DISCLAIMER: The information contained in this document originates from a third party and is intended to provide guidance and, generally, allows for professional discretion and/or deviation when the individual health care provider, or if applicable, the "Approver" deems appropriate under the circumstances. Baylor Scott & White Quality Alliance recommends following the third-party guideline and to support alignment has summarized key findings from the third party as described in this Guideline Alignment.

Title:	Depression Screening and Follow-up Plan	
Applicable to:	Primary Care Providers	
Source(s):	See References	
Read Full Guideline:	See References	
Developer(s):	BSWH NTX Behavioral Health Advisory Council and BSWQA Primary Care Subcommittee	
Reviewer:	Scott & White Health Plan (08/2025) BSWQA Pharmacy Team (08/2025)	
Approver(s):	BSWQA Quality Improvement Committee (10/2025) Board of Managers (11/2025)	
Document Number:	BSWQA.CLE.022.S	
Origination Date: 01/14/2013	**Approved Date:** 11/17/2025	**Last Updated:** 10/23/25

SUMMARY

This document applies to primary care clinicians when screening patients for depression and self-harm and creating a follow up plan for patients who screen positive for depression.

This document does not apply to:

- Patients receiving treatment for moderate to severe depressive disorder within a psychiatric inpatient facility or a specialty behavioral health outpatient clinic.
- Patient or patient's legal guardian who does not consent.
- Patients with severe mental and/or physical incapacity with impaired decisional capacity where the person is unable to express himself/herself in a manner understood by others. For example, cases such as delirium, major neurocognitive disorder, or other illnesses with severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized assessment tools.
- Pediatric patients under 18 years old.

DEFINITIONS

When used in this document with initial capital letter(s), the following word(s)/phrase(s) have the meaning(s) set forth below unless a different meaning is required by context

Medical Clearance - The process required to reach the point, with reasonable clinical confidence, at which any remaining systemic medical problems can be treated on an outpatient basis. This is the point at which a qualified primary or specialty medical provider has made the determination that it is medically appropriate to discharge the patient or transfer to a psychiatric facility.

Mental Health Specialist - A specially trained clinician who evaluates the patient and recommends appropriate mental health treatment and/or disposition

Qualified Provider - Staff including Registered Nurses ("RN"), APPs, Licensed Masters Level Social Workers or Counselors, and others who have been trained in providing self- harm risk assessments

