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## **Executive Summary: Executive Leadership System Improvement Improving Depression Screening and Follow Up Processes**

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# Walden University

College of Nursing

This is to certify that the doctoral study by

Rebecca Hidalgo Salomon

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.

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Walden University

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Executive Summary: Executive Leadership System Improvement

Improving Depression Screening and Follow-Up Processes

by

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MSN, University of San Francisco, 2013

Executive Summary Submitted in Partial Fulfillment

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## **Introductory Summary**

Depression remains a significant public health burden in the United States, contributing to disability, healthcare utilization, and economic cost. Internal 2024 audits at the project site identified variability in Patient Health Questionnaire-9 (PHQ-9) screening and follow-up processes, with 68% of screenings completed, 55% of follow-ups timely, and disparities among patients with limited English proficiency. These findings indicate a systems-level reliability and equity gap. This executive leadership system improvement project focused on developing a standardized, nurse-led, electronic health record-supported workflow to improve PHQ-9 completion and timely follow-up. The practice-focused question asked how a nurse-led, EHR-enhanced workflow improves the reliability of screening and follow-up in outpatient psychiatric and primary care settings. The project was guided by the Johns Hopkins evidence-based practice model. Evidence supports multicomponent interventions that combine workflow standardization, EHR-integrated clinical decision support, and culturally responsive communication to improve depression care processes. Expected outcomes include improved screening and follow-up rates, enhanced care coordination, and reduced disparities. Organizational alignment is summarized in Appendix A, the logic model is presented in Appendix B, team roles and communication pathways are outlined in Appendix C, implementation planning is detailed in Appendix D, the budget is presented in Appendix E, and the evaluation plan is presented in Appendix F.

## **Background**

### **Problem**

The project site organization identified inconsistent and inequitable PHQ-9 screening and follow-up processes. Although screening is routine, completion, documentation, and follow-up vary, and positive results do not reliably trigger timely evaluation, treatment, or coordinated follow-up. This reflects a system-level gap rather than an individual performance gap. Without a standardized workflow, follow-up responsibility is diffuse, increasing delays, missed referrals, and fragmented care. These gaps disproportionately affect patients with limited English proficiency (Garcia et al., 2022; Twersky et al., 2024). Screening without reliable follow-up reduces clinical value and conflicts with national recommendations requiring systems to ensure diagnosis, treatment, and monitoring (U.S. Preventive Services Task Force [USPSTF], 2023).

### **Purpose, Goals, Project Outcomes**

I developed a leadership-informed, evidence-based approach in this executive leadership project to improve PHQ-9 process reliability, consistency, and equity through a standardized nurse-led, EHR-enhanced workflow. The goals are to reduce process variability, improve follow-up reliability, and address disparities affecting patients with limited English proficiency. Target outcomes include 90% screening completion, 85% follow-up within 14 days, and at least a 50% reduction in disparity gaps. These outcomes reflect the intended transition from variable processes to engineered reliability supported by standardized workflows and EHR integration.

### **Supportive Data**

Internal data demonstrated 68% screening completion and 55% follow-

up within 14 days, indicating low reliability. Disparities are most pronounced among multilingual populations. External data confirmed depression as a leading contributor to morbidity and cost (Brody & Tarver, 2025; Centers for Disease Control and Prevention, 2025; Greenberg et al., 2021). Patients with limited English proficiency experience lower follow-up rates and reduced access to treatment (Garcia et al., 2022; Twersky et al., 2024). These findings support the need for a standardized, equity-focused system and highlight the risk of perpetuating disparities without intentional redesign of workflows.

### **Key Literature**

Evidence supports standardized workflows, EHR-integrated decision support, and team-based care to improve screening reliability and follow-up adherence (Blackstone et al., 2022; Last et al., 2021; USPSTF, 2023). National guidance has emphasized that screening must be paired with systems ensuring diagnosis, treatment, and continuity of care, with nurses playing a central leadership role (American Association of Colleges of Nursing, 2021; American Nurses Association [ANA], 2022). Studies have proven that EHR prompts, task routing, and structured documentation improve follow-up adherence and reduce missed opportunities for intervention (Franco et al., 2024; Kim et al., 2025). Evidence has also shown that screening without equity-focused follow-up may worsen disparities, reinforcing the importance of culturally responsive and language-access-integrated care models (Garcia et al., 2022).

### **Organizational Need to Be Addressed**

The organizational need is for a reliable, equitable system to ensure timely follow-up after positive screening. Current workflows do not consistently convert

screening results into clinical action, limiting effectiveness and exposing patients to preventable delay. From an executive perspective, screening without dependable follow-up undermines quality, patient experience, and performance under value-based frameworks (USPSTF, 2023). Addressing this gap is essential to ensure that screening translates into meaningful clinical outcomes rather than isolated documentation.

### **Data Supporting the Significance of the Issue**

Internal data confirmed low reliability in screening and follow-up. Disparities among patients with limited English proficiency increase the urgency of addressing this issue. External evidence supports these findings and reinforces the need for system-level intervention (Garcia et al., 2022; Twersky et al., 2024). Effective approaches include standardized workflows, EHR prompts, task routing, proactive outreach, and team-based accountability (Blackstone et al., 2022; Franco et al., 2024; Kim et al., 2025). Nurse-led models improve adherence by clarifying roles and reducing reliance on informal processes (Last et al., 2021). Equity-focused design is essential to prevent widening disparities and requires integration of language access and culturally responsive communication (Garcia et al., 2022).

### **Initial Stakeholders and Relevant Expertise**

Stakeholders include nursing leadership, psychiatry and primary care clinicians, informatics specialists, quality leaders, language access representatives, and executive leadership. These groups contribute expertise in workflow design, clinical care, EHR functionality, and equity integration. Early stakeholder engagement supports feasibility assessment, interdisciplinary alignment, and identification of potential implementation barriers prior to operational investment.

**Organizational Readiness to Change**

Readiness is moderate to high, supported by existing EHR infrastructure and quality monitoring systems. Constraints include competing priorities, staffing limitations, and workflow burden. A staged approach supports feasibility assessment before implementation and aligns with best practices in change management by minimizing disruption while evaluating organizational capacity.

**Logic Model**

Inputs support workflow standardization, EHR optimization, training, and monitoring, resulting in a standardized process with improved screening, timely follow-up, and reduced disparities. A detailed logic model is provided in Table 1 and Appendix B.

**Table 1***Logic Model for Project Development to Improve Depression Screening Follow-Up*

Inputs	Activities	Outputs	Anticipated outcomes (perceptual/leadership-focused)
Executive leadership support Nursing leadership expertise Existing electronic health record infrastructure, evidence-based depression screening guidelines Internal audit data, Community-level behavioral health data	Review and synthesize current-state PHQ-9 screening and follow-up processes Analyze internal and community-level data to define the practice gap Review and summarize supporting literature Develop a conceptual standardized follow-up workflow Assess conceptual alignment with existing EHR capabilities	Evidence-informed business proposal, Conceptual standardized workflow model, Logic model framework Leadership-facing summary materials	Improved leadership understanding of current practice gaps Increased clarity regarding feasibility and organizational fit. Enhanced leadership confidence in the proposed approach, Leadership review and acceptance of the proposal

*Note.* This illustrates proposed relationships among inputs, planning activities, outputs, and anticipated leadership-level outcomes.

**Alignment to Organization**

The project aligns with organizational priorities, emphasizing patient-centered, equitable, and value-based care. The standardized workflow improves care integration, reduces fragmentation, and embeds accountability and measurable outcomes into routine practice, strengthening quality performance and reporting readiness (see Centers for Medicare & Medicaid Services [CMS], 2024). Organizational mission, vision, and values alignment are summarized in Appendix A.

**Potential Risks and Benefits**

Risks include feasibility constraints, stakeholder resistance, workflow burden, alert fatigue, and potential mismatch between increased screening and behavioral health

capacity. Inaction perpetuates variability and inequities. Benefits include improved reliability, alignment with quality frameworks, and proactive leadership decision-making. Financial modeling projects a 210% return on investment (see CMS, 2024; Greenberg et al., 2021). Additional benefits include improved patient outcomes, enhanced care coordination, reduced avoidable utilization, and strengthened documentation and reporting accuracy.

### **Impact on the Organization**

The project provides an evidence-based roadmap to address a defined care gap. The project strengthens infrastructure by clarifying roles, improving accountability, and increasing transparency through measurable metrics. Embedding reliability within workflow design supports sustainability, scalability, and adaptability to evolving regulatory and reimbursement demands.

