STANDARDIZED SCREENING TOOLKIT

Ascend/MAXIMUS MED Review

Abstract

We will be testing the following tools to assess their contribution in informing MED Review decisions. If symptoms of a mental illness are presenting as potentially the driver of the person's functioning, then administer the corresponding screening tool (e.g., depression screening, mania, anxiety or psychosis. If the person has unexplained cognitive loss (not impairment associated with dementia), the short BLESSED cognitive screen should be completed. Note that these screens were not designed to identify drivers; rather, they provide information about the severity of a presenting mental health condition, which is one aspect in considering the driver of the person's needs

STANDARDIZED SCREEN	DESCRIPTION	SCORING	COMPLETE IF	COMPLETE BY
Patient Health Questionnaire (PHQ-9)	Depression Scale. PHQ-9 total score for the nine items ranges from 0 to 27. Potential dual-purpose instrument in its capacity to establish depressive disorder and assess depressive symptom severity	Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score. Scores of **5, 10, 15, and 20 represent cut points for mild, moderate, moderately severe and severe depression**, respectively. Sensitivity to change has also been confirmed.	symptoms of depression are presenting as potentially the driver of the person's functioning	Self-administered by the person
Global Anxiety Disorders Scale (GAD-7)	Anxiety Scale. total score for the seven items ranges from 0 to 21. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder.	Scores **of 5, 10, and 15 represent cut points for mild, moderate, and severe anxiety,** respectively. When screening for anxiety disorders, a recommended cut point for further evaluation is a score of 10 or greater.	symptoms of anxiety are presenting as potentially the driver of the person's functioning	Self-administered by the person
Altman Self Rating Mania Scale (ASRM)	Adult screen for bipolar disorder; specifically assesses the presence and severity of manic symptoms	Psychometric properties: cutoff **of 6 or higher indicates high probability of a manic or hypomanic condition**. May indicate need for treatment. Score of 5 or lower is less likely to be associated with significant symptoms of mania	symptoms of mania are presenting as potentially the driver of the person's functioning	Self-administered by the person
Brief Psychiatric Rating Scale or Clinician Rated Dimensions of Psychosis Symptom Severity	Adult screen to measure severity of mental health symptoms across psychotic disorders, including delusions; hallucinations; disorganized speech; abnormal psychomotor behavior; negative symptoms (i.e., restricted emotional expression or avolition); impaired cognition; depression; and mania. The severity of these symptoms can predict important aspects of the illness, such as the degree of cognitive and/or neurobiological deficits. The measure is intended to capture meaningful variation in the severity of symptoms, which may help with treatment planning, prognostic decision-making, and research on pathophysiological mechanisms. The measure is completed by the clinician at the time of the clinical assessment. Each item asks the clinician to rate the severity of each symptom as experienced by the individual during the past 7 days.	Clinician Rated Dimensions of Psychosis Symptom Severity: Clinician rates patient on a five-point scale (0= no symptoms, 1=equivocal, 2= present, but mild, 3=present and moderate, 4 = present and severe); complex -- results are weighed in relationship to other collected data and requires expertise in assessment of psychiatric disorders This tool is typically used as a comparative rating over time	symptoms of psychosis are presenting as potentially the driver of the person's functioning	Completed by the MED Reviewer
Short BLESSED Cognitive Screen		**Score 0 – 4:** The score for this test does not reveal	There are unexplained cognitive deficits or deficits potentially	Completed by the MED Reviewer

		signs related to dementia or cognitive impairment. **Score 5 – 9:** Questionable cognitive impairment **Score 10 – 28:** The score for this test reveals signs related to cognitive impairment due to dementia or other disorder.	associated with dementia. It is not necessary to administer if the person clearly has both a clear severe mental illness and a dementia, because executive functioning impairments are present for both conditions and this test is not beneficial in differentiating the two	

PATIENT HEALTH QUESTIONNAIRE- 9 (PHQ-9)

(this is a self-administered screen)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use " ✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep or sleeps too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. 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**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

Coding **(_____+ _____+ _____+ _____)**

=Total Score: _____

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
☐	☐	☐	☐

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https://www.phqscreeners.com/select-screener/36

https://www.integration.samhsa.gov/images/res/STABLE_toolkit.pdf

GLOBAL ANXIETY DISORDER SCALE - 7 (GAD-7)

(this is a self-administered screen)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use " ✔" to indicate your answer)

	Not at all	Several days	More than 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 is 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**

Coding **(_____+ _____+ _____+ _____)**

=Total Score: _____

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https://www.phqscreeners.com/select-screener/36

