2017 Tenth National Doctors of Nursing Practice Conference: New Orleans Celebrating 10 Years

Diversity & Inclusion in Practice

Improving Depression Screening and Primary Care Collaboration with Behavioral Health Community Providers

Kara Schrader, DNP, NP-C
Family Nurse Practitioner MSU HealthTeam Michigan State University College of Nursing
Objectives

- Update the epidemiology of depression within the US
- Awareness of the importance of recognizing depressive disorders and early initiation of treatment
- Review methods of screening and barriers to screening within a primary care clinic
- Discuss evidenced based methods for depression care workflow within the primary care clinic
- Offer options for improving access to behavioral health providers and collaboration
Major Depressive Disorder (MDD)

◆ Depression is the leading cause of disability worldwide (WHO, 2015)

◆ Familial and societal burdens associated with under recognized and/or undertreated depression (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013)

◆ Decrease in work productivity
◆ Substance abuse
◆ Disability
◆ Unemployment
◆ Suicide
Major Depressive Disorder (MDD)

◆ Increasing financial burden of depression in the United States (US):
  ◆ $173.2 billion in 2005 to $210.5 billion in 2010

(Atkinson, et al., 2013; Greenberg, Sisitsky, Crystal, & Kessler, 2015)

FOR EVERY $1 IN TREATMENT FOR ANXIETY AND DEPRESSION RETURN ON INVESTMENT IS $4

(Chisholm, et al., 2016)
Major Depressive Disorder (MDD)

- 6.6% of adult population with episode MDD in past 12 months though only 1/3 obtain treatment (Substance Abuse and Mental Health Services, 2015)
- Due to stigma, short appointment times or cultural assumptions, feeling depressed not often shared or apparent (Conner, et al., 2010; Coventry et al., 2011)
- Can present with different symptoms
- Often co-exists with anxiety
- Early and appropriate treatment improves symptoms and can prevent adverse outcomes (Substance Abuse and Mental Health Services, 2015)
- Associated with increased morbidity with many co-existing chronic illnesses
Depression and Chronic Illness

◆ Cardiovascular Disease
  ◆ Higher mortality rates with co-morbid depression (Leung et al., 2012; Saint Onge, Krueger & Rogers, 2014)
  ◆ Depression independent predictor of poorer outcomes in coronary heart disease (Leung et al., 2012)

◆ Chronic Pain
  ◆ Increased opioid misuse (Grattan, Sullivan, Saunders, Campbell, & Von Korff, 2012)
  ◆ Increased opioid tolerance, poorer pain control (Wasan et al. 2015)
  ◆ More likely to have prescription written for opioids (Kapoor & Thorn, 2014)
Depression and Chronic Illness

◆ **COPD**
  - 59-65% higher risk of depression (Atlantis, Fahey, Cochran & Smith, 2013)
  - Depression increases mortality risk by 83% (Atlantis, Fahey, Cochran & Smith, 2013)

◆ **Dementia**
  - 87-92% increased risk with history depression
  - Two or more episodes doubles risk (Dotson, Beydoun, & Zonderman, 2010)

◆ **Diabetes**
  - Multiple studies showing association with higher rates of depression (Green, Basata, Fox & Grandy, 2012; Nouwen et al., 2010)
Major Depressive Disorder (MDD)

◆ Criteria #1:
  ◆ 5 or more of the following symptoms nearly every day in the same 2 weeks—
    depressed mood or loss of interest or pleasure must be one of the 5 symptoms:
  ◆ Depressed mood most of the day *
  ◆ Decreased interest in pleasure or interest in the normal activities of one’s life *
  ◆ Weight loss or weight gain or change in appetite
  ◆ Insomnia or Hypersomnia
  ◆ Psychomotor agitation or retardation (restless or moving slowly)
  ◆ Fatigue or loss of energy
  ◆ Feelings of worthlessness or excessive guilt
  ◆ Decrease ability to concentrate
  ◆ Recurrent thoughts of death, recurrent suicidal ideation with or without plan

◆ Criteria #2: The symptoms cause significant distress or impairment

◆ Criteria #3: Cannot be caused from the effects of a substance, or medical condition

Screening recommendations

Screening for depression recommended by:

◆ The United States Preventative Services Task Force [USPSTF] (USPSTF, 2016)

◆ American Association of Family Physicians [AAFP] (AAFP, 2016)

◆ American Diabetes Association [ADA] (ADA, 2017)

◆ Institute for Clinical Systems Improvement [ICSI] (ICSI, 2016)

