APNA National Conference

Depression Matters: Advocating for the Best Care

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The presenters have no conflicts of interest to disclose

(Permission obtained to use the Cedars-Sinai photographs and logo)

Objectives

At the end of the presentation, the participant will be able to:

1. Describe at least 3 ways in which depression impacts medical outcomes.
2. Describe the process for responding to patients who screen positive for depression and/or suicidality.
3. Identify priorities for implementing a Depression/ Suicide screening for adult inpatients.

Depression & Chronic Medical Illness

Depression = **cause *and* result** of:

- Diabetes
- Cancer
- Cardiovascular disease
- Stroke
- HIV/AIDS
- Epilepsy

- **Increased Depression**
  - Chronic Hepatitis C Infection
  - Peptic Ulcer Disease
  - Inflammatory Bowel Disorders
  - Sleep Apnea
  - Lupus
  - Rheumatoid Arthritis
  - Scleroderma
  - Thyroid Disorders
  - Pain Syndromes, Fibromyalgia
  - Chronic Fatigue Syndrome

Depression & medical illness

- **After MI**: 50% develop depressive symptoms; 25% MDD
- **Diabetes**-
  - ~40% ↑ mortality
  - 50% ↑ morbidity
  - 100% ↑ diabetic foot ulcers
- **Chronic Pain** → Depression → Pain: ↓Serotonin & Norepinephrine dysregulates pain modulatory system
- **Traumatic Brain Injury -** 52% →mood disorder symptoms; ***quadruples*** risk of completed suicide
- Among those who attempt suicide- 40% have a chronic general medical condition
- 70% of those > 60 yrs who attempt suicide have a chronic general medical condition

Depression & Healthcare Utilization

- **High Utilizers** (>6 visits/6mos):
  - Depressed men **1.5x** higher rate of use
  - Depressed women **3x** higher rate of use
- **Readmission Rates:**
  - Mild depression: 50% higher
  - Severe depression: 100% higher
- **Depression →↑total medical $$$:**
  - 50% higher in DM, 30% in CHF
  - Only 10%= inpatient or outpatient mental health

Katon (2011), Cancino (2014)

Effect on Patient MD Relationship

- **Depression & Noncompliance:→**
  Hopelessness & helplessness; "I deserve to be sick", or passive suicidality

- **Poor communication**:
  - Difficulty express symptoms, concerns, expectations
  - Patients report that MD had poorer explanations

Aren't sadness and anxiety a normal reaction to medical illness?

- Depressed, anxious, irritable mood can be part of a normal response to medical illness
- However, these symptoms often → significant **suffering** that is often "normalized" and not addressed
- Extensive evidence → these symptoms are relieved with psychotropic medications (eg. antidepressants) and psychotherapy even in acute hospital setting
- Depression in medically ill improves with **psychotherapy emphasizing social support, emotional expression, cognitive restructuring,** and improved **coping skills**

(Levenson 2007)

Joint Commission

Epidemiology

- Annually: 2.5million Americans plan; 1.1million attempt; 33,000 complete
- 38-76% of completers saw their PMD in prior month

TJC Sentinel Event Alert of November, 2010:

- "In order to effectively reduce the risk of suicide in the medical/surgical and emergency department settings, organizations need to identify patients at risk of suicide and then intervene to prevent suicide in those patients identified as at risk."

Regulatory requirements

→ National Patient Safety Goal 15.01.01

1. Conduct a risk assessment that identifies specific individual characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the individual's immediate safety needs and most appropriate setting for treatment.
3. When an individual at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.

Cedars Sinai Medical Center

- >800 bed general acute care hospital
- Large metropolitan area
- No inpatient or outpatient psychiatric services
- Robust psychiatric consultation and liaison service:
  - 5 Psychiatrists Mon-Fri
  - Psychiatrist on site 24/7
  - Psychologist
  - Psychiatric SW
  - Psychiatric RN-me!

