# MOMD Survey Key Takeaways & Goal Setting for 2022

# **MOMD Team Talk Summary**

### **Logistics/ Putting Together all the Details**

- 1. Build a collaborative referral network and establish provider relationships
- Develop consents that will ask for what you need (what, for how long, how to revoke or renew)
- 3. Build screening and follow up workflows (goal is to effectively treat, not just refer)
- 4. Engage patients about the why and how the information will be used
- 5. Create time within the appointment time to have conversations about mental health concerns

### **Relational Medical Care**

- 1. Build Trust through active listening
- 2. Talk about Birth Plans earlier in pregnancy care and use a trauma and mental health lens to discuss
- 3. Reinforce patient autonomy by having them be responsible for sharing the information
- Use targeted questions that demonstrate empathy, respect, and compassion in your daily work
- Have conversations regarding what to expect in tandem with doulas
- 6. Acknowledge the healing that needs to occur following a life saving procedure; ask, how are you?

## **Summary Continued**

#### Be Intentional about the Culture You Build

- 1. Ask how do I contribute to the culture? Do my behaviors, attitudes, and language communicate respect, listening, and caring?
- 2. Initiate conversations around racially concordant care
- 3. How do you overcome the fact that you may not have racially concordant care for the people you serve?
- 4. We all have biases. What do you do on a yearly basis other than what the hospital requires to continue to learn about your own biases?
- 5. Discuss the ideology around who "owns" the patient?
- 6. Have a process for holding team members accountable

Example of Collaborative Care Form that MH Providers could initiate and have client present to provider's office.

#### Feedback:

Like the idea that patient is involved in the process.

Like the idea that the MH provider discusses what can happen that could alter a birth plan and how to manage the loss of the ideal birth.

Can use form to start the conversation and as a tool to build trust.

Families can decide what to share.

MH provider can use form to coach patient in building trust with providers.

	ch Clinician:			
Address:				
Phone:				
Email:				
	f Services:		ons:	
Address: Phone:	e Provider:			
Initial Date of	f Services:	Estimated Due Date	2.	
Date Of Service	Goals/ Discussion		Planning	- G

### **Discussion Questions**

- Do plan on incorporating any new strategies with patients?
- What steps will you take to implement a new strategy and how will you measure success?

- Describe your current process
  - What is working well?
  - What do you need help or support with?

# Goal Setting for 2022

Looking at the data from the quarterly surveys to drive QI

What follow-up actions occur in your hospital or outpatient offices in response to a positive depression screen? (check all that apply)

Diagnosi	8	Medio	cations	mental	specialty health ment	to integrated health con	varm hand off d behavioral nsultants or anagers	Referral	to <b>home</b> programs	сотп	to other nunity urces	'		ases with a suicide risk respo	
	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept
Baseline Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)
No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes
No	No	No	No	No	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	Yes	No	No	Yes	No
No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	No	No
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	No	No	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No	No	No
Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	No	No	No	Yes
No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes

### Which quality metrics do you use to inform continuous improvements to your depression screening and follow-up processes? Note: Please refer to the definition of the HEDIS measure for the Prenatal and Postpartum Depression Screening Percentages

Scree	Depression ening entage	Prenatal I Screening I Perce		Scre	n Depression ening entage	Screening	n Depression Follow-up entage	(50% or great symptoms meas	oonse Percentage er reduction in ured by symptom uch as the PHQ-9)	Depression		Oth			lot Know	Uns	
Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept	Baseline	(July - Sept			Baseline	(July - Sept	Baseline	(July - Sept	  Baseline	(July - Sept	Baseline	(July - Sept
Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)	Baseline Survey	(July - Sept 2021)	Survey	2021)	Survey	2021)	Survey	2021)	Survey	2021)
Yes	No	Yes	No	Yes	No	Yes	No	No	No	No	No		•			·	
Yes	Yes	No	No	Yes	Yes	No	No	No	No	No	No						
No	Yes	No	No	No	No	No	No	No	No	No	No	Other					[  -  -
No	No	No	No	Yes	Yes	No	No	No	No	No	No						
No	No	No	No	No	No	No	No	No	No	No	No				Do Not Know	Unsure	Unsure
No	No	No	No	No	No	No	No	No	No	No	No				Do Not Know		
Yes	No	No	No	Yes	No	No	No	No	No	No	No		Other				р Н С С
Yes	Yes	No	No	No	Yes	No	No	No	No	No	No						
Yes	Yes	No	No	No	Yes	No	No	No	No	No	No						
Yes	Yes	No	No	No	Yes	No	No	No	No	No	No						
Yes	Yes	No	No	No	Yes	No	No	No	No	No	No						
No	Yes	No	No	Yes	Yes	No	No	No	No	No	No						

Do you <b>stratify</b> the maternal <b>improveme</b> depression and follow-up <b>racial disp</b>		Conducted a quality improvement project to reduce racial disparities for maternal mental health quality measures?		improvement project to reduce racial disparities for maternal		provement project to reduce institutional policies are cial disparities for maternal facilitating or alleviating racial		wide educa racial and eth	providew staff- ation on perinatal nic disparities and causes?	Do you work with advocates or com to inform your mate screening ar proce	munity resources ernal mental health nd follow-up	Do you work with patient/family advocates or community resources to inform your work to reduce racial disparities?		
F	Response	Re	sponse	Response		Re	esponse	Response		Resp	ponse			
Baseline		Baseline				Baseline								
Survey	(July - Sept 2021)	Survey	(July - Sept 2021)	Baseline Surveu	(July - Sept 2021)	Survey	(July - Sept 2021)	Baseline Survey	(July - Sept 2021)	Baseline Survey	(July - Sept 2021)			
	No; Have Not Started	No	No; Have Not Started		No; Have Not Started	Yes	Yes; In Place	Yes	Yes; In Place	Yes	No; Have Not Started			
No	No; Working on It	No	No; Have Not Started	No	No; Have Not Started	No	Yes; In Place	Yes	Yes; In Place	No	No; Have Not Started			
, No	No; Working on It	No	No; Working On It	No	No; Working On It	Yes	Yes; In Place	No	No; Working On It	No	No; Working On It			
Yes	Yes; In Place	No	No; Working On It	Yes	Yes; In Place	Yes	Yes; In Place	Yes	No; Have Not Started	Yes	No; Have Not Started			
100	-	No	No; Have Not Started	Yes	Yes; In Place	No	No; Have Not Started	No	No; Have Not Started	No	No; Working On It			
	-	No	No; Working On It	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Working On It			
	No; Have Not Started		No; Have Not Started	No	No; Working On It	Yes	Yes; In Place	Yes	No; Working On It	No	No; Working On It			
No	Yes; In Place	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Have Not Started	No	No; Have Not Started			
No	Yes; In Place	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Have Not Started	No	No; Have Not Started			
No	Yes; In Place	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Have Not Started	No	No; Have Not Started			
No	Yes; In Place	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Have Not Started	No	No; Have Not Started			
No	Yes; In Place	No	No; Working On It	Yes	No; Working On It	No	No; Working On It	No	No; Have Not Started	No	No; Have Not Started			

### Ideas for Collective Focus Heading into 2022

### Follow-Up:

- Following an organizational suicide risk response policy
- Diagnosis
- Referral to home visiting programs

### **Quality Measures:**

- Prenatal Depression Screening /Follow Up
- Postpartum Depression Screening/ Follow Up

#### **Racial and ethnic Disparities:**

- Stratifying measures by race and ethnicity
- Sharing strategies currently being worked on to reduce racial disparities
- Community Listening Sessions