Hello, and welcome to Alliant Quality's learning and action network for improving identification of depression alcohol use disorder in primary care. As Alliant Quality's Behavioral Task Lead, I would like to extend my appreciation to you for participating in today's learning event and for your commitment to improving the outcomes of the patients you serve. Before beginning with today's presentation, I would like to remind you that in addition to our free webinars, we provide free evidence-based tools, resources and technical assistance to an enhance your service delivery operational efficiency, and overall, leadership capacity. I encourage you to take advantage of the opportunities and frequently engage with us to share your ideas and best practices, as you initiate and apply your implementation process.

Now, it's my honor to introduce our featured guest speaker, Dr. Paula Hartman-Stein. Dr. Hartman-Stein is a clinical geropsychologist with more than 30 years of experience as a healthcare provider and educator. She has edited two books and published numerous articles on behavioral healthcare in late life. She currently works as an independent consultant and is the Medicare Correspondent for the National Psychologist Newspaper. Her current academic appointments include Associate Professor of Psychiatry at Northeast Ohio Medical University, Jr. Fellow at the Institute for Life Span Development and Gerontology at the University of Akron, and adjunct faculty in the Integrated Primary Care Certificate Program at the University of Massachusetts Medical School. Welcome, Dr. Hartman-Stein.

Thank you, Matthew, and thank you also to Alliant Quality Health for this opportunity to teach professionals about geriatric depression. Most mental health treatments of older Americans today is done in primary care, not in specialty care. I feel it's really important to provide information, support and assistance to those who really work in the trenches, those who work in primary care. Our Quickinar will talk about late life depression, the factors that contribute to it. We will talk about some of the medical conditions that are exacerbated by depression, why it is important to do screenings. We will talk about -- I will mention three different screening tools for older adults and to evaluate the strategies for these valid screening results.

Let's start with a quiz. We won't grade you on this but here is a little quiz. What do you think is the reason that we should screen? Why bother to learn to screen for late life depression in primary care? Is it number one? The Affordable Care Act pays for depression screening as a preventive service, so your clinic can bill and receive extra money? Or is the reason that screening contributes to a higher quality score, again, adding more money? Or is it number three, that identifying and treating depression in patients with more than one condition saves dollars for Medicare and other payers? There's more choices. Or, should you screen to identify screening depression to reduce misery of people's lives? Or is it number five, that you can save lives by identifying depression? Or is the most important reason is you will potentially lose your job if you do not screen? We won't look at your answers, but, the answer is that all are true. I don't know if you would lose your job, but the truth is that there are monetary, economic, as well as humanitarian reasons behind the need to screen. The fact is that the Affordable Care Act has expanded its focus on preventive services, and as you probably know, or will know by the end of this, Medicare covers screening in the annual wellness visit.

There is a code for Depression screening in primary care. To use Medicare lingo, beneficiaries, that is your patients, must be furnished to screen and primary care settings that have depression care supports in place. It's not enough just to do the screening, you have to have the staff to assure effective treatment and follow-up.

Now, let's get to a little bit about economics. Depression screens our one of the quality measures and the new program you will hear more and more about called MIPS, merit-based incentive payment system. This is so current that on October 14, 2016, CMS just came out with a lot of information about the quality payment program that will be instituted beginning January 2017. If you are a Physician, a Physician Assistant, a Nurse Practitioner, a Clinical Nurse Specialist, or a Certified Registered Nurse Anesthetist, you qualify to be in this quality payment program. Depression screening is one of the measures that you can use. Now, in 2017, there is another thing going on. There are six new CPT codes that are coming out for psychiatric collaborative care management services. All of these things are happening.

Here is our second question on the quiz. Depression is unexpected and normal part of old age. Do you believe that is true or false?

What percentage do you think primary care physician agrees that depression is normal and to be expected in old age based on a study done in 2011 using something called, the expectations regarding aging scale. Do you think it is 5%, 10%, or 25%? Here is our answer. Depression is a serious problem that affects older Americans, and it is more common in women than men. Certainly present in men as well. We do not consider it a normal part of aging. Why? Number one, it causes misery. It can increase the disability people have from other conditions. It can worsen memory problems and lead to memory problems and lower the overall quality of life. The good news is that older adults can benefit from treatment as well as any other age group. There have been some meta- analytic studies and it doesn't matter the age. In fact, I am reminded by something a mentor of mine over 30 years ago, Dr. Jeanette Royer, the first woman faculty in the department of psychology at Kent State University, she said to me, “Paula, never give up on your patient no matter how all they are.” My dear friend and mentor, Jeanette, she was right. A large-scale study, I like the study because it's so big. There was a large scale study done of people in Norway. I think it was 63,000 people, population -based study that found in early stages of depression, many older adults do not need medication, but they can benefit from non-pharmacological behavioral interventions.