ALTMAN SELF-RATING MANIA SCALE (ASRM)

(this is a self-administered screen)

1. There are five statements groups on this questionnaire; read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling for the past week,
3. Check the box next to the numbers/statement selected.
4. *"Occasionally"* when used here means **once or twice**. "*Often"* means **several times or more** and "*Frequently"* means **most of the time.**

Question 1	
☐ **0**	I do not feel happier or more cheerful than usual
☐ **1**	I occasionally feel happier or more cheerful than usual
☐ **2**	I often feel happier or more cheerful than usual
☐ **3**	I feel happier or more cheerful than usual most of the time
☐ **4**	feel happier or more cheerful than usual all of the time
Question 2	
☐ **0**	I do not feel more self-confident than usual
☐ **1**	I occasionally feel more self-confident than usual
☐ **2**	I often feel more self-confident than usual
☐ **3**	I feel more self-confident than usual
☐ **4**	I feel extremely self-confident all of the time
Question 3	
☐ **0**	I do not need less sleep than usual
☐ **1**	I occasionally need less sleep than usual
☐ **2**	I often need less sleep than usual
☐ **3**	I frequently need less sleep than usual
☐ **4**	I can go all day and night without any sleep and still not feel tired
Question 4	
☐ **0**	I do not talk more than usual
☐ **1**	I occasionally talk more than usual
☐ **2**	I often talk more than usual
☐ **3**	I frequently talk more than usual
☐ **4**	I talk constantly and cannot be interrupted
Question 5	
☐ **0**	I have not been more active (either socially, sexually, at work, home or school) than usual
☐ **1**	I have occasionally been more active than usual
☐ **2**	I have often been more active than usual
☐ **3**	I have frequently been more active than usual
☐ **4**	I am constantly active or on the go all of the time

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https://www.pasrrassist.org/sites/default/files/attachments/Sanderson_PTAC_review_of_MH_screens_Jan2016.pdf

BRIEF PSYCHIATRIC RATING SCALE

(this is a clinician-administered screen)

0=Not assessed, 1= Not present, 2=Very mild, 3=Mild, 4= Moderate, 5= Moderately Severe, 6= Severe, 7=Extremely Severe

Score	
☐	1. SOMATIC CONCERN Preoccupation with physical health, fear of physical illness, hypochondriasis
☐	2. ANXIETY Worry, fear, over-concern for present or future, uneasiness
☐	3. EMOTIONAL WITHDRAWAL Lack of spontaneous interaction, isolation, deficiency in relating to others
☐	4. CONCEPTUAL DISORGANIZATION Though processes confused, disconnected, disorganized, disrupted
☐	5. GUILT FEELINGS Self-blame, shame, remorse for past behavior
☐	6. TENSION Physical and motor manifestations of nervousness, over-activation
☐	7. MANNERISMS AND POSTURING Peculiar, bizarre, unnatural motor behavior (not including tics)
☐	8. GRANDIOSITY Exaggerated self-opinion, arrogance, conviction of unusual power or abilities
☐	9. DEPRESSIVE MOOD Sorry, sadness, despondency, pessimism
☐	10. HOSTILITY Animosity, contempt, belligerence, disdain for others
☐	11. SUSPICIOUSNESS Mistrust, belief others harbor malicious or discriminatory intent
☐	12. HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence
☐	13. MOTOR RETARDATION Slowed, weakened movements or speech, reduced body tone
☐	14. UNCOOPERATIVENESS Resistance, guardedness, rejection of authority
☐	15. UNUSUAL THOUGHT CONTENT Unusual, odd, strange, bizarre thought content
☐	16. BLUNTED AFFECT Reduced emotional tone, reduction in formal intensity of feelings, flatness
☐	17. EXCITEMENT Heightened emotional tone, agitation, increased reactivity
☐	18. DISORIENTATION Confusion or lack of proper association for person, place and time

The BPRS is typically used as a comparative rating over time.

