

**PACE MEASURE SPECIFICATIONS AND DATA COLLECTION INSTRUCTIONS ON:**

**Percentage of Participants With an Advance Directive or Surrogate Decision-Maker**

**Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate  
Decision-Maker**

**Percentage of Participants Not in Nursing Homes**

**Percentage of Participants With Depression Receiving Treatment**

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## **Percentage of Participants With an Advance Directive or Surrogate Decision-Maker**

### **Percentage of Participants With an Annual Review of Their Advance Directive or Surrogate Decision-Maker**

#### ***Introduction***

The Patient Self-Determination Act, which took effect at the end of 1991, states that patients have the right to accept or refuse treatment and must be informed of this right on admission to any health care institution accepting Medicare or Medicaid funds. Advance directives (e.g., living wills, health-related power of attorney) empower patients and families to evaluate their own beliefs and wishes regarding medical interventions and formally communicate these wishes to caregivers and health care providers. However, advance directives have not been universally adopted. In a sample of those receiving Medicare Supplement insurance, 72 percent had completed some form of advance directive, but there were variations across sex, ethnicity, education, income, illness severity, and geographic location (Musich, Wang, Hawkins, & Yeh, 2015).

Research studies have concluded that when people are able to specify their end-of-life wishes in advance, they choose less aggressive medical treatments (Brinkman-Stoppelenburg, Rietjens, & Heide, 2014; Kossman, 2014; Nicholas, Langa, Iwashyna, & Weir, 2011; Silveira, Kim, & Langa, 2010; Teno, Gruneir, Schwartz, Nanda, & Wetle, 2007; Wright et al., 2008). Because of less aggressive treatment, medical expenditures are significantly lower for those with advance directives specifying end-of-life care preferences (Musich et al., 2015; Nicholas et al., 2011; Zhang et al., 2009). The potential for improved allocation of financial resources at end of life and the empowerment of participants and their families make advance directives a potentially beneficial quality indicator domain for Programs of All-Inclusive Care for the Elderly (PACE) organizations.

#### ***Measure Specifications***

This section of the instructions presents the definitions of the two advanced directives measures, and specifies the numerator, denominator, and inclusion and exclusion criteria. All key terms are defined. Read and understand the instructions before you begin data collection. Refer to them as needed throughout the course of data collection.

- 1. Percentage of PACE participants with an advance directive or surrogate decision-maker documented in the medical record, and**
- 2. Percentage of PACE participants who had documentation in the medical record of an annual review and discussion about their advance directive or surrogate decision-maker**

Advance Directive Measures	
Definitions of the Measures	<p><b>1) The percentage of PACE participants with an advance directive or surrogate decision-maker documented in the medical record.</b></p> <p><b>Numerator:</b> Number of PACE participants with an advance directive or surrogate decision-maker documented in the medical record.</p> <p><b>Denominator:</b> Number of PACE participants enrolled during the reporting period.</p> <p><b>2) The percentage of PACE participants who had documentation in the medical record of an annual review and discussion about their advance directive or surrogate decision-maker.</b></p> <p><b>Numerator:</b> Number of PACE participants who had documentation in the medical record of an annual review and discussion about their advance directive or surrogate decision-maker.</p> <p><b>Denominator:</b> Number of PACE participants with an advance directive or surrogate decision-maker documented in the medical record.</p>

