MATERNAL OPIATE MEDICAL SUPPORT

MOMS Care Coordination Model

Step 1: MOMS Readiness Process
Step 2: Patient Presents to MOMS Entry Point
Step 3: Care Delivered by MOMS Care Coordination Team

FIRST VISIT
- First Contact Assessment Tree
- Care Coordination Team Tree
- BH Entry to MAT Services Tree
- OB/GYN Assessment Tree

SECOND VISIT
- BH Assessment Tree

FOLLOWING ASSESSMENT
- Person Centered Care Planning Tree

PRENATAL
- BH Prenatal MAT Services Tree
- OB/GYN Prenatal Care Tree
- New Patient Presents Labor Triage or ED

LABOR & DELIVERY
- OB/GYN Labor & Delivery Tree
- BH Labor & Delivery MAT Management Tree
- OB/GYN & BH Post Delivery Care Trees

- Client
- Client's family and support system
- Care coordinator(s)
- Obstetrics and Gynecology (OB/GYN)
- Behavioral Health (BH)
- Medication Assisted Treatment (MAT)
- Pediatricians
- Primary care
- 3rd party case management
  - Medicaid managed care
  - Private insurance

Ongoing Care for Mother and Infant

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Maternal Opiate Medical Support

Site Readiness Process

This document is intended to serve as a readiness tool for sites in the process of establishing a MOMS Maternal Care Home. It describes the personnel, processes, and structure necessary to provide coordinated patient care in a manner consistent with the MOMS decision trees. To establish and operate a MOMS model requires a significant investment of resources and education among departments/partners regarding MAT services and the unique needs of this population. Sites report spending at least a year in the initial planning phase with a designated budget.

Initial Site Administrative Oversight Team

Members

Upper-level administrators, such as clinical director and office manager

Staff members designated for quality improvement data collection

Finance and legal staff

Core clinicians from MOMS Maternal Care Home

Members of MOMS Maternal Care Home

Care Coordination Team

Client and client's family/support system
Care coordinator(s)
Obstetrics and Gynecology (OB/GYN)
Behavioral Health (BH)
Medication Assisted Treatment (MAT)
Pediatrics
Primary care
3rd party case management
- Medicaid managed care
- Private insurance

Key Service Providers/Program Partners

Onboard Early
Psychiatrist
Neonatologist
Addiction and recovery support
Social service agencies

Onboard Later
Child welfare department
Public assistance
Hospital administration

Onboard as Needed
Medical specialist
Legal authorities
Local health department
Behavioral health state and county boards

Preparation

Initial Site Administrative Oversight Team reviews MOMS Maternal Care Model to identify potential partners to join MOMS Maternal Care Home

Invite potential partners to kick-off meeting

Ask invitees to review Model in preparation for kick-off

Kick-off meeting
- Discuss the prevalence of Neonatal Abstinence Syndrome in the community
- Review MOMS decision trees
- Identify gaps/challenges to providing services as outlined in decision trees
- Identify missing stakeholders and community service providers needed to cover all areas of service, including detoxification and MAT

Establish Partnerships

Brand MOMS Maternal Care Home
- Program name and description

Outreach and engage partners as needed
- May be ongoing

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Site Readiness Plan

Planning

Initiate series of MOMS Maternal Care Home Meetings to determine:

1) What services will be offered to MOMS patients and what will be unique about the delivery of those services

- Wrap-around medical, behavioral health, and MAT services
- Ongoing care coordination
- Social service needs partners
  - Housing
  - Personal safety
  - Transportation
  - Food
  - Clothing
  - Childcare
  - Legal services
  - Education/Employment

2) Roles

- Provision of services and care coordination
- Written implementation plan and schedule
  - Patient flow
    - Awareness by all potential entry points
    - Care plan
- Identify potential care coordinator sources and define role

3) Budget

- Create funding plan
- Secure funding sources

4) Policies

- Determine policy regarding notification of child and family welfare department
- Determine policy regarding adherence with scheduled visits, including incentive plan.

