

Oregon Health & Science University
School of Medicine

Scholarly Projects Final Report

Title

Bringing Annual Anxiety Screening to the Center for Women's Health: A Quality Improvement Project

Student Investigator's Name

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2023

Project Course

Scholarly Projects Curriculum

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Project/Research Question

Within the Center for Women's Health primary care clinic, will adding the Generalized Anxiety Disorder-2 questionnaire to the annual health screening form increase the monthly percentage of individuals screened for anxiety among patients 18 years and older who were due for and completed health maintenance screening during a new patient, Medicare Wellness, or annual wellness visit?

By extension, will this intervention increase the percentage of patients newly diagnosed with anxiety or the percentage of patients who receive counseling on anxiety treatment during a wellness visit?

Type of Project

Quality Improvement Project

Key words

Anxiety; Anxiety Screening; Quality Improvement; Health Maintenance; Primary Care; Women's Health

Meeting Presentations

None

Publications

None

Submission to Archive

No restrictions

Next Steps

- Continue the PDSA cycle to address the 10% of patients who did not receive follow-up for positive GAD-2 scores. Are there other screening tools or workflow changes that could facilitate more consistent follow-up?
- Expand annual screening for anxiety to other OHSU affiliated primary care clinics in the community.

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Introduction

The most common mental health concern in women is anxiety. In the United States, anxiety disorders have a lifetime incidence of 30.5% in women.¹ These disorders are associated with reduced quality of life and a higher burden of illness resulting from missed work, disrupted relationships, and increased utilization of emergent and primary care services.² Anxiety disrupts sleep and increases the risk of stroke, chronic headaches, gastrointestinal distress, and musculoskeletal disorders.^{3,4,5} Women with anxiety are also at higher risk for substance use disorders, and individuals with untreated anxiety who undergo treatment for substance use experience worse outcomes.^{6,7} Given the variety of adverse effects, untreated anxiety is a significant health risk that may benefit from screening.

Historically, the primary care clinic at the OHSU Center for Women's Health (CWH) limited anxiety screening to two specific patient populations. The first group consisted of patients overtly complaining of mood symptoms. The second group included patients who initially screened positive for depression. Since these two disorders share a lifetime comorbidity of 59.2%, offering anxiety screening to both patients with depression and patients complaining of anxiety symptoms ideally identified many at-risk individuals.⁸ However, this protocol failed to identify women with anxiety alone who did not otherwise discuss mood symptoms with their provider.

In 2020, the Women's Preventative Services Initiative (WPSI) released new guidelines to better identify all women suffering from untreated anxiety. They recommend that all adult women should receive annual anxiety screening.⁹ In 2022, the United States Preventative Service Task Force (USPSTF) published recommendations for screening of all children, adolescents and adults including pregnant and postpartum persons up to age 64 for anxiety.^{10,11} This quality improvement project sought to adopt these new recommendations into the CWH primary care clinic. The primary aim was to increase the monthly percentage of individuals screened for anxiety, among patients 18 years and older who were due for and completed health maintenance screening during a new patient or wellness visit, to 70% by incorporating an anxiety screening tool into the clinic's established health maintenance screening form. The secondary aim was to increase the monthly percentage of individuals connected to appropriate resources and treatment among patients who were identified to have an underlying anxiety disorder.

Methods

This project was conducted at the CWH primary care clinic. This was a large academic institution with a patient population mostly comprised of women. The project specifically focused on patients 18 years and older who were due for and completed health maintenance screening at an in-office wellness visit. Clinic staff included receptionists, medical assistants, nurses, and providers. Representatives from each group were included in the quality improvement team.

Intervention

Anxiety screening was incorporated into the Annual Behavioral Health Screening Form (previously referred to as the Screening, Brief Intervention and Referral to Treatment (SBIRT) form). This form was already utilized for annual health maintenance screening in the clinic, and it was updated to include the GAD-2 patient questionnaire [See Supplemental Figure 1]. The GAD-2 is a validated anxiety screening tool comprised of the first two questions of the GAD-7. A score of three or more is positive for this tool. It was chosen over the GAD-7 because the brevity was expected to encourage patient participation.

