Ideas for Closing Performance Gaps

Key Activity: Perform Adolescent Depression Screening and Follow-up

Rationale: Adolescent depression is very common, affecting between 12% and 25% of adolescents. Lifetime prevalence of depression and dysthymia increases from 8.4% for ages 13–14 years to 15.4% for ages 17–18 years. Depression in adolescents is not always characterized by sadness, but can be seen as irritability; anger; boredom; an inability to experience pleasure; or difficulty with family relationships, school, and work. It is important to screen for depression to identify the source and assess the severity of depression. "The wide mood changes in adolescents' challenge providers to distinguish between a mental health disorder and troubling, but essentially normal behavior."

Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Adolescent depression screening is not routinely performed at annual health supervision visit for patients 12 to 21 years of age.*		

Health care providers and/or staff do not recognize the importance of adolescent depression screening.
 	
The practice is unaware of new AAP recommendations for adolescent depression screening between the ages of 12 to 21 years.
	• Review the following sections of the Bright Futures Guidelines with all staff:
	  ○ Adolescent Visits—11 to 21 Years
	  ○ Promoting Mental Health
	
	• Review the AAP resources:
	  ○ AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management
	  ○ AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management
	  ○ Mental Health Competencies for Pediatric Primary Care.
	
	• Review the US Preventive Service Task Force Clinical Summary for depression screening in children and adolescents and the AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders.
	
	• Review the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.
		• Discuss with all staff the importance of adolescent depression screening and stress the following:
		  ○ Suicidality is the third leading cause of death in adolescents.
		  ○ Adolescents who have major difficulties in one area of functioning often demonstrate symptoms and difficulties in other areas of daily functioning.
		  ○ Depression is present in 10% to 15% of adolescents at any given time.
		  ○ Having a parent with depression doubles to quadruples a child's risk of a depressive episode.
		  ○ Depression in adolescents is not always characterized by sadness, but can be seen as irritability; anger; boredom; an inability to experience pleasure; or difficulty with family relationships, school, and work.
		• Conduct a Lunch and Learn or similar session with fellow health care providers to ensure all providers are aware of the criteria for depression in adolescents.

Copyright © 2017 American Academy of Pediatrics. All rights reserved.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Review the Bright Futures Periodicity Schedule with all staff: ○ Post a copy of the periodicity schedule on the wall in all exam rooms.	

Screening is not being routinely performed because of lack of knowledge of the screening tools available and which ones to use.
 	
The practice is not familiar with how to interpret, follow up, and document adolescent depression screening results.
	• Become familiar with the following standardized depression screening tools and determine which tools your practice will use:
	  ○ Start with a general tool, like Bright Futures Supplemental Screening Tool.
	  ○ If there is a positive response to depression questions, use a more specific tool like Patient Health Questionnaire 9 (PHQ-9) or PHQ-9 Modified for Adolescents (PHQ-A).
	  Note: *The PHQ-9: Modified for Adolescents indicates only the likelihood that an adolescent is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.* The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit includes a copy of this tool.
		• Conduct educational sessions about screening and management of depression and of suicide risk in adolescents.

Screening is not performed because of lack of time in the visit.	• Develop patient tool that can be easily scored. Provide a previsit questionnaire to the adolescent prior to the visit. ○ Start with PHQ-2. If positive, follow up with PHQ-A. • Develop work flows for screening and managing patients with depression.	
Adolescent patients are not seen in the office for health supervision visits as often as younger children.	• If possible, utilize EHR-based flags/prompts to remind health care providers to perform adolescent depression screening between the ages of 12 to 21 years. • Utilize previsit questionnaires to identify mental health concerns when adolescents are in the office for sick visits. • Update and reinforce screening via the recall system.	Consider administrating brief depression screen for adolescents coming to the office for something other than health supervision visits.
The practice does not have a systematic approach for adolescent depression screening.	• Make sure depression screening tools are available in each exam room. • Integrate screening into the office flow for any adolescent visit.	

Copyright © 2017 American Academy of Pediatrics. All rights reserved.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Adolescent depression concerns are not discussed with the patient & family*		
The health care provider is not comfortable discussing mental health concerns with families. • Language barriers and cultural differences and attitudes toward depression impede discussions. • Parents/guardians are resistant to discussing/accepting that the adolescent is depressed. • Resources are not available (or not utilized) to guide a patient/family discussion of depression.	• Use previsit questionnaires as a way to begin a dialogue of common adolescent concerns. ✓ Bright Futures Previsit Questionnaires: – Older Child/Early Adolescent Visits—For Parents – Older Child/Younger Adolescent Visits – Early Adolescent Visits – 15- to 17-Year Visits – 18- to 21-Year Visits • Use supplemental questionnaires as a way to ask additional questions regarding the adolescent's development: ✓ Bright Futures Supplemental Questionnaires: – 11- to 14-Year—Parent – 11- to 14-Year Older Child/Younger Adolescent—Patient – Early Adolescent—Patient – 15- to 17-Year Middle Adolescent—Patient – 18- to 21-Year Late Adolescent—Patient • Use the **Common Factors** approach. • For patients and families with specific needs (eg, language, culture, LGBT populations), refer to community providers with experience and tools to provide needed services. • Designate an office champion for all adolescent issues.	• Review the Mental Health Competencies for Pediatric Primary Care. • Engage the family for assistance and support.

Copyright © 2017 American Academy of Pediatrics. All rights reserved.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Routine education of depression concerns are not part of the practice's standard visit flow.	• Make discussion and/or brochure about adolescent depression routine part of visit. • Make depression education a routine part of designated well-child visits. • Provide a handout to patients and/or parents/guardians during the visit that includes a list of information resources. • Post signs or posters in waiting rooms to make patients and families aware that your practice is equipped to discuss and manage mental health concerns in a confidential manner.	• Appoint an office mental health champion to educate patients and families. • Utilize information available from HealthyChildren.org: ○ Mental Health and Teens: Watch for Danger Signs ○ Your Family's Mental Health: 10 Ways to Improve Mood Naturally • Create a Mental Health or Adolescent portal on your practice Web site with educational resources including information on your practice's approach to mental health concerns and where and how to get help.
Mental health information is communicated to the family but discussions are not documented in the medical record.	• Use the Bright Futures Documentation forms to document depression screening performed; results and family discussion/educational materials provided. ○ 11- to 14-Year (page 737-765) ○ 15- to 21-Year (page 767-821)	

Copyright © 2017 American Academy of Pediatrics. All rights reserved.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Practice does not have follow-up procedures for patients with positive screens.		
The practice does not have a plan in place for what to do when a patient has a positive screen for adolescent depression.	• Before you begin the practice of adolescent depression screening, first set up the office practice flow for follow-up to screening. Note: Screening must be simultaneous with your referral and follow-up plan.	
The practice does not have a plan in place for children at immediate risk of suicide.	• Prepare the practice for different levels of response. • Develop an emergency plan (crisis plan) for suicidal patients. Gather contact and access information for local facilities for emergency evaluation, triage, and hospital admission for pediatric psychiatric issues.	
There is not enough time in the visit to adequately counsel patients and families regarding mental health resources and initiate referrals to mental health professionals.	• Develop a script for staff on how to deal with the next steps. • Co-locate a mental health professional in the office for follow-up. • Identify available community resources for referral and/or ongoing management and support.	
There are no child-centric crisis service providers in your area.	• Contact resources already present in your community and agree on how to handle adolescent depression emergencies.	

Copyright © 2017 American Academy of Pediatrics. All rights reserved.