Depression Screening &
Treatment in Primary Care,
Part Two:
Workflow and
Engaging the
Clinical Team

October 5, 2016
We Want To Hear From You!

Type questions into the **Questions Pane at any time during this presentation**.
Oregon’s PCPCH Model is defined by six core attributes, each with specific standards and measures

- **Access to Care** “Health care team, be there when we need you”
- **Accountability** “Take responsibility for making sure we receive the best possible health care”
- **Comprehensive Whole Person Care** “Provide or help us get the health care, information and services we need”
- **Continuity** “Be our partner over time in caring for us”
- **Coordination and Integration** “Help us navigate the health care system to get the care we need in a safe and timely way”
- **Person and Family Centered Care** “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness”

Learn more: [http://primarycarehome.oregon.gov](http://primarycarehome.oregon.gov)
Presenters

Laura Fisk, PsyD
Wellness Center Behaviorist
Yamhill Community Care

Jeri Turgesen, PsyD
Psychologist
Providence Medical Group
Learning Objectives

• Review of depression and other behavioral health screening tools
• Share practical tools to address depression in primary care, including workflows, protocols, care pathways, ongoing evaluation - for practices both with and without a behavioral health provider
• Expand on information presented in Part 1 of this webinar series
Depression Diagnosis

A. Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

American Psychiatric Association, 2013
Prevalence of Depression

2009-2012 – 7.6% of Americans aged 12 and over had depression (CDC.gov)

- Depression is more prevalent among females and persons aged 40-59

2014 – 15.7 million adults aged 18 or older had at least one major depressive episode in the past year.

- 6.7% of all US adults

National Institute of Mental Health, Major Depression Among Adults
12-month Prevalence of Major Depressive Episode Among U.S. Adults (2014)

Data courtesy of SAMHSA

*NH/OP = Native Hawaiian/Other Pacific Islander
**AI/AN = American Indian/Alaska Native
Prevalence in Primary Care

• 70-80% of antidepressants are prescribed in primary care
  (Mojtabai, 2008)

• The prevalence of depression is higher in PC than in the general population
  (Craven & Bland, 2013)
Severity of Depression

• Depression produces greater decrease in quality of health compared to other chronic conditions
  (Moussavi, 2007)

• It is one of the leading causes of disability ages 15 and over
  (Siu, 2016)
Impact of Depression

• Depression costs the United States $13.3 million per year in sick days and $2.2 billion in lost productivity (Sederer & Clemens, 2002)

• Depression is estimated to cost the health care system 50% more than other chronic medical conditions and makes additional chronic diseases difficult to manage (Moussavi et al., 2007; Whooley, 2012)
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4107381/

• Up to 75% of those who commit suicide have seen their primary care provider in the past month (Feldman et al., 2007)
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2000302/
Screening for Depression

What, Why, When & How
Screeners – Why?

• In 2016 U.S. Preventive Services Task Force updated recommendation to screen for depression:
  – general adult population
  – pregnant women
  – postpartum women

• Screening + adequate support systems in place = improved clinical outcomes

• Treatment identified through screening decreases morbidity

• Magnitude of harm in screening is small to none

(Siu, 2016)

Benefit of Standard Screening

• Quick & objective data
• More than half of all depressed pts go unrecognized in the primary care setting
  (Saver, Van- Nguye, Keppel, & Doescher, 2007)

• Approximately 50% of cases are missed without a formal screening program
  (NCQA, 2008)
  http://www.ncqa.org/publications-products/other-products/quality-profiles/focus-on-depression/barriers-to-effective-management-of-depression

• Control of depression assists with the ability to control other chronic illnesses
  (Agency for Healthcare Research and Quality [AHRQ], 2008)
  http://www.ahrq.gov/research/findings/factsheets/mental/mentalhth/index.html

• Screening assist with monitor sxs over time
  – Response to intervention
### Screeners – What

