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Health Resources & Services Administration

# Depression Screening and Intervention Within an Integrated Care Setting

May 5, 2021


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Vision: Healthy Communities, Healthy People

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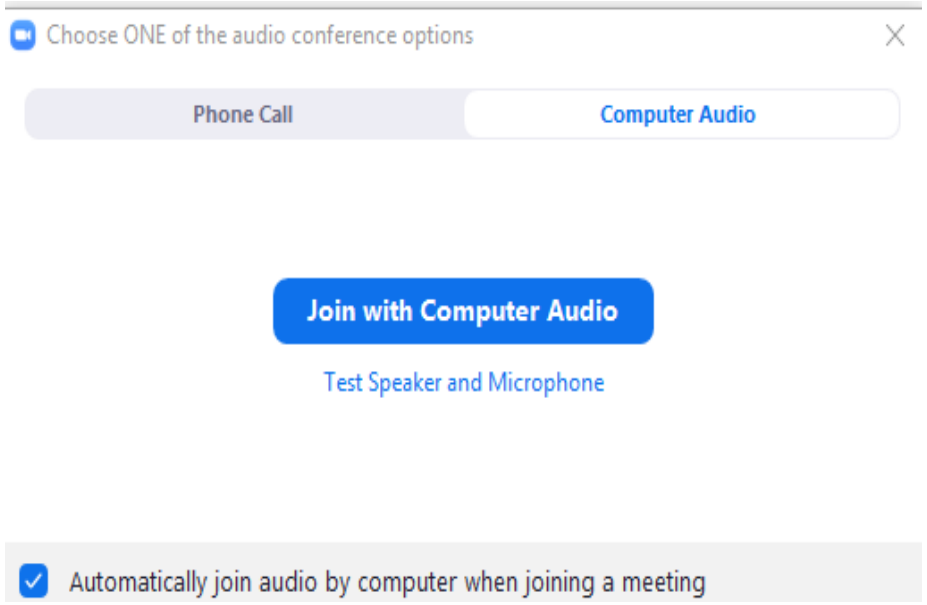


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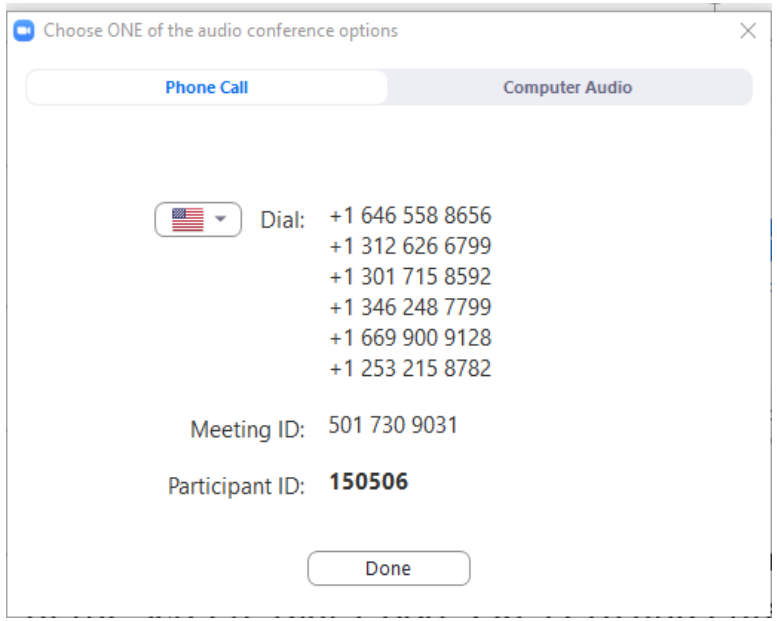

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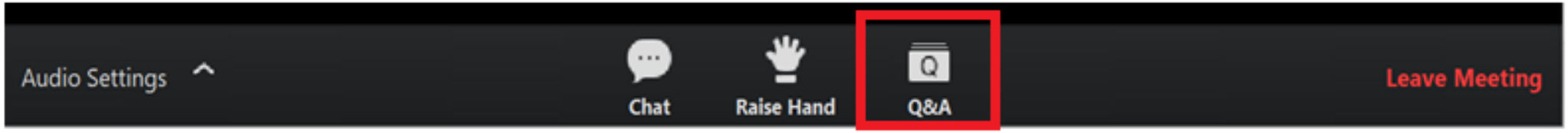


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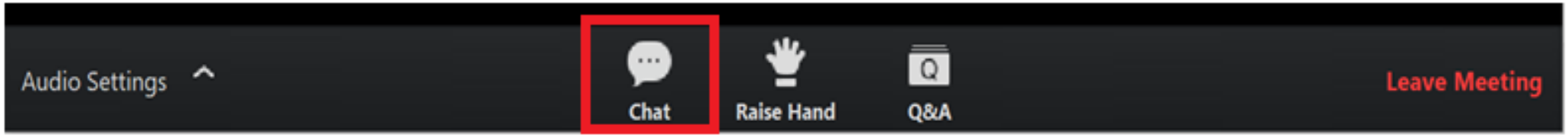

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# Upcoming TA Opportunities!

