

**Call for Applications:**

**RI MomsPRN 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 another funding opportunity to help support perinatal behavioral health screening, treatment, and referral workflows.**

**The goal of the RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative is to help prenatal care practices increase the identification, early intervention, and treatment of depression, anxiety and substance use among their pregnant and postpartum patients. Up to six prenatal care practices and/or locations will be selected. Applications are due by Month, Day, 2020. Project activities will begin in January 2021 and will continue for 15 months**.

**Who can to apply**: Outpatient or hospital-based practices that provide prenatal and postpartum clinical care and use an electronic health record system

**About the 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 partnered with CTC-RI and the Center for Women’s Behavioral Health (CWBH) at Women and Infants Hospital to establish the Rhode Island Maternal Psychiatry Resource Network (RI MomsPRN) Program. This new statewide program is pleased to offer practices new supports to help them identify, diagnose, and manage depression, anxiety, and/or substance use among their pregnant and postpartum patients, which are detailed below.

1. **A free phone consultation service** that is staffed by perinatal behavioral health experts at the CWBH at Women and Infants Hospital. Any health care provider treating a pregnant or postpartum patient who is looking for help with behavioral health diagnosis, treatment planning, medication management, as well as identification of an appropriate resource and/or referral are welcome to call **(401) 430-2800, Monday through Friday, between 8 a.m. and 4 p.m.** Please note this teleconsultation service is available to any provider regardless of their selection with this funding opportunity. For more information about this free teleconsultation service, please visit, [www.womenandinfants.org/RIMomsPRN](https://urldefense.proofpoint.com/v2/url?u=http-3A__www.womenandinfants.org_RIMomsPRN&d=DwMFaQ&c=tSLbvWYfvulPN3G_n48TUw&r=hEMdTF1w7HYpmCzvn4VTzRWmUuA2lcqyjQFzJ172URk&m=okHiVXPtb81Gk0_EEnMdagIjMNwynHD4GTD0rOaZtVY&s=edzsTVxBPRYpnUUYox8GeksLThJBLA07R3QrYFeYC8Y&e=)
2. **On-site practice coaching** **and clinical quality improvement assistance** that is provided by CTC-RI to establish practice workflows to screen pregnant and postpartum patients at least once for depression, anxiety, and substance use using validated screening tools of the practice’s choosing. Assistance will include training and education, screening tool advisement, workflow development and improvement, electronic health record (EHR) documentation and reporting support, and help with developing protocols for addressing positive screens.

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

* Improve universal screening rates of eligible pregnant and postpartum patients for depression, anxiety, and substance use using evidenced-based screening tools with the goal that 100% of women will be screened once for all three conditions during the prenatal/postpartum period;
* Support prenatal care practices in addressing perinatal depression, anxiety and substance use through skill training, peer learning opportunities and in collaboration with the RI MOMSPRN Perinatal Behavioral Health Consultation Team;
* Improve provider and team confidence and skills in managing mild-to-moderate behavioral health matters;

**Benefits**

* Two practice infrastructure payments totaling $5,000 that can be used to off-set costs associated with EHR modifications, staff time, and participation in related 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
* Timely identification of patient perinatal behavioral health concerns which has increased importance in the context of COVID-19;
* Virtual professional education presented quarterly by perinatal behavioral health specialists and includes best practice sharing
* Customized team training that can be provided for your staff on screening and responding to the needs behavioral health needs of your patients;
* Increased provider efficacy addressing perinatal behavioral health matters/concerns
* Monthly virtual consultation from a trained clinical quality improvement facilitator
* Data management training and support provided by CTC-RI and RIDOH that can assist you with developing internal reporting capacity and sustainable quality improvement reporting;
* Improved ability to meet the Office of the Health Insurance Commissioner’s behavioral health quality measure in the aligned maternity measure set

**Application Process:**  Practices interested in applying can submit by Month, Day, 2020:

* Completed application by Month, Day, 2020;
* Cover letter that indicates practice commitment and capacity for meeting project expectations; *Please see Appendix A for template*
* Letter of support if part of a system of care (i.e. accountable care organization or accountable entity); *Please see Appendix B for template*

Note: Practices with multiple sites have the option to apply as a single entity or just on behalf of an individual site. If pursuing the later, please fill out an application and Appendix A form for each practice site that includes information specific to just that location.

