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CME Disclosure

Lisbeth Lazaron, MD, FAAFP, faculty for this educational activity, has no relevant financial relationship(s) with ineligible companies to disclose.

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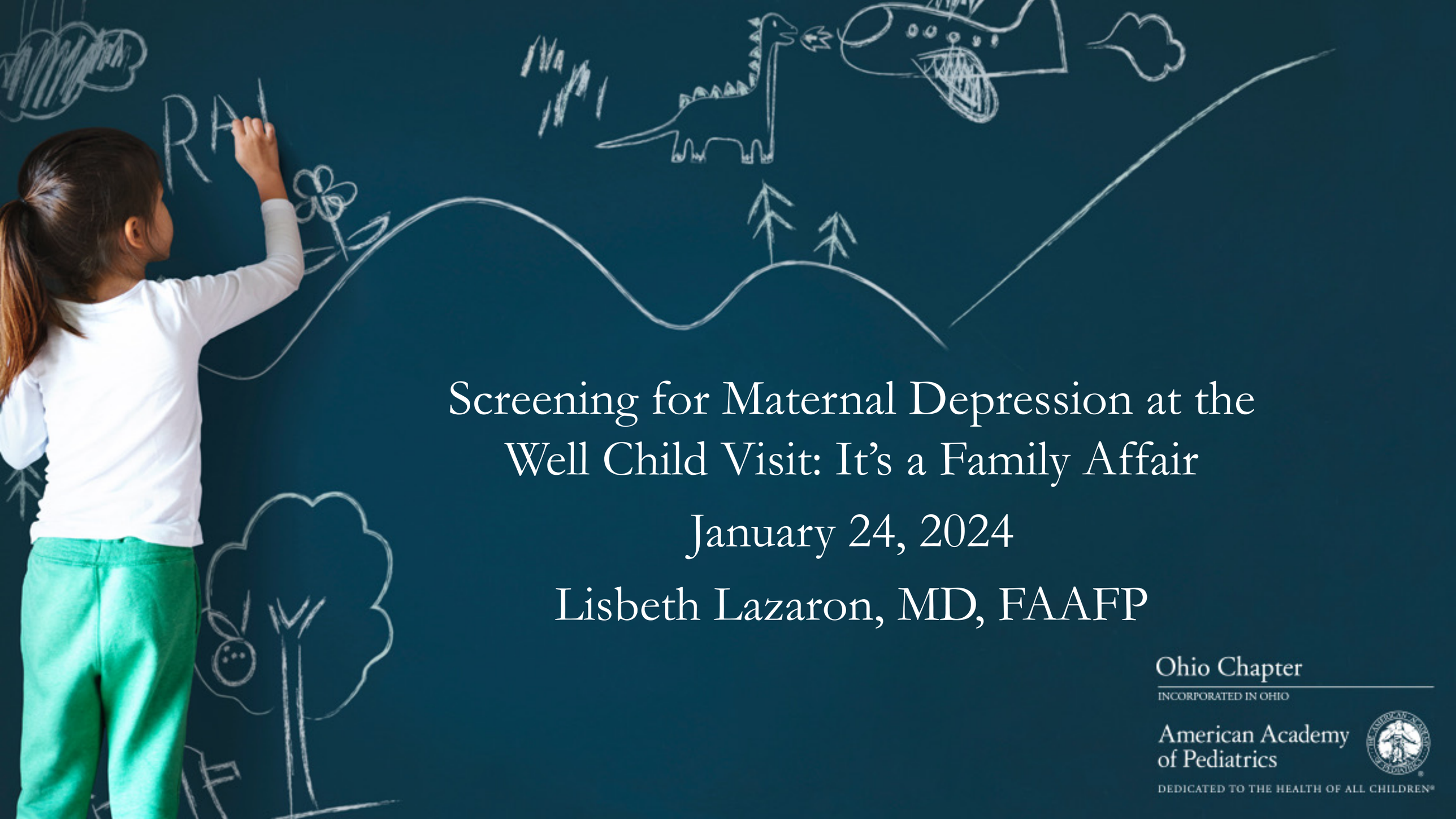

Screening for Maternal Depression at the Well Child Visit: It's a Family Affair

January 24, 2024

Lisbeth Lazaron, MD, FAAFP

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Screening for Maternal Depression

Has the consistent consumption of chocolate been shown to decrease the likelihood of depression symptoms**?**

__ yes

__ no

__ only dark chocolate

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Screening for Maternal Depression

Has the consistent consumption of chocolate been shown to decrease the likelihood of depression symptoms**?**

__ yes

__ no

√√ **only dark chocolate**

"Those who consumed dark chocolate***** had a 57% lower odds of depression symptoms compared to those who ate no chocolate (OR=0.43 95%cl 0.19-0.96)"

*** 104-454 g of dark chocolate/day**

Question #1

Approximately what percentage of women experience postpartum depression?

a) __ 1%
b) __ 2%
c) __ 10%
d) __ 50 %

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Question #2

Maternal perinatal depression is associated with the following adverse outcomes in children:

1) __ more missed well child visits & missed immunizations
2) __ early discontinuation of breast feeding
3) __ poorer scores on cognition, language & behavior that persist into childhood and adolescence
4) __ all of the above

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Question #3

Which ones of the following are associated with screening or treatment of depression in women during the first 3 months following childbirth?

a) __ No impact on the incidence of major and moderate depression at 9 months postpartum

b) __ Significant decreases in both major and moderate depression at 9 months postpartum

c) __ Mothers receiving intervention had significantly better scores in functional outcomes of parenting, anxiety sxs and mental health functioning at one year postpartum

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Question #4

When can I use CPT code 96161 to bill for caregiver screening for depression in Ohio?

a) __ hospital newborn visit only
b) __ all infant visits from birth to 2 months of age
c) __ well child visits only from birth to 6 months of age
d) __ all infant visits from birth to 12 months of age

Objectives

- ***Why*** is screening for postpartum depression important?

