"A ***Knowledgeable*** and ***Compassionate*** partner"

BROAD RIVER REHAB

QM Series Part III - Quality Measurement and Impacts of Depression

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Agenda

- Depression in Long Term Care?
- What does the current RES DAC data suggest.
- Depression and the MDS
- Depression and the QMs a Closer Look
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- Q&A

Depression in Long Term Care?

- "Up to 35% of residents in long-term care facilities may experience either major depression or clinically significant depressive symptoms. These symptoms are often not recognized for at least 2 reasons: depression is not the focus of physicians and nursing personnel, and depression is frequently comorbid with other problems that are common in long-term care, such as cognitive impairment, medical illness, and functional impairment.) (1) (Depression) "…is a treatable condition and deserves the attention of the entire medical and nursing staff."
- "In one large study of a long-term care facility, 12.4% experienced major depression and 35.0% experienced significant depressive symptoms. In another study, depression was found in 20.0% of patients admitted to a long-term care facility. Incidence of major depression at 1 year was 6.4%." (1)
- "In yet another nursing home study, prevalence of major depressive disorder among testable subjects was 14.4% and prevalence of minor depression was 17.0%." (1)
- **"Less than 50.0% of cases were recognized by nursing and social work staff. Thus, depressive disorders are widely prevalent in nursing homes, contributing substantially to disability in this frail population, and yet are often overlooked."** (1)

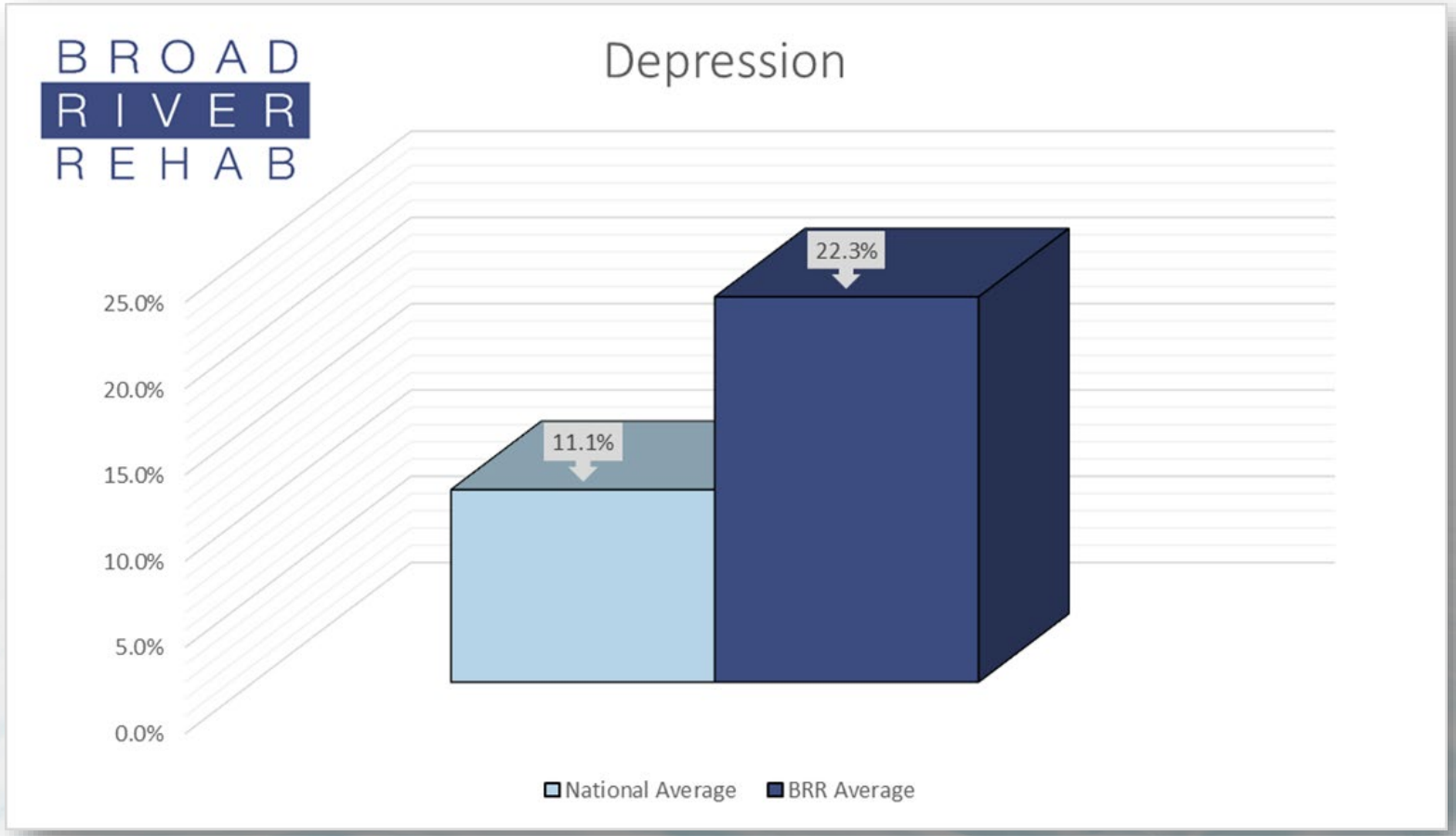
Depression in Long Term Care?

