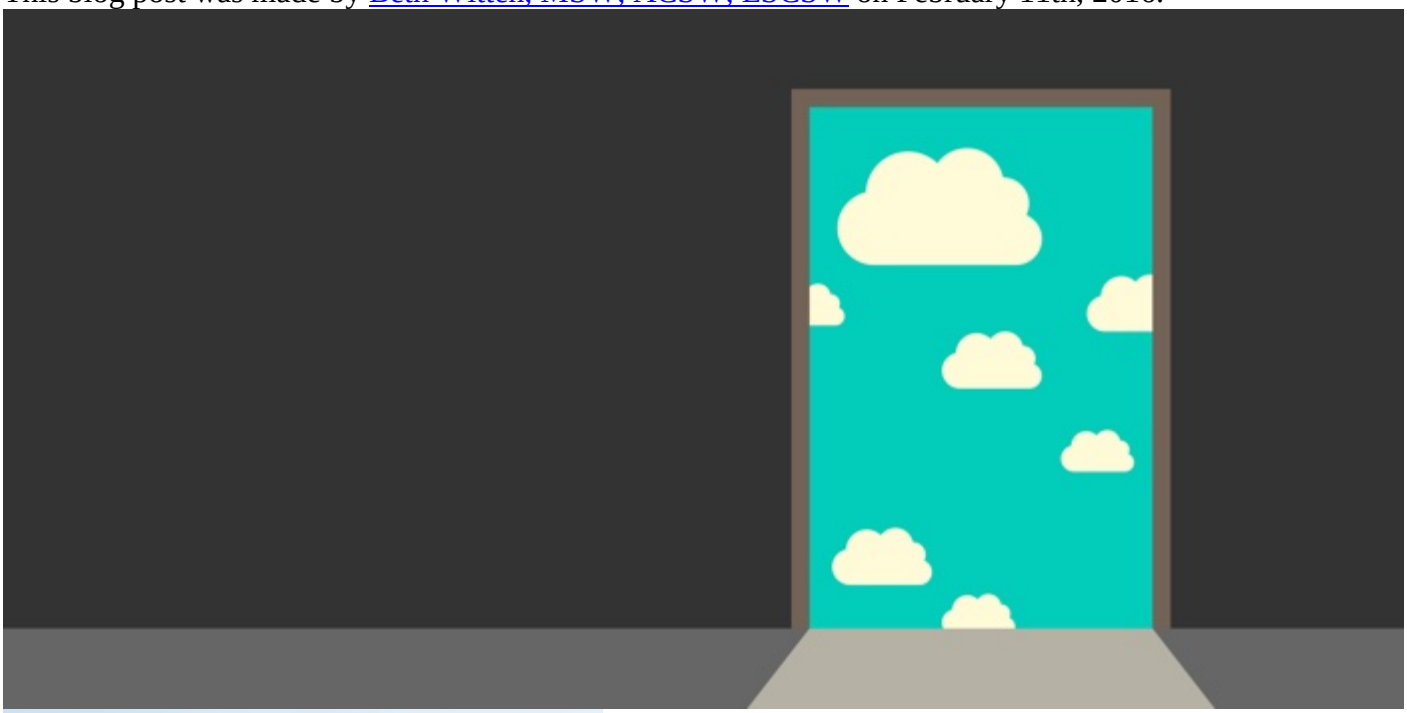
New CMS Reporting Requirement for 2016: Clinical Depression Screening for Dialysis

This blog post was made by Beth Witten, MSW, ACSW, LSCSW on February 11th, 2016.



Medicare wants to be sure that clinics assess dialyzors for clinical depression at least annually. Why should you care if your patient is depressed? Depression can lead to behaviors that affect dialysis outcomes, including skipping and shortening dialysis, fluid overload, forgetting to take medications, and substance abuse. While research has shown that depression increases the risk of hospitalization and death, it is still underdiagnosed and undertreated in people on dialysis.

