EPIC TIP SHEET: DEPRESSION AND ANXIETY SYMPTOM ASSESSMENTS

Table of Contents

Overview 2

How can you tell who is due for depression / anxiety symptom assessments? 3

How can you complete a PHQ-2/9, PHQ-9, GAD-2/7, or GAD-7 in patients when they are not due for the assessment? 4

Depression and Anxiety Screening 4

How do you complete depression (anxiety) screening? 4

Depression and Anxiety Surveillance 5

How do you complete depression (anxiety) surveillance? 5

Depression and Anxiety Monitoring 6

How do you complete depression (anxiety) monitoring? 6

What happens if a patient meets symptom criteria for major depressive disorder or generalized anxiety disorder? 7

What happens if a patient screens positive for suicide? 7

Depression Management Smartset 8

Where can I find PHQ2/9 and GAD2/7 Results? 9

Clinical Decision Support Tools 10

Infectious Disease – Hiv Patients 14

Overview

At UChicago Medicine, we have several EHR tools to help you screen and manage depression and anxiety in your patients. There are 3 main health maintenance activities and best practice advisories for each condition to help manage your patients: 1) screening (for patients without the condition), 2) surveillance (for patients with history of the condition, 3) depression monitoring (for patients with active symptoms. The screening tool for depression is the PHQ-2/9 and for anxiety is the GAD-2/7. The monitoring and surveillance tools are the PHQ-9 and GAD-7, because the 2-item tools are not sensitive enough to detect symptoms in patients with a history of, or active, depression or anxiety. These tools were designed based on evidence-based medicine, which demonstrates that measuring symptoms with a formal diagnostic tool increases the chances of detection and symptom remission. Also, these tools comply with insurance requirements for depression quality measurement. So with these tools, you can help patients while also meeting documentation requirements!

The same health maintenance activities, best practice advisories, and smartforms are used throughout UChicago Medicine and link to each other, so completion of depression / anxiety symptom assessments in one clinic, leads to completion in other clinics at UChicago Medicine. Different clinics can have different frequencies of assessments (i.e., oncology screens and surveils every 3 months), but still the assessments are linked. So for example if a patient is seen in oncology and assessed, then goes to primary care within the next 12 months, the health maintenance activities and best practice advisories will already have been completed. However, the reverse will not be true because of the different frequencies.

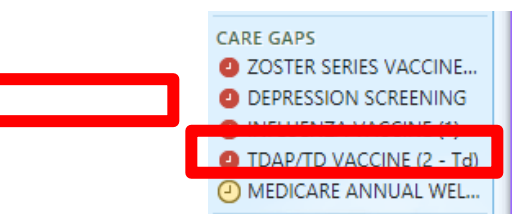
Many clinics at UChicago Medicine have joined forces to manage depression and anxiety by using these tools. All clinics are using the same tools, but they have customized aspects for their patients. For example, oncology is assessing their patients every 3 months (vs. annually). Here is a list of the clinics that are currently doing these assessments and of clinics in the planning phases:

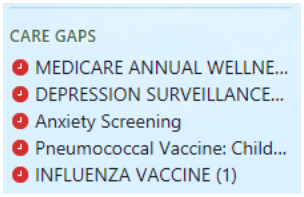
Depression (As of 11/11/2020): All Internal Medicine, Family Medicine, Pediatric, and Geriatric Primary Care clinics, Pediatric Endocrinology, Infectious Disease (HIV patients). By 2021: All Oncology clinics, Nephrology, Gastroenterology, Pain

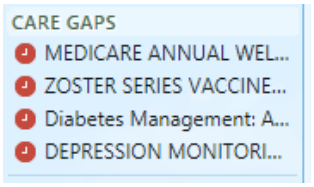
Anxiety: Infectious Disease (HIV patients). By 2021: All Oncology clinics, Gastroenterology, Pain

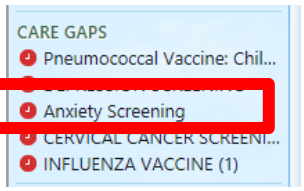
How can you tell who is due for depression / anxiety symptom assessments?

You can tell if someone is due for any of these health maintenance activities by looking in one of two places: care gaps on the sidebar, or within a visit under ROOMING or PLAN → BEST PRACTICE. There 6 types of CARE GAPS: depression screening, depression surveillance, depression monitoring, anxiety screening, anxiety surveillance, anxiety monitoring. Some examples are below.









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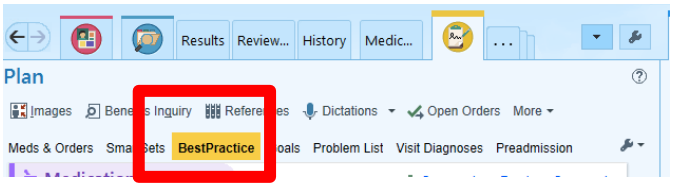

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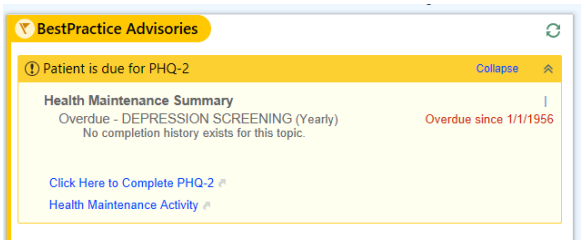
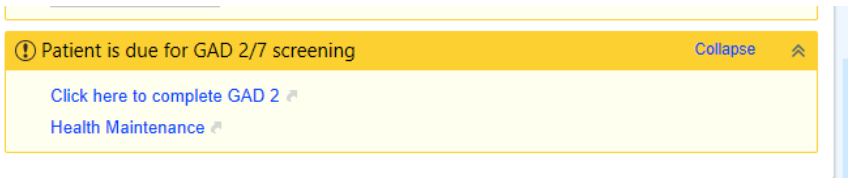
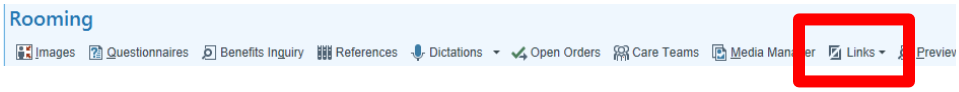




How can you complete a PHQ-2/9, PHQ-9, GAD-2/7, or GAD-7 in patients when they are not due for the assessment?

