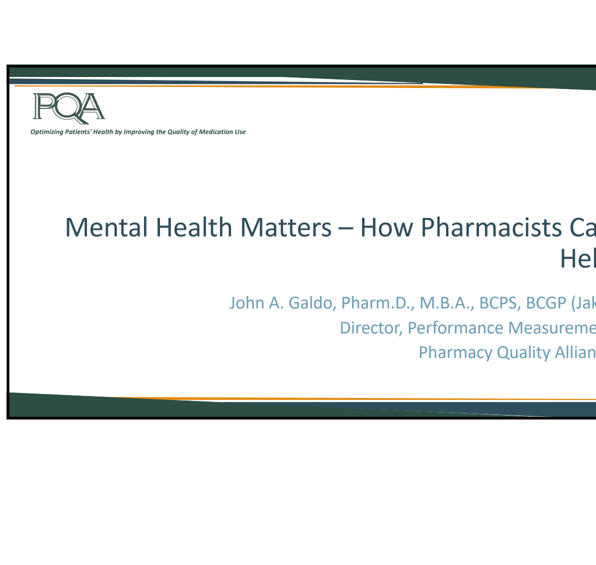
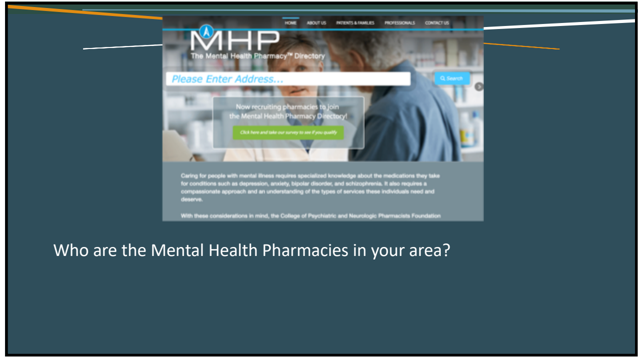


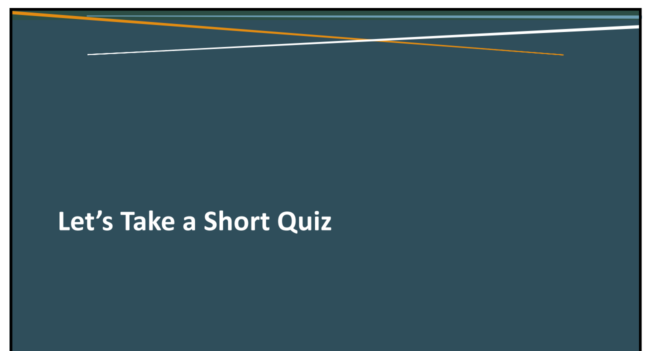
Disclosure

- Dr. Galdo is an employee of the Pharmacy Quality Alliance
- Dr. Galdo received grant funding from the Community Pharmacy Foundation for the DSIP Study

Learning Objectives

- Describe the current landscape of mental health care in the United States
- Understand the role of quality metrics in mental health care
- Customize patient care with pharmacotherapy updates
- Implement pharmacist-led mental health services
- Discuss Arkansas Medicaid changes, including PASSE


MHP
The Mental Health Pharmacy™ Directory
Please Enter Address...
Now recruiting pharmacies to join the Mental Health Pharmacy Directory!
Who are the Mental Health Pharmacies in your area?


Let's Take a Short Quiz

THE HILL
Senators press administration on mental health parity
93
• Passed in 2016, requirement for equal mental health as physical health for insurance coverage
• Based on the 21st Century Cures Act
PQA

2017 State of Mental Health in America - Access to Care Data

- The Access Ranking indicates how much access to mental health care exists within a state. A high Access Ranking indicates that a state provides relatively more access to insurance and mental health treatment.
  1. Adults with AMI who Did Not Receive Treatment
  2. Adults with AMI Reporting Unmet Need
  3. Adults with AMI who are Uninsured
  4. Adults with Disability who Could Not See a Doctor Due to Costs
  5. Youth with MDE who Did Not Receive Mental Health Services
  6. Youth with Severe MDE who Received Some Consistent Treatment
  7. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
  8. Students Identified with Emotional Disturbance for an Individualized Education Program
  9. Mental Health Workforce Availability

Access to Care

Rank	State
1	Vermont
2	Massachusetts
3	Maine
4	Connecticut
5	Minnesota
6	New Hampshire
7	South Dakota
8	Rhode Island
9	Iowa
10	Alaska
11	District of Columbia
12	Pennsylvania
13	Maryland
14	Wisconsin
15	Delaware
16	Colorado
17	New Jersey

Rank	State
18	Michigan
19	New York
20	North Dakota
21	Oregon
22	Kansas
23	New Mexico
24	Washington
25	California
26	North Carolina
27	Wyoming
28	Hawaii
29	Ohio
30	Illinois
31	Kentucky
32	Nebraska
33	Utah
34	West Virginia

Rank	State
35	Montana
36	Missouri
37	Indiana
38	Virginia
39	Oklahoma
40	Arizona
41	Louisiana
42	Idaho
43	Florida
44	Arkansas
45	South Carolina
46	Texas
47	Georgia
48	Tennessee
49	Mississippi
50	Alabama
51	Nevada

Mental Illness without Coverage

- 17% (over 7.5 million) of adults with a mental illness remain uninsured.
- In 2011, 19% of adults with a mental illness were uninsured.
  - Alabama, Louisiana, Oklahoma, and New Mexico had the largest increase in access to mental health coverage among adults.
- 56.5% of adults with mental illness received no past year treatment
  - 20.3% continue to report unmet treatment needs.
- The state prevalence of uninsured adults with mental illness ranges from 2.7% in Massachusetts to 28.2% in Nevada.

Percent without Treatment

Rank	State	%	#
1	Vermont	43.1	43,000
2	Maine	44.7	106,000
3	Iowa	45.4	175,000
4	Massachusetts	45.7	466,000
5	Minnesota	46.0	341,000
6	North Carolina	48.6	649,000
7	New Hampshire	49.0	108,000
8	Connecticut	50.4	237,000
9	Arkansas	50.8	222,000
10	Virginia	51.3	570,000
11	Missouri	51.4	433,000
12	Delaware	52.0	71,000
13	Kentucky	52.0	334,000
14	Pennsylvania	52.4	904,000
15	Oregon	52.5	384,000
16	Wyoming	52.7	45,000
17	Michigan	52.9	789,000
18	South Dakota	53.2	50,000
19	Idaho	53.3	131,000
20	Kansas	53.3	188,000
21	Wisconsin	53.4	418,000
22	Alabama	53.6	382,000
23	Ohio	53.7	951,000
24	West Virginia	53.9	175,000
25	Montana	54.2	81,000
26	Illinois	54.5	849,000

Rank	State	%	#
27	Rhode Island	54.6	101,000
28	District of Columbia	55.2	59,000
29	South Carolina	55.4	346,000
30	Utah	55.7	249,000
31	Nebraska	55.8	138,000
32	New Jersey	56.3	562,000
33	Tennessee	56.5	563,000
34	New Mexico	56.7	178,000
35	Indiana	57.2	566,000
36	Maryland	57.2	412,000
37	North Dakota	58.0	46,000
38	Oklahoma	58.3	345,000
39	Washington	58.6	635,000
40	Louisiana	58.9	406,000
41	Arizona	59.3	541,000
42	Texas	59.7	1,963,000
43	New York	60.3	1,645,000
44	Mississippi	60.5	253,000
45	Alaska	61.3	59,000
46	Georgia	61.6	839,000
47	Colorado	61.7	421,000
48	California	62.3	3,272,000
49	Florida	62.3	1,559,000
50	Hawaii	66.0	126,000
51	Nevada	67.5	257,000
	National	56.5	24,644,000

Unmet Needs

- One out of five (20.3%) adults with a mental illness report they are not able to get the treatment they need.
- States with the highest levels of unmet need (bottom 10) are 1.6 times more likely to have people report unmet need.
- Once a person recognizes that they may have a mental health problem, finding support especially the right kind of support is often difficult. Several systemic barriers to accessing care include:
  - Lack of insurance or inadequate insurance
  - Lack of available treatment providers
  - Lack of available treatment types (inpatient treatment, individual therapy, intensive community services)
  - Insufficient finances to cover costs – including, copays, uncovered treatment types, or when providers do not take insurance.
- The state prevalence of adults with AMI reporting unmet treatment needs ranges from 13.6% in Hawaii to 25.9% in Missouri.

Youth without Mental Health Services

- 64.1% of youth with major depression do not receive any mental health treatment.
  - That means that 6 out of 10 young people who have depression and who are most at risk of suicidal thoughts, difficulty in school, and difficulty in relationships with others do not get the treatment needed to support them.
- The state prevalence of untreated youth with depression ranges from 42.1% in New Hampshire to **77.0% in Arkansas.**

Mental Health Deserts

- Nationally, there is one mental health provider for every 529 individuals.
  - Psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care.
- The workforce shortage among specialized mental health professionals are even higher.
  - Estimated 8,300 child psychiatrists across the county compared to over 15 million youths with mental health disorders.
- Over 4,000 areas across the US are considered mental health professional shortage areas, leaving people to travel hours or across state lines to access services.
- The state rate of mental health workforce ranges from 200:1 in Massachusetts to 1,200:1 in Alabama.

