



Increasing postpartum depression screening and resources in pediatric primary care: A quality improvement project to enhance provider confidence



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ABSTRACT

Background: Unidentified and untreated postpartum depression (PPD) can have a negative impact on children. This Quality Improvement (QI) project aimed to increase PPD screening through provider education and enhancing pediatric primary care provider (PCP) confidence in using the Edinburg Postnatal Depression Screening (EPDS) tool, discussing PPD with mothers, and providing resources.

Design and methods: PCPs and staff were educated on the project. Providers were surveyed prior to and after implementation to assess confidence with screening for and addressing PPD. Mothers of infants 0–6 months were screened using the EPDS at well-care visits. Discussion of PPD and resource support was provided if needed.

Results: A total of 273 mothers met criteria for screening, and of those 65% ($n = 178$) had a documented score. 12.4% of mothers had a score of 10 or greater, indicating high risk for PPD. Results from PCPs were compared both pre- and post-project. Screening for PPD increased from 3 to 4.5, using the EPDS tool from 2.25 to 4.75, discussing PPD with mothers from 2.75 to 4.25, and providing resources from 2.25 to 4.25.

Conclusions: PPD screening increased, and provider confidence with using the EPDS, discussing PPD with mothers, and providing resources in pediatric primary care increased.

Practice Implications: Educating PCPs on the importance of PPD screening and providing resources for at-risk mothers can increase identification of PPD in the primary care setting. Enhancing the confidence of providers to discuss PPD with mothers and offer resources to those in need can lead to better outcomes for pediatric patients and their families.

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Problem description

Postpartum depression (PPD), a psychological disorder that can cause mood swings, crying spells, poor appetite and sleep, fatigue, feelings of worthlessness, and thoughts of death or suicide, affects 10–20% of mothers in the first year after giving birth (Docherty et al., 2020; Kurtz et al., 2017; Sorg et al., 2019). PPD affects women most often during the first three months after delivery, but they remain at risk for up to one year postpartum (Kurtz et al., 2017). In the past, screening for PPD was generally done by adult primary care providers, such as nurse practitioners or obstetricians (Gilbert et al., 2017), and is typically completed once at the 6-week postpartum visit.

The role of screening mothers for PPD should be extended to pediatric primary care providers, as they interact with mothers of infants more

during their first year of life than any other provider and mothers remain at risk for PPD after the 6-week postpartum visit (Kurtz et al., 2017; Olin et al., 2017; Orringer et al., 2019; Russomagnò & Waldrop, 2019). Pediatric primary care providers, such as physicians (MD), nurse practitioners (NP), and physician's assistants (PA), have more frequent contact with postpartum women, as compared to other healthcare providers, due to the frequency of well-care visits in the child's first year of life, thus providing an optimal environment for PPD screening (Earls et al., 2019). However, PPD screening is currently not routinely performed in pediatric primary care (Earls et al., 2019). Untreated PPD can result in health-related burdens to the mother, child, and family unit (Gerbaso et al., 2020). If PPD continues to not be addressed in the pediatric primary care medical home, children are at risk of experiencing an unhealthy prolonged activation of the stress response (feeling pressured and overwhelmed over a long period of time), which can increase the risk of delays in cognitive, social-emotional and language development (Earls et al., 2019): therefore; this phenomenon should be addressed.

