CCNC Adult Depression Toolkit for Primary Care

Community Care of North Carolina

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Link to the full document can be found here: https://www.communitycarenc.org/media/related-downloads/ccnc-depression-toolkit.pdf.

Introduction

In the Spring of 2012, a Community Care of North Carolina (CCNC) workgroup comprised of Network Psychiatrists, Network Medical Directors, Pharmacists, Behavioral Health Coordinators, and representatives from area academic centers came together to create a toolkit designed to assist primary care providers in screening and treating adult depression in the primary care setting. This toolkit was adapted from an earlier version created by Community Care of Western Carolina (CCWNC), which was adopted from The MacArthur Initiative on Depression and Primary Care at Dartmouth & Duke, Version 9.0 -January 2004. This toolkit has now been revised and streamlined for 2015.

This Toolkit is designed to help busy primary care practitioners access practical, evidence based tools to help them successfully treat depression in adults. It includes implementation recommendations, an overall algorithm to help with the initial assessment to determine severity and the corresponding recommended treatment approach, screening tools, critical decision points, medication recommendations, and many other useful guides. In addition, the toolkit highlights what to do when patients are not responding adequately, including when a referral to a psychiatrist for consultation would be indicated.

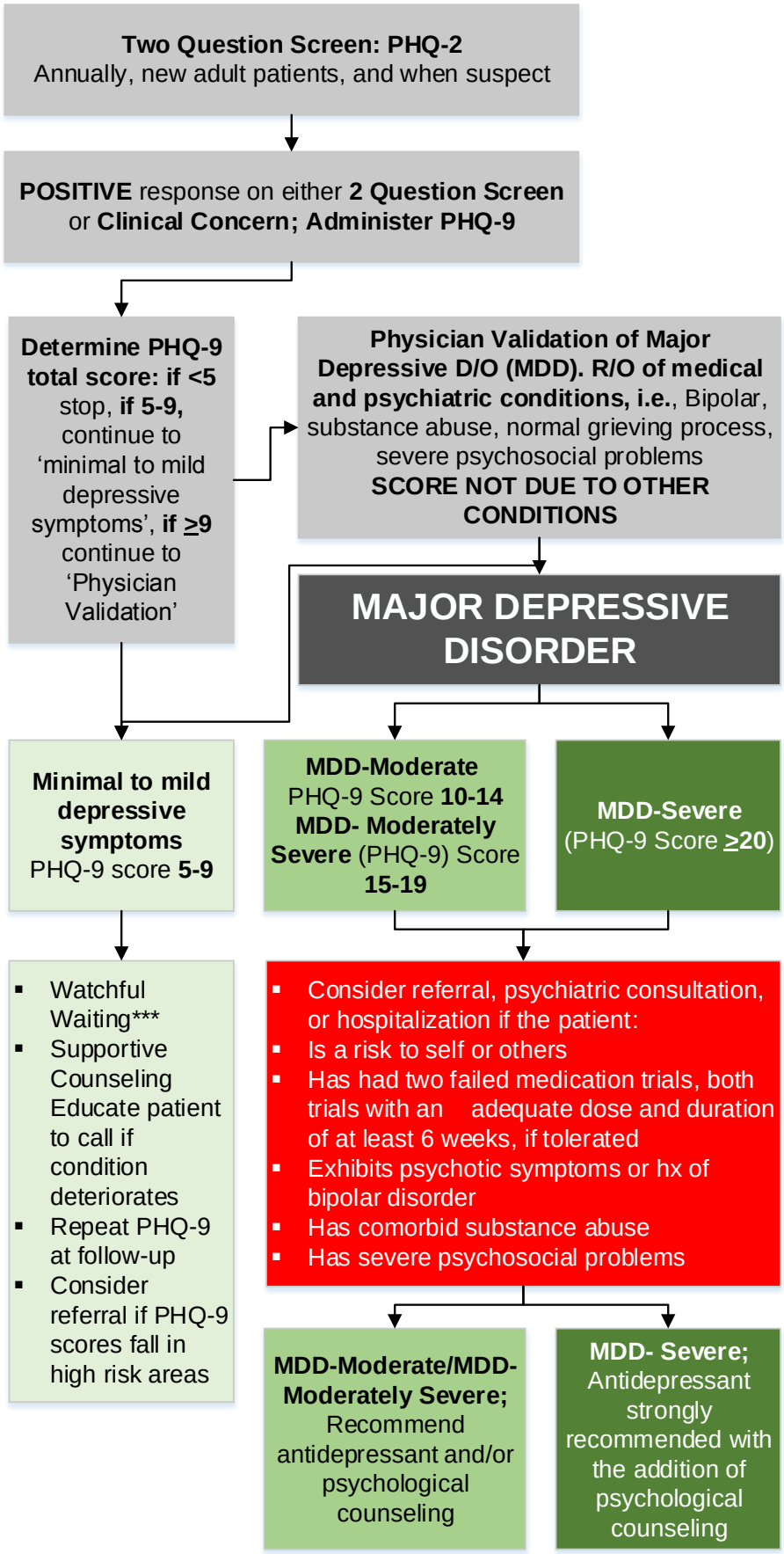
Please let us know if you have questions or would like to be connected with your local CCNC resources.

Warm Regards,
CCNC Behavioral Health Integration Team

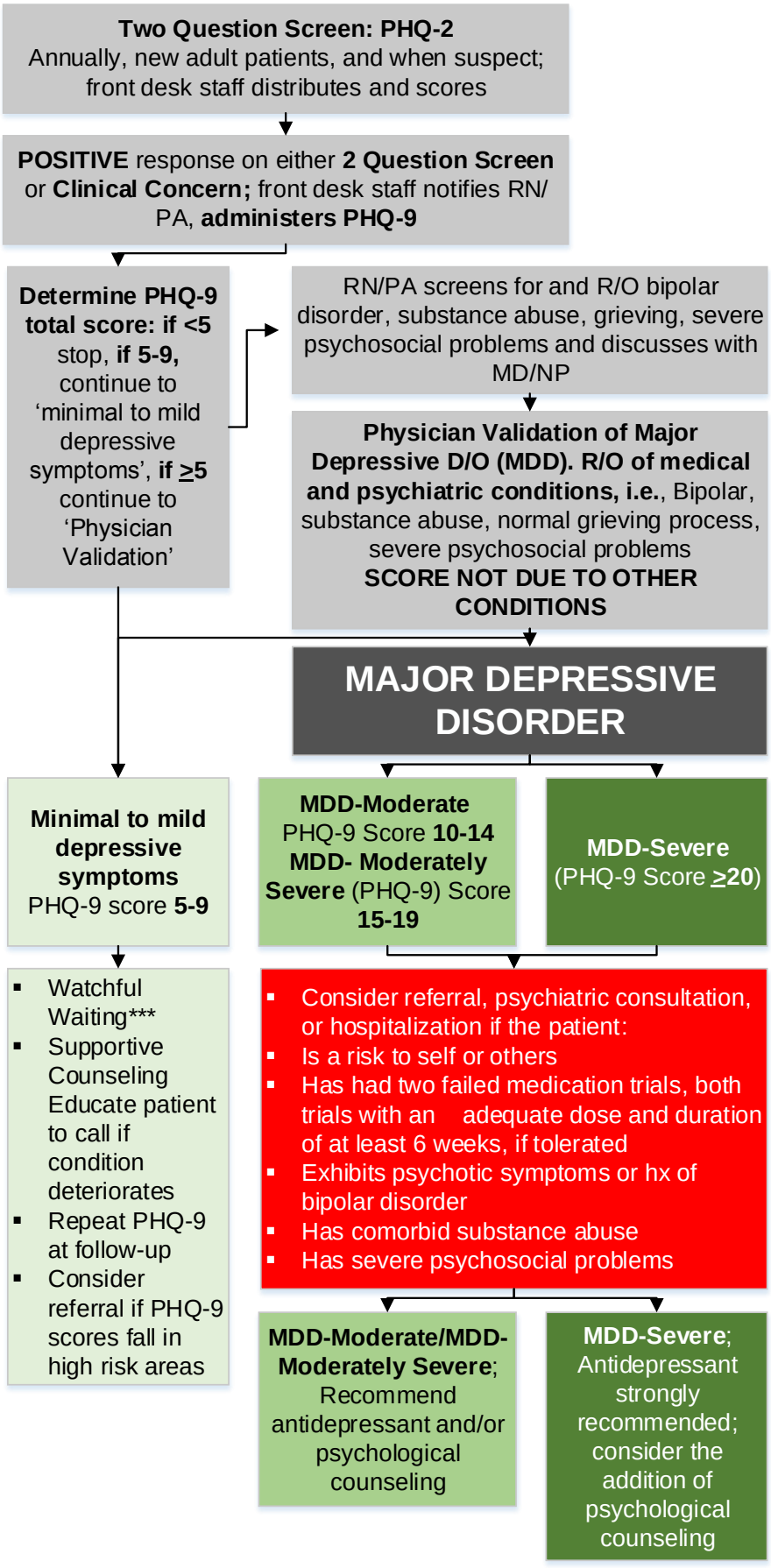
Treatment Algorithm

Community Care of North Carolina

Adult (>18 years) Depression Flow Chart (Generic)



Adult (>18 years) Depression Flow Chart (Practice-Specific Workflow Example)



Overview of Care Process in the Treatment of Depression

STEP 1: SCREENING AND DIAGNOSIS

- Display of risk factors and warning signs for possible Depressive Diagnosis
- Completion of **2 QUESTION** screening for all patients
- Completion of **PHQ-9** for patients with positive screening
- **Scoring** PHQ-9 for diagnosis and severity
- **Additional Screening** for Suicide Risk, Substance Abuse, Bipolar Disorder, Psychosis, or comorbidity as indicated with referral to a mental health provider for urgent/emergent cases

