Implementation of Adult Depression Screening in Solo Free-Standing Primary Care Clinics

or Practices

Matilda Agyemang, PMHNP-BC, FNP-C, ANE

School of Nursing, The University of North Carolina at Greensboro

NUR 898E-60/61/62/63: Applied Evidence-Based Practice & Translational Methods Project

Dr. Lori Lupe

February 20, 2023

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Dedication

First and foremost, I am grateful to God for granting me the strength to pursue my passion, obtaining this terminal degree. I also appreciate the support from the University of North Carolina, Greensboro (UNCG) advanced nursing faculty, especially Dr. Lupe. I will never forget your support, patience, and encouragement. Thank you to Professor Mittal for all your guidance with the data interpretation and graphing. Your guidance meant a lot. Finally, special thanks to Calvary Clinic Clinical Team; despite Covid with challenging staff, you still accommodated my needs. Without you, my quality improvement project would not have been a success.

Lastly, I would like to thank my husband and children for making it possible to complete my assignment. Even with my regular schooling, you were very understanding. Your support meant everything to me. To my mother, who unfortunately could not live to witness me graduate, I know you will be watching me from heaven and smiling. Thank you for instilling in me the importance of education. I am forever indebted to you. May you continue to rest in perfect peace. And to all my new friends I made at the University of North Carolina, you made it easy to come to class every meeting day. I appreciate you all.

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Abstract

This project aims to summarize the effects of depressive screening at independent practice clinic about depression in adults and how to effectively screen for depression to promote early intervention compared to their usual practice. The project aimed to screen adults 18 years or older during wellness visits to determine whether implementation of the Patient Health Questionnaire-2 (PHQ2) and Patient Health Questionnaire-9 (PHQ-9) during wellness visits, compared to usual care can lead to identification and intervention for adult patients with depression in 12 weeks. The evidence supporting the effects of depression and its relationship with the covid-19 pandemic, comorbidities, and screening effectiveness are discussed. This review involves the before and after clinical findings of depressive screening and its effects on depression and early intervention.

Keywords: Depression; Anxiety; psychological; comorbidities; ACE star; USPSTF; PHQ-2, PHQ-9

Implementation of Adult Depression Screening in Solo Free-Standing Primary Care Clinics

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Depression is a problem in the United States. According to the National Alliance on Mental Illness (NAMI, 2022)**,** 1:5 Americans experience some form of mental illness in any given year. In the general population, 1: 20 adults live with some sort of severe mental condition such as schizophrenia, bipolar disorder, or long-term reoccurring depression. Depression affects more than 300 million people worldwide, among whom are almost 10% of the adult population in the United States, but unfortunately this disorder often goes unrecognized and untreated (Akagawa et al., 2017). The World Health Organization (2017) foresees depression as the second leading cause of disability and COVID-19 pandemic has made depression more prevalent (Sepúlveda-Loyola et al., 2020; Sher, 2020).

Depression is associated with higher suicide, loss of productivity, and outcomes with chronic conditions. Depression and suicide are complexly tangled, as suicide is a complication of untreated depression. Growing evidence demonstrates that early recognition and treatment of behavioral health disorders can help improve outcomes; complications such as suicide can be prevented, enhance the quality of life, and help reduce overall health care costs (Akagawa et al., 2017).

Although depression is quite prevalent in the United States, patients face extremely long waits for assessment and treatment and a shortage of mental health clinics and providers (Wainberg et al., 2017). Stigma, fragmented care, and absence of research power to promote policy change also contribute to the current mental health treatment gap (Wainberg et al., 2017). The United States Preventive Services Task Force (USPSTF, 2016) recommends depression screening at all primary care visits. NAMI, in their 2015 report, *A Long Road Ahead: Achieving*

True Parity in Mental Health and Substance Use Care, notes that since barriers to accessibility of mental health providers, counselors, or facilities exist, depression soared by over 40%, leaving people with depression without proper treatment. With the shortage of mental health providers, clinicians must acknowledge that depression impacts patient treatment adherence in primary care settings. The depressed person may not have the energy or interest to exercise, take medications as prescribed, make healthy food choices or follow treatment plans. Ganasan (2019) indicates that the integration of routine depression screening in the primary care setting may improve overall health outcomes and competence in implementing care. Knowing depression's impact on several medical conditions such as heart failure, diabetes, and hypertension shows the driving need for the primary care setting to get on board with screening for depression and treat it accordingly.