GUIDELINE

Figure 1: EBM – Evidence-Based Medicine Treatment

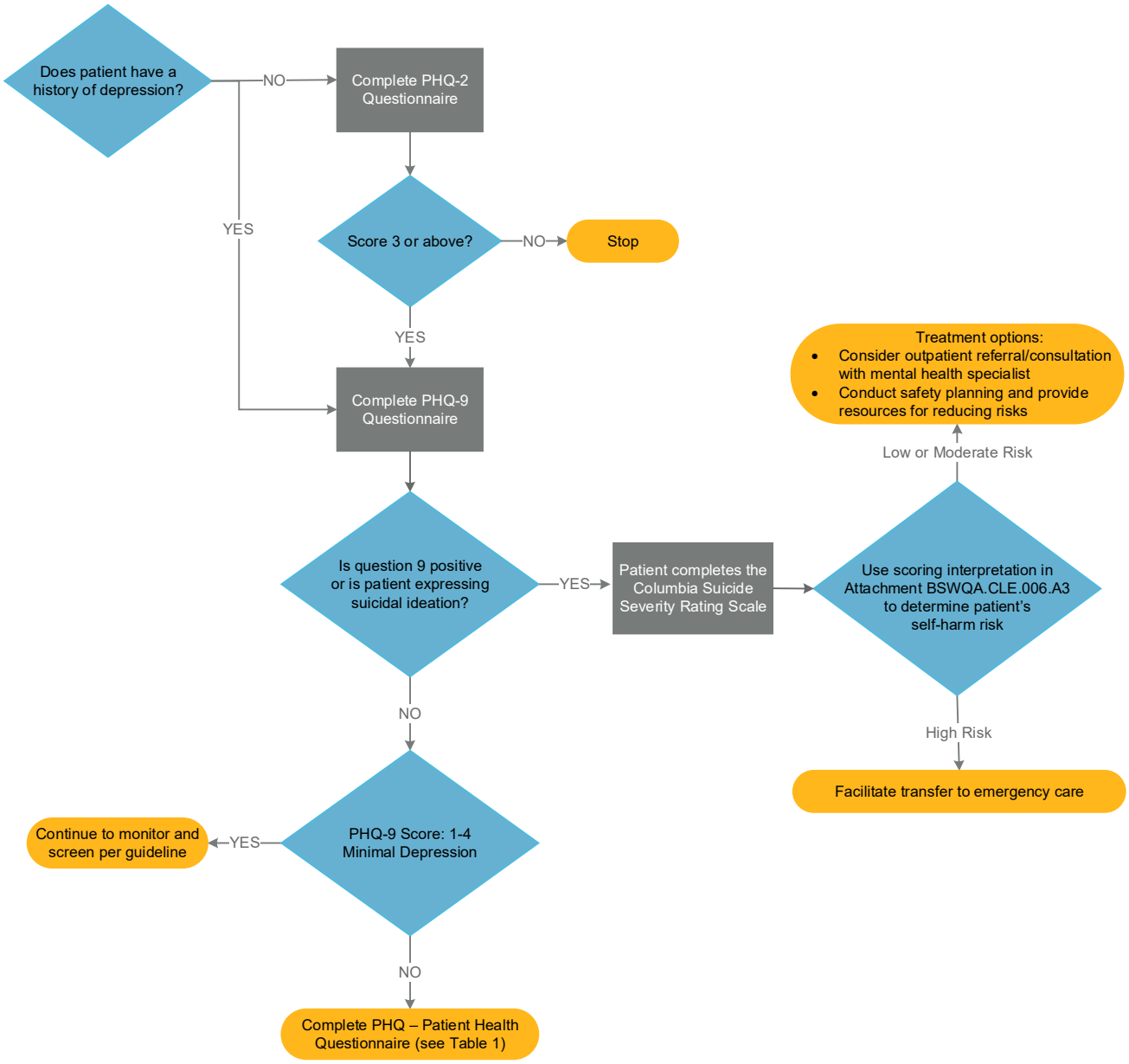

Table 1: PHQ – Patient Health Questionnaire

PHQ-9 Score	Treatment Pathway 1 Employed Providers	Treatment Pathway 2 Independent Providers
5-9 (Mild)	• Provide educational resources on depression* • Refer for CBT*, Administer PHQ9 every 2-4 weeks • Use E-Consult (to Psychiatry) for *specific* questions	• Provide educational resources on depression • Administer PHQ9 every 2-4 weeks • Refer to therapy*
10-14 (Moderate)	• Provide educational resources on depression • Refer for CBT or start antidepressant** • Administer PHQ9 every 2-4 weeks*** • Use E-Consult (to Psychiatry) for *specific* questions	• Provide educational resources on depression • Refer for CBT or start antidepressant**Administer PHQ9 every 2-4 weeks
15-19 (Moderately Severe)	• Provide educational resources on depression • Refer for CBT or start antidepressant** • Administer PHQ9 every 2-4 weeks*** • Use E-Consult (to Psychiatry) for *specific* questions; consider referral to therapy	• Provide educational resources on depression • Refer for CBT or start antidepressant** • Administer PHQ9 every 2-4 weeks***
20-27 (Severe)	• Start antidepressant (or CBT if treatment is available now); do not allow referral to delay starting treatment. • At the same time, place referral to psychiatry. When patient is stable, psychiatrist will refer back to primary care	• Start antidepressant (or CBT if treatment is available now); do not allow referral to delay starting treatment. • At the same time, place referral to psychiatry. When patient is stable, psychiatrist will refer back to primary care

***** The ACP suggests using CBT alone for patients with mild depression. This is a conditional recommendation based on low certainty evidence.,

** The ACP strongly recommends starting with either cognitive behavioral therapy (CBT) or a second-generation antidepressant such as an SSRI or SNRI for patients with moderate to severe depression. This is a strong recommendation based upon moderate certainty evidence. Utilization of both CBT *and* antidepressant should be subject to informed decision making (e.g. benefits, harms, adverse effects, cost, feasibility) and may include personalization to patient's specific symptoms, comorbidities, other medication usage, preferences, etc. Combined CBT and antidepressant use is *conditionally* recommended by the ACP based on low certainty evidence.

See Care for Patients at Risk of Self-Harm (Suicide) – Ambulatory/Clinic policy for timing and frequency and screening questions.

