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Implementing Patient Health Questionnaire-9 Screening in Adult Mental Health: A Staff Education Initiative

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Executive Summary: Staff Education Project

Implementing Patient Health Questionnaire-9 Screening in Adult Mental Health: A Staff Education Initiative

by

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Summary

This project was a staff education program aimed at the use of the Patient Health Questionnaire-9 (PHQ-9) as a universal depression screening instrument within a mental health facility. The project was conducted in an urban area of the United States at an outpatient behavioral health facility and was focused on addressing the stagnation in the staff's correct use of evidence-based measures of depression screening that inhibits the prompt detection and treatment of major depressive disorder (MDD). The practice-focused question was: Following participation in a staff education program, will staff demonstrate increased knowledge on depression screening and use of the PHQ-9? As analytical strategies, I used descriptive statistics to assess participants' knowledge gains in the form of pre- and posttests and coded a qualitative review of program evaluation forms.

Results demonstrated a mean knowledge increase of 25%–40% among participants. The implementation of the PHQ-9 increased the staff's confidence, quality of documentation, and clinical decision-making. Some of the major deliverables are the curriculum plan, PHQ-9 slide deck, handouts, and case study booklet. The project contributes to the betterment of nursing practice by equipping nurses with a standardized, evidence-based tool to identify depression, enhancing their ability to provide accurate assessments and timely referrals. This ensures that patient care decisions are based on validated data rather than subjective observation, strengthening overall clinical judgment and workflow efficiency. The initiative also promotes equitable mental health screening and early intervention, which are essential to reducing disparities in patient outcomes.

Background

Gap in Practice

Despite the existence of validated instruments, like the PHQ-9, informal observation and subjective assessment methodologies remain common in many mental health care settings (Ford et al., 2020). There was no official policy requiring the utilization of standardized depression screening instruments throughout the intake or follow-up audits at the project site. Consequently, the degree of depression was underreported most of the time or reported poorly, creating delays in important interventions and jeopardizing patient outcomes. There was a lack of an integrated procedure at the project site to recognize and mitigate depressive symptoms across clinicians, resulting in treatment inequality. This discrepancy added to missed diagnoses, ineffective treatment planning, and minimal involvement of the patient in care. There was a realization that a standardized screening was needed to enhance accuracy during diagnosis and support timely mental health interventions. In addition, the PHQ-9 was not included in regular records, thus missing the chance to refer to therapy, interventions on medication, or crisis response. There were also some symptoms of depression, like fatigue, hopelessness, or social withdrawal, that were either ignored or not properly treated as a result of unstructured evaluation systems. The lack of a clear and consistent measurement to determine the depressive symptoms prolonged suffering of patients at the site and reduced quality of care.

Studies have indicated that the application of the PHQ-9 in primary and mental health care facilities enhances the detection and management of depression, as it provides

a validated, standardized approach to screening (Sun et al., 2020; Villarreal-Zegarra et al., 2023). However, the tool was inadequately used at the project site, where informal symptom tracking was the common practice. This gap formed a strong basis for implementing a staff education program focused on PHQ-9 use. Closing this practice gap was essential to improve depression management, ensure early intervention, and align care practices with evidence-based standards at the project site.

Project Purpose and Practice Question

The purpose of this Doctor of Nursing Practice (DNP) project was to design, implement, and assess a staff education program on the use of the PHQ-9 as an assessment tool to identify the degree of depression. I developed the intervention to support the knowledge, confidence, and consistency of clinical staff in administration and interpretation of the PHQ-9 to produce improved documentation and patient referrals in a timely manner. Depression is one of the top disabilities worldwide, and early detection using evidence-based instruments is essential to increasing patient outcomes (Habtamu et al., 2023). I anticipated that the project would help advance earlier diagnosis, clinical decision-making, and overall mental health outcomes.

The practice question guiding this initiative was: Following participation in a staff education program, will staff demonstrate increased knowledge on depression screening and use of the PHQ-9? I used this evidence-based question to structure the assessment of the project and inform the creation of educational material and strategies for implementation. The question was focused on measurable results, and it was clear that there was a need to put evidence into practice in the real world at the project site.

Through comparing the systematic application of the PHQ-9 with informal symptom monitoring in the project, I aimed to show that standardized tools resulted in more improvement in clinical outcomes and consistency of diagnosis. In addition, the practice question assisted in establishing the nature of the project in terms of clinical effectiveness, feasibility, and sustainability within the applicable organizational setting. The question was also consistent with the broader DNP competencies in the area of evidence-to-practice translation and quality improvement leadership.

The rationale for using the PHQ-9 was based on evidence both in the literature and institutional benchmarking. According to Sun et al. (2020), the psychometric characteristics of the PHQ-9 include sensitivity and specificity in the measures of diagnosis of MDD, which are high. Siniscalchi et al. (2020) proved the effectiveness of the PHQ-9 integrated with electronic health records (EHRs) to improve the coherence of clinical documentation and referral patterns. Furthermore, nurse-led screening with the PHQ-9 was identified to assist in early intervention and engagement of patients. The inclusion of the tool into the workflow enhances care coordination and also standardizes the processes of initiating treatment, which is important in urgent situations of mental conditions. Carroll et al. (2020) also reported the clinical effectiveness of the PHQ-9 with various populations in mental health. This evidence supported the significance of this DNP project and guided the development of the education program.

Evidence Supporting the Project Change

Strong evidence supported the implementation of the PHQ-9 as a standardized screening measure for depression, and most of the reviewed literature consistently

pointed toward the need for this change. The synthesized findings, based on the Johns Hopkins' Synthesis and Recommendation Tool (see Appendix E), were appraised using the Melnyk and Fineout-Overholt Hierarchy of Evidence. According to this framework, the majority of studies reviewed were classified as Level I (systematic reviews and meta-analyses of randomized controlled trials) and Level II (well-designed randomized controlled trials). These high-quality studies demonstrated the effectiveness of the PHQ-9 in improving depression detection, guiding timely intervention, and enhancing continuity of care across diverse clinical environments (Sun et al., 2020; Villarreal-Zegarra et al., 2023). Villarreal-Zegarra et al. (2023) reiterated how the PHQ-9 is highly sensitive and specific in detecting MDD, so it is a dependable test to rely on periodically. Ford et al. (2020) also established the PHQ-9's applicability in community-based mental health settings, achieving better levels of detection and patient performance in receiving such a tool in the clinical workflow. In addition, research has also shown that nurses, when trained to give and interpret PHQ-9 scores, can comfortably start care trainings, make suitable referrals, and decrease the delays in diagnosing and treatment (Sun et al., 2020). These conclusions offer a strong argument in favor of the use of the PHQ-9 as a part of the standard mental health assessment at the project site.

The literature also emphasized the practicality and effectiveness of PHQ-9 inclusion in the work of EHR systems. Albright et al. (2021) showed that the integration of the PHQ-9 in the documentation guidelines helps to increase communication among clinicians and guarantee continuation of care. Albright et al. (2021) also revealed that case-based training increases the confidence and improved scoring accuracy of the staff,

particularly within the outpatient and aspiring care environment. Depression screening programs led by nurses have proven to raise early detection of mental health and patient engagement, especially in underserved populations (Isaacs & Mitchell, 2024). All the available evidence indicates that the PHQ-9 is not only an efficient tool but a convenient solution that does not contradict quality improvement initiatives or the patient-centered care pattern. Because the project relied on high-level studies, the educational and implementation plans that I developed were evidence based and practical in every assessment and could be feasible to deliver measurable enhancements in clinical practice.

Staff Education Project Development

Project Setting and Participants

The DNP project was carried out in a community-based outpatient mental health clinic and was positioned in an urban community whose client population was diverse. The project site provides behavioral healthcare, such as psychiatry, drug regimen management, and supportive counseling. Twelve staff members, including registered nurses, case managers, and intake specialists, participated in the project. Among all members of the staff, there was an everyday coordination of patient assessment, documentation, and coordination of care. The staff members did not regularly follow up intake or conduct follow-up visits with a standardized depression screening tool, such as the PHQ-9, before the project. This rendered them a perfect target group for the specific education intervention to enhance consistency in depression screening.

Leadership of the clinic was involved with the project and offered me support and resources in the form of a designated training room, printed information of all types, and

time so that the staff could attend the session without clinical interruption. The participants' range of professional backgrounds and years of experience enriched the group discussion process during the education session. Participants were eager to get to know and apply the PHQ-9 tool, especially taking into consideration the existing deficiencies in care and their consequences. These individuals were familiar with the tool but lacked formal training on its scoring and documentation practices. The structure of the education session helped them to be engaged, using case scenarios that they could relate to and that were similar to their everyday clinical practice.

Procedures for Developing and Implementing the Staff Education

My preparation of the project began with a review of evidence-based literature both in terms of PHQ-9 implementation and depression screening in outpatient settings. I developed the education program to include a PowerPoint presentation, scenarios, and discussion. Five learning points addressed the definition of depression, the structure of PHQ-9, the procedures of administration, the scoring parameters, and its incorporation into the clinic-based work (see Appendix A). Prior to implementation, I sent all program teaching materials to the project mentor and my doctoral committee as drafts to get their input and refine before delivery (see Appendix B). The site mentor took an active role in case study analysis, futuristic PHQ-9 questionnaire scoring, and documenting results as per sample EHR templates. Such practical experience served to consolidate learning process goals and provided the assurance that the project was conducted in line with the clinic's working environment.

The 90-minute-long education session was implemented in late July at a regularly scheduled staff development meeting. After the session, I uploaded all learning content to a common drive to be referred to later and in the orientation of new employees. Additionally, a printed handout with the three case studies was provided to participants for clinical use.

Collection and Analysis of Evidence

The participants took part in a 15-item multiple-choice test prior to and following the staff education session. Crucial points about using the PHQ-9, symptom identification, scoring, appropriate clinical responses, and documentation procedures were assessed with the tests. I developed the test questions according to the training content and directly linked them to the learning objectives stated in the Curriculum Plan. Every effort was made to eliminate bias and guarantee accuracy by requiring test subjects to not discuss test items with one another and completing the tests apart. Similarity in the questions used in the pre- and posttest permitted me to directly assess participants' knowledge prior to and following the intervention (see Appendix C). This strategy helped the project team to determine the immediate effect of the education on staff knowledge and willingness to use PHQ-9 protocols.

