The Postpartum Depression (PPD) Patient Journey: The Provider Perspective

Second in a Series of Articles on the Patient Journey and Management Challenges of PPD
THE POSTPARTUM DEPRESSION (PPD) PATIENT JOURNEY: THE PROVIDER PERSPECTIVE

INTRODUCTION

This is the second supplement in a series of articles on the patient journey and management challenges of postpartum depression (PPD). In our first supplement, we learned 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 on the mother but the whole family (Darcy 2011, Field 2010, O’Hara 2013, Paulson 2010, Stein 2014). In addition, diagnosis rates of PPD remain low among postpartum mothers (Evins 2000, Georgiopoulos 2001).

Through earlier patient interviews, we have learned that there is an unmet need in PPD education and an increased need for PPD awareness. This supplement will continue the perinatal journey—now examining the condition through the provider perspective and illustrating the important role that the obstetrician-gynecologist (OB-GYN) can play in screening, diagnosing, and treating this patient population. We will discuss the importance of diagnosing and treating patients in a timely manner, as well as highlighting screening recommendations and policies, and reviewing the current available treatment options for this patient population.

To gather further insight on the continued patient journey and management challenges, we have conducted interviews with healthcare providers who specialize in treating mothers who have experienced PPD. These insights will be shown throughout our provider perspective supplement.

THE PPD PATIENT JOURNEY: PRENATAL AND POSTPARTUM

OB-GYNs and other perinatal care providers, including midwives and nurses, are the healthcare providers (HCPs) diagnosing more PPD patients than any other HCPs, as these providers are often the primary medical resource to see patients during 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, support patient engagement, and counsel patients about treatment options. After delivery, the role of the primary maternal care provider, including the OB-GYN, certified nurse midwife, family physician, or women’s health nurse practitioner, often is to ensure that the woman’s postpartum needs are sufficiently monitored and addressed during her postpartum follow-up visit as appropriate. The primary maternal care provider may also serve in the important role of the “first call” for any acute concerns during the postpartum period and may also provide ongoing routine well-woman care after the comprehensive postpartum visit (ACOG 2018).

IN A PREGNATAL QUESTIONNAIRE COMPLETED BY 509 WOMEN, 69% PREFERRED TO RECEIVE HELP FOR PPD, IF NEEDED, AT THEIR OBSTETRIC CLINIC (GOODMAN 2009).
Recently, the American College of Obstetricians and Gynecologists (ACOG) published new guidance to reinforce the importance of the “fourth trimester,” proposing a new paradigm for postpartum care (ACOG 2018). ACOG defines the “fourth trimester” as individualized patient-centered care services designed to meet the needs of women in the postpartum period. Under this new paradigm of care, ACOG suggests women should receive an initial assessment (either by phone or in person) within the first 3 weeks postpartum to address acute postpartum issues. After the initial assessment, the patient may require follow-up and ongoing care as needed, concluding with a comprehensive well-woman visit no later than 12 weeks after giving birth (ACOG 2018).

According to ACOG, one way to prepare for postpartum care delivery is to develop a postpartum care plan and care team. The mother and her provider can work together to develop a postpartum care plan and establish a care team that includes friends and family who will provide social support following the birth, as well as additional medical providers who will care for both the mother and child (ACOG 2018). ACOG suggests that the care plan should identify the primary care provider, such as an OB-GYN, and other providers who will help care for the mother postdelivery, as well as providers who may work together to coordinate care (ACOG 2018). Tables 1 and 2 show suggested components of a postpartum care plan and care team from ACOG.

