12-2018

Quality Improvement on Depression Protocols in the Military Training Environment

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QUALITY IMPROVEMENT ON DEPRESSION PROTOCOLS IN THE MILITARY TRAINING ENVIRONMENT

by

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ACKNOWLEDGMENTS

"Be thankful in the small things because it is in them that your strength lies".

Mother Teresa

For all those who have helped me in so many ways, big and small during the duration of this project, I will always be eternally thankful of the strength you've provided me.

Priscilla Rebecca Colunga

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Abstract

Background. Active Duty military members are highly susceptible to depression and suicide due to separation from family during training and deployments, exposure to traumatic experiences in combat, and loss of friends during combat. **Purpose and Objectives**. Depression and suicide remain a high priority among military personnel. This process improvement project aimed to improve the rate of depression screening and improve the assessment, treatment, and management of soldiers with depression in a primary care setting to prevent disease progression while waiting to be seen by a behavior health specialist. **Interventions**. During the 6 week time frame, all active duty military and reservists seen in a primary care clinic were screened for depression using the Patient Health Questionnaire-2 (PHQ2). All positive PHQ2 screenings moved on to the more in depth Patient Health Questionnaire-9 to measure depression symptoms and severity. Based on symptom severity, initiated treatment plans included education, material resources, psychotherapy, pharmacotherapy, safety contracts and Behavioral Health referral. **Evaluation plans**. Patient screening forms were gathered weekly to assess for 100% screening and 100% treatment initiation of all positive depression screenings. After the 6 week time period, a review of data was performed to assess adherence and sustainability. **Implications for practice**. Diagnosis of depression before symptoms progress minimizes patient complications, morbidity and most importantly minimizes mortality. Utilizing the patient centered care model, patients and healthcare personnel can work together to provide the best treatment to improve the health of the service member while temporarily assigned away from their primary care providers at their home base.

Keywords: Patient Health Questionnaire 2, Patient Health Questionnaire 9, Military Depression

Streamlining Depression Protocols in the Military Training Environment

The primary care clinic used during the project is one of six outpatient Army clinics that lies within the Military Health System in San Antonio (U.S. Army Medical Department, 2016). The clinic is unique in that it provides care to all active duty and reservist students who have been temporarily assigned to the military base while they complete training in their specific military occupational specialty. The military base trains more than 25,000 students annually in 14 different medical specialties, with training ranging from 3 months to 3 years (502nd ABW Headquarters, 2017). With so many students continuously in and out-processing, the challenge becomes providing quality healthcare services to patients who have no assigned primary care provider while in training. More specifically, treating trainees who have behavioral health issues who may require prescriptions for new medication, lab work, and follow up appointments can be a huge challenge.

For those trainees that come in to the clinic for behavioral health issues such as depression, providers at the clinic must provide initial treatment for a period of 30-60 days until the patient can be seen in the Behavioral Health Clinic by a psychiatrist. For these specific trainees, the lack of a primary care provider, the starting of a new career, being away from home, and a new behavioral health diagnoses makes them a vulnerable population for the military. It requires a unique approach to treatment that ensures optimal health in order to promote the best atmosphere for learning and success. Through a work-flow assessment of the clinic and with speaking to staff about issues seen within the clinic, the biggest concern identified was the shuffling around of these specific patients between the troop clinic and behavioral health clinics. Although it is the standard of care that all patients seen at the clinic who come in for behavioral health concerns get escorted to the Behavioral Health Clinic for assessment, often times the

clinic cannot treat patients; so patients are then sent back to the primary care clinic for treatment. During this back and forth process, vital resources, assessments, safety contracts, educational material, and one-on-one education from staff is lost and it is the patient that suffers. Because the potential for self-harm is high in patients with depression who have suffered traumatic events such as combat or prolonged separation from loved ones during training and deployments, several staff members also voiced concerns of patient risk for suicide. Three separate stories were disclosed about suicide attempts seen within the Family Medicine Department in recent years to include one story at the clinic. Because even one suicide is too many, the goal of this project is to implement evidence based guidelines to manage the behavioral healthcare of patients who are seen at the clinic needing treatment for depression.

Statement of the Problem

The problem identified was the treatment process of individuals seen at the clinic for behavioral health issues. These patients initially came into sick call at 5:30 a.m. and were triaged by a Physician Assistant who sent them to the Behavioral Health clinic which does not open until 6:00 a.m. At the CBHS, walk-in appointments were given to soldiers in training; however, these walk-in appointments were only to assess and triage patients. More importantly, these services were done by a social worker or behavioral health tech with no licensing authority to treat or prescribe the appropriate behavioral health medication. After assessments were completed, an appointment was made for the soldier to see a licensed professional; however, because of the limited number of providers available, appointments were 30 to 60 days out. The soldier was then sent back to the primary care clinic for acute management until the time of their behavioral health appointment. During the time period where patients were being treated for depression at the primary care clinic, there was no set protocols for patients to receive follow-up appointments

to monitor symptom progression. Patients also lacked education from nursing staff and were not given a list of available resources such as educational tools, group counseling, or crisis hotlines specific to soldiers.

An assessment of the number of behavioral health patients seen at the Clinic was completed using chart reviews and staff interviews. Staff interviews were completed on two separate occasions. Results showed that an average of eight to 10 patients per week were seen for Behavioral Health symptoms to include depression and anxiety. On a larger scale, these data translates into 416 to 520 troops a year, all of which need acute management of their behavioral health symptoms and must wait 30 to 60 days to be seen by a licensed behavioral health provider.

Background and Significance

Depression in the military population is unique in that the nature of the job makes them a more susceptible group for depression in general and the mindset of the military makes it harder to diagnose and treat. Due to separation during training and deployments as well as exposure to traumatic experiences during combat, depression is more prevalent in military personal than civilians (Brockington et al., 2016). The Army Study to Assess Risk and Resilience in Service members found that the 30 day prevalence of depression in military members was five times higher than in civilians (Kessler et al., 2014). Several risk factors are associated with depression in service members to include age 17 to 25, unmarried, and having less than a college education (Gadermann et al., 2012). With this training base being the "Home of the Combat Medic," these three risk factors are seen in majority of the trainees seen at the clinic. Surveillance of depression among the two sexes showed that being female was also a major risk factor for depression in the military however, it was military men who were at an increased risk of suicide when diagnosed

with depression (Gadermann et al., 2012; LeardMann et al., 2013). With the recent wars in Iraq and Afghanistan, mental health diagnoses have doubled among service members, creating a shortage of behavior health providers as well as overburdening those providers with heavy case-loads (Currier, Stefurak, Carroll, & Shatto, 2017). Despite the Department of Defense and the Veteran's Health Administration's attempts to higher more providers, the number of those needing behavioral health help is still not being met and contributes to difficulties in making appointments, lower appointment attendance rates as well as high attrition rate with treatment (Currier et al., 2017). Although community based providers may be an option to some service members, a national survey conducted in 2013 found that only 13% of military members felt like their community based provider understood their issues in relation to their military service, which is why access to military behavioral health providers is so important (Currier et al., 2017).

Assessment

Clinic Assessment

The clinic itself consists of four administrators to include one Medical Doctor, one Nurse Practitioner, one Registered Nurse, and one Licensed Vocational Nurse. The administrators help with patient flow and administrative duties for the clinic and seldom partake in patient care. Staff that daily participate in patient care include one Physician Assistant, one Medical Doctor, one Nurse Practitioner, one Visiting Provider, two Registered Nurses, one RN Case Manager, three Licensed Vocational Nurses, three medics, and two secretaries.

The clinic is open to all active duty military personal and reservists who are assigned to Ft. Sam for medical training which includes an estimated 25,000 soldiers per year (U.S. Army Medical Department, 2016). Soldiers that require routine appointments are encouraged at the

time they arrive to Ft. Sam to enroll as a patient to the primary care clinic; however, there are only 1200 patients who have taken advantage of this opportunity.

The clinic is open from 5:30 a.m. to 3:00 p.m., Monday through Friday, but soldiers in training must be present between the hours of 5:30 a.m. to 7:30 a.m. to be guaranteed a same day appointment. There are a designated 86 appointment slots daily. On average, providers see about 75 patients; 65% male and 35% female. Most patients seen at the clinic are seen for orthopedic issues; however because the clinic serves as a temporary primary care clinic for those in training, visits range from initiation of birth control, behavioral health issues, respiratory/seasonal allergy issues, and anything else that may warrant a visit to a normal primary care practitioner. Monday, Wednesday, and Friday are the busiest days because they are the days that all soldiers do Physical Training. The clinic's peak hours are from 5:30 a.m. to 9:00 a.m. due to the high number of patients being triaged and seen in the early morning.