Let's quickly look at some stats. The good news is that if you look at population and people living in their home who are older adults, it's relatively speaking low, one to 4%. When you start seeing people in your primary care settings, it bumps up to about 5% or 10%. People who receive home health care prevalence up again too as much as 25%, 26%. For the medically ill, those with chronic conditions, prevalence of depression goes up as much as 40% level. The worst-case scenario, suicide. Depression is certainly the main risk factor for suicide and the highest suicide rate in the United States is among white men ages 85 and older. I point out this resource for you that came out last year. It's free. It's from SAMSHA called Promoting Emotional Help Preventing Suicide: A Toolkit for Senior Centers. It's says senior centers, but it's for any type of center, any type of place where older adults are going to be seen. It's pretty sophisticated. It is not simplistic. It gives lots of information and tools. I highly recommend someone on your staff or, you, yourself, take the responsibility to go online and order for your clinic. It's free.

Let's talk more about economics. Depression certainly adds to health care costs. Here is another example of a condition, a medical condition that in a 2009 study, people with diabetes or congestive heart failure and depression, one of the comorbid things, have higher health care costs than those who do not have coexisting depression. Indeed, why do you think the government wanted to screen, because

they do want to save some money and studies like this have enabled them to require these screenings. This is going back to the Norwegian study. The European Society of cardiology came out in 2014. They came out with the study of 63,000 people and found that depression increases heart failure risk by 40%. We talk about smoking, lifestyle and bad diet, etc. Guess what, depression is a major risk factor as well for cardiac conditions. What are the triggers for late life depression? There is a lot of them. I put loneliness at the top. Loneliness is definitely a trigger for dysphoric mood. Feeling unwanted; not having a purpose anymore; feeling ignored.

Some people talk about retirement stress. I have heard just last week a woman in her 80s say that, "if I retired. I don't know who I am anymore." There is certainly the need that if one does retire from active employment, it's important to find other meaningful, worthwhile pursuits that make you feel that life is worth living. Now, as we age, of course, it's more likely that we are going to lose loved ones such as spouses, family members.

Now, bereavement is what I refer to as nature's response to severe loss. It's normal. Where we get into trouble -- where people get into trouble and need some treatment is when the bereavement is complicated. Then it can lead to depression. What do I mean by that? Let me give you a quick example. I had a gentleman patient a few years ago who lost his wife of over 50 years. A few months after she died, the gentleman started to be very poor in his self care. He stopped bathing; stopped going out; lost a lot of weight. His adult children became very concerned. They got him to see his Primary Care Doctor for the patient need. In interviewing him, he revealed to me that his wife had an affair with a best friend of his many years earlier in their marriage. This is a deep, dark secret. They stayed married. The family did not know about it, but when she died, all of that bubbled up. It bubbled up in him and he needed to talk it out and he didn't. He actually got better within a couple of months, much better and normal. That's an example of complicated bereavement.

Chronic illness including Dementia it is also a trigger for late life depression. Not every person with memory loss has depression, but a good percentage do. That needs to be addressed because not addressing it increases the disability, basically, of the depression. Also if people have conditions such as low-vision, and they are depressed, that increases their depression. People who are caregivers also can slip into, I should say, or go into a late life depression.

Now, let's talk about screening. One of the important things I want to underscore is the way you talk to the patient about these issues. There is a really excellent resource I would like to point out. It was published by the Gerontological Society of America in 2012 called Communicating with Older Adults and Evidence-Based Review of What Really Works. I took this point from that resource to avoid patronizing speech. We cannot -- I am guilty of it as well when elders speak calling someone honey or sweetie. Try to avoid that. My mother taught me this many years ago, do not assume -- she used to say, "Do not call your clientele by their first name, Paula. Do not assume they like that because they are older. Ask them how they want to be addressed."

Okay, we want to minimize background noise when you are doing a screening. Clinics are noisy places. Try to find a quieter place. Face the older person when you're speaking with them because if they have a hearing loss, they have probably learned how to do some lip reading. One thing I like to do is have a visual aid such as having the screening questions in writing to show the patient. That's also helpful. And consider some clinics have a list of depression symptoms to check off and that is also an easy way.

Let's go to the tool. One of the most commonly used one is the 2 depression screen from PHQ-9, very simple questions. During the last two weeks, have you often been bothered by having little interest or pleasure in doing things? During the last two weeks have you been bothered by feeling down, sad, or hopeless? If person says, yes, to either one, the directions are to follow up by the full PHQ-9 or refer to somebody for more comprehensive evaluation.

Another tool is called the geriatric depression tool. There are three items here. Do you feel your life is empty? Do you often feel downhearted and blue? Do you feel pretty worthless the way you are now? A simple yes/no question. This instrument is in the public domain, and you can easily access it. By the way, let me go back to this. I happen to like the GDS personally better than the PHQ-9 for people who have memory problems. It's a bit easier to follow. For people who have more moderate to severe dementia, a very will validated screening tool called Cornell scale for depression and dementia. The questions it there are asked to the caregiver.

