Relevance to Population
Depression is the most common psychiatric disorder in the general population and the most common mental health condition in primary care. It is a treatable cause of pain, suffering, disability and death, yet primary care clinicians detect major depression in only one-third to one-half of their patients with major depression. Depression is associated with higher rates of chronic disease, increased health care utilization and impaired functioning. It is characterized by mood, cognitive and physical symptoms. Few patients discuss their symptoms of depression with their primary care clinicians. Instead they present with various somatic symptoms making the detection of depression more difficult. The prevalence of diagnosed depression continues to increase. In 2015 it was estimated that about 16.1 million adults have at least one episode of major depression in the past year representing about 6.7% adults. The highest prevalence’s were for women (8.5%), 18-25-year old’s (10.3%). Additionally, major depression was second only to back and neck pain for having the greatest effect on disability days, at 386.6 million U.S. days per year. It is associated with increased mortality due to suicide and impaired ability to manage other health issues. This disorder often disrupts an individual’s work, family, and personal life. Its impact is often severe, and can be fatal. Depression in postpartum and pregnant women affects not only the woman but her child as well. Postpartum depression can lead to impaired maternal-infant bonding and child development. Depression imposes a significant economic burden through direct and indirect costs. In the United States, an estimated $22.8 billion was spent on depression treatment in 2009 and lost productivity cost an additional estimated $23 billion in 2011. Depression Statistics in Pennsylvania Results from the 2014 Behavioral Risk Factor Surveillance System (BRFSS): Behavioral Health Risks of Pennsylvania Adults identified the following groups to have an increased prevalence of depression in Pennsylvania:

- Women (23%) greater than men (16%)
- 45-64-year-old age group
- Persons with less than a high school education
- Household income < $15,000
- Hispanics (21%) > white and black, non-Hispanics (20%)

If left untreated, depression can increase both morbidity and mortality rates. Depression is associated with adverse health behaviors including smoking, alcohol consumption, physical inactivity and sleep disturbance (Centers for Disease Control and Prevention, 2013). Research demonstrates that depression is highly treatable with medications and/or psychotherapy. The vast majority of people seeking treatment for depression significantly improve. The earlier treatment can begin the more effective it is.

At UPMC Health Plan, depression is the most common mental health disorder. In calendar year 2016 depression ranked second in the top ten inpatient behavioral health diagnoses, first in outpatient behavioral health diagnosis and ranked third in ED visits for a behavioral health diagnosis across all lines of business (UPMC Health Plan Planning and Disease Prevalence Report CY 2017). One of our top pharmacy costs is for antidepressant medications.

Population Covered by Guideline
All members aged 18 and older who are diagnosed with or who are at risk for developing a major depressive disorder.

Clinical Indicators Measured by UPMC Health Plan - HEDIS® 2016
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported by HEDIS®
• **Effective Acute Phase Treatment**: The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).

• **Effective Continuation Phase Treatment**: The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

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**US Preventive Services Task Force (USPSTF): Screening for Depression in Adults**

In 2016 the USPSTF updated its 2009 recommendations for screening depression in the general adult population to include pregnant and postpartum women. The current recommendation statement has omitted the recommendation regarding selective screening based on available supports in recognition that such support is now more widely available and accepted as part of mental health care. The USPSTF recommends having “adequate systems in place” so that those patients who screen positive are either diagnosed and treated with evidence-based care or referred out so such services can be provided.\(^5\)

