

Depression Screening Tools: Policy and Nephrology Social Work Interventions



QIRN3 ANNUAL MEETING

PINES MANOR

EDISON, NJ

By

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Financial Disclosure

- I have no financial relationships or conflicts of interest to disclose.
- However, I am open to having my professional integrity tested, for cash.



Learning Objectives

- State the **purpose** of Depression Screening in the CMS Quality Incentive Program for CY 2016.
- Explain how to **implement** the policy in your dialysis clinic.
- Identify **treatment plans** for the signs and symptoms of depression.

History of Depression

- Depression was initially called "melancholia". The earliest accounts of melancholia appeared in ancient Mesopotamian texts in the second millennium B.C.
- In 1621, Robert Burton published *Anatomy of Melancholy*, in which he described the psychological and social causes (such as poverty, fear and solitude) of depression.
- Towards the beginning of the 19th century, new therapies for depression included water immersion (keeping people under water for as long as possible without drowning them) and a special spinning stool to induce dizziness (to rearrange the contents of the brain into the correct positions).

*Historical Understandings of Depression: Rashmi, Nemade, PhD.,
Natalie Staats Reiss, PhD., and Mark Dombeck, PhD. Sept 19, 2007*



Global Burden of Disease

- A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020.
- A collaborative effort between the Harvard School of Public Health, the World Health Organization (WHO) and the World Bank.
- Edited by Christopher Murray – Harvard University and Alan Lopez – WHO.



Global Burden of Disease

- Unipolar Major Depression – Accounted for 11% of all disabilities worldwide in 1990 (#1).
- The number one leading cause for disease burden for women in 1990.
- Projected to be the second leading cause of disease burden worldwide by 2020.



Worldwide Depression

- **350,000,000** - The number of people globally who are [affected by some form of depression](#).
- Over 800,000 people die due to suicide every year.
- fewer than half of those affected in the world (in many countries, fewer than 10%) receive treatment.

World Health Organization – Depression Fact Sheet – October 2015.

WHO-Age Standardized Suicide Rates

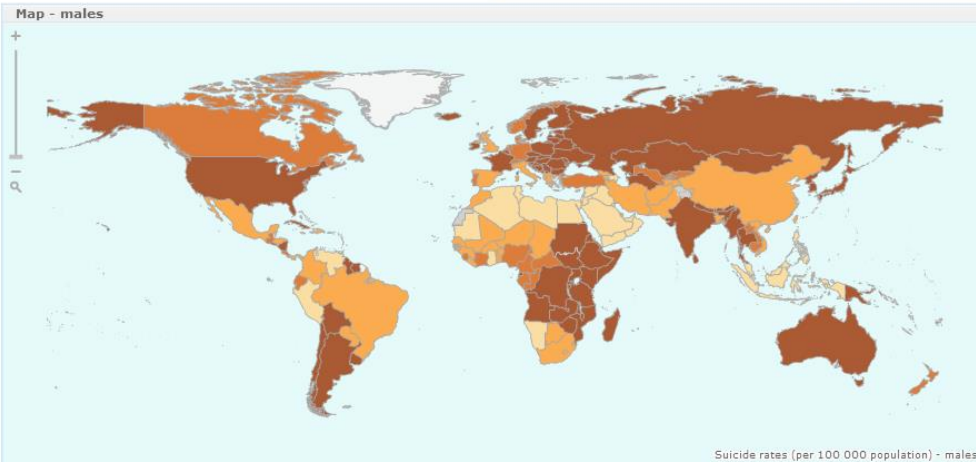


Mental health
Age-standardized suicide rates (per 100 000 population), 2012

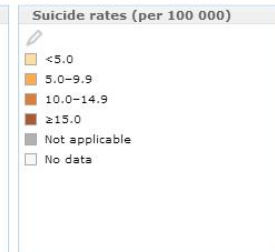
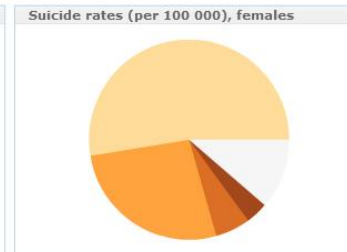
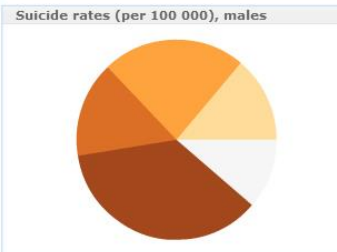
Switch map view (males/females)

