Maternal Depression

Screening For Postpartum Depression at Infant Well-Visits

July, 2017
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Suggested Pediatric Postpartum Depression Screening and Follow Up Protocol

Many women experience postpartum blues after giving birth. For some, the feelings of sadness, irritability or anxiety do not resolve after 2 weeks. These women may be experiencing postpartum depression. The overall population rate of post-partum depression is approximately 12%. However, low-income women and teenage mothers experience higher rates of depression, as high as 40-60% in some studies. Maternal postpartum depression threatens the mother-child relationship (attachment and bonding) and can have negative effect on the cognitive development, social-emotional development, and behavior of the child. As such, identifying women with post-partum depression, getting them support and services, and closely monitoring the infants’ development is important.

Since July 1st, 2016, North Carolina Medicaid reimburses providers for up to 4 maternal depression risk screens administered to mothers during the infant’s first year postpartum. AAP recommends screening at the 1, 2, 4, and 6 month visits. This suggested protocol and accompanying algorithm may help with the process.

1. Routinely administer [Edinburgh post-partum screening](#) to all mothers of infants
   - Suggested schedule – 2 weeks-1 month, 2 month, 4 month, and 6 month well child visit
   - Couple screening with normalizing statement, e.g., “Postpartum depression is the most common complication women experience after childbirth. Supporting a mother’s emotional health can help both mother and the baby.”

2. Score Edinburgh

3. If score is 10 or greater, or positive answer on Q10 (suicidality/homicidality) assess for immediate concerns and extent of suicidality/homicidality. See [page 13](#)

4. Provide education, support, and referral of mother to additional services, as indicated and available. Provide follow-up and ensure linkage whenever possible.

5. Conduct heightened surveillance of infants with mothers with post-partum depression and provide additional education, support and resources for infants and mothers, as needed and available.

6. Use appropriate CPT codes:
   - CPT code 96161 for the Edinburgh (Health Risk Screen, for caregiver-focused health risk assessment for the benefit of the patient) one (1) unit per administration, with EP modifier when billing for this service. When conducted as part of a comprehensive Health Check Early Periodic Screening visit, this screen may be billed to the infant’s Medicaid coverage.
   - If the mother is the patient, bill CPT Code 96127. OB Providers can bill CPT code 96127 in addition to OB package codes.
   - CPT code for ASQ-SE: 2 or BPSC is 96127
   - If there are concerns about the dyad relationship, the code Z62.898, Parent-infant Bonding Problem, or Z62.820, Relationship Specific Disorder or Infancy/Early Childhood, (published in the DC: 0-5 - Diagnostic Classification for 0-5 year olds, 2016) can be used as secondary to the well-visit code
<table>
<thead>
<tr>
<th>Edinburgh</th>
<th>Possible Action to Take</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 10 is negative</td>
<td>Routine support and care. Provide education and brief intervention if necessary</td>
</tr>
</tbody>
</table>
| 10 or > and no immediate concerns | Provide education – e.g. *Post-partum depression pamphlet, Your baby's development-Birth to 3 months, Self-Care handout*  
Consider referral to Care Coordination for Children or OB Care Management  
If woman has been seen at any WCHS health clinic within the past year, can refer to Sandi Painter at 919-212-7148.  
Refer to integrated MH professional, if available  
Refer to Alliance Customer Services (1-800-510-9132)  
Document result of screening, risk assessment, and plan  
Follow up after referral to ensure linkage |
| 10 or > WITH immediate concerns | Call Alliance Customer Services (1-800-510-9132) to assess if mother has  
existing MH provider, with or without enhanced services  
Can call and refer to Crisis and Assessment – Wake (1-919-250-1260), Johnston (1-919-989-5500) if, per clinical judgment, the mother can get there.  
Can contact Mobile Crisis Services (1-877-626-1772 for Johnston and Wake County), if mother cannot get to Crisis and Assessment (should respond by telephone immediately and face to face within 2 hours)  
Refer to integrated MH professional, if available  
Refer to Care Coordination for Children or OB Care Management  
Assess natural support system, social situation, child care resources e.g.  
- Who can care for the baby? Are there other children in home?  
- What is the mother’s support system? (father, grandmother, etc.);  
- Are there contributing factors (e.g. domestic violence, substance abuse)  
- Has the mother been offered services in the past – refused or not followed through or what was the outcome?  
Document result of screening, risk assessment, and plan  
Follow up after referral to ensure linkage |
| Positive on Question 10 indicates suicidal or homicidal ideation | Call Alliance Customer Services (1-800-510-9132) to assess existing MH provider  
Call and refer to Crisis and Assessment – Wake (1-919-250-1260), Johnston (1-919-989-5500) if, per clinical judgment, the mother can get there.  
Contact Mobile Crisis Services (1-877-626-1772 for Johnston and Wake County), if mother cannot get to Crisis and Assessment (should respond by telephone immediately and face to face within 2 hours)  
Police Department can be called to provide transportation and if situation is escalating with concern of personal safety. In Wake County, request a Crisis Intervention Team (CIT) officer.  
Refer to integrated MH professional, if available  
Refer to Care Coordination for Children or OB Care Management  
Assess natural support system, social situation, child care resources as above  
Refer to CPS, if clinical judgment supports  
If mother refuses evaluation, consider commitment for evaluation at Crisis and Assessment  
Document result of screening, risk assessment, and plan  
Follow up after referral to ensure linkage |
Screening Guidance

