



Oklahoma State
Department of Health

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
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OASIS

Special points of interest:

- Points to Ponder
- Automation Tips, Reminders & Updates



Volume 2, Issue 1
January 2016

Treating Depression in Older Adults

Demand is growing for mental health services for older adults. Older adults make up 12 percent of the American population, but will grow to 20 percent of the population by 2030. Although depression is not a normal response to changes that occur in older adulthood, this medical problem affects many older adults. It is widely under-recognized and undertreat-

ed. Depression can impair an older adult's ability to

cause suffering and family disruption. Without treatment, the symptoms of depression can last for years.



function independently and can contribute to poor health outcomes. It can

Screening for depression improves your ability to recognize and diagnose depression, and in doing so provide appropriate treatment and improve outcomes of depression. Depression is often under-recognized and under-treated in older adults. The PHQ-2 can help rate the se-

Points to Ponder

Are you effectively communicating and completing the PHQ-2 with your patients?

Capturing the elder's voice provides valuable insight into what they are thinking and feeling. Taking the time to show genuine interest in what the elder is saying shows the individual they matter, and how they are feeling matters. This can go a long way when trying to provide appropriate care for them as it establishes trust between the patient and caregiver.

The PHQ-2 is a screening tool and is not intended to diagnose. However, it will lead you to contributing

factors that will help you understand why the individual is experiencing feelings of depression.

By using the PHQ-2 or other standardized, validated depression screening tool, you will also identify:

- Unique characteristics and strengths of each individual patient
- Areas of concern that should be addressed
- Possible interventions to help maintain or achieve their highest practicable level of well-being and
- The needs and desires of the individual

For those who have not experienced depression, it can be incomprehensible. Assisting and addressing depression in the elderly who are dealing with depression will "help unlock a closet from which many souls [are] eager to come out." (Quote from "Darkness Visible" by William Styron).



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Depression and Risk for Adverse Falls

Falls are highly prevalent, harmful events for older adults. Identification of patients at risk for falling is a high priority. It has been demonstrated that patients who indicate depressive symptoms on the home health Outcome and Assessment Information Set are at risk for falls. A study (data from the OASIS) shows that patients who fall are twice as likely to be depressed. So you can see that depression and falls are linked. Data suggests there is a potential benefit of including depression screening for multifactorial fall prevention interventions.

Bowel incontinence, high medical comorbidity, stair use, injury and poisoning, memory deficit, and antipsychotic medication use were

also predictors, but no association was found for antidepressant medications.

Fall prevention has clear clinical importance and organizational relevance in that adverse falls (i.e., falls that trigger emergent care) is one of Medicare's quality indicators and is associated with increased costs. Including timely identification of patients at high risk for falls, as well as modifiable risk factors in the fall risk assessments is important. Fall prevention and intervention programs are physically oriented, focusing on exercise, increased mobility, and environmental assessment. Few, if any, address the mental health of older adults. One reason depression has not been a focus of fall prevention interventions is that most previous research on fall risk has excluded depression or used it

only as a variable without considering depression as a potential target for fall prevention.

The reason depression increases fall risk is unknown, at this time. Perhaps, depression leads to decreased activity of the individual and this increases the potential for muscle wasting, which in turn leads to falls. Continuing a depression screening in conjunction with fall risk screening tools may help identify more individuals at risk for falls. Thus allowing needed interventions to be put in place to maintain the individuals highest level of uncton and safety.

1. Byers, A.; Sheeran, T.; Mlodzianowski, A.; Meyers, B.; Nasisi, P.; Bruce, M. 2008 Oct; Depression and Risk for Adverse Falls in Older Home Health Care Patients. *Res Gerontol Nurs.* 245-251; DOI: 10.3928/19404921-20081001-03

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verity of depressive symptoms and help make a diagnosis of depression.

When selecting a treatment plan it is important that the plan best fits the needs of the older adults you serve. When selecting an applicable treatment, the practitioner should work with older adults to identify the best available evidence and the expected outcomes of that treatment, and understand their treatment preferences.

