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Nurse Practitioner's Perspectives on Treating Depression in the Nursing Home Setting

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Nurse Practitioner's Perspectives on Treating Depression in the Nursing Home Setting

Bryan Mullaney

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Abstract

Those living within the nursing home setting, or long-term care facilities, are at higher risk to succumb to the symptoms of depression due to illness, separation from family, and loss of autonomy. The available data has demonstrated that nurse practitioners are educated and trained to identify and treat depression. However, there is a lack of research that discusses the perspectives of nurse practitioners, such as how they utilize their clinical experience to tailor their treatment modalities on a case by case basis within the nursing home setting. They do this by using their specific assessment method to screen for depression, by monitoring patient's activities of daily living, and by collaborating with those who specialize in psychiatry. This study aimed to uncover the perspectives of nurse practitioners who routinely diagnose, treat, and manage depression of nursing home residents. The data were collected through semi-structured interviews of fifteen nurse practitioners. It was discovered that the holistic treatment of depression in nursing home residents involves nurse practitioner's collaboration with psychiatrists, monitoring of patient's ADL, and the use of various assessment tools depending upon the level of clinical experience of the nurse practitioner.

Background

Depression is the most frequently diagnosed psychiatric disorder across the lifespan (McCrae & Khan, 2014). It falls under the category of a mood disorder, which can run a chronic, intermittent, or recurrent course (Llewellyn-Jones & Snowden, 2007). According to Marcus, Yasamy, van Ommeren, and Chisolm (2012), "Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration" (p. 6). Estimates published from the World Health Organization have determined that as many as 1 out of 20 people have suffered with some form of depression within the last 12 months (Marcus et al., 2012).

While depression can affect people of all ages, it is extremely detrimental to the elderly residing within nursing homes. Researchers have found that rates of elder depression in nursing homes is significantly greater than that of elders found living within their home residence (Gaboda, Lucas, Siegal, Kalay, & Crystal, 2011). According to Llewellyn-Jones and Snowden (2007), depression has an increased effect upon health status, levels of pain, and the rates of disability of those residing in nursing homes. Many nursing home residents suffer from cognitive impairment, and 10-33% of those individuals have also been identified as being depressed (Gaboda et al., 2007). Those who suffer with dementia typically lose functional ability, and those with a concurrent diagnosis of depression, are admitted to nursing homes with greater frequency than those diagnosed with dementia without depression (Gaboda et al., 2007).

Problem

Depression is not always diagnosed or treated within nursing homes. Research has shown that the rates of diagnosis are quite different among different populations. According to Gaboda et al. (2011), if a resident of a nursing home suffers with dementia, or happens to be African

American or Hispanic, they will be less likely to receive a diagnosis of depression. If a nursing home resident does not receive a diagnosis of depression, they may not receive psychopharmacological treatment, which research has shown may help alleviate the issues associated with depression.

Depression is a unique disorder that manifests itself in many ways. For some, it is quite apparent and easily detectable. For others, only slight subtle cues may give insight into how a person may suffer with depression, such as eating less, showering less often, or avoiding things that at one time were found to be pleasurable. In the nursing home setting, residents may not see their care provider frequently enough for the provider to be able to detect the obscure symptoms related to depression, such as anhedonia, or insomnia. In the study carried out by Iden, Hjørleifsson, and Ruths (2011), physicians noted that they were not the ones diagnosing depression. These physicians did not have enough face time with their patients and had to rely upon the reports of the nursing staff to provide insight into the status of their patients (Iden et al., 2011).

Physicians face multiple challenges in their practice, and one such challenge is that there are not enough available physicians to treat the American population. Crommins (2015) asserts that an impending healthcare crisis may occur as our population grows, and the amount of physician training is not commensurate to the population expansion. According to Crommins (2015), while discussing the impending physician shortage, the “shortfall could hit 90,000 by 2025 if healthcare fails to aggressively embrace and promote the use of non-physician clinicians...” (p. 1). The clinicians that Crommins spoke of are nurse practitioners as well as physician assistants. Nurse practitioners are advanced practice nurses who have received special training and education, to fill specific roles such as primary care, or geriatric care (Bakerjian,

2008). Research has shown that nurse practitioners have proven that they are an integral part of the health care team for those residing within nursing homes.

According to Bakerjian (2008), nurse practitioners are not only qualified to care for the geriatric population found in nursing homes but have been shown to excel as compared to their physician counterparts. In a review of literature, Bakerjian (2008), stated that “NPs were found to provide equivalent or better management of chronic diseases, such as hypertension, diabetes, depression, and congestive heart failure than did physicians” (p. 179). Bakerjian (2008) goes on to state that nurse practitioners, as compared to physicians, were better at improving disease states, while lowering acute care visits. It was also found that nurse practitioners could align their treatment protocols more closely to acceptable medical practices than physicians.

While the research has shown that nurse practitioners are quite effective in the nursing home setting, the perspectives of dealing with mental health issues, specifically the diagnosis and treatment of depression, is unknown. Dealing with residents who have comorbidities, as well as psychological disorders may present with a unique set of challenges. The purpose of this study is to determine how nurse practitioners navigate the intricacies of diagnosing and managing depression within the nursing home setting. Nurse practitioners who are new to the profession or new to the nursing home setting will be able to use the knowledge gained from this study to enhance their treatment modalities for depression and improve the overall psychological care of this population.

Purpose Statement

The purpose of this study is to describe the nurse practitioner's perspectives on recognizing and treating depression within the nursing home setting.

Research Question

How do nurse practitioners assess and treat depression holistically in nursing home residents?

Theoretical Framework

This study has been framed using the theoretical underpinnings of holistic care. According to Erickson (2007), the body, mind, and spirit are inextricably intertwined, and must be viewed as a dynamic entity. Using the holistic care model, residents' illnesses are not viewed as the primary reasons for needing care. People's need for care is based on the needs of their mind as well as the needs of their body. The aim of holism is to help people find meaning in their life experiences, giving them hope, even when disease threatens their physical state.

Holistic nursing theorists have created multiple conceptual frameworks. However, central to all of them, is the combination of science and the art of nursing (Erickson, 2007). Ultimately, what this means for this study is, that it is necessary to uncover how nurse practitioners deal with interconnectedness of the mind, body, and soul. It is essential to determine how a care provider can create a working relationship with their patients, so that they can gain the trust necessary to allow the person to share their human experiences. The relationship allows the caregiver and patient to merge as holistic unit (Erickson, 2007). The insights gained from in-depth interviews will improve clinician's knowledge on the strategies involved to holistically care for patients who are at risk for depression due to old age and multiple co-morbidities.

Literature Review

Literature Search Method

A PubMed database search without time frame parameters was carried out. The subject headings included: advanced practice nurse*, nurse practitioner*, depression, nursing home*. This search yielded 29 results. After the review of the articles, 1 article espoused the benefits that

nurse practitioners bring to the nursing home population, including diagnosing and treating depression. Adjusting the search parameters and using quotation marks around the search terms nurse practitioner, as well as the search terms depression and nursing home, yielded 7 results. A secondary search using quotation marks around the search term advanced practice nurse, as well as using the search terms depression and nursing home yielded 9 results. None of the retrieved articles proved to be relevant to the search query.

A search of the CINAHL database was then carried out, spanning the years of 2000-April 2017. The terms used to search the database included nurse practitioner, advanced practice nurse*, depression, nursing home*. This search yielded 28 results. Additional search terms were added such as diagnosing depression, depression and treatment, psychiatric nurse practitioner, long term care, and psychiatric care. The additional searches either revealed irrelevant material or material that had been already found in the previous searches. Articles that proved to be of use included research that discussed the screening of depression within nursing homes, treatment for depression in the nursing home setting, and staff members identifying newly onset depression within the nursing home setting.

Of the articles that appeared to be relevant, the research articles were reviewed for information regarding depression in nursing homes and its treatment by advanced practice nurses. The main purpose of the literature search was to find information concerning the screening practices of nurse practitioners for depression in nursing home residents, as well as the treatment modalities used to care for this population. The articles used in this literature review contain an assortment of original quantitative research, meta-analysis of completed quantitative research, as well as qualitative research.

Advance Practice Nurses, Depression, and Nursing Home Residents

According to Llewellyn-Jones and Snowdon (2007), depression is not only very common in the nursing home setting; it is often undetected and underdiagnosed. Moreover, “The use of psychotropic and antidepressant medication in nursing homes is often inappropriate or inadequate”, according Llewellyn-Jones and Snowdon (2007, p. 628). Depression in the nursing home setting has been linked to poor physical health, pain, and disability (Llewellyn-Jones & Snowdon, 2007). While the identification and treatment of depression is improving, further research is necessary to determine the efficacy of antidepressant medication treatment among those in nursing homes (Llewellyn-Jones & Snowdon, 2007).

According to Gaboda, Lucas, Siegel, Kalay, and Crystal (2011), antidepressant medications have become staples in the treatment of depression among older adults, and are quite safe. During the years of 1999 and 2007, the rates of diagnosing depression among nursing home residents rose from 33% of all residents to 51%. With the increased identification of depression within the nursing home setting, the rate of use of antidepressants has also increased. According to Gaboda et al. (2011), 82.8% of those diagnosed with depression in their study were prescribed an antidepressant. Advanced Practice Nurses (APNs) as care givers within the nursing home setting have helped contribute to not only the identification of depression, but also the appropriate administration of antidepressants.

Upon admission to a nursing home, The Centers for Medicare and Medicaid mandatorily require the completion of the Minimum Data Set (MDS). The MDS has been used in many studies due to the amount of information that it contains and due to the sheer number of respondents in its database. The MDS, if completed correctly, can help care givers identify depression in nursing home patients. In a study completed by Jones, Marcantonio, and

Rabinowitz (2003), a comparison of verbal reports of depression compared to the MDS, was carried out. What was found is that verbal reports of depression far outweighed what was found in the MDS. This may mean that those who deliver care in the nursing home setting must rely more upon their own assessments, than those found within the patients' chart.

Other researchers have found the importance of patient interviews when it pertains to the identification of depression. In the study carried out by Drageset, Eide, and Ranhoff (2013), face-to-face interviews were used to determine if residents suffered with depression. The researchers compared their results with that of the patient data found within their respective medical charts. The study found that twice as many residents were living with undiagnosed depression as well as anxiety, as compared to their charts. This lends to the fact that APNs must be aware that patients' historical data found in their records can often be incorrect and can also change over time.

Nursing homes are long-term care facilities that house those individuals who are unable to live alone or care for themselves. Most nursing home residents have a plethora of medical issues that necessitate the care of nurses, ancillary nursing staff, physicians, physician assistants, and nurse practitioners. Historically, medical care has been provided to these patients by physicians. With the change in the delivery of modern medicine, physician assistants as well as APNs have joined the ranks to provide nursing home residents medical care. A study carried out by Donald et al. (2013) set out to determine the effectiveness of nurse practitioners in the long term residential setting. According to Donald et al. (2013), "...APNs improve or reduce decline in some health status indicators including depression" (p. 2155). Donald et al. (2013) concluded that while APNs have improved the care of residents of nursing homes, "further exploration is needed to determine the resident satisfaction with care, and quality of life" (p. 2148).

Many factors have been discovered that can cause depression among nursing home residents. In a study carried out by Eisseset al. (2004), “functional impairment, loneliness, higher education levels, a family history of depression, and neuroticism are associated with depressive symptoms” (p. 634). APNs providing medical care can utilize this data to ensure that they are adequately obtaining accurate patient histories, when assessing their patients. Understanding the risk factors for depression can aid the APN to adequately diagnose and treat depression in the nursing home setting.

While APNs have been shown to be effective with their treatment of depression, patients may not initially present with depression. Medical care providers often rely on the report of staff members regarding observed symptoms of depression. In the study carried out by Towsley, Blazej, Neradilek, Snow, and Ersek (2012), residents rated themselves using the Cornell Scale for Depression. Each resident was paired with a nurse who rated the resident as a proxy. The findings showed that the nurses were lacking in depression recognition and needed further education to be able to recognize depression. One reason that staff members may have an issue with identifying depression is due to the lack of listening to their patients.

A qualitative study carried out by Mellor, Davison, McCabe, and George (2008) uncovered that care givers, such as nurses, often cannot identify depression reliably in their elderly patients. It was surmised that care givers may not possess the knowledge regarding depression and its symptomatology. One theme that appeared in the research was regarding the act of listening. Many of the elderly respondents surveyed stated that care givers didn't ask much more than “How are you?” Other comments from the elderly respondents included statements such as:

“I don't like it when they tell me how I feel. Sometimes they get it wrong.”

“Some staff members were very good, but other staff couldn't care less.”

“I doubt it's her job to worry about it (depression) too much. It's the doctor's role. I can talk to the doctor easily” (Mellor et al., 2008, p. 395).

These data demonstrate how imperative it is that APNs must identify depression among the elderly residing in nursing homes. APNs possess the knowledge and training to adequately identify depression as well as treat it.

The literature is abound with discussions on the issues commonly faced by nurse practitioners in the nursing home setting. Nursing home residents are predisposed to higher rates of depression than those living within the community. Depression can make existing ailments worse, and the available screening tools are not always useful. To better serve those within the nursing home setting, it is imperative that residents be properly screened for depression, as well as be well-cared for through holistic treatment if diagnosed. To better prepare nurse practitioners serving this population, this study aims to uncover the perspectives of nurse practitioners working in this setting. By gaining a better understanding of the assessment tools used by nurse practitioners, as well as understanding their personal insights as to how they diagnose and treat depression holistically, future care of this population can be significantly enhanced.

Methods

Design

This study utilized a descriptive, qualitative study design. Nurse practitioners who work in nursing home setting were surveyed on how they assess, diagnose, and treat depression

holistically. Nurse practitioners who specifically work with those residing in the nursing home setting or those who are transitioning to the nursing home setting were interviewed to understand what their specific perspectives are. To ensure content validity, the Doctor of Nursing Practice (DNP) Project Committee members who are doctorally prepared have reviewed and approved the interview questions.

Study Sample and Setting

The study participants are nurse practitioners who work in nursing home, long-term care setting, or along the continuum of care. The nurse practitioners who were interviewed varied in their respective specialties, adding a well-rounded perspective on treating nursing home residents with depression along the continuum of care. A few of the study participants dealt with nursing home patients as they are transitioning into the nursing home. These nurse practitioners managed depression specifically, prior to patient's admission to the nursing home facility. Other study participants were primarily responsible for the overall medical care of patients at the nursing homes including management of depression.

Method Rationale

This study has been carried out using qualitative survey methodology with interviews as the primary method of data collection. According to Clifford (n.d.), from Duke University, "Interviews provide greater detail and depth than the standard survey, allowing insight into how individuals understand and narrate aspects of their lives. Additionally, "Interviews can be tailored to the knowledge and experience of the interviewee" (p.1). Due to purposive sampling, as well as using the snowball technique, nurse practitioners with varying experience have been interviewed. Semi-structured interviews allowed participants to elaborate on their specific

experiences and perspectives. These perspectives have helped to uncover recurring themes, which will ultimately add to the body of nursing knowledge.

Data Collection

The interviews took place in quiet rooms, free of other people and distractions. Due to the use of recording devices, most rooms were free of any ambient noise. The rooms were comfortable in temperature and setting. The primary investigator travelled to each of the participants and met them in their work setting. The interviews varied greatly in length, and level of detail in the responses.

Implementation

The principal investigator has obtained CITI training, pertaining to human subjects, as well as to removing bias, as it relates to the interview process. The primary investigator became familiar with interviewing techniques that helped promote rigor, validity, and consistency. At the beginning of each interview, each interviewed nurse practitioner completed a demographic form. The form asked for age, sex, years of practice as a registered nurse, and years of practice as a nurse practitioner. This has allowed for basic demographic information coding. It has also aided in providing basic statistics such as average years in practice. Each demographic form has been numbered sequentially, and the form number will become the participant identifier. This aided in participant anonymity, and human subject protection. Once the form was completed by the nurse practitioner, they received instructions. The instructions covered how many questions were going to be asked, the existence of prompt questions, the ability to pause the interview, instructions regarding going off record, and the fact that there will be two audio devices recording the interview. When this was explained, the formal interviews began, and both audio recording devices were set to record.

Each interviewee was asked 6 questions. Each question was meant to gain insight into the perspectives, practices, and tool usage of the nurse practitioner. If the nurse practitioner was unable to answer the question, or veered of topic, the follow up prompt question was utilized. The goal of the prompt question was to refocus the question, or to aid the nurse practitioner to understand the question being asked, or to gain greater depth and detail. When an interviewee appeared uncomfortable with a question, question reframing was used to elicit the desired response. Notes were taken to objectively describe any observed body language during the interview process. The final question served as a snowball sampling technique to garner additional participants. Each interview that was recorded and appeared to promote bias, or added extraneous variables, has been discarded, unless otherwise directed by the DNP Project Committee members.

Evaluation

Analysis Plan

During each interview the primary investigator took notes regarding any key pieces of information uncovered. An audit trail has been used, so that if the DNP Project Committee chooses, an independent auditor could come to the same conclusions regarding the obtained data. All interview documentation, as well as notes, has been scanned and saved. The documents have been saved to a secure cloud storage system, as well as be placed on an external drive to add an additional layer of safe storage. The recordings of all the conversations have been transcribed by the primary investigator. The primary investigator, as well as the projects' faculty chair, have assessed the data for constant comparative analysis, and consensus building. Data coding of the interview transcriptions have taken place to facilitate thematic analysis.

Evaluation Measures

Evaluation has consisted of reviewing the findings for perspectives, holistic interactions, and treatments. Assessment of tools used, as well as methods for treatment plans have been analyzed. To accomplish analyzation of the transcriptions, NVivo software has been utilized. This software systematically analyzed the interview transcriptions for phenomena found within the interviews that have formed the basis of the thematic analysis. It has also aided in the coding of the data, as well as provided visual representations of relationships between uncovered themes. Full committee consensus will be sought to determine if thematic saturation has been met.

Outcomes

The goal for analysis was to attempt to find a theme for each interview question. These uncovered themes have formed the basis of the results of this study. Through analyzation of the uncovered themes, a clearer perspective regarding the holistic treatment of nursing home residents has been uncovered. This discovery will aid in the present and future care of those suffering from depression in the nursing home setting. The DNP Project Committee members have been asked to review the uncovered themes, to ensure that the results and conclusions are valid and reliable. Once the committee members have granted approval, the primary investigator will document all findings and results, and compile them into a cohesive research paper.

Interview Schedule

The main instrument that has been used was the six-question survey. The survey questions have been specifically created to be open-ended questions that allowed nurse practitioners to expound on their experiences and perspectives. Each question has been created with follow up prompt questions, to elicit further engagement of the nurse practitioner or to clarify the questions for them. Audio recorded answers provided by the participants have been

transcribed and validated. All validated transcripts were imported to NVivo qualitative software for thematic coding analysis.

Method of Analysis

After each interview was completed, it was transcribed. The qualitative data was searched for coding. According to Polit and Beck (2017), coding is a method to index recurring words. When these recurring words were analyzed, they contributed to thematic analysis. Themes are abstracts that give meaning to specific experiences (Polit & Beck, 2017). Using NVivo software, the coding within the transcripts has been uncovered. Using investigator triangulation, the primary investigator has had one or more members of the DNP Project Committee to aid in all coding and thematic analysis decisions. This has allowed for a convergence of “true” information, by removing any irrelevant or idiosyncratic information (Polit & Beck, 2017). After each interview was transcribed, constant comparative analysis took place to compare all new data with previously collected data. This allowed the primary investigator to understand if the initial uncovered codes and themes are in-line with the newest found data. This helped to determine if the themes were valid and credible, adding to the rigor of this study. The unit of analysis could be one sentence or an entire paragraph depending on the questions asked and follow-up question prompts.

When the primary investigator and the faculty chair reached complete concordance, the findings were presented to the full DNP Project Committee for final approval.

Results

Demographic Data

The study was comprised of a convenience sample of nurse practitioners who practice in the greater Chicago metropolitan area. In total, 15 nurse practitioners who deal with nursing

home residents along their continuum of care were interviewed between September and November of 2017. Many of the nurse practitioners dealt with the nursing home residents directly in the nursing home setting while some of the nurse practitioners dealt with the residents either during hospitalizations or just prior to admission to a nursing home. 13 of the 15 participants identified as female (86.6%) and 2 identified as male (13.3%) (Table 6.). The ages of the participants ranged between 27 and 71, with an average age of 43.73 years old, and a median age of 39 years old, with a range of 44 years (Table 6.). 12 of the 15 nurse practitioners identified as being Caucasian (80%), 2 identified as being African American (13.3%), and 1 nurse practitioner identified as being Asian or Pacific Islander (6.7%) (Table 6.). All 15 nurse practitioners identified as being non-Hispanic (100%) (Table 6.).

The average years of practicing as a registered nurse, a pre-requisite for being a nurse practitioner, for the 15 nurse practitioners is 18.73 years (Table 6.). The average years of practicing as a nurse practitioner are 7.5 years (Table 5.). The average years of practice in the nursing home setting for the 15 nurse practitioners are 3.22 years (Table 4.). Of the 15 nurse practitioners 8 (53.3%) are Family Nurse Practitioners, 4 (26.7%) are Psychiatric Nurse Practitioners, 2 (13.3%) are Geriatric Nurse Practitioners, and 1 (6.7%), is an Adult Nurse Practitioner (Table 3.).

Thematic Analysis

The research study participants varied greatly in their responses when asked what tools they utilize to assess for depression. 7 nurse practitioners noted that they use some form of standardized assessment form or mnemonic. Study participant # 14 stated "I do screening scale with the PHQ-9 and then other than that, I typically just go over any symptoms from the DSM,

evaluate the length of time that they've been experiencing the symptoms and what the change in baseline is, but the main screening tool would be the PHQ-9" (Table 1.). 8 nurse practitioners mention not using a standardized assessment form. These 8 nurse practitioners feel that they are able to use their clinical experience to determine if a resident is suffering from depression. Study participant # 1 stated, "I think I do a really good clinical interview, so that's my primary tool. I rarely use objective measures like the PHQ-9 or the GAD or whatever because I have confidence in my clinical interviewing skills and my ability to make a diagnosis from the history."

Out of all the participants, 10 nurse practitioners mention that monitoring the activities of daily living (ADL'S) were key to not only identifying depression, but also play an important role in monitoring the treatment of depression (Table 1.). These activities are key indicators of not only being able to care for self, but an assessment of the desire to do so. Depressed individuals often isolate, withdraw from peers, stop caring about hygiene, suffer from anhedonia, and experience appetite.