Shortages

Rank	State	Ratio
1	Massachusetts	200:1
2	District of Columbia	230:1
3	Maine	240:1
4	Vermont	260:1
5	Oklahoma	270:1
6	Oregon	270:1
7	New Mexico	280:1
8	Rhode Island	280:1
9	Alaska	300:1
10	Connecticut	300:1
11	Wyoming	330:1
12	Colorado	350:1
13	California	360:1
14	Washington	380:1
15	New Hampshire	390:1
16	Utah	390:1
17	Montana	400:1
18	Nebraska	410:1
19	New York	420:1
20	Delaware	440:1
21	North Carolina	440:1
22	Hawaii	450:1
23	Michigan	450:1
24	Maryland	470:1
25	Minnesota	490:1
26	Arkansas	520:1
27	Idaho	520:1
28	Kansas	550:1
29	Illinois	560:1
30	Kentucky	560:1
31	Nevada	570:1
32	New Jersey	570:1
33	Pennsylvania	580:1
34	Wisconsin	590:1
35	Missouri	600:1
36	North Dakota	610:1
37	South Dakota	630:1
38	Ohio	640:1
39	South Carolina	650:1
40	Virginia	680:1
41	Florida	690:1
42	Indiana	710:1
43	Tennessee	750:1
44	Arizona	800:1
45	Louisiana	810:1
46	Iowa	830:1
47	Mississippi	830:1
48	Georgia	850:1
49	West Virginia	910:1
50	Texas	990:1
51	Alabama	1,200:1
	National	529:1

MEDICAL REPORT JANUARY 24, 2011 ISSUE

THE HOT SPOTTERS

Can we lower medical costs by giving the neediest patients better care?

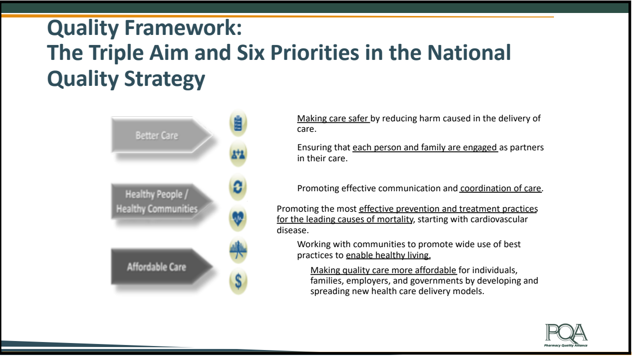
By Atul Gawande

If Camden, New Jersey, becomes the first American community to lower its medical costs, it will have a murder to thank. At nine-fifty on a February night in 2001, a twenty-two-year-old black man was shot while driving his Ford Taurus station wagon through a neighborhood on

National Quality Strategy (NQS): Introduction

The **Affordable Care Act (ACA)** required the Secretary of the Department of Health and Human Services (HHS) to establish a ***national*** strategy to improve:

- The delivery of health care services
- Patient health outcomes
- Population health



Political Tailwind: Random Acts of Bipartisanship

- Medicare Access and CHIP Reauthorization Act (MACRA; 2015)

PQA 19

Quality of Care

- What is quality?
- **Who defines quality of care?**
  - Is it the government?
  - Is it the patient?
  - Is it the provider?
  - Is it private insurers?
  - Is it the caregiver?
  - Is it the employer?
- How do we measure it?

PQA 20

Measuring Quality

- Core principle of quality improvement is that what is not measured cannot be improved
  - Therefore, performance measures are EVERYWHERE
- Ultimate goal is to improve care and outcomes
  - Impossible if we only tract; must provide change!
- Find the root cause and fix it!
- Quality improvement is mostly derived from W. Edwards Deming
  - Taught to stop depending on mass inspection to achieve quality, but focus on improving production process and put quality first

PQA

Measures of Quality of Healthcare

Structure	Healthcare Processes	Outcomes
• Characteristics of individual healthcare providers, organizations, or facilities • Possession of electronic medical record, percentage of board certified	• Delivery of specific clinical services • Percentage of patients status post MI who receive a beta blocker	• Ultimate goal of healthcare • Affected by healthcare, but also influenced by patient factors • 30-day mortality rate

PQA

Patient Empowerment

Patient Experience

- Provides feedback on patients' experiences of care
  - Ex: is the care conversation is such language any patient understands?

Patient Centered Care

- The patient helps establish the care plan
- Healthcare providers infuse personal bias into care
  - 80 year old man with stroke
  - Surgery to extend life for 1 year, but paralyzed
  - Without surgery, life expectancy is 4 months

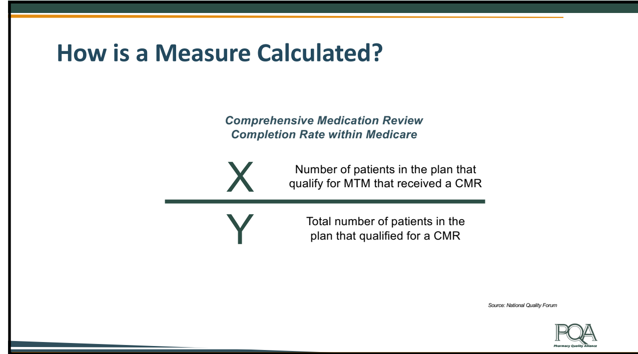
FamilesUSA. Measuring Health Care Quality: An Overiew of Quality Measures. http://familiesusa.org/sites/default/files/product_documents/HSI%20Quality%20Measurement_Brief_final_web.pdf

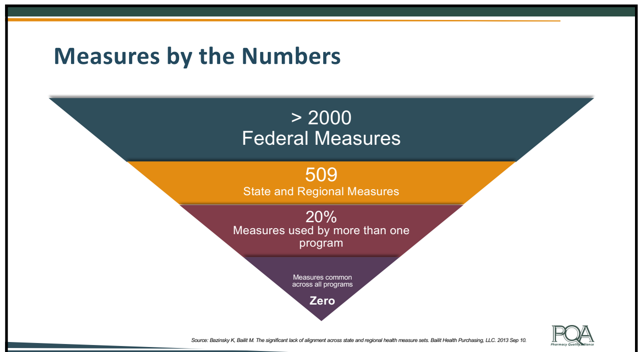
PQA

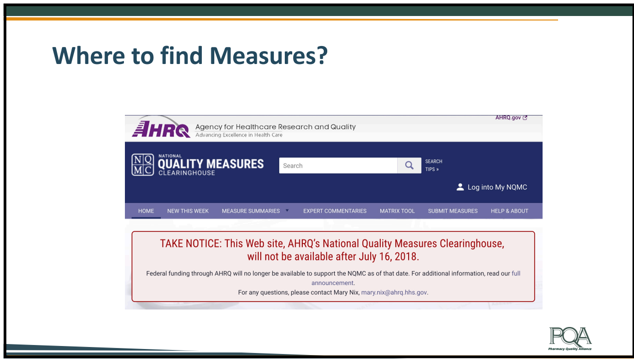
The French Laundry

When you acknowledge, as you must, that there is no such thing as perfect food. Only the idea of it, then the real purpose of striving towards perfection becomes clear. To make people happy. That is what cooking is all about.

PQA


How is a Measure Calculated?
Comprehensive Medication Review
Completion Rate within Medicare
X
Number of patients in the plan that qualify for MTM that received a CMR
Y
Total number of patients in the plan that qualified for a CMR
Source: National Quality Forum
PQA


Measures by the Numbers
> 2000
Federal Measures
509
State and Regional Measures
20%
Measures used by more than one program
Measures common across all programs
Zero
PQA


Where to find Measures?
AHRQ
Agency for Healthcare Research and Quality
QUALITY MEASURES
CLEARINGHOUSE
Log into My NQMC
HOME
NEW THIS WEEK
MEASURE SUMMARIES
EXPERT COMMENTARIES
MATRIX TOOL
SUBMIT MEASURES
HELP & ABOUT
TAKE NOTICE: This Web site, AHRQ's National Quality Measures Clearinghouse, will not be available after July 16, 2018.
PQA

the Evaluation Center@HSRI

Selecting Process Measures for Quality Improvement in Mental Healthcare

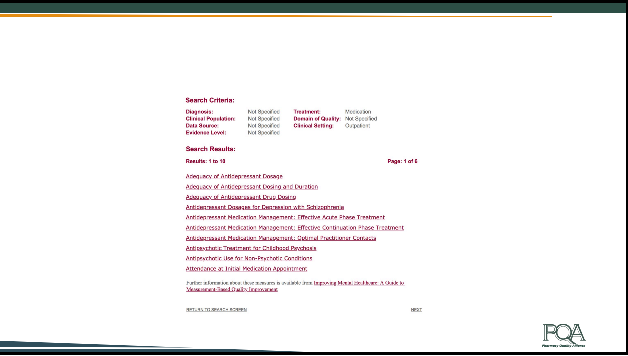
Richard C. Hermann, M.D., M.S.
Center for Quality Assessment and Improvement in Mental Health
Harvard Medical School

