

ILPQC Perinatal Mental Health Initiative FAQ

Q: What should I do if there have been changes to my team's QI team roster?

Contact Rebecca Ainis, PMH Project Coordinator at rebecca.ainis@northwestern.edu

Q: How can I access the PMH data forms for my hospital in REDCap?

Contact Rebecca Ainis, PMH Project Coordinator at rebecca.ainis@northwestern.edu

Q: Who should have access to the PMH data system and reports in REDCap?

All provider and nurse champions should have access to the PMH data system and reports in REDCap, as well as QI team members named on the roster form as needing access, including any team members who will be submitting data or reviewing data.

Q: What if we cannot identify 10 or more patients per month with active PMH conditions using all criteria provided on the data form?

Make sure you have looked at all criteria provided, and if you cannot identify 10 patients, you can just input data for as many patients as you have.

Q: On the PMH data forms, what does "PMH training" for nurses and providers in obstetric and emergency settings entail?

See the "Recommended e-modules/trainings for clinical staff" section in the "Provider Education and Engagement" portion of the [PMH toolkit](#). We will hold a webinar describing PMH training options for nurses and providers in obstetric and emergency settings on September 22nd. If you have questions regarding how your planned training aligns with the PMH training goals, please reach out to Rebecca Ainis, PMH Project Coordinator at rebecca.ainis@northwestern.edu.

Q: How do I access the recordings and slides from the PMH webinars?

Go to <https://ilpqc.org/perinatal-mental-health-initiative-resources> under "past webinars"

Q: If we complete the 10-question EPDS, does that count as screening for both depression and anxiety?

Yes, EPDS does include a 3-item subscale to screen for anxiety. The 3-item subscale to screen for anxiety includes questions 3, 4, and 5 on the EPDS ("I have blamed myself unnecessarily when things went wrong," "I have been anxious or worried for no good reason," and "I have felt scared or panicky for no very good reason.") **Providers should be trained to identify the 3-item anxiety subscale and have a process flow to respond appropriately. When the subscale questions summed score is 5 or higher, the score**

correlates with a positive GAD-7 anxiety screen. [See attached](#) for the ACOG recommended process flow for screening and assessment of anxiety. Alternatively, screening can include PHQ-9 or EPDS screening tool for depression and GAD-7 screening tool for anxiety.

Q: What qualifies as a “positive screen” for PMH concerns? Should I use a certain screening tool and score?

Any of the ACOG recommended screening tools for PMH conditions (see below) can be utilized and if the patients score on that screening tool is above the positive screen threshold, that would be considered a positive screen. In this work we have been focused on depression and anxiety screening during pregnancy and the delivery admission (though a positive screen for bipolar disorder could be utilized if applicable). The **scores for a positive screen** for each PMH condition are as follows according to ACOG recommendations:

Table 2. Commonly Used Perinatal Mental Health Validated Screening Instruments				
PMH Condition	Screening Instrument	No. of Items/Self-Administered (Y/N)	Sensitivity and Specificity	Score for Positive Screen
Depression	EPDS	10/Y	Sensitivity: 55–98% Specificity: 68–97%	≥10
	PHQ-9	9/Y	Sensitivity: 53–77% Specificity: 85–94%	≥10
Anxiety	GAD-7	7/Y	Sensitivity: 73% Specificity: 67%	≥5
	EPDS— anxiety subscale (items 3, 4, 5)	3/Y	Not enough data to estimate; correlates with GAD-7	≥5
	STAI	20/Y	Sensitivity: 81% Specificity: 78%	≥40
Bipolar disorder	MDQ	3 (Q1 with 13 items)/Y	Sensitivity: 44–90% Specificity: 61–92%	≥7 of the 13 items in Q1
	CIDI	2–3 (branching logic)/N	Sensitivity: 69–100% Specificity: 98–99%	Yes to Q3 (Q3 is asked if Q1 or Q2 are affirmed)

Abbreviations: CIDI, Composite International Diagnostic Interview; EPDS, Edinburgh Postnatal Depression Scale; GAD-7, Generalized Anxiety Scale-7; MDQ, Mood Disorder Questionnaire; PMH, perinatal mental health; PHQ-9, Patient Health Questionnaire-9; Q, question; STAI, State-Trait Anxiety Inventory.

