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Staff Education Program on Postpartum Depression Screening

Pamela Barstow
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Pamela Barstow

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Review Committee
Dr. Joan Moon, Committee Chairperson, Nursing Faculty
Dr. Anita Manns, Committee Member, Nursing Faculty
Dr. Donna Bailey, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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Project Submitted in Partial Fulfillment

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Abstract

Postpartum depression (PPD) in the US is a serious health concern that negatively impacts an average of 11.5% of women, with 13.36% of women in Virginia in 2018 reporting PPD symptoms. Mothers experiencing PPD may have trouble bonding with their infants, which may negatively impact childhood growth and development. However, fewer than one-half of pediatricians screen mothers of infants for PPD. Literature supports staff education on PPD to promote the wellbeing of postpartum mothers and their infants. Using the analysis, design, development, implementation, and evaluation model of instructional design, the purpose of this Doctor of Nursing Practice project was to plan and evaluate a pediatric staff education curriculum and pretest/posttest on PPD to promote positive maternal mental health and infant wellbeing. Evidence generated for this project was obtained through evaluation of the curriculum plan and validation of pretest/posttest items by three content experts—a pediatrician, an obstetrician, and a perinatal counselor—based upon their experience in their respective areas of expertise. Seven objectives were met, with an average score of one being met for each objective; thus, the plan was deemed acceptable by the content experts. The content experts also conducted item analysis of the test items which resulted in a S-CVI of .97, exceeding the .78 acceptable limit. Educating pediatric primary healthcare providers about PPD promotes social change by raising provider awareness of PPD and interventions for women, thereby promoting maternal mental and physical health and psychosocial wellness of children and families.

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Section 1: Nature of the Project

Introduction

Postpartum depression (PPD) in the US is a serious public health concern that negatively impacts an average of 11.5% of women in the postpartum period following childbirth (Ko et al., 2017). The adverse effects of PPD are not solely experienced by new mothers; infants and other family members are also affected. Mothers experiencing PPD may have trouble bonding with their infants (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018) which may negatively impact their growth and development from infancy through adolescence (Webber & Benedict, 2018). Children of mothers with a history of PPD have difficulties with cognitive, social-emotional, and language development, as well as internalizing and externalizing behaviors (van der Zee-van den Berg et al., 2017). Maternal PPD also places fathers at risk for experiencing paternal PPD during the child's first year of life (Goodman, 2004) as approximately 8% of men also experience PPD (Cameron, Sedov, & Tomfohr-Madsen, 2016).

However, PPD is a treatable condition with early detection being shown to decrease negative impacts for mothers and children (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018). Ideally, detection begins with screening (Ko et al., 2017). Traditionally, women receive a postpartum visit with their obstetrical providers 4 to 6 weeks after delivery. However, in 2018, the American College of Obstetricians and Gynecologists (ACOG) published new care recommendations endorsing that postpartum women should have their initial postpartum visits with obstetrical care providers within the first 3 weeks after delivery (sooner if a comorbidity is present, such as diabetes, hypertension, or cesarean delivery) and a

comprehensive visit between 4 to 12 weeks postpartum (based upon maternal preference and schedule) to include screening for mood and mental health status. The American Academy of Pediatrics (AAP) recognizes the impact maternal mental health has upon children and recommends screening mothers for PDD during 1-, 2-, 4-, and 6-month visits (Earls et al., 2019). The US Preventative Services Task Force (USPSTF) supports ACOG and AAP recommendations and encourages interprofessional collaboration when treating women for PPD. Additionally, one of the objectives of the Healthy People 2020 initiative is decreasing the proportion of women delivering live births who experience PPD symptoms (Office of Disease Prevention and Health Promotion, 2019). Other noteworthy professional organizations that also support screening, treating, and referring women for PPD include the American Medical Association (AMA), National Association of Pediatric Nurse Practitioners (NAPNAP), and American College of Nurse Midwives.

Pediatric primary healthcare providers lack knowledge related to identification of PPD symptoms and screening, thereby creating a need for education. This lack of knowledge and subsequent failure to screen women creates missed opportunities for identifying women who may be suffering from PPD. PPD treatment can be effective if providers are educated on PPD and how to identify it through screening measures (van der Zee-van den Berg et al., 2017). To address lack of provider knowledge, I developed a staff education curriculum, including a pretest/posttest, that will be delivered to pediatricians and clinical staff members in a private pediatric primary care clinic after my graduation from Walden University. Educating these pediatric healthcare providers about PPD, screening tools, and referral resources will lead to

social change through awareness and intervention. Identifying and promoting maternal mental health is a valuable public health measure this facilitates physical and psychosocial wellness of children and families.

Problem Statement

The problem identified in this Doctor of Nursing Practice (DNP) project was the clinical staff's need for staff education regarding PPD and screening in the private pediatric clinic in Virginia where the project will take place. The rate of PPD among women in the US is approximately 11.5% (Ko et al., 2017) with 12.5% of women in Virginia reported experiencing PPD symptoms (Centers for Disease Control [CDC], n.d.), with an increase to 13.36% in 2018 (Virginia Department of Health, n.d.). Early identification of PPD symptoms and subsequent treatment is needed in order to foster positive interactions between mothers and babies and promote the mental and physical wellbeing of women and children (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018). Although screening has recently been adopted in the clinic, no PPD education has been provided to clinic staff. Clinic staff consists of one registered nurse plus three recently hired medical assistants who replaced licensed practical nurse employees who left during the COVID pandemic. These employees have not had any education in PPD, yet administer PPD screenings.

DNP programs are designed to guide students in terms of translating evidence-based research into practice and driven by the American Association of Colleges of Nursing (AACN) *Essentials of Doctoral Education for Advanced Practice Nursing.* This DNP project to educate healthcare providers in my place of employment about PPD, screening, and referral is in

alignment with Essentials I and III. Essential I involves application of science to promote positive health outcomes, while Essential III involves translation of research into best practice.

Purpose Statement

The gap in practice at the project site is lack of knowledge of PPD by clinic staff. Apart from the registered nurse at the clinic, medical assistants are either newly certified or do not have women's health or pediatric backgrounds. The purpose of this DNP project was to plan and evaluate a pediatric staff education curriculum and pretest/posttest regarding PPD. The goal of the project was to address the gap in practice and promote positive maternal mental health and infant wellbeing by educating clinic staff about PPD, screening tools, and referral options.

Practice-Focused Questions

RQ1: Is there evidence demonstrating the benefits of educating staff on PPD and the nursing profession?

RQ2: Will a staff education curriculum meet course objectives as determined by a team of content experts?

RQ3: Will a content item analysis with a pretest/posttest meet an acceptable content validity index of .78 in order to be acceptable for administration?

Nature of the Doctoral Project

Sources of Evidence

Current evidence-based practice guidelines of multiple healthcare governing bodies and agencies support promotion of maternal mental health through PPD screenings during the postpartum period, including the ACOG, AAP, the USPSTF, as well as the Healthy People 2020

initiative. Additional evidence was obtained through a review of literature, published between 2018 and 2022, using the following databases: Cumulative Index to Nursing & Allied Health Literature (CINAHL), MEDLINE, ProQuest, Embase, PubMed, and Google Scholar. Search terms were: *postpartum depression*, *maternal depression*, *perinatal depression*, *screening*, *pediatric*, and *primary care*.

Procedural Steps

The knowledge gap and barriers were addressed through the development of a staff education curriculum and pretest/posttest involving PPD, to be presented after my graduation from Walden University. The project followed the steps of the *Walden Staff Education Manual*, except for implementation of the analysis, design, development, implementation, and evaluation (ADDIE) model (see Appendix A). Implementation of the project has been delayed until after I graduate from Walden University due to staffing concerns and the COVID-19 pandemic. First, all nursing staff at the project site resigned, and finding replacements has been a challenge. The project site has only been able to higher one registered nurse and three medical assistants. Furthermore, the COVID-19 pandemic changed the way healthcare is offered to patients and how people interact in social settings. Social distancing has become the new normal and at the project site, in-person large group meetings are not allowed. Because of social distancing restrictions and decreased staffing, I am unable to implement my project until after I graduate. Once the project site is fully staffed and the company's COVID-19 protocols allow for in-person large group meetings, I will implement the project.

Planning

The first phase in the ADDIE model was analyzing the pediatric primary healthcare provider need for professional development by identifying a gap in practice A literature search was conducted and the evidence was put into a literature review matrix (see Appendix B) using the Johns Hopkins Nursing Evidence-Based Practice Research (see Appendix C) and Non-Research Evidence Appraisal Tools (see Appendix D), for which permission was received (see Appendix E). The tools assist the user in appraising evidence found in the literature as part of the process of translating evidence into best practice. I discussed the clinical staff's need for the project with my organization's leadership and obtained a verbal commitment of support to proceed. Ethical approval was obtained using blanket preapproval parameters established by Walden University's Institutional Review Board (IRB) for staff education doctoral projects.

Three content experts participated in the project. The first content expert was a board-certified pediatrician who finished her undergraduate studies in 1981, graduated from medical school in 1985, and completed her pediatric residency in 1988. She is currently the Chief Executive Officer and Medical Director of a large pediatric practice. The second content expert was a board-certified obstetrician-gynecologist who received her medical degree in 2012, then completed her training in obstetrics and gynecology in 2016. She currently practices at a private practice OB-GYN clinic in her hometown. The third content expert was a registered licensed professional counselor and certified perinatal mental health professional. She received a bachelor's degree in communications in 2003. She then earned her master's degree in education in 2009 and currently practices at a privately-owned counseling center. Content experts reviewed

the literature review matrix, evaluated curriculum related to course objectives and literature, and validated pretest/posttest items based on course objectives and curriculum. Test item construction was reviewed by an outside expert who had a Doctor of Philosophy (PhD) with assessment expertise.

Three curricula for the project were identified and adapted to fit needs of the project in accordance with evidence-based literature. They were ALLEGRA Learning Solutions LLC's Postpartum Depression module (ALLEGRA, n.d.), Addressing Maternal Mental Health in the Pediatric Medical Home (Ward-Zimmerman & Vendetti, 2014), and Depression in Mothers: More Than the Blues: A Toolkit for Family Service Providers (Substance Abuse and Mental Health Services Administration, 2014).

Implementation

The implementation phase will occur after my Walden graduation. This involves explaining to clinical staff and providers why the educational activity is needed, determining who should attend, where the activity will occur, what costs will be, and which format will be used. After formative review and final revisions of the curriculum (see Appendix F) and pretest/posttest (see Appendix I) by content experts and approval of leadership were received, the program was deemed ready for presentation to the clinical staff at an appropriate time in the future. The pretest/posttest will be administered before and after the curriculum is presented via a PowerPoint presentation (see Appendix N). Furthermore, all participants will receive a PPD resource kit (see Appendix M) that includes the Edinburgh Postnatal Depression Scale (screening tool) and instructions for scoring, a list of referral resources, and a referral algorithm.

Evaluation

Evidence for this project was provided by content experts and included curriculum evaluation and content validation of pretest/posttest items. Results of both will be presented to clinical leadership showing that the program is approved to be implemented.

Significance

Stakeholders

There are two groups of key stakeholders who may be impacted by this DNP project as the gap in practice is addressed: clinical staff and patients and their families. Clinical staff are direct participants in the program as they gain a better awareness of PPD, how mental illness affects women and their children, and how screening for PPD can be a crucial step in identifying women in need of mental health services. By applying knowledge from the project, pediatric nursing staff will be able to adopt more proactive and less reactive approaches to PPD identification and support. Patients and their families are also significant stakeholders as they stand to benefit from the identification of PPD. If PPD is identified and subsequently treated, negative health implications for infants and mothers can be minimized (Ko et al., 2019).

Contributions to Nursing Practice

Nurses need to exhibit leadership skills when collaborating with peers, physicians, and other health professionals, as well as demonstrate the highest level of competency. In order to improve patient care and help shape health policy, nurses need to develop and strengthen mutually beneficial relationships with other healthcare providers, politicians, community leaders, health advocates, and private citizens to help realize mutual goals (IOM, 2010). The AACN

mandates all DNP graduates develop necessary skill sets during their doctoral studies to become healthcare leaders. In turn, those leadership skills should be used to improve patient care and policies. Nurses can improve patient care and shape policy through implementing evidence-based practice. Gray et al. (2017) said evidence-based practice is "the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of quality, cost-effective health care" (p. 18). Evidence-based practice is the foundation of modern medical and nursing practice and is constantly changing as new research becomes available. This DNP project is an example of translating evidence and screening for PPD in a private pediatric primary care setting in Virginia into best practice. Through the project, leadership qualifications of DNP educated nurses are highlighted, thereby leading to increased recognition of advanced practice nurses by clinic administrators, physicians, and clinical staff as leaders and full partners with physicians in the practice.

Social Change

Positive social change is the priority of Walden University. Nursing scholars at Walden University are encouraged to effectively promote positive change through research, leadership, and professional activities that strive to improve the health of society. Educating pediatric healthcare providers about PPD and red flags associated with PPD, as well as providing education on use of the Edinburgh Postnatal Depression Scale standardized PPD screening tool will assist in the identification of women with PPD. By identifying these women, interdisciplinary interventions can be initiated to assist in treatment of PPD. Therefore, negative health implications for mothers and their children may be mitigated. Promoting maternal mental

health and other healthcare services along the continuum of care and across the human life span to meet the mental health needs of women, children, and families can result in positive social change, thus improving the human condition.

Summary

In Section 1, I identified clinical staff's need for staff education regarding PPD and screening in the private pediatric primary clinic in Virginia where the project will take place. Literature and multiple professional organizations support screening for PPD in the pediatric setting. Guided by practice-focused questions and the Walden University Staff Education Manual and ADDIE model, this DNP project involved establishing a staff education program about PPD, screening methods, and referral options for pediatric healthcare providers and their staff. This DNP project was significant because pediatric healthcare provider lack of knowledge about PPD and subsequent failure to screen women creates missed opportunities for identifying women who may be suffering from PPD. Educating pediatric primary healthcare providers about PPD, screening tools, and referral resources promotes social change by raising provider awareness of PPD and interventions for women and their families. Identifying and promoting maternal mental health is a valuable public health measure that facilitates psychosocial wellness of families. In Section 2, I discuss the ADDIE model, relevance to nursing practice, local background and context, my role as the DNP student, and role of the project team.

Section 2: Background and Context

Introduction

The problem identified in this Doctor of Nursing Practice (DNP) project was the clinical staff's need for staff education regarding PPD and screening in the private pediatric clinic in Virginia where the project will take place. The practice-focused questions guiding this project were:

RQ1: Is there evidence demonstrating the benefits of educating staff on PPD and the nursing profession?

RQ2: Will a staff education curriculum meet course objectives as determined by a team of content experts?

RQ3: Will a content item analysis with a pretest/posttest meet an acceptable content validity index of .78 in order to be acceptable for administration?

The purpose of this DNP project was to plan and evaluate a pediatric staff education curriculum and pretest/posttest on PPD. This section includes a review of the ADDIE model, relevance to nursing practice, local background and context, role of the DNP student, and role of the project team.

ADDIE Model

This project was framed using the ADDIE model, which was a flexible yet linear framework for developing the content of course materials and training programs. The ADDIE model has been used as a framework for developing nursing education curricula in the US and

globally. The established structure of the model is an effective tool for developing nursing education programs.

Analysis, Design, and Development Phase

The first phase in the ADDIE model is analyzing the clinical staff's need for professional development by identifying a gap in practice. Analysis includes reviewing available data sources, conducting a needs assessment, and determining key stakeholders (Jeffery et al., 2015). There are four levels of need to be considered: professional, individual, community, and organizational (Jeffery et al., 2015). To collect data for a needs assessment, an educator using the ADDIE model might choose to gather qualitative data, then validate that information via quantitative means. During this initial phase, goals and objectives are also established (Lasky, 2018).

Once an analysis has been performed, the next step is designing and developing professional activities that address the gap in practice. During the design phase, the educator creates the blueprint for the instructional material he or she is creating. This involves producing the structure and content of instructional materials, developing assessment methods, and determining what resources and activities are required to meet learning objectives (Lasky, 2018). The educator then uses the blueprint to develop hands-on educational materials.

Implementation Phase

The processes of analyzing, designing, and developing are pre-implementation activities that lead to the next step in the ADDIE model—implementation. During the implementation phase, the educator's focus shifts to explaining to educational project's attendees why the educational activity is needed, who should attend, where the activity will occur, what costs will

be, and which format will be used (Jeffery et al., 2015). Learners benefit most from an educational activity if they find value in the information being taught. Providing learners with a rationale for the educational activity can be beneficial in terms of obtaining support. The implementation phase also involves promoting the educational activity to the target audience, determining a date for the activity, securing a classroom, printing course materials and evaluations, and arranging for equipment that may be needed (Jeffery et al., 2015).

Evaluation Phase

The final step is evaluation. This is a time of reflection to consider if the learning activity spurred changes and to what degree, as well as how the gap in practice and stakeholders were impacted (Jeffery et al., 2015). For this project, evaluation occurs during the planning phase when content experts evaluate the curriculum and determine a content validation index score for the pretest/posttest.

Relevance to Nursing Practice

PPD

In the US, perinatal mood disorders are the most common obstetrical complication and are often undiagnosed and untreated (Earls et al., 2019; Evans et al., 2015). Of the perinatal mood disorders, PPD is especially concerning. PPD is associated with increased healthcare expenses, deficits in care provided to infants, cessation of breastfeeding, conflicts within the family, abuse and neglect, and negative implications for infant brain development (Earls et al., 2019). Populations at highest risk for PPD include low-income families, African American and Hispanic women, first-time mothers and teenage mothers, and women with complicated

pregnancies (Evans et al., 2015). Risk factors for PPD include a previous history of PPD, history of depression or anxiety before or during pregnancy, familial history of mental health problems, substance use or abuse, and poor social support systems (Evans et al., 2015). Fewer than one half of pediatricians screen mothers of infants for PPD (Earls et al., 2019).

Screening for PPD

Many tools exist for screening women for PPD and are applicable to the pediatric well-child visit. These are tools used to assess and not diagnose PPD, and include the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire (PHQ), Postpartum Depression Screening Scale (PDSS), and Beck Depression Inventory II. The AAP endorses use of the EPDS by pediatricians for screening mothers of infants for PPD (Earls et al., 2019). The EPDS is a 10-item questionnaire completed by the mother that involves assessing depression, anxiety, and suicidality (Earls et al., 2019; Sorg et al., 2019). Hewitt et al. (2009) said the EPDS can correctly identify PPD with a sensitivity of 79% (95% confidence interval [CI], 0.74 to 0.83). Using the EPDS allows pediatric healthcare providers to create a dialog with mothers about protective and risk factors that are integral to the safety and social-emotional wellbeing of the mother-child dyad (Earls et al., 2019).