Advance Directive Measures	
Definitions of the Measures (cont.)	<p>An <b>advance directive</b> must include at least one of the following:</p> <ul style="list-style-type: none"> <li>• A State-approved POST (Physician Order for Scope of Treatment), POLST (Physician Order for Life-Sustaining Treatment), MOST (Medical Orders for Scope of Treatment), or MOLST (Medical Orders for Life-Sustaining Treatment) form.</li> <li>• Living Will (this is not the same as a Last Will and Testament that addresses estate issues) or Five Wishes document.</li> <li>• A written or oral statement by a participant about treatment preferences documented in the electronic medical record or recorded on a paper copy and placed in the medical record.</li> </ul> <p>A <b>surrogate decision-maker</b> may include any of the following, but must meet the State's requirements to legally make decisions for the participant in the event that the participant is unable to make health care decisions:</p> <ul style="list-style-type: none"> <li>• A Durable Power of Attorney for Health Care.</li> <li>• A health care agent, proxy, surrogate, representative, attorney-in-fact, or patient advocate.</li> </ul> <p>A <b>review and discussion of the advance directive or surrogate decision-maker</b> must include the participant, if the participant is able to make health care decisions, and may include the surrogate decision-maker. The current medical record documentation of an advance directive and/or surrogate decision-maker must be reviewed using terms the participant can understand. Additional discussion may include, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Any changes the participant may wish to make to his or her advance directive or surrogate decision-maker, including the creation of one or the other.</li> <li>• Explanation of the participant's current health condition, diagnosis, and prognosis and how that relates to an advance directive or surrogate decision-maker.</li> <li>• Explanation (including purpose and probable outcomes) of life-prolonging measures, including cardiopulmonary resuscitation, endotracheal intubation and mechanical ventilation, tubing feedings, and other measures pertinent to the participant's health status.</li> </ul>
Exclusion Criteria for Both Numerator and Denominator	<ul style="list-style-type: none"> <li>• Exclude participants with written documentation in the medical record that the participant did not wish or was unable to provide an advance directive or identify a surrogate decision-maker.</li> <li>• For both measures, exclude participants who have been enrolled in PACE for less than six (6) months. For the measure "Percentage of PACE participants with documentation of an annual review and discussion of the advance directives," exclude participants who had their advance directives or surrogate decision-maker documentation for less than one (1) year, as it does not yet qualify for an annual review.</li> </ul>

Advance Directive Measures	
Inclusion Criteria for the Denominator	<ul style="list-style-type: none"> <li>• Include participants regardless of living setting (home, nursing home, assisted living facility, etc.).</li> <li>• If a death occurs for a participant who was enrolled in PACE for at least six (6) months, include the participant in the quarterly count for quarters in which he or she was enrolled for at least one (1) day. For example, if a participant has been enrolled in PACE for at least a year and dies on the second day of the quarter, he or she would be included in the participant count for the quarter.</li> </ul>

### Data Entry Instructions

Data will be reported on an Excel spreadsheet. Data are to be collected from participant health care records—both paper and electronic. You will submit the spreadsheet through a secure online application.

Advance Directive Measures	
Auto-Generated Participant Number	1 through <i>n</i> , total number of non-excluded participants
Participant Residence  <i>Use the residence that applied for the majority of days [≥50%] during the quarter</i>	<ol style="list-style-type: none"> <li>1. Own home</li> <li>2. Assisted Living Facility</li> <li>3. Nursing Home</li> <li>4. Residential Hospice</li> <li>5. Rehabilitation Facility</li> <li>6. Skilled Nursing Facility</li> <li>7. Other</li> <li>99. Not documented</li> </ol>
Participant has documentation of an advance directive or surrogate decision-maker, or meets exclusionary criteria	<ol style="list-style-type: none"> <li>1. Documentation of BOTH an advance directive and a surrogate decision-maker</li> <li>2. Documentation of an advance directive only</li> <li>3. Documentation of a surrogate decision-maker only</li> <li>4. No documentation of an advance directive or surrogate decision-maker</li> <li>5. Documentation that the participant does not wish to have or discuss an advance directive or surrogate decision-maker</li> <li>6. Documentation that the participant is unable to provide an advance directive or identify a surrogate decision-maker</li> <li>7. Participant has been enrolled in PACE for less than one (1) year</li> </ol>

