

DEPRESSION TREATMENT GUIDE

Key Activities of Depression Care:
Integrating Elements of Collaborative
Care Into Primary Care



Nearly 60 percent of New York City adults with depression do not receive treatment. Identifying and treating depression within primary care is one of the best ways to reduce this gap. Integrating depression care into primary care allows health care providers to offer patients “whole person care,” which views the mind and body as one system. It also lets patients receive behavioral health treatment from providers they already know and trust.

Many primary care practices now strive to integrate behavioral health care and services into primary care to improve patient outcomes.

Collaborative care is an established, evidence-based model that outlines best-practice steps on how to integrate depression and other behavioral health care into your workflow. Your organization might not be able to replicate all the roles (e.g., care manager) and tools (e.g., registries) that are part of the collaborative care approach. However, the key activities in this model are flexible, allowing practices of all resource and capacity levels to use them.

This treatment guide explains the key activities of the collaborative care model for the management of depression care, and can help you find opportunities to integrate these approaches into your practice.

KEY ACTIVITIES OF DEPRESSION CARE

Screen and Diagnose

1. Screen all patients for depression at least annually* using the Patient Health Questionnaire-9 (PHQ-9)
2. Diagnose and confirm the diagnosis

Employ a Stepped, Treat-to-Target Approach

1. Determine treatment options
2. Connect and/or refer patients to a depression care manager or other behavioral health specialist
3. Review additional services and resources, as needed
4. Follow up with patients on the treatment plan (also called the stepped, treat-to-target care pathway)

Support Patient Engagement and Self-Care

1. Use evidence-based support, self-care and counseling methods to improve outcomes and engagement

* Due to limited available evidence, the United States Preventive Services Task Force does not specify a screening interval for asymptomatic, average-risk adults. The recommendation to screen at least annually derives from expert opinion.

SCREEN AND DIAGNOSE

1. Screen all patients for depression at least annually* using the PHQ-9.

The PHQ-9 includes the nine criteria on which DSM-IV disorders are based. Screening with the PHQ-9 allows health care providers to diagnose depressive disorders and grade the severity of a patient’s symptoms. Many members of the care team can administer the PHQ-9, including primary care providers, nurses and social workers. Patients can also screen themselves using a questionnaire during intake. Treatment response depends on the score a patient receives on the PHQ-9, as well as any reported distress. For more information on diagnosing depression, reported distress and symptoms of depression, see Step 2.

PATIENT HEALTH QUESTIONNAIRE-9 PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Circle "0" to indicate your answer.

	Not at all	Several days	Most days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0, 1, 2, 3
* Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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PHQ-9 Scoring:

- **Less than 10 without distress reported by the patient:** Screen the patient at their next annual visit, or more often if there is a clinical concern or increase in stressors, such as a significant loss or change in the patient’s life.
- **Less than 10 with distress reported by the patient:** Ask the patient about reported distress and follow up for change over time, or ask if the patient has any concerns or worries that impair their ability to function.
- **Greater than or equal to 10:** Consider a depression diagnosis. See Step 2.
- **Any positive response to the suicide ideation question:** Further evaluate according to practice guidelines and assessment tools.** If imminent self-harm is identified, obtain an in-house behavioral health consultant (if available) to further evaluate, or call 911 to transfer the patient to an emergency department. Plan to closely follow up with the patient in your office with additional support between visits. NYC Well (1-888-NYCWELL or nycwell.cityofnewyork.us/en) is a publicly available support and assessment resource for patients.

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** Refer to City Health Information: Detecting and Treating Depression in Adults (page 3), Substance Abuse and Mental Health Services Administration (SAMHSA) or professional organizations, such as the American College of Physicians, for algorithms and tools. A Columbia-Suicide Severity Rating Scale has been designed for a primary care setting and is available at: cssrs.columbia.edu/documents/c-ssrs-screener-triage-primary-care.

2. Determine and confirm the diagnosis.

Diagnose depression and rule out other conditions using **DSM-5 criteria**.

Note: Criteria A through C represent a major depressive episode (score greater than or equal to 10 on the PHQ-9).

