**NCQA 2011: Depression**

PAFP/IPIP CES Residency Program Collaborative  
LS2  
November 2, 2012  
Lancaster, PA

George Valko, M.D.  
Gustave and Valla Amsterdam Professor of Family and Community Medicine  
Vice-Chair for Clinical Programs  
Department of Family and Community Medicine  
Jefferson Medical College
Learning Objectives

• Understand the importance of depression screening in their patient population
• Be able to incorporate depression into their practice using demonstrated tools and techniques
• Understand the initial management and monitoring of depression
• Understand how depression is incorporated in the 2011 NCQA application
• Learn from practical examples of depression screening for the 2011 NCQA application
Pre Test Instructions:

• Use the clicker provided to choose a response to the questions on the next slides.
• You will have 5-10 seconds to respond.
• Note the countdown timer to make sure you answer before the poll closes.
I understand the importance of depression screening in the patient population.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I understand the tools and techniques to screen for depression.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I understand the initial management and monitoring of depression.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I understand how depression is incorporated in the 2011 NCQA Standards for PCMH.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I am able to present examples of depression screening for the 2011 NCQA application.

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
**NCQA 2011: Depression**

**PCMH 2: Identify and Manage Patient Populations**

**Element C: Comprehensive Health Assessment**

<table>
<thead>
<tr>
<th>Element</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Documentation of age- and gender-appropriate immunizations and screenings</td>
<td>100%: The practice meets 8-9 factors, 75%: The practice meets 6-7 factors, 50%: The practice meets 4-5 factors, 25%: The practice meets 2-3 factors, 0%: The practice meets 0-1 factors</td>
</tr>
<tr>
<td>2. Family/social/cultural characteristics</td>
<td></td>
</tr>
<tr>
<td>3. Communication needs</td>
<td></td>
</tr>
<tr>
<td>4. Medical history of patient and family</td>
<td></td>
</tr>
<tr>
<td>5. Advance care planning (NA for pediatric practices)</td>
<td></td>
</tr>
<tr>
<td>6. Behaviors affecting health</td>
<td></td>
</tr>
<tr>
<td>7. Patient and family mental health/substance abuse</td>
<td></td>
</tr>
<tr>
<td>8. Developmental screening using a standardized tool (NA for adult-only practices)</td>
<td></td>
</tr>
<tr>
<td>9. Depression screening for adults and adolescents using a standardized tool.</td>
<td></td>
</tr>
</tbody>
</table>
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Factor 6: Assessment of risky and unhealthy behaviors should go beyond physical activity and smoking status. Assessment may include nutrition, oral health, dental care, familial behaviors, risky sexual behavior and secondhand smoke exposure. Unhealthy behaviors are often linked to the leading causes of death—heart disease, stroke, cancer, diabetes and injury. (CDC BRFSS)

Factor 7: The practice assesses whether the patient or the patient’s family has any mental health conditions or substance abuse issues (e.g., stress, alcohol, prescription drug abuse, illegal drug use, maternal depression).

Factor 8: For newborns through 3 years of age, periodic developmental screening is done using a standardized screening test. If there are no established risk factors or parental concerns, screens are done by 24 months. Factor 8 may be marked “NA” by practices that serve only adult patients, and the practice will be considered to have met the factor. The practice must provide a written explanation for an NA response.

Factor 9: The USPSTF recommends:

- Adults: Screening adults for depression when staff-assisted depression care support systems are in place to assure accurate diagnosis, effective treatment and follow-up.
- Adolescents (12–18 years): Screening for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up.

Documentation

Factors 1–9: The practice provides a process showing how the information is consistently collected or a completed patient assessment (de-identified) of the factors documented during the health assessment. NCQA encourages practices to highlight or otherwise indicate the information in the documentation that meets each factor. Do not provide large portions of a medical record.
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PCMH 3: Plan and Manage Care

The practice systematically identifies individual patients and plans, manages and coordinates their care, based on their condition and needs and on evidence-based guidelines.

Element A: Implement Evidence-Based Guidelines

The practice implements evidence-based guidelines through point-of-care reminders for patients with:

1. The first important condition
2. The second important condition
3. The third condition, related to unhealthy behaviors or mental health or substance abuse.

Scoring

<table>
<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 3 factors</td>
<td>No scoring option</td>
<td>The practice meets 2 factors, including factor 3</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>

Yes | No
Factor 3 has been identified as a critical factor and must be met for practices to receive a 50% or 100% score, at least one identified condition must be related to unhealthy behaviors (e.g., obesity, smoking), substance abuse (e.g., illegal drug use, prescription drug addiction, alcoholism) or a mental health issue (e.g., depression, anxiety, bipolar disorder, ADHD, ADD, dementia, Alzheimer’s).

