

Depression in the nursing home: a cluster-randomized stepped-wedge study to probe the effectiveness of a novel case management approach to improve treatment (the DAVOS project)

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Study protocol

Keywords: late-life depression, nursing home, cluster-randomized intervention study, case management, psychotherapeutic treatment, stepped-wedge design

Posted Date: June 19th, 2019

DOI: <https://doi.org/10.21203/rs.2.462/v3>

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Version of Record: A version of this preprint was published on July 11th, 2019. See the published version at <https://doi.org/10.1186/s13063-019-3534-x>.

Abstract

Background Depression is the second most common psychiatric illness in old people. Up to 30% of nursing home residents suffer from minor or major depression. Although depressive disorders in old age can be improved and even cured with adequate therapy, they often go unnoticed in nursing home residents and remain untreated. This highlights a striking deficit in health care and might result not only in lower quality of life among those concerned but also in poor physical functioning, premature mortality and increased hospitalization rates. **Methods** The aim of the interdisciplinary research project DAVOS is to implement an innovative and stepped structural case management program to improve depression treatment in nursing home residents by a modularized intervention and to assess it in terms of its effectiveness. Intervention modules are in line with recommendations given by the German national treatment guidelines for depression (S3 guidelines). Ten nursing homes in Frankfurt, Germany, will participate in the project which aims to recruit a study population of N = 380. The recruitment will continue throughout the trial (open cohort). Persons (>60 years) that live in a nursing home, have no medical diagnosis of dementia and can provide their informed consent to participate are eligible for inclusion in the study. Residents with a clinical diagnosis of dementia, alcohol or substance related disorders or other serious psychiatric illnesses will be excluded. DAVOS is a controlled cluster-randomized study that employs a stepped-wedge design. **Discussion** Our main hypothesis is that the implementation of the intervention will lead to a decline in the prevalence of depression and a reduction in depression symptoms among the home residents. In addition, we expect the intervention to have a positive impact on secondary outcomes such as level of functioning, quality of life and social participation. The project's results can make an important contribution towards improving the health care of nursing home residents suffering from late-life depression.

Background

Depression is the second most common psychiatric illness in old and very old people. Depending on the study, estimates of the prevalence of late-life depression (≥ 75 years of age) vary from 4.6% to 9.3% (pooled prevalence: 7.2%) for major depression and 4.5% to 37.4% (pooled prevalence: 17.1%) for milder forms of depressive illnesses (minor depression, persistent depressive disorder / dysthymia) [1]. At 6.8%, the incidence of clinically relevant depression symptoms in persons over 70 years of age is twice as high as the incidence of dementia [2, 3]. Furthermore, the varying presence of so-called subsyndromal symptomatic depression is also common in later life and is a risk factor for the development of clinical depression. Further risk factors for late-life depression include frailty, multimorbidity, polypharmacy and critical life events associated with old age, such as the loss of independence or a spouse [4]. Depression occurs significantly more often among old adults whose physical capacity is steadily declining and who are increasingly unable to participate in activities of daily living. Consequently, the prevalence of depression in nursing homes is almost twice as high as in late life in general: A field study conducted by Kramer et al. (2009) showed that around 30% of nursing home residents are suffering from acute depression (major depression: 14.4%; minor depression: 14.4%) [5]. Although depressive illnesses in old

age can easily be treated, they often remain unnoticed and are not dealt with in nursing home residents. As a result of the structural peculiarities of the German health care system, a mere 42.9% of nursing home residents with major depression are actually diagnosed as having the disease and only half of them receive an appropriate therapy. [5]. This highlights a striking deficit in health care and results not only in lower quality of life among those concerned but also in poor physical functioning, premature mortality and increased hospitalization [6–8]. Furthermore, the existence of chronic untreated depression has been shown to have a negative influence on the course of numerous somatic diseases, as well as the risk of polypharmacy [9].

The aim of the project “Depression in the nursing home: Using a stepped collaborative care model to improve treatment” (DAVOS: *Depression im Altenpflegeheim: Verbesserung der Behandlung durch ein gestuftes kollaboratives Versorgungsmodell*) is to implement an innovative and stepped structural case management program to improve depression treatment of nursing home residents by a modularized intervention and to assess it in terms of its effectiveness.