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However, as a limited screening tool, patients with positive results required follow-up with the GAD-7. Providers were also more familiar with the GAD-7, so this follow-up made it easier to plan appropriate clinical interventions. Results were documented in EPIC flowsheets. Since the GAD-2 lacked a distinct flowsheet, the first two questions of the GAD-7 flowsheet were used to represent the GAD-2 results. Clinic staff received education on the new workflow.

In addition to these adjustments, April Sweeney M.D. with CWH Behavioral Health and Wellness created a flow chart to recommend appropriate anxiety treatments relative to the severity of the GAD-7 score. This assisted providers with managing patients with newly identified anxiety disorders.

Measures

The primary outcome measure was the monthly percentage of patients screened for anxiety during a wellness visit with the GAD-2 or the GAD-7. Including both screening tools in this measure facilitated pre- and post-implementation comparison of anxiety screening to assess the project's primary aim. The secondary outcome measures were the average percentage of patients diagnosed with anxiety and the average percentage of patients receiving counseling on anxiety treatments during a wellness visit. These measures evaluated the impact of screening on patient care.

Many process measures were selected to monitor workflow and assess for variations in the patient population. The percentage of patients with a positive GAD-2 who did not receive follow up with a GAD-7 was measured to ensure appropriate workflow was completed. The percentage of patients with a positive GAD-2 who scored moderate or severe on the follow-up GAD-7 was measured to assess whether the GAD-2 identified patients who were most in need of clinical intervention for underlying anxiety. Measuring the percentage of patients with a history of an anxiety diagnosis among those with a positive GAD-2 or GAD-7 score helped ascertain if the tools selectively identified patients with old or new anxiety diagnoses. Finally, the project measured the percentages of patients with a moderate or severe GAD-7 score who were newly diagnosed with an anxiety disorder, who received counseling on anxiety treatments, and who were referred to therapy or encouraged to add or adjust a medication. These variables evaluated whether at-risk individuals received appropriate clinical care. All process measures were additionally used to assess for variation in the patient population.

Balancing measures monitored for disruptive changes in other aspects of the clinic workflow. These included the average visit duration and average ratings from a provider satisfaction survey. This survey was created and distributed to clinic providers to determine their overall satisfaction with the new screening [See Supplemental Figure 2]. This was not a validated survey.

Chart Review and Analysis

Data for project measures was collected through retrospective chart review in EPIC. Charts were randomly selected from among patients 18 years and older who were due for and completed health maintenance screening at an in-office new patient, Medicare Wellness, or annual wellness visit.

Baseline data was collected from October 2020 to February 2021 among a total of 592 wellness visits. To address both project aims, the sample size was calculated with the intent to evaluate the outcome measure hypothesized to have the smallest change—the percentage of new anxiety diagnoses. One study estimated that 5-10% of patients were expected to have new or worsening mood disorders during the baseline period.¹² With this reference, the Select Statistical Services Population Proportion – Sample

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Size calculator recommended a baseline sample size of 100 patient charts with a 5% margin of error and a 95% confidence level (n=20 patients/month).¹³

Post-implementation data was collected from July 2021 to October 2022. The percentage of patients receiving a new anxiety diagnosis was hypothesized to increase less than 5%. The Select Statistical Services Two Proportion – Sample Size calculator recommended a sample size of 586 patient charts with a confidence level of 95% and a power of 80% (n=37 patients/month).¹⁴ After completing the chart reviews, average monthly percentages were calculated and analyzed using run charts.

Ethical Considerations

This project was evaluated by the OHSU Institutional Review Board (IRB) and deemed exempt from IRB oversight as quality improvement work.