While large organizational or corporation primary care facilities may have programs set in place to meet the demands of treating mental disorders such as depression, the smaller practices continue to face challenges in meeting the needs (Owens-Gary et al., 2019). Primary care personnel do not feel confident in screening for depression, they feel they lack education (Haefner et al., 2017); hence screening during primary care visits is not sufficient to detect the increasing risks of depression (Ganasan, 2019). Early interventions have been proven to improve depression outcomes and primary care providers need to be prepared to screen for depression; hence this quality improvement (QI) project aimed to provide education and screening tool to increase screening and identification of clients at risk of or suffering from depression for early detection and treatment.

The project aimed to screen adults 18 years or older during wellness visits and minors were excluded.

Population - Among adult patients in primary care practices

Intervention - Does implementation of the Patient Health Questionnaire-2 (PHQ2) and

Patient Health Questionnaire-9 (PHQ-9) during wellness visits,

Comparison - compared to usual care,

Outcome - lead to identification and intervention for adult patients with depression

Time - in 12 weeks.

The project was conducted in a primary care practice in an urban area of the southeastern U.S. This family practice predominantly serves adult patients to manage multiple medical problems, including hypercholesterolemia, diabetes, and hypertension. Gorman et al. (2021) supports primary care practices incorporating clinical staff rather than physician-only screening and including screening utilizing the PHQ-2 and PHQ-9 during wellness visits to detect depression and early intervention. The PHQ-2 / PHQ-9 was used because it has excellent sensitivity and specificity in screening tool for depression (Levis et al., 2020). International guidelines also recommend screening for depression using the PHQ-9 as the screening tool, and it has been identified as the most reliable screening tool (Ganasan, 2019).

Search Strategy, Variables, Factors, and Concepts

I conducted searches through search engines such as Cinahl Complete and PubMed with search words such as adult depression, early intervention, depression screening in primary care settings, covid-19 pandemic impact on depression, depression and medical conditions, depression and hypertension, heart failure, and diabetes. The search was also restricted to English language full text articles published within the most recent five years. My search terms identified 1,359 articles of which about 99 were relevant. I also used key search terms: adult

depression, early interventions, depression screening in independent primary care practices, and evidence-based practice. When the content type delimiters of peer reviewed and randomized control trials, meta-analyses, systematic reviews, longitudinal, or quasi-experimental were added, selected, the searches yielded 599 results. When further focused using depression screening in primary care practices, yielded about 66 items remained. There was also an overwhelming result on the effective causes, symptoms, and maintenance of depression.

<div align="center">

Literature Review

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Current State of Knowledge, Gaps and Synthesis

Covid-19 Pandemic and Depression

Sepúlveda-Loyola et al. (2020) investigated association of the covid-19 pandemic with a significant rise in depressive symptoms among older people. These researchers conducted a descriptive cross-sectional review of this association from 2019-to 2020. It involved about 20,069 individuals from diverse backgrounds across Asia, Europe, and America to determine the impact of social isolation during the covid-19 pandemic on the mental and physical health of older people and the recommendations for patients, caregivers, and health professionals. The reviewers found that a significant number of participants' negative mental health concerns, especially depression and anxiety, increased.

In addition, Sher (2020) suggests that the covid-19 pandemic has had intense psychological and social effects. The pandemic's emotional sequela is predicted to persist for months and years. Sher reported that studies have shown a relationship between the covid-19 pandemic and stress-related mental health conditions, including depression and insomnia in the general population and healthcare professionals. Further, the pandemic crisis may also have increased suicide rates and is expected to peak even after the pandemic.

