Gap: National screening rates for depression in primary care settings are suboptimal.

Learning Objective: Participants will recognize patients that are appropriate for depression screening, understand the barriers to screening, and perform an accurate screening assessment using a validated tool, such as the Patient Health Questionnaire-9, to determine if further treatment is warranted.

Supporting Rationale

- The US Preventative Services Task force recommends universal screening for depression in the general adult population.[1] This recommendation is based on a review of 71 clinical studies, which collectively indicate that screening programs in general increase the likelihood of treatment response and remission in those with clinical depression.[2]

- Despite the recommendations, physicians and other health care providers are not screening their patients universally. Data from the 2012 and 2013 National Ambulatory Medical Care Survey found that in a sample of 33,653 physician-patient encounters, the overall rate of depression screening was only 4.2%.[3]

- While many practitioners believe that they can diagnose depression without a standardized tool, research has shown this is often not the case. A 2009 meta-analysis of 50,000 patients revealed that without using a standardized screening tool, general practitioners only correctly identify depression in 47.3% of cases.[4] The Patient Health Questionairre-9 (PHQ-9) is the most commonly used objective screening tool used to screen for depression.[5] Numerous studies have shown it to be a valid instrument for depression screening.[6,7,8] It has been shown to have a high sensitivity and specificity for depression screening using a cutoff point of 10.[7]

- Barriers to depression screening exist and it is important that physicians are aware of these barriers. Patients have expressed concerns about the side effects and amount of anti-depressant medications.[9] In addition, numerous patients feel that the problem is not severe enough or that depression is without risk.[9] Physician barriers to screening exist as well. These include physician time constraints, competing clinical priorities, limited coverage and treatment access, discontinuity of care, lack of support for effective follow-up, physician beliefs about depression, skill deficits in patient interviewing, and medicalization of depression symptoms. [10]

Gap: Although measurement-based care has been shown to be superior to standard care in the treatment of depression, physicians and other primary caregivers are not familiar with this practice and do not routinely follow it.

Learning Objective: Participants will understand and be able to implement measurement-based care regarding depression, so that the accuracy of ongoing assessment can be improved

and treatment can be better tailored to the individual patient with the goal of sustained remission.

Supporting Rationale

- Measurement-based care can be defined as the practice of basing treatment on objective patient data. Many areas of medicine have practiced this for years, but mental health has lagged behind.[11] The Joint Commission defines measurement-based care as care that is based on standardized tools and assessments.[12] A physician or organization uses a standardized tool or instrument to monitor a patient's progress in achieving his or her treatment goals, then gathers and analyzes data generated through standardized monitoring. The physician or organization then uses that data to adjust the individual's plan of care. Finally, outcomes of care for a population are analyzed via a standardized monitoring effort.

- Measurement-based care works, and specifically, works for mental health. A 2015 randomized controlled trial revealed that 86.9% of patients with major depression received response with measurement-based care compared to only 62.7% for those who received standard treatment.[13] More significant, 73.8% of those patients who were treated with measurement-based care achieved remission, compared with only 28.8% of patients who received standard treatment.[13]

- Although it is evidence based, measurement-based care is used by less than 20% of behavioral health clinicians in the United States.[14] Only 13.9% of mental health providers report using standardized tools to measure progress at least monthly and 61.5% never use such tools.[14] Many providers argue that they do not need to use measurement-based care. However, the data reveals that when using subjective clinical judgment alone, mental health providers detect deterioration for only 21.4% of their patients who are experiencing worsening symptoms of depression.[15]

- Many strategies exist to help physicians integrate measurement-based care into their practice. Implementation strategies include electronic health care enhancements that can embed standardized questions into the electronic health record.[16] Physician focus groups as well as individual or group training on managed-based care can also help health care providers.[16]

Summary of Needs Assessment

- Depression affected an estimated 16.2 million adults, or 6.7% of all United States adults, in 2016.[17]

- Universal screening of adults with a standardized, objective screening tool is recommended and has been shown to improve detection rates of depression.

