Expert Teams – Depression

Case-Based Learning & Mentorship

Tuesday, January 9, 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

Case Studies From the Field

Dawn Gromley, LMSW, LCSW, LISW-S
Social Work, Manager
Dialysis Care Center

Cassie Jones, MSW, LCSW
Social Worker
Dialysis Clinic, Inc. – Columbia, MO
and
Debbie Ulm
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DIALYSIS CARE CENTER

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PATIENT SCENARIOS

Patient #1: Patient transferred to In-center after being on PD for a year. Patient was willing to complete the PHQ-9. After being identified as positive for depression, interventions were medication and a referral for counseling. He was willing to try medication but eventually he took himself off the medication stating it was not helpful and he had side effects.

Later patient decided to move forward with transplant. During the evaluation process, depression was identified and in order to get listed for transplant he had to agree to 6 weeks of counseling. Patient finally agreed to it as part of the requirements for pursuing transplant. What began as a requirement for transplant still continues. Patient reported that it was helping him quite a bit and made the decision to continue counseling even after no longer required for transplant.

PATIENT SCENARIOS 2 AND 3

Patient #2: Patient was on home dialysis and switched to In-Center after some other medical issues. Patient was willing to complete the PHQ-9. Patient originally scored negative. However, later that year he was diagnosed with prostate cancer. After seeing changes in his mood a second PHQ-9 was completed and it was positive for depression, he agreed to medication interventions but was resistant to a referral for counseling. In the next few months he agreed to in home counselling which he has now been doing 6 months. His affect is now brighter and he reports to feeling better as well.

Patient #3: Patient did not want to complete the PHQ-9. Social Worker read the questions to the patient. Patient scored a 6. She would miss treatments 2-3 times per month as well. She was not interested in taking anymore medications than she actually takes and was interested in pursuing counseling so we talked about what she thinks about her results. She felt her mood would be better if she could get some assistance in her home. She felt like she sits around and looks at what she should be doing but does not usually feel up to completing the tasks. She was willing to consider the option of getting assistance in her home. Referral was made to The Disability Network, she now has a case manager and a caregiver that helps several hours per week. This has much improved her mood and overall her treatment attendance.

PATIENT SCENARIO 4

Patient #4: Patient is a home dialysis patient. He was always happy-go-lucky at the clinic visits. When his PHQ resulted in a score of 9 it was surprising. Only after this result and having a discussion around it, did patient divulge some stressful events going on in his personal life. Processed thoughts and feelings with patient. Suggested some interventions but he declined any mental health services. Although he declined, he began opening up more to SW on clinic day and told her multiple months how talking about the situation had made him empowered to make changes at home and that talking it out was helpful. He still did not want to pursue counseling.

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COMMON BARRIERS EXPERIENCED

COOPERATION IN COMPLETING

Some patients don't want to complete the surveys or will give reasons to not complete at treatment. SW offered to read the questions.

ACCESS TO RESOURCES

Some rural communities and spread out. Transportation concerns

OTHER

Patients feel they already have enough appointments. They don't feel comfortable initiating the process of finding a therapist.

STIGMA

Does not want others to feel they need "help."

FINANCIAL

Patients are often concerned with out of pocket costs.

USEFUL INTERVENTIONS

UTILIZE OTHER COMMUNITY RESOURCES

Contacted the Disability Network on to assist with psychosocial issues.

SW COMPLETES BRIEF INTERVENTIONS

Opening dialogue with patient and giving them some tools/coping skills and strategies to help manage their issues on their own

REFER TO TELEHEALTH COUNSELING AND IN HOME COUNSELING WHERE AVAILABLE

Explore alternatives to traditional in-person services.

THANK YOU

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NCC Depression Expert Team Case Study

1/9/24

Pilot Project with Burrell Behavioral Health

- Network began working with Burrell Behavioral Health and Dialysis Clinic, Inc. (DCI) clinics in Mid-Missouri to address access to mental health treatment for patients screening positive for depression
- Network staff worked with Burrell and DCI Social Workers to develop a care pathway where local dialysis clinics could refer patients in need of mental health treatment
- Referred patients would be seen initially by a Psychiatrist who has knowledge of dialysis and transplant
- The initial appointment (in person or virtually) would ideally take place within 7-10 days of referral and would consist of medication management
- DCI Social Workers were trained on the care pathway and encouraged to begin referrals
- Pilot project began at the end of October 2023

Case Study Presenter

Cassie Jones, MSW, LCSW

Nephrology Social Worker-Dialysis Clinic, Inc.

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Case Study-Patient A

- Female age 57
- In-center hemodialysis
- History of depression and anxiety
- Recent positive PHQ-9 screening
- 3 recent hospitalizations within 6 weeks due to altered mental state
- Last hospitalization was due to hallucinations
- Hallucinations were not aggressive but distressing and causing issues in her dialysis care and family relationships
- Barrier for mental health care: patient also does not drive or have reliable transportation to get to multiple appointments

Case Study-Patient A Continued

- Patient had been seen by a Psychiatrist at Burrell Behavioral Health in the past but was having trouble getting back in and did not like the original Psychiatrist that she saw
- One hospitalization the patient was prescribed a 10-day supply of medication but was unable to get in to see a provider or get a refill on her meds
- Since the pilot project, the patient was referred but due to scheduling could not be seen before she had another hospitalization.
- Once out of the hospital, the patient was seen by the Psychiatrist familiar with dialysis through a telehealth visit

Case Study-Patient A Continued

- Patient reported feeling great about the provider and has another appointment scheduled next month
- Patient is also going through the intake process to be seen regularly for ongoing therapy at Burrell

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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

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Thank You

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