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## Clinical Practice Guideline for Universal Anxiety Screening for Advanced Practice Providers

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# Walden University

College of Nursing

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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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Executive Summary: Clinical Practice Guideline  
Clinical Practice Guideline for Universal Anxiety Screening for Advanced Practice  
Providers  
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## Summary

This project was a clinical practice guideline (CPG) focused on anxiety screening in a primary care setting using the Generalized Anxiety Disorder (GAD-7) screening tool. The practice problem addressed general anxiety disorder and the need for standardized assessments for risk, as recently been recommended by the U.S. Prevention Service Task Force (USPSTF). Anxiety disorder is common but frequently untreated, due in part to low rates of screening. Lack of an evidence-based guideline for anxiety screening may contribute to delayed diagnosis and inconsistencies. The practice-focused question was, Does the evidence support development of an evidence-based CPG for universal anxiety screening in the ambulatory care clinic that receives expert panel quality scoring via the AGREE II Instrument and receives approval for use in practice by end users? The John Hopkins evidence-based practice model was used to guide evidence appraisal and synthesis, with 21 articles initially identified and 13 high-quality studies included, primarily Level I evidence such as systemic reviews, meta-analysis, and national guidelines. Results of the three-member expert panel AGREE II review showed quality scores for all six domains ranging from 81.5% to 97.2%. The overall quality score was 6.5/7, and the CPG was accepted for use in practice by end-users by a score of 7/7. Implementation of this CPG is expected to standardize universal anxiety screening, improve early identification of anxiety symptoms, and treatments methods. For nursing practice, the guideline provides a clear, evidence-based framework that can enhance clinical decision-making and promote consistent screening for the practice.

## **Background**

Anxiety disorders are highly prevalent and frequently underrecognized in adult primary care facilities, creating a gap in timely diagnosis and treatment plans (Barry et al., 2023). Primary care practices typically rely on symptomatic screening and with the increased prevalence of anxiety, the standards for screening patients (Barry et al., 2023). The project facility is encountering a gap between current symptom-based screening and a standardized screening for anxiety risk. However, the facility lacks a CPG with evidence-based standards for universal anxiety screening assessment. Therefore, the U.S. Prevention Service Task Force (USPSTF) will be used as a recommendation for anxiety screening (Barry et al., 2023). The USPSTF is an independent national panel that recommends evidence-based screening recommendations to healthcare organizations and providers. The USPSTF has recommended that adults between the ages of 18 and 64 years old in primary care settings (including pregnant and postpartum patients) should receive anxiety screenings. A total of 21 articles were screened using the Johns Hopkins Research Evidence Appraisal tool, with 13 articles meeting the inclusion criteria for developing the CPG, primarily high-level evidence such as randomized controlled trials and systematic reviews.

The practice-focused question was: Does the evidence support development of an evidence-based CPG for universal anxiety screening in the ambulatory care clinic that receives expert panel quality scoring via the AGREE II Instrument and receives approach for use in practice by end users? The purpose of this project was to develop a CPG that receives an expert appraisal to support the practices transition from symptomatic to

universal anxiety screenings for adults (ages 18-64) using GAD-7 as seen in the Appendix. Various, large epidemiological and meta-analytical studies have demonstrated the doubling of anxiety prevalence from 2008 to 2018 showing approximately 30% of the nation has experienced anxiety in one point in their lives (Santabárbara et al., 2021; Twenge & Joiner, 2020). There has been a large increase in the prevalence of anxiety since COVID-19, showing that pre-pandemic to post-pandemic has experienced a tripling in anxiety, from 8% to 25% (Santabárbara et al., 2021; Twenge & Joiner, 2020). Approximately 30% of individuals in the United States have experienced anxiety at one point in their lives, which continues to support the need to provide universal screenings (Santabárbara et al., 2021; Twenge & Joiner, 2020).

The rapid increase in anxiety disorder prevalence has brought attention to the screening process for anxiety, which led to recommended changes by USPSTF. The USPSTF is an independent national panel that recommends evidence-based screening recommendations to healthcare organizations and providers (Barry et al., 2023). For example, Santabarbara et al. (2021) evaluated 161,556 participants, showing a marked increase in anxiety prevalence across the nation during COVID-19. In addition to the steady increase in anxiety disorders, additional research has demonstrated that adults were 3 times more likely to report anxiety and depression symptoms in comparison to 2019, which shows that the COVID-19 pandemic exacerbated the disorder more than during previous years (Twenge & Joiner, 2020). The CDC evaluated this again in 2022 with prevalence of 18.2% for adults 18 and older showing a decline in anxiety but still considerably high, showing the problem is still concerning (Terlizzi & Zablotsky, 2024).