STEP 2: TREATMENT SELECTION

1. **Clinical Interview** to identify previous history/treatment of depression or other mental health disorder
2. Utilize PHQ-9 Score and patient preference to drive selection of treatment plan:
    1. Referral to Mental Health provider for **Urgent/Emergent Care**
    2. **Wait** and **Observe**
    3. **Medication** alone
    4. **Medication** plus **Counseling**
    5. **Counseling** alone
3. **Referral** to Clinical phone follow up for Education and Follow---Up Plan

STEP 3: INITIATION OF TREATMENT PLAN

- Provide the following:
    1. **Educational Materials** with **Verbal Instruction** during office visit or by Phone Call and Mailing within
    2. Provide assistance with **obtaining medication** (samples, sliding scale) to include written medication
    3. Establish **Treatment Care Plan** with patient engagement
    4. **Schedule** time for first clinical phone follow---up contact

STEP 4: ACUTE PHASE FOLLOW-UP (See Clinical Decision Points (CDPs below)

- **1st FOUR MONTHS of treatment – Goal: achieve remission**
- Clinical phone call follow-up at set intervals per protocol, to include:
    1. Documentation of repeat PHQ-9 to determine treatment response
    2. Use of **Medication Effectiveness/Side Effect Evaluation** tool to determine patient's medication compliance and effectiveness of therapy if patient experiences sub-optimal response
    3. Reminders to foster patient adherence to follow-up appointment schedule with Primary Care Provider schedule with Primary Care Provider (**Initial Visit + 3 PCP/MHP Visits** over the first 12 weeks of treatment is recommended by HEDIS)
- Continued assistance with obtaining medication at no charge / reduced charge
- Ongoing communication with PCP regarding patient's progress

STEP 5: CONTINUATION AND MAINTENANCE CARE

- **Goal: Prevent relapse/recurrence**
- Continue pharmacologic and/or counseling treatment for:
    - 1st episode – 7 to 12 months of continuous pharmacotherapy
    - 2nd episode – 1 to 2 years OR lifetime with complicating factors
    - 3rd episode – lifetime therapy if all 3 episodes occur within one 5 year period
- Provide patient education related to **symptoms of relapse**
- Continue schedule of **repeat PHQ-9** per phone call to monitor patient adherence to treatment plan and to provide support/re-teaching as needed
- Ensure that patient is scheduled for further **PCP visits** if PHQ-9 scoring indicates recurrence/worsening of symptoms
- PCP to determine patients at highest risk for need of **Long Term Prophylactic Treatment**
- Follow patients requiring treatment > 6 months per protocol

CCNC Depression Work Group Implementation Recommendations

To meet the requirements for evidence based depression treatment in the primary care setting certain levels of "support" need be in place at a practice. Screening with a PHQ-9 for depression is not by itself sufficient to be considered evidence based care. However, in appreciation of the scarcity of resources at most practices the depression work group had as a goal to come up with the **minimum** requirements that a practice would need to have in place to meet that standard. These are:

- A practice based "champion" who would be responsible for organizing an "implementation team" that would include buy in from physicians, nursing, and administration.
- A community based psychiatrist who would be an identified provider and who would serve primarily as a resource to the practice assuring enhanced community psychiatric access (referrals would be seen quickly by this provider). This would likely NOT include phone consultation since there is no billing mechanism. It is possible the network psychiatrist could fill that role but this would need to be worked out by each network.
- Someone in the practice who could make follow-up phone calls and then track when patients are due for follow-ups as they go through the depression algorithm.
- A commitment to monitor how the program is working (primarily fidelity measures rather than patient outcomes at first; see Audit Tool for suggestions). The initial suggested fidelity measure would be the presence of a PHQ-9 having been completed at baseline for anyone who has had an anti-depressant initiated (1st anti-depressant or change to a new anti-depressant).

We would suggest that each practice choose which specific patients to target for screening based on what would best fit their needs, and give the best chance for implementation success. Some possible choices are patients with diabetes, cardiovascular disease, patients already receiving anti-depressants, chronic pain patients, or high users of resources.

Critical Decision Points (CDPs) for Acute Phase Treatment of Major Depression

CDP	PHQ-9 Baseline Severity Parameters	Treatment Modification	Treatment Options Designed for medication treatment only. Psychotherapy for mild to moderate depression is also considered evidenced based.
WEEK 0 ***CDP #1***	Severity ≥ 10		Initiate antidepressant medication at lower end of the dose range.
WEEK 1 **Phone Call**	If severity >20 or clinical concern		Evaluate patient status, initial response to therapy, medication tolerance; if PHQ-9 question #9 (suicide) was +, conduct Suicide Screening and assessment; May be from trained physician, therapist, nurse, or care manager (If indicated return appointment scheduled prior to week 4.)
WEEK 2 **Phone Call**	Recommended for all patients (Do PHQ-9)		Evaluate patient status, initial response to therapy, medication tolerance. Increase antidepressant dose to medium dose range, as tolerated. May be from trained physician, therapist, nurse, or care manager (If indicated return appointment scheduled prior to week 4.)
WEEK 4 ***CDP #2***	PHQ-9 ≤ 5	None	
	PHQ-9, >5 and <10	Modify based on functionality & pt. preference	Continue antidepressant in medium dose range, as tolerated. Communicate with psychotherapist about progress (if applicable). Consider switch to a different antidepressant if tolerability is an issue
	PHQ-9 ≥10	Modify treatment	Schedule a return appointment for week 6. Consider switching to a different antidepressant. If no improvement at week 6, recommend switching antidepressant
WEEK 6 **Phone Call**	Recommended for all patients (Do PHQ-9)		Evaluate patient status, response to therapy, medication tolerance. If PHQ-9 question #9 (suicide) was +, conduct Suicide Screening and assessment. May be from trained physician, therapist, nurse, or care manager (If indicated return appointment scheduled prior to week 8.)

WEEK 8 ***CDP #3***	PHQ-9 ≤ 5	None	Enter Continuation Phase
	PHQ-9, >5 and <10	Modify based on functionality & pt. preference	Increase antidepressant dose to higher dose range as tolerated. Communicate with psychotherapist about progress (if applicable). Consider switching to a different antidepressant.
	PHQ-9 ≥10	Modify treatment	Increase antidepressant dose to higher range if there has been a partial response. Consider switching antidepressant.
WEEK 10 **Phone Call**	For patients who remain in the acute phase (Do PHQ-9)		Evaluate patient status, response to therapy, medication tolerance. If PHQ-9 question #9 (suicide) was +, conduct Suicide Screening and assessment. May be from trained physician, therapist, nurse, or care manager (If indicated return appointment scheduled prior to week 12.)
WEEK 12 **(q 4 wks)** ***CDP #4***	PHQ-9≤ 5	None	Enter Continuation Phase
	PHQ-9, >5 and <10	Modify based on functionality & pt. preference	Increase antidepressant to higher dose range as tolerated. Communicate w/psychotherapist about progress (if applicable). Consider psychiatric consultation.
	PHQ-9 ≥10	Modify Treatment	Increase antidepressant dose to highest dose. Switch antidepressant (if only had 1 antidepressant trial) *Consider psychiatric consultation

*Patients who do not achieve remission after 2 adequate 6-8 week trials of antidepressants (shorter if unable to tolerate higher doses) should have a psychiatric consultation for diagnostic & management suggestions. Goal is 100% Symptom Reduction by week 12.

Screening/Evaluation

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Nine Symptom Checklist for Depression Screening

Name: _____ **DOB:** _____

Provider: _____ **Diagnosis/ICD-9/10 Code:** _____

Date of Initial Diagnosis: _____ **Screening Date:** _____

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2):

The first two questions of the PHQ-9 have been validated as a sensitive way to screen for depression
A negative answer to each question (score = 0) means no further questions are necessary
A positive result means further evaluation is indicated; administer the full PHQ-9 (below)

Complete Questions 1 - 9 Initially then at all Critical Decision Points Over the **last 2 weeks** how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	0	0	0
2. Feeling down, depressed, or hopeless	0	0	0	0
3. Trouble falling/staying asleep, sleeping too much	0	0	0	0
4. Feeling tired or having little energy	0	0	0	0
5. Poor appetite or overeating	0	0	0	0
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	0	0	0
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
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	0	0	0
9. Thoughts that you would be better off dead or hurting yourself in some way. (if positive, complete the Suicide Risk Assessment)	0	0	0	0
PHQ-9 Scoring Formula				
# Symptoms	___ **X 0 =**	___ **X 1 =**	___ **X 2 =**	___ **X 3 =**
Per Category	_____ **+**	_____ **+**	_____ **+**	_____ **=**
		PHQ-9 Total Score:		_____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, & Colleagues. For research information contact Dr. Spitzer at rls8@columbia.edu.

PHQ-9 Screening and Diagnosis

PHQ-9 Quick Depression Assessment for Initial Diagnosis:

- If there are at least **4** positive responses in the ***"More than half the days"*** or ***"Nearly every day"*** columns (including Questions #1 and #2), consider a **depressive disorder. Add scores to determine severity.**
- Consider **Major Depressive Disorder** if there are at least **5** positive responses in the ***"More than half the days"*** or ***"Nearly every day"*** columns (one of which is Question #1 or #2).
- Consider **Other Depressive Disorder** If there are **2-4** positive responses in the ***"More than half the days"*** or ***"Nearly every day"*** columns (one of which is Question #1 or #2).
- **Functional Assessment: Question #10**

NOTE: Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning and ruling out normal bereavement, a history of Manic Episode (Bipolar Disorder), and a physical disorder, medication or other drug as the biological cause of the symptoms.

