Home Health Care Nurse Perceptions of Geriatric Depression and Disability Care Management

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Purpose of the Study: Psychosocial interventions alone or combined with antidepressant medication can effectively treat mild to moderate geriatric depression. However, most home health care patients with depression and disability do not receive these interventions. Moreover, relatively little is known about home health care nurse views about depression management. Therefore, our research purpose was to provide a deeper understanding about how home health care nurses perceive and experience depression detection and evaluation within the context of caring for geriatric patients with disabilities.

Design and Methods: This qualitative descriptive study involved 2 focus groups and 16 semistructured interviews with nurses providing care to geriatric home health care patients followed by observation during 25 nurse home visits to geriatric patients who had depression and disability.

Findings: Nurses demonstrated confidence in caring for elderly patients with disabilities. However, they expressed different views about the nature of depression and the integration of depression and disability care in daily practice. Evidence points to a need for advanced training that supports an enhanced role for generalist homecare nurses in providing depression care management for this vulnerable geriatric population.

Implications: Policy challenges are associated with ways in which home health care is fiscally organized primarily to address patients’ physical and acute skilled care needs and not depression.

Key words: Depression management, Home health care, Disability maintenance/improvement, Therapeutic nurse–patient relationship, Chronic care model

Depression is a common problem in older adults and is widely prevalent among persons who, due to illness and/or disability, are receiving services from a certified home health care (HHC) agency (Brown, McAvay, Raue, Moses, & Bruce, 2003; Bruce et al., 2002). There is also strong evidence of a mutually reinforcing association between depression and disability. Disabling conditions, chronic illnesses, and medical comorbidities make individuals vulnerable to depression; and the more persistent and severe physical impairment becomes the stronger and larger the...
effect on depression (Barry, Soulos, Murphy, Kasl, & Gill, 2013; Bruce, 2001, 2002). The negative spiraling trajectory results in further reductions in activity and social interaction, leading to poorer health and worsening disability over time (Barry, Allore, Bruce, & Gill, 2009).

There is growing evidence that the psychological distress of comorbid depression can exacerbate disability associated with chronic illnesses. (Schmitz, Wang, Malla, & Lesage, 2007). Depression may also be antecedent and contributory to chronic disease. Consequently, different intervention strategies may be required for long-standing premorbid depression in contrast to treatment of depression arising out of illness or disability (Almeida, 2012).

The burden of comorbid disability and depression in HHC patients is substantial, resulting in increased use of outpatient, HHC, and physician services, increased use of nursing home placement, and 2–3 times higher rates of hospitalization (Byers, et al., 2008; Friedman, Delavan, Sheeran, & Bruce, 2009; Gellis, 2009; Middleton, Hung, & Xu, 2007; Sheeran, Byers, & Bruce, 2010). Depression may reduce motivation to adhere to healthy behaviors, such as physical activity, while competing demands to address medical comorbidities can divert attention and resources away from treating the underlying mental health problem (i.e., depression). Failure to effectively treat depression and address its impact on disability in HHC is associated with increased morbidity, disability, suicide, and mortality from other causes (Brown et al., 2004; Raue, Meyers, Rowe, Heo, & Bruce, 2007).

Despite this evidence of untoward health outcomes, late-life depression can be treated effectively, as demonstrated by treatment studies that report a high percentage of older patients with depression responding well when provided with adequate depression care (i.e., antidepressants; Pickett, Raue, & Bruce, 2012; Turvey & Klein, 2008). Pharmacological and psychotherapeutic treatment of depression in HHC patients also has increased over the past decade (Pickett, Raue et al., 2012; Shao, Peng, Bruce, & Bao, 2011). Nevertheless, many HHC patients with clinically significant depressive symptoms often remain untreated or are being treated inadequately (Bruce et al., 2002; Ell, 2006; Pickett, Raue et al., 2012). Furthermore, HHC patients often consult a primary care physician (PCP) for treatment when they develop depression symptoms rather than a mental health provider. Many times these PCPs do not follow evidence-based guidelines in prescribing or in adjusting treatment in response to persistent symptoms that may lead to undertreatment or even overtreatment of depression (Bruce et al., 2007; Mojtabai, 2013; Pickett, Weissman, & Bruce, 2012; Weissman, Meyers, Ghosh, & Bruce, 2011). Studies documenting the problems of under-recognition, undertreatment, and overtreatment of HHC patients have led to initiatives aimed at improving depression assessment, referral, and treatment, including Centers for Medicare and Medicaid Services (CMS)-broadened criteria for depression assessment questions using the HHC assessment tool Outcome and Assessment Information Set (OASIS-C; CMS, 2010, 2011).

**Depression Management and HHC Nursing**

HHC nurses are in an optimal position to deliver psychosocial treatments that address both depression and disability (Suter et al., 2008; Thompson, Lang, & Annells, 2008). In contrast to a larger number of studies on the role of HHC nurses in depression screening, referrals, and medication adherence, there are fewer that demonstrate HHC nurse potential to assess and deliver depression care management in collaborative interprofessional practice. Examples are the Depression CAREPATH intervention by Bruce and colleagues (2011), designed to be delivered by nurses, therapists, and primary providers in the home, and the home-based chronic care model by Suter and colleagues (2008), designed to provide comprehensive care for HHC patients with multiple chronic illnesses. However, there is a paucity of studies that capitalize on HHC nurses’ unique opportunity to integrate delivery of both depression and disability care management within the HHC episode. Evidence suggests that nurses can have a broader role, in collaboration with other professional care providers, in sustaining depression treatment through psychological interventions delivered as part of the therapeutic nurse–patient relationship (Suter et al., 2008). This relationship is the core component of the HHC nurse intervention process through which nurses deliver education, brief counseling, and continued monitoring of depression (Summers & Barber, 2003). Prior research has demonstrated that therapeutic nurse–patient interactions delivered and maintained over multiple visits have a major influence on how patients view care experiences, lead to beneficial health outcomes, and are an expected part of effective nurse care management (Hagerty & Patusky, 2003). Nevertheless, HHC agencies have been slow to acknowledge the full potential of the nurse–patient relationship with depressed geriatric HHC patients (Markle-Reid et al., 2011; Suter et al., 2008). Notably, HHC nurses are not currently recognized for the important therapeutic work they perform, which can be crucial or additive to depression care management, and it is also not reimbursed by the Medicare prospective payment system (PPS; Cabin, 2010). Moreover, relatively little is known about which therapeutic strategies can most effectively treat older HHC patients with depressive symptoms and concomitant disability (Forsman, Schierenbeck, & Wahlbeck, 2011).
Given that the focus of Medicare HHC is on physical health despite the high prevalence of depression, we separately evaluated nurse perceptions of disability and depression care management. However, since disability and depression mutually reinforce one another, we also explored nurse perceptions and experiences of integrating both disability and depression care management into their daily practice.