## Communities of Practice (CoP) – Weekly for 6 Sessions

- **Social Determinants of Health and Integrated Care**
  - *Cohort 1: Tuesdays, 4/27/21 – 6/1/21, 2:30–4:00 p.m.*
    **REGISTRATION IS CLOSED**
  - *Cohort 2: Tuesdays, 6/8/21 – 7/13/21, 2:30–4:00 p.m.*
    **https://zoom.us/meeting/register/tJYkdeivqz4jHNGwrJzV8L4gUoaxTCSCPGLu**

- **Integrated Behavioral Health and Value-Based Reimbursement: Two Sides of the Sustainability Coin**
  - *Cohort 1: Thursdays, 4/29/21 – 6/3/21, 2:30–4:00 p.m.*
    **https://zoom.us/meeting/register/tJwuceCsrDkvGdZGr9I1dxpCDLEkmPq3nSg4**
  - *Cohort 2: Thursdays, 6/10/21 – 7/15/21, 2:30–4:00 p.m.*
    **https://zoom.us/meeting/register/tJUuduqhpjIuHtwabD2xSdkmuHLR5Qju0XeD**

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# Upcoming TA Opportunities!

## Webinars

- **Strategies for Addressing Health Disparities in Medication Assisted Treatment for Opioid Use Disorders**

  *Wednesday, June 2, 3:00 – 4:00 PM ET*

*Registration Link:* **https://zoom.us/webinar/register/WN_hUz8J4lvQ0eidc8x6XCkFQ**

- **Reducing Health Disparities by Addressing Integrated Behavioral Health in a Maternal Child Health Care Setting**

  *Thursday, July 29, 3:00 – 4:00 PM ET*

*Registration Link:* **https://zoom.us/webinar/register/WN_smCvIfV5RP2qz5awjlYZrA**

**You can receive 1 hour of Continuing Education credit for your participation.**

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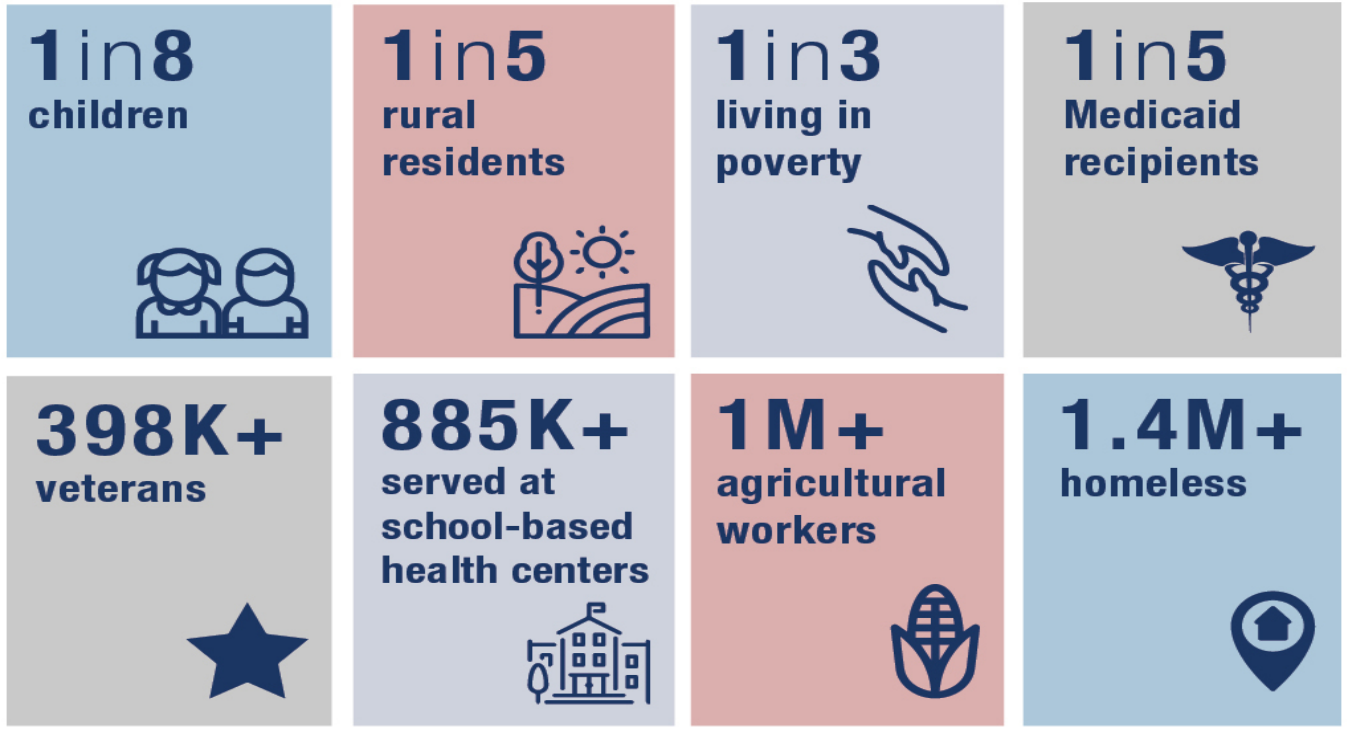
# Health Center Program Patients

## HRSA-Funded Health Centers Improve Lives

Nearly 30M people—that's **1 in 11** in the U.S.—rely on a HRSA-funded health center for care, including:




Source: Uniform Data System, 2019

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# Presenters

Joe Hyde M.A., LMHC, CAS

JBS International

Win Turner, Ph.D.

Center for Behavioral Health Integration

# Learning Objectives

- Identify risk factors, etiologies, and comorbidities associated with major depression.
- Identify barriers to depression screening
- Know variations of the PHQ-9
- Understand how the PHQ-9 guides risk stratification, treatment approach, and treatment outcomes monitoring
- Understand types of depression screening: universal, selected, and targeted
- Understand workflow considerations for depression screening

# Agenda

1. Background on depression
2. Major depression in primary care
3. Barriers to depression screening
4. Screening for depression = the PHQ-9
5. Types of depression screening:
    a. Universal
    b. Selected
    c. Targeted
6. Depression Screening workflow options
7. Questions and answers

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# About Major Depression

Source: ThinkStock

- Relapsing and remitting illness.
- Episodes may last a few months to years.
- Half of episodes fully remit within 6 to 12 months with or without treatment.
- Lack of treatment, however, may lead to chronicity.
- Initial episode predisposes patients to subsequent episodes.