Help

Suicide rates (per 100 000 population)		
Country ▲	Males	Females
Afghanistan	6.2	5.3
Albania	6.6	5.2
Algeria	2.3	1.5
Andorra	No data	No data
Angola	20.7	7.3
Antigua and Barbuda	No data	No data
Argentina	17.2	4.1
Armenia	5	0.9
Australia	16.1	5.2
Austria	18.2	5.4
Azerbaijan	2.4	1
Bahamas	3.6	1.3
Bahrain	11.6	2.9
Bangladesh	6.8	8.7
Barbados	4.1	0.6
Belarus	32.7	6.4
Belgium	21	7.7
Belize	4.9	0.5
Benin	8.8	3.1
Bhutan	23.1	11.2
Bolivia (Plurinational St...	16.2	8.5
Bosnia and Herzegovina	18	4.1
Botswana	5.7	2
Brazil	9.4	2.5
Brunei Darussalam	7.7	5.2
Bulgaria	16.6	5.3
Burkina Faso	7.3	2.8
Burundi	34.1	12.5
Cambodia	12.6	6.5
Cameroon	10.9	3.4
Canada	14.9	4.8



Suicide rates (per 100 000 population) - males



Use your mouse to select data. Use Ctrl-key to make multiple selections. Click on the right mouse button to clear selections.

© WHO 2014. All Rights Reserved. Map Disclaimer.

Depression in the United States Household

Population, 2005 - 2006

- 5.4% of American 12 years of age or older experienced depression, in any 2-week period.
- Rates of depression were higher among poor persons than those with higher income (1621 Robert Burton).
- 80% of persons with depression reported some level of functional impairment because of their depression.
- 27% reported serious difficulties in work and home life.
- 29% of all persons with depression reported contacting a mental health professional in the past year and only 39% with severe depression reported contact.

*Laura A. Pratt, PhD., and Debra J. Brody, MPH
Centers for Disease Control*

Depression in the United States Household

Population, 2005 - 2006

BARRIERS TO TREATMENT

- Unaware they have an illness to treat.
- Do not believe treatment works.
- Stigma surrounding mental illness.
- Lack of insurance coverage for treatment.
- Lack of mental health resources.

*Laura A. Pratt, PhD., and Debra J. Brody, MPH
Centers for Disease Control*

8 Statistics That Will Change The Way You

Think About Depression

- **11%** - The percentage of adolescents who have [a depressive disorder by the age of 18](#).
- **70%** - The percentage by which [women are more likely than men](#) to experience depression in their lifetime.
- **16,000,000** - The estimated number of U.S. adults who had [at least one major depressive episode 2012](#). This made up approximately [6.9 percent of all adults in the country](#).
- **14%** - The percentage of women from a 2013 postpartum depression study who had the disorder [four to six weeks after giving birth](#).
- **30%** - The number of college students who [reported feeling depressed](#), which disrupted their ability to function in school.
- **50%** - The percentage of Americans with major depression who [don't seek treatment for the mental illness](#).
- **10%** - The estimated [number of American adults age 65 and older](#) who have a diagnosable depressive disorder.
- **10 – 20** - The number of weeks [psychotherapy treatments for depression usually lasts](#) (though it varies depending on the condition). In order for antidepressants to take full effect, experts recommend giving the medication [four to six weeks](#).

The Huffington Post, Healthy Living Editor, January 20, 2015

National Quality Forum

NQF is committed to helping our nation achieve better and affordable care, and improving the overall health of Americans. Specifically, NQF:

- Sets standards.
- Recommends measures for use in payment and public reporting programs.
- Identifies and accelerates quality improvement priorities.
- Advances electronic measurement
- Provides information and tools to help healthcare decision-makers



NQF Endorses Behavioral Health Measures

- Endorsed 20 quality measures focused on behavior health.
- Behavioral health refers to a state of mental or emotional being and choices and actions that affect wellness.
- 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)



Screening for Clinical Depression and Follow-Up Reporting Measure

- Depression is the most **common** psychological disorder in patients with ESRD.
- Depression **causes suffering**, a decrease in quality of life, and impairment in social and occupational functions; it is also associated with increased health care costs.
- Current estimates put the depression prevalence rate as high as **20 percent to 25 percent** in patients with ESRD.[\[19\]](#)
- Studies have also shown that depression and anxiety are the most common comorbid illnesses in patients with ESRD.[\[20\]](#)
- Moreover, **depressive affect** and **decreased perception of social support** have been associated with higher rates of mortality in the ESRD population, and some studies suggest that this association is as strong as that between medical risk factors and mortality.[\[21\]](#)
- Nevertheless, depression and anxiety **remain under-recognized and under-treated**, despite the availability of reliable screening instruments.[\[22\]](#)
- Therefore, a measure that assesses whether facilities screen patients for depression, and develop follow-up plans when appropriate, offers an **opportunity** to improve the health of patients with ESRD.

