

This work was written as part of one of the author's official duties as an Employee of the United States Government and is therefore a work of the United States Government. In accordance with 17 U.S.C. 105, no copyright protection is available for such works under U.S. Law. Access to this work was provided by the University of Maryland, Baltimore County (UMBC) ScholarWorks@UMBC digital repository on the Maryland Shared Open Access (MD-SOAR) platform.

Please provide feedback

Please support the ScholarWorks@UMBC repository by emailing scholarworks-group@umbc.edu and telling us what having access to this work means to you and why it's important to you. Thank you.



Barriers and facilitators to depression screening in older adults: a qualitative study

Erin M. Colligan, Caitlin Cross-Barnet, Jennifer T. Lloyd and Jessica McNeely

Centers for Medicare and Medicaid Services, Baltimore, Maryland, USA

ABSTRACT

Objectives: The objective of this qualitative study was to better understand facilitators and barriers to depression screening for older adults.

Methods: We conducted 43 focus groups with 102 providers and 247 beneficiaries or proxies: 13 focus groups with Medicare providers, 28 with older Medicare beneficiaries, and 2 with caregivers of older Medicare beneficiaries. Each focus group was recorded, transcribed, and analyzed using principles of grounded theory.

Results: There was widespread consensus among beneficiary and provider focus group participants that depression screening was important. However, several barriers interfered with effective depression screening, including stigma, lack of resources for treatment referrals, and lack of time during medical encounters. Positive communication with providers and an established relationship with a trusted provider were primary facilitators for depression screening. Providers who took the time to put their beneficiaries at ease and used conversational language rather than clinical terms appeared to have the most success in eliciting beneficiary honesty about depressive symptoms. Respondents stressed the need for providers to be attentive, concerned, non-judgmental, and respectful.

Conclusion: Findings indicate that using person-centered approaches to build positive communication and trust between beneficiaries and providers could be an effective strategy for improving depression screening. Better screening can lead to higher rates of diagnosis and treatment of depression that could enhance quality of life for older adults.

ARTICLE HISTORY

Received 18 May 2018

Accepted 29 September 2018

KEYWORDS

Depression; mental health assessments; qualitative research; psychosocial and cultural aspects

Introduction

Nearly thirteen percent of adults aged 65 and older experience depressive symptoms (Federal Interagency Forum on Aging-related Statistics, 2016), with rates higher in older adults with comorbid chronic conditions (Ewald, Loganathan, Hasche, & Lochner, 2017; Park & Unutzer, 2011). Depression may worsen physical health, both because of underlying psychobiological changes related to depression and an increased risk for conditions such as obesity, sedentary lifestyle, smoking, and poor adherence to medical treatments (Katon, 2011). Depression may be missed by clinicians because it manifests differently in older adults. For instance, older adults may interpret affective, somatic and cognitive symptoms of depression such as fatigue, sleeping difficulties, and changes in memory as part of the typical aging process (Fiske, Wetherell, & Gatz, 2009). Left untreated, depression in older adults can lead both to loss in functional status and quality of life and to loss in quality-adjusted life years (Noel et al., 2004; Unutzer et al., 2000). Untreated depression can also lead to death from suicide. An average of 58% of older adults who commit suicide had contact with primary care providers the month before death and 77% had contact with a primary care provider the year before death (Luoma, Martin, & Pearson, 2002).

Despite the wide availability of effective treatments for depression and virtually universal health insurance coverage for older adults in the U.S. under the Medicare program,

depression in older adults remains underdiagnosed and undertreated (Barry, Abou, Simen, & Gill, 2012; Byers, Areal, & Yaffee, 2012; Small, 2009). Because older adults are less likely than younger patients to seek treatment (Klap, Unroe, & Unutzer, 2003), primary care can be an ideal setting for identifying depressive symptoms and addressing depression. Approximately two-thirds of older adults treated for depression obtain their treatment—which can involve either medication or referral for psychotherapy—from a primary care physician (Harman, Veazie, & Lyness, 2006).

As of 2011, annual depression screening in primary care has been covered by Medicare at no cost to beneficiaries (Centers for Medicare and Medicaid Services, 2018). The Affordable Care Act (ACA) requires all services rated A or B by the United States Preventive Services Task Force be covered by Medicare without co-pays (Cassidy, 2010). The ACA established codes for billing for depression screening, formally recognizing the need for routine screening in older adults. Despite these policy changes, use of the benefit in Medicare fee-for-service (FFS) remains low, with only 3% of beneficiaries receiving a visit specifically addressing depression screening in 2016 (Lloyd, 2018). Medicare also covers an initial “Welcome to Medicare” (WMV) visit and an Annual Wellness Visit (AWV) where routine depression screenings can be administered. Therefore, an additional 22% of Medicare FFS beneficiaries may have been screened for depression in 2016 as part of their annual preventive visit (Misra, Lloyd, Strawbridge, & Wensky, 2018).

