Improving Depression Screening and Management

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Objectives

- Review best practices for the screening process and workflows
- Define actions for positive PHQs
- Develop strategies for follow up and tracking

Section 1: Depression Screening

Depression is projected to become the leading cause of disability globally by 2020. It is estimated that the devastation caused by depression—defined as the number of years lost to death or disability—by 2020 will be surpassed only by heart disease.

http://www.who.int/mental_health/advocacy/en/Call_for_Action_MoH_Intro.pdf

Screeners are not diagnostic but informs of the need for further assessment.

Why screen?

- Prevent onset of illness through management of health risk factors
- Engage in early detection
- Determine level of intervention
- Better management of chronic health conditions
- Manage total health care needs of patient through referral and coordination
- Providers can dramatically decrease medical utilization and costs by treating psychological problems directly

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	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
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 speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

Source: Kroenke, K., Spitzer, R., & Williams, J. (2001). The PHQ-9 validity of a brief depression severity measure. J GEN INTERN MED, 16, 606-613

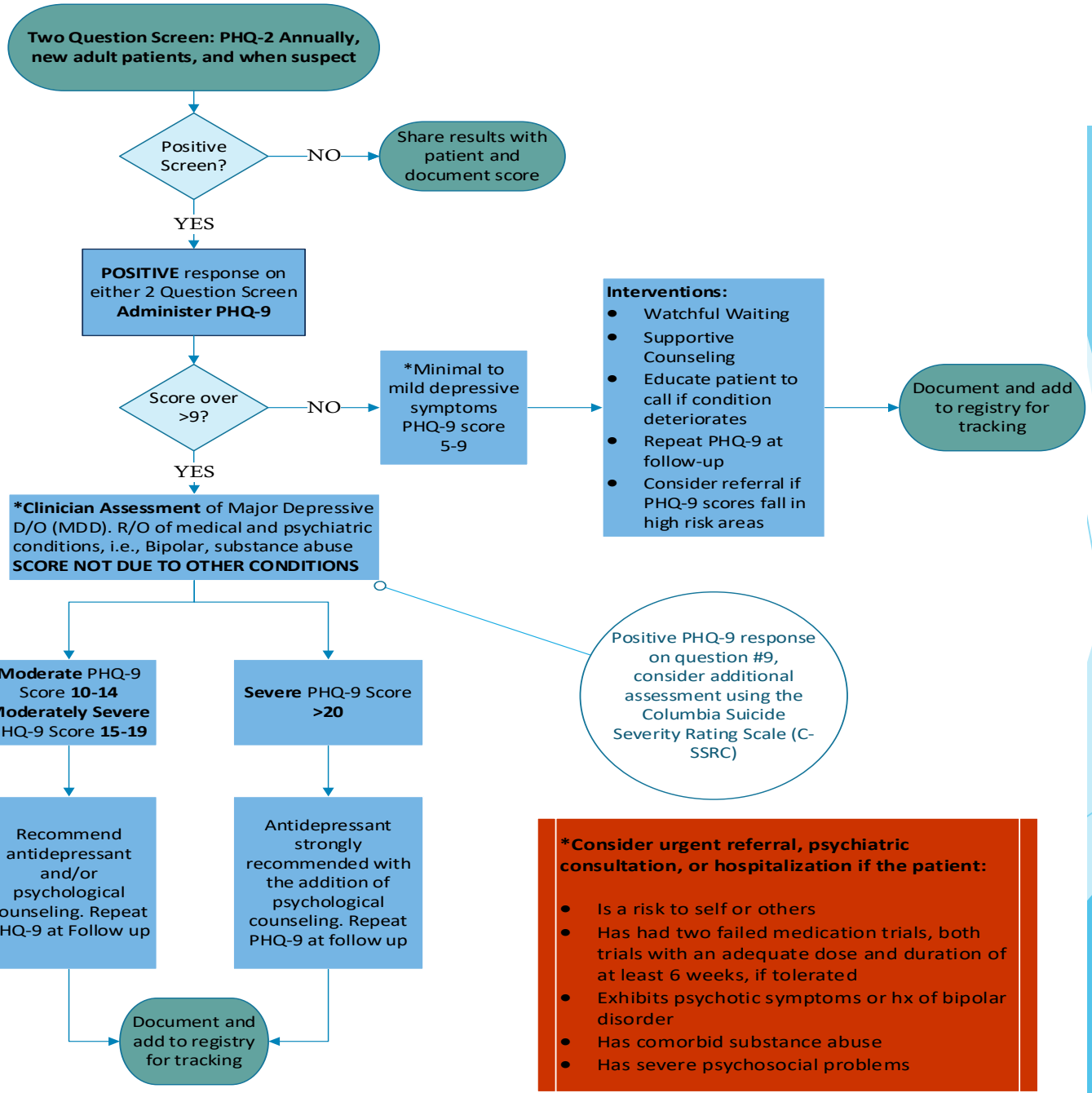
The PHQ Guidelines

- The full PHQ and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM 5 disorders
- A positive score is considered a 10 unless a woman is pregnant, then it is 15
  - Use pre and post pregnancy
- Often a score under 10 is representative of situational stress

Patient Health Questionnaire (PHQ)-9 Scores Translated Into *Diagnostic and St* *Manual of Mental Disorders, Fifth Edition* (DSM-5) Diagnoses and Practic

PHQ-9 Symptoms and Impairment	PHQ-9 Scores	Intensity	Initial Management	Next
One – Four Symptoms Minimal Functional Impairment	5 – 9	Subclinical	• Instruct the patient to call if he/she feels worse • Prescribe physical activity • Educate patient to schedule daily pleasurable activities	If patient has not im month, consider ref behavioral health fo
Two Symptoms Score 2+ on Question 1 or 2 Functional Impairment	10 – 14	Mild Major Depression	• Perform all actions for Subclinical Depression, plus • Psychotherapy, pharmacotherapy or both	Initially, keep in cor patient on a weekly adequate engagem to monthly check-in
