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| **Comprehensive List of Aims, Sub-aims, Goals, and Approaches to Measurement** |
| Before launching any new implementation project, it is important to come up with a specific plan for setting goals, monitoring progress, and sharing results. Below we provide some examples of goals that have been helpful in other practices. In general, the best goals are highly specific and measurable. Measurable goals facilitate progress monitoring, which can be done via EHR review, surveys, or interviews with staff and/or patients. In the following table the Aims and Sub-aims align with the Output tab of the *Tool to Schedule Implementation and Create Practice Goals but* contains a much more comprehensive list than is included in the *Tool*. You may choose to use this document as another way to review and select goals for your practice or to get ideas about different ways to measure progress toward achieving each one.  |
| **Aim 1:** Provide psychoeducation, destigmatize perinatal mental health conditions, and help engage women in treatment using a strength-based approach. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 1.1.a | Our practice explains to all our patients that screening for perinatal mental health conditions will happen routinely as part of their obstetric care. | By *DATE,* we will incorporate an explanation of screening into our intake workflow for each new prenatal patient. | Identify the date by which workflow document includes suggested verbiage that those administering the screening can use |
| By *DATE*, we will have a staff meeting focused on reviewing how to implement patient-centered language, trauma informed care, and strength-based communication. | The date of the meeting regarding goal content |
| 1.2.a | Our practice has procedures for providing training to clinicians and clinical staff about perinatal mental health conditions. | By *DATE,* we will have training materials available to clinical staff about addressing perinatal mental health conditions. | The date the practice has acquired or developed at least one type of training material (document/slide presentation/online seminar) presented at a level consistent with the education/training/skills for each type of clinical staff |
| 1.2.b | By *DATE,* we will provide education and training to clinicians and clinical staff about perinatal mental health conditions. | The date of training/meeting completion |
| 1.2.c | By *DATE,* we will have a plan for providing ongoing education and training to clinicians and clinical staff about perinatal mental health conditions. | The date that the practice has a perinatal mental health training plan for clinicians and staff that identifies the frequency and content of initial training for new personnel and follow-up training after initial training for all in ongoing manner |
| 1.2.d | By *DATE,* we will have established the frequency and intensity of all ongoing education and training.  | The date that the practice has a perinatal mental health training plan for clinicians and staff that identifies the frequency and content of initial training for new personnel and follow-up training after initial training for all  |
| 1.2.e | By *DATE,* we will have identified training needs specific to different staff (e.g., nursing, front desk, clinicians) and a plan to provide training tailored to the needs. | The date that the practice has a list of knowledge and skills required by each type of practice personnel and a plan for personnel to acquire said knowledge and skills |
| 1.2.f | By *DATE*, all clinicians will have been provided a copy of the materials for obstetric care clinicians and participated in a session to review its contents. | The date of completion of for obstetric care clinicians review session for clinicians |
| 1.2.g | By DATE, all clinicians will have completed the Lifeline4Moms e-module training on mental health screening, assessment, and treatment. | The date that all clinicians completed e-modules |
| 1.3.a | Our practice has procedures for providing education to patients about perinatal mental health conditions. | Beginning *DATE,* we will provide (name of literature regarding prenatal and/or postpartum mental health) via (print packet, electronic link, EMR, email) to each patient scheduled for an OB intake visit. | A designee (who?) will spot-check 10% of prenatal packets on the first ‘x’ day (e.g., Tuesday) of each month. |
| 1.3.b | Beginning DATE, the OB intake nurse, medical assistant or equivalent will provide psychoeducation and provide at least one piece of literature about perinatal mental health to all patients. | One month following implementation, the designee (who?) will spot-check medical records of 10% of new OBs in the prior month for documentation of psychoeducation and literature |
| 1.3.c | By *DATE,* we will identify at least one language other than English that reflects the patients we serve and by *DATE* will have literature available in that language.  | The date that the practice has multiple copies of one type of perinatal mental health literature in non-English language in the literature area of the practice.  |
| 1.3.d | By *DATE* we will implement the “teach back” method where staff ask patients to repeat back the information conveyed in the educational materials presented. | The date of the staff “Teach Back” method training |
| 1.4.a | Our practice's website has information on perinatal mental health conditions readily available. | By *DATE,* our website will contain information about perinatal mental health conditions. | The date of audit/posting of perinatal mental health content on the website. |
