

Depression Screening and Case-Finding: Training Tools for Primary Care Teams

Updated February 14, 2019

This toolkit includes training materials, training ideas, and examples that can be used to help create, test, and train clinic staff to a reliable workflow for screening patients for signs and symptoms of depression. Some of the materials included here can be used to orient and train front desk and back office staff. These team members play a major role in maintaining an effective workflow.

The audience for this toolkit includes clinic managers, QI staff and practice coaches, front desk and rooming staff supervisors, and any others responsible for creating and maintaining a systematic approach to screening and follow up for depression signs and symptoms.

PHQ Basics

What is the Patient Health Questionnaire?

The PHQ 9 is a nine-question form used to screen for signs and symptoms of depression and monitor changes in symptoms. Some responses to the PHQ 9 also prompt providers to assess their patients for their potential risk of suicide.

What's the difference between the PHQ 2 and the PHQ 9?

The PHQ 2 is simply the first two questions of the PHQ 9. The PHQ 2 can be used as a preliminary screening tool administered prior to the PHQ 9. If the patient responds “not at all” to both questions on the PHQ 2, no further questions are required.

When patients screen positive on the PHQ 2, clinic staff should immediately follow up with the remaining seven questions, completing the PHQ 9.

Should we administer the PHQ or let our patients complete it on their own?

The PHQ was developed to be self-administered by the patient. The screener is administered in person or over the telephone by many clinic staff, though most validation studies have focused on results from self-administered PHQ.

The [American Academy of Family Physicians \(AAFP\) white paper on depression screening](#) recommends: **Empower your staff!** Because patients already complete many standardized screening tools independently, office staff can initiate the screening process.

Providing printed copies of the PHQ 9 at check-in lets patients complete the screener at their own pace, before entering the exam room. Rooming staff can then enter the information into the EHR so that it is available to the provider for the visit. Care team members can provide patients assistance with completing the PHQ, given the care team understands the purpose and importance of the PHQ and has been trained in engaging patients to complete the screener accurately.

Should patients complete the PHQ on paper or in the EHR?

If your organization elects to administer the PHQ and enter responses directly into the EHR, it is very important that you provide adequate training, instructions, and practice opportunities for rooming staff. Rooming staff are under pressure to keep their providers on a busy appointment schedule and may not feel that they have enough time or the right skills to administer the PHQ 9 without training support. We've seen major “fails” in screening workflows due to lack of training for medical assistants and other front desk or rooming staff.

The PHQ 2-to-PHQ 9 workflow typically requires clinic rooming staff to administer the remaining questions instead of allowing the patient to complete it on their own, at their own pace, in the waiting room. Many organizations find that this workflow works best if their EHR prompts staff to follow up with the PHQ 9 upon a positive screen.

Many organizations find that it is easier to maintain a reliable screening process by asking the patient to complete the PHQ 9 independently on paper as much as feasible, sometimes electing to bypass the two-step screening process. The more steps in a process, the more likely a workflow may break down - especially in a fast-paced clinic in which rooming staff are trying to help keep their providers on an appointment schedule.

Screening directly with the PHQ 9 also allows providers to understand if their patients have any thoughts about hurting themselves or being “better off dead.” Researchers have estimated that up to 75% of those who commit suicide have seen their primary care provider in the past month ([Feldman et al., 2007](#)).

How often should we screen patients for depression?

Studies have not established an optimal screening frequency. The decision to screen more frequently is sometimes driven by pay-for-performance metrics. Michael Thase, MD, offered recommendations in JAMA:

- “For people with a history of depression, it would make sense to ‘screen’ for illness activity **at each visit**.
- For groups at intermediate risk, such as patients receiving regular care for chronic medical conditions such as diabetes or heart disease, it is reasonable to screen **at least once each year**.
- For patients in generally good health who only see their primary care physicians sporadically, it may make sense to **screen at each visit**, although it is likely that a person who rarely sees a physician may not necessarily schedule an appointment to see a primary care physician within weeks or even months of onset of a depressive syndrome. For such individuals, it may more sense to incorporate periodic web-based ‘health checks.’”

Thase, M, JAMA.2016, <https://jamanetwork.com/journals/jama/fullarticle/2484316>

Free PHQ Copies, Translations and Scoring Instructions

[PHQScreeners.com](#) is a great resource supported by Pfizer that offers free, downloadable PHQ and GAD-7 questionnaires in many translations. The website also offers scoring instructions for both of these tools.