Study participant # 1 stated "I think my own treatment is quite holistic in the sense that I really attend to the psychosocial. To some extent I attend to the spiritual, and then also the biological part, such as things like activity, nutrition, okay." Many nurse practitioners explained how they used the reports of staff members to determine if residents were sleeping, isolating, eating, joining in daily resident activity groups etc. They used this data as either baseline data as a gauge current status, or as a functional gauge which could measure ongoing treatment improvement or deterioration. Study participant # 1 speaking about ADL's stated, "I would want to see that they're eating, sleeping a reasonable amount at night, if they are supposed to be independent and they're grooming, that they're able to do that. Those would be the three reasons that I would ... The three, I guess, focus areas, as part of my treatment."

The central theme to nurse practitioner's practice in regards to treating depression is the use of collaboration. 14 nurse practitioners all mentioned that they do collaborate with psychiatrists, psychologists, and social workers (Table 1.). Many participants discussed how collaboration guided their treatment plans. Some of the study participants either deferred all treatment for depression to the psychiatrists or would refer patients to them that may have been too complex for them to care for. Some of the participants discussed initiating treatment for depression, but then referring care to the psychiatrist. These consults served to help provide the nurse practitioner with either additional help, insight into the specific mental health issue, or as a consult asking the psychiatric provider to assume control of the treatment of the patient's depression. Study participant # 11 stated, "Luckily in the nursing homes where I currently work at, we have a psychiatrist that comes weekly, so that really helps me managing these patients, and managing their symptoms, and diagnosis. I personally am a newer NP, and I don't have a psych background, so that help is really ... Really helps me."

4 of the participants felt that they were not able to deliver holistic care. The recurring theme from these respondents was that the nursing home was not the optimal location to treat depression. Factors such as residents being ill, having food that is not of high quality, or poor staffing levels, were noted as contributors to the resident's depression. Study participant # 4 stated, "From all aspects no because I feel like unfortunately because they're in a nursing home it's automatically like, again, not trying to down the psychiatrist that's here, but everybody's majorly depressed, that's the diagnosis across the board that I've seen so far. I feel like nothing else is incorporated, the families aren't necessarily always called, and trying to find out like oh what are their favorite activities, what else do they like to do, let's get them out of the room and unfortunately I think the burden that the nurses have to deal with is that they are the ratios so

they don't really know these patients or if they do know them they don't have the time to really just go in and talk with the patient, get them out to activities, make sure they're involved in the activities, and then make sure not everyone is stapled with the label of dementia. "Holistically do I feel like I treat these people that route and do I feel comfortable with it? No, to answer your question", one participant says.

Discussion

This research study highlights the modalities used and experiences of nurse practitioners who work with nursing home residents along their continuum of care. Their insights and perspectives on treating nursing home residents were widely varied; however, they held many similarities. The majority of the nurse practitioners were ultimately striving to provide the nursing home resident with the best holistic care that they could provide. To deliver holistic care, the nurse practitioners first had to accomplish three specific tasks. These tasks relate to holism because each task is intertwined with caring for the mind, body, and soul. The assessment of depression relates directly to caring for mind. The monitoring of ADL's is a superb way of measuring functioning of the body. Lastly, the use of collaboration with multiple specialties provides a team approach to provide for caring for the soul.

To begin to deliver holistic care, nurse practitioners had to first assess their patients for depression. Many patients come to the nursing home with an existing diagnosis of depression. For those that did not have a pre-existing diagnosis, nurse practitioners used two specific methods to identify depression. The nurse practitioners who on average had less than three years of experience reported using standardized assessment forms. These forms have been thoroughly researched and have been found to be effective at diagnosing depression. The nurse practitioners who had more experience frequently relied upon their own clinical judgement to detect

depression in nursing home residents. This clinical judgement has its basis in the many experiences encountered by the highly experienced nurse practitioner. Regardless of chosen method of diagnostic assessment, assessing a patient for depression is imperative if there is suspicion that a resident may be suffering from depression.

The second task that is necessary to deliver holistic care is the monitoring of Activities of Daily Living (ADL). By monitoring these activities, the nurse practitioners are able to better understand how the residents are reacting to their environment, if medication adjustments may be necessary, or if alternate treatment modalities are warranted. Also, many of the participants noted that they cannot accomplish the task of monitoring ADL's without the assistance of the nursing and ancillary staff members. These staff members become the eyes and ears of the nurse practitioners and are often the ones who are noticing the subtle changes in behavior that cause the nurse practitioner to assess for depression.

The third task that is necessary for nurse practitioners to accomplish while delivering holistic care is use of collaboration. The referring of patients to the psychiatrist is completely in line with the mandate of nurse practitioners, which is to understand their scope of practice as well as their limitations. While it is well within the scope of a nurse practitioner who deals primarily in a specialty like a family nurse practitioner to prescribe an antidepressant, many realize that if initial treatment modalities fail, they need to seek out the expertise of psychiatry. The ability to recognize one's own limitation lends to treating patients holistically because these nurse practitioners understand that their patients have a need that they are unable to fulfill.

A few nurse practitioners were satisfied with their ability to treat patients holistically. Holism or holistic treatment carries different definitions depending on the nurse practitioner. Many nurse practitioners felt that their ability to treat holistically needed improvement. For a few

nurse practitioners, holistic treatment meant looking at the entire patient and all their activities. For others, treating a patient with talk therapy and pharmacotherapy was sufficient when discussing their opinion on delivering holistic care. However, not all participants were pleased with their ability to deliver holistic care.

Rates of identifying cases of depression in the nursing home setting has been steadily on the rise. Studies have shown that those who are admitted to the nursing home are already suffering from depression at higher rates than those who do not need to be admitted to a nursing home. Within the nursing home setting, disease and pain are commonplace and major contributors to depression. When discussing a population that may be at risk for depression, there are few groups at greater risk than nursing home residents. Therefore, it is imperative that these patients not only be identified early but be constantly managed throughout their residency at the nursing home by nurse practitioners.

To accomplish the early identification and the management of depression, nurse practitioners must continue to use their assessment skills to manage the course of the depression. By measuring ADL's, by way of staff reporting, improvements or setbacks can be closely monitored and dealt with if necessary. Collaboration with psychiatrists or other psychiatric specialists continues to be the mainstay of treatment for those who need psychiatric care. Using a team approach is beneficial to not only the resident but for the nurse practitioners giving care to these patients. This collaboration gives the nurse practitioner the experience necessary to be able to judiciously use their clinical judgement on present and future cases. Ultimately, using all these tools in conjunction with each other leads to being able to treat patients holistically. While the definition of holism may mean different things to different nurse practitioners, ultimately,

carrying out the three tasks necessary to deliver holistic care leads to being able to better treat the nursing home residents mind, body, and spirit.

Limitations

The primary investigator explained to several participants what the definition of holism was. By doing so, bias was introduced. Any responses to the question regarding holistic treatment after an explanation was given, was not used in the study results. The small sample size also limits the generalizability of results to the overall population of nurse practitioners who diagnose and treat depression in nursing homes.

Implications

What this research uncovered is that newer nurse practitioners rely heavily upon standardized tests such as the PHQ-9, however, it was also uncovered that those with several years of experience no longer rely upon the forms to make their assessment. Further research may need to be carried out regarding the repeated use of the PHQ-9. Many providers screen for depression with the PHQ-9 prior to the initiation of pharmacotherapy. Then after the patient has been on a medication for a while, a provider may choose to re-screen the patient for depression. While the PHQ-9 is certainly considered the gold standard of the assessment of depression, frequent or repeated use by the same patient may introduce bias into their responses.

Conclusion

The holistic treatment of depression in nursing home residents involves nurse practitioner's collaboration with psychiatrists, monitoring of patient's ADL, and the use of various assessment tools depending upon the level of clinical experience of the nurse practitioner. More systematic studies are needed to determine the best holistic approach to depression among nursing home residents.

Acknowledgements

The primary researcher would like to acknowledge the work completed by the co-investigator, Rosalinda Mullaney. The primary researcher would also like to acknowledge the DNP PROJECT committee chairperson for this research study, Dr. Shannon Simonovich PhD, who has been the primary source of information, direction, encouragement, and guidance throughout the study. The primary researcher would like to thank Dr. Joseph Tariman PhD, for his assistance with the selection of the theoretical framework, assistance with the IRB process, and for his ability to answer any question related to nursing research. The primary investigator would also like to thank Robbie Lasica MSN, for being a role model, a mentor, and a fierce advocate of those who deal with mental health issues. The primary researcher would also like to thank his spouse, Caryn Janush-Mullaney BA, for her countless hours of encouragement, support, and all of her assistance with proofreading.

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Table 1. Major Themes on Holistic Care of Depression Among Nursing Residents

Theme	Explanation	Exemplar Quotes	Frequency
Collaborating with psychiatry	Nurse practitioners refer to professionals in the field of psychiatry to not only collaborate on treatment plans and goals, but to also gain direction and insight into a patient's mental health disorders.	"Luckily in the nursing homes where I currently work at, we have a psychiatrist that comes weekly, so that really helps me managing these patients, and managing their symptoms, and diagnosis. I personally am a newer NP, and I don't have a psych background, so that help is really ... Really helps me."	14
Monitoring activities of daily living	Activities of daily living are activities carried out by people who are daily tasks necessary to care for oneself and are used as an indicator of independence (e.g. bathing, eating, using the restroom).	"I think my own treatment is quite holistic in the sense that I really attend to the psychosocial. To some extent I attend to the spiritual, and then also the biological part, such as things like activity, nutrition, okay."	10
Clinical judgment	The ability to use past experiences to make an accurate clinical assessment without the use of standardized assessment forms (e.g. PHQ-9, GAD-7).	"I think I do a really good clinical interview, so that's my primary tool. I rarely use objective measures like the PHQ-9 or the GAD or whatever because I have confidence in my clinical interviewing skills and my ability to make a diagnosis from the history."	8
Assessment tools	Standardized assessment forms that contain questions that can be scored to help aid in the diagnosis of mental health disorders.	"I do screening scale with the PHQ-9 and then other than that, I typically just go over any symptoms from the DSM, evaluate the length of time that they've been experiencing the symptoms and what the change in baseline is, but the main screening tool would be the PHQ-9."	7

Table 2. Years of Experience as Nurse Practitioners in Nursing Home

Years NP in NH					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.25	1	6.7	6.7	6.7
	.42	1	6.7	6.7	13.3
	.50	1	6.7	6.7	20.0
	.66	1	6.7	6.7	26.7
	1.00	4	26.7	26.7	53.3
	2.00	2	13.3	13.3	66.7
	2.50	1	6.7	6.7	73.3
	3.00	1	6.7	6.7	80.0
	4.00	2	13.3	13.3	93.3
	25.00	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

Table 3. Nurse Practitioner Specialties

		What kind of NP			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Adult Nurse Practitioner	1	6.7	6.7	6.7
	Geriatric Nurse Practitioner	2	13.3	13.3	20.0
	Psychiatric Nurse Practitioner	4	26.7	26.7	46.7
	Family Nurse Practitioner	8	53.3	53.3	100.0
	Total	15	100.0	100.0	

Table 4. Years Spent as NP in Current Practice Setting

		Years in current setting			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.17	1	6.7	6.7	6.7
	.25	1	6.7	6.7	13.3
	.50	1	6.7	6.7	20.0
	1.00	4	26.7	26.7	46.7
	2.00	3	20.0	20.0	66.7
	2.50	1	6.7	6.7	73.3
	3.00	2	13.3	13.3	86.7
	4.00	2	13.3	13.3	100.0
	Total	15	100.0	100.0	

Table 5. Years of Practice as a Nurse Practitioner

		Years NP			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.5	1	6.7	6.7	6.7
	1.0	2	13.3	13.3	20.0
	1.5	1	6.7	6.7	26.7
	2.0	3	20.0	20.0	46.7
	2.5	1	6.7	6.7	53.3
	3.0	1	6.7	6.7	60.0
	4.0	2	13.3	13.3	73.3
	8.0	1	6.7	6.7	80.0
	15.0	1	6.7	6.7	86.7
	31.0	1	6.7	6.7	93.3
	35.0	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

Table 6. Sociodemographic data

		Ethnicity			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Asian or Pacific Islander	1	6.7	6.7	6.7
	Black or African American	2	13.3	13.3	20.0
	White	12	80.0	80.0	100.0
	Total	15	100.0	100.0	

Years RN

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3	1	6.7	6.7	6.7
	6	1	6.7	6.7	13.3
	7	1	6.7	6.7	20.0
	8	3	20.0	20.0	40.0
	9	1	6.7	6.7	46.7
	10	1	6.7	6.7	53.3
	16	1	6.7	6.7	60.0
	25	1	6.7	6.7	66.7
	30	1	6.7	6.7	73.3
	36	2	13.3	13.3	86.7
	37	1	6.7	6.7	93.3
	42	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	2	13.3	13.3	13.3
	Female	13	86.7	86.7	100.0
	Total	15	100.0	100.0	

Frequency Table

		Age			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	27	1	6.7	6.7	6.7
	28	1	6.7	6.7	13.3
	30	1	6.7	6.7	20.0
	31	1	6.7	6.7	26.7
	32	1	6.7	6.7	33.3
	36	1	6.7	6.7	40.0
	37	1	6.7	6.7	46.7
	39	2	13.3	13.3	60.0
	48	1	6.7	6.7	66.7
	54	1	6.7	6.7	73.3
	58	1	6.7	6.7	80.0
	60	1	6.7	6.7	86.7
	66	1	6.7	6.7	93.3
	71	1	6.7	6.7	100.0
	Total		15	100.0	100.0



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Appendix A

Participant ID # _____

ADULT CONSENT TO PARTICIPATE IN RESEARCH

Nurse Practitioner's Perspectives on Treating Depression in the Nursing Home Setting

Principal Investigator: Bryan Mullaney RN, BSN, Graduate Student
Institution: DePaul University, Chicago, Illinois, USA

Department (School, College): College of Health and Science

Faculty Advisor: Dr. Shannon Simonovich RN PhD, Committee Chair, College of Health and Science

What is the purpose of this research?

We are asking you to be in a research study because we are trying to learn more about the perspectives of nurse practitioners working with depressed patients in the nursing home setting. This study is being conducted by Bryan Mullaney RN, BSN at DePaul University, a graduate student at DePaul University as a requirement to obtain his Doctoral degree. This research is being supervised by his faculty advisor, Dr. Shannon Simonovich.

We hope to include a total of 15 nurse practitioners as participants in this research study.

Why are you being asked to be in the research?

You are invited to participate in this study because you are a nurse practitioner who works in the nursing home setting treating depressed patients. You must be age 18 or older to be in this study. This study is not approved for the enrollment of people under the age of 18.

What is involved in being in the research study?

If you agree to be in this research study, it involves being interviewed by the primary investigator. The interview will take 30 minutes, and will consist of 6 questions. The questions will assess what tools and methods you use to assess, diagnose, and treat depression among nursing home residents. You will be asked to fill out a survey form to gather basic data including your age, sex, race, and characteristics related to your practice as a nurse practitioner such as years in practice, years as a nurse, years as a nurse practitioner, years in your current role, and which type of nurse practitioner you are. All study data will be kept confidential. You will be assigned a participant number. Your responses to the interview questions will be linked to your participant ID number. The interview will be audio recorded. After the audio recordings have

been transcribed and the transcriptions have been verified for accuracy, the audio recordings will be destroyed.

How much time will this take?

This study will take 30 minutes.

Are there any risks involved in participating in this study?

Being in this involves minimal risk, similar to the risk you would encounter in your daily work. You may feel uncomfortable or embarrassed about answering certain questions. You do not have to answer any question you do not want to. There is the possibility that others may find out what you have said, but we have put protections in place to prevent this from happening. We will assign you an ID number to use instead of your name on documents related to your interview. We ask that you do not provide any personal or sensitive information about your individual patients during the interview to protect their privacy.

Are there any benefits to participating in this study?

You will not personally benefit from being in this study.

We hope that what we learn will help novice nurse practitioners as well as those new to the nursing home setting to provide better care to patients with depression. Your answers will offer insight into your perspectives on treating nursing home residents with depression.

Can you decide not to participate?

Your participation is voluntary, which means you can choose not to participate. There will be no negative consequences, penalties, or loss of benefits if you decide not to participate or change your mind later and withdraw from the research after you begin participating.

Who will see my study information and how will the confidentiality of the information collected for the research be protected?

All research records will be kept for 3 years after the closure of the study with the IRB. Research records include all consent documents, documents approved by the IRB, all communication with the IRB, and all study data. After the mandatory 3-year period of saving all research records, the research study transcripts will be scanned and kept stored indefinitely in a locked cabinet at the office of Dr. Shannon Simonovich, this research study's faculty advisor. This will be done to defend the research study's findings if any future requests are made to do so. Your information will be combined with information from other nurse practitioners taking part in the study. When we write about the study or publish a paper to share the research with other researchers, we will write about the combined information we have gathered. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is.

The audio recordings will be transcribed and will be stored in a password protected cloud storage account, they will also be stored on a password protected external drive, and they will be physically stored in a locked cabinet at the office of Dr. Shannon Simonovich, this research study's faculty advisor. Once the recordings have been transcribed and reviewed for accuracy,

the audio recordings will be destroyed. The research findings will be documented and presented as a final project to complete the Doctor of Nursing program at DePaul University

Who should be contacted for more information about the research?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study or you want to get additional information or provide input about this research, you can contact the researcher, Bryan Mullaney RN, BSN at (847) 840-4210 brymullaney@gmail.com or the faculty advisor for this study, Dr. Shannon Simonovich at s.d.simonovich@depaul.edu. (313) 212-4234

This research has been reviewed and approved by the DePaul Institutional Review Board (IRB). If you have questions about your rights as a research subject you may contact Susan Loess-Perez, DePaul University's Director of Research Compliance, in the Office of Research Services at 312-362-7593 or by email at sloesspe@depaul.edu.

You may also contact DePaul's Office of Research Services if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.

You will be given a copy of this information to keep for your records.

Statement of Consent from the Subject:

I have read the above information. I have had all my questions and concerns answered. By signing below, I indicate my consent to be in the research.

Signature: _____

Printed name: _____

Date: _____

Dear _____,

Thank you for your interest in participating in the research study entitled "Perspectives on Treating Depression in the Nursing Home setting. At this time, the data collection portion of this research study has concluded.

Sincerely,

Bryan Mullaney RN, BSN

DePaul IRB Approved
Protocol #BM071017NUR
August 16, 2017 Through August 15,
2018

Dear (Insert name),

I would like to thank you once again for participating in the research study that I am carrying out. I would greatly appreciate it if you could distribute the attached flyer to any of your colleagues that may be interested in being a part of this research study. I greatly appreciate your assistance with this matter.

Sincerely,

Bryan Mullaney RN, BSN

<p>DePaul IRB Approved Protocol #BM071017NUR August 16, 2017 Through August 15, 2018</p>
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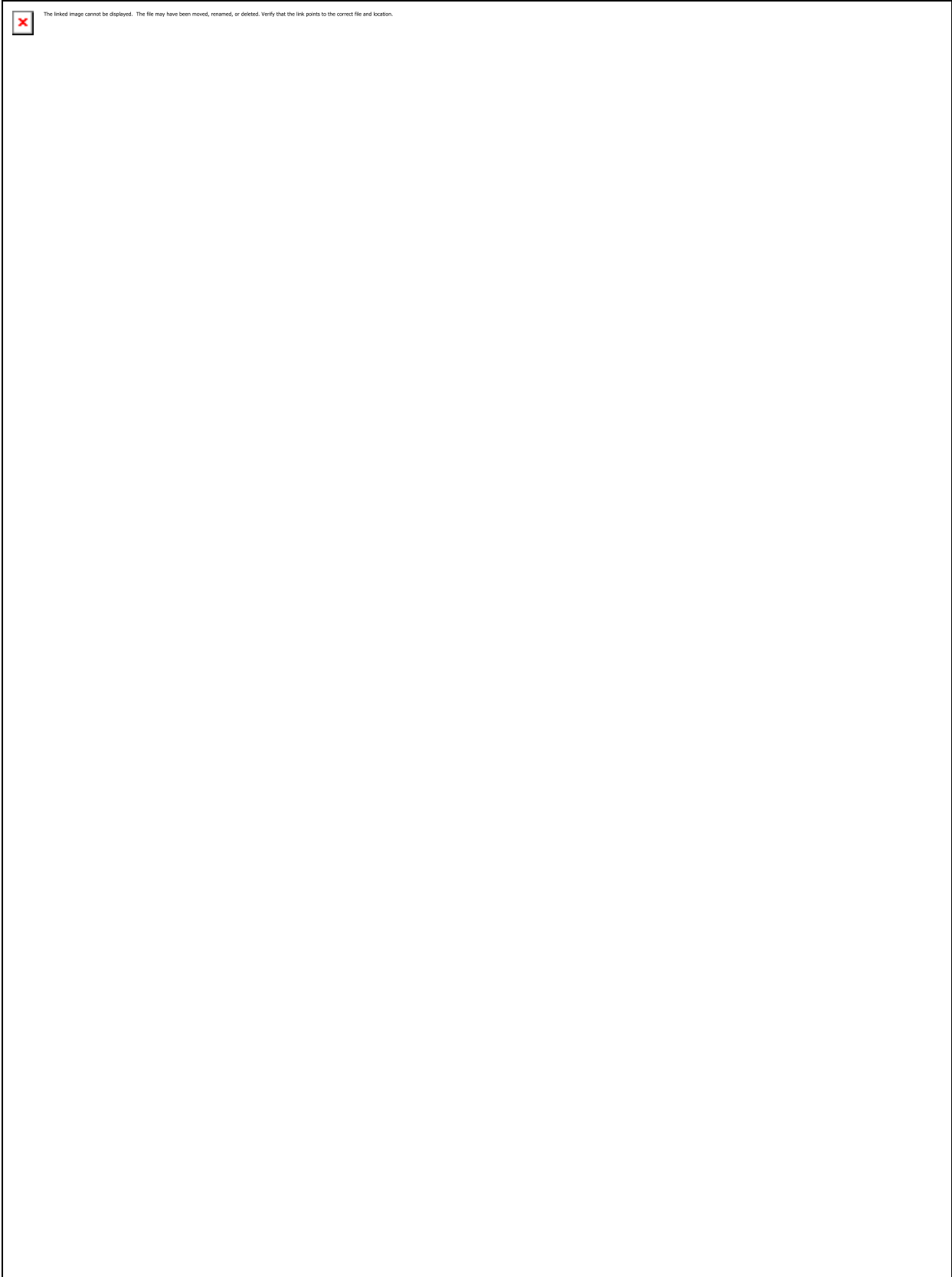
Dear _____,

Thank you for your interest in participating in the research study entitled "Perspectives on Treating Depression in the Nursing Home setting. At this time the data collection portion of this research study has concluded.