All recommendations: screen only if system in place for follow-up of positive screens
Primary care role in assessment and management of depression

◆ Institute of Medicine’s definition of primary care:
  ◆ “Primary care is responsible for the majority of personal health care needs, which include physical, mental, emotional, and social concerns” (Donaldson, Yordy, Lohr, & Vanselow, 1996, p. 3)
Depression screening in primary care settings

Primary care providers:

- Have the more opportunities for contact
- Typically have built trust
- Have ability to assess for associated social determinants
- Linkage to early and effective treatment
Depression screening in primary care settings

Depression and anxiety most often managed in the primary care setting (Beck et al., 2011; SAMHSA, 2013)

◆ Primary care providers have ability to diagnose depression though often miss it (Mitchell, MJ, Vaze, A., Rao, S., 2009)

◆ 2012-2013: 4.2% adults screened (Ackincigil & Matthews, 2017)
Depression screening in primary care settings

◆ Merit Based Incentive Payment System (MIPS) 2017
  ◆ Formally PQRS
  ◆ Depression care with measurements
    ◆ Coordination of care for adults with MDD and specific co-morbid conditions+
    ◆ Suicide Risk Assessment for adults and children/adolescents+ with MDD
    ◆ Anti-depressant medication management in adults
    ◆ Consumer Assessment of Healthcare Providers and Systems group survey: communication and access to specialists +
    ◆ Depression remission at six months (PHQ-9 <5) +, *
    ◆ Depression remission at six months (PHQ-9 <5) Depression remission at twelve months (PHQ-9 <5) +, *
    ◆ Utilization of PHQ-9 tool for adults with diagnosis of depression/dysthymia during 4 month period
    ◆ Screening for clinical depression and documented follow-up plan (ages 12 and older)

+high priority item
*with screening score >9
Depression screening in primary care settings

- Reasons stated for not screening
  - Providers often assume that they know their patients well enough to recognize depression
  - No workflow in clinic to screen
  - Time involved to screen
  - Increasing complexity of patients being seen
  - Comfort of provider
  - No universal reimbursement
  - Inability to follow-up due to overbooked schedules
  - Limited access or knowledge of available behavioral health services (Alson, et al. 2016; Mitchell, Vaze, & Rao, 2009)
Barriers to adequate depression care in primary care

◆ **Treatment to goal measures low**
  ◆ Provider discomfort with management or understanding of treatment guidelines
  ◆ Less aggressive treatment when other chronic conditions present \cite{gill2008}

◆ **Inadequate time to follow-up a + depression diagnosis**
  ◆ Decreased adherence to treatment \cite{tamblyn2014, warden2014}

◆ **Over-utilization of medications** \cite{rhee2016}

◆ **Financial non-sustainability for care management assistance or collaborative care**

◆ **Care management services prioritized for other chronic illnesses and population health measures**
Limitations of referral to behavioral health services

- Behavioral health (BH) provider access limited
- Carve out system
- Lack of workflow for initial referral to BH
- Psychiatry provider shortage
- Process of follow-up on referrals to BH services not given same priority as other specialties (Kessler, et al. 2014)
- Lack of knowledge of community BH resources (Kravitz, et al., 2005)
National shortage of psychiatry providers

- Few accept publicly funded insurances (Kaiser Commission on Medicaid and and the Uninsured, 2013)
- Low reimbursement rates from state Medicaid programs (National Council for Behavioral Health, 2017)
- 40% of the nation’s psychiatry workforce practice only in “cash-only” private practice (National Council for Behavioral Health, 2017)
- Psychiatry providers do not have the resources or training to deal with the multiple social determinants that are associated with severe depression and anxiety in the Medicaid population (National Council for Behavioral Health, 2017)
- 77% of US counties are considered underserved in regards to psychiatry (National Council for Behavioral Health, 2017)
- 55% states are considered to have a serious shortage of psychiatry providers that specialize in child and adolescent psychiatry (National Council for Behavioral Health, 2017)
- The majority of primary care providers report difficulty in obtaining psychiatric care access (Cunningham, 2009)
Screening Tools

◆ Patient Health Questionnaire 9 (PHQ-9)
  ◆ Nine questions
  ◆ Assesses severity of depression
  ◆ A score of 9 or greater specificity 85%, sensitivity 95% for depression
    (Kroenke et al., 2001)
  ◆ Available in most EHRs

◆ PHQ-2
  ◆ Adapted from PHQ-9
  ◆ Two questions
  ◆ Cut off score of 3 or greater 90% specific, 89% sensitive for depression
  ◆ Score greater than 3 requires screen with PHQ-9
    (Kroenke, Spitzer & Williams, 2003)
**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)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: \[0 + 1 + 2 + 3\] = 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 □