- ***What*** clinical features in the WCC would raise my concern for postpartum depression?

- ***How*** can I implement postpartum depression screening effectively, when the mom is not my patient?

  (and get paid for the work I am doing)

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Why: Maternal Depression Affects Infant Well Being

Children who are exposed to maternal depression before age 1:

- ➢ Are at risk for delays in social, emotional, cognitive and physical development
- ➢ Higher risk for early discontinuation of breastfeeding & malnutrition
- Increased secondhand smoke exposure: parent was **twice** as likely to resume smoking after delivery
- ➢ Reduced use of preventive services, such as immunizations & WCCs
- Higher use of emergency rooms for care, **3x** increase in child abuse

1 in 8 women report symptoms of postpartum depression

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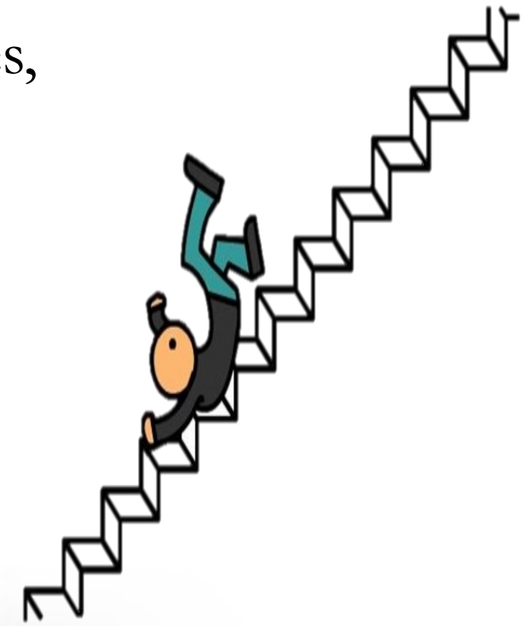
Why: Persistent Childhood Consequences

- **Prenatal:** Preterm delivery, low birth weight, spotty prenatal care
- **Infant:** lower cognitive scores, dysregulated behavior & arousal
- **Toddler:** passive, less autonomy & creative play, lower cognitive scores,
- **School age:** more ADHD, lower IQ; more mood, anxiety & conduct do
- **Adolescent:** ADHD & LD, lower IQ, plus more alcohol & substance abuse, depression, panic & conduct disorders



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Why: Trauma and Development

- **Depressed moms:**
  - Have a harder time responding to infant's needs and cues
    - Affects attachment style
  - Depressed parents report more negative interactions with infants
    - Children are more depressed
    - Children have more behavior problems
    - At risk for harsh parenting

- **Young children:**
  - Are vulnerable to events involving safety and harm
  - Ability to cope is directly related to caregiver's response to distress

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Why: How Young Children Respond

- **Sleep disturbances** -- increased arousal
- **Regression** -- many children need to return to an earlier stage when they felt safer
- **Behavioral change** --passive and quiet, easily alarmed

  -- less secure about being provided with protection
- **Hypervigilance, aggressive outbursts, exaggerated startle**

  --if low nurturing caregiver, child may learn exaggerated response to stress
- **Dose response of Toxic Stress** --trauma exposures in childhood correlate with high health risk factors in adulthood

Why: Withdrawn Mother - How Young Children Respond

- Mom with Apathy, poor concentration → **Poor limit setting**
  - Child does not learn how to regulate emotions and behaviors
- Mom with amotivation, irritability, anhedonia → **Unable to model appropriate behavior**
  - Child acts out until he gets attention
  - Mother reacts and re-exposes child to aggressive model
  - Child expects hostility and aggression
- Aggressive child triggers mom
  - Mom is frightened and unable to soothe child

Results in anxiety and fear for both

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Why: Mom is Not my Patient…. And…

- Major Depressive Disorder incidence peaks at 6-10 weeks postpartum
- Dysthymia peaks at 2-3 months, and again at 6 months, and again at 12 months
- Most maternal **deaths** due to PD occur at **6-12 months**
- Mom's get one F/U visit 6 weeks post-partum & 1/3 of them do not make this appointment!
- Women often stop their own medical care for first 18-24 months after child is born

1 in 8 women report symptoms of postpartum depression

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Why: Mom is Not my Patient…. And…

1 in 8 women report symptoms of postpartum depression

- women with perinatal depression had **3x** higher risk of suicidal behavior

- The suicidal risk was **highest** for women with postnatal depression in the first year after diagnosis

- The risk **persisted** for 18 years

***cohort study of 952 061 participants with a maximal follow-up of 18 years**

Why: Mom is Not my Patient…. And…

1 in 8 women report symptoms of postpartum depression

69% of postpartum depression goes unrecognized

- Only 6 to 9% of those diagnosed receive evidence-based care
- A single untreated case of untreated PD can cost society $97,209 over the lifespan [estimate June 16, 2023]
- Cultural concerns: Hispanic and AA women with PD are more likely to self-report at 2 weeks, while white women take longer to become recognized because of self-reporting conflicts over privacy & disclosure. [e.g. reportable to state medical board?]