Results

After adding the GAD-2 anxiety screening tool into the clinic’s Annual Behavioral Health Screening form, the updated screening was piloted for one month with a single provider. The intent was to gradually expand screening to the entire clinic. Initial feedback was positive. Patients participated without significant complaint, and the additional anxiety questions and documentation were relatively easy to adopt into the clinic workflow. However, the pilot was burdensome for medical assistants as a different workflow was needed depending upon the provider. This feedback resulted in immediate introduction of the new screening protocol to the entire primary care clinic in July 2022 to alleviate this complication.

Outcome Measures

Identifying the percentage of patients screened annually for anxiety was the primary outcome measure of this quality improvement project. After incorporating the GAD-2 questionnaire into the Annual Behavioral Health Screening form, the monthly average percentage of patients screened for anxiety among patients who received annual health maintenance screening increased from 10% to 79% [See Figure 1]. This corresponded with an upward shift in the run chart following the implementation of the new workflow. Of those patients screened with the GAD-2, 18% had a positive score warranting additional screening.

Measuring the percentage of patients receiving new anxiety diagnoses or counseling on anxiety treatments assessed the project’s impact on meaningful patient care. After implementing the updated form, the average percentage of patients diagnosed with anxiety during a wellness visit increased from 2% to 5%. However, run chart analysis did not show shifts or trends. The average percentage of patients counseled on anxiety treatments during a wellness visit increased from 10% to 15%. This did present with an upward shift in the run chart after implementing the new form. Among patients who received counseling, the percent recommended to start a new therapy or adjust medications increased from 3% to 6%, yet this did not appear significant on run chart analysis. The number of newly diagnosed or counseled patients was too small to analyze whether these individuals also had positive GAD-2 scores, thus this potential measure was omitted.

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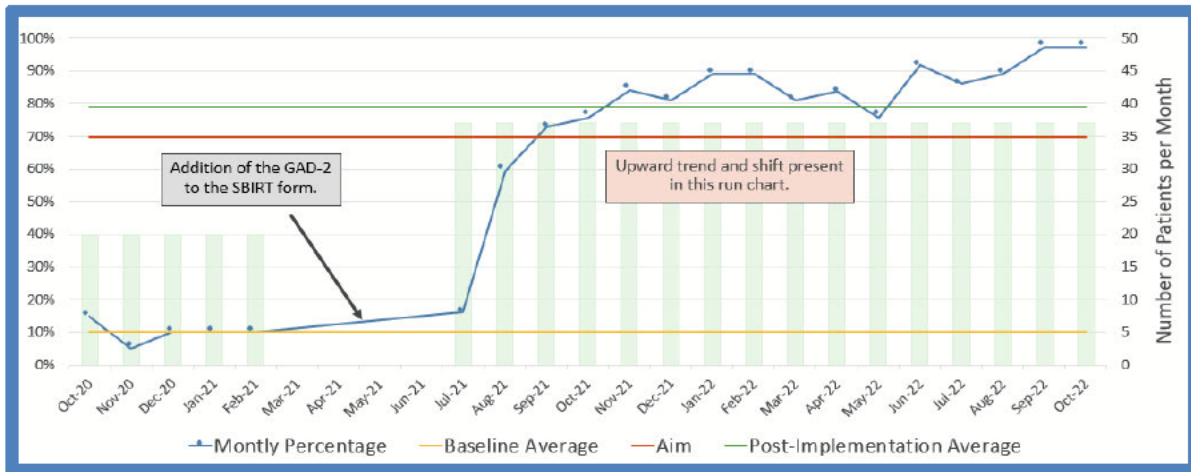


Figure 1: Monthly percentage of patients screened for anxiety among those who completed health maintenance screening during a wellness visit.

