Background: Postpartum depression (PPD) affects up to 20% of American mothers and, if left untreated, can have serious, lifelong effects on women and their children. For the latter, PPD can negatively affect behavior, language and cognitive development, and physical health. It is estimated that less than half of PPD cases are even identified—resulting from screening and treatment recommendation discrepancies from major domestic and international organizations. PPD screening performed in the hospital after a newborn’s birth is performed too early to make a diagnosis and, although most obstetricians screen for PPD at the six-week postpartum visit, this interaction is usually terminated after the appointment—making follow-up inadequate. Due to their longitudinal relationship with their patients and their patients’ families, pediatric providers are uniquely situated to effectively screen mothers for PPD while educating them on symptoms, treatments, and resources. The American Academy of Pediatrics recommends that pediatric practices screen for PPD at the 1-, 2-, 4-, and 6-month well child checks (WCCs). Despite the NAPNAP-supported endorsement, few pediatric practices oblige.

Change Aims: This quality improvement project aimed to improve PPD screening rates and referrals at a rural pediatric clinic in Virginia. Currently, the clinic uses the Edinburgh Postnatal Depression Scale (EPDS) to screen mothers for PPD; however, they screen inconsistently. The clinic serves a large number of teenage mothers and it is estimated that 28.5% of the town’s residents are living in poverty. Considering that PPD rates have been observed to be as high as 60% in low-income and teenage mothers, it is imperative that this clinic employs consistent, evidence-based screening and referral efforts.

Innovation Details: This project standardized the clinic’s PPD screening schedule and developed a novel referral algorithm that was concurrently implemented. The EPDS was administered at the clinic’s newborn, 2-week, 1-month, 2-month, 4-month, and 6-month WCCs. Depending on the EPDS score, mothers were referred to their obstetrician/gynecologist, primary care provider, and/or a local mental health counselor using a resource and referral guide developed for this project. The clinic’s electronic health record was adjusted—inserting an EPDS section in the aforementioned WCC templates to document the scale’s administration, reason for no administration, EPDS score, referral location, and/or reason for no referral.

Outcomes: This project significantly increased the clinic’s screening rate: screening rates were 33% pre-implementation and 80% post-implementation (p<0.001). Although not statistically significant, the project improved referral rates from 66% to 79%. The referral algorithm was function for providers and can be replicated by other pediatric practices. Mother refusal to be screen only accounted for 13% of instances when screening was not performed appropriately.

Implications: Effective PPD screening can take as little as one minute. By standardizing PPD screening, developing a referral/resource guide, and implementing a referral algorithm in the pediatric setting, more PPD cases can be identified, further evaluated, and treated—directly improve maternal and infant health outcomes. The small changes this project represents can be transferable and adaptable by pediatric practices in any setting.

Discussion Question: What barriers impede pediatric practices from consistently screening patient mothers for postpartum depression?

References
6. S. Kirkhart, Personal Communication, January 8, 2017
Introduction and Background

- Postpartum depression (PPD) affects up to 20% of American mothers and it is not known how many go undiagnosed\(^1\).
- Due to their longitudinal relationship with their patients and their patients’ families, pediatric providers are uniquely situated to screen mothers for PPD and educate them on symptoms, treatments, and resources\(^2\).
- The American Academy of Pediatrics recommends that pediatric practices screen for PPD at the one-, two-, four-, and six-month well child check (WCCs)\(^2\).
- There are few published reports of primary care pediatric practices compliance with this recommendation\(^3\).

Conclusions

- PPD screening can be effective in the pediatric setting.
- The referral algorithm using a depression screening tool was functional for providers and can be replicated and adapted by other pediatric practices.
- Mothers are generally receptive to being screened for PPD by pediatric providers: only 8 mothers refused screening out of a sample size of 414.
- This is one of only a handful of studies to quantify the effectiveness of standardizing screening schedules in pediatrics and the first to study the effectiveness of a referral algorithm.

Methods

- The project standardized the clinic’s PPD screening schedule and developed a novel referral algorithm and resource/referral guide that was concurrently implemented.
- The Edinburgh Postnatal Depression Scale (EPDS) was administered at the clinic’s newborn, two-week, one-month, two-month, four-month, and six-month WCCs.
- A decision support algorithm was developed to provide guidance to providers based on EPDS score (see figure).
- The clinic’s electronic health record was adjusted and an EPDS section was inserted into the templates for the above mentioned WCCs to document: the scale’s administration, reason for no administration, EPDS score, referral location, and/or reason for no referral.

Implications

- Standardizing PPD screening in the ambulatory pediatric setting coupled with implementing a referral algorithm and resource/referral guide can help more PPD cases be identified, further evaluated, and treated—ultimately improving maternal and infant health outcomes.
- Further research on outcomes of mothers who did access recommended services is needed.
- Pediatric providers may be reimbursed for PPD screening by using the CPT code 99420 and ICD-10 code Z13.89.

References