Adult Major Depressive Disorder
Updates: Practical Treatment of Depression in Primary Care

Lindsay Botsford, MD, MBA, CMQ, FAAFP

ACTIVITY DISCLAIMER

The material presented here is being made available by the American Academy of Family Physicians for educational purposes only. Please note that medical information is constantly changing; the information contained in this activity was accurate at the time of publication. This material is not intended to represent the only, nor necessarily best, methods or procedures appropriate for the medical situations discussed. Rather, it is intended to present an approach, view, statement, or opinion of the faculty, which may be helpful to others who face similar situations.

The AAFP disclaims any and all liability for injury or other damages resulting to any individual using this material and for all claims that might arise out of the use of the techniques demonstrated therein by such individuals, whether these claims shall be asserted by a physician or any other person. Physicians may care to check specific details such as drug doses and contraindications, etc., in standard sources prior to clinical application. This material might contain recommendations/guidelines developed by other organizations. Please note that although these guidelines might be included, this does not necessarily imply the endorsement by the AAFP.

This live CME session is supported by an educational grant from Takeda Pharmaceuticals U.S.A., Inc. and Lundbeck.
DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflict of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

All individuals in a position to control content for this session have indicated they have no relevant financial relationships to disclose.

The content of my material/presentation in this CME activity will include discussion of unapproved or investigational uses of products or devices as indicated:

Liothyronine, Lithium for off-label use for antidepressant augmentation based on Star*D trial. Gabapenti, pregabalin, modafinii for off-label use as adjunct to antidepressants to help with depressive syndromes. Sildenafil, Bupropion, Buspirone to manage sexual side effects of SSRI.

Lindsay Botsford, MD, MBA, CMQ, FAAFP

Family physician, Iora Health, Houston, Texas

Dr. Botsford earned her medical degree from Baylor College of Medicine, Houston, and completed a family medicine residency at Baylor College of Medicine/Kelsey-Seybold Clinic, Houston. She earned her Master of Business Administration (MBA) degree at the University of Houston’s Bauer College of Business after graduating from residency. During her nine years in practice, she has been in both employed practice and academics. She recently transitioned from medical director with Memorial Hermann Medical Group: Physicians at Sugar Creek into a role as a market medical director with Iora Health. She has been recognized for her teaching by the Texas Medical Association, receiving Silver-Level Recognition in 2016. She has been actively involved in projects related to quality, registries, electronic health record (EHR) optimization, and population health. She received her certification from the American Board of Medical Quality (ABMQ) in 2017. Dr. Botsford has been active within organized medicine at both the state and national levels. She was a member of the AAFP Commission on Quality and Practice from 2014-2018, serving as chair in 2018. In 2017, she was appointed to the National Quality Forum’s Primary Care and Chronic Illness Standing Committee.
Learning Objectives

1. Utilize appropriate diagnostic criteria to evaluate and screen patients for depression, mood disorders, and suicide risk.

2. Evaluate non-pharmacologic interventions that are effective for the treatment of depression.

3. Recognize the risks associated with certain drugs used to treat depression and mood disorders, including contraindications for certain classes of medications.

4. Coordinate care for patients who require referral to sub-specialists or admission to hospitals for suicide prevention.

5. Devise collaborative treatment plans for depression that take into account severity, suicidality, developmental stage, and environmental and social factors.

Audience Engagement System

Step 1

Step 2

Step 3
Depression in the US

• 9.5% of population
• 16 million adults diagnosed annually
• 9.3% of physician office visits have depression as a diagnosis
• Commonly co-occur with anxiety disorders and substance abuse

Underdiagnosis & Undertreatment

Visits/year for patients treated for depression

Primary care physicians: 1.7
Mental health providers: 7.4

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.
Deadly Effects on Chronic Illness

- Recent Heart Attack
  - 2x risk of death
  - 2x risk of repeat MI

- Diabetes
  - 50% ↑ death
  - 30% ↑ limb amputation
  - ↓ glucose control

Diagnostic criteria
Screening Recommendations

USPSTF Grade B Recommendation for all adults
USPSTF Grade B Recommendation for adolescents 12 to 18 years

- Screen with “adequate systems in place to ensure adequate diagnosis, effective treatment, and appropriate follow-up.”

