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Staff Education to Impact Staff Knowledge of Depression Screening in Primary Care

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Walden University

College of Nursing

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Nkeiruka Unaegbu

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.

Review Committee

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Walden University
2025

Executive Summary: Staff Education Project
Staff Education to Impact Staff Knowledge of Depression Screening in Primary Care

by

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MS, Walden University, 2020

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Executive Summary Submitted in Partial Fulfillment
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Summary

This doctoral project was a staff education program designed to improve depression screening among patients in an adult primary care setting. The practice problem addressed was the lack of standardized depression screening that led to inconsistent detection, delayed diagnosis, and fragmented mental health care. A move to address the issue is critical in nursing practice since nurses play a central role in early identification, patient advocacy, and integration of behavioral health into primary care. The practice-focused question guiding the project was, Will implementing a nursing staff education program impact their knowledge of Clinical Practice Guideline (CPG) for depression screening and willingness to use /adopt PHQ-9 as a standard routine for monitoring and managing depression among adult patients? The project's purpose was to educate nurses on standardizing depression screening through the adoption of the PHQ-9 tool and to strengthen staff confidence in its use. The analytical strategies used in the project included pre-and post-training questionnaires, with quantitative data analyzed using descriptive statistics and normalized learning gain calculations in Excel, and qualitative responses coded for emergent themes. The findings showed significant improvements in knowledge (average scores increased from 57% to 90%), substantial normalized gains (average of 34%), and enhanced staff confidence. The qualitative results highlighted leadership support, improved recognition of mental health parity, and the need for clear referral pathways. Overall, the project produced a structured depression screening guideline using PHQ-9. Its implications include strengthening nursing practice through consistent, evidence-based screening and promoting positive social change by advancing equity, inclusion, and access to mental health care in diverse populations.

Background

Gap In Practice

The World Health Organization (2025) documents that an estimated 5.7% of adults suffer from depression. However, in primary care, it goes undetected without routine standardized screening. Failure to detect depression results in significant health and societal consequences. The prevailing evidence indicates that around two-thirds of all cases of depression in the United States are undiagnosed (Williams et al., 2017). The challenge also manifests at identified project site. The absence of formal clinical practice guidelines for depression screening, variable use of screening across providers, and limited structured training on the PHQ-9 for clinical staff contribute to this issue. These site-specific factors were identified through observation, chart review, and staff feedback. In essence, such variables created missed opportunities for early identification and coordinated treatment.

Project Question and Purpose

The project type is a staff education initiative which emphasizes translating evidence into practice by equipping clinical staff with the skills and resources to adopt routine depression screening. The project sought to determine changes in staff knowledge, confidence, and attitudes towards depression screening using the PHQ-9.

The project was guided by the clinical question: “Will implementing a nursing staff education program impact their knowledge of Clinical Practice Guideline (CPG) for depression screening and willingness to adopt PHQ-9 as a standard routine for monitoring and managing depression among adult patients?” The purpose of the project was to educate staff on standardized depression screening using PHQ-9. The initiative would translate to improving early detection of depression, enhance treatment referral rates, and strengthen

the continuity of health care. The above aspects can be accomplished once the providers can accurately administer, score, and respond to PHQ-9 results.

Evidence Supporting the Project Change/ Gap in Practice

The prevailing evidence recognizes the prevalence of missed opportunities for depression screening in clinical settings. For instance, Kato et al. (2018) recognized that many Americans were not having their depression needs assessed and specific populations were more likely to be missed. According to Kato et al. (2018), men above 75 years, minorities, and the uninsured were more vulnerable to not having assessments for depression. Similarly, Ethan (2024) discovered that most missed opportunities for depression screening are due to non-standardized documentation and assessment, and not due to a lack of interventions. Garcia et al. (2022) encouraged implementing routine screening in primary care to reduce disparities in screening rates. Overall, the prevailing evidence asserts that the gap in practice extends beyond the project site and manifests in other regions.

Evidence Supporting the Change

The prevailing evidence supports staff education on depression screening in primary care settings to improve mental health outcomes for adults. For instance, Barry et al. (2023) conducted a systematic review and presented the U.S. Preventive Services Task Force (USPSTF) recommendation statement on depression and suicide risk screening in adults. The evidence was drawn from a large body of studies across primary care and community settings, offering Level I, high-quality evidence. Barry et al. (2023) recommended universal depression screening for adults due to a moderate net benefit for early detection and timely follow-up treatment. The recommendations confirms that

routine screening using validated tools like the PHQ-9 is both evidence-based and nationally endorsed.