### **Contribution to Social Change, Diversity, Equity, and Inclusion**

The project advances equitable depression care through nursing-led systems design. The project prioritizes accessibility, continuity, and culturally responsive communication to improve outcomes and reduce disparities (see ANA, 2022). Equity is embedded within workflow design through interpreter integration and stratified monitoring, ensuring improvements do not widen disparities.

### **Implementation Planning**

Implementation planning included stakeholder engagement, workflow analysis, workflow standardization, and operational model development. Stakeholders provided interdisciplinary input to ensure alignment with organizational priorities. Roles and communication pathways are outlined in the Team Charter (Appendix C), and the phased

implementation plan is outlined in Appendix D. Additional planning considerations include identifying workflow integration points within existing clinical processes, assessing documentation burden, and aligning proposed changes with staffing models. Early engagement of frontline staff supports feasibility and reduces resistance by incorporating user-centered design principles. Communication strategies emphasize transparency, role clarity, and iterative feedback to support adoption and sustainability.

### **Accreditation Standards**

The project aligns with USPSTF (2023) and ANA (2022) guidance requiring systems to support diagnosis and follow-up. Regulatory considerations include privacy, documentation standards, and alignment with scope of practice. Alignment with accreditation and quality standards strengthens the organization's ability to meet external expectations related to depression screening and follow-up performance. Standardized documentation and workflow processes support compliance with quality reporting requirements and enhance audit readiness. Integration with CMS (2023, 2024) quality measures further reinforces the organization's alignment with national performance benchmarks and value-based care initiatives.

### **Project Outcomes**

Expected outcomes include improvements in screening completion from 68% to 90% and in follow-up within 14 days from 55% to 85%. Financial modeling projects an annual benefit of \$19,235 against an implementation cost of \$6,212, yielding a 210% return on investment (see Appendix E). Equity outcomes include at least a 50% reduction in the screening and follow-up disparity gap for patients with limited English proficiency (see Appendix F). Additional evaluation indicators include screening rates,

follow-up adherence, workflow compliance, and stratified equity measures, with ongoing monitoring proposed to support sustainability and mitigate unintended operational impacts.

### **Summary**

In this executive leadership system improvement project, I evaluated variability and inequities in depression screening follow-up within an outpatient psychiatric and primary care setting and developed a systems-level plan to address them. The practice problem involved inconsistent PHQ-9 screening completion and follow-up, resulting in reduced care reliability and disparities among patients with limited English proficiency. The project question examined whether a nurse-led, EHR-enhanced workflow improves screening completion and timely follow-up.

Analytical strategies included internal data analysis, workflow mapping, literature synthesis, and application of an evidence-based practice model to design a standardized, system-level intervention. The resulting intervention design integrates structured documentation, automated prompts, task routing, and escalation protocols to improve reliability and accountability. Implementation planning incorporated EHR configuration, competency-based training, and governance oversight. Financial modeling projected a positive return on investment through improved follow-up completion and alignment with value-based performance measures. The evaluation plan includes process, outcome, equity, and financial metrics with continuous monitoring parameters.

This project demonstrates the executive feasibility and organizational value of standardized workflows and informatics integration to improve care coordination, reduce disparities, and strengthen alignment with quality and equity priorities.

Implications for nursing practice include expanded leadership in systems design, care coordination, and population health improvement.

### **New Technology**

In this project, I planned the use of existing EHR infrastructure with enhancements, including structured documentation fields, automated prompts, task routing, escalation triggers, and reporting dashboards. (see Franco et al., 2024; Kim et al., 2025). No new hardware is required. Training focuses on workflow adoption, documentation accuracy, and interpreter-supported outreach. Alert fatigue is a potential risk and is mitigated through streamlined design and ongoing monitoring. Costs associated with configuration, reporting development, and training are included in Appendix E. Additional considerations include user acceptance testing, iterative refinement of decision support tools, and alignment of dashboards with leadership performance review processes.

### **Regulatory, Legal, and Union Issues**

The project complies with patient privacy, documentation, and scope-of-practice requirements. Escalation protocols align with established safety standards (see USPSTF, 2023). Quality reporting aligns with CMS (2024) measures for depression screening and follow-up. Workflow standardization requires clear role delineation and proactive communication with leadership to mitigate perceived task shifting. Additional considerations include ensuring alignment with labor agreements and maintaining adherence to professional standards. Ongoing monitoring of compliance and documentation practices supports regulatory adherence and patient safety.

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**Appendix A**

**Organizational Alignment**

**Appendix B**

**Logic Model Framework for Change**

**Appendix C**

**Team Charter**

**Appendix D**

**Detailed Implementation Plan**

**Appendix E**

**Budget Plan**

**Appendix F**

**Evaluation Plan**

## **Appendix A: Organizational Alignment**

### **Organizational Mission Alignment**

The organization provides outpatient psychiatric and primary care services to a diverse community, emphasizing accessible, patient-centered behavioral health care. This project aligned with that mission by evaluating current depression screening and follow-up processes and developing an evidence-informed framework to strengthen reliability, equity, and continuity of care.

### **Organizational Vision Alignment**

The organization's vision emphasizes integrated, equitable, and high-value care. This project supported that vision by using internal data, evidence-based guidance, and workflow analysis to design an improved depression screening follow-up process. Its focus on consistency, timely responses, and reducing inequities aligns with broader organizational goals for coordinated, patient-centered care.

### **Organizational Values Alignment**

This project reflects core organizational values through:

- **Patient-Centeredness:** Emphasizing continuity and clarity in follow-up processes
- **Equity:** Identifying disparities and incorporating culturally responsive considerations
- **Accountability:** Promoting standardized, clearly defined workflow processes and measurable performance expectations
- **Collaboration:** Engaging interdisciplinary stakeholders throughout
- **Quality Improvement:** Applying evidence-based frameworks to support executive decision-making

## **Appendix B: Logic Model Framework for Change**

### **Scope Statement**

This appendix describes the change theory for the implementation of a standardized nurse-led, electronic health record-supported PHQ-9 depression screening and timely follow-up workflow in outpatient psychiatric and primary care settings. It aligns with the Appendix D Detailed Implementation Plan, the Appendix E Budget Plan, and the Appendix F Evaluation Plan.

### **Problem Statement**

Current PHQ-9 screening and follow-up processes exhibit reliability gaps and inequitable performance: baseline screening completion is 68 percent, and documented follow-up within 14 days is 55 percent, with disparities affecting patients with limited English proficiency.

### **Aim**

Improve reliability and equity of depression screening and follow-up through a standardized nurse-led workflow with electronic health record decision support, closed-loop tracking, and executive governance.

### **Inputs**

- Executive sponsorship and governance support from nursing operations and executive leadership
- Lean interdisciplinary team capacity and routine huddle cadence
- Existing electronic health record infrastructure and informatics build time
- Baseline internal audit data and operational performance data
- Evidence-based standards and guidance for depression screening with follow-up

systems in place (USPSTF, CMS Quality Measure 134)

- Language access workflows and interpreter resources
- Training time and workflow job aids
- Budgeted resources for configuration, reporting infrastructure, and materials as specified in Appendix E

### **Core Activities**

- Governance activation, workflow mapping, defect identification, and redesign of screening to follow-up pathway
- Electronic health record hardwiring, including structured fields, prompts, routing logic, escalation pathways, and closed-loop follow-up confirmation
- Workforce activation through competency-based education, role clarity, and standard work adoption
- Performance monitoring with monthly formative review and rapid cycle correction using defect logs and root cause analysis
- Equity stratification of measures by language status, with interpreter integration prompts and culturally responsive outreach scripts
- Sustainment planning with dashboard integration, ownership assignment, and ongoing review cadence

### **Outputs**

Deliverables that operationalize change

- Standardized workflow algorithm from screening through follow-up completion
- Electronic health record templates, required documentation prompts, and task routing logic for positive screens

- Escalation protocol for high-risk PHQ-9 findings and suicidal ideation pathways
- Standardized outreach scripts and documentation templates, including language access considerations
- Executive dashboard specifications and validated reporting logic for screening, follow-up, equity stratification, and financial surveillance
- Competency validation documentation and staff job aids
- Implementation plan artifacts in Appendix D, budget artifacts in Appendix E, and evaluation plan artifacts in Appendix F

## **Outcomes**

### Short-term outcomes during implementation stabilization

- Increased completion of PHQ 9 screening through standardized prompts and encounter workflow integration
- Increased documentation completeness and reduced omission of follow-up plan documentation
- Improved visibility of positive screens through routing and task completion tracking
- Improved reliability of risk escalation documentation for high-risk scores
- Early identification of operational impacts such as throughput change, no-show rate variation, and staff burden indicators