Nursing staff can play an integral role in PPD screening during well-child visits. Nurses can effectively be tasked with explaining the purpose of PPD screening to mothers and providing guidance for completing the screening questionnaire (Sorg et al., 2019; van der Zee-van den Berg et al., 2017). Because clinical staff typically interact with patients prior to physicians and nurse practitioners, “nurses are often the first to come into contact with postpartum mothers and to

screen them for PPD symptoms and should have an important role in improving these women's mental health" (Bina et al., 2019, p. 140). With informal and formal training, nurses can also offer support and counseling to postpartum women about mental health resources (Bina et al., 2019; Kang et al., 2019). A statewide survey of registered nurses (RNs) in Iowa who had a minimum of a Bachelor of Science in Nursing (BSN) and who were employed in women's health, pediatrics, public health, or psychiatric settings revealed that RNs favor PPD screening and counseling by nurses (Segre et al., 2010).

Role of Nurse Practitioners

Family and pediatric nurse practitioners are uniquely suited for addressing PPD during well-child visits. The National Association of Pediatric Nurse Practitioners (NAPNAP) recommends screening women for PPD during well-child visits (NAPNAP, 2011). Nurse practitioners in pediatric primary care clinic are qualified to administer and score PPD screenings and making necessary referrals for follow-up care for positive screens (Sorg et al., 2019), as well as making follow-up calls to women to check on maternal and infant well-being (Rychnovsky & Brady, 2008). Nurse practitioners can also participate as members or leaders of multi-disciplinary teams to establish PPD screening and referral protocols (Russomagno & Waldrop, 2019). Nurse practitioners can also assume educational roles to train other nurse practitioners, nursing staff, and pediatricians.

Local Background and Context

While the rate of PPD among women in the US is approximately 11.5 percent (Ko et al., 2017), data from the 2016-2017 Pregnancy Risk Assessment Monitoring System (PRAMS)

indicates 12.5 percent of women in Virginia reported experiencing PPD symptoms (CDC, n.d.), with an increase to 13.36 percent in 2018 (Virginia Department of Health, n.d.). The project site provides pediatric primary care services in northern Virginia and has five clinic locations and over 40 healthcare providers (physicians, nurse practitioners, and physician assistants).

My Role

I have been a family nurse practitioner since 2015. I initially practiced in adult medicine and women's health, before transitioning to pediatrics. I have worked as a nurse practitioner at my current place of employment providing pediatric primary care since 2017, in addition to offering lactation support as a certified lactation counselor to patients since 2019. There are five clinical sites within my organization. The project will be piloted in the clinic I primarily work at before being introduced at the four remaining clinics. I am enthusiastic about my role in promoting organizational change through educating the providers and clinical staff at the project site. I do not have any biases that could influence this project.

My motivation for the project is multifaceted. The project is born out of my desire to provide holistic care to children, which includes supporting the mental health and emotional needs of caregivers. Demonstrating the leadership capabilities of nurse practitioners is a secondary motivation for the project as change and policy within my organization has historically been physician driven. Nurse practitioners should be viewed as more than physician extenders; we are peers with whom physicians can collaborate and learn from each other. My final motivation behind the project is to show the registered nurses and licensed practical nurses

in my clinic that nurses are more than accessory personnel. Through formal and informal leadership roles, nurses can bring about changes that positively impact the quality of patient care.

Role of Content Experts

Three content experts participated in the project: a pediatrician, obstetrician, and perinatal mental health counselor. The content experts evaluated the curriculum and validated each test item resulting in a content validation index score for the pretest/posttest. Once the packets are ready and distributed, the content experts were given two weeks to complete and return the documents. Communication with the content experts will occur via telephone, e-mail, or Zoom.

Summary

Section 2 opened with a discussion of the ADDIE model which provided framework for developing the project. In Section 2, I also discussed the relevance of nursing to PPD, including screening for PPD, referring at risk women, and educating healthcare team members. The local background and context, my role as the DNP student, and role of the content experts were also highlighted. In Section 3, I will review the sources of evidence generated by this project, the participants, procedures, protection, and analysis and synthesis of the evidence.

Section 3: Collection and Analysis of Evidence

Introduction

The problem identified in this Doctor of Nursing Practice (DNP) project was the clinical staff's need for staff education regarding PPD and screening in the private pediatric clinic in Virginia where the project will take place. The purpose of this DNP project was to plan and evaluate a pediatric staff education curriculum and pretest/posttest on PPD. The goal of the project was to address the gap in practice and promote positive maternal mental health and infant wellbeing by educating clinic staff about PPD, screening tools, and referral options. Section 1 provided background information about PPD identified the need for staff education about screening for PPD in the pediatric clinic setting where the project will take place. Section 2 included a review of the ADDIE model, relevance to nursing practice, local background and context, role of the DNP student, and role of the project team. Section 3 includes sources of evidence for this DNP project, as well as analysis and synthesis of evidence.

Practice-Focused Questions

While the rate of PPD among women in the US is approximately 11.5% (Ko et al., 2017), 12.5% of women in Virginia reported experiencing PPD symptoms (CDC, n.d.), with an increase to 13.36% in 2018 (Virginia Department of Health, n.d.). The private practice I work for provides pediatric primary care services in northern Virginia and has five clinic locations and over 40 healthcare providers (physicians, nurse practitioners, and physician assistants). However, routine screening for PPD during early well-child visits is not included in clinic and organizational workflows. Failure to screen is indicative of lack of knowledge regarding PPD by

pediatric healthcare providers as well as lack of a standardized PPD screening tool with referral processes within the practice. Therefore, the gap in practice at the project site was lack of knowledge of PPD by clinic staff. The practice-focused questions guiding this project were:

RQ1: Is there evidence demonstrating the benefits of educating staff on PPD and the nursing profession?

RQ2: Will a staff education curriculum meet course objectives as determined by a team of content experts?

RQ3: Will a content item analysis with a pretest/posttest meet an acceptable content validity index of .78 in order to be acceptable for administration?

The purpose of this DNP project was to plan and evaluate a pediatric staff education curriculum and pretest/posttest on PPD. Sufficient evidence exists in literature to support the planning, implementation, and evaluation of PPD staff education. Furthermore, literature indicates pediatric staff education on PPD results in increased pediatric care provider knowledge about PPD.

Evidence

Evidence Generated to Support the Project

A literature review was ongoing throughout the planning and development of the project. I used a literature review matrix (see Appendix B) in order to address the practice-focused questions. The matrix included a summary of evidence gathered from the literature that supports the practice-focused questions. Data in the literature review matrix included full references for literature used in this DNP project, applicable theoretical or conceptual frameworks, summaries

of research questions and hypotheses, research methodologies, descriptions of sources, conclusions, and a grade for evidence. Evidence for the project was appraised using the Johns Hopkins Nursing Evidence-Based Practice Research (see Appendix C) and Non-Research Evidence Appraisal Tools (see Appendix D), for which permission was received (see Appendix E). The review was provided to content experts for use in their formative evaluations of curriculum and validation of pretest/posttests.

Evidence Generated by the Project

Evidence generated for this DNP project was obtained through evaluation of the curriculum plan (see Appendix F) and validation of the pretest/posttest (see Appendix I). The curriculum plan was adapted by me. The plan includes course objectives, detailed content covered within each objective, reference to evidence in the literature review matrix that supports the content of each objective, grades for evidence using Johns Hopkins Nursing Research/Non-Research Evidence Appraisal Tools, and pretest/posttest items corresponding to each objective.

Pretest/Posttest

A pretest/posttest from course content was created to evaluate PPD knowledge of participants before and after project presentation.

Participants

Participants for the project were the three content experts. The content experts were chosen based upon their clinical expertise regarding maternal and/or infant health.

Procedures

Templates used in this DNP project were developed by my project chairperson for organizational purposes. Consequently, there is no need for reliability and validity. These templates include the curriculum plan (see Appendix F), curriculum plan evaluation by content experts (see Appendix G), curriculum plan evaluation by content experts summary (see Appendix H), pretest/posttest (see Appendix I), and pretest/posttest content validation by content experts (see Appendix J).

Johns Hopkins Tools

A literature search was conducted and evidence was logged in the literature review matrix (see Appendix B) using the Johns Hopkins nursing evidence-based practice research and non-research evidence appraisal tools, for which permission was received. Appraisal tools were designed by a panel of experts at Johns Hopkins School of Nursing as aids for assessing articles and undergo review and revision on a regular basis. As such, the tools are not subject to validity and reliability testing.

Content Validity Index

The relevance of each pre/posttest item was scored using the item content validity index (I-CVI) method. Each score given a 1 or 2 by the content expert was rated a 0, while a score of 3 or 4 was rated a 1. Then, the total number for items was divided by the number of experts evaluating each item. After achieving the I-CVI for each item, they were added for all items and divided by the total number of items to achieve the Scale Content Validity Index (S-CVI).

According to Polit et al. (2007), a S-CVI of .78 or higher would be considered evidence of good content validity for the S-CVI test.

Content Expert Packet

Each content expert received a content expert packet to review. All forms were approved by my chair prior to distribution. Each packet contained a letter (see Appendix L) thanking the expert for participating, outlining the packet contents, and providing instructions for each form. Packet contents included the literature review matrix (see Appendix B), the curriculum plan (see Appendix F), the curriculum plan evaluation by content experts (see Appendix G), the pretest/posttest (see Appendix I), and the pretest/posttest content validation by content experts (see Appendix J). Each packet was identified with numbers only to ensure anonymity and mailed to each expert by my office manager. I did not have access to or knowledge of which numbered packet each content expert received. A pre-addressed, pre-paid envelope was included in each packet for the content experts to return their completed forms to my office manager who placed the completed forms in a blank envelope before delivering to me. When returned to me, I analyzed and synthesized the information.

Protection

The names of the content experts and project site were masked. My office manager anonymously mailed and received documents to and from the content experts. All mailed documents were placed in a blank envelope by my office manager prior to returning the documents to me. Ethical approval of this DNP project was obtained using the blanket pre-approval parameters established by Walden University's Institutional Review Board (IRB) for

Staff Education Doctoral Projects. Upon acceptance of this proposal by my chair, I submitted Form A to the IRB. The IRB approval number is 01-21-21-0336274.

Analysis and Synthesis

Once the evaluations were analyzed, the findings were synthesized with appropriate revisions made and reviewed with the content experts. The findings and recommendations are reported in Section 4.

Curriculum Plan Evaluation by Content Experts Summary

The content experts evaluated the curriculum plan (see Appendix F) using a met (1) or not met (2) dichotomous scale which was analyzed using descriptive statistics.

Pretest/Posttest Content Validity Index Scale Analysis

When computing the I-CVI, the relevance of each test item was rated by the content experts using a Likert 4-point scale ranging from 1 to 4. The scale most used was 1=not relevant, 2=somewhat relevant, 3=quite relevant, 4=highly relevant (Davis, 1992). For each item, the I-CVI was computed as the number of experts giving a rating of either 3 or 4, divided by the number of experts to determine the proportion in agreement about relevance (Polit et al., 2007). Acceptable minimum level for the CVI is >.78.

Summary

Section 3 include a review of practice-focused questions, sources of evidence, and how evidence was analyzed and synthesized. Evidence generated to address practice-focused questions was derived from the literature review. Evidence generated for the project involved using the literature review matrix (see Appendix B), curriculum plan (see Appendix F), and

pretest/posttest (see Appendix I). Section 3 also includes a review of procedures that were used to create and protect evidence and participants, and how evidence was analyzed and synthesized. Section 4 includes findings and recommendations generated by evidence, contributions of the doctoral project team, and strengths and limitations of the project.

Section 4: Findings and Recommendations

Introduction

The problem identified in this Doctor of Nursing Practice (DNP) project was the clinical staff's need for staff education regarding PPD and screening in the private pediatric clinic in Virginia where the project will take place. The gap in practice was clinic staff's lack of knowledge of PPD and PPD screening, while literature shows the importance of such knowledge and screenings. The practiced-focused questions were:

RQ1: Is there evidence demonstrating the benefits of educating staff on PPD and the nursing profession?

RQ2: Will a staff education curriculum meet course objectives as determined by a team of content experts?

RQ3: Will a content item analysis with a pretest/posttest meet an acceptable content validity index of .78 in order to be acceptable for administration?

The purpose of this DNP project was to plan and evaluate a pediatric staff education program on PPD via a curriculum and pretest/posttest with formative evaluation by content experts. Evidence generated by the project included the curriculum plan evaluation by content experts (see Appendix G) and pretest/posttest content validation by content experts (see Appendix J). Findings and implications of the project, recommendations, contributions of the doctoral project team, and strengths and limitations of the project are discussed in this section.

Findings and Implications

Each of the seven learning objectives contained in the curriculum plan (see Appendix F) were evaluated by three content experts. Each objective was evaluated as *met* (1) or *not met* (2) based upon developed curriculum. Findings showed that all objectives were met and the curriculum was deemed acceptable by content experts.

Content experts then provided content validation for each test item. Items were analyzed using a four-point Likert scale ranging from one to four, with one being not relevant, two somewhat relevant, three relevant, and four very relevant. No test items evaluated by content experts were given a score of one. Relevance of each pre/posttest item was scored using the I-CVI method. Each score given a one or two by the content expert was rated zero, while a score of three or four was rated a one. Then, the total number for items was divided by number of experts providing the I-CVI for each item. After achieving I-CVI for each item, all items were added and divided by total number. The S-CVI of test items was .97. Therefore, a staff education pretest/posttest developed from the curriculum for this project met the .78 S-CVI threshold for acceptable use.

The desired outcome of the project was to create an evidence-based program that can be implemented to close the gap in practice by educating clinical staff at the project site about PPD, PPD screening, and referral options for women who screen positive for PPD. However, as previously discussed, because of ongoing staffing changes and COVID restrictions, I will not be able to present my project until after I have graduated.

Recommendations

When evaluating the curriculum and pretest/posttest, content experts had the opportunity to provide recommendations for the project. One of the content experts said "it's important for providers to be aware of the other disorders than can occur" during the postpartum phase. The same content expert recommended nursing staff and physicians approach women with open-ended questions about feelings and coping, rather than relying solely on screening tools.

Contribution of Content Experts

Contributions of content experts generated evidence for the project. Content experts independently and anonymously evaluated the curriculum to confirm its objectives were met. They also provided content validation of pretest/posttest items.

Strengths and Limitations of the Project

A major strength of the project was incorporating the input of three independent content experts who have different education and clinical backgrounds—pediatrics, obstetrics, and mental health. Each of these backgrounds was necessary for unique viewpoints in terms of authenticity and validity of the project. Implementing a system that ensured anonymity of content experts further strengthened the project by eliminating my potential biases toward individual people.

Although content experts' knowledge base and backgrounds are a strength of the project, there were also weaknesses. Content experts were originally asked to return the curriculum plan evaluation by content experts (see Appendix G) and pretest/posttest content validation by content

experts (see Appendix J) within 2 weeks. However, multiple reminders had to be given to content experts, and time to receive all documents was approximately 2 months.

Inability to fully implement the project is also a weakness. Implementation of the project has been delayed until after I graduate from Walden University due to staffing concerns and the COVID-19 pandemic. The COVID-19 pandemic changed the way healthcare is offered to patients and how people interact in social settings. At the project site, in-person large group meetings are not allowed. Because of social distancing restrictions and decreased staffing, I was unable to implement my project until after I graduate. Once the project site is fully staffed and the company's COVID-19 protocols allow for in-person large group meetings, I will implement the curriculum. Moving forward, staff education projects should involve incorporating technology as a workaround for meeting COVID-19 restrictions.

Summary

The purpose of this DNP project was to plan and evaluate a pediatric staff education program on PPD with formative evaluation by content experts of a curriculum and pretest-posttest. Evidence generated by the project included the curriculum plan evaluation by content experts (see Appendix G) and pretest/posttest content validation by content experts (see Appendix J). Findings and implications of the project, recommendations, contributions of the doctoral project team, and strengths and limitations of the project were discussed in this section. Curriculum revised from literature on PPD was deemed acceptable by content experts providing formative evaluations of the program. With a S-CVI of .97, the pretest/posttest met the .78 CVI threshold for acceptable use. Roles of content experts and strengths and weaknesses of the

project were also discussed in Section 4. Section 5 includes a discussion of plans to disseminate this work to the clinic where the gap in practice exists and describes completion of the project by analysis of myself as a scholar, practitioner, and project manager.

Section 5: Dissemination Plan

The finalized education product will be disseminated to the Chief Medical Officer at the project site for consideration at four other offices within the practice group. Education and resources will be available for physicians, nurse practitioners, physician assistants, and clinical staff within the organization.

Analysis of Self

As the project has taken approximately 2 years, I provide an analysis of my roles as a practitioner, scholar, and project manager as well as project experiences and long-term professional goals.

Practitioner

I have been a family nurse practitioner since 2015. I initially practiced in adult medicine and women's health before transitioning to pediatrics. I have worked as a nurse practitioner providing pediatric primary care since 2017, in addition to offering lactation support as a certified lactation counselor to patients since 2019. I am enthusiastic about my role in terms of promoting organizational change through educating providers and clinical staff at the project site. This project was born out of my desire to provide holistic care to children, which includes supporting mental health and emotional needs of caregivers. Demonstrating leadership capabilities of nurse practitioners is a secondary motivation as policy changes within my organization have historically been physician-driven. Nurse practitioners should be viewed as more than physician extenders; they are peers that physicians can collaborate with and learn from. My final motivation was to show registered and licensed practical nurses in my clinic that

nurses are more than accessory personnel. Through formal and informal leadership roles, nurses can bring about changes that positively impact quality of patient care.

Scholar

All DNP students are required to complete an intensive scholarly project that involves translating evidence into practice that can be applied to policies. DNP students' knowledge and skills are reflected in the project, as is integration of scholarship into practice. My project is a translation of science into evidence-based practice in order to improve patient outcomes and a collaboration between myself, my designated project chair, and other healthcare professionals. My DNP project has been a 2-year process through which I was able to learn and apply intricacies of scholarly writing, thinking, and planning. I plan to apply my knowledge by pursuing a secondary career in nursing education, specifically as master of science in nursing for nurse practitioner students.

Project Manager

In the past, I have participated in various professional and scholastic projects, but never as a leader. With the onset of the COVID-19 pandemic and due to an acute personal health crisis, my project fell behind schedule. Because I felt like my project had been delayed, finding the motivation to get return was difficult. As a result, I acquired an appreciation for developing and abiding by a project timeline in order to meet goals.

Summary

Challenges of this project strengthened my critical thinking skills by forcing me to look for solutions and seek insights from sources outside of my comfort zone. I am proud of my work

and look forward to being able to formally complete my project once staffing improves and my organization allows large in-person meetings.