The main hypothesis of this research project is that the implementation of the intervention program will lead to a decline in the prevalence of depression and a reduction in the symptoms of depression (depression severity) among the residents of the participating nursing homes. Furthermore, it is expected to have a positive impact on secondary parameters that are influenced by depressive illnesses, such as level of functioning, quality of life and social participation.

Methods/design

The DAVOS study has been approved by the Ethics Committee of the Goethe University of Frankfurt am Main, Germany (reference 129/18 and conforms to the Declaration of Helsinki (Version Fortaleza 2012). Trial registration is DRKS00015686 (www.drks.de).

DAVOS is a controlled cluster-randomized trial that uses the stepped-wedge design. This type of waiting control group design employs repeated assessments, whereby each of the clusters (= nursing home) of the mentioned cluster group begins in the control phase. Each cluster group in DAVOS includes residents from 3-4 different nursing homes. After a certain delay, the intervention is gradually introduced in each cluster group (see Figure 1). During the waiting control phases, patients receive “usual care”. The point at which clusters pass from the control to the intervention phase is fixed. As soon as a new cluster group passes into the intervention phase, relevant data is collected from all clusters. In this way, data is gathered throughout the duration of the intervention (T1-T4), irrespective of whether the intervention has already been introduced or not. The T4 assessment can be classified as post-data collection. Furthermore, baseline (T0) and follow-up (T5) assessments are conducted four months before and four months after the intervention, respectively. Thus, depending on time point of recruitment and inclusion in to the study, residents will be repeatedly measured up to five times. Overall, 10 nursing homes (about 1,250 care places) are included and randomized to three cluster groups. We aim to recruit a study population of N = 380. As a result of newly admitted nursing home residents, the recruitment process will

be continuous (open cohort), enabling the size of the study population included at baseline to be kept more or less constant throughout the study. In this way, the drop-outs that are a natural part of the process, perhaps due to severe illness or death, can be compensated for, and the number of assessments in each survey period can be kept almost constant.

The stepped-wedge design allows comparisons to be made within and between the clusters, receiving and not receiving the intervention. Furthermore, insights can be obtained into whether and from when the complex intervention is effective (the separate modules of the intervention have already been demonstrated to be effective in previous randomized studies).

[FIGURE 1]

Randomization

The nursing homes are the units of randomization (unrestricted randomization). We randomly assigned the 10 nursing homes (cluster) to the three cluster groups with computer-generated random numbers. We used online software to generate a randomization using a list randomizer (<http://www.random.org>). Finally, each cluster group includes residents from 3-4 different nursing homes. There are certain time points at which the cluster groups pass from the control to the intervention phase. All nursing homes and the included residents are informed about these time points.

Setting and study population

The recruitment of participants and implementation of the intervention will take place at 10 outpatient nursing home facilities with a total of more than 1,250 care places. This will be possible as a result of the cooperation with the two social services organizations (German: *Frankfurter Verband für Alten- und Behindertenhilfe e.V.*; *Agaplesion Markus Diakonie gGmbH*). Based on nursing home records (e.g., on known diagnoses and health status), the nursing home residents that are, in principle, suitable for participation in the study, will be approached by the previously appointed case managers. At this point, residents with a clinical diagnosis of dementia (ca. 50%), are unable to provide consent, or who have a known alcohol or substance related disorder will be excluded from participation. It can be assumed from previous research that about one third of the overall population (ca. 36%) will be eligible for participation in the study and will provide their consent (Figure 2). The data of residents that agree to participate in the study will be collected at baseline and checked against the inclusion and exclusion criteria.