You can always use **LINKS** in **ROOMING, PLAN, OR WRAP-UP** to complete assessments for screening (PHQ-2/9 or GAD-2/7) and surveillance/monitoring (PHQ-9, GAD-7). It is not possible to include a screenshot because it is a drop-down menu.

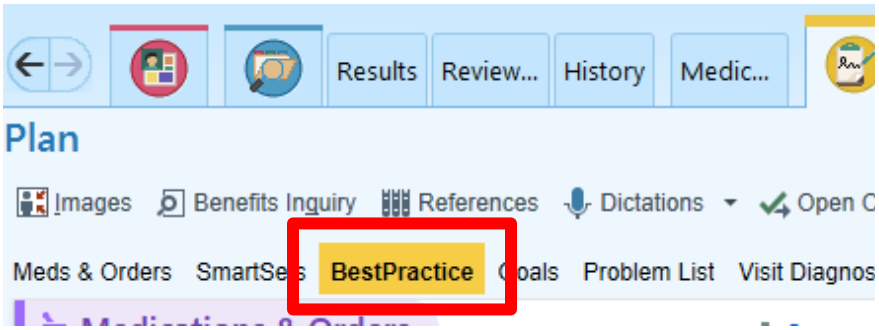


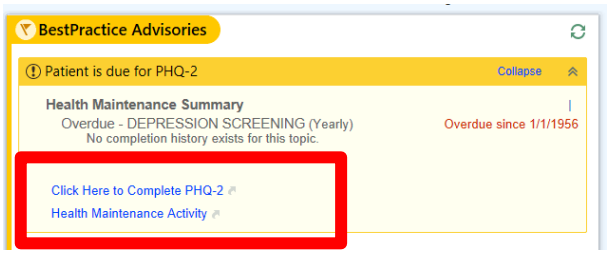
Depression and Anxiety Screening

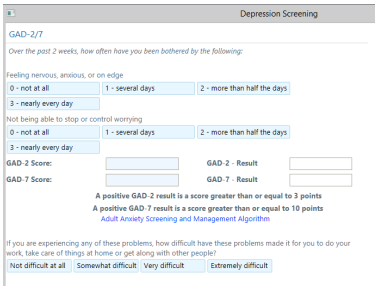
Depression (anxiety) screening is to determine if patients without a history of depression (anxiety) are exhibiting symptoms of depression (anxiety). It's recommended annually and we use a PHQ-2 (GAD-2) for screening. If patients score 3 or higher, then the additional 7 questions in the PHQ-9 (5 questions in the GAD-7) will appear, as well as the question that asks about functional limitations due to symptoms. The last question of the PHQ-9 asks about suicidal ideation, and positive responses to this question should be noted in particular.

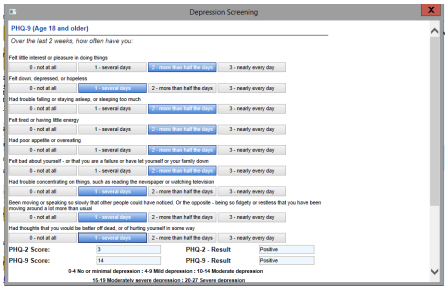
How do you complete depression (anxiety) screening?

1. The best option is to use **ROOMING or PLAN → BEST PRACTICE** to complete the PHQ2/9 or GAD2/7. **BEST PRACTICE** is built to always have the correct assessment tool depending on the patient's needs. This is the best way to find out what the patient is due for and means you don't have to look at CARE GAPS at all.

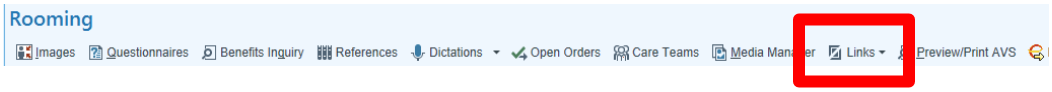








2. You can use **LINKS** in **ROOMING, PLAN, OR WRAP-UP** to complete the PHQ-2/9 (GAD-2/7). It is not possible to include a screenshot because it is a drop-down menu. The same PHQ-2/9 (GAD-2/7) as above will appear.