- A.** Patient must present with a minimum of five symptoms, nearly every day for at least two weeks. One of the five symptoms must be either depressed mood or loss of interest or pleasure in activities.
- Depressed mood
 - Loss of interest or pleasure in activities
 - Significant weight loss or gain
 - Decreased or increased appetite
 - Insomnia or hypersomnia
 - Feelings of restlessness or of being slowed down
 - Fatigue or lack of energy
 - Feelings of worthlessness or inappropriate guilt
 - Decreased concentration or increased indecisiveness
 - Recurrent thoughts of death, or plans and attempts at suicide
- B.** Symptoms cause significant distress or impairment in functioning.
- C.** Symptoms are not caused by a substance or related to another medical condition or a significant loss or change in the patient's life. Symptoms due to a significant loss may be appropriate when considering the patient's history and cultural norms for expressing distress.
- D.** Schizophrenia or other psychotic disorders are not present.
- E.** No history of a manic or a hypomanic episode. (A manic episode is characterized as an elevated, expansive or unusually irritable mood that lasts at least one week. Hypomania is a shorter and less intense form of mania.) If the patient's history is consistent with bipolar disorder – especially manic episodes – antidepressants may be contraindicated and prompt psychiatric referral may be warranted.

Consider differential diagnoses and medications that may have raised the risk of depression:

- **Drugs that may cause or exacerbate depression:** cardiovascular or central nervous system drugs, hormonal replacements, antibiotics and steroids.
- **Differential diagnoses:** dementia, adjustment disorder, bipolar disorder, premenstrual dysphoric disorder (PMDD), obstructive sleep apnea and hypothyroidism.

EMPLOY A STEPPED, TREAT-TO-TARGET APPROACH

Once you have determined a diagnosis, work with patients to create a care plan using a stepped, treat-to-target care pathway. Treat-to-target involves close and frequent engagement to track patients' progress over time, adjusting treatment as needed based on reported PHQ-9 symptom measures. This approach is helped by the use of a dedicated registry or Electronic Health Record (EHR) reports. **The goal of treat-to-target care is to maintain repeated contact with the patient, respond to signs of worsening or stalled progress, and revise treatment with an aim to reduce the PHQ-9 score to less than 5** (i.e., improvement to remission*). Document PHQ-9 symptom measures at each contact or visit.

The following guidance pairs DSM-5 diagnoses with PHQ-9 scores to help you determine the severity of depression and create a treatment plan.

Moderate Depression (PHQ-9 scores 10 to 14):

- ✓ Refer for psychotherapy and/or pharmacotherapy or prescribe pharmacotherapy.
- ✓ Offer patients an opportunity to reassess their symptoms, especially patients who are hesitant or resistant to treatment. Many of these patients get better on their own or with engagement in self-management strategies.
- ✓ Re-evaluate diagnoses with a behavioral health specialist if patients show a lack of improvement or worsening, and step up or increase treatment as needed.

Moderately Severe Depression (PHQ-9 scores 15 to 19):

- ✓ Maintain regular contact with patients until they improve to ensure treatment adherence. Once adherence is established, meet with patients monthly.
- ✓ Strongly recommend pharmacotherapy treatment.
- ✓ Re-evaluate through a treat-to-target approach that systematically monitors and steps up treatment as needed.

Severe Depression (PHQ-9 scores ≥ 20):

- ✓ Unless patients are in mental health treatment elsewhere, follow up at least weekly until they improve to ensure adherence. Then schedule visits approximately every two to four weeks at a minimum.
- ✓ Refer patients to pharmacotherapy (required).
- ✓ Recommend patients participate in psychotherapy.
- ✓ Re-evaluate through a treat-to-target approach that systematically monitors and steps up treatment as needed.

* Remission is defined as improved PHQ-9 scores and other reported improvement in symptoms and functioning.

1. Determine treatment options.

Effective care incorporates shared decision-making between the care team and the patient, and includes evidence-based self-management strategies, as well as psychotherapy and/or pharmacotherapy. An effective care strategy also considers comorbid conditions and other risk factors when developing the treatment plan. Explain the differences in treatment options to patients so you can work together to formulate a plan.

