Implementing and Improving Depression Screenings in the Primary Care Setting

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Behavioral Health Project Manager
Today’s Objectives

Participants will:

• Increase understanding of how to implement depression screenings in the primary care setting

• Understand the importance of continuously monitoring patients’ depressive symptoms to attain remission

• Consider one action/goal to take back to practice
Utah with High Rates of Depression

Utah Suicide Rates

Suicide by Sex and Year, Utah and U.S., 1999-2014 and U.S. 1999-2013

Data Table

Suicide by Sex and Year, Utah and U.S., 1999-2014 and U.S. 1999-2013

<table>
<thead>
<tr>
<th>UT M, UT F, US M, US F</th>
<th>Year</th>
<th>Age-adjusted Rate per 100,000 Population</th>
<th>Lower 95% CI</th>
<th>Upper 95% CI</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah Males</td>
<td>1999</td>
<td>24.3</td>
<td>21.2</td>
<td>27.7</td>
<td>241</td>
<td>1,094,405</td>
</tr>
<tr>
<td>Utah Males</td>
<td>2000</td>
<td>22.4</td>
<td>19.4</td>
<td>25.7</td>
<td>222</td>
<td>1,124,675</td>
</tr>
</tbody>
</table>

2014 Suicide Rates

- Suicide was the leading cause of death for Utahns ages 10-17 and 18-24
- Second leading cause of death for ages 25-44
- Fourth leading cause of death for ages 45-64
- Overall, suicide is the eighth-leading cause of death for Utahns ages 10+

Depression Treatment in Primary Care

- Between 13.1 and 14.2 million U.S. citizens will experience an episode of major depressive disorder\(^1\)
- 1978: Large national study found that > 50 percent with depression treated in primary care -- “The de facto mental health system”\(^2\)
- Depression costs the U.S. $40 billion annually\(^3\)
- Medication treatment is the most widely used intervention\(^3\)

Depression Treatment in Primary Care

Between 13.1 and 14.2 million will experience MDD

• Half will seek help
• 10 to 20 percent of those will receive adequate treatment
  – Of those, only 30 percent reach remission
• Patients with two or more failed treatment responses present complex problems\(^1\)
• Significant issues impairing patient improvement:
  – Lack of symptom monitoring, follow-up, and treatment intensification\(^2\)

Consequences of Failure to Achieve Remission

- Increased risk of relapse and recurrence
- Increased risk of treatment resistance
- Continued psychosocial limitations
- Decreased ability to work and workplace productivity
- Increased costs to patients and health system
- Sustained suicide and addiction risk
- Worsened morbidity/mortality of other conditions
Remission Rates

• Remission rates in primary care practices over a 2-year period are estimated at only 45 percent\textsuperscript{1}

• Depressed patients who were unimproved or partially improved after six weeks of SSRI treatment had the lowest chance to reach remission by week 10\textsuperscript{2}


The 5 R’s of Depression Treatment Outcomes

1. Response: Clinically significant reduction in overall symptom severity relative to beginning of treatment

2. Remission: Absence of symptoms

3. Recovery: Sustained period of remission following an episode of major depression

4. Relapse: Return to a major depressive episode during continuation treatment (i.e., before recovery)

5. Recurrence: New depressive episode following recovery of previous episode
“Recovery” and “remission” are often used interchangeably.

Distinction may not be drawn between response and remission.

But remission should always be the goal of treatment!
Remission Challenges

- Accuracy of diagnosis
- Partial response
- Medication sub-optimization
- Failure to capture residual symptoms
- Substance abuse
- Co-morbidities
- Care access
- Non-adherence*
- Stigma

*Strongest predictor of relapse, rehospitalization, and non-remission

Premature Treatment Discontinuation

• Triggered by a number of factors
  – Lack of adequate education about the disease
  – Failure on the part of physician or patient to establish goals for follow-up
  – Psychosocial factors
  – Adverse side effects

• Appropriate ongoing collaborative care can increase remission rates to as much as 76 percent by 24 months