Is screening all that simple? Simply -- technically, the answer is, yes. For the bare-bones, what I call the bare bone economic requirement. But let's say your clinical impression from the person's body language, facial expression, or clues from family member in the room that there is more to the story when the screening is negative. But your gut, your clinical sense, your observations say, I am not sure that's right. What should you do then? First of all, you should pay attention to the risk factors about depression and suicide. Is the person abusing any medications? Or are they abusing other substance it? How disabled are they? Are they isolated? You can ask of the person lives alone next are they part of any social groups next know about stressful events. We should not minimize this. The death of a pet can be a real significant trigger to depression. Pets really are our friends. Sometimes the only friend that an older person living alone has, and don't be afraid to ask about lethal means for suicide.

So, I am going to go back to one other thing here. When we talked about your gut tells you, your gut tells you that there is more to the story, then that's when, as a clinician, I strongly suggest that you have a list of symptoms that you go over in more depth and/or you ask the family member that is there observing. I think we have some time. You can contact me if you would like but I think we have some time for some questions now.

Jen or Matt, do you want to take over?

Sure, Dr. Hartman-Stein. Thank you for the presentation. We now have time for questions. We encourage you to use the WebEx chat feature to send your messages to all of the panelists using the chat feature located in the lower right-hand side of your screen. Have a few questions in the queue now. I will start with the first one.

This is as it pertains to the geriatric depression scale. What you prefer that over the PHQ?

For about five years I used both the PHQ and the geriatric depression's tail on every person I saw. This is an anecdotal thing and then I will follow it up with the research. I found that the older adults had less difficulty in understanding the straightforward yes/no questions on the GDS. That was my observation in my practice. If you look at the literature, we found out that the GDS is valid also for people who have mild to even moderate memory impairment. In fact, in the study using the minimental(?) state exam, people who had scores as low as 15 on that minimental(?) state could accurately or validly address the

yes/no questions on the geriatric depression scale. It's a little easier for people to comprehend and that's why I like it.

Thank you.

We have another question. If someone's screen is negative but your clinical sense is the screen is not valid, how do you document that in the medical record?

Right, the documentation is certainly important as well. As I said earlier in our broadcast, if you already have a list of symptoms from the DSM typed out and put it in a page protector, you show them the questions and just go over the symptoms such as weight loss, weight gain, sleep problems, insomnia, hypersomnia, fatigue, loss of energy, psychomotor education, either slow motor movement or very restlessness, feelings of worthlessness, inability to concentrate, thoughts of suicide. If you have those items and you specifically go over that when your gut says the screen isn't valid, that's what I recommend. It isn't anywhere in your documentation, you say, you indicate that the score, the official technical score was whatever it is. But then additional questioning showed more symptoms, perhaps that. Or a family member was present and he/she mentioned these other symptoms. You really do need to indicate both of them. You also want to address what the Cornell scale is. I have used it for years and years also and I like it when necessary. It has five different sections. Mood related signs, behavioral disturbance, signs about the appetite, weight and energy. It also adds cyclic functions such as are symptoms worse in the morning, does the person have early-morning awakening our multiple awakenings during sleep and ideational disturbances? Thoughts about life not worth living? Self blame, self-deprecation, pessimism and mood delusions of poverty or illness or loss. It's pretty thorough. It takes longer, that is true, but for people with moderate to severe dementia, it is a necessary scale to use.

Thank you. I have another question.

How do you involve the caregivers in the screening process?

Good question. If the person, again, has significant memory loss, it's imperative to do so. If the person doesn't and the family member is present, I will ask if they are in the room, obviously the patient agreed for the family member to be in the room then I will ask -- I have asked directly, do you agree? Is that your observation too - what your family member just said to the questions we asked. I asked their opinion. I am very open and direct, and you can document that in your record that the family members said they either agreed or, more importantly, if they disagree, I guess.

Great advice. Thank you.

I think we have time for one more question.

Have the screening methods been tested with people in diverse ethnic groups?

Yes, they have. I don't know all of the studies but I do know that a colleague of mine, Peter [Lichtenberg?] in Detroit, Michigan, has extensively used the geriatric depression scale with an African-American population, with low education. Also I know that I'm not sure which University in Texas has done work with the PHQ with the Latino population. And I just ran across an unusual one with the Korean population, the Cornell scale for depression and damage a has been utilized with that group, and

has also found valid results. There is probably more out there, but those are the ones that I know off of the top of my head.

Thank you. With that, I would like to hand things back over to Matthew Prentice to say a few words in closing for us today.

Thank you Dr. Hartman-Stein, thank you for the excellent presentation. Thank you all for participating as well. I would like to remind you to fill out the post presentation evaluation. Then you will download your CE certificate. If at any time you have questions or concerns, feel free to reach out at me using the contact information you see before you. I look forward to our continued engagement and your participation on our next LAN Quickinar on November 16th. Until then, take good care.