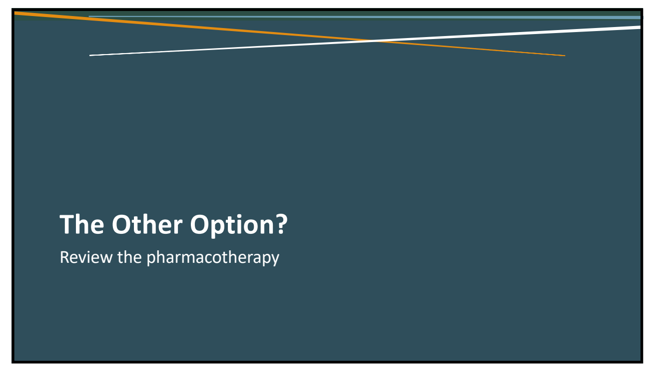
H. Stephen Leff, Ph.D.
the Evaluation Center@HSRI

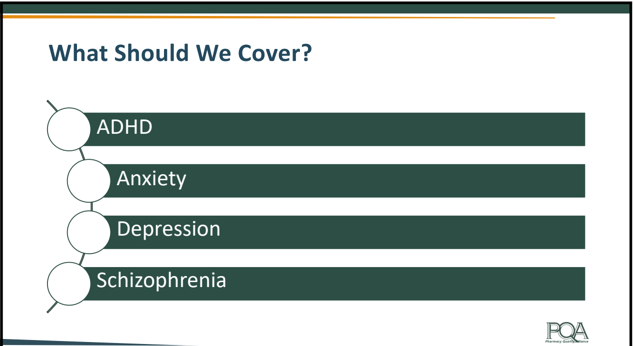
Greta Lagodmos, B.A.
Center for Quality Assessment and Improvement in Mental Health

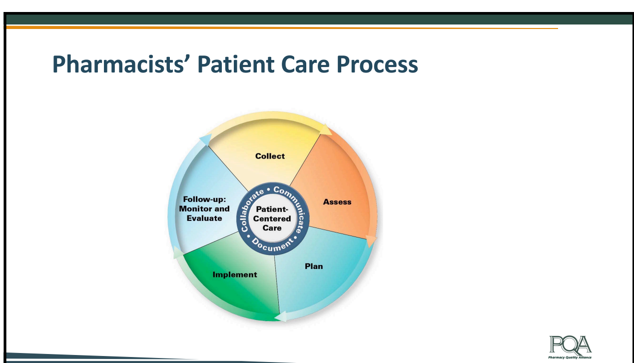
July 2002

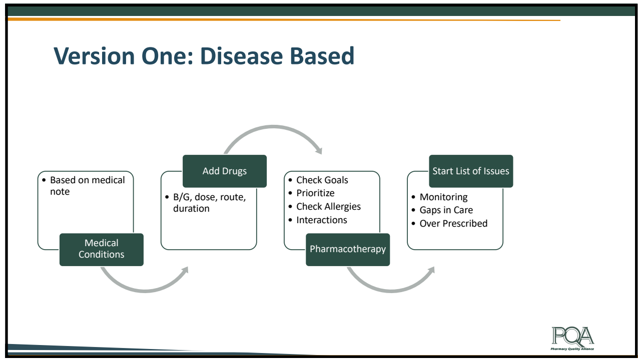
***You can print or download this PDF copy, or order a paper copy at http://hsri.org/index.asp?id=pubs**

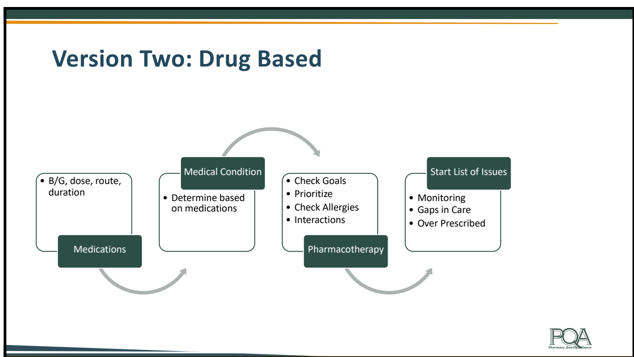



The Other Option?
Review the pharmacotherapy


What Should We Cover?
ADHD
Anxiety
Depression
Schizophrenia
PQA


Pharmacists' Patient Care Process
Collect
Assess
Plan
Implement
Follow-up: Monitor and Evaluate
Patient-Centered Care
Collaborate • Communicate • Document
PQA





Think of Everything

Medications

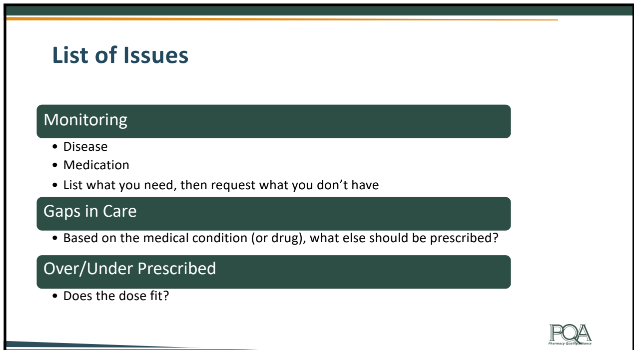
- Brand and Generic
- Dose (strength, sig)
- Route
- Duration

Medical Conditions

- List – does it have an ICD-10?

Pharmacotherapy

- Check Goals
  - Clinical or PCO?
- Prioritize
  - Goal or Not?
  - Kill now, or later?
- Check Allergies
  - Do we have any?
- Interactions
  - Drug, Drug
  - Drug, Disease
  - Drug, Food



Cost of Prescription Drug-Related Morbidity and Mortality

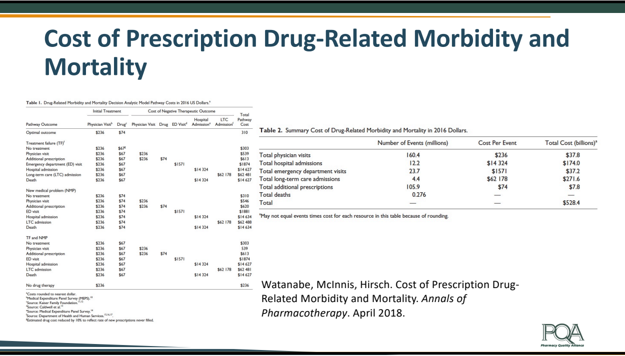


Table 1. Drug-Related Morbidity and Mortality Decision Analytic Model Pathway Costs in 2016 US Dollars.[a]

	Initial Treatment		Cost of Negative Therapeutic Outcome					
Pathway Outcome	Physician Visit[b]	Drug[c]	Physician Visit	Drug	ED Visit[d]	Hospital Admission[e]	LTC Admission[f]	Total Pathway Cost
Optimal outcome	$236	$74						310
Treatment failure (TF)[f]								
No treatment	$236	$67[g]						$303
Physician visit	$236	$67	$236					$539
Additional prescription	$236	$67	$236	$74				$613
Emergency department (ED) visit	$236	$67			$1571			$1874
Hospital admission	$236	$67				$14 324		$14 627
Long-term care (LTC) admission	$236	$67					$62 178	$62 481
Death	$236	$67				$14 324		$14 627
New medical problem (NMP)								
No treatment	$236	$74						$310
Physician visit	$236	$74	$236					$546
Additional prescription	$236	$74	$236	$74				$620
ED visit	$236	$74			$1571			$1881
Hospital admission	$236	$74				$14 324		$14 634
LTC admission	$236	$74					$62 178	$62 488
Death	$236	$74				$14 324		$14 634
TF and NMP								
No treatment	$236	$67						$303
Physician visit	$236	$67	$236					539
Additional prescription	$236	$67	$236	$74				$613
ED visit	$236	$67			$1571			$1874
Hospital admission	$236	$67				$14 324		$14 627
LTC admission	$236	$67					$62 178	$62 481
Death	$236	$67				$14 324		$14 627
No drug therapy	$236							$236

[a] Costs rounded to nearest dollar.
[b] Medical Expenditure Panel Survey (MEPS).[10]
[c] Source: Kaiser Family Foundation.[11,12]
[d] Source: Caldwell et al.[13]
[e] Source: Medical Expenditure Panel Survey.[14]
[f] Source: Department of Health and Human Services.[15,16,17].
[g] Estimated drug cost reduced by 10% to reflect rate of new prescriptions never filled.

Table 2. Summary Cost of Drug-Related Morbidity and Mortality in 2016 Dollars.