**2016 USPSTF Recommendation Statement Highlights:**\(^6\)

1. The USPSTF recommends screening for depression in the general adult population (adults 18 years and older), including pregnant and postpartum women.
2. The USPSTF recommends screening in all adults regardless of risk factors, however a number of risk factors are associated with an increased risk of depression
   • Prevalence rates vary by sex, age, race/ethnicity, education, marital status, geographic area and employment status.
3. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
   • “Adequate systems in place”, refers to having systems and clinical staff to ensure that patients are screened and, if positive, are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care.
4. The USPSTF found convincing evidence that screening improves the accurate identification of adult patients with depression in primary care settings, including pregnant and postpartum women.
5. The USPSTF concluded at least with moderate certainty that there is a moderate net benefit to screening for depression in adults, including older adults, who receive care in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up after screening.
6. The optimal timing and interval for screening for depression is undetermined at this time. A pragmatic approach in the meantime would be to screen all adults who have not been previously screened and use clinical judgment in considering risk factors, comorbid conditions and life events to determine if additional screening of high risk patients is indicated.

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**Importance of Screening for Depression in the Primary Care Setting**

- The goal of screening is to identify people who have depression so that they can get the help they need\(^8\)
- People who screen positive for depression should be further evaluated to determine how severe their depression is, whether they have any physical illness that may be contributing to the symptoms, and if they have any other mental health disorders.\(^8\)
- Approximately one out of every two members newly diagnosed with depression is in the sole care of their PCP. Up to 45% of patients who die by suicide have visited their primary care physician within a month of their death.\(^9\)
- Patients may not present initially with a complaint of depressed mood though the clinician may suspect major depression in the presence of multiple medical visits, multiple unexplained symptoms, work or relationship dysfunction, poor follow through with recommendations, fatigue, sleep problems, cognitive problems, irritable bowel syndrome, complaints of stress.\(^9\)

The negative impact of peri-partum/post-partum depression on women and their children has been widely

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UPMC HEALTH PLAN MANAGING ADULTS WITH DEPRESSION
Initial QIC Approval 09/2001
Revised and Approved by QIC: July 2017

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recognized. The available evidence suggests that the prevalence of depression in postpartum women mirrors that in other women of reproductive age.

- Higher rates of depression are found in women, young and middle aged adults, and nonwhite persons, those who are undereducated, previously married, unemployed. Chronic illnesses, other mental health disorders, or family history of psychiatric disorders also increase risk.
- Risk factors for older adults include disability, poor health related to medical illness, complicated grief, chronic sleep problems, loneliness and history of depression.
- Risk factors for depression during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal anxiety, life stress, decreased social support, single/un-partnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status and unintended pregnancy.\(^6\)

**Co-Morbidities**
Depression often co-exists with other illnesses which can precede it, cause it or be a consequence. More than 80% of patients with depression have a medical comorbidity.\(^1\) Studies have shown that people who have depression along with a medical illness often have more pronounced symptoms of both illnesses, more difficulty adapting to their medical condition as well as more medical costs than those with no co-existing depression. Frequently seen co-morbidities include:
- anxiety disorders such as PTSD, obsessive-compulsive, panic or social phobia
- alcohol and/or substance abuse/dependence
- cardiovascular disease
- stroke
- cancer
- HIV/AIDS
- diabetes (most disabling combination)
- Parkinson’s disease
- obesity
- chronic pain

**DSM 5 Criteria for Major Depressive Disorder**
Five or more of the following symptoms must be present during the same two-week period, represent a change from previous functioning and at least one of the symptoms is either depressed mood or loss of interest or pleasure (American Psychiatric Association, 2013):

- depressed mood
- loss of interest or pleasure in nearly all activities
- weight loss/gain
- insomnia/hypersomnia
- psychomotor retardation/agitation
- fatigue/loss of energy
- feelings of worthlessness/guilt
- impaired concentration
- recurrent thoughts of death/suicide

The symptoms must cause significant distress or impaired functioning and are not attributable to the physiologic effects of a substance or another medical disorder.
Depression Screening Tools

Use of patient-administered screening tools has increased as a quick and reliable option in the first step of depression assessment or as a treatment monitor. Screening can easily be incorporated into preventive health care visits for all adults. These tools are an instrument for making criteria-based diagnoses of depression in primary care.