It is also important to note that the USPSTF report explained how anxiety disorders, while common, are frequently underrecognized in the primary care settings, validating the use of various tools such as the GAD-7 and the GAD-2, as these performed well in this national analysis (O'Connor et al. 2023). Other authors such as Barry et al. (2023) have also investigated anxiety screenings and concluded that all adults younger than 65 years old should receive anxiety screening in primary care, including pregnant and postpartum women. Although there has been insufficient evidence for participants over the age of 65 years old, the result concluded that adults younger than 65 would benefit from this screening protocol. There have been various investigations into the two screening tools recommended by USPSTF, showing how GAD-2 and GAD-7 are both viable screening tools with strong psychometric performance and note they are practical for universal screening (Park & Park, 2025; Sapra et al., 2020). Park and Park (2025) analyzed 45 studies based on the inclusion criteria and concluded the sensitivity of GAD-7 was 0.81 and the specificity was 0.78. Although GAD-7 is the gold standard for screening patients with anxiety disorder, the GAD-2 demonstrates acceptable sensitivity and specificity when comparing it to the gold standard, which supports their use for a quick anxiety screening (Hlynsson & Carlbring, 2024).

There are more supporting studies showing the viability in universal anxiety screenings for primary care centers. There were two quality improvement studies that have been implemented by authors in universal screenings into practice, focused on anxiety, both showing positive results after switching to universal screenings (Garcia, 2020; Salinas et al., 2024). Salinas et al. (2024) explained how they evaluated routine

screenings in college health primary care offices and how this screening was not only feasible, but they had increased their detection and follow-up rates with patients who were positive for anxiety. Furthermore, Garcia (2020) authored a dissertation on implementing a treatment protocol with GAD-7 in primary care and illustrated the practicality of the screening process and how it can also be effective. The American Academy of Family Physicians (2022) has supported the use of standardizing generalized anxiety and panic disorder screenings in the primary care practice to improve detection and outcomes as well.

A total of 21 articles were screened using John Hopkins Research Evidence Appraisal tool, with 13 articles meeting the inclusion criteria for developing the CPG, primarily high-level evidence such as randomized controlled trials and systemic reviews. Thirteen studies were included in the review, eight of which were Level I studies that encompassed systematic reviews, meta-analysis, and the recommendations by the USPSTF (a national organization). Five studies were Level 2-V, which included cohort, quality improvement, or expert opinions. These articles were evaluated based on the John Hopkins Evidenced-Based Practice Model, which aided in the appraisal of these studies. The strength of the evidence is tied directly to its level of evidence, because this helped support the need for this CPG. The eight Level I articles demonstrated a robust explanation of why changing from symptomatic anxiety screening to universal screening was pertinent for this primary care practice.

## **Clinical Practice Guideline Development**

The CPG for universal GAD-7 anxiety screening was developed and evaluated through structured, stepwise process designed to ensure methodological rigor and organizational relevance. An expert panel of three clinicians was convened to evaluate and appraise the CPG. The panel members were selected based on their expertise in primary care, mental health, nursing practice, medicine, and quality improvement. The clinicians were selected based on their years of experience (no new graduates), education (physician or advanced practice provider), and area of practice (primary care and/or mental health). Their background was key to their selection process. This diverse background provides a multidisciplinary perspective. This will provide expert review from a group with a robust background, enabling a comprehensive review of the CPG to ensure the quality aligns with the USPSTF recommendations

The CPG was developed in several chronological steps, first starting with the practice gap being identified, which focused on the organization relying on symptomatic screening for anxiety rather the universal screening. The second step focused performing a literature review with current evidence and national guidelines to identify the best practices for screening adults with anxiety. The third step was to draft recommendations for the CPG and discuss a target population (18-64 years old including pregnant, postpartum, new and follow-up patients), screening frequency, scoring thresholds, and follow-up actions. The fourth step was to draft a CPG into a clear, provider-friendly format that aligns with the documentation guidelines. The fifth step was to gather an expert panel and provide them with the CPG and the AGREE II materials as well as the

instructions for standardization and score sheets. The last step was then asked to evaluate and calculate their findings to determine if the CPG met the quality threshold.

The AGREE II instrument was used to evaluate the CPG methodology across 23 items in six domains. AGREE II is an updated internal tool developed to evaluate the methodology of a CPG and the rigor used to develop it, as well as its transparency. The six domains are scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence, all which receive ratings based on a 7-point Likert scale ranging from *strongly disagree* to *strongly agree*. Each domain reflects a key aspect of quality when evaluating a guideline, and the AGREE II provides a score on the quality of each section. Once the ratings were returned, the items were scored into a spreadsheet, the domains were totaled, and the scores were calculated for each expert and then converted into a percentage. The screening tool is being used because it is designed to formally appraise a CPG, which is the essence of this project. Once the AGREE II instrument data was obtained and evaluated, then the next step was to evaluate the overall quality and assessment of the CPG using the AGREE II-Global Rating Scale (AGREE II-GRS). The Global Rating Score consists of five items that assess how well this CPG is reported. First, the Global Rating Scale rates the quality of the CPG by using the 7-point scale (1 being lowest quality to 7 being the highest quality), with five items: rate the overall quality of the guideline development methods, rate the overall quality of the guideline presentation, rate the completeness of reporting, rate the overall quality of the guideline recommendations and rate the overall quality of the guideline. The second part of the Global Rating Scale is rating the overall guideline

assessment of the CPG, using the 7-point scale with 1 being *strongly disagree* to 7 being *strongly agree*, asking two questions: Would you recommend this guideline for use in your practice? Would you make use of this guideline of this quality in your professional decisions? The formula used for these calculations was:

Minimum and maximum for each (Min = 1 × items × 3; Max = 7 × items × 3)

$$\text{Percentage Score} = \frac{\text{Raw} - \text{Min}}{\text{Max} - \text{Min}} \times 100$$

### Results

The expert panel evaluation demonstrated that the CPG for universal GAD -7 screening met criteria for high-quality guideline suitable for use in this primary care practice. The results were gathered from a three-member expert panel who reviewed the CPG on GAD-7 for universal screenings and evaluated it using the AGREE II instrument. The AGREE II instrument evaluates 23 items across six domains on a scale of 1 to 7 assessing methodological quality and suitability for the practice. The goal was to receive a quality score above 70% for each of the six domains and the global scores, indicating a high-quality guideline that is suitable for practice and should be considered for permanent implementation.

An expert panel of three clinicians with experience in primary care, mental health, and quality improvement used the AGREE II Instrument to assess this CPG. The AGREE II instrument assessed methodological quality across six domains, using a 7-point Likert Scale. All six domain scores exceeded the 70% quality threshold with scores ranging from 81.5% to 97.2%. with the six domains as follows: Scope & Purpose scored 87%, Stakeholder Involvement scored 81.5%, Rigor of Development scored 96.4%, Clarity of

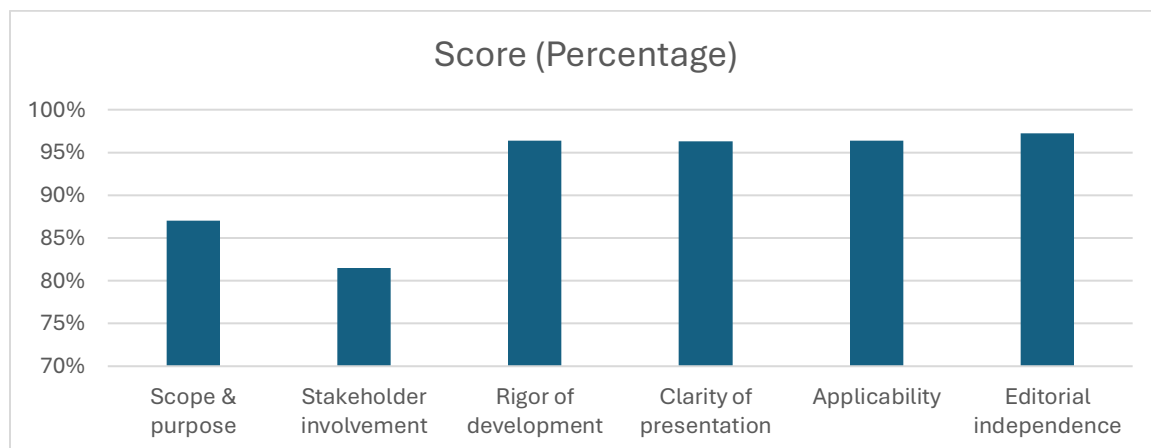
Presentation scored 96.3%, Applicability 96.4%, and Editorial Independence scored 97.2%. Overall score was (6.5/7) and the CPG was accepted for use in practice by a score of (7/7). This indicates a high-quality guideline. The CPG is expected to standardize anxiety screening for this practice which will yield earlier identification and management of anxiety and provide positive social change by promoting equitable, evidence-based mental health care for patients. Using the AGREE II scoring tool, the domain scores (see Figure 1) were calculated for scope and purpose, stakeholder involvement, rigor of development, clarity of presentation, applicability, and editorial independence.

The Agree II results demonstrate a high-quality CPG that is ready for use in this primary care setting and highlight specific areas for future refinement. The stakeholder involvement had the lowest score (81.5%) but still demonstrated adequate quality and demonstrates potential for future enhancements. These future enhancements include a broader inclusion of frontline staff, patients, or family representatives in the guideline development and review. In contrast, the scores for rigor of development, clarity of presentation, applicability, and editorial independence indicate a robust methodological approach that supports use of the CPG in this primary care setting.

Adoption of this CPG has potential positive impacts on the organization by standardizing universal anxiety screenings, which may increase identifying patients with anxiety symptoms, while promoting more consistent referrals and follow-up pathways. The standardizations may also improve workflow predictability, support provider decision-making, and align the organization with evidenced-based recommendations for mental health screenings.

The project has several limitations that may affect the interpretation and generalization of results. The first limitation is the AGREE II evaluation, which was completed by three expert panel members, limiting the diversity of perspectives and may increase influence of individual raters, meaning it may need more evaluators. The second limitation is the appraisal focused mostly on guideline quality but did not measure the provider adherence, screening rates, or patient outcomes, and this leaves room for questioning real-world effectiveness. The last limitation is the project focused on a single primary care organization with its own resources, culture, and patient population, which may differ from practice to practice.