Depression and Comorbidities

Evidence shows that depression significantly affects managing medical conditions such as diabetes and heart failure which impacts the need for primary care clinics to screen for depression (American Diabetes Association [ADA], 2017; USPSTF, 2016). Depression and diabetes distress have been prevalent disorders among people with type 2 diabetes and both conditions can affect self-care and diabetes control. Depression among people with diabetes can impact the patients' physical and psychosocial self-care, thereby decreasing treatment adherence and quality of life, and ultimately increase the risk of mortality; hence, the ADA (2017) and the USPSTF (2016) recommend routine evaluations for depression and diabetes distress for ideal disease management and prevention of life-threatening complications. However, primary care facilities and small independent clinics may face hurdles in making screening a success (Owens-Gary et al., 2019). This challenge shows there are opportunities to make depression screening for people with diabetes a success. In addition, the Ishak et al. (2020) systematic review and meta-analysis found that screening identified high levels of depression among heart failure patients. These reviewers found that that the PHQ-9 and Beck depression inventory were the most used tools to screen for depression in heart failure patients.

Screening Effectiveness and Issues

Evidence shows the PHQ-2 and the PHQ-9 are practical depressive screening tools (Levis et al., 2019; 2020). Both self-administered instruments are used to detect depression. The PHQ-9 also assesses the severity of depression. The PHQ-2 consists of the first two items of the PHQ-9, which evaluate the frequency of depressed mood and anhedonia and can be used as a first step to identify patients for evaluation with the full PHQ-9. The Levis et al. (2020) study aimed to estimate the accuracy of the PHQ-2 alone and when combined with the PHQ-9 for detecting

major depression. The PHQ-2 scores range from 0-6, and the PHQ-9 are from 0-27. Levis et al. (2020) concluded from their meta-analysis concluded that the combination of the PHQ-2 (with cutoff $\geq$ 2) followed by the PHQ-9 (with cutoff $\geq$ 10) had similar sensitivity but higher specificity compared with the PHQ-9 alone (Levis et al., 2020).

With the shortage of mental health providers, primary care providers face managing several mental health conditions such as depression, although screening rates remain low in primary care settings. Eren et al. (2008) found that depression detection rates improved when the PHQ-9 was used to screen patients with chronic medical conditions, history of recent stressful life events, and other known risk factors. The study was conducted in a primary health setting in South Africa utilizing the self-administered PHQ-9 questionnaire. A PHQ-9 score of less than five was deemed a negative screen for depressive features, with a score of six or more being considered a positive screen. The study led to early diagnosis, early intervention and helped improve overall health outcomes (Eren et al., 2008)

The efficacy and utility of the PHQ-9 as a screening tool has been investigated in a variety of settings. Mulvaney-Day et al. (2018) performed a systematic literature review to identify and evaluate publicly available tested screening tools in primary care physicians to screen adult patients for mental and substance use disorders such as depression, anxiety, and alcohol use disorders. The review showed that the PHQ-9 was valid in screening for depression. As the PHQ-9 supports the clinician by offering evidence-based guidelines and resources to assist primary care providers with treatment protocols, Haefner (2017) compared the use of this instrument in identifying depression to the clinic's usual care practice of self-report. The PHQ-9 allowed for the identification of significantly more patients as moderately to severely depressed than did the clinic's usual care practice of patient self-report. The study consisted of 200 patients

and the results were analyzed via a chi-square, which revealed a significantly higher proportion of patients in the study group were newly diagnosed with depression compared to the control group. Haefner's results also support the mounting evidence indicating that early recognition and treatment of behavioral health disorders can prevent complications, improve quality of life, and help reduce health care costs.

Although screening led to early intervention and improved outcomes, low screening remains a significant problem in primary care settings (Gorman et al., 2021). A 2-year quasi-experimental study conducted in an adult primary care setting at an urban clinic to determine the change in the rates of completion of the PHQ-2 after the implementation of a medical assistant screening compared with the physician-only screening showed when medical assistants were trained to screen for depression, screening increased to 57% from 18% when only physicians were screening patients. Gorman et al. concluded that trained medical assistants in primary care settings screen for depression can help reduce the socio-demographic screening disparities which exist in primary care settings.