- Women in pregnancy and postpartum period
  - Screen once in pregnancy and once 4-8 weeks postpartum
  - AAP recommends screening at infant’s one, two and four month visits

Screening Tools

- No significant difference in performance
  - Patient Health Questionnaire (PHQ-2, PHQ-9, PHQ-A)
  - Beck Depression Inventory for Primary Care (BDI)

- Questionnaires for special populations
  - Geriatric Depression Scale (GDS)
  - Edinburg Postpartum Scale (EDPS)
  - Cornell Scale for Depression in Dementia (CSDD)

- Utilize staff and technology to administer
Preferred Screening Strategy:
Administer PHQ-2 during routine **preventive** visits

Over the past month, have you felt down, depressed, or hopeless?
Over the past month, have you felt little interest or pleasure in doing things?

<table>
<thead>
<tr>
<th>PHQ2</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 1</td>
<td>96%</td>
<td>60%</td>
</tr>
<tr>
<td>≥ 2</td>
<td>86%</td>
<td>78%</td>
</tr>
<tr>
<td>≥ 3</td>
<td>61%</td>
<td>92%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHQ9</th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 8</td>
<td>82%</td>
<td>85%</td>
</tr>
<tr>
<td>≥ 10</td>
<td>74%</td>
<td>91%</td>
</tr>
<tr>
<td>≥ 12</td>
<td>61%</td>
<td>94%</td>
</tr>
</tbody>
</table>

PHQ2 ≥ 2 → PHQ9 ≥ 10 → Interview with DSM-5 Criteria


Diagnosing Major Depressive Disorder

Depressed mood or Anhedonia +
4 Additional Symptoms
- Sleep changes
- Feelings of Guilt or Worthlessness
- Energy decrease or fatigue
- Concentration/cognition difficulties
- Appetite or weight change
- Psychomotor Agitation or Retardation
- Suicidal ideation or recurrent thoughts of death

Symptoms also cause distress or functional impairment

X Two Weeks
DSM-5 Changes

- Category of Depressive Disorders separate from Bipolar disorders
  - Includes Persistent Depressive Disorder (Dysthymia)

- Addition of two new depressive disorders
  1. Disruptive mood dysregulation disorder
     - 6-18yo with persistent irritability and frequent out-of-control behavior
  2. Premenstrual dysphoric disorder
     - Severe form of premenstrual syndrome with strong emotional symptoms

- Eliminates bereavement exclusion

Depression Specifiers in DSM-5

New
- With mixed features
- With anxious distress
  weird statements
  Manic symptoms without mania
  2/5 constructs; associated with higher risk

Clarified Definition
- Peripartum onset
  During pregnancy or 4 weeks postpartum
Initial Evaluation

• Consider secondary causes
  • Especially in older patients
  • Thyroid, infection, anemia, chronic disease

• Rule out bipolar disorder, PTSD, other disorders
  • Mood Disorders Questionnaire (MDQ) is specific, but not sensitive

• Document follow-up strategy
• Evaluate safety and self-care
• Consider partnering with behavioral health

Nonpharmacologic Interventions
Poll Question 1

Which of the following patients has a high likelihood of successful depression treatment with cognitive behavioral therapy without an antidepressant?

A. 55 year old female with moderate depression who had an episode of depression 3 years ago and failed treatment with an SSRI.
B. 36 year old female with mild to moderate depression going through a stressful divorce.
C. 27 year old male with moderate to severe depression who does not want to take medication.
D. Cognitive behavioral therapy is unlikely to ever be an effective treatment when used alone.