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Available knowledge

The current literature supports the interventions of this quality improvement (QI) project to screen for PPD at the initial visit through 6-month well-child visits and provide resources if necessary. Screening is recommended at 1, 2, 4, and 6-months (Kurtz et al., 2017; Orringer et al., 2019; Rafferty et al., 2019; Russomagno & Waldrop, 2019). There are many tools that can be used to screen for PPD, including the Edinburg Postnatal Depression Screen (EPDS), Patient Health Questionnaire 2 (PHQ-2), Patient Health Questionnaire 9 (PHQ-9), and the Hamilton Depression Rating Scale (HAM-D-17) (Gerbaso et al., 2020; Kumar et al., 2021; Rafferty et al., 2019; Waldrop et al., 2018). Several studies have evaluated and compared these screening tools (Gerbaso et al., 2020; Kumar et al., 2021; Orringer et al., 2019; Rafferty et al., 2019; Sorg et al., 2019; Waldrop et al., 2018). These studies concluded that the EPDS is an adequate and feasible screening tool to use for assessment of PPD in primary care (Gerbaso et al., 2020; Kumar et al., 2021; Rafferty et al., 2019; Waldrop et al., 2018). It is a validated and reliable screening tool that is commonly used to assess the likelihood of depression, identify depressive symptoms, it is recommended by the American College of Obstetricians and Gynecologists (ACOG) and United States Preventative Services Taskforce, and it is shown to be more consistent than the other screening tools (ACOG, 2018; Rafferty et al., 2019; Waldrop et al., 2018).

The literature supports providing resources for those who screen positive for PPD (Earls et al., 2019; Rafferty et al., 2019). Depression screening alone is of little benefit, but when associated with enhanced depression care in the form of referral services, positive outcomes were established, such as decreasing PPD symptoms, identification of community resources for the mother, depression treatment, and identification of resources that support both the mother and child (Olin et al., 2017; Orringer et al., 2019; Rafferty et al., 2019; Russomagno & Waldrop, 2019). Having a referral process in place for those who screen high risk for PPD can empower the provider to have discussions about PPD and offer resource support (Russomagno & Waldrop, 2019; Sorg et al., 2019; Waldrop et al., 2018).

Aims

The overall purpose of this QI project was to improve the health and well-being of pediatric patients and their families through identifying mothers who are at high risk for PPD. Previously, at the pediatric primary care medical home involved in this project, no screening protocol was in place. Thus, the aim of this QI project was to start screening for PPD utilizing the EPDS with all mothers who brought their child in for a well-care visit from newborn to 6 months old in order to help identify mothers who were at high risk for PPD. In order to achieve this aim, it was imperative that the QI project include provider education to enhance provider awareness of the need to screen for PPD and increase provider confidence with screening for PPD, discussing PPD with mothers, and providing resource support. For those who screened high-risk for PPD, resources were to be provided.

Objectives are measurable actions that result in achieved goals (Moran et al., 2017). The first SMART objective for this QI project was to implement PPD screening in at least 90% of women who met criteria using the EPDS at all infant well child checks (ages newborn to 6 months). The second SMART objective was to increase pediatric primary care provider confidence with using the EPDS as a screening tool, discussing PPD with mothers at well-child exams, and offering referrals and resources to mothers experiencing PPD. Achievement of this objective was measured by a provider survey given before and after QI project implementation. The last SMART objective was, of mothers who screen high-risk for PPD at well child checks (ages newborn to 6 months), at least 90% will be provided with resources and support from the pediatric primary care provider during the project implementation period.

Methods

Context

The participants of the QI project included mothers of children aged between newborn to 6 months old who speak English or Spanish. Inclusion criteria for the mothers completing the PPD screening were biological mothers at well-care visits only, for children being examined at their newborn through 6-month visits, even if not previously screened for PPD. Exclusion criteria included anyone other than the biological mother, and any mother whose child was being evaluated for a well visit greater than six months, those being seen for a sick visit, and those who spoke any language other than English or Spanish. The pediatric primary care providers also played an important role in this QI project, as they were the ones who had to implement the PPD screening and feel confident in discussing PPD with mothers, therefore they were also included as participants in the QI project. Inclusion criteria for the pediatric primary care providers included being a MD, NP, or PA that was employed at the pediatric primary care medical home involved in this pilot QI project. Providers that did not work at the location of the pilot QI project were not included. While other staff such as nurses, medical assistants, and front desk staff were involved in implementing the QI project, they were not asked to complete the provider survey, and no data was collected from them.

