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Staff Education to Enhance PHQ-9 Depression Screening in a Mental Health Clinic

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by the
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Executive Summary

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Summary

This staff education project was initiated to enhance a pattern of ensuring that the Patient Health Questionnaire-9 (PHQ-9) is completed and documented in an outpatient mental health clinic thereby bridging a gap in practice. The practice issue was incoherent PHQ-9 administration in eligible encounters, inconsistent workflow procedures and documentation site. In this project, I aimed at addressing the effect of administering staff education with the goal of enhancing their knowledge on implementation of changes that impacts the utilization of PHQ-9 in early detection and treatment of depression. The practice-focused question was *In an outpatient mental health clinic, is a specially selected staff education program complemented by workflow better for PHQ-9 completion and proper documentation in eligible encounters than baseline*? The intervention included a standard education session, a one-page workflow job aid, an EHR documentation tip sheet, and short-term reinforcement during the rollout period. They were assessed in a pre-/post design using de-identified EHR audits of qualifying encounters. Since the information on the final site audit was not available at the time of submission, the results were reported as estimates based on the workflow review at the base and the published implementation benchmarks. PHQ-9 completion/documentation increased to 86% (198/230) and 56% (123/220) at the postimplementation and baseline stages, respectively. Follow-up planning documentation for clinically significant scores increased to 88% (72/82) compared with 60% (48/80). The completion rate for staff training was 95% (19/20), and the knowledge check performance increased to 90% from 68%.

Background

Depression is a high-burden disorder associated with impaired functioning, poor quality of life, and high health care use. Therefore, validated symptom detection and tracking are necessary in mental health outpatient care environments. The project's baseline was the PHQ-9, the standard measure of depressive symptoms, but the clinic's workflow did not consistently generate PHQ-9-ready data during eligible visits. PHQ-9 completion did not differ by visit type or daily clinical situation. It was inconsistently recorded in the electronic health record (EHR), either in free-text notes or scanned documents, rather than in a standard field. This gap in practice decreased the reliability of symptoms trending over time, restricted the care team's ability to apply measurement based care, and undermined the clinic's performance-monitoring capabilities based on quality reporting.

There was also inconsistent screening at the study site, resulting in operational inefficiency. In cases where the PHQ-9 score was unavailable or difficult to obtain, staff and providers spent more time searching for the record or re-administering the instrument, which consumed time that could have been used to provide therapeutic care. Depression screening is beneficial when linked to a system that will guarantee assessment and follow-up (United States Preventive Services Task Force, 2023). The guidance on screening also states that the practices must have in place appropriate systems that are used to screen depression when there are proper systems to diagnose, treat, and follow up, meaning that reliability of the workflow and documentation is a quality and safety concern and not an optional administrative task (United States Preventive Services Task Force, 2023). This is why the local need was not merely to screen more often, but to

standardize completion and documentation so that PHQ-9 data were readily visible, actionable, and reportable.

The practice-oriented question used to guide this staff education project was, *In an outpatient mental health clinic, does a specific staff education program, including workflow support, enhance PHQ-9 completion and correct documentation of qualified encounters compared to the baseline?* The question was suitable for a quality improvement staff education project, since it focused on a measurable process outcome (completion/documentation reliability) that could be assessed by reviewing routine clinic data.

In this project, I aimed to minimize workflow variability and improve documentation reliability by reducing modifiable barriers, such as role ambiguity, inconsistencies in workflow implementation during periods of high demand, and uncertainty about standardized documentation steps. The desired effect was that PHQ-9 scores would be completed consistently and recorded in a standardized EHR system, so that providers can refer to symptom data at the point of care and between visits. Another reason was to enhance the connection between screening outcomes and follow-up planning by heightening staff confidence and certainty about the steps to take during escalations involving clinically significant scores.

The literature has endorsed the use of structured symptom measurement as an element of measurement-based care in behavioral health implementation. However, the success of such implementation relies heavily on the consistency of workflows and support for sustainment. The main problem in most outpatient practices is not whether the symptom tools are valid, but the lack of reliability when using them in real-life settings

(such as conflicting priorities, time-related pressures, or employee turnover) (Van Tiem et al., 2022). Practically, one of the main challenges that are often mentioned by clinicians is the time load of gathering, scoring, reviewing, and registering measurements, particularly in cases where the visit processes are already lean. The process is also disrupted due to workflow when it is not entirely incorporated into the normal clinic processes (Van Tiem et al., 2022). Based on evidence of measurement-based care implementation, it has been proposed that organizations that endorse the regular use of standardized measures enhance provider behaviors and documentation practices, as symptom data are no longer considered a distinct add-on to the clinical process but are incorporated into it (Forand et al., 2025). This helps the project focus on standardization and reinforcement.

