POSTPARTUM DEPRESSION SCREENING INTERVENTION REPORT

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This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016

Phone 602.264.6382 • Fax 602.241.0757

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Introduction and Background

Introduction

The Colorado Department of Health Care Policy & Finance's (the Department's) contract with Health Services Advisory Group, Inc. (HSAG) requires that HSAG conduct quality activities to improve client outcomes related to the Department's mission, vision, and quality strategy. Based on findings from the most recent Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) survey, postpartum depression was identified as an issue of significance in the Medicaid population. The Department and HSAG developed a pilot, provider-based intervention designed to identify strategies to increase the number of Medicaid providers who administer postpartum depression screenings and, as applicable, to provide treatment referrals to the appropriate regional behavioral health organizations (BHOs) or community mental health centers (CMHCs).

Background

Postpartum depression is a moderate-to-severe depression a woman may experience after giving birth and that may occur soon after delivery or up to a year later. The most prevalent form of mood disorder after childbirth is commonly referred to as the "baby blues." Many reports estimate that up to 80 percent of new mothers experience some symptoms of the baby blues, which might include sadness, irritability, anxiety, decreased concentration, and trouble sleeping. The symptoms of postpartum depression, however, are more intense and longer-lasting.[1]

Postpartum depression is recognized as an important maternal and child health concern. In addition to directly influencing the emotional well-being of mothers, the Centers for Disease Control and Prevention (CDC) reports that postpartum depression has also been shown to affect marital relationships, mother-infant bonding, and infant behavior. Mothers with postpartum depression may be less responsive, less sensitive to infant cues, and less emotionally available. Infants of depressed mothers are less likely to have well-child visits, be up-to-date on immunizations, and more likely to use urgent and emergency care.[2]

Colorado PRAMS data from 5,798 surveys of mothers compiled over three years (2005–2007) indicated that the prevalence of postpartum depression among Colorado women was 12.8 percent, or nearly 10,000 women.[3] Using the 2006 PRAMS data, the Colorado Department of Public Health and Environment (CDPHE) compared women's characteristics, pregnancy risk factors, health care utilization, and birth outcomes among women with Medicaid coverage and women without Medicaid coverage. The study concluded that despite having more risk factors during pregnancy, birth outcomes for women with Medicaid were not significantly different than for women without

[1] O`Hara, M., & Swain, A. (1996). Rates and risk of postpartum depression-a meta-analysis. International Review of Psychiatry, 8, 37-54.
[2] Beck, C.T. The effects of postnatal depression on maternal-infant interaction; a meta-analysis. Nursing Research 44:298-304, 1995
[3] http://www.cdphe.state.co.us/hs/pubs/pramsmedicaid.pdf

Medicaid. The study did reveal two significant differences between the Medicaid and non-Medicaid groups, however. Fewer mothers with Medicaid breast-fed their babies, and a significantly greater number of women with Medicaid reported always feeling depressed, down, or hopeless (4.0 percent) after giving birth than did women without Medicaid (0.4 percent).[4]

Screening women for postpartum depression is recommended by the American Congress of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Academy of Family Physicians.[5] Administering screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-9) identifies mothers with depressive symptoms who may be at increased risk for major depression and provides an opportunity for early referral into appropriate treatment.

Study Goals and Objectives

The primary goal of this intervention study was to identify the barriers to providing postpartum screening that were experienced by Colorado Medicaid providers and to develop strategies that will lead to an increase in the number of depression screenings administered during postpartum visits.

Methodology

Overview

The Department identified and supplied HSAG with a list of 13 obstetrics and gynecology provider offices in the Denver Metro area that serve a relatively high number of people with Medicaid. Providers were sent a letter of introduction from the Department's manager of health outcomes and quality management that explained the study, introduced HSAG, and requested the providers' voluntary participation. HSAG followed up each letter with a telephone call to the clinic manager of each practice to answer any questions and to ask each clinic if it wished to participate. HSAG emphasized that participation was voluntary.

HSAG scheduled an introductory appointment with each clinic manager who agreed to participate. During the initial appointment, HSAG collected baseline data from the office staff regarding the types of depression screening instruments used, if any, and the frequency of use.

HSAG delivered to each participant an information packet that contained hard-copy materials and a compact disk with electronic versions of each item:

- Two depression screening instruments (the EPDS and the PHQ-9), in both English and Spanish.
- A list of behavioral health referral resources.
- A *Dear New Mother* template letter that explained the symptoms of postpartum depression and included regionally specific telephone numbers a woman could call for additional services.

[4] http://www.cdphe.state.co.us/hs/pubs/ppdepression2.pdf
[5] http://www.cchap.org/newsletter-twelve

- A tracking sheet for office staff members to record the number of postpartum appointments, screenings administered, and referrals made to CMHCs or BHOs during the study period of April through July.

The regional BHOs were notified in advance of the study and had the opportunity to specify how their contact information was to be listed on the resource list provided to participants. Some BHOs also contributed ideas for the *Dear New Mother* template letter.

