Pennsylvania Depression
Quality Improvement Collaborative

in partnership with
Southeastern Pennsylvania Association for Healthcare Quality (SPAHQ)
Abramson Center for Jewish Life
Polisher Research Institute

Toolkit

Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
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Overview

Depression is a significant and prevalent concern in nursing homes. Estimates of depressive symptoms for the 1.5 million U.S. nursing home residents range from 22% to 40% (Sahyoun, 2001). As one particularly poignant antidepressant TV advertisement points out “depression hurts.” For nursing home residents, the psychological suffering of depression is only part of the impact on the person’s wellbeing and quality of life. Research has demonstrated that untreated depression can have a host of other damaging effects for nursing home residents such as increased functional impairment and disability, poorer health outcomes, greater risk of physical injury, and increased rates of hospitalization (Bartels et al., 2003).

Numerous studies have found that depression, even in the cognitively impaired, is a treatable condition in nursing home residents (Snowden et al., 2003). In 2003, the American Geriatrics Society (AGS) and the American Association for Geriatric Psychiatry (AAGP) developed a consensus statement aimed at improving the quality of mental health care in U.S. nursing homes (JAGS, 2003). In 2007, a team of researchers and clinicians at the Abramson skilled nursing facility decided that this consensus statement did not go far enough in its scope. The consensus statement focused only on the treatment of persons who were already diagnosed with depression. What would happen if we created a depression management program that identified nursing home residents who were at risk for depression, but did not yet meet the criteria for a minor or major depressive disorder?

In seeking to answer that question, this team developed a program that could be individualized depending on the resident’s severity of depressive symptoms, previous history of depression and resident and family preferences for treatment. The goal of this program was to ameliorate existing depressive symptoms, but to also prevent depression from occurring in residents who were at risk. We call this program “Promoting Positive Wellbeing” (or PPW for short).
Managing Depression

A new program takes a preventative approach to depression management that employs early detection methods and individualized interventions.

When a team of researchers and clinicians at the Madlyn and Leonard Abramson Center for Jewish Life, North Wales, Pa., decided to create a new depression management program, they wanted to focus on a treatment process that incorporated alternative approaches for its skilled nursing facility (SNF) residents who were at risk for depression but who may not yet meet the criteria for a major depressive disorder.

The result was a program based on a well-known theoretical model (P. Lewinsohn) that posits that depression is the result of an interaction of individual vulnerabilities, environmental stressors, disruption of preferred behavioral patterns, and emotional responses. According to this model, the most effective treatments for depression are individualized interventions that systematically target the availability and frequency of preferred positive events and activities.

The program is designed to help nursing facilities develop an efficient system to monitor and improve the effectiveness of depression management, facilitate early identification of residents at risk for depression, and deliver interventions that are socially appropriate for the level of depression indicated.

Three Levels
A team comprised of staff members from the psychology, social work, therapeutic recreation, and nursing departments rolled out the program at the Abramson’s 324-bed SNF in September 2007.

Program participants are encouraged to participate in activities such as exercise and pet therapy programs.

The program employs three levels of intervention:

- Level 1—Activities and Exercise. The first level of intervention is overseen by the therapeutic recreation staff and utilizes behavioral activation—a model that seeks to help people overcome environmental sources of their depression by promoting behaviors—such as getting out of bed and attending activities and meals in the dining room—that might lessen the depression.

At this level, staff members review the activity preference assessment that was completed upon the resident’s admission. If a resident is identified as at risk for depression, recreation staff members attempt to increase the number of activities the resident attends as well as work to connect the individual with activities that have special interest or meaning for her.

In addition, a staff member develops an individualized care plan for the resident, which may include the use of the center’s exercise program, as well as tailored attendance at activities.
Focus On CAREGIVING

such as bingo, pet therapy, a gardening club, or music therapy classes.

All Level 1 participants are screened for appropriateness by a physical therapist for participation in the exercise program. The screen encompasses cognitive abilities, such as the ability to follow instructions and willingness to participate, and physical abilities, such as transfer onto equipment and medical limitations for equipment use. An initial exercise plan of care typically includes equipment, resistance level, and length of time on equipment. Two certified nurse assistants (CNAs) monitor residents’ pre- and post-vital signs, assist them with transferring on and off equipment, and document minutes exercised on the equipment.

After the resident’s participation has been closely monitored for six weeks—the time frame recommended by the American Psychiatric Association to determine whether a depression treatment was robust enough to reduce the depressive symptoms in half—a summary note is written about the individual’s response to the Level 1 interventions.

- Level 2—Social Work. For residents who do not respond adequately to Level 1 activities, social workers function within this level as “case managers” to help determine the biological, psychological, and social causes of the depressive symptoms and work toward connecting the residents with the appropriate care or services to meet their needs.

At this level of care, the social worker typically assesses for adjustment issues, such as how well a resident has settled into the new environment, the death of a loved one, spiritual needs, existential concerns, or family or friend relationship issues. A social worker at this level may provide a supportive ear to the resident to assist in working through difficulties in adjustment, as well as arrange for a chaplaincy service visit or work with family members to modify family visits.

- Level 3—Psychology and Psychiatry. Intervention activities at this level are what traditionally have been considered in the nursing facility as a first-line treatment approach. If residents do not respond to Level 1 or Level 2 approaches, a referral to psychology and/or psychiatry is initiated. Of course, it is always within the purview of a staff member to initiate Level 3 referrals at any point in the process if they deem it necessary.

Implementation

Abramson staff began implementation of the program by identifying participants through completion of the minimum data set (MDS). A resident was enrolled in the program when the MDS assessment required completion of the Mood and Behavior section.

The facility’s social worker then completed a Geriatric Depression Scale (GDS), for residents who were cognitively capable of answering questions about their mood, or the Cornell Scale for depression in dementia, to the direct care workers of the resident who were not able to respond to issues related to their mood.

Following the assessments, the activity therapist took the resident under her wing and encouraged greater participation in activities over a six-week period.

Following this period, she wrote a summary note in the resident’s electronic medical record describing the nature of his participation.

Assessments at the Abramson Center now typically occur on a quarterly and annual basis. Once the MDS 3.0 is formally implemented, the center plans to replace the GDS with the Patient Health Questionnaire (PHQ-9).

Follow-up

The social worker re-administers the depression screener after the initial six-week period and, based on the findings as well as the activity therapist’s summary notes, will take one of the following actions:

- Discharges the resident from the program if the screen is negative and activities have become habituated;
- Maintains the resident on Level 1 for maintenance period if the depression screen is negative but the activity participation does not appear to be habituated;
- Maintains the resident on Level 1 only if depression screen is positive but significant improvement is detected;
- Maintains the resident on Level 1, but adds Level 2 if the resident tolerated Level 1 well but did not experience a significant symptom reduction; or
- Places the resident on Level 2.

**ABRAMSON RESIDENCE DEPRESSION MANAGEMENT PROGRAM RESULTS**

**Graph 1: Change In Depressive Symptoms**

- Improved: 22.4%
- Unchanged: 10.4%
- Worsened: 67.2%

**Graph 2: Percent Of Residents With Positive Response To Depression Program**

- At Risk for Depression: 58.2%
- Depression Remission: 41.8%

**Graph 3: Combinations Of Depression Interventions**

- Level I only: 7.1%
- Levels I and II: 3.6%
- Level II only: 7.1%
- Levels I, II, and III: 14.3%
- Spontaneously recovered: 67.9%

only—in the rare case in which a resident had a negative response or declined all attempts to provide Level 1 interventions.