A systematic review of studies published from 1995 to 2018 on the effectiveness of PHQ-9 in adolescent and adult populations (aged 12 years and older) in primary care settings was performed by Ostantini et al. (2021). About 95% of the identified studies were conducted in affluent countries and focused on adult populations. The accuracy of PHQ-9 was evaluated utilizing the two-stage screening system, starting with PHQ-2 then progressing to PHQ-9 when there was PHQ-2 positive screening of 2 or more. The review employed a cutoff of a PHQ-9 score of 10 or higher. Apart from the lack of heterogeneity in the primary care practice, which posed a limitation for the study, the reviewers concluded PHQ-9 is valid and is recommended in the two-stage depression screening process (Ostantini et al., 2021).

Design Methods and Procedures

I utilized convenience sampling for the QI project. The project took place in a small independent primary practice and implemented by educating the clinical staff about depression and the use of the PHQ-9 depression screening tool. The PHQ-2 tool was utilized to screen adults 18 years or older to determine if there is a need for increased screening. Before educating the clinical staff, a 10-question pretest was given to the clinical staff members to evaluate their knowledge about depression and utilization of the PHQ-9. After the education, the same questions were given as post-test. The lead medical assistant collected both the pre- and post-tests and sealed them in a manilla envelope. The clinical team lead was my contact person. I followed up weekly and reviewed the clinical practice screening habits for three months to measure any changes in depressive screening compared to usual practice prior the in-service. Any questions the clinical staff members regarding implementing the depressive screening were also addressed at these times.

In-service education was given to the clinical staff about depression and how to utilize the PHQ-2 and PHQ-9 to screen patients during annual and follow-up visits. The team received education on how to improve depression awareness and encourage patients to be honest about their depressive symptoms. A list of ambulatory psychiatric resources, including walk-in, sliding scale/low-income mental health clinics, with contact person, hours, addresses, were compiled and provided to the clinic to give to those patients whom the clinic depression symptom management was inappropriate. For those patients who screened as having suicidal ideations, resources including suicide or crises hotline information were provided. For those with a high risk of suicide, such as suicidal ideations with a plan, past suicide attempt, family history of suicide, or high-risk behaviors such as substance abuse, the clinic notified the emergency

medical system to have them transported to the nearest emergency room for further screening for acute psychiatric hospitalization consideration. I visited the clinic weekly and spent about 2 hours with staff to follow up on the progress of the QI project and answer all questions the clinical staff had.

The translational framework for this project was Plan, Do, Study, Act (PDSA). According to the Institute of Healthcare Improvement (n.d.), the PDSA is a reiterative interactive 4 stage problem-solving method used to improve a process. This method is action-oriented; the process will involve planning, carrying on the test, observation, and learning that can then be used to apply to modifications if needed (Coury et al., 2017). Staff were educated about depression, how to utilize the PHQ-2 and the PHQ-9 to screen for depression as the QI project aimed to estimate the accuracy of PHQ-2 alone and when combined with PHQ-9 for detecting major depression.

The project utilized Stevens (2013) ACE STAR model of knowledge transformation as the theoretical framework. The ACE star knowledge model consists of five steps: discovery research, evidence summary, translation into guidelines, practice integration, and process outcome evaluation. This star model aims to convert one form of knowledge to the next and incorporate the best research evidence. For example, Stevens suggests its used in redesigning effective, safe, and efficient care.

The exclusion criterion were minors, as the QI project aimed at 18 years or older adults. The project's champion was the lead medical assistant who helped access depressive screening information for analysis while removing patient demographics. The anticipated budget was about $2170, however I spent about $2024 because the clinic screened only 99 patients. The budget breakdown is as follows: The clinic sees about 20 patients daily. It took about 15 minutes per