The QI project was implemented at a pediatric primary care medical home in New Mexico. The pediatric primary care medical home is privately owned and has 4 locations. The project was piloted at 1 of the 4 locations. The pilot medical home has 4–5 pediatric primary care providers on average per day, with a total of 6 that rotate days. The pediatric primary care medical home has 12 patient rooms and each provider sees an average of 80 patients per week.

Interventions

To prepare pediatric primary care providers and staff for the QI project, a power point presentation and training was provided prior to project implementation. The training discussed the prevalence of PPD and the importance of screening in pediatric primary care, the use of the EPDS, how to discuss PPD with mothers and provide resources if needed and need for consistent documentation of screening and interventions in the electronic health record (EHR) for ease and accuracy of data collection. The provider survey was administered before the training session to collect baseline data regarding provider confidence in screening for and addressing PPD. The same survey was given post-project implementation for comparison and to evaluate the provider-related outcomes of the QI project.

Before EPDS screening began, a resource list was developed for the providers to distribute to those who screened high-risk for PPD, or for those with scores indicating thoughts of self-harm. The resources were compiled after researching local and national organizations focused on helping those suffering from PPD. Information from the Office on Women's Health (2021) was used to create a list of activities that the mother could do to help with PPD while they were waiting to see an adult provider. The list of resources also included contact information for Postpartum Support International, National Suicide Prevention Lifeline, a link to help mothers find local resources and treatment centers and provided information on what to do in an emergency. The resources handout was printed on the back side of the EPDS questionnaire, which allowed for easy access to the provider when needing to offer support to mothers who screened high risk, and the mothers were allowed to take the handout home with them. The resource list was translated into Spanish by a licensed interpreter and was checked for clarity of translation.

The first step of the QI project was to have the front desk staff hand out the EPDS to mothers who presented to the pediatric primary care medical home with their infants 0–6 months old for well-care visits.

The mothers were asked to fill the EPDS out while waiting for the medical assistants (MAs) to bring them back to the exam room. While entering vitals the MA also entered the EPDS score into the EHR under the EPDS tab. The three options available for the MA to choose from in the EHR were: test administered, mother not present, and mother declines screening. If any response other than “test administered” was entered into the EHR, no further prompts became available. If “test administered” was chosen, 2 more options became available for documentation: “total score”, and “question 10 score”. Question 10 on the EPDS addresses self-harm. Once vitals and EPDS scores were entered, the pediatric primary care provider could review prior to entering the room for the appointment.

The EPDS scores were reviewed with the mother by the provider, and if the mother’s score was a 10 or greater, the provider discussed the risk for PPD and resources were offered via the handout, in both English and Spanish. The providers in the pilot clinic received a script to review during project implementation training that served as a guide to help them effectively communicate with the mothers. In the EHR if the total score entered was 10 or greater, or if a response to question 10 was 1 or greater, 3 options for documentation by the provider became available: “list of resources provided”, “referred to emergency services”, “resources declined by mother”. Documentation began at any well-care visit between 0 and 6 months old during the QI project implementation period. If a second or third well care visit was done during the project implementation period, the mother was re-screened. As this was a pilot project, the implementation period was brief, from May 2022 to August 2022.

Study of the intervention

Aims of this QI project included implementing screening for PPD in mothers and providing resources to those who were at risk for the development of PPD. To measure achievement of this aim, a chart review tool was created to audit the screening rate of mothers who met the inclusion criteria, and if there was documentation of an EPDS score and discussion of PPD resources with the mother. Chart reviews were conducted at the end of project implementation and data was extracted to complete the audit. Other information such as patient and mother demographics and follow up EPDS scores were also extracted to help further analyze PPD in this cohort. A manual review was done to make sure data extracted from the EHR was accurate. A total of 273 participants met the criteria for screening. The numeric score of the EPDS screening tool was assessed, as well as the intervention given for those who scored high risk for PPD.

