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Depression Screening in Primary Care: Implications for Practice

Donna Pittman

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DEPRESSION SCREENING IN PRIMARY CARE: IMPLICATIONS FOR PRACTICE

by

Donna Pittman

A Doctoral Project
Submitted to the Graduate School,
the College of Nursing and Health Professions
and the School of Leadership and Advanced Nursing Practice
at The University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Nursing Practice

Approved by:

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ABSTRACT

Depression is a mood disorder that has affected lots of people worldwide.

Depression is a disease that affects an individual's social functioning, relationships, and finances. Individuals with depression may have feelings of sadness, loss of interest in formerly enjoyed activities, hopelessness, irritability, decreased energy, difficulty concentrating and sleeping changes in appetite, or chronic generalized aches and pains. Over the recent year, there has been a rise in individuals presenting to the primary care providers with symptoms of depression. Mental disorders attribute to one of the leading causes of disability in the United States.

Healthcare providers in the primary care setting have the greatest opportunity to screen for depression. The U.S. Preventive Services Task Force (USPSTF) recommends depression screening in primary care for all adolescents (age 12), adults, pregnant women, and postpartum women (Maurer et al., 2018). The use of depression screening tools such as the PHQ2 and PHQ9 is useful in diagnosing and treating depression. This study utilized the Revised Depression Attitude Questionnaire (R-DAQ) tool to assess healthcare provider views and knowledge of depression in a rural clinic in northeast Mississippi. The purpose of this Doctor of Nursing Practice (DNP) project was to develop and implement an evidence-based depression screening protocol in the primary care setting to increase early detection, initiation of treatment, and continuation of care. A depression screening protocol was developed to use as a guide for healthcare provider decision-making in the treatment of depressed patients. Utilizing these tools, providers were able to identify several individuals with depression and suicide ideations.

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DEDICATION

I would like to thank my mother who has been my number one supporter from day one. To my sons, Bryan and Jacolby, the two of you have always been my inspiration. Special thanks to my friend, Dr. Cynthia Harrington for endless encouragement and support.

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LIST OF ABBREVIATIONS

<i>AAFP</i>	American Academy of Family Physicians
<i>APA</i>	American Psychiatric Association
<i>ASQ</i>	ASK Suicide Screening Question
<i>AND</i>	Associate Degree in Nursing
<i>CDC</i>	Centers for Disease Control
<i>LPN</i>	Licensed Practical Nurse
<i>NCQA</i>	National Committee for Quality Assurance
<i>NIH</i>	National Institute of Health
<i>OMS-HC</i>	Open Minds Stigma Scale for Healthcare Providers
<i>PCP</i>	Primary Care Provider
<i>PHQ2</i>	Patient Health Questionnaire 2
<i>PHQ9</i>	Patient Health Questionnaire 9
<i>PI</i>	Principal Investigator
<i>POSAC</i>	Planning- Organizing -Staffing- Actuating - Controlling
<i>R-DAQ</i>	Revised Depression Attitude Questionnaire
<i>RN</i>	Registered Nurse
<i>U.S.</i>	United States
<i>USPSTF</i>	United States Preventive Service Task Force

CHAPTER I - INTRODUCTION

Depression is a common mental disorder that affects a person's mood. Depression is a mood disorder that causes feelings of sadness, loss of interest in previously enjoyed activities, hopelessness, irritability, decreased energy, difficulty concentrating and sleeping, changes in appetite, or somatic symptoms for at least two weeks (National Institute of Mental Health [NIMH], 2018). Depression is one of the leading causes of disability worldwide and ranges from mild to severe depression. According to Hankerson et al. (2015), mental and behavioral disorders account for 13.6% of all disabilities in the United States (U.S.).

In the United States, approximately 50% of Americans are diagnosed with a mental illness during their lifetime (Centers for Disease Control and Prevention [CDC], 2018). The disease is multifactorial and attributed to many causes, including genetic, psychosocial, environmental stressors, and other conditions such as hypertension, diabetes, and cancer. People of all ages, racial, ethnic, and socioeconomic backgrounds experience depression, but it affects people differently. For example, mental disorders are disproportionately higher in racial and ethnic minorities (American Psychiatric Association [APA], 2017).

Depression can create a significant social and financial burden on individuals, families, and society. The disorder is a leading cause of death, morbidity, and a primary cause of distress (Razzak et al., 2019). Most research studies confirm that only half of the individuals with depression are diagnosed and receive adequate mental health care (Dogu & Aydemir 2018). The absence of screening leads to missed opportunities to identify

individuals with depression and link them to care. The primary care setting is the optimal environment for depression screening.

Background

Depression is one of the most common mental disorders in the United States and the leading cause of disability globally (World Health Organization [WHO], 2020).

Depression is disabling and costly, with an annual estimated \$210 billion (Siniscalchi et al., 2020). In addition, mental health plays a significant role in maintaining good physical health. Recent data reveals an estimated 17.3 million adults in the U.S. population experience an episode of depression each year (NIH, 2019), making this the second leading cause of disability in the country (Haddad et al., 2015). Depression does not discriminate, and it affects all people regardless of age, gender, income, social status, race/ethnicity, religion/spirituality, or sexual orientation (O'Connor et al., 2016).

Over 14% of women have perinatal depression, and an estimated 16% have postpartum depression (Cox et al., 2016). Depression untreated during pregnancy increases premature birth, suicidality, and severe post-delivery depression (Cox et al., 2016). In addition, it can affect bonding with the infant, cause developmental disorder, and impact family dynamics (Lutkiewicz et al., 2020).

Depression is the fourth leading cause of death among adolescents ages 15-19 (WHO, 2020). Moreover, adolescents' depression can progress to long-term morbidities such as substance abuse, anxiety, and panic disorder (National Committee for Quality Assurance [NCQA], 2020). The risk of suicide attempts has increased in depressed adolescents than in non-depressed adolescents (WHO, 2020).

Depressed older adults are more likely to be seen in primary care but not routinely screen for depression. Diagnosis of elderly individuals can be challenging for primary care providers (PCP) due to factors such as cognitive impairments, social stigma, medical comorbidity, and atypical or vague clinical presentation (Avasthi & Grover, 2018). Elderly patients often under-report their depressive symptoms, and they may not acknowledge being sad, down, or depressed (Akincigil & Matthews, 2017). Common depressive symptoms include lack of enjoyment in usual activities, loss of interest in life, poor sleep, recurrent thoughts of death, pain, poor concentration, or impaired memory in the elderly. The providers want to diagnose old age, dementia, or poor health in the elderly, leading to misdiagnosis. Over years of misdiagnosis among the elderly, depression is under-detected and untreated for a long time, leading to suicide (Avasthi & Grover, 2018).

