Quality in Action | Journal Club

EFFECTIVENESS OF TWO SYSTEMS-LEVEL INTERVENTIONS TO ADDRESS PERINATAL DEPRESSION IN OBSTETRIC SETTINGS (PRISM): AN ACTIVE CONTROLLED CLUSTER-RANDOMIZED TRIAL

February 24, 2026

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Advancing ob-gyn care for all.

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- The opinions expressed in this presentation do not reflect the official position of the Agency for Healthcare Research and Quality (AHRQ).
- This information is not being offered as legal or medical advice.
- Seek competent legal counsel for specific guidance.

Disclaimer

- Dr. Moore Simas is
  - Author on article being discussed.
  - MPI on the study funded by the CDC about which the article is written.
  - Consultant for MCPAP for Moms as obstetric engagement liaison.
  - Member of ACOG OB CPG committee, and co-chair PMHC EWG.

Before We Get Started

This webinar will be recorded

If you need help during the call, please chat an ACOG staff member

Submit your questions throughout this session using the chat box

Any questions following this webinar can be sent to obgynsafety@acog.org

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Introducing…

Quality in Action

AN ACOG FOUNDATION PATIENT SAFETY ORGANIZATION

A New Partner in Quality and Patient Safety

Combining ACOG's trusted expertise with real-world support to help hospitals and health systems deliver safer, more equitable care.

- Evidence-based quality improvement strategies
- Plan to support review of patient safety work
- Tailored support for frontline teams
- Designed for measurable impact

Let's improve ob-gyn care–together.

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About Quality in Action Journal Club…

This journal club creates space for multidisciplinary clinicians to engage deeply with the literature, share insights, and propose applications to and future directions for obstetric and gynecologic quality and safety. Each session in the topic-specific series centers a selected article that explores priority areas in obstetric and gynecologic care. Facilitated by Quality in Action's PSO program staff, the Journal Club helps participants translate evidence into action while identifying opportunities for innovation and improvement.

For more information about Quality in Action and related services visit:
obgynsafety.org

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Journal Club Intentions

Foster a Safe Learning Environment

Encourage Open Sharing of Ideas

Practice Interdisciplinary Communication and Collaboration

Continuously Improve

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Journal Club Format

Welcome/Introduction

Article Overview

Participant Discussion

Related Resources & Conclusion

Upcoming Journal Club Session

March 31, 2026
11:00-12:00pm ET

Journal Club

Pursuing CE

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Today’s Guest Lead

Article:

Effectiveness of two systems-level interventions to address perinatal depression in obstetric settings (PRISM): an active controlled cluster-randomized trial

Document authors:

Nancy Byatt, DO, Linda Brenckle, MS, Padma Sankaran, MS, Julie Flahive, MS, Jean Y. Ko, PhD, Cheryl L. Robbins, PhD, Martha Zimmermann, PhD, Jeroan Allison, MD, Sharina Person, PhD, Tiffany A Moore Simas, MD

Our Guest :
Tiffany A. Moore Simas, MD, MPH, MEd, FACOG

OBJECTIVE OF ARTICLE

- Understand how system-level implementation strategies can improve perinatal depression outcomes in obstetric settings
- Interpret the design and findings of a cluster-randomized trial evaluating real-world mental health interventions
- Critically evaluate scalability, cost, and equity implications of perinatal mental health interventions

IMPORTANCE OF TOPIC

- **Perinatal depression is common, harmful, and under-treated**
  - Around 1 in 7–8 pregnant or postpartum patients experience depression, with downstream effects on maternal functioning, obstetric outcomes, infant development, and family well-being. Yet the majority of people who screen positive never receive adequate treatment. That gap isn't about lack of evidence-based therapies—it's about failure of delivery.
- **Obstetric care is where patients already are—but systems aren't built for mental health**
  - Professional guidelines recommend screening and treatment within obstetric settings, but most practices lack training, workflows, psychiatric backup, and referral pathways. This study directly tackles the "implementation problem": not *what* works for depression, but *how* to make care actually happen in routine obstetrics.

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IMPORTANCE OF TOPIC

- **It provides rare, pragmatic evidence comparing scalable system-level solutions**
  - By comparing a statewide, low-intensity access model (MCPAP for Moms) with a more intensive, practice-level implementation strategy (PRISM), the study addresses a question health systems and policymakers actually face:
    Do we need intensive, expensive practice transformation—or can broader, lower-cost programs achieve similar clinical benefit?
- **The findings directly inform policy, funding, and scale-up decisions**
  - Showing clinically meaningful symptom improvement with a population-based model has implications for state and national investment in perinatal psychiatry access programs, especially given limited resources and workforce shortages.