Sincerely,

Bryan Mullaney RN, BSN

DePaul IRB Approved Protocol #BM071017NUR August 16, 2017 Through August 15, 2018



Dear _____,

Appendix B

I would like to thank you for your interest in participating in the research study, Perspectives on Treating Depression in the Nursing Home Setting. The interview process will take 30 minutes, and it will need to take place in a quiet comfortable room, that is private and available for use. If you would like to move forward, I would like to schedule a time that is convenient for you either at your office, a private DePaul Library Study room, or at the office of Dr. Shannon Simonovich, my DePaul University faculty advisor. Once you have decided on which location you would prefer, I will contact the location to secure a private room. What day, location, and time work best for you?

Sincerely,

Bryan Mullaney RN, BSN

<p>DePaul IRB Approved Protocol #BM071017NUR August 16, 2017 Through August 15, 2018</p>
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Dear _____,

I would like to thank you for your interest in participating in the research study, Perspectives on Treating Depression in the Nursing Home Setting. The interview process will take 30 minutes, and it will need to take place in a quiet comfortable room, that is private and available for use. If you would like to move forward, I would like to schedule a time that is convenient for you either at your office, a private DePaul Library Study room, or at the office of Dr. Shannon Simonovich, my DePaul University faculty advisor. Once you have decided on which location you would prefer, I will contact the location to secure a private room. What day, location, and time work best for you?

Sincerely,

Bryan Mullaney RN, BSN

DePaul IRB Approved Protocol #BM071017NUR August 16, 2017 Through August 15, 2018
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Dear _____,

Thank you for your interest in participating in the research study entitled "Perspectives on Treating Depression in the Nursing Home setting. At this time, the data collection portion of this research study has concluded.

Sincerely,

Bryan Mullaney RN, BSN

DePaul IRB Approved
Protocol #BM071017NUR
August 16, 2017 Through August 15,
2018

VERBAL SCRIPT – DIRECT APPROACH

A STUDY ON THE PERSPECTIVES OF NURSE PRACTITIONERS TREATING DEPRESSION IN THE NURSING

HOME SETTING

Principal Investigator: Bryan Mullaney RN, BSN

Faculty Sponsor: Dr. Shannon Simonovich

Institution: DePaul University, USA

My name is Bryan Mullaney and I am a doctoral student at DePaul University School of Nursing. I am conducting a research study on the perspectives of nurse practitioners who work in the nursing home setting and treat depression. I am asking you to be in this research study because you are a nurse practitioner who works in this setting, treating this specific population.

If you agree to be in this study, you will be asked to complete a 30-minute research interview. The research interview will include questions about your perspectives on treating depression in the nursing home setting. I will also ask you to complete a short demographic characteristics survey assessing personal information such as age, gender, race and ethnicity, educational level, and number of years of practice experience. If there is a question you do not want to answer, you may skip it. The research study interview will be recorded.

Research data collected from you will be kept confidential. Once the interview is completed, there will be no personal identifier that will be attached to the electronic file to keep it confidential.

Your participation is voluntary, which means you can choose not to participate. There will be no negative consequences if you decide not to participate or change your mind later after you begin the study. Your decision whether to participate or not will have no effect on your job

employment. The information gathered from this interview will allow those new to the profession, or new to the nursing home setting, to gain insights into the treatment modalities that are currently in use, as well as shed light on the perspectives of those using these specific modalities.

Inclusion criteria for this study: You are a nurse practitioner directly providing care to patients with depression in the nursing home setting.

If you have questions, concerns, or complaints about this study or you want to get additional information, please contact me at (847) 840-4210 or email at brymullaney@gmail.com. Or you may contact Dr. Shannon Simonovich at s.d.simonovich@depaul.edu or (313) 212-4234

If you have questions about your rights as a research subject you may contact Susan Loess-Perez, DePaul University's Director of Research Compliance, in the Office of Research Services at 312-362-7593 or by email at sloesspe@depaul.edu. You may also contact DePaul's Office of Research Services if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.

Participant ID # _____

Perspectives on Treating Depression Within the Nursing Home Setting Demographic

Characteristics Form

What is your age? _____

What is your gender? (circle one) Male Female Non-Binary Prefer not to say

What is your ethnicity? _____

1. American Indian or Alaskan Native
2. Asian or Pacific Islander
3. Black or African American
4. White

Are you of Hispanic or Latino of Spanish origin? _____

1. Yes
2. No

How many years have you been in practice as a nurse (years since graduation)?

How many years have you been in practice as a nurse practitioner?

How many years have you been in practice as a nurse practitioner in the nursing home setting?

How many years have you worked in your current setting?

What kind of nurse practitioner are you?

- | | |
|-----------------------------------|----------------------------------|
| 1. Adult nurse practitioner | 2. Geriatric nurse practitioner |
| 3. Psychiatric nurse practitioner | 4. Family nurse practitioner |
| 5. Clinical specialist | 6. Acute care nurse practitioner |
| 7. Other nurse practitioner | |

Interview Guide

1. What is your experience with treating depression in the nursing home?

Follow up: What do you do to make sure the status of your ill and depressed patients does not deteriorate?

2. What are the tools that you use to assess your patients specifically for depression?

Follow up: (Geriatric Depression Scale, PHQ-9)

3. What does your follow up consist of?

Follow up: Do you seek out staff opinion regarding patient status post treatment implementation? Do you return for a follow up at a specific time?

4. Are you satisfied with your ability to recognize and treat depression holistically?

Follow up: Do you use strategies to improve health status, as well as depression. Simultaneously? (e.g. Encouragement to interact in group activities, medication compliance)

5. Do you often seek out consultations from those working in psychiatry?

Follow up: Do you have a resource to suggest medications or mental health promotion strategies?

6. Do you have a colleague that may be willing to answer these questions?

Appendix C
Supplemental Files

Interview 1

Interviewer: All right, this is interview participant number one. Question number one. What is your experience with treating depression in the nursing home?

Participant #1: Okay, so I have not actually functioned as an APN in the nursing home setting, but I encounter quite a few patients, especially on consult, where they need psychiatric assessment before they return to the nursing home, sometimes as part of their treatment while they're here. The return to the nursing home is if they have a psych diagnosis, the nurse SNF won't take them unless there's a psych consult.

Often that doesn't really require any treatment, per se, but we also have patients who come from nursing homes who maybe are depressed or do have a psychosis or do have a behavioral or mood disturbance related to their dementia. That would be, I think, my main exposure. On inpatient psych, we do less often, but we do have patients who come from nursing homes. You're referring to gero patients, right, or ICF patients?

Interviewer: Anyone.

Participant #1: Occasionally we do get patients who are in SNFs and come in because of a worsening mood problem. Then we also get patients who are in ICFs who maybe aren't elderly, but they have a severe mental illness that requires them to be at that level of care. I think that's it.

Interviewer: What are the tools that you use to assess your patients specifically for depression?

Participant #1: I think I do a really good clinical interview, so that's my primary tool. I rarely use objective measures like the PHQ-9 or the GAD or whatever, because I have confidence in my clinical interviewing skills and my ability to make a diagnosis from the history.

Interviewer: What does your follow-up consist of? Meaning once you make your decision, how do you follow up?

Participant #1: With consults, I, when needed, return and evaluate them on a day-to-day basis, or every other day and do medication management. Sometimes it's also an assessment of suicide risk or aggression risk that's required before they can be discharged. On the inpatient side, it's the same thing. Med management, assessment of symptoms, and making a decision about suitability for discharged, usually based on suicide risk or aggression risk, and with older adults also often, or nursing home patients, on ability to self-care.

I would want to see that they're eating, sleeping a reasonable amount at night, if they are supposed to be independent and they're grooming, that they're able to do that. Those would be the three reasons that I would ... The three, I guess, focus areas, as part of my treatment.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant #1: No. First of all, I don't think I know enough about complementary and alternative medicine options. I'm not as knowledgeable as I should be about herbal supplements. I don't think I'm able to get enough information about

vitamin levels in especially older folks who maybe don't eat as well or their absorption's not as good, and that might be because I don't think those labs are readily available.

I'm not even ... Honestly, I don't know much about the research about the use of that, but I'm suspicious that vitamin levels are important to these patients' condition. Let's see. Can you ask me the question again?

Interviewer: I'm sorry. Yeah, are you satisfied with your ability to recognize and treat depression holistically?

Participant #1: Okay, so I'm focusing on the "holistically" part.

Interviewer: Meaning all around, like would you encourage staff to do anything in particular for your nursing home patient? Would you encourage particular activities once they've been sent to...

Participant #1: Yeah, okay. One, I think, obstacle to that is ... I pay attention to sleep hygiene. I think hospital care and sleep hygiene are almost antithetical to one another. It's almost impossible for patients to have a regular sleep schedule, to be able to be active enough and out of the bed enough ... Once again, I'm thinking of the consults ... Enough during the day to have enough stimulation so that they can sleep at night.

Here on the unit, with folks like that, patients are exposed to fluorescent light up until time to go to bed, and I don't think that provides a natural process for getting tired and being able to sleep. I experience pressure from nursing staff to give sleeping meds when I might prefer not to, so sometimes that's a struggle.

I think my own treatment is quite holistic in the sense that I really attend to the psychosocial. To some extent I attend to the spiritual, and then also the biological part, such as things like activity, nutrition, okay.

Interviewer: Question number five. Do you often seek out consultations from those working in psychiatry, for example, psychiatrist, psychologist?

Participant #1: Yes, I use psychologists. Certainly not as often as ... It's rather infrequent. I use psychologists to clarify diagnosis. It's especially helpful if we're documenting dementia and decision-making capacity. I use my collaborating psychiatrist for consultations when I am maybe stuck or not sure what options I might be overlooking or if I'm not getting a good outcome from the interventions I've tried. I do also informally use other APNs, but also psychiatrists when I need somebody to bounce ideas off of or to provide some input. I think that's about it.

Interviewer: Great. Last question. Do you have a colleague that might be willing to answer these questions?

Participant #1: Yes, I do.

Interviewer: Excellent. Thank you very much.

Interview 2

Interviewer: All right. This is participant number two, and we are starting with question number one. What is your experience with treating depression in the nursing home?

Participant # 2: First I identify the symptoms. A lot of times, the nursing home nurses know the patient the best. So, if they point out that the patient's depressed or I can get that in an evaluation, then I usually will do a PHQ-9 if they're able to do it. And is that good for you then? Okay.

Interviewer: Number two, what are the tools that you use to assess your patients, specifically for depression?

Participant # 2: Well, sleep, appetite ... I ask the patient if they feel depressed, their mood, their affect, the people surrounding them, what ... you know, maybe the family, the nurse, peers maybe if they allow me to talk to them ... and like I said, I've used the PHQ-9 scale.

Interviewer: What does your follow up consist of?

Participant # 2: Well, do you want to know what I start with or you're ... you didn't ask-

Interviewer: Anything you ... so the ... So, you've identified depression.

Participant # 2: Mm-hmm (affirmative).

Interviewer: You've decided a course of treatment.

Participant # 2: Mm-hmm (affirmative).

Interviewer: What do you do to follow up? What is your plan? Do you follow up in a month? Two weeks? A day?

Participant # 2: Oh. Oh. Well it depends on the medication. For an SSRI it's gonna be at least two weeks. And then ... you know, two weeks to a month. But since I worked for MPEC I was stationed at a nursing home. So, I didn't have to wait a month. So, it'd be two weeks and the psychiatrist there had a similar pattern of two weeks. And I did collaborate with them as well. And so, two weeks post follow up and then check how the patients doing, possible medication increase. Then check 'em again in two weeks. I usually start out with an SSRI. For me, I like the newer generation SSRI's. Although public eight doesn't always like that so sometimes they dictate

what I can order. And then, I would go to the SSRI, SNRI, or even type ... a Wellbutrin type of medication, which is in its own class, but it is a stimulant ... so if they're sleeping a lot. But usually the SSRI and then the ... SSRI/SNRI medications like Effexor and Cymbalta. And then Wellbutrin. And sometimes, you know, after a while a combo, like an antidepressant and a stimulant. It depends.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant # 2: Yes. I ... in a nursing home, patients gotta get out of their room. You encourage them to go to activities. The nursing home I was in was a behavioral health nursing home, so attending groups, encouraged family visits, interaction with other ... but they, you know, they have activities that go on and the patients can ... they get points for going and then they have a store they can go to. But, you know, when they're depressed they might not feel like going. So, encouraging them to get out of the room and that even some light exercise ... 'cause they have a rehab gym there, and also like a morning stretching class for people that are into this fit ... for them to go to win Bingo, and arts and crafts, and other things that they can go to.

Interviewer: Do you often seek out consultation from those working in Psychiatry, meaning psychiatrists, psychologists, or even therapists?

Participant # 2: Yes. If I've had a treating physician I may, if it's working, I just follow their treatment plan. If it's not working, I ... like some psychiatrists follow their own patients. So, I would suggest certain medication for people that are still having anxiety or ... you know, we're not sure it's related to depression, or something else. So, just kind of conferring with the psychiatrist about what they think. I give my opinion. And then we come to a solution together.

Interviewer: Perfect. Very last question is do you have any colleagues that you might be willing ... that might be willing to answer these same questions?

Participant # 2: Nurse practitioners?

Interviewer: Yes.

Participant # 2:I've got to think about that and get back to you.

Interviewer: Sounds great.

Participant # 2:Yeah.

Interviewer: Perfect. That ends my questions. Thank you for your time.

Interview 3

Interviewer: This is interview with participant #3. What is your experience with treating depression in the nursing home setting?

Participant # 3:Consistently see depressed individuals when I do coverage at a nursing home.

Interviewer: Excellent. What are the tools that you use to assess your patients specifically for depression?

Participant # 3:I don't use a specific tool. I use the Daniel Carlat mnemonic system for my assessments.

Interviewer: Excellent. What does your follow up consist of? Meaning if you find depression in a patient and you treated them originally, what do you do next?

Participant # 3:I would follow up on the same things I assessed. Specifically, the things that I hoped to treat symptom wise from the patient. For instance, if they had fatigue and that was the main symptom we were going to treat with like an NDRI, Wellbutrin, I would follow up on the key thing we were looking to treat like that fatigue. So, follow up on the symptoms we were targeting with the medication.

Interviewer: Great. Are you satisfied with your ability to recognize and treat depression holistically?

Participant # 3:I feel like-

Interviewer: Is there anything you want to improve on?

Participant # 3:Yeah. I feel like you know my DNP program was highly psychopharmacology based and I know the basics of some CBT and motivational interviewing, but there are some other things where they don't necessarily get great therapy resources at a nursing home. So being able to spend a little more time in that and be more efficient and effective in my therapy would be an improvement for me.

Interviewer: That's great. Do you often seek out consultations from those working in psychiatry?

Participant # 3:No.

Interviewer: No. A follow up question if possible. Meaning, neuropsych testing?

Participant # 3:Often would not be the right term. Do I? Yes, but not-

Interviewer: Not frequently?

Participant # 3: Yeah.

Interviewer: Understood. Then last but not least, do you have a colleague that might be willing to answer these questions?

Participant # 3: No.

Interviewer: Okay thank you very much. This has concluded the interview, thank you.

- Interviewer: This is Participant #4, we're going to start with question number one. What is your experience with treating depression in the nursing home?
- Participant #4: In the nursing home setting I've only been working as a nurse practitioner in the nursing home setting for four to five months. Prior to that I did internal medicine so I was very used to working with patients in treating depression and I had a lot of older and geriatric patients so some of the experiences carried over into the nursing home setting. Most of the time what I would do is I'll start off with at least getting a psych evaluation.
- Interviewer: Are you doing number one?
- Participant #4: Oh sorry, no I was answering number one.
- Interviewer: Oh okay, okay.
- Participant #4: What is my experience, so my experience ... I'm sorry, I get off track.
- Interviewer: No problem.
- Participant #4: ... Is that I will say I'm novice with treating patients in the nursing home setting with depression.
- Interviewer: That's good, a great answer. So number two, what are the tools that you use to assess your patient's specifically for depression?
- Participant #4: I'm used to the PHQ-9, so I'll mentally go through those questions as I'm asking the patient to assess if they're truly depressed. Unfortunately with this patient population you do want to rule out infectious cause first, so I'll do, or an organic cause, so I'll do a thyroid panel just to make sure it's not hypothyroidism. Then I'll also do a UA way just to make sure it's not a UTI. If they have any behavioral disturbances I might do a chest x-ray if they have any symptoms going that route or if they're on two feedings or something like that. But then the tools I use, like I said, is the PHQ-9, then I'll consult psych, I'll do some baseline labs, CBC, CMP, and then I'll do depending on the patient I might do some ... You don't ask about labs?
- Interviewer: No, no I'm just asking.
- Participant #4: Oh sorry.
- Interviewer: I was just looking. No, no, we're doing fine.
- Participant #4: Then I may do, like I said, TSH, I may to an HIV or an RPR to make sure they don't have syphilis or neural syphilis. But tools-wise, sticking to the question, PHQ-9.

Interviewer: The next question is, and I'm going to clarify it a little bit, what does your follow-up consist of? You find depression by some mechanism, what do you do then?

Participant #4: Typically if they're diagnosed as depressed by the psych doctor, the follow-up I'll do is I'll read the psychiatrist and go with their recommendation. So I'll follow up with the patient and if they start them on an SSRI which I know is typically first line then I'll make sure that that's the right dose, make sure it doesn't interact with any other medications, then make sure any recommended labs are needed or necessary for that medication then I'll make sure the orders are put in. Unfortunately here at Fairmont the psychiatrist doesn't always see the patients in a timely fashion or if he does see them everybody's majorly depressed and so then I'll defer to the primary physician and I'll actually say, "Hey, maybe for this patient if they have a poor appetite," I'll be like, "Hey can start them on Remeron instead?" My follow-up may be making sure you get out to activities every day, make sure the nurse gets them up, those kind of things because I don't want to always just to pharmacol therapeutics so then I'll be trying to do what other nursing intervention we could do.

Interviewer: Out of all the people I've interviewed that was the answer I was hoping to get and that was the first time I got it, so thank you very much. Some people get a little confused by this question, are you satisfied with your ability to recognize and treat depression holistically?

Participant #4: From all aspects no because I feel like unfortunately because they're in a nursing home it's automatically like, again, not trying to down the psychiatrist that's here, but everybody's majorly depressed, that's the diagnosis across the board that I've seen so far. I feel like nothing else is incorporated, the families aren't necessarily always called, and trying to find out like oh what are their favorite activities, what else do they like to do, let's get them out of the room and unfortunately I think the burden that the nurses have to deal with is that they are the ratios so they don't really know these patients or if they do know them they don't have the time to really just go in and talk with the patient, get them out to activities, make sure they're involved in the activities, then make sure not everyone is stapled with the label of dementia. Holistically do I feel like I treat these people that route and do I feel comfortable with it? No, to answer your question.

Interviewer: Okay...

Participant #4: I just went in this whole circle.

Interviewer: I like that answer though because I feel that your previous answer said you touched on medications, you touched on dealing with lab works, avoiding the common pitfall such as dementia, and then you went a little bit into the psychosocial of getting other people involved to promote activity. So from an outsider's perspective I believe that you do treat holistically. But to each his own.

Number five, do you often seek out consultations from those working in psychiatry?

Participant #4: So I've learned, again, I'm new here at Fairmont so we do have a psychologist, Doctor Brennan, that rounds on the patients, and I'm not sure what his caseload is but I have had quite a few cases that I'm like, "Hey, could you just go and talk to this patient, and just do some talk therapy?" So I always consult the psych first to make sure that I'm not doing anything that's unsafe and to make sure that they're clinically actually diagnosed by a specialty. Then if I can't get that psychiatrist, unfortunately not a lot of these patients leave the facility so then we have to wait. There's a chaplain that rounds so I'll see if the chaplain can get involved, I'll see if restorative nursing can come and see these patients more often and do other activities with them. Outside of who's working the site, yeah so then it's psych and then Doctor Brennan is a psychologist.

Interviewer: You're the first person who mentioned pastoral care as someone else working outside of psychiatry so thank you for that. Last question, and you can answer it with a yes or a no, do you have any colleagues that might be willing to answer these questions?

Participant #4: Well you've already reached out to all the Paragon NP's, right? So my sister but she works in a walk-in so probably not. But do I have any other friends?

Interviewer: Thank you so much for your time.

Participant #4: No problem.

Interviewer: You've answered all my questions.

Participant #4: Sorry that I...

Interviewer: Have a great day.

Participant #4: That I totally went off

- Interviewer: And, this is interview participant number five. I'm going to go ahead and start with question number one. What is your experience with treating depression in the nursing home?
- Participant #5: It's been tricky. I tend to treat depression pretty aggressively in the nursing home, given the population and the high risk for depression in this setting. I do find it difficult, as far as starting new medications, with the elderly population, with all the side effects that go along with it. It's also difficult because, of the facilities that I've been in, there are psychiatrists in the building, and depending on the involvement of the psychiatrist in the building, is how hands on or hands off I am with the patient and their direct psych care. Those are the biggest barriers, I would say.
- Interviewer: Sure, could you just expand on that about the elderly and your choice of medications. Have you found that there's a medication that there's an issue with?
- Participant #5: Yeah, I mean, the biggest one that I could see is with Benzodiazepines. Seems to be pretty common that I'll have elderly patients on the long acting benzo's and I generally try to stray away from any of them.
- Interviewer: Everybody's making that move, it seems.
- Participant #5: Mm-hmm (affirmative)
- Interviewer: Number two; what are the tools that you use to assess your patients specifically for depression?
- Participant #5: I exclusively PHQ-9.
- Interviewer: Do you use a specific scoring model? Like at a certain number, do you treat? The finding's like a 20, 30, the scoring model?
- Participant #5: Yeah. I'd have to look at the-
- Interviewer: Okay. I understand. You answered it, it's perfect. Let's say your PHQ-9 determines that the patient has depression. Question number three; what does your follow up consist of?
- Participant #5: I'm typically coming weekly, so my follow up would be in one week intervals.
- Interviewer: Okay. Meaning, do you check up with nursing staff?
- Participant #5: Yep.