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Why: Is there Evidence for Depression Screening?

From USPSTF:

- Does depression **screening** in postpartum women result in improved outcomes? **YES** [screening **alone** improves dep rate at 9 months]
- What screening practices have the best performance? **Edinburgh > PHQ-9**
- Are there harms associated with screening? **NO**
- Does **treatment** result in improved health outcomes? **YES, CBT>MEDs** [**any** treatment improves depression scores and functional outcomes at 12 months]
- Are there harms associated with **treatment**? **Very low incidence w/meds postpartum, but not therapy**

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Why: 35 % of Women do not Keep Their Postpartum Appt!

- **Why not?**
- Because they are at the **pediatrician's** office
  - EPSDT Screening
    - Newborn
    - 1,2,4,6,9,12,15,18,24 months
    - Not counting weight checks and acute visits
- **You can make a difference!** Depression screening at 1, 6, 12 months-old WCC picked up **13% (more)** mothers at high risk for depression

  (**AAP** recommends 1,2,4,6) (**USPSTF** recommends 1,2,4,6,9,12)

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What: Recognizing Depression Red Flags in the WCC

- **Risk Factors for postpartum depression**
  - -- unplanned C/S, preterm delivery, LBW, anemia
  - -- child with significant medical needs or disability
  - -- h/o depression or PMS *before* pregnancy
  - -- lack of support, domestic violence, single parent
  - -- lack of sleep, smoking
- **Clinical outcomes that may raise concern**
  - --frequent missed or cancelled appointments
  - -- early cessation of breast feeding
  - -- lower confidence in parenting skills

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What: Treatments of Postpartum Depression that Work

Depression Severity	EPDS Score	PHQ9	Treatments
None to minimal	0-6	0-4	Rescreen at f/u; offer social/peer supports as needed
Mild	7-13	5-9	CBT or interpersonal therapy IPT; second line SSRI
Moderate	14-19	10-14	CBT or IPT + SSRI; referral to social/peer supports
Severe	19-30	15-27	SSRI, start CBT *after improving*; second line SNRI; third line consider rapid acting therapies [e.g. IV brexanolone $19,000]

What: Depression Medications & Breastfeeding

Parents look to you as a trusted source on whether medication use is safe in breastfeeding

- Use of most antidepressants during lactation (including brexanolone) have a relative infant dose of ≤ 10% of maternal serum levels

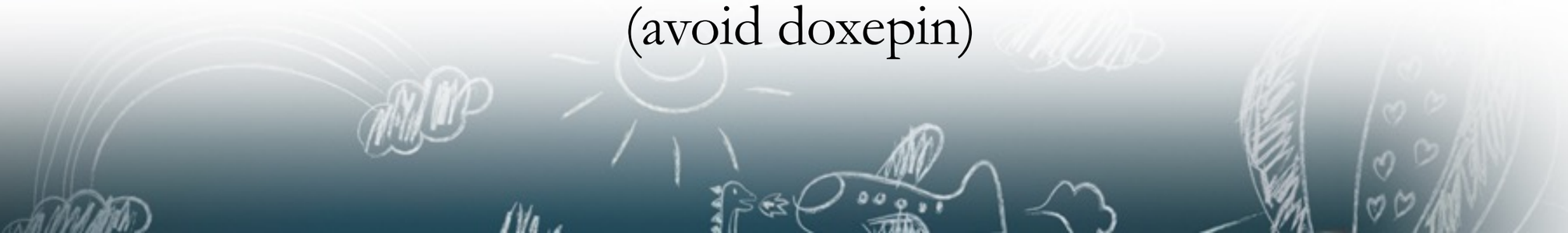
  -- SSRIs: **sertraline** & **paroxetine** are preferred

  (avoid fluoxetine, fluvoxamine, citalopram)

  -- second line SNRIs: venlafaxine favored over duloxetine

  -- alternative TCAs: nortriptyline

  (avoid doxepin)



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What: Non-Pharmacologic Treatment for PD

- Motivating Our Mothers
  - Screen + offer education + permission for phone call f/u
    - 20% more contacted resources
  - Engage with community partners
    - Head Start, Early Head Start , Infant and Early Childhood MH Consultants (e.g. Every Child Succeeds)
  - Find YOUR local list of referral sources for moderate - major depression who provide CBT, IPT or medication

What: National Maternal Mental Health Hotline

1(833)-TLC-MAMA

24/7, free, confidential hotline for pregnant and new moms in English and Spanish

The National Maternal Mental Health Hotline can help. Call or text 1-833-TLC-MAMA (1-833-852-6262). TTY users can use a preferred relay service or dial 711 and then 1-833-852-6262.

⚠ If you are in suicidal crisis, please call or text 988 or visit the 988 Suicide & Crisis Lifeline.

Pregnancy and a new baby can bring a range of emotions. Many new moms feel overwhelmed, sad, anxious, or exhausted at different times during their pregnancy or after the baby is born.

