A Change Package To Improve Screening and Referral for Depression

Key Change Ideas for Dialysis Facilities to Drive Local Action

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ESRD NCC
NATIONAL COORDINATING CENTER

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I. Introduction

This change package is intended to support dialysis facilities and End State Renal Disease (ESRD) Networks in increasing the number of patients screened for depression and referred for treatment. The change package includes actionable change ideas, collected from top-performing dialysis facilities. The change ideas presented are intended as a menu of interventions from which program leaders can choose to implement within their facilities.

How to Get Started

Change happens at the local level. Dialysis facility Quality Assessment & Performance Improvement (QAPI) meetings are the perfect place to start. Giving interdisciplinary team (IDT) members this change package for review will allow them to identify and prioritize change ideas that could be implemented to increase the number of patients screened for depression and referred for treatment.

The change ideas presented in this change package represent the practices used by high-performing dialysis facilities. They are not meant to serve as the entire universe of approaches to assist dialysis facilities in their efforts to screen and refer patients for depression. They can, however, serve as "tests of change" that drive performance improvement and quality improvement programs.

About QAPI: QAPI merges quality assessment (QA) and performance improvement (PI) into a comprehensive approach to quality management. QA is the process of meeting standards and ensuring care reaches an acceptable level. PI is the proactive, continuous study of processes with the intent to identify opportunities and test new approaches to fix the underlying causes of persistent, systemic problems. Data-driven QAPI programs may be customized to facility needs. Key steps include:

- Identifying the problem and defining the goal
- Deciding on a measurement to monitor improvement
- Brainstorming solutions based on barriers and root causes
- Planning an intervention
- Using plan-do-study-act (PDSA) to implement the improvement project

Learn more about QAPI: https://esrdnetworks.org/toolkits/professional-toolkits/qapi-toolkit/

Contacting ESRD Networks

Dialysis facilities can contact their local ESRD Networks for assistance with PDSA principles and practices, questions about change strategies, and depression resources. A complete listing of ESRD Networks can be found at https://esrdncc.org/en/ESRD-network-map/.

II. Change Package Methodology

The ideas presented in this change package were identified through interviews with high-performing dialysis facilities. The facilities were selected using data from the ESRD Quality Reporting System (EQRS). During the interviews, systemic themes emerged, which were organized into driver diagrams, visual displays of what drives and contributes to achieving an overall aim.[1] The diagrams include drivers and associated change ideas, which were reviewed by social workers from three ESRD Networks to ensure relevance to a broad range of dialysis facilities. The input of these experts was incorporated into the document.

III. Drivers to Improve Screening and Referral for Depression

Interviews with high-performing dialysis facilities revealed primary and secondary drivers being utilized to increase the screening and referral of patients for depression (Table 1). "Primary drivers are the most important influencers" that "contribute directly to achieving the aim." Secondary drivers are the actions and interventions that impact the primary drivers.[2]

The primary and secondary drivers (Tables 1–12), as well as the associated change ideas in the driver diagrams (Tables 2–12), are not in ranked order. They are numbered for easy reference.

Table 1. Primary and Secondary Drivers to Improve Screening/Referral for Depression

AIM: IMPROVE SCREENING AND REFERRAL FOR DEPRESSION	
PRIMARY DRIVERS	**SECONDARY DRIVERS**
1. Create a culture that promotes trust	1a: Build rapport with patients 1b: Support patients in coping with dialysis
2. Use a team approach to screen patients for depression and refer for treatment	2a: Engage the whole team 2b: Maintain communication among team members
3. Implement processes to ensure depression is recognized and treated	3a: Navigate conversations about depression 3b: Consider the effect of chronic pain on mental health 3c: Screen patients for depression 3d: Track data and incorporate into QAPI processes 3e: Refer patients for treatment
4. Educate patients and staff	4a: Provide patient education, so patients will be receptive to treatment 4b: Equip staff with knowledge to screen and refer patients for treatment

IV. Key Change Ideas

The following driver diagrams (Tables 2–12) expand on the drivers (Table 1) and include specific change ideas for all the secondary drivers identified with high-performing dialysis facilities. The visualizations show the relationships between the primary and secondary drivers and the associated change ideas.