Providing pediatric primary care provider education regarding PPD was also vital in achieving the aims of this QI project. After this education it was hoped that increasing pediatric primary care provider awareness of PPD and their confidence in utilizing the EPDS, discussing PPD with mothers, and providing resources the QI project could gain support and be implemented successfully. A pre- and post-project questionnaire was used to measure confidence of pediatric primary care providers regarding PPD screening and implementing discussion and providing resources to mothers in need. Means for the overall questionnaire, as well as individual questions, were compared pre- and post to evaluate

if the education and implementation of the QI project helped to increase provider confidence.

Measures

The screening tool that was used to screen mothers for PPD was the EPDS, which was available in English and Spanish (Cox et al., 1987). The EPDS is a 10-item screening tool that can be easily administered and completed via self-report in <5 min. According to Tsai et al. (2013), the validity and reliability of the EPDS were 88% and 75% respectively. This systematic review and meta-analysis by Tsai et al. (2013) demonstrated reliability of the data with internal consistency, inter-rater reliability, and test-retest reliability. Additional factors that also made the EPDS a good screening tool to use was that it is written at an appropriate reading level, and is the shortest validated tool specifically made for use in the postpartum period (Russomagno & Waldrop, 2019). The EPDS is validated in 18 languages, including Spanish, which is a version that was also used in this QI project.

A second tool was used to evaluate pediatric primary care provider confidence in screening for PPD, using the EPDS tool, discussing PPD with mothers, and providing PPD resources to high-risk mothers (see Table 1). The survey was developed by the author, as there was no survey found in the literature already created that could assess what the author was seeking in regards to healthcare provider confidence with PPD screening. The questions were created based on information gathered from Docherty et al. (2020), and Kurtz et al. (2017) regarding the gap in pediatric primary care provider knowledge on the effects of PPD on young children and the need for screening for PPD in the primary care pediatric setting. The survey contained four questions that the providers answered on a Likert scale that ranged from 1 (not at all confident) to 5 (extremely confident). The same survey was given post-project for a comparison.

Analysis

Data collected for this QI project were analyzed by using quantitative analytical methods to evaluate if project aims were met. The IBM Statistical Package for the Social Sciences (SPSS) Version 28 was used. Frequency and descriptive statistics were used to identify rates of screening, EPDS scores, reasons why scores were not documented, interventions provided, and to evaluate if pediatric primary care provider confidence increased post-project implementation.

Ethical considerations

Prior to beginning of project implementation, the project plan was submitted to the Institutional Review Board (IRB). The IRB deemed the project exempt from IRB review or approval as it was QI in nature and did not meet the definition of human subjects’ research (IRB Number 1870322–1). Participation in the QI project by the mothers and the clinic staff/providers was voluntary and an informational flyer was utilized to describe the purpose, procedure, benefits/risks, and voluntary nature of participation, ability to withdraw at any time without consequence, and the contact information for the project director and IRB. If

Table 1
Pre- and post-project provider questionnaire.

Provider Questionnaire Item	Not at all confident	Slightly confident	Somewhat confident	Quite confident	Extremely confident
1. How confident do you feel screening for PPD?	1	2	3	4	5
2. How confident are you with using the Edinburg Postnatal Depression Screen?	1	2	3	4	5
3. How confident do you feel discussing PPD with your patient’s mothers?	1	2	3	4	5
4. How confident are you with providing resources to those who screen high risk for PPD?	1	2	3	4	5

a mother was offered a screening and she did not want to participate she could voluntarily leave the EPDS blank or stop filling it out at any time.

Confidentiality and privacy were honored throughout the implementation of the QI project by utilizing individual examination rooms and entering results of the EPDS screening, as well as any discussion and provision of resources, directly into the secure EHR. Data from the QI project was de-identified after abstraction from the EHR and prior to analysis. Data was stored until the completion of the project in a password-protected file and only the authors had access to the data. Ethical concerns regarding women who screened high risk for PPD or became distressed during the screening or clinic visit were addressed by adequately educating and training staff and providers prior to the implementation of the QI project. The training included how to discuss PPD with mothers and provide resources if needed. Additionally, a protocol was developed for those with positive screens. All providers had access to the list of resources, which included the National Suicide Prevention Lifeline and what to do in case of emergencies.

