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Improving Depression Remission Rates at 12 Months

RAYSENE R. HALL
Walden University

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College of Nursing

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Raysene Hall

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Jill Walsh, Committee Chairperson, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Executive Summary: Clinical Practice Guideline
Improving Depression Remission Rates at 12 Months

by

Raysene Hall

MS, Walden University, 2024

BS, University of Phoenix, 2021

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
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Summary

I developed this Doctor of Nursing Practice (DNP) project to create a clinical practice guideline (CPG) aimed at improving depression remission rates at an outpatient clinic where outcomes were below national benchmarks. National standards for managing major depressive disorder (MDD) prioritize remission as the primary treatment goal. I identified a practice gap involving inconsistent follow-up care, irregular use of PHQ-9 assessments, and non-standardized workflows.

The guiding question for this project was: Will a CPG that is designed to improve depression remission rates at 12 months be approved by subject matter experts (SMEs) using the Appraisal of Guidelines for Research and Evaluation (AGREE II) tool? To address this, I conducted a systematic literature review and critically appraised evidence to develop the CPG. A panel of five SMEs evaluated the guideline using the AGREE II tool, with responses submitted anonymously. The AGREE II panel review revealed consistently strong scores across all items in the six domains, with mean values ranging from 5.80 to 6.40 based on a Likert scale from 1 (*strongly disagree*) to 7 (*highly agree*). Based on their feedback, I revised the CPG and then assessed its usability with end users, who rated it as practical and feasible.

This CPG has the potential to enhance remission rates, improve consistency in terms of care delivery, and align clinical practice with national standards. Quarterly audits of PHQ-9 completion rates are recommended to monitor adherence. Ultimately, this project supports nurses and behavioral health providers in leading evidence-based mental health interventions, promoting equitable care for underserved populations, and reducing the long-term impact of untreated depression.

Background

MDD is a leading cause of disability worldwide and contributes substantially to the global burden of disease (Simon et al., 2024). National standards for managing MDD prioritize remission as the primary treatment goal. Nationally, remission rates for depression average 13.6%, but underserved populations experience significantly lower rates due to access barriers and resource constraints (Bondesson et al., 2022; Núñez et al., 2024). Relapses are common, with many patients experiencing recurrence within the first year following initial treatment (Niarchou et al., 2024). Structured follow-up, routine PHQ-9 use, and collaborative care improve remission outcomes (Bansal et al., 2025; Rosas et al., 2024). At the outpatient clinic, the remission rate was 4.6%, underscoring a critical gap in practice. Barriers included inconsistent PHQ-9 screening, irregular follow-up, and lack of standardized workflows. The purpose of this DNP project was to develop a CPG that is tailored to the multispecialty clinic that addresses these gaps. The practice-focused question guiding this project was: Will a CPG that is designed to support the process for improving depression remission rates at 12 months be approved by a group of SMEs using the AGREE II tool?

Evidence supporting this CPG was appraised using the Johns Hopkins evidence-based practice (EBP) model, with included studies that were rated as levels I through III and overall rated in terms of quality. This provides strong support for quarterly PHQ-9 monitoring, collaborative care integration, and structured follow-up workflows to improve remission outcomes.

CPG Development

I developed a standardized evidence-based CPG that was aimed at improving depression remission rates at 12 months (see Appendix A). To ensure its quality and relevance, five SMEs evaluated the guideline using the AGREE II tool (AGREE Next Steps Consortium, 2017). The expert panel included two psychiatric mental health nurse practitioners with over 5 years of experience, one licensed behavioral health therapist specializing in psychotherapy, and one primary care provider who was involved in integrated behavioral health. These individuals were selected for their direct experience with depression care and quality improvement initiatives. Their evaluations played a critical role in refining the CPG to better meet clinical needs.

The AGREE II Manual and the 23-item instrument (AGREE Next Steps Consortium, 2017) were distributed electronically via the project preceptor, maintaining anonymity. Based on scores and feedback, the CPG underwent revisions to enhance its clarity and applicability.

Following these revisions, six end users (two primary care providers, one behavioral health therapist, one nurse, and two medical assistants) were invited to review the CPG for usability, clarity, and clinical relevance. Their feedback indicated the CPG was both practical and feasible for implementation.