There are no published studies specifically assessing provider perspectives on depression screening in older adults. Prior quantitative research has suggested potential patient-level reasons for low uptake, including stigma associated with seeking help for mental health problems (Conner et al., 2010; Segal, Coolidge, Mincic, & O'Riley, 2005). The literature suggests that stigma around screening and treatment may be even more pronounced in vulnerable populations. For instance, Asian-American and Hispanic older adults report greater embarrassment over seeking help for mental illness than non-Latino whites (Jimenez, Bartels, Cardenas, & Alegria, 2013). For African-Americans, mistrust of the medical system and poor patient-provider communication serve as additional barriers to seeking treatment for depressive symptoms (Conner et al., 2010; Jimenez, Bartels, & Alegria, 2013; Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014).

In light of recent policy changes, it is possible that providers and older adults have increased awareness and access to resources related to depression and that perspectives may have changed among more recent cohorts of Medicare beneficiaries. Perspectives may also vary among patients according to their cultural values, beliefs, and practices, and by race/ethnicity, rural/urban status, or sexual orientation, among other factors. The purpose of this study is to examine current perspectives from a diverse array of both Medicare providers and beneficiaries regarding the availability, uptake, and use of depression screenings within a primary care setting. By illuminating potential facilitators and barriers to effective depression screening, practitioners can better identify and treat depression in older adults and address an important public health concern.

Methods

Design

In order to better understand facilitators and barriers to depression screening and other preventive services in older adults, we conducted three waves of focus groups with diverse Medicare beneficiaries and providers. Soliciting input from both providers and beneficiaries allowed assessment of a broad perspective regarding factors that affect depression screening at the beneficiary, practice, system, and societal levels. The focus group format allowed us to explore the use of preventive services in depth and observe agreement and disagreement among participants over key issues. We specifically included minority populations, including those that the literature indicates have lower rates of screening and treatment, such as African-Americans, Hispanics, and Southeast Asians.

Sampling and recruiting

We conducted 43 focus groups with 102 providers and 247 beneficiaries or proxies in three waves. Details for composition of all focus groups are provided in Tables 1–4.

The authors first conducted 3 focus groups of 10 to 15 participants with convenience samples of providers who were attending national meetings. This research was IRB exempt per Section 45 Code of Federal Regulations 46.101[b][5] because it was conducted on behalf of a

Table 1. Beneficiary focus groups, 2016–2017.

	Target Population	Location	N
1	English-speaking Hispanics	Bethesda, MD	9
2	African-Americans	Bethesda, MD	8
3	English-speaking Hispanics	San Antonio, TX	9
4	Spanish-speaking Hispanics	San Antonio, TX	9
5	English-speaking Hispanics	Los Angeles, CA	8
6	Spanish-speaking Hispanics	Los Angeles, CA	8
7	Lesbian, Gay, Bisexual, Transgender	Los Angeles, CA	9
8	Lesbian, Gay, Bisexual, Transgender	Atlanta, GA	8
9	Dual Eligibles	Detroit, MI	10
10	African-Americans	Detroit, MI	10
11	Rural	Miles City, MT	8
12	Dual Eligibles	Billings, MT	9
13	Dual Eligibles	Omaha, NE	10
14	Rural	Grand Island, NE	8
15	Dual Eligibles	Vicksburg, MS	8
16	African-Americans	Vicksburg, MS	4
17	Various	Baltimore, MD	8
18	Various	Baltimore, MD	8
19	Various	Baltimore, MD	8
20	Various	Memphis, TN	8
21	Various	Memphis, TN	8
22	Various	Memphis, TN	8
23	Various	Miami, FL	8
24	Various	Miami, FL	8
25	Various	Miami, FL	8
26	Various	New York, NY	8
27	Various	New York, NY	8
28	Various	New York, NY	8
	Total		231

public benefit program. However the researchers followed standard ethical protocols, including reading a statement about the purpose of the research and the voluntary nature of participation at the beginning of focus groups, obtaining verbal consent for participation and recording by respondents, and ensuring anonymity of participants. One group included a demographically diverse range of providers that included physicians, nurses, pharmacists, social workers, and other health workers. A second group included only African American physicians. The third included only osteopaths.

The second and third waves of focus groups were conducted in accordance with IRB procedures established by contractors that convened and conducted groups. Procedures included an explanation of the purpose and voluntary nature of the research, followed by participants' signing informed consent to be interviewed and video recorded. The authors attended some of these groups in-person and observed the others through live-streaming.

The second wave included 12 focus groups, three each in 4 metropolitan areas in eastern and southern states. Local focus group recruitment firms used their databases to convene groups of 8 participants, most of whom were white or African American, with a smaller number of Hispanics. Groups were balanced between men and women and between beneficiaries who were had enrolled in Medicare within the prior two years and those who had been enrolled for two years or longer. All participants were 65 or older.

