Taming the Black Dog: Delivering Effective and Confident Depression Treatment in Primary Care

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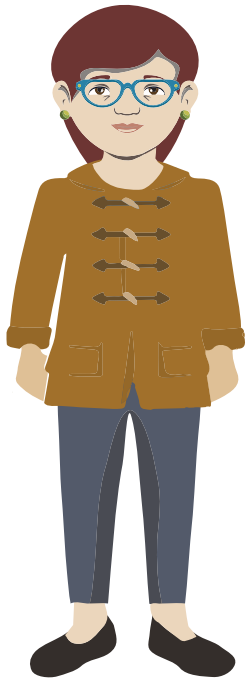
Agenda

- Screening
- History
- Treatment (with focus on processes of care)
- Documentation and billing

Typical Patient Journey Accessing Depression Care



This is Susan.
Susan lives in Maine
She thinks she's depressed.
Time: Week 0

Talks to her partner & friends

Takes Lexapro she found in the cabinet from 2 years ago, but stops after 2 weeks.

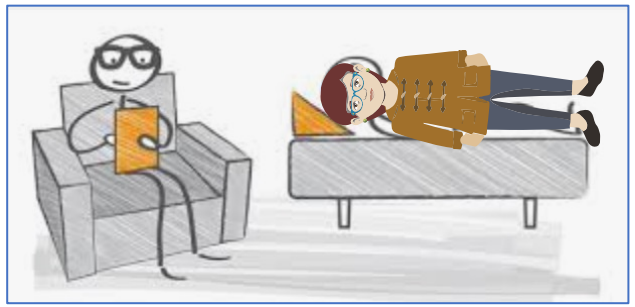
Increases alcohol and marijuana use

Tries to go for daily walks, but can't stay motivated

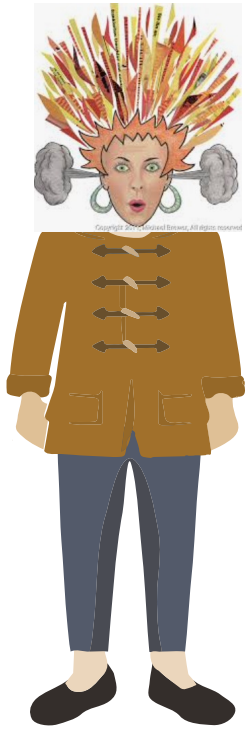
Time: Weeks 1-10

This is Marshall.
He is a PCP.