When selecting conditions, practices should consider the following:
- Diagnoses and risk factors prevalent in patients seen by the practice (data from PCMH 2, Elements B and C)
- The importance of care management and self-management support in reducing complications
- The availability of evidence-based clinical guidelines
- Patients with the conditions selected in factors 1–3 will be used for the medical record review required in PCMH 3, Elements C and D, and in PCMH 4, Element A.
### Element B: Provide Referrals to Community Resources

<table>
<thead>
<tr>
<th>The practice supports patients/families that need access to community resources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintains a current resource list on five topics or key community service areas of importance to the patient population</td>
</tr>
<tr>
<td>2. Tracks referrals provided to patients/families</td>
</tr>
<tr>
<td>3. Arranges or provides treatment for mental health and substance abuse disorders</td>
</tr>
<tr>
<td>4. Offers opportunities for health education programs (such as group classes and peer support.)</td>
</tr>
</tbody>
</table>

**Scoring**

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<thead>
<tr>
<th>100%</th>
<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 3 factors</td>
<td>The practice meets 2 factors</td>
<td>The practice meets 1 factor</td>
<td>Practice does not provide services</td>
</tr>
</tbody>
</table>

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Factor 3: The practice provides treatment or identifies a treatment provider and helps patients get care for mental health and substance abuse problems, if needed.
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70  PCMH 6: Measure and Improve Performance

PCMH 6: Measure and Improve Performance  
20 points

The practice uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.

Element A: Measure Performance  
4 points

The practice measures or receives data on the following:

1. At least three preventive care measures  
2. At least three chronic or acute care clinical measures  
3. At least two utilization measures affecting health care costs  
4. Performance data stratified for vulnerable populations (to assess disparities in care).

Scoring

<table>
<thead>
<tr>
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<th>75%</th>
<th>50%</th>
<th>25%</th>
<th>0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The practice meets all 4 factors</td>
<td>The practice meets 2-3 factors</td>
<td>No scoring option</td>
<td>The practice meets 1 factor</td>
<td>The practice meets no factors</td>
</tr>
</tbody>
</table>
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Explanation

The practice reviews its performance on a range of measures to help it understand its care delivery system’s strengths and opportunities for improvement. Data may be from internal or external sources. If an external source (such as a health plan) provides the data, the practice must state that the information represents 75 percent of its eligible population. While some measures may fit into multiple categories appropriately, each measure may be used only once for this element.

When it selects measures of performance, the practice must document the period of measurement, the number of patients represented by the data and the patient selection process.

Factor 1: Preventive measures include: 1) services recommended by the U.S. Preventive Services Task Force (USPSTF), 2) immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), 3) preventive care and screenings for children and for women as recommended by the Health Resources and Services Administration (HRSA) or 4) other standardized preventive measures, including those identified in Bright Futures for pediatric patients. Examples of measures include:

- Cancer screening
- Developmental screening
- Immunizations
- Osteoporosis screening
- Depression screening
- Assessment of behaviors affecting health, such as smoking, BMI and alcohol use.
Mental Health in Context: Depression

Hillary Bogner MD MSCE
Assistant Professor
Department of Family Medicine and Community Health
University of Pennsylvania
Goals of this lecture

- Discuss the importance of screening
- Provide you with some screening tools
- Discuss ways to open the conversation about treatment (preferences)
- Discuss initial management and monitoring
Who provides mental health in the US?

- Psychiatrists
- Psychologists, counselors
- Social workers

Primary care providers provide up to 75% of psychiatric care in this country -> depression
Depression in Primary care

- 1 of 5 most common conditions in PC
- Nearly 10% of all primary care visits are depression related
  - But far fewer are noted as such
Primary care patients with depression are more likely to present with physical symptoms.

69% Presented with only physical symptoms

n = 1146 patients
Why do patients present with physical symptoms?

- Higher prevalence of depression in chronic disease (default focus)
- Depression amplifies physical symptoms (e.g. pain)
- Perceptions of what medicine is: “doctors just want to check on your heart and lungs and things”
- More common when patient doesn’t have ongoing relationship with PMD
MH-PH links

- Mental Health affects the onset, progression and outcomes of physical illness
  - MH is associated with health risk behaviors e.g.
    - Substance abuse, tobacco use
    - Physical inactivity

- Chronic disease can have a profound impact on individual’s mental health
  - Change in self perception, change in lifestyle, and interaction with others, loss of work or function...
DSM IV criteria MDD

at least 5/9 symptoms below for two weeks or more, for most of the time almost every day, and this is a change from his/her prior level of functioning. One of the symptoms must be either (a) depressed mood, or (b) loss of interest.

