Postpartum Depression: Improving Screening and Outcomes Amongst Providers

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Postpartum Depression: Improving Screening and Outcomes Amongst Providers

A Scholarly Project Presented to the Faculty of the Nicole Wertheim College of Nursing and Health Sciences

Florida International University

In partial fulfillment of the requirements
For the Degree of Doctor of Nursing Practice

By

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Supervised By

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Approval Acknowledged: _____________________________, DNP Program Director

Date: __10/11/2021____________________
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Abstract

This quality improvement project aimed to educate clinicians and improve their knowledge regarding postpartum depression (PPD) to increase this population's outcomes. The post-birth period yields the best results for self-reporting and self-recognition of PPD (Martin, Norris, and Martin, 2020). When the clinician educated the client about PPD before birth, it prepared the patient with the knowledge required to be autonomous and informed regarding PPD and early intervention. Doing this allowed the patient to seek help earlier and treatment if signs and symptoms of PPD develop before their postpartum visit. To evaluate education to the participant, the clinician took a pre-test, participated in the educational intervention, and completed the study by taking a post-test which determined retained knowledge. Doing this allows the provider to determine gaps in knowledge and direct educational efforts in a focused manner. Collecting, analyzing, and comparing this data with the placebo will help determine that education to providers yielded early treatment with PPD and improved patient outcomes. This quality improvement project provided a solution to PPD, and in turn, allowed for prompt recognition, early treatment and ensured safety to the mother and child.
Introduction

Postpartum depression (PPD) is defined as a period of depression that follows birth in postpartum women. According to the Mayo Clinic (2018), any new mother can experience postpartum depression following birth. It affects women of all ages in their reproductive years. This form of depression is specific to this population of women following a child's birth and manifest in various forms and severity. Such forms of PPD include "baby blues," PPD, and postpartum psychosis (Postpartum depression, 2018). These three forms of PPD all have different levels of severity. "Baby blues" is a mild form, and postpartum psychosis is the most extreme. Regardless of the severity level, all forms need early identification, recognition, referral, and treatment to ensure a positive outcome for mother and baby. Historically, the patient's postpartum visit is the only time during their postpartum journey that PPD is assessed unless the further assessment is warranted with future visits.

According to Women's Health (2019), the incidence of PPD affects 1 in 10 women during or after the birthing process. This astonishing statistic depicts the prevalence of PPD in this specific population. The lack of education on the clinician regarding PPD increases the rate of underdiagnosing, misdiagnosing, or a potentially poor outcome for the mother and infant. The prevalence of PPD is further increased based on certain risk factors. These include the history of depression, lack of family support, low socioeconomic background, alcoholism, various ethnic minorities, and many more (Gress-Smith, Luecken, Lemery-Chalfant, and Howe, 2012). The incidence of PPD in the United States is as high as 10-15% of new mothers affected by PPD, and the rates climb even higher when one of the risk factors mentioned above is present. The clinical significance of education, management, and treatment of PPD extends past negative impacts to the client and her child.
Problem Statement

More than half of all maternal deaths occur during postpartum (Gress-Smith, Luecken, Lemery-Chalfant, and Howe, 2012). Because of this staggering statistic, the problem of PPD is imperative for all clinicians to know and understand current trends and guidelines to treat and manage PPD in this population. The current Medicare guidelines for postpartum care have been extended to 60 days after delivery (Prenatal and Postpartum, n.d.). These Medicare guidelines have recently been updated to reflect and extend care during the postpartum period to provide adequate care during this sensitive time. Currently, the six-week postpartum visit only includes one visit between the patient and clinician. The current PPD screening, identification, and referral protocol are hindered by having only one postpartum visit following a child's birth. According to the American College of Obstetrics and Gynecology (ACOG), new guidelines for postpartum care recommend contact with the patient within the first three weeks following birth (Postpartum depression, n.d.). This initial visit can be done via a phone call, telehealth, or in-person appointment. However, not all clinics and practices follow this new developing protocol. The organization is also in the process of extending postpartum care to 12 weeks after delivery to reflect new guidelines implemented by Medicare. Despite these recommendations, current guidelines and protocols only include one postpartum visit required by insurance for the postpartum period. This gap in inconsistency and continuity of care allows for the mental illness of PPD to fall through the cracks and become mismanaged and undiagnosed. Another problematic area is the lack of education on the client's end regarding early recognition, education, and understanding of PPD (Lile-Brown and Joslyn, 2019). They further identify that PPD does not end at a specific timeframe. However, it is on a continuum, and continuous education is needed. This, unfortunately, results in under and miss-diagnosed cases, lack of
treatment, and poor outcomes for the mother. By addressing client education on PPD, we as providers help our clients bridge this gap between guidelines and early intervention.

There are numerous consequences of inadequate education on PPD. The impact of untreated or unrecognized PPD can potentially result in suicidal thoughts or attempts made by the mother. According to Women's Health (2012), new research addresses these consequences to impact the mother and the child, resulting in potential behavioral problems, language and developmental delays, and poor maternal bonding with the child. Another possible consequence of lack of education and treatment of PPD is increased healthcare costs to the mother. The gross financial impact of PPD on the nation is estimated to be around 14 million dollars (Clark, Searing, Ross, Wagnerman, and Gardner, 2019). According to new emerging research, women with lower incomes often suffered more from PPD and, in turn, had higher financial costs, strictly related to lack of Medicaid coverage. Prompt recognition and treatment of PPD will result in the mother and child's safety and well-being.

**Significance**

The negative impacts of not educating, addressing, and treating PPD can result in suicidal thoughts, ideations, or attempts at the postpartum mother. These impacts are most severe around month five following birth (Gress-Smith et al., 2012). According to Lile-Brown and Joslyn (2019), as much as 60%-80% of women will struggle with the less severe form of PDD, identified as "baby blues." This less severe form, if left untreated, can advance further and develop into PPD. The clinical significance of educating the client prior to delivery may attempt to combat this data and reduce the occurrence and result in earlier treatment for the patient.
Furthermore, a more severe form of PPD can result if left untreated, which is postpartum psychosis. According to data collected from the Centers for Disease Control, 1 in 8 women experiences the symptoms of postpartum depression. These statistics vary from state to state and can increase to as high as 1 in 5 in certain states (Depression Among, 2020). Suicide is the seventh leading cause of death during the postpartum period (Barnes and Brown, 2018). As much as 59% of suicide was related to PPD or postpartum psychosis. The rate of occurrence of postpartum psychosis is around 2 out of every 1000 births (Postpartum Psychosis, n.d.). The consequences of PPD, if left untreated, not only affect the mother but can extend to their child and leave harmful effects such as child neglect. The devasting effects extend to the child may even include behavioral and development problems.