| 1.4.b | By *DATE,* we will have our website reviewed by a mental health professional to solicit feedback on content. | The date of feedback received from mental health professional |
| 1.5.a | Our practice's social media account(s) and/or app-based education platforms have information on perinatal mental health conditions or links to available resources. | By *DATE,* our social media and app-based platforms will contain information about perinatal mental health conditions. | The date(s) of audit/posting of perinatal mental health content and type of social media used |
| 1.6.a | Our practice supports and expects clinicians and staff to have the confidence and skills they need to discuss perinatal mental health conditions with patients. | By *DATE,* we will provide at least one training to licensed independent professionals (i.e., MD, DO, NP, PA, CNMW) regarding perinatal mental health. | The percentage of licensed independent professionals attending/completing trainings |
| 1.6.b | By *DATE,* we will provide at least one training to nursing and other medical staff (i.e., RN, LPN, MA, PCA) regarding perinatal mental health. | The percentage of nursing and other medical staff attending/completing trainings |
| 1.6.c | By DATE, we will provide at least one training to clinical staff (i.e., registration staff) regarding perinatal mental health. | The percentage of clinical staff attending/completing trainings |
| 1.6.d | Beginning DATE, we will include perinatal mental health on the agenda of 1 licensed independent professional (i.e., MD, DO, NP, PA, CNMW) meeting, semi-annually to discuss barriers to optimal perinatal mental health care and potential solutions. | The dates of the licensed independent professional (i.e., MD, DO, NP, PA, CNMW) meetings regarding barriers/potential solutions to barriers within the practice  |
| 1.6.e | Beginning DATE, we will include perinatal mental health on the agenda of 1 nursing and other medical staff (i.e., RN, LPN, MA, PCA) meeting, semi-annually to discuss barriers to optimal perinatal mental health care and potential solutions. | The dates of the nursing and other medical staff (i.e., RN, LPN, MA, PCA) meetings regarding barriers/potential solutions to barriers within the practice  |
| 1.6.f | Beginning DATE, we will include perinatal mental health on the agenda of 1 clinical staff) meeting, semi-annually to discuss barriers to optimal perinatal mental health care. | The dates of clinical staff meetings regarding barriers/potential solutions to barriers within the practice. |
| 1.6.g | By DATE, we will develop/revise our practice mission statement to include care for perinatal mental health conditions as part of perinatal care. | The date of audit of the mission statement for perinatal mental health condition content |
| 1.6.h | BY *DATE*, we will have perinatal mental health screening procedures  | The date that the practice has perinatal mental health screening procedures |
| 1.6.i | By *DATE* we will introduce quarterly brown bag lunches for staff to informally share experiences, knowledge, and questions regarding the mental health needs of our patients.  | The dates of brown bag lunches and percentage of staff attending |
| 1.7.a | According to our patient charts, our clinicians are documenting patient engagement in treatment in those who screen positive on a mental health screen at the following rate: | By *DATE*, *X*% of clinicians will be asking about and documenting engagement in treatment after a positive mental health screen.*50% minimum goal* | Three months after implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of patient engagement in treatment |
| 1.8.a | According to our patient charts, our clinicians are providing psychoeducation to patients who endorse a prior psychiatric history at the following rate: | By DATE, *X*% of clinicians will provide psychoeducation to patients that endorse a prior psychiatric history and will document in their chart that they did so. *75% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a prior psychiatric history for documentation of education regarding perinatal mental health |
| 1.8.b | By *DATE*, we will have developed or identified standardized psychoeducational materials for patients with a previous psychiatric history that includes information on psychiatric relapse and relapse prevention.  | The date that the practice develops/identifies materials to be provided to patients with a previous psychiatric history |
| 1.8.c | By *DATE*, we will have made standardized psychoeducational materials available for patients with a previous psychiatric history that includes information on psychiatric relapse and relapse prevention.  | The date that the practice makes materials available to patients with a previous psychiatric history |
| 1.9.a | According to our patient charts, our clinicians are providing psychoeducation to patients who screen positive on a mental health screen at the following rate: | By *DATE*, *X*% of clinicians will be providing psychoeducation to patients that screen positive on a mental health screen and will document in their chart that they did so. *75% minimum goal* | One month following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of education regarding perinatal mental health |
| 1.9.b | By *DATE*, we will develop or identify standardized psychoeducational materials for patients who screen positive.  | The date that the practice develops/identifies materials to be provided to patients who screen positive |