**Practice Team QI Initiative Activities (3 Month Preparation Period January – March 2021)**

* Identify members of the practice quality improvement (QI) team, which should include a provider champion, practice leader, and an IT staff member;
* Meet with CTC-RI facilitator monthly to develop practice workflows and identify quality improvement activities relating to screening for perinatal depression, anxiety and substance use disorder using validated tools selected by the practice that can be documented/reported in the EHR system;
* Attend a virtual orientation kick off learning session\* with CWBH staff to learn about evidence based behavioral health screening tools and use of the teleconsultation supports (with all practice providers and other relevant staff expected to participate);
* Attend a Practice Reporting meeting with RIDOH staff to discuss screening data parameters, timeline to test IT plans and data submission expectations (with relevant QI team members expected to attend);
* Relevant staff complete baseline clinical and practice level self-efficacy surveys within 45 days of award notification *(Surveys are available for review upon request);*
* Baseline report for depression, anxiety, and substance use screening due by 03/30/2021;
* Utilizes the RI MomsPRN clinical social worker for customized staff training and provider telehealth consultation line for clinical consultation based on patient/clinical need;
* Develops draft workflows to implement screening for perinatal depression, anxiety and substance use disorders and trains staff by March 31, 2021.

\*Note: Practice team eligible to receive $2,500 with provider champion, practice leader, IT staff (and other staff members as available) attending orientation kick off meeting and team attendance at initial practice facilitation meeting and completion of practice and provider self-efficacy surveys.

**Practice Team QI Initiative Activities (Performance Period April 2021 – March 2022)**

* Begins screening for perinatal depression, anxiety and substance use with validated tool(s) of their choosing starting in April, test workflows and submit finalized workflow descriptions by 6/30/2021
* Submits a Plan-Do-Study-Act performance improvement plan detailing improvement activities to optimize perinatal behavioral health screening, treatment, and referral by February 28, 2021(done with support from CTC-RI practice facilitator;
* Participates in monthly meetings with CTC-RI practice facilitator with the goal of developing internal capacity for implementing behavioral health screenings, obtaining, using teleconsultation clinical support and generating and using practice performance screening reports to improve population health;
* Submits quarterly de-identified practice screening reports and proportion of positive screens by zip code. *(Please see Appendix C for details and note RIDOH will provide reporting assistance.)*
* Submits a completed P-D-S-A performance improvement plan by August 31, 2021\* (done in conjunction with the CTC-RI practice facilitator);
* Attends and actively participates in quarterly virtual peer best practice learning sessions
* Completes provider and practice follow-up self-efficacy surveys and any other evaluation surveys

Note:

Practice team eligible to receive second infrastructure payment ($2,500) with team attendance at quarterly learning sessions, submission of quarterly screening reports and submission of completed P-D-S-A and quarterly reporting (August 31, 2021)

Practice team eligible to receive final payment ($5,000) with final submission of quarterly screening reports demonstrating continued improvement in reaching goal of 100% screening for patient population (depression, anxiety and substance use disorder) and submission of practice/provider self-efficacy surveys.

**Timeline for Selection Process**

|  |  |  |
| --- | --- | --- |
| **Step** | **Activity** | **Date** |
| 1 | Conference call with interested parties to answer any questions.Call-in number: | Month Day at 12-1 |
| 2 | Submit application electronically: Via email to: RIDOH@ctc-ri.orgVia fax to: FILL IN | Month Day by 5 pm |
| 3 | Notification will be sent to practices | Month Day |
| 4 | Orientation for newly selected practices | TBD |

**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)*
 |
|  | 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)*
 |

**Completed application packages should be received by 5:00 PM on Month Date, 2020.**

Email application package to: RIDOH@ctc-ri.org

Fax application package to: NUMBER

For questions, contact: RIDOH@ctc-ri.org

**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 [ ]   |

For Multisite practices only:
If multiple locations are participating, are these sites applying as one entity or separately: \_\_\_\_\_\_\_\_\_\_\_\_
*If separately, you will need to provide an application for each site that includes data specific to just that location.*

Provider Champion who will help ensure clinical adoption, attend monthly QI team meetings and quarterly peer learning sessions:

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

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

Practice Leader who will be responsible for project implementation, attend monthly QI team meetings and quarterly peer learning sessions:

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

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

IT/EHR Staff Member who will be assist with technology/reporting matters and be responsible for generating screening reports that are submitted to RI DOH quarterly and shared with the QI team:

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 2019** |
| 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 indicate if your practice or site location is anticipating undergoing any major planned changes (i.e. change in clinical leadership, office location, or other consolidation/merger) within the next 15 months.**
Yes [ ]  No [ ]

If yes: please indicate:
2. **Please provide the name of the Electronic Health Record system your practice currently uses.**
3. **Please indicate if your practice is anticipating changing its Electronic Health Record within the next 15 months**.

Yes [ ]  No [ ]
4. **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:
5. **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 7.)