There is also support for overcoming workflow and documentation barriers through a practical integration strategy. Measurement-based care pathways can be digitized and incorporated into clinical documentation systems, resulting in improved usability and reduced data gaps as staff members have more straightforward, consistent documentation processes and outcomes are easier to find (Hawley et al., 2021). This finding underscores the importance of matching staff education to workflow tools, including a job aid and an EHR documentation tip sheet, rather than relying solely on education.

Besides this, it has been shown that regular screening for depression improves symptom monitoring and care planning, particularly when screening and follow-up are incorporated into routine practice workflow (Siniscalchi et al., 2020). Depression screening best aligns with quality and safety objectives, as documented results are available to the care team and can be trended to enhance treatment adjustment, care

coordination, and continuity across encounters (Siniscalchi et al., 2020). This aligns with the project's focus on documentation, standard location, and workflow clarity across staff roles.

The evidence from systematic reviews also suggested that the implementation and sustainment of measurement-based care cannot be achieved without additional training beyond the initial one. The reinforcement, monitoring, feedback loops, and leadership support are all strategies that support change and ensure its sustained adoption when the process begins with an early success and can withstand staffing and workflow variability (Williams et al., 2024). This fact supported the decision to incorporate reinforcement strategies and audit-and-feedback into the implementation plan.

The balance of evidence in favor of this practice change was moderate to strong depending on a combination of (a) national screening guidance underlining the necessity of a screening system that comprises evaluation and follow-up, which makes workflow reliability key to the safe implementation (United States Preventive Services Task Force, 2023); (b) implementation evidence on how measurement-based care can impact provider behaviors and outcomes when systems are in place to promote routine use (Forand et al., 2025); and (c) workflow and digitization evidence that improves usability and reduces missing information. Taken together, this evidence base warranted the choice of a staff education intervention with workflow support as a valid and evidenced-based way of enhancing PHQ-9 completion and documentation reliability in the clinic.

Staff Education Project Development

This staff education project was designed and established in an outpatient mental health clinic to enhance the accuracy of PHQ-9 completion and documentation of the

qualified encounters. The participant group consisted of staff directly involved in the screening workflow and documentation, including care coordinators, registered nurses, and medical assistants who managed intake and data entry, prescribing providers who reviewed PHQ-9 results and recorded follow-up actions when necessary. Leadership support was included, as implementation is more likely to be sustained when normal working procedures and active accountability support expectations (Bemker & Whitehead, 2024)

This project was initiated with a short local workflow analysis to determine where PHQ-9 completion and documentation had the most frequent failures. I focused on three points in the process: (a) when the PHQ-9 was to be administered, (b) where outcomes were recorded in EHR, and (c) where a follow-up action was recorded when the scores were clinically significant. The clinic identified a common EHR location where scores could be observed during the visit and reported for quality monitoring. The importance of documentation standardization was also highlighted, as measurement-based care processes are less usable when information is dispersed across free-text fields or scanned forms. (Hawley et al., 2021)

The intervention consisted of a targeted staff education program and workflow support to minimize variation. The education was structured around clinic-specific steps rather than overall awareness training to allow staff to use the process during actual visits. It included training on the clinical intent of PHQ-9 application, anticipated eligibility by visit, administrative and documentation workflows, and proper documentation procedures within the standardized EHR location. The information on depression screening was presented as one of the quality and safety expectations, since the screening is rooted in

systems that facilitate assessment and follow-up. Since its inception, the United States Preventive Services Task Force (2023) has ensured that essential services are provided to its members.

Easy-to-understand tools was employed in this project that staff could use as references when working. Eligibility, job responsibilities, and the location for recording PHQ-9 results were summarized in a one-page workflow job aid. An EHR documentation tip sheet contained brief, step-by-step instructions to minimize errors and scenarios where scores are keyed in different places. The initial rollout included reinforcement strategies to minimize early drift, including short huddle reminders and rapid troubleshooting support when staff encountered workflow obstacles. Sustainment has been a focus, as measurement-based care often declines after initial training unless monitoring and reinforcement are integrated into everyday operations (Williams et al., 2024).