PPD is a mental illness that explicitly affects women of childbearing years, more precisely, following childbirth. Symptoms of PPD include feeling withdrawn, angry, distant from loved ones, loneliness, anxiety, worrying, intrusive thoughts, doubting the ability to care for the infant, and thoughts of hurting themselves or the infant (Lile-Brown and Joslyn, 2019). Currently, there are no national mandated protocols for PPD screening. Historically, if a provider felt a patient was at risk or signs and symptoms of PPD were identified, the Edinburgh postnatal depression screen would be implemented. This gap in treatment protocols may affect the provider’s ability to appropriately identify postpartum women suffering from PPD. A nationwide mandated screening for PPD is needed during the postpartum period to improve screening and outcomes related to PPD. Medicare defines the postpartum period as 60 days after delivery (Prenatal and Postpartum, n.d.). Before this can be done, education to providers is imperative to provide evidence-based practice. The quality improvement project researched PPD screening and educated providers to boost childbearing women. By educating providers caring for postpartum
women, we ensure that evidence-based screening, treatment, and recognition of PPD are implemented.

Summary of the literature

A literature review was conducted on the topic of PPD. The research method utilized was through the Florida International University library database. In addition, DynaMed, Pubmed, and CINAHL databases were used within the medical library. Articles were searched within the databases since the time of conception. Specifically, within the Dynamed database, PPD point of care was researched, which led to discovering medical journals and studies regarding the topic.

Inclusion and Exclusion Criteria

The search revealed 55 articles primarily peer-viewed and randomized control trials for the inclusion criteria. This number was decreased based on their date of publication and. The exclusion criteria included abstracts and publication dates less than nine years. Further refinement of the articles resulted in 12 journals for the literature review. These specific journals were all correlated with the topic of postpartum depression. Therefore, those studies were focused on a systematic review and peer-reviewed articles. Keywords searched were postpartum education, postpartum depression, and postpartum depression education.

When researching journals, articles, and studies related to postpartum depression, education was focused. Studies used within the literature review are revered highest on the research hierarchy, and the most used were randomized control trials or meta-analyses.

Why do clinicians need education?
According to the American College of Obstetrics and Gynecology (ACOG), new guidelines for postpartum care recommend contact with the patient within the first three weeks following birth (Postpartum depression, n.d.). However, not all clinics and practices follow this new developing protocol. The lasting effects it has on the mother and child can be detrimental. This taboo disease requires prompt education to the provider regarding screening, and intervention is needed to ensure best practice care. The provider's level of knowledge was assessed throughout the quality improvement project. This process will be achieved by evaluating the provider's current knowledge using a pretest, educational intervention, and posttest to improve outcomes of postpartum depression. Educating providers to routinely use a simple screening tool for all antepartum, intrapartum, and postpartum women will ensure positive outcomes and timely treatment for postpartum depression. Through the comprehensive research conducted of the 12 articles, conclusions drawn stress the importance of screening all postpartum patients and instituting a psychological intervention to improve the mother and child outcomes.

Key topics researched and analyzed related to PPD include education to providers to advance screening and outcomes. Emphasis related to education and screening methods were placed on past and current guidelines on the national and state level. New guidelines are emerging, including nine states to be mandated to assess PPD during the postpartum period (Lile-Brown & Joslyn, 2019). With such a vast gap and lack of congruence, women suffering from the effects of postpartum depression are going unrecognized. According to Women's Health (2019), the incidence of PPD affects 1 in 10 women during or after the birthing process. The incidence of PPD in the United States is as high as 10-15% of new mothers affected by it, and the rates climb even higher when one or more of the risk factors are present. According to the
Florida Pregnancy Risk Assessment Monitoring System (2010), PPD rates in Florida are as high as 11-18%. Of these numbers, 90.5% of those women did not seek medical treatment with feelings of hopelessness, sadness, or depression. According to their statistics in 2010, 58.8% of women suffered from symptoms of postpartum depression months following birth. Those most at risk are non-Hispanic black mothers and those younger than 19. More than half of all maternal deaths occur during the postpartum period due to suicide (Gress-Smith, Luecken, Lemery-Chalfant, and Howe, 2012). This lack of recognition by the provider negatively affects both the mother and her infant.

**Evidence related to the clinical question**

The evidence related to postpartum depression and the lack of education that clinicians have reflected within the literature. Furthermore, more research is needed to fully understand the importance of education on the negative impact of mood disorders following birth. According to Stephens et al. (2016), more than 90% of PPD cases are managed within the primary care setting. The prevalence of PPD is significantly seen within Women's Health settings and in primary care; therefore, educating providers may decrease PPD rates and improve patients' health outcomes. Their research stressed that the type of therapy they received did not matter; the participants still reduced their symptoms past the 6-month postpartum period. One screening tool used was the Edinburgh Screening tool to assess for PPD. This research stresses the provider's proper screening and intervention have on patients who suffer from PPD.

**Incidence**

Shorey et al. (2018) conducted a meta-analysis and systematic review that focused on the incidence and prevalence of PPD in women with no history of depression. They concluded the
prevalence of PPD was 12%, and the incidence was 17%. Identified within their research was that Middle Eastern (26%) women held the highest rates of PPD, and women from Europe (8%) held the lowest rates. The prevalence rate of PPD in those with a history of depression was similar. This research sheds awareness, and providers should educate that any postpartum women may be at risk for developing PPD regardless of their mental health history. Certain factors place them at risk for the development of PPD but should not dictate who gets screened.

**Knowledge**

Shorey et al. (2012) looked at 122 postnatal women's knowledge on postnatal psychological disorders. The research focused on postpartum depression education, and it yielded that the women whom their provider educated had better outcomes related to their mental health. This randomized control trial pertains to the project and supported research of providing education to healthcare providers to improve outcomes related to PPD. By instituting a brief educational intervention, such as the Edinburgh Postnatal Depression Screening Scale, the PPD at 6 and 12 weeks during the postpartum period. The Edinburgh Postnatal Depression Screening Scale is the current screening tool used by providers to assess the patients at risk of developing PPD. It consists of 10 questions regarding the patient's feelings in the last seven days. The questions are answered on a scale of yes, sometimes, often, most times, and all the time. Scores of 12 indicate the possibility of PPD, and further assessment and intervention are needed (Stephens et al., 2016).

