Template | Planning Questions for the PDSA Cycle

SMARTIE Aim Statement

What is your updated SMARTIE?

Objective for PDSA cycle

What question(s) do you want answered with this PDSA cycle?
Write a concise statement of what you plan to do in this testing. This will be much more focused and smaller than the full implementation of the tool. It will be a small portion of the implementation.

We plan to....

Who will carry out the test?
When will they carry out the test?
What are the specific details of the test (of patients, # of days, # of staff, # of phone calls, etc.)?
Where will the test be done?

Data collection tool

What data do we need to collect (e.g., time, date, response, observation, etc.)?

We hope this will..

Indicate a measurement or outcome you hope to achieve. This may include quantitative data or qualitative data.

Perlman Clinic | Planning for the PDSA Cycle

SMARTIE Aim Statement

We, Perlman Clinic, will improve patient experience related to mental health care, by increasing the percentage of patients seen by and serviced by our mental health coaching team, for all patients 18 years or older; especially focusing on age groups that are least likely to seek mental health care virtually, ages 65+; from 0% to 18% by December of 2025.

Objective for PDSA cycle

We hope to determine if patients who are older than 65 years of age are being scheduled with our coaching team at all, and hope to find out if those who are being referred over are scheduling to be seen and being seen.

We plan to….

- UCSD will generate report to show direct correlation with patients that had both a referral placed for “MPC COACHING” and who were scheduled with the visit type: “CC COACHING”
- Otherwise, Perlman Clinic team will have to manually assign individuals on our team to go through the referrals placed and determine if patients scheduled or successfully completed a telemedicine visit.
- We don't have specific details yet because we need to determine which outcome will work best
  - We can draw more data and more often/regularly if it's a report that can be ran
  - Manual data entry will not be prioritized regularly as we do not have a team to dedicate to this; meaning data and information will not be pulled as consistently within the EMR system

Data collection tool

We hope this will..

We will see an increase in the number of patients who are seen and serviced by our coaching team among patients ages 65+ from 0% to 18% by December of 2025.

Pomona Valley |Planning for the PDSA Cycle

SMARTIE Aim Statement

By December 31, 2025, Pomona Valley aims to increase PHQ-9 follow-up screening rates (within 4-8 months) among Latino and Hispanic patients from 35.6% to 50%.

Objective for PDSA cycle

Increase follow-up screening and improving continuity of care through educating and offering BHI support to Latino and Hispanic men ages 18 and older.

We plan to....

Calvin provide the data set. Dr. Blocker identified 42 men who met criteria for telephonic outreach up to three attempts to repeat screening. If still positive, Dr. Blocker will provide BHI education and try to enroll in BHI program.

Data collection tool

Excel file of:

- Patient outreached
- Date outreach
- Attempt #/ Success
- PHQ9 score
- Positive PHQ9 accepted referral to BHI or not

We hope this will..

Improve screening follow-up and care for subsection of a vulnerable population. Continual PDSA to expand outreach to other vulnerable population.

Scripps Health | Planning for the PDSA Cycle

SMARTIE Aim Statement

We will improve screening and treatment, at Rancho Bernardo Clinic, for patients presenting with mild to moderate anxiety and depression by incorporating behavioral health treatment in primary care setting through Collaborative Care Model (CoCM) for patients 12+YO with scores 10 or above on the PHQ9/GAD7 or with presenting symptoms and assess performance across patient groups by race, ethnicity, and preferred language in order to evaluate equitable outcomes of less than 10% variance by December 2025.

Objective for PDSA cycle

Will screening rates increase if PHQ9 forms are available in other languages?

We plan to….

BHI Project Team will print out PHQ9 forms in languages spoken most frequently (besides English). Continue screening workflows with these additional tools and compare against the baseline data on % depression screening & follow-up after 6 months. Test runs May-Nov 2025.

Data collection tool

- Patient's preferred language
- Depression Screening & Follow-Up rate

We hope this will..

Increase screening rates and decrease variance to less than 10%

Sharp Rees-Stealy | PDSA

SMARTIE Aim Statement

Will improve depression screening using the standard PHQ-2 tool. From 48% (current) to 50% at pilot site while also closing the gap between seniors and patients 18-64 (Currently 71.4%, 40.26% Goal 75%, 50%) Patients Ages 12-64 = 5752, Patients Age 65+ = 1674

Objective for PDSA cycle

Accomplished Work not sustainable as it was a Manual process. Wanted to spread organization wide so patients coming in for office visits could have their results discussed w/PCP at visit.

We plan to….

New Member onboarding for Depression Screening optimizing Epic capabilities

Data collection tool

Use of our Healthy Living Texting programs to screen patients not accessing care.

