Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well Child Checks

Minnesota Department of Health

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Why screen for postpartum depression during well child checks?

Maternal postpartum depression (PPD) can have serious adverse effects on the mother and child relationship, resulting in an environment that can disrupt the infant's development. Infants who live in a neglectful or depressed setting are likely to show delays in development and impaired social interaction.

In a new clinical report by the American Academy of Pediatrics (AAP), "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice," published in the November print issue of Pediatrics (published online Oct. 25), pediatric practices are encouraged to screen mothers for postpartum depression, to use community resources for the treatment and referral of the depressed mother, and to provide support for the mother-child relationship.

Estimated rates of depression among pregnant and postpartum women can range between 5 percent and 25 percent. A family history of depression, alcohol abuse and a personal history of depression increase the risk of perinatal depression. A prenatal visit in the pediatric medical home is an excellent opportunity to establish a relationship with the parents, assess for risk of depression and supports, and initiate preventive strategies. Postpartum depression can lead to increased medical costs, inappropriate medical care, discontinuation of breastfeeding and child abuse and neglect.

Screening is recommended by Bright Futures and the AAP Mental Health Task Force, and is a best practice in caring for infants and their families. (American Academy of Pediatricians, 2015).

Many mothers are screened for postpartum depression at their 6 week postpartum visit, as is recommended by the American College of Obstetricians and Gynecologists (American College of Obstetricians and Gynecologists, 2015). However, providers who deliver well child checks are likely to see the mothers more often and have an opportunity to screen for PPD during a wider range of dates. In addition, an infant is more likely to receive a 2 month well child check - 92% in Minnesota's Medicaid population in 2012 (Minnesota Department of Health, 2014) - than a mother is likely to receive a postpartum visit.

Nationally, 64% of mothers covered by a Medicaid health plan receive a postpartum care visit, compared with 82% covered by commercial health plans (Onstad, 2014).

Effective, free, relatively quick, validated screening tools exist to identify mothers at risk for postpartum depression. Treatments exist and are accessible, with great variability depending on location and insurance, for mothers to treat postpartum depression. Untreated, postpartum depression can have a negative impact on a baby's overall health and development.

Providers administering well child checks are in a key position to interact with the baby's primary caretaker and to universally screen for postpartum depression, as part of the care they provide for the child.

The consequences of maternal depression on child development

(Canadian Paediatirc Society, 2004)

- Prenatal
  - Inadequate prenatal care, poor nutrition, higher preterm birth, low birth weight, pre-eclampsia and spontaneous abortion.
- Infant
  - Behavioral: Anger and protective style of coping, passivity, withdrawal, self-regulatory behavior, and dysregulated attention and arousal
  - Cognitive: Lower cognitive performance
- Toddler
  - Behavioral: Passive noncompliance, less mature expressions of autonomy, internalizing and externalizing problems, and lower interaction
  - Cognitive: Less creative play and lower cognitive performance
- School Age
  - Behavioral: Impaired adaptive functioning, internalizing and externalizing problems, affective disorders, anxiety disorders and conduct disorders
  - Academic: Attention deficit/hyperactivity disorder and lower IQ scores
- Adolescent
  - Behavioral: Affective disorders (depression), anxiety disorders, phobias, panic disorders, conduct disorders, substance abuse and alcohol dependence
  - Academic: Attention deficit/hyperactivity disorder and learning disorders

Basic Implementation

Work Flow

In developing a work flow for implementing the PPD screen in well child checks, the key components are:

- Introduction and completion of the screen
- Provider review of score and identification of next steps
- Discussion of score and any necessary next steps with parent
- Documentation and any necessary follow up

Potential interventions that would be appropriate, depending on the score on the screening tool are:

- Very low score: Basic education regarding postpartum depression and maintaining positive mental health – Maternal Wellbeing Plan (found at http://www.health.state.mn.us/divs/cfh/topic/pmad/pmadfs.cfm)
- Mild to moderate score: Warm referral to see a provider regarding the mental health concern. Education regarding postpartum depression. Possibly other community supports.
- High or crisis score: Immediate transfer to a provider for parent. Create a plan for this process before launching universal screening.