### TABLE 1.

**ACOG’s Suggested Components of the Postpartum Care Plan**

<table>
<thead>
<tr>
<th>Topics</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care team</td>
<td>Name, phone number, and office or clinic address for each</td>
</tr>
<tr>
<td>Postpartum visits</td>
<td>Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments</td>
</tr>
<tr>
<td>Infant feeding plan</td>
<td>Intended method of infant feeding, resources for community support (eg, WIC, mother’s groups), return-to-work resources (eg, mother’s room)</td>
</tr>
<tr>
<td>Reproductive life plan and commensurate contraception</td>
<td>Postpartum family planning and method of contraception discussions</td>
</tr>
<tr>
<td>Pregnancy complications</td>
<td>Recommended follow-up or test results (eg, glucose screening for gestational diabetes, blood pressure check for gestational hypertension)</td>
</tr>
<tr>
<td>Mental health</td>
<td>Discussion around signs, symptoms, and management recommendations for women with anxiety, depression, or other psychiatric issues identified during pregnancy or in the postpartum period</td>
</tr>
<tr>
<td>Chronic health conditions</td>
<td>Treatment plan for ongoing physical and mental health conditions outlining the care team member responsible for follow-up</td>
</tr>
</tbody>
</table>


## TABLE 2.

**ACOG’s Suggested Care Team Members*  

<table>
<thead>
<tr>
<th>Team Members</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family and friends</td>
<td>• Assist in caring for the infant and older children, help with housekeeping and preparing meals, provide transportation</td>
</tr>
<tr>
<td></td>
<td>• Ensure the woman has assistance for breastfeeding support</td>
</tr>
<tr>
<td></td>
<td>• Monitor for signs and symptoms of complications, including mental health</td>
</tr>
<tr>
<td>Primary maternal care provider (OB-GYN, certified nurse midwife, family physician, or women’s health nurse practitioner)</td>
<td>• Ensures the patient’s postpartum needs are assessed and met</td>
</tr>
<tr>
<td></td>
<td>• Serves as “first call” provider for acute concerns during the postpartum period</td>
</tr>
<tr>
<td></td>
<td>• Provides ongoing routine well-woman care after initial postpartum care visit</td>
</tr>
<tr>
<td>Primary care provider (also may be the obstetric care provider)</td>
<td>• May co-manage chronic conditions (eg, hypertension, diabetes, depression) during the postpartum period</td>
</tr>
<tr>
<td></td>
<td>• Assumes primary responsibility for ongoing healthcare after comprehensive postpartum visit</td>
</tr>
<tr>
<td>Lactation support (professional IBCLC, certified counselors and educators, peer support)</td>
<td>• Provide guidance and support for breastfeeding</td>
</tr>
<tr>
<td></td>
<td>• Co-manage complications with pediatric and maternal care providers</td>
</tr>
<tr>
<td>Care coordinator or case manager</td>
<td>• Coordinates health and social services among members of postpartum care team</td>
</tr>
<tr>
<td>Home visitor</td>
<td>• Provides home visit services to meet specific needs of mother or infant after discharge from maternity care</td>
</tr>
<tr>
<td>Specialty consultants (eg, behavioral healthcare provider)</td>
<td>• Co-manage complex medical problems during postpartum period</td>
</tr>
<tr>
<td></td>
<td>• Provide prepregnancy counseling for future pregnancies</td>
</tr>
</tbody>
</table>


IBCLC=international board-certified lactation consultant.  

*Members of the care team may vary depending on the needs of the mother and infant and locally available resources.  

According to ACOG, another way to support postpartum follow-up care is to make sure that the comprehensive postpartum visit, which typically occurs between 4 and 6 weeks postpartum and no later than 12 weeks after birth, takes place. The comprehensive postpartum visit allows the provider to perform a full assessment of the physical, social, and psychological well-being of the patient, and addresses these 7 key domains (ACOG 2018):

- Mood and emotional well-being
- Infant care and feeding
- Sexuality, contraception, and birth spacing
- Sleep and fatigue
- Physical recovery from birth
- Chronic-disease management
- Health maintenance

In addition to ACOG, several other national organizations, such as the US Preventive Services Task Force (USPSTF) and the American Academy of Pediatrics (AAP), recommend routine screening to help improve the identification of at-risk patients for PPD; see additional information on screening on page 6 (ACOG 2015, AAP, Earls 2010, USPSTF 2016). These recommendations will hopefully encourage healthcare providers, including OB-GYNs, to screen patients to support early detection and intervention in PPD.

"THE REVISED ACOG GUIDELINES ON THE ‘FOURTH TRIMESTER’ ARE MUCH MORE HOLISTIC, AND THEY HAVE THE POTENTIAL TO BE MORE HELPFUL, ESPECIALLY IF THE STANDARD OF CARE IN REDESIGNING OBSTETRIC CARE WILL ALSO FOCUS ON MENTAL HEALTH AS A PRIORITY.”

