Performance Measure for Improvement in Depression

Data Definitions

Positive Depression Screen
The patient scores as mildly depressed or greater on one of the following depression screening tools: PHQ-9, BDI-II, PRFS, or HADS

Decrease in Depressive Symptoms
Defined in detail in the performance measure. Refers to a reduction of one or more levels of severity in depressive symptoms, e.g. from moderate to mild, from the score at the beginning of CR to the completion of CR.

Denominator Exclusions
Patients who dropped out of cardiac rehabilitation and/or patients whose baseline depression scores did not reach the mild range or greater on a depression screen.

Frequently Asked Questions

Please define “The number of patients whose depression screening score is at least in the Mild Range at intake to CR who reduce symptom severity by at least one level by the time they complete the CR program.”

“At least in the Mild Range” means the patient’s results place him or her in the Mild, Moderate or Severe Range of the depression screener. “Who reduce symptom severity by at least one level” means the initial score might have been in the Moderate Range and is reduced to the Mild Range by program completion, or reducing from the Mild Range to the Subclinical Range. “By the time they complete the CR program” means the patient has undergone a final, formal discharge assessment session and updated treatment plan.

Should patients who cannot self-administer the measures (e.g., impaired reading due to illiteracy or language barrier) be excluded?

It may be appropriate for programs to utilize staff to read items to patients if they are unable to read and have the cognitive capacity to complete the test. This task should not be assigned to family members as it could more easily skew patient responses. Some scales are available in multiple languages if the patients are unable to read in English. Psychometric properties of translated tests would need to meet acceptable standards. Depending on the setting, hospital interpreter staff may be able to read the scale items to patients in the test version that is written in his/her own language if patient is unable to read.

Many depression screening tools include measuring depressive symptoms such as change in appetite, sleep, and energy level, all of which may be related to physiological effects of surgery rather than simply depression. These can improve without any specific intervention other than time and recovery.

Including physical symptoms in screening tools may inflate depression scores; however, depression may also include somatic symptoms. Multiple tests exclude somatic items to avoid including physical symptoms that may be due to the patient’s medical disease. Either method has potential benefits and risks of excluding items that may spuriously increase the score vs. not capturing symptoms that are present, which will erroneously deflate the score. The selected depression screeners address appetite,
sleep, and energy to varying degrees. PHQ-9: 3 of 9 items, BDI-II: 4 of 21 items, PRFS: 1 of 14 items, HADS: 0 of 7 items. Programs can decide on the best fit with which they are comfortable.

It is important to note these tools are screeners of potential depressive symptoms and should be used to determine if follow up with a qualified professional is warranted. Tools that include more somatic symptomatology will, in a sense, cast a broader net. Regardless of a patient’s total score on a depression scale, any patient who screens positive on a suicide question requires immediate follow-up and further assessment by qualified program staff to determine whether the patient requires emergent care. Staff need to be aware of applicable hospital policies for the possibilities of patients with suicidal thoughts.

How important is it that programs address depression scores that are in the mild range?
It is important that even mild range scores are considered significant. There is evidence that even lower levels of depression lead to greater levels of future morbidity. In considering future outcomes for the patient and the program, it is important to ensure this area is addressed optimally.

Would patients be excluded if they score in normal range at entry, but increase to mild or greater later?
Patients who initially score below the mild range are excluded from this measure.

Depression is a difficult area of our patients’ lives for cardiac rehab professionals to influence. Traditionally, we have sought primarily to notify the referring physician of psychosocial concerns and it is not always predictable whether this area is addressed between the patient and physician. Most programs do not have and/or cannot afford psychosocial providers. Depression is a difficult area for CR professionals to address with the patients and also for the patients themselves. It remains important to ensure communication occurs with the referring physician regarding our patients’ psychosocial concerns. However, many programs likely have more psychosocial resources available to them than is immediately recognized and these resources are generally affordable utilizing the CPT 93797 billing code. This code was approved by CMS to allow for individualized care of our patients with activities other than ECG monitored exercise, including psychosocial consultations and psychosocial classes.

Additionally, it would be very helpful for staff to be competent in discussing depression’s impact on morbidity and mortality and have at least one staff member or consultant proficient in motivational interviewing to assist in helping the patient address this behavior change of addressing psychosocial treatment.