Workshop: Management of Depression in the Primary Care Setting, Kaiser Permanente of Ohio’s Multidisciplinary Model

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Disclosure

Presenters reported no financial interest relevant to this presentation
Objectives

To review the development of a current multidisciplinary program at Kaiser Permanente of Ohio (KPOH) designed for the management of depression in a primary care setting.

To identify and understand the potential barriers while developing and implementing a workflow for a depression screening program in a primary care setting.

To develop potential workflows and ideas for each attendee to potentially apply to his/her own clinical practice.
Introduction to KPOH’s Program

Prior Attempts:
• Brainstorming with trial & error for several years
• How to integrate BHS in the most practical way?
  • Several facilities to service.

Current program:
• Took about 6 months to develop
• Went live 08/2011
Who else has experience with this?

What have been your challenges?

What are your experiences & concerns?

What would you like to talk about regarding this topic?
Forming a Workflow

Let's Compare and Contrast

*Ideas* and *Experiences*
FIRST Step – Team Formation?

Who needs to be involved in order to create an improved process for the management of depression in primary care?

Discuss:
Think of your practice and facility – who would you need to be a part of your team?
FIRST Step – KPOHs Team

Behavioral Health Representatives

Primary Care Representatives
- Physician and nursing

Care Manager Representatives
- Clinical pharmacy
SECOND Step - What is the Patient Population?

Who should be screened for depression? EVERYONE is a lot of people!

Discuss:
What 4 populations would you screen within your patient base?
Why?
SECOND Step - KPOH’s Patient Population?

1) Diabetes (HgbA1c >9%)
2) Coronary Artery Disease
3) Congestive Heart Failure
4) Asthma (local initiative)

What about Hypertension?
What about chronic pain?
SECOND step: KPOH’s Screening Tool

We wanted electronic notification

Teamed up with our data department to create a Best Practice Alert (BPA)

BPA fires upon rooming for initial screening

If BPA positive, prompts full screening and a depression smart set
SECOND step: KPOH’s Screening Tool PHQ2

UPON ROOMING

**DEPRESSION SCREENING: Actions:**
1. Click Accept to open SmartSet and complete (PHQ2) Questionnaire and sign the SmartSet;
2. If patient answered YES to one of the questions, complete PHQ9 and inform provider;
3. Screening not performed - select appropriate Acknowledge reason.

Acknowledge Reason:  

- Patient Refused Screening
- Clinically Inappropriate
- Other

Open SmartSet: SCREENING DEPRESSION NURSE OH preview
SECOND step: KPOH’s Screening Tool

PHQ2 → PHQ9

IF “YES” TO EITHER QUESTION → PHQ9
SECOND step: KPOH’s Screening Tool Provider

PROVIDER OPENS OFFICE VISIT ENCOUNTER

**DEPRESSION:** Your patient completed PHQ9. Actions:
1. Please review the PHQ9 results with patient;
2. Click Accept to order medication/Referral from the SmartSet;
3. Medications/Referral not ordered - Select appropriate Acknowledge Reason.

Acknowledge Reason: [Field]

- Patient Refused Medications
- Clinically inappropriate
- Other

Open SmartSet: DEPRESSION MEDS OH preview
THIRD Step – What is the Treatment Algorithm? What about Follow up?

How to treat depression with the resources currently available?

Discuss:
How would you treat the various severity levels of depression at your facility?
### THIRD Step – What is the Treatment Algorithm? What about Follow up?