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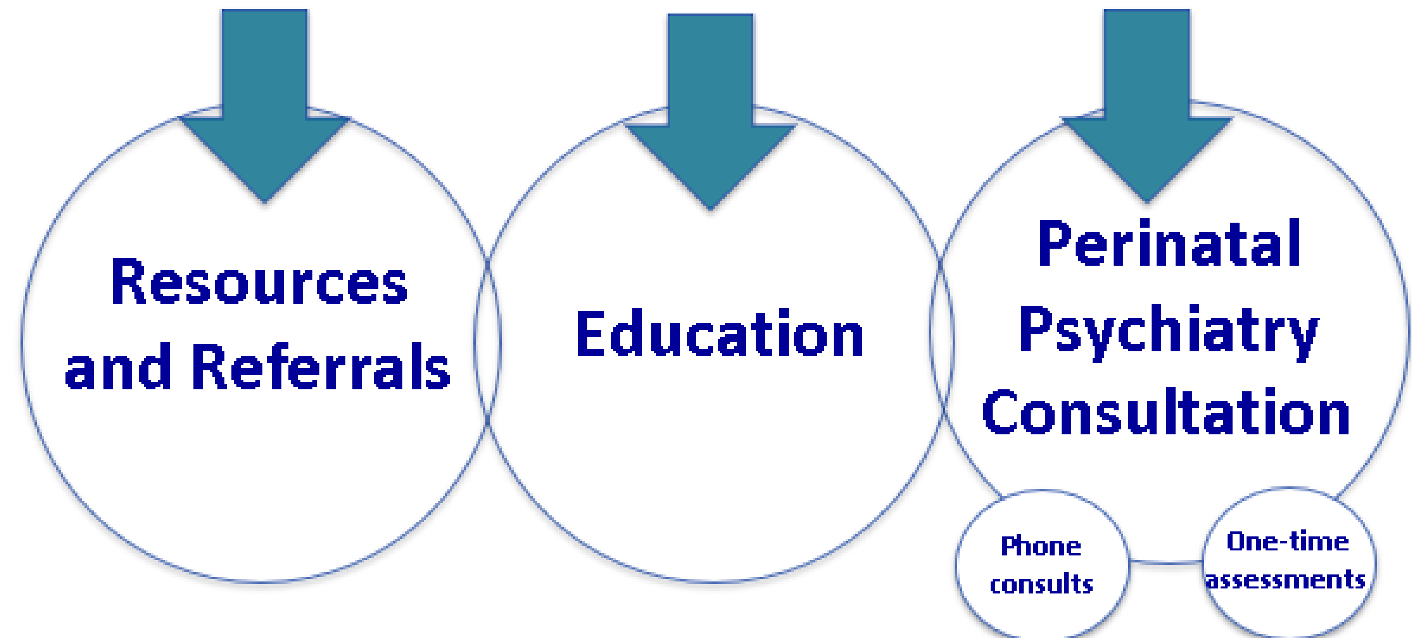
KEY DEFINITIONS

MCPAP for Moms:

Perinatal Psychiatry Access Program



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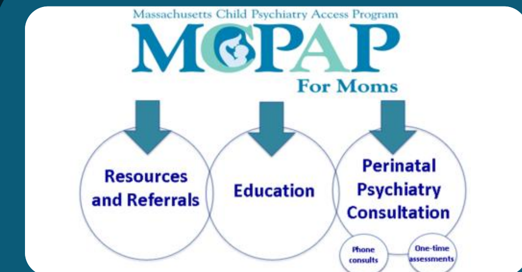
KEY DEFINITIONS

- Program in Support of Moms (PRISM)
  - MCPAP for Moms
  - On-site implementation support thru sustainment
  - Assess practice readiness
  - Customize training, toolkits, workflows
  - Patient monitoring via registry and navigator
  - Case review

PRISM

MCPAP for Moms + proactive, multifaceted, OB practice-level intervention with intensive implementation support

State-wide Population-based



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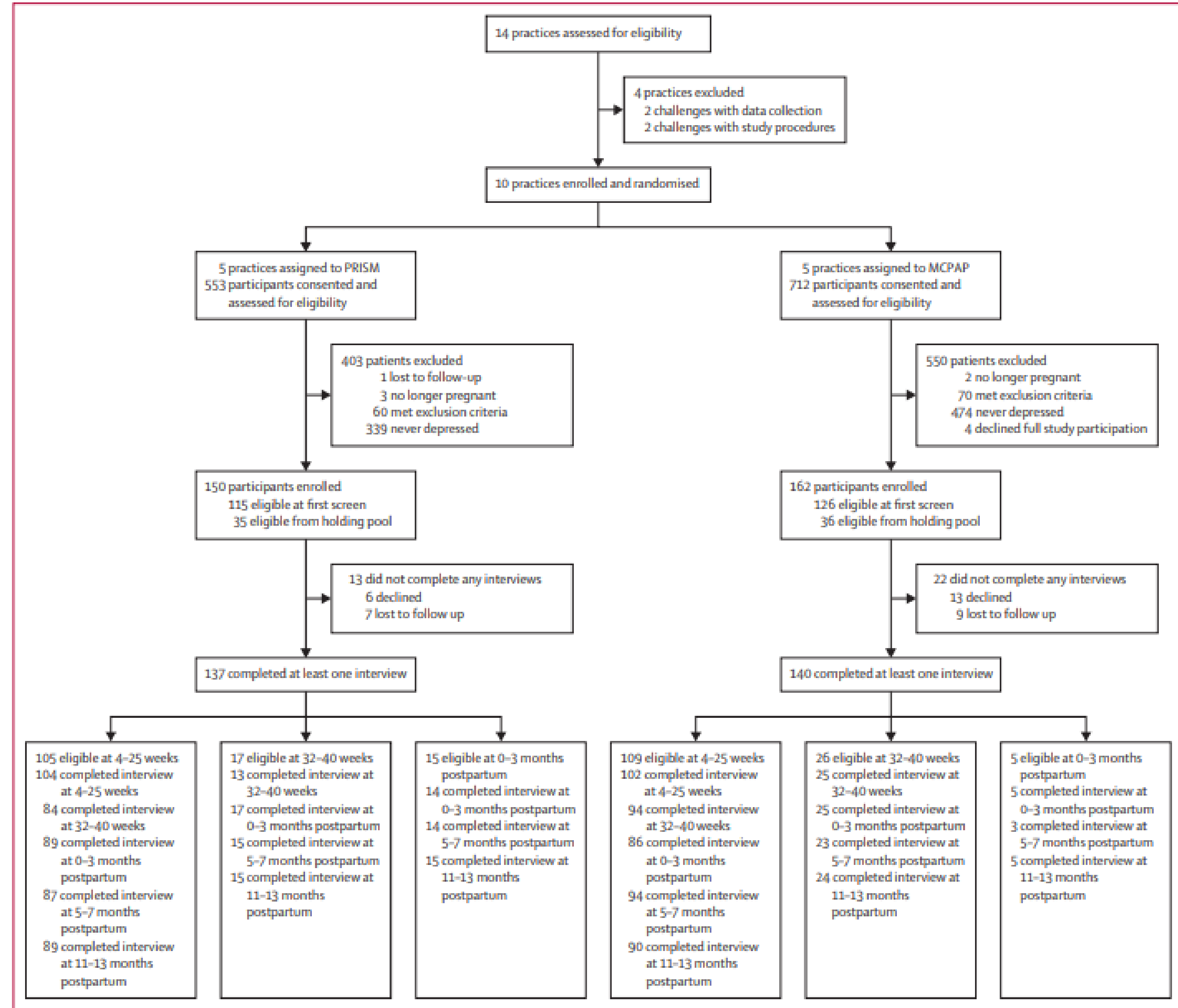
KEY DEFINITIONS