During the study period, HSAG made monthly follow-up telephone calls to each participating clinic to ask if it was administering the screenings and to address any questions or comments.

At the end of the study, a focus group meeting was conducted with each participating provider office to identify any challenges associated with administering the postpartum depression screening instrument, and to solicit ideas that would encourage the provider practice to adopt the screening process as a routine procedure for postpartum visits.

Findings

Of the 13 clinic locations identified by the Department, three agreed to participate in the pilot intervention. One office was already participating in several studies and the office manager did not feel they could take on any more projects. A group of three affiliated clinics initially showed interest, but later declined to participate without giving a reason. The remaining clinics failed to respond to the Department's letter and HSAG's telephone calls.

The first provider group that chose to participate treated women from two clinic locations. Prior to this study, the group had not used any formal postpartum depression screening tool. The doctors simply asked general questions such as, "How are you feeling?" Furthermore, the practice had no formal referral resources for women identified as having symptoms of postpartum depression. If a provider was uncomfortable treating the patient, he or she would suggest the new mother seek care from a behavioral health specialist.

The first provider group agreed to administer the EPDS tool at all postpartum appointments at both clinic locations. This group provided 27 women with postpartum appointments during the study period (this number includes both commercial insurance carriers and Medicaid), and all 27 women completed the screening tool. Once the tool was completed, the provider reviewed it with each woman. Of the 27 women screened, one was identified as needing further evaluation. This woman indicated she was already in treatment with one of the community mental health centers. The clinic manager stated that the office staff made follow-up telephone calls to her to ensure she continued her behavioral health care.

The second provider group that agreed to participate was already administering the EPDS tool prior to the study. This practice administered the EPDS beginning with the patient's first prenatal visit. The number of times a patient was asked to complete the EPDS depended on her risk (assessed at the first appointment) and her score on the prior screening. At a minimum, each woman was asked to fill out the EPDS three times: at her initial appointment, once between the 28th and 32nd week of the pregnancy, and again at the postpartum appointment. This group provided postpartum appointments to 96 women with Medicaid coverage during the study period. Of the 96 women screened, 17 were

identified as needing further evaluation. For those needing further evaluation, the procedure at this location was for the provider office staff to schedule an appointment with a behavioral health specialist for the new mother before she left the postpartum appointment. Staff members from this provider group stated during the focused group discussion that in their experience, a new mother was more likely to receive follow-up behavioral health care if the appointment was made for her, as opposed to asking her to schedule the appointment herself.

In addition to giving clients the referral list of behavioral health treatment providers that HSAG provided, the second group gave them additional postpartum resources that included a list of counselors who would provide services on a sliding-fee scale, postpartum support groups, and Web sites with information about postpartum depression, tips for overcoming depression, and—in some cases—chat rooms for new mothers. Women who declined a behavioral health referral at the time of the postpartum appointment received the list of resources to take with them. The providers reported that it was not uncommon for women who had refused a referral to call back within three months to seek help. The providers felt that after three months the new mother would have established a routine with her baby and would have more energy to address any problems she might have.

During the focused group meetings, providers reported that patients consistently completed the screening tool without hesitation; they commented that the tool gave them more specificity to describe how the woman was feeling. Examples of questions in the EPDS tool included, “In the last seven days, how often have you felt sad or miserable?” and “How often have you been so unhappy that you cry?” Providers stated they were comfortable scoring and reviewing the results of the tool with their patients as part of the postpartum examination. Providers who were interviewed agreed that the tool was effective and efficient and they planned to continue using it.

Providers found HSAG’s referral information to be very helpful and suggested making it available to all clinics that provided obstetrical care. Having referral resources, especially for the Medicaid population, contributed to their willingness to screen for postpartum depression.

During the focus group interviews, providers discussed their belief that the biggest barrier to a woman seeking treatment for postpartum depression was the stigma associated with it. They felt that women were uncomfortable admitting they were experiencing symptoms, that their symptoms were something they should work through on their own, and that they should just “tough it out.” Other barriers to treatment, they felt, included the fact that many new mothers are exhausted by the demands of caring for a newborn and have little energy to seek care for themselves. Further, the lack of available/affordable child care and transportation complicate a woman’s ability to access treatment. Traveling with a newborn, and perhaps older siblings, on a bus can be overwhelming to a new mother.

Conclusions and Recommendations

Conclusions

Participating providers were pleased with the ease and effectiveness of the EPDS tool. They commented that the tool gave them and their patients a way to define and quantify what a woman was feeling.

Providers were more comfortable administering a screening tool knowing that they had referral resources they could provide to a woman on Medicaid should she be identified as needing further evaluation.

While patients were willing to fill out the screening tool at the postpartum appointment (typically scheduled within six weeks of delivery), providers stated that it was not uncommon for depression symptoms, or the woman's readiness to address them, to surface three or more months after the birth of the baby.