Needs Assessment

A needs assessment was conducted to gauge organizational readiness for change in the management of care for patients waiting to see a psych/behavioral health provider. There was a consistent response from both nursing staff and providers alike, that the management of trainees with Behavioral Health issues has been a significant problem. Provider interviews revealed a concern with overprescribing medications with a 30 to 60 day supply that needs close monitoring with no consistent follow up care. Because the patient population consists of military service members, providers also worry that patients did not follow up with behavioral health providers because of the stigma attached to a behavioral health diagnosis within the military. Another provider concern was related to assessment validity. Nursing staff routinely perform the appropriate Patient Health Questionnaire 2 (PHQ2) screening for depression regardless of the

stated reason for the patient visit for all patients, but there was concern about whether or not they actually took their time and listened to the patient during the assessment. More specifically, the concern was that some patients come in multiple times during a short time frame for different aches and pains when really, after close evaluation, the patient does not know how to ask for behavioral health help and the frequent visits are really a cry for help. Interviews with nursing staff revealed concerns with patient flow and care. One concern was once patients leave the primary care clinic to go to the Behavioral Health Clinic, there is a risk that they may change their mind about receiving help after being assessed at the behavioral health clinic and may not return to the clinic for a prescription. The multiple step assessment process could be a major barrier toward successfully providing treatment.

Organization's Readiness for Change

The clinic's readiness for change was assessed as high utilizing the Organizational Readiness for Change Assessment (ORCA) (Appendix A). ORCA meets the National Collaborating Centre for Methods and Tools standards of reliability and validity by providing the synthesis, dissemination, exchange and ethically-sound application of knowledge in order to strengthen and improve the health care system. It was important to all employees at the clinic that military trainees receive the appropriate care needed for them to be successful in school and in their military careers. Because all staff members had acknowledged a need for change in this particular patient population and had voiced cooperation in these changes, stakeholder engagement were also high. Collaboration from all staff members was needed to make an effective change within the organization. With stakeholders voicing both the need for change and the willingness to change, literature suggested that a positive change could be made within the

organization as policy and performance outcomes are improved with an active stakeholder's engagement (National Collaborating Centre for Methods and Tools, 2013).

Project Identification

Purpose

The purpose of this project was to implement evidence-based guidelines to improve the assessment, treatment, and management of care for soldiers presenting with signs and symptoms of behavioral health concerns at the military base primary care clinic. These guidelines were utilized in order to help provide supportive care during the delay in seeing a licensed behavior health provider and improve collaboration between both clinics' providers.

Objectives

With the collaboration of behavioral health specialists, the outcomes for this project included:

- 100% of patients seen at the primary care clinic will have been screened for depression using the with the PHQ2
- 100% of patients with a positive PHQ2 screenings will have received a PHQ9 to assess depression symptoms and severity
- 80% of patients with a new diagnosis of depression will have the Depression Action Plan initiated based on PHQ9 score (score range: 4 to 27)

Anticipated Outcomes

With the execution of the above objectives, the major anticipated outcomes were to assist both providers and nursing staff in providing high quality, interdisciplinary care for military trainees with depression who lacked a primary care provider until they could be seen at the behavioral health clinic. It is the intent of this project, to work in conjunction with the

Department of Behavioral Health to improve collaborative-care, by implementing evidence-based guidelines in the primary care clinic that would aid in the successful treatment of depression in the primary care setting.

Summary and Strength of the Evidence

Behavioral Health Assessment

In the United States, the most common psychiatric disorder in the general population along with the most common behavioral health condition seen in the primary care clinic is depression (Kessler et al., 2011). Few patients chose to discuss their depression symptoms with their PCP; rather two-thirds of patients with depression present with somatic symptoms such as back pain or headache making it more difficult for the PCP to develop an appropriate diagnosis and treatment plan (Kessler et al., 2011). When primary care clinics institute screening for depression in all of their patients, it is estimated that 50% of patients with major depression can be identified (Kessler et al., 2014). The project clinic screens all patients with a two-item depression screening (PHQ2) whether or not the patient is being seen for depressive symptoms. However, patients are still hesitant to share depression symptoms in the primary care setting as there is a stigma attached to a behavioral health diagnosis, concerns with confidentiality, and concerns with how the diagnosis will affect their career (Kessler et al., 2011). These concerns are even more important for someone in the military who could possibly be designated as "unfit for duty" with certain behavioral health diagnoses (Brockington et al., 2016).

A literature search of successful interventions in addressing depression screening and treatment was completed to assess the current evidence-based guidelines. The search criteria included those studies conducted within the last five years and included data bases from PubMed, CINAHL Plus, EBSCO, and the Cochrane Library. A study completed by the U.S.

Preventive Services Task Force (USPSTF) found that adult depression screening without any other tool for detection, resulted in a 10% to 47% increase in depression diagnosis (Siu et al., 2016). The PHQ2 is a two question depression screening that comes from the larger and more thorough depression screening tool Patient Health Questionnaire 9 (PHQ9) (Mitchell, Yadegarfar, Gill, & Stubbs, 2016). The PHQ2 has an 87% reliability with 83% sensitivity and a 90% specificity in the detection of depression making it a valid tool. The larger version, the PHQ9 on the other hand, is a more reliable and valid detector of depression with an 82% reliability and 88% sensitivity and an 88% specificity making it a valid tool for depression screening (Mitchell et al., 2016). Both of these depression screening tools can be done by staff prior to the primary care provider's assessment.

More importantly for the use of this project, the U.S. Preventive Services Task Force studied the use of screening tools in combination with staff support activities to include referrals, symptoms monitoring, self-management treatment plans developed with the patient (Thota et al., 2012). For those patients who received staff interventions, the USPSTF reported that patients with staff interventions not only had a more significant improvement in depressive symptoms than the control groups, but they also had a better 5-year outcome than the control group (Thota et al., 2012). In summary, for effective diagnosis and treatment, depression specific screening tools along with staff support and close symptom monitoring was most effective in treating depression in the primary care setting.

Collaborative Care in Treatment

A review of literature on collaborative care in the primary care setting for the treatment of patients with depression all showed that for treatment of patients to be highly effective, collaborative care between the patient, the provider, nursing staff, and behavioral health

providers (as a resource) was vital (Kravitz et al;, 2013). Patient engagement and self-management plans developed between the staff and the patient to include were shown to be highly effective interventions in aiding newly diagnosed depression patients (Kravitz et al., 2013). Included in the self-management plans were ways to identify support systems, lifestyle modifications such as healthy sleeping and eating habits, relaxation techniques as well as bibliotherapy (Kravitz et., 2013). Per the Veterans Affairs/Department of Defense (VA/DOD) clinical practice guideline for assessment and management of major depressive disorder, collaborative care and self-management of treatment should be assessed for a 16 week minimum although no guidelines are offered on how many times during that 16 weeks a patient should have follow up visits (Brockington et al, 2016).

Methods

Project Intervention

The intervention took place from March 7, 2018 to April 13, 2018 for a total of six weeks. During this time period, every patient was screened for depression electronically in the electronic health record, as well as in paper form by the triaging nurse (see Appendix B: Trainee Depression Screening Tool: PHQ-2/9). To ensure that each patient is screened in paper form, the form was in yellow and attached to every patient chart created by the receptionist. When the patient was called to the triaging room for vitals, medication assessment and patient history, the triaging nurse did the electronic PHQ2 as well as on the yellow Trainee Depression Screening Tool: PHQ-2/9. The nurse followed both computer prompting for further assessment of patient's depression as well as on the yellow Trainee Depression Screening Tool: PHQ-2/9 depending on the patient's score.

Patient Health Questionnaire 2. All patients were screened for depression symptoms utilizing the PHQ2 Depression Assessment. The PHQ2 is a Likert, self-reporting tool consisting of two questions with four responses ranging from 0⁄3 for "Not at all'', 1/3 for "Several days", 2/3 for "More than half the days", and 3/3 for ''Nearly every day'' when measuring depression severity. Scores can range from 0 to 6 with a "positive screening" of any patient who scores a four or greater. With an optimal cutoff of three, the PHQ2 has a sensitivity of 83% and a specificity of 92% making it a valid tool (Kroenke, Spitzer, & Williams, 2003).

