CONSIDERATIONS:

1. Research indicates that almost 50% of home care patients are clinically depressed, resulting in increased morbidity, mortality, and poor health outcomes. This includes re-hospitalization, poor self-management of other conditions, and lower OASIS outcome scores.
2. Common signs and symptoms of depression include:
    a. Persistent sadness, anxiety or "empty" feelings
    b. Sleeping too much or insomnia, early morning awakening or awakening frequently
    c. Reduced or increased appetite and/or weight loss or gain
    d. Loss of interest or pleasure in activities
    e. Fatigue, lack of energy, irritability or restlessness
    f. Aches or pains, headaches, cramps, or digestive problems that are not improved with treatment
    g. Difficulty thinking or concentrating, remembering or making decisions
    h. Thoughts of death or suicide, including suicide attempts
    i. Feelings of inappropriate guilt, worthlessness, helplessness or hopelessness
3. Screening tools for depression in the public domain include:
    a. PHQ-2, included in OASIS-C, M1730. If a patient is positive for depression on this screening tool (score of 3 or greater), a more in depth depression scale is indicated
    b. PHQ-9 (Patient Health Questionnaire-9) is a nine-item self-administered depression scale
    c. GDS-15 (Geriatric Depression Scale Short Form) is a fifteen item depression scale developed for adults age 65 and older
4. Both the PHQ-9 and GDS-15:
    a. Are dual purpose instruments that establish the existence of a depressive disorder and grade the severity of the depression
    b. Are available in multiple languages:
        i. PHQ-9: http://www.phqscreeners.com/overview.aspx?Screener=02_PHQ-9
        ii. GDS-15: http://www.stanford.edu/~yesavage/GDS.html
5. Avoid using the word "depression" when introducing the scale to patients. This will minimize patient issues around depression stigma:
    a. PHQ- 9 is called a "patient health questionnaire"
    b. GDS is referred to as a "Geriatric Mood Scale"
6. The clinician should demonstrate sensitivity and preserve patient privacy during test administration. The questions and responses may be difficult for a patient to answer. Both instruments are easily understood, relatively simple to use and can be administered in about 15 minutes or less time.

EQUIPMENT:

Either:

PHQ-9 with score calculation instructions (Addendum)

GDS-15 with score calculation instructions (Addendum)

PROCEDURE:

1. PHQ-2:
    a. Administer the PHQ-2 according to instructions on OASIS-C 1730
    b. Count number of points between the two questions:
        i. Range of points: 0 - 6
        ii. Score of 3 or more indicates risk of depression; further evaluation is indicated
    c. If score is above 3, administer a more intensive depression screening with the PHQ-9 or GDS-15
2. PHQ-9 (See Addendum B):
    a. Either:
        i. Give a copy of the PHQ-9 to the patient to self-administer
        ii. Assist the patient by reading items on the scale and recording patient's responses
3. Transfer patient's scores to PHQ-9 Score Tallying Sheet, included in Addendum B.
4. Calculate score:
    a. Range of points: 0 - 27
    b. Each of the 9 items are scored from 0 to 3
    c. 0 means the patient never experiences the particular depression symptom
    d. 3 means the patient experiences the symptom nearly every day
5. Interpret the score using "How to Score the PHQ-9," included in Addendum B.
    a. Tool indicates depression if:
        i. Score is 5 or more points
        ii. Answer to 9th question is 1, 2 or 3
    b. Depression severity:
        i. Mild: 5 - 9 points
        ii. Moderate: 10 - 14 points
        iii. Moderately severe: 15 - 20 points
        iv. Severe: 21 - 27 points
6. GDS-15: (*See Addendum C*)
    a. Either:
        i. Give a copy of the GDS-15 to the patient to self-administer
        ii. Assist the patient by reading items on the scale and recording patient's responses

   b. Compare patient's response to the Scoring the Geriatric Depression Scale (GDS-15) (*See Addendum: C):*
      i. Range of points: 0 - 15
      ii. Each of the 15 items is worth 1 point
   c. Interpret the score:
      i. Score greater than 5 = depression
      ii. Mild depression = 6 - 10
      iii. More severe depression = 11+

AFTER CARE:

1. Document:
   a. Depression scale used and patient's score
   b. Instructions given to patient/caregiver to manage symptoms and when to call nurse or physician
   c. Communication with primary provider about patient's status and plan of care
2. Teach patient/caregiver:
   a. To engage social support system
   b. To participate in diversion activities
   c. Signs and symptoms of worsening depression and suicidal risk and need to report these to the primary provider
3. Communicate with primary provider:
   a. Immediately, if suicide potential is discovered
   b. If patient screens positive on depression screening tools
   c. Communicate that an evidence-based depression screening tool was administered
   d. Provide the depression severity score. This will help the provider determine the appropriate interventions
   e. Referrals for services:
      i. MSW or Psych mental health nurse
      ii. Occupational Therapist for meaningful manageable activities
      iii. Chaplin for spiritual support
      iv. Other community based mental health services
4. Communicate with team members for need to monitor for signs/symptoms/coping.

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