[FIGURE 2]

Residents over 60 years of age and without obvious signs of dementia, an addictive disorder, or another severe mental illness will be included in the study. Inclusion criteria for participation in the interventional modules as described below are the presence of a subsyndromal depressive disorder or clinical depression. It makes sense to include subsyndromal symptomatic depression because it is common in old age and defines an important target population for the use of secondary preventive measures. In any case diagnosis of subsyndromal or clinically manifest depression is based on ICD 10 criteria following the judgement of a psychotherapist who is licenced by a state board (in Germany: *Approbiertes Psychotherapeut*). The establishment of a proper clinical diagnosis is already part of the intervention as described below.

Intervention

The case management program as well as the interventional modules are shown in Figure 3. The depression case managers play an important integrative role in the intervention, as they are at the interface between residents, nurses, physicians, and psychotherapists. The case managers are nurses selected by the management of the respective nursing homes, and who have been trained for this role before the intervention begins. In every participating nursing home two depression case managers are selected. Altogether 20 depression case managers are trained during the study. The case manager's tasks include the identification of suitable study participants, prompt presentation during the psychotherapeutic consultation hour (see below) in the case of positive screening of depression, and coordinate the treatment modules for the participants.

The trainings for case managers will include the following four elements: 1) communication of basic medical-psychological information on late-life depression, 2) use of the screening instrument, 3) information on how to deal with residents with depression and 4) the organization of project-related requirements.

Case managers will be supervised throughout the study.

[FIGURE 3]

The intervention is initiated by a screening applied to the participating residents using a modified version of the Depression Monitoring List (DeMoL) with integrated PHQ-D assessment [10]. The screening is performed by the depression case manager or by other members of the nursing staff under the supervision of the case manager. In case of positive screening the participant is referred to a *psychotherapeutic consultation hour* (in German: *Psychotherapeutische Sprechstunde*) in accordance with §92, paragraph 6a, German Social Code (in German: *Sozialgesetzbuch*) during which a board licenced psychological psychotherapists will provide a diagnostic assessment (according to ICD 10 criteria). As part of DAVOS, the psychotherapeutic consultation hour will be implemented as an "in house" service in the nursing home which is an innovative approach compared to the usual practice in the

German health care system. The assessment in the psychotherapeutic consultation hour will conclude with recommendations for several interventions that are elaborated in accordance with the German S3 guideline, and the National Disease Management Guideline on Unipolar Depression [6], and are part of three interventional modules. Ranging from “watchful waiting”, participation in basic intervention (module 1) and a recommendation for psychotherapy (module 3) to the involvement of the general practitioner or a specialist physician, e.g. psychiatrist (module 2), the measures will cover a wide spectrum of possible interventions:

Module 1 (= basic intervention) consists of participation in group sessions that are offered to all participants with and without any symptoms of depression (including persons suffering from subsyndromal depressive disorders). Key components of this module are supportive and psychoeducative approaches (on the subjects of “successful ageing”, “mindfulness” etc.). By preparing a weekly plan, for example, the residents are to be animated to participate in measures involving physical activity, as well as other social and leisure pursuits. The case managers initially assist to carry out this module but later take on full responsibility for it. The aim is to establish this basic intervention as part of the daily nursing routine and to encourage everyday companions and other nurses to use it after the intervention is over. The case managers are thus to adopt the role of multipliers.

Module 2 contains aspects of treatment that require the therapeutic involvement of the general practitioner in charge of the resident and/or a specialist physicians (such as exclusion or treatment of somatic causes of depression, drug therapy / antidepressants, interactions with other drugs, polypharmacy, hospital admissions etc.). The role of the case manager here is to prompt and coordinate appointments with the doctors in charge following recommendations derived from the psychotherapeutic consultation hour.

Module 3 covers participation in psychotherapeutic groups and, where applicable, individual psychotherapy conducted by psychologists. The employed interventions include elements of cognitive behavioral therapy (e.g., planning pleasant daily activities, problem solving, mindfulness-based meditation and cognitive restructuring [6, 11–15]). Individual psychotherapy sessions will be provided if required, to residents with major depression, dysthymia, and adjustment disorders. Psychotherapy will partly be delivered by psychologists in clinical training from the outpatient clinic of the Department of Clinical Psychology and Psychotherapy at Goethe University Frankfurt. The psychologists will receive additional training in CBT for late-life depression [16] and mindfulness-based cognitive therapy [14,15].