The collection of all test answers was done anonymously, and paper forms were used to ensure that nobody could trace the behavior of a particular participant, encouraging them not to be afraid to give their answers. I analyzed the forms manually and input them into Microsoft Excel after collection. The effectiveness of the training

intervention was measured on the basis of descriptive statistics, including the mean score and percentage improvement.

In addition to the pre- and posttest questionnaires, the participants completed a structured program evaluation form that consisted of Likert items and open-ended questions to provide their feedback (see Appendix D). These questions were used to evaluate content clarity, training material usefulness, presenter quality, and their perceived confidence in using the PHQ-9 in clinical practice. The use of open responses gave the participants the opportunity to identify both the strong aspects of the program, such as relevance of the case studies, and areas of possible program improvement, such as follow-up sessions and a more comprehensive reference tool.

Results

Knowledge Gain Results

Comparisons between the participants' pre- and posttest scores showed that there was a great improvement in staff knowledge after the PHQ-9 education session. The participants' mean pretest score was 48% and their mean posttest score increased to 85%, indicating that overall, there was a change in score with a mean 37% increase. Each of the 12 participants showed personal improvement in the form of increased scores, and some had more than a 46% gain in score (see Table 1). The biggest gains were in the areas of detection of PHQ-9 scoring levels and which clinical decisions to make. These findings highlight the efficiency of the organized learning session where both theoretical sources and practical experience were involved. The positive change in the participants'

test scores implies that there was improvement in their knowledge and retention of the materials associated with the PHQ-9.

Table 1

Pre- and Posttest Score Results

ID	Pretest score	Pretest %	Posttest score	Posttest %	Change %
1	7	47%	13	87%	+40%
2	8	53%	14	93%	+40%
3	6	40%	12	80%	+40%
4	7	47%	13	87%	+40%
5	8	53%	12	80%	+27%
6	9	60%	13	87%	+27%
7	6	40%	12	80%	+40%
8	7	47%	13	87%	+40%
9	7	47%	14	93%	+46%
10	8	53%	12	80%	+27%
11	9	60%	13	87%	+27%
12	7	47%	12	80%	+33%
	M	48%		85%	+37%

Disaggregation of the scores further showed that most participants increased their knowledge scores between 27% and 40%. This was attested by the fact that the questions used in the pre- and posttest were the same, which ensured that learning gains were as a result of the content presented during the session. A single, face-to-face session, 90 minutes in length with real-life examples was enough to contribute to the valuable learning. This finding means that small-scale, but properly organized training courses can considerably affect the level of staff preparedness and self-confidence. Such outcomes warrant the idea to expand the same training modules to other clinical locations. The

results validate the importance of the targeted, case-based education to improve the competency of mental health in outpatient community setups.

Evaluation of The Staff Education Program

The PHQ-9 education program received very positive feedback among the staff members. One hundred percent of the respondents either strongly agreed or agreed that the session was useful to their clinical roles on the evaluation form. The most mentioned benefit of the case studies was that they were specifically useful in understanding how to interpret scores and when care escalation was needed. In unstructured answers, participants noted the presentation clarity, relevance of example, and discussion of real-life situations. One of the participants stated that after the session, they felt more qualified to examine patients and report the findings accordingly. Another participant emphasized that they could now appreciate why it is important to document suicidal ideation since the emergence of case-based practice.

The participants' responses also ensured that the educational goals of the project (i.e., the intention of PHQ-9, meaning of score ranges, incorporation of screening into action, and documenting accordingly) were met clearly. A number of participants indicated they would like more refresher training in the future or printed reference guides. The evaluation responses validated that the session increased the knowledge, skills, and confidence of the staff in relation to depression screening. A participant could memorize the content and directly transfer them to their work because of the combination of the structure and manner in which the teaching was done and practical application.

Impact on the Organization

Organizational practices at the project site were directly influenced by the use of the PHQ-9 training program. Before the project, the outpatient clinic staff did not record depressive symptoms in a consistent way because they were usually based on subjective observations. After the intervention, the PHQ-9 was accepted as a routine incorporation during patient intake and follow up. The staff started to incorporate the screening tool more consistently and increased the consistency in documenting severity of depression. This has resulted in the earlier prediction of patients at risk and increased referral of patients to behavioral health services. Uniformity in documentation also increased communication among the providers and the nursing staff.

In addition, the education initiative enabled the nursing and intake teams to develop abilities to assume proactive roles with regard to mental health assessment. The standardization of the PHQ-9 use decreased variability and created a culture of evidence-based screening. Employees stated that they now feel confident enough to discuss the topic of mental health with patients and use standardized tools to guide clinical decision-making. Supervisors noted an increase in documentation quality in the EHRs by the auditing of charts in use. Another benefit that the project illuminated was the need to give nonspecialist employees further professional training in mental health. Such changes in the organization are beneficial to the patients and support the quality care standards.

Limitations

One significant limitation of this DNP project was the small size of the sample, which included only 12 people. Although the results of the project can be measured in

terms of the definite changes in participants' knowledge and working practices, the small sample size of the workforce partly limits the applicability of the results. These findings might not be a depiction of what happens in broader or different clinical environments. The project was also conducted within a brief implementation period of 6 weeks and, as such, did not allow for the measuring of long-term knowledge or behavior retention. There was no measurement of patient outcome data (e.g., the level of depression decreased or the postvisit rates increased) because the project was too small-scale.

The other limitation was associated with the use of self-reported feedback to evaluate the program. Although the positive feelings of the participants were overwhelming, their responses might indicate short-term gratification and not long term. There was also no control group to compare with, and thus, the impact of external factors cannot be ruled out. Follow-up measures, which will be conducted as a follow through to reinforce training and collect more significant time outcome data, should also be implemented in the future. Longitudinally assessing documentation practices and patient care metrics would be suitable to give a more thorough evaluation of the intervention's efficacy. However, the implications of the results make the project a valuable input in the quality aspect of screening practices for depression at the project site.

Project Relevance Beyond Project Site

Although the intervention took place in one outpatient mental health clinic, the design and outcomes are applicable in other clinical settings. The PHQ-9 is an automated depression screening that has national support and is known to be validated. Integration of this brief tool within the scope of daily practice can provide added value to primary

care settings, school-based health centers, and other outpatient clinics. Reflectively, the staff education program (i.e., the test case-based learning, short sessions, and alignment of workflow) is flexible enough to be applied to different clinical scenarios. The scalability improves the applicability of the project even beyond the site of implementation. Moreover, there are general lapses during depression screening discussed in the program, such as inconsistent recording, low staff confidence, and workflow. These are not the only issues faced in several clinical systems; they were also experienced by the project site. Through the provision of evidence-based training, the project provided practical applications that can be applied in the other related projects. This intervention is adaptable and may be used by health administrators who want to fulfill regulatory demands or enhance the performance of the behavioral health tests. Such training can be applied even in the smaller clinics with proper leadership support aimed at improving the standards of care.

Conclusions

The major objective of this staff education project was fulfilled because the staff members of the outpatient clinic obtained the necessary knowledge base and tools to use the PHQ-9 screening tool. After the intervention, each of the 12 participants had progressed incrementally with improvements in comprehending, rating, and recording depression evaluations through the PHQ-9. This addressed one of the central disadvantages in clinical practice in which personnel could only depend on the opinion-based measurements instead of evidence-based instruments. The actualization of the PHQ-9 within the clinical workflow led to more coherent tracking and a credible

framework within which to share the mental health requirements with clinicians. In staff feedback, there are indications of heightened confidence and readiness to work through depressive symptomatology in a various range of patient cases. Such gains indicate a realistic practice change possibility around short and limited educational programs.

Besides knowledge, the project implemented systemic improvements in intake and documentation processes and created a more responsive and standardized care environment. Before the intervention, screening measures to detect depression were applied randomly and resulted in delays in making a diagnosis or incomplete interventions. After the project, the PHQ-9 has been integrated into the routine workflow, and patients stand a better chance to obtain timely intervention that is consistent with best practices. Realistic case study usage in the education session also led to the increased reception of the material and its application into real life. The project mediated the gap between theory and practice by facilitating the translation of evidence-based recommendations into the practical tools that can be used by professionals on a daily basis. This was in alignment with organizational objectives and better patient outcomes.

Further Recommendations

The education program was successful in meeting the short-term goals, whereas in the future, periodic refresher courses should be included to support and strengthen participants' knowledge while sustaining practice behaviors. Follow-ups are planned after 6 to 12 months to help staff retain crucial information and remain consistent with evidence-based practices. Offering booster education sessions combined with continuing education (CE) credits may further motivate staff participation and promote long-term

engagement with the program. The continuing application of the PHQ-9 in medical records, along with systematic monitoring of patient outcomes (e.g., depression severity levels and referral rates), would provide a clearer understanding of the long-term effects and sustainability of the intervention. As an example, the emergence of training modules on suicidal risks policies and crisis responses may reinforce personnel preparedness in case of high-risk situations. The delivery of education is also likely to be multimodal (e.g., e-learning, workshops and peer-led sessions) and appeal to diverse learning styles.

My next suggestion would be to increase the extent of mental health screening by including the tools on the co-occurring disorders, like anxiety. The General Anxiety Disorder-7 is a validated tool and helps to complement the PHQ-9 because it gives a more comprehensive view of patients' mental health. This dimension might facilitate the more comprehensive planning of care and response to treatment.

Moreover, this intervention could be extended to other units or satellite clinics of the project site organization and increase its benefits. Continuity of care may also be improved by liaisons with mental health referrals and support groups through community resources. The organization can turn into a pioneer in the field of compound, evidence-based mental health screening by building on the success of this project.

