



CREATING A WORKFLOW FOR DEPRESSION SCREENS & FOLLOW UP TREATMENT

Considerations for Primary Care Practices

March 2021



Table of Contents

Section 1: Best Practices: Screening For Depression In Primary Care.....	3
Rationale for Depression Screening in Primary Care Settings.....	3
Suicide Risks	3
Section 2: Coding For Depression Screening.....	4
What codes should be used for depression screening?.....	4
Section 3: Evidence-Based Screening Tools Available	4
Is a positive score on the PHQ-2 or the PHQ-9 enough to diagnose depression?	5
Screening Tools for Special Populations	5
Pregnancy-Related Depression.....	5
Adolescent Depression.....	5
Re-assessing Depression Screens.....	5
Example Workflow & Implementation for Depression Screening in Integrated Care Settings.....	6
Example Workflow & Implementation for Depression Screening in Non-Integrated Care Settings.....	7
Section 4: Recommendations For Follow-Up On Positive Screens.....	8
What should be considered in a follow-up plan for a patient who screens positive?	8
Suggested Workflow for Follow Up.....	8
Section 5: Scope Of Integrated Care Vs. Specialty Mental Health Treatment.....	9
Integrated Care.....	9
Specialty Mental Health Treatment.....	9
Section 6: Colorado Access Options For Treatment And Follow-Up.....	10
The Virtual Care Collaboration and Integration (VCCI) Program	10
Colorado Access Behavioral Health Care Management	10
Section 7: Action Plan Checklist	11
Resources	12

Section 1: Best Practices: Screening For Depression In Primary Care

Rationale for Depression Screening in Primary Care Settings

In 2016, the US Preventive Services Task Force (USPSTF) recommended “screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up”¹. The task force also gave a similar recommendation to screen adolescents ages 12 to 18 for depression². In 2018, 47.6 million adults aged 18 or older in the US (19.1% of all US adults) had any mental illness (AMI) and 1 in 7 adolescents aged 12 to 17 (3.5 million) had a major depressive episode (MDE) in the last year³. However, effective mental health treatment and appropriate follow-up barriers exist, as only 43.3% of adults with AMI and 41.4% of adolescents with MDE received treatment³. There are many more individuals with an undiagnosed AMI who also have unmet behavioral health (BH) needs. **Screening and identification of mental health symptoms in primary care settings with BH integration and/or effective referral streams with external BH providers, leads to increased behavioral health engagement rates and helps ensure members get connected with necessary treatment.**

The 2019 Colorado Health Access Survey (CHAS) found that 15.3% of Coloradans reported poor mental health, as defined by eight or more days of poor mental health in the past month, and 13.5% of Coloradans reported that they did not get needed mental health care in the past year⁴.

Nearly half of all mental illness begins by the age of 14 and unfortunately, most cases go undetected and untreated⁵. The Healthy Kids Colorado Survey⁶ has also found alarming increases on multiple mental health measures since 2013 to the last report in 2019. This includes but is not limited to:

- Increase from 24.3% in 2013 to 34.7% in 2019 for the percentage of high school students who felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing usual activities.
- Increase from 6.6% in 2013 to 7.6% in 2019 for the percentage of students who actually attempted suicide one or more times during the past 12 months.
- Increase from 14.5% in 2013 to 17.5% in 2019 for the percentage of students who seriously considered attempting suicide during the past 12 months.

¹U.S. Preventive Services Task Force. (2016). *Final recommendation statement depression in adults: Screening*. uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening

²U.S. Preventive Services Task Force. (2016). *Final recommendation statement depression in children and adolescents: Screening*. uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-children-and-adolescents-screening

³Substance Abuse and Mental Health Services Administration (SAMHSA). (2019, August). Key substance use and mental health indicators in the United States: Results from the 2018 national survey on drug use and health. [amhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf](https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf)

⁴Colorado Health Institute. (2020, November 13). *2019 Colorado health access survey: Behavioral health*. coloradohealthinstitute.org/research/2019-colorado-health-access-survey-behavioral-health

⁵World Health Organization (WHO). (2018). *Mental health in primary care: Illusion or inclusion*. Technical series on primary health care. [who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2](https://www.who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2)

⁶Colorado Department of Public Health & Environment. (2021). *Health kids Colorado survey data*. cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data

Suicide Risks

Historically, **Colorado has one of the highest suicide rates in the nation** and has ranked in the top ten for at least eight consecutive years^{7,8}. Between 2018 and 2019, there were 2,558 suicide deaths in Colorado, with males making up 76%.