The psychologists’ tasks are: 1) participation in regular meetings at the nursing home facilities with case managers to ensure exchange of information about cases and treatments, 2) conducting psychotherapeutic consultations in order to motivate the patient for psychotherapy and select a suitable setting, 3) conducting either individual or group CBT including elements of mindfulness-based meditation [6, 11–15]).

After two months, individuals who meet the inclusion criteria for the intervention but do not wish to participate will be contacted again and informed about the provided treatment.

Data collection

Questionnaires and psychometric instruments that have been validated in clinical and gerontology research will be used to collect data face-to-face. For this purpose, instruments have been selected that are well-established and time-efficient, but that simultaneously cover a wide range of outcome-relevant variables. Data collection will be mainly quantitative but also supplemented qualitative methods (e.g., interviews with case managers, focus groups). These qualitative data will be analyzed by the sequential analysis in dependence on Rosenthal [17] and the Grounded Theory [18].

Subsequently, paper-pencil data will be digitalized, checked and subjected to missing values analysis. Questionnaires with more than 30% of values missing will not be included in the subsequent analysis. An estimate of isolated missing values will be made, using, for example, the FIML (full information maximum likelihood algorithm).

The raters responsible for data collection are part of the study team but not involved in the intervention (e.g. psychotherapy). They will receive intensive training in using the deployed instruments (test methods, questionnaires). The exclusive use of standardized instruments will ensure the influence of individual raters is negligible and that the data is valid. During the trainings, the trustworthiness of the data collection process will also be controlled by calculating interrater reliability.

Outcomes

The prevalence of depressive disorders and the severity of depression symptoms (or any change in them) among nursing home residents are the primary outcomes of DAVOS. Secondary outcomes are quality of life, functional status (instrumental activities of daily living), social participation and the type, frequency and duration of any hospitalization during the observation period. In addition to collecting data on primary and secondary outcomes (T0 to T5), relevant personal and sociodemographic data will be collected at baseline (including family background, socioeconomic status, educational level, subjective health status [19], personality characteristics [20], cognitive status [21], current medication and somatic comorbidities). To minimize the stress of data assessment nursing home documentation can serve as additional data source. Some of the variables, such as health status and cognitive status, will be measured repeatedly at the T5 follow-up assessment. All instruments are well introduced, validated and have frequently been used in previous research. An overview of the instruments and associated validation references are given in Table 1.

The primary outcomes (prevalence of depressive disorders and severity of depression symptoms) will be assessed using the structured clinical interview for DSM-IV (SCID-I) [22] and the Geriatric Depression Scale (GDS) [23]. SCID-I is a commonly used means of recording and diagnosing selected mental syndromes and disorders. The 15 items on the GDS are part of the geriatric assessment for the evaluation of depressive disorders in old age.

Baseline assessments are conducted simultaneously in all the clusters to determine prevalence rates of depression at differing levels of severity. We expect a significant decrease of prevalence rates of depression as well as severity of depression symptoms in the clusters that receive interventions, as compared to clusters receiving care as usual (stepped-wedge approach). The screenings conducted by the case managers that are part of the intervention are independent of the outcome assessments and cannot therefore result in an increase in prevalence.

Established instruments and scales which are developed especially for old adults will be used to measure secondary outcomes such as quality of life, functional competence and social participation. Examples of these are the Philadelphia Geriatric Center Morale Scale (PGCMS) [24], the WHO Quality of Life (short form) (WHOQOL-OLD) [25, 26], a questionnaire for the assessment of aspects of quality of life in later life, the short form of the Late Life Function and Disability Instrument (SF-LLFDI) [27], and the Social and Emotional Loneliness Scale (short form) [28]. Information on the frequency and duration of hospitalization will be taken from nursing home records.