Sometimes these feelings go away on their own. But if these feelings last for more than two weeks, and make it hard to carry out daily tasks, like caring for themselves or their family, a mom may have perinatal depression or anxiety. These are common and treatable health conditions during or after pregnancy. And that's why a new mom, or those supporting them, should reach out right away for help.

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What: Non-Pharmacologic Treatment for PD

Resource directory: NAMI.org

POSTPARTUM DEPRESSION

See, also, ***Anxiety, Depression*** *and* ***New Mothers Support*** *sections of Resource Directory.*

- Postpartum Progress: www.postpartumprogress.com
  Online blog supporting the international postpartum community providing information, resources, stories of shared experience and an ***in-person support group*** *finder. Offers a "New Mom" Postpartum Depression Checklist in Spanish.*

- Postpartum Support International: **(800) 944-4773** / www.postpartum.net
  Provides information and resources for postpartum parents (males and females), including loss of a child and other related struggles; also includes an ***online weekly chat****. Offers a non-crisis HelpLine (800) 944-4773. Website also offered in Spanish; accepts Spanish-language calls.*

- PostpartumMen: www.postpartummen.com
  A place for men with concerns about depression, anxiety or other problems with mood after the birth of a child. Provides info, resources and ***online forum*** *for dads to talk to each other. Offers article in Spanish on website on PPD for men.*

How: Screening for Maternal Depression

If the child is the patient

➢ **at a well child visit, can *screen* the PARENT for depression**

As a quick screen the PHQ2 is your "first step" approach:

"In the last 2 weeks how often have you been bothered by the following problems: 1) little interest or pleasure in doing things (0-3)

2) feeling down depressed or hopeless (0-3)"

➢ **If the screen is positive, perform an *assessment*, either:**

-- PHQ 9 (can be used at any visit for *any caregiver)*

-- Edinburgh (used for assessing birth mother, at 0-12 month WCC)

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How: Get the TEAM to Screen for Maternal Depression

- **at a well child visit, can *screen* the PARENT for depression**

Consider having your MA ask the caregiver the PHQ2 as part of the rooming process for the child

PHQ2: "In the last 2 weeks how often have you been bothered by the following problems:
1) little interest or pleasure in doing things (0-3)
2) feeling down depressed or hopeless (0-3)"

- **If the screen is positive, have your MA give the parent the *assessment* form** for your to review**, either:**

-- PHQ 9 (can be used at any visit for ***any caregiver)***

-- Edinburgh (used for assessing birth mother, at 0-12 month WCC)

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How: Coding for Depression Assessment

If the child is the patient

- **at a well child visit, if you use the PHQ9 or Edinburgh to *assess* the PARENT for depression:**

-- CPT **96161** "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument"

-- ODH will pay* for this screening **at *every* infant visit from birth to age 1**!

*** 96161 ODH pays $3.43; commercial insurance up to $30**

-- use ICD10 codes:

ICD Z13.31 "Encounter for screening for depression" *-or-*

ICD Z13.32 "Encounter for screening for maternal depression"

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How: The Screen is Positive for Depression—*what now?*

- Even brief interventions are effective:

  - Let them know that you are here to help … their health is *also* important
  - Ask if you can check in with them at the next visit
  - Offer resources they can walk out the door with
  - Consider local parenting social support groups and resources:
    - Baby Café, AMEN!, BOOBS, L.E.C.H.E.
    - Centering Parenting
    - Triple P – Positive Parenting Program

How: The Screen is Positive for Depression—*what now?*

Be prepared with community referral resources—we screen **BECAUSE** we can help:

- Community resources for family support have shown to show improvement in depression scores at 9 months, even in **mild** depression

- If you screen + offer education + permission for phone call f/u, ***20% more patients contacted the resources***

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How: The Screen is Positive for Depression—*what next?*

- Use EHR tools to help for documentation & follow-up:

➢ Consider adding one of the following ICD10 codes to the problem list:

-- **P00.89** for "newborn affected by maternal depression"

-- **Z62.9** "h/o adverse childhood experiences" if it is caregiver depression

➢ Route note to staff for phone follow-up

➢ Use reminders to screen for depression at subsequent visits.

➢ Consider using 'sticky notes' to remember to ask *"how they are doing"* at future visits

➢ Consider using brand new code HCPCS code: **G2211** as an addition to your E & M code for those office visit that require more complex care & referrals

*How: M*aking Depression Screening Standard Work

- **As a standalone event (illness visit)**

  -- build documentation smart-phrases that incorporate diagnosis & billing codes

  -- empower staff to administer the depression patient screening tools at the same time as child development screens

- **As a standardized practice**

  -- add the screening tool to your standard well child note template

  -- add the billing & dx codes to your preference lists or smart-sets

  -- establish practice protocols to allow staff to place these charges for you to co-sign

How: Financial Incentives to Make this Standard Work

- In **Fee for Service** billing: The 2021 billing changes that incorporate **risk based medical decision making** allow for risk or time-based billing to account for the all the additional work you do, ***if*** *you document the work*

- Starting Jan 2024 HCPCS code: **G2211*** is an 'add on' code that can be added to the E&M charge when you are the focal point of care for a single, serious condition. *e.g: "child affected by maternal depression"*

***CMS pays $16.04 in 2024; commercial ????**

- In **Value Based** contracting: Demonstrating consistent screening and referral or treatment for some elements of SDoH is the basis for added payments to the Medical Home.