Table 2. Build Rapport With Patients

PRIMARY DRIVER #1: CREATE A CULTURE THAT PROMOTES TRUST
Secondary Driver #1a: Build rapport with patients
Developing relationships with patients builds trust, which is essential if staff and patients are to have meaningful conversations about sensitive topics, such as depression. That trust will enable staff to screen patients effectively for depression and allow patients to be open to conversations about treatment. **Change Ideas** 1. On the first day of treatment, ask patients to come in early to meet with the social worker, manager, and other staff to establish connections. 2. Have staff introduce themselves. 3. Be transparent about roles, e.g., conducting an annual depression screening. 4. Promote a culture where staff welcome and greet all patients, not just the patients assigned to them, on each visit. 5. Let patients know that the team can be reached at any time, and they can call the social worker to talk. 6. Have brief conversations with patients to connect with them. 7. Ask two magic wand questions: "If your life were perfect and you were perfectly healthy, what would you be doing right now?" and "What do you miss most about your life before having to be on dialysis?" 8. Spend time with patients, e.g., patient care technicians (PCTs) sitting with patients during dialysis, managers taking time with patients who are newly admitted. 9. Arrange staffing so nurses are available to meet with patients one-on-one monthly. 10. Match patients to staff who share their culture, as patients may relate to staff of similar cultural backgrounds on behavioral health treatment. 11. Use staff who speak the same language as the patients or use a phone translation service to communicate, educate, and involve patients in their treatment options. 12. Show an interest in what is going on in patients' lives (e.g., grandchildren), rather than meeting with patients only for a dialysis-related purpose, e.g., conducting a depression screening. 13. Implement a patient satisfaction survey to involve patients. 14. Communicate and involve families with permission of patients.

Table 3. Support Patients in Coping With Dialysis

PRIMARY DRIVER #1: CREATE A CULTURE THAT PROMOTES TRUST
Secondary Driver #1b: Support patients in coping with dialysis
Offering support to patients positively affects their ability to maintain mental health while living with dialysis. It also shows patients that staff care about them, which increases the likelihood that patients will be willing to discuss how they are feeling and share their thoughts. **Change Ideas** 1. Encourage patients to lead normal lives as much as possible. 2. Offer coping strategies, e.g., a relaxation technique in the chair where patients find their favorite place, remember their favorite place, pretend that they are there, and tune out whatever is going on around them. 3. Support patients in quality-of-life activities, e.g., accommodating their schedules and rearranging their treatments, so they can travel. 4. Discuss reasons for stress and help patients find solutions, e.g., if a patient's ride is picking the patient up too late for prayer time, ask the social worker to find other transportation. 5. With permission of patients, engage families in quality-of-life goals, e.g., if taking walks makes the patient feel better, suggest that the daughter come over once a week and take a walk with the patient. 6. Recognize that significant life events, such as a death in the family, could affect patients' mental health. 7. Connect patients with other patients (with permission of patients). Ask patients if it would be helpful for them to talk to other patients. Facilitate the phone calls. 8. Provide support to families and caregivers by offering resources that will support them, e.g., if a patient's wife is feeling overwhelmed, help her find resources such as house cleaning services or Meals on Wheels. 9. Encourage exercise, as approved by the physician.

Table 4. Engage the Whole Team

PRIMARY DRIVER #2: USE A TEAM APPROACH TO SCREEN PATIENTS FOR DEPRESSION AND REFER FOR TREATMENT
Secondary Driver #2a: Engage the whole team

The whole team is needed to make sure depression is identified and treated. Each team member plays a role in observing signs of depression and collaborating with the rest of the team to get help for the patient.

