High levels of depressive symptoms are common and contribute to poorer clinical outcomes even in geriatric patients who are already taking antidepressant medication. The Depression CARE for PATients at Home (Depression CAREPATH) intervention was designed to meet the needs of medical and surgical patients who suffer from depression. The intervention’s clinical protocols are designed to guide clinicians in managing depression as part of routine home care.
Most clinicians have observed depressive symptoms in many of their older medical/surgical patients (Brown et al., 2003; Bruce et al., 2002; Ell et al., 2005; Suter et al., 2008). High levels of depressive symptoms that persist across time are clinically significant, whether or not a patient has received a formal depression diagnosis or is already taking antidepressant medication. Given the negative impact of depression on clinical care and outcomes in medical and surgical patients, these depressed patients require ongoing depression care management (DCM) (Suter et al., 2008).

The Depression CARE for PATients at Home (Depression CAREPATH) intervention was designed specifically for use in home healthcare in managing depression as part of ongoing care for medical and surgical patients. The CAREPATH intervention was designed to be delivered by nurses, physical therapists, and primary providers in the home. Training occupational therapists and other care providers to assist in the delivery further strengthens the intervention. A key feature of the intervention is that rather than assigning DCM to a specialist, all primary clinicians are expected to manage depression as part of the routine care provided to their patients. The DCM protocol guides clinicians in when and how to take advantage of specialists and other resources. Home care clinicians are expected to manage an array of patients’ problems in addition to the presenting, mostly acute, conditions and to consult experts as needed. Thus, the management of depression is treated like the management of many other medical conditions.

The purpose of this article is to describe the clinical protocols developed as part of the Depression CAREPATH intervention to guide home care clinicians in the management of depression in their medical and surgical patients. The intervention also helps home health agencies (HHAs) develop the infrastructure needed to implement and sustain DCM as part of routine care. Effective use of the DCM protocol by clinicians requires that each HHA tailor key procedures to fit its own resources and routines. For example, HHAs should specify their own guidelines for case coordination so that clinicians will know whom to contact (e.g., the patient’s physician, a psychiatric nurse, another specialist) when case coordination or referral is indicated by the DCM protocol. Similarly, each HHA should tailor a suicide risk protocol that operationalizes both gradations of suicide risks and the specific steps that should be taken by clinicians at each stage. They should also develop a list of the mental health resources available in the communities that serve their patients.
Two Protocols

The Depression CAREPATH includes a “Screening Protocol” for identifying patients who require DCM as well as the “DCM Protocol” itself. Each is described in the following section.

Depression Screening Protocol

The recommended process for identifying patients who require DCM is illustrated in Figure 1. The Depression Screening Protocol builds on the start-of-care Outcome and Assessment Information Set (OASIS) M1730. It is recommended that agencies use the two-item Patient Health Questionnaire (PHQ) option to screen for depression because it (1) assesses the two “gateway symptoms” of depression, including little interest or pleasure in doing things and experiencing a depressed mood, at least one of which is required in determining a clinically significant depression; (2) is an evidence-based approach to depression screening (Kroenke et al., 2003); and (3) leads naturally to the PHQ-9, a well-used measure of depression severity that is also a component of the DCM protocol (Kroenke et al., 2001).

Patients who screen positive for depressive symptoms on the PHQ-2 should then be assessed with the full PHQ-9 to determine depression severity. Consistent with the CMS OASIS-C Guidance Manual (Centers for Medicare & Medicaid Services, 2009), research (Lowe et al., 2005) and clinical experts (Carson & Vanderhorst, 2010), a total score of 3 or higher is the recommended indicator for additional assessment. Because the first two questions of the PHQ-9 have been asked by the PHQ-2, the most efficient approach is to ask the PHQ-9’s remaining seven questions immediately following M1730. Agencies may, however, decide to use a lower cutoff score on the PHQ-2 as a criterion for further assessment or to have nurses conduct a full PHQ-9 later in the visit. More thorough discussion of how to use the PHQ-9 in home healthcare has been discussed elsewhere (Ell et al., 2005; Sheeran et al., 2010).

Who Requires DCM?