### Intermediate outcomes after workflow stabilization

- Screening completion improves from 68 percent baseline toward 90 percent target
- Documented follow-up within 14 days improves from 55 percent baseline

toward 85 percent target

- Reduced process fragmentation and clearer accountability across nursing, administrative, behavioral health, and clinician roles
- Equity gap reduction through stratified monitoring and interpreter-integrated workflow supports, targeting at least a 50 percent reduction in disparity gap for limited English proficiency populations

Long-term outcomes and sustainment

- Embedded governance and monitoring structures that maintain performance and prevent drift
- Financial benefit realization consistent with Appendix E modeling, with ongoing validation in Appendix F
- Reduced risk of missed follow-up and improved continuity of depression care aligned with evidence-based expectations that screening must include systems for diagnosis, treatment, and monitoring

### **Measures and Data Sources**

Process and reliability measures

- PHQ-9 screening completion rate
- Percentage of positive screens with documented follow-up within 14 days
- Percentage of high-risk scores with documented and time-appropriate escalation
- Documentation completeness in structured fields

Operational measures

- Visit throughput time compared to baseline
- No-show rate compared to baseline
- Task routing completion reliability

#### Equity measures

- Screening completion stratified by language status
- Follow-up compliance stratified by language status
- Interpreter utilization rate during screening encounters

#### Financial measures

- Incremental completed follow-up visits attributable to routing and outreach
- Recovered no-show encounters
- Avoided downstream cost signals where measurable

These measures are structured for formative monthly monitoring and summative pre-post outcome evaluation as specified in Appendix F.

### **Assumptions and Constraints**

#### Key assumptions

- Electronic health record build and reporting changes can be completed within the available informatics capacity
- Staff can complete competency training with minimal productivity disruption
- Follow-up appointment capacity and scheduling reliability can absorb increased detection and routing

#### Constraints and risks

- If follow-up access capacity does not scale with increased identification, screening gains can create backlog, dissatisfaction, or delayed care, reducing

clinical benefit and eroding projected financial return

- If alert design is excessive, alert fatigue can reduce adherence and documentation quality
- If equity monitoring is not acted on, standardized processes can preserve or worsen disparities

## **Appendix C: Team Charter**

### **Team Purpose**

The purpose of this team was to design and prepare for organizational implementation of a standardized, nurse-led, electronic health record-enhanced workflow to improve the reliability of depression screening and the timeliness of follow-up for adult primary care patients. The team was accountable for developing a systems-level model intended to increase PHQ-9 screening completion rates, improve documented follow-up within 14 days for positive screens, reduce disparities among patients with limited English proficiency, and align with quality performance and fiscal stewardship goals.

### **Team Structure & Roles/Responsibilities**

- Executive Sponsor and Primary Care Medical Director - Provides strategic oversight, ensures alignment with organizational priorities, approves resource implications, and removes system-level barriers. Evaluates fiscal impact, value-based care alignment, and potential cost avoidance. Advises on clinical feasibility, provider workflow integration, and alignment with primary care standards.
- Behavioral Health Lead - Guides follow-up protocol design, treatment initiation pathways, and care coordination standards.
- Nursing Leadership Representative - Leads workflow standardization, nursing role optimization, and staff engagement strategies.
- Health Informatics Specialist - Designs and optimizes EHR-based alerts, documentation templates, and reporting dashboards.

- Quality Data Analyst - Develops performance metrics, monitors screening and follow-up data, and conducts stratified equity analyses.
- Interpreter Services Representative - Advises on culturally responsive processes and integration of language-access workflows.

### **Team Processes**

Team Huddles: Biweekly operational huddles to review workflow development progress, address barriers, and assess emerging data trends.

Team Meetings: Monthly structured meetings to review performance metrics, equity stratification, financial considerations, and strategic alignment.

Team Decision-Making: Consensus-based decision-making for workflow design and protocol development. Executive sponsor retains final authority for strategic and financial decisions.

Team Communication: Documented meeting minutes, shared project dashboards, structured executive updates, and alignment with DNP Executive Summary reporting requirements.

Knowledge Exchange With Other Teams: Regular collaboration with population health, behavioral health integration, and quality improvement teams to ensure coordination and avoid duplication of initiatives.

### **Relationships**

Team Values: Equity, transparency, accountability, psychological safety, interdisciplinary collaboration, and fiscal responsibility.

Standards of Behavior (How We Work Together): Respectful and data-informed dialogue; shared accountability for outcomes; commitment to culturally responsive care; proactive identification of risks; adherence to agreed upon scope and timelines.

Decision Making: Evidence-informed and aligned with organizational strategy, quality performance frameworks, and regulatory standards. Disagreements will be addressed through structured discussion and, when necessary, escalated to the executive sponsor.

**Other Insights to Record in This Charter:**

The team acknowledges that internal audit data demonstrate 68 percent PHQ-9 screening completion and 55 percent documented follow-up within 14 days for positive screens, with disparities among patients with limited English proficiency. This charter prioritizes reducing variation and embedding equity monitoring through stratified reporting mechanisms. The team further commits to integrating financial analysis to ensure alignment with value-based reimbursement models and long-term sustainability.

## **Appendix D: Detailed Implementation Plan**

### **Project Goals**

1. Increase PHQ-9 screening completion to  $\geq 90\%$ .
2. Increase documented 14-day follow-up compliance to  $\geq 85\%$ .
3. Reduce LEP-related screening and follow-up disparity gaps by  $\geq 50\%$ .
4. Embed sustainable governance and monitoring structures into routine operations.
5. Achieve positive financial return relative to implementation cost.

### **Responsible Parties**

This initiative was planned within a lean interdisciplinary team structure consisting of:

- DNP Project Lead serving in Nursing Operations role
- Chief Executive Officer / Medical Director
- Administrative Manager
- Social Worker / Case Manager
- Therapists
- Nursing staff

Governance oversight was shared between Nursing Operations and Executive Leadership to ensure alignment with organizational priorities.

### **Phase I: Governance Activation and Current-State Redesign**

**Timeline: Week 1–2**

**Objectives**

- Conduct detailed workflow mapping of screening-to-follow-up processes.
- Identify breakdown points between screening, documentation, referral, and appointment completion.
- Define explicit escalation thresholds for moderate and high-risk PHQ-9 findings.
- Establish measurable performance targets aligned with national guidance (USPSTF; CMS Quality Measure 134).
- Develop initial equity stratification framework.

**Deliverables**

- Approved standardized workflow algorithm.
- Escalation protocol for suicidal ideation and high-risk scores.
- Defined documentation standards for follow-up action.
- Governance review confirmation.

**Phase II: EHR Hardwiring and Workflow Standardization****Timeline: Week 3–4****Objectives**

- Activate structured PHQ-9 documentation fields within eligible encounter templates.
- Embed required follow-up documentation prompts to reduce omission.
- Configure routing logic to ensure visibility of positive screens.
- Integrate interpreter-access reminders for LEP patients.

- Standardize documentation language for outreach attempts.
- Establish closed-loop confirmation process for follow-up completion.

### **Deliverables**

- EHR documentation template modifications.
- Structured routing logic for positive screens.
- Standardized outreach documentation template.
- Closed-loop follow-up tracking tool.

### **Phase III: Workforce Activation and Competency Validation**

#### **Timeline: Week 5-6**

### **Objectives**

- Deliver focused workflow education to nursing and clinical staff.
- Reinforce culturally responsive communication practices.
- Conduct competency validation using real-case simulation scenarios.
- Clarify cross-role sequencing for screening, outreach, scheduling, and confirmation.
- Establish documentation accuracy standards aligned with reporting requirements.

### **Deliverables**

- Education materials and workflow reference guide.
- Competency validation checklist.
- Updated role sequencing documentation.
- Training attendance verification.

## **Phase IV: Performance Monitoring and Rapid-Cycle Refinement**

### **Timeline: Week 7–8**

#### **Objectives**

- Monitor weekly PHQ-9 screening completion rates.
- Monitor 14-day follow-up compliance rates.
- Track adherence to high-risk escalation protocols.
- Stratify outcomes by LEP status and payer mix.
- Monitor depression-related no-show rates.
- Conduct structured root cause analysis for missed follow-up events.
- Evaluate revenue trends relative to projected ROI.

#### **Deliverables**

- Executive performance dashboard.
- Equity disparity trend report.
- Defect log with corrective action plans.
- Mid-cycle financial impact summary.

## **Phase V: Sustainability Integration and Governance Transition**

### **Timeline: Week 9**

#### **Objectives**

- Integrate PHQ-9 metrics into monthly leadership review agenda.
- Formalize monitoring cadence and escalation review process.

- Validate financial impact relative to projected 210% ROI.
- Define ownership of ongoing performance review.
- Establish performance drift thresholds triggering corrective review.