Change Ideas

1. Use a team approach to identify possible signs of depression:
    a. Changes in the patient's behavior, e.g., a patient starts crying during treatment and will not tell the staff why or the staff notices that the patient is not "like himself."
    b. A decline in hygiene, e.g., body odor or looking unkempt.
    c. Statements made by the patient, such as, "I am feeling down" or "I am feeling depressed."
    d. Missed treatments and a decline in interest in coming to treatment.
2. Report observations to the social worker and the manager.
3. Be alert for physical signs that could indicate depression, such as a low albumin. Consult the IDT to investigate the cause, e.g., the patient does not feel like eating. Discuss in the care planning meeting.
4. Empower PCTs, who may have the closest relationships with the patients, to speak with the social worker or the manager about concerns.
5. Promote sharing of observations about all patients by all staff, rather than limiting observations to the patients assigned to particular staff.
6. As the social worker:
    a. Develop relationships with patients, so they feel comfortable. Check in with patients often. Walk around the facility and engage patients. Asks them, "How are you doing?" "Do you need anything?" "Did you watch the football game?"
    b. See every patient at least every two weeks.
    c. Let patients know the door is always open if they need to talk.
7. Support other staff, e.g., if they are having a rough day, staff can go to the social worker's office and talk about it or take a moment of silence to work through whatever is bothering them.

Table 5. Maintain Communication Among Team Members

Primary Driver #2: USE A TEAM APPROACH TO SCREEN AND REFER PATIENTS FOR DEPRESSION
Secondary Driver #2b: Maintain communication among team members
Effective communication among the IDT is an extremely important element in a facility's strategy to support patients with depression. **Change Ideas** 1. Keep in contact with each other throughout the day by talking directly while in the unit or via email or phone, as needed. 2. For disciplines that are not in the facility daily (e.g., social worker or dietitian), provide updates to them when they are on site. 3. Conduct huddles to talk about patients with depression or patients who may be exhibiting signs of depression. 4. Hold weekly IDT meetings, where each discipline focuses on specific patients. 5. Immediately inform the whole IDT when patients score high on depression screening. 6. Form a culture of communication with the nephrologists. Interact directly during rounds. Call or text securely when needed. Encourage all staff (e.g., PCTs, nurses, social workers, and dietitians) to speak with the nephrologists.

Table 6. Navigate Conversations About Depression

PRIMARY DRIVER #3: Implement Processes to Ensure Depression Is Recognized and Treated
Secondary Driver #3a: Navigate conversations about depression

When staff conduct conversations about depression with sensitivity, patients may be more willing to answer questions about depression and discuss treatment options. These conversations may also help to reduce the stigma associated with depression.

Change Ideas

1. If patients are struggling and do not want to talk about it, ask open-ended questions, e.g., "How have you been feeling lately?" Summarize what the patient says, give a different perspective. Do not force the issue.
2. Direct the conversation somewhere else besides depression (e.g., grandkids), so patients see that staff are interested in them, not just gathering information on depression.
3. Give patients whatever time they need to talk about whatever they want to talk about.
4. Consider patients' beliefs and cultures related to behavioral health screening, diagnosis, and treatment.
5. Avoid using the term "mental illness" when speaking with patients about depression.
6. Explain the statistics of patients on dialysis and depression. Assure patients that they are not the only ones with depression.
7. If patients do not want to talk during dialysis treatment, give them the option of going to the social worker's office before or after dialysis or ask the social worker to call them.
8. While completing admission paperwork, ask patients new to dialysis who their primary care provider (PCP) is, if they have a history of depression, if they have ever been diagnosed with depression, and how they are coping with dialysis at this time.
9. Explore further if patients are receiving or have had treatment for depression. Are they taking medication? Do they feel like the medication is working or did it work when they were taking it? Do they think getting their medication adjusted would be beneficial or would they consider counseling?
10. For patients who screen positively for depression, discuss their overall goals and help them see that treatment for depression will help them reach those goals.
11. Use a positive approach to engage patients in their care plan, e.g., "Let's talk about how we can get you feeling better." Share the benefits of treatment.