1. **Patient Health Questionnaire-2 (PHQ-2)** - a two question tool intended to screen for depression in a “first step” approach. Its purpose is not to establish final diagnosis or to monitor depression severity. It is comprised of the first 2 items in the PHQ-9.  
   - Over the past two weeks, how often have you been bothered by feeling down, depressed, or hopeless?  
   - Over the past two weeks, how often have you been bothered by little interest or pleasure in doing things?  
   Patients who screen positive should be further evaluated with the PHQ-9 to determine if they meet the criteria for a depressive disorder.

2. **Patient Health Questionnaire-9 (PHQ-9)** - a nine item screening tool that asks about the frequency of symptoms of depression over the past 2 weeks. A total score of 0-27 is calculated. Depression is a PHQ-9 score of 10 or higher. The PHQ-9 is especially useful as it takes only a few minutes to complete, can be self-administered, is easily repeatable to track progress, and incorporates the 9 criteria listed in the DSM 5 which are to be considered in making a diagnosis of major depression. This tool can be found at: [https://www.icsi.org/guideline_sub-pages/depression/appendix_a_patient_health_questionnaire_phq-9/](https://www.icsi.org/guideline_sub-pages/depression/appendix_a_patient_health_questionnaire_phq-9/)

3. **Geriatric Depression Scale (GDS)** - a 15 question assessment designed to aid in detecting depression in the geriatric population; a 5 question shorter version is also available. It can be self-administered or as an interview and the questions are presented in a yes/no format to compensate for any age related impaired cognitive function. The 5-item scale demonstrated a significant agreement in the clinical diagnosis of depression with the 15-item scale. The 15 item tool can be found at: [http://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335297-1859039-1859095.pdf](http://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335297-1859039-1859095.pdf) and the 5 item tool can be found at [http://www.fpnotebook.com/Psych/Exam/FvItmGrtrcDprsnScl.htm](http://www.fpnotebook.com/Psych/Exam/FvItmGrtrcDprsnScl.htm)

4. **Edinburgh Postnatal Depression Scale (EPDS)** – a 10 question tool screening tool for identifying pregnant and postpartum women at risk for perinatal or postpartum depression. Woman scoring 9 or more points or indicating any suicidal ideation (scoring 1 or higher on question #10) should be referred immediately for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The tool can be found at [http://www.blackdoginstitute.org.au/docs/CliniciansdownloadableEdinburgh.pdf](http://www.blackdoginstitute.org.au/docs/CliniciansdownloadableEdinburgh.pdf)

   - **Recommendations of the American College of Obstetrics and Gynecology (ACOG):**
     1. Clinicians should screen patients at least once during the prenatal period for depression and anxiety symptoms using a standardized validated tool.
     2. Postpartum women should be screened at least once, a reasonable time to screen is four to eight weeks after delivery.

Assessment should include symptoms of:

- Bipolar disorder
- Mood disorder due to general medical condition (e.g. stroke, cancer, HIV/AIDS, Parkinson’s, dementia, multiple sclerosis, thyroid, etc.)
- Psychotic symptoms

Suicide Risk Assessment

Assessment of suicide potential is an essential part of the evaluation for clinical depression. Evaluation should include:
• Assess suicide risk factors: hopelessness, general medical illnesses, family history of substance abuse and or/suicide, psychotic symptoms, living alone or lack of social support, prior suicide attempts
• Ask directly about the content and frequency of suicidal ideation, intent and plans
• Protective factors: those that would decrease the chance of member making an attempt
• Access to means of suicide and lethality of those means

If the assessment indicates any significant degree of suicidal risk, then immediate arrangements should be made for psychiatric assessment for the appropriate level of care. The Agency for Healthcare Research and Quality (AHRQ) recommends that primary care health clinics develop their own suicide protocols within the scope of their system and available resources.