If significant depressive symptoms appear, or if suicidal ideation is present, social workers and other staff always have the option of administering Level 3, requesting a referral for psychology and/or psychiatry evaluation and treatment if the resident is not already receiving these services or has not been seen for these services in some time.

A referral for Level 3 services can also be considered when the resident has completed six weeks on Level 2 and does not display a significant, detectable improvement.

The same process of screening—intervention and re-screening at six-week intervals—occurs for all residents in the depression management program.

In some cases, residents receive all three levels of care and still have significant depressive symptoms. In this instance, the treatment team usually informs the psychiatrist who then considers whether the antidepressant treatments need adjustment.

Making Rounds
Pulling the entire process together are “mood and behavior rounds.” As an integral part of the program, this practice provides another layer of quality assurance for the participants.

The rounds team, which includes the staff psychologist, social worker, household nurse, CNA, and quality improvement officer, visits one household within the facility each week for between 30 minutes to one hour. During this time, the team discusses each program participant as well as any other resident with mood or behavioral issues.

The team also reviews medical records, including psychology and psychiatry notes, as needed, as well as activity therapy notes, and gets feedback from household staff. The information is then synthesized by the team, and recommendations are given for specific interventions.

Positive Outcomes
Abramson staff believe that regular screening enables them to identify subclinical levels of depression earlier and, through preventive interventions, stave off cases of clinical levels of depression before they become more resistant to treatment and require more stigmatizing and costly levels of care.

Of the 363 residents screened for depression between June 2007 through March 2008, 80 were positive or deemed to be at risk for depression. Among the 80 at-risk residents, 67 were in the program long enough to receive a follow-up screening.

Two-thirds experienced some improvement, while 22.4 percent experienced some worsening of symptoms, and 10.4 percent stayed the same (Graph 1, page 52).

Nearly 42 percent of the 67 went from an initially positive score on a depression screener to a negative score on a follow-up depression screener (Graph 2).

The 27 residents who experienced a remission of depression symptoms averaged 78.9 days in the program. Two-thirds participated only in Level I activities, 14 percent participated in both Level I and II activities, 7 percent participated in Level II-only activities, and 7 percent participated in all three levels. One resident spontaneously recovered (Graph 3).

Although the Abramson Residence relied predominantly on internal staff members, this program could easily be modified to facilities that contract for rehabilitation, activity, and/or mental health staff members.

It would likely require a staff member, such as a nurse manager or social worker, within a facility to coordinate these services.

For More Information
Contact Scott Crespy at (215) 371-1810 or screspy@abramsoncenter.org.
Data and Measurement Tool
and Requirements
I. **Purpose.** The purpose of the Depression Data Tool is two fold: 1) it serves as a useful case management tool to track residents who are “at risk” for becoming depressed as well as those who are likely to be experiencing significant symptoms of depression; 2) it serves to track and trend the population statistics (i.e., aggregate results) related to depressive symptoms of the residents in the nursing home.

II. **Depression Data Tool.** The data tool was modeled after the data tools used in the “Advancing Excellence” campaign (A National Quality Initiative lead by a Steering Committee of 28 organizations; www.nhqualitycampaign.org). It is an Excel database and has three separate tab types: 1) Instructions, 2) Totals & Rates, and 3) Monthly Tabs.

1. **Instructions Tab** – information is included to assist you in defining terms and in using the data base.

2. **Total & Rates Tab**
   - *A faxed copy of the “Total & Rates” tab is the only sheet that is to be sent for monthly submission for the PA Depression Collaborative (please fax attn: Carol Slingsby, Fax: 215-371-3032, to verify receipt, call her at: 215-371-1806).*
   - a. The “Total & Rates” tab will be completed when information is entered into the monthly case management data sheets (Jan, Feb, etc.). The information from these forms will automatically populate the “Total & Rates” tab.
   - b. **Be sure to enter your Facility Name, Provider Number & Contact Name on the “Total & Rates” tab before faxing (The monthly tabs will automatically be populated when you fill this in).**

3. **Month Tabs** - The monthly tabs are designed as an easy to use case management tracking tool to keep track of residents whose Total Severity Scores (either D0300 [resident interview] or D0600 [staff interview]) fall in the 5 and above range.
   - o Typically, residents scoring 5-9 fall in the Mild Depression range for which prevention or maintenance is the focus.
   - o For residents scoring 10 and above – symptom reduction is likely the focus.
   - a. **Total # of Assessments in current month (Required)** represents the total number of MDS Assessments for
which the Mood Section (D) was completed – MDS Assessment Tally (upper right-hand corner) may be useful to keep count of MDS assessments completed throughout the month.

b. **Room #** (Optional) as this is an internal document – facilities may use whichever identifier(s) they wish (the monthly pages are **NOT** to be faxed as part of facility data requirements).

c. **Resident Name/ID #** (Optional) as an internal document – facilities may use name column as they would like.

d. **Date** represents the date that the Mood Section (D, PHQ-9 specifically) was completed.

e. **Total Severity Score** (Required) represents either the number in D0300 if a resident interview is conducted or the value in D0600 if a staff interview is conducted.

- The next 4 categories (No Level Intervention, Level 1, Level 2 and Level 3) are Required Fields. Please place an “X” in the appropriate box based on the intervention(s) that the resident received. If the resident received more than one intervention, please mark all appropriate boxes.

f. **No Level Intervention** if the resident did not receive any specific level intervention (see Level Example Table in Toolkit).

g. **Level 1 interventions** represent any specific Level 1 intervention that the resident received (see Level Example Table in Toolkit).

h. **Level 2 interventions** represent any specific Level 2 intervention that the resident received.

i. **Level 3 interventions** represent active and regular involvement by either a psychologist and/or psychiatrist.

- For the final 2 categories (which are optional), please place an “X” in the appropriate box if you choose to use these.

j. **Suicidal Ideation** (Optional) Nursing homes may want to track whether the resident indicated any thoughts that “they would be better off dead…or harming themselves” in Mood Section question “i.”

k. **Behaviors** (Optional) Nursing home may want to track residents who have had verbal, physical or other problematic behaviors toward others (Behavior Section).
## Level Interventions: Usual care vs. Depression specific approaches

