The Postpartum Depression (PPD) Patient Journey: Payer Considerations

Third in a Series of Articles on the Patient Journey and Management Challenges of PPD
INTRODUCTION

This is the third supplement in a series of articles on the patient journey and management challenges of postpartum depression (PPD). The previous supplements highlighted that PPD is the most common complication of pregnancy and childbirth (CDC 2017, DeSisto 2014, Knight 2009, Ko 2017, Reddy 2015) and may be associated with significant negative effects not only for the mother but the whole family (Vliegen 2014, Netsi 2018, Matthey 2000, Kerstis 2012, Kourta 2013, Surkan 2014). In addition, diagnosis rates of PPD in the United States still remain low among postpartum mothers (Cox 2016, Evins 2000, Georgiopoulos 2001, Goodman 2010) even though state-mandated screenings and other condition management programs have been implemented for several years in some states.

Through extensive patient and healthcare provider (HCP) interviews, unmet needs in PPD education and an increased demand for PPD awareness were not only identified by patients but also providers. In addition, providers also expressed the need for more treatment options and a greater need for patients to have access to treatments. This supplement will continue the postpartum journey—now including considerations for payers, such as the call for health plans to consider enhancements to their maternal and postnatal management programs. There is shift for postpartum care to include the physical, social, and psychological well-being in a routine wellness check, as supported by patients, providers, and the American College of Obstetricians and Gynecologists (ACOG) (ACOG 2018). This supplement will review the importance of diagnosing and treating patients in a timely manner; state and plan-level PPD screening recommendations, policies, and programs; and currently available PPD treatment options.

To gather further insight around the patient journey and associated management challenges of PPD, interviews were conducted with patients who related their experiences with PPD during the prenatal and postpartum periods, and HCPs who specialize in treating mothers who have experienced PPD. These insights will be shown throughout this payer considerations supplement.

SPOTLIGHT OF FINDINGS FROM PATIENT AND PROVIDER INTERVIEWS:

“PPD prevented me from bonding with my child; I was unable to get out of bed, bathe myself or my child, and I was unable to communicate how I was feeling and how much I was struggling.”

“Mental and emotional health need to become a part of [the] routine wellness check during OB/GYN care visits, postpartum care, and also during well-child visits.”
To recap what we have covered, PPD is a disorder that is underdiagnosed (Cox 2016, Evins 2000, Georgiopoulos 2001, Goodman 2010), and it is distinct from “baby blues” due to the timing, duration, and/or severity (ACOG 2013, APA 2013, Earls 2010, CDC 2008, Robertson 2003, CDC 2017, NIH). A mother with “baby blues” may experience symptoms such as anger, irritability, fatigue, and sadness (Earls 2010, Thurgood 2009). The onset of “baby blues” generally peaks within the first few days post-delivery and resolves without treatment in two weeks (Earls 2010, NIH).

PPD symptoms may occur during pregnancy or post-delivery (APA 2013, ACOG 2015, Roberston 2003, CDC 2008). Opinions of experts vary as to the exact timing of symptom occurrence in PPD post-delivery. According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), PPD symptoms can begin during pregnancy or in the 4 weeks following childbirth (APA 2013), whereas ACOG, World Health Organization (WHO), and the Centers for Disease Control and Prevention (CDC) state that PPD symptoms can occur during pregnancy and up to 1 year after giving birth (ACOG 2015, Roberston 2003, CDC 2008). A mother suffering from PPD may experience symptoms such as trouble bonding with her baby, thoughts of self-harm or harm to baby, experiencing anger or rage, and feelings of worry, anxiety, and restlessness (NIH).

While the exact cause of PPD is unknown, a combination of factors may play a role, including perinatal hormonal fluctuations (Bloch 2000, Schiller 2015). In addition, other factors, include sleep disturbances (Bhati 2015), history of depression (Robertson 2004, Silverman 2017), history of trauma (Howard 2013), chronic stress (Yim 2015), and low socioeconomic status (Goyal 2010).