- Interviewer: Do you check up with therapists? What are you looking for when you consult with nursing staff or therapy or aides?
- Participant #5: In the beginning of the treatment, obviously they're not going to have any full effect for several weeks, but I would be looking for the medication side effects. I would look at their appetite, their sleep habits, their activity level, different pain components, any other new issues that arise, in those first couple of weeks where I would be able to tell if they're having any direct side effects from the medications or the treatments. Then, at that one month mark, is probably when I would repeat a PHQ-9.
- Interviewer: Great answer. Are you satisfied with your ability to recognize and treat depression holistically?
- Participant #5: Yes.
- Interviewer: Can you give me an example of how you feel you treat it holistically?
- Participant #5: For all my patients, in addition to any medications, I also do direct counseling. I'm lucky enough that every facility I go to has, what's the word I'm looking for, like a clinical person that's able to provide counseling-
- Interviewer: therapy?
- Participant #5: Exactly, for patients, I add that, as well as providing my own emotional support.
- Interviewer: Great answer. Okay. We're almost done. Do you often seek out consultation from those working in psychiatry, so before you answer, I'll say you kind of already said the therapist, so that's one. Is there anybody else? Do you ever get neurological testing, or psych testing done?
- Participant #5: Yes. Depending on how clear-cut I am with the diagnosis, I always, if I'm suspecting depression, will consult psychiatry in addition. But, then if the patient has more neuro-cognitive issues, where it might be more difficult to tease out, I will sometimes consult neuro-psych as well.
- Interviewer: That is a wonderful answer. Let me just ask, do you ever try to get staff involved, saying, "Make sure this person goes to group activities. Make sure this person gets out of their room." Or, do you also, I see you shaking your head yes, correct?
- Participant #5: Yes.

Interviewer: Do you do anything else? Is there anything, do your nurses or your techs monitor your sleep patterns for you?

Participant #5: They do-

Interviewer: Like are they recorded?

Participant #5: I don't know that it's recorded. I usually just talk to the nurse or the aide that's on for that day. That one's a little bit more difficult to assess. They are able to tell me usually, if the patient has sleep issues, if they're not sleeping, if they sleep all day, how much their napping throughout the day.

Interviewer: All right. I just have one final question for you. Do you have any colleagues that you think might be willing to answer these same questions?

Participant #5: Yes.

Interviewer: Thank you so much. We are concluded with the interview.

Interviewer: This is the beginning of interview number six. What is your experience with treating depression in the nursing home?

Participant #6: Most of my nursing home patients are, usually it's just med management for people who have already initiated antidepressants.

Interviewer: In your experience doing that, have you ever found someone who maybe wasn't initiated where you thought that you might want to move forward with initiating?

Participant #6: Yeah.

Interviewer: Excellent. The next question leads right into that. What are the tools that you use to assess your patients specifically for depression?

Participant #6: I informally use the PHQ-9 as a background guideline, but basically just relying on the patient's report of symptoms and how much it's affecting their functioning and how the patient feels about their symptoms.

Interviewer: Okay. That leads directly into three. What does your follow up consist of? Let me just ad lib a little bit. Your patient tells you they have symptoms. You begin to treat, then what?

Participant #6: We have to monitor pretty frequently especially in older people. You're going to follow up with them at least within a week and reassess. Assess side effects. In a short term setting, you're not really going to see much of a difference in depression, but mostly in that initial phase you are just watching for side effects.

Interviewer: Start low and go slow.

Participant #6: Mm-hmm (affirmative)

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant #6: As a provider, yes. In the nursing home, no. Although you do in the nursing home usually depending on the facility, we usually have pretty quick access to talk therapists so that's sometimes a nice bonus.

Interviewer: Let me give you examples of other responses. Sometimes people would say that they are treating holistically by monitoring food intake, activity participation, family interaction. Do you ever find yourself encouraging those activities or monitoring those activities?

Participant #6: Well, yeah. Although I think that most of the time, people in nursing homes are sort of out of their normal life, and so that's a real limiting factor. You're not going to be able to go walk your dog every night or see your kids every day or whatever.

Interviewer: Yes. Now that you ... Question number five is you've found this person with depression, do you find yourself often seeking consultations from those working in psychiatry?

Participant #6: In the nursing home, yes. Most of my experience has been in primary care so, no, but in the nursing home, yes, because there's usually underlying dementia or cerebral vascular disease or ... It's almost always multi-layered.

Interviewer: And for that, do you consult neuropsych?

Participant #6: Neuropsych. Yeah.

Interviewer: Last question. Might you know anybody that might be willing to answer these questions? You can answer with a yes or a no.

Participant #6: Not really. I'm kind of on my own.

Interviewer: Okay.

Interviewer: And this I participant number seven. What is your experience with treating depression in the nursing home?

Participant 7: In the nursing home setting ...

Interviewer: Long term, rehab

Participant 7: Especially in L-tech it is pretty frequent. So, we do have a lot of experience treating it here. We see it a lot in the long term setting especially after life changing things such as CVAs and ...

Interviewer: Do you diagnose it frequently in your experience? Or is it usually there in prior existing?

Participant 7: I think a good mix of both.

Interviewer: Excellent.

Participant 7: I definitely diagnose my fair share of depression here and treated it as well.

Interviewer: Number two, what are tools you use to assess your patients specifically for depression?

Participant 7: Honestly, I don't have any specific tools here, just is basically review systems that I use. Asking about depression, asking about mood anxiety.

Interviewer: Excellent.

Participant 7: Things like that. Yeah.

Interviewer: Let's say you're using your review of systems, you diagnosed depression. Do you decide to move forward with some form of treatment. What do your follow-up consist of?

Participant 7: Once ... We have a very good psychiatrist here, so once somebody does exhibit depressive symptoms, we usually do a psych consult. Honestly, kind of hand off to them at that point. I would do follow up to see if their symptoms are improving. If their mood is changing, getting for the better.

Interviewer: What about your follow-up on medications?

Participant 7: A lot of those are handled by the psychiatrist here.

Interviewer: Okay.

Participant 7: Okay. Now, I'll follow-up. I will see how they're feeling and then I'll touch base with psych to see if they want to trade any of the medications.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant 7: You know holistic treatment of depression at an L-tech and snf setting is kind of challenged. A lot of the holistic and I guess non-pharmaceutical ways to treat depression. Eating right, dieting, exercise. A lot of patients here, you're limited. You'll have a menu and this what you're gonna get.

Interviewer: But do you follow-up with your staff members saying, hey, did they eat today? Did they eat yesterday? What about their sleep habits? Do you..

Participant 7: I follow-up with both staff and patients. Most of the time the patients can tell me if they're sleeping okay or if there's some sort of insomnia. Additionally, I often ask what the patient appetite is.

Interviewer: I see.

Participant 7: Then what percentage of the tray they're finishing.

Interviewer: You kind of already answered number five a little bit. But it says, do you often seek out consultations from those working in psychiatry?

Participant 7: Almost always.

Interviewer: Do you frequently find yourself ordering uh neuropsych testing or just psych testing? Do you find once you ask psychiatry, they come and they take care of that.

Participant 7: It's kinda ... I've ordered it a few times here, not too often, a lot of times with social work already on the case, they'll come to me and say, hey, can we get a neuropsych consult? This is what we have going on.

Interviewer: But you're responsible for ordering it?

Participant 7: Yeah.

Interviewer: Great so then you give your input as a provider as to how you should move forward?

Participant 7: Yes.

Interviewer: Then just the last question, you can answer with a simple yes or no. Do you ... Might you know someone who might be willing to answer these questions?

Participant 7: Yes.

Interviewer: Thank you.

Interviewer: And this is Participant #8. I'd like to start by asking you, #1, what is your experience with treating depression in the nursing home?

Participant # 8: Well, in the setting that I'm in right now, it's pretty minimal. Previous to that, I worked at the VA, Heinz VA, for 12 years. It was pretty extensive. I worked on a weekly basis with one of the psychiatrists in treating depression. She would visit our unit every Friday, and we rounded together. However, I am of, maybe old-school, of the opinion of really deferring to the experts for treatment of depression, especially in older people and in the nursing home. Initiating drugs, not terribly commonplace for me. I really prefer deferring to the experts.

Interviewer: Excellent. What are the tools that you use to assess your patients, specifically for depression? So, let's say the experts haven't come in yet. You're the first-line person.

Participant # 8: Generally, it's the geriatric depression scale, and just the information that's gathered throughout, through the history when a patient is first admitted. Often, signs and symptoms such as poor appetite, difficulty or inability to sleep, agitation, irritability, restlessness, some personality issues that family may describe as different or changed. I would say those kinds of things.

Interviewer: Excellent. Good answers. So you've used your geriatric depression scale. Here's question three. What does your follow-up consist of?

Participant # 8: Hm, I'm a little confused on that question, Bryan.

Interviewer: I should have clarified.

Participant # 8: It's okay.

Interviewer: You've used your geriatric depression scale, and it has shown you conclusively, or maybe through your clinical scales that you've seen depression in that patient. You've diagnosed them.

Participant # 8: Okay, got you. Okay, so what would I do next?

Interviewer: What do you do next when you move forward?

Participant # 8: Okay, I understand. Well, I really prefer to first talk, if the patient is cognitively intact, I would talk with them about the fact that I think they may benefit from counseling or talking with a therapist, a psychologist, and/or a psychiatrist, geriatric. I really prefer a geriatric psychiatrist, by the way. I'm really convinced that we need to have someone with that subspecialty, and/or family members, because I think that ... I have a lady right now, for example. I'm going off on a tangent.

Interviewer: Go ahead, please.

Participant # 8: Who's 97 years old. I would say she's depressed. But she just didn't think she would live this long. She is at that point in her life where, "Enough already." I would not refer her to a psychiatrist. I totally understand what she's experiencing just in terms of the aging process, and I'd hate ... She's mentally, cognitively intact, she's got a bit of a hearing deficit, and I would hate for her to be possibly given medications that might have untoward effects, so I wouldn't even refer her. But I would, in conjunction with talking with a patient and/or family members, if they felt it might be beneficial that we then consult the psychologist and/or geriatric psychiatrist, if that's indicated.

I have had some really good luck with the psychology, with doing counseling and meeting with them on regular patients on a regular basis, and just providing support of counseling. I found that extremely beneficial.

Interviewer: Awesome. Excellent. #4, are you satisfied with your ability to recognize and treat depression holistically?

Participant # 8: I think I am. I personally suffer from depression, and most of my family members have problems with depression. I feel that I definitely am someone who is very sensitive to the signs and symptoms, and especially the signs and symptoms of older persons. With the losses that they experience, are very commonplace, and really set the stage for most people as they age to experience some type of depression. I feel that it's not something that you necessarily always have as we age, but it's something that, when you look at all the losses that people go through, the chronic illnesses they experience, et cetera, the meds that they're on, they do have, certainly, a high risk for being depressed. I just went off on a tangent again. I do feel I'm satisfied though with my ability.

Interviewer: Can you give me an example of how you treat depression holistically?

Participant # 8: Mm-hmm (affirmative). Holistically? Certainly. I would want to have various team members be involved with treating depression, be it recreation therapy, as I mentioned before, a psychologist. If a psychiatrist is indicated, and that basically is, in my opinion, only when medications might be considered. I feel like the psychology is more the counseling. And if even psychology felt that maybe psychiatry needs to get involved. I don't see psychiatry's role, at least for geriatrics in my experience, for the counseling portion of it. I would like to see a social worker, psychiatric social worker involved if that's something that would be indicated as well. Therapies in terms of keeping patients, getting patients optimized in terms of any types of deficits they have with physical problems, or occupational issues for occupational therapy, those kinds of things. I'm not sure if that's what you meant?

Interviewer: No, that's perfect. So, you've kind of answered this, but if you could just summarize. #5, do you often seek out consultations from those working in psychiatry?

Participant # 8: Yes, when it's indicated. One of the things we have here, at least in the Lexington facilities that basically I've been going to, is there's a psychologist as well as a psychiatrist. They often work together. Some of them are actually partnered. But I generally will go with a psychologist first, and then see based on their thorough assessment, then see if they feel that psychiatry would be indicated. I'm also very pro-neuropsychiatry, by the way, in terms of I feel there's a specific role for neuropsychiatry for the older person that does a much more thorough assessment for the older patient. If someone has a neuropsych background that would be the person I'd like to go to for working in geriatrics.

Interviewer: I completely agree with that. And this last question you can answer with a yes or a no. Do you have a colleague that may be willing to answer these questions?

Participant # 8: Oh, absolutely. As I mentioned, Bryan, I would be more than happy to try to help you recruit some nurse practitioners.

Interviewer: And I appreciate that greatly. And this concludes interview #8.

Participant # 8: I enjoyed that!

- Interviewer: This is participant number nine. Question number one. What is your experience with treating depression in the nursing home?
- Participant #9: I just review the patient's history, how their physical exam goes, if they've been feeling any symptoms of depression or isolation. If they do then we just refer to psych, here.
- Interviewer: Just because of the way you answered it, let me ask you this. Do most of your patient's self-report, or do you find yourself diagnosing more than a self-reporting patient? Depression specifically.
- Participant #9: I think overall I find myself diagnosing it.
- Interviewer: Excellent. Number two. What are the tools that you use to assess your patients, specifically for depression?
- Participant #9: Evidence based tools you wanted?
- Interviewer: Sure.
- Participant #9: I don't have any.
- Interviewer: I'll give you an example of what some people have been saying. My clinical experience, PHQ-9 nine, Geriatric Depression Scale. If you don't use any of those tools, it sounds like you do more of a review of systems. Would you say that yourself?
- Participant #9: Yes. Review of systems.
- Interviewer: Anything else?
- Participant #9: No. And then, our social workers, they would do the evidence based scales.
- Interviewer: Understood. That's great that your social workers do that. So, you and your team have diagnosed depression. Number three, what does your follow-up consist of?
- Participant #9: If they consent to letting one of our psychiatrists see them, then we follow-up on what their recommendations were. And if they're willing to go along with his treatment recommendations.
- Interviewer: Do you always do a consult for psych once you've diagnosed depression, or do you ever manage it yourself?
- Participant #9: No, in here, within this setting, it's always under the psych.

- Interviewer: Excellent. But at least you diagnose it. That's great. Are you satisfied with your ability to recognize and treat depression holistically?
- Participant #9: I can always get room for improvement. Recognizing it, I'm satisfied with it. Treating it, no, because I always refer out and ask other people, and have the psychiatrists recommend.
- Interviewer: Let me ask you a follow-up question. So the psychiatrist makes a recommendation, do you order the medication? Or does the psychiatrist?
- Participant #9: Usually it's the psychiatrist.
- Interviewer: Do you ever change the dosages once they've initiated treatment?
- Participant #9: I would, but I wouldn't change it until they'd been on it for a few weeks.
- Interviewer: Okay. So you would change?
- Participant #9: Yeah.
- Interviewer: If there was a clinical based evidence reason why.
- Participant #9: Right.
- Interviewer: Right, okay. And last but not least. You already kind of answered it, but do you often seek out consultations from those working in psychiatry?
- Participant #9: Yes.
- Interviewer: Okay. Besides a psychiatrist or a therapist, is there anyone else you've ever asked to consult on your case?
- Participant #9: There have been a few residents here that would need a neuropsych.
- Interviewer: Excellent. And do you find neuropsych testing to be efficient?
- Participant #9: Yes.
- Interviewer: Conclusive? Great.
- Participant #9: Very thorough.
- Interviewer: Very thorough. Great. And then the last but not least, and you can answer it with a yes or a no. Do you maybe have a colleague that might be willing to answer these questions?

Participant #9: Yes.

Interviewer: Thank you. This concludes this interview.

Interviewer: This is interview number 10. We'll be starting with question number one. What is your experience with treating depression in the nursing home?

Participant #10: Well, anyone who is on any kind of anti-anxiety, antipsychotic, any medicine for depression or anxiety, they are being seen usually by the ... I refer to them to the psychiatrist here and the psychologist.

Interviewer: Okay. Maybe number two will answer this a little better. What are the tools that you use to assess your patients specifically for depression? You have a patient that you're treating some way along their line of treatment. How do you know someone's depressed before you send them to psychiatry?

Participant #10: Because I work for Elmhurst Hospital actually and so when the assessment comes over from the psychiatrist at Elmhurst Hospital, I read through that first and see what that person recommends. It could be like newly diagnosed. Then I would talk to the patient about how well they know what the medicine is, side effects of the medicine, kind of review that with them, and then ask them if they would like to see a psychologist, psychiatrist here with their diagnosis of whatever they have been diagnosed with.

Interviewer: In your experience, you don't do as much of the diagnosing.

Participant #10: We don't do any of the diagnosing. Usually people are already diagnosed prior to coming here.

Interviewer: Okay. So-

Participant #10: I mean, I would say 100% of our patients that I-

Interviewer: From Elmhurst, got it.

Participant #10: ... From Elmhurst that I see. Yeah, we don't put them on ... I take that back. Remeron is a medicine we use a lot for patients, but it's more to help with like appetite and things like that. But it also helps with their depression, and their failure to thrive, and things like that too.

Interviewer: Okay, so here's the question. I'm going to ask it, but then I'm going to modify it for you, to get your experience. What does your follow-up consist of? It sounds as if they come with a diagnosis, you go to psych for their treatment plan, but that it's most probably you giving the hands-on care. How do you follow up with that Remeron, or those kinds of meds, once the diagnosis has been made? Do you increase dosages? Do you decrease dosages? Do you change timing of dosages?

Participant #10: I might change timing of dosages, if it affects their sleep or something. But I wouldn't change their medicine dose typically. Now, Xanax or Ativan, things like that, I change that all the time. Like, I might prescribe those with

people who are like anxiety, you know, people who are have a hard time being here. That is a psych area that I wouldn't need a psychiatrist to do that. We do that, and then I evaluate them the next day.

Interviewer: Great, so that's my question there then. Using, let's say a benzo, what does your follow-up consist of when you're ordering a psychotrope?

Participant #10: I see them the next day, how they reacted to it. Did it sedate them? Did it help them? Does the dose need to be increased? Does the does need to be decreased? Do they need something else?

Interviewer: Excellent. That's a great answer. Number four, are you satisfied with your ability to recognize and treat depression holistically?

Participant #10: Okay, I don't really know what that means, but holistically meaning like ...

Interviewer: I'll give you an example.

Participant #10: Like, say I don't notice their...

Interviewer: Some people might use their PHQ-9 to diagnose depression. If it's less say basic standard depression, most people start with an SSRI. To treat holistically, one might be checking on are they sleeping, are they eating, are they being encouraged by stuff to get up and to do their ADLs? What do you-

Participant #10: Yes, so I those things. Any time I see any new patient, for sure, if they have a diagnosis or not a diagnosis of depression, or I think they're depressed or anxious or whatever the case may be, to always assess that. Like, how is their appetite? Are they sleeping? Is this a new diagnose?

Cancer, cancer's my specialty. I've been a nurse practitioner in cancer for over 30 years. Depression was a huge thing, which was induced by the situation. A lot of times they might have been depressed even before their diagnosis of cancer, but with the situation of newly diagnosed, especially a bad prognosis, and it happens very quickly for people, then everybody wants to jump on the bandwagon, they need to see a psychiatrist and they need to be on antidepressants, and things like that.

But I usually make sure, you know, is the patient sleeping? Are they eating? If they don't have any of these, are they not wanting to get out of bed? Do they want to sit in the dark all day? Those kind of things. That would tell me, oh yeah, they would really benefit from antidepressant or even anti-anxiety medicine, or were benefiting from seeing a psychologist or a psychiatrist. But if it's no, no, no to all those things, you know, they're not sitting in the dark, they're not withdrawing from their family members, they're still active as they usually, their sleep hasn't been changed, they're eating okay, but might be decreased because of their cancer

diagnosis, because of the stomach cancer or colon cancer, their side effects of treatment, not necessarily their depression.

Interviewer: Your perspective is invaluable because I wasn't looking specifically into that-

Participant #10: Oh.

Interviewer: No, no, that population of cancer, but one has to understand that that has got to be a very large percentage of your cases that you see in the nursing homes.

Participant #10: They're like a fourth of our population. Also with hearts, I don't know if you know the studies with patients that have open heart surgery, but with men they suffer depression more frequently than women do, with having open heart surgery.

Interviewer: Beta-blocker blues.

Participant #10: Right, that too. But it's specifically with open heart surgery, with men. That's something that you might want to look into too, because the other thing is our patients too, we have a contract with Elmhurst, and the cardiac surgeon actually sends his patients here, and they're going to start like a cardiac ward here.

Interviewer: That's great. Something I could look into, might be able to add some more oomph to my paper.

Participant #10: Right, right. Look into open heart surgery with men especially. Women too. And then with the oncology population, they're like a fourth of our population here. Even though they might be young, they might be elderly, it just depends. There are people that have never been diagnosed with anything, and they're 80 years old. Suddenly they get diagnosed with like cancer, or even heart disease, and need open heart surgery, or need chemotherapy, and they can't handle it, so they do go into like a funk of depression. But is it true depression, or is it depression from the situational, from their diagnosis, that they can get over? Because they don't have any other symptoms of depression. They just feel depressed or sad, but they don't sit in the dark. They don't stop eating. They don't stop socializing. All those things that I like, psych and depression-

Interviewer: No, that's why I picked this setting, because people who get admitted to these facilities are already either at higher rates of depression than the general public, the comorbidity of depression and illness makes their morbidity, mortality rates greatly increase. I wanted to see how we can use this information to help this population better. Hopefully we can get some solid answers, and I think you've given me a lot to look at.

You've kind of answered this in your answers, but I want to ask this question. Do you often seek out consultations from those working in psychiatry?

Participant #10: Oh, absolutely. All our new patients, when we first see them, sure. We definitely ask questions about, "Have you lost weight? How's your appetite? How is sleeping?" All those things that would be a trigger for if they're depressed, or, "Is this a new diagnosis for you? How have you handled stress in the past? Have you been on any medicines in the past for depression, for anxiety, things like that?"

Then we reconcile their meds, look through their meds, and we find that they are on antipsychotic, or they're on sleeping med, or they've been on pain meds for chronic pain. You know, things like that. Or people that have been on like a slew of medicines, are on every psych med, every sleeping med, every pain med that's out there. You know that they have some sort of baseline psych disorder. We have a lot of hoarders in this place as well, and they have major psych issues as well, right, because they're hoarders. You know that that stems from somewhere. We have those people too.