| 1.9.c | By *DATE*, we will have made standardized psychoeducational materials available to patients who screen positive. | The date that the practice makes materials available to patients who screen positive |
| 1.10.a | Educational materials are posted or available (e.g., posters, brochures, etc.) in the follow percentage of our practice's spaces: | By *DATE*, *X*% of the practice's spaces (e.g., bathrooms, exam rooms, waiting room, etc.) will have educational materials about perinatal mental health posted or available. | The designee (who?) will walk through all practice spaces and document the number of spaces where perinatal mental health materials are displayed/posted  |
| 1.11.a | The educational materials in our practice represent the diversity of the patients we serve. | By *DATE,* we will review all patient perinatal educational materials, the website, and posted materials to determine if they represent the full breadth of perinatal individuals we serve. | The date that the practice has a written list of ethnic, racial, sexual orientation and gender diversity information to describe their patient population. |
| 1.11.b | By *DATE*, we will update all patient perinatal educational materials, the website, and other posted materials to represent the full breadth of perinatal individuals we serve. | The date perinatal educational materials, website, and posted materials update is completed |
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| **Aim 2:** Implement screening for depression, anxiety, and PTSD twice during pregnancy (at prenatal care initiation and later in pregnancy) and at postpartum visits. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 2.1.a | Depression screening rates in the first half of pregnancy:Anxiety screening rates in the first half of pregnancy:PTSD screening rates in the first half of pregnancy: | *(Goal covers all conditions at this time point)* By *DATE*, *X*% of patients who have a new OB visit on or after *DATE* will be screened for depression, anxiety, and PTSD at the time of their new OB visit using Sections A, B, and C, of the Screening for Mood changes During Pregnancy and After Giving Birth Screener.*80% minimum goal* | On the first Friday of the month, the [*designee*] will spot-check 15 charts of patients in at least their second half of pregnancy and check for the documentation of screening results in the first half of pregnancy (paper form, completed electronic form, or documented scores) |
| 2.1.b | XX months after implementation, we will review progress towards goals and identify common barriers to screening in the first half of pregnancy.  | Date *[suggested 3 months following implementation]* to review goals and progress towards goals using Excel Crosswalk tool |
| 2.2.a | Depression screening rates in the second half of pregnancy:Anxiety screening rates in the second half of pregnancy:PTSD screening rates in the second half of pregnancy: | *(Goal covers all conditions at this time point)* By *DATE*, *X*% of patients who have a new OB visit after *DATE* will be screened for depression, anxiety, and PTSD in the second half of pregnancy using Sections A, B and C of the Follow-up Screening for Mood changes During Pregnancy and After Giving Birth Screener.*80% minimum goal* | On the first Friday of the month, the [*designee*] will spot-check 15 charts of postpartum patients and check for the documentation of screening results in the second half of pregnancy (paper form, completed electronic form, or documented scores) |
| 2.2.b | XX months after implementation, we will review progress towards goals and identify common barriers to screening in the second half of pregnancy.  | Date *[suggested 3 months following implementation]* to review goals and progress towards goals using Excel Crosswalk tool |
| 2.3.a | Depression screening rates in the postpartum period:Anxiety screening rates in the postpartum period:PTSD screening rates in the postpartum period: | *(Goal covers all conditions at this time point)* By *DATE*, *X*% of patients who have a new OB visit after *DATE* will be screened for depression, anxiety, and PTSD at the time of their *X*-week postpartum visit using Sections A, B, and C of the Follow-up Screening for Mood changes During Pregnancy and After Giving Birth Screener.*80% minimum goal* | On the first Friday of the month, the [*designee*] will spot-check 15 charts of birthing persons that are > 6 months postpartum patients and check for the documentation of screening results in the early postpartum period (0-3 months postpartum) (paper form, completed electronic form, or documented scores) |
| 2.3.b | XX months after implementation, we will review progress towards goals and identify common barriers to screening in the postpartum period.  | Date *[suggested 3 months following implementation]* to review goals and progress towards goals using Excel Crosswalk tool |
| 2.4.a | Our practice has standardized procedures or recommendations for clinicians in how to screen for mental health conditions (e.g., when, how, next steps) that help to ensure that screens are completed and addressed. | *(Goal applies to more than one sub-aim)* BY *DATE*, we will have perinatal mental health screening procedures, including a description of the screening component of a stepped-care model.  | Date by which the description and procedures will be completed |
| 2.5.a | Our practice supports and expects clinicians and staff to have the confidence and skills they need to screen for perinatal mental health conditions. | *(Goal applies to more than one sub-aim)* By *DATE,* we will havecompleted clinician training on use and interpretation of the perinatal mental health screeners to be used in our practice. | Date by which clinicians will expected to have completed training |