- Cluster-randomized controlled trial
  - Instead of randomizing individual patients, *entire obstetric practices* were randomized to MCPAP for Moms or PRISM. This is done to avoid "contamination" (eg, providers changing behavior for all patients once trained), but it complicates analysis and interpretation.
- Active-controlled trial
  - There was **no true "usual care" group**. Both arms received an intervention (MCPAP for Moms vs PRISM + MCPAP), which matters when interpreting the finding that outcomes were "equally effective."

STUDY DESIGN

- **Cluster RCT – active control**
- **Practices: 14 → 10 randomized**
  - 5 PRISM
  - 5 MCPAP for Moms
- **Patients:**
  - **eligible if English-speaking & EPDS ≥ 10; excluded with BPD or SUD**
  - **1265 → 312 patients (24.7%)**
    - 150 PRISM
    - 162 MCPAP for Moms
    - (~30 per practice)
- **Recruitment/Evaluation points:**
  - 4-25 wks GA
  - 32-40 wks GA
  - 0-3 mos PP
  - 5-7 mos PP
  - 11-13 mos PP
- **Outcomes:**
  - **Primary:** Change EPDS BL → 11-13 mos pp
  - **Secondary:** Treatment initiation & sustainment



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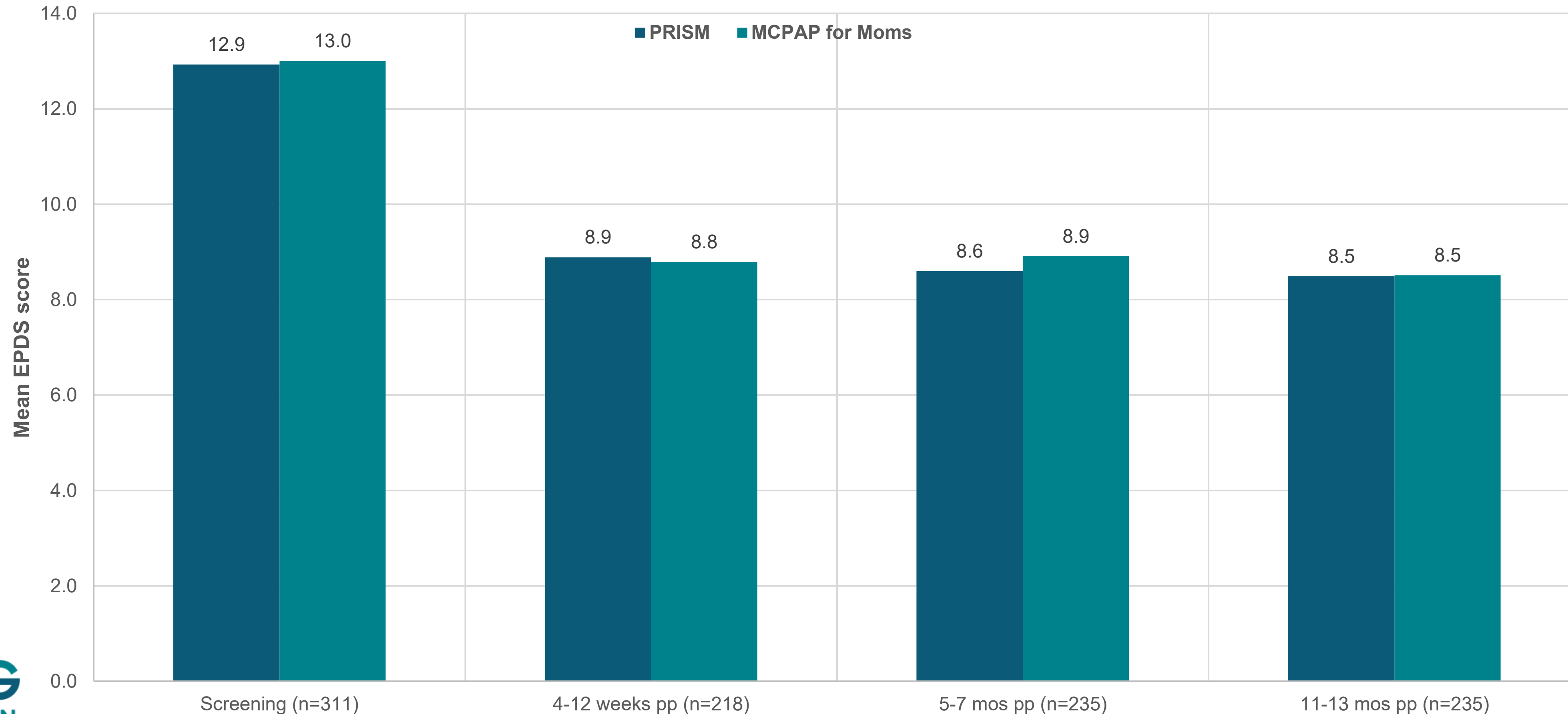
KEY FINDING/CONCLUSION 1: Mean differences in depression symptomatology among patient participants receiving care from both MCPAP for Moms and PRISM practices decreased from recruitment to follow-up

