2025 ECM QIP Depression Screening Tools: PHQ-2, PHQ-9, PHQ-A, PHQ-9-OV©, GDS

January 15, 2025

Patient Health Questionnaire (PHQ-2)

The following **PHQ-2 Pre-Screening** is a tool to assist providers with establishing whether or not a depressive disorder is likely to be present in a member.

Over the last two weeks, you have been bothered with the following:	Not at all	Several days	More than half of 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

Score:

- 0-2 = Normal
- 3 or more = a depressive disorder is likely

Patient Health Questionnaire (PHQ-9)

The following **PHQ-9 Screening** is the follow-up tool to aid in a member's diagnosis of depression and can be used to monitor symptoms to track the severity and improvement with treatment. The tool uses the nine questions below to determine the member's score.

Over the last two weeks, you have been bothered with the following:	Not at all	Several days	More than half of 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 feeling that you are a failure or 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 hurting yourself in some way	0	1	2	3

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Based on the PHQ-9 score, the depression severity is determined. Providers can utilize the proposed actions that correspond to the level of depression severity.

PHQ-9 Score	Depression Severity	Proposed Actions
0-4	None or Minimal	None
5-9	Mild	Watch and repeat PHQ-9 in follow up
10-14	Moderate	Consider counseling or pharmacotherapy
15-19	Moderately Severe	Active treatment with psychotherapy or pharmacotherapy
20-27	Severe	Expedited referral to a mental health specialist for treatment or collaborative management

Severity Measure for Depression – Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

The APA is offering a number of "emerging measures" for further research and clinical evaluation. These patient assessment measures were developed to be administered at the initial patient interview and to monitor treatment progress. They should be used in research and evaluation as potentially useful tools to enhance clinical decision-making and not as the sole basis for making a clinical diagnosis. Instructions, scoring information, and interpretation guidelines are provided; further background information can be found in DSM-5. The APA requests that clinicians and researchers provide further data on the instruments' usefulness in characterizing patient status and improving patient care at http://www.dsm5.org/Pages/Feedback-Form.aspx.

Measure: Severity Measure for Depression – Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A])

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Rights holder: This measure was adapted from the PHQ-9 modified for Adolescents (PHQ-A), which is in the public domain (http://www.phqscreeners.com/instructions/instructions.pdf). The original measure was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. The reference for the original measure is: Johnson JG, Harris ES, Spitzer RL, Williams JBW: The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolescent Health 30:196–204, 2002.

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Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ☐ **Female** ☐ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

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Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If three or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or two items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were answered (i.e., seven or eight). The formula to prorate the partial raw score to Total Raw Score is:

$$\frac{\text{(Raw sum x 9)}}{\text{Number of items that were answered}}$$

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

Staff Assessment of Resident Mood (PHQ-9-OV©)

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0150-D0160) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

		1. Symptom Presence	2. Symptom Frequency
		↓ Enter Scores in Boxes ↓	
A.	Little interest or pleasure in doing things	☐	☐
B.	Feeling or appearing down, depressed, or hopeless	☐	☐
C.	Trouble falling or staying asleep, or sleeping too much	☐	☐
D.	Feeling tired or having little energy	☐	☐
E.	Poor appetite or overeating	☐	☐
F.	Indicating that they feel bad about self, are a failure, or have let self or family down	☐	☐
G.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H.	Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that they have been moving around a lot more than usual	☐	☐
I.	States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J.	Being short-tempered, easily annoyed	☐	☐

Staff Assessment of Resident Mood (PHQ-9-OV©)

Item Rationale

Health-related Quality of Life

PHQ-*2 to* 9© **Resident Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of *residents* are unable or unwilling to complete the PHQ-*2 to* 9© **Resident Mood Interview**. Therefore, staff should complete the PHQ-9© Observational Version (PHQ-9-OV©) **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified.

Persons unable to complete the PHQ-*2 to* 9© **Resident Mood Interview** may still have a mood disorder.

Even if a resident was unable to complete the **Resident Mood Interview**, important insights may be gained from the responses that were obtained during the interview, as well as observations of the resident's behaviors and affect during the interview.

The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.

It is important to note that coding the presence of *clinical signs and symptoms of depressed mood* does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis *as a result of the outcomes of the PHQ-2 to 9© or the PHQ-9-OV©*; they simply record the presence or absence of specific clinical *signs and symptoms of depressed* mood.

Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-*2 to* 9© **Resident Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

When the resident is not able to complete the PHQ-*2 to* 9©, scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

Steps for Assessment

Conduct the interviews during the 7-day look-back period based on the ARD.

Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.

Many of the same administration techniques outlined above for the PHQ-*2 to* 9© **Resident Mood Interview** and Interviewing Tips & Techniques *can* be followed when staff are interviewed.

Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.

Staff Assessment of Resident Mood (PHQ-9-OV©)

D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self

They say God should take *them* already.

They complain that *people were* not meant to live like this.

D0500J, Being Short-Tempered, Easily Annoyed

They're OK if you know how to approach *them*.

They can snap but usually when *their* pain is bad.

Not with me.

They're irritable.

Coding Instructions for Column 1. Symptom Presence

Code 0, no: if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.

Code 1, yes: if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency.**

Coding Instructions for Column 2. Symptom Frequency

Code 0, never or 1 day: if staff indicate that the resident has never or has experienced the symptom on only 1 day.

Code 1, 2-6 days (several days): if staff indicate that the resident has experienced the symptom for 2-6 days.

Code 2, 7-11 days (half or more of the days): if staff indicate that the resident has experienced the symptom for 7-11 days.

Code 3, 12-14 days (nearly every day): if staff indicate that the resident has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

Ask the staff member being interviewed to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., "nearly every day" or 3 = 12-14 days) to select a frequency response.

If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.

If the staff member has difficulty selecting between two frequency responses, code for the **higher** frequency.

If the resident has been in the facility for less than *2 weeks*, also talk to the family or significant other and review transfer records to inform selection of the frequency code.