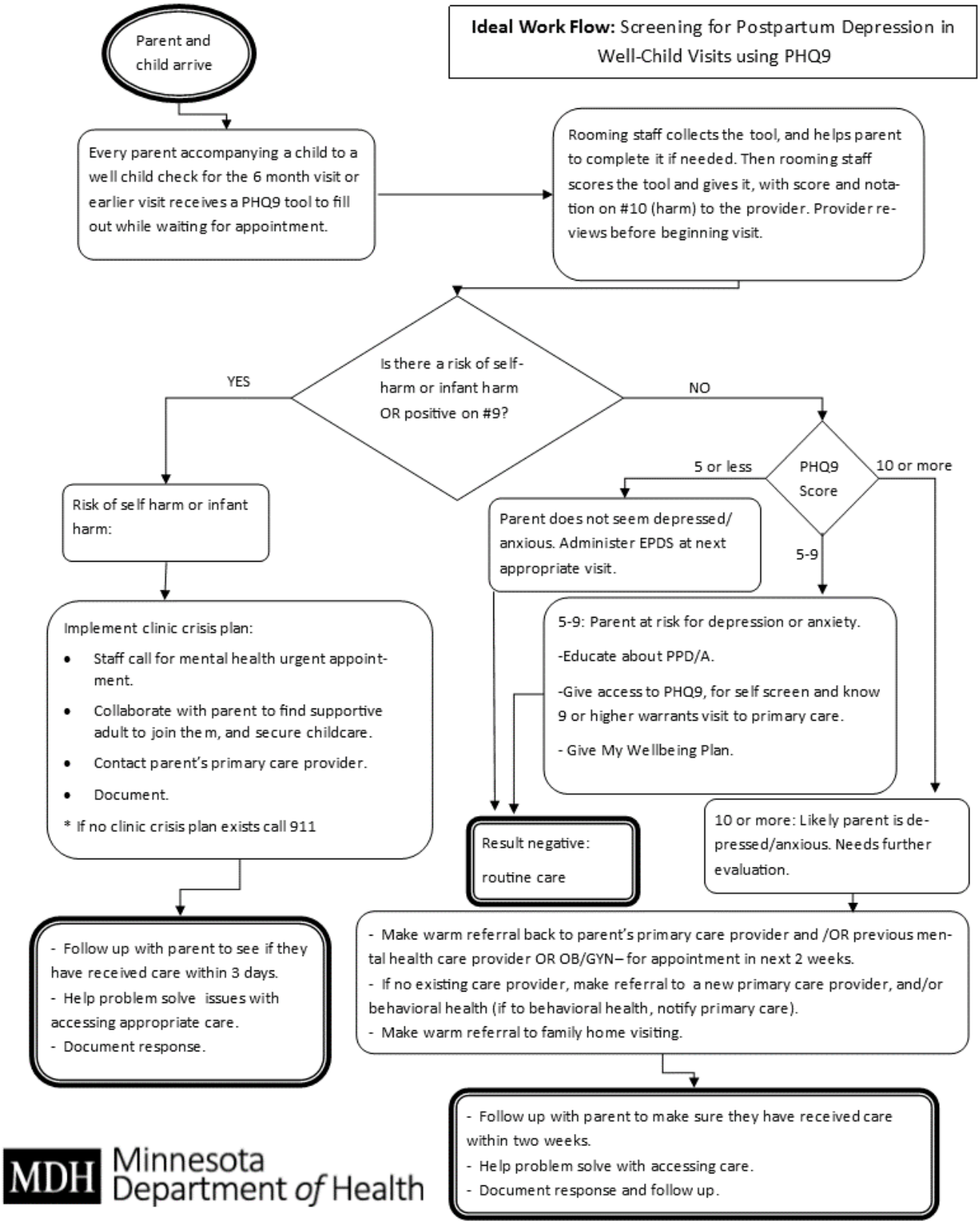
The community resources and other interventions offered to a parent could be developed by clinic staff. They may include local public health, family home visiting, early childhood family education, and other social service supports.