**Deliverables**

- Sustainability integration memorandum.
- Governance oversight framework.
- Preliminary ROI validation report.
- Annual reassessment recommendation.

## References

- Dang, D., Dearholt, S. L., Bissett, K., Ascenzi, J., & Whalen, M. (2021). *Johns Hopkins evidence-based practice for nurses and healthcare professionals: Model and guidelines* (4th ed.). Sigma Theta Tau International.
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- US Preventive Services Task Force, Barry, M. J., Nicholson, W. K., Silverstein, M., Chelmow, D., Coker, T. R., Davidson, K. W., Davis, E. M., Donahue, K. E., Jaén, C. R., Li, L., Ogedegbe, G., Pbert, L., Rao, G., Ruiz, J. M., Stevermer, J. J., Tsevat, J., Underwood, S. M., & Wong, J. B. (2023). Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement. *JAMA*, 329(23), 2057–2067.  
<https://doi.org/10.1001/jama.2023.9297>

## **Appendix E: Budget Plan**

### **Executive Financial Context**

The project site operates as a small outpatient psychiatric and primary care practice with limited operating margin and high dependence on visit-based reimbursement. In this environment, quality improvement initiatives must demonstrate fiscal prudence, minimal operational disruption, and measurable financial return. Unlike large academic health systems, small practices cannot absorb prolonged productivity loss, additional full-time equivalent staffing, or substantial capital investment without destabilizing operations.

This nurse-led, EHR-enhanced depression screening workflow was therefore intentionally designed as a low-capital systems redesign leveraging existing personnel, infrastructure, and documentation platforms. The DNP Project Lead's 160 practicum hours were included in the academic requirement and did not generate incremental salary expense for the organization. However, opportunity cost related to staff education, limited EHR configuration, reporting infrastructure, and workflow materials represents a direct financial impact and is transparently itemized below.

### **Staff Education and Competency Validation**

Four clinical staff members are anticipated to participate in structured education and competency validation sessions to ensure fidelity to the standardized workflow. Education will cover PHQ-9 administration, documentation standards, escalation protocols, equity considerations, and follow-up accountability.

Education time per staff member: 2 hours

Average visit revenue per clinical hour: \$89

Calculation:  $4 \text{ staff} \times 2 \text{ hours} \times \$89/\text{hour} = \$712$

This reflects lost billable productivity rather than additional payroll expenditure.

### **Electronic Health Record Configuration**

Targeted EHR modifications required to operationalize the intervention, including automated PHQ-9 prompts, structured follow-up documentation fields, escalation routing logic for high-risk scores, and reporting extraction fields.

Estimated internal informatics allocation: \$3,000

This cost reflects configuration within existing infrastructure rather than the acquisition of a new platform.

### **Data Reporting and Dashboard Infrastructure**

Reliable executive oversight require the development of structured reporting logic to track screening completion, 14-day follow-up compliance, equity stratification by language status, documentation completeness, and financial impact.

Estimated cost for build, validation, and dashboard deployment: \$2,000

### **Workflow Materials and Patient Communication Tools**

The development of standardized algorithms, escalation protocols, culturally responsive outreach scripts, and staff reference guides required minimal resources for material development.

Estimated cost: \$500

Total Direct Organizational Cost

Staff education opportunity cost: \$712

EHR configuration: \$3,000

Reporting infrastructure: \$2,000

Materials: \$500

Total Projected Implementation Cost: \$6,212

### **Financial Benefit Modeling**

Financial benefit in an outpatient model derives from five primary mechanisms: improved documentation-supported billing capture, increased completed follow-up visits, reduced no-show rates, avoided crisis-level emergency referrals, and stabilization of quality performance metrics relevant to value-based reimbursement frameworks.

Baseline assumptions are intentionally conservative to avoid overestimating projected returns. The clinic maintains approximately 1,200 active adult patients, with an estimated 300 eligible for PHQ-9 screening each year. Improved workflow reliability is projected to generate 75 additional documented follow-up encounters attributable to structured routing and accountability mechanisms.

#### Revenue From Additional Completed Follow-Up Visits

75 additional visits × \$89 average reimbursement = \$6,675

#### No-Show Reduction Revenue Recovery

Improved follow-up reliability and patient engagement are projected to reduce missed appointments by 40 visits annually.

40 visits × \$89 = \$3,560

#### Avoided Crisis-Level Emergency Referral Exposure

Depression left untreated increases acute utilization and crisis-level presentations (Greenberg et al., 2021). Conservative modeling estimates preventing five emergency referrals annually, with an estimated financial exposure of \$1,800 per event when

accounting for uncompensated care risk, coordination burden, and downstream utilization.

$$5 \times \$1,800 = \$9,000$$

Total Projected Annual Financial Benefit

\$6,675

\$3,560

\$9,000

Total = \$19,235

Return on Investment Calculation

$$\text{Net Benefit} = \$19,235 - \$6,212 = \$13,023$$

$$\text{ROI} = (\$13,023 \div \$6,212) \times 100 = 210 \text{ percent}$$

This indicates the initiative returns more than double its implementation cost within the first operational year.

Break-Even Analysis

Break-even threshold in visit terms:

$$\$6,212 \div \$89 = 70 \text{ additional completed visits}$$

Alternatively, preventing four emergency referrals would fully recover the implementation cost.

Payer-Mix Sensitivity Analysis

To account for reimbursement variability, a conservative scenario was modeled with average reimbursement reduced to \$70 per visit and emergency referral exposure reduced to \$1,200 per event.

75 visits  $\times$  \$70 = \$5,250

30 recovered no-shows  $\times$  \$70 = \$2,100

3 avoided referrals  $\times$  \$1,200 = \$3,600

Total conservative benefit = \$10,950

Net benefit = \$10,950 – \$6,212 = \$4,738

ROI = 76 percent

Even under pessimistic reimbursement assumptions, the initiative approaches cost neutrality while delivering measurable clinical and equity improvements.

### **Financial Outcome Indices for Ongoing Evaluation**

- Annual ROI percentage
- Net financial benefit
- Cost per improved follow-up case
- Revenue per additional completed follow-up visit
- Avoided emergency referral cost estimate
- Quality performance stabilization metrics

These indices will be reassessed annually to validate financial sustainability.

### **Executive Financial Conclusion**

With a total direct implementation cost of \$6,212 and a projected annual benefit of \$19,235, this initiative demonstrates strong financial stewardship in a small outpatient environment. The projected 210 percent ROI, combined with equity-focused performance improvement, supports sustained integration into routine clinical operations.

## **Appendix F: Evaluation Plan**

### **Evaluation Philosophy**

Evaluation must balance methodological rigor with operational feasibility. An overly complex analytics infrastructure would exceed the capacity of a small outpatient psychiatric and primary care practice. However, insufficient evaluation would undermine executive accountability, fiscal stewardship, equity oversight, and long-term sustainability.

This evaluation plan integrates formative and summative performance monitoring, financial validation aligned with projected return on investment, equity stratification, and operational risk surveillance. The framework reflects NURS 8515 executive leadership competencies in data-driven decision-making, systems performance oversight, resource stewardship, interprofessional governance, and strategic sustainability planning.

Evaluation is intentionally structured to ensure direct alignment between clinical reliability outcomes and the financial projections outlined in the Executive Financial Stewardship analysis. Clinical improvement without financial validation would weaken sustainability; financial return without equity and safety oversight would contradict organizational values and nursing leadership standards.

### **Formative Evaluation Measures**

Formative evaluation focuses on early detection of workflow breakdown, productivity disruption, documentation drift, and unintended financial erosion during implementation stabilization. Measures are intended to be collected monthly during the active implementation period and reviewed in leadership huddles.

### Clinical Reliability and Process Measures

- PHQ-9 screening completion rate
- Percentage of positive screens with documented follow-up within 14 days
- Percentage of high-risk PHQ-9 scores with documented and time-appropriate escalation
- Documentation completeness rate within structured EHR fields

### Operational Performance Measures

- Visit throughput time compared to baseline
- No-show rate compared to baseline
- Task routing completion reliability within the EHR
- Staff-reported workflow burden indicators

### Financial Surveillance Measures

- Monthly depression-related billed encounters
- Number of completed follow-up visits attributable to standardized routing
- Revenue trends compared to baseline quarter

### Equity Surveillance Measures

- Screening completion stratified by language status
- Follow-up compliance stratified by language status
- Interpreter utilization rate during screening encounters
- Follow-up completion among high-risk Limited English proficiency (LEP) patients

These measures enable rapid-cycle corrections and protect against productivity declines that could erode projected financial returns. Root cause analysis will be initiated for sustained deviation below the defined stabilization thresholds:

- Screening completion < 75 percent during transition phase
- Follow-up documentation < 65 percent
- No-show rate increase > 5 percent from baseline
- Visit throughput increase > 10 percent
- Escalation documentation failure in any high-risk case

Early executive review ensures workflow stabilization before financial or safety erosion develops.

