

Depression Screening & Response Guide for Dialysis Teams



Introduction

Caring for patients with ESRD means addressing both physical and emotional health. Depression is common among dialysis patients and can affect how individuals feel, function, and engage in their care.

This manual provides practical tools and guidance to help care teams recognize depression early and respond effectively. By supporting patients' mental health, staff can play a key role in improving overall well-being and quality of life.

Legend



Suggested Resources

Table of Contents

Introduction	2
Depression Screening and Follow-Up Quick Guide for ESRD Care Teams.....	4
1. Why it Matters.....	4
2. When to Screen	4
3. Simple Screening Workflow	4
4. Intervention Zones and Actions	5
5. Brief Conversation Guide for Staff	6
6. Treatment Options.....	6
7. Documentation Essentials	7
8. Common Barriers and Solutions.....	7
9. When to Refer	7
10. Key Takeaways.....	7
Understanding CMS Requirements for ESRD Depression Screening and Reporting	8
Key Points	8
Frequency	8
Overcoming Common Challenges When Implementing Screening for Depression	
Practical Conversation Prompts.....	9
Stage-Matched Brief Interventions	10
Depression and Mental Health Resources for ESRD Care Team	11
Depression and Suicide Screening Tools	11
Renal-Specific Mental Health Resources	11
Peer and Emotional Support	11
Antidepressant FAQ Websites.....	11

Depression Screening and Follow-Up

Quick Guide for ESRD Care Teams

1. Why it Matters

- Depression is common in dialysis patients and impacts outcomes, adherence, and quality of life.
- Many patients go untreated and early identification can improve care and outcomes.
- Screening is recommended annually (at minimum) and supported by CMS/QIP requirements.

2. When to Screen

- All new patients
- At least yearly for all established patients
- Anytime there is a concern (missed treatments, withdrawal, mood or major life changes)



Treat depression screening like a routine vital sign to normalize it and reduce stigma.

3. Simple Screening Workflow

Step 1: Prescreen: PHQ-2 (1 minute)

Ask:

- Little interest or pleasure in doing things?
- Feeling down, depressed, or hopeless?
- Score 0-6
- ≥ 3 = Positive → move to PHQ-9

Step 2: Full Screening: PHQ-9 preferred (<5 minutes)

Measures symptom frequency over past 2 weeks

PHQ-9 Score Guide

- 0–4: Minimal
- 5–9: Mild
- 10–14: Moderate
- 15–19: Moderately severe
- 20+: Severe



A positive screen does not equal diagnosis. It guides next steps.

Step 3: Safety Check (ALWAYS if positive)

Ask directly:

“Are you having thoughts about harming yourself?”

- Yes → urgent response (Zone Red)
- No → proceed to intervention planning

4. Intervention Zones and Actions

Green Zone: At Risk / Mild Symptoms

- Normalize symptoms
- Provide brief education:
 - “Depression is common and treatable”
- Encourage:
 - Sleep routine
 - Physical activity
 - Social connection
- Monitor (re-screen at next visit)



[*Depression Zone Tool*](#)

Yellow Zone: Positive / Moderate Symptoms

- Review results with patient
- Link mood to health (missed dialysis, fatigue, etc.)
- Offer treatment options:
 - Medication (PCP/nephrologist collaboration)
 - Therapy referral
 - Behavioral activation (restart simple activities)

Behavioral Activation Examples:

Start small:

- Call a friend
- Take a short walk
- Resume a hobby
- Plan specifics: what, when, where

Follow-up: Close monitoring and document plan.

Red Zone: Crisis / Suicidal Risk

Immediate actions:

- Stay calm and present
- Do NOT leave patient alone
- Alert provider immediately
- Arrange:
 - Crisis services / ER
 - Mental health evaluation
- Engage support person (with permission)



[*Depression Signs and Treatment, Depression Zone Tool*](#)

Key point: Safety overrides all other care priorities.

5. Brief Conversation Guide for Staff

Start the conversation

"We ask all patients about mood because it affects overall health."

If positive

"Would you like help improving how you've been feeling?"

Assess motivation

"How ready are you to work on improving this (scale of 1-10)?"

- 7-10: Start intervention
- 1-6: Build motivation

If not ready

- Offer support and revisit later
- Provide educational resources



[*Discussing Depression Handout, Myths vs. Facts About Depression, Seasonal Affective Disorder Resource*](#)

6. Treatment Options

Patients may benefit from:

1. Medication

- Antidepressants (not addictive)
- May take 2–12 weeks for full effect

2. Behavioral Strategies

- Activity scheduling
- Problem-solving skills
- Routine building

3. Therapy

- CBT, problem-solving therapy, behavioral activation

4. Ongoing Monitoring

- Reassess symptoms regularly
- Adjust plan as needed

7. Documentation Essentials

Ensure documentation includes:

- Screening tool used
- Score/result
- Follow-up plan (if positive)

Reminder: A positive screen must have a follow-up plan.

8. Common Barriers and Solutions

Barrier	What Helps
No time	Add to intake/routine visits
Patient discomfort in completing screening	Normalize: “We ask everyone.”
Staff unsure what to do	Use Zone Tool to assess
Low follow-through	Use small goals and motivational interviewing

9. When to Refer

Refer to behavioral health if:

- Moderate–severe symptoms
- Poor response to initial support
- Suicide risk or safety concerns
- Patient preference for therapy

Tip: Patients are more likely to follow through if:

- They understand why the referral matters
- They feel involved in the decision



10. Key Takeaways

- ✓ Screen routinely
- ✓ Use PHQ-2 → PHQ-9
- ✓ Always assess safety
- ✓ Match interventions to severity
- ✓ Document everything
- ✓ Follow up consistently

Understanding CMS Requirements for ESRD Depression Screening and Reporting

CMS requires that all Medicare-certified dialysis facilities with at least 11 eligible patients during the calendar year of assessment report depression screening and follow-up information in EQRS. Facilities are required to document depression screening and follow-up outcomes for all ESRD patients aged 12 or older who have been treated at their facility for 90 days or longer within the calendar year of assessment.

