



Use of Screening Tools in Practice



Introduction

Magellan is launching its screening programs!

Target Population:

- Members that have co-occurring mental health and substance use disorders
- Member that have depressive symptoms

Who should be using these tools?

- Providers working with the target population

Magellan launches screening programs because:

- NCQA requirement
- Support providers within intake process and reassessment

Why have screening programs?

Think about this...

-61.5 million Americans experience mental illness in a given year (1 in 4 adults)

-1 in 17 adults live with a serious mental illness (SMI)

-SMI costs America \$193.2 billion in lost earnings per year

**National Alliance on Mental Illness

-Depression is a disorders that affects 5.4% of the American population

-18.8 million people are affected by depression disorders; many of them do not seek treatment

**2014 Statistics from the US Census Bureau Center for Disease Control and Prevention

-8.9 million adults have co-occurring substance abuse and mental health disorders

-Only 7.4% of individuals receive treatment for both conditions; 55.8% receive no treatment at all

**Substance Abuse and Mental Health Services Administration

Screening Tools



Screening Tools



Magellan has selected two screening tools as resources for providers:

- 1) GAIN SS (screening for dual diagnosis)
- 2) PHQ 2 (screening for depression)

How did Magellan select these tools?

- Tools were selected based on reasonable scientific evidence adopted from nationally recognized behavioral healthcare organizations that have developed guidelines based on scientific and research literature
- Tools were selected based on best practices that are based on industry standards or expert opinion within proven reliability
- Magellan will review best practices and update its programs every two years

Benefits of screening tools

- Screening tools support providers in identifying members that need support
- Screening tools support diagnosis, treatment, and recovery
- The tools selected are brief and easy to understand
- The tools can be used in a variety of setting such as correctional facilities, emergency rooms, primary care offices, school or social services
- The tools selected require minimal training

Let's Get Started!



PHQ-2 Screening Tool for Depression

- This tool is consists of the first two items from the longer Patient Health Questionnaire-9, which consists of nine items that align with the DSM-IV criteria for major depression.
- Focuses on frequency of depressed mood and loss of pleasure or interest over the past 2 weeks
- Screening can help these individuals identify symptoms of depression in minimal time
- The tool can be used as a “first step” approach

Quick view of the PHQ-2

PHQ 2 9 (2).pdf (SECURED) - Adobe Reader

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TOOL 1. The Patient Health Questionnaire-2 (PHQ-2)

Instructions: Print out the short form below and ask patients to complete it while sitting in the waiting or exam room.

Use: The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a “first-step” approach.

Scoring: A PHQ-2 score ranges from 0 to 6; patients with scores of 3 or more should be further evaluated with the PHQ-9, other diagnostic instrument(s), or a direct interview to determine whether they meet criteria for a depressive disorder.

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2 validity of a two-item depression screener. *Med Care*. 2003;41:1284-1292. ©2007CQAIMH. All rights reserved. Used with permission.

PHQ 2 continued

Scoring:

- scores from 0-6 will be identified**
- If a member scores a 3 or above; further screening with the PHQ-9 would be appropriate (this tool can be viewed on the next slide)**
- Not designed to establish a diagnosis, but helps to screen for symptoms of depression**
- Clinicians should also rule out physical causes of depression, or bereavement**

PHQ-9 For Reference



PHQ 2 9 (2).pdf (SECURED) - Adobe Reader
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TOOL 2. The Patient Health Questionnaire-9 (PHQ-9)

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

10. If you checked off any problems listed above, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all Somewhat difficult Very difficult Extremely difficult

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med.* 2001;16:606-613. ©OQAIMH. All rights reserved. Used with permission.

GAIN SS

- Developed by Chestnut Health Systems
- Brief 5 to 10 minute instrument designed to quickly and accurately screen general populations
- For both adults and adolescents
- Endorsed by the Department of Mental Health and Disability Services
- A result in moderate to high problem severity in any single area or overall would suggest further assessment needed
- Please utilize www.gaincc.org for information about licensing costs

GAIN SS continued

Four sub screeners:

- 1) Internalizing Disorder Screener (IDScr)**
- 2) Externalizing Disorder Screener (EDScr)**
- 3) Substance Disorder Screener (SDScr)**
- 4) Crime and Violence Screener (CVScr)**

Four sub screeners make up the Total Disorder Screener (TDSr) which consists of 23 items

Screeners can be calculated for experiences with the past month, past 90 days, past 12 months, and lifetime behaviors. This is referred to as time frame anchoring (a calendar should be referenced to support memory with the time frame)

Introducing GAIN SS to members

Interviewing instructions:

To help us get a better understanding of any problems you might have, how those problems are related to each other, and what kind of services might help you the most, I would like to spend about 5 to 10 minutes asking you some questions as part of a short screener that we use with many of our clients. Your answers are private and will be used only for your treatment and to help us evaluate our own services.

