Depression Screening

Chelly Dykes, M.D.
GI Care for Kids / Children’s Healthcare of Atlanta
Our center

- 15 physicians
- 1 IBD PA (clinical and program support)
- Multiple satellite locations
- Large geographic area served
- 2 psychologists (shared with CHOA-Egleston)
KEY DRIVER DIAGRAM
Project Name: Inflammatory Bowel Disease (IBD)
Project Leaders: Chelly Dykes, MD, Ben Gold, MD, Glen Lewis, MD, Clair Talmadge, PA
Revision Date: 8/9/17

SMART AIM
By August 30, 2019, the IBD population will reach the following targets:

1. Increase % of patients with inactive disease from 76% to 80%*
2. Increase % of patients with sustained remission from 45% to 50%
3. Maintain % of patients with satisfactory nutrition at or above 90%
4. Maintain % of patients with satisfactory growth at or above 90%

IBD Population:
Infants, adolescents & young adults diagnosed with Crohn’s Disease (CD), Ulcerative Colitis (UC) or Indeterminate Colitis (IC) who are seen in GI Care for Kid’s clinics and are listed in the IBD registry.

GLOBAL AIM
Design and implement a comprehensive delivery system for the care of patients with Inflammatory Bowel Disease (Crohn’s Disease, Ulcerative Colitis or Indeterminate Colitis) that is effective, evidenced-based, efficient, family centered and safe in order to optimize clinical status and quality of life.

KEY DRIVERS

Standardized and Complete Care (correct diagnosis, adequate nutritional care, appropriate growth monitoring)

Safe and Effective Use of Medications
Balancing Measures:
- Maintain % of patients not taking prednisone at or above 95%**

Appropriate Access to Information (care, patient data, information and financial support)

Timely and Relevant Educational, Self-Management and Transition Tools (staff education, self-management, transition to adult care, public awareness)

INTERVENTIONS

Pre-Clinic Planning
Clear process and tools for pre-visit planning implemented across clinic with ongoing monitoring for consistency
Reliability Level: 2

Registry/Population Management Tools
Consistent, reliable data entry process, enumeration of entire population and population management
Reliability Level: 2

Medication/Model Care Guidelines
Clear process and tools to access model care guidelines
Reliability Level:

Psychological Support Screening
Access to psychologist in clinic
In-clinic psychological support screening
Reliability Level: 1

Adult Transition Program

Self-Management Skills
Appropriate process, tools and education to provide patients with self-management support
Reliability Level: 1/2

Parent/Patient Engagement
Appropriate process and activities for patients and parents to be engaged in the IBD team and their own care
Reliability Level: 1

Notes:
* Patients diagnosed > 112 days before current visit
** Excluding patients diagnosed in last 112 days
How we began to approach depression screening

- Drawing from past knowledge
- Resources available on the exchange
- Plan to use QI to guide implementation

Summary

- Spirit fingers
- Steal shamelessly, share seamlessly
ICN Exchange

www.icnexchange.org

Pediatric IBD
Depression Screening Toolkit 3.0
4/23/18

NEW & IMPROVED!

Useful changes!

Children’s Healthcare of Atlanta
Children’s Healthcare of Atlanta

Modules in Toolkit 3.0

www.icnexchange.org

- File Attachment (document, spreadsheet, video, etc.):
  - Contents and Revision Notes 3.0
  - Module 1 Why Screen
  - Module 2 Depression Screeners and Algorithms
  - Module 3 Managing Suicidal Ideation
  - Module 4 Educational and Referral Resources
  - Module 5 Scripts
  - Module 6 Implementing Screening in Clinic
  - Module 7 Staff Training and Support

Children’s Healthcare of Atlanta
Depression Screening in IBD Clinic

Slides adapted from Brandi Whitaker, PhD, Cheyenne Hughes-Reid, PhD, Meghan McAuliffe Lines, PhD, Elise Fallucco, MD, and Nemours Health and Prevention Services
WHY SCREEN?

Treating IBD From Your Head to Your Toes: We Provide Better Care When We Care for the Whole Person
National Rates of Depression

- Depression is the **number one health** and mental health problem in adolescents.
- By age 18, 1 in 5 adolescents will experience a major depressive episode.
- Rates of depression are increasing in adolescents and young adults.
- **75%** of adolescents with depression go unrecognized.