Results

Table 1 presents the results of the AGREE II evaluation that was conducted by a panel of five SMEs, including their ratings across 23 domains using a seven-point Likert scale (1 = strongly disagree to 7 = strongly agree).

Table 1*AGREE II Domain Scores for the CPG*

Domain	Reviewer 1	Reviewer 2	Reviewer 3	Reviewer 4	Reviewer 5	<i>M</i> Score
Scope and Purpose	[6]	[6.33]	[6]	[7]	[6.33]	[6.33]
Stakeholder Involvement	[6]	[7]	[6]	[7]	[6]	[6.40]
Rigor of Development	[6]	[7]	[6]	[7]	[5.88]	[6.38]
Clarity of Presentation	[6]	[7]	[6]	[7]	[6]	[6.40]
Applicability	[6]	[7]	[6]	[7]	[5.75]	[6.35]
Editorial Independence	[6]	[7]	[6]	[7]	[4]	[5.80]
Overall guide quality	[6]	[7]	[6]	[7]	[6]	[6.40]
Recommendation	yes with modification	yes with modification	yes	yes	yes	

The AGREE II panel review revealed consistently strong scores across all items in the six domains, with mean values ranging from 5.80 to 6.40 based on feedback from five SMEs. These scores indicate the CPG was developed with a high level of methodological rigor, stakeholder relevance, and real-world applicability. Stakeholder involvement and clarity of presentation received the highest ratings (6.40), reflecting strong interdisciplinary input and a user-friendly and clearly formatted guideline. These findings support scholarly validity and clinical utility of the CPG in its current form.

Stakeholders at the outpatient clinic, including quality improvement, behavioral health, and nursing leadership, reviewed the CPG using the AGREE II tool. This instrument enabled both quantitative assessment and qualitative feedback from SMEs for

six domains: scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence. Reviewers endorsed the guideline as feasible and appropriate for clinical use, with two recommending minor clinic-specific adaptations. Recommended edits such as clarifying PHQ-9 follow-up intervals and integrating culturally responsive follow-up strategies were incorporated before I finalized the CPG.

Editorial independence emerged as the lowest-scoring domain, with a mean score of 5.80. Although still acceptable, this score suggests reviewers may have perceived insufficient clarity regarding external funding influence or conflict of interest management. To address this concern, the guideline should clearly state development was conducted without external funding, and all recommendations were derived solely from evidence-based research and SME consensus.

Despite overwhelming positive feedback, several limitations affected the project's overall scope. Most notably, my role was limited to CPG development without implementation or outcome evaluation that were the responsibility of organizational leadership. As a result, real-world data on clinician adherence and depression remission rates could not be gathered. Additionally, the expert panel consisted of five reviewers; although adequate, a larger and more diverse group could have provided a broader range of perspectives. The site-specific nature of AGREE II feedback based solely within the outpatient clinic also limited generalizability to other settings without further contextual adaptation.

Adopting the finalized CPG at the outpatient clinic has the potential to improve depression care quality and outcomes significantly. Currently, the outpatient clinic's

depression remission rate at 12 months is approximately 2.8%. This is well below the national benchmark of 13.6% (Agency for Healthcare Research & Quality, 2024). The CPG proposes structured PHQ-9 follow-up intervals at 1, 3, 6, and 12 months, as well as supportive strategies such as telehealth use and increased psychiatric mental health nurse availability to promote adherence and continuity. These strategies are designed to improve symptom tracking, identify treatment resistance earlier, and engage patients more meaningfully in their care plans. The CPG promotes team-based interprofessional collaboration for integrating behavioral health in alignment with standards established by the Health Resources and Services Administration and National Committee for Quality Assurance.

Beyond the outpatient clinic, this project offers broader significance to other federally qualified health centers and outpatient clinics serving underserved populations. By standardizing depression follow-up and intervention workflows, the CPG supports national efforts to reduce behavioral health disparities and improve outcomes in high-need populations. Structure, scalability, and low-resource demands of the guideline make it a viable model for adaptation across diverse outpatient care settings. With further validation and organizational support, this CPG could also contribute to institutional policies, training protocols, and national quality metrics in primary behavioral healthcare.