### **Summative Evaluation Measures**

Summative evaluation assesses sustained clinical reliability, equity impact, operational stability, and financial performance following workflow stabilization.

#### Clinical Outcome Targets

Baseline screening completion: 68 percent

Target:  $\geq 90$  percent

Baseline 14-day follow-up compliance: 55 percent

Target:  $\geq 85$  percent

Disparity reduction target:  $\geq 50$  percent reduction in screening and follow-up gap between English-speaking and LEP patients

Additional outcome indicators include:

- Change in crisis-level emergency referrals
- Change in no-show rate
- Reduction in documentation variability

The effect size will be calculated using the absolute percentage improvement. Where sample size permits, chi-square analysis will evaluate the statistical significance of pre- and post-implementation changes in screening and follow-up compliance.

### **Financial Validation and ROI Monitoring**

Financial validation directly mirrors projections in the Executive Financial Stewardship analysis.

#### Projected Annual Targets

- 75 additional documented follow-up visits
- 40 recovered no-show visits
- 5 crisis-level emergency referrals prevented

Using the \$89 reimbursement model:

$75 \times \$89 = \$6,675$  incremental revenue

$40 \times \$89 = \$3,560$  no-show recovery

$5 \times \$1,800 = \$9,000$  avoided downstream exposure

Total projected annual benefit: \$19,235

Implementation cost: \$6,212

Projected net benefit: \$13,023

Projected ROI: 210 percent

The quarterly financial review will compare realized revenue and avoided exposure to projections. ROI will be recalculated annually. If the cumulative realized benefit falls

below 50 percent of the projected annual target by the mid-cycle review, structured workflow refinement and financial reassessment will be initiated.

Break-even performance will be reassessed using actual visit volume to confirm sustainability under real payer mix conditions.

### **Equity Evaluation Framework**

Baseline audit data demonstrate measurable disparity in screening and follow-up completion among patients with limited English proficiency. Executive accountability requires stratified reporting by language status, race when available, and payer category.

Equity evaluation includes:

- Absolute difference in screening rates between English-speaking and LEP patients
- Absolute difference in follow-up compliance rates
- Interpreter utilization rate during screening
- Depression-related visit completion stratified by payer mix
- Escalation timeliness for high-risk multilingual patients

A reduction in the disparity gap by at least 50 percent will be considered a clinically meaningful improvement. Persistence of disparity beyond two consecutive review cycles will prompt reassessment of interpreter workflow integration, outreach scripting, scheduling processes, and structural barriers affecting access.

Equity monitoring is embedded within routine governance reporting to ensure workflow standardization does not unintentionally perpetuate structural inequities. This approach reflects NURS 8515 leadership competencies in advancing social change through systems redesign and executive accountability.

## Executive Oversight and Sustainability

Evaluation findings will be reviewed during standing leadership meetings and integrated into ongoing quality dashboards. Sustainability will be defined as:

- Screening reliability  $\geq$  90 percent for two consecutive quarters
- Follow-up compliance  $\geq$  85 percent for two consecutive quarters
- Maintained ROI  $\geq$  100 percent after year one
- Demonstrated reduction in LEP disparity gap
- Stable visit throughput and no-show rates
- No increase in documented workflow burden beyond baseline tolerance

Embedding these measures within governance structures ensures the transition from a time-limited project to an operational standard of care.

### **Executive Evaluation Conclusion**

This evaluation framework integrates clinical reliability, financial stewardship, equity accountability, and operational stability into a unified executive monitoring structure. By aligning measurable outcomes with ROI projections and stratified equity reporting, the initiative demonstrates systems-level improvement consistent with executive nurse leader competencies and NURS 8515 expectations for implementation rigor and sustainability planning.

Rev.3/17/26

**Executive Leadership Checklist**

Student Name: Rebecca Hidalgo Salomon, MSN, RN  
 Project Title: Improving Depression Screening and Follow-Up Processes at Vista Psychiatry  
 Date: December 4, 2025

**Instructions:**

Complete the Introduction and Background Sections in NURS 8514.  
 Complete the Implementation Planning Section in NURS 8515.  
 Add the Summary to the end of your Final Draft in NURS 8515.

<b>Checklist Items 8514</b>	<b>Page Number/ Appendix</b>
<b>Introduction</b>	
Explain the impetus for a new program/change in the organization.	Pg. 1-2
Provide the data supporting that this was an issue for the organization, including both internal and external data.	Pg. 1-2
Summarize the purpose, goals, and projected outcomes.	Pg. 1-3
Note any risks and benefits to the organization and the organization’s readiness to change.	Pg. 1, Pg. 7-8
Summarize the required resources and return on the investment.	Pg. 1, Pg. 33-37, Appendix E
Summarize the contribution to social change, diversity, equity, and inclusion.	Pg. 1, Pg. 8
<b>Background</b>	
Explain the impetus for a new program/ change in the organization.	Pg. 2-3
Provide data this this is an issue of importance to the organization, including both internal data and community-level data.	Pg. 2-4
Summarize key literature that supports an approach to change. Cite databases, key words, and limitations (peer-reviewed within 5 years, full-text, English only). Cite organizations with practice guidelines.	Pg. 3-6
Present the logic mode for change as a figure.	Pg. 5-6, Figure 1
Present how this new program/ business model is aligned with the organizations’ mission, vision and values (Attachment A-Alignment of Project’s Mission,Vision and Values with the Organization)	Pg. 6-7, Table 1, Appendix B
Detail any potential risks/ benefits to the organization using the SWOT analysis.	Pg. 7-8, Pg. 9-10, Appendix A
Identify the positive impacts on the organization, the profession of nursing, and a population. Identify the positive social change. Identify potential impacts of diversity, equity, and inclusion.	Pg. 8-9
<b>Checklist Items 8515</b>	
<b>Implementation Planning</b>	
Present the team charter (Appendix B-JH Question Development Tool ).	Pg. 7-8, Appendix

	C, Pg. 24 to
Reference any accreditation standards.	Pg. 9
Address any new technologies or software needs and any supply chain and training needs that may need to be addressed.	Pg. 9-11
Detail any regulatory, legal, and union issues that may need to be addressed.	Pg. 9-11
Analyze the value to the organization.	Pg. 6-7, Appendix E
Provide a detailed implementation plan with goals, objectives, responsible parties, deliverables, and timelines (Appendix C).	Pg. 7-8, Appendix D
Provide a draft budget which includes evaluation of outcomes using ROI or other indices (Appendix D).	Pg. 26-38, Appendix E
Provide an evaluation plan which specifies summative measures.	Appendix F, Pg. 37-42
Justify the potential outcomes for the organization and/or community.	Pg. 8-9
Summarize the contribution of this change to the organization, nursing profession, social change, diversity, equity and inclusion.	Pg. 8-10

### Final Executive Summary: NURS 8515

<b>Checklist Items - Executive Leadership</b>	
<b>Summary</b>	
Indicate the type of project.	Pg. 1-2
Describe the practice problem and why it is important to address within the context of nursing practice.	Pg. 1-3
Summarize the practice-focused question(s) and the purpose for the doctoral project.	Pg. 1-3
Concisely describe the analytical strategies used in the doctoral project.	Pg. 4-6
Concisely summarize the findings and implications.	Pg. 4-6
Concisely identify major products, conclusions, and/or recommendations as appropriate.	Pg. 10
Summarize potential implications for nursing practice and for positive social change, diversity, equity, and inclusion.	Pg. 8-10
<b>Problem</b>	
Explain the impetus for a new or revised program/practice proposal.	Pg. 2-3
Provide data this this is an issue of importance to the organization, including both internal data and community-level data. What could happen if the project is not implemented?	Pg. 3-4
Summarize evidence that supports an approach to change. Cite databases, key words, and limitations (peer-reviewed within 5 years, full-text, English only). Cite organizations with practice guideline.	Pg. 4-6
Present how this new program/ business model is aligned with the organizations' mission, vision and values. (Attachment A)	Pg. 6-7, Appendix A
Detail any potential risks/ benefits to the organization using the SWOT analysis as a reference.	Pg. 7-8
Justify the potential outcomes for the organization and/or community Identify the positive impacts on the organization, the profession of nursing and the population of interest.	Pg. 8-9
<b>Executive Leadership Projects Phase 8515</b>	
Describe stakeholders, their role in the success of this program and the plan to initiate	Pg. 4-5,

stakeholder involvement.	App C
Describe any accreditation standards and the plan for how these will be addressed.	<b>Pg. 9</b>
Describe any new technologies or software needs and any supply chain issues.	<b>Pg. 10</b>
Propose training needs and recommendations for meeting these needs.	Pg. 10, Appendix D
Detail any regulatory, legal, and union issues that may arise.	Pg. 10-11
Present the logic model for change as a figure.	Pg. 5-6, Figure 1; Appendix B
Provide a detailed implementation plan with goals, objectives, responsible parties, deliverables, and timelines.	Appendix D
Provide a budget which includes staffing needs, evaluation of outcomes using ROI or other indices. Project cost-effectiveness related to health outcomes.	Appendix E
Provide an evaluation plan. Include the plan for the proposal review during the implementation phase as well as the process for the outcome evaluation of the program. What kinds of data will help determine if this program is successful. What baseline data will be needed to have prior to implementation? What data will be collected to measure interim progress?	Attachment F
Summarize the purpose, benefit to the organization, and potential social change. State how this supports diversity, equity and inclusion.	Pg. 9-10

### Partner Site Masking Self-Check

Walden capstones typically mask the identity of the partner organization. The methodological and ethical reasons for this practice as well as criteria for exceptions are outlined [here](#) (link to posted guidance).