Patient Health Questionnaire (PHQ-9) Form Symptoms & Impairment	PHQ-9 Severity	Provisional Diagnosis
1-4 symptoms (not including questions 1 or 2), + functional impairment	<10	Mild or Minimal Depressive Symptoms
2-4 symptoms including question 1 or 2, + functional impairment	10-14	Moderate Depressive Symptoms (Major Depression)*
> 5 symptoms including question 1 or 2, + functional impairment	15-19	Moderate Severe Major Depression
> 5 symptoms including question 1 or 2, + functional impairment	≥ 20	Sever Major Depression

* If symptoms present for > 2 years, chronic depression, or functional impairment is severe, remission with watchful waiting is unlikely. IMMEDIATE active treatment is indicated for Major Depression.

Three (3) Phases of Depression Treatment**	
Acute Phase	Aims at minimizing depressive symptoms – typically first 3- 4 months of therapy
Continuation Phase	Tries to prevent return of symptoms in the current episode – 4-12 months (Repeat PHQ-9 Q 4-6 months).
Maintenance Phase	Tries to prevent return of symptoms within 2 years – 12-24 months
Medication Therapy is recommended for at least 9 months after return to well state.	

** REFERRAL or co-management with mental health specialty clinician if the patient is:
High Suicide Risk
Bipolar Disorder
Inadequate Treatment Response
Complex Psychosocial Needs
Other Active Mental Disorder

Adopted from The MacArthur Initiative on Depression and Primary Care at Dartmouth & Duke, Version 9.0 -January 2004.

Differential Diagnosis Screening

Patient Name: _____ **DOB:** _____ **Date:** _____

GRIEF REACTION SCREENING	YES	NO
1. Did your most recent period of feeling depressed or sad begin after someone close to you died?		
2. If so, did the death occur more than 2 months ago?		
If "NO" to first question, or if "YES" to both questions, treat the patient for depression.		

MANIA SCREENING - rule out Bi Polar Disorder	YES	NO
1. Has there ever been a period of at least four days when you were so happy or excited that you got into trouble, or your family or friends worried about it or a doctor said you were manic?		
A "yes" response indicates potential bipolar disorder. Assess further for mania.		
2. Diagnostic criteria include the concurrent presence of at least **4** of the following symptoms (**one** of which must be the **first symptom** listed):		
a. **A Distinct Period of Abnormal, Persistently Elevated, Expansive, or Irritable Mood**		
b. Less Need for Sleep		
c. Inflated Self-Esteem/Grandiosity		
d. More Talkative than usual (pressured speech)		
e. Distractibility		
f. Increased Goal-Directed Activity or Psychomotor Agitation		
g. Excessive involvement in pleasurable activities without regard for negative consequences (e.g., buying sprees, sexual promiscuity)		

ALCOHOL USE / ABUSE SCREENING (CAGE):	YES	NO
1. Have you ever felt you ought to **CUT DOWN** on your drinking?		
2. Have people **ANNOYED** you by criticizing your drinking?		
3. Have you ever felt bad or **GUILTY** about your drinking?		
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE-OPENER)?		
Two or more "yes" responses are positive for possible alcohol abuse.		

Action Taken:

- Screening **negative**; no further action required
- **Positive** Screening; **medication** prescribed
- **Positive** Screening; **medication** prescribed and referral to staff for **Phone Protocol**
- **Positive** Screening; patient referred to **Mental Health Provider**

Name of MH Provider:

Comments:

ResouRces

- Download this card and additional resources at http://wwww.sprc.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.sprc.org/library/jcsafetygoals.pdf
- sAFe-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

AcKNoWLeDGMeNTs

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193

Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1

IDeNTIFY RIsK FAcToRs

Note those that can be modified to reduce risk

2

IDeNTIFY PRoTecTIVe FAcToRs

Note those that can be enhanced

3

coNDucT suIcIDe INQuIRY

Suicidal thoughts, plans, behavior, and intent

4

DeTeRMINe RIsK LeVeL/INTeRVeNTIoN

Determine risk. Choose appropriate intervention to address and reduce risk

5

DocuMeNT

Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- suicidal behavior: history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- Family history: of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- Precipitants/stressors/Interpersonal: triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- change in treatment: discharge from psychiatric hospital, provider or treatment change
- Access to firearms

2. PROTECTIVE FACTORS Protective factors, even if present, may not counteract significant acute risk

- Internal: ability to cope with stress, religious beliefs, frustration tolerance
- external: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY Specific questioning about thoughts, plans, behaviors, intent

- Ideation: frequency, intensity, duration—in last 48 hours, past month, and worst ever
- Plan: timing, location, lethality, availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* For Youths: ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* Homicide Inquiry: when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- Assessment of risk level is based on clinical judgment, after completing steps 1–3
- Reassess as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

Medication Information

Community Care of North Carolina

Quick Guide to Common Antidepressants

Medication	Therapeutic Dose Range (mg/day)	Initial Suggested Dose	Titration Schedule	Additional Information
Serotonin Reuptake Inhibitors (SSRIs) – All available as generic				
FLUOXETINE *(Prozac)*	10-80	20 mg in the morning (10 mg in the elderly, patients with hepatic disorder & when treating panic disorder)	May increase the dose by 10 to 20 mg/day every 7-14 days as tolerated.	**Advantages:** Long half-life is good for poor compliance; low risk for withdrawal syndrome. Capsules, tablets, oral solution, and delayed-release capsules are bioequivalent. **Disadvantages:** Slower onset of action. Higher risk for drug interactions due to cytochrome P450 inhibition. More likely to cause insomnia/agitation than other SSRIs
CITALOPRAM *(Celexa®)*	20-40	20 mg/day	May increase the dose to 40 mg after a minimum of 1 week. (max dose: 40 mg/day in patients <60 years) (max dose: 20 mg/day in patients ≥60 years and patients with hepatic impairment)	**Advantages:** Low risk for drug interactions due to cytochrome P450 interactions. **Disadvantages:** Doses >40 mg are associated with prolonged QT interval. Avoid concomitant 2C19 inhibitors (i.e., cimetidine, omeprazole); if used with 2C19 inhibitors maximum dose is 20 mg/day. Limited range for dose escalation.
ESCITAL OPRAM *(Lexapro®)*	10-20	10 mg/day	May increase dose to 20 mg after a minimum of 1 week.	**Advantages:** 2x more potent than citalopram. Low risk for drug interactions due to cytochrome P450 interactions. **Disadvantages:** Limited range for dose escalation.
SERTRALINE *(Zoloft®)*	25-200	50 mg/day	Increase by 50 mg/day at intervals of at least 1 week as needed to a maximum dose of 200 mg/day.	**Advantages:** Low risk for drug interactions due to cytochrome P450 interactions; risk increases at doses >150 mg. Can be used for post-MI patients; proven safe for HF patients. **Disadvantages:** Greater GI side effects, especially diarrhea. Can be stimulating or sedating.
PAROXETINE *(Paxil®)*	10-50	20 mg/day, preferably in the morning (10 mg in the elderly & patients with severe renal or hepatic impairment)	Increase by 10 mg/day at intervals of at least 1 week as needed to a maximum dose of 50 mg/day (max dose: 40 mg/day in the elderly & patients with severe renal or hepatic impairment).	**Advantages:** Tends to be more sedating than other SSRIs which may be beneficial for patients who have trouble sleeping. **Disadvantages:** High risk for drug interactions due to cytochrome P450 inhibition. Significant anticholinergic effects. May have more sexual dysfunction and weight gain. Short half-life can lead to withdrawal syndrome with abrupt treatment discontinuation. Pregnancy category D

Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) – All available as generic				
VENLAFAXINE IR and ER *(Effexor and Effexor XR)*	IR: 75–375 ER: 75-225	IR: 75 mg/day in 2-3 divided doses with food ER: 75 mg/day (May start with 37.5 mg/day for 4-7 days to allow patient to adjust to medication)	Increase by increments of up to 75 mg/day every 4-7 days as tolerated.	**Advantages:** Low risk for drug interactions due to cytochrome P450 inhibition. Daily dosing (ER). SNRIs can be effective for different pain syndromes. **Disadvantages:** BID or TID dosing (IR). May cause nausea, especially at treatment initiation. May ↑ blood pressure at higher doses (>150 mg/day). Monitor blood pressure. Requires dose adjustments in renal and hepatic impairment.
DULOXETINE *(Cymbalta)*	40-60 Max dose: 120 mg (Doses greater than 60 mg/day confer no additional benefit.)	40-60 mg/day (20-30 mg twice daily)	Initial dosage should be given BID. May start with 30 mg daily for 1 week before increasing to 60 mg daily, to allow patients to adjust to the medication.	**Advantages:** Dosing may be daily or BID. SNRIs can be effective for different pain syndromes. **Disadvantages:** May cause N/V, sexual dysfunction, insomnia, dysuria. Not recommended for use in patients with hepatic impairment, CrCl <30 ml/min, or ESRD. Moderately potent inhibitor of the hepatic cytochrome P450 enzyme CYP2D6
Norepinephrine and Dopamine Reuptake Inhibitors – All available as generic				
BUPROPION *(Wellbutrin)*	300-450	IR: 100 mg BID SR, XL: 150 mg QAM	IR: Increase to 100 mg TID after 3 days with at least 6 hours between doses. If no clinical improvement after 3-4 weeks increase to a max dose of 150 mg TID. SR: After 3 days may increase to 150 mg twice daily with at least 8 hours between doses; if no clinical improvement after 3-4 weeks, may increase to a maximum dose of 200 mg twice daily XL: After 3 days, may increase to 300 mg once daily; if no clinical improvement after 3-4 weeks, may increase to a maximum dose of 450 mg once daily.	**Advantages:** Little or no sexual dysfunction. No weight gain. Can be used to augment SSRI/SNRI treatment. **Disadvantages:** Contraindicated in patients with seizure disorders, hx of anorexia/bulimia, or undergoing abrupt d/c of EtOH or sedatives. ↑ risk of seizures at higher doses, especially with IR formulation. Can cause anxiety/agitation, insomnia, decreased appetite/weight loss. Requires dose adjustments in the elderly and patients with hepatic impairment.