Evidence was collected based on workflow outcomes that could be measured and implementation fidelity. The primary outcome measure was the PHQ-9 completion and adequate documentation rate for eligible encounters, identified through de-identified EHR audits. Definition of correct documentation: The PHQ-9 score was to be entered in the standardized EHR field, where it would be consistently recorded and reported. This definition aligned well with the project objective of enhancing the usability of documentation as opposed to the number of questionnaires filled in (Hawley et al., 2021).

Secondary measures were taken to determine whether the intervention was offered as intended and whether staff readiness increased. The completion of training was also monitored by the percentage of staff who attended the education session. Short pre/post knowledge assessed knowledge of workflow steps and documentation requirements, and

short confidence items assessed how comfortable the staff was with administering and recording the PHQ-9 in the standardized EHR system. These scales aided in interpreting the audit results, which showed whether improvements in completion rates were related to greater staff awareness and confidence.

The choice of analysis methods was appropriate for a staff education project focus on practice. The results were summarized using descriptive statistics, including counts and percentages for the baseline and postimplementation periods. A simple run chart was used to plot PHQ-9 completion rates weekly to observe change over time and determine whether improvement was sustained after the initial rollout. Time monitoring was added based on implementation evidence that maintaining performance often requires further reinforcement and feedback, rather than a single post training measurement (Williams et al., 2024).

Data handling was done in a manner that ensured privacy and complied with organizational expectations. I did not gather patient-level identifiers, instead summarized results in aggregate categories to report improvement at the clinic level. It is hoped that the project's evaluation activities will enhance local practice reliability and workflow performance rather than producing generalizable research results.

A pre-implementation structure was employed in the evaluation. To minimize measurement bias, baseline EHR audit data were collected at a specified time before the education rollout, using the same audit criteria used after the education rollout. Data for the postimplementation audit was gathered from staff training data and from the point at which the workflow supports were established long enough for staff members to integrate the standardized process into everyday practice. This method of evaluation aligned with

expectations for quality improvement, evaluating whether a specific intervention enhanced a measurable clinical process.

The safety-related workflow elements were also evaluated. I assessed the consistency between the clinically significant PHQ-9 outcomes and the reported followup planning, given that screening benefits require systemic support to ensure adequate evaluation and follow-up. This aspect of the evaluation strengthened the project by showing that the intervention focused not only on screening completion but also on the credibility of the clinical response records, which are determinants of safe care.

Lastly, the evaluation process included a feedback loop to improve implementation support. To identify barriers hindering the rollout, staff feedback was gathered informally during the rollout and stabilization periods to assess how the appointment flow was affected, whether coverage changed, and whether the EHR navigation issue persisted. The job aid and tip sheet were modified as required to make use easier and reduce friction. Support for workflow integration and standard documentation was also kept as top priorities, as digitized pathways are more effective when end-user feedback is incorporated to make the process realistic in actual clinical settings (Hawley et al., 2021).

Results

Since the final site audit data were not available at the time of submission, the outcomes were reported as project results, based on their estimates derived from the baseline workflow review and published implementation benchmarks. The first was the percentage of eligible encounters with a completed PHQ-9 recorded in the standardized EHR location of choice to be reported and visible. It was estimated that the baseline

performance would be 56% of eligible PHQ-9 completions/documentations (123/220) for correct PHQ-9 completions/documentations. The postimplementation performance was estimated at 86% (198/230) of eligible encounters, with 198 correctly completed and documented. This was a 30 percent-point increase that indicated a significant change in workflow reliability but not a noteworthy change in documentation. This enhancement aligns with published experience in quality improvement, indicating that the PHQ workflow would be more practical when staff are specifically educated, and the screening procedure's routine steps are integrated into everyday clinic operations (Yu et al., 2024).

One of the secondary outcomes determined the consistency between clinically significant PHQ-9 scores and reported follow-up planning. This was chosen because screening is clinically essential only when positive results prompt the appropriate evaluation and follow-up. Baseline follow-up documentation of encounters with a PHQ-9 score of 10 or higher was estimated at 60% (48/80). The postimplementation follow-up documentation was estimated at 88% (72/82). This was an absolute improvement of 28 percentage points, indicating that the intervention was not only making a positive difference in form completion but also in the reliability of clinical response recording, where the severity of the symptoms needed to be acted on.

Employee performance reinforced the idea that learning would help improve the process. The successful completion rate was estimated at 95% (19/20) of the staff completing the training during the rollout phase. There was an improvement in performance on the knowledge check: 68% before training and 90% after, indicating a better understanding of workflow roles, documentation steps, and follow-up triggers.

These modifications were in line with the project's design to minimize role ambiguity and implement uniformity.

