

Perinatal Mental Health Screening

Background

When one considers the various complications of pregnancy, several conditions generally come to mind- diabetes, high blood pressure, preeclampsia, eclampsia, etc. However, it turns out that maternal depression is the highest complication in the pregnant population. Maternal depression encompasses a spectrum of depressive conditions to include prenatal and postpartum depressions as well as postpartum psychosis. These conditions can be present up to twelve months after delivery.

Research has shown that as much as 20% of women¹ experience depression at some point during their pregnancy. They can present with appetite disturbance, anhedonia, anxiety, weepiness, etc. After pregnancy, anywhere between 10-20% of new mothers¹ have been diagnosed with postpartum depression with symptoms to include frequent crying, poor bonding with baby, insomnia, feeling overwhelmed, etc.

While depression is not usually a life-threatening complication during/after pregnancy, it is associated with increased rates of infanticide and maternal suicide if left untreated. Maternal depression can have real effects on morbidity and socioeconomic status. What's more is that the mother's mental state will affect her child as well.

Patients who suffer from depression and other psychiatric disorders may neglect their health as well as the health of the baby. These women are more likely to have preterm deliveries and babies with low birth weight. Additionally, children who lack a secure attachment and bond with the mother are at risk for emotional and cognitive developmental delay as well as failure to thrive. The children may also be subject to psychological abuse including neglect.

Response

There has been significant work this past year between the Los Angeles Perinatal Mental Health Task Force and staff at USC to develop a pilot program to address this the problem of maternal depression that is commonly overlooked. The screening pathway below has been instituted and many of the residents have been trained on the process.

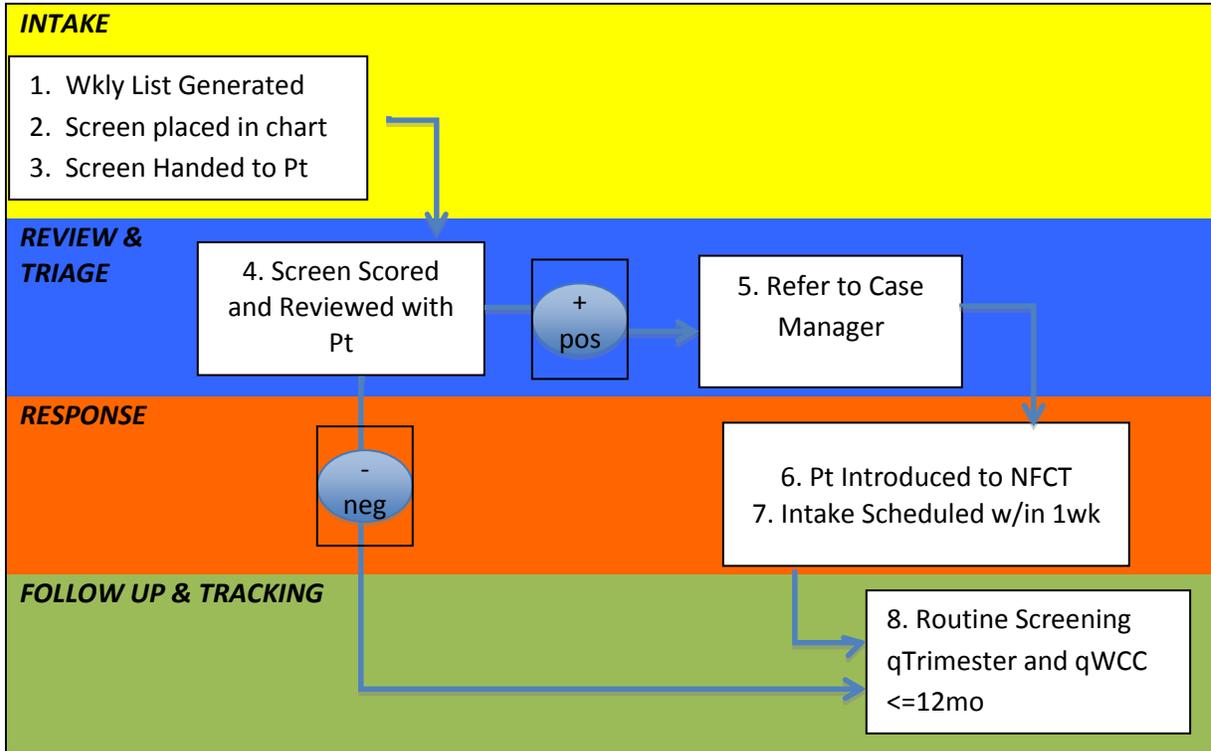
To summarize, a weekly list is generated of the patients that should be screened. A Patient Health Questionnaire (PHQ)-9 and Edinburgh Postnatal Depression Scale (EPDS)-3, "the screen," is placed into the chart of each patient on the list. The screen is handed to and completed by the patient when she comes for her appointment. The screen is then scored. If it is positive (PHQ-9 greater than 9 or EPDS-3 greater than 3) the patient is referred to the case manager.

