

Managing Depression in Primary Care Using the VA/DoD Major Depressive Disorder Clinical Practice Guideline

Slide 1 Title

Hello. I'm Colonel Charles Engel, the Director of the Deployment Health Clinical Center and an associate professor of psychiatry at the Uniformed Services University of the Health Sciences. Today I'm going to be talking with you about Major Depressive Disorder and the VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder in Adults.

Slide 2 Presentation Objectives

The objectives for this presentation are to:

- Review the patient assessment process described in the VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder
- Describe the tools that have been developed to support you as you manage major depressive disorder according to the MDD-CPG

Slide 3 Major Depressive Disorder (MDD)

Major Depressive Disorder is one of the affective disorders or mood disorders, which means that it is manifested primarily by a disturbance of mood rather than a disturbance of thought processes or thought content, such as schizophrenia. It is attributable to an imbalance of central nervous system networks that control pleasure, pain, motivation, reward, biological rhythms, appetite, sexuality, psychomotor function, cognition, and other bodily functions.

Major depression and its milder variant, dysthymia, affects about 13 million (5 percent) Americans at any given time and one out of 20 Americans over the course of their individual lives will develop depressive disorders severe enough to be diagnosed as Major Depressive Disorder.

Depression is twice as common in women as it is in men; it is estimated that 20 percent of women and 10 percent of men will have an episode of major depression at some point in their lives.

Depressive disorders exist along a continuum based on severity and number of symptoms and the duration of those symptoms. Depressive disorders tend to be recurring with up to 75 percent recurrence within the first three to four years after the first episode without treatment.

Follow up studies show that one year after a major depressive episode, 40 percent of patients have no identifiable mood disorder while 40 percent of patients still meet criteria

for Major Depressive Disorder. About five to ten percent of individuals with a first episode of major depression go on to have mania, a manifestation of bipolar disorder.

The presence of suicidal ideation is particularly important as up to 15 percent of people with Major Depressive Disorder die by suicide. Over 90 percent of suicides are in people who are believed to have mental disorders.

Slide 4 Diagnostic Criteria for MDD

The diagnostic criteria for Major Depressive Disorder include; depressed mood, diminished interest or pleasure in activities, significant weight loss or weight gain when not dieting, insomnia or hypersomnia, psychomotor retardation or agitation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicidal ideation. To make a diagnosis of MDD, at least five of these symptoms must be present for two weeks nearly every day with at least one of the first two symptoms, the depressed mood or loss of interest in usual activities, prominent.

Slide 5 Co-Occurring Disorders

Depression can also occur in association with other disorders. The association of substance abuse disorders with Major Depressive Disorder is a sign of danger because of the facilitating effect of drugs such as alcohol on suicidal behavior. Other chronic debilitating medical conditions associated with Major Depressive Disorder include; cancer and chronic obstructive pulmonary disease. Some medications such as steroids can precipitate a major depressive syndrome. Some medical disorders such as hypothyroidism can create major depression as well.

The impact of Major Depressive Disorder on a person can be devastating. In addition to the risk of suicide as noted before, costs of medical care can be up to 50 percent higher in people with untreated Major Depressive Disorder. In addition to the burden on family and quality of life, untreated depression is associated with adverse medical outcomes, higher mortality rates apart from suicide, and chronic decrements in functioning and well being.

Slide 6 Treatment

The good news is that Major Depressive Disorder is highly responsive to treatment with response rates of up to 85 percent with biological treatments such as medications or ECT, electroconvulsive therapy, as well as with psychological treatments such as cognitive behavioral therapy. The choice of treatments depends on the capabilities of available providers, patient history and their preferences, and the severity and nature of their symptoms. Effective treatment can reduce and/or eliminate symptoms of depression, improve health-related quality of life, and, in some research, even improve work-related performance and productivity of patients with Major Depressive Disorder.