For patients who scored a three or less on the PHQ2, no further steps were needed unless the nurse felt the patient would benefit from the full PHQ9, at which time they proceeded with the full PHQ9 assessment. A designated spot for the nurse to annotate that nursing judgment was used to proceed to the full PHQ9 assessment was included on the Trainee Depression Screening Tool. For patients who scored a three or more on the PHQ2, the full PHQ9 was completed with the total of all nine questions added up for a cumulative total.

Patient Health Questionnaire 9. The PHQ9 is a Likert, self-reporting tool with four responses ranging from 0⁄3 for "Not at all'', 1/3 for "Several days", 2/3 for "More than half the days", and 3/3 for ''Nearly every day'' when measuring depression severity. Scores can range from 0 to 27. The PHQ9 is one of the most widely used depressions scales and has a high reliability ($r = 0.894$, $p < 0.001$) as well as a high validity ($r= 0.884$, $p < 0.01$) (Kocalevent, Hinz, & Brähler, 2013).

A symptom severity screening, item number ten, was done to assess the impact of the symptoms on the patient's daily life. Both the PHQ9 score and the symptoms severity rating was transcribed on the back of the sheet onto the Symptom Severity and Action Plan Checklist (see Appendix C). The triaging nurse then completed the top portion of the Trainee Depression

Screening Tool to include the date of visit, patient's medical record number (MRN), whether the patient has had a previous diagnosis of depression and whether this is the patient's initial or follow up appointment for depression.

At this time, the nurse gave patients a 6-inch by 9-inch manila envelope that contained a DOD provided Crisis Resource Sheet (see Appendix D) with numbers the soldier can utilize during time of crisis or if having thoughts of suicide, a Department of Defense Depression Education Packet (Appendix E), a DOD Psychoeducational Strategies (Appendix F), as well as a DOD Depression Self-Management Worksheet (Appendix G) they could fill out at their convenience. The triaging nurse reviewed these items with patients who received the PHQ9 screening and then placed them back in the manila envelope for the patient's privacy.

The patient was then seen by the provider who assessed the patient and the PHQ9 score. Based on the provider's assessment, judgment, and PHQ9 scoring, recommendations for pharmacotherapy, psychotherapy or both were discussed and prescribed to the patient based on the evidenced based clinical practice guidelines put out by the Department of Defense (Brockington et al., 2016). The provider notated what treatment modality was chosen and patients scheduled a follow-up appointment at the primary care clinic and BHC based on the guidelines provided in the Action Plan Checklist and the patient's PHQ9 score.

The patient then checked out with the receptionist, where they made their appointment for follow-up care at the clinic as well as their initial behavioral health appointment, both at the same time. This reduced the need to move patients from the clinic to the behavioral health clinic and then back again to the clinic. All Symptom Severity and Action Plan Checklists were gathered at the end of the day by the nursing staff and given to Mr. Garcia to lock in his office until they were reviewed by the DNP student project leader.

Action plan checklist. It is important to note that the guidelines used in the Action Plan were based from the 2016 VA/DOD Clinical Practice Guidelines for the Management of Major Depressive Disorder (Brockington et al., 2016). For mild to moderately severe depression, the DOD recommends evidence based monotherapy with either pharmacotherapy or psychotherapy (Hollon et al., 2014; Weirsma et al., 2014). Pharmacotherapy recommendations were based off the 2016 VA/DOD Depression Clinical Practice Guidelines and included the use of selective serotonin reuptake inhibitors (SSRIs) with the exception of fluvoxamine (not approved by the FDA for depression), the usage of Serotonin and norepinephrine reuptake inhibitors (SNRIs), Bupropion, and Mirtazapine (Brockington et al., 2016). For treatment of severe or recurrent depression, the DOD suggested combination therapy of medication and cognitive behavioral therapy as it is more effective in the treatment of major depressive disorders (Hollon et al., 2014).

Implementation

Implementation of the project can best be visualized through the Action Plan Timeline (Appendix H). All printed patient educational materials and screening tools (Trainee Depression Screening Tool: PHQ-2/9 and Symptom Severity and Action Plan Checklist) were prepared and available by March 01, 2018. A pre-project meeting occurred on March 5, 2018 with the Head Nurse at the clinic to review the final project protocol and answer any questions. On March 7, 2018, in lieu of a staff meeting, all staff participated in a skills training and where they also received one one one training on the Trainee Depression Screening Tool: PHQ-2/9 and Symptom Severity and Action Plan Checklist. Project implementation, evaluation, and educational material was reviewed. The next two days staff had access to the project coordinator to ask questions that may arise with the implementation of the project.

The project lasted six weeks, from March 7, 2018 through April 13, 2018. During this time, daily visits were conducted the first week, followed by visits to the clinic two to three times a week for data collection and to answer questions. Assessment of data collection included comparing the daily patient census and diagnoses to the actual patients that were screened with the more advanced PHQ9 and ensure the Depression Action Plan was utilized. All patients were also assessed to see if a general patient depression screening with the PHQ2 was done. After the project ended on April 13, 2018, the final data was gathered and reviewed between April 14 and April 19, 2018. A post-project meeting with the Head Nurse was held on April 20, 2018 as well as with staff on April 25, 2018. At both meetings, a summary of the project results, outcomes, and the impact on the clinic was discussed.

Planned Improvements

The clinic has a screening tool on their electronic charting system that is supposed to screen all patients seen at the clinic for depression using the PHQ2; however, some nurses skip through these questions or answer no to them if the patient is not being seen for a behavioral health issue. With this project, planned improvements were to increase those patients screened for depression from 88% to 100%. With the appropriate screening in place, the goal was to have 100% of those who have a positive PHQ2 score go on to have a full PHQ9 assessment done. Improvements in staff education to include a better awareness of suicide and depression was also planned and completed. Because patients may present to the clinic with psychosomatic conditions such as pain that is secondary to depression, it was also projected that those being seen at the clinic multiple times would appropriately be diagnosed and treated if the true diagnosis was depression rather than chronic pain or fatigue.

Setting/Population

The project was conducted at the Primary Care Clinic housed on a local military base in south Texas. All staff members were educated on the project protocol to include the four administrators, three permanent providers, six nurses, three medics and both secretaries. The population targeted was all active duty military seen at the clinic, both male and female ages 18 years of age and older.

Organizational Barriers

Because there is always a stigma attached to any behavioral health diagnosis, patients can feel judged when being asked about depression. To further complicate issues, because these patients are all military members, there is a worry that a behavioral health diagnosis could ultimately lead to a "medical boarding" diagnosis which means that due to the given diagnosis, the military member is deemed unfit for duty and the process for forced separation from the military is activated against the soldiers wishes.

As with any new project, there was also the concern that providers may see an outsider giving them the latest clinical practice guidelines as threatening since the oldest practitioner has been practicing medicine for over 25 years.

Facilitators

It was staff that came forward and discussed their concerns with the current depression screening methods and who shared personal stories about patients attempting suicide. Because staff helped develop the idea of assessing the depression screening, staff buy-in was beneficial. In addition, all staff are required to partake in a process improvement (PI) project yearly for their evaluation. Because all staff participated in the project, the Nursing Supervisor automatically gave each staff member full credit in the PI section of their yearly evaluation.

Ethical Considerations

Any process improvement project in the medical field could have ethical concerns because the projects will almost always affect patients; this process improvement project is no exception. Ways to ensure that patient confidentiality was preserved was by using medical record numbers instead of patient names on the Symptom Severity and Action Plan Checklist. All records were stored in a secure location at all times through the completion of the project. Once all data was gathered and the project ended, all Symptom Severity and Action Plan Checklists gathered were shredded using a DOD designated patient information shredder.

Evaluation Plan

General Evaluation

Outcome one was measured by assessing if all patients received a PHQ2 during their visit by assessing the electronic medical record. Outcome two was measured by reviewing all patients with a positive PHQ2 score and ensuring that all received a PHQ9 was completed. Those patients that already had a current diagnosis of depression, as well as a history of depression, should have automatically received a PHQ9 regardless of their PHQ2 score. Lastly, outcome three was measured by identifying those with a new depression diagnoses and ensuring that the Depression Action Plan was initiated based on the patient's PHQ9 score. This was assessed through surveillance of the written out Depression Action Plan as well as through the electronic health record to ensure appropriate medication was prescribed, follow up appointments were made, behavioral health appointments (to include group and scheduled appointments) were created for the patient.