Three or More Symptoms Score 2+ on Question 1 or 2 Functional Impairment	15 – 19	Moderate Major Depression	• Perform all actions for Mild Major Depression	Initially, keep in cor patient on a weekly adequate engagem perform check-ins e (unless patient is se health treatment el
Four or More Symptoms Score 2+ on Question 1 or 2 Marked Functional Impairment Motor Agitation	≥20	Severe Major Depression	• Perform all actions for Mild Major Depression: pharmacotherapy as necessary; psychotherapy when patient is able to participate	Keep in contact on until symptoms are patient is seeking m treatment elsewher

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



Considerations for Implementation

Important to strategize in advance on how you plan to use the data, rather than just keep it for its own sake

Most successful practices use the screening score as the first data point in a depression registry

May be easily incorporated into review of systems or SMART Form in EHR

May choose to do serial PHQ-9 measurements over time to determine if improvement has occurred

- Can be completed over the phone

May choose to focus efforts of your staff in handling medically "high-risk" patients (e.g., may choose to focus on depressed diabetic or cardiac patients first)

Consider clinical workflow and protocol

- Adding a BH specialist or collaborating with community BH resource
- Preparing/training existing staff
- Tracking and outreach

Columbia-Suicide Severity Rating Scale (C-SSRS)

Screen with Triage Points for Primary Care

Ask questions that are in bold and underlined.

Ask Questions 1 and 2	Past month YES	NO
1) **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2) **Have you had any actual 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) **Have you been thinking about how you might do this?** e.g. "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."		
4) **Have you had these thoughts and had some intention of acting on them?** as opposed to "I have the thoughts but I definitely will not do anything about them."		
5) **Have you started to work out or worked out the details of how to kill yourself?** Do you intend to carry out this plan?		
6) **Have you ever done anything, started to do 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 pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
		Past 3 Months
If YES, ask: Was this within the past 3 months?		