Home health patients require DCM when they experience clinically significant depressive symptoms, regardless of whether or not they are currently taking antidepressant medication or have a formal depression diagnosis. The screening protocol identifies clinically significant depression as a score of (a) 10 or higher on the total PHQ-9, or (b) 1 or higher on the PHQ-9’s Item 9 (“Thoughts of death or harming yourself”). Because Item 9 screens for suicide ideation, a clinician should always follow positive responses to Item 9 with additional questions to determine the level of such risk and follow their agency’s own suicide risk protocol as indicated.

Patients who screen positive for depressive symptoms on the PHQ-2 but score less than 10 on the PHQ-9 may have mild levels of depression. These patients may be evaluated...
by their physician if judged to be clinically indicated, but, as standard practice, we recommend that such patients be monitored with weekly PHQ-9 scores for 2 weeks to identify patients whose depression is worsening or those who may have underreported symptoms at the start of care. Such information on the course of depressive severity is useful for reevaluating the need for DCM. While monitoring symptoms, it is also recommended that clinicians provide these patients and their families educational materials about depression and depression treatment.

The protocol recommends weekly PHQ-2 screening for 2 weeks for patients who score 2 or less at the start of care. Clinicians have frequently commented that some patients may be more willing to acknowledge depressive symptoms after they have gotten to know the clinician better or when the immediate medical needs that led to home healthcare are under control.

**Home Care DCM Protocol**

The Home Care DCM protocol (Figure 2) is designed to fit within a routine visit. The protocol should be followed weekly or, for patients seen less frequently, at each visit. For patients whose depression is identified at first visit, the initial DCM visit may be integrated into this visit or as part of a more extended start of care. Each DCM visit involves five basic (and interrelated) clinical functions: (1) assessment, beginning with the full PHQ-9; (2) case coordination; (3) medication management; (4) education of patients and families; and (5) patient goal setting. Each is described in the following section.

**Assessment**

The purpose of depression assessment is not to make a formal diagnosis but to identify its presence and follow the course of clinically meaningful symptoms across time. The DCM protocol recommends using the PHQ-9 as an efficient, evidence-based approach to quantifying depression severity and changes in severity over time. Because it was originally developed for use in primary care, many physicians understand the clinical meaning of PHQ-9 scores, thus making communication with physicians easier. The symptoms assessed by the PHQ-9 parallel those of **Diagnostic and Statistical Manual of Mental Disorders, 4th edition** criteria for major depressive episode, so that physicians and specialists may use the results in diagnostic decision making as well as determining severity.

The DCM protocol requires that clinicians assess depressed patients with the full PHQ-9 and document these scores on a weekly basis and at discharge from the HHA. The ongoing record or chart of weekly scores is useful in clinical decision making, case coordination, discussions with physicians, and patient education.

**Figure 2.** Depression Care Management Protocol. © Weill Cornell Homecare Research Partnership.
At discharge, it is important that information on depression and depression care is available to the patient’s primary care physicians or other clinicians who will be providing patient care.

Case Coordination
Case coordination is integral to DCM, and an expected first step following the first DCM visit. Evidence of clinically significant depressive symptoms indicates that some form of treatment may be needed or, for patients already taking an antidepressant, a review and possible change in treatment is required. The steps for case coordination will depend upon the agency and its resources, and should be developed into formal guidelines for clinicians. Typically, these guidelines require clinicians to contact the patient’s physician, although agencies with psychiatric nurses, clinically trained social workers, or access to other mental health specialists may designate these clinicians as the initial point of contact. It is important, however, that case coordination at some point involve someone with the professional knowledge and authority to make changes in medications, especially for symptomatic patients who are already taking an antidepressant or patients with very high PHQ-9 scores.

The DCM protocol requires that clinicians recontact the patient’s physician or mental health specialist when depressive symptoms or suicide ideation emerges or worsens, patients have adverse side effects to medications, or if there has been no change in symptoms after 4 weeks or otherwise clinically indicated. As discussed above, providing a record or chart of the weekly PHQ-9 scores will be important to clinical decision making in these consultations.

Case coordination is most effective when clinicians present information that is clear, concise, and contains the information needed by physicians for their own decision making. A Case Presentation Template, shown in Figure 3, was developed to facilitate such a discussion (Brown et al., 2010). Clinicians who are unable to reach the physician can fax or e-mail the pertinent information using this same tool. This information includes clear and unembellished statements regarding the (1) reason for the call; (2) patient’s age, gender, race/ethnicity, and marital status; (3) the symptoms of depression, their duration and severity (PHQ-9 scores), suicidal ideation, and psychiatric history (if any); (4) key psychosocial factors (e.g., living situation or social support stressors); (5) medical illnesses, medications; and (6) recommendation for further evaluation by medical doctor or psychiatric nurse. It was found that, with training, case presentations following this template usually take less than 2 minutes.

