Section D
Mood

Intent
To assess the resident's perception of his/her mood and psychosocial well-being.

To record staff observations of indicators of the resident's mood and psychosocial well-being.

To identify and immediately protect residents who may be at risk for self-harm.

Significant Changes
D0200, D0500, D0600 – Beginning of or decrease in number of sad or anxious mood pattern

Care Area Triggers
D0200, D0600 – Mood State
D0200, D0500, D0600 – Psychosocial Well-Being

Quality Indicators
D0200, D0500, D0600 – Symptoms of Depression

Enhanced Quality Measures
D0200, D0500, D0600 - Percent of residents who have become more depressed or anxious

RUG IV Categories
D0200, D0500 - End Splits: Special Care High, Special Care Low, Special Care, Clinically Complex

Skilled Charting
Depression

Care Plans
Depression
Anger
Anxiety
Depression
Fear
Insomnia
Paranoia
Social Isolation
Suicidal Ideation
Withdrawal from Care / Activities

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents	
	0. No (resident is rarely/never understood) → Skip to D0500-D0650, Staff Assessment of Resident Mood. **1. Yes** → Continue to D0200, Resident Mood Interview (PHQ-9)

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

0. No (resident rarely/never understood) → Skip to D0500-D0650, Staff Assessment
1. Yes → Continue to D0200, Resident Mood Interview (PHQ-9)

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

D0200. Resident Mood Interview (From PHQ-9) 14 day look back

RUG – End Splits: Special Care High, Special Care Low, Special Care, Clinically Complex
QI – Symptoms of Depression CAT – Psychosocial Well-Being CAT – Mood State
EQM – Percent of residents who have become more depressed or anxious

The 9-Item Patient Health Questionnaire (PHQ-9© Pfizer Inc.) for residents who can report mood symptoms. Based on the Diagnostic and Statistical Manual of Mental Disorders, 4th Revision (DSM-IV) criteria, it is a more useful tool for screening because it allows for a defined threshold score that triggers attention and a summed score that can track changes over time.

Explain the reason for the interview before beginning.

Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

For each question in **Resident Mood Interview** (D0200), read the item as it is written.

Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for himself what "tired" means; the item should be scored based on the resident's interpretation.

Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.

Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated.

Select only one frequency response per item. If the resident has difficulty selecting between two frequency responses, code for the higher frequency. Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
Noncommittal responses such as "not really" should be explored. Probe by asking neutral or nondirective questions such as: "What do you mean?" "Please be more specific."

Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"

A. Little interest or pleasure in doing things **CAT - Activities**

B. Feeling down, depressed, or hopeless **C. Trouble falling asleep, or sleeping too much**

D. Feeling tired or having little energy **E. Poor appetite or overeating**

F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

G. Trouble concentrating on things, such as reading the newspaper or watching television

H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving a lot more than usual.

I. Thoughts that you would be better off dead, or of hurting yourself in some way
The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc). Follow facility protocol for evaluating possible self-harm.

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident, "*about **how often** have you been bothered by this?"*
Read and show the resident a cared with the symptom frequency choices. Indicate response in column 2, Symptom frequency.

A resident card for symptom frequency can be found on the following page.

Symptom Presence
0. **No** (Enter 0 in column 2)
1. **Yes** (Enter 0-3 in column 2)
9. **No** Response (Leave column 2 blank)

Symptom Frequency
0. **Never or 1 Day**
1. **2-6 Days** (Several days)
2. **7-11 days** (Half or more of the days)
3. **12-14 Days** (Nearly every day)

How often have you been bothered by the problem during the past two weeks?

Never or 1 Day

2-6 Days (Several days)

7-11 days (Half or more of the days)

12-14 Days (Nearly every day)

D0300. Total Severity Score		
		Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (Symptom Frequency is blank for 3 or more items.)