The aims of our study were to: (best)

- Describe HHC nurses’ perceptions of depression and disability care management.
- Identify, observationally, nurses’ use of care management and therapeutic strategies to evaluate and address depression in home visits to patients with chronic illness and disabilities.
- Assess HHC nurse skill sets that, when supported and utilized, may have valuable potential to improve patient depression and disability outcomes.

Theoretical Underpinnings

The conceptual basis for this research was the Chronic Care Model (CCM) (Wagner, Austin, & Von Korff, 1996; Wagner et al., 2001), a well-established framework for chronic care management and modification of health care delivery. The model can be applied to a variety of health care settings and patient populations, making it ideally suited to address the needs of chronically ill older persons with disabilities and mood disorders. In this study, care management components of CCM informed data analysis. We focus this article specifically on HHC nurse experiences with screening and managing patient depression when caring for geriatric patients with chronic illnesses and disabilities.

Methods

The research protocol included informed consent from all participants and was approved by the researchers’ institutional review board and by the Director of the participating HHC agency. We conducted a qualitative descriptive study (Sandelowski, 2000, 2010) from October 2011 to December 2012.

Participants

We used purposeful criterion-based sampling. The sample included 16 registered nurses who were full-time agency employees, had experience of 1 year or more working with geriatric patients, and were providing agency-based HHC services for >60-year-old persons with chronic illness, disability, and depression. Of these, 10 were prepared at the associate degree level and 6 were baccalaureate prepared. Previous experience in geriatric community health nursing ranged from 1 year \((n = 3)\), 2–5 years \((n = 2)\), 6–10 years \((n = 4)\), 11–15 years \((n = 2)\), and more than 20 years \((n = 5)\).

The sample also included five HHC geriatric patients who consented to participate by allowing the researcher (D. V. Liebel) to be present in their homes as an observer during nurse visits. They were informed of the research purpose and study procedures (i.e., observation of nurse activities during care management) and were assured that observation and recording would not occur during personal care or per patient request. Sampling criteria for patients included community-dwelling older persons (60+ years old) receiving HHC services, needing assistance in 1+ activities of daily living (ADL: bathing, grooming, eating, transferring, toileting) and 2+ instrumental activities of daily living (IADL: housekeeping/telephone); and experiencing depression (i.e., current or nonreoccurring). Patients were excluded if they had diagnosed cognitive impairment (PCP Diagnosis/Cognitive Function on OASIS-C), were receiving hospice care, or had reoccurring chronic depression that was identified by having recurring or multiple major depressive episodes (MDEs) in the past according to the Mini-International Neuropsychiatric Interview-Major Depressive Episode Module 6.0. Ages of participating patients who met these criteria (three women and two men) ranged from 60 to 89. All reported having four or more chronic illnesses (e.g., congestive heart failure, arthritis, diabetes, hypertension). All needed ADL/IADL assistance, had depressive symptoms (mean score of 4 on the Patient Health Questionnaire [PHQ-2] depression scale), and no MDE.

Procedures

The study was designed in two parts. The first part involved focus groups and individual in-depth interviews with nurses; and the second part involved home visits. D. V. Liebel conducted the data collection for both parts.

Focus Groups and Interviews

Nurses participated in two 60- to 90-min focus groups and follow-up individual semistructured interviews. Focus group and individual interviews were audio-recorded and transcribed verbatim with fieldnotes recorded after each session. Fieldnotes included ideas and impressions about the interviews and descriptions of events observed in the agency setting where the focus groups and interviews took place. See Table 1 for focus group and interview guide content fields and sample questions.

Home Visits

Home visit data were obtained over a 4-month period by accompanying participating HHC nurses on 25 patient
home visits (30–120 min). During the home visits, D. V. Liebel (a registered nurse) engaged in what Spradley (1980) has described as moderate participation, primarily observing the interaction between patient and HHC nurse and responding conversationally in socially appropriate ways. A structured observation guide (Table 1) was used to capture elements of therapeutic nurse behavior, as described by Peplau (1997). Home visits were audio-recorded and transcribed verbatim with consent. Fieldnotes also were recorded after each visit.