Table 7. Consider the Effect of Pain on Mental Health

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED
Secondary Driver #3b: Consider the effect of chronic pain on mental health
Persons who are in chronic pain are more likely to experience depression. Assessing and addressing patients' pain could help in the management of depression, if pain is one of the root causes. **Change Ideas** 1. Conduct a pain screening during each treatment to determine new or chronic pain. a. Ask, "Are you hurting anywhere?" "Are you having any pain?" b. Use a scale of one to 10 to quantify the pain. If it is greater than five, determine if the patient is taking pain medication. c. Ask specifics about the pain, e.g., location and patterns, such as when the pain starts and how often it is occurring. 2. Alert staff to be aware of and report unspoken signs of pain, e.g., PCT notices that the patient looks uncomfortable or is moving around in the chair and notifies the nurse. 3. For patients with chronic pain: a. Ask if the patient is seeing a PCP or a pain specialist. b. Refer the patient to his/her PCP or nephrologist for follow-up. c. Assess the need to ask for a referral to a pain management specialist or clinic. Discuss with the patient. Work with the nephrologist or PCP to get the referral. d. Evaluate if another specialist would be needed, e.g., orthopedist, depending on the source of the pain. Communicate the assessment to the nephrologist or PCP. 4. Report the results of pain screenings to the manager, nurse practitioner, or nephrologist, as needed. 5. Perform medication reconciliations monthly to document and update pain medications.

Table 8. Screen Patients for Depression

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED
Secondary Driver #3c: Screen patients for depression

Timely and thoughtful screening of patients for depression is the first step in referring patients for treatment.

Change Ideas

1. Review the hospital discharge summary and the history and physical related to depression.
2. Ensure that the patient understands the screening questions and the purpose of the screening:
    a. Utilize staff who speak the patient's language or use a phone translation service when completing a depression screening.
    b. Ask patients with visual impairment if they are comfortable having staff read the questions to them or if family can participate (with the patient's permission).
    c. Involve family members if patients have significant dementia and are not able to make their own decisions.
    d. Sit with patients who cannot read and record their answers to the questions.
3. Use different screening tools, such as the Kidney Disease Quality of Life (KDQOL), the Patient Health Questionnaire-2 (PHQ-2), the Patient Health Questionnaire-9 (PHQ-9), a distress thermometer, the General Anxiety Disorder-7 (GAD-7), and the Brief Anxiety and Depression Scale (BADS), to obtain a clear picture of the patient and depression.
4. Let the patient read the questions; walk away; come back to collect the form.
5. If space allows, perform assessments at chairside. Otherwise, use an office or other private area.
6. Document results of screenings in the electronic health record (EHR).

<u>KDQOL</u>

7. Administer the KDQOL initially, at 90 days, annually, and whenever an identified need arises.
    a. Use it as a gateway to start conversations and encourage the patient to talk about something he/she has not mentioned.
    b. Document identified patient issues.
8. To assess for possible depression, focus on the emotional/mental health questions, e.g., "Have you felt calm and peaceful?" or "Have you felt downhearted and blue?" Review physical well-being questions that could indicate the potential for depression, e.g., "How much did pain interfere with your normal work?"
9. Conduct the KDQOL like a conversation rather than asking a list of questions.

<u>PHQ-2 and PHQ-9</u>

10. Conduct the PHQ-2 within 30 days, at 90 days, annually, and as needed, based on observations.
11. If the patient scores a 3 or higher on the PHQ-2, then use the PHQ-9.
12. Administer the PHQ-9 within 90 days of admission and annually, unless a patient is showing symptoms of depression or if a staff member reports observations that indicate a patient may be depressed.

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED

Secondary Driver #3c: Screen patients for depression

13. Make the assessment informal and conversational, rather than saying, “I'm going to do your depression screening.”
14. Consider cultural aspects, e.g., Spanish-speaking males may answer “no” to the questions on the PHQ-2. Use the PHQ-9 to ask questions about sleep or feelings of guilt or thoughts that they might be better off dead.

Distress Thermometer

15. Use a distress thermometer, a simple, easy-to-complete tool that contains visual cues that rate the patient’s perspectives on issues that could affect mental health, such as housing, insurance, financial, or food concerns. Ask the patient to rate his/her distress using a scale, e.g., 0 to 10 with 10 being extreme distress.
16. Use the responses to open a conversation.