Between 2008 and 2019, the prevalence of suicide deaths in Colorado increased by 60.7%. An analysis of the Colorado Violent Death Reporting System from 2014 to 2018 found that 54.4% of all individuals had a current diagnosis of a mental health issue, with the majority (39.8%) indicating depression. Although almost half (46.1%) had been treated for mental health or substance abuse problems, only 29.9% were currently receiving treatment at time of death⁸. This analysis also found that 31.5% of death by suicide individuals had a problem with alcohol and 22.9% had a problem with a substance other than alcohol.

Section 2: Coding For Depression Screening

For State Fiscal Year 2020-2021, the Department of Health Care Policy and Financing (HCPF) identified depression screening and follow-up as an area of improvement. HCPF has recommended using G8431 and G8510 to indicate a positive or negative depression screen.

Section 3: Evidence-Based Screening Tools Available

A meta-analysis identified 24 evidence-based tools that screen for behavioral health disorders in the primary care setting—13 short instruments with five or fewer items, and 11 longer instruments⁹. Some of the most commonly used include the [Beck Depression Inventory \(BDI\)](#), [Hamilton Depression Rating Scale \(HDRS\)](#), and [Patient Health Questionnaire \(PHQ\)](#), which can be used to identify patients who may be experiencing depression symptoms and track symptoms over time. There are also screening measures targeted at specific populations, such as pregnant women and mothers of newborns (e.g. The [Edinburgh Postnatal Depression Scale](#)).

Although Colorado Access does not endorse one screening tool over another, and encourages practices to utilize a screening tool that best fits the practice, the most widely used tools across the network are the [PHQ-2](#) or [PHQ-9](#). The PHQ-2 is a brief, two-question screening tool that if positive, leads to the administration of the PHQ-9. The PHQ-9 has been mostly validated in primary care environments but has also been used successfully in behavioral health centers. It can be self-administered or administered by a clinician. The PHQ-9 is used to assist with diagnosis and identification of problematic symptoms. At the follow-up visit, the PHQ-9 is used to measure treatment response and identify specific symptoms that are not responding¹⁰.

The advantages of utilizing the PHQ-2 or PHQ-9 include:

- Shorter than other depression rating scales
- Can be administered by a clinician in person, via telehealth, by telephone, or self-administered
- Facilitates diagnosis of depression disorders
- Provides assessment of symptom severity
- Is well-validated and documented in a variety of populations
- Can be used in adolescents 12 years of age or older

⁷Centers for Disease Control and Prevention (CDC). (2020, April 29). *Suicide mortality by state*. National Center for Health Statistics. cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

⁸Jamison, E., Orten, K. Bretsch, C., & Bol, K. (2020, December). *Suicide in Colorado, 2014-2018: A summary from the Colorado Violent Death Reporting System*. Colorado Department of Public Health and Environment HealthWatch, 112. Retrieved from drive.google.com/file/d/1Y6Rlr439tG5xeKaogeEvDrjID1aE3yc2/view on <https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/colorado-violent-death-reporting-system>

¹⁰University of Washington. (2020). *PHQ-9 Depression Scale*. Advancing Integrated Mental Health Solutions (AIMS) Center. aims.uw.edu/resource-library/phq-9-depression-scale

Is a Positive Score on the PHQ-9 Enough to Diagnose Depression?