Unidentified and untreated depression has many consequences leading to poor quality of life, direct and indirect healthcare cost-related increases, and increased medical comorbidities. Despite increased attention to depression screening and treatment, patients in primary care are still unrecognized and undertreated (Siniscalchi et al., 2020). Primary care clinics are ideal for screening for depression and for managing those who screen positive.

Problem Statement

Screening for depression refers to using a depression screening questionnaire to identify patients who may have depression. The U.S. Preventive Services Task Force (USPSTF) and the American Academy of Family Physicians (AAFP) recommend depression screening in primary care for all adolescents (age 12), adults, pregnant

women, and postpartum women (Maurer et al., 2018). Sui & USPSTF (2016) recommends PCPs screen for depression at wellness and as needed on routine office visits. The primary care provider's role is vital in the early diagnosis, treatment, and continuing care.

Early screening, diagnosis, and treatment of depression among patients in the primary care setting can improve their quality of life and increase the management and treatment of depression. Screening patients in the primary care setting should be screened using a standardized depression screening tool such as the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9) for depression screening (NCQA, 2020). Zung Depression Scale, Beck Depression Inventory and Geriatric Depression Scale (for patients over 65) are other reliable depression screening tools that can be utilized by healthcare providers (Maurer & Darnall, (2012).

Significance

Depression is the most common psychiatric disorder in primary care. Patients with chronic conditions prefer to receive services in primary care. Those with depression and other mental health disorders are more likely to have unmet medical care from their PCPs. These patients suffer from depression, but the disease is overlooked and untreated.

A providers' understanding of mental illness can be affected by previous opinions and experiences. Knowledge about mental disorders varies from country to country and PCP to PCP. It depends on the education and training received by the individuals. Part of that challenge is to understand the views, beliefs, and attitudes of PCPs about depression treatment. The goal is to determine barriers, target the practice for a specific change, and make sure PCPs are comfortable with depression diagnosis and treatment.

Those providers who work in primary care and hold stigmatizing attitudes towards people with mental disorders are more doubtful about patients' adherence to the treatment of both psychological and physical illnesses. Therefore, their medical decisions are constructed on mistaken beliefs and or stigmatizing attitudes contrary to usual care standards. Attitudes and knowledge of non-psychiatric physicians are essential factors for recognizing and treating depression, as negative attitudes can interfere with patients' willingness to receive and comply with treatment (Haddad et al., 2017).

A client with depressive symptoms will obtain treatment from their primary care provider instead of a mental health professional (Akincigil et al., 2017). Depressive symptoms are known to vary in all races/ethnicities depending on the stage of illness. Stigma concerning mental illness often discourages individuals from seeking the help they need. A clinician's lack of awareness, attitude, and behavior towards mental illness can hinder a client seeking treatment. A negative mindset can cause clients to feel undervalued, dismissed, and debased.

Needs Assessment

The study was conducted in a small rural health clinic located in Winston County, Mississippi. The county has an estimated population of 17,700 (U.S. Census Bureau, 2021). The rural Mississippi town has three mental health facilities. One for children and adolescents, one for geriatrics, and a Community Service Center for all ages. The nearest crisis stabilization center is over 60 miles from the town.

At the time of the study, the clinic did not have a standard protocol for depression screening. General depression screening is performed only at annual wellness visits for the elderly. The clinic consists of two family practice physicians, four family nurse

practitioners, one dual family, and psychiatric nurse practitioner, five registered nurses (RNs), and six licensed practical nurses (LPNs).

Due to the lack of mental health services provided consistently in this rural Mississippi town, it is challenging for PCPs to treat patients with depression and other mental illnesses. Primary care providers may be hesitant to diagnose depression due to a lack of knowledge in diagnosing and treating major depressive disorders, coupled with a lack of supportive services in the behavioral health field or an awareness of services available. Primary care providers, including nurse practitioners in rural areas, are critical for diagnosing and treating patients with depression.

PICOT

The purpose of this DNP project was to develop and implement an evidence-based depression screening protocol in the primary care setting to increase early detection and treatment of depression. A provider's lack of knowledge and attitude about depression can affect treatment outcomes for patients. Will implementing a depression screening protocol in the primary care setting improve how PCPs diagnose and treat depression?

Purpose and Objective

The purpose of this Doctor of Nursing Practice (DNP) project was to develop and implement an evidence-based depression screening protocol in the primary care setting to increase early detection, initiation of treatment, and continuation of care. A depression screening protocol, following national guidelines for depression screening in the primary care clinic, was presented to the Louisville Medical Clinic administrator by the DNP

student. The revised Depression Attitude Questionnaire (R-DAQ) was used to assess and evaluate the staff's understanding and attitude about depression.

Objectives

The objective of the study was to implement a quality improvement program to increase depression screening in a primary care clinic. Providers was educated on depression screening national guidelines and recommendations. They were also educated on depression screening tools that can be utilize to screen for depression and its severity.

1. The protocol provided a standardized method for the providers to screen patients in primary care for depression during annual wellness and office visits.
2. Patient Health Questionnaire 2 (PHQ-2) and Patient Health Questionnaire 9 (PHQ-9) screening tools was used by clinicians to screen clients for depression or a depressive disorder.
3. Identified patients who were depressed and initiated early treatment, referral, and crisis intervention if needed.
4. Utilized a team-based approach to appropriately screen for depression and manage depression in primary care.
5. Monitored antidepressant therapy in patients with major depression.
6. Reduced suicide risk, improved quality of life and overall well-being in a holistic approach.

Literature Search

A literature search was achieved using search engines and databases such as CINAHL, Cochrane, Google Scholar, Medline, and EBSCOhost. Search terms used were primary care, depression, depression screening, healthcare providers, depression knowledge, and attitude. There were several relevant articles related to depression screening, six articles related to depression treatment, and four articles relevant to depression screening guidelines in rural primary care.

The purpose of the investigations was to locate scholarly peer-reviewed articles related to depression screening and clinicians' attitudes in the primary care setting. Inclusion criteria included participants ages 12 and older, pregnant, and postpartum women living in rural Mississippi, English speaking, and do not have a diagnosis of depression and a positive PHQ-2. Participants under the age of 12 and currently being treated for depression was excluded from the study.

Synthesis of Evidence

An online literature search was performed using search engines and databases such as CINAHL, Cochrane, Google Scholar, Medline, and EBSCOhost. The purpose of the searches was to find scholarly peer-review articles related to depression screening and attitudes of clinicians in the primary care setting. Inclusion criteria included participants aged 12 and older, pregnant women, and postpartum women living in rural Mississippi. Participants did not have a previous diagnosis of depression and has a positive PHQ-2.

Search terms used were primary care, depression, and depression awareness. Sixty journal articles were reviewed and 29 were used for this project. Articles that did not address depression in primary care were excluded.