Conclusions

This CPG provides the outpatient clinic with a standardized and evidence-based approach to depression care that incorporates measurable outcomes and aligns with national benchmarks. Specifically, the CPG aims to improve 12-month depression

remission rates toward or above the national goal of 13.6% while also reducing disparities in behavioral health services.

The CPG was reviewed by five SMEs using the AGREE II tool, with results indicating strong support for the guideline's quality, clarity, rigor, and stakeholder alignment. Minor revisions were recommended particularly related to enhancing editorial independence, but overall feedback validated the CPG's readiness for finalization and dissemination.

Implementation recommendations included quarterly audits of PHQ-9 completion rates, structured staff training involving collaborative care principles, and use of electronic health record dashboards to track remission outcomes.

End-user feedback from three clinical and behavioral health staff highlighted both strengths and areas for refinement (see Appendix B). While the CPG's PHQ-9 follow-up intervals were noted to be clear, feedback varied regarding their actionability, citing challenges such as inconsistent patient interpretation, chronic comorbidities, and provider time constraints. Suggestions included incorporating built-in electronic health record reminders, joint interprofessional training, clarified documentation workflows, and expanding culturally responsive communication strategies. Feedback on the collaborative care framework affirmed the CPG fosters team communication but would benefit from explicitly encouraging regular case huddles and shared documentation practices. These insights informed final edits to the CPG to improve its feasibility, inclusivity, and alignment with outpatient workflows.

Organizationally, the CPG offers a clear and stepwise framework for PHQ-9 monitoring, referral and escalation protocols, and documentation of follow-up intervals.

These tools are designed to enhance staff consistency, improve patient outcomes, and promote fidelity to best practice guidelines.

Nursing practice implications are significant. This CPG equips nurses and behavioral health providers with validated tools to lead depression care initiatives, reinforcing the nursing profession's role in advancing evidence-based mental health interventions. It promotes a culture of clinical scholarship, professional accountability, and equity in care delivery.

Beyond the outpatient clinic, this CPG model is scalable to other federally qualified health centers and outpatient clinics serving vulnerable populations. Its adoption supports national efforts to reduce the burden of untreated depression and advance positive social change, particularly in terms of promoting diversity, equity, and inclusion across mental health systems.

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Appendix A: Clinical Practice Guideline: Improving Depression Remission Rates

Clinical Practice Guideline Title: Improving Depression Remission Rates at 12 Months

Introduction: The outpatient clinic currently has a depression remission rate of 4.6% which is below the national benchmark of 13.6%. This gap results from inconsistent follow-up, irregular PHQ-9 monitoring, and lack of standardized workflows. The purpose of this Clinical Practice Guideline (CPG) is to provide an evidence-based approach to improve depression remission rates at 12 months from diagnosis. My practice-focused question is: “Will a CPG designed to support the process for improving depression remission rates at 12 months be approved by a group of subject matter experts using the AGREE II tool?” Content experts will include licensed psychiatric mental health nurse practitioners and behavioral health therapists. The target user group includes frontline behavioral health providers, primary care providers, nursing staff, and medical assistant leads. The clinical context is an integrated community health center with diverse patients and resource constraints including limited provider capacity and time for consistent follow-up, and inconsistent patient appointment follow-up. My role as a student is to develop this CPG, obtain SME and end-user feedback, and finalize the CPG. The organization’s responsibility is the implementation after approval. Major depressive disorder (MDD) continues to be a tremendous public health challenge with high relapse and recurrence rates within the first year following initial treatment response numerous evidences show that consistent follow-up care models, PHQ-9 monitoring, and collaborative care interventions can improve sustained remission rates. A gap in practice

exists at the outpatient clinic related to standardizing follow-up processes and evidence-based decision support for depression remission outcomes.

AGREE II Domains Incorporated

- 1. Scope and Purpose:** The overall objective of this Clinical Practice Guideline (CPG) is to provide clear, evidence-based recommendations to improve depression remission rates at 12 months for individuals 12 and older with major depressive disorder (MDD) at the outpatient clinic. The specific practice-focused question guiding this guideline is: “Will a CPG designed to support the process for improving depression remission rates at 12 months be approved by a group of subject matter experts using the AGREE II tool?” This guideline applies to patients (ages 12 and older) diagnosed with major depressive disorder (MDD) who receive care at the outpatient clinic, with a focus on underserved and diverse populations needing consistent follow-up and evidence-based interventions.
- 2. Stakeholder Involvement:** The guideline development group includes input from psychiatric mental health nurse practitioners (PMHNPs), behavioral health therapists, primary care providers, quality improvement leaders, and medical assistant leads. These stakeholders serve as subject matter experts (SMEs) and frontline reviewers to ensure the guideline is evidence-based and practical for our community health center setting. The target users of this guideline include behavioral health clinicians, primary care providers, RNs, medical assistants, and medical assistant leads who are responsible for PHQ-9 screening, follow-up, and care coordination for adult patients diagnosed with major depressive disorder at the outpatient clinic.