Using the PHQ 2 and the PHQ 9

A Training Guide for Medical Assistants, Front and Back Office Staff

Depression screening workflows include front desk staff, medical assistants or rooming staff, and other care team members who might not be used to talking with patients about mental health concerns. This guide on pages 5 and 6 provides information about your role in screening patients for depression.

What is the Patient Health Questionnaire?

The PHQ 9 is a nine-question form used to screen for signs and symptoms of depression and monitor changes in symptoms. Some responses to the PHQ 9 also prompt providers to assess their patients for their potential risk of suicide.

The PHQ 2 is simply the first two questions of the PHQ 9. It can be used as a preliminary screening tool administered prior to the PHQ 9. If the patient responds “not at all” to both questions on the PHQ 2, no further questions are required.

Screening with the PHQ

The patient’s PHQ 2 and PHQ 9 scores should be recorded at the beginning of a visit, like blood pressure or other vital signs. The PHQ 9 can be filled out in two ways:

Patient completes PHQ on paper form:

- You can directly hand a copy of the PHQ to the patient to complete on their own. The PHQ 9 was developed to be used in this way. Many studies have shown that patients can successfully fill out this form by themselves and do not need your assistance.
- If the patient completes the PHQ 9 on paper, immediately enter the score into the EHR.
- You may be asked to be responsible for alerting the provider if follow up is indicated by the patient’s score.

Rooming staff complete PHQ with the patient:

- Some rooming staff administer the PHQ 2 and PHQ 9 as part of the rooming process, entering the score directly in the EHR.
- If you are administering the PHQ 9 in this way, **it is very important that you ask the questions exactly as written on the form.**
- **Be sure that you do not make the patient feel rushed in any way so as to ensure accurate responses.**
- Make a note in the EHR about why PHQ 9 scores are not available.

Do NOT enter “0” in the EHR if the patient did not complete the PHQ.

Frequent Patient Questions about the PHQ

Patient Question:	Why do I need to fill this out?
Answer	<p>Screening: This is much like taking your blood pressure or temperature. It helps your provider understand your overall health and well-being over the past 2 weeks.</p> <p>Follow up: (<i>patient already in depression treatment</i>) Your provider wants to know more about your overall health so that we can properly gauge if the treatment is working the way it should.</p>
Patient Question:	If I don't feel like I have these problems, should I still fill this out?
Answer	Yes. This information is just as important as tracking your blood pressure or temperature. It helps your provider assess your overall health and well-being.
Patient Question:	Do I have to fill this out even if I'm not comfortable answering these questions?
Answer	You never have to fill out a form or answer questions that you're not comfortable with. If you have concerns about completing this, I'll tell your provider you would like to talk about it.
Patient Question:	I would rather just talk to my provider about these questions instead of filling this out. Is that OK?
Answer	Yes, of course.
Patient Question:	I don't understand some of these questions. Can you help me?
Answer	If you have questions about the specific items on the form and how they apply to you, it would be best to talk about that with your provider.

Strategies for Training, Testing, and Making Improvements in Depression Screening Workflows

- **Use materials from this toolkit as well as your own resources to create a custom guide** for front desk and rooming staff. Use your custom guide as part of new staff orientations.
- **Create an easy-to-follow screening workflow graphic in PowerPoint or Visio for your care team.**
Make sure that your graphic clearly designates WHO is responsible for each step and describes WHAT each action step is required at that point in the process.
- **If rooming staff are administering the PHQ 9, create opportunities for periodic training that includes role play and practice with the PHQ 9.** Make it fun! Ask other staffers to be practice patients, responding in role play with various levels of depression symptoms.
- **Engage your QI staff or another practice coach to help with PDSA cycles** if the workflow is not being used consistently and may need a tune-up.
- **Send a “fake patient” through the screening process, starting at the front desk. Debrief the patient’s experience with the team.** Enlist one of your staff to volunteer to simulate a patient visit and go through your current screening process. Coach your volunteer to have a high PHQ score. Debrief what went right and what went wrong, and what made people feel uncomfortable. What better way to evaluate your clinic’s screening work flow than to experience it from a patient’s perspective!

