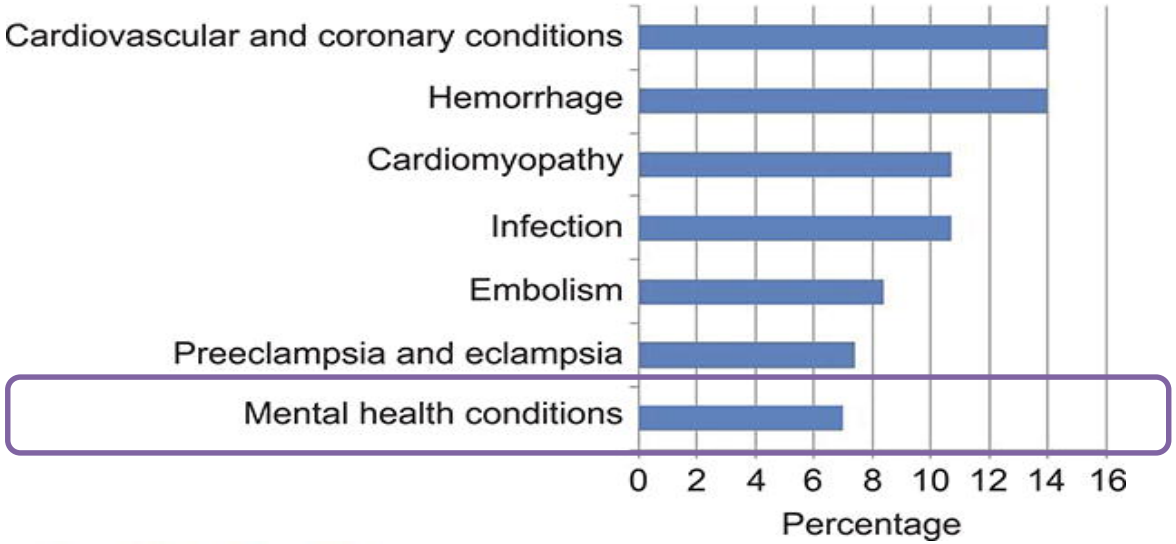
Perinatal Depression:
Where We Should Be and How We Should Get There

Emily S Miller, MD MPH
Assistant Professor
Department of Obstetrics & Gynecology
Division of Maternal Fetal Medicine

Northwestern

No disclosures

Perinatal Depression



Maternal Risks

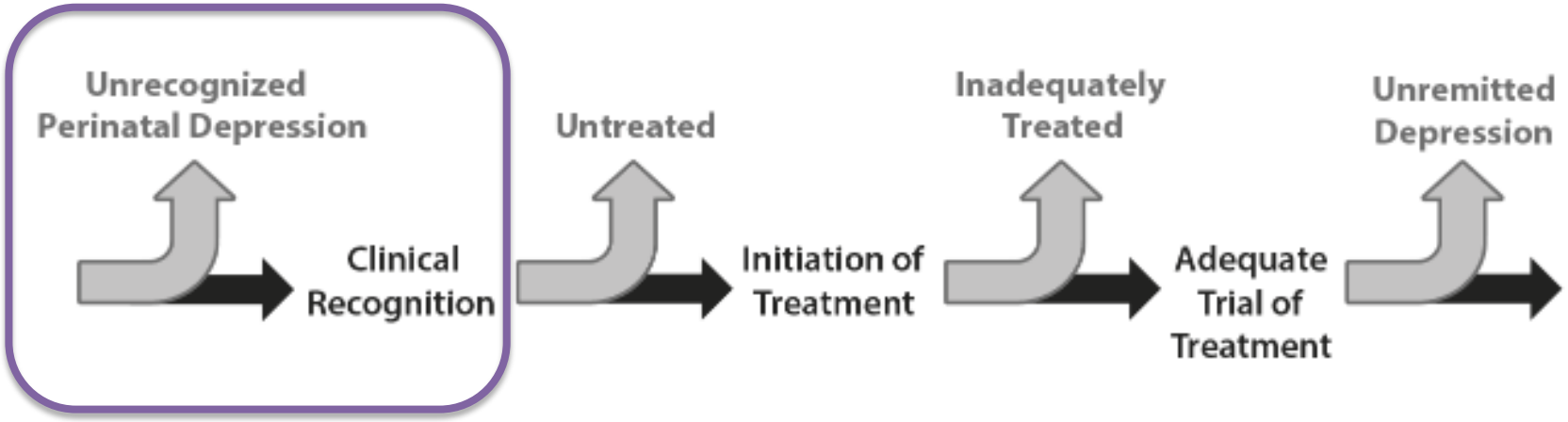
Risks to Infants

Metz TD. Obstet Gynecol 2018

Objectives

- Describe the perinatal depression treatment cascade and contemporary mental health outcomes
- Understand the evidence to support efficacy of perinatal collaborative care
- Review implementation strategies for perinatal collaborative care at MetroHealth

Perinatal Depression Treatment Cascade



Audience Question

What percentage of women with perinatal depression in the US with achieve remission of their symptoms?

A: 3-5%

B: 18-20%

C: 38-40%

D: 53-55%

Clinical Recognition

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG COMMITTEE OPINION

Number 757

(Replaces Committee Opinion No. 630, May 2015)

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetrician

INTERIM UPDATE: This Committee Opinion is updated as highli
language and supporting evidence regarding prevalence, benefi

Screening for Perinatal Depres

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Guidance for the Clinician in Rendering Pediatric Care

Clinical Report—Incorporating Recognition and
artum Depression

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine
High-risk pregnancy experts

Obstetric Care Consensus | #8

smfm.org

Interpregnancy Care

Check for updates

This document is endorsed by the American College of Nurse-Midwives and the National Association of Nurse Practitioners in Women's Health. This document was developed by the American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine in collaboration with Judette Marie Louis, MD, MPH; Allison Bryant, MD, MPH; Diana Ramos, MD, MPH; Alison Stuebe, MD, MSc; and Sean C. Blackwell, MD

Special Communication | USPSTF RECOMMENDATION STATEMENT

Screening for Depression in Adults
US Preventive Services Task Force Recommendation Statement

OBSTETRICS & GYNECOLOGY

Perinatal Obstetric Office Depression Screening and Treatment: Implementation in a Health Care System

Tracy Flanagan, MD[a] and **Lyndsay A. Avalos, PhD, MPH**[b]

[a]The Permanente Medical Group, Regional Offices, Kaiser Permanente Northern California, Oakland, California

[b]Division of Research, Kaiser Permanente Northern California, Oakland, California

- Identification of a site physician lead
- Formation of a Task Force for planning/oversight
- Collaboration with Behavioral Health/Psychiatry
- Screening incorporated into prenatal office workflow
- Education of clinicians about perinatal depression
- Staff orientation to workflow processes

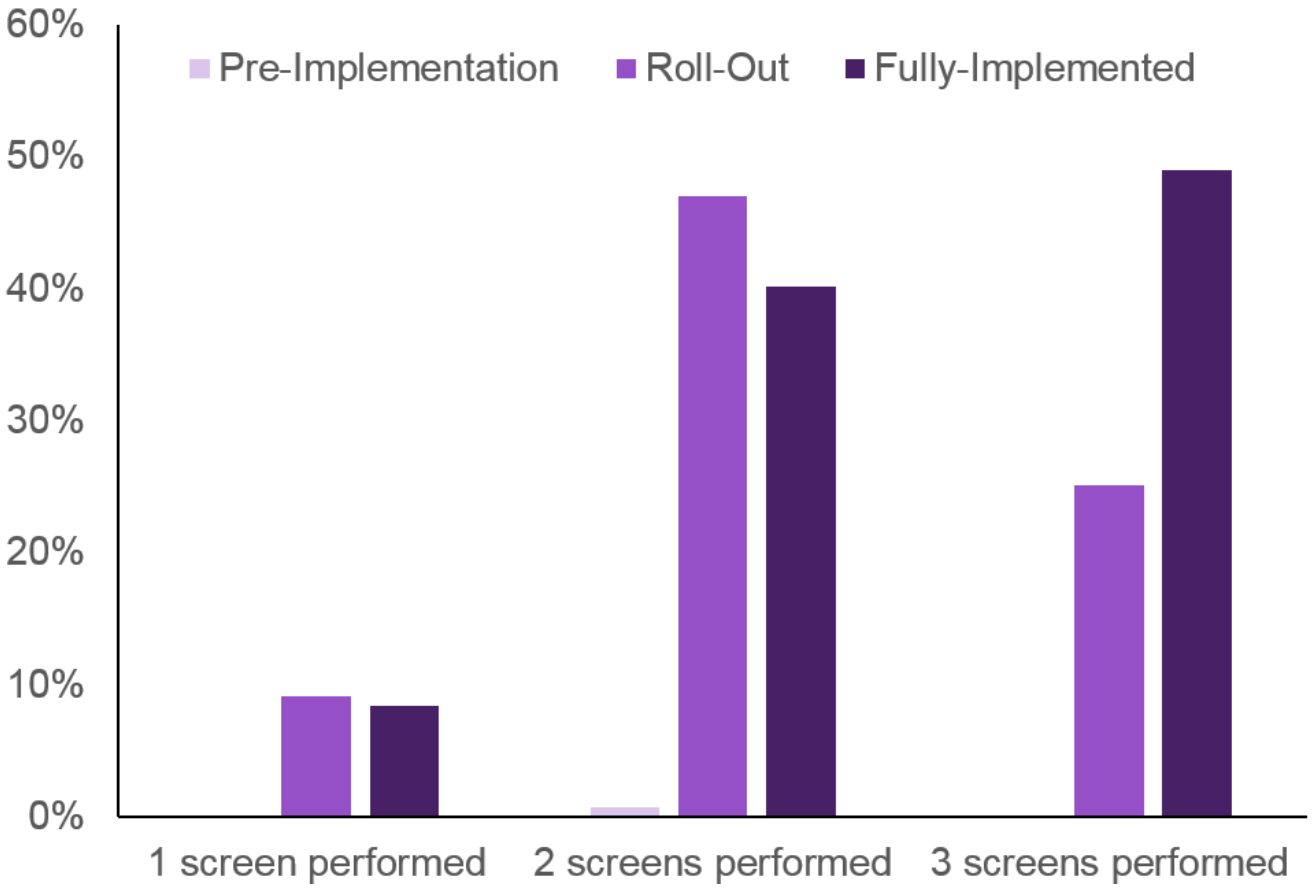
OBSTETRICS & GYNECOLOGY

Improved Perinatal Depression Screening, Treatment, and Outcomes With a Universal Obstetric Program

Lyndsay A. Avalos, PhD, MPH[a], Tina Raine-Bennett, MD, MPH[a], Hong Chen, MPH[a], Alyce S. Adams, PhD[a], and Tracy Flanagan, MD[b]

[a]Division of Research, Kaiser Permanente Northern California, Oakland, California

[b]The Permanente Medical Group, Regional Offices, Kaiser Permanente Northern California, Oakland, California

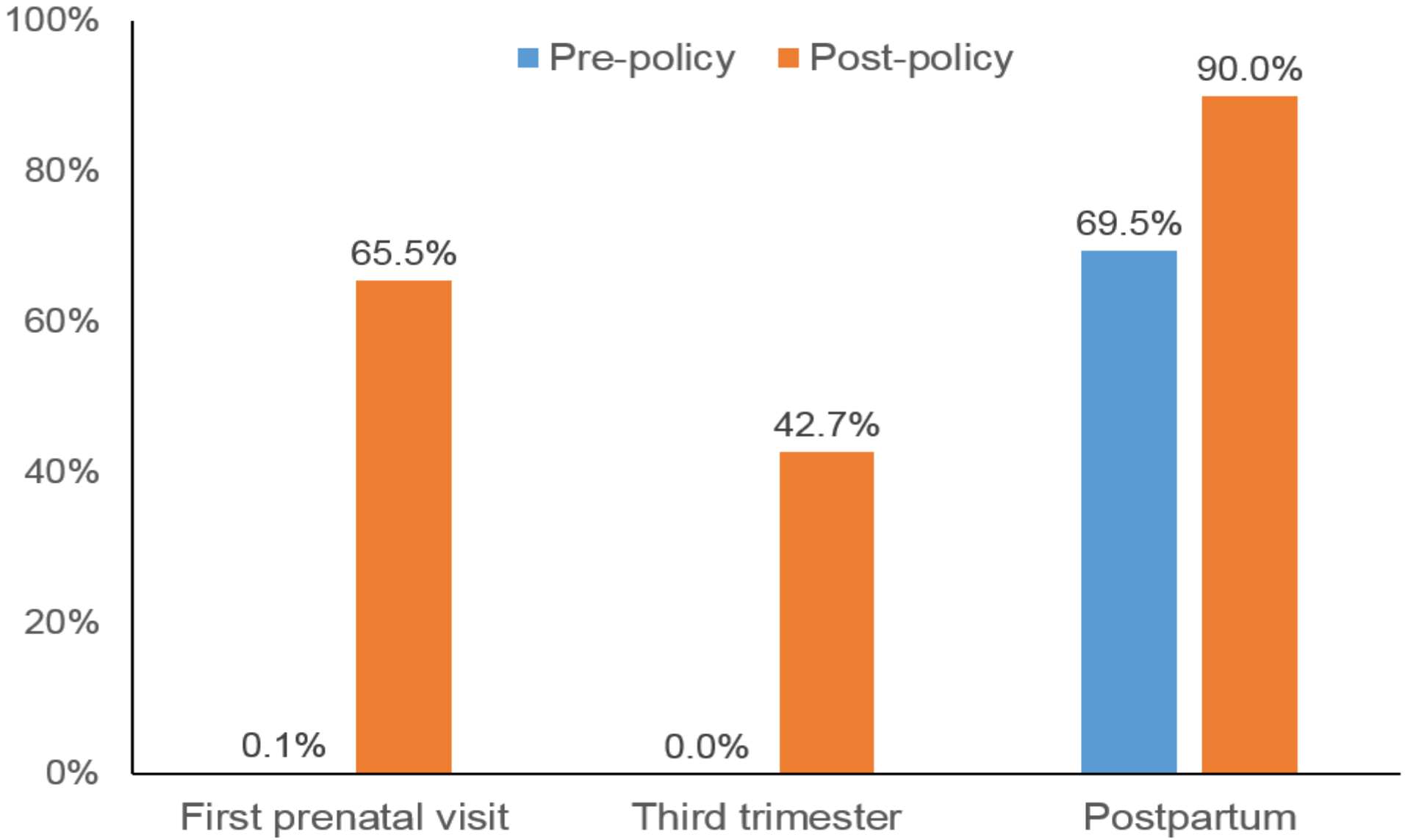


Prentice: Clinical Recognition

- Perinatal Mental Health Disorders Prevention and Treatment Act (405 ILCS 95/1)