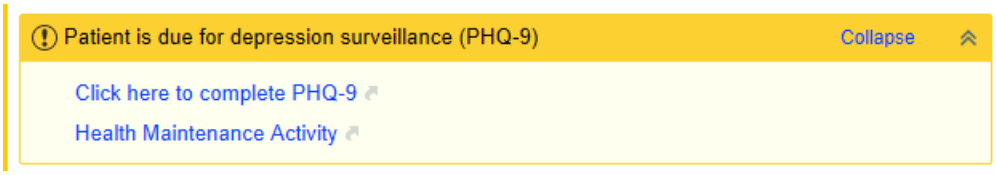


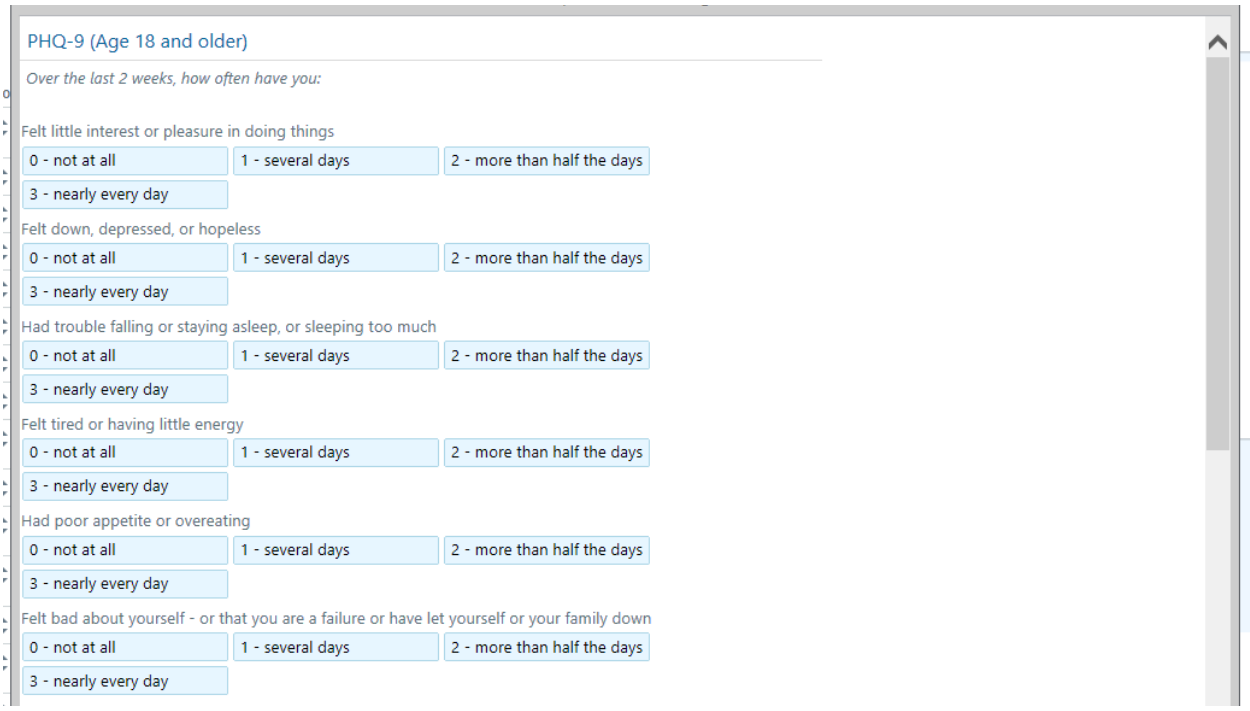
Depression and Anxiety Surveillance

Depression and anxiety surveillance is to check in on symptoms in patients with depression or anxiety, based on the problem list, history, elevated previous score, or visit diagnosis. It's recommended that patients are assessed once a year.

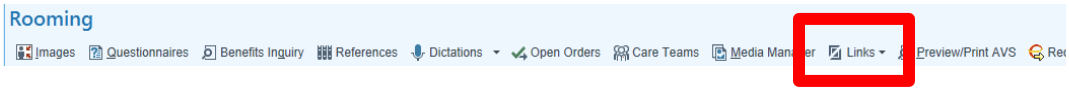
How do you complete depression (anxiety) surveillance?

1. The best option is to use **ROOMING or PLAN → BEST PRACTICE** to complete the PHQ-9 or GAD-7. **BEST PRACTICE** is built to always have the correct assessment tool depending on the patient's needs. This is the best way to find out what the patient is due for and means you don't have to look at CARE GAPS at all.





2. You can also use **LINKS** in **ROOMING, PLAN, OR WRAP-UP** to complete the PHQ-9 (GAD-7). It is not possible to include a screenshot because it is a drop-down menu. The same PHQ-9 (GAD-7) as above will appear. This is also a great option if you are completing the PHQ or GAD off-cycle.



Depression and Anxiety Monitoring

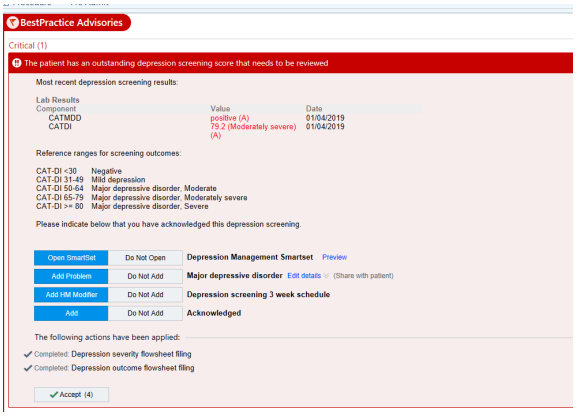
Depression / anxiety monitoring is to check in on symptoms of depression/ anxiety in patients with active depression/anxiety to help make decisions about treatment. It's recommended that patients get a monthly PHQ-9 / GAD-7 to steer treatment decisions. Once a patient has remission of depression / anxiety symptoms (a score <5), even with medications, this BPA will no longer be active. It will re-activate if the patient scores >=10 on the PHQ / GAD-7 in the future.

How do you complete depression (anxiety) monitoring?

The options are the same as for surveillance (via BEST PRACTICE or LINKS).

What happens if a patient meets symptom criteria for major depressive disorder or generalized anxiety disorder?

If patients meets symptom criteria for major depressive disorder (PHQ-9>=10) or generalized anxiety disorder (GAD-7>=10), then a red critical BPA will be present under the BPAs asking you to add the diagnosis to the problem list and visit diagnoses, offer to open the depression smartset (for both anxiety and depression – a new behavioral health smartset which can be used for any behavioral health problem for adults is being built), enroll the patient in the monitoring BPAs, and acknowledge the positive result. Accepting this BPA complies with the documentation requirements for depression quality measurement for positive screens – so please click "ACCEPT". This critical BPA currently applies to only screening, but is being built to apply for positive monitoring and surveillance results by January 2021. This BPA is NOT a pop-up and going to BPAs is the only way you will see it.