3. Rigor of Development: I used a systematic search strategy following the Johns Hopkins EBP Model to find recent, relevant peer-reviewed studies focused on depression remission at 12 months, PHQ-9 monitoring, collaborative care models, and adherence strategies. My evidence selection criteria included studies on adult patients with major depressive disorder, measurable remission outcomes, use of PHQ-9, and interventions supported by Level II or Level III evidence rated good or high quality. The evidence base includes multiple nonexperimental and quasi-experimental studies supporting routine PHQ-9 monitoring and collaborative care. A strength is the consistent positive impact on remission rates. A limitation is that some emerging areas, like neural biomarkers, still require more large-scale validation. The evidence base includes multiple nonexperimental care. A strength is the consistent positive impact on remission rates. A limitation is that some emerging areas, like neural biomarkers, still require more large-scale validation. I developed the recommendations using my evidence synthesis, the Johns Hopkins EBP Model for rating evidence, and feasibility considerations specific to the outpatient clinic. They will be appraised by SMEs using the AGREE II tool and revised based on end-user input before final approval. The CPG recommendations weigh the health benefits of improved remission rates against risks such as medication side effects, which may impact adherence. My synthesis addresses these factors and includes evidence-based strategies for early identification and personalized follow-up. Each recommendation clearly cites the supporting studies, level of evidence, and quality ratings. This ensures transparency and rigor when presenting the evidence base. I will submit my draft CPG for formal review by subject matter experts, including PMHNPs and behavioral health therapists, using the AGREE II tool. Their feedback will be incorporated, and then the guideline will be shared with end-users for practical input before finalization. I recommend that the outpatient clinic review and update this guideline at least every three years, or sooner if

new high-quality evidence emerges. This future update process will be the organization's responsibility after my student delivery is complete.

- 4. Clarity of Presentation:** Each recommendation in my CPG is written clearly and specifically describes what follow-up actions should be taken, such as conducting PHQ-9 screenings every three months, using collaborative care, and addressing medication adherence issues. The wording avoids vague language to ensure frontline staff can understand exactly what is expected. My recommendations highlight different evidence-based strategies that can be used to improve depression remission rates at 12 months, including PHQ-9 monitoring, psychotherapy integration, medication management, and the potential for personalized approaches using symptom profiles or neural biomarkers. These options help the organization choose what fits best in their workflow after the guideline is approved. Key recommendations are listed separately with clear headings in the CPG draft. Each recommendation states the action, what the evidence shows, the level of evidence, and the citation, making it easy for SMEs and end-users to locate and review them during appraisal.
- 5. Applicability:** In my CPG draft, I describe facilitators such as strong executive support, engaged interdisciplinary teams, and existing PHQ-9 workflows that can help apply the recommendations. I also note barriers like limited provider time, workflow variation, and mental health staffing shortages. I include practical advice within the recommendations, such as scheduling quarterly PHQ-9 screenings and using collaborative care approaches. I also recommend that the organization consider supportive tools like EHR templates or dashboards to help staff follow the guidelines consistently, although any informatics builds will be the organization's responsibility after my student work is complete. Adopting this guideline may require the organization to invest in follow-up tracking systems, PRN staffing models, or staff training sessions. I do not manage these resource

implications as a student, but I highlight them so leadership can plan for them during future implementation. My CPG suggests that the organization monitor key outcomes such as quarterly PHQ-9 completion rates, 12-month remission percentages, and adherence trends. I recommend using existing dashboards or EHR reports to support auditing. Actual monitoring will be handled by the organization after my guideline is approved.

