Expert Teams – Depression

Case-Based Learning & Mentorship

Wednesday, April 24, 2024

Moderator: Julie Moss, MS
ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Lines will be open for all high performing organizations
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Who Is On The Call?

- Clinician and Practitioner Subject Matter Experts
- Dialysis Facility and Transplant Professionals
- ESRD Network Staff
- Kidney Care Trade Association Members
- Centers for Medicare & Medicaid Services (CMS) Leadership

What are Expert Teams?

Participants from varying levels of organizational performance, each with lived experience and knowledge, come together to support continual learning and improvement

Help others learn faster by sharing what worked and what didn't work around a particular case, situation, or circumstance

Bring the best possible solutions to the table

Expert Team Topic Goals

- Increase the percentage of patients screened for depression
- Increase the percentage of patients identified with depression that have received treatment by a mental health professional

How Might We …

- Improve depression screening and patient reporting of mental health symptoms?
- Improve patient access to treatment for depression?
- Communicate differently to reduce the stigma of depression?

Presentation by Guest Expert

Kristin Kuntz, Ph.D.
Associate Professor of Psychiatry-Clinical
The Ohio State University

Addressing Depression in Patients on Dialysis- A recap

Kristin Kuntz, Ph.D.

Associate Professor of Psychiatry-Clinical

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

~~Review~~

- Over the past three sessions discussed:
  - How to introduce screening for depression in dialysis patients
  - Different types of screening tools for depression
  - Talking to patients about depression treatment

Why does identification of depression matter?

- Depression is the most common psychological issue in those w/ESRD

- Multiple reasons for this (long-term hx vs adjustment disorder)
- Depression is Associated with poorer quality of life
    - An independent risk factor for increased illness, hospitalizations, pain, cardiovascular events, sleep disturbance, sexual dysfunction, and death in dialysis patients
    - A risk factor for nonadherence
    - A contributor to cognitive dysfunction
    - Potential barrier to transplantation

Introducing Screening

- Prepare patients for the depression screening schedule and method of screening used
  - Paper and pencil tools
  - More informal verbal “check-ins” with pt
  - Potentially discussions with the support system

- Need for close reviewing of individual symptoms since there is overlap between ESRD and depression symptoms

Screening Strategies

- Measures
  - Reliability
  - Validity
- Examples- PHQ-9, CES-D, Hamilton Depression Rating Scale
- Be aware of patients' literacy levels; when questionnaire data does not match pt report, follow up
- In interviews, don't forget depression can be part of bipolar or a substance use disorder
- Collateral information from support system may be helpful

Talking About Treatment

- Depression has been identified as being clinically significant so:
  - Provide feedback (why was concern identified?)
  - Ask for pt's thoughts
  - Explain why the dialysis cares about pts being depressed
  - Gauge pt's interest in treatment
    - Medications (new RX, adjustment to current meds)
    - Psychotherapy
      - In-person
      - Telehealth
      - In dialysis center

Talking About Treatment 2 of 2

- Have some basic information about meds/therapy to answer pt's initial questions/concerns
  - Antidepressants don't change who we are, just help to regulate certain brain chemicals that make us feel more "even keeled"
  - Therapy isn't just "talking about your week"
  - Have 1-2 providers pt could contact- more than that can be overwhelming

- Can use anonymous examples of how treatment has helped other patients

Points to Consider

- Treating depression is important
- Resistance to treatment is common
- May need to use motivational/ACT interviewing tools
- May need to address different patient concerns/myths
- Majority of patients will find a combo of meds/therapy to be most helpful

Case Studies From the Field

Lucille Fernandez, LCSW
Justin Carr, LCSW
ESRD Networks 13 & 15

Cheri Brown, LMSW-S, LCDCi
Certified eHypnotherapist

HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

ESRD Network 13 & 15 Expert Teams Depression Call

April 24, 2024

Lucille Fernandez & Justin Carr

Engaging in the Treatment of Patients Identified as Having Signs of Depression

ESRD Networks 13 & 15

Overview

- Discuss the CMS goal
- Discuss perceived barriers
- Discuss how the Network is addressing barriers