Screening during the perinatal period can be administered in any facility that provides care for new mothers and children, including obstetric and pediatric settings (Horowitz 2009), since symptoms can occur at different periods of postpartum (Earls 2009, Kennerley 1989, Kozhimannil 2011, NIH, Thurgood 2009). Appropriate screening and early intervention can be important in improving health outcomes in patients with PPD (O’Connor 2016). Screenings have been recommended during both pregnancy and the postpartum period to help clinicians identify women who are at an increased risk for or may already have PPD so that healthcare professionals can provide appropriate and timely treatment should a confirmatory PPD diagnosis be made through a clinical assessment. Screening recommendations from multiple nationally recognized professional societies are shown in Table 3 (ACOG 2015, AAP, Earls 2010, USPSTF 2016).
Although there is no “universally recommended” screening instrument to help identify patients at-risk for PPD, a number of validated screening tools exist and are commonly used by clinicians (ACOG 2015). The screening tools highlighted in Table 4 are recommended by ACOG and may include screening tools that are typically used for depressive disorders (ACOG 2015, Beck 1961, Cox 1987, Radloff 1977, SAMHSA 2005, Zung 1965). All of the screening tools listed in Table 4 can be used to identify patients who should seek further clinical assessment for PPD (ACOG 2015).

**TABLE 3.**

**Multiple Professional Societies Recommend Screening for PPD**

<table>
<thead>
<tr>
<th>Source</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACOG</td>
<td>ACOG recommends that providers screen for depressive symptoms at least once during the perinatal period, using a validated screening tool</td>
</tr>
<tr>
<td>AAP</td>
<td>AAP recognizes that depression screening is part of family-centered well-child care, given pediatricians’ early access to mother and infant • AAP also recommends integrating PPD surveillance and screening at the 1-, 2-, 4-, and 6-month infant visits</td>
</tr>
<tr>
<td>USPSTF</td>
<td>USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women • USPSTF also recommends screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up</td>
</tr>
</tbody>
</table>


**TABLE 4.**

**Validated Depression Screening Tools**

<table>
<thead>
<tr>
<th>Screening tool</th>
<th>Number of items</th>
<th>Time to complete (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh Postnatal Depression Scale (EPDS)</td>
<td>10</td>
<td>Less than 5</td>
</tr>
<tr>
<td>Postpartum Depression Screening Scale (PDSS)</td>
<td>35</td>
<td>5-10</td>
</tr>
<tr>
<td>Patient Health Questionnaire (PHQ-9)</td>
<td>9</td>
<td>Less than 5</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI)</td>
<td>21</td>
<td>5-10</td>
</tr>
<tr>
<td>Beck Depression Inventory-II (BDI-II)</td>
<td>21</td>
<td>5-10</td>
</tr>
<tr>
<td>Center for Epidemiologic Studies Depression Scale (CES-D)</td>
<td>20</td>
<td>5-10</td>
</tr>
<tr>
<td>Zung Self-rating Depression Scale</td>
<td>20</td>
<td>5-10</td>
</tr>
</tbody>
</table>


Source: ACOG 2015.
The most commonly used screening instruments for identifying symptoms in postpartum and pregnant women include EPDS and PHQ-9 (ACOG 2015, USPSTF 2016).

- The EPDS tool can be used at the 4- to 8-week postpartum visit or at the 2-month well-child visit
  - Each question is scored on a scale from 0 to 3
  - Can be completed or filled out by most patients in about 5 minutes
- The questions mostly cover feelings of depressed mood and anxiety, but they also address thoughts of harming oneself
- Only indicates how the mother was feeling during the previous week; a clinical assessment should be carried out to make a diagnosis

**Most Common Tools Used for PPD Screening**

**Edinburgh Postnatal Depression Scale (EPDS)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Date of Birth:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Baby’s Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

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

Here is an example: all easily completed.