Response Protocol to C-SSRS Screening (use protocol in accordance with clinical judgment)

Risk Level	Suggested Interventions
High Risk Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) ***or*** Suicidal behavior within past three months (C-SSRS Suicidal Behavior)	Call 911 for transport to the emergency room or contact community crisis line in your area to provide on-site evaluation. Place individual in a room that is away from exits but close to staff where patient is observed at all times until help arrives.
Medium Risk Suicidal ideation WITHOUT plan, intent or behavior in past month (C-SSRS screen #2 or #3) ***or*** Suicidal behavior more than three months ago (C-SSRS Suicidal Behavior)	If patient is already receiving mental health treatment, get release of information. If not, refer to mental health provider for further assessment (within one week). Consider pharmacological treatment. Provide education on safe fire arms storage, suicide warning signs and 1-800-273-TALK (8255) and local contacts.
Low Risk Wish to die (C-SSRS Suicidal Ideation #1) without plan, intent or behavior ***or*** Suicidal ideation more than one month ago WITHOUT plan, intent or behavior (C-SSRS screen #2 or #3)	Assess for any other mental health or substance use conditions and consider behavioral health and/or pharmacological treatment. Provide education on safe fire arms storage, suicide warning signs and 1-800-273-TALK (8255) and local contacts.

Geriatric Depression Scale

Directions to Patient: Please choose the best answer for how you have felt over the past week.
Directions to Examiner: Present questions VERBALLY. Circle answer given by patient. Do not show to patient.

1.	Are you basically satisfied with your life?	yes	**no** (1)
2.	Have you dropped many of your activities and interests?	**yes** (1)	no
3.	Do you feel that your life is empty?	**yes** (1)	no
4.	Do you often get bored?	**yes** (1)	no
5.	Are you hopeful about the future?	yes	**no** (1)
6.	Are you bothered by thoughts you can't get out of your head?	**yes** (1)	no
7.	Are you in good spirits most of the time?	yes	**no** (1)
8.	Are you afraid that something bad is going to happen to you?	**yes** (1)	no
9.	Do you feel happy most of the time?	yes	**no** (1)
10.	Do you often feel helpless?	**yes** (1)	no
11.	Do you often get restless and fidgety?	**yes** (1)	no
12.	Do you prefer to stay at home rather than go out and do things?	**yes** (1)	no
13.	Do you frequently worry about the future?	**yes** (1)	no
14.	Do you feel you have more problems with memory than most?	**yes** (1)	no
15.	Do you think it is wonderful to be alive now?	yes	**no** (1)
16.	Do you feel downhearted and blue?	**yes** (1)	no
17.	Do you feel pretty worthless the way you are now?	**yes** (1)	no
18.	Do you worry a lot about the past?	**yes** (1)	no
19.	Do you find life very exciting?	yes	**no** (1)
20.	Is it hard for you to get started on new projects?	**yes** (1)	no
21.	Do you feel full of energy?	yes	**no** (1)
22.	Do you feel that your situation is hopeless?	**yes** (1)	no
23.	Do you think that most people are better off than you are?	**yes** (1)	no
24.	Do you frequently get upset over little things?	**yes** (1)	no
25.	Do you frequently feel like crying?	**yes** (1)	no
26.	Do you have trouble concentrating?	**yes** (1)	no
27.	Do you enjoy getting up in the morning?	yes	**no** (1)
28.	Do you prefer to avoid social occasions?	**yes** (1)	no
29.	Is it easy for you to make decisions?	yes	**no** (1)
30.	Is your mind as clear as it used to be?	yes	**no** (1)

TOTAL: Please sum all bolded answers (worth one point) for a total score. _____

Scores: **0 - 9 Normal** **10 - 19 Mild Depressive** **20 - 30 Severe Depressive**

Geriatric Depression Scale Intervention Tool

Screening for Depression in Older Adults

WHAT: The Geriatric Depression Scale (GDS-15) short form consists of 15 questions. It takes five to seven minutes to complete.

WHO: The GDS-15 may be used for adults 65 years and older. The GDS-15 short form is more easily used by physically ill patients and patients with mild to moderate dementia who have short attention spans and/or feel easily fatigued.

WHY: Identifying depression in older adults is especially relevant, since it may be comorbid with other illnesses, exacerbate existing physical symptoms or be responsible for the symptoms a patient is experiencing. Older adults are more likely to seek and accept services in primary care.

WHEN:
- Once per year (or during a new patient's first appointment)
- Every two weeks if the patient started on an antidepressant until the patient is in remission (under a score of 5)
- Every six months for patients with a history of depression

SCORING: Of the 15 items, 10 items indicate the presence of depression when answered "**Yes**." The rest of the items indicate depression when answered "***No***."

