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FINAL REPORT—Executive Summary

Depression in Nursing Facility Seniors

Prepared by:

Center for Health Policy and Research (CHPR)
in collaboration with the Division of Medical Assistance

Project Team

Center for Health Policy and Research

Mardi Coleman
Jennifer Graves
Ann Lawthers
Judy Savageau
Debra Hurwitz
Jay Himmelstein, Director

Division of Medical Assistance

Ellie Shea-Delaney
Phyllis Solomon
Sandra Tocman

Department of Public Health

Jill Mazzola

Vital Solutions, Incorporated

Pat Lambert
Brian McCarthy
Robin Morin

Executive Summary

The Division of Medical Assistance (DMA) spends over \$1.4 billion dollars a year for nursing facility care for its senior members, and is committed to working with the nursing facility industry to ensure the delivery of appropriate care to its MassHealth members. One particular area of interest to DMA has been elder depression. Depression in the elderly is common and is thought to be under-treated in seniors and for those elders residing in nursing facilities^{1 2 3}. In 1999, DMA commissioned a study conducted by UMass Commonwealth Medicine to learn what types of antidepressant medications, dosage and duration of medications were being prescribed to nursing facility residents. The findings from that study demonstrated that almost all Massachusetts nursing facility residents were, in fact, prescribed the newer SSRI antidepressant medications to MassHealth residents, in the appropriate dosage. While the study found Massachusetts nursing facility medical staff to be in the forefront for prescribing practices, it was beyond the study's scope to determine whether residents who were being treated for depression had an appropriate diagnosis of depression, whether other treatment options were being offered, and whether medications were being appropriately monitored. Further, the 1999 study could not determine whether other treatment options were being offered, and if medications were monitored in accordance with current standards. In August 2001, DMA commissioned the UMass Center for Health Policy and Research (CHPR) to conduct a second study, Depression in Nursing Facility Seniors, in order to:

- Assess the (rates of) screening and (appropriate) diagnosis of depression among elderly members residing in a sample of nursing facilities.
- Assess rates of treatment of depression in elderly MassHealth nursing facility residents.
- Identify potential best practice treatment guidelines, policies and procedures regarding how nursing facility staff can identify elders at risk of depression in nursing facilities.

This initiative would also examine whether the appropriate prescribing patterns found in the 1999 study had been sustained over time.

Methodology

The Nursing Facility Senior Depression Initiative used a multiple method approach to gather information, utilizing both quantitative and qualitative data gathering activities. The initiative included two study areas, one that focused on a record review process, and the other which focused on a review of nursing facility policy and procedures. The record review portion of the study provided data to document practice patterns for diagnosis and treatment. The policy and procedures portion of the study provided a context for the data gathered from the records and documented policy and procedures that contribute to promising practice.

¹ Ryden, M. B., V. Pearson, et al. (1998). "Assessment of depression in a population at risk ... newly admitted nursing home residents." J Gerontol Nurs **24**(2): 21-9.

² Heston LL, Gerrard J, Makris L, et al. (1992). "Inadequate treatment of depressed NH elderly." J Am Geriatr Society **53S**:25-31

³ Bagley, H., L. Cordingley, et al. (2000). "Recognition of depression by staff in nursing and residential homes." J Clin Nurs **9**(3): 445-50.

Summary of Findings and Related Recommendations

In order to provide a context for report recommendations and findings, the Executive Summary is organized by recommendation area. The findings that support each recommendation area follow the general recommendations. The recommendations presented below have filtered up through intensive data review and discussions held over the course of this initiative. The recommendations chapter (Chapter 7) includes possible strategies for implementing these recommendations.

Screening and Assessment for Depression (Chapter 4)

Recommendations:

- Facilities should make screening for depression part of routine activities.
- Facilities should recognize that some residents, because of specific characteristics such as increasing age, sensory deficits or communication impairments, are at risk for being passed over for screenings.
- DMA should promote the use of routine screening and assessment for depression by nursing facilities.
- The nursing facility industry, DMA and member facilities should work collaboratively to increase screening and assessment for depression.
- DMA should work collaboratively with the nursing facility industry and/or stakeholder groups to investigate how mental health consultancy teams can best support nursing facilities in the identification, assessment and treatment of depression.

What is the basis for these recommendations?