Perinatal women are often reluctant to seek help for symptoms related to PPD due to the stigma of the disease and barriers to available treatment options (Byatt 2013), which may result in a delayed formal diagnosis of and treatment for PPD. Other barriers may include (Byatt 2013, Goodman 2009):

- Patients are reluctant to acknowledge mental health concerns to family, friends, or HCPs due to shame, guilt, or the fear of potential consequences—including hospitalization—due to admitting thoughts of harming themselves or their children
- Lack of access to treatment or knowledge about where to seek it
- Childcare access during postpartum visits
- Patients may feel initial screening does not encourage engagement in treatment with their HCP
Among the patients interviewed, some faced emotional factors and social stigma, which influenced whether they sought help. The following outlines the feelings and challenges they faced when confiding in family, friends, and providers.

- Not feeling blissful over the birth of the child
- Fearing how family and friends may view them as mothers
- Uncertainty about when to seek professional help
- Confiding in family who assured them it was normal to feel this way
- Thinking the symptoms would go away on their own
- Lack of comfort or being reluctant to voice their concerns and feelings with family, friends, or physicians

As a health plan provider, are you providing educational materials or support programs around PPD?

Awareness efforts can help start a conversation among providers and members. There is a need for a shift in care so that healthcare providers can speak about PPD with the same ease and comfort as other pregnancy complications.
Obstetricians/gynecologists (OB/GYNs), midwives, and nurses are the HCPs diagnosing more patients with PPD than any other HCPs, as these providers are often the primary medical resource to see patients throughout the course of the pregnancy and postpartum (Kozhimannil 2013, DOF Medscape ICD9 2017/Symphony 2016). These professionals can be well-positioned to identify patients who may be experiencing PPD symptoms, then assess the severity level of PPD, support patient engagement, and counsel patients about treatment options.

Since symptom onset can occur at different time points in the perinatal period, maternal screening should be considered and may be administered in the obstetric and pediatric settings (Earls 2010, Howard 2009, Mayberry 2007, NIH, Netsi 2018, Thurgood 2009, Vliegen 2014). Appropriate screening and early intervention can be important in improving health outcomes in patients with PPD (O’Connor 2016). Screening is recommended during both pregnancy and the postpartum period (ACOG 2015, Siu 2016, AAP) to help clinicians identify women who are at an increased risk for or who may already have PPD. Screenings help HCPs provide appropriate and timely treatment should a confirmatory diagnosis of PPD be made through a clinical assessment.

With the limited number of providers and appointments available, some patients may need to wait several weeks before they can see a psychiatrist.

OB/GYNs, midwives, and nurses, as well as pediatricians, who have access to the mother in the perinatal and postpartum periods, often are responsible for treating these patients. Patients are more likely to confide in a provider they are familiar with; having a comfortable and supporting setting may help them open up more and start the conversation on symptoms and concerns they may be experiencing.
In addition to nationally recognized organizations involved with the development of PPD screening recommendations, a growing number of states—including Florida, Illinois, Massachusetts, New Jersey, and West Virginia—have enacted policies aimed at addressing many challenges associated with perinatal behavioral health needs, while also encouraging routine PPD screening by HCPs.

As reviewed above, in recent years, state mandates and program-specific policies have developed initiatives to help support screening practices.

How can improved PPD screening help broaden maternal health initiatives at your plan?

*The public awareness initiatives include declaring a yearly PPD awareness month; establishing toll-free hotlines for patients and providers for mental health services; and making public service announcements (PSAs) on perinatal mental healthcare via flyers, posters, and press releases.

In recent years, some commercial and government payers, as well as some notable employers, have developed programs designed to help support screening practices and provide educational support for their members and HCPs.

**EXAMPLES OF REAL-WORLD SCREENING AND SUPPORT PROGRAMS**

---

**Commercial Payers**

**EmblemHealth®: Healthy Beginnings PATH Pregnancy Management Program**

EmblemHealth offers a free pregnancy program to members called the Healthy Beginnings PATH program, which provides guidance throughout the member’s pregnancy and postpartum period. The program offers telemedicine communications with a maternity nurse, health surveys to help the member’s HCP take care of the member and child, and educational materials and resources for the member (EH PATH Program). In addition, the program offers patient education on baby blues and PPD and how to differentiate between the 2 disorders. The program also offers an online PPD survey for members to fill out; depending on the score, the survey directs the member to call an HCP or call the Mental Health and Substance Abuse department number available on the member’s health plan ID card (EH BB PPD). For more information, please visit: [www.emblemhealth.com/](http://www.emblemhealth.com/).