Zuckerbrot et al, 2012; Mojtabai et al, 2016
National Rates of Depression

- Only **25 – 33%** of depressed adolescents get treatment
- Untreated depression is related to social/academic problems, teen pregnancy, substance abuse, lower income levels in adulthood
- Depression can lead to **suicide**
- *Asking about suicide does not increase risk of suicide*  
  
  Zuckerbrot et al, 2012; Mojtabai et al, 2016
Top 10 Causes of Death in US in 2015

Unintentional Injury: 44%
Other: 11%
Homicide: 17%
Malignant Neoplasm: 5%
Heart Disease: 4%
Congenital Anomalies: 7%
Homicide: 7%
Congenital Anomalies: 7%

Ages 10-14
Suicide: 19%
Other: 14%

Ages 15-25
Suicide: 19%
Unintentional Injury: 44%
Homicide: 17%
Malignant Neoplasm: 5%
Heart Disease: 4%
Congenital Anomalies: 7%
Homicide: 7%

SUICIDE #3

SUICIDE #2

CDC
Emotional Functioning in Pediatric IBD

- Youth with IBD are at increased risk for depression
  - Rates as high as 25%

Psychosocial
- General QOL
- Emotions
  - General depression/anxiety symptoms
  - Depression dx in a subset
- Social difficulty
- School
  - QOL and absences
- Parent QOL, distress

Greenley et al., 2010; Mackner et al., 2013
Why Screen?

- Depression is common in pediatric settings
  - Especially youth with IBD
  - But often under-detected
- Screening increases identification of psychosocial issues
  - Especially for minority youth
- Many youth who attempt suicide had recent contact with a health professional
  - But no depression or related concerns were noted
- Adolescents report willingness to discuss mental health concerns with their doctor
Guidelines for Depression Screening

- **USPSTF:** Screen adolescents 12+ at well visits
- **AAP 2018 recommendations:**
  - Screen adolescents 12+ annually; more often for high risk patients
- **CF Foundation:**
  - Screen adolescents 12+ for depression and anxiety annually
  - Screen caregivers for depression and anxiety annually
Guidelines for Depression Screening

- Pediatric inflammatory bowel disease:
Guidelines for Depression Screening

- Pediatric inflammatory bowel disease:

  ImproveCareNow has created a collaborative community where clinicians, researchers, parents and patients are empowered to learn and continuously improve to bring about more reliable, proactive IBD care for healthier children and youth.

  Our purpose is to transform the health, care and costs for all children and adolescents with Crohn's disease and ulcerative colitis (Inflammatory Bowel Disease or IBD) by building a sustainable collaborative chronic care network. We are engaging patients, families, clinicians and researchers to work together in a learning health care system to accelerate innovation, discovery and the application of new knowledge.

  ImproveCareNow has raised the bar for the standard of care in pediatric IBD.
Ultimately, Why Screen?

We provide better care when we care for the whole person
Guidelines for IBD Depression Screening

Recommendation: Screen adolescents with IBD ages 12+ for depression annually

Psychosocial Screening Task Force
SCREENING USING THE PHQ-9
Who, When, and What?

Who?
• All IBD patients 13 years and older

When?
• Annually
• Rescreen at subsequent visits per algorithm
• Screen PRN if clinical suspicion of depression and/or anxiety

What?
• PHQ-9 (ages 13+)
• C-SSRS per algorithm
• Discuss results and make referrals as needed
Patient Health Questionnaire-9 (PHQ-9)

• Why we like it:
  – Free, brief, easy to administer and score
  – Strong psychometric properties
    • Well-validated for use with adults
    • Demonstrates good sensitivity (89.5%) and specificity (77.5%) with adolescents 13-17
    • Research suggests using a higher cutoff score with adolescents than used with adults (score=11)

Richardson et al, 2010
**PHQ-9**

This can be found in Module 2

### Ages 13+

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by any of the following problems?</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 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: [ ] + [ ] + [ ] + [ ]

=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>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>
</tr>
</tbody>
</table>
Disease vs. Depression Symptoms

• Some IBD and depression symptoms overlap
• Endorsing these IBD symptoms + some depression symptoms may result elevated PHQ-9 scores
• Use your clinical judgment
  – Prior history of depression?
  – Timing of disease/depression symptoms correspond?
• Re-screen next visit
• Tell family to call if symptoms worsen
Discuss Results