patient to answer the screening questions on the PHQ-9 and about 15 minutes for each interpretation. The daily screening time was about 30 minutes of additional time per patient multiplied by the number of patients seen in a day. The patient who was sent to the emergency room took about an hour as the EMS were called to transport patient to the hospital emergency department for suicidal ideation. The goal was to screen about 20 patients daily, however, which did not happen due to time limitations. With a clinical staff of 10, the in-service took a total of about 2 hours, with weekly follow-ups, resulting in about 2 hours of other clinical time per week for about 12 weeks, some 24 hours over the project period. The salary related costs the hourly rate for the clinical staff is about $15 per hour. The timeline was three months. The cost of the ink was about $60, I used about one cartridge ink every four weeks and a pack of printing paper, expecting about $100 monthly, pencils $20 monthly, and gas from home to clinic about $60 monthly. The gas money was me as the project lead. Although the project seems costly to the clinic, in the long run, it will help reduce possible litigation lawsuits about suicide attempts or completions, which may otherwise be missed without the QI project. Also, additional diagnoses on patient medical records could generate income by increasing the intensity of the patient's illness, which will lead to higher acuity billing.

A clinical site was secured in a primary care practice through several inquiries. A site approval consent was obtained from the CEO of the primary care practice. Clinic personnel screened adult patients whether they show depressive symptoms or not, starting with PHQ2. The clinics serves predominantly English-speaking population with about 10% Hispanics. The PHQ-9 comes in both English and Spanish, and there is a certified Spanish interpreter helped interpret the Spanish PHQ-9 for the clinical provider and patients as needed.

Variables

The most significant barrier was securing a clinical site. With the covid-19 pandemic, staff members were overwhelmed and resistant to any student's QI project. A clinical site was secured in a primary care practice after several inquiries. Variables that impacted this project included the clinical staff's unwillingness to participate in the QI project. The team members perceived the screening as additional work to their already busy schedule. Other variables were patients' refusal to be screened and deliberately providing misleading information about their depressive symptoms due to the stigma of mental conditions.

Results

The primary care clinic employs ten clinical staff, and the pre-questionnaire showed that none of the staff was comfortable utilizing the depression screening tool. They reported that they did not feel they were knowledgeable enough about the topic. The post-questionnaire results showed nine team members out of 10 to be satisfied with using the PHQ-2 and PHQ-9 (see Table). During the 12 weeks, 99 patients were screened. Out of the 99 people screened, 22 people showed mild depression, five patients showed moderate depression, two people showed severe depression with suicidal ideation, and 21 patients showed no depressive signs or symptoms (see Figure). The patients who showed mild depressive symptoms were referred to a psychotherapist. The patients identified with moderate depressive were started on low-dose SSRI and referred to a psychotherapist with ambulatory resources. Lastly, severely depressed patients with suicidal ideation were sent to the emergency department via the emergency medical system.

Table

Pre- and Project Implementation Responses

Assessment	Staff Response	No. of Patients Identified	Clinician Response
Staff Depression Knowledge Questionnaire			
Pre-education	10/10 staff uncomfortable with topic due to lack of knowledge		
Post-education	9/10 comfortable		
Patient Health Questionnaire-9 Screening			
Pre-Implementation	0	0	0
Implementation Period	99 patients screened	22 + mild depression, 5 moderate, 2 sent to ED for severe depression with suicidal ideation	Mild-moderate depression referred to therapist; moderate provided ambulatory resources

Figure

Depression Assessment Results during 12-week Project
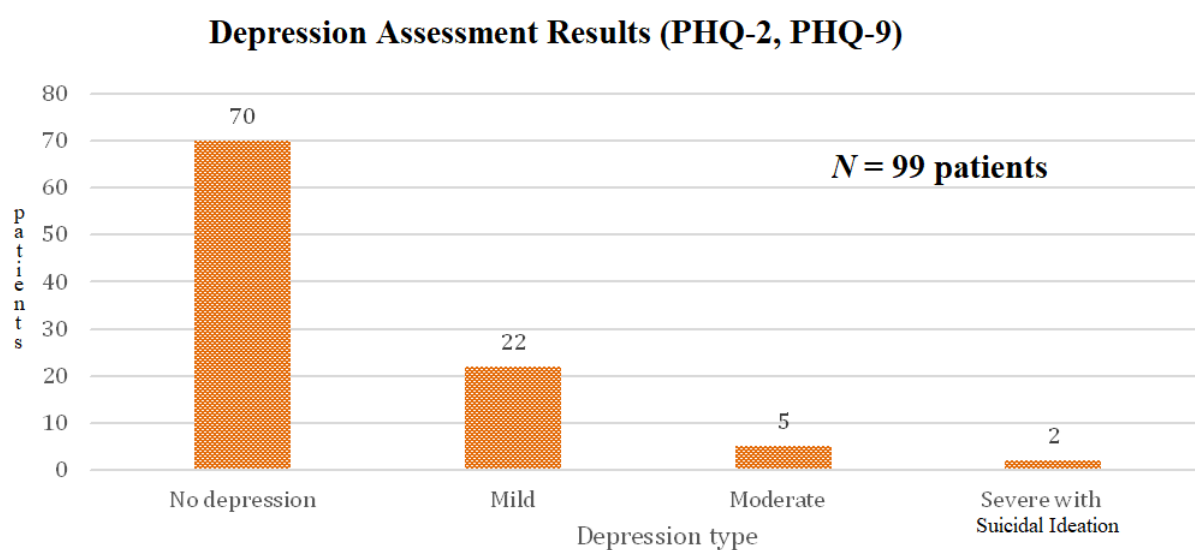
Note. PHQ-2 - Patient Health Questionnaire-2. PHQ-9 - Patient Health Questionnaire-9