Behavioral Health Goal

- Increase patients getting treated for depression

Barriers

- Patient engagement barriers
- Provider barriers (e.g., lack of providers)
- Insurance barriers (e.g., IP not accepted)

Network Intervention-
Step 1: Assessment

- Network queried facilities
- Most common barriers are tied to lack of patient engagement
- Responses highlighted staff burnout

Network Intervention-
Step 2:Resource Creation and Dissemination

The Networks worked together to develop and share resources that:

- Re-engaged both patients and staff.
- Were flexible enough to support various paths to treatment.
- Supported the goal of getting patients treated.

Network Intervention-
Step 2: Resource Creation and Dissemination (Cont.)

Patient: _____

Dialysis Facility: _____

Dear Dr. _____,

Our shared patient _____, DOB: _____, screened positive for depression using the Patient Health Questionnaire-9 (PHQ-9) on (date)_____. I'm reaching out to request additional assessment and follow-up at your office. If the patient does not have an appointment already, we would appreciate your office reaching out to the patient for scheduling or any other needs.

The patient's PHQ-9 score is _____. Please refer to the table below for score interpretation.

We have discussed this information and referral with the patient and have educated them on using their Medicare benefits to obtain mental health care. We have also included a list of provider codes that can be used if depression is addressed during your visit with the patient.

Please feel free to contact me with any questions or concerns at _____, (email or phone #)

Thank you so much for your support in aiding our patient's wellbeing,

_____

PHQ-9 Score Reference Sheet

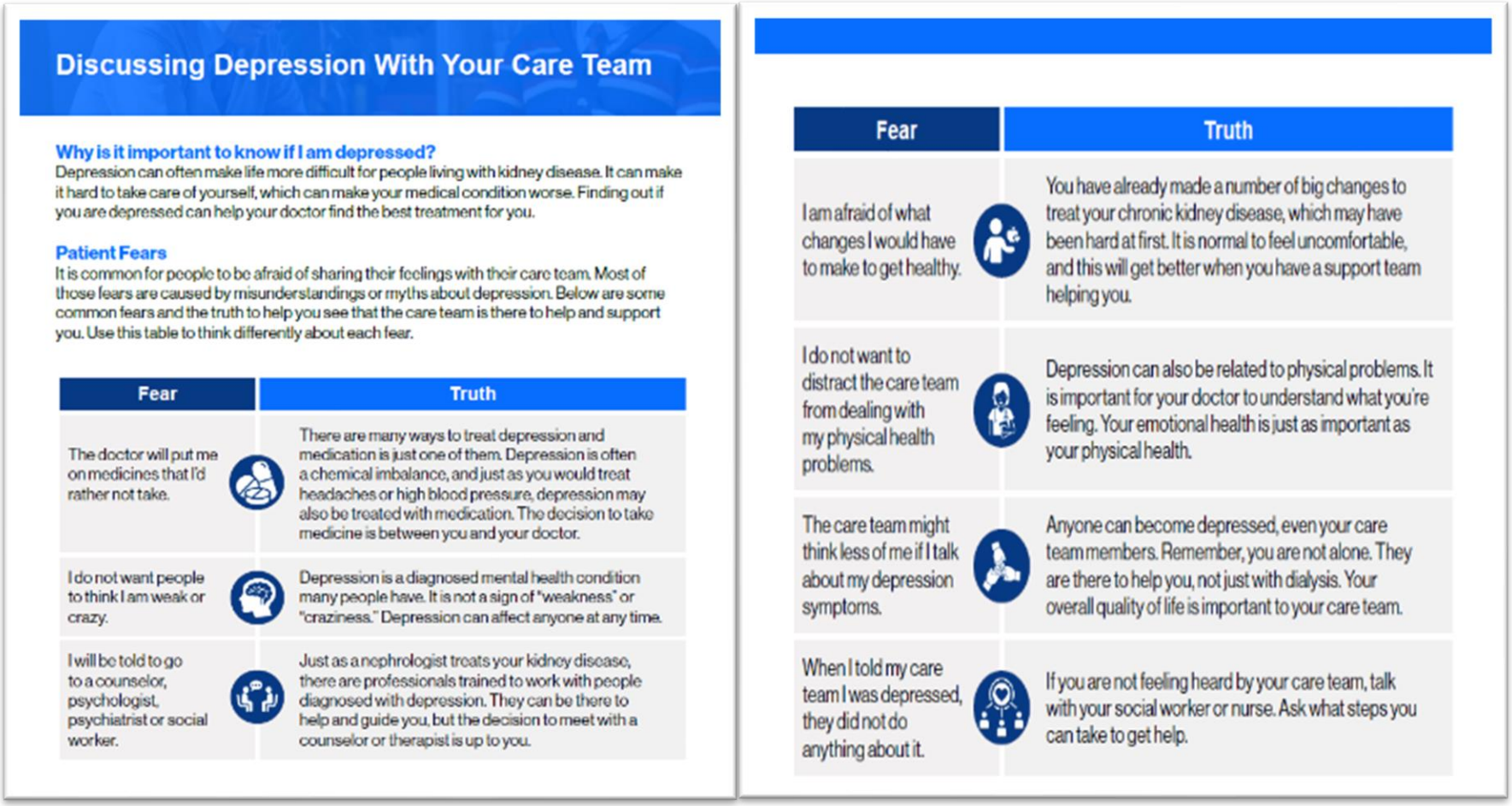
Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