Please answer each question as accurately as you can. If you are not sure about an answer, please give us your best guess. If you simply do not know the answer to a question, you can tell me and I'll enter "DK" for that item. You may also refuse to answer any question, and I'll enter "RF" for that item. Please ask if you do not understand a question or a word. At the end of the interview, I will check to make sure that everything is complete, and I'll answer any additional questions.

Do you have any questions before we begin?

****Provided by Global Appraisal of Individual Needs Short Screener Administration and Scoring Manual Version 3 July 2013**

Cognitive Impairment Screener GAIN SS

2. Cognitive Impairment Screener

Because we are going to ask you a lot of questions about when and how often things have happened, I need to start by getting a sense of how well your memory is working right now.

a. What year is it now?

(Circle 4 for any error)0 4

b. What month is it now?

(Circle 3 for any error)0 3

Please repeat this phrase after me: John Brown, 42 Mark Street, Detroit.

(No score—used for f below)

b. About what time is it?

(Circle 3 for any error)0 3

d. Please count backwards from 20 to 1.

[20, 19, 18, 17, 16, 15, 14, 13, 12, 11, 10, 9, 8, 7, 6, 5, 4, 3, 2, 1]

(Circle 2 for one error, 4 for 2 or more errors)0 2 4

e. Please say the days of the week in reverse order.

[Sat, Fri, Thurs, Wed, Tues, Mon, Sun]

(Circle 2 for one error, 4 for 2 or more errors)0 2 4

f. Please repeat the phrase I asked you to repeat before.

[John / Brown / 42 / Mark Street / Detroit]

(Circle 2 for each subsection of /text/ missed) ...0 2 4 6 8 10

g. (Add up scores from a through f and record) |__|__|

GAIN Short Screener 3.0 Interviewer Instruction Sheet

Quick View of the GAIN SS (IDScr and EDScr)

GAIN-SS_Manual_3_0.pdf - Adobe Reader

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months ago, 1 or more years ago, or never. 4 3 2 1 0

IDScr 1. When was the last time that you had significant problems with...

- a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 4 3 2 1 0
- b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 4 3 2 1 0
- c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 4 3 2 1 0
- d. becoming very distressed and upset when something reminded you of the past? 4 3 2 1 0
- e. thinking about ending your life or committing suicide? 4 3 2 1 0
- f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts? 4 3 2 1 0

EDScr 2. When was the last time that you did the following things two or more times?

- a. Lied or conned to get things you wanted or to avoid having to do something 4 3 2 1 0
- b. Had a hard time paying attention at school, work, or home. 4 3 2 1 0
- c. Had a hard time listening to instructions at school, work, or home. 4 3 2 1 0
- d. Had a hard time waiting for your turn. 4 3 2 1 0
- e. Were a bully or threatened other people. 4 3 2 1 0
- f. Started physical fights with other people 4 3 2 1 0
- g. Tried to win back your gambling losses by going back another day. 4 3 2 1 0

SDScr 3. When was the last time that...

- a. you used alcohol or other drugs weekly or more often? 4 3 2 1 0

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GAIN SS Responses from Member

Providers will utilize the following scoring system:

Past month	4
2 to 3 months ago	3
4 to 12 months ago	2
1+ years ago	1
Never	0

DK = Do not know

RF = refused to response

GAIN SS Scoring

Moderate (1 or 2) to high (3+) scores on the Internalizing Disorder Screener suggest the need for mental health treatment related to somatic complaints, depression, anxiety, trauma, suicide, and, at extreme levels, more serious mental illness (e.g., bi-polar, schizoaffective, schizophrenia).

Moderate (1 or 2) to high (3+) scores on the Externalizing Disorder Screener suggest the need for mental health treatment related to attention deficits, hyperactivity, impulsivity, conduct problems, and, in rarer cases, for gambling or other impulse control disorders.

Moderate (1 or 2) to high (3+) scores on the Substance Disorder Screener suggest the need for substance use disorder treatment and, in more extreme cases, detoxification or maintenance services.

Moderate (1 or 2) to high (3+) scores on the Crime and Violence Screener suggest the need for help with interpersonal violence, drug-related crimes, property crimes, and, in more extreme cases, interpersonal or violent crimes.

GAIN SS Scoring Example

<p>The following questions are about common psychological, behavioral, and personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on.</p> <p>After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.</p>	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1.	When was the last time that you had significant problems with...					
a.	feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?.....	4	3	2	1	0
b.	sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?.....	4	3	2	1	0
c.	feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?.....	4	3	2	1	0
d.	becoming very distressed and upset when something reminded you of the past?.....	4	3	2	1	0
e.	thinking about ending your life or committing suicide?.....	4	3	2	1	0
f.	seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

Screeners	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f	1	2	1	0
EDScr	2a – 2g	0	1	1	1
SDScr	3a – 3e	2	2	3	3
CVScr	4a – 4e	0	0	0	1
TDSCr	1a – 4e	3	5	5	5

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Thanks



Questions???