Table 1. Interview and Observation Guides

<table>
<thead>
<tr>
<th>Overview of guide used for focus groups and interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse attitudes and perceptions about depression and disability</td>
</tr>
<tr>
<td>Do you encounter depressed patients in your practice? What tells you that they are depressed?</td>
</tr>
<tr>
<td>Why do you think patients experience depression? Where does it originate from?</td>
</tr>
<tr>
<td>What is your role when you encounter a patient with disabilities who is depressed?</td>
</tr>
<tr>
<td>Do you think there are actions that you can take that will improve a patient’s depression? What do you do?</td>
</tr>
<tr>
<td>Do you think there are actions that you can take that will improve a patient’s disability? What do you do?</td>
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<tr>
<td>Patient self-care management</td>
</tr>
<tr>
<td>What types of *nursing case management activities do you use to support and promote patient self-care? (*diagnostic, therapeutic, disease management, community resources, health promotion)</td>
</tr>
<tr>
<td>What are your thoughts about use of the nurse-patient relationship in your case management activities?</td>
</tr>
<tr>
<td>What works best in building and maintaining the nurse-patient relationship . . . what is the hardest?</td>
</tr>
<tr>
<td>Delivery system design</td>
</tr>
<tr>
<td>How do institutional policies and procedures affect depression/disability care management?</td>
</tr>
<tr>
<td>How do economic and reimbursement factors affect depression/disability care management?</td>
</tr>
<tr>
<td>What is the presence of mental health providers like at your agency? In the community?</td>
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<tr>
<td>What is the role of agency mental health providers in caring for depressed patients? For disabled patients?</td>
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<tr>
<td>Decision support</td>
</tr>
<tr>
<td>How do you approach decisions to call or refer patients to a mental health provider?</td>
</tr>
<tr>
<td>What types of decision support for depression and disability detection and care management are available to you? How do you know which depression instruments to use? What do you think about depression guidelines or protocols?</td>
</tr>
<tr>
<td>Clinical information system</td>
</tr>
<tr>
<td>What do you think about the electronic system for tracking depression and disability?</td>
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<tr>
<td>How do you use the clinical information system to communicate with other home health care team members?</td>
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</table>

<table>
<thead>
<tr>
<th>Overview of guide used for observations</th>
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</thead>
<tbody>
<tr>
<td>Case management activities</td>
</tr>
<tr>
<td>All aspects of health/illness-related nursing care</td>
</tr>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Elimination</td>
</tr>
<tr>
<td>Nutrition</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Disability and depression management tasks</td>
</tr>
<tr>
<td>Assesses patient activities associated with patient independence (ADLs and IADLs)</td>
</tr>
<tr>
<td>Assesses signs of patient depression</td>
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<tr>
<td>Inquires about whether the patient’s doctor or other health providers talk to him/her about depression</td>
</tr>
<tr>
<td>Assesses patient relationships with family members and friends</td>
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<tr>
<td>Therapeutic relationship between nurse and patient</td>
</tr>
<tr>
<td>Evidence of being totally present physically and mentally (“being there”)</td>
</tr>
<tr>
<td>Evidence of trust (e.g., reaching out, sharing, balancing power roles)</td>
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<tr>
<td>Evidence of collaborative goal setting and negotiation</td>
</tr>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Verbal: affective communication (concern, empathy); guidance, direction, clarification; respect for lifestyle/feelings</td>
</tr>
<tr>
<td>Nonverbal: use of eye contact, body language, facial expression, affective touch</td>
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Note: ADL = activities of daily living; IADL = instrumental activities of daily living.

Data Analysis

Discussion of interview/home visit transcripts and associated fieldnotes was concurrent with ongoing data collection. This iterative analytic process facilitated evaluation of database quality and identification of topics for further exploration. Conventional qualitative content analysis of focus group/interview content (Hsieh & Shannon, 2005) involved data reduction via coding and categorization of information. The matrix approach by Miles and Huberman (1994) was
used to display the reduced data. This aided identification of patterns relevant to nurses’ views and activities regarding care management of depression and disability related to key elements of the CCM (health care system, community services, and individual patient/family levels of care). Analysis of content in the matrix led to identification of themes (Ryan & Bernard, 2003). (We refer in this report to content analysis results of home visit data related to nurse activities that were reflective of therapeutic nurse behavior. Details of observed nurse–patient interactions during these visits are the focus of another paper.) Insights from the analysis of interview and home visit data were guided by and mapped to elements of the CCM (Wagner et al. 1996, 2001).

Validation and Reliability
Several measures were integrated into the methodological design of this study to maximize rigor and enhance validity/credibility of the results (Creswell, 2007). These included triangulating multiple sources of data to corroborate findings (e.g., focus groups, individual interviews, and participant observation), collecting rich data (e.g., encouraging study participants to talk freely, seeking clarification and corroboration); peer debriefing and plausibility checking (e.g., soliciting feedback about the credibility of codes and emerging themes from expert colleagues, participating nurses, and other nurses working in local HHC agencies); prolonged engagement in the field, including an orientation to the agency and the computerized documentation system used by nurses in their care activities; and demonstration of dependability by maintaining an audit trail (i.e., a carefully organized collection of research materials and documented record of decisions governing the research process).

Findings
Care of Geriatric Patients With Depression and Disability (HHC Nurses’ Views)
Nurses demonstrated confidence in their abilities to care for elderly HHC patients with disabilities. However, they expressed different views about integrating depression and disability care in daily practice without additional training and support. Data analysis yielded four themes: balancing system and patient care, knowing how to manage depression, encouraging disability maintenance/improvement, and meeting patients where they are.

Theme 1: Balancing System and Patient Care
Time Constraints and Financially Driven Priorities.
Balancing system-level demands and direct patient-level care was described as a trade-off. The term “system” refers to the broad system of health care regulated by the CMS and to policies governing individuals’ eligibility and enrollment. The most significant trade-off involved financially driven CMS priorities requiring nurses, as gatekeepers for patient entrée into CMS-supported HHC services, to weigh physical health more heavily than mental health.

The acuity score for Medicare funding is based on physical ability. [The system] is geared toward elderly home-bound physically disabled patients who have an acute thing going on right now.
If they’re having depression, it might be dealt with, but it’s not going to be the main focus.

Often nurses observed how patients’ chronic conditions would exacerbate and improve over time, causing them to shift in and out of HHC eligibility and complicating determination of ongoing eligibility for HHC services, especially for patients who had mental status changes (i.e., depression). Nurses desired to see expanded eligibility criteria allowing patients to receive needed services unavailable under existing Medicare regulations (e.g. depression care/long-term care).

