CHAPTER 6 – SECTION F

PERCENT OF RESIDENTS WHO HAVE BECOME MORE DEPRESSED OR ANXIOUS

QM Description

This measure reflects the percent of long-term residents who have become more depressed or anxious in the nursing home since the last time they were assessed.

Rationale for Depression or Anxiety QM

Depression is a medical problem of the brain that can affect how you think, feel, and behave. Anxiety is excessive worry and can include trembling, muscle aches, and irritability. Nursing home residents are at a high risk for developing depression and anxiety for many reasons, such as loss of a spouse, separation from family members, illness, chronic pain, difficulty adjusting to the nursing home, and frustration with memory loss. Identifying depression and anxiety can be difficult in elderly patients because the signs may be confused with the normal aging process, a side effect of medication, or the result of a medical condition. Additional information about this clinical condition, as well as quality improvement strategies, can be found on CMS's website at www.MedQIC.org.

MDS Assessments Used

- **Target assessment**: OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period.
- **Prior assessment**: AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date.

QM Specifications

NUMERATOR

Residents whose Mood Scale scores are greater on target assessment relative to prior assessment (Mood Scale score [t] > Mood Scale score [t-1]).

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MOOD SCALE DEFINITION

Mood Scale score is defined as the count of the number of the following eight conditions that are satisfied (range 0 through 8) on the target assessment:

1. Any verbal expression of distress (E1a > 0, E1c > 0, E1e > 0, E1f > 0, E1g > 0, E1h > 0).
2. Shows signs of crying, tearfulness (E1m > 0).
3. Motor agitation (E1n > 0).
4. Leaves food uneaten (K4c = checked) on target or last full assessment.
5. Repetitive health complaints (E1h > 0).
6. Repetitive/recurrent verbalizations (E1a > 0, E1c > 0, or E1g > 0).
7. Negative Statements (E1a > 0, E1e > 0, or E1f > 0).
8. Mood symptoms not easily altered (E2 = 2).

Note: Some MDS items count toward multiple depression symptoms. In addition, different items can trigger the same depression symptom.

DENOMINATOR

All residents with a valid target assessment and a valid prior assessment, after exclusions are applied.

RISK ADJUSTMENT STRATEGIES USED

Exclusion….Yes Stratification….No Regression….No

EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- The Mood Scale score is missing on the target assessment [t].
- The Mood Scale score is missing on the prior assessment [t-1] and the Mood Scale score indicates symptoms present on the target assessment (Mood Scale [t] > 0).
- The Mood Scale score is at a maximum (value 8) on the prior assessment.
- The resident is comatose (B1 = 1) or comatose status is unknown (B1 = missing) on the target assessment.

COVARIATES USED IN REGRESSION

No covariates are used in the depression/anxiety quality measure.

MDS Elements Related to QM

E1a Indicators of Depression, Anxiety, or Sad Mood - Resident made negative statements

E1c Indicators of Depression, Anxiety, or Sad Mood - Repetitive verbalizations

E1e Indicators of Depression, Anxiety, or Sad Mood - Self deprecation

E1f Indicators of Depression, Anxiety, or Sad Mood - Expressions of what appear to be unrealistic fears

E1g Indicators of Depression, Anxiety, or Sad Mood - Recurrent statements that something terrible is about to happen

E1h Indicators of Depression, Anxiety, or Sad Mood - Repetitive health complaints

E1m Indicators of Depression, Anxiety, or Sad Mood - Crying, tearfulness

E1n Indicators of Depression, Anxiety, or Sad Mood - Repetitive physical movements

E2 Mood Persistence – One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over the last seven days.

K4c Nutritional Problems - Leaves 25% or more of food uneaten at most meals

B1 Comatose - The resident has been diagnosed as comatose or in a persistent vegetative state.

MDS RAI Coding Instructions

SECTION E. MOOD AND BEHAVIOR PATTERNS

NOTE: MDS ITEMS THAT DO NOT TRIGGER THE QUALITY MEASURES ARE INTENTIONALLY IN GRAY TEXT.

It is important to note that coding the presence of indicators in Section E does not automatically mean that the resident has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in Section E.; they simply record the presence or absence of specific indicators and behaviors. It's important that facility staff recognizes these clinical indicators and consider them when developing the resident's care plan.

E1. Indicators of Depression, Anxiety, Sad Mood (30-day look back)

Intent: To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older nursing facility population. Rather, distress is more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. **Resident Made Negative Statements** - e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

b. **Repetitive Questions** - e.g., "Where do I go; What do I do?"

c. **Repetitive Verbalizations** - e.g., Calling out for help, ("God help me").

d. **Persistent Anger with Self or Others** - e.g., easily annoyed, anger at placement in nursing facility; anger at care received.

e. **Self Deprecation** - e.g., "I am nothing; I am of no use to anyone".

f. **Expressions of What Appear to Be Unrealistic Fears** - e.g., fear of being abandoned, left alone, being with others.

g. **Recurrent Statements that Something Terrible is About to Happen** - e.g., believes he or she is about to die, have a heart attack.

h. **Repetitive Health Complaints** - e.g., persistently seeks medical attention, obsessive concern with body functions.

i. **Repetitive Anxious Complaints/Concerns (non-health related)** - e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationship issues.

DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES:

SLEEP CYCLE ISSUES - Distress can also be manifested through disturbed sleep patterns.

j. **Unpleasant Mood in Morning** - e.g., angry, irritable.

k. **Insomnia/Change in Usual Sleep Pattern** - e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

SAD, APATHETIC, ANXIOUS APPEARANCE

l. **Sad, Pained, Worried Facial Expressions** - e.g., furrowed brows

m. **Crying, Tearfulness**

n. **Repetitive Physical Movements** - e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST - These items refer to a change in resident's usual pattern of behavior.

o. **Withdrawal from Activities of Interest** - e.g., no interest in long standing activities or being with family/friends. If the resident's withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the resident has withdrawn from activities of interest or has shown no interest in being with family/friends.

p. **Reduced Social Interaction** - e.g., less talkative, more isolated

Process: Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts, if possible, and family who have direct knowledge of the resident's behavior. Relevant information may also be found in the clinical record.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week (*i.e., exhibited at least once during the last 30 days but less than 6 days a week*)
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

Clarifications:

- The keys to obtaining, tracking and recording accurate information in Item E1, Indicators of Depression are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

  - Daily communication between nurses, nurse assistants and other direct care providers is crucial for resident monitoring and care giving.

  - Educate all caregivers (including direct care staff and staff who routinely come into contact with residents, such as housekeepers, maintenance, and dietary personnel about the residents' status in this area, and how to observe mood and behavior patterns that are captured in MDS Item E1. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated. Part of the reason may be that over time, these symptoms tend to be perceived as the residents' "normal" or "usual" behaviors.

  - Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor, on an on-going basis, the resident's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

- The mood items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether or not it occurred at all. If not, use code "0". If the resident exhibited the behavior almost daily (6 or 7 days a week), or multiple times daily, code "2". If codes "0" or "2" do not reflect the resident's status, but the behavior occurred at least once, use code "1".

- If an indicator of depression occurs twice in the last 30 days (not 2 times each week), it should be coded as "1" to indicate that the indicator of depression was exhibited up to 5 days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the 30-day period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days.

Example

Mr. F is a new admission that becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He chastises her 'for not taking him into her home,' and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, tearful, and says "What's the use. I'm no good. I wish I died when my wife did." **Coding "1" for a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self deprecation), m. (Crying, tearfulness); remaining Mood items would be coded "0".**

E2. Mood Persistence (7-day look back)

Intent: To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up," console, or reassure the resident over the last seven days.

Process: Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding: Enter "**0**" if the resident did not exhibit any mood indicators over last seven days, "**1**" if indicators were present and easily altered by staff interactions with the resident or "**2**" if any indicator was present but not easily altered (e.g., behavior persisted despite staff efforts to console resident).

E3. Change in Mood (90 days ago)

Intent: To document change in the resident's mood as compared to his or her status of 90 days ago (or since last assessment, if less than 90 days ago). This item asks for a snapshot of the resident's status in the current observation period as compared to 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: **Change in Mood** - Refers to status of any of the symptoms (new onset, improvement, worsening) described in Item E1 (verbal expressions of distress, sleep cycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and Item E2 (mood persistence). Such changes include:

- increased or decreased numbers of expressions or signs of distress
- increased or decreased frequency of distress occurrence

- There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F 326) and 483.20(b)2(xi), resident assessment nutritional status and requirements (F 272), which corresponds to the MDS 2.0 Section K, Oral/Nutritional status.

  The parameters for weight loss identified in the guidelines referenced above are:

  1 month 5% significant >5% severe

  3 months 7.5% significant >7.5% severe

  6 months 10% significant >10% severe

  The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process.

  However, if the resident is losing/gaining a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in one month, 7.5% in three months, or 10% in six months should prompt a thorough assessment of the resident's nutritional status. For example, a 10% loss/gain within 4 months should also be coded here, and carefully evaluated. An adequate assessment should result in a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs and expressed desires.

K4. Nutritional Problems (7-day look back)

Intent: To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

Definition:

a. **Complains About the Taste of Many Foods** - The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based - e.g., someone used to eating spicy foods may find nursing facility meals bland.

b. **Regular or Repetitive Complaints of Hunger** - On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

c. **Leaves 25% or More of Food Uneaten at Most Meals -** Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day. This assumes the resident is receiving the proper amount of food to meet their daily requirements and not excessive amounts above and beyond what they could be expected to consume.

d. *NONE OF ABOVE*

Process: Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, and dietary progress notes/assessments. Consult with direct-care staff, dietary staff and the consulting dietitian. Ask the resident if he or she experienced any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating? Would you eat if something else was offered?" Observe if resident winces or makes faces while eating. **NOTE:** Facilities are required to offer substitutions when residents do not eat or like the food being served. Observe whether or not residents have refused offers for substitute meals.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE.*

K5. Nutritional Approaches (7-day look back)

Definition:

a. **Parenteral/IV -** Intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (Keep Vein Open), or via heparin locks. Do not code IV "push" medications here. Do include the IV fluids in IV piggybacks. IV medications dissolved in a diluent, as well as IV push medications are captured as IV medications in P1ac. Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay.

b. **Feeding Tube -** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

c. **Mechanically Altered Diet -** A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below.