Antidepressants Side Effects Evaluation

1. Choose all of the side effects you are experiencing that you believe are due to the medication you have taken for your depression.

Jittery, activation, restlessness	*Insomnia*	*Nausea, vomiting, diarrhea, abdominal cramps, anorexia*	*Headache*	*Sexual dysfunction*	*Daytime sleepiness or feeling tired*	*Confusion, disorientation, memory impairment*
☐	☐	☐	☐	☐	☐	☐

2. Choose the response that best describes the frequency (how often) of the side effects of the medication you have taken within the past week for your depression. Do not rate side effects if you believe they are due to treatments that you are taking for medical conditions other than depression. Rate the frequency of these side effects for the past week.

No side effects	*Present 10% of the time*	*Present 25% of the time*	*Present 50% of the time*	*Present 75% of the time*	*Present 90% of the time*	*Present all the time*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

3. Choose the response that best describes the intensity (how severe) of the side effects that you believe are due to the medication you have taken within the last week for your depression. Rate the intensity of the side effect(s), when they occurred, over the last week.

No side effects	*Trivial*	*Mild*	*Moderate*	*Marked*	*Severe*	*Intolerable*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

4. Choose the response that best describes the degree to which antidepressant medication side effects that you have had over the last week have interfered with your day-to-day functions.

No impairment	*Minimal impairment*	*Mild impairment*	*Moderate impairment*	*Marked impairment*	*Severe impairment*	*Unable to function*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

The response to question 4 may suggest that a change in treatment is necessary.

Q4 Score 0-2: Treatment should continue unless concerns exist about safety or symptom severity
Q4 Score 3-4: The side effect should be addressed (e.g. decrease dose)
Q4 Score 5-6: Change treatment (e.g. decrease dose or switch medication)

Adapted from: Wisniewski SR, Rush AJ, Balasubramani GK, Trivedi MH, Nierenberg AA. Self-rated global measure of the frequency, intensity, and burden of side effects. J Psychiatr Pract. 2006;12:71-79.

Important Information About Your Depression Medication

IMPORTANT THINGS TO REMEMBER WHILE TAKING ANTIDEPRESSANTS:

- It takes time for your medication to work.
- Antidepressants only work if they are taken **EVERY DAY**!
- Most people start to feel better in **1-4 WEEKS**.
- **DON'T GIVE UP** if you don't feel better right away.
- **The first week is the hardest.** Some people have mild side effects and don't feel that the medicine is working. The side effects usually go away in a few days.
- After you begin to feel better, continue to take the medicine **exactly** as your provider ordered it, even if you feel better.

If you are thinking about stopping your medication, **CALL YOUR DOCTOR FIRST.**

Common side effects include the following:

- Sleepiness or difficulty sleeping
- Dry mouth
- Constipation
- Nausea and/or Vomiting
- Skin rash
- Restlessness
- Weight gain or loss
- Dizziness
- Headache
- Sexual dysfunction

It is important for you to report any side effects from your medicine and to keep all follow-up appointments. Depending on your symptoms you may need to continue to take medication for an extended period of time even after you are feeling better. For some people, continuation of medication over a long time period is very successful in preventing a relapse. STOP taking the medicine and call the clinic if you develop a rash or if side effects are severe.

Provider: _____
Phone: _____

References: 1) Rost K. Depression Tool Kit for Primary Care NIMH grant NH54444. 2) 2003 CIGNA Behavioral Health. 3) AHCPR, Management of Major Depressive Disorder in Adults, Instructions for Patient Education, Patient's Guide, 1993. 4 Strock, Margaret (2004). Depression. NIH Publication No. 04-3561, National Institute of mental Health, National Institutes of health, U.S. Department of Health and Human Services, Bethesda, MD, 20 pp.http://www.nimh.nih.gov/publicat/depression.cfm

Documentation & Quality Improvement

Risk Factors for Depression

- Female
- Native American
- Middle-aged
- Widowed, separated, divorced
- Low income
- Other psychiatric disorders
    - Substance Abuse
    - Panic Disorder
    - Generalized Anxiety Disorder
- Personality Disorders
- Stressful life events and vulnerability to stress
- General Medical Condition
    - Diabetes
    - Stroke
    - Cancer
    - Chronic Pain
- First-degree relative with depression
- History of Depression

Warning Signs for Depression

- Multiple Unexplained Somatic Symptoms
- High Healthcare Utilizer
- Chief Complaint of Sleep Disturbance, Fatigue, Appetite or Weight Change

DSM-5 Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2 week period and represent a change from previous functioning: at least one of the symptoms is either (1) or (2):
    1. Depressed mood most of the day, nearly every day
    2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
    3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
    4. Insomnia or hypersomnia nearly every day
    5. Psychomotor agitation or retardation nearly every day
    6. Fatigue or loss of energy nearly every day
    7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day
    8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
    9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition (e.g., hypothyroidism).
D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.

Adapted from the Diagnostic and Statistical Manual of Mental Disorders, 5th ed.

ICD-9/ICD-10 CODING

(scheduled to be phased out in October 2015)

- Is the depressed mood better accounted for by a **general medical condition, substance use, or another mental disorder**?

ICD-9 Coding	ICD-10 Coding
293.83 Mood Disorder Due to General Medical Condition	F06.31 Mood Disorder due to Another Medical Condition (name) with depressive features or F06.32 with Major Depressive-like episode
291.8 Alcohol-Induced Mood Disorder	F10.188 Alcohol abuse with other alcohol induced disorder F10.288 Alcohol dependence with other alcohol induced disorder
292.89 Substance-Induced Mood Disorder (incl meds)	Substance/Medication Induced Depressive Disorder F11 through F19 with meds and symptoms specified

- Has the depressed mood or loss of interest or pleasure **persisted over a 2-week period**?

ICD-9 Coding	ICD-10 Coding
296.20 Major depressive disorder, single episode	F32.X Major depressive disorder, single episode
296.30 Major depressive disorder, recurrent episode	F33.X Major depressive disorder, recurrent (.0 mild; .1 moderate; .2 severe; .3 with psychotic features; .4 in partial remission)
311 Depression NOS	F32.9 Unspecified Depressive Disorder

- Has the depressed mood been present **for most of the past 2 years** (1 yr. in children)?

ICD-9 Coding	ICD-10 Coding
300.4 Dysthymic Disorder (Depression with anxiety)	F34.1 Persistent Depressive Disorder

- Has the mood occurred in response to an identifiable psychological stressor & does not meet criteria for any of the preceding disorders?

ICD-9 Coding	ICD-10 Coding
309.0 Adjustment Disorder with Depressed Mood	F43.21 Adjustment Disorder with Depressed Mood F43.23 Adjustment Disorder with Mixed Anxiety and Depressed Mood
309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood	

- Is the mood clinically significant, & are the **criteria not met for any of the above described disorders**?

ICD-9 Coding	ICD-10 Coding
311 Depressive Disorder NOS	F32.9 Unspecified Depressive Disorder

Stein DJ, Gorman JM: Pharmacotherapy Algorithms for Primary Care, MBL Publishing, New York, 2001.
Codes updated per ICD-9 CM 2005 classifications.

Depression Flow Sheet

Depression Flow Sheet	Patient Name:______________	DOB: ________________
Severity: Mild Moderate Severe	**ID#:** _______________________	**Gender:** M F

Depression Flow Sheet

Intervention: Watch/Wait: Medication Psychotherapy *(circle all that apply)*

Date Provider Initials Type of Visit	**PHQ Scores & Tx phase repeat PHQ q 4-6 wks and prn**	*** Medication Flow (see indicators for med ∆ below)**	*** Psychotherapy Flow (see indicators for Tx change below)**	**Next scheduled Follow-Up visit Type of Visit**
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx • Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ • No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact
Date: _______________ Provider: ____________ • Office Visit ○ Depression ○ Other Reason • Phone Call	Score: __________ • Watch/Wait • Acute phase Tx • Cont. Phase Tx Maint. Phase Tx	• New Rx: __________________ • Dosage changed to: __________________ • Dced: ___________ No Change	• Community Mental Health Center • PCP Behavioral Health • Private Counseling ○ New Referral ○ Current Patient	Next scheduled visit due: ____________________ Type of visit: • Office Visit • Phone Contact

Three (3) Phases of Depression Treatment		
ACUTE	Aims at minimizing depressive symptoms – typically first 3- 4 months of therapy	* Consider change in therapy, medication of addition of medications if no response at 6 weeks or partial response at 12 weeks.
CONTINUATION	Tries to prevent return of symptoms in the current episode – 4-12 months (repeat PHQ-9 Q 4-6 months).	
MAINTENANCE	Tries to prevent return of symptoms within 2 years – 12-24 months	
Medication Therapy is recommended for at least 9 months after return to well state.		