Research indicates that certain scores on the PHQ-9 are strongly correlated with a subsequent major depression diagnosis. However, not everyone with an elevated PHQ-9 is certain to have major depression. The PHQ-9 is intended as a tool to assist clinicians with identifying and diagnosing depression but is not a substitute for diagnosis by a trained clinician¹². A clinical guideline is attached to the screening tool that offers a scoring rubric and provides guidance for next steps for assessment.

Screening Tools for Special Populations

Pregnancy-Related Depression

Pregnancy-related depression, or perinatal depression, may occur during pregnancy or up to one year postpartum. It is the most common complication of pregnancy for mothers nationwide and is a serious threat to a mother's ability to provide responsive and nurturing parenting. Perinatal depression has an estimated prevalence rate of 8% to 19% nationwide. Studies have documented even higher rates in low-income populations, with measured prevalence as high as 59% for socioeconomically disadvantaged mothers. Perinatal depression is a burden not only to the mother who is experiencing depressive symptoms but can also have lifelong implications for infants during a critical developmental window¹¹.

The [Edinburgh Postnatal Depression Scale](#) was developed for screening pregnant and postpartum women in outpatient settings. The test can usually be completed in less than five minutes, and questions provide insight into perinatal depression and anxiety indicators.¹²

Adolescent Depression

In 2018, an estimated 3.5 million adolescents aged 12 to 17 in the United States had at least one major depressive episode. This number represented 14.4% of the U.S. population aged 12 to 17³. Depression is a cause of significant disability, and major depressive disorder in children and adolescents is strongly associated with depression in adulthood, other mental health disorders, and suicide. Therefore, USPSTF advises primary care clinicians to screen adolescents ages 12 to 18 years². Use of the PHQ-2 or PHQ-9 has been validated in ages 12 and up, however an adapted version, the [PHQ-A](#), is modified for teens.

Re-Assessing Depression Screens

Practices should select a policy for reassessments that is appropriate for their population and staffing arrangements. Best practices indicate administering a tool like the PHQ-9 on a yearly basis, or more frequently if clinically indicated. Practices may integrate a screening tool into every patient visit to capture a broader clinical picture. One factor practices should consider is whether their electronic health record (EHR) has the ability to capture these discrete data points.

