

Depression Management

Arizona Nursing Home Work Group
Learning Session 5
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Presented By:

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Information for Health Care Improvement



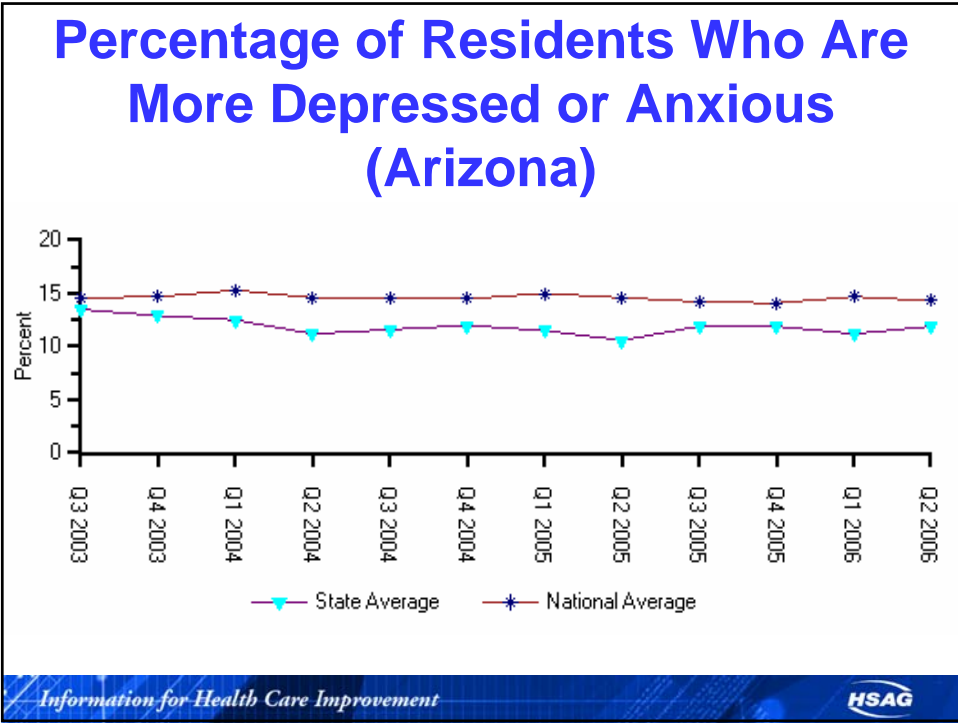
Objectives

- Understand nursing home depression rates in Arizona.
- Learn how the depression quality measure (QM) is calculated.
- Define depression and key information in completing an accurate assessment.
- Determine the personnel involved in the assessment of depression.
- Identify steps the nursing home staff can take after the depression assessment process is complete.

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The Depression QM

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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]).

Denominator:

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

QM Specifications (continued)

Exclusions:

- 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.

MDS Elements Related to the 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.

MDS Elements Related to the QM (continued)

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.

MDS Elements Related to the QM (continued)

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.

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MDS Elements Related to the QM (continued)

K4c Nutritional Problems:

Leaves 25 percent or more of food uneaten at most meals.

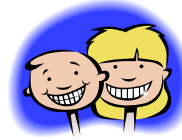
B1 Comatose:

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

SECTION E. MOOD AND BEHAVIOR PATTERNS		SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS		
1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	3. PAST ROLES	Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines NONE OF ABOVE	a. f. g. h.
	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters. I would rather be dead. I'll be there when I 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 home, 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		Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community NONE OF ABOVE	a. b. c. d.
2. 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 last 7 days 0. No mood 1. Indicators present, not easily altered 2. Indicators present, easily altered	SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS		
3. CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	1. (A) ADL SELF-PERFORMANCE—Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup		
4. BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days	0. INDEPENDENT—No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days		
		(B) ADL SUPPORT PROVIDED—Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification		(A) (B)
		0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist		SELF-PERF SUPPORT
		a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
		b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
		c. WALK IN ROOM	How resident walks between locations in his/her room	
		d. WALK IN CORRIDOR	How resident walks in corridor on unit	
		e. LOCOMOTION	How resident moves between locations in his/her room and adjacent corridor on same floor, if in wheelchair, self-sufficiency	

What Causes Depression?

