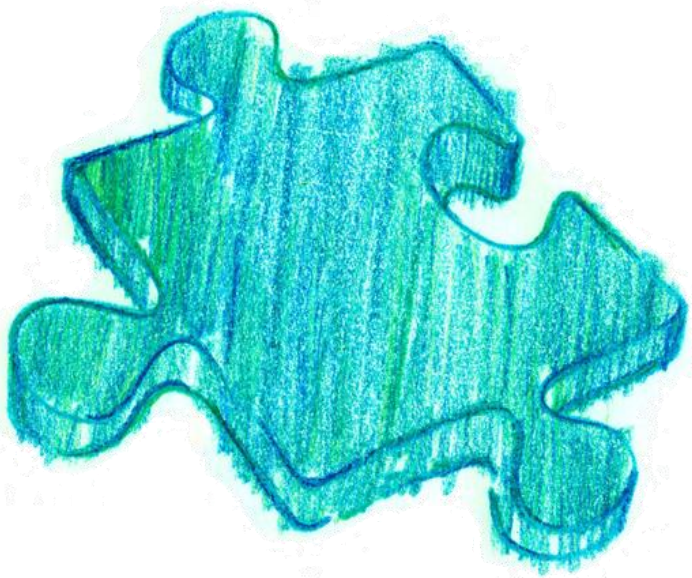
SBIRT

Screening

Brief Intervention

Referral to Treatment



for

Substance Use Disorder (SUD)

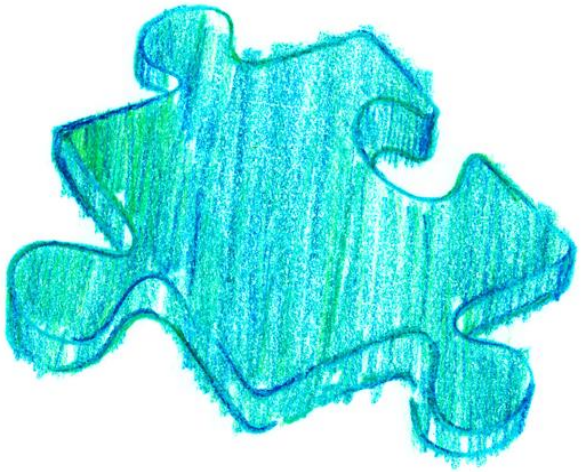
MHN Quality Improvement Department

Health Net®

MHN
A Health Net Company℠

What is SBIRT?

SBIRT is an approach to early intervention and treatment for people with or at risk for substance use disorders and is the recommended approach by CMS and SAMSHA[1]



Presentation Agenda and Objectives

Agenda

Introduction to SBIRT for Substance Use Disorder (SUD)

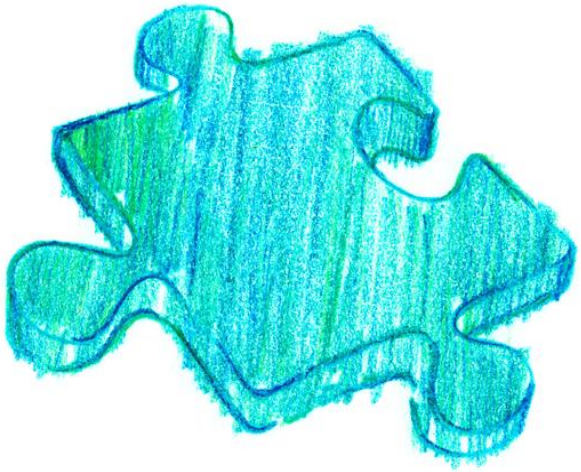
1. Impact of alcohol and drugs
2. Why brief interventions work in the PCP setting
3. SBIRT elements
4. Implementing SBIRT
5. 14-day follow-up visit
6. SBIRT training for PCPs/staff
7. Practitioner and member resources
8. Questions and answers

Please remember to mute your phone.

Goals: promote routine screening, skillful interventions, and follow-up

Objectives – after this course you will know:

1. Describe the advantages of screening, assessing and initiating treatment for SUD in the PCP setting
2. State the key components of the SBIRT process
3. Describe SBIRT training requirements
4. List three topics to cover during the 14-day follow-up session
5. Identify when it is necessary to refer patients to behavioral health services for SUD treatment



ALCOHOL and OPIOID USE

Impact & Response to Alcohol Misuse

Alcohol:

- 3rd leading preventable cause of death
- 17 million adult Americans have alcohol use disorder[2]
- causal factor in more than 200 diseases/injuries, TB and HIV/AIDS[3]

BUT… Only 8.4 percent receive treatment!

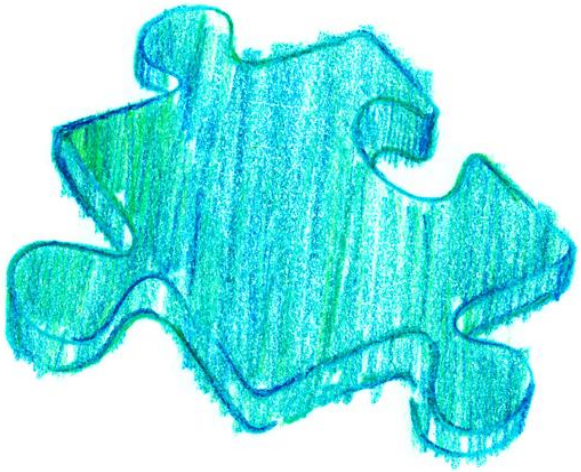
Binge drinking has become the #1 form of alcohol misuse[4]

- Most binge drinkers are **not alcohol dependent** and are over the age of 26 with household incomes of $75,000 or more
- Binge drinkers are **14 times more likely** to report alcohol-impaired driving than non-binge drinkers

Impact & Response to RX Opioid Abuse

Opioid use has now reached epidemic proportions[5]

- In 2009, 7 million Americans abused prescription drugs
  (more than the number using cocaine, heroin, hallucinogens, and inhalants combined)
- Opioid RX misuse increased over 400 percent from 1998-2008
- Drug overdose is now the 2nd leading cause of accidental death, exceeded only by car crashes



Brief Interventions Work in the PCP Setting

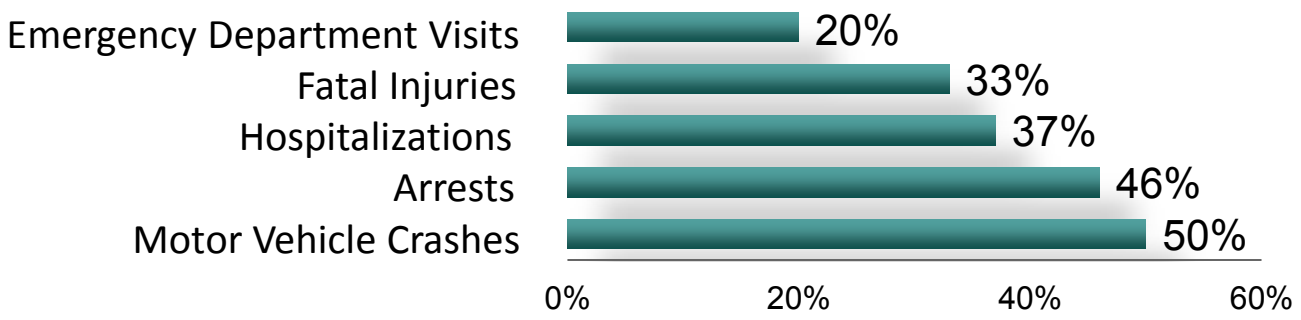
SBIRT Works in the PCP Setting

Patients form trusting bonds with their PCP

Why SBIRT in the PCP setting?[6]

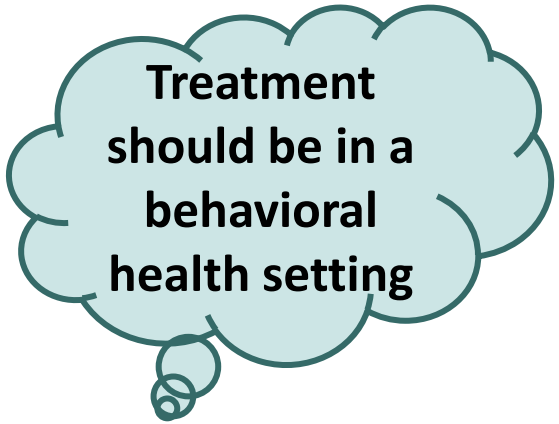
Patients prefer follow-up with their PCP