Discussion

The goal was to screen about 20 patients daily for depression. If this plan had been achieved, the clinic would have screened about 1200 patients compared to the sample size of 99 within 12 weeks. Unfortunately, I did not complete my targeted sample size goal. Variables that impeded the screening include the small solo independent practices facility staff reporting feeling overwhelmed, lacking motivation, staff burnout, and adding the PHQ 9 screening to the schedule. In addition, variables that impeded the initial targeted screening goal are the stigma of mental conditions such as depression which likely led to some patients not being honest about their symptoms. The staff did not appear to feel motivated; hence I do not see this project as feasible or sustainable for the solo independent clinic after the project. The project investigator contacted and visited the clinic at least once weekly to encourage staff to screen all patients. Staff lack of motivation includes reimbursement structure issues as they commented that preventative screening was not always reimbursable and the initiative might not be good for business. This lack of motivation provided no incentive for staff to screen the patients. Perhaps in the future, greater emphasis on the reimbursement structure associated with preventative screenings will serve as an incentive for staff members and small solo independent clinics to actively participate in preventive screenings. Based on the results, the project showed an increase in depression screening, leading to early intervention.

Plan for Dissemination

My QI findings will be shared online via a live poster presentation. My target audience for the exhibition will be healthcare clinicians. I want to publish my QI project in the New England Journal of Medicine. I prefer to publish my finding in this journal because it is one of the world's leading medical journals that publishes quality articles for informed care delivery and

improved patient outcomes, which aligns with my QI project's goal. In addition, I believe publishing this article will help encourage solo primary care practices to start screening all patients during well visits and follow-up.

Conclusion

Depression is prevalent in the United States. Suicide is complexly tangled with depression. The Covid-19 pandemic had a negative impact on depression, and other comorbid conditions such as diabetes, hypertension, and heart failure can be challenging to manage in the presence of depression. The depressed person may lack the motivation to engage in pertinent routines such as exercise and treatment adherence, hence the driving need for depression screening for all providers, including primary care practices, to screen for depression. Although depression continues to soar and negatively impacts many people, stigma and limited psychiatric practices have called for the need for primary care providers to get on board to engage in depression screening. Studies indicate that early intervention can improve outcomes; however, competence and reimbursement structuring issues have hindered successive screening in independent practices. PH-2 and PHQ-9 have been proven effective in screening for depression; hence when primary care providers can screen patients during well visits, it can lead to early detection and intervention.

