Abstract

Objectives: To test the feasibility and validity of the Patient Health Questionnaire-9 item interview (PHQ-9) and the newly developed Patient Health Questionnaire Observational Version (PHQ-9 OV) for screening for mood disorder in nursing home populations.

Methods: The PHQ-9 was tested as part of the national Minimum Data Set 3.0 (MDS 3.0) evaluation study among 3822 residents scheduled for MDS 2.0 assessments. Residents from 71 community nursing homes (NHs) in eight states were randomly included in a feasibility sample (n = 3258) and a validation sample (n = 418). Each resident’s ability to communicate determined whether the PHQ-9 interview or the PHQ-9 OV was initially attempted. In the validation sample, trained research nurses administered the instruments. For residents in the validation sample without severe cognitive impairment (MS < 30) agreement between PHQ-9 and the modified Schedule for Affective Disorders and Schizophrenia (m-SADS) was measured with weighted kappas (k). For residents with severe cognitive impairment (MS ≥ 30), agreement between PHQ-9 interview or PHQ-9 OV and the Cornell Scale for Depression in Dementia (Cornell Scale) was measured using correlation coefficients. Staff impressions were obtained from an anonymous survey mailed to all MDS assessors.

Results: The PHQ-9 was completed in 86% of the 3258 residents in the feasibility sample. In the validation sample, the agreement between PHQ-9 and m-SADS was very good (weighted k = 0.69, 95% CI = 0.61 – 0.76), whereas agreement between MDS 2.0 and m-SADS was poor (weighted k = 0.15, 95% CI = 0.06 – 0.25). Likewise, in residents with severe cognitive impairment, PHQ correlations with the criterion standard Cornell Scale were superior to the MDS 2.0 for both the PHQ-9 (0.63 vs 0.34) and the PHQ-9 OV (0.84 vs 0.28). Eighty-six percent of survey respondents reported that the PHQ-9 provided new insight into residents’ mood. The average time for completing the PHQ-9 interview was 4 minutes.

Discussion: Compared with the MDS 2.0 observational items, the PHQ-9 interview had greater agreement with criterion standard diagnostic assessments. For residents who could not complete the interview, the PHQ-9 OV also had greater agreement with a criterion measure for depression than did the MDS 2.0 observational items. Moreover, the majority of NH residents were able to complete the PHQ-9, and most surveyed staff reported improved assessments with the new approach.

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The correct recognition of the signs and symptoms of depression in long term care populations is important for a multitude of reasons. Depression is associated with poor quality of life, decreased functional status, increased physical and pain complaints, rejection of care behaviors, and increased mortality risk. It is also associated with poorer outcomes for chronic disease, acute illness, and rehabilitation interventions. The presence of depression also predicts increased health care utilization and institutionalization. It is therefore important that assessments accurately identify those who require treatment, and that they detect those who are not responding to care and who therefore may require modification or intensification of depression treatment.

Although depression is one of the most frequently coded diagnoses in nursing home (NH) populations, independent evaluations consistently show that the signs and symptoms of depression are inaccurately categorized in NH residents with as many as 34% of residents having clinically significant depressive symptoms on independent evaluation. At the same time, NHs have witnessed an almost three-fold increase in the number of residents prescribed antidepressants, which despite significant side effect profiles, often do not correlate with medical record indications for treatment. These observations have led to concerns that some clinicians may be instituting treatment for depression but not modifying or intensifying treatment for those who do not respond to first line approaches, while on the other hand, un-targeted prescribing of antidepressants or inappropriate maintenance is occurring for other residents.

This paradox may partly relate to the consistent finding that the MDS 2.0 list of 15 observed indicators of depression had poor sensitivity for identifying persons with depressive symptoms or depression. A consensus statement from the American Geriatrics Society (AGS) and the American Association for Geriatric Psychiatry (AAGP) concluded that the MDS 2.0 with its reliance on staff observations was not adequate for depression screening in NH populations and recommended that additional instruments be used. These concerns were reflected in our early evaluation activities where a validation panel ranked the mood items as having low validity, and only 22% of nurses in our baseline survey reported that the MDS 2.0 mood items were easy to complete accurately.