Depression Screening Initiative

- All adults admitted as inpatients screened on admission for depression using **PHQ-2 (Patient Health Questionnaire)**
- House wide screening began March, 2014
- 2 questions asked; if either are positive → 9 questions are asked- **PHQ-9**
- A "No" answer to both questions would end the screen.
- A "Yes" answer to either question would cascade to the **PHQ-9** depression screening questions

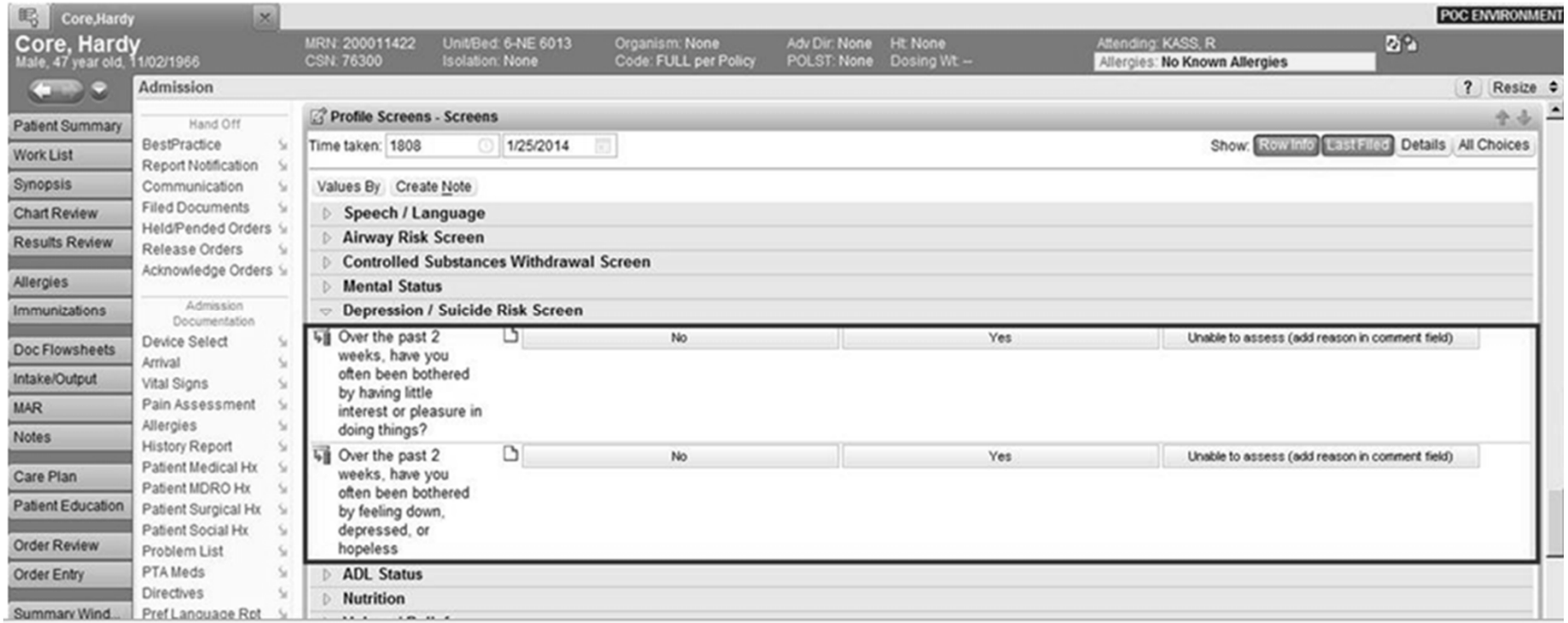
Depression Screening Initiative

- If patient scores >12, **BPA** (Best Practice Advisory) fires:
  - By accepting **BPA**
    - Order for Social Work consult entered per scope of practice (must enter reason)
    - Care plan initiated (Care plan developed for Depression)
  - Nurse is prompted to inform MD and document notification in progress note

Screening for Depression cont'

