

Developing a Depression and  
Pain Management Program

# Developing a Depression and Pain Management Program

## Arizona Nursing Home Workgroup Learning Session 4

Presented By:  
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Clinical Quality Specialist  
Health Services Advisory Group (HSAG)

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## Presentation Topics

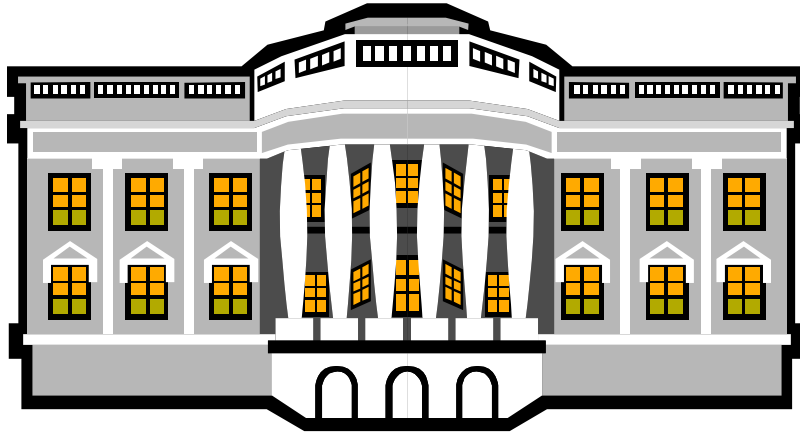
- Arizona Nursing Home Workgroup overview
- Depression and pain management trends in Arizona
- Developing a successful depression and pain management program
- Common assessment tools to incorporate in your depression and pain management programs

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## Developing a Depression and Pain Management Program

### What Does CMS Want?



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### HSAG

As Arizona's Quality Improvement Organization (QIO), HSAG:

- Contracts with the Centers for Medicare & Medicaid Services (CMS).
- Works with physicians, hospitals, *nursing homes*, home health agencies, and others to improve quality of health care.
- Helps people with Medicare address concerns about the quality of their health care.

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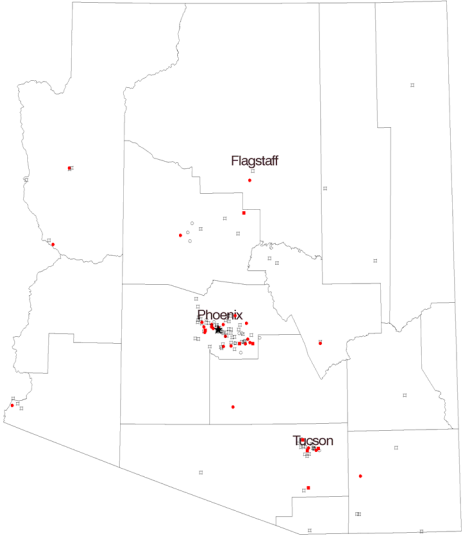
**Arizona Nursing Home  
Quality Initiative (NHQI)**

**2005–2008**

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**38 Nursing Homes Participating**



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## Developing a Depression and Pain Management Program

### Clinical Performance and Culture Change

#### Work to reduce:

- High-risk pressure ulcers
  - Restraints
  - Depression
  - Chronic-care pain
- and*
- Set annual STAR quality measure (QM) goals
  - Use the Nursing Home Improvement Feedback Tool (NHIFT)
  - Increase resident and employee satisfaction
  - Decrease CNA turnover