At discharge, it is important that information on depression and depression care is available to the patient’s primary care physicians or other clinicians who will be providing patient care. As it is not always possible for this information to be transferred directly from an agency, it is recommended that clinicians provide patients and their families a summary of their depression care with the instructions to bring it with them to their next doctor’s visit and next level of care. The Case Presentation Template (Figure 3) can be modified for this purpose. The summary is important to a successful transition of care for patients with short, as well as long, lengths of stay.

Medication Management
Antidepressant medication and psychotherapy are the most effective treatments for depression in late life. The most commonly used treatment is antidepressant medication, most often a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI), although other classes of antidepressants are also effective. Approximately one in three geriatric home healthcare patients will be already taking an antidepressant at the start of care (Shao et al., 2011), and a significant number of patients taking an antidepressant will still be experiencing clinically significant depressive symptoms (Bruce et al., 2007). The persistence of symptoms despite antidepressant medication is an indicator that a review of, and possible change in, treatment is indicated.

While managing antidepressant medication is similar to general medication management, there
recommended therapeutic dose of their specific antidepressant (Mojtabai & Olfson, 2008). More generally, finding an effective antidepressant regimen for a specific patient can take time. The therapeutic dose for most antidepressants is not a single value but falls within a range of values. Treating depression often involves changing doses, changing to a different antidepressant (or different class

---

**Figure 3.** Depression Case Presentation Template for Use By Nurses.

<table>
<thead>
<tr>
<th>Date: <strong><strong>/</strong></strong>/______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dear Dr. _______________</td>
</tr>
<tr>
<td>I am writing about your patient Mr./Ms.<em><strong><strong><strong><strong><em><strong><strong>(D.O.B.</strong></strong></em>/</strong></strong><em>/</em></strong></strong></em>) whom I suspect has symptoms of depression. The following information is pertinent to this case:</td>
</tr>
<tr>
<td>Marital Status, Race, Gender ____________________________</td>
</tr>
<tr>
<td>Psychosocial (Living situation, social support, stressors) ________________________________</td>
</tr>
<tr>
<td>PHQ-9 Score (dated) and Clinically Significant Symptoms (duration, frequency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>PHQ-9 Score</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Suicidal Thoughts or Plan? YES NO
If Yes, please elaborate: ______________________________________________________________ |
____________________________________________________________________________________ |
Medical illness and Medications (include dose for Psychotropic medication) |
____________________________________________________________________________________ |
____________________________________________________________________________________ |
Recommendation for further evaluation by the physician or psychiatric nurse, psychologist, or social worker:______________________________________________ |
*Please contact our agency or the nurse at __________ when you receive this form.*
as with other medications, managing antidepressants involves understanding possible side effects. an advantage of ssris and snris is that serious side effects are rare, although knowledge about how to identify them and when to contact a physician is important. most side effects are not serious, however, and appear within days after the patient first begins taking the medication or after an increase in dosage. most are also

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Usual Daily Dose Range (mg)</th>
<th>Common Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>escitalopram¹</td>
<td>Lexapro</td>
<td>10-20</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sleepiness, Insomnia, Increased sweating, Headache, Restlessness, Sexual dysfunction</td>
</tr>
<tr>
<td>citalopram¹</td>
<td>Celexa</td>
<td>10-40</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sleepiness, Insomnia, Increased sweating, Sexual dysfunction</td>
</tr>
<tr>
<td>venlafaxine</td>
<td>Effexor</td>
<td>75-225</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sedation/fatigue, Sleepiness, Headache, Increased sweating, Increased blood pressure, Sexual dysfunction</td>
</tr>
<tr>
<td>paroxetine¹</td>
<td>Paxil</td>
<td>20-50</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sleepiness, Insomnia, Increased sweating, Headache, Restlessness, Sexual dysfunction</td>
</tr>
<tr>
<td>fluoxetine¹</td>
<td>Prozac</td>
<td>10-40</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sleepiness, Insomnia, Increased sweating, Headache, Restlessness, Sexual dysfunction</td>
</tr>
<tr>
<td>sertraline¹</td>
<td>Zoloft</td>
<td>50-150</td>
<td>Nausea/constipation/diarrhea, Dry mouth, Sleepiness, Sedation/fatigue, Insomnia, Increased sweating, Headache, Restlessness, Sexual dysfunction</td>
</tr>
<tr>
<td>mirtazapine²</td>
<td>Remeron</td>
<td>15-45</td>
<td>Sedation/Sleepiness, Weight/appetite increase, Dizziness</td>
</tr>
<tr>
<td>bupropion</td>
<td>Wellbutrin</td>
<td>150-450</td>
<td>Headache, Dry mouth, Insomnia, Nausea/constipation/diarrhea, Anxiety/restlessness, Tremor</td>
</tr>
<tr>
<td>nortriptyline³</td>
<td>Pameler</td>
<td>50-100</td>
<td>Sedation, Constipation (moderate), Blurred vision Orthostatic Hypotension, Slowed cardiac conduction, Increased sweating, Tremor, Urinary retention</td>
</tr>
</tbody>
</table>