Results

PPD screening and resources for mothers

The first SMART objective was to implement PPD screening in at least 90% of mothers who met criteria using the EPDS at all infant well child checks (ages newborn to 6 months). After completion of the chart audit, 273 mothers met criteria for PPD screening using the EPDS. Of those, 65% (n = 178) were screened, while 35% (n = 95) do not have documented scores. The reasons for no documentation include (see Table 2): screened but no score documented (n = 5), mother not present (n = 19), mother declined screening (n = 12), and not screened and no reason documented (n = 59).

A score >10 is indicative of high risk for PPD, and 12.4% (n = 22) of mothers screened had a score of 10 or greater (see Table 2). The last SMART objective was, of mothers who screen high-risk for PPD at well-care visits (ages newborn to 6 months), at least 90% will be provided with resources and support from the provider during the project implementation period. The percentage of those who screened high risk

Table 2
Age at time of Screening and EPDS score.

Age at time of screening								
EPDS score	Frequency of mothers	A few days EPDS score	2 weeks old	2 months old	4 months old	6 months old	Total	
	N	%						
0	33	18.5	6	11	9	7	0	33
1	15	8.4	0	6	5	4	0	12
2	22	12.4	4	7	3	8	0	22
3	20	11.2	7	7	2	4	0	20
4	18	10.1	3	5	4	6	0	18
5	15	8.4	3	5	5	1	1	15
6	14	7.9	3	4	6	1	0	14
7	9	5.1	0	3	5	1	0	9
8	6	3.4	0	4	1	1	0	6
9	4	2.2	2	1	0	1	0	4
10	3	1.7	2	1	0	0	0	3
11	3	1.7	3	0	0	0	0	3
12	3	1.7	1	0	1	1	0	3
13	4	2.2	0	0	1	2	1	4
14	3	1.7	0	3	0	0	0	3
15	2	1.1	0	0	0	2	0	2
16	0	0.0	0	0	0	0	0	0
17	1	0.6	0	0	1	0	0	1
18	1	0.6	0	0	1	0	0	1
19	0	0.0	0	0	0	0	0	0
20	2	1.1	0	0	1	1	0	2
Total	273	100	34	57	45	40	2	178

Table 3
Low and high-risk scores and age at time of screening.

Age at time of screening and amount of low and high-risk scores						
EPDS score	A few days old	2 weeks old	2 months old	4 months old	6 months old	Total
0-9	28	53	40	34	1	156
10-20	6	4	5	6	1	22

for PPD and were then provided resources was 86.4% (n = 19). The percentage of those who had no intervention documented was 13.6% (n = 3). There were more mothers screened at their child's 2-week visit than any other well-care visit, although the highest number of mothers with EPDS scores >10 was seen at the newborn, 2-month, and 4-month well-care visits. There were 6 mothers that scored 10 or greater at the initial newborn (21%) and 4-month (17.6%) well care visits, and 5 mothers that scored 10 or greater at the 2-month well-care visit (12.5%) (see Table 3). The lowest amount of mothers with EPDS scores >10 were seen at the 2-week well-care visit (7.5%). There were only two mothers screened at the 6-month well-care visit which does not provide enough data to offer an accurate percentage. No mothers scored 1 or greater on question 10, the question that addresses self-harm risk.

There were 22 mothers who screened high-risk for PPD. Of those mothers, 4 of them were seen again in the QI project implementation period. One of those mothers declined screening, and 2 of them had EPDS score that increased. The others that screened high-risk for PPD were either not seen again at the project implementation site or were seen again and screened, but after the project implementation period. Data from outside the implementation period was not included in the data set.