General Terms

Depression: Depression is common and often referred to as a major mood disorder or clinical depression. The symptoms can affect how one feels, thinks, and handles daily activities, such as sleeping, eating, or working, which characterize depression. To be diagnosed with depression, the symptoms must be present for at least two weeks NIMH (2018). They include loss of interest in things one likes to do, feeling sad or empty, feeling irritable, being unable to enjoy things that were once pleasurable activities, feeling hopeless, loss of self-esteem, physical complaints, or changes in sleep such as waking up early or sleeping too much, lack of energy, loss or increase in appetite, weight loss or gain, unexplained generalized body pain, and suicidal thoughts or actions

Depression screening: Depression screening is described as a test that healthcare providers use to confirm a preliminary diagnosis of depression. These tests may provide some insight to the providers about the patient's mood to diagnose the patient with more certainty (Haefner et al., 2017).

Depression screening tools: These are tools that healthcare providers frequently used to detect self-reported symptoms of depression. There are various tools available such as PHQ-2, PHQ-9, Beck's Depression Inventory, and the McArthur Foundation Depression Tool kit that the United States Department of Human and Health Services (USDHHS) and the Centers for Medicare and Medicaid (CMS) use.

Stigma: A negative view of someone based on a personal trait or other characteristics that some people believe to be a disadvantage or negative attribute

Patient Health Questionnaire 2-item (PHQ-2): A validated self-reported screening tool used to screen for major depression. The PHQ-2 consists of a brief two-

question which is a quick screen questionnaire. This tool assesses for main symptoms of depression which are depressed mood and anhedonia. It has a sensitivity is 61% and 92% specificity for detecting a major depressive disorder on a positive screening of 3 or more (Arroll et al., 2010).

Patient Health Questionnaire-9 (PHQ-9): A validated self-reported screening tool described for diagnosis, screening, monitoring, and measuring the severity of depression. The PHQ-9 is a self-reported tool that incorporates the DSM-V depression diagnostic criteria. It has a sensitivity is 74% and a 91% specificity rate (Arroll et al., 2010).

Revised Depression Attitude Questionnaire (R-DAQ): R-DAQ is a revised 22-item tool that is used to examine healthcare professionals' views and knowledge of depression. The tool is a self-reported tool and validated. It has a Cronbach's alpha coefficient of 0.84 and was found satisfactory for test-retest reliability (Haddad et al., 2015).

Synthesis of Evidence

Chronic medical conditions increase a patient's risk for depression. Siu & USPSTF (2016) has recommended depression screening in primary care. It is essential to equip primary care providers with a consistent way to screen, diagnose and treat depression in a rural setting. Multiple components in a person's life contribute to depression, making the illness multifaceted. Each person's presentation of depression is unique, dependent on environment, culture, faith, and experiences. Primary care providers play a critical role in depression screening for adult patients.

Using a flow map process to implement depression screenings in primary care can help identify patients with depression at early onset and provide optimal care. Depression

care includes collaboration with a behavioral health counselor in addition to medication therapy. Research has shown that implementing evidence-based guidelines for depression screening in primary care is beneficial for the patient.

Depression and Chronic Illness

The use of evidence-based clinical practice guidelines for depression screening in the primary care setting is significantly underutilized. Studies have shown that there is a higher incidence of depression in individuals with diabetes. Bajracharya et al. (2016) conducted a prospective, post-intervention, quasi-experimental design study with 378 participants in a rural primary care clinic in New Mexico. The study evaluated the effectiveness of integrating a depression screening protocol and using PHQ2 and PHQ9 in the patient's electronic health records. There was an increase in the detection of depression in a patient with chronic medical conditions, and treatment outcomes improved.

Providers Attitude Towards Depression

The stigma of mental illness is a barrier to treatment for both patient and healthcare providers. The beliefs of providers in primary care can decrease the effectiveness of treatment. A cross-sectional study conducted by Saif et al. (2019) examined the attitudes of healthcare providers in Bahrain towards mental illness and adopting an evidence-based practice protocol. The study included 547 healthcare providers from primary care clinics and a mental health care hospital. The providers completed a self-reported questionnaire called Opening Minds Stigma Scale for Healthcare Providers (OMS-HC) and the Evidence-Based Practice Attitude Scale (EBPAS). The study concluded that healthcare providers in Bahrain had a significant bias

towards mental illness. Providers that treated mentally ill patients had decreased stigma towards mental illness and were open to using evidence-based protocols.

Disparities in Treatment

Depressed symptoms in the primary care setting are often dismissed as physical symptoms. However, Akincigil et al. (2017) conducted a secondary analysis of data from a national survey conducted in 2012 and 2013 by National Ambulatory Medical Care. Physician-patient encounters reviewed in the study were 33,653. The study population consisted of 64% females under the age of 65. The majority were Caucasian. Of the participants screened, 47% received a new diagnosis of depression.

The study found that African Americans and elderly patients were less likely to be screened because their symptoms were more somatic than mood-related. Patients with one or more chronic medical conditions received depression screening compared to those with no chronic medical conditions. Patients with depressive symptoms and suicide ideations will more than likely present to their primary care initially for treatment. The study concluded that using an electronic health record system could assist in improving low depression screening rates and screening inequalities. Primary care clinics should implement a protocol to screen for depression in their workflow.

Barriers to Treatment

Haynes et al. (2017) conducted a qualitative study with 50 participants in a rural South area exploring mental health, treatment, and barriers in African Americans. In this study, the participants recognized the social inequities, racism, unemployment, and poverty increased the risk of experiencing mental illness. Depressive symptoms in African Americans were considerably increased due to prolonged exposure to stressors.

Depression in this community was more debilitating resulting in higher hospitalizations, low employment rates, and impaired social interaction. They believed positive thinking affects their emotional wellness

The authors suggested implementing protocols and interventions to improve mental health awareness, education, and teaching strategies to cope with racism and poverty. The most referred to barrier cited was stigma and low mental health literacy. Mental health education programs have been used successfully to educate and improve mental health literacy and stigma.

Theoretical Framework

Depression is a multifactorial disease that affects an individual's life socially, career and relationships. Healthcare managers have access to various change management theories for quality improvements. This project utilized Kurt Lewin Change Theory. His Three-Step Model (Unfreezing, Changing/Moving, Refreezing/Freeze) for change was published in 1947. Lewin's theory analyzes behavior that can serve as the guide or restrictive force for change. His theory is widely used by healthcare organizations to implement and maintain organizational changes to improve patient outcomes.

Medication errors can be fatal. Southerland (2013) used Lewin's Change Theory to change how the medication is administered in the hospital setting. The hospital implemented the use of computer assistance of bar-coded medication scanning to reduce medication errors. Problems are solved by utilizing an interpersonal style. The stability and continuation of an organization is depended upon its response to environmental changes (Wojciechowski et al., 2016).