Despite these limitations, the project is important beyond the local site because it contributes to the rigorously developed, high quality, CPG for the use of universally screening GAD-7. The CPG can serve as a model for other primary care practices seeking to strengthen mental health screening processes within their practice. The AGREE II domain scores, particularly in rigor of development and applicability, demonstrate the methodology is sound and can be replicated or adapted by the organizations.

**Figure 1***AGREE II Domain Scores from Expert Panel*

### Conclusions

The implementation of the CPG is expected to have a meaningful impact on the organization by standardizing anxiety screening processes and strengthening evidenced-based care in the primary care settings. This CPG was developed to help the practice transition from symptomatic anxiety screenings to universal anxiety screenings using the GAD-7, which is expected to provide the organization with a clear, evidence-based framework to screen, identify, and assess patients with anxiety. The guidelines were designed for Advanced Practice Providers to screen adults between the ages of 18 and 64 years old, including new patients, follow-ups, pregnant, and postpartum patients. Implementing this CPG is anticipated to reduce the reliance on patients to disclose their symptoms, standardize the screening process, and improve timely identification and assessment of anxiety. This outcome can enhance the primary care practice ability to provide consistent, evidence-based health care.

Further recommendations include implementation in a phased manner to allow the practice to adapt workflows gradually and avoid overwhelming the staff. The organization will need to establish a process for regularly reviewing and updating the CPG as a response to the ongoing changes in healthcare. The practice should also stay up to date with the USPSTF recommendations and changes that emerge and consider future revisions to strengthen stakeholder involvement.

For the nursing practice, the CPG clarifies roles in administering the GAD-7, documenting the results, and coordinating follow-up care for patients, which enhances nurse-led patient care. By promoting universal screenings as the standardized screening process rather than symptom-based assessments, the guideline supports more equitable care for patients and may lead to a positive social change through more timely diagnosis.

The project was evaluated through a structured expert panel review using the AGREE II instrument. Three experts on the panel independently reviewed the completed CPG and rated each of the 23 AGREE II items, organized into six domains. These domains were scope and purpose, stakeholder involvement, rigor and development, clarity of presentation, applicability, and editorial independence and rated on a 7-point Likert scale from *strongly disagree* to *strongly agree*. The items were scored within each domain and were summed across raters and converted into percentages per domain using the AGREE II scoring formula. Two global ratings were noted as well, which included scoring overall quality using the 7-point scale from the lowest quality to highest quality and the and overall assessment of the CPG using 7-point scale from *strongly disagree* to

*strongly agree*. Overall, both AGREE II scoring agents aligned with the recommendation for using the CPG in practice.

## References

- Barry, M. J., Nicholson, W. K., Silverstein, M., 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., Tsevat, J., Underwood, S. M., & Wong, J. B. (2023). Screening for anxiety disorders in adults: US Preventive Services Task Force recommendation statement. *JAMA*, *329*(24), 2163-2170.  
<https://doi.org/10.1001/jama.2023.9301>
- Garcia, D. E. (2020). *Implementation of an anxiety screening and treatment protocol in primary care* (Doctoral capstone project, Nova Southeastern University).  
 NSUWorks. [https://nsuworks.nova.edu/hpd\\_con\\_stuetd/74](https://nsuworks.nova.edu/hpd_con_stuetd/74)
- Goodwin, R. D., Weinberger, A. H., Kim, J. H., Wu, M., & Galea, S. (2020). Trends in anxiety among adults in the United States, 2008–2018: Rapid increases among young adults. *Journal of Psychiatric Research*, *130*, 441-446.  
<https://doi.org/10.1016/j.jpsychires.2020.08.014>
- Hlynsson, J. I., & Carlbring, P. (2024). Diagnostic accuracy and clinical utility of the PHQ-2 and GAD-2: A comparison with long-format measures for depression and anxiety. *Frontiers in Psychology*, *15*, Article 1259997.  
<https://doi.org/10.3389/fpsyg.2024.1259997>
- O'Connor, E. A., Henninger, M. L., Perdue, L. A., Coppola, E. L., Thomas, R. G., & Gaynes, B. N. (2023). Anxiety screening: Evidence report and systematic review for the US Preventive Services Task Force. *Jama*, *329*(24), 2171-2184.  
<https://doi.org/10.1001/jama.2023.6369>