Implications for Nursing Practice

The current project focused on the importance of the frontline staff and nurses diagnosing and recognizing mental disorders at the early stages of the patient journey. The integration of evidence-based instruments, like the PHQ-9, will allow nurses to make a more significant contribution to standardized mental health screening. The intervention

showed that, by investing a small amount of resources and time, nurses were able to substantially enhance their clinical documentation and care coordination with respect to depression. This transformation goes in tandem with the increasing boundaries of nursing practices, especially in outpatient and community practices. Empowering nurses to assume leadership roles in the screening process will contribute to filling service delivery loopholes and helping patients receive the appropriate interventions. The project confirms the significance of the inclusion of mental health education in nurses' continuing education.

The effectiveness of this program also highlights the importance of planned education initiatives to establish confidence among the staff and interprofessional collaboration. With the skills acquired by using the PHQ-9, nurses will be in a better position to communicate clinical concerns to physicians, psychiatrists, and social workers and can consequently refer and follow up. Standardized measurement also goes a long way to assist in making sure that the nurses are not only using subjective judgments, which may differ depending on who provides it. This uniformity is particularly necessary in contexts where patients are not readily available to be provided with psychiatric care and require nurses as the first source of assessment. Lastly, such projects validate the importance of nursing to quality improvement and health equity because these projects drive mental health assessment to become routine, reliable, and patient centered.

Implications for Positive Social Change, Diversity, Equity, and Inclusion

The inclusion of standardized depression screening procedures based on the PHQ-9 has considerable effects on enhancing the provision of equal mental health care across

all patients. The adoption of this objective tool in all instances of attending to the patient will eliminate provider bias, and any process of examining depressive symptoms will be uniform across all ages, genders, races, and socioeconomic statuses. This assists in filling in the gaps in the diagnosis of mental health that disproportionately impact minority and underserved populations. According to Harry et al. (2021), the PHQ-9 demonstrates strong cross-cultural validity, with proven reliability across diverse ethnic and linguistic groups. Its cultural neutrality and availability in multiple language translations ensure that it can be administered effectively to a broad range of patients, reducing barriers to equitable screening. Utilized regularly, the tool helps in early detection and culturally responsive measures that support the advancement of justice and health equity. One of the key means of mitigating disparities in the results of behavioral health is ensuring that all patients receive uniform screening.

Additionally, this project resulted in an enhanced clinic culture that is accommodative and sensitive to unique patient needs. Training of the personnel on interpreting scores focused on discussing the implications of taking scores as a part of the overall lived experience of a patient and promoting empathy and active listening. The project also contributes to the de-stigmatization of mental illness as mental health assessments are made a part of regular care, especially in the case of groups of people who were not accustomed to accepting psychological assistance in the past. Potential areas for the future adaptation of the training involve modules about cultural competence and trauma-informed care that will make it more inclusive. On a larger scale, the application of the PHQ-9 screening model and the staff education framework leads to the

development of a healthcare system that is sensitive and responsive to inequities in mental health assessment and treatment. This intervention helps in realizing the objective of offering empathetic, qualified, and fair treatment to every person with a depression disorder.

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Appendix A: Curriculum Plan for Staff Education: PHQ-9 Implementation

Project Title:
Implementation of a Depression Management Program Using PHQ-9 in a Mental Health Setting for Adults

Target Audience:
- Frontline nursing staff (RNs, LPNs, psychiatric nurses)
- Mental health clinicians and support staff involved in depression care at Zitel Healthcare Services

Learning Objectives (By the end of training, staff will be able to):

1. Define depression and its impact on adult mental health outcomes.
2. Describe the purpose and structure of the PHQ-9 screening tool.
3. Demonstrate correct administration, scoring, and interpretation of PHQ-9.
4. Distinguish between PHQ-9 scoring thresholds and appropriate clinical actions.
5. Integrate PHQ-9 screening into routine workflow and documentation procedures.
6. Recognize the benefits of standardized depression screening over symptom observation alone.

Content Outline:

Module	Topic	Description	Delivery Format	Time
1	Overview of Depression in Adult Mental Health	Define depression, prevalence, and its impact on physical and mental health outcomes in adults. Discuss risk factors and comorbidities.	PowerPoint presentation/video with case examples	20 min
2	Introduction to PHQ-9 Tool	Explain the purpose of PHQ-9 as a depression screening and severity measurement tool. Cover its 9-question structure and 2-week time frame.	Interactive lecture with Q&A	20 min
3	PHQ-9 Administration: Best Practices and Scoring	Demonstrate step-by-step PHQ-9 administration (self-completed or read aloud). Explain scoring (0–3 per item, max 27) and interpretation of ranges (e.g., 5–9 minimal, 15–19 moderately severe).	Demonstration & discussion with practice forms	25 min

Module	Topic	Description	Delivery Format	Time
4	Documentation and Workflow Integration	Outline how to document PHQ-9 results in electronic health records (EHR). Discuss integration into intake/follow-up workflows and communication with clinicians.	Case-study	20 min
5	Interpreting PHQ-9 Results and Referral Protocols	Review score-based actions (e.g., monitor, refer, immediate action for suicidal ideation). Practice interpreting scores using case scenarios.	Group activity and quiz	15 min
6	Pre/Post Knowledge Assessment and Feedback	Administer pre/post-tests to measure learning gains. Collect feedback on training usability and confidence in using PHQ-9.	Multiple-choice test + survey	20 min

Total Training Duration: ~2 hours

Resources:

- **Slide Deck:** PowerPoint with visuals on depression, PHQ-9 structure, scoring, and case examples (developed by Precious Adaso).
- **PHQ-9 Forms:** Blank and sample completed forms for hands-on practice (sourced from public domain PHQ-9 template).
- **Quick Reference Handout:** 1-page guide summarizing PHQ-9 scoring ranges, administration steps, and referral protocols.
- **EHR Simulation Tool:** Access to Zitel Healthcare Services' EHR training module for documentation practice.
- **Pre/Post-Test:** 15-question multiple-choice test (as provided in artifact ID: 554bc4b0-32c6-4a87-a65a-548a3a2da5ef) to assess knowledge.
- **Feedback Survey:** Likert-scale form to evaluate training satisfaction and self-confidence.
- **Equipment:** Projector, laptops for EHR simulation, printed handouts, and pens.
- **Facilitator Guide:** Detailed script for trainers with discussion prompts and case scenarios.

Alignment of Pre/Post-Test Questions to Learning Objectives:
The pre/post-test questions (from artifact ID: 554bc4b0-32c6-4a87-a65a-548a3a2da5ef) align with the learning objectives as follows:

- **Objective 1 (Define depression and its impact):** Question 1 (purpose of PHQ-9, indirectly tied to understanding depression's role in screening).
- **Objective 2 (Describe PHQ-9 purpose and structure):** Questions 2 (number of questions), 3 (time frame), 8 (administration), and 10 (PHQ-9 questions).
- **Objective 3 (Demonstrate administration, scoring, interpretation):** Questions 6 (maximum score), 13 (completion time), and 14 (scoring responsibility).
- **Objective 4 (Distinguish scoring thresholds and actions):** Questions 4 (score 5–9), 5 (moderately severe range), 7 (suicidal thoughts action), and 11 (score 0 action).
- **Objective 5 (Integrate into workflow):** Question 15 (when to screen).
- **Objective 6 (Recognize benefits of standardized screening):** Question 12 (why PHQ-9 is preferred).

Educational Methods:

- Slide deck with visuals and structured content for modules 1–2.
- Group discussion and real-world case examples for modules 1, 3, and 5.
- Hands-on demonstration of PHQ-9 completion in module 3.
- Pre/post-test (15 questions, artifact ID: 554bc4b0-32c6-4a87-a65a-548a3a2da5ef) to assess learning outcomes.
- Quick reference handout for ongoing use during patient care.
- Case-based role-play with EHR simulation for module 4.

Evaluation Plan:

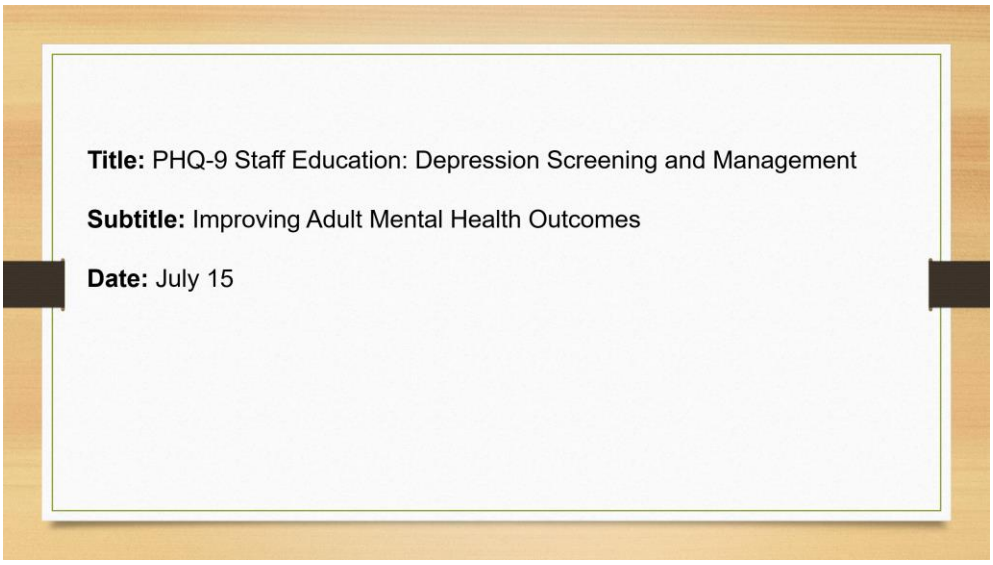
Component	Method	Timing	Success Criteria
Knowledge acquisition	Pre- and post-tests (15 questions)	Before/after session	≥80% score improvement post-test
Skill competency	Direct observation during demonstration	Day of training	100% staff complete PHQ-9 correctly
Satisfaction & usability	Training feedback form (Likert-scale)	After session	≥90% rate training as useful/relevant