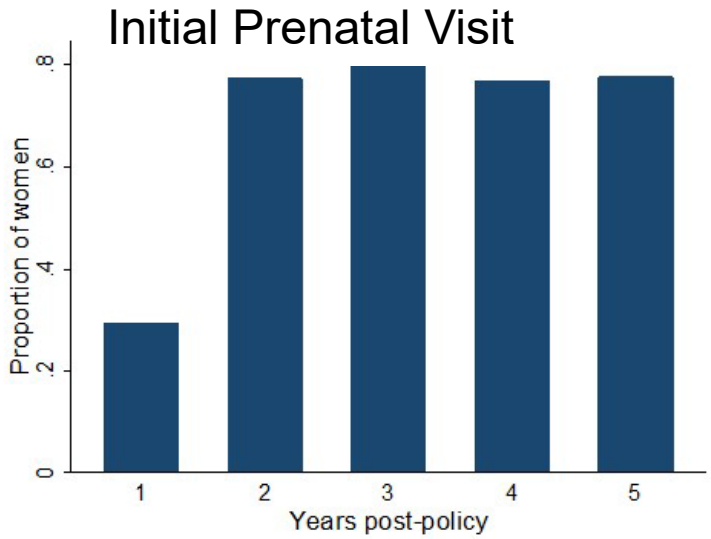
- Prentice screening recommendations:
  - First prenatal visit
  - 3rd trimester
  - Postpartum

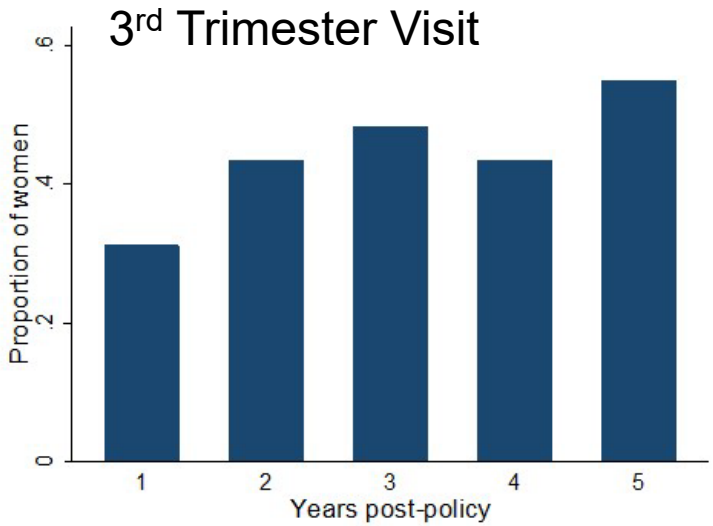
Prentice: Clinical Recognition

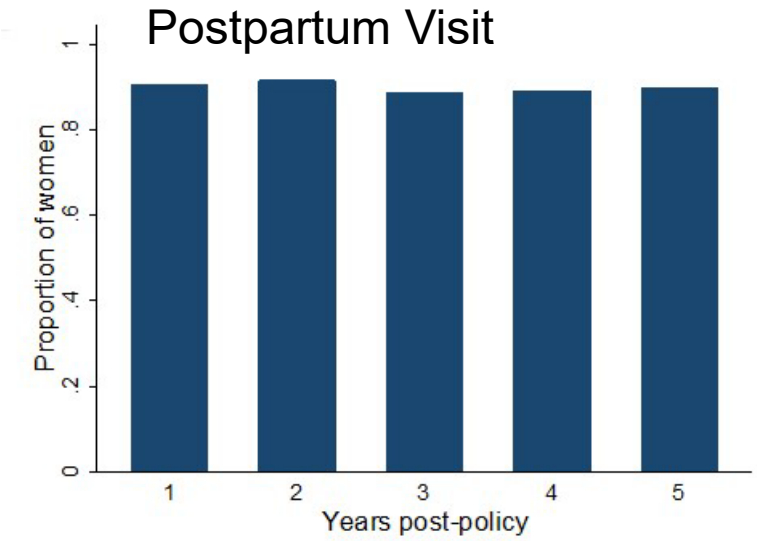


Miller ES et al, AJOG 2018

Prentice: Clinical Recognition

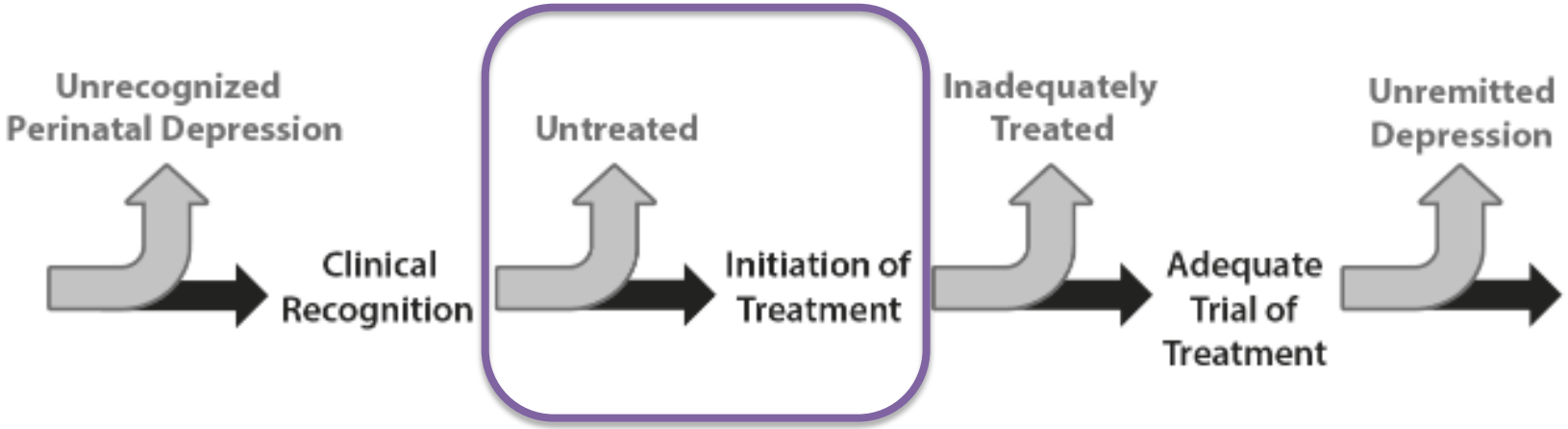






Miller ES et al, AJOG 2018

Perinatal Depression Treatment Cascade



OBSTETRICS & GYNECOLOGY

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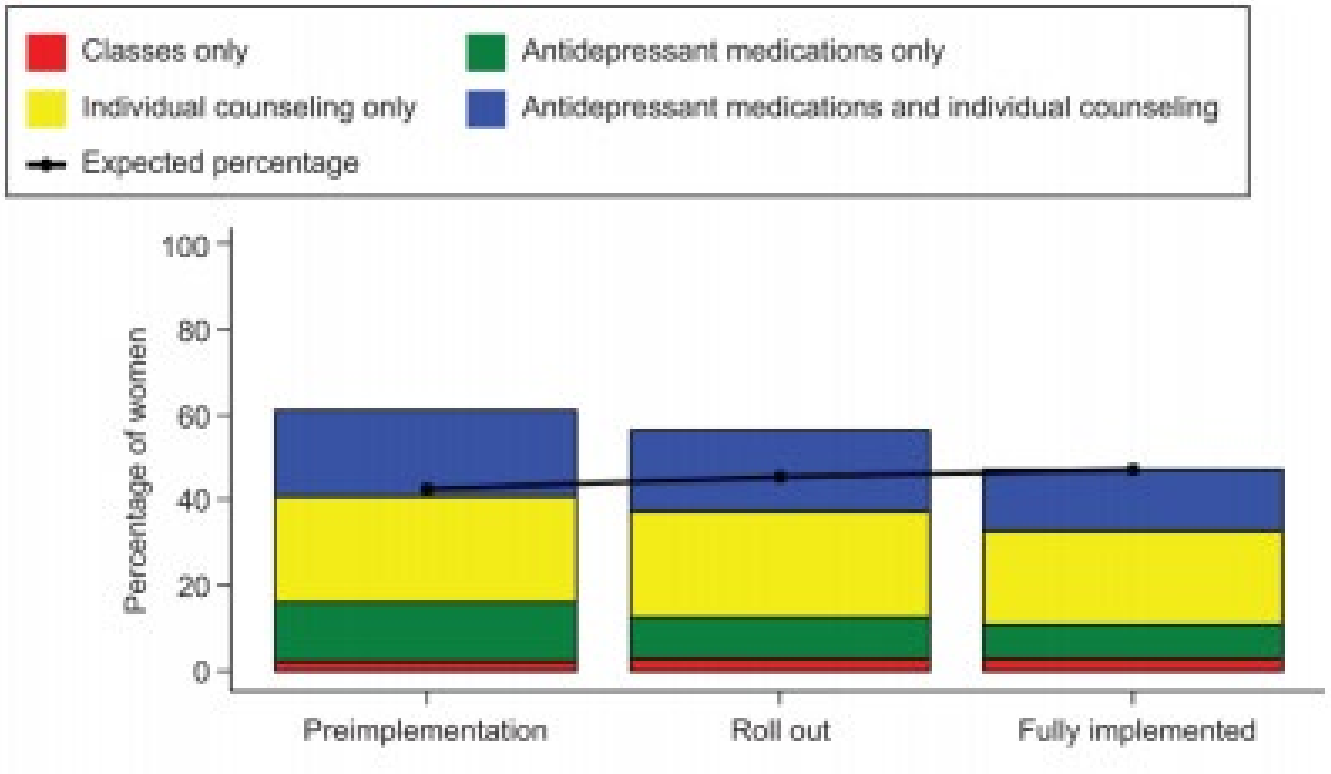
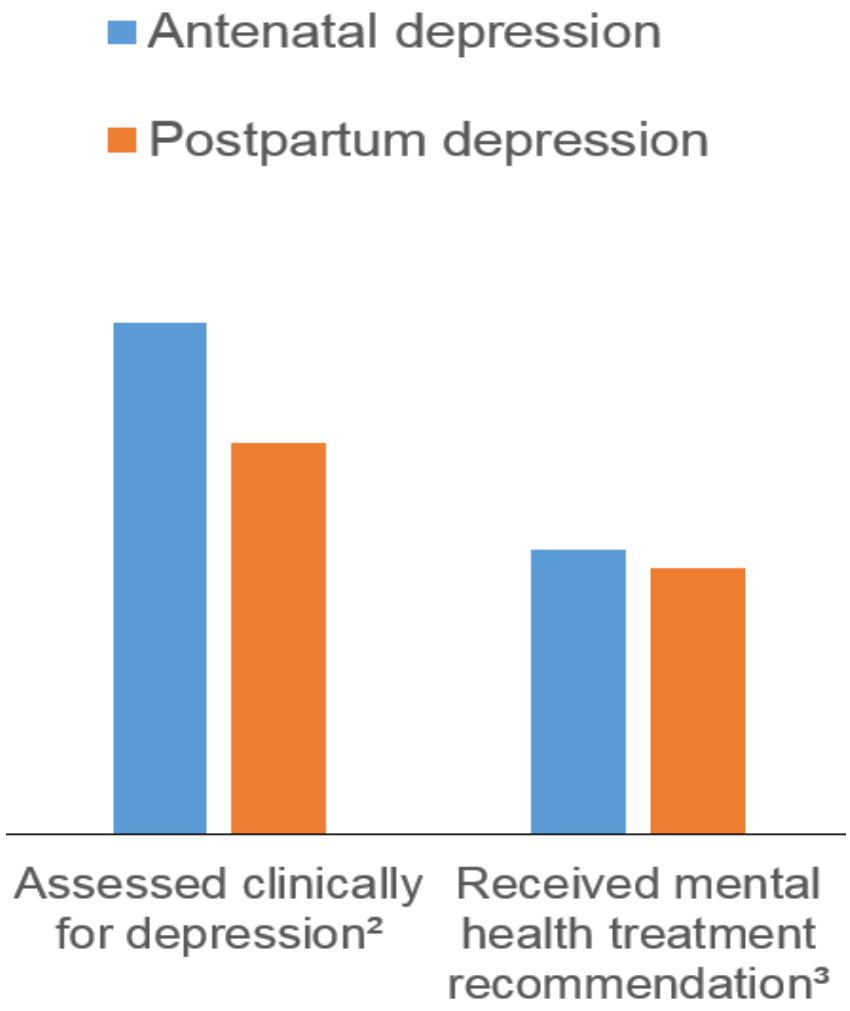
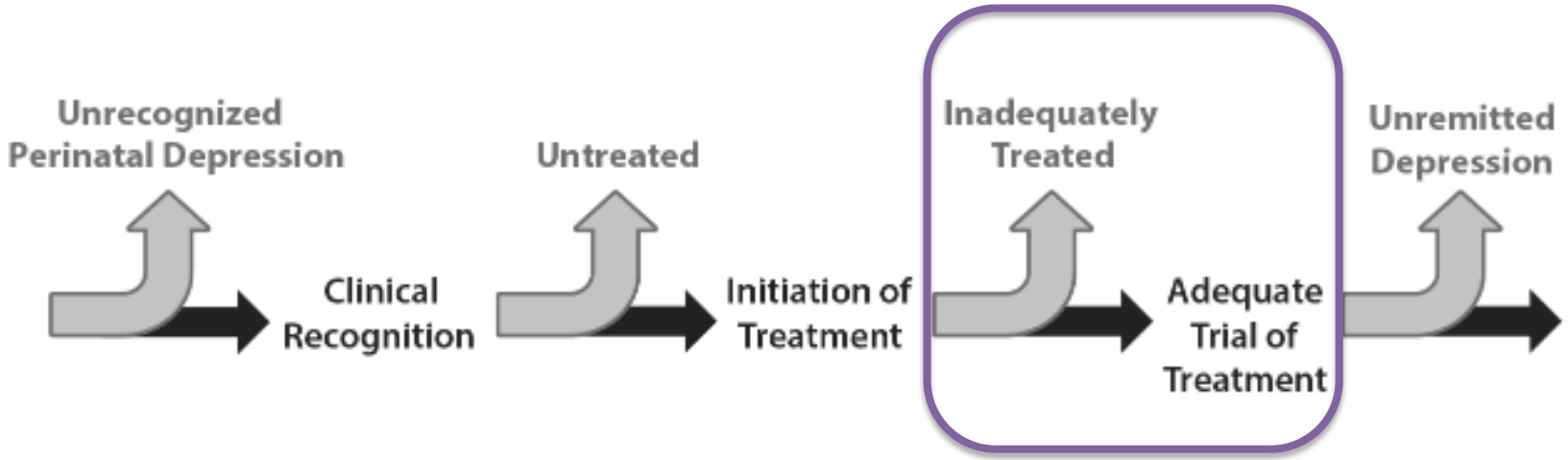