5) Care Coordination Team 

- Hire and/or engage care coordinator (site-based, managed care plan, behavioral health center)
- Determine communication strategy and method
  - What patient information will be shared
  - Method and roles if there are multiple care coordinators
- Establish workflow and contact list with partners involved in MOMS team
  - 24/7 access
- Establish information sharing procedures
  - Access to client medical records
  - Patient consent
  - Consider universal release form for all MOMS care providers
- Comprehensive patient follow-up
  - Tracking appointment attendance
  - Making timely referrals
  - Follow-up with referral providers
  - Follow-up and share care plan as needed
  - Develop action plan for women who test positive for illicit substances

Site Readiness Plan

Planning

6) Recruitment and Enrollment

- Development of recruitment materials and strategies focused on early identification
- Method for enrolling clients in MOMS Maternal Care Home
- Consider development of consumer-focused information which highlights program benefits

7) Engagement, Retention, and Re-engagement

- Develop engagement and retention plan including strategies for engaging patients in their own care
  - Incentives for patient participation (including behavioral and policy incentives)
  - Reminder calls
  - Align appointments on same day at same location if possible
  - Arrange transportation if needed
  - Incentives for providers with good participation rates
  - Plan for re-engaging patients who are lost to follow-up

8) Develop Quality Improvement (QI) Plan

- Establish a QI team with a lead and several support members with buy-in from organization's leadership
- As part of a Plan-Do-Study-Act (PDSA) cycle:
  - Establish performance measures to monitor the progress of implementation and service delivery (e.g. level of client participation in OB/GYN and MAT services)
  - Establish outcome measures to monitor improvement in patient outcomes (e.g. improved birth weight)
- Establish method of data collection, analysis, and reporting
- Identify plan to review performance measures regularly

9) Commitment

- Establish contractual agreement as needed
- Written agreement should:
  - Obtain commitment from all stakeholders
  - Identify roles and responsibilities
  - Outline communication plan between stakeholders
  - Require participation in quality improvement activities

Implementation

1) Enroll patients and provide coordinated care as outlined in decision trees

2) Initiate patient engagement, retention, and re-engagement strategies

3) Implement Quality Improvement (QI) activities which will include:

- Establishing regular meetings to evaluate processes and effectiveness
- Ensuring alignment of activities with performance outcomes and measures
- Reviewing data to identify best practices and areas of improvement
- Monitoring outcomes

4) Care Coordination Team continually conducts the following activities:

- Evaluate client needs to determine necessary services
- Revise person centered care plan as needed
- Ongoing recovery program (recovery-oriented MAT services)
- Ongoing education, counseling, support, and planning

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Entry Points

Disease Management
Treatment for medical conditions, pain management

Child Welfare
Prevent, identify, assess, and treat to ensure child and family safety

OB/GYN
- Prenatal Care
- Delivery
- Postpartum Care
- Breastfeeding
- Family planning

Social Services
Housing, education, selfcare, employment, public welfare programs

COMMUNICATION

SCREENING

EARLY DETECTION

MOMS MATERNAL CARE HOME

Behavioral Health
Psychiatric counseling including therapy, behavioral modification, and relationship/ family counseling

Primary Care Clinician
General medical care
Pediatrician

Addiction Services
Medication assisted treatment, therapy, vocational, housing, transportation, relapse prevention

Legal System
Placement decisions

Emergency Department/ Hospitalization
Acute trauma care, opiate-related admission, labor & delivery

Others
Church, friends, family, self-referral, health department

Return to Model Map

First Contact Assessment Tree (F.1-F.9)

Woman presents to any MOMS Maternal Care Home Entry Point

F.1 Quick Screen

- ☐ **Standard exam and vital signs**
  - •Current medication(s) and/or diagnoses
- ☐ **Assess for acute withdrawal or risk of withdrawal from opioids**
  - **Signs and symptoms of withdrawal:** achiness, anxiety, increased sensitivity to pain, irritability, restlessness, sweating, pupil size, runny nose or tearing, GI upset, tremor, yawning, gooseflesh skin (See *COWS*)
  - **Risk factors:** regular or daily use
- ☐ **Assess for acute withdrawal or risk of withdrawal from alcohol or benzodiazepines ("benzos")**
  - **Signs and symptoms of withdrawal:** agitation, anxiety, auditory disturbances, clouding of sensorium, headache, nausea/vomiting, paroxysmal sweats, tactile disturbances, tremor, visual disturbances; cues like alcohol on breath (See *CIWA-Ar*)
  - **Risk factors:** regular or daily use
- ☐ **Withdrawal may threaten the life of a mother or fetus and should be addressed immediately**
  - •Assess for other substance use
  - •Conduct a more thorough substance use screen as soon as possible (See *5Ps Plus)*

F.2
Is patient experiencing or at risk of acute withdrawal from alcohol or benzos?

YES → **F.3**
- ☐ Detoxification from alcohol or benzos must be given priority
- ☐ Medically supervised inpatient detoxification

NO → **F.4**
Is patient experiencing or at risk of acute withdrawal from opioids?