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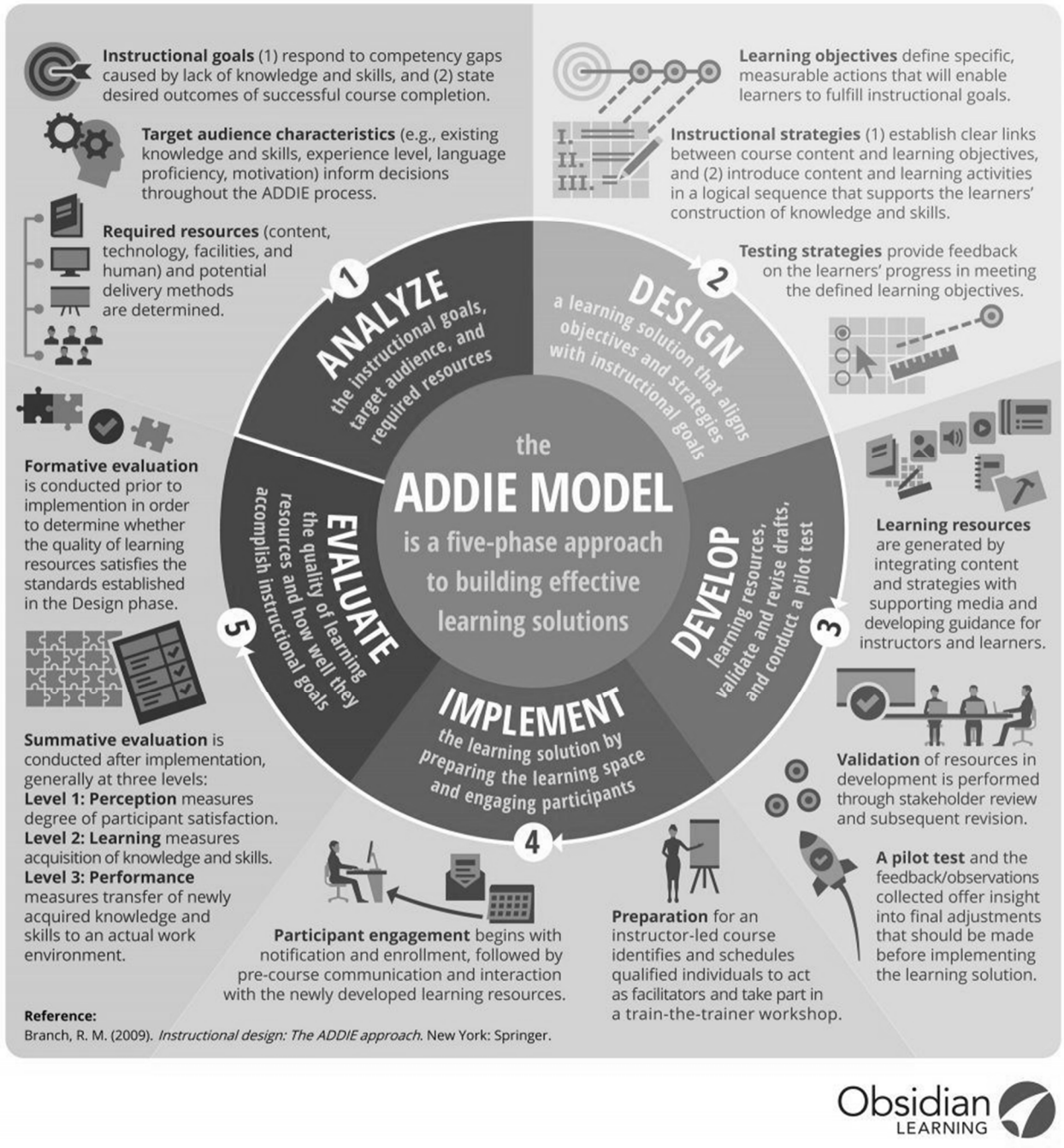
Appendix A: ADDIE Model of Instructional Design



Appendix B: Literature Review Matrix

Full Reference	Research Question(s) / Hypotheses	Research Methodology	Description	Conclusions	Grading The Evidence
American College of Nurse Midwives. (2013). Position statement: Depression in women. https://www.midwife.org/acnm/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf		Position statement		Addresses/supports screening, treating, referring for postpartum depression	Level IV, Low quality
American College of Obstetricians and Gynecologists. (2018a). ACOG committee opinion: Optimizing postpartum care. https://www.midwife.org/acnm/files/ACNMLibraryData/UPL		Position statement		Women should be screened for postpartum depression using a validated tool.	Level IV, High quality

OADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf					
American College of Obstetricians and Gynecologists. (2018b). ACOG committee opinion: Screening for perinatal depression. *Obstetrics and Gynecology, 132*(5), e208-e212. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression		Position statement		OB-GYNs should collaborate with pediatricians to facilitate care for women.	Level IV, High quality
Bina, R., Glasser, S., Honovich, M., Levinson, D., & Ferber, Y. (2019). Nurses perceived preparedness to screen, intervene, and	Examination of perceived preparedness of public health nurses to screen, intervene, and refer women for	Cross-sectional study.	Customized survey using Likert scale.	Training positively influenced perceived preparedness to screen; knowledge increased preparedness.	Level III, High quality

refer women with suspected postpartum depression. *Midwifery, 76*, 132-141. https://doi.org/10/1016/j.midw.2019.05.009	postpartum depression.				
Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics, 143*(1), n.p. https://pediatrics.aappublications.org/content/143/1/e20183259		Position statement		Recommends pediatricians screen for postpartum depression with a validated screening tool at 1-, 2-, 4-, and 6-month well-child visits.	Level III, Good quality
Evans, M. G., Phillippi, S., & Gee, R. E. (2015). Examining the	What are the postpartum depression screening practices of	Systematic literature review of articles from 2003-2013.	169 articles narrowed down to 90, then further narrowed	The lowest postpartum depression screening rates are	Level II, High quality

screening practices of physicians for postpartum depression: Implications for improving health outcomes. *Women's Health Issues, 25*(6), 703-710. https://doi.org/10.1016/j.whi.2015.07.003	obstetricians, pediatricians, and family practitioners? Hypothesized that screening rates will be low across the board, but lowest among pediatricians.		down to the 11 that were selected. All of the 11 used surveys.	among pediatricians, as is the greatest need for education. Increased physician training is needed in the assessment and management of postpartum depression.	
Kang, P. S., Mohazmi, M., Ng, Y. M., Liew, S. M. (2019). Nurses' knowledge, beliefs and practices regarding the screening and treatment of postpartum depression in maternal and child health clinics: A cross-sectional survey. *Malaysian Family Physician, 14*(1), 18-25. https://ezp.waldenulibrary.org/login?url=https://search.ebscohost.com/login.	Determine nurses' knowledge levels, beliefs, and practices associated with postpartum depression and screening practices.	Cross-sectional study.	Questionnaire.	Interventions to improve postpartum depression screening practices should also increase nursing knowledge.	Level III, High quality

aspx?direct=true&db=a9h&AN=137103972&site=eds-live&scope=site					
Kim, S., Choi, S., Seo, M., Kim, D. R., & Lee, K. (2020). Designing a clinical ethics education program for nurses based on the ADDIE model. *Research and Theory for Nursing Practice: An International Journal, 33*(3), 205-222. https://dx.doi.org/10.1891.RTNP-D-19-00135	Develop and evaluate a clinical ethics education program for nurses.	Mixed methods design	ADDIE model was used to develop a clinical ethics program	Supports use of ADDIE model as an effective tool in nursing education by offering an established structure for developing educational programs.	Level V, Good quality
Ko, J., Rockhill, K., Tong, V., Morrow, B., Farr, S., & the Centers for Disease Control and Prevention (2017). Trends in postpartum depressive symptoms—27 states, 2004,	Describe self-reported postpartum depression by state.	Case study	Results of 1.6 million women sampled from 27 states representing 41% of U.S. births.	National prevalence of postpartum depression is 11.5%, highlighting the need for universal postpartum depression screening.	Level IV, Low quality

2008, and 2012. *Morbidity and Mortality Weekly Report, 66*(6), 153-158. https://www.cdc.gov/mmwr/volumes/66/wr/mm6606a1.htm					
National Association of Pediatric Nurse Practitioners. (2011). NAPNAP position statement on the PNP's role in supporting infant and family well-being during the first year of life. *Journal of Pediatric Health Care, 25*, 9A-11A. https://doi.org/10.1016/j.pedhc/2010.10.004		Position statement		Supports and encourages screening for postpartum depression in the pediatric healthcare setting.	Level IV, Low quality
Robinson, B. K., & Dearmon, V. (2013). Evidence-based nursing education: Effective use of instructional design and	Discuss the application of the ADDIE model to the use of simulation in nursing education in an effort to facilitate			Substantiated the use of the ADDIE model in clinical nursing simulation activities and curricula.	Level V, Good quality

simulated learning environments to enhance knowledge transfer in undergraduate nursing students. *Journal of Professional Nursing, 29*(4), 203-209. http://dx.doi.org/10.1016/j.profnurs,2012.04.022	improved clinical performance in new graduate nurses.				
Russomagno, S., & Waldrop, J. (2019). Improving postpartum depression screening and referral in pediatric primary care. *Journal of Pediatric Health Care, 33*, e19-e27. https://doi.org/10/1016/j.pedhc.2019.02.011	Purpose was to improve postpartum depression screening rates and referrals in the pediatric setting.	Quality improvement project	Staff were educated about a new postpartum depression screening and referral workflow. Baseline and periodic chart reviews were performed to assess efficacy of the workflow and screening efforts.	Standardization of postpartum depression screening and referral algorithm can be effectively implemented in the pediatric primary care setting. The use of an algorithm helped and gave providers confidence.	Level V, High quality
Rychnovsky, J. D., & Brady, M. A. (2008).		Expert opinion	Discusses postpartum depression,	Postpartum depression screening can	Level III, High quality

Choosing a postpartum depression screening instrument for your pediatric practice. *Journal of Pediatric Health Care, 22*(1), 64-67. https://www.jpedhc.org/article/S0891-5245(07)00374-4/fulltext			screening options, and referral resources.	be quickly integrated into well-child visits. Pediatric practices need policies and guidelines for screening for postpartum depression and referring positive screens.	
Segre, L. S., O'Hara, M. W., Arndt, S., & Beck, C. T. (2018). Nursing care for postpartum depression, part 1: Do nurses think they should offer both screening and counseling? *The American Journal of Maternal/Child Nursing, 35*(4), 220-225. https://doi.org/10.1097/nmc.0b013e3181dd9d81	Assess nurses' views of postpartum depression screening.	Non-experimental study; descriptive survey	520 nurses surveyed using 4-point Likert-type scale Descriptive statistics were used to analyze demographic data	Nurses favor screening women for postpartum depression. Screening programs should include staff education, selection of a screening tool, and establishment of a screening protocol and referral resources.	Level V, Good quality

Sorg, M., Coddington, J., Ahmed, A., & Richards, E. (2019). Improving postpartum depression screening in pediatric primary care: A quality improvement project. *Journal of Pediatric Nursing, 46*, 83-88. https://doi.org/10.1016/j.pedn.2019.03.001	Integrate postpartum depression screening in a pediatric clinic in order to determine the potential effect on detecting postpartum depression.	Quality improvement project	Standardized screening was implemented per the American Academy of Pediatrician recommendation for postpartum depression screening. Baseline and periodic chart reviews were performed to assess efficacy of the workflow and screening efforts.	Standardization of postpartum depression screening and can be effectively implemented in the pediatric primary care setting and resulted in increased detection of postpartum depression.	Level V, High quality
van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Groothuis-Oudshoorn, C. G. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017). Post-up study: Postpartum	Determine if repeated screening for postpartum in well-child clinics followed by routine care for screen-positive mothers results in improved outcomes at both the maternal level	Prospective, quasi-experimental, comparative design	Participants (mothers of infants) received either care as usual or postpartum depression screening during their child's 1-, 3-, and 6-month well-child visit.	Screening for postpartum depression in a well-child clinic is an effective way to reduce maternal depressive symptoms. Potentially beneficial effect of screening for postpartum	Level II, High quality

depression screening in well-child care and maternal outcomes. *Pediatrics, 140*(4), n.p. https://doi.org/10.1542/peds.2017-0110	and child level at the end of the first year postpartum compared with care as usual.			depression on parenting.	
van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017). Screening for postpartum depression in well-baby care settings: A systematic review. *Maternal and Child Health Journal, 21*(1), 9-20. https://doi.org/10.1007/s10995-016-2088-8	Investigates the evidence of the effectiveness of screening for postpartum depression in well-child clinics.	Systematic literature review	Extracted data from 6 studies	Supports the screening of postpartum depression in the pediatric setting.	Level III, High quality
Waldrop, J., Ledford, A., Perry, L. C., & Beeber, L. S. (2018). Developing a	How are pediatric primary care providers incorporating postpartum	Systematic review of reports after 2010	One randomized-controlled trial, three quasi-experimenta	The evidence supports the feasibility of screening for postpartum depression in	Level III, Good quality

postpartum depression screening and referral procedure in pediatric primary care. *Journal of Pediatric Health Care, 32*(3), e67-e73. https://doi.org/10.1016/j.pedhc.2017.11.002	depression screening into practice and what is done with positive screens?		l studies, two quality improvement projects, and one qualitative study	pediatric practices. Team-based staff education is most effective.	
Webber, E. & Benedict, J. (2018). Postpartum depression: A multi-disciplinary approach to screening, management, and breastfeeding support. *Archives of Psychiatric Nursing, 33*(3), 284-289. https://doi.org/10.1016/j.apnu.2019.01.008	Focus on the effect postpartum depression can have on infant development.	Expert opinion		Supports early detection of postpartum depression with screening using Edinburgh scale. Encourages multi-faceted multi-disciplinary approach to treatment and referrals	Level IV, Low quality

Appendix C: Johns Hopkins Nursing Evidence-Based Practice Research Appraisal Tool

Johns Hopkins Nursing Evidence-Based Practice Research Evidence Appraisal Tool

Evidence Level and Quality:_____

Article Title:		Number:	
Author(s):		Publication Date:	
Journal:			
Setting:	Sample (Composition & size):		
Does this evidence address my EBP question?	☐Yes	☐No Do not proceed with appraisal of this evidence	

Level of Evidence (Study Design)

A. Is this a report of a single research study? ***If No, go to B.***		☐Yes	☐No
1. Was there manipulation of an independent variable?		☐Yes	☐No
2. Was there a control group?		☐Yes	☐No
3. Were study participants randomly assigned to the intervention and control groups?		☐Yes	☐No
If Yes to all three, this is a Randomized Controlled Trial (RCT) or Experimental Study →	☐ LEVEL I		
If Yes to #1 and #2 and No to #3, OR Yes to #1 and No to #2 and #3, this is Quasi Experimental (some degree of investigator control, some manipulation of an independent variable, lacks random assignment to groups, may have a control group) →	☐ LEVEL II		
If No to #1, #2, and #3, this is Non-Experimental (no manipulation of independent variable, can be descriptive, comparative, or correlational, often uses secondary data) **or Qualitative** (exploratory in nature such as interviews or focus groups, a starting point for studies for which little research currently exists, has small sample sizes, may use results to design empirical studies) →	☐ LEVEL III		
NEXT, COMPLETE THE BOTTOM SECTION ON THE FOLLOWING PAGE, "STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION"			

Johns Hopkins Nursing Evidence-Based Practice
Research Evidence Appraisal Tool

B. Is this a summary of multiple research studies? ***If No, go to Non-Research Evidence Appraisal Form.***		☐Yes	☐No
1. Does it employ a comprehensive search strategy and rigorous appraisal method (**Systematic Review**)? ***If No, use Non-Research Evidence Appraisal Tool; if Yes:***		☐Yes	☐No
a. Does it combine and analyze results from the studies to generate a new statistic (effect size)? (**Systematic review with meta-analysis**)		☐Yes	☐No
b. Does it analyze and synthesize concepts from qualitative studies? (**Systematic review with meta-synthesis**)		☐Yes	☐No
If Yes to either a or b, go to #2B below.			
2. For Systematic Reviews and Systematic Reviews with meta-analysis or meta-synthesis:			
a. Are all studies included RCTs? →	☐ LEVEL I		
b. Are the studies a combination of RCTs and quasi-experimental or quasi-experimental only? →	☐ LEVEL II		
c. Are the studies a combination of RCTs, quasi-experimental and non-experimental or non-experimental only? →	☐ LEVEL III		
d. Are any or all of the included studies qualitative? →	☐ LEVEL III		
COMPLETE THE NEXT SECTION, "STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION"			

STUDY FINDINGS THAT HELP YOU ANSWER THE EBP QUESTION:

NOW COMPLETE THE FOLLOWING PAGE, "QUALITY APPRAISAL OF RESEARCH STUDIES", AND ASSIGN A QUALITY SCORE TO YOUR ARTICLE

Johns Hopkins Nursing Evidence-Based Practice
Research Evidence Appraisal Tool

Quality Appraisal of Research Studies			
• Does the researcher identify what is known and not known about the problem and how the study will address any gaps in knowledge?	☐Yes	☐No	
• Was the purpose of the study clearly presented?	☐Yes	☐No	
• Was the literature review current (most sources within last 5 years or classic)?	☐Yes	☐No	
• Was sample size sufficient based on study design and rationale?	☐Yes	☐No	
• If there is a control group:			
○ Were the characteristics and/or demographics similar in both the control and intervention groups?	☐Yes	☐No	☐NA
○ If multiple settings were used, were the settings similar?	☐Yes	☐No	☐NA
○ Were all groups equally treated except for the intervention group(s)?	☐Yes	☐No	☐NA
• Are data collection methods described clearly?	☐Yes	☐No	
• Were the instruments reliable (Cronbach's α [alpha] ≥ 0.70)?	☐Yes	☐No	☐NA
• Was instrument validity discussed?	☐Yes	☐No	☐NA
• If surveys/questionnaires were used, was the response rate ≥ 25%?	☐Yes	☐No	☐NA
• Were the results presented clearly?	☐Yes	☐No	
• If tables were presented, was the narrative consistent with the table content?	☐Yes	☐No	☐NA
• Were study limitations identified and addressed?	☐Yes	☐No	
• Were conclusions based on results?	☐Yes	☐No	

Quality Appraisal of Systematic Review with or without Meta-Analysis or Meta-Synthesis		
• Was the purpose of the systematic review clearly stated?	☐Yes	☐No
• Were reports comprehensive, with reproducible search strategy?	☐Yes	☐No
○ Key search terms stated	☐Yes	☐No
○ Multiple databases searched and identified	☐Yes	☐No
○ Inclusion and exclusion criteria stated	☐Yes	☐No
• Was there a flow diagram showing the number of studies eliminated at each level of review?	☐Yes	☐No
• Were details of included studies presented (design, sample, methods, results, outcomes, strengths and limitations)?	☐Yes	☐No
• Were methods for appraising the strength of evidence (level and quality) described?	☐Yes	☐No
• Were conclusions based on results?	☐Yes	☐No
○ Results were interpreted	☐Yes	☐No
○ Conclusions flowed logically from the interpretation and systematic review question	☐Yes	☐No
• Did the systematic review include both a section addressing limitations and how they were addressed?	☐Yes	☐No