Another concern with a solely observational approach to mood assessment is the increasing recognition that resident self-report and input should be central to assessing this important domain of quality of life. The use of structured interviews to obtain self-report of Diagnostic and Statistical Manual of Mental Disorders (DSM IV) symptoms is the preferred approach for depression screening in both community and health care settings. One such structured and validated depression interview is the 9-item Patient Health Questionnaire (PHQ-9). The performance of the PHQ-9 has been tested in older adults, home health, persons with cancer, persons with spinal cord injury, and rehabilitation populations. The PHQ-9 is in wide use in community and hospital settings and has been shown to be sensitive to change over time.

However, there are questions about whether NH residents can provide self-reports of symptoms and about whether PHQ-9 will be reliable and valid when applied in NH populations. The current study examines the performance of the PHQ-9 as part of the national testing of the Minimum Data Set 3.0 (MDS 3.0) for Nursing Homes. In this national evaluation, we aimed to test the feasibility and validity of the PHQ-9 interview for residents capable of self-report and to test an alternative staff reporting approach for those residents who could not self-report.

### Methods

#### Pilot Testing and Item Development in the Veterans Health Administration (VHA)

The VHA Health Services Research and Development pilot test found that direct resident interview for signs and symptoms of depression is feasible, even in residents with moderately severe cognitive impairment. This finding is consistent with prior NH studies. A newer finding was that the PHQ-9 required less time to complete and showed more internal consistency across varying levels of cognitive ability than did the Geriatric Depression Scale (GDS).

As part of the VHA pilot testing, we developed a staff questionnaire with the intent of having the PHQ-9 collected from staff reports of their observations for residents who could not self-report. The PHQ-9 staff observation version (PHQ-OV) includes the nine signs and symptoms of depression found in the PHQ-9 plus an additional irritability item. We considered irritability for inclusion because of its association with mood disorder in persons with cognitive impairment. In the data below, we show the PHQ-9-OV score that includes the additional irritability item. In a sample of 247 veterans, the PHQ-9 resident self-report was modestly but significantly correlated with a staff version of the PHQ-9-OV developed for the pilot study. No other combination of staff assessment and resident self-report included in the pilot had a significant correlation.

#### Sample

Sample selection is detailed in the description of overall MDS 3.0 development and testing. In brief, 3822 residents who were scheduled for MDS assessments were assigned to the study based on their scheduled MDS 2.0 assessment. The only exclusion criterion was comatose status. From the larger sample scheduled for MDS assessments, an algorithm was used to randomly assign residents to a feasibility sample, a test of research nurse agreement in collecting the criterion measures, and a validation sample. Nurses were trained in the randomization process and were provided templates to guide assignment.

#### Measures

##### MDS 3.0 Items

We included the PHQ-9 resident interview and the 10-item staff PHQ-9 OV in the MDS 3.0 that underwent national testing. The interview was formatted in a manner approved by the PHQ-9 developer to allow an unfolding approach to item response. With this approach, the individual is oriented to the interview items. Then they are asked if they have been bothered by the symptom. If they respond yes, then they are asked to select a frequency response. This interview approach has been validated and is more commonly used with vulnerable populations to facilitate response. If the resident could not answer items, then the assessor was instructed to interview the staff member who knows the resident best to complete the PHQ-9 OV.

##### Cognitive

We used the 3MS cognitive test to classify resident’s cognitive status as either severe impairment (3MS <30) or no to moderate impairment (3MS score ≥30).

##### Criterion Measures

The national validation protocol included as a criterion depression measure the modified Schedule for Affective Disorders and...
Schizophrenia (m-SADS)\textsuperscript{87–89} for residents with 3MS score \( \geq 30 \). The m-SADS is a validated 23-item semi-structured interview in which symptoms are scored for presence and clinical significance. For residents with severe cognitive impairment (3MS < 30) we used the Cornell Scale for Depression in Dementia (Cornell Scale), a validated 19-item structured assessment for mood disorder that incorporates multiple inputs: caregiver report, resident self-report, observations of resident behavior, and medical record review.\textsuperscript{50,51} Possible Cornell Scale scores range from 0–38.

