

SECTION D: MOOD

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D, they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan.

- Depression can be associated with:
 - psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain),
 - decreased participation in therapy and activities (e.g., caused by isolation),
 - decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and
 - poorer outcomes (e.g., decreased appetite, decreased cognitive status).
- Findings suggesting mood distress should lead to:
 - identifying causes and contributing factors for symptoms,
 - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
 - ensuring resident safety.

D0100: Should Resident Mood Interview Be Conducted?

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents	
Enter Code <input type="checkbox"/>	<p>0. No (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)</p> <p>1. Yes → Continue to D0200, Resident Mood Interview (PHQ-9©)</p>

Item Rationale

This item helps to determine whether or not a resident or staff mood interview should be conducted.

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about mood directly from the resident, sometimes called “hearing the resident’s voice,” is more reliable and accurate than observation alone for identifying a mood disorder.

D0100: Should Resident Mood Interview Be Conducted? (cont.)

Planning for Care

- Symptom-specific information from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan.
- If a resident cannot communicate, then **Staff Mood Interview** (D0500 A-J) should be conducted.

Steps for Assessment

1. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV[®]).
2. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
 - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted. This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV[®]).
- **Code 1, yes:** if the resident interview should be conducted. This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present. Continue to item D0200, Resident Mood Interview (PHQ-9[®]).

Coding Tips and Special Populations

- If the resident needs an interpreter, every effort should be made to have an interpreter present for the PHQ-9[®] interview. If it is absolutely not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D0650.

D0200: Resident Mood Interview (PHQ-9[®])

D0200. Resident Mood Interview (PHQ-9 [®])			
Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.			
If yes in column 1, then ask the resident: "About how often have you been bothered by this?"			
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. No (enter 0 in column 2)	0. Never or 1 day		
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)		
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)		
	3. 12-14 days (nearly every day)		
		↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down		<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>	<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- Depression can be associated with:
 - psychological and physical distress,
 - decreased participation in therapy and activities,
 - decreased functional status, and
 - poorer outcomes.
- Mood disorders are common in nursing homes and are often underdiagnosed and undertreated.

Planning for Care

- Findings suggesting mood distress could lead to:
 - identifying causes and contributing factors for symptoms and
 - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.

DEFINITION

9-ITEM PATIENT HEALTH QUESTIONNAIRE (PHQ-9[®])

A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

Steps for Assessment

Look-back period for this item is 14 days.

1. Conduct the interview preferably the day before or day of the ARD.
2. Interview any resident when D0100 = 1.
3. Conduct the interview in a private setting.
4. If an interpreter is used during resident interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the resident's responses. Interpreters are people who translate oral or written language from one language to another.
5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
6. Be sure the resident can hear you.
 - Residents with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
 - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
 - Minimize background noise.
7. If you are administering the PHQ-9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.
8. Explain the reason for the interview before beginning.

Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."
9. Explain and /or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident comprehend the response choices.

Suggested language: "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."
10. Interview the resident.

Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"

Then, for each question in **Resident Mood Interview** (D0200):

 - Read the item as it is written.
 - Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for himself what "tired" means; the item should be scored based on the resident's interpretation.
 - Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
 - Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated; this is considered a **nonsensical** response (e.g., when asked the question about "poor appetite or overeating," the resident answers, "I always win at poker.").

D0200: Resident Mood Interview (PHQ-9[®]) (cont.)

- For a **yes** response, ask the resident to tell you how often he or she was bothered by the symptom over the last 14 days. Use the response choices in D0200 Column 2, **Symptom Frequency**. Start by asking the resident the number of days that he or she was bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1, yes:** if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

Coding Instructions for Column 2. Symptom Frequency

Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

- **Code 0, never or 1 day:** if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that he or she has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates that he or she has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates that he or she has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- For question D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
 - The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc). Follow facility protocol for evaluating possible self-harm.
 - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,
 - Experienced interviewers have found that most residents who are having this feeling appreciate the opportunity to express it.

D0200: Resident Mood Interview (PHQ-9[®]) (cont.)

- Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the resident is already feeling.
- The best interviewing approach is to ask the question openly and without hesitation.
- If the resident uses his or her own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using his or her own words, ask him to tell you how often he or she was bothered by that symptom.
- Select only one frequency response per item.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Residents may respond to questions:
 - verbally,
 - by pointing to their answers on the cue card, OR
 - by writing out their answers.

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
 - **Example:** Say, “That’s interesting, now I need to know...”; “Let’s get back to...”; “I understand, can you tell me about...”
 - Validate your understanding of what the resident is saying by asking for clarification.
 - **Example:** Say, “I think I hear you saying that...”; “Let’s see if I understood you correctly.”; “You said.... Is that right?”
- If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
 - **Example:** Say, “Would you say [name symptom] bothered you more than half the days in the past 2 weeks?”
 - If the resident says “yes,” show the cue card and ask whether it bothered him or her nearly every day (12-14 days) or on half or more of the days (7-11 days).
 - If the resident says “no,” show the cue card and ask whether it bothered him or her several days (2-6 days) or never or 1 day (0-1 day).