YES → **F.6**
Initiate MAT Therapy as Appropriate for Stabilization
- ☐ See *Behavioral Health Entry to MAT Services Tree, Step BH.5*
- ☐ See *MAT Protocols and Crosswalk*

NO → **F.5**
Refer to appropriate level of care

F.7
Assessing Urgent Needs
- ☐ Recent drug use (urine drug testing)
- ☐ Initial obstetrical ultrasound to confirm viability and gestational dating
- ☐ Current personal safety *(See ACOG-DV, HITS screen)*
- ☐ Immediate psychosocial needs
  - •Housing, safety, childcare, etc.
- ☐ Homicidal, suicidal, and threats of violence
- ☐ Pain management needs
- ☐ Behavioral health history and status

F.8
Initiate Necessary Care Processes

- ☐ Activate MOMS Care Team to complete the following:
  - •Obtain patient consent for all MOMS Care Home service providers to coordinate care
  - •Inform patient if state child welfare department notification will be made
  - •Engage health plan case management for insured patients
  - •Check patients' insurer/payor for coverage of MAT services
  - •Assist patient to enroll for Medicaid benefits if qualifies
  - •Initiate prompt process to obtain state-issued ID card if needed

F.9
Transfer
Direct transfer into outpatient, inpatient, or residential opioid treatment

- **OB/GYN** — Proceed to Assessment Tree
- **BH** — Proceed to Entry to MAT Services Tree

Return to Model Map

Care Coordination Team Tree (CC.1-CC.7)

CC.1
Care Coordination Team Roles and Responsibilities

(See *Site Readiness Plan*. Team includes Care Coordinator(s), OB/GYN, Behavioral Health, MAT Providers and Pediatrician)

Communication

- Introduce MOMS Care Team to client and build rapport
- Ongoing communication with client and care providers
- Frequent team meeting to ensure care plan is updated and client needs are met
- Ensure clear delineation of responsibilities when there are multiple care coordinators and maintain primary and backup points of contact with client

Comprehensive client follow-up

- Track appointment attendance
- Make timely referrals
- Follow-up with referral providers
- Follow-up and share care plan as needed

Provide support and incentives

- Build rapport and trust
- Establish partnership with client
- Implement incentive plan

Engage medical and other service providers/program partners

- As needed, onboard other service providers to team and facilitate a warm hand-off to clients

CC.2
Conduct initial assessments and ongoing reevaluation

CC.3
Determine types of services needed (specialty medical, mental health, pain management, social services, etc.)

CC.4
Revise/develop person centered care plan including plan for safe and stable environment for infant

CC.5
Ongoing Recovery Program

- Engage/refer recovery program with patient for recovery-oriented MAT services
  - Recovery/treatment programs including case management, individual and group counseling, and support groups
- Engage behavioral health services for treatment of mental illness or trauma
- Program should include ongoing education/counseling (see CC.6) and care coordination (see CC.7)
- Action plan for retention and re-engagement or lost to follow-up
- In case of relapse or lapse in treatment, return to CC.2

CC.6
Ongoing Education, Counseling, Support, and Planning

Health Education

- Contraceptive and sexually transmitted infection prevention counseling
- Smoking cessation and/or strategies to eliminate secondhand smoke
- Substance abuse
- Nutrition and exercise
- Stress management

Counseling

- Behavioral health services
- Peer counseling
- Personal safety and domestic violence
- Sober partners/dating choices
- Nutrition

Support

- Vocational/employment training and services
- Social service needs such as stable housing and safety
- Support system

Planning

- Support for other children of MOMS client (Al-Anon, etc.)
- Childhood immunizations and ongoing pediatric care
- Safe sleep/Sudden Infant Death Syndrome (SIDS)
- Breastfeeding
- Family planning
- Establishing a home environment that is sober

CC.7
Ongoing Care Coordination

- Ongoing care coordination to facilitate medical and behavioral health treatment
- Ongoing communication to ensure entire care team is informed
- Periodic child and family welfare assessment, including housing and safety needs
- Enroll for available community services for ongoing social service needs
- Child reunification, if applicable

Return to Model Map

Return to Model Map

Behavioral Health Entry to MAT Services Tree (BH.1-BH.5)

BH.1 Screen for MAT Services

- ☐ Crisis intervention
- ☐ Education
- ☐ Eligibility verification
- ☐ Identification of treatment barriers
- ☐ Screening of emergencies (living environment supports MAT)
- ☐ Clarification of the treatment alliance
- ☐ Legal status/needs

BH.2
Is patient eligible and/ or willing to enroll in MAT therapy?
(ASAM Checklist)

NO

BH.3
Refer to appropriate level of care
(i.e., if patient presents potential threat to self or others, refer for emergency psychiatric evaluation)
(State procedural - emergency petition)

YES

BH.4
Enroll in MAT services

BH.5 Selected Treatment Regimen(s)
(MAT Protocols and Crosswalk)

OPTION: METHADONE

- ■ Introduce during any trimester to be monitored during first 7 days to prevent overmedication.