Slide 7 MDD and Primary Care

It has been estimated that about 10 to 15 percent of all primary care patients have Major Depressive Disorder, making it perhaps the most common disorder that primary care providers see in their day to day practices. In fact, over half of depression-related healthcare in the US occurs in the offices of family practitioners, general internists, and other general medical providers, while only about a fifth of depression-related healthcare occurs in specialty mental healthcare settings. Unfortunately, many studies have found that primary care providers fail to diagnose and adequately treat depression for up to one half of their adult patients. Problems with diagnosing depression in primary care settings may result because the patient's symptoms may not be clearly identifiable or because the patient has multiple medical and mental health problems that require identification and management.

Slide 8 MDD – An Important Public Health Problem

To summarize, Major Depressive Disorder is a serious public health problem. It is common, significantly disabling, potentially life threatening, and reduces functioning and quality of life. It is associated with behavioral health risks such as substance abuse, is detectable and eminently treatable, but is under-diagnosed and under-treated.

Slide 9 Clinical Practice Guidelines

Implementation of evidence-based clinical practice guidelines is one strategy the Veterans Health Administration and the Department of Defense have adopted to improve healthcare by reducing variation in practice and systematizing “best practices”. The Institute of Medicine has defined clinical practice guidelines as “systematically developed statements to assist practitioner and patient decisions about appropriate health care services for specific clinical circumstances.” Practice guidelines contain evidence-based statements based on medical research findings which are designed to:

- Reduce variation in practice and improve outcomes
- Ensure continuity of care across the healthcare system, and
- Improve provider and customer satisfaction.

Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research. Research has shown that guideline-driven improvements in the quality of care for patients with depression can result in improved symptoms and symptom-related quality of life.

Slide 10 Clinical Practice Guideline for Major Depressive Disorder

The VA/DoD Major Depressive Disorder Clinical Practice Guideline was developed to standardize and improve the management of depression by increasing awareness and improving diagnosis and treatment. The initial version of the Guideline was developed by the Department of Veterans Affairs and was released in January 1997. The Guideline drew heavily from the clinical practice guidelines on depression of the American

Psychiatric Association and the Agency for Healthcare Research and Quality. Version 2.0 was a collaborative effort between the VA and the Department of Defense. It was developed by a multidisciplinary expert panel from the VA and DoD healthcare systems, civilian practitioners, and policy makers. The current Major Depressive Disorder Clinical Practice Guideline, Version 2.1, was released in May 2000. The Guideline is evidence-based whenever possible, and in the places where evidence is weak or nonexistent, the vast clinical experience of the panel members was used to guide development of consensus recommendations.

To assist providers in implementing the Guideline, a Tool Kit was developed and distributed in July 2002. A 2 hour satellite broadcast discussing the Guideline, the Guideline Metrics and the Tool Kit was presented on 4 September 2002.

Review and update of the Guideline by a multidisciplinary panel was begun in December 2006.

Slide 11 Depression Guideline Structure

Now I am going to provide a brief overview of the Guideline. Let me start out by saying that the Guideline consists of three major modules. The module that we will be focusing on here is the module for primary care. There are two additional modules one on outpatient mental health care and another on inpatient mental health care.

Slide 12 Main Guideline Points

Now the treatment of major depressive disorder in primary care is definitely not something that lends itself to a cookbook approach. At the same time there are certain basic principles, and on this slide I've attempted to show what some of those principles are. The steps in the Guideline are:

- Screening for depression;
- An assessment of acute emergencies;
- A thorough baseline assessment from which to develop a database to make a diagnosis and design subsequent treatment;
- A look for physical causes of depression that may perpetuate or increase depressive symptoms;
- A psychiatric differential diagnosis and, as appropriate, the diagnosis of major depressive disorder;
- Followed by a review of potential therapies with the patient and selection of a therapy;
- Determination of whether care will be best provided in a primary care or mental health care setting, and finally,
- Initiation of care and monitoring the effectiveness of therapy through scheduled follow-up every 1 to 2 weeks with a reassessment at 4 to 6 weeks and again at 12 weeks.