Kozonszky et al.'s (2012) research showed that education to providers and clients had been shown to improve patient outcomes related to psychosocial and psychological disorders. The randomized control trial regarding the provider educating the client during the antepartum
period yielded psychosocial education decreased and improved PPD symptoms. This research supported the project by displaying how education to the provider and client is needed to improve outcomes. PPD can improve with provider education and by improving screening measures and outcomes. These authors’ methods involved implementing four educational sessions between the provider and client to discuss postpartum psychosocial issues. This research stressed and emphasized the importance of education to providers. Such education should be required to identify areas of focus to evaluate and identify clients suffering from PPD promptly. By focusing on education to the provider, we supported their current practice related to screening and outcomes.

**Prevalence**

PPD does not discriminate and is not limited to older women. It can also affect the younger pregnant population. Adolescent or teen pregnancy occurs in those females who are 19 years and younger (Mueller et al., 2017). Phipps et al. (2020) discussed that adolescents put them at risk for PPD. In the randomized control trial of 250 adolescent pregnant females, they studied how therapy with the women's healthcare provider might change PPD rates among this age. The adolescents' groups received five group sessions related to mental health and PPD following the postpartum period. Their conclusion, however, stated that there was no difference between the intervention and control group. Even with these conflicting results, the data sheds awareness on the vast devastation placed on postpartum women regardless of their age.

**Screening Tools**

Utilizing a brief screening tool as the routine practice can help the provider identify those at risk for PPD. Organizations such as the ACOG support the use of routine screening for
postpartum depression; however, there are no recommended guidelines for women's health providers on routine PPD screening. According to Learman (2018), multiple barriers affect the use of routine screening. They identified some barriers to be inconsistent with protocols, such as the lack of the Edinburgh screen with each patient. With universal screening, providers can overcome disease identification and progression in the women's health setting. A pretest, posttest, and educational intervention will be utilized to educate providers to combat this.

**Disease Process**

PPD does not have a concrete timeline for occurrence; it is instead thought to have a fluid timeline. Some signs and symptoms of PPD can begin two weeks postpartum and are identified as postpartum blues. However, if these symptoms progress and go unrecognized by the provider for longer than two weeks, it is considered PPD. PPD can occur for as long as 12 months postpartum (Hamel et al., 2019). For this reason, education to providers is required for the safety and efficacy of treatment. Such education measures included evidence-based practices and guidelines that will help prompt recognition, treatment, and positive outcomes to clients affected by PPD. In Canada, a protocol was implemented to assess and screen for PPD up to 12 months following childbirth. Their method was discussed using two systematic reviews to offer information on various screening tools for PPD. These findings were then used in conjunction with the Canadian Task Force to create protocols for PPD screening to be utilized by providers.

**Risk Factors**

Upadhyay et al. (2017) performed a meta-analysis that involved over twenty thousand participants. They found 19% of the participants to have PPD within two weeks of delivery. They identified numerous risk factors such as financial difficulties, previous history of
psychiatric illness, marital problems, domestic abuse, and lack of paternal support following delivery. Having providers assess their patients and determine those at risk for postpartum depression can ensure the mother and infant's safety. This study conducted in India concluded that Indian mothers are at risk for developing PPD and more resources need to be allocated to prevent mental illness in postpartum women.

Newborn Impacts

According to Slomian et al. (2019), numerous factors affect the mother and extend to the newborn. This randomized control trial studied the effects of postpartum depression on the mother and the newborn. Their research focused on maternal consequences, infant consequences, and mother-child relationship/interaction. In the discussion of their research, they state that PPD is not conducive to building a solid maternal-infant relationship. Furthermore, the research stated that concerning maternal and infant consequences, the infants suffered from more negative implications related to PPD than the mothers. They understand that the provider plays an avid role in maternal mental health and the infant's health and well-being are imperative to ensure safety and well-being. This information solidifies the importance of provider education regarding postpartum depression within the women's health specialty.

Aoyagi and Tsuchiya (2019) conducted a literature review regarding the effects PPD has on newborns. They examined the infant's language, neuromotor, physical and overall cognitive development when conducting their research. They focused their research on cohort and case-control studies related to women no more than six months postpartum suffering from depressive symptoms. Their results concluded that there is some relationship between a mother suffering from PPD and the infant's neurodevelopment and cognitive development. Emphasis should be
placed on screening all postpartum women during their postpartum visit, as this is when most symptoms of postpartum depression are evident. A brief screening tool would help the clinical setting improve patient outcomes.

Bell, Bloor, and Hewitt (2019) discuss that PPD is an underdiagnosed disorder in their research. These implications extend to the infant and can have long-lasting effects on their development until 7. Their method compared mothers diagnosed with PPD and receiving treatment versus those without treatment. This study evaluated the mothers one year postpartum and focused on the child's long-term effects. In addition, they conducted a longitudinal survey of 10,893 families in the United Kingdom. Their results concluded that both diagnosed with treatment and self-reported cases of PPD had detrimental effects on the child, specifically on their behavioral development. Applying their findings into practice suggests more research to improve both the mother and infant's treatment.

Treatment

Werner et al. (2016) proposed the idea of treating PPD as a mother-infant dyad rather than solely the mother. This theory was the focus of their randomized control trial. There is a strong relationship linking PPD and infant/child developmental effects. Therefore, they proposed that focusing on this dyad would lead to better outcomes for all members involved in PPD. Their results (n=54) of the brief intervention stated that it was tolerated and effective in reducing the signs and symptoms of PPD. They concluded that this intervention successfully reduced the incidence of PPD and improved the mother-child relationship.

Provider Education
According to Lile-Brown and Joslyn (2019), extending provider education to the clinic staff such as Medical Assistants and Registered Nurses can assist in prompt identification of PPD. Educating all licensed staff regarding PPD, screening, and intervention can decrease the severity and ensure postpartum women's safety. Nurses in the state of Kansas are speaking up about PPD and insisting on a routine state-mandated screening tool to be used in practice. They stated that 9 out of the 50 states have participated in a statewide mandated protocol for routine screening of PPD. This lack of congruence among our nation allows for an adverse sequela of disease progression to occur, which can ultimately end with suicide. Ensuring the continuity of care and safety to patients within the women's healthcare setting, education to providers regarding up-to-date protocols and screening measures is needed to ensure positive outcomes.

**Conclusion**

After conducting an extensive literature review on PPD, the research yielded that those providers have limited knowledge of PPD. Therefore, educating providers about PPD is essential for improving patients’ outcomes. By recommending that patients are seen before the routine postpartum visit, in addition to extending the traditional PPD risk window, allowed providers more chances to recognize, assess, and treat their patients who are suffering from postnatal mood disorders. Incorporating these findings into the practice at Progressive OBGYN allowed providers to serve their community better and contribute to a higher likelihood of patient improvement.