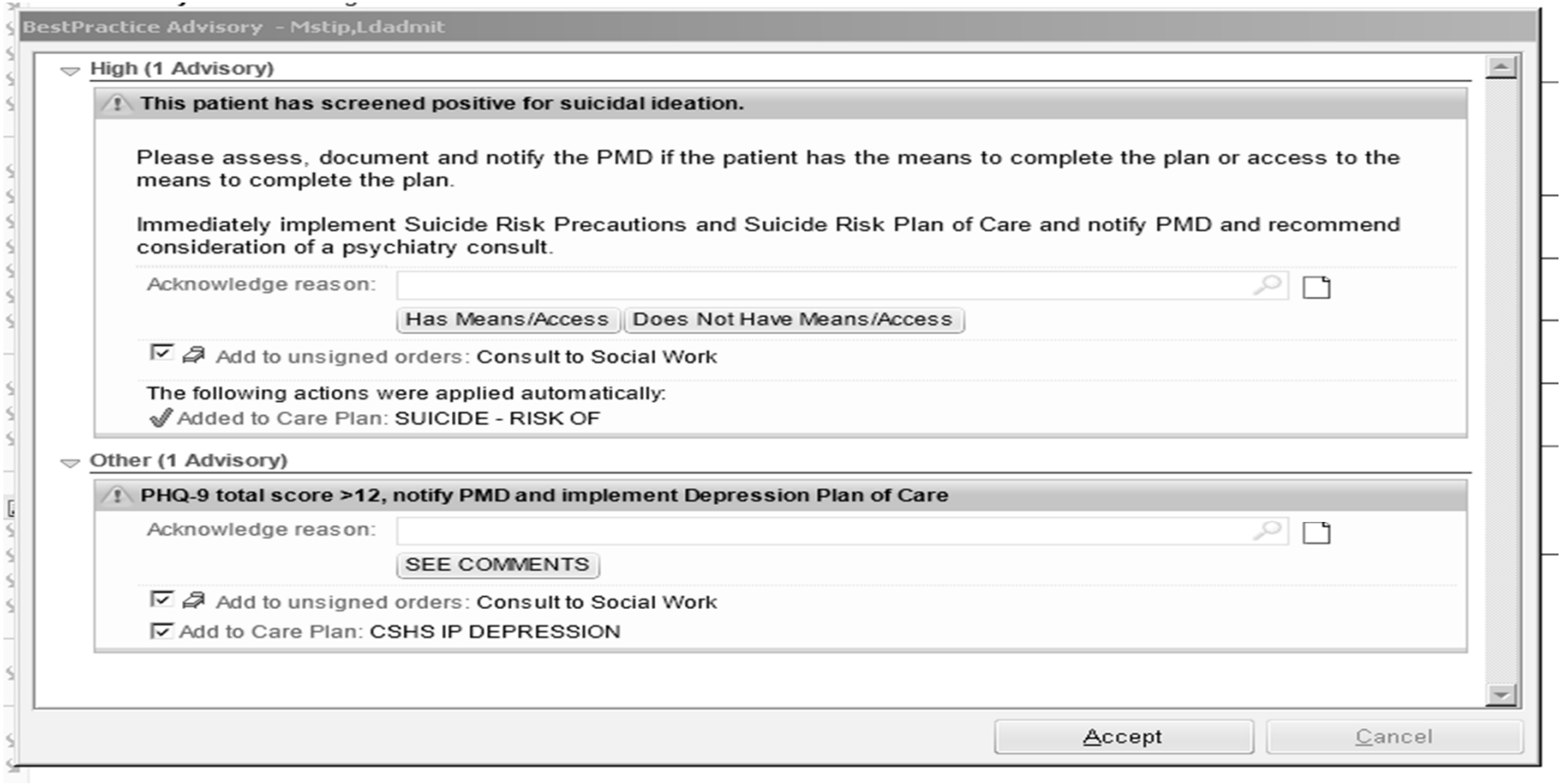
- Similar process for **+ suicidality - Q #9**
  - In addition, nurse must assess patient for suicidality and document in progress note-
    - Plan, means, access
  - Notify MD immediately and recommend psych consult for thorough risk assessment
  - Obtain sitter if patient verbalizes a plan