<table>
<thead>
<tr>
<th>Level 1 Interventions</th>
<th>Usual Care Examples</th>
<th>Depression Specific Approach Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic Recreation</strong></td>
<td>Invite household residents to daily programming, supplies provided for independent leisure, visit those who need 1:1 interventions at least 2-3 times per week</td>
<td>Involve resident in the planning of preference congruent leisure pursuits and work toward matching their preference pursuits with the identified cluster of depression symptoms. For example: a resident with low self worth to play a role on the welcoming group for new resident on the household</td>
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<td><strong>Restorative Nursing</strong></td>
<td>Works with resident to complete assigned restorative nursing programs</td>
<td>Use of enhanced motivational “Tips” when decline in resident performance of ADLs appears to be related to mood and/or depression issues</td>
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<td><strong>Exercise</strong></td>
<td>Offer regularly scheduled exercise programs (e.g., morning stretch, volunteer exercise class, etc.)</td>
<td>Active Life Exercise Program - doctor’s order, supervised use of weights and exercise equipment</td>
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<td><strong>Social Services</strong></td>
<td>Case management functions during admissions, readmissions and discharges and as needed. MDS Assessments</td>
<td>Clinical and/or case management support during periods of adjustment, loss of abilities and bereavement. Work with resident and/or family to assist with adjustment to facility and/or build social networks</td>
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<td><strong>Chaplaincy Services</strong></td>
<td>Invite to worship services, religious life events, religious holiday celebrations</td>
<td>Chaplain visits with individual for therapeutic spiritual care. Planned weekly spiritual care visits with spiritual-psychosocial plan of care coordinated with the social worker</td>
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<td><strong>Volunteer Services</strong></td>
<td>Volunteer offers books, assists in technology room, library and at events</td>
<td>Coordinated friendly volunteer visits with resident who have signs and symptoms of depression and who may benefit from additional social supports</td>
</tr>
</tbody>
</table>

### Level 2 Interventions
- Individual and/or group psychotherapy, psychological evaluations

### Level 3 Interventions
- Individual psychiatric evaluations, psychotropic medication management

Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
## 2011 At Risk Depression Tracking Tool
### March Assessments

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### 2011 At Risk Depression Tracking Tool

| Month          | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 | # RES. 5-9 | # RES. >10 |
|----------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| January        | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| February       | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| March          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| April          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| May            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| June           | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| July           | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| August         | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| September      | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| October        | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| November       | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |
| December       | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0          |

#### At Risk Rates and Interventions

| Percentage of Residents With Score Positive | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No Intervention                             |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 1 Intervention                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 2 Intervention                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 3 Intervention                        |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

#### At Risk Rates and Interventions

| Average YTD Percentage of Residents With Score Positive | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| No Intervention                                         |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 1 Intervention                                    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 2 Intervention                                    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Level 3 Intervention                                    |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

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Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
2011 At Risk Depression Tracking Tool

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Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
Quality Improvement Process

Quality Improvement (QI) is a process for enhancing organizational performance that uses defined methods and strategies. Results are achieved through a systematic process that identifies gaps between desired and actual performance. Some processes that are used are root cause analysis, flow charting and data management. QI identifies the root cause, selects, designs and implements interventions to fix the problem and measures changes in performance based on those interventions. QI is a continuously evolving process that uses the results of monitoring and feedback to determine whether progress has been made and to plan and implement additional changes.

The goal of QI is to identify opportunities for improvement at the Organizational, system, process and employee levels in order to achieve desired outcomes. The QI process is most likely to achieve its goal and desired result when the following the factors are present:

- Organizational leaders are involved in defining quality and safety expectations and promoting a culture that supports improvement
- All levels of the organization is involved in the planning and implementation stages
- The focus is on improving processes rather than punitive measures
- Results are measured
- Effective decisions are based on data analysis and information
- Communication and education is included in all steps of the process
- The QI process is systematic and ongoing
Quality Improvement Process:
Depression Prevention and Management Program

The primary intervention in the PA Depression Collaborative is a continuous Quality Improvement (QI) Process that drives quality of care provided to persons in nursing homes that are depressed or at risk for depression.

The QI process has four interconnected components in its PDSA Cycle:

1. **Plan**: nursing home staff members participate in Training Sessions and put into place necessary components of the Depression Prevention and Management Program.

2. **Do**: nursing home staff administer valid and reliable screener of depressive symptoms (PHQ-9- MDS 3.0) and track depressive symptoms over time; and use evidence based practice guidelines for Therapeutic Recreation, Exercise, Restorative Nursing, Social Work, Chaplaincy, Psychology and Psychiatry as appropriate/available.

3. **Study**: nursing home staff use systematic structure to track and evaluate system and treatment outcomes and drive implementation of evidence based practices.

4. **Act**: based on systems and patient-specific outcomes, systems and individual interventions are added, modified or removed.

QI Process Informs Clinical Work Flow

1. Quarterly PHQ9 assessment (typically by Social Worker)
2. Results shared with interdisciplinary staff
3. Referrals made for specific level assessment/evaluation
4. Based on assessment findings individual disciplines implement and care plan evidence based practices
5. Review response to interventions, maintain or modify treatment planning in weekly interdisciplinary group meeting (each household visited at 6-week intervals)
6. Quarterly depression screen and follow-up by interdisciplinary team which makes the decision to increase, decrease, or keep same level of treatment intensity based on outcome of screen
7. Person followed by team as long as depressive symptoms remain

Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
Depression Screening

One of the primary recommendations of the 2003 American Geriatrics Society (AGS) and the American Association for Geriatric Psychiatry (AAGP) consensus panel was to go beyond the MDS 2.0 depression assessment items when assessing for depression. The developers of the MDS 3.0 chose the Personal Health Questionnaire 9 (PHQ9: Spitzer et al., 1999) as the selected depression assessment tool.

As a validated depression screening tool, the PHQ-9 and others (e.g., Geriatric Depression Scale [GDS], Hamilton Depression Rating Scale [HAM-D], Beck Depression Inventory [BDI], Zung Self-Rating Depression Scale [SDS], and the Cornell Scale for Depression in Dementia [CSDD]) indicate the likelihood that an individual is at risk for having a Major Depressive Disorder. Like the other depression screeners, the PHQ-9 has a distinct cut-off point that suggests whether depression symptoms are present. In the MDS 3.0 the PHQ-9 score is referred to as the “Total Severity Score.” A score of 10 or greater is generally considered to be a moderate level of depressive symptoms which require intervention. Collaborative members are encouraged to consider putting into place prevention measures for PHQ-9 scores of 5-9 (mild depression range).

A depression screener result is like having a blood test result for a medical condition (e.g., PT/INR) - it can help one know whether the depressive symptoms are under control or not. Depending on follow-up results, it can tell you about the effectiveness of the current care plan and interventions.

The PHQ-9 has an important distinction to the other depression screeners, the developers derived the 9 items of the screener from the 9 symptoms of Major Depressive Disorder from the Diagnostic and Statistical Manual, the American Psychiatric Association’s diagnostic tool. While there are other important considerations in making a diagnosis of depression (e.g., rule out bereavement, hypothyroidism, other psychiatric diagnoses, etc.) the results of the PHQ-9 can nevertheless aid in this determination.
Depression Screening Process

I. MDS 3.0 Assessment: Mood Section D:

The social worker performs the MDS 3.0 interview/assessment with each resident or staff person at least every 3 months or as indicated by the MDS guidelines. Residents who are able to express or communicate requests, needs and/or opinions are directly interviewed by the social worker who uses the PHQ-9. For all others, the social worker interviews care giving staff most familiar with the resident using the PHQ-9-OV.

The Total Severity Score is then calculated for the PHQ-9 - the range of the score is between 0 and 27. Table 1 provides interpretations for PHQ-9 Total Severity Scores (e.g., 1-4 = Minimal Depression, 5-9 Mild Depression, etc.).