Data from Byatt N, Masters GA, Bergman AL, Moore Simas TA. Screening for mental health and substance use disorders in obstetric settings. *Curr Psychiatry Rep* 2020;22:62 and Byatt N, Mittal LP, Brenckle L, Logan DG, Masters GA, Bergman A, et al. Lifeline for moms perinatal mental health toolkit. University of Massachusetts Medical School; 2019. Accessed December 7, 2022. <https://www.umassmed.edu/lifeline4moms/products-resources/toolkits-and-apps/2019/11/lifeline4moms-perinatal-mental-health-toolkit/>

You can find the recommended PMH screening and scoring tools in the “Screening and Assessment” portion of our [PMH toolkit](#).

Q: Does a history of anxiety and depression and/or a pre-existing mental health condition automatically become a PMH concern once someone becomes pregnant?

Not necessarily. Patients should be re-screened for mental health conditions once they become pregnant and during the delivery admission. Family history, prior symptoms, past psychiatric treatments, etc. should all be discussed with the patient to assess for the presence and severity of perinatal mental illness. See the [ACOG workflow](#) for assessing perinatal mental health conditions.

In terms of the ILPQC data collection for patients with active PMH conditions:

Inclusion criteria: Patient-Level Data form is completed for 10 charts per month of delivered patients with active PMH conditions.

Patients delivered with an active PMH condition, as defined by:

1. **Currently screened positive:** The patient screens positive for depression (EPDS or PHQ-9 with a score of ≥ 10 or any non-zero answer to the self-harm question) or for anxiety (GADS-7 or EPDS anxiety subscale with a score of ≥ 5) during their pregnancy or delivery admission.

If you have fewer than 10 patients delivered in a month who meet the criteria above, you can additionally include patients with the below criteria:

1. **History of PMH diagnosis, currently reporting signs/symptoms:** The patient has a history of PMH condition (diagnosed before or during pregnancy) AND has experienced or reported active symptoms of anxiety or depression or other perinatal mental health condition during this pregnancy or the delivery admission.
2. **History of PMH diagnosis, currently/recently on medication:** The patient is actively prescribed medication for anxiety, depression, or any related mental health condition at some point within three months before pregnancy, during pregnancy or delivery admission.

Q: When a patient screens positive in the outpatient setting, how should that be communicated to the inpatient site?

Your hospital team should collaborate with your outpatient provider sites, including private providers, to create a process flow for documenting and sharing patients who screen positive for PMH conditions during pregnancy with labor and delivery clinical staff. This

communication from outpatient prenatal care sites to L&D team to identify PMH screen positive patients will help you identify at risk patients to confirm you are providing optimal care for patients with active perinatal mental health conditions during the delivery admission, will allow you to compare prenatal outpatient PMH screening results to delivery admission PMH screening results, and will help identify PMH screen positive patients to track improvement efforts. Your hospital should identify strategies to track patients who screen positive for PMH conditions during pregnancy or delivery hospitalization so that a sample of these patients can be used to track your progress linking patients to treatment and follow up. Other prenatal screens such as GBS/HIV are communicated from outpatient prenatal care sites to L&D to optimize clinical care, you may need to trial different strategies to document and communicate outpatient PMH positive screens with your L&D team to determine what is most effective for your hospital.

Q: What months are included in the baseline data collection due on September 1?

October 2024, November 2024, and December 2024

Q: How many chart audits should we do per month for PMH?

- For the PMH hospital-level data form, you will audit 10 charts per month, randomly sampled from ALL birthing patients that month to track progress on PMH screening.
- For the patient-level data form, you will audit 10 charts per month, randomly sampled from patients delivered that month who screen positive for PMH conditions during pregnancy or delivery hospitalization to track progress on linking patients with PMH conditions to treatment and follow up. See the [patient-level data form](#) for additional criteria.

Q: Will this initiative be addressing PMH in the postpartum period?