The RN is presented with 2 primary screening questions; response = “yes”, “no”, “unable to assess”:



In the last two weeks, have you had little interest or pleasure in doing things?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you been feeling down, depressed or hopeless?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you had trouble falling asleep, staying asleep or sleeping too much?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you been feeling tired or having little energy?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you had poor appetite or been overeating?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you been feeling bad about yourself, or that you're a failure or have let yourself or family down?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you been moving or speaking so slowly that other people could have noticed; Or, the opposite - being fidgety or restless that you have been moving around a lot more than usual?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
In the last two weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way?	0=Not at all	1=Several days	2=More than half the days	3=Nearly every day
PHQ-9 Score	27			

If total score >12, or if patient responds other than “not at all” to question #9 re: suicidality, 1 or both BPAs fire:



Depression / Suicide Screening Educational Tool

	Depression Management	Suicidal Management
Positive Screening Criteria *(Note: If patient is unable to answer questions, RN should select "unable to assess" and revisit later)*	• A "Yes" answer to either PHQ -2 question will open additional questions (PHQ-9) • Total PHQ 9 score ≥ 13 is a Positive Depression Screen	• Any answer other than "Not at all" To PHQ 9 question #9 is a Positive Suicide Screen *Note: If prior documentation of suicidality exists (+SI) during current hospitalization, RN will inform PMD despite negative Suicide Risk screen or patient denial.*
Next Steps When Patients Screen Positive?	• Accept the Best Practice Advisory (BPA) to: o implement a Depression Care Plan o enter order for Social Worker (SW) consult *(must enter reason "positive depression screen" in comments)*	• Accept the BPA to: o implement a Suicide Risk Care Plan o enter order for SW consult *(must enter reason "positive suicidality risk screen" in comments)*
RN must Notify *(RN to document Notifications within CS-Link Progress Notes)*	• Notify PMD (non-urgently) prior to end of shift *(document in Progress note)* • Report during POC Rounds	• Notify PMD urgently • Report during POC Rounds
RN to Suggest Psych Consult when:	• *Psychiatry not yet consulted* • Symptoms are interfering with care • Is in imminent danger of hurting self and/ or others • Is an Elopement risk	• *Psychiatry not yet consulted* • Based on severity of suicide assessment findings *(See page #2)* • Demonstrates severe emotional distress • Symptoms are interfering with care • Patient is in imminent danger of hurting self and/ or others • Patient is an Elopement risk
Interventions *(RN to incorporate into patient care plan)*	• Reassess for Depression q shift & prn • Use Therapeutic Communication • Encourage verbalization of thoughts and feelings • Reflect acceptance of feelings without comparing with others • Provide emotional (empathetic) support (i.e; acknowledge emotional state) • Redirect negative thoughts and identify positive coping strategies (Reinforce strengths and capabilities) • Identify sources of hope (e.g., personal relationships, beliefs, etc.) • Identify at least 2 support persons &/or community resources post discharge • Contract to inform staff immediately if develops urge to harm self	• Reassess Suicidality qshift & PRN *(See Suicide Assessment on reverse)* • Consider use of Depression Interventions • Maintain Visual contact (line-of-sight) contact at all times (if High Risk) • Monitor closely for Behavioral changes; (i.e. agitation, attitude, impulsivity, etc.) • Conduct Safety Evaluation of patient's room / personal belongings & remove potentially dangerous items (document within Progress Notes) • Provide nonjudgmental approach when discussing suicidal ideations • Contract with patient to inform staff immediately if develops urge to harm self