List of Codes for Recording Depression Visits

ICD-10	Description
F06.30	Mood disorder due to known physiological condition, unspecified
F06.31	Mood disorder due to known physiological condition with depressive features
F06.32	Mood disorder due to known physiological condition with major depressive-like episode
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression

Network Intervention- 2 of 4

Step 2: Resource Creation and Dissemination (Cont.)



Discussing Depression With Your Care Team

Why is it important to know if I am depressed?

Depression can often make life more difficult for people living with kidney disease. It can make it hard to take care of yourself, which can make your medical condition worse. Finding out if you are depressed can help your doctor find the best treatment for you.

Patient Fears

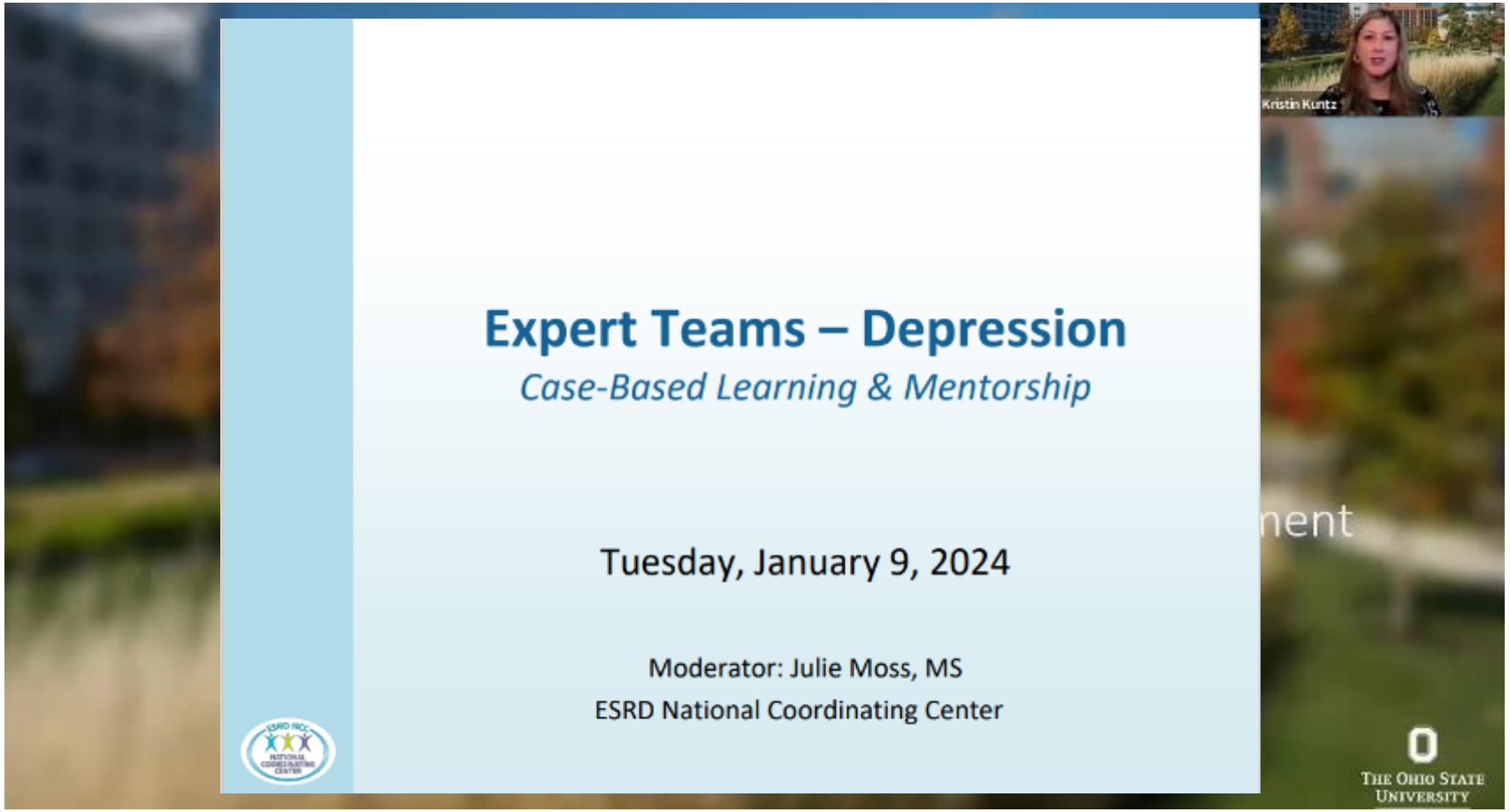
It is common for people to be afraid of sharing their feelings with their care team. Most of those fears are caused by misunderstandings or myths about depression. Below are some common fears and the truth to help you see that the care team is there to help and support you. Use this table to think differently about each fear.

Fear	Truth
The doctor will put me on medicines that I'd rather not take.	There are many ways to treat depression and medication is just one of them. Depression is often a chemical imbalance, and just as you would treat headaches or high blood pressure, depression may also be treated with medication. The decision to take medicine is between you and your doctor.
I do not want people to think I am weak or crazy.	Depression is a diagnosed mental health condition many people have. It is not a sign of "weakness" or "craziness." Depression can affect anyone at any time.
