Session # J7a

Depression Treatment Pathway in Primary Care

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify process for implementing a depression treatment pathway in a primary care setting
- Describe the benefits of integrating BH to support depression treatment in primary care
- Define components of a depression treatment pathway for primary care

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Bibliography / Reference

Intermountain Healthcare (December, 2014), *Depression – 2014 update*, retrieved from *https://kr.ihc.com/ext/Dcmnt?ncid=51061767*

MSSP (GPRO - NQF 0418) measure results as of March 17, 2015

Boeing (NQF 0712) measure results as of March 18, 2015

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Depression Treatment Pathway Swedish Medical Group

Depression Treatment Pathway - 2016

Our Vision:

To develop a collaborative pathway involving primary care providers that provides continuity of care across populations and improves the quality of care and outcomes of patients

- CDC Morbidity and Mortality Report reveals 8% of Americans report depression*
- Annual financial cost of depression is $26 billion*
- Overall, 2% of SMG patients 12 years or older are screened for depression and have a follow-up plan, when appropriate**
- SMG currently completes a PHQ-9 in 13.2% of patients diagnosed with major depression at the time of, or within one month of, the initial diagnosis.

Our Focus:

- Universal screening
- How to screen for depression
- How to diagnose depression (define depression)
- How to treat to target (monitoring)
- Treatment pathway for primary care
- Initial treatment: pharmacological and non-pharmacological treatment

*Intermountain Healthcare (December, 2014), *Depression – 2014 update*, retrieved from https://kr.ihc.com/ext/Dcmnt?ncid=51061767

***MSSP (GPRO - NQF 0418) measure results as of March 17, 2015*

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Depression Pathway – 2016

Four tips for excellent depression care

TIP #1: Screen for depression. Every adult. Every year.

PHQ-2
Administer to all patients 12+ annually. A positive PHQ-2 screen is a score of 3 or higher. Administer the PHQ-9 to patients who screen positive on the PHQ-2.

PHQ-9
If question 9 (suicide risk) has a score of 1, 2 or 3, review and implement the SMG Suicide Assessment and Management policy.

TIP #2: Stage depression severity with the PHQ-9

A major depressive episode is defined as having five or more of the following symptoms lasting more than two weeks and must include the first **or** second symptom.

- **Depressed mood**
- **Loss of interest/pleasure**
- Insomnia/hypersomnia
- Lack of concentration
- Weight gain/loss
- Feelings of guilt/worthlessness
- Psychomotor agitation/retardation
- Fatigue/lack of energy
- Thoughts of death/suicide

Not due to medical or other psychiatric condition

Code depression based on the PHQ-9

	PHQ-9 score	ICD-10 codes
Mild	10-14	F33.0 and F32.0
Moderate	14-19	F33.1 and F32.1
Severe	20-27	F33.2 and F32.2

TIP #3: Treat to target (remission)!

Severity	Mild	Moderate and moderate-severe	Severe
Treatment	Psycho-therapy	Pharmacotherapy with/without psychotherapy	• Pharmacotherapy necessary • Psychotherapy if patient able to participate

Evidence-based antidepressant prescribing tips:

1. Aim to achieve the maximum (target) dose of antidepressant in four to six weeks. Dose adjustments can be made as soon as two weeks based on symptoms, medication adherence and side effects.
2. Recommend follow-up in two to four weeks to re-assess PHQ-9 (target less than 10 or a 50 percent decrease in score).
3. If the symptoms do not respond to anti-depressant treatment at a maximum dose for four to six weeks, consider augmenting or changing treatment.
4. Ensure an adequate trial of antidepressants at the maximum (tolerated) dose before switching agents or augmenting treatment.

TIP #4: Refer to Behavioral Health

Embedded Behavioral Health (Tier 1) – Some clinics have an embedded behavioral health service, which consists of a combination of behavioral health consultants (BHCs) embedded in primary care clinics, delivering brief, on-demand, behavioral help to patients. Any patient with a problem that has a behavioral component can benefit. When a BHC is on staff, a warm handoff should be made, especially for patients being started on an antidepressant. Referrals are placed in EPIC using **SMG Behavioral Health Counseling* [clinic name].