- 6. Editorial Independence:** This Clinical Practice Guideline was developed as part of my Doctor of Nursing Practice (DNP) project at the outpatient clinic. There was no external funding body involved, so no external views have influenced the content or recommendations in this guideline. I have confirmed that no competing interests exist among my subject matter experts or end-user reviewers who will appraise the guidelines. All SMEs and reviewers will declare any potential conflicts during the AGREE II tool appraisal process before final approval.

CPG Recommendations

Target Population:

Ages 12 to adult patients diagnosed with major depressive disorder receiving care at the outpatient clinic.

Recommendation 1: Conduct routine PHQ-9 screening every three months and follow up for all adult patients diagnosed with major depressive disorder. Monitor for early signs of relapse, medication adherence, side effects, and psychosocial stressors.

Evidence shows that consistent PHQ-9 follow-up, including use of tools like heat maps, helps identify patients at risk for relapse earlier and supports data-informed clinical decisions to increase remission at 12 months.

Level of Evidence: III Quality: Good. (Rosas et al., 2024; Núñez et al., 2024)

Recommendation 2: Use a collaborative care model that combines systematic PHQ-9 monitoring, psychotherapy, and medication management.

Evidence shows that collaborative care approaches, including internet-based CBT and structured follow-up, significantly improve 12-month remission rates and reduce healthcare utilization compared to usual care.

Level of Evidence: I, Quality: Good (Bondesson et al., 2022)

Level of Evidence: III, Quality: Good (Simon et al., 2024)

Recommendation 3: Incorporate routine assessment of medication side effects and adherence during quarterly PHQ-9 follow-ups to identify patients at risk of poor remission outcomes.

Evidence shows that side effects significantly affect medication adherence, and early identification helps adjust treatment to sustain remission.

Level of Evidence: I, Quality: Good (Niarchou et al., 2024)

Recommendation 4: Establish referral pathways for patients not achieving remission

Patients who do not reach remission—defined as a PHQ-9 score ≥ 10 —by the 6- 9-month intervals should be promptly referred for psychiatric consultation, medication review, or additional services such as psychotherapy or case management. This ensures a timely escalation of care and addresses persistent symptoms.

- Simon et al. (2024) emphasized that stepped care models with clearly defined referral pathways improved remission rates by matching treatment intensity to symptom severity.

- Núñez et al. (2024) found that network analysis of symptom profiles supports personalized care plans and underscores the value of reassessment and referral when patients show poor progress.

Level of Evidence: Level III, Quality: Good (Núñez et al., 2024; Simon et al., 2024)

Recommendation 5: Consider emerging use of neural biomarkers and patient-specific symptom profiles to guide personalized treatment pathways for depression remission.

Patients not achieving remission (PHQ-9 ≥ 10) at 6 and 9 months should receive prompt referrals to higher levels of care, medication adjustments, or additional supportive services.

Predictive neural biomarkers can identify patients who may need tailored care strategies to sustain remission, although more validation is needed.

Level of Evidence: III, Quality: Good (Bansal et al., 2025)

Expected Outcomes:

- **Primary:** Increased percentage of patients achieving PHQ-9 scores < 5 at 12 months.
- **Process Measures:** Percentage of patients screened every three months, staff adherence to referral pathways, and staff satisfaction with the guideline's usability.

Monitoring and Evaluation:

- Quarterly review of remission rates and adherence to PHQ-9 screening.
- Collect staff feedback on usability post-rollout.

End-user feedback from three clinical and behavioral health staff highlighted both strengths and areas for refinement. While the CPG’s PHQ-9 follow-up intervals were noted to be clear, feedback varied regarding their actionability—citing challenges such as inconsistent patient interpretation, chronic comorbidities, and provider time constraints. Suggestions included incorporating built-in EHR reminders, joint interprofessional training, clarified documentation workflows, and expanding culturally responsive communication strategies. Feedback on the collaborative care framework affirmed that the CPG fosters team communication but would benefit from explicitly encouraging regular case huddles and shared documentation practices. These insights informed final edits to the CPG to improve its feasibility, inclusivity, and alignment with outpatient workflows.

Clinical Practice Guideline References

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Appendix B: End-User Feedback

As part of the finalization of the CPG, three end users across clinical and behavioral health roles were invited to review and provide feedback on the guideline. Their perspectives were gathered via a structured open-ended feedback survey, focusing on feasibility, clarity, and alignment with clinical workflows for improving depression remission at 12 months.