Acute Phase Treatment Options

- Somatic therapies
  - Electroconvulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Vagus nerve stimulation
  - Light therapy
- Psychotherapy
- Pharmacotherapy

➤ Choice depends on severity and patient preference
Psychotherapy

• Interpersonal (IPT) or Cognitive Behavioral Therapy (CBT)
• Important for long term maintenance and remission

• Effectiveness similar to medication for mild to moderate symptoms
  • Can be expensive and hard to find
  • Online CBT and telepsychiatry may be options
  • Self-directed CBT has shown some effectiveness

Adjunctive Treatments for Depression

• Aerobic and resistance exercise (SORT B)
• Sleep hygiene (SORT C)
• Yoga (SORT B)
• Mindfulness-based meditation (SORT B)
  • U.S. Department of Veteran Affairs apps
  • Headspace app
Alternative Therapies

- Strength of evidence for supplements is low
  - S-Adenosyl methionine (SAMe)
  - St. John’s Wort
    - Drug-drug interactions

- Saffron, Omega-3 fatty acids, acupuncture, Chinese herbal medicine not more effective than antidepressants in most meta-analyses

5 Minute Behavioral Health Tools

1. Encourage patient to draw on social supports
2. Increase frequency of patient visits with you
3. Assist patient in focusing on gratitude
4. Teach breathing and mindfulness exercises
5. Prescribe physical exercise
6. Encourage behavioral activation by creating a routine or schedule

Poll Question 2

Sarah is a 48yo female who presents with depressed mood, fatigue, early-morning wakening, decreased appetite and trouble concentrating for the last month. Her PHQ-9 is 18. She would like to try counseling, but is open to starting a medication as well. Which medication would be the best first choice for her?

A. Mirtazapine
B. Amitriptyline
C. Trazodone
D. Sertraline
E. Selegiline
Major Classes of Antidepressants

- Selective Serotonin Reuptake Inhibitors (SSRI)
- Serotonin- Norepinephrine Reuptake Inhibitors (SNRI)
- Monoamine Oxidase Inhibitors (MAOI)
- Tricylic Antidepressants (TCA)

Base choice on cost, patient preference, and adverse effect profile for initial episode.

**Selective Serotonin Reuptake Inhibitors (SSRI)**

- Sertraline, Citalopram and Escitalopram are all first line
- Contraindicated in older adults:
  - Fluoxetine is activating and long ½ life; approved for children
  - Paroxetine is sedating, BEERS list and higher side effects/withdrawal
- Side effects relatively similar:
  - Weight gain
  - Sexual dysfunction
  - Nausea/diarrhea
  - Hyponatremia
  - GI Bleed
  - Headaches
  - QTc prolongation-citalopram, escitalopram
  - Increased suicidal thoughts
### Selective Serotonin Reuptake Inhibitors (SSRI)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Initial Daily Dose</th>
<th>Titration</th>
<th>Max Daily Dose</th>
<th>Initial Dose for &gt; 60 Years Old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>20 mg</td>
<td>20 mg weekly</td>
<td>40 mg; 20mg &gt; 60yo</td>
<td>10-20 mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10 mg</td>
<td>10 mg weekly</td>
<td>20 mg</td>
<td>5-10 mg</td>
</tr>
<tr>
<td>Sertraline</td>
<td>50 mg</td>
<td>50 mg weekly</td>
<td>200 mg</td>
<td>25 mg</td>
</tr>
</tbody>
</table>

➢ Start low, but don’t be afraid to escalate

### SSRIs in Pregnancy & Breastfeeding

- Generally safe in pregnancy
  - Sertraline usually first choice
  - Avoid paroxetine (Class D)
  - May have earlier delivery, lower birth weight

- No known risk with breastfeeding
  - Most get in breastmilk, but only at low levels
  - Sertraline transfers in lower concentration
Selective Serotonin Reuptake Inhibitors (SNRI)

- Slightly better than SSRI at improving symptoms
- Higher adverse effects (nausea, vomiting) and discontinuation rates
- Potential for fewer sexual side effects

Duloxetine
- Start 20mg BID
- Limited benefit above 60mg/day
- Indications for chronic nerve pain and fibromyalgia
- Avoid in hepatic impairment

Venlafaxine
- Start IR 37.5 BID/ XR 75mg daily
- Max effective dose 225mg
- Can increase blood pressure
- Can help menopausal symptoms
- Higher doses for chronic pain
Second-Line Treatment Options

