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Timely Information for Providers in South Carolina
An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.
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DEPRESSION & ANXIETY ARE PAINFUL

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PICK UP QUICK TIPS ON…
screening for depression and anxiety

Use rating tools to screen for undiagnosed depression and anxiety, **to assess** symptom severity before initiating treatment, **and to evaluate/ monitor treatment response.**

QUICK tip SC

Many payers reimburse for depression screening; coverage varies for anxiety.

QUICK FACTS TO CONSIDER

- Approximately **1 in 3** US adults **with major depressive disorder go untreated.**
- Nearly **1 in 2 completed suicides** occurred in patients who **contacted their primary care provider within the preceding month.**
- Almost **1 in 3** US adults **experience an anxiety disorder at some point** during their lifetime.
- **Patients with depression or anxiety are more likely to misuse** their pain medications, including **opioids.**

CLINICAL PEARLS

What tool you select to screen for depression or anxiety is less important than screening routinely. The same goes for what symptom-based tools you use to measure and document treatment response – just be consistent.

PHQ-2 & PHQ-9 are quick tools validated in primary care to screen for depression.

When patients screen positive on the PHQ-2 self-assessment (score ≥ 3), they typically complete the PHQ-9 as the next step. PHQ-9 may be the preferred initial screen over PHQ-2 for high risk patient populations, including those with chronic pain and/or on chronic opioid therapy for pain management.

For patients diagnosed with depression, the PHQ-9 becomes a useful tool to assess symptom severity before initiating treatment and at regular intervals to assess patient response.

PHQ-9 offers a starting point to assess suicide risk. Item 9 screens for suicidal ideation.

Just the fact that medical illnesses and depression are often comorbid increases the odds that a patient may contemplate or complete suicide. If patients reveal suicidal ideation on the PHQ-9, consider asking, "Are you having thoughts of harming yourself in some way?" A positive response indicates an immediate need to further assess the level of acute suicide risk – how quickly the patient may act helps determine your plan of action (e.g., escorted transfer to emergency department/facility if acute high risk).

For all patients with suicidal ideation:

- Provide the National Suicide Prevention Lifeline, 1-800-273-TALK (8255), and local suicide hotlines and peer support contacts
- Establish a **safety plan**, working with the patient to identify possible coping strategies
- Discuss limiting access to lethal means of self-harm (e.g., guns, medicine)

GAD-7 is a quick tool validated in primary care to screen for anxiety.

GAD-2, the first two questions of the GAD-7, has been used as an initial screen in primary care (positive score ≥ 3). GAD-7 is the recommended starting point for high risk populations and offers a scale to assess symptom severity at baseline and ongoing.

Currently there is no guideline to screen everyone for anxiety akin to the USPSTF recommendation to screen all patients 12 and older for depression. The data does point toward screening all patients at increased risk (e.g., family history) and/or a higher likelihood of co-morbid anxiety (e.g., patients at risk for OUD, patients with depressive disorders).

KEY: GAD-2 Generalized Anxiety Disorder 2-item scale; **GAD-7** General Anxiety Disorder 7-item scale; **OUD** Opioid Use Disorder; **PHQ-2** Patient Health Questionnaire 2-item depression scale; **PHQ-9** Patient Health Questionnaire 9-item depression scale; **USPSTF** United States Preventive Services Task Force

Patient Health Questionnaire (PHQ-9) and Scoring Instructions

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. **Over the last 2 weeks, how often have you been bothered by:**	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would have been better off dead or of hurting yourself in some way				
Subtotals				
Total Score				

If you checked off any problems on this questionnaire so far, 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

Instructions for Use (for doctor or healthcare professional only)

Assessment for initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✔s in the two right columns (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 two right columns (one of which corresponds to Question #1 or #2).*

   Consider Other Depressive Disorder
   - If there are 2 to 4 ✔s in the two right columns (one of which corresponds to Question #1 or #2).*

* Question 9 about suicidal ideation counts if present at all (i.e., the ✔ is in one of the three right columns).

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and 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 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 ✔: Not at all = 0;
   Several days = 1; More than half the days = 2; and Nearly every day = 3.
3. Add together column scores to get a TOTAL score.
4. Interpretation of TOTAL score (see table at right).
5. Results may be included in patients' records to assist you in setting up treatment goal, determining degree of response, as well as guiding treatment intervention.

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

SCREENING AND ASSESSING ANXIETY

Generalized Anxiety Disorder (GAD-7) Scale and Scoring Instructions

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 ___________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Intern Med. 2006;166:1092-1097.

Instructions for Use (for doctor or healthcare professional only)

1. Patient completes the GAD-7 Assessment.
2. Calculate score for each column (e.g., sum all circled '3s' under 'Nearly every day' – if circled two 3's, the column total = 6).
3. Add together column totals to get a TOTAL score (maximum possible score is 21).
4. Interpretation of TOTAL score.

Interpretation for initial diagnosis:

- Further evaluation is recommended for scores of 10 or greater.
- The GAD 7-item scale was designed primarily as a screening and severity measure for generalized anxiety disorder. It is moderately good at screening for panic disorder, social anxiety disorder, and post-traumatic stress disorder (a score of 8 or greater may optimize sensitivity).

Note: Since the assessment relies on patient self-report, all responses should be verified by the clinician, and the definitive diagnoses is made on clinical grounds, taking into account how well the patient understood the assessment, as well as other relevant information from the patient. Diagnose of GAD or other anxiety disorder also require ruling out a physical disorder (e.g., hyperthyroidism, asthma), medication/substance (e.g., caffeine, decongestants, corticosteroids) or intoxication or withdrawal from substances of abuse as the biological cause of the anxiety symptoms.

Interpretation to monitor severity over time for newly diagnosed patients or patients in current treatment of anxiety:

- Patients may complete questionnaire at baseline and at regular intervals.
- Results may be included in patients' records to assist you in setting up treatment goal, determining degree of response, as well as guiding treatment intervention.

Total Score	Anxiety Severity
5-9	Mild
10-14	Moderate
15-21	Severe

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WRITING GROUP

Writing Group (and Disclosures for Pharmaceutical Relationships): Sarah Ball, PharmD (none), Kelly Barth, DO (none), Sandra Counts, PharmD (none), Nancy Hahn, PharmD (none), Jenna McCauley, PhD (none), Joseph McElwee, MD (none), William Moran, MD (none), Megan Pruitt, PharmD (none), Sophie Robert, PharmD (none), Chris Wisniewski, PharmD (none).

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This information is intended to assist primary care providers in the management in adults in a primary care setting. This information is advisory only and is not intended to replace sound clinical judgment nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac; liver/renal impairment; addiction; debility; elderly; and pregnancy/breast-feeding).