QUALITY RATING BASED ON QUALITY APPRAISAL

A **High quality:** consistent, generalizable results; sufficient sample size for the study design; adequate control; definitive conclusions; consistent recommendations based on comprehensive literature review that includes thorough reference to scientific evidence

B **Good quality:** reasonably consistent results; sufficient sample size for the study design; some control, and fairly definitive conclusions; reasonably consistent recommendations based on fairly comprehensive literature review that includes some reference to scientific evidence

C **Low quality or major flaws:** little evidence with inconsistent results; insufficient sample size for the study design; conclusions cannot be drawn

Appendix D: Johns Hopkins Nursing Evidence-Based Practice Non-Research Appraisal Tool

Evidence Level & Quality:_____

Article Title:			Number:
Author(s):			Publication Date:
Journal:			
Does this evidence address the EBP question?	☐Yes	☐No Do not proceed with appraisal of this evidence	
Clinical Practice Guidelines: Systematically developed recommendations from nationally recognized experts based on research evidence or expert consensus panel. LEVEL IV Consensus or Position Statement: Systematically developed recommendations based on research and nationally recognized expert opinion that guides members of a professional organization in decision-making for an issue of concern. LEVEL IV			
• Are the types of evidence included identified? • Were appropriate stakeholders involved in the development of recommendations? • Are groups to which recommendations apply and do not apply clearly stated? • Have potential biases been eliminated? • Were recommendations valid (reproducible search, expert consensus, independent review, current, and level of supporting evidence identified for each recommendation)? • Were the recommendations supported by evidence? • Are recommendations clear?		☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes	☐No ☐No ☐No ☐No ☐No ☐No ☐No
Literature Review: Summary of published literature without systematic appraisal of evidence quality or strength. LEVEL V			
• Is subject matter to be reviewed clearly stated? • Is relevant, up-to-date literature included in the review (most sources within last 5 years or classic)? • Is there a meaningful analysis of the conclusions in the literature? □ Are gaps in the literature identified? • Are recommendations made for future practice or study?		☐Yes ☐Yes	☐No ☐No

	☐Yes ☐Yes ☐Yes	☐No ☐No ☐No
Expert Opinion: Opinion of one or more individuals based on clinical expertise. LEVEL V		
• Has the individual published or presented on the topic? • Is author's opinion based on scientific evidence? • Is the author's opinion clearly stated? • Are potential biases acknowledged?	☐Yes ☐Yes ☐Yes ☐Yes	☐No ☐No ☐No ☐No

Organizational Experience:

Quality Improvement: Cyclical method to examine organization-specific processes at the local level. LEVEL V

Financial Evaluation: Economic evaluation that applies analytic techniques to identify, measure, and compare the cost and outcomes of two or more alternative programs or interventions. LEVEL V

Program Evaluation: Systematic assessment of the processes and/or outcomes of a program and can involve both quantitative and qualitative methods. LEVEL V

Setting:	Sample (composition/size):	
• Was the aim of the project clearly stated? • Was the method adequately described? • Were process or outcome measures identified? • Were results adequately described? • Was interpretation clear and appropriate? • Are components of cost/benefit analysis described?	☐Yes ☐Yes ☐Yes ☐Yes ☐Yes ☐Yes	☐No ☐No ☐No ☐No ☐No ☐No ☐N/A
Case Report: In-depth look at a person, group, or other social unit. LEVEL V		
• Is the purpose of the case report clearly stated? • Is the case report clearly presented? • Are the findings of the case report supported by relevant theory or research? • Are the recommendations clearly stated and linked to the findings?	☐Yes ☐Yes ☐Yes	☐No ☐No ☐No

	☐Yes	☐No
Community Standard, Clinician Experience, or Consumer Preference Community Standard: Current practice for comparable settings in the community LEVEL V Clinician Experience: Knowledge gained through practice experience LEVEL V Consumer Preference: Knowledge gained through life experience LEVEL V		
Information Source(s):	Number of Sources:	
• Source of information has credible experience. • Opinions are clearly stated. • Identified practices are consistent.	☐Yes ☐Yes ☐Yes	☐No ☐No ☐N/A ☐No ☐N/A
Findings that help you answer the EBP question:		

QUALITY RATING FOR CLINICAL PRACTICE GUIDELINES, CONSENSUS OR POSITION STATEMENTS (LEVEL IV)

A High quality: Material officially sponsored by a professional, public, private organization, or government agency; documentation of a systematic literature search strategy; consistent results with sufficient numbers of well-designed studies; criteria-based evaluation of overall scientific strength and quality of included studies and definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years.

B Good quality: Material officially sponsored by a professional, public, private organization, or government agency; reasonably thorough and appropriate systematic literature search strategy; reasonably consistent results, sufficient numbers of well-designed studies; evaluation of strengths and limitations of included studies with fairly definitive conclusions; national expertise is clearly evident; developed or revised within the last 5 years.

C Low quality or major flaws: Material not sponsored by an official organization or agency; undefined, poorly defined, or limited literature search strategy; no evaluation of strengths and limitations of included studies, insufficient evidence with inconsistent results, conclusions cannot be drawn; not revised within the last 5 years.

QUALITY RATING FOR ORGANIZATIONAL EXPERIENCE (LEVEL V)

A High quality: Clear aims and objectives; consistent results across multiple settings; formal quality improvement or financial evaluation methods used; definitive conclusions; consistent recommendations with thorough reference to scientific evidence

B Good quality: Clear aims and objectives; formal quality improvement or financial evaluation methods used; consistent results in a single setting; reasonably consistent recommendations with some reference to scientific evidence

C Low quality or major flaws: Unclear or missing aims and objectives; inconsistent results; poorly defined quality improvement/financial analysis method; recommendations cannot be made

QUALITY RATING FOR LITERATURE REVIEW, EXPERT OPINION, COMMUNITY STANDARD, CLINICIAN EXPERIENCE, CONSUMER PREFERENCE (LEVEL V)

A High quality: Expertise is clearly evident; draws definitive conclusions; provides scientific rationale; thought leader in the field

B Good quality: Expertise appears to be credible; draws fairly definitive conclusions; provides logical argument for opinions

C Low quality or major flaws: Expertise is not discernable or is dubious; conclusions cannot be drawn

Appendix E: Johns Hopkins Permission

JHNEBP MODEL AND TOOLS-
PERMISSION

Thank you for your submission. We are happy to give you permission to use the JHNEBP model and tools in adherence of our legal terms noted below:

- You may not modify the model or the tools without written approval from Johns Hopkins.
- All reference to source forms should include "©The Johns Hopkins Hospital/The Johns Hopkins University."
- The tools may not be used for commercial purposes without special permission.

If interested in commercial use or discussing changes to the tool, please email ijhn@jhmi.edu.

Appendix F: Curriculum Plan

Title of Project: Staff Education Program on Postpartum Depression Screening

Student: Pamela Barstow, MSN, FNP-BC

Problem: The problem identified in this Doctor of Nursing Practice (DNP) project was the clinical staff's need for staff education regarding PPD and screening in the private pediatric clinic in Virginia where the project will take place.

Purpose: The purpose of this DNP project is to plan, implement, and evaluate a pediatric staff education program on postpartum depression, including the introduction of a standardized PPD screening tool and referral protocol for the at-risk postpartum mother.

Practice Focused Question(s):

RQ1: Is there evidence demonstrating the benefits of educating staff on PPD and the nursing profession?

RQ2: Will a staff education curriculum meet course objectives as determined by a team of content experts?

RQ3: Will a content item analysis with a pretest/posttest meet an acceptable content validity index of .78 in order to be acceptable for administration?

Method of Presenting: PowerPoint slide show followed by question and answer session

Objective Number and Statement	**Detailed Content Outline**	**Evidence (from Literature Review Matrix)**	**Method of Evaluation Pretest/ Posttest Item Number**
1) Briefly describe the three types of postpartum depressive disorders, including symptoms	• Postpartum blues, also known as baby blues o Short-lived o Mild mood problem ▪ Mood swings ▪ Anxiety, sadness, or feeling overwhelmed ▪ Irritability ▪ Confusion	ALLEGRA Learning Solutions, LLC. (n.d.). Earls, M. F., Yogman, M. W., Mattson,	1, 2, 3, 4, 12

and risk factors.	▪ Tearfulness or episodes of crying ▪ Fatigue ▪ Discomfort ▪ Overstimulation ▪ Difficulty sleeping or eating • Postpartum depression o Major depressive episode with a postpartum onset o DSM-V criteria ▪ At least five of nine symptoms in the same 2-week period representing a change from previous functioning • Depressed mood • Loss of pleasure • Change in weight or appetite • Insomnia or hypersomnia • Fatigue or loss of energy • Feelings of worthlessness or guilt • Impaired concentration or indecisiveness • Recurrent thoughts of death or suicidal ideation/attempt ▪ Symptoms cause significant distress or impairment ▪ Episode not attributed to a substance or medical condition ▪ Episode is not better explained by a psychotic disorder ▪ There has never been a manic or hypomanic episode	G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2019). Evans, M. G., Phillippi, S., & Gee, R. E. (2015).	

	○ "Minor depression peaks at two to three months postpartum, and the peak for major depression is at six weeks postpartum. There is another peak for depression at six months postpartum" (Earls et al., 2019, p.3). • Postpartum psychosis ○ Rare ○ Symptoms of depression (as above) ○ Accompanied by delusions, hallucinations, paranoia ○ Elation, mood lability, rambling speech ○ Disorganized behavior ○ Phobias ○ Overconcern for the baby or a focus on the baby dying ○ Excessive activity ○ Lack of interest in the baby ○ Obsessive behavior ○ Panic attacks ○ History of manic depression ○ Catatonic behavior • Populations at highest risk for postpartum depression ○ Low-income families ○ African American and Hispanic women ○ First-time mothers ○ Teenage mothers ○ Women with complicated pregnancies (Evans et al., 2015) • Risk factors for postpartum depression ○ A previous history of postpartum depression ○ A history of depression or anxiety before or during pregnancy ○ Familial history of mental health problems, substance use or abuse ○ Poor social support system (Evans et al., 2015).		

2) State the incidence of postpartum depression in the United States and Virginia.	• In the US, perinatal mood disorders are the most common obstetrical complication
	  o Often undiagnosed and untreated (Earls et al., 2019; Evans et al., 2015)
	• The rate of postpartum depression among women in the US is approximately 11.5 percent (Ko et al., 2017)
	• Data from the 2016-2017 Pregnancy Risk Assessment Monitoring System (PRAMS) indicates 12.5 percent of women in Virginia reported experiencing PPD symptoms (CDC, n.d.)
	  o With an increase to 13.36 percent in 2018 (Virginia Department of Health, n.d.)
		Centers for Disease Control and Prevention. (n.d.).
		
		Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2019).
		
		Evans, M. G., Phillippi, S., & Gee, R. E. (2015).
		
		Ko, J., Rockhill, K., Tong, V., Morrow, B., Farr, S., & the Centers for Disease Control and Prevention (2017).
		
		Virginia Department
			5, 11

		of Health (n.d.).	

3) Review the short-term and long-term consequences of postpartum depression for pediatric patients.	• Mothers experiencing postpartum depression may have trouble bonding with their infants (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018)
	  o May negatively impact a child's growth and development from infancy through adolescence (Webber & Benedict, 2018)
	• Children of mothers with a history of postpartum depression have been noted to have difficulties with
	  o Cognitive, social-emotional, and language development
	  o Internalizing and externalizing behaviors (van der Zee-van den Berg et al., 2017)
		van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017).
		
		van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Groothuis-Oudshoorn, C. G. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017).
		
		Webber, E. & Benedict, J. (2018).
			6, 19

4) Describe methods of screening women for postpartum depression.	• Many tools exist for screening women for PPD and are applicable to the pediatric well-child setting.
	  o These are tools used to assess for, not diagnose, postpartum depression
	  o Edinburgh Postnatal Depression Scale (EPDS), the Patient Health
		Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics	7, 13, 14

	Questionnaire (PHQ), (Earls et al., 2019; Waldrop et al., 2018) ▪ The AAP endorses the use of the EPDS by pediatricians for screening mothers of infants for PPD (Earls et al., 2019) • Using the EPDS allows pediatric healthcare providers an opportunity to create a dialog with moms about protective and risk factors integral to the safety and social-emotional w ell-being of the mother-child dyad (Earls et al., 2019) ▪ The EPDS is a 10-item questionnaire completed by the mother that assesses depression, anxiety, and suicidality (Earls et al., 2019; Sorg, Coddington, Ahmed, & Richards, 2019) ▪ A meta-analysis by Hewitt et al. (2009) determined the EPDS is able to correctly identify PPD with a sensitivity of 79% (95% confidence interval (CI), 0.74 to 0.83) o Postpartum Depression Screening Scale (PDSS) (Evans, et al., 2015) o Beck Depression Inventory II (Evans, et al., 2015)	Committee on Psychosocial Aspects of Child and Family Health. (2019). Evans, M. G., Phillippi, S., & Gee, R. E. (2015). Hewitt, C., Gilbody, S., Brealey, S., Paulden, M., Palmer, S., Mann, R. … Richards, D. (2009). Sorg, M., Coddington, J., Ahmed, A., & Richards, E. (2019).. Waldrop, J., Ledford, A., Perry, L. C., & Beeber, L. S. (2018).	

5) Discuss the rationale for screening women for postpartum depression in the pediatric setting.	• Less than one-half of pediatricians screen mothers of infants for PPD (Earls et al., 2019)
	• Educating pediatric healthcare providers about PPD and red flags associated with PPD, as well as providing education on the use of a standardized PPD screening tool will assist in the identification of women with PPD
	  ○ By identifying these women, interdisciplinary interventions can be initiated to assist in treatment of PPD
	  ▪ Therefore, the negative health implications for mothers and their children may be mitigated
	• Promoting maternal mental health and other healthcare services along the continuum of care and across the human life span to meet the needs of individuals and local and global communities can result in positive social change, thus improving the human condition
	• Postpartum depression is a treatable condition with early detection being shown to decrease the negative impact for mothers and children (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018).
	  ○ Detection begins with screening (Ko et al., 2017)
	• The American College of Obstetricians and Gynecologists (ACOG) (2018b) recommends all obstetrician-gynecologists and related women's healthcare providers thoroughly assess and screen a woman's mood and mental health during her comprehensive four- to twelve-week postpartum clinic visit
	  ○ In 2018, the ACOG set forth to optimize postpartum care by
		refer. (2013).
		
		American College of Obstetricians and Gynecologists. (2018a).
		
		American College of Obstetricians and Gynecologists. (2018b).
		
		American Medical Association. (2017).
		
		Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2019).
		
		Ko, J., Rockhill, K., Tong, V., Morrow, B.,
			8, 15, 16,
			
			18, 20

	publishing new care recommendations (ACOG, 2018a) ▪ Under the new guidelines, women now routinely have their first (initial) postpartum visit with their obstetrician within the first three weeks after delivery (sooner if a co-morbidity is present, such as diabetes, hypertension, or cesarean delivery) and a comprehensive visit between four to twelve weeks postpartum based upon maternal preference and schedule (ACOG, 2018a) • The American Academy of Pediatrics (AAP) recognizes the impact maternal mental health has upon children and recommends screening mothers for postpartum depression at the 1-, 2-, 4-, and 6-month well-child visits (Earls et al., 2019) • The United States Preventative Services Task Force (USPSTF) (Siu & USPSTF, 2016) supports the ACOG and the AAP recommendations and encourages interprofessional collaboration when treating women for PPD • One of the objectives of the Healthy People 2020 initiative is decreasing the proportion of women delivering a live birth who experience postpartum depressive symptoms (Office of Disease Prevention and Health Promotion, 2019) • Other noteworthy professional organizations that also support screening, treating, and referring (when applicable) women for postpartum depression include	Farr, S., & the Centers for Disease Control and Prevention (2017). National Association of Pediatric Nurse Practitioners. (2011). Office of Disease Prevention and Health Promotion. (2019). Siu, A., & the United States Preventative Services Task Force. (2016). van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017).	

	○ The American Medical Association (AMA) (2017) ○ The National Association of Pediatric Nurse Practitioners (NAPNAP) (2011) ○ The American College of Nurse Midwives (2013)	van der Zee-van den Berg, A. I., Boere-Boonekamp, M. M., Groothuis-Oudshoorn, C. G. M., Ijzerman, M. J., Haasnoot-Smallegange, R. M. E., & Reijneveld, S. A. (2017). Webber, E. & Benedict, J. (2018).	
6) Briefly describe treatment options for postpartum depression.	• Anti-depressant (SSRI) • Psychotherapy • Cognitive Behavioral Therapy (CBT) • Support groups • Part-time or full-time mother's helper • Meditation • Massage • Bright light therapy • Dietary modifications • Exercise	ALLEGRA Learning Solutions, LLC. (n.d.). Ward-Zimmerman, B., & Vendetti, J. (2014).	9
7) Discuss pediatric healthcare provider interventions for a positive maternal screening for postpartum depression.	• Recommend follow-up with maternal PCP or OB • Recommend seeking a therapist and/or support group ○ Provide list of community resources • Recommend ER, if highly concerned • Positive messaging ○ Normalize--Feelings the woman is experience are normal ○ De-stigmatize--Not the woman's fault ○ Instill hope--Postpartum depression is treatable	Ward-Zimmerman, B., & Vendetti, J. (2014).	10, 17

	○ Promote self-care		

Appendix G: Curriculum Plan Evaluation by Content Experts

Date:

Student: Pamela Barstow, MSN, FNP-BC

Reviewer:

Products for Review: Curriculum Plan, Complete Curriculum Content, Literature Review Matrix

Instructions: Please review each objective related to the curriculum plan, content and matrix. The answer will be a met or not met with comments if there is a problem understanding the content or if the content does not speak to the objective. At the conclusion of this educational experience, the participant will be able to:

Objective Number	Objective Statement	Met	Not Met	Comment
1	Briefly describe the three types of postpartum depressive disorders, including symptoms and risk factors.			
2	State the incidence of postpartum depression in the United States and Virginia.			
3	Review the short-term and long-term consequences of postpartum depression for pediatric patients.			
4	Describe methods of screening women for postpartum depression.			
5	Discuss the rationale for screening women for postpartum depression in the pediatric setting.			
6	Briefly describe treatment options for postpartum depression.			
7	Discuss pediatric healthcare provider interventions for a positive maternal screening for postpartum depression.			