<table>
<thead>
<tr>
<th>Population</th>
<th>Scales</th>
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</thead>
<tbody>
<tr>
<td><strong>Adults</strong></td>
<td>• Patient Health Questionnaire – PHQ-9</td>
</tr>
<tr>
<td><strong>Adolescents</strong></td>
<td>• Patient Health Questionnaire Adolescents – PHQ-A</td>
</tr>
<tr>
<td><strong>Children</strong></td>
<td>• Center for Epidemiological Studies Depression Scale for Children (CES-DC)</td>
</tr>
<tr>
<td><strong>Elderly Population</strong></td>
<td>• Geriatric Depression Scale</td>
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<tr>
<td><strong>Maternity Population</strong></td>
<td>• Edinburgh Postnatal Depression Scale</td>
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</tbody>
</table>
Screeners

- **Edinburgh Postnatal Depression Scale**
  - Better validated scale for pregnant or postpartum population
  - Score 13 and above indicates major depression
  - Sensitivity = 95%, specificity = 84%
    - (Thompson, Harris, Lazarus, & Richards, 1998)

- **Center for Epidemiological Studies Depression Scale for Children (CES-DC)**
  - Ages 6-17
  - Cut-off score of 15
  - Sensitivity = 83.7%; specificity = 75.2%
    - (Roberts & Seeley, 1991)
Diagnostic (or not diagnostic?)

- A positive screen on the PHQ-9 or any other screening tool does not in and of itself mean a diagnosis of depression.
- A low score on the PHQ-9 or any additional screening tool does not always rule out a diagnosis
  - 1 in 5 true cases of depression score below the threshold
    (Thase, 2016)
- “All positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (eg, anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions.”
  (JAMA, 2016)
- Take into consideration contextual factors
  - E.g. grief, substance use, etc.
Workflow

Screening Guidelines
USPSTF

- **Recommendation**: “The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.”
  - B recommendation

  (JAMA, 2016)

- **Recommendation**: “The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.”
  - B Recommendation

  Annals of Internal Medicine and Pediatrics on February 9, 2016
  http://annals.org/article.aspx?articleid=2490526
## Recommendations

<table>
<thead>
<tr>
<th>Organization, Year</th>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td><strong>American Academy of Family Physicians (AAFP), 2012</strong></td>
<td>The AAFP recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. The AAFP recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. These recommendations are based on the 2009 USPSTF recommendation.</td>
</tr>
<tr>
<td><strong>American Academy of Pediatrics (AAP), 2010</strong></td>
<td>The AAP recommends that pediatricians screen mothers for postpartum depression at baby’s one-, two- and four-month visits.</td>
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<tr>
<td><strong>American College of Physicians (ACP), 2009</strong></td>
<td>The ACP recommends that primary care providers should screen all adults for depression and that all primary care providers should have systems in place, either within the primary care setting itself or through collaborations with mental health professionals, to ensure the accurate diagnosis and treatment of this condition. The ACP supports the 2009 USPSTF recommendation.</td>
</tr>
<tr>
<td><strong>Institute for Clinical Systems Improvement, 2013</strong></td>
<td>Clinician should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation.</td>
</tr>
<tr>
<td><strong>National Institute for Health and Care Excellence (NICE), 2013</strong></td>
<td>•The NICE recommends the first step in depression management is recognition, assessment and initial management…. consider asking people who may have depression two questions, …</td>
</tr>
<tr>
<td><strong>Community Preventive Services Task Force (CPSTF), 2009</strong></td>
<td>The CPSTF recommends collaborative care for the management of depressive disorders based on strong evidence of effectiveness in improving depression symptoms, adherence to treatment, response to treatment, and remission and recovery from depression. This collaboration is designed to improve the routine screening and diagnosis of depressive disorders, as well as the management of diagnosed depression.</td>
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**Screening for Depression in Adults: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force**, Jan 2016

Screening Recommendations

- The U.S. Preventive Service Taskforce (USPSTF) recommends screening adults, including older adults, for depression in outpatient primary care settings when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. They have found adequate evidence that screening improves the accurate identification of depressed patients in primary care settings, and that treatment of depressed adults identified in primary care settings decreases clinical morbidity.

  Recommendation available online at:  
  [www.uspreventiveservicestaskforce.org/uspsft/uspsaddepr.htm](http://www.uspreventiveservicestaskforce.org/uspsft/uspsaddepr.htm)

- The USPSTF also recommends screening of adolescents (12 – 18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow up.

