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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MDS

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Special points of interest:

- Points to Ponder
- QM tips

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

function independently and can contribute to poor health outcomes. It can cause suffering and family disruption. Without treatment, the symptoms of depression can last for years.

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 undertreated in older adults. The

Points to Ponder

Are you effectively completing the Mood interview items in Section D with your residents? The instructions in the RAI Manual direct us to attempt the interview items with all residents that are able to make themselves understood at least some of the time. That is the only criteria to consider when determining whether or not to complete the interviews.

Capturing the resident's voice provides valuable insight into what the resident is thinking and feeling. Taking the time to show 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 care for them.

The PHQ-9 will trigger items that when investigated will lead you to root causes and contributing factors that will help you understand why the resident may be experiencing feelings of depression.

When implemented properly, the CAA process will help you:

- Consider each individual with unique characteristics and strengths
- Identify areas of concern
- Develop possible interventions to help maintain or achieve their highest practicable level of well-being
- Address the needs and desires of the individual and provide symptom relief, if needed.

Identifying and addressing depression in the elderly will "help unlock a closet from which many souls [are] eager to come out". (Quote from "Darkness Visible" by William Styron)

Inside this issue:

Depression and Risk for Falls

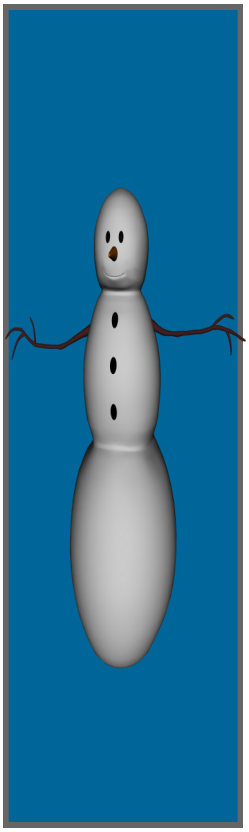
Falls are highly prevalent, harmful events for older adults. Identification of patients at risk is a high priority. It has been demonstrated that patients who indicate depressive symptoms on the data set for community dwelling elderly individuals are at risk for falls. On the other hand, a study from the above mentioned data set shows that patients who fall are twice as likely of being depressed. So you can see 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 functioning 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



Treating Depression in Older Adults (continued from page 1)

nine-item PHQ-9 can help rate the severity 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

MDS Coding : D0200

"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)

The following techniques may be utilized when interviewing the resident in order to achieve the greatest accuracy:

• Repeat a question if you think that it has been misunderstood or misinterpreted.
• Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
• If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
• Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:

— "What do you mean?"
— "Tell me what you have in mind."
— "Tell me more about that."
— "Please be more specific."
"Give me an example."

• Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.

If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a resident has moderate cognitive impairment but can respond to simple, direct questions.

Example: Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
• You can break the item down as follows: "How often are you having problems falling asleep?" (pause for response) "How often are you having problems staying asleep?" (pause for response) "How often do you feel you are sleeping too much?"

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 disorders 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.

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

When chronic physical illness occurs with depression, physical 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.

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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.

MDS Automation Tips

Recent Q&A's to our MDS Help Desk

Question: I submitted data on 10-16-2015 and still can not locate my validation report, and when I resubmitted everything it was all rejected as a duplicate record. **Answer**; Go to CASPER and click on Reports, then click MDS 3.0 Validation Report; 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.

Question: Rumor has it that a new QM manual went into effect 10-1-2015. **Answer**: This is true. Go to QTSO.com, click MDS 3.0. Then click MDS 3.0 QM manual.

Question: I have had some issues with my ICD-10 codes being accepted when I transmit the assessment to ASAP. **Answer** : Due to some late adjustments to the ICD-10 data formatting rules this has been an issue nationwide. Refer to your error message manual message -3852 for further clarification. The Error Message Manual was updated effective 9-2015.

Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)

QM Triggers related to coding MDS

Numerator
Long-stay residents with a selected target assessment where the target assessment meets either or both of the following two conditions:
1. Condition #1: resident report almost constant or frequent moderate to severe pain in the last 5 days. Both of the following conditions must be met:
1.1. Almost constant or frequent pain (J0400 = [1, 2]), and
1.2. At least one episode of moderate to severe pain: (J0600A = [05, 06, 07, 08, 09] or J600B = [2, 3]).
2. Condition #2: resident reports very severe/horrible pain of any frequency (J0600A = [10] or J0600B = [4]).

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

Reference page 22 new QM Manual effective 10-1-2015.

Contact Us!

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MARK YOUR CALENDAR!

Upcoming MDS Training (Tentative)

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

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http://mds.health.ok.gov

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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