- I have felt happy
  - Yes, all the time
  - Very much of the time
  - Most of the time
  - Some of the time
  - Very little of the time
  - None at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things.
   - Yes, most of the time
   - No, not very much
   - No, not at all

2. I have been able to enjoy things that I used to enjoy.
   - Yes, most of the time
   - No, not very much
   - No, not at all

3. I have been able to put things in a new context.
   - Yes, most of the time
   - No, not very much
   - No, not at all

4. I have been able to enjoy new activities.
   - Yes, most of the time
   - No, not very much
   - No, not at all

5. I have felt at ease without efforts.
   - Yes, most of the time
   - No, not very much
   - No, not at all

6. I have been able to think about things.
   - Yes, most of the time
   - No, not very much
   - No, not at all

7. I have been able to concentrate on things.
   - Yes, most of the time
   - No, not very much
   - No, not at all

8. I have been able to feel the same as usual.
   - Yes, most of the time
   - No, not very much
   - No, not at all

9. I have been able to feel as though I have been getting on.
   - Yes, most of the time
   - No, not very much
   - No, not at all

10. I have been able to get things done.
    - Yes, most of the time
    - No, not very much
    - No, not at all

Score:

1. I have felt happy
   - Yes, all the time
   - Very much of the time
   - Most of the time
   - Some of the time
   - Very little of the time
   - None at all

The EPDS tool can be used at the 4- to 8-week postpartum visit or at the 2-month well-child visit

- Completed by the patient and can be scored by the office staff
  - Each question is scored on a scale from 0 to 3
  - Can be completed or filled out by most patients in about 5 minutes
- The questions mostly cover feelings of depressed mood and anxiety, but they also address thoughts of harming oneself
- Only indicates how the mother was feeling during the previous week; a clinical assessment should be carried out to make a diagnosis

**PHQ-9**

- Easy and useful tool in clinical practice—it can be administered in less than 10 minutes
  - Completed by the patient and scored by the provider
  - Can be used more than once to show changes in improvement or worsening symptoms of depression

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**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

NAME: __________________________ DATE: __________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure is doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
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<td></td>
<td></td>
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<tr>
<td>6. Feeling sad about yourself—or that you are a failure or have let yourself or your family down</td>
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<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
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<tr>
<td>8. Moving or speaking so slowly that other people could have noticed</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thought that you would be better off dead, or of having yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</td>
<td>Not difficult at all</td>
<td>Sometimes difficult</td>
<td>Very difficult</td>
<td>Extremely difficult</td>
</tr>
</tbody>
</table>

Score:

- The PHQ-9 is a multipurpose tool for screening, diagnosing, monitoring, and measuring the severity of depression
  - Includes 1 non-scoring question that screens the patient’s level of function and how the symptoms affect the patient’s functionality
- Easy and useful tool in clinical practice—it can be administered in less than 10 minutes
  - Completed by the patient and scored by the provider
  - Can be used more than once to show changes in improvement or worsening symptoms of depression
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 the many challenges associated with perinatal behavioral health needs, while also encouraging routine PPD screening by healthcare providers.

**Florida**
- In January 2019, a perinatal mental health bill will go into effect
- This bill outlines that the state will:
  - Establish and maintain a toll-free hotline for the public to disseminate information about perinatal mental health
  - Establish and maintain a toll-free hotline for healthcare providers that maintains and offers contact information of healthcare providers throughout the state who have experience in caring for the mental health of pregnant or postpartum patients
  - Develop public service announcements to educate the public about perinatal mental healthcare
  - Encourage healthcare providers to attend continuing medical education courses on perinatal mental healthcare
  - Mandates hospitals that provide birthing services must provide a postpartum evaluation, follow-up care to include a mental health screening, and certain information on PPD
  - Encourage hospitals that provide birthing services to provide the same postpartum evaluation and follow-up care that birth centers require

**Massachusetts**
- Requires annual reporting by providers that conduct or oversee screening for PPD, using a validated screening tool during a routine clinical appointment, in which medical services are provided to a woman who has given birth within the previous 6 months
- Aims to develop a culture of awareness, destigmatization, and screening for perinatal depression so that residents of the commonwealth may be assured of the most effective and affordable provision of public health services possible

**New Jersey**
- Prenatal care providers are required to perform PPD screening and provide education to new parents regarding PPD
- New mothers must be screened for PPD symptoms prior to discharge from the birthing facility and at the first few postnatal check-up visits

**West Virginia**
- Has developed a tool to identify women at risk for preterm birth or other high-risk conditions

OF THE STATES IMPLEMENTING PPD POLICIES, DISEASE-STATE EDUCATION IS THE MOST COMMON COMPONENT, FOLLOWED BY PPD TASK FORCES, SCREENING MANDATES, AND PUBLIC AWARENESS CAMPAIGNS.