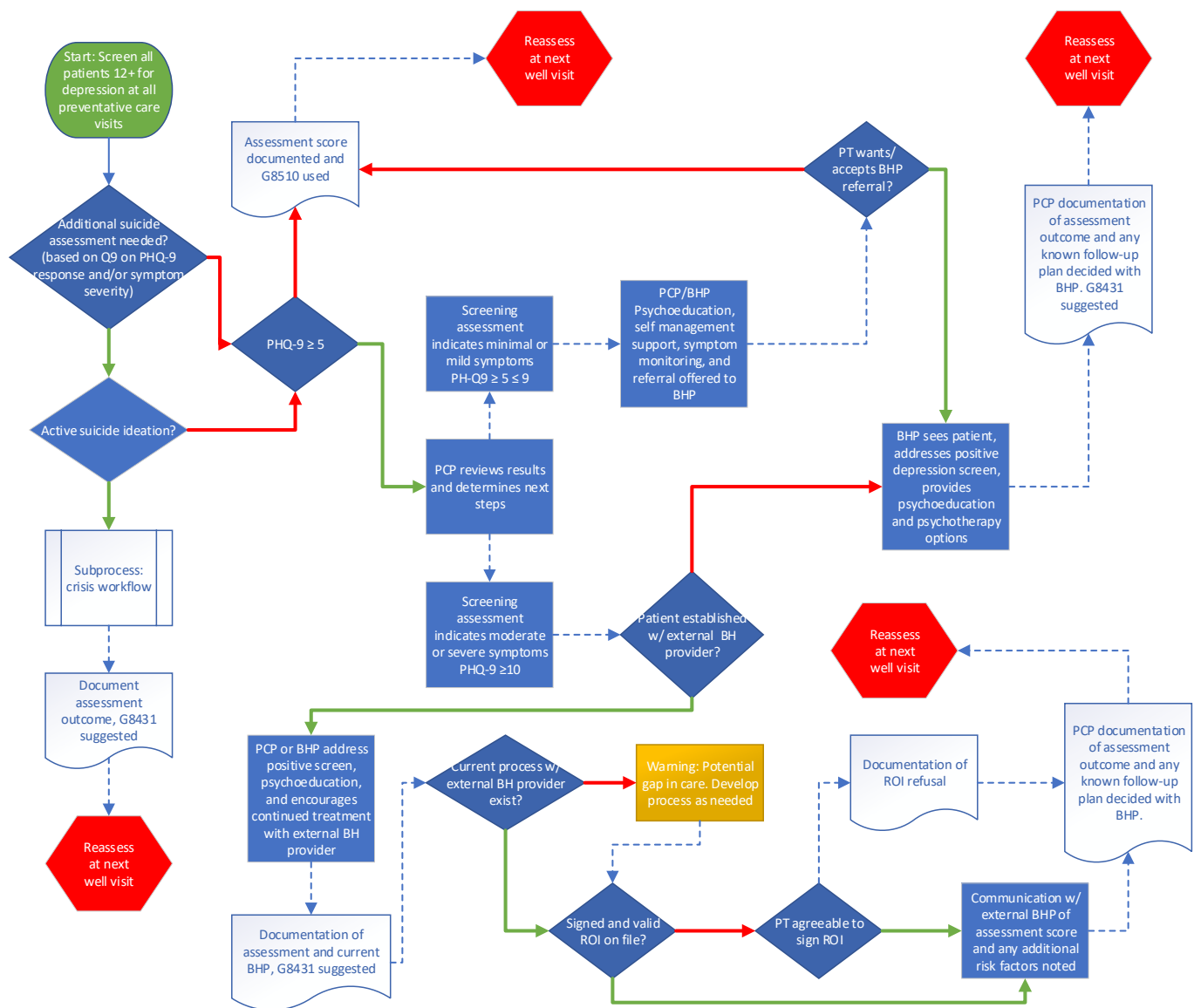
If this is not available in their EHR, an alternative option would be to consider using a registry to keep track of patients, interventions delivered, and their reports of symptom changes and functional improvements over time. This approach is important because it makes space for:










- Assessing the clinical effectiveness of interventions within primary care and making adjustments as needed.
- Demonstrating high-quality care and serving as leverage in value-based payment negotiations.
- Highlighting for patients domains in which they are improving or feel stuck and helping to facilitate deeper conversations about symptoms and overall functioning¹².

¹¹Shore, J. H., Waugh, M., Calderone, C., Donahue, A., Rodriguez, J., Peters, D., Thomas, M., & Giese, A. (2020). Evaluation of telepsychiatry-enabled perinatal integrated care. *American Journal of Psychiatry*, 71(5), 427-432.
doi.org/10.1176/appi.ps.201900143