All data collected from the results of the PHQ2 and PHQ9 was tracked on a Depression Screening Log (Table 1) in order to confirm that the clinical practice guidelines listed in the Symptom Severity and Action Plan Checklist were met.

As previously mentioned, visits to the clinic were done several times a week to gather and analyze data. Preliminary results were discussed at staff meetings on March 21, 2018 and April 4, 2018 as well as on April 6, 2018 at the clinic's process improvement meeting. The finalized data analysis was presented to the Head Nurse on April 20, 2018 and to all staff on April 25, 2018.

Results

During the six-week period, a total of 3,742 soldier visits were conducted at the primary care clinic. Chart audits were done for each patient to ensure that PHQ2 screening was completed as well as PHQ9 screening for those who required it. The data was then placed into excel spread sheets where it was assessed through percentages. The spreadsheets used were the Depression Screening Log (Table 1) as well as in the Daily Depression Screening Log; Table 2.

Outcome One

Out of the 3,742 visits, a total of 3,585 soldiers were screened with the PHQ2, for a total of 95.8%. This number increased by 25.8% from the original assessment of 70% prior to the start of the project. A week by week comparison of PHQ2 compliance, Figure 1, showed that the screening rate consistently remained at 92% or above each week. The second week of the project showed the highest screening percentage at 97.3% with a slow trend down the following two weeks.

Table 1

Depression Screening Log Example

Date	Medical Record Number	PHQ 2 Score	PHQ 9 Score	Symptom Difficulty	Interpretation	New or Recurrent Diagnosis	Psycho-therapy	Pharmaco-therapy	Next TMC Appt.	Behavioral Health Appt.
4/4/18	***7865	6	18	Very	ModSevere	New	SENT TO ED FOR SUICIDAL IDEATIONS			
4/4/18	***7278	5	14	Somewhat	Moderate	Recurrent	Yes	Yes	4/11/18	4/5/18
4/4/18	***6369	3	14	Somewhat	Moderate	New	Yes	No	4/11/18	4/16/18

Table 2

Daily Depression Screening Log Example

Date	Total Seer	Total Rec. PHQ2	No PHQ2	Pos PHQ2 w/o 9	Total NeediP HQ9	Total Rec. PHQ9	Missed PHQ9	Need DAP	Total DAP Initiated	Total # ED	Total # New DX
4/2/18	139	137	2	0	8	6	2	4	4	0	2
4/3/18	157	153	4	0	4	2	2	0	0	0	0
4/4/18	113	105	8	0	7	5	2	5	4	1	2

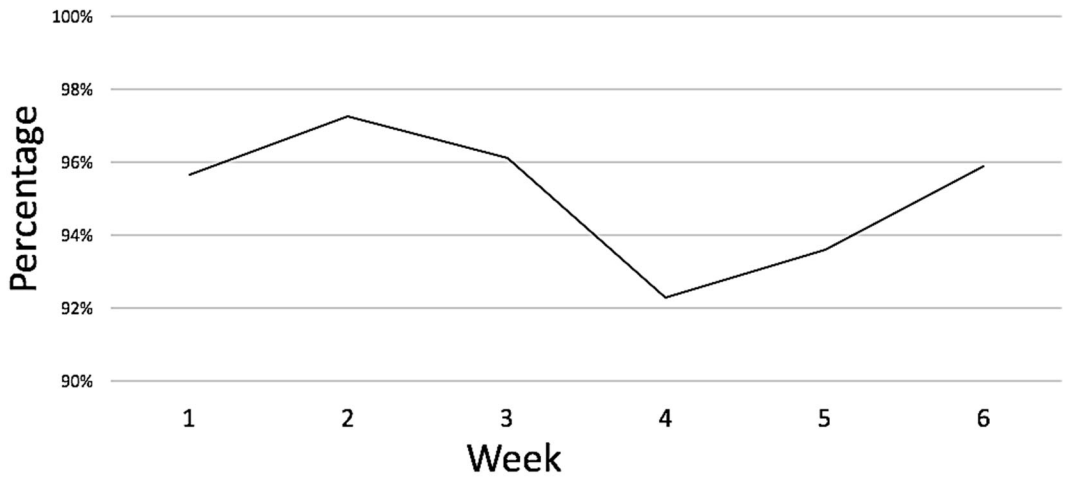

Figure 1. Patients receiving PHQ2 screening.

Outcome Two

Of the patients screened, 122 patients had a positive PHQ2; requiring a further screening with the PHQ9. A total of 119 patients were screened with the PHQ9 translating into a 98% screening with the PHQ9. Prior to the project, PHQ9 screening compliance for those who had a positive PHQ2 was at 88%. When the total of people with positive PHQ2 scores as well as those patients with a current diagnosis or history of depression was combined, the total patients needing a PHQ9 assessment was 309, translating into 8.6% of all patients seen at the clinic. See Figure 2. Of those 309 patients, 185 patients, 58.9%, actually received the PHQ9.

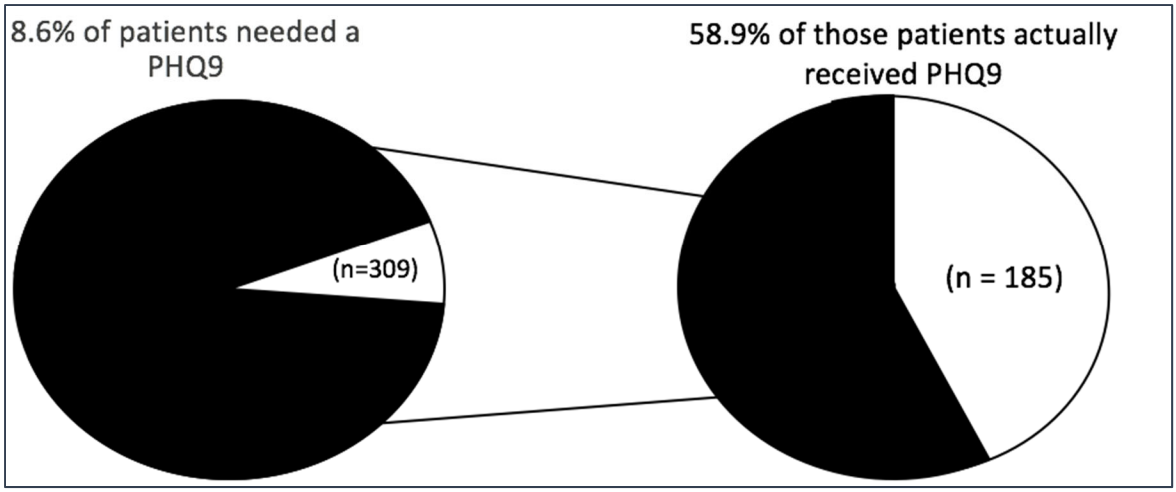

Figure 2. PHQ9 assessment results.

Outcome Three

A total of 82 Depression Action Plans were completed out of a total of 91 patients who scored positive for depression per their PHQ9 score. The goal for this outcome was 80% however, this number was exceeded, with 91% of patients who needed a DAP, actually receiving one.

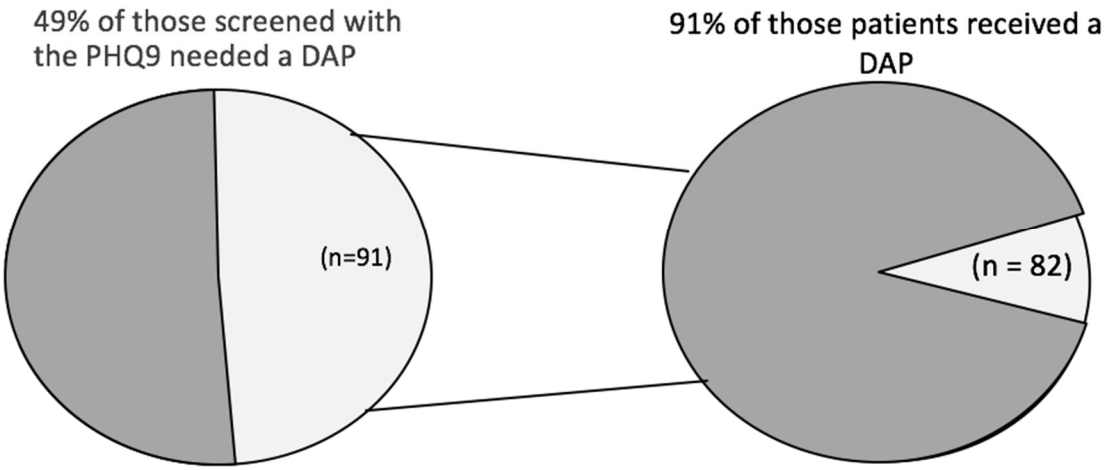

Figure 3. Initiation of depression action plan.