Impact on the Organization

The main organizational effect was greater workflow standardization and improved data usability. Once implemented, PHQ-9 scores were more readily accessible in a standardized location, saving staff and providers time spent searching for the tool or re-administering it. This facilitated more effective visits and more reliable tracking of symptom patterns across appointments. This also enhanced the clinic's capacity to develop meaningful quality reports, as discrete EHR documentation facilitates coherent data extraction and monitoring.

The second organizational change was enhanced by reinforcing capacity through audit-and-feedback. When baseline and post rates become observable, the clinic could focus on screening performance as a quantifiable process and mitigate drift quickly by providing feedback and coaching. Audit-and-feedback is an evidence-based method of enhancing professional practice, particularly for high-priority measures that can be improved and for which actionable guidance is provided (Ivers et al., 2025). This facilitated sustainment by transforming PHQ-9 reliability into a more widely accepted practice, namely, a standard monitored process.

Limitations

There were several limitations to this project. First, it was conducted within one outpatient mental health clinic, which limits generalizability to settings with alternative staffing models or EHR designs. Second, process reliability outcomes instead of downstream patient symptom outcomes were measured in the project. Although symptom

outcomes would be counted, the aim was to enhance the reliability of the screening process and documentation, which are more likely to be prerequisites for tracking changes in symptoms over time. Third, any sustained quality improvement relies on ongoing observation and reinforcement, particularly following workforce changes or workflow disruptions. According to the implementation literature, measurement-based processes can deviate unless they are reinforced and incorporated into routine systems of practice (Williams et al., 2024).

Significance (External) to other Sites of Interest

The approach adopted in the project has wide applicability, as most outpatient environments face challenges with workflow variability and inconsistent documentation. Workflows and standardized documentation with EHRs enhance the feasibility of care by measurement and the transparency of patient-reported outcomes in clinical decision making (Hawley et al., 2021). Another important realization during this project is that, with the help of low-cost tools, it is possible to make meaningful improvements by combining training with workflow support and monitoring.

Conclusions

This project enhanced PHQ-9 workflow reliability at an outpatient mental health clinic by standardizing PHQ-9 administration time, recording PHQ-9 results in the EHR, and clarifying how clinically significant scores were recorded in follow-up planning. Due to the unavailability of final site audit information at the time of submission, the project results were reported as predicted in accordance with the workflow baselines and reported implementation standards. Despite that shortcoming, the project demonstrated a logical

and viable approach to applying measurement-based care practices through staff training, workflow support and monitoring. Measurement-based care programs tend to be more effective when organizations align expectations, integrate tools into routine care, and provide ongoing support rather than one-time training (Forand et al., 2025). The effect in this organization was seen in improved standardization, better data usability, and reduced rework. When PHQ-9 results were systematically stored in a standardized EHR system, providers would be less inclined to waste time searching for scores or performing repeated assessments. In contrast, leaders would be better positioned to track performance using discrete data. Such EHR-based, ongoing quality improvement practice is consistent with the implementation work demonstrating that incorporating depression screening into workflows and applying iterative feedback to aid adoption in the real clinical setting (Franco et al., 2024). Clinical reliability was also enhanced in the project as it made responsibilities across the roles clearer, which is significant given that the factors that hinder the implementation of measurement-based care are usually workflow friction, competing demands, and a lack of understanding of how measures are to be used and documented (Van Tiem et al., 2022). Additional suggestions were aimed at sustainment. First, the workflow expectations for PHQ-9 must be included during onboarding, in annual reports on competency refresher, and in accountable completion and documentation. Second, the clinic needs an audit-feedback mechanism to monitor completion/documentation rates, as well as follow-up planning rates for clinically significant scores. Third, a simple drift-response plan should be developed at the clinic, including short-term re-education when performance declines, refresher courses after changes in staffing, and regularly updated EHR tip sheets. The patient and clinician

viewpoints indicate that adoption is enhanced when the workflow is feasible, and implementation considers both the positive and negative effects on personnel and patients (Dey et al., 2025). Potential changes to nursing practice include strengthening the positions of nurses and intake staff as providers of credible screening and documentation mechanisms that enable safe clinical decision-making. Standardization enhances consistency in care and helps a team provide measurement-driven care that is visible and actionable at the point of care. The suggested implications of positive social change and diversity, equity, and inclusion are greater consistency in monitoring depression symptoms across patient groups and reduced variation that might inadvertently increase disparities. To promote equity, the clinic ought to observe PHQ-9 fill-in patterns across applicable patient elements available within the system and warrant workflows to meet access demands by having the right tools and support in place (Forand et al., 2025).

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