- Park, S. H., & Park, S. K. (2025). An updated systematic review and meta-analysis of the predictive validity of the general anxiety disorder (GAD)-7 and GAD-2 in screening for anxiety disorders. *Journal of Affective Disorders*, 391, Article 119913. <https://doi.org/10.1016/j.jad.2025.119913>
- Salinas, A., Crenshaw, J. T., Gilder, R. E., & Gray, G. (2024). Implementing the evidence: Routine screening for depression and anxiety in primary care. *Journal of American College Health*, 72(8), 2893-2898. <https://doi.org/10.1080/07448481.2022.2138406>
- Santabárbara, J., Lasheras, I., Lipnicki, D. M., Bueno-Notivol, J., Pérez-Moreno, M., López-Antón, R., De la Cámara, C., Lobo, A., & Gracia-García, P. (2021). Prevalence of anxiety in the COVID-19 pandemic: An updated meta-analysis of community-based studies. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 109, Article 110207. <https://doi.org/10.1016/j.pnpbp.2020.110207>
- Sapra, A., Bhandari, P., Sharma, S., Chanpura, T., & Lopp, L. (2020). Using generalized anxiety disorder-2 (GAD-2) and GAD-7 in a primary care setting. *Cureus*, 12(5), Article e8224. <https://doi.org/10.7759/cureus.8224>
- Terlizzi, E. P., & Zablotsky, B. (2024). *Symptoms of anxiety and depression among adults: United States, 2019 and 2022*. National Center for Health Statistics. <https://doi.org/10.15620/cdc/164018>
- Twenge, J. M., & Joiner, T. E. (2020). U.S. Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19

pandemic. *Depression and Anxiety*, 37(10), 954-956.

<https://doi.org/10.1002/da.23077>

## **Appendix: Clinical Practice Guideline**

### **Clinical Practice Guideline for Universal Anxiety Screening in Primary Care Using GAD-7**

#### **Introduction**

The purpose of this evidence-based clinical practice guideline is to help the practice transition from symptomatic anxiety screenings to universal anxiety screenings. The recommendations are directly from the United States Prevention Service Task Force (USPSTF), which has mentioned the need to screen patients for anxiety as long as they meet the criteria. The criteria are to fall between the ages of 18 and 65, and this includes women who are pregnant or postpartum (O'Connor et al., 2023; Barry et al., 2023). The focus is on adults in the outpatient settings, and we will be focused on using the Generalized Anxiety Disorder item-7 screening tool for this guideline.

#### **Background**

Anxiety is one of the most common mental health disorders that continue to affect a large portion of the population, and this has received significant attention. Approximately 30% of the nation has experienced anxiety in one point in their lives, which continues to support the need to provide universal screenings (Santabárbara et al., 2021; Twenge & Joiner, 2020). There has been a large increase in the prevalence of anxiety since COVID-19, showing that pre-pandemic to post-pandemic has experienced a tripling in anxiety, from 8% to 25% (Santabárbara et al., 2021; Twenge & Joiner, 2020). Although the prevalence of anxiety has continued to climb, we are left with the same

routine, which was symptomatic screenings of anxiety based on when the patients disclose their symptoms. The symptom-based approach continues to lag behind while the need for change is radiating, which may be related to delayed diagnosis and treatment, and this can lead to poor health outcomes. Current practices continue to lack standardized protocols, which the USPSTF has focused on changing, by recommended changes in how providers routinely screen patients. The lack of standardization means that patients were not receiving a timely intervention, which could have helped close the time gap between their diagnosis and treatment plans.

### **Intended Audience**

The clinical practice guideline is intended to provide a standardized protocol for providers and credential staff members in the primary care settings to screen patients for anxiety. These members include physicians, nurse practitioners, physician assistants, registered or license-practical nurses, medical assistants, and behavioral health consultants to provide this screening to patients.

### **How to Use this Clinical Practice Guideline**

The clinical practice guideline is designed to provide a standardized protocol for providers to implement universal anxiety screenings in their primary care settings. The guideline is designed to help clinicians facilitate these screening processes. The purpose of this healthcare framework is to guide:

- Understand and use the evidence-based research supporting the universal anxiety screening
- Learn to use the Generalized Anxiety Disorder item-7 screening tool

- Follow standardized protocols for administration and scoring of the GAD-7
- Interpret the screening results
- Determine the appropriate follow-up measures and steps
- Integrate universal anxiety screening into their current practice

### **Scope of the Clinical Practice Guideline**

The scope of the clinical practice guideline is to outline the universal anxiety screening approach in the primary care settings for patients between the ages of 18 and 64, including pregnant and postpartum patients. The guideline emphasizes on GAD-7, which was the selected anxiety screening tool for this clinical practice guideline.

### **Included in the Guideline**

- Recommendations on patients that should receive screening
- Screening tool
- How to use GAD-7
- How to score GAD-7
- How to respond to positive GAD-7 scores
- Referral pathway for follow-up care (if cannot be managed in house)
- How to integrate the GAD-7 into current workflow

### **Not Included in the Guideline**

- How to perform a comprehensive evaluation of anxiety disorder
- Treatment, including medication management or psychotherapy
- How to manage generalized anxiety disorder
- How to screen for other mental health disorders

- Patients under 18 or older than 65 years old
- How to respond to emergent psychiatric interventions

### **Target Audience**

This focuses on the audience that will be screened and the criteria that they must meet to receive this anxiety screening.

