

Depression Care Moving Into Patients' Homes

BY ALICIA AULT

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NEW ORLEANS — Several home care organizations affiliated with hospitals in the New York metropolitan area have determined that nurses trained to screen for depression and to offer interventions can effectively improve outcomes in homebound patients, several presenters said at the annual meeting of the American Association of Geriatric Psychiatry.

Nurses are the front line for providing care to homebound patients but do not often recognize depression symptoms or have the ability to clearly communicate the issue to physicians, noted Ellen Brown, a registered nurse who developed an education and intervention program while at Cornell University, New York. She is now with the Stein Gerontological Institute in Miami.

The education program includes a video with portrayals of patients with symptoms

of depression and suicidal ideation, a “nuts and bolts” tool kit that includes a checklist of symptoms and information to gather, and a two-session training course that uses role-playing and other interactive methods.

Several pilot studies by Ms. Brown and her colleagues had shown that the program improved nurses' ability to communicate information to physicians. But it was not clear whether these improvements with simulated cases would trans-

late into better patient management in the real world, she said.

The home care agency at the Montefiore Medical Center, New York, put the training module to the test, said Dr. Paula Marcus of the department of psychiatry at the Albert Einstein College of Medicine, New York. In 2004, the hospital's home care agency was given a 3-year grant from the United Jewish Appeal to integrate psychiatric services.

The Montefiore home care agency's daily census averages 1,200 people who will be in the system for 6 weeks or less and 650 who are in longer term. To teach them how to identify depression in the home care setting, about 100 nurses, and physical, occupational, and speech therapists were given two 2-hour sessions over several weeks, which included viewing the video.

Since that time, thousands of patients have been screened for depression, and hundreds have been referred to the Montefiore home care agency's behavioral health program, Dr. Marcus said.

Once patients are referred to behavioral health, they are screened by a social worker and sent to a geriatric psychiatrist or geriatric psychiatry fellow if necessary. So far, psychiatrists have made an average 120-150 initial home evaluations yearly, Dr. Marcus said.

The home care agency also has been able to bill Medicare, Medicaid, and private insurers for the psychiatric visits, she said.

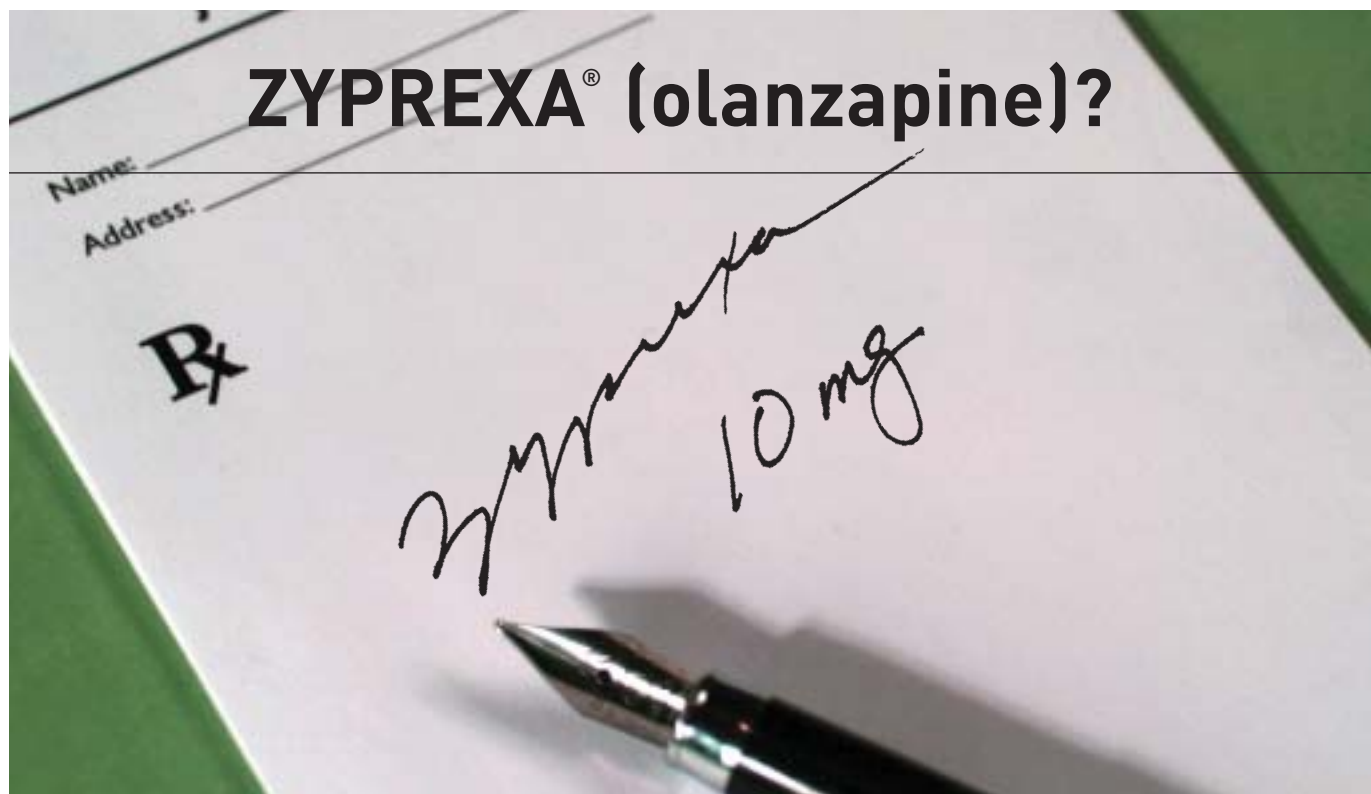
In a real-world test of a different model, the home care agency in Albany County, New York, sent licensed clinical social workers into the homes of medically ill patients who had been identified as severely depressed. Dr. Zvi Gellis, director of the Center for Mental Health and Aging Research at the State University of New York at Albany, presented initial results.

In the pilot, 30 patients received a behavioral intervention called problem-solving therapy for 1 hour a week for 6 weeks. The steps of that program include breaking down the problem, identifying potential solutions, creating those solutions, and then executing them. The patients also were given “homework,” being asked to substitute two pleasurable activities a day for negative thoughts.

They were compared with 32 patients who received basic home care, some psychoeducation, but no problem-solving therapy. The mean age of the patients was 77. Eighty-five percent were white, and 80% lived alone—a risk factor for depression, Dr. Gellis noted.

They were evaluated using the Hamilton Depression Rating Scale, the Geriatric Depression Scale, and self-reported satisfaction scores. The independent assessments were conducted by blinded evaluators at the end of the sessions, and then 3 and 6 months after therapy. There was a 50% reduction in the Hamilton score for the treatment group at 6 weeks and 3 months—from 20 to 10, compared with a minor drop for the control group, Dr. Gellis said.

The Geriatric Depression Scale score dropped from almost 14 to 8 for the treatment group at all three time intervals, compared with about a 1-point decline—from 14 to 13—for the control arm. ■



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