

Ocean Mental Health Practice Support Program

Definitions:

“eForm” – The questionnaire that a patient completes on a tablet.

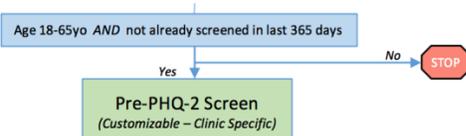
“Tablet Rules” – a programmable set of criteria, or instructions, that automatically pre-loads an eForm on the tablet for a patient to complete when they sign in to the tablet.

“eForm Actions” – programmable instructions that can add additional eForms for the patient to complete, depending on the answers to certain questions within the questionnaire, he/she is completing at the time.

The Flowsheet:

Patient Check-in, all pts given tablet, 3-digit code entry → Demographics Update

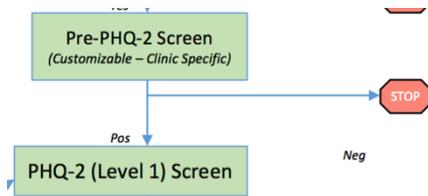
As a general workflow, all patients are handed a tablet on check-in. A personalized identifier (3-digit code) is entered. The patient is automatically prompted to confirm (or update) his/her contact information.



If the patient meets the criteria of age 18-65yo AND has not already completed the Pre-PHQ-2 Screen in the last 365 days, then the tablet will proceed down the algorithm by loading the Pre-PHQ-2 eForm.

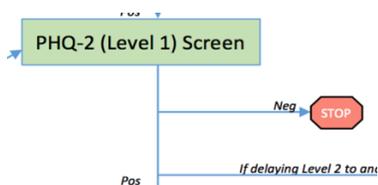
If the patient is not age 18-65yo, or has already been screened within the last year, then the tablet will *not* proceed any further down the algorithm.

NOTE: for most EMRs (Telus PS Suite, OSCAR, Accuro) that can pull data (like patient age) from the actual EMR chart, this will all occur automatically. For some EMRs that do not fully integrate with Ocean, the selection process for giving the tablet and/or loading the Pre-PHQ-2 eForm must be done manually.

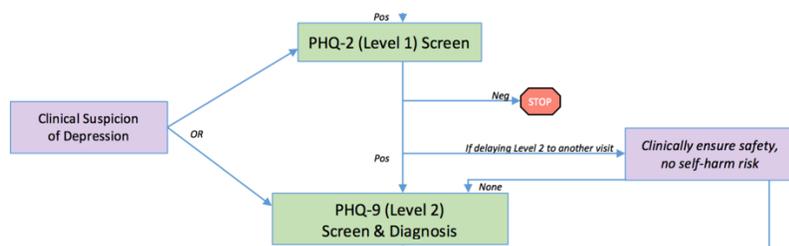


There is conflicting evidence on whether or not all patients should be screened for depression with a PHQ-2. Accordingly, screening can be targeted to only those with certain risk factors (*i.e. substance abuse; certain chronic medical conditions such as diabetes, COPD, or chronic pain; family history of depression, etc*). The “Pre-PHQ-2” eForm is used to identify these risk factors, based on the patients answers. This eForm can be customized to a clinic’s individual preferences.

If a patient answers “no” to all of the risk factors, the “Pre-PHQ-2” screen is *negative*, and the tablet will not proceed any further down the algorithm. If a patient answers “yes” to one or more risk factors, the “Pre-PHQ-2” screen is positive and then the automated eForm Actions proceed to having the patient complete the PHQ-2 screen.

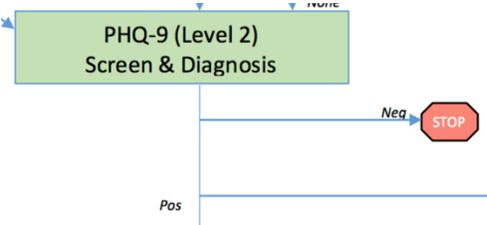


The patient completes the eForm for the PHQ-2, which is a fast, simple, 2-question questionnaire to screen for depression. If the patient answer “no” to both questions, the screen is *negative* and the tablet will not proceed any further down the algorithm. If a patient answers “yes” to either, then the screen is *positive* and then the automated eForm Actions proceed to having the patient complete the PHQ-9 screen.