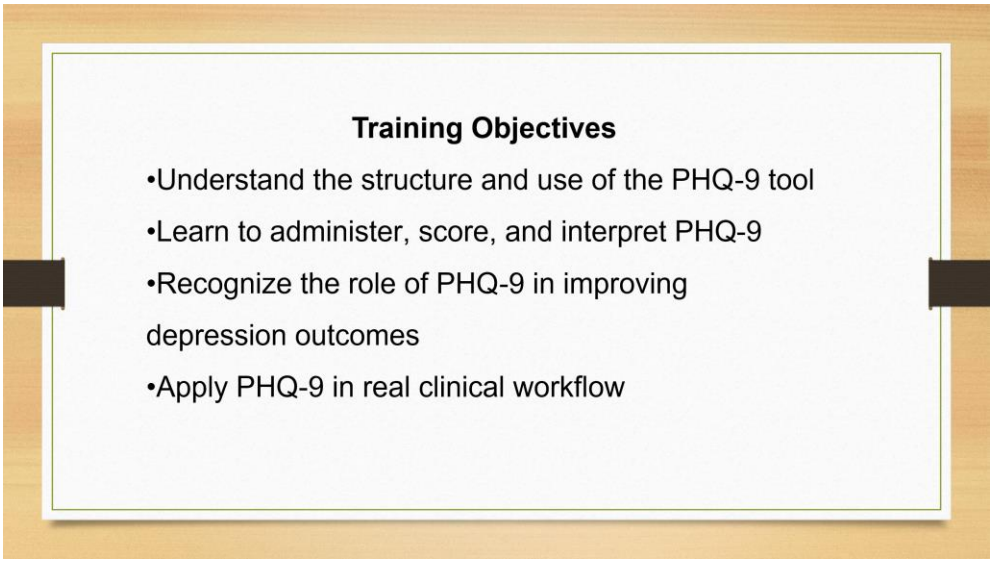
Component	Method	Timing	Success Criteria
Implementation readiness	Self-confidence rating (survey)	After session	Majority feel confident using PHQ-9

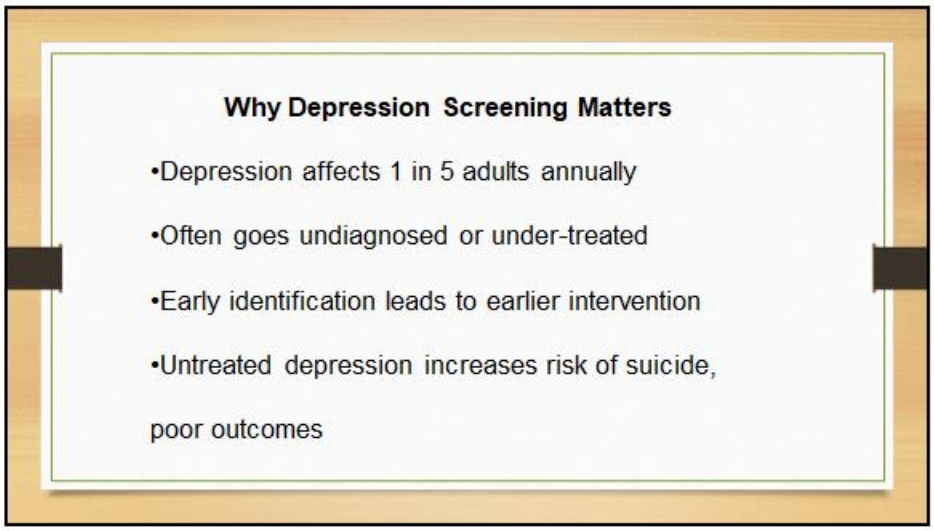
Timeline for Curriculum Delivery:

Week	Task	Responsible
June 30–July 4	Finalize content, slide deck, and print handouts	Precious Adaso
July 7–11	Deliver training to all nursing shifts	Precious + Site Mentor
July 14–18	Conduct post-tests and evaluate training outcomes	Precious Adaso
July 21–25	Implement PHQ-9 fully in patient workflow	Nursing staff
July 28–31	Analyze final outcome data and complete reporting	Precious Adaso

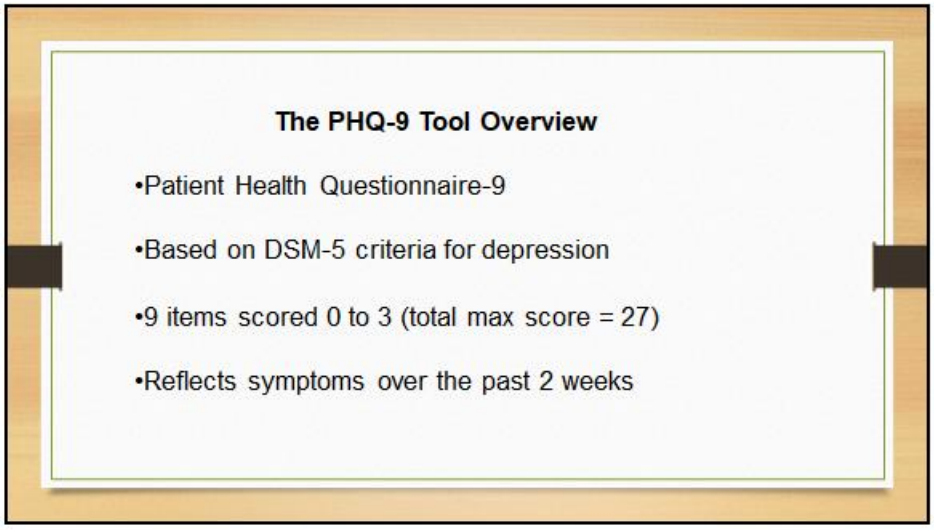
Appendix B: Teaching Materials



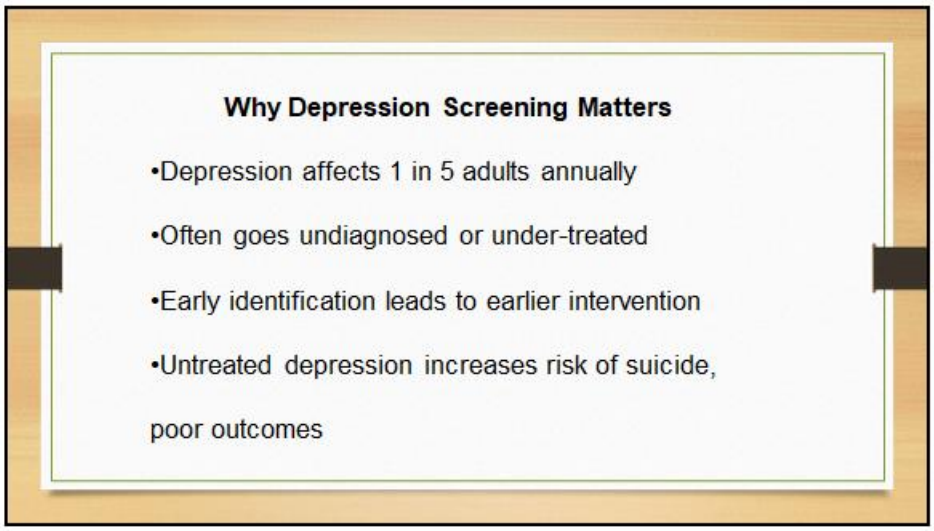



Why Depression Screening Matters
•Depression affects 1 in 5 adults annually
•Often goes undiagnosed or under-treated
•Early identification leads to earlier intervention
•Untreated depression increases risk of suicide, poor outcomes

3


The PHQ-9 Tool Overview
•Patient Health Questionnaire-9
•Based on DSM-5 criteria for depression
•9 items scored 0 to 3 (total max score = 27)
•Reflects symptoms over the past 2 weeks