Source: Moore DP et al. Mood Disorders. In: Moore & Jefferson: Handbook of Medical Psychiatry, 2nd ed. Philadelphia: Mosby; 2004.

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# Contributing Risk Factors for Major Depression

- Family problems
- Family history (alcoholism, mood disorders, family or domestic violence)
- Social isolation
- Personality factors
- Exposure to stressful life experiences (e.g., Adverse Childhood Experiences (ACEs)
- Comorbid health conditions such as diabetes, arthritis, cancer, and chronic pain

Source: Kessler RC. Epidemiology of women and depression. Journal of Affective Disorders. 2003;74(1):5.

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# Global Burden of Major Depression

## Today

- Leading cause of disability
- Fourth leading contributor to global burden of disease
- Second leading burden of disease for those 15 to 44
- 877,000 deaths from suicide annually worldwide

## By 2030

- Major depression projected to be second leading burden of disease for all ages and both men and women


**Sources:**

1. Mental health: Depression. World Health Organization web site. http://www.who.int.db.usip.edu/mental_health/management/depression/definition/en/. Accessed May 2, 2007.
2. Mathers CD et al. Projections of global mortality and burden of disease from 2002 to 2030. PLoS Med. 2006;3(11):e442


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# Depression in the Age of COVID-19

- 2018 Annual Incidence of depression in adults: 8.1%. (CDC)[1]
- 2020 Annual Incidence of depression in adults: 21%. (CDC) [2]
- 2021 Incidence of depression in adults: 24%. (Kaiser Family Foundation) [3]
- 2021 Incidence of suicidal ideation in adults: 11%. (Kaiser Family Foundation) [3]

**What does this mean?** The disruption in our social fabric caused by the pandemic has created a second pandemic!


Sources:

1. https://www.cdc.gov/nchs/data/databriefs/db303.pdf
2. https://www.cdc.gov/nchs/products/databriefs/db379.htm
3. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/view/footnotes/


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# Occurrence in Common Comorbid Medical Conditions

## Major depression frequently occurs in common comorbid medical conditions:

- Pain
- Arthritis
- Cardiovascular disease
- Diabetes
- Obesity

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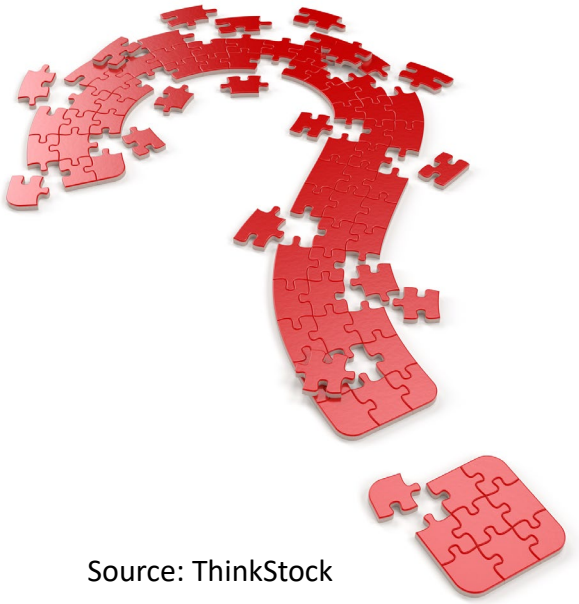
# Impact of Behavioral Health and Physical Comorbidity

- Depression, anxiety and sleep disturbance often co-occur with chronic conditions such as pain, diabetes, and cancer (and other chronic health conditions).
- Poorly managed behavioral health conditions negatively impact treatment for physical health conditions.
- Conversely, reasonably managed behavioral health conditions positively impact care.
- An integrated team approach supports whole-person care.
- A range of evidence-based nonpharmacologic interventions should be considered to maximize care planning (e.g., relaxation training, mindfulness, Motivational Interviewing, cognitive behavioral therapy, yoga).

# Poll Question 1

Who is most likely to identify and treat depression?

1. Primary care physician
2. OB/GYN
3. Psychiatrist
4. Psychologist/Social Worker



Source: ThinkStock

# Major Depression in Primary Care

- Common in primary care
  - >60% of anti-depressants prescribed by PCP
- Depression is often underdiagnosed
- Depression is often undertreated

# Why Undertreatment Matters

- Undertreatment leads to
  - continued symptoms of depression,
  - greater risk of relapse in patients, and
  - a significant waste of financial resources.
- Undertreatment impacts overall health and commonly co-occurs with chronic health conditions.

Source: Weilburg JB et al. Costs of antidepressant medications associated with inadequate treatment. Am J Manag Care. 2004;10(6):357-365.

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# Barrier: Medical Providers Don’t Address Depression

- Lack of training in medical school and during their residency.
- Patients with depression often don’t exhibit symptoms providers are trained to focus on.
- Underdeveloped interpersonal skills to elicit information needed for diagnosis.

Source: Hirschfeld RM et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA. 1997;277(4):333-340.

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# Barrier: Depression Diagnosis Time Constraints

Diagnosing and treating depression is significantly more time-consuming than diagnosing and treating strictly physical concerns.

Solution: an integrated team approach can significantly assist in identification and intervention.


Sources:

1. Davidson JR et al. The underrecognition and undertreatment of depression: what is the breadth and depth of the problem? J Clin Psychiatry. 1999;60 Suppl 7:4-9.
2. Practical strategies for diagnosing and treating depression in women at midlife and beyond. Changing Lives CME Series. Fort Worth, Texas: University of North Texas; 2007.