The narrow focus on physical care and technical efficiency left inadequate time for development of therapeutic nurse–patient relationships. Some stated that they chose HHC nursing because of the unique opportunity to develop rich connected relationships with patients and spend time as educators and partners in their care. But their abilities to deliver comprehensive nursing care to patients were conditioned by the payment for service policies they were responsible to uphold. (See Table 2 for examples of Medicare eligibility criteria and nurses’ comments about regulatory considerations.)

New Depression Screening Tool
Some nurses viewed the new CMS depression screening and assessment tool (i.e., the PHQ-2 on OASIS-C) as useful for directing attention to depression. OASIS-C is a modification to the OASIS that HHC agencies must complete for each patient receiving CMS-covered HHC services. The two PHQ-2 questions provide language to use for asking about depression. However, because the PHQ-2 screen is only required at certain intervals (e.g., certification, recertification), nurses used other documentation mechanisms for ongoing interprofessional depression care management. Some nurses said that the PHQ-2 wording describing mood changes associated with depression was problematic for patients who attributed their low mood to old age or illness. In these cases, nurses reported rewording or skipping the PHQ-2 questions and filling in the answers with their own assessment of patients’ depression.

The questions used for tracking depression might be a good starting point. But most people [when asked if they’re depressed] aren’t honest.
<table>
<thead>
<tr>
<th>Selected eligibility criteria</th>
<th>Nurses comments about regulatory considerations</th>
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</thead>
<tbody>
<tr>
<td>Home health care is needed to appropriately treat the medical condition and is considered medically necessary</td>
<td>The questions [that determine the acuity score] are not weighted equally. If [the patient] is diabetic, the acuity score . . . the [reimbursement] goes way up. [Medical conditions] are weighted heavily . . . If [patients] have mood problem . . . a thought process problem . . . you get almost no points [for it] to be considered a serious problem that's going to require more treatment, time and effort. Homecare is not designed for it. It's geared toward elderly homebound physically disabled patients who have an acute thing going on right now.</td>
</tr>
<tr>
<td>Skilled services—such as nursing, physical therapy or speech therapy—are required and cannot be performed by a nonmedical person</td>
<td>Every patient that you see has to have a skilled need; and if they don’t, then you can’t see them. You know, where insurance is concerned it’s all about skilled need. We [can’t] just walk in and do a non-skilled thing like pre-fill a medset [medication organizer]. [The focus is on] physical ability. That’s the way they want the questions answered [i.e., wording . . . how scoring is oriented]. If patients can’t [perform ADLs] because they’re depressed, they want you to say they can do it because, physically [in terms of physical ability], they’re able to.</td>
</tr>
<tr>
<td>Must be homebound</td>
<td>With Medicaid, you don’t have to be homebound. But [to be eligible for Medicare] our patients have to stay in the home. They can go out weekly to [places like] church or the hair dresser. But they are [essentially] homebound and [PT and OT personnel] go out to see them in their homes. It is hard [for Medicare patients who need long-term care], because Medicare is geared to physical [acute] care; [but for them it] is enough to get them by until we can get them [Medicaid long-term care] services like chore [home help] service and the Personal Emergency Response System [PERS] button and Meals on Wheels.</td>
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<tr>
<td>A “face-to-face encounter” (medical visit) is required for traditional Medicare patients (the 90 days prior to or the 30 days following, the start of home care services)</td>
<td>If they are gone [e.g. hospitalization, rehab, out of state visiting family] for more than 30 days, we have to discharge them. We have some people go, and we put their cases on hold for two weeks. That’s okay if their certification period [has not expired]. But if they’re in the hospital (if their certification period comes up and they’re still [hospitalized]) then we have to close. [Then] if they come out of the hospital, we can do a physical therapy and/or occupational therapy referral . . . call the doctor . . . do a one-day order and give a brief description of what you want (strengthening exercise . . . equipment).</td>
</tr>
<tr>
<td>Must have a plan of care</td>
<td>[There is] documentation that you pull up (the interdisciplinary care plan) . . . It’s all about the documentation. Some days I think I live with my computer on my lap. [And if the need is not listed in the plan of care] you have no ability to see this patient anymore . . . in their home . . . because [they] have no further skilled need [or] plan of care . . . even though they’re depressed and you’ve given them the options . . . you’ve given them medications . . . you’re waiting for [the medications] to work [because under Medicare you’ve got 21 days on the new medication]. But after 21 days [if] they don’t get it [do as directed] . . . [for example] they’re not using it . . . they’re not compliant . . . or they can’t verbalize any understanding or actually show you that they understand . . . then you’ve got nothing behind you to keep you there. [On the one hand], you can’t keep extending [visits] if you’re not getting anywhere . . . If you’re writing that you’re not getting anywhere with this patient or if the doctor won’t put [a patient] on anything [medication] . . . whatever it is . . . you can’t go back. [On the other hand, if you improve the conversation and the therapeutic things are working] then you can go back. It’ll be reimbursed.</td>
</tr>
<tr>
<td>The patient is expected to improve—goals are set and progress is seen</td>
<td>If you’ve got a depression diagnosis and a physician order for taking depression meds, they’re [the auditors are] going to expect at least one entry that you did something. You have to remember, though, that if it’s taught and you don’t document that you taught it and what the response was, [it is as if] we didn’t [do it] and then it’s not reimbursable. So you have to be careful and understand the whole workings of Medicare. You have to show that you are at least talking about it . . . teaching about [the defined care need], and what the patients’ responses were. And if, after three or four times their response is the same and they can’t get it or they’re non-compliant . . . in six months they [CMS] is going to say [in effect], “You have no ability to see this patient anymore because [he/she] has no further skilled need.”</td>
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If the doctor decides the patient does have depression, we would need the doctor to confirm the diagnosis so we can put it on our charts and we can put [the plan of care] into action. If we fill out the depression stuff [chart about depression] and it’s not in their diagnosis [medical plan of care] it alerts the [auditors] when they come to check us out. They’ll ask [things like] ‘Why are you assessing depression?’
Almost all nurses questioned the rationale for asking the questions on the initial OASIS assessment visit. They believed patients tend not to answer the PHQ-2 questions truthfully until a trusting relationship is developed. However, “having enough time to develop relationships and perform nursing tasks” sometimes led to conscious choices to “play the depression down” in order to focus on complex clinical disease management concerns. Nurses described emotionally distancing themselves from patients in order to preserve time to perform nursing tasks that addressed the acute problem (e.g., calling it the “tyranny of the acute”). In contrast, other nurses said the screening questions provided an opening for them to begin to explore patients’ depressive symptoms in greater depth. In many instances, this led to initiation of dialogues with other health care providers about referrals, medications, and alternative therapy options.