Screening for Clinical Depression and Follow-Up

Reporting Measure

CITATIONS

- 19) Kimmel PL, Cukor D, Cohen SD, Peterson RA. Depressin in end-stage renal disease patients: a critical review. *Advances in Chronic Kidney Disease*. 2007;14 (4):328-34.
- (20) Feroze, U., Martin, D., Reina-Patton, A., Kalantar-Zadeh, K., & Kopple, J.D. (2010). Mental health, depression, and anxiety in patients on maintenance dialysis. *Iranian Journal of Kidney Disease*, 4(3), 173-80.
- (21) Cukor, D., Cohen, S.D., Petersen, R.A., & Kimmel, P.L. (2007). Psychosocial aspects of chronic disease: ESRD as a paradigmatic illness. *Journal of American Society of Nephrology*. 18(12) 3042-3055; and Kimmel, P.L. Petersen, R.A., Weihs, K.L., Simmens, S.J., Alleyne, S., Cruz, I., Veis, J.H. (2000). Multiple measurements of depression predict mortality in a longitudinal study of chronic hemodialysis outpatients. *Kidney International*, 57(5), 2093-2098.
- (22) Preljevic, V.T., Osthus, T.B.H., Sandvik, L., Opjordsmoen, S., & Dammen, T. (2012). Screening for anxiety and depression in dialysis patients: Comparison of the Hospital Anxiety and Depression Scale and the Beck Depression Inventory. *Journal of Psychosomatic Research*, 73(2), 139-144

Depression in Dialysis Patients:

The Situation

Nearly 30% of beneficiaries with ESRD experience significant symptoms of depression, leading to:

- Lower energy
- Fatigue
- Sleep disturbance
- Anorexia

Source: S. Susan Hedayatiet. al, "A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease," *Kidney International* 81, 247 –255 (February (1) 2012).

Depression in Dialysis:

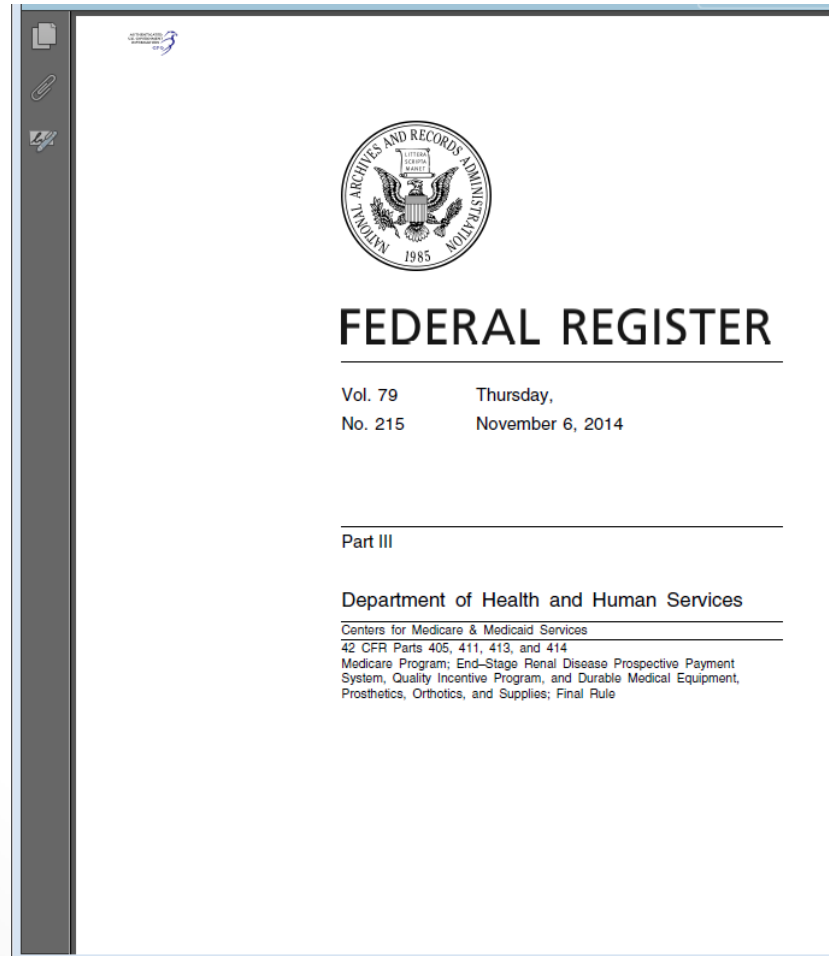
The Impact

- Patients on chronic hemodialysis with depression are **twice as likely** to die or require hospitalization within a year than others without depression.
- **POTENTIAL CONSEQUENCES:**
- Skipped/missed treatments
- Non-adherence to medication regimen
- Compromised daily life activities
- Reduced health-related quality of life
- Increased hospitalizations
- Self-medication (substance abuse)
- Critical treatment provided in emergency rooms/intensive care units
- Fatalities

Source: S. Susan Hedayatiet. al, "A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease," *Kidney International* 81, 247 –255 (February (1) 2012).

Federal Register, Vol. 79, No. 215

ESRD Quality Incentive Program



Purpose

- CMS states that this measure is intended to ensure ESRD patients who may be experiencing depression are identified and referred, if necessary, for follow-up treatment.
- It does not require the dialysis facility to diagnose the nature and causes of depression because these tasks are not suitable for a dialysis facility.
- Rather, we recognize that treatment for clinical depression should be furnished by appropriately trained practitioners and other mental health professionals, and it is our hope that these professionals will evaluate psychosocial causes and engage patients in the selection of treatment goals.

Finalized PY 2018 Reporting Measure

Clinical Depression Screening and Follow-Up

Clinical Depression Screening and Follow-Up Reporting	
Measure Description	Facility reports in CROWNWeb one of the six conditions below for each qualifying patient once before February 1, 2017. Based on NQF #0418
Exclusions	<ol style="list-style-type: none"> 1. Patients who are younger than 12 years 2. Patients treated at the facility for fewer than 90 days 3. Facilities with a CCN open date after July 1, 2016 4. Facilities treating fewer than 11 qualifying patients during the performance period
Data Sources	<ol style="list-style-type: none"> 1. REMIS, CROWNWeb, and other CMS ESRD administrative data
Additional Information	<ol style="list-style-type: none"> 1. Facilities must report one of the following conditions for each eligible patient: <ol style="list-style-type: none"> a) Screening for clinical depression is documented as being positive, and a follow-up plan is documented b) Screening for clinical depression documented as positive, and a follow-up plan not documented, and the facility possess documentation stating the patient is not eligible c) Screening for clinical depression documented as positive, the facility possesses no documentation of a follow-up plan, and no reason is given d) Screening for clinical depression is documented as negative, and a follow-up plan is not required e) Screening for clinical depression not documented, but the facility possesses documentation stating the patient is not eligible f) Clinical depression screening not documented, and no reason is given

Implementation

- What instrument do you use?
- Screen at 90 days?
- With KDQOL?
- After KDQOL?
- Same exclusions as the KDQOL?
- Do you rescreen?
- How long until rescreening?
- If they go for treatment are they off your radar?





Building Partnerships. Delivering Results.

Addressing Depression in Dialysis Patients

A New ESRD QIP Reporting Initiative

Tamyra Garcia, MPH
ESRD QIP Program Lead and Policy Lead
Division of Value, Incentives, and Quality Reporting

Follow us on Twitter: @QIOProgram
Tweet with our conference hashtag: #CMSQualCon15

Reporting Measure Definitions

Clinical Depression Screening and Follow-Up reporting measure was finalized for PY 2018 (performance period begins Jan. 1, 2016)

Definition: Indicate the outcome of clinical depression **screening**¹ and **follow-up plan**² documented for the selected **patient**³

1. “Screening” – Completion of a clinical or diagnostic **standardized tool** used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms
 - “Standardized tool” – an assessment tool that has been appropriately normalized and validated for the population in which it is used
2. “Follow-Up Plan” – A documented outline of care for a positive depression screening (see next slide)
3. “Patient” – Individual who has been admitted and received dialysis at a facility for the payment year in question