So moving on to the Guideline, there are four pages of algorithms that describe the primary care aspect of the Guideline, and I will try and highlight in those eight areas that

I just listed, how to manage major depressive disorder in primary care. So let's start at the beginning.

Slide 13 Screening

First off, there is screening, and the Guideline recommends that you initiate the Guideline when depression is suspected. The key things to look for when assessing for depression are: depressed mood; loss of pleasure in usually pleasurable activities, and thirdly, in primary care, medically unexplained symptoms that are a common first presentation, if not the most common first presentation of depression.

Slide 14 Screening for Depression in Primary Care

When screening for depression, the Guideline recommends that every primary care patient be screened at least once annually for depression using a validated screening tool. There are several available screening tools to determine if the patient has depression. Each has its own strengths and weaknesses; however using the two-item screen may be as effective as longer instruments. The two-item screen involves asking two questions. The first question is: within the last two weeks have you had feelings of being down or depressed and the second question is: have you in the past two weeks experienced little pleasure or interest in doing things. A 'yes' response to either of the two question indicates a positive screen. The Guideline recommends that the screening tool should be filled out before the patient sees the provider.

Slide 15 Identify Emergencies

Once you suspect that the patient is suffering from depression, the next step is to assess for emergent problems. The sorts of emergent problems that are key to focus on are:

- Acute or severe psychosis,
- Delirium,
- Acute danger to self or others as evidenced by acute suicidality or acute violent ideation,
- Catatonia, which is sort of a state of complete incapacity related to depression or other mental disorder, and finally,
- An unstable medical condition.

If any of these problems are present, then appropriate action should be taken with a referral to either an outpatient mental health acute care setting or an emergency room setting depending on the circumstances.

Slide 16 Baseline Assessment

Next we move on to the baseline assessment part of the algorithm. The main priorities here are to look for certain red flag types of problems. The second is to obtain a medical and psycho-social history and complete an examination. And the third is to assess depression symptoms.

Slide 17 Assess for Red Flags

The initial effort should be focused on comprehensive psycho-social aspects of care as well as complicating medical problems. In terms of red flags, the Guideline recommends that you look for medically unexplained symptoms, as I mentioned before, as a source of suspicion for depression, chronic illness, substance use, family history of depression, a history of significant loss or trauma, including abuse or neglect, that the patient may have experienced either in childhood or as an adult. For military populations, it is important to look for wartime trauma or other military-related trauma. The evidence of other psychiatric problems may also be associated with signs of depression.

Slide 18 Baseline Assessment (continued)

On the mental status exam, it's particularly important to focus on looking for psychotic signs, which I'll discuss more later, as well as to look for and to question the patient about suicidal ideas. It's important to assess the complete range of medications that the patient is on: prescription medications, over the counter medications as well as herbal medications such as St. John's Wart that the patient may be taking to self medicate their depression.

Slide 19 Assess for Depressive Episode SIG E CAPS

And then finally, an assessment of depressive symptoms is crucial, and we recommend the use of a mnemonic, which is outlined along with some of the previously mentioned red flags and tools that support the Guideline. The mnemonic is SIG E CAPS, which stands for sleep, interests, guilt, energy, concentration, appetite, psychomotor changes, and suicidal ideas. SIG E CAPS – prescribe energy capsules. To make a diagnosis of major depressive disorder, five or more of these symptoms must be present nearly every day for at least two weeks, and one or two of the symptoms must be a decrease in interest and/or depressed mood. The mnemonic is pretty well known to most primary care practitioners in this day, and it helps you be thorough in your symptom assessment. If, after completing that symptom assessment, you feel that the symptoms of depression are present, then move on to the next step in the algorithm.

Slide 20 Secondary Level Assessment for Urgent Problems

The next step is to move to a secondary level of assessment for urgent problems. These are problems that may not have been identified during the emergency screen but still persist as urgent problems and detailed assessment is needed.