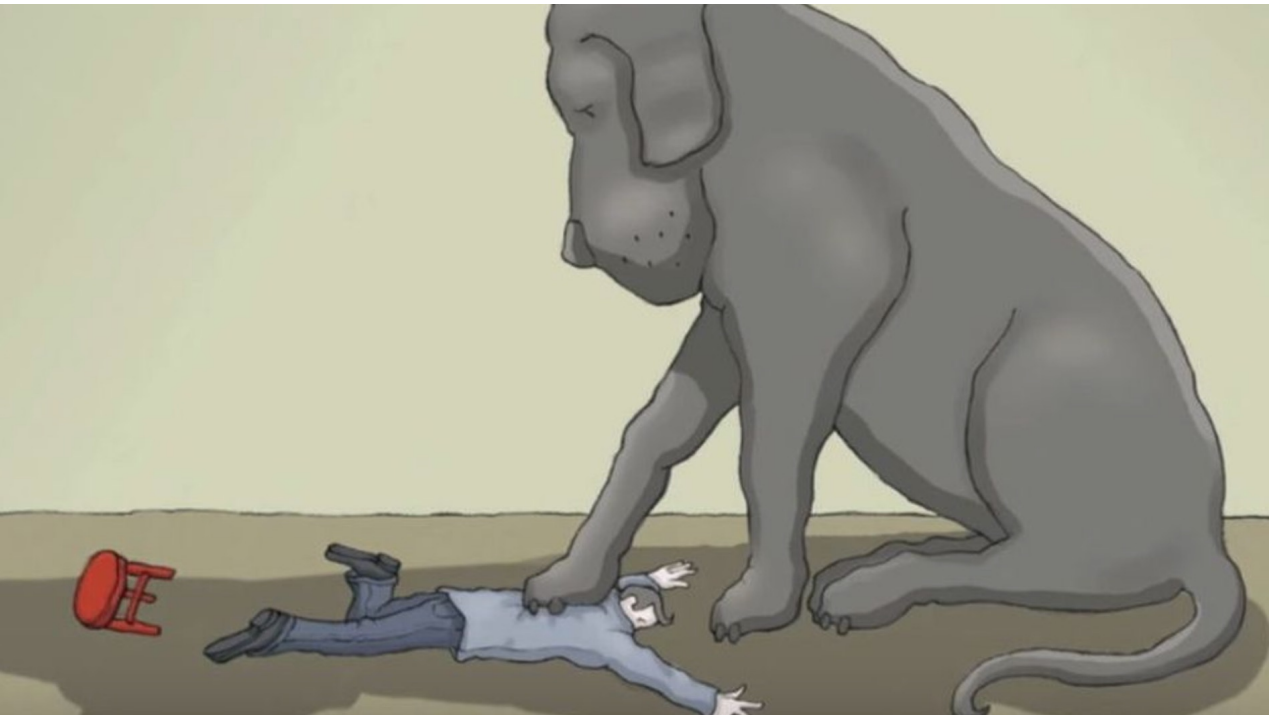
Time to get appt:
Weeks 11-13



Time to get meds:
Weeks 14-15
Time to psychologist appt: Week 31



Week 50: Susan's symptoms worsen, and she has suicidal thoughts



Everyone's Depression is Unique

- English writer Samuel Johnson wrote to a friend:"… What will you do to keep away the black dog that worries you at home?"
- Winston Churchill : "I don't like standing near the edge of a platform when an express train is passing through. I like to stand back and, if possible, get a pillar between me and the train. I don't like to stand by the side of a ship and look down into the water. A second's action would end everything. A few drops of desperation."
- "I think this man might be useful to me – if my black dog returns. He seems quite away from me now – it is such a relief. All the colours come back into the picture."

Depression in Primary Care

- 60% of mental health care delivery occurs in the primary care setting.
- 80% of antidepressant prescriptions are written by providers who are not specialty-trained mental health care providers.
- Stigma remains a primary barrier to recognizing and providing treatment for mental illness.

Frank et al. *Psychiatr Serv* 2003; Mark et al. *Psychiatr Serv* 2009; Sartorius. *Lancet* 2007.

Rationale for Treating Depression in 1˚ Care

- Depression is **a medical condition with psychological symptoms.**

- **Depression worsens medical conditions and is lethal.**

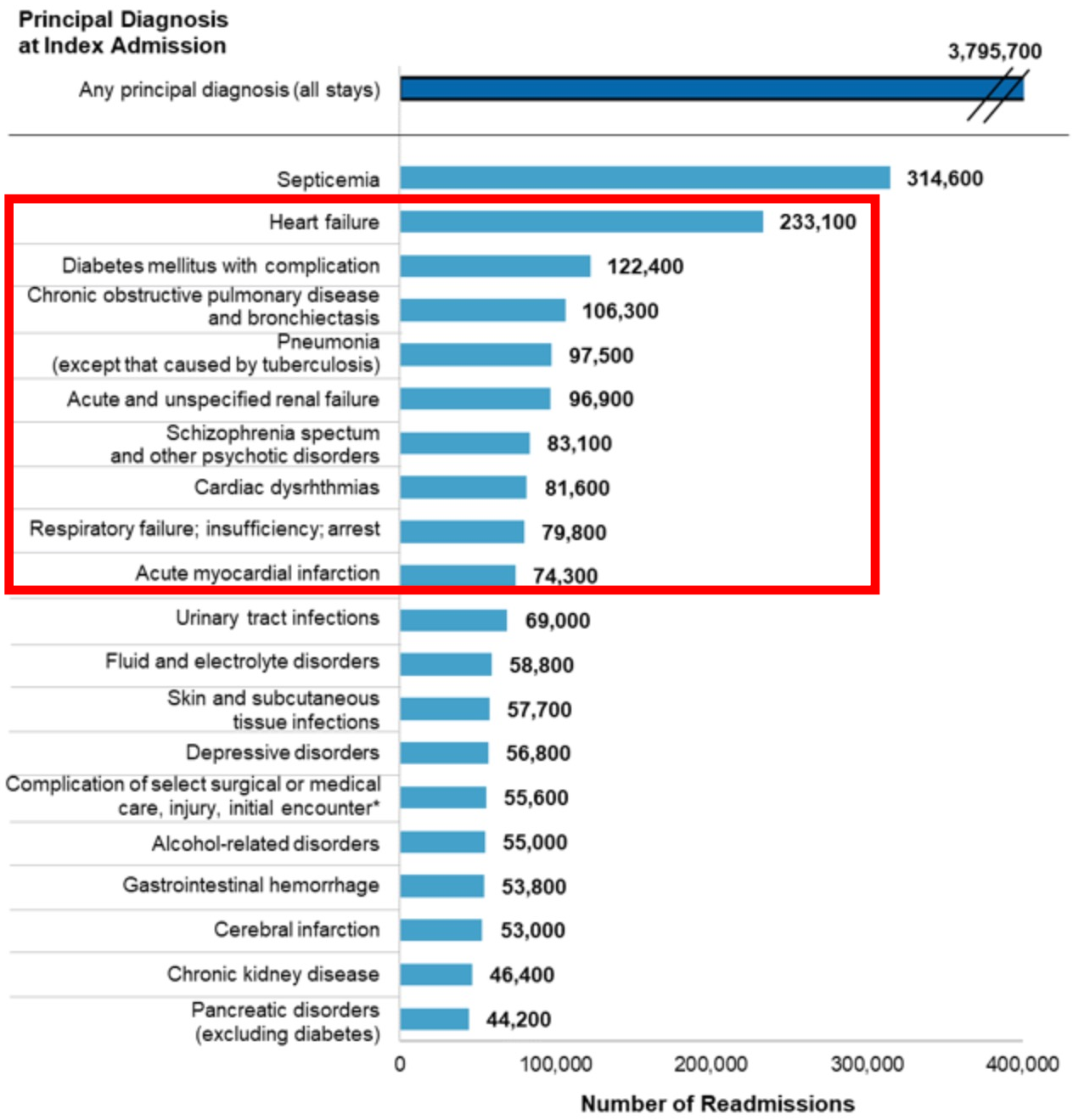
  ↑Sticky platelets ↓Cardiac conduction variability ↓Immunity ↓Cognitive function ↓Vascular health

