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Your Extended Family.

Primary Care Management of Depression

John Briles, MD, Medical Director

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Primary Care Management of Depression

- Molina Healthcare of Michigan uses a HEDIS measure for Antidepressant Medication Management (AMM) to measure how well treating providers (PCPs) appropriately diagnose, treat, follow-up with major depression

Primary Care Management of Depression

Tools and resources available:

- The Michigan Quality Improvement Consortium Guideline for Primary Care Diagnosis and Management of Adults with Depression

  http://mqic.org/guidelines.htm

- Molina Behavioral Health Toolkit for Primary Care Providers

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Michigan Quality Improvement Consortium Guideline

January 2016

Primary Care Diagnosis and Management of Adults with Depression

The following guideline recommends screening for depression, assessing suicide risk, following diagnostic criteria, shared decision-making and treatment planning, monitoring and adjusting treatment.

Eligible Population	Recommendation and Level of Evidence	Frequency
Adults 18 years or older, including pregnant and postpartum women	Detection and Diagnosis: Screen for depression with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up **[A]**. Use a validated screening tool (e.g. PHQ-2, PHQ-9) **[A]**. Assess if criteria are met using DSM-5 criteria **[A]**. Criteria A, B, C and D must be met.	Annually At each evaluation where the patient's high-risk status, symptoms or signs raise suspicion of current or uncontrolled depression. At the first prenatal care visit; on post-partum visits (within 3-8 weeks of discharge) and if symptoms or signs raise suspicion using the Edinburgh Postnatal Depression Scale[1].
Individuals diagnosed with a depressive disorder	Assessment of suicide risk: Assess risk of suicide by direct questioning about suicidal ideation, and if present, suicidal planning, potential means, and personal/family history of suicidal attempts. **[D]** See established clinical tools for risk assessment and suicide prevention[2,3]. ■ **If patient at moderate to severe risk for suicide, refer to emergency department or crisis intervention center. Develop safety plan.**	At each encounter addressing depression until patient is treated to remission and has not expressed suicidal thinking in previous visits.
	Treatment and follow-up: Educate and engage patient. Include self-management support and life-style modifications (e.g., behavioral activation, healthy sleep and diet, exercise, stress-management, social support, spiritual support, online resources) **[C]**. Utilize shared decision-making in treatment planning **[A]**. Consider onset and severity of symptoms, impairment, past episodes, psychosocial stressors, medical and psychiatric comorbidities, patient preference, resource accessibility. For mild to moderate symptoms consider pharmacotherapy and/or evidence-based psychotherapy **[A]**. For severe symptoms consider both pharmacotherapy and evidence-based psychotherapy **[A]**. Monitor response to treatment using standardized scale (e.g., PHQ-9). On PHQ-9, adequate response is 50% reduction in score, remission=total score <5. Consider referral to behavioral health specialist when additional counseling is desired, primary physician is not comfortable managing patient's depression, diagnostic uncertainty, complex symptoms or social situation, response to medication at therapeutic dose is not optimal, considering prescribing multiple agents, or more extensive interventions are warranted **[D]**. If initiating antidepressant medication, follow manufacturer's recommended doses. If no response after 2-4 weeks, increase dosage as tolerated not to exceed the highest recommended dose. If discontinuing antidepressant, taper dose over several weeks. If limited or no response to treatment, assess for non-adherence, inadequate dosing, diagnostic inaccuracy or comorbid conditions exacerbating symptoms. Consider: increased doses of medication or frequency of psychotherapy, switching treatments or augment treatment with other medications or psychotherapeutic interventions, consultation. Patients with recurrent major depression usually require lifelong treatment. Continue medication for at least 9 – 12 months after acute symptoms resolve. **[A]**	Schedule sufficient follow-up visits to assess response to treatment and titrate dose (typically every two weeks, monthly at a minimum). **[D]**

DSM-5 criteria	Major Depression	Persistent Depressive Disorder
A. Symptoms	5 total for ≥ 2 weeks and must include symptom #1 or #2	3 total for ≥ 2 years. Must include symptom #1. Never > 2 months symptom-free
1. Depressed mood	x	x
2. Marked diminished interest/pleasure	x	
3. Significant weight gain/loss, appetite decrease/increase	x	x
4. Insomnia/hypersomnia	x	x
5. Psychomotor agitation/retardation noticeable by others	x	
6. Fatigue/loss of energy	x	x
7. Feelings of worthlessness or inappropriate guilt	x	x
8. Diminished concentration or indecisiveness	x	x
9. Recurrent thoughts of death or suicidal ideation	x	
10. Hopelessness		x
B. Symptoms cause clinically significant distress or impairment in functioning		
C. Symptoms not attributed to a substance or other medical condition		
D. Lack of psychotic disorder or history of manic or hypomanic symptoms		

Assess for comorbid conditions that might impact treatment (e.g., medical and medication-induced conditions, drug or alcohol abuse, bipolar disorder, anxiety disorders, psychosis).