Prentice: Initiation of Treatment



Miller ES et al, AJOG 2018

Perinatal Depression Treatment Cascade

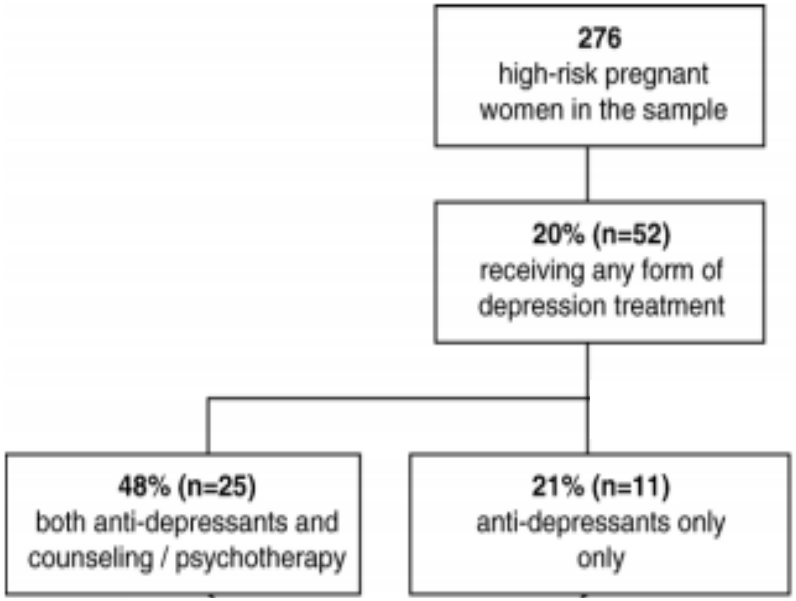


Rates and predictors of depression treatment among pregnant women in hospital-affiliated obstetrics practices

Heather A. Flynn, Ph.D.[a,*], Frederic C. Blow, Ph.D.[a,b], Sheila M. Marcus, M.D.[a]

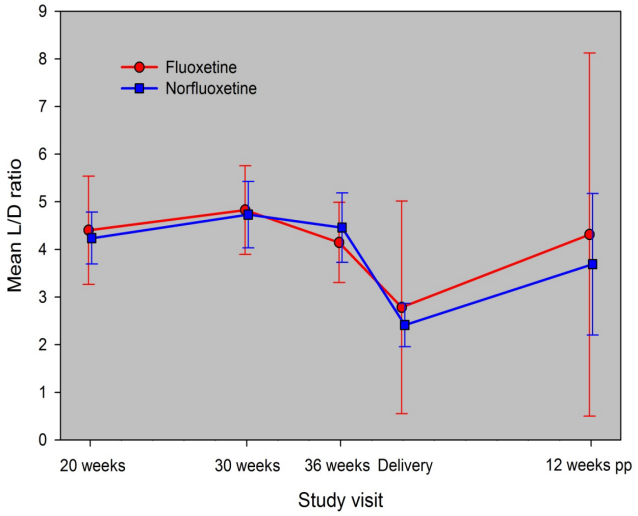
[a]University of Michigan Medical School, Ann Arbor, MI 48105, USA

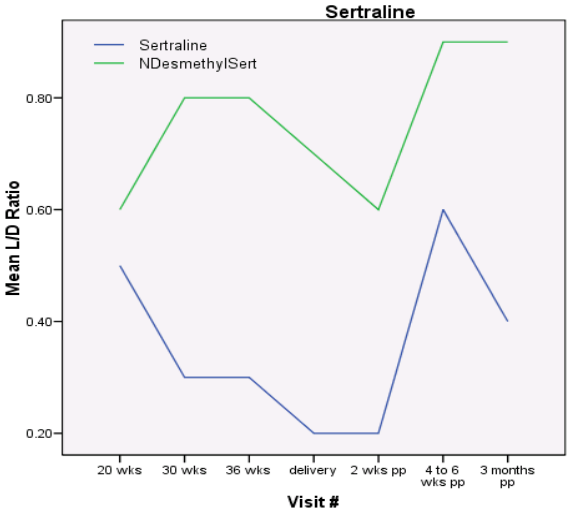
[b]Serious Mental Illness Treatment Research and Evaluation Center (SMITREC), Health Services Research and Development (HSR&D), Department of Veterans Affairs Medical Center, Ann Arbor, MI 48105, USA

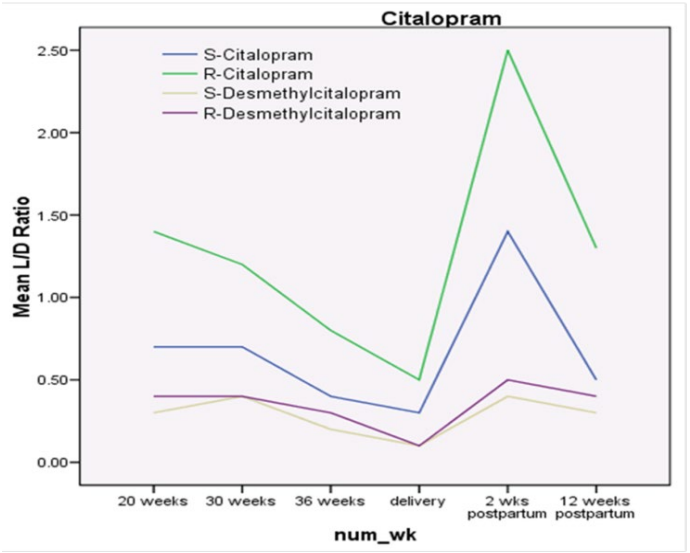


Adequate anti-depressant use: Receiving at least 6 weeks of daily use of antidepressants at the recommended starting dose or more

Adequate Trial of Treatment







Sit DK et al, J Clin Psych 2008
Sit DK et al, J Clin Psychopharmacol 2010

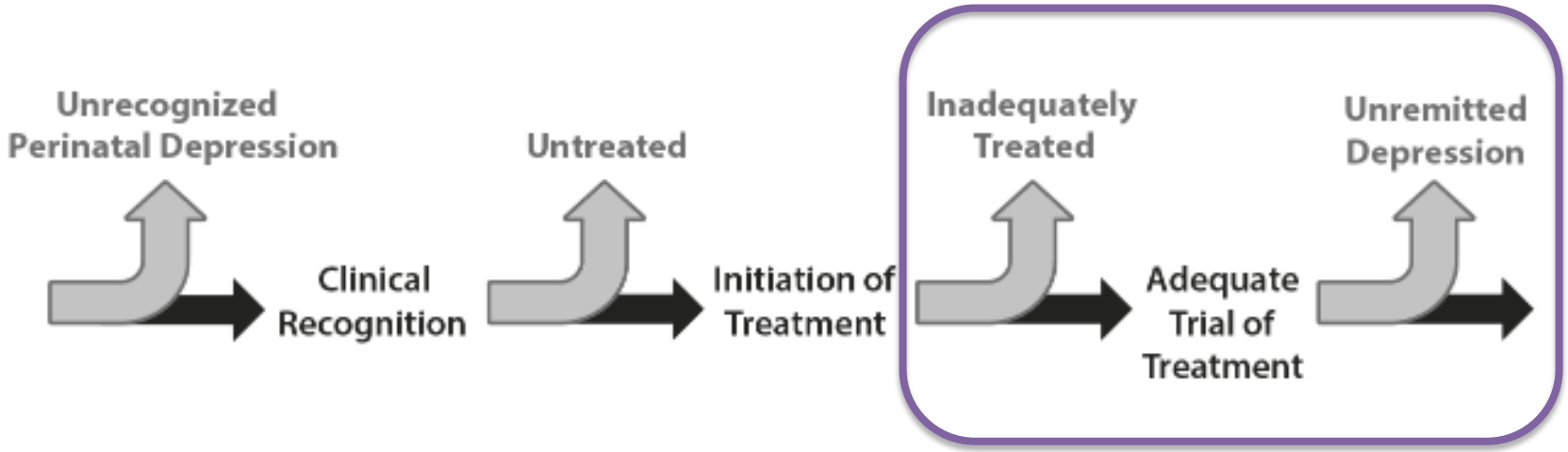
Adequate Trial of Treatment

SERTRALINE mg/day, N=24
% **remitted**

<100mg	100mg	125-150mg	200mg
1 (4%)	12 (50%)	4 (17%)	7 (29%)