Yes, we are addressing the postpartum period through education on PMH conditions warning signs and linkage to follow up behavioral health care and support. We will track if a two-week postpartum visit is made before delivery admission discharge, as well as a perinatal mental health behavioral health follow up appointment. Individual hospital teams may identify other ways they may want to address PMH in the postpartum period in OB, ER, and pediatric outpatient settings.

Q: My unit provides PMH education to patients, but the education doesn't include all the education resources listed on the data form, does this still count towards the process measure?

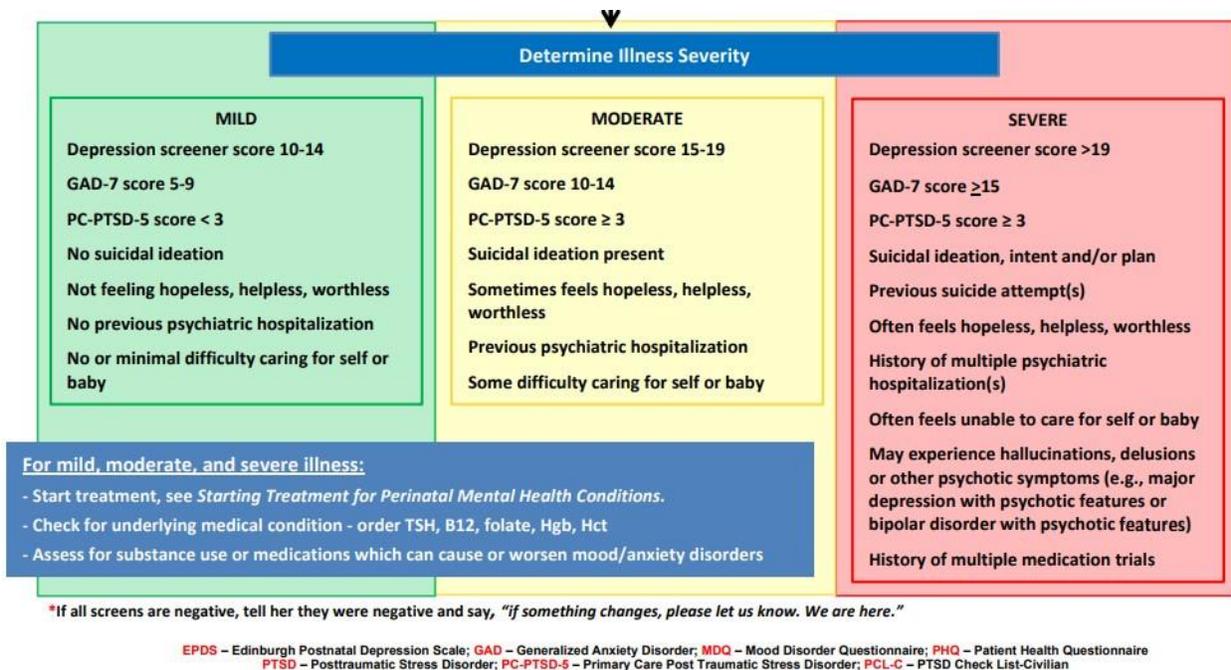
You are welcome to include additional resources in your patient education as described in the ILPQC PMH Toolkit patient education resources section such as the National Maternal Mental Health Hotline 833-852-6262 or the PSI Helpline Call 1-800-944-4773 available in English or Spanish or resources specific to your institution, but please include the following state resources as well: IL MOMs Line and IL MAR Now.

Q: What is the threshold for treating a patient who screens positive for PMH concerns?

Treatment should be started based on the [ACOG clinical practice guidelines for Treatment and Management of Mental Health Conditions](#). See the “[Starting Treatment for Perinatal Mental Health Conditions](#)” in the “Optimizing Treatment” portion of our PMH toolkit. See below for the recommended treatment options based on illness severity.