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# Barrier: Patient Presentation

- Patients rarely indicate depression or other behavioral health condition.
- Internalized stigma prevents acknowledgement.
- Many patients will not bring up concerns unless they are directly asked.

**Remember: If you don't ask, you don't know!**

Source: Hirschfeld RM et al. The National Depressive and Manic-Depressive Association consensus statement on the undertreatment of depression. JAMA. 1997;277(4):333-340.

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# Solution: Screening - a Quick, Evidence-based Solution

- Include questions about depression and other behavioral health conditions in general set of wellness questions presented to all patients (universal screening).
- Incorporate questions about depression into standard of care.
- Use the screening tool results to start conversation with patient about depression.

Source: Practical strategies for diagnosing and treating depression in women at midlife and beyond. Changing Lives CME Series. Fort Worth, Texas: University of North Texas; 2007.

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# Why Is Screening Important?

## Depression Screening Can:

- Improve accurate detection and treatment of depressed patients
- Improve health outcomes and decrease clinical morbidity of your patients
- Improve comorbid physical conditions of your patients
- Improve provider/clinic performance and clinical quality measures


Sources:
1. US Preventive Services Task Force. Screening for depression: recommendations and rationale. Ann Intern Med. 2002;136(10):760-764.
2. MacMillan HL et al. Screening for depression in primary care: recommendation statement from the Canadian Task Force on Preventive Health Care. Cmaj. 2005;172(1):33-35.

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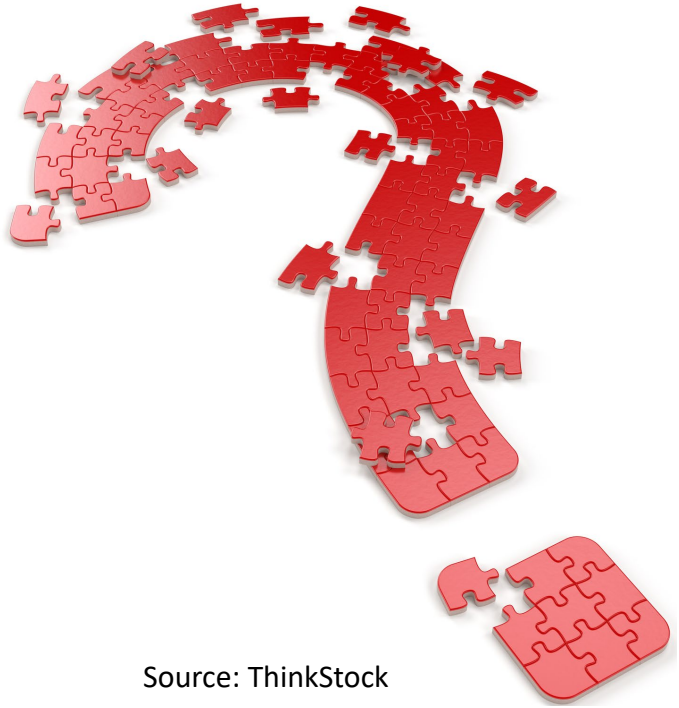
# Poll Question 2

Does your practice screen for depression?

1. Not at all
2. We screen patients with known behavioral health conditions
3. We universally screen all patients in our practice setting



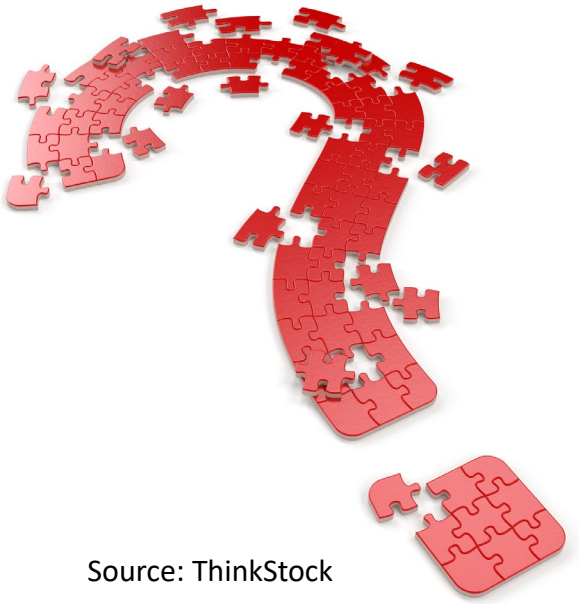
Source: ThinkStock

# Introducing the Patient Health Questionnaire-9 (PHQ-9) and its Variations

# Poll Question 3

How familiar are you with the PHQ-9?

1. Not at all familiar
2. Somewhat familiar
3. Very familiar



Source: ThinkStock

# About the PHQ-9

- Created **to effectively and quickly diagnose** some of the more common behavioral health disorders in a primary care setting
  - Depression
  - Anxiety
  - Somatoform
- Validated, publicly available and commonly used
- Clinical applications:
  - To universally screen patients for behavioral health comorbidities
  - To stratify patients into risk categories: low risk, moderate risk, severe risk
  - To ensure patients get access to and receive the appropriate level of care needed based on risk category

# The PHQ-9

## 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 |

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# Variations of the PHQ-9

- Multiple validated versions available based on your needs/constraints
  - Full PHQ-9 for adults
  - Full PHQ-9 for adolescents
  - PHQ-2
  - PHQ-3 = PHQ-2, plus Question #9 from PHQ-9

# The PHQ-2 & Considerations for Use

**The Patient Health Questionnaire-2 (PHQ-2)**

Patient Name _____ Date of Visit _____

| Over the past 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, depressed or hopeless | 0 | 1 | 2 | 3 |