First the patient should be assessed for risk to self or others. The Guideline and the tools that support it describe a specific line of questioning that can be used in primary care to pursue the level of suicidal ideation that a patient may be experiencing at the time of presentation. If you deem that there is significant risk to self or others, then we recommend at least, consultation with an outpatient mental health provider.

Slide 21 Assess for Psychosis

The next assessment is to look at psychosis to decide whether the patient is suffering from delusions or hallucinations. Delusions are fixed false beliefs, and hallucinations are sensory experiences that the patient is having that are not real. In psychiatric illness such as depression, the most common is auditory hallucinations, sometimes visual hallucinations. For either visual hallucinations or olfactory hallucinations, hallucinations that involve smell, one should think first of an underlying medical problem causing those symptoms. If you deem that psychosis is present, the Guideline recommends an appropriate referral to the outpatient mental health setting.

Slide 22 Look for Physical Causes DSM

The next step in the management of depression in primary care is to explicitly think about the physical causes for depressive symptoms. To help you be comprehensive in your coverage of this area, an easy mnemonic to use is DSM which stands for diseases, substances and medications.

In the area of diseases, certain chronic diseases or systemic diseases, neurologic diseases and other diseases can cause changes in mental state that manifest as depression. Substance use disorders should be assessed, particularly alcohol abuse and dependence. The CAGE criteria are commonly known and commonly used in primary care and a good device for looking at alcohol abuse and dependence.

Finally there are medications such as steroids or opioid analgesics, benzodiazepines used as a sedative, hypnotics or anxiolytics, which can also exacerbate depression, and the patient should be assessed for those.

Slide 23 Manage Physical Causes First

If any of these physical causes of depression are identified, the Guideline stipulates that those physical causes should be managed first, that one should maximize the management of those physical causes. In the event that while maximizing the management of presumed physical causes of depression, the patient improves, then obviously you would want to continue on the course with what you have started.

Slide 24 Psychiatric Differential Diagnosis

If the patient does not improve, then we move to the next step of the Major Depressive Disorder Clinical Practice Guideline. And that step includes a review of the psychiatric differential diagnosis.

First one looks to make the diagnosis of a major depressive episode. This is just short of making a diagnosis of major depressive disorder. A major depressive episode requires that five of the nine cardinal symptoms of depression be present.

If someone has a major depressive episode, they should be assessed for evidence of bipolar disorder or a history of mania or hypomania as well as a history of a psychotic episode.

And then finally if mania is not present and the diagnosis of major depressive disorder is made, the provider should assess the patient for key co-morbid psychiatric disorders such as post traumatic stress disorder, other anxiety disorders and personality disorders and if those disorders are present, it may complicate the therapy for major depression. It doesn't necessarily mean that the patient cannot be appropriately treated within primary care, but it may affect your threshold as to how soon you might want to consider consultation with a specialist.

Slide 25 Review Therapy Options

The next step in the Guideline, having made the diagnosis of major depressive disorder, is to review the therapy options and initiate therapy. The key elements of reviewing therapy options with the patient are to provide education and information with regard to major depression and the treatment options. Second is to assume a collaborative posture where the two of you are exchanging information in a constructive way and the patient is encouraged to make choices based on his or her own sense as to what the right thing is to do, and to negotiate between the choices of what is best.

The options generally include some form of talk therapy, such as cognitive behavioral therapy or interpersonal psychotherapy, or pharmacologic therapies.

Slide 26 Determine Site of Care – Primary Care or Mental Health

If a form of psychotherapy is to be completed, the Guideline recommends referral to an outpatient mental health setting. Patients will often have preferences as to whether they want to go directly to psychotherapy or to try medication first.

Medication management is clearly the most common form of therapy for major depressive disorder treated in primary care. Many patients will prefer medications before psychotherapy, and it is clearly the most feasible strategy in the primary care setting.