Depression in the elderly may have an atypical presentation. It is likely to be denied by the resident, or overlooked due to widespread beliefs that depression is normal or to be expected in the elderly.⁴ To identify depression in the elderly, the literature strongly recommends regular depression screening of nursing home residents using tools such as the Geriatric Depression Scale (GDS)—5, 15, or 30 question versions, the Cornell Scale for Depression in Dementia (Cornell), or the Hamilton Rating Scale for Depression (HAM-D).^{5 6}

It is not necessary to be a mental health provider to administer these depression screening tools. The GDS-5 can be completed in less than five minutes; therefore, it is possible that residents could be screened for depression by existing nursing facility staff as part of their quarterly MDS assessment. Elders who screened positive for depression symptoms would then be referred for further medical testing as warranted and/or formal depression assessment.

⁴ Katz IR. (1998). "Diagnosis and treatment of depression in patients with Alzheimer's disease and other dementias." *J Clinical Psychiatry Supple* 9:38-44.

⁵ Pomeroy, I. M., C. R. Clark, et al. (2001). "The effectiveness of very short scales for depression screening in elderly medical patients." *Int J Geriatr Psychiatry* 16(3): 321-6.

⁶ Other screening tools include the Center for Epidemiologic Studies Depression Scale (CES-D), Zung Self-Rating Depression Scale (SDS), and Montgomery-Asberg Depression Rating Scale (MADRS).

The results of this study showed:

- 52% of residents had been screened or assessed for depression in the last 90 days of the review period. Of those assessed, 76% were found to be newly depressed or to benefit from continued treatment for depression.
- Residents with sensory impairments and communication deficits were significantly less likely to be screened than residents without these impairments. In addition, those residents 85 years of age and older were less likely to be screened than those ages 65-84.
- Residents most likely to be screened included those residents with a current diagnosis of any psychiatric comorbidity, including depression.
- Two types of approaches to screening emerged—**proactive**, whereby facilities established a comprehensive baseline for resident behavior; screening for depression on a quarterly basis and in response to major life changes before symptoms occurred; and **reactive**, whereby residents were screened for depression in response to symptom emergence.
- Five of the thirty-five study site facilities were routinely screening and assessing all residents on a quarterly basis, but regular screening was far from universal.
- Once a resident was diagnosed with depression, s/he was likely to remain in the screening “loop” and would likely continue to be screened, but getting into the loop for the first time could be difficult for residents with sensory or communication deficits and increasing age.

Treatment of Depression (Chapter 6)

Recommendations:

- Nursing facilities should continue practices that support residents receiving appropriate antidepressants in accordance to practice guidelines for the elderly.
- Nursing facilities should encourage the development and implementation of multi-faceted treatment plans for depression that includes multiple modalities for addressing depression.
- DMA should encourage policies and initiatives to ensure that nursing facilities are recognized as institutions serving substantial numbers of cognitively or mentally impaired residents.
- The nursing facility industry should develop regional work groups for facilities to share promising practices and ideas for improvement of treatment of residents with depression.

What is the basis for these recommendations?

The literature suggests that a combination of pharmacological and psychosocial interventions is more effective than either intervention alone in treating and preventing recurrence of major

depression.^{7 8 9} The literature also suggests that because of levels of training, care plans will be more comprehensive when specific clinical providers, such as psychiatrists, are involved.

The results of this study showed:

- 92% of residents identified as having a depression diagnosis or as being monitored for depression had a depression care plan. However, the content of the care plan varied widely. While most care plans included treatment interventions that were relatively easy to accomplish, e.g. antidepressants, behavior modification interventions, and increased opportunities for socialization, less than half of reviewed care plans included more person-centered or individualized components, such as increased opportunities for family involvement or special activity programs.
- Depression care plans developed after an assessment by a psychiatrist were more likely to contain a broad range of care components, e.g. recommendations for special activity programs, involving family members in care, and support for resident autonomy.
- 83% of residents had either a cognitive and/or psychiatric impairment and 31% had a combination of medical, cognitive and psychiatric impairments.
- 82% of residents with a diagnosis of depression were taking antidepressant medication. Residents with cognitive impairments were more likely to be receiving antidepressants for depression than residents without cognitive impairments.
- Antidepressant medication was prescribed for residents without a diagnosis of depression as well as for residents with a diagnosis of depression. Factors which predicted an antidepressant prescription included cognitive impairment and being in a facility with self-reported high RN turnover. Residents with severe communication or sensory impairments were *less* likely to receive antidepressant medication.
- SSRI antidepressants were prescribed to over half of residents with depression (55%) and only three percent of residents with depression were receiving tricyclic antidepressants.