4-point decrease in EPDS score is clinically significant



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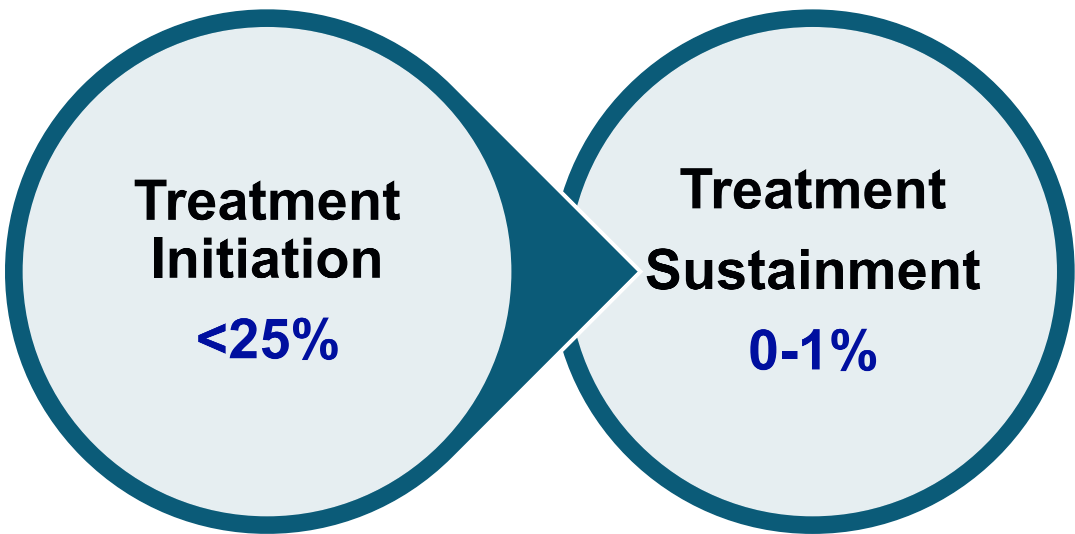
Byatt et al. (2024). I*The Lancet Public Health.* **CDC 1U01DP006093**

KEY FINDING/CONCLUSION 1 – EPDS Scores

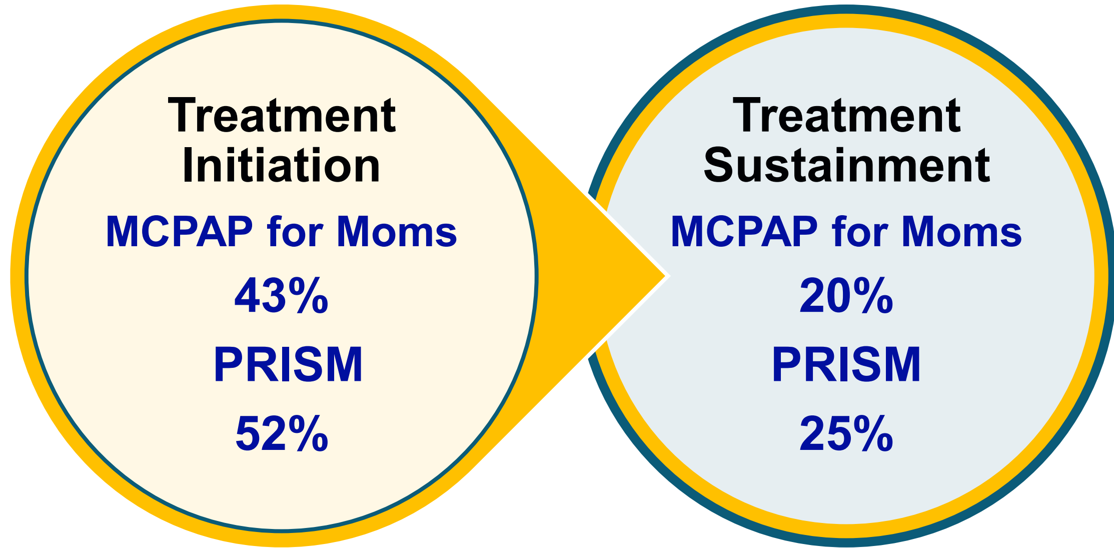
- Participants in both intervention arms showed a **clinically significant and sustained reduction in depression symptoms**, with mean Edinburgh Postnatal Depression Scale (EPDS) scores decreasing by about **4 points from baseline to 11–13 months postpartum** in each group. The magnitude of improvement did **not differ between PRISM and MCPAP for Moms**, indicating no added benefit of the more intensive intervention on symptom reduction (adjusted between-group difference ≈0.1 points; not statistically significant)
- Conclusion: Both system-level interventions were **equally effective** in improving perinatal depression symptoms over the first postpartum year, demonstrating that the lower-intensity, population-based MCPAP for Moms can achieve **comparable clinical improvements in EPDS scores** to the more resource-intensive PRISM model

