



Section D

Mood



Objectives

- State the intent of Section D Mood.
- State the purpose and benefits of the PHQ-9®.
- Describe effective interviewing techniques for the PHQ-9®.
- Describe how to conduct the assessment for Section D Mood.
- Code Section D correctly and accurately.

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Intent of Section D

- Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home.
- Associated with significant morbidity.
- Signs and symptoms of mood distress are treatable.
- Treatments are very effective.

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Depression

- Depression can be associated with:
 - Psychological and physical distress
 - Decreased participation in therapy and activities
 - Decreased functional status
 - Poorer outcomes

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Goal of Assessment

- Findings that suggest mood distress should lead to:
 - Identifying causes and contributing factors for symptoms.
 - Identifying interventions that could address symptoms.
 - Ensuring resident safety.
- **Coding the presence of indicators does not automatically mean a diagnosis of depression or other mood disorder.**

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Resident Mood Interview

- Section D uses the Patient Health Questionnaire (PHQ-9[®]) Resident Mood Interview.
- Incorporates resident voice in assessment.
- Complete the Staff Assessment **only** if an interview cannot be completed.
- Do not complete **both** the Resident Mood Interview and the Staff Assessment.



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Item D0100

Should Resident Mood Interview Be Conducted?

D0100 Importance

- Most residents who are capable of communicating can answer questions about how they feel.
- More reliable and accurate than observation alone for identifying a mood disorder.
- "Hearing the resident's voice."


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D0100 Should Resident Mood Interview Be Conducted?



- Determine whether to attempt an interview or conduct the staff assessment.
- Most residents are able to attempt the interview.

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

0. No resident is rarely/never understood → Skip to and complete D0600-D0600, Staff Assessment of Resident Mood (R1425-9047)

1. Yes → Continue to D0300, Resident Mood Interview (R1425-9047)


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D0100 Conduct the Assessment

- Determine if resident is rarely or never understood.
- Conduct the interview if resident can respond:
 - o Verbally
 - o By pointing to answers on a cue card
 - o By writing out his or her answers
- Review A1100 Language to determine if the resident wants or needs an interpreter.
 - o Make every effort to have an interpreter available if needed.

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D0100 Coding Instructions

- If **0. No**, complete the staff assessment.
- If **1. Yes** complete the Resident Interview for Mood.
- Attempt to conduct an interview with all residents if at all possible.

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

0. No resident is rarely/never understood → Skip to and complete D0200-D0600 Staff Assessment of Resident Mood (PHQ-9-CAM)

1. Yes → (continue) Resident Interview (PHQ-9-C)

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Item D0200

Resident Mood Interview (PHQ-9[©])

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Patient Health Questionnaire (PHQ-9[®])

- Consists of a validated interview.
- Screens for symptoms of depression.
- Provides a standardized severity score.
- Provides a rating for evidence of a depressive disorder.
- Assesses for both the **presence** and the **frequency** of each symptom.

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D0200 Conduct the Assessment

- Establish a conducive environment.
- Use an interpreter if needed.
- Make sure the resident can hear you.
- Explain the reason for the interview.
- Explain the response choices.
- Show responses in large font as appropriate.
- Allow resident to write responses if needed.
- Allow the resident to complete the interview on paper if necessary.

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D0200 Conduct the Interview₁

- Start by asking the resident if he or she has been bothered by any of the following problems over the last 2 weeks.
- Read each item as it is written.
 - Do not provide definitions of terms in the questions.
 - The meaning of each question must be based on the resident's interpretation.
 - An interpreter should not attempt to determine intent, meaning or significance behind the resident's response.

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D0200 Conduct the Interview₂

- Ask each question in sequence to assess the **presence** and **frequency** of a symptom.
- Determine the presence of a symptom (resident answers "Yes" to a question).
- Ask about the frequency of the symptom before asking the next question.
- Briefly explore further if the resident uses his or her own words to describe a symptom.