**Purpose**

This quality improvement project aimed to assess clinicians' knowledge related to screening for PPD, to improve this population's outcomes. The post-birth period yields the best

Educating the client about PPD before birth prepares the patient with the knowledge required to be autonomous and informed regarding PPD and early intervention. Doing so will allow the patient to seek help earlier and treatment if signs and symptoms of PPD develop before their postpartum visit. To evaluate the provider’s knowledge acquisition, they took a pre and posttest following an educational intervention. This allowed the provider to address the gaps in knowledge, thus directing their educational efforts in a focused manner. Collecting, analyzing, and comparing this data with the placebo helped determine if early education yields early treatment with PPD. By proposing this solution to PPD, allowed for prompt recognition and yielding early treatment, ensuring safety to the mother and child.

Knowledge gaps related to PPD extend not only to clients but to government-funded research and education (Pregnancy Risk, n.d.). PPD lacks in Florida's Pregnancy Risk Assessment Monitoring System (PRAMS). This system is in place to monitor maternal-related behaviors and involvement during the prenatal, perinatal, and postnatal periods (Pregnancy Risk, n.d.). With this vast gap in knowledge, research is lacking concerning PPD. This research is needed to determine the rate of PPD, suicide attempts, and treatment. To bridge this gap in knowledge and research, education to the client is imperative before delivery to ensure the mother and infant's safety. The provider's education included the disease process, signs and symptoms, risk factors, and treatment. As mentioned above, "baby blues," if left untreated, can develop into PPD. Baby blues typically develops within the first four weeks postpartum. For this reason, it is imperative to educate the client before birth to identify and recognize the signs and symptoms of both "baby blues" and PPD. Doing so will ensure that if the client develops either
form of PPD, early intervention, and treatment initiated before the 6-week postpartum visit improved patient outcomes.

PPD affects women during their childbearing years. It disrupts their mood, leaving them with feelings of hopelessness, inadequacy, and severe presents with thoughts of suicide or homicide (Postpartum depression, 2018). The provider’s role is to assess and recognize these symptoms in their patients during this vulnerable postpartum period. With prompt recognition of PPD, patients received prompt care and had better outcomes. Extending the postpartum period within the clinical setting can help achieve these goals.

Women are seen for their first postpartum visit at the six-week mark at this clinic, which is up to date with standard postpartum care. Comparing this time frame for follow-up care with the new emerging guidelines presented by ACOG, patients within the clinic should be seen before this benchmark (Postpartum depression, 2020). To assess mothers for PPD, the clinic has begun seeing some of their postpartum patients before the six-week visit. The clinic facilitated this change in protocol, and it was based on new emerging guidelines implemented by Medicare and ACOG. This new evidence-based research from ACOG stated that postpartum women should be seen by their provider initially around 2-3 weeks postpartum and at the standard six-week period. A second visit is to be included in the postpartum follow-up care to identify the first signs and symptoms of PPD. Stone (2021) lectured that stretching postpartum healthcare to four to six months will further recognize PPD within clinical settings. More PPD is recognized because patients realize they cannot continue with the postpartum mood disorder and seek treatment. The local OBGYN clinic extended care given to postpartum women to improve their identification of PPD.
PICO Clinical Questions

Will education of postpartum depression to clinicians improve the recognition, intervention, and treatment of postpartum depression before their 6-week postpartum visit?

P - Providers who work with Postpartum women

I - Provide educational intervention to providers who screen for PPD

C - Compared to no education intervention

O - To increase providers' comfort and knowledge in screening PPD by 50%.

Objectives

To close this knowledge gap, clinicians need to understand the current treatment guidelines for PPD. According to Dynamed (n.d.), current evidence-based practice about PPD includes assessing women during the perinatal period. Further assessment is required for those at risk of developing depression or who have had a history of depression. Clinicians should further question those who display anhedonia, change in sleep or appetite, fatigue, decreased energy, inability to concentrate, and thoughts of harming the infant or self. History of present illness includes having signs and symptoms of PPD for longer than two weeks. The diagnosis of PPD is made using the Diagnostic and Statistical Manual (DSMV) of Mental Health Disorders, the fifth edition. Detailed in this manual are the full criteria for diagnosis. It requires five or more symptoms to be present for two weeks or longer. It is imperative to include differential diagnoses of postpartum blues, postpartum psychosis, bipolar depression, and hyperthyroidism hypothyroidism. Current management of PPD is using brexanolone and cognitive behavioral
therapy. The above-stated medication is the only one approved by the FDA to treat and manage PPD. These clinical guidelines state the treatment of PPD, but there is a lack of time frames for management. Women's health organizations lack congruent protocols across all platforms.

Definition of Terms

The following terms in this QI project include postpartum depression, postpartum baby blues, postpartum psychosis, postpartum mood disorders, screening tools, and postpartum depression education. Postpartum depression is defined as a period of depression lasting longer than two weeks following the birth of a child related to hormonal changes (Postpartum depression, 2018). Postpartum depression and postpartum mood disorders have similar definitions; however, mood disorders are an umbrella term to cover various kinds, and postpartum depression is specific to depression during the postpartum period (Kozinszky et al., 2012). Postpartum depression is specifically referred to the depression following childbirth. Depression can extend from the antenatal, perinatal, and postnatal periods; the focus was entirely on depression that occurs during the postpartum period (Warner, n.d.). Current guidelines include only one postpartum visit, only allowing the provider one opportunity to assess for postpartum depression. Educating providers regarding new emerging guidelines set in place by Medicare and ACOG is imperative to reduce the number of patients diagnosed with postpartum depression. Within this definition of terms included screening tools for postpartum depression. For example, providers assessing the patients during their hospital admission for childbirth may be one way to bridge this knowledge gap.

Theoretical Framework of the Project
Theoretical frameworks helped guide this study and give it a conceptual visual map that assisted their work. Vision an iceberg, the top portion visible to all is small, but beneath the surface is an enormous iceberg portion. This visual mapping was applied to the QI project of PPD. This conceptual, theoretical framework allowed the student to visualize the unknown vastness of all that encompasses PPD. This theory is identified as the Iceberg Theory.