SBIRT has been shown to reduce:[7]



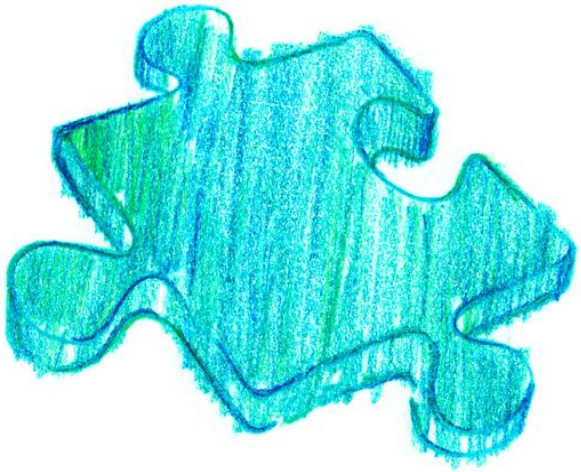
Concerns of Using SBIRT in the PCP Setting:[8]

- SBIRT services can be 15 to 30 minutes and is billable
- Follow-up visits consist of a conversation about how well the patient is progressing and setting new goals



- PCPs are the most trusted health care providers and have the greatest impact on patient's wellness
- Office staff can become qualified to administer all aspects of SBIRT working under supervision of PCP or licensed clinical staff
- The four hour online training is available through several websites

- If patients indicate, through the screening, they have an alcohol or drug use issue, they are likely to be relieved or even appreciative to have a discussion with someone they trust with this issue
- Evidence shows brief discussions have a positive effect on creating awareness and changing behavior
- Patients will be more likely to return to their PCP than to a treatment program



ELEMENTS OF SBIRT SERVICES

SBIRT Components

Screening for alcohol and drug misuse

S B I R T

Screening for Alcohol and Drug Misuse

Screening

Screening:[9]

- Should be performed on an annual basis
- Can take as little as a minute to complete or ten minutes for a more in-depth look
- Can be administered face-to-face, through a paper questionnaire, or online in the office

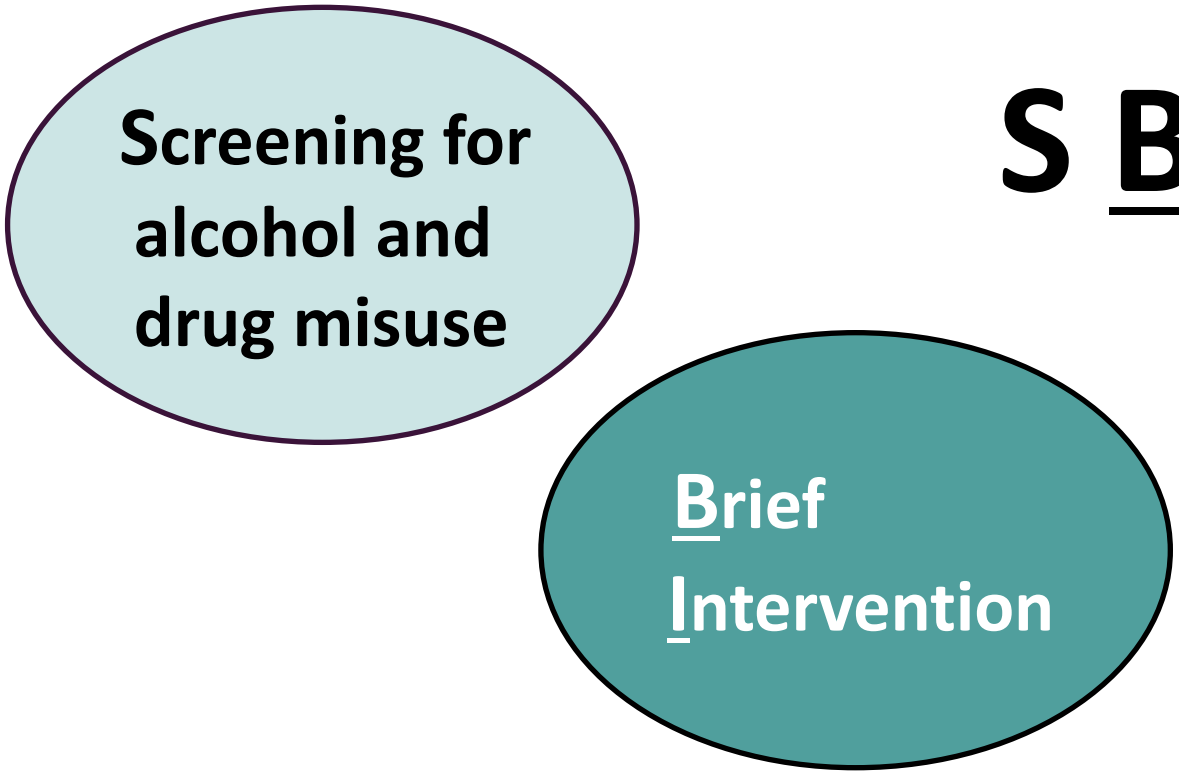
Additional Screening Tools

Screening

Commonly used evidence-based screening tools

Screening Tool	Screening for	# of Questions	Target Patients	Minutes to Administer	Other Info:
AUDIT	Alcohol	10	Adults	2-4	Detects at-risk, heavy and binge drinking. Free from cultural bias
AUDIT - C	Alcohol	3	Adults	1	Brief alcohol screen for hazardous or harmful drinking
CAGE-AID	Alcohol and drugs	4	Adults and adolescents	1	does not ask about tobacco or assess for severity of SUD
CRAFFT	Alcohol, drugs, Opioids (similar to CAGE for adults)	6	Teens and adolescents	5	Does not assess severity of problem or ask about tobacco
DAST 10	Drugs	10	Adults and adolescents	3	Includes screen for RX use
HSA	Alcohol	1	Adults	Part of larger screen	For Medi-Cal members
NIDA Quick screen	All substances	5	Adults	2-3	If yes to any questions, screen further with appropriate tool*
NM ASSIST	Drugs	15	Adults	15	Screens for all substances and frequency of use
Opioid Risk Tool (ORT)	Opioids	5	Adults	1	Risk for aberrant behavior when prescribed opioids for chronic pain

SBIRT Components



S B I R T

Brief Inter-vention

Brief Intervention – 7 steps

Step 1: Confirm your concern about responses to the screen[10]

1. Discuss responses to the screening tool

2. Make sure your patient was clear about what the screening questions were asking

Brief Inter-vention

Brief Intervention

Step 2: Ask about the patient's view of the situation[11]

- Patients who do not feel they have a problem will be more resistant to treatment.
  - To help create awareness, ask patients about the effects their drinking has on family and friends

- Try not to label their drinking as a problem until the patient comes to view it that way.
  - Labeling a patient's SUD as a problem may work against the treatment

- Ask patients to identify the factors in their environment that make it difficult to quit.
  - Help your patient identify friends, family, activities or other triggers that make it difficult to quit

Brief Inter-vention

Brief Intervention

Step 3: Discuss the consequences of their SUD and provide time for questions[12]

As a health care provider, express your concern about:

Social risks:
- Detachment from family and friends
- Isolation
- Domestic violence
- Incarceration

Health risks:
- Heart disease
- Cancer
- Brain deterioration
- Depression
- Memory loss
- High blood pressure

Injury risks:
- Auto accidents
- Falls
- Head trauma
- Victim of crime

Brief Intervention

Step 4: Effective Patient Communication[13]

Targeted communication

- Discuss advantages of changing behavior
- Use open-ended questions
- Offer specific advice about changing behavior

Non-judgmental advice

- Empathize with your patient
- Convey a non-judgmental attitude

Brief Intervention

Step 5: Treatment options[14]