Clinic Protocols to Manage Suicide Risk (Question 9 of PHQ)

A positive response to question 9 of the PHQ 9 should prompt appropriate clinic staff to assess patients for suicide risk. While suicide is rare, all clinic providers and staff should know what to do when patients screen positive on this question. Below are some best practices to consider establishing in your clinic when working with patients at risk of suicide.

- **Help clinicians get comfortable directly discussing suicide with patients.**
Asking patients directly about suicidal thoughts and plans can feel uncomfortable. Part of providing effective treatment to patients is accepting this discomfort, taking each patient's situation seriously, and gathering the information needed to assess each patient's risk.
- **Assess patients at risk with the Columbia-Suicide Severity Rating Scale (C-SSRS).**
The C-SSRS is a series of questions that assess for presence and severity of suicide risk. This tool can be a useful follow-up for gathering more information when patients screen positive on question 9.
- **Build a clinic-wide protocol to respond to patients with thoughts of suicide. Ensure everyone knows how to use the protocol.**
At minimum, the protocol should include a plan for gathering additional information when a patient screens positive for suicidal thoughts and a triage plan for determining next steps (e.g., sending a patient to the emergency room vs. outpatient care). All clinic staff should have access to the protocol and be prepared to follow this protocol when patients screen positive on question 9.

Using EHR Reports for Depression Case-Finding

Many health systems use their EHR data to find patients with a current depression diagnosis that may have fallen through the cracks. A typical approach is outlined below:

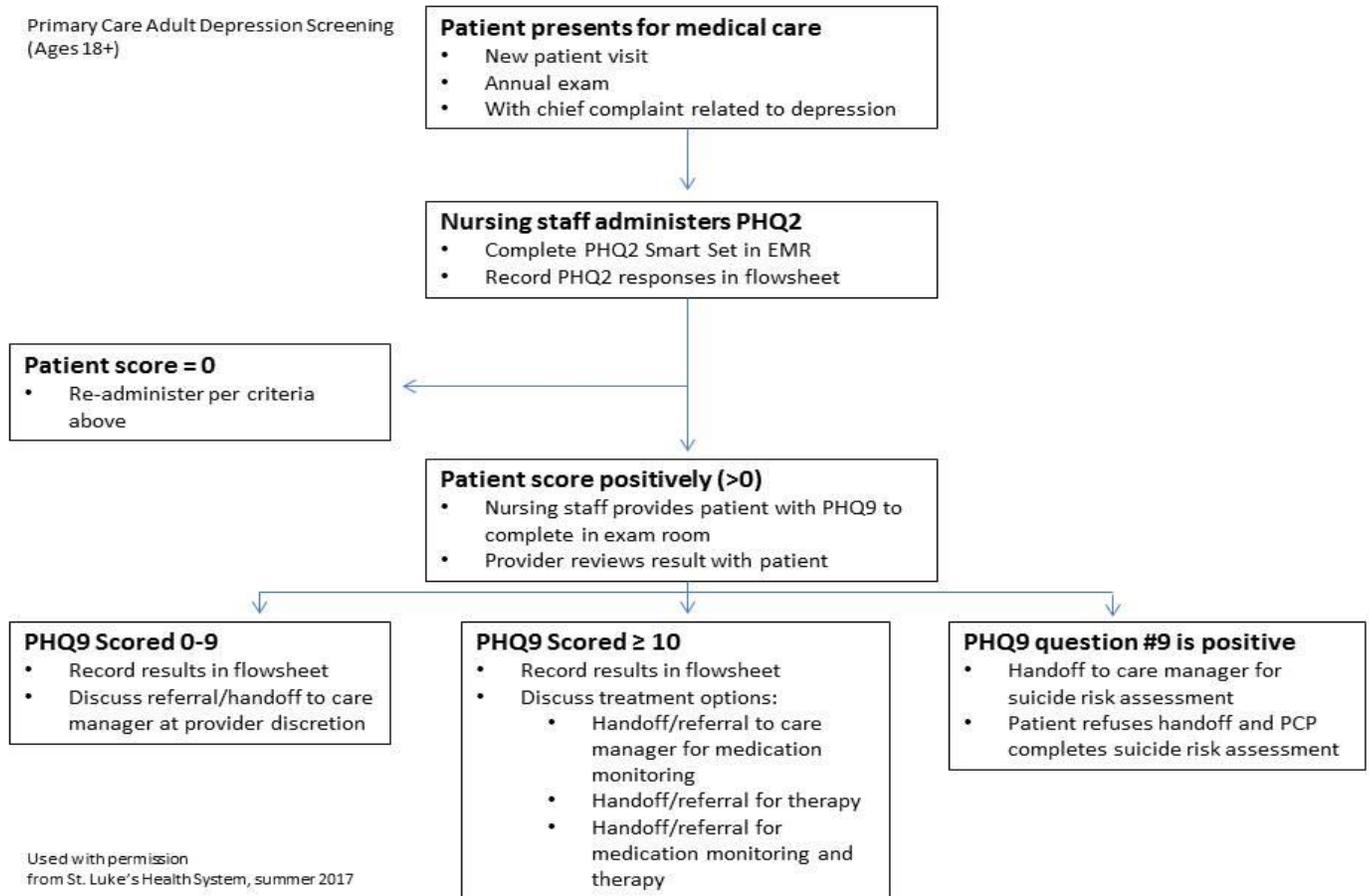
First, look for patients prescribed medication for depression or anxiety during the past 2-3 months.