	Number of Events (millions)	Cost Per Event	Total Cost (billions)[a]
Total physician visits	160.4	$236	$37.8
Total hospital admissions	12.2	$14 324	$174.0
Total emergency department visits	23.7	$1571	$37.2
Total long-term care admissions	4.4	$62 178	$271.6
Total additional prescriptions	105.9	$74	$7.8
Total deaths	0.276	—	—
Total	—	—	$528.4

[a] May not equal events times cost for each resource in this table because of rounding.

Watanabe, McInnis, Hirsch. Cost of Prescription Drug-Related Morbidity and Mortality. *Annals of Pharmacotherapy*. April 2018.

Attention deficit hyperactivity disorder

Attention deficit hyperactivity disorder

- The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) consensus criteria
- For children <17 years, the DSM-5 diagnosis of ADHD requires ≥6 symptoms of hyperactivity and impulsivity or ≥6 symptoms of inattention.
- For adolescents ≥17 years and adults, ≥5 symptoms of hyperactivity and impulsivity or ≥5 symptoms of inattention are required.
- The symptoms of hyperactivity/impulsivity or inattention must:
  - Occur often
  - Be present in more than one setting (eg, school and home)
  - Persist for at least six months
  - Be present before the age of 12 years
  - Impair function in academic, social, or occupational activities
  - Be excessive for the developmental level of the child

PQA

Symptoms

Hyperactivity and impulsivity

- Excessive fidgetiness (eg, tapping the hands or feet, squirming in seat)
- Difficulty remaining seated when sitting is required (eg, at school, work, etc)
- Feelings of restlessness (in adolescents) or inappropriate running around or climbing in younger children
- Difficulty playing quietly
- Difficult to keep up with, seeming to always be "on the go"
- Excessive talking
- Difficulty waiting turns
- Blurting out answers too quickly
- Interruption or intrusion of others

Inattention

- Failure to provide close attention to detail, careless mistakes
- Difficulty maintaining attention in play, school, or home activities
- Seems not to listen, even when directly addressed
- Fails to follow through (eg, homework, chores, etc)
- Difficulty organizing tasks, activities, and belongings
- Avoids tasks that require consistent mental effort
- Loses objects required for tasks or activities (eg, school books, sports equipment, etc)
- Easily distracted by irrelevant stimuli
- Forgetfulness in routine activities (eg, homework, chores, etc)

Differential diagnosis for attention-deficit hyperactivity disorder in children and adolescents*

	Methods to distinguish from ADHD
Developmental variations	
Intellectual disability	Psychometric testing
Giftedness	Psychometric testing
Normal variation	History
Neurologic or developmental disorders	
Learning disability	Psychometric testing
Language or communication disorder	Psychometric testing
Autism spectrum disorders	History; structured observation
Neurodevelopmental syndromes (eg, fetal alcohol syndrome, fragile X syndrome)	History; examination; genetic testing
Seizure disorder	History; electroencephalography if clinically indicated
Sequelae of central nervous system trauma or infection	History
Motor coordination disorder	History; examination; occupational therapy evaluation
Emotional/behavioral disorders	
Depression or mood disorder	Broadband behavior scale; mental health evaluation
Anxiety disorder	Broadband behavior scale; mental health evaluation
Oppositional defiant disorder	Broadband behavior scale; mental health evaluation
Conduct disorder	Broadband behavior scale; mental health evaluation
Obsessive compulsive disorder	Broadband behavior scale; mental health evaluation
Posttraumatic stress disorder	Broadband behavior scale; mental health evaluation
Adjustment disorder	Broadband behavior scale; mental health evaluation
Psychosocial or environmental problems	
Child abuse or neglect	Medical history; psychosocial history; examination
Stressful home environment	Psychosocial history
Inadequate or punitive parenting	Psychosocial history
Parental psychopathology or substance abuse	Psychosocial history
Inappropriate educational setting	Symptoms occur at school but not at home
Frequent school absence	Psychosocial history
Selected medical conditions	
Hearing or vision impairment	Hearing and vision screen
Sleep disorder	History; sleep study as indicated by clinical findings
Iron deficiency anemia	Complete blood count and other hematologic studies as indicated
Lead poisoning	Measurement of blood lead level
Endocrine disorders (eg, thyroid disease, diabetes mellitus)	Laboratory studies as indicated by clinical findings
Cardiac disorders (eg, heart failure)	Medical history; echocardiograph/pediatric cardiology consultation as indicated
Substance abuse	History; toxicology screening
Food allergy	History; allergy testing as indicated
Undernutrition	Assessment of growth parameters
Medication side effects	History

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ADHD - Treatment

- Based on age (consensus with AAP, AACAP, NIHCE, and others)
- Preschool (4 to 5)
  - Behavioral over medication
  - Medication (methylphenidate), if expulsion, risk of injury, family history of ADHD, CNS injury
- School-aged (≥6 years)
  - Stimulate with behavioral therapy
- Monitor!

PQA

Ratings scales in the assessment and monitoring of ADHD

Scales	Behaviors assessed
Broadband assessment	
Conners 3rd Edition[1]	Inattention, hyperactivity/impulsivity, learning problems, executive functioning, aggression, peer relations, DSM-IV symptoms scales for inattentive, hyperactive-impulsive and combined type of ADHD (DSM-5 scoring is also available as a supplement), ODD, conduct disorder
Behavior Assessment System for Children (BASC)[2]	Hyperactivity, aggression, conduct problems, anxiety, depression, somatization, atypicality, withdrawal, attention problems, learning problems, lack of adaptability/social/leadership/study skills
Child Behavior Checklist/Teacher Report Form[3,4]	Somatic complaints, social/thought/attention problems, anxiety/depression, aggressive/delinquent behavior, withdrawal
Narrow-band assessment	
ADHD Comprehensive Teacher's Rating Scale (ACTeRS): Boys' and girls' form[5]	Attention problems, hyperactivity, lack of social skills, oppositional
ADHD Rating Scale[6]	Symptoms of ADHD according to DSM-IV criteria
Childhood Attention Problems Scale[7]	Combined measure of attention problems, impulsivity, hyperactivity
Conners 3rd Edition: Short version[1]	Selected items from the long version to measure inattention, hyperactivity/impulsivity, learning problems, executive function, aggression, and peer relations
BASC Monitor Rating Scale[8]	Attention/adaptive problems, hyperactivity, problems with internalizing
Disruptive Behavior Rating Scale[9]	DSM-IV symptoms of ODD, ADHD, and CD (parent form only)
Vanderbilt Assessment Scales [10,11]	Symptoms of ADHD according to DSM-IV criteria; screen for comorbid conditions (ODD, CD, anxiety, depression)
Assessment of medication side effects	
Side Effects Rating Scale[9]	Sleeping/appetite problems, staring/daydreaming, withdrawal, anxiety, irritability, somatic complaints, emotional lability, dizziness, tics

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Criteria for initiation of pharmacotherapy in children with ADHD

Diagnostic assessment is complete and confirms diagnosis of ADHD
Child is age six years or older*
Parents accept medication as a contribution to management
School will cooperate in administration and monitoring¶
No previous sensitivity to the chosen medication
Child has normal heart rate and blood pressure
Child is seizure freeΔ
Child does not have Tourette syndromeΔ
Child does not have pervasive developmental delayΔ
Child does not have significant anxiety
Substance abuse among household members is not a concern (for children who will be treated with immediate-release stimulants)◊

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Comparison of drugs used to treat attention deficit hyperactivity disorder in children

	Advantages	Disadvantages	Comments
Short-acting stimulants	Extensive data efficacy and safety Generic formulations available Flavored oral suspension and chewable tablet available for methylphenidate	Must be taken two to three times per day if full-day coverage is desired	
Long-acting stimulants	Can be dosed once per day (can avoid administration at school)	Side effects may extend later in the day Increased cost Fewer generic options	Short-acting stimulant can be added in PM for afternoon boost when needed
Single-pulse sustained release (eg, Metadate ER)	Generic formulations available		Must be swallowed whole Preferably taken 30 to 45 minutes before meal
Extended release oral suspension (Quillivant XR, Adzenys ER), extended-release chewable tablet (QuilliChew ER), or orally disintegrating tablet (Adzenys XR-ODT, Cotempla XR-ODT)	May be used for children who have difficulty swallowing pills These preparations are flavored and may be more palatable	No generic options Increased cost	May be taken with or without food* Do not mix oral suspensions with food or other liquids before taking
Sustained release bead preparations (eg, Ritalin LA, Focalin XR, Adderall XR, Metadate CD, Aptensio XR, Mydayis¶)	Approximates a twice-per-day or three-times-per-day dosing schedule Can be sprinkled into soft foods for children who have difficulty swallowing pills Generic formulations are available for some products		The beads should not be chewed Some products should not be taken with antacids or other drugs that decrease gastric acidity Ingestion with a high-fat meal may delay time of onset and increase peak concentration
Osmotic release (eg, Concerta)	Approximates a three-times-per-day dosing schedule Generic formulations available	Children with decreased GI absorption or intestinal resection may not receive the full benefit	Capsule should not be opened or chewed Capsule is passed through the GI tract and into the stool intact
Patch (Daytrana)	Can be used for patients who cannot take oral medications	Patch must be applied two hours before needed effect Has been associated with permanent loss of pigmentation at the site of application No generic options Increased cost	Early removal of the patch permits controlled duration (effects last approximately two to three hours after patch is removed)
Prodrug (Lisdexamfetamine [Vyvanse])	May have lower risk for abuse Capsules can be opened and mixed with water for children who have difficulty swallowing capsules Chewable tablet available	No generic options Increased cost	
Atomoxetine	Can be dosed once per day Lower potential for abuse than stimulants Not a controlled substance Generic formulation available	May be less efficacious than stimulants Potential increased risk of suicidal ideation More time to steady state (up to two weeks for initial response; up to eight weeks for maximal effect) "Drug holidays" are not an option	Taking with food may prevent nausea Requires dosing adjustment if administered with agents that inhibit the cytochrome P450 2D6 (CYP2D6) enzyme
Extended release alpha-2-adrenergic agonists	Not a controlled substance May also treat coexisting conditions (eg, sleep disorders, tic disorders) Generic formulations available	May be less efficacious than stimulants More time to steady state (up to two weeks for initial response) "Drug holidays" are not an option	Must be swallowed whole, not crushed or chewed May lead to hypotension and orthostasis