Increase/Attend to Screening for Child(ren)

If the depression/anxiety screen for the parent is positive, be sure to closely follow the physical and emotional health of the child and siblings. Monitor weight and growth, and screen regularly for developmental or social-emotional delays.

This may mean making a separate flag in the child's health record. Even if your clinic does not screen regularly at well child checks, take a step to make sure the child will receive both Developmental and Social-Emotional screens at all upcoming visits, since a positive screen will indicate additional high risk for the child and for other children in the family.

Ideal Work Flow: Screening for Postpartum Depression in Well-Child Visits using PHQ9



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Documenting and Charting for Postpartum Depression in Well Child Checks

When screening for postpartum depression in well child checks, the most essential documentation practices are:

- Have the results of the screen available, in the child's chart, to the child's provider.
- Document the follow up that occurs following a positive score on the screen.

Finding the right way to accomplish these two essentials can be tricky. It may be done very differently in different settings and clinical systems. There is not one "recommended" practice, but the following are ways systems have met these priorities along with HIPAA and their unique clinic/system expectations.

"Provider" refers to child's provider (not parent's).

Options	**Details**	**Advantages**	**Disadvantages**	**Clinic Types**
In the Parent's Record – Parent is in same EMR	1. Completed paper screening tool is scored, then used by provider during the well child check. 2. Well child check in record has a note that a tool was used to complete a screen. 3. Provider opens up parent's record, puts score and follow up activities in parent's record only (not child's). 4. Tool may be scanned into parent's record. 5. Internal message may be sent to parent's provider to ask them to complete necessary follow up.	• All information only in parents file, only parent and parent's provider have access. • Parent's provider can do follow up. • May get easier as technology improves.	• Parent may not have a file in system, may not pop up at future well child checks. • May take more care coordination time.	Systems where parent sees a provider in the same system, especially when provider is same for parent and baby.
In the Child's Record	1. Completed paper screening tool is scored, then used by provider during the well child check. 2. Provider/support puts information about the tool being completed, score of tool, and follow up activities into child's record. 3. Encounters in child's record are used to track follow up.	• Information regarding the child's health is readily accessible to child's provider but is not clear to all readers (i.e. using "pass" or other coded words).	Mental health information on parent is available from child's record.	Systems where parent sees a provider in the same system.

Options	Details	Advantages	Disadvantages	Clinic Types
In the Child's Record (cont.)	4. Parent's provider, if in system, can be notified through internal messaging. 5. Tool may be scanned into child's record.	• Tracking follow up from pediatric visit is easier.		
In a stand-alone file	1. Completed paper screening tool is scored, then used by provider during the well child check. 2. WCC has a note that a tool was used to complete a screen. 3. Care coordination staff put score and parent information, and follow up, into separate, stand-alone file—like Excel spread sheet. 4. Tool may be scanned into unattached folder on protected drive.	• Information on parent is not connected to child's record. • Information is available, if you know where to look.	Difficult (maybe impossible) to do flagging, reporting.	Systems where the parent is not a patient.
Send to parent's provider	1. Screening tool comes with a consent form for information to be shared with parent's provider, and spot to fill in provider information. 2. Completed paper screening tool is scored, then used by provider during the well child check. 3. WCC has a note that a tool was used to complete a screen. 4. Care coordination staff forward screen information and recommendation for follow up care to parent's provider.	• Information on parent is not connected to child's record. • Information is available, if you know where to look. • Parent will (if it works) receive follow up care from own provider.	Difficult (maybe impossible) to do flagging, reporting.	Systems where parent is not a patient.