Note: An affirmative response to the Mood Section, PHQ-9 “better off dead” question (Section D0200I) and/or any behaviors noted during this period are used in consideration of services for referral.

Total Severity Score – Context is Key!

A Total Severity Score of 10, in the moderate depression range, is a significant finding for an individual with historically lower levels of depression. For example, for a resident who has had a Total Severity Score of 2 in the past, a 10 may indicate a significant increase in depressive symptoms. However, a Total Severity Score of 10 for a resident who previously scored 20 would indicate a significant response to current care plan (the American Psychiatric Association suggests that 50% reduction in symptoms represents an effective response). In this case, current interventions would likely be kept in place with perhaps some minor additions that might reduce the symptoms further.

Clinical Discretion for those in the Mild Range

For residents scoring between 5-9 on the Total Severity Score, falling in the “Mild Depression” range with a negative response on “better off dead” and no related behaviors, professional discretion is employed to decide the appropriate response (see Table 1). For example, if the resident is currently experiencing an acute medical illness, making them...
particularly lethargic, with related depressed activity, the social worker may decide that the score in this range is short term and situational as opposed to a true indicator for depression.

**Prevention Services for those in the Mild Range**

On the other hand, a score in the Mild range (5-9) may prove to be an affirmation of the resident’s overall emotional decline, reinforced by updates through the daily interdisciplinary rounds or other observation. Closer monitoring by social service in either circumstance is warranted, but in this case, a referral to Level 1 and/or Level 2 interventions may apply as they may be indicators of mild depression.

**Staff Response to Residents with scores at or above 10**

Those residents scoring 10 and above, or answering affirmatively to “better off dead,” and with or without related behaviors are routinely enrolled in Level 1 and/or Level 2 interventions.

A protocol of response has been instituted for residents answering affirmatively to the “better off dead” question (see attached diagram). Essentially, the social worker immediately screens for risk of self-harm, providing 1:1 supervision until more data is gathered. The social worker also notifies the DON, NHA, floor supervising nurse and medical director or attending physician, and requests an evaluation by psychology and/or psychiatry as appropriate.

**Any resident who expresses suicidal ideation or co-existent psychotic symptoms is immediately referred to a mental health professional.**

Residents who fail to demonstrate a lessening of depressive symptoms over a three-month period are subsequently advanced to a higher level of intervention until they demonstrate symptom remission. Residents who show complete remission of symptoms (e.g., less than 5 on the PHQ-9) are discharged from the program, but continue to receive quarterly assessments using the PHQ-9.

Clinicians are always encouraged to use clinical judgment when selecting a given level of intervention for a given resident. Mood & Behavior Rounds, conducted on a regular basis (e.g., every 6 weeks on each household) serve as another assessment tool for multidisciplinary discussion of residents’ emotional status.
Table 1: Patient Health Questionnaire (PHQ-9) Score, Interpretation and Possible Actions

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<th>Total Severity Score</th>
<th>Depression Severity</th>
<th>Actions Needed</th>
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| 1-4                  | Minimal depression      | **Initial Assessment** – This score suggests the patient, at this time, may not need depression treatment.  
**Ongoing Monitoring** – Reduction of score to this level implies remission of depression. Provide ongoing treatments as they appear to be working well. |
| 5-9                  | Mild depression         | **Initial Assessment** – Use clinical judgment in deciding the appropriate treatment. If no symptoms of suicidality, consider referral to level 1 intervention.  
**Ongoing Monitoring** – A 5-point reduction in score or greater indicates a solid response to treatment. Continue to provide ongoing treatments. |
| 10-14                | Moderate depression     | **Initial Assessment** – Use clinical judgment in deciding the appropriate treatment. If no symptoms of suicidality, consider referral to level 1 and/or level 2 interventions.  
**Ongoing Monitoring** – A 5-point or greater reduction indicates a solid response to treatment. A Reduction of less than 5 points within 12 weeks indicates a lack of response. Treatment plan change may be considered at this time. Consider additional levels of treatment. |
| 15-19                | Moderately severe depression | **Initial Assessment** – Treatment for depression using level 3 interventions: Psychiatry (antidepressant), referral for Psychology or a combination of treatment with or without Levels 1 and 2.  
**Ongoing Monitoring** – Indicates poor or no response unless score has decreased 5 or more points. Lack of response within 12 weeks may require medication change, additional medication or augmentation or referral to a psychiatrist. |
| 20-27                | Severe depression       | **Initial Assessment** – Warrants treatment for depression using antidepressants or a combination of antidepressants and psychotherapy and other treatments as well.  
**Ongoing Monitoring** – Indicates severe depression that would require psychiatric referral for consultation and/or management. |

Developed by the Abramson Center for Jewish Life and its Polisher Research Institute
Depression Interventions

The Promoting Positive Well-being program employs three levels of intervention depending on the overall severity of symptoms, past history of depression, and resident and/or family preferences: Level 1) Increased availability and frequency of preferred activities, restorative nursing and exercise; Level 2) Support with resident adjustment issues and enhanced social support/social network; and Level 3) treatment by mental health professional.
Level 1 Interventions

As a quality improvement initiative, the Abramson Promoting Positive Well-being Program (Depression Prevention & Management Program) categorizes each of the depression interventions into three Levels. While this provides a very useful way of administering interventions in a step-wise or increasing intensity framework, we realize that interventions at each level can focus on aspects of physical, cognitive, social, emotional and spiritual needs of the resident.

While there may be multiple mechanisms that explain the efficacy of the Level 1 Interventions, Behavioral Activation, appears to describe the process best. Behavioral Activation is a theory that originated from cognitive behavior therapy and postulates that depression results from too little environmental reinforcement or too much negative feedback from the environment. Behavioral activation has been found to be an effective treatment for depression (Spates, C.R., Pagoto, S. and Kalata, A., (2006) on a par with other therapies as well as antidepressant use (Dimidjian, S., et al., 2006).

As a behavioral approach, one of the major goals of behavioral activation is to increase the level of activity with residents who have diminished psychomotor movement related to depression. In its simplest terms, it is to “get the resident going.” It can include anything from encouraging them to get out of bed, brush their teeth, comb their hair, ambulate to meals, and participate in leisure pursuits individually or in groups, as well as exercise.

Some helpful characteristics of an effective intervention using the principles of behavioral activation include:

- establishing goals (restorative nursing, recreation, exercise)
- placing emphasis on resident preference based activities (or highly reinforcing activities)
- beginning with the easiest tasks first (success is inherently reinforcing)
- monitoring progress toward goals (adjust as necessary)
- reinforcing success throughout the process

In sum, the goal of Level 1 interventions it to create rewarding opportunities to foster greater resident movement and activity for the purpose of reducing symptoms of depression.
Level 1 Intervention: Behavioral Activation
Therapeutic Recreation

I. **Description.** Residents who may be at risk for depression often benefit from engaging in leisure pursuits. Having the opportunity to engage in or participate in a preferred activity provides the participant with a sense of control, empowerment and self-worth. It is important that a resident at risk for depression is involved in personalized leisure not just any activity; this will help ensure a positive outcome.

II. **Assessment Process.** Upon completion of the MDS 3.0 PHQ-9 depression screener, the social worker will notify the recreation director of a new resident entering “level one activity.” The recreation director then initiates steps to determine if the resident is appropriate for recreation intervention.