4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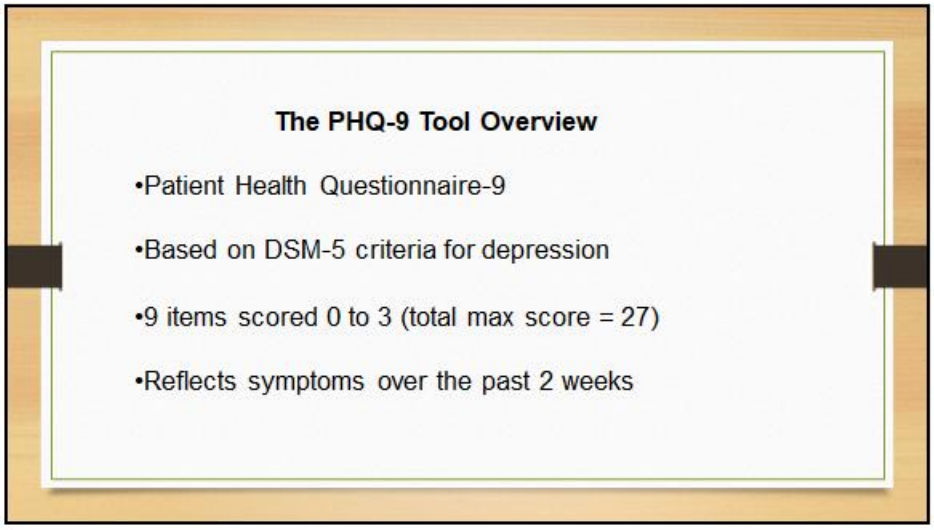
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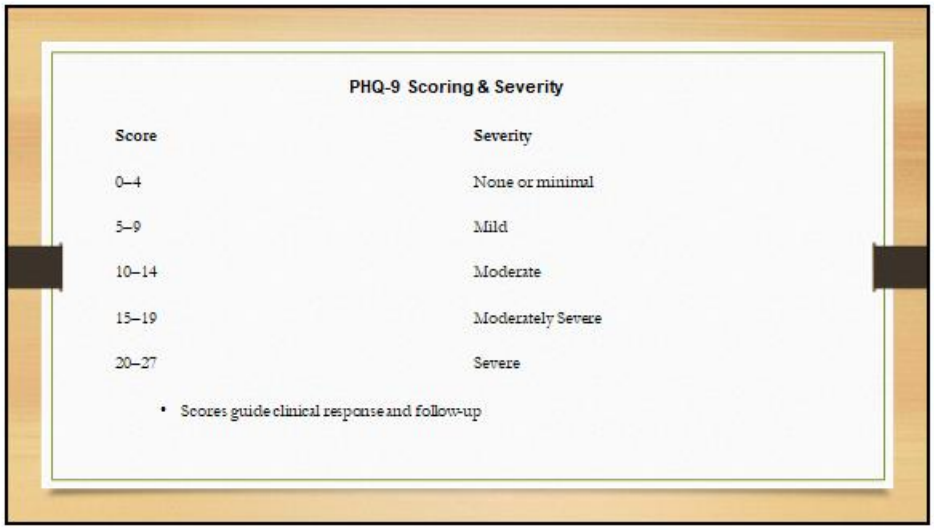
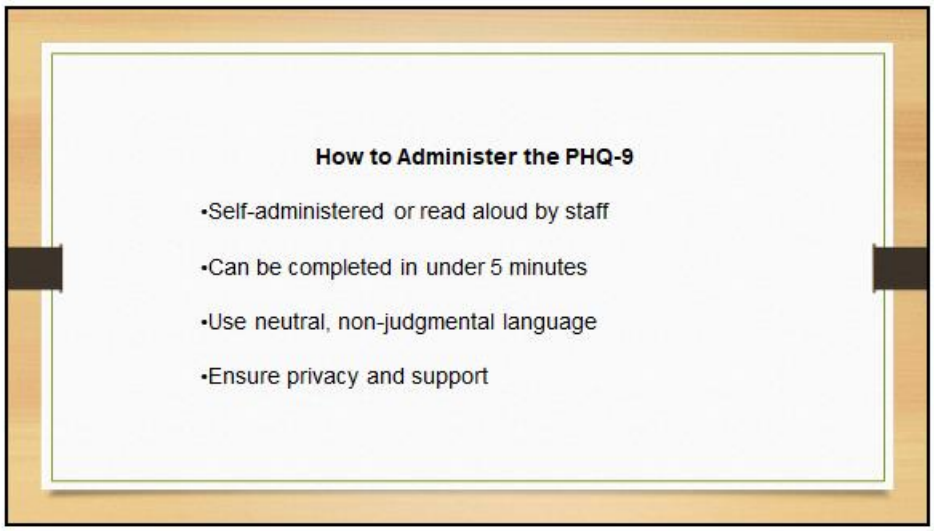
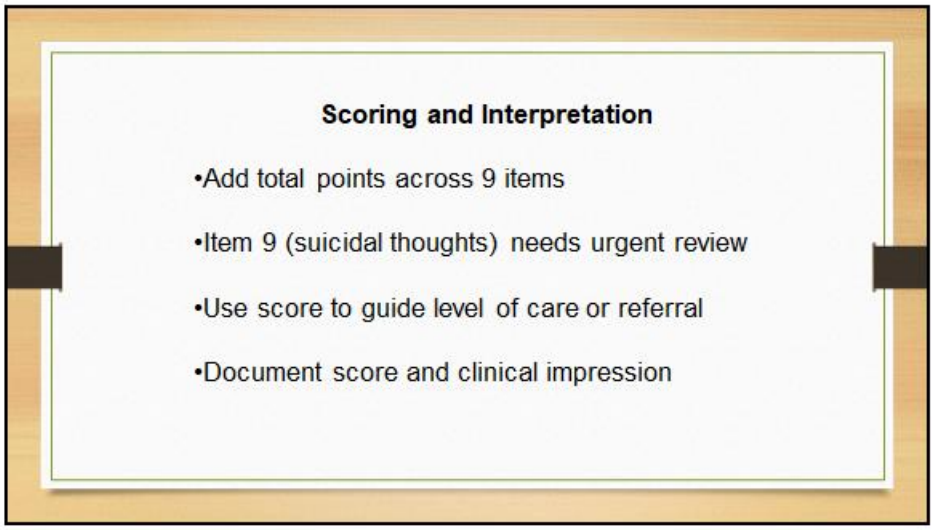

PHQ-9 Scoring & Severity
Score
Severity
0–4
None or minimal
5–9
Mild
10–14
Moderate
15–19
Moderately Severe
20–27
Severe
• Scores guide clinical response and follow-up

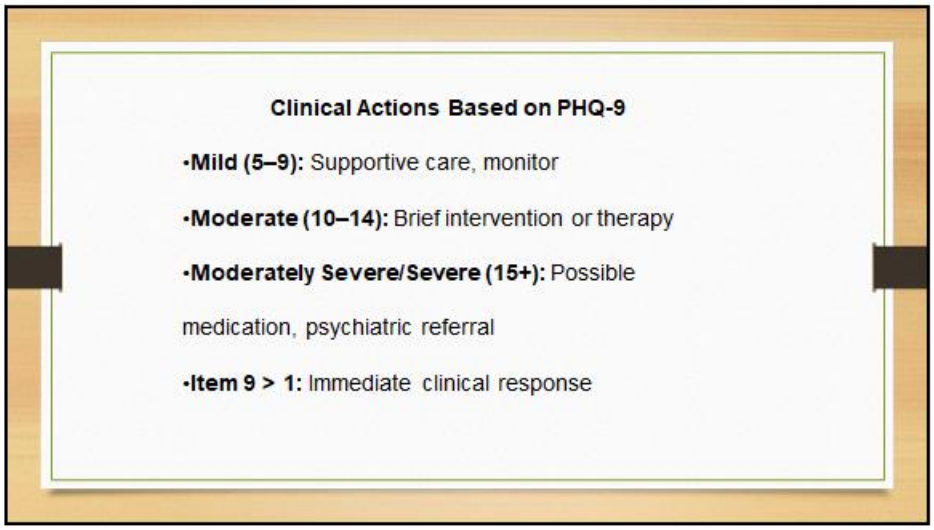
5


How to Administer the PHQ-9
•Self-administered or read aloud by staff
•Can be completed in under 5 minutes
•Use neutral, non-judgmental language
•Ensure privacy and support

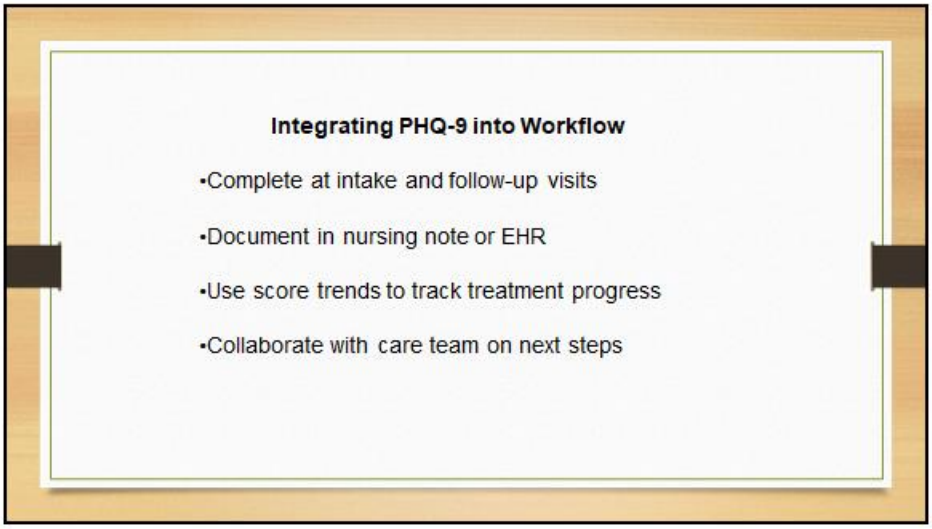
6


Scoring and Interpretation
•Add total points across 9 items
•Item 9 (suicidal thoughts) needs urgent review
•Use score to guide level of care or referral
•Document score and clinical impression

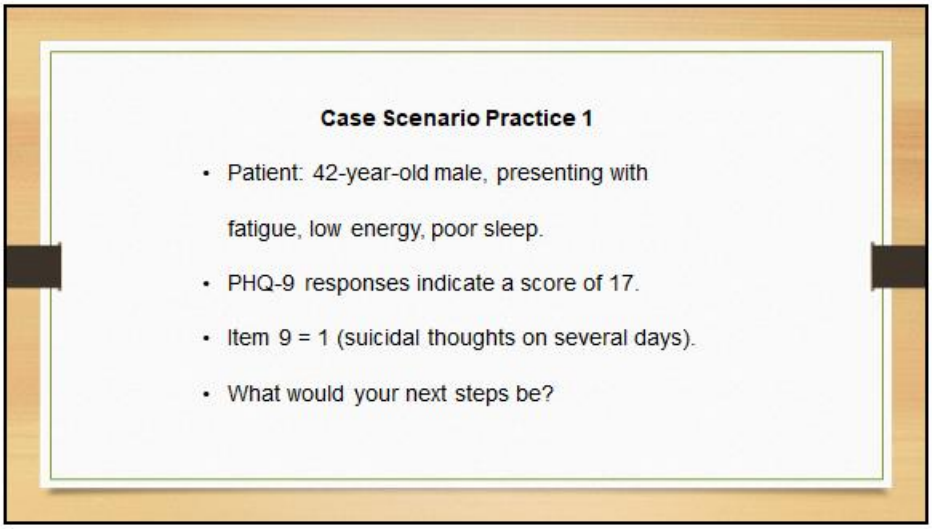
7


Clinical Actions Based on PHQ-9
•Mild (5–9): Supportive care, monitor
•Moderate (10–14): Brief intervention or therapy
•Moderately Severe/Severe (15+): Possible medication, psychiatric referral
•Item 9 > 1: Immediate clinical response

8


Integrating PHQ-9 into Workflow
•Complete at intake and follow-up visits
•Document in nursing note or EHR
•Use score trends to track treatment progress
•Collaborate with care team on next steps

9


Case Scenario Practice 1
• Patient: 42-year-old male, presenting with fatigue, low energy, poor sleep.
• PHQ-9 responses indicate a score of 17.
• Item 9 = 1 (suicidal thoughts on several days).
• What would your next steps be?