We hope this will produce..

Spread to all departments communicating with SRS patients to screen (call center, urgent care, virtual urgent care)

Chinese Hospital | Planning for the PDSA Cycle

SMARTIE Aim Statement

We, Chinese Hospital & Clinics, will improve the linkage to behavioral health care services by increasing the number of patients (ages 12+ with a PHQ-9 score of 10+ or a common chronic illness such as depression and anxiety) referred to CoCM program that agree to services from 40 to 80 patients by December 31, 2025.

Objective for PDSA cycle

To explore strategies for expanding CoCM to clinics/providers with stagnant referral rates, and to evaluate whether adding bilingual staff improves treatment adherence and health outcomes for Chinese-speaking CoCM patients.

We plan to….

Who? Assign two new bilingual BHCs to lead the test at Excelsior and Sunset clinics.
When? July – August 2025
What? Involve up to **20** Chinese-speaking CoCM patients (ages 12+, with depression, anxiety, or PHQ-9 ≥10). Each of the two BHCs will manage up to 10 patients and conduct at least one contact per month (phone, telehealth, or in-person). BHCs will also provide culturally appropriate support, including scheduling, follow-ups, and health education.
Where? All clinics – Gellert, Excelsior, Sunset, and Support

Data collection tool

Patient Interaction: Date & time, type of contact, duration, language used, and coordinator involved, as well as patient responses (e.g., answered, rescheduled).
Engagement & Success: # outreach attempts, # completed contacts, appointment attendance, barriers faced, and # referrals made.
Clinical Outcome: PHQ-9/GAD-7 scores, treatment adherence, new CoCM enrollments, and patient satisfaction feedback through surveys or check-ins.
Staff: Monitor coordinator activities by documenting time spent on tasks, noting any challenges, and assessing workflow efficiency to identify delays or communication gaps.

We hope to...

↑ Patient engagement
↑ Improved communication and trust
↑ Higher satisfaction scores
↑ Better treatment adherence
↑ Improved clinical outcomes (reduced PHQ-9/GAD-7 scores)
↑ Efficient care coordination

CMH: Planning for the PDSA Cycle

SMARTIE Aim Statement

By December 31, 2025, Ashwood clinic will increase depression screening and follow- up rates from 13.4% to 33.2% among Latino or Hispanic population between the ages of 18-64.

Objective for PDSA cycle

Increase BH education and awareness for screening among Latino and Hispanic population.

We plan to....

We plan to develop patient education material about depression screening and resources in English and Spanish to post at primary locations in the Ashwood Clinic waiting room and exam rooms.

Data collection tool

Pilot site process measures (baseline in Q2 2025). Run reports monthly to see if patient education material are increasing BHI referrals.

We hope this will..

Increase behavioral health for Latino and Hispanic population.

Riverside Family | Planning for the PDSA Cycle

SMARTIE Aim Statement

We Riverside Family Physicians will improve depression screening rates for diabetic patients by monitoring the completion rate for each provider and implementing warm hand-offs for patients with an A1c level of 10.0 or higher from 56% as of 12/31/24 to 80% by December 2025.

Objective for PDSA cycle

To increase the rate of depression screening among high-risk patient populations.

We plan to....

Identify patients with an A1c level of 10.0 or higher who have not completed a depression screening in 2025.

Our Behavioral Health team will reach out to these patients to complete the PHQ-9 depression screening.

Data collection tool

We will utilize our Population Health platform to monitor key metrics, including the number of patients requiring depression screening, the number successfully screened, completed warm hand-offs, and A1c levels.

We hope this will..

We hope to increase our depression screening rate by 24% for our uncontrolled diabetic population.

SFHN | Planning for the PDSA Cycle

SMARTIE Aim Statement

The SFHN will improve access to Behavioral Health Integrated services for B/AA patients diagnosed with hypertension by increasing the percentage of those patients who meet with a Behavioral Health Clinician by 10% per self-identified race/ethnicity over the next 12 months.

Objective for PDSA cycle

Since we know one of the root causes is isolation, does BH involvement when a patient is diagnosed with HTN positively impact their disease trajectory?

We plan to....

Have 1 BHC at SEFHC assigned to 1 teamlet provide >1 visit to every new B/AA patient diagnosed with HTN in the month of June 2025. Visit will provide psychoeducation regarding the condition, instill hope, and use MI to determine plan to support patient with their goals.

Data collection tool

1)Changes in blood pressure over the next 12 months
2)show-rate to BH and Medical appointments over the next 3 months

We hope this will produce..

1)Patient engagement with medical care team represented by show rate to Behavioral Health and Medical appointments.
2)10% RI in HTN 12 months after baseline