

**Call for Applications:**

**Perinatal Behavioral Health Quality Improvement Initiative**

**The Rhode Island Department of Health (RIDOH) and the Care Transformation Collaborative of Rhode Island (CTC-RI) are pleased to offer prenatal care practices the opportunity to apply for funding to join the RI MomsPRN perinatal behavioral health quality improvement initiative.**

**This application is for funding to support health care practices in clinical quality improvement to increase the identification, early intervention, and treatment of depression, anxiety and substance use among pregnant and postpartum patients. Up to six prenatal care practices will be selected. Extended deadline: September 25, 5:00pm. Project activities will begin in October 2019 and will continue for 15 months.**

**Prerequisites**

* Outpatient or hospital-based practices that provide prenatal and postpartum clinical care
* Uses an electronic medical record system
* Submits a completed application and cover letter from practice team indicating commitment and capacity for meeting project expectations detailed below *(Please see Appendix A for template)* by September 17, 2019
* If part of a system of care (i.e. accountable care organization or accountable entity), submits an additional letter of support *(Please see Appendix B for template)* by September 17, 2019

Note: Practices with multiple sites have the option to apply on behalf of an individual site or for all sites

**About RI MomsPRN Program**

In Rhode Island, like many other places in the U.S., behavioral health conditions in perinatal women are common yet undertreated. To address this need, the RIDOH, CTC-RI, and the Center for Women’s Behavioral Health (CWBH) at Women and Infants Hospital have established the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN). The goal of this new statewide program is to help health care practices identify, diagnose, and manage depression, anxiety, and substance use in pregnant and postpartum women (the 12-week period after giving birth). The RI MomsPRN program components are:

1. **A free phone consultation service** for health care providers treating pregnant or postpartum women to receive assistance from a perinatal behavioral health expert at the CWBH at Women and Infants Hospital. RI MomsPRN staff can answer clinical questions and/or provide resources and referrals regarding perinatal depression, anxiety, and substance use. Starting in September, health care providers can reach this free teleconsultation service by calling 401-430-2800 Mondays through Fridays between 8:00 am-4:00 pm.
2. **On-site practice coaching** **and clinical quality improvement assistance** to universally screen all pregnant and postpartum patients for depression, anxiety, and substance use. Assistance will include training and education for practice staff, identifying evidenced-base screening tools, screening and referral workflow, EMR documentation, and developing a plan for positive screens.

**RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative Objectives**

* Support prenatal care practices in screening, identification, and management of perinatal depression, anxiety and substance use
* Improve prenatal care provider confidence and skills in managing mild-to-moderate cases of perinatal depression, anxiety, and substance use
* Improve universal screening rates of eligible pregnant and postpartum patients for perinatal depression, anxiety, and substance use using evidenced-based screening tools

**Benefits**

* Practice infrastructure payment of $5,000 that practices can use to off-set costs associated with EMR modifications, staff time, and participation in quality improvement activities
* Eligible for up to $5,000 of incentive payments based on increasing perinatal depression, anxiety, and substance use screening rates using evidenced-based tools
* Monthly on-site consultation from a trained clinical quality improvement facilitator
* Data management training and support
* In-person professional education presented quarterly by perinatal behavioral health specialists and includes best practice sharing
* Timely identification of patient perinatal behavioral health concerns
* Increased provider efficacy addressing perinatal behavioral health matters/concerns

**QI Initiative Activities (3 Month Preparation Period October – December 2019)**

* Identify members of the practice quality improvement (QI) team. The team should consist of 3 to 4 staff in different roles and include a practice clinical champion and an IT/EHR staff member.
* Practice QI team participation in monthly meetings with the practice QI facilitator
* Practice QI team attendance and participation at in-person kick-off learning session
* Plan and test practice workflows to implement screening for perinatal depression, anxiety and substance use with validated screening tool(s)
* Test EMR system to determine workflow for documentation of screening results
* Submit a baseline report of screening rates for perinatal depression, anxiety, and substance use
* Complete baseline clinical provider self-efficacy survey within 45 days of award notification   
  *(Please see Appendix D)*
* In conjunction with the QI practice facilitator, identify quality improvement activities to optimize perinatal behavioral health screening, treatment and referral