- **Considerations for Use**
  - When your clinic resources don't allow for full PHQ-9 screening (some is better than none)
  - When behavioral health staff are available to follow up and administer full PHQ-9 or other screening if indicated
  - When your patient population indicates that the PHQ-2 works as effectively as the PHQ-9 in developing risk stratification categories

# The PHQ-3 & Considerations for Use

| PHQ-2 + Question 9 (PHQ-3) | | | | |
|---|---|---|---|---|
| **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, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

- **Considerations for Use**
  - Recommended with known uptick in mental health challenges during the pandemic
  - **Ensure self-harm is assessed and can be addressed immediately if needed**
  - Same considerations as PHQ-2

# PHQ-9 Scoring & Risk Stratification

# PHQ-9 Scoring

| Score | Depression Severity |
|---|---|
| 1 – 4 | Minimal/None |
| 5 – 9 | Mild |
| 10 – 14 | Moderate |
| 15 – 19 | Moderately Severe |
| 20 – 27 | Severe |

***A positive response to question 9 (self-harm) regardless of score should trigger intervention by behavioral health.***

## 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 |
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| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
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| 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 |
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| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

# How Do PHQ-9 Scores Inform Care?

| Score | Depression Severity/ Risk Category | Treatment/Care Approach |
|---|---|---|
| 1 – 4 | Minimal/None | Normal, no intervention indicated |
| 5 – 9 | Mild | Monitor or explore brief counseling |
| 10 – 14 | Moderate | Evidence-based psychosocial intervention (MI/CBT) |
| 15 – 19 | Moderately Severe | Psychosocial intervention (MI/CBT) and consider pharmacologic intervention |
| 20 – 27 | Severe | Pharmacologic intervention and psychosocial intervention |

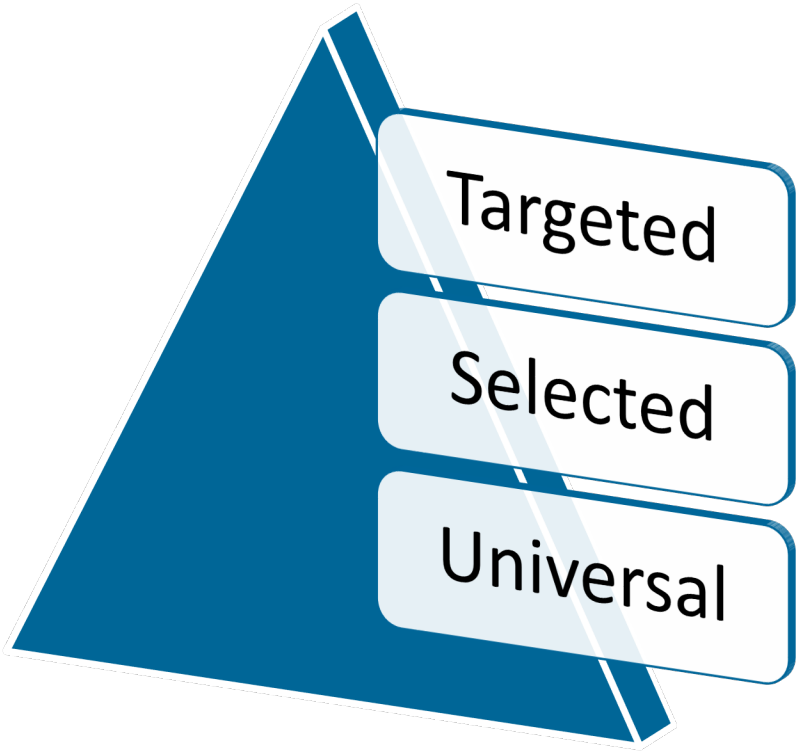
***A positive response to question 9 (self-harm) regardless of score should trigger intervention by behavioral health.***

# Key Treatment Approaches to Keep in Mind

- An integrated team approach supports whole-person care.
- ***A positive response to question 9 (self-harm) regardless of score should trigger intervention by behavioral health.***
  - If positive for self-harm conduct more intensive & sensitive screens or assessments and ensure the patient is seen by behavioral health staff
    - ✓ The Columbia-Suicide Severity Rating Scale (C-SSRS) is robust and recommended
- For more severe depression (PHQ score over 19), pharmacologic intervention should be a first approach.
  - **Note:** Many SSRIs and other psychiatric medications can impact metabolic syndrome.
- Patients scoring in any PHQ-9 severity level can benefit from a range of evidence-based psychosocial interventions (e.g., relaxation training, mindfulness, Motivational Interviewing, cognitive behavioral therapy, yoga).

# PHQ Screening Options & Workflow

# PHQ Screening & Workflow Options




# Universal Screening = Screen Everyone

**What does universal mean?**

As best you are able, triage **screen everyone** coming through the door.

**What does triage screen mean?**

- Use a short screening tool to quickly get results
  - PHQ-2/PHQ-3
- A triage screen is not a diagnostic tool.

**Who does universal screening?**

Medical assistants, nursing assistants, front desk staff (if included in check-in paperwork) behavioral health consultants

**Where does universal screening happen?**

Waiting room, exam rooms, telehealth visits, online portal

**When does universal screening happen?**

At least annually with wellness checks.

