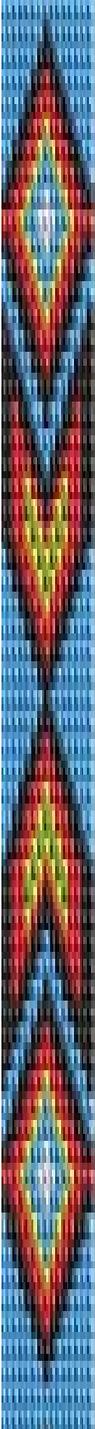




# Depression Screening

Oklahoma City Indian Clinic



# OKC Indian Clinic

- Centrally located in Oklahoma City
- Serves American Indian people in the Oklahoma City metropolitan area
- User Population  $\approx$  15,000
- Serve over 220 tribes
- Urban Site
- Began GPRA reporting in 2007



# Issues

- Inconsistent Screening
- Documentation
- Provider/Nurse education
- Patients lost to follow-up

# Improvements

- Started with patient flow sheets
- Developed universal screening tool for Depression, Alcohol, Intimate Partner Violence

# Screening Tool

In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your nurse. Thank you for taking an active part in your health care.

If the health screenings are positive, would you like to be contacted by the Behavioral Health Department?

Yes /  No

Are you currently a patient at the Oklahoma City Indian Clinic Behavioral Health Department?

Yes /  No

## Depression Screening

Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
i. Thinking that you would be better off dead or that you want to hurt yourself in some way	0	1	2	3
(Office Use Only) Totals				

Score	Chart	Action
0-14	DP -	Chart Only
≥ 15	DP +	BH Referral
I ≥ 1	DP +	BH Staff

Behavioral Health Use Only

Name: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM Phone: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

In an effort to provide complete and comprehensive preventative care to our patients we would appreciate your assistance with completing this questionnaire. Please complete the questions as completely as you can and give to your nurse. Thank you for taking an active part in your health care.

## CAGE Questionnaire: Screening Test for Alcohol Dependence

Chart #: \_\_\_\_\_ Date: \_\_\_\_\_

Please check the one response to each item that best describes how you have felt and behaved over your whole life.

Do you currently drink alcohol, beer or wine?

Yes

No → Please proceed to Intimate Partner/Domestic Violence Screening

1. Have you ever felt you should *cut* down on your drinking?

Yes

No

2. Have people *annoyed* you by criticizing your drinking?

Yes

No

3. Have you ever felt bad or *guilty* about your drinking?

Yes

No

4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (*eye-opener*)?

Yes

No

CAGE Score	Chart	Action
Unable to Screen	ETOH UAS	Chart Only
0	ETOH -	Chart Only
1	ETOH -	Chart Only
2	ETOH +	BH Referral
3+	ETOH +	BH Staff

## Intimate Partner/Domestic

### Violence Screening (*Females only*):

1. Are you in a relationship with a person who physically hurts or threatens you?

Yes

No

2. Have you ever been in a relationship with a person who hurt you?

Yes

No

3. Would you like to talk to someone about Intimate Partner/Domestic Violence?

Yes

No

IP/DV	Chart	Action
Unable to Screen	DV-UAS	Chart Only
1Y	DV-PR	BH Referral
2Y	DV-PA	Chart Only
1N or 2N	DV-N	Chart Only

**PLEASE RETURN THE COMPLETED FORM TO YOUR NURSE**

# Process

- Patients are given screening tool at Registration
- Fill out while waiting to be called back to Medical
- Nurse scores sheet and documents on PCC
- If positive screen, then BH called over to counsel patient while still in the exam room.
- Immediate intervention is provided if needed, or an appointment is made with the patient for follow-up

# Outcomes