Advance Directive Measures	
Participant has documentation in the medical record of an annual review and discussion about their advance directive or surrogate decision-maker	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No documentation of a review and discussion about their advance directive or surrogate decision-maker has occurred in the past year</li> <li>3. Not applicable – advance directive or surrogate decision-maker documentation occurred less than one (1) year ago and does not yet require an annual review</li> <li>4. Not applicable – Participant is unable to participate in a review and discussion</li> <li>99. Participant does not have an advance directive or surrogate decision-maker, or is excluded from the documentation of an advance directive/surrogate decision-maker measure</li> </ol>

## References

- Brinkman-Stoppelenburg, A., Rietjens, J. A., & Heide, A. van der. (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative Medicine*, 269216314526272. <http://doi.org/10.1177/0269216314526272>
- Kossman, D. A. (2014). Prevalence, views, and impact of advance directives among older adults. *Journal of Gerontological Nursing*, 40(7), 44–50. <http://doi.org/http://dx.doi.org/10.3928/00989134-20140310-01>
- Musich, S., Wang, S. S., Hawkins, K., & Yeh, C. S. (2015). Disparities among those with advance directives in a Medicare Supplement population. *The American Journal of Hospice & Palliative Care*. <http://doi.org/10.1177/1049909115574837>
- Nicholas, L. H., Langa, K. M., Iwashyna, T. J., & Weir, D. R. (2011). Regional variation in the association between advance directives and end-of-life Medicare expenditures. *JAMA*, 306(13), 1,447–1,453. <http://doi.org/10.1001/jama.2011.1410>
- Silveira, M. J., Kim, S. Y. H., & Langa, K. M. (2010). Advance directives and outcomes of surrogate decision making before death. *The New England Journal of Medicine*, 362(13), 1,211–1,218. <http://doi.org/10.1056/NEJMSa0907901>
- Teno, J. M., Gruneir, A., Schwartz, Z., Nanda, A., & Wetle, T. (2007). Association between advance directives and quality of end-of-life care: a national study. *Journal of the American Geriatrics Society*, 55(2), 189–194. <http://doi.org/10.1111/j.1532-5415.2007.01045.x>
- Wright, A. A., Zhang, B., Ray, A., Mack, J. W., Trice, E., Balboni, T., ... Prigerson, H. G. (2008). Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*, 300(14), 1,665–1,673. <http://doi.org/10.1001/jama.300.14.1665>
- Zhang, B., Wright, A. A., Huskamp, H. A., Nilsson, M. E., Maciejewski, M. L., Earle, C. C., ... Prigerson, H. G. (2009). Health care costs in the last week of life: associations with end-of-life conversations. *Archives of Internal Medicine*, 169(5), 480–488. <http://doi.org/10.1001/archinternmed.2008.587>

## **Percentage of Participants Not in Nursing Homes**

### ***Introduction***

PACE organizations provide services to participants who are eligible for State-certified nursing homes, are aged 55 or older, and live in their own homes (or in home-like settings) in the community. The goal of PACE is to reduce the need for nursing home care and prevent adverse events and harms that may occur in a nursing home setting. Although PACE participants are at high risk of mortality, mainly due to being older and more cognitively impaired, they have longer median survival (4.2 years), compared with non-PACE Medicaid nursing home residents (2.3 years) and residents in a waiver program like Community Choices (3.5 years) (Wieland, Boland, et. al., 2010). Furthermore, institutionalization is expensive and may lead to many adverse psychological, social, and physical outcomes (Friedman, Steinwachs, et. al., 2005). Therefore, PACE organizations enable participants to be cared for in their community settings, rather than be institutionalized in nursing homes.