- Trial period of graduated reduction
  - *Ask the patient what steps need to be taken to cut back*
  - *Set limit on number of drinks per week*
  - *Reinforce /limit number of days to drink*
- Trial period of abstinence (as appropriate)
- Use of medication, if necessary

Brief Intervention

Step 6: Provide patient support and encouragement[15]

Encourage your patient to change habits

Motivate your patient to commit to changes when there are failures

Provide information about community resources and support groups

Identify sources of support

- **Family**
- **Friends**
- **Work associates**
- **Church or other social groups**
- **12-step programs**
- **Learn to meditate**
- **Learn to dance**

Brief Inter-vention

Brief Intervention

Step 7: Patient education[16]

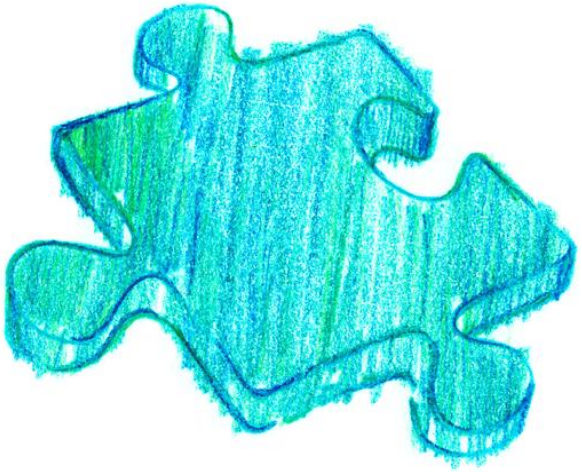
Provide printed educational materials

Provide online educational materials
(resources information in the reference section)

*** Schedule a follow-up appointment <u>within 14 days</u> of Dx.**

Schedule 2 more follow-up appointments within 30 days of the 1st appointment.

Convey to your patient your concern about their well-being



14-day Follow-up Appointment

Follow-Up Visit Within 14 Days[17]

1. Review Patient Risks	• Medical risks • Increased probability of traumatic injury or death • Relationships with family, friends and work
2. Review Goals	• Steps needed to cut back on drinking • Drink limit per week • Encourage abstinence, if appropriate • Number of days per week to drink
3. Review Barriers to Goals	• What stands in the way to cut usage? • What are the 3 most common triggers for drinking or drug using • Are there social situations to avoid • Address triggering events
4. Review Sources of Support	• Family - friends - work associates - church • 12-step programs • Activity groups - learn to meditate - learn to dance

***Schedule 2 more appointments in the next 30 days or refer to behavioral health**

Brief Intervention – PCP pocket guide

1. Screen for alcohol/drug use.

2. If results are positive:

   A. Increase patient insight and awareness
   B. Set and agree on goals and motivate/assist toward change
   C. Discuss barriers to goals – how to overcome
   D. Identify sources of support and engage in activities

   E. Schedule a follow–up appointment within 14 days

3. Schedule 14-day appointment:

   A. Review patient progress in changing behaviors
   B. Review reasons to cut back or abstain
   C. Review sources of support/programs for recovery

   Proceed with one of the following:
   D. Schedule 2 more appointments within the next 30 days or
   E. Refer to behavioral health services if appropriate

Follow-Up Appointments Affect HEDIS* Scores

Initiation and Engagement of Alcohol and Other Drugs (IET-AOD)

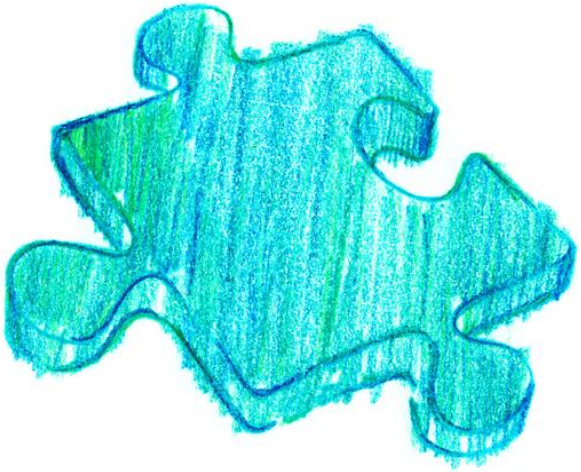
1. **Initiation Phase:** follow-up appointment within 14 days of diagnosis
2. **Engagement Phase**: 2 more appointments within 30 days of the 14-day appt

Health Net current rate for 14-day measure:

Commercial LOBs: 28 – 36 percent
Medicare LOBs: 16 – 38 percent

Goal:
50th percentile
Comm - 39%
MCR - 37%

***HEDIS – Healthcare Effectiveness Data Information Set**



Working With Special Populations

SBIRT for Teens

According to the National Institute on Alcohol and Alcoholism[18]

- One in 3 children start drinking by the end of 8th grade – half of them report being drunk
- Drinking often goes undetected
- Many teens will discuss drinking when they are assured of confidentiality
- PCP is in a prime position to identify and treat drinking

HEDIS also measures follow-up visits for 13-17 year olds

SBIRT for Teens

Considerations When Treating Minors

1. Patient confidentiality for minors:

- CA grants confidentiality to minors, 12 and over, for SUD[19]
- AZ grants confidentiality to minors, 12 and over, for SUD[20]
- OR grants confidentiality to minors, 14 and over, for SUD[21]

*Always check for regulatory updates to laws that govern care for minors

IF there is no evidence of harm to self or others and does not include use of methadone or other medications

2. Appropriate screening – 2 questions[22]

- Screen aims to help prevent alcohol related problems at an early age
- Empirically based and a strong predictor of negative consequences of alcohol
- First tool to include friends' drinking

Question 1:
Ask about friends' drinking

Question 2:
Ask about patient drinking

SBIRT for Teens

3. Appropriate interventions

- Provide brief advice - Explore options and troubleshoot - Ask if parents know
- Arrange for follow-up or refer to specialty services based on severity

Resources For Teens 11-13:

- NIAAA's The Cool Spot, an interactive Web site to help kids identify and resist peer pressure to drink — www.thecoolspot.gov/

Support for patients whose parents have drinking problems:

- Al-Anon Family Groups, including Alateen — www.al-anon.alateen.org
- National Association for Children of Alcoholics "Just 4 Kids" page — www.nacoa.org/kidspage.html

Treating Teens/Adolescents[23]

Adolescents differ from adults physiologically and emotionally:

- Their substance use may stem from different causes
- Difficult to project the consequences of their drinking

Any teen/adolescent should be screened who:

Entered the child welfare system	Has run away	Dropped out of school	Needs emergency services
Shows significant changes in school functioning	Develops medical problems or an infection associated with substance use		Shows increased oppositional behavior

Treating Teens/Adolescents

Treatment works best when their individual needs and concerns are addressed.

Considerations:

- Developmental stage (maturity level)
- The family
  (involve them in all phases of treatment, unless there is a history of abuse, instability, or violence)
- Ethnicity
  (immigrants, cultural traditions)
- Gender
  (females more likely to have been sexually or physically abused, or have children and need additional services)
- Coexisting Disorders
  (ADHD, anxiety, PTSD – may need referral)

An Invisible Epidemic: SUD Among Older Adults (60+)[24]

- One of the fastest growing health problems
- Under identified, under diagnosed, and under treated
- SUD diagnosis difficult due to dementia or behavioral health disorders
- Families choose to not address SUD in older adults
- Unspoken, pervasive assumption that it is not worth treating

Effects of Alcohol on Older Adults

Decrease in body water (increases concentration of alcohol)

Higher alcohol concentration can lead to increased sensitivity to alcohol (increased accidents and injuries)

Decrease in alcohol metabolism (due to decrease in dehydrogenase enzyme to metabolize alcohol in the GI tract)

Brief Interventions for Older Adults (60+)