Step One (Unfreezing)

This step determines and identifies the need for change. Changes in practice are often met with resistance by the group or individuals. The first step is achieved by undoing current beliefs and patterns of behavior. The driving force moves the group in the preferred direction while restraining forces move the group in the opposing direction (Wojciechowski et al., 2016). Staff was educated on why changes in practice are necessary. The identified need is to increase screening for depressive disorders in primary care. The Revised Depression Attitude Questionnaire (R-DAQ) was used to evaluate the staff's understanding and attitude about depression. The U.S. Preventive Services Task Force (USPSTF) and American Academy of Family Physicians (AAFP) recommend depression screening in all patients beginning at age 12, pregnant, and postpartum women. Screening individuals for depression can also identify individuals at risk for suicide.

Step Two (Changing/Moving)

This step explores the benefits of change and decreases adverse forces that affect change (Wojciechowski et al., 2016). In this step, the individuals are ready for change. Change is achieved through seeking new methods, education, or brainstorming. The goal is to change 'individuals' behavior in the direction that will improve patient care. A 45-minute educational program was conducted to educate the staff on how to identify clients with depression or depressive disorder by utilizing Patient Health Questionnaire 2 (PHQ-2) and Patient Health Questionnaire 9 (PHQ-9).

Step Three (Refreezing)

In the stage of refreezing, the new concept is accepted by the individuals. Retraining is successful and the individuals agree to implement the desired change. For change to be sustained it is important that managers lead by adopting the new behavior, allow individual or group input to work out any problems, and reward the group (Hussain et al., 2018). A depression screening protocol was developed to assist providers in screening patients in primary care for depression during annual wellness and office visits.

Hidayat et al. (2019) conducted a mini project at a military hospital in Jakarta to optimize nurse management delegation functions. Data were collected by using the Planning-Organizing-Staffing-Actuating-Controlling (POSAC) method from four head nurses. A fishbone diagram was used to ascertain the main problem. Kurt Lewin's change management method was used to resolve management delegation problems of nursing duties among head nurses and team leaders in a Military hospital.

In the unfreezing stage, management recognized the need for delegation and the duties of management were not in line with the 'hospital's vision and mission. Guidelines for nursing delegation and operations standards were developed during the movement stage. Refreezing stage evaluated the application of the management delegation guidelines. The study concluded that delegation duties by management to team leaders were effective. Further training of all nursing staff is needed to increase their self-awareness and knowledge in delegating.

DNP Essentials

DNP Essential I: Scientific Underpinnings for Practice

This DNP Essential was met through a review of evidence-based depression literature and the recommendations from The U.S. Preventive Services Task Force (USPSTF) and the American Academy of Family Physicians (AAFP) for annual depression screening in primary care.

DNP Essential II: Organizational and Systems Leadership for Quality Improvement and System Thinking

The organization's depression screening practices were evaluated. The clinic did not have a formal depression screening protocol in place. Depression screening utilizing PHQ2 and PHQ9 was not being utilized by most of the healthcare providers in this facility. This DNP essential was achieved by providing a 30-minute evidence-based PowerPoint educational presentation on depression, diagnosis, and treatment to improve patient outcomes.

DNP Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

This essential was met by developing an evidence-based depression screening protocol that serves as a guide for healthcare providers in the primary care setting to increase depression screening and patient outcomes. The importance of incorporating the use of the PHQ2 and PHQ9 to screen for depression and suicide ideations. The R-DAQ was used to assess the stigma and attitudes of healthcare providers.

DNP Essential IV: Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Technology of Health Care

This essential was accomplished by using Qualtrics Research Suite to analyze questionnaires completed by healthcare providers. Zoom was used to present a PowerPoint presentation on depression. The primary means of communication with the clinic administrator was via email.

DNP Essential V: Health Care Policy for Advocacy in Health Care

Mental disorder is underdiagnosed and treated in the primary care setting. Its effects can be debilitating. This essential was accomplished by advocating increase screening in primary care as recommended by national guidelines for early detection and treatment of depression.

DNP Essential VI: Interprofessional Collaboration for Improving Patient and Population

This essential was achieved through collaboration with members of the healthcare team and community resources. Members of the healthcare team in this rural primary care clinic consisted of physicians, nurse practitioners, and/or physician assistants and a mental health professorial, crisis centers, or emergency room for coordination of care.

DNP Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

This essential was met by focusing on improving health outcomes in various cultures in the rural community. Within this community, there is limit available mental health resources. This essential was achieved through educating the staff on diagnosing, treating, and referral of patients a depression and suicide ideations.

DNP Essential VIII: Advancing Nursing Practice

A depression screening protocol was developed by the DNP student to identify patients who are depressed and initiate early treatment, referral, and crisis intervention if needed.

Summary

The primary care setting is the optimal environment for depression screening. Chronic medical conditions increase the patient's risk for depression. All patients in the primary care setting, beginning at the age of 12, should be screened for depression using the PHQ2 depression screening tool. If PHQ2 is positive, PHQ9 should use to determine the severity of depression. Racial disparities can and do impact access to care and treatment.

CHAPTER II – METHODS

Introduction

Positive health outcomes for the patients determine the quality of healthcare. Depression affects the quality of life in many communities. The purpose of the study was to increase early detection of depressive symptoms and improve treatment outcomes in adolescents, adults, older adults (ages 60 and older), pregnant women, and postpartum. Increasing staff knowledge on the importance of depression screening in the primary care setting using a standardized depression screening tool, PHQ2. If positive on PHQ2 will further evaluate with PHQ9 for a depressive disorder.

Intervention

The clinic administrator assisted with data collection. The administrator reviewed and approved the depression screening protocol. Copies of depression screening protocol and PowerPoint teach presentation was given to each participant. She obtained consent from participants to participate in the study.

A depression screening tool protocol, developed by a DNP student, following national guidelines for depression screening in the primary care clinic, was presented to the Louisville Medical Clinic administrator. The Revised Depression Attitude Questionnaire (R-DAQ) was used to evaluate the staff's understanding and attitude about depression. Permission to use the tool in the study was obtained from the author of the tool. The duration of the study was four weeks. The number of participants will be 10. The time required for participants will be 30 minutes. There will be no restrictions on routine activities or invasive techniques. Demographic information will be collected such

as age, race, education, socioeconomic and medical history was be completed anonymously.

The LPN and R.N. administered the PHQ-2 to the patient during the triage interview and if positive, the PHQ-9 was administered. For a patient that scored two or higher on question number 9 on the PHQ-9 (more than half the days), the LPN or R.N. will notify the FNP and complete a suicide assessment. The Ask Suicide-Screening Question (ASQ) will be used to screen for suicide and if positive, an immediate referral will be made to the nearest facility for further evaluation. The P.I. conducted an educational class via zoom with a maximum of 10 participants. COVID guidelines will be followed including individual facemask, seating 6 feet apart, and hand sanitizing.

Population of Interest

The participants of the study include the clinic administrator, physicians, Family Nurse Practitioners, registered nurses, and licensed practical nurses. The number of participants was 10. Inclusion criteria for selection of participants will be employed by a rural primary care clinic in central Mississippi, 18 years of age and over, able to read and write English.