Appendix H: Curriculum Plan Evaluation by Content Experts Summary

Met = 1 Not Met = 2

Objective Number and Statement	Evaluator A	Evaluator B	Evaluator C	Average Score
1. Briefly describe the three types of postpartum depressive disorders, including symptoms and risk factors.	1	1	1	1
2. State the incidence of postpartum depression in the United States and Virginia.	1	1	1	1
3. Review the short-term and long-term consequences of postpartum depression for pediatric patients.	1	1	1	1
4. Describe methods of screening women for postpartum depression.	1	1	1	1
5. Discuss the rationale for screening women for postpartum depression in the pediatric setting.	1	1	1	1
6. Briefly describe treatment options for postpartum depression.	1	1	1	1
7. Discuss pediatric healthcare provider interventions for a positive maternal screening for postpartum depression.	1	1	1	1

Appendix I: Pretest/Posttest Staff Education Program on PPD Screening

This quiz contains 10 multiple choice questions, followed by 10 true/false questions. The purpose of this quiz is to assess your knowledge about postpartum depression, screening methods, and treatment/referral recommendations. Read each question thoroughly and select the best possible answer. The quiz should take no more than 5-10 minutes to complete.

Multiple Choice

1. Which postpartum depressive disorder can be described as a short-lived, mild mood problem?

    a. Postpartum psychosis

    b. Postpartum depression

    c. Postpartum blues*

2. Which rare postpartum depressive disorder may include delusions, hallucinations, and paranoia?

    a. Postpartum psychosis*

    b. Postpartum depression

    c. Postpartum blues

3. "Minor depression peaks at two to three months postpartum, and the peak for major depression is at ____ weeks postpartum" (Earls et al., 2019, p. 3).

    a. 2

    b. 4

    c. 6*

    d. 8

4. Populations at highest risk for postpartum depression include (Evans et al., 2015) (Choose all that apply):

    a. Wealthy families

    b. African American and Hispanic women*

    c. First-time mothers*

    d. Teenage mothers*

    e. Women with uncomplicated pregnancies

5. The rate of postpartum depression among women in the US is approximately 11.5% (Ko et al., 2017). The percentage of women in Virginia who experience postpartum depression symptoms is:

    a. Lower than the national average

    b. The same as the national average

    c. Higher than the national average*

6. Mothers experiencing postpartum depression may have trouble bonding with their infants (van den Berg et al., 2017; Webber & Benedict, 2018). Poor bonding may:

    a. Force an infant to self soothe

    b. Result in a quiet infant who doesn't cry much

    c. Negatively impact a child's growth and development from infancy through adolescence*

    d. Heighten a child's self-awareness and aptitude for social and educational activities

7. The American Academy of Pediatrics (AAP) endorses the use of which screening tool for pediatricians to use to screen mothers of infants for postpartum depression (Earls et al., 2019).

a. The Edinburgh Postnatal Depression Scale*

b. The Patient Health Questionnaire

c. The Postpartum Depression Screening Scale

d. Beck Depression Inventory II

8. Select the organization(s) that recommend and/or support screening women for postpartum depression:

    a. The American College of Obstetricians and Gynecologists*

    b. The American Academy of Pediatrics*

    c. The Global Commission on Health Screenings

    d. The United States Preventative Services Task Force*

    e. Healthy People 2020*

9. Which of the following options is **not** a recommended treatment for postpartum depression?

    a. Anti-depressant medications

    b. Cognitive behavioral therapy

    c. Dietary modifications

    d. All of the above

    e. None of the above*

10. Which recommendation is **not** appropriate for a pediatric healthcare provider to make for a positive maternal screening for postpartum depression?

    a. Follow-up with PCP or OB

    b. Make a reservation at Club Med*

    c. Join a support group

d. Follow-up with the ER

True or False

11. In the US, perinatal mood disorders are the most common obstetrical complication (Earls et al., 2019; Evans et al., 2015).

    a. True*

    b. False

12. Women with a previous history of postpartum depression are not at risk for experiencing postpartum depression again (Evans et al., 2015).

    a. True

    b. False*

13. Tools that screen women for postpartum depression are diagnostic in nature (Earls et al., 2019; Waldrop et al., 2018).

    a. True

    b. False*

14. The Edinburgh Postnatal Depression Scale is a 10-item questionnaire completed by the mother that assesses for depression, anxiety, and suicidality (Earls et al., 2019; Sorg et al., 2019).

    a. True*

    b. False

15. Although postpartum depression is a treatable condition, early detection has not been shown to decrease the negative impact for mother and children (van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018).

    a. True

    b. False*

16. The American Academy of Pediatrics recommends screening mothers for postpartum depression at the 1-, 2-, 4-, and 6-month well-child visits (Earls et al., 2019).

    a. True*

    b. False

17. Normalizing and stigmatizing a woman's feelings are appropriate interventions for pediatric staff members to make (Ward-Zimmerman & Vendetti, 2014).

    a. True

    b. False*

18. More than one-half of pediatricians screen mother of infants for postpartum depression (Earls et al., 2019).

    a. True

    b. False*

19. Children of mothers with a history of postpartum depression have been noted to have difficulties with internalizing and externalizing behaviors (van der Zee-van den Berg et al., 2017).

    a. True*

    d. False

20. Postpartum depression detection begins with screening (Ko et al., 2017).

    a. True*

    b. False

Appendix J: Pretest/Posttest Content Validation by Content Experts

Title of Project: **Staff Education Program on Postpartum Depression Screening**

Student: **Pamela Barstow, MSN, FNP-BC**

Respondent:

Accompanying Packet: Curriculum Plan, Pretest/Posttest with answers, Pretest/Posttest Expert Content Validation Form

INSTRUCTIONS: Please check each item to see if the question is representative of the course objective and the correct answer is reflected in the course content.

Test Item #

1. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

2. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

3. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

4. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

5. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

6. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

7. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

8. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

9. Not Relevant_____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

10. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

11. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

12. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

13. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

14. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

15. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

16. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

17. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

18. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

19. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

20. Not Relevant____ Somewhat Relevant_____ Relevant_____Very Relevant_____

Comments:_____

Appendix K: Pretest/Posttest CVI-S Analysis

Rating on X-Items Scale by Three Experts on a 4-point Likert Scale

Pretest/Posttest Items	Expert 1	Expert 2	Expert 3	CVI
1	1	1	1	1
2	1	1	1	1
3	1	1	1	1
4	1	1	1	1
5	1	1	1	1
6	1	1	1	1
7	1	1	1	1
8	0	1	0	0.33
9	1	1	1	1
10	1	1	1	1
11	1	1	1	1
12	1	1	1	1
13	1	1	1	1
14	1	1	1	1
15	1	1	1	1
16	1	1	1	1
17	1	1	1	1
18	1	1	1	1
19	1	1	1	1
20	1	1	1	1
Total	59	79	76	
Proportion Relevant	0.7375	0.9875	0.95	S-CVI-.97

For each rating of 1 or 2 a score of 0 is placed in the content expert responses. For each rating of a 3 or 4 a score of 1 is placed in the responses.

I-CVI, item-level content validity index. The I-CVI = Number of responses with a relevance rating of 3 or 4 = 1. Add horizontally and divide by the number of content experts.

S-CVI/UA, scale-level content validity index, universal agreement calculation method. Add all I-CVI scores vertically and divide by the number of items to achieve the S-CVI. The scale (test) CVI is the mean of the 20 I-CVIs. Adopted from Polit, D. F., & Beck, C. T. (2006).

Appendix L: Content Expert Packet Letter

Date

Dear (Content Expert identifier)

I am so very excited that you have agreed to participate in my doctoral journey. Please allow me to thank you in advance for your valued input as one of my three content experts. Your participation is integral to my Doctor of Nursing Practice (DNP) project. For my project, I have developed a staff education program on postpartum depression screening in the pediatric primary care setting. The enclosed packet includes five items for your review and input. Each item has a set of instructions in the top section.

- Literature Review Matrix—objectives and content in the curriculum plan are referenced from the Literature Review Matrix
- Curriculum Plan
- Evaluation of Curriculum Plan by Content Experts
- Pretest/Posttest
- Pretest/Posttest Content Validity by Content Experts

Please be assured that all input is anonymous. Each content expert is only identified by a letter: A, B, or C. My office manager mailed a packet to each content expert and I am blinded as to which letter (A, B, or C) corresponds which content expert. Your completed forms will be returned to my office manager in the enclosed pre-paid envelope. Once all forms are received, my office manager will return them to me in a blank envelope. If you have any questions, please do not hesitate to contact me by phone or e-mail. If you have concerns that you think need to be brought to my committee's attention, please contact Dr. Joan Moon at (419) 308-3714 or joan.moon@waldenu.edu. Thank you in advance for your time.

Sincerely,

Pamela Barstow, MSN, FNP-BC, DNP Student
E-mail: Pbarstow@capitalareapediatrics.com
Cell: (803) 429-6466

Appendix M: PPD Resource Kit

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] 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 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

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

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

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (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
   - ☐ As 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
   - ☐ Yes, 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

*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

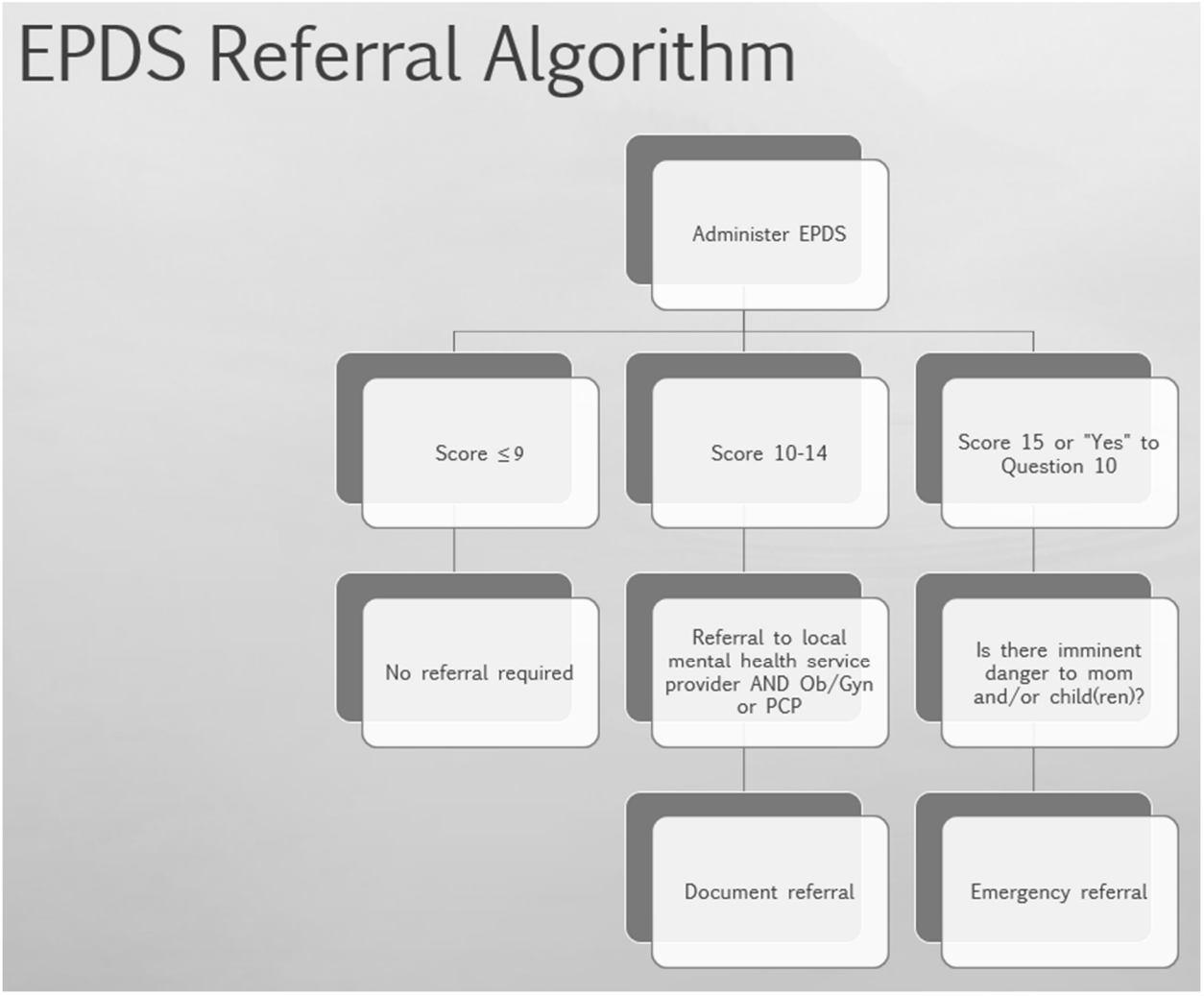
*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199


EPDS Referral Algorithm
Administer EPDS
Score ≤ 9
Score 10-14
Score 15 or "Yes" to Question 10
No referral required
Referral to local mental health service provider AND Ob/Gyn or PCP
Is there imminent danger to mom and/or child(ren)?
Document referral
Emergency referral

COMMUNITY RESOURCE LIST-POSTPARTUM HEALTH

POSTPARTUM SUPPORT PROGRAMS

- **Postpartum Virginia**- www.postpartumva.org- online and phone support, resources, and information for new moms and their families on anxiety and depression. Has lists of local therapist and psychiatrists who specifically work with post-partum mothers.
- **Pace**- www.pacemoms.org emotional and educational support groups for first and second time moms in the Washington DC Region
- **Inova Health System New Moms Support Programs**- offers post-partum and breastfeeding support groups and also groups for meeting other new moms. www.inova.org/our-services/inova-well/childbirth-parenting/new-moms-support-groups or call 571-472-1401
- **Your OB-GYN provider** may also be able to give you resources and support. We encourage you to talk with them about your feelings.

If you are feeling suicidal, please go to the Emergency room or call the National Suicide Prevention Lifeline at 800-273-TALK (8255)

THERAPISTS SPECIALIZING IN POSTPARTUM/MATERNAL DEPRESSION:

(THERAPISTS PROVIDE COUNSELING, INFORMATION AND RESOURCES BUT CANNOT PRESCRIBE MEDICATIONS)

PSYCHIATRISTS FOR POSTPARTUM/MATERNAL DEPRESSION:

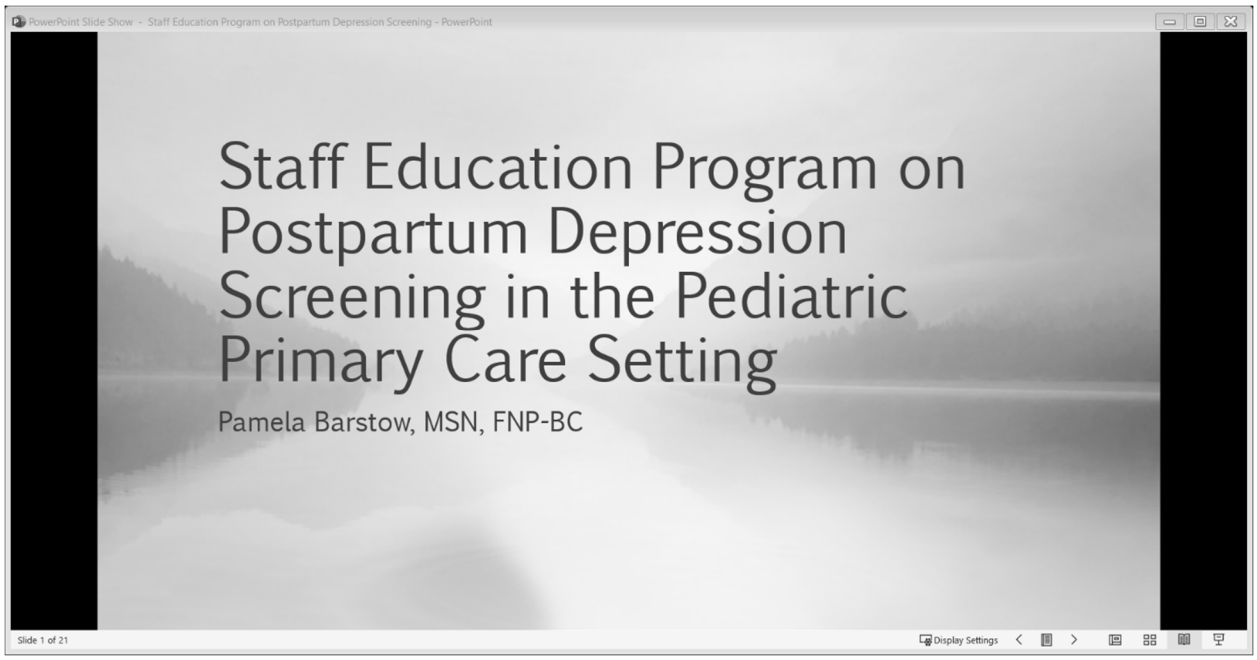
(PSYCHIATRISTS ARE MEDICAL DOCTORS WHO CAN PRESCRIBE MEDICATIONS AND RULE OUT ANY UNDERLYING MEDICAL CONDITIONS)

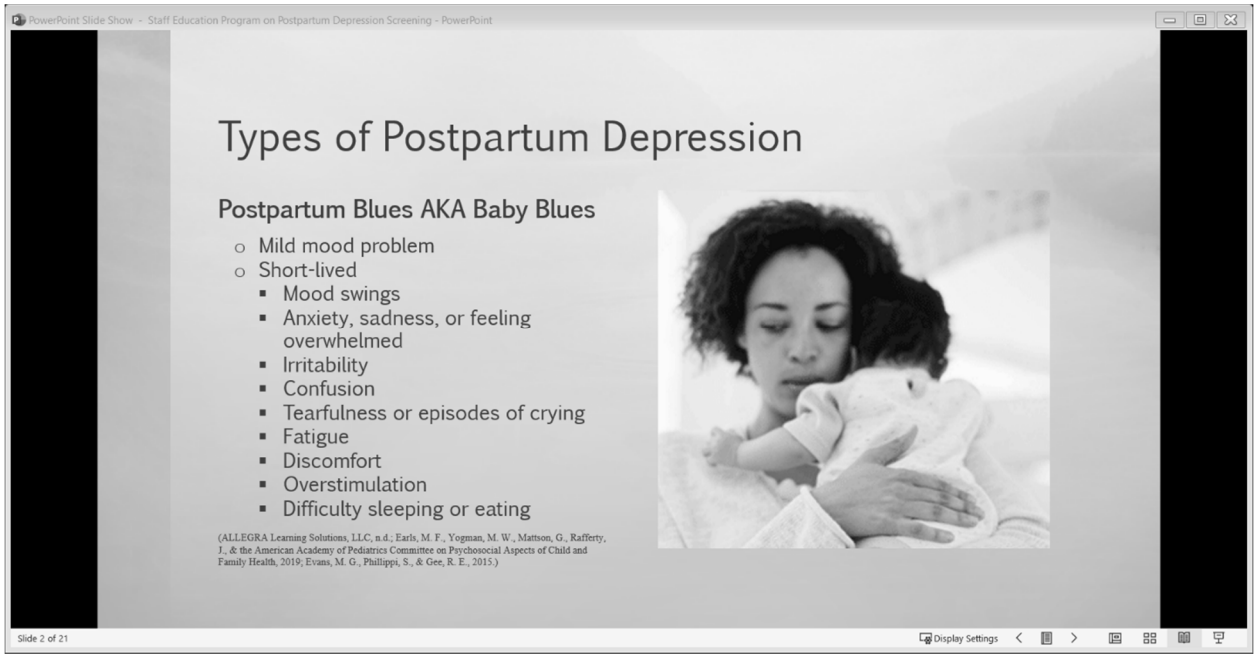
If you are being abused or need support to leave a partner, please call:

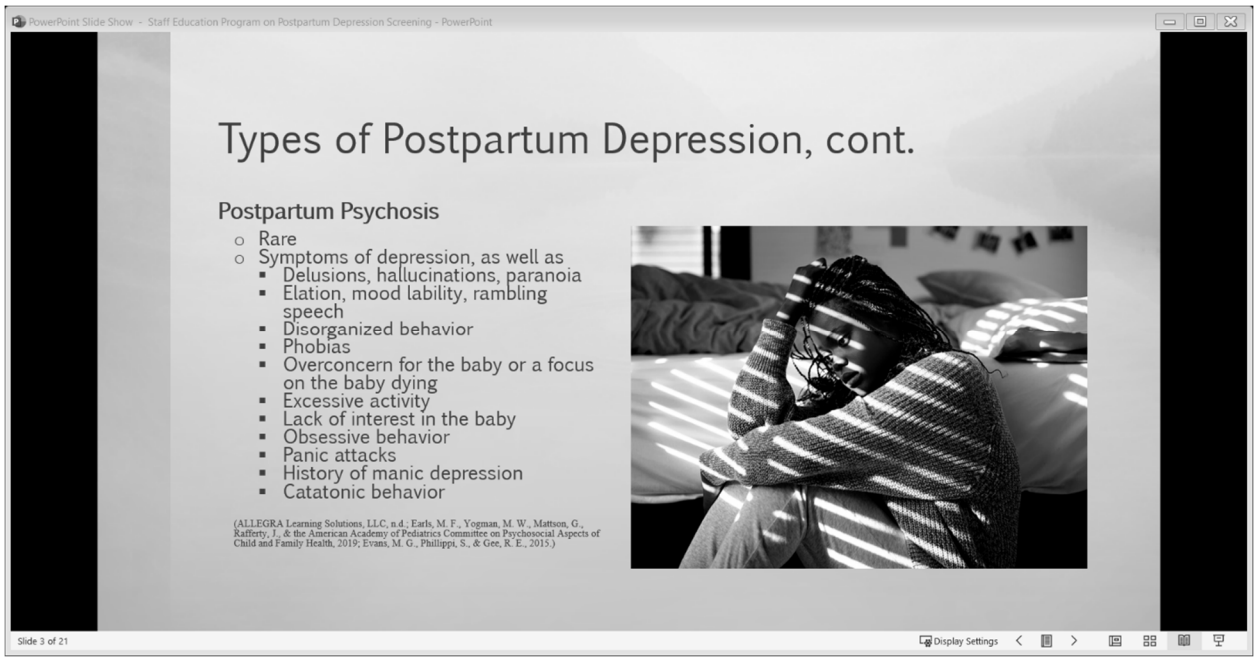
Loudoun Abused Women's Shelter and 24/7 hotline at (703)-777-6552 or go to www.lcsj.org/laws

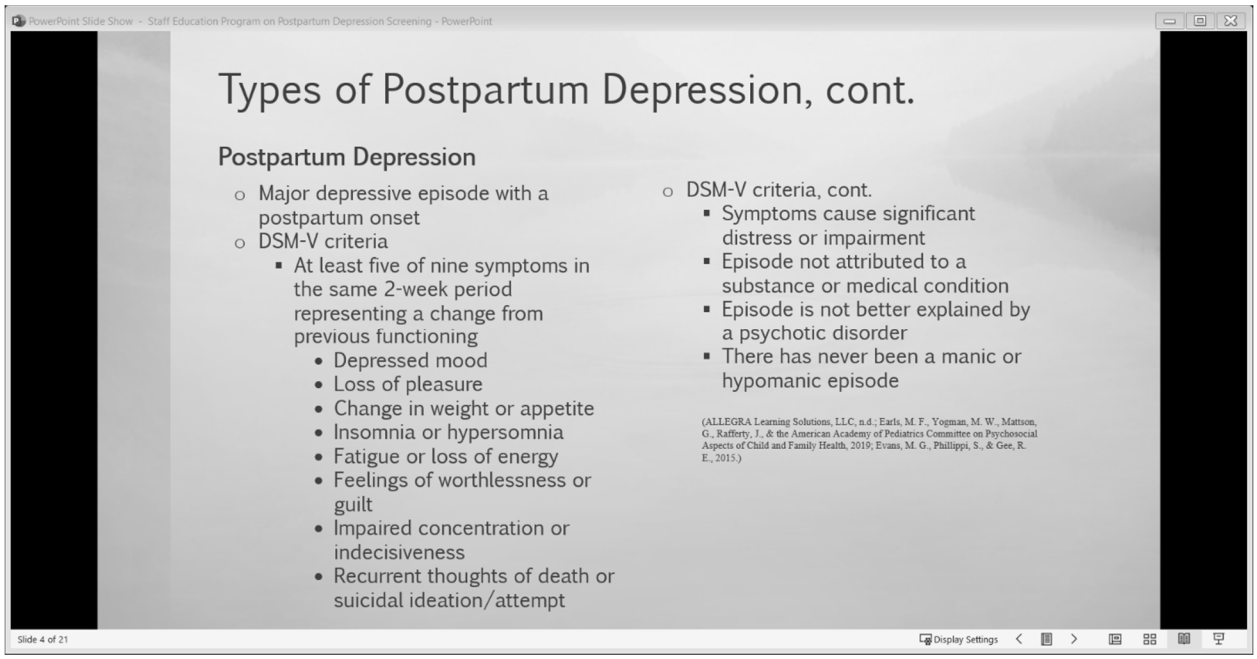
Fairfax County Dept of Family Services Domestic Violence 24/7 Hotline (703) 360-7273

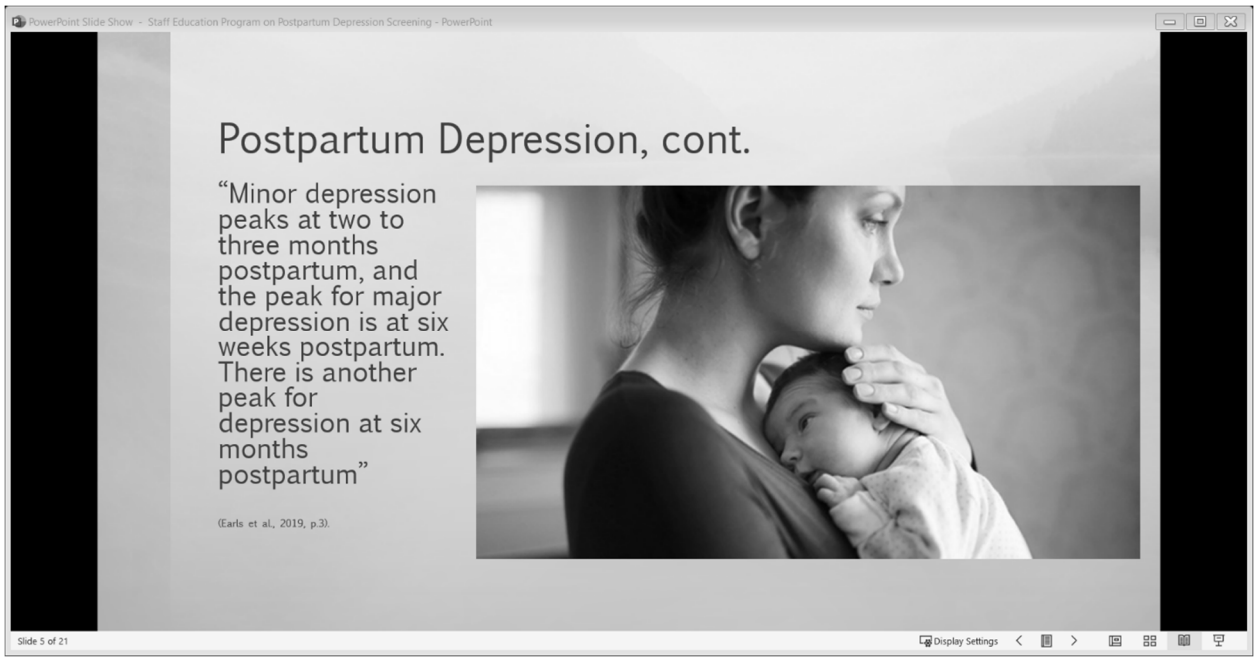
Appendix N: PowerPoint Presentation

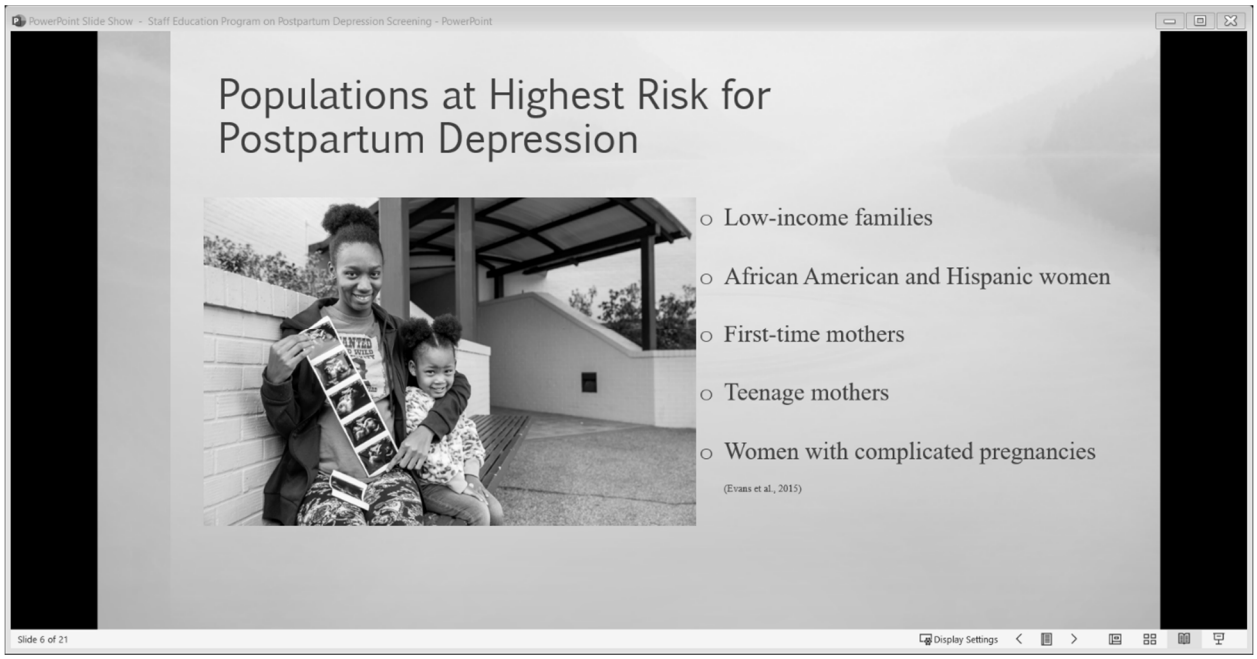


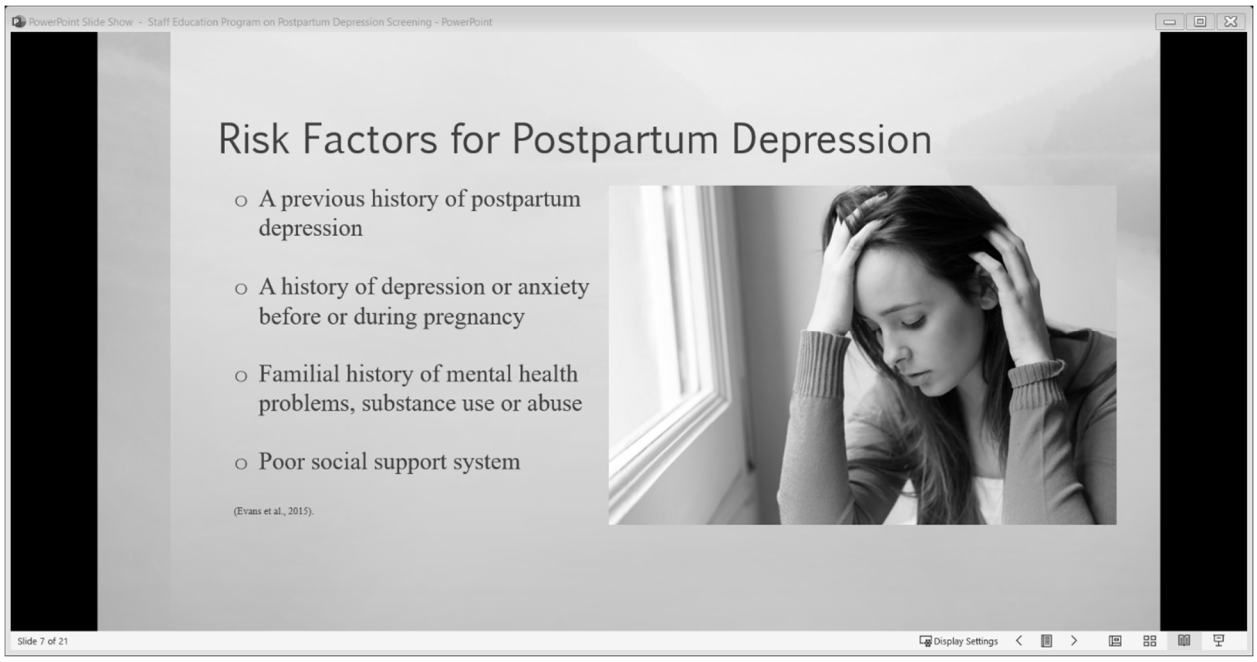


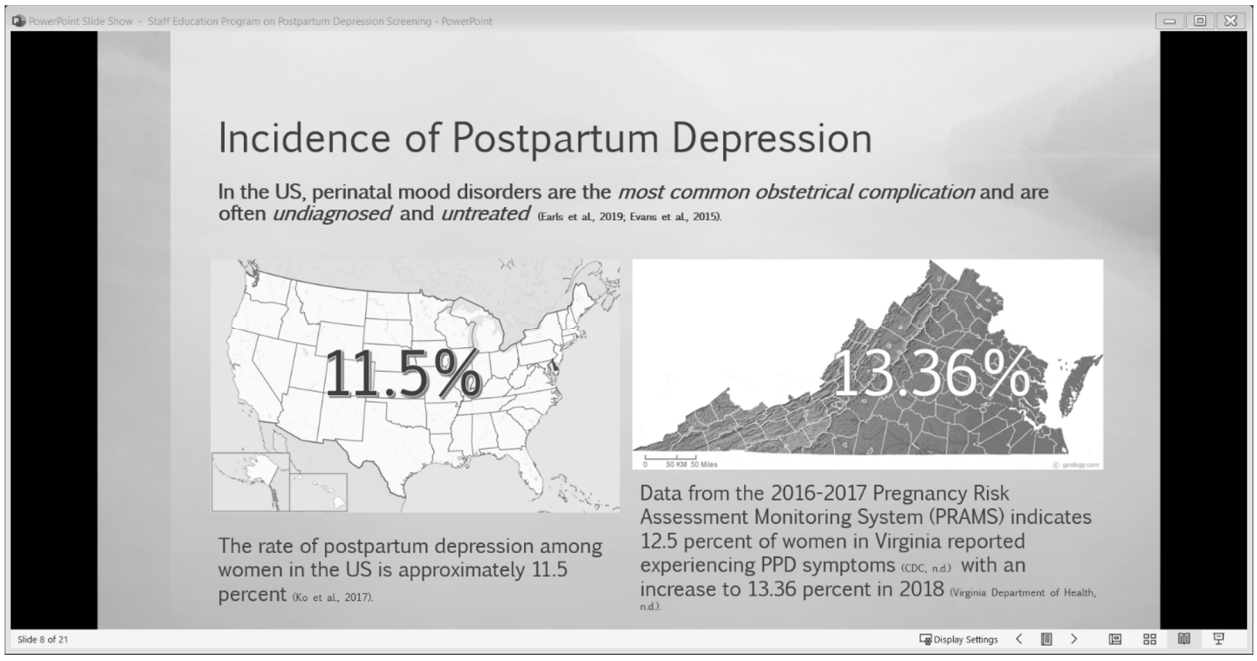

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Types of Postpartum Depression, cont.
Postpartum Psychosis
Rare
Symptoms of depression, as well as
Delusions, hallucinations, paranoia
Elation, mood lability, rambling speech
Disorganized behavior
Phobias
Overconcern for the baby or a focus on the baby dying
Excessive activity
Lack of interest in the baby
Obsessive behavior
Panic attacks
History of manic depression
Catatonic behavior
(ALLEGRA Learning Solutions, LLC, n.d.; Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, 2019; Evans, M. G., Phillippi, S., & Gee, R. E., 2015.)
Slide 3 of 21
Display Settings