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D0200 Assessment Guidelines

- Neither staff nor residents have reported the PHQ-9[®] to be burdensome or intrusive.
- Multiple interviews have led to improved symptom identification.
- Conduct interview preferably the day before or day of the Assessment Reference Date (ARD).
- The look-back period is **14 days**.



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PHQ-9[®] Resident Mood Interview

Interview Techniques



Effective Interviewing Techniques

- Several interview techniques are helpful in conducting this interview.
 - Repeat a question.
 - Guide the conversation.
 - Ask for clarification.
 - Unfolding to help select a frequency.
 - Probing to explore noncommittal responses.
 - Echoing to summarize long answers.
 - Disentangling to help residents understand the question.

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Guide the Conversation

- Some residents are eager to talk and may stray from the topic.
- Acknowledge the response and guide the conversation back to the topic.
 - "That's interesting, now I need to know..."
 - "Let's get back to..."
 - "I understand, can you tell me about..."

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Ask for Clarification

- Validate your understanding of what the resident is saying.
 - "I think I hear you saying that..."
 - "Let's see if I understood you correctly."
 - "You said.... Is that right?"

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Unfolding

- Resident has difficulty selecting a frequency.
- Start by offering a single frequency response.
- Follow with a sequence of more specific questions.
- Say, "Would you say [name symptom] bothered you more than half the days in the past 2 weeks?"
 - o If the resident says "yes," show the cue card and ask whether it bothered her nearly every day or on half or more of the days.
 - o If the resident says "no," show the cue card and ask whether it bothered her several days or never or 1 day.

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Probing

- Explore noncommittal responses such as "not really."
- Gently encourage reluctant residents to report any symptoms.
- Probe by asking neutral or nondirective questions.
 - o "What do you mean?"
 - o "Tell me what you have in mind."
 - o "Tell me more about that."
 - o "Please be more specific."
 - o "Give me an example."

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Echoing₁

- Sometimes respondents give a long answer.
- Summarize longer answers to narrow the answer to the response choices available.
- Then ask which response option best applies.

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Echoing₂

- Item D0200E, Poor Appetite or Overeating.
 - Resident response: “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?”


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Disentangling

- Separate the item into shorter parts.
- Provide the resident an opportunity to respond after each part.
- Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
- Break the item down as follows:
 - “How often are you having problems falling asleep?”
 - “How often are you having problems staying asleep?”
 - “How often do you feel you are sleeping too much?”


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Item D0200

Resident Mood Interview (PHQ-9[©]) Coding

Under the agreements with the Annals of Internal Medicine and Pfizer, entities that administer the MDS 3.0 assessment, organizations that create either paper or electronic versions of the assessment tool are covered under the CMS license agreement. The CAM or the PHQ-9 (or PHQ-2 and PHQ-5) cannot be modified in any manner with regards to wording assessment. The copyright notice must appear on any paper or electronic version of the MDS 3.0 instrument as indicated on the item set for the respective instruments.

D0200 Coding Guidelines

- Code one frequency response per item.
- Code the higher frequency if resident has difficulty selecting between two options.
- Code the higher frequency if the resident gives different frequencies for items that contain more than one phrase.
- Code **9** for any nonsensical response.
 - o Leave Column 2 blank.


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PHQ-9[®] Resident Mood Interview


Practice Activity

Activity Instructions



- Turn to D0200 in your MDS instrument.
- Watch the video of the PHQ-9[®] interview.
- Notice the interview techniques used throughout the interview.
- Code the PHQ-9[®] interview in item D0200 in your MDS instrument.

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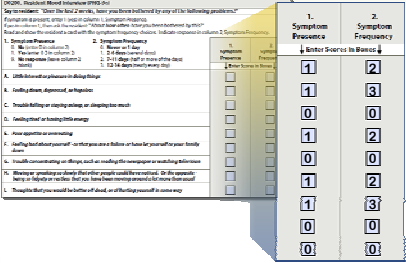
PHQ-9[®] Interview Video





The Video on Interviewing Vulnerable Elders (VIVE) was funded by the Picker Institute and produced by the UCLA/ JH Borun Center. DVD copies can be ordered from the Pioneer Network.