Available Treatment Options for Depression Management in the Primary Care Setting

1. **Mild Depression**: Watchful waiting with supportive guidance is often a highly effective strategy for patients with mild depression. Patients often can benefit from this approach provided the clinician offers support, encourages positive coping skills, and prompts behavioral changes such as increasing pleasurable activities and exercise.

2. **Mild to Moderate Depression**: Psychotherapy alone can be considered as an initial treatment choice alone for mild to moderate depressive disorder. Recommended use an evidenced-based model; a depression-focused psychotherapy such as cognitive behavioral therapy.

3. **Moderate to Severe Depression**: Psychopharmacology is recommended for: moderate to severe depression. Psychopharmacology plus Psychotherapy: may be particularly helpful for complicated, chronic presentations or if partial responder. 16

4. Consider hospitalization if suicidal ideation is present

5. The clinician selects the treatment modality based upon the diagnosis, severity of illness, patient preference, and monitoring of treatment response. Referral for a psychiatric evaluation is also an option.

6. Most patients benefit from a combination of psychotherapy and anti-depressant medication.11 Although medication can be prescribed by a primary care physician, therapy is generally provided by a mental health professional.2

7. Management of pregnant women with perinatal mood disorders should be done in consultation with OB care providers and mental health experts that are experienced in the treatment options for pregnant women. Given the complexities around use of medications during pregnancy. In addition to the use of pharmacologic agents, clinicians are encouraged to consider CBT or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding women and in consultation with experienced health care providers. 15

Pharmacotherapy Treatment for Depression in the Primary Care Setting

1. Approximately 70-80% of antidepressants are prescribed in primary care; thus, it is important that clinicians are knowledgeable about their use and have a system that supports best practice.1

2. The selection of a specific medication in Major Depression is based on individual clinical circumstances and should be guided by a combination of the experience of the practitioner and the American Psychiatric Association’s “Practice Guideline for the Treatment of Patients with Major Depression”, Third Edition.15 While this guideline predates DSM-5 it remains clinically relevant.

3. If you elect to provide pharmacotherapy for members with depressive symptoms, please arrange for at least 3 follow-up visits in the first 12 weeks of treatment. One of these visits should be with the prescribing practitioner to adequately evaluate clinical response, side effect profile, and compliance. Behavioral health practitioners can share valuable observations for the other visits if you deem this appropriate. Coordination of care is critical to treatment success. Two-way communication among clinicians treating the same patient is essential to quality care.

4. In managing patients who are prescribed antidepressant medications, clinical guidelines suggest to:
   - Begin the medication trial following the manufacturer’s recommended doses. Selective serotonin reuptake inhibitors (SSRIs) are typically first choice. Use a single agent unless patients fail several trials
of individual agents (i.e., three trials at full dosage for adequate length of time).

- Assess the effects of the medications frequently and adjust to a therapeutic level not to exceed the highest recommended dose.
- Switch to another antidepressant medication if the response is not satisfactory in six weeks at maximum recommended dosages. Avoid polypharmacy.
- Be aware of medication interactions with antidepressants (especially those with P450 metabolism).

5. Remember elderly patients are at higher risk for significant side effects or drug interactions; consider lowest possible dose and slow titration.

6. Ensure length of medication trial is adequate. For patients suffering from a single depressive episode, continue the antidepressant for at least six months after depressive symptoms have remitted. This strategy diminishes the risk of relapse. For patients with two or more episodes of depression, continue antidepressant medication for at least one year or consider ongoing treatment indefinitely at an effective dose — typically at the same dosage used in the acute phase of the illness. Maintaining patients with a history of depression on an antidepressant medication over the long term has been found to not only reduce the likelihood of recurrence but also to reduce the severity of symptoms that are suffered if a relapse should occur.