Chart Review Tool for Depression

Patient Name:	**DOB:**	**Program:** CHN/HCAP CCNC
Medicaid ID Number:		
Primary Care Physician:		**Date Last OV:**

OUTCOME MEASURE	**AUDIT RESULT**		
	Yes	**No**	**N/A**
Adult Primary Care patient with evidence of **annual 2 question screening for depression** or an initial screening for a new patient			
Evidence of completion of **PHQ-9 +3 Question Diagnostic Screening Tool for Depression** secondary to a positive response to one of 2 Question Screening items			
Evidence of appropriate **Follow-Up Contacts:** at least 3 follow-up contacts with a PCP or mental health practitioner during the 12 week Acute Treatment Phase, at least one with the prescribing practitioner for patient with a new episode of depression and treated with antidepressant medication (if less than 3 visits, indicate # of visits : 0; 1; 2)			

		Yes	**No**
Effective **Acute Phase** Treatment: For patients diagnosed with a new episode of depression:	treated with **antidepressant medication**		
	remained on antidepressant during the entire **12 week** Acute Treatment Phase		
Effective **Continuation Phase** Treatment: For patients diagnosed with a new episode of depression:	treated with **antidepressant medication**		
	patient remained on an antidepressant for at least **6 months.**		
Effectiveness of Treatment: patient shows improvement using repeat PHQ-9	at least a **50% reduction** in symptoms by week **12**		
Percentage of average improvement of patients using PHQ-9 at week 12		**%**	

OPTIONAL DATA:	**Circle appropriate response**		
Has this patient been **referred to a Specialist** for Mental Health Therapy?	Yes	Past Yr	Never
Did the patient receive a **MH visit**?	Yes	No	UK
Documentation of a **Depression Action Plan**?	Yes	Past Yr	No

Antidepressant: Drug Name	**Drug Dose/Frequency**	**Date of Rx**	**Date D/Ced**

Comments:

Date of PHQ-9	**Initial Screen:**	**2**	**3**	**4**
Score of PHQ-9	**Initial Screen:**	**2**	**3**	**4**
Auditor:	**Date of Audit:**			

Patient Education

Community Care of North Carolina

Depression and You

Who gets depressed?
Depression is a very common but highly treatable condition that affects about 1 in every 20 Americans each year. Depression is not a character flaw, a sign of personal weakness or a condition that can be willed or wished away. Depression is a medical illness that can affect anyone. Over 11 million people every year have this illness, with twice as many women as men. Many women are particularly vulnerable after the birth of a baby. Men are less likely to suffer from depression but are also less likely to admit that they have the illness.

Unfortunately, many people with depression do not tell their primary care doctor how they are feeling. Talking to their doctor about how they feel is the depressed person's first important step toward getting better.

What is depression?
Since depression is a medical condition, like diabetes or heart disease, it is more than just of feeling of sadness or being "down in the dumps". It affects your day to day life and your thoughts, ideas, actions and physical well being.

Some common causes may include: certain medical conditions, some medications, drugs or alcohol, family history or other mental illness conditions. It may result from certain life events, such as the loss of a loved one, or by stress. An imbalance in the chemicals in the brain that control mood can also cause depression.

REMEMBER: Depression is NOT the result of a weakness or a fault, it is a medical illness that can be effectively treated.

How will I know if I am depressed?
People who are depressed generally experience one or more of the following symptoms **ALL DAY, NEARLY EVERY DAY, FOR AT LEAST 2 WEEKS.**

- Loss of interest in things previously enjoyed
- Feeling sad, blue, or down in the dumps.
- You may also have at least three (3) of the following symptoms:
    - Feeling restless, slowed down or unable to sit still
    - An increase or decrease in appetite or weight
    - Thoughts of death or suicide
    - Difficulty thinking, concentrating, remembering or making decisions
    - Sleeping too much or too little
    - Feeling tired all the time, or loss of energy.
- Other symptoms you may experience include:
    - Headaches
    - Aches and pains
    - Being anxious or worried
    - Digestive problems
    - Feeling hopeless
    - Nausea and/or vomiting

What should I do if I have these symptoms?
TALK TO YOUR DOCTOR: Many people suspect that something is wrong but hesitate to find help or feel guilty or responsible for their symptoms. Sometimes they are not aware that help and treatment is available. If you think you may have a problem there are health care providers that can help you. They

can help you find out if there is a physical cause for your symptoms, treat the symptoms or refer you to a mental health specialist for evaluation.

How will treatment help me?
Treatment will help to lessen or remove your symptoms and return you to your normal life. Treatment is aimed at complete remission of symptoms and staying well afterward. You can also help your primary care doctor treat you more effectively by participating in your treatment through ASKING QUESTIONS and FOLLOWING THROUGH WITH TREATMENT that both you and your doctor decide is best for you.

What type of treatment will I get?
As with any illness, sometimes more than one type of treatment may be tried to find what works best for you. It is important not to get discouraged since many options exist and many people can expect improvement and recovery.

The primary treatments for depression include medication, talking with a therapist or medication combined with talking to a therapist.

Who may provide mental health treatment?
Depression, depending upon the symptoms, may be treated by primary care providers as well as specialized mental health providers. The primary care provider you see may refer you to a mental health specialist such as: a psychiatrist, a psychologist, a social worker, or a case manager.

Who should see a mental health specialist?
Although many people are successfully treated for depression by their primary care provider, there are times when it may be necessary for referral to a specialized mental health provider. Some common reasons for a referral may include the need for a combination of treatments, or for very severe or persistent symptoms that do not improve with treatment. If you think you need to see a specialty provider, talk to the doctor, nurse, or case manager.

How will doctor or nurse know if I have depression?
Your health care provider will assess your physical and mental condition during your visit in order to decide if you are depressed. The following activities may occur:

- Answering Depression Screening Questions of filling out a Health Questionnaire.
- Discussion of your symptoms
- Perform a physical exam to determine your general health status
- Perform some basic laboratory tests.
- Inquire about your family's medical and mental history

THERE IS HOPE. THERE IS HELP. TALK TO YOUR DOCTOR TODAY.

The common types of **TREATMENT** for depression include:
- Antidepressant medicine
- Therapy with a mental health specialist
- A combination of mental health therapy and medication

Your provider will discuss your treatment with you and you may want to explore risks and benefits of each. A treatment plan will be recommended by your provider based upon your specific needs and condition. If you are using DRUGS or ALCOHOL, please discuss this with your provider.

Your antidepressant medication is not addictive or habit forming. It is not an upper; it is not a downer.

Depression Self-Care Action Plan

Patient: _____ DOB: _____

Practice: _____ Phone No: _____

Depression is TREATABLE and RECOVERY is the RULE and not the EXCEPTION!

1. **Stay Physically Active.** Make sure you make time to address your basic physical needs. Try taking a walk for a certain amount of time each day.

2. **Make Time for Pleasurable Activities.** Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some FUN activity each day – like doing a hobby, listening to your favorite music, or watching a video.

GOAL: Every day during the next week, I will spend at least _____ minutes doing _____ _____.

3. **Spend Time with People who can Support you.** It's easy to avoid contact with people when you are depressed, but you need the support of friends and loved ones. Explain to them how you feel, if you can. If you can't talk about it, THAT'S OK – just ask them to be with you, maybe accompanying you on one of your activities.

GOAL: During the next week, I will make contact for at least _____ minutes with
_____ (name), doing/talking about _____.
_____ (name), doing/talking about _____.
_____ (name), doing/talking about _____.

4. **Practice Relaxing.** For many people, the changes that come with depression – no longer keeping up with our usual activities and responsibilities, feeling increasingly sad and hopeless – lead to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, taking a warm bath, or just finding a quiet, comfortable, peaceful place and repeat comforting things to yourself like "IT'S OK."

GOAL: Every day during the next week, I will practice physical relaxation at least _____ times, for at least _____ minutes each time.

Simple Goals and Small Steps.
It is easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and aren't thinking clearly. Try breaking things down into **SMALL STEPS.**
Give yourself credit for each step that you accomplish.

THE PROBLEM IS:_____
MY GOAL IS: _____
STEP 1: _____
STEP 2: _____
STEP 3: _____

How likely are you to follow through with these activities prior to your next visit?

Not likely 1 2 3 4 5 6 Very Likely

Depression Support Resources: Telephonic/Care Management Follow-up

Role of the Phone Clinician in the Treatment of a Depressed Patient

"You hold the keys to success!"

The phone clinician will initiate the phone Call Protocol following a referral from the medical clinician.

The phone clinician may provide additional phone call or support to the patient as part of their clinical judgment and/or based on the medical clinician's request.

The phone clinician will document all contact with the patient via the CMIS system, to include completion of the Phone Call Follow-Up Form with each call, administration of the PHQ-9, provision/reinforcement of patient education, assessment of medication compliance and efficacy