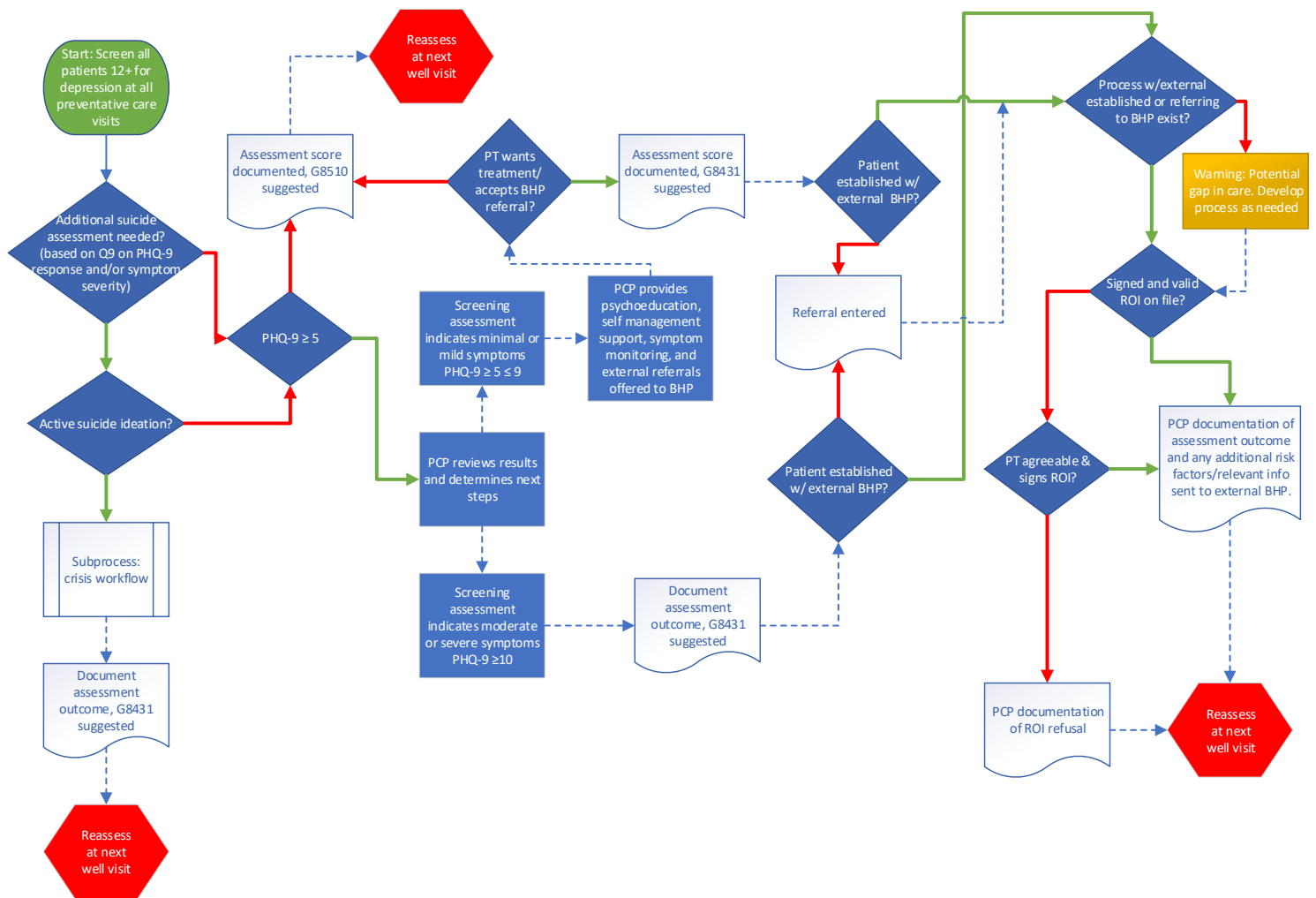
¹²Center of Perinatal Excellence (COPE). (2021). *Using the EPDS as a screening tool*.
cope.org.au/health-professionals/health-professionals-3/calculating-score-epds/










Example Workflow & Implementation for Depression Screening in Integrated Care Settings



Key	
	Start
	Stop
	Subprocess
	Decision
	Documentation
	Process step
	Yes decision
	No decision
	Process next step
BHI	Behavioral health provider
ROI	Release of information

Example Workflow & Implementation for Depression Screening in Non-Integrated Care Settings



Key	
	Start
	Stop
	Subprocess
	Decision
	Documentation
	Process step
	Yes decision
	No decision
	Process next step
BHI	Behavioral health provider
ROI	Release of information