Key Points

- Facilities must submit Clinical Depression Screening and Follow-up information for each eligible patient at least once during the calendar year.
- Clinical Depression information is entered on the Clinical Depression screen under the Patients tab in EQRS.
- The assessment period runs from January 1– December 31 of each calendar year.
- Users can enter data during the entire assessment period and are given two months past the end of the assessment period to complete reporting.
- After the submission deadline, the previous year's assessment period closes and the reported value becomes read-only and cannot be modified.

Frequency

- Annually
- Assessment must be entered into EQRS within two months past the end of the assessment period.

Reference: [*ESRD Quality Reporting System \(EQRS\) Patient Registry Data Management Guidelines*](#)

On May 28, 2026, the Centers for Medicare & Medicaid Services (CMS) released a redesigned Clinical Depression Screening module in the End Stage Renal Disease (ESRD) Quality Reporting System (EQRS). Use the [Clinical Depression Screening Module Guide](#) for detailed instructions on how to add clinical depression screening results.

Overcoming Common Challenges When Implementing Screening for Depression- Practical Conversation Prompts

Challenges	Potential Solutions
There isn't enough time for screening.	Make screening a routine component of existing workflow by implementing behavioral health vitals.
The visit is complicated enough without identifying additional problems requiring treatment.	The problem is present even if it is not identified through screening. Identification and treatment of depression will likely improve management of comorbid conditions.
Worry about offending the patient.	Introduce screening as means of offering comprehensive healthcare and describe depression as a treatable health condition.
Limited confidence and competence to treat the problems identified by screenings.	Dialysis providers spend a lot of time with patients. They may be able to offer first-line interventions (i.e., education, advice, medication, etc.). As with other health conditions, a specialty referral may be needed to provide a more intensive level of care.
Not sure how to refer.	Identify a referral issue the patient is concerned about. Ask the patient to meet with the referral source so that he/she "can help me, help you" address the patient's primary area of concern.
Concern that the patient won't follow through with the referral.	Patients may need assistance recognizing a problem and building motivation to engage in treatment. Education and motivational interviewing can assist patients in following through with referrals.

Stage-Matched Brief Interventions

Readiness to Change Stages

Brief Interventions

"I resent your assertion that I have a problem."

Stop, don't push. Convey readiness to help in the future.

"I respect that you don't want to talk about ____ today. I'd like to partner with you to improve all aspects of your health. Maybe we could talk about ____ at another time."

"I don't have a problem."

Don't push. Ask permission and build awareness by providing personalized information.

"Would it be okay if I told you why I am concerned about your ____?"

"I worry that your ____ is..."

"I know I have a problem, but I have no interest in changing at this time."

Don't push too hard. Encourage the patient to talk about his/her perception of the problem and discuss the potential benefits of changing.

"Would you tell me why you think your ____ is a problem?"

"If you decided you wanted to, can you think of potential benefits of changing?"

"I'd like to change soon, but need some help determining how to begin."

Reinforce desire to change.

"Excellent, we'd like to partner with you to make changes in your ____."

Problem-solve barriers and identify small action steps.

"Are there things that are getting in the way of you starting to make changes?"

"Patients often find that ____, ____, or ____ are helpful first steps. Would you like to try one of these options?"

"I'm starting to make changes, but need help to continue to make progress."

Reinforce any progress thus far. Problem-solve barriers and refine action plan.

"Are there things that are getting in the way of you making more progress?"

"What have you already tried (or considered trying)?"

"What has been most helpful so far?"

"I've made changes and am stable, but need help to stay that way."

Reinforce maintenance of progress. Identify successful strategies and problem-solve ways to continue to employ these.

"Can you identify strategies that have helped you manage your ____ successfully?"

"Can you identify any barriers to continuing these strategies to manage your ____?"

Depression and Mental Health Resources for ESRD Care Team

Depression and Suicide Screening Tools

- [PHQ-9 \(Patient Health Questionnaire-9\) - APA](#)
- [Geriatric Depression Scale \(GDS\) Short Form - AHRQ](#)
- [Hamilton Depression Rating Scale \(HAM D\) - APA](#)
- [Columbia Suicide Severity Rating Scale \(C-SSRS\): Columbia Protocol](#)
- [SAMHSA Safety Plan](#)

Renal-Specific Mental Health Resources

- [ESRD Networks Depression Toolkit](#)- Patient-centered education and coping tools
- [National Kidney Foundation Coping & Support](#)- Depression, stress, and coping guidance for kidney patients
- [NKF – Depression & Dialysis](#)- Symptoms, treatment, and impact on outcomes
- [American Kidney Fund – Mental Health](#)- Depression/anxiety in CKD and dialysis

Peer and Emotional Support

- [NKF Peer Mentoring \(NKF Peers\)](#)- 1:1 support from trained kidney patients
- [Renal Support Network \(RSN\)](#)- Support groups, education, and patient stories
- [AAKP Support Groups](#)- Local + virtual peer groups
- [NKF Online Communities](#)- Moderated online discussion forums

Antidepressant FAQ Websites:

- [National Alliance on Mental Illness \(NAMI\) Frequently Asked Questions](#)

Note: Check websites for additional language availability.