Process Measures

The workflow was assessed for effectiveness and complications. On average, 9% of patients with a positive GAD-2 score did not receive appropriate follow-up with the GAD-7 questionnaire [See Figure 2]. Of the patients with a positive GAD-2 who did receive appropriate follow-up, 60% scored moderate or severe on the GAD-7. Moderate to severe scores (GAD-7 score > 10) are suggestive of an underlying anxiety disorder which may benefit from intervention. All variables were stable on run chart analysis.

Despite the potential to accumulate points from any question on the GAD-7, 60% of patients who completed this screening scored greater than three points with the first two questions. This is equivalent to having a positive GAD-2 score. Thus, the GAD-2 tool appeared to identify commonly reported patient concerns and demonstrated moderate success as an initial screening tool in this clinic.

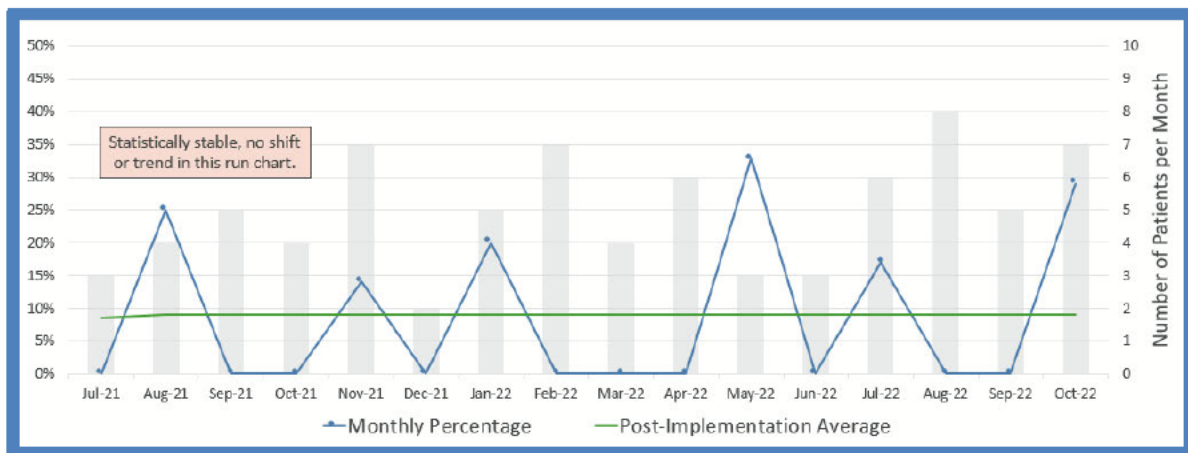


Figure 2: Monthly percentage of patients with a positive GAD-2 score who did not receive follow up with the GAD-7.

The project also evaluated the usefulness of the GAD-7 in diagnosing, monitoring, and treating anxiety disorders during wellness visits. On average, 73% of patients who completed the GAD-7 scored positive, with 47% of patients having a moderate or severe score. Patients with a moderate or severe GAD-7

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score were most at-risk for underlying anxiety disorders and had the greatest potential to benefit from treatment. Among the patients seen for wellness visits, an average of 28% of patients with a moderate or severe GAD-7 score were newly diagnosed with an anxiety disorder [See Figure 3]. This appeared stable pre- and post-implementation of the updated annual screening form, though the baseline sample was small (n=1 patient/month). With regards to treatment, 60% of patients with a moderate or severe GAD-7 score received counseling on anxiety treatments during a wellness visit [See Figure 4]. This too was stable pre- and post-implementation with new referrals and medication adjustments comprising 50% of the treatment recommendations. Again, the baseline sample size was small and limited effective pre- and post-implementation comparison, though the run charts were stable.