<table>
<thead>
<tr>
<th></th>
<th>Treatment Options</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ-9 Score 5-9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 Score 10-14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 Score 15-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 Score = &gt;20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 SCORE</td>
<td>SEVERITY OF SYMPTOMS</td>
<td>IS IT MDD?</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>0 - 4</td>
<td>None</td>
<td>Unlikely MDD</td>
</tr>
<tr>
<td>5 - 9</td>
<td>Mild</td>
<td>Unlikely MDD</td>
</tr>
<tr>
<td>10 - 14</td>
<td>Moderate</td>
<td>Probable MDD</td>
</tr>
<tr>
<td>15 - 19</td>
<td>Moderately severe</td>
<td>Probable MDD</td>
</tr>
<tr>
<td>20 - 27</td>
<td>Severe</td>
<td>Probable MDD</td>
</tr>
<tr>
<td>PHQ-9 Score</td>
<td>Treatment Options</td>
<td>Follow up</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5-9</td>
<td><strong>Mild</strong> • Offer psychotherapy (if patient agrees, refer to BHS)</td>
<td>• Repeat PHQ-9 in 4 - 6 weeks</td>
</tr>
<tr>
<td></td>
<td>• Provide Resource Guide and refer to kp.org website</td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td><strong>Moderate</strong> • Offer psychotherapy (if patient agrees, refer to BHS)</td>
<td>• Upon starting medication, refer to depression care manager (Behavioral Health Pharmacist)</td>
</tr>
<tr>
<td></td>
<td>• Start medication (Acute phase for 18+ yo – initial medication trial for minimum 90 days.)</td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td><strong>Moderately Severe</strong> • Start medication (Acute phase for 18+ yo – initial medication trial for minimum 90 days.) • Offer psychotherapy (if patient agrees, refer to BHS)</td>
<td>• Upon starting medication, refer to depression care manager (Behavioral Health Pharmacist) • If suicidal: immediately call BHS triage in Parma and Cleveland Heights at number above, call 911 in all other locations</td>
</tr>
<tr>
<td>&gt;20</td>
<td><strong>Severe</strong> • Refer to BHS immediately • If suicidal: immediately call BHS triage in Parma and Cleveland Heights at number above, call 911 in all other locations</td>
<td></td>
</tr>
</tbody>
</table>
DIAGNOSIS
Please consider **Depressive Disorder** if there are at least 4 positive answers including Question # 1 or # 2.
Please consider **Major Depressive Disorder, Single** or **Recurrent** if with at least 5 positive answers.

**DEPRESSION DIAGNOSIS BPA OH**
- MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE [296.20B]
- MAJOR DEPRESSIVE DISORDER, RECURRENT MODERATE [296.30B]
- DEPRESSIVE DISORDER [311C]

**MEDICATIONS - INITIAL OPTION**

**DEPRESSION MEDS INITIAL OPTION BPA OH**
- CITALOPRAM 10 MG ORAL TAB
  - TAKE 1 TAB PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal
- CITALOPRAM 20 MG ORAL TAB
  - TAKE 1 TAB PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal
- FLUOXETINE 10 MG ORAL CAP
  - TAKE 1 CAP PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal
- FLUOXETINE 20 MG ORAL CAP
  - TAKE 1 CAP PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal
- PAROXETINE HCL 10 MG ORAL TAB
  - TAKE 1 TAB PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal
- PAROXETINE HCL 20 MG ORAL TAB
  - TAKE 1 TAB PO ONCE DAILY FOR DEPRESSION, Disp-90, R-1, First occurrence now until 2/7/13, Normal

**MEDICATIONS - SECOND OPTION**

**DEPRESSION MEDS SECOND OPTION BPA OH**

**REFERRALS**
Order **REFERRAL PHARM, BEHAVIORAL HEALTH SERVICE** - if antidepressant was initiated and member will be followed up in primary care setting.
**DO NOT** use this referral if severely depressed (PHQ9 >20) or endorsing thoughts of self harm.
Order **REFERRAL BEHAVIORAL HEALTH** - if member desires psychotherapy, is severely depressed (PHQ >20) and/or is endorsing thoughts of self harm.

**REFERRAL TO BH OH**
- ✔ REFERRAL PHARM, BEHAVIORAL HEALTH SERVICE
- 🔴 Internal referral
- ☐ REFERRAL BEHAVIORAL HEALTH
  - Internal referral
THIRD Step – What about Follow up? Evidence Based Resources for the Care Manager Role

MacArthur
http://www.depression-primarycare.org/

IMPACT
http://impact-uw.org/
THIRD Step - KPOHs Primary Care Depression Care Managers

- KPOH has Clinical Pharmacists providing depression telecare for the primary care setting
- Manage other disease states

- Role is based on care manager role of MacArthur 3 compartment model

Care Manager can be a variety of disciplines!
FOURTH Step: Review and Adjust – What are the Potential Barriers?

What barriers would you anticipate if your facility adopted a similar program?

Discuss:

What barriers are you currently experiencing in your practice with the management of depression?
FOURTH Step: KPOH’s Barriers Identified and Adjusted So Far

- Getting the team set up
- Patient identification
- Access for severe depression
- Access for suicidal ideation
- Etc.
KPOH’s Program Progress To Date

- 345 patients enrolled as of 02/14/2012
  - 62 patients non-compliant with the antidepressant
  - 22 Transferred to BHS either due to case complexity, severe depression endorsed or suicidal ideation endorsed
  - 39 patients completed program and compliant
    - 9 achieved documented remission during first 3 months
    - 2 additional documented response during first 3 months

~25% non-response rate to telecare
Special Thanks to Our RN and Pharm.D Depression Telecare Providers

Sheila Maynard, RN • Behavioral Health
Yolanda Harris, RN • Behavioral Health
Amanda Tomko, Pharm.D • Primary Care
Jackie Guttenberg, Pharm.D • Primary Care

Without them this program would not be possible!
Thank You for Participating!