D0200: Resident Mood Interview (PHQ-9[©]) (cont.)

- Noncommittal responses such as “not really” should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
 - “What do you mean?”
 - “Tell me what you have in mind.”
 - “Tell me more about that.”
 - “Please be more specific.”
 - “Give me an example.”
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
 - **Example:** Item D0200E, **Poor Appetite or Overeating**. The resident responds “the food is always cold and it just doesn’t taste like it does at home. The doctor won’t let me have any salt.”
 - Possible interviewer response: “You’re telling me the food isn’t what you eat at home and you can’t add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?”
 - **Example:** Item D0200A, **Little Interest or Pleasure in Doing Things**. The resident, when asked how often he or she has been bothered by little interest or pleasure in doing things, responds, “There’s nothing to do here, all you do is eat, bathe, and sleep. They don’t do anything I like to do.”
 - Possible interview response: “You’re saying there isn’t much to do here and I want to come back later to talk about some things you like to do. Thinking about how you’ve been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things.”
 - **Example:** Item D0200B, **Feeling Down, Depressed, or Hopeless**. The resident, when asked how often he or she has been bothered by feeling down, depressed, or hopeless, responds: “How would you feel if you were here?”
 - Possible interview response: “You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?”
- If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a resident has moderate cognitive impairment but can respond to simple, direct questions.
 - **Example:** Item D0200E, **Poor Appetite or Overeating**.
 - You can simplify this item by asking: “In the last 2 weeks, how often have you been bothered by poor appetite?” (pause for a response) “Or overeating?”

D0200: Resident Mood Interview (PHQ-9[®]) (cont.)

- **Example:** Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
 - You can break the item down as follows: “How often are you having problems falling asleep?” (pause for response) “How often are you having problems staying asleep?” (pause for response) “How often do you feel you are sleeping too much?”
- **Example:** Item D0200H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual.
 - You can simplify this item by asking: “How often are you having problems with moving or speaking so slowly that other people could have noticed?” (pause for response) “How often have you felt so fidgety or restless that you move around a lot more than usual?”

D0300: Total Severity Score

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm	
Enter Code <input type="checkbox"/>	Was responsible staff or provider informed that there is a potential for resident self harm? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up.
- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9[®] that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists.

Planning for Care

- The PHQ-9[®] **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.

DEFINITION

TOTAL SEVERITY SCORE

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

D0300: Total Severity Score (cont.)

Steps for Assessment

After completing D0200 A-I:

1. Add the numeric scores across all frequency items in **Resident Mood Interview** (D0200) Column 2.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
3. The maximum resident score is 27 (3 x 9).

Coding Instructions

- The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9[®].
- If symptom frequency is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as “99” and the **Staff Assessment of Mood** should be conducted.
- Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or “99” if symptom frequency is blank for 3 or more items).
- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9[®] Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9[®] can indicate possible depression. Responses can be interpreted as follows:
 - Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
 - Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
 - In addition, PHQ-9[®] **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
 - 1-4: minimal depression
 - 5-9: mild depression
 - 10-14: moderate depression
 - 15-19: moderately severe depression
 - 20-27: severe depression

D0350: Follow-up to D0200I

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm	
Enter Code <input type="checkbox"/>	Was responsible staff or provider informed that there is a potential for resident self harm? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that he or she had thoughts of being better off dead, or hurting him or herself in some way.
- It is well-known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life threatening behaviors, including poor nutrition and treatment refusal are common.
- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.

Planning for Care

- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at <http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm>).

Steps for Assessment

1. Complete item D0350 **only** if item D0200I1 **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1 indicating the possibility of resident self-harm.

Coding Instructions

- **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.
- **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV[®])

D0500. Staff Assessment of Resident Mood (PHQ-9-OV [®])		
Do not conduct if Resident Mood Interview (D0200-D0300) was completed		
Over the last 2 weeks, did the resident have any of the following problems or behaviors?		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency.		
1. Symptom Presence 0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2)	2. Symptom Frequency 0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	
1. Symptom Presence	2. Symptom Frequency	
↓ Enter Scores in Boxes ↓		
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self	<input type="checkbox"/>	<input type="checkbox"/>
J. Being short-tempered, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- PHQ-9[®] **Resident Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the PHQ-9[®] **Resident Mood Interview**. Therefore, staff should complete the PHQ-9-OV[®] **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified.
- Persons unable to complete the PHQ-9[®] **Resident Mood Interview** may still have a mood disorder.
- Even if a resident was unable to complete the **Resident Mood Interview**, important insights may be gained from the responses that were obtained during the interview, as well as observations of the resident's behaviors and affect during the interview.
- The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.
- It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV[®]) (cont.)

- Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9[®] **Resident Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

- When the resident is not able to complete the PHQ-9[®], scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

Steps for Assessment

Look-back period for this item is 14 days.

1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
2. The same administration techniques outlined above for the PHQ-9[®] **Resident Mood Interview** (pages D-4–D-6) and Interviewing Tips & Techniques (pages D-6–D-8) should also be followed when staff are interviewed.
3. Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.
4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation.
5. If frequency cannot be coded because the resident has been in the facility for less than 14 days, talk to family or significant other and review transfer records to inform the selection of a frequency code.

Examples of Staff Responses That Indicate Need for Follow-up Questioning with the Staff Member

1. **D0500A, Little Interest or Pleasure in Doing Things**
 - The resident doesn't really do much here.
 - The resident spends most of the time in his or her room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
 - She's 95—what can you expect?
 - How would you feel if you were here?
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
 - Her back hurts when she lies down.
 - He urinates a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
 - She's 95—she's always saying she's tired.
 - He's having a bad spell with his COPD right now.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV[®]) (cont.)

5. D0500E, Poor Appetite or Overeating

- She has not wanted to eat much of anything lately.
- He has a voracious appetite, more so than last week.

6. D0500F, Indicating That S/he Feels Bad about Self, Is a Failure, or Has Let Self or Family Down

- She does get upset when there's something she can't do now because of her stroke.
- He gets embarrassed when he can't remember something he thinks he should be able to.

7. D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television

- She says there's nothing good on TV.
- She never watches TV.
- He can't see to read a newspaper.

8. D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite— Being So Fidgety or Restless That S/he Has Been Moving Around a Lot More than Usual

- His arthritis slows him down.
- He's bored and always looking for something to do.

9. D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self

- She says God should take her already.
- He complains that man was not meant to live like this.

10. D0500J, Being Short-Tempered, Easily Annoyed

- She's OK if you know how to approach her.
- He can snap but usually when his pain is bad.
- Not with me.
- He's irritable.

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.
- **Code 1, yes:** if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency**.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV[®]) (cont.)

Coding Instructions for Column 2. Symptom Frequency

- **Code 0, never or 1 day:** if staff indicate that the resident has never or has experienced the symptom on only 1 day.
- **Code 1, 2-6 days (several days):** if staff indicate that the resident has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if staff indicate that the resident has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if staff indicate that the resident has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- Ask the staff member being interviewed to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., “nearly every day” or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.
- If the staff member has difficulty selecting between two frequency responses, code for the **higher** frequency.
- If the resident has been in the facility for less than 14 days, also talk to the family or significant other and review transfer records to inform selection of the frequency code.

D0600: Total Severity Score

D0600. Total Severity Score	
<input type="text"/> <small>Enter Score</small>	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

Item Rationale

Health-related Quality of Life

- Review Item Rationale for D0300, **Total Severity Score** (page D-8).
- The PHQ-9[®] Observational Version (PHQ-9-OV[®]) is adapted to allow the assessor to interview staff and identify a **Total Severity Score** for potential depressive symptoms.

Planning for Care

- The score can be communicated among health care providers and used to track symptoms and how they are changing over time.
- The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression.

D0600: Total Severity Score (cont.)

Steps for Assessment

After completing items D0500 A-J:

1. Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2.
2. Maximum score is 30 (3×10).

Coding Instructions

The interview is successfully completed if the staff members were able to answer the frequency responses of at least 8 out of 10 items on the PHQ-9-OV[®].

- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9-OV[®] Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9-OV[®] can indicate possible depression. Responses can be interpreted as follows:
 - Major Depressive Syndrome is suggested if—of the 10 items, 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
 - Minor Depressive Syndrome is suggested if—of the 10 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
 - In addition, PHQ-9[®] **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
 - 1-4: minimal depression
 - 5-9: mild depression
 - 10-14: moderate depression
 - 15-19: moderately severe depression
 - 20-30: severe depression

D0650: Follow-up to D0500I

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm	
Enter Code <input type="checkbox"/>	Was responsible staff or provider informed that there is a potential for resident self harm? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that they had thoughts of being better off dead, or hurting him or herself in some way.
- It is well known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life-threatening behaviors, including poor nutrition and treatment refusal are common.

Planning for Care

- Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at <http://www.agingcare.com/Featured-Stories/125788/Suicide-and-the-Elderly.htm>).

Steps for Assessment

1. Complete item D0650 only if item D0500I, **States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self** = 1 indicating the possibility of resident self-harm.

Coding Instructions

- **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.
- **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.