Improving Depression Screening in Primary Care by Implementing a Systematic Annual Screening Protocol: A Quality Improvement Initiative

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Background

- Depression is recognized as the prevailing mental disorder in the U.S. and the primary risk factor for suicide
- According to the CDC, 20% of U.S. adults met criteria for depression in 2019
- Approximately 1 in 5 people in the U.S. will experience some form of mental illness in any given year

Objectives

1. To increase the annual mental health screening rate in the resident clinic
2. To identify a system that could be easily implemented in graduate medical education continuity clinics and other similar practices

Methods

This study was conducted at the Triad Internal Medicine clinic in North Carolina. The clinic is affiliated with Triad Medical Center and HCA HealthCare and provides primary care services to approximately 2,000 patients, including residents aged 18 and older without a current or past mood disorder. Exclusion criteria included patients with a current or past mood disorder.

The project team used the Pheno. Do. Study Act (PDASA) model throughout the study.

Phase 1: July 1, 2021 – December 31, 2021
- The study team utilized the Allen Connect system to generate Merit-Based Incentive Payment System (MIPS) quality reports on MHS completion rates using MIPS measure #134 for each of the 10 residents.
- The initial screening year was 2021 because the system was designed for prospective use and data extraction to the current calendar year.

Phase 1: January 1, 2022 – April 30, 2022
- The project team implemented a systematic MHS protocol in the clinic as outlined in the following five diagram.
- During the period of Cohorts 1 (PGY-1 residents) and Cohorts 3 (PGY-3 residents) from April 2021 to April 2022, the project team implemented a standardized set of reminders and prompts for depression screening.

Phase 2: May 1 – June 30, 2022
- The project team analyzed data from the screening phase of the study, recording data as collected in 12% follow-up implementation of the MHS protocol compared with baseline levels of less than 2%. However, communication rates remained below 50% overall and varied widely across the five-day clinic setting.

Phase 3: July 1 – October 31, 2023
- In July 2022, additional data were collected from Cohort 3 (PGY-3 residents) entered the clinic, bringing the total number of residents in the study to 33. No further changes were made to the MHS protocol during the phase.

Results

- The implementation of a systematic annual mental health screening protocol significantly increased the percentage of patients undergoing MHS across the five-visit phase.
- At the conclusion of the study, we successfully achieved our goal of a greater than 5% increase in MIPS for more than 70% of the residents.
- The introduction of text message reminders in later phases positively influenced screening processes.
- The 50% screened cohort is the largest study cohort and a significant increase in MIPS process support for the overall effectiveness of the intervention and the value of continued efforts to refine the protocol.
- Limitations include data access challenges and coding concerns, as well as increased training in future interventions, including more consistent training for medical assistants, additional resident physician training workshops, web-based data entry, and improved data feedback.

Conclusion

- Depression is now the primary global cause of disability and has incurred a cost of over $280 billion to the U.S. healthcare system.
- The coronavirus pandemic has exacerbated this mental health crisis, particularly impacting adolescents and young adults.

Discussion

- The increase in annual mental health screening rates observed in this study is consistent with previous research, demonstrating the effectiveness of systematic screening protocols in improving patient outcomes.
- Regular screening and prompt recognition of mental health issues are crucial in reducing the financial and social burden associated with depression.

References