Questions?
Additional Slides for Questions
## How to Select an Antidepressant?

| Subjective: |  
| --- | --- |
| Chief Complaint | Patient presents with |
|  | • DEPRESSION |
|  | PH! off and on for years; has never been evaluated by MD and wants to talk to someone |
|  | has been depressed on and off for years |
|  | C/o stressors at work |
|  | Wakes up at night |
|  | She lives with her |
|  | Social history, medications, allergies reviewed |
|  | doesn't smoke rare etoh no drugs |
|  | never treated for it wants to start prozac, (her dog takes it) |

Better Health Greater Cleveland
An Alliance for Improved Health Care
How to Select an Antidepressant

1) Positive predictors of response: patient history, family history

2) Initial therapy: typically an SSRI, SNRI or bupropion. Monotherapy vs. dual therapy?

3) Compelling indications: e.g. patient is a chronic pain patient, therefore would pick an antidepressant with noradrenergic (norepinephrine) properties

4) Side Effect Profile

5) Drug Interaction Profile – any concerns?

6) Formulation – e.g. avoid long acting in gastric bypass, swallowing difficulties, etc.
How to Select an Antidepressant – Side Effects

- **Sertraline** (serotonin): most serotonergic
  - Associated with more diarrhea

- **Paroxetine** (serotonin): most anticholinergic SSRI
  - Anticholinergic: sedating, *not preferred in elderly*, more weight gain
  - Can accumulate in renal impairment
  - Avoid in pregnancy, caution in women of child bearing potential

- **Fluoxetine** (serotonin): most activating SSRI, longest half life
  - Always dose in the AM
  - Associated with more nausea
  - Longer half-life therefore less chance of withdrawal
    - Good for patients that tend to be non-compliant
How to Select an Antidepressant – Side Effects

- **Citalopram** (serotonin): most data in hepatically impaired
  - Concerns regarding QTc prolongation
    - Maximum dose lowered for certain populations / drug interactions
    - Monitoring

- **Venlafaxine** (NE and serotonin):
  - Short half-life → tough withdrawal symptoms

- **Bupropion** (NE and DA): highest seizure risk therefore →
  - Contraindicated in those with a seizure disorder
  - Contraindicated in patients with bulimia

- **Mirtazapine** (multimodal): very sedating
  - Dose at bedtime, need to get to at least 30mg for depression benefit
  - Significant weight gain
How to Select an Antidepressant - Interactions

- **Citalopram**: minimal CYP450 interaction concern

- **Fluoxetine**: inhibits CYP450 2C19, 2D6, 3A4
  - Avoid with clopidogrel, tamoxifen, etc.

- **Sertraline**: weak inhibitor of CYP450 2C19, 2D6 and 3A4 (dose dependent)
  - Avoid with clopidogrel

- **Paroxetine**: Strong inhibitor of CYP450 2D6
  - Avoid with tamoxifen, monitor BP with metoprolol, etc.

*WHEN in doubt, check your favorite drug resource for interactions, OR ask you local pharmacist 😊*
How to Select an Antidepressant

- **GENERALLY, ALL ANTIDEPRESSANTS:**
  - Slight QT Prolongation (only a few exceptions)
    - Citalopram - double check your facility policy
  - Decrease in seizure threshold (TCAs & bupropion decrease the most)
  - Potential for mild SIADH
  - Increased risk of GI Bleeding when used with NSAIDs or ECASA

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**Table 2. The O/E for Upper Gastrointestinal Tract Bleeding Among 26,005 Current Users of Antidepressant Medication in the County of North Jutland, Denmark, 1991-1995***

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of Persons†</th>
<th>Person-Years at Risk</th>
<th>Obs</th>
<th>O/E (95% CI), RD‡ per 1000</th>
<th>Treatment Years</th>
<th>Number Needed to Harm (NNH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSRI only</td>
<td>17320</td>
<td>12,760.2</td>
<td>55</td>
<td>3.6 (2.7-4.7)</td>
<td>3.1</td>
<td>323</td>
</tr>
<tr>
<td>SSRI and NSAIDs only</td>
<td>4107</td>
<td>960.2</td>
<td>17</td>
<td>12.2 (7.1-19.5)</td>
<td>16.3</td>
<td>62</td>
</tr>
<tr>
<td>SSRI and low-dose aspirin only</td>
<td>2640</td>
<td>1,532.9</td>
<td>20</td>
<td>5.2 (3.2-8.0)</td>
<td>12.4</td>
<td>81</td>
</tr>
</tbody>
</table>