- **Self-management strategies:** These methods help patients identify, address and improve their emotional and physical health concerns. (See “Support Patient Engagement and Self-Care.”)
- **Psychotherapy:** This treatment can help patients develop healthier habits and behaviors through dialogue with a provider. Patients with psychosocial problems that have a specific cause (e.g., marital dispute or role transition) may respond well to these evidence-based therapies: problem-solving therapy (PST), interpersonal therapy (IPT) or cognitive-behavioral therapy (CBT). Work together with patients to determine which talk therapy best meets their needs.
- **Pharmacotherapy:** This treatment uses medication to manage depression symptoms. Discuss the types of medications available, drug interactions, possible side effects and their management, and when patients should expect to feel better. Monitor patients’ responses and adjust treatment as needed. Increase the medication dose along established treatment guidelines, like the ones found in the City Health Information (CHI) document Detecting and Treating Depression in Adults. Remind patients to talk with their health care provider before stopping any medication, even if they think it’s not working. To prevent relapse, continue pharmacotherapy after remission is achieved based on the patient’s history, medication tolerance and preferences:
 - First episode: Continue for four to nine months
 - Second episode: Continue for two years, discuss gradual tapering off
 - Persistent depressive disorder: Continue indefinitely

Consider comorbid conditions and additional risk factors when developing a treatment plan with patients:

- **Comorbid medical disorders:** cancer, chronic pain, diabetes, endocrine and metabolic disorders, heart disease, HIV, hypertension, myocardial infarction, obesity, and stroke
- **Comorbid psychiatric or neurological disorders:** Alzheimer’s disease, anxiety, eating disorders, post-traumatic stress disorder, sleep disorders, smoking, and substance use (including alcohol)
- **Risk factors:** history of or exposure to trauma, poverty and unemployment
- **High-risk populations:** elderly, LGB and transgender and gender nonconforming (TGNC) individuals, postpartum parents, and victims of intimate partner violence

2. Connect and/or refer patients to a depression care manager or other behavioral health specialist.

Refer patients to a behavioral health provider or, preferably, to your practice's identified care manager. The care manager oversees the stepped, treat-to-target care pathway; supports patient engagement, motivation and self-care; and keeps track of and maintains consistent communication with patients and providers. The care manager can be an individual or several people from different disciplines.

3. Review additional services and resources, as needed.

Integrated care also positions the care team to address social factors that affect a patient's mental and physical health. Include this review in care planning and refer patients for services, as needed.

- Discuss barriers to treatment, such as shame, fear of stigmatization, lack of family support, treatment location and cost, fear of losing a job, medication side effects and adherence.
- Discuss the economic and social risk factors (e.g., cost and perceived stigma) of treatment failure and relapse.
- Identify community and other resources to address risk factors for comorbid conditions (e.g., chronic diseases) and unmet social and economic needs (e.g., poverty, unemployment).
- Identify and encourage the use of support networks for crisis intervention and relapse prevention.

Use the Health Information Tool for Empowerment (hitesite.org), an online resource directory run by the Greater New York Hospital Association, for information on free and low-cost social services.

Learn more by referring to the Addressing Your Patients' Social Needs for Better Mental Health Worksheet.

ADDRESSING YOUR PATIENTS' SOCIAL NEEDS FOR BETTER MENTAL HEALTH

The environment in which we live, work and play can have an effect on our physical and mental health, and well-being. Living in places with limited access to quality jobs and schools, as well as healthy foods and safe spaces to exercise can increase the risk of depression and limit the ability to manage chronic diseases.

Addressing patients' social needs and linking them to appropriate resources is an important and critical new step for health care providers and the care team. Incorporating these conversations into your workflow may be challenging at first. However, addressing your patients' social needs can improve their treatment adherence, and mental and physical health outcomes. **The steps below can help you create a standardized approach to meeting your patients' needs.**

Step 1: PREPARE

- Collect information on community resources relevant to your patient population. Talk to local community-based organizations to understand what resources are available. Create a list of resources you feel comfortable referring patients to. Make sure the list includes mental health and substance use services, as well as the following resources. Visit nyc.gov/health and search for **depression** for service providers and contact information.

Financial assistance programs	Earned Income Tax Services (EITS), Temporary Assistance for Needy Families (TANF)
Food assistance programs	Supplemental Nutrition Assistance Program (SNAP), Emergency Food Assistance Program
Housing and homeless services	New York City (NYC) Department of Homeless Services
Immigrant support services	Mayor's Office of Immigrant Affairs Resource and Referral Guide
Social supports services	Mayor's Office to Combat Domestic Violence Resource Directory
Youth and family services	Nurse-Family Partnership, LGBTQ Youth Empowerment Group
Free fitness classes	Shape Up NYC
Healthy eating resources	Farmers Markets, Health Bucks

ACCESS NYC can also help patients find assistance with food, finances, housing, employment and more. Visit access.nyc.gov for more information.