Data analysis and data quality assurance

The evaluation will be conducted using a stepped-wedge design with open cohorts [29]. That means that not only at the beginning but also during the course of the trial, new participants will be recruited into each of the 10 clusters. Each new recruit will generally undergo all the data assessments (periods) from his inclusion into the trial until she/he either leaves the nursing home or the project ends. The percentage (point prevalence) of participants with depression will be assessed at the end of each period, with some of the trial participants being assessed for the first time and others not. Assuming the new care model to be effective, the prevalence of depression is expected to decline significantly. The use of a stepped-wedge design ensures that results do not reflect a general period effect, meaning that they do not result from a change in prevalence in all the clusters, independently of whether a cluster is in the control or intervention phase.

A hierarchical generalized linear model with a logit link function will be used for the analysis and will account for not only fixed treatment and period effects but also random effects on both cluster and patient level. In order to analyze the second primary endpoint (depression severity), we will fit a hierarchical logistic regression model for ordinal target variables (cumulative odds model). Details will be laid down in a statistical analysis plan. The statistical models mentioned above are suitable for use with correlated categorical data for the incomplete courses that the planned design leads us to expect. Bias can be avoided or at least limited through the use of randomization and the standardization of data collection methods.

Based on a sample size of 38 participants to be assessed in each cluster (nursing home) in each period, cluster groups of three, four and three (10 nursing homes), a type 1 error probability of 0.05 in a two-tailed test, a prevalence (including subsyndromal symptomatic depression) of 33% under control conditions

[30] and 22% under intervention conditions, and assuming a between cluster standard deviation of prevalences of 4%, and assuming independence between repeated observations on the same patients within clusters across periods, the power of the study will be 0.80. We assumed a time constant random cluster effect, which induces a correlation structure with an intraclass coefficient (ICC) of 0.0072 under the null hypothesis and of 0.0092 under alternative hypothesis within intervention periods, both within periods and between periods. Note, that this assumption also implies a perfect autocorrelation of random cluster effects across time. For power calculation, we used the R package swCRTdesign [31]. In fact, patient level random effects will introduce dependencies within clusters across periods. This induces a reduction in effective sample size for repeated observation under the same treatment and increased effective sample size for repeated observation under different treatments. We expect that the latter effect will dominate because the majority of patients will be observed under both treatment conditions. At the planning stage of the project, we did not perform further sensitivity analyses to account for variability in cluster size, for attrition, and for more realistic correlation structures. For attrition, we expect a limited impact, because new patients will be recruited while the study is ongoing accounting for eventual drop out and patients dying.

Discussion

Collaborative and multiprofessional treatment concepts are an effective and efficient means of providing appropriate health care for old and very old persons and have recently also been recommended for the treatment of nursing home residents with depression [32, 33]. Nevertheless, there are a few health care programs available that address the problem of late-life depression in Germany [11]. The results of an RCT on the effectiveness of the Dutch program “Act in Case of Depression” (AiD) represent one of the few records of a program for the treatment of non-demented nursing home residents with depression. Previous results show that the implementation of AiD in Dutch nursing homes led to a significant decline in the prevalence of depression and an improvement in quality of life among residents [34–36]. Based on the experiences gathered in the AiD program, DAVOS will develop and implement a comprehensive case management program for institutionalized long term care settings in Germany, and conduct a controlled cluster-randomized trial to evaluate it by an interdisciplinary group of experts.

The program addresses important reasons for the health care deficits related to the adequate treatment of depression in German nursing home. These are firstly that depressive illnesses (including the subsyndromal symptomatic depression that is more common in later life) are often recognized too late or not at all. Secondly, previously described structural peculiarities also play a role, as they generally complicate the provision of appropriate medical treatment for nursing home residents (e.g. interface problems such as insufficient coordination and cooperation between nurses and doctors) [37]. In Germany, in addition to structural obstacles that are typical in a decentrally organized and fragmented health care system, appropriate treatment of nursing home residents with depression is also complicated by certain legal conditions and guidelines. One of these obstacles is the high threshold for licensed psychotherapists in providing and billing psychotherapeutic treatment in nursing homes. In this respect,

the results and practical experiences gained during the DAVOS project can be expected to give indications how needs-oriented healthcare can be provided to nursing home residents with depression in the future.

