NDoc® *Reference* for Depression Screening Tools

Summary:

This reference provides an overview of depression screening in NDoc.

Screening Tools:

The SOC OASIS (RFA 1) and ROC OASIS (RFA 3) include M1730 to indicate whether the patient was screened for depression. Either the PHQ-2©* scale or another standardized tool can be used as directed per agency policy. The PHQ-2© scale is included within the content of the M00 question under the Neuro/Emotion Category. Separately, this tool can also be accessed under the Wellness/Screenings>Depression Screening section within Today's Care, other OASIS assessments, and HIS charting screens in order to document depression screening at additional time points.

To complete the PHQ-2© scale, ask the patient *"Over the last two weeks, how often have you been bothered by any of the following problems?":*

	PHQ-2©	Not at all (0-1 day)	Several Days (2-6 days)	More than half the days (7-11 days)	Nearly Every Day (12-14 days)	N/A Unable to Respond
a)	Little interest or pleasure in doing things	0	1	2	3	NA
b)	Feeling down, depressed, or hopeless?	0	1	2	3	NA

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Separate from the OASIS question, NDoc has also integrated the PHQ-9 screener offered by Pfizer through the Patient Health Questionnaire (PHQ) Screeners site: https://www.phqscreeners.com/ The PHQ-9 is among of the PHQ family of measures. This tool includes the two questions from the PHQ-2©, but then allows users to evaluate further with the remaining seven questions as shown below.

	PHQ-9©	Not at all (0-1 day)	Several Days (2-6 days)	More than half the days (7-11 days)	Nearly Every Day (12-14 days)	N/A Unable to Respond
1)	Little interest or pleasure in doing things	0	1	2	3	NA
2)	Feeling down, depressed, or hopeless?	0	1	2	3	NA
3)	Trouble falling or staying asleep, or sleeping too much	0	1	2	3	NA
4)	Feeling tired or having little energy	0	1	2	3	NA
5)	Poor appetite or overeating	0	1	2	3	NA
6)	Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3	NA
7)	Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3	NA
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	NA
9)	Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3	NA

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Charting Logic:

In processing this charting, NDoc tallies the score for each line. If the total score is three or more for the first two questions (either within the PHQ-2© or PHQ-9© independently) then further depression screening is indicated and questions 3-9 are required. NDoc will trigger a problem of 'depressive feelings present' with appropriate instructions and outcomes required if the PHQ-2© or PHQ-9© score is three or more or depressed is selected for the patient's current mental status (DE#183). Should it be determined after further evaluation that the patient is not depressed, all instructions and outcomes should be addressed as appropriate to resolve the problem. Note the following considerations:

- If both of the PHQ-2© fields are charted and are not both NA, then the PHQ-2© fields 3) through 10) are enabled but not required,
- If the PHQ-2© Score is < 3 then the PHQ-9© fields 1) and 2) will not populate unless you chart one of the PHQ-9© fields 3) through 10)
- If PHQ-2© Score > 2 then the PHQ-9© fields are required and the PHQ-9© fields 1) and 2) will populate.
- If the PHQ-2© fields are changed so they are both NA or if they are 'cleared' using the clear button, then the PHQ-9© fields are cleared and disabled.

Plan of Care (POC) Integration:

The PHQ-2© and the PHQ-9© are accessible within the POC Review screens. The charted values flow to the Mental/Psychosocial/ Cognitive Status section of the POC. Note: any charting of the either tool is saved in the POC Review screens, but if new charting is added or changed from what has flowed from the charting screens, those edits will not flow back to the patient record.

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