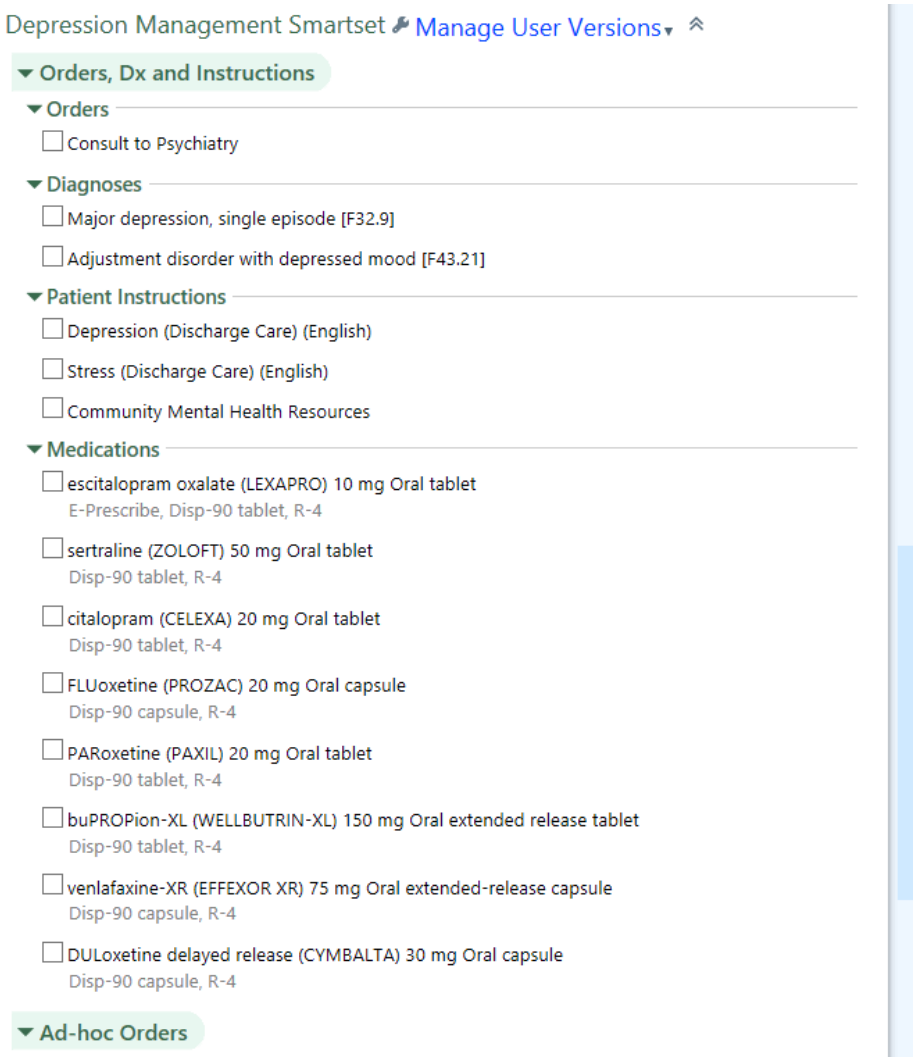


What happens if a patient screens positive for suicide?

The critical acknowledgment BPA is being updated so you will be less likely to miss this result. In the meantime, it is important that the clinical teams work together to not miss this event. In response to positive screens, the Columbia Suicide Severity Rating Scale is a validated tool to assess suicide risk. The clinical decision support tool to triage adult patients who screen positive for suicide is below.

Depression Management Smartset

Here is a screenshot of the Depression Management Smartset that is available to you. It has patient instructions and starting medications. Also, depression and anxiety tools for adults, adolescents, and adults with HIV are available at the end of this document.

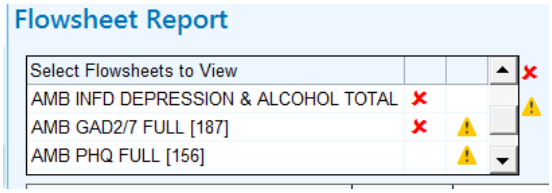


Where can I find PHQ2/9 and GAD2/7 Results?

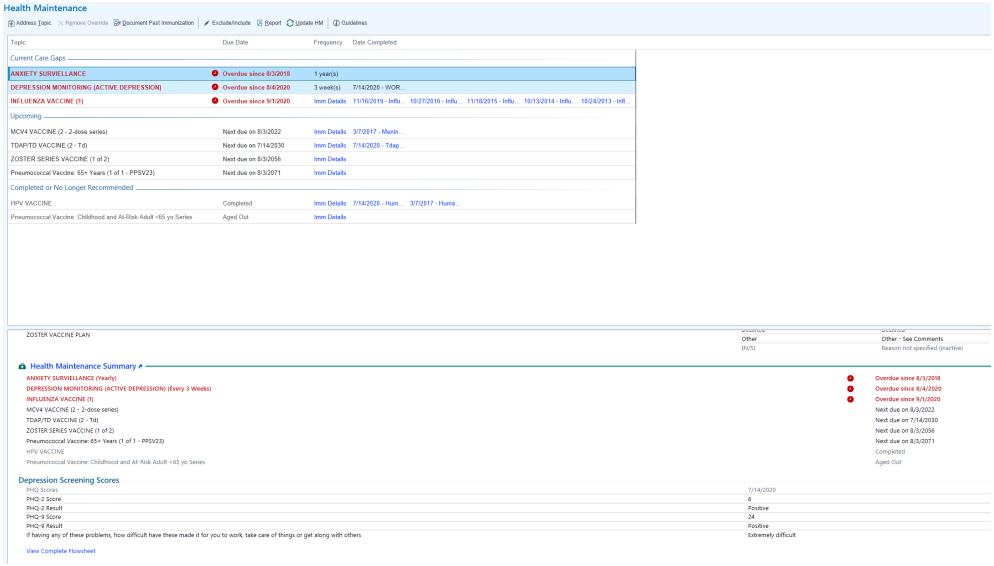
The PHQ2/9and GAD2/7 results can be seen in a few places: 1) Review Flowsheets 2) at the bottom of Health Maintenance (click CARE GAPS), 3) Widescreen view, and 4) using the dotphrase .phq2phq9 (dotphrase for GAD2/7 is being built).