**Recreation Director’s Steps:**

A. Determine the residents score. Typically, we want to focus on residents with a PHQ-9 score of 5 or above.

B. Determine if any residents are not appropriate for recreational interventions, e.g., the resident is already highly involved in preference based leisure AND their symptoms are not directly resolved through leisure.

C. Assign residents who need to receive level 1 recreation interventions to recreation staff.

D. If your facility employs a CTRS (certified therapeutic recreation specialist) or a MT-BC (music therapist-board certified) this program creates an excellent opportunity to utilize Section O “special treatments, procedures and programs” of MDS 3.0. To do so, obtain a physicians order and set clear treatment goals.

E. Supervise recreation staff in reviewing the particular cluster of depression symptoms present (e.g., feeling down, depressed, hopeless; feeling tired, or little energy) to determine which preference-based interventions may be the most successful.

*Note: If the resident has a co-morbid diagnosis of dementia, interventions modified to fit their needs are provided (e.g., sensory stimulation). As well as modifying interventions for residents with sensory or functional impairment.*
Recreation Assistant steps:

A. Conduct a review of the resident’s leisure interest assessment OR complete a new leisure interest assessment. The PELI (Preferences for Every Day Living Inventory) is an excellent tool (developed by the Polisher Research Institute).

B. Determine whether the resident would benefit from small groups, large groups or 1:1 interventions, or a combination.

C. Create Specific Care plan Goals, when appropriate, involve the resident in the development of his/her care plan goals, which can increase positive outcomes.

III. Intervention Phase. Recreation interventions can include, but are not limited to:

A. General therapeutic recreation activities
   o Exercise (simple chair/wheelchair exercises, ball toss, stretching, etc)
   o Art (painting, art appreciation, etc.)
   o Music (sing along, song writing, etc.)
   o Storytelling (Timeslips)
   o Reading (book club)
   o Crafts (woodworking, knitting, etc.)
   o Horticulture
   o Reminiscing/discussion
   o Cooking
   o Trivia
   o Card Games
   o Table Games
   o Relaxation techniques (guided imagery, deep breathing, massage, etc.)
   o Volunteering (greeting new residents)
   o Computer (skype, emailing, etc.)

B. Specialized therapeutic modalities
   a. Recreation therapy (delivered by a CTRS)
   b. Music therapy (delivered by a MT-BC)
   c. Pet therapy (utilizing certified therapy animals)
   d. Horticulture therapy (delivered by a HTR)
C. Intervention Tips:
   a. When conducting any size group:
      o Introduce the participants to each other, include an icebreaker or warm-up
      o Introduce the purpose of the group and its expected outcomes
      o Conclude the group with review of the outcomes
      o Thank attendees for their participation
   b. It is important to provide the correct level of cueing during recreational programming. Empower residents to complete as much of the task on their own as possible, this may mean less content in the group and more processing of the tasks.
   c. The group environment should be free of distraction (background noise, etc.) as well as an environment where trust is established (residents know the length of time the group will meet and that they will be returned to their rooms/apartments)
   d. Utilize the residents PHQ-9 areas to guide your interventions, for example:
      o A resident who is “feeling bad about self” may benefit from an intervention that allows her to feel a sense of accomplishment (i.e., providing a service to another resident).
      o A resident who has “trouble concentrating” may need a 1:1 intervention so that she can feel she has the time to focus and respond.

IV. List of links.
    www.recreationtherapy.com (the resources link)
    www.atra-online.com (the networking and resources link)
    www.timeslips.org (reminiscing programming)
    www.in2l.com (“it’s never to late” - computer programming)
    www.flaghouse.com (Snoezelen- sensory stimulation)

V. Forms/Tools.
To obtain the PELI Assessment: contact Dr. Kimberly Van Haitsma at kvanhaitsma@abramsoncenter.org
See attached “Depression Caseload Management Tool”
<table>
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<tr>
<th>Resident Name or ID #</th>
<th>Resident Room</th>
<th>Date (m/d/yy)</th>
<th>Total Severity Score</th>
<th>Depression Symptoms</th>
<th>Notes</th>
<th>Initiated Intervention</th>
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Level 1 Intervention:  
Behavioral Activation/Restorative Nursing

I. **Description.** Residents with depression or depressive symptoms can lose interest in conducting many of their ADLs. The members of the nursing department bring a positive caring attitude to help residents do as much as they can for themselves. Those who have depressive symptoms (low energy, lack of interest, feeling sad, down or depressed, etc.) often require a refined subset of interpersonal tools (reinforce small successes, minimize emphasis on failures, tap into residents’ motivation [e.g., their kids would be proud, personal pride, etc.]) to encourage residents to make the effort when they may not feel like it. Some residents with cyclical depression only require restorative programs when they experience ADL declines during depressive phases.

II. **Assessment Process.** Typically CNA staff report mild declines in ADLs and report them to the Nurses. MDS assessments can also pick up changes from one quarter to the next, which may have been too gradual for usual detection methods. Nursing consults with members of the interdisciplinary team for feedback in determining whether a restorative nursing program is warranted and which one. Residents with diminished psychomotor activity are typically given restorative nursing programs to increase such activity.

III. **Intervention Phase.** Restorative nursing program selection and restorative nursing program administration are rolled out in a step-wise manner to build resident successes and confidence. The following approaches may have the most value to foster behavioral activation:
   a. Ambulation
   b. Transfer
   c. Toilet Use
   d. Range of Motion
   e. Dressing
   f. Eating

IV. **Forms/Tools.** Restorative nursing programs are readily available on the market. Attached is a CNA training sheet when caring for residents who have depressive symptoms.
Tips for Motivating Residents to Self-Perform ADLs
When Symptoms of Depression are Present

While the Nursing Department maintains a positive caring attitude toward all residents, residents with depressive symptoms such as low energy, little interest in doing ADLs, feeling sad, down or blue, may require additional motivational tools.

1. Establish Achievable Goals for ADLs
   a. Residents with depressive symptoms may not have the energy or interest to do the ADLs for which they are physically capable.
   b. Working with residents to set goals that are within reach and are attainable – when accomplished can be self-motivating and enhance self-efficacy (Cultivating competence, self-efficacy, and intrinsic interest through proximal self-motivation. Bandura & Schunk [1981])
   c. It is better for residents to do some or part of their ADLs than none at all.
   d. “Mrs. Smith, I see you are not feeling your best, how about you put one pant leg on and I will help you with the other?”

2. Reinforce Small Successes and Minimize Emphasis on Failures
   a. Residents with depressive symptoms can feel like a failure and focus on what is wrong or not going well – an emphasis by staff on what the resident can do and does do can provide needed encouragement.
   b. “Mrs. Smith, for someone not feeling her best, you pushed yourself today and did a very nice job with putting your socks on!”

3. Tap into Residents’ Motivation
   a. Residents with symptoms of depression may lack the motivation and therefore lack the confidence to do their ADLs or appreciate the importance of doing them (Lifestyle Change; Dunn & Rollnick, 2003).
   b. Pointing to resident successes in the recent past may help them to have the confidence to try their ADLs today.
   c. Tap into past conversations with the resident. Remind the resident what she has told you in the past about why it was important to maintain as much independence as possible. “Mrs. Smith, you mentioned to me that you like to keep up your skills and abilities so that your grandchildren see you as healthy as possible, how about trying to brush your hair for them today?”