The three provider offices that participated were pleased with the direct contact from the Department's "agent" and the information and resources provided. Eight of 13 providers identified by the Department for inclusion in the study declined to participate for unknown reasons. One provider did not participate because of involvement with "several other studies." It is not known whether any of these practices currently administer a postpartum screening tool.

Recommendations

1. Make it easy. Change the focus of this activity from a pilot to a concentrated provider-focused campaign that provides all necessary screening, scoring, and patient education and referral materials during one in-person visit from the Department's representative. Rather than requesting that providers participate in a study, schedule a one-time office call to provide all materials.

2. Expand selected provider types. Due to the potential for delayed presentation of postpartum depression symptoms for several months after delivery, include family practice and pediatric providers in the campaign to screen new mothers for postpartum depression.

3. Provide respected local endorsements. Include in the materials given to providers a brief postpartum depression fact sheet with information/statistics specific to Colorado and include letters endorsing screening tools such as EPDS from the study participants, Dr. Stafford from the Kemp Center, and the acting Department of Health Care Policy & Financing medical director.

4. Expand the list of resources provided to include Internet resources such as:

   - Postpartum Support International, the primary organization for postpartum depression awareness, www.postpartum.net.
   - The Commonwealth Fund, which provides practical tools and resources to assist primary care providers in screening for postpartum depression, www.commonwealthfund.org/usr_doc/Implementation_manual_4_16_use.pdf?section=4039.

- MedEdPPD, which offers professional training information about postpartum depression screening and research, www.medeeppd.org.
- The Kempe Center Web site, which provides an explanation of the postpartum depression diagnostic tools and guidelines for administering, scoring, and referring based on the score. In addition, a provider can arrange for a special training session for staff members and providers with Brian Stafford, MD, MPH, medical director, Perinatal Mental Health Program, The Children's Hospital.

Appendix A. Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) follows this cover page.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Appendix B. Dear New Mother Template Letter

The *Dear New Mother* template letter follows this cover page.

Dear New Mother,

Postpartum depression is a mood disturbance or problem that affects about 10–15% of new mothers. At your recent visit to our office, we asked you a few questions to find out if you might be experiencing symptoms of post partum depression. These symptoms could include:

- Loss of appetite
- Insomnia
- Intense irritability and anger
- Overwhelming fatigue
- Loss of interest in sex
- Lack of joy in life
- Feelings of shame, guilt or inadequacy
- Severe mood swings
- Difficulty bonding with your baby
- Withdrawal from family and friends
- Thought of harming yourself or the baby

Postpartum depression is not a weakness—it is just something that happens to some women after giving birth (www.mayo.clinic.com). If you have some of the symptoms of post partum depression, we encourage you to speak with a mental health professional. They can help you decide if you do have postpartum depression, and if so, what you can do to feel better.

Since you have Medicaid, there is no cost to you for an evaluation or treatment for post-partum depression. To get started, you can call your local community mental health center.

- If you live in Boulder or Broomfield Counties, call The Mental Health Center Serving Boulder and Broomfield Counties at 303-443-8500.

- If you live in Clear Creek, Gilpin or Jefferson Counties, call Jefferson Center for Mental Health at 303-425-0300.

- If you live in Arapahoe County, Adams County, or Douglas County, call Behavioral HealthCare Inc. at 303-490-4400.

- If you live in Denver, call Access Behavioral Care at 303-751-9030.

If you have any questions, please call this office (OBGYN's number).

Sincerely,

Appendix C. Postpartum Depression Referrals

The postpartum depression referrals follow this cover page.

Postpartum Depression Referrals

Behavioral Health Organization (BHO)	Service Area	Telephone No.	Web site
Access Behavioral Care (ABC)	City and County of Denver	(303) 751-9030	www.coaccess.com
	PROVIDER OFFICE MAY CONTACT Mary Burleigh, RN, Care Manager 800-511-5010 ext. 5539		
Behavioral HealthCare, Inc. (BHI)	Adams, Arapahoe, and Douglas counties	(720) 490-4400	www.bhicares.org
	Adams County residents should call Community Reach Center at 303-853-3733		
	Arapahoe and Douglas County resdients should call Arapahoe Douglas Mental Health Network at 303-723-5910		
	Aurora residents should call Aurora Mental Health Center at 720-339-1189		
Colorado Health Partnerships (CHP)	West, Southwest, and Southeast Colorado	800-804-5008	www.coloradohealthpartnerships.com
Foothills Behvioral Health Partners (FBHP)	Boulder, Broomfield, Jefferson, Gilpin, Clear Creek counties	(303) 432-5956	www.fbhpartners.com
	Residents of Boulder and Broomfield counties should call The Mental Health Center Serving Boulder and Broomfield Counties 303-443-8500		
	PROVIDER OFFICE MAY CONTACT Beverly LaRoe, 303-661-0433 with a referral and/or to request follow-up		
	Clear Creek, Gilpin, or Jefferson County residents should call Jefferson Center for Mental Health at 303-425-0300		
Northeast Behavioral Health Partnership (NBHP)	Northeast Colorado	888-296-5827	www.nbhpartnership.com