CAPSULE COMMENTARY

Capsule Commentary on Pfoh et al., the Impact of Systematic Depression Screening in Primary Care on Depression Identification and Treatment in a Large Health Care System: a Cohort Study

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Depression accounts for significant morbidity, quality of life, and economic impacts,¹ yet prior studies suggest that most patients do not receive treatment even with screening.² The study by Pfoh et al. demonstrates clinical impact of a depression screening algorithm paired with a clinical decision support alert on the identification and treatment of depression for adults within a large US health system.³ After implementation, 59% of over 250,000 patients underwent screening. Depression diagnoses statistically significantly increased in the month before and after implementation. The study also used a novel technique to demonstrate, through a secondary analysis looking at PHQ-9 score cutoffs for depression identification and treatment odds, how the paired approach increases treatment.

While the authors provide a pragmatic, real-world trial, there are limitations in their sensitivity analysis. The authors defined identification of depression as the addition of an ICD-10 depression diagnosis to the patient's visit diagnosis(es). They then used an ICD-10 diagnosis on the problem list as the gold standard for calculation in sensitive analyses for the PHQ-9. However, the PHQ-9 has already been well validated in the primary care setting including against semi-structured diagnostic mental health interviews with high pooled sensitivity (88%) and specificity (85%).⁴ This is above the weighted sensitivity (50%) and specificity (81%) of unassisted diagnosis of depression by primary care providers in a separate meta-analysis.⁵

Based on this, prior studies suggest the "real" false-positive rate should be lower. Thus, rather than viewing the > 2000 patients without a depression diagnosis but a positive PHQ-9 as false positives, from a systems-level view, these patients

expose potential care delivery gaps. The authors reviewed 50 random potential false positives and identified over half with depression or a confounding diagnosis such as anxiety, pain, or fatigue. Moving forward, further understanding of this population, especially the 42% who had no mood disorder or other potentially confounding diagnosis, is needed. Recognition of depression, initiation of appropriate treatment, and measurement of clinically meaningful outcomes are ongoing challenges to health systems nationwide. Paired screening and clinical decision support has value, and refining its use will be necessary for population-level systematic care approaches.

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Compliance with Ethical Standards:

Conflict of Interest: The author has no conflicts of interest with this article.

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