Discussion

One of the most important successes during the project was 27 patients were newly identified as depressed during the project and were able to have treatment started within the clinic without having to wait for a behavioral health appointment. Of those patients that were newly diagnosed and had their follow up appointment at the primary care clinic, a total of 60% had a decrease in their PHQ9 score, as is represented in Figure 4. The other 40% were split in the middle, with 20% maintaining their PHQ9 score and the other 20% having an increase in their PHQ9 score; with both requiring further treatment adjustments.

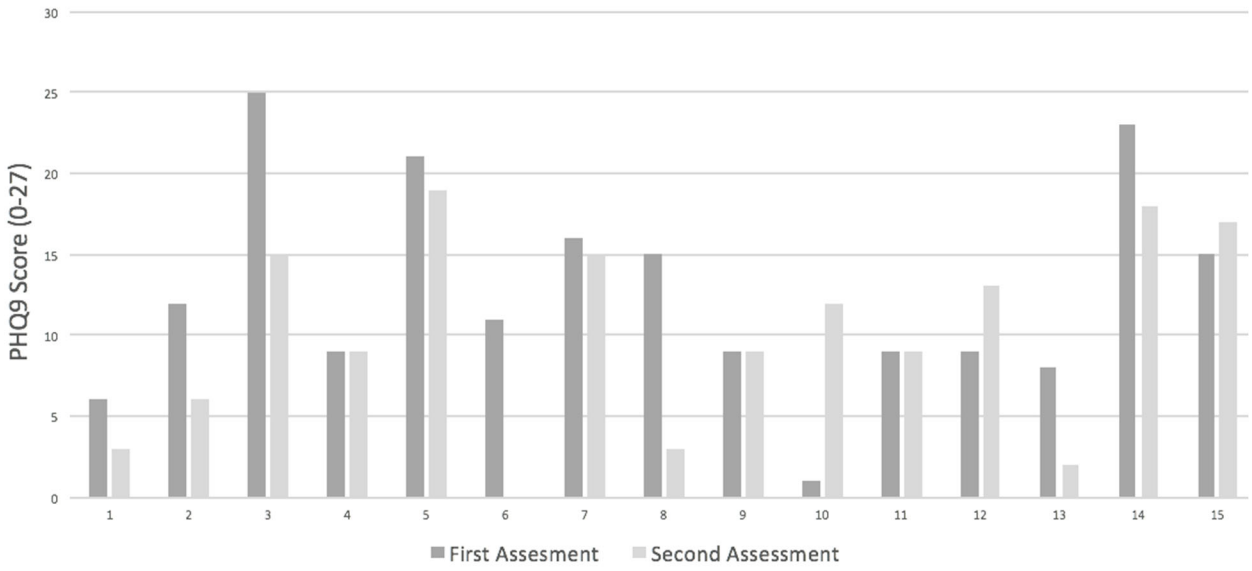

Figure 4. PHQ9 Score Assessment. Comparison of PHQ9 scores in newly diagnosed patients at first appointment and at their follow up appointment.

An additional success was the project was able to help identify four patients with suicidal ideations and one patient with suicidal and homicidal ideations that were all able to get immediate professional treatment. These patients were escorted to the emergency department immediately for admission and inpatient treatment. Prior to this project the clinic was not able to capture and respond to needs such as this. Now with the implementation of the DOD treatment

guidelines, they are able to identify patients at immediate risk and initiate a plan of action to possibly save their lives and those in their community/family. Prevention of one loss of life makes the project worthwhile and successful.

When assessing the number of patients that needed a PHQ9, it is important to note why only 58.9% actually received it. This number included those patients who had a current diagnosis of depression or had a history of depression and it is not clinic policy for either of these two groups to receive the more extensive a PHQ9. Further assessment also showed that of the people who did not receive a PHQ9, they had a PHQ2 score of zero and staff didn't feel the need for further assessment with the PHQ9. To alleviate this issue, it is recommended that the clinic adopt the VA/DOD guidelines as policy to increase compliance.

In relation to the data, it is important to note the how similar the data was to Kessler et al., (2014) who stated that two-thirds of patients with depression present with somatic symptoms. As demonstrated in Figure 5, pain fatigue and headache accounted for 62% of the chief complaints of those with positive PHQ2 scores and only 7% actually coming in for depression or other behavioral health concerns such as anxiety.

Another important relation to the literature was stating men where at an increased for suicide. Of the five individuals hospitalized for suicidal or suicidal/homicidal ideations, 60% were men, with only two of the five being female. The same article stated that risk factors for depression included those ages 17 to 25, unmarried and with less than a college education (Gadermann et al., 2012). Of the five individuals hospitalized, four were unmarried and one was divorced, four were under the age of twenty and those same four had no college education. A demographics assessment of those patients who received a Depression Action Plan, as seen in Table 3, also so shows that 61% of those patients were under the age of 25 and 76% were under the age of 30.

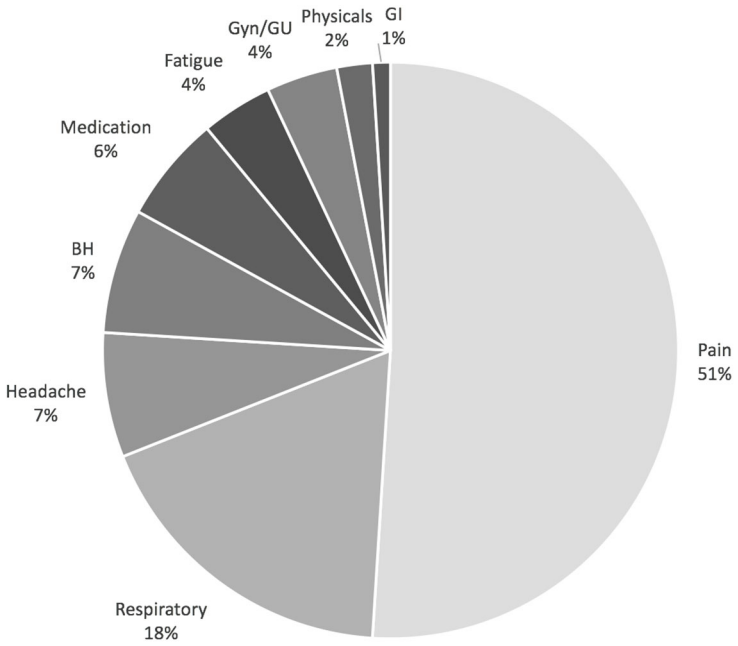

Figure 5. Chief complaint of positive PHQ2 patients.

Limitations

Several factors were identified as barriers which hindered results. First, a PHQ9 assessment for those patients who have a history or current diagnosis of depression, even if the chief complaint for the visit was not depression, is not a clinic policy. It is, however, within the VA/DOD guidelines to assess patients with a current or previous diagnosis as it is a way to assess treatment efficacy and monitor depression symptoms. As the goal of the project was to implement national standards of care, the clinic during the six week period was asked to follow the national VA/DOD guidelines. Because the national guidelines were not a clinic policy, only 60% of those needed a PHQ9 due to diagnosis history, actually received it. Again, the recommendation is to implement the national VA/DOD guidelines within the clinic to increase compliance and increase depression screening in this population.

