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CARING FOR DEPRESSION IN OLDER HOME HEALTH PATIENTS

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Abstract

Depression is common in older home health patients and increases their risk of adverse outcomes. Depression screening is required by Medicare's OASIS. The Depression CAREPATH was developed as a feasible strategy for home health nurses to manage depression in their medical patients. The protocol builds on nurses' existing clinical skills and is designed to fit within routine home visits. Major components include ongoing clinical assessment, care coordination, medication management, education and goal setting. In a randomized trial, Depression CAREPATH patients had greater improvement in depressive symptoms compared to usual care. The difference between groups was significant at three months, growing larger and more clinically meaningful over one year. The intervention had no impact on patient length-of-stay, number of home visits, or duration of visits. Thus, home health nurses can play a pivotal role in the long term course and outcomes of depressed patients.

Depression is a major contributor to the overall burden of disease in the United States, reflecting both its high prevalence and its consequences (National Institute of Mental Health, 2015). Depressive orders are common in older home health patients and increase their risk of adverse outcomes. It is estimated that 13.5% of older adults who require home healthcare experience major depression (CDC, 2015). A variety of factors, such as medical illness, disability, side effects from medication, progressive sensory loss, sleep disturbances, a history of falls, social isolation, and personal losses, contribute to the risk of depression in older adults (Cuijpers et al., 2015; Mental Health America, 2015). Given the predominate role of nurses in most care settings, nurses are well positioned to both identify and care for depression in older adults.

Depression is not always expressed by sadness. In older adults especially, depression is commonly expressed by changes in energy levels, sleep patterns, and appetite; difficulties with concentration or decision making; lack of pleasure in activities that were previously enjoyed; and feelings of hopelessness that may include thoughts of suicide (Mental Health America, 2015; Robinson, Smith, & Segal, 2015). In most home health patients, depression is not a simple "reaction" to recent medical events but has typically been ongoing for months and, without intervention, will likely persist well into the future.

In home health patients specifically, depression increases the risk of falls (Byers et al., 2008) and hospitalization (Sheeran, Byers, & Bruce, 2010). Home health nurses report that depression seriously interferes with the goals of home health care because depressed patients have low motivation for recovery and poor compliance with medical regimens (Bao, Eggman, Richardson, & Bruce, 2014). In the words of one nurse in the Bao et al. study, *"it*

[depression] presents a big challenge in trying to help them garner the strength and the willpower to do what they need to do to stay out of the hospital…" (unpublished data).

DEPRESSION SCREENING

Medicare has long required home health nurses to document depressive symptoms on the Start of Care OASIS (Outcome and Assessment Information Set). With the introduction of the OASIS-C, clinicians are expected to use a standardized approach to depression screening. The OASIS-C provides the 2-item Patient Health Questionnaire (PHQ-2), an evidence-based approach to depression screening used widely in health and social services settings (Bruce et al, 2011).

The main purpose of depression screening is to identify the subset of patients for whom further assessment is needed to determine depression severity and appropriate interventions. Medicare recommends using a PHQ-2 score of "3+" as indicator of screening positive for depression. This score may be too stringent in older, medically ill patients and using a "2+" will result in fewer "false negatives". This approach makes sense when screening is coupled with further assessment that differentiates patients needing active intervention versus watchful waiting.

DEPRESSION CARE MANAGEMENT

Interventions developed for primary care have demonstrated that nurses can play a pivotal role in managing depression in older patients. With Collaborative Care models, a nurse or other clinician serves as Depression Care Manager and works with primary care clinicians and psychiatric specialists to ensure that patients receive both guideline-based treatment and ongoing management (Bruce et al., 2004; Guide to Community Preventive Services (2014). The Collaborative Care model fits naturally with home health, which already uses a team approach to develop and follow a patient's Medicare-mandated "Care Plan" (Hennessey & Suter, 2011). The patient's primary care provider (PCP) authorizes the Care Plan and is responsible for treatment decisions. The home health nurse supports the patient by providing in-home patient care and consulting with the PCP and specialists as clinically indicated both during care and at discharge.

The ***Depression CAREPATH (CARE for PATients at Home)*** was developed collaboratively by researchers, psychiatric nurses, home health clinicians, and administrators to formulate a clinically effective intervention that could be easily integrated into routine practice without further burdening nurses or patients (Bruce, Raue, et al., 2011; Bruce, Sheeran, et al., 2011). The model draws on both standard psychiatric home health and the Collaborative Care model. Like Collaborative Care, the Depression CAREPATH's cornerstone is managing depression as a chronic illness. And like Collaborative Care, a non-specialist takes day-to-day responsibility for depression care management and consults with psychiatric specialists as needed. But in contrast to primary care where a single clinician is designated the depression care manager, the CAREPATH asks every home health nurse to manage depression. Home health nurses commonly manage many chronic diseases secondary to the primary reason for home care (e.g., diabetes in patients receiving wound care). Given the

similarity of depression care management to care for these other diseases, most nurses are clinically prepared to learn and integrate depression care into routine home health practice (Suter, Suter, & Johnston, 2008).