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Activity Coding Results




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D0200 The Hard Question₁

- Refer to D02001 *Thoughts that you would be better off dead, or of hurting yourself in some way.*
- Some interviewers may feel uncomfortable asking this question because:
 - o Fear upsetting the resident
 - o Feel that the question is too personal
 - o Worry it will give resident inappropriate ideas


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D0200 The Hard Question₂

- Experience with this question indicates:
 - Residents appreciate the opportunity to express this.
 - It does not give residents any ideas toward self harm.
 - It helps the provider better understand what the resident is feeling.
- Ask this question openly and without hesitation.

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D0200I Interview Video



The Video on Interviewing Vulnerable Elders (VIVE) was funded by the Picker Institute and produced by the UCLA/ JH Borun Center. DVD copies can be ordered from the Pioneer Network.



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Item D0300

Total Severity Score



D0300 Importance₁

- Summary of frequency scores on the PHQ-9[®] questions.
- Indicates extent of potential depression symptoms.
- Can be useful for requesting additional assessment by providers or mental health specialists.
- Does not diagnose a mood disorder or depression.

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D0300 Importance₂

- Provides a standard score which can be communicated to authorized staff for appropriate follow up.
- Provides a way to track symptoms and changes in symptoms over time.

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D0300 Conduct the Assessment

- Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2.
- **Total only the frequency items.**
- Do not total the values in Resident Mood Interview Column 1, indicating the presence of symptoms.


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D0300 Coding Instructions


- Do not calculate the score during the interview.
- Focus your full attention on the interview.
- Enter the score as a two-digit number.
- Score will be between **00** and **27**.

D0300. Total Severity Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27.
 Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).




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Complete/ Incomplete Interview

- Interview is complete if the resident provides frequency responses for at least 7 of 9 items.
 - Includes code **0** for the frequency.
- If the symptom frequency column is blank for 3 or more items, the interview is **not** complete.
 - Code **9** for the presence of 3 or more symptoms.
 - Code the Total Severity Score as **99**.
 - Complete the Staff Assessment of Resident Mood.



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Item D0350

Safety Notification

D0350 Importance



- Untreated depression can cause significant distress and increased mortality beyond the effects of other risk factors.
- Although rates of suicide have historically been lower in nursing homes, indirect self-harm and life threatening behaviors are common.
- Recognition and treatment of depression can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.


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D0350 Conduct the Assessment

- Complete this item **only** if D0200I Column 1 is coded 1.
- Indicates the possibility of resident self-harm.

E. Poor appetite or anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>


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D0350 Coding Instructions

- Code **0** indicates that staff has not been notified.
- Code **1** indicates that staff has been notified.

D0350. Safety Notification - Complete only if D0200I = 1 indicating possibility of resident self harm

Was responsible staff or caregiver informed that there is a potential for resident self harm?

0 No
 1 Yes




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Item D0500

Staff Assessment of Resident Mood



D0500 Importance₁

- Persons unable to complete the PHQ-9® Resident Mood Interview may have a mood disorder.
- Attempting the interview may provide important insights.
- Identifying symptom presence and frequency and observations are important.
 - Need for treatment
 - Type of treatment

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D0500 Importance₂

- An alternate means of assessing mood must be used for residents who do not complete the interview.
 - Cannot communicate.
 - Refuse or are unable to participate in the interview.
- This ensures that information about their mood is not overlooked.
- Remember that coding the presence of indicators does not automatically mean a diagnosis of depression or other mood disorder.

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D0500 Conduct the Assessment₁

- Interview staff from all shifts who know the resident best.
- Use the same interview techniques discussed previously when interviewing staff.
- Encourage staff to report symptom frequency.
- Staff should report all symptoms even if they believe the symptom to be unrelated to depression.



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D0500 Conduct the Assessment₂

- Explore unclear responses.
 - Focus discussion on the specific symptom listed.
 - Do not expand into a lengthy clinical evaluation.
- If the resident has been in the facility for less than 14 days:
 - Talk to family or significant other.
 - Review transfer records.