	Suicide Assessment
Suicide Assessment *(Conduct q-shift & prn)*	• Ask if any Suicidal Ideation (SI)? *(Are you having any thoughts of wanting to die or to kill yourself?)* If „Yes": determine if PASSIVE vs. ACTIVE • If Active; ask - Do you have a PLAN? o Does patient has MEANS to complete plan? o Does patient have ACCESS to means to carry out plan? • *RN must document Suicide Assessment findings within CS-Link Progress notes*
Suicide Assessment Do's & Don'ts	• DO ask about direct questions about suicidal ideation (SI). Studies show that asking about suicidal thoughts does not increase attempts. • DO 1st ask about passive SI: "Do you ever wish that God would just take you" or "Do you ever wish you could just close your eyes and not have to wake up again?" • DO then ask about active SI, "Have you ever considered acting on those thoughts? Have you thought about killing yourself?" • DO offer empathic statements "that sounds very painful." • DON'T say something meant to induce guilt or shame "You shouldn't talk like that" or "God would be angry to hear you say that." • DON'T promise confidentiality for suicidal statements. If you have offered confidentiality in a general way, DON'T hesitate to break confidentiality to optimize the patient's safety. • DON'T leave the patient alone if they have verbalized unsafe thoughts or have demonstrated unsafe behavior. • DON'T allow patient to close bathroom door during hygiene/ toileting (must remain visible to sitter at all times).

Note: The need for each patient's specific Suicide Interventions will be determined on an individualized Risk Assessment by the Physician/psychiatrist/RN and the clinical team.

What do these results mean?

- Results lower than literature would suggest
  - Possible reasons:

- Patient factors
  - Fatigue, pain
  - "Question fatigue"
  - Stigma
  - Comprehension-
    - Language, cultural barriers
    - What does it mean to be "depressed"?
    - What will happen if I say I'm "depressed"?

- Nursing factors
  - Skill/comfort in asking questions
  - Perceived value of questions
  - Competing priorities
  - Who is answering questions?

- Other issues?

Compliance audits

- Daily chart audits conducted for compliance

- All charts audited for :
  - RN note indicating MD notified
  - Order for SW consult entered
  - Care plan entered

- Follow up done for fall outs
  - phone call to nurse caring for patient and/or
  - e-mail to manager

Challenges in completing protocol for positive depression and/or suicide risk screen

- Notification of physician
- Unclear if physician has been notified if no progress note
- Information not in shift change hand off
- Competing priorities

Case Example

- 29 yo M, admitted for severe Ulcerative Colitis
- Cited recent work related stressors
- Psychiatry consulted for severe depression & c/o ↓ pleasure; insomnia, ↓ self esteem, psychomotor retardation, ↓ concentration, ↓ appetite; hopeless; frustrated; anxious
- Denied suicidal ideation
- Hopeless; ↓ sense of connection to God, stopped meditating, exercising
- ↑ Zoloft; started Trazodone & Adderall
- Psychiatrist: supportive psychotherapy: ↑ coping skills (prayer, exercise, distraction)
- Psychologist: Cognitive Behavior Therapy
- DEPRESSION DRAMATICALLY IMPROVED
- Instilled sense of ***HOPE, EMPOWERMENT***

Keys to success

- Executive sponsorship-CNO and Dept. Chair
- Education for MDs
  - Dept. chair
    - Performance Improvement Committees
    - MD/RN Collaboratives
- Compliance audits with follow up for fallouts
- SW involvement
- Media publicity
  - Hospital/dept. newsletters
  - Screen savers
  - LA Times article
- Don’t rely on verbal communication

Examples

1. Patient scored positive on depression screen. Verbalized no desire to hurt herself or kill herself, no plan. However, patient does note that she has had such thoughts in the past. Patient counseled at length…

2. Pt scored 26 on depression screening scale. Pt reports feelings of depression and frequent thoughts about dying. …Pt denies suicidal ideation at this time. Emotional support provided to Pt.

3. Pt endorses previous thoughts of suicidal ideation prior to admission, at this time pt denies desire to hurt herself and agrees to not try to hurt herself at this time, 1:1 sitter continuing to monitor

4. patient has a positive depression screening; patient verbalized "I wish to just curl up in a fetal position and hope that the Lord will take me." Patient and patient's daughter, who's at the bedside informed about the hospital's suicide/depression protocol. Patient was encouraged to verbalized her feelings.

Questions

"Without mental health there can be no true physical health".

Dr Brock Chisholm, a psychiatrist and the first Director-General of the World Health Organization (WHO).