Check here to confirm that you will mask the identity of the organization in the final capstone that you publish in ProQuest.

If you perceive that your partner organization's identity would be impossible to mask or if there is a strong rationale for naming the organization in your capstone, please check this box so that your Program Director can review your request for an exception. If granted, that exception must be confirmed by the IRB during the ethics review process.

The IRB will also ensure that your consent form(s) and/or site agreement(s) permit naming the organization.

### **Organizational Mission Alignment**

The organization provides outpatient psychiatric and primary care services to a diverse community, emphasizing accessible, patient-centered behavioral health care. This project aligned with that mission by evaluating current depression screening and follow-up processes and developing an evidence-informed framework to strengthen reliability, equity, and continuity of care.

### **Organizational Vision Alignment**

The organization's vision emphasizes integrated, equitable, and high-value care. This project supported that vision by using internal data, evidence-based guidance, and workflow analysis to design an improved depression screening follow-up process. Its focus on consistency, timely responses, and reducing inequities aligns with broader organizational goals for coordinated, patient-centered care.

### **Organizational Values Alignment**

This project reflects core organizational values through:

- **Patient-Centeredness:** Emphasizing continuity and clarity in follow-up processes
- **Equity:** Identifying disparities and incorporating culturally responsive considerations
- **Accountability:** Promoting standardized, clearly defined workflow processes and measurable performance expectations
- **Collaboration:** Engaging interdisciplinary stakeholders throughout
- **Quality Improvement:** Applying evidence-based frameworks to support executive decision-making

### Scope Statement

This appendix describes the change theory for the implementation of a standardized nurse-led, electronic health record-supported PHQ-9 depression screening and timely follow-up workflow in outpatient psychiatric and primary care settings. It aligns with the Appendix D Detailed Implementation Plan, the Appendix E Budget Plan, and the Appendix F Evaluation Plan.

### Problem Statement

Current PHQ-9 screening and follow-up processes exhibit reliability gaps and inequitable performance: baseline screening completion is 68 percent, and documented follow-up within 14 days is 55 percent, with disparities affecting patients with limited English proficiency.

### Aim

Improve reliability and equity of depression screening and follow-up through a standardized nurse-led workflow with electronic health record decision support, closed-loop tracking, and executive governance.

### Inputs

- Executive sponsorship and governance support from nursing operations and executive leadership
- Lean interdisciplinary team capacity and routine huddle cadence
- Existing electronic health record infrastructure and informatics build time
- Baseline internal audit data and operational performance data
- Evidence-based standards and guidance for depression screening with follow-up systems in place (USPSTF, CMS Quality Measure 134)
- Language access workflows and interpreter resources

- Training time and workflow job aids
- Budgeted resources for configuration, reporting infrastructure, and materials as specified in Appendix E

### **Core Activities**

- Governance activation, workflow mapping, defect identification, and redesign of screening to follow-up pathway
- Electronic health record hardwiring, including structured fields, prompts, routing logic, escalation pathways, and closed-loop follow-up confirmation
- Workforce activation through competency-based education, role clarity, and standard work adoption
- Performance monitoring with monthly formative review and rapid cycle correction using defect logs and root cause analysis
- Equity stratification of measures by language status, with interpreter integration prompts and culturally responsive outreach scripts
- Sustainment planning with dashboard integration, ownership assignment, and ongoing review cadence

### **Outputs**

Deliverables that operationalize change

- Standardized workflow algorithm from screening through follow-up completion
- Electronic health record templates, required documentation prompts, and task routing logic for positive screens
- Escalation protocol for high-risk PHQ-9 findings and suicidal ideation pathways
- Standardized outreach scripts and documentation templates, including language access

considerations

- Executive dashboard specifications and validated reporting logic for screening, follow-up, equity stratification, and financial surveillance
- Competency validation documentation and staff job aids
- Implementation plan artifacts in Appendix D, budget artifacts in Appendix E, and evaluation plan artifacts in Appendix F

## **Outcomes**

Short-term outcomes during implementation stabilization

- Increased completion of PHQ 9 screening through standardized prompts and encounter workflow integration
- Increased documentation completeness and reduced omission of follow-up plan documentation
- Improved visibility of positive screens through routing and task completion tracking
- Improved reliability of risk escalation documentation for high-risk scores
- Early identification of operational impacts such as throughput change, no-show rate variation, and staff burden indicators

Intermediate outcomes after workflow stabilization

- Screening completion improves from 68 percent baseline toward 90 percent target
- Documented follow-up within 14 days improves from 55 percent baseline toward 85 percent target
- Reduced process fragmentation and clearer accountability across nursing, administrative, behavioral health, and clinician roles
- Equity gap reduction through stratified monitoring and interpreter-integrated workflow

supports, targeting at least a 50 percent reduction in disparity gap for limited English proficiency populations

#### Long-term outcomes and sustainment

- Embedded governance and monitoring structures that maintain performance and prevent drift
- Financial benefit realization consistent with Appendix E modeling, with ongoing validation in Appendix F
- Reduced risk of missed follow-up and improved continuity of depression care aligned with evidence-based expectations that screening must include systems for diagnosis, treatment, and monitoring

#### **Measures and Data Sources**

##### Process and reliability measures

- PHQ-9 screening completion rate
- Percentage of positive screens with documented follow-up within 14 days
- Percentage of high-risk scores with documented and time-appropriate escalation
- Documentation completeness in structured fields

##### Operational measures

- Visit throughput time compared to baseline
- No-show rate compared to baseline
- Task routing completion reliability

##### Equity measures

- Screening completion stratified by language status
- Follow-up compliance stratified by language status
- Interpreter utilization rate during screening encounters

#### Financial measures

- Incremental completed follow-up visits attributable to routing and outreach
- Recovered no-show encounters
- Avoided downstream cost signals where measurable

These measures are structured for formative monthly monitoring and summative pre-post outcome evaluation as specified in Appendix F.

#### **Assumptions and Constraints**

##### Key assumptions

- Electronic health record build and reporting changes can be completed within the available informatics capacity
- Staff can complete competency training with minimal productivity disruption
- Follow-up appointment capacity and scheduling reliability can absorb increased detection and routing

##### Constraints and risks

- If follow-up access capacity does not scale with increased identification, screening gains can create backlog, dissatisfaction, or delayed care, reducing clinical benefit and eroding projected financial return
- If alert design is excessive, alert fatigue can reduce adherence and documentation quality

- If equity monitoring is not acted on, standardized processes can preserve or worsen disparities

### **Team Purpose**

The purpose of this team was to design and prepare for organizational implementation of a standardized, nurse-led, electronic health record-enhanced workflow to improve the reliability of depression screening and the timeliness of follow-up for adult primary care patients. The team was accountable for developing a systems-level model intended to increase PHQ-9 screening completion rates, improve documented follow-up within 14 days for positive screens, reduce disparities among patients with limited English proficiency, and align with quality performance and fiscal stewardship goals.

### **Team Structure & Roles/Responsibilities**

- Executive Sponsor and Primary Care Medical Director - Provides strategic oversight, ensures alignment with organizational priorities, approves resource implications, and removes system-level barriers. Evaluates fiscal impact, value-based care alignment, and potential cost avoidance. Advises on clinical feasibility, provider workflow integration, and alignment with primary care standards.
- Behavioral Health Lead - Guides follow-up protocol design, treatment initiation pathways, and care coordination standards.
- Nursing Leadership Representative - Leads workflow standardization, nursing role optimization, and staff engagement strategies.
- Health Informatics Specialist - Designs and optimizes EHR-based alerts, documentation templates, and reporting dashboards.
- Quality Data Analyst - Develops performance metrics, monitors screening and follow-up data, and conducts stratified equity analyses.

