ICSI
Institute for Clinical Systems Improvement

Executive Summary – March 2016

Major Depression in Adults in Primary Care Guideline

Scope and Target Population:

The purpose of this guideline is to assist primary care in developing systems that support effective assessment, diagnosis and ongoing management of initial and recurrent major depression and persistent depressive disorder in adults age 18 years and over, and assist patients to achieve remission of symptoms, reduce relapse and return to previous level of functioning. This guideline does not address the pediatric population. Diagnoses with significant overlap of symptoms outside the scope of this guideline include anxiety disorder, adjustment disorder and bipolar disorder.

Aims:

The aims and measures in this guideline are based upon evidence supporting impact of system elements and process elements, and promoting actual symptom and functional patient improvement and outcomes, and are aligned with MN Community Measurement where there is overlap. The work group has elected to use PHQ-9 in the measures, since it is broadly utilized by various organizations. There are other evidence-based tools that may be used. If other tools are chosen for measurement, they should be sensitive, specific, reliable and valid for measuring intensity levels and response and remission rates.

1. Increase the percentage of patients accurately diagnosed with major depression or persistent depressive disorder.
2. Decrease the number of completed suicides in patients with major depression or persistent depressive disorder managed in primary care.
3. Increase the percentage of patients with major depression or persistent depressive disorder who are screened for substance use disorders.
4. Increase the screening for major depression or persistent depressive disorder of primary care patients presenting with additional high-risk conditions such as diabetes, cardiovascular disease, post-stroke, chronic pain and all perinatal women.
5. Improve communication between the primary care physician and the mental health care clinician (if patient is co-managed).
6. Increase the percentage of patients with major depression or persistent depressive disorder who have improvement in outcomes from treatment for major depression or persistent depressive disorder.
7. Increase the percentage of patients with major depression or persistent depressive disorder who have follow-up to assess for outcomes from treatment.

Additional Background:

In 2016, the U.S. Preventive Services Task Force (USPSTF) updated its recommendations to include routine screening for depression of the general adult population, pregnant and postpartum women. There was moderate evidence that screening pregnant and postpartum women reduced depression prevalence and increased remission and treatment response even in the absence of additional treatment supports. Outcomes were better with such supports. There was low to moderate evidence showing the same for the general adult primary care population but insufficient evidence to show benefit in older adults. They concluded that generalizing from evidence in all adults to older adults may be reasonable. Furthermore, the American College of Preventive Medicine (ACPM) supports this recommendation and adds that all primary care practices should have such systems of care in place. Given that the outcomes are better when reliable systems and supports are put in place to diagnose, follow-up and modify treatment as needed, this guideline will be highlighting evidence-based, effective ways to implement such supports.

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 reliable process for routine evaluation and documentation of DSM-5 criteria for major depression.
2. The clinic or medical group should have a systematic way to provide and document:
    a. **Engagement and Education:** The patient and his/her family are actively educated, 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 is in place to ensure ongoing contacts with the patient during the first 12 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 to reliably and consistently monitor and improve outcomes for individuals and to improve systemwide 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 clinicians 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. Approximately 70-80% of antidepressants are prescribed in primary care, making it critical that clinicians know how to use them and have a system that supports best practices.

At any given time, 9% of the population has a depressive disorder, and 3.4% has major depression. In a 12-month time period, 6.6% of the U.S. population will have experienced major depression, and 16.6% of the population will experience depression in their lifetime.

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 a 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 disabling combination was depression and diabetes.

A 2011 study showed a relationship between the severity of depression symptoms and work function. Data was analyzed from 771 depressed patients who were currently employed. The data showed that for every 1-point increase in PHQ-9 score, patients experienced an additional mean productivity loss of 1.65%. And, even minor levels of depression symptoms were associated with decrements in work function.

Cultural Considerations

Clinicians should acknowledge the impact of culture and cultural differences on physical and mental health. There is evidence that non-majority racial and cultural groups in the U.S. are less likely to be treated for depression than European Americans. In an epidemiological study that compared rates of diagnosing and treating depression in the early 1990s to patterns 10 years later, only 4.9% of minorities were treated with antidepressants compared with 12.4% of non-Hispanic Caucasians.

A person's cultural and personal experiences influence his/her beliefs and therefore attitudes and preferences. If these experiences are taken into consideration, openness to and readiness to change (including readiness to seek and adhere to treatment) will be enhanced. People of differing racial/ethnic groups are optimally treated using currently available evidence-based interventions when differential personal elements, from biological to environmental to cultural, are considered during the treatment planning process.

Assessment and treatment tools

- Many **assessment tools** may not be useful for certain populations. Screening instruments are validated in certain groups. Use caution because a tool may not be applicable to all groups.
- Most empirically supported **therapies** have been evaluated with Caucasian, middle-class, English-speaking populations.

Cultural beliefs and common presentations

- When dealing with patients from diverse cultures, the impact of patient's cultural beliefs around depression, cultural stigma and manifestation of depression in physical symptoms vs. psychological can play a role in how patients perceive depression and subsequently seek treatment.
- Clinicians can create a more comfortable environment for a patient of another culture by acknowledging the impact of culture and cultural differences on physical and mental health.
- Bodily idioms of distress are very common in many cultures. In place of psychosomatic theories that emphasize individuals' inner conflict, many traditions of medicine have sociosomatic theories that link bodily and emotional distress to problems in the social world.
- The concept of depression varies across cultures. For example, in many cultures, for depression to become a problem for which a person seeks medical treatment, symptoms may include psychosis, conversion disorders or significant physical ailments.