Research nurses were trained on both criterion assessments by a geriatric psychiatrist and psychiatric nurse with significant experience in training data collectors. For the m-SADS and Cornell Scale, the trainers went with pairs of research nurses to a local NH where the nurses observed these trainers completing the assessments with residents. In addition each nurse in the pair conducted a supervised assessment, being observed by the other nurse and by the psychiatrist or the psychiatric nurse trainer. All assessments were reviewed and discussed by the research nurse pair and trainers. Finally, to further validate the research nurse assessments using the criterion measure in the national validation study, we tested research nurse to research nurse agreement on the validation items.

**Staff Feedback Survey**

Nurses who participated in the MDS national study anonymously completed a feedback survey at the end of the study. The structured questionnaire used Likert scale responses to obtain feedback on the PHQ-9 and PHQ-9 OV; the survey also provided space for written comments.

**Data Collection**

Because the PHQ-9 performed well across all levels of cognitive ability in the pilot, we instructed staff members to approach for PHQ-9 interview all the residents assigned to the feasibility arm of the study if the resident was capable of any communication. Assessors were trained to explain and show the response scales to the resident on separate sheets of paper or cue cards. Assessors were also instructed to strictly record the resident’s responses to the PHQ-9 interview in the testing form. For residents who could not complete the PHQ-9 interview or who were unable to make him or herself understood at least some of the time, assessors completed the PHQ-9 OV. For all residents, the MDS 2.0 that was completed by NH staff was also obtained.

For the residents in the validation sample, one research nurse completed the PHQ-9 interview or PHQ-9 OV and another independently completed either the m-SADS or Cornell Scale. Order and research assignment for PHQ vs criterion measure were switching for the PHQ-9 and PHQ-9 OV; the survey also provided space for written comments.

**Analysis**

The ability of residents to complete interviews was calculated as the number of completed interviews (numerator) divided by the number of residents in the sample (denominator). We defined completion of the PHQ-9 as responding to six or more PHQ-9 items and the related frequencies if the symptom was reported as present.

To obtain time estimates for completing the PHQ-9 interview, research nurses entered start and stop times in hours and minutes directly on the data collection form. These times were entered into the data set and we calculated the time elapsed.

We calculated PHQ-9, 3MS, m-SADS, and Cornell Scale scores based on published values and scoring rules. Two approaches are available for scoring the PHQ-9. The first relies on the DSM definitions of minor and major depression. Minor depression is defined as two to four symptoms present more than half of the days and one of these is either anhedonia/loss of interest or feeling down/depressed/hopeless. Major depression is defined as five or more symptoms present more than half of the days and one of these is either anhedonia/loss of interest or feeling down/depressed/hopeless. The second approach to scoring PHQ9 is a total severity score obtained by adding frequency responses.

We considered three existing approaches to scoring the MDS 2.0 mood items: the quality indicator (QI) approach that uses a scoring algorithm to try to match the DSM diagnostic algorithm for determining depression prevalence; the continuous score used to generate the quality measure (QM) used in NH Compare; and the scoring logic that is used in RUGs, which yields a continuous measure and a 0/1 indicator. We considered these alternate approaches to optimize the opportunity for MDS 2.0 agreement with the criterion measure.

To test whether the PHQ-9 interview or MDS 2.0 mood scale better matched the criterion measure, we considered two possible samples. The first included residents who completed the PHQ-9 interview and who because their 3MS score was \( \geq 30 \) were also assessed by the m-SADS criterion measure. The second included residents who completed the PHQ-9 interview, but who, because their 3MS score was < 30, were assessed with the Cornell Scale. To test whether the PHQ-9 OV or MDS 2.0 mood scale better matched the criterion measure, we had two other possible samples. The first included residents who had the PHQ-9 OV completed but who had a 3MS score \( \geq 30 \) and were therefore assessed by the m-SADS criterion measure (ultimately no residents in the sample were in this category). The second included residents who had the PHQ-9 OV completed and who, because their 3MS score was < 30, were assessed with the Cornell Scale.