Depression Follow-up Recommendations

For patients who screen positive for depression, but are not at immediate risk, a follow-up plan must be documented in the medical record on the day of the screening. Follow-up recommendations can include:

- Provider clinical evaluation to make a diagnosis. HCC/billing specificity is recommended (e.g. MDD, recurrent, moderate).
- Provider documents referral to BH support service (see above chart) if Employed Physician. If patient declines, or if Independent Physician, provider documents plan for follow up appointment for repeat PHQ9 to track treatment progress. If severe depression (PHQ9 ≥ 20), provider makes referral for psychiatry, and schedules follow up visits with patients till psychiatry can establish.

NOTE: Avoid sending to multiple services as this may crowd service queues and increase wait times. The follow-up plan will vary depending on the patient's score (see algorithm on *page 2*). See attachments to learn more about the Pearls of Treatment (BSWQA.CLE. 006.A4) and for a list of resources for patients in crisis (BSWQA.CLE. 006.A5).

Pharmacologic Treatment

Second-generation antidepressants (e.g. SSRI or SNRI) *or* CBT should be started as initial treatment for patients with moderate and severe major depressive disorders (ACP strong recommendation, moderate certainty evidence). Utilization of both antidepressants *and* CBT may be used in conjunction with informed decision making as described above (conditional recommendation, low certainty).** All primary care providers (PCPs) should document antidepressant medication use on the patient's medication list and update the medication list when changes are made to antidepressant medication therapy

Acute Phase Treatment

Acute Phase Treatment is/are the intervention(s) required for the patient to achieve remission or at least response. There are various factors to be considered when choosing the right antidepressant for the patient--please consider benefits, adverse effects, harms, alternatives, patient symptoms profile, personal preference, cost, and efficacy in a context of informed/collaborative decision making. Consult practice guidelines and medication fact sheets to aid clinical decision making. The initial dose should be incrementally increased until one of the following occurs: remission is achieved, a maximum FDA approved dose is reached with validated medication compliance, or treatment-limiting significant side effects are encountered. Remission is defined as a PHQ-9 score of <5 on 2 consecutive assessments. A clinically significant improvement is a drop of > 5 points from previous PHQ-9 and a PHQ-9 score of < 10.

Table 2: PHQ-9 Response

Response	PHQ-9 at each follow-up contact	Treatment Plan
Responsive	Drop of > 5 points from previous PHQ-9 and PHQ-9 score is < 10	No treatment change needed. Follow up in 4 more weeks.
Partially Responsive	Drop of 2-4 points from previous PHQ-9 or PHQ—9 score is > 10	Consider upward titration of current antidepressant +/- adding another medication or referring for psychotherapy
Non-Responsive	Drop of 1 point or no change or increase in PHQ-9 score relative to previous PHQ-9 score	Consider the following: Antidepressant if receiving psychotherapy alone Adjust dose of the medication A different class of antidepressant Augmentation strategy Adding psychotherapy Psychiatric consultation

Below are some treatment recommendations:

Although some patients will see improvements in the first 2 weeks, the full benefits are not achieved at a dose until the patient has been taking it for > 4 to 8 weeks.

- **Consider initial reassessment at 2 weeks after initiating therapy**

  If PHQ-9 score hasn't improved by at least 20% at 2 weeks, consider earlier treatment adjustment. Refer to the table below.

- For the elderly population
  - Start antidepressants at lower doses, titrate slowly
  - Monitor closely for side effects (e.g., falls, sodium levels)
  - Avoid paroxetine due to anticholinergic effects
  - Avoid TCAs and citalopram due to cardiac adverse effects

Table 3: Pharmacologic Titration Strategies

Stage 1	SSRIs, SNRIs (first-line antidepressants based on efficacy and tolerability)	Response → Continuation Inadequate Response → Go to Stage 2
Stage 2	• Increase dose of antidepressant and/or • Augment with one of the following: SSRI, SNRI, bupropion, mirtazapine, buspirone, or T3 (choosing a different mechanism of action than the stage 1 drug)	Response → Continuation Inadequate Response → Go to Stage 3
Stage 3	If at maximum tolerated dose of current antidepressant, then switch to antidepressant monotherapy from a different drug class	Response → Continuation Inadequate Response → Go to Stage 2 with new antidepressant *If patient has already trialed maximum tolerated doses of 2 different classes of antidepressants with augmentation, may consider psychiatric consultation.