Many things can cause depression:



- **Biological:** A chemical imbalance
- **Hereditary:** It can run in families
- **Physical:** Hormonal, seasonal, or lifestyle changes
- **Medications:** Some cause depression
- **Medical:** Stroke, cancer, heart disease, thyroid problems
- **Situational:** Difficult life events

Symptoms of Depression

- Sleep disturbances
- Psychomotor agitation
- Decrease/increase in appetite and/or weight
- Concentration difficulties
- Loss of energy, fatigue, and tiredness
- Depressed mood
- Diminished/lost interest in activities
- Guilt or feeling of worthlessness
- Suicidal ideations or thoughts of death

Why Screen for Depression?



Depression is grossly undetected in the geriatric population:

- Approximately 10 percent of elderly people who require psychiatric treatment receive it.
- Approximately 40 percent of depressed nursing home residents are accurately diagnosed.
- Less than 25 percent of depressed nursing home residents receive treatment.

The Screening Process

- Social Service Department should administer the depression screening tool
- Use the most appropriate tool
- American Geriatric Society and American Association for Geriatric Psychiatry recommend screening 2–4 weeks from admission
 - Because of decreasing lengths of stay—OK to screen within 7 days of admission

The Screening Process

- Choose a quiet and confidential place
 - Try to use the same location each time the tool is administered
- Involve your Medical Director and the attending physician in setting treatment goals

Samples of Depression Screening Tools

- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- Beck Depression Inventory (BDI)
- Center for Epidemiologic Studies Depression Scale (CES-D)
 - Not recommended for multi-ethnic groups
- Hamilton Rating Scale for Depression (HAM-D)
- PRIME-MD or Patient Health Questionnaire (PHQ-9)

Behavioral Interventions— What I Can Do?

- Recognize that all staff members play a role in monitoring and intervening.
- Consider this a kind of chronic disease management—treatment goals include reducing excess disability, restoring function, etc.
- Recognize depression is among the most disabling, but also the most treatable, of medical conditions.
- Address nutritional needs.
- Address physical needs.
- Increase UV light (daytime).
- Exercise.
- Promote relaxation, restful sleep.



What I Can Do?



- Address spirituality needs.
- Foster person-to-person contact/support.
- Journal, reminiscence.
- Address hopeless, suicidal thoughts. Take it seriously and take measures to save a life.
- Challenge and reframe negative thoughts.
- Increase social contact and pleasant activity.
- Decrease isolation.
- Employ interactive therapies—think culturally and age-appropriate.
- Enhance mealtime.

I Can Help

- Recognize when you can negotiate to motivate your depressed resident
 - Timing is essential
- Help to overcome the resident's feeling of powerlessness
- Enhance the POWER—interpersonal relationships
 - Consistent staff assignment when possible
 - Consistent approach is always possible

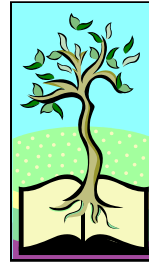


The Top “10” Improving Your Depression Quality Measure

1. Understand the quality measure
2. Screen all admissions for depression
3. Take time to complete the admission MDS assessment
4. Address triggers individually
5. Educate staff



The Top “10” (continued)



6. Educate physicians
7. Educate residents and families
8. Implement person-centered care practices
9. Involve contracted services, state organizations, and community groups
10. Include pharmacological and nonpharmacological treatments in the care plan

Whose goal is this? – yours, mine, and ours!

Helpful Web Sites

<http://nhqi.hsag.com>

<http://www.nhqi-star.org>

<http://www.qualitynet.org>

<http://www.medqic.org>



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Questions?



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*All Medicare beneficiaries **have the right to appeal their discharge** from a hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.*

*For more information, go to <http://www.hsag.com/azmedicare> or call **1.800.359.9909**.*

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