Consider treatment options based on highest level of illness severity		
If severity of symptoms overlap, clinical decisions should be based on the assessment, with strong consideration of higher level treatment options.		
<p style="text-align: center;">MILD</p> <p>Therapy referral Consider medication treatment</p>	<p style="text-align: center;">MODERATE</p> <p>Therapy referral Strongly consider medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See next page.</p>	<p style="text-align: center;">SEVERE</p> <p>Therapy referral Medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See next page.</p>
<ul style="list-style-type: none"> • Use internal resource list to refer patient to therapy • Call Postpartum Support International (PSI) at 1-877-499-4773 to schedule a consultation by phone with a perinatal psychiatry expert • Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at https://www.umassmed.edu/lifeline4moms/ • If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or contact Postpartum Support International (PSI) for resources: 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), or direct patients to search online at https://psidirectory.com/ 		

Refer to the ACOG recommended Lifeline for Moms screening and scoring guidelines below to discern illness severity.



For additional PMH treatment questions, please consult IL DocAssist at (866) 986-2778 (the Perinatal Psychiatry Access Program referenced above for Illinois), available Monday-Friday, 9am-5pm to answer questions (can leave a message to be returned next business day). Additionally, Postpartum Support International can be contacted by providers for advice on PMH treatment / management decisions at (877) 499-4773.

Q: How should I treat patients who screen positive for PMH concerns?

Treatment recommendations depend on the severity of the patient’s condition. One of the key strategies of the PMH Initiative will be to provide clinical staff who care for pregnant / postpartum patient with improved understanding of protocols for starting treatment and follow up for PMH conditions. Please see the [ACOG clinical practice guidelines for Treatment and Management of Mental Health Conditions](#) and [Lifeline for Moms Starting Treatment for Perinatal Mental Health Conditions](#) document for guidance. **We have even more resources under the “Optimizing Treatment” portion of our PMH toolkit**, including those for medication, billing, and immediate mental health support. **Illinois DocAssist ((866) 986-2778)** is also available Monday-Friday, 9am-5pm **for clinical consultation for providers** with patients with perinatal mental health conditions or substance use disorders who have treatment/management questions. Additionally, Postpartum Support International can be contacted by providers for advice on PMH treatment / management decisions at (877) 499-4773.

Q: Are therapy and medication the only options for treatment?

All patients who screen positive, regardless of illness severity, should be referred to behavioral health therapy or be advised to continue behavioral health therapy. ACOG recommends using the [Lifeline for Moms Starting Treatment for Perinatal Mental Health Conditions](#) algorithm to provide guidance on medication treatment. The Policy Center for Maternal Mental Health provides a [“A Menu of Prevention and Treatment Options for Maternal Mental Health”](#) that can be used in addition to following the ACOG clinical practice guidelines on treatment options. Providers should counsel on therapy and medication according to the resources and algorithms provided above. If a patient declines these options, there is an option to note this on the PMH patient-level data form. Additional options to support the patient could include peer support groups, home visiting, visits with a social worker, and doula visits and strategies to improve wellness including sleep, stress reduction and support (see “Optimizing Treatment” section of the [PMH toolkit](#) for more resources).

Q: How do I distinguish between providing treatment vs. linkage and follow-up to behavioral health on the patient level data form?

All patients who screen positive, regardless of illness severity, should be referred to behavioral health follow up or be advised to continue therapy. Use a local resource list to refer your patient to therapy, based on illness severity, and be sure to give them information for the IL MOMS Line (1-866-364-MOMS (6667)). The IL MOMS Line phone number is answered by perinatal social workers 24 /7 to provide support to pregnant/postpartum patients and assistance with navigating to follow up behavioral health care. Other behavioral health follow-up options can include home visiting programs, peer support groups, visits with a social worker and doula visits. ACOG recommends behavioral health follow up if the patient is on medication. If you need additional support and would like to consult with a perinatal psychiatry expert regarding treatment and linkage to care, you can call Illinois DocAssist Monday-Friday, 9am-5pm at (866) 986-2778 or Postpartum Support International at (877) 499-4773. Linked to follow up behavioral health care would mean that they have been linked to follow up with a warm hand off or the follow up appointment has been scheduled. Providing treatment could include offering medication treatment or therapy.