Continuation Phase of Treatment

The Continuation Phase consists of at least 9 to 12 months of continuous treatment on the same antidepressant regimen and dosage(s) after achievement of remission. The provider should monitor the patient's symptoms and assess response using standardized assessments, such as the PHQ-9.

Figure 2: Continuation Phase of Treatment

Acute phase (12 weeks of continuous treatment)

↓

Continuation Phase (12 months of continuous treatment)

Begins after symptom resolution
Continue medication at full strength
Contact every 2-6 months (phone contact appropriate in some cases)
Generally uses the same anti-depressant(s) as in the acute phase

↓

Maintenance Phase for recurrent depression

For the patient with 2 episodes of major depression, treat for 2 years
For the patient with 3+ episodes of major depression or chronic depression, should be on anti-depressants for 3-5 years or indefinitely
Consider for patients with additional risk factors (e.g. stressors, co-morbidities, family history)
Use PHQ-9 to monitor every 2-6 months
Goal is to prevent relapse

↓

Tapering antidepressant medication (if clinically indicated)

Taper over several weeks
Educate about side effects and relapse
Flu-like symptoms are common
With SSRI or SRNI may have anxiety/agitation, sweating, or paresthesia's

Recommendation on PGx Testing

There is insufficient evidence to recommend for or against pharmacogenetic (PGx) testing to guide the choice or dosing of antidepressants. (For further information, see Appendix 9 (BSWQA.CLE.006.A9).

FACTS AND FIGURES

1. Figure 1: EBM – Evidence-Based Medicine Treatment
2. Figure 2: Continuation Phase of Treatment
3. Table 1: PHQ – Patient Health Questionnaire
4. Table 2: PHQ-9 Response
5. Table 3: Pharmacologic Titration Strategies

ATTACHMENTS

1. PHQ-2 Questions and Scoring Interpretation (BSWQA.CLE. 006.A1)
2. PHQ-9 Questions and Scoring Interpretation (BSWQA.CLE. 006.A2)
3. CSSRS Questions and Scoring Interpretation (BSWQA.CLE. 006.A3)
4. Pearls of Treatment (BSWQA.CLE. 006.A4)
5. Crisis Resources (BSWQA.CLE. 006.A5)
6. Pharmacological Therapy (BSWQA.CLE. 006.A6)
7. Antidepressant Discontinuation Syndrome Patient Handout (BSWQA.CLE. 006.A7)
8. ACP Initial Treatments of Adults in the Acute Phase of Major Depressive Disorder (BSWQA.CLE. 006.A8)
9. Discussion on PGx Testing (BSWQA.CLE. 006.A9)