Access to Specialized Mental Health Care/Providers

Mental health providers were said to make few home visits because visits were not reimbursable by Medicare. Notably, because there was only one mental health care nurse for the entire agency, this specialized nurse was usually reserved for patients considered to have serious mental illnesses (e.g., active psychosis). Social workers and/or physicians were notified about patient depression. However, patient preferences for treatment not available in the home setting (e.g., homebound patients unable to visit a therapist) limited nurses’ abilities to mobilize resources on their behalves.

There is a lack of resources for the elderly or anyone, actually, that can’t pay out-of-pocket. Most doctors will help you; but most of them don’t accept Medicaid. The patients have to pay [and] they’re not going to. It’s a vicious circle.

Theme 2: Knowing How to Manage Depression

Nature of Depression

Some nurses saw depression as part of aging, whereas other nurses viewed depression as an entirely treatable illness. All gave understandable causes to be acute, unexpected, and/or cumulative decline in health and functionality with concomitant loss of close personal ties. Subsequent loss of independence and altered living situations were believed to contribute to fear, loneliness, and mood or thought-processing problems. However, nurses noted that sometimes depression signified a chronic condition patients had for a protracted time. Additionally, they identified factors that they believed protected older persons against development of depression (e.g., family/caregiver support and willingness to ask for and accept help).

Self-Confidence

Most nurses felt confident about screening for depression symptoms but were ambivalent about their role in depression care management. Some said their fear of saying something wrong led them to intentionally avoid working with depressed patients.

I’m no good at that [managing depression]. I already know that is my weakness.

Other nurses believed that dealing with depression was not within the scope of nursing practice.

That’s not my job. My job is to get them to a certain point (medically/surgically), and make sure the doctor knows their depression is not a good piece . . . that we need to fix this.

Nurses with previous favorable experiences caring for depressed patients expressed desire and a sense of responsibility to relay positive perceptions of depression management to their colleagues. However, nurses who felt “uncomfortable” or “not qualified” to talk about depression/sadness described using strategies, such as reassurance and humor, to deflect patients’ questions or comments about depressive symptoms. Some expressed lack of confidence in their knowledge about depression medications (e.g., antidepressants) and/or in their ability to determine whether patients were being adequately treated for depression.

Building Knowledge.

Overall, nurses expressed interest in greater access to education and skill training tailored to treatment of depression and disability.

There’s not a lot [on depression management]. I feel it gets overlooked.

Lack of specialized knowledge and communication skills were seen as primary reasons for feeling unsure about addressing patients’ emotional needs.

I can’t think of any training where we talk about [things] like situational depression or signs and symptoms to look for. We talk a lot about pain.

Depression kind of falls in the background.

Nurses used textbooks, Internet sites, and colleagues as education sources on mental health issues. All welcomed the idea of additional training. They explicitly desired an educational program that would build on the OASIS-C tool (PHQ-2 questions) infrastructure covering depression detection and education/treatment strategies to improve depression management.
Theme 3: Encouraging Disability Maintenance/Improvement

Nature of Disability
Nurses held similar views about origins of disability being deeply rooted in experiences of loss of bodily integrity and role identity that rendered many former activities impossible and necessitated assistance with basic ADLs.

They probably thought they’d never have to depend on somebody, that their privacy and intimate times would be so invaded by other people [helping with] toileting, changing, showering, dressing and all those things.

Men especially have this thing about [loss of] driving.

Nurses identified presence of multimorbidities or geriatric syndromes as contributors to patient worsening disability, depression, and threats to self-esteem. Most did not think that treating depression would improve disability. Instead they felt that patients were more accepting of disability when strategies to adapt to it (e.g., learning to use walkers) led to improved self-reliance and self-sufficiency. Impediments to nurses helping patients adapt to disability were when nurses focused on disease management or perceived that patients did not have the physical and/or mental capacity to engage in goal setting.

Self-Confidence
Nurses were confident about their abilities to help patients and caregivers use self-care strategies to cope with consequences of physical losses. They taught patients to use such approaches as adapting to the disability; encouraging spirituality; and reframing their loss, changing routines, or lowering personal expectations. Nurses felt these interventions enabled patients to avoid extensive medical care and to manage their illnesses at home while maintaining a sense of dignity and acceptance. At times, commiserating with patients and sharing personal experiences of similar losses were seen to promote trust and deepen nurse–patient bonds.

Building Knowledge
Nurses believed that they were fairly knowledgeable about how to assess disability and evaluated evidence of disability worsening on every visit. This included assessment of environmental impact on patient mobility, abilities to perform self-care management activities, and need for help with IADLs/ADLs.

I try to get them out. If we could get more people into water therapy . . . but we can’t get transportation for them because it’s not considered a medical appointment. We can put PT in if they fall or if we see their endurance decreased. Even then, it still may be only once a week.