**Harvard Pilgrim Health Care: Healthy Pregnancy Program**

Harvard Pilgrim offers members a Healthy Pregnancy program that provides educational information and support to help women better understand the importance of timely and comprehensive prenatal and postpartum care (HPHC Healthy Pregnancy Program). The program components include healthy pregnancy outreach, high-risk outreach and management, patient education materials on PPD, and educational mailings and online resources (HPHC Healthy Pregnancy Program May 2017). For more information on this program, please visit: [www.harvardpilgrim.org/](http://www.harvardpilgrim.org/).

**Humana: HumanaBeginnings®**

Humana members can enroll for free in a special program for expectant moms. The HumanaBeginnings program provides information to help the mother understand each step of her pregnancy (HumanaBeginnings Program). Once a member has enrolled (online or by phone), she will receive a phone call from a specially trained HumanaBeginnings nurse who will tailor the conversation based on the member’s health concerns and questions. The member will also receive a welcome letter that explains how HumanaBeginnings works (HumanaBeginnings Program). Members will receive personalized guidance, education, and resources from their nurse, who will follow up at each trimester, tailoring to the member’s needs and preferences (HumanaBeginnings Program). For more information on this program, please visit: [www.humana.com/](http://www.humana.com/).

---

Although the programs highlighted above provide a snapshot of what is available for pregnant women, current research has identified limitations, including lack of proactive communication with members, difficulty accessing the benefits, and the limited PPD-specific programs available to expectant or new moms.

As a health plan provider, what steps will you take to advance maternal programs to include behavioral health resources and education for your members — through programs like these or with communications throughout pregnancy? As learned from interviews with patients and providers, education and awareness of PPD is beneficial throughout the pregnancy and postpartum periods.

---

1Please refer to References, on page 16, for the full website address for each program.
EXAMPLES OF REAL-WORLD SCREENING AND SUPPORT PROGRAMS (cont)

Government Payers

**Medicaid Maternal Depression Screening**

State Medicaid programs provide coverage of maternal depression screening. While not all state Medicaid agencies are required to cover maternal depression screening, it is recommended by the Centers for Medicare & Medicaid Services (CMS) (AAP 2016, CMS 2016). State Medicaid agencies may cover this screening as part of the well-child visit under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (CMS 2016). For more information on this mandate, please visit: [www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf](http://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf).

**Employer Efforts**

Some employers can play a role in providing supporting programs tailored to their employees and families. For example, The National Business Group on Health (NBGH) has developed a toolkit on maternal and child health with recommendations that can assist employers in developing, implementing, and evaluating maternal-tailored benefits, programs, and policies (NBGH 2007).

The NBGH suggests the following toolkit components for employers to think about when developing maternal health offerings and programs (NBGH 2007):

- Ensuring healthcare benefits provide preconception, prenatal, and postpartum services
- Developing information packets about healthy pregnancies and disseminating during open enrollment
- Promoting pregnancy health education programs through a variety of formats such as emails, phone calls, flyers, webinars, and podcasts. The following are suggested types of information and services to include in these programs:
  - Preconception counseling and support regarding exercise, healthy eating, health maintenance, and family planning
  - Printed and electronic educational resources for employees and family
  - Prenatal classes
  - On-site well-baby/pregnancy education counselors or phone access to similar services
- Educating beneficiaries on maternity leave, the Family and Medical Leave Act (FMLA), parental leave, and other support policies a company may offer

The National Institute of Child Health and Human Development launched an initiative called Moms’ Mental Health Matters, which provides free educational content and resources that can be utilized by workplaces to support employees during the perinatal period. Resources include action plans, posters, and tips for family and friends to use to start a conversation about this depression with their loved one (APA CWMH, NIH MMHS). For more information, please visit: [https://www1.nichd.nih.gov/ncmhep/Pages/index.aspx](https://www1.nichd.nih.gov/ncmhep/Pages/index.aspx).
The rate of diagnosed patients may vary between 40% and 70%, which is supported by a data on file (DOF) reference.† Estimates are based on relevant literature and treated PPD cutoff of Edinburgh Postnatal Depression Scale (EPDS) rating ≥13 using the McCabe-Beane reference to support the frequency tables to estimate the proportion of patients in the following severity groups: mild PPD=13, moderate PPD=14-18, severe PPD=≥19. Using the lower threshold of EPDS ≥7 to depict the treated PPD population will result in the following severity distribution: mild PPD=74% [7-13], moderate PPD=19% [14-18], and severe PPD=7% [19-30] (McCabe-Beane 2016, PACT 2015).