Additionally, Carroll et al. (2020) conducted a systematic review to establish the reliability and validity of mental health screening instruments, with a particular focus on the PHQ-9, in resource-constrained primary care settings. The findings of the study provided Level I, high-quality evidence. Carroll et al. (2020) concluded that the PHQ-9 is a valid and reliable tool for detecting depression even when resources are limited. The findings directly support the staff education initiative by demonstrating that the PHQ-9 is both practical and evidence-based, regardless of setting constraints.

Costantini et al. (2021) also carried out a systematic review focused on the use of the PHQ-9 for depression screening in primary care. The study provides Level I, high-quality evidence. The findings demonstrate that the PHQ-9 is highly effective in identifying depression, with strong sensitivity and specificity. The aspect makes it one of the most reliable tools for routine use in primary care. However, Costantini et al. (2021) cautioned that the PHQ-9 is inconsistently applied in many primary care settings, which mirrors the practice gap at the practicum site, where providers lack standardized guidelines and structured training

Additionally, Habtamu et al. (2023) conducted a systematic review examining interventions designed to improve the detection of depression in primary healthcare. The study synthesized findings from diverse studies across adult primary care populations and presented Level I, good-quality evidence. According to Habtamu et al. (2023), interventions such as provider training and standardized screening protocols significantly

improve the rates of depression detection. The findings reinforce this project's emphasis on structured staff education.

Lee et al. (2020) also performed a systematic review of global guidelines for the management of depression. The study analyzed evidence from a wide range of healthcare systems and populations. It provides a Level I, high-quality evidence by highlighting how standardized guidelines can improve screening, early intervention, and follow-up care. Lee et al. (2020) emphasized that consistent application of guidelines leads to better clinical outcomes, while variability in guideline adoption across regions often results in uneven patient care. The findings support the rationale for this project since the practicum site lacks a formal guideline for depression screening, which results in inconsistency in provider practices.

Miller et al. (2020) conducted a systematic review examining the role of pharmacists in conducting depression screening in community settings. The review provides a Level I, high-quality evidence. The findings indicated that pharmacists can play a valuable role in identifying undiagnosed depression using validated screening tools such as the PHQ-9 and demonstrated positive outcomes in community-based screening initiatives. Notably, the context of the study differs from the context of primary care. However, the findings illustrate the broader applicability and reliability of the PHQ-9 across diverse healthcare environments. Its relevance to this project lies in reinforcing the adaptability of the PHQ-9 across provider roles and care settings, while also highlighting that structured training and follow-up processes are critical to achieving sustainable results.

Negeri et al. (2021) also conducted a meta-analysis using individual participant data (IPD) to evaluate the accuracy of the PHQ-9 in detecting major depression across diverse

populations and healthcare settings. The study presented Level I, high-quality evidence. The findings confirmed that the PHQ-9 has high sensitivity and specificity, which makes it one of the most accurate tools for identifying major depression in both clinical and community settings. The article is relevant to the project since it justifies the selection of PHQ-9 as the centerpiece of the Clinical Practice Guideline. It also strengthens the case for staff education by ensuring that the tool is applied consistently and accurately within the project site to close the existing gap in screening practices.

Moreover, Nollett et al. (2020) conducted a mixed-methods study exploring barriers to integrating routine depression screening into community low vision rehabilitation services. The research provided Level III, good-quality evidence and offers practical insights into real-world challenges of screening implementation. Some of the key barriers that were identified included staff resistance, resource constraints, and a lack of standardized protocols. The insights from the study highlight the importance of anticipating barriers and addressing them through structured staff education and leadership support for the sustainable implementation of the PHQ-9 within the practicum site.

Lastly, Reilly et al. (2020) conducted a narrative review of studies examining the effectiveness of perinatal depression screening programs. The review provided Level V, good-quality evidence that screening is most effective when combined with structured follow-up care and treatment. The review emphasizes that while tools like the PHQ-9 or EPDS can successfully identify depression, the benefits to patient outcomes are maximized only when there are clear referral pathways and continuity of care. These findings align directly with the project's aim of standardizing depression screening with the PHQ-9 and ensuring positive screens lead to appropriate follow-up care in the primary care setting.