| 2.5.b | XX months after implementation, we will solicit clinician and staff feedback on barriers and facilitators to screening for perinatal mental health conditions. | Date *[suggested 3 months following implementation]* to conduct discussion and review with clinicians on barriers and facilitators to screening. |
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| **Aim 3:** Implement screening for bipolar disorder at initiation of care or after a positive depression screen. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 3.1.a | Bipolar disorder screening rates at any point during pregnancy: | Beginning DATE, X% of patients will be administered the Mood Disorder Questionnaire (MDQ) to screen for bipolar disorder at their OB intake visit or after a positive depression screen*80% minimum goal* | On the first Friday of the month, the [*designee*] will spot-check 15 charts of patients in at least their second half of pregnancy and check for the documentation of screening results for bipolar disorder at the OB intake visit or after a positive depression screen (paper form, completed electronic form, or documented scores) |
| 3.2.a | Bipolar disorder screening rates prior to prescribing antidepressant medications: | By DATE, *X*% of patients who are prescribed an antidepressant were screened for bipolar disorder at least once prior to prescribing*80% minimum goal* | On the first Friday of the month, the [*designee*] will spot-check 15 charts of postpartum patients and check for the documentation of screening results for bipolar disorder prior to prescribing any psychiatric medications (paper form, completed electronic form, or documented scores) |
| 3.2.b | By *DATE*, any patient who has been prescribed antidepressant medications in the past will have at least one bipolar screen documented in the XXX section of their chart.  | On the first Friday of the month, the [*designee*] will spot-check 15 charts of postpartum patients and check for the documentation of screening results for bipolar disorder in XXX section of their chart if they are prescribed antidepressants (paper form, completed electronic form, or documented scores) |
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| **Aim 4:** When a perinatal mental health screening tool is positive, assess the patient and determine treatment approach. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 4.1.a | According to our patient charts, after a positive screen, our patients are assessed by a licensed independent professional (e.g., Ob/Gyn NP, midwife) at the following rates: | *(Goal applies to more than one sub-aim)* By *DATE*, charts of *X*% of patients with a positive mental health screen will contain documentation (e.g., in progress notes, on the screening form, or via signature and date by the clinicians on the screening form) that screening results were evaluated *70% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of assessment by a licensed independent professional |
| 4.1.b | By *DATE* standardized language will be developed and implemented documenting an evaluation of the patient for a mental health or alternative condition, following a positive screen. | The date by which the practice will have developed standardized language for documentation |
| 4.2.a | According to our patient charts, after a positive screen, our clinicians routinely check labs to rule out medical causes (e.g., TSH, B12, folate, etc.) at the following rates: | By *DATE*, *X*% of patients with a positive mental health screen also had relevant lab results in their charts that can be used to rule out medical conditions.*50% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of relevant lab results in their charts that can be used to rule out medical conditions |
| 4.2.b | By *DATE*, any lab results older than XXX will be repeated.  | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of repeated lab results in their charts that are older than XXX |
| 4.3.a | Our practice supports and expects our clinicians and staff to have the confidence and skills we need to assess and address for perinatal mental health conditions. | *(Goal applies to more than one sub-aim)* By DATE, charts of X% of patients with a positive mental health screen will contain documentation (e.g., in the progress notes, on the screening form, or via signature and date by the clinician on the screening form) that screening results were evaluated and acted upon  | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation that screening results were formally evaluated and acted upon |
| 4.4.a | Our clinicians routinely inquire about *all* patients' prior histories of psychiatric illness and/or treatment, regardless of screening outcomes. | *(Goal applies to more than one sub-aim)* By *DATE*, X% of patient charts will contain documentation of the patient’s personal and family history of mental health conditions and treatment.*80% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts for documentation of the patient’s personal and family mental health history |
| 4.4.b | By XX, we will develop a standardized documentation template for family history of mental health conditions | The date by which the practice will have developed standardized documentation template for personal and family mental health history |