CLINICIAN-RATED DIMENSIONS OF PSYCHOSIS SYMPTOMS SEVERITY

(this is a clinician-administered screen
https://www.pasrrassist.org/sites/default/files/attachments/Sanderson_PTAC_review_of_MH_screens_Jan2016.pdf
AMA DSM5 Clinician-Rated Dimensions of Psychosis Symptoms Severity

Domain	0	1	2	3	4	Score
I. Hallucinations	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon voices, not very bothered by voices)	❑ Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)	❑ Present and severe (severe pressure to respond to voices, or is very bothered by voices)	
II. Delusions	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered psychosis)	❑ Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)	❑ Present & moderate (some pressure to act upon beliefs, or somewhat bothered by beliefs)	❑ Present and severe (severe pressure to act on beliefs, or very bothered by beliefs)	
III. Disorganized speech	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered disorganization)	❑ Present, but mild (some difficulty following speech)	❑ Present and moderate (speech often difficult to follow)	❑ Present and severe (speech almost impossible to follow)	
IV. Abnormal psychomotor behavior	❑ Not present	❑ Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)	❑ Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)	❑ Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)	❑ Present and severe (abnormal or bizarre motor behavior or catatonia almost constant)	
V. Negative symptoms (restricted emotional expression or avolition)	❑ Not present	❑ Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior	❑ Present and severe decrease in facial expressivity, prosody, gestures, or self-initiated behavior	
VI. Impaired cognition	❑ Not present	❑ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)	❑ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)	❑ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)	❑ Present and severe (severe reduction in cognitive function; below expected for age and SES, > 2 SD from mean)	
VII. Depression	❑ Not present	❑ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)	❑ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)	❑ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)	❑ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)	
VIII. Mania	❑ Not present	❑ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)	❑ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)	❑ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness)	❑ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness)	

SHORT BLESSED COGNITIVE SCREEN

	Question	Maximum Error	Patient's # Errors	Multiplier (X)	Weighted Sub score *(Errors times Multiplier)*
a.	**Ask the following questions and score the results:** The method for counting item errors is provided within each question. Once complete, multiply the errors against the number provided to arrive at the weighted sub score				
	Multiply the errors within each line to the corresponding multiplier to arrive at the weighted sub score.				
a1.	**What is the year?** *(0= Correct; 1=Incorrect)*	**1**	_____ X	**4 =**	_____
a2.	**What month is it now?** *(0= Correct; 1=Incorrect)*	**1**	_____ X	**3 =**	_____
a3.	**I will give you a name and address to remember for a few minutes. Listen to the entire name and address and then repeat it after me.** *John Brown, 42 Market Street Chicago* **Number of trials to learning:** _____ (*Allow up to 5 trials)*				
a4.	**About what time is it without looking at your watch?** *(0= Correct or within an hour; 1=Incorrect)*	**1**	_____ X	**3 =**	_____
a5.	**Count aloud backwards from 20 down to 1.** 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 *Any incorrect response is an error; but score only first two errors.* *(0=Correct and/or self-corrected; 1=One Incorrect; 2=Two Incorrect)*	**2**	_____ X	**2 =**	_____
a6	**Say the months of the year in reverse order.** D N O S A JL JN MY AP MR F J *Any incorrect response is an error; but score only first two errors.* *(0=Correct and/or Self Corrected; 1=One Incorrect; 2=Two Incorrect)*	**2**	_____ X	**2 =**	_____
a7.	**Repeat the name and address I asked you to remember.** *(Mark each incorrect word or phrase as noted below; you may score up to 5 errors. The thoroughfare term (Street) is not required. If the patient cannot spontaneously recall the name and address, cue with "John Brown" one time only. If this cue is necessary, the patient automatically has 2 errors.* **John Brown 42 Market Street Chicago** _____ *0=Correct and/or self-corrected and no cues required;* *1=One Incorrect;* *2=Two incorrect or all correct but cue was required;* *3=Three incorrect or one incorrect and cue was required;* *4=Four incorrect or two incorrect and cue was required;* *5=Five incorrect or three incorrect and cue was required.*	**5**	_____ X	**2 =**	_____
	TOTAL WEIGHTED ERROR SCORE				_____
a8.	**Are the reported cognitive status and scores believed to be accurate? (e.g., if the person is too medically ill or refused to participate, then the scores would not be valid)**	☐ The score is believed to be valid ☐ The score is not believed to be valid, Explain _____			

DESCRIPTION	SCORING
The SBT is a screening tool that aids in detecting early cognitive changes through 6 weighted questions that evaluate orientation, registration, and attention. It is important to note that the test does not differentiate the source of neurocognitive impairment, where neurocognitive impairment is clinically common both for individuals with dementia as well as individuals with major mental illnesses. As such, the SBT should not be used to diagnose dementia.	**Score 0 – 4:** The score for this test does not reveal signs related to dementia or cognitive impairment. **Score 5 – 9:** Questionable cognitive impairment **Score 10 – 28:** The score for this test reveals signs related to cognitive impairment due to dementia or other disorder.

available for free at: http://www.mybraintest.org/dl/ShortBlessedTest_WashingtonUniversityVersion.pdf