

Perinatal Depression Screening and Referral Project ★

Location: Connecticut
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 Category: **Emerging Practice**

BACKGROUND

Depression during pregnancy and the postpartum period is a serious public health problem, as it affects the health and well being of women and can impact birth outcomes. Elevations in maternal cortisol during pregnancy have been demonstrated to be among risk factors contributing to preterm birth. Maternal depression has also been demonstrated to affect the developmental outcomes of children including learning and behavior. Although the incidence of perinatal depression is estimated to affect 10 – 15% of women, the prevalence among low income women is estimated to be 25-30% with depression rates higher for all women living in poverty regardless of ethnicity. Perinatal depression is often undetected and untreated. Universal screening can help identify depression during the perinatal period and might enhance a woman's ability to access treatment.

PROGRAM OBJECTIVES

The Perinatal Depression Screening and Referral Pilot Project was established by the Connecticut (CT) Department of Public Health to determine the rate of perinatal depression in at risk women receiving services in a Federally Qualified Health Center (FQHC). The project also examined the feasibility of screening and establishing a referral system for women during prenatal, postpartum and well baby visits.

The goals of the project are:

- To determine the prevalence of perinatal depression among a low income population of women.
- To determine if a plan to screen, detect and refer women for depression can be operationalized within a Federally Qualified Health Center setting.
- To determine if women who screen positive for depression will accept referrals for treatment.
- To determine differences among subpopulations that may need additional targeted efforts.

TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED
#1: Percent of women with a past year preventive visit.

TARGET POPULATION SERVED

The pilot project took place at three sites of Community Health Center, Inc. (CHCI) spanning both rural and medium sized urban areas. CHCI is a FQHC in CT that offers prenatal services, behavioral health services and well child care in addition to primary care, dental and other services. The sites of care were Clinton, Middletown and Meriden CT. During an 8-month screening period 512 individual women were screened.

PROGRAM ACTIVITIES

The program design was based in the Health Belief Model (HBM) and the Transtheoretical Model (TTM). TTM identifies stages of change and processes of change. This theory acknowledges that people vary in their readiness to change during the behavior change process and often move forward and backward in the process of change before the change is fully realized. Screening at various intervals as we did as part of our study design allows us to capture women at various intervals during the perinatal period when they might be more or less receptive to accepting an offered intervention. Additionally, self-efficacy is a variable associated with the HBM theory and influences a person's expectations around an intervention's outcome. Once a woman is screened for depression she will have the option to discuss the assessment results, offer her feedback and engage in decision making around options for care.

The process began in 2006 and the pilot project took place over an 8-month period. The initial project was delivered in the three CHCI sites which offer prenatal care but after the project period this service was expanded to be delivered at all CHCI primary care locations. The agency policy accounted for the fact that some women may not have received prenatal care through our agency. For women receiving prenatal care at CHCI screening is administered during the prenatal and postpartum period as defined in the pilot project. For women who receive prenatal care elsewhere but establish well-baby care for their newborns,

screening begins during the well-baby care visits. Education about postpartum depression and a handout about depression during and after pregnancy along with a postpartum depression policy information sheet are given to each newborn's mother at the first well-baby visit and screenings are done during each ensuing well-baby visit through the 12 month visit. Referrals are made to our Behavioral Health Department for positive screens and a warm handout process was developed in order to address immediate concerns. If mothers are not CHCI patients and have a positive screening result they are asked to sign an affirmation of receipt of screening results form.

After the pilot period ended CHCI developed a policy on perinatal depression screening and subsequently institutionalized this practice. The screening tool adopted for perinatal depression screening is the Maternal Depression Screening Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9). Both the PHQ -2 and the PHQ-9 are recommended in the Bright Futures Tool and Resource kit and can be found in their developmental, behavioral, psycho-social screening and assessment forms.