Interviewer: Who do you seek out consultations for, for those people?

Participant #10: A psychologist and psychiatrist. He comes weekly. We actually found a new person, and we had a nurse practitioner who was a PhD nurse practitioner in psych, but she wasn't very beneficial to us because she didn't come very often. She maybe came once a month, once every six weeks. That didn't help us because patients are here now and they're not here for that long, or for sub-acute rehab, and so we really need somebody weekly, especially if they were diagnosed recently in the hospital, or they had a long-standing history of psych problems or anxiety.

Now we have a guy who comes. He's a gerontology psychiatrist, and he comes once a week. We've had him all summer, and it's been wonderful, because he sees every single patient on the list once a week. With a psychologist.

Interviewer: Can I ask, do you ever order neuropsych testing?

Participant #10: Absolutely. A lot.

Interviewer: Can you tell me why?

Participant #10: Patients who have problems with memory, or they haven't really necessarily been diagnosed with dementia, or they live alone, and they're not safe to live at home alone. Frequent readmission to the hospital because of memory, or left their stove on, they didn't know they did, but family says they're all okay. "My mom's 80 years old, she's always been fine." Or even a 70-year-old. We've had a 50-year-old who was diagnosed with early dementia. I mean, for reasons of starting the car, and then leaving the car on and walking out of the car, doing things that are ... Or driving into a pond, or, you know, people do things that aren't their norm, but the family's kind of in denial.

For those people that, we order neuropsych all the time, to make sure that they can go home safe, that their decisional making, so the neuropsych exams are done. That's why the nurse practitioner PhD nurse was not good for our area, because we need to know the answer like today. With neuropsych testing, we need a note in the chart that day or the next day. The notes we didn't see, the note's in the chart for like six weeks. Well, that didn't help us to tell us if the patient's safe to go home or not alone.

If they do have dementia, and it gives us proof to give to the family that, "Hey, neuropsych saw this patient. They're recommending this, these things." Then the family's like, "Oh," because it's from a doctor, from a PhD. They acknowledge it, and they're okay with it. But they-

Interviewer: In my experience, a lot of my families that have patients that undergo neuropsych testing, they want that testing done to validate their findings of that.

Participant #10: Some do, some don't. We have a lady right now who we're recommending neuropsych because she was diagnosed with dementia, but the family said she does not have dementia. He wants to start her on Aricept, but the family said, "No, I don't want her on that medicine." Because she doesn't have dementia. But she keeps falling, and she lives alone at home, and so they're going to put her in assisted living, which is a good choice for this lady, it's perfectly fine, but her dementia is only going to get worse. It's actually

Interviewer: Yeah, without the Aricept, too, it might go a little quicker.

Participant #10: Right, right.

Interviewer: I just have one last final question.

Participant #10: Yeah? Did I help you at all?

Interviewer: Yes, you did. No, you did. Perfect answers. You said so many things that other people said, so when I have professionals that are all saying the same thing, that is exactly what I am looking for, so that I can take that to the new generation of nurse practitioners and say, "This is what the pros do. This is what their experience is. Please do what they do." Obviously there's new evidence that comes out all the time. You clearly follow that, but there's a lot of things we do that will never be studied that make sense to do.

The last question. You can answer yes or no. Do you have somebody that you might be able to refer to me to answer these questions?

Participant #10: I do.

Interviewer: Awesome. I'm going to turn this recorder off. Thank you for your participation.

Interviewer: What is your experience with treating depression in the nursing home?

Participant #11: We encounter patients that have depression a lot in the nursing home, among the elderly population. If I were to estimate what percentage of my population have current or a history of depression, probably would say like 90%. I encounter it a lot. Luckily in the nursing homes where I currently work at, we have a psychiatrist that comes weekly, so that really helps me managing these patients, and managing their symptoms, and diagnosis. I personally am a newer NP, and I don't have a psych background, so that help is really ... Really helps me.

Interviewer: Question number two. What are the tools that you use to assess your patients, specifically for depression?

Participant #11: So I we, I typically consult a psychiatrist or psychologist in the setting, or we can use like scales-

Interviewer: What kind of scales?

Participant #11: To evaluate. Like Mini-Mental, there's multiple scales out there.

Interviewer: Anyone you find particularly useful?

Participant #11: Mini-Mental is fine, but there's-

Interviewer: You never use the PHQ9, geriatric depression scale?

Participant #11: Yes, but typically our psychiatrist will use them, or psychologist, or our social worker on admission to the facility. We, as nurse practitioners, don't usually use them ourselves. Typically they're already done and we have the results available.

Interviewer: Ok, let's say you do diagnose depression, let's say it snuck through the cracks. Once you diagnose that, and you decide to move forward with treatment, what does your follow up consist of?

Participant #11: Follow up of depression?

Interviewer: Or just the treatment process?

Participant #11: Typically I like to evaluate how long the patient has had depression. Is it based on a situation, or is this something that's kind of embedded within them and is not based on a situation, on a bad situation that might've happened to the patient? I like to try non-pharmacological treatment initially versus giving these patients medications. Especially the elderly patients, because the medications used for depression have a lot of side effects and interactions. Not all, but for the most part they do.

Interviewer: Could you give me an example of the side effects that you're weary of?

Participant #11: Like Serotonin syndrome, drowsiness, there's so many out there. Suicidal ideation with some of these antidepressants. Especially with the elderly who are a fall risk, or already have core diagnosis of dementia. I don't really like to put them on medications unless I have to, unless it's clinically necessary, and unless non-pharmacological treatment such as counseling, spending time with family, joining a support group, those types of things don't work.

Interviewer: Great. That kind of leads into my next question, which is number four. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #11: I think that I am satisfied with my ability to treat depression holistically, but as far as managing depression with medications I do find myself needing the help of a psychiatrist or a psychologist, being a new FNP.

Interviewer: I'm going to have you explain more when you answer the next one. Which is, do you often seek out consultations from those working in psychiatry, and if so could you explain what they do?

Participant #11: Correct. I seek out consultations very regularly. At my current rehab facility the psychiatrist comes once to twice a week. We put them on consult for patients who have active depression, or patients who have unmanaged depression, or a history of depression. Especially patients on antipsychotics, or multiple medications for depression. Typically, I have a one to one meet with the psychiatrist every time he comes to the facility. We talk about the patients that we're putting him on consult, and why, and what medications they're on. Then the psychiatrist goes on to evaluate the patient, and change the treatment regimen if it needs to be changed.

Interviewer: One thing that keeps coming up in my interviews is neuropsych testing. Could you tell me what you think about neuropsych testing, or if you use it?

Participant #11: Sure. Typically we'll use the neuropsych testing if we want to evaluate whether or not a patient has competency to make their own decisions. We would obtain it if we come into a situation where the patient has no relatives, we're not sure that they can make their own decisions. That's one we usually get that type of consultation. In this particular rehab we don't really have those types of patients to much, but in another rehab where I used to work at we did, and we used it quite often.

Interviewer: Great. Last question, you can answer with a yes or a no. Might you have a colleague that would be willing to answer these same questions?

Participant #11: I think so. Yes.

Interviewer: Excellent. Thank you for your time. Have a great day.

- Interviewer This is interview number 12. Question one: what is your experience with treating depression in the nursing home setting?
- Participant #12: I think it's undertreated, possibly.
- Interviewer So, do you treat depression?
- Participant #12: We do treat depression, but most of the time we would usually refer to psychiatrist or psychologist. We can start the patient on a low dose Lexapro. That's usually what we do because of the least interactions. Lexapro has the least interactions, so we can initiate it, but even though we would refer the patient to psychiatrist.
- Interviewer So, for you to start Lexapro can I assume correctly that you're diagnosing depression to do it?
- Participant #12: It's either diagnosed by an assessment when the social services probably interview-
- Interviewer Do you ever diagnose it, like if it snuck past the social service?
- Participant #12: I have not diagnosed.
- Interviewer Okay.
- Participant #12: So far.
- Interviewer That works. So-
- Participant #12: Usually they come with the diagnosis of depression, they state they're depressed, I mean if they feel down in the last weeks, no pleasure in the usual activities. You can diagnose them with the depression, start them on a low dose antidepressant, an SSRI, and go from there.
- Interviewer That leads into my next question, number 2: what are the tools that you use to assess your patient specifically for depression? So, it sounds as if sometimes people do have symptoms that you do catch that somebody else doesn't catch.
- Participant #12: Correct, for the tool technically I haven't used any tool, personally.
- Interviewer I'm thinking you use your clinical judgment-
- Participant #12: Clinical judgment.
- Interviewer Clinical experience?

- Participant #12: Yeah, correct, but not the particular tool. There is a mini-mental scale. As I'm saying, this is not a long-term. Most of the time they will come, this is a subacute rehab, so the patients that come here are either diagnosed with depression and already on something, or they, if something comes up, usually we refer to psychiatrists in subacute setting to diagnose for depression.
- Interviewer Do any of your patients ever go to nursing homes from here?
- Participant #12: We do have couple of them that continue as a long-term patient.
- Interviewer Great, then that completely qualifies. That's exactly what I was looking for. So, looks like-
- Participant #12: But we don't treat long-term patients unless there is a specific request.
- Interviewer Okay. As long as you take care of the patient on the continuum, which it sounds like you do, then I can keep going forward with the questions.
- Let's say you decide to move forward with the Lexapro, question three asks: what does your follow-up consist of?
- Participant #12: The follow-up would consist of assessing the changes in behavior, after a week follow-up. Usually it takes three to four weeks, so I can't say that any changes can be visible after a week. Maybe psychologically as a placebo they can say they feel better. I have seen that.
- Interviewer Okay. That's a great answer.
- Participant #12: But, you've got to follow up on a weekly basis.
- Interviewer That makes sense. Are you satisfied with your ability to recognize and treat depression holistically? Meaning the whole person.
- Participant #12: I know. I think that here I have no reason, this setting, majority of people are depressed or lonely. So long as it's one of the biggest factors of depression. Either the person lives alone, is single or does not have a good family support. The family is out of state or far away. Those people are mostly affected with depression. If they have a good family support and good friend circle, usually they are not depressed.
- Interviewer Do you do anything about your patient's loneliness to help them?
- Participant #12: If they are here there is a lot of activities going on. It's different when they are here, they have therapy that sort of cheer them up, distract them from the depressive thoughts. They're pretty busy.

- Interviewer Do you ever encourage staff to, let's say get a depressed patient ... Can you make sure that patient goes to activities?
- Participant #12: Oh yes.
- Interviewer Excellent.
- Participant #12: We do that.
- Interviewer That's one really good thing to treat people holistically.
- Participant #12: I think, Bryan, that here, this is a subacute setting, so it's a little different than the long term care would be.
- Interviewer So, in your setting, question number five: do you often seek out consultations from those working in psychiatry, being a psychiatrist or a psychologist or social workers, therapy?
- Participant #12: Oh yeah. All the time.
- Interviewer Can you give me an example?
- Participant #12: Consultation would be seeing the activity person. Just consult with them, letting them know what's going on with the patient. They can engage the patient more if I can do activities. Usually those are the patients that are either demented. I will say, the (garbled) but demented mostly.
- There is depression and dementia a lot, going hand by hand. Yes, we do. We do communicate that to the activities, to the therapists so they're a little bit more engaged. CNAs are often involved because they have to be involved with the care, so they will take them here for a movie or distract them in any way possible.
- Interviewer Do you ever consult the psychiatrist yourself?
- Participant #12: When I was a support nurse I did, in that case. Not as a NP
- Interviewer Not in this particular setting?
- Participant #12: Not in this particular setting. I would talk to the psychiatrist, give him a heads up, what's going on with the patient, why we're seeking the consult.
- Most of the time the patients are, when they come to subacute rehab, they're all already on either Lexapro or Celexa. They do start in the hospital patient are not even aware that they've been on antidepressants. So, when they hear that they're on antidepressants, because here they

require consent for the treatment, and they get surprised. Majority of them, eight out of ten people would get surprised that they're on antidepressants.

Interviewer People aren't telling them?

Participant #12: No.

Interviewer Oh, wow. That's weird.

Participant #12: It's really interesting. So, and they will seek, when they want to get off the antidepressants. We have cases, you just can't take them off the antidepressant like that so they have to be tapered down. In that case I would consult, you know, I would talk to the psychiatrist explain what the problem is.

We had a patient that wanted to, and the family, to wean off the antidepressant, but after talking to the psychiatrist they decide they're going to continue with the Lexapro. It's in the diagnosis and what's going on.

Sometimes it's really interdisciplinary approach.

Interviewer My last question is a yes or no question: do you have anybody that might be able to answer the same questions you've answered?

Participant #12: No.

Interviewer Thank you.

Interviewer: This is interview number 13. Here's question one. What is your experience with treating depression in the nursing home?

Participant #13: My experience with treating depression in the nursing home was in a psychiatric nurse practitioner consultation role. Where I would go in, if a nursing home administrator or primary care attendee provider would put in a referral. Usually for elderly patients with depression.

Interviewer: Okay. What are the tools that you use to assess your patients, specifically for depression?

Participant #13: I use the symptoms of depression via the DSM or the Columbia rating scale, were the main two that I would use.

Interviewer: I'd like to ask a side question. Do you ever use the PHQ9?

Participant #13: Yes, I've used that too.

Interviewer: Okay. When you ... Number three is what does your follow up consist of? So, you've found depression in someone, what do you do?

Participant #13: I will do a mental status exam. Look at their medical history. Look at ... Interview the nursing home staff primarily, that are during the day-to-day care, which would usually be the charge nurse or the assistant nursing director, the nursing director themselves of the nursing home. They would pretty much know all of the history and then also talk with the family. And learn how long they've been sad. What was the precipitant, was there any neuro-vegetative systems, in terms of their appetite. Which was a common symptom, of having decreased appetite. Hopelessness. Just low energy and some suicidal, passive suicidal thoughts of ...

Usually cause it was coexisting of losing their independence. Losing their health and being in a nursing home was the biggest trigger

Interviewer: I can see that

Participant #13: But they may have had a depression as a long term history, on top of whatever led to them having to be in the nursing home.

Interviewer: Okay. Thank you. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #13: Actually, no because you're kind of bound when they're in a nursing home, it's not really too much holistically. I mean, they ... The food is bad, they're understaffed. It's so quick to see them. A lot of them are demented and not really responsive when they ... Well, in the nursing home. So holistically, I don't think

the opportunity even presented itself to do that holistically. If you look at faith, okay, so that wasn't fully addressed unless it was a person's and their family to do that. The family was pretty much the biggest piece and if they didn't have family then it felt like they were just in an institution. Just being rarely just cared for in terms of just their physical part. You know just getting them up and having contact but I don't think that there was lot of opportunity for full, holistic care.

Interviewer: I like that answer. You were the second person to mention food. First person to mention faith. I like that. Everyone takes that word holistically and they have their own definition and I am fine with that cause I think it really just means treating the person as a whole. Outside of just ordering medication. And I think your answer was great and honest. Do you often seek out consultations from those working in psychiatry? So clearly, you work in psychiatry but do you ever look for additional help?

Participant #13: With what type of patients?

Interviewer: So, let's say your ... Had a patient who's possible depressed and you want to rule out dementia versus Alzheimer's to see if that treatment plan would be different.

Participant #13: Often times by the time they do the psych consult, they pretty much you know are pretty much kind of already are in that state or some of them are already being followed by neuro. In terms of their depression or dementia on top of. Or early dementia or Alzheimer's. Yeah, a lot of them were already ...

Participant #13: So, let me ask you a side question. Do you ever consult social work?

Participant #13: I have not because usually that's already done out the gate. Soon as they come in, they're already managed.

Interviewer: So, you never identified depression on your own prior to admission?

Participant #13: No.

Interviewer: Okay.

Participant #13: No, it was always a consultation. And usually the biggest consultation was decreased appetite and sleep and the biggest ... you know Mirtazapine was their biggest ...

Interviewer: You're the second person to mention adjusting remeron

Participant #13: And a couple of occasion it didn't work as well as it was supposed to. Then they would be ... Some of them were co-morbidly anxious or psychotic.

Interviewer: So, When I was preparing this, some of the research I found said those medicare forms, the CMS forms. They were really lengthy in admission and they get the patient to self-report but for some reason many patients go undiagnosed at that point and it isn't until they do face-to-face in person that they really get a true reporting of depression. Alright, so we are ...

Participant #13: Usually it's the nursing people who are taking care of them or social work that's taking care of them. They've already noticed it based on if they're not eating or moving or talking.

Interviewer: Right. Last question. You can answer with a yes or no. Do you have any colleagues that may be willing to answer these questions?

Participant #13: No.

Interviewer: Thank you very much. This will conclude the interview.

Interviewer: This is participant #14 and we're going to begin with question number one. What is your experience with treating depression in the nursing home or nursing home patients?

Participant #14: I had a few patients that have come from nursing homes. Also patients who I have seen that were not in a nursing home that I had ended up hospitalizing and recommended discharge to a nursing home for a few months. Then they were again discharged. It is not I guess super frequent that I see patients from nursing homes, but I have had several. Once they have gone to the nursing home, I typically have not had much interaction with the providers there. Once they leave, I usually get faxed discharge paperwork and then ... Yeah. Then they follow up and continue their treatment after that.

Interviewer: What are the tools that you use to assess your patients specifically for depression?

Participant #14: Tools. I do screening scale with the PHQ-9 and then other than that, I typically just go over any symptoms from the DSM, evaluate the length of time that they've been experiencing the symptoms and what the change in baseline is, but the main screening tool would be the PHQ-9.

Interviewer: You got it. That's the majority of the responses. All of a sudden, you notice there's depression. What does your follow-up consist of? Do you ever follow up once they leave your hospital setting?

Participant #14: In terms of inpatient or ...

Interviewer: Both. Do you do inpatient?

Participant #14: Rarely.

Interviewer: Okay.

Participant #14: Mostly it's outpatient. Typically if inpatient. If someone comes to me with depression, I will either start them on medication, adjust their medication and if they're starting on a new medication, I typically see them back within two weeks.

Interviewer: Two weeks? That's great.

Participant #14: If they are still depressed and not really wanting to change medications, I'll see them back in about a month. Sometimes they're just resisting to changing medication if they're had chronic depression and have been on medications for a long time. I also typically have done GeneSight testing. I do that a lot, especially for patients who have chronic depression that have

not really seen great results from their medication. The genetic testing has really helped to rule out some of the 450 enzyme systems.

Interviewer: Is that fairly expensive for the population you see?

Participant #14: Actually, no. Anyone with Medicaid or Medicare, it is completely covered, which is wonderful because the majority of our patients have Medicaid or Medicare. There have been a few people who I've not been able to do it for because they have private insurance, but most of the population here is Medicaid and Medicare. It's completely covered.

Interviewer: Next question. Thank you very much for that answer. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #14: I think for the most part, I would say yes. In terms of pharmacotherapy and personal individual talk therapy, I think those respects, yes. I tend to wish I had more resources of systems that are available to patients in the community that would be more helpful to them. I find with so many patients, sometimes I'm spinning my wheels because a lot of them, their environment is so bad that even the medication and the therapy, it doesn't really ... They're not really getting anywhere because their environment is so bad. I wish that I had more access to programs that were available to them. I think that's mainly the missing link, but other than that, I think yes, I'm satisfied with that.

Interviewer: Do you ever ask staff members to take special care of certain individuals? Do you ever have them monitor food or sleep or involvement in milieu activities?

Participant #14: Here, I try to refer as many people as I can for individual therapy if they're willing. Once they're referred here for individual therapy, they're preserved sort of on the other side of the floor here. We will collaborate on a case by case basis to see what has been discussed in therapy and what progress we're making with medications to see if there's anything that needs to really be tailored. We also have case managers here and that has been really helpful in terms of the last question before this about the holistic approach because they have more access to the programs that are available. In terms of milieu setting I don't really do much with the inpatient work. Yeah.

Interviewer: The last question number five is do you often seek out consults from those working in psychiatry? You've already said you seek out therapists. Do you frequently speak with psychologists or psychiatrists?

Participant #14: Yes. I have a collaborating physician who I speak with regularly, but it's more of a case by case basis as well. If I need some extra insight or more

opinion on the matter, we'll collaborate and discuss, especially particularly interesting cases. We do have a psychologist that works in the office and I don't necessarily collaborate with him any more than the therapists, but in a similar fashion, if there was a certain person that we're both seeing and treating, we'll collaborate on them and discuss their cases.

Interviewer: A common theme I'm getting is a lot of ... Especially in the nursing home setting, neuropsych testing. Do you find yourself ordering that?

Participant #14: No, I do not. A lot of times the population is not able to really afford neuropsych testing.

Interviewer: \$1,200.

Participant #14: Yeah. That's the biggest limitation more than anything.

Interviewer: Okay. My last question you can answer with a yes or no.

Participant #14: Okay.

Interviewer: Do you have anybody that might be able to answer these same questions that you just answered?

Participant #14: No.

Interviewer: Okay. Thank you so much. Have a great day.

- Interviewer: This is participant #15. Let's start with question number one. What is your experience with treating depression in the nursing home or the nursing home setting?
- Participant #15: I'm trying to figure out how to be succinct. I've had a fair amount of experience treating depression in older adults. Some have been in the nursing home. Some have not.
- Interviewer: Okay, perfect. What are the tools that you use to assess your patients specifically for depression?
- Participant #15: What is the tool? It's the standard. They're the standard questions. I don't think I have a tool out in front of me. Essentially I look at ... I think that might be related to another question. Oh, PHQ-9 is what some places have given me and others have not been doing research on it. They haven't been collecting the data.
- Interviewer: Let me just clarify. You sit down with the patient.
- Participant #15: Right.
- Interviewer: You were diagnosing depression. What tool do you use? I don't want to put any words in your mouth, but do you always go off of let's say a standardized form or do you use a different method?
- Participant #15: I usually do the interview. It's more of an interview with me. If there is a form that depending on where I am and there is a form to use, I'll use the form as well. Always it's more of an interview and understanding that person in the full context. They can answer the questions, but then you've got cultural factors also that play into it. Understanding the person and what their prior behavior was like.
- Interviewer: Okay. Number three, what does your follow-up consist of? You've determined someone has depression. You've decided a course of action. We're working on that course of action. What do you do now?
- Participant #15: If I start somebody on medications to treat the depression, then I want to see them within two weeks. Sometimes a week. Then the follow-up goes from there. Once they've been on the medications for a month and they're doing okay, there are signs of improvement, then I might push it out to a month. Generally it's every two weeks for two to three times with the older adult because they can change rapidly.
- Interviewer: Got it. Good answer. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #15: Yes.