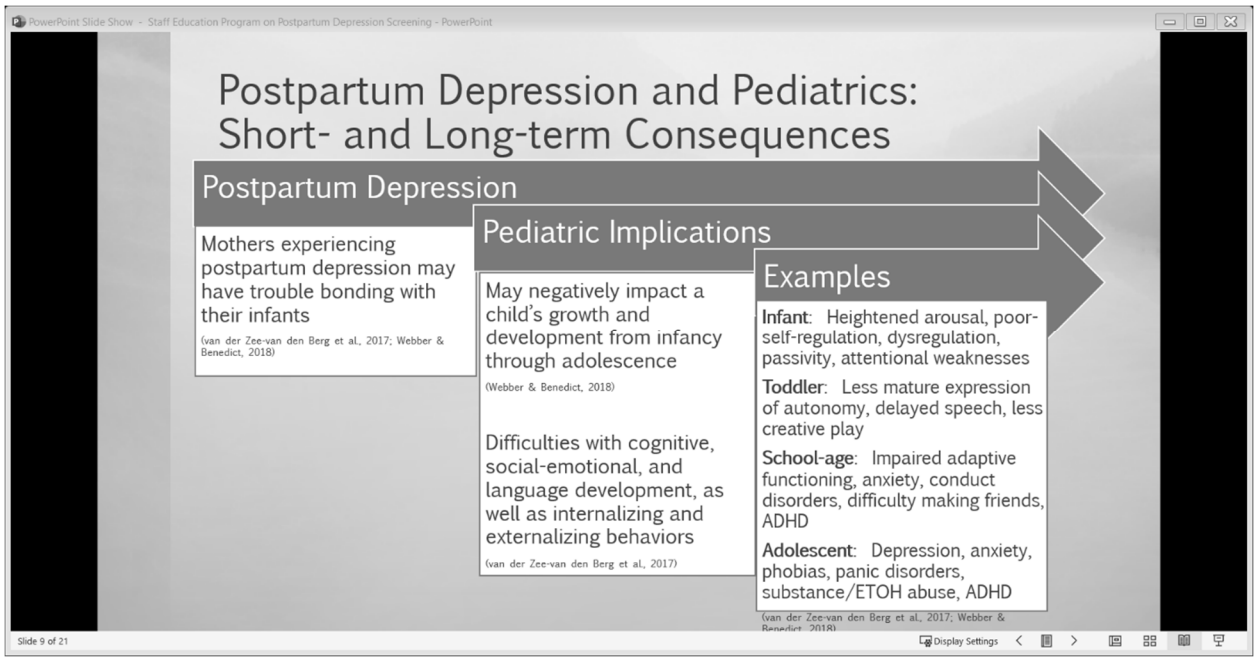

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Types of Postpartum Depression, cont.
Postpartum Depression
Major depressive episode with a postpartum onset
DSM-V criteria
At least five of nine symptoms in the same 2-week period representing a change from previous functioning
Depressed mood
Loss of pleasure
Change in weight or appetite
Insomnia or hypersomnia
Fatigue or loss of energy
Feelings of worthlessness or guilt
Impaired concentration or indecisiveness
Recurrent thoughts of death or suicidal ideation/attempt
DSM-V criteria, cont.
Symptoms cause significant distress or impairment
Episode not attributed to a substance or medical condition
Episode is not better explained by a psychotic disorder
There has never been a manic or hypomanic episode
(ALLEGRA Learning Solutions, LLC, n.d.; Earls, M. F., Yogman, M. W., Mattson, G., Rafferty, J., & the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health, 2019; Evans, M. G., Phillippi, S., & Gee, R. E., 2015.)
Slide 4 of 21
Display Settings

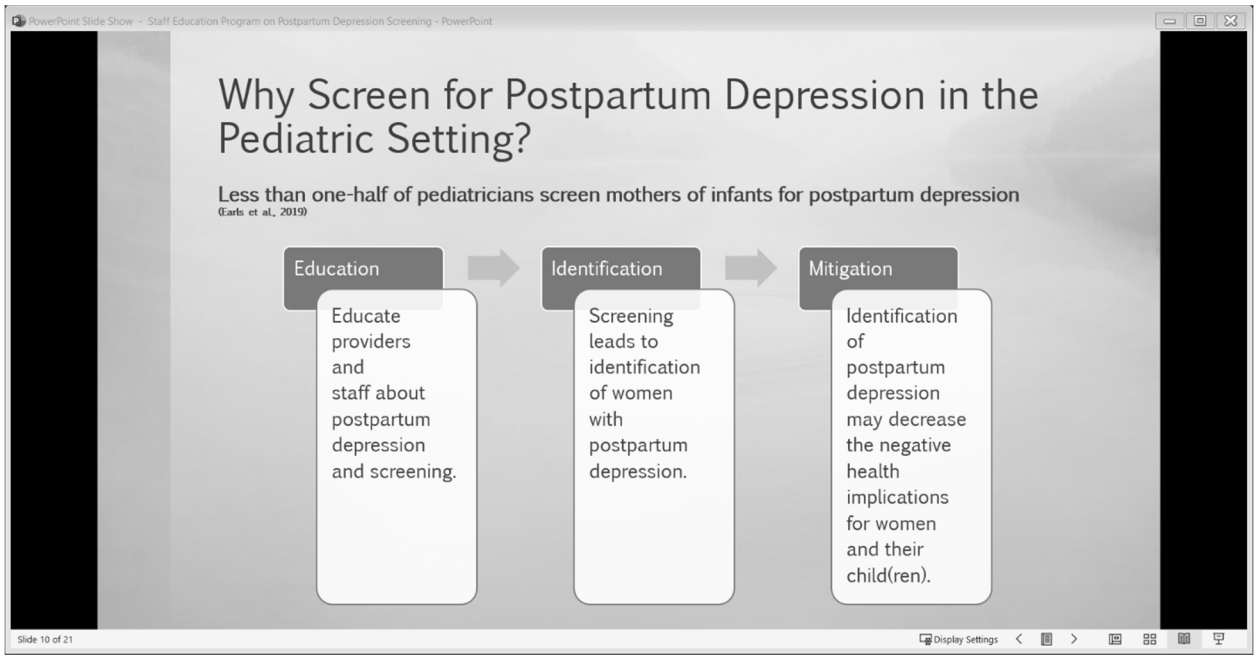

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Postpartum Depression, cont.
"Minor depression peaks at two to three months postpartum, and the peak for major depression is at six weeks postpartum. There is another peak for depression at six months postpartum"
(Earls et al., 2019, p.3).
Slide 5 of 21
Display Settings

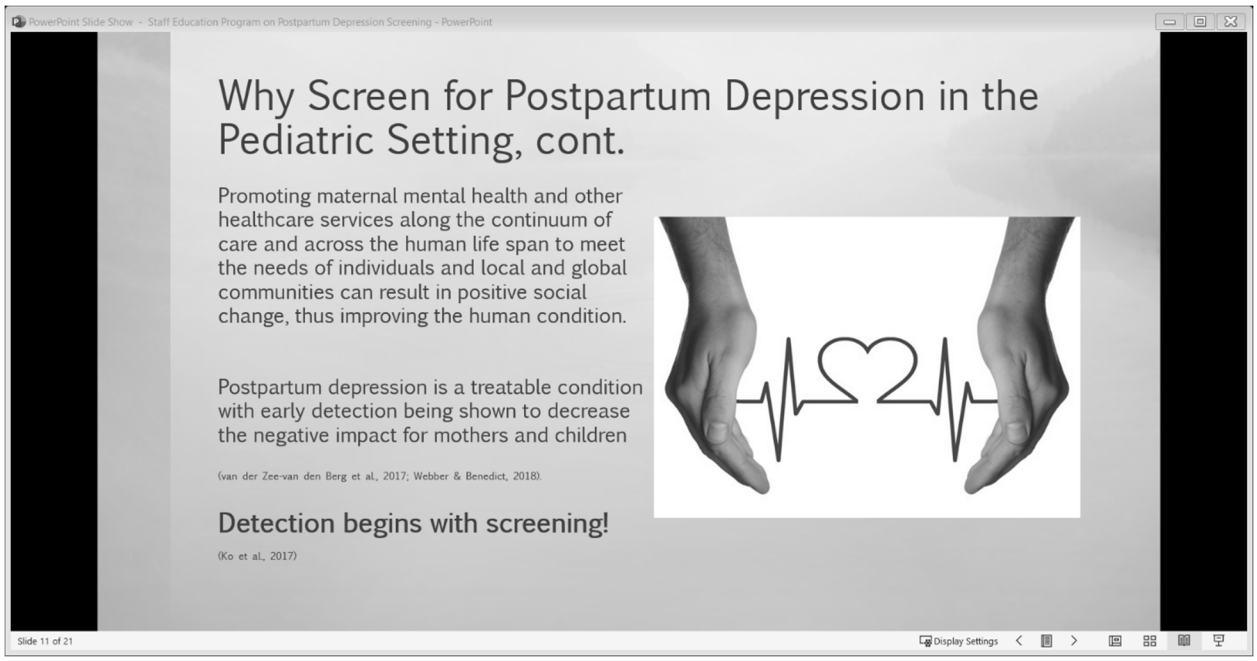

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Populations at Highest Risk for Postpartum Depression
Low-income families
African American and Hispanic women
First-time mothers
Teenage mothers
Women with complicated pregnancies
(Evans et al., 2015)
Slide 6 of 21
Display Settings

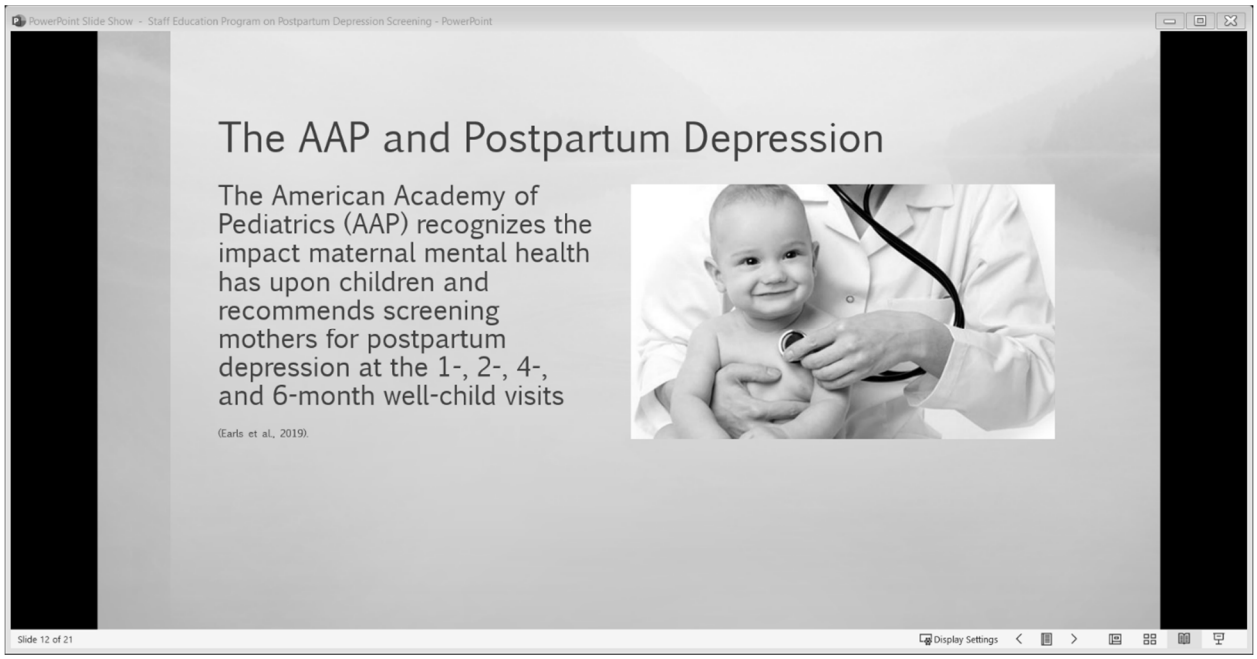

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Risk Factors for Postpartum Depression
o A previous history of postpartum depression
o A history of depression or anxiety before or during pregnancy
o Familial history of mental health problems, substance use or abuse
o Poor social support system
(Evans et al., 2015).
Slide 7 of 21
Display Settings

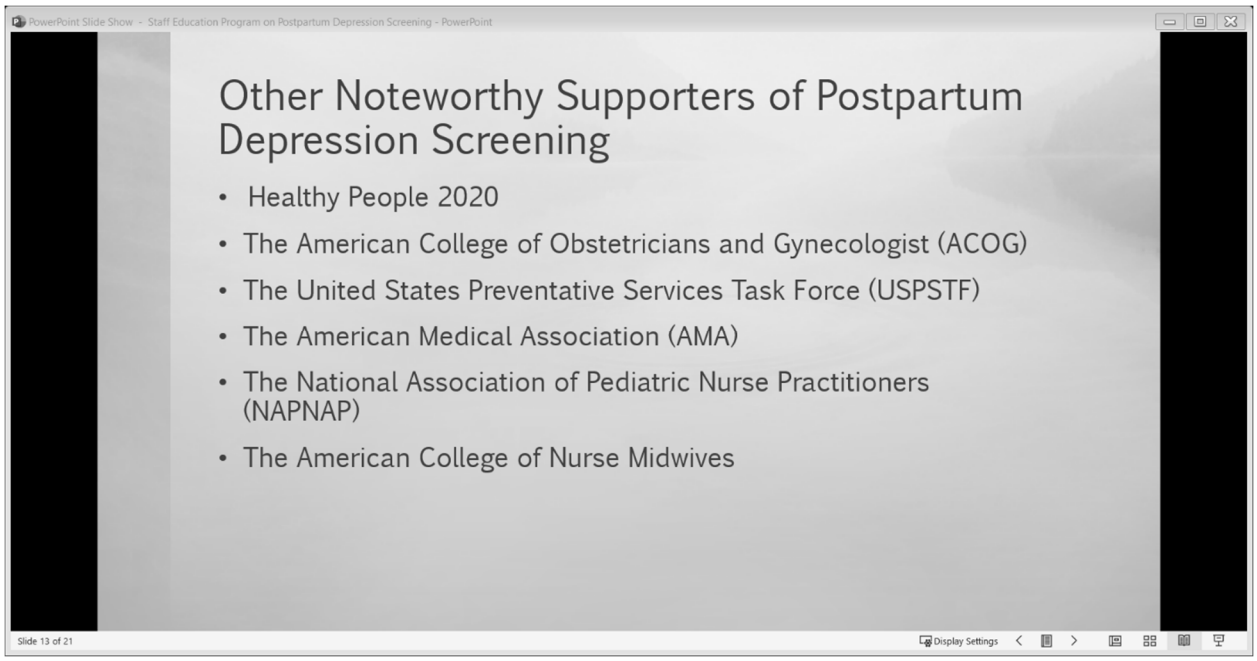

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Incidence of Postpartum Depression
In the US, perinatal mood disorders are the *most common obstetrical complication* and are often *undiagnosed* and *untreated* (Earls et al., 2019; Evans et al., 2015).
11.5%
13.36%
0 50 KM 50 Miles
The rate of postpartum depression among women in the US is approximately 11.5 percent (Ko et al., 2017).
Data from the 2016-2017 Pregnancy Risk Assessment Monitoring System (PRAMS) indicates 12.5 percent of women in Virginia reported experiencing PPD symptoms (CDC, n.d.) with an increase to 13.36 percent in 2018 (Virginia Department of Health, n.d.).
Slide 8 of 21
Display Settings

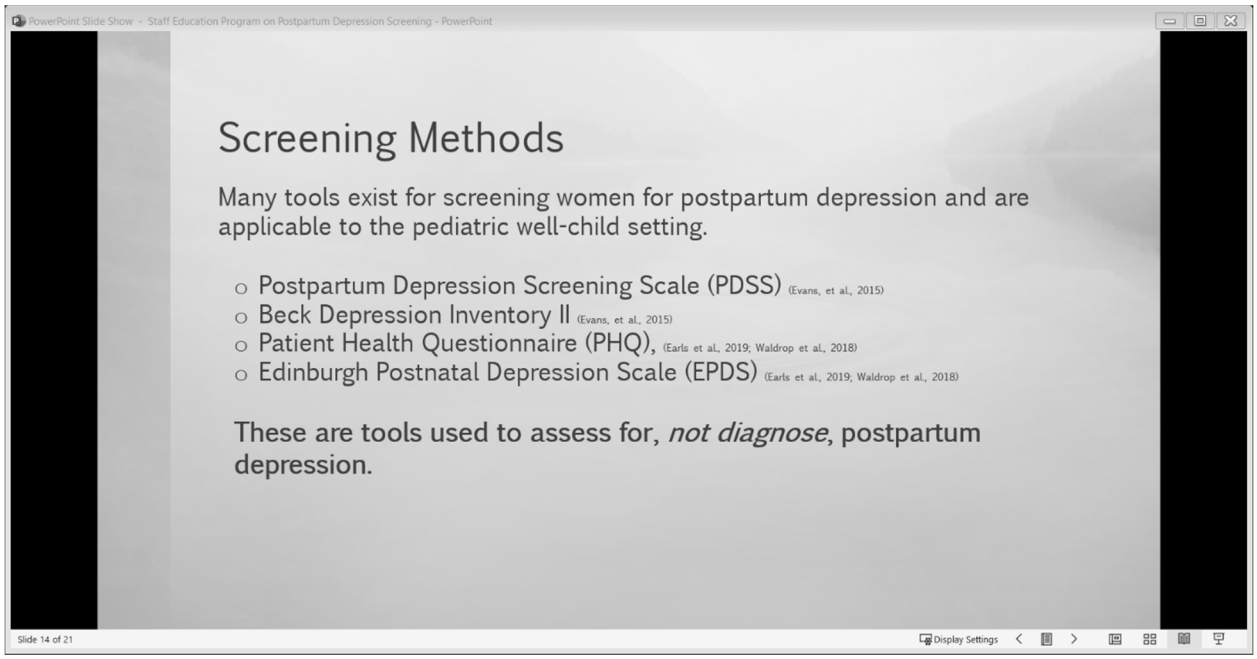

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Postpartum Depression and Pediatrics: Short- and Long-term Consequences
Postpartum Depression
Mothers experiencing postpartum depression may have trouble bonding with their infants
(van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018)
Pediatric Implications
May negatively impact a child's growth and development from infancy through adolescence
(Webber & Benedict, 2018)
Difficulties with cognitive, social-emotional, and language development, as well as internalizing and externalizing behaviors
(van der Zee-van den Berg et al., 2017)
Examples
Infant: Heightened arousal, poor-self-regulation, dysregulation, passivity, attentional weaknesses
Toddler: Less mature expression of autonomy, delayed speech, less creative play
School-age: Impaired adaptive functioning, anxiety, conduct disorders, difficulty making friends, ADHD
Adolescent: Depression, anxiety, phobias, panic disorders, substance/ETOH abuse, ADHD
(van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018)
Slide 9 of 21
Display Settings

