



Depression Clinical Practice Guidelines 2004-2005 Key Points

Provided by:

Highmark Behavioral Health Clinical Quality Improvement Committee

Introduction

The Highmark Behavioral Health Clinical Quality Improvement Committee has reviewed, evaluated and adopted the **Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline titled, "Depression in Primary Care: Detection, Diagnosis, and Treatment."** This guideline is utilized in the 2004 HEDIS® measure for behavioral health, which identifies medication management of depression as an area for focus. This particular guideline is geared toward treating depression in the primary care setting. The committee also reviewed, evaluated and adopted the **American Psychiatric Association (APA) Clinical Practice Guideline for the Treatment of Patients with Major Depression.** This practice guideline is a more extensive guide for the management of adult patients suffering from major depressive disorder.

Note: The "Depression in Primary Care" Guideline was developed by AHCPR, now known as Agency for Healthcare Research and Quality (AHRQ) and last reviewed by that organization in April 1993. The Highmark Behavioral Health Quality Improvement Committee has approved the continued use of this guideline for the PCP network because the guideline contents are still relevant to current medical practice and the guideline is the reference used by NCQA (National Committee on Quality Assurance) as the basis for its Antidepressant Medication Management Effectiveness of Care measure.

Selected Clinical Guidelines

The full guidelines are available on the following World Wide Web sites:

- <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.14485>
(Vol. 1, Detection and Diagnosis)
- <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.chapter.15593>
(Vol. 2, Treatment)
- http://www.psych.org/psych_pract/treatg/pg/Depression2e.book.cfm

Additional References and Resources

- Please fax your request for a Highmark **Depression Management Toolkit** to Mark Zine @ 412-544-2619.
- Please refer your Highmark patients to a Health Coach at **Blues On Call (1-888-BLUE-428)** for continued support in the management of your patients with a diagnosis of depression.
- The Physician Consortium for Performance Improvement / Major Depressive Disorder Core Physician Performance Measurement Set is available in the Highmark Depression Management Toolkit. Both an abbreviated version and full Major Depressive Disorder Core Physician Performance Measurement Set also are available at the AMA's Division of Clinical Quality Improvement website: <http://www.ama-assn.org/go/quality>. For additional information, contact the AMA at (312) 464-4908.
- A Quick Reference Guide for Clinicians, Number 5. Depression in Primary Care: Detection, Diagnosis, and Treatment. Publication # 93-0552, April 1993.

Some flexibility in specific cases will require deviations from guideline recommendations. All providers are responsible for individualizing recommendations to the specific clinical characteristics of each patient. Please refer your Highmark patient to Blues on Call (1-888-BLUE-428) or our Website at <http://www.highmark.com/>, for free health education services such as: tobacco dependency treatment programs, individual nutrition counseling, weight and stress management programs and classes on advance directives.

As with any insurance, members are eligible for services only as long as they are active members of the plan and the services are covered benefits of their group contract.

Physicians are encouraged to reference the Highmark Drug Formulary when selecting prescription drug therapy for eligible members, which may be found at <http://highmark.formularies.com/>. Members with a closed formulary benefit do not have coverage for non-formulary drugs. If appropriate, prescribe formulary medications to avoid non-coverage.

	DEPRESSION MANAGEMENT KEY POINTS	PCP Consider Psychiatric or Behavioral Health Consult
Evaluation	Screen all patients with two-question depression screen (U.S. Preventive Services Task Force): "Over the past two weeks, - Have you felt down, depressed, irritable, or hopeless? - Have you felt little interest or pleasure in doing things?" 1. Perform mental health evaluation	
Diagnosis	1. Accurately establish a diagnosis (please refer to DSM-IV-TR) - Major Depressive Disorder - Bipolar Disorder - Dysthymia - Adjustment Disorder with Depressed Mood 2. Determine the severity of symptoms 3. Evaluate the risk of suicide or harm¹----- 4. Determine family history of psychiatric illness²----- 5. Determine past history of illness and response to treatment 6. Determine presence of co-morbid physical or mental illnesses³----- - Prior to initiating an antidepressant medication, review patients symptoms and family history for Bipolar Disorder 7. Determine functional impairment	X X X
Treatment	1. Discuss treatment alternatives, benefits and risks, with the patient and family (Please note FDA Antidepressant Medication Warning) 2. Determine and implement a treatment plan - Medication with Patient Management⁴----- - If positive for Bipolar Disorder, establish a mood stabilizer first - If medication is prescribed, monitor closely, and be alerted to the FDA warning regarding antidepressants and suicide - Psychotherapy - Integrated Psychotherapy/Medication Management⁵----- - Split Psychotherapy/Medication - Consultation (psychiatrist or mental health professional) - Secure support services - Referral for inpatient or intermediate care (partial hospitalization or IOP)	X X
Follow-Up and Re-Evaluation	1. Communicate treatment plan to PCP/psychotherapist/psychiatrist 2. See the patient at least three times during the 12- week acute phase to assess progress, reevaluate the risk of harm and the presence of co-morbid conditions. 3. Communicate treatment status to PCP/psychotherapist/psychiatrist 4. If not substantially recovered at 12 weeks and not on medication managed by a psychiatrist, consider a psychiatric referral.⁶----- 5. Monitor patient for relapse for an additional twelve weeks, continuing antidepressant medication. 6. Educate the patient and family on the risk recurrence and establish a recurrence prevention plan. 7. Document all evaluation and treatment visits with the patient and family in the medical record.	X

¹ Consider a psychiatric or mental health consult with the presence of any suicidal ideation or behaviors. The dangerousness of suicidal signs can be difficult to assess.

² Consider a psychiatric consult first if patient/family members have ever suffered an attack of mania (fast, pressured speech; euphoria; grandiose feelings, impulsivity, hyperactivity, staying up and active much of the night; excessive sexual behavior). Placing patient on an anti-depressant alone could risk mania.

³ Depression may be a precursor to, comorbid with, or the result of a medical condition. BH practitioners will help patients adapt to catastrophic illness, chronic disorders such as diabetes, pain, Alzheimer's etc., assess suicidal risks and aid in compliance and decision making.

⁴ Physicians are encouraged to reference the Highmark Drug Formulary, which may be found at Highmark.formularies.com when selecting prescription drug therapy for eligible members. Members with a closed formulary benefit do not have coverage for non-formulary drugs. If appropriate, prescribe formulary medications to avoid non-coverage.

⁵ A BH practitioner can address psychosocial stressors through psychotherapy which will help monitor a potentially unstable emotional state, help patient learn how thinking styles can sustain or improve depression, learn how to cope better with the difficult stressors, and involves the family and social network in the patient's care.

⁶ Psychiatric consultation may be indicated based on the patient's level/type of response under the following circumstances; the patient has not responded to adequate trials of two antidepressants taken 6 to 8 weeks each, a partial response to one medication at a maximal dose or there is a good response to the antidepressant but side effects are excessive.