Pediatric primary care provider confidence

The second SMART objective was to increase pediatric primary care provider confidence with using the EPDS as a screening tool, discussing PPD with mothers at well-care visits, and offering referrals and resources to mothers experiencing PPD, as measured by an increase in pre and post-test mean scores. Data of 4 pediatric primary care providers (n = 4) was used to assess confidence pre and post QI project implementation (see Table 1). Confidence in screening for PPD, using the EPDS tool, discussing PPD with mothers, and providing PPD resources to high-risk mothers, all increased post-project implementation (see Table 4). Mean scores for confidence in screening increased from 3 pre-project implementation to 4.5 post-project implementation. The questionnaire scores ranged from 1 to 5. Mean scores for confidence in using the EPDS increased from 2.25 pre-project implementation to 4.75 post-project implementation. Mean scores for confidence in discussing PPD with mothers increased from 2.75 pre-project implementation to 4.25 post-project implementation. Mean scores for confidence in providing PPD resources to mothers increased from 2.25 pre-project implementation to 4.25 post-project implementation.

Discussion

The results of this QI project support similar studies (Docherty et al., 2020; Earls et al., 2019; Lamere & Golova, 2022; Olin et al., 2017; Orringer et al., 2019; Sorg et al., 2019; Waldrop et al., 2018), that discuss the feasibility and importance of implementing PPD screening in the pediatric primary care medical home, as well as providing resources to those in need. While the overall implementation of PPD screening utilizing the EPDS in this project was feasible and beneficial, the screening rates in pediatric primary care for this project were less when compared to other studies (Orringer et al., 2019; Sorg et al., 2019). The exact cause for why more mothers were not screened needs to be further addressed.

Table 4

Pre- and post-project implementation mean scores.

Provider Questionnaire Item	Pre-project Implementation		Post-project Implementation	
	Mean	Std. Deviation	Mean	Std. Deviation
Confidence in screening for PPD	3.00	0.816	4.50	0.577
Confidence in using EPDS tool	2.25	1.258	4.75	0.500
Confidence in discussing PPD with mothers	2.75	0.957	4.25	0.957
Confidence in providing PPD resources to high-risk mothers	2.25	0.957	4.25	0.957

Hypothesized reasons as to why more mothers were not screened include: screened but failure to document score, visiting pediatric primary care providers unaware of screening process, and failure to give screening tool at check-in. Young et al. (2019) also discussed that stigma, fear of Child Protective Services, and barriers to access to mental health care could be contributing factors to not seeking care. Waldrop et al. (2018) suggest the use of a clearly defined path/algorithm and clinical decision support system to enhance screening rates. Although the screening rate in this project was 65%, more mothers were screened and received resources when compared to before project implementation when there was no standardized process in place.

This project also found that more mothers were screened and had higher rates of risk for PPD within the first 2 months of the child's life, which supports findings from other studies regarding the onset for PPD (Kurtz et al., 2017; Orringer et al., 2019; Rafferty et al., 2019; Russomagno & Waldrop, 2019; Sorg et al., 2019). This further reinforces that early screening at pediatric primary care well visits starting at the initial newborn visit is important, but it is even more vital to continue to rescreen mothers throughout the first 6 months of the post-partum period and undiagnosed PPD can negatively impact a child's mental health (Engelhard et al., 2022). While other studies have examined characteristics of the mother and infant that could increase risk for PPD (Kurtz et al., 2017; Rafferty et al., 2019; Sorg et al., 2019), that was outside the scope of this QI project. Many characteristics can place mothers at risk for PPD such as history of depression prior to pregnancy, adolescent pregnancy, or being the mother of an infant who was admitted to the neonatal intensive care unit. These additional attributes could be examined in correlation with EPDS scores to further help providers identify those at risk and those needing close follow-up.

