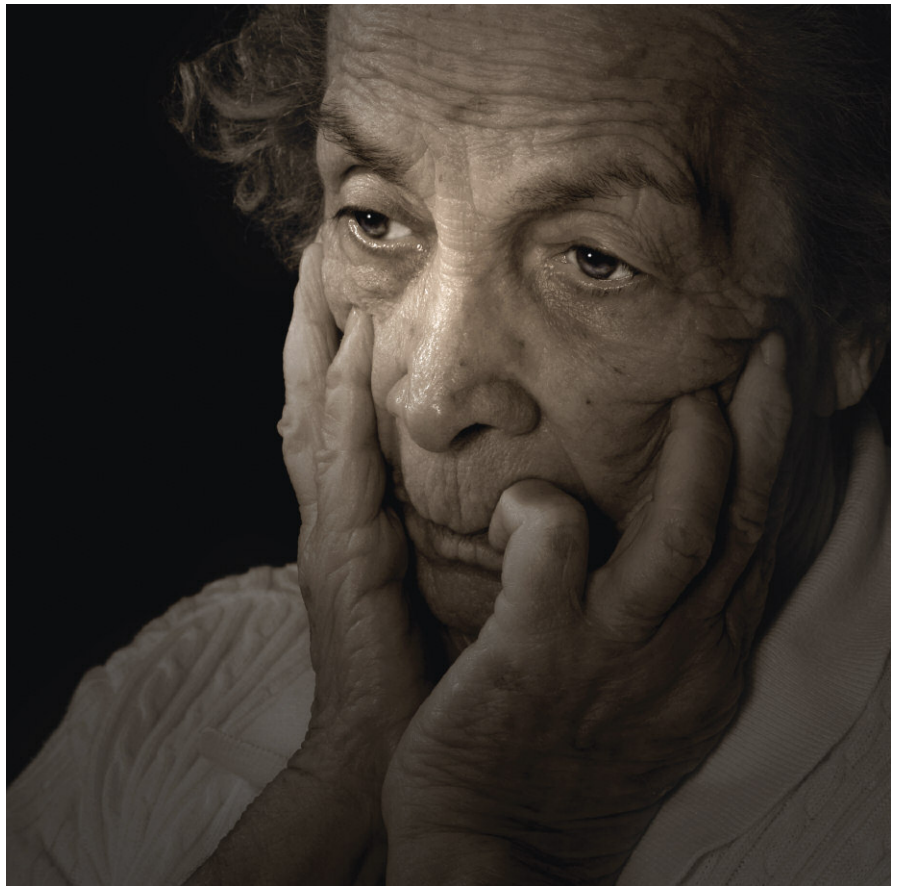


Team Management of the Depressed Assisted Living Resident

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In the final article of our 3-part series on depression in assisted living (AL), we have changed the title from our original “Best Practices in Management of Depression in Assisted Living” to “Team Management of the Depressed Assisted Living Resident.” Despite the title change, the focus remains on describing the best practices in the management of these ill residents. The reason for using the term *team management* is to stress the importance of the team in achieving best practices. This article describes specific steps to ensure proper care of these residents and addresses the link between depression and quality measures.

In the first article of this series (see page 30, July/August issue; www.assistedlivingconsult.com/issues/04-04/alc78-Depression-721a.pdf), we explored the prevalence of depression among AL residents. The second article, titled “Comorbid Medical Conditions: Compounding the Problem of Depression in Assisted Living,” (see page 28, September/October issue; <http://www.assistedlivingconsult.com/issues/04-05/alc910-Depression-720pt%202-924a.pdf>) discussed the relationship of depression and comorbid medical conditions such as myocardial infarction, diabetes, cerebrovascular accident, cancer, and Parkinson’s disease.



Prevalence

In 2007, there were nearly 975,000 AL beds in the US, an increase of 4% over 2004.¹ This growing community provides the perfect opportunity to develop programs dedicated to managing depression among seniors, especially because depression is so common in late life. In

2005 and 2006, 81.9% of adults aged 50 years and older who were diagnosed with depression received treatment in the prior year for depression, compared with 70.3% of those aged 35 to 49 years, 62% of those aged 26 to 34 years, and 46.9% of those aged 18 to 25 years.² One study of depression in AL found

that 19.3% of AL residents have symptoms of depression.³

Watson and colleagues found that depression among AL residents, with and without dementia, is common, undertreated, and related to physical burden. In a study of 196 AL residents (67.4% with dementia) in 22 facilities, the rate of depression was 24%; only 43% of depressed residents were being treated.⁴ In a second study of more than 2000 AL residents, more than half of whom had dementia, in 193 facilities across 4 states, Watson and colleagues found that 13% were depressed.⁵ The rate of depression was lower (7%) among those who had no cognitive impairment. Depression rates were 15% in those with mild cognitive impairment, 25% in those with moderate impairment, and 20% in those with severe impairment.⁵ Those who were depressed were 1.5 times more likely to be transferred to nursing homes.⁵ Watson and colleagues concluded that, considering the mission of AL—to help older adults retain autonomy, privacy, and quality of life in a personalized environment—greater effort should be made among AL staff and practitioners to detect and treat depression.⁵ Other studies have also shown that depressed residents are discharged to nursing homes at a higher rate than nondepressed residents, even when other chronic illnesses are taken into account.⁶