- Edinburgh Postpartum Depression Scale; or PHQ-2 followed by the Edinburgh or PHQ-9
- Screen at the 1, 2, 4, and 6 month well visits
- When positive, follow-up screen to assess attachment between the mother and infant within the next month.
- ASQ SE:2 (Ages and Stages Questionnaire- Social-Emotional 2), BPSC (Baby Pediatric Symptom Checklist)

Edinburgh Postpartum Depression Scale

- Completed by the caregiver
- At 1 month, 2 month, 4 month, 6 month visits
- Simple 10 multiple choice questions
- Score of 10 or greater indicates possible depression
- English and Spanish
- Sensitivity – 86%; Specificity – 78%
- Available on line

Coding for Screening

- AAP recognizes the screening as a measure of risk in the infant’s environment.
- CMS endorsed coverage under EPSDT at infant visits (May 2016)
- Billing is appropriate at the infant’s visit.
- CPT code 96161 for the Edinburgh (for caregiver-focused health risk assessment for the benefit of the patient, new in January 2017)
- CPT code for ASQ-SE:2 or BPSC is 96127
- If there are concerns about the dyad relationship, the code Z62.898, Parent-infant Bonding Problem, or Z62.820, Relationship Specific Disorder or Infancy/Early Childhood, (published in the DC: 0-5 - Diagnostic Classification for 0-5 year olds, 2016) can be used as secondary to the well-visit code.
Provider “Next Steps” on Positive Edinburgh Screen

Suggested one month follow up with other follow up on an “as needed” basis. This could be determined by the mother’s risk, social supports, and child’s own developmental trajectory.

Ways for follow up

1. Enhanced visit schedule -
   • Documentation should support need for enhanced schedule. Should reflect potential impact of maternal condition on infant development. Example: “Infant at risk for cognitive and developmental delay based on mother’s psychiatric impairment.”
   • Provider Visits
     • Well child visits and E & M codes for enhanced visits
     • ASQ – SE: 2 (96127) as screening tool for infants 3 months and older

2. Periodic phone calls to the family

3. Home visits by OB Care manager for first 60 days after delivery or CC4C care manager for ongoing visits

Suggested content of follow up:

Assessment

Infant – Ages and Stages Questionnaire–Social Emotional (ASQ-SE: 2). Can use 6 month ASQ-SE: 2 from 3 to 8 months of age. Consider reviewing responses with mother as her ability to adequately report may be compromised by depression.

Mother – Possible strategies to assess mental status, social support, connection into resources
   o Follow up questions:
     o The last time you were here, you answered several questions about your feelings and emotions since the baby was born. How are you doing now when compared to the last time we spoke?
     o The last time we spoke, you were going to follow up with a mental health provider/counselor/therapist. Have you had an appointment yet? If so, how was the appointment?
     o How are you and the baby? Do you have help or support from others?
     o Repeat Edinburgh Screens

Education - Handout on Development/Bonding 0-3 months

Referrals for problems identified in follow up
   o OBCM (if within 60 days postpartum), CC4C/CCWJC, CDSA (if documented developmental delay – e.g. abnormal ASQ-SE: 2)
   o All referral forms can be found at our website http://www.ccwjc.com/. Click on “Make a Referral” on the left side of the homepage—or use this link
Considerations of incorporating elements of protocol into workflow