KEY FINDING/CONCLUSION 2: These approaches are effective in improving treatment initiation and sustainment rates, compared with previously reported outcomes

Systematic Review (2015)



MCPAP for Moms & PRISM



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Byatt et al. (2015). *Ob Gyn*. Byatt et al. (2024). *The Lancet Public Health.*

CDC 1U01DP006093

KEY FINDING/CONCLUSION 2

- Rates of **treatment initiation and sustainment did not differ significantly** between the two intervention groups. Approximately **43–52% of participants initiated treatment**, and only **20–25% sustained treatment** over time, regardless of whether they received care in PRISM or MCPAP for Moms practices. Although point estimates favored PRISM, these differences were **not statistically significant after accounting for clustering** at the practice level
- Conclusion: Both interventions were **similarly effective—but limited—in promoting engagement with mental health care**. While treatment initiation rates were higher than those reported in prior usual-care studies, **most participants did not initiate treatment, and the majority did not sustain it**, highlighting persistent gaps in engagement that are not fully addressed even by intensive, practice-level implementation strategies

LIMITATIONS

- **Limited generalizability**
  - Conducted in **only 10 obstetric practices within a single state (MA)**
  - Participants were **English-speaking only**
- **No true usual-care control group**
- **Underpowered secondary outcomes**
- **Higher attrition in the MCPAP for Moms group**
  - Attrition was greater in the lower-intensity MCPAP arm, which could bias comparisons despite attempts to mitigate this through over-recruitment and sensitivity analyses.

LIMITATIONS (Continued)

- **Potential influence of study participation itself**
  - Recruitment, repeated screening, and follow-up interviews may have **influenced participant awareness and care-seeking**, potentially enhancing outcomes in both groups.
  - Although data collection occurred outside clinical workflows, some contamination through heightened attention cannot be ruled out.
- **Limited cost data**
  - While cost estimates exist for MCPAP for Moms, **formal cost-effectiveness data for PRISM were not available**, limiting conclusions about comparative efficiency.
- **COVID-19 context**
- **Persistent unmet need despite interventions**
  - Even with both interventions, **more than 50% of participants did not initiate treatment and ≥75% did not sustain treatment**, indicating that important barriers to engagement remain unaddressed.

CONCLUSION

Both PRISM and MCPAP for Moms produced clinically meaningful and equivalent improvements in perinatal depression, suggesting that scalable, lower-intensity psychiatry access programs can deliver substantial public health benefit, although major gaps in treatment engagement remain.

(Other PRISM publications share additional results and benefits)

DISCUSSION TIME

- TAKE A FEW MOMENTS TO COLLECT YOUR THOUGHTS FROM THE ARTICLE AND RECAP – WE WANT TO HEAR FROM YOU!

GROUP DISCUSSION

- Is the information in this article expected or unexpected? How does it match up with your real-world experience?
- What are some key strengths and limitations that should be considered when thinking about the information in this article?
- What are some unmentioned factors that may also influence the conclusions identified in this article?
- How can we improve practice as it relates to the information in this article?
- What additional questions does the article raise?

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ACOG RESOURCES

CLINICAL PRACTICE GUIDELINE

NUMBER 4
JUNE 2023
REPLACES COMMITTEE OPINION 757, NOVEMBER 2018

Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Tiffany A. Moore Simas, MD, MPH, MEd; M. Camille Hoffman, MD, MSc; Emily S. Miller, MD, MPH; and Torri Metz, MD, MS; with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.
The Society for Maternal-Fetal Medicine endorses this document.
The Committee on Women's Mental Health of the American Psychiatric Association reviewed and provided feedback on this document.