State-mandated PPD Screening Education
Task Forces Public Awareness

Among the providers interviewed, all agree that screening at various time points during the perinatal periods is critical in identifying patients at risk for PPD.

"Women often will not reveal the symptoms thus we must screen everyone at multiple time points of the perinatal period."

"At my practice, we recommend screenings to be conducted twice during pregnancy, at the initial and 24 weeks visits, and then again at the postpartum visit. The goal is to detect depression early, so that we can treat our patients earlier."

"Even if a patient does not screen positive early for PPD, the exposure to screening and a conversation on symptoms help women recognize signs and symptoms that may occur later. Awareness at any stage of the perinatal period and educating patients and family are very important."
Examples include:
Cigna: Healthy Pregnancies, Healthy Babies® maternity program

In 2012, Cigna announced that it recognizes and supports mothers during Maternal Depression Awareness Month (May). Additionally, Cigna offers support to its members through a free online toolkit, which includes postpartum depression education, questions for patients to ask their doctors, and a short PPD assessment that members can take to determine if they may be at heightened risk for the condition—and could potentially benefit from speaking with their doctor. Members can enroll in the Cigna Healthy Pregnancies, Healthy Babies® maternity program and have access to screening for stress and possible depression during pregnancy, 2 to 5 days following delivery, and 3 weeks after delivery to help to identify PPD. Cigna also offers physicians a free depression screening tool on its website (Cigna 2012). For more information* on this program, please visit www.cigna.com.

Anthem Blue Cross of California: Maternity Depression Toolkit

The toolkit contains educational materials and other tools to help providers and women during pregnancy or the postpartum period. The program includes continued medical education courses, screening tools, and care pathway tools (Anthem Blue Cross of California Toolkit). For more information* on this program, please visit www.anthem.com.

Aetna: The Beginning Right maternity program

Aetna has extended The Beginning Right maternity program. Collaborating with its Behavioral Health division, Aetna has developed a pregnancy and postpartum depression screening program that aims to reduce the severity, duration, and impact of depression during and after pregnancy. The program uses a screening tool to help identify members who may be at risk for depression. Prenatal depression screening is included on all pregnancy risk surveys performed by phone. Postpartum screening is administered to all members who qualify; the program reaches out within 3 to 5 weeks postdelivery and again 3 to 4 months postdelivery. If a member screens positive for prenatal depression or PPD, the program provides access to the appropriate Aetna behavioral health provider or refers a member to an obstetric care provider if she does not have coverage for behavioral health (Aetna Women’s Health Manual 2017). For more information* on this program, please visit www.aetna.com.

In recent years, some commercial payers have developed programs that help support screening practices and provide educational support for their members and healthcare providers.

State Medicaid programs provide coverage of maternal depression screening. While state Medicaid agencies are not required to cover maternal depression screening, it is recommended by the Centers for Medicare and 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.

Legend

This map represents the 36 states that require, recommend, or allow maternal depression screening to be provided as part of a well-child visit for Medicaid members.

*Please review references on page 17 for the full website addresses for each program.
EXAMPLES OF REAL-WORLD SCREENING IMPLEMENTATION STRATEGIES

The following section provides details on examples of real-world screening implementation strategies payers may consider if they plan to develop similar programs and tools for their plan members and providers.