(See *MAT treatment resources)*

OPTION: BUPRENORPHINE

- ■ Induction can be more challenging depending on recent opioid use.

(See *MAT treatment resources)*

Check patient history in OARRS

Currently treated
↓
Continue current therapy

- ■ If previously successful on methadone, consider continuation of methadone unless buprenorphine is preferred
- ■ If already stable on naltrexone/Vivitrol, not necessary to transfer to agonist

Currently untreated
↓
Buprenorphine

- ■ Determine MAT history and dosages

Common Considerations	Education	Monitoring
■ Reduction of risk behaviors ■ Compliance with prenatal care ■ Availability in community ■ Interaction with other meds ■ Gradually increase dose to prevent overdose ■ Preventing withdrawal symptoms	■ Managing storage and safeguard of medication	■ System/procedure to minimize diversion during unsupervised administration of MAT (See *MAT treatment resources)*

Proceed to BH Assessment Tree

Return to Model Map

Return to Model Map

OB/GYN Assessment Tree (OB.1-OB.4)

OB.1 Initial Assessment

Timely assistance, scheduling flexibility, and appropriate empathy and optimism for change are needed from first contact.

- ☐ **Provide trauma informed care** (*See Training)*
- ☐ **Check patient history in OARRS**
- ☐ **Focused medical history and obstetrical history and exam**
- ☐ **Complete physical examination**
- ☐ **Confirmatory pregnancy testing (confirmation of gestational age) and assess fetal well-being**
- ☐ **Laboratory tests** (See *Recommended Panel*)
  - TB testing
  - HIV testing
  - Urine drug testing (or get results)
  - STD testing (including syphilis testing - RPR or VDRL)
  - Hepatitis testing
    (Hep. B surface antibody/surface antigen; Hep. C antibody followed by quantitative RNA if positive)
- ☐ **Notify MAT provider of labs drawn and results**

OB.2
Is patient appropriate for MAT services?
(ASAM Checklist)

NO

OB.3

Refer to appropriate level of care

(i.e., if patient presents potential threat to self or others, refer for emergency psychiatric evaluation)

(State procedural - emergency petition)

YES

OB.4
Refer to MAT services

Proceed to Person Centered Care Planning Tree

Return to Model Map

Behavioral Health Assessment Tree (BH.6-BH.9)

BH.6
Comprehensive Assessment and Orientation to Services

■ **Timely assistance, scheduling flexibility, and appropriate empathy and optimism for change are needed from first contact**
- Provide trauma informed care (*See Training*)

■ **History and extent of substance use**
- Check patient history in OARRS
- Substances of abuse including route of administration
- Tobacco/nicotine use (See *5As Screen*)
- Pattern of daily preoccupation with opioids
- Method and level of opioid and medication use

■ **5Ps Plus addiction screen**
- **P**arents: Did any of your parents have a problem with alcohol or other drug use?
- **P**artner: Does your partner have a problem with alcohol or drug use?
- **P**ast: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- **P**regnancy: In the month before pregnancy, did you smok any cigarettes, drink any alcohol, or use any other drugs?
- **P**resent: Have you smoked any cigarettes, including e-cigarettes, or used any alcohol or any drug at any time in this pregnancy?

■ **Consider comprehensive addiction screens**
- See *DAST-20* •*See TWEAK* •*See T-ACE*
- Obtain and/or verify medical history and results of laboratory testing
- Prior treatment history
- History of domestic trauma or abuse
- Compulsive behaviors

■ **Orientation to MAT**
- Age (≥ 18 years)
- Patient personal recovery resources
- Recovery environment
- Scheduling the next appointment
- Patient motivation and reasons for seeking treatment
- Confirm eligibility in cases of uncertainty
- Exemptions from SAMHSA'S 1-year dependence duration rule

■ **Resources**
- *OHBH admission form*
- *Patient engagement and retention guide*

BH.7
Is patient able to participate in psychosocial assessment?