**QI Initiative Activities (Performance Period January – December 2020)**

* Implement screening for perinatal depression, anxiety and substance use with validated screening tool(s)
* Utilize the RI Moms PRN provider teleconsultation line as needed
* Report de-identified practice screening rates and proportion of positive screens quarterly and by zip code
* Practice QI team participation in monthly meetings with the practice QI facilitator
* Practice QI team attendance and participation in quarterly in-person learning network meetings
* Complete provider self-efficacy surveys on an annual basis

**Timeline for Selection Process**

|  |  |  |
| --- | --- | --- |
| **Step** | **Activity** | **Date** |
| 1 | Conference call with interested parties to answer any questions. Call-in number: 1-888 895 6448,,,4997329# (code) | September 5 at 12-1 September 10 at 12-1 |
| 2 | Submit application electronically to: [RIDOH@ctc-ri.org](mailto:RIDOH@ctc-ri.org) | September 17 by 5 pm |
| 3 | Notification will be sent to practices | September 27 |
| 4 | Orientation for newly selected practices | Tues October 29 2019 7:30 to 9:00am RIQI |

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**Application Checklist**

|  |  |
| --- | --- |
| **Check if complete** | **Item** |
|  | 1. **Application form** filled out completely *(Please see next page)* |
|  | 1. **Practice cover letter** indicating the practice’s commitment and acceptance of the conditions stated in the application, signed by all members of the quality improvement team and by a practice leadership representative.  *(Please see Appendix A for template)* to: [RIDOH@ctc-ri.org](mailto:RIDOH@ctc-ri.org)) |
|  | 1. **If applicable, a System of Care (i.e. accountable care organization or accountable entity) cover letter** indicating the level of support provided for this initiative. *(Please see Appendix B for template)*   [RIDOH@ctc-ri.org](mailto:RIDOH@ctc-ri.org) |

**Extended deadline: September 25, 5:00pm**

Email application package to: [RIDOH@ctc-ri.org](mailto:RIDOH@ctc-ri.org)

For questions, contact: Candice Brown, CTC Project Coordinator office number: 401 519-3919

**RI MomsPRN Application Form**

Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Zip \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_\_

Practice Tax ID Number (TIN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Practice (e.g. OB, FQHC, Hospital-Based Clinic) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Multisite practice: Yes/No\_\_\_\_   
*(If yes) please identify all other practice sites locations below and indicates which site(s) will be participating:*

|  |  |
| --- | --- |
| **Additional practice site location(s)** | **Indicate** **Participation** |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |
|  | Yes  No |

*If not using the practice support cover letter template in Appendix A, please provide the following contacts.*   
Provider Champion contact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Leader who will be responsible for project implementation:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IT/EHR Staff Member who will be assist with technology/reporting matters:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **List name and NPI number for all Practitioners (MDs, DOs, NPs and PAs):** | | | |
| Name | NPI# | Name | NPI# |
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| **Approximate Payer Mix of Deliveries for Calendar Year 2018** | | | | | |
| Payer | # of Deliveries | % of All Deliveries | Payer | # of Deliveries | % of  All Deliveries |
| BCBSRI |  |  | Medicaid FFS |  |  |
| NHP-RI Commercial |  |  | NHP-RI Medicaid |  |  |
| Tufts Commercial |  |  | Tufts Medicaid |  |  |
| United Commercial |  |  | United Medicaid |  |  |
| Insured Other |  |  | Uninsured |  |  |
| Total |  |  | Total |  |  |

1. **Please provide the name of the Electronic Health Record system your practice currently uses.**
2. **Please indicate if your practice is anticipating changing its Electronic Health Record within the next 15 months**.  
     
   Yes  No
3. **Does your practice belong to a system of care (e.g. owned, managed, overseen by a hospital or other health care organization)?**  
   Yes  No    
     
   If yes: please indicate:
4. **A) When treating pregnant and postpartum patients currently, does your practice routinely and   
    universally screen for …**  
     
   Depression Yes  No  Unsure    
   Anxiety Yes  No  Unsure    
   Substance Use Yes  No  Unsure

**B) If yes for any domain, please specify the evidence-based screening tool, if any, your practice   
 utilizes**  
 Depression \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance Use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **A) If your practice does routinely screen, how are screening results documented?**   
     
    Paper records only   
    Electronic health record only   
    Both electronic health record or paper records   
    Other (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    Unsure   
    Not applicable (my practice does not screen. Please skip to question 6.)  
     