  3Ds: Depression, Diabetes, Dementia

- **What Matters Most** to patients (usually quality of life, vigor and energy, sleep, family and social, finances, independence, internal peace, joy, being pain-free) – are **all impacted by depression.**

- Disease silos in medicine are artificial. Like it or not, treating depression is a job responsibility of primary care providers.

Top 20 principal diagnoses with the highest number of 30-day all-cause adult hospital readmissions, 2018



Clinical Conditions With Frequent and Costly Hospital Readmissions

"Screening positive for mild and moderate-to-severe depressive symptoms during a hospitalization on a general medical service is associated with an increased dose-dependent readmission rate within 30 days of discharge in an urban, academic, safety-net hospital. Further research is needed to determine whether treatments targeting the reduction of depressive symptoms reduce the risk of readmission."

Cancino et al. J Hospital Medicine. 2014.

"Care transition support and post-discharge depression treatment can reduce unplanned hospital use with sufficient uptake of the Re-Engineered Discharge for Depression (RED-D) intervention."

Mitchell et al. Annals of Family Medicine. 2022.

Statistical Brief #278. Healthcare Cost and Utilization Project (HCUP). July 2021. Agency for Healthcare Research and Quality, Rockville, MD.

Screening: Case Example #1

- New patient visit.

- 36-year-old married Hispanic woman with two children. She is an associate at a corporate law firm. She has a good marriage, her children are healthy and doing well in school, and her parents live nearby and help with childcare. She exercises regularly with her friends. Her medical problems include environmental allergies. Only medication is oral contraceptive. She rarely drinks alcohol, denies any drug use, and is looking forward to a family vacation.

- Should you screen her for depression, and how?

U.S. Preventive Services TASK FORCE

Special Communication | USPSTF RECOMMENDATION STATEMENT

Screening for Depression in Adults
US Preventive Services Task Force Recommendation Statement

Albert L. Siu, MD, MSPH; and the US Preventive Services Task Force (USPSTF)

DESCRIPTION Update of the 2009 US Preventive Services Task Force (USPSTF) recommendation on screening for depression in adults.

METHODS The USPSTF reviewed the evidence on the benefits and harms of screening for depression in adult populations, including older adults and pregnant and postpartum women; the accuracy of depression screening instruments; and the benefits and harms of depression treatment in these populations.

POPULATION This recommendation applies to adults 18 years and older.

RECOMMENDATION The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

JAMA. 2016;315(4):380-387. doi:10.1001/jama.2015.18392

Editorial pages 349 and 351

Author Audio and Video Interviews and **JAMA Report Video** at jama.com

Related article page 388 and **JAMA Patient Page** page 428

CME Quiz at jamanetworkcme.com and **CME Questions** page 411

Related articles at jamapsychiatry.com, jamainternalmedicine.com, and jamaneurology.com

Author Affiliations: Author affiliations are listed at the end of this article.