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What: Case Study *"Mathilda has a Baby"*

Intro: You are so pleased when 'Matilda' calls your office to ask if you are taking new patients, and would be the doctor for her newborn daughter, 'MJ'

Background: Matilda was a patient of your practice from early childhood, until she moved away to attend college. You remember with pleasure taking care of this bright and energetic individual who was first in her family to finish high school and attend college (nursing school). Matilda was usually accompanied to visits with her grandmother, as her home life had some challenges with unstable housing and parents with substance use disorder. In addition to well childcare, she was also treated for asthma, headaches and briefly required treatment for depression/complicated grief in high school after the death of her grandmother.

Newborn visit: 'MJ' is seen 2 days after hospital discharge accompanied by both parents and PGM. She is a term breastfed infant who passed all of her hospital newborn screens but was noted to have a limb difference with syndactyly of the 2nd & 3rd digits of the Right hand and shortened forearm. You refer them to "Help Me Grow" due to the limb difference, and for a consult with peds plastic surgery, and ask that they return for a weight check in 1 week, as not yet back up to birthweight.

What: Case Study *"Mathilda has a Baby"*

One-week weight check: Visit rescheduled on day of visit to 10 days due to transportation issues. Baby back up to birthweight, but mother now supplementing with formula at night-time feedings.

One month visit: Both parents come for MJ's visit. She is now bottle fed as mom back in school. Good weight gain, has not made contact/apt with Help Me Grow or plastic surgery yet. Father concerned that baby is not sleeping through the night yet.

Two-month visit: MJ received immunizations. Mother concerned that baby won't be able to hold her own bottle due to limb difference

Four-month visit: Rescheduled X2 due to lack of transportation.

Six-month visit: Catch-up of missed 4 month immunizations. MJ's weight gain appropriate, able to roll both ways, sits with support, smiles and babbles. Mother has dropped out of nursing school. Missed appointment to plastic surgeon x2 and not rescheduled, did not return phone calls to Help Me Grow according to agency notes.

What: Case Study - Breakout Session w/Red Flags

Intro: You are so pleased when 'Matilda' calls your office to ask if you are taking new patients, and would be the doctor for her newborn daughter, 'MJ'

Background: Matilda was a patient of your practice from early childhood, until she moved away to attend college. You remember with pleasure taking care of this bright and energetic individual who was first in her family to finish high school and attend college (nursing school). Matilda was usually accompanied to visits with her grandmother, as her home life had some challenges with unstable housing and parents with substance use disorder. In addition to well child care, she was also treated for asthma, headaches and briefly required treatment for depression/complicated grief in high school after the death of her grandmother.

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One-month visit: Both parents come for MJ's visit. She is now bottle fed as mom back in school. Good weight gain, has not made contact/apt with Help Me Grow or plastic surgery yet. Father concerned that baby is not sleeping through the night yet.

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Four-month visit: Rescheduled X2 due to lack of transportation.

Six month visit: Matilda is here alone with MJ. Catch-up of missed 4 month immunizations. MJ's weight gains appropriate, able to roll both ways, sits with support, smiles and babbles. Mother has dropped out of nursing school. Missed appointment to plastic surgeon x2 and not rescheduled, did not return phone calls to establish care with Help Me Grow according to agency notes.

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What: Case Study - Breakout Session w/Dep Screen

One-week weight check: Visit rescheduled on day of visit to 10 days due to transportation issues. Baby back up to birthweight, but mother now supplementing with formula at night-time feedings. **(screen not done as done within 2 weeks in hospital)**

One-month visit: Both parents come for MJ's visit. She is now bottle fed as mom back in school. Good weight gain, has not made contact/apt with Help Me Grow or plastic surgery yet. Father concerned that baby is not sleeping through the night yet **(PHQ =4, 2 for sleep, 1 for fatigue, 1 weight loss)**

Two-month visit: MJ received immunizations. Mother concerned that baby won't be able to hold her own bottle due to limb difference **(PHQ =7, 2 for sleep, 2 for concentration, 3 fatigue)**

Four-month visit: Rescheduled X2 due to lack of transportation.

What: Case Study - Breakout Session w/Dep Screen

Six-month visit: Matilda is here alone with MJ. Catch-up of missed 4 month immunizations. MJ's weight gains appropriate, able to roll both ways, sits with support, smiles and babbles. Mother has dropped out of nursing school. Missed appointment to plastic surgeon x2 and not rescheduled, did not return phone calls to establish care with Help Me Grow according to agency notes. **(PHQ9 = 14 little interest or pleasure, sleep, fatigue, depression, feelings of failure)**

Take aways:

- Screen early, screen often
- Consider Edinburgh in place of PHQ9 if result borderline (3-9) as eliminates questions on weight loss and fatigue that can be normal immediately postpartum
- OK to refer for help early when red flags also present

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Question #1

Approximately what percentage of women experience postpartum depression?

a) __ 1%
b) __ 2%
c) √√ 10%
d) __ 50 %

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Question #2

Maternal perinatal depression is associated with the following adverse outcomes in children:

1) __ more missed well child visits & missed immunizations
2) __ early discontinuation of breast feeding
3) __ poorer scores on cognition, language & behavior that persist into childhood and adolescence
4) √√ **all of the above**

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Question #3

Which of the following are associated with screening or treatment of depression in women during the first 3 months following childbirth?