**Tricylic Antidepressants (TCA)**
- Nortriptyline, Desipramine are most tolerable
- Sedating, anticholinergic
- Off-label for co-morbid conditions
- QTc prolongation
- Lethal in overdose; monitor blood concentrations

**Monoamine Oxidase Inhibitors (MAOI)**
- Tranylcypromine, Selegiline
- Require low tyramine diet except selegiline patch
- Caution with other antidepressants; observe washout times

Second-Line: Serotonin Modulators

**Vilazodone**
- Partial agonist 5-HT1A receptors
- Start 10mg QHS to limit GI effects
- Goal 20mg-40mg daily
- Take with food
- No effect on QTc, weight
- Limited sexual side effects
- $$$$  

**Vortioxetine**
- 5-HT3 receptor antagonist
- Start 5-10mg once daily
- Moderate to severe depression
- Nausea is most common effect
- No effect on QTc, weight
- May help cognitive slowing
- Not more effective
- $$$$
Medications for Special Populations

• **Brexanolone (Zulresso): Depression in peripartum period**
  • GABA A Receptor Positive Modulator
  • Continuous IV infusion over 60 hours in certified facility
  • REMS due to risk of excess sedation and loss of consciousness

• **Bupropion: Depression w/ seasonal pattern (SAD)**
  • Bupropion XL 150mg-300mg in morning
  • No sexual side effects and can be stimulating
  • Can’t use in seizure disorder or eating disorders

Managing Side Effects

• **Increased risk of suicidality in young adults**
  • First months after starting SSRI

• **Sexual side effects**
  • Can add Sildenafil, Bupropion, Buspirone

• **SSRI/SNRI Withdrawal**
  • Dizziness, flu-like symptoms, sensory phenomena
  • Onset 2-3 days after stopping medication
  • Paroxetine and SNRI's have increased symptoms
  • Fluoxetine active metabolite has half life of one week, minimizing withdrawal

• **Watch for Serotonin syndrome when using combinations**
Poll Question 3

What scenario most likely represents a patient with major depressive disorder in remission?

A. 42yo female whose PHQ-9 improved from 11 to 4 after 6 weeks of cognitive behavioral therapy.
B. 28yo female whose PHQ-9 improved from 21 to 7 over 4 weeks taking escitalopram 20mg daily.
C. 31yo male who has been on citalopram 10mg for 6 weeks.
D. 51yo male with PHQ-9 score that decreased 50% after 3 weeks on sertraline 100mg.

Use Data to Optimize Management

• Assess severity and track response
  • Response = 50% reduction in score
  • Titrate or augment until remission
  • Continue 4-6 months after remission

• Ask questions if no response
  • Are side effects or cost limiting adherence?
  • Is dosage high enough?
  • Is diagnosis correct?
  • Are there untreated co-morbid conditions?

<table>
<thead>
<tr>
<th>Classification</th>
<th>PHQ-9 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>10-14</td>
</tr>
<tr>
<td>Moderate</td>
<td>15-19</td>
</tr>
<tr>
<td>Severe</td>
<td>≥ 20</td>
</tr>
<tr>
<td>Remission</td>
<td>&lt; 5</td>
</tr>
</tbody>
</table>

* Quick Inventory of Depressive Symptomatology-Self Report (QIDS-SR-16) can track/trend severity
What To Do If No Improvement: STAR*D Trial

• If no response to SSRI:
  • Choose a different antidepressant 1 in 4 will improve
  • Add new medication to existing SSRI 1 in 3 will improve

• If no response to two medications:
  • Choose different antidepressant 1 in 7 will improve
  • Add new medication to existing SSRI 1 in 5 will improve

• Treatment-Resistant Depression
  • 2 adequate treatment trials without response, poor prognosis

No response after trial → Switch or Augment


Switching Antidepressants

• Most potential for withdrawal occurs when used for > 6 weeks
• Limited evidence on best switching strategy, so individualize treatment

Conservative
Moderate
Direct switch
Cross-taper

4 week taper → washout period → start new medication
Gradual wean with immediate switch to new medication
Swap within class from one day to next
Gradual wean then overlap new medication