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### Outcome Indicators

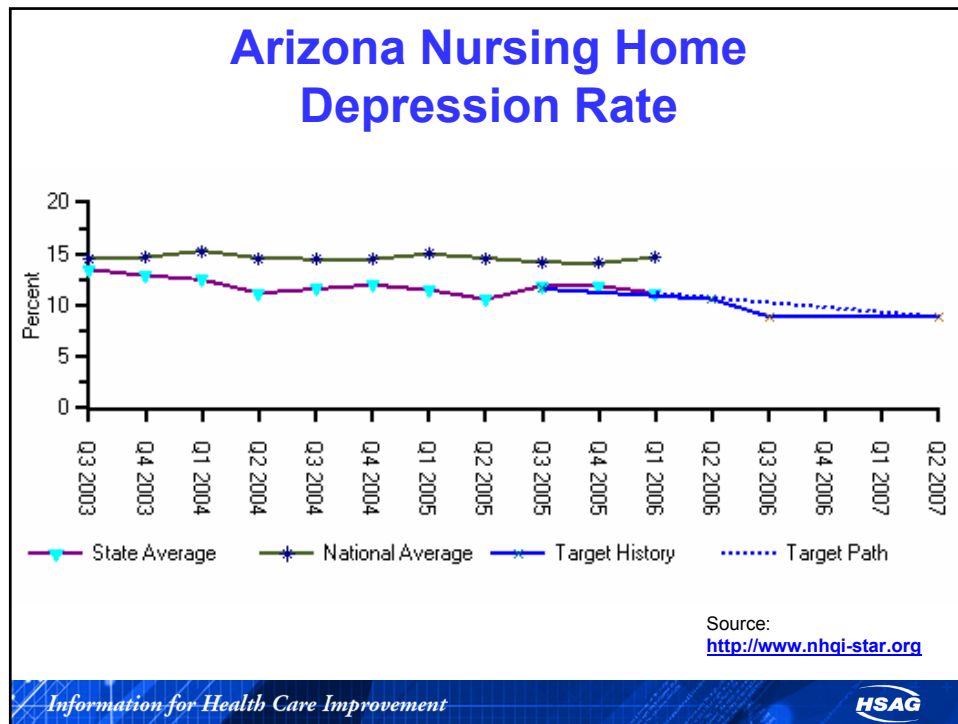
- Publicly reportable QMs
- QI/QM Report
- Answers how the resident responds to your processes
- Final result of your work

Powell, Suzanne K., *Advanced Case Management: Outcomes and Beyond*, (2000)

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## Developing a Depression and Pain Management Program



## What is Depression?

- Depression is a serious medical illness that disrupts a person's mood, behavior, thought processes, and physical health.
- Depression is a biochemical imbalance.
- It should not be mistaken for the passing feelings of unhappiness that everyone experiences, and is not a normal consequence of age.

## 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.

Source-MPRO

## Consequences of Missed Diagnosis/ Inadequate Treatment

- Increased morbidity/mortality
- Increased severity of depression
- Psychosocial and financial costs
- Suicide

Source- MPRO

## Developing a Depression and Pain Management Program

### The Screening Process

- Who?
- What?
- When?
- Where?

Source-MPRO

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### Who?

#### Sec 483.15 Quality of life

##### Social Services

- The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.
- A facility with more than 120 beds must employ a qualified social worker on a full-time basis.

Source: MPRO

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# Developing a Depression and Pain Management Program

## What?

### Screening tools for depression

- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- Beck Depression Inventory (BDI)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Hamilton Rating Scale for Depression (HAM-D)

Source- MPRO

What?

**Screening tools for depression**

- Geriatric Depression Scale (GDS)
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Source- MPRO

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## Geriatric Depression Scale (Short Form)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Instructions: Choose the best answer for how you felt over the past week.*

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	Yes / No	
2.	Have you dropped many of your activities and interests?	Yes / No	
3.	Do you feel that your life is empty?	Yes / No	
4.	Do you often get bored?	Yes / No	
5.	Are you in good spirits most of the time?	Yes / No	
6.	Are you afraid that something bad is going to happen to you?	Yes / No	
7.	Do you feel happy most of the time?	Yes / No	
8.	Do you often feel helpless?	Yes / No	
9.	Do you prefer to stay at home, rather than going out and doing new things?	Yes / No	
10.	Do you feel you have more problems with memory than most?	Yes / No	
11.	Do you think it is wonderful to be alive?	Yes / No	
12.	Do you feel pretty worthless the way you are now?	Yes / No	
13.	Do you feel full of energy?	Yes / No	
14.	Do you feel that your situation is hopeless?	Yes / No	
15.	Do you think that most people are better off than you are?	Yes / No	
TOTAL			

Geriatric Depression Scale (Short Form)

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TOTAL			

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# Developing a Depression and Pain Management Program

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ DATE \_\_\_\_\_

### Cornell Scale for Depression in Dementia

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

SCORING SYSTEM

a = Unable to evaluate    0 = Absent  
1 = Mild to Intermittent    2 = Severe

**Score greater than 12 = Probable Depression**

**A. MOOD-RELATED SIGNS**

1. Anxiety; anxious expression, rumination, worrying	a	0	1	2
2. Sadness; sad expression, sad voice, tearfulness				
3. Lack of reaction to pleasant events				
4. Irritability; annoyed, short tempered				