In order to gain a diverse array of perspectives from a variety of provider types and both typical and vulnerable populations in Medicare, the final wave included purposively sampled groups from across the United States and represented metropolitan and rural populations. Eighteen groups consisted of English or Spanish-speaking beneficiaries from a specific demographic: African-American; Hispanic; Asian-American; rural; gay, lesbian, bisexual,

Table 2.

	Age		Sex		Race					Education		
	Under 65	65+	Male	Female	White	African-American	Hispanic	Asian	Other	High School or Less	Some College	4-year degree or more
	N											
Salter Mitchel Groups	96	0	42	54	41	41	11	0	3	17	57	22
English-speaking Hispanics	9	0	4	5	0	0	9	0	0	0	2	7
African-Americans	8	0	4	4	0	8	0	0	0	1	6	1
English-speaking Hispanics	9	0	4	5	0	0	9	0	0	4	4	1
Spanish-speaking Hispanics	9	0	4	5	0	0	9	0	0	0	2	7
English-speaking Hispanics	8	0	3	5	0	0	8	0	0	4	3	1
Spanish-speaking Hispanics	8	0	4	4	0	0	8	0	0	7	0	1
LGBT	9	0	6	3	4	4	1	0	0	1	3	5
LGBT	8	3	6	2	5	3	0	0	0	1	4	3
Dual Eligibles	10	1	5	5	2	8	0	0	0	4	5	1
African-Americans	10	0	5	5	0	10	0	0	0	5	2	3
Rural	8	0	2	6	8	0	0	0	0	2	2	4
Dual Eligibles	9	4	3	6	9	0	0	0	0	6	2	1
Dual Eligibles	10	2	2	8	7	1	0	1	1	3	3	4
Rural	8	0	2	6	8	0	0	0	0	3	2	3
Dual Eligibles	8	0	1	7	1	7	0	0	0	5	3	0
African-Americans	4	0	1	3	0	4	0	0	0	2	2	0

Table 3. Provider Focus Groups, 2016–2017.

	Target Population	Location	N
1	Small Practice Physicians	San Antonio, TX	6
2	Large Practice Physicians	Virtual	5
3	Nurse Practitioners and Physician Assistants	Atlanta, GA	7
4	Nurse Practitioners and Physician Assistants	Virtual	6
5	Small Practice Care Team	Virtual	5
6	Large Practice/Community Clinic Care Team	Detroit, MI	8
7	Large Practice/Community Clinic Care Team	Virtual	7
8	Small Practice Care Team	Omaha, NE	3
9	Nurse Practitioners and Physician Assistants	Billings, MT	8
10	Primary Care Providers	Jackson, MS	10
11	Various	Washington, DC	15
12	African American Physicians	Washington, DC	12
13	Osteopaths	Washington, DC	10

Table 4. Caregiver Focus Groups, 2017.

	Target Population	Location	N
1	Southeast Asian Caregivers	Long Beach, CA	8
2	Southeast Asian Caregivers	Long Beach, CA	8

transgender, and queer (LGBTQ); or dually eligible for Medicare and Medicaid. Two additional groups consisted of English-speaking caregivers of older Southeast Asian Medicare beneficiaries who spoke a variety of languages. All groups included men and women and represented beneficiaries of varying ages (ranging from 65 to over 90). Ten provider groups, some in-person and some virtual (to increase geographic representation) consisted of providers from large, medium, and small practices. Some groups targeted primary care providers, including physicians, nurse practitioners (NPs) and physician assistants (PAs); others targeted ancillary providers such as nurses, medical assistants, and community health workers. In most cases, market research firms conducted recruitment, screened participants, and provided facilities for the focus groups, but in limited situations, local organizations were used to assist in recruitment of certain groups such as rural beneficiaries.

Procedure

The initial three provider focus groups used open ended questions to address barriers and facilitators to preventive services. Groups began with a brief presentation to identify key priority services, including depression screening. Initial coding of these groups informed development of a more structured focus group guide for general beneficiary focus groups and further groups with providers. The guide addressed three primary topics: awareness of preventive services; barriers and facilitators to accessing or using the services; and questions on specific services, including depression. Groups included a chart of priority services as a prompt and featured questions regarding how participants obtained information on preventive services and which services they had received. The final groups with vulnerable populations added further specific prompts on priority services, including depression. Providers were asked about which services they offered or suggested and which they were able to provide "in house." For all three waves, a trained moderator facilitated each session; sessions lasted approximately 90 minutes. One to three additional researchers attended focus groups as observers and note-takers. All groups were digitally recorded. Focus group

recordings were used to create full transcripts and summaries.