Table 3

Demographic Information for Depression Action Plan Patients

Characteristic	Total Patients (*n*=82) *n*	%
Gender, *n* (%)		
Male	46	56
Female	36	44
Age (year)		
18-19	13	38
20-24	19	23
25-29	17	21
30-34	4	5
35-39	6	7
40-44	1	1.5
45-49	1	1.5
50-54	2	3

The next biggest factor that decreased project effectiveness was the frequency of guest providers the clinic utilized on a daily basis. Because this is a training facility, a large number of providers act as full time instructors; however, along with teaching, they are still required to maintain their credentials by seeing a specific amount of patients yearly and are allowed to schedule time to work within the clinic to maintain their license. During the six weeks of project implementation, an average of two to three guest providers worked within the clinic per week. For the project, this meant educating guest providers on the project was a challenge as it was impossible to be at the clinic every morning at 5:30 a.m. to do one-on-one teaching. A project binder was left for guest providers as independent learning however, it is recommended to have a roster where providers could sign in order to verify training was received. The second part to this issue was that guest providers did not have the same buy-in as regular providers. Guest providers were not able to see the impact the project had on patient care and they also did not have to worry about audit results, as they were only in the clinic for a few days out of the year. Lastly, as

seen in Figure 1, the fourth week of the project had the lowest percentage screened at 92.3%. Again, this was due to the increased number of guest providers during this period because permanent providers were rotating through vacation time during spring break.

The last major barrier seen within the project was double documentation on the electronic medical record as well as the paper Depression Action Plan. Depression screening of both the PHQ2 and the PHQ9 was mandated per the clinic to be done in the patient's electronic medical record. For the project, staff was asked to take additional time to fill out the paper Depression Action plan so the project coordinator could easily assess those with a positive PHQ2. Although the paper DAP was not time consuming, it was additional charting and there was some reluctance in both filling the form out in general as well as filling the form out appropriately. Biggest issues seen with the developed DAP was that it too asked for the same information in multiple spots. Items such as the patient medical record, PHQ9 score, and symptom severity was asked on both sides of the DAP sheet and often, it was these three items that were missed on the form, simply because it was completed on the opposite side.

Recommendations

As stated previously, double documentation was a barrier seen during the project, as it required more time from the nursing staff. Now that the project has concluded, screening with the PHQ2 and PHQ9 can revert back to electronic charting only, easing the time constraint placed on nursing staff.

It is recommended that the PHQ9 score be mandatory on electronic charting for those with a history of depression or a current diagnosis of depression in order to sustain this project without the use of paper charting to assess those patients. By making this a policy, the clinic would not only be compliant to national guidelines set forth by the VA/DOD, but it would also

allow for providers to easily assess treatment success and symptoms management in patients with a diagnosis of depression. This recommendation was supported by the clinic's Director of Nursing but most importantly, was supported by the providers at the conclusion of the project as they began to remind nurses to do the PHQ9 on patients with a history or current diagnosis of depression.

The second recommendation is to keep the Depression Action Plan available to the clinic as a quick reference of what medications and therapies the VA/DOD recommends based on PHQ9. Again, this recommendation was endorsed by providers as the DAP made it easy for them to chart, make treatment changes, and schedule a follow-up appointment within the appropriate amount of time. Provider endorsement at the conclusion of this project is important as it will contribute to the sustainability of this project.

The next recommendation is yearly competency checklist for all staff on PHQ2 and PHQ9 along with depression protocols per the VA/DOD. The rationale behind this recommendation is that if staff buy-in is not continuously addressed or if training is not consistent, compliance to screening will began to dwindle back do to 70% which leads to the last recommendation.

The last recommendation was implemented during the middle of the project, which is to maintain PHQ2 and PHQ9 audits to ensure compliance. The clinic's Quality Improvement Team has now started to do monthly audits on all patients to ensure the PHQ2 and PHQ9 are adequately being done and to make sure staff compliance remains high. Because this recommendation is already being implemented, the sustainability of this project is high.

Implications for Practice

In order to effectively execute this project, collaboration between Providers, Nurses, Ancillary Staff and Behavioral Health is vital to ensure 100% screening for depression as well as

to decrease morbidity and mortality. This collaboration followed DNP essential six: interprofessional collaboration for improving patient and population health outcomes; mandating for safe, timely, effective, efficient, and equitable patient- centered care. Twenty-seven patients during this time line were newly diagnosed with depression and with the help of interprofessional collaboration, treatment was able to begin immediately within the clinic without making a patient wait for the next available behavioral health appointment.

Implementation of VA/DOD depression guidelines focused on needs of the clinic in order to improve patient safety and health care outcomes which followed DNP essential seven: clinical prevention and population health for improving the nation's health as well as DNP essential two: organizational and systems leadership for quality improvement and systems thinking. This accounts for the implementation of clinical prevention in order to achieve the national goal of improving the health status of the population of the United States. This also ensures accountability for quality of health care and patient safety given while making improvements to meet the needs of current and future patient populations. Most importantly, implementing these clinical guidelines has empowered providers to become leaders within the organization; who are now requesting nursing staff to utilize the PHQ9 on all patients was a history of depression in order to assess symptom improvement.

Conclusion

Through a collaborative care approach, all staff had an active role in the depression screening and treatment of the patients seen at the clinic. Through this project, the goal of successfully screening all patients for depression in order to decrease morbidity and mortality and keep and trainees healthy was successful. More importantly, several patients were identified as depressed and with the use of the Trainee Depression Action Plan, these soldiers had

immediate access to treatment before symptoms could escalate. Although it may not be statistically significant, it is important to remember that four patients total were sent to the hospital for suicidal ideations with an additional patient sent for both suicidal and homicidal ideations. If preventing just one of these patients from hurting themselves or someone else, then the project was a success. Although the number five, the number of patients hospitalized, or twenty-seven, the number of patients with a new depression diagnosis, both seem like small numbers when looking at a sample size of 3,742, the implications on these individual's life is beyond measure. If it is possible to already help this number in only six weeks, it is reasonable to predict a much larger need for this project to be sustained so that many others in similar situations can receive the help they need.

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Appendix A

Organizational Readiness for Change Assessment

This assessment assumes that the respondent is in an organization with a disruptive change that is underway (or will be soon). It may be beneficial to capture the opinions of multiple individuals within your organization to generate a broader understanding of strengths to leverage and challenges to overcome.

INSTRUCTIONS:

1. Please mark your level of agreement with each statement.
2. Calculate the numerical average for each section and record it. Lower averages indicate challenges that may impede the success of the change effort.

Section I: **Leadership**		strongly disagree	disagree	neutral	agree	strongly agree
1	We have the right leaders in place to ensure the change is a success.	①	②	③	④	⑤
2	Executives demonstrate (in words and actions) support for the change.	①	②	③	④	⑤
3	Front-line managers demonstrate (in words and actions) support for the change.	①	②	③	④	⑤
4	Our leaders listen to employee concerns about the change and are able to adequately address them.	①	②	③	④	⑤
5	Our leaders are effective and they work well together.	①	②	③	④	⑤
		Section Average:				

Section II: **Communication**		strongly disagree	disagree	neutral	agree	strongly agree
6	Employees have a clear vision of what the organization will look like after the change.	①	②	③	④	⑤
7	Our leaders are unified and aligned in their communications about this change.	①	②	③	④	⑤
8	Employees receive accurate information about the change.	①	②	③	④	⑤
9	Employees receive timely information about the change.	①	②	③	④	⑤
10	Communication about the change is clear and easy to understand.	①	②	③	④	⑤
		Section Average:				

Section III: **Planning & Support**		strongly disagree	disagree	neutral	agree	strongly agree
11	It is clear how we will measure success in this change.	①	②	③	④	⑤
12	We are appropriately staffing this change to ensure its success.	①	②	③	④	⑤
13	We are appropriately funding this change to ensure its success.	①	②	③	④	⑤
14	We will get all the technical support we need to make this change a success.	①	②	③	④	⑤
15	The plan to implement the change will ensure that important daily work still gets done.	①	②	③	④	⑤
		Section Average:				

Section IV: **Risk Mitigation**		strongly disagree	disagree	neutral	agree	strongly agree
16	We have identified all the major risks that threaten the change's success.	①	②	③	④	⑤
17	We have defined mitigation strategies for all the major risks we have identified.	①	②	③	④	⑤
18	We clearly understand how this change will negatively impact customers.	①	②	③	④	⑤
19	We clearly understand how this change will negatively impact employees.	①	②	③	④	⑤
20	We clearly understand how this change will negatively impact suppliers.	①	②	③	④	⑤
		Section Average:				

Section V: **Engagement**		strongly disagree	disagree	neutral	agree	strongly agree
21	Employees believe that this change is necessary.	①	②	③	④	⑤
22	All employees who will be affected by the change understand what the change is.	①	②	③	④	⑤
23	Employees' opinions count in determining how the change will be implemented.	①	②	③	④	⑤
24	Employees' roles in the change are clear to them.	①	②	③	④	⑤
15	Employees actively help other employees get committed to the change.	①	②	③	④	⑤
		Section Average:				