PURPOSE: To review evidence on the current understanding of mental health conditions in pregnancy and postpartum, with a focus on mood and anxiety disorders, and to outline guidelines for screening and diagnosis that are consistent with best available scientific evidence. The conditions or symptoms reviewed include depression, anxiety and anxiety-related disorders, bipolar disorder, suicidality, and postpartum psychosis. For information on psychopharmacologic treatment and management, refer to American College of Obstetricians and Gynecologists (ACOG) Clinical Practice Guideline Number 5, "Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum" (1).
TARGET POPULATION: Pregnant or postpartum individuals with mental health conditions. Onset of these conditions may have predated the perinatal period or may have occurred for the first time in pregnancy or the first year postpartum or may have been exacerbated in that time.
METHODS: This guideline was developed using an a priori protocol in conjunction with a writing team consisting of one specialist in obstetrics and gynecology and one maternal–fetal medicine subspecialist appointed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics and two external subject matter experts. ACOG medical librarians completed a comprehensive literature search for primary literature within Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE. Studies that moved forward to the full-text screening stage were assessed by two authors from the writing team based on standardized inclusion and exclusion criteria. Included studies underwent quality assessment, and a modified GRADE (Grading of Recommendations Assessment, Development and Evaluation) evidence-to-decision framework was applied to interpret and translate the evidence into recommendation statements.
RECOMMENDATIONS: This Clinical Practice Guideline includes recommendations on the screening and diagnosis of perinatal mental health conditions including depression, anxiety, bipolar disorder, acute postpartum psychosis, and the symptom of suicidality. Recommendations are classified by strength and evidence quality. Ungraded Good Practice Points are included to provide guidance when a formal recommendation could not be made because of inadequate or nonexistent evidence.

CLINICAL PRACTICE GUIDELINE

NUMBER 5
JUNE 2023
REPLACES PRACTICE BULLETIN NUMBER 92, APRIL 2008

Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum

Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Emily S. Miller, MD, MPH; Torri Metz, MD, MS; Tiffany A. Moore Simas, MD, MPH, MEd; and M. Camille Hoffman, MD, MSc; with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.
The Society for Maternal-Fetal Medicine endorses this document.
The Committee on Women's Mental Health of the American Psychiatric Association reviewed and provided feedback on this document.

PURPOSE: To assess the evidence regarding safety and efficacy of psychiatric medications to treat mental health conditions during pregnancy and lactation. The conditions reviewed include depression, anxiety and anxiety-related disorders, bipolar disorder, and acute psychosis. For information on screening and diagnosis, refer to American College of Obstetricians and Gynecologists (ACOG) Clinical Practice Guideline Number 4, "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum" (1).
TARGET POPULATION: Pregnant or postpartum individuals with mental health conditions with onset that may have predated the perinatal period or may have occurred for the first time in pregnancy or the first year postpartum or may have been exacerbated in that time.
METHODS: This guideline was developed using an a priori protocol in conjunction with a writing team consisting of one specialist in obstetrics and gynecology and one maternal–fetal medicine subspecialist appointed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics and two external subject matter experts. ACOG medical librarians completed a comprehensive literature search for primary literature within Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE. Studies that moved forward to the full-text screening stage were assessed by two authors from the writing team based on standardized inclusion and exclusion criteria. Included studies underwent quality assessment, and a modified GRADE (Grading of Recommendations Assessment, Development and Evaluation) evidence-to-decision framework was applied to interpret and translate the evidence into recommendation statements.
RECOMMENDATIONS: This Clinical Practice Guideline includes recommendations on treatment and management of perinatal mental health conditions including depression, anxiety, bipolar disorders, and acute postpartum psychosis, with a focus on psychopharmacotherapy. Recommendations are classified by strength and evidence quality. Ungraded

CLINICAL PRACTICE UPDATE

DECEMBER 2025

Zuranolone and Brexanolone for the Treatment of Postpartum Depression

This Clinical Practice Update was developed by the American College of Obstetricians & Gynecologists with the assistance of Tiffany A. Moore Simas, MD, MPH, MEd, MHCM; M. Camille Hoffman, MD, MSc; Kay Roussos-Ross, MD; Emily S. Miller, MD, MPH; Manisha Gandhi, MD; and Andrea Shields, MD, MS.
The Society for Maternal-Fetal Medicine endorses this document.

This Clinical Practice Update provides revised guidance on the use of brexanolone and zuranolone in the postpartum period for depression that has onset in the third trimester or within 4 weeks postpartum. This document is a focused update of related content in Clinical Practice Guideline No. 5, *Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum* (Obstet Gynecol 2023;141:1262–88) and replaces the August 2023 Practice Advisory, *Zuranolone for the Treatment of Postpartum Depression.*

BACKGROUND

Perinatal mental health conditions, manifesting in outcomes such as suicide and overdose or poisoning, are a leading cause of overall and preventable maternal mortality (1, 2). As such, understanding, discussing, and recommending nonpharmacologic therapy, as well as providing pharmacologic treatment when indicated and needed, fall within the scope of the obstetrician–gynecologist's practice (3). Although selective serotonin reuptake inhibitors (SSRIs) and serotonin–norepinephrine reuptake inhibitors (SNRIs) are commonly used medications to treat major depressive disorder including perinatal depression, the only U.S. Food and Drug Administration (FDA)–approved treatments specifically for postpartum depression are two neuroactive steroids that act as positive allosteric modulators of gamma-aminobutyric acid (GABA) A receptors: brexanolone (approved in 2019) and zuranolone (approved in 2023) (4, 5). Brexanolone, administered as an inpatient 60-hour intravenous infusion, is no longer commercially available in the United States as of January 1, 2025 (6, 7). Zuranolone is available; it is administered orally for 14 days.

UPDATED CLINICAL RECOMMENDATION

The American College of Obstetricians & Gynecologists recommends consideration of zuranolone in the postpartum period (ie, within 12 months of delivery) for severe depression that has onset in the third trimester or within 4 weeks postpartum. The decision to use zuranolone should balance the benefits (ie, significantly improved and rapid symptom resolution compared with placebo) alongside challenges specific to initiating and managing this medication that are described in this Clinical Practice Update.