See the GDS-15 scale on the second page. Responses indicating depression are in BOLD.

GDS-15 Score	Level of Severity	Proposed Actions/Intervention
0-4	Considered Normal	• No intervention or self-management support (e.g., exercise, stress management) • Brief action plan
5-10	Mild Depression	• Brief diagnostic assessment • Watchful waiting – provide self-management support (e.g., educate patient to call if symptoms worsen, offer self-help recommendations (books, websites)) • Have patient return in one month to repeat screening and reassess
11-19	Moderate Depression	• Comprehensive diagnostic assessment (including suicide assessment) • Develop treatment plan with consideration of counseling/psychotherapy, antidepressant medication and follow-up • Monitor with continued screenings over time
20-27	Severe Depression	• Comprehensive diagnostic assessment (including suicide assessment) • Expedited referral to a mental health specialist for psychotherapy and/or inpatient • Collaborative management • Consider immediate initiation of antidepressant medication • Monitor with continued screenings over time

Note: When drug treatment is required, a selective serotonin re-uptake inhibitor (SSRI) should be the first-line therapy. Tricyclic antidepressants have anti-cholinergic side effects and should be avoided in older people.

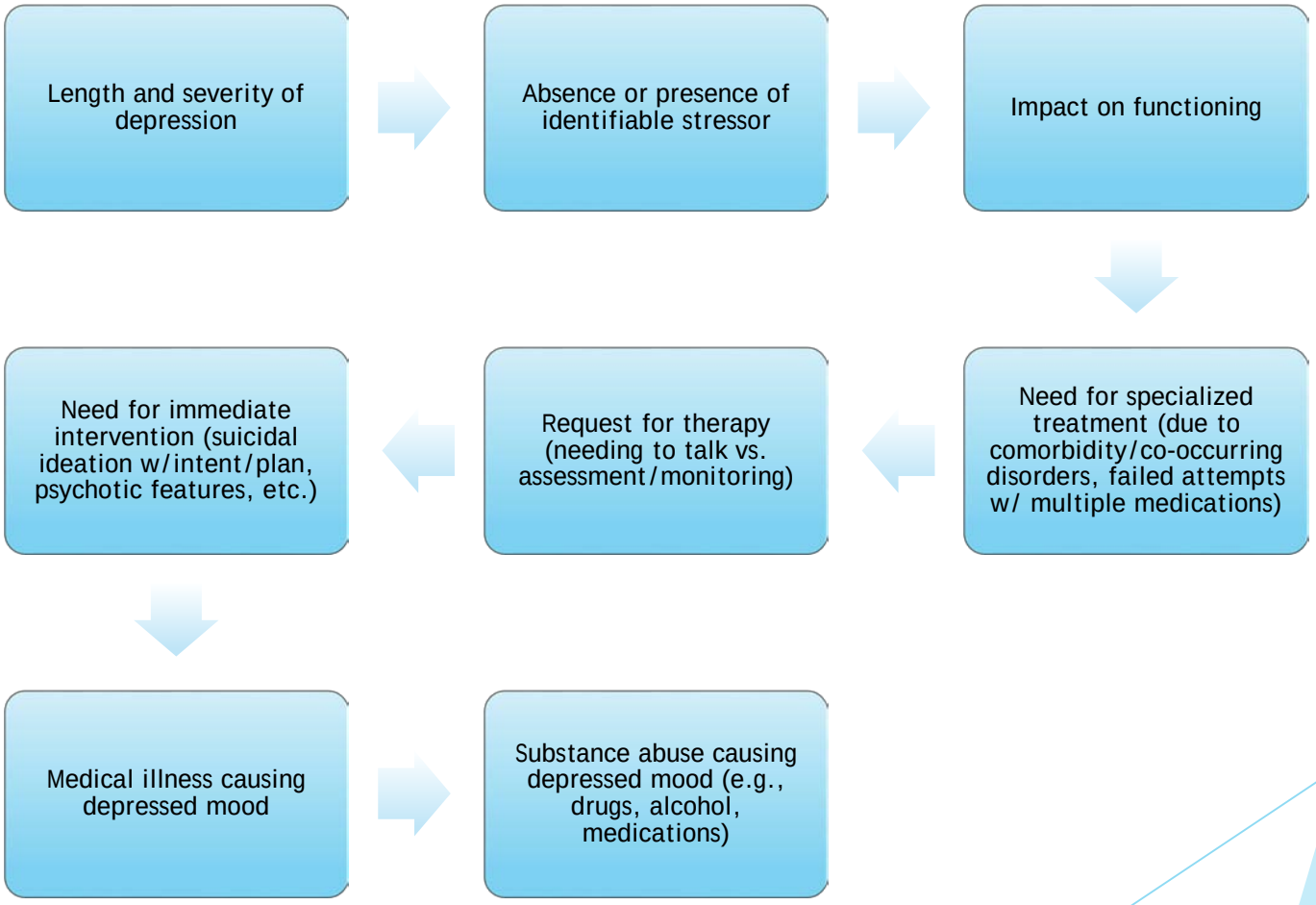
Activity

- At your table, identify a person to take notes
- Discuss:
  1. What is your current process?
  2. What works and what does not?
  3. What would “perfect depression care” look like?
  4. What changes would you need to make or resources would you need to add?
  5. What is one idea that you can test next week?
- Report Out

Section 2: Depression Evaluation and Intervention

You have a positive PHQ, now what?

Evaluate


Length and severity of depression
Absence or presence of identifiable stressor
Impact on functioning
Need for specialized treatment (due to comorbidity/co-occurring disorders, failed attempts w/ multiple medications)
Request for therapy (needing to talk vs. assessment/monitoring)
Need for immediate intervention (suicidal ideation w/intent/plan, psychotic features, etc.)
Medical illness causing depressed mood