Interviewer: Can you give me an example?

Participant #15: Yes. One patient stands out for me. It's kind of straightforward I think, but for whatever reason, she stands out. This is a woman who came to me with problems with sleep, problems with feeling sad and blue, never had had this before, had always been active. She was a teacher and she was close to retirement or trying to decide whether she was going to retire. She had a lot of pressure at work. It was a catholic school. She had always been proud to be there, but they seemed to be looking for ways to have some people leave and bring in new people. They were being tested and observed. This was stressful for her. She wasn't sure why because she said, "You know, I know what I do and I know when I'm good and I know when I'm not and I know what I don't know." She said, "I can't sleep." She had lost quite a bit of weight. She was very anxious about her day to day responsibilities and doing them correctly.

I think it was a situational depression, but it had gone long enough so that it had become more of a full-blown depression. It started out situationally, but it was impacting her whole life. She was not feeling much pleasure in life, not wanting to do the usual things that she did. She always had a lot of get up and go. Anyway, I treated her for depression with Lexapro, which helped her to sleep because sleep had been one of the problems. She slept and she started feeling better probably within a month. She was feeling like she was getting back to her normal self. When she did get better, we sustained it. I had educated her about depression and wanted her to stay on the meds for at least probably close to a year. Then if she wanted to come off, we'd wean her off because it explained about the chemicals having to stabilize.

Anyway, she did all that, but she really was fearful of coming off so she never did come off the meds with me. She never did stop them. There would be something else. She was more in tune with that maybe she had been depressed earlier in her life, but just kept busy and ignored it. It wasn't serious enough.

Interviewer: I like your answer. Yeah, I see where your view of holism comes in.

Participant #15: Yeah.

Interviewer: Okay. Do you often seek out consultations from those working in psychiatry?

Participant #15: Not too often, but if I have a complicated case that is kind of stymieing me a little bit, then I do. I mean it's pretty easy to do and it's always fun to talk about cases. You always get another view.

Interviewer: A fresh pair of eyes.

Participant #15: A fresh pair of eyes. Yes.

Interviewer: Last question - yes or no - do you know anyone else that might be willing to answer these questions?

Participant #15: Let me see. Linda Hale. No names? Okay.

Interviewer: I'll take care of it. Thank you and this concludes the study. Thank you.

Participant #15: That's it?

Interview 1

- Interviewer: All right, this is interview participant number one. Question number one. What is your experience with treating depression in the nursing home.
- Participant #1: Okay, so I have not actually functioned as an APN in the nursing home setting, but I encounter quite a few patients, especially on consult, where they need psychiatric assessment before they return to the nursing home, sometimes as part of their treatment while they're here. The return to the nursing home is if they have a psych diagnosis, the nurse SNF won't take them unless there's a psych consult.
- Often that doesn't really require any treatment, per se, but we also have patients who come from nursing homes who maybe are depressed or do have a psychosis or do have a behavioral or mood disturbance related to their dementia. That would be, I think, my main exposure. On inpatient psych, we do less often, but we do have patients who come from nursing homes. You're referring to gero patients, right, not ICF patients?
- Interviewer: Anyone.
- Participant #1: Occasionally we do get patients who are in SNFs and come in because of a worsening mood problem. Then we also get patients who are in ICFs who maybe aren't elderly, but they have a severe mental illness that requires them to be at that level of care. I think that's it.
- Interviewer: What are the tools that you use to assess your patients specifically for depression?
- Participant #1: I think I do a really good clinical interview, so that's my primary tool. I rarely use objective measures like the PHQ-9 or the GAD or whatever, because I have confidence in my clinical interviewing skills and my ability to make a diagnosis from the history.
- Interviewer: What does your follow-up consist of? Meaning once you make your decision, how do you follow up?
- Participant #1: With consults, I, when needed, return and re-evaluate them on a day-to-day basis, or every other day and do medication management. Sometimes it's also an assessment of suicide risk or aggression risk that's required before they can be discharged. On the inpatient side, it's the same thing. Med management, assessment of symptoms, and making a decision about suitability for discharged, usually based on suicide risk or aggression risk, and with older adults also often, or nursing home patients, on ability to self-care.

I would want to see that they're eating, sleeping a reasonable amount at night, if they are supposed to be independent and they're grooming, that they're able to do that. Those would be the three reasons that I would ... The three, I guess, focus areas, as part of my treatment.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant #1: No. First of all, I don't think I know enough about complementary and alternative medicine options. I'm not as knowledgeable as I should be about herbal supplements. I don't think I'm able to get enough information about vitamin levels in especially older folks who maybe don't eat as well or their absorption's not as good, and that might be because I don't think those labs are readily available.

I'm not even ... Honestly, I don't know much about the research about the use of that, but I'm suspicious that vitamin levels are important to these patients' condition. Let's see. Can you ask me the question again?

Interviewer: I'm sorry. Yeah, are you satisfied with your ability to recognize and treat depression holistically?

Participant #1: Okay, so I'm focusing on the "holistically" part.

Interviewer: Meaning all around, like would you encourage staff to do anything in particular for your nursing home patient? Would you encourage particular activities once they've been sent to the nursing home

Participant #1: Yeah, okay. One, I think, obstacle to that is ... I pay attention to sleep hygiene. I think hospital care and sleep hygiene are almost antithetical to one another. It's almost impossible for patients to have a regular sleep schedule, to be able to be active enough and out of the bed enough ... Once again, I'm thinking of the consults ... Enough during the day to have enough stimulation so that they can sleep at night.

Here on the unit, with folks like that, patients are exposed to fluorescent light up until time to go to bed, and I don't think that provides a natural process for getting tired and being able to sleep. I experience pressure from nursing staff to give sleeping meds when I might prefer not to, so sometimes that's a struggle.

I think my own treatment is quite holistic in the sense that I really attend to the psychosocial. To some extent I attend to the spiritual, and then also the biological part, such as things like activity, nutrition, okay.

Interviewer: Question number five. Do you often seek out consultations from those working in psychiatry, for example, psychiatrist, psychologist?

Participant #1: Yes, I use psychologists. Certainly not as often as ... It's rather infrequent. I use psychologists to clarify diagnosis. It's especially helpful if we're documenting dementia and decision-making capacity. I use my collaborating psychiatrist for consultations when I am maybe stuck or not sure what options I might be overlooking or if I'm not getting a good outcome from the interventions I've tried. I do also informally use other APNs, but also psychiatrists when I need somebody to bounce ideas off of or to provide some input. I think that's about it.

Interviewer: Great. Last question. Do you have a colleague that might be willing to answer these questions?

Participant #1: Yes, I do.

Interviewer: Excellent. Thank you very much.

Interview 2

- Interviewer: All right. This is participant number two, and we are starting with question number one. What is your experience with treating depression in the nursing home?
- Participant # 2: First I identify the symptoms. A lot of times, the nursing home nurses know the patient the best. So, if they point out that the patient's depressed or I can get that in an evaluation, then I usually will do a PHQ-9 if they're able to do it. And is that good for you then? Okay.
- Interviewer: Number two, what are the tools that you use to assess your patients, specifically for depression?
- Participant # 2: Well, sleep, appetite ... I ask the patient if they feel depressed, their mood, their affect, the people surrounding them, what ... you know, maybe the family, the nurse, peers maybe if they allow me to talk to them ... and like I said, I've used the PHQ-9 scale.
- Interviewer: What does your follow up consist of?
- Participant # 2: Well, do you want to know what I start with or you're ... you didn't ask that yet.
- Interviewer: Anything you ... so the ... So, you've identified depression.
- Participant # 2: Mm-hmm (affirmative).
- Interviewer: You've decided a course of treatment.
- Participant # 2: Mm-hmm (affirmative).
- Interviewer: What do you do to follow up? What is your plan? Do you follow up in a month? Two weeks? A day?
- Participant # 2: Oh. Oh. Well it depends on the medication. For an SSRI it's gotta be at least two weeks. And then ... you know, two weeks to a month. But since I worked for MPEC I was stationed in a nursing home. So, I didn't have to wait a month. So, it'd be two weeks and the psychiatrist there had a similar pattern of two weeks. And I did collaborate with them as well. And so, the two weeks post follow up and then check how the patients doing, possible medication increase. Then check 'em again in two weeks. I usually start out with an SSRI. For me, I like the newer generation SSRI's. Although

Public Aid doesn't always like that so sometimes they dictate what I can order. And then, I would go to the SSRI, SNRI, or even type ... a Wellbutrin type of medication, which is in its own class, but it is a stimulant ... so if they're sleeping a lot. But usually the SSRI and then the ... SSRI/SNRI medications like Effexor and Cymbalta. And then a Wellbutrin. And sometimes, you know, after a while a combo, like a antidepressant and a stimulant. It depends.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant # 2: Yes. I ... in a nursing home, patients gotta get out of their room. You know. You encourage them to go to activities. The nursing home I was in was a behavioral health nursing home, so attending groups, you know encourage family visits, interaction with other ... but they, you know, they have activities that go on and the patients can ... they get points for going and then they have a store they can go to. But, you know, when they're depressed they might not feel like going. So, encouraging them to get out of the room and that even some light exercise ... 'cause they have a rehab gym there, and also like a morning stretching class for people that are into this fit ... for them to go to and Bingo, and arts and crafts, and other things that they can go to.

Interviewer: Do you often seek out consultation from those working in Psychiatry, meaning psychiatrists, psychologists, or even therapists?

Participant # 2: Yes. If I've had a treating physician I may, if it's working, I just follow their treatment plan. If it's not working, I ... like some psychiatrists follow their own patients. So, I would suggest certain medication for people that are still having anxiety or ... you know, we're not sure it's related to depression, or you know something else. So, just kind of conferring with the psychiatrist about what they think. I give my opinion. And then you know we come to a solution together.

Interviewer: Perfect. Very last question is do you have any colleagues that you might be willing ... that might be willing to answer these same questions?

Participant # 2: Nurse practitioners?

Interviewer: Yes.

Participant # 2: I'd have to think about that and get back to you.

Interviewer: Sounds great.

Participant # 2: Yeah.

Interviewer: Perfect. That ends my questions. Thank you for your time.

Interview 3

- Interviewer: This is interview with participant #3. First question is, what is your experience with treating depression in the nursing home setting?
- Participant # 3: Consistently see depressed individuals when I do coverage at a nursing home.
- Interviewer: Excellent. What are the tools that you use to assess your patients specifically for depression?
- Participant # 3: I don't use a specific tool. I use the Daniel Carlat mnemonic system for my assessments.
- Interviewer: Excellent. What does your follow up consist of? Meaning, you find depression in a patient and you treat them originally, what do you do next?
- Participant # 3: I would follow up on the same things I assessed. Specifically, the things that I hoped to treat symptom wise from the patient. For instance, if they had fatigue and that was the main symptom we were going to treat with like an NDRI, Wellbutrin, I would follow up on the key thing we were looking to treat like that fatigue. So, follow up on the symptoms we were targeting with the medication.
- Interviewer: Great. Are you satisfied with your ability to recognize and treat depression holistically?
- Participant # 3: I feel like-
- Interviewer: Is there anything you want to improve on?
- Participant # 3: Yeah. I feel like you know my DNP program was highly psychopharmacology based and I know the basics of some CBT and motivational interviewing, but there are some other things where though they don't necessarily get great therapy resources at a nursing home. So being able to spend a little more time in that and to be more efficient and effective in my therapy would be an improvement for me.
- Interviewer: That's great. Do you often seek out consultations from those working in psychiatry?
- Participant # 3: No.

Interviewer: No. A follow up question if possible. Meaning, neuropsych testing?

Participant # 3: Often would not be the right term. Do I? Yes, but not-

Interviewer: Not frequently?

Participant # 3: Yeah.

Interviewer: Understood. Then last but not least, do you have a colleague that might be willing to answer these questions?

Participant # 3: No.

Interviewer: Okay thank you very much. This has concluded the interview, thank you.

Interview #4

- Interviewer: This is Participant #4, we're going to start with question number one. What is your experience with treating depression in the nursing home?
- Participant #4: In the nursing home setting I've only been working as a nurse practitioner in the nursing home setting for four to five months. Prior to that I did internal medicine so I was very used to working with patients in treating depression and I had a lot of older dot and geriatric patients so some of that experience has carried over into the nursing home setting. Most of the time what I'll do is I'll start off with at least getting a psych evaluation.
- Interviewer: Are you doing number two?
- Participant #4: Oh sorry, no I was answering number one.
- Interviewer: Oh okay, okay.
- Participant #4: What is my experience, so my experience ... I'm sorry, I get off track.
- Interviewer: No problem.
- Participant #4: ... Is that I will say I'm novice with treating patients in the nursing home setting with depression.
- Interviewer: That's good, a great answer. So number two, what are the tools that you use to assess your patient's specifically for depression?
- Participant #4: I'm used to the PHQ-9, so I'll mentally go through those questions as I'm asking the patient to assess if they're truly depressed. Unfortunately with this patient population you do want to rule out infectious cause first, so I'll do, or an organic cause, so I'll do a thyroid panel just to make sure it's not hypothyroidism. Then I'll also do UA just to make sure it's not a UTI. If they have any behavioral disturbances I might do a chest x-ray if they have any symptoms leaning, going that route or if they're on two feedings or something like that. But then the way I will, like the tools I use, like I said, is the PHQ-9, then I'll consult psych, I'll do some baseline labs, CBC, CMP, and then I'll do depending on the patient I might do some ... You don't ask about labs?
- Interviewer: No, no I'm just asking.
- Participant #4: Oh sorry.
- Interviewer: I was just looking. No, no, we're doing fine.

- Participant #4: Then I may do, like I said, TSH, I may to an HIV or an RPR to make sure they don't have syphilis or neural syphilis. But tools-wise, sticking to the question, PHQ-9.
- Interviewer: The next question is, and I'm going to clarify it a little bit, what does your follow-up consist of? You find depression by some mechanism, what do you do then?
- Participant #4: Typically if they're diagnosed as depressed by the psych doctor, the follow-up I'll do is I'll read the psychiatrist's note and go with their recommendation. So I'll follow up with the patient and if they start them on an SSRI which I know is typically first line then I'll make sure that that's the right dose, make sure it doesn't interact with any other medications, then make sure any recommended labs are needed or necessary for that medication then I'll make sure the orders are put in. Unfortunately, here at Fairmont the psychiatrist doesn't always see the patients in a timely fashion or if he does see them, everybody's majorly depressed and so then I'll defer to the primary physician and I'll actually say, "Hey, maybe for this patient if they have a poor appetite," I'll be like, "Hey can start them on Remeron instead?" Or like, my follow-up may be making sure you get out to activities every day, make sure the nurse gets them up, those kind of things because I don't want to always just jump to pharmacol therapeutics so then I'll be like trying to do what other nursing intervention we could do.
- Interviewer: Out of all the people I've interviewed that was the answer I was hoping to get and that was the first time I got it, so thank you very much. Some people get a little confused by this question, are you satisfied with your ability to recognize and treat depression holistically?
- Participant #4: From all aspects no because I feel like unfortunately because they're in a nursing home it's automatically like, again, not trying to down the psychiatrist that's here, but everybody's majorly depressed, that's the diagnosis across the board that I've seen so far. I feel like nothing else is incorporated, the families aren't necessarily always called, and trying to find out like oh what are their favorite activities, what else do they like to do, let's get them out of the room and unfortunately I think the burden that the nurses have to deal with is that they are the ratios so they don't really know these patients or if they do know them they don't have the time to really just go in and talk with the patient, get them out to activities, make sure they're involved in the activities, and then make sure not everyone is stapled with the label of dementia. Holistically do I feel like I treat these people that route and do I feel comfortable with it? No, to answer your question.
- Interviewer: Okay...

- Participant #4: I just went in this whole circle.
- Interviewer: I like that answer though because I feel that your previous answer said you touched on medications, you touched on dealing with lab works, avoiding the common pitfall such as dementia, and then you went a little bit into the psychosocial of getting other people involved to promote activity. So from an outsider's perspective I believe that you do treat holistically. But to each his own.
- Number five, do you often seek out consultations from those working in psychiatry?
- Participant #4: So I've learned, again, I'm new here at Fairmont so we do have a psychologist, Doctor Brennan, that rounds on the patients, and I'm not sure what his caseload is but I have had quite a few cases that I'm like, "Hey, could you just go and talk to this patient, and just do some talk therapy?" So I consult the psych first to make sure that I'm not doing anything that's unsafe and to make sure that they're clinically actually diagnosed by a specialty. Then if I can't get that psychiatrist, unfortunately not a lot of these patients leave the facility so then we just kind of have to wait. There's a chaplain that rounds so I'll see if the chaplain can get involved, I'll see if restorative nursing can come and see these patients more often and like do other activities with them. Outside of those working on site, yeah so then it's psych and then Doctor Brennan, psychologist.
- Interviewer: You're the first person who mentioned pastoral care as someone else working outside of psychiatry so thank you for that. Last question, and you can answer it with a yes or a no, do you have any colleagues that might be willing to answer these questions?
- Participant #4: Well you've already reached out to all the Paragon NP's, right? So my sister but she works in a walk-in so probably not. But do I have any other friends?
- Interviewer: Thank you so much for your time.
- Participant #4: No problem.
- Interviewer: You've answered all my questions.
- Participant #4: Sorry that I ...
- Interviewer: Have a great day.
- Participant #4: That I totally went off

INTERVIEW #5

- Interviewer: And, this is interview participant number five. I'm going to go ahead and start with question number one. What is your experience with treating depression in the nursing home?
- Participant #5: It's been tricky. I tend to treat depression pretty aggressively in the nursing home, given the population and the high risk for depression in this setting. I do find it difficult, as far as starting new medications, with the elderly population, with all the side effects that go along with it. It's also difficult because, of the facilities that I've been in, there are psychiatrists in the building, and depending on the involvement of the psychiatrist in the building, is how hands on or hands off I am with the patient and their direct psych care. Those are the biggest barriers, I would say.
- Interviewer: Sure, could you just expound on that about the elderly and your choice of medications. Have you found that there's a medication that there's an issue with?
- Participant #5: Yeah, I mean, the biggest one that I could see is with Benzodiazepines. Seems to be pretty common that I'll have elderly patients on the long acting benzo's and I generally try to stray away from any of them.
- Interviewer: Everybody's making that move, it seems.
- Participant #5: Mm-hmm (affirmative)
- Interviewer: Number two; what are the tools that you use to assess your patients specifically for depression?
- Participant #5: I exclusively PHQ-9.
- Interviewer: Do you use a specific score in the model? Like at a certain number, do you treat? The finding's like a 20, 30, the scoring model?
- Participant #5: Yeah. I'd have to look at the-
- Interviewer: Okay. I understand. You answered it, it's perfect. Let's say your PHQ-9 determines that the patient has depression. Question number three; what does your follow up consist of?
- Participant #5: I'm typically coming weekly, so my follow up would be in one week intervals.
- Interviewer: Okay. Meaning, do you check up with nursing staff?

- Participant #5: Yep.
- Interviewer: Do you check up with therapists? What are you looking for when you consult with nursing staff or therapy or aides?
- Participant #5: In the beginning of the treatment, obviously they're not going to have any like full effect for several weeks, but I would be looking for the medication side effects. I would look at their appetite, their sleep habits, their activity level, different pain components, any other new issues that arise, in those first couple of weeks where I would be able to tell if they're having any direct side effects from the medications or the treatments. Then, at that one month mark, is probably when I would repeat a PHQ-9.
- Interviewer: Great answer. Are you satisfied with your ability to recognize and treat depression holistically?
- Participant #5: Yes.
- Interviewer: Can you give me an example of how you feel you treat it holistically?
- Participant #5: For all my patients, in addition to any medications, I also do direct counseling. I'm lucky enough that every facility I go to has, what's the word I'm looking for, like a clinical person that's able to provide counseling-
- Interviewer: therapy?
- Participant #5: Exactly, for patients, I add that, as well as providing my own emotional support.
- Interviewer: Great answer. Okay. We're almost done. Do you often seek out consultation from those working in psychiatry, so before you answer, I'll say you kind of already said the therapist, so that's one. Is there anybody else? Do you ever get neurological testing, or psych testing done?
- Participant #5: Yes. Depending on how clear-cut I am with the diagnosis, I always, if I'm suspecting depression, will consult psychiatry in addition. But, then if the patient has more neuro-cognitive issues, where it might be more difficult to tease out, I will sometimes consult neuro-psych as well.
- Interviewer: That is a wonderful answer. Let me just ask, do you ever try to get staff involved, saying, "Make sure this person goes to group activities. Make sure this person gets out of their room." Or, do you also, I see you shaking your head yes, correct?
- Participant #5: Yes.

Interviewer: Do you do anything else? Is there anything, do your nurses or your techs monitor your sleep patterns for you?

Participant #5: They do-

Interviewer: Like are they recorded?

Participant #5: I don't know that it's recorded. I usually just talk to the nurse or the aide that's on for that day. That one's a little bit more difficult to assess. They are able to tell me usually, if the patient has sleep issues, if they're not sleeping, if they sleep all day, how much they're napping throughout the day.

Interviewer: All right. I just have one final question for you. Do you have any colleagues that you think might be willing to answer these same questions?

Participant #5: Yes.

Interviewer: Thank you so much. We are concluded with the interview.

INTERVIEW #6

Interviewer: This is the beginning of interview number six. What is your experience with treating depression in the nursing home?

Participant #6: Most of my nursing home patients are subacute, so usually it's kind of just med management for people who have already initiated antidepressants.

Interviewer: In your experience doing that, have you ever found someone who maybe wasn't initiated where you thought that you might want to move forward with initiating?

Participant #6: Yeah.

Interviewer: Excellent. The next question leads right into that. What are the tools that you use to assess your patients specifically for depression?

Participant #6: I sort of informally use the PHQ-9 as a background guideline, but basically just relying on the patient's report of symptoms and how much it's affecting their functioning and sort of how the patient feels about their symptoms.

Interviewer: Okay. That leads directly into three. What does your follow up consist of? Let me just ad lib a little bit. Your patient tells you they have symptoms. You begin to treat, then what?