Require close monitoring; cross-taper not appropriate for all meds

**Augmentation of SSRI**

- Bupropion may help suppress appetite and improve energy
- Lithium* used with success in Star*D trials
- Liothyronine 25-50 mcg*
- TCAs can be used with caution
- Second-generation (atypical) antipsychotics
  - Aripiprazole, Quetiapine XR, Olanzapine, Brexpiprazole have FDA approval
  - Olanzapine long-acting injectable approved with REMS
  - Weight gain, “inner feeling of restlessness”, require close monitoring


**Potential Ways to Manage Residual Symptoms**

- **Anxious features**
  - Buspirone
  - Gabapentin* or pregabalin*
  - Hydroxyzine
  - Mirtazapine

- **Insomnia**
  - Trazodone 50mg

- **Residual fatigue**
  - Stimulants such as Modafanil*

* Off-label use
Role of Other Medications?

- **Iron**
  - Low iron may affect neurotransmitter levels
- **Zinc and selenium**
  - Observational data shows lower levels in depressed patients
- **Folate**
  - L-methylfolate is only form able to cross blood brain barrier
- **Omega-3 fatty acids**
  - Possible role in augmentation, but more studies needed

- **No proven role** for genetic testing

---

Relapse or Recurrence?

- Risk of relapse highest **two months** after stopping
- Recurrence rates ↑ with more than one episode of MDD

---

Poll Question 4

What is the most common method of suicide in the US?
A. Hanging, strangulation and suffocation
B. Firearms
C. Solid, liquid and gas poisons
D. Jumping from high place
Suicide

• USPSTF Grade I Recommendation to screen for suicide risk
• 50% of people who die by suicide see PCP 1 month before

Suicide by Method (2017) Courtesy of CDC

Screening For Suicidal Thoughts

• Ask directly → Does not create suicidal ideation
• No single validated suicide assessment scale
  • Columbia Suicide-Severity Rating Scale
  • SAFE-T (Suicide Assessment Five-step Evaluation and Triage)
• P4 Screener For Assessing Suicide Risk
  • Past suicide attempt
  • Suicide Plan
  • Probability of completion
  • Preventive factors (social support, positive personal traits)

### Columbia Suicide-Severity Rating Scale

- Available online
- Free & customizable
- Helps triage based on level of risk
- Can embed in EMR
- Endorsed by CDC and WHO

### Level of Risk for Suicide Attempt

<table>
<thead>
<tr>
<th>Acute Risk for Suicide</th>
<th>Indicators of risk</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| High Risk              | Suicidal ideation **with** intent in last 1 **mo.** Suicide attempt in last 3 **months** | * Psychiatric admit or ER  
* Transfer with escort  
* Document risk |
| Intermediate Risk      | **Current** suicidal ideation- no intent/plan; Limited protective factors | * Develop safety plan  
* Suicide prevention strategies |
| Low Risk               | **Recent** suicidal ideation- no intent/plan; No history of previous attempt; Strong protective factors | * Outpatient referral |
Safety Plans

- No role for suicide prevention contract
- SAFE-T can help develop plan
- Treat with medications AND psychological interventions if suicidal thoughts
- **Crisis Text Line**
  - Text HOME to 741741 for free crisis support
- National Suicide Prevention Lifeline
  - 1.800.273.TALK (8255)

Access to Mental Health Care

- Facilitating referral can improve likelihood of patient engaging therapist or psychiatrist
- Develop internal list of crisis centers or mental health facilities for acute admissions
- AAFP Neighborhood Navigator
### Getting Paid

#### Billing for Screening

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Examples</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>96127</td>
<td>“Brief emotional/behavioral assessment, with scoring and documentation, per standardized instrument”</td>
<td>PHQ-9; EPDS (mom)</td>
<td>Screen or follow-up</td>
</tr>
<tr>
<td>G0444</td>
<td>“Brief emotional/behavioral assessment, with scoring and documentation, per standardized instrument”</td>
<td>PHQ-9</td>
<td>Not covered at IPPE or IAWV</td>
</tr>
<tr>
<td>96161</td>
<td>“Administration of caregiver-focused health risk assessment instrument for the benefit of the patient…”</td>
<td>EPDS (baby)</td>
<td>Mother does not have to be a patient</td>
</tr>
</tbody>
</table>