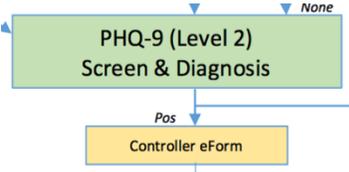


Sometimes patients will enter the algorithm directly based on the clinician’s clinical suspicion. For example, if a doctor notices ahead of time that a particular patient is booked in that day, and the doctor has a suspicion the patient may have depression (either related or unrelated to the visit reason that day), then the doctor can manually pre-load either the PHQ-2 or the PHQ-9 eForm for the patient to complete upon check-in. From there, the algorithm proceeds as normal.

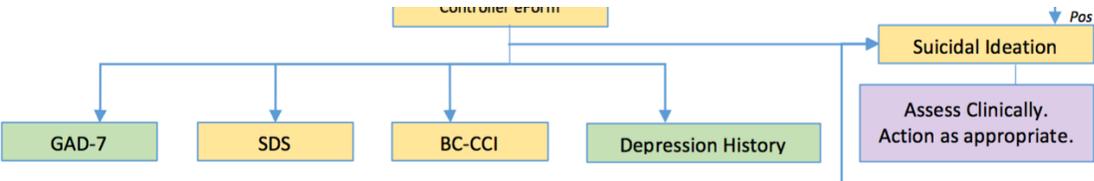
Sometimes the clinical suspicion for depression may unexpectedly arise *during* a visit. In these cases, the doctor can quickly, *verbally*, apply a PHQ-2 screen to the patient. If positive, there may not be enough time left in that visit to fully and properly assess the patient for depression. In these cases, the doctor can have the patient complete PHQ-9 eForm using the tablet *after* the visit, before leaving, with the plan to have the patient return for a follow-up visit to explore the possible depression. **(As part of this workflow, the doctor should clinically assess the patient to rule out the risk of self-harm and suicidal ideations prior to the patient leaving the exam room, in case the patient answers “yes” to thoughts of self-harm on the PHQ-9).**



This is a central part of the algorithm. Here, the patient completes the PHQ-9 eForm. The answers are used to confirm a diagnosis of depression, as well as the severity of depression. If the screen is negative, the tablet will not proceed any further down the algorithm. If the screen is positive, the algorithm branches out into many different possibilities depending on the patient’s answers.



The “Controller” eForm is a “behind the scenes” piece of the algorithm that is required to remember a patient’s most recent PHQ-9 score and direct the frequency of follow-up screens on future visits. All that the patient sees here is a message that says, “Thank you for using this tablet. According to your answer, we’d like to ask you a few more questions about how you are feeling. Please click *next* to continue.”



If the PHQ-9 is positive for depression, using the automated *eForm Actions*, certain additional eForms will be added for the patient to complete.

All patients with a positive PHQ-9 will be prompted to complete a GAD-7 questionnaire, as well as a “General Depression History” questionnaire. (Please refer to screenshot examples of these eForms at the end of this document).

10. If you checked off any problems, 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

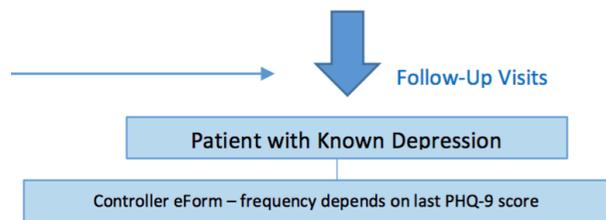
Here in the PHQ-9, if a patient answers any of “Somewhat difficult”, “Very difficult”, or “Extremely difficult”, then the patient will automatically be directed to also complete an eForm for the *Sheehan Disability Scale* (“SDS”) to assess and quantify the impact depression is having on the patient’s *function* at work/school, social, and family life.