Participant #6: We have to monitor pretty frequently especially in older people. You're going to follow up with them at least within a week and reassess. Assess side effects. In a short term setting, you're not really going to see much of a difference in depression, but mostly in that initial phase you are just watching for side effects.

Interviewer: Start low and go slow.

Participant #6: Mm-hmm (affirmative)

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant #6: As a provider, yes. In the nursing home, no. Although you do in the nursing home usually depending on the facility, we usually have pretty quick access to talk therapists so that's sometimes a nice bonus.

Interviewer: Let me give you examples of other responses. Sometimes people would say that they are treating holistically by monitoring food intake, activity participation, family interaction. Do you ever find yourself encouraging those activities or monitoring those activities?

Participant #6: Well, yeah. Although I think that most of the time, people in nursing homes are sort of out of their normal life, and so that's a real limiting factor. You're not

going to be able to go walk your dog every night or, you know, see your kids every day or whatever.

Interviewer: Yes. Now that you ... Question number five is so you've found this person with depression, do you find yourself often seeking consultations from those working in psychiatry?

Participant #6: In the nursing home, yes. Most of my experience has been in primary care so, no, but in the nursing home, yes, because there's usually underlying dementia or cerebral vascular disease or ... It's almost always multi-layered.

Interviewer: And for that, do you consult neuropsych?

Participant #6: Neuropsych. Yeah.

Interviewer: Last question. Might you know anybody that might be willing to answer these questions? You can answer with a yes or a no.

Participant #6: Not really. I'm kind of on my own.

Interviewer: Okay.

INTERVIEW #7

Interviewer: And this is participant number seven. What is your experience with treating depression in the nursing home?

Participant # 7: In the nursing home setting ...

Interviewer: Long term, rehab...

Participant # 7: Especially in L-tach it is pretty frequent. So, we do have a lot of experience treating it here. We see it a lot in the long term setting especially after life changing things such as CVAs and ...

Interviewer: Do you diagnose it frequently in your experience? Or is it usually there in prior existing?

Participant # 7: I think a good mix of both.

Interviewer: Excellent.

Participant # 7: I definitely diagnose my fair share of depression here and treated it as well.

Interviewer: Number two, what are tools you use to assess your patients specifically for depression?

Participant # 7: Honestly, I don't have any specific tools here, just is basically review a systems that I use. Asking about depression, asking about mood anxiety.

Interviewer: Excellent.

Participant # 7: Things like that. Yeah.

Interviewer: Let's say you're using your review of systems, you diagnosed depression. Do you decide to move forward with some form of treatment? What does your follow-up consist of?

Participant # 7: Once, you know... We have a very good psychiatrist here, so once somebody does exhibit depressive symptoms, we usually do a psych consult. Honestly, kind of hand it off to them at that point. I would do follow up to see if their symptoms are improving. If their mood is changing, getting for the better.

Interviewer: What about your follow-up on medications?

Participant # 7: A lot of those are handled by the psychiatrist here.

Interviewer: Okay.

Participant # 7: Okay. Now, I'll follow-up. I will see how they're feeling and then I'll touch base with psych to see if they want to trade any of the medications.

Interviewer: Are you satisfied with your ability to recognize and treat depression holistically?

Participant # 7: You know holistic treatment of depression at an L-tach and SNF setting is kind of challenged. A lot of the holistic and I guess non-pharmaceutical ways to treat depression. Eating right, dieting, exercise. A lot of patients here, you're limited. You'll have a menu and this what you're gonna get.

Interviewer: But do you follow-up with your staff members saying, hey, did they eat today? Did they eat yesterday? What about their sleep habits? Do you...

Participant # 7: I follow-up with both staff and patients. Most of the time the patients can tell me if they're sleeping okay or if there's some sort of insomnia. Additionally, you know, I often ask how the patient's appetite is.

Interviewer: I see.

Participant # 7: Then what percentage of the tray they're finishing.

Interviewer: You kind of already answered number five a little bit. But it says, do you often seek out consultations from those working in psychiatry?

Participant # 7: Almost always.

Interviewer: Do you frequently find yourself ordering, let's say, neuropsych testing or just psych testing? Do you ... once you ask psychology to come they come and take care of that?

Participant # 7: It's kinda ... I've ordered it a few times here, not too often, a lot of times with social work already on the case, they'll come to me and say, hey, can we get a neuropsych consult? This is what we have going on.

Interviewer: But you're responsible for ordering it?

Participant # 7: Yeah.

Interviewer: Great so then you give your input as a provider as to how you should move forward?

Participant # 7: Yes.

Interviewer: Then just the last question, you can answer with a simple yes or no. Do you ...
Might you know someone who might be willing to answer these questions?

Participant # 7: Yes.

Interviewer: Thank you.

INTERVIEW #8

Interviewer: And this is Participant #8. I'd like to start by asking you, #1, what is your experience with treating depression in the nursing home?

Participant # 8: Well, in the setting that I'm in right now, it's pretty minimal. Previous to that, I worked at the VA, Heinz VA, for 12 years and it was pretty extensive. I worked on a weekly basis with one of the psychiatrists in treating depression. She would visit our unit every Friday, and we rounded together. However, I am of, maybe old-school, of the opinion of really deferring to the experts for treating depression, especially in older people and in the nursing home. Initiating drugs, not terribly commonplace for me. I really prefer deferring to the experts.

Interviewer: Excellent. What are the tools that you use to assess your patients, specifically for depression? So, let's say the experts haven't come in yet. You're the first-line person.

Participant # 8: Generally, it's the geriatric depression scale, and just the information that's gathered throughout, through the history, when a patient is first admitted. Often, signs and symptoms such as poor appetite, difficulty or inability to sleep, agitation, irritability, restlessness, some personality issues that family may describe as different or changed. I would say those kinds of things.

Interviewer: Excellent. Good answers. So you've used your geriatric depression scale. Here's question three. What does your follow-up consist of?

Participant # 8: Hm, I'm a little confused on that question, Bryan.

Interviewer: I should have clarified.

Participant # 8: It's okay.

Interviewer: You've used your geriatric depression scale, and it has shown you conclusively, or maybe through your clinical scales that you've seen depression in that patient. You've diagnosed them.

Participant # 8: Okay, got you. Okay, so what would I do next?

Interviewer: What do you do next when you move forward?

Participant # 8: Okay, I understand. Well, I would probably ... I really prefer to first talk, if the patient is cognitively intact, I would talk with them about the fact that I think they may benefit from counseling or talking with a therapist, a psychologist, and/or a psychiatrist, geriatric. I really prefer a geriatric psychiatrist, by the way. I'm really convinced that we need to have someone with that subspecialty, and/or

family members, because I think that ... I have a lady right now, for example. I'm going off on a tangent.

Interviewer: Go ahead, please.

Participant # 8: Who's 97 years old. And, she is ... I would say she's depressed. But she is really ... she just didn't think she would live this long. She is at that point in her life where, "Enough already." I would not refer her to a psychiatrist. I totally understand what she's experiencing just in terms of the aging process, and I'd hate ... She's mentally, cognitively intact, she's got a bit of a hearing deficit, and I would hate for her to be possibly given medications that might have untoward effects, so I wouldn't even refer her. But I would, in conjunction with talking with a patient and/or family members, if they felt it might be beneficial that we then consult the psychologist and/or geriatric psychiatrist, if that's indicated.

I have had some really good luck with the psychology, with doing counseling and meeting with them on regular patients on a regular basis, and just providing support of counseling. I found that extremely beneficial.

Interviewer: Awesome. Excellent. #4, are you satisfied with your ability to recognize and treat depression holistically?

Participant # 8: I think I am. I personally suffer from depression, and most of my family members have problems with depression. I feel that I definitely am someone who is very sensitive to the signs and symptoms, and especially the signs and symptoms of older persons. The losses that they experience, are very commonplace, and really set the stage for most people as they age to experience some type of depression. I feel that it's not something that you necessarily always have as we age, but it's something that, when you look at all the losses that people go through, the chronic illnesses they experience, etcetera, the meds that they're on, they do have, certainly, a high risk for being depressed. I just went off on a tangent again. I do feel I'm satisfied though with my ability.

Interviewer: Can you give me an example of how you treat depression holistically?

Participant # 8: Mm-hmm (affirmative). Holistically? Certainly. I would want to have various team members be involved with treating depression, be it recreation therapy, as I mentioned before, a psychologist. If a psychiatrist is indicated, and that basically is, in my opinion, only when medications might be considered. I feel like the psychology is more the counseling. And if even psychology felt that maybe psychiatry needs to get involved. I don't see psychiatry's role, at least for geriatrics, in my experience, for the counseling portion of it. I would like to see a social worker, psychiatric social worker involved if that's something that would be indicated as well. Therapies in terms of keeping patients, getting patients optimized in terms of any types of deficits they have with physical problems, or

occupational issues for occupational therapy, those kinds of things. I'm not sure if that's what you meant?

Interviewer: No, that's perfect. So, you've kind of answered this, but if you could just summarize. #5, do you often seek out consultations from those working in psychiatry?

Participant # 8: Yes, when it's indicated. I again ... You know, one of the things we have here, at least in the Lexington facilities that basically I've been going to, is there's a psychologist as well as a psychiatrist. They often work together. Some of them are actually partnered. But I generally will go with a psychologist first, and then see based on their thorough assessment, then see if they feel that psychiatry would be indicated. I'm also very pro-neuropsychiatry, by the way, in terms of I feel there's a specific role for neuropsychiatry for the older person that does a much more thorough assessment for the older patient. If someone has a neuropsych background that would be the person I'd like to go to for working in geriatrics.

Interviewer: I completely agree with that. And this last question you can answer with a yes or a no. Do you have a colleague that may be willing to answer these questions?

Participant # 8: Oh, absolutely. As I mentioned, Bryan, I would be more than happy to try to help you recruit some nurse practitioners.

Interviewer: And I appreciate that greatly. And this concludes interview #8.

Participant # 8: I enjoyed that!

INTERVIEW #9

- Interviewer: This is participant number nine. Question number one. What is your experience with treating depression in the nursing home?
- Participant #9: I just review the patient's history, how their physical exam goes, if they've been feeling any symptoms of depression or isolation and then if they do, then we just refer to psych, here.
- Interviewer: Just because of the way you answered it, let me ask you this. Do most of your patient's self-report, or do you find yourself diagnosing more than a self-reporting patient? Depression specifically.
- Participant #9: I think overall I find myself diagnosing it.
- Interviewer: Excellent. Number two. What are the tools that you use to assess your patients, specifically for depression?
- Participant #9: Evidence based tools you wanted?
- Interviewer: Sure.
- Participant #9: I don't have any.
- Interviewer: I'll give you an example of what some people have been saying. My clinical experience, PhD nine, Geriatric Depression Scale. If you don't use any of those tools, it sounds like you do more of a review of systems. Would you say that yourself?
- Participant #9: Yes. Review of systems.
- Interviewer: Anything else?
- Participant #9: No. And then, our social workers, they would do the evidence based scales, like their depression....
- Interviewer: Understood. That's great that your social workers do that. So, you and your team have diagnosed depression. Number three, what does your follow-up consist of?
- Participant #9: If they consent to letting one of our psychiatrists see them, then we follow-up on what their recommendations were. And if they're willing to go along with his treatment recommendations.
- Interviewer: Do you always do a consult for psych once you've diagnosed depression, or do you ever manage it yourself?

- Participant #9: No, in here, within this setting, it's always under the psych.
- Interviewer: Excellent. But at least you diagnose it. That's great. Are you satisfied with your ability to recognize and treat depression holistically?
- Participant #9: I can always get room for improvement. Recognizing it, I'm satisfied with it. Treating it, no, because I always refer out and ask other people, and have the psychiatrists recommend.
- Interviewer: Let me ask you a follow-up question. So the psychiatrist makes a recommendation, do you order the medication? Or does the psychiatrist?
- Participant #9: Usually it's the psychiatrist.
- Interviewer: Do you ever change the dosages once they've initiated treatment?
- Participant #9: I would, but I wouldn't change it until they'd been on it for a few weeks.
- Interviewer: Okay. So you would change?
- Participant #9: Yeah.
- Interviewer: If there was a clinical based evidence reason why.
- Participant #9: Right.
- Interviewer: Right, okay. And last but not least. You already kind of answered it, but do you often seek out consultations from those working in psychiatry?
- Participant #9: Yes.
- Interviewer: Okay. Besides a psychiatrist or a therapist, is there anyone else you've ever asked to consult on your case?
- Participant #9: There's been a few residents here that would need a neuropsych.
- Interviewer: Excellent. And do you find neuropsych testing to be efficient?
- Participant #9: Yes.
- Interviewer: Conclusive? Great.
- Participant #9: Very thorough.

Interviewer: Very thorough. Great. And then the last but not least, and you can answer it with a yes or a no. Do you maybe have a colleague that might be willing to answer these questions?

Participant #9: Yes.

Interviewer: Thank you. This concludes this interview.

INTERVIEW #10

- Interviewer: This is interview number 10. We'll be starting with question number one. What is your experience with treating depression in the nursing home?
- Participant # 10: Well, anyone who is on any kind of anti-anxiety, antipsychotic, any medicine for depression or anxiety, they are being seen usually by the ... I refer to them to the psychiatrist here and the psychologist.
- Interviewer: Okay. Maybe number two will answer this a little better. What are the tools that you use to assess your patients specifically for depression? You have a patient that you're treating some way along their line of treatment. How do you know someone's depressed before you send them to psychiatry?
- Participant # 10: Because I work for Elmhurst Hospital actually and so when the assessment comes over from the psychiatrist at Elmhurst Hospital, I read through that first and see what that person recommends. It could be like newly diagnosed. Then I would talk to the patient about how well they know what the medicine is, side effects of the medicine, kind of review that with them, and then ask them if they would like to see a psychologist, psychiatrist here with their diagnosis of whatever they have been diagnosed with.
- Interviewer: So in your experience, you don't do as much of the diagnosing.
- Participant # 10: We don't do any of the diagnosing. Usually people are already diagnosed prior to coming here.
- Interviewer: Okay. So-
- Participant # 10: I mean, I would say 100% of our patients that I-
- Interviewer: From Elmhurst, got it.
- Participant # 10: ... From Elmhurst that I see. Yeah, we don't put them on ... I take that back. Remeron is a medicine we use a lot for patients, but it's more to help with like appetite and things like that. But it also helps with their depression, and their failure to thrive, and things like that too.
- Interviewer: Okay, so here's the question. I'm going to ask it, but then I'm going to modify it for you, to get your experience. What does your follow-up consist of? It sounds as if they come with a diagnosis, you go to psych for their treatment plan, but that it's most probably you giving the hands-on care. How do you follow up with that, Remeron, or those kinds of meds, once the diagnosis has been made? Do you increase dosages? Do you decrease dosages? Do you change timing of dosages?

Participant # 10: I might change timing of dosages, if it affects their sleep or something. But I wouldn't change their medicine dose typically. Now, Xanax or Ativan, things like that, I change that all the time. Like, I might prescribe those with people who are like anxiety, you know, people who are have a hard time being here. That is a psych area that I wouldn't need a psychiatrist to do that. We do that, and then I evaluate them the next day.

Interviewer: Great, so that's my question there then. Using, let's say a benzo, what does your follow-up consist of when you're ordering a psychotrope?

Participant # 10: I see them the next day, how they reacted to it. Did it sedate them? Did it help them? Does the dose need to be increased? Does the does need to be decreased? Do they need something else?

Interviewer: Excellent. That's a great answer. Number four, are you satisfied with your ability to recognize and treat depression holistically?

Participant # 10: Okay, I don't really know what that means, but holistically meaning like ...

Interviewer: I'll give you an example.

Participant # 10: Like, say I don't notice their...

Interviewer: Some people might use their PHQ-9 to diagnose depression. If it's less say basic standard depression, most people start with an SSRI. To treat holistically, one might be checking on are they sleeping, are they eating, are they being encouraged by staff to get up and to do their ADLs? What do you-

Participant # 10: Yes, so I those things. Any time I see any new patient, for sure, if they have a diagnosis or not a diagnosis of depression, or I think they're depressed or anxious or whatever the case may be, to always assess that. Like, how is their appetite? Are they sleeping? Is this a new diagnose?

Cancer, cancer's my specialty. I've been a nurse practitioner in cancer for over 30 years. Depression was a huge thing, which was induced by the situation. A lot of times they might have been depressed even before their diagnosis of cancer, but with the situation of being newly diagnosed, especially a bad prognosis, and it happens very quickly for people, then everybody wants to jump on the bandwagon, they need to see a psychiatrist and they need to be on antidepressants, and things like that.

But I usually make sure, you know, is the patient sleeping? Are they eating? If they don't have any of these, are they not wanting to get out of bed? Do they want to sit in the dark all day? Those kind of things. That would tell me, oh yeah, they would really benefit from antidepressant or even anti-anxiety medicine, or were benefiting from seeing a psychologist or a psychiatrist. But if it's no, no, no to all

those things, you know, they're not sitting in the dark, they're not withdrawing from their family members, they're still active as they usually, their sleep hasn't been changed, they're eating okay, but might be decreased because of their cancer diagnosis, because of the stomach cancer or colon cancer, their side effects of treatment, not necessarily their depression.

Interviewer: Your perspective is invaluable because I wasn't looking specifically into that-

Participant # 10: Oh.

Interviewer: No, no, that population of cancer, but one has to understand that that has got to be a very large percentage of your cases that you see in the nursing homes.

Participant # 10: They're like a fourth of our population. Also with hearts, I don't know if you know the studies with patients that have open heart surgery, but with men they suffer depression more frequently than women do, with having open heart surgery.

Interviewer: Beta-blocker blues.

Participant # 10: Right, that too. But it's specifically with open heart surgery, with men. That's something that you might want to look into too, because the other thing is our patients too, we have a contract with Elmhurst, and the cardiac surgeon actually sends his patients here, and they're going to start like a cardiac ward here.

Interviewer: That's great. Something I could look into, might be able to add some more oomph to my paper.

Participant # 10: Right, right. Look into open heart surgery with men especially. Women too. And then with the oncology population, they're like a fourth of our population here. Even though they might be young, they might be elderly, it just depends. There are people that have never been diagnosed with anything, and they're 80 years old. Suddenly they get diagnosed with like cancer, or even heart disease, and need open heart surgery, or need chemotherapy, and they can't handle it, so they do go into like a funk of depression. But is it true depression, or is it depression from the situational, from their diagnosis, that they can get over? Because they don't have any other symptoms of depression. They just feel depressed or sad, but they don't sit in the dark. They don't stop eating. They don't stop socializing. All those things that I like, psych and depression-

Interviewer: No, that's why I picked the setting, because people who get admitted to these facilities are already either at higher rates of depression than the general public, the co-morbidity of depression and illness makes their morbidity, mortality rates greatly increase. I wanted to see how we can use this information to help this population better. Hopefully we can get some solid answers, and I think you've given me a lot to look at.

You've kind of answered this in your answers, but I want to ask this question. Do you often seek out consultations from those working in psychiatry?

Participant # 10: Oh, absolutely. All our new patients, when we first see them, sure. We definitely ask questions about, "Have you lost weight? How's your appetite? How is sleeping?" All those things that would be a trigger for if they're depressed, or, "Is this a new diagnosis for you? How have you handled stress in the past? Have you been on any medicines in the past for depression, for anxiety, things like that?"

Then we reconcile their meds, look through their meds, and we find that they are on antipsychotic, or they're on a sleeping med, or they've been on pain meds for chronic pain. You know, things like that. Or people that have been on like a slew of medicines, are on every psych med, every sleeping med, every pain med that's out there. You know that they have some sort of baseline psych disorder. We have a lot of hoarders in this place as well, and they have major psych issues as well, right, because they're hoarders. You know that that stems from somewhere. We have those people too.

Interviewer: Who do you seek out consultations for, for those people?

Participant # 10: A psychologist and psychiatrist. He comes weekly. We actually found a new person, and we had a nurse practitioner who was a PhD nurse practitioner in psych, but she wasn't very beneficial to us because she didn't come very often. She maybe came once a month, once every six weeks. That didn't help us because patients are here now and they're not here for that long, or for sub-acute rehab, and so we really need somebody weekly, especially if they were diagnosed recently in the hospital, or they had a long-standing history of psych problems or anxiety.

Now we have a guy who comes. He's a gerontology psychiatrist, and he comes once a week. We've had him all summer, and it's been wonderful, because he sees every single patient on the list once a week. With a psychologist.

Interviewer: Can I ask, do you ever order neuropsych testing?

Participant # 10: Absolutely. A lot.

Interviewer: Can you tell me why?

Participant # 10: Patients who have problems with memory, or they haven't really necessarily been diagnosed with dementia, or they live alone, and they're not safe to live at home alone. Frequent readmission to the hospital because of memory, or left their stove on, they didn't know they did, but family says they're all okay. "My mom's 80 years old, she's always been fine." Or even a 70-year-old. We've had a 50-year-old who was diagnosed with early dementia. I mean, for reasons of

starting the car, and then leaving the car on and walking out of the car, doing things that are ... Or driving into a pond, or, you know, people do things that aren't their norm, but the family's kind of in denial.

For those people that, we order neuropsych all the time, to make sure that they can go home safe, that their decisional making, so the neuropsych exams are done. That's why the nurse practitioner PhD nurse was not good for our area, because we need to know the answer like today. With neuropsych testing, we need a note in the chart that day or the next day. The notes we didn't see, the note's in the chart for like six weeks. Well, that didn't help us to tell us if the patient's safe to go home or not, alone.

If they do have dementia, and it gives us proof to give to the family that, "Hey, neuropsych saw this patient. They're recommending this, these things." Then the family's like, "Oh," because it's from a doctor, from a PhD. They acknowledge it, and they're okay with it. But they-

Interviewer: In my experience, a lot of my families that have patients that undergo neuropsych testing, they want that testing done to validate their findings of that.

Participant # 10: Some do, some don't. We have a lady right now who we're recommending neuropsych because she was diagnosed with dementia, but the family said she does not have dementia. He wants to start her on Aricept, but the family said, "No, I don't want her on that medicine." Because she doesn't have dementia. But she keeps falling, and she lives alone at home, and so they're going to put her in assisted living, which is a good choice for this lady, it's perfectly fine, but her dementia is only going to get worse. It's actually gotten worse

Interviewer: Yeah, without the Aricept, too, it might go a little quicker.

Participant # 10: Right, right.

Interviewer: I just have one last final question.

Participant # 10: Yeah? Did I help you at all?