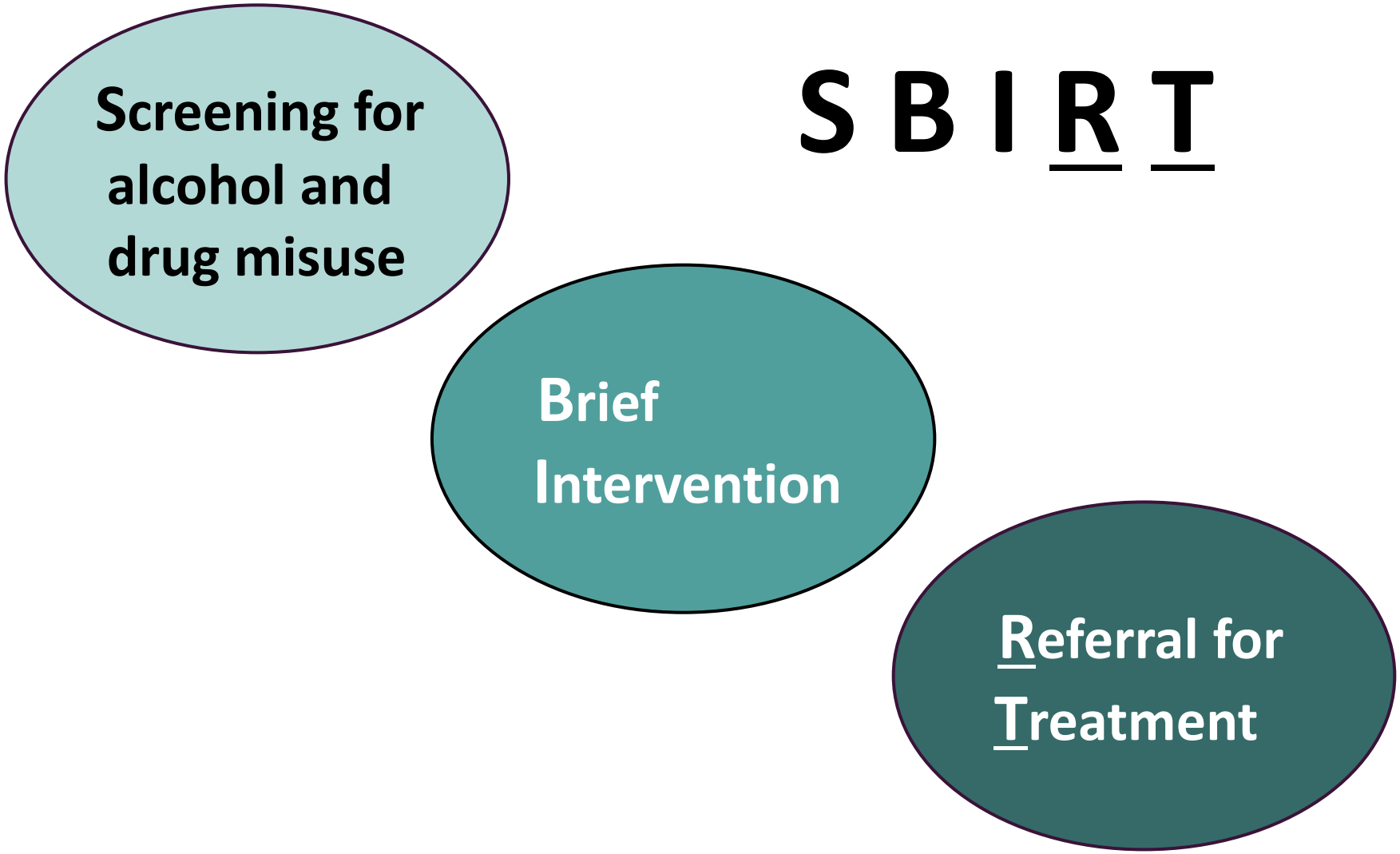
Discuss:

- Reasons for drinking (coping with loss, loneliness, and isolation)
- Consequences of drinking even if within recommended limits
- Cutting down to maintain independence, financial security and mental capacity

Strategies to cut down:

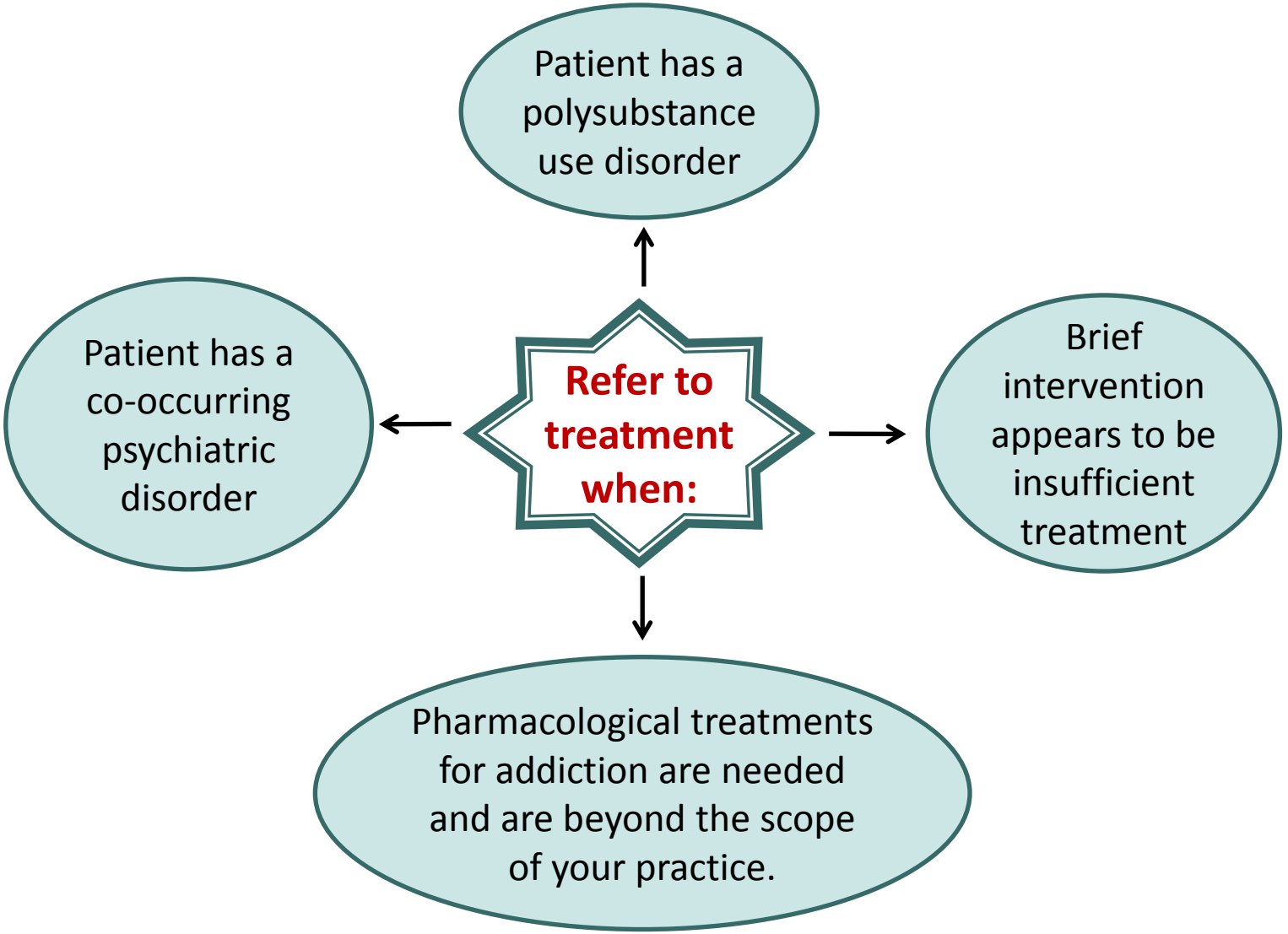
- Develop social opportunities without alcohol
- Pursue volunteer activities or start a hobby
- Written drinking agreement in the form of an Rx, signed by the patient

SBIRT Components



Referral to Treatment

Referring to Behavioral Health Treatment[25]