¹SSRI (selective serotonin reuptake inhibitor), ²Heterocyclic, ³Tricyclic

Figure 4. Commonly Used Antidepressants.

of antidepressant), or augmenting one medication with another. Therefore, basic knowledge of antidepressant classes and access to information on dosing for specific antidepressants are useful to clinicians in discussions with physicians. A list of commonly used antidepressants (Figure 4) can be useful to clinicians while conducting home visits, although they will want additional information for more complex circumstances.
chotherapy plan, monitor symptoms, and communicate their progress to clinicians.

Some of the most frequently asked questions from patients and family members include: What makes you think I’m depressed? What are the signs of serious depression? What causes depression? How do you treat depression? Clinicians are encouraged to use patient education handouts to convey information about the clinical manifestation of depression, the underlying biology, known risk factors, and treatment options in a straightforward way. Figure 5 lists some of the many sources of free patient depression educational materials.

It is important to neither dismiss their symptoms nor try to “cheer patients up” with the expectation that symptoms will go away that easily. Helping patients understand that depression is a medical illness, not a character flaw or a condition that they have brought upon themselves, is especially important. At the same time, patients will benefit from reminders that depression is treatable and that treatment works best when patients are adherent and participate in goal setting (described below). Thus, there is reason for patients to be hopeful.

Although depression is becoming better understood in society as a whole, many people still have misconceptions about depression that make patient education more challenging, but also more important. On the one hand, some people believe that depression is a “normal” or “inevitable” part of the aging process, especially with older adults who experience significant medical illness, disability, or loss. Although these factors can contribute to the risk of depression, they do not mean that living with depression is necessary. On the other hand, some people consider depression a character flaw or somehow self-inflicted so that patients merely need to “buck up” to relieve themselves from depression. Again, helping

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**Education**

Although patient education is part of all good clinical care (Suter & Suter, 2008), it may be particularly important for depression and depression treatment, as both are subject to myths, preconceptions, misinformation, and stigma. The more patients and families know what depression is, what causes it, and how to treat it, the more likely they will follow the prescribed medication or psychotherapy plan, monitor symptoms, and communicate their progress to clinicians.

**Figure 5. Resources for Patient Education on Depression.**

A Guide to Mental Wellness in Older Age: Recognizing and Overcoming Depression, Geriatric Mental Health Foundation: [http://www.gmhfonline.org/gmhf/consumer/depression_toolkit.html](http://www.gmhfonline.org/gmhf/consumer/depression_toolkit.html)

NIH Senior Health: Depression, National Institute of Health: [http://nihseniorhealth.gov/depression/toc.html](http://nihseniorhealth.gov/depression/toc.html)

Patient Education Resources, The MacArthur Initiative on Depression and Primary Care: [http://www.depression-primarycare.org/clinicians/toolkits/materials/patient_edu/](http://www.depression-primarycare.org/clinicians/toolkits/materials/patient_edu/)

Many older medical and surgical home care patients experience depressive symptoms that are clinically significant. These patients will benefit from clinical care that manages depression as much as care for other chronic illnesses.

Conclusion

Many older medical and surgical home care patients experience depressive symptoms that are clinically significant. These patients, their families, and clinicians will benefit from clinical care that manages depression as much as care for other chronic illnesses. The Depression CAREPATH intervention was developed to provide the home care clinician skills and procedures needed to include DCM in routine practice.

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