SSRI=selective serotonin reuptake inhibitor; SNRI=serotonin-norepinephrine reuptake inhibitor; SMS=serotonin modulator and stimulator; TCA/TeCA=tricyclic or tetracyclic agent.

Combination therapies include: SSRI/miscellaneous, SSRI/SMS, SSRI/TCA or TeCA, SNRI/SMS, SNRI/miscellaneous, SMS/miscellaneous, and SSRI/SNRI.


FIGURE 2.
Breakdown of Therapeutic Options Among Moderate-to-Severe PPD Patients

The following figure illustrates the breakdown of common therapeutic options for patients with moderate-to-severe symptoms. This illustration was developed with an estimated number of individuals who may be affected by PPD with moderate-to-severe symptoms each year in the United States and the potential therapies that may be offered.*†

Treatment options may depend on the severity of symptoms, current medications, patient preference, and treatment and medical history (Sriraman 2015). Personalized treatment is needed, as not all patients are the same; access to treatment should be expanded instead of taking a “one-size-fits-all” approach.

As a health plan provider, how are you staying current on advances in the maternal mental health space?

*The rate of diagnosed patients may vary between 40% and 70%, which is supported by a data on file (DOF) reference.
†Estimates are based on relevant literature and treated PPD cutoff of Edinburgh Postnatal Depression Scale (EPDS) rating ≥13 using the McCabe-Beane reference to support the frequency tables to estimate the proportion of patients in the following severity groups: mild PPD=13, moderate PPD=14-18, severe PPD=≥19. Using the lower threshold of EPDS ≥7 to depict the treated PPD population will result in the following severity distribution: mild PPD=74% [7-13], moderate PPD=19% [14-18], and severe PPD=7% [19-30] (McCabe-Beane 2016, PACT 2015).
THE POSTPARTUM DEPRESSION (PPD) PATIENT JOURNEY: PAYER CONSIDERATIONS

THE PPD PATIENT JOURNEY PERSPECTIVE: THE BURDEN OF PPD

PPD may negatively impact the mother’s ability to function, the development of the child, and the well-being of the family.

- Increased risk of preterm delivery
- Breastfeeding complications
- Risk of suicide
- Symptoms of PPD may continue more than 1 year postpartum

- Impaired cognitive and fine motor development
- Cognitive delay, poor functioning on cognitive object tests, and poor communication skills
- Increased gastrointestinal symptoms

- Disruption in sleep routines for the infant and mother
- Impaired mother–infant bonding
- Negative parenting practices
- Increased risk of relationship problems between mother and partner
- Risk of paternal depression

PPD can add to the burden on the healthcare system, as women with PPD can incur higher health services expenditures than mothers without PPD.

Women with PPD have 11 more outpatient visits and greater prescription drug use versus mothers without PPD in the first year post-childbirth.

Women with PPD incur 90% higher health services expenditures than mothers without PPD.

Households with a woman with PPD incur 22% higher medical costs than households without a PPD patient.


As a health plan provider, do your maternal health benefits consider and support both members and their immediate family members/caregivers?

Consider offering maternal and postnatal educational materials not only for the members but their families. These materials may help your members identify the signs and symptoms of PPD earlier and start the conversation with their providers.
Among the patients interviewed, some described their personal experiences; these experiences are summarized on pages 12 and 13.

In an ideal journey, a patient would follow one stage of the patient journey to the next, similar to how it is depicted below.

During key milestones of the pregnancy, the OB/GYN will perform screenings with the patient leading up to the delivery to determine potential PPD risk.

A patient* will recognize something is wrong and schedule a follow-up with her provider.

Her provider will be familiar with PPD and conduct a questionnaire screening. Based on the results, her provider will determine if a further assessment is required.

At the appropriate time, the provider and patient will discuss potential treatment options based on history of medications and preference.

The patient will begin treatment and adhere to therapy (eg, medication, talk therapy) as prescribed.