Developed by Drs. R.L. Spitzer, J.B. Williams, K. Kroenke and colleagues with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.
Both PHQ-2 and PHQ-9 free and easy to use, efficient and have appropriate validity to use for screening in primary care (Narayana & Wong, 2014)

Patient Health Questionnaire-2 (PHQ-2)

Instructions:
Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:
0=Not at all; 1=Several days; 2=More than half the days; 3=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

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Other Screening Tools

◆ Beck’s Depression Inventory
  ◆ 21 questions
  ◆ Score greater than 4 specificity 99%, sensitivity 97%
  ◆ Requires fee to use
  ◆ More time needed than PHQ-9 (Beck, et al., 1961, Narayana & Wong, 2014)

◆ World Health Organization Five (WHO-5)
  ◆ Five item scale
  ◆ Looks at wellbeing and percent change
  ◆ No fee
  ◆ More sensitive, less specific than PHQ-2 (Narayana & Wong, 2014)
"The raw score is calculated by totaling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life. To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

Interpretation:
It is recommended to administer the Major Depression (ICD-10) Inventory if the raw score is below 13 or if the patient has answered 0 to 1 to any of the five items. A score below 13 indicates poor wellbeing and is an indication for testing for depression under ICD-10.

Monitoring change:
In order to monitor possible changes in wellbeing, the percentage score is used. A 10% difference indicates a significant change."  (WHO-5, English version, page 2)
Best care for Depression in Primary Care Settings

- **Integrated Care:** Primary care Providers, Clinical Pharmacists, RN Care Managers, on-site behavioral health provider/psychiatry
  - Most evidenced based to improve outcomes
  - Decreases fragmentation of health care
  - Supported by National Committee on Quality Assurance (NCQA), Institute of for Clinical System’s Improvement (ICSI), AAFP, APA, IOM and many others
  - Agency for Healthcare Research and Quality (AHRQ) Patient Centered Medical Homes (PCMH)
    - #1 Key function: Comprehensive Care, #3 Coordinated Care
  - Full reimbursement for services lacking
  - Expensive, need funding and community support for sustainability

Other Care Models

◆ Collaborative Care: Care manager (RN or MSW) utilized for liaison between PCP, patient and BH
  ◆ Based upon the Chronic Care Model components
  ◆ Psychiatry usually not co-located though accessible
  ◆ Cases discussed on routine basis with psychiatry and recommendations forwarded by care manager to PCP
  ◆ Has shown effectiveness in improving outcomes of depression and other chronic illnesses
  ◆ Reimbursement also an issue

(Peck, C.J. 2013; Thota, et al., 2012)
No resources or support for defined integrated or collaborative care?

◆ Need workflow for follow up and access to BH resources if screening for depression
◆ Need workflow/policy when screening for suicide
◆ Mild and moderate depression effectively treated by education about depression and self care, and psychotherapy (ICSI, 2016)
◆ Often difficult for patient to initiate BH services
◆ Setting up a referral process from primary care office to BH provider requires community BH provider involvement
◆ Behavioral health network
Setting up a behavioral health network

- **Begin making calls**
  - Get to know a few community BH providers
  - Word gets out

- **Make a resource/catalogue of therapists or therapy groups**
  - Licensing, qualifications
  - Location
  - Insurance panel or cash payments?
  - Wait times
  - Association with psychiatry
  - Inquire if they accept direct referrals and best method (HIPPA compliant fax?)

- **Check with state rules regarding the sharing of BH information**

- **Create special referral form to help facilitate referral**

- **Request confirmation of services and/or short consult note**
Setting up behavioral health network

◆ Educate staff regarding workflow process
◆ Emphasize the importance of initiating and following up on referrals
◆ Still need PCP clinic follow up to assess for improvement
◆ Connect often with BH providers to assess process
◆ Consider meet and greet “fairs” for PCPs and BH providers
Resources

- Lexicon for Behavioral Health Integration “Lexicon”
  https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
- 2017 MIPS quality measures
  https://qpp.cms.gov/mips/quality-measures
- Example of a referral to behavioral health services (Community Care of NC)
- Example of BH communication to PCP (Community Care of NC)
- Example of a flowchart for BH referrals (Dept of health Sarasota, FL county)
- Link to Columbia Suicide Severity Rating Scale
  http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/
- Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
  http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/healthcare/
- PHQ-9 for Adolescents:
References


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