One of the primary goals of the PACE program is to prevent the placement of frail, elderly persons in nursing homes, instead keeping participants safely in their homes and community which includes assisted living facilities, rehabilitation facilities, skilled nursing facilities, and hospice facilities. Overall, evidence on the effect of PACE enrollment on nursing home utilization is mixed and inconclusive (U.S. Department of Health and Human Services, 2014). Some research studies have found that PACE participants had lower rates of nursing home admissions compared to non-PACE or waiver participants (Chatterji, Burnstein, et. al., 1998; Meret-Hanke, 2011; Segelman, Cai, et. al., 2015; Segelman, Szydlowski, et. al., 2014). A measure of “Percent of Participants Not in Nursing Homes” will demonstrate how effective PACE organizations are in accomplishing this goal.

### ***Measure Specifications***

This section of the instructions presents the definitions of the Percent of PACE Participants Not in Nursing Homes measure, and specifies the numerator, denominator, and inclusion and exclusion criteria. All key terms are defined. Read and understand the instructions before you begin data collection. Refer to them as needed throughout the course of data collection.

Not in Nursing Homes Measure	
Definition of the Measure	<p>The percentage of reporting quarter PACE participants with no nursing home stays or those with short stays in nursing homes (less than 90 days since the date of admission).</p> <p>This measure is calculated by subtracting the percentage of PACE participants with an extended nursing home stay (at least 90 days since the date of admission) from 100.</p> <p><b>Numerator and Denominator of the Percentage of Participants with Nursing Home Stays:</b></p> <p><b>Numerator:</b> Number of reporting quarter PACE participants whose <b>nursing home stay</b> has been at least 90 days since the date of admission to the nursing home. For these participants, the nursing home is their usual place of residence.</p> <p><b>Denominator:</b> Number of PACE participants enrolled in the reporting quarter.</p>
Exclusion Criteria for Both Numerator and Denominator	<ul style="list-style-type: none"> <li>• Exclude persons who were not enrolled as PACE participants in the reporting quarter.</li> <li>• Exclude persons who were enrolled as PACE participants for <b>less than one (1) day</b> in the reporting quarter.</li> </ul>
Exclusion Criteria for the Numerator	<ul style="list-style-type: none"> <li>• Exclude reporting quarter PACE participants who had a short stay in a nursing home (less than 90 days since the date of admission).</li> </ul>
Inclusion Criteria for the Denominator	<ul style="list-style-type: none"> <li>• Include participants who were enrolled as PACE participants, regardless of place of residence (nursing home, home, assisted living facility, skilled nursing facility, hospice facility, rehabilitation facility, etc.).</li> <li>• Include participants who were enrolled as PACE participants for <b>at least one (1) day</b> in the reporting quarter, regardless of their enrollment status at the end of the quarter.</li> <li>• Include participants who are deceased, but were enrolled as PACE participants for <b>at least one (1) day</b> in the reporting quarter.</li> </ul>

### **Data Entry Instructions**

Data will be reported on an Excel spreadsheet. Data are to be collected from administrative records at PACE organizations—either paper or electronic—including medical or billing records. You will submit the spreadsheet through a secure online application.



Not in Nursing Homes Measure	
<b>Total number of PACE participants enrolled at the site</b>	Enter the total number of participants who were enrolled in PACE for <b>at least one (1) day</b> in the reporting quarter.

Not in Nursing Homes Measure	
<b>Auto-Generated Participant Number</b>	1 through n, total number of non-excluded participants
<b>Date of Participant's Admission to the Nursing Home</b>	Enter the date of nursing home admission for the reporting quarter PACE participant who had an extended <b>nursing home stay</b> (at least 90 days since the date of admission). <b>NOTE: In most instances, the date of admission would be in an earlier quarter.</b>
<i>* This information will be used to figure out the numerator of the fraction, which is the number of participants with nursing home stays</i>	<p>The date should be entered as MM/DD/YYYY.</p> <p>Enter 99/99/9999 if the date was not available in the medical or billing records, but the participant stayed in the nursing home <b>at least 90 days</b>.</p>