Overall, the reviewed literature provides a compelling rationale for addressing the current practice gap in depression screening within primary care. High-quality systematic reviews and meta-analyses (Barry et al., 2023; Carroll et al., 2020; Costantini et al., 2021; Negeri et al., 2021; He et al., 2020) confirm the PHQ-9 as a reliable, valid, and accurate tool for detecting depression across diverse populations and healthcare settings. Additional evidence highlights that interventions combining provider training on standardized guidelines improve screening rates and early detection (Habtamu et al., 2023; Lee et al., 2020; Reilly et al., 2020). Finally, evidence on barriers to implementation (Nollett et al., 2020) highlights the need for staff education, leadership engagement, and workflow redesign to ensure sustainability.

Staff Education Project Development

The project was implemented in a primary care clinic in Maryland that serves an adult population. The patients present with a wide range of chronic and acute health needs. Besides, the facility operates six days a week and provides preventive screenings, chronic disease management, and behavioral health referrals. However, the site lacked a standardized depression screening protocol, which resulted missed diagnoses, inconsistent use of tools like the PHQ-9 and fragmented follow-up care.

The recruitment of participants in the project was conducted internally at the clinic. The staff were invited to participate with the training being voluntary but highly encouraged. The staff also provided consent to complete the pre- and post-training questionnaires, and participation rates reached 100% due to strong leadership endorsement. A total of 14 nurses took part in the project.

The implementation of the staff education was done in a three-phase process. The pre-training questionnaire was administered at the start of this phase to establish baseline knowledge, attitudes, and self-reported competency. The second phase entailed education and training on interpreting scores and initiating referrals to behavioral health services when indicated. The staff participated in structured in-service training sessions that covered depression recognition, PHQ-9 administration and scoring, and referral pathways for patients with positive screens. During the third phase, the post-training questionnaire was administered to measure changes in staff knowledge, attitudes, and confidence.

Collection and Analysis of Evidence

A pre-post training questionnaire served as the primary data collection tool. It measured staff knowledge of depression and PHQ-9 use, attitudes toward screening, self-reported competency, and workflow readiness. The quantitative data from multiple-choice and Likert-scale questions highlighted measurable changes in knowledge and confidence. At the same time, qualitative responses from open-ended items provided insights into perceived barriers and support needs.

Evaluation Process

Quantitative data, including knowledge scores and Likert-scale responses on confidence and attitudes, were entered into Microsoft Excel for descriptive statistical analysis. Measures such as frequencies, percentages, and mean score changes were calculated to highlight improvements in staff understanding, confidence, and perceptions of depression screening. Improvements in knowledge, confidence, and positive attitudes toward depression screening were indicators of the training's effectiveness. Besides, qualitative data from open-ended reflections were reviewed and thematically analyzed to

identify recurring patterns related to workflow challenges, perceived benefits, and ongoing resource needs. The evaluation provided a comprehensive picture of how staff education influenced screening readiness and adoption of the CPG. A normalized learning gain formula was used to determine the effectiveness of the staff education initiative. The formula for calculating a learning gain is $(\text{Post-Learning Score} - \text{Pre-Learning Score}) / (\text{Maximum Score} - \text{Pre-Learning Score}) \times 100$, derived from Brigham and Women's Hospital Center for Nursing Excellence (2021). The highest possible score on the knowledge aspects was 30 marks.