Interviewer: Yes, you did. No, you did. Perfect answers. You said so many things that other people said, so when I have professionals that are all saying the same thing, that is exactly what I am looking for, so that I can take that to the new generation of nurse practitioners and say, "This is what the pros do. This is what their experience is. Please do what they do." Obviously there's new evidence that comes out all the time. You clearly follow that, but there's a lot of things we do that will never be studied that make sense to do.

The last question. You can answer yes or no. Do you have somebody that you might be able to refer to me to answer these questions?

Participant # 10: I do.

Interviewer: Awesome. I'm going to turn this recorder off. Thank you for your participation.

Participant # 10: Let me ...

INTERVIEW #11

Interviewer: What is your experience with treating depression in the nursing home?

Participant #11: We encounter patients that have depression a lot in the nursing home, among the elderly population. If I were to estimate what percentage of my population have current or a history of depression, probably would say like 90%. I encounter it a lot. Luckily in the nursing homes where I currently work at, we have a psychiatrist that comes weekly, so that really helps me managing these patients, and managing their symptoms, and diagnosis. I personally am a newer NP, and I don't have a psych background, so that help is really ... Really helps me.

Interviewer: Question number two. What are the tools that you use to assess your patients, specifically for depression?

Participant #11: I typically consult a psychiatrist or psychologist in the setting, or we can use like scales-

Interviewer: What kind of scales?

Participant #11: To evaluate. Like Mini-Mental, there's multiple scales out there.

Interviewer: Any one you find particularly useful?

Participant #11: Mini-Mental is fine, but there's-

Interviewer: You ever use the PHQ9, geriatric depression scale?

Participant #11: Yes, but typically our psychiatrist will use them, or psychologist, or our social worker on admission to the facility. We, as nurse practitioners, don't usually use them ourselves. Typically they're already done and we have the results available.

Interviewer: Let's say you do diagnose depression, let's say it snuck through the cracks. Once you diagnose that, and you decide to move forward with treatment, what does your follow-up consist of?

Participant #11: Follow up of depression?

Interviewer: Just the treatment process?

Participant #11: Typically I like to evaluate how long the patient has had depression. Is it based on a situation, or is this something that's kind of embedded within them and is not based on a situation, on a bad situation that might've happened to the patient? I like to try non-pharmacological treatment initially versus giving these patients medications. Especially the elderly patients, because the medications

used for depression have a lot of side effects and interactions. Not all, but for the most part they do.

Interviewer: Could you give me an example of the side effects that you're wary of?

Participant #11: Like Serotonin syndrome, drowsiness, there's so many out there. Suicidal ideation with some of these antidepressants. Especially with the elderly who are a fall risk, or already have co-diagnosis of dementia. I don't really like to put them on medications unless I have to, unless it's clinically necessary, and unless non-pharmacological treatment such as counseling, spending time with family, joining a support group, those types of things don't work.

Interviewer: Great. That kind of leads into my question, which is number four. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #11: I think that I am satisfied with my ability to treat depression holistically, but as far as managing depression with medications I do find myself needing the help of a psychiatrist or a psychologist, being a new FNP.

Interviewer: I'm going to have you explain more when you answer the next one. Which is, do you often seek out consultations from those working in psychiatry, and if so, could you explain what they do?

Participant #11: Correct. I seek out consultations very regularly. At my current rehab facility the psychiatrist comes once to twice a week. We put them on consult for patients who have active depression, or patients who have unmanaged depression, or a history of depression. Especially patients on antipsychotics, or multiple medications for depression. Typically I have a one-to-one meet with the psychiatrist every time he comes to the facility. We talk about the patients that we're putting him on consult, and why, and what medications they're on. Then the psychiatrist goes on to evaluate the patient, and change the treatment regimen if it needs to be changed.

Interviewer: One thing that keeps coming up through my interviews is neuropsych testing. Could you tell me what you think about neuropsych testing, or if you use it?

Participant #11: Sure. Typically we'll use the neuropsych testing if we want to evaluate whether or not a patient has competency to make their own decisions. We would obtain it if we come into a situation where the patient has no relatives, we're not sure that they can make their own decisions. That's one we usually get that type of consultation. In this particular rehab we don't really have those types of patients too much, but in another rehab where I used to work at we did, and we used it quite often.

Interviewer: Great. Last question, you can answer with a yes or a no. Might you have a colleague that would be willing to answer these same questions?

Participant #11: I think so. Yes.

Interviewer: Excellent. Thank you for your time. Have a great day.

INTERVIEW #12

- Interviewer: This is interview number 12. Question one: what is your experience with treating depression in the nursing home setting?
- Participant #12: I think it's undertreated, possibly.
- Interviewer: So, do you treat depression?
- Participant #12: We do treat depression, but most of the time we would usually refer to psychiatrist or psychologist. We can start the patient on a low dose Lexapro. That's usually what we do because of the least interactions. Lexapro has the least interactions, so we can initiate it, but even though, we would refer the patient to psychiatrist.
- Interviewer: So, for you to start Lexapro can I assume correctly that you're diagnosing depression to do it?
- Participant #12: Well, it's either diagnosed by an assessment when the social services probably interview-
- Interviewer: Do you ever diagnose it, like if it snuck past the social service?
- Participant #12: I have not diagnosed.
- Interviewer: Okay.
- Participant #12: So far.
- Interviewer: That works. So-
- Participant #12: Usually they come with the diagnosis of depression, they state they're depressed, I mean if they feel down in the last weeks, no pleasure in the usual activities. You can diagnose them with the depression, start them on a low dose antidepressant, an SSRI, and go from there.
- Interviewer: That leads into my next question, number 2: what are the tools that you use to assess your patient specifically for depression? So, it sounds as if sometimes people do have symptoms that you do catch that somebody else doesn't catch.
- Participant #12: Correct, for the tool technically I haven't used any tool, personally.
- Interviewer: I'm thinking you use your clinical judgment-
- Participant #12: Clinical judgment.

- Interviewer: Clinical experience?
- Participant #12: Yeah, correct, but not the particular tool. There is a mini-mental scale. As I'm saying, this is not a long-term. Most of the time they will come, this is a subacute rehab, so the patients that come here are either diagnosed with depression and already on something, or they, if something comes up, usually we refer to psychiatrists in subacute setting to diagnose for depression.
- Interviewer: Do any of your patients ever go to nursing homes from here?
- Participant #12: We do have couple of them that continue as a long-term patient.
- Interviewer: Great, then that completely qualifies. That's exactly what I was looking for. So, looks like-
- Participant #12: But we don't treat long-term patients unless there is a specific request.
- Interviewer: Okay. As long as you take care of the patient on the continuum, which it sounds like you do, then I can keep going forward with the questions.
- Let's say you decide to move forward with the Lexapro, question three asks: what does your follow-up consist of?
- Participant #12: The follow-up would consist of assessing the changes in behavior, after a week follow-up. Usually it takes three to four weeks, so I can't say that any changes can be visible after a week. Maybe psychologically as a placebo they can say they feel better. I have seen that.
- Interviewer: Okay. That's a great answer.
- Participant #12: But, you've got to follow up on a weekly basis.
- Interviewer: That makes sense. Are you satisfied with your ability to recognize and treat depression holistically? Meaning the whole person.
- Participant #12: I know. I think that here I have no reason, this setting, majority of people are depressed or lonely. So long as it's one, I would say, of the biggest factors of depression. Either the person lives alone, is single or does not have a good family support. The family is out of state or far away. Those people are mostly affected with depression. If they have a good family support and good friend circle, usually they are not depressed.
- Interviewer: Do you do anything about your patient's loneliness to help them?

- Participant #12: If they are here there is a lot of activities going on. It's different when they are here, they have therapy that sort of cheer them up, distract them from the depressive thoughts. They're pretty busy.
- Interviewer: Do you ever encourage staff to, let's say get a depressed patient ... Can you make sure that patient goes to activities?
- Participant #12: Oh yes.
- Interviewer: Excellent.
- Participant #12: We do that.
- Interviewer: That's one really good thing to treat people holistically.
- Participant #12: I think, Bryan, that here, this is a subacute setting, so it's a little different than the long term care would be.
- Interviewer: So, in your setting, question number five: do you often seek out consultations from those working in psychiatry, being a psychiatrist or a psychologist or social workers, therapy?
- Participant #12: Oh yeah. All the time.
- Interviewer: Can you give me an example?
- Participant #12: Consultation would be seeing the activity person. Just consult with them, letting them know what's going on with the patient. They can engage the patient more if I can do activities. Usually those are the patients that are either demented. I will say, (garbled) the but demented mostly.
- There is depression and dementia a lot, going hand by hand. Yes, we do. We do communicate that to the activities, to the therapists so they're a little bit more engaged. CNAs are often involved because they have to be involved with the care, so they will take them here for a movie or distract them in any way possible.
- Interviewer: Do you ever consult the psychiatrist yourself?
- Participant #12: When I was a support nurse I did, in that case. Not as an NP.
- Interviewer: Not in this particular setting?
- Participant #12: Not in this particular setting. I would talk to the psychiatrist, give him a heads up, what's going on with the patient, why we're seeking the consult.

Most of the time the patients are, when they come to subacute rehab, they're all already on either Lexapro or Celexa. They do start in the hospital the patients are not even aware that they've been on antidepressants. So, when they hear that they're on antidepressants, because here they require consent for the treatment, and they get surprised. Majority of them, eight out of ten people would get surprised that they're on antidepressants.

Interviewer: People aren't telling them?

Participant #12: No.

Interviewer: Oh, wow. That's weird.

Participant #12: It's really interesting. So, and they will seek, when they want to get off the antidepressants. We have cases, you just can't take them off the antidepressant like that so they have to be tapered down. In that case I would consult, you know, I would talk to the psychiatrist explain what the problem is.

We had a patient that wanted to, and the family, to wean off the antidepressant, but after talking to the psychiatrist they decided they're going to continue with the Lexapro. It's in the diagnosis and what's going on.

Sometimes it's really interdisciplinary approach.

Interviewer: My last question is a yes or no question: do you have anybody that might be able to answer the same questions you've answered?

Participant #12: No.

Interviewer: Thank you.

INTERVIEW #13

Interviewer: This is interview number 13. Here's question one. What is your experience with treating depression in the nursing home?

Participant #13: My experience with treating depression in the nursing home was in a psychiatric nurse practitioner consultation role. Where I would go in, if a nursing home administrator or primary care attendee provider would put in a referral. Usually for elderly patients with depression.

Interviewer: Okay. What are the tools that you use to assess your patients, specifically for depression?

Participant #13: I use the symptoms of depression via the DSM or the Columbia rating scale, were the main two that I would use.

Interviewer: I'd like to ask a side question. Do you ever use the PHQ9?

Participant #13: Yes, I've used that too.

Interviewer: Okay. When you ... Number three is what does your follow up consist of? So, you've found depression in someone, what do you do?

Participant #13: I will do a mental status exam. Look at their medical history. Look at ... Interview the nursing home staff primarily, that are during the day-to-day care, which would usually be the charge nurse or the assistant nursing director, the nursing director themselves of the nursing home. They would pretty much know all of the history and then also talk with the family. And learn how long they've been sad. What was the precipitance, was there any neuro-vegetative symptoms, in terms of their appetite. Which was a common symptom, of having decreased appetite. Hopelessness. Just low energy and some suicidal, passive suicidal thoughts of ...

Usually cause it was co-existing of losing their independence. Losing their health and being in a nursing home was the biggest trigger.

Interviewer: I can see that

Participant #13: But they may have had depression as a long-term history, on top of whatever led to them having to be in the nursing home.

Interviewer: Okay. Thank you. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #13: Actually, no, because you're kind of bound when they're in a nursing home, it's not really too much holistically. I mean, they ... The food is bad, they're

understaffed. It's so quick to see them. A lot of them are demented and are not really responsive when they're ... well, in the nursing home. So holistically, I don't think the opportunity even presented itself to do that holistically. Because, you know, if you look at faith, okay, so that wasn't fully addressed unless it was a person's and their family to do that. The family was pretty much the biggest piece and if they didn't have family then it felt like they were just in an institution. Just being rarely just cared for in terms of just their physical part. You know, just getting them up and having contact but I don't think that there was lot of opportunity for full, holistic care.

Interviewer: I like that answer. You were the second person to mention food. First person to mention faith. I like that. Everyone takes that word holistically and they have their own definition and I am fine with that cause I think it really just means treating the person as a whole. Outside of just ordering medication. And I think your answer was great and honest. Do you often seek out consultations from those working in psychiatry? So clearly, you work in psychiatry but do you ever look for additional help?

Participant #13: With what type of patients?

Interviewer: So, let's say your ... Had a patient who's possible depressed and you want to rule out dementia versus Alzheimer's to see if that treatment plan will be different.

Participant #13: Oftentimes, by the time they do the psych consult, they pretty much kind of already are in that state or some of them are already being followed by neuro. In terms of their depression or dementia on top of. Or early dementia or Alzheimer's. Yeah, a lot of them were already ...

Interviewer: So, let me ask you a side question. Do you ever consult social work?

Participant #13: I have not because usually that's already done out the gate. Soon as they come in, they're already managed.

Interviewer: So, you never identified depression on your own prior to admission?

Participant #13: No.

Interviewer: Okay.

Participant #13: No, it was always a consultation. And usually the biggest consultation was decreased appetite and sleep and the biggest ... you know, Mirtazapine was their biggest ...

Interviewer: You're the second person to mention adjusting Remeron

Speaker: And a couple of occasion it didn't work as well as it was supposed to. Then they would be ... Some of them were co-morbidly anxious or psychotic.

Interviewer: When I was preparing this, some of the research that I found said that those medicare forms, the CMS forms. They were really lengthy in admission and they get the patient to self-report but for some reason many patients go undiagnosed at that point and it isn't until they do face-to-face in person that they really get a true reporting of depression. Alright, so we are ...

Participant #13: Usually it's the nursing people who are taking care of them or the social work that's taking care of them. They've already noticed it based on if they're not eating or moving or talking.

Interviewer: Right. Last question. You can answer with a yes or no. Do you have any colleagues that may be willing to answer these questions?

Participant #13: No.

Interviewer: Thank you very much. This will conclude the interview.

INTERVIEW #14

- Interviewer: This is participant #14 and we're going to begin with question number one. What is your experience with treating depression in the nursing home or nursing home patients?
- Participant #14: I've had a few patients that have come from nursing homes. Also patients who I have seen that were not in a nursing home that I had ended up hospitalizing and recommended discharge to a nursing home for a few months. Then they were again discharged. It is not, I guess, super frequent that I see patients from nursing homes, but I have had several. Once they have gone to the nursing home, I typically have not had much interaction with the providers there. Once they leave, I usually get faxed discharge paperwork and then ... Yeah. Then they follow up and continue their treatment after that.
- Interviewer: What are the tools that you use to assess your patients specifically for depression?
- Participant #14: Tools. I do screening scale with the PHQ-9 and then other than that, I typically just go over any symptoms from the DSM, evaluate the length of time that they've been experiencing the symptoms and what the change in baseline is, but the main screening tool would be the PHQ-9.
- Interviewer: You got it. That's the majority of the responses. All of a sudden, you notice there's depression. What does your follow-up consist of? Do you ever follow up once they leave your hospital setting?
- Participant #14: In terms of inpatient or ...
- Interviewer: Both. Do you do inpatient?
- Participant #14: Rarely.
- Interviewer: Okay.
- Participant #14: Mostly it's outpatient. Typically if someone comes to me with depression, I will either start them on medication, adjust their medication and if they're starting on a new medication, I typically see them back like two weeks.
- Interviewer: Two weeks? That's great.
- Participant #14: If they are still depressed and not really wanting to change medications, I'll see them back in about a month. Sometimes they're just resistant to changing medication if they're had chronic depression and have been on medications for a long time. I also typically have done GeneSight testing. I

do that a lot, especially for patients who have chronic depression that have not really seen great results from their medication. The genetic testing has really helped to sort of rule out some of the 450 enzyme systems.

Interviewer: Is that fairly expensive for the population you see?

Participant #14: Actually, no. Anyone with Medicaid or Medicare, it is completely covered, which is wonderful because the majority of our patients have Medicaid/Medicare. There have been a few people who I've not been able to do it for because they have private insurance, but most of the population here is Medicaid/Medicare so it's completely covered.

Interviewer: Next question. Thank you very much for that answer. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #14: I think for the most part, I would say yes. In terms of pharmacotherapy and personal individual talk therapy, I think in those respects, yes. I tend to wish I had more resources of systems that are available to patients in the community that would be more helpful to them. I find so many patients, sometimes I'm spinning my wheels because a lot of them, their environment is so bad that even the medication and the therapy, it doesn't really ... They're not really getting anywhere because their environment is so bad. I wish that I had more access to programs that were available to them. I think that's mainly the missing link, but other than that, I think yes, I'm satisfied with that.

Interviewer: Do you ever ask staff members to take special care of certain individuals? Do you ever have them monitor food or sleep or involvement in milieu activities?

Participant #14: Here, I try to refer as many people as I can for individual therapy if they're willing. Once they're referred here for individual therapy, they're preserved sort of on the other side of the floor here. We will collaborate on sort of a case-by-case basis to see what has been discussed in therapy and what progress we're making with medications to see if there's anything that needs to really be tailored. We also have case managers here and that has been really helpful in terms of the last question before this about the holistic approach because they have more access to the programs that are available. In terms of milieu setting I don't really do much with the inpatient work. So, yeah.

Interviewer: The last question. Question number five is, do you often seek out consults from those working in psychiatry? You've already said you seek out therapists. Do you frequently speak with psychologists or psychiatrists?

- Participant #14: Yes. I have a collaborating physician who I speak with regularly, but it's more of a case-by-case basis as well. If I need some extra insight or more opinion on the matter, we'll collaborate and discuss, especially particularly interesting cases. We do have a psychologist that works in the office and I don't necessarily collaborate with him any more than the therapists, but in a similar fashion, if there was a certain person that we're both seeing and treating, we'll collaborate on them and discuss their cases.
- Interviewer: A common theme I'm getting is a lot of ... Especially in the nursing home setting, neuropsych testing. Do you find yourself ordering that?
- Participant #14: No, I do not. A lot of times the population is not able to really afford neuropsych testing.
- Interviewer: \$1,200.
- Participant #14: Yeah. That's the biggest limitation more than anything.
- Interviewer: Okay. My last question you can answer with a yes or no.
- Participant #14: Okay.
- Interviewer: Do you have anybody that might be able to answer these same questions that you just answered?
- Participant #14: No.
- Interviewer: Okay. Thank you so much. Have a great day.

INTERVIEW #15

- Interviewer: This is participant #15. Let's start with question number one. What is your experience with treating depression in the nursing home or the nursing home setting?
- Participant #15: I'm trying to figure out how to be succinct. I've had a fair amount of experience treating depression in older adults. Some have been in the nursing home. Some have not.
- Interviewer: Okay, perfect. What are the tools that you use to assess your patients specifically for depression?
- Participant #15: What is the tool? It's kind of the standard. They're the standard questions. I don't think I have a tool out in front of me. Essentially I look at ... I think that might be related to another question. Oh, PHQ-9 is what some places have given me and others have not been doing research on it so they haven't been collecting the data.
- Interviewer: Let me just clarify. You sit down with the patient.
- Participant #15: Right.
- Interviewer: You were diagnosing depression. What tool do you use? I don't want to put any words in your mouth, but do you always go off of let's say a standardized form or do you use a different method?
- Participant #15: I usually do the interview. It's more of an interview with me and if there is a form that depending on where I am and there is a form to use, I'll use the form as well. But always it's more of an interview and understanding that person in the full context. They can answer the questions, but then you've got cultural factors also that play into it. Understanding the person and what their prior behavior was like.
- Interviewer: Okay. Number three, what does your follow-up consist of? You've determined someone has depression. You've decided a course of action. We're working on that course of action. What do you do next?
- Participant #15: If I start somebody on medications to treat the depression, then I want to see them within two weeks. Sometimes a week. Then the follow-up goes from there. Once they've been on the medications for a month and they're doing okay, there are signs of improvement, then I might push it out to a month. Generally, it's every two weeks for two to three times with the older adult because they can change rapidly.

Interviewer: Got it. Good answer. Are you satisfied with your ability to recognize and treat depression holistically?

Participant #15: Yes.

Interviewer: Can you give me an example?

Participant #15: Yes. One patient stands out for me. It's kind of straightforward I think, but for whatever reason, she stands out. This is a woman who came to me with problems with sleep, problems with feeling sad and blue, never had had this before, had always been active. She was a teacher and she was close to retirement or trying to decide whether she was going to retire. She had a lot of pressure at work. It was a catholic school. She had always been proud to be there, but they seemed to be looking for ways to have some people leave and bring in new people so they were being tested and observed. This was stressful for her. She wasn't sure why because she said, "You know, I know what I do and I know when I'm good and I know when I'm not and I know what I don't know." She said, "I can't sleep." She had lost quite a bit of weight. She was very anxious about her day-to-day responsibilities and doing them correctly.

I think it was a situational depression, but it had gone long enough so that it had become more of a full-blown depression. It started out situationally, but it was impacting her whole life. She was not feeling much pleasure in life, not wanting to do the usual things that she did. She always had a lot of get up and go. Anyway, I treated her for depression with Lexapro, which helped her to sleep because sleep had been one of the problems. She slept and she started feeling better probably within a month. She was feeling like she was getting back to her normal self. When she did get better, we sustained it. I had educated her about depression and wanted her to stay on the meds for at least probably close to a year. Then if she wanted to come off, we'd wean her off because it explained about the chemicals having to stabilize.

Anyway, she did all that, but she really was fearful of coming off so she never did come off the meds with me. She never did stop them. There would be something else. She was more in tune with that maybe she had been depressed earlier in her life, but just kept busy and ignored it. It wasn't serious enough.

Interviewer: I like your answer. Yeah, I see where your view of holism comes in.

Participant #15: Yeah.

Interviewer: Okay. Do you often seek out consultations from those working in psychiatry?

Participant #15: Not too often, but if I have a complicated case that is kind of stymieing me a little bit, then I do. I mean it's pretty easy to do and it's always fun to talk about cases. You always get another view.

Interviewer: A fresh pair of eyes.

Participant #15: A fresh pair of eyes. Yes.

Interviewer: Last question - yes or no - do you know anyone else that might be willing to answer these questions?

Participant #15: Let me see. Linda Hale. No names? Okay.

Interviewer: I'll take care of it. Thank you and this concludes the study. Thank you.

Participant #15: That's it?