4. Supportive Communication
   a. Residents with depressive symptoms often feel unloved or hopeless, a few extra minutes of staff lending a supportive ear goes a long way.
   b. “Mrs. Smith, I enjoy seeing your smile everyday – you look a little down today, is there something on your mind that you would like to talk about?”
Level 1 Intervention:
Behavioral Activation: Exercise

I. **Description.** Depression can be prevalent in the elderly and contributing factors include: medication side effects, the onset of Alzheimer’s disease and other ailments, and a sense of loss (loss of loved ones, income, functional abilities, health). Exercise activities and fitness programs can help to contribute to a more independent lifestyle for residents through regulating blood glucose levels, stimulating catecholamines, improving sleep patterns, improving cardiovascular endurance and efficiency and enhancing safe mobility, thus, improving the overall quality of life. While physical benefits are the most noticeable outcome of exercise, there may also be significant psychological and social benefits. Exercise can play a part in relieving the symptoms of depression by creating a general sense of well-being, improving relaxation, decreasing stress hormones, improving cognition, motor control and skill learning. Exercising in a group format adds social benefits by improving self-confidence and self-esteem and by the formation of new friendships. These were many of the factors that went into the development of the Abramson Center’s exercise program, referred to as the “Active Life Program.”

II. **Assessment Process.** Residents who express an interest in exercising and participating in the Active Life Program obtain a physician’s order for rehabilitation referral. Rehabilitation performs an evaluation to determine if a resident meets the criteria to participate in Active Life.

The criteria are as follows:

a. resident is cooperative and able to follow simple commands
b. resident is able to transfer with assistance of one person
c. resident is able to walk with assistance of one person, with or without an assistive device
d. resident is able to sit in a regular chair and not attempt to get up unassisted

Once it is determined that the resident meets these requirements, the therapist establishes an exercise and ambulation program, based on the resident’s functional abilities and interests.

III. **Intervention Phase.** At the current time, our Active Life/wellness program is being redesigned. While popular and successful, it had not been updated for several years. In the past, Active Life functioned as an
8-week program to allow as many residents as possible to rotate through this activity. Residents were eligible to participate in Active Life as many times as they wished, as long as they continued to meet the above noted criteria.

The updated program will include:

a. strength training through latex bands, cuff weights, dumbbells  
b. balance activities in both sitting and standing positions  
c. ambulation with or without an assistive device  
d. cardiovascular activities using the NuStep recumbent exerciser, arm ergometer, walking programs  
e. flexibility activities to promote range of motion and self-care

While the exercises can be performed on an individual basis, it is preferable to work in a small group format to encourage socialization and camaraderie.

IV. **List of links.**

a. Kepler, I.A. & Jenkins, M.(2006); Older Adult Fitness, AAAI/ISMA, New Hope, PA  
e. [http://www.webmd.com/depression/guide/depression-elderly](http://www.webmd.com/depression/guide/depression-elderly)

V. **Forms/Tools.** Wellness and exercise programs are readily available on the market. Whichever program you use, remember to properly document participation and tolerance. At a minimum, a program would benefit from the following documentation:

a. Documentation of volitional participation  
b. Documentation of resident’s functional mobility status  
c. Documentation of exercise recommendations from therapist  
d. Attendance Logs
Level 2 Interventions

Social support is an important component of promoting positive well-being. Social support is especially important to people who are at risk for depression and those who have developed it, because it provides a healthy way to cope with emotions and stress. Social support networks can include family, peers, staff members, volunteers and visitors.

Stressful experiences such as death of a loved one, loss of physical abilities, or decline in mental acuity, among other things, contribute to depression. The literature suggests that people who receive social and emotional support during these events can recover more quickly. Trained therapists (recreation, music, art, social worker, psychologist and clergy) are well equipped to help residents adjust to many of the stressful experiences mentioned above, as well as to a new living arrangement (i.e., in a skilled nursing facility).

Social support may also help prevent depression by functioning as a buffer to future stressful events. Building social supports and a social network for residents who are “at-risk” for depression (i.e., whose depression is in the Mild range) can be a potent barrier to prevent residents from developing worsening levels of depression.

In the Promoting Positive Well-being Program, Level 2 interventions include: social work interventions, chaplaincy services (pastoral counseling) and volunteer visits.
Level 2 Intervention
Adjustment/Social Networking: Social Services

I. Description: The social worker focuses on the whole person as s/he responds to the psychosocial needs of elders at risk for depression. The social worker uses him/herself as a listener, facilitator, an advocate and a collaborator with the resident in long-term care, their families and co-workers in all disciplines. The social worker enhances the quality of communication, empowering the client, family and interdisciplinary team in addressing risks for the development or worsening of a depressive syndrome.

II. Assessment Process:

1. **Interdisciplinary Rounds.** Interdisciplinary rounds occur each weekday morning at the Abramson Center SNF. During these rounds, the social worker listens for updates on resident mood and behavior as it relates to illness, mobility, and overall function. With input from colleagues and his/her knowledge of the resident the social worker considers the need for a change in the plan of care.

2. **MDS 3.0 Assessment.** Additionally, the social worker performs the MDS.3 interview/assessment with each resident or staff person at least every 3 months. The total severity score of that mood interview, an affirmative response to the “better off dead” question (Section D0200I) and any behaviors during this period are used to highlight possible indicators for risk of depression. The social worker uses the MDS 3.0 Assessment as a time to explore further any positive symptoms of depression (or other emotional/mental health issue).

3. **Mood and Behavior Interdisciplinary Rounds.** A third screening mechanism utilized to capture residents at risk is the weekly Mood and Behavior rounds. In preparation for this meeting, the social worker surveys the residents on the designated floor or household reviewed for that week, who trigger through the MDS.3 interview process with scores greater than 5 on mood, answer positive to “better off dead” or have related behaviors. The social worker looks back to the previous rounds conducted on the floor of residents 6 weeks previously to consider those who may have been assessed and continue with symptoms, and obtains information about antidepressant medication these residents may have been prescribed.
At the rounds, these residents are discussed by the attending nurse, medical director, psychologist, recreation director, quality improvement officer and social worker.

If no formal assessment was done within this 6-week period, the resident may be included in the report for Mood and Behavior Rounds if the social worker identifies that the mood of the particular resident continues to be a concern.

All disciplines participate in the discussion of factors impacting the resident’s emotional and behavioral status. Level 1, 2 and 3 are discussed and employed and/or modified as necessary.

III. Intervention Phase. The social worker meets with the resident, family, colleagues as needed to provide support when depression is a concern. She or he coordinates with related disciplines in responding to the resident’s stated needs. The social worker stays in regular communication with the resident, family and other disciplines to assess the resident’s response and the effectiveness of the interventions.