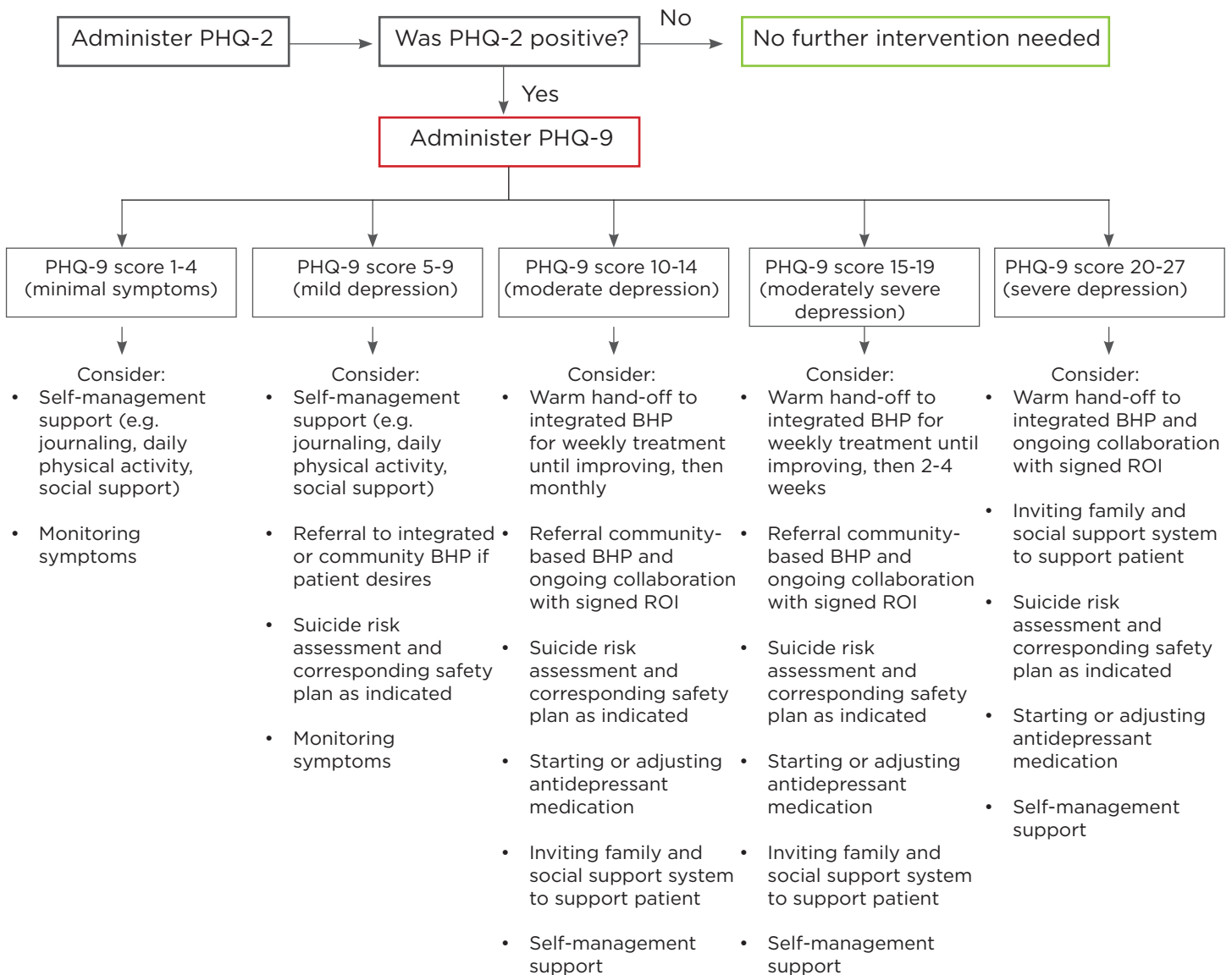
Section 4: Recommendations For Follow-Up On Positive Screens

What Should Be Considered in a Follow-Up Plan for a Patient Who Screens Positive?

Follow-up plans should take into account (a) the severity of the symptoms and their impact on functioning and wellbeing, (b) patient preferences for types of treatment and modalities (e.g. medication, individual vs. family therapy vs. group therapy), and (c) evidence-based guidelines for effective treatment such as those available from the [American Psychiatric Association \(APA, 2010\)](#) and [Institute for Clinical Systems Improvement \(ICSI, 2016\)](#).