Review Flowsheets

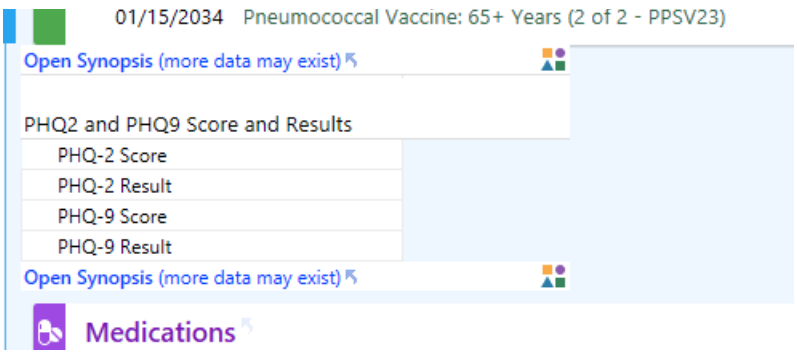
Lookup AMB PHQ FULL and AMB GAD2/7 FULL to see detailed results.



Health Maintenance

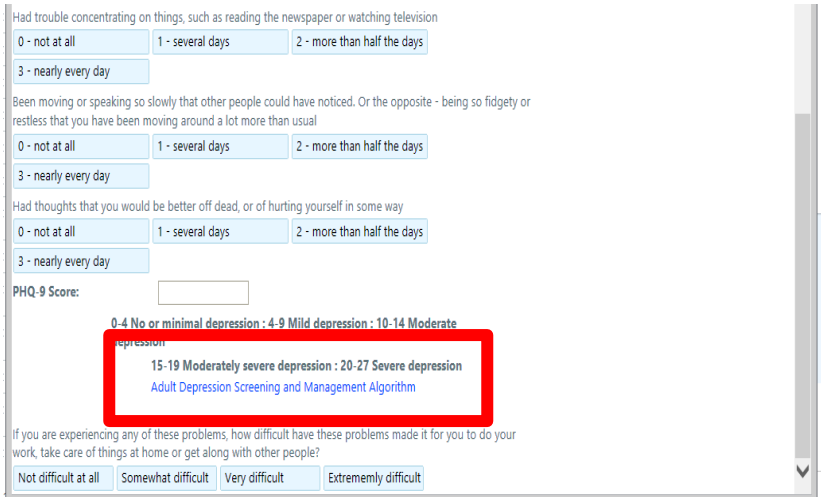


Widescreen view

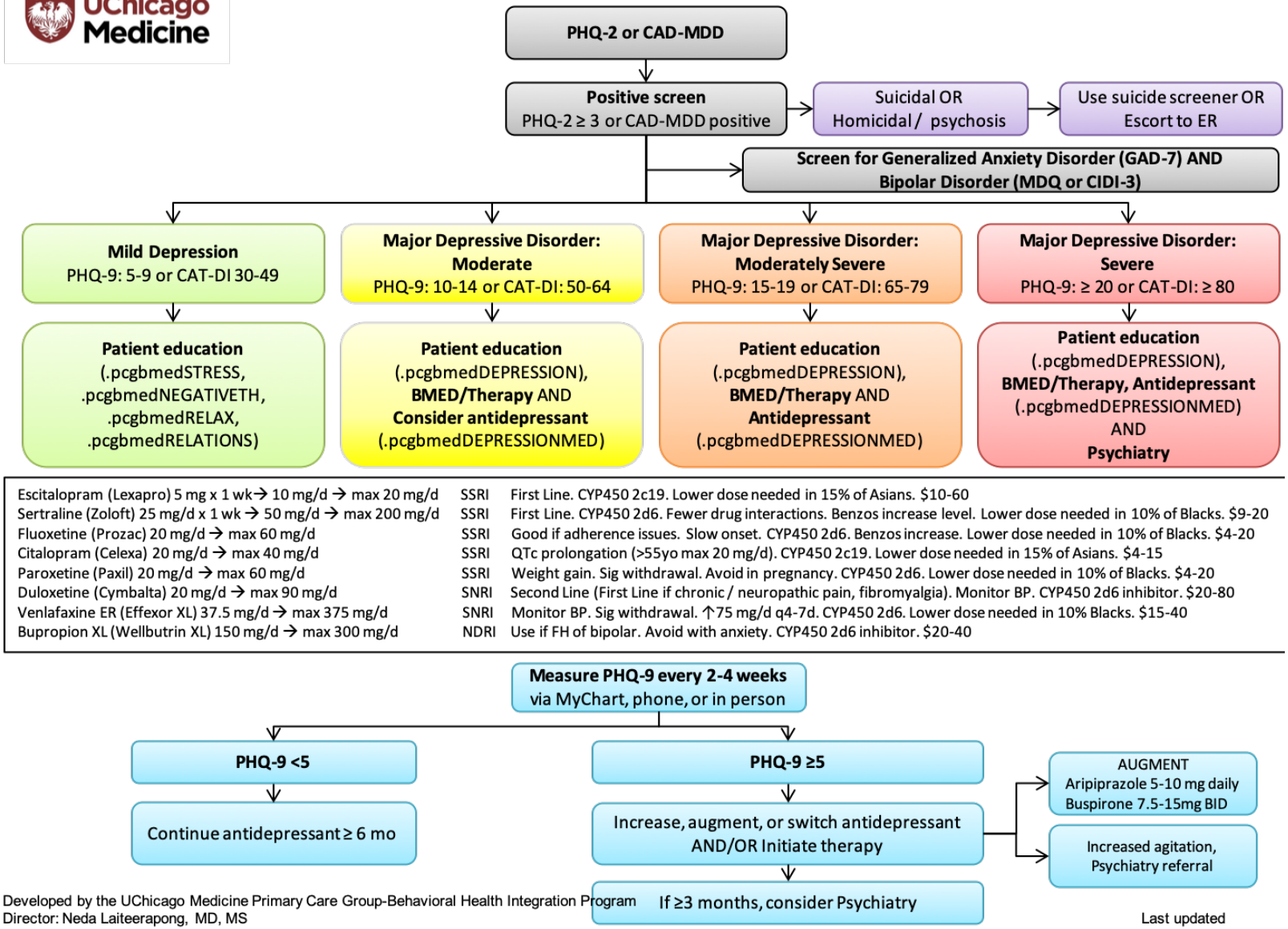


Clinical Decision Support Tools

There are clinical decision support tools developed in collaboration with the Department of Psychiatry and Behavioral Neuroscience to guide the screening and management of depression and anxiety. They are available in the smartforms:



Adult Depression Screening and Management



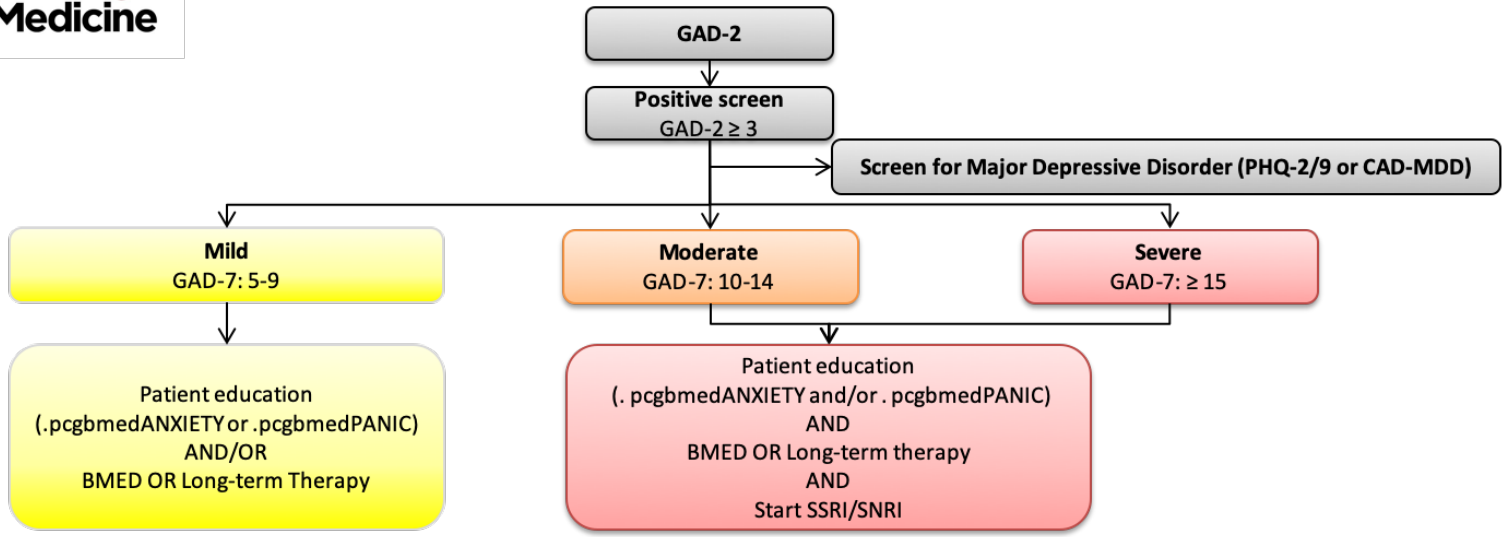
Escitalopram (Lexapro) 5 mg x 1 wk→ 10 mg/d → max 20 mg/d	SSRI	First Line. CYP450 2c19. Lower dose needed in 15% of Asians. $10-60
Sertraline (Zoloft) 25 mg/d x 1 wk → 50 mg/d → max 200 mg/d	SSRI	First Line. CYP450 2d6. Fewer drug interactions. Benzos increase level. Lower dose needed in 10% of Blacks. $9-20
Fluoxetine (Prozac) 20 mg/d → max 60 mg/d	SSRI	Good if adherence issues. Slow onset. CYP450 2d6. Benzos increase. Lower dose needed in 10% of Blacks. $4-20
Citalopram (Celexa) 20 mg/d → max 40 mg/d	SSRI	QTc prolongation (>55yo max 20 mg/d). CYP450 2c19. Lower dose needed in 15% of Asians. $4-15
Paroxetine (Paxil) 20 mg/d → max 60 mg/d	SSRI	Weight gain. Sig withdrawal. Avoid in pregnancy. CYP450 2d6. Lower dose needed in 10% of Blacks. $4-20
Duloxetine (Cymbalta) 20 mg/d → max 90 mg/d	SNRI	Second Line (First Line if chronic / neuropathic pain, fibromyalgia). Monitor BP. CYP450 2d6 inhibitor. $20-80
Venlafaxine ER (Effexor XL) 37.5 mg/d → max 375 mg/d	SNRI	Monitor BP. Sig withdrawal. ↑75 mg/d q4-7d. CYP450 2d6. Lower dose needed in 10% Blacks. $15-40
Bupropion XL (Wellbutrin XL) 150 mg/d → max 300 mg/d	NDRI	Use if FH of bipolar. Avoid with anxiety. CYP450 2d6 inhibitor. $20-40

Developed by the UChicago Medicine Primary Care Group-Behavioral Health Integration Program
Director: Neda Laiteerapong, MD, MS
10/6/2020