[1] Edinburgh Postnatal Depression Scale
[2] Suicide Prevention for Primary Care Toolkit
[3] Suicide Assessment Five-step Evaluation and Triage

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline is based on several sources, including: Final Update Summary: Depression in Adults: Screening. U.S. Preventive Services Task Force, January 2016; American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders Fifth Edition - DSM-5; Nonpharmacological Versus Pharmacological Treatments for Adult Patients with Major Depressive Disorder, AHRQ Publication No. 15(16)-EHC031-EF, AHRQ, December 2015; Adult Depression in Primary Care health care guideline. Institute for Clinical Systems Improvement, updated September 2013; Suicide Prevention Toolkit for Primary Care; Suicide Assessment Five-Step Evaluation and Triage - SAFE-T. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

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- **When to refer:**
  - When additional counseling is desired
  - Primary physician is not comfortable managing patient's depression
  - Diagnostic uncertainty
  - Complex symptoms or social situation
  - Response to medication at therapeutic dose is not optimal
  - Considering prescribing multiple agents
  - More extensive interventions are warranted

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- **How to refer:**

  – Call Molina Healthcare of Michigan

  Member Services: 888 898-7969

  ✓ For a referral to a behavioral health specialist - psychiatrist, therapist, community mental health, etc.

  ✓ For referral to a Molina Behavioral Health Case Manager or Community Connector

  *As of October 1, the 20 visit limit for Medicaid recipients has been lifted!

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- **Molina Behavioral Health Toolkit for Primary Care Providers (available on molinahealthcare.com)**
  - Includes assessment and diagnosis of common conditions (depression, alcohol and other drug use, ADHD)
  - HEDIS Tips (including Antidepressant Medication Management)
  - Risk Adjustment

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Depression Screening

Molina Healthcare recommends the use of the ***PHQ-9 Depression Assessment Tool*** to assess depression.

- A component of the longer *Patient Health Questionnaire,* the *PHQ-9* is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
- The tool is a ***diagnostic measure*** for Major Depression as well as for recognizing subthreshold depressive disorders.
- It can be administered repeatedly – reflecting improvement or worsening of depression in response to treatment.
- Refer to Molina's ***Depression Clinical Guidelines Quick Reference Guide (QRG)*** included in this guide for recommended treatment interventions based on the results of the *PHQ-9*.
- For claims billing confirmation:
  - Use HCPCS G8431 if positive screen for clinical depression and follow-up plan is documented
  - Use HCPCS G8510 if negative screen for clinical depression.
  - Use the codes indicated above only if appropriate for the service/s rendered.

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Over the last 2 weeks, how often has the patient been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself and/or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself in some way	0	1	2	3
Scoring:	0	+ _____	+ _____	+ _____
TOTAL SCORE :	_____			

10. If the patient checked off any problems, how difficult have those problems made it for him/her to do work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

NOTE: If member answers YES to question #9 no matter what the overall scoring is, crisis protocols should be followed. At all levels, crisis policies for the practice should be followed.

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Consider total score as possible indicator of level of depression. Circle the appropriate score/severity indicator	
	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression
Q.10 – a non-scored question used to assign weight to the degree to which depressive problems have affected the patient's level of function.	

NOTE: The clinician should rule out physical causes of depression, normal bereavement and a history of manic/hypomanic episode

Screening tool available at the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) website:
http://www.integration.samhsa.gov/clinical-practice/screening-tools

Kroenke K, Spitzer RL, and Williams JBW. *The PHQ-9: validity of a brief depression severity measure.* J Gen Intern Med. 2001 Sep; 16(9): 606–613.