Consultative Psychiatry (Tier 3) – Offers brief psychiatric consultation for patients. Tier 3 aims to stabilize patients and to return them to primary care for ongoing management. **Patients who are acutely suicidal or homicidal should be evaluated in the ED.** Please refer to the SMG Suicide Assessment and Management Policy. Referrals are placed in EPIC using **SMG Behavioral Health Psychiatry*.

Additional resources

- **Postpartum:** Visit The Lytle Center for Pregnancy and Newborns for more information: http://www.swedish.org/services/pregnancy-and-childbirth/resource-center/lytle-center-resources
- **Geriatric Depression Scale** (short form): https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf

References to evidence-based algorithm for antidepressants:

- 2009 Lancet Depression SSRI Meta Analysis
- 2011 Annals of Internal Medicine – Comparative benefits and harms of second generation antidepressants for treating MDD

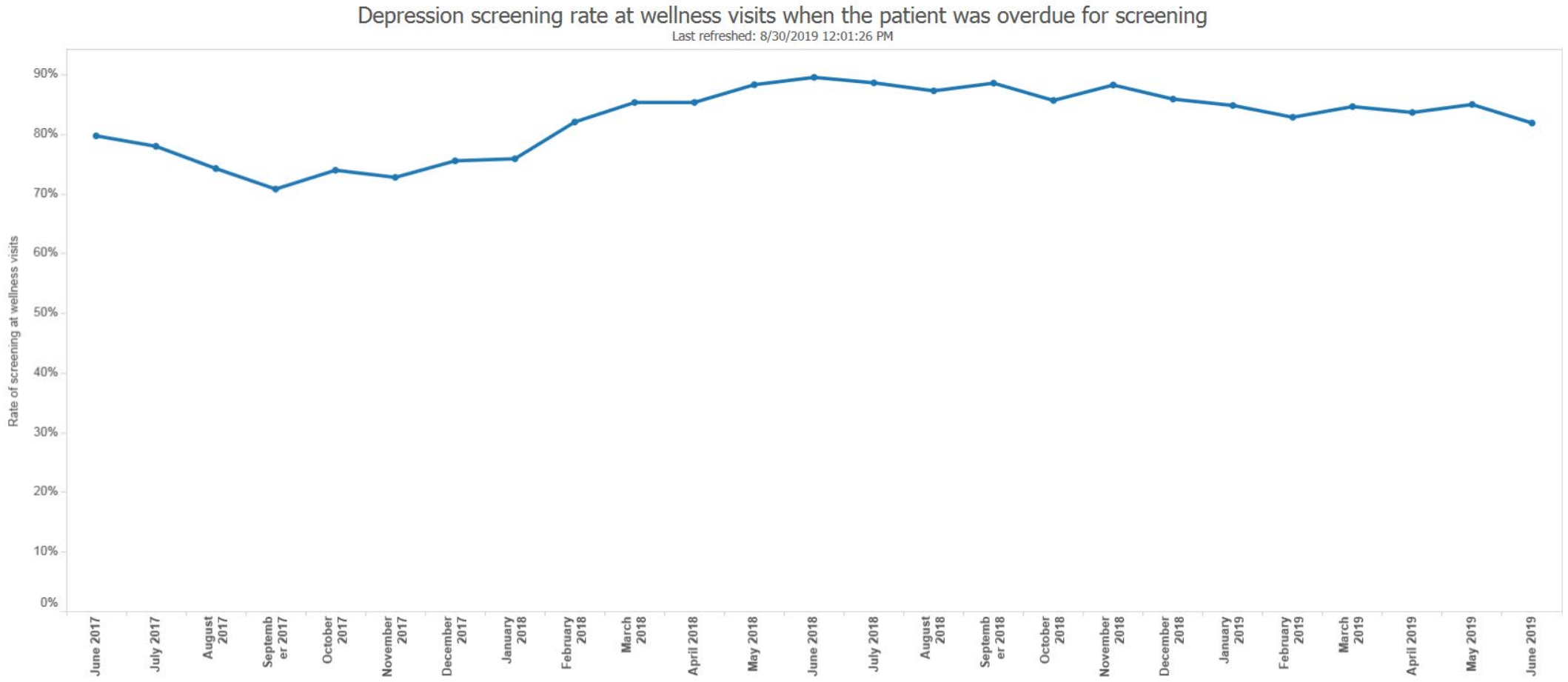
Although there is no significant difference in efficacy between second generation antidepressants, the agents cannot be considered identical, especially with regard to side-effect profile and potential drug-interactions. The pathway team selected sertraline and escitalopram based on least potential for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