Referral to Treatment

Referral to Treatment

- Health Net Commercial
- Health Net Medicare

→ Refer to MHN A Health Net Company℠

MHN Physician Help Line (800) 289-2040
M-F 5 a.m. To 5 p.m. Pacific Time

- CalViva members

→ CalViva HEALTH

CalViva Health Member Services (888) 893-1569

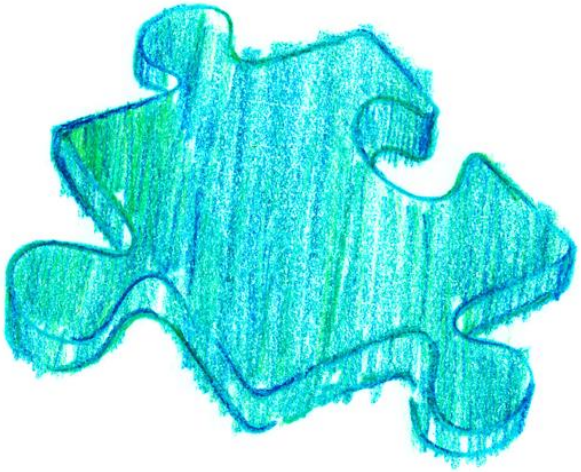
Referral to Treatment for
CA Medi-Cal members and AZ Medicaid (AHCCCS)

Referral to Treatment

Medi-Cal members → County Mental Health Services

Arizona Medicaid members AHCCCS → **Refer to RBHA** Regional Behavioral Health Authority

Call the Maricopa County Regional Behavioral Health Authority (RBHA) at 1800-564-5465 or fax referral to 844-424-3975



SBIRT: BILLING AND TRAINING

Summary of Billing Codes[26]

Billing codes for FFS (fee for service) plans:

Payer	Code	Description
Commercial Insurance*	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes
Medicare*	G0396	Alcohol and/or substance abuse structured **assessment** (AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes
	G0397	Greater than 30 minutes
Medi-Cal/ Medicaid*	H0049	Alcohol and/or drug screening
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes

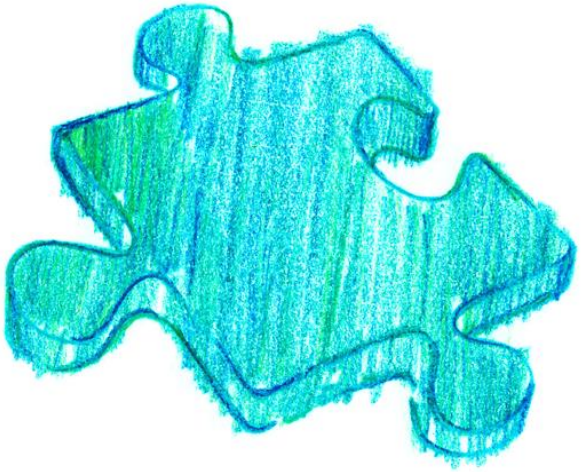
*Per Substance Abuse and Mental Health Services Administration (SAMHSA) website as of June, 2014

*See appendix for further details

SBIRT Training Information

- www.sbirtTraining.com – online training, approximately 4 hours with CME credits and certificate of completion. Cost is $50

- http://www.dhcs.ca.gov/services/medi-cal/Pages/SBIRT.aspx - includes information about webinars and online training for PCPs and non-Primary Care.



PRACTITIONER and MEMBER RESOURCES

Materials and Tips for PCPs to Treat SUD

The Substance Abuse and Mental Health Services Administration (SAMHSA) has PCP materials and tips to assist in the treatment of SUD. These materials can be ordered at no cost from their website or downloaded and printed in your office. There are no copyright restrictions to print and distribute.

Brochures for PCPs:

1. **TIP 24: A guide to Substance Abuse Services for Primary Care Clinicians**
   Content includes guiding clinicians through stages of primary care for SUD. Discusses warning signs, screening, follow-up, brief interventions, treatment models and legal issues.

   http://store.samhsa.gov/product/TIP-24-Guide-to-Substance-Abuse-Services-for-Primary-Care-clinicians/SMA08-4075

2. **TIP 26: Substance Abuse Among Older Adults**
   Content include shame in older adults, relationship between aging and substance abuse, unique vulnerabilities, guidance for addressing substance use and also dementia which can mimic SUD.

   http://store.samhsa.gov/product/TIP-26-Substance-Abuse-Among-Older-Adults/SMA12-3918

3. **Tip 31 and 32: Screening, Assessing, and Treating Adolescents For Substance Use Disorders**
   Content includes tips and tools to tailor screening, assessment of school and home life, and treatment for teens.

   http://store.samhsa.gov/product/Screening-Assessing-and-Treating-Adolescents-for-Substance-Use-Disorders/SMA01-3596

4. **Talking With Your Patients about Alcohol, Drugs, and/or Mental Health Problems – a guide for PCPs**
   Content includes tips on how to initiate a conversation with patients about emotional or other stresses and substance use.

   http://store.samhsa.gov/shin/content//SMA12-4584/SMA12-4584.pdf

5. **Medication for the Treatment of Alcohol Use Disorder: A Brief Guide – 2015**
   (For physicians who prescribe medications for SUD)

   Content includes evidence that medications for alcohol use and dependence are underused, data showing that 10 to 20% of patients in primary care have a diagnosable alcohol use disorder but most go untreated. Also contains a comparison between DSM-IV and 5 for SUD.

   http://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/All-New-Products/SMA15-4907

SBIRT Screening Tools – AUDIT

(to identify people at risk for alcohol problems)

1. How often do you have a drink containing alcohol?
   (0) Never – skip to question 9-10
   (1) Monthly or less 2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

3. How often do you have six or more drinks on an occasion?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you started?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

SBIRT Screening Tools - AUDIT

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after dinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have your or someone else been injured as a result of your drinking?
   (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
    (0) No (2) Yes, but not in the last year (4) Yes, during the last year[20]

A score of 8 or more indicates harmful drinking behavior

Practitioner Resources

National Institute on Alcohol Abuse and Alcoholism (NIAAA) – materials for providers and patients
http://www.niaaa.nih.gov/guide - (A Clinician's Guide for Helping Patients Who Drink Too Much.)

National Institute of Drug Abuse
http://drugabuse.gov

Department of Health and Human Services – Centers for Medicare and Medicaid
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf

DHCS Website Document on SBIRT – January 23, 2014
http://www.dhcs.ca.gov/services/medi-cal/Documents/SBIRT%20Fact%20Sheet%20Dec%2016%202013.pdf

Overview and Materials for PCPs about SBIRT
http://www.integration.samhsa.gov/clinical-practice/SBIRT

Institute for Research, Education and Training in Addictions
http://www.integration.samhsa.gov/clinical-practice/SBIRT.pdf

Online Information - SAMHSA SBIRT Webinar
http://www.integration.samhsa.gov/images/res/SBIRT%20Webinar,%20PPP%20final.pdf

Practitioner Resources – screening tools

AUDIT Screening Tool - Complete guide to implementation in the PCP Setting
http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

Staying Healthy Assessment (SHA) questionnaire - DHCS: plans may use alternate screens with prior approval from Medi Cal Managed Care Division
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/DHCS_7098_H_ENGLISH_SHA_Adult.pdf

AUDIT, CAGE AID, AUDIT-c, DAST-10
http://www.integration.samhsa.gov/clinical-practice/screening-tools

Member Resources

National Institute on Alcohol Abuse and Alcoholism (NIAAA) – brochures and fact sheets for patients. Includes topics on risky drinking, cutting back, college drinking, pregnancy and drinking, driving and drinking, alcohol and women, alcohol and the Hispanic community, and alcohol and older adults
http://www.niaaa.nih.gov/publications/brochures-and-fact-sheets

National Institute on Drug Abuse
http://www.drugabuse.gov/Infofacts/Infofaxindex.html

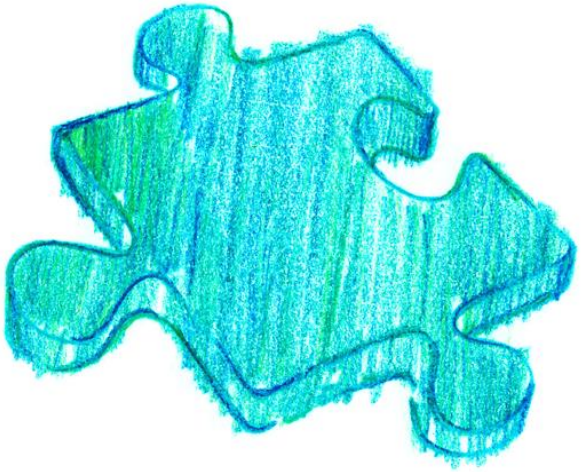
Drink Alcohol Only in Moderation - Online Patient Education/Taking Action to Cut Back on Drinking
http://healthfinder.gov/HealthTopics/Category/health-conditions-and-diseases/heart-health/drink-alcohol-only-in-moderation

Online Publications: SAMHSA – Center for Integrated Health Solutions

Rethinking Drinking http://rethinkingdrinking.niaaa.nih.gov/.
Tips for Cutting Down on Your Drinking http://pubs.niaaa.nih.gov/publications/Tips/tips.pdf
Harmful Interactions: Mixing Alcohol with Medications
http://pubs.niaaa.nih.gov/publications/Medicine/Harmful_Interactions.pdf

Additional resources:
Alcoholics Anonymous – www.aa.org
Narcotics Anonymous – www.na.org
Self-Management and Recovery Training (SMART) - http://www.smartrecovery.org/
Women for Sobriety - www.womenforsobriety.org/

THANK YOU



QUESTIONS?