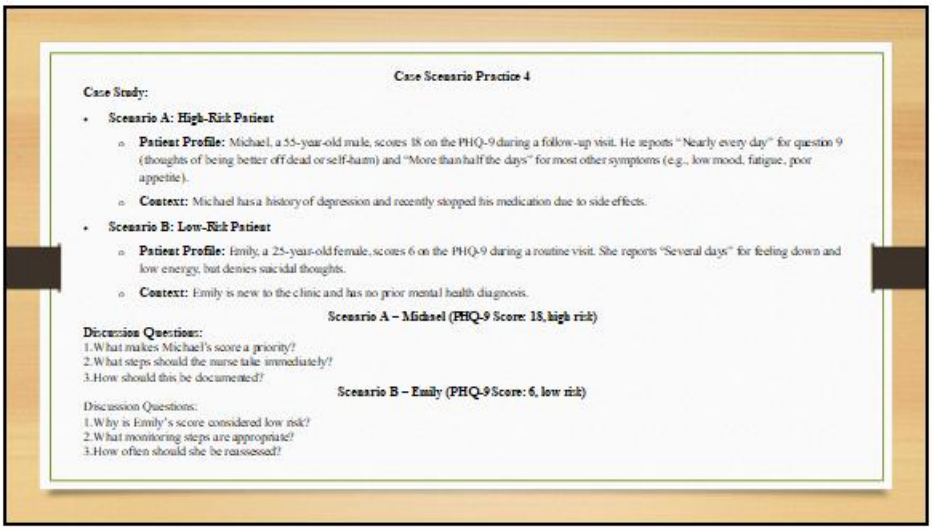
10

Case Scenario Practice 2

- **Patient Profile:** John, a 45-year-old male, presents with complaints of persistent fatigue, social withdrawal, and difficulty sleeping for the past 3 months. He recently lost his job and reports feeling "hopeless" about finding new employment. He denies suicidal thoughts but mentions reduced appetite and weight loss.
- **Context:** John has a history of hypertension and has missed recent primary care appointments. His family reports that he has been less engaged in family activities.
- **Discussion Prompts:**
  - What signs suggest John may have depression?
  - How might his job loss contribute to his symptoms?
  - What are the potential long-term consequences if his depression goes unaddressed?

Case Scenario Practice 3

- **Patient Profile:** Sarah, a 30-year-old female, presents for an intake appointment. She completes a PHQ-9, scoring 12 (moderate depression). Her responses include “More than half the days” for feeling down, loss of interest, and poor concentration, with no suicidal thoughts reported.
- **Context:** The nurse must document Sarah’s PHQ-9 score in the electronic health record (EHR), communicate findings to the clinician, and schedule a follow-up appointment.
- **Discussion Prompts:**
  - What specific details should be documented in the EHR for Sarah’s PHQ-9 score?
  - How can the nurse ensure effective communication with the clinician?
  - What workflow adjustments might ensure PHQ-9 is consistently used at intake?



Case Scenario Practice 4

Case Study:

- **Scenario A: High-Risk Patient**
  - **Patient Profile:** Michael, a 55-year-old male, scores 18 on the PHQ-9 during a follow-up visit. He reports "Nearly every day" for question 9 (thoughts of being better off dead or self-harm) and "More than half the days" for most other symptoms (e.g., low mood, fatigue, poor appetite).
  - **Context:** Michael has a history of depression and recently stopped his medication due to side effects.
- **Scenario B: Low-Risk Patient**
  - **Patient Profile:** Emily, a 25-year-old female, scores 6 on the PHQ-9 during a routine visit. She reports "Several days" for feeling down and low energy, but denies suicidal thoughts.
  - **Context:** Emily is new to the clinic and has no prior mental health diagnosis.

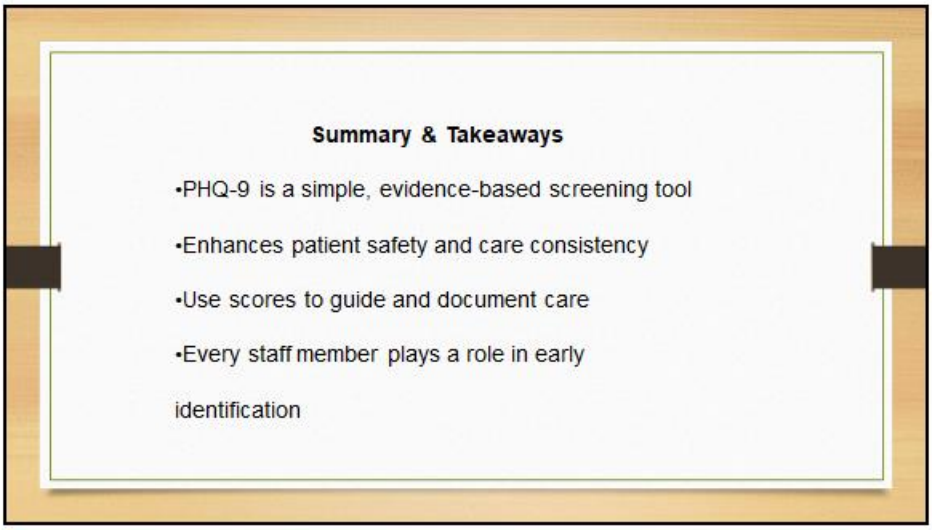
Scenario A – Michael (PHQ-9 Score: 18, high risk)

Discussion Questions:
1. What makes Michael's score a priority?
2. What steps should the nurse take immediately?
3. How should this be documented?

Scenario B – Emily (PHQ-9 Score: 6, low risk)

Discussion Questions:
1. Why is Emily's score considered low risk?
2. What monitoring steps are appropriate?
3. How often should she be reassessed?

13



Summary & Takeaways

- PHQ-9 is a simple, evidence-based screening tool
- Enhances patient safety and care consistency
- Use scores to guide and document care
- Every staff member plays a role in early identification

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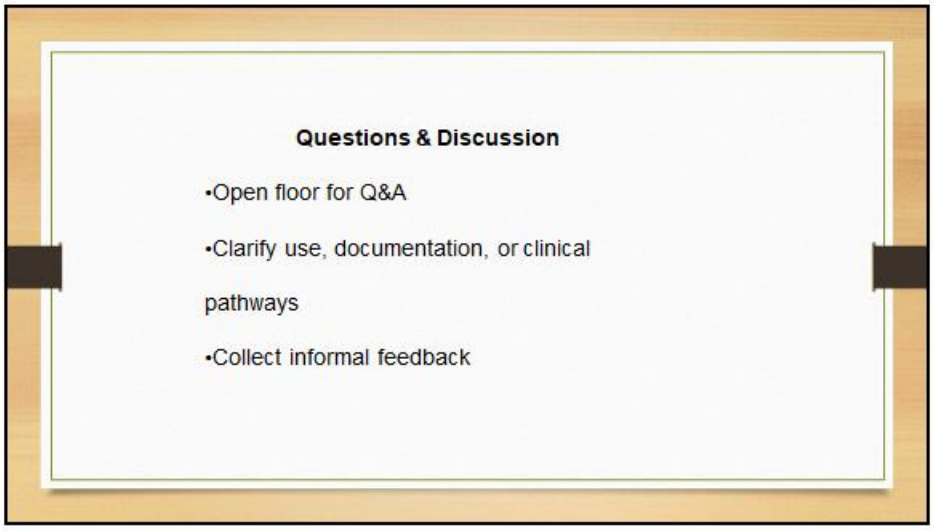
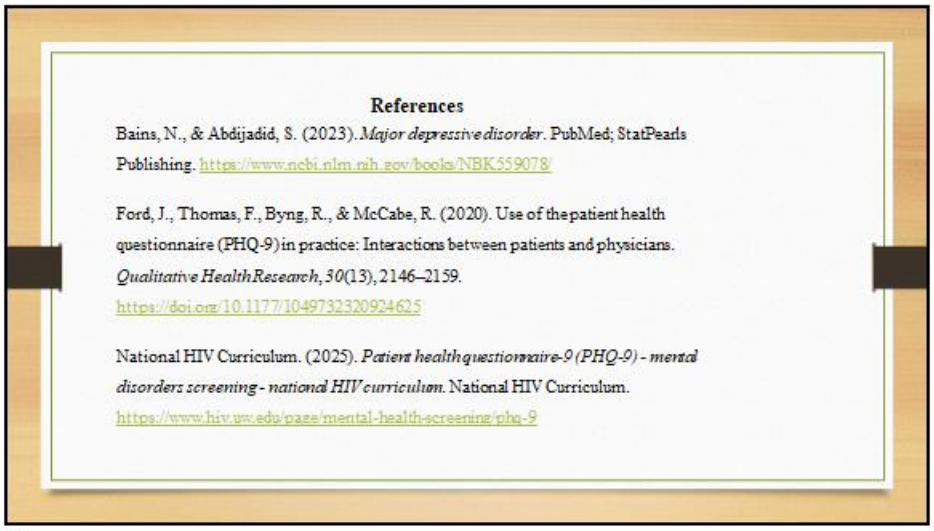

Questions & Discussion
•Open floor for Q&A
•Clarify use, documentation, or clinical pathways
•Collect informal feedback

15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Bains, N., & Abdijadid, S. (2023). Major depressive disorder. PubMed; StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK559078/
Ford, J., Thomas, F., Byng, R., & McCabe, R. (2020). Use of the patient health questionnaire (PHQ-9) in practice: Interactions between patients and physicians. Qualitative Health Research, 30(13), 2146–2159. https://doi.org/10.1177/1049732320924625
National HIV Curriculum. (2025). Patient health questionnaire-9 (PHQ-9) - mental disorders screening - national HIV curriculum. National HIV Curriculum. https://www.hiv.uw.edu/page/mental-health-screening/phq-9

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PHQ-9 Case Studies and Discussion Notes for Staff Education

Case Study 1: Overview of Depression in Adult Mental Health (Module 1)

Objective Alignment: Learning Objective 1 (Define depression and its impact on adult mental health outcomes).