Slide 27 Mental Health Specialty Involvement Levels

The figure on this slide helps to put into perspective when mental health specialty care should be sought in providing care for depression. If we think of the patient population, about a third of those patients, those in the bottom circle, have symptoms of depression at any given time. Not all of those people have major depression, however. Only about ten percent or so go up to the next layer as a result of screening and assessment in the primary care setting. Once they have been assessed, the primary care provider must determine how they should be managed and once they have been managed, they must be monitored to determine whether they get complications or get better. As each layer goes up, there should be more mental health specialty involvement and finally at the top layer

there are patients that probably should always be managed in specialty mental health care because their management is so difficult that it's really not feasible to manage them in primary care, even with mental health specialty back up.

Slide 28 Initiate Therapy

Once the decision has been made that medication is the management of choice, the primary care provider initiates therapy.

Slide 29 General Principles of MDD Pharmacotherapy

There are many effective agents available for treating depression. Although no one antidepressant medication is clearly more effective than another or results in remission for all patients, there are patient factors and drug side effect profiles that may favor one class of antidepressants over another for a given patient. The clinician should determine which medications have been most helpful in the past and what dosages. Generally, medications with favorable side effect profiles should be used, however, previously effective medications, regardless of class, should be considered as a first choice if medications with favorable side effect profiles have not been effective in the past.

The choice of medication should be based on: side effect profile, history of previous response, family history of response, type of depression, co-morbid medical conditions, concurrently prescribed medications, and cost.

Slide 30 General Principles of MDD Pharmacotherapy (continued)

Selective Serotonin Reuptake Inhibitors or venlafaxine, a Selective Serotonin and Norepinephrine Reuptake Inhibitor, are generally considered first line antidepressants for most patients in the primary care setting. This is because of their ease of administration and low toxicity in overdose relative to other antidepressants. The Guideline contains specific information which should be helpful in selecting the appropriate medication. My comments from this point regarding management of major depression in primary care will relate mainly to pharmacotherapy for major depressive disorder, however the same general strategy applies for the patient receiving psychotherapy in an outpatient mental healthcare setting whom you may be following in parallel in primary care.

Slide 31 Follow-Up Every 1-2 Weeks

The first step to keep in mind in following up is early intensive follow up. The Guideline recommends that the patient be seen every one to two weeks and assessed for side effects to that medication as well as their adherence to the overall treatment strategy.

Slide 32 Reassess and Adjust at 4-6 Weeks

At four to six weeks, a more comprehensive assessment of symptom response should be made. At this time you should be able to gauge, in general, how well the patient is

responding to therapy. If the patient is worse at four to six weeks, we would recommend, in accordance with the Guideline, that consultation with outpatient mental health be considered. If the patient has fully responded in four to six weeks, which will probably be the unusual situation, then clearly the therapy should continue as it has previously gone.

The more difficult situation is when patients have an incomplete response or no response. In the case of an incomplete response, providers will sometimes want to continue on with the idea that a complete response will be achieved over a longer period of time or they may opt to, in collaboration with the patient, alter the course of therapy, adjusted in some fashion. Clearly if the patient is not responding in four to six weeks, we would recommend that the general strategy be re-looked and adjusted.

Slide 33 Reassess and Adjust at 12 Weeks

Assuming that you have made the appropriate adjustments, the patient is then followed for the subsequent 6 weeks and is followed up again for an intensive reassessment at 12 weeks. At 12 weeks again, the symptoms of depression are thoroughly assessed and a distinction is made as to whether the patient has achieved a remission of symptoms or whether they have only achieved a partial or non response.

Again, if a remission of symptoms has been achieved, the Guideline recommends that you continue as you have been doing to move to the continuation phase of treatment.

If an incomplete resolution of symptoms has occurred at 12 weeks, the Guideline recommends that consultation be pursued with an outpatient mental health provider.