• May consider asking parent to leave the room
• Describe the symptoms the patient endorsed while normalizing and providing validation
• Use algorithms to determine which specific script(s) to use
• Use algorithms to determine if educational resources and/or referrals are needed
• See Module 5 Scripts for more info
Make Referrals as Needed

• See Module 4 Educational and Referral Resources
  – Educational materials for family and teens on stress management, depression and suicide
  – Finding a Mental Health Provider resource
  – Information for community behavioral health therapists
  – Ideas for developing a community behavioral health referral network
SmartPhrases in Epic

![Image of SmartPhrase Editor]

**SmartPhrase Editor**

- **Name:** PSYCHREFATL
- **Content:** (Text is not visible in the image)

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**Pediatric Psychology Referrals**: Be sure to confirm benefits with your insurance provider.

**Atlanta**

**Katherine S. Spencer, PsyD**
Behavioral Institute of Atlanta
8000 Lake Forrest Drive
Atlanta, GA 30328
404-256-9325 ext. 727

**Dr. Wendy Blumenthal**
www.docwendy.com
Lake Forrest Drive, Suite 115
Atlanta, GA 30328
404-943-1612
Accepts Medicaid

**Powers Ferry Psychological Associates**
http://www.atlantapsychologist.com/index.html
Marietta Office
1827 Powers Ferry Rd., Building 22
Atlanta, GA 30339

**Anita Grover, PsyD**
Licensed Psychologist

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**PSYCHIATRY**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>DECATUR FAMILY PSYCHIATRY</td>
<td>404.500.4286</td>
<td>404.500.4283</td>
</tr>
<tr>
<td>ROY SANDERS, M.D.</td>
<td>404.814.0733</td>
<td>404.814.0784</td>
</tr>
<tr>
<td>NINA BASS, M.D.</td>
<td>770.995.2313</td>
<td>770.495.3745</td>
</tr>
<tr>
<td>DENNIS NUTTER, M.D.</td>
<td>404.237.3987</td>
<td>404.237.3707</td>
</tr>
<tr>
<td>TARA HAMMOND, M.D.</td>
<td>770.772.0909</td>
<td>770.442.1542</td>
</tr>
</tbody>
</table>

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SCRIPTS
Scripts

• Scripts are meant to be basic templates
  – Not the only thing you’d say to a patient, incorporate scripts into your usual language

• Scripts include . . .
  – Introducing screening
  – Asking caregiver to leave the room
  – Discussing results of PHQ-9
  – Referring to therapy
Scripts

• Scripts include . . .
  – Introducing the C-SSRS
  – Safety planning
  – Talking with patient about need to tell caregiver
    • Including reluctant patients and caregivers who downplay the ideation
  – Telling caregiver about suicidal ideation
  – Need to send patient to ED
    • Including reluctant families
MANAGING SUICIDAL IDEATION
Does asking about suicide make someone suicidal?

- See the review paper in this module (Dazzi et al, 2014)
  - 13 studies were reviewed
  - None found a significant increase in suicidal ideation
  - 5 reported significantly decreased distress
Columbia Suicide Severity Rating Score

This can be Found in Module 3

### Columbia Suicide Severity Rating Scale

#### Screen Version – Recent

**Suicide Ideation Definitions and Prompts**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask questions that are bolded and underlined.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ask Questions 1 and 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Wish to be Dead:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you wished you were dead or wished you could go to sleep and not wake up?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Suicidal Thoughts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you actually had any thoughts of killing yourself?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.g.: &quot;I thought about taking an overdose but I never made a specific plan as to when or how I would actually do it...and I would never go through with it,&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you been thinking about how you might do this?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Suicidal Intent (without Specific Plan):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you had these thoughts and had some intention of acting on them?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Suicide Intent with Specific Plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Suicide Behavior Question:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES, ask: <em>Was this within the past three months?</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# C-SSRS Algorithm