Other interesting options include:

- Obtaining consent from the parent to put the score into the child's record.
- Upload actual screening tool into parent's chart.
- Keep parent and baby linked in medical record (may expire after a certain amount of time after birth).
- Only record if screen is high.

Scripts for Screening and Referral for PPD

Training may be helpful for all of the staff involved in administering the postpartum depression screen and needed follow up. Here are scripts that could be used. These are scripts to be used as a guide by staff and providers to discuss postpartum depression.

These scripts should NOT be given to patients. Segments of it could be adapted into written form if desired. The italics are recommended words to be used when speaking to the parent.

Please review and adapt to the needs of the families in the clinic population.

Handing out the Screen

This block could be printed on the screen:

Congratulations on your new baby! It's a big adjustment and we would like to know how you are feeling. Please check the answer that comes closest to how you have been feeling in the past 7 days, not just how you feel today.

Front desk staff: (The person handing the parent the screening tool.)

Having a baby is a big adjustment and your provider would like to check in with you and find out how you are feeling. Please fill this out, thinking about how you have been feeling over the past week. Your (nurse/medical assistant) will collect it from you in the room.

Introducing the Screen to Patients:

- PROVIDER: *As your child's provider, I'm concerned about the wellbeing of your child and so I'm also concerned about the wellbeing of the people who take care of your child. I'd like to know how you are feeling and how you have been coping. Please take a few minutes to fill out this short survey.* (OR – *Thank you for filling this out.)*

Response to a positive PPD screen:

- PROVIDER: *This is a screen for depression. I'm concerned because you have a high score. Have you been feeling down, depressed, or anxious lately?*
    - PROVIDER: *Would you be willing to see someone for help?*
        - PROVIDER: *Do you have someone you feel comfortable talking with, such as your clinician, doctor, midwife, or a therapist you already see?*

- Yes: PROVIDER: *Can we help you make an appointment?*
- No: PROVIDER: *Let's talk about who you would like to talk with.*
    - PROVIDER: *Can we help you identify a provider or connect you to a therapist?*

Follow Up Plan:

If the screen was high:

- A follow up phone call within hours or days after the initial screen was high
    - clinic should decide who will be the staff member who makes this call consistently use this staff member
- A follow up appointment with the parent's provider or therapist should take place within a week.

Follow-up Call:

- PROVIDER: *I wanted to follow up with you about the discussion we had when you were in last week. Have you been able to connect with your provider or therapist?*
    - Yes: PROVIDER: *How did everything go?*
        - Things went well: PROVIDER: *I am glad to hear that, please let us know if you need any additional information or referrals.*
        - Things did not go well: PROVIDER: *Can I help connect you to a different provider?*
    - No: PROVIDER: *What has prevented you from connecting with the referral?*
        - Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/transportation provide additional information.

How to Respond to High Positive Screen:

- PROVIDER: *This is a screen for depression. Based upon your response(s) and/or our discussion, I'm worried about your wellbeing. I believe you need to see someone today. I can help you set something up right now.*
    - PROVIDER: *Let's talk about how this process will go.*
        - Discuss how clinic handles crisis- walk parent through the process, and physically have a staff member get them to emergency room, OR bring in behavioral health OR find transportation for them to emergency room.
        - It's very important that the clinic has a plan for the child while the parent receives care. Possible options in Minnesota include:
            - Clinic is connected to behavioral health/emergency room and can make arrangements for child care with family.
            - Clinic works with mom to contact Mother-Baby Program at Hennepin County Medical Center (612)873-6262, to create plan for family.

- The place where parent is being transferred does not have child care: ask parent if they have someone they can call to come and be with them, who can also watch child (mother, sister, partner)
- Help parent manage any additional responsibilities (Childcare, eldercare etc.)