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D0500 Assessment Guidelines

- The look-back period is **14 days**.
- Ask staff member to select how often a symptom occurred during the look-back period.
- Select higher frequency rating reported for a symptom.
- Code the higher frequency if staff has difficulty selecting between two options.



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D0500 Coding Instructions₁

- Code the presence of each symptom.

1. Symptom Presence
 0. No (enter 0 in column 2)
 1. Yes (enter 0-3 in column 2)

		1.	2.	3.	4.
		Symptom Presence			
A. Lethargic or phlegm in sputum		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing ill, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or unintended weight loss		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling that you have lost interest in things, or that you are not doing things the way you used to		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Thinking about harming yourself or others, or thoughts of suicide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Trouble concentrating or things seem to be slipping your mind		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Trouble remembering things that other people have said, or you forget things often		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Being slowed down or not moving as well as you used to		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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D0500 Coding Instructions₂

- Code the frequency of each symptom.

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)

		0.	1.	2.	3.
		Symptom Frequency			
A. Lethargic or phlegm in sputum		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing ill, depressed, or hopeless		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or unintended weight loss		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling that you have lost interest in things, or that you are not doing things the way you used to		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Thinking about harming yourself or others, or thoughts of suicide		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Trouble concentrating or things seem to be slipping your mind		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Trouble remembering things that other people have said, or you forget things often		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Being slowed down or not moving as well as you used to		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Item D0600

Total Severity Score



D0600 Importance₁

- Summary of the frequency scores on the PHQ-9-OV®.
- Indicates the extent of potential depression symptoms.
- Can be useful for requesting additional assessment by providers or mental health specialists.
- Does not diagnose a mood disorder or depression.


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D0600 Importance₂

- Provides a standard score which can be communicated to authorized staff for appropriate follow up.
- Provides a way to track symptoms and changes in symptoms over time.


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D0600 Conduct the Assessment


- Add the numeric scores across all frequency items in the Staff Assessment for Resident Mood (D0500) Column 2.
- Total only the frequency items.
- Do not total the values in Staff Assessment for Resident Mood Column 1, indicating the presence of symptoms.


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D0600 Coding Instructions

- Enter the score as a two-digit number.
- Score will be between **00** and **30**.

D0600 - Total Severity Score
Add scores for all frequency responses in Column 2; symptom frequency. Total score must be between 00 and 30.



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Item D0650


Safety Notification

D0650 Importance

- Documents if appropriate staff were informed that the resident expressed thoughts of being better off dead or hurting himself or herself in some way.
- Sample resident responses:
 - o She says God should take her already.
 - o He complains that man was not meant to live like this.



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D0650 Conduct the Assessment

- Complete this item **only** if D05001 Column 1 is coded 1.
- Indicates the possibility of resident self-harm.

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. Mentions speaking so loudly that other people have noticed. Or the opposite - being so fidgety or nervous 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 checked="" type="checkbox"/>	<input type="checkbox"/>
J. Being short-tempered, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self		1

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D0650 Coding Instructions

- Code **0. No** indicates that staff has not been notified.
- Code **1. Yes** indicates that staff has been notified.

D0650. Safety Notification - Complete only if D05000 = 1 indicating possibility of resident self-harm.

Label Code: 0. No 1. Yes

0 No
1 Yes

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Section D

Summary

Section D Summary₁

- MDS 3.0 uses the PHQ-9[®] resident interview or staff assessment to assess resident mood.
- Follow guidelines for resident interviews.
- Use interview techniques such as probing, echoing, and unfolding as needed.
- Calculate and enter the Total Severity Score.
- This score can be used to track changes in resident mood over time.



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Section D Summary₂

- Conduct a staff assessment only if the interview cannot be completed.
- Notify appropriate personnel of results of assessment.
- Report any instances of a resident responding "Yes" to items D02001 or D05001 (thoughts of or attempts at self-harm).



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