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Depression Screening: Network Resources

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Agenda

- Depression Screening
- Depression Screening Tools

Depression Screening

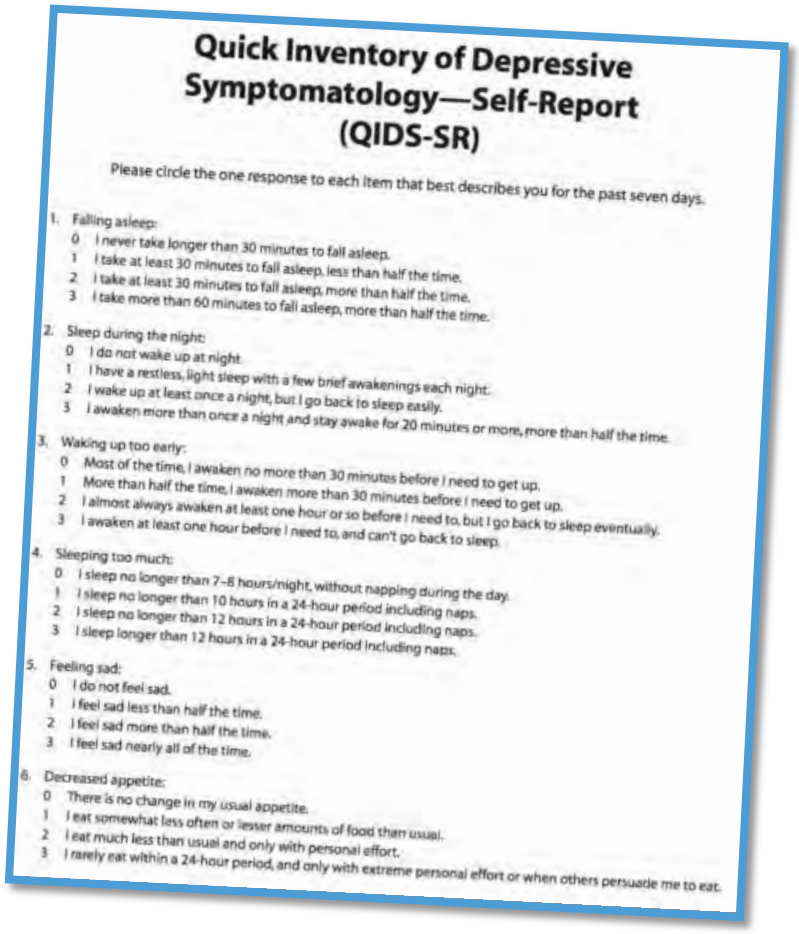
- Required for the 2019 QIP Score
- Each patient is to be evaluated for depression annually
    - It does not matter when the evaluation is done
- 30-day grace period after 2017 to complete the patient evaluations
- If a patient is identified as depressed, their chart will need to describe their subsequent treatment plan
- Transient patients are not required to be screened for depression

Depression Screening Tools

- Quick Inventory of Depressive Symptomatology – Self Report (QIDS-SR) Scale
- Beck Depression Inventory – II (BDI-II)
- Patient Health Questionnaire (PHQ-9)
- Hamilton Rating Scale for Depression (HAM-D)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Short Form (36) Health Survey (SF-36)
- Kidney Disease Quality of Life Questionnaire (KDQOL-SF)

Quick Inventory of Depressive Symptomatology – Self Report (QIDS-SR) Scale

- Self administered
- 16 item inventory
- Measures the severity of the symptoms of depression



Quick Inventory of Depressive Symptomatology—Self-Report (QIDS-SR)

Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time.
   3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night:
   0 I do not wake up at night.
   1 I have a restless, light sleep with a few brief awakenings each night.
   2 I wake up at least once a night, but I go back to sleep easily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early:
   0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   1 More than half the time, I awaken more than 30 minutes before I need to get up.
   2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