References

[1] http://www.samhsa.gov/sbirt/about

[2] http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics

[3] http://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/hiv-aids

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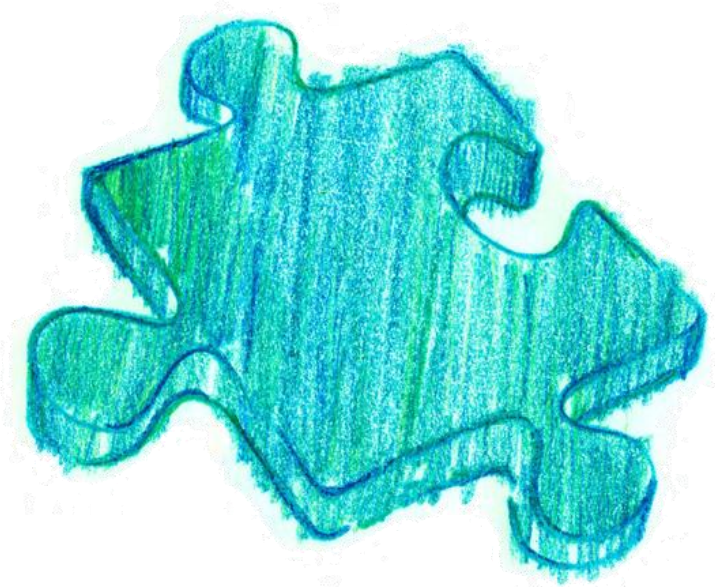
Cal MediConnect: Screening for Clinical Depression with a Follow-Up Plan



Presentation for:
Provider Teleconference

April 2015

Candace Ryan, BSN, CPHQ

Health Net®

Learning Objectives

Participant will be knowledgeable of:

- Definition of Quality Withhold metrics for Cal MediConnect
- Coding required to meet documentation requirements for Clinical Depression Screening and Follow-Up metric
- Resources available to providers for depression screening

Cal MediConnect Quality Withhold

Quality withhold measures are a subset of a larger and more comprehensive set of quality and reporting requirements that health plans participating in Cal MediConnect must adhere to under the demonstration project period.

Screening for Clinical Depression and Follow-Up Plan Metric

Health Net

Definition:

The percentage of Cal MediConnect enrollees age 18 and older with an outpatient visit who were screened for clinical depression using a standardized depression screening tool, and if positive, had a follow-up plan documented on the date of the positive screen.

Data Collection:

The data to measure this metric is collected from coding completed by providers

HCPCS Codes to Identify Clinical Depression Screen

HCPCS Codes	Description
G8431	Positive screen for clinical depression using a standardized tool and a follow-up plan documented
G8510	Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

HCPC Codes to Identify Exclusions

HCPCS Codes	Description
G8433	Screening for clinical depression not documented, patient not eligible/appropriate
G8940	Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate

Documentation of Follow-Up for Positive Depression Screen

- Additional evaluation
- 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

The documented follow-up plan must be related to positive depression screening, for example: “Patient referred for psychiatric evaluation due to positive depression screening.”

Depression Screening and Follow-Up Resources

Standardized Depression Screening Tools

Depression screening tools usually incorporated into electronic health records

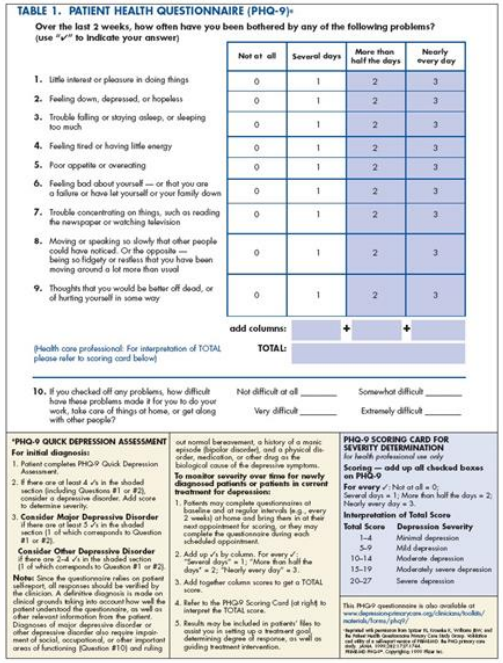


TABLE 1. PATIENT HEALTH QUESTIONNAIRE (PHQ-9)*

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
add columns:		+	+	
(Health care professional: For interpretation of TOTAL please refer to scoring card below)	TOTAL:			

10. 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 _____

*PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 or #2), consider a depressive disorder. Add score to determine severity.
3. **Consider Major Depressive Disorder** if there are at least 5 ✓'s in the shaded section (1 of which corresponds to Question #1 or #2).

Consider Other Depressive Disorder if there are 2–4 ✓'s in the shaded section (1 of which corresponds to Question #1 or #2).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician. A definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of major depressive disorder or other depressive disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a manic episode (bipolar disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring, or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓'s by column. For every ✓: "Several days" = 1; "More than half the days" = 2; "Nearly every day" = 3.
3. Add together column scores to get a TOTAL score.
4. Refer to the PHQ-9 Scoring Card (at right) to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for health professional use only

Scoring — add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3.

Interpretation of Total Score

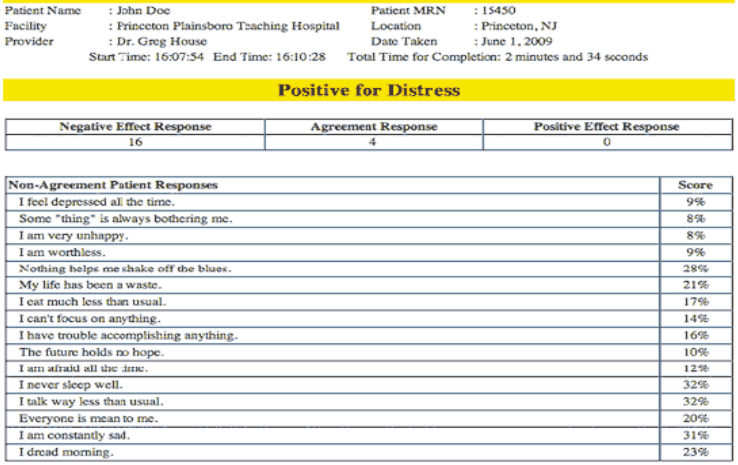
Total Score	Depression Severity
1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

This PHQ-9 questionnaire is also available at www.depressionscreening.org/clinicians/toolkits/materials/forms/phq9/

Reprinted with permission from Spitzer RL, Kroenke K, Williams JBW, and the Patient Health Questionnaire Primary Care Study Group. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. JAMA. 1999;282:1737-1744.

PRIME-MD PHQ-9®. Copyright© 1999 Pfizer Inc.