Proper preparation and training for pediatric primary care providers is important prior to implementing a PPD screening protocol, as it has been reported that over 60% of pediatricians state they had inadequate training or skills needed to do the screening and they lack confidence in managing PPD (Olin et al., 2017; Waldrop et al., 2018). This QI project did utilize training on the prevalence of PPD, importance of screening, the use of the EPDS, and most importantly, how to discuss PPD with mothers and provide resources if needed. Pediatric primary care provider confidence with PPD screening and discussion, EPDS use, and confidence in providing resources for PPD to those at risk all increased. Having a well-developed resource list available to providers prior to project implementation reduced provider apprehension to project implementation. Having this process in place for those who screen high risk for PPD empowers providers to easily discuss PPD with their patient's mothers and feel confident with offering resources (Olin et al., 2017; Russomagno & Waldrop, 2019; Sorg et al., 2019; Waldrop et al., 2018).

Limitations

The QI project included an incomplete data set as there were several mothers who did not have EPDS scores entered into the EHR, interventions documented, or were never screened. This could limit the generalizability of the findings. Data gathered was categorized by age of child (newborn, 2-weeks, 2-months, 4-months, 6-months) and there may

have been some infants that were actually 1, 3 or 5 months old, and attended their well-child exam early or late. This could have affected correlation of EPDS scores with ages of infants. Only 2 mothers were screened at 6 months old which is a very small sample size as compared to other months and restricts the generalizability of the 6-month findings. Additionally, given the sensitive nature of self-harm and social stigma of mental health disorders such as PPD, the mothers could have answered the EPDS with a social desirability bias, which could have skewed results and not identified all mothers who were at risk.

There were also limitations regarding the pediatric primary care provider perspective of the QI project. Not all providers completed the post project questionnaire, so their data could not be included, leading to a small sample size of providers ($n = 4$) which could limit the applicability of the findings to other providers. Additionally, the project only evaluated a change in provider confidence in relation to PPD screening, communication, and providing resources.

Implications for practice

Utilization of a PPD screening tool within pediatric primary care can help increase the screening rate of all mothers and better identify risk for PPD. Recognizing mothers who are at increased risk is vitally important so that resources and help can be offered if needed, as untreated PPD can have long-term negative health outcomes for not only them other, but the child and the family unit (Earls et al., 2019; Gerbasi et al., 2020). Results from this QI project, as well as others within the literature (Earls et al., 2019; Lamere & Golova, 2022; Olin et al., 2017; Orringer et al., 2019; Sorg et al., 2019; Waldrop et al., 2018), continue to demonstrate the need for integration of PPD screening within pediatric primary care as PCPs potentially have a higher number of contacts with the mother, when compared to other providers (Earls et al., 2019). Unfortunately, the current rate of PPD screening within pediatric primary care is between 7 and 44% (Rafferty et al., 2019; Waldrop et al., 2018). While QI studies such as this one outline processes that can be used to implement a standardized screening process, screening rates after implementation can remain low.

Conclusion

Evaluation for PPD is very important as it is something that affects up to 20% of mothers (Sorg et al., 2019) and completing the screening in the pediatric primary care medical home is practical and useful, as pediatric primary care providers typically see the mother more often than their own providers. Implementation of a standardized screening tool, like the EPDS, helps pediatric primary care providers easily identify mothers who are at risk for PPD so that resources can be provided in a timely manner. This can help minimize risks not only to the mother, but also the child. This QI project demonstrated that implementation of the EPDS is effective and easy to incorporate into current clinic workflow, that a standardized process is needed, and that it did identify mothers who were at high-risk for PPD. This project showed that proper education for pediatric primary care providers to increase awareness of PPD and the importance for screening is needed, as well as training on how to properly communicate with mothers on this topic and offer resources. Increased confidence can lead to better provider adherence to the screening. Future projects should continue to focus on PPD screening in primary care in areas such as looking at risk factors for increased PPD, following those who score high risk more closely to minimize negative effects of untreated PPD, and examining ways to better support providers in their screening and documentation efforts.

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CRedit authorship contribution statement

Rachel E. Marquez: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Resources, Writing – original draft, Visualization, Project administration. **Kristina S. Miller:** Writing – review & editing, Supervision.

Declaration of Competing Interest

The authors have no conflicts of interest to disclose.

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