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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,

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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.

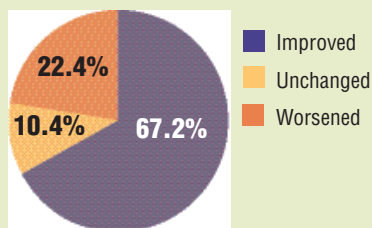
■ **Level 2—Social Work.** For residents who do not respond adequately to Level 1 activities, social workers function within this level as “case managers” to help determine the biological, psychological, and social causes of the depressive symptoms and work toward connecting the residents with the appropriate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

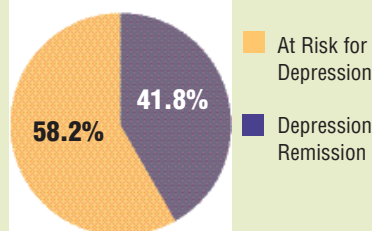
■ **Level 3—Psychology and**

ABRAMSON RESIDENCE DEPRESSION MANAGEMENT PROGRAM RESULTS

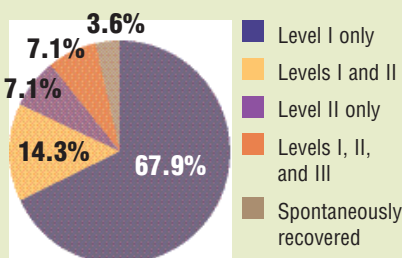
Graph 1: Change In Depressive Symptoms



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



Graph 3: Combinations Of Depression Interventions



Source: The Madlyn and Leonard Abramson Center for Jewish Life, North Wales, Pa.

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 partici-

pants 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

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.

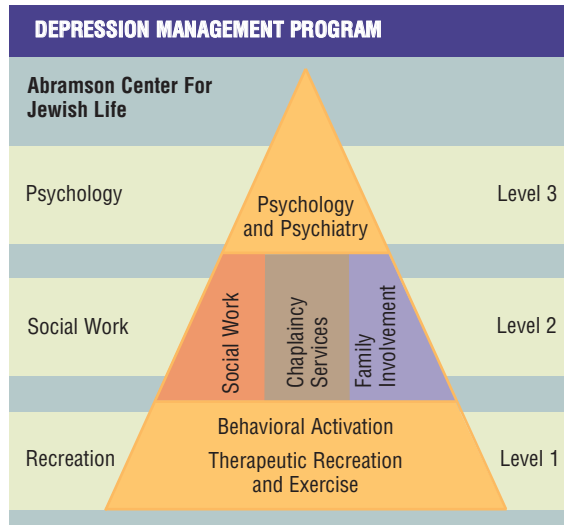
In some cases, residents receive all three levels of care and still have significant depressive symptoms. In this instance, the treatment team usually informs the psychiatrist who then considers whether the antidepressant treatments need adjustment.

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 infor-



An Abramson resident gets her reps in with staff supervision.

mation 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 sub-clinical 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

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