This theory's creator is the genius Ernest Hemmingway, and his framework was created in 1923. To better understand how this theory can broaden the QI project is best to visualize the entire iceberg, not just what is visible but best to envision what is beneath the surface. PPD is more than what is on the surface; it is a complex disease process with many facets and layers to be understood. Applying this framework to the project enhanced the clinician's understanding of identifying and treating PPD. The creation of this theory by Hemmingway represented his specific genre and style of writing. His writing depicted short stories and revealed hidden meanings and messages within his writing (Private Security Professionals of America Editorial Staff, n.d.). Hemmingway allowed mystery within his stories for his readers by writing this way. They had to depict and dissect the hidden, more profound messages to his short stories (Private Security Professionals of America Editorial Staff, n.d.). By applying this theory to his stories, only a tiny portion of the truth was known. The larger story was hidden beneath the surface. The Iceberg theory can be applied to numerous outlets and is used by countless researchers to guide their studies.

This Iceberg theory can improve the clinician's knowledge of PPD by demonstrating more to know and understand. Using this theory can provide a visual depiction of what we know about PPD and the severity of what more is to be known regarding the mood disorder. Not all
cases of PPD present the same way, and it can manifest in various forms and severity. The clinician needs to be aware that some women conceal their culturally taboo disorder feelings.

This theory can also show the clinician that we only know a portion of PPD, and more can be learned through research and education. Not all women are screened for PPD in the clinic or office. It is seen as a need be screening. For example, if the patient has risk factors for PPD or reveals certain feelings, a screening for PPD will be implemented. When a patient does not express feelings to their provider, we might be missing the portion of the "iceberg underneath the surface."

To combat this, screening all patients is imperative but cannot be achieved until providers are educated about the recognition and treatment protocols of PPD. Knowledge of screening tools used in practice proved beneficial in identifying those suffering from PPD, as evidenced by the literature review. The postpartum period is a time of vulnerability, change of identity, and roles. Along with these changes comes the constant fear of raising a baby and places enormous stress on the new mother. At times women think that their feelings are normal, and most mothers experience the same feelings; however, persistent feelings may manifest into baby blues, PPD, or postpartum psychosis. Multiple encounters between the patient and provider are imperative to monitor and address these feelings. New emerging guidelines from various organizations are beginning to address this need, but these are needed for providers to improve patient care and outcomes related to PPD. Using Ernest Hemmingway's Iceberg theory can help the student provide a visual map of PPD.

Methodology

Study Design
This quality improvement project was conducted at an OBGYN office. Clinicians' knowledge regarding screening for PPD was assessed using an educational intervention, a pretest, and a posttest. The quasi-experimental study researched whether the educational intervention enhanced the provider's education with the target population (postpartum women). The educational intervention was presented in a PowerPoint with a voiceover lecture that the investigators participated in. Participants completed a pretest to determine their baseline knowledge of PPD and then a posttest to determine their knowledge acquisition following the educational intervention. After the presentation was completed, the participants completed a post-educational test to determine their level of knowledge acquisition. The educational intervention included an overview, current practices, signs and symptoms, treatment/management, and newly emerging research. The pretest was sent via email before they received their educational intervention. Topics covered were PPD, current guidelines, new emerging guidelines, assessment, treatment, and management. The tool focused on providers’ assessment strategies to facilitate their education on PPD. The participants were informed of the study’s requirements and agreed to participate in all study aspects.

**Setting and Participants**

This quality improvement project was conducted at a local OBGYN clinic, an obstetric and gynecologic office that serves women and their health needs across their reproductive lifespan. With the SWOT analysis, the practice was analyzed, and all organizational factors were considered for the project. The participants included physicians, certified nurse-midwives, nurse practitioners, and registered nurses (n=15). The educational intervention created was a voiceover PowerPoint.
**Intervention**

The intervention used in this project was an educational PowerPoint with a voiceover lecture. The intervention used up-to-date information regarding PPD. An in-depth literature review was conducted to supplement the intervention and ensure relevant and reliable topics were presented.

The educational lecture was sent to the participants after they completed the pretest. They had one week to watch the presentation and complete the posttest survey. Topics related to PPD and healthcare were included in the presentation. Specifically, signs and symptoms, risk factors, assessment tools, treatment, management, referral, and follow-up. These key areas highlight the most important information relevant to PPD and providers within the healthcare setting.

The pre-educational test included the following questions. 1) What do you know about PPD? 2) What are your current practice guidelines for PPD? 3) What are the signs and symptoms of PPD? 4) What are the risk factors? 5) What are the assessment tools for PPD? 6) When should patients be assessed for PPD? 7) What is the management of PPD? 8) What is follow-up care for PPD? 9) Have you ever completed PPD training? 10) Are you aware of your impact on clients with PPD?

The post-educational test included the following questions. 1) I understand my role in providing care for patients with PPD? 2) I understand current evolving guidelines for PPD? 3) Self-rated knowledge about PPD? 4) Self-rated level of confidence in identifying someone with PPD? 5) I feel comfortable asking someone if they have thoughts of harming themselves or their infant? 6) Self-rated comfort level in treating someone with PPD? 7) Confidence in identifying those who are at risk for PPD? 8) Confidence in using the assessment tools to identify PPD? 9)
Was this presentation impactful in your treatment and management of those with PPD? 10)

Comments, questions, concerns, or suggestions? After completing both tests, the results were analyzed using the statistical software SPSS to assess the knowledge acquisition of healthcare providers.

Data Collection

A consent form was sent to the participants to begin the data collection process. They received the consent form via email. The consent form discussed a brief overview of the quality improvement project. Topics discussed in the consent form included: the purpose of the study, duration, procedures used, risks and benefits, alternatives, confidentiality, use of information, compensation, right to decline, and the researcher's contact. If the participant consented to participate, they were directed to a link via the consent form for survey monkey.

The data collection process was done anonymously by using a third-party site SurveyMonkey. The participants were sent the initial pre-education test was sent to all, and they were given two weeks to complete it. After they completed the intervention, they were all sent a follow-up posttest. Both surveys tested clinicians' PPD knowledge, attitudes, and feelings. The pretest and posttest are tools used to analyze the data collection. Both tests were converted into a percentage score to reflect the data collected.