The Depression CAREPATH protocol is designed to fit within a routine visit. Nurses follow the guidelines during one routine visit per week (or at every visit for patients seen less frequently) and as part of discharge planning at the end of care. The depression care management protocol involves categories of assessment, care coordination, medication management, education, and goal setting.

Assessment

When patients screen positive for depression, the first step is a more thorough assessment to determine depression severity. The purpose of depression assessment is not to make a formal diagnosis but to identify and follow the course of clinically meaningful symptoms across time. The CAREPATH protocol recommends using the nine-item Patient Health Questionnaire (PHQ-9) as an efficient, evidence-based approach to quantifying depression severity and changes in severity over time (Bruce et al., 2011). Because it was originally developed for use in primary care, many PCPs understand the clinical meaning of PHQ-9 scores, thus making communication with them easier. The symptoms assessed by the PHQ-9 parallel those of DSM-5 criteria for major depressive episode, so that PCPs and specialists may use the results in diagnostic decision making.

Clinically significant depression warranting full depression care management is defined by PHQ-9 scores of 10 and greater. The protocol requires that clinicians assess depressed patients with the full PHQ-9 on a weekly basis and at the end of home health care. The ongoing record or chart of weekly scores is useful in clinical decision making, case coordination, discussions with PCPs, patient education, and discharge planning. Guidance is given in how to gauge clinical status by change (or lack of change) over time. Nurses are asked to monitor patients who score less than 10 on the PHQ-9 for signs of worsening depression and to conduct a follow-up PHQ-9 when indicated. These procedures are consistent with “watchful waiting”.

Care Coordination

Home health nurses are expected to be in contact with patients’ PCPs about their clinical status and plan of care. As part of the Depression CAREPATH, nurses report symptoms to patients’ PCPs and review possible interventions (e.g. initiation or changes in medication and/or psychotherapy treatment) and possible consultation or referral to a psychiatric nurse (if available), social worker, or outside mental health specialist. The protocol also requires that nurses re-contact the PCP or specialist when depressive symptoms or suicide ideation emerge or worsen, patients have adverse side effects to medications, or there has been no change in symptoms after 4 weeks or otherwise clinically indicated. Referring to a record or chart of the weekly PHQ-9 scores is an essential component of these consultations. Finally, care coordination includes discharge planning to ensure that depression treatment and management continue after patients end home health care.

Many nurses find that discussing depressive symptoms can be difficult with PCPs who focus only on the patients' medical conditions, discount the importance of depressive symptoms, or are already treating patients with antidepressants. The Depression CAREPATH protocol and educational resources help nurses prepare and present information to PCPs that is clear, concise, and relevant to clinical decision making. This presentation does not include speculation about why a patient may be depressed (e.g., "lonely") but simple statements about the patient's sociodemographic and medical status, depression symptom profile and severity, and depressant treatment history. Nurses can be most helpful when they understand the meaning of PHQ-9 scores over time and have basic knowledge of antidepressant use guidelines.

Medication management

Both antidepressant medication and psychotherapy can be effective treatments for depression in medically ill older adults. A combined approach may be most effective, reflecting the biological and psychosocial aspects of depression in late life. However, a shortage of mental health specialists results in few older adults having access to affordable and acceptable psychotherapy (Institute of Medicine, 2012).

A large proportion of depressed older adults do not receive any depression treatment (Cuijpers et al., 2015). In some cases, clinicians do not recognize depressive symptoms, attribute them to medical illness, or choose to focus on competing clinical demands. In others, patients do not report depressive symptoms without being explicitly asked because they view their symptoms as a "character weakness" or believe they are normal signs of aging (Robinson, Smith, & Segal, 2015). Other patients may refuse depression treatment because they worry about stigma or have greater reliance on faith than medicine.

Equally important is the large number of patients who do report depressive symptoms, despite treatment. The number of patients who are prescribed antidepressants has increased steeply over the past decade. Today, over one in three home health patients, regardless of whether depression is documented, have been prescribed an antidepressant (Shao, Peng, Bruce, & Bao, 2011). Use of antidepressants, however, does not necessarily indicate that a depressed patient is being treated adequately. It is important for physicians and advanced practice nurses with prescriptive authority to evaluate the effectiveness of prescribed medication. In some cases, patients may not be taking medication as prescribed. In other cases, antidepressants may have been ordered to appropriately 'start low, go slow' for older and medically ill patients but then the sub-therapeutic doses were not increased. Fewer than half of older patients respond (i.e., 50% reduction in depression severity) or reach full remission to their first course of antidepressant treatment (Kozel et al., 2008).

Finding an effective antidepressant regimen for a specific patient can take time. Treating depression often involves changing doses, changing to a different antidepressant (or different class of antidepressant), or augmenting one medication with another. Understanding side-effects of the medication is important. The Depression CAREPATH education provides resources to equip nurses with basic knowledge of antidepressant classes and offers information on dosing for specific antidepressants, which can be very helpful in discussions with PCPs who have prescribed the medications.