1) Identify time intervals for screening.
2) Follow stratification of [Edinburgh score](#) for diagnosis, triage, and treatment.
3) Identify crisis and continuity care resources for patients and clinicians that are available in your community. Place this information in a readily available place in your clinic.
4) Consider where you want to document maternal mental health information.
5) Provide education about postpartum depression to family members and staff.
6) Identify clinic champions to assist in acute and nonacute referral for additional support and care.
7) If your clinic has a mental health professional on site, clarify the internal vs. external referral criteria and workflow.
8) Identify timing for initial follow up.
9) Provide education on attachment and development.
Resources
Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: ___________________________  Address: ___________________________

Your Date of Birth: ___________________

Baby’s Date of Birth: ___________________  Phone: ___________________________

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

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time  (This would mean: “I have felt happy most of the time” during the past week)
- No, not very often  Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared or panicky for no very good reason
   - Quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven’t been able to cope at all
   - Yes, sometimes I haven’t been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever  As

*7 I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8 I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10 The thought of harming myself has occurred to me
   - Quite often
   - Sometimes
   - Hardly ever
   - Never

Administered/Reviewed by ___________________________  Date ___________________________


**Escala de Edinburgo**

La depresión después del parto es la complicación más común que las mujeres padecen después de dar a luz. Tratar la depresión le puede ayudar a usted y a su bebé. Por favor CIRCLE la respuesta que más se acerca a como se ha sentido en los últimos 7 días, no solo como se siente hoy.

**Como por ejemplo:**
Me he sentido contenta:
1) Sí, siempre
2) Sí, casi siempre
3) No, a menudo
4) No

**Conteste subrayando En los últimos 7 días:**

<table>
<thead>
<tr>
<th>1. He podido reír y ver el lado bueno de las cosas:</th>
<th>6. Las cosas me oprimen o abruman:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Como siempre</td>
<td>1) No</td>
</tr>
<tr>
<td>1) No tanto</td>
<td>2) No, casi nunca.</td>
</tr>
<tr>
<td>2) Mucho menos.</td>
<td>3) Sí, a veces</td>
</tr>
<tr>
<td>3) No, no he podido</td>
<td>4) Sí, casi siempre</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>2. He mirado al futuro con placer:</th>
<th>7. Me he sentido tan mal, que he tenido dificultad para dormir:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Como siempre</td>
<td>1) No</td>
</tr>
<tr>
<td>2) Un poco menos que antes</td>
<td>2) No muy a menudo</td>
</tr>
<tr>
<td>3) Definitivamente menos, que antes</td>
<td>3) Sí, a menudo</td>
</tr>
<tr>
<td>4) No</td>
<td>4) Sí, casi siempre</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Me he culpado sin necesidad cuando las cosas marchaban mal:</th>
<th>8. Me he sentido triste y desanimada:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) No, nunca</td>
<td>1) No</td>
</tr>
<tr>
<td>2) No muy a menudo</td>
<td>2) A menudo</td>
</tr>
<tr>
<td>3) Sí, algunas veces</td>
<td>3) Sí, bastante</td>
</tr>
<tr>
<td>4) Sí, casi siempre</td>
<td>4) Sí, casi siempre</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. He estado ansiosa y preocupada sin motivo:</th>
<th>9. He estado tan mal que he estado llorando:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) No</td>
<td>1) No</td>
</tr>
<tr>
<td>2) Casi nada</td>
<td>2) Sólo algunas veces</td>
</tr>
<tr>
<td>3) Sí, a veces</td>
<td>3) Sí, a menudo</td>
</tr>
<tr>
<td>4) Sí, a menudo</td>
<td>4) Sí, casi siempre</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>5. He sentido miedo o pánico sin motivo alguno:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) No</td>
</tr>
<tr>
<td>2) No, no mucho</td>
</tr>
<tr>
<td>3) Sí, a veces</td>
</tr>
<tr>
<td>4) Casi siempre</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. He pensado en hacerme daño a mí misma o a mi bebé:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Nunca</td>
</tr>
<tr>
<td>3) Sí, a menudo</td>
</tr>
</tbody>
</table>
Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Postpartum depression is the most common complication of childbearing. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center<www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