Treatment Resources

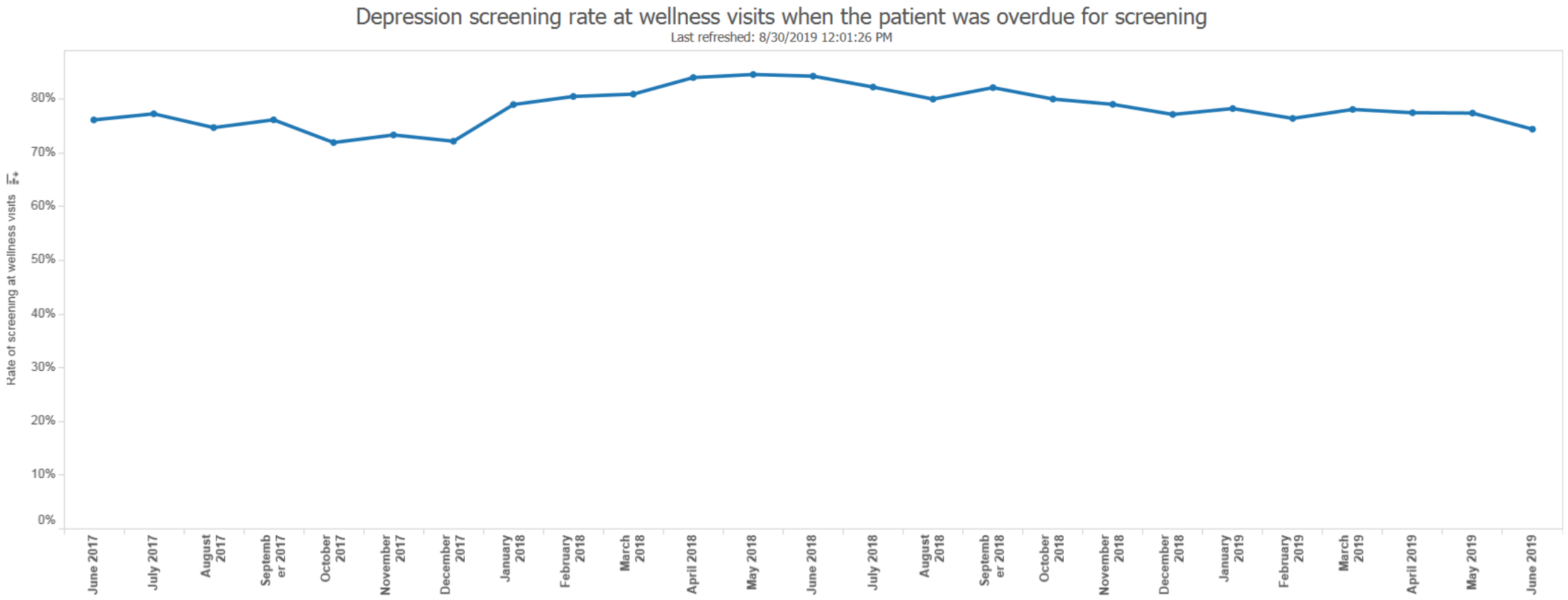
- Medication Guidelines
- Integration of BH Providers – PCBH model
- Integration of Consultation Psychiatry