  Recommendation available online at:  
  [http://www.uspreventiveservicestaskforce.org/uspsft/uspschdepr.htm](http://www.uspreventiveservicestaskforce.org/uspsft/uspschdepr.htm)

- The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at baby’s one-, two-, and four-month visits.

  Recommendation available online at:  
  [http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.abstract](http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.abstract)

- The American Medical Association recommends screening for depression among adolescents who may be at risk due to family problems, drug or alcohol use, or other indicators of risk.

  Recommendation available online at:  

- The American Academy of Pediatrics recommends that pediatricians ask questions about depression in routine history-taking throughout adolescence.

  Recommendation available online at:  
Frequency of Screening

**Adolescent Screening Intervals**

“The USPSTF found no evidence on appropriate or recommended screening intervals, and the optimal interval is unknown. Repeated screening may be most productive in adolescents with risk factors for MDD. Opportunistic screening may be appropriate for adolescents, who may have infrequent health care visits.”

**Adult Screening Intervals**

“There is little evidence regarding the optimal timing for screening. The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.”

USPSTF, 2016

https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
Depression Screening

• USPSTF report supports routine screening for adults
  – Notable that an optimal frequency of screening has not been formally established.
  – Benefits of screening directly tied to likelihood that a pt or group of pts has entered a depressive state.

• Considerations for screening
  – “For people with a history of depression, it would make sense to “screen” for illness activity at each visit.
  – For groups at intermediate risk, such as patients receiving regular care for chronic medical conditions such as diabetes or heart disease, it is reasonable to screen at least once each year.
  – For patients in generally good health who only see their primary care physicians sporadically, it may make sense to screen at each visit, although it is likely that a person who rarely sees a physician may not necessarily schedule an appointment to see a primary care physician within weeks or even months of onset of a depressive syndrome. For such individuals, it may more sense to incorporate periodic web-based “health checks.”

Thase, M, JAMA. 2016
CCO Metric

Annually or when clinically indicated.

Screening Frequency
For members enrolled in Medicaid, the screening benefit is limited to medical appropriateness. Usually one screen per rolling 12 months is sufficient; however, there may be clinical indication that an additional screen is needed.
Workflow

Pts annually administered PHQ-2 (rolling 12 mo)

- Chart scrub administered by MA prior to arrival of pt (1-2 days prior to scheduled OV).
- Pt administered PHQ-2 as part of rooming process
  - Conjoined with SBIRT screening as indicated.

Positive screen – pt administered appropriate screen (PHQ-9, PHQ-A)

- Screen is completed prior to provider entering room
- Physician reviews and scores
- Engages pt in discussion of treatment options
  - Documents score and decision making for tx into progress note.

MA enters results of PHQ into EMR
Close f/u scheduled – BHI vs PCP

Not locked in to annual screen:
- More frequent screens conducted as a result of Physician perceived indication
- Regular screening for high risk pt
  (presenting signs and sxs; complex/chronic medical, personal or family hx)
Treatment Considerations

The NCQA (2008) includes three recommendations for the effective treatment of depression.

- Pt have three follow-up visits within the first 12 weeks, either of treatment initiation or diagnosis of depression.
- Recommendation that the pt remain on the medication during the entire acute phase.
- Recommendation that the pt remain on antidepressant medication for at least 6 months.
Sample Workflow

Provider
Note adult patients desired to be screened on the day sheet

YES TO EITHER QUESTION

MA/RN or NP student
Administer CES-D questionnaire to patient
Score CES-D survey

POSITIVE SCREEN = CES-D SCORE>16

Provider
Counsel patient & develop follow up plan
Document treatment plan for data base

Provider
If medication is prescribed:
RN visit two weeks (check med compliance)
Provider visit four weeks (follow up)

MA/RN or NP student
Ask patient two initial screening questions as part of triage
Y/N During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?
Y/N During the past two weeks, have you been bothered by little interest or pleasure in doing things?