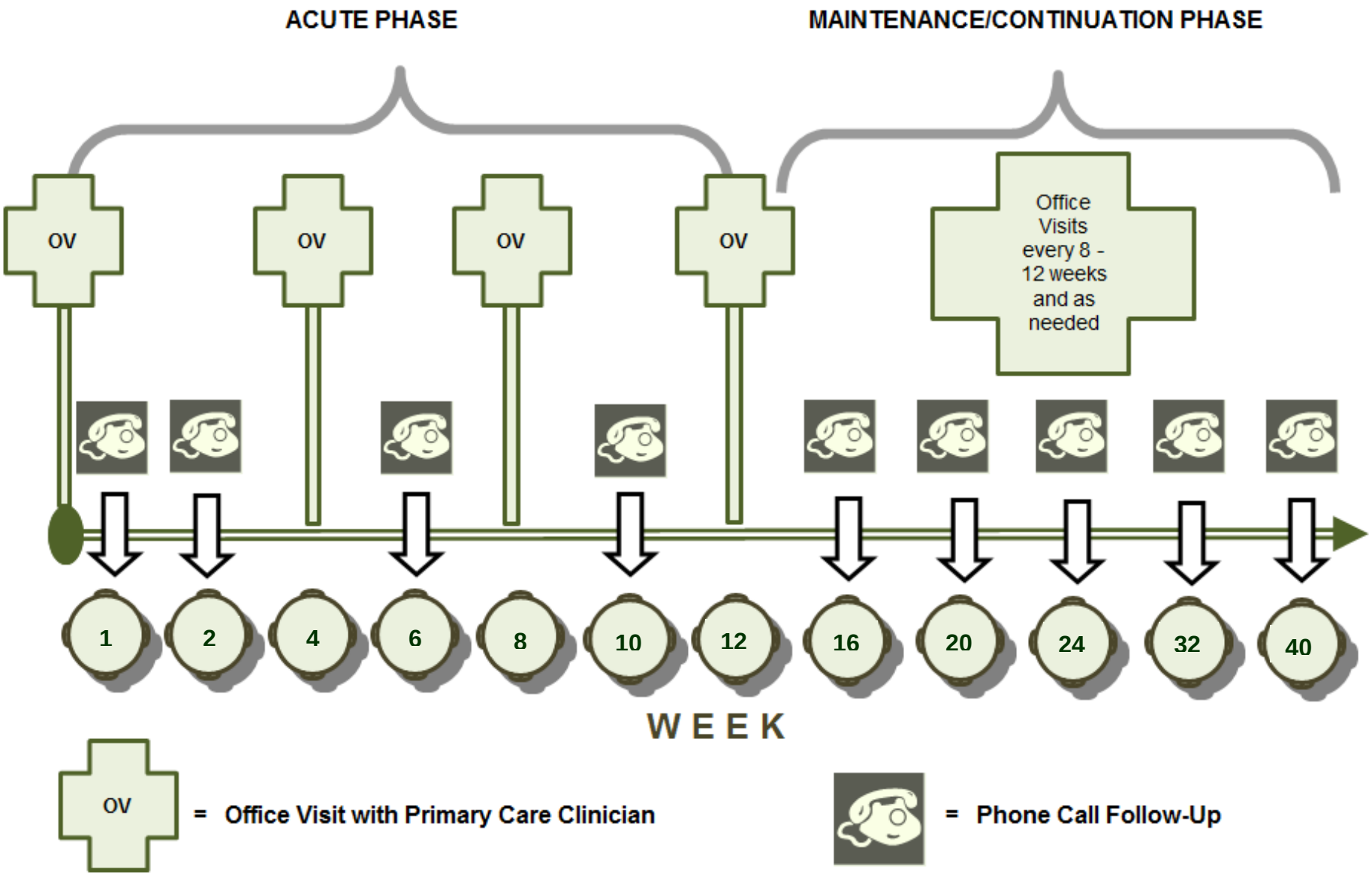
The phone clinician will ensure that all completed CMIS forms are printed out and placed on the Medical Record for the medical clinician to review.

The phone clinician will secure additional assistance from the medical clinician or designated on-call medical clinician if patient responses indicate suicidal tendencies or symptom exacerbation indicating the need for emergent intervention.

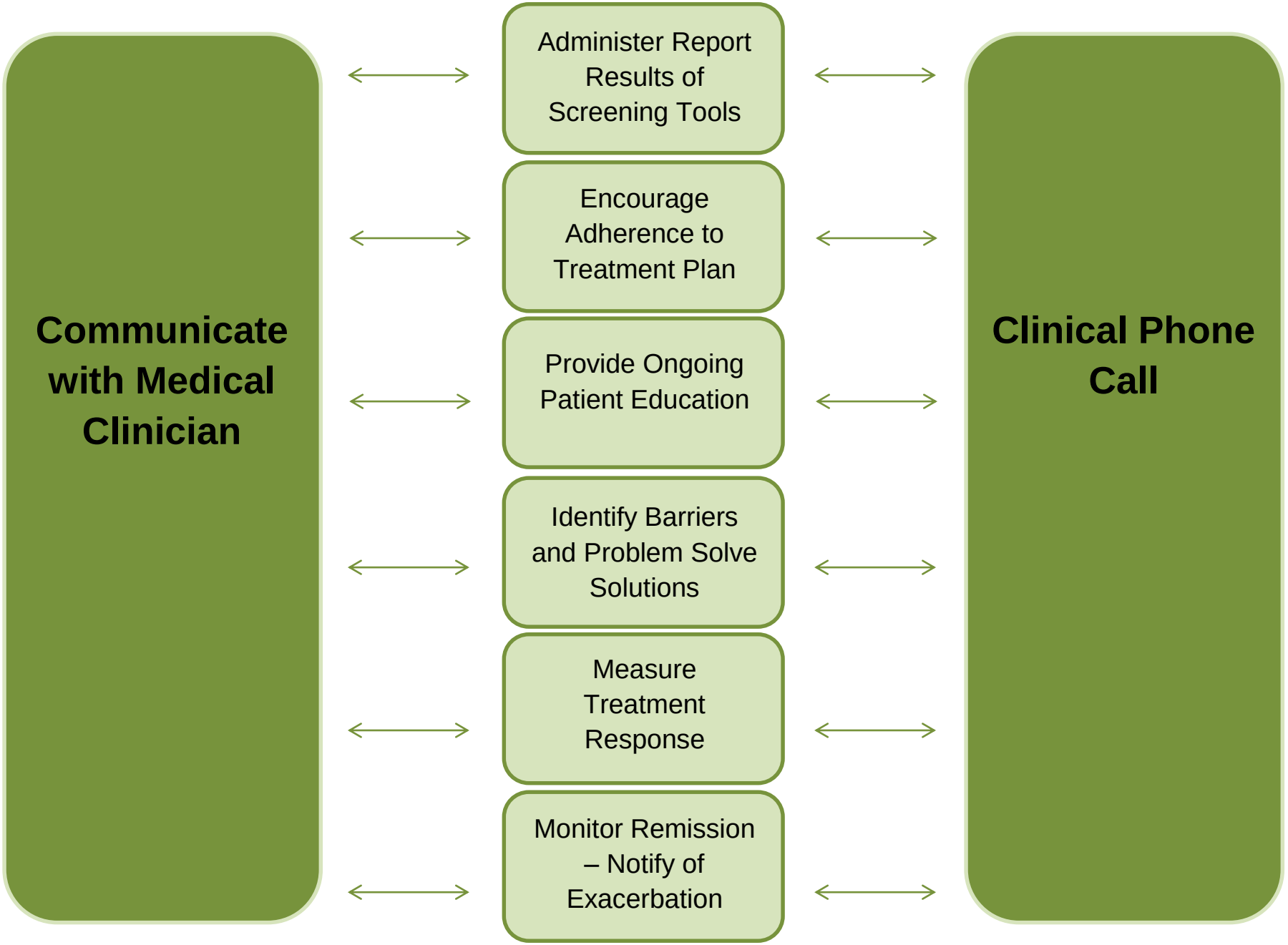
The phone clinician will initiate and update the patient's "Self-Management Depression Action Plan" and place a copy of the Action Plan on the Medical Record for medical clinician review. The phone clinician will identify barriers to the treatment plan and help the patient problem solve and identify possible solutions.

The phone clinician will make at least 3 attempts to locate the patient by phone, documenting each attempt in CMIS. If unable to reach the patient by phone, a letter will be sent to the patient and copied to the medical clinician, explaining that a good faith effort was made, and providing the number of the phone clinician should the patient desire further services. The patient's status will then be **DEFERRED** in CMIS.

Phone Call Follow-Up Protocol in the Treatment of Depression



Phone Call Follow-Up Interventions for Clinicians



Sample Scripts for Phone Call Interventions in the Treatment of Depression

Possible Barriers To Treatment With Recommended Interventions

1. Patient has not begun taking Medication for the Following Reasons:

A. Patient is not comfortable with the "DEPRESSION" diagnosis.
Possible patient responses:

- "I don't really feel depressed."
- "I don't really think that I am that depressed."
- "I'm just stressed out, not depressed."

Interventions:

- Explain to the patient that their primary care clinician feels that they are depressed and that the treatment would help.
- Explore why the patient is uncomfortable about the diagnosis - equate with severe mental illness or is frightened of the "label."
- Explore what they think having depression means and dispel some of the myths.
- If patient insists that they are not depressed, focus more on their symptoms.
- For example, if their main symptom is insomnia, suggest that the medication they have been prescribed will help to relieve that symptom.

B. Patient is not comfortable taking medication in general.
Possible patient responses

- "I'm just not a medication type of person."
- "I just don't like taking drugs."

Interventions:

- Help the patient think about times when medications have been necessary and useful.
- Talk about depression medication as no different from taking medication for high blood pressure or diabetes. Involve them in naming other diseases where medication is both necessary and helpful.
- Try using the "BUS ANALOGY." Someone with a broken leg can get from point A to point B by different means. He can walk, but with a great deal of difficulty, or he can take the bus, which is a lot easier and faster. Then, once the leg is healed, he will not need the bus. He only took advantage of its service for the short term when it was needed. The same is true for taking medication for depression. It can be a temporary help during difficult times. When the depression is considered in remission, the person will be able to decide, with his clinician, when he does not need to take it anymore.
- Point out that some people feel so much better on the medication that they decide to continue taking it indefinitely, especially if they have a history of multiple episodes.
- Remind the patient that their symptoms have not gone away over a period of time, and that for most people, the symptoms will not resolve on their own.

C. Patient is worried about being labeled as "mentally ill" if medication is taken.
Possible patient responses:

- "I don't want to be on a medicine for a mental condition."
- "I wouldn't want anyone to know that I was on this kind of medicine."
- "People will think of me differently if they find out I'm on this kind of drug."

Interventions:

- Frame taking medication with taking care of yourself. How would others judge you if they felt that you were not taking care of yourself?
- How would you feel about someone you knew not taking a medicine that could help them feel better?
- Explain that depression is a medical condition that occurs when a chemical in the brain is not produced in sufficient amounts, just like diabetics do not produce insulin needed by the body.
- Ask the patient, have you ever known someone with high blood pressure or diabetes?

- Would you expect them to "buck up" and handle it themselves or take medication necessary to treat their medical condition?
- Rehearse what the patient can tell friends and family about the medication they are taking. Refer to the Patient Education Instructions related to Anti-Depressant medications.

D. Patient is unclear about what the medication does.
Possible patient responses:
- "I don't understand why the doctor prescribed this medicine."
- "I don't even know what the medicine does or how it will help me."