Last updated

AT THE FOREFRONT
UChicago Medicine

Adult Anxiety Screening and Management



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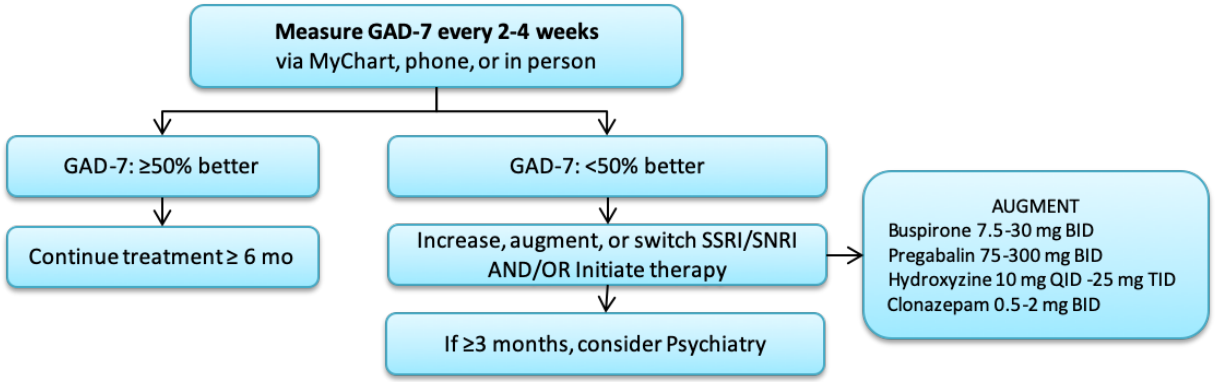
Possible diagnoses:
Adjustment Disorder
Generalized Anxiety Disorder
Social Anxiety Disorder
Panic Disorder (see algorithm)
Obsessive Compulsive Disorder
Phobia
PTSD (see algorithm)

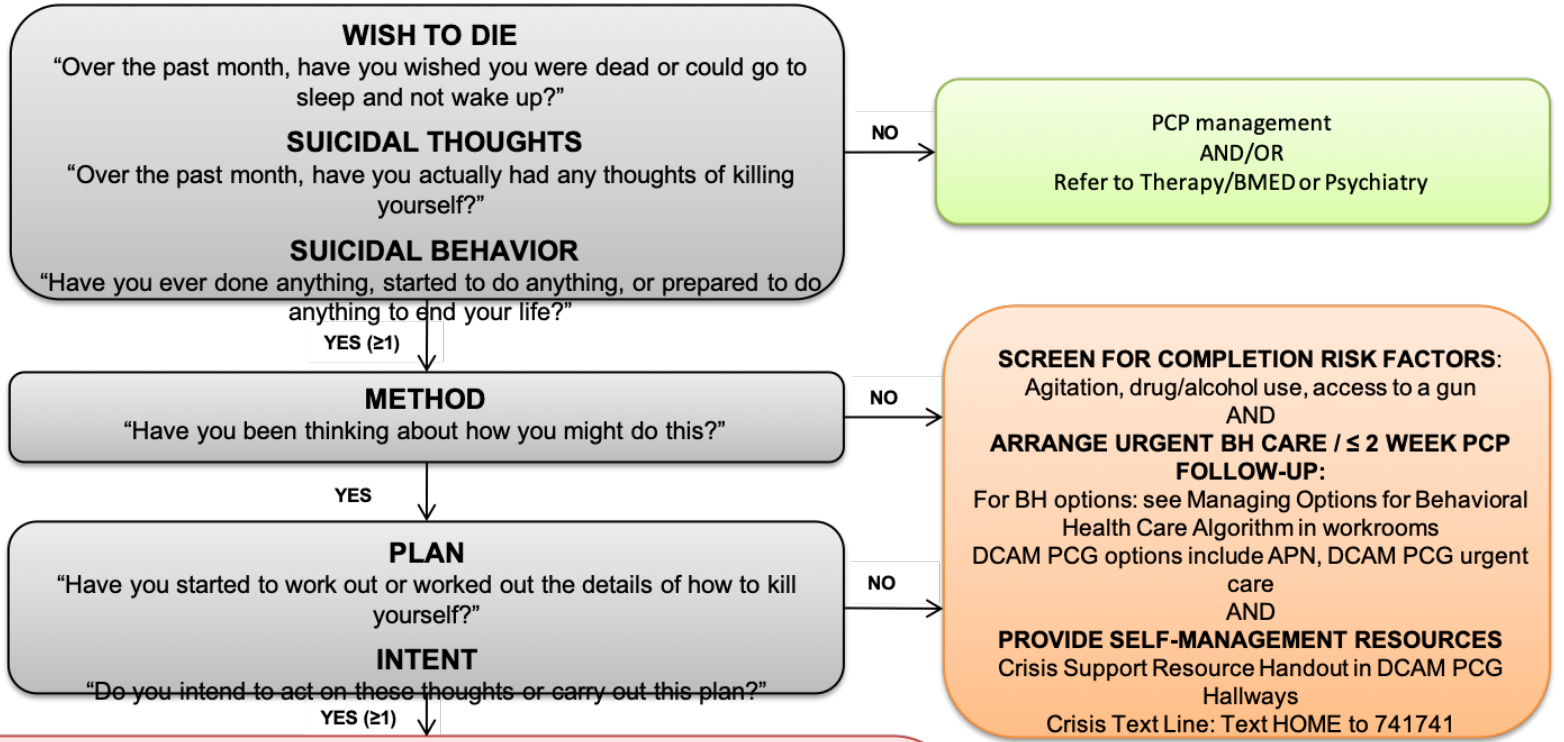


Developed by the UChicago Medicine Primary Care Group-Behavioral Health Integration Program
Director: Neda Laiteerapong, MD, MS
10/6/2020

Adapted from Bandelow et al. Intl J Psych Clin Pract 2012.16:77-84.

Last updated

Adult Suicide Screening and Management



WISH TO DIE
"Over the past month, have you wished you were dead or could go to sleep and not wake up?"

SUICIDAL THOUGHTS
"Over the past month, have you actually had any thoughts of killing yourself?"