Declarations

Trial status

At the time the manuscript was submitted, first participants had been recruited into the study. Recruitment begins 20.12.2018. The study is expected to be completed in March 2021. Trial registration: DRKS, DRKS00015686 (10.10.2018). Protocol Version 1.0 12.02.2019 VT.

Ethics approval and consent to participate

The DAVOS study has been approved by the Ethics Committee of the Goethe University of Frankfurt am Main, Germany (reference 129/18 and conforms to the Declaration of Helsinki (Version Fortaleza 2012)).

Consent for publication

Not applicable.

Availability of data and materials

Not applicable.

Competing interests

The authors declare that they have no competing interests.

Funding

The study will be funded by the Innovation committee at the federal joint committee (health care) (contact: The DLR Project Management Agency, Heinrich-Konen-Straße 1, D-53227 Bonn, Germany). The funding body has no role in the design of the study and collection, analysis, and interpretation of data and in writing the manuscript.

Authors' contributions

All authors substantially contributed to the conception and design of the study. VT and AS coordinated the study and share first authorship. Both authors contributed equally to the manuscript. VT, AS, US, USt, FO, MK, EA, and JP participated in conducting the study and critically revising the manuscript to include important intellectual content. VT, AS, US, USt, FO, MK, JK, MB, EA, and JP provided all scientific and practical information in the context of the neuro-psychological assessments, the intervention and data analysis. All authors read and approved the final manuscript.

Acknowledgements

It would not have been possible to realize the project without the help of our cooperation and practice partners. We are especially grateful to Theresa Töttel, Sophie Wittersheim, Marie-Claire Rossius, Maurice Rochau, Jonas Ambrosius-Eichner and Anna Chlup for their assistance. Our special thanks go to Phillip Elliott for editing and proofreading of the manuscript.

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Table 1

Table 1: Target variables and survey instruments of DAVOS

Baseline- und follow-up assessments (T0 & T5), in addition to outcomes
Variables / instruments
Sociodemographic variables: age, gender, family background, further relevant sociodemographic data (<i>only T0</i>)
Subjective health status: 12-Item Short-Form Health Survey (SF-12_v2)
Personality characteristics: Big-Five Inventory Short Version (BFI-10)
Dementia screening: Mini-Mental State Examination (MMSE)
Primary outcomes (T0-T5)
Variables / instruments
Prevalence of depression, dysthymia, adjustment disorders: Structured Clinical Interview DSM-IV (SCID-I)
Severity of depression symptoms: Geriatric Depression Scale (GDS)
Secondary outcomes (T0-T5)
Variables / instruments
Frequency and duration of hospitalizations: Nursing home records
Quality of life: WHO Quality of Life, short form (WHOQoL Old)
Quality of life (Attitude toward own aging): Philadelphia Geriatric Center Morale Scale (PGCMS)
Functional activity level: Late Life Function and Disability Instrument, short form (SF-LLFDI)
Social participation: Social and Emotional Loneliness Scale - short form