Wisner KL et al, J Clin Psychopharm 2006

Perinatal Depression Treatment Cascade

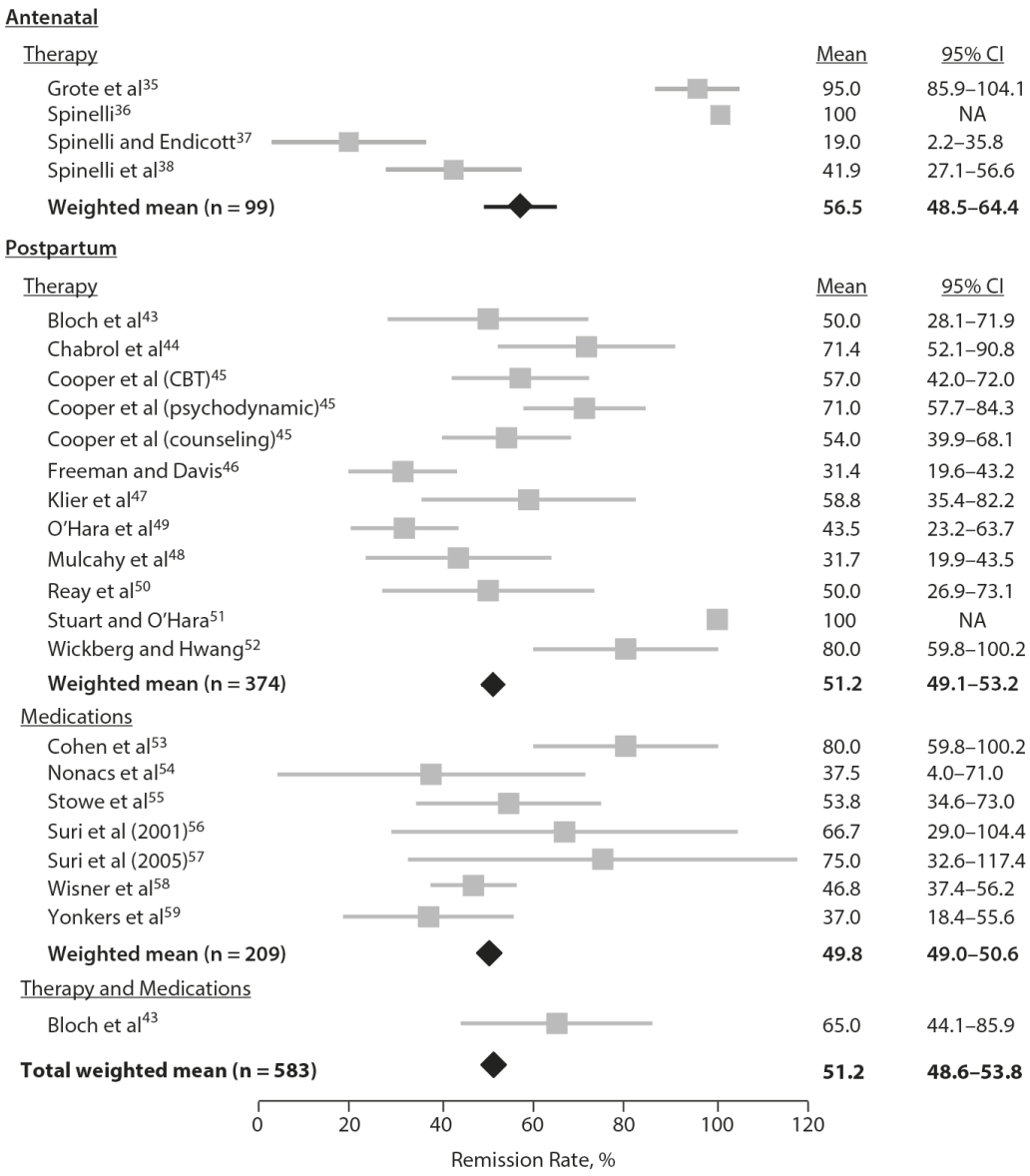


The Perinatal Depression Treatment Cascade:
Baby Steps Toward Improving Outcomes

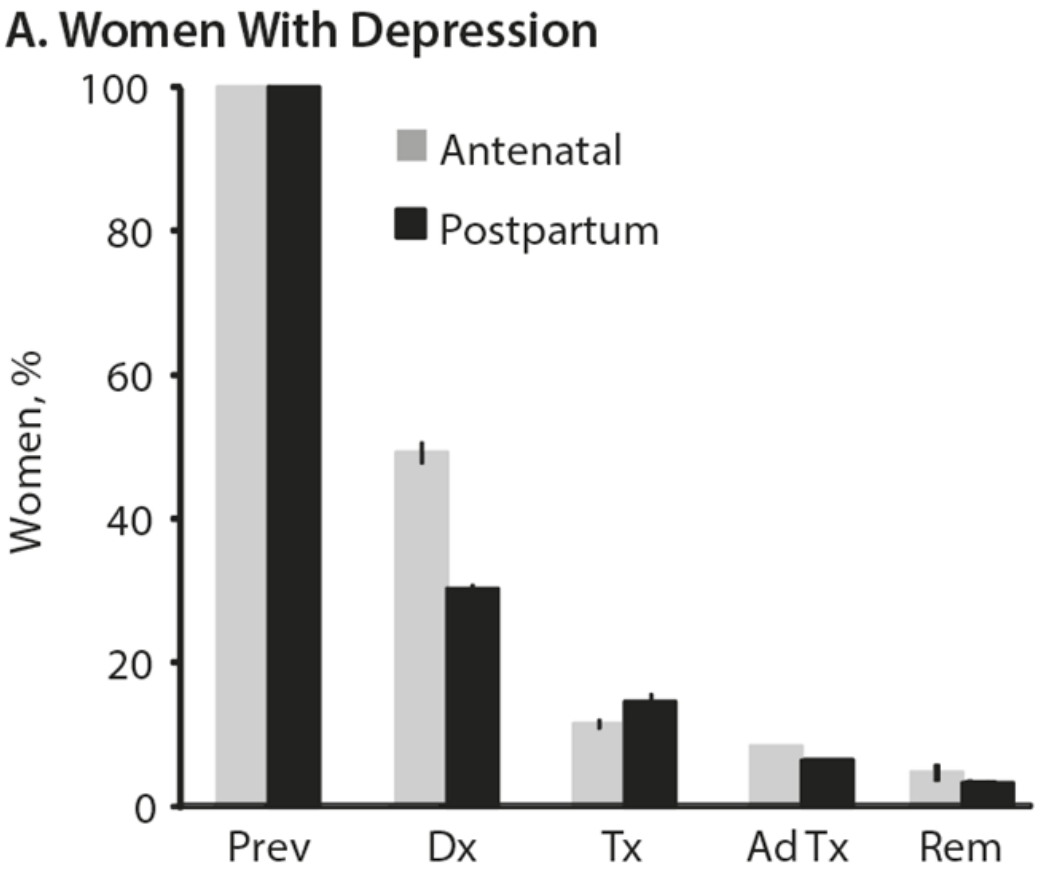
Elizabeth Q. Cox, MD[a,*]; Nathaniel A. Sowa, MD, PhD[a]; Samantha E. Meltzer-Brody, MD, MPH[a]; and Bradley N. Gaynes, MD, MPH[a]

THE JOURNAL OF CLINICAL PSYCHIATRY

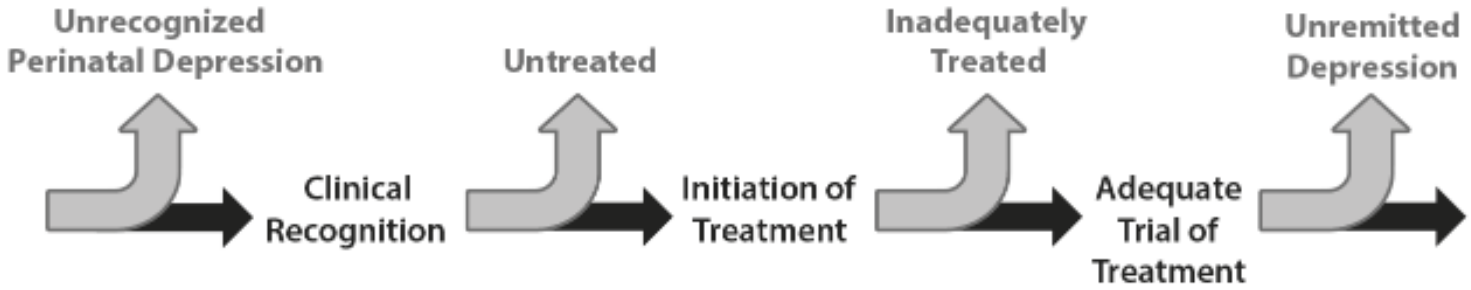
Figure 4. Analysis of Studies of Perinatal Depression Remission



Abbreviations: CBT = cognitive-behavioral therapy, CI = confidence interval, NA = not applicable.



Abbreviations: Ad Tx = adequate trial of treatment, Dx = diagnosis, Prev = prevalence, Rem = remission, Tx = treatment



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Collaborative Care
Mental Health
Obstetric Care
Social Services

Degrees of Integration

- Co-exist
- Most Common

- Consult
- Helpful

- Co-location
- Better

- Collaborate
- IDEAL

"*None of us is smart as all of us*"

Core Principles of Collaborative Care

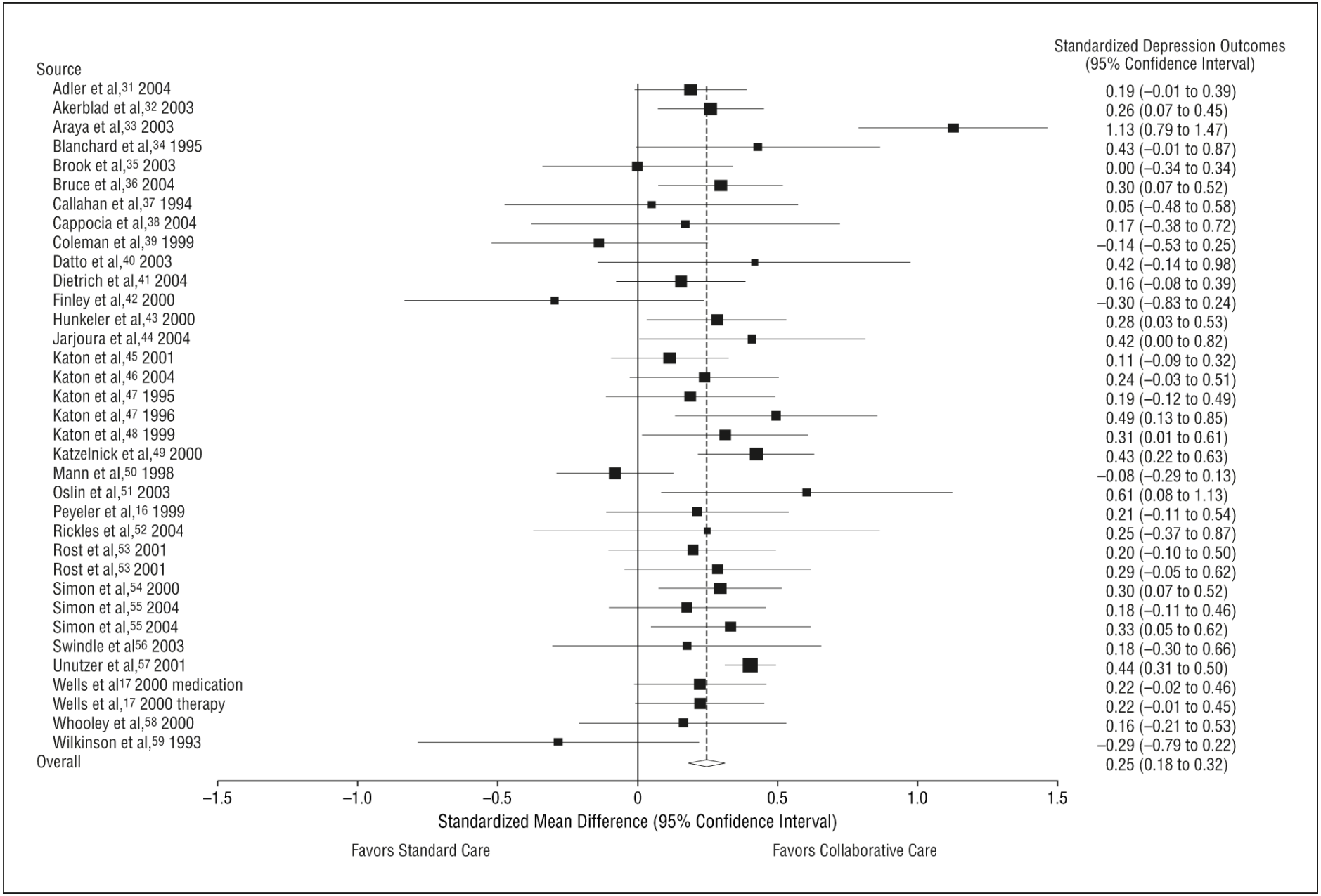
- Patient centered team care

- Population-based care

- Measurement-based treatment to target

- Evidence-based care

- Accountable care



Gilbody S et al, JAMA Internal Medicine 2006
Archer J et al, Cochrane Database Syst Rev 2012

What about Perinatal Collaborative Care?

Primary Care

- Longitudinal relationship with clinician
- Depression more often seen as within scope of clinician
- Care focused on individual patient
- Multiple visits
- Lower prevalence rates

Perinatal Care

- Multiple care transitions
- More specifically defined scope of care
- Competing demands of patient + fetus/child
- Postpartum care = one clinician visit
- Higher prevalence rates

Official Publication of the Anxiety Disorders Association of America
Depression AND Anxiety

COLLABORATIVE CARE FOR PERINATAL DEPRESSION IN SOCIOECONOMICALLY DISADVANTAGED WOMEN: A RANDOMIZED TRIAL

Nancy K. Grote, Ph.D.,[1]* Wayne J. Katon, MD,[2] Joan E. Russo, Ph.D.,[2] Mary Jane Lohr, MS,[1]
Mary Curran, MSW,[1] Erin Galvin, MSW,[1] and Kathy Carson, B.S.N[3]

MOMCare + MSS-Plus
N=83

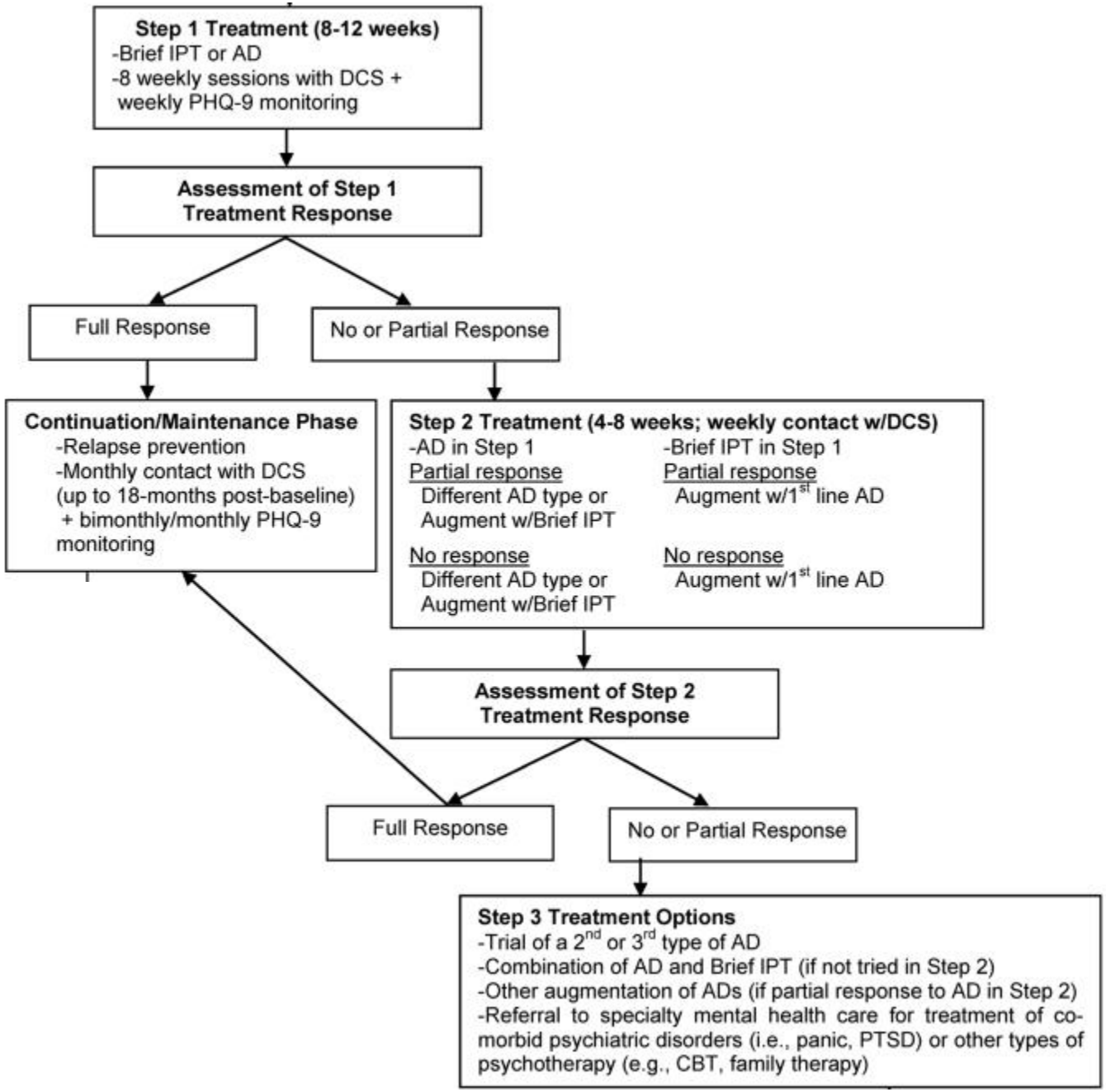
MSS-Plus
N=81

Educational depression materials
Case management
Notification of MSS social worker or OB provider