Analysis

The previous literature is devoid of provider perspectives on depression screening and has usually assessed patient uptake quantitatively. Given the dearth of prior research, the authors used a systematic grounded theory approach (Strauss & Corbin, 1998) to analyze notes and transcripts from the initial wave of interviews with providers. During the open coding phase, the lead researcher read all transcripts and notes to identify emergent themes. Major themes were categorized and subcoded during the axial phase; for instance, references to specific services emerged as their own codes, and depression became a subcode under specific preventive services. Using the axial codes to identify priority information, the research team developed summary memos of each transcript, which we entered in Dedoose (2018) in order to allow for selective coding.

The following two waves made use of the code tree established in wave 1. Using Dedoose, respective contract staff used closed coding to identify key information in each of the focus groups they conducted. Closed codes, following the structure of the focus group guide, included awareness, barriers, facilitators, providers, sources of information, and specific services. Each “parent” code was followed by “child” and sometime “grandchild” subcodes (Dedoose, 2014). The parent code “specific services” had a child code for each category of services, including one for behavioral screening and counseling, which in turn had grandchild codes for alcohol use, obesity counseling, tobacco cessation, and depression. After initial closed coding was complete, the authors reviewed transcripts and met collectively to add to the codes through a consensus process. Previous qualitative work has either addressed a general beneficiary population or focused on a specific vulnerable group. Thus, given our data’s breadth, the authors allowed for further open coding, informed by a more constructivist approach (Charmaz, 2006) to identify new core phenomena that aligned with patient values and experiences, such as culturally specific attitudes toward individual services or healthcare in general and patient-provider trust. The lead researcher reviewed all final coding for consistency.

The analysis of depression involved a review of all coded data related to depression, general facilitators and barriers to preventive care, and emergent axial codes related to trust and stigma. In addition, we conducted a word search in all other data for “depress[ion][ed],” “mental[ly],” “behavior[al],” “sad[ness],” “feeling[s],” “trauma[tic],” “death,” “die[d],” “counsel[ed][or][ing],” “psych[ology][ologist][iatrist] [osocial],” “substance abuse,” “addict[ed][ion],” and “social worker” to identify relevant segments for the research. The lead author, with review and input from co-authors, used selective coding informed by a constructivist approach to conduct the final analysis.

Results

Medicare providers and beneficiaries generally agreed on the importance of depression screening but reported different experiences with administering or receiving the

screening. Stigma, previously identified as a barrier to seeking treatment, emerged as a barrier to offering or accepting preventive screening. Both providers and beneficiaries also identified limited resources as a barrier to offering depression screening effectively. Our data revealed that both providers and patients believe that individual approaches, trust and familiarity based on established provider-beneficiary relationships, and cultural sensitivity can facilitate effective depression screening.

Experience with depression screening

Despite research that indicates many older adults are reluctant to address mental health, focus group participants expressed widespread consensus that depression screening was important. As one rural beneficiary noted, “physical health and mental health walk hand in hand,” a theme echoed in numerous other groups. Some respondents thought depression screening could detect social isolation. Other beneficiaries noted that depression screening is crucial for suicide prevention, one cautioning, “There is danger of death, that people with depression commit suicide. So for me it is very important.” Another respondent added that depression can affect a whole family, which they felt provided an additional incentive to be screened and treated.

Despite their agreement over the importance of depression screening, participants’ experiences with screening were mixed. Though most providers reported administering depression screening in some capacity, beneficiaries were split over whether or not they had received screenings, with no obvious trends by group or region. Responses indicated that some beneficiaries may not have been aware that they were being screened. Some providers used general language without formally discussing depression, which some indicated they did to avoid confronting stigma. One beneficiary who said she had not been screened for depression said her provider always asked “are you eating, sleeping, are you active,” but that she thought this was just conversational talk.

Regardless of whether or not they believed that they had ever received screening, beneficiaries generally reported being amenable to the idea of depression screening. Even beneficiaries who indicated they would refuse screenings said they wanted their providers to offer the screenings.

Barriers: stigma of mental illness

Although beneficiaries agreed that depression screening was important and should be offered, the most common barrier discussed by both providers and beneficiaries across all settings and geographical areas was the stigma associated with depression and mental illness. Providers discussed the difficulty not only of offering screening but also of obtaining accurate results from any screening that they conducted. As an NP explained, “I see that it is a lot harder for the folks over 65 to admit that they are experiencing depression. A lot of them are on a lot of medications for other illnesses, but they get depressed—even dealing with the pain can trigger depression—but they won’t admit it.” Another NP noted, “I think that it is hard for older people

because they may not believe in mental health, and so as provider you have to get over that cultural hump. They don't want to be labeled with that. If you use the word 'depressed,' you see the wall go up." One PA said, "Depression is like the big 'D' word. Don't mention depression to them" and referred to the "pull yourself up by your bootstraps" mentality of his rural, white beneficiaries.