To incorporate continuous quality improvement a sub-group of women participating in the project were interviewed and asked on specific quantitative and qualitative barriers to care and also participated in an ethnographic interview intended to better understand participant's perceptions of behavioral health and treatment. This was done under the direction of Stephanie Milan PhD from the University of Connecticut.

PROGRAM OUTCOMES/EVALUATION DATA

During an 8-month period 512 individual patients were screened for depression at three CHCI sites at various intervals during pregnancy and the year following birth. Using a validated tool, women were screened for depression during their first prenatal appointment, between the 30th and 35th week of pregnancy, at the 6 week postpartum visit, at the 4 month well baby visit and one time between the 6 and 9 month well baby visit. The screening process was universally applied to our perinatal target population.

Those who scored above the threshold for depression were offered a behavioral health appointment and had their appointment scheduling expedited. Patients were followed by a care coordinator for appointment compliance and were offered follow-up assistance to reschedule missed appointments. A project access database tracked each time a patient was screened for depression, her screening score, if a referral was offered and accepted, if the patient kept her behavioral health appointment and the reason why she declined to enter into behavioral health services.

Of the women screened, 33% scored above the threshold indicative of depressive symptomatology. There were significant differences in the rates of depression by marital status ($X^2 = 8.07, p < .05$) and race ($X^2 = 4.50, p < .05$), with highest rates among African American and single women. No difference was found by age.

Of the women who screened positive and were offered a behavioral health referral, 83% accepted the referral. However, only 40% of these women completed at least one behavioral health appointment. Behavioral Health utilization differed by race ($X^2 = 15.83, p < .001$) but not by other demographic factors.

The pilot project demonstrated that screening and referrals during the prenatal, postpartum and well-baby care visits are feasible and can be successfully implemented in a federally qualified health center with co-located services. The project also demonstrated promising results in the number of women who screened positive for depression that will accept referrals for treatment. As a result, the screening/referral policy and protocol were further developed and institutionalized universally.

However, results suggest that screening, referrals and access to Behavioral Health services are not sufficient strategies for engaging low income women in treatment for perinatal depression. The universal screening and referral process helps ensure identification and access to care and is an important first step because there are significant health consequences associated with perinatal depression for women and their children. Additional research is necessary to identify and remove barriers to treatment of depression during the perinatal period.

PROGRAM COST

The initial grant supported program start-up expenses such as: research support, data collection design and analysis. The ongoing cost of the program is cost neutral since existing staff are utilized to screen and refer patients to care.

Please contact program staff for estimates on the start-up expenses.

ASSETS & CHALLENGES

Assets

In 2005, the Connecticut Department of Health convened a perinatal depression advisory committee and then released an RFP for a perinatal depression screening, referral and treatment pilot project. During this same period the Quality Assurance Sub-Committee of the Connecticut Medicaid Managed Care Council also identified perinatal depression as a significant public health issue. This sub-committee



convened a forum on the topic of perinatal depression addressing the two generational effects on mother and child. The Woman's Health Sub-Committee of the Council continued this work and convened additional forums on perinatal depression bringing together Medicaid consumers, state leaders, agencies, and national experts on the subject.

The Council on Medical Assistance Program Oversight (formerly the Medicaid Managed Care Council) was established under CGS 17b-28 as a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise our state's Medicaid agency on the development of Connecticut's Medicaid Managed Care program and for legislative and public input to monitor the implementation of the program. (<http://www.cga.ct.gov/med/>)

In 2013 the Connecticut Medicaid agency authorized reimbursement for maternal depression screening during pregnancy and the postpartum period through a specific billing code. Of note is that the reimbursement for this screening is separate from the visit.

Challenges

During the implementation phase, the role of a care coordinator and project director facilitated compliance with the pilot's plan. After the initial phase it was necessary to have institutional support at the administrative level so that the intervention could be institutionalized and continued. The agency policy and the operationalization of this policy drove provider by in and compliance.

Overcoming Challenges

Staff in-servicing took place during the initial pilot phase of this project. Ongoing staff education and strong agency leadership at the highest levels supported the development and adoption of our universal screening, referral and treatment policy and the integration of this into daily practice.