Authors/Group Information: The USPSTF members are listed at the end of this article.

Corresponding Author: Albert L. Siu, MD, MSPH (albert.siu@mssm.edu).

Patients want to be screened for depression.

Qualitative study of patients with coronary heart disease.
Patients are in favor of standardized routine screening for depression in cardiac practice, **if the rationale was disclosed.**

Patients felt that standardized screening addresses holistic care demands, **promotes validation of individual symptom burden and legitimizes the display of psychological distress in cardiac practice.**

Ohanyan et al. Investigating patients´ views on screening for depression in cardiac practice: A qualitative interview study. J Psychosomatic Res. 2021.

How to Screen

- "Tell me about your mood."
- "Do you think you are depressed."
- *"In the past month, have you lost interest or pleasure in things you usually like to do?"*
- *"Have you felt sad, low, down, depressed or hopeless?"*

- For the PHQ-4, a score of $\geq$ 3 for either the anxiety or depression subset supports subsequent screening for depression or anxiety.

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems? *(circle one per question)*		Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Little interest or pleasure in doing things	0	1	2	3
4	Feeling down, depressed, or hopeless	0	1	2	3

Löwe B, et al. A 4-item measure of depression and anxiety: validation and standardization of the Patient Health Questionnaire-4 (PHQ-4) in the general population. J Affect Disord. 2010.

Risk Assessment and Screening Interval

Women, young and middle-aged adults, and minoritized persons have higher rates of depression, as do persons who are undereducated, previously married, or unemployed. Chronic illnesses, other mental health disorders, or a family history of psychiatric disorders also increases risk.

Risk factors in older adults include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and history of depression.

Risk factors during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.

The optimal timing and interval for screening for depression is not known.
A pragmatic approach might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.

Taking a Depression History

- Symptoms
  - Sleep
  - Interest
  - Guilt
  - Energy
  - Concentration
  - Appetite
  - Psychomotor
  - Suicide

(SIG E CAPS)

- Context
  - Duration
  - Triggers
  - Severity
  - Impairment
  - SDoH

- History
  - Previous episodes
  - Current treatment
  - Previous treatments
    - Dose and duration
  - Family hx
  - Hx suicide attempt(s)
  - Hospitalizations
  - “Is this the most depressed you’ve ever been?”
  - Have you ever been so depressed you couldn’t get out of bed?”

- Comorbidities
  - Anxiety
  - Substance use
  - Loneliness
  - Grief
  - Mania
  - SDoH & Trauma
  - Cognition
  - Somatic preoccupation
  - Psychosis
  - Sleep apnea
  - Pain
  - Multiple comorbidities

History: Case Example #2

- 45-year-old woman meets criteria for MDD. This is her fifth episode. She is compliant with notriptyline (Pamelor) 100 mg (plasma level 90 ng/ml) and olanzapine (Zyprexa) 10 mg. She has a family history of bipolar disorder, numerous motor vehicle accidents with 2 TBIs, she tried to die by suicide both by overdose, and has been treated with 4 different antidepressants in the past and 1 course of ECT (9 treatments). She has multiple comorbidities, smokes 1 ppd, is unemployed and disability is pending, and uses marijuana edibles nightly to help with insomnia.

When To Refer A Depressed Patient to Psychiatry

- Elevated risk of suicide
- Psychotic depression
- Treatment resistant depression or anxiety (i.e., not responded to 2 adequate dose and duration trials of an antidepressant).
- Bipolar condition that is not stable a/o is compromised by addiction or reproductive concerns.
- Diagnostic uncertainty
- Personality traits interfering with medical management
- Neurodegenerative disease with emotional changes

Treatment Resistant Depression: Clinical Peals To Obtain a More Useful Clinical History

- Remember to screen for:
  - Obstructive sleep apnea
  - Alcohol and marijuana and opioid (and meth) misuse. (really any disorders that activate the reward system and can disrupt sleep including gaming and excessive social media use)
  - Benzodiazepine misuse
  - Adherence: Aim for $\geq$ 80%
  - Bipolar: “Have you even been the opposite of depressed, euphoric or incredibly irritable for many days…”
- Learn to take an actionable sleep and insomnia history.
- For all patients 70+ administer an annual cognitive screen.

Three (Minimal) Goals in the Primary Care Treatment of Depression

1. Take a really good history.
2. Get really good at first- and second-line pharmacotherapy options.
3. Implement the trauma-informed care skills you will learn today from Dr. Sprang and learn to manage your own emotional response to challenging patients that you will learn about from Dr. Pritchard.