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Anxiety

Anxiety, DSM-5 Diagnostic Criteria

A. Excessive anxiety and worry occurring more days than not for at least six months, about a number of events or activities
B. The individual finds it difficult to control the worry.
C. Three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past six months; only one for a child):
   1. Restlessness or feeling keyed up or on edge
   2. Being easily fatigued
   3. Difficulty concentrating or mind going blank
   4. Irritability
   5. Muscle tension
   6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)
D. Cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
E. The disturbance is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication) or another medical condition (eg, hyperthyroidism).
F. Not explained by another medical condition

Anxiety - Treatment

- Mild subtype of GAD whose symptoms do not interfere significantly with functioning may reasonably elect to forgo treatment initially.
- Clinical follow-up with the patient every six months would be important to monitor the course of the disorder, and determine if symptoms were worsening and/or impeding functioning
- Initial treatment with a serotonergic antidepressant, cognitive-behavioral therapy (CBT), or both.
  - The choice between medication and CBT for GAD can be made on the basis of treatment availability and/or patient preference. There are no head-to-head comparisons of CBT and serotonergic antidepressants; meta-analyses have found their effect sizes to be roughly equivalent

Pharmacology of medicines for treatment of adults with generalized anxiety disorder (GAD)

Drug	Initial daily oral dose (mg)*	Daily oral dose range (mg)*	Primary metabolism¶	Effect on metabolism of other drugs¶	Selected characteristics relevant to treatment of adults with GAD

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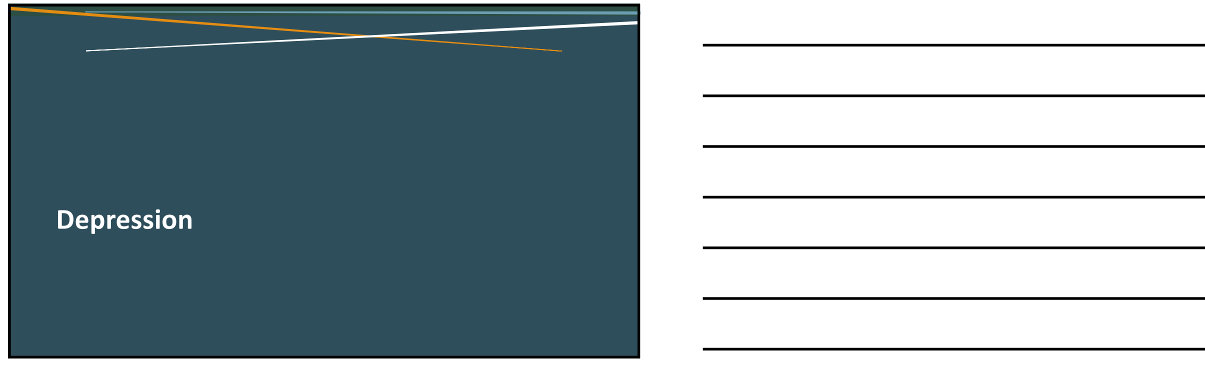

Types of Depression

- Unipolar major depression (major depressive disorder)
- Persistent depressive disorder (dysthymia)
- Disruptive mood dysregulation disorder
- Premenstrual dysphoric disorder
- Substance/medication induced depressive disorder
- Depressive disorder due to another medical condition
- Other specified depressive disorder (eg, minor depression)
- Unspecified depressive disorder

DSM-5 diagnostic criteria for a major depressive episode

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

NOTE: Do not include symptoms that are clearly attributable to another medical condition.

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad, empty, hopeless) or observations made by others (eg, appears tearful). (NOTE: In children and adolescents, can be irritable mood.)

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)

3) Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (NOTE: In children, consider failure to make expected weight gain.)

4) Insomnia or hypersomnia nearly every day

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6) Fatigue or loss of energy nearly every day

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by their subjective account or as observed by others)

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the direct physiological effects of a substance or to another medical condition.

NOTE: Criteria A through C represent a major depressive episode.

NOTE: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic or hypomanic episode.

NOTE: This exclusion does not apply if all of the manic-like or hypomanic-like epsidoes are substance-induced or are attributable to the physiological effects of another medical condition.

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DSM-5 diagnostic criteria for manic episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

1) Inflated self-esteem or grandiosity.
2) Decreased need for sleep (eg, feels rested after only three hours of sleep).
3) More talkative than usual or pressure to keep talking.
4) Flight of ideas or subjective experience that thoughts are racing.
5) Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (ie, purposeless non-goal-directed activity).
7) Excessive involvement in activities that have a high potential for painful consequences (eg, engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication, other treatment) or to another medical condition.

NOTE: A full manic episode that emerges during antidepressant treatment (eg, medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

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DSM-5 diagnostic criteria for hypomanic episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least four consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:

1) Inflated self-esteem or grandiosity.
2) Decreased need for sleep (eg, feels rested after only three hours of sleep).
3) More talkative than usual or pressure to keep talking.
4) Flight of ideas or subjective experience that thoughts are racing.
5) Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7) Excessive involvement in activities that have a high potential for painful consequences (eg, engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication, or other treatment).

NOTE: A full hypomanic episode that emerges during antidepressant treatment (eg, medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for a diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

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DSM-5 diagnostic criteria for persistent depressive disorder (dysthymia)

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least two years.

NOTE: In children and adolescents, mood can be irritable and duration must be at least one year.

B. Presence, while depressed, of two (or more) of the following:

1) Poor appetite or overeating.
2) Insomnia or hypersomnia.
3) Low energy or fatigue.
4) Low self-esteem.
5) Poor concentration or difficulty making decisions.
6) Feelings of hopelessness.

C. During the two-year period (one year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than two months at a time.

D. Criteria for a major depressive disorder may be continuously present for two years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (eg, a drug of abuse, a medication) or another medical condition (eg, hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

NOTE: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than two years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

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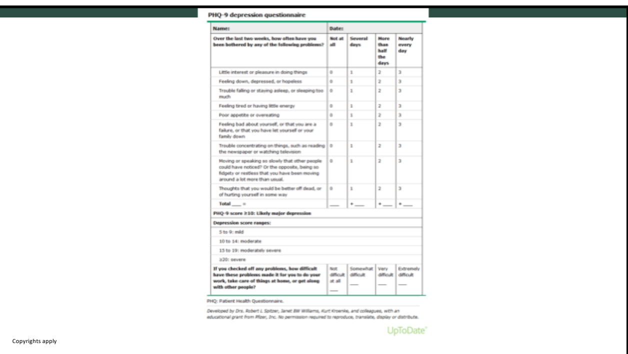
Unipolar Depression, Monitoring

- Response – Improvement ≥50 percent but less than the threshold for remission.
- Remission – specific value defined as the normal range
  - Hamilton Rating Scale for Depression or the Montgomery-Asberg Depression Rating Scale
    - score ≤7
  - Patient Health Questionnaire – Nine Item (PHQ-9)
    - score <5



PHQ-9 depression questionnaire

Name:	**Date:**			
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total ____ =	____	+ ____	+ ____	+ ____
PHQ-9 score ≥10: Likely major depression				
Depression score ranges:				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
≥20: severe				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ____	Somewhat difficult ____	Very difficult ____	Extremely difficult ____

PHQ: Patient Health Questionnaire.