RATIONALE

ACOG recommended consideration of brexanolone administration by intravenous infusion in the postpartum period for moderate-to-severe perinatal depression with onset in the third trimester or within 4 weeks postpartum (3). However, brexanolone is no longer commercially available in the United States as of January 1, 2025. The FDA approval was withdrawn as of April 14, 2025, as requested by the manufacturer given practical treatment limitations associated with complex logistics and high cost, along with strategic realignment toward a new oral therapy (8). The oral agent with a similar mechanism of action, zuranolone, received FDA priority review approval after two phase 3 randomized, double-blind, placebo-controlled, multicenter studies demonstrated efficacy for treatment of severe perinatal depression with third-trimester onset or onset in the first 4 weeks postpartum (9, 10). The primary endpoint of both zuranolone studies was the change in depressive symptoms using

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ADDITIONAL RESOURCES

PERINATAL MENTAL HEALTH CONDITIONS

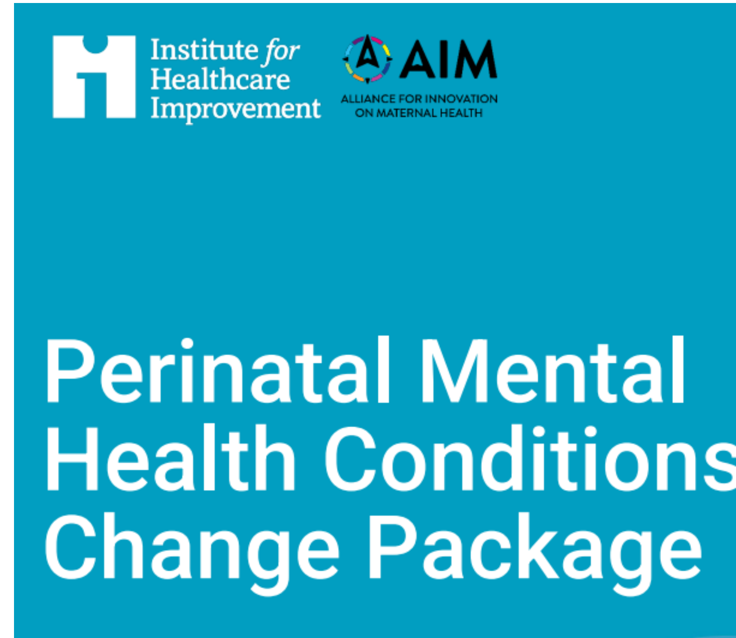
For the purposes of this bundle, perinatal mental health conditions refer to mood, anxiety, and anxiety-related disorders that occur during pregnancy or within one year of delivery and are inclusive of mental health conditions with onset that predates pregnancy. These conditions include and are not limited to depression, anxiety and anxiety-related disorders like posttraumatic stress disorder and obsessive-compulsive disorder, bipolar disorder, and postpartum psychosis.

- READINESS
- RECOGNITION & PREVENTION
- RESPONSE
- REPORTING & SYSTEMS LEARNING
- RESPECTFUL, EQUITABLE & SUPPORTIVE CARE

View the Introduction to Perinatal Mental Health Conditions video HERE.

QUICK LINKS

- Printable Bundle (PDF)
- National Maternal Health Hotline
- Perinatal Mental Health Conditions Element Implementation Details (PDF)
- Perinatal Mental Health Conditions Implementation Webinar (Video)
- Perinatal Mental Health Conditions Data Collection Plan (PDF)
- Perinatal Mental Health Conditions Bundle Implementation Resources (PDF)
- COMING SOON: Perinatal Mental Health Conditions Change Package (PDF)



	Key Resources and Tools
y a member of the l health conditions l at regular intervals le should include n visit *	American College of Obstetricians and Gynecologists (ACOG): Perinatal Mental Health: Patient Screening[22]
ve screen (Who pathways ready	Massachusetts Child Psychiatry Access Program (MCPAP) for Moms: Obstetric Provider Toolkit[23] Orange County (OC) Health Care Agency: Perinatal Mood and Anxiety Disorders: Maternal Screening and Care Pathway[24]
rs to get support ns positive to allow r community, explore are *	UMass Chan Medical School: Resources for Integrating Mental Health into Obstetric Settings: Sample Workflows (pp. 57 - 58)[25] Maternal Mental Health Leadership Alliance (MMHLA): Psychiatry Access Programs[26] Postpartum Support International (PSI): Perinatal Psychiatric Consult Line[27]
As feasible, set up mechanisms to pre-schedule mental health care for post-delivery in the event of a positive screen during pregnancy	Increasing Warm Handoffs: Optimizing Community Based Referrals in Primary Care Using QI Methodology[28]

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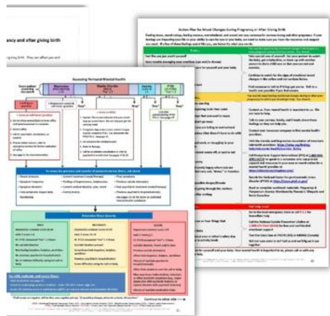
ADDITIONAL RESOURCES