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Psychopharmacology For Behavioral Health Utilization Management

Medical Conditions that may cause or mimic depression

- Hypothyroidism/other endocrine disorders
- Stroke
- Heart Disease
- Kidney Disease
- Diabetes
- Anemia
- Arthritis
- HIV/AIDS
- Lupus/other auto-immune diseases
- Dementia
- CNS Tumors
- Multiple Sclerosis
- Sleep disorders

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Psychopharmacology For Behavioral Health Utilization Management

Medications with Severe or Very Common Psychiatric Side Effects, Including Depression

- Antibiotics- confusion, euphoria, depression, psychosis
- Beta-Blockers (Propranolol, Atenolol, Metoprolol)- depression
- Calcium Channel Blockers (Norvasc, Cardizem)- depression
- Steroids- depression, manic, mixed symptoms, paranoia/hallucinations, aggression
- Interferon (for Hepatitis C)- depression

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Complete diagnostic criteria for *Depressive Disorders* can be found in the DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*)

Overview of Criteria for Major Depressive Disorder (adapted from DSM-5)

Single Episode: 296.2x/F32.x; Recurrent Episode: 296.3x/F33.x

A. Five (or more) of the following symptoms have been present during the same 2- week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

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Molina Behavioral Health Toolkit for Primary Care Providers (available on molinahealthcare.com)

- Antidepressant Medication Management (HEDIS tip) Best Practices:
  - When starting an antidepressant medication, educate patients that it usually takes 1-6 weeks to start feeling better. Sleep and appetite often improve first – mood, energy and thinking may take longer
  - Inform patients that once they begin to feel better it's important to stay on medication for at least another 6 months
  - Develop plan in event of a crisis or thoughts of self-harm
  - Regularly monitor to assess response to treatment as well as side effects and safety

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ANTIDEPRESSANT MEDICATIONS

Description	Generic Name	Brand Name
Miscellaneous antidepressants	Buproprion Vilazodone Vortioxetine	Wellbutrin®; Zyban® Viibryd® Brintellix®
Phenylpiperazine antidepressants	Nefazodone Trazodone	Serzone® Desyrel®
Psycho-therapeutic combinations	Amitriptyline-chlordiazepoxide; Amitriptyline-perphenazine; Fluoxetine-olanzapine	Limbitrol® Triavil®; Etrafon® Symbax®
SNRI antidepressants	Desvenlafaxine Levomilnacipran Duloxetine Venlafaxine	Pristiq® Cymbalta® Effexor®
SSRI antidepressants	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Sertraline	Celexa® Lexapro® Prozac® Luvox® Paxil® Zoloft®
Tetracyclic antidepressants	Maprotiline Mirtazapine	Ludiomil® Remeron®
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6mg) Imipramine Nortriptyline Protriptyline Trimipramine	Elavil® Asendin® Anafranil® Norpramin® Sinequan® Tofranil® Pamelor® Vivactil® Surmontil®
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine Selegiline Tranylcypromine	Marplan® Nardil® Anipryl®; Emsam® Parnate®

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Antidepressants

- **SSRIs** (Prozac, Zoloft, Paxil, Celexa, Lexapro, Luvox)- general side effects- headache, akathisia/anxiety/increased energy, sexual dysfunction, increased risk of bleeding, generally mild weight gain, **suicidal thoughts** (black box warning, controversial). Discontinuation syndrome (nausea, headache, dizziness, chills, etc), especially Paxil; less so with Prozac.

- **SNRIs** (Effexor, Cymbalta, Pristiq)- similar side effects to SSRIs, perhaps slightly less severe. Also discontinuation syndrome, especially Effexor. May elevate blood pressure, should be carefully monitored. Cymbalta also indicated for fibromyalgia/chronic pain.

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Antidepressants

- **Wellbutrin** (NDRI) – also for smoking cessation. Increased risk for seizures. **No** sexual dysfunction or weight gain.

- **Remeron-** Sedation, weight gain, dry mouth. Little or no sexual dysfunction.

- **Trazodone-** sleep-inducing effects (often the reason used in hospitals). Rare but dramatic side effect = priapism (sustained > 4 hour erection).

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Older Antidepressants

- **Tricyclics (TCAs-** Elavil, Anafranil, Tofranil, Pamelor**)-** dry mouth, urinary retention, drowsiness, akathisia/anxiety/increased energy, sexual dysfunction, discontinuation syndrome, **cardiac arrhythmias and more danger in overdose** (main reasons less used).

- **MAOIs (monoamine oxidase inhibitors-** Nardil, Parnate**)-** very effective in treating atypical depression (increased appetite, increased sleep). Less used due to potentially lethal dietary (foods containing tyramine –aged cheese, wine- may cause hypertensive crisis) and drug interactions. Discontinuation syndrome. Serotonin syndrome, especially if taking another serotonergic agent.

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Thank you!

- **Questions???**