1. Depressed mood. For children and adolescents, this may be irritable mood.
2. A significantly reduced level of interest or pleasure in most or all activities.
3. A considerable loss or gain of weight (e.g., 5% or more change of weight in a month when not dieting). This may also be an increase or decrease in appetite. For children, they may not gain an expected amount of weight.
4. Difficulty falling or staying asleep (insomnia), or sleeping more than usual (hypersomnia).
5. Behavior that is agitated or slowed down. Others should be able to observe this.
6. Feeling fatigued, or diminished energy.
7. Thoughts of worthlessness or extreme guilt (not about being ill).
8. Ability to think, concentrate, or make decisions is reduced.
9. Frequent thoughts of death or suicide (with or without a specific plan), or attempt of suicide. And:
   – The persons' symptoms do not indicate a mixed episode.
   – The person's symptoms are a cause of great distress or difficulty in functioning at home, work, or other important areas.
   – The person's symptoms are not caused by substance use (e.g., alcohol, drugs, medication), or a medical disorder.
   – The person's symptoms are not due to normal grief or bereavement over the death of a loved one, they continue for more than two months, or they include great difficulty in functioning, frequent thoughts of worthlessness, thoughts of suicide, symptoms that are psychotic, or behavior that is slowed down (psychomotor retardation).

B. Another disorder does not better explain the major depressive episode.

C. The person has never had a manic, mixed, or a hypomanic Episode (unless an episode was due to a medical disorder or use of a substance).
Conceptually these symptoms may be grouped as disturbances in:

- Emotions (depressed mood, loss of interests or pleasure)
- Ideation (worthlessness or guilt, death or suicide)
- Neurovegetative or somatic symptoms (sleep, appetite or weight, energy, psychomotor, concentration)
Conceptually these symptoms may be grouped as disturbances in:

- Emotions (depressed mood, loss of interests or pleasure)
- Ideation (worthlessness or guilt, death or suicide)
- Neurovegetative or somatic symptoms (sleep, appetite or weight, energy, psychomotor, concentration)
“SIG-E-CAPS” mnemonic

SLEEP changes: increase during day or decreased sleep at night
INTEREST (loss): of interest in activities that used to interest them
GUILT (worthless): depressed elderly tend to devalue themselves
ENERGY (lack): common presenting symptom (fatigue)
COGNITION/CONCENTRATION: reduced cognition &/or difficulty concentrating
APETITE (wt. loss): usually declined, occasionally increased
PSYCHOMOTOR: agitation (anxiety) or retardations (lethargy)
SUICIDE attempts

SEXUALITY - decreased in major depression
SOMATIC - headaches, stomach ache or backache
But many primary care patients will have some but not all criteria for MDD

- subsyndromal depression
- masked depression
- atypical depression
- minor depression without mood disturbance
- subclinical depression
- subthreshold depression
- subdysthymic depression
- nondysphoric depression
The spectrum of depression symptoms is different in primary care

- **Ambulatory primary care patients**
  - 5-10% have MDD
  - 20%-40% have depressive symptoms, not MDD
    - Often co-occur with other chronic disease

- **The “full spectrum” of Depression**
  - contributes to disability
  - interferes with medical care (adherence)
  - may be a predictor of underlying chronic disease (CVD) and can become MDD
Why is depression missed?

- Most people who are depressed do not seek help for depression
  - May expect PMD to “pick up on it”
  - May feel MH not in doc’s purview
  - don’t want to bother the doc (“good patient”)　
  - afraid the doc will prescribe an antidepressant
  - Some patients cannot articulate emotional concerns
How can we as docs do a better job?

- Screening?
- Listening/observing “between the lines”
- Preferences and values
- Get out of the default
When to screen? (red flags)

- A history of depression
- Multiple unexplained somatic symptoms
- A recent major stress or loss
- Frequent use of the emergency room or frequent office visits
- Chronic pain
- Chronic illness(es)
- Sleep disturbance, fatigue, appetite or weight change as the chief complaint
Screening recommendations

- Many practices use screening tools (e.g. waiting room)
- But what are USPTF recommendations?
  - Screening for all adults in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.
Laboratory evaluation

- Complete blood count
- Serum electrolytes and glucose
- BUN and creatinine
- Hepatocellular enzymes
- TSH
- RPR (especially in older or patients otherwise at-risk for neurosyphilis)
- Serum B12 and folate
- Urinalysis
Two question screen

During the past two weeks, have you ever been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

if yes to either, go further

sensitivity 97% and specificity of 67%
**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✓ to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**For office coding**

0 + 0 + 0 + __________ = Total Score: ________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Level</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Only about 50% of patients with MDD get adequate treatment

- Physician monitoring/adjustment
- Patient barriers to accepting/getting/sticking with treatment

- Preferences and values
Realities about treatment: what patients tell us

Preferences: most prefer counseling over meds
- “deals with social and psychological causes”
- “helps me re-structure how I approach problems”
- “not just a quick fix”
- “meds too many side effects/interacts with other meds”

But few actually follow through with referral to therapist
- Reimbursement
- No communication b/w psych and PMD
- Stigma/admitting it’s depression/do buy into psychiatry (“loss of faith” not a problem that requires medicine)
Preferences

- Patients want to avoid side effects
- Older patients, women and minorities tend to prefer counseling over meds
- Most patients prefer counseling with PMD or in PMD’s office as opposed to MH specialist, spiritual advisor, community center
- Integrated with other health care
When patients get their preferences...