Next, look for any patients who fit the following criteria:

- Prescribed medication for depression, anxiety, or sleep issues in past 12 months;
- Diagnosed with depression or anxiety in the last 12 months (include all the possible ICD-10 codes that might be applied); and/or
- Scored 10 or higher on the PHQ 9 or GAD-7 in the last 12 months – no evidence of follow up in EHR.

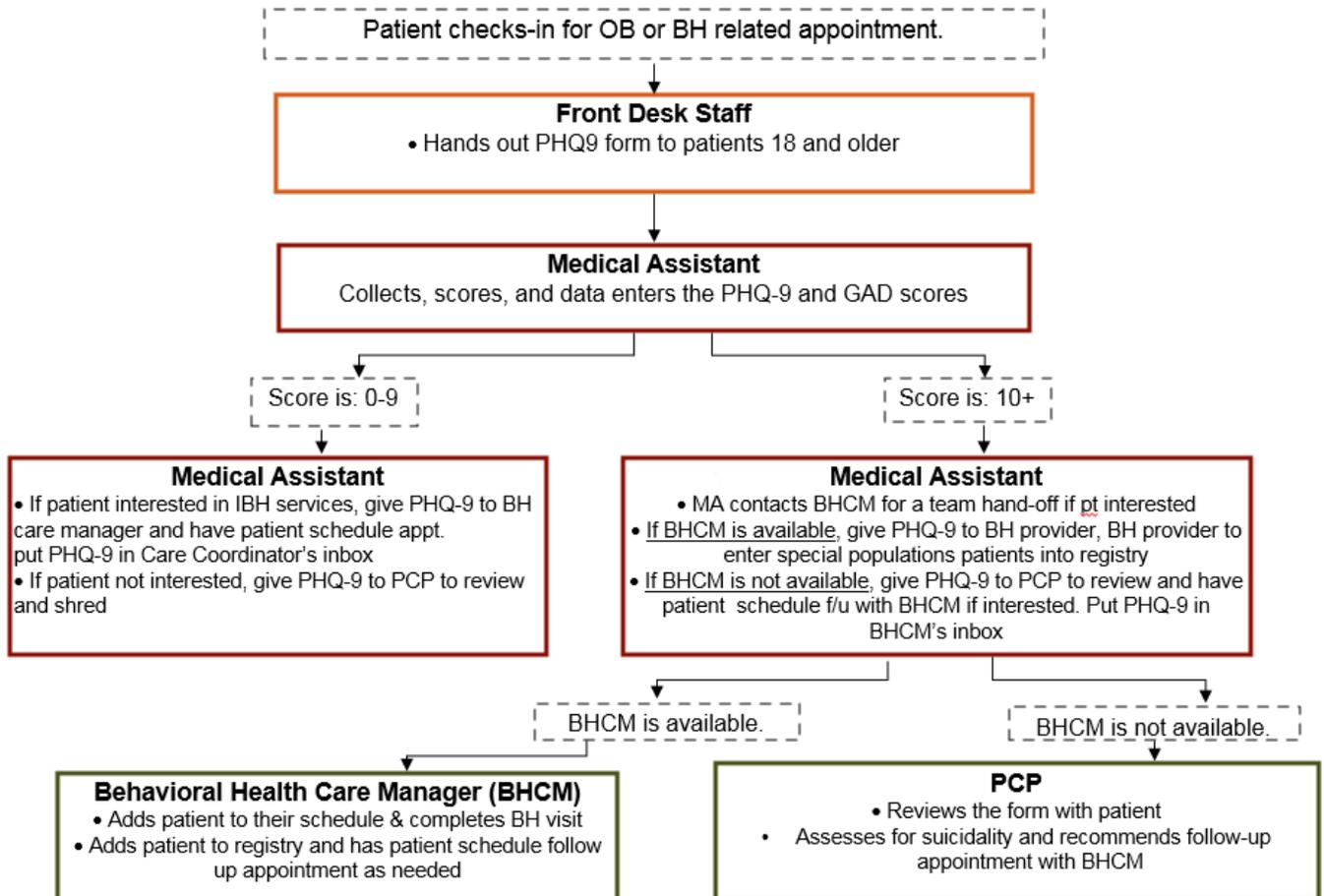
Sample Depression Screening Workflows

Used with permission from St. Luke's Health System in Idaho



Sample Depression Screening Workflow

Used with permission from HealthPoint CHC



Billing Opportunities for PHQ-9 Screening

January 2019

Not all payers reimburse for every code below. Always check with payers to determine necessary qualifications for designated billing providers.

Medicare - CPT G0444 (Depression Screen – 15 Minutes)

- ✓ Must be billed under a physician (e.g., PCP, other MD, or psychiatrist), but services can be completed under MD supervision
- ✓ Reimbursed once per year
- ✓ No coinsurance or deductible for patient
- ✓ Variety of screens are reimbursable, including PHQ-9
- ✓ Must have ability to provide patients who screen positive internal services or staff-supported referral to external services
- ✓ Eligible practices include primary care office, outpatient hospital, independent clinic, FQHC, and RHC

Other Payers - CPT 96127 (Brief Emotional /Behavioral Assessment)

- ✓ Must be billed under a physician (e.g., PCP, other MD, or psychiatrist), but services can be completed under MD supervision
- ✓ Can be billed for a variety of screening tools, including the PHQ-9 as well as validated screens for ADHD, anxiety, substance abuse, eating disorders, suicide risk
- ✓ For depression, use in conjunction with the ICD-10 diagnosis code Z13.89 (screening for depression)