Secondary to lack of education and barriers to implementation, screening rates among adults in primary care settings is suboptimal.

- Measurement-based care; using standardized tools to measure progress and monitor treatment effects; has been shown to be superior to standard care for the treatment of depression. However, few clinicians practice this method of treatment, leading to worsening patient outcomes.

References

1. Siu AL and the US Preventative Services Task Force. Screening for depression in adults: US Preventative Services Task Force recommendation statement. *JAMA*. 2016;315(4):380-387.
2. O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU, Henderson JT, Bigler KD, Whitlock EP. Screening for depression in adults: an updated systematic evidence review for the U.S. Preventive Services Task Force [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Jan.
3. Akincigil A, Matthews EB. National rates and patterns of depression screening in primary care: results from 2012 and 2013. *Psychiatr Serv*. 2017;68(7):660-666.
4. Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. *The Lancet*. 2009; 374(9690): 609-619.
5. El-Den S, Chen TF, Gan YL, O'Reilly, CL. The psychometric properties of depression screening tools in primary healthcare settings: a systematic review. *J Affect Disord.* 2018 Jan 1;225:503-522..
6. Christensen KS, Oernboel E, Zatzick D, Russo J. Screening for depression: rasch analysis of the structural validity of the PHQ-I in acutely injured trauma survivors. *Journal of Psychosomatic Research*. 2017;97:18-22.
7. Moriatry AS, Gilbody S, McMillan D, Manea L. Screening and case finding for major depressive disorder using the Patient Health Questionnaire (PHQ-9): a meta-analysis. *General Hospital Psychiatry*. 2015; 37(6):567-576.
8. Manea LM, Gilbody S, McMillan D. A diagnostic meta-analysis of the Patient Health Questionairre-9 (PHQ-9) algorithm scoring method as a screen for depression. *General Hospital Psychiatry.* 2015; 37(1): 67-75.
9. Farrokhi F, Beanlands H, Logan A, Kurdyak P, Jassal SV. Patient-perceived barriers to a screening program for depression: a patient opinion survey of hemodialysis patients. *Clinical Kidney Journal*. 2017;6(1):830-837.
10. Harrison DL, Miller MJ, Schmitt MR, Touchet BK. Variations in the probability of depression screening at community-based physician practice visits. *Prim Care Companion J Clin Psychiatry*. 2010; 12(5): PCC.09m00911.
11. Scott K, Lewis CC. Using measurement-based care to enhance any treatment. *Cogn Behav Pract.* 2015; 22(1):49-59.
12. Lavin P, Berry L, Williams S. Measurement based care in behavioral health [webinar]. Joint Commission Accreditation Behavioral Health Care; April 11, 2017.

https://www.jointcommission.org/assets/1/6/bhc_Joint_Commission_measures_webinar_041117.pdf
13. Guo T, Xiang YT, Xiao L, et al. Measurement-based care versus standard care for major depression: a randomized controlled trial with blind raters. *Am J Psychiatry.* 2015 Oct;172(10):1004-13.
14. Jensen-Doss A, Haimes EMB, Smith AM, Lyon AR, Lewis CC, Stanick CF, et al. Monitoring treatment progress and providing feedback is viewed favorably but rarely used in practice. *Adm Policy Ment Health*. 2016;45:1–14.
15. Hatfield D, McCullough L, Frantz SH, et al: Do we know when our clients get worse? An investigation of therapists' ability to detect negative client change. *Clinical Psychology and Psychotherapy.* 2010;17: 25–32.
16. Lewis C, Puspitasari A, Boyd MR, et al. Implementing measurement based care in community mental health: a description of tailored and standardized methods. *BMC Research Notes*. 2018; 11(76).
17. Major depression. National Institute of Mental Health website. Retrieved from https://www.nimh.nih.gov/health/statistics/major-depression.shtml. Updated November 2017. Accessed February 5, 2018.