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Improving Depression Remission Screening Compliance

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Executive Summary

Introduction of the Problem

Depression is a common and treatable mental disorder in the United States. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) defines depression as a depressive episode lasting for a period of at least two weeks when an individual experiences a depressed mood or loss of interest or pleasure in daily activities and has specified symptoms such as problems with sleeping, eating, energy, concentration, or self-worth (U.S. Department of Health and Human Services (HHS), 2021). In 2019, there were an estimated 19.4 million adults in the United States that had at least one major depressive episode, representing 7.8% of adults aged 18 or older in the U.S. (HHS, 2021). The prevalence of depression sharply rose during the COVID 19 pandemic. In 2017, the prevalence of depression was 3.44%. The pooled prevalence of depression rose to 25% in 2020, seven times higher, suggesting the significant impact the COVID-19 pandemic had on mental health in the U.S. (Bueno-Notivol et al., 2020). One metropolitan primary care family practice office was screening, diagnosing, and treating depression according to the United States Preventative Services Task Force (USPSTF) guidelines but had trouble assessing the status and effectiveness of ongoing depression treatment among patients with a depression diagnosis. A major barrier to assessing patients undergoing treatment for remission of depression symptoms was a lack of a database or registry to easily identify patients due for depression remission screening. This DNP project focused on increasing compliance of screening for depression remission using the PHQ-9.

Literature Review

The Patient Health Questionnaire (PHQ) is one of the most frequently used depression screening tools in the United States (HHS, 2021). According to the American Psychological Association (APA) (2021), “PHQ-9 scores > 10 had a sensitivity of 88% and a specificity of 88% for major depressive disorder with a high internal consistency demonstrated by Cronbach alpha

scores ranging from .86 and .89". The PHQ-9 is endorsed by the National Quality Forum for behavioral health screening, and is reimbursed by Medicaid, Medicare, and most private insurance companies (Mulvaney-Day et al., 2017). It has shown high sensitivity and specificity clinically, making it useful in screening for symptoms of depression while a patient is undergoing treatment for depression. Evidence demonstrates that a team approach to depression screening and rescreening which utilizes clinical staff, such as medical assistants and nurses, to administer tools such as the PHQ-9 has greater efficacy than reliance on the healthcare provider alone. Ensuring patients are properly managed for depression is essential for improved depression remission rates, which leads to improved mental and physical health.

Methods

The setting for this DNP project was a metropolitan Midwest primary care office. The purpose of this project was to increase compliance with screening for depression remission. The goal was to reach a 99% compliance rate. The DNP student project lead met with administrators at the healthcare organization to consider a change in workflow. It was determined the best system for efficient clinic flow was to utilize front desk staff to assist in identifying patients with a depression diagnosis due for PHQ-9 reassessment using the quality improvement system (QIS). Front desk staff were granted access to the QIS in May 2022 and an educational meeting was held. A step-by-step poster board presentation was provided to explain how the QIS could be accessed. The process change of having front desk staff oversee handing out the PHQ-9 forms to patients when they check in for their appointment was introduced and discussed. The front desk staff began identifying patients due for their 12-month depression remission screening and distributing the PHQ-9 screen at check in on June 1, 2022 and continued through July 29, 2022.

Evaluation

A gap report measuring provider and clinic compliance with recommended patient screenings and quality care measures was used to evaluate the outcomes of this DNP project.

Gap reports were free of patient identifiers and personal information. The number and percentages of recommended depression screenings and depression remission screenings were evaluated to determine provider and clinic success at meeting goals for depression screening and rescreening. The final adherence rate for depression remission screening compliance at the commencement of this DNP project was 67% respectively. A gap report from February to May 2021 revealed 103 patients due for depression remission screening during this time frame, and 69 patients received the proper screening. A gap report was run for May of 2022, immediately preceding the implementation of this DNP project, and the compliance rate was 60%; there were a total of 15 patients due for depression remission screening and 9 of these patients received a remission screening.

An educational meeting about the importance of depression remission screening and accessing the QIS within the electronic health record was held on May 24, 2022, with front desk staff, clinical staff, and providers to identify patients with a diagnosis of depression. The educational meeting was crucial because some staff members did not have access to the quality improvement system and others did not know how to utilize the quality improvement system. Project implementation started on June 1, 2022, and ended on July 31, 2022. During this time, there were 27 patients due for a depression remission screening and of these, 24 were given the proper screening. The percentage of compliance during the implementation phase of this project was 88%, which was an improvement of 28% from the baseline measurement of 60% the month prior to project implementation.

Some limitations of the project were the possibility of incorrect patient depression remission due date information in the QIS, missing cases of depression due to inaccurate patient self-report or failure of staff to enter a diagnosis of depression in the EMR. If documentation mistakes existed, including documentation omissions, the compliance rates reported may not be precise. Another limitation of the project was patients missing their scheduled depression follow up appointments. The gap report documents a missed screening even when patients failed to appear in clinic to have the screening administered. The generalizability of project findings is limited by small sample size and limited time for project implementation. Project strengths include enhanced teamwork amongst the clinic staff and awareness among clinic providers and staff to improve depression remission screening compliance. Prior to this project, clinic staff were not privy to how important depression remission screening is for patients and the treatment of their mental health.

Impact on Practice

This DNP project was clinically pertinent and significantly impacted depression remission screening compliance. Before this project was implemented, this primary care office did not have a routine for identifying patients with a depression diagnosis and the need for remission screening. The lack of routine may have been a contributing factor to the low compliance percentage. The project leader followed closely with clinic and support staff during the implementation of changes which kept staff focused and engaged in the process. During a follow-up meeting after implementation, staff and providers expressed motivation to continue the change that was made during this project in hopes that it would keep their compliance percentage high. Recommendations were made to the clinic to provide QIS training to new

employees transferring within the institution to keep compliance levels high.

Conclusion

Prior to implementation of this DNP project, no routine protocol existed at this primary care office to properly identify patients in need of a depression remission screening which resulted in low compliance percentages. Granting front desk staff access to the QIS and delegating staff the responsibility of handing out the PHQ-9 at patient appointment check-in helped increase compliance from 60% to 88%, which was an improvement of 28%. If this protocol is continued and future staff members are trained appropriately, this slight change could be made in other primary care offices throughout this institution to increase depression remission compliance.

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