- "The rate of depression in SNFs is much higher than in the general population because these residents are simultaneously experiencing medical problems, disability, disconnection from home and community, and uncertainty about their futures." (2)
- "Nursing home residents encounter many challenges medically, socially and functionally… loss and grief, isolation and declining health and mental capabilities." (3)
- "Geriatric depression increases risk of both morbidity and mortality. Among all nursing home residents, 12-14% meet the criteria for Major Depressive Disorder (MDD). The rates of depressive symptoms in general are between 30-45%. For long-term care residents with dementia, the prevalence of clinical depression is estimated to be as high as 63% (Adams-Fryatt, 2010; Espinoza & Unutzer, 2016)." (4)
- "Late-onset depression (depression that occurs after the age of 60 years), often develops as a consequence of **accumulating losses** (Espinoza & Kaufman, 2014)." (4)

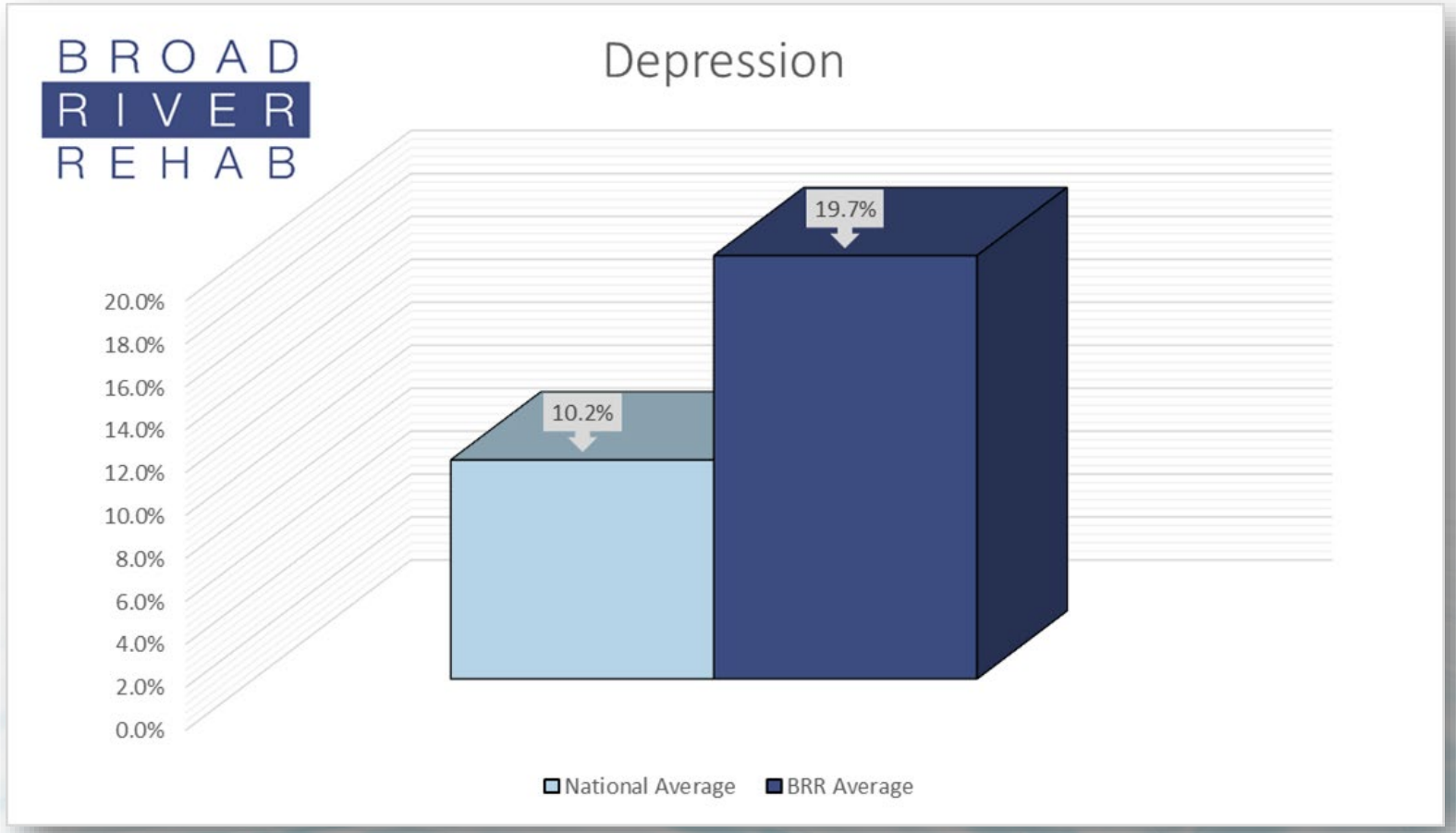
Depression in Long Term Care?

- "Depression tends to present atypically in elderly persons. They are less likely to report sadness or crying spells and more likely to report **anorexia, disruption in sleep patterns, and fatigue. Multiple somatic complaints are also common**. **Depression is the most common cause of unintentional weight loss in the elderly** (Adams-Fryatt, 2010; Espinoza & Kaufman, 2014; Taylor, 2014)." (4)
- "Suicidal ideation and passive suicide attempts can be found in up to 31% of long-term care (LTC) residents. LTC residents with depression who engage in self-harming behaviors, such as refusing food or medical care, may be expressing a suicide attempt (Adams-Fryatt, 2010)." (4)