Use ICD-10, Z13.89 Encounter for screening for other disorder
Verify payers’ plans- Most have frequency limits, some require 96160
**HCC Coding For Depression**

- F32.9 Major depressive disorder, single episode, unspecified
  - No risk adjustment
- Risk adjust by using ICD-10 codes with **HCC Weight**
  - F32.0-F32.5 Major depressive disorder, single episode
  - F33.x Major depressive disorder, recurrent

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-10 Code</th>
<th>HCC</th>
<th>HCC Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>F32.9</td>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>Major depressive disorder, recurrent, mod.</td>
<td>F33.1</td>
<td>58</td>
<td>0.395</td>
</tr>
</tbody>
</table>

**Collaborative Care Model: “IMPACT Care” Trial**

- 2002 JAMA study - greater patient **and** physician satisfaction
  - Doubles effectiveness of usual care
  - Patients report less pain and better physical functioning
  - More cost-effective (ROI $6.50:1)

- 80 Subsequent RCTs show consistent effect in primary care
  - Emerging data for anxiety, PTSD, ADHD, alcohol use disorder

- **Psychiatric Collaborative Care Codes** created in 2017
  - PCP, Behavioral Care Manager and Psychiatric Consultant collaborate

Archer, J. et al., 2012
Collaborative Care Model

• Behavioral care manager
  • Develops care plan, coordinates with psychiatric consultant, communicates with PCP, maintains registry and documents time
  • Trained in behavioral health (social work, nursing, psychology, etc.)

• Psychiatric consultant
  • Recommends psychiatric care and diagnosis at least weekly
  • Does not typically see the patient nor prescribe the medications

• PCP
  • implements care plan, bills patient

Summary of diagnosis, functional status, treatment modalities and plan, progress are excluded from HIPAA definition of psychotherapy notes

Psychiatric Collaborative Care Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Time (Minutes)</th>
<th>Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99492</td>
<td>Initial 70 minutes</td>
<td>36-85</td>
<td>$161.24</td>
</tr>
<tr>
<td>99493</td>
<td>Subs. calendar month, 60 minutes</td>
<td>31-75</td>
<td>$128.84</td>
</tr>
<tr>
<td>99494</td>
<td>Addtl. 30 minutes initial or subs.</td>
<td>&gt;15</td>
<td>$66.58</td>
</tr>
</tbody>
</table>

Initial month, 86-116 minutes, report both 99492 and 99494
Subsequent month, 76-105 minutes, report both 99493 and 99494

*2018 Medicare payment allowances

• 86 minutes in initial month = $161.24 + $66.58 = $227.82
• Billed monthly under MEDICAL benefits
• PCP pays care manager and psychiatrist on a contract basis
Practice Recommendations

Implement universal screening for depression with a PHQ2 for all age groups. (SORT C)

Initiate therapy with an SSRI or SNRI and continue for at least 4 months after remission. (SORT C)

Integrate behavioral health into practice through a collaborative care model to improve patient outcomes and physician satisfaction. (SORT B)

Contact Information

Lindsay Botsford, MD, MBA, CMQ, FAAFP
lkbotsford@gmail.com
@lindsaybotsford

www.iorahealth.com
Questions

Resources/Supplemental Material

- AIMS Center University of Washington
  - Table of Commonly Prescribed Psychotropic Medications
- VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder
- APA Practice Guideline for the Treatment of Patients with Major Depressive Disorder
- APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors
- SAMHSA Suicide Resource Prevention Center
### References

- Cipriani, Andrea; et al. Comparative efficacy and acceptability of 21 antidepressant drugs for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. The Lancet. V 391, Issue 10128, P1357-1366, APRIL 07, 2018

### Collaborative Care Model Resources

- CMS Fact Sheet
  - [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-Fact-Sheet.pdf)


- [https://aims.uw.edu/collaborative-care](https://aims.uw.edu/collaborative-care)
Collaborative Care References


• Katon W et al., Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Archives of General Psychiatry* 2012; 69(5):506-14.