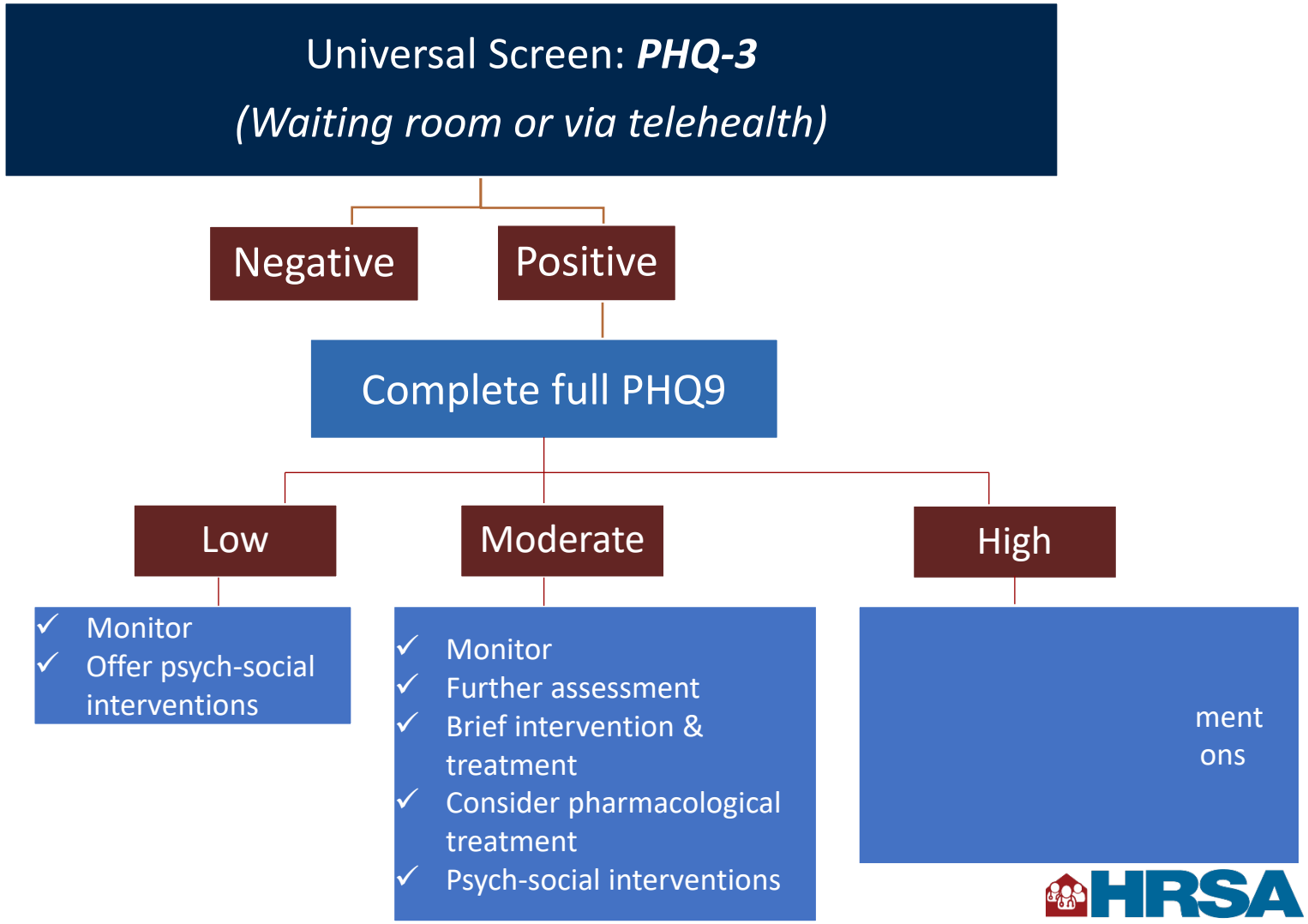
# Universal Screening: The first step in SBIRT

## Best Known As SBIRT

- **S**creening, **B**rief **I**ntervention, and **R**eferral to **T**reatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of identification, early intervention, and treatment services.
- Originally developed for early identification of risky or harmful substance use, but today commonly includes depression and anxiety screening.

# Universal Screening as part of an SBIRT Workflow

1. Screening is conducted **as part of Annual wellness visit**
2. Patient is triaged with PHQ-2 in waiting area, in exam room, portal or other virtual technology
3. A positive screen results in full screen and brief intervention
4. Follow-up including monitoring or BHP referral for further assessment and treatment




Sensitivity/Specificity: 88%/88%

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# Selected Screening = Patients with Chronic Conditions

Patients with **certain conditions should be routinely screened** for depression (and anxiety, and substance use).

Conditions such as:

- Chronic pain
- Diabetes
- Cancer

***A positive response to question 9 (self-harm) regardless of score should trigger intervention by behavioral health.***

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# Selected Screening

**What does selected mean?**

More frequent and in-depth screening with patients **at risk for depression or with comorbid conditions**

**What does screen mean?**

- Use a brief screening tool that can also help you stratify risk
  - Examples: PHQ-9, GAD7, AUDIT
- These screening tools may inform a diagnosis, but may not alone warrant a diagnosis

**Who does selected screening?**

- It depends on your practice setting and structure.
- Medical assistants, nursing assistants, behavioral health consultants, appropriate medical staff