- "Chronic medical problems may confer a predisposition to depression, and depression is associated with worse outcomes for some conditions. T**he elderly patient is more likely to take multiple medications that can cause or contribute to the development of depression (such as beta blockers, benzodiazepines, or opiates)**." (4)

What does the current RES DAC data suggest (Q1 2020)



What does the current RES DAC data suggest (Q3 2020)



Depression and the MDS

The PHQ9 (Patient Health Questionnaire 9 items). The intent of completing the PHQ-9 in section D of the MDS is to address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. **It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable**.

A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

D0200. Resident Mood Interview (PHQ-9©) $$ CATs QMs

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence** $$ CATs QMs
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency** $$ CATs QMs
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence $$ CATs QMs	2. Symptom Frequency $$ CATs QMs
	Enter Scores in Boxes	
A. *Little interest or pleasure in doing things* CAA: *7, *10, *N030.02*	☐	☐
B. *Feeling down, depressed, or hopeless N030.02*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way* CAA: *8	☐	☐

D0300. Total Severity Score $$ CATs QMs

Enter Score ☐☐

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. CAA: *8, 8, *N030.02*
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items). CAA: 8

Depression and the MDS

The PHQ-9-OV (Patient Health Questionnaire 9 items Observational) A small percentage of patients are unable or unwilling to complete the Resident Mood Interview. Therefore, staff should complete the PHQ-9 Observational Version (PHQ-9-OV) Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified.