Table 9. Track Data and Incorporate into QAPI Processes

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED
Secondary Driver #3d: Track data and incorporate into QAPI processes
Facilities that are effective in referring patients for the treatment of depression track patient information and depression metrics. They incorporate this information into IDT and quality meetings during which the team collaborates on strategies. **Change Ideas** 1. Implement a paper document to be used during weekly huddles to capture staff concerns, e.g., changes in patient behavior. 2. Use the EHR system to track the timing of assessments, auto-populate when the next one is due for each patient and send alerts to staff. 3. Develop a system where the physician gets the results of the PHQ-9 if it is positive, e.g., develop a form to securely fax the patient's results to the nephrologist with team recommendations. 4. Create a spreadsheet that lists patients who have positive depression screening results. Discuss these patients during QAPI meetings. Collaborate on any patients with scores that indicate the need for behavioral health referrals. 5. Track metrics, such as how many KDQOL assessments have been completed and how many patients have been screened and referred for depression. 6. Review metrics, such as the percentage of patients being screened for depression and the percentage of patients who have positive depression screenings being referred for treatment, during monthly QAPI meetings.

Table 10. Refer Patients for Treatment

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED
Secondary Driver #3e: Refer patients for treatment

Referral of patients for treatment of depression is a collaborative effort among the dialysis facility staff, the nephrologist, the PCP, behavioral health clinics, the patient, and the family. The culture, perspectives, preferences, and needs of the patients drive the process.

Change Ideas

1. Discuss positive findings from screening tools with patients. Involve patients in their treatment options.
2. Individualize care, e.g., factor in the patient's culture and experiences. "It's not cookie cutter."
3. Engage the social worker to:
    a. Conduct an in-depth assessment, which includes determining if the patient is in danger of self-harm.
    b. Recommend treatment options that may include cognitive behavioral therapy, dialectical behavioral therapy, behavioral activation, or problem solving; referral of the patient to the PCP or the patient's psychiatrist or the behavioral health treatment facility where he/she is being treated if a change has occurred; and counseling by the social worker.
    c. Coordinate care with healthcare providers.
4. Notify the PCP and the nephrologist of positive depression screenings to discuss the plan of care, including prescribing medications or referral to counseling. Send a letter that includes the patient's name, the date of the screening test, a copy of the screening tool, and the score.
5. Refer patients to their PCP or nephrologist. Sit with patients chairside and reach out to the provider's office to schedule an appointment or follow up to ask if an appointment has been scheduled.
6. Ask if patients are taking medications to help with the symptoms. If not, explore if patients would be willing to take medications.
7. If patients are reluctant to take medications for depression, find out the reasons (e.g., their experience with medications) and reframe taking medications, e.g., "If you take this one pill, it might make it easier for you to take all your other pills because you are going to feel much better."
8. If patients are already taking medication, refer patients back to their PCP or psychiatrist for a possible change in the medication.
9. Maintain a folder that has therapists in different agencies and locations. Include names of agencies with which PCPs have had success.
10. Refer patients to behavioral health clinics.
    a. Provide patients with a list of counselors in the area or who are conveniently located.
    b. Work with the behavioral health clinics to get patients scheduled in the next few days.
    c. Help patients find providers who accept their insurance and have the availability to work around dialysis treatments.

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED

Secondary Driver #3e: Refer patients for treatment

   d. If patients call a behavioral health agency themselves, assist them with the initial contact via phone.
   e. Consider patient preferences, including telehealth or in-person counseling and male or female counselor.
   f. Investigate telehealth options, depending on the patient's preferences and needs (e.g., living in a rural area), including telehealth via phone for the patients that may not use tablets or Internet services.