### SCORING

**QUESTIONS without an asterisk (*)** are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

| Maximum score: 30 |
| Possible Depression: 10 or greater |
| Always look at item 10 (suicidal thoughts) |

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

### Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

---


**Items to address for assessment of immediate concerns in mother**

Please consider medico-legal implications of having mother’s mental health documentation in child’s chart.

a) **Individual and family history:** history of mood disorders, psychotic, and anxiety disorders, history of self-harm/suicidality, prior violence/homicidality, or impulsivity.

b) **Access to means:** Does patient have access to firearms?

c) **Irritability:** shouting at others, starting fights, arguing

d) **Mania:** feeling so good, high, excited, or hyper that other people thought mother was not her normal self, or mother got into trouble

e) **Psychosis:** disorganized thought patterns, auditory or visual hallucinations

f) **Self-harm or baby harm:** thoughts or behaviors of wanting to harm self or baby (including severity of thoughts, plans, intent, safety situation)
   a. Assess if ideation is active and current
      1. Do you have thoughts you’d be better off dead, or are you having thoughts of harming or killing yourself or your baby?
      2. There’s a big difference between having a thought and acting on a thought. Do you think you might actually attempt to hurt yourself or your baby in the near future?
      3. Are you having these thoughts right now? When did you last have them?
   b. If active, current suicidal or homicidal ideation, assess plans and intent
      1. Do you have any plans on how you would harm yourself or your baby?
      2. If yes – what have you thought about?
      3. Do you have what you need to successfully follow through with a plan to hurt yourself or your baby?
         4. Have you actually done anything to hurt yourself or your baby?

**Sample Verbiage for Minimal Brief Documentation of Risk Assessment**

**Acute Risk:** Acute safety concerns are/are not present today as evidenced by presence or absence of_______ thoughts, presence or absence of plan, presence or absence of_______intent.

**Chronic Risk:** The chronic risk of self-harm is elevated secondary to risk factors of (ethnicity), (history of mental illness), (history of impulsivity), (past history of attempts), (family history of suicide), (substance abuse), (psychosocial stressors), (access to means), (gender-male), (medical problems).

**Risk Mitigation Factors:** These risks are mitigated by (social supports), (therapeutic alliance), (lack of access to means), (other factors).
Sample documentation form for more complete Assessment of Immediate Concerns

Please consider medico-legal implications of having mother’s mental health documentation in child’s chart.

Child’s ID: __________________________ Mother’s Name: __________________________

Date: __________________________ EPDS Score: __________ Response to Item 10: __________

a) Individual and family history: history of mood disorders, psychotic disorders, anxiety disorders, self-harm/suicidality, violence/homicidality/impulsivity:

b) Access to means: does patient have access to firearms? __________________________

c) Irritability: shouting at others, starting fights, arguing:

____________________________

d) Mania: feeling so good, high, excited, or hyper that other people thought mother was not her normal self, or mother got into trouble __________________________

e) Psychosis: disorganized thought patterns, auditory or visual hallucinations

________________________________

g) Self-harm or baby harm: thoughts or behaviors of wanting to harm self or baby

1. Do you have thoughts you’d be better off dead, or are you having thoughts of harming or killing yourself or your baby? __________________________

2. Do you think you might actually attempt to hurt yourself or your baby in the near future?

____________________________

3. Are you having these thoughts right now? When did you last have them?

____________________________

If active, current suicidal or homicidal ideation, assess plans and intent

1. Do you have any plans on how you would harm yourself or your baby? __________________________

2. If yes – what have you thought about? __________________________

3. Do you have what you need to successfully follow through with a plan to hurt yourself or your baby? __________________________

4. Have you actually done anything to hurt yourself or your baby? __________________________
Assessment

**Acute Risk:** Acute safety concerns are/are not present today as evidenced by presence or absence of thoughts, presence or absence of plan, presence or absence of intent. (Please see previous form)

**Chronic Risk:** The chronic risk of self-harm is elevated secondary to risk factors of (ethnicity), (history of mental illness), (history of impulsivity), (past history of attempts), (family history of suicide), (substance abuse), (psychosocial stressors), (access to means), (gender-male), (medical problems).

