

OASIS ITEM

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2©*	Not at all 0 - 1 day	Several days - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

- ☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- ☐ 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

* Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.

ITEM INTENT

Identifies if the home health agency screened the patient for depression using a standardized depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others.
- To meet the definition of "standardized," the depression screening tool must 1) have been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.); and 2) include a standard response scale. The standardized tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered as indicated in the instructions.
- If a standardized depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.
 - In order to select Responses 1, 2 or 3, the standardized depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

Guidance for this item updated 12/2011

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)

- Select Response 0 if a standardized depression screening was not conducted.
 - If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected.
- Select Response 1 if the PHQ-2© is completed, and mark the appropriate responses in rows a and b. If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.
 - If the PHQ-2 is not used to assess the patient, you may choose to administer a different standardized depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment.
- Select Response 2 if the patient is screened with a different standardized assessment AND the tool indicated the need for further evaluation.
- Select Response 3 if the patient is screened with a different standardized assessment BUT the tool indicates no need for further evaluation.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ-2© can be found in Chapter 5 of this manual.
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.