Policy Options for Clinical Depression Screening Tools

The CY 2015 ESRD Prospective Payment System (PPS) final rule **identifies (but does not recommend)** several examples of appropriate screening tools (see 79 FR 66120, 66201 (2014))

Adolescent Screening Tools (12 – 17 years)	Adult Screening Tools (18 and older)
Patient Health Questionnaire for Adolescents (PHQ-A)	Patient Health Questionnaire (PHQ-9)
Beck Depression Inventory- Primary Care Version (BDI-PC)	Beck Depression Inventory (BDI or BDI-II)
Center for Epidemiological Studies Depression Scale (CES-DC)	Center for Epidemiological Studies Depression Scale (CES-D)
PRIME MD-PHQ2	PRIME MD-PHQ2
Mood Feeling Questionnaire (MFQ)	Depression Scale (DEPS)
	Duke Anxiety-Depression Scale (DADS)
	Geriatric Depression Scale (GDS)

Note: The name of the age-appropriate standardized depression-screening tool that the facility used must be documented in the medical record.



Defining Conditions (continued)

- **Not eligible for follow-up** – A patient may not be eligible for follow-up plan, or it may not be appropriate for a patient to undergo treatment or therapy for depression because such treatments are medically contraindicated
- **Not eligible for screening** – A patient is not eligible for depression screening if one or more of the following reasons are documented in the patient's medical record:
 - Patient refuses to participate
 - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
 - Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g., certain court-appointed cases; cases of delirium)
 - Patient has an active diagnosis of depression
 - Patient has a diagnosed bipolar disorder

Justification for any of these findings should be documented in the patient's medical record



Defining Conditions

- **Positive** – Based on the scoring and interpretation of the specific standardized tool used, and through discussion during the patient visit, the provider should determine if the patient is deemed positive for signs of depression
- **Negative** – Based on the scoring and interpretation of the specific standardized tool used, and through discussion during the patient visit, the provider should determine if the patient is deemed negative for signs of depression

Justification for any of these findings should be documented in the patient's medical record



“Follow-Up Plans”

An appropriate follow-up plan outlines a proposed course of action, including at least one of the following:

- Additional evaluation for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression



Reporting Measure Requirement

Facilities must report one of the following conditions for each eligible patient before February 1, 2017:

1. Screening for clinical depression is documented as being “**positive**,” and a **follow-up** plan is documented
2. Screening for clinical depression documented as “**positive**,” and a **follow-up plan not documented**, and the facility possess documentation stating the patient is **not eligible**
3. Screening for clinical depression documented as “**positive**,” the facility possesses no documentation of a **follow-up** plan, and no reason is given
4. Screening for clinical depression is documented as “**negative**,” and a **follow-up plan is not required**
5. Screening for clinical depression **not documented**, but the facility possesses documentation stating the patient is **not eligible**
6. Clinical depression screening **not documented**, and no reason is given



Anticipated Application of the Depression Screening Measure

In the ESRD QIP, reporting measures are intended to provide the basis for potential future clinical measures

Current: Reporting measure scores facilities on the basis of whether the facility submitted data about its screening of patients