**Risk Mitigation Factors:** These risks are mitigated by (social supports), (therapeutic alliance), (lack of access to means), (other factors).

**Decision-Making:**
Is crisis intervention indicated? yes no

**Response/Plan/Recommendations:**
- Education provided on postpartum depression
- Encouraged family/social support, increased activity/mild exercise
- Education provided on community resources, mental health resources, access to crisis services, if needed
- Mental health referral made/discussed:
- Mother connected to a crisis intervention service:
- Infant referred to CC4C
- Infant referred to CPS
- Other:

**Provider Signature:**

______________________________
**Address Immediate Concerns**

If a telephone call is received from mother or family member with reports of suicidal or homicidal ideation, or other acute safety concerns, call Mobile Crisis Services (1-877-626-1772), or Police Department to go to the mother.

**Involuntary Commitment:**

Any individual may complete an Affidavit and Petition for Involuntary Commitment. This form must be notarized. A physician or PhD psychologist can have the notarized form faxed to the magistrate. The PhD Psychologist or physician can then call the office to review the case with the magistrate. All other individuals must go to the local courthouse and file commitment papers in person. If safety concerns arise in the clinic setting, the patient must be under supervision of a staff member during this entire process.


The magistrate considers whether or not the contents of the petition meet the legal standard. If the magistrate determines that the contents of a petition merit examination, the magistrate issues a custody order that then allows local police to take the patient to a location, such as Crisis and Assessment or an emergency department, where an Examination and Recommendation to Determine Necessity for Involuntary Commitment (often referred to as a Qualified Provider Examination – QPE) will be performed. Crisis and Assessment is preferable if the mother is thought to be medically stable. This QPE actually puts the involuntary commitment in place, if deemed appropriate by the examining provider.

The primary care physician or PhD psychologist can perform the QPE in the outpatient setting to put the involuntary commitment in place, if they desire, but it is not necessary. If the primary care physician or psychologist does complete the QPE, the examination form and the petition will go with the patient to the ED or Crisis and Assessment. A second QPE will be done in the ED or Crisis and Assessment setting and the patient could be released from involuntary commitment, if this second provider does not feel the commitment is warranted.

Wake County Magistrate’s office (Phone: 919-255-7700, extension 4, extension 0. Fax: 919-792-4903).

Johnston County Magistrate’s Office (Phone: 919-209-5462, Fax: 919-209-5492)
CCNC Pediatrics: Maternal Depression Screening

Psycho-social screening and surveillance for risk is an integral part of routine care and the relationship with the child and family. Medical Homes can be timely and proactive by implementing the screening, supporting the mother-child relationship and using community resources for referral and treatment.

40% - 60% of parenting teens and mothers who have low income report depressive symptoms

<table>
<thead>
<tr>
<th>Spectrum of Maternal Depression</th>
<th>Prevalence</th>
<th>Time Frame</th>
<th>Characteristics</th>
<th>Recommended Treatment Mom</th>
<th>Recommended Treatment Dyad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity (Baby) Blues</td>
<td>50%-80% of all mothers experience “baby blues” after birth</td>
<td>Begins a few days after birth. May last up to 2 weeks</td>
<td>Transient depressed mood, irritability, crying, anxious, afraid, confused</td>
<td>Family support</td>
<td>Family Support groups</td>
</tr>
<tr>
<td>Postpartum Depression</td>
<td>13%-20% of mothers experience PD after birth</td>
<td>Occurs during postpartum or within the 1st year</td>
<td>Meets DSM V criteria as a minor/major depressive disorder. depressed mood, reduced interest in activities, loss of energy, difficulty concentrating</td>
<td>Family Support Mental Health provider</td>
<td>Early Childhood Mental Health provider</td>
</tr>
<tr>
<td>Postpartum Psychosis (PPP)</td>
<td>1-3 of 1,000 mothers experience PPP after birth</td>
<td>Occurs in the first 4 weeks after birth</td>
<td>Paranoia, mood shift, hallucinations, delusions, suicidal/homicidal thoughts</td>
<td>Emergency mental health services Mobile Crisis Inpatient setting</td>
<td>Early Childhood Mental Health provider</td>
</tr>
</tbody>
</table>