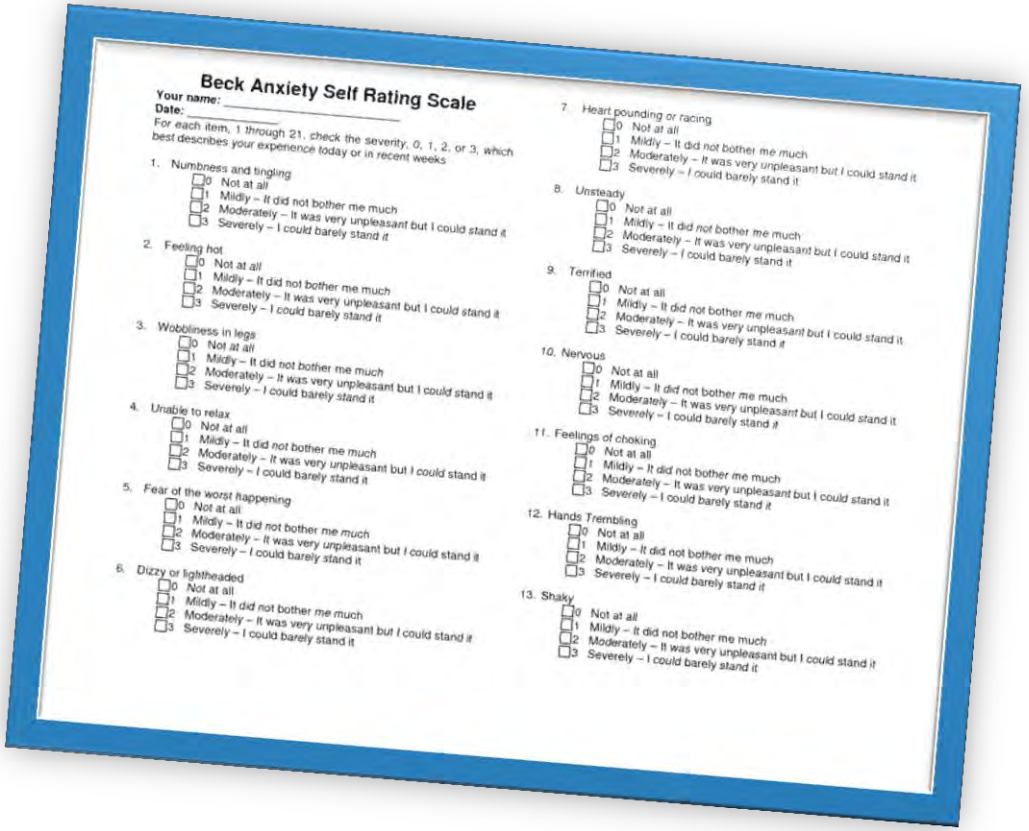
4. Sleeping too much:
   0 I sleep no longer than 7–8 hours/night, without napping during the day.
   1 I sleep no longer than 10 hours in a 24-hour period including naps.
   2 I sleep no longer than 12 hours in a 24-hour period including naps.
   3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
   0 I do not feel sad.
   1 I feel sad less than half the time.
   2 I feel sad more than half the time.
   3 I feel sad nearly all of the time.

6. Decreased appetite:
   0 There is no change in my usual appetite.
   1 I eat somewhat less often or lesser amounts of food than usual.
   2 I eat much less than usual and only with personal effort.
   3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

Beck Depression Inventory – II (BDI-II)

- 21 item self report instrument
- Designed to determine the presence and severity of symptoms of depression
- Creates a single score that indicates the intensity of the depressive symptoms
- Four point scale for each item ranging from 0 to 3



Beck Anxiety Self Rating Scale

Your name: _____

Date: _____

For each item, 1 through 21, check the severity, 0, 1, 2, or 3, which best describes your experience today or in recent weeks