#### **Inclusion criteria**

- Adults between the ages of 18 and 64
- Patients in the primary care settings
- All patients, new patients, wellness exams, and follow-ups
- Patients who are pregnant
- Postpartum patients
- Patients with and without a history of mental health disorders

#### **Exclusion criteria**

- Anyone under the age of 18 or older than 64 years old
- Patients experiencing emergency psychiatric concerns
- Patients unable to consent
- Patients receiving treatment from other mental health specialists

### **Methods**

#### **Guideline Developmental Process**

The developmental process required extensive literature support and reviews to align with the objectives of this clinical practice guideline. Once the research was obtained, compiled, and synthesized, it was put into this clinical practice guideline draft.

The guideline will be appraised by the AGREE II framework, which provides a comprehensive review over the material compiled in this draft regarding the quality.

### **Strategy to Search Literature**

A systematic approach was taken to gather literature, which focused on major databases that focused on housing healthcare/medical journals and articles. The evidence focused on generalized anxiety disorder and the screening tool, GAD-7. The databases were

- PubMed
- Medline
- CINAHL
- Cochrane
- Google Scholar

There was various search terms used to locate the journals to support this clinical practice guideline, which emphasized on the Boolean operating mechanics between the years 2020 and 2025. These key words helped facilitate the Boolean operator search for articles related to the topic while filtering out outdated articles and articles that did not have relevance to the research question. The keywords were a combination of the following words and phrases “Anxiety,” “Anxiety Disorder,” “Primary Care,” “Primary Care Settings,” “Primary Care Providers,” “PCP,” “Screening Tool,” “GAD-2,” “GAD-7,” “Anxiety Screening Tool,” “Anxiety Prevalence,” “Prevalence,” “Anxiety Recommendations,” “Anxiety Protocols,” “COVID-19,” “Post-COVID-19,” and “Primary Care Screening.”

## **Evidence Selection**

Studies were selected based on an inclusion and exclusion criteria, which allowed for a more effective method to select the articles.

### ***Inclusion***

- Systematic reviews, meta-analysis, randomized controlled trials, cohort studies, quality improvement articles, or peer-reviewed articles
- Studies evaluating GAD-2 and GAD-7 screening tools
- Primary care studies
- Studies that included sensitivity and specificity of screening tools
- Guidelines by national organizations

### ***Exclusion***

- Studies outside of the primary care settings
- Screening tools that excluded GAD-2 and/or GAD-7
- Non-peer reviewed articles

## **Evidence Review**

There were 13 studies included in the review, which included 8 level I studies that encompassed systematic reviews, meta-analysis, and the recommendations by the USPSTF (a national organization). There were 5 studies that were level 2-V, which included cohort, quality improvement, or expert opinions. These articles were evaluated based on the John Hopkins Evidence-Based Practice Model, which aided in the appraisal of these studies.

## **Expert Panel Evaluation and AGREE II Assessment**

The AGREE II is a screening tool to ensure the clinical practice guidelines are sufficient to deploy into practice. The screening tool is a validated tool that assesses the methodological rigor that has been used to understand the quality of the guideline. The tool is a standardized framework that allows experts to evaluate the guidelines across any specialty or problem and has been widely adopted across the world. The AGREE II is considered the gold standard for quality appraisal and serves to assess the quality of the guidelines, the methodologies involved in its development, and inform how it should be reported. The expert panel will consist of independent reviewers/experts that cannot communicate regarding their findings to keep the results unbiased.

## **Validation of AGREE II**

The AGREE II assessment tool has been vetted extensively to ensure it is reliable and valid, which is why it has had its psychometric properties vetted thoroughly. The tool has been established as the gold standard because it can differentiate between high-quality and low-quality guidelines across different dynamics and clinical settings. It has a 23-item structure that has been thoroughly developed and can be used to measure the strength of the guidelines while maintaining usability and feasibility. The expert panel will consist of 3-5 independent reviewers/experts that cannot communicate regarding their findings to keep the results unbiased, which can also increase reliability.

## **Structure and Components of AGREE II**

There are 23 items across 6 different domains, each playing a crucial role in the evaluation of the clinical practice guidelines. Each domain serves a specific purpose, and

the domains are scored independently. The domains are scored from 1-7 and show the level of agreement, ranging from strongly disagree (1) to strongly agree (7), showing the reliability of the clinical practice guidelines.

### **Domain 1: Scope and purpose**

Domain 1 focuses on the overall project objective and expected health benefits, which encompasses the scope and purpose of the project. It focuses on a specific clinical question and addresses it with the guideline. It also takes a closer look at the patient population addressed (the ones this guideline applies to).

### **Domain 2: Stakeholder involvement**

The second domain determines if the guideline development group includes relevant professional groups. It also evaluates whether the patient views and preferences are considered. It also determines whether the guidelines have the targeted audience been clearly defined.

### **Domain 3: Rigor of development**

Domain 3 looks into the rigor by evaluating the systematic methods were used to search for evidence. It also has a criterion that determines if the guidelines use evidence and if that was clearly described. It also weighs the strengths and limitations of evidence and makes sure it is quantified. It takes a closer look at the methods for formulating recommendations are described and the health benefits, side-effects, and risks are considered. It determines if there is a link between recommendations and evidence and evaluates whether the guidelines are reviewed before approval and if there is a way to update the guideline.