Evidence-Based Intervention:
- Edinburgh Postpartum Depression Scale – available in English and Spanish
  - Mother completes a 10 multiple choice questionnaire at 1, 2, 4, and 6 month visits. (Note peak occurrence at 2-3 months for minor depression; 6 weeks for major depression)
  - Billed at the infant visit with CPT code 99420. As of January 2017 this code will change to 96161 (health risk screen of the caregiver for the benefit of the patient).
  - If the mother is the patient, (i.e. Family Medicine or OB practice), Bill CPT Code 96127
  - Per NC DMA, OB providers can bill CPT code 96127 in addition to OB package codes

For Positive Screens:
- If the Edinburgh score is **20 or greater**, or the mother answers yes on question 10, or if the mother expresses concern about her or her baby’s safety or the PCP suspects the mother is suicidal, homicidal, severely depressed/manic/psychotic
  - Contact your Mobile Crisis provider: service available through your MCO
  - Refer to emergency mental health services and be sure she leaves with a support person
- Communication, Support, Demystification and focus on wellness
- Referral Resources: see above

Follow-up of the infant includes social-emotional screening.

CCNC Pediatrics - September 2016 (v6)
REFERENCES/Clinical Guidelines/HIPAA

ASSUMPTIONS: (links to resources provided)
PCC’s (Primary Care Clinicians) are conversant with:

- The AAP Statement on perinatal and postpartum depression:

USPSTF
- Recommends perinatal depression screening using either the Edinburgh or PHQ-9
- Grade B recommendation
- January 2016
- Therefore mandates payment by all commercial payers, without cost-sharing, under the Affordable Care Act (ACA)


NQF
- NQF 1401: Maternal Depression Screening
- Endorsed by CMS for EHR Incentive Program 2013
- % of children who turned 6 months of age during the measurement year, who had a face- to-face visit between the clinician and child during the child’s first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life

CMS Guidance May 11, 2016
- Based on AAP 2010 Clinical Report
- On May 11, 2016, the Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin on maternal depression screening and treatment, emphasizing the importance of early screening for maternal depression and clarifying the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences, and connecting mothers and children to the help they need.

- State Medicaid agencies may cover maternal depression screening as part of a well-child visit.
• In addition to screenings, states must also cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additionally, treatment for maternal depression that includes both the child and the parent, such as family counseling, may also be paid for under EPSDT.

• While Medicaid programs are permitted to pay for these services, states must affirmatively act to implement coverage. States also have discretion regarding the procedures used to pay pediatricians for providing maternal depression screening services.

**Evidence-based Interventions for the Dyad.**

• Circle of Security ([www.circleofsecurity.org](http://www.circleofsecurity.org))

• Child-Parent Psychotherapy (Child First)

• ABC (Attachment & Biobehavioral Catch up)
**HIPAA Privacy Rule and Provider to Provider Communication**

American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides an important privacy rights and protections standard for patients with respect to their health information. HIPAA provides a uniform minimum standard, which individual state laws may supersede by mandating additional restrictions. AAP and AACAP both support the importance of this HIPAA rule in helping to protect against the inappropriate release of private health information, as well as to optimize safe care by allowing important clinical information to be shared among the clinicians of the patient’s care team. It is considered a best practice to inform patients and parents about the critical need for care providers to communicate with each other in providing high quality care.

Unfortunately there are misperceptions about the HIPAA Privacy Rule which have developed and persisted over the past decade, which can interfere with appropriate patient care. Collaborative and integrated care systems rely on the appropriate and timely sharing of clinical information among a patient’s treatment providers. If professionals do not appropriately communicate about their shared patients under the belief that HIPAA requires a signed consent for each communication, then patient care may suffer. Therefore AAP and AACAP have created this issue brief to clarify what the HIPAA rule does and does not limit regarding clinical care information exchange among pediatricians, child psychiatrists and other physicians and mental health providers.

The following are answers to commonly asked questions:

1. **What information can be disclosed between treatment providers without a patient/legal guardian’s written authorization under HIPAA?**

   Any pertinent clinical care information, including mental health treatment information, can be disclosed and discussed between a patient’s current treatment providers without written disclosure authorization except for the following two types of information: A) the content of written psychotherapy notes (see below), and B) substance abuse treatment records that are maintained by a licensed substance abuse program (42 USC § 290dd–2; 42 CFR 2.11). Substance abuse information obtained in other treatment settings may be communicated among a patient’s treating providers without written consent.

