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Hello, there. This is Ed Boudreaux, I'm a consultant for this task order and today's Bite Sized Learning is going to cover screening for depression and alcohol and the various pathways for implementation.

Today, we're going to answer three important questions; what are the best screeners to use for depression and alcohol in primary care settings? What are your options for administering these in clinical practice? And what are the strengths and weaknesses of the different pathways or work flows?

Following this video our expectation is that you will be better prepared to select a good fit, validated instrument to screen for depression and alcohol and to understand the pros and cons of different pathways for implementation.

While unfortunately, there are a variety of screeners out there and it can get pretty confusing pretty quickly, we are lucky that the Institute of Medicine has weighed in on this issue. If you don't know the Institute of Medicine it's a very influential group that helps to set the national agenda for healthcare. It helps to influence policy. They release recommendations for the social and behavioral determinants of health that should be integrated into all electronic health records. And we're unfortunate because two of the most widely and strongly recommended domains are depression and alcohol and within depression and alcohol the Institute of Medicine surveyed all of the different measurements and screeners that were available and came up with their recommendations.

For depression they recommended the PHQ-2, which is a short version. The first two items of the patient health questionnaire are PHQ-9 and for alcohol they recommended the Audit-C, which is the first three items of the Audit that are slightly modified for the purposes of administering them as a quick screener.

Let's take each of these in a little bit more depth. For depression the Patient Health Questionnaire 9 has become the industry leader for screening and monitoring depression in primary care. It has many strengths; it's intuitive, it's easy to use, it has strong psychometric properties. The sub-section of the PHQ-9, which the first two items the PHQ-2, which the first item accesses Anhedonia, and the second item assesses what feelings of being down, depressed or hopeless. The PHQ-2 is the instrument that the IOM has recommended be incorporated into all electronic health records.

So the accuracy of the PHQ-2 with the screening positive threshold of greater than or equal to three has been shown to be very similar to the PHQ-9 so it's a really good instrument to use for

primary screening and for situations where time may be of concern. If the person screens positive on the PHQ-2, generally, what this means is that they have some risk level above an acceptable threshold for having a serious depression issue or disorder and should be followed up with either clinician assessment or with the rest of the PHQ-9 instrument. So the major strengths are that it's short, it's recommended by the Institute of Medicine so it will eventually be integrated into all electronic health records if it's not already in your electronic health record and the thresholds are very clear.

The weaknesses of the PHQ-2 is, as you can see, the response options use a categorical response from 0 to 3 so it's very difficult to administer this in a completely verbal format. It becomes cumbersome so often the patient has to take this either by paper and pencil, on a computer, or the clinician if they're going to administer it verbally, has to have a placard to show to the patient.

The screener for alcohol is the Audit-C. As you can see here it's three items, also, with categorical response options that are summed and the thresholds for a positive screen differ based off of whether the person is a male or a female. In men a score of four or more is considered positive and is able to identify at risk drinking or patients who might be at risk for developing an alcohol use disorder. And for women the score is a three or more. Once again the strengths of the Audit are similar to the PHQ-2 where the instrument is very short and there are clear thresholds.

The drawbacks are similar to the PHQ-2 in that even just these three items are a bit difficult to administer simply using a verbal interview and so some kind of visual representation of the response options are needed in order to preserve standardization. So it has to administered by paper or on a computer, or a placard has to be available if it's going to be used as an interview.

So, let's talk a little bit more about the different administration options that you might have for administering these screeners. The lowest tech form is paper. The medium is electronic health record form or template or flow sheet so this is something that the clinician sees and the most advanced and technologically involved is a computerized self-administration.

So, let's talk a bit about paper. Most of the time if paper is going to be used the screener will have to be hand scored and compared to a threshold so someone has to do that in a clinic setting. Some clinician or other personnel has to then enter the score and the response options into the electronic health record for it to be part of the medical record. In contrast if the form is already in the electronic health record, the patient could be interviewed by clinician or other personnel and the answers entered through the interview by the clinician or other personnel directly into the electronic health record, thereby, obviating the need for paper.

The final version can be done two ways, the computer self-administration can occur through the patient portal with the electronic health record or through an external vendor. There are software companies that specialize in patient reported measures and as long as that external vendor is integrated into the electronic health record this can be a viable option.

So, let's talk a little bit about what these work flows would look like. If the screener is going to initiated by paper usually what happens for a scheduled visit is the medical clinic will mail the document to the patient's home and the patient will complete the document before they come into the clinic and bring it with them to the clinic. Once they're at the clinic someone from the clinic, a personnel there, a registrar or usually a medical assistant will enter the information from the paper into the electronic health record. This works well or can work well for scheduled visits. For unscheduled visits it's a little bit more difficult so, usually, a clinic will have the ability to administer the questionnaire during the visit or right before the person enters the treatment room and once, again, someone would then enter that information into electronic health record.

Our second work flow pathway where the tool is integrated into electronic health record and there is no paper, requires someone, a clinician or some other personnel, to perform the interview and then to enter the information into the computer, either in real time while the clinician or personnel are talking with the patient or after the interview is done.

The final pathway can be administered at home so the clinic or the provider will order or send the questionnaire through the patient portal, the patient will access their patient portal at home, will complete the screener and that information will be available for the physician or the other clinical personnel once the person arrives at the clinic. Alternatively, the person can complete the screener while they're in the waiting room or in the treatment area prior to the physician or clinician seeing the patient.

So each of these pathways have their strengths and weaknesses. Paper is strong because it's low tech and it's ubiquitous. Paper can be found everywhere and it's really the de facto method that many clinics use currently if they're going to screen or get patient reported measures from patients. The weaknesses is that there are many stages associated with the paper and it's highly susceptible to error or failure and requires clinicians or other personnel to track and document the paper into translated electronic health record which can be cumbersome.

For an electronic health record interview the strengths can fit with existing work flow, particularly, if their computer is already being used in the setting and it's fairly easy to build a clinician form in the electronic health record. And, in fact, with the IOM recommendations the screeners that we just talked about will probably be already in the electronic health record. If they're not there they'll be there soon. The weaknesses that this is not necessarily very efficient because it requires someone to interview the patient and then enter the information into

electronic health record so it requires a person to do the work a computer can do and it's difficult to read these standardized questionnaires, like mentioned before, to a patient they have to have some kind of visual representation of the item so they understand what the response options are or standardization is ruined.

The final option, a computerized self-administration. The major strengths of that is it's efficient, it can be extensible to other screening and educations or additional information besides alcohol and depression could be obtained from these screeners and it can also deliver patient education, particularly, if it's being used in conjunction with a patient portal. And these instruments can be centrally updated so that the individual clinic doesn't have to worry about maintaining the instruments.

The weakness is that the patient reported measures and patient portal can be difficult to build. These are not easy tasks and they require ITIS support. Integration of an external vendor into the electronic health record, if the external vendor is the route that's chosen, can be difficult and time consuming and costly.

So, in summary, the Patient Health Questionnaire 2 and the Audit-C are the most practical and evidence supported. Primary screen is for depression and alcohol and they align well with the IOM's recommendations for electronic health records so we can count on them in the future to be supported. The administration route and pathway or work flow will be dictated by what's feasible at your clinic. And each of these options of strengthen and weaknesses though the field is moving towards electronic administration because the developments in the electronic health records, patient portals are improving and this is likely to yield tremendous efficiency and accuracy once they become available.

Thank you.