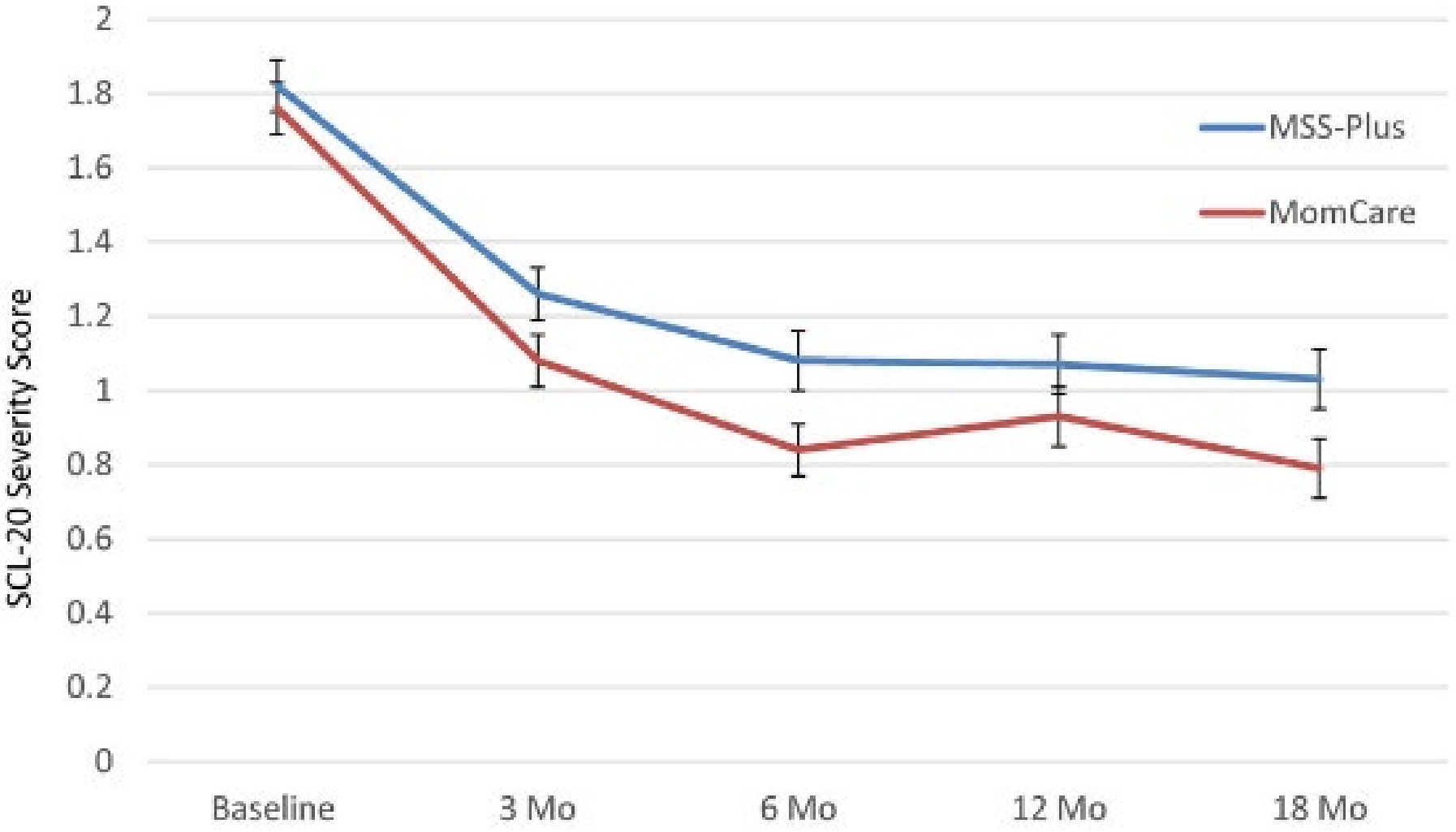
Pre-treatment engagement session
IPT or antidepressant
Collaboration with OB provider
Stepped care

Referral for depression care

Masked outcome assessments:
3, 6, 12, 18 months post-baseline



Grote NK et al, Depress Anxiety 2015



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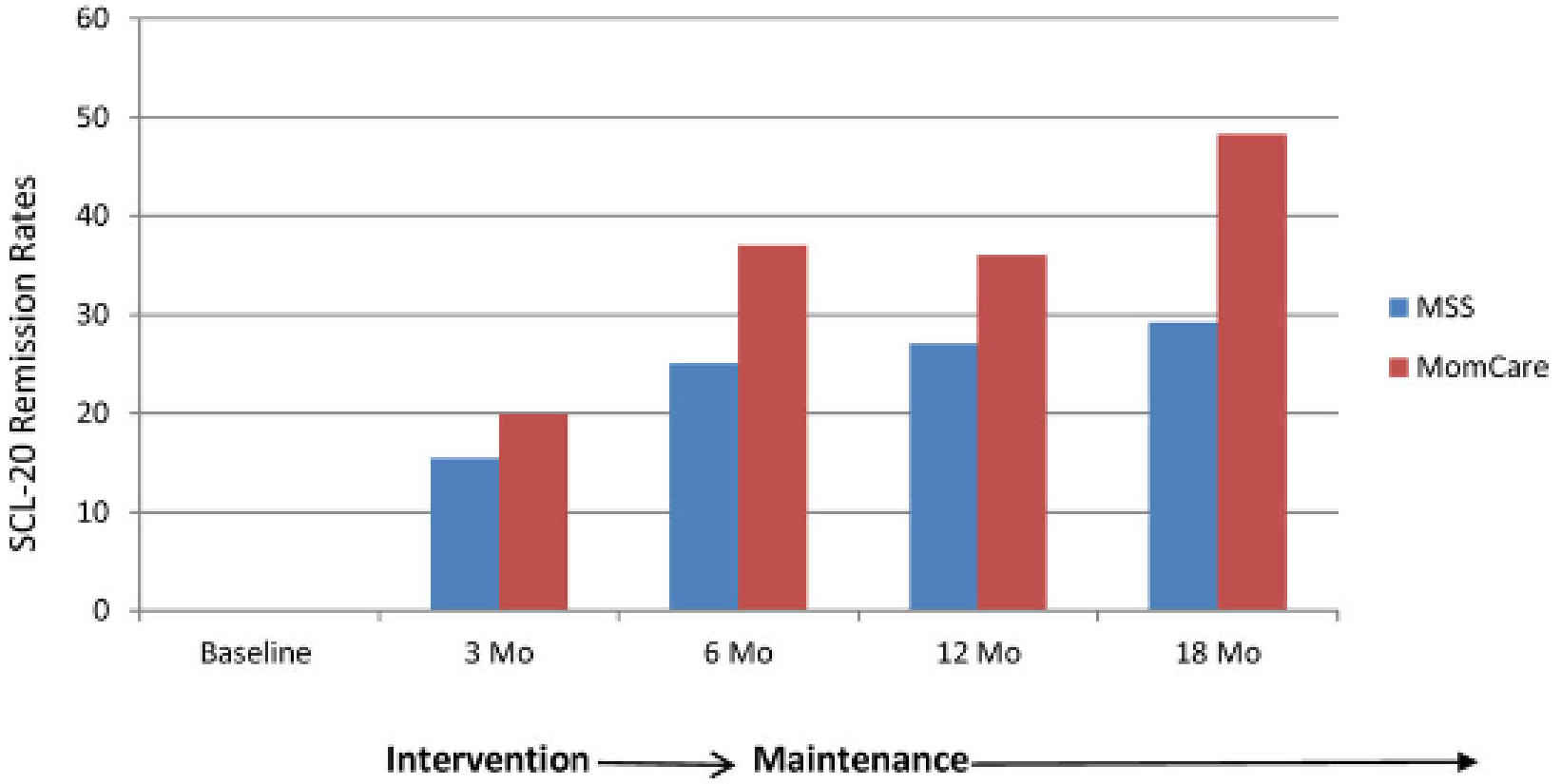


Grote NK et al, Depress Anxiety 2015

OBSTETRICS & GYNECOLOGY

Improving Care for Depression in Obstetrics and Gynecology: A Randomized Controlled Trial

Jennifer L. Melville, MD, MPH[1], Susan D. Reed, MD, MPH[2], Joan Russo, PhD[3], Carmen A. Croicu, MD[3,4], Evette Ludman, PhD[5], Anna LaRocco-Cockburn, MSW, MPH[3], and Wayne Katon, MD[3]

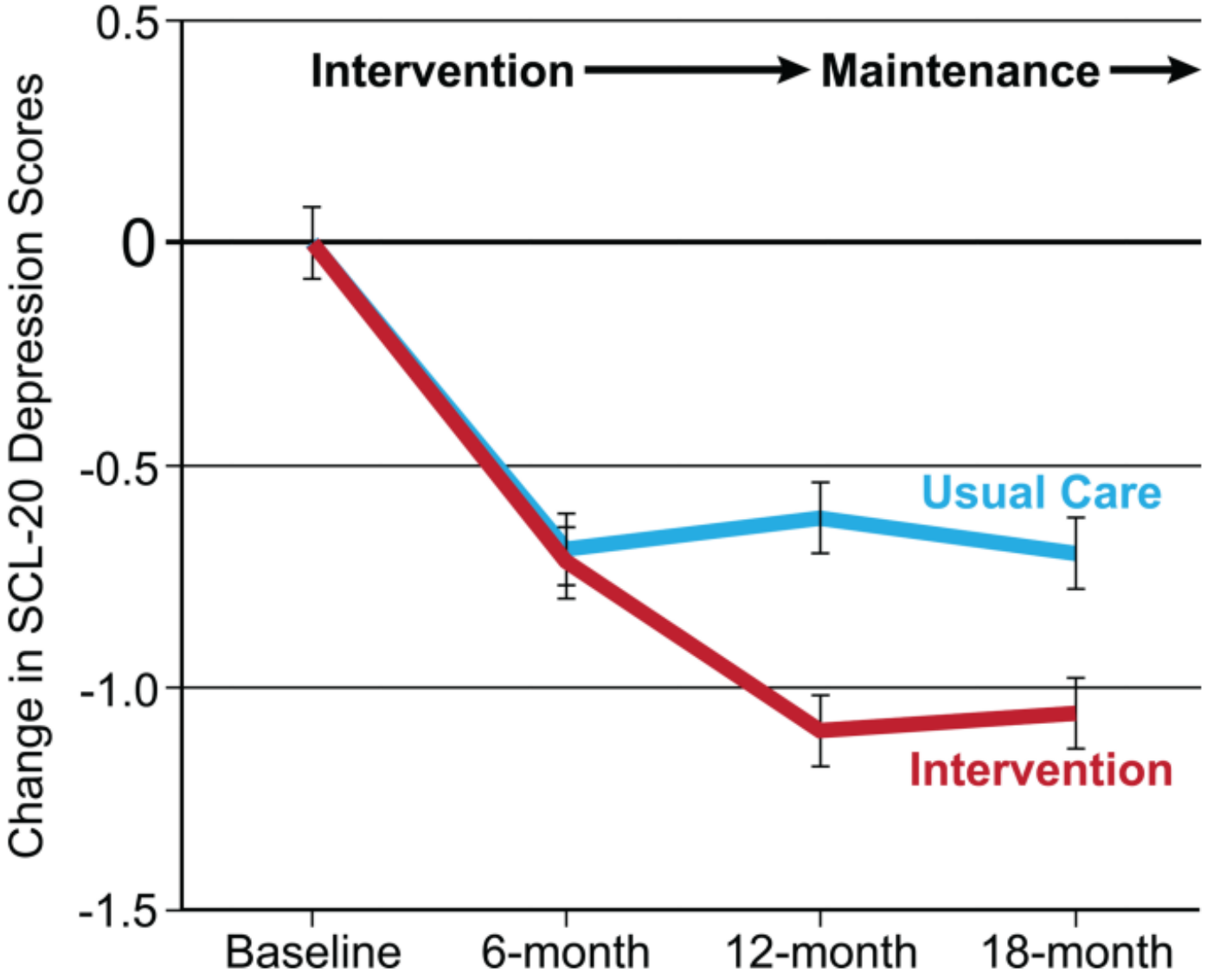
12 months of Collaborative Care Depression Management
N=102