## References

- Chatterji, P., Burstein, N. R., Kidder, D., & White, A. (1998). Evaluation of the Program of All-Inclusive Care for the Elder (PACE) demonstration: The impact of PACE on participant outcomes. In: *The Health Care Financing Administration*, ed. Cambridge, MA: Abt Associates, Inc.
- Friedman, S. M., Steinwachs, D. M., Rathouz, P. J., Burton, L. C., & Mukamel, D. B. (2005). Characteristics predicting nursing home admission in the program of all-inclusive care for elderly people. *Gerontologist*, 45(2), 157–166.
- Meret-Hanke, L. A. (2011). Effects of the Program of All-Inclusive Care for the Elderly on hospital use. *The Gerontologist*, 51(6), 774–785.
- Segelman, M., Szydlowski, J., Kinosian, B., et al. (2014). Hospitalizations in the Program of All-Inclusive Care for the Elderly. *Journal of the American Geriatric Society*, 62(2), 320–324.
- Segelman, M., Cai, X., van Reenen, C., & Temkin-Greener, H. (2015). Transitioning from community-based to institutional long-term care: Comparing 1915(c) waiver and PACE enrollees. *Gerontologist*.
- U.S. Department of Health and Human Services. Evaluating PACE: A review of the literature. In: Office of Disability A, and Long-Term Care Policy, ed2014.

Wieland, D., Boland, R., Baskins, J., & Kinosian, B. (2010, July). Five-year survival in a Program of All-inclusive Care for Elderly compared with alternative institutional and home- and community-based care. *Journals of Gerontology, Series A, Biological Sciences and Medical Sciences*, 65(7), 721–726.

## **Percentage of PACE Participants With Depression Receiving Treatment**

### ***Introduction***

PACE provides services to participants who are eligible for State-certified nursing homes, live in their own homes (or in home-like settings) in the community, and are aged 55 or older. The goal of PACE is to reduce the need for institutional care, such as nursing home care, and prevent or treat adverse events that can harm the participants' quality of life.