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Depression, Treatment

- Combination of pharmacotherapy and psychotherapy
  - More effective than either of these treatments alone
  - Clinical trials have not established the superiority of any combination

Unipolar depression in adults: Antidepressant doses*

Drug	Usual total starting dose per day (mg)¶	Usual total dose per day (mg)	Extreme daily dose range (mg)¶
Selective serotonin reuptake inhibitors			
Citalopram	20	20 to 40[Δ]	10 to 40[Δ]
Escitalopram	10	10 to 20	5 to 30
Fluoxetine	20	20 to 60	10 to 80
Fluvoxamine	50	50 to 200	25 to 300
Fluvoxamine CR	100	100 to 200	100 to 300
Paroxetine	20	20 to 40	10 to 50
Paroxetine CR	25	25 to 50	12.5 to 62.5
Sertraline	50	50 to 200	25 to 300
Serotonin-norepinephrine reuptake inhibitors			
Desvenlafaxine	25 to 50	50 to 100	50 to 400*
Duloxetine	30 to 60	60 to 120	30 to 120[§]
Levomilnacipran	20	40 to 80	20 to 120
Milnacipran	12.5	100 to 200	50 to 300
Venlafaxine	37.5 to 75	75 to 375	75 to 375
Venlafaxine XR	37.5 to 75	75 to 225	75 to 375
Atypical agents			
Agomelatine[‡] (not available in United States)	25	25 to 50	25 to 50
Bupropion	200	300 (maximum single dose 150 mg)	100 to 450
Bupropion SR 12 hour	150	300 (maximum single dose 200 mg)	150 to 400
Bupropion XL 24 hour	150	300	150 to 450 (United States) 150 to 300 (Europe)
Bupropion hydrobromide 24 hour	174	348	174 to 522
Mirtazapine	15	15 to 45	7.5 to 60
Serotonin modulators			
Nefazodone**	200	300 to 600	50 to 600
Trazodone	100	200 to 300	100 to 600
Trazodone ER	150	375	150 to 375
Vilazodone	10	40	10 to 40
Vortioxetine	10	20	5 to 20
Tricyclics and tetracyclics[¶¶]			
Amitriptyline	25	150 to 300	10 to 300
Amoxapine	25	200 to 300	25 to 400
Clomipramine	25	100 to 250	25 to 300
Desipramine	25	150 to 300	25 to 300
Doxepin	25	150 to 300	25 to 300
Imipramine	25	150 to 300	10 to 300
Maprotiline	25	100 to 225	25 to 225
Nortriptyline	25	50 to 150	10 to 150
Protriptyline	10	15 to 60	5 to 60
Trimipramine	25	150 to 300	25 to 300
Monoamine oxidase inhibitors[¶¶]			
Isocarboxazid	10	10 to 40	10 to 60
Phenelzine	15	15 to 90	7.5 to 90
Selegiline transdermal	6 mg/24 hour patch	6 to 12 mg/24 hour patch	6 to 12 mg/24 hour patch
Tranylcypromine	10	30 to 60	10 to 60

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Side effects of antidepressant medications

Drug	Anticholinergic	Drowsiness	Insomnia/agitation	Orthostatic hypotension	QTc prolongation*	Gastrointestinal toxicity	Weight gain	Sexual dysfunction
Selective serotonin reuptake inhibitors (SSRIs)[¶]								
Citalopram	0	0	1+	1+	1+[Δ]	1+ (all SSRIs: see[◊])	1+	3+
Escitalopram	0	0	1+	1+	1+	1+	1+	3+
Fluoxetine	0	0	2+	1+	1+	1+	1+	3+
Fluvoxamine	0	1+	1+	1+	0 to 1+	1+	1+	3+
Paroxetine	1+	1+	1+	2+	0 to 1+	1+	2+	4+
Sertraline	0	0	2+	1+	0 to 1+	2+[§]	1+	3+
Atypical agents								
Agomelatine[‡] (not available in United States)	0	1+	1+	0	0	1+	0	0 to 1+
Bupropion	0	0	2+ (immediate release) 1+ (sustained release)	0	1+	1+	0	0
Mirtazapine	1+	4+	0	0	1+	0	4+	1+
Serotonin norepinephrine reuptake inhibitors (SNRIs)[¶**]								
Desvenlafaxine[‡]	0	0	1+	0	0	2+	unknown	1+
Duloxetine	0	0	1+	0	0	2+[¶¶]	0-1+	1+
Levomilnacipran[‡]	0[ΔΔ]	0	0-1+	0-1+	0	2+[¶¶]	0	1+
Milnacipran[‡]	0	1+	0	0	0	2+[¶¶]	0	1+
Venlafaxine[‡]	0	1+	1+	0	1+	2+	0-1+	3+
Serotonin modulators								
Nefazodone[◊◊]	1+	2+	0	1+	0	2+	0	0
Trazodone	0	4+	0	1+ (hypnotic dose) 3+ (antidepressant dose)	1+ (hypnotic dose) 2+ (antidepressant dose)	1+ (hypnotic dose) 3+ (antidepressant dose)	0 (hypnotic dose) 1+ (antidepressant dose)	1+[§§]
Vilazodone	0	0	2+	0	0	4+[¥¥]	0	2+
Vortioxetine	0	0	0	0	0	3+	0	1+
Tricyclic and tetracyclic antidepressants (TCAs)[‡‡]								
Amitriptyline	4+	4+	0	3+	3+	1+ (all TCAs: see[††])	4+	3 to 4+
Amoxapine	2+	2+	2+	2+	2+	0	2+	ND
Clomipramine	4+	4+	1+	2+	2+	1+	4+	4+
Desipramine	1+	2+	1+	2+	3+	0	1+	ND
Doxepin	3+	3+	0	2+	3+	0	4+	3+
Imipramine	3+	3+	1+	4+	3+	1+	4+	3+
Maprotiline	2+	3+	0	2+	3+	0	2+	ND
Nortriptyline	2+	2+	0	1+	3+	0	1+	ND
Protriptyline	2+	1+	1+	2+	3+	1+	1+	3 to 4+
Trimipramine	4+	4+	1+	3+	1+	0	4+	ND
Monoamine oxidase inhibitors								
Isocarboxazid	1+	1+	2+	2+	0	1+	1+	4+
Phenelzine	1+	2+	1+	3+	0	1+	2+	4+
Selegiline	1+	0	1+	1+	0	0	0	0
Tranylcypromine	1+	1+	2+	2+	0	1+	1+	4+

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Schizophrenia

DSM-5 diagnostic criteria for schizophrenia

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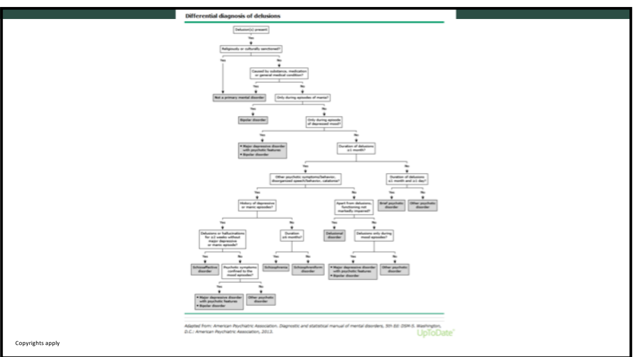

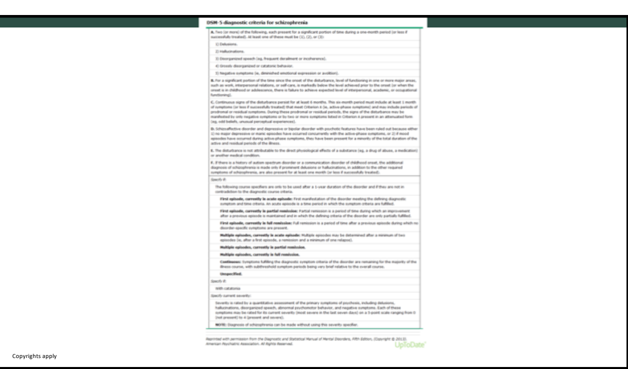

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Selected adverse effects of antipsychotic medications for schizophrenia

	Weight gain/diabetes mellitus	Hyper-cholesterolemia	EPS/TD	Prolactin elevation	Sedation	Anticholinergic side effects	Orthostatic hypotension	QTc prolongation
First generation agents								
Chlorpromazine	+++	+++	+	++	+++	+++	+++	+
Fluphenazine	+	+	+++	+++	+	-/+	-	ND
Haloperidol	+	+	+++	+++	++	-/+	-	+
Loxapine	++	ND	++	++	++	+	+	+
Perphenazine	++	ND	++	++	++	+	-	ND
Pimozide	+	ND	+++	++	+	+	+	++
Thioridazine*	++	ND	+	+++	+++	++++	++++	+++
Thiothixene	++	ND	+++	++	+	+	+	+
Trifluoperazine	++	ND	+++	++	+	+	+	ND
Second generation agents								
Aripiprazole	+	-	+	-	+	-	-	-/+
Asenapine	++	-	++	++	++	-	+	+
Brexpiprazole¶	+	+	+	-/+	+	-/+	-/+	-/+
Cariprazine¶	+	-/+	++	-/+	+	-/+	-/+	-/+
Clozapine Δ	++++	++++	-/+	-/+	+++	+++	+++	+
Iloperidone	++	++	-/+	-/+	+	+	+++	++
Lurasidone	-/+	-/+	++	-/+	++	-	+	-/+
Olanzapine	++++	++++	+	+	++	++	+	+
Paliperidone	+++	+	+++	+++	+	-	++	+
Pimavanserin	+	-	-/+	-	+	+	++	+
Quetiapine	+++	+++	-/+	-/+	++	++	++	+
Risperidone	+++	+	+++	+++	+	+	+	+
Ziprasidone	-/+	-/+	+	+	+	-	+	++

Adverse effects may be dose dependent.