1) __ **No** impact on the incidence of major and moderate depression at 9 months postpartum
2) √√ **Significant decreases in both major and moderate depression at 9 months postpartum**
3) √√ **Mothers receiving intervention had significantly better scores in functional outcomes of parenting, anxiety sxs and mental health functioning at one year postpartum**

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When can I use CPT code 96161 to bill for caregiver screening for depression in Ohio?

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c) __ well child visits only from birth to 6 months of age
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Acknowledgments

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- Ohio Chapter, American Academy of Pediatrics
- Ohio Department of Health
- Dr. Emily Harris, pediatric psychiatry, for local & regional resources for maternal depression treatment
- Dr. Stephen Ratcliffe, FAAFP, for introducing me to ALSO & IMPLICIT

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2. **"Perinatal Depression: A Guide to Detection & Management in Primary Care";** JABFM 2023; https://doi.org/10.3122/jabfm.2023.230061R

3. **"Association between Maternal Perinatal Depression and Child & Adolescent Development: a meta-analysis":** JAMA Pediatr 2020; https://doi.org/10.1001/jamapediatrics.2020.2910

4. **"Detection of Postnatal Depression. Development of the 10-item Edinburgh Postnatal Depression Scale":** Br J Psychiatry https://doi.org/10.1192/bjp.150.6.782

5. **"Postpartum Depression Screening in Well-Child care"**: Pediatrics https://doi.org/10.1542/peds.2017-0110

6. **"Perinatal Depression and Risk of Suicidal Behavior":** JAMA https://doi.org/10.1001/jamanetworkopen.2023.50897

7. **"Is there a relationship between chocolate consumption and symptoms of depression? A cross-sectional survey of 13,626 US adults"**: Depress Anxiety. https://doi.org/10.1002/da.22950

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References – Implementation & Billing

2021 Reference Guide for EM coding
https://www.aaaai.org/Aaaai/media/MediaLibrary/PDF%20Documents/Practice%20Management/finances-coding/Updated-2021-Reference-Guide-for-EM-Coding.pdf

G2211 Add-on Code: What it is and When to use it

https://www.aafp.org/family-physician/practice-and-career/getting- paid/coding/evaluation-management/G2211-what-it-is-and-how-to-use-it.html

2023 Quick Reference for Social Determinants of Health (SDoH) Coding:

https://downloads.aap.org/AAP/PDF/SDOH.pdf

Edinburgh Postnatal Depression Survey form:
https://downloads.aap.org/AAP/PDF/Postnatal%20Depression%20Scale.pdf

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Additional Resources

- **Breastfeeding Hotline**
  - 888-588-3423 or text BFHOTLINE to 839863. Interpreters available!
  - https://odh.ohio.gov/media-center/odh-news-releases/odh-announces-statewide-breastfeeding-hotline#:~:text=The%20hotline%20is%20available%20at,the%20ODH%20Office%20of%20Communications.

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Referral resources
Mental Health, Parenting, Community Support

National Maternal Mental Health Hotline 1-833-TLC MAMA https://mchb.hrsa.gov/national-maternal-health-hotline/toolkit

NAMI.org National Alliance on Mental Illness

-- Postpartum Support International non-crisis helpline:1-800-944-4773 www.postpartum.net

-- Postpartum Men "Sad Daddy" www.postpartummen.com

Ohio resources

-- Positive Parenting Program – **Triple P** – Ohio https://octf.gov or www.triplep.online/ohio

-- Mom Groups SW Ohio Breastfeeding Coalition https://swohio-bc.org/momgroups

-- POEM www.mhaohio.org/get-help/maternal-mental-health/ central OH including Dayton

-- Every Child Succeeds "Moving Beyond Depression" www.movingbeyonddepression.org SW Ohio

Video parenting resources

-- SPARK videos well child visit https://www.sparkvideoseries.com/watch-now 3-5 day visit

-- Caring for your Newborn https://www.you.tube.com/watch?v=2vqhTU16Dr4

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Lead-Free Ohio Practice Coaching

The Lead-Free Ohio Practice Coaching Program will familiarize pediatricians and practices with information about how to create an office workflow for lead screening and treatment for elevated blood lead levels.

Begins with a kick-off webinar on either February 8th or February 16th at Noon.

This will be followed by a personalized one-hour office visit from one of our practice coaches.