Substance abuse causing depressed mood (e.g., drugs, alcohol, medications)

Questions to Include for a Positive PHQ-9

When did this start (out of the blue or with a precipitating event)?

- Use to rule out stress, grief and adjustment

Have you ever felt like this before?

- Try to get age of onset
- Try to understand if it is cyclic in nature
- Ask what helped them feel better when experienced it before
  - Medication? Therapy? Exercise?

Ask about sleep:

- Difficulty falling asleep (maybe anxiety) or early morning awakenings (maybe depression)

Any history of psychiatric treatment (counseling, medication, inpatient)?

Functionality

Functional Domain	Moderately Impaired	Severely Impaired
Family Relationships	Quiet, negative and oppositional	Withdrawn, won't talk, brusque, angry, aggressive
School and Academics/Work	Grades/work performance deteriorating, missing/cutting class or work, decreased effort, moderate academic or work stress	Failing performance, missing school or work, doesn't care about work, oppositional, argumentative, high academic or work stress
Peer Relationships	Decreased socializing or extracurricular activities , more time on computer	Isolated, discontinued extracurricular activities, excessive computer time
Stress Level, Anxiety	Minimizes or denies issues, projects onto others or blames others	Withholds feelings, won't talk
Suicidal Ideation	Vague/occasional	Frequently considered, has a plan or prior attempt
Other Self-Harm	Occasional thoughts but no attempts	Cutting, other self injury

Patient is not comfortable with the BH diagnosis.

Possible patient responses:

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

Interventions:

- Explain to the patient that their symptoms are very common and easily treated.
- Discuss that the brain is an organ and sometimes needs adjustment
- Explore why the patient is uncomfortable about the diagnosis - equate with severe mental illness or is frightened of the "label”.
- Explore what they think having depression/anxiety/SA means and dispel some of the myths.
- For example, if their main symptom is insomnia, suggest that the medication they have been prescribed will help to relieve that symptom.