Providers sensed that their beneficiaries were particularly fearful of a mental health diagnosis being in their medical records or leading to unintended consequences. One beneficiary cautioned, "I hate the questions about suicide and whether you are going to harm someone. Sometimes you put the answers they want to hear because you don't want to be admitted." Some providers noted that reluctance to discuss depression was most acute among African-American, Hispanic, LGBTQ, and rural beneficiaries. In addition to age, gender appeared to add an additional barrier to openly discussing depressive symptoms. One physician noted that, older white men were particularly likely to be resistant, commenting, "It is still taboo for older men to be depressed."

Most beneficiaries confirmed providers' perception of stigma. Some expressed discomfort with discussing depression with their providers because of "embarrassment." Other beneficiaries emphasized the personal nature of mental health and preferred to talk about their problems with their friends rather than their medical providers. Many beneficiaries indicated that addressing depression was an individual responsibility. Some stressed that staying busy was the best way to manage depression. Another said, "I think psychologists are for people who can't help themselves." There was widespread agreement among caregivers of Southeast Asian beneficiaries that their family members would have difficulty discussing mood and feelings because these discussions are taboo. As one noted, "Older generations – they like to keep it to themselves. They don't want to talk about it – how much pain it is, they keep it in their heart." The caregivers also explained that though their parents (the beneficiaries) had experienced traumatic events in their countries of origin, cultural norms prevented discussing depression, and their parents didn't understand mood as something relevant to health care in any case. Beneficiaries generally felt that discussing "stress" was easier than focusing on "depression."

Barriers: limited resources

Another obstacle to effective screening for depression was an adequate supply of mental health practitioners to provide treatment. Not surprisingly, providers in rural areas noted a dearth of mental health professionals able to serve their beneficiaries. One PA in a rural area noted that once a depression diagnosis was made, a lack of psychiatrists and therapists often made a referral impossible, a point echoed by others in the group. Beneficiaries in rural areas also commented on the lack of mental health providers in their areas and cited this as a barrier to seeking screening and treatment. One rural participant indicated that that waits to see a new psychiatrist or therapist were typically at least 6 to 8 weeks even in more densely populated areas, and that the availability of providers and wait times were even worse outside the "city." However, the lack of

mental health practitioners was not confined to rural areas. Beneficiaries in an urban area cited difficulty in scheduling appointments with mental health professionals and wait times that could be 6 months to a year. Asian-American caregivers in an urban area also referred to long lag times between referrals and appointments. One physician noted that systems like the Veterans Administration (VA) where physicians can seamlessly make referrals to behavioral health specialists were ideal in order to ensure a "warm hand off," but that such hand offs were not usually available to typical Medicare beneficiaries.

Providers and beneficiaries both cited lack of time during appointments as a hindrance to depression screening. One physician observed what she described as a common complaint among her peers:

"I can't do that because if I get a positive, it's going to make my visit 20 minutes longer and I can't do that in my practice because ... once they get a flag, they have to do a deeper drill down and then they have to look at a referral or call in the social worker or all these other things that frighten them. So rather than having to blow up their day on one patient, they don't do it. And you know, they know it's wrong. But at the same time, they just feel, 'I've got a waiting room full of people. And if I have one suicidal person, that's going to push all of those people for the day.'"

An NP commented that when a beneficiary screens positive for depression, the provider needs additional time to offer counseling, but the 15-30 minute window allotted for primary care visits is inadequate. Another physician explained that the Annual Wellness Visit, which covers depression screening among other preventive services, actually takes 1 hour but the providers only have a half hour at most. One small practice physician indicated higher costs involved in offering potentially time consuming services, stating, "In a practice like mine, I see as many people as possible ... If you received more compensation to spend more time with your patients, you could do all of that."

Beneficiaries also referred to the lack of time in primary care visits to address depression. As one noted, time with their doctor only allowed discussion of their immediate health problems, so ongoing conditions like depression weren't a priority. Beneficiaries sometimes felt dehumanized by the fast pace of clinical visits. One beneficiary quipped, "They only see you for eight minutes, like cattle." Another respondent indicated that they preferred NPs and PAs to doctors because, "they would actually take a moment to ask you about mood and feelings." Some beneficiaries equated lack of time with lack of concern or compassion. There was a perception among a few participants that time constraints hampered providers' bedside manner, for instance, that providers were too focused on documentation rather than making personal connections with beneficiaries or even looking at or touching them.