     
   **B) Does your practice generate screening reports about …**Depression Yes  No    
   Anxiety Yes  No    
   Substance Use Yes  No    
     
   **C) Does your practice team meet to review screening rate performance?**  
   Yes  No
2. **A) Does your practice provide on-site counseling for the treatment of …**  
     
   Depression Yes  No    
   Anxiety Yes  No    
   Substance Use Yes  No    
    **B) If yes to any domain**, who provides the counseling? (please select all that apply)  
     
    Psychiatrist  
    Psychologist  
    Psychiatric Clinical Nurse Specialists (PCNS)  
    Licensed Clinical Social Worker (LCSW)  
    Licensed Mental Health Counselor (LMHC)  
    Licensed Marriage and Family Therapist (LMFT)  
    Advanced Chemical Dependency Professional (ACDP, LCDP)  
    Peer Recovery Specialist  
    Other (please specify)

**RI MomsPRN Selection Committee Policy and Procedure (2019)**

To ensure an objective, fair, and transparent process for reviewing applications, the following policy and procedure for application review is being shared with applicants:

**Selection Committee Process for Review of Applications:** The RI MomsPRN team will convene in September 2019. All reviewers will read and score each application independently using the scoring criteria below. The maximum number of points is 27. The RI MomsPRN team reserves the right to interview applicants if further review is warranted. The applications will be rank ordered by final scores. In the event of a tie, the following criteria will be used:

1. Completeness of application
2. Priority will be given to practices that serve a high percentage of patients enrolled in Medicaid
3. Practice location in a geographic location with high rates of pregnant women with substance use as identified using RIDOH data
4. Practice with a higher number of deliveries

**Conflict of interest:** Reviewers will disclose any potential conflict of interest related to a specific applicant. A conflict of interest is defined as a real or potential monetary benefit or having an affiliation with the applicant. The Selection Committee will discuss the potential conflicts of interest and decide of whether a conflict of interest exists. If so, the reviewer must recuse themselves from the review of that application.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Quality Improvement Team** | **Score** |  | **Average # of deliveries over the past three years** | **Score** |  | **% deliveries covered by Medicaid** | **Score** |
| Practice champion identified | Add 1 point | < 100 | Add 1 point | <10% | Add 1  point |
| Practice leader identified | Add 1 point | 100-500  deliveries | Add 2 points | 10-30% | Add 2 points |
| IT/EHR staff member identified | Add 1 point | >500 deliveries | Add 3 points | >30% | Add 3 points |
| Practice support and/or system of care cover letter(s) submitted and complete | Add 1 point |  |  |  |  |
| **Screening Protocols** | **Score** | **Screening Documentation** | **Score** | **On-site Counseling** | **Score** |
| Performs depression screening | Add 1 point | Unsure/ Does not screen | 0 points | Provides on-site counseling for depression | Add 1 point |
| Performs anxiety screening | Add 1 point | Paper records only | Add 1 point | Provides on-site counseling for anxiety | Add 1 point |
| Performs substance use disorder screening | Add 1 point | Both electronic health record or paper records | Add 2 points | Provides on-site counseling for substance use disorder | Add 1 point |
| Uses a validated screening tool | Add 1 point  **per survey** | Electronic health record only | Add 3  points |  |  |
|  |  | Electronic health record system not changing | Add 1 point |  |  |
|  |  | Generates practice-level screening reports | Add 1 point  **per each domain** |  |  |
|  |  | Practice team meets to review screening rates | Add 1 point |  |  |

**Appendix A: Practice Support Cover Letter Template**

*For multisite practices choosing to apply for multiple locations where quality improvement teams will differ,   
please provide the below letter for each site.*

To: RI MomsPRN Selection Committee

From: Practice Leadership Representative

RE: RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative

Date:

On behalf of (practice name \_\_\_\_\_\_\_\_\_\_\_\_\_), please accept the following practice support cover letter for the RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative. As an organizational leader representative, I can attest the following staff members accept the conditions stated in the application and if awarded, are committed to achieving the objectives of this initiative.   
  
