What is your health center's problem statement for your depression screening and follow up clinical quality measure?
WMCHC provides care in rural communities, majority of our patients experience co-morbidities majority our patients 50-79 years old. WMCHC is trying to increase depression screening and follow up documentation compliance; but, we need workflow education/reinforcement and buy-in because we're inundated with administrative burdens, there are unclear work flow expectations, varying levels of computer literacy and understanding screening impact overall health which makes us feel overwhelmed but optimistic.
We are a community based fqhc serving the under served in an urban/suburban catchment area trying to increase our rates of depression screening and follow up but we are experiencing problems with documentation, access and workflow because of staff turnover it is difficult to get people trained and up to speed on workflow and documentation as well as open the schedules fully to create additional access, this is at best tiring and creates a sense of always being behind.
We are a health center that serves the LGBTQIA+ population trying to improve the completion rate of follow ups and PHQ-9s for our patients. We currently have a process in place, but doesn't seem to be working to get to everyone of our patients. If we had an opportunity to change the process and workflow to something that would help our providers and MAs remember to give the PHQ-9 to the patients and also have the providers insist on a follow-up appointment for patients indicating depression, we could increase our satisfactory numbers.
We complete depression screenings on everyone, and offer behavioral health services. My question is should we be dropping cpt codes for the depression screenings?
We are a health center that serves a rural population of all ages in the Upper Peninsula of Michigan trying to improve depression screening rates, and more importantly, follow-up rates; but, our workflows make this difficult, because our EMR (eClinicalWorks) is not user-friendly and requires additional steps to achieve the desired result and fully document care which makes us feel frustrated.
We are a health center that serves over 46,000 patients annually in Southwest Florida trying to increase the amount of depression screenings being completed during f/u visits but clinical staff typically complete the screener during a well visit or if it’s been a year from a pt’s previous screening because staff are under the assumption that the pt will return again during the year for their well visit which makes us feel uneasy about our process because we understand a patient may not come back for a well visit and we also understand pts may not feel well enough to complete a depression screening during a f/u visit so it becomes a “missed opportunity” for our health center.

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We are a health center that serves 1110,000 medical, dental and behavioral health patient visits annual at 32 healthcare sites trying to increase depression screening at every visit but if no screening can be completed we need to document the exceptions because if no screening is completed we missed referrals to behavioral health
We are an urban FQHC that serves primarily the underinsured and uninsured trying to increase the number of patients with up-to-date depression screenings, but we have a challenge with understanding why employees are not conducting screenings because of lack of policies and employee buy-in/accountability which makes us feel concerned about the quality of patient care.
We are a health center that serves a predominantly rural and under served area in north east Arkansas trying to increase our number of patients screened for depression from 46% to our goal of 66%. But where the follow up is to be documented in our EMR is not easy to access in patient's chart during normal workflow. Which makes us feel frustrated. We feel this work is being done, it is just not captured within our EMR.
We are a health center that serves low income and underserved populations from surrounding rural areas trying to reduce missed opportunities with depression screening and increase number of patients with a follow up plan but we do not always have provider buy in because of time constraints and education on process which makes us feel frustrated and concerned for patient needs that may be missed.
We are a health center that serves all ages in Northeast Kansas with integrated health care trying to improve follow-up for depression screening but lack consistency in templates because of care team workflow variation and lack of understanding of all measure components which makes us feel like we can't trust our data or the decisions being made based on it.
We are a health center who offers high quality healthcare services to all people located in Atchison County and its surrounding areas. We are trying to improve our depression screening and follow-up measure by ensuring all providers and nurses are screening every appropriate patient and doing a follow-up plan when needed. One barrier is not all providers and nurses have full understanding of what the quality measure consists of and how we meet the measure. Another barrier is as a smaller rural clinic, often individuals have many roles, and it is difficult to incorporate more into the already busy workflow. The root cause of this barrier is the clinic historically hasn’t had anyone dedicated to quality improvement or providing routine education. The clinic has recognized this gap in care and now has a role dedicated to quality and incorporates quality into our daily huddles.

What is your health center's problem statement for your depression screening and follow up clinical quality measure?
We are a health center that serves the inner city of the Southwest side of Chicago trying to improve depression screenings on our patients affected most by trauma they may have experienced or currently are experiencing but we are unable to capture all patients' data properly because many patients do not how to seek the best help for their needs, and this makes us feel slightly disempowered and unaware how to provide the best resources.
We are a health center that serves uninsured populations trying to improve health care in the community.
We are an Urban Indian Health Center and HRSA FQHC in Santa Barbara, CA serving the uninsured, Medicaid and Medicare populations' needs for medical, optometry, ENT, dental, orthodontia, endodontics, mental and behavioral health, substance use services and community cultural needs for whole person care trying to improve our documentation of the various methods of follow up care and care planning but staff needs to be well trained because there are a number of newer staff and turnover which makes us feel like there is always room for improvement.
We are a health center that serves greater Camden County trying to give better access mental health to our patients. But stigma and stereotypes hinder our ability to reach our patients. Because our patient base feels mental health is a sign of weakness. Which makes us feel we need to work harder to provide services.
We are a health center that serves low-income, underserved, and/or limited English proficient patients of all races and ethnicities across King County, WA, trying to continue improving our score on the depression screening and follow-up measure for all of our patients. But there are challenges capturing accurate information from patients with limited English proficiency and patients in the 12-18 age range because patients often lack literacy skills in their own languages and, if they are young, are uncomfortable discussing the issue in front of their parents. This makes us feel that, despite the fact that our current percentage is higher than the national average, there is still room for improvement.
SCHC's service area is composed of both suburban and rural areas and contains a significant number of migrant and seasonal farmworkers in Hillsborough and Polk Counties. The disparities of health associated with this vulnerable population creates numerous barriers to care. Patients' behavioral health needs, including stress/anxiety and drug abuse, require additional attention. Within the service area there are pockets of population with lower than average educational attainment, higher percentages living in poverty and overall poorer health status than the general population. SCHC has a long history of addressing these barriers to care and working to serve the medically underserved population.

What is your health center's problem statement for your depression screening and follow up clinical quality measure?
We are a health center that serves the medically underserved communities in the Trenton, NJ area trying to improve our depression screening and follow up QM by 15%, but this has been complicated because it requires better behavioral health referral coordination, as well as unique data collection methods which make us feel overwhelmed at times.
We are a FQHC health center that provides primary care to homeless youth between the ages of 18 - 21 and as well the general public. The health center has made several improvements in the measure of focused. We are screening all of our patients and ensuring that it reflects both in our medical notes and in billing. Due to the homeless population we serve we find it most challenging to follow up because most of our youth are non-complaint with there follow-up appointments. We have implemented several strategies to confirm appointment to ensure continuity of care.
We are a health center that serves community members of all ages trying to improve our depression screening rates and the documentation of the follow up care for patients aged 12-17 who have a positive depression screening but we are experiencing challenges in staffing to focus on the project which makes us feel concerned about patient needs and data quality.