Interventions:
- Educate the patient on how their medication works and review medication instruction sheet. If patient did not receive the Instructions, go over them and mail out to patient.
- Recommend that the patient talk to the clinician during the next office visit.

E. Patient is concerned about becoming addicted to the medication.
Possible patient responses:
- "I don't want to take this medicine forever."
- "I don't want to get addicted to this medicine."

Interventions:
- Inform the patient that depression medication is NOT addictive.
- Explain that it takes time for the medication to start working, and that once in remission, it is not unusual for patients to stay on the medicine for 6 months to a year. Also emphasize that the decision for length of anti-depressant therapy is to be made with the clinician.
- Emphasize the importance of staying on the medication and not to discontinue the drug without discussing it with the clinician.
- Mention the tendency of some people to go off the medication as soon as they start feeling better and that stopping too soon may put them at risk for a relapse.

F. Patient is concerned about their ability to pay for the medicine.
Possible patient responses:
- "I don't have insurance, so I can't possibly pay for this medicine."

Interventions:
- If patient is an HCAP recipient, they can utilize HCAP Medication Assistance Program
- Suggest that they discuss with their PCP if any less expensive generic drugs are available to treat them, if samples are available, or refer them to a community Medication Assistance Program, especially if long term therapy is anticipated.

2. Patient is considering or has stopped taking medicine for the following reason(s)

A. Patient is experiencing distressing side effects.
Possible patient responses:
- "I feel like my mouth is full of cotton."
- "My husband/wife says I'm not interested in sex anymore."
- "I feel like throwing up after I take the medicine."

Interventions:
- Explain that most side effects are temporary and usually resolve in a few weeks.
- Give the patient tips on how to handle the side effect i.e., put ice in their mouth or suck on hard candy for dry mouth.
- For more complex side effects such as loss of interest in sex, explore whether this symptom is medication induced or whether it may be a part of their depression.
- If the patient cannot tolerate the side effect, offer to speak with the clinician and call them back if a different prescription is ordered.
- Acknowledge that it can be frustrating finding the right medication or combination of medications, but it will be worth the effort to resolve their depression.

B. Patient is feeling better.
Possible patient responses:
- "I feel better now so I think I can stop taking the medicine."

Interventions:
- Acknowledge that it is great that the medication is working, but explain that it is best to remain on the drug until they and the clinician talk about it. Even then, the medication may be discontinued slowly and the patient will need to be monitored for possible relapse.

3. Patient referred to a Mental Health Specialist but has not made/kept an appointment

A. Patient has had a negative experience
Possible patient responses:
- "I have been before but it didn't help me."

Interventions:
- Discuss the reasons why the counseling was not effective.
- Help the patient to understand more about what they didn't like the experience.
- Help the patient determine what they would like to happen if they wished for the session to be helpful.

B. Patient is uneasy about what the visit will be like and the perceived stigma of needing to receive assistance from a mental health specialist.
Possible patient responses:
- "I'm not sure if I want to go right now."
- "I don't really need to see somebody like that." "I'm not that bad off yet."
- "I'm not totally crazy you know."

Interventions:
- Educate the patient about what they can expect to happen during counseling.
- Determine what they "think" will happen during a visit and dispel any misconceptions.
- Assure them that "totally crazy" people do not go to counseling.

Depression: Phone Call Follow-Up

Patient Name: _____ DOB: _____ ID#: _____
Initial Diagnosis Date: _____ Date of Phone Call: _____

Per Protocol, minimum standard requires phone contact during the first 4 months of treatment at weeks **1, 2, 6, 10** and **16,** then at **5 months (20 weeks)**, **6 months (24 weeks)**, **8 months (32 weeks)** and **10 months (40 weeks)**.								
Call Interval:	☐ **1**	☐ **2**	☐ 3	☐ 4	☐ 5	☐ **6**	☐ 7	☐ 8
Week:	☐ 9	☐ **10**	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15	☐ **16**
Month:	☐ **5**	☐ **6**	☐ 7	☐ **8**	☐ 9	☐ **10**	PRN:_____	
Phase of Treatment:		☐ Acute Phase			☐ Continuation/Maintenance Phase			

Phone Call Intervention	**YES**	**NO**	**N/A**
1. PHQ-9 QUESTIONNAIRE – Enter PHQ-9 Data from previous office encounter. If no PHQ-9 is in the system within the past month, complete the PHQ-9 Form per Phone Call and ENTER.			
a. PHQ-9 QUESTIONNAIRE complete and data entered in CMIS:			
b. If **Question 9** (Suicide Potential) of the most recent PHQ-9 is POSITIVE, the **Suicide Screening Form** is to be completed, data entered in CMIS and a copy printed for the Medical Record.			
2. ANTI-DEPRESSANT MEDICATION is prescribed:(if no medication, proceed to next question)			
a. patient **obtained prescription**			
b. patient is **taking medication** as prescribed			
c. if medication is being **titrated**, the new dosage has been started			
d. patient is experiencing adverse side effects; If "**YES**", note **symptoms, severity** and **ability to tolerate** in Additional Information section below.			
e. patient had **poor response** to medication therapy and an attempt was made to **schedule an office appointment** prior to the next scheduled visit			
3. SELF MANAGEMENT GOALS ADDRESSED THROUGH DEPRESSION ACTION PLAN (DAP) (may mark N/A after week 16 if Action Plan is no longer needed)			
a. **Goals initiated/updated** during phone call			
b. Patient is **practicing** Self-Management Goals			
c. Copy of new or updated **Depression Action Plan** (DAP) placed on **record** for provider review			
4. PATIENT EDUCATION			
a. **Reinforce** patient education material			
b. **Provide additional** patient education material			
5. FACILITATE NEXT ACTION STEP:			
a. Patient informed of next scheduled follow-up visit per protocol guidelines - at least 3 follow-up Contacts with a PCP or mental health practitioner during the **12 week Acute Treatment Phase**, at least one with the prescribing provider.			
b. **After week 16**, patient is experiencing poor response to therapy or symptoms indicate an exacerbation - appointment scheduled with the practitioner			
c. **Poor response** to therapy; request that Provider **consider referral** to Mental Health Specialist			

Additional Information for the Provider:
NOTE: Every contact should end by confirming when the **next phone call** and office visit will occur. Remind the patient that the physician will receive an update of their progress following each phone call session.
PRINT OUT THE COMPLETED FORM AND PLACE IT ON THE MEDICAL RECORD

Next Phone Call Scheduled: _____
Next Visit Scheduled: _____

Phone Clinician's Phone Call Tracking Log

Patient Name: _____ ID#: _____
Phone Number: _____ DOB: _____

Week #	Date	Type of Call	Call Completed? (Yes or No)	Failed Call Attempt #	Best Time of Day to Call	Next Call Date

Minimal Call Frequency - Weeks 1, 2, 6, 10, 16, 20, 24, 32, 40

Type of Call: PRN Routine Phone Manager: _____

Spanish Language Resources

2 PREGUNTAS PARA LA EVALUACIÓN DE LA DEPRESIÓN

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2. ¿Sintiéndose desanimado, deprimido o sin esperanza?		

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LA DEPRESIÓN Y USTED

¿Quién se deprime?
La depresión es una condición muy común pero altamente tratable, la cual afecta a 1 de cada 20 Americanos cada año. La depresión no es una falla o defecto del carácter, una señal de debilidad personal o una condición que puede ser traspasada. La Depresión es una enfermedad médica que puede afectar a cualquiera. Más de 11 millones de personas contraen esta enfermedad cada año. De estos la mitad son mujeres. Muchas mujeres son especialmente vulnerables después de haber dado a luz. Los hombres tienen menos probabilidades de sufrir esta enfermedad, pero de igual manera es menos probable que lo admitan.

Desafortunadamente, muchas de las personas que padecen depresión no le hablan a su médico de sus síntomas. El primer paso hacía el mejoramiento de la persona con depresión es hablar con su médico acerca de sus síntomas.

¿Qué es depresión?
Debido a que la depresión es una condición médica, al igual que la diabetes o enfermedades del corazón, está es más que un sentimiento de tristeza. Afecta su vida cotidiana y sus pensamientos, ideas, acciones y bienestar físico.

Algunas causas comunes pueden incluir: ciertas condiciones médicas, algunos medicamentos, drogas o alcohol, historial familiar u otras condiciones de enfermedades mentales. Pueden ser el resultado de ciertos eventos de la vida, como la pérdida de un ser querido, o por causas de estrés. Un desequilibrio de los químicos en el cerebro que controlan el humor también puede causar depresión.

RECUERDE: LA DEPRESIÓN NO ES EL RESULTADO DE DEBILIDAD O CULPA, ES UNA ENFERMEDAD MÉDICA LA CUAL PUEDE SER TRATADA EFICAZMENTE.

¿Cómo sabré si estoy deprimido?

Las personas deprimidas por lo general experimentan uno o más de los siguientes síntomas:

TODO EL DÍA, CASI TODOS LOS DÍAS, DURANTE POR LO MENOS 2 SEMANAS:
- Pérdida de interés en cosas que disfrutaba anteriormente.
- Sentimiento de tristeza o melancolía.

TAMBIÉN PUEDE EXPERIMENTAR POR LO MENOS 3 DE LOS SIGUIENTES SÍNTOMAS:
- Sentirse inquieto, lento e incapaz de estar sentado. I Incremento o reducción en apetito o peso.
- Pensamientosdemuerteosuicidio.
- Dificultad para pensar, concentrarse, recordar o tomar decisiones.
- Durmiendo demasiado o muy poco.
- Sentimiento de cansancio todo el tiempo, o pérdida de energía.
- Otros síntomas que puede experimentar incluyen:
    - Dolor de cabeza
    - Dolor y malestar
    - Ansiedad o preocupación
    - Problemas Digestivos
    - Sentimiento de desesperación

¿Qué debo hacer si tengo estos síntomas?