Analysis

Data will be analyzed and measured by using a descriptive pilot study survey result. The expected outcome is to improve depression knowledge and treatment options for clients in a rural community in North Mississippi. The providers' knowledge will be evaluated using pre-intervention and post-intervention responses to a depression knowledge survey. A significant increase in post-test SED scores will determine the success of a one-day education program on depression symptoms and treatment.

Ethical Considerations

The project was approved by The University of Southern Mississippi Institutional Review Board (Protocol # IRB-20-525). Participants' names were not used in the data. The participants were assured that their identities would be confidential and anonymous. Full signatures were required for the informed consent form and this document was collected by the clinic administrator. She will be assisting with data collection as well as all other data collection documents.

Documents will be placed in a manila envelope and placed in a locked storage box in the P.I. home office, accessible only to the P.I. Participants' information was confidential, and no participant was identified in the dissemination of the findings through publications and presentations. Data was destroyed after the evaluation of the data was complete. A letter of support was obtained from the Louisville Medical Clinic administrator.

Summary

The purposed outcome of the study is participants will gain increased knowledge and awareness about the importance of depression screening in the primary care setting. They will also gain an understanding of treatment options and collaborative care management. Knowledge assessment will be indicated by an increase in depression screening utilizing PHQ-2 on triage.

CHAPTER III - RESULTS

Qualtrics was used to send 10 participants surveys via email. All ten participants responded to the demographic survey, pre-R-DAQ and post-R-DAQ questionnaire, and post-teaching questionnaire. Qualtrics analyzed data. Inclusion criteria were met by the ten participants. The participants were all females between the ages of 25-54 (Figure 1), non-Hispanic, Caucasian, and African Americans (Figure 2). Their educational level ranged from a doctoral degree in nursing, master's degree in nursing (Advanced Practice Nurse), Bachelor's of nursing degree (RN), Associate degree in nursing (AND), and some college (LPN) (Figure 3).