Depression Screening Rates

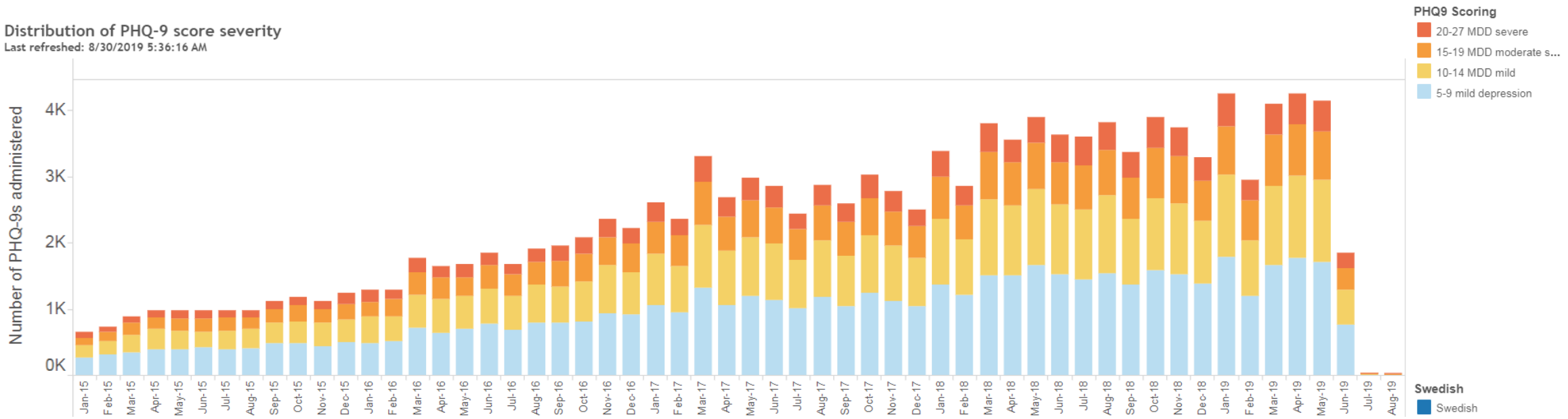
Depression Screening Rates – no BHP



Depression Screening Rates - with BHP

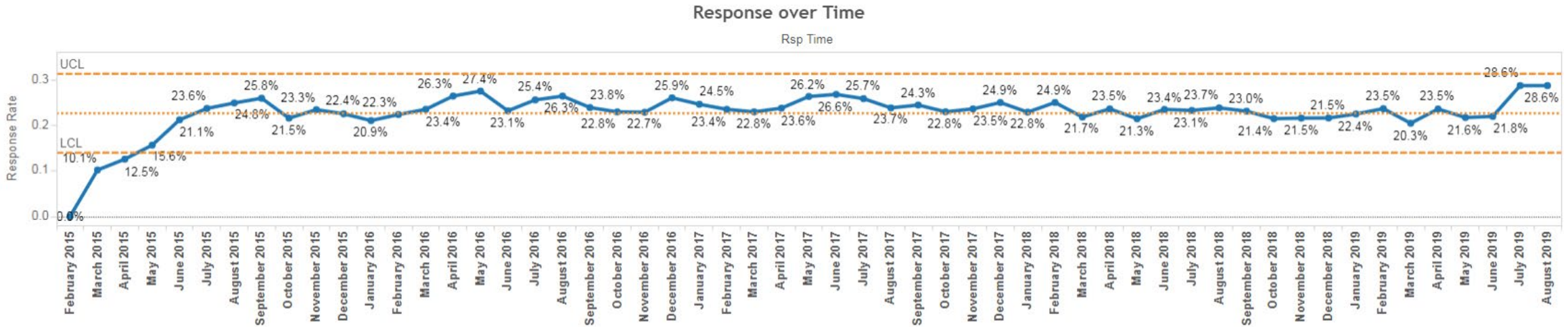


Distribution of PHQ Scores



Depression Treatment Response – over time (all Primary Care Clinics)

General description of metric
A patient (age 12+) achieves a response to treatment when they have achieved a reduction in their initially elevated PHQ-9 score (score >9). Scores that drop 50% or are <10 within six months of the patient's initial elevated PHQ-9 score are considered to be a response. The response is calculated using the last (i.e., most recent) PHQ-9 score during the 6-month period. For example, a patient with an elevated index PHQ-9 score in May 2017 who achieves a response to treatment in November 2017 would be included in the November 2017 data.



Lessons Learned – Pathway 2.0

- Screening every patient every time – PHQ2 as a vital sign
- Guidelines for putting Depression on the problem list
- Pre-visit preparation guidelines / standing orders for Medical Assistant
- EMR Support for prompting follow up PHQ9 for monitoring
- Increased BH support for positive screenings
- Quality incentive for treatment response/ remission – going beyond screening

Questions?

Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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Join us next year in Philadelphia, Pennsylvania! Thank you!