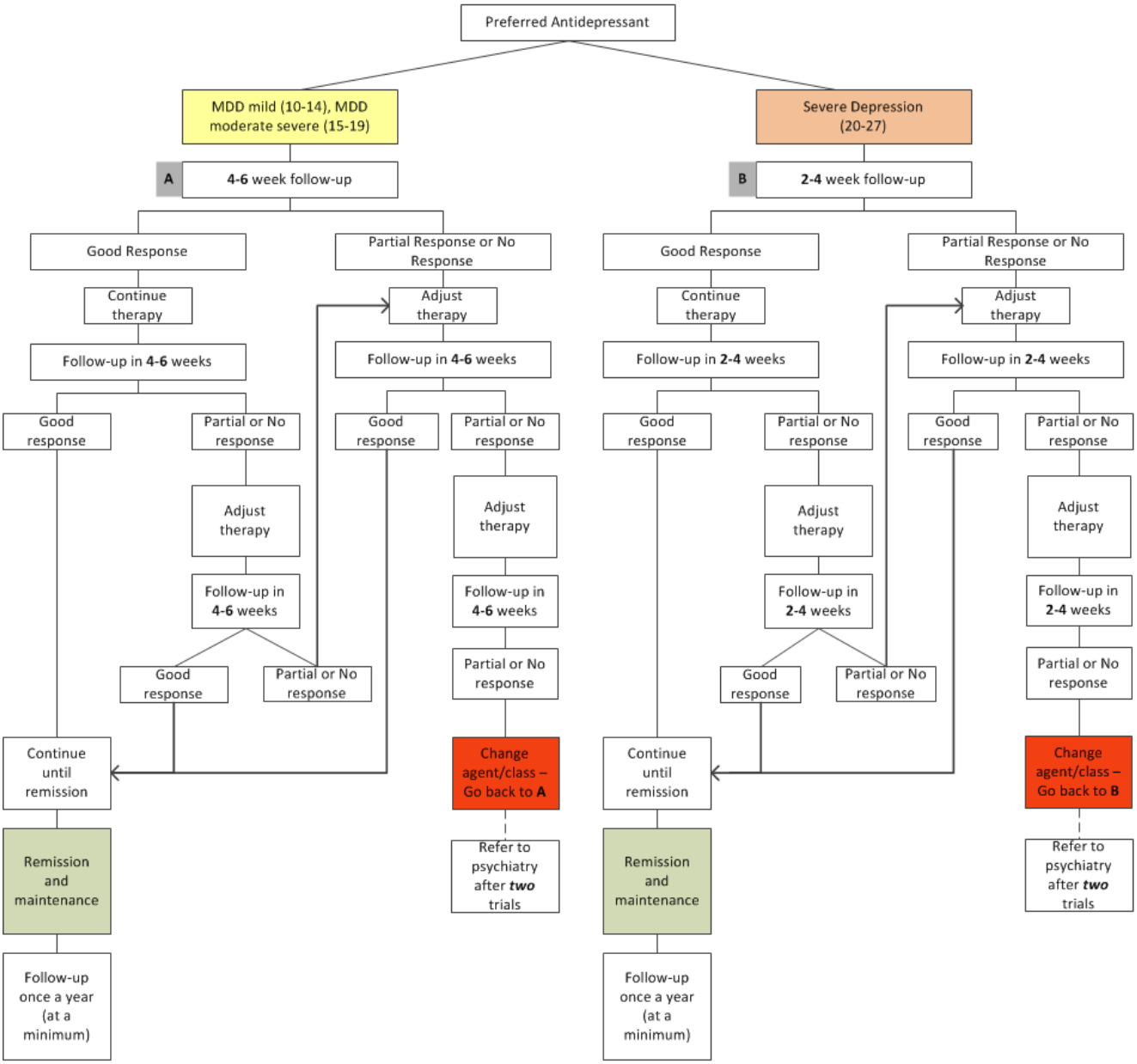


APPENDIX B: DECISION TREE

2nd Level Screening (example with PHQ-9)



ADULT FOLLOW UP ALGORITHM



HEDIS requirements:
Monitoring requirements: Patients with depression need to be monitored/seen once in each of the following periods: Jan 1- Apr 30; May 1- Aug. 31; Sept. 1 – Dec. 31.

Dose recommendations:

Antidepressant	Starting Dose	Dose Increase 1	Dose Increase 2	Dose Increase 3	Dose Increase 4
Sertraline	50 mg	100 mg	200 mg		
Venlafaxine	37.5 mg [A]	75 mg [A]	112.5 mg [A]	150 mg	300 mg
Bupropion (Combination therapy)	150 mg				

A. Dose increases after 7 days

Definitions	
Remission:	Score reduction of >90% or a score of <5 (on PHQ-9)
Response:	Score reduction of 50% or a PHQ-9 score of <10

Response Rates	
Good Response:	PHQ-9 score improves by ≥50%
Partial Response:	PHQ-9 score improves but by <50%
No Response:	No or insignificant improvement in PHQ-9

References

System Pathway WellSpot: https://www.wellspot.org/groups/system-depression-pathway-workgroup/overview

System wide link to most updated version of this pathway document: https://community.providence.org/sites/LearnLib/SystemClinicalPathways/System%20Adult%20and%20Adolescent%20Depression%20Pathway.pdf

Document History

Version	Date	Description of changes
1.0	11/14/16	Initial documentation, approved A-CDT and Ambulatory Quality Council.
1.1	1/9/17	Updates to Adolescent Algorithm and Pharmacotherapy section; removed appendix D algorithm for adolescents approved by A-CDT.
1.2	5/16/17	Formatting, logo update, verbiage clarification for Adolescent dosing table, naming convention corrections.
1.3	6/6/17	Updated system metric links, edited step 2a to include a link to the Columbia Suicide Severity Rating Scale tool.
1.4	6/17/17	Updated remission and follow up section, minor formatting changes.
1.5	6/29/17	Finalized for July ECO Release, added additional linked tools, updated decision trees, formatting

For pathway questions/concerns, please email: Julie.Nelson@providence.org

Clinical Pathway Sponsor: Arpan.Wahgray@Swedish.org

Governance Pathway Sponsor: Howard.Mun@Providence.org