Instruments (Survey Questions)

Demographics

1. Male or Female
2. Age: ______

3. Ethnicity:

Hispanic  Caucasian  Other  Black  Asian

4. Position at the clinic: __________

5. Years in Medical Field:

Less than 1 year  5 to 10 years  10 to 20 years  More than 20 years

Perception

1. How many training programs on postpartum depression have you attended throughout your medical experience?

None  1  3  More than 3  I don't know

2. Which population group is at risk for human postpartum depression?

Everyone  Caucasian  Blacks  Hispanic  Asian

3. I know how to identify and screen for postpartum depression:

Strongly Agree  Undecided  Disagree  Strongly Disagree

4. When you first think of postpartum depression, what comes to mind:

Suicide  Sadness  Common  Exaggerated  I don't know

5. I understand my role in identifying postpartum depression:
Strongly Agree  Undecided  Disagree  Strongly Disagree

Indicators

Knowledge

1. When I think of the term 'postpartum depression':

A) I'm not sure what this means

B) This term is unclear and confusing to me

C) I don't know the difference between depression and postpartum depression

D) Depression is the same as postpartum depression

E) I understand the term

2. Self-rated level of knowledge about postpartum depression

Excellent  Good  Fair  Poor  I'm not sure

3. The different forms of postpartum depression are:

A) I don't know the different forms

B) Postpartum depression only

C) Postpartum depression, 'baby blues, postpartum psychosis

D) Depression and postpartum depression

E) I'm not sure what these mean
4. Physical indicators of postpartum depression include: (Circle all that apply)

- Guilt
- hopelessness
- loss of interest or pleasure in activities
- crying
- irritability
- restlessness
- fatigue
- loss of appetite
- weight gain
- weight loss
- happiness
- joy
- depression
- fear maternal-infant bonding
- I don't know the indicators

5. Postpartum depression is defined as:

A) I don't know the definition
B) Period of depression that follows the birth
C) Period of happiness following birth
D) Two weeks of sadness following birth
E) Depression that occurs while you are pregnant

Behaviors

1. I have the strategy or skills to identify postpartum depression?
   Yes  No

2. I have enough time to ask about postpartum depression if I suspect a person?
   Yes  No

3. I should immediately call 911 if a patient has suicidal or homicidal ideation associated with postpartum depression?
4. I have suspected that a patient of mine had postpartum depression:

Yes  No

5. (Answer if you answered 'Yes' to question 4) Did you appropriately refer the patient:

Yes  No

Communication

Knowledge

1. I attended a communication skills course

Yes  No

2. I have received training on communication skills to use when interacting with a person with postpartum depression:

Yes  No

3. Effective communication can be achieved by actively listening and taking turns talking:

Never  Not Often  Sometimes  Often  Always

4. When postpartum depression is suspected, open-ended questions play a big impact on ineffective communication

Yes  No
5. Those suffering from postpartum depression are easy to speak with and will reveal to the provider their true feelings

Yes  No

**Attitude**

1. I am comfortable asking a person if they feel they are a danger to themselves or their infant:

Yes  No

2. I am more comfortable assessing patients who speak English or my native language:

Yes  No

3. I feel certain communication skills are needed to interact with patients suffering from postpartum depression:

Yes  No

4. Body language can affect a patient's response:

Never  Not Often  Sometimes  Often  Always

5. Learning how to communicate with a postpartum depression patient is important:

Yes  No

**Behaviors**

1. When I listen to what a patient is saying, I predict what their conclusion will be:
2. When I am not sure what someone is saying to me, I stop asking questions:

Never  Not Often  Sometimes  Often  Always

3. I become impatient when patients do not express their thoughts clearly:

Never  Not Often  Sometimes  Often  Always

4. When I ask questions, they are open-ended and cannot be answered with a 'yes' or 'no' response:

Never  Not Often  Sometimes  Often  Always

5. When I suspect postpartum depression, I know the communication strategies needed to interact with them:

Yes  No

Data Analysis

The study's data was kept secure and private; only the co-investigator had access to review and analyze the data. Furthermore, the site SurveyMonkey was used and guarded by a secure password to keep all records from the study private. The third-party site used a program called TLS, a secure cryptographic to safeguard the information.

The co-investigator was the only one who oversaw and implemented the pre-education and post-educational surveys. Both questionnaires were given grades and were calculated collectively. The score was then be used and recorded according to its domain. After the data
analysis portion was completed, the information was destroyed to further protect the human subjects involved.

Teoli and Sanvictores (2020) state the SWOT analysis that was used to evaluate the practice related to achieving the project goal. SWOT stands for strengths, weaknesses, opportunities, and threats. These four areas were used to assess a business and improve its effectiveness. Using this approach helped bring the organization employees to improve the business. By creating a matrix grid with the SWOT topics, the student was able to write down areas that belonged to each category.

Methods

Descriptive statistics were used to examine the distribution of demographic characteristics in the sample. Differences in responses from pre- to -post on items measuring perception, knowledge, communication knowledge, communication attitudes, and communication behaviors were analyzed using mean scores and percentages between the two respectively. It should be noted that perception and communication attitudes had the greatest increase in mean average and percentage between the pre-test and post-test.

Results

Sample Characteristics

The demographics of this quality improvement project consisted of 15 respondents. Approximately half (46.7%) of the participants were between 18-30 years old, and the other half (53.3%) were between 31 and 55 years old. The majority (73.3%) were White, only one was Black or African American (6.7%), and three were Asian or Asian American (20%).
Approximately half of the participants were nurse practitioners (53.3%), while the other half consisted of registered nurses (20.0%), certified nurse-midwives (20.0%), and one doctor (6.7%). One-third of the sample had less than one year of experience in the medical field (33.3%), half had between 5 and 10 years of experience (53.3%), and 13.3% had 10 to 20 years of experience. When asked how many training programs on PPD they had participated in, close to half said none (46.7%), a quarter said one (26.7%), 13.3% said more than three, and the other 13.3% said they did not know.

**Perception**

When asked what population group is most at risk for PPD, 13 participants answered correctly at the pretest, and everyone answered correctly at the posttest. In the pretest, the participants answered if they knew how to identify and screen for postpartum, there were no significant differences noted in the pretest and posttest responses, c2 (3, N = 15) = 3.00, p = .479. When the participants were asked what first comes to mind when they think of PPD, there were no significant differences noted in the responses between pretest and posttest, c2 (3, N = 15) = 2.95, p = .086. Based on the pretest and posttest findings, the mean score of perception increased from 46.66 to 82.66. These results resulted in a totaled percentage increase of 77.1%. Data analysis yielded this as the most significant area of knowledge retainment when compared with all other frequencies.

**Knowledge**

When participants were asked whether they understood the term PPD, no significant differences were noted in the responses between pretest and posttest, c2 (1, N = 15) = 0.17, p = .685. When asked to self-rate their level of knowledge about PPD, there were no significant differences noted in the responses between pretest and posttest, c2 (2, N = 15) = 3.06, p = .217.
When the participants were asked to identify the different forms of PPD, 14 respondents answered correctly at the pretest, and all answered correctly at the posttest. When participants were asked to identify the physical indicators of PPD, no significant differences were noted in the responses between pretest and posttest, $c^2 (1, N = 15) = 0.60, p = .438$. Finally, when asked about the timing associated with PPD, 11 respondents answered correctly at the pretest, and all answered correctly at the posttest. The mean knowledge score increased from 53.26 to 79.84 between the pretest and posttest scores. These results yielded an increase in 49.9% of knowledge retention.