Patient Health Questionnaire (PHQ9)



CES-DM

Patient Name	: John Doe	Patient MRN	: 15450
Facility	: Princeton Plainsboro Teaching Hospital	Location	: Princeton, NJ
Provider	: Dr. Greg House	Date Taken	: June 1, 2009

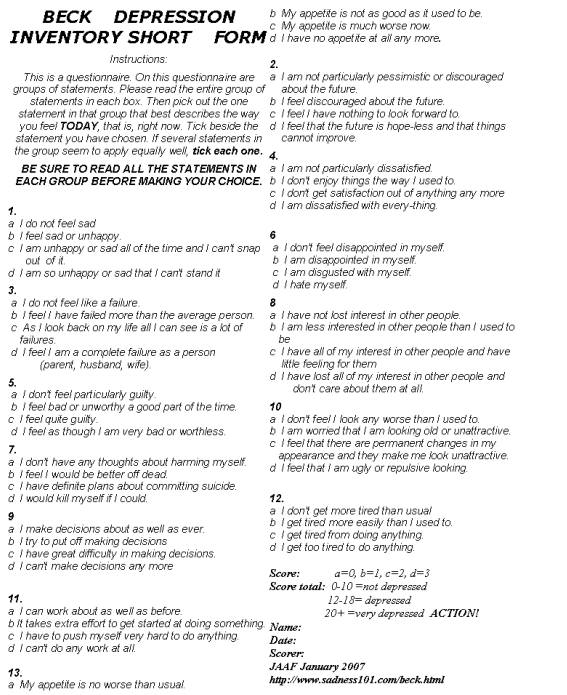
Start Time: 16:07:54 End Time: 16:10:28 Total Time for Completion: 2 minutes and 34 seconds

Positive for Distress

Negative Effect Response	Agreement Response	Positive Effect Response
16	4	0

Non-Agreement Patient Responses	Score
I feel depressed all the time.	9%
Some "thing" is always bothering me.	8%
I am very unhappy.	8%
I am worthless.	9%
Nothing helps me shake off the blues.	28%
My life has been a waste.	21%
I eat much less than usual.	17%
I can't focus on anything.	14%
I have trouble accomplishing anything.	16%
The future holds no hope.	10%
I am afraid all the time.	12%
I never sleep well.	32%
I talk way less than usual.	32%
Everyone is mean to me.	20%
I am constantly sad.	31%
I dread morning.	23%

Center for Epidemiologic Studies Depression Scale (CES-D)



BECK DEPRESSION INVENTORY SHORT FORM

Instructions:

*This is a questionnaire. On this questionnaire are groups of statements. Please read the entire group of statements in each box. Then pick out the one statement in that group that best describes the way you feel **TODAY**, that is, right now. Tick beside the statement you have chosen. If several statements in the group seem to apply equally well, **tick each one.***

BE SURE TO READ ALL THE STATEMENTS IN EACH GROUP BEFORE MAKING YOUR CHOICE.

1.
a I do not feel sad
b I feel sad or unhappy.
c I am unhappy or sad all of the time and I can't snap out of it.
d I am so unhappy or sad that I can't stand it

3.
a I do not feel like a failure.
b I feel I have failed more than the average person.
c As I look back on my life all I can see is a lot of failures.
d I feel I am a complete failure as a person (parent, husband, wife).

5.
a I don't feel particularly guilty.
b I feel bad or unworthy a good part of the time.
c I feel quite guilty.
d I feel as though I am very bad or worthless.

7.
a I don't have any thoughts about harming myself.
b I feel I would be better off dead.
c I have definite plans about committing suicide.
d I would kill myself if I could.

9
a I make decisions about as well as ever.
b I try to put off making decisions
c I have great difficulty in making decisions.
d I can't make decisions any more

11.
a I can work about as well as before.
b It takes extra effort to get started at doing something.
c I have to push myself very hard to do anything.
d I can't do any work at all.

13.
a My appetite is no worse than usual.
b My appetite is not as good as it used to be.
c My appetite is much worse now.
d I have no appetite at all any more.

2.
a I am not particularly pessimistic or discouraged about the future.
b I feel discouraged about the future.
c I feel I have nothing to look forward to.
d I feel that the future is hope-less and that things cannot improve.

4.
a I am not particularly dissatisfied.
b I don't enjoy things the way I used to.
c I don't get satisfaction out of anything any more
d I am dissatisfied with every-thing.

6
a I don't feel disappointed in myself.
b I am disappointed in myself.
c I am disgusted with myself.
d I hate myself.

8
a I have not lost interest in other people.
b I am less interested in other people than I used to be
c I have all of my interest in other people and have little feeling for them
d I have lost all of my interest in other people and don't care about them at all.

10
a I don't feel I look any worse than I used to.
b I am worried that I am looking old or unattractive.
c I feel that there are permanent changes in my appearance and they make me look unattractive.
d I feel that I am ugly or repulsive looking.

12.
a I don't get more tired than usual
b I get tired more easily than I used to.
c I get tired from doing anything.
d I get too tired to do anything.

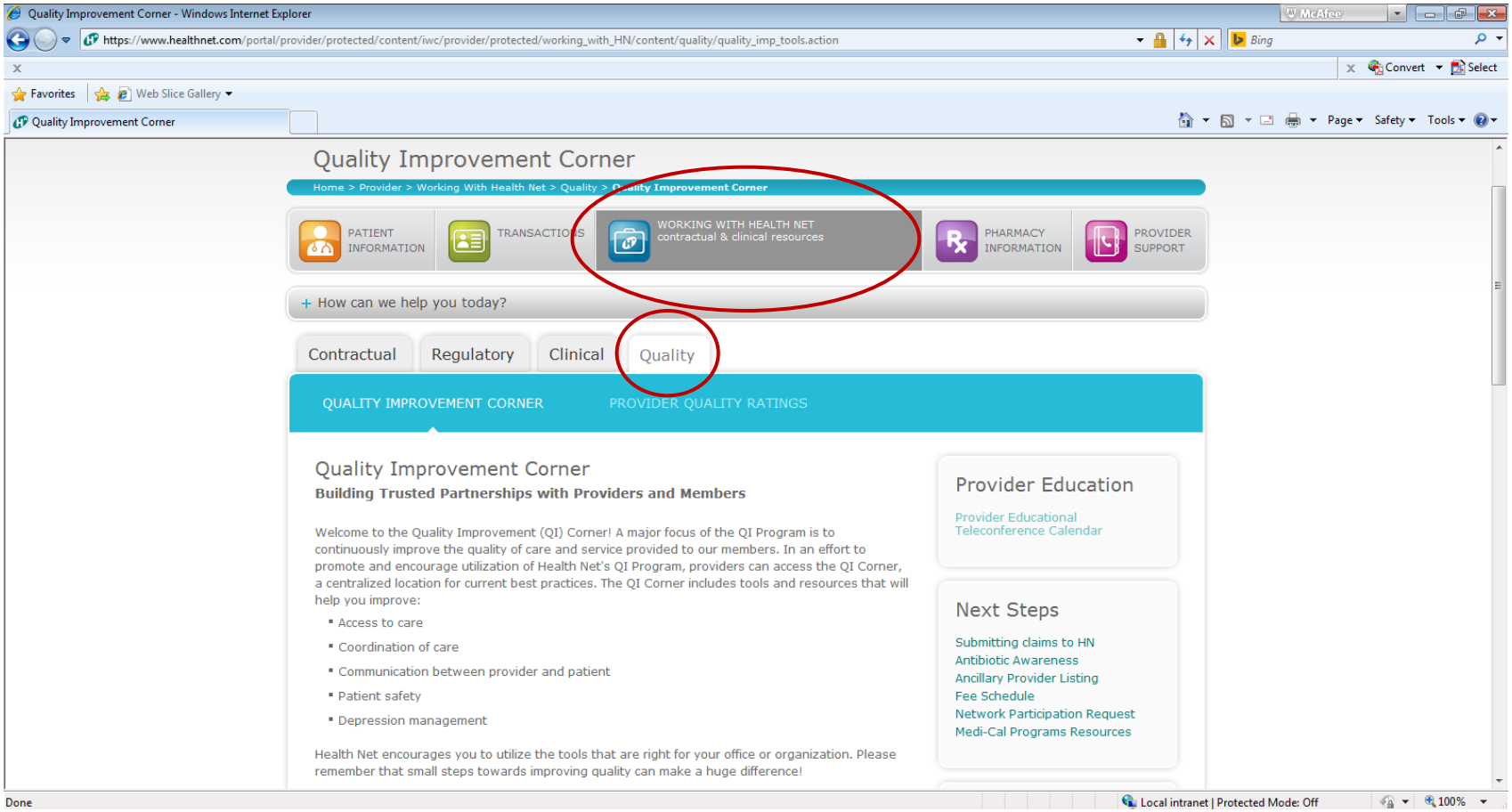
Score: *a=0, b=1, c=2, d=3*
Score total: *0-10 =not depressed*
12-18= depressed
20+ =very depressed ACTION!