Identifying events triggering disability worsening and suggesting strategies to minimize/reverse disability were challenging when patients had high levels of depression. This was particularly true when patients were experiencing other difficulties, such as an unsafe home environment. At these times, advice from nurses about basic safety and personal crises (e.g., obtaining heat for homes) superseded suggestions related to disability maintenance/improvement. Being relatively isolated in the field, nurses relied on physical therapists to help maintain or improve patients’ disability status. They also made patient referrals to community programs that included exercise (e.g., Tai Chi), favoring adult day care programs that also provided socialization. They were frustrated by an uneven distribution of community programs and options that disadvantaged patients in resource-poor communities.

Theme 4: Meeting Patients Where They Are

Engaging With Patients in Their Homes
Homecare nurses have the unique advantage, as teachers, to be able to take time to connect and most of all to touch people in their homes.

When I walk into somebody’s house, it’s all about the patients. It’s their environment and I’m there as a visitor. And you take that opportunity to do everything you can with them in the time that you have. It’s the holistic view of what nursing is about.

Nurses also defined themselves, in this role, as a "jack of all trades," largely because they often deal with patients’ multiple problems and multiple chronic conditions, which requires great flexibility and ability to deal with a wide range of needs.

Establishing a Therapeutic Relationship
All nurses felt that the therapeutic nurse–patient relationship was the primary vehicle for helping patients learn how to manage disability and depression. For most, such relationships developed gradually and were characterized by high levels of social conversation, deep trust and rapport, and nonjudgmental attitudes.

Sometimes people just need to talk. So I close my computer and just let them talk. They just want someone to listen to them. So you get to all the clinical stuff later. The emotional stuff is just as important.

When patients received a limited number of home visits or when there were frequent changes in personnel (e.g., multiple nurses), nurses believed their abilities to create and sustain sound therapeutic relationships were seriously
challenged. Nurses also recognized that the strategy of making purposeful self-disclosures was needed to set the stage for a reciprocal exchange of information and to let patients know they “really cared.” Within these exchanges, nurses and patients were able to touch upon common human experiences such as dealing with change, managing difficult feelings, coping with illness, or living with a growing sense of impending death. Nurses also recognized the importance of maintaining boundaries that sustained a professional nurse–patient relationship. They expressed a general sense of “knowing” that it was not possible to help everyone and that not all patients want a close therapeutic relationship. Nurses reported more difficulty working with patients who resisted a partnership, expected to be directed by nurses, or were untruthful. Others said that when they recognized that they just could not “bond” with a patient, they would transfer that patient to another nurse (a.k.a the “clean-up nurse”). Overall, perceived rewards of caring for older patients buffered the stresses encountered from challenging patients/situations.

Integrating Depression Care and Overall Health Care Management

Establishing therapeutic nurse–patient relationships was seen as integral to the way in which nurses carry out their professional roles. However, nurses said that as patient depression worsened, nurse–patient relationships often became more challenging to maintain.

If you don’t address the depression [first] you can’t get them to take their medicines or deal with their illness or anything like that because they don’t want to.

Some nurses reported assuming the initiative in persuading patients to accept additional help and in contacting other appropriate health care providers (e.g., physicians). These nurses also reported being more directive and task oriented in their care management (e.g., Nurse: “I want you to take your Toprol at night.” Patient: “Oh, OK! If you tell me to!”), shifting focus away from the impact of depression on patient conditions to address the acute issues.

We try to manage it [but] I think depression does take a back seat if they have some kind of issue that’s more pressing—physical things like if they have a wound that opens up or their diabetes gets out of control.

Nurses were sensitized to how “being on patients’ home turf” meant that patients had the greater amount of influence in determining how their health care would be managed (e.g., patient chooses medication times). Nurses noted that their role as HHC nurses was in sharp contrast to other nursing roles they had previously held in institutional settings where health care professionals have more control over care management.

Therapeutic Nurse–Patient Relationships (A View From the Field)

Observations during nurse home visits validated what was learned from interviews. In summary, system-level demands and trade-offs constraining nurses’ abilities to build ongoing collaborative relationships and deliver case management were evident as nurses laid strategic plans for managing daily visitation schedules and made calculated decisions about patient care priorities (Theme 1). Despite time pressures, they clearly tried to negotiate self-care management strategies with patients designed to facilitate independence and lessen disability worsening (Theme 3). Depression care was not always well integrated into discussions about approaches to patients’ overall health care management (Theme 2). But empathic communication enhanced patients’ abilities to express feelings about disability and depressive symptoms. Patients’ homes were the focal point for these collaborative partnerships, where nurses and patients developed caring relationships, reflecting trust and a level of solidarity (Theme 4). Consequently, we strongly agree that the types of educational programming nurses believed would enhance their abilities to more effectively participate with other team members in managing patient depression (Theme 2) are well suited to incorporation within the mechanism of the therapeutic relationship, that is, the primary means by which nurses deliver patient care. (See Table 3 for overview of home visits.)

Discussion

Insights derived from study findings were guided by and mapped to Wagner and colleagues’ CCM (1996, 2001). This population-based model envisions community resources and policies and health system organization (including payment structures) interacting to support chronically ill individuals and their families by means of self-management support, delivery system design, decision support, and clinical information systems.

