Disparities in Depression Screening in a Primary Care Clinic

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I. Introduction

- University of Utah, Sugar House Clinic, is a primary care clinic in Salt Lake City, Utah. They implemented a universal depression screening protocol in 2019 to address low depression screening rates.
- Utah has consistently higher rates of self-reported lifetime depression than the U.S. average (24.2% vs. 20.1% in 2021).[2]
- Annual screening using validated questionnaires is an effective way of detecting depression and initiating treatment. Members of marginalized groups are often screened less than their White peers, which may worsen mental health outcomes.[1]
- After implementing universal depression screenings, do differences in screening rates exist when comparing patients by gender, race, language preference, and insurance coverage?

II. Methods

Project Design

- Retrospective data analysis of depression screening rates at the University of Utah Sugar House Health Clinic.
- Inclusion Criteria:
  - Seen at any University of Utah Health location between June 1, 2021 – December 31, 2022
  - Assigned primary care provider (PCP) practiced in the Sugarhouse Health Clinic.
  - At least 12 years old.

Statistical Analysis

- The outcome of interest was depression screening in the past 12 months (completed or not completed).
- Depression screening rates between demographic groups were compared using percentages and odds ratios.
- Chi-Square was used to determine statistical significance.
- Results were considered statistically significant if $p \leq .05$.
- Our reference groups for comparison were female, White race, English language preference, and private insurance.

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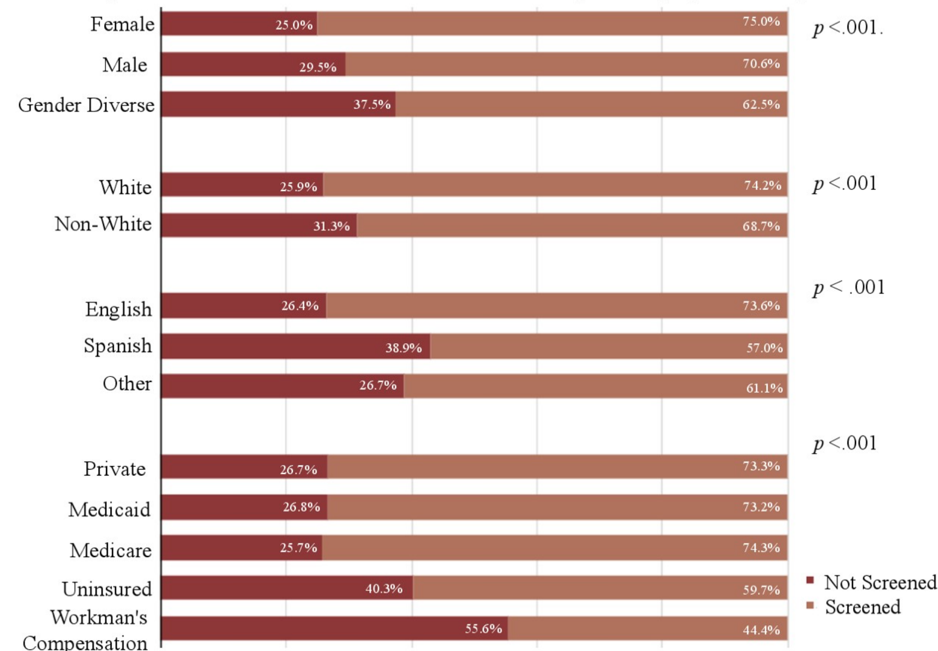
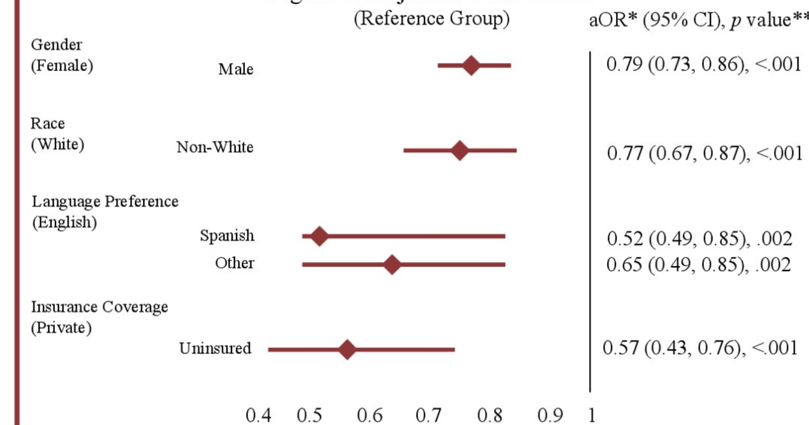
Table 1. Patient population breakdown by gender, race as analyzed, language preference, and insurance coverage.

Demographics	n	%	Demographics	n	%
Gender			**Language Preference**		
Female	7446	59.9%	English	12081	97.2%
Male	4974	40.0%	Spanish	100	0.8%
Gender Diverse	8	0.1%	Other	247	2.0%
Race			**Insurance Coverage**		
White	9317	75.0%	Private	9317	75.0%
Black or African American	200	1.6%	Medicaid	910	7.3%
Latino or Hispanic	889	0.5%	Medicare	2309	18.6%
Native Hawaiian, Pacific Islander	59	0.5%	Uninsured	211	1.7%
Asian	506	4.1%	Workman's Compensation	9	0.1%
Multi-Race/Ethnicity	80	0.6%			
Unkown/Declined	994	2.7%			
Other	334	2.7%	**Total**	12428	100%

Figure 2. Percent Screened and not Screened by Demographic Group*



*Significance established with $p < .05$



*Adjusted for patient demographics not being analyzed (gender, race, ethnicity, language, insurance coverage).
** Significance established with $p < .05$

III. Results

Figure 2 shows the percent of patients screened in each group. We compare screening rates of patients to those who reported female, White, English preference, and private insurance.

- 4.4% fewer males, 12.5% fewer gender diverse patients screened.
- 5.5% fewer Non-White patients screened.
- 16.6% fewer Spanish speakers and 12.5% fewer patients speaking other languages screened.
- 13.6% fewer uninsured patients and 28.9% fewer patients covered by Workman's Compensation screened.

Figure 3 shows the likelihood of screening compared to females, Whites, English speakers, and those with private insurance.

- Males were 21% less likely to be screened.
- Non-White patients were 23% less likely to be screened.
- Spanish speakers were 42% less likely to be screened.
- Other language speakers were 35% less likely to be screened.
- Uninsured patients were 43% less likely to be screened.

IV. Discussion

- Racial and ethnic minority groups carry a disproportionate share of chronic disease burden.[1,3] We may see lower rates of depression screening in non-White patients because depression screening is a lower priority for providers in more medically complex patients.
- The validity of the PHQ-9 has been shown in some Spanish speaking countries, but not in the US.[5] Lack of provider confidence in the translated screening tool may contribute to lower screening rates in non-English speaking patients.

V. Conclusion

- Despite recommendations that all adults be screened for depression regardless of risk factors[4], men, non-White, non-English speakers, and uninsured patients are being screened at lower rates.
- Future interventions should be tailored to the specific needs of these groups to close these disparities.

VI. References and Acknowledgements

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