Evaluating use of Depression Screeners to Improve Assessment of Symptoms within a Primary Care Clinic

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Introduction

- Depression is common in primary care, though screening is often infrequent
- 15 million physician office visits document depressive disorders as a primary diagnosis and 11% indicate depression on the medical record (CDC, 2023)
- A 2010-2018 survey indicated 13.1% of primary care encounters involved depression diagnoses with screenings completed 4.1% of the time (Jackson et al. 2020)
- Patient Health Questionnaire (PHQ) and the Patient-Reported Outcomes Measurement Information System (PROMIS) are recommended for use in primary care to assess for symptoms of depression (Cella et al., 2010; Kroenke et al., 1999)
- Barriers previously identified in research include personnel trainings, perceived clinical relevance, reading and rephrasing questions, patient opinions on purpose of screening, patient cooperation, time constraints, and workflow inefficiencies (Pilipenko & Vivar-Ramon, 2023)

Aim of project:

- To gain an understanding of medical residents and Advanced Practice Practitioners knowledge and utilization of depression screeners

Methods

Design:
Qualitative data was gathered via semi-structured focus group with interview led by first author documented using Otter.ai, an online transcription software.

Participants:

- Internal Medicine residents (n = 10) were interviewed on 3/17
- Advanced Practiced Practitioners (APPs; n = 6) were interviewed on 3/27
- Both interviews lasted approximately 10 min

Meeting Discussions:
Participants in each meeting were asked to discuss:

- How they currently screen for depression
- Use/experience with depression screening tools
- Barriers to completing depression screenings
- Thoughts regarding current depressions screeners
- Potential improvements to the screening process

Analysis:
Transcripts from the meetings with the residents and the APPs were entered into ChatGPT to identify key themes and differences between the two transcripts.

Results

🔑 Key Themes from Both Groups

🧠 1. Inconsistent Use & Triggers for Screening

- **General screening is not standardized**

🛠️ 2. Workflow & System Barriers

- **Time pressures**
- **Disorganized digital flow**
- **Pre-visit electronic completion**
- **Low digital literacy**

💬 3. Concerns About Validity & Clinical Usefulness

- **PHQ-9 scoring is often seen as misleading**
- **No surprises**

👥 4. Patient Experience & Comfort

- **Discomfort with screening by unfamiliar staff**
- **Confused about why they're being screened**

🔐 5. Safety & Suicide Risk Screening

- **Suicide-related item should be emphasized more**
- **Shift the tone of the visit dramatically**

🌱 6. Opportunities for Improvement

- **Pre-visit or waiting room screening**
- **Cultural and linguistic adaptations**
- **Alternative or supplemental tools**

⚖️ Differences Between Groups

Topic	APPs	Residents
Use of screening tools	More frequent mention of practical usage in med titration, disability paperwork, and care coordination	More focused on **philosophical and clinical validity concerns** about PHQ-9
Alternative tools	Mentions **GAD-7**, and wonders about screening for **mania** or using other tools	Discusses the **PROMIS questionnaire**, and critical review of **PHQ's research validation**
Patient interaction concerns	Frustration with **patients not understanding the questionnaire** or being confused by it	Raises concern that **PHQ might be misinterpreted due to medical symptoms** and patients may **not be honest with unfamiliar staff**
Screening logistics	Suggestions like printing PHQs, using sticky notes to document, or integrating them into routine triage	Suggestions for **embedding the PHQ in appointment reminders**, or doing **pre-visit screening through MyChart**

Average Depression Screening Data from the Primary Care Clinic: Nov 2024 to April 2025

Resident Practice:	57.14%
Faculty Practice:	78.08%
Total:	66.41%

This metric calculates the % of patients 18+ years of age who have been screened for depression in the last year. The data is taken from the flowsheets for PROMIS, PHQ, Glasgow or Edinburgh screening.

Discussion & Conclusion

- Key themes and differences identified in this project can be useful when considering how we can provide education around depression screening and address areas of concern
- These preliminary findings are similar to those of past research by Pilipenko and Vivar-Ramon (2023)
- Screeners, such as the PHQ-9, increase the likelihood of accurately screening for depression in primary care (Gilbody et al., 2007; Jeffrey et al., 2022)
- Screening for depression and use of collaborative care models for depression is a cost-effective way to address the gaps in identifying and treating depression (Jiao et al., 2017)
- Self-report depression screeners have limitations in assessing clinical change and clinicians should use additional clinical assessment when interpreting changes (Hobbs et al., 2021)
- *Future directions:* Next steps for this project should be including other groups within the primary care setting (e.g., faculty providers, clinical and clerical support staff, etc.) and collaboration with clinic leadership to identify areas of training
- *Limitations:* The primary goal of this project was to gain an understanding of the knowledge and utilization of depression screeners within a primary care setting. ChatGPT was used to analyze the transcripts, and the results should be interpreted with caution

References