**Communication Knowledge**

When asked if they attended a communication skills course for PPD, no significant differences were noted in the pretest and posttest responses, $c^2 (1, N = 15) = 0.00, p > .999$. When asked if they had received training on communication skills when interacting with someone with PPD, no significant differences were noted in the pretest and posttest responses, $c^2 (1, N = 15) = 0.29, p = .591$. When asked whether effective communication can be achieved by actively listening and taking turns talking, no significant differences were noted between pretest and posttest responses, $c^2 (2, N = 15) = 2.64, p = .267$. When asked whether open-ended questions significantly impact ineffective communication when PPD is suspected, all respondents answered yes at both the pretest and posttest. Finally, when asked whether people with postpartum depression are easy to speak with and reveal to their provider their true feelings, 14 respondents said no at the pretest, and they all said no at the posttest. The mean score of communication knowledge increased from 85 to 96, which increased 12.9% between the pretest and posttest. It should be noted that this frequency had the lowest scoring comparatively.

**Communication Attitudes**
When asked whether the participants were comfortable asking a person if they feel they are a danger to themselves or their infant, 14 respondents said yes at the pretest, and all respondents answered yes at the posttest. When asked whether they are more comfortable assessing patients to speak English or their native language, 14 people said yes at both pre and post, and one person said no at both pre and post. When asked whether they feel specific communication skills are needed to interact with patients suffering from postpartum depression, 15 respondents said yes at the pretest, and all said yes at the posttest. When asked whether body language can affect a patient’s response, no significant differences were noted between pretest and posttest responses, $c^2 (4, N = 15) = 6.67, p = .155$. Finally, when asked whether learning to communicate with a PPD patient is essential, everyone said yes at both the pretest and the posttest. Comparatively, communication attitudes had a pretest mean score of 52 and posttest mean of 65.33. This analysis resulted in an increase respectively of 25.6% between both tests.

**Communication Behaviors**

When asked whether they predict what their conclusion will be when listening to what a patient is saying, no significant differences were noted in the responses between pretest and posttest, $c^2 (8, N = 15) = 5.00, p = .758$. When asked whether they stop asking questions when they are unsure what someone is saying to them, no significant differences were noted in the responses between pretest and posttest, $c^2 (8, N = 15) = 11.00, p = .202$. When patients become impatient when they do not express their thoughts clearly, no significant differences were noted in the pretest and posttest responses, $c^2 (6, N = 15) = 4.87, p = .560$. When asked if the questions they ask are open-ended and cannot be answered with a yes or no response, at pretest, respondents usually answered or sometimes, and at posttest, they always answered, usually, or rarely, $c^2 (2, N = 15) = 7.05, p = .030$. Finally, when asked whether they know the
communication strategies needed to interact with patients they suspect have PPD, no significant
differences were noted in the pretest and posttest responses, $c^2 (3, N = 15) = 2.44, p = .486$.
When asked if they understand their role in identifying PPD, no significant differences were
noted between pretest and posttest responses, $c^2 (3, N = 15) = 3.64, p = .304$. Lastly, the mean
score of communication behavior increased from 6.66 to 31.11. These results yielded an increase
of 67.1% between both tests. It should be noted that this is the second-highest scoring topic area
of knowledge retainment.

**Benefits**

Benefits to this QI project included improving the clinician's knowledge of PPD. Thus,
enhancing their ability to identify, treat, refer, and manage postpartum women suffering from
PPD. By completing this study, clinicians caring for women in the clinical setting gained
knowledge, confidence, and a better understanding of PPD to improve their postpartum clientele
outcomes.

The strength of the practice was the team's ability to recognize the importance of PPD
and make a change to better this population. They are willing to change the current guidelines of
PPD to maintain congruence with evidence-based practice. The clinicians shared ideas and
concerns to meet the community's needs best. The student is grateful for this open-ended
communication regarding a change in the current PPD protocol.

**Risks**

The QI project is voluntary, and all participants had the opportunity to withdraw from
such at any point in time. The QI project exhibited no confidentiality breach related to its
anonymous nature. A consent form was sent to all participants ensuring legal protection to all those involved. Doing so ensured all investigators were protected economically, socially, physically, and psychologically.

Limitations of this project was the small sample size. Currently, there are only three providers within Progressive OBGYN. To bridge this gap, the student identified that the practices covering physician groups would benefit from PPD education. Bethesda East Hospitalist group is the covering practice for Dr. Lang and Progressive OBGYN. This hospitalist group consisted of numerous physicians, certified nurse midwives, nurse practitioners, and registered nurses who benefited from the student's education intervention, further benefiting the community.

**Protections of Human Subjects**

All the participants involved in the quality improvement project completed the Collaborative Institutional Training Initiative (CITI Program). The CITI Program assists in training students, educators, healthcare institutions, research, and government agencies. They provide their users with education seminars and courses to facilitate human research subjects' protection (Center for Drug, n.d.). Another feature to protect human participants in the study was done by approval from International Review Board (IRB).

The IRB is a governmental agency that safeguards and protects human subjects in research. The IRB is an ordinance with the Federal and Drug Administration (FDA) and regulates the continuation or discontinuation of research they deem unsafe to the subjects. This organization aims to protect the rights of human subjects and protect their well-being within the
research (Raymond Longaray, n.d.). They require documents such as informed consent and research protocol to continue with the QI project. IRB approved this QI project.

All participants were informed that this is a voluntary study, given a consent form, and can opt-out at any point in the study. The participants were also strongly encouraged to engage in the lecture and complete the pre- and post-educational questionnaires. Furthermore, the participants were informed that their identity remained confidential in the demographical data. A third-party site, SurveyMonkey, was utilized to disseminate the questionnaires to the participants, and their results will remain secure. By complying with the CITI Program and IRB, it ensured all proper measures were placed to protect human subjects involved with the QI project.

**Conclusion**

As a result of this study, clinicians caring for the postpartum female need clear concise guidelines, training, and education regarding prompt recognition and treatment of postpartum depression. The clinical question of this project yielded an acquisition of the participants knowledge of postpartum depression and its screening practice to therefore improve the overall well-being and best practice care for this population.