- Collaborative care
  - -Initial engagement session
  - -Proactive outreach for missed sessions
  - -Depression care managers
  - -Multi-disciplinary weekly meetings

Treatment as Usual
N=103

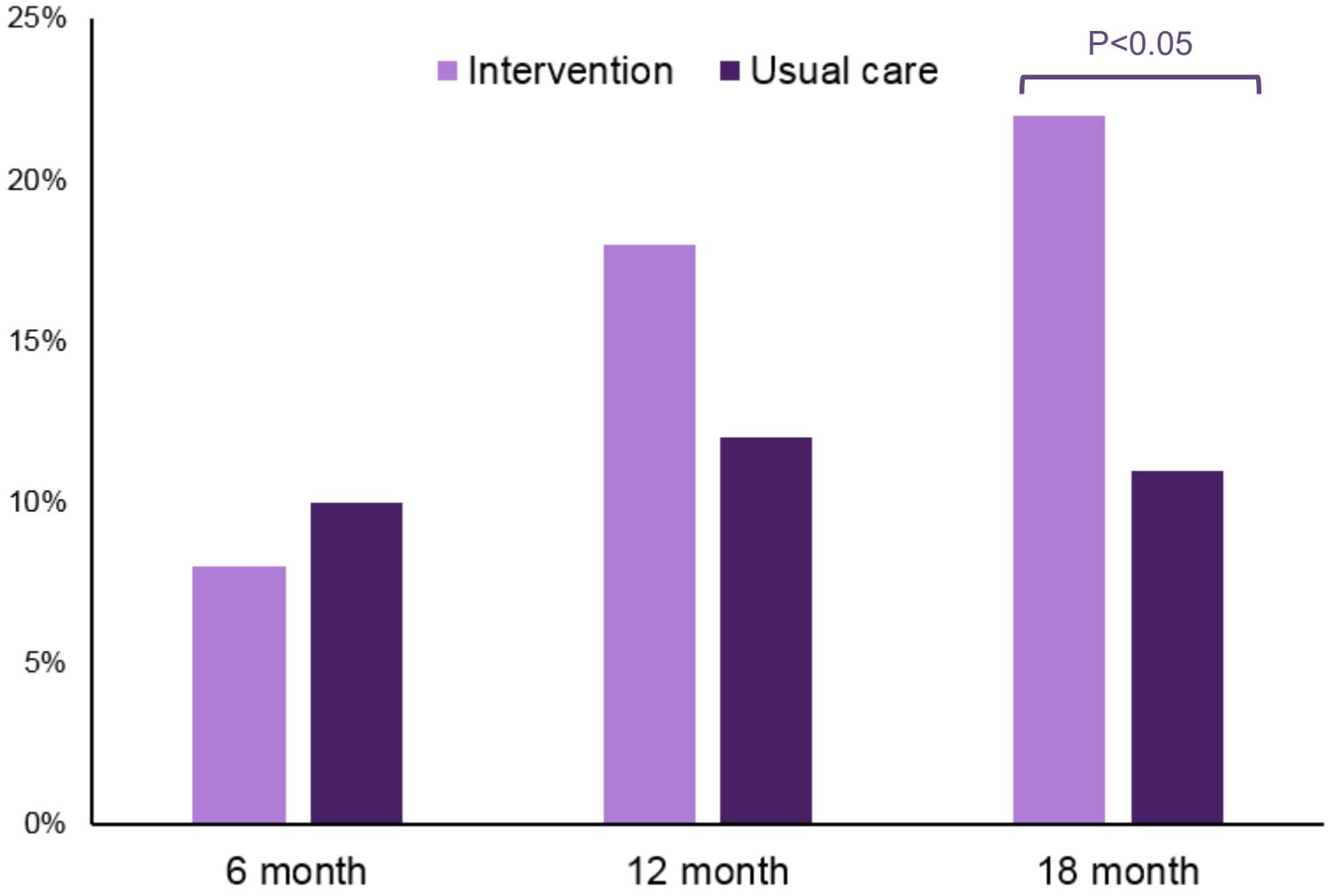
- Educational depression materials
- Informed of diagnosis
- Depression education booklet
- Referral to community
- OB provider notified

Masked outcome assessments:
6, 12, 18 months post-baseline



Melville JL et al, Obstetrics & Gynecology 2014

Complete remission of depression symptoms (SCL-20 < 0.5)



Melville JL et al, Obstetrics & Gynecology 2014

Gaps in Evidence

- Somatic benefits
  - Reduction in adverse pregnancy outcomes

- Implementation
  - Efficacy vs effectiveness
  - Guidelines for implementation

Somatic Benefits

Table 5: Meta-analysis of associations between depression and incident somatic disease

Incident event	Reference	Studies included	Subjects included	Pooled risk (95% CI)	Maternal Health Corollary
Heart disease	Nicholson et al	21	124,509	1.81 (1.53 to 2.15)	Preeclampsia
Hypertension	Meng et al	9	22,367	1.42 (1.09 to 1.86)	
Diabetes	Mezuk et al	13	212,019	1.60 (1.37 to 1.88)	Gestational diabetes
Obesity	Luppino et al	9	6,436	1.58 (1.33 to 1.81)	Gestational weight gain

Unutzer J et al. JAMA 2002
Katon WJ et al. Arch Gen Psychiatry 2004
McGregor M et al. J Ambul Care Manage 2011

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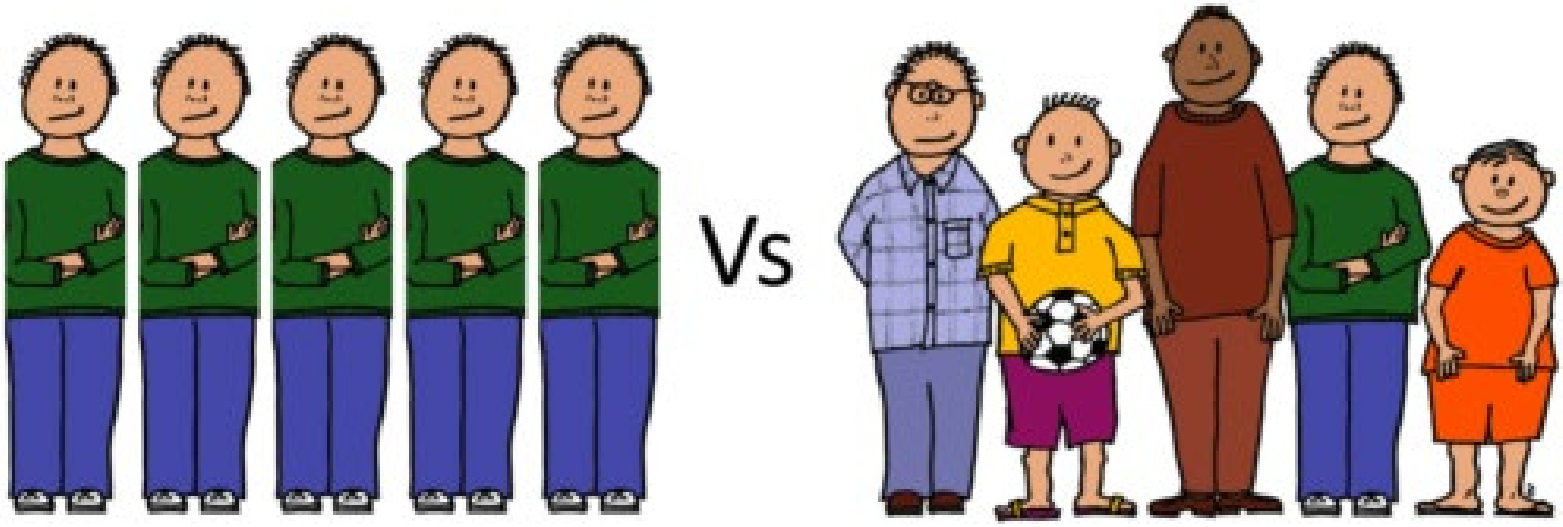


Solberg LI et al, Implementation Science 2013
Solberg LI et al, Ann Fam Med 2015

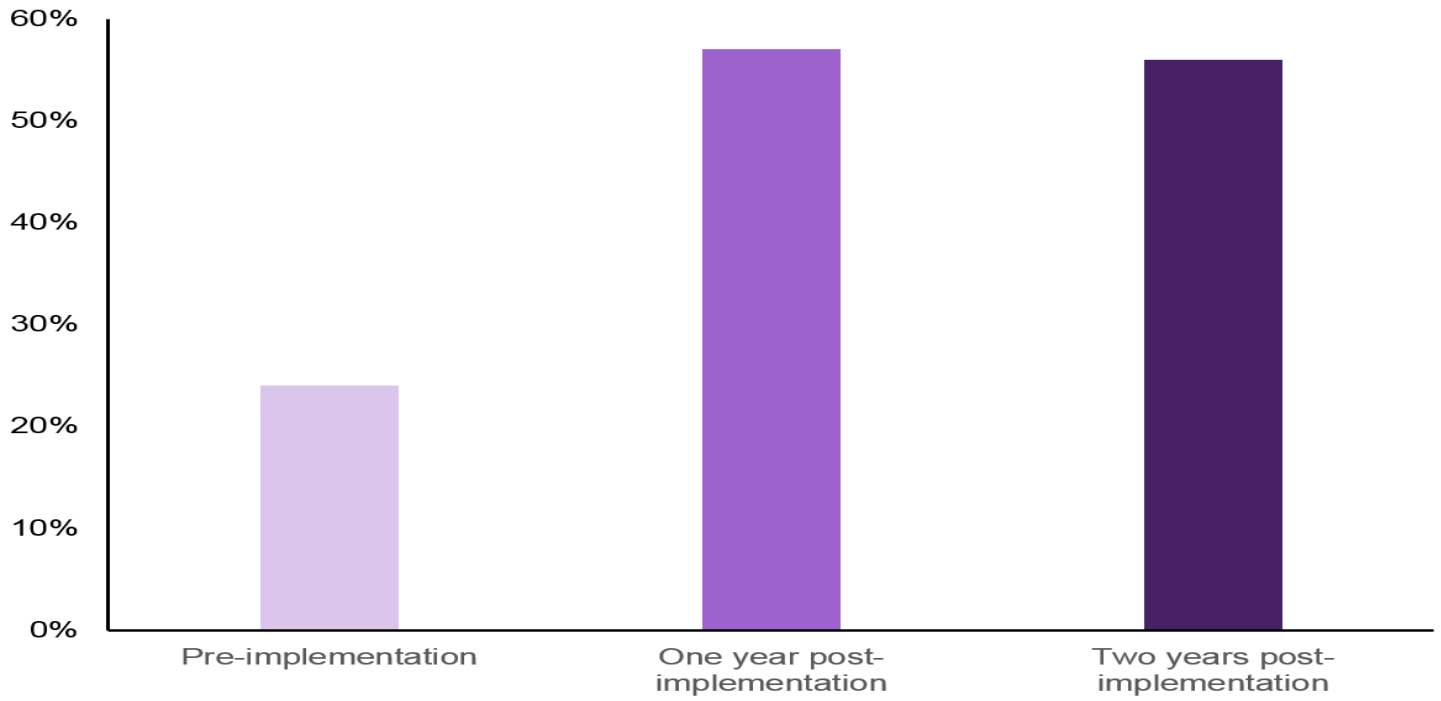
IMPLEMENTATION SCIENCE

The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics

Leif I Solberg[1*], A Lauren Crain[1], Nancy Jaeckels[2], Kris A Ohnsorg[1], Karen L Margolis[1], Arne Beck[3], Robin R Whitebird[1], Rebecca C Rossom[1], Benjamin F Crabtree[4] and Andrew H Van de Ven[5]

1. Consistent use of a standardized tool for assessing and monitoring depression severity
2. Systematic patient tracking (registry)
3. Treatment intensification for those not improving
4. Relapse prevention
5. A care manager to educate, monitor, and coordinate care
6. Weekly psychiatric caseload review
7. Monthly report of overall performance measures from each clinic