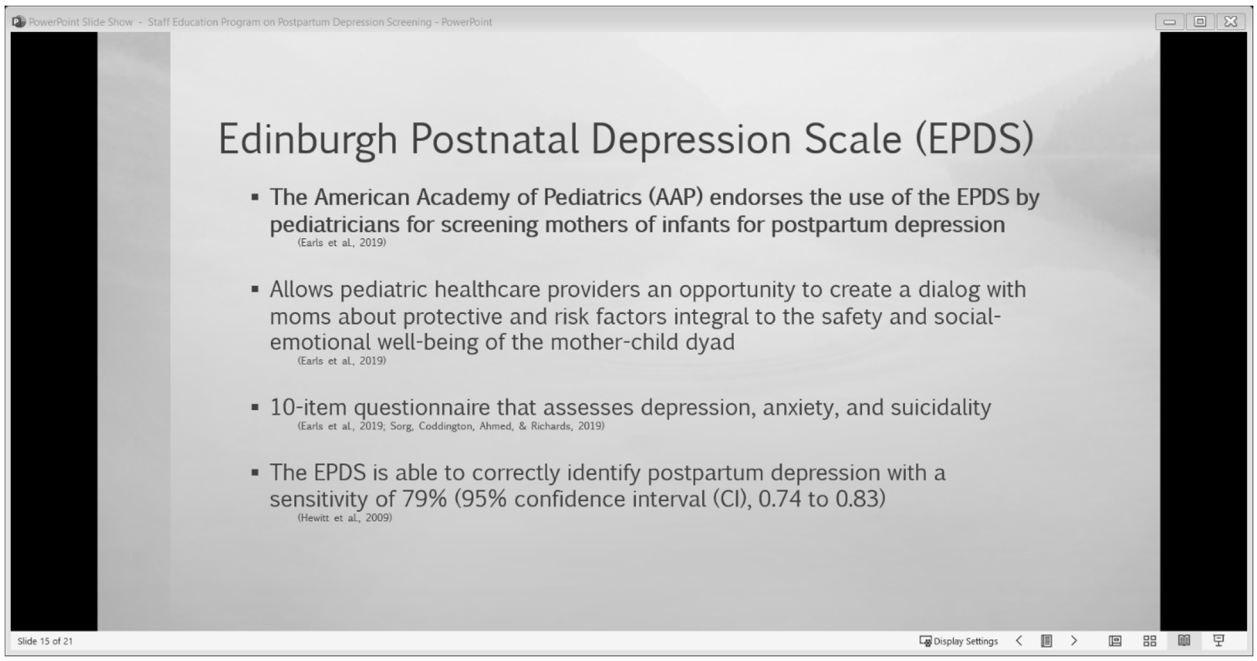

PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Why Screen for Postpartum Depression in the Pediatric Setting?
Less than one-half of pediatricians screen mothers of infants for postpartum depression
(Earls et al., 2019)
Education
Educate providers and staff about postpartum depression and screening.
Identification
Screening leads to identification of women with postpartum depression.
Mitigation
Identification of postpartum depression may decrease the negative health implications for women and their child(ren).
Slide 10 of 21
Display Settings


PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Why Screen for Postpartum Depression in the Pediatric Setting, cont.
Promoting maternal mental health and other healthcare services along the continuum of care and across the human life span to meet the needs of individuals and local and global communities can result in positive social change, thus improving the human condition.
Postpartum depression is a treatable condition with early detection being shown to decrease the negative impact for mothers and children
(van der Zee-van den Berg et al., 2017; Webber & Benedict, 2018).
Detection begins with screening!
(Ko et al., 2017)
Slide 11 of 21
Display Settings


PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
The AAP and Postpartum Depression
The American Academy of Pediatrics (AAP) recognizes the impact maternal mental health has upon children and recommends screening mothers for postpartum depression at the 1-, 2-, 4-, and 6-month well-child visits
(Earls et al., 2019).
Slide 12 of 21
Display Settings


PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Other Noteworthy Supporters of Postpartum Depression Screening
• Healthy People 2020
• The American College of Obstetricians and Gynecologist (ACOG)
• The United States Preventative Services Task Force (USPSTF)
• The American Medical Association (AMA)
• The National Association of Pediatric Nurse Practitioners (NAPNAP)
• The American College of Nurse Midwives
Slide 13 of 21
Display Settings


PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Screening Methods
Many tools exist for screening women for postpartum depression and are applicable to the pediatric well-child setting.
o Postpartum Depression Screening Scale (PDSS) (Evans, et al., 2015)
o Beck Depression Inventory II (Evans, et al., 2015)
o Patient Health Questionnaire (PHQ), (Earls et al., 2019; Waldrop et al., 2018)
o Edinburgh Postnatal Depression Scale (EPDS) (Earls et al., 2019; Waldrop et al., 2018)
These are tools used to assess for, not diagnose, postpartum depression.
Slide 14 of 21
Display Settings


PowerPoint Slide Show - Staff Education Program on Postpartum Depression Screening - PowerPoint
Edinburgh Postnatal Depression Scale (EPDS)
The American Academy of Pediatrics (AAP) endorses the use of the EPDS by pediatricians for screening mothers of infants for postpartum depression
(Earls et al., 2019)
Allows pediatric healthcare providers an opportunity to create a dialog with moms about protective and risk factors integral to the safety and social-emotional well-being of the mother-child dyad
(Earls et al., 2019)
10-item questionnaire that assesses depression, anxiety, and suicidality
(Earls et al., 2019; Sorg, Coddington, Ahmed, & Richards, 2019)
The EPDS is able to correctly identify postpartum depression with a sensitivity of 79% (95% confidence interval (CI), 0.74 to 0.83)
(Hewitt et al., 2009)
Slide 15 of 21
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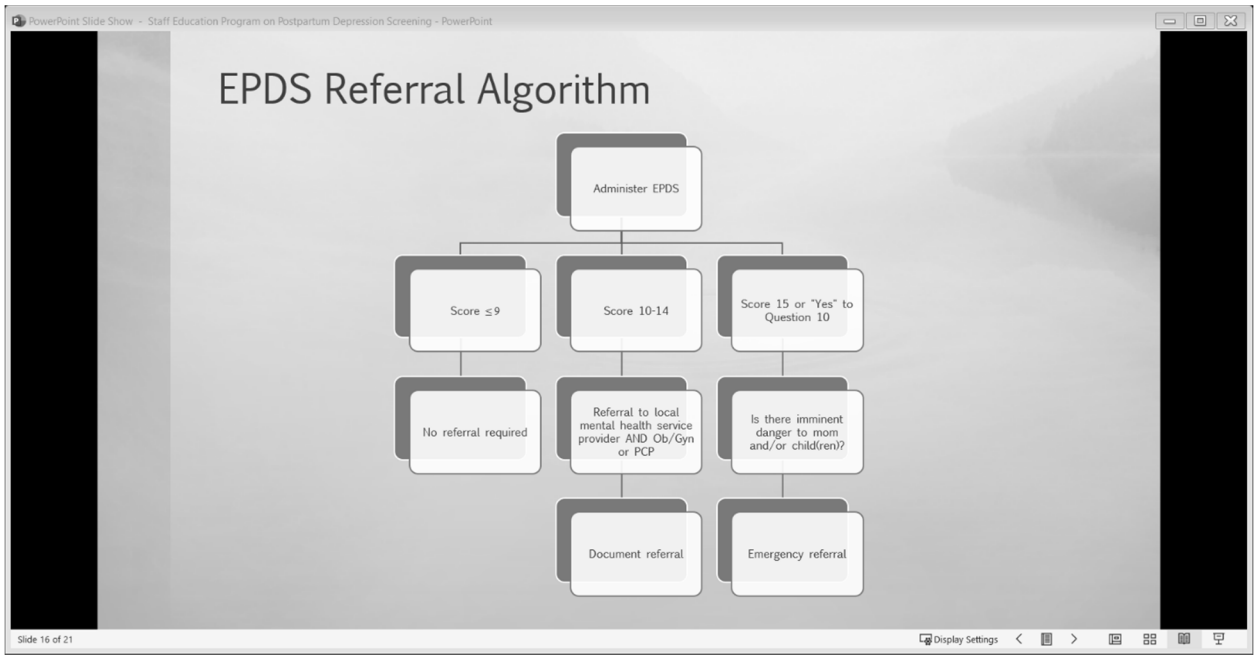
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EPDS Referral Algorithm
Administer EPDS
Score ≤9
Score 10-14
Score 15 or "Yes" to Question 10
No referral required
Referral to local mental health service provider AND Ob/Gyn or PCP
Is there imminent danger to mom and/or child(ren)?
Document referral
Emergency referral
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Pediatric Healthcare Provider and Staff Interventions
Provide list of community resources
Provide positive messaging
Normalize
"What you're feeling is normal."
De-stigmatize
"This is not your fault."
Instill hope
"Postpartum depression is treatable."
Promote self care
Ward-Zimmerman, B., & Vendetti, J. (2014)
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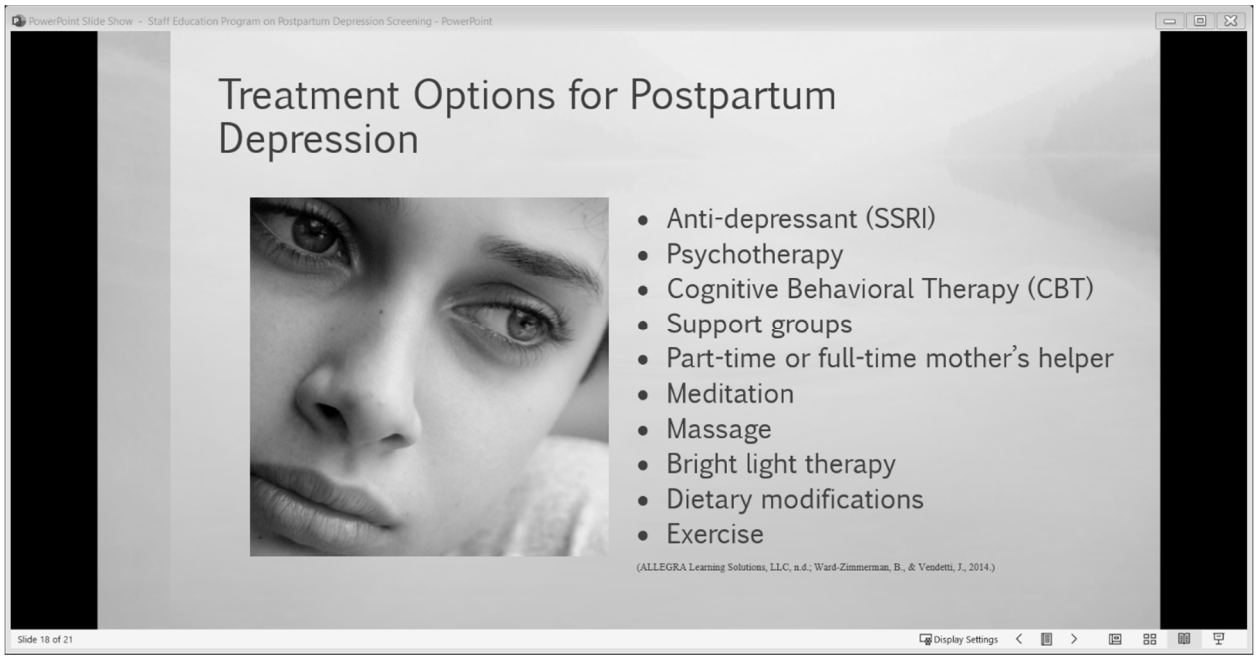
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Treatment Options for Postpartum Depression
Anti-depressant (SSRI)
Psychotherapy
Cognitive Behavioral Therapy (CBT)
Support groups
Part-time or full-time mother's helper
Meditation
Massage
Bright light therapy
Dietary modifications
Exercise
(ALLEGRA Learning Solutions, LLC, n.d.; Ward-Zimmerman, B., & Vendetti, J., 2014.)
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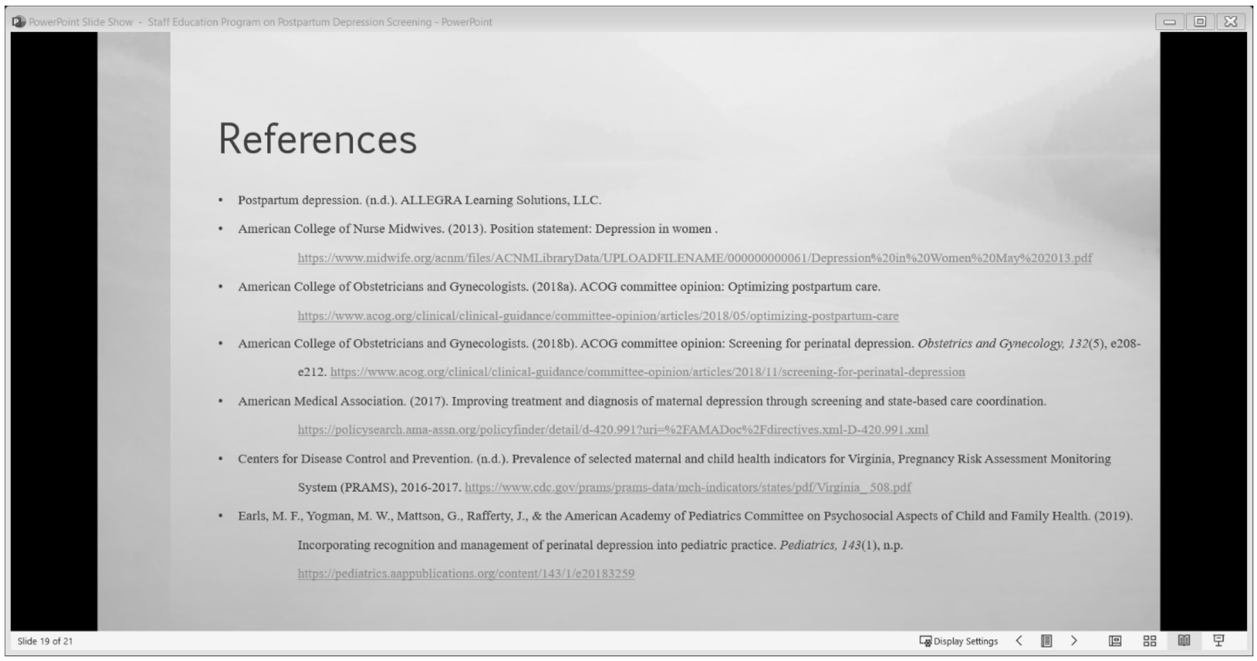
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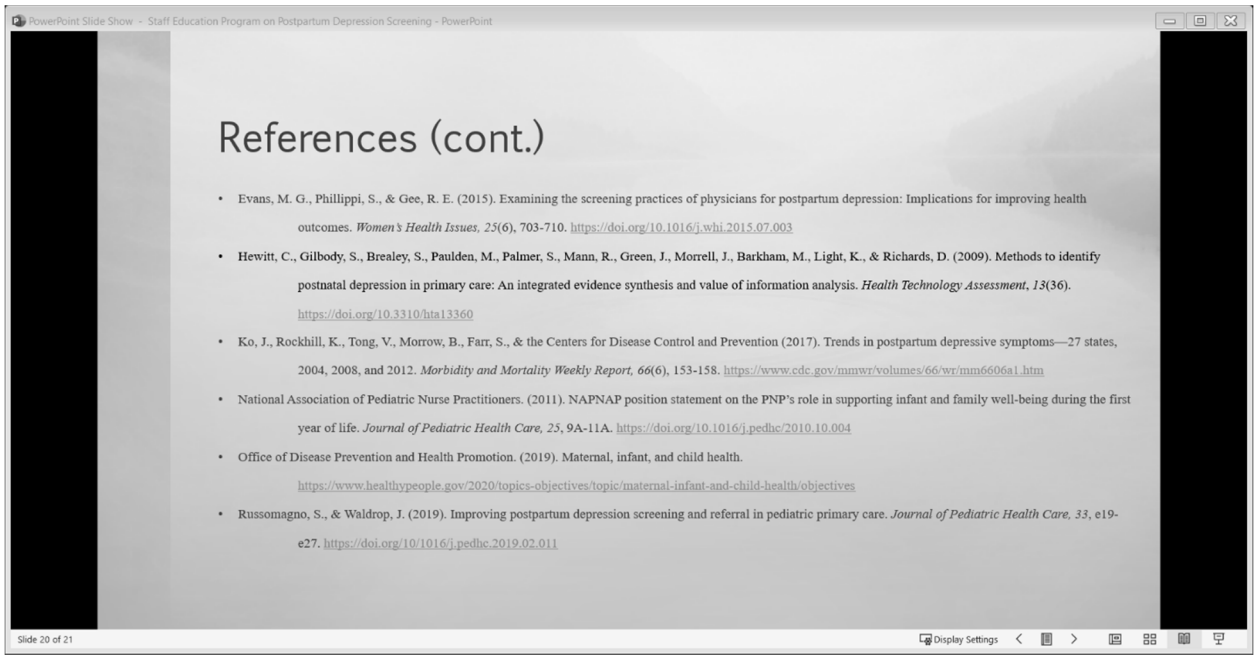
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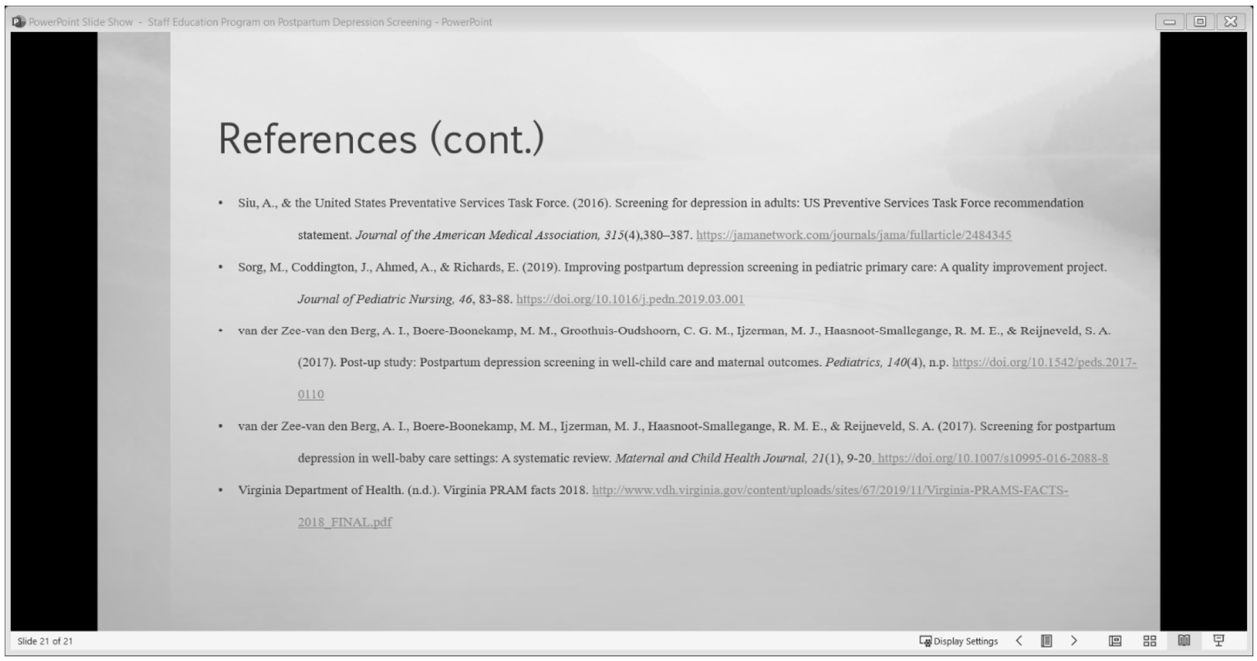
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