Dialysis clinics must screen eligible dialyzors age 12 or older and those who have been on dialysis at least 90 days for clinical depression (both as of October 31, 2016 before February 1, 2017) using a standardized screener once between January 1, 2016 and before February 1, 2017. There are several standardized screeners, but two that are validated for all ages include the PRIME MD PHQ-2 and the CES-D. Facilities that opened before July 1, 2016

and those that treat more than 11 dialyzors will get a score for depression screening and follow-up that will be used with other QIP measures to determine the facility's payment for 2018.

To comply with this new requirement, dialysis clinics will report in CROWNWeb one of these conditions for each eligible dialyzor at least once between January 1, 2016 and before February 1, 2017:

1. Screening for clinical depression is documented as positive, and a follow-up plan is documented.
2. Screening for clinical depression is documented as positive, a follow-up plan is not documented, and the facility has documentation stating that the patient is not eligible.
3. Screening for clinical depression is documented as positive, the facility has no documentation of a follow-up plan, and no reason is given.
4. Screening for clinical depression is documented as negative, and a follow-up plan is not required.
5. Screening for clinical depression not documented, but the facility has documentation stating that the patient is not eligible
6. Clinical depression screening is not documented, and no reason is given.

In # 2 and 5 above, examples of patients who are "not eligible" could include those who already have a diagnosis of depression or bipolar disorder or limited functional capacity that would invalidate the results, patients with urgent or emergency need that any treatment delay could risk their health, or those who refused to complete the survey.

So far as the plan for a positive screening for depression, a CMS presentation suggested such things as "additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, other interventions or follow-up for the diagnosis or treatment of depression."

The medical record should indicate the depression treatment:

- **Goal** - e.g., reduce depression as indicated by score on depression screener.
- **Plan** - e.g., provide counseling or refer for counseling.
- **Timeline** - e.g., reassess in x months.
- **Outcome** - e.g., score on depression screener shows improvement and patient reports improved mood, etc.

If a patient screened positive for depression but there is no plan to treat, the dialysis staff should document why not, (e.g., treatment is not appropriate, treatment is medically contraindicated, etc.) If there was a plan and the goal was not achieved, the IDT, including the patient, should revise the plan to address barriers.

Speaking of barriers, research has shown that most people on standard in-center HD who are referred to outside mental health providers choose not to go. Why would they? They're already spending 3 days a week at dialysis or recovering from dialysis. Adding another appointment with a person they have to establish a relationship with and tell their whole "story" seems too overwhelming. They may have a hard time finding someone who accepts Medicare, and if they don't they worry that they may have one more bill to add to their stress, which could be contributing to depression. They may worry about how having a diagnosis of depression in their medical record and how that will affect their future, transplant listing, jobs, etc. And those concerns don't even count having to deal with society that stigmatizes depression and other mental illness as "weakness."

There may be another way. What about making sure that people with kidney failure are using the treatment option and setting that allows them to enjoy the highest quality of life?

- The dialysis social worker should be able to provide brief supportive counseling to address depression at no additional charge, or can refer to a community mental health provider.
- Dialysis facilities should make sure the social worker's license includes counseling and give social workers sufficient time to provide it.
- The nephrologist and team can review patients' symptoms and make appropriate changes in diet, medications, and the dialysis prescription that might improve symptom management and reduce depression.

Depression is one of those areas where “it takes a village.” The social worker or any other individual team member can’t do it alone.

I always worry that too many dialyzors identify themselves as being a “dialysis patient” rather than being “someone who needs dialysis to live a full life.” How many isolate themselves when they could be out and about with friends or family, working even part-time, volunteering, or doing anything to build their self-esteem? What barriers prevent them from doing things that could counter depression? **Can the dialysis team help dialyzors identify and overcome those barriers? It’s important to help dialyzors to see themselves as survivors, not victims**. I’ve said before that people live up or down to our expectations. Yet too many staff view dialyzors as dependent, helpless, and worthy of pity. How would that make anyone feel?

Want to know more? Read the technical specifications for all the measures for performance year 2016 including the reporting measure for Screening for Clinical Depression and Follow-Up, look at the Federal Register describing this new measure, watch the CMS presentation, and search PubMed for research articles on depression in dialysis. When I looked, there were over 1900 articles.