I will be told to go to a counselor, psychologist, psychiatrist or social worker.	Just as a nephrologist treats your kidney disease, there are professionals trained to work with people diagnosed with depression. They can be there to help and guide you, but the decision to meet with a counselor or therapist is up to you.
I am afraid of what changes I would have to make to get healthy.	You have already made a number of big changes to treat your chronic kidney disease, which may have been hard at first. It is normal to feel uncomfortable, and this will get better when you have a support team helping you.
I do not want to distract the care team from dealing with my physical health problems.	Depression can also be related to physical problems. It is important for your doctor to understand what you're feeling. Your emotional health is just as important as your physical health.
The care team might think less of me if I talk about my depression symptoms.	Anyone can become depressed, even your care team members. Remember, you are not alone. They are there to help you, not just with dialysis. Your overall quality of life is important to your care team.
When I told my care team I was depressed, they did not do anything about it.	If you are not feeling heard by your care team, talk with your social worker or nurse. Ask what steps you can take to get help.

Source: https://esrd.qsource.org/quality-improvement/depression/

Network Intervention- 3 of 4

Step 2: Resource Creation and Dissemination (Cont.)



Source: https://esrdncc.org/en/professionals/expert-teams/

Network Intervention- 4 of 4

Step 2: Resource Creation and Dissemination (Cont.)