REFERENCES

1. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder (3rd Edition). October 2010. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. (Accessed June 5, 2020).
2. Amir Qaseem, Douglas K. Owens, Itziar Etxeandia-Ikobaltzeta, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med.2023;176:239-252. [Epub 24 January 2023]. doi:10.7326/M22-2056
3. Bousman CA, Stevenson JM, Ramsey LB, Sangkuhl K, Hicks JK, Strawn JR, Singh AB, Ruaño G, Mueller DJ, Tsermpini EE, Brown JT, Bell GC, Leeder JS, Gaedigk A, Scott SA, Klein TE, Caudle KE, Bishop JR. Clinical Pharmacogenetics Implementation Consortium (CPIC) Guideline for CYP2D6, CYP2C19, CYP2B6, SLC6A4, and HTR2A Genotypes and Serotonin Reuptake Inhibitor Antidepressants. Clin Pharmacol Ther. 2023 Jul;114(1):51-68. doi: 10.1002/cpt.2903. Epub 2023 May 30. PMID: 37032427; PMCID: PMC10564324.
4. Bousman et al. Antidepressant prescribing in the precision medicine era: a prescriber's primer on pharmacogenetic tools. BMC Psychiatry (2017) 17:60
5. Caudle KE, Gammal RS, Whirl-Carrillo M, et al. Evidence and resources to implement pharmacogenetic knowledge for precision medicine Am J Health-Syst Pharm. 2016; 73:1977-85
6. Caudle KE, Klein TE, Hoffman JM, et al. Incorporation of Pharmacogenomics into Routine Clinical Practice: The Clinical Pharmacogenetics Implementation Consortium (CPIC) Guideline Development Process Curr Drug Metab. 2014 Feb; 15(2): 209–217.
7. Columbia Suicide Severity Screening Rating Scale. (2017). The Columbia Lighthouse Project. [online]. Available at http://cssrs.columbia.edu/ [Accessed 11 Aug. 2017].
8. Department of Veterans Affairs & Department of Defense. (2022). VA/DoD clinical practice guideline for the management of major depressive disorder (Version 4.0). https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf
9. Dubovsky SL. The limitations of genetic testing in psychiatry. Psychother Psychosom 2016 Apr; 85:129.
10. Guideline Development Panel for the Treatment of Depressive Disorders. (2022). Clinical practice guideline for the treatment of depressive disorders. American Psychological Association. https://www.apa.org/depression-guideline/guideline.pdf
11. Hicks, J. K., Sangkuhl, K., Swen, J. J., Ellingrod, V. L., Müller, D. J., Shimoda, K., ... & Caudle, K. E. (2016). Clinical Pharmacogenetics Implementation Consortium (CPIC) guideline for CYP2D6 and CYP2C19 genotypes and dosing of tricyclic antidepressants: 2016 update. Clinical Pharmacology & Therapeutics, 102(1), 37–44. https://doi.org/10.1002/cpt.597
12. Hicks JK, Swen JJ, Thorn CF et al. Clinical Pharmacogenetics Implementation Consortium guideline for CYP2D6 and CYP2C19 genotypes and dosing of tricyclic antidepressants. Clin Pharmacol Ther. 2013; 93:402-8.
13. Hicks JK, Bishop JR, Sangkuhl K et al. Clinical Pharmacogenetics Implementation Consortium (CPIC) guideline for CYP2D6 and CYP2C19 genotypes and dosing of selective serotonin reuptake inhibitors. Clin Pharmacol Ther. 2015; 98:127-34.
14. Hodgson K et al. Genetic differences in cytochrome P450 enzymes and antidepressant treatment response. J Psychopharmacol 2014 Feb; 28:133.
15. Rosenblat JD et al. Does pharmacogenomic testing improve clinical outcomes for major depressive disorder? A systematic review of clinical trials and cost-effectiveness studies. J Clin Psychiatry 2017 Jun; 78:720.
16. The Joint Commission. (2013). [BoosterPakTM on Suicide Risk NPSG 15.01.01] Oakbrook Terrace, IL: The Joint Commission. Available at: http://www.jointcommission.org [Accessed 11 Aug. 2017].
17. Lam RW, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 Update on Clinical Guidelines for Management of Major Depressive Disorder in Adults: Can J Psychiatry. 2024 Sep;69(9):641-687. doi: 10.1177/07067437241245384. Epub 2024 May 6. Erratum in: Can J Psychiatry. 2025 Jun 9:7067437251349087. doi: 10.1177/07067437251349087. PMID: 38711351; PMCID: PMC11351064.
18. Lam, R. W., Milev, R. V., McIntosh, D., Parikh, S. V., Kennedy, S. H., Ravindran, A. V., ... & CANMAT Depression Work Group. (2024). Canadian Network for Mood and Anxiety Treatments (CANMAT) 2023 update on clinical guidelines for management of major depressive disorder in adults. Canadian Journal of Psychiatry, 69(9), 641–687. https://doi.org/10.1177/07067437241245384
19. Rush J, Thase ME. Improving Depression Outcome by Patient-Centered Medical Management. Am J Psychiatry 2018; 175:1187–1198.
20. Treating Major Depressive Disorder, A Quick Reference Guide. American Journal of Psychiatry. 2010; 3.Qaseem, A., Owens, D. K., Etxeandia-Ikobaltzeta, I., Miller, M. C., Kansagara, D., Forciea, M. A., & Clinical

Guidelines Committee of the American College of Physicians. (2023). Nonpharmacologic and pharmacologic treatments of adults in the acute phase of major depressive disorder: A living clinical guideline from the American College of Physicians. Annals of Internal Medicine, 176(2), 239–252. https://doi.org/10.7326/M22-2056