Toolkit

eModule

Guide

Access Programs



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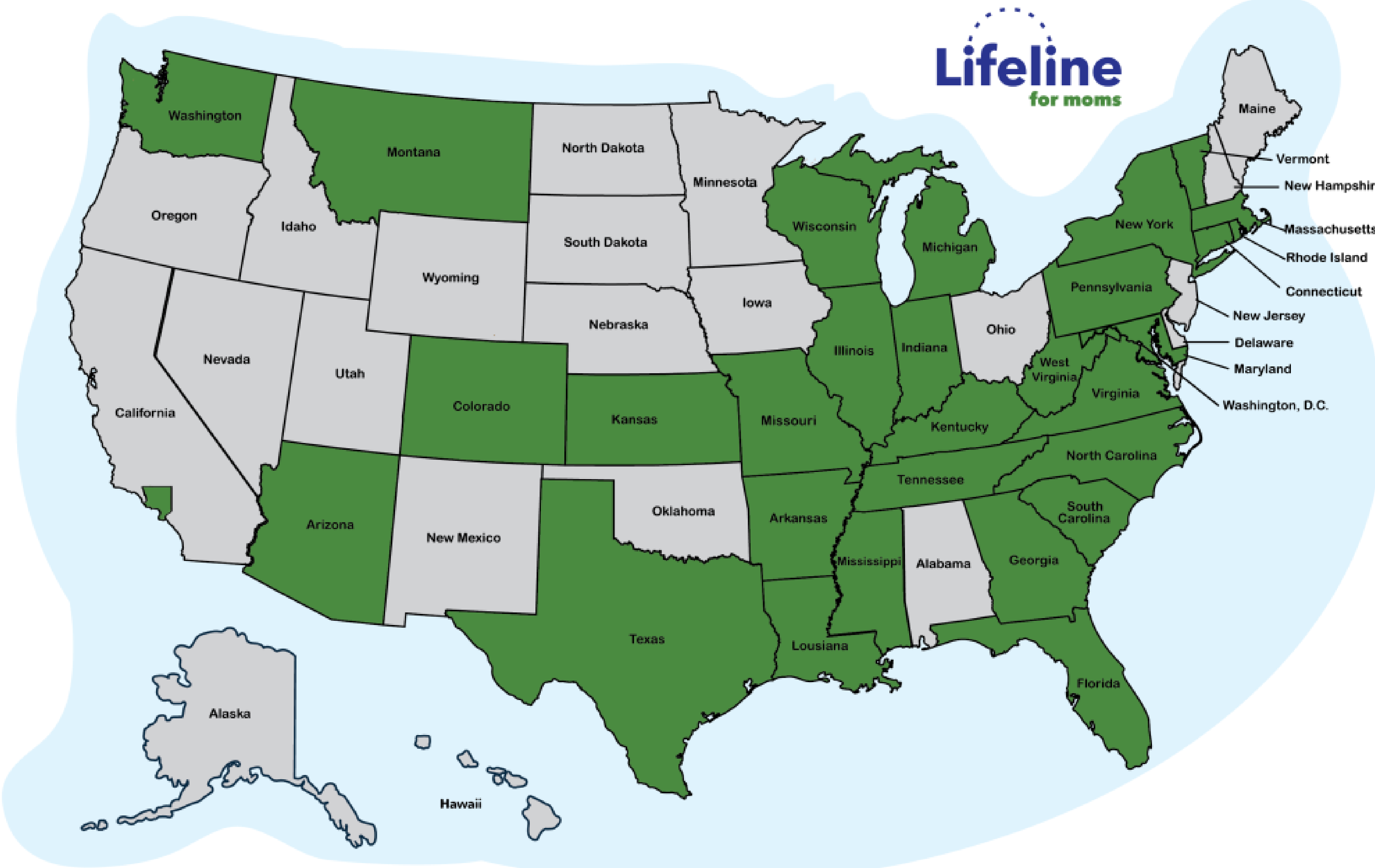
[Perinatal Mental Health | ACOG]

National Network of Perinatal Psychiatry Access Programs

There are 30 statewide and regional Perinatal Psychiatry Access Programs with the potential to cover 2.6 million or over 70% of the 3.7 million births in the US.



Active Programs

Active national programs: (1) Postpartum Support International (PSI) Perinatal Psychiatric Consult Line & (2) Veterans Affairs (VA) Reproductive Mental Health Consultation Programs

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ADDITIONAL RESOURCES - PSI

Many high-quality patient-facing resources.

How to Get Help for Your Mental Health

PSI HelpLine	National Maternal Mental Health Hotline	National Suicide & Crisis Lifeline
1-800-944-4773	1-833-852-6262	988
For individuals who are not in crisis but need resources and referrals	For individuals who are not in crisis but need real-time support and resources	For individuals needing support for suicidal or mental health crisis
Call or text, volunteers respond	Available 24/7/365	Available 24/7/365
English & Spanish	English & Spanish, other languages available via translator	English & Spanish, other languages available via translator
Serving pregnant, postpartum, & post-loss people worldwide	Serving pregnant & postpartum people in the United States	Serving anyone in the United States
Staffed by volunteers	Staffed by professionals	Staffed by volunteers & professionals
Provides connection to PSI resources	Provides hand-offs to 988, DV hotlines	Provides hand-offs to National Maternal Mental Health Hotline

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Thank You!

Please send any questions to obgynsafety@acog.org

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