**B. BEHAVIORAL DISTURBANCE**

5. Agitation; restlessness, hand wringing, hair pulling	a	0	1	2
6. Retardation; slow movements, slow speech, slow reactions				
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only)				
8. Loss of interest; less involved in usual activities (score 0 only if change occurred acutely, i.e., in less than one month)				

**C. PHYSICAL SIGNS**

9. Appetite loss; eating less than usual	a	0	1	2
10. Weight loss (score 2 if greater than 5 pounds in one month)				
11. Lack of energy; fatigues easily, unable to sustain activities				

**D. CYCLIC FUNCTIONS**

12. Diurnal variation of mood; symptoms worse in the morning	a	0	1	2
13. Difficulty falling asleep; later than usual for this individual				
14. Multiple awakenings during sleep				
15. Early morning awakening; earlier than usual for this individual				


**E. IDEATIONAL DISTURBANCE**

16. Suicidal; feels life is not worth living	a	0	1	2
17. Poor self-esteem; self-blame, self-deprecation, feelings of failure				
18. Pessimism; anticipation of the worst				
19. Mood congruent delusions; delusions of poverty, illness or loss				

NOTES/CURRENT MEDICATIONS: \_\_\_\_\_

ASSESSOR: \_\_\_\_\_

Score \_\_\_\_\_

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## When?

- 2001 Consensus Statement from American Geriatric Society (AGS) and American Association for Geriatric Psychiatry (AAGP) recommended screening 2-4 weeks after admission and repeated at least every 6 months.
- Recognizing that length of stay rates are decreasing, NHIFT tool recommends screening within 7 days of admission.
- Screening tools may also be used to monitor depression (improvement or lack of).

Source-MPRO

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### Where?

- Choose a quiet place that ensures patient confidentiality
- Provide the privacy
- Assess if the patient is comfortable and ready to begin answering questions
- Try to use the same location each time the test is administered

Source-MPRO

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## Developing a Successful Depression Management Program

Treatment for positive screening may include:

- Group therapy.
- Medication.
- Counseling.
- Changes in environment.
- Spiritual intervention.

Source: NHIFT

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## Developing a Successful Depression Management Program (continued)

Management considerations may include:

- Community involvement.
- Reminiscence groups.
- Involvement in activities.

Source: NHFT

## Goals of Treatment

- Decrease and resolve symptoms without causing additional symptoms and complications
- Improve quality of life
- Enhance patient's ability to function
- Improve health status
- Prevent relapse and recurrence
- Reduce health care costs

Source-MPRO

## Developing a Depression and Pain Management Program

### Take Home Points

- The screening process is essential in determining which residents require further clinical assessment and watchful waiting.
- The screening tool does not diagnose depression.
- The screening tool helps identify “at-risk” residents who may benefit from preventive efforts (management of depressive symptoms).
- The screening process needs to be consistently implemented.