Intermountain® Healthcare Connect Care Pro®
Intermountain Healthcare has launched one of the nation’s largest virtual hospital services, a program called Intermountain Connect Care Pro. Connect Care Pro brings together 35 telehealth programs, including basic medical care, mental health counseling, intensive care, and newborn critical care, with more than 500 caregivers to help patients receive medical care regardless of location and setting (IH 2018). Connect Care Pro services are provided both online and through digital platforms, including cameras, speakers, and television screens, to connect patients and providers in different locations. In addition, Connect Care Pro can offer services in clinics and hospitals or provide care for patients in their own homes (IH 2018, IHCCP Services). For more information, please visit https://intermountainhealthcare.org/services/urgent-care/connect-care/pro/.

Postpartum Depression: Action Towards Causes and Treatment (PACT)
The PACT Consortium is a research study that has developed an app called PPD ACT™, available for iOS and Android phones (PPD ACT). The app asks the user a series of questions about childbirth and mood and anxiety symptoms that may have developed after childbirth. Depending on the responses, the PPD ACT app will populate a list of providers in the user’s area who specialize in evaluating and treating women with PPD. For more information, please visit http://www.pactfortheecure.com/.

Massachusetts General Hospital (MGH)
The MGH Perinatal Depression Scale smartphone app provides digital versions of perinatal depression screening tools, including the EPDS, as well as other instruments that measure symptoms associated with peripartum disorders. The user can complete the screening questionnaires and share the results with researchers to help in the development of more specific screening tools (WMH MGH App). For more information, please visit https://womensmentalhealth.org/posts/announcing-mgh-perinatal-depression-scale-apple-store/.

Massachusetts Child Psychiatry Access Program (MCPAP)
The MCPAP for Moms aims to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to 1 year after delivery to effectively prevent, identify, and manage depression. MCPAP for Moms also supports connecting patients with community-based services and support groups. MCPAP for Moms has 3 core components: trainings and toolkits for providers and staff, real-time psychiatric consultation and resources, and links to community-based resources including mental health care and support groups, as well as other resources that support the wellness and mental health of pregnant and postpartum women (MCPAP About). For more information, please visit https://www.mcpap.com/About/McPAPforMOM.aspx.

Dignity Health Foundation (DHF): Postpartum Depression Initiative
Dignity Health has implemented a pilot program to standardize how health providers screen for and treat maternal mood disorders to help them communicate with and educate community members about PPD (Minda 2016). Dignity Health obstetrical care experts provide universal screenings and supportive and knowledgeable care, including identifying PPD in patients at DHF Birth Centers in the Bay Area of California (DHF PPD Hospitals). For more information, please visit https://www.dignityhealthfoundation.org/what-we-support/postpartum-depression-initiative.

Sage Therapeutics is not affiliated with these organizations. By listing these resources, Sage Therapeutics is not endorsing any particular service or group and we are not responsible for the content of these sites or services. They are provided here for informational purposes only.
Treatment options may depend on the severity of symptoms, current medications, patient preference, and treatment and medical history (Sriraman 2015). The most commonly used treatment options include nonpharmacological interventions, such as psychosocial treatment and psychotherapy, as well as pharmacotherapy with antidepressants (Meltzer-Brody 2015, Sriraman 2015).
While there are limited studies evaluating the use of antidepressants in the treatment of PPD, SSRIs are the most commonly used pharmacologic treatment (Molyneaux 2014).

**FIGURE 3.**
Antidepressant Therapies Used for PPD

- **SSRI:** 75.3%
- **SNRI:** 5.9%
- **SMS:** 1.3%
- **TCA/TeCA:** 0.8%
- **Miscellaneous:** 4.3%
- **Combination:** 2.2%
- **Non-pharmacological:** 10.2%

Source: DOF, Partnership for Health Analytic Research.
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.
Among the providers interviewed, all agreed that communication with patients on diagnosis and treatment decisions is critical in identifying the right treatment for the right patient.

Identifying Appropriate Treatment Options

Among the providers interviewed, there was a common theme on how they identified the right treatment for each patient:

- Previous medications and patient health history
- Patient preference
- Severity of the disorder, based on the screening tool and clinician’s assessment

“Conducting a further assessment—reviewing the severity level and patient health history—helps us identify the best treatment choice for our patients.”

Patient-centered Communication

“How we talk about treatment matters—often [the treatment around] perinatal depression [disorders] is talked [about] in a way that it almost sounds optional. ‘Well, do you want to go to therapy?’ ‘Well, would you be interested in taking a medication?’ versus how we would approach other physical health such as high blood pressure and diabetes...”