Prevention of Depression (Chapter 6)

Recommendations:

- Facilities should promote the prevention of depression, whenever possible through proactive initiatives and a normalized facility environment, one that promotes a homelike atmosphere and routines, and offers residents the opportunity for autonomy.

⁷ Bartels, S. J., A. R. Dums, et al. (2002). "Evidence-based practices in geriatric mental health care." Psychiatr Serv **53**(11): 1419-31.

⁸ American Geriatrics Society. 1997. AGS Position Statement Psychotherapeutic Medication in the Nursing Home.

⁹ Alexopoulos G., et al. (2001). Pharmacotherapy of Depressive Disorders in Older Patients. October. A Postgraduate Medicine Special Report.

- DMA should work collaboratively with other stakeholder agencies and/or stakeholder groups to promote the prevention of depression through collaborative initiatives and further study.

What is the basis for these recommendations?

The literature suggests that 44-68% of nursing facility seniors exhibit symptoms of depression. The literature also suggests that seniors in general are susceptible to depression when confronted with significant changes in their health status, loss of autonomy, loss of privacy, loss of functional status, loss of significant relationships, or loss of mobility. Facility conditions that actively work to minimize these losses may help decrease the likelihood that some residents will experience depression¹⁰.

The results of this study showed:

- Facilities identified a number of proactive depression prevention strategies in the areas of: activities, facility adjustment, supporting family or friend involvement, facility leadership and philosophy of care, resident-staff interactions, staffing patterns and longevity, intake process; screening and evaluation, symptom monitoring, care plan/treatment, and mental health related services.
- Facilities reported volunteers extended the range and frequency of activities that facilities were able to offer, increased resident participation in activities, and provided 1:1 (secular and non-secular) support and companionship to residents.
- 67% of facilities reported that their staff received training on symptoms of depression in the last 12 months, with staff having direct care responsibilities more likely to receive training on symptoms of depression compared to non-direct care staff.
- About two-thirds of facilities had family councils. Many facilities offered other structured ways to engage families such as governance, education, or social activities.

Improving Coordination of Care

Recommendations:

- Facilities should encourage good record documentation to facilitate coordination and quality care.
- The Nursing Facility industry should work to improve the consistency and completeness of documentation in the resident record.

What is the basis for these recommendations?

In reviewing records for this study, it was noted that there were no standardized formats for nursing facility documentation. The lack of standardization complicates comparisons of

¹⁰ Facility environment may impact situational depression or dysthymia, but is unlikely to effect the onset of severe clinical depression.

treatments and outcomes, and may interfere with the coordination of care between different caregivers. Resident record data should be readily accessible in a predictable, standard format in order to facilitate care giving and treatment.

The results of this study showed:

- Among residents with a diagnosis of depression who have carried the diagnosis for more than 4 years, 31% were without apparent treatment, suggesting an inactive diagnosis. However, the documentation in the record did not permit distinguishing between active and inactive depression diagnoses.
- Documented pharmacy monitoring varied substantially by facility. Only 11 of the 35 study site facilities had documentation of monthly pharmacy monitoring for all residents receiving antidepressants. The nursing facility industry suggests this may reflect open pharmacy recommendations generated from a pharmacy review remaining in the doctor's order book until finalized.

Recommended Areas for Further Study

- Identify what nursing facility conditions and resources are needed to support the routine use of standardized screening tools such as the Geriatric Depression Scale.
- Assess whether mental health consultancy teams are consistently supporting the industry to meet the needs of residents, and how their roles can be strengthened.
- Study the variability between types of clinical providers and their rates of depression diagnosis and types of care plan components these providers recommend for treatment.
- Research the impact of comprehensive volunteer programs on the rate of resident depression and treatment modalities.
- Research and confirm the resident and nursing facility characteristics that decrease or increase the likelihood of resident screening for or diagnosis of depression, and receiving antidepressant medication.
- Study barriers to pharmacy monitoring documentation being located permanently in the resident record.

Conclusion

Although nursing facilities have made great strides in identifying, diagnosing and treating depression in seniors, there are potential areas of improvement nursing facilities and DMA may wish to consider. The recommendations and promising practices developed for this report are based on the literature, survey responses and input from the consulting content experts. However, it is important to note that each nursing facility has its own unique culture depending on its size, management philosophy, location, regional economics, organizational health, client mix, etc. While some recommendations and findings will have broad applicability across the industry, readers are invited to look at the range of responses offered by nursing facility staff from across the state and summarized in this report to see what is most relevant.