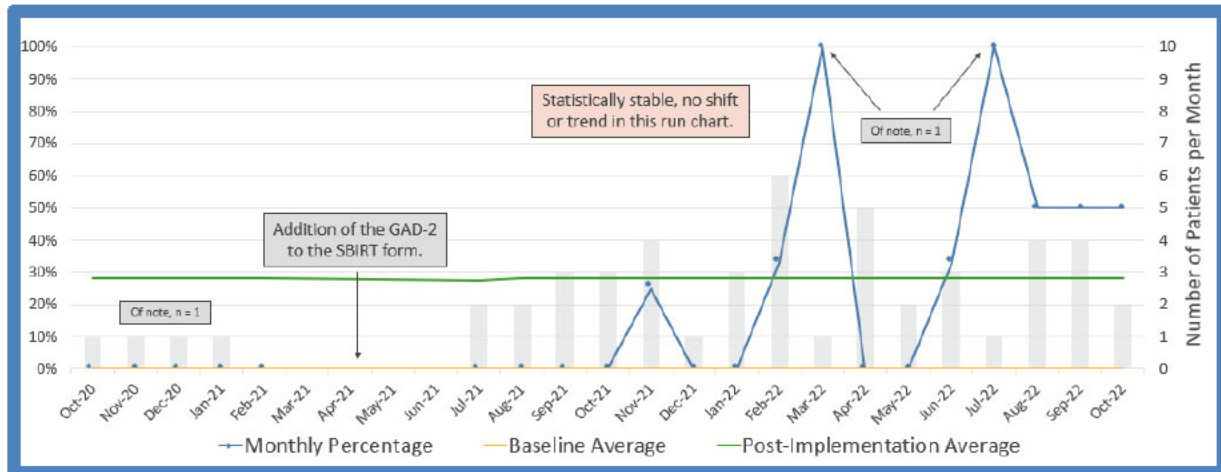


Figure 3: Monthly percentage of patients with a moderate or severe GAD-7 score who were newly diagnosed with an anxiety disorder.

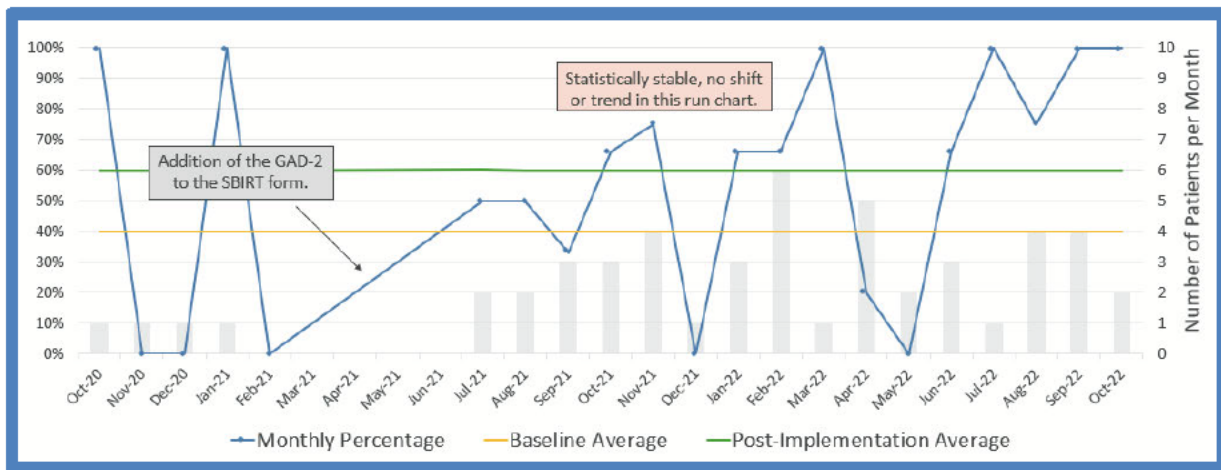


Figure 4: Monthly percentage of patients receiving counseling on anxiety treatments among those with a moderate or severe GAD-7 score.

Lastly, the composition of the patient population was evaluated. After updating the Annual Behavioral Health Screening form, 62% of patients with a positive GAD-2 and 60% of patients with a moderate or severe GAD-7 had a history of an anxiety disorder. The small number of patients with these positive screening results again limited effective pre- and post-implementation comparison.