11. If long wait times are encountered for behavioral health providers, reach out to other social workers within the community or dialysis organization to see if they have had success with finding mental health professionals.
12. Arrange transportation to the behavioral health clinics, as needed.
13. Establish good relationships with transportation providers, so they will accommodate urgent requests, such as, "Please help me out with this patient on this day. We really need to get them in for an appointment."
14. Involve the family with the patient's permission. Coordinate a meeting with the patient, family, IDT, and physician in a conference room to discuss the patient's symptoms. Collaborate on the treatment plan. Let the family know what is expected to happen and what to look for. Continue conversations after the meeting to monitor progress and provide support.
15. Follow up with patients to see if they have scheduled and kept their appointments.
16. Ask patients if they are willing to share provider names and sign a release of information, so dialysis staff can communicate with the providers to collaborate on working toward the same goals.
17. Engage patients to receive counseling for depression from the social worker, including patients who prefer that approach or who are hesitant to go to an outside counselor:
    a. Offer to meet with patients in the office, via phone, or chairside.
    b. Meet weekly for two to eight sessions.
    c. Use the type of interventions relevant to the patient, e.g., cognitive behavioral therapy, relaxation techniques.
    d. Reassess patients after the sessions. Use the same screening tool before and after treatment.
18. For patients who do not speak English, use translator services and engage the family with the patient's permission.
19. If patients are already receiving treatment for depression, coordinate efforts with their behavioral health providers.
20. Rescreen patients within 30 days of being referred for treatment.
21. Document the treatment plan and monitor progress, e.g., patients verbalizing that they have noticed improvement or feel better and PHQ-9 screenings. Include information gained from patients and families.
22. Discuss findings and symptoms during plan of care meetings.
23. Include discussions of patients with depression in the monthly quality meetings.

PRIMARY DRIVER #3: IMPLEMENT PROCESSES TO ENSURE DEPRESSION IS RECOGNIZED AND TREATED

Secondary Driver #3e: Refer patients for treatment

24. Overcome patient hesitancy to be referred for treatment:
    a. Continue to build rapport, so patients become comfortable talking with staff. Be a constant presence in their lives. Talk with them two to four times a month and check in on them. Engage them in conversations, e.g., "You had a birthday last week." "I remember your granddaughter was coming. Tell me about that."
    b. Tell them, "I appreciate what you told me now. I will check in on you next week."
    c. Try to have patients visualize where they would like to be, e.g., for a patient who is depressed, isolated, and lonely after the death of a spouse, walk the patient through what it would look like going back to church or going to family functions and how that would make the patient feel.
    d. Ask, "Can you identify why you think treatment is not going to be helpful?"
    e. Explain that counseling is having a conversation with somebody to help them work through how they are feeling.
    f. Let them know that therapy is their decision. Continue to have that conversation with them.
    g. Request a meeting with the patient and family to discuss what the staff has noticed about the patient.
    h. Give patients treatment options, e.g., visiting their PCPs who can prescribe medications or share the name of a counselor that another patient has used and liked.
    i. Discuss the hesitancy with the IDT to coordinate the approach.
    j. Offer counseling from the social worker.
25. For patients who are thinking of hurting or killing themselves:
    a. Notify the nurse manager and the nephrologist immediately. Reach out to the nephrologist to facilitate treatment.
    b. Call the social worker who will further assess the patient, contact the family (e.g., to find out if there are any weapons in the home), and formulate a plan.
    c. Follow the dialysis organization's policies on caring for patients in mental health crises to keep them safe from harm.
    d. Once any imminent danger has been addressed, consider developing a safety plan that might include whom the patient would call in a moment of crisis and a list of coping skills.
        - Write out the safety plan and give it to the patient to put in a place where he/she can see it. If the patient starts to feel bad again, the patient can look at it to find resources or emergency help line numbers.
        - Follow up with the patient to see how he/she is feeling.
        - Keep a copy for facility records.

Table 11. Provide Patient Education, So Patients Will Be Receptive to Treatment

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4a: Provide patient education, so patients will be receptive to treatment

Educating patients on mental health and depression from the beginning of dialysis and regularly prepares the way for depression screenings and referrals. Patients realize that depression sometimes accompanies a chronic illness, better understand the need for the screenings, and may be more open to treatment.

