Perinatal Mental Health Initiative Structure Measures and Steps to Achieve Change Ideas / Systems Changes

Structure Measure	How to Get to Green
Hospital has established a process to educate all OB clinical staff caring for pregnant/postpartum patients on PMH warning signs, PMH screening, updated treatment protocols, referral processes, use of hotlines/warmlines for assistance (IL Doc Assist, IL MOMS Line, MAR Now) and trauma informed care.	• Select education components • Have a process in place for providing education • Have a process in place for tracking and reported who has completed education
Hospital has established a process to educate all ER clinical staff caring for pregnant/postpartum patients on PMH warning signs, PMH screening, updated treatment protocols, referral processes, use of hotlines/warmlines for assistance (IL Doc Assist, IL MOMS Line, MAR Now) and trauma informed care.	• Select education components • Have a process in place for providing education • Have a process in place for tracking and reported who has completed education
Create a multidisciplinary PMH Access Workgroup with inpatient and outpatient care team representatives and community stakeholders across perinatal continuum of care to identify barriers to perinatal mental health care and opportunities to enhance care coordination and innovative strategies to improve access to perinatal mental health care for pregnant and postpartum patients.	• Identify workgroup members • Establish aims for workgroup and 30/60/90-day plan to achieve aims • Workgroup has held its first meeting
Hospital has established a process to provide postpartum patients education on PMH conditions warning signs for patients and family members and follow up options including, hotlines/ warmlines, such as IL MOMS line, PSI, and MAR Now, before delivery discharge.	• Select education components for patients and families • Include information on hotlines, such as IL MOMS line, PSI, and MAR Now • Establish process to share education materials with all postpartum patients before delivery discharge
Hospital has established a process to share PMH patient education resources with outpatient settings, such as prenatal care sites, FQHCs, emergency departments, and pediatric offices.	• Select patient education resources to share • Identify contacts at outpatient settings

	• Establish process to share education materials with outpatient settings
Hospital has established a process to share validated PMH screening tools and screening/treatment algorithms and process flow for linkage to PMH follow up with outpatient settings, such as prenatal care sites, FQHCs, emergency departments, and pediatric offices. Include resources to support utilization of IL Doc Assist for PMH clinical consultation, and IL MOMS Line to support patient linkage to follow up.	• Select PMH materials, such as screening tools, treatment algorithms, and process flow for linkage to behavioral health care, including information on IL Doc Assist and IL MOMS Line to share • Identify contacts at outpatient settings • Establish process to share PMH materials with outpatient settings
Hospital has identified a patient partner to join PMH quality improvement team and / or other opportunities to engage patients and community members with lived experiences and prioritize their recommendations.	• Identify a patient partner with lived PMH experience • Onboard patient partner to PMH QI team and identify a main contact on your QI team to connect with your patient partner. • Engage community partners who work with perinatal mental health support (such as Home visiting program, County Health Department, Doula, outpatient behavioral health program) for input to PMH QI team.
Hospital has established process flow to screen all OB patients for PMH conditions with validated screening tools during delivery hospitalization.	• Identify and trial screening tools for use on labor and delivery. • Establish screening process flow based on PDSA cycle(s). • Establish process for documenting screening results.
Hospital has established process flow for treating positive PMH screens during delivery hospitalization including treatment initiation algorithms using tiered assessment based on severity and risk of harm, include utilization of IL DocAssist for PMH clinical consultation.	• Identify and trial process flow for treating positive PMH screens. • Establish process for utilization of IL DocAssist for PMH clinical consultation. • Establish process to share process flow and algorithms with clinical team members.
Hospital has established a process flow for referral to link patients who screen positive	• Map community behavioral health resources available for your

for PMH conditions during delivery hospitalization to follow up behavioral health care and support, include utilization of IL MOMS Line to support patient linkage to follow up mental health care.	patients, including ILPQC PMH Quick Reference Guide. • Establish process flow for referral of patients to postpartum behavioral health care follow up. • Establish process for utilization of IL MOMS Line to support patient linkage to follow up mental health care.
Identify and implement innovative strategies to address barriers to follow up behavioral health care for patients with both private and Medicaid health insurance, such as: *telehealth behavioral health services, technology/apps to support PMH, home visiting programs, online PSI peer supports, PMH peer support groups by IL county through Medicaid, case management, task sharing with nurses/community health workers trained to provide behavioral health care/support, and/or other community resources that expand treatment and behavioral health follow up options*.	• Work with multidisciplinary inpatient/outpatient PMH Access Workgroup to identify barriers and innovate strategies to improve access for behavioral health care follow up for your patients. • Trial and implement an innovative strategy to address barriers and improve access to behavioral health care and support services.
Hospital has established process flow for linkage to recovery treatment services for positive perinatal SUD screens in OB settings, including utilization of IL DocAssist for clinical consultation and MAR Now to link patients to recovery treatment services and care coordination with a warm handoff.	• Establish process flow for SUD treatment algorithms and utilizing IL DocAssist and MAR Now for positive SUD screens during delivery hospitalization to link patients to recovery treatment services. • Share with clinical team members. • Process to track compliance and provide clinical team feedback
Hospital has established process flow for treatment/linkage to recovery treatment services for positive perinatal SUD screens in ER settings, including treatment initiation algorithms and process for utilization of IL DocAssist for clinical consultation and MAR Now to link patients to recovery treatment services and care coordination with a warm handoff.	• Establish protocol and process flow for SUD treatment algorithms and utilizing IL DocAssist and MAR Now for positive SUD screens during delivery hospitalization to link patients to recovery treatment services with warm hand offs. • Share with clinical team members. • Process to track compliance and provide clinical team feedback

Improve risk reduction for SUD through participation in DOPP to access and distribute free Naloxone for pregnant/postpartum patients with a history of OUD/use of opioids during delivery hospitalization and in emergency departments, and/or outpatient OB clinics or other community locations.	• Register your hospital with DOPP and order Narcan kits for distribution. • Establish a protocol and process flow for distributing free Naloxone kits to pregnant and postpartum patients using opioids / at risk of overdose.