7. Trouble concentrating on things, such as
 reading the newspaper or watching television

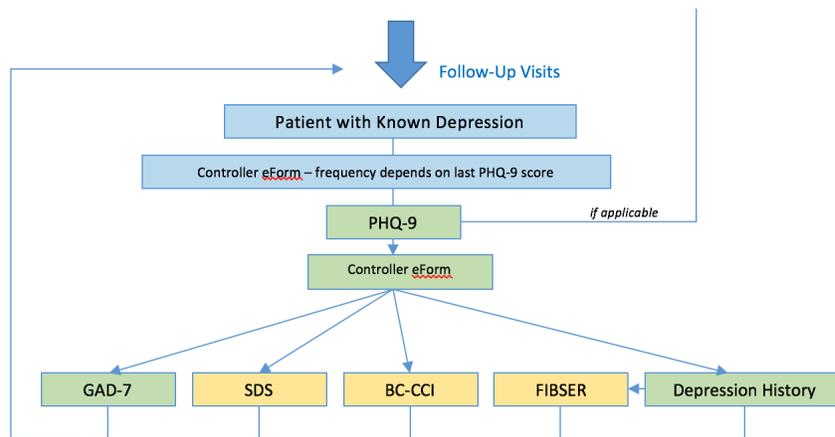
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Here in the PHQ-9, if a patient answers any of “Several Days” (1), “More than Half the Days” (2), or “Nearly Every Day” (3), then the patient will automatically be directed to also complete an eForm for the *BC-CCI* to more thoroughly assess and quantify the impact depression is having on the patient’s concentration and cognitive abilities.

Finally, in the PHQ-9, if the patient answers “yes” to any questions regarding self-harm or suicidal ideations, then the note is flagged in *bold red font* and the patient will automatically be directed to also complete an eForm to explore the patient’s risk of self-harm. Most importantly, the algorithm directs the clinician to assess the the patient’s safety and take action as appropriate.



The final section of the algorithm applies to patients with depression when they are being seen at follow-up visits. This applies to patients who have already gone through the first sections of the screening and diagnosis algorithm. As noted above, the “Controller” eForm is used to remember a patient’s previous diagnosis of depression and most recent PHQ-9 score.



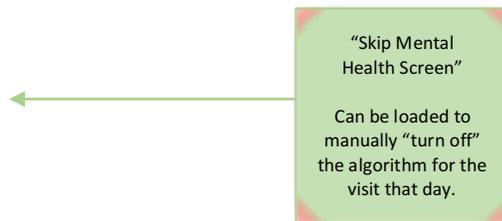
As above, when applicable, patients will be automatically prompted to complete an updated PHQ-9 eForm.

Just as the in the first part of the algorithm, the automated eForm Actions will load additional eForms depending on the patients answers in the PHQ-9. Additionally, if the patient answers “yes” to having side effects from a depression-related medication in the “Depression History” eForm, then the eForm Actions will automatically load a FIBSER scale eForm to explore the severity of the side effects.

This cycle repeats itself on future follow-up visits. The frequency of reassessment depends on the patient’s most recent PHQ score. The higher the PHQ-9 score, the more frequently the patient will be reassessed:

- *If last PHQ-9 was less than 5, then will not automatically rescreen until 365 days.*
- *If last PHQ-9 was 5-9, then will not automatically rescreen until 183 days.*
- *If last PHQ-9 was 10-14, then will automatically rescreen after 30 days.*
- *If last PHQ-9 was 15 or higher, then will not automatically rescreen after 14 days.*

How to Turn Off the Algorithm for a Visit:



In a busy medical practice, there will be visits when it is too busy or inappropriate to explore mental health screening that day. For example, if a patient is already coming in for a complicated visit with many other issues to discuss, the clinician and/or the patient may not have time to go into mental health screening that day. In these instances, the clinician can simply manually add the eForm called “PSP Skip Mental Health Screen” to that visit. This will “turn off” the mental health algorithm for that visit.

When the “PSP Skip Mental Health Screen” eForm is added, the patient simply sees an extra page on their tablet that says *“Thank you for using this tablet technology to improve patient care. Please click “Next” to continue.”*

Sample Screenshots:

PHQ-2 eForm and the text note it generates:

Over the last two weeks:

Have you felt down, depressed, or hopeless?

Have you felt little interest or pleasure in doing things?

This panel shows how the note will appear in the chart.
(drag this box out of the way as necessary)

PHQ-2

1. Feeling down, depressed or hopeless: **"More than half the days"**

2. Anhedonia: **"Nearly every day"**

Score for @PHQ-2: 5 / 6

POSITIVE screen.

PHQ-9 eForm and the text note it generates:

Over the last two weeks, how often have you been bothered by any of the following symptoms?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
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
9. Thoughts that you would be better off dead, or of hurting yourself in some way

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?

Have you had any thoughts of harming yourself lately?