Suggested Workflow for Follow-Up

Sample Follow-Up Plans Based on PHQ-9 Score



Section 5: Scope Of Integrated Care Vs. Specialty Mental Health Treatment

Integrated Care

If a practice has an integrated behavioral health provider (BHP), this clinician can be a great asset for patients with depression and other behavioral health needs. Integrated behavioral health (IBH) providers are clinically licensed masters or doctoral level licensed mental health providers, including social workers, psychologists, licensed professional counselors, and/or marriage and family therapists.

Although there are wide variations across practices, the target population for patients treated with integrated behavioral health is usually those who have mild to moderate symptoms and behavioral health needs. In addition to depression-related disorders, integrated care may treat anything that would likely improve through habitual, behavioral, or emotional change, such as:

- Stress
- Anxiety
- Depression
- Anger
- Relationship issues
- Grief/loss
- Alcohol/substance use disorders
- Insomnia
- Chronic pain
- Headache
- Fibromyalgia
- Low back pain
- Weight loss
- Inactivity
- Chronic illness management
- Diabetes
- Gastrointestinal (GI) problems
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Medication adherence

(University of Massachusetts Medical School, 2014)

One of the foundations of an integrated behavioral health model is offering a warm hand-off where the patient can be introduced to the BHP before scheduling the next appointment or engaging in a brief intervention during the medical encounter. Warm hand-offs serve the purpose of beginning a trusting relationship and answering any questions the patient may have about IBH services in the clinic.

Specialty Mental Health Treatment

Most integrated BHPs continue to refer patients who require a higher level of care (or desire additional privacy with a therapist separate from their primary care clinic) to community mental health centers and additional independent and agency-based behavioral health providers in the community. Offering primary care-based access to IBH services for patients with mild to moderate symptoms helps protect the limited resources available in specialty mental health centers for patients who need an array of psychiatric, peer, group, community, and individual services.

¹³Reiter, J., Raney, L., & Wyatt, S. (2017, October). *Integrated care models: What are they and how do they work?* Presented at the Collaborative Family Healthcare Association annual conference. Slides retrieved from cfha.net/page/2016Resources

Section 6: Colorado Access Options For Treatment And Follow-Up

The Virtual Care Collaboration and Integration (VCCI) Program

Colorado Access members are eligible to receive telebehavioral health services through the VCCI program, which is offered by AccessCare services, the virtual care delivery arm of Colorado Access. AccessCare Services helps increase access to behavioral health for contracted Colorado Access primary care practices by taking referrals from practices that agree to work with them. VCCI services are offered at no cost to all Colorado Access contracted primary care practices, and can be provided with minimal setup. AccessCare Services is comprised of virtual psychiatrists and clinically licensed therapists that provide pharmacologic and therapeutic interventions over telehealth. VCCI services can be rendered in the primary care setting and/or in the patient's home. If you are interested in becoming a VCCI partner, please contact George Roupas at george.roupas@coaccess.com.

Colorado Access Behavioral Health Care Management:

All Colorado Access members are eligible to receive behavioral health care management services. These services include connection to mental health providers in the Colorado Access network. For more information, please contact bhcaremanagement@coaccess.com.

Section 7: Action Plan Checklist

- ☐ Evaluate current protocol for screening patients above the age of 12 for depression. Where is the process clear, and where does it leave some gaps?
- ☐ Run reports from EMR to establish a baseline for depression screening. What strategies can increase the percentage of patients who receive a depression screening at least annually?
- ☐ Determine what current percentage of patients who screen positive for depression are connected with mental health services. How can this be increased, and what strategies can help improve this percentage?
- ☐ Identify opportunities for improving screening rates for special populations (perinatal, adolescents, racial and ethnic minorities, LGBTQ, etc.). Consider engaging with support staff and soliciting their ideas on how to improve screening rates.
- ☐ Explore hiring an integrated behavioral health provider, or consider contracting with the VCCI service for free behavioral health care offered by Colorado Access.
- ☐ Consider initiating a care compact with community mental health providers to clarify expectations about referral management and care coordination for shared patients.
- ☐ Partner with nearby licensed mental health providers. They could become referral sources for coordinating care, contracted professionals for co-location, or future employees as integrated behavioral health providers. A list of current contracted behavioral health providers can be found at bitly.ws/awZI