7. Medication should not be abruptly discontinued, taper after providing education about relapse prevention.

8. Partial responders who have residual symptoms although improved are at greater risk for relapse.

Management of Antidepressant Medications

ACUTE PHASE

Treatment Goal:
- Reduce and eliminate symptoms and restore baseline functioning

Treatment Strategy:
- The initial goal should be to achieve a targeted dose (in the upper range of FDA recommendations for antidepressant medications) by week 6 and monitor progress for another 6 weeks. Thus, a trial should be 12 weeks in duration.
- Every 1 – 2 weeks, monitor patient compliance and symptoms.
- Selection of antidepressant is based on patient preference, anticipated side effect profile (sedating, activating, weight gain, impact on sex life; anticholinergic side effects), safety and tolerability, co-occurring conditions, potential drug interactions, half-life, cost.
- Side effects are often responsible for discontinuing medication prematurely. Strategies for management of side effects include acknowledge patient’s complaints, supportive waiting as some side effects subside within 2 weeks, temporarily lower the dose, treat side effects, consider change to different antidepressant
- If partial response/remission, the antidepressant medication trial should be continued for another 6 weeks.
- If no response by 6 weeks — increase dose or switch drugs and/or add psychotherapy.
- If no response by 12 weeks — increase dose or switch drugs and/or consult a behavioral health specialist.

Expected Response:
- 4 – 8-week trial — 50% reduction in symptoms. Recommend the use of standardized self-reports of symptom severity and adverse effects to be given to patient at every visit to help the clinician quantify the benefit of the antidepressant medication. If after another 4-8 weeks’ treatment there is minimal or no response, then consider optimizing the dose of medication, augmentation with depression focused psychotherapy, other agents, and change to another non-MAO antidepressant.
- 10 – 12-week trial — nearly 100% reduction in symptoms.
CONTINUATION PHASE

Treatment Goal:
• Prevent relapse (most common in the first 6 months).

Treatment Strategy:
• Continue antidepressant medication for 4 – 9 months to prevent relapse. In general, the dose in continuation phase is same as in acute phase.
• Visits can be extended to every 4-8 weeks.
• To prevent relapse in continuation phase, depression focused psychotherapy recommended, best evidence is for cognitive behavioral therapy (CBT).

MAINTENANCE PHASE

Treatment Goal:
• Prevent future episodes in high risk patients (recurrence rates increase with every new episode)

Treatment Strategy:
• Continue antidepressant medication for at least 12 months using similar dosage as prescribed in acute phase.
• Initially, the patient should be evaluated every one to two weeks to monitor patient compliance, symptom improvement, and medication side effects.
• The patient should have at least a partial response (50% reduction in symptoms) by 6 weeks and remission by 10-12 weeks.
• The medication dose should be increased (or, if this is ineffective, the antidepressant should be changed) if there is not a partial response by 6 weeks or remission by 10-12 weeks.
• The antidepressant should be continued at least six months after depressive symptoms have remitted.
• Patients who have two or more episodes of major depression in a five-year period may be considered for maintenance antidepressant therapy.
• Psychological counseling may be used alone (if the patient prefers this to medications) in cases of mild to moderate depression. As with antidepressants, the patient should have at least a partial response by 6 weeks and remission by 10-12 weeks.
• In more severe depression, psychological counseling should only be used in conjunction with antidepressants. In some patients, such adjunctive psychological counseling may prevent subsequent relapses and recurrences once treatment with antidepressants ends.


Who needs behavioral health specialty care?

Physicians are encouraged to refer patients to a behavioral health practitioner if presenting with:
• Severe psychiatric disorders, for example, depression with psychotic features or mania
• History of mania
• Treatment-resistant disorders, i.e., depression not responsive to one or two adequate psychotropic medication trials
• Risk of lethality
• Severe impairment in daily functioning
• A need for a combination of psychotropic medications
• Alcohol or substance abuse
• A complicated or uncertain diagnosis
• Complex social situation
• A need for psychiatric inpatient admission
• A need for psychotherapy; this service can be utilized in combination with the PCP following a patient on an antidepressant.
• Referrals should also be made if the primary physician is not comfortable managing the patient’s depression.
• Patients hospitalized for major depression should be seen by a behavioral health specialist within seven days of discharge.