Case Study:

- **Patient Profile:** John, a 45-year-old male, presents with complaints of persistent fatigue, social withdrawal, and difficulty sleeping for the past 3 months. He recently lost his job and reports feeling "hopeless" about finding new employment. He denies suicidal thoughts but mentions reduced appetite and weight loss.
- **Context:** John has a history of hypertension and has missed recent primary care appointments. His family reports that he has been less engaged in family activities.

Discussion Notes:

- **Symptoms of Depression:** Identify potential depression symptoms in John's case (e.g., fatigue, social withdrawal, sleep issues, hopelessness, reduced appetite). Discuss how these align with DSM-5 criteria for major depressive disorder.
- **Risk Factors:** Highlight job loss as a psychosocial stressor. Discuss other potential risk factors (e.g., social isolation, financial stress).
- **Impact on Health Outcomes:** Explain how untreated depression can exacerbate physical health issues (e.g., worsening hypertension due to poor self-care) and mental health outcomes (e.g., increased risk of anxiety or substance use).
- **Discussion Prompts:**
    - What signs suggest John may have depression?
    - How might his job loss contribute to his symptoms?
    - What are the potential long-term consequences if his depression goes unaddressed?
- **Key Takeaway:** Depression is a common mental health condition with significant physical and psychological impacts, necessitating early identification and intervention.

Case Study Discussion and Answers:

- **What signs suggest John may have depression?**
    - John exhibits several symptoms consistent with depression, including persistent fatigue, social withdrawal, difficulty sleeping (insomnia), hopelessness, reduced appetite, and weight loss. These align with DSM-5 criteria for major depressive disorder, particularly as they have persisted for over 2 weeks and impact his daily functioning.
- **How might his job loss contribute to his symptoms?**
    - Job loss is a significant psychosocial stressor that can trigger or exacerbate depression. It may lead to financial insecurity, loss of identity or purpose, and reduced social interaction, all of which contribute to feelings of hopelessness and social withdrawal. John's reported hopelessness about finding new employment directly ties to this stressor.
- **What are the potential long-term consequences if his depression goes unaddressed?**
    - Untreated depression can worsen John's mental health, potentially leading to severe depression, anxiety, or suicidal ideation. Physically, it may exacerbate his hypertension due to poor self-care (e.g., missing appointments, unhealthy eating). Socially, his withdrawal could strain family relationships, and his disengagement may hinder re-employment, perpetuating a cycle of stress and depression.

Case Study 2: Documentation and Workflow Integration (Module 4)

Objective Alignment: Learning Objective 5 (Integrate PHQ-9 screening into routine workflow and documentation procedures).

Case Study:

- **Patient Profile:** Sarah, a 30-year-old female, presents for an intake appointment at XXXXXX. She completes a PHQ-9, scoring 12 (moderate depression). Her responses include "More than half the days" for feeling down, loss of interest, and poor concentration, with no suicidal thoughts reported.
- **Context:** The nurse must document Sarah's PHQ-9 score in the electronic health record (EHR), communicate findings to the clinician, and schedule a follow-up appointment.

Discussion Notes:

- **Documentation Steps:** Outline the process: (1) Enter PHQ-9 score (12) in the EHR under the mental health assessment tab, (2) Note specific symptoms (e.g., anhedonia, concentration issues), (3) Flag the score for clinician review.
- **Workflow Integration:** Discuss how PHQ-9 fits into intake procedures (e.g., administered at check-in, reviewed during consultation). Emphasize communication with the clinician via EHR notes or direct handoff.
- **Follow-Up Planning:** Recommend scheduling a follow-up within 2 weeks for monitoring and potential treatment planning (e.g., counseling referral).
- **Discussion Prompts:**
    - What specific details should be documented in the EHR for Sarah's PHQ-9 score?
    - How can the nurse ensure effective communication with the clinician?
    - What workflow adjustments might ensure PHQ-9 is consistently used at intake?
- **Key Takeaway:** Proper documentation and workflow integration ensure PHQ-9 results are actionable and seamlessly incorporated into patient care.

Case Study Discussion and Answers:

- **What specific details should be documented in the EHR for Sarah's PHQ-9 score?**
    - The nurse should document the total PHQ-9 score (12, indicating moderate depression) in the EHR's mental health assessment tab. Specific symptoms should be noted, such as "More than half the days" for feeling down, loss of interest, and poor concentration. The absence of suicidal thoughts (question 9 score of 0) should also be recorded. The entry should include the date of administration and a flag for clinician review.
- **How can the nurse ensure effective communication with the clinician?**
    - The nurse can use the EHR to send a notification or message to the clinician, summarizing the PHQ-9 score and key symptoms. If the clinician is on-site, a direct handoff during the patient's visit can ensure immediate discussion. Including a brief note in the EHR (e.g., "PHQ-9 score 12, moderate depression, recommends clinician review") ensures clarity and traceability.

- **What workflow adjustments might ensure PHQ-9 is consistently used at intake?**
    - Adjust the intake process to include PHQ-9 administration as a standard step, with forms provided at check-in. Train reception staff to prompt patients to complete the PHQ-9 before the nurse's assessment. Integrate a reminder in the EHR system to flag incomplete PHQ-9s, ensuring consistent use across all intake appointments.

Case Study 3: Interpreting PHQ-9 Results and Referral Protocols (Module 5)

Objective Alignment: Learning Objective 4 (Distinguish between PHQ-9 scoring thresholds and appropriate clinical actions).
Case Study:

- **Scenario A: High-Risk Patient**
    - **Patient Profile:** Michael, a 55-year-old male, scores 18 on the PHQ-9 during a follow-up visit. He reports "Nearly every day" for question 9 (thoughts of being better off dead or self-harm) and "More than half the days" for most other symptoms (e.g., low mood, fatigue, poor appetite).
    - **Context:** Michael has a history of depression and recently stopped his medication due to side effects.
- **Scenario B: Low-Risk Patient**
    - **Patient Profile:** Emily, a 25-year-old female, scores 6 on the PHQ-9 during a routine visit. She reports "Several days" for feeling down and low energy, but denies suicidal thoughts.
    - **Context:** Emily is new to the clinic and has no prior mental health diagnosis.

Discussion Notes:

- **Scenario A (Michael, Score 18):**
    - **Interpretation:** Score of 18 indicates moderately severe depression. The "Nearly every day" response on question 9 signals high risk for suicidality.
    - **Actions:** Immediate notification of a clinician or supervisor, initiate safety protocols (e.g., suicide risk assessment, possible hospitalization), and document urgency in EHR.

    - **Discussion Prompts:** What makes Michael's score a priority? What steps should the nurse take immediately? How should this be documented?

- **Scenario B (Emily, Score 6):**
    - **Interpretation:** Score of 6 indicates minimal to mild depression symptoms.
    - **Actions:** Document the score, recommend monitoring, and schedule a follow-up in 4–6 weeks. Discuss potential non-urgent referral to counseling if symptoms persist.
    - **Discussion Prompts:** Why is Emily's score considered low risk? What monitoring steps are appropriate? How often should she be reassessed?
- **Key Takeaway:** PHQ-9 scores guide clinical actions, with high scores (especially with suicidal ideation) requiring urgent intervention and lower scores warranting monitoring.

Case Study Discussion and Answers:

- **Scenario A (Michael, Score 18):**
    - **What makes Michael's score a priority?**
        - Michael's score of 18 falls in the moderately severe depression range (15–19), but the critical factor is his "Nearly every day" response to question 9, indicating frequent suicidal thoughts. This elevates the urgency, as it suggests a high risk of self-harm or suicide, requiring immediate action.
    - **What steps should the nurse take immediately?**
        - The nurse should immediately notify a clinician or supervisor, initiate a suicide risk assessment (e.g., using a standardized tool like the Columbia-Suicide Severity Rating Scale), and ensure Michael is not left alone. If necessary, the clinician may recommend hospitalization or an urgent psychiatric evaluation.
    - **How should this be documented?**
        - Document the PHQ-9 score (18) in the EHR, noting the high score on question 9 and the urgency of the situation. Include details of actions taken (e.g., "Clinician notified at [time], suicide risk

assessment initiated, patient referred for urgent evaluation"). Flag the entry as high priority for immediate clinician review.

- **Scenario B (Emily, Score 6):**
    - **Why is Emily's score considered low risk?**
        - Emily's score of 6 falls in the minimal to mild depression range (5–9), indicating less severe symptoms. Her denial of suicidal thoughts (question 9 score of 0) further suggests low immediate risk, as there are no urgent safety concerns.
    - **What monitoring steps are appropriate?**
        - Document the score in the EHR and recommend monitoring for changes in symptoms. Provide Emily with educational resources on mental health and encourage her to report worsening symptoms. Schedule a follow-up appointment in 4–6 weeks to reassess with another PHQ-9.
    - **How often should she be reassessed?**
        - Reassess Emily with the PHQ-9 in 4–6 weeks during her follow-up visit, or sooner if she reports worsening symptoms. Regular monitoring ensures early detection of any progression to moderate or severe depression.

Appendix C: PHQ-9 Staff Education: Pretest

Instructions: Choose the best answer for each question.