Considering Processes of Care to Improve Outcomes

	Majority consensus and minority alternative
Step 1	Escitalopram Alternatives: sertraline, duloxetine
Step 2 for minimal or non-response)	Switch to duloxetine Alternatives: venlafaxine, desvenlafaxine
Step 3 for minimal or non-response	Switch to nortriptyline Alternative: bupropion
Step 2-3 for partial response	Augment antidepressant with ~~lithium or an~~ atypical antipsychotic Alternatives: combine SSRI or SNRI with mirtazapine or bupropion
Duration of each step	6 weeks Alternatives: 4 weeks; 8 weeks

Using Data From Studies of Late-Life Depression as an Example Depression Response Rates

Treatment as Usual	Collaborative Care	Receiving Placebo in a Randomized Controlled Trial
20%	40%	30-40%

Processes of Care When Using Antidepressants Under Usual Care vs Experimental Conditions		
	Usual Care (20% response)	**Experimental Conditions (40% response)**
Schedule of visits	Based on physician & patient availability; 2-3 visits/12 wks	Fixed; 4-6 visits/6 weeks; 6-12 visits/8-12wks
Duration of visits	10-20 minutes	30-60 minutes
Treatment protocol	Individualized for each patient based on their characteristics and preferences	Predetermined; minimal adaptations based on patient's characteristics (e.g., frailty)
Selection of antidepressant	Large # of antidepressants, each used in a small number of patients; matching patient's clinical characteristics with perceived features of specific antidepressants	Small # of antidepressants preselected based on best evidence or guidelines and used in all patients.
Dose titration and change in tx	Negotiated at each visit with each patients based on perceived adverse effects or lack of improvement. Changes often ill-advised or ill-times	Predetermined; based on operationalized criteria, protecting clinicals from personal biases or pressures from patients or their families.
Monitoring of sx and adverse effects	Monitoring based on spontaneous reports and ad-hoc clinical interviews	Systematic monitoring with use of structured interviews and validated scales.
Main focus on clinical interactions	Negotiating whether and how antidepressants should be used, titrated up or down, switched, or augmented, selection of augmenting or alternative agents	Maximizing treatment adherence with psychoeducation, characterization of changes in patient's symptoms, management of adverse events.

Mulsant et al. A systematic approach to pharmacotherapy for geriatric major depression. Clin Geriatric Med. 2014.

Documentation and Coding of ICD-10-CM Major Depressive Disorder

- Frequency (single episode or recurrent)
- Severity (mild, moderate, severe with or without psychotic fx)
- AND/OR: Clinical status of current episode (partial or full remission).

- Severity is based on number of symptoms, (obviously) severity of symptoms, and degree of functional impairment or disability.

- Document suicidal thoughts and behaviors at every encounter, even if negative.

Getting Credit for Primary-Care Delivered Psychotherapy

- Know it or not, you provide psychotherapy.
- Usually this is:
  - Supportive psychotherapy, behavioral activation, motivational interviewing, problem solving therapy, family-focused therapy with the patient present.
- If you provide psychotherapy for at least 16 minutes, do this:
  - Bill your E/M code using MDM* (not time-based approach).
  - Use add-on psychotherapy code 90833.

**MDM: Medical Decision Making*

Getting Credit for Primary-Care Delivered Psychotherapy

- Create a template to support the 90833 code.
- (Underlined text reflects drop-down choices):

On 03/11/2023 I provided 16 minutes of psychotherapy (start time/end time) to address depression. Using a supportive/CBT/PST/MI/other approach, the pertinent themes addressed include low self-esteem/relationship problems/insomnia/grief/managing stress/staying sober. Since last visit the patient has improved/worsened. There are/are not concerns about self-harm. (Free text option at end).

Karp's 5 Tips for Successful Treatment of Depression in Primary Care

1. Clarify: Single Episode versus Recurrent depression.

2. Charter a treatment course, instill confidence, and set expectations.
   - "Let's consider treatment as an experiment. If what I'm prescribing does not work, I have a plan for what to do next."
   - "I consider depression treatment in 6-month 'chunks' of time."

3. Leverage your medical assistants and nurses for between session check-ins.

4. Don't go down the ADHD "rabbit hole," especially for those using excessive marijuana.

5. Assure obstructive sleep apnea and diabetes are well-controlled.

Thank you for choosing to spend your Saturday with us at the Psych4PCPs conference.

We are hiring:

psychiatry.arizona.edu/about-us/available-positions