From there, the patient is introduced to the New Family Care Team (NFCT) program and scheduled for an intake interview within one week. The patient's case will also be discussed at the next NFCT meeting. The patient will be screened once every trimester and every well child

¹ Identifying and Treating Maternal Depression: Strategies & Considerations for Health Plans. National Institute for Health Care Management Issue Brief. June 2010

check (WCC) thereafter. If the screen is initially negative or becomes negative during a subsequent appointment, the patient will continue to be routinely screened. The figure below represents the process in place.

Perinatal Mental Health Screening Pathway (Pre-NFCT Meeting)



Though this process was put in place, compliance with the steps has been relatively dismal, especially since the departure of the occupational therapists that were intimately involved with its execution. Over the span of one week, I performed a time-study on the perinatal mental health screening pathway to determine breakdowns in the process and areas that might need modification or improvement.

Additionally, I audited and reviewed all charts of patients scheduled to be screened within the last month. My primary focus was to record every questionnaire completed in the chart for the patient and verify if any of the screens were performed on the scheduled date from July 20-August 17. The NFCT patient registry was updated with the information collected. I also made a note of questionnaires that were left blank or not fully completed inside charts. The pertinent data is reflected below.

Perinatal Mental Health Screening Data

WK	Patients Scheduled	Visits verified	Patients Screened on Scheduled Date	%pts screened on scheduled date
7/20 - 7/27	20	18	4	22.22%
7/30 - 8/3	31	31	4	12.90%
8/6 - 8/10	11	11	2	18.18%
8/13 - 8/17	37	37	7	18.92%
7/20 - 8/17	99	97	17	17.53%
	Total Charts Reviewed	Patients w/ hx of screen	Patients w/ pos screen	Pts w/ neg screen
7/20 - 8/17	85	53	18	35
	% pts EVER screened	62.35%		
	% screened pts w/ pos	33.96%		

Perinatal Mental Health Screening Pathway Evaluation

Based on the time-study and chart audit, the following evaluation was generated.

1. Patient List Generated Every Week
 - a. Person Responsible- Robin, Eisner volunteer
 - b. Problem Encountered- She is not a permanent employee at the residency clinic. While she is a completely reliable asset right now, the system would become significantly unsustainable if/when she leaves.
 - c. Potential Solution- There are three approaches to consider.
 - i. The residency clinic will be getting a manager for the medical assistants (MA) soon. I am not sure what exactly her responsibilities entail, but I think including her and making her an integral part of this process would be highly beneficial. If she could generate the list every week, it would make her more involved in the next two steps of this process.
 - ii. We could utilize NextGen. Again, I am not sure of its full capabilities, but I believe it would not be difficult to have all patients flagged who are pregnant, postpartum, coming in for a pregnancy test, or under the age of 1 for a mental health screen.
 - iii. A dedicated coordinator could be assigned to this task. To ensure the sustainability of this service, the person responsible for this task must be a long-term employee.

2. Screen Placed in Chart
 - a. Person Responsible- Johanne, Medical Records MA

- b. Problem Encountered- Screens are not consistently being placed into the charts. There is some confusion as to when a screen should be placed. Apparently, if there is a previous screen found in the chart or another screen (similar but different from ours) being placed in the chart, then a new screen has not been placed.
 - c. Potential Solution- I believe Johanne has been the most consistent out of all the MAs in carrying out her tasks; she just requires more training. There seems to be some misunderstanding in when (and probably even why) the screening needs to be done, and some formal clarification would help resolve this issue
- 3. Screen Handed to Patient
 - a. Person Responsible- MA
 - b. Problem Encountered- This is one of the areas that is done the most inconsistently. Originally, the OT's would highlight the patients that needed a screen on the MAs daily list, so that the MAs knew who they should hand one to. According to the lead MA, if a patient's name is not highlighted, the MA will not give them the screen; even though, it may be in the chart.
 - c. Potential Solution- There are three approaches to consider
 - i. Again, since the clinic will be getting a manager for the MAs, she could be responsible for ensuring that the MAs hand out the screen to the designated patients. If the manager is responsible for generating the weekly list, as suggested in step one, it would not be difficult to highlight (or reinforce in some other fashion) which patients the MAs need to remember.
 - ii. Training would also be a necessary adjunct to the previous point. If the MAs are appropriately trained as to why this screening is done, and more importantly WHO needs to be screened, the reinforcements (e.g. highlighting, seeing the screen in the chart) will not be solely relied upon.
 - iii. As in Step 1, NextGen can be utilized to flag the patients that need to be handed a screen.
- 4. Screen Scored
 - a. Person Responsible- Resident
 - b. Problem Encountered- Patients will fill out the screen, but it is not totaled/scored. This indicates that steps 1-3 are being successfully executed, but the residents are neglecting to go over the sheet with the patient. I have only found 2-3 instances of this in the chart. One can assume that this is because the resident is not aware that the sheet has even been filled out (as opposed to seeing the sheet and neglecting to follow through).
 - c. Potential Solution- Training is the best way to tackle this problem. Given that it only occurred in max 3 charts that I checked (and over half of the registered patients were checked), the hope is that this is incidental and not overwhelmingly significant. As the residents become more aware of the need and who needs to be screened, this problem should be resolved.
- 5. Positive Screen Referred to Case Manager
 - a. Person Responsible- Resident
 - b. Problem Encountered- There have been instances where a patient scores positive but is not referred to the case manager. There is only evidence of this occurring once in the past month.