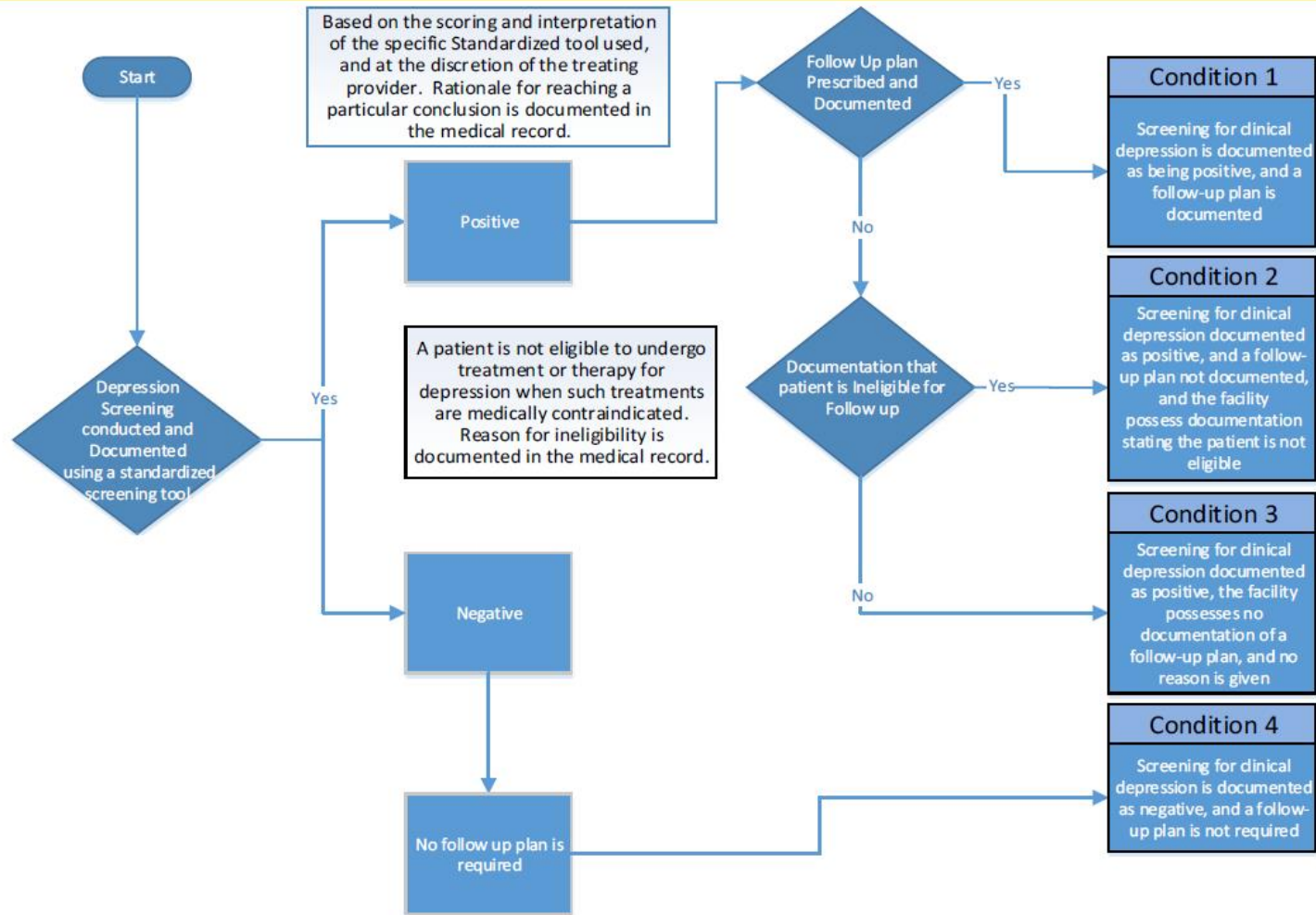
- Facilities are not required at this time to screen their patients – they simply have to disclose whether they conduct the screening (and, if so, what follow-up plan it established) for each patient
- Facilities do not currently provide the results of the screening to CMS

Future application: Potential clinical measure scores facilities on the quality of its screening practices