21. Greden JF, Parikh SV, Rothschild AJ, Thase ME, Dunlop BW, DeBattista C, et al. Impact of pharmacogenomics on clinical outcomes in major depressive disorder in the GUIDED trial: A large, patient- and rater-blinded, randomized, controlled study. J Psychiatr Res. 2019;111:59-67. doi:10.1016/j.jpsychires.2019.01.003. PubMed PMID: 30677646.
22. Ramsey CM, Lynch KG, Thase ME, Gelernter J, Kranzler HR, Pyne JM, et al. Prevalence of predicted gene-drug interactions for antidepressants in the treatment of major depressive disorder in the Precision Medicine in Mental Health Care Study. J Affect Disord. 2021;282:1272-1277. doi:10.1016/j.jad.2021.01.034. PubMed PMID: 33601706.
23. Zhu J, et al. Serotonin Transporter Gene Polymorphisms and Selective Serotonin Reuptake Inhibitor Tolerability: Review of Pharmacogenetic Evidence. Pharmacotherapy 2017;37(9):1089–110401s.

Attachment 1: The Patient Health Questionnaire-2 (PHQ-2) (BSWQA.CLE.006.A1)

Patient Name: _____ Date of Visit:_____

Over the past 2 weeks, how often have you been bothered by any of the following?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Attachment 2: Patient Health Questionnaire (PHQ-9) (BSWQA.CLE.006.A2)

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	1	2	3
2. Feeling down, depressoed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speking so slowing that other people could have noticed. Or the oposite, being so figety, or restless tha you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add columns		+	+	
TOTALS				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying score card)

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self -report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (bipolar disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

3. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
4. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
5. Add together column scores to get a TOTAL score.
6. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
7. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all - 0; Several days - 1, More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	**Minimal depression**
5-9	**Mild depression**
10-14	**Moderate depression**
15-19	**Moderately severe depression**
20-27	**Severe depression**

A26623 10-04-200

Attachment 3: CSSRS Questions and Scoring Interpretation (BSWQA.CLE.006.A3)

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screening Version – Since Last Visit

Suicide Ideation Definitions and Prompts	Since Last Visit	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1.) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2.) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3.) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." ***Have you been thinking about how you might kill yourself?***		
4.) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them." ***Have you had these thoughts and had some intention of acting on them?***		
5.) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6.) Suicide Behavior ***Have you done anything, started anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took the pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1501 Riverside Drive, New York, New York, 10032;
posner@nyspi.columbia.edu

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Primary Care *Screen with Triage Points*

Suicide Ideation Definitions and Prompts	**Past month**	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1.) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2.) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3.) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." ***Have you been thinking about how you might kill yourself?***		
4.) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts but I definitely will not do anything about them." ***Have you had these thoughts and had some intention of acting on them?***		
5.) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***		
6.) Suicide Behavior ***Have you done anything, started anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took the pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime** **Past 3 Months**	

Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

Item 1 - Behavioral Health Referral
Item 2 - Behavioral Health Referral
Item 3 - Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 - Behavioral Health Consultation and Patient Safety Precautions
Item 5 - Behavioral Health Consultation and Patient Safety Precautions
Item 6 - Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 - 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

For inquiries and training information contact: Kelly Posner, Ph.D.

Attachment 4: Pearls of Treatment (BSWQA.CLE.006.A4)

Shared Decision Making:

- Provide education on diagnosis
- Review treatment options (based on PHQ-9 score)
- Discuss treatment barriers: family/work responsibilities, insurance, transportation
- Discuss treatment plan
- Set timeline: response, side effects and treatment duration
- Educate on importance of adherence
- Develop safety plan for suicidal ideation
- See Depression Medication Choice Decision Aid (mayoclinic.org)

Promote Healthy Behaviors

- Exercise
- Social support
- Faith/spiritual support
- Healthy sleep pattern
- Healthy diet
- Alcohol only in moderation
- Cessation of tobacco and illicit drug use
- Engagement in positive activities
- Stress management
- Educational books and online resources

Additional Considerations

- Current or planned pregnancy: psychotherapy preferred if symptoms tolerable
- Start with lower dose for panic/anxiety or the elderly
- Level of functioning/activities of daily living
- Psychiatry consultation, including ECT, ketamine or rTMS evaluation

Consider Prompt Referral or Consult

- Suicidal or homicidal
- Bipolar disorder
- Substance abuse
- Psychotic features
- Cognitive impairment
- Multiple Meds

Attachment 5: Crisis Resources (BSWQA.CLE.006.A5)

What to do if there is a crisis with a person or patient in the clinic?