Change Ideas

1. For patients new to dialysis, provide written materials, including information on adjusting and living with a chronic illness. Review the stages of change and common feelings when starting dialysis, such as a depressed mood, anxiety, or anger. Include families or caregivers in the education.
2. Engage physicians to educate patients on depression during rounds.
3. Provide education one-on-one, including written materials. Sit with patients and discuss mental health, depression, symptoms of depression, barriers that interfere with their care, and tools to manage depression, anxiety, or post-traumatic stress disorder (PTSD).
4. Utilize resources from a variety of sources, e.g., the Dialysis Patient Depression Toolkit from the National Forum of ESRD Networks, flyers and materials from the ESRD Network, resources from dialysis corporate offices, and resources from the National Kidney Foundation.
5. Accommodate patients' needs:
    a. Make materials available in large font for patients with visual difficulties.
    b. Share materials at a lower reading level for patients with low literacy.
    c. Communicate in the patient's language by using an interpreter, a phone translation service, or a video translator via tablet where the patient and the translator can see each other.
    d. Provide materials in the patient's language.
6. Consider the patient's culture, e.g., Hispanic patients that may be resistant to seeing a behavioral health professional.
7. Use bulletin boards in the lobby and above the patient scale. Include information on reasons for missed treatments, such as depression, and tips on how to talk to nurses or the social worker about feelings.
8. Place folders at the bottom of the bulletin boards with handouts for patients who do not want to talk to the social worker.
9. Schedule monthly educational sessions with the social worker around mental health, e.g., stress, depression.
10. In May, focus on Mental Health Awareness Month and talk about what depression can look like, how to manage feelings, and ways to cope with depression.
11. Organize a health fair and ask the behavioral health clinic to come to the facility to provide education and pamphlets and information about support groups.

Table 12. Equip Staff With Knowledge to Screen and Refer Patients for Treatment

PRIMARY DRIVER #4: EDUCATE PATIENTS AND STAFF
Secondary Driver #4b: Equip staff with knowledge to refer patients for treatment
Staff who are educated on depression understand the complexities of depression and will be able to identify patients who may be depressed, either through screening or observation. This could result in more patients with depression being referred for treatment. **Change Ideas** 1. Provide annual training on sexual orientation and cultural diversity and incorporate examples as they relate to depression screening and referral, e.g., a Muslim male may not be open to suggestions from women, or a Cambodian male may be seen as the strong one in the family and may not be willing to talk about his mental health. Offer cultural competency training in monthly staff meetings. 2. Educate staff on depression annually, including the stigma surrounding diagnosis and treatment. 3. Educate staff during huddles. a. Ask the social worker to share information on signs that patients may be depressed, such as a change in a patient's behavior or a patient comment that could indicate depression. b. Discuss concerns about individual patients and how to address them. 4. Instruct staff to convey information about patients that could indicate depression to the social worker or nurse. 5. Explain how depression could manifest itself as noncompliance. Dive into why patients are missing treatments. 6. Share handouts, articles, or other educational materials on mental health and how it impacts a patient's life, depression (e.g., symptoms, treatment), grief, elder abuse, and compassion fatigue. 7. Take advantage of teachable moments, e.g., if a patient that dresses nicely comes in with mismatched shoes, coach the staff to spend extra time with the patient and get to the root cause through general questions, such as, "How are you doing?" "How is your family?" 8. Have the social worker work 1:1 with staff as they relate patient concerns that might be signs of depression, e.g., which questions to ask, how to ask the questions. 9. During weekly IDT meetings, address mental health topics, such as the effect of negative strong family members on patients.

V. Conclusion and Next Steps

The ideas presented in this change package are being implemented in high-performing dialysis facilities across the United States. These ideas can be tailored and adapted to fit the needs of dialysis facilities and the patients with ESRD that they serve across the country.

As with any change, a best practice is to start small and build improvement toward systemic change. Facilities can start with one test of change and do it well. This will relieve the burden on staff and encourage buy-in when change begins. Measuring and monitoring performance improvement will ensure the facility stays on track with goals. Celebrating every success with staff, patients, families, and community partners at every change will be contagious. Above all, the best time to start performance improvement is now. With this change package in hand, program leaders, administrators, and staff should ask themselves, "What can I do by next Tuesday to get this started?"

VI. References

1. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi. Accessed February 5, 2020.

2. Institute for Healthcare Improvement. *QI Essential Toolkit* [ebook]. 2017; pp. 7–8. Available at: http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx?utm_campaign=QI-Toolkit-Promotion&utm_medium=Whiteboard-Video&utm_source=ihi. Accessed February 5, 2020.

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