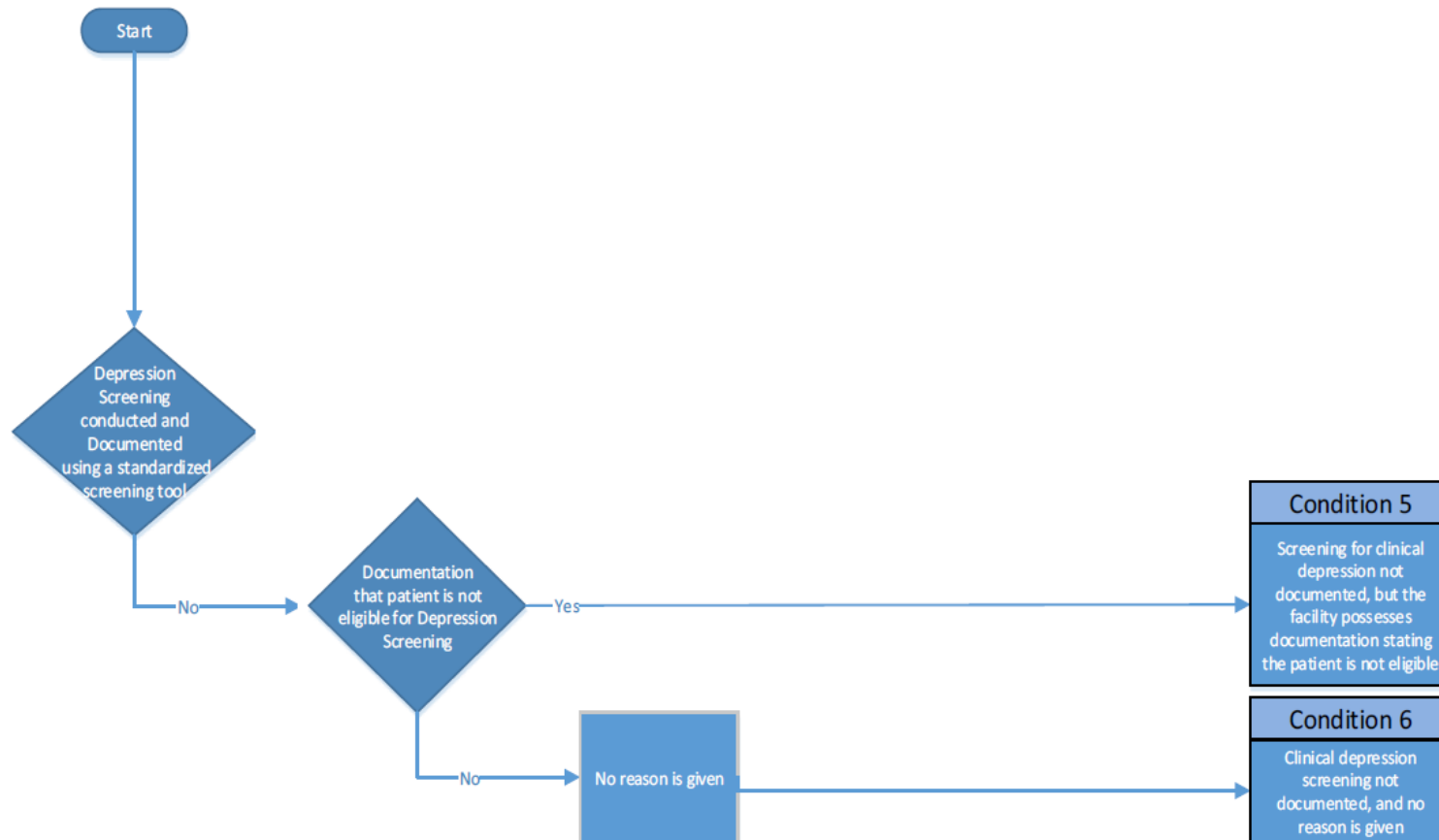
- Facilities will be required to screen their patients and establish appropriate follow-up plan
- ***Facilities will not be measured or penalized*** on their patients' mental health, but instead on the quality (not outcome) of the steps taken to assist patients



Clinical Depression Screening = YES



Clinical Depression Screening = NO



Purpose

- CMS states that this measure is intended to ensure ESRD patients who may be experiencing depression are identified and referred, if necessary, for follow-up treatment.
- It does not require the dialysis facility to diagnose the nature and causes of depression because these tasks are not suitable for a dialysis facility.
- Rather, we recognize that treatment for clinical depression should be furnished by appropriately trained practitioners and other mental health professionals, and it is our hope that these professionals will evaluate psychosocial causes and engage patients in the selection of treatment goals.
- “will develop a follow up plan to ensure.....treatment”

United States Preventive Services Task Force

December 2009

- Recommends routinely screening adults for depression when staff-assisted depression care supports are in place and recommends against routinely screening when supports are not in place.
- Found good evidence that programs **combining depression screening and feedback with staff-assisted depression care supports improve clinical outcomes** in adults and older adults.
- Found fair evidence that screening and feedback alone without staff-assisted care supports **do not improve** outcomes in adults and older adults.

United States Preventive Services Task Force

December 2009

- 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care.
- 39% were seen during the week prior.

O'Connor and colleagues (2009)

- Noted that as many as 40 - 67% of patients **discontinue** their antidepressant medication within 3 months, and few receive adequate follow-up.



New Jersey Postpartum Screening Policy Offers

Roadmap for Other States

- 20% of new mothers suffer from postpartum depression.
- In 2006 NJ enacted the nation's first statewide depression screening program.
- 93% of mothers with hospital births screened in 2014 in NJ.
- 50% were referred to a behavioral health hotline.
- Half of the state's licensed psychiatrists are not taking new patients.
- Most women follow-up with PCP for medication but not therapy.