| 4.5.a | According to our patient charts, our clinicians inquire about patients' prior history of psychiatric illness and/or treatment at the following rates: | *(Goal applies to more than one sub-aim)* By *DATE*, X% of patient charts will contain documentation of history of mental health conditions and treatment.80% minimum goal | Three months following implementation, the designee (who?) will audit 15 charts for documentation of the patient’s history of mental health treatment |
| 4.5.a | Our clinicians routinely inquire about our patients' family histories of psychiatric illness and/or treatment. | *(Goal applies to more than one sub-aim)* By *DATE*, X% of patient charts will contain documentation of patient and family history of mental health conditions and treatment.*80% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts for documentation of the patient’s family history of mental health treatment |
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| **Aim 5:** Develop and use a repository of mental health resources and treatment referral sources. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 5.1.a | Our practice has procedures for referring patients with perinatal mental health conditions to non-pharmacologic treatments.  | *(Goal applies to more than one sub-aim)* By DATE, the QI Implementation Team will have identified where and in what format a repository of resources for mental health care will be available to the practice for patient referrals. | The date by which the QI team will have made the repository of resources for mental health care available to the practice for patient referrals |
| 5.1.b | *(Goal applies to more than one sub-aim)* By *DATE,* we will havecompleted clinician and clinical staff training on the perinatal mental health care workflow for referral resources. | The date by which all clinician and staff will have completed the training on the perinatal mental health care workflow for referral resources |
| 5.1.c | By *DATE*, we will have put copies of all perinatal mental health patient educational materials in the educational materials area in the practice. | The date by which copies of all perinatal mental health patient educational materials will be available in the practice  |
| 5.2.a | Our practice has procedures for referring and/or providing patients with perinatal mental health conditions access to pharmacotherapy.  | *(Goal applies to more than one sub-aim)* By DATE, the QI Implementation Team will have identified where and in what format a repository of resources for mental health care will be. | The date by which the QI team will have made the repository of resources for mental health care available to the practice for patient referrals |
| 5.2.b | *(Goal applies to more than one sub-aim)* By DATE, *(Who)* will have customized the Customizable Practice Resource and Referral Directory to include our preferred local mental health clinicians (psychiatrists and other prescribers, therapists, support groups) | The date by which the [*designee*] will have identified and made the Practice Resource and Referral Directory to include preferred local mental health clinicians |
|  5.3a | Our practice has resources for non-pharmacologic treatments that are responsive to the diverse needs of all patients we care for. | By DATE, WHO will have reviewed the Customizable Practice Resource and Referral Directory to assure inclusion of local mental health clinicians (psychiatrists and other prescribers, therapists, support groups) for patients who speak \_\_\_\_\_. | The date by which the [designee] will have reviewed the Practice Resource and Referral Directory to assure inclusion of local mental health clinicians for patients who speak \_\_\_\_ |
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| **Aim 6:** Refer patients who screen positive for psychotherapy, group therapy, or other treatment and support options. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 6.1.a | According to our patient charts, after a positive screen, our patients were asked about current therapy or offered a referral at the following rates: | By *DATE*, X% of patients with a positive screening for any mental health condition will have documentation within the chart of a treatment plan that indicates current participation in therapy, referral to therapy, or patient decline of therapy.*80% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of a treatment plan that indicates current participation in therapy, referral to therapy, or patient decline of therapy |
| 6.1.b | By XX, we will have developed a standardized script for explaining the therapy and referral options to patients. | The date by which the practice will have developed standardized language for explaining the therapy and referral options to patients |
| 6.2.a | Our embedded treatment options include clinicians who will conduct therapy for women with perinatal mental health conditions. | By *DATE*, we will have a plan to pursue integrating embedded therapy clinicians within our practice. | The date by which the practice will have plan for integrating/ embedding therapy services into the practice |
| 6.3.a | According to our patient charts, if the bipolar disorder screen is positive at any time point, our practice refers women to a consultation or for treatment with a psychiatrist at the following rates: | Beginning *DATE*, X% of patients with a positive screen for bipolar disorder will have documentation within the chart of a treatment plan that indicates current psychiatric care, referral to a psychiatrist, or patient decline of psychiatric referral.*80% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive screen for bipolar disorder for documentation of a treatment plan that indicates current psychiatric care, referral to a psychiatrist, or patient decline of psychiatric referral. |