Practice Name/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quality improvement team**, including providers, nurse care manager, behavioral health clinician, practice manager, social worker, medical assistant, IT support staff member, as applicable:

|  |  |  |
| --- | --- | --- |
| **Position** | **Name** | **Email** |
| Key contact person responsible for project implementation |  |  |
| Provider champion |  |  |
| Practice manager |  |  |
| Behavioral health clinician |  |  |
| Social worker |  |  |
| Medical assistant |  |  |
| IT support staff member |  |  |
| Other |  |  |

**Phone number of provider champion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number of key contact person:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Letter signed by practice leadership representative and all members of the quality improvement team:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Practice Leadership Representative Date Quality Improvement Team Member Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Quality Improvement Team Member Date Quality Improvement Team Member Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Quality Improvement Team Member Date Quality Improvement Team Member Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Quality Improvement Team Member Date Quality Improvement Team Member Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Quality Improvement Team Member Date Quality Improvement Team Member Date

**Appendix B: System of Care Letter of Support Template**

*Please only complete if your practice is part of a system of care (i.e. accountable care organization or accountable entity).*

To: RI MomsPRN Selection Committee

From: System of Care Representative

RE: RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative

Date:

[Practice name and site] is a member of our System of Care. The practice is interested in participating in the RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative. We believe that this practice would benefit from participation and as a system of care, we are willing to provide the management support to assist the practice with making this transformation.

As a system of care, we will provide the practice with (check all that apply):

Practice reporting support for perinatal depression, anxiety, substance use screenings

IT assistance for behavioral health templates within the practice electronic health record

A System of Care representative that will meet with the RI MomsPRN practice facilitator during the   
 startup phase and thereafter as needed

Commitment to collaborate and communicate with the RI MomsPRN practice facilitator to ensure   
 that initiative requirements are met within designated timeframes.

Other: (please describe below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_  
Signature of System of Care Date Signature of Prenatal Care Practice Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position Position

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Phone

**Appendix C: Screening Measure Resource**

All selected prenatal care practices will be provided with access to data management platforms to assist with the submission of required de-identified screening data that is detailed below. In addition, practices will have access to data visualization tools to track their progress and measure quality improvement efforts. Practices can choose which validated screening tool(s) they would like to use. If needed, advisement about screening tools is available by RI MomsPRN practice facilitators.

|  |  |
| --- | --- |
| **Screening Measures for Each Domain:  1) Depression 2) Anxiety and 3) Substance Use** | |
| Percent and number of pregnant and postpartum women who received at least **one** screening using a standardized validated tool during pregnancy or the first 12 months after delivery | * This measure will be analyzed quarterly and by zip code |
| Percent and number of pregnant and postpartum women who screened **positive** | * This measure will be analyzed quarterly and by zip code |

**Appendix D: Annual Provider Self-Efficacy Survey**

**Baseline Questionnaire**

*For selected practices, this baseline self-efficacy survey will need to be completed by all providers within 45 days of being selected and once again in the last quarter of 2020.*

**Thank you for taking a few minutes to complete this questionnaire. The following questions address your experiences with perinatal mental health.**

Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| 1. What is your gender?  Female   Male  Other (Specify)  Prefer not to answer   1. What race do you consider yourself? (select all that apply)  American Indian/Native American   Alaska Native  Asian/Asian American  Black/African American/African  Native Hawaiian/Other pacific Islander  White/Caucasian   Other (Specify)  Prefer not to answer   1. What ethnicity do you consider yourself?  Hispanic or Latino   Non-Hispanic or Latino  Prefer not to answer   1. What is your professional title?  Physician   Attending  Fellow  Resident  Certified Nurse Midwife  Nurse Practitioner  Nurse Manager  Social Worker or Case Manager  Other (Specify) | 1. What is your primary medical specialty?  Obstetrics only   Gynecology only  General Obstetrics and Gynecology  Maternal-Fetal Medicine Specialist  General Psychiatry  Perinatal Psychiatry  Primary Care/Family Medicine  Other (Specify)   1. How many years have you been in practice? 2. Which of the following best describes your practice location?  Urban – inner city   Urban – non-inner city  Suburban  Mid-sized town (10,000-50,000)  Rural  Military  Other (Specify)   1. Which of the following best describes your type of practice?   Solo Private Practice  Partnership or Group Practice  Multi-Specialty Group  HMO/Staff Model  University Full-Time Faculty and Practice  Military  Other (Specify) |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **At the following time points, which of the following do you consistently screen for (using a validated screening tool)?** | | | | | | | |
|  | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* | *Not applicable* |
| **Depression?** | | | | | | |
| Early pregnancy *(0-20 wks. GA)* |  |  |  |  |  |  |
| Late pregnancy *(21 wks. or more GA)* |  |  |  |  |  |  |
| Hospitalization for delivery |  |  |  |  |  |  |
| Early postpartum *(0-3 months PP)* |  |  |  |  |  |  |
| Late postpartum *(4-12 months PP)* |  |  |  |  |  |  |
| **Anxiety?** | | | | | | |
| Early pregnancy |  |  |  |  |  |  |
| Late pregnancy |  |  |  |  |  |  |
| Hospitalization for delivery |  |  |  |  |  |  |
| Early postpartum |  |  |  |  |  |  |
| Late postpartum |  |  |  |  |  |  |
| **Bipolar disorder?** | | | | | | |
| Early pregnancy |  |  |  |  |  |  |
| Late pregnancy |  |  |  |  |  |  |
| Hospitalization for delivery |  |  |  |  |  |  |
| Early postpartum |  |  |  |  |  |  |
| Late postpartum |  |  |  |  |  |  |
| **Substance use disorders?** | | | | | | |
| Early pregnancy |  |  |  |  |  |  |
| Late pregnancy |  |  |  |  |  |  |
| Hospitalization for delivery |  |  |  |  |  |  |
| Early postpartum |  |  |  |  |  |  |
| Late postpartum |  |  |  |  |  |  |
| **Trauma/PTSD?** | | | | | | |
| Early pregnancy |  |  |  |  |  |  |
| Late pregnancy |  |  |  |  |  |  |
| Hospitalization for delivery |  |  |  |  |  |  |
| Early postpartum |  |  |  |  |  |  |
| Late postpartum |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Please consider the following statements regarding your pregnant and postpartum patients and indicate the most appropriate response:** | | | | | | |
|  | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* | *Not applicable* |
| I am able to provide education around depression and anxiety to my patients. |  |  |  |  |  |  |
| I discuss depression and anxiety and their treatment options with my patients. |  |  |  |  |  |  |
| I discuss the risks and benefits of antidepressant use during pregnancy and postpartum. |  |  |  |  |  |  |
| I discuss the risks and benefits of other psychiatric medications during pregnancy and postpartum. |  |  |  |  |  |  |
| I am able to treat my patients with antidepressant medications. |  |  |  |  |  |  |
| I am able to treat my patients with other psychiatric medications. |  |  |  |  |  |  |
| I am confident determining when to refer for therapy vs. when to start medications for depression or anxiety in my patients. |  |  |  |  |  |  |
| I am able to adequately access non-medication treatments for my patients with depression and anxiety. |  |  |  |  |  |  |
| When I need a perinatal psychiatric consultation, I am able to receive one in a timely manner. |  |  |  |  |  |  |
| I can facilitate referrals for my patients to depression/anxiety treatment. |  |  |  |  |  |  |
| I am able to ensure that my patients with depression and anxiety receive treatment in a timely manner. |  |  |  |  |  |  |
| I am confident monitoring depression/anxiety and adjusting medications for depression/anxiety in my patients. |  |  |  |  |  |  |
| When my patient’s care is complete, I am able to transition her for ongoing depression or anxiety follow-up if needed. |  |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- |
| **Please consider the following statements regarding your pregnant and postpartum patients and indicate the most appropriate response:** | | | | | | |
|  | *Never* | *Rarely* | *Sometimes* | *Often* | *Always* | *Not applicable* |
| I am able to provide education around substance use disorders to my patients. |  |  |  |  |  |  |
| I discuss substance use disorders and treatment options with my patients. |  |  |  |  |  |  |
| I am able to treat my patients with opioid use disorders by prescribing medications such as buprenorphine or methadone. |  |  |  |  |  |  |
| I am confident determining when to refer for therapy vs. when to start medications for substance use disorders in my patients. |  |  |  |  |  |  |
| I am able to adequately access non-medication treatments for my patients with substance use disorders. |  |  |  |  |  |  |
| When I need a perinatal substance use consultation, I am able to receive one in a timely manner. |  |  |  |  |  |  |
| I can facilitate referrals for my patients to substance use disorder treatment. |  |  |  |  |  |  |
| I am able to ensure that my patients with substance use disorders receive treatment in a timely manner. |  |  |  |  |  |  |
| I am confident monitoring substance use disorders and adjusting medications for substance use disorders. |  |  |  |  |  |  |
| When my patient’s care is complete, I am able to transition her for ongoing substance use disorder follow-up if needed. |  |  |  |  |  |  |