- ✓ Reimbursed at \$6 per screen and can use up to 4 screening instruments per visit
- ✓ Can be billed for initial screen as well as monitoring response to treatment, so no limit on how often it can be billed

Billing for PHQ-9 Screening As Part of SBIRT

SBIRT Brief Intervention CPT codes, Billable by *Multiple Licensed Providers*

99408 (Private)	}	15-30 minutes Full Screening and Brief Intervention for substance misuse
G0396 (Medicare)		
H0049 (Medicaid)		

99409 (Private)	}	30+ minutes Full Screening and Brief Intervention for substance misuse
G0397 (Medicare)		
H0050 (Medicaid)		

HEDIS PHQ 9 Based Measures for Depression Screening and Follow Up Depression Remission/Improvement

The PHQ 9 is the most commonly-used screening tool in measurement-based behavioral health care.

The impetus for providers to adopt measure-based care made a significant step forward with the adoption of PHQ-9 based depression measures by [NCQA](#). Two [depression measures](#) in particular are critical to effective measurement-based screening and treatment:

- [Depression Screening and Follow-up for Adolescents and Adults](#)
 - ✓ **Screening:** The proportion of patients who were screened for depression using a standardized tool during the measurement year
 - ✓ **Follow-Up:** The proportion of patients who screened positive for depression and received follow-up care within 30 days of the positive screen
- [Depression Remission or Response for Adolescents and Adults](#)
 - ✓ **Remission:** The percentage of patients who achieved remission (a PHQ 9 score <5) within 4-8 months after the initial, elevated PHQ 9 score
 - ✓ **Response:** The percentage of patients who showed response (a ≥50% reduction in PHQ 9 score) within 4-8 months after the initial, elevated PHQ 9 score