ADDRESSING ADOLESCENT & YOUNG ADULT DEPRESSION IN PRIMARY CARE

Depression Screening Tools and Operationalizing Screening

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Peer Learning Breakout Summary

What from Dr. Irwin's presentation will you apply in your clinic?

- Wondering if they should switch from PSC to the PHQ-2 or PHQ-9
    - PSC ages 5-11 switch to PHQ-9 when they hit age 12
- Been using 96160 code for screening, but may change to 96127

What is working really well at your practice?

- Start with PHQ-2 and cascade to PHQ-9 if PHQ-2 is positive
- The PHQ serves as a launching point for discussion with the AYA patient
- Use a suicide checklist as well
- In specialty clinic, the full care team (doctor, social worker, BH specialist, etc.) all see the patient at the same time and take turn asking questions.
- Front desk checks to see if a screen was completed in past 9 months and if not gives the patient the PHQ-2. The provider reviews and administers the PHQ-9 if indicated.
- Screening & follow up is a quality measure for their productivity/compensation. Monitoring done via extracting data from EMR.
- Consultation model with monthly meetings; this provider has become more comfortable through these mtgs./education lunch & learns and is now often able to treat patients without referring.
- Screening data goes directly into EMR so parents don't see it unless they look over the patient's shoulder.

What challenges do you have when screening for depression?

- Overwhelmed with screening for other things (like COVID) during sick visits, but PHQ-2 might be feasible in these settings

- How to make sure that people aren't at real high risk for suicide
    - How to respond to those results
- Large percentage of bilingual individuals—PHQ-2 doesn't translate super well into Spanish
    - Has to rely on interpreters—is this tool as validated in Spanish?
- Sometimes adolescents don't really understand what the question is asking—particularly the first question (seen this in adults too!)
- Not enough time; how to implement and follow through without sending them off knowing they have a concern
- Not comfortable prescribing meds for depression
- Need a template for informed consent for psychotropic medications
- Parents complain about the amount of paperwork and screeners they're asked to complete
- Parents sometime fill out paperwork meant for the adolescent
- Challenge having time alone with patient (significant Mormon community)
- Screening was previously a quality metric but they weren't doing well so was removed.

Are you screening at all visits; why or why not?

- Some do screen at every visit—the older the kids are, the less likely they are to come every year for well visit
    - 11 and 12 they come in for vaccines and after that there are gaps for a couple years, so 12 and above they screen at every visit
- Screen an annual visit – PSC it too long to do at every visit. May consider switching to the PHQ
- Screening at every visit isn't practical for their clinic
- Primarily screen at well visits (PHQ-2 → PHQ-9), but began to do at some acute visits if the chief complaint (e.g., "headaches") seemed to warrant.

How do you get screening done on busy days or during short appointments?

- MAs do the PHQ-2; sometimes a comfort level with PHQ-9
    - Sometimes they'll go back and redo the questionnaire and re-ask the questions if the results seem to "not match the kid"
- Some double time slot one patient so they can get enough time
    - Hard to do this during regular visits; there isn't enough time
    - Kids coming in with mental health concerns get double time schedule

        - But hard to plan for that if screening at every visit and PHQ turns out positive

What are your processes for screening for depression during telehealth appointments?

- This has been harder; ask them to complete the questionnaire before seeing them; either send it over or go through it together during the actual appointment
- MAs will see them first and then go to different practitioners