If the parent says they do not want to see someone today:

- PROVDIER: *Is there a reason why you are hesitating?*
  - Listen to parent, try to help parent deal with issues around why they don't want to see someone. Try NOT to be confrontational, rather gently work with parent to help them feel safe visiting additional resources.
  - PROVIDER: *Can I call someone to be with you? (Such as your mom, partner, sister, friend etc.)*
  - If a parent absolutely refuses to seek further care today, work as hard as you can to have someone come meet them.

Follow up for High Positive Screen:
Make a follow up call to high positive screens within days or hours. Child's clinic will make call to see if the mother has connected to care. It would be best to have mother make an appointment for herself within 1 week.

If a patient refused further care, call them within 24 hours and continue trying to follow up call until reached. If having trouble reaching them use emergency contact to try and reach them (without breaking HIPAA-just ask if the emergency contact can help you reach the parent for follow up)

- *I wanted to follow up with you about the referral you received when you were in last week. Have you been able to connect with the referral?*
  - Yes: *Did everything go alright?*
    - Yes: *I am glad to hear that, please let us know if you need any additional information or referrals*
    - No: *Would you like a referral to a different provider?*
  - No: *What has prevented you from connecting with the referral?*
    - Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/transportation provide additional information.

Every clinic should have a Crisis Response Plan prepared. If clinic has no Crisis Resource in place at time of emergency call 911.

Key Issues

Choosing Well-Child Visits for Postpartum Depression Screening

The best option for screening mothers for postpartum depression is to screen at all well child checks within the first year, or at least up to and including the 6 month check. In Minnesota, a maternal depression screen at a well child check in the first 12 months is billable, up to three times in a calendar year. It is a recommended part of a complete Child and Teen Check Up (Minnesota's Early and Periodic Screening, Diagnostic, and Treatment) in visits within the first year.

Some pediatric clinics choose specific well child checks at which to do the PPD screen. This may be useful for clinics who have significant differences between visits (i.e. other screens only done at certain visits) and but may not be helpful for clinics with patients who came for well child checks in a less than regular fashion. A practical suggestion: if you must pick only one visit (*not recommended)* than do it at the 2 month – unless you know all your moms are attending and getting screened at their 6 week postpartum visit, then do it at the 4 month.

Here are some things to consider in deciding which well child visits to do PPD screening at:

Visit	*Advantages*	*Disadvantages*	*Data*
1 or 2 week (new born)	If there is a concern, it is best to catch it as early as possible.	Most parents are still in the middle of major adjustment to the hormonal changes and generally having a baby. Concerns over anxiety or depression are expected and not out of the ordinary.	Psychosis presents itself within two weeks in 65% of all cases of postpartum psychosis. (Heron, 2007), (MGH Center, 2008), (Scotland, 2012).
2 month	• Most important time to catch this with a caregiver. • The initial "baby blues" have passed and this is the point where depression/anxiety will start to have an effect on the child. • Anxious or depressed moms and moms in low-income communities are less likely to attend their 6 week check.	Many mothers will also attend their 6 week postpartum visit, where they will (hopefully) be screened.	Children who are younger when first exposed to their mother's depression may be more vulnerable to the development of psychopathology than children not exposed until later (Goodman, 2011), (AAP, 2010).

Visit	*Advantages*	*Disadvantages*	*Data*
4 or 6 month	• If it hasn't been caught yet, this may be the last good chance to catch it and start to address the effect upon the baby. • No verified differences in screening at 4 or 6 month.	Late, so if screening here, should also be screening earlier.	There is a strong body of research on the impact of a depressed parent on children. Effects include increased risk of mood disorder in children, impaired cognitive functioning, and poor language development (Conroy, 2012) (Grace, 2003) (Zajicek-Farber, 2009) (Scotland 2012), (AAP 2010). One study suggests screening at 6 month is better than 4 (Sheeder, 2008). One study notes no significant difference (Whichman, 2010).
All visits	• Don't have to remember which visit it is. • More chances to find caregivers with concerns.	Caregiver may tire of the screen (no clear research to support this concern)	

Additional Screening Advice:

- Parents with a previous mental health history should be screened at every well-child visit.
- Parents with PPD/ or anxiety symptoms should be screened at every well-child visit.