4. Follow up with patients on the treatment plan (also called the stepped, treat-to-target care pathway).

One key to success for any depression treatment plan is for the care manager or other health care provider to contact patients at least every other week to review progress, symptoms and motivation, as well as conduct treatment-adherence checks. Some patients may require more frequent contact, especially in the beginning of treatment or if the patient is not improving. Regular contact includes asking about side effects or other concerns, providing support and engagement methods, and readministering the PHQ-9.

Until stable improvement occurs, primary care providers should regularly contact patients to treat to target or review responsiveness to treatment and PHQ-9 scores, and adjust care and support accordingly. If there is no improvement within six to eight weeks, increase or step up the intensity of psychotherapy or medication dose according to established treatment guidelines (see the CHI). Also consider working with patients to switch medications.

The primary care provider can perform systematic interval monitoring and provide stepped care. However, outcomes can improve if these activities are specifically assigned to a care team member and if a behavioral health specialist reviews patients' progress with the care manager. The care manager should regularly check in and repeatedly monitor progress.

Tips to Support a Treat-to-Target Approach

- Use a team-based collaborative care approach to specify who, where and how available team members will assess, track and follow up with patients.
- Begin treatment and management roles in your office with current staff, collaborate with on-site behavioral health practitioners or develop close working relationships and networks with external providers to whom you can refer patients for specialized care.
- Incorporate patients' goals in a shared care plan with a behavioral health specialist.
- Monitor patient engagement, adherence and PHQ-9 scores through a table, graph, registry, EHR or other specific recording method used in your practice.
- Use the information from your record-keeping system to proactively follow up with patients.
- Adjust treatment and escalate review as needed if patients are not improving as expected.
- Identify community-based organizations that can provide support.
- Make sure the patient has access to all eligible benefits (e.g., SNAP, unemployment).

SUPPORT PATIENT ENGAGEMENT AND SELF-CARE

1. Use evidence-based support, self-care and counseling methods to improve outcomes and engagement.

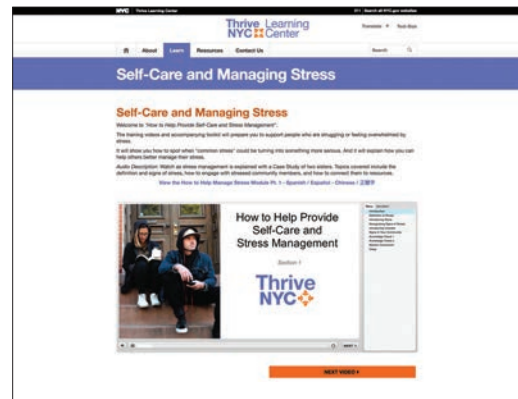
Providers should stay engaged with patients and care team members from initial assessment through ongoing treatment. During regular visits, trained medical providers or non-specialist staff can provide the following evidence-based counseling and self-care strategies to all patients. These counseling methods promote engagement, activation and mood improvement, and help move patients along the stepped, treat-to-target care pathway:



- **Motivational interviewing***: In this method, providers:
 - Express empathy
 - Avoid arguing
 - Develop discrepancy, or help patients realize how their current behaviors differ from their goals
 - Accept that patients may be resistant to change and shift the conversation accordingly
 - Support patients' belief in their own ability to change

* Rollnick, S., & Miller, W. R. What is MI?. *Behavioural and Cognitive Psychotherapy*, 23, 325-334

- **Behavioral activation:** Working with their patients, providers identify work, social, health or family activities patients have stopped participating in because of their mood. Together, providers and patients brainstorm concrete steps to re-introduce these activities into the patients' lives and decrease behaviors that contribute to a depressed mood.
- **Problem-solving therapy:** This intervention can help patients develop an action plan to reduce psychological distress and cope with stressful life experiences. Patients gain an understanding of the connection between stressors and emotions, and learn appropriate and adaptive coping or problem-solving techniques.
- **Self-care:** This includes providing patients with self-care tools including breathing techniques and coping skills, as well as recommending behavioral and lifestyle changes (e.g., eating a healthy diet, exercising regularly, getting a good night's sleep and making time for enjoyable activities). Use the My Self-Management Goal for Depression Tool to help patients set small, achievable goals.



Tip to support engagement and self-care workflow

- Assess current state of integrated practices and existing resources for becoming fully integrated, including needed personnel and technology and reimbursement options. For more information on how to assess your practice, visit uhfnyc.org/publications/881131 and download "Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework."

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