• Persons unable to complete the PHQ-9© Resident Mood Interview may still have a mood disorder.

• Even if a resident was unable to complete the Resident Mood Interview, important insights may be gained from the responses that were obtained during the interview, as well as observations of the resident's behaviors and affect during the interview.

• The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*) $$ CATs QMs

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence $$ CATs QMs**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency $$ CATs QMs**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence $$ CATs QMs	2. Symptom Frequency $$ CATs QMs
	Enter Scores in Boxes	
A. Little interest or pleasure in doing things CAA: *7, *10, *N030.02*	☐	☐
B. Feeling or appearing down, depressed, or hopeless *N030.02*	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self CAA: *8	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score $$ CATs, QMs

Enter Score ☐☐ Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. CAA: *8, 8, *N030.02*

Depression and the MDS

CAA 7: Psychosocial Wellbeing

CAT Specifications: 7 Psychological Well-Being

Triggering Conditions	MDS 3.0 Item	Description	Response Values
1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:	• D0200A1	PHQ resident mood interview: little interest or pleasure in doing things-presence	= 1
2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:	• D0500A1	PHQ staff assessment of resident mood: little interest or pleasure in doing things-presence	= 1
3. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:	• E0200A • I4800 • I4200	Physical behavioral symptoms directed toward others Non-Alzheimer's Dementia Alzheimer's disease	= 1 – 3 AND 0 OR Dash (-) AND 0 OR Dash (-)
4. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:	• E0200B • I4800 • I4200	Verbal behavioral symptoms directed toward others Non-Alzheimer's Dementia Alzheimer's disease	= 1 – 3 AND 0 OR Dash (-) AND 0 OR Dash (-)
5. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 or 4 as indicated by:	• F0500F	Resident interview: how important is it to you to do your favorite activities	= 3 OR 4
6. Any six items for interview for activity preferences has the value of 4 and resident is primary respondent for daily and activity preferences as indicated by:	• F0500A • F0500B • F0500C • F0500D • F0500E • F0500F • F0500G • F0500H • F0600	Resident interview: how important is it to you to have books, newspaper, magazines to read Resident interview: how important is it to you to listen to music Resident interview: how important is it to you to be around animals/pets Resident interview: how important is it to you to keep up with news Resident interview: how important is it to you to do things with groups of people Resident interview: how important is it to you to do your favorite activities Resident interview: how important is it to you to go outside in good weather Resident interview: how important is it to you to participate in religious practices Primary respondent: daily/activities preferences	= 4 OR = 4 OR = 4 OR = 4 OR = 4 OR = 4 OR = 4 OR =4 AND = 1
7. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities:	• F0800Q	Staff assessment: participating in favorite activities	Not Checked

Depression and the MDS

CAA 8:

