

Scope and Target Population:

To assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of new or existing diagnosis of major depression in adults age 18 and over and assist patients to achieve remission of symptoms, reduce relapse and return to previous level of functioning.

This guideline is an evidence-based document based on best care; it has also evolved to include information on best-practice systems for implementation. A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force. Depending on resources and systems, a group or clinic might also consider an interim plan of screening high-risk patients such as those with diabetes, cancer, chronic pain, coronary artery disease and post-stroke, as well as those with a history of previous depression and all perinatal patients.

Per work group request, patient feedback was sought through ICSI's Patient Advisory Council.

Clinical Highlights and Recommendations:

- A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment plan and follow-up of major depression is to consider:
 - how well the diagnosis is documented
 - how well the treatment team engages and educates patients/families
 - how reliably the ongoing patient contacts occur and response/remission to treatment are documented
 - how well the outcomes are measured and documented
- Use a standardized instrument to document depressive symptoms. Document baseline symptoms and severity to assist in evaluating future progress, including response and remission rates.
- Additional considerations should be taken into account:
 - Patients with a high risk of common comorbid depression conditions such as substance abuse, diabetes, cardiovascular disease and chronic pain should be screened for depression.
 - Older persons, pregnant women and the cultural experiences of patients require special considerations regarding risk, assessment and treatment of depression.
- Antidepressant medications and/or referral for psychotherapy are recommended as treatment for major depression. Factors to consider in making treatment recommendations are symptom severity, presence of psychosocial stressors, presence of comorbid conditions, and patient preferences. Physical activity and active patient engagement are also useful in easing symptoms of major depression.)
- If the primary care provider is seeing incremental improvement, continue working with that patient to augment treatment or increase medication dosage to reach remission. This can take up to three months. Don't give up on the patient whether treating in primary care or referring. Studies have shown that primary care can be just as successful as specialty care.
 - For medication treatment, patients may show improvement at two weeks but need a longer length of time to really see response and remission. Most people treated for initial depression need to be on medication at least 6-12 months after adequate response to symptoms. Patients with recurrent depression need to be

- treated for three years or more.
- For psychotherapy treatment, it can take 8-10 weeks of regular and frequent therapy to show improvement.
- The key objectives of treatment are to:
 - achieve remission of symptoms in the acute treatment phase for major depression
 - reduce relapse and reduction of symptoms
 - return patient to previous level of occupational and psychosocial function

Priority Aims:

The aims and measures in this guideline are based upon evidence supporting impact of system elements, process elements, promoting actual symptom and functional patient improvement and outcomes, and are aligned with MN Community Measurement and the DIAMOND Initiative where there is overlap.

1. Increase the accuracy of diagnosis of major depression.
2. Improve the frequency of assessment of response to treatment in patients with major depression.
3. Improve the outcomes of treatment for major depression.
4. Improve the frequency of assessment of patients with major depression for the presence of substance abuse.
5. Increase the assessment for major depression of primary care patients presenting with additional high-risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women.
6. Improve communication between the primary care physician and the mental health care provider (if patient is comanaged).
7. Decrease the number of completed suicides in patients managed for their depression in primary care.

Additional Background:

The U.S. Preventive Services Task Force (USPSTF) recommends routine depression screening for all adults but only in clinical practices that have systems in place to assure accurate diagnosis, effective treatment and follow-up. The purpose of this guideline is to assist ICSI members to develop systems that support effective diagnosis and treatment of major depression.

A reasonable way to evaluate whether a system is successfully functioning in its diagnosis, treatment and follow-up of major depression would be to consider the following:

1. **Diagnosis:** The clinic or medical group should have a mechanism to assure that they are routinely evaluating for and documenting the presence for two weeks of at least five vegetative signs and symptoms of major depression (and that one includes sadness or loss of interest or pleasure in usual activities) in order to substantiate that the patient meets the DSM-IV TR criteria for major depression.
2. The clinic or medical group should have a systematic way to provide and document:
 - a. **Engagement Education:** The patient and his/her family is actively engaged and participating in self-management, based on knowledge of the nature of the disease, risk/benefits of treatment options, and consideration of patient preferences.
 - b. **Ongoing Contacts:** A documented system to assure ongoing contacts with the patient during the first six to twelve months of care (scheduled follow-up appointments, phone calls and some way to react and/or reach out if the patient drops out of treatment) based on use of a standardized, objective tool used at each contact to document and track treatment response.
3. **Outcomes:** The system should have a way of reliably and consistently monitoring outcomes of individuals and systemwide to improve individual care and the effectiveness of the clinical practice overall.

Importance of Major Depression Focus in Primary Care

Major depression is a treatable cause of pain, suffering, disability and death, yet primary care providers detect major depression in only one-third to one-half of their patients with major depression. Additionally, more than 80% of patients with depression have a medical comorbidity. Usual care for depression in the primary care setting has resulted in only about half of depressed adults getting treated and only 20%-40% showing substantial improvement over 12 months.

In a national survey from the World Health Organization of more than 9,000 adults age 18 and over, the prevalence of major depression was 6.7%. Additionally, major depression was second only to back and neck pain for having the greatest effect on disability days, at 386.6 million U.S. days per year.

In another WHO study of more than 240,000 people across 60 countries, depression was shown to produce the greatest decrease in quality of health compared to several other chronic diseases. Health scores worsened when depression was a comorbid condition, and the most disability combination was depression and diabetes.

Work productivity is significantly decreased in employees with major depression with 8.4 hours lost on average per worker per week. This is estimated to cost employers \$44 billion per year in lost productivity.