Some Evidenced Based Practices (EBPs) for treating depression in older adults include:

- Psychotherapy interventions
- Cognitive behavioral therapy

- Behavioral therapy
- Problem-solving treatment
- Interpersonal psychotherapy
- Reminiscence therapy
- Cognitive bibliotherapy
- Antidepressant medications
- Multidisciplinary geriatric mental health outreach services

...physical disorders complicate the identification, course, and treatment of depression...

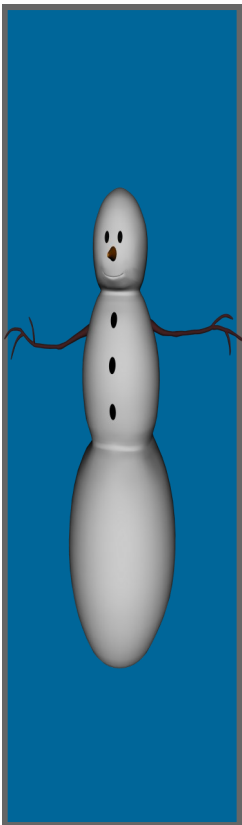
- Collaborative and integrated mental and physical health care

The effectiveness of EBPs may be improved if that treatment

is provided to them along with other supportive services. Supportive services can include the following:

- Support for family members and caregivers
- Assistance with other health and social concerns
- Treatment of co-occurring physical or mental disorders
- Treatment of co-occurring substance use problems (including problems with alcohol and illicit drug abuse, and medication misuse)
- Education about depression

Older adults with depression typically need multiple medical and social services. The practitioner is more likely to provide comprehensive and effective



M2250 Q&As

“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being...” (Code of Federal Regulation, 42 CFR 483.25)

Question: During a SOC visit, the assessing clinician determines the patient is not depressed, has no symptoms of depression and no diagnosis of depression. Because she has assessed for signs & symptoms of depression as part of her initial comprehensive assessment and will continue to assess the patient for signs & symptoms of depression as part of her psychosocial assessment during her revisits, she selects the intervention "Skilled observation and assessment of signs and symptoms of depression" on her plan of care. May we answer "Yes" on M2250, Row d since the plan of care has a depression intervention?

Answer: If the clinician

determines it would be appropriate for a specific patient and obtains an order for "Skilled observation and assessment for signs and symptoms of depression" from the physician during the SOC or ROC allowed timeframe, M2250d may be answered "Yes" even if the formal assessment was negative and/or the patient has not been formally diagnosed with depression. Note, just checking off an intervention on a plan of care does not equate to "obtaining a physician order."

Question: Please provide further clarification regarding when I can select "Yes" indicating the physician was notified of a positive depression screening for M2250, Plan of Care Synopsis, Row d and M2400, Intervention Synop-

sis, Row c. May I select "Yes" if I simply leave a voice mail for a physician regarding a positive depression screening or must I receive an acknowledgement of the message?

Answer 9 When completing M2250d, the assessing clinician may answer "Yes" in cases where the physician was notified of the positive depression screening by the end of the allowed assessment time period. Communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status is sufficient. There is no requirement that you receive acknowledgement of your message in order to select "Yes".

CMS Quarterly Q&As –Excerpts from January and July 2014

Treating Depression in Older Adults (Continued from page 2)

care by working together with mental health, aging, and general medical health practitioners. A key consideration is that physical dis-

Having an understanding that the physical and psychological needs must both be addressed to achieve wellness is critical.

orders complicate the identification, course, and treatment of depression. Therefore, you should simultaneously evaluate physical and mental causes of symptoms. Depression shares symptoms with physical disorders such as congestive heart failure and cancer. These

can include low energy, poor appetite, impaired functioning, fatigue, irritability, and feelings of hopelessness. A recent physical evaluation can help you exclude potential physical causes or contributors to symptoms of depression.