Figures

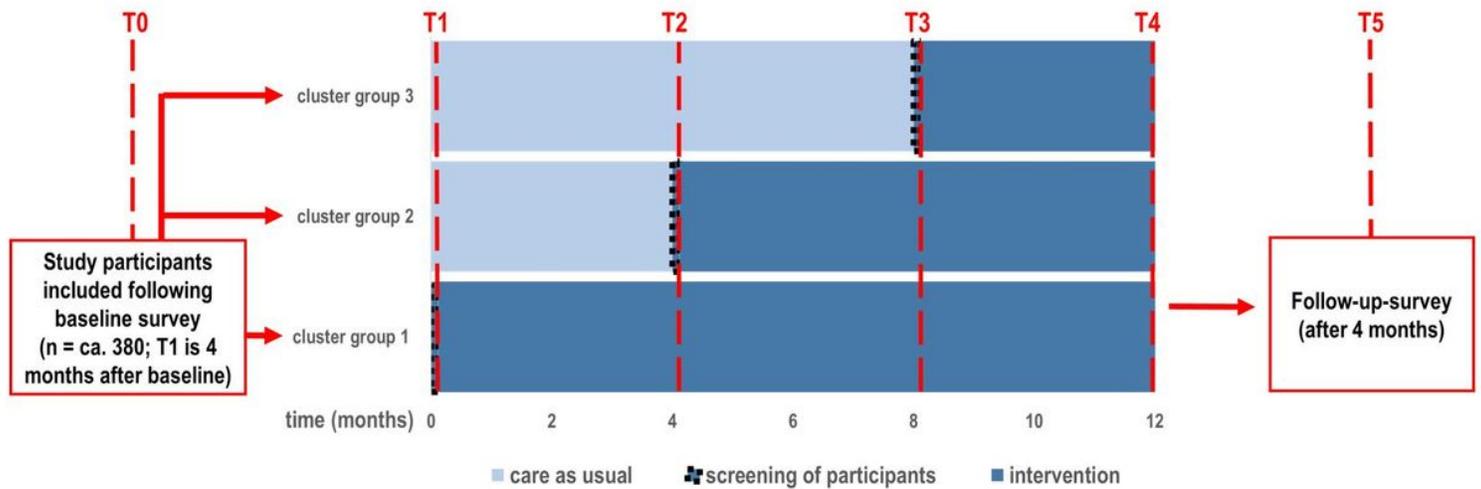


Figure 1

Study design

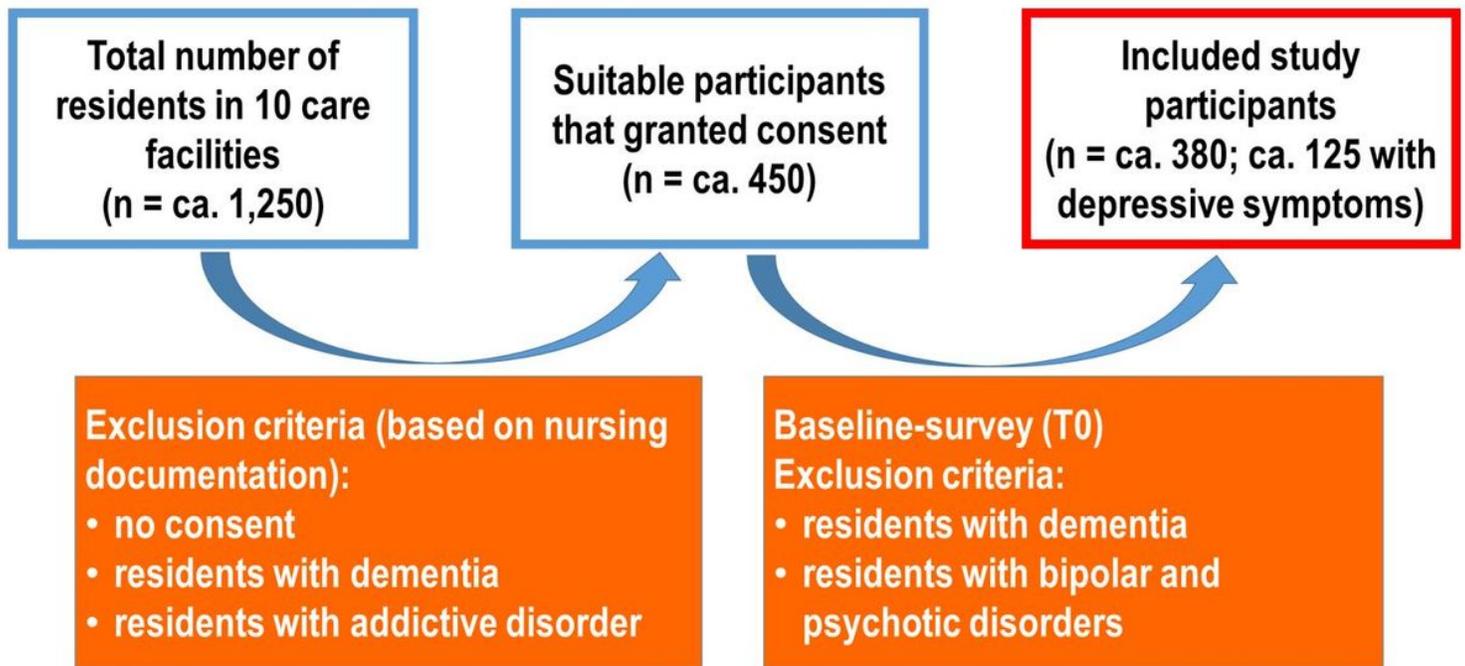


Figure 2

Participant recruitment process. Study participants with depression symptoms / depressive disorders (n = ca. 125) and