Appendix B

Trainee Depression Screening Tool: PHQ-2/9

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
	add columns		+	+

Continue below if score is GREATER than 3 →

____ ← Check if less than 4 but continued per nursing judgment TOTAL:

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 figety 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	0	1	2	3
	add columns		+	+

Add ALL columns together including questions 1 & 2 → → → → → TOTAL:

10. 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 _____

Appendix C

Symptom Severity and Action Plan Checklist

Date of Visit: _____ Patient's MRN: _____
PHQ9 Score: _____ Prior Depression Dx:(Circle) YES / NO
Symptom Difficulty: (Circle) N S V E Visit:(Circle) Initial / F/U

PH9 Score	Interpretation	Action Plan (Please check appropriate areas to confirm treatment)	CLINIC Appointment Requirement
1-4	Minimal depression	**Give the Following:** **____ Psych-educational Strategies** **____ Crisis Resource Flyer** **____ Depression Education Packet** **____ Self Management Worksheet**	• None required • Follow-up if systems persist or worsen
5-9 10 -14 15-19	Mild depression Moderate depression Moderately severe depression	**MONOTHERAPY** **Pharmacotherapy Options:** ____ SSRI (not fluvoxamine) ____Mirtazapine ____ SNRI ____ Bupropion **Psychotherapy Options:** ____ Behavioral Group Therapy at Behavior Health ____ Ask: Current thoughts of hurting yourself/suicidal*** **Give the Following:** **____ Psych-educational Strategies** **____ Crisis Resource Flyer** **____ Depression Education Packet** **____ Self Management Worksheet**	• Appointment every 4 weeks if medication prescribed
20-27	Severe depression or Recurrent depression	**COMBINATION THERAPY** **Pharmacotherapy Options:** ____ SSRI (not fluvoxamine) ____Mirtazapine ____ SNRI ____ Bupropion **Psychotherapy Options:** ____ Behavioral Therapy for Cognitive Behavioral Therapy ____ Ask: Current thoughts of hurting yourself/suicidal*** **Give the Following:** **____ Psych-educational Strategies** **____ Crisis Resource Flyer** **____ Depression Education Packet** **____ Self Management Worksheet**	• Appointment every 2 weeks at clinic. • Schedule appointment with Behavioral Health Clinic

Appendix D

Crisis Resource Sheet

CRISIS RESOURCE SHEET

DOD and VA Resources

Military/Veterans Crisis Line
800-273-8255, service members and veterans, press 1 www.veteranscrisisline.net

Military OneSource
800-342-9647 www.militaryonesource.mil

Real Warriors
www.realwarriors.net

Be There
844-357-7337 www.betherepeersupport.com

Defense Centers of Excellence Outreach Center
866-966-1020
www.dcoe.mil/Families/Help.aspx

My HealtheVet
www.myhealth.va.gov

Deployment Health Clinical Center
www.pdhealth.mil

External Resources

National Suicide Prevention Lifeline
800-273-8255
www.suicidepreventionlifeline.org

Depression and Bipolar Support Alliance
800-826-3632
www.dbsalliance.org

Families for Depression Awareness
781-890-0220
www.familyaware.org

National Alliance on Mental Illness
www.nami.org

Mental Health America
800-969-6642
www.mentalhealthamerica.net

National Institute of Mental Health
866-615-6464
www.nimh.nih.gov

SAMHSA's National Helpline
Provides 24-hour free and confidential information and treatment referrals in English and Spanish;
Call 800-662-HELP (4357)

Appendix E

Depression Education Packet

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF MAJOR DEPRESSIVE DISORDER

Department of Veterans Affairs
Department of Defense

Patient Guide

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2016

I. Major Depressive Disorder

Major depressive disorder, commonly known as depression, is a mental health condition characterized by sadness for a long duration of time and indifference or lack of interest in the normal pleasures of life. There are different kinds of depression, including persistent depressive disorder (formerly known as dysthymic disorder) which is persistent, mild symptoms of depression; seasonal affective disorder, which is depression with a seasonal component; and postpartum depression, which is depression after giving birth. Depression is a serious condition where those affected feel so sad and hopeless that they are unable to function normally. If untreated, depression results in a poor quality of life and even death by suicide. Fortunately, there are many effective treatments for depression.

A. Depression in the Military Population

Military personnel are especially prone to depression which has been associated with traumatic experiences, including witnessing combat, and with separation from family during deployment or military trainings.[1,2] Over a quarter of military servicemen and women report symptoms of depression.[1]

II. What are the causes of depression?

Depressive illnesses are disorders of the brain. Most likely, depression is caused by a combination of genetic, biological, environmental, and psychological factors. Trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode. However, depressive episodes may occur with or without an obvious trigger, and while depression can run in families, it also occurs in people without a family history of depression.

Depression typically presents during the young adult years or between the ages of 20-40, though it can present earlier or later.[3] Depression is more common in women compared to men, but women are also more likely to seek treatment and less likely to commit suicide.[3]

Frequently Asked Questions:

How do I decide which treatment is best for me?

Discuss medications, talk therapy, and other treatments with your provider to help you figure out which treatment might be best for you with the fewest side effects.

Why do I need to see my provider so often?

It may take several months and many visits to adjust your treatment to help you feel as well as possible.

My depression is better. Can I stop treatment?

No, depression treatment needs to continue even after you feel better. Most people are on medication for at least 6-12 months or longer or even indefinitely to prevent the depression from getting worse. Speak to your provider before discontinuing any part of your treatment.

III. How do I know if I have depression?

People don't always realize they have depression and might just think they have the blues and should be able to feel better without help. But depression is more than just feeling down for a few days. It can also appear as:[4,5]

- Lack of interest or motivation in things you typically enjoy
- Sadness for a long time or unexplained crying

- Eating more or less than usual
- Poor sleep
- Irritability and anger
- Low energy; tiredness
- Feelings of guilt, worthlessness
- Inability to concentrate
- Unexplained aches and pains
- Recurring thoughts of death or suicide
- Problems making decisions
- Excessive worrying
- Memory problems
- Inability to function normally at home or work

IV. What can I expect from my doctor?

Your doctor will ask you a few questions to see if you might be depressed. If you might be depressed, your doctor will ask a longer set of questions as part of an interview to see if you have a more serious form of depression and might benefit from treatment. Your doctor may also do some blood or laboratory testing to see if you have other conditions that can cause or contribute to depression such as:

- A thyroid test
- A pregnancy test
- A drug test

If your doctor thinks you might harm yourself or others, you will be referred for emergency treatment with a specialist.

V. How can I treat my depression?

Many people who are depressed do not seek treatment and fare poorly as a result. It is very important to seek treatment for depression and to stay engaged with care to get the help you need. Treatment typically includes medication, talk therapy, both, or other treatments.

A. Antidepressant medications

There are several different classes of medications that treat depression effectively but they have different mechanisms and side effects. Discuss medications with your doctor to find the best treatment for your particular situation. When you start treatment, you may have to see your provider often to adjust medications.

B. Psychotherapy

Psychotherapy—or talk therapy—is a form of counseling where you discuss your problems with an individual therapist or as part of a group. There are different approaches to therapy that might involve, for example, focusing on behavior change, self-awareness, or relationships.

C. Other treatments

Although your provider will probably suggest medications and/or talk therapy first, there are other treatments that can help people with depression. These include electroconvulsive treatment, transcranial magnetic stimulation, light therapy, and herbal treatments. Discuss these options with your provider to see if they might help you.

VI. What can I do to improve my health?

In addition to seeking help and sticking to treatment, there are things you can do to help yourself feel better. These include:

- Exercise
- Eat right
- Practice good sleep habits
- Bibliotherapy (reading texts for healing)
- Eliminate use of tobacco and alcohol during an episode
- Reach out to friends and family for support and company
- Call your doctor or someone immediately if you are feeling worse or thinking about harming yourself.

Where Can I Find More Information?

National Institute of Mental Health: https://www.nimh.nih.gov/health/topics/depression/index.shtml

American Psychological Association: http://www.apa.org/topics/depress/

Centers for Disease Control and Prevention: http://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm

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Appendix F

Psychoeducational Strategies

Self-management strategies to reduce depression symptoms

It can often take a few weeks before you feel an improvement from psychotherapy or medication. There are a number of things you can do to help yourself, as listed below.