D0300. Total Severity Score CAT – Psychosocial Well-Being
QI – Symptoms of Depression CAT – Mood State
EQM – Percent of residents who have become more depressed or anxious

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

Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:

Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.

Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).

In addition, PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
1-4: minimal depression
5-9: mild depression
10-14: moderate depression
15-19: moderately severe depression
20-27: severe depression

D0350. Safety Notification– Complete only is D0200I = 1 indication possibility of resident self-harm	
	Was responsible staff or provider informed that there is a potential for resident self harm? **0. No** **1. Yes**

D0350. Safety Notification

Complete only is D0200I = 1 indication possibility of resident self-harm

Was responsible staff or provider informed that there is a potential for resident self harm?
0. No 1. Yes

The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc). Follow facility protocol for evaluating possible self-harm.

D0500. Staff Assessment of Resident Mood Interview (From PHQ-9OV)		
Do not conduct if Resident Mood Interview (D0200-D0300) was completed.		
Over the last 2 weeks, did the resident have any of the following problems or behaviors?		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency. **Symptom Presence** 0. **No** (Enter 0 in column 2) 1. **Yes** (Enter 0-3 in column 2) **Symptom Frequency** 0. **Never or 1 Day** 1. **2-6 Days** (Several days) 2. **7-11 days** (Half or more of the days) 3. **12-14 Days** (Nearly every day)	**1. Symptom Presence** **Enter Scores in Boxes**	**2. Symptom Frequency**
A. Little interest or pleasure in doing things		
B. Feeling down, depressed, or hopeless		
C. Trouble falling or staying asleep, or sleeping too much		
D. Feeling tired or having little energy		
E. Poor appetite or overeating		
F. Feeling bad about yourself – or that you are a failure or have let yourself or your family down		
G. Trouble concentrating on things, such as reading the newspaper or watching television		
H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving a lot more than usual.		
I. Thoughts that you would be better off dead, or of hurting yourself in some way		

D0500. Staff Assessment of Resident Mood Interview (From PHQ-9OV) 14 day look back

RUG – End Splits: Special Care High, Special Care Low, Special Care, Clinically Complex QI – Symptoms of Depression CAT – Psychosocial Well-Being CAT - Activities EQM – Percent of residents who have become more depressed or anxious

Do not conduct if Resident Mood Interview (D0200-D0300) was completed.

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

A. Little interest or pleasure in doing things

B. Feeling down, depressed, or hopeless

C. Trouble falling or staying asleep, or sleeping too much

D. Feeling tired or having little energy

E. Poor appetite or overeating

F. Feeling bad about yourself – or that you are a failure or have let yourself or family down

G. Trouble concentrating on things, such as reading the newspaper or watching television

H. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving a lot more than usual.

I. Thoughts that you would be better off dead, or of hurting yourself in some way

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

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

Symptom Frequency 0. **Never or 1 Day** 1. **2-6 Days** (Several days)
2. **7-11 days** (Half or more of the days) 3. **12-14 Days** (Nearly every day)

D0600. Total Severity Score		
		Add scores for all frequency responses in Column 2, Symptom Frequency. Total score may be between 00 and 30.

D0600. Total Severity Score

QI – Symptoms of Depression
CAT – Psychosocial Well-Being **CAT – Mood State**
EQM – Percent of residents who have become more depressed or anxious

Add scores for all selected frequency responses in Column 2, Symptom Frequency. Total score may be between 00 and 30.

Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:

Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.

Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).

In addition, PHQ-9© **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
1-4: minimal depression
5-9: mild depression
10-14: moderate depression
15-19: moderately severe depression
20-27: severe depression

D0650. Safety Notification – Complete only is D0500I = 1 indication possibility of resident self-harm	
	Was responsible staff or provider informed that there is a potential for resident self harm? **0. No** **1. Yes**

D0650. Safety Notification

Complete only is D02200I = 1 indication possibility of resident self-harm

Was responsible staff or provider informed that there is a potential for resident self harm?
0. No 1. Yes