- Interpreter Services Representative - Advises on culturally responsive processes integration of language-access workflows.

### **Team Processes**

**Team Huddles:** Biweekly operational huddles to review workflow development progress, address barriers, and assess emerging data trends.

**Team Meetings:** Monthly structured meetings to review performance metrics, equity stratification, financial considerations, and strategic alignment.

**Team Decision-Making:** Consensus-based decision-making for workflow design and protocol development. Executive sponsor retains final authority for strategic and financial decisions.

**Team Communication:** Documented meeting minutes, shared project dashboards, structured executive updates, and alignment with DNP Executive Summary reporting requirements.

**Knowledge Exchange With Other Teams:** Regular collaboration with population health, behavioral health integration, and quality improvement teams to ensure coordination and avoid duplication of initiatives.

### **Relationships**

**Team Values:** Equity, transparency, accountability, psychological safety, interdisciplinary collaboration, and fiscal responsibility.

**Standards of Behavior (How We Work Together):** Respectful and data-informed dialogue; shared accountability for outcomes; commitment to culturally responsive care; proactive identification of risks; adherence to agreed upon scope and timelines.

**Decision Making:** Evidence-informed and aligned with organizational strategy, quality performance frameworks, and regulatory standards. Disagreements will be addressed through structured discussion and, when necessary, escalated to the executive sponsor.

**Other Insights to Record in This Charter:**

The team acknowledges that internal audit data demonstrate 68 percent PHQ-9 screening completion and 55 percent documented follow-up within 14 days for positive screens, with disparities among patients with limited English proficiency. This charter prioritizes reducing variation and embedding equity monitoring through stratified reporting mechanisms. The team further commits to integrating financial analysis to ensure alignment with value-based reimbursement models and long-term sustainability.

**Project Goals**

1. Increase PHQ-9 screening completion to  $\geq 90\%$ .
2. Increase documented 14-day follow-up compliance to  $\geq 85\%$ .
3. Reduce LEP-related screening and follow-up disparity gaps by  $\geq 50\%$ .
4. Embed sustainable governance and monitoring structures into routine operations.
5. Achieve positive financial return relative to implementation cost.

**Responsible Parties**

This initiative was planned within a lean interdisciplinary team structure consisting of:

- DNP Project Lead serving in Nursing Operations role
- Chief Executive Officer / Medical Director
- Administrative Manager
- Social Worker / Case Manager
- Therapists
- Nursing staff

Governance oversight was shared between Nursing Operations and Executive Leadership to ensure alignment with organizational priorities.

**Phase I: Governance Activation and Current-State Redesign**

**Timeline: Week 1–2**

## **Objectives**

- Conduct detailed workflow mapping of screening-to-follow-up processes.
- Identify breakdown points between screening, documentation, referral, and appointment completion.
- Define explicit escalation thresholds for moderate and high-risk PHQ-9 findings.
- Establish measurable performance targets aligned with national guidance (USPSTF; CMS Quality Measure 134).
- Develop initial equity stratification framework.

## **Deliverables**

- Approved standardized workflow algorithm.
- Escalation protocol for suicidal ideation and high-risk scores.
- Defined documentation standards for follow-up action.
- Governance review confirmation.

## **Phase II: EHR Hardwiring and Workflow Standardization**

### **Timeline: Week 3–4**

## **Objectives**

- Activate structured PHQ-9 documentation fields within eligible encounter templates.
- Embed required follow-up documentation prompts to reduce omission.
- Configure routing logic to ensure visibility of positive screens.
- Integrate interpreter-access reminders for LEP patients.

- Standardize documentation language for outreach attempts.
- Establish closed-loop confirmation process for follow-up completion.

### **Deliverables**

- EHR documentation template modifications.
- Structured routing logic for positive screens.
- Standardized outreach documentation template.
- Closed-loop follow-up tracking tool.

### **Phase III: Workforce Activation and Competency Validation**

#### **Timeline: Week 5-6**

### **Objectives**

- Deliver focused workflow education to nursing and clinical staff.
- Reinforce culturally responsive communication practices.
- Conduct competency validation using real-case simulation scenarios.
- Clarify cross-role sequencing for screening, outreach, scheduling, and confirmation.
- Establish documentation accuracy standards aligned with reporting requirements.

### **Deliverables**

- Education materials and workflow reference guide.
- Competency validation checklist.

- Updated role sequencing documentation.
- Training attendance verification.

#### **Phase IV: Performance Monitoring and Rapid-Cycle Refinement**

**Timeline: Week 7–8**

##### **Objectives**

- Monitor weekly PHQ-9 screening completion rates.
- Monitor 14-day follow-up compliance rates.
- Track adherence to high-risk escalation protocols.
- Stratify outcomes by LEP status and payer mix.
- Monitor depression-related no-show rates.
- Conduct structured root cause analysis for missed follow-up events.
- Evaluate revenue trends relative to projected ROI.

##### **Deliverables**

- Executive performance dashboard.
- Equity disparity trend report.
- Defect log with corrective action plans.
- Mid-cycle financial impact summary.

#### **Phase V: Sustainability Integration and Governance Transition**

**Timeline: Week 9**

**Objectives**

- Integrate PHQ-9 metrics into monthly leadership review agenda.
- Formalize monitoring cadence and escalation review process.
- Validate financial impact relative to projected 210% ROI.
- Define ownership of ongoing performance review.
- Establish performance drift thresholds triggering corrective review.

**Deliverables**

- Sustainability integration memorandum.
- Governance oversight framework.
- Preliminary ROI validation report.
- Annual reassessment recommendation.

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**Executive Financial Context**

The project site operates as a small outpatient psychiatric and primary care practice with limited operating margin and high dependence on visit-based reimbursement. In this environment, quality improvement initiatives must demonstrate fiscal prudence, minimal operational disruption, and measurable financial return. Unlike large academic health systems, small practices cannot absorb prolonged productivity loss, additional full-time equivalent staffing, or substantial capital investment without destabilizing operations.

This nurse-led, EHR-enhanced depression screening workflow was therefore intentionally designed as a low-capital systems redesign leveraging existing personnel, infrastructure, and documentation platforms. The DNP Project Lead’s 160 practicum hours were included in the academic requirement and did not generate incremental salary expense for the organization. However, opportunity cost related to staff education, limited EHR configuration, reporting infrastructure, and workflow materials represents a direct financial impact and is transparently itemized below.

**Staff Education and Competency Validation**

Four clinical staff members are anticipated to participate in structured education and competency validation sessions to ensure fidelity to the standardized workflow. Education will cover PHQ-9 administration, documentation standards, escalation protocols, equity considerations, and follow-up accountability.

Education time per staff member: 2 hours

Average visit revenue per clinical hour: \$89

Calculation: 4 staff × 2 hours × \$89/hour = \$712

This reflects lost billable productivity rather than additional payroll expenditure.

### **Electronic Health Record Configuration**

Targeted EHR modifications required to operationalize the intervention, including automated PHQ-9 prompts, structured follow-up documentation fields, escalation routing logic for high-risk scores, and reporting extraction fields.

Estimated internal informatics allocation: \$3,000

This cost reflects configuration within existing infrastructure rather than the acquisition of a new platform.

### **Data Reporting and Dashboard Infrastructure**

Reliable executive oversight require the development of structured reporting logic to track screening completion, 14-day follow-up compliance, equity stratification by language status, documentation completeness, and financial impact.

Estimated cost for build, validation, and dashboard deployment: \$2,000

### **Workflow Materials and Patient Communication Tools**

The development of standardized algorithms, escalation protocols, culturally responsive outreach scripts, and staff reference guides required minimal resources for material development.

Estimated cost: \$500

Total Direct Organizational Cost

Staff education opportunity cost: \$712

EHR configuration: \$3,000

Reporting infrastructure: \$2,000

Materials: \$500

Total Projected Implementation Cost: \$6,212

### **Financial Benefit Modeling**

Financial benefit in an outpatient model derives from five primary mechanisms: improved documentation-supported billing capture, increased completed follow-up visits, reduced no-show rates, avoided crisis-level emergency referrals, and stabilization of quality performance metrics relevant to value-based reimbursement frameworks.

Baseline assumptions are intentionally conservative to avoid overestimating projected returns. The clinic maintains approximately 1,200 active adult patients, with an estimated 300 eligible for PHQ-9 screening each year. Improved workflow reliability is projected to generate 75 additional documented follow-up encounters attributable to structured routing and accountability mechanisms.