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Appendix A

PRE-Test

1. 1:5 of Americans experiences some sort of mental illness in any given year and in the general population. True/False

2. 1:20 adult is living with some sort of serious mental condition such as such as long-term reoccurring depression, schizophrenia, bipolar disorder. True/ False

3. Depression affects more than 300 million people worldwide- True/ False 4.

4. In United States, Depression affects about:

   a) 15% of the adult population

   b) 10% of the adult population)

   c) 25% OF adult population

5. Growing evidence shows early intervention can improve outcome. True/ false

6. The following are evidenced based screening tools for depression except: a)Hamilton Depression rating scale (HDRS)

b) Patient Health questionnaire (PHQ)

c) Beck depressive scales are effective screening tool (BDI)

d) Major depression inventory (MDI)

e) Center for epidemiologic studies depression scale (CES-D) f) Mini mental Status examination (MMSE)

7. What is PHQ-9?

a) A screening tool bipolar disorder b) a screening tool for anxiety

c) A self-report measure designed to screen depressive symptoms

8. Depression impact treatment compliance in other comorbid illness: True or False

9. The PHQ-9 consists of 9 depressive screening questionnaire- True or False

10. To score PHQ-9 screening tool requires a complex excel spread sheet- True or False

Posttest

1. 1:5 of Americans experiences some sort of mental illness in any given year and in the general population. True/False

2. 1:20 adult is living with some sort of serious mental condition such as such as long-term reoccurring depression, schizophrenia, bipolar disorder. True/ False

3. Depression affects more than 300 million people worldwide- True/ False

4. In United States, Depression affects about:

a) 15% of the adult population

b) 10% of the adult population

c) 25% of adult population

5. Growing evidence shows early intervention can improve outcome. True/ false

6. The following are evidenced based screening tools for depression except:

a) Hamilton Depression rating scale (HDRS)

b) Patient Health questionnaire (PHQ)

c) Beck depressive scales are effective screening tool (BDI)

d) Major depression inventory (MDI)

e) Center for epidemiologic studies depression scale (CES-D)

f) Mini mental Status examination (MMSE)

7. What is PHQ-9?

 a) A screening tool for bipolar disorder

 b) A screening tool for anxiety

8. Depression impact treatment compliance in other comorbid illness: True or False

9. The PHQ-9 consists of 9 depressive screening questionnaire- True or False

10. To score PHQ-9 screening tool requires a complex excel spread sheet- True or False

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___0___ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un "☐" para indicar su respuesta)*	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Sin apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING __0__ + _____ + _____ + _____

=Total Score: _____

Si marcó <u>cualquiera</u> de los problemas, ¿qué tanta <u>dificultad</u> le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil	Un poco difícil	Muy difícil	Extremadamente difícil
☐	☐	☐	☐

PHQ-9 Questionnaire for Depression Scoring and Interpretation Guide

For Provider use only Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated

below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table

below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____

Several days (#) _____ x 1 = _____

More than half the days (#) _____ x 2 = _____

Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 scores

Diagnosis	Total Score	For Score	Suggested Action
Minimal depression	0-4	Less or equal to 4	May not need depression treatment
Mild depression	5-9	5-14	Use clinical judgement to initiate treatment based on symptom duration and functional

			impairment
Moderate Depression	10-14		
Moderately to severe depression	15-19	Greater than 14	Recommended treatment for depression: antidepressants with psychotherapy
Severe Depression	20-27		

Community Mental Health Resources

Psychiatry Practices

Presbyterian Psychiatric Associates
1900 Randolph Rd. Suite 800
Charlotte, NC 28207
(704) 384-1246
Psychiatrists and Counselors available
Adults, Adolescents and Children

Eastover Psychological and Psychiatric Group
3303 Latrobe Dr.
Charlotte, NC 28211
(704) 362-2663
Psychiatrist and Counselors available
Adults, Adolescents and Children

Dr. Frank Highley – Psychiatrist
429-A South Sharon Amity Rd.
Charlotte, NC 28211
(704) 362-0866
Adults

Dr. John Barkenbus - Psychiatrist
NC Neuropsychiatry
5208 Park Road
Charlotte, NC 28209
(704) 529-4101Adults, Adolescents and Children

Dr. Fred Caudill – Psychiatrist
130 Matthews Station St., Suite 2B
Matthews, NC 28105
(704) 846-2833
Adults

Dr. Madhu Engineer - Psychiatrist
7820 Ballantyne Commons Parkway, Suite 108
Charlotte, NC 28277
(704) 341-2191
Adults, Adolescents and Children

Southeast Psychological Services
6115 Park South Drive
Charlotte, NC 28210
(704) 552-0116
Adults, Adolescents and Children