- Improve more quickly (but not more adherent)
- may be linked to how well treatment fits with beliefs about depression
## Depression and Anxiety Meds

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication</th>
<th>Initial</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI</td>
<td>*^ Citalopram</td>
<td>5-20mg</td>
<td>20-60mg</td>
</tr>
<tr>
<td></td>
<td>*^ Sertraline</td>
<td>12.5-50mg</td>
<td>50-250mg</td>
</tr>
<tr>
<td></td>
<td>* Escitalopram</td>
<td>5-10mg</td>
<td>10-40mg</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine</td>
<td>10-20mg</td>
<td>20-80mg</td>
</tr>
<tr>
<td></td>
<td>Paroxetine</td>
<td>5-20mg</td>
<td>20-60mg</td>
</tr>
<tr>
<td></td>
<td>Luvoxamine</td>
<td>25mg</td>
<td>50-300mg</td>
</tr>
<tr>
<td>SNRI</td>
<td>Duloxetine</td>
<td>20mg</td>
<td>20-120mg</td>
</tr>
<tr>
<td></td>
<td>Desvenlafaxine</td>
<td>50mg</td>
<td>50-100mg</td>
</tr>
<tr>
<td></td>
<td>^ Venlafaxine</td>
<td>12.5-37.5mg</td>
<td>75-375mg</td>
</tr>
</tbody>
</table>

*SSRI with least drug interactions, ^ Generic

*FDA Warning!*
# Other Medications

<table>
<thead>
<tr>
<th>Class</th>
<th>Med</th>
<th>Initial</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant</td>
<td>Bupropion</td>
<td>25-150mg</td>
<td>100-450mg</td>
</tr>
<tr>
<td></td>
<td>Mirtazapine</td>
<td>7.5-15mg</td>
<td>15mg-60mg</td>
</tr>
<tr>
<td>Tricyclic</td>
<td>Nortriptyline</td>
<td>10-25mg</td>
<td>Blood level 50-150</td>
</tr>
<tr>
<td></td>
<td>Desipramine</td>
<td>10-25mg</td>
<td>100-300 mg</td>
</tr>
</tbody>
</table>
Education: Starting Antidepressants

- Why is it important?
- How long will it take to work?
- Potential side effects?
- How long to stay on treatment?
  - Single episode
    - 6-9 months after remission, taper slowly
  - Recurrent/psychotic/severe
    - 3 strikes and you’re on!

Write out directions
Starting Antidepressants

- Start Low if anxious, or older, but work it up as tolerated
  - 1/4-1/2 the usual starting dose for younger adults
- Increase dose
  - Dosages should be increased if there is lack of response after two weeks (6-8 weeks if older)
- Don’t Stop
  - If needed for symptom resolution, get to near-max doses
- Be Patient
  - Up to 12 weeks for anxiety
Incomplete Response

- Always increase dose first
- Augment
  - Lithium, T3 (cytomel) best evidence
  - Bupropion, mirtazapine more common
  - Occasionally a stimulant
- Can switch in or between classes
- Don’t combine 2 SSRI/SNRIs
  - Serotonin Syndrome
Always consider depression in the face of chronic disease/pain/somatic c/o
Get comfortable with screening qq
Keep lines of communication open
Work with patients to find a treatment that fits with needs (preferences, beliefs/explanations)
I understand the importance of depression screening in the patient population.*

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I understand the tools and techniques to screen for depression. *

1. Strongly Agree
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I understand the initial management and monitoring of depression.*

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I understand how depression is incorporated in the 2011 NCQA Standards for PCMH.*

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
I am able to present examples of depression screening for the 2011 NCQA application.*

1. Strongly Agree
2. Agree
3. Neutral
4. Disagree
5. Strongly Disagree
Please Rate the overall Speaker Ability. (Results not shown)

1. Poor
2. Fair
3. Satisfactory
4. Good
5. Excellent
The information presented is directly applicable to patient care and practice behavior.

1. Not at all
2. Somewhat
3. Average
4. To a great degree
5. Completely
Questions?