#### Revenue From Additional Completed Follow-Up Visits

75 additional visits × \$89 average reimbursement = \$6,675

#### No-Show Reduction Revenue Recovery

Improved follow-up reliability and patient engagement are projected to reduce missed appointments by 40 visits annually.

40 visits × \$89 = \$3,560

#### Avoided Crisis-Level Emergency Referral Exposure

Depression left untreated increases acute utilization and crisis-level presentations (Greenberg et al., 2021). Conservative modeling estimates preventing five emergency referrals annually, with an estimated financial exposure of \$1,800 per event when accounting for uncompensated care risk, coordination burden, and downstream utilization.

5 × \$1,800 = \$9,000

Total Projected Annual Financial Benefit

\$6,675

\$3,560

\$9,000

Total = \$19,235

Return on Investment Calculation

Net Benefit = \$19,235 – \$6,212 = \$13,023

ROI = ( $\$13,023 \div \$6,212$ )  $\times 100 = 210$  percent

This indicates the initiative returns more than double its implementation cost within the first operational year.

Break-Even Analysis

Break-even threshold in visit terms:

$\$6,212 \div \$89 = 70$  additional completed visits

Alternatively, preventing four emergency referrals would fully recover the implementation cost.

Payer-Mix Sensitivity Analysis

To account for reimbursement variability, a conservative scenario was modeled with average reimbursement reduced to \$70 per visit and emergency referral exposure reduced to \$1,200 per event.

75 visits  $\times$  \$70 = \$5,250

30 recovered no-shows  $\times$  \$70 = \$2,100

3 avoided referrals  $\times$  \$1,200 = \$3,600

Total conservative benefit = \$10,950

Net benefit = \$10,950 – \$6,212 = \$4,738

ROI = 76 percent

Even under pessimistic reimbursement assumptions, the initiative approaches cost neutrality while delivering measurable clinical and equity improvements.

### **Financial Outcome Indices for Ongoing Evaluation**

- Annual ROI percentage
- Net financial benefit
- Cost per improved follow-up case
- Revenue per additional completed follow-up visit
- Avoided emergency referral cost estimate
- Quality performance stabilization metrics

These indices will be reassessed annually to validate financial sustainability.

### **Executive Financial Conclusion**

With a total direct implementation cost of \$6,212 and a projected annual benefit of \$19,235, this initiative demonstrates strong financial stewardship in a small outpatient environment. The projected 210 percent ROI, combined with equity-focused performance improvement, supports sustained integration into routine clinical operations.

## **Appendix F: Evaluation Plan**

### **Evaluation Philosophy**

Evaluation must balance methodological rigor with operational feasibility. An overly complex analytics infrastructure would exceed the capacity of a small outpatient psychiatric and primary care practice. However, insufficient evaluation would undermine executive accountability, fiscal stewardship, equity oversight, and long-term sustainability.

This evaluation plan integrates formative and summative performance monitoring, financial validation aligned with projected return on investment, equity stratification, and operational risk surveillance. The framework reflects NURS 8515 executive leadership competencies in data-driven decision-making, systems performance oversight, resource stewardship, interprofessional governance, and strategic sustainability planning.

Evaluation is intentionally structured to ensure direct alignment between clinical reliability outcomes and the financial projections outlined in the Executive Financial Stewardship analysis. Clinical improvement without financial validation would weaken sustainability; financial return without equity and safety oversight would contradict organizational values and nursing leadership standards.

### **Formative Evaluation Measures**

Formative evaluation focuses on early detection of workflow breakdown, productivity disruption, documentation drift, and unintended financial erosion during implementation stabilization. Measures are intended to be collected monthly during the active implementation period and reviewed in leadership huddles.

### Clinical Reliability and Process Measures

- PHQ-9 screening completion rate
- Percentage of positive screens with documented follow-up within 14 days
- Percentage of high-risk PHQ-9 scores with documented and time-appropriate escalation
- Documentation completeness rate within structured EHR fields

### Operational Performance Measures

- Visit throughput time compared to baseline
- No-show rate compared to baseline
- Task routing completion reliability within the EHR
- Staff-reported workflow burden indicators

### Financial Surveillance Measures

- Monthly depression-related billed encounters
- Number of completed follow-up visits attributable to standardized routing
- Revenue trends compared to baseline quarter

### Equity Surveillance Measures

- Screening completion stratified by language status
- Follow-up compliance stratified by language status
- Interpreter utilization rate during screening encounters
- Follow-up completion among high-risk Limited English proficiency (LEP) patients

These measures enable rapid-cycle corrections and protect against productivity declines that could erode projected financial returns. Root cause analysis will be initiated for sustained deviation below the defined stabilization thresholds:

- Screening completion < 75 percent during transition phase
- Follow-up documentation < 65 percent
- No-show rate increase > 5 percent from baseline
- Visit throughput increase > 10 percent
- Escalation documentation failure in any high-risk case

Early executive review ensures workflow stabilization before financial or safety erosion develops.

### **Summative Evaluation Measures**

Summative evaluation assesses sustained clinical reliability, equity impact, operational stability, and financial performance following workflow stabilization.

#### Clinical Outcome Targets

Baseline screening completion: 68 percent

Target:  $\geq$  90 percent

Baseline 14-day follow-up compliance: 55 percent

Target:  $\geq$  85 percent

Disparity reduction target:  $\geq$  50 percent reduction in screening and follow-up gap between English-speaking and LEP patients

Additional outcome indicators include:

- Change in crisis-level emergency referrals
- Change in no-show rate
- Reduction in documentation variability

The effect size will be calculated using the absolute percentage improvement. Where sample size permits, chi-square analysis will evaluate the statistical significance of pre- and post-implementation changes in screening and follow-up compliance.

### **Financial Validation and ROI Monitoring**

Financial validation directly mirrors projections in the Executive Financial Stewardship analysis.

#### Projected Annual Targets

- 75 additional documented follow-up visits
- 40 recovered no-show visits
- 5 crisis-level emergency referrals prevented

Using the \$89 reimbursement model:

$75 \times \$89 = \$6,675$  incremental revenue

$40 \times \$89 = \$3,560$  no-show recovery

$5 \times \$1,800 = \$9,000$  avoided downstream exposure

Total projected annual benefit: \$19,235

Implementation cost: \$6,212

Projected net benefit: \$13,023

Projected ROI: 210 percent

The quarterly financial review will compare realized revenue and avoided exposure to projections. ROI will be recalculated annually. If the cumulative realized benefit falls

below 50 percent of the projected annual target by the mid-cycle review, structured workflow refinement and financial reassessment will be initiated.

Break-even performance will be reassessed using actual visit volume to confirm sustainability under real payer mix conditions.

### **Equity Evaluation Framework**

Baseline audit data demonstrate measurable disparity in screening and follow-up completion among patients with limited English proficiency. Executive accountability requires stratified reporting by language status, race when available, and payer category.

Equity evaluation includes:

- Absolute difference in screening rates between English-speaking and LEP patients
- Absolute difference in follow-up compliance rates
- Interpreter utilization rate during screening
- Depression-related visit completion stratified by payer mix
- Escalation timeliness for high-risk multilingual patients

A reduction in the disparity gap by at least 50 percent will be considered a clinically meaningful improvement. Persistence of disparity beyond two consecutive review cycles will prompt reassessment of interpreter workflow integration, outreach scripting, scheduling processes, and structural barriers affecting access.

Equity monitoring is embedded within routine governance reporting to ensure workflow standardization does not unintentionally perpetuate structural inequities. This approach reflects NURS 8515 leadership competencies in advancing social change through systems redesign and executive accountability.

## Executive Oversight and Sustainability

Evaluation findings will be reviewed during standing leadership meetings and integrated into ongoing quality dashboards. Sustainability will be defined as:

- Screening reliability  $\geq$  90 percent for two consecutive quarters
- Follow-up compliance  $\geq$  85 percent for two consecutive quarters
- Maintained ROI  $\geq$  100 percent after year one
- Demonstrated reduction in LEP disparity gap
- Stable visit throughput and no-show rates
- No increase in documented workflow burden beyond baseline tolerance

Embedding these measures within governance structures ensures the transition from a time-limited project to an operational standard of care.

### **Executive Evaluation Conclusion**

This evaluation framework integrates clinical reliability, financial stewardship, equity accountability, and operational stability into a unified executive monitoring structure. By aligning measurable outcomes with ROI projections and stratified equity reporting, the initiative demonstrates systems-level improvement consistent with executive nurse leader competencies and NURS 8515 expectations for implementation rigor and sustainability planning.