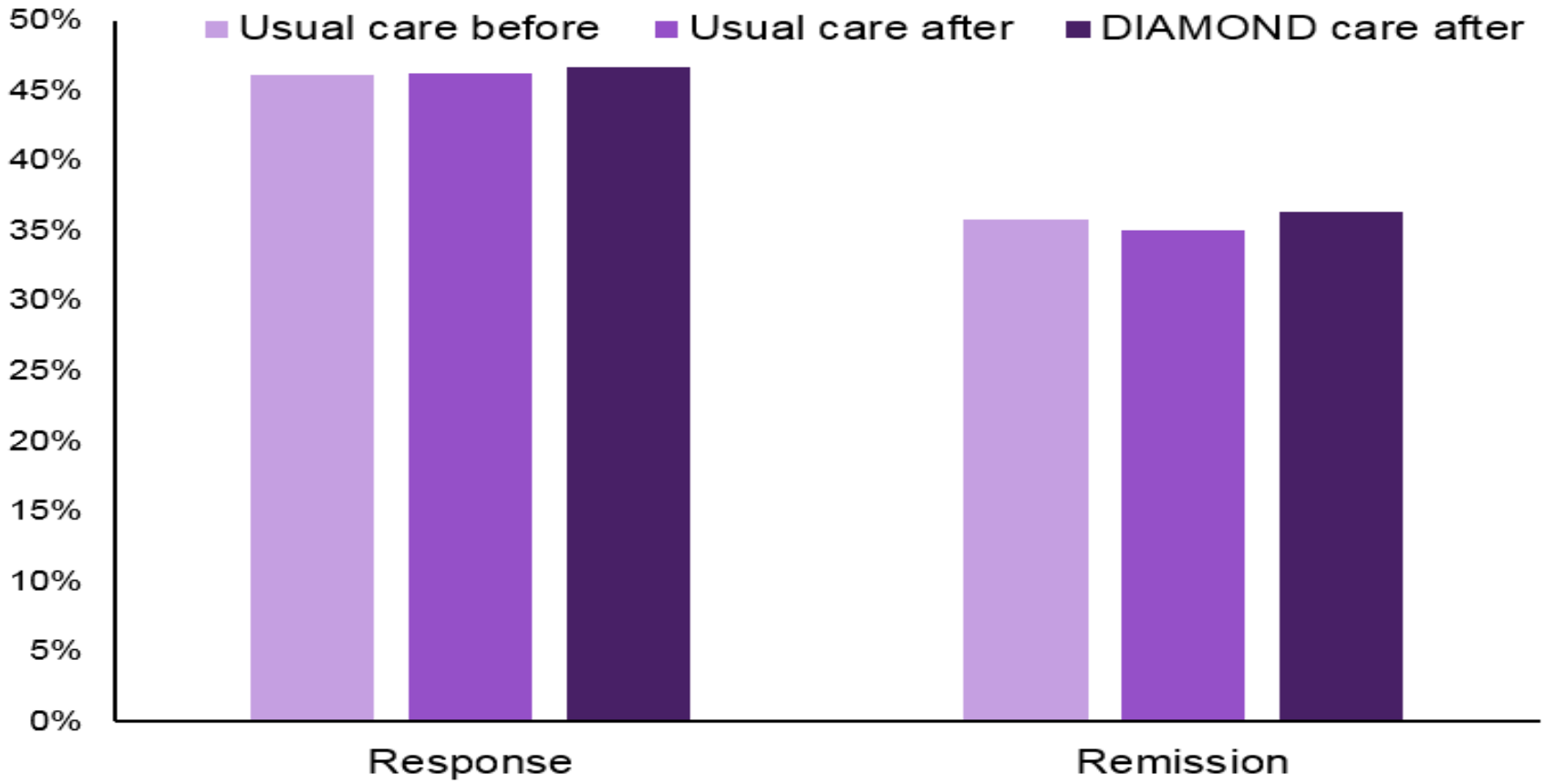
Adherence to Collaborative Care Principles



- 18 clinics demonstrated no or minimal change
- 12 clinics ultimately dropped out of the program

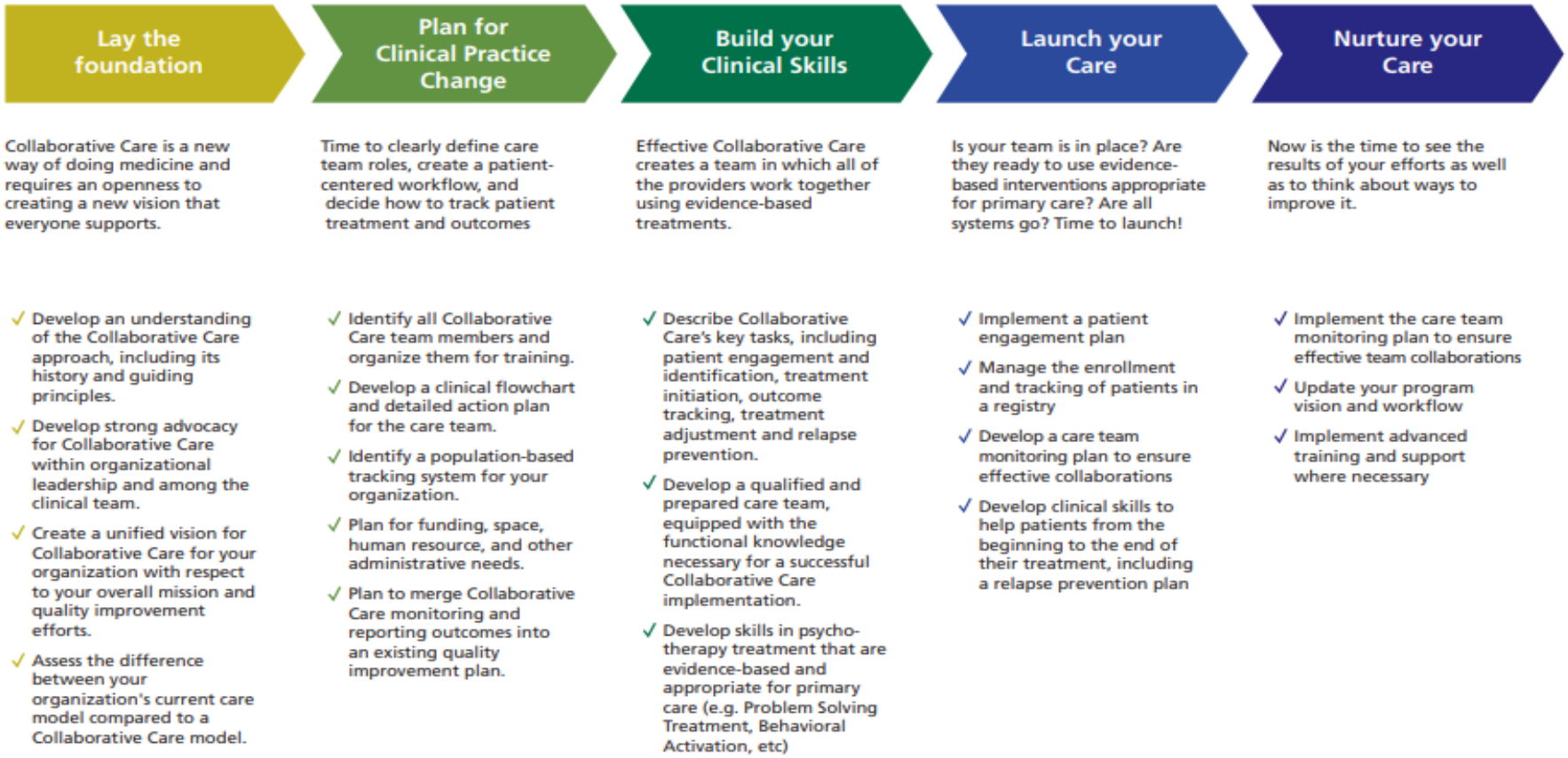
Solberg LI et al, Implementation Science 2013

A Stepped-Wedge Evaluation of an Initiative to Spread the Collaborative Care Model for Depression in Primary Care



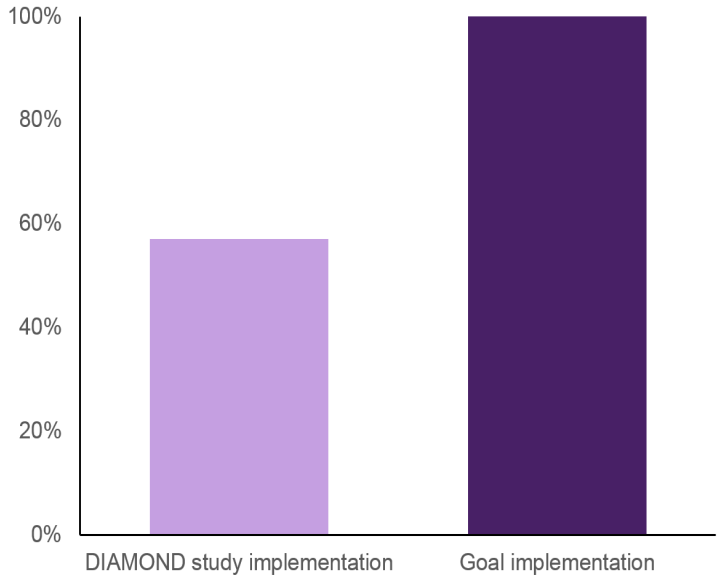
Solberg LI et al, Ann Fam Med 2015

Guidelines on Implementation



AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Guidelines on Implementation