LESSONS LEARNED

Our initial project had a rapid turn-around period of 8 months. Adequate lead in time would have allowed us to better educate and support provider knowledge and confidence around implementing the universal screening and referral protocol. The utilization of a validated screen for maternal depression is a paradigm shift for many providers. Although some providers rely on maternal appearance to identify potential depression, the administering of a validated tool, followed by a brief discussion by the provider, has proven to be a more effective strategy. Studies reveal that provider confidence in screening and diagnosing and the importance they place on screening and treatment for women suffering with perinatal depression is related to their commitment to screen, refer and treat. Motivational interviewing for providers has been an effective strategy

affecting provider practices and attitudes around screening, referrals and treatment for perinatal depression. The theory of motivational interviewing suggests that strengthening confidence and belief in a behavior will move a subject towards a desired behavioral change related to the desired outcome. This intervention might support enhanced provider compliance and commitment to the screening, referral and treatment process.

FUTURE STEPS

As noted, CHCI has developed and implemented an agency wide universal screening policy and protocol. This work continues and is ongoing but has been integrated into the daily work flow of the agency's practice.

CHCI has established a "Warm Handoff" policy so that women can receive immediate care with a behavior health specialist in specific circumstances. This policy continues to be developed. Per our perinatal depression screening policy the "warm handout" is implemented in the following circumstances:

"Immediate warm handoff" or real-time consultation with a behavioral health provider for acute patients, or those with a score of 15+ (moderately severe/severe depression), evidence of suicidality or homicidality, evidence of psychosis and/or concurrent active substance abuse. This may be to a CHCI provider if the mother is a CHCI patient or to a crisis center in the area if they are not a CHCI patient (or if no BH provider available)."

Although our state Medicaid agency covers the screening for perinatal depression within the primary care, obstetric and pediatric setting, work continues through multiple venues to identify the needs of low income women and to address the need for appropriate treatment options. Additionally, The CT. Behavioral Health Partnership has recently included perinatal mood disorder as an area of specialization and includes a corresponding list of providers who specialize in this area.

COLLABORATIONS

The pilot project was funded by the Connecticut Department of Public Health and was overseen by the Department and the State Perinatal Depression Advisory Committee. We also collaborated with Stephanie Milan, PhD from the University of Connecticut on the data analysis and qualitative components of the pilot project.



PEER REVIEW & REPLICATION

This project has been presented as a paper at the Connecticut Department of Public Health Perinatal Depression Advisory Committee meeting (2006) and as a poster presentation at the Annual Maternal and Child Health Epidemiology Conference (2007).

While the project has not been replicated outside the state, the initial pilot project has expanded from the original three CHCI sites to all CHCI primary care sites.

RESOURCES PROVIDED

The following resources are available:

- [CHCI Perinatal Depression Screening Policy](#)
- [CHCI Postpartum Depression Policy Information to Mothers](#)
- [CHCI Affirmation of Receipt Postpartum Screening Results](#)
- CHCI Handout: Depression During and After Pregnancy. Frequently Asked Questions:
- <http://www.womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf>

Resources available in Connecticut:

- Connecticut Infoline
<http://www.211ct.org/search/default.asp>
- Dial 2-1-1 from anywhere in Connecticut and you will reach a highly-trained call specialist who will assess your needs and provide referrals to the resources in your community. Every day, call specialists help callers find assistance for complex issues such as financial problems, substance abuse and suicide prevention and for simpler issues such as finding volunteer opportunities and donation options. 2-1-1 is available 24 hours a day every day of the year. Multilingual assistance and TDD access is also available.
- Connecticut Behavioral Health Partnership
<http://www.ctbhp.com/services.htm>
 - Perinatal mental health provider specialization options
 - Peer/family peer specialists and intensive case management services

For more information, please contact:

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★ This program was highlighted at AMCHP's 2014 Annual Conference with an Emerging Practice award.