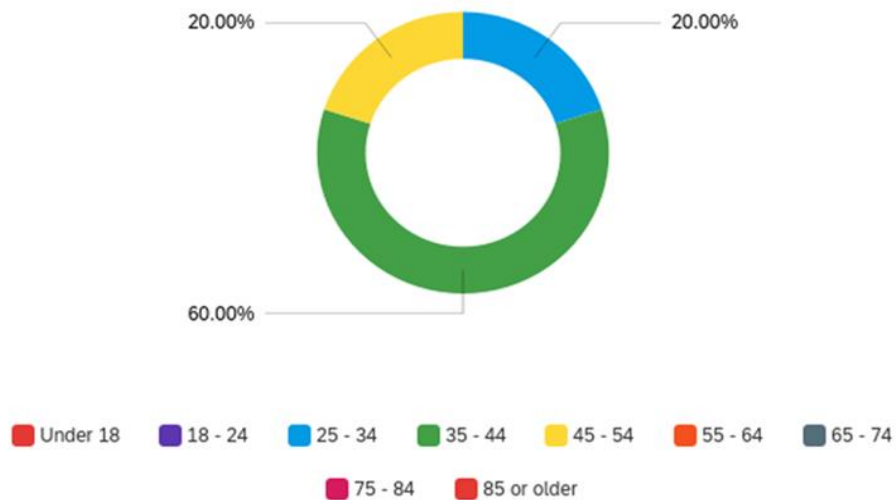


Figure 1. Age of Providers

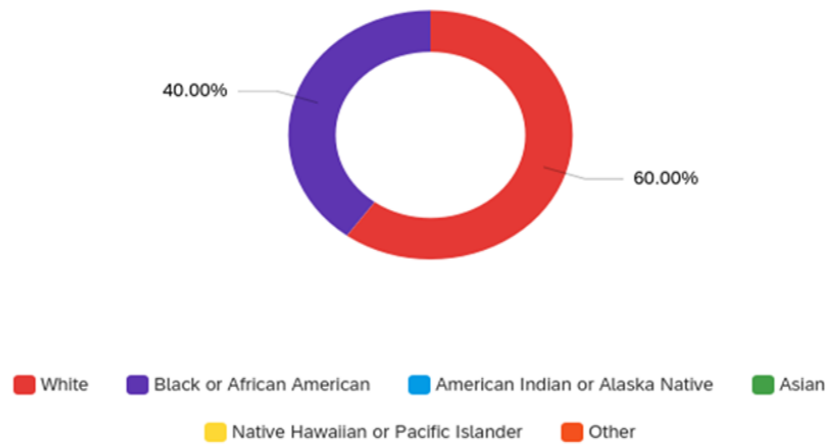


Figure 2. Ethnicity of Healthcare Providers

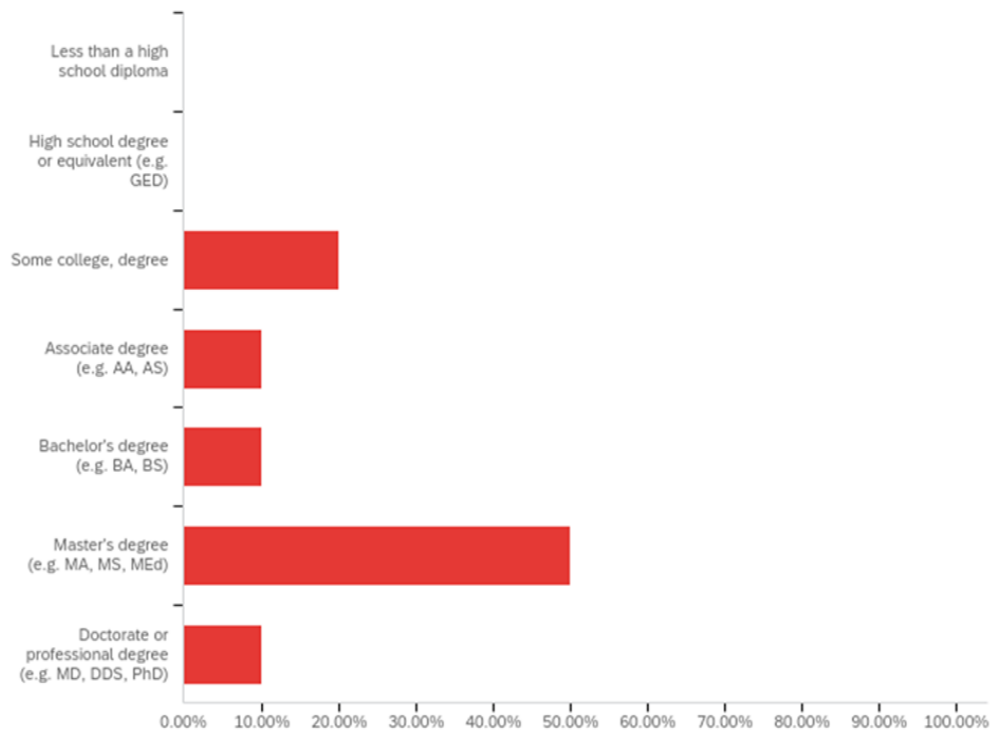


Figure 3. Education Level

Results from Pre and Post R-DAQ Questionnaire

Knowledge about mental disorders varies among healthcare providers and depends on their education and training. The R-DAQ post teaching intervention results show providers had significant confidence in assessing and dealing with depressed patients. (Figure 4). Providers (75%) strongly agreed post teaching that depression was like any other disease and disagreed (87%) that antidepressant therapy was unsuccessful in a depressed patient. However, both pre-teaching and post-teaching strongly agreed that anyone could suffer from depression and disagreed depression is natural in adolescence. Suicide risk assessment confidence increased to 70% post teaching compared to 40% pre-teaching. Results of the post teaching question providers reported teaching on depression was relevant to their practice. They had a better understanding of depression and using PHQ2 and PHQ9 depression screening tools.

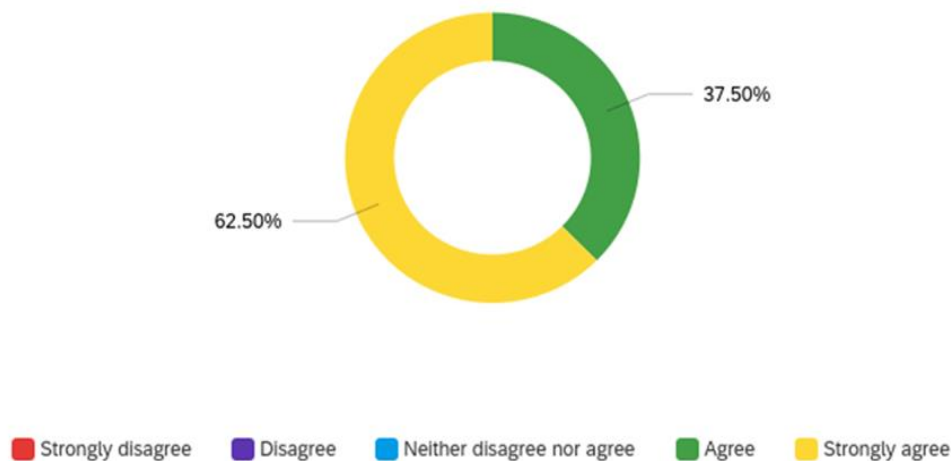


Figure 4. R-DAQ Q1 I feel comfortable in dealing with depressed patients' needs (post teaching intervention)

Results of Depression Screening

The goal of depression protocol was to identify patients who are depressed and initiate early treatment. All patients met inclusion criteria. The patient age range was from 18 -90 years of age 37% were males (n=27), and 62% were females (n=44). Visit types included 28% chronic care (n=20), 22% wellness (n=16), 32% acute (n=23), 14% follow-up visit (n=10), 1% were new patient and nurse visit. Using the PHQ2, 71 patients were screened for depression. Patients that score three or more on PHQ2 were 15% (Figure 5). Patients with a score of 3 or more on PHQ2 were screened for severity using PHQ9. The Suicide Screening tool was used for a positive answer to question #9.

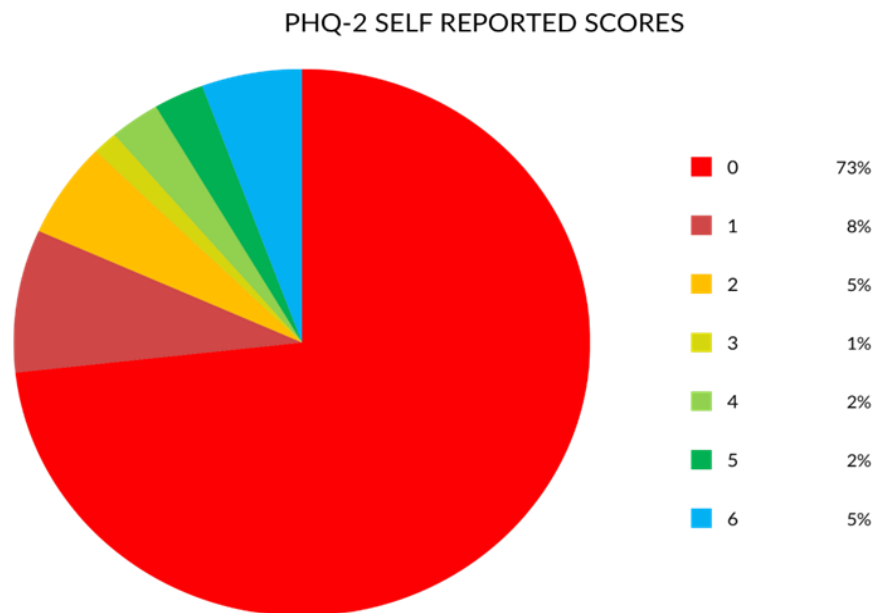


Figure 5. PHQ2 Results

Although only 9 out of 71 patients had a positive PHQ2, 12 participants had a positive PHQ9 screening of moderate depression and greater (Figure 6). Two was able to identify these and get them treated. A patient that screened positive for suicide ideation was two. The Ask Suicide-Screening Question (ASQ) was utilized to screen the two positive suicide. Both were non-acute and were referred to dual-certified PMHNP/FNP who works in the clinic. The positive patient was treated with oral medication.