Resources

American Academy of Child and Adolescent Psychiatry (n.d.). PHQ-9: Modified for Teens. Retrieved from aacap.org/

American Academy of Pediatrics (2020) Edinburgh Postnatal Depression Scale (EPDS). Retrieved from aap.org/en-us/advocacy-and-policy/aap-health-initiatives/practicing-safety/Documents/Postnatal%20Depression%20Scale.pdf

American Psychiatric Association (APA, 2010). Practice guideline for the treatment of patients with major depressive disorder, 3rd ed. Retrieved from psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

Centers for Disease Control and Prevention (CDC). (2020, April 29). Suicide mortality by state. National Center for Health Statistics. cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

Center for Integrated Primary Care - UMass Medical School - Worcester. (2016, July 08). Retrieved from umassmed.edu/cipc/

Center of Perinatal Excellence (COPE). (2021). Using the EPDS as a screening tool. cope.org.au/health-professionals/health-professionals-3/calculating-score-epds/

Cohen, D., PhD, & Botts, S., PharmD, FCCP, BCCP. (n.d.). Mental Health for Primary Care. Lecture. Retrieved October 10, 2016.

Colorado Department of Public Health & Environment. (2021). Health kids Colorado survey data. cdphe.colorado.gov/center-for-health-and-environmental-data/survey-research/healthy-kids-colorado-survey-data

Colorado Health Institute. (2020, November 13). 2019 Colorado health access survey: Behavioral health. coloradohealthinstitute.org/research/2019-colorado-health-access-survey-behavioral-health

Institute for Clinical Systems Improvement, (ICSI, 2010). Healthcare guideline: Depression in primary care. Retrieved from icsi.org/_asset/fnhdm3/Depr.pdf

Jamison, E., Orten, K. Bretsch, C., & Bol, K. (2020, December). Suicide in Colorado, 2014-2018: A summary from the Colorado Violent Death Reporting System. Colorado Department of Public Health and Environment HealthWatch, 112. Retrieved from drive.google.com/file/d/1Y6RIr439tG5xeKaogeEvDrjID1aE3yc2/view

Mulvaney-Day, N., Marshall, T., Downey Piscopo, K., Korsen, M., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Shoma Ghose, S. (2017). Journal of General Internal Medicine, 33(3), 335-346. DOI: 10.1007/s11606-017-4181-0

Reiter, J., Raney, L., & Wyatt, S. (2017, October). Integrated care models: What are they and how do they work? Presented at the Collaborative Family Healthcare Association annual conference. Slides retrieved from cfha.net/page/2016Resources

Rocky Mountain Health Plans (2019). Creating a Follow Up Plan for Positive Depression Screens. Workflow Considerations for Primary Care. Retrieved from rmhpcommunity.org/

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019, August). Key substance use and mental health indicators in the United States: Results from the 2018 national survey on drug use and health. samhsa.gov/data/sites/default/files/cbhsqreports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

- Shore, J. H., Waugh, M., Calderone, C., Donahue, A., Rodriguez, J., Peters, D., Thomas, M., & Giese, A. (2020). Evaluation of telepsychiatry- enabled perinatal integrated care. *American Journal of Psychiatry*, 71(5), 427-432. doi.org/10.1176/appi.ps.201900143
- University of Washington. (2020). PHQ-9 Depression Scale. Advancing Integrated Mental Health Solutions (AIMS) Center. aims.uw.edu/resource-library/phq-9-depression-scale
- U.S. Preventive Services Task Force. (2016). Final recommendation statement depression in children and adolescents: Screening. uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-children-and-adolescents-screening
- U.S. Preventive Services Task Force. (2016). Final recommendation statement depression in adults: Screening. uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/depression-in-adults-screening
- World Health Organization (WHO). (2018). Mental health in primary care: Illusion or inclusion. Technical series on primary health care. who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2