Hello,

Thank you for taking part in the CMS Behavioral Project these last few months.
As we enter the end of this phase of the project, we'd like to share with you some insight from other facilities that have effectively engaged patients in their mental health.
The hope is you can fold some of these suggestions into your work with patients' behavioral health going forward.

The three most common barriers we have had reported on engaging patients in their mental health are:

1) Patient engagement barriers (e.g. refusal to engage in their mental health, refusal to follow-up on referral, etc)
2) Provider barriers (e.g. lack of providers, limited or no availability, provider uncomfortable with diagnosing patients, etc)
3) Insurance barriers (e.g. Medicare not accepted by providers in the area, patient(s) does/do not have Medicare, authorization issues)

To address these barriers, facilities reported they did the following:

- Involve the IDT (Nephrologist, trusted staff).
  - One facility shared on this point, "Utilize a team approach and involve all members of IDT, including the Medical Director to discuss Mental Health and recommendations."
- Provide education and reapproach later.
  - One facility shared, " Share with the patient quick facts about depression i.e., depression is manageable and treatable, normalize that many people deal with depression every day."
- Refer to telehealth or another provider.
  - One facility shared, "I would recommend offering various levels of options to the patient. Usually, I would include providers that are in-network, support groups that are free, and telehealth providers."
- Involve a Primary Care Physician to assist (in either evaluation/treatment or in getting authorization).
  - One facility shared, "Many times basic needs need to be met first, if the patient is struggling with housing/food typically that is a priority, once those needs are met it is much easier for patients to have time and energy to work on their mental health. Many patients are more willing to see their PCP for medication, vs attend counseling or see a psychiatrist."
- Involve/include family members in getting help (with patient permission).
  - One facility shared, "Always involve the whole IDT and the family, this encourages the patient to see how much support they have."

Feedback on the Project

- After both PDSA cycles, the Networks collected feedback from the facilities on project interventions.
- Feedback was generally positive:
  - "The project was helpful."
  - "[It fostered a] team approach."

Next Steps & Future Work

- The project established foundations for addressing mental health throughout the both Networks' coverage area
- The resources and best practices will be used in ongoing case work in each Network.

HSAG HEALTH SERVICES ADVISORY GROUP

ESRD Networks 7, 13, 15, 17, 18

Thank you!

Lucille Fernandez, LCSW

lfernandez@hsag.com

Justin Carr, LCSW

jcarr@hsag.com

SELF HYPNOSIS & ESRD

Adapted from Shane Fozad's Australian Success Academy eHypnotherapy Certification program

By Cheri Brown, LMSW-S, LCDCi
Certified eHypnotherapist

GOALS

To increase Dialysis Treatment Attendance
Improve Sleep, Reduce Anxiety, Pain,
Smoking, and Weight Loss

COMMON FORMS OF HYPNOSIS

Awakening from or going to sleep
Watching Movies
Using Imagination
Disassociation during routine tasks such as driving, working on an assembly line, listening to music.

THE DEVELOPMENT OF HYPNOSIS

- 1500 Paracelus – Healing with Magnets
- 1600 Valentine Braithwaite – Hands on
- 1740 Father Maximilian Hell – Magnets
- 1760 Franz Anton Mesmer
- 1800 Puyssegur – discovered "Somnambulist"
- 1820 James Braid (Invented the word "Hypnosis"
- 1840 Elliotson – Adopted Mesmerism
- 1850 Bernheim forms the Nancy School of Hypnosis with Liebeault Esdaile – Mesmerism in India
- 1860 Charcot attempts to revive Mesmerism, discredited by Bernhein
- 1890 Sigmund Freud studies with Charcot at Nancy but doesn't study Hypnosis
- 1933 Clark Hull
- 1944 Leslie LeCron, G.H. Estabrooks
- 1957 Andre Weitzenhoffer, Milton Erickson
- 1964 Dave Elman
- 1982 Al Krasner