NO →

BH.8
Postpone full psychosocial assessment until patient can complete assessment process or gather information in smaller sessions

YES ↓

BH.9 Psychosocial Assessment

- Patient motivation and readiness for change
- Cultural assessment
- Socio-demographic history
- History of physical or sexual abuse
- **Housing status and safety concerns**
- Insurance status
- Military or other service history
- Sexual orientation and history
- Recreational and leisure activities
- Personality (volatile, sensitive, plan ahead vs. spur-of-the-moment)
- Family and cultural background, relationships, and supports
- Educational history and identified disorders, e.g., ADHD
- History of co-occurring disorders and current mental status, including past history of postpartum depression
- In utero exposure to substance use
- In utero exposure to tobacco/nicotine
- **Interpersonal violence**
- Peer relations and support
- Criminal history and legal status
- Employment history
- Spirituality
- Patient's ability to manage money
- Personal birth and delivery history
- See *PHQ-9*
- See *Addiction Severity Index*

Proceed to Person Centered Care Planning Tree

Return to Model Map

Person Centered Care Planning Tree (CP.1-CP.10)

CP.1

- ☐ Designate care coordinator from available resources (e.g., in-house coordinator, health plan case management, etc.)
- ☐ If more than one care coordinator is involved, designate **primary** care coordinator to interact with patient and determine communication flow
- ☐ See *MOMS Readiness Checklist*

CP.2
Determine types of services needed

CP.3
Identified mental health and/or addiction needs?

YES

CP.4
Is pain management needed?

YES

CP.5
Identified social service/ safety needs?

YES

CP.6
Prenatal/postnatal care

CP.7
Engage mental health and/or appropriate additional addiction services (e.g., AA, NA) *(See Community Services List)*

CP.8
Engage pain management specialist

CP.9
Engage child welfare and appropriate social services *(See Community Services List)*

CP.10
Develop person centered care plan
(See Clinical Opinion)

NO

OB/GYN
Proceed to Prenatal Care Tree

BH
Proceed to Prenatal MAT Services Tree

Return to Model Map

Behavioral Health Prenatal MAT Services Tree (BH.10-BH.14)

BH.10
Pharmacological Strategies for Stabilization and Managing Relapse

METHADONE
- Consider split dosing needs specific to pregnancy
- Monitor for need of dose changes

BUPRENORPHINE
- Limited evidence for split dosing during pregnancy
- Monitor for need of dose changes

- Ongoing monitoring of OARRS.
- Common stabilization considerations: stabilization can occur in 2-3 days, monitoring for withdrawal and overmedication signs and symptoms over the course of pregnancy.
- Common management considerations: monitoring for risk of relapse and/or nonadherence, determine whether other illicit and/or legal drugs are involved, manage detoxification as appropriate, and behavioral management.
- Consider prescription of naloxone rescue kit for patient to have at home in case of emergency, life-threatening overdose.
- Consider treatment implications of marijuana, alcohol, and nicotine/tobacco dependence.
- Reevaluate for coexisting physical and psychiatric conditions and consider treatment implications of pharmacological intervention.

BH.11
Behavioral Strategies for Stabilization and Managing Relapse
- See *Behavioral Treatment Resources*

BH.12
Create written delivery plan with MOMS team for client file

BH.13
Reassess types of services needed with MOMS team including housing and safety needs

BH.14
Revise person centered care plan with MOMS team

Proceed to BH Labor and Delivery M.A.T Management Tree

Return to Model Map

OB/GYN Prenatal Care Tree (OB.5-OB.8)

Woman Already Enrolled in MOMS Care Team

New Patient Presents - Labor Triage or ED

- Toxicology testing and brief, focused clinical screening (e.g. *SBIRT*)
  - i. Quick Screen 1: How many times in the past 12 months have you had 4 or more drinks in one day?
  - ii. Quick Screen 2: In the past 12 months, how often have you used the following: tobacco, prescription drugs, illegal drugs?
  - iii. Evaluate: Screen is positive if any response is given other than zero.
- Medical and obstetrical assessment
- Check patient history in OARRS
- If possible, return to *First Contact Assessment Tree*

OB.5 Prenatal Care

- Confirmatory pregnancy testing (confirmation of gestational age) and assess fetal well-being
- *Fetal Well-being Resources*
- Check patient history in OARRS

- Routine prenatal appointments
- Low birth weight (LBW) education
- Dietary consult
- Nicotine withdrawal/smoking cessation (5A's)
- Neonatal abstinence syndrome (NAS) education (*See ACOG Committee Opinion 524 and Pediatrics Journal*)
- Contraceptive and sexually transmitted infection prevention counseling
- Child birth education and labor support
- Assess **housing and safety needs** and refer to care coordinator when necessary.