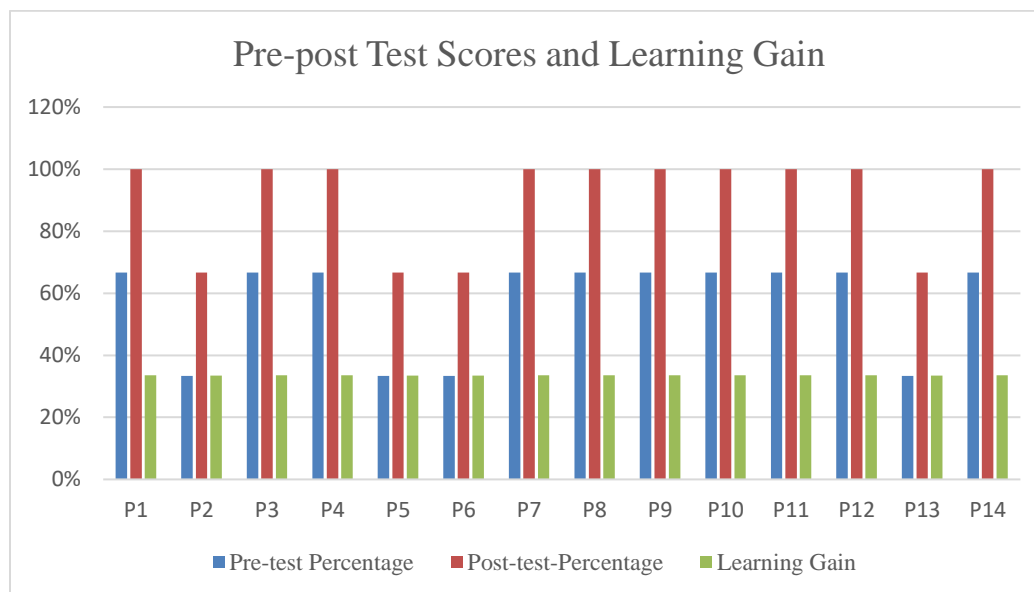
Results

Post-Implementation Results

A total of 14 clinical staff members took part in the educational initiative and completed the pre-post-test questionnaires. The quantitative analysis demonstrated substantial improvements in knowledge and competency related to depression screening using the PHQ-9. The pre-training scores ranged from 33% to 67% with an average score of 57%, reflecting significant variability in baseline knowledge. Post-training scores improved to a range of 67% to 100%, with an average of 90%. Furthermore, the highest post-training score achieved was 100% ($n = 10$), while the lowest was 67% ($n = 4$ participants). Also, the participants illustrated learning gains between 33% to 34%. The mean normalized gain across all participants was 34% and indicated a moderate overall learning impact. Table 1 shows learning gain results. Figure 1 illustrates the distribution of pre- and post-test knowledge scores and the learning gains, highlighting the upward shift in performance across participants.

Table 1*Learning Gains Result*

Participant	Pre-test percentage	Post-test-percentage	Learning gain
P1	67%	100%	34%
P2	33%	67%	33%
P3	67%	100%	34%
P4	67%	100%	34%
P5	33%	67%	33%
P6	33%	67%	33%
P7	67%	100%	34%
P8	67%	100%	34%
P9	67%	100%	34%
P10	67%	100%	34%
P11	67%	100%	34%
P12	67%	100%	34%
P13	33%	67%	33%
P14	67%	100%	34%
<i>M</i>	57%	90%	34%

Figure 1*Pre-test and Post-Test Scores*

The qualitative findings revealed several key themes as illustrated in Table 2. For instance, the staff consistently reported increased confidence in administering and scoring the PHQ-9. Besides, their attitude also emphasized the importance of mental health screening as equal to physical health checks. Additionally, many participants acknowledged strong leadership support as a facilitator for adoption. However, a few challenges were also recognized. Such included workflow integration pressures in the form of time constraints during intake, uncertainty about referral pathways, and patient reluctance to discuss mood-related symptoms. The staff also expressed interest in ongoing refresher training to sustain momentum.

Table 2*Summary of Qualitative Themes from Staff Feedback*

Theme	Frequency (n = 14)	Representative quotes	Interpretation
Increased confidence in screening	10	“I now feel confident in administering and scoring the PHQ-9.”	Training boosted staff self-efficacy in recognizing and managing depression.
Leadership and organizational support	8	“Our nurse manager has been very supportive, which makes implementation easier.”	Perceived support from leadership encouraged adoption and reduced resistance.
Workflow integration challenges	6	“Fitting PHQ-9 into a busy intake can be tough at times.”	Staff anticipated time constraints.
Importance of mental health parity	9	“Depression screening is just as important as checking blood pressure or diabetes.”	Staff recognized the value of integrating mental health into routine care.
Need for clear referral pathways	7	“Sometimes I’m not sure where to send patients after a positive screen.”	Highlighted the necessity of structured referral processes for continuity of care.
Patient-related barriers	5	“Some patients hesitate to answer questions about mood.”	Patient reluctance was acknowledged as a barrier requiring communication strategies.
Desire for ongoing education/support	6	“Refresher training will help keep us consistent.”	Staff emphasized the need for continuous support to sustain practice change.

Overall, the staff education led to measurable improvements in provider knowledge, confidence, and readiness. It also led to the recognition of possible barriers

that can be overcome through a combination of strong leadership support and scalability of the clinical practice guideline.

Impact on Organization

The project strengthened the organization's overall capacity to deliver integrated, evidence-based care. For instance, the improved staff confidence and leadership engagement fostered a culture supportive of mental health as a core component of primary care. The changes will enhance continuity of care and referral processes and positioned the site as a model for sustainable depression screening practices.