Tell someone if you are thinking about death or hurting yourself.

Thoughts of death or hurting yourself may accompany depression. Always discuss these thoughts with your health care provider and/or mental health provider and reach out to your battle buddy, shipmate, fellow Marine, wingman, your spouse or a relative who can get you immediate emergency professional help.

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1. **Engage in physical activities and exercise**
   - Regular exercise can improve your mood
   - Even taking a short walk every day may help you feel a little better
2. **Make time for activities you enjoy** – Even though you may not feel as motivated or happy as you used to, commit to scheduling a fun activity (such as a favorite hobby) at least a few times a week.
3. **Spend time with people who can support you.**
   - It's easy to avoid contact with people when you're feeling down, but it's during these times that you actually need the support of your battle buddies, shipmates, fellow Marines, wingmen and family
   - You might try to explain to them what you are feeling or just ask them to be with you during an activity
   - Suggestions: Meet a friend for coffee or watching videos, take a walk with a neighbor or work in the garden with your friend or family member
4. **Practice relaxation** – Since physical relaxation can lead to mental relaxation, try deep breathing, taking a hot shower, or just finding a quiet, comfortable and peaceful place.

5. **Take small steps to take care of larger problems.**
   - It's easy to feel overwhelmed by problems and decisions when you're feeling depressed, have little energy or aren't thinking as clearly as usual
   - Try breaking down one large problem into several smaller ones and then take one small step at a time to solve it

6. **Avoid making major life decisions while feeling depressed**
   - Major decisions might include whether to change jobs, make a financial investment, relocate, divorce or make a major purchase
   - If you feel you must make a major decision about your life, ask your mental health provider, your commander, your family member or someone you trust for advice

7. **Eat nutritious, balanced meals**
   - Many people find that when they eat more nutritious, balanced meals, they not only feel better physically, but also emotionally and mentally
   - To learn about choosing healthy foods, talk with a nutritionist or visit My HealtheVet at https://www.myhealth.va.gov/

8. **Avoid using alcohol, illegal drugs and tobacco**
   - Alcohol is a depressant and can add to feeling down and alone
   - Alcohol and illegal drugs can also reduce the effectiveness of antidepressant medications and may create harmful side effects

9. **Follow your health care provider's instructions about your treatment**
   - It is important to take your medication as prescribed each day, to keep your appointments with your health care provider, even when you begin to feel better
   - Talk to your health care provider if you have concerns or questions about your treatment

10. **Remain hopeful – depression is treatable**
    - With treatment, most people with depression begin to feel better, but it may take some time
    - Remember that negative thinking (blaming yourself, feeling hopeless, expecting failure and other similar thoughts) is part of depression – as the depression lifts, so will the negative thinking

Appendix G

Department of Defense Self Management Worksheet

Self-Management Worksheet

You can do several things to help yourself feel better, even when you're not at your best. Start by selecting one of the activities from this list. Remember to take it slowly and add new things as you begin to feel better. *(Make copies of this worksheet, and review it weekly with your mental health provider or a trusted family member or friend to track your progress.)*

1. Tell someone if you are thinking about death or hurting yourself.
   If I am thinking about death or hurting myself, I will call
   _____.
   *(friend or family member), the **Military/Veterans Crisis Line** 800-273-8255 or the National Suicide Prevention Lifeline 800-273-TALK (8255).*

2. Make time for physical activities and exercise.
   For ____days next week, I'll spend at least ____minutes doing _____
   _____.
   (Remember to make your goal reasonable.)

3. Find time for pleasurable activities.
   For ____days next week, I'll spend at least ____minutes doing _____
   _____.

4. Spend time with people who can support you.
   During the next week, I'll make contact at least____times
   with_____(name) to do/talk about_____
   _____.

5. Practice relaxation.
   For ____days next week, I'll practice physical relaxation
   at least ____times for at least ____ minutes each time.

6. Take small steps to take care of larger problems.

   The problem is: _____.

   My goal is: _____.

   I can achieve this goal by taking the following steps:

   Step 1: _____.

   Step 2: _____.

   Step 3: _____.

7. Avoid making major life decisions when you are feeling depressed.

   *If I need to make a major life decision, I will reach out to*_____

   _____.

8. Eat nutritious, balanced meals.

   During the next week, I will improve my diet by: _____

   _____.

   (Example: "Strive for five." Eat at least five fruits and vegetables a day.")

9. Avoid or minimize use of alcohol.

   I will avoid drinking alcohol or limit my alcohol intake to no more than two drinks on no more than two days per week.

10. Follow your health care provider's instructions about your treatment and communicate openly.

    I will take my medication each day at _____ (time), even when I begin to feel better. I will keep my appointment with my health care provider and be honest about how I am feeling.

11. Practice positive thinking.

    When I have negative thoughts, I will tell myself _____

    _____.

    (Example: "Depression is highly treatable. I am taking steps to help myself feel better.")

Appendix H

Action Plan Timeline

Task	**Date/Time/Location/Staff**	**Goal/ Agenda/Supplies**
Request Resource material from ASAP office	December 27, 2017	Goal • Coordinated for enough printed material from the Army Alcohol and Substance Abuse Program (ASAP) Office on Suicide prevention
Resource Preparation	January 08, 2018	Goal • All resources Xeroxed and placed in manila envelopes for patients. • Staff Education PowerPoint created
Pre-Project Meeting with Mr. Garcia	March 05, 2018 0930-1030 Clinic Head Nurse Office Eugene Garcia, RN	Goal • Discussed 1:1 Staff Training • Reviewed Staff Education PowerPoint Supplies/Preparation: • Resources and Staff PowerPoint to Review
1:1 Staff Training and Education	March 07, 2018 Clinic All Staff	Goal • Clarified any questions providers and staff may have with the Depression Screening Form • Educated Staff on Project Agenda • Review PH2 scoring and criteria for advancement to PHQ9 • Reviewed PHQ9 scoring • Reviewed clinic and Behavioral Health appointment requirements based on scoring. • Reviewed Resources that was given to patients based on scoring • Reviewed Suicide Protocol Supplies/Preparation: • Bring all materials for patient education • Bring PHQ9/Assessment forms • Have resources and VA/DOD CPG available for questions

START OF PROJECT	March 7, 2018 –through– April 13, 2018	START OF PROJECT
Daily Visits	March 08-09, 2018 1300-1400 Troop Medical Clinic All Staff	Goal • Available to staff to discuss questions/concerns Agenda • Assisted staff with assessments and be available as a resource for questions Supplies/Preparation: • Resources and VA/DOD CPG available for questions
March Staff meeting	March 7, 2018 1300-1400 March 25, 2018 1300-1400 Clinic Conference Room A All Staff	Goal • Available to staff to discuss questions/concerns Agenda • Questions/Concerns from staff • Discussed "areas of improvement" with staff • Discussed "good catches" and praise exceptional performance among staff Supplies/Preparation: • PowerPoint with areas of improvement and areas for praise
END OF PROJECT	April 13, 2018	END OF PROJECT
Data Review	April 14-19, 2018	Goal • Reviewed all data for final DNP Presentation
Post-project Meeting with Mr. Garcia	April 20, 2018	Goal • Discussed Project Summary Agenda Discussed the results of the process improvement project
Post Project Wrap-up/ Staff meeting	April 25, 2018 1300-1400 Troop Clinic Conference Room A All Staff	Goal • Discussed Project Summary Agenda • Thanked staff for participation • Discussed sustainability Supplies/Preparation: PowerPoint to discuss findings

Appendix I

Letter of Support

University of the Incarnate Word
Ila Faye Miller School of Nursing & Health Professions
4301 Broadway, CPO #285
San Antonio, TX 78209

November 17, 2017

I write on behalf of the [redacted] Medical Clinic in support of Ms. Priscilla Colunga's Doctoral Process Improvement Project on Streamlining Depression Protocols in the Military Training Environment based on the published VA/DoD Clinical Practice Guidelines - 2016.

As an organization, the VA/DoD acknowledges that the mental health of our service members is a priority as depression can result in poor quality of life, decreased productivity, and increase mortality from suicide. It is our goal to improve the health and wellbeing of our patients through clinical practice guidelines that are supported by evidence.

Through this letter, we acknowledge the collaboration between UIW FNP-DNP student Ms. Priscilla Colunga, RN BSN, the [redacted] Medical Clinic and the [redacted] Staff.

Sincerely,

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