- Lactation consult
- Consider maternal fetal medicine consultation
- Pediatrician referral
- Pain management and/or anesthesia consultation

OB.6

Create written delivery plan/notes with MOMs team for client file

OB.7

Reassess types of services needed with MOMs team

OB.8

Revise person centered care plan with MOMs team

Proceed to **OB/GYN Labor & Delivery Tree**

Return to Model Map

OB/GYN Labor & Delivery Tree (OB.9-OB.12)

OB.9 Labor and Delivery

- Check patient history in OARRS
- Substance use screen
- Nicotine withdrawal/smoking cessation *(See 5A's)*
- Pain/stress management during labor and delivery *(See Pain Management Protocols)*
- Pain management – postpartum, post-operative, and/or anesthesia consultation *(See Pain Management Protocols)*
- Newborn care / NAS Screening / Pediatrician or Pediatric Nurse *(See Finnegan Scale)*
- Lactation consult

OB.10

Contact care coordination team to ensure care coordination and adequate support for mom and baby

OB.11

Engage on-call member of care coordination team

OB.12 Inpatient Postpartum Care

- Assess and address immediate care needs
- In case of fetal demise, initiate grief counseling
- Pain management – postpartum and/or post-operative (See *Pain Management Protocols*)
- Education regarding late onset NAS (See *ACOG Committee Opinion 524 and Pediatrics Journal*)
- Continuation of nicotine replacement
- Contraceptive and sexually transmitted infection prevention counseling
- Lactation consult
- Child welfare service referral if needed
- Ensure stable housing and safety needs and refer to care coordinator when necessary

Proceed to
Post Delivery Care Tree

Return to Model Map

Behavioral Health Labor & Delivery MAT Management Tree (BH.15-BH.18)

BH.15
Pain Medication Management During Labor and Delivery
(See Pain Management Protocols)

METHADONE
- Continue methadone
- Avoid opioid antagonists
  (Naloxone, Nubain, Stadol, Talwin)

BUPRENORPHINE
- Continue buprenorphine
- Avoid opioid antagonists
  (Naloxone, Nubain, Stadol, Talwin)

BH.16
Engage care coordinator

BH.17
Inpatient Postpartum Management
(See Pain Management Protocols)

METHADONE
- Dose adjustment may be needed

BUPRENORPHINE
- Dose adjustment may be needed

- Monitor for signs of overmedication
- Ongoing monitoring of OARRS
- Ensure stable housing and safety needs are met for mom and child at home
- Educate and support regarding smoking replacement therapies and eliminating secondhand smoke exposer

B.18
Breastfeeding Guidelines

METHADONE
- Some evidence of withdrawal following abrupt discontinuation

BUPRENORPHINE
- Low oral bio-availability so medication not likely to affect infant

- Encourage breastfeeding unless HIV + or other contraindications apply, help mother understand Neonatal Abstinence Syndrome (NAS)
- Discuss risks/benefits of breastfeeding *(See Breastfeeding & Psychiatric Medications)*

Proceed to
Post Delivery Care Tree

Return to Model Map

Return to Model Map

Post Delivery Care Tree (PD.1-PD.2)

OB/GYN
PD.1
Initial Postpartum Health Maintenance

- Ongoing monitoring of housing and safety needs
- Ensure pediatric and postpartum follow-up appointments are kept
- Postpartum depression screening (EPDS)
- Lactation consult
- Contraceptive and sexually transmitted infection (STI) prevention counseling
- Readdress birth control for ongoing plan
- Education regarding safe sleep/SIDS and parenting NAS babies
- Hepatitis/STI treatment if applicable
- Follow-up on specialty medical referrals if applicable and ensure patient compliance
- Schedule nurse home visits

Behavioral Health
PD.2
Initial Postpartum BH Maintenance

- Ongoing child and family welfare assessment, including housing and safety needs
- Postpartum depression screening (EPDS)
- Assist/encourage patient to establish a home environment that is sober
- Educate regarding managing, storing, and safeguarding medications
- Specialty behavioral health referrals if needed and ensure patient compliance
- Grief counseling, if applicable

Proceed to