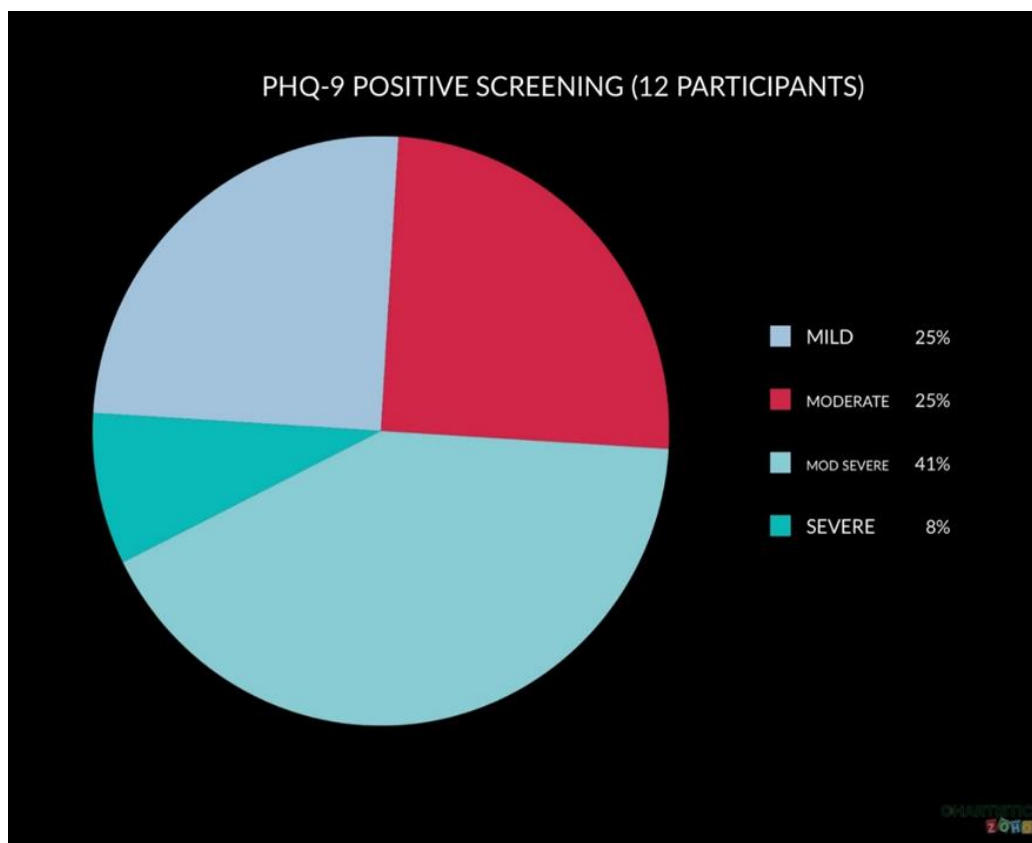


Figure 6. PHQ9 Results

Summary

Patients with depressive symptoms often present to their primary care initially for the treatment of depression. Diagnosis and treatment are delayed because screening is not done utilizing evidence-based depression screening tools. Provider's knowledge of depression screening, treatment, and referral was increased. Research data has shown that early detection and treatment of mental illness has a positive outcome for patients.

CHAPTER IV - DISCUSSION

The goal of this intervention was to identify patients who are depressed and initiate early treatment, referral, and crisis intervention if needed. Implementing a standardized, evidence-based protocol to serve as a guide for providers. Utilizing an evidence-based depression screen tool, such as the PHQ2 and PHQ9. Provider in primary care should collaborate with a mental professional based on the severity of depression symptoms.

Key Findings

Depression screening in the primary care setting is critical. Primary care providers' knowledge of depression is limited to their exposure to mental illness. Education about mental illness does impact the provider's attitude and stigma as it relates to treatment outcomes for the patient. Based on the result of the study, depression teaching had a positive impact on the providers' attitudes and stigma regarding depression. Providers felt more comfortable in dealing with and treating depressed patients. The study was able to identify and initiate treatment for 12 patients that had moderate to severe depression. The study also identified two patient that had a non-acute screening for suicidal ideations

Strengths and Limitations of the Project

One limitation of the project was interaction with healthcare providers due to COVID-19 restrictions. All healthcare providers within the clinic did not participate in the study. Communication was limited to the clinic administrator. One strength of the project was providers' wiliness to use the PHQ2 and PHQ9 to screen for depression at clinic visits. The goal was to identify barriers to treatment, target the practice for specific

changes in depression screening. As a result, the providers were more comfortable with depression diagnosis and treatment medical decisions options. At this time, the depression screening protocol is still being considered by the clinic administrator. They are considering adding mental health services to their practice.

Impact of the DNP Project

The findings from this project show that routine depression screening in the primary care setting has a positive impact on treatment outcomes for individuals diagnosed with depression. The project made a difference in nursing practice by increasing depression screening of patients at their annual wellness and office visits. Depression screening also provides an opportunity to evaluate suicide risk decreasing the mortality rate of death by self-infliction.

Implications for Future Practice

Patients present to their primary care provider for initial treatment of depression. A system must be in place that addresses screening, treatment, and referral. Additional study is needed to evaluate barriers to treatment. Are the barrier due to patient behavior or the stigma and attitudes of providers.

Conclusion

In the primary care setting, it is imperative that healthcare providers adhere to national guidelines and recommendations for depression screening. Primary care clinics should have a depression screening protocol that serves as a guide for diagnosing, treatment, referral and crisis intervention. Utilizing evidence-based depression screening tools in their practice is of utmost importance.

APPENDIX A - Patient Health Questionnaire-2

Patient Health Questionnaire-2 (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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

For office coding: 0 + + + +
= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016.
See website for additional information and translations.

APPENDIX B - PHQ9

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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from
Pfizer Inc. No permission required to reproduce, translate, display or distribute.

APPENDIX C – Suicide Screening Tool



Ask the patient:

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
- If yes, please describe: _____

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - ☐ “Yes” to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
 - ☐ “No” to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient’s care.

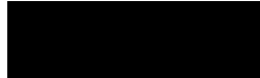
Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

APPENDIX D – Request to Use Tool

November 2, 2020

Donna Pittman



OBJECT: PERMISSION REQUEST TO USE COPYRIGHTED MATERIAL

Dear Dr. Mark Haddad,

I am contacting you because you are the author of revised Depression Attitude Questionnaire (R-DAQ) and I would like to use the questionnaire.

I am a graduate student at The University of Southern Mississippi. I am currently enrolled in the Doctor of Nursing Practice program (DNP). The purpose of my DNP project is to develop and implement an evidence-based depression screening protocol in the primary care setting to increase early detection and treatment of depression. I plan to limit use of your material to assess staff understanding and attitude knowledge about depression. I will not use it in any other way besides mentioned above.

I respectfully request your support as the copyright holder to allow me the right to use the revised Depression Attitude Questionnaire (R-DAQ) free of charge in the manner described herein. If this is acceptable, you can simply sign and return to me a copy of this letter.

Thank you for your consideration and your time.

Sincerely,

Donna Pittman, MSN, FNP-BC, PMHNP-BC

Permission is Hereby Granted Pursuant To the Terms and Conditions of this Letter

[Dr. Mark Haddad]

APPENDIX E – Permission from Author

RE: Copyrighted Material

Haddad, Mark <Mark.Haddad.1@city.ac.uk>

Sun 11/8/2020 7:11 AM

To: donna pittman <donna.pittman@msn.com>

 4 attachments (4 MB)

HaddadRDAQLAhore2016.pdf; spanish-validation-RDAQ.2019.pdf; RDAQDevelopment2015.pdf; DAQPooled2012.pdf;

Dear Donna,

You are very welcome to use the Revised Depression Attitude Questionnaire in your studies. The R-DAQ has been requested and used in studies in several countries and settings, and possibly in the future there may be opportunity to compare data from these different studies.

I am attaching some articles relevant to this scale that might be useful.

Wishing you well for success in your research.