Collaboration and Coordination of Care
Other health care professionals in addition to primary care provider, including behavioral health providers may be involved in the patient’s overall treatment. It is important that care is coordinated, clinical information (with appropriate release of information) relevant to treatment is shared, and treatments are coordinated.

Additional Resources for UPMC Health Plan patients
• MyHealth Advice Line is staffed by experienced Registered Nurses and is available 24/7 to provide telephone support to members. Call 1-866-918-1591. TTY/TDD users should call 1-866-918-1593.
• Health Coach Programs provide intensive case management for members with specific chronic illnesses or conditions. The programs are built upon best practices and accepted clinical guidelines and include:
  ▪ Diabetes
  ▪ Asthma/COPD
  ▪ Behavioral Health
    ▪ Depression
    ▪ Anxiety
    ▪ ADHD
    ▪ Substance Abuse
  ▪ Cardiovascular
    ▪ Heart failure
    ▪ Coronary artery disease
    ▪ Hypertension
    ▪ Hyperlipidemia
  ▪ Low Back Pain

• Members and providers can obtain additional information about the health coach programs by calling 1-866-778-6073.
• Prescription for Wellness Program is a way for providers to prescribe healthy behaviors and engagement with a health coach as part of a treatment plan. The order for the prescription is placed along with all other orders at the time of the visit. Providers can also write a Prescription for Wellness in the Electronic Medical Record (EMR). Providers can select from the following list of condition management programs and write in any concerns to be addressed. The order automatically generates a note to the Health Plan with the referral information. The health coaches will then reach out with the appropriate support program. A printed copy can also be provided to the patient.
Condition Management Programs

- **Physical Health Conditions**
  - Respiratory health
    - Asthma (for adults and parents/caregivers)
    - COPD
  - Cardiovascular health
    - Heart failure
    - Coronary artery disease
    - Hypertension
    - Hyperlipidemia
  - Diabetes (for adults and parents/caregivers)
  - Low back pain
  - Chronic Kidney Disease

- **Behavioral Health**
  - ADHD (for parents and caregivers)
  - Anxiety
  - Depression
  - Substance use

- **Online** interactive preventive health programs and resources are available in partnership with WebMD at [www.upmchealthplan.com](http://www.upmchealthplan.com).
  - MyHealth OnLine Tobacco Cessation Program
  - MyHealth OnLine Physical Activity Program
  - MyHealth OnLine Nutrition Program
  - MyHealth OnLine Weight Management Program
  - MyHealth OnLine Stress Management Program
  - MyHealth OnLine Emotional Health Program

- **Member Educational Materials:**
  Recovery is often more successful when patients are active participants in treatment efforts. Educating patients about depression, its treatment, and especially steps they can take to get well can greatly aid in the recovery process. Excellent patient educational materials for adults can be found at:

  - [http://www.DBSAlliance.org](http://www.DBSAlliance.org) Depression and Bipolar Support Alliance website.
  - [http://www.psychiatry.org/mental-health](http://www.psychiatry.org/mental-health) American Psychiatric Association website
  - [http://www.mentalhealthamerica.net/go/depression](http://www.mentalhealthamerica.net/go/depression) Mental Health America website
  - [http://nihseniorhealth.gov/depression/toc.html](http://nihseniorhealth.gov/depression/toc.html) NIH Senior Health
**Scientific Evidence**


12. Screening for Prenatal Depression: [http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression](http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression)


16. American College of Physicians, March 2016 Amir Qaseem, MD, PhD, MHA; Michael J. Barry, MD; and Devan Kansagara, MD, MCR, for the Clinical Guidelines Committee of the American College of Physicians Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients with Major Depressive Disorder: A Clinical Practice Guideline from the American College of Physicians