Depression Care Path

Screening and Diagnosis

Diagnosis: Major Depressive Disorder is defined as depressed mood, markedly diminished interest or pleasure in almost all activities, >5% body weight changes in 1 month, insomnia/hypersomnia, fatigue, loss of energy, feelings of worthlessness, hopelessness, inability to concentrate and/or recurrent thoughts of death. These symptoms should be present most of the day, nearly every-day and cause significant distress or impairment in functioning.

Clinical Care Pathway

Inclusion criteria
• Patients age > 12
• PHQ-2>2 (New patients) and/or
• PHQ-9>9 (known depression diagnosis)

Initial Clinic Evaluation
• Precipitating factors
• Organic causes
• Consider baseline labs
• Check comorbidities (e.g., substances abuse, sleep disorders)
• Past Psych history
• Check family history

If diagnosis is depression

Determine severity

PHQ9 of 10-14
Moderate
Consider counseling and/or pharmacotherapy

PHQ9 of 15-19
Moderately Severe
Recommend counseling and/or pharmacotherapy

PHQ9 of ≥ 20
Severe
Strongly recommend counseling and/or pharmacotherapy

Screen for Bipolar Disease and assess suicide risk

Emergency Department Referral

If patient response positive to question 9 Refer to Medication Management Flowchart*

Management
• Ensure adherence
• Manage medication side effects
• Continue with titration to usual therapeutic dose
• Monthly PHQ-9

Depression Remission

For moderate + moderate severe depression, clinic visit every 4-6 wks.

Evaluate for

For severe depression, clinic visit ≤ 4 wks.

Continue Treatment
Continue medication 6-13 months

Debate 8 Month reevaluation
Consider patient symptoms risk for recurrence Preference for continuation

If deciding to discontinue medication recommend taper

If patient improves, follow up phone call 2-3 weeks

After discontinuation

Annual PHQ-9 for monitoring

Note:
Remission defined as PHQ-9 score of ≤ 5 (Goal: Achieve remission 11-13 months from initial diagnosis)

Note:
Improvement: Positive changes to work, sleep, eating, socialization, and/or a reduction in PHQ-9 score

Note:
At any point during pathway if pt. exhibits evidence of suicidality or significant psychiatric worsening then psychiatry consult should be considered

Note:
Remission defined as PHQ-9 score of <5

Note:
Improvement: Positive changes to work, sleep, eating, socialization, and/or a reduction in PHQ-9 score.

For moderate + moderate severe depression, clinic visit every 4-6 wks.

For severe depression, clinic visit ≤ 4 wks.

After discontinuation

Follow up phone call 2-3 weeks

Annual PHQ-9 for monitoring

Patient well

Please note: The Via Christi Health Alliance in Accountable Care, Inc. (the “ACO”) in consultation with its affiliated ACO providers developed these care pathways and guidelines based on the most recent evidence-based medicine data. The ACO is continually researching and updating its care pathways and guidelines to reflect the most recent evidence-based standards. This information is intended to provide health professionals with information to improve the quality of care and ultimately lower the cost of such care to the patients they serve. By providing this evidence-based information, it is not the intention of the ACO to provide specific medical advice for particular patients. Rather, we urge each provider to review this material when consulting and evaluating the treatment options suitable for their patients. The ACO affiliated providers are solely responsible for confirming the accuracy, timeliness, completeness, appropriateness and helpfulness of this material and making all medical, diagnostic or prescription decisions.
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Medication Management Flow Chart

Start an SSRI: Watch for gastrointestinal side effects, sexual side effects and restlessness.
- Fluoxetine
- Paroxetine: pregnancy category D
- Fluvoxamine
- Sertraline
- Citalopram: Watch for QTc prolongation with citalopram. Max dose is 20mg if concomitant use of omeprazole. Max dose of citalopram in patients > 60 years in 20 mg.
- Escitalopram

Switch to another SSRI
- Fluoxetine
- Paroxetine: pregnancy category D
- Fluvoxamine
- Sertraline
- Citalopram: Watch for QTc prolongation with citalopram. Max dose is 20mg if concomitant use of omeprazole. Max dose of citalopram in patients > 60 years in 20 mg.
- Escitalopram

Switch to SNRI
- Refer to Psychotherapy
- Refer to Psychiatrist

Augment with
- Aripiprazole: Would not be recommended at primary care setting. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia.
- Bupropion: Contraindicated in patients with seizure disorder, binge & purging behavior and hx of TBI. Avoid if co-morbid anxiety or chronic heavy alcohol use.
- Buspirone: Consider if co-morbid anxiety.
- Lithium: Would not be recommended at primary care setting. check Renal Function Tests and Thyroid Function Tests. Avoid in females of child bearing age (risk of cardiac defects) and in patients with electrolyte abnormalities. Avoid when patients are taking NSAIDs, ACE inhibitors and thiazide diuretics. Narrow therapeutic index and requires therapeutic drug monitoring with Lithium level. Avoid if high risk of suicide.
- Mirtazapine: consider if poor appetite & insomnia.
- Quetiapine: Would not be recommended at primary care setting. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke).

Other Considerations:
- Remove access to means of self-harm in severe phase of a depressive episode such as firearms. Avoid giving 90 day supply of medications.
- If patient needs emergent mental health services because of suicidal thoughts or self-care failure, send patient to nearest ED.
- If concerned about safety of the patient and patient is not reachable, can ask law enforcement to do a “welfare check” on the patient.

Patient Engagement
- Psychoeducation
- Encourage compliance
- Sleep hygiene education
- Community engagement
- Exercise

Specialist Consult

When to Refer:
- Poor treatment response, intolerable side effects.
- Co-morbid personality disorders, substance abuse or psychotic symptoms.
- Complex psychosocial environment.

References:
- The Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM–5; American Psychiatric Association [APA], 2013.