Best wishes, Mark

Dr Mark Haddad
Senior Tutor for Research
Senior Lecturer in Health Services Research
Centre for Health Services Research
School of Health Sciences
City, University of London
1 Myddelton Street
London EC1R 1UW

APPENDIX F - R-DAQ

Revised Depression Attitude Questionnaire (R-DAQ), Haddad et al 2015

	Please read the statement and tick/click the box that relates best to your personal opinion	Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree
1	I feel comfortable in dealing with depressed patients' needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Depression is a disease like any other (e.g. asthma, diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Psychological therapy tends to be unsuccessful with people who are depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Antidepressant therapy tends to be unsuccessful with people who are depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	One of the main causes of depression is a lack of self-discipline and will-power	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Depression treatments medicalise unhappiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	I feel confident in assessing depression in patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I am more comfortable working with physical illness than with mental illnesses like depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Becoming depressed is a natural part of being old	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	All health professionals should have skills in recognising and managing depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	My profession is well placed to assist patients with depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Becoming depressed is a way that people with poor stamina deal with life difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Once a person has made up their mind about taking their own life no one can stop them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	People with depression have care needs similar to other medical conditions like diabetes, COPD or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	My profession is well trained to assist patients with depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Recognising and managing depression is often an important part of managing other health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	I feel confident in assessing suicide risk in patients presenting with depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Depression reflects a response which is not amenable to change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	It is rewarding to spend time looking after depressed patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Becoming depressed is a natural part of adolescence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	There is little to be offered to depressed patients who do not respond to initial treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Anyone can suffer from depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Haddad et al (2015) The development and psychometric properties of a measure of clinicians' attitudes to depression: the revised Depression Attitude Questionnaire (R-DAQ). *BMC Psychiatry* 2015, 15:7

APPENDIX G – Post Teaching Questions

DNP Post Teaching Questions

Question	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
1. The information provided at this event is relevant to my practice.					
2. I found the information useful.					
3. I have a better understand about depression.					
4. How likely are you to use this information in the future?					
5. I have a better understanding of how to use PHQ2 to screen for depression.					
6. I have a better understanding of how to use PHQ9 to screen for severity of depression.					

APPENDIX H – Louisville Medical Clinic Depression Screening Protocol

Purpose

This clinical protocol is to serve as a guide for screening for depressive disorders in primary care. The U.S. Preventive Services Task Force (USPSTF) and American Academy of Family Physicians (AAFP) recommend depression screening in all patients beginning at age 12, pregnant, and postpartum women.

Objective

This protocol assists providers in screening patients in primary care for depression during annual wellness and office visits. The goal of screening is to identify clients with depression or depressive disorder by utilizing Patient Health Questionnaire 2 (PHQ-2) and Patient Health Questionnaire 9 (PHQ-9).

Goal

- To identify patients who are depressed and initiate early treatment, referral, and crisis intervention if needed.
- Use a team-based approach to appropriately screen for depression and manage depression in primary care.
- Select and monitor antidepressant therapy in patients with major depression
- Reduce suicide risk, improve quality of life and overall well-being in a holistic approach

Outcomes

- Initiate screening early diagnosis intervention treatment
- Restoration of functioning improve the quality of life
- Medication and therapy adherence compliance remission
- Decision making collaborative team psychiatrist, PCP, FNP, PMHNP, case manager, social worker, counselors, ministry, psychologist, family, nurse, and patient (if capable of making medical decisions)
- Identify high-risk patients psychosis, substance, or alcohol use disorder refer immediately
- Most important outcome reduce suicide
- Referrals behavioral health services or CCS psychiatrist or PMHNP crisis center

Algorithm

This algorithm assists with screening for depression in the primary care setting and clinical decision-making to manage depression.

Assessment and Triage

1. Depression screening begins with the triage nurse (RN or LPN).
2. The nurse should review the patient chart to ensure the patient has had a depression screen in the last 12 months using a depression screening tool (PHQ2 and PHQ9).
3. If no depression screen is present or the screen is greater than 12 months, the patient will complete the PHQ 2.
4. If PHQ 2 is positive (score of 3 or higher), the patient should complete PHQ 9.
5. If PHQ 9 is positive, scores can range from 1-27, mild to severe depression.
6. If question #9 on the PHQ 9 is two or more, the patient should have a suicide assessment.
7. The nurse will ask patient questions on the Suicide Risk Screening Tool. If patient has a yes response to any questions 1-4, patient should then be asked question 5. If question 5 is no, patient has a non-acute positive screen potential risk. If answer to question 5 is yes, patient is at imminent risk. In both situations, patient should be evaluated for safety and MD or NP should be notified immediately. Patient should be referred to local emergency room, psychiatric crisis center or psychiatric facility for inpatient treatment.
8. N.P. or M.D. should review the results with the patient at the time of visit.
9. If the depression screen is positive, consider which therapy is best for the patient. See PHQ 9 Scores and Treatment Recommendation table.
10. All positive depression screens warrant a review and clinical decision-making for a mental health provider referral (psychiatrist or PMHNP).
11. The patient should have a follow-up appointment in two to four weeks for depression or sooner if needed.
12. Provide education on diagnosis, symptoms, medication, diet, exercise, handouts, medication compliance, and 24/7 suicide hotline number 1-800-273-8255 at discharge.
13. The provider will document and bill accordingly for the mental health services provided.
14. When in doubt, please consult with mental health provider (psychiatrist or PMHNP) when depression is complicated with disorders such as personalities, schizophrenia, bipolar, substance use, alcohol, psychosis, and anxiety disorders.

- * Repeat PHQ-9 within 4–6 months after the initial elevated PHQ-9 score to evaluate depression response or remission.

PHQ-9 Scores and Treatment Recommendations

PHQ-9 Score	Depression Severity	Proposed
		Treatment Recommendation
0 to 4	None	None
5 to 9	Mild	Psychotherapy
10 to 14	Moderate	Medications, psychotherapy, or both
15 to 19	Moderately Severe	Medications and psychotherapy
20 to 27	Severe	Medication management and psychotherapy. Refer to a mental health specialist

APPENDIX I - IRB Approval Letter

**Office of
Research Integrity**



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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure: The risks to subjects are minimized and reasonable in relation to the anticipated benefits. The selection of subjects is equitable. Informed consent is adequate and appropriately documented. Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects. Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data. Appropriate additional safeguards have been included to protect vulnerable subjects. Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident template on Cayuse IRB. The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months. Face-to-Face data collection may not commence without prior approval from the Vice President for Research's Office.

PROTOCOL NUMBER: IRB-20-525

PROJECT TITLE: Depression Screening in Primary Care: Implications for Practice

SCHOOL/PROGRAM: School of LANP, Leadership & Advanced Nursing

RESEARCHER(S): Donna Pittman, Carolyn Coleman

IRB COMMITTEE ACTION: Approved

CATEGORY: Expedited

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

PERIOD OF APPROVAL: December 17, 2020

Donald Sacco, Ph.D.

Institutional Review Board Chairperson

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