Register Here:
https://ohioaap.org/leadfreeohio#impactreg

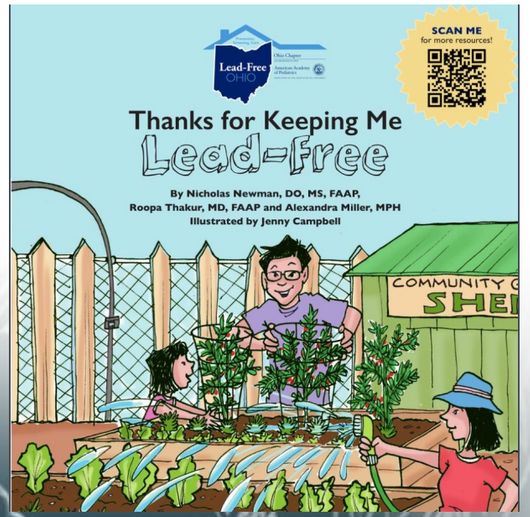
Order Books Here:
https://ohioaap.org/leadbooks

Incentives:

- $500 Practice Stipend

- Personalized in-office training

- 120 Copies of lead board book "Thanks for Keeping me Lead-Free"



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New Developments in Diabetes 1 and 2

- Information on new developments in screening, testing, and treatment for diabetes types 1 and 2.
- Dr. Amber Healy (Ohio University) and Dr. Ryan Farrell (University Hospitals)
  - March 28, 1:00 pm – 2:00 pm
- Register at this link: https://ohioaap.org/education-cme-moc-ii/preventive-health-program/#trainings

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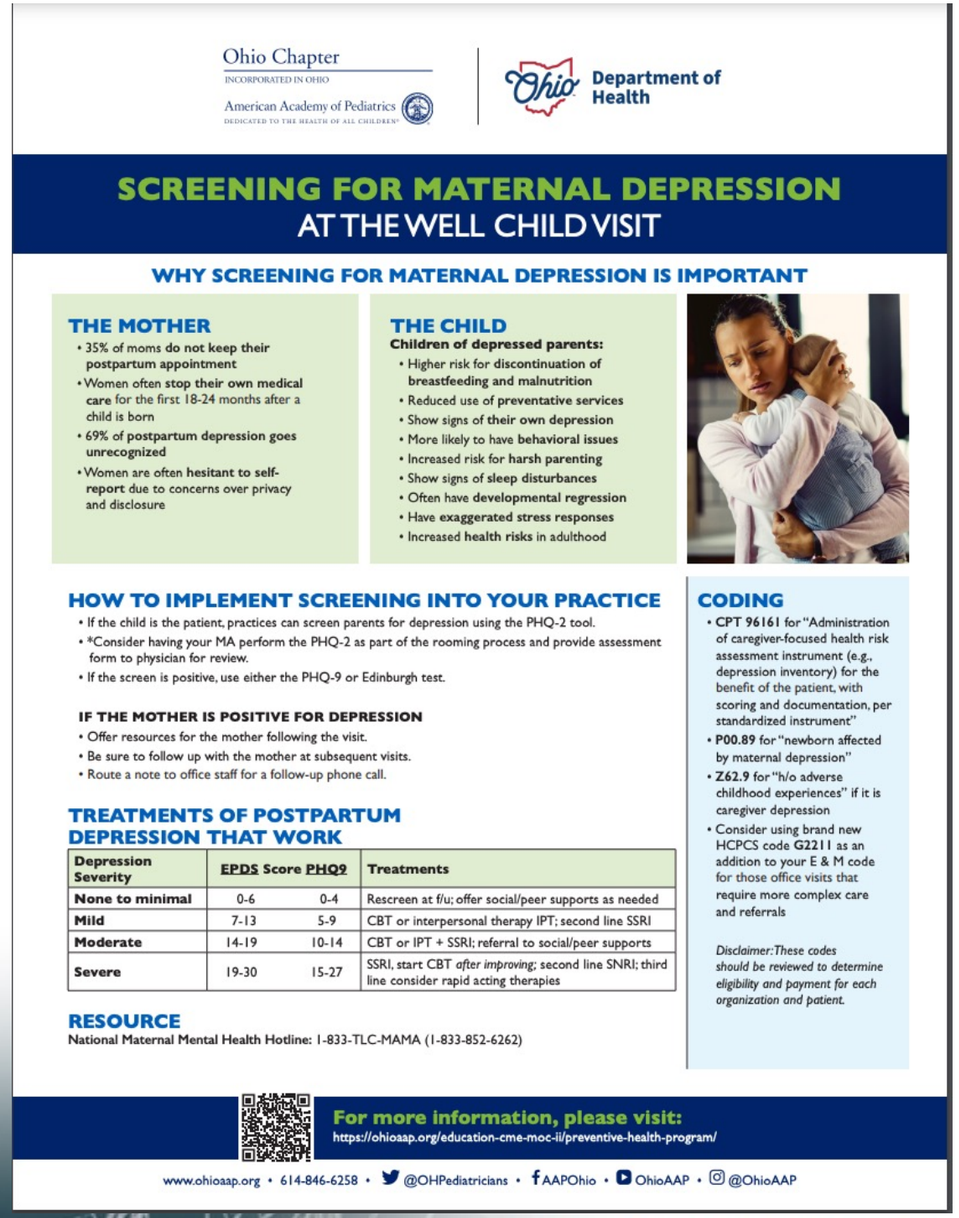
Thank You

- Webinar Presenter: Dr. Lazaron
- Break-Out Leaders: Dr. Bolling, Dr. Robinson, Dr. Romano



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Ohio Department of Health

SCREENING FOR MATERNAL DEPRESSION AT THE WELL CHILD VISIT

WHY SCREENING FOR MATERNAL DEPRESSION IS IMPORTANT

THE MOTHER

- 35% of moms **do not keep their postpartum appointment**
- Women often **stop their own medical care** for the first 18-24 months after a child is born
- 69% of **postpartum depression goes unrecognized**
- Women are often **hesitant to self-report** due to concerns over privacy and disclosure

THE CHILD

Children of depressed parents:

- Higher risk for **discontinuation of breastfeeding and malnutrition**
- Reduced use of **preventative services**
- Show signs of **their own depression**
- More likely to have **behavioral issues**
- Increased risk for **harsh parenting**
- Show signs of **sleep disturbances**
- Often have **developmental regression**
- Have **exaggerated stress responses**
- Increased **health risks** in adulthood

HOW TO IMPLEMENT SCREENING INTO YOUR PRACTICE

- If the child is the patient, practices can screen parents for depression using the PHQ-2 tool.
- *Consider having your MA perform the PHQ-2 as part of the rooming process and provide assessment form to physician for review.
- If the screen is positive, use either the PHQ-9 or Edinburgh test.