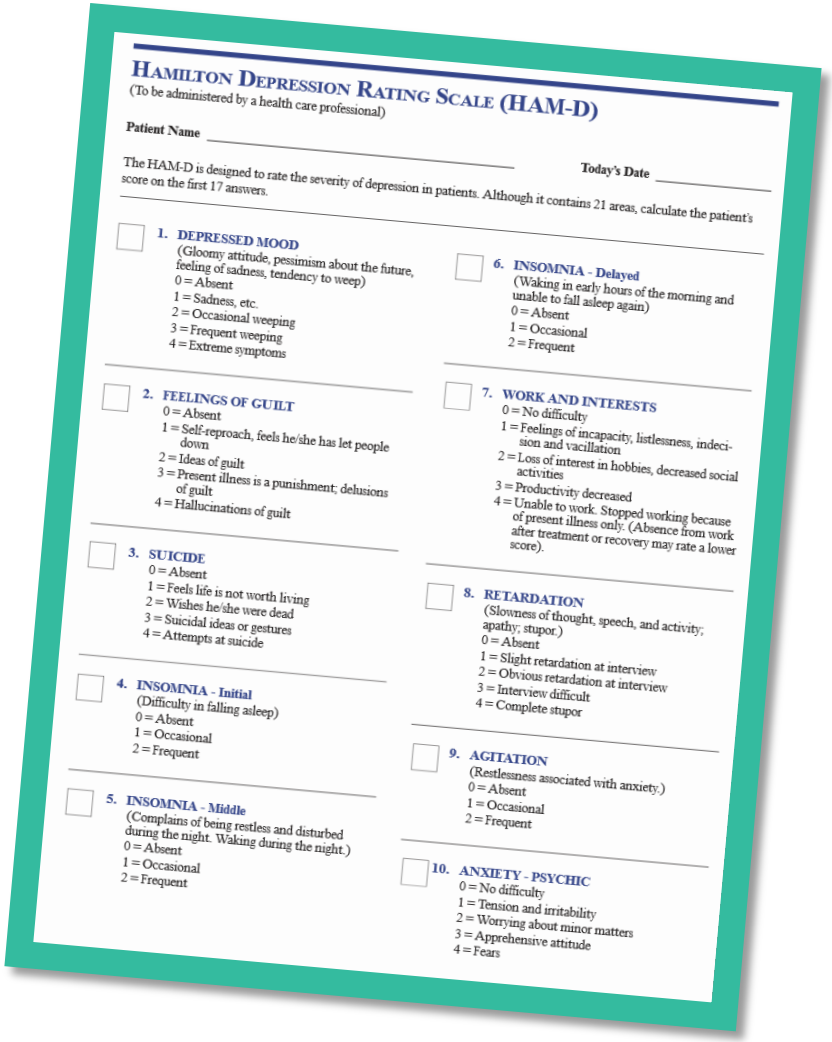
1. Numbness and tingling
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
2. Feeling hot
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
3. Wobbliness in legs
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
4. Unable to relax
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
5. Fear of the worst happening
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
6. Dizzy or lightheaded
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
7. Heart pounding or racing
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
8. Unsteady
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
9. Terrified
   - ☐0 Not at all
   - ☐1 Mildly – It did not bother me much
   - ☐2 Moderately – It was very unpleasant but I could stand it
   - ☐3 Severely – I could barely stand it
10. Nervous
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it
11. Feelings of choking
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it
12. Hands Trembling
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it
13. Shaky
    - ☐0 Not at all
    - ☐1 Mildly – It did not bother me much
    - ☐2 Moderately – It was very unpleasant but I could stand it
    - ☐3 Severely – I could barely stand it

Patient Health Questionnaire (PHQ-9)

- Instrument to measure depression severity
- PHQ – three page self administered questionnaire
- PHQ-9 – nine item depression module of the PHQ
- PHQ-9 – scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe and severe depression

Hamilton Rating Scale for Depression (HAM-D)

- Patient rated by a clinician
- Scored on a three or five point scale
- Scores over 20 indicate moderate, severe, or very severe depression



HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name _____ **Today's Date** _____