Mood State

CAT Specifications: 8 Mood State

Triggering Conditions	MDS 3.0 Item	Description	Response Values
1. Resident has had thoughts he/she would be better off dead, or thoughts of hurting him/herself as indicated by:	• D0200I1	Resident Mood Interview PHQ-9: thoughts better off dead-presence	= 1
2. Staff assessment of resident mood suggests resident states life isn't worth living, wishes for death, or attempts to harm self as indicated by	• D0500I1	Staff assessment of resident mood PHQ-9-OV thoughts better off dead-presence	= 1
3. The resident mood interview total severity score has a non-missing value (0 to 27) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the resident interview summary score on the current non-admission comprehensive assessment (D0300) is greater than the prior assessment (V0100E) as indicated by:	• A0310A • D0300 • V0100E • D0300	Federal OBRA reason for assessment Resident Mood Interview PHQ-9: total mood severity score Resident Mood Interview PHQ-9 total mood severity score (Prior Assessment) Resident Mood Interview PHQ-9: total mood severity score	= 03 OR 04 OR 05 AND = 0 - 27 AND = 0 - 27 AND > V0100E (Resident Mood Interview PHQ-9 total severity score Prior Assessment)
4. The resident mood interview is not successfully completed (missing value on D0300), the staff assessment of resident mood has a non-missing value (0 to 30) on both the current non-admission comprehensive assessment (A0310A = 03, 04, or 05) and the prior assessment, and the staff assessment current total severity score on the current non-admission comprehensive assessment (D0600) is greater than the prior assessment (V0100F) as indicated by:	• A0310A • D0300 • D0600 • V0100F • D0600	Federal OBRA reason for assessment Resident Mood Interview PHQ-9: total mood severity score Staff assessment of resident mood PHQ-9-OV total severity score Staff assessment of resident mood PHQ-9-OV total severity score (Prior Assessment) Staff assessment of resident mood PHQ-9-OV total severity score	= 03 OR 04 OR 05 AND = Dash (-) OR 99 AND = 00 – 30 AND = 00 – 30 AND > V0100F Staff assessment of resident mood PHQ-9-OV total severity score (Prior Assessment)
5. The resident mood interview is successfully completed, and the current total severity score has a value of 10 through 27 as indicated by:	• D0300	Resident Mood Interview PHQ-9: total mood severity score	= 10 - 27
6. The staff assessment of resident mood is recorded, and the current total severity score has a value of 10 through 30 as indicated by:	• D0600	Staff assessment of resident mood PHQ-9-OV total severity score	= 10 - 30

Depression and the MDS

CAA 10: Activities

CAT Specifications: 10 Activities			
Triggering Conditions	**MDS 3.0 Item**	**Description**	**Response Values**
1. Resident has little interest or pleasure in doing things as indicated by:	• D0200A1	Resident Mood Interview PHQ-9: little interest or pleasure in doing things-presence	= 1
2. Staff assessment of resident mood suggests resident states little interest or pleasure in doing things as indicated by:	• D0500A1	Staff assessment of resident mood PHQ-9-OV: little interest or pleasure in doing things-presence	= 1

Depression and the MDS

Section N: Medications

N0410. Medications Received CATs QMs ★	
Indicate the number of DAYS the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days	
Enter Days ☐	**A. Antipsychotic** CAA: *17, *N011.02 ★, *N031.03 ★
Enter Days ☐	**B. Antianxiety** CAA: *11, *17, *N033.02, *N036.02
Enter Days ☐	**C. Antidepressant** CAA: *11, *17
Enter Days ☐	**D. Hypnotic** CAA: *17, *N033.02, *N036.02
Enter Days ☐	**E. Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)
Enter Days ☐	**F. Antibiotic**
Enter Days ☐	**G. Diuretic**
Enter Days ☐	**H. Opioid**
N0450. Antipsychotic Medication Review	

Depression and the MDS

Section I:

Active Diagnosis

Nutritional $$ QMs ★
I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition ***N015.03*** ★
Psychiatric/Mood Disorder
I5700. **Anxiety Disorder**
I5800. **Depression** (other than bipolar)
I5900. **Bipolar Disorder**
I5950. **Psychotic Disorder** (other than schizophrenia)
I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
I6100. **Post Traumatic Stress Disorder (PTSD)**

Depression and the QMs: a Closer Look

Percent of Residents Who Have Depressive Symptoms (LS)
(CMS ID: N030.02) (NQF #0690 – Withdrawn)

Measure Description

The measure reports the percentage of long-stay residents who have had symptoms of depression during the 2-week period preceding the MDS 3.0 target assessment date.

Measure Specifications

Numerator

Long-stay residents with a selected target assessment where the target assessment meets *either* of the following two conditions:

CONDITION A (The resident mood interview must meet Part 1 *and* Part 2 below)

PART 1:

- Little interest or pleasure in doing things half or more of the days over the last two weeks (D0200A2 = [2, 3]).

or

- Feeling down, depressed, or hopeless half or more of the days over the last two weeks (D0200B2 = [2, 3]).

PART 2:

The resident interview total severity score indicates the presence of depression (D0300 ≥ [10] and D0300 ≤ [27]).