1. What is the main purpose of the PHQ-9 tool?

   A. To diagnose anxiety disorders

   B. To prescribe medication

   C. To screen for depression and measure its severity

   D. To assess substance use patterns

2. How many questions are on the PHQ-9?

   A. 5

   B. 7

   C. 9

   D. 10

3. What time frame does the PHQ-9 ask the patient to consider?

   A. The last 24 hours

   B. The past 3 months

   C. The past week

   D. The past 2 weeks

4. What does a PHQ-9 score of 5–9 indicate?

   A. Severe depression

   B. Minimal symptoms

   C. Moderate depression

   D. Psychosis

5. Which of the following is a correct PHQ-9 scoring range for moderately severe depression?

   A. 0–4

   B. 10–14

   C. 15–19

   D. 20–27

6. What is the maximum score on the PHQ-9?

   A. 10

   B. 15

   C. 27

   D. 30

7. If a patient scores “Nearly every day” on question 9 (suicidal thoughts), what should the nurse do first?

   A. Discharge the patient

   B. Ignore and proceed with the form

   C. Immediately notify a clinician or supervisor

   D. Schedule a follow-up in one month

8. Which statement best describes the PHQ-9 administration?

   A. It must be done only by a psychiatrist

   B. It is completed by the patient or read aloud by a nurse

   C. It is administered through a computer only

   D. It is used only in emergency rooms

9. How often should the PHQ-9 be used for tracking treatment outcomes?

    A. One time only

    B. Every 6 months

    C. At regular intervals during treatment

    D. Only after hospitalization

10. Which of the following is NOT a question on the PHQ-9?

    A. Feeling tired or having little energy

    B. Thoughts that you would be better off dead

    C. Drinking more alcohol than usual

    D. Trouble concentrating on things

11. What is the appropriate action if a patient scores 0 on all PHQ-9 items?

    A. Schedule a psychiatric evaluation immediately

    B. Begin treatment for depression

    C. Document and monitor; no current signs of depression

    D. Refer to crisis intervention

12. Why is PHQ-9 preferred over symptom observation alone?

    A. It is less time-consuming

    B. It requires fewer staff

    C. It provides a standardized and measurable format

    D. It replaces clinical judgment completely

13. How long does it typically take to complete the PHQ-9?

    A. 30–45 minutes

B. Less than 5 minutes

C. 1 hour

D. 15–20 minutes

14. Who is responsible for scoring the PHQ-9 after a patient completes it?

A. Only the physician

B. Only the administrative clerk

C. A trained staff member such as a nurse

D. The patient themselves

15. When is PHQ-9 screening most appropriate in a mental health setting?

A. Only after hospitalization

B. During every medication refill

C. During intake and follow-up appointments

D. Only when the patient complains

PHQ-9 Staff Education: Posttest

Instructions: Choose the best answer for each question.

1. What is the main purpose of the PHQ-9 tool?

A. To diagnose anxiety disorders

B. To prescribe medication

C. To screen for depression and measure its severity

D. To assess substance use patterns

2. How many questions are on the PHQ-9?

A. 5

B. 7

C. 9

D. 10

3. What time frame does the PHQ-9 ask the patient to consider?

   A. The last 24 hours

   B. The past 3 months

   C. The past week

   D. The past 2 weeks

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   A. 0–4

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   D. 20–27

6. What is the maximum score on the PHQ-9?

   A. 10

   B. 15

C. 27

D. 30

7. If a patient scores “Nearly every day” on question 9 (suicidal thoughts), what should the nurse do first?

   A. Discharge the patient

   B. Ignore and proceed with the form

   C. Immediately notify a clinician or supervisor

   D. Schedule a follow-up in one month

8. Which statement best describes the PHQ-9 administration?

   A. It must be done only by a psychiatrist

   B. It is completed by the patient or read aloud by a nurse

   C. It is administered through a computer only

   D. It is used only in emergency rooms

9. How often should the PHQ-9 be used for tracking treatment outcomes?

   A. One time only

   B. Every 6 months

   C. At regular intervals during treatment

   D. Only after hospitalization

10. Which of the following is NOT a question on the PHQ-9?

    A. Feeling tired or having little energy

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C. Drinking more alcohol than usual

D. Trouble concentrating on things

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    A. Only after hospitalization

    B. During every medication refill

    C. During intake and follow-up appointments

    D. Only when the patient complains

Appendix D: PHQ-9 Staff Education Program Evaluation Form

Program Title:
Implementation of PHQ-9 in a Depression Management Program for Adult Mental Health Patients
Date of Training: _____
Facilitator(s): _____

Instructions:
Please indicate your level of agreement with the following statements by checking the appropriate box.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The learning objectives were clearly stated.	☐	☐	☐	☐	☐
2. The training was well-organized and easy to follow.	☐	☐	☐	☐	☐
3. The facilitator demonstrated knowledge and expertise on the topic.	☐	☐	☐	☐	☐
4. The PHQ-9 tool was clearly explained.	☐	☐	☐	☐	☐
5. I feel confident in my ability to administer and score the PHQ-9 correctly.	☐	☐	☐	☐	☐
6. The content was relevant to my clinical practice.	☐	☐	☐	☐	☐
7. The training met my expectations.	☐	☐	☐	☐	☐
8. I will use the PHQ-9 in my daily patient care when appropriate.	☐	☐	☐	☐	☐
9. The pre/post-test helped evaluate my knowledge gained.	☐	☐	☐	☐	☐
10. I would recommend this training to other staff members.	☐	☐	☐	☐	☐

Open-Ended Questions:

1. **What did you find most helpful about this training?**

2. **What suggestions do you have to improve the training?**

3. **What additional training or support would you find helpful going forward?**

Overall Rating of the Training (circle one):

☆ ☆ ☆ ☆ ☆

(1 = Poor, 5 = Excellent)

Appendix E: Synthesis and Recommendations Tool

EBP Question:
Following participation in a staff education program, will staff demonstrate increased knowledge on depression screening and use of the PHQ-9?

Strength		**Number of Sources (Quantity)**	**Synthesized Findings With Article Number(s)** (This is *not* a simple restating of information from each individual evidence summary—see directions.)
Level	Overall Quality Rating (Strong, good, or low)		
Level I ▪ Experimental studies	Strong	4	Wang et al. (2021) demonstrates that the PHQ-9 is an effective tool for screening depression with similar performance to the EPDS in perinatal populations. Its widespread use and validation across different settings make it a strong candidate for inclusion in a depression management program aimed at improving mental health outcomes and treatment adherence among adult patients at Zitel Healthcare Services Inc. Negeri et al. (2021) state that the findings from this article indicate that the PHQ-9 is an accurate tool for detecting major depression in adults when used with a cut-off value of ≥10. It has high sensitivity and specificity, which can improve mental health outcomes by identifying individuals who need treatment and reducing false positives. This evidence supports implementing a depression management program utilizing the PHQ-9 at Zitel Healthcare Services Inc. The use of PHQ-9 and GAD-7 in this article demonstrates that structured programs incorporating these tools can lead to significant improvements in mental health outcomes post-intervention. This aligns with the EBP question, suggesting that implementing a depression management program utilizing PHQ-9 at Zitel Healthcare Services Inc. could improve mental health outcomes and treatment adherence, according to Caraway et al. (2024) Chen et al. (2025) state that a systematic review and meta-analysis demonstrate that PHQ-9 is a valid tool for predicting depression among patients, particularly poststroke patients. This supports its use in structured depression management programs to improve mental health outcomes and treatment adherence in adult patients at Zitel Healthcare Services Inc.
	Strong		
	Strong		
	Strong		

Level II ▪ Quasi-experimental studies	Good Good	2	Siniscalchi et al. (2020) state that the study implemented VitalSign6 in primary care settings, resulting in improved depression screening and management. 95.4% of patients received initial screening, and measurement-based care was provided to 236 patients, with significant decreases in depression scores. Matthew Lee Smith et al. (2023) state that their study supports the hypothesis that structured depression management programs using standardized tools like the PHQ-9 can lead to significant improvements in mental health outcomes. The PEARLS program demonstrated effectiveness in reducing depressive symptoms among older adults, suggesting potential applicability for similar programs targeting adult patients (ages 18-65) at Zitel Healthcare Services Inc., aiming to improve mental health outcomes and treatment adherence.
Level III ▪ Nonexperimental, including qualitative studies	Good Good Good	3	The article by Ford et al. (2020) provides qualitative evidence on the use of the PHQ-9 in clinical practice, showing its impact on diagnosing depression and recommending treatment. This suggests that implementing a structured depression management program using the PHQ-9 at Zitel Healthcare Services Inc. could improve mental health outcomes and treatment adherence compared to standard care. However, careful consideration of potential biases in clinician administration is necessary. Coleman et al. (2020) provide evidence that implementing a collaborative care model for depression management using the PHQ-9 can be effective in improving mental health outcomes and treatment adherence among adult patients, which aligns with the EBP question for Zitel Healthcare Services Inc. This evidence supports the potential benefits of transitioning from standard care to a structured depression management program. Korsen and Gerrish (2022) state the study suggests that implementing a structured depression management program utilizing the PHQ-9 in primary care settings can potentially improve mental health outcomes by addressing the current underutilization of this tool for monitoring depression This aligns with the EBP question's focus on improving treatment adherence and outcomes through structured monitoring tools like the PHQ-9.

Level IV ▪ Clinical practice guidelines or consensus panels		0	
Level V ▪ Literature reviews, QI, case reports, expert opinion	Good Good. Strong Good	5	Blackstone et al. (2022) suggest that the article demonstrates that structured interventions in primary care settings can significantly improve adherence to depression screening protocols, which is crucial for managing depression effectively among adult patients (ages 18–65). This aligns with the EBP question by highlighting the potential benefits of systematic approaches to depression management, which could be applied in a program utilizing the PHQ-9 at Zitel Healthcare Services Inc. Costantini et al. (2020) emphasize the importance of using PHQ-9 as a validated tool for screening depression in primary care settings among adult populations. It supports implementing a two-stage screening process to improve mental health outcomes and treatment adherence while highlighting the need for standardized approaches and further longitudinal studies to evaluate long-term effectiveness. Carroll et al. (2020) state that the systematic review summarized findings from 49 studies validating the PHQ-9 in LMICS and emphasized the importance of contextual adaptation to improve its reliability and validity in different settings. The findings support its use as a key tool in depression management programs, particularly when tailored to account for linguistic and cultural nuances, which can enhance mental health outcomes and treatment adherence among adult patients with depression. Mehmetoglu et al. (2025) demonstrate the utility of PHQ-9 as an effective tool for identifying depression in patients with chronic illnesses like SSc and highlight the importance of integrating mental health care into chronic disease management programs. The findings suggest that implementing a depression management program utilizing PHQ-9 could improve mental health outcomes and treatment adherence in adult patients with depression at Zitel Healthcare Services Inc.

	Strong		Chae et al. (2024) state that the PHQ-9 is validated for use in diverse populations and is effective for tracking depression severity and outcomes across demographics. It supports its implementation in a structured depression management program.