Source-MPRO

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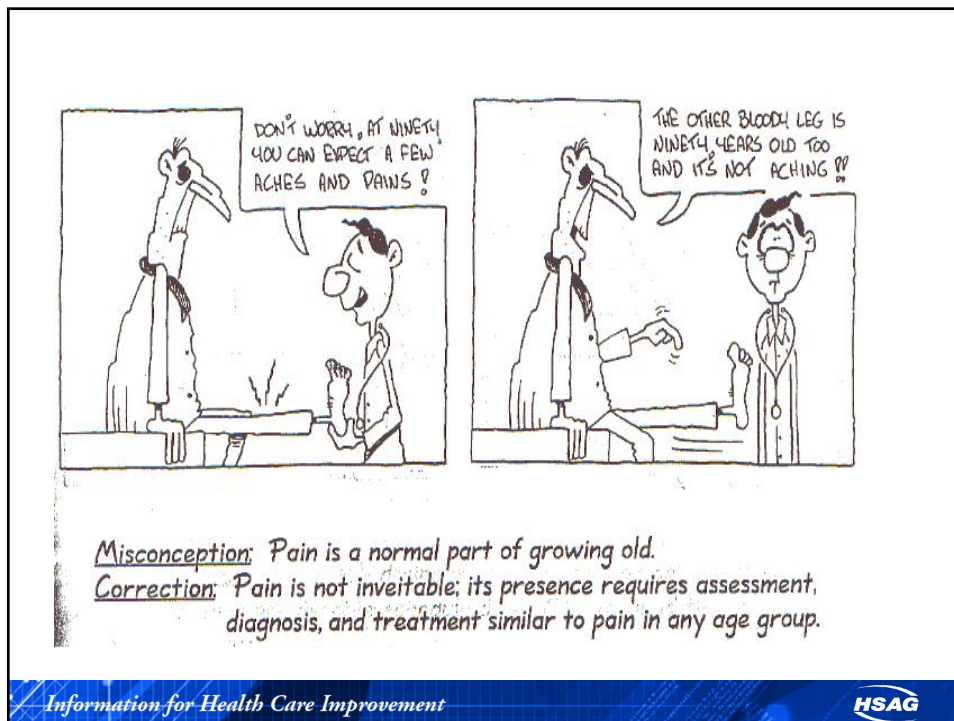
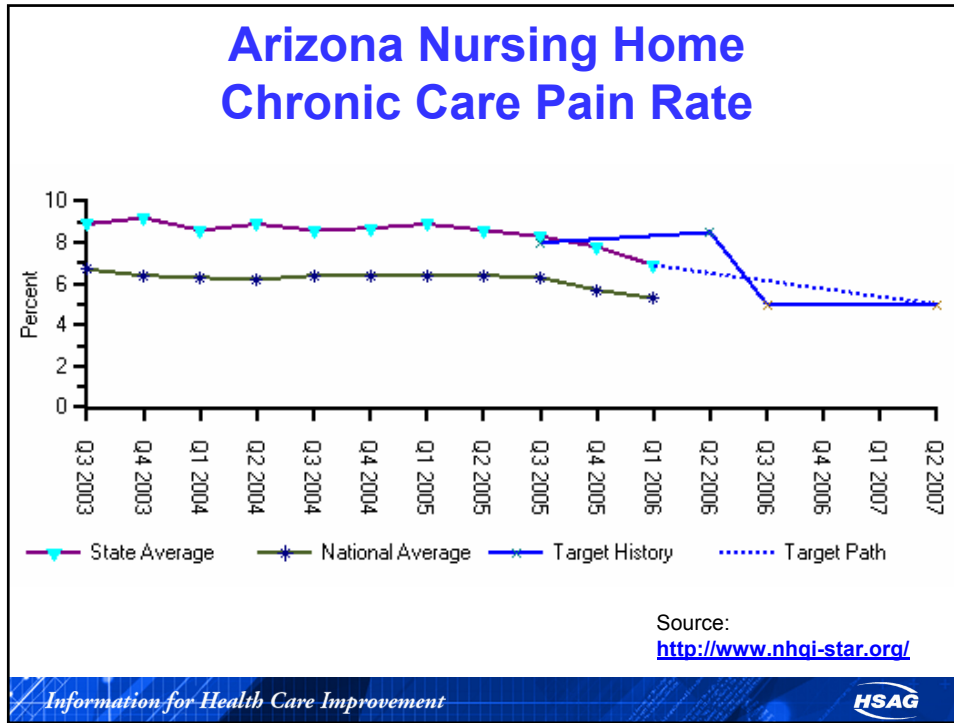
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### Pain Management

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## Developing a Depression and Pain Management Program



## Developing a Depression and Pain Management Program

### What is Pain?

“Pain is the most powerful and tangible force in life. The threat of torture, for instance, is stronger than the threat of death. Execution can be faced, but pain is corrosive, like an acid eating at the personality. Pain, as anyone with a toothache knows, drives out all other emotions and sensations before it. Pain is priority. It may even be man’s strongest and most undeniable reality.”

Source: Tom Boswell in *The Washington Post*,  
quoted by Howard Helt

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### Why Focus On Pain?