Six survey questions were created to capture open ended, detailed feedback based on the CPG recommendations.

1. How clear and actionable do you find the CPG's recommendations for PHQ-9 follow-up intervals and documentation workflows?
2. Are the CPG recommendations for structured follow-up (1, 3, 6, 12 months) and care coordination realistic and feasible in our current outpatient workflow? If not, what changes would make them more practical?
3. What barriers do you anticipate when trying to apply this CPG in routine depression care (e.g., time, training, patient engagement, EHR usability)?
4. How culturally appropriate and inclusive do you find the communication strategies outlined in the CPG for our diverse patient population?
5. In what ways could this CPG better support collaborative care and interprofessional communication among nursing, behavioral health, and primary care staff?
6. What changes, if any, would you suggest to improve this CPG's usefulness in helping our clinic meet the national depression remission benchmark (13.6%)?

End User Feedback Integration

1. Clarity and Actionability of PHQ-9 Workflows

Two out of three reviewers strongly endorsed the clarity and structure of the PHQ-9 follow-up documentation process. They emphasized that transitioning from PHQ-2 to PHQ-9 supported more consistent depression tracking and provider communication, a sentiment reinforced by Rosas et al. (2024), who demonstrated that structured PHQ-9 use facilitates clinical decision-making. However, one reviewer expressed that although the recommendations were “clear,” they may not always be actionable, citing that PHQ-9 interpretations can vary based on patients’ lifestyles (e.g., chronic pain, fatigue).

2. Feasibility of Follow-Up Intervals and Care Coordination

While all three end users supported the clinical merit of the 1-, 3-, 6-, and 12-month structured follow-ups, feasibility within the current outpatient workflow was a concern. One noted that limited scheduling availability and provider time constraints make consistent adherence difficult, although progress is being made toward full integration. Another emphasized the importance of balancing necessary mental health follow-up with the realities of brief primary care visits. These concerns align with Simon et al. (2024), who highlight that logistical challenges often hinder longitudinal depression management in outpatient care settings.

3. Anticipated Barriers to Implementation

The most commonly cited barriers included:

- Time constraints during visits
- Training gaps in behavioral health and PHQ-9 administration

- Patient frustration with perceived repetition of questions

To address these challenges, reviewers suggested targeted provider education, EHR streamlining, and incorporating mental health topics into routine patient conversations. These suggestions are supported by Bansal et al. (2025), who found that consistent engagement and structured reinforcement improve depression outcomes over time.

4. Cultural and Inclusive Communication

Two reviewers agreed the CPG offered general inclusivity, but pointed out that PHQ-9 items may lack cultural nuance or be perceived as too broad. One recommended guided interpretation of questions to reduce confusion, especially for patients from diverse backgrounds. This aligns with Niarchou et al. (2024), who emphasized that cultural responsiveness and addressing perception-related barriers can improve patient adherence to depression care plans.

5. Support for Collaborative Care and Interprofessional Communication

Respondents highlighted the importance of strengthening team-based care models and offered suggestions such as:

- Shared EHR notes between providers
- Joint training across disciplines
- Routine interprofessional huddles

Such practices have been identified in the literature as high-impact strategies for improving depression management and care coordination (Núñez et al., 2024; Simon et al., 2024).

6. Suggestions to Improve CPG Utility in Meeting the 13.6% National Benchmark

All three reviewers recommended actionable strategies, including:

- Built-in EHR alerts for PHQ-9 reassessments
- Culturally sensitive patient education materials
- Motivational interviewing techniques to support long-term engagement

One reviewer emphasized the need to modify PHQ-9 questions to better reflect the lived experience of individuals with clinical depression. These recommendations are directly supported by Bondesson et al. (2022), who found that improved patient engagement and follow-up tracking correlate with enhanced remission outcomes in outpatient depression care.

In summary, the end user feedback confirmed that the CPG was well-received, clinically relevant, and strategically positioned to enhance depression remission outcomes. While some adjustments are needed to optimize real-world implementations such as improved staff training, cultural tailoring, and EHR automation—the CPG remains feasible, scalable, and evidence-based. All three end users endorsed the guideline for implementation, with two suggesting specific enhancements to strengthen practice alignment.