For a concern that the patient/person might hurt others or themselves while in the clinic

- **Call 911**
- State your name and location and describe the situation, description of the patient,

  patient's address, etc. The dispatcher will guide you, so don't worry if you can't remember every detail. *The important thing is to remember to call 911.*

Crisis Text Line: A national 24/7 service; patients can utilize this service by texting 741741 or through a Facebook message. Find out more at www.crisistextline.org

National Suicide Prevention Lifeline: A national 24/7 crisis line. Phone number is 988. Alternately, 1-800-273-TALK (8255). Find out more at https://988lifeline.org/

CSSRS Training: Anyone can complete this training and become a screener. The training takes between 30-60 minutes. Find out more at http://cssrs.columbia.edu/training/training-options/

Attachment 6: Pharmacological Therapy (BSWQA.CLE.006.A6)

There is insufficient evidence to recommend one antidepressant medication over another for all patients. Choosing an antidepressant agent depends on depressive symptoms, side effect profile, personal or family response history, drug interactions, comorbid medical conditions, and cost.

- SSRIs, and SNRIs are generally regarded as the first-line treatment for depression due to efficacy and tolerability of these agents
- Augment with one of the following: SSRI, SNRI, mirtazapine, buspirone, bupropion, or T_3 (choosing a different mechanism of action than the Stage 1 drug)
- If the augmentation strategy is ineffective, the patient should be placed on an antidepressant from a different antidepressant class than what was initiated in the inaugural trial while maintaining the augmentation strategy or referred to Psychiatry for evaluation
- Refer to psychiatry for more complex augmentation strategies (e.g., anticonvulsants, antipsychotics, lithium)

- See BSWQA.CLE. 006.A8 for medication cost analysis. Costs are based on the average claims paid for the drugs across all BSWQA contracts (Scott & White Health Plan, United Health Care, Cigna, Aetna, Humana Medicare Advantage, and Scott & White Medicare Advantage). The date range is February 2019 to January 2020. There were no claims for some drugs, which is noted as “no claims” in the table.

If safety and efficacy are equivalent, the more cost-effective option is preferred.

Attachment 7: Antidepressant Discontinuation Syndrome Patient Handout (BSWQA.CLE.006.A7)

Baylor Scott & White HEALTH

Antidepressant Discontinuation Syndrome

What is Discontinuation Syndrome?
Discontinuation Syndrome can happen if you suddenly stop taking an antidepressant medicine. It is not dangerous, but it can be uncomfortable and upsetting.

What are the signs of Discontinuation Syndrome?
The symptoms of Discontinuation Syndrome happen within 1 to 2 days after stopping or lowering the dose of an antidepressant medication.

You may feel:
- dizzy
- shaky
- sweaty
- irritable or agitated
- anxious or nervous

You may have:
- a headache
- nausea or vomiting
- flu-like symptoms
- trouble-sleeping, nightmares, or lots of dreams

Call your doctor for instructions if you have symptoms of Discontinuation Syndrome and you stopped taking or lowered the dose of an antidepressant medicine in the last few days.

Which medicines cause Discontinuation Syndrome?
Stopping any antidepressant medicine can cause Discontinuation Syndrome.
The most common antidepressants that can cause Discontinuation Syndrome are:
- venlafaxine (Effexor®)
- duloxetine (Cymbalta®)
- desvenlafaxine (Pristiq®)
- paroxetine (Paxil®)
- escitalopram (Lexapro®)
- sertraline (Zoloft®)
- citalopram (Celexa®)

How is Discontinuation Syndrome treated?
You may need to restart the antidepressant medicine. Talk with your doctor about why you stopped taking the antidepressant. If you and your doctor decide you should stop the medicine, you may need to slowly take less medicine over time until you stop completely.

How can you protect yourself from dangerous reactions to medicines?
- Tell all your doctors and pharmacists about all the prescription and over-the-counter medicines, vitamins, and supplements you take.
- Talk to your doctor before stopping any medicine and make a plan to do it safely. If you have to stop a medicine for a short time, restart it as soon as possible.

To access handout: Microsoft Word - Discontinuation Syndrome_FINAL_01.2018.docx (sharepoint.com)

Attachment 8: ACP Initial Treatments of Adults in the Acute Phase of Major Depressive Disorder (BSWQA.CLE.006.A8)

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

Initial Treatments of Adults in the Acute Phase of Major Depressive Disorder

Recommendations

RECOMMENDATION 1a: ACP recommends monotherapy with either cognitive behavioral therapy or a second-generation antidepressant as initial treatment in patients in the acute phase of moderate to severe major depressive disorder (strong recommendation; moderate-certainty evidence).

