PEAK
Performance Excellence and Accountability in Kidney Care

QUALITY PARTNERS OF RHODE ISLAND

BROWN

TECHNICAL/CLINICAL TOOLS

BEST PRACTICE 7: Depression Screening and Management

WHY IS THIS IMPORTANT?

Depression causes fluctuations in mood, low self-esteem and loss of interest or pleasure in normally enjoyable activities, and can affect weight and sleep. Depression can also critically impact cognition, hospitalization rate and mortality rate. Depression significantly impairs quality of life and increases costs to patient and society consequent to increased hospitalization. Depression responds to evidence based treatment. Also, depression is highly prevalent among ESRD patients, may be masked, and often goes undiagnosed. Patients should therefore be systematically screened, detected, referred and/or adequately treated for depression. The best practice is to regularly screen and treat depression in all patients, and more often in high risk patients (e.g., patients wishing to withdraw from dialysis; difficulty in following the treatment plan; death of a family member or friend; failed transplant or vascular access, etc). (Refer to Pt/Family Best Practice 4 for additional information.) All members of the care team have a role to play in the detection and management of depression.

BEST PRACTICE 7

Depression adversely affects quality of life and is associated with greater morbidity, mortality and poorer adherence to prescribed care, and therefore requires attentiveness to screening and management.

HOW DO YOU ACHIEVE THIS BEST PRACTICE?

1) Screen and detect all ESRD patients for depression, using acceptable tools, at treatment initiation and yearly thereafter, or as depression is suspected.
    a) Establish a policy and implementation procedures to ensure depression is detected and managed.
    b) Establish procedures for operationalizing the above policy.
        i) Write procedures that explicitly name who will be responsible for depression screening (e.g., MSW), and who refers depressed patients for treatment and follows and monitors those patients.

ii) KDQOL-36 should be administered in the first four months and at least annually thereafter, or according to current regulations and guidelines

c) Select a tool or tools for depression screening. Include a checklist to assure differential diagnosis is considered and adequately evaluated. Agree on a cut-off score that triggers intervention and follow-up interval. Anyone who screens positive should have their diagnosis confirmed with a diagnostic interview.

d) Educate all members of the Interdisciplinary Team to recognize common signs and symptoms of depression, depressed mood, and modifiable factors (loss of appetite, under nutrition; sleep disorders; diminished pleasure in ADLs; poor adherence to dialysis, diet or medication regimen; social withdrawal; changing complaints including pain; psychosis; increased irritability, hopelessness, helplessness; trend for change in weight). Identify routine screening questions for staff during dialysis sessions (e.g., "down in the dumps;" "downhearted and blue". (Note: Patients can mask symptoms of depression: they may not be apparent.)

e) Record positive or negative findings in Patient Assessment and Plan of Care.

2) Recognize that management of depression – especially major or incapacitating depression - may require the time and expertise of mental health professionals. Not all dialysis center staff members will be equipped to diagnose and treat this condition. However, they ARE in a position to:

a) Identify patients at risk for or with depression signs (see 1.d. above) and ensure these observations are documented

b) Initiate appropriate referrals and liaise with other professionals who may become involved

c) Take steps to inform patients about the prognosis of depression, treatment options and the risks benefits and burdens of the treatment options as listed below. Share decisions with the patient and discuss with the patient about one or more of the following as they may pertain to signs and symptoms, such as those in 1(d) above:
   i) Counseling for coping skills to overcome fear, anxiety, sadness, poor adjustment, burnout, etc.
   ii) Patient to patient support and mentoring
   iii) Medication options (noting appropriate dose and/or timing adjustments)
   iv) Modifiable treatment-related problems, including the discussion of alternative ESRD treatment modalities that may better fit patients' preferred lifestyles
   v) Strategies that mental health experts may be able to implement (e.g., cognitive-behavioral therapy)

d) Agree on a schedule for recurrent assessment for those where treatment is initiated or changed for depression to determine treatment response and need for regimen or dose change, consistent with current guidelines for any depressed patient.

e) Record treatment or referral in Plan of Care.

f) Control depression by medication adjustment or referral for continual follow up.

3) Monitor depression symptoms over time.

a) Record status of depression in Plan of Care over time.

b) Monitor depression detection, treatment and control in the aggregate of ESRD patients in the facility's Quality Assessment and Performance Improvement Program.

c) Identify and employ tracking tools to assure assessments are performed, reported and results generate a trackable action, consistent with the facility's QAPI program.

4) The social worker will evaluate the psychosocial needs in the initial assessment (within first 30 calendar days or first 13 dialysis treatments), and subsequently as required by The Conditions for Coverage. Establish a quality target for proportion of patients assessed on schedule; adjust goals as targets are reached.

5) Assess and periodically reassess cognitive status to determine if improvement has occurred and after patient has clearly responded to depression intervention.

6) Identify care partner stress/depression among home and in-center dialysis families.

    a) Have counseling resources and support groups identified and readily available to refer to as appropriate.

TECHNICAL/CLINICAL BEST PRACTICE #6: MANAGEMENT OF CKD-MBD	
Printed Tools and Resources	
Beck Depression Inventory	http://www.ibogaine.desk.nl/graphics/3639b1c_23.pdf
Cornell Depression Scale	http://qmweb.dads.state.tx.us/Depression/CSDD.htm
Geriatric Depression Scale	http://www.depression-help-resource.com/geriatric-depression-scale.pdf
Hospital Anxiety and Depression Scale	http://www.svri.org/HADScale.doc
Mini-mental state exam	http://www.nmaging.state.nm.us/pdf_files/Mini_Mental_Status_Exam.pdf
Link for PHQ9 information	http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
Patient Health Questionnaire (PHQ-9)	http://steppingup.washington.edu/keys/documents/phq-9.pdf
St. Louis University Mental Status (SLUMS) Examination	http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf
Structured Clinical Interview for DSM (SCID) -IV	http://www.scid4.org/faq/clinician_version.html
Quick Inventory of Depressive Symptomatology - Self Report	http://counsellingresource.com/quizzes/qids-depression/index.html
RPA 2010 Clinical Practice Guidelines. Shared Decision Making in the Appropriate Initiation of and Withdrawal from Dialysis, 2nd Edition. Free Recommendations Summary	Renal Physicians Association http://www.renalmd.org/catalogue-item.aspx?id=682
Supporting Literature	
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