Slide 34 Performance Measures/Metrics

As part of the Major Depressive Disorder Clinical Practice Guideline process, measurements or metrics were identified for four points along the care process continuum – detection, assessment, treatment and outcomes. It's important to mention that the metrics were developed by the Guideline committee members using a Delphi process.

The four measurements are as follows:

To determine if patients were being screened for depression, the measure is; the percent of patients seen in general medicine, primary care, women's clinics or mental health primary care, who were screened for depression in the previous 12 months;

To evaluate for the prevalence of depression in the primary care population, the measure is the percent of patients diagnosed with a depressive disorder within the previous 12 months;

Slide 35 Performance Measures/Metrics (continued)

To measure treatment adherence, the measure is the percent of patients newly diagnosed with and treated for MDD during the past 12 months who continue on prescribed medication for at least 90 days during the next 120 day period or had at least 8 psychotherapy sessions in the next 180 days: finally,

To measure if clinicians are assessing the outcome of depression treatments, the measure is percent of patients who were seen during the past 12 months with a diagnosis of major depression who have had a systematic symptom assessment at 12 weeks following diagnosis or if in remission by week 12, a systematic symptom assessment at the time of the documented remission.

Slide 36 Metrics Web Sites

Guidance for the VA's implementation of depression metrics can be found in the MDD Measures Technical Manual on the VA Office of Quality and Performance Web site. These metrics are assessed as part of VA's external peer review program.

The approach in the Department of Defense is essentially the same as that pursued within the VA. Implementation of studies is done via the Department of Defense's National Quality Management Program (NQMP). The National Quality Management Program is analogous to the VA's external peer review program but focuses more on the use of electronic data collection for monitoring metrics.

Slide 37 VA/DoD MDD-CPG Tool Kit - Provider Tools

As the final part of this presentation, I am briefly going to describe the Tool Kit that has been produced by the Department of Veterans Affairs and the Department of Defense to supplement the Major Depressive Disorder Clinical Practice Guideline. As you can see on this slide, the Tool Kit contains a number of items that can be helpful for the busy clinician.

The Provider Reminder Cards offer a handy, readily available summary of the most important aspects of the MDD Guideline. The Key Points Card lists the main points in the Guideline. The Pocket Guide also contains the key points and in addition provides a list of medical conditions related to depression and a list of medications that can cause depression. The other side of this card contains a table of antidepressant medications, including, doses, efficacy, safety margin, and side effects which affect the patient's ability to tolerate a given medication. The Guideline Summary provides a distillation of the comprehensive MDD Guideline. The complete algorithm includes box numbers that link to the comprehensive Guideline providing a rapid reference source that allows the clinician to maximize time with the patient while minimizing time spent looking up Guideline details.

Also contained in the Tool Kit are Provider Reference Cards. They are designed to be placed on metal rings and then hung in each primary care clinic exam room to be readily available for primary care provider reference. Those cards contain: the algorithm for the primary care of patients with depression and a list of the key points of the Guideline. There are also medication tables to assist in the treatment of the patient. There is assessment information to assist providers in determining if a patient might be a threat to self or others and the DSM-IV criteria to assist in the diagnosis of patients with depression. The Guideline metrics are also included.

Slide 38 Depression Care Forms - Provider Tools

In support of the Guideline, the US Army Medical Command developed two forms to assist providers in documenting their management of patients diagnosed with depression. MEDCOM Form 717-R, entitled Depression Outpatient Documentation, is used to document assessment and treatment. The form has three sections: Section I, vital signs/visit information, is completed by ancillary support staff; Section II, depression self-assessment, is completed by the patient; and Section III, medical assessment/diagnosis/treatment plan/education, is completed by the provider. MEDCOM Form 723-R, Behavioral Health Referral/Response Documentation, is used to document a Primary Care Clinic patient referral to Behavioral Health and Behavioral Health's findings. The front of the form is used by primary care managers to initiate a patient referral to a military or civilian behavioral health clinic. The back of the form may be used by any military or civilian behavioral healthcare specialist to document examinations, findings, and other recommendations

