Clinical Practice Guideline 2006 Key Points

**Adult Depression**

Provided by:

**Highmark Behavioral Health Clinical Quality Improvement Committee**

In accordance with Highmark’s commitment to quality care, the Highmark Behavioral Health Quality Improvement Committee, consisting of network Primary Care Physicians and Specialists, has adopted the **Agency for Health Care Policy and Research (AHCPR) Clinical Practice Guideline** titled, “Depression in Primary Care: Detection, Diagnosis, and Treatment.” The committee also 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:


**Resources for Your Highmark Patients**

- Please fax your request for a Highmark **Depression Management Toolkit** to Mark Zine @ 412-544-2619.
- To access the **Behavioral Health Unit** for information regarding behavioral health benefits, levels of care available to members, or care and case management services, call 1-800-485-2889 (Option 1).
- If you would like to speak to someone regarding the **“Depression Management Program,”** call 1-800-596-9443 and listen to the menu option for “Depression Management Program.”

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 or direct pay contract.
### DEPRESSION KEY POINTS

- 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

#### 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 harm
4. Determine family history of psychiatric illness
5. Determine past history of illness and response to treatment
6. Determine presence of co-morbid physical or mental illnesses
7. Prior to initiating an antidepressant medication, review patient’s symptoms and family history for Bipolar Disorder
8. Determine functional impairment

#### 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
   a. Medication with Patient Management
   b. Psychotherapy
   c. Integrated Psychotherapy/Medication Management
   d. Secure support services
   e. Referral for inpatient or intermediate care (partial hospitalization or IOP)

#### 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.
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.

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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 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.
5 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.
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 Select (formerly the Highmark Closed Formulary) benefit do not have coverage for nonformulary drugs. When selecting prescription drug therapy for eligible Medicare Advantage members, please consider referencing the Highmark Medicare-Approved Formulary which may be found at http://highmark.medicare-approvedformularies.com.

If appropriate, consider prescribing medications included in the formulary to avoid noncovered expenses for your patient. Physicians may request to have a nonformulary drug covered for an individual patient. Evidence to support the ineffectiveness of formulary alternatives for the particular patient’s condition or a reasonable expectation of adverse reactions from the use of formulary products must be submitted for a request to be considered.

Instructions and the request form for this process are located on the Provider Resource Center under “Provider Forms”.