- c. Potential Solution- Again, training is the best way to tackle this problem. Given that the resident has gone through and scored the screen, it is only a matter of fully appreciating what must be done next to complete the screening process. While it is clearly listed on the green screening sheet that patients must be referred to the case manager, training will help it become more intuitive to the resident who should be involved next. Fluid communication between the residents and case manager should be encouraged to ensure that this handoff occurs.

- 6. Patient Introduced to NFCT
 - a. Person Responsible- Case Manager
 - b. Problem Encountered- In this situation, the order for referral to the case manager has been made, but the case manager does not see the patient that day. There are two main problems to executing this step successfully.
 - i. The Case Manager may be busy when the patient is ready to see her. If the Case Manager is with another patient, it can sometimes take 20min+ to provide services, and she is not able to leave to introduce the patient to the program.
 - ii. The patient is directed back to the waiting room before being seen by the Case Manager. This provides the perfect opportunity for patients to leave before being seen.
 - c. Potential Solution- There are several approaches to this problem.
 - i. The student social worker can also be utilized to introduce positively screened patients to the program.
 - ii. The Case Manager or student social worker can be notified while the patient is in the room to go see them. This can be accomplished by the residents putting up the green flag after they encounter a positive patient. It would then be the MA's job to notify the Case Manager or MSW that a patient is ready to be seen. As this currently is not a part of the MAs' culture at the residency clinic, training would be required.
 - iii. If there is more fluid communication between providers and the case manager/MSW, they will become more readily aware when a patient requires their services.
 - iv. The discharge MA can also be trained to ask positively screened patients if they have already spoken with the case manager or MSW. If they have not, they can be directed back to the case manager or MSW (provided one of them is available) before sitting in the waiting room.

- 7. Intake Scheduled Within One Week
 - a. Person Responsible- Discharge MA
 - b. Problem Encountered- In the current system, there is some ambiguity of how the patient gets scheduled for a follow up appoint. It is my understanding that the recommendation comes from the case manager initially, and the discharge MA provides the patient with instructions to get it done. However, if there is a breakdown in Step 6, the patient may leave without being aware of our program and without the intake being performed.
 - c. Potential Solution- Given that EVERY positively screened patient will require an intake screening within one week, we could add "schedule intake appointment within one week" to the green screening sheet. That way it will be considered an

order, and the discharge MA would automatically take care of it regardless if the patient has received a formal introduction from the case manager or social worker.

8. Follow-Up Screen

- a. Person Responsible- None designated
- b. Problem Encountered- Many patients have not been screened more than one or two times. Almost 60% of patients have gotten screened at some point in time but not even 20% of scheduled patients were screened in the past month. There are two primary aspects to this problem
 - i. No one has been designated to ensure that patients receive the appropriate follow-up. The OT's were formerly managing this task, but they are no longer here.
 - ii. There are no resources currently utilized to make this process minimally time consuming
- c. Potential Solution-
 - i. The best person to take on this responsibility that we will soon have would be the MSW. Once a designated coordinator can be obtained this would become a part of his/her responsibility
 - ii. Attached is a spreadsheet designed to make following up easier to manage.

Summary

Given that this project has been presented to the staff as a pilot, I believe that most people view it as a temporary procedure that will not last. If that is the case, then there is no need to commit this process to memory and make it a part of routine healthcare for perinatal patients. Considering that 33% of the patients screened scored positive for having a mental illness, greater than the general population, the need for the healthcare team to adopt mental health screening as part of their routine and culture is prudent. Training will definitely be in order for the faculty, residents/interns, and MA's at the clinic.

In order for the effectiveness of the screening process to be assessed, follow up is going to have to improve dramatically. Currently, we are unable to adequately analyze trends or whether patients are improving with the current regimen. As it stands, very few patients have three or more screenings performed, and those that do usually score 15< on the PHQ-9.

If this project is going to be developed into a potential research project in the future and if there is going to outreach for additional funding, a more sustainable routine will need to be developed. Most importantly, there needs to be a reliable way to determine whether these women are actually being helped.

With the advent of the EHR, there are a considerable number of possibilities to improving each stage of this screening process, particularly Intake and Followup/Tracking. As NextGen is relatively new to the staff, it would be wise to incorporate the perinatal mental health screen as soon as possible, so that it can be adopted into the routine as the residents and MAs are becoming accustomed to it.

The process in place has already been well developed and thought out. The primary means of improvement are going to be training, reinforcement and a more consistent/concise plan for follow up. A necessary adjunct to training will be a culture/perspective change among all players involved. There is ample opportunity for the project to improve given the upcoming staff changes and software capabilities. We need only to seize the opportunity.