Name:
Date:
Scorer:
JAAF January 2007
http://www.sadness101.com/beck.html

Beck Depression Inventory (BDI or BDI-II)

Quality Improvement Corner

Accessible at www.provider.healthnet.com → Working with Health Net → Quality Improvement Tab



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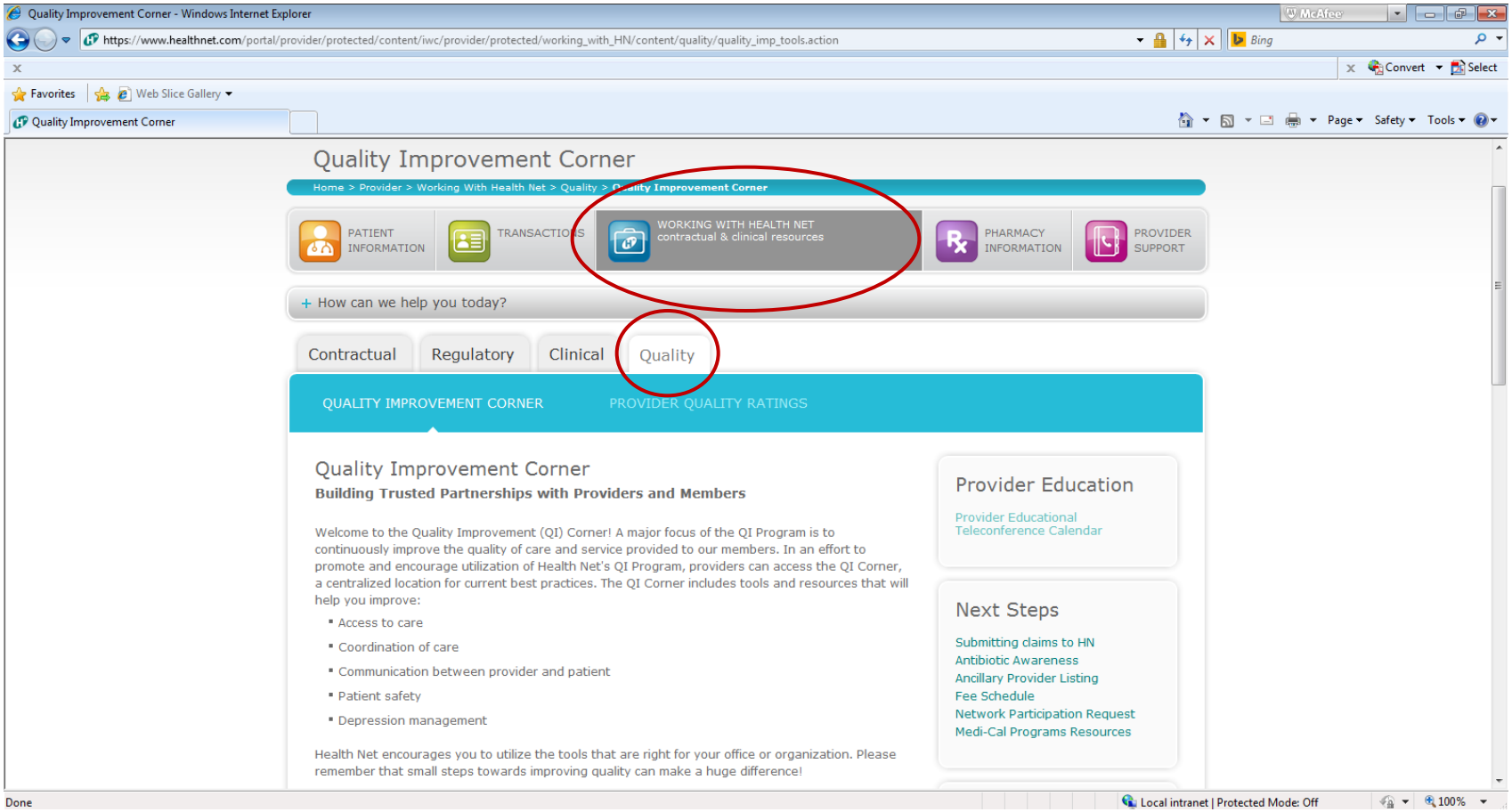
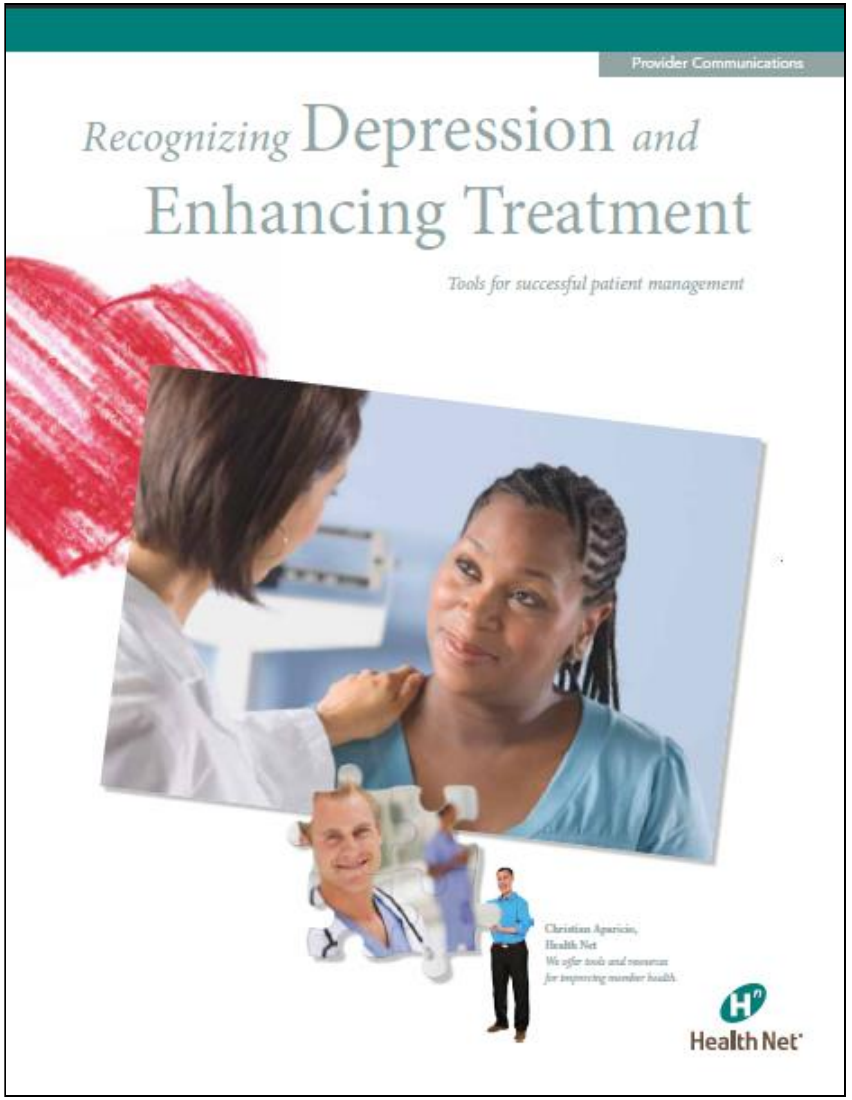


Health Net Depression Toolkit

- Identifying depression
- Treating depression
- Coordinating care
- Promoting medication adherence
- Communicating with patients
- Educational materials for patients



Questions

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