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# Parental Depression Screening: Incorporating Validated Screening Tools into your Practice

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# Disclosures

- Sandra G Wood, CNM, PMHNP
  - I have no relevant financial relationships to disclose or conflicts of interest to resolve
  - I will not discuss unapproved or off-label pharmaceuticals

# What?

- Screening: strategies for identifying parents who are experiencing symptoms of depression using clinical interview questions and/or standardized tools.

- Assessment: an in depth method used to verify depression among parents who screen positive for symptoms by identifying specific symptoms, making a diagnosis, and choosing an appropriate treatment approach.

- Pediatric Clinician's Guide to Parental Depression Screening
  - Assess
    - Conduct brief parental depression screening at well child visits
    - Score to determine if risk for major depression
  - Address
    - Discuss screening results and the possibility of depression
    - Explain impact of parental mood on children
  - Agree
    - Doctor and parent jointly agree on what to do next
  - Assist & Arrange
    - Assist with child developmental or behavioral issues when needed
    - Provide parent with educational materials
    - Provide referrals to community resources and other providers
  - Address Again
    - Follow up at next pediatric visit or sooner if needed

# Why?

- Prevalence warrants screening.
  - In biological mothers it is one of the most common complications of the perinatal period.
  - Up to 4 to 25% of fathers
- Essential for recognition and treatment
- Early detection can make an impact on the course of treatment and may prevent a crisis.
- Treatment can reduce the impact of parental depression on children and other family members.
- This is a time when families intersect with the health care professions.

# Barriers

- Responsibility/liability
- Time
- Training
- What to do with positive screen
- Culture/stigma
- Reimbursment.

# When?

- Ideally
  - Every visit
    - Pre-pregnancy
    - Prenatal and postpartum visits
    - Well child visits
- At risk times
  - Problem visits
  - Transition points.
- Recommendations
  - US Preventative Services Task Force USPSTF
  - American Academy of Pediatrics AAP
  - American Academy of Family Physicians AAFP
  - American Congress of Obstetricians and Gynecologists ACOG
  - Association of Women's Health, Obstetric and Neonatal Nurses AWHONN
  - American College of Nurse-Midwives ACNM

# U.S. Preventative Services Task Force
# USPSTF 2016

- Adults, including pregnant women and women who have recently given birth, should be screened for depression.
- Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Screening Timing and Interval
  - There is little evidence regarding the optimal timing for screening.
  - The optimum interval for screening for depression is also unknown
  - Ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.

# Whom do I screen?

- Everyone
  - No one is immune to depression
  - Looks can be deceiving
- High risk groups
  - Past history
  - Family history
  - Substance abuse
  - Significant medical stressors
  - Limited social support
  - Victims of Interpersonal violence - IPV
- Prior positive screen

# How to Incorporate Screening ?

- Involve and educate staff

- Establish a set screening and assessment protocol.
  - Use validated tools
  - Staff responsibility
  - Procedures, scripts
  - Identify the score that needs intervention
    - Develop workflow that responds to the scores
  - Documentation
  - Follow up

- Crisis Action Plan
- Increase parent awareness with educational materials
- Establish a referral network
- Coding and billing

- Embed the pathway in the EMR

# Effective Screening

- Standardized tool
  - Alerts the provider to concerns that can be addressed in the visit.
  - Gives the parent language to use with the clinician
  - Creates opportunity to discuss emotional health
- Validated tool
  - A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), sensitivity (the probability of correctly identifying a patient with the condition).
- Standardized Process
  - Established roles, consistency

# Edinburgh Postnatal Depression Scale (EPDS)

- Designed to detect perinatal mood and anxiety disorders (PMAD) in healthcare settings
  - 10-question screen
  - Can be completed in about 5 minutes.
- Sensitivity: 78-86% Specificity: 78-99%
- Most widely studied and thoroughly validated
  - Extensively Validated for postpartum depression PPD
  - Women parents beyond postpartum
  - Teens
  - Fathers
- Available in more than 20 languages
- Free
- Easy to score

- Not linked to DSM V criteria
- Not diagnostic
- Score does not indicate severity

# Instructions for using the EPDS

- Ask the parent to check the response that comes closest to the way s/he has been feeling in the past 7 days.
- The parent should complete the scale him/herself unless there is limited English or reading difficulty.
  - Is available in multiple languages
- All items must be completed
- Fill out without discussion with others- family or provider.