IV. Tools.

Social worker interventions include, but are not limited to the following areas:

- Coping support/stress management activities such as deep breathing
- Counseling to normalize need for additional support
- Encourage life story telling and/or gratitude journaling
- Utilize cognitive behavioral techniques to stimulate correct and positive thinking
- Coordinate efforts with other care providers to increase social network of resident
- Encourage spiritual activities
- Encourage healthy lifestyle
- Provide teaching and learning opportunities for resident

V. References.

1. Transformational Leadership in Organizations
   a. Empowered Work Teams in Long-Term Care Strategies for Improving Outcomes for Residents and Staff By Dale E. Yeatts, Ph.D., Cynthia M. Cready, Ph.D., and
Linda S. Noelker, Ph.D.
b. The Lost Art of Listening: How Learning to Listen Can Improve Relationships by Michael P. Nichols

2. Mental Health/Depression Prevention
   a. PA Behavioral Health & Aging Coalition, Linda Shumaker, R.N.C., M.A., Director
   b. Aging and mental health, By Michael Smyer, Sarah Honn Qualls, Blackwell Publishers
   b. Pennsylvania Department of Aging
      http://www.aging.state.pa.us/portal/server.pt/community/department_of_aging_home/18206
   e. A Guide to Mental Wellness in Older Age: Recognizing and Overcoming Depression (A Depression Recovery Toolkit, Geriatric Mental Health Foundation 7910 Woodmont Avenue, Suite 1050, Bethesda, MD 20814 301.654.7850 www.GMFOnline.org
Protocol for Response to MDS 3.0 Mood Interview

MDS 3.0:
Thoughts that you/resident would be better off dead, or of hurting yourself/him/herself in some way

Yes

Immediately further clarify risk with either resident, staff or family member; (whoever is interviewed) and screen for safety

Does the resident have thoughts about hurting him or herself?

No

Document that resident is not at immediate suicide risk

No

Update Care Plan
Document in Electronic Med. Records (SW notes)
Alert Nurse Manager and attending physician via phone. Consider psychology-psychiatry consultation.

Yes

Does the resident have a plan?

No

Is means of self-harm available?

No

Yes

Immediately remove means of self-harm

Yes

Check if the attending physician is not available.
• Contact Medical Director if the attending physician is not available.
• Psychology and/or psychiatry consultation but if not immediately available consider hospital evaluation.
• Resident placed on 24 hr report
• Update care plan
• Document in Electronic Medical Records

No

No further action.
I. **Description.** Chaplaincy services provide the spiritual care and support for individuals challenged by depression. Chaplains work with people facing depression by helping them access internal strength derived from hope and faith and helping them feel reconnected to a caring community of peers, loved ones, and compassionate caregivers. When someone is feeling hopeless, worthless, and purposeless, the chaplain's role is to be an empathic presence that truly understands the crisis and despair experienced, to help that someone find the strength and hope in life from within himself/herself, from faith in God, a Higher Power, and/or a benevolent universe, and to be a representative of a caring and accepting community that embraces him/her.

II. **Assessment Process.** The chaplain assesses the cause and the nature of the spiritual crisis primarily through listening carefully to what the individual is saying and being aware of inflection, body language. In assessing the crisis and the nature of the depression, it is important to take note of the following:

- Verbal content: What is the person saying? What problems and challenges is he/she overtly expressing?
- Capacity for hope: What is the individual’s level of hope—current and future? Does the person express true hopelessness via non-inflective verbalization or numbness, searching for hope via crying or other intense emotions, or possession of hope via statements of hope (e.g. I know it will get better; God is watching over me).
- Strengths: Does the individual exude strength even while in crisis? What is the history of meeting life’s challenges? What tools does the person have to access—capacity to express self through art, poetry, music, song, writing?
- Faith resource: What role does faith—faith in God, a Higher Power, Love of family—play in the person’s life?
- Social support: What support does the person have from family, caregivers, friends?
- Environmental clues: Is the room dark? Are there symbols of connection to the living such as photos, art work?

III. **Intervention Phase.** The primary tool for intervention is active and empathic listening. A chaplain’s primary role is to personify empathy and validation by listening to and reflecting on what the individual is expressing – verbally and non-verbally. The metaphor of the chaplain’s role is to step inside the rowboat...
of the person adrift—struggling with the sea of depression—and to row the boat together with the person. Being an empathic presence helps shed the sense of isolation and helps the person find the internal strengths to access hope.

IV. List of links.
http://plainviews.healthcarechaplaincy.org/
http://www.healingpsalm.com/
http://www.worldprayers.org/
http://www.professionalchaplains.org/index.aspx?id=249

V. Tools. Spiritual assessment forms—this link has good guidance for developing an assessment tool:
Prayers — please see above links for prayers and ideas for composing prayers
Sacred Song and Music: Chants, religious songs, inspirational songs. Stories: folk tales, biblical stories, creating life stories with the individual.
Level 3 Interventions

The current standard of care and entry level treatment of depression in the long-term-care industry is psychological services (Talk Therapy by a Psychologist) or psychiatric services (anti-depressant therapy). Anti-depressant medications may also be prescribed by a family doctor or nurse practitioner.

These along with ECT (Electroconvulsive therapy) are evidence based treatments for depression and remain an important part of any depression prevention and management program. In the Promoting Positive Well-being program, these services are referred to as Level 3 Interventions.

Level 3 interventions are typically used in Moderate-Severe levels of depression and in instances in which suicidal ideation is present. Clinical judgment is always key—Level 3 interventions may be used in parallel to Level 1 and/or Level 2 interventions or at any time it is believed to be needed.
Level 3 Intervention:
Psychology Assessment/Intervention

I. Description: Residents with significant depressive symptoms are always candidates for psychology evaluation and treatment. Licensed psychologists have training and expertise to successfully assess and intervene with depressed residents in a variety of modalities, as well as to advise other staff in successfully intervening.

II. Assessment Process: After referral, a licensed psychologist typically interviews the resident and appropriate staff, and the resident’s family when necessary; reviews the medical record, and conducts psychological testing as needed to clarify diagnoses. Testing can be limited to simple screening measures like the Geriatric Depression Scale (GDS) and the Folstein Mini-mental State Exam (MMSE), but can also include more comprehensive testing instruments or even a referral for full neuropsychological evaluation. All assessment information is combined to determine a diagnosis and treatment plan, including recommendations for further staff interventions.

III. Intervention Phase: Psychology intervention can include individual, group, or family psychotherapy, or even more intensive modalities like partial hospitalization or inpatient psychiatric hospitalization if necessary. Psychologists may also request referrals for evaluations for psychiatric medications. Psychotherapy treatment plans are individualized for residents based on their psychosocial stressors, personalities, cognitive functioning, and other personal resources. Psychologists often include other staff’s assistance in pursuing common goals like increasing socialization, increasing independent functioning, and so forth. Psychotherapy resources are identified below.

IV. List of Links: The American Psychological Association has a number of very useful resources on-line for psychologists working with older adults or in long-term-care settings:

- What practitioners should know about working with older adults: http://www.apa.org/pi/aging/resources/guides/practitioners-should-know.aspx
o REM: A manualized psychotherapy for treating depression in long-term care residents with dementia:

V. **Forms/Tools:** The MMSE and GDS are both available online
   o GDS: http://www.chcr.brown.edu/GDS_SHORT_FORM.PDF
   o MMSE: http://www.isu.edu/nursing/opd/geriatric/MMSE.pdf
Level 3 Intervention
Psychiatry Assessment/Intervention

I. Description: Antidepressant medication is a cornerstone of treatment of moderate to severe depression. While primary care physicians prescribe many of the antidepressants used in long-term care, a psychiatrist (especially one with specialized training and experience in geriatrics) is best equipped to treat depression with psychiatric medications, most notably when co-occurring with other mental health and medical issues. When referred to evaluate a resident with depressive symptoms, psychiatrists can pull together information from a variety of sources, and carefully calibrate medication dosages to attempt to alleviate depression and improve a resident's emotional and psychosocial functioning.