**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)
3. **Indicate reason why your team is interested in participating in the RI MOMSPRN program. how you plan to use infrastructure payment ($10,000) support staff participation**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RI MomsPRN Selection Committee Policy and Procedure (2020)**

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 Month 2020. All reviewers will read and score each application independently using the scoring criteria below. The maximum number of points is 28. 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 located in a geographic area with high rates of perinatal women with substance use as identified using RIDOH data will be prioritized
4. Practice with a higher number of deliveries will be prioritized

**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** |
| Provider champion identified | Add 1 point | < 100 | Add 1 point | <10% | Add 1point |
| Practice leader identified | Add 1 point | 100-500deliveries | Add 2 points | 10-30% | Add 2points |
| IT/EHR staff member identified | Add 1 point | >500 deliveries | Add 3 points | >30% | Add 3points |
| Practice support and/or system of care cover letter(s) submitted and complete | Add 1 point | **Screening Documentation** | **Score** | **On-site Counseling** | **Score** |
| **Practice Stability**  | **Score** | Unsure/Does not screen | 0 points | Provides on-site counseling for depression | Add 1 point |
| Major changes planned in next 15 months  | Add 0 point | Paper records only | Add 1 point | Provides on-site counseling for anxiety | Add 1 point |
| No major changes anticipated  | Add 1 point | Both electronic health record or paper records | Add 2 points | Provides on-site counseling for substance use disorder | Add 1 point |
| **Screening Protocols** | **Score** | Electronic health record only | Add 3points |  |  |
| Performs depression screening | Add 1 point | Electronic health record system changing in next 15 months | Add 0 point |  |  |
| Performs anxiety screening | Add 1 point | Electronic health record system not changing | Add 1 point |  |  |
| Performs substance use disorder screening | Add 1 point | Generates practice-level screening reports  | Add 1 point**per each domain** |  |  |
| Uses a validated screening tool | Add 1 point **per survey** | Practice team meets to review screening rates | Add 1 point |  |  |

**Appendix A: Practice 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: (Insert Practice Leadership Representative)

RE: RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative

Date:

On behalf of (insert practice name), please accept the following practice 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 including clinical participation in the monthly quarterly peer learning meetings.

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

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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: (Insert System of Care Representative)

RE: RI MomsPRN Perinatal Behavioral Health Quality Improvement Initiative

Date:

[Insert practice name and/or 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 and/or site location 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 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

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Email Email

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Phone Phone

**Appendix C: Screening Measure Resource**

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| --- |
| Required Measure 1: Screening for Perinatal Clinical Depression, Anxiety and Substance Use  |
| Description: | The percentage of pregnant and postpartum patients screened for clinical depression, anxiety and substance use using an age appropriate standardized tool  |
| Age  | The eligible population are patients aged 11-55 years at the time of encounter  |
| Numerator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period**-AND-**Screened for clinical depression, anxiety and substance use at least once during the reporting period using an age appropriate standardized tool. **Stratification by Zip Codes**: List of zip codes for patients seen for a prenatal or postpartum visit during the reporting period and were screened for clinical depression, anxiety and substance use at least once during this reporting period.  |
| Denominator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period.  |

All selected prenatal care practices will be provided with access to data management platforms to assist with the quarterly submission of required and optional de-identified screening data that is detailed below. 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. The RIDOH will assist with zip code and de-duplication reporting and analysis for each measure.

|  |
| --- |
| Required Measure 2: Screening Positive for Perinatal Clinical Depression, Anxiety and Substance Use   |
| Description: | The percentage of pregnant and postpartum patients who were screened for clinical depression, anxiety and substance use, and screened positive, using an age appropriate standardized tool |
| Age  | The eligible population are patients aged 11-55 years at the time of encounter |
| Numerator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period**-AND-**Screened for clinical depression, anxiety and substance use at least once during this reporting period using an age appropriate standardized tool. **-AND-**Screened positive for clinical depression, anxiety and substance use at least once during the reporting period**Stratification by Zip Codes**: List of zip codes for patients seen for a prenatal or postpartum visit during the reporting period and were screened for clinical depression, anxiety and substance use at least once during this reporting period.  |
| Denominator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period **-AND-**Screened for clinical depression, anxiety and substance use at least once during the reporting period using an age appropriate standardized tool.  |

|  |
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| Optional Measure 3: Screening Positive for Perinatal Clinical Depression, Anxiety and Substance Use and Treated by Practice and/or Referred for Treatment  |
| Description: | The percentage of pregnant and postpartum patients who screened positive for clinical depression, anxiety and substance use using an age appropriate standardized tool and were treated by the practice and/or referred for treatment |
| Age  | The eligible population are patients aged 11-55 years at the time of encounter |
| Numerator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period**-AND-**Screened for clinical depression, anxiety and substance use at least once during this reporting period using an age appropriate standardized tool.**-AND-**Screened positive for clinical depression, anxiety and substance use at least once during this reporting period **-AND-**Treated by the practice and/or referred for treatment **Stratification by Zip Code**: List of zip codes for patients seen for a prenatal or postpartum visit during the reporting period and were screened for clinical depression, anxiety and substance use at least once during this reporting period. |
| Denominator Statement: | Patients seen for a prenatal or postpartum visit during the reporting period **-AND-**Screened for clinical depression, anxiety and substance use at least once during this reporting period using an age appropriate standardized tool. **-AND-**Screened positive for clinical depression, anxiety and substance use at least once during this reporting period. |