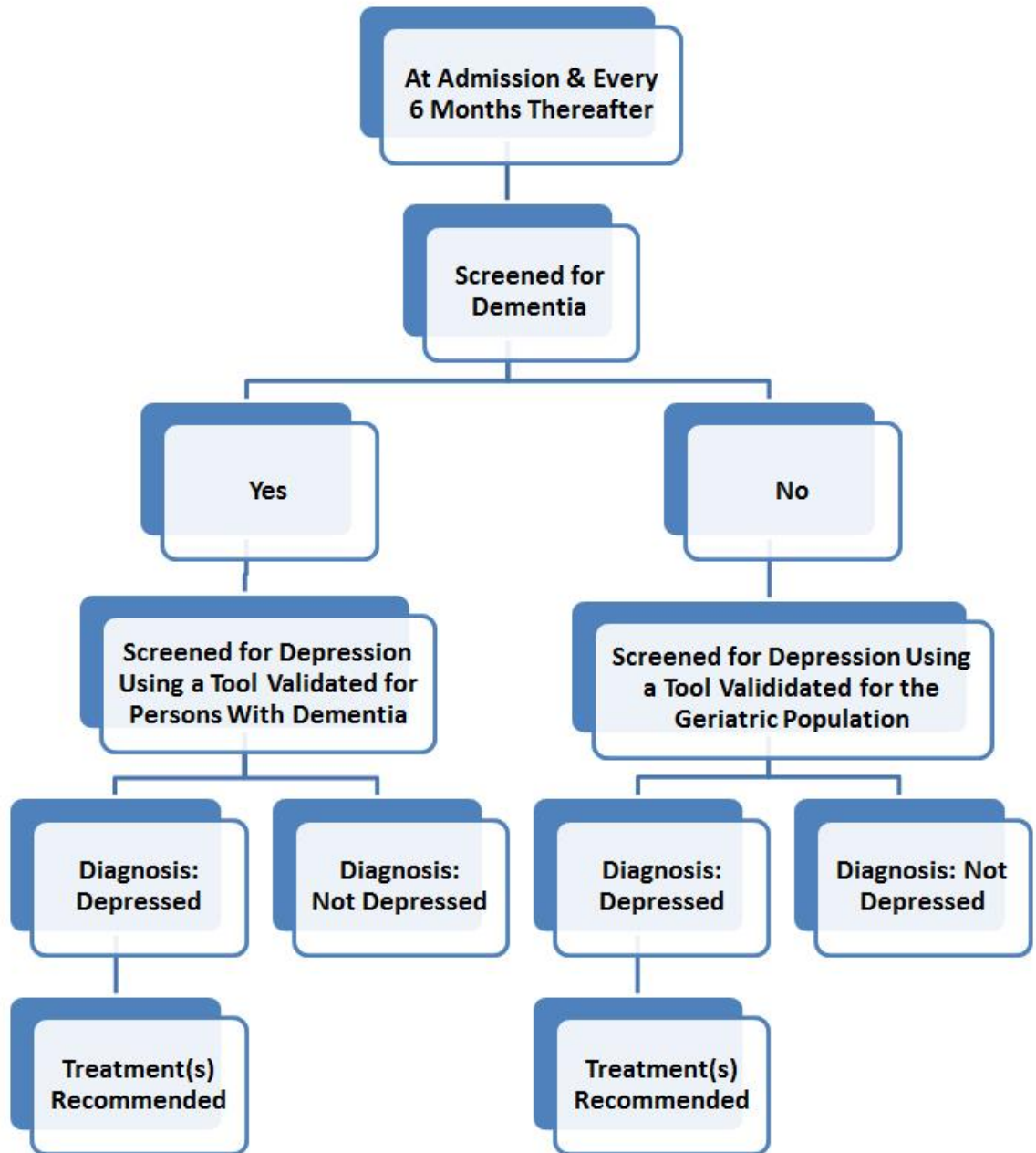
Depression is prevalent among the geriatric population and may arise from situational factors (e.g., physiologic decline, loss of independence, isolation, lower socioeconomic status, chronic pain, grief and loss) or from physiological factors (Park & Unützer, 2011, p. 476; Siu et al., p. 382). Comorbid conditions may complicate the diagnosis of depression; these conditions may include neurological disorders (e.g., stroke), Parkinson's disease, Alzheimer's disease and other forms of dementia, hypothyroidism, myocardial infarction, and cancer and cancer treatment. Some symptoms of depression overlap with symptoms of comorbid medical illnesses such as low energy level, fatigue, or sleep or appetite disturbances.

For the PACE population, mild and more severe cognitive impairment can make it difficult to diagnose depression and can be symptomatic of depression. In order to have a valid diagnosis of depression, it is important to screen for dementia prior to screening for depression. Screening for dementia and depression among PACE participants should be conducted using tools that have been validated for the geriatric population. If a participant has dementia, depression should be screened for using a tool that has been recommended as appropriate for persons with dementia. Recommended screening tools for depression among persons with dementia include the Cornell Scale for Depression in Dementia, or if dementia is not advanced, the Geriatric Depression Scale or the Patient Health Questionnaire-9.

The effectiveness of depression treatment in the geriatric population may be modest, due to the aging brain, the presence of comorbid conditions, and reduced socioemotional status, all of which are common among the elderly. Treatment of depression in the PACE population may include drug therapy, individual or group counseling, and alternative/complementary medical therapies. As with any medical treatment, PACE participants may elect to refuse treatment. Persons who have medical power of attorney for a participant also may decline.

### ***Measurement Model and Assumptions***

The measurement model for the Percentage of PACE Participants with Depression assumes that the clinical process for identifying and treating depression is represented by this chart.



## Measure Specifications

This section of the instructions presents the definitions of the Percent of PACE Participants Treated for Depression measure, and specifies the numerator, denominator, and inclusion and exclusion criteria. All key terms are defined. Read and understand the instructions before you begin data collection. Refer to them as needed throughout the course of data collection.