**Where does selected screening happen?**

Waiting room, exam rooms, telehealth visits, online portal

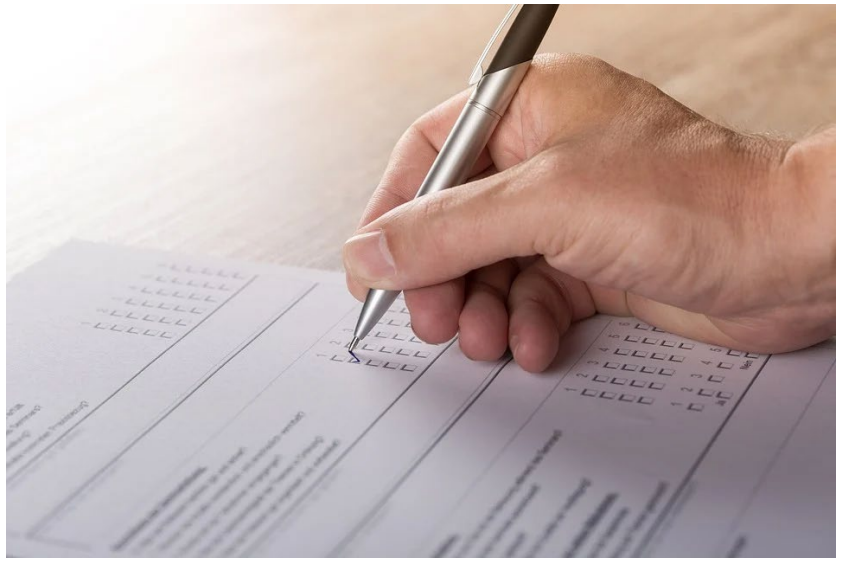
**When does selected screening happen?**

Frequently: **Quarterly – or at each visit**

# Targeted Screening = Patients with Diagnosed Depressive Disorder

**Patients with a depression diagnosis or with a PHQ score over 9 should be screened at every encounter to determine:**

- Are symptoms getting better or worsening?
- Is treatment working?
- Are patients reasonably doing what they need to do (treatment adherence, activation)?
- Are there concerns with activation?
- Does the plan need to be modified?



***A positive response to question 9 (self-harm) regardless of score should trigger intervention by behavioral health.***

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# Targeted Screening

**What does targeted mean?**

More frequent, in-depth screening to monitor and track treatment outcomes for patients with **known diagnosis**

**What does screen mean?**

- Use an assessment tool that can also helps you monitor treatment
- These tools may inform a diagnosis either alone or with other assessment information

**Who does targeted screening?**

- It depends on your practice setting and structure.
- Behavioral health consultants, appropriate medical staff

**Where does selected screening happen?**

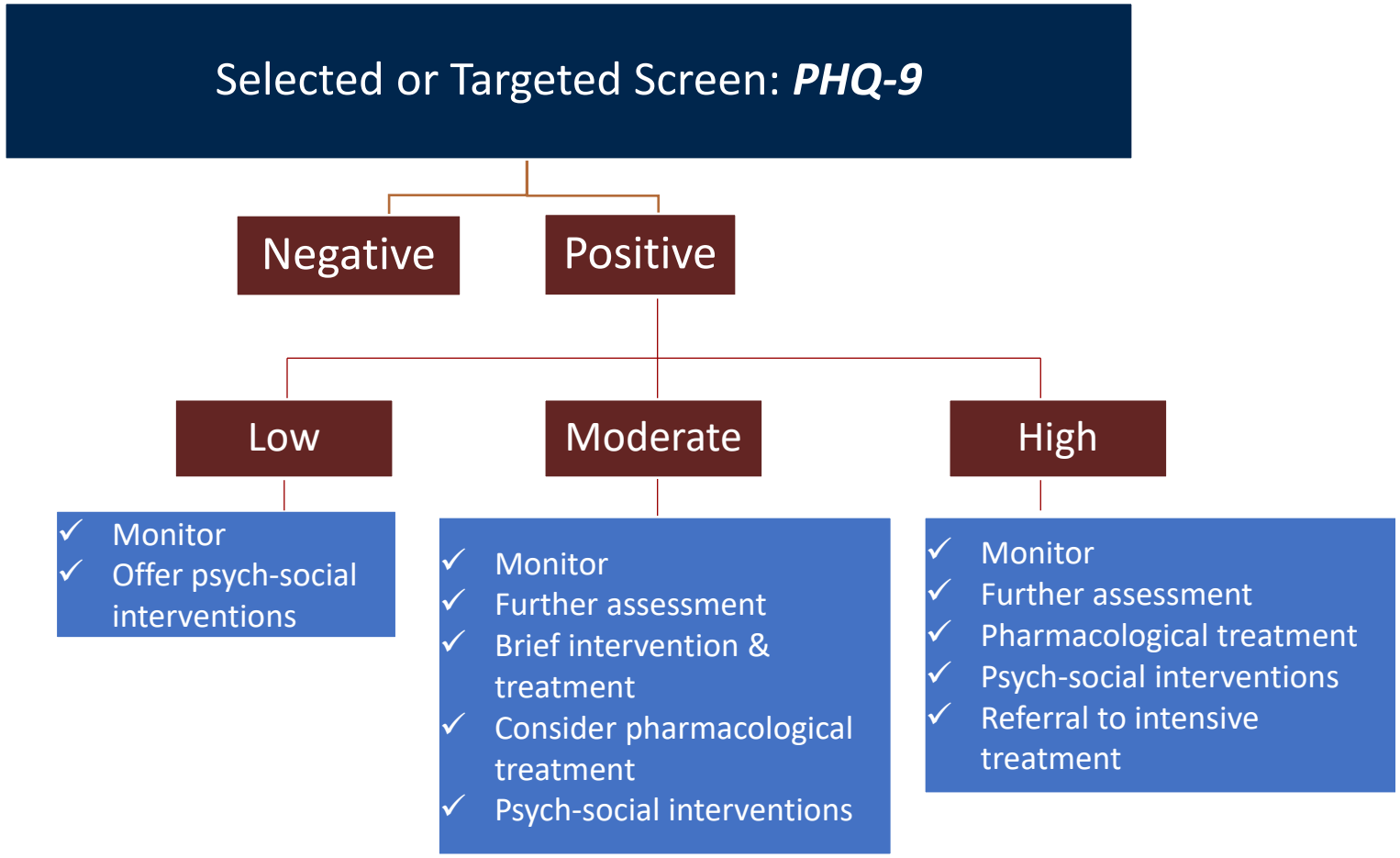
Waiting room, exam rooms, telehealth visits

**When does selected screening happen?**

Regularly: **At each visit**

# Selected & Targeted Screening in an Integrated Care Workflow

1. Triage screening for depression is part of the workflow **at each visit**
2. Patient is triaged using PHQ-9 in waiting area, or in exam room
3. A positive screen triggers additional screening/assessment, consult with behavioral health
4. Offering psych-social interventions at minimum




Sensitivity/Specificity: 88%/88%

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# Poll Question 4

What is your greatest barrier to implementing **universal screening**?