SUICIDAL BEHAVIOR
"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"

NO → PCP management
AND/OR
Refer to Therapy/BMED or Psychiatry

YES (≥1) ↓

METHOD
"Have you been thinking about how you might do this?"

NO → **SCREEN FOR COMPLETION RISK FACTORS**:
Agitation, drug/alcohol use, access to a gun
AND
ARRANGE URGENT BH CARE / ≤ 2 WEEK PCP FOLLOW-UP:
For BH options: see Managing Options for Behavioral Health Care Algorithm in workrooms
DCAM PCG options include APN, DCAM PCG urgent care
AND
PROVIDE SELF-MANAGEMENT RESOURCES
Crisis Support Resource Handout in DCAM PCG Hallways
Crisis Text Line: Text HOME to 741741
1-800-SUICIDE
.pcgbmedHELPLINES

YES ↓

PLAN
"Have you started to work out or worked out the details of how to kill yourself?"

INTENT
"Do you intend to act on these thoughts or carry out this plan?"

NO → **SCREEN FOR COMPLETION RISK FACTORS**:
Agitation, drug/alcohol use, access to a gun
AND
ARRANGE URGENT BH CARE / ≤ 2 WEEK PCP FOLLOW-UP:
For BH options: see Managing Options for Behavioral Health Care Algorithm in workrooms
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Crisis Support Resource Handout in DCAM PCG Hallways
Crisis Text Line: Text HOME to 741741
1-800-SUICIDE
.pcgbmedHELPLINES

YES (≥1) ↓

1. Keep patient in view of staff at all times and within 6 feet
2. Ask a BH professional for help
   Check if DCAM PCG BMED clinic is open (posted flyers in clinic rooms, resident workroom)
   If not, then check if Daviel Thomas, LCSW is available (nursing office, 5-6240 / 5493)
   If not, then check if ER Behavioral Health Unit is available (5-4349 / 3310)
3. Complete petition for involuntary admission (form/example in PCG clinic drawers)
4. Ask your nurse to contact UCM Public Safety (2-6262) to escort patient via wheelchair or hospital bed (if elopement concerns)
5. Call the ER (2-6250) AND Behavioral Health Unit (3310 / 5-4349 / 847-508-1713)
6. Escort patient yourself or with BH professional or Nurse

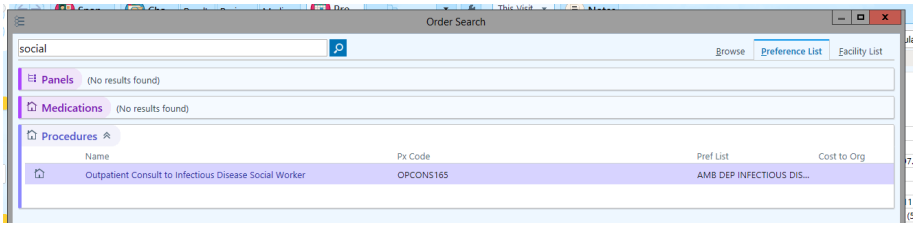
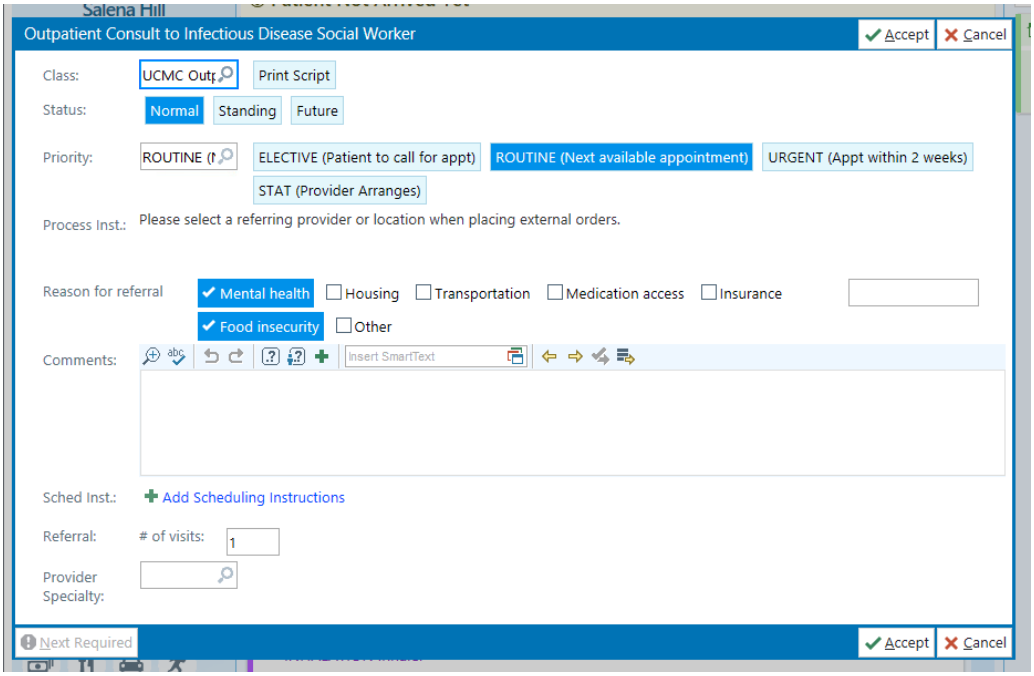
* If patient refuses to stay or elopes, call patient's local police department (311 for Chicago only) to do a wellness check AND provide them with a copy of the involuntary admission petition so they can bring the patient in for Emergent Care

AT THE FOREFRONT UChicago Medicine

Adapted from the Columbia Suicide Severity Rating Scale of the UChicago Medicine Primary Care Group-Behavioral Health Integration Program
Last updated 2/19/2020

Infectious Disease – HIV Patients

For patients living with HIV who meet symptom criteria for major depressive disorder or generalized anxiety disorder, refer patients to the **ID social worker** using the new order.



In the order, please mark the reason for referral, which can help with triage.