NO TO BOTH QUESTIONS

MA/RN or NP student
Record answers on Depression Screening Data Sheet
Make a copy of data sheet and file in outcome folder/give to case manager
Return original data sheet to medical record

MA/RN or NP student
For patients who want counseling for depression:
Offer psychoeducation or counseling appointment through case manager
Notify case manager of treatment plan (for follow up and record in data base)

Cashman, Hale, Candib, Nimiroski & Brookings, 2004
Sample Workflow

Great opportunity for Shared Decision Making!

Cashman, Hale, Candib, Nimiroski & Brookings, 2004
SDM originally was derived from the patient-centered view of health care
Levenstein et al, 1986

Shared Decision Making

- **SDM Process**
  - Mutual recognition of the need for a treatment decision
    - Pt and clinician with equal roles in arriving at decision
  - Exchange of information, open discussion of the pros and cons of varying treatment options
  - Discussion of pt expectations and preferences
  - Formulation of an agreed-upon treatment decision
  - Follow-up to discuss and evaluate outcomes

Charles et al., 1999
Recently researchers have begun investigating SDM’s impact on depression treatment and outcomes

- SDM may be particularly relevant for depressed individuals since it seeks to enhance their sense of autonomy and empowerment, thus overcoming the helplessness and hopelessness intrinsic to major depression.

(Raue, Schulberg, Lewis-Fernandez, Boutin-Foster, Hoffman & Bruce, 2010)

Shared Decision-Making Intervention

**In-Person Contact (30 mins)**
1. Review depressive symptoms
2. Provide psychoeducation about depression
3. Elicit patient experiences, values, and preferences regarding a variety of depression treatments, including complementary approaches and watchful waiting
4. Use decision aid materials to educate the patient regarding effectiveness, speed of onset, side effects, and costs of these treatments
5. Identify and address practical and psychological barriers to treatment
6. Arrive at a mutually agreed-upon decision about which treatment(s) the patient will begin
7. Provide an antidepressant prescription from the PCP and/or psychotherapy referral as appropriate

**One and Two-Week Telephone Contacts (10-15 mins)**
1. Review final treatment decision(s) and success in implementing and adhering to them
2. Address ongoing treatment barriers as needed
3. Re-engage in shared decision-making as needed

(Raue, Schulberg, Lewis-Fernandez, Boutin-Foster, Hoffman & Bruce, 2010)

Shared Decision Making Tools

• **Mayo Clinic: Depression Medication Choice**

• Decision aids to be used during the encounter:
  – Decision aid
  – Online version (coming soon)
  – Take-home brochure for pts
  – Spanish Depression Aid
  – Spanish Depression Aid brochure

• **Additional resources:**
  – Storyboard showing the steps in using the cards (Spanish Version)
  – Video demonstration of how to use the cards
  – Shared Decision Making Resource Center

http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/depression-medication-choice/
Shared Decision Making Tools

- The International Patient Decision Aids Standards (IPDAS) Collaboration
- Depression
  - Depression: Should I stop taking my antidepressant? Healthwise
  - Depression: Should I take an antidepressant? Healthwise
  - Depression: Should I take antidepressants while I'm pregnant? Healthwise
  - Depression: Should My Child Take Medicine to Treat Depression? Healthwise
  - Medicines for Treating Depression: A Review of the Research for Adults Agency for Healthcare Research and Quality (AHRQ)
- IPDAS website: https://decisionaid.ohri.ca/index.html
Suicide in Primary Care

Prevalence and Assessment
From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24%, from 10.5 to 13.0 per 100,000 population.

The pace of increase greater after 2006.

Suicide rates increased from 1999 through 2014 for both males and females and for all ages 10–74.

The percent increase in suicide rates for females was greatest for those aged 10–14, and for males, those aged 45–64.

The most frequent suicide method in 2014 for males involved the use of firearms (55.4%), while poisoning was the most frequent method for females (34.1%).

Percentages of suicides attributable to suffocation increased for both sexes between 1999 and 2014.

Nat’l Center for Health Statistics, April 2016
Prevalence

Number of deaths: 41,149

- Deaths per 100,000 population: 13.0
- Cause of death rank: 10

~113 suicides each day or one every 13 minutes.