Adult depression in primary care. Retrieved from the AHRQ Website at: https://www.guideline.gov/summaries/summary/47315
Using PHQ-9 to Diagnose and Provide Proactive Follow-Up to Monitor Progress
Best Practices: Managing Patients to Remission

• Use of standardized screening tools (PHQ-9) and proactive follow-ups to monitor and manage treatment\(^1,2\)
• Collaborative team approach\(^3\)
• Comprehensive ongoing patient and family education
• Setting goals with patients
• Collaboration with mental health

## Patient Health Questionnaire-9

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

<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>
Intermountain Healthcare CPM

Available at https://intermountainhealthcare.org
Measurement Algorithm

Begin Antidepressant Therapy

Two week follow-up. Phone call or visit. Reinforce education and assess side effects.

Four week follow-up. Repeat PHQ-9.

- Good response
  - Continue therapy
  - Follow up in 4 more weeks
- Partial response
  - Increase dosage by 50% or augment
  - Consider psychotherapy
- No response
  - Assess for compliance, bipolar disorder, active substance abuse, other precipitating factors
  - Follow up in 4 weeks

Eight week follow-up. Repeat PHQ-9.

- Good response
- Partial response
  - Increase dose by 50%, switch, augment
  - Add psychotherapy
- No response (after initial trial)
  - Reassess compliance
  - Switch medication to another 1st line drug
  - Add psychotherapy
- No response (after 2 four week trials)
  - Reassess compliance
  - Continue until response is good

12 week follow-up Repeat PHQ-9

- Good response
  - Continue therapy until remission achieved
- No response (after initial response)
  - Augment if not already tried
- No response (after 2 four week trials)
  - Inadequate response after 3 trials, refer for psych eval

Remission and Maintenance

- Follow-up every 3 months; repeat PHQ-9
- 1st Episode: taper after 9 – 12 months of remission, consider long term maintenance, if needed

Adapted from Intermountain 2015 Depression Care Process Model. Available at https://intermountainhealthcare.org
Summary of Follow-up Schedule

• Two weeks: Phone call or visit
• Every four weeks with repeat PHQ-9 until GOOD RESPONSE
• Every three months until nine to 12 months of remission achieved

Intermountain 2015 Depression Care Process Model. Available at https://intermountainhealthcare.org
PHQ-9 Response Definitions

1. **Good Response:** PHQ-9 severity score improves by $\geq 25$ percent, or absolute score is $<5$

2. **Partial Response:** PHQ-9 severity score improves, but by $<25$ percent

3. **No Response:** No or insignificant improvement in PHQ-9 severity score

**For any failure to respond:** Assess patient adherence and review for Bipolar Disorder, active substance abuse, comorbid medical conditions like thyroid disease and other precipitating factors.

*Intermountain 2015 Depression Care Process Model. Available at https://intermountainhealthcare.org*
Collaborative Care, Patient Education, and Goal Setting
Team Approach is Best

- Randomized controlled trials demonstrate the effectiveness of the collaborative care model, in which primary care treatment of depression is provided by a team
  - Improved medication compliance
  - Reduced relapse risk
  - Reduced suicidal ideation
  - Improved provider satisfaction¹,²

Team Approach Cont.

• A team member to utilize the tracking system, make frequent contacts with the patients to provide further education and self-management support, and monitor for response in order to aid in facilitating treatment changes and in relapse prevention

• Communication between primary care team and psychiatry to consult frequently and regularly regarding patient under clinical supervision, as well as direct patient visits as needed
Discussion Questions

How well does your practice promote team-based care?