Over time, the provider will follow up with the patient to see how the treatment is working, how she is feeling, and whether any changes are required or if the patient is ready to taper off the treatment. For patients who attend psychotherapy, the provider may assess how the therapy is working and whether or not there is a need to increase or decrease the amount of sessions.

*In some cases, a family member or caregiver may recognize symptoms of PPD and may encourage the patient to schedule an appointment with her provider.
THE POSTPARTUM DEPRESSION (PPD) PATIENT JOURNEY: PAYER CONSIDERATIONS

THE PPD PATIENT JOURNEY PERSPECTIVE: EXAMPLE REAL-WORLD PATIENT JOURNEY

In a real-world patient journey, a woman suffering from PPD can and often does face many different and difficult obstacles and barriers in the process from initial recognition of symptoms, to timely screening, confirmatory diagnosis, and then to successful treatment. Some of these challenges include:

- Patients not knowing where to go or whom to speak with regarding their PPD symptoms
- Physicians not feeling supported around comprehensively managing women affected by PPD
- Payers looking to advance stronger condition management programs

This illustration reflects how a real-world PPD patient journey may deviate from the predictability and seamlessness often associated with the ideal patient journey.
She calls her PCP to make an appointment.

At her appointment, her PCP screens and suggests she may have PPD. The PCP refers her to a psychiatrist for further assessment and treatment.

While the patient may be facing internal stigma, she realizes she may not be strong enough to overcome her symptoms independently. She decides to call the psychiatrist’s office and is scheduled for a consult appointment.

A patient may drop out of care if she experiences challenges with access to a psychiatrist provider and obtaining treatment.

A patient may drop out of care if she doesn’t want to meet with a mental health provider due to self-stigma or fear of stigma among her family, and she will go untreated.

Potential hurdles:
- Long waits for an appointment
- Insurance coverage challenges
- Delays in treatment
- Internal stigma and potential judgment from family and friends
- Lack of available childcare during appointments

A patient may drop out because of side effects.

A patient may drop out of care if she experiences frustrations because symptoms are not improving as quickly as she had hoped.

A patient may drop off from treatment if she does not feel as though anything has changed.

Potential hurdles:
- Multiple dose changes, changes in medications, or doses not changing at all
- Length of treatment plan—longer than expected
- Difficulties scheduling follow-up appointments with the provider
- Delays or interruption in treatment

An OB/GYN may refer the patient to consult with a psychiatrist for additional treatment and/or therapy.

At the appointment, her psychiatrist conducts an assessment, diagnoses her with PPD, and prescribes medication.

Several weeks later
CONCLUSION

In conclusion, even with state-mandated screening and educational initiatives in place, PPD still remains underdiagnosed (Cox 2016, Evins 2000, Georgiopoulos 2001, Goodman 2010). The findings from the provider perspective highlighted the need to conduct earlier screening and coordination of care from the prenatal period throughout the postpartum period; this may improve health outcomes for patients with PPD (O’Connor 2016). The insights from the patient perspective showed how continued communication, education, and awareness of PPD may help improve outcomes as patients navigate their postpartum journeys, as these efforts may have helped them identify their symptoms earlier, speak more openly with their providers on PPD, and obtain treatment much earlier in their journeys.

As reviewed, there are a growing number of states and commercial and government payers taking a proactive approach to establish maternal mental health initiatives, which could result in better identification and treatment of women with PPD. In order to continue to raise awareness of PPD, suggestions provided in this supplement may help payers advance advocacy efforts for mothers and ensure proper screening, diagnosis, and treatment to prevent untreated PPD from impacting the larger family unit and becoming a burden on the healthcare system.

“We want payers to understand how important patient education is; if patients do not know where to go, they might not seek help.”

“We need to change the treatment paradigm for patients with PPD; we need to speak more about the condition, provide more education to patients, continue to educate providers, and remove stigma of how PPD is viewed.”

We would like to take a moment to thank our contributors for all of their key insights that helped us develop our series, as well as the readers for taking the time to join our journey. For more information on our full series of Patient Journey and Management Challenges of PPD supplements, please visit: PostpartumDepression.today.
REFERENCES


Data on file, OPTN HCRU Study.

Data on file, Partnership for Health Analytic Research.

Data on file, Patient diagnosis rate.

REFERENCES (cont)


REFERENCES (cont)