2. **What constitutes psychotherapy note information that cannot be disclosed under HIPAA without a patient’s explicit consent?**

   The HIPAA definition of a “psychotherapy note” is quite restrictive. A psychotherapy note per HIPAA can only consist of a mental health professional’s written analysis of a conversation that occurred during a private counseling session that is maintained separately from the medical record. These written analyses serve as working process notes about sessions to assist the therapist, and are not put into the medical record billing document. Anything which appears in the patient’s medical record cannot be categorized as a psychotherapy note under the HIPAA rule. Specific content that has been listed as not falling under the “psychotherapy note” protections include medication management information, counseling session start and stop times, the type and frequency of treatment delivered, the results of clinical tests, diagnosis summaries, functional status, treatment plan, symptoms, prognosis,
and progress to date. 45 CFR 164.501

3. **Can treatment providers who work in separate care systems communicate with each other about a shared patient?**

   Yes. Treatment providers do not have to share the same employer or share the same electronic health record in order to disclose pertinent protected health information about a mutual patient without consent from the patient or parent. The key component for this HIPAA allowance is that both providers have a treatment or consultative role with that patient. (See also http://www.hhs.gov/ocr/hipaa). Whenever PHI is transmitted electronically (eg, telephone voice response, text messaging, faxback, or email, etc) it is covered by the Security Rule and must be made secure by measures such as encryption, secure platforms, or closed systems. Voice mail messages, telephone conversations, and paper-to-paper faxes are not subject to the Security Rule. All PHI (eg, in oral, electronic and written forms) fall under the Privacy Rule.

4. **Does HIPAA allow for sharing treatment information via an electronic health record without written consent?**

   Yes, but there are additional regulations around the security standards needed for protecting electronic health records. Essentially, rules and procedures are required in the maintenance of an electronic health record to prevent their unauthorized access, alteration, deletion, and transmission. These security regulations for electronic records are outlined in the HIPAA security rule of 2005, and the HITECH act of 2009.

5. **Are there any other regulations that conflict with HIPAA communication allowances?**

   Yes. Providers need to be aware that any state regulations that are more restrictive than the HIPAA rules will take precedence in those states, and so providers need to be aware of their own state’s information regulations. If you are unfamiliar with your state’s regulations, it will be important to specifically seek out your state department of health’s privacy rules. To obtain information on current state laws, you may also contact the AAP Division of State Government Affairs at stgov@aap.org

   Also, clinical information obtained at a certified substance abuse treatment center is subject to additional federal privacy rules, which at this time do not allow provider to provider communication without formal consent.

Case examples where HIPAA allows for provider to provider communication without a signed release:

1. At his 13 yr old well-visit, an adolescent (and his parent) tells his pediatrician that he is seeing a psychiatrist because of depression and he is doing better. The pediatrician contacts the psychiatrist to discuss medication and the pediatrician’s role in supporting the young man and his family.

2. A 13 year old boy is receiving depression treatment from a child psychiatrist, including both a fluoxetine prescription and counseling. The same boy is also having problems with recurrent pain for which he regularly sees his pediatrician, who has been prescribing a low dose of amitriptyline for that problem. Because of treatment plan overlaps, both treatment providers discuss and coordinate their care.

3. A 15 year old girl has just completed a well child check at her pediatrician’s office. It was noted that
she had a blood pressure of 145/95 and pulse of 130. The pediatrician learns that she has recently started taking methylphenidate as prescribed by a child psychiatrist. Because high blood pressure may be a side effect of methylphenidate, the pediatrician contacts the child psychiatrist to discuss and coordinate care.

4. A 5 year old boy with significant behavior problems is being seen by a child psychiatrist. In the course of treatment, it becomes apparent that poorly skilled parenting practices at home are the main reason for his symptoms. The psychiatrist reaches out to the child’s pediatrician to share this assessment and the behavior management advice that is being offered to the family.

View other case examples and the rest of the FAQs at www.aap.org/mentalhealth.

Disclaimer: This information is intended to be educational in nature. It is not intended to constitute financial or legal advice. A financial advisor or attorney should be consulted if financial or legal advice is desired. HIPAA has many different requirements and regulations. Practitioners need to be aware that their own state laws can be more restrictive than HIPAA.