- Scores needing intervention
  - 10 or greater
  - Greater than 13 = high likelihood of MDD
  - Any positive answer on item 10

# Diagnostic and Statistical Manual of Mental Disorders

- DSM-V criteria for Major Depressive Episode
  - Depressed mood
  - Anhedonia
  - Significant increase or decrease in appetite/weight
  - Insomnia/hypersomnia
  - Psychomotor agitation/retardation
  - Fatigue/loss of energy
  - Feelings of worthlessness/inappropriate guilt
  - Diminished ability to think, concentrate, or make decisions
  - Recurrent thoughts of death or suicide

# Patient Health Questionnaire (PHQ-9)

- Designed to compare depressive symptoms against DSM criteria items in a healthcare setting
  - 10-item scale
  - Can be completed in 5 minutes.
- Sensitivity: 75-88%  Specificity: 88-90%
- Useful for a broad range of clients as it was developed for Family Practice
  - 12 or older
- Validated for use with PMAD and by phone.
  - Electronic and telephonic administration so far are finding similar results.
- Free
- Easy to score
- Assess and track treatment response

- Not diagnostic, despite reflecting diagnostic criteria
- Not specific to PMAD and does not capture anxiety symptoms

# PHQ2

- Over the past 2 weeks, how often have you been bothered by any of the following problems?
  - Little interest or pleasure in doing things.
    - **0** = Not at all
    - **1** = Several days
    - **2** = More than half the days
    - **3** = Nearly every day
  - Feeling down, depressed, or hopeless.
    - **0** = Not at all
    - **1** = Several days
    - **2** = More than half the days
    - **3** = Nearly every day
- Validated for postpartum depression

# Instructions for Using the PHQ9 and PHQ2

- Useful tool for integrated care settings
- Can be administered by a variety of different staff and can be used with different approaches.
- PHQ 2/PHQ 9 should be completed by the patient, usually in the waiting room
  - Often administrative staff or medical assistants score this form and subsequently enter the score into the electronic health record.
- In cases where patients have difficulty with reading or comprehension, a staff member can assist the patient in completing the tool.
- Assistance with completing the tools can be provided by any level of staff who has been trained in understanding the purpose and importance of the PHQ tools and in strategies for engagement and completion of the tools.

- Scores needing intervention
  - PHQ9
    - 10 or greater
    - Any positive answer on question #9
  - PHQ2
    - 3 or greater
    - Next step could be PHQ9

# Bright Futures

- Pre visit questionnaire
- “For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions. Thank you.”
- PHQ2
- Timing: By 1 month, 2, 4, 6 months

# SWYC: Survey of Wellbeing of Young Children

- Free. Comprehensive screening instrument for children less than 5 years old
- Short,  easy to read and score
- < 15 minutes
- Built in at 2, 4,  6,  9, and  12 month visits

- PHQ 2
  - Suggested follow up with PHQ9 if positive score

# SEEK: Safe Environment for Every Kid

- Abbreviated PHQ2
  - Yes/no
  - Available in English, Spanish, Chinese and Vietnamese

| | |
|---|---|
| □ Yes □ No | **Do you often feel under extreme stress?** |
| □ Yes □ No | Over the past 2 weeks, have you often felt down, depressed, or hopeless? |
| □ Yes □ No | Over the past 2 weeks, have you felt little interest or pleasure in doing things? |