Facilitators: sensitive communication

In addition to barriers, providers and beneficiaries discussed several facilitators to depression screening. Some providers successfully mitigated stigma and discomfort in discussing depression through conscious efforts toward sensitive communication and building trusting relationships. One NP observed that beneficiaries often reacted to a suggestion that they were depressed with statements

like “Oh no, I’m not crazy.” Providers agreed that they must approach the topic of depression delicately. Another NP said, “I think it’s the way you ask [about depression], the way you’re talking to them, and one thing just opens up something else.” She further explained, “[another provider] may not be able to get them to open up but then I approach them totally different (sic) and something hits... I think it just depends on, can you meet them where they are, and can you really relate?” Still another NP suggested that general terms such as those in the PHQ-9 (Kurt Kroenke, Spitzer, & Williams, 2001), which asks if a respondent is feeling “hopeless or down,” were easier for beneficiaries to admit to than “depression.” Another commented that going through the PHQ-9 allowed for more time to make the beneficiary comfortable so that they would be more likely to be honest. One medical assistant in a large practice suggested prefacing the screen with, “Hey, I ask every single patient this. I don’t want you to feel like I’m intruding in your personal life.”

Beneficiaries also stressed the importance of how depression was addressed. As one observed of her providers, “absolutely you can feel some have bedside manner... and some, it feels like an assembly line, a machine, and so sometimes I was saying I won’t volunteer information about moods and feelings... It all depends on the personality.” Another agreed that it is better to ask about mood in a “roundabout way” because, “If they come out and ask straight out are you depressed, everyone is going to say no.” Other beneficiaries had different preferences about how they wanted providers to address depression. For instance, one suggested that providers should be “straight up” in talking about depression, while another indicated a written questionnaire that could be discussed in a follow up was preferable to the provider asking directly.

Facilitators: established Provider-Beneficiary relationships

Communicating about depression sensitively and having an established relationship with and trust in the provider were cited as important facilitators for depression screening. One physician in a large practice explained that they may not do depression screening on the first or second visit with a beneficiary, but rather on a follow-up visit once they have built rapport. A medical assistant in another large practice explained that it was easier to discuss sensitive topics like depression with beneficiaries who had been with the practice for a long time. One PA said they had gone so far as to share their own experience with mental health issues to put beneficiaries at ease. An NP observed, “Even if they don’t tell you on the questionnaire, you might get through (to) them... you have some that will come multiple visits, so you can kind of tell, is there something really wrong, or they’re lonely.” Some providers noted that establishing trust is especially important with African American beneficiaries, who often have a mistrust of the medical system as a result of a long history of discrimination and exploitation.

Beneficiaries also noted the importance of having an established relationship with a provider in order to facilitate conversations about depression. Rural beneficiaries noted that their providers know them well because they

live in small communities, and so their providers often knew if they were depressed. Racial and ethnic minority respondents particularly noted the importance of relationships and trust. An African-American beneficiary noted, “When you talk about someone’s psyche you have to know the person to detect that.” Another African-American beneficiary explained, “I am going to a doctor where I can deal with a doctor on a one-on-one basis so you can build a rapport, and there are some people you would feel more comfortable talking to about some of this stuff.” A Hispanic respondent noted, “If you can be open with your doctor, you feel more comfortable.” Another Hispanic participant explained that they had better relationships with providers in their country of origin because they would have “conversations” rather than rushed clinical encounters.

Discussion

Providers and beneficiaries identified several barriers that interfere with effective screening at the cultural, structural, and individual levels. The stigma of mental illness influences providers’ willingness to administer screening and beneficiaries’ receptiveness to being screened. Addressing this barrier requires the development of positive communication and trust between providers and beneficiaries. This kind of trust and communication is inextricably tied to time, as it takes time to build trust, but our current health structure emphasizes short, routinized appointments and requirements for charting that often have a provider facing a computer screen rather than the beneficiary. Given different, often individual or culturally specific, beneficiary preferences for how to broach the subject of depression, there is not a one-size-fits-all method that will work for all beneficiaries. Applying a routinized approach could feel dehumanizing for beneficiaries, as when they said that care was “like an assembly line” or that patients were treated “like cattle.” However, some providers, particularly NPs and PAs, identified strategies for building trust through subtle language changes and tailored methods of approaching sensitive topics, which beneficiaries often found more palatable than a focused depression screen. In particular, they discussed avoiding language that beneficiaries associated with stigma, such as the word “depression” itself, which beneficiaries sometimes associated with being labeled as “crazy.” Questions about depressive symptoms such as sleep and eating patterns or general stress were often interpreted as more conversational and less threatening to a patient’s identity around their health or their personal strength. An essential goal is for providers to build rapport with their beneficiaries so that they can get to understand their respective preferences, build trust, and choose the most effective approach. Using an appropriate instrument in a sensitive manner is an especially important consideration for depression screening with non-English speaking populations.

At the structural level, the lack of referral resources in addition to inadequate time during appointments made it logistically challenging for providers to attend to depression screening needs. The nationwide shortage of mental health providers affects primary care providers’ willingness to screen and was noted as an issue in both urban and rural areas. Screening goes hand-in-hand with treatment,

and without sufficient mental health resources to treat the beneficiary, providers may feel screening is not useful. The dearth of resources speaks to a structural devaluation of mental health, which can in turn exacerbate individuals' feelings that mental health is not really part of health or that mental health problems are rare and stigmatizing. Mitigating these barriers necessitates larger scale change in healthcare delivery.