1. No barriers – we have fully implemented
2. Getting buy-in from leadership to implement universal screening
3. Identifying when to administer universal screening
4. Identifying the best place or format for universal screening
5. Identifying who should administer universal screening
6. Having resources to support patients who screen positive
7. Other

Source: ThinkStock

# Poll Question 5

What is your greatest barrier to implementing **selected or targeted screening**?

1. No barriers – we have fully implemented
2. Identifying when to administer selected/targeted screening
3. Identifying who should administer selected/targeted screening
4. Having resources to support patients who screen positive
5. Knowing resources for referral to intensive treatment
6. Other

Source: ThinkStock

# Key Takeaways to Consider Moving Forward

## Screening for depression and other behavioral health conditions should be a standard of care because:

- If you don't ask, you don't know!
- Screening can be easily adopted into differing types of workflow: With every annual physical, periodically for patients with comorbid health conditions, at every clinical encounter for patients with major depression.
- Universal screening is a core component of value-based care models.
- Untreated or poorly managed depression negatively impacts physical health and contributes to chronic health conditions.
- An integrated approach between physical health and behavioral health yields better results for patients with chronic health conditions.
- Screening can connect patients to a range of evidence-based behavioral health interventions that support health and well-being.
- Screening should be used to monitor progress.

# We're Here to Help!

- The new UDS measures for care planning and screening for remission have caused some concerns within health centers.
- Implementing depression screening can feel overwhelming and challenging
- We can provide TA support in this area
  - 1:1 coaching
  - Up to a 4-hour site visit
- What we can provide support with:
  - Support training your staff in effective and appropriate depression screening
  - Workflow development and implementation of depression screening

# Thank you! Questions?

# Current TA Opportunities

- One-on-One Coaching
- Site Visits (Virtual)
- Community Outreach Using Social Media

To register go to: https://bphc-ta.jbsinternational.com/

# Upcoming TA Opportunities!

## Webinars

- **Strategies for Addressing Health Disparities in Medication Assisted Treatment for Opioid Use Disorders**

  *Wednesday, June 2, 3:00 – 4:00 PM ET*

*Registration Link:* **https://zoom.us/webinar/register/WN_hUz8J4lvQ0eidc8x6XCkFQ**

- **Reducing Health Disparities by Addressing Integrated Behavioral Health in a Maternal Child Health Care Setting**

  *Thursday, July 29, 3:00 – 4:00 PM ET*

*Registration Link:* **https://zoom.us/webinar/register/WN_smCvIfV5RP2qz5awjlYZrA**

**You can receive 1 hour of Continuing Education credit for your participation.**

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# Upcoming TA Opportunities!

## Communities of Practice (CoP) – Weekly for 6 Sessions

- **Social Determinants of Health and Integrated Care**
  - *Cohort 1: Tuesdays, 4/27/21 – 6/1/21, 2:30–4:00 p.m.*
    **REGISTRATION IS CLOSED**
  - *Cohort 2: Tuesdays, 6/8/21 – 7/13/21, 2:30–4:00 p.m.*
    **https://zoom.us/meeting/register/tJYkdeivqz4jHNGwrJzV8L4gUoaxTCSCPGLu**

- **Integrated Behavioral Health and Value-Based Reimbursement: Two Sides of the Sustainability Coin**
  - *Cohort 1: Thursdays, 4/29/21 – 6/3/21, 2:30–4:00 p.m.*
    **REGISTRATION IS CLOSED**
  - *Cohort 2: Thursdays, 6/10/21 – 7/15/21, 2:30–4:00 p.m.*
    **https://zoom.us/meeting/register/tJUuduqhpjIuHtwabD2xSdkmuHLR5Qju0XeD**

# Continuing Education Credit

- We will be offering **1 CE credit** for attending today's webinar.
- You **must** complete the Health Center Satisfaction Assessment after **each** session you plan on receiving CEs for.
- **CE credits will be distributed to webinar participants who complete the Satisfaction Assessment within 2 weeks of the webinar.**
- We will provide details on how to complete the Satisfaction Assessment at the end of the webinar.

This course has been approved by JBS International, Inc. as a NAADAC Approved Education Provider, for educational credits. NAADAC Provider #86832, JBS international, Inc. is responsible for all aspects of their programming.

JBS International, Inc. has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6442. Programs that do not qualify for NBCC credit are clearly identified. JBS International, Inc. is solely responsible for all aspects of the programs.

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# Health Center Satisfaction Assessment

**You MUST complete the Health Center Satisfaction Assessment after each session for which you plan on receiving CEs.**

- The link to the Satisfaction Assessment will automatically open in your browser at the conclusion of this webinar.
- You can also click the link for the Satisfaction Assessment provided in the Zoom chat feature—click the link now to open it in your browser.
- We will also email you a link to the Satisfaction Assessment.

**Please take 2–3 minutes to complete the Satisfaction Assessment directly following this session.**

**Thank you!**

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Health Resources & Services Administration

# Thank You!

## Presenter Contact Information:


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