Because m-SADS and PHQ-9 can both categorize depression into no, minor, or major, we used weighted kappas (\( \kappa \)) to consider the agreement between these instruments. The MDS 2.0 Quality Indicator (QI) and RUGs definitions for mood differ, but both can yield a binary coding of a mood problem (no/yes). Therefore to compare m-SADS to these measures, we recoded m-SADS as 0 = no, 1 = minor or major. For comparisons to the Cornell Scale criterion continuous measure we used correlations to compare it to PHQ-9 total score, total score on NH Compare QM cross-sectional count, and total score on the MDS 2.0 RUGs. Statistical analyses were performed using SAS (SAS Institute, Inc., Cary, NC).

For staff responses to the anonymous survey described above, we recoded the five-point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree) into three categories as follows: strongly agree or agree; neutral; disagree or strongly disagree.
Results

Completion Rates and Time Requirements for the PHQ-9

Of 3258 residents in the feasibility analyses, 2797 (86%) completed the PHQ-9 interview. For the 461 who did not complete the interview, 270 (8% of the total sample) were not approached, and 191 (6% of total sample) had an interview attempted but they could not complete it.

Staff were able to complete PHQ-9 OV for 424 (92%) of the 461 residents who did not complete the resident interview. In sum, 3221 of the 3258 residents (99%) in the sample had PHQ-9 or PHQ-9 OV scores.

The average PHQ-9 interview completion time, based on recorded start and stop times for the validation interviews was 4.0 minutes (SD 3.8; median = 3.0; mode = 3.0).

Staff Feedback on PHQ-9 Interview and PHQ-9 OV

National Survey feedback from PHQ-9 users was positive. Eighty-two percent reported that the mood section was improved overall (7% neutral, 6% disagreed). Responses were slightly more favorable for the interview items. Most felt that the MDS 3.0 interview was superior to the MDS 2.0 at capturing the resident’s mood (88% of respondents), that the PHQ-9 interview provided new insights into resident’s mood (86%), and that the PHQ-9 would better allow staff to calculate a score and trigger resident assessment protocols (78%).

For the PHQ-9 OV, 74% of survey respondents strongly agreed or agreed that they found the MDS 3.0 staff observational items to be easier than the MDS 2.0 assessment approach, while 90% felt that staff detection and communication about mood disorder might improve if they learned to watch for PHQ-9 OV signs and symptoms.

PHQ-9 Diagnostic and Depression Severity Results

A total of 418 of 419 residents assigned to the validation arm had matched data for inclusion in analyses. Of these, 368 (88%) completed the PHQ-9 interview with a mean score of 6 and a range of 0–26 and 48 residents who did not complete the PHQ-9 interview had staff PHQ-9 OV assessments. Considering the 10 items, the average score was 6 and ranged from 0 to 17. Probable DSM-IV diagnoses using the PHQ-9 diagnostic algorithm as well as the distribution of severity scores are summarized in Table 1.

Criterion Standard Validation

As described in the Methods section, we used two different gold-standard measures for mood disorder, based on the resident’s cognitive ability. The 324 residents in the validation sample with 3MS scores ≥30 were assessed with the m-SADS. As shown by the weighted k in Table 2, the PHQ-9 had excellent agreement with the m-SADS whereas both MDS 2.0 scoring approaches had poor agreement.

Of 88 residents in the validation sample with 3MS scores <30, 80 had complete Cornell Scale scores. Of these 80 residents, 38 (48%) successfully completed the PHQ-9 resident interview. In other words, even though they had severe cognitive impairment on the 3MS, they were capable of making themselves understood at least some of the time AND were able to complete the PHQ-9 interview. For the 42 residents who could not make him or herself understood or who could not complete the PHQ-9 interview, assessors used the PHQ-9 OV that includes the 9 signs and symptoms of depression found in the PHQ-9 plus an additional irritability item. As shown in Table 3, both the PHQ-9 interview and PHQ-9 OV (completed by residents unable to complete interview) were superior to the MDS 2.0 mood measures as demonstrated by much stronger correlations with the Cornell Scale.