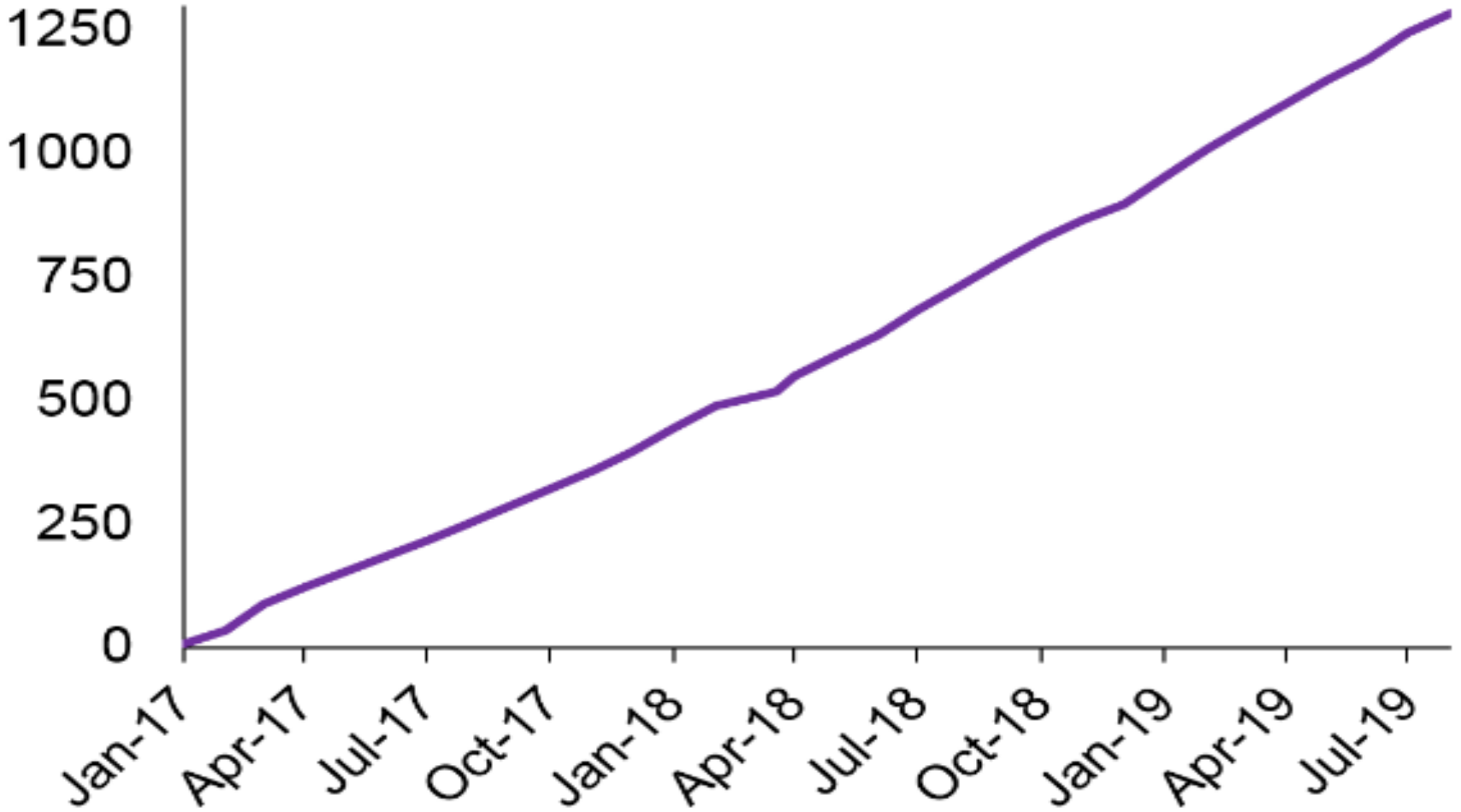


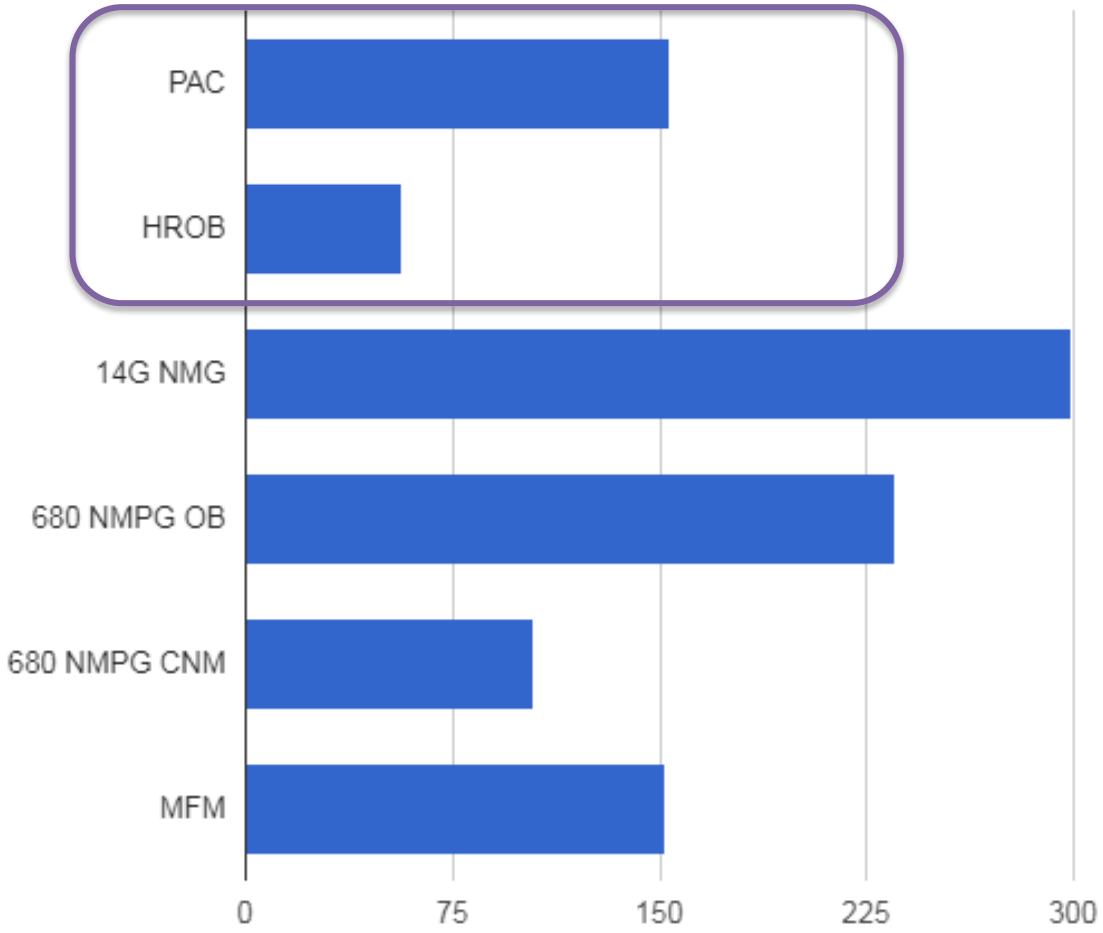
- Health disparities implications
  - Clinics with a lower proportion of commercially insured patients were more likely to drop out of the DIAMOND study
- Implementation within perinatal care

A Collaborative Care Model for Perinatal Depression Support Services (COMPASS)

FRIENDS OF Prentice
NORTHWESTERN MEMORIAL HOSPITAL

COMPASS Referrals




PAC
HROB
14G NMG
680 NMPG OB
680 NMPG CNM
MFM
0
75
150
225
300

Core Principles of Collaborative Care

- Patient centered team care

- Population-based care

- Measurement-based treatment to target

- Evidence-based care

- Accountable care

Core Principles of Collaborative Care

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Depression Screening Algorithm for Obstetric Providers

COMPASS

The PHQ-9 should be administered during:

→ Initial intake or first obstetric visit
→ Visit in 3rd trimester
→ If high-risk* patient, 2 weeks post-partum
→ 6 weeks post-partum visit

PHQ-9 Score < 10
Does not suggest depression

Educate patient about the importance of emotional wellness.

Provide COMPASS brochure for future reference.

PHQ-9 Score ≥ 10
May suggest depression

(1) Assess patient clinically
Consider comorbid illnesses, such as substance use or medical causes of depression (e.g. anemia, thyroid disorders)

(2) Score of 2+ (more than half of the time) **on questions #1** (anhedonia) **or #2** (depressed mood) **likely indicate depression.**

(3) Screen for Bipolar Disorder using MDQ (Mood Disorder Questionnaire)

Positive score on question #9
Suggests risk of self-harm or suicide

Assess for risk of suicide or harm

Do NOT let the patient leave without developing a safety plan. Further assessment or treatment plan must be established and documented in medical record.

Call COMPASS Care Coordinator

For clinical concerns of mental illness, call COMPASS Care Coordinator

COMPASS collaborates with you and the patient to determine a treatment plan that can include on-site psychotherapy and/or psychiatry consultation, then follows-up with you and the patient frequently until remission.

Core Principles of Collaborative Care

- Patient centered team care
- Population-based care
- Measurement-based treatment to target
- Evidence-based care
- Accountable care

COMPASS

Antidepressant Medications

	Drug	Dosing Notes	Side Effects	Specific Drug Information
SSRI	**Sertraline** (Zoloft)	Prescribe 50 mg tabs Start: ½ tab for 2 days, if no side effects, increase to 50 mg/day Increase by 25-50 mg/day Q 2 weeks until remission unless side effects occur Range: 50-200mg/day	Common: nausea, diarrhea, headaches; sexual side effects common- anorgasmia, low desire –may improve over months Rare: Although SSRIs have been reported to increase bleeding risk, this has not been confirmed and is a rare event if the association exists. When using other drugs that affect bleeding risk, educate patient to monitor for bleeding as you usually would and adjust dose as needed	**First line in pregnancy and lactation** due to minimal risk for interaction with other drugs, tolerability and low risk of neonatal discontinuation signs in infants born to treated pregnant women
	Citalopram (Celexa)	Prescribe 20 mg tabs Start ½ tab for 2 days, if no side effects, increase to 20 mg QAM Range: 10-40 mg/day (20mg/day if hepatic impairment) Range: 20-40 mg/day		Citalopram and Escitalopram are not recommended for patients with congenital long QT syndrome, bradycardia, hypokalemia, or hypomagnesemia, recent acute myocardial infarction, or uncompensated heart failure. Citalopram should be used with monitoring of the EKG in patients who are taking other drugs that prolong the QT interval (erythromycin, hydroxychloroquine, quetiapine, olanzapine, methadone).
	Escitalopram (Lexapro)	Prescribe 10 mg tabs Start: ½ tab for 2 days, if no side effects increase to 10mg am Range: 10-20mg/day		
	Fluoxetine (Prozac)	Prescribe 20 mg capsules Start one cap Q AM and skip one day Take 20 mg QAM if no side effects; increase by 20 mg every 4 weeks until remission or until side effects occur Range: 20-60 mg /day		More activating than other SSRIs; long half-life reduces withdrawal risk Potent CYP 2D6 inhibitor; will increase the concentrations of other 2D6 substrates – *e.g:* metoprolol, metoclopramide, ondansetron, oxycodone; nortriptyline and amitriptyline. Decrease the initial dose of these drugs and assess effects or prescribe a different antidepressant.
	Paroxetine (Paxil)	Start: Prescribe 20 mg tabs Start: ½ tab for 2 days, if no side effects a 20mg/day; may be sedating and can be taken at HS Range: 20-60mg/day		**Second line drug**. Anticholinergic; weight gain; significant withdrawal syndrome and neonatal discontinuation signs for infants of treated pregnant women Potent CYP 2D6 inhibitor (see note under fluoxetine)

SNRI	**Venlafaxine** (Effexor)	Start: IR-37.5mg BID x 4 days then increase to 75 mg BID; ER-75mg QAM x 4 days then increase to 150 mg QAM Range 150-375mg/day	Same as SSRIs May increase BP and heart rate	**Second line drug**. More activation and GI side effects than SSRIs; significant withdrawal syndrome even with missed doses and neonatal discontinuation signs for infants of treated pregnant women
	Duloxetine (Cymbalta)	Start: 30mg qday x 4 days then increase to 60mg qday Range: 60-120mg/day		**Second line drug**, used more commonly in depression with chronic pain
Other	**Mirtazapine** (Remeron)	Start: 15mg qhs x 3-5 days then increase to 30mg qhs Range: 30-60mg/day	Sedating; increases appetite Long term weight gain	**Second line drug**. Sedating and appetite promoting; rarely associated with neutropenia An alternative drug for Hyperemesis gravidarum
	Bupropion (Wellbutrin)	Start: IR-100mg bid x 5 days then increase to 100mg tid; SR-150mg qam x 3-5 days then increase to 150mg bid; XL-150mg qam x 3-5 days then increase to 300mg qam Range: 300-450mg/day	Stimulating; may increase insomnia, anxiety initially May increase BP	**Second line drug**. Contraindicated in seizure disorder, eating disorders, alcohol use disorders, and history of traumatic brain injury because it decreases seizure threshold; stimulating; less effective for anxiety disorders Potent CYP 2D6 inhibitor; will increase in concentration for a few drugs commonly used by ob/gyns; see note under fluoxetine
Tricyclic	**Nortriptyline** (Pamelor)	Start 25 mg at HS for 4 days, then increase to 50 mg for 4 days, then to 75 mg Check plasma level after 7 days at 12 hours post-dose and adjust dose.		Therapeutic plasma level is 50-150; preferably 80-120 ng/ml. Dose to plasma level is linear; for example, if 100 mg dose yields level of 60 ng/ml, 150 mg will yield 1.5 (60) or 90 ng/ml. Cardiac toxicity with overdose.

Antidepressant Medication Warnings/Precautions: 1) Potential increased suicidality at the start of treatment; if anxiety increases or patient becomes agitated or energized, discontinue the antidepressant and have patient contact prescriber; 2) Discontinuation symptoms (similar to flu) may occur with abrupt discontinuation.

About Serotonin Syndrome—overstimulation of serotonin receptors: Serotonin syndrome symptoms usually occur within several hours of taking a new drug or increasing the dose. Signs and symptoms include: Agitation or restlessness, confusion, rapid heart rate and high blood pressure, dilated pupils, muscle incoordination, twitching or rigidity, heavy sweating, diarrhea, headache, shivering; if severe: high fever, seizures, cardiac conduction abnormalities; loss of consciousness. Mild to moderate cases can be treated with discotninuation of serotonergic agents plus cyproheptadine, 4 – 8 mg orally, which usually takes effect within a half hour may need to be repeated if symptoms recur.

REDCap
Research Electronic Data Capture

Core Principles of Collaborative Care

- Patient centered team care
- Population-based care
- Measurement-based treatment to target
- Evidence-based care
- Accountable care

Record ID	treatment1				treatment2			treatment3			treatment4			treatment5			treatment6			treatment7			treatment8		
	PHQ9 enrollment	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale	PHQ9	Dose Change	Side Effect Rating Scale
C747	●	●	○	○	✓	○	○	●	○	○	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C748	●	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C749	●	●	○	○	●	○	○	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C753	●	●	●	✓	✓	○	○	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C754	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C755	●	✓	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C756	●	●	●	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C757	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○
C759	●	●	○	○	●	○	○	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C760	●	●	○	○	✓	○	○	✓	○	○	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○
C761	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C763	●	●	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C764	●	●	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C766	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C768	●	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C769	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○
C770	●	●	○	○	●	○	○	●	○	○	●	●	○	●	○	○	○	○	○	○	○	○	○	○	○
C771	●	●	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○
C772	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	●	○	✓	○	○	✓	○	○	✓	○	○
C773	●	✓	●	○	●	○	○	✓	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C774	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	●	○	○	✓	●	✓	✓	○	○	○	○	○
C775	●	●	○	○	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C776	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C777	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C778	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
C779	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○
C780	●	●	●	✓	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○	○	○	○
C781	●	✓	○	○	✓	○	○	●	○	○	✓	○	○	✓	○	○	✓	○	○	●	○	○	○	○	○
c782	●	✓	○	○	✓	○	○	✓	○	○	✓	○	○	●	○	○	○	○	○	○	○	○	○	○	○
c783	●	●	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○
C784	●	✓	○	○	✓	○	○	●	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○
c785	●	✓	●	✓	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	✓	○	○	○	○	○
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c787	●	●	○	○	✓	○	○	●	○	○	✓	○	○	○	○	○	○	○	○	○	○	○	○	○	○
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C791	●	●	○	○	●	○	○	●	○	○	●	○	○	●	○	○	●	○	○	●	○	○	○	○	○
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c801	●	●	○	○	●	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
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Antidepressant Treatment Algorithm

Use **half** the recommended dose for **2 days**, then increase in specified increments **every 2 weeks** until patient achieves remission or has side effects*

sertraline (Zoloft)	fluoxetine (Prozac)	citalopram (Celexa)	escitalopram (Lexapro)
50-200 mg	20-60 mg	10-40 mg	5-20 mg
•Increase in 50 mg increments	•Increase in 10 mg increments	•Increase in 10 mg increments	•Increase in 5 mg increments

Reevaluate depression treatment every **2 weeks** via PHQ-9 and clinical assessment

If PHQ-9 remains ≥ 5...

- If no/minimal side effects → increase dose and/or add psychotherapy
- If side effects* → consider switching to different medication
- Consider contacting COMPASS Care Coordinator to facilitate psychiatry consultation

If PHQ-9 is < 5 and no/minimal side effects...

- Reevaluate every month and at postpartum visit

Educate Patient: Within first few doses, if she has marked increase in anxiety, becomes agitated, or feels energized, stop the medication and contact COMPASS

*Common side effects of SSRI include: nausea, dry mouth, insomnia, diarrhea, headache, dizziness, agitation, sexual problems, and drowsiness

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Objectives

- Describe the perinatal depression treatment cascade and contemporary outcomes
- Understand the evidence to support efficacy of perinatal collaborative care
- Review implementation strategies for perinatal collaborative care at MetroHealth

COMPASS Team

COMPASS program director

Emily Miller

clinical liaison

Jackie Gollan

COMPASS care coordinators (CCC)

Rebekah Jensen
Lauren Ratliff

psychiatrists

Aparna Chatterjee

Louisa Olushoga

therapist

Rachel Ostrov

mentorship team

Kathie Wisner
Bill Grobman

data management team

Jody Ciolino
Daniel Erikson
Katelyn Zumpf

Thank you