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Balancing Measures

The duration of wellness visits was monitored from October 2020 to October 2022. A slight shift in the monthly average occurred five months after the project intervention [See Figure 5]. Contextually, this data encompasses visits that took place during and after the coronavirus pandemic. Thus, confounding variables likely contribute to these results.

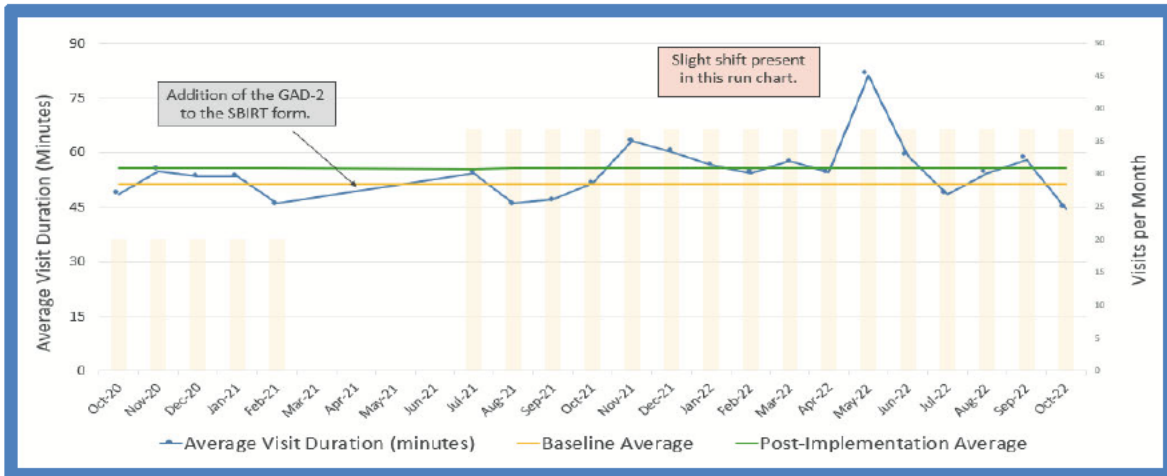


Figure 5: Monthly average visit duration in minutes.

Providers were surveyed to ascertain their overall satisfaction with the Annual Behavioral Health Screening form and its impacts on workflow. The survey had a 62.5% response rate (n=8 providers). Results are detailed in the figure below, the most notable being an overall satisfaction rating of 4.8/5 and various measures noting difficulties with time management during wellness visits [See Figure 6].

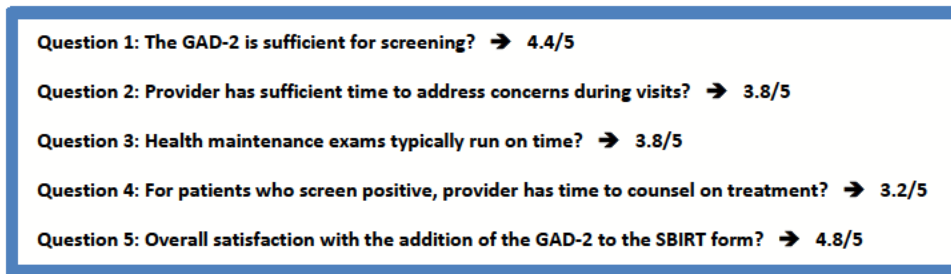


Figure 6: Average ratings from provider satisfaction survey.

Discussion

This project sought to incorporate recommended annual anxiety screening into the standard of care at the CWH primary care clinic. The addition of the GAD-2 to the annual screening form was successful in increasing the number of patients screened for anxiety. The initial rise was gradual as anticipated as the clinic adjusted to the workflow, but the result exceeded the goal established in the primary aim by 9%. Given these results, this project offers one successful model that could be applied in other clinics seeking to adopt newly recommended annual anxiety screening.