If the provider suspects PPD/ or anxiety, parent should be screened at every well-child visit (Heron , Robertson Blackmore, McGuinness, Craddock, & Jones, 2007).

Deciding Which Tool to Use

Factors to take into consideration when selecting a validated tool to use for the postpartum depression screen:

- Is the tool specifically designed for pregnant or postpartum mothers? EPDS is, PHQ9 is not.
- Is the tool used within the medical community, outside of OB/GYN, and therefore the score and concern is easily communicated to a provider? PHQ9 is, EPDS is not.
- Are there other providers in the clinic system who have already chosen a tool to use? Is consistency in the system important?
- Is the tool billable within the state Medicaid rules? In Minnesota, the approved tools are the Beck, PHQ9, and EPDS.
- Is the tool free and easily accessible? PHQ9 and EPDS are both free.
- Is the tool available and verified, in other languages spoken in our patient population?
- Is the tool already available for use in the clinic electronic health record?

Billing

This information is from the Minnesota Department of Human Services Child & Teen Checkups Provider Guide, as of 11/30/2015. It will likely be different in other states.

When billing for a maternal depression screening, refer to the following criteria:

- Use CPT code 99420 with modifier UC.
- Use the child's MHCP recipient ID number.
- Bill it on the same claim as the C&TC screening or other pediatric visit.
- May be billed on the same date as a child's developmental screening (96110), and or a social-emotional screening (96127).

When a maternal depression screening is performed using one of the standardized screening instrument during a well-child check, and reported on the claim, that line item on the claim will be paid at our fee schedule rate. The fee schedule rate for the CPT code 99420 is $8.67.

Resources

The Minnesota Department of Health has created an information sheet and a tool for helping plan for maternal wellbeing – the Maternal Wellbeing Plan. These are available online, in 7 languages (Amharic, English, Hmong, Karen, Russian, Somali, and Spanish) at http://www.health.state.mn.us/divs/cfh/topic/pmad/.

For Parents

There are many sources for support and information regarding postpartum depression, including:

For immediate help:

Call 911 or

Crisis Connection at 866-379-6363; TTY 612-379-6377 or
Text "LIFE" to 61222 available in many rural areas.

For resources and support:

Pregnancy Postpartum Support Minnesota
Resource List: www.ppsupportmn.org
PPSM HelpLine call or TEXT to (612) 787-PPSM or PPSMhelpline@gmail.com
Support and information provided by peer volunteers 7days a week.

Mother-Baby HopeLine at Hennepin County Medical Center
(612) 873-HOPE or (612) 873-4673
Mental health support and resources. The HopeLine is not a crisis phone line.
They will call you back within 2 days.

Postpartum Support International
www.postpartum.net

For Providers

Here are a few of the resources available for providers:

Mother-Baby HopeLine at Hennepin County Medical Center:

(612) 873-HOPE or (612) 873-4673

Mental health support and resources. The HopeLine is not a crisis phone line. They will call you back within 2 days. Staffed by trained professionals with experience providing technical assistance to other providers.

Depression in Mothers: More Than the Blues

http://store.samhsa.gov/product/Depression-in-Mothers-More-Than-the-Blues/SMA14-4878

A free toolkit designed for providers who come in contact with mothers experiencing depression. It includes facts about depression, screening tools, referrals, resources and handouts for mothers who are depressed.

Substance Abuse and Mental Health Services Administration: Toolkit for providers.

Support and Training to Enhance Primary Care for Postpartum Depression (Step-PPD)

http://www.step-ppd.com/step-ppd/home.aspx

A free online training course for primary care providers designed to increase understanding of postpartum depression (PPD), and provide education on caring for women with postpartum depression. The course covers basic understanding of PPD, how to assess PPD, and how to treat PPD.

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