EPS: extrapyramidal symptoms; TD: tardive dyskinesia; ND: no data.
* Thioridazine is also associated with dose dependent retinitis pigmentosa. Refer to text.
¶ Based upon limited experience.
Δ Clozapine also causes granulocytopenia or agranulocytosis in approximately 1 percent of patients requiring regular blood cell count monitoring. Clozapine has been associated with excess risk of myocarditis and venous thromboembolic events including fatal pulmonary embolism. These issues are addressed in the UpToDate topic review of guidelines for prescribing clozapine section on adverse effects.

References:
1. Lexicomp Online. Copyright © 1978-2017 Lexicomp, Inc. All Rights Reserved.
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3. Rummel-Kluge C, et al. Head-to-head comparisons of metabolic side effects of second generation antipsychotics in the treatment of schizophrenia: a systematic review and meta-analysis. Schizophr Res 2010; 123:225.
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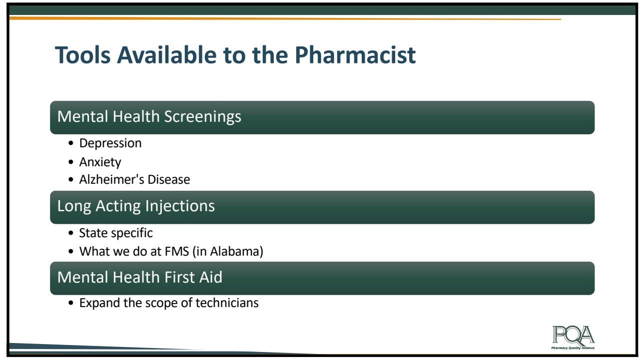
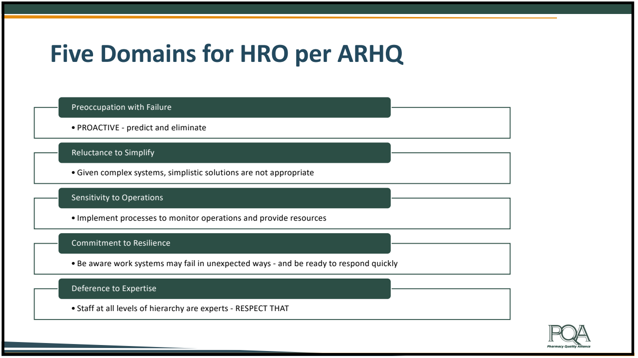
Pharmacy-Led Services


Tools Available to the Pharmacist
Mental Health Screenings
• Depression
• Anxiety
• Alzheimer's Disease
Long Acting Injections
• State specific
• What we do at FMS (in Alabama)
Mental Health First Aid
• Expand the scope of technicians
PQA

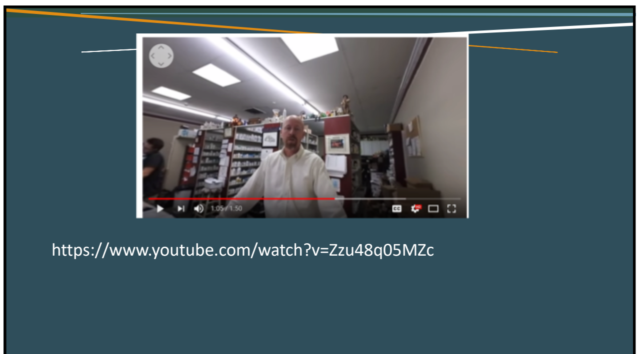
High Reliability Organizations (HROs)
• Various models and definitions
• Reason: “organizations which have less than their fair share of accidents…”
• Business operations shifted to healthcare
Specific Characteristics
"State of Mindfulness"
Impact on Care
PQA


Five Domains for HRO per ARHQ
Preoccupation with Failure
• PROACTIVE - predict and eliminate
Reluctance to Simplify
• Given complex systems, simplistic solutions are not appropriate
Sensitivity to Operations
• Implement processes to monitor operations and provide resources
Commitment to Resilience
• Be aware work systems may fail in unexpected ways - and be ready to respond quickly
Deference to Expertise
• Staff at all levels of hierarchy are experts - RESPECT THAT
PQA

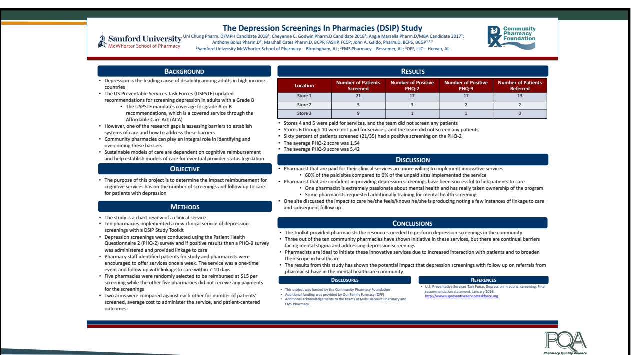
Incorporating High Reliability into Practice

- Top down buy in and accountability
- Incorporate principles and practice of a safety culture throughout the organization
- Adopt and deploy most effective process

- The "Keystone Habit" – single habit shift that causes a cascade of many positive outcomes
  - Find the purpose of an organization, and engage all staff to transform the outcomes



https://www.youtube.com/watch?v=Zzu48q05MZc



The Depression Screenings In Pharmacies (DSIP) Study

Samford University McWhorter School of Pharmacy
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[1]Samford University McWhorter School of Pharmacy - Birmingham, AL; [2]FMS Pharmacy – Bessemer, AL; [3]OFF, LLC – Hoover, AL
Community Pharmacy Foundation

Background

- Depression is the leading cause of disability among adults in high income countries
- The US Preventable Services Task Forces (USPSTF) updated recommendations for screening depression in adults with a Grade B
  - The USPSTF mandates coverage for grade A or B recommendations, which is a covered service through the Affordable Care Act (ACA)
- However, one of the research gaps is assessing barriers to establish systems of care and how to address these barriers
- Community pharmacies can play an integral role in identifying and overcoming these barriers
- Sustainable models of care are dependent on cognitive reimbursement and help establish models of care for eventual provider status legislation

Objective

- The purpose of this project is to determine the impact reimbursement for cognitive services has on the number of screenings and follow-up to care for patients with depression

Methods

- The study is a chart review of a clinical service
- Ten pharmacies implemented a new clinical service of depression screenings with a DSIP Study Toolkit
- Depression screenings were conducted using the Patient Health Questionnaire 2 (PHQ-2) survey and if positive results then a PHQ-9 survey was administered and provided linkage to care
- Pharmacy staff identified patients for study and pharmacists were encouraged to offer services once a week. The service was a one-time event and follow up with linkage to care within 7-10 days.
- Five pharmacies were randomly selected to be reimbursed at $15 per screening while the other five pharmacies did not receive any payments for the screenings
- Two arms were compared against each other for number of patients' screened, average cost to administer the service, and patient-centered outcomes

Results

Location	Number of Patients Screened	Number of Positive PHQ-2	Number of Positive PHQ-9	Number of Patients Referred
Store 1	21	17	17	13
Store 2	5	3	2	2
Store 3	9	1	1	0

- Stores 4 and 5 were paid for services, and the team did not screen any patients
- Stores 6 through 10 were not paid for services, and the team did not screen any patients
- Sixty percent of patients screened (21/35) had a positive screening on the PHQ-2
- The average PHQ-2 score was 1.54
- The average PHQ-9 score was 5.42

Discussion

- Pharmacist that are paid for their clinical services are more willing to implement innovative services
  - 60% of the paid sites compared to 0% of the unpaid sites implemented the service
- Pharmacist that are confident in providing depression screenings have been successful to link patients to care
  - One pharmacist is extremely passionate about mental health and has really taken ownership of the program
  - Some pharmacists requested additionally training for mental health screening
- One site discussed the impact to care he/she feels/knows he/she is producing noting a few instances of linkage to care and subsequent follow up

Conclusions

- The toolkit provided pharmacists the resources needed to perform depression screenings in the community
- Three out of the ten community pharmacies have shown initiative in these services, but there are continual barriers facing mental stigma and addressing depression screenings
- Pharmacists are ideal to initiate these innovative services due to increased interaction with patients and to broaden their scope in healthcare
- The results from this study has shown the potential impact that depression screenings with follow up on referrals from pharmacist have in the mental healthcare community

Disclosures

- This project was funded by the Community Pharmacy Foundation
- Additional funding was provided by Our Family Farmacy (OFF)
- Additional acknowledgements to the teams at Mills Discount Pharmacy and FMS Pharmacy

References

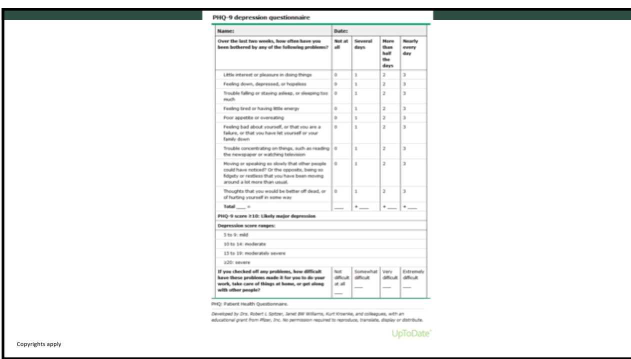
- U.S. Preventative Services Task Force. Depression in adults: screening. Final recommendation statement. January 2016. http://www.uspreventiveservicetaskforce.org

Use Our Toolkit!