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1</td>
<td>Safety Plan and refer for evidence-based psychotherapy such as CBT</td>
</tr>
<tr>
<td>Item 2</td>
<td>Safety Plan and refer for evidence-based psychotherapy such as CBT</td>
</tr>
<tr>
<td>Item 3</td>
<td>Safety Plan and urgent referral for psychotherapy</td>
</tr>
<tr>
<td>Item 4</td>
<td>Emergent referral/emergency room</td>
</tr>
<tr>
<td>Item 5</td>
<td>Emergent referral/emergency room</td>
</tr>
</tbody>
</table>
| Item 6 | • If 1 week or less – Emergent referral  
     | • If between 1 week to 3 months – Urgent referral  
     | • Over 3 months – Routine referral                                    |
Safety Planning

Elements to include:

• Warning signs (thoughts, mood, situation, behavior):
• Internal coping strategies (relaxation, physical activity):
• People and social settings that provide distraction:
• People whom I can ask for help:
• Professionals or agencies I can contact during a crisis:
• Making the environment safe:
• The one thing that’s most important to me and worth living for:

More training in safety planning:
http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/sp/
# Safety Planning

## Patient Safety Plan Template

<table>
<thead>
<tr>
<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: People and social settings that provide distraction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_____ Phone_____</td>
</tr>
<tr>
<td>2. Name_____ Phone_____</td>
</tr>
<tr>
<td>3. Place_____ 4. Place_____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: People whom I can ask for help:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_____ Phone_____</td>
</tr>
<tr>
<td>2. Name_____ Phone_____</td>
</tr>
<tr>
<td>3. Name_____ Phone_____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinician Name_____ Phone_____</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #_____</td>
</tr>
<tr>
<td>2. Clinician Name_____ Phone_____</td>
</tr>
<tr>
<td>Clinician Pager or Emergency Contact #_____</td>
</tr>
<tr>
<td>3. Local Urgent Care Services</td>
</tr>
<tr>
<td>Urgent Care Services Address</td>
</tr>
<tr>
<td>Urgent Care Services Phone</td>
</tr>
<tr>
<td>4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)</td>
</tr>
<tr>
<td>5. Crisis Text Line: text 741741</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 6: Making the environment safe:</th>
</tr>
</thead>
</table>
Issues to consider

• The patient’s caregiver will need to be told about the suicidal ideation
  – If the patient is uncomfortable with this, you can give him/her a choice:
    • “Would you like me to tell them, or would you like to tell them? You’d stay in the room while I told them so we could all talk about it.”
    • They almost always want you to tell them
  – It is very rare that a patient will put up a lot of resistance
    • If so, acknowledge that it is difficult, but your job is to get him/her help
  – Some patients feel some relief that someone finally knows
IMPLEMENTING SCREENING
Step 1: Consensus and basic training

- Review and discussion of PHQ9, rationale, and algorithms
- Plan for training, initial PDSAs and core team
  - Initially: 3 physicians, 2 psychologists, 1 PA
    - Then: same + 4 nurses for “core team”
- All core team trained in PHQ9 scripts and C-SSRS with role play
  - (like we had practiced at a previous community conference)
- Steal shamelessly, share seamlessly!!!
Screening plan at GI Care for Kids

• Began April 2019 with 3 physicians
  — Patients 13yo or older
  — PHQ-9 given to patients in room by MAs
  — Scored by physicians

• If Suicidality endorsed
  — Core team of Columbia assessors trained

• Templates for documentation created as Smart Phrases in Epic
• Include total score, severity, and disposition (epic smart phrases)
  – Annual screening for symptoms of depression was completed today using the PHQ-9. Total score was [**] which falls in the [minimal/mild/moderate/severe] range. Patient [did/did not] endorse suicidal ideation.
  – [Provided educational handouts/support, referral for outpatient therapy and handout on Finding a Mental Health provider/ referral for outpatient psychiatry/consult Psychology or SW.]
  – [Recommendation to re-screen next visit.]
If suicidal ideation endorsed:

- Safety planning consisted of [further assessment of suicidal ideation through administration of the C-SSRS/consult Psychology, Psychiatry, or SW/transfer to local emergency room]

- All of these were put into dot phrases in Epic
PDSA’s for Process

• Weekly PDSA’s to help establish process
• Phase 1 PDSAs: 3 MDs in main office
  – List of eligible patients coming in the following week
  – Patients 13yo or older who have not had annual screen
  – Patients who need rescreening based on last visit’s score
  – Emailed weekly list to head MA and 3 MDs the Friday before
  – MAs provided PHQ 9 while rooming the patient
  – MD scored PHQ 9, documented in note using dot phrase
Phase 1 learnings: Lots of small tests and changes were needed