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The project's secondary aim was not clearly met. Indeed, the percentage of patients who were newly diagnosed with an anxiety disorder and who were counseled on treatments for anxiety increased after implementing the new screening. The change for both was small, less than 5%, but only counseling demonstrated a significant upward shift following the project's intervention. However, this project selectively screened patients presenting for in-office wellness visits. This likely biased the patient population. For example, if healthier patients are more likely to schedule and attend wellness visits, then selective screening may miss patients who are at greatest risk of having untreated anxiety. Developing a workflow that annually screens all patients, not just those presenting for wellness visits, may increase the percentage of new anxiety diagnoses made and yield significant results. This additional research will better determine whether annual anxiety screening is cost- and time-effective and therefore should remain the new standard of care.

The stable trends noted among the process measures pre- and post-implementation strengthen the argument that the increases in screening and counseling were associated with the project intervention. There were no significant changes in the composition of the patient population or patient management. The percent of patients with positive screening scores who had a history of anxiety did not significantly change after introducing the new form. Nor did the percent of patients receiving a new anxiety diagnosis. This suggests that there was not an unexpected influx of individuals with anxiety disorders in the months following the implementation. Similarly, the percentage of patients with moderate or severe GAD-7 scores who were counseled on treatment was stable. This suggests that providers did not change their overall management of patients during this time, and the new screening did not significantly disrupt patient care. Overall, these measures demonstrated that the project's encouraging outcomes were most likely associated with the new screening, and that this project did not appear to negatively impact the management of patients with anxiety. However, the small sample sizes limit these conclusions and warrant additional research.

The GAD-2 questionnaire seemed effective as an initial screening tool. Two thirds of patients with a positive GAD-2 score had moderate or severe GAD-7 scores. This suggests that the GAD-2 was moderately successful at identifying patients who are at risk for underlying anxiety disorders that may benefit from clinical intervention. Despite its desired brevity and success, the GAD-2 required a more complicated workflow and documentation method. Unfamiliarity with this tool resulted in the need for a follow-up GAD-7 which was not appropriately offered to nearly 10% of patients each month. Therefore, this workflow has the potential to leave patients vulnerable to insufficient work-up and treatment. In addition, since the GAD-2 is not commonly used by other CWH or OHSU providers, it will likely be difficult to adopt into other clinics. Future research should seek to define optimal anxiety screening tools that could be standardized. Standardization would improve workflow and facilitate expansion of annual anxiety screening to other clinics in the community.

The satisfaction survey introduced an additional concern that may impact annual anxiety screening. While providers were overall satisfied with the updated Annual Behavioral Health Screening form and workflow, providers felt they occasionally lacked sufficient time to address concerns and reliably counsel patients. This belief was supported by the mild increase noted in the average visit duration in 2022. Since the change occurred over five months after implementing screening, it is more likely the result of confounding variables such as an overall increase in the number of patient concerns following pandemic-associated lapses in care. Regardless, these time constraints limit the opportunities for providers to offer appropriate counseling at the initial visit. Future research should evaluate potential

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confounding variables and assess whether patients receive follow-up visits for all unaddressed positive screening results. This is needed to prevent unintentional patient harm due to annual anxiety screening.

Limitations

Project limitations included a limited sample size, broad inclusion criteria, and human error. The sample size was appropriate to address the outcome measures, but the subsequent filtering variables used to assess the process measures resulted in months with insufficient samples (n=1 patient/month) which resulted in astronomical data points in numerous run charts. This most substantially impacted the baseline data and made comparison and run chart analysis difficult. In addition to limited sample sizes, this project did not exclude patients over the age of 65. Since the USPSTF does not currently recommend annual anxiety screening in patients over 65 years old, additional work may be needed to identify ways to selectively screen the appropriate patient population. Finally, chart review and calculations were conducted manually, thus the results are subject to human error.