II. Assessment Process: Psychiatrists generally interview the resident as well as relevant staff and family members as appropriate. The focus of the interviews is developing an understanding of the resident's current condition and need for treatment; attention is also paid to past history of psychiatric treatment, current medical issues, and developmental and social history. A psychiatrist may use screening tests similar to those used by a psychologist (GDS, MMSE), and may also order lab tests or other sorts of medical assessments to help clarify diagnoses.

III. Intervention Phase: If appropriate, a psychiatrist may write an order for a resident to begin an antidepressant or other psychiatric medications, or may change dosages of current medications. For more severely depressed residents, a psychiatrist may make a referral for partial hospitalization or inpatient psychiatric hospitalization, or may consider electroconvulsive therapy (ECT) either as an in- or outpatient. Bright light therapy is sometimes recommended if a resident's depression is thought to have a seasonal component. Psychiatrists also refer residents to other mental health professionals for psychotherapy, or occasionally conduct it themselves.

IV. List of Links: The American Psychiatric Association's website has a large number of informative practice guidelines.

V. **Forms/Tools:** Psychiatrists practicing in long-term care often use screening tests like the MMSE and GDS; the link to guidelines for psychiatric evaluation of adults (above) also contains descriptions of other recommended clinical rating scales.

- GDS: [http://www.echer.brown.edu/GDS_SHORT_FORM.PDF](http://www.echer.brown.edu/GDS_SHORT_FORM.PDF)
Wellness Rounds
(Mood and Behavior Rounds)
Wellness Rounds
(Mood and Behavior Rounds)

I. **Purpose.** The purpose of the “Wellness Rounds” is to provide a regular time and space for an interdisciplinary team to review, discuss, develop a plan of care, determine the effectiveness of the plan of care, and modify plan of care as needed for each resident/patient with mood and/or behavior issues – these residents remain in the program (on caseload) until their symptoms are in remission.

II. **Attendees.** The rounds team, which includes the medical director, staff psychologist, social worker, nurse manager, recreation supervisor, and quality improvement officer, participate on weekly rounds. It consists of visiting two households (total of 54 residents) weekly for between 30 minutes to one hour. It takes 6 weeks to complete the cycle of reviewing all necessary residents in a 324-bed facility.

III. **Preparation.** Preparation is key to making the “Wellness Rounds” (Mood and Behavioral Rounds) a successful process. In advance of the meeting, the Social Worker identifies and communicates with the attendees from the other disciplines which residents will be discussed. This list includes, but is not limited to residents who:
  o had already been in the Depression program (those discussed in the previous meeting 6 weeks ago)
  o who are newly identified on a recent MDS 3.0 Assessment
    o for prevention purposes who are in the Mild Range with a Total Severity Score of 5-9
    o for treatment purposes who are in the Moderate or greater range with a Total Severity Score of 10 or greater
  o have newly identified behaviors directed toward others:
    o verbal behavioral symptoms directed toward others
    o physical behavioral symptoms directed toward others
    o other behavioral symptoms directed toward others
  o all residents/patients on psychotropic medications
    ▪ note: our SNF combines Wellness Rounds with Psychotropic Reduction Rounds
    ▪ nursing separately prepares documentation for the meeting of residents on psychotropic medications

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The Social Worker completes part of the “Mood and Behavioral Rounds Note” form in advance of the meeting, to include (this information is gleaned from the medical records, including psychology and psychiatry notes, as needed, and discusses to household staff):

- Resident’s name, room number, etc.
- Specific Reason for “triggering”
  - PHQ-9, score & identified symptoms
  - Specific behavioral issues
  - Current symptoms
- Relevant psychotropic medications (especially anti-depressants)
- Diagnoses or events that may contribute to the current depressive symptoms (i.e., hypothyroidism, bereavement, loss of independence)
- Depression intervention levels currently receiving

IV. Wellness Rounds: The Social Worker leads the team discussion by:

- Introducing the pertinent resident information and the specific reason that the resident is being reviewed
- Each team member then discusses the nature, frequency, duration and progress/effectiveness of their current discipline’s involvement with residents reviewed
- The team reviews the current plan of care, including any specific depression intervention levels, the effectiveness of the interventions, the residents’ ability to tolerate the interventions and any modification to existing interventions or newly applied interventions
- At the completion of this process, the form is circulated for each member to sign and a copy goes in the patient/resident medical chart and a copy is held by the Social Worker for the next meeting in 6 weeks
- Resident/patient care plans are updated

V. Tips. While this system may seem daunting, it gets easier and goes faster as:

- Social Workers are familiar with information needed to prepare for the meeting
- Social Workers develop a level of comfort in leading the meeting
- Participants are coached to stay on task and bring forth information that addresses presenting issues
  - when tangent discussions are encountered, they need to be reigned back in
  - in time, members will learn how to differentiate relevant clinical information from non-relevant information
• Have fun! Celebrate successes! Also, while some patients/residents may spontaneously recover – give the team and staff the benefit of the doubt and give them credit!
Mood and Behavior Rounds Note

☐ Depression Program  ☐ Suicidal Ideation
☐ Behavior Affecting Other  ☐ Other _______________________________

PHQ-9 Score(s)/Current Symptoms: ____________________________________________

________________________________________________________

Diagnoses/Factors that may affect symptom remission _____________________________

________________________________________________________

Pertinent medications (that will affect remission; positive or negative) ______________

________________________________________________________

<table>
<thead>
<tr>
<th>Intervention(s)</th>
<th>Level 1</th>
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<tbody>
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<tr>
<td>☐ Exercise</td>
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Interventions in Care Plan _______________________________________________________

____________________________________________________________________________

Response to Interventions _______________________________________________________

____________________________________________________________________________

Intervention initiated? Yes or No  Intervention effective? Yes or No

New recommendations __________________________________________________________

____________________________________________________________________________

Team signatures Date: ___/___/___

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

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Suicidal Ideation
Suicidal Ideation Resources

I. *A Guide to Promoting Mental Health and Preventing Suicide in Senior Living Communities.* A current and comprehensive guide developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.

Available at:

http://store.samhsa.gov/shin/content/SMA10-4515/SMA10-4515-02.pdf

II. The Suicide Screening Tools (Tool 2.b) listed in “*A Guide to Promoting Mental Health and Preventing Suicide in Senior Living Communities:*” include:

1. **Suicide Assessment Five-step Evaluation and Triage (SAFE-T)**
2. **Geriatric Suicide Ideation Scale**
3. **Suicidal Older Adult Protocol (SOAP)**
4. Scale for Suicide Ideation (SSI)
5. The Paykel Suicide Questions

* The bolded suicide screening tools (1 – 3) are highlighted on Learning Session 3 of the PA Depression Collaborative.