# Other Brief Tools

- PHQ4
  - Anxiety, worry, low mood, anhedonia, SI
- EPDS3
  - Anxiety, SI

# Postpartum Depression Screening Scale (PDSS)

- 35-item scale has subscales and a response validity indicator. It takes less than 10 minutes. A shorter, 7-item version takes less than 5 minutes.
- Assesses for suicidal thoughts
- Sensitivity: 91%–94%
  Specificity: 72%–98%
- Post Partum Depression-specific
- Validated
- Questions based on interviews with postpartum women
- Length of the tool may make it less feasible for clinical use
- Self-report
- Must purchase
- Available from Western Psychological Services
  (800) 648-8857 www.wpspublish.com

# What do I say to Parents?

- Depression after childbirth is common in families.
- The number one complication of childbirth is depression
- We are interested in how you are doing.
- We screen everyone.
- This screening tool helps us to know if you need additional support at this time.

- Privacy Language: information not released unless we are concerned about your safety or the child's safety

# What to do with a Positive Screen?

- Assessment
  - Preliminary clinical interview to determine next steps
    - Psychiatric assessment
    - Rule out medical sources of symptoms
- Intervention
  - Educate
  - Support
  - Referral
    - Passive
    - Active
  - Crisis
- Follow up

# Documenting/Charting for Screening 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.
- The note for the well child visit includes
  - Tool used
  - Score
  - Assessment
  - Follow up plan
    - No intervention
    - Resource handout
    - Passive referral
    - Active referral
    - Crisis intervention
    - Rescreen, return visit
- Follow up
  - Planned contact
  - Rescreen at next visit
  - Referral

# Factors influencing Documentation and Follow up

- Parent sees a provider in the same system, especially when provider is same for parent and baby.
- System where the parent/caregiver is not a client
- Paper vs EMR
- Availability of behavioral services on site
- Billing and coding

# Models/Resources

- http://www.commonwealthfund.org/usr_doc/Implementation_manual_4_16_use.pdf
- http://www.health.state.mn.us/divs/cfh/topic/pmad/professionals.cfm
- https://www.brightfutures.org/
- http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf
- Suicide Risk Assessment
- http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

# Finding meaningful data (language) for complex conditions

- We discuss this in our food insecurity panels, but it is appropriate here as well.
- Robust use of the problem list and existing SNOMED CT codes can balance the limitations of ICD

# Assessment

| ICD10- E-Bill | SNOMED CT- Problem List |
| --- | --- |
| Postpartum Depression/Puerperal Psychosis<br>F53 | Postpartum/Puerperal Depression<br><br>58703003 |
| Postpartum mood disturbance<br>O90.6<br><br>F43 adjustment disorder<br>G47 Insomnia<br>G51.02 insomnia due to stress<br>O99.35 mental disorder of mother postpartum complication<br>O26.819 fatigue in pregnancy delivered<br>R45.0 nervousness<br>R45.84 anhedonia<br>Z91.89 at risk for depressed mood postpartum | ***Neonatal/Newborn effects of maternal postpartum depression***<br>1104797100011910 9 |

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# Screening

| **CPT- *BILLABLE and Able to be tracked in claims based analysis*** | **SNOMED CT – Problem List Documentation** |
|---|---|
| 96161<br><br>Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per **standardized instrument** | Maternal Depression Screening/ Maternal Postpartum Depression Screening<br>428221000124108<br><br>Edinburg Postnatal Depression scale screening offered<br>2571000175108<br><br>Depression screening using patient health questionnaire 9 nine item score<br>71525007 |

# Intervention

| CPT | SNOMED |
| --- | --- |
| Counsel Codes 99401-99409 (however these cannot be used with preventative codes E/M codes) | Education about postpartum depression 439366005<br><br>Maternal postpartum depression care/treatment 428231000124106 |

# References


- AAP Guide to Preventative Care, 2017

https://www.aap.org/en-us/Documents/coding_preventive_care.pdf

- Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice

http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf

- AAP Postpartum Depression Toolkit

http://www.aafp.org/patient-care/nrn/studies/all/trippd/ppd-toolkit.html