This panel shows how the note will appear in the chart.
(drag this box out of the way as necessary)

Patient Health Questionnaire (PHQ-9)

Over the last two weeks:

Anhedonia: More than half the days

Low mood: Nearly every day

Sleep problems: Several days

Fatigue: More than half the days

Appetite problems: More than half the days

Guilt: More than half the days

Difficulty concentrating: More than half the days

Psychomotor changes: Several days

Thoughts of death or self-harm: **Several days**

Ability to function: "Very difficult"

Depressed thoughts on most days in the past 2 years: "Yes"

Having thoughts of self-harm.

Severity Score for @PHQ-9: 16

(PTHADMENTALHEALTHVISITODAY)

Suicidal Ideation eForm and the note it generates:

We understand you have expressed some thoughts of harming yourself recently.

PLEASE SEEK HELP

** If you haven't already spoken with us about your most recent thoughts, please contact us immediately via phone for assistance.

If you cannot reach us right away, please call 911 or proceed immediately to the emergency department and tell them you are having some thoughts of harming yourself. We very much want to help you and ensure that you are safe. **

In the meantime, you may answer the questions below to provide us with additional information.

How would you describe these thoughts of suicide or self-harm? (select all that apply)

extremely rare rare infrequent frequent repetitive constant passive fleeting scary

Do you have a specific plan in mind for harming yourself or ending your life? No Yes

Are you afraid you might act on these thoughts? No Yes

Were you seeking help for these thoughts today? No Yes

What are reasons why you have considered harming yourself?

Have you ever harmed yourself in the past? No Yes

Have you ever attempted to end your life in the past? No Yes

Do you have a history of depression? No Yes

Do you have a history of alcohol abuse? No Yes

Do you have a history of drug abuse? No Yes

Do you have a history of psychosis, mania, or schizophrenia? No Yes

Are you a religious person? No Yes

This panel shows how the note will appear in the chart.
(drag this box out of the way as necessary)

Suicidal Ideation

Thoughts of self-harm characterized as: infrequent; passive; fleeting

No specific plan.

Does not fear she will act on these thoughts.

Was not seeking help today for these thoughts.

Previous suicidal/parasuicidal behaviour:

No previous incidents of self-harm

Risk Factors and Protective Factors:

History of depression.

History of alcohol abuse.

No history of drug abuse.

No history of psychosis or mania.

Religious.

Cultural or religious barrier to suicide.

In a relationship.

Has social support.

No family history of suicide.

Identifies good coping skills.

Patient-identified protective factors:

My children.

Recent traumatic event. Grandfather passed away

No access to firearms.

General Depression eForm and the note it generates:

Depressed mood:

How long have you had a low mood?

What are your main concerns regarding your mood today?

How do your symptoms today compare to when the problem started?

What things have been making you feel worse lately?

What things have been helping your mood lately?

Have you had any thoughts of harming yourself lately? No Yes

Past Psychiatric History:

Have you ever been diagnosed with a mental health condition? No Yes

Have you ever been hospitalized for a mental health reason? No Yes

Have you had episodes of depression in the past? No Yes

Have you ever attempted suicide in the past? No Yes

Have you ever had an unusually very elevated mood that lasted for days or weeks? No Yes

Are any of the following making your mood worse lately?

Spouse/Partner No Yes

Home life No Yes

This panel shows how the note will appear in the chart.
(drag this box out of the way as necessary)

Depression:

Low mood for about 1 year. Compared to when started, symptoms are **getting worse**. Negative influences: "not able to find a job". Positive influences: "talking with my friends".

No suicidal ideation

Past Psychiatric History: No prior mental health history. No prior hospitalization. No prior episodes of depression. No prior suicide attempt

No prior episode of prolonged elevated mood.

Stress/Triggers: Financial; Work; Death/Grief

Not Spouse/Partner; not Home; not Personal Health Issues; not Caregiver stress

Lifestyle: Alcohol 11-15. Recreational drug use past month:

Yes - Multiple Times. Exercise None significant. Feels sleep quality is Poor.

Avg hours Sleep per night: 5

Social/Leisure activities lately: none

Mood Medications: **Not taking mood med.**

Patient interested in: One on One Counselling; Self-help

online or books; Medications for mood; Medications for sleep; Advice regarding financial strain.

No Exercise advice; no Healthy diet advice; no Advice with alcohol or drugs; no Help with improving social/fun activities;

no Sleep advice (non-medication)

(PTHADMENTALHEALTHVISITODAY)