“After a patient has screened positive for PPD, our practice counsels the patient on treatment options, including antidepressant use, risk of antidepressant use during pregnancy and postpartum, and the risk of PPD if left untreated.”

Treatment Follow-up

“In my practice, we will generally follow up 1 to 2 weeks after a medication is prescribed to see how she is feeling or if the condition is worsening. Then we will check in every month up until we see start seeing full remission of symptoms before we start tapering off the medication.”
THE PPD PATIENT JOURNEY PROVIDER PERSPECTIVE: UNMET NEEDS IN PPD

Among the providers interviewed, each responded with a variety of unmet needs in the treatment and management of PPD.

Access

“  All women should have access to the healthcare community; some providers do not screen patients due to the lack of time and resources. One way to advance the increase of screening is for payers to reimburse for screening and consulting of care for their patients. ”

“  Patients need more access to resources and treatment. Psychotherapy is not often available to patients with PPD; most OBs will prescribe medication instead, because that is what is available to them. ”

Providers

“  We need to build the capacity of front-line providers—those who are serving these women, who have the skills and resources they need to treat these women. There will never be enough psychiatric resources out there to cover these patients. ”

Treatment

“  Once a treatment is prescribed, we need a follow-up plan to get patients better. We can have the best treatments in the world, but if a patient can’t access them, it doesn’t matter. ”

“  When it comes to treatment, there is a lot of misunderstanding about what is safe for pregnant and postpartum women. As medical providers, we need to understand that mothers need the best available option, and it is our responsibility to help facilitate and help [them] receive the treatment. ”

“  It would be great if there were treatments that worked more quickly and helped patients immediately in the short-term; it could potentially avoid a hospitalization or crisis situation. ”

Shift in Postpartum Care

“  Mental and emotional health need to become a part of [the] routine wellness check during OB care visits, postpartum care, and also during well-child visits. ”

“  We need to promote the message to women that emotional health is important, and we need to start talking about it. ”
CONCLUSION

In conclusion, although PPD is the most common complication of pregnancy and childbirth (CDC 2017, DeSisto 2014, Knight 2009, Ko 2017, Reddy 2015), PPD remains underdiagnosed (Evins 2000, Georgiopoulos 2001). As front-line physicians with both women who are pregnant and women who recently delivered a baby, OB-GYNs are well-positioned to provide overall management and clinical support for postpartum women to be screened and potentially treated as a result of being diagnosed with having PPD. Early diagnosis and coordination of care from prenatal through the postpartum period may improve health outcomes for patients with PPD. Many organizations remain committed to improving screening rates to help ensure early detection of and intervention in PPD to better ensure that patients with PPD receive appropriate treatment in a timely manner (AAP, ACOG 2018, ACOG 2015, Earls 2010, O’Connor 2016, USPSTF 2016).

Many states and payers are also taking an approach to establish maternal health initiatives that could result in better identification and treatment of women with PPD. As we highlighted in our first supplement (“The Postpartum Depression [PPD] Patient Journey: A Patient Perspective”), PPD may result in a substantial burden on the mother, child, and family unit (Darcy 2011, Field 2010, O’Hara 2013, Paulson 2010, Stein 2014), which only serves to drive the need to better screen for, diagnose, and treat this condition. Continued communication, education, and awareness of PPD may help improve patient outcomes as patients navigate their postpartum journeys.

Early in the fall, our final installment of the Patient Journey and Management Challenges of PPD series will focus on payer considerations. That supplement will highlight key unmet needs in the PPD category and the need for a safe and effective treatment that aims to treat this PPD patient population and meet the needs of patients and other key stakeholders. If you missed our first supplement on the patient perspective, please visit PostPartumDepression.today.

We would like to thank the providers for the insights they provided on the continued patient journey and management challenges. These contributors included various specialists, including OB-GYNs, midwives, and psychiatrists.
REFERENCES


THE POSTPARTUM DEPRESSION (PPD) PATIENT JOURNEY: THE PROVIDER PERSPECTIVE

REFERENCES (cont)