CONDITION B: (The staff assessment of resident mood must meet Part 1 *and* Part 2 below)

PART 1:

- Little interest or pleasure in doing things half or more of the days over the last two weeks (D0500A2 = [2, 3]).

or

- Feeling or appearing down, depressed, or hopeless half or more of the days over the last two weeks (D0500B2 = [2, 3]).

PART 2:

The staff assessment total severity score indicates the presence of depression (D0600 ≥ [10] and D0600 ≤ [30]).

Denominator

All long-stay residents with a selected target assessment, except those with exclusions.

Exclusions

1. Resident is comatose or comatose status is missing (B0100 = [1, -]).

Measure Specifications Continued
2. Resident is not included in the numerator (the resident did not meet the depression symptom conditions for the numerator) AND both of the following are true: 2.1. D0200A2 = [^, -] *or* D0200B2 = [^, -] *or* D0300 = [99, ^, -]. 2.2. D0500A2 = [^, -] *or* D0500B2 = [^, -] *or* D0600 = [^, -].
Covariates
Not applicable.

"A ***Knowledgeable*** and ***Compassionate*** partner"

Trauma Informed Care; Evidenced Based Practice; and Skilled Care

Depression & Trauma Informed Approach

- **Trauma-informed Care understands…**
- **The 3-E's**
  - **Events** – what happened
  - **Experience** – The resident's unique experience
  - **Effect** – How did the experience effect the resident
- **The 4-R's**
  - **Realizes** the widespread impact of trauma and understands potential paths for recovery.
  - **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
  - Seeks to actively **resist re-traumatization**
  - **Responds** by full integrating knowledge about trauma into policies, procedures, and practices

Trauma Informed Approach

- **Trauma-informed Care understands…**

- **The 6 Key Principles**
  - **SAFETY** — all people associated with the organization feel safe. This includes the safety of the physical setting and the nature of interpersonal interactions.
  - **TRUSTWORTHINESS AND TRANSPARENCY** — your organization is run with the goal of building trust with all those involved.
  - **PEER SUPPORT** — support from other trauma survivors is a key to establishing safety and hope. Peer support may be from others in the community.
  - **COLLABORATION AND MUTUALITY** — recognition that everyone at every level can play a therapeutic role through healing and safe relationships. Your organization emphasizes the leveling of power differences and taking a partnership approach with staff.

Trauma Informed Approach

- **Trauma-informed Care understands…**

- **The 6 Key Principles (Cont.)**
  - **EMPOWERMENT, VOICE, AND CHOICE** — your organization recognizes and builds on the strengths of people — staff members and residents. You recognize the ways in which nursing home residents and staff members may have been diminished in voice and choice and have at times been subject to coercive treatment. You support and cultivate skills in self-advocacy, and seek to empower residents and staff members to function or work as well as possible with adequate organizational support.
  - **CULTURAL, HISTORICAL, AND GENDER ISSUES** — your organization actively moves past cultural biases and stereotypes (gender, region, sexual orientation, race, age, religion), leverages the healing value of cultural traditions, incorporates processes and policies that are culturally aware, and recognizes and addresses historical trauma.

Trauma Informed Care is a process not a destination

Clinical Reminder
Post Intensive Care Syndrome (PICS)

- ***Post-intensive care syndrome*, or PICS, is made up of health problems that remain after critical illness. They are present when the patient is in the ICU and may persist after the patient returns home.**
- These problems can involve the patient's body, thoughts, feelings, or mind and may affect the family.
- PICS may show up as an easily noticed **drawn-out muscle weakness, known as *ICU-acquired weakness*; as problems with thinking and judgment, called *cognitive (brain) dysfunction*; and as other mental health problems**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Behavioral and Emotional Status Critical Element Pathway

Use this pathway to determine if the facility is providing necessary behavioral, mental, and/or emotional health care and services to each resident. Similarly, the facility staff members must implement person-centered, non-pharmacological approaches to care to meet the individual needs of each resident. While there may be isolated situations where pharmacological intervention is required first, these situations do not negate the obligation of the facility to develop and implement non-pharmacological approaches. Refer to the Dementia Care pathway to determine if the facility is providing the necessary care and services necessary.