Despite the prevalence of depression and availability of effective pharmacological and psychological interventions, barriers such as stigma remain a critical obstacle in pursuing screening in older adults. Many older beneficiaries across all racial, language, socioeconomic, and geographical groups in this study were fearful of being labelled as depressed, consistent with previous research of depression in older adults (Conner et al., 2010; Jimenez et al., 2013; Segal, Coolidge, Mincic, & O'Riley, 2005; Sirey, Franklin, McKenzie, Ghosh, & Raue, 2014). Beneficiaries were particularly afraid of having a depression diagnosis in their medical records, which could be accessed by people other than their personal provider. Thus, even when a patient had a trusting relationship with their primary care provider, they did not necessarily trust that their information could be kept private from entities they did not trust, such as an unfamiliar provider or their insurance company. Providers, in turn, assumed beneficiaries were not comfortable talking about depression, and as a result, many either avoided screening or conducted an impersonal, cursory screening without follow through. Such an approach allowed a provider to state that they had provided the service but did not ensure beneficiaries received appropriate care.

Even when beneficiaries has a trusted provider, revealing a stigmatized condition such as depression could be difficult. A predominant theme in the general discussions of preventive screenings in our focus groups was that beneficiaries often built trust with providers they had seen many times but were unlikely to trust providers when they saw someone different at each visit. Not only did lack of continuity make beneficiaries more reluctant to discuss sensitive topics such as depression, it also prevented effective longitudinal follow up to determine if treatments were working or needed to be adjusted. Provider continuity can facilitate open discussions about mental health and potentially improve the willingness of beneficiaries to accept help. Continuity can also allow a provider to track a beneficiary's mood or demeanor and recognize changes that may signify depression. Beneficiaries may be more willing to report changes that indicate depression—even if they don't self-identify as depressed—to a provider they know.

Another implication of our findings is the potential benefit of team-based approaches to depression and other preventive screenings in order to address the structural barrier of insufficient time. Physicians in one of our focus groups also noted that physicians' training does not emphasize preventive health and suggested that strategic incorporation of nurses, PAs, and social workers into care teams would improve preventive care. NPs and PAs often reported having longer appointment times than physicians, with some typically having 30 minute slots rather than only 15 minutes, which allowed more time to address preventive care and conduct screenings. When appointment times are short, delegating some screenings to support staff such as

nurses and medical assistants can ease time burdens. Having a team-based approach may also lead to a more holistic treatment of the beneficiary that spans the spectrum of prevention and treatment.

Finally, addressing the shortage of mental health providers in the US is a critical step in any approach to improve depression screening in older adults. This includes strategic compensation for providers, better coverage of mental health services by insurers, and innovative strategies to improve access to mental health services. For instance, telehealth consults for mental health may help to bridge barriers to access, especially in rural communities (Perle & Nierenberg, 2013; Straus & Sarvet, 2014). Co-locating mental health providers within primary care settings and the use of care coordinators have also been shown to be effective in integrating mental health and primary care (McGough, Bauer, Collins & Dugdale, 2016; Thielke, Vannoy, & Unützer, 2007). Additionally, specialized, targeted training for primary care providers could allow them to offer more mental health services themselves, as most are already able to prescribe psychotropic medications independently.

Limitations

This study has several limitations worth noting. While the sample of providers and beneficiaries that participated in focus groups was broad and diverse, the opinions expressed by respondents may not be representative of the whole population of Medicare providers and beneficiaries. Findings are subject to selection bias, as those who chose to participate may have characteristics different than those of the average provider or beneficiary. Additionally, as the focus groups addressed a variety of preventive services, we may not have delved into the barriers and facilitators to depression specifically in sufficient depth to elicit all relevant themes. Despite these limitations, this study provides valuable perspectives on depression screening a few years after ACA policy changes were implemented that were intended to increase preventive screenings among beneficiaries and providers throughout the U.S.

Conclusions

Older adults are underdiagnosed and undertreated for depression. This study suggests two primary reasons for this phenomenon, namely the stigma associated with depression and the lack of sufficient resources for adequate attention in primary care or referral to specialty mental health services. Strategies to address these barriers include improving beneficiary-provider communication; individualized approaches; establishing provider continuity and trust; innovative, beneficiary-specific approaches to mental health services to overcome access issues; and broadening Medicare access to mental health professionals.

Acknowledgments

The authors would like to acknowledge the assistance of L&M Policy Research, Salter Mitchell, and the CMS Office of Communications in conducting focus groups.

Disclosure statement

No potential conflict of interest was reported by the authors.

Funding

This work was supported by the Centers for Medicare and Medicaid Services under Contract Number HHSM-500-2011-00019L.