As with other medications, adherence to antidepressants increases the likelihood of their being effective. A challenge in promoting adherence to antidepressants, however, is that most patients do not respond to antidepressant medication for several weeks. Full remission may take much longer. Patients who do not get better quickly may want to stop their medication because they feel discouraged. Patients who do get better may want to stop the medication because they think it is no longer needed. Nurses can intervene by reminding patients that they should never make changes to antidepressant treatment without supervision. Helping patients understand the purpose of antidepressant medication and dispel myths about depression can help them understand the need to follow their treatment plan.

Education

While patient education is part of all good clinical care, it may be particularly important for depression and depression treatment, as both are subject to myths, preconceptions, misinformation, and stigma. The more patients and families understand what depression is, what causes it, and how to treat it, the more likely they will follow the prescribed medication or psychotherapy plan, monitor symptoms, and communicate their progress to clinicians. Some of the most frequently asked questions from patients and family members include: What makes you think I'm depressed? What are the signs of serious depression? What causes depression? How do you treat depression? Nurses are encouraged to use patient education handouts to convey information about the clinical manifestation of depression, the underlying biology, known risk factors, and treatment options in a straightforward way. Many depression education guides are available for patients and can be helpful.

Goal setting

Home health nurses commonly encourage changes in patient behavior such as getting out of bed, brushing one's hair, following physical therapy exercises, and other feasible activities that involve goal setting and activation. These activities are useful for depression as well. While not a formal psychotherapy, goal setting is consistent with many evidence-based psychotherapies that try to activate patients with the belief that activation will improve mood. As part of depression care management, nurses help patients set and review weekly goals for self-care, pleasurable activities, and social contact.

OUTCOMES

The effectiveness of the Depression CAREPATH in reducing depressive symptoms in Medicare Home Health patients has been demonstrated in a randomized trial conducted in six, geographically distinct home health agencies (Bruce et al., 2015). The study randomized teams of nurses to intervention or enhanced usual care. The intervention (Depression CAREPATH) consisted of nurses managing depression by weekly home visits that included assessment, medication management, care coordination, education, and goal setting. Enhanced usual care included provision of care that followed agencies' standard procedures. Both sets of nurses participated in educational programs for depression screening but the intervention nurses also participated in education specifically related to the Depression CAREPATH protocols.

All patients who screened positive for depression on the Start-of-Care OASIS PHQ-2 and other eligibility criteria (e.g., no dementia, no active suicide ideation, spoke English or Spanish, expected survival over 6 months) were eligible for research interviews and follow-up. With their consent, 306 patients were interviewed in their home and then followed by telephone with the Hamilton Depression Rating Scale (HAM-D), a structured clinical interview used in many depression trials (Bruce et al., 2015).

The study findings showed that depressed patients who were under the care of nurses in the Depression CAREPATH group had significantly greater improvement in depression severity than their counterparts receiving usual care. The difference in HAM-D scores between groups was statistically significant at three months, growing larger and more clinically meaningful over one year. The size of the effect was considered clinically beneficial (Community Preventive Services Task, 2012). No effect was observed for patients who screened positive for depression but only had mild symptoms, the same group for which the protocol recommends “watchful waiting”. Equally important, the intervention did not add to nurse burden. Home health nurses are under pressure to maintain productivity (e.g., number of patient home visits per day). The intervention did not change how long patients stayed in home care, the number of nursing home visits, or the duration of these visits. By designing the intervention to be integrated into routine care and to be consistent with routine practice, there was minimal impact on service delivery. Indeed, the Depression CAREPATH offers a way for home health nurses to increase clinical competency without further burden on their workload.

The Depression CAREPATH website (mentalhealthtrainingnetwork.org/) offers educational resources to interested nurses. These resources include two e-learning modules, each offering Continuing Education Units. The first provides education for using the PHQ-2 and PHQ-9 effectively with vulnerable older adults. The second provides information about each component of the Depression CAREPATH. The e-modules take about an hour each and both include videotaped examples of assessing specific symptoms of depression. The website also includes downloadable patient education material, instructions in implementing the intervention agency-wide, and other resources.

CONCLUSION

Depression is common in older home health patients, undermines clinical care, and increases the risk of adverse outcomes. Home health nurses can play a pivotal role in the long term course and outcomes of depressed patients. In the clinical trial, the effect of the Depression CAREPATH on depression continued to grow long after most patients ended home health services. Thus the changes that nurses put into motion during home care can have long lasting effects. The most immediate change may have been adjustments in patients’ antidepressant treatment. But more broadly, the Depression CAREPATH helped home health nurses change how advanced practice nurses, physicians, families, and patients themselves understood depressive symptoms. Depression became recognized as an essential, modifiable, but not inevitable part of the patients’ clinical picture. Through assessment, care coordination, medication management, education, and goal setting, home health nurses can

initiate a “mid-course” correction that changes the trajectory of patient care and wellbeing well beyond the home health episode of care.

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