Impact on Nursing Practice and Social Change

The project reinforced nursing's role as a frontline driver of quality improvement in primary care. The move to equip nurses with the skills and confidence to implement standardized depression screening, advanced, holistic, patient-centered care. Besides, the nurses became empowered to identify mental health concerns early, initiate timely referrals, and reduce the stigma associated with depression. The project also supports Walden University's mission of social change by promoting equitable access to mental health services, improving patient outcomes, and strengthening the integration of behavioral health into primary care systems.

Limitations

Several limitations were identified in the project. For instance, the small sample size (n=14) limits generalizability beyond the practicum site. Besides, the improvements could reflect short-term training effects rather than long-term practice change. Additionally, self-reported attitudes and open-ended reflections may also be subject to response bias. In addition, time constraints and competing priorities within primary care

settings could affect sustained implementation of depression screening. Despite the above limitations, the findings provide valuable insights into the feasibility and impact of structured staff education paired with guideline-based screening.

Impact of Study Beyond Local Site

The findings of the study have broader implications beyond the local site. The use of a standardized depression screening guideline supported by staff education offers a scalable model that can be adapted across diverse clinical settings. The project demonstrates how structured training and evidence-based tools can reduce practice variability, enhance care quality, and promote health equity on a larger scale.

Conclusions

The project demonstrated that implementing a standardized depression screening guideline supported by staff education had a positive organizational impact. The organization advanced its capacity to deliver timely, evidence-based behavioral health care. Plausible recommendations to improve the practice include providing periodic refresher trainings, clarifying referral pathways, and continuing leadership engagement to address workflow challenges. For nursing practice, the project highlights the central role of nurses in early identification of depression and in fostering holistic, patient-centered care. The broader implications extend to social change, as systematic depression screening promotes equity in access to mental health services, reduces stigma, and ensures that diverse patient populations receive timely and appropriate support.

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Appendix: Questionnaire

Pre- and Post-Training Questionnaire

Project Title: Enhancing Depression Screening in Primary Care

Participant Role: Nurse Medical Assistant Provider Other (Specify):

Date: _____

Section A: Knowledge Assessment

1. Multiple Choice

Which of the following statements best describes the PHQ-9 screening tool?

- A. A tool used to assess anxiety levels in primary care settings
- B. A validated questionnaire that assesses the severity of depressive symptoms
- C. A diagnostic tool for bipolar disorder
- D. A non-standardized mood self-assessment form

2. True/False

The PHQ-9 can be self-administered by the patient or administered by a clinician.

True False

3. Multiple Choice (Select all that apply)

Which of the following PHQ-9 score ranges indicates moderate depression?

- 0–4
- 5–9
- 10–14
- 15–19
- 20–27

Section B: Attitudes and Beliefs (Likert Scale)

Please indicate your level of agreement with the following statements:

(1 = Strongly Disagree, 5 = Strongly Agree)

Statement	1	2	3	4	5
Depression screening should be a routine part of primary care visits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I believe I can make a meaningful impact on patient outcomes through proper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

depression screening.					
I feel adequately supported by leadership to implement new screening practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health screening is equally as important as screening for chronic physical conditions (e.g., diabetes, hypertension).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C: Self-Assessment of Competency (Pre/Post Comparison)

Rate your current level of confidence in the following areas:

(1 = Not Confident, 5 = Very Confident)

Competency	1	2	3	4	5
Recognizing signs and symptoms of depression in adult patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Administering and scoring the PHQ-9 accurately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documenting PHQ-9 results correctly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiating referrals for patients who screen positive for depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section D: Workflow and System Readiness

12. Select One

Which of the following best describes your perception of how depression screening will fit into your current workflow?

- Seamlessly integrate without disruptions
- Require moderate adjustments but manageable
- Pose significant workflow challenges
- Unsure at this time

13. Multiple Choice (Select all that apply)

What potential barriers do you foresee in implementing routine depression screening?

- Time constraints during patient visits
- Lack of confidence in using the screening tool
- Uncertainty about referral pathways
- Patient reluctance to discuss mental health
- Other (Specify): _____

Section E: Open-Ended Reflections

14. In your own words, describe why you believe (or do not believe) routine depression screening is important in primary care.

15. What additional support or resources would you need to confidently perform depression screening as part of your daily practice?