Follow-up Plans

An appropriate follow-up plan outlines a proposed course of action, including at least one of the following:

- **Additional evaluation** for depression
- Suicide risk assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- **Other interventions** or follow-up for the diagnosis or treatment of depression

Differential Diagnosis

Sign/Symptoms – Depression

National Institute of Mental Health

- ▶ Persistent sad, anxious, or "empty" mood
- ▶ Feelings of hopelessness, pessimism
- ▶ Feelings of guilt, worthlessness, helplessness
- ▶ Loss of interest or pleasure in hobbies and activities
- ▶ Decreased energy, fatigue, being "slowed down"
- ▶ Difficulty concentrating, remembering, making decisions
- ▶ Difficulty sleeping, early-morning awakening, or oversleeping
- ▶ Appetite and/or weight changes
- ▶ Thoughts of death or suicide; suicide attempts
- ▶ Restlessness, irritability
- ▶ Persistent physical symptoms

Signs/Symptoms – CKD

Mayo Clinic

- Nausea
- Vomiting
- Loss of appetite
- Fatigue and weakness
- Sleep problems
- Changes in urine output
- Decreased mental sharpness
- Muscle twitches and cramps
- Hiccups
- Swelling of feet and ankles
- Persistent itching
- Chest pain, if fluid builds up around the lining of the heart
- Shortness of breath, if fluid builds up in the lungs
- High blood pressure (hypertension) that's difficult to control

Depression in Dialysis Patients:

The Situation

Nearly 30% of beneficiaries with ESRD experience significant symptoms of depression, leading to:

- Lower energy
- Fatigue
- Sleep disturbance
- Anorexia

Source: S. Susan Hedayati et. al, "A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease," *Kidney International* 81, 247 –255 (February (1) 2012).

Depression in Dialysis:

The Treatment

- Pharmacological Interventions
- Non-pharmacological Interventions
 - Alterations in the dialysis treatment
 - Cognitive behavioral therapy
 - Exercise training program

Source: S. Susan Hedayati et al, "A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease," *Kidney International* 81, 247–255 (February (1) 2012).

Pharmacological Interventions

- Based on what data are available, if a trial of medication is considered, **SSRIs** would likely be a prudent choice because of established safety in patients with CV disease.
- Once medication is initiated, response to treatment, need for dose adjustment, and the development of **side effects** should be **monitored** closely.
- This can be easily accomplished in ESRD patients given repeated encounters with health-care providers during routine presentation to the HD unit.
- The medication dose should not be escalated sooner than at intervals of at least 1 to 2 weeks, and only as tolerated. Special attention should be given to drug–drug interactions, as well as **increased risk of suicidal ideation** after initiation of antidepressant medications.

Source: S. Susan Hedayatiet. al, “A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease,” *Kidney International* 81, 247 –255 (February (1) 2012).

Non-Pharmacological Interventions

- Alterations in the dialysis treatment
 - FREEDOM Study
 - Frequent Hemodialysis Network Trial
- Exercise Training Programs
- Cognitive Behavioral Therapy

Source: S. Susan Hedayatiet. al, "A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease," *Kidney International*81, 247 –255 (February (1) 2012).

Cognitive Behavioral Therapy

- 69 ESRD patients in 22 dialysis units in Louisiana after hurricane-related trauma.
- Social workers were provided with training kits from the National Kidney Foundation using a cognitive behavioral framework.
- There was a **significant amelioration of depressive symptoms** in patients who participated in sessions as compared with patients who did not discuss the material with their social worker.
- Importantly, this study involved 22 social workers with limited but focused training, suggesting that more widespread use of CBT techniques may be promising in ESRD facilities and/or CKD clinics.
- Weiner S, Kutner NG, Bowles T, Johnstone, S. Improving psychosocial health in hemodialysis patients after a disaster. Soc Work Health Care 2010; 49:513–525.

Dual Therapy

- The possible efficacy of combining antidepressant medications with CBT in CKD patients has not been explored in published studies.
- This is relevant as a large recent study involving 681 patients with chronic major depression showed that the response rate to medication or CBT alone was 48%, compared with a **73% response rate in patients receiving combined therapy**.
- It would seem reasonable to explore trials involving combined approaches given the challenges presented in treating the CKD patient with depression.

Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive behavioral analysis system of psychotherapy, and their combination for the treatment of chronic depression.

N Engl J Med. 2000;342:1462–1470

Credits

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QUESTIONS?