RECOMMENDATION 1b: ACP suggests combination therapy with cognitive behavioral therapy and a second-generation antidepressant as initial treatment in patients in the acute phase of moderate to severe major depressive disorder (conditional recommendation; low-certainty evidence).

The informed decision on the options of monotherapy with cognitive behavioral therapy versus second-generation antidepressants or combination therapy should be personalized and based on discussion of potential treatment benefits, harms, adverse effect profiles, cost, feasibility, patients' specific symptoms (such as insomnia, hypersomnia, or fluctuation in appetite), comorbidities, concomitant medication use, and patient preferences.

RECOMMENDATION 2: ACP suggests monotherapy with cognitive behavioral therapy as initial treatment in patients in the acute phase of mild major depressive disorder (conditional recommendation; low-certainty evidence).

RATIONALE

Moderate to severe MDD: Use of SGAs is common because of their availability, ease of use, and effectiveness. However, up to 70% of patients with MDD do not achieve remission following initial pharmacologic treatment with an SGA, and fewer patients with severe MDD achieve remission compared with those with moderate or mild MDD. It is important to take an individualized approach using shared decision making when treating MDD, because there may be important variability in patients' preferences for different treatment options. Overall, moderate-certainty evidence showed that there were probably no differences between monotherapy with CBT or SGAs, and low-certainty evidence showed that there may have been no additional benefit of combination therapy with an SGA and CBT relative to monotherapy with an SGA.
In the United States, CBT may be more expensive for patients than the SGA, but it is also covered by some insurers and is generally more common and established than other psychotherapies. Patients may have more difficulty accessing CBT due to barriers such as limited availability of mental health professionals, transportation to and from appointments, time needed to attend appointments, and costs associated with care. Hence, it is important to individualize approaches and increase options of treatments that have demonstrated similar effects on response and remission.

Mild MDD: The CGC extrapolated from evidence on using CBT as initial treatment because studies mainly enrolled patients with moderate to severe MDD and downgraded the overall certainty of evidence to low and the strength of the recommendation to conditional due to the lack of direct evidence in patients with mild MDD. Furthermore, the CGC had concerns about adverse effects of SGAs in these patients and suggests that the use of SGAs as initial treatment of these patients should be based on additional considerations, such as limited access to or cost of CBT, history of moderate or severe MDD, or patient preferences.

Population
Adults in the acute phase of MDD

Interventions*
- Psychotherapies: CBT and other psychotherapies (such as integrative therapy, psychodynamic therapy, third-wave CBT)
- Complementary and alternative medicine (CAM): acupuncture, omega-3 fatty acids, S-adenosyl-L-methionine (SAMe), St. John's wort (*Hypericum perforatum*)
- Exercise
- Any combination of psychotherapies, CAM, and/or exercises with SGAs

Comparator
- Selective serotonin reuptake inhibitors: citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
- Serotonin–norepinephrine reuptake inhibitors: desvenlafaxine, duloxetine, levomilnacipran, venlafaxine
- Other antidepressants: bupropion, mirtazapine, nefazodone, trazodone, vilazodone, vortioxetine

Attachment 9: Discussion on PGx Testing (BSWQA.CLE.006.A9)

Discussion on PGx Testing

This review focuses on studies of **clinical outcomes**, not biological correlations. While genetic associations with antidepressant metabolism are well documented, few trials have tested whether PGx improves treatment results, and most have been underpowered because only 15–20% of patients studied have actionable genotypes.

The largest RCT (n=1,541) found no difference in symptom severity between patients treated with or without PGx guidance (primary outcome studied), though secondary outcomes of remission and relapse rates showed some improvement with certain commercial panels (Greden et al., 2019). A smaller RCT (n=304) found no advantage of PGx-guided care (Ramsey et al., 2021).

Evidence on adverse effects is minimal, with no clear benefit shown. While FDA labeling and CPIC guidelines highlight gene–drug interactions for certain antidepressants, these recommendations are based on pharmacokinetic data rather than demonstrated clinical outcomes.

Given very low confidence in the evidence, mixed findings, and variable patient preferences—but no identified harms—this guideline recommends n*either for nor against* pharmacogenetic (PGx) testing.