Could a team approach be used for depression care in your practice?
  – What kinds of activities might a team do?
Patient Education is Critical

• Take your medication daily
• You must take your medication for two to four weeks before there may be a noticeable effect
• Continue taking your medication, especially if you feel better
• Do not stop taking your medication without checking with your provider
• Expect side effects; they should improve in one to two weeks
Patient Education

• Depression is not a character flaw
  – Biological disease with high heritability

• Antidepressant therapy must be closely monitored initially to determine effectiveness (may require change as only half respond to first medication prescribed)

• Make sure medications are affordable

• Encourage patients to share concerns and misperceptions about treatment

• Treatment goal is remission – explain the entire process
Behavioral Activation

• Help patients set up self-management goals that include increasing positive interactions
  – As effective as antidepressant and traditional psychotherapy
  – Regular outings, get-togethers, participation in activities likely to reduce depression
• Reinforce positive to slowly replace negative coping skills learned during depressive episode

Setting Activation Goals

• Focus on resuming old pleasurable activities patients have avoided
  – Don’t recommend new life or health goals due to high risk of failure
• Small, sequential, attainable steps each week with high likelihood of success
• Short and long-term goals
• Congratulate all efforts
Prescribing Continuous Exercise

- Continuous exercise works well as monotherapy or as augmentation to medication in moderate depression\(^1\), and treatment resistant depression in women\(^2\).
- Aerobic not more effective than strength training\(^3\); mixture seems to be best\(^4\).
- Intensity appears to have more effect than frequency (but must be continuous).

When to Refer for Psychiatric Consultation

- Patients experiencing suicidal thoughts, especially if they have plans, intent and/or high anxiety
- Have history of Bipolar Disorder
- Are actively abusing drugs or alcohol
- Are experiencing hallucinations or delusional thinking
- Are not improving after three trials of antidepressant therapy

Intermountain 2015 Depression Care Process Model. Available at https://intermountainhealthcare.org
Best Free Local Resource!

Project ECHO
Behavioral Health

Behavioral health concerns are pervasive across the United States with approximately one in five Americans suffering from a mental disorder. A recent report from the Substance Abuse and Mental Health Services Administration cites Utah as having the highest rate of mental illness in the country (22.4%). Moreover, mental disorders are the leading cause of disability in the US. Behavioral Health ECHO aims to support community providers in patient management by offering specialist consultation (case-based learning), in addition to traditional didactic presentations.

Behavioral Health ECHO clinics occur every other Friday from 7:30 to 8:30 AM (MST) and will typically be comprised of case presentations and—time permitting—a didactic presentation pertaining to some aspect of mental health (not necessarily related to any particular case presentation). Please consult our Clinic Times for specific dates and times.

Clinic Times
Every other Friday 7:30–8:30 AM (MST)

Clinical Team
Paula Gibbs, MD
Medical Director-5 West Med-Psych Unit
Email: paula.gibbs@hsc.utah.edu

Jordan Holloman
Program Coordinator

http://healthcare.utah.edu/echo/behavioral-health.php#overview
Consider: What One Thing Can My Practice Do to Impact Depression Care?

• Develop team care approach
• Improve patient education
• Implement use of screening tool to diagnose MDD
• Use screening tool to diagnose AND monitor symptoms to remission
• Consider alternative types of treatment
  – Behavioral activation
  – Prescribing exercise
• Join Project ECHO
Handouts

**Improving Behavioral Health for Older Adults**

**Depression and Alcohol Screening Site Information Form**

1. What proportion of your patients are treated for a behavioral health condition in your clinic? ____________________________

2. What proportion are referred out? ____________________________

3. Are there existing efforts for:
   a. Depression screening? ____________________________
   b. Alcohol screening? ____________________________

4. Are standardized screening tools used? Which tools, who administers and scores? How is screening done? (paper, iPad, EHR)
   a. Depression screening ____________________________
   b. Alcohol screening ____________________________

5. How is clinic coding and billing? (Single visits, Annual Wellness Visits, Which codes are used)
   a. Depression screening ____________________________
   b. Alcohol screening ____________________________

6. What type of education do newly diagnosed patients receive? Who provides it? ____________________________

7. How often are newly diagnosed patients seen? What are follow-up intervals? ____________________________

8. Does staff receive training on how to work with behavioral health patients? How often? ____________________________

9. Do providers receive training on diagnosis and treatment for patients with behavioral health issues? ____________________________

**Gap Analysis:**

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<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
<th>Action Steps</th>
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Nevada * New Mexico * Oregon * Utah
healthinsight.org/improving-behavioral-health
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