IF THE MOTHER IS POSITIVE FOR DEPRESSION

- Offer resources for the mother following the visit.
- Be sure to follow up with the mother at subsequent visits.
- Route a note to office staff for a follow-up phone call.

TREATMENTS OF POSTPARTUM DEPRESSION THAT WORK

Depression Severity	EPDS Score	PHQ9	Treatments
None to minimal	0-6	0-4	Rescreen at f/u; offer social/peer supports as needed
Mild	7-13	5-9	CBT or interpersonal therapy IPT; second line SSRI
Moderate	14-19	10-14	CBT or IPT + SSRI; referral to social/peer supports
Severe	19-30	15-27	SSRI, start CBT *after improving*; second line SNRI; third line consider rapid acting therapies

RESOURCE

National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)

CODING

- **CPT 96161** for "Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument"
- **P00.89** for "newborn affected by maternal depression"
- **Z62.9** for "h/o adverse childhood experiences" if it is caregiver depression
- Consider using brand new HCPCS code **G2211** as an addition to your E & M code for those office visits that require more complex care and referrals

Disclaimer: These codes should be reviewed to determine eligibility and payment for each organization and patient.

For more information, please visit:
https://ohioaap.org/education-cme-moc-ii/preventive-health-program/

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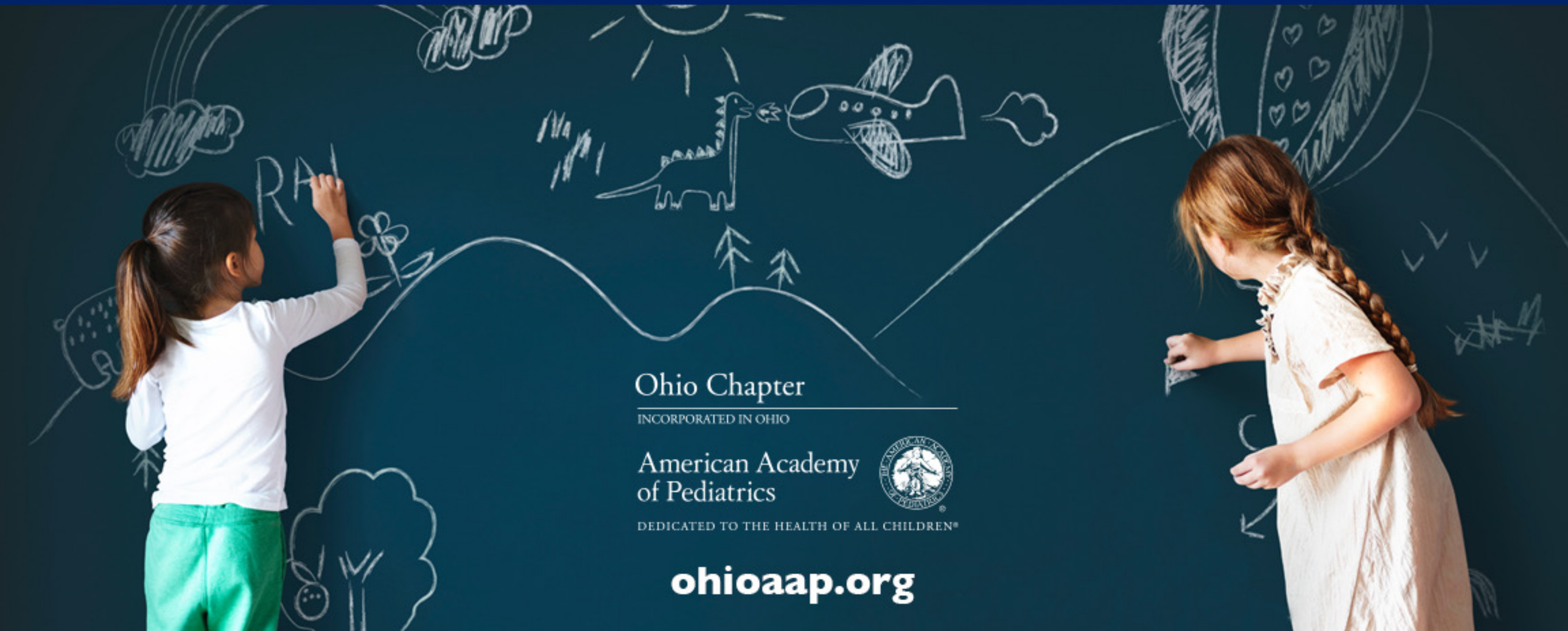
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