Depression Receiving Treatment Measure	
Definition of the Measure	<p>The percentage of PACE participants with a diagnosis of depression who are receiving treatment during the calendar quarter.</p> <p><b>Numerator:</b> Number of PACE participants diagnosed with depression who received treatment during the calendar quarter.</p> <p><b>Denominator:</b> Number of PACE participants with a new or ongoing diagnosis of depression during the calendar quarter.</p>
<p>Depression Diagnosis ICD 10 Codes</p> <p><i>Abstract the data using these codes.</i></p> <p><i>You will not report the codes, just whether there had been a diagnosis of depression.</i></p>	<ul style="list-style-type: none"> <li>• F32 Major depressive disorder, single episode.</li> <li>• F33 Major depressive disorder, recurrent.</li> <li>• F34.1 Dysthymic disorder.</li> <li>• F43.31 Adjustment disorder with depressed mood.</li> <li>• F06.31 Mood disorder due to known physiological condition with depressive features.</li> <li>• F06.02 Mood disorder due to known physiological condition with major depressive-like episodes.</li> <li>• F23.1 Schizoaffective disorder, depressive type.</li> </ul>
Treatment Modalities for Depression	<p>Include prescriptions, counseling or therapy, and alternative and complementary medicine approaches to treatment.</p> <p>Fourteen (14) types of treatment are included in the data submission form. Please see the form for the full list.</p> <p>Two (2) types of alternative and complementary treatments merit further definition:</p> <ul style="list-style-type: none"> <li>• Biofield therapy consists of the clinician interacting with the patient's biofield, such as: Reiki, therapeutic touch, or healing touch.</li> <li>• Bioelectromagnetic therapies consist of the application of electromagnetic fields to the patient.</li> </ul>

Depression Receiving Treatment Measure	
Exclusion Criteria for Both Numerator and Denominator	<ul style="list-style-type: none"> <li>Exclude participants who were diagnosed with depression but refused treatment or their health care power of attorney declined treatment on their behalf.</li> </ul>
Inclusion Criteria for Both Numerator and Denominator	<ul style="list-style-type: none"> <li>Include participants who are deceased but were enrolled as PACE participants for <b>more than one (1) day</b> during the reporting month.</li> <li>Include participants with a dual diagnosis of depression and dementia.</li> </ul>

The data collection and reporting spreadsheet asks for information on the following list of additional variables:

- Participant residence
- Dementia screening
- Dementia screening tool used
- Dementia diagnosis
- Depression screening
- Depression screening tool used
- Depression diagnosis
- Treatment for depression recommended

The operational definitions of these additional variables are provided in the following data entry section.

### ***Data Entry Instructions***

Data will be reported on an Excel spreadsheet. Data are to be collected from participant health care records—both paper and electronic. You will submit the spreadsheet through a secure online application.

Depression Receiving Treatment Measure	
Auto-Generated Participant Number	1 through <i>n</i> , total number of non-excluded participants
Participant Residence  <i>Use the residence that applied for the majority of days [≥50%] during the quarter.</i>	<ol style="list-style-type: none"> <li>1. Own home</li> <li>2. Assisted Living Facility</li> <li>3. Nursing Home</li> <li>4. Residential Hospice</li> <li>5. Rehabilitation Facility</li> <li>6. Skilled Nursing Facility</li> <li>7. Other</li> <li>99. Not documented</li> </ol>