THE MINDSET THAT WORKS

- Willingness to suspend disbelief and go beyond ones comfort zone
- Credibility and Accountability
- Time and Effort
- Completion of an ordeal – demonstration of commitment
- Use of Senses (Visual, Auditory, Kinesthetic, Olfactory, Gustatory)

HABIT SCIENCE TRANSFORMING UNWANTED TO WANTED BEHAVIORS

Trigger

Desire

Behavior

Reward

BEST PRACTICE

- Clients are informed of what self-hypnosis is and what it isn't. And have the right to chose or refuse the strategy.
- Practitioners empower Clients to:
- Be in Control of their thoughts & feelings.
- Feel safe. Trust the process & the practitioner.
- Accept that they are responsible for their Success.
- Not intended for individuals with recent brain injury, or inability to maintain connection with reality

GETTING TO WHAT MATTERS TO YOU

- On a scale of 1-10, with 1 being "Not Much" and 10 being "A lot," how much of a concerns is this problem for you right now?

- At the end of this session, on a scale of 1-10, how much of a concern would you like the problem to be for you then?
- Change How will your life improve when you've overcome this problem
- Positive If you are feeling ___, what would you be feeling instead
- Behavior When you are feeling more ___, what would you be doing differently?
- When will this be happening
- Where would you be doing more ___, feeling ___
- Who would you be doing more ___ location, feeling, day and time
- How would that make you Feel?

CASE STUDY 1
ANXIETY & PAIN REDUCTION

- 62 y.o. White/Non-Hispanic Female
- Rural Dialysis Clinic
- Resided in Skilled Nursing Facility
- Diabetic – Wheelchair bound
- Pain during connection and disconnection
- Mood: Anxious & Depressed
- Socially Isolated by choice
- At the point of wanting to discontinue dialysis
- BMI prevented transplant as an option
- After learning techniques – Increased attendance, Improved sleep, Continued Dialysis, Moved out of state to be with family

CASE STUDY 2
SMOKING CESSATION

- 44 y.o. White/Hispanic Male
- Urban Dialysis Clinic
- Diabetes Type 1 & 2
- Chronic Smoker – Stroke Risks
- From College Professor to Homeless to Residing in a SNF
- Wheelchair – legally blind
- Interested in transplant
- Receiving Independent Living Skills
- After – Reduction in Nicotine, Improved Mood

RESEARCH & TREATMENT

American Journal of Clinical Hypnosis
Hypnotic Treatment of a Kidney Dialysis Patient
Richard /E. Dimond, Ph.D. Vol 23, 1981, issue 4

Shane Fozad, Austrailin Success Academy, founder of eHypnotherapy

Mayo Clinic
https://www.mayoclinic.org/tests-procedures/hypnosis/about/pac-20394405

Through a Glass Darkly: The Psychoanalytic use of Hypnosis with Post-Traumatic Stress Disorder
Mary Jo Peebles, Menninger Clinic
International Journal of Clinical & Experimental hypnosis Vol 37, 1989 Iss.3, Pages 192-206 | Received 15 Sep 1986, Published online: 31 Jan 2008

National Institutes of Health (NIH) Library of Medicine
Hypnosis and end-stage renal disease: Review and treatment
David M. Wark https://pubmed.ncbi.nlm.nih.gov/32744487/

VA.gov
Guided Imagery, Biofeedback, and Hypnosis - VA HSRD

Knowledge Into Action

Top Take-Aways

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community
  - Using Case Study examples to identify new ways of doing something and missed opportunities

- Next meeting – Tuesday, April 9, 2024 @ 2 PM ET

- Visit the ESRD NCC website to find materials and share https://esrdncc.org/en/professionals/expert-teams/

Social Media

ESRD National Coordinating Center

@esrd_ncc

@esrdncc

ESRD NCC | End Stage Renal Disease
National Coordinating Center (NCC)

Thank You

Julie Moss
jmoss@hsag.com
813-300-6145

This material was prepared the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy nor imply endorsement by the U.S. Government. FL-ESRD NCC-NC3TDV-04222024-01