Review the Following in Advance to Guide Observations and Interviews:

- ☐ Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for Sections A – PASARR and Conditions (A1500 – A1580), C – Cognitive Patterns, D – Mood, E – Behavior, G – Functional Status, I – Active Diagnoses – Psychiatric/Mood Disorders (I5700 – I6100), N – Medications, and O – Special Treatment/Proc/Prog – Psychological Therapy (O0400D).
- ☐ Physician orders.
- ☐ Pertinent diagnoses.
- ☐ Care plan (e.g., states concerns related to a resident's expressions or indications of distress in behavioral and/or functional terms as they relate specifically to the resident, potential cause or risk factors for the resident's behavior or mood, person-centered non-pharmacological and pharmacological interventions to support the resident and lessen distress, if pharmacological interventions are in place how staff track, monitor, and assess the interventions, and alternative means if the resident declines treatment).

Observations Across Various Shifts:

- ☐ If the resident is exhibiting expressions or indications of distress (e.g., anxiety, striking out, self-isolating) how does staff address these indications?
- ☐ Are staff implementing care planned interventions to ensure the resident's behavioral health care and service needs are being met? If not, describe.
- ☐ Focus on staff interactions with residents who have a mental or psychosocial disorder to determine whether staff consistently apply accepted quality care principles.
- ☐ Is there sufficient, competent staff to ensure resident safety and meet the resident's behavioral health care needs?
- ☐ What non-pharmacological interventions (e.g., meaningful activities, music or art therapy, massage, aromatherapy, reminiscing, diversional activities, consistent caregiver assignments, adjusting the environment) does staff use and do these approaches to care reflect resident choices and preferences?
- ☐ How does staff monitor the effectiveness of the resident's care plan interventions?
- ☐ How does staff demonstrate their knowledge of the resident's current behavioral and emotional needs? Does staff demonstrate competent interactions when addressing the resident's behavioral health care needs?
- ☐ Is the resident's distress caused by facility practices which do not accommodate resident preferences (e.g., ADL care, daily routines, activities, etc.)?

Occupational Therapy and Mental Health

Functional Performance and Occupational Engagement: This can include caring for self and others, staying in school, keeping a job, and maintaining positive and supportive relationships.

Engagement in occupations can be transformative: aids in creating social and personal identities, connects a person with their community, and enable ongoing personal growth.

Support the development of self management skills: including ADL/IADL, medication management, and plan for contingencies. Accommodate for cognitive impairments and visual impairments.

Identify and address impairments that can lead to rehospitalization and/or readmission.

Enhance coping skills and reduce symptoms of illness through engagements in healthy roles and routines.

Mental Health and OT Considerations

Many mental health disorders are a secondary effect of untreated pain*: What Can OT do to treat Pain?*

Mental health disorders may be related to a traumatic event: *How as an event shaped the person, coping mechanism, routines, roles?*

Mental health disorders are a common cause of disability: *Occupational disengagement*?

Mental health disorders are common in individuals with other chronic health conditions

OT and Mental Health

Utilization of EBP to shape clinical treatment options for optimal client outcomes

Work in collaboration with the client to produce client centered treatment plans

- What are the client's goals
  - Short range and long-range goals

Provide Education on mental health diagnosis at client’s cognitive level of understanding

- First step in successful treatment is understanding the disease
- Second Step = how to successfully manage the disease = skill acquisition

OT and Mental Health Interventions

Comprehensive evaluation with standardized assessment and outcome measures.

- OT Profile
  - Are we asking the right questions
  - OT Lens
    - Frame of Reference and Theories (MOHO, Kawa, Ecology of Human Performance)

Assessment and treatment of all functional components' areas: refer to the OTPF IV.

- Cognition: executive functioning, processing speed, memory, attention, social cognition

Collaborate with the Interprofessional team on care planning, discharge planning, and transitional planning to ensure needs are met and approaches are client centered and clinically supported

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QUESTIONS?