Discussion

NH staff successfully used the Patient Health Questionnaire-9 item (PHQ-9) interview, a validated depression screener that allows identification of changes in depression severity over time, to assess their residents. Most (86%) of the 3258 residents in the national feasibility study completed the PHQ-9 interview. The majority of staff who used the PHQ-9 interview found it better at capturing resident mood than the MDS 2.0 subjective mood items. The staff participants also preferred the related observer version of the PHQ-9, the PHQ-9 OV, for those residents who were unable to complete the interview.

In the validation sample, both the PHQ-9 resident interview and PHQ-9 OV were more highly correlated with criterion assessments of depression than were the MDS 2.0 mood items. Residents with mild, moderate, and even some with severe cognitive impairment were able to complete the interview. The interview scores, even in persons with severe cognitive impairment, were more highly correlated with independent measures of probable depression. For residents who could not be interviewed, a staff-based assessment based on PHQ-9 items, the PHQ-9 OV, also proved superior to the MDS 2.0 mood measures.

Based on the results of pilot and national testing in NHs, the PHQ-9 and PHQ-9 OV were included in the final MDS 3.0. The current MDS 3.0 PHQ-9 interview item set is shown in the Appendix. The inclusion of the PHQ-9 interview in the MDS 3.0 aligns MDS with an emerging and increasingly applied approach to screening for depression in other settings. It provides a standardized severity score and a rating for evidence of depression. The interview allows the assessor to identify a summary score for depressive symptoms that can be communicated to healthcare providers, to easily identify and track symptoms, and to track how symptoms are changing. Scores can be useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression. The PHQ-9 is currently among the most widely used depression scales and is available in more than 80 translations, some of which are freely available on a public domain website (www.phqscreeners.com).

Table 1

<table>
<thead>
<tr>
<th>DSM IV-Based Probable Diagnosis by PHQ-9 Algorithm</th>
<th>PHQ-9 (n = 368)</th>
<th>PHQ-9 OV (n = 48)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No depression</td>
<td>65</td>
<td>58</td>
</tr>
<tr>
<td>Minor depression</td>
<td>18</td>
<td>31</td>
</tr>
<tr>
<td>Major depression</td>
<td>17</td>
<td>10</td>
</tr>
</tbody>
</table>

Severity of depression (PHQ-9 score ranges)

| None (0–4)                                      | 52             | 54             |
| Mild (5–9)                                      | 20             | 13             |
| Moderate (10–14)                                | 15             | 23             |
| Moderately severe (15–19)                       | 11             | 10             |
| Severe (20–27 for interview; 20–30 for PHQ-9 OV) | 2              | 0              |

Table 2

<table>
<thead>
<tr>
<th>Agreement between Candidate MDS Measures and m-SADS Criterion Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Residents Without Severe Cognitive Impairment</td>
</tr>
<tr>
<td>Candidate Measure Compared with m-SADS</td>
</tr>
<tr>
<td>PHQ-9 Resident interview</td>
</tr>
<tr>
<td>MDS 2.0 Ql definition</td>
</tr>
<tr>
<td>MDS 2.0 RUGs definition</td>
</tr>
</tbody>
</table>
Table 3
Agreement between Candidate MDS Measures and Cornell Scale

<table>
<thead>
<tr>
<th>Candidate Measure Compared with Cornell Scale for Depression in Dementia</th>
<th>Correlation</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents who could be interviewed (n = 38)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 Resident interview</td>
<td>.63</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>MDS 2.0 QI definition</td>
<td>.34</td>
<td>.03</td>
</tr>
<tr>
<td>MDS 2.0 RUGs definition</td>
<td>.21</td>
<td>.20</td>
</tr>
<tr>
<td>Residents who could not be interviewed (n = 42)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ-9 OV Staff interview</td>
<td>.84</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>MDS 2.0 Quality measure</td>
<td>.14</td>
<td>.38</td>
</tr>
<tr>
<td>MDS 2.0 RUGs definition</td>
<td>.28</td>
<td>.08</td>
</tr>
</tbody>
</table>