| 6.4.a | Our practice has an emergency referral protocol to manage safety concerns in patients at risk of harm to self or others (e.g., baby) or unable to care for herself or her baby due to psychiatric illness. | *(Goal applies to more than one sub-aim)* By *DATE,* we will havecompleted clinician and clinical staff training on the perinatal mental health care workflow for emergency referrals and managing safety concerns. | The date by which all clinicians and staff will have completed the training on the perinatal mental health care workflow for emergency referrals and managing safety concerns |
| 6.4.b | By XX, we will have a documented workflow for screening, assessing, and disposition plan for managing patients who are experiencing suicidality or in acute mental health crises. | The date by which the practice will have a documented workflow for screening, assessing, and disposition plan for managing patients who are experiencing suicidality or in acute mental health crises |
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| **Aim 7:** Start medication treatment when indicated. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 7.1.a | According to our patient charts, after a positive screen, our patients were asked about current medication treatment or offered medication, *when appropriate,* at the following rates: |  By *DATE*, X% of patients with a positive screening for any mental health condition will have documentation within the chart of a treatment plan that indicates current medication prescription, consideration of prescribing medication, or patient decline of medication.*50% minimum goal* | Three months following implementation, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of consideration of medication treatment |
| 7.2.a | Our practice has procedures for providing embedded treatment (e.g., co-located care, OBs that will provide bridge pharmacotherapy, etc.) to patients with perinatal mental health conditions, to help bridge the gap until they are able to get into longer-term care. | *(Goal applies to more than one sub-aim)* By *DATE*, we will have a plan to pursue integrating embedded bridge therapy and pharmacotherapy clinicians within our practice. | The date that the practice has a plan for goal criteria |
| 7.2.b | By *DATE*, we will have identified at least one preferred clinician who can see patients via tele/video for brief, bridge therapy | The date that the clinician’s name was included in the Resource and Referral Directory |
| 7.3.a | Our embedded treatment options include obstetric clinicians who will prescribe psychiatric medications to women with perinatal mental health conditions. | *(Goal applies to more than one sub-aim)* By *DATE*, we will have a plan to pursue integrating embedded bridge therapy and pharmacotherapy clinicians within our practice (includes training, provision of algorithms/toolkits, etc.). | The date that the practice has a plan for pursuing integrating embedded bridge therapy and pharmacotherapy clinicians |
| 7.4.a | Our practice supports and expects our clinicians and staff to have the confidence and skills we need to treat perinatal mental health conditions. | *(Goal applies to more than one sub-aim)* BY *DATE*, we will have completed a perinatal mental health procedure that sets the expectation that all perinatal patients with a suspected mental health condition (via positive screen AND assessment) have a treatment plan addressing the screening results. | The date that the practice has a procedure regarding perinatal mental health that meets goal criteria |
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| **Aim 8:** Follow-up and monitor perinatal mental health conditions once treatment is initiated. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 8.1.a | Our practice has a system in place to monitor and follow up with patients who screen positive for perinatal mental health conditions. | By *DATE*, our EMR will display mental health screening in a way that comparison between repeat screens is easily accomplished. | The date that screen results in EMR are displayed as a flowsheet or other format for sequential comparison |
| 8.1.b | By *DATE*, we will implement standardized documentation of presence or absence of psychiatric symptomatology. | Two months following implementation of standardized documentation, the designee (who?) will audit 15 patient charts of patients for consistency with the documentation plan |
| 8.2.a | According to our patient charts, positive screens in earlier visits are addressed by clinicians during follow-up visits at the following rates: | Beginning *DATE, X*% of patients with a positive mental health screening will have documentation in their chart at 50% of subsequent visits of the clinician addressing the mental health condition until patient is in sustained remission, with treatment adjusted as needed.*50% minimum goal* | On the second Friday of every third month, the designee (who?) will audit 15 charts of patients with a positive mental health screen for documentation of sustainment of mental health care |
| 8.3.a | According to our patient charts, our patients with earlier positive screens are re-screened by clinicians in follow-up visits at the following rates:In our practice, if a patient has a positive result(s) on a mental health screening tool, our clinicians continue to screen and assess her at multiple time points to monitor her status and adjust care. | Beginning *DATE, X*% of patients with a positive screen for depression, and/or anxiety, and/or PTSD will have a repeat screening completed [TIME, e.g., monthly is recommended] after the initial screening until the patient is in sustained remission, with treatment adjusted as needed.*50% minimum goal* | On the second Friday of the month the designee (who?) spot-checks 15 charts selected two months prior for documentation of repeat screening |
