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## Improving Depression Surveillance at the We Care Clinic

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## **Executive Summary**

### **Introduction of the Problem**

According to Henry et al. (2020), depression affects more than 16 million people each year in the United States. Many factors can increase the risk for depression; however, minority and low socioeconomic populations are at greatest risk for serious depressive disorders (Rodriguez et al., 2018). Despite the prevalence of depression, screening inconsistencies, cultural stigma, and lacking culturally competent providers contribute to depression being one of the most underdiagnosed and untreated diseases for racial and ethnic minorities (Bailey et al., 2019; Henry et al., 2020, as cited in Cooper et al., 2003). The use of consistent screening processes is essential in adult primary care settings as these settings are utilized more often for mental health services than mental health clinics or specialists (NAMI, n.d.).

Exceeding the national average of 3.8 days, St. Clair County, Illinois was found to have an average of 4.1 poor mental health days in a 30-day period (University of Wisconsin Population Health Institute, 2020). A primary care clinic in this region, East St. Louis, Illinois, that serves a high-risk population for depression, was found to lack standardization in initiating depression screenings. Establishing a consistent process for depression screening in an adult primary care setting was useful in several ways. It guided staff to ensure at-risk patients were screened, identified patients who met the criteria for depression, and helped prevent patients with depression from going undetected.

### **Literature Review**

The utilization of quality screening practices and tools are vital in identifying patients with depression and connecting them to appropriate care. According to Ferenchick et al. (2019), primary care is a suitable setting for depression screening because it has the capacity for

diagnosis, treatment, and follow-up. Optimal timing for depression screenings has not been established, although, according to United States Preventative Service Task Force (2016), one method is to screen all adult patients who have not been screened. Another approach is to screen based on patient risk factors, comorbid conditions, and life events (USPSTF, 2016). Regardless of the approach, using a consistent method to screening is important because only small number of patients with a depressive disorder will present with obvious complaints of hopelessness or depressed mood.

In comparison to other depression screening tools, the 2-item Patient Health Questionnaire (PHQ-2) and the 9-item Patient Health Questionnaire (PHQ-9) were unsurpassed in utility, specificity, and sensitivity (Mulvaney-Day et al., 2018). Interventions that integrate culturally competent care, promote staff education, and guide decision-making are possible ways to increase depression screening rates (Lee-Tauler et al., 2018; Henry et al., 2020). Ongoing education to providers and ancillary staff is key to sustaining depression surveillance.

## **Project Methods**

This project took place at the Southern Illinois University Edwardsville (SIUE) We Care Clinic, a primary care clinic located in East St. Louis, Illinois. Through staff education and the development of a straightforward and evidence-based depression screening protocol, the aim of this project was to improve the surveillance of depression at the We Care Clinic. The project was submitted to the Institutional Review Board of SIUE and deemed a quality improvement project.

Project methods included pre-and post- implementation staff surveys [assessing depression knowledge and current practice], pre-and post- implementation data collection, the development of an evidence-based depression screening protocol, and an educational PowerPoint presentation with staff. A depression screening protocol was developed in collaboration with the

clinic's director to standardize screening and improve staff decision-making as to when to provide depression screenings. The PowerPoint presentation to staff explained depression prevalence, risks associated with undiagnosed depression, the importance of screening, and how to use the proposed screening protocol.

## **Evaluation**

The evaluation of project objectives was accomplished via pre-and post-implementation surveys and patient data collection. First, a five-question pre-implementation survey was anonymously distributed to clinic staff to evaluate knowledge about depression prevalence in their patient population, feelings toward the adequacy of current screening practices, level of confidence in performing depression screenings, suitability of depression screening in primary care, and beliefs if their clinic could benefit from guidelines as to when to perform depression screenings. On a scale of strongly disagree to strongly agree, five of six staff members who completed the survey either agreed or strongly agreed in their confidence to administer depression screenings. Two staff participants agreed their patients were being adequately screened for depression, whereas two disagreed, and one neither agreed nor disagreed. Five staff members agreed that the clinic could benefit from guidelines as to when to perform depression screenings.

During implementation, completed depression screenings were collected in a designated folder for later evaluation. Following implementation, a seven-question post-survey was given to clinic staff to evaluate knowledge about depression prevalence in their patient population, feelings towards primary care being an appropriate setting for depression screening, level of screening confidence, clarity and usefulness of the screening protocol, and likeliness to change practice. On a scale of strongly disagree to strongly agree, all five participants who completed

the survey agreed or strongly agreed the depression screening protocol clarified when a patient should be screened and increased the number of patients screened. Additionally, all five staff members strongly agreed they would like to continue using the screening protocol in the future.

Moreover, an increase in the number of patients screened for depression was observed. Eight weeks prior to project implementation, 26 patients had documented depression screenings. A total of 58 patients had documented depression screenings eight weeks following project implementation. Of fifty-two patients who were screened with the PHQ-2, 16 of them scored positively. In line with the depression screening protocol, 9 of the 16 patients had PHQ-9 screenings documented following their positive PHQ-2. Their PHQ-9 scores ranged from 8-24, indicating moderate to severe depressive disorders. It was unknown why 5 patients who scored positively on the PHQ-2 did not have a documented PHQ-9 administered. When the protocol was utilized, moderate to severe depressive disorders were detected.

The We Care Clinic staff strives to improve patient care and reduce morbidity associated with depression. The clinic was generally receptive to practice change through education and the introduction of a new screening protocol. The goal of 80% participation in both pre-and post-implementation surveys was met.

Limitations of the project include quality of pre-implementation data, small sample size, and Covid-19 pandemic restrictions. During initial meetings with the clinic's director and advanced provider, the rate at which patients were screened for depression was not known or consistently recorded in the electronic medical record (EMR). Data collected in the eight-week pre-implementation period assumes the results of every patient screened for depression were consistently transcribed into the EMR. Throughout the course of this project, Covid-19 pandemic restrictions limited meeting times and on-site visits. Between the number of staff and patient

participants, a small sample size was observed. Six out of seven staff members completed the pre-implementation survey, and five out of six staff members completed the post-implementation survey.

### **Impact on Practice**

This quality improvement project led to an immediate increase in the number of patients screened for depression. Clinic staff also noted improved confidence in how and when to administer a depression screening using the new protocol. The predicted long-term impact is improved depression surveillance for an at-risk patient population. Staff education and a clinical protocol has the potential to improve staff confidence and ensure consistent depression screening. Increased screening can promote open conversations with patients about depression with the goal of early identification, education, and intervention.

Recommendations for ongoing implementation include continued use of the depression screening protocol, protocol modifications and staff education. Additionally, a barrier prior to implementation was the recording of depression screening into the electronic medical record. It is important that screening and documentation is a straightforward process to ensure consistent use going forward.

### **Conclusions**

Through discussion with the stakeholder and data collection, barriers to depression screening in a primary care setting were identified. The literature review and data demonstrate staff education and the use of a standardized depression screening protocol are effective methods to increase depression screening rates. When staff was provided with education and a standard protocol, their awareness of depression and confidence in screening patients improved, therefore an increased amount of depression screenings was observed. The continued utilization of a

depression screening protocol has the potential to enhance surveillance of depression for early identification and intervention.

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