Early Detection and Management of Anxiety/Depression in the Critically Ill

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INTRODUCTION

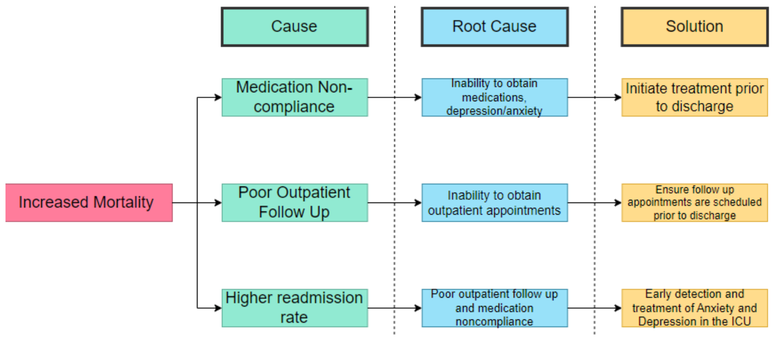
- Several studies have noted a high prevalence of depression/anxiety in the critically ill post-discharge, and these patients have been shown to have a higher likelihood of readmission, medication non-adherence, and worse overall mortality.

- The goal of this QI project is to implement a system reduce prevalence of post-discharge anxiety and depression for ICU patients by implementing a screening process using the Hospital Anxiety and Depression Scale (HADS)

METHODS

- Impact Effort Analysis
  - High Impact, Low Effort: Screening and Initiating Treatment
  - High Effort, High Impact: Outpatient follow up and data collection on mortality and readmission rates
- Inclusion Criteria – all patients > 18 y/o admitted to the ICU for ≥ 24 hours, A&Ox3 and have capacity to consent
- Exclusion Criteria – patients with a known history of anxiety/depression and on treatment, those unable to consent
- Variables collected: HADS screening tool scores
- Plan: HADS screening tool prior to ICU discharge/downgrade
- Do: Initiate treatment and/or follow up prior to hospital discharge
- Study: Examine readmission rates and mortality rates in patients in this protocol comparatively with retrospective data
- Act: Optimize the protocol to maximize benefit

RESULTS



Step 1:

Patients admitted to the ICU ≥ 24 hours complete HADS screening tool prior to discharge or downgrade

Step 2:

Scores that are > 7 on either the depression or anxiety warrant further evaluation. Scores between 8-10 should be reassessed prior to discharge. If patient is being discharged within 24 hours of first scoring, patient should have follow up for subclinical depression or subclinical anxiety with PCP

Scores > 10 are suggestive of diagnosis of anxiety or depression and patient should be evaluated for starting treatment prior to discharge at the discretion of the primary team with follow up also scheduled as outpatient.

Step 3:

If patient has a score of ≥ 12 this would warrant an in-house consult to psychiatry/behavioral health ONLY once primary team has discussed with patient and patient is amenable to psych evaluation.

PCP would get recommendations for treatment (including contingency plan with prospective guidance) rather than outpatient psych follow up unless requested by inpatient psych/behavioral health for complex/severe cases.

CONCLUSIONS

- The prevalence of depression and anxiety in the critically ill post-discharge are as high as 55%
- Specifically, those with depression had a 47% increased mortality in the first two years after ICU discharge as compared to those that did not
- There have been studies examining the effects of early ICU psychologic intervention and its effects on recovery from PTSD, depression, and anxiety in the critically ill with promising results.
- Implementing a protocol that would identify and address depression and anxiety in the critically ill post-discharge will help improve readmission rates as well as improve patient medication compliance, outpatient follow up, health related quality of life, and mortality

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