Salience
TMS Neuro Solutions

August 2019

CLINICAL NEWSLETTER

Using Measurement-Based Care to Improve Depression Treatment

Salience has promoted the use of measurement-based care to improve the ability of our clinicians to treat to target. Our target, whenever possible, should be **remission**, or the best improvement in symptoms and function that we can attain. How do clinical scales assist with this effort? Not at all if we fail to use them as a measure of symptom severity and effectiveness of treatment over time. How are you using the clinical scales that are collected on every patient? Are you watching trends? When a patient is not demonstrating improvement over the course of treatment, when do you intervene and make a change in the treatment plan? This month, the newsletter will look at the use of clinical scales to drive clinicians to make timely and informed decisions about care.

The PHQ-9 was designed as a self-report to assist in the screening and diagnosis of depression in Primary Care Settings. It can be clinician or phone administered. The patient is to rate their response based on how they felt over the last 2 weeks. Not every high PHQ-9 score is due to depression. As the tool was designed for the PCP setting, it has not been extensively studied in the psychiatric setting. One study of 153 patients in a psychiatric setting found the PHQ-9 to have excellent reliability and validity for screening for major depressive episodes and for measuring the severity of depressive symptoms. However, in psychiatric settings, the study suggested that the PHQ-9 is useful only for screening for a current MDE, as a result of its low positive predictive value and not for the diagnosis of MDD. It also can have low specificity and can produce false-positives, especially with bipolar disorder and panic disorder. (BMC Psychiatry, 12 (73), (2012)). In the psychiatric setting the PHQ-9 can assist but should be used with the clinical assessment to make a diagnosis.

Use the PHQ-9 to track symptom severity and progress in treatment. If the score is not improving, adjust the treatment plan: adjust meds, refer to TMS, add therapy – Respond!

Clinical Pearl: As I work with patients over the years, I have reviewed many rating scales. Most of the time the patient's presentation and the rating scales are congruent. However, on occasion the patient will give a low PHQ-9 score and present as clearly depressed or will give a score in the depressed range and deny depression. At those times it is valuable to review the scores with the patient and clarify with them what is going on. Sometimes the low score reflects a misunderstanding of the scoring system. The patient may say they feel ok today but when reminded the scale is for the past two weeks then they score differently. Sometimes they will explain that a recent health change or other stress has temporarily increased the score. Sometimes they will explain they are minimizing their issues. In any case when there is a discrepancy between presentation and score it is up to us to use our clinical skills and investigate further.

-Dr. Dan Steinfink

SELF-REPORT VS. CLINICIAN ADMINISTERED

Self-Report Pros: cost-effective; do not require clinician time; correlate well with clinician-administered scales.

Self-Report Cons: reporting bias may result in under or over-reporting of symptoms; patients must understand the instructions and properly fill out the scale.

"The agreement between self-reported and clinician-rated measures of depression severity are far from perfect." "Results demonstrate that self-reported and clinician-rated outcomes are not equivalent. Self-report and clinician-rating each provide unique information that is relevant to clinical prognosis." "Clinician-rated scales contain unique information that is not captured with self-report and is prognostically relevant." "Clinician-rated scales should be combined with a self-report instrument to provide an accurate assessment since each modality provides unique nonredundant information that complements the other in predicting treatment outcomes."

Uher, R., et al. (2012) *Depress Anxiety*.

Salience Database

Salience has amassed one of the largest databases on TMS treatment and outcomes. We have delivered over 150,000 treatments, and the company is working to add historical data to our current growing database. We realize that the time has come to add a clinician-rated scale to our process so that we can better identify candidates, monitor response, and identify remission.

SALIENCE WILL BEGIN INTRODUCING THE HAM-D SOON. CLINICIANS SHOULD RATE THE PATIENT AT THE INITIAL ASSESSMENT AND AGAIN AT THE END OF TREATMENT. WE WOULD ENCOURAGE OUR THERAPY DIRECTORS TO INCLUDE THE USE OF THE HAM-D IN THEIR CLINICS AS AN ADDITIONAL TOOL.

Hamilton Rating Scale for Depression (HAM-D)

- *Long-standing, widely used measure of depression severity*
- *"Gold Standard"- widely used in research*
- *Can be used before, during, and after treatment to track symptom severity*
- *Scoring is based on 17 items*
- *Sensitivity 86.4%*
- *Specificity 92.2%*
- *0-7 Normal; 8-13 Mild; 14-18 Moderate; 19-22 Severe; ≥23 Very Severe Depression*
- *The HAM-D6 is a shortened version, which focuses on the depression symptoms*