When chronic physical illness occurs with depression, physi-

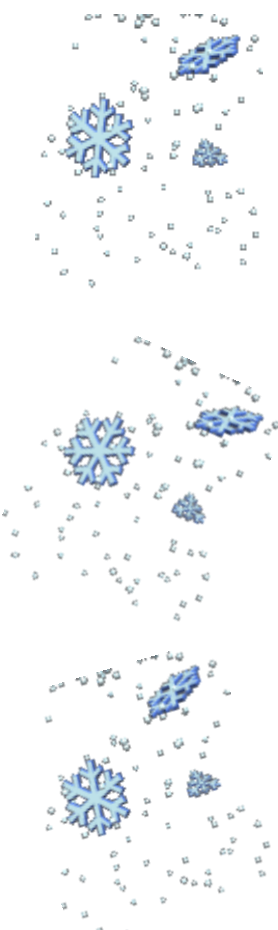
Approaches that neglect one area at the expense of the other are unlikely to be successful.

cal illness can worsen the course of depression and, conversely, depression can worsen the course of physical illness. In either case, you should provide coordinated and integrated care for both depression and

the physical disorder. Approaches that neglect one area at the expense of the other are unlikely to be successful.

In conclusion: It would be beneficial for nursing home practitioners, home health providers, and anyone involved in care for the elderly to be aware of the EBP regarding treatment of depression in the elderly. Understanding that the physical and psychological needs must both be addressed to achieve wellness is critical. True continuity of care may take some time and effort but the positive results would be invaluable.

The above is a summary of the information found in: Substance Abuse and Mental Health Services Administration. *The Treatment of Depression in Older Adults: Practitioner's Guide for Working with Older Adults with Depression*. HHS Pub. No. SMA-11-4631, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.



OASIS Automation Tips

Recent Q&A to our OASIS Help Desk

Q22. If a patient died before being formally admitted to an inpatient facility, do I collect OASIS for Death at Home?

A22. The OASIS discharge due to death is used when the patient dies while still under the care of the agency (i.e., before being treated in an emergency department or admitted to an inpatient facility). A patient who dies en route to the hospital is still considered to be under the care of the agency and the death would be considered a death at home. A patient, who is admitted to an inpatient facility or the hospital's emergent care center, regardless of how long he/she has been in the facility, is considered to have died while under the care of the facility. In this situation, the agency would need to complete any agency-required discharge documents (e.g., a discharge summary) and a transfer assessment (RFA 7, Transfer to Inpatient Facility, Patient Discharged) to close out the OASIS episode. (source Q&A's Cat 2)

Reminder, that any pay source of Medicare or Medicaid (M0150 = 1,2,3 or 4) should be submitted to ASAP, if patient qualifies for OASIS.



MARK YOUR CALENDAR!

Upcoming OASIS Training (Tentative)

Look for our 2016 Training Calendar on our website and in our next Newsletter!



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Wanda Roberts, RN
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Website:
<http://oasis.health.ok.gov>

General Information

Question: I submitted data on 10-16-2015 and still can not locate my Validation Report, and when I resubmitted the batch all the records rejected as duplicate records. **Answer;** Go to CASPER and click on Reports, then click OASIS Validation Report and then order the Validation Report for just that date. The report will then appear in "My Inbox". The report does not reside where it normally should due to a system glitch on that date.

If an OASIS record is rejected with a new fatal error -5460, the provider should contact the vendor that created the data entry software to ensure that they are using the correct version of the software for the M0090 value (Date Assessment Completed) of the record (as of 11-17-2015).

Have you missed our prior newsletters? Go to <http://oasis.health.ok.gov> and click on educational resources. Scroll down to newsletters and enjoy.

Contact Us!

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Automation Tip:

New minimum system requirements have been posted to QTSO. com and are effective 10-1-2015. Make sure you have this information available when purchasing a new computer. Note, that certain advanced technology is not supported by CMS and could create problems for automation people.

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