The OBGYN clinic improved provider knowledge acquisition and outcomes related to PPD by participating in the student's QI project. The direct providers not only benefited, but the covering practice also benefited, and the effects will extend to all they care for. The practice also collaborated with the hospitalists to create protocols for PPD with the labor and delivery unit and postpartum unit. Threats to the QI project have been identified as a lack of clinicians' participation. Some providers may push back in the event of change none the less from a student.
To combat this potential identified threat was to provide them with up-to-date information supported by evidence to encourage their QI project participation.

Consent Form

ADULT ONLINE CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Postpartum depression improving screening and outcomes amongst providers: A quality improvement project

SUMMARY INFORMATION

Things you should know about this study:

- **Purpose:** This quality improvement project aims to improve provider education, screening, and outcomes related to postpartum depression among women of childbearing age.

- **Procedures:** Participants will complete an anonymous pre-test survey to assess their knowledge, perceptions, and current clinical practice regarding postpartum depression. After completion of the pre-test, the participants will be provided with an education voiceover PowerPoint discussing education, screening tools, and treatment guidelines for postpartum depression. Following the education intervention, the participants will complete the post-test survey that mirrors the initial test, with a goal of determining their knowledge and perception of postpartum depression.

- **Duration:** The pre-test and post-test will take 15-20 minutes each to complete. Additionally, the voiceover PowerPoint will take 20-30 minutes to participate in.

- **Risks:** Participants are not expected to experience any more than minimal risks, harms, or discomfort through participation of this project. Potential risks may be experienced by feeling uncomfortable with any of the interactions or is concerned about the content of the information shared with the interviewer, he/she may choose to withdraw from the study. There is no cost or legal intervention.
• **Benefits:** Benefits to participants include improved knowledge of postpartum depression management and improved clinical skills for patients suffering from postpartum depression.

• **Alternatives:** There are no known alternatives available to you other than not taking part in this study.

• **Participation:** Taking part in this research project is voluntary. You can withdraw at any time without giving reason or without cost.

Please carefully read the entire document before agreeing to participate.

**PURPOSE OF THE STUDY**

The purpose of this study is to enhance providers knowledge of postpartum depression including screening and management to improve patient outcomes. As a result of this project, it is expected that participants will gain increased knowledge of the postpartum depression. Furthermore, it is anticipated that this study will benefit society by guiding healthcare providers in the effective screening and management of postpartum depression, thus improving outcomes to this population.

**NUMBER OF STUDY PARTICIPANTS**

If you decide to be in this study, you will be one of 15 people in this research study.

**DURATION OF THE STUDY**

Pre-test survey 15-20 minutes  
Voiceover educational PowerPoint 20-30 minutes  
Post-test survey 15-20 minutes

**PROCEDURES**

If you agree to be in the study, we will ask you to do the following things:
1. Pre-test survey  
2. Voiceover education PowerPoint  
3. Post-test survey

**RISKS AND/OR DISCOMFORTS**

Participants are not expected to experience any more than minimal risks, harms, or discomfort through participation of this project. Potential risks may be experienced by feeling uncomfortable with any of the interactions or is concerned about the content of the information
shared with the interviewer, he/she may choose to withdraw from the study. There is no cost or legal intervention. If a participant feels uncomfortable with any of the interactions or is concerned about the content of the information shared with the interviewer, he/she may choose to withdraw from the study.

**BENEFITS**
Benefits to participants include improved knowledge of postpartum depression management and improved clinical skills for patients suffering from postpartum depression.

**ALTERNATIVES**
There are no known alternatives available to you other than not taking part in this study. Any significant new findings developed during the course of the research which may relate to your willingness to continue participation will be provided to you.

**CONFIDENTIALITY**
All data will be collected anonymously. To ensure confidentiality, the participants will create their own personal identifier to be used during the pre-test and post-test. An example of this can be four numbers followed by a letter (i.e., 4438K). Creating this personal identifier will link the results from each test and ensure the participants remain anonymous. No identifiable private information will be collected as a part of the pre-test and post-test surveys. Only investigators will have access to the completed pre-test and post-test surveys. There will be no hard copies of the pre- or post-test surveys. Data collected from the pre-test and post-test surveys will be tabulated via survey monkey an online system and will be maintained on a password protected laptop computer.

**USE OF YOUR INFORMATION**
No personal identifiable information will be used for this study.

**COMPENSATION & COSTS**
You will not receive a payment for your participation. There are no costs to you for participating in this study.

**RIGHT TO DECLINE OR WITHDRAW**
Your participation in this study is voluntary. You are free to participate in the study or withdraw your consent at any time during the study. You will not lose any benefits if you decide not to participate or if you quit the study early. The investigator reserves the right to remove you without your consent at such time that he/she feels it is in the best interest.

**RESEARCHER CONTACT INFORMATION**
If you have any questions about the purpose, procedures, or any other issues relating to this research study you may contact Jessica Hoke at (561) 306-9386 or jhoke004@fiu.edu.

**IRB CONTACT INFORMATION**
If you would like to talk with someone about your rights of being a subject in this research study or about ethical issues with this research study, you may contact the FIU Office of Research Integrity by phone at 305-348-2494 or by email at ori@fiu.edu.

**PARTICIPANT AGREEMENT**
I have read the information in this consent form and agree to participate in this study. I have had a chance to ask any questions I have about this study, and they have been answered for me. By clicking on the Survey Monkey link [https://www.surveymonkey.com/r/VGXPGGF](https://www.surveymonkey.com/r/VGXPGGF) I agree to participate in this QI project.

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**MEMORANDUM**

To: Dr. Rosa Roche  
CC: Jessica Hoke  
From: Elizabeth Juhasz, Ph.D., IRB Coordinator  
Date: July 28, 2021  
Protocol Title: "Postpartum depression improving screening and outcomes amongst providers: A quality improvement project"

The Florida International University Office of Research Integrity has reviewed your research study for the use of human subjects and deemed it Exempt via the Exempt Review process.

**IRB Protocol Exemption #:** IRB-21-0335  
**IRB Exemption Date:** 07/28/21  
**TOPAZ Reference #:** 110559

As a requirement of IRB Exemption you are required to:

1) Submit an IRB Exempt Amendment Form for all proposed additions or changes in the procedures involving human subjects. All additions and changes must be reviewed and approved prior to implementation.
2) Promptly submit an IRB Exempt Event Report Form for every serious or unusual or unanticipated adverse event, problems with the rights or welfare of the human subjects, and/or deviations from the approved protocol.

3) Submit an IRB Exempt Project Completion Report Form when the study is finished or discontinued.

Special Conditions: N/A

For further information, you may visit the IRB website at http://research.fiu.edu/irb.

References


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