- Pain is a symptom most expected and most feared by dying patients
- Unrelieved pain can have enormous physiological and psychological effects on the resident and their loved ones
- Pain negatively affects the quality of life by impairing daily functions, social relationships, sleep, and/or self worth
- Although pain can be relieved in up to 90 percent, many residents receive inadequate or no treatment

Source:  
<http://www.medqic.org>

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## Pain Effects In The Elderly

- Impairs mobility, slows rehabilitation
- Decreases socialization
- Increases depression and sleep disturbances
- May worsen cognitive impairment
- Contributes to poor food intake and malnutrition
- Increases morbidity

Source:

<http://www.medqic.org>

## The Screening Process

- Consider pain the “5th vital sign”
- When to screen
  - Admission
  - Readmission
  - Each MDS assessment
  - Change in condition
- Process defined and understood by all staff

Source:

<http://www.medqic.org>

## Developing a Depression and Pain Management Program

### Common Screening Tools for Pain Management

- Wong-Baker Faces Scale
- 1-10 Scale
- PAINAD Scale

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### Wong-Baker (Faces Scale)



Faces Scale	Score	=	MDS Section J2 (b)	Score
Hurts Little Bit	1	=	Mild Pain	1
Hurts Little More/Even More	2 or 3	=	Moderate Pain	2
Hurts Whole Lot/Hurts Worst	4 or 5	=	Horrible/Excruciating Pain	3

Brief Instructions: Point to each face using the words to describe the pain intensity. Ask the individual to choose face that best describes their pain and record the appropriate number.

\*Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p.1301. Copyrighted by Mosby, Inc. Reprinted by Permission.

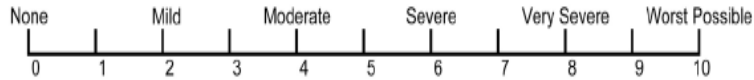
Source:  
<http://www.medqic.org/>

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## Developing a Depression and Pain Management Program

### 1-10 Scale



10-Point Numerical Rating Scale	Score	=	MDS Section J2 (b)	Score
Mild Pain	1-3	=	Mild Pain	1
Moderate Pain	4-6	=	Moderate Pain	2
Severe Pain	7-10	=	Horrible/Excruating Pain	3

Brief Instructions: Ask the individual to rate pain according to descriptions and 0-10 scale above and record number.

Source:

<http://www.medic.org/>

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### PAINAD

#### Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
<b>Breathing independent of vocalization</b>	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
<b>Negative vocalization</b>	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
<b>Facial expression</b>	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
<b>Body language</b>	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
<b>Consolability</b>	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
<b>Total**</b>				

Source:

<http://www.amda.org/>

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## Developing a Depression and Pain Management Program

### **Developing a Successful Pain Management Program** (continued)

Items to consider in resident pain assessment within  
24 hours of admission:

- Documentation of what improves (relieves) pain
- Documentation of what worsens (increases) pain
- Documented effects of medication (past or present)
- Effects of pain on activities of daily living, sleep, and mood documented
- Frequency of pain documented
- Intensity of pain documented
- Location of pain documented

Source: NHIFT

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### **Developing a Successful Pain Management Program** (continued)

- Alternative medicine (e.g., aromatherapy, Reiki)
- Cutaneous stimulation/relaxation (e.g., deep breathing, massage therapy, TENS)
- Psychosocial (e.g., counseling, distraction)
- Therapy-related (e.g., heat treatment, cold treatment)
- Unspecified non-drug therapies

Source: NHIFT

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## Developing a Successful Pain Management Program

(continued)

Indicate orders for pain medication within 24 hours of identification of resident's pain:

- Regularly scheduled pain medication and PRN medication for breakthrough pain
- Regularly scheduled pain medication only
- PRN medication for breakthrough pain only
- No pain medication prescribed

Source: NHIFT

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## Developing a Successful Pain Management Program

(continued)

Don't forget!

Did the resident have a diagnosis for the underlying cause(s) of pain within 30 calendar days of admission?

Source: NHIFT

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**“If you always do what you always did, you  
will always get what you always got”**

**—Anonymous Quote**

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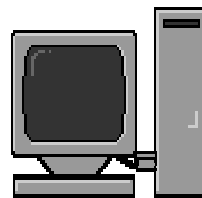
## **Helpful Web Sites**

**<http://nhqi.hsag.com>**

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

**<http://www.qualitynet.org>**

**<http://www.medqic.org>**



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## Developing a Depression and Pain Management Program

# Questions?

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## HSAG NHQI Contacts

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