- Lists were relatively “easy” to generate
- Multiple early PDSAs to get the list to “turn into” delivered screeners
  - Education of MAs
  - Standardized emails to head MA
- Scoring the forms easy
- PDSAs for documentation to simplify epic “dot phrases”
Phase 2 and 3: Scale up

• Phase 2: Same 3 MDs but added Satellite offices
  – List of patients expanded to include satellite locations
  – MD/RN emailed list of patients and attached PHQ 9 to print
  – Pre charting alert in Epic:
    
    **Depression Screening in Satellite**
    This patient is eligible for depression screening today
    The PHQ-9 has been emailed to you and your nurse
    The smart phrases you can copy/paste into your note are:
    PHQ9NOSI or PHQ9SI

• Phase 3: All MDs
  – Presented Depression Screening at morning conference
  – Trained MDs individually on Columbia protocol
Keeping Track

• Weekly list of eligible patients
  – Included: DS Completed (Yes/No), Score, SI (Yes/No), Action Taken
  – List emailed to MAs and MDs the Friday before
  – Updated during the week as PHQ 9s returned
  – Added to master list at end of week

• Running list of patients screened
  – Quickly identify if annual screening has already been done
  – Flag patients who need repeat screening

• Run chart: updated weekly
• Score chart: updated weekly
• PDSA: updated weekly
Percentage of Depression Screening Completed Each Week

- **MA process clarified, weekly emails**
- **First satellite, only 2 patients**

<table>
<thead>
<tr>
<th>Date</th>
<th>Patients Screened</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Mar-19</td>
<td>02</td>
</tr>
<tr>
<td>11-Mar-19</td>
<td>05</td>
</tr>
<tr>
<td>18-Mar-19</td>
<td>05</td>
</tr>
<tr>
<td>25-Mar-19</td>
<td>02</td>
</tr>
<tr>
<td>1-Apr-19</td>
<td>05</td>
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<tr>
<td>8-Apr-19</td>
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<td>15-Apr-19</td>
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<td>22-Apr-19</td>
<td>06</td>
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<tr>
<td>29-Apr-19</td>
<td>06</td>
</tr>
<tr>
<td>6-May-19</td>
<td>04</td>
</tr>
<tr>
<td>13-May-19</td>
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- **Weekly Averages**
- **Median**
- **Goal (0.8)**
Depression Screening Scores

Depression Screening

- None: 67
- Mild: 16
- Moderate: 10
- Severe: 3
- SI: 5
Depression Screening Scores

• **No or minimal** *(PHQ-9 score 0 – 4)*
  - Normal range, coping well
  - **Plan:** screen again in one year

• **Mild** *(PHQ-9 score 5 – 10)*
  - Mild symptoms of depression at times
  - **Plan:** provide handouts, repeat screening next visit

• **Moderate** *(PHQ-9 score 11 – 14)*
  - Would benefit from talking with a therapist
  - **Plan:** provide handouts, resources, make referral
Depression Screening Scores

- 96 Patients have been screened
- 67 did not show signs of depression
- 16 mild, 10 moderate, 3 severe
- 5 endorsed Suicidal Ideation
  - MD followed Columbia Protocol
  - All 5 left with Safety Plan and Urgent Appointment with our Psychologist

- 30% of patients screened have had actionable scores
  - Educational resources provided
  - Referrals made if not already seeing a therapist
Depression Screening Scores

• **Severe** (*PHQ-9 score ≥ 15*)
  - Would benefit from talking to a mental health provider
  - And consultation about antidepressant medication
  - **Plan:** provide educational handouts
    how to find a mental health provider
    make referral if applicable.

• **Suicidal ideation** (*PHQ-9 #9 >0*)
  - Go to Columbia-Suicide Severity Rating Score (C-SSRS)
  - **Plan:** establish Safety Plan and make referral
Special Thanks to

- Clair Talmadge, PA
- Alex Jofriet
- Aisha Rizwan
- Bonney Reed, PhD
NEXT STEPS AND QUESTIONS
Screening support

Psychosocial screening forum on the exchange:
www.icnexchange.org/forum/1248

IBD from your head to your toes

We provide better care when we care for the whole person

Children’s Healthcare of Atlanta