Dr. Thomas Fitzgerald – Psychiatrist
Southlake Psychiatry
18047 W. Catawba Ave. Suite 200
Cornelius, NC 28031
(704) 894-9309
Adults

Monarch
5700 Executive Drive, Suite 110
Charlotte, NC 28212
Therapists & Psychiatrists
Walk-in clinic for initial registration
8am - 2pm Monday – Friday

Treatment Resources

Assessment and Referral Line
Mecklenburg County
(704) 336-6404

Support Works
Listing of local support groups
www.supportworks.org
(704) 331-9500

Behavioral Health Call Center
Mecklenburg County Emergency Crisis

University Psychological Associates
10001 Old Concord Rd.

Line
(704) 444-2400

Carmel Counseling Center
1145 Pineville Matthews Road
Matthews, NC 28105
www.carmelcounselingcenter.org
(704) 849-0686
Adults, Adolescents, Children and
Families

Miracles, Inc. Healing Center
134 Professional Park Dr., Suite 400
Mooresville, NC 28117
www.miraclesinchealingcenter.com
(704) 664-1009
Adults, Adolescents and Children

**South Charlotte Counseling and
Consulting**
10720 Carmel Commons Blvd. Suite
350
Charlotte, NC 28226
www.southcharlottecounseling.com
(704) 421-5811
Adults, Adolescents and Families
English/Spanish

Charlotte, NC
Satellite Office:
726 East Blvd.
Charlotte, NC
www.universitypsychologicalassociates.com
(704) 547-1483
Counselors and Psychologists
Adults, Adolescents and Children

United Family Services
www.unitedfamilyservices.org
Charlotte (704) 332-9034
Cabarrus County (704) 786-7918
Mooresville/Lake Norman (704) 655-8745

Mind Changing Solutions, PLLC
537 West Sugar Creek Road, Suite 203
Charlotte, NC.28213
980-875-9473
MCS@MindChangingSolutions.com
MindChangingSolutios.com

Additional Resources

Alanon
(704) 333-9523

Autism Society of NC
Mecklenburg Co. Chapter
(704) 894-9678

Mecklenburg Mobile Crisis
5820 East WT Harris Blvd
Suite 211
Charlotte, NC 28215
(704) 566-3410

Narcotics Anonymous (NA)
(704) 379-0440
Rape Crisis Center
(704) 375-9900
Crisis Counseling and support to victims of
rape
The Relatives

Alcoholics Anonymous (AA)
(704) 332-4387

Battered Women's Shelter
(704) 332-2513
Women and children of domestic violence
Shelter and Counseling

Victim's Assistance
(704) 336-4126
Crisis Intervention, short-term counseling,
and assistance for victims of domestic
violence

National Suicide Hotline
1-800-SUICIDE (784-2433)
Salvation Army
(704) 334-4731
Temporary housing for women and children

Uptown Men's Shelter

(704) 377-0602
Temporary shelter for teens
Women's Commission
(704) 336-3414
Services for adult victims of domestic violence

(704) 334-3187
Temporary housing for men

Union County Resources

Daymark Recovery Services
1190 West Roosevelt Blvd.
Monroe, NC 28110
www.daymarkrecovery.org
(704) 296-6200
Adults, Adolescents and Children
Union County Residents,
Counseling and Psychiatrist,
Outpatient substance abuse
services, emergency services and
mobile crisis services

Excel Personal Development
1333 W. Roosevelt Blvd.
Monroe, NC 28110
www.xlpdc.cp,
(704) 282-0638
Adults, Adolescents and Children
Counseling, Community Support and Case
Management, Specializing in Anger Management

Safe Alliance
604 Lancaster Ave.
Monroe, NC 28112
www.unitedfamilyservices.org
(704) 226-1352
Adults, Adolescents and Families
Counseling
Union County Department of Social Services
1212 W. Roosevelt Blvd.
Monroe, NC   28110
(704) 296-4300

Turning Point
(704) 283-7233
Women and Children of Domestic Violence
Shelter, Legal Advocate and Counseling
English/Spanish