without depression symptoms / depressive disorders (n = ca. 255)

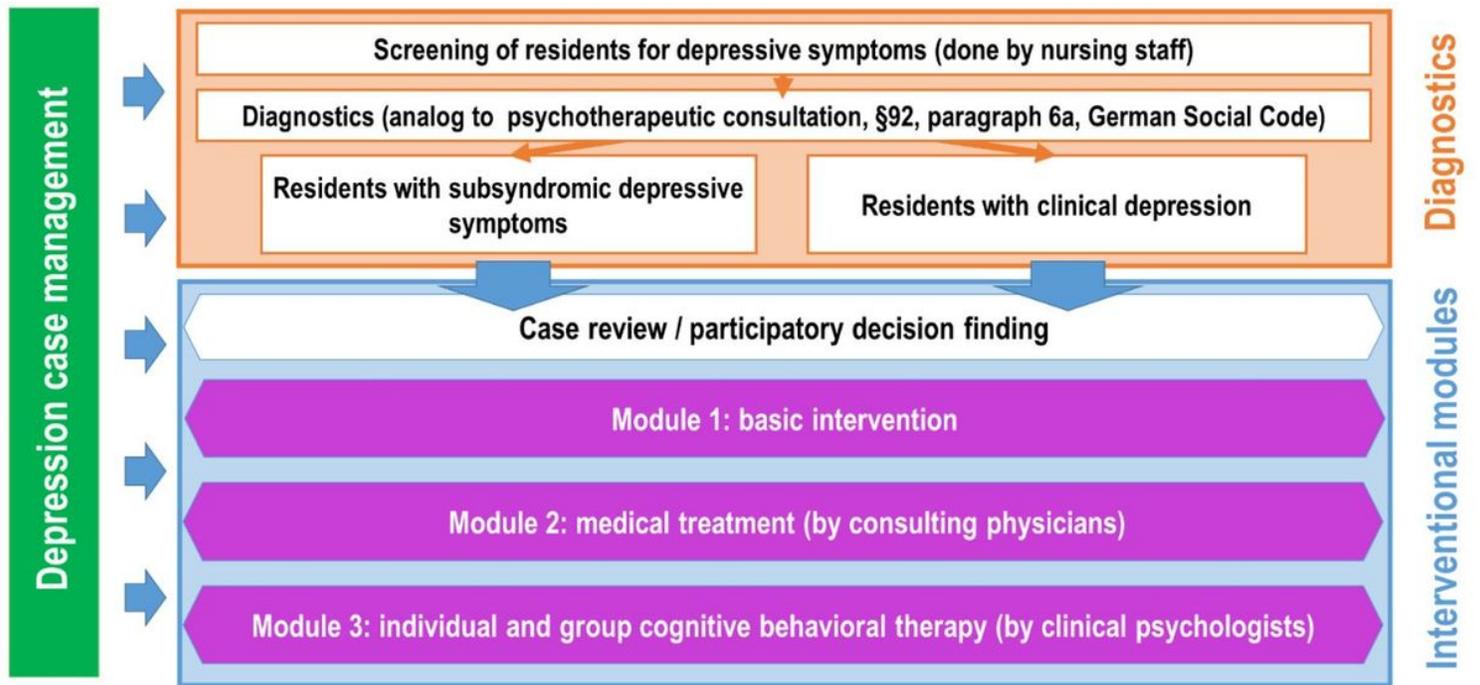


Figure 3

Presentation of the case management program and the interventional modules

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