Hable con su médico. Muchas personas sospechan que algo anda mal pero dudan en buscar ayuda o se sienten culpables o responsables por sus síntomas. En ocasiones no se dan cuenta que existe ayuda y tratamiento. Si piensa que puede tener un problema, existen proveedores de salud que le pueden ayudar. Le pueden ayudar a encontrar si existe alguna causa física, la cual pueda estar afectando sus síntomas, tratarlos o referirlo a un especialista en salud mental para su evaluación.

¿Cómo me puede ayudar el tratamiento?
El tratamiento le ayudará a disminuir o alejar sus síntomas y regresarlo a su vida normal. El tratamiento propone una remisión completa de síntomas y a estar bien después de este. Usted también puede ayudar a su médico a tratarlo más eficazmente a través de su participación en el tratamiento, haciendo preguntas y llevando un seguimiento de su tratamiento, el cual entre usted y su médico decidirán cual es el mejor.

¿Qué clase de tratamiento recibiré?
Al igual que con cualquier otra enfermedad, en ocasiones más de un tipo de tratamiento será necesario para saber cual funciona mejor para usted. Es muy importante no desanimarse ya que existen muchas opciones y existe recuperación y mejoramiento.

LOS TRATAMIENTOS PRINCIPALES PARA DEPRESIÓN INCLUYEN MEDICAMENTOS, HABLAR CON UN TERAPEUTA, O LA COMBINACIÓN DE MEDICAMENTO Y HABLAR CON UN TERAPEUTA.

¿Quién puede proveer tratamiento de salud mental?
Dependiendo de los síntomas, la depresión puede ser tratada por médicos generales al igual que por especialistas en salud mental.

Su médico puede referirlo a un especialista en salud mental como lo son: siquiatra, psicólogo, trabajador social o un administrador de casos.

¿Quién debe ver a un especialista en salud mental?
Aunque muchas personas son tratadas exitosamente por su médico de cabecera, existen ocasiones en las cuales será necesario ser referido a un especialista en salud mental. Algunas razones comunes para ser referido pueden incluir la necesidad de una combinación de tratamiento o síntomas severos y persistentes. Si considera la necesidad de acudir a un especialista, hable con su médico, enfermera o administrador de casos.

¿Cómo sabrá mi médico o enfermera si tengo depresión?
Su médico evaluará su condición física y mental durante su visita al consultorio para decidir si está deprimido. Pueden ocurrir las siguientes actividades en su consulta:

- Contestar preguntas para revisión de depresión o llenar cuestionarios de salud.
- Discusión de sus síntomas.
- Llevar a cabo de un examen físico para determinar su estado de salud en general.
- Realizar exámenes básicos de laboratorio.
- Preguntas acerca de su historial familiar médico y mental.

EXISTE ESPERANZA, EXISTE AYUDA, HABLE CON SU MÉDICO HOY MISMO.

EVALUACIÓN DE EFECTOS SECUNDARIOS DE ANTIDEPRESIVOS

1. Escoja todos los efectos secundarios que está teniendo que usted cree que es debido a la medicación que ha tomado para su depresión.

Nervioso/a, inquietud	*Insomnio*	*Nausea, vómito, diarrea, dolor de estómago, anorexia*	*Dolor de cabeza*	*Disfunción sexual*	*Sensación de cansancio durante el día*	*Confusión, desorientación, deficiencias cognitivas*
☐	☐	☐	☐	☐	☐	☐

2. Escoja la repuesta qué mejor describa la frecuencia de los efectos secundarios del medicamento que ha tomado durante la semana pasada para su depresión. No marque repuesta si cree que los efectos secundarios son debidos a tratamiento(s) que estaba realizando por otras razones médicas diferentes a la depresión. Determine la frecuencia de estos efectos secundarios en la semana más reciente.

Ningún efecto secundarios	*Presente 10% de las veces*	*Presente 25% de las veces*	*Presente 50% de las veces*	*Presente 75% de las veces*	*Presente 90% de las veces*	*Presente siempre*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

3. Escoja la repuesta que mejor describa la intensidad (¿cuán grave?) de los efectos secundarios que usted atribuye a los medicamentos que ha tomado durante la semana pasada para su depresión. Describa la intensidad de estos efectos secundarios, cuando ocurrieron, durante la semana pasada.

No tengo efectos secundarios	*Insignificante*	*Leve*	*Mediano*	*Bastante*	*Grave*	*Intolerable*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

4. Escoja la repuesta que mejor describa en qué medida los efectos secundarios de los medicamentos antidepresivos que usted ha usado esta semana pasada han interferido con su vida diaria.

Sin limitación	*Mínimas limitaciones*	*Leves limitaciones*	*Limitaciones moderadas*	*Bastantes limitaciones*	*Graves limitaciones*	*Incapaz de funcionar*
☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6

The response to question 4 may suggest that a change in treatment is necessary. Q4 Score 0-2: Treatment should continue unless concerns exist about safety or symptom severity Q4 Score 3-4: The side effect should be addressed (e.g. decrease dose) Q4 Score 5-6: Change treatment (e.g. decrease dose or switch medication)

Adapted from: Wisniewski SR, Rush AJ, Balasubramani GK, Trivedi MH, Nierenberg AA. Self-rated global measure of the frequency, intensity, and burden of side effects. J Psychiatr Pract. 2006;12:71-79.

INFORMACIÓN IMPORTANTE ACERCA DE SU MEDICAMENTO ANTIDEPRESIVO

Los tipos de **TRATAMIENTO** para la depresión más comunes incluyen:

- Medicamentos anti-depresivos
- Terapia con un especialista en salud mental
- Una combinación de terapia de salud mental y medicamento

Su proveedor de salud discutirá su tratamiento con usted y quizá usted quiera conocer los riesgos y beneficios de cada uno. Un plan de tratamiento será recomendado por su médico basándose en sus necesidades específicas y condición. Si está usando DROGAS O ALCOHOL, por favor discuta esto con su proveedor de salud.

SU MEDICAMENTO ANTIDEPRESIVO NO ES ADICTIVO. NO HARÁ QUE SE SIENTA ELEVADO, NI DESGANADO

COSAS IMPORTANTES PARA RECORDAR MIENTRAS ESTÁ TOMANDO ANTIDEPRESIVOS:

- Toma algún tiempo para que su medicamento funcione
- Antidepresivos solamente funcionan si se toman **DIARIO**!
- La mayoría de las personas comienzan a sentirse mejor en un lapso de **1 a 4 semanas**
- **NO SE DÉ POR VENCIDO** si no se siente bien inmediatamente.
- La primera semana es la más difícil. Algunas personas tienen efectos secundarios leves y piensan que el
  medicamento no está funcionando. Los efectos secundarios por lo general se quitan a los pocos días.
- Después de comenzar a sentirse mejor continué tomando su medicamento exactamente como se lo ordeno el médico, a pesar de que ya se sienta mejor.

Si está pensando en dejar de tomar su medicamento. **LLAME A SU MÉDICO PRIMERO.** Los efectos secundarios comunes incluyen lo siguiente:

- Boca seca
- Estreñimiento
- Aumento o pérdida de peso
- Salpullido en la piel
- Nerviosismo
- Dolor de Cabeza
- Mareo
- Dificultad para dormir o para mantenerse dormido
- Náusea y/o vómito
- Trastorno sexual

ES MUY IMPORTANTE QUE REPORTE CUALQUIER EFECTO SECUNDARIO QUE TENGA QUE VER CON SU MEDICAMENTO Y CONTINUAR CON SUS CITAS MÉDICAS

Dependiendo de sus síntomas quizá necesite continuar tomando su medicamento por un período de tiempo largo a pesar de continuar sintiéndose mejor. Para algunas personas, continuar tomando el medicamento por un periodo de tiempo largo resulta muy exitoso para prevenir una recaída.

Si desarrolla un salpullido, o si los efectos secundarios son severos **no** continué tomando su medicamento y
llame a la clínica.

Provider :_____

Número de Teléfono: _____

CUESTIONARIO DE SALUD DEL PACIENTE (PHQ-9)

Lista de los Nueve Síntomas para Revisión de la Depresión

Nombre del Paciente: _____ Fecha De Nacimiento: _____ Fecha: _____

¿En las últimas dos semanas, con qué frecuencia ha experimentado los siguientes síntomas?

PREGUNTAS	Nunca	Varios dias	Más de la mitad de los días	Casi todos los días
Conteste las preguntas 1-9 inicialmente y después todos los Puntos de Decisión Crítica (PDC)	**0**	**1**	**2**	**3**
1. Poco interés o placer en hacer cosas	0	0	0	0
2. Sentirse desanimado, deprimido o sin esperanza	0	0	0	0
3. Tener problemas para dormir, mantenerse dormido o dormir demasiado	0	0	0	0
4. Sentirse cansado o tener poca energía	0	0	0	0
5. Poco apetito o comiendo demasiado	0	0	0	0
6. Sentir falta de amor propio o pensar que es un fracaso o fallarle a usted mismo o a su familia	0	0	0	0
7. Tener dificultad en concentrarse en cosas tales como leer el periódico o ver televisión	0	0	0	0
8. El moverse o hablar tan despacio que otras personas a su alrededor se dan cuenta; o todo lo contrario, que cuando está nervioso/a o inquieto/a usted se mueva muchísimo más de lo normal.	0	0	0	0
9. Pensamientos de que pudiera estar mejor muerto o hacerse daño a si mismo. (Si contestó afirmativamente, complete la Evaluación de Riesgo de Suicidio)	0	0	0	0
PHQ-9 Scoring Formula				
# Symptoms	**___ X 0 =**	**___ X 1 =**	**___ X 2 =**	**___ X 3 =**
Per Category	**_____ +**	**_____ +**	**_____ +**	**_____ =**
		PHQ-9 Total Score:		_____

Network Specific Information