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

1. **DEPRESSED MOOD**
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

2. **FEELINGS OF GUILT**
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

3. **SUICIDE**
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

4. **INSOMNIA - Initial**
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

5. **INSOMNIA - Middle**
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

6. **INSOMNIA - Delayed**
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

7. **WORK AND INTERESTS**
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

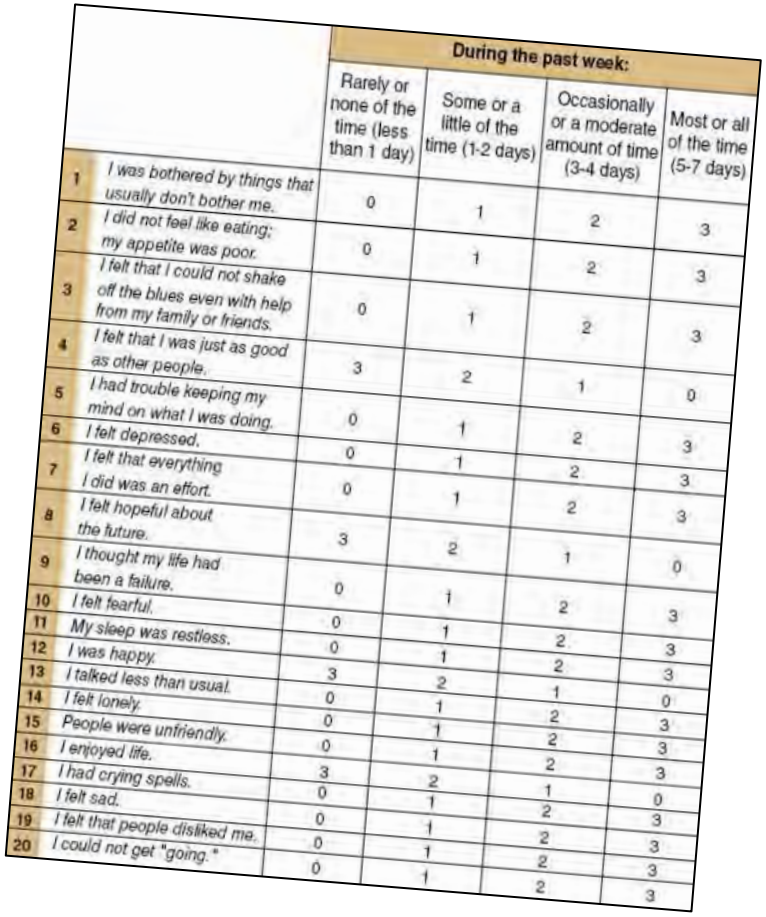
8. **RETARDATION**
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

9. **AGITATION**
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

10. **ANXIETY - PSYCHIC**
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

Center for Epidemiologic Studies Depression Scale (CES-D)

- 20 item measure assessing symptoms of depression with items phrased as self statements (ex: I feel hopeful about the future)
- Ratings based on a 4 point Likert scale ranging 0 (rarely or none of the time) to 3 (most or all the time [5 - 7 days])
- Measures symptoms associated with depression experienced during the past week



		During the past week:			
		Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1	I was bothered by things that usually don't bother me.	0	1	2	3
2	I did not feel like eating; my appetite was poor.	0	1	2	3
3	I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4	I felt that I was just as good as other people.	3	2	1	0
5	I had trouble keeping my mind on what I was doing.	0	1	2	3
6	I felt depressed.	0	1	2	3
7	I felt that everything I did was an effort.	0	1	2	3
8	I felt hopeful about the future.	3	2	1	0
9	I thought my life had been a failure.	0	1	2	3
10	I felt fearful.	0	1	2	3
11	My sleep was restless.	0	1	2	3
12	I was happy.	3	2	1	0
13	I talked less than usual.	0	1	2	3
14	I felt lonely.	0	1	2	3
15	People were unfriendly.	3	2	1	0
16	I enjoyed life.	0	1	2	3
17	I had crying spells.	0	1	2	3
18	I felt sad.	0	1	2	3
19	I felt that people disliked me.	0	1	2	3
20	I could not get "going."	0	1	2	3

Short Form Health Survey (SF-36)

- 36 question survey to assess health status
- One multi-item scale that assesses eight health concepts
    1. Limitations on physical activities because of health problems
    2. Limitations on social activities because of physical and emotional problems
    3. Limitations on usual role activities because of physical health problems
    4. Bodily pain
    5. General mental health (psychological distress and well being)
    6. Limitations on usual role because of emotional problems
    7. Vitality
    8. General health perceptions

Kidney Disease Quality of Life Questionnaire (KDQOL-SF)

36 question survey with five subscales

- Measure of physical and mental functioning
- Burden of kidney disease
- Symptoms and problems (sore muscles, chest pain, problems with access)
- Effects of kidney disease on daily life (fluid limitations, diet restrictions, travel)

Summary

- **Every patient needs to be assessed for depression**
- **There is no preferred evaluation tool, it is the choice of the clinician**
- **If treatment is needed, a subsequent treatment plan is to be documented detailing the next steps in the patient's care.**

Thank you

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