Slide 39 VA/DoD MDD-CPG Tool Kit - Patient Education Materials

Patient tools in the Tool Kit include: a depression brochure, which is based on the Agency for Healthcare Research and Quality's Depression brochure. It can be used to educate the patient and family members about depression and is available in English and Spanish. To assist in "de-stigmatizing" Major Depressive Disorder for both patients and healthcare team members, posters have been developed which emphasize that depression is just one of many chronic diseases. Also included in the Tool Kit are a depression video from the Milner-Fenwick Company and a CD-ROM produced by the Veterans Health Administration to help patients learn more about their illness.

In addition, there is a patient self management action plan. The Robert Wood Johnson Foundation and the Institute for Clinical Systems Improvement have found that self management is one of the key points in disease management programs, and this self management action plan was developed to provide patients with depression, the needed assistance in managing their own illness.

Slide 40 VA and MEDCOM Web Sites – CPG Pages

The VA's Office of Quality and Performance provides a Web site that lists all of the approved VA Clinical Practice Guidelines. For each CPG, all the development materials

are supplied. The US Army MEDCOM Quality Management Office's Web site provides many of the same resources as the VA site. In addition, a link is provided to permit military medical treatment facilities to order Tool Kit items online.

Slide 41 Web Support for Post-Deployment Health Care www.PDHealth.mil

The DoD Deployment Health Clinical Center, which is the DoD Center of Excellence for Post-Deployment Health, maintains a Web site at www.PDHealth.mil. The Web site was initiated as a Web-based tool in support of the Post-Deployment Health Clinical Practice Guideline to distribute timely information to clinicians on deployment-related exposures and post-deployment health issues. It contains information and related links to all the clinical practice guidelines and clinical assessment tools, including a page devoted to the Depression Guideline. It also provides patients and their families with information to help answer their questions regarding deployment-related health concerns.

Slide 42 DoD/VA Post-Deployment Health Clinical Practice Guideline (PDH-CPG)

The DoD/VA Post-Deployment Health Clinical Practice Guideline is an evidence-based Guideline for the evaluation and management of patients with deployment-related health concerns and conditions in the primary care setting. It was initiated in January 2002. The Post-Deployment Health Clinical Practice Guideline has its own Toolbox with laminated Provider Desk Reference Cards, including a card on Major Depressive Disorder.

Slide 43 Review of Main Guideline Points

So in summary, again, the treatment of major depressive disorder in primary care is anything but a cookbook process, but there are some guiding principles and those are, as I've outlined: screening for depression; a review of emergent situations; a careful baseline assessment from which to design treatment and make a diagnosis; a look for physical causes with an eye toward maximizing the treatment of those physical causes; a review of the psychiatric differential diagnosis, and the diagnosis of a major depressive episode and disorder as appropriate; a review collaboratively with the patient of the treatment options; a determination of whether care should be provided in Primary Care or in Behavioral Health; and the initiation of therapy with follow up every one to two weeks in the early going and a more thorough reassessment occurring in between four and six weeks and 12 weeks after initiation of treatment.

Slide 44 Questions, Information, and Assistance

This concludes my discussion of the VA/DoD Clinical Practice Guideline for Major Depressive Disorder. I encourage all healthcare providers to go to the Web to familiarize yourselves with the Guideline along with the tools that support it. If you need assistance or have questions regarding this Guideline, you can call the Deployment Health Clinical Center's Clinician Helpline at 1-866-559-1627.

Slide 45 Credit

This presentation was adapted in May 2007 from the Major Depressive Disorder Guideline Satellite Broadcast on 4 September 2002. A videotape of the Major Depressive Disorder Clinical Practice Guideline Satellite Broadcast, which runs for 2 hours, is available from the Army MEDCOM QMO Web site. It can be found in the Shopping Cart under the Depression Clinical Practice Guideline ToolKit.