Depression Receiving Treatment Measure	
<p>Participant Screened for Dementia Using Validated Tool</p> <p><i>Use the most recent screening at or after enrollment. This screening could be in the reporting quarter or earlier.</i></p>	<p>1. Yes 2. No 99. Not documented</p>
<p>Dementia Screening Tool Used</p> <p><i>These tools are among the most recommended and widely used in the United States.</i></p>	<p>1. Mini Mental Status Exam 2. Montreal Cognitive Assessment 3. St. Louis University Mental Status 4. Other 99. Not documented</p>
<p>Diagnosed With Dementia</p> <p><i>The diagnosis could have occurred in the reporting quarter or earlier.</i></p> <p><i>Diagnosis should be recorded in the health care record.</i></p>	<p>1. Yes 2. No 99. Not documented</p>
<p>Participant Screened for Depression</p> <p><i>Use the most recent screening at or after enrollment. This screening could be in the reporting quarter or earlier.</i></p>	<p>1. Yes 2. No 99. Not documented</p>

Depression Receiving Treatment Measure	
<p>Depression Screening Tools Used</p> <p><i>The screening tools listed here are among the most recommended and widely used in the United States.</i></p> <p><i>Record up to <b>two (2)</b> tools that were used in the most recent screening of this participant.</i></p>	<ol style="list-style-type: none"> <li>1. Beck Depression Inventory</li> <li>2. Center for Epidemiologic Studies Depression Scale (CESD)-10</li> <li>3. CESD-20</li> <li>4. Cornell Scale for Depression in Dementia</li> <li>5. Geriatric Depression Scale (GDS)-5</li> <li>6. GDS-15</li> <li>7. GDS-30</li> <li>8. Modified Depression Scale (MDS)</li> <li>9. Patient Health Questionnaire (PHQ)-2</li> <li>10. PHQ-9</li> <li>11. Other Screening Tool</li> <li>99. Not documented</li> </ol>
<p>Diagnosed With Depression</p> <p><i>Diagnosis may be based on screening or on clinician judgement.</i></p> <p><i>Depression is defined by ICD-10 codes, listed in the definition section above.</i></p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> <li>99. Not documented</li> </ol>
<p>Depression Treatment During the Quarter</p> <p><i>Record only those treatments for depression recommended by a clinician.</i></p> <p><i>The recommended treatments should be in the health care record.</i></p>	<ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No, clinician did not recommend treatment</li> <li>3. No, participant refused treatment</li> <li>4. No, participants' health care power of attorney declined treatment</li> <li>5. No, participant had adverse reaction to medication and medication discontinued</li> <li>6. No, participant in remission, treatment discontinued</li> <li>99. No documentation of treatment</li> </ol>



Depression Receiving Treatment Measure	
Type of Treatment	<ol style="list-style-type: none"> <li>1. Prescription medication</li> <li>2. Individual counseling</li> <li>3. Group therapy</li> <li>4. Electroconvulsive therapy</li> <li>5. Dietary or herbal supplements (e.g., Omega-3 fatty acids, St. John's Wart, folate, SAM-e, Valerian)</li> <li>6. Relaxation treatment</li> <li>7. Yoga or Tai Chi</li> <li>8. Physical exercise</li> <li>9. Massage therapy</li> <li>10. Acupuncture</li> <li>11. Light therapy</li> <li>12. Art, music, dance therapy</li> <li>13. Meditation, prayer, pastoral counseling</li> <li>14. Biofield therapies or bioelectromagnetic-based therapies</li> <li>99. Not documented</li> </ol>
Record up to <b><u>three</u></b> (3) of the most important treatments.	

## References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Centers for Medicare & Medicaid Services. ICD 10 Code Look Up. Downloaded on 06/10/2016.

Park, M. & Unützer, J. (2011). Geriatric depression in primary care. *Psychiatric Clinics of North America*, 34, 469–487. doi:10.1016/j.psc.2011.02.0090193-953X/11/\$.

Siu, A. L., Bibbins-Domingo, K., Grossman, D. C., Baumann, L. C., Davidson, K. W., Ebell, M., & Pignone, M. P. (2016). Screening for depression in adults: US preventive services task force recommendation statement. *Journal of The American Medical Association*, 315(4), 380–387. doi:10.1001/jama.2015.18392.