Brief Interventions

- Medication/follow up with primary care physician
- Provide basic education on depression
- Normalize the prevalence of depression (50 percent of people experience depression at least once in their life and assure that it is treatable)
- Self-management
- Referral to specialty mental health for counseling
- Referral to psychiatry for medication treatment-resistant depression or when depression co-occurs with other mental health diagnosis (e.g., bipolar, severe anxiety)

Depression Actions

Sleep hygiene	• Patient should use their bed for sleep and sex only. Move the television out of the bedroom. Develop a regular and relaxing routine for bedtime. Set a regular time to get up and get dressed each day. Drink caffeinated beverages in the morning only.
Exercise	• Exercise is an excellent antidepressant. This exercise need not be strenuous. Daily walking for 30 minutes is enough. Do some exercise outside the house every day, if possible. Aerobic exercise (walking, swimming, running, biking) is best, but strength building (weight lifting and using exercise machines) also helps.
Social activation	• People with depression tend to isolate themselves and constantly think about their failings. It is important that they remain connected with family and friends, even if they do not feel like it. They should schedule meetings and activities that they used to enjoy. This is adopting the "fake it until you make it" approach.
Quit drugs & limit alcohol	• Many illicit drugs, like cocaine and methamphetamines, elevate mood in the short term but make depression worse over time. Alcohol will reduce anxiety in the short term but worsens depression and increases risk of suicide. Alcohol makes falling asleep easier but staying asleep harder. Support your patients to quit.

Depression Self-Care Action Plan

Patient: _____

Provider: _____

Clinic: _____

Phone Number: _____

Depression is treatable!

1. Stay physically active.

Make sure you make time to address your basic physical needs, for example, walking for a certain amount of time each day.

Every day during the next week, I will spend at least _____ minutes (make it easy, reasonable) doing _____.

2. Make time for pleasurable activities.

Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day - for example, doing a hobby, listening to music, or watching a video.

Every day during the next week, I will spend at least _____ minutes (make it easy, reasonable) doing _____.

3. Spend time with people who can support you.

It's easy to avoid contact with people when you're depressed, but you need the support of friends and loved ones. Explain to them how you feel, if you can. If you can't talk about it, that's OK - just ask them to be with you, maybe accompanying you on one of your activities.

During the next week, I will make contact for at least _____ minutes (make it easy, reasonable) with
_____ (name) doing/talking about _____
_____ (name) doing/talking about _____
_____ (name) doing/talking about _____

4. Practice relaxing.

For many people, the changes that come with depression - no longer keeping up with our usual activities and responsibilities, feeling increasingly sad and hopeless - leads to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, or a warm bath, or just finding a quiet, comfortable, peaceful place and saying comforting things to yourself (like "It's OK.")

Every day during the next week, I will practice physical relaxation at least _____ times, for at least _____ minutes each time. (make it easy, reasonable)

5. Simple goals and small steps.

It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down in to small steps. Give yourself credit for each step you accomplish.

The problem is _____
_____
My goal is _____
_____
Step 1: _____
Step 2: _____
Step 3: _____

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

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely

Section 3: Referrals , Follow –Up and Tracking

Warm Handoff

- Describe treatment options to patients based on available services
- Develop relationships with other providers and treatment centers
- Facilitate hand-off by:
  - Calling to make appointment for patient
  - Providing directions and clinic hours to patient
  - Coordinating transportation when needed

Tracking

- Create a registry for all patients with a positive PHQ
- Track visits and screening results over time
- Share trends with patients
- Create discharge criteria

Determine PHQ Metrics

- % Screened
- % Positive
- % of Positive with one or more BH visits
- % of Positive in remission at 1 year

Putting it all together

- Evidence-based tools
- Data-driven
- Patient or provider requests

- Shared decision making
- Family and caregivers involvement

- Treatment needs identified
- Consider psychological, cultural, and social aspects

- Evidence-based treatment for functional outcomes
- Referral to a higher level care
- Reflect in care plan

- Communicate with team
- Treat to target
- Goal reassessment
- Tracking

Leave in Action

1 Identify Next Steps For Your Practice

Action Steps

- What is the issue that you want to resolve?
- What change would result in improvement?
- What solution will you test?

2 Plan for Change

Action Steps

- Who should be involved?
- What tasks are needed?
- What is the timeline and tracking mechanism?

3 Test Change

Action Steps

- What actually happened?
- What were the results?
- What modifications need to be made?

Resources

- https://www.icsi.org/guidelinesmore/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/
- http://www.annfammed.org/content/5/2/126.full.pdf
- https://www.magellanprovider.com/MHS/MGL/education/member_ed/F-PCE10%20PCP%20Dep.pdf