Impact of Depression Screenings in Community Pharmacies

Principal Investigator	**John Galdo, PharmD BCPS CGP**
Project Title	**Impact of Depression Screenings in Community Pharmacies**
Grants Awarded Number	**176**
Status	**In Study**
Organization	**Samford Unversity**
Location	
Grant Category	**Therapeutics, Diseases & Populations**
Keyword	**Depression Screening**
Grant Docs	Tool | Poster | Poster | Video
Objectives	**This project is designed to assess the impact of United States Preventative Task Force USPTF recommended screening of depression for adult patients in community pharmacies. One in six adults suffer from depression, and the guidelines recommend every adult patient be screened. The DSIP Depression Screenings in Pharmacies project will be focused on developing a payment model for community pharmacists. DSIP will take place in a practice-based research network with all sites receiving identical training, however only half will be reimbursed for the service. The DSIP service will consist of the personal health questionnaire-2 PHQ-2, linkage-to-care for positive screens, and follow up from pharmacy staff to patients.**

https://communitypharmacyfoundation.org/grants/grants_list_details.asp?grants_id=71319. Accessed 10.9.2017

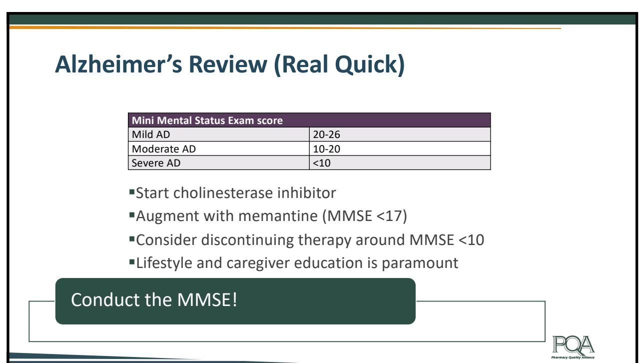


PHQ-9 depression questionnaire

Name:	**Date:**			
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Total ___ =	___	+ ___	+ ___	+ ___
PHQ-9 score ≥10: Likely major depression				
Depression score ranges:				
5 to 9: mild				
10 to 14: moderate				
15 to 19: moderately severe				
≥20: severe				
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ___	Somewhat difficult ___	Very difficult ___	Extremely difficult ___

PHQ: Patient Health Questionnaire.

Developed by Drs. Robert L Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.



Anxiety Screenings

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

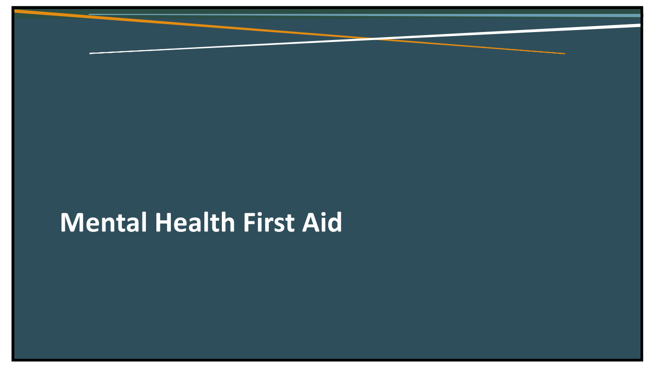
PQA

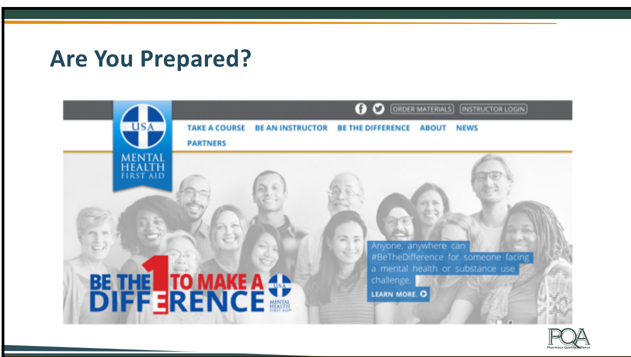
Injections!

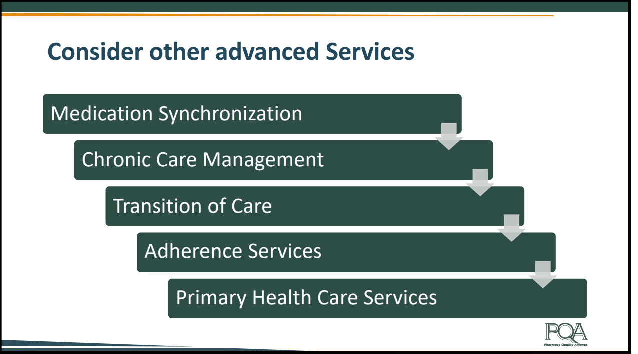
Injections of Long Acting Antipsychotics

- Triaged through the pharmaceutical companies
- Does provide direct reimbursement to the pharmacist/pharmacy

PQA


Mental Health First Aid


Are You Prepared?
TAKE A COURSE
BE AN INSTRUCTOR
BE THE DIFFERENCE
ABOUT
NEWS
PARTNERS
USA
MENTAL HEALTH FIRST AID
BE THE 1 TO MAKE A DIFFERENCE
LEARN MORE
PQA


Consider other advanced Services
Medication Synchronization
Chronic Care Management
Transition of Care
Adherence Services
Primary Health Care Services
PQA

What's Going on in Arkansas?

Medicaid changes!

PASSE

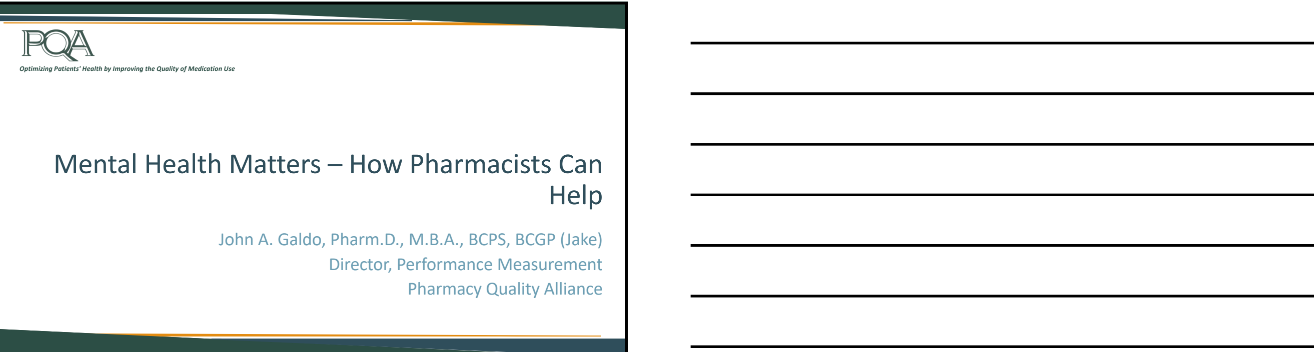
- The Provider-led Arkansas Shared Savings Entity (PASSE) is a new model of organized care that will address the needs of certain Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs. Under this unique organized care model, providers of specialty and medical services will enter into new partnerships with experienced organizations that perform the administrative functions of managed care. Together, these groups of providers and their managed care partners will form a new business organization called a PASSE.

PQA

Purpose of PASSE

- To improve the health of Arkansans who have need of intensive levels of specialized care due to mental health, intellectual or developmental disabilities.
- To link providers of physical health care with providers of behavioral health care and services for individuals with developmental disabilities.
- To coordinate care for all community-based services for individuals with intensive levels of specialized care needs.
- To reduce excess cost of care due to underutilization and overutilization of services.
- To allow flexibility in the array of services offered to the population served.
- Will reduce costs by organizing care, not just by managing finances.
- To increase the number of service providers available in the community to the population covered.

PQA


PQA
Optimizing Patients' Health by Improving the Quality of Medication Use
Mental Health Matters – How Pharmacists Can Help
John A. Galdo, Pharm.D., M.B.A., BCPS, BCGP (Jake)
Director, Performance Measurement
Pharmacy Quality Alliance