Making the Diagnosis

As we discussed in the first article of this series, the diagnosis of depression can start simply enough with the 2-question screen (Table 1). A “yes” answer to either question indicates the need for further evaluation.^{7,8} To assess further, practitioners can use scales such as the Geriatric Depression Scale (GDS),⁹ the Cornell Scale for Depression in Dementia,¹⁰ or the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.¹¹ To read more about these, refer to “How Big an Issue Is

Table 1.
Two-Question Screen⁸

During the past month, have you often been bothered by:

1. Feeling down, depressed, or hopeless?
☐ Yes ☐ No
2. Little interest or pleasure in doing things?
☐ Yes ☐ No

If the patient's response to both questions is “no,” the screen is negative. If the patient responded “yes” to either question, consider asking more detailed questions.

Depression in Assisted Living?” on page 30 of the July/August issue of *ALC* (www.assistedlivingconsult.com/issues/04-04/alc78-Depression-721a.pdf).

Comorbid medical conditions can contribute to depression, and the reverse is also true: Depression can worsen many comorbid medical conditions. This has been shown in a review of dozens of studies of depression in community, primary care, and inpatient settings.¹² Therefore, being particularly astute in assessing and monitoring residents with comorbid medical conditions for possible depression would benefit both the staff and patient in understanding and improving the quality of treatment of residents.

Treatment Options

The American Psychiatric Association (APA) guidelines¹³ call for the treatment of depression to start with an evaluation, followed by the initiation of therapy, and then an assessment of the adequacy of the response to therapy after 6 to 8 weeks. This assessment can determine the extent of the patient's or resident's response to the initial treatment (ie, whether there is an initial response failure, a partial response, or a full response to treatment). Modifications to treatment may be necessary, at which point reassessment is needed after an additional 6 to 8 weeks.¹³

One approach to treating depression in AL residents that I have found helpful is to:

1. Select the most appropriate medication or therapy.
2. Ensure resident adherence to the regimen and appropriate dose.
3. Monitor the drug's or therapy's effectiveness.
4. If a failure is noted, make an appropriate change to a different agent.

Depression Quality Measures

Three of the 2008 Physician Quality Report Initiatives (PQRI) apply to physicians who treat patients with depression, including AL residents¹⁴:

- Antidepressant medication during acute phase for patients with a new episode of major depression
- Patients who have major depressive disorder who meet *DSM-IV* criteria
- Patients who have major depressive disorder who are assessed for suicide risks

Including these existing quality measures in the development of a depression management system in your AL facility may help you provide appropriate care for your depressed residents.

Caregiver Support

The American Association of Retired Persons (AARP) recently released a study examining the role

of caregivers, noting that unpaid caregivers provided more than \$350 billion in care for elderly family members in 2006.¹⁵

Families must be active members of the care team, even when the care is provided by a LTC service. It is my experience that family caregivers can improve the quality of life for their loved ones in AL or other LTC settings by:

1. Providing guidance in the care planning process
2. Providing additional personal hands-on assistance within the facility
3. Taking the family member outside the LTC facility to visit community sites and attend outside functions

This type of hands-on participation by the family is helpful not just for depressed AL residents, but for all AL residents.

Care Team

A team of researchers and clinicians at the Madelyn and Leonard Abramson Center for Jewish Life in North Wales, PA,¹⁶ developed a depression management team that comprises staff members from psychology, social work, therapeutic recreation, and nursing. Although this program was developed in a skilled nursing facility, the concepts of the program may be relevant to an AL facility. The program uses three levels of intervention:

1. Activities and exercise
2. Social work
3. Psychology and psychiatry

The facility reports that nearly 42% of the 67 residents who were assessed as being depressed went from a positive score on a depression screen to a negative score on a follow-up depression screen after participation in the program.¹⁶

As someone deeply involved in the AL care setting, I believe a care team should include formal caregivers such as certified nursing assistants (CNAs), physicians, nurse

practitioners, physician assistants, pharmacists, social workers, psychologists, and therapists. One member should be chosen to lead the team. This leader needs to have not only the responsibility, but also the authority to pull together all the members of the team, ensure training in recognizing signs and symptoms of depression, and emphasize each team member's role in care so that all care is provided according to a professional's scope of practice.

Plans should be in place to enable health care practitioners to diagnose residents with depression or with risk factors for depression when they are admitted. Once practitioners identify depressed residents, they must then develop a treatment plan—such as what has been presented in our 3 articles—and inform the care team of their individual roles in providing the care. Assessment and monitoring procedures must be initiated to ensure that the care provided is appropriate and effective. Using PQRI measures may help the AL facility monitor its provision of appropriate, effective care. In the end, effective evaluation and treatment of depressed residents will help allow them to age in place and not be transferred to a nursing home.

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