**Domain 4: Clarity of presentation**

The next domain checks for recommendations to make sure they are specific and unambiguous while also seeing if there are different management options presented. It is important to have alternatives available and determine if the key recommendations are identifiable.

**Domain 5: Applicability**

The 5<sup>th</sup> domain evaluates the guidelines, describes facilitators and barriers, and determines if there are strategies for implementation and whether tools are provided. It checks resources and the associated implications as well as monitoring and auditing criteria.

**Domain 6: Editorial independence**

The last domain makes sure the views of the funding have not influenced the content for the guideline and there is no competing interest of guideline developers has been recorded and addressed.

**Scoring with AGREE II Tool**

The AGREE II instrument has 23 domains that are each scored on a Likert Scale from 1-7, which will be described below.

**Rating Scale**

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Somewhat disagree
- 4 = Neither agree nor disagree

- 5 = Somewhat agree
- 6 = Agree
- 7 = Strongly agree

### **Calculate Domain Scores**

Each domain must be scored individually by the following methods.

1. Calculate the sum of all items scored within each domain
2. Subtract the minimum possible score from the specific domain
3. Divide this score of maximum possible score minus the minimum possible score
4. Multiple the final score by 100

### **Formula to calculate**

$$\text{Domain Score (\%)} = \frac{\text{Obtained Score} - \text{Minimum Possible Score}}{\text{Maximum Possible Score} - \text{Minimum Possible Score}} \times 100$$

### **Example of how to use formula**

- Domain 1 has 3 items rated by 3 appraisers
- Minimum possible score = 3 items x 3 appraisers x 1 = 9
- Maximum possible score = 3 items x 3 appraisers x 7 = 64
- Hypothetical score calculation = 54
- Domain score =  $[(54-9)/(64-9)] \times 100 = (45/55) \times 100 = 81.81\%$

### **Interpretation**

If each of the 6 domains receive a score above 70%, then the clinical practice guideline may be considered good quality.

**Overall Assessment**

The rating will take place across 6 domains and 23 items, which will give the appraisers/expert panel the option to rate the domains 1-7 and make recommendations for changes within each domain.

**Guideline Updates**

The clinical practice guidelines will likely require updates that align with the USPSTF, which can be annually, biannually, or even every 3 years, but not longer than that. Research becomes outdated after five years and therefore, this should be updated when the new recommendations are released.

**Conflicts of Interest**

There are no conflicts of interest, and no funding was received.

**Evidence for Practice**

O'Connor et al. (2023) and Barry et al. (2023) performed an analysis regarding the USPSTF recommendation for anxiety screening, which demonstrated the need to transition from symptomatic anxiety screenings to universal anxiety screenings. These recommendations were crucial because it showed that clinicians should offer a GAD-7 screening or GAD-2 (whichever they are most comfortable with) because it can help improve patient outcomes. There were other articles that continued to support the need for this implementation, including Salinas et al. (2024) that supported these two screening tools, which supported the choice of moving forward with GAD-7. Also, Garcia (2020) demonstrated how this can be effective when implementing this study into a primary care

setting, which continued to demonstrate the need for transitioning from symptomatic anxiety screening to universal anxiety screenings.

The GAD-7 has been extensively evaluated and continuously validated, demonstrating itself as one of the most reliable and efficient screening tools for anxiety, which is likely why it was selected by the USPSTF. The psychometric properties of the screening tool have an excellent Cronbach score. The research performed by Sapra et al. (2020) showed the psychometric properties of GAD-7, demonstrating that it had an excellent Cronbach alpha score of 0.85, showing it has good test-retest reliability, particularly when scoring 10 or more points on the GAD-7. Sapra et al. has demonstrated that these instruments effectively made it a good choice for screening for anxiety, considering a positive score is above 10 and this is where it was becoming noteworthy with its sensitivity and specificity.

Anxiety has continued to climb over the past few years, particularly during COVID-19 and after it, showing a need to improve the screening process for this disorder. Goodwin et al. (2020) has been showing an increase in anxiety since 2008, and up until 2018, which has a positive secular trend, but not significant enough to warrant screening changes. However, COVID-19 substantially exacerbated these rates, from 8% to 25%, which is over triple the prevalence in 3 years of COVID-19 (Santabárbara et al., 2021; Twenge & Joiner, 2020). This increase in anxiety demonstrates a significant public health concern that warrants changes in the primary care settings.

There have been several studies that have demonstrated the need to implement a new anxiety screening into primary care practices and also success with these

implementations. GAD-2 and GAD-7 have both been successfully implemented into the primary care settings, which have improved detection rates and referrals to psychiatric mental health services (Salinas et al., 2024; Garcia, 2020; Hlynsson & Carlbring, 2024). The findings from these studies continue to align with the recommendations that were outlined by the USPSTF, showing that universal screening is not only effective but can be successfully implemented into the practice without interrupting the workflow.