Suicide rates across demographic groups are higher in rural counties than in urban counties.

CDC 2016
http://www.cdc.gov/violenceprevention/suicide/statistics
Suicide in Primary Care

Up to 90% of people who die by suicide had contact with their PCP in the year prior to their death.

Up to 76% had contact with their PCP in the month prior to their suicide.

20% of individuals who complete suicide contact their PCP within a day of their suicide.

These individuals were more than twice as likely to have seen their PCP as opposed to a mental health professional in both the year and month prior to their suicide.
Risk Assessment

Screening to ‘rule-in’ the possibility of suicide

Suicide is a low base-rate phenomenon

(Bryan & Rudd, 2011)
Warning Signs: Direct and Indirect

Monitor for warning signs while talking with pts:

**Strongest indicators**

- Talking about or threatening harm to self.
- Looking for ways to harm self, seeking access to firearms, pills, means.
- Talking/writing about suicide/death, particularly when this is out of the ordinary for a person.
- Hopelessness
- Depression/Mood Disorders

**Additional Warning signs:**

- Anxiety/agitation
- Insomnia/sleep disturbance
- Increased EtOH/substance use
- Purposelessness
- Hopelessness
- Withdrawing from friends, family or society
- Rage, uncontrolled anger
- Reckless behaviors, risky activities
- Dramatic mood changes
- Sense of being trapped
- Deterioration in health
Ask the Questions

“Are you having thoughts of suicide?”
• Ask the question directly.

“What can I do to support you right now”

“Do you have a plan?” / “Have you thought of ways you might try to hurt yourself?”
• Access “Do you have pills/weapons in the home?”

“Are you alone?”

“Do you think you might try to hurt yourself today?”

“Have you tried to hurt yourself before?”

Confirm location, address, phone number
• Please don’t rely on the information in the EMR.
Community Resources

• Develop relationships with community mental health providers
  – Open relationship with a direct referral stream can help to increase collaboration
  – Send referrals with an ROI – different training re: Confidentiality/HIPPA
    » Designated contact person with in the clinic
    » Coordinator for referrals
      • Case Management
      • Appointed MA

• Lifelines
  – Local suicide hotlines
  – National Suicide Prevention Lifeline

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org
Suicide Safe by SAMHSA – The Suicide Prevention App for Primary Care and Behavioral Health Providers
By SAMHSA

Open iTunes to buy and download apps.

Description
Suicide Safe is a suicide prevention learning tool for primary care and behavioral health providers and is based on the nationally recognized Suicide Assessment Five-step Evaluation and Triage (SAFE-T) practice guidelines. Suicide Safe helps providers feel confident to assist patients who present with suicidal ideation. The app offers tips on how to communicate effectively with patients and their families, determine appropriate next steps, and make referrals to treatment and community resources.

Features:
• Learn the five steps of the SAFE-T approach in working with patients and easily download resources for use offline.
• Study interactive sample case studies to see the SAFE-T approach in action.
• Browse conversation starters that provide sample language and tips for talking with patients about their suicidal ideation.
• Explore clinical and educational resources and share crisis line phone numbers and other patient-focused materials.
• Use SAMHSA’s Behavioral Health Treatment Services Locator to provide timely referrals for patients. The Locator can be filtered by type and distance.

Email SAMHSA at SAMHSAInfo@samhsa.hhs.gov with any questions or comments.
Note: This app is a free resource provided by the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, and was funded by Federal resources.

SAMHSA Web Site › Suicide Safe by SAMHSA – The Suicide Prevention App for Primary Care and Behavioral Health Providers Support ›

What's New in Version 1.2
What Questions Do You Have?

Type questions into the Questions Pane at any time during this presentation.
Resources & Thanks!

• Previous Institute webinars related to this topic:
  – [Depression Screening & Treatment in Primary Care, Part One: Physician Overview of Treatment Guidelines](#)
  – [Ready, Set, Share! Tools for Implementing Shared Decision Making](#)
  – [Referral Coordination: Primary Care & Community-Based Resources](#)
  – [Depression Screening & SBIRT for Adolescents: Practical Considerations](#)

Thanks!
Please complete post-webinar survey