Higher PHQ-9 scores indicate an increasing probability of clinically significant depressive disorder. Scores of 15 or higher often correspond to major depressive disorder and scores of 5–9 typically represent milder degrees of depressive symptoms rather than major depressive disorder. Scores of 10 or higher should prompt further probing by a clinician to determine if treatment for mood disorder is warranted and lower scores 5–9 should prompt facility staff to consider approaches to mitigating symptoms and for follow-up assessment and monitoring.

It is important to note that the PHQ-9 score does not diagnose depression. Symptoms are recorded regardless of etiology or attribution, and once identified require a clinical assessment for causes in this population with multiple co-morbidities. This is true of other mood screeners. In addition, the ultimate diagnosis of depression relies on a determination that the symptoms are impairing life-function. However, a meta-analysis of 17 validation studies found that the PHQ-9 was comparable to longer clinician screens in a variety of populations and settings.

These questions raised some of the greatest concerns in the initial training. Comments included “I can’t do that”; “It will take too much time”; “What if they cry and I can’t get my work done?” These responses are not significantly different from those encountered when initially training clinicians in other settings on mood surveys like the PHQ-9 and the Geriatric Depression Scale. However, after brief training on how to interview older adults and a few attempted interviews with actual residents, attitudes for most nurses shifted dramatically. One nurse remarked “We had no idea he was suffering so much. He was always so cooperative. I’m glad we found out how he was feeling.” Another nurse commented “The residents don’t seem to mind. I thought they would, but they don’t.” In addition to improving MDS validity, the acquisition of these interview skills has potential clinical applications outside of the MDS assessment. Online training materials for this and other interview sections are available to support staff.

Limitations

The gold-standard measure for depression is a diagnostic evaluation by a trained mental health specialist. It was not feasible to apply this standard in the current study. However, our validation testing used criterion measures that have been validated against this gold-standard. The PHQ-9 measures in the validation sample were collected by motivated research nurses who we trained. It is possible that their interviews were more carefully conducted than what would happen in actual facility care. However, average times that they reported for their PHQ-9 interviews (4 minutes) would argue that they did not spend an inordinate amount of time completing the interview.

Conclusions

The PHQ-9 is a structured depression interview that can be completed by NH staff in the overwhelming majority of residents. Staff satisfaction with the gains they saw from the time that they invested was high. The PHQ-9 interview and newly developed PHQ-9 OV show high levels of agreement with longer, validated depression assessments, and provide information on DSM-IV signs and symptoms of depression in NH populations. This approach to mood assessment yields probable diagnostic categories that are useful in communication as well as severity scores that can be used to measure change over time. Finally, online training materials for this and other interview sections are available to support staff.

References

**Appendix A**

### Section D: Mood

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

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td>Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)</td>
</tr>
<tr>
<td>1. Yes</td>
<td>Continue to D0200, Resident Mood Interview (PHQ-9-H)</td>
</tr>
</tbody>
</table>

**D0200. Resident Mood Interview (PHQ-9-H)**

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 card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

<table>
<thead>
<tr>
<th>1. Symptom Presence</th>
<th>2. Symptom Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No (enter 0 in column 2)</td>
<td>0. Never or 1 day</td>
</tr>
<tr>
<td>1. Yes (enter 0-3 in column 2)</td>
<td>1. 2-6 days (several days)</td>
</tr>
<tr>
<td>9. No response (leave column 2 blank)</td>
<td>2. 7-14 days (half or more of the days)</td>
</tr>
<tr>
<td>12. 12-14 days (nearly every day)</td>
<td></td>
</tr>
</tbody>
</table>

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 around a lot more than usual

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

**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 (i.e., Symptom Frequency is blank for 3 or more items).

**D0500. Safety Notification** - Complete only if D0200X = 1 indicating possibility of resident self harm

<table>
<thead>
<tr>
<th>Entry Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>