The evidence displayed in this body of evidence continues to demonstrate that universal anxiety screenings with the GAD-7 screening tool is necessary. Not only is it necessary, but it is effective in the primary care settings, feasible, and clinically beneficial for patients. The evidence illustrates a strong argument for the development of the clinical practice guideline for the primary care practice with a substantial amount of supporting information. The evidence not only supports the need for the guideline, but also the success in implementing these guidelines into practice, making universal screening an important change in modern anxiety screening.

### **Recommendations**

#### **Recommendation 1: Implement universal anxiety screening**

**Recommendation:** Draft and implement a clinical practice guideline that focuses on universally screening anxiety for adults from the ages 18 to 64 in the primary care settings using GAD-7.

**Evidence level:** Level I, from eight sources

**Quality rating:** Strong evidence with consistency across the results

**Rationale:** Aligns with the recommendations made by the USPSTF guidelines and current clinical practice guidelines being developed for primary care practices.

### **Recommendation 2: Alternative screening option**

**Recommendation:** use GAD-2, which is effective at screening patients for anxiety as well, but has less questions and can be used in the clinical settings that experience time constraints

**Evidence level:** Level I, strong evidence

**Quality rating:** Strong

**Rationale:** GAD-2 retains the core questions from GAD-7, and gets straight to the point, which can then be expanded to GAD-7 if the screening tool is positive.

### **Recommendation 3: Framework**

**Recommendation:** Follow the USPSTF recommendations and use this as the framework to implement this clinical practice guideline in the primary care settings.

**Evidence level:** Level I, strong evidence

**Quality rating:** Strong

**Rationale:** USPSTF is a nationally recognized organization that provides recommendations that are on par with evidence-based practices and is frequently cited when focusing on screening protocols.

**Recommendation 4: Workflow integration**

**Recommendation:** The organization can implement this program into their practice.

**Evidence level:** Level II-V, good supporting evidence

**Quality rating:** Good

**Rationale:** Quality improvement studies support the implementation of the clinical practice guidelines

**Guideline****Who Should be Screened:**

- Patients between the ages of 18 and 64 years old in the primary care settings
- New, old, follow-up patient visits, essentially, anyone who has not been screened in the past year
- Screen pregnant and postpartum patients

**Screening Protocol****Step 1: Administer GAD-7**

- Ask the patient the 7 questions on the GAD-7 screening tool
  1. "Feeling nervous, anxious, or on edge?"
  2. "Not being able to stop or control worrying?"
  3. Worrying too much about different things?
  4. Trouble relaxing?
  5. Being so restless that it is hard to sit still?
  6. Becoming easily annoyed or irritable?
  7. Feeling afraid as if something awful might happen?

- Score each question on a 0-3 scale
- Total GAD-7 Score: 0-21

## **Step 2: Interpret the GAD-7 Score**

### **Minimal anxiety (0-4 score)**

- No intervention needed
- Document results
- Routine screening either every six months or year

### **Mild Anxiety (5-9 score)**

- Educate the patient on anxiety and the ability to self-manage it
- Recommend changes to their lifestyle (sleep, exercise, reduce stress, limit caffeine, drugs, or alcohol)
- Provide written education materials for their use after discharge
- Reassess their anxiety in 4-6 weeks at their follow-up visit

### **Moderate Anxiety (10-14 score)**

- Assess for suicidal ideation and self-harm
- Discuss treatment options with patient
- Treatment options include:
  - In-house treatment
  - Offer referral to psychiatry/mental health professional
  - Briefly counsel the patient on available interventions
  - Discuss the options of psychotherapy
  - Discuss the options of psychopharmacological interventions

- Follow-up with the patient in 2-4 weeks
- Repeat GAD-7 during follow-up

### **Severe Anxiety (15-21 score)**

- Assess for suicidal ideation and self-harm
- Discuss treatment options with patient
- Treatment options include:
  - In-house treatment
  - Offer expedited referral to psychiatry or same-day referral to psychiatry
  - Extensively counsel the patient on available interventions
  - Discuss the necessity of psychotherapy
  - Discuss the necessity of psychopharmacological interventions, possibly immediately
  - Immediate 1-2 week follow up in-house

### **Step 3: Electronic Health Record Documentation**

- Date of screening
- GAD-7 used for screening
- Total score from GAD-7
- Clinical interpretation and plan of action
- Follow-up plan and referrals
- Next screening date and follow-up scheduled

**Step 4: Integration of CPG into Workflow**

- Option 1: Medical assistants or nurse (if available) to administer screening tool during intake
- Option 2: Patient completes screening in the office waiting room (self-assessment)
- Option 3: Patient completes screening at home before arrival (self-assessment)

**Staff Training Requirements**

- The necessity of universally screening anxiety
- How to administer GAD-7
- Document the training protocols and methods
- When to alert a provider when the results are positive

**Quality Monitoring Metrics**

- Screen at least 80% of the patients in the pilot
- Document follow-up on 100% of the positive patients

Document plan of action and referral with moderate and severe scores with a 95% fidelity

# Anxiety Screening Workflow