Conclusions

Anxiety impacts many women throughout their lifetime, and new standards of care seek to identify individuals suffering from untreated anxiety disorders. This quality improvement project demonstrated one model of annual anxiety screening. The recommendation to screen all children, adolescents, and adults under the age of 65 for anxiety allows this model to be generalized to other clinical settings in the community. By incorporating the GAD-2 into the Annual Behavioral Health Screening form, the clinic successfully increased the percentage of women screened for anxiety. Additionally, the intervention yielded a small benefit to patient outcomes as more individuals received counseling on anxiety management, yet it remains unclear whether annual screening will result in effective, value-based care.

Next Steps

Future PDSA cycles could address the inconsistent GAD-7 follow-up, trial a different screening tool, or explore options for anxiety screening documentation in EPIC. Optimized documentation would facilitate expansion of anxiety screening to other OHSU-affiliated clinics in the community and offer avenues for automated data collection. Ultimately, future research should determine if annual anxiety screening improves patient outcomes and should therefore remain a national recommendation.

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Supplemental Figures

Supplemental Figure 1: Annual Behavioral Health Screening Form

	Oregon Health & Science University Hospitals and Clinics	Account NO. MED. REC. NO. NAME BIRTHDATE
ANNUAL PATIENT QUESTIONNAIRE		<i>Patient Identification</i>
Page 1 of 1		

Date: _____

Once a year, all our patients are asked to complete this form because drug use and alcohol use can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below. (Use "X" to indicate your answers below)

Are you currently in recovery for alcohol or substance use? Yes No

Alcohol: 1 Drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

		None	1 or More
MEN:	How many times in the past year have you had 5 or more drinks in a day?	<input type="checkbox"/>	<input type="checkbox"/>
WOMEN:	How many times in the past year have you had 4 or more drinks in a day?	<input type="checkbox"/>	<input type="checkbox"/>

Drugs: Recreational drugs include cannabis (marijuana, pot), cocaine, stimulants (Ritalin, Concerta, Adderall), methamphetamine (speed, crystal), inhalants (paint thinner, aerosol, glue), sedatives (Valium, Xanax, Rohypnol), hallucinogens (LSD, mushrooms, ecstasy), street opioids (heroin).

		None	1 or More
	How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

Mood: Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling little interest or pleasure in doing things?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Feeling nervous, anxious or on edge?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Not being able to stop or control worrying?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

If questions 1 and 2 (PHQ2) combined score ≥ 3, please give the patient a PHQ9/GAD7 form.

OR

If questions 3 and 4 (GAD2) combined score ≥ 3, please give the patient a PHQ9/GAD7 form.

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Supplemental Figure 2: Provider Satisfaction Survey

Provider Satisfaction Survey

Please rate the following statements regarding the addition of the GAD2 to the SBIRT form for annual anxiety screening on a scale from 1—5:

1. The GAD2, now on the SBIRT form, appears sufficient in order to screen my patients for untreated anxiety.

1 = Strongly Disagree, 2 = Disagree, 3 = unsure/neutral, 4 = agree, 5 = strongly agree

Rating:

2. After the addition of the GAD2 to the SBIRT, I still have sufficient time to address both my and the patient's top concerns during health maintenance exams.

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

Rating:

3. Even with the addition of the GAD2 to the SBIRT, health maintenance exams typically run on time and allow me to remain on schedule.

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

Rating:

4. When patients screen positive for substance use, depression, and/or anxiety during health maintenance exams, I have sufficient time to address these concerns and perform necessary interventions.

1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

Rating:

5. Please rate your overall satisfaction with the addition of the GAD2 to the SBIRT form as a means of annual anxiety screening.

1 = very unsatisfied, 2= unsatisfied, 3 = neutral, 4= satisfied, 5 = very satisfied

Rating:

6. Please use the space below to elaborate on any positive or constructive feedback you may have regarding the addition of the GAD2 to the SBIRT form and ways we could further improve annual anxiety screening in the clinic.