References

- Barry, L. C., Abou, J. J., Simen, A. A., & Gill, T. M. (2012). Under-treatment of depression in older persons. *Journal of Affective Disorders, 136*(3), 789–796.
- Byers, A. L., Arean, P. A., & Yaffe, K. (2012). Low use of mental health services among older Americans with mood and anxiety disorders. *Psychiatric Services, 63*(1), 66–72.
- Cassidy, A. (2010). Preventive services without cost sharing. *Health Affairs: Health Policy Brief*, Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20101228.861785/full>
- Centers for Medicare and Medicaid Services. (2018). Depression screenings. Retrieved from <https://www.medicare.gov/coverage/depression-screenings.html>.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., & Brown, C. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *American Journal of Geriatric Psychiatry, 18*(6), 531–543.
- Dedoos. (2014). Code systems are serious business. Retrieved from <https://www.dedoos.com/blog/code-systems-are-serious-business>
- Dedoos Version 7.0.23. (2018). *Web application for managing, analyzing, and presenting qualitative and mixed method research data*. Los Angeles, CA: SocioCultural Research Consultants, LLC.
- Ewald, E., Loganathan, S., Hasche, J., & Locher, K. (2017). Access to care among Medicare beneficiaries with and without depression. *MCBS Data Highlight*, Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/ATC_Depression_2017.pdf.
- Federal Interagency Forum on Aging-related Statistics. (2016). *Older Americans 2016: Key Indicators of Well-Being*. Washington, DC: Government Printing Office.
- Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual Review of Clinical Psychology, 5*, 363–389.
- Harman, J. S., Veazie, P. J., & Lyness, J. M. (2006). Primary care physician office visits for depression by older Americans. *Journal of General Internal Medicine, 21*(9), 926–930.
- Jimenez, D. E., Bartels, S. J., Cardenas, V., & Alegria, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care. *International Journal of Geriatric Psychiatry, 28*(10), 1061–1068.
- Katon, W. J. (2011). Epidemiology and treatment of depression in patients with chronic medical illness. *Dialogues in Clinical Neuroscience, 13*, 7–23.
- Klap, R., Unroe, K. T., & Unutzer, J. (2003). Caring for mental illness in the United States: a focus on older adults. *American Journal of Geriatric Psychiatry, 11*(5), 517–524.
- Kurt Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.
- Lloyd, J. T. (2018). Internal analysis of Medicare 2016 claims and enrollment data through the Chronic Conditions Warehouse. Depression screenings were identified among continuously enrolled fee-for-service beneficiaries using Medicare's Healthcare Common Procedure Coding System code G0444 in claims records.
- Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry, 159*(6), 909–916.
- McGough, P. M., Bauer, A. M., Collins, L., & Dugdale, D. C. (2016). Integrating behavioral health into primary care. *Population Health Management, 19*(2), 81–87.
- Misra, A., Lloyd, J. T., Strawbridge, L. M., & Wensky, S. G. (2018). Use of welcome to medicare visits among older adults following the Affordable Care Act. *American Journal of Preventive Medicine, 54*(1), 37–43.
- Noel, P. H., Williams, J. W., Unutzer, J., Worchel, J., Lee, S., Cornel, J., ... Hunkeler, E. (2004). Depression and comorbid illness in elderly primary care patients: Impact on multiple domains of health status and well-being. *Annals of Family Medicine, 2*(6), 555–562.
- Park, M., & Unutzer, J. (2011). Geriatric depression in primary care. *The Psychiatric Clinics of North America, 34*(2), 469–487.
- Perle, J. G., & Nierenberg, B. (2013). How psychological telehealth can alleviate society's mental health burden: A literature review. *Journal of Technology in Human Services, 31*(1), 22–41.
- Segal, D. L., Coolidge, F. L., Mincic, M. S., & O'Riley, A. (2005). Beliefs about mental illness and willingness to seek help: A cross-sectional study. *Aging & Mental Health, 9*(4), 363–367.
- Sirey, J. A., Franklin, A. J., McKenzie, S. E., Ghosh, S., & Raue, P. J. (2014). Race, stigma, and mental health referrals among clients of aging services who screened positive for depression. *Psychiatric Services, 65*(4), 537–540.
- Small, G. W. (2009). Differential diagnoses and assessment of depression in elderly patients. *The Journal of Clinical Psychiatry, 70*(12), e47.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Procedures and techniques for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage [Database].
- Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts child psychiatry access project. *Health Affairs, 33*(12), 2153–2161.
- Thielke, S., Vannoy, S., & Unutzer, J. (2007). Integrating mental health and primary care. *Primary Care, 34*(3), 571–592.
- Unutzer, J., Patrick, D. L., Diehr, P., Simon, G., Grembowski, D., & Katon, W. (2000). Quality adjusted life years in older adults with depressive symptoms and chronic medical disorders. *International Psychogeriatrics, 12*(1), 15–33.