EmblemHealth | HealthCare Partners, IPA HealthCare Partners, MSO

Behavioral Health Screening Tools

MEASURES	TOOL	ABOUT THE TOOL	LINK TO TOOL	SCORING AND ACTION STEPS
Depression	PHQ-2[1]	Depression Screen – 2 Questions	**https://www.commonwealthfund.org/sites/default/files/documents/_usr_doc_PHQ2.pdf**	**Score of 0-2 = Negative screen** **Action**: None **Score of 3+ = Positive screen** **Action**: Administer the PHQ-9.
	PHQ-9[1]	Depression Screen – 9 Questions	**phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf**	**Score of 1-4 = Minimal depression** **Action**: Watchful waiting; repeat PHQ-9 at follow-up visit. **Score of 5-9 = Mild depression** **Action**: Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 10-14 = Moderate depression** **Action**: Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 15-19 = Moderately severe depression** **Action**: Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 20-27 = Severe depression** **Action**: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. ***Positive Score on Item 9*** ***Action:*** *Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.*
	PHQ-9 Modified for Teens[2]	Depression Screen – 9 Questions	**https://www.emblemhealth.com/~/media/Files/Provider%20Manual%20Related%20Documents/Behavioral%20Health%20Services/Patient_Health_Questionnaire_for_Adolescents.pdf**	**Score of 1-4 = Minimal depression** **Action**: Watchful waiting; repeat PHQ-9 at follow-up visit. **Score of 5-9 = Mild depression** **Action**: Watchful waiting; repeat PHQ-9 at follow-up visit. Possible referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 10-14 = Moderate depression** **Action**: Develop treatment plan, consider pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 15-19 = Moderately severe depression** **Action**: Active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. **Score of 20-27 = Severe depression** **Action**: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management. ***Positive Score on Item 9*** ***Action:*** *Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.*
	Edinburgh Postnatal Depression Scale (EPDS)[3]	Depression Screen – 10 Questions	**http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf**	**Score of 0-9 = Low probability of depression** **Action**: Watchful waiting; repeat Edinburgh Postnatal Depression Scale at follow-up visit. **Score of 10-30 = High probability of moderate to severe depression** **Action**:: Develop treatment plan, possible active treatment with pharmacotherapy and/or referral to behavioral health care professional for psychotherapy within 30 days of positive screen. ***If a patient scores a 1, 2, or 3 on question 10, please address suicidal thoughts immediately.*** **Action**: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
	Geriatric Depression Scale (GDS) – Short Form[4]	Depression Screen – 15 Questions	**http://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF**	**Score of 1-4 = Minimal depression** **Action**: Watchful waiting; repeat GDS at follow-up visit. **Score of 5-15 = Mild to severe depression** **Action**: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.

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Behavioral Health Screening Tools

MEASURES	TOOL	ABOUT THE TOOL	LINK TO TOOL	SCORING AND ACTION STEPS
Anxiety	GAD-2[1]	Anxiety Screen – 2 Questions	**integration academy.ahrq.gov/sites/default/files/GAD-2_0.pdf**	**Score of 0-2 = Negative screen** **Action**: None **Score of 3+ = Positive screen** **Action**: Administer the GAD-7.
	GAD-7[1]	Anxiety Screen – 7 Questions	**phqscreeners.com/sites/g/files/g10016261/f/201412/GAD-7_English.pdf**	**Score of 1-4 = Minimal anxiety** **Action**: Watchful waiting; repeat GAD-7 at follow-up visit. **Score of 5-9 = Mild anxiety** **Action**: Watchful waiting; repeat GAD-7 at follow-up visit. **Score of 10-14 = Moderate anxiety** **Action**: Further diagnostic assessment by PCP or behavioral health care professional. Consider pharmacotherapy and/or psychotherapy. **Score of 15-21 = Severe anxiety** **Action**: Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy exists, expedite referral to behavioral health care professional for psychotherapy and/or collaborative management.
Substance Abuse/ Dependence	NIDA – Quick Screen[5]	Alcohol/Drug and Tobacco Screen – 4 Questions (Single Question Screener Included)	**drugabuse.gov/sites/default/files/pdf/nmassist.pdf**	**If respondent indicates "No" for all drugs in prescreen.** **Action**: Reinforce abstinence. **If respondent indicates "Yes" to any of the drugs listed.** **Action**: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.
	AUDIT-C[6]	Alcohol Screen – 3 Questions	**https://www.integration.samhsa.gov/images/res/tool_auditc.pdf**	**Score of 0-3 in Men / Score of 0-2 in Women = Minimal to moderate use. Low probability of abuse or dependence.** **Action**: Reinforce abstinence. Watchful waiting; repeat AUDIT-C at follow-up visit. **Score of 4-12 in Men / Score of 3-12 in Women = Moderate to severe use. High probability of abuse or dependence.** **Action**: Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.
	AUDIT[7]	Alcohol Screen – 10 Questions	**https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf**	**Score of 1-7 = Minimal to moderate use. Low probability of abuse or dependence.** **Action**: Reinforce abstinence. Watchful waiting; repeat AUDIT at follow-up visit. **Score of 8-15 = Moderate to severe use. Moderate probability of abuse or dependence.** **Score of 16-19 = Moderate to severe use. Moderate to high probability of abuse or dependence**. **Score of 20-40 = Severe use. High probability of abuse or dependence.** **Action steps for scores of 8 or higher:** Review current list of medications to ensure medications prescribed are not at risk for abuse. Provide brief counseling (5-15 minutes) to help the patient develop a plan to reduce drinking, identify high-risk situations, and learn coping strategies. Consider referral to behavioral health care professional within 60 days of positive screen.
Suicidality	CSSRS – Clinical Screener[8]	Severity Screen, Clinical Practice Screener – Recent – 6 Questions	**http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english**	**1 or more "Yes" responses are a positive screen.** **Action**: Refer to behavioral health care professional to evaluate risk factors and determine appropriate treatment setting. ***A "Yes" response to question #4 or #5 in the past month or any behavior in question #6 is an indication of severe risk.*** ***Action:*** *Refer to behavioral health care professional to evaluate for hospitalization.*

Please also consult the Beacon Health Options PCP Toolkit at **pcptoolkit.beaconhealthoptions.com** for additional resources.

[1]Spitzer, R.; Williams, J. B.W.; Kroenke, K. and colleagues, with an educational grant from Pfizer. No permission required to reproduce, translate, display, or distribute. [2]Johnson J.G., Harris E.S., Spitzer R.L., Williams J.B.W.: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002. [3]Cox, J.L., Holden, J.M., and Sagovsky, R., 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786. *and* K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199. [4]Yes average: The Use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986. [5]National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. [6]Bradley, K. A., Bush, K. R., Epler, A. J., et al (2003). Two brief alcohol-screening tests from the Alcohol Use Disorders Identification Test (AUDIT): Validation in a female Veterans Affairs patient population. Arch Intern Med. 163:821-9 *and* Bush, K., Kivlahan, D.R., McDonell, M.B., et al (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Arch Intern Med. 158:1789-95. [7]Babor, T.F.; de la Fuente, J.R.; Saunders, J.; and Grant, M. AUDIT. *The Alcohol Use Disorders Identification Test. Guidelines for use in primary health care.* Geneva, Switzerland: World Health Organization, 1992. [8]Developed by Drs. Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.