| 8.3.b | Beginning *DATE*, we will implement automatic reminders in the EHR to rescreen patients after they screen positive for a perinatal mental health condition.  | The date of EHR perinatal mental health rescreening reminder implementation |
| 8.3.c | Beginning *DATE, X%* of patients with a positive repeat screen for depression, and/or anxiety, and/or PTSD will have chart documentation of review of the treatment plan.*50% minimum goal* | On the second Friday of the month the designee (who?) spot-checks 15 charts selected two months prior for the monthly spot check for documentation treatment plan review when repeat screening remains positive |
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| **Aim 9:** Ensure mental health care is ongoing until at least one year postpartum with transition to primary care or another clinician as needed. |
|  | **Sub-aim** | **Goal** | **How will this be measured** |
| 9.1.a | According to our patient charts, in patients with positive screens in earlier visits, the positive screen(s) is noted in the treatment plan at the comprehensive postpartum visit at the following rates: | Beginning *DATE, X%* of patients with a positive screening for mental health conditions during pregnancy have documentation of the positive screen(s) in the treatment plan at the comprehensive postpartum visit.*50% minimum goal* | Three months following implementation, the designee (who?) will spot-check 15 charts of patients with a positive mental health screen during pregnancy for documentation of the pregnancy screens in the comprehensive postpartum visit treatment plan |
| 9.2.a | Our practice has a procedure for continuing to care for women with mental health conditions when postpartum care is complete and/or transitioning them to ongoing care with a PCP or other mental health/behavioral health clinician. | By *DATE*, we will have completed a perinatal mental health procedure that includes language that ongoing care for perinatal patients with a positive screen for mental health conditions at the time of the comprehensive postpartum visit is included in the treatment plan. | The date that the practice perinatal mental health procedure includes guidance regarding documentation of positive prenatal screens in the comprehensive postpartum visit treatment plan |
| 9.2.b | By *DATE,* we will develop standardized documentation for correspondence with the PCP regarding onset, trajectory, treatment, and current status of patients’ perinatal mental health conditions. | The date that the practice perinatal mental health procedure includes guidance regarding corresponding with post-perinatal care clinicians to transition patient mental health care for women who continue to screen positive |

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| 9.3.a | According to our patient charts, if the screener is still positive at the postpartum visit, follow-up care with another health care clinician is noted and/or the OB clinician plans to continue care until transfer to another clinician could be arranged at the following rates: | Beginning *DATE, for* patients with a positive screen for mental health conditions when postpartum care is complete, *X%* are in care with a mental health/behavioral health clinician they will continue with, or they have been transitioned to their PCP for ongoing care.*50% minimum goal* | Three months following implementation, the designee (who?) spot-checks 15 charts of patients with a positive mental health screen at postpartum for documentation or communication regarding transition of care |
| 9.4.a | Our practice has a procedure for communicating and collaborating with the infant's clinician about mother and infant's care postpartum (e.g., maternal medications, treatment plan, breastfeeding, family support, and community resources). | By *DATE,* our practice will have a procedure for communicating with the infant’s clinician about mother and infant’s care postpartum.  | The date that the practice perinatal mental health procedure includes guidance regarding corresponding with post-perinatal care clinicians to transition patient mental health care for women who screen positive |
| 9.4.b | By *DATE*, we will develop standardized documentation for correspondence with the pediatrician regarding onset, trajectory, treatment, and current status of patients’ perinatal mental health conditions. | The date that the practice perinatal mental health procedure includes guidance regarding corresponding with post-perinatal care clinicians to transition patient mental health care for women who screen positive |
| 9.5.a | According to our patient charts, if psychiatric medications were prescribed for mental health conditions by an OB clinician during the perinatal period, prescriptions were continued postpartum to help the patient avoid gaps in medication treatment at the following rates: | Beginning *DATE*, X% of patients requiring continued psychiatric medication at the completion of postpartum care were provided with a prescription to avoid gaps in medication treatment.*50% minimum goal* | Three months following implementation, the designee (who?) will spot-check 15 charts of patients with a positive mental health screen at postpartum treated with medication for documentation of prescribing bridge medication |
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