How Long to Treat

<table>
<thead>
<tr>
<th>Eligible population</th>
<th>Recommended duration of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of at most one prior episode of major depression and taking antidepressants</td>
<td>Continue antidepressants for 6-10 months AFTER REMISSION Total for at least 1 year</td>
</tr>
<tr>
<td>History of two or more prior episodes of major depression, taking antidepressants or participating in psychotherapy</td>
<td>Continue treatment for 3 years or longer after remission.</td>
</tr>
</tbody>
</table>

***History of suicide attempt, treat for life***
How to Discontinue

Treatment Discontinuation

- Establish a relapse prevention plan that specifies the patient's personal warning signs of recurring depression.
- Follow-up visits: Schedule at least one phone contact or office visit during tapering of medications, and another one 2–3 weeks after discontinuing treatment.

Table 11. Tapering antidepressants

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial step down</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs, SNRIs, and bupropion</td>
<td>Taper over 2–4 weeks (^1,^2)</td>
</tr>
</tbody>
</table>

\(^1\) Slow tapering may reduce the risk of relapse and allows for improved awareness before any symptoms of relapse become severe. Abruptly stopping SSRIs may cause discontinuation symptoms. A single safest and most effective medication taper has not been established.

\(^2\) Consider tapering more slowly for those who have been on treatment for prolonged periods, recurrent depression, or initially with severe symptoms. Consult with BHS “Mind Phone.”
## How to Track? – KPOH uses Excel

<table>
<thead>
<tr>
<th>Provider</th>
<th>MRN</th>
<th>NAME</th>
<th>Diagnosis</th>
<th>Medication start date</th>
<th>Date of next call? (Sort to Organize Call Schedule)</th>
<th>Antidepressant / daily dose</th>
<th>Date next refill due</th>
<th>BASELINE PHQ9</th>
<th>2 weeks Calculated Date Due for Follow Up</th>
<th>2 weeks Date Reached</th>
<th>2 weeks Outcome</th>
<th>2 weeks Medication Continued?</th>
<th>4 Weeks Calculated Date Due for Follow Up</th>
<th>4 Weeks Date Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>Depression NOS / Depressive disorder</td>
<td>12/7/2011</td>
<td>2/1/2012</td>
<td>bupropion IR 75mg titrated to 2 tabs bid</td>
<td>1/7/2012</td>
<td>18</td>
<td>12/21/2011</td>
<td>12/20/2011</td>
<td>Pt had OV for follow up of depression within several days of due date</td>
<td>Yes - medication continued</td>
<td>1/4/2012</td>
<td>1/4/2012</td>
</tr>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>Major Depression</td>
<td>12/9/2011</td>
<td>2/2/2012</td>
<td>fluoxetine 20mg</td>
<td>n/a</td>
<td>n/a</td>
<td>12/22/2011</td>
<td>12/22/2011</td>
<td>Pt had OV for follow up of depression within several days of due date</td>
<td>Yes - medication continued</td>
<td>1/5/2012</td>
<td>1/5/2012</td>
</tr>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>depression</td>
<td>9/16/2011</td>
<td>2/3/2012</td>
<td>paroxetine 40mg (increased from 20mg has been on since 2007)</td>
<td>1/17/2012</td>
<td>not completed (has been on since 2007)</td>
<td>9/30/2011</td>
<td>10/3/2011</td>
<td>Reached via telephone</td>
<td>Yes - medication continued</td>
<td>10/14/2011</td>
<td>10/14/2011</td>
</tr>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>Depression NOS / Depressive disorder</td>
<td>10/14/11</td>
<td>2/3/2012</td>
<td>citalopram 20mg</td>
<td>1/14/2012</td>
<td>14</td>
<td>10/28/2011</td>
<td>No answer, sent letter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>depression</td>
<td>1/9/2012</td>
<td>2/6/2012</td>
<td>citalopram 20mg</td>
<td>2/9/2012</td>
<td>17</td>
<td>1/23/2012</td>
<td>1/24/2012</td>
<td>Reached via telephone</td>
<td>Yes - medication continued</td>
<td>2/6/2012</td>
<td>2/6/2012</td>
</tr>
<tr>
<td>:)</td>
<td>:)</td>
<td>:)</td>
<td>depression</td>
<td>09/19/11</td>
<td>2/6/2012</td>
<td>bupropion XL 300mg daily</td>
<td>12/19/2011</td>
<td>not completed</td>
<td>10/3/2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>