Self-Management Support

Literature supports the preeminence of the therapeutic nurse–patient relationship (where patients develop trust in nurses who recognize, respect, and adapt to their culture, lifestyle, values, and habits) as the vehicle for delivery of patient self-management strategies (Lindahl, Liden, & Lindblad, 2011). Nurses enter patients’ homes as “welcomed guests” that recognize the predominance of patients and their families in these settings (McGarry, 2010). The ethnographic study of HHC nurses by Millard, Hallett, and Luker (2006) describes how, as also described in this study (Theme 4), nurses used friendliness and engagement
<table>
<thead>
<tr>
<th>Nurse activities</th>
<th>Summary of nurse activities observed across all patient visits</th>
<th>Associated themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management activities</td>
<td>Fairly consistent performance of case management tasks across patients included: Physical assessment</td>
<td>Theme 1: Balancing system and patient care</td>
</tr>
<tr>
<td>All aspects of health/illness-related nursing care</td>
<td>Medication management Referrals</td>
<td>Observed nurses balancing system-level demands and delivery of case management tasks in the following ways: Acute care needs had highest priority Need to perform OASIS assessments (1–2 h) determined amount of available time to spend with patient caseload for the day Unexpected changes in visitation schedule/daily assignments extended nurses’ work hours and shortened available time with individual patients</td>
</tr>
<tr>
<td>Medication Elimination</td>
<td>Discourse of system and regulatory barriers associated with care management, patient insurance, and ability to access additional services</td>
<td>Theme 2: Knowing how to manage depression</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Inconsistency of assessment of the level of social and environmental support</td>
<td>Theme 3: Encouraging disability maintenance/improvement</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>Observed nurses feeling confident and knowledgeable about helping patients restore function and decrease disability</td>
</tr>
<tr>
<td>Disability and depression management tasks</td>
<td>Consistency of confidence and knowledge of how to assess and evaluate disability Patient level of independence and evidence of disability worsening assessed on every visit</td>
<td>Theme 4: Meeting patients where they are</td>
</tr>
<tr>
<td>Assessment of activities associated with patient independence</td>
<td>Discussion of depression sometimes avoided by focusing on disease management, using humor, changing subject, or denial strategies</td>
<td>Observed nurses feeling discomfort and lack of confidence about discussing issues related to depression Nurses at times expressed need for more training and information</td>
</tr>
<tr>
<td>Assessment of signs of patient depression</td>
<td>Depression care not always well integrated into discussions about approaches to patients’ overall health care management Nurse-expressed needs to researcher for additional training and information about depression</td>
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<tr>
<td>Assessment of patient relationships (family/friends)</td>
<td></td>
<td>Observed a variety of nurse strategies to create and sustain therapeutic relationships with patients</td>
</tr>
<tr>
<td>Inquiries about other health providers knowledge of patient depression</td>
<td>Nurse-patient relationships developed and established over multiple visits evidenced deep trust Therapeutic relationships that formed were patient-centered, exhibited mutual reciprocity/sharing of personal and professional experience, with appropriate use humor Inconsistent recognition and reinforcement of patient autonomy</td>
<td></td>
</tr>
<tr>
<td>Therapeutic relationship between nurse and patient</td>
<td>Focus on physical care, acute problems, and performance of nursing tasks (e.g., wound dressings) led to less development of therapeutic relationships Shared decision making and collaborative goal setting occurred mostly for disease management goals Close relationships occurred more often among long-term patients</td>
<td></td>
</tr>
<tr>
<td>Collaboration goal setting and negotiation</td>
<td></td>
<td>Each case was unique. Apparent stage of nurse-patient relationship and acuity of patient needs influenced balance of attention to personal exchange and mutual goal setting/negotiation</td>
</tr>
<tr>
<td>Communication</td>
<td>Consistent demonstration of concern and empathy for patients Consistent attention to listening and providing reassurance</td>
<td>Theme 4: Meeting patients where they are</td>
</tr>
<tr>
<td>Verbal communication</td>
<td></td>
<td>Observed that nurses used verbal and nonverbal communication skills consistently and effectively</td>
</tr>
<tr>
<td>Affective communication (concern, empathy)</td>
<td></td>
<td></td>
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<tr>
<td>Guidance, direction, clarification</td>
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in “small talk” to foster social connections with patients, which seemed to help dissipate professional boundaries and enable patients to become more involved in discussing personal issues (e.g., depression). Thus, through well-established therapeutic nurse–patient relationships, nurses reaffirm the importance of the patient over the technical nursing task (Lindahl et al., 2011). Our findings suggest that when these relationships take precedence over nursing tasks, there is a better chance for addressing depression (Theme 4).

In this study, nurses had greater confidence in their abilities to help patients engage in disability management than in depression management (Theme 3). In some cases, nurses even used strategies to distance themselves from talking to patients about depression, citing lack of confidence in their abilities to discuss depression accurately (Theme 2). However, most nurses tried to mobilize mental health resources on their patients’ behalves and expressed a need for greater access to educational opportunities and skill training tailored to depression care management (Themes 1 and 2). Similar to previous studies, nurses in this study reported that even if they felt competent to ask depression questions, patients often provided untruthful responses (Sheeran, Reilly, Raue, Weinberger, Pomerrantz, & Bruce, 2010). This raises concern, since prior research stresses the need for depressed patients to receive education, emotional support, and advocacy, all of which are important aspects of the HHC nurse’s role (Valente, 2005).

### Delivery System Design

Delivery of effective, efficient clinical care through collaborative practice, planned patient interactions, regular follow-up, and case management are critical components of delivery system design (Russell, Rosati, Rosenfeld, & Marren, 2011). Nurses in this study reported that collaborating and communicating with physicians and other team members was essential to providing patient care. Nurses also reported that having additional depression care management skills would help them contribute more to multidisciplinary team efforts aimed at maximizing patients’ independence (Themes 1–3). This included communication with patients’ physicians about antidepressants and depression screening (PHQ-2), as well as family dynamics and adequacy of home resources that might be contributing to depression and disability worsening. Literature lends support to this idea, as documented in a series of research studies conducted in HHC agencies that found beneficial impacts of nurse-led depression assessment (e.g., Training in the Assessment of Depression) and depression care management based on depression care models adapted from primary care to HHC settings (i.e., Depression CAREPATH; Pickett, Raue et al., 2012).

Nevertheless, our findings are consistent with prior research that despite the persistent need for mental health care, there are myriad system barriers, unique to HHCC, that prevent the dissemination of depression care models, as well as nurse delivery of depression care management (Ell, 2006). Foremost of these is how nurses have to navigate the regulatory maze of HHCC regulations that determine how and what type of care can be delivered within the home and still meet strict Medicare guidelines for reimbursement under the PPS. This added an additional level of complexity for nurses in this study to deal with while they were trying to collaborate with patients to manage disease, provide personal care, address disability, and assess depression (See Table 2). Moreover, nurses were aware that delivery of depression management would not affect the case weighting used by Medicare to calculate Home Health Resource Group scores needed to receive payment from Medicare under PPS (CMS, 2010). Therefore, many times, unless there was an existing depression diagnosis, nurses in this study found it challenging to prioritize delivery of depression care management and treatment over disease management (e.g., patients receiving postacute care after a hospitalization). Furthermore, when a patient’s depression screen (PHQ-2) was positive for depression on the start of care or resumption of care, nurses might contact the physician in follow-up, but they were not required to perform

### Table 3. Continued

<table>
<thead>
<tr>
<th>Nurse activities</th>
<th>Summary of nurse activities observed across all patient visits</th>
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</thead>
<tbody>
<tr>
<td>Respect for lifestyle/feelings</td>
<td>Consistent use of appropriate affective touch, eye contact, and facial expression</td>
<td>More likely to use directive communication from the nurse perspective during education about disease or medication management</td>
</tr>
<tr>
<td>Nonverbal</td>
<td>Directive guidance was mainly related to topics associated with patient physical health/illness concerns and teaching needs</td>
<td>Inconsistent solicitation of patient perspectives in setting and negotiating goals of care</td>
</tr>
<tr>
<td>Use of eye contact</td>
<td>During information sharing about disease and medication management, directive guidance, at times, was given from nurses’ perspectives of patient needs, rather than patients’ perspectives</td>
<td></td>
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<tr>
<td>Body language</td>
<td></td>
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<tr>
<td>Facial expression</td>
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<tr>
<td>Affective touch</td>
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Note: OASIS = Outcome and Assessment Information Set.
follow-up assessment of depression beyond the initial depression screening. This is alarming, given the mounting evidence that improving depression outcomes may have a positive effect on patient disability status and potentially increase the number of years during which geriatric HHC patients live independently (Callahan et al., 2005).

Decision Support
Delivery of efficient clinical care includes appropriate use of expert consultation, care management, regular screening, and follow-up (Themes 1 and 2). CMS implemented an enhanced section on the OASIS-C including screening questions for the “gateway” symptoms of major depression depressed mood and anhedonia (PHQ-2). The introduction of these questions into the OASIS-C assessment is an important first step to improving depression management. Health care systems need to eliminate the single disease focus and make disease and depression management synergistic, thereby disrupting the process of mutual reinforcement that occurs between depression, disease, and disability (Detweiler-Bedell, Friedman, Leventhal, Miller, & Leventhal, 2008). HHC agencies are uniquely positioned to deliver this type of depression and disability care (Liebel, Friedman, Watson, & Powers, 2009). However, because there is a glaring shortage of mental health nursing professionals in HHC, only as few as 20% of patients receive follow-up care (Brown, Kaiser, & Gellis, 2007). Consequently, there is a need to create an infrastructure that provides depression diagnosis, treatment, and follow-up and affords generalist HHC nurses a role in providing overall depression management (Markle-Reid et al., 2011).

Clinical Information Systems
Clinical information systems are designed to enable patients and providers to set self-management goals and review reported progress to determine whether predetermined goals have been met. In this study, nurses conducted face-to-face visits in patients’ homes, beginning with a computerized comprehensive physical, psychosocial, functional, and educational needs assessment (OASIS-C) shared by all visiting HHC providers. Past research has demonstrated that this type of interdisciplinary communication and care is essential in efforts to help patients maintain/improve disability and stop the cascade of negative events leading to worsening disability (Hirdes et al., 2004). Physicians play a key leadership role on interdisciplinary teams by identifying the specific home health services their patients need to help them improve disability and live with greater independence.

Nurses in this study used the electronic chart and other media tools to communicate patient progress and to request additional HHC services in collaboration with patients’ physicians and other health care providers (e.g., physical therapists/social workers). They also used the electronic chart (i.e., interdisciplinary notes) to document concerns regarding depression and need for referrals to physicians/mental health providers or additional community resources (Themes 1 and 2). Since HHC nurses are members of interprofessional teams, this type of communication system and networking is essential to providing competent care (Williamson, 2007). Nurses’ communication would be enhanced by providing them with greater access to skill training tailored to combined treatment of depression and disability management.

Limitations
The intent of this research was to obtain nurses’ subjective points of view. Thus, self-reported nurse data must be taken at face value. Observations of therapeutic nurse behavior also rely on researcher interpretations of actions consistent with documented standards of therapeutic nursing practice. We could not control the selection of patient cases, as these were determined on the basis of nurses’ daily assignments and compatibility with nurse/researcher schedules. Finally, the study sample was small and limited to nurses in one HHC agency. Thus, findings are not generalizable to other HHC nurses/agencies. However, insights gained may be deemed transferable to other settings and situations.

Conclusion
HHC is fiscally organized primarily to address patients’ physical and medically acute skilled care needs. The introduction of the PHQ-2 depression-detection screening questions on the OASIS-C calls attention to the need to diagnose depression in Medicare HHC patients. This establishes depression as a diagnosable condition that enables the interprofessional HHC team to begin to address this important need. However, there is no standard way in which individual HHC agencies implement depression care management. In this study, HHC nurses were more confident in meeting patient disability and acute care needs than in addressing depression care management strategies. Although provided with mechanisms to assess and track depression symptoms, options for follow-up and personal strategies to deal with patients experiencing depression were felt to be more limited. Our findings suggest that the nurse–patient relationship provides a potential mechanism for generalist HHC nurses to provide valuable care management for depression at the same time that they are addressing chronic illness and disability patient needs. However, new models of education and
training will need to be integrated into the organization and practice of HHC. Consequently, we recommend using this existing resource (the therapeutic nurse–patient relationship) for integration of depression and disability care management. Ultimately, this will provide a more effective way to sustain needed changes within the current HHC system without requiring substantive health care system redesign.

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