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

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

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

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.

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.
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.”


“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.”

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?
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.

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 ≥ 3 for either the anxiety or depression subset supports subsequent screening for depression or anxiety.

PHQ-4

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

### Risk Assessment and Screening Interval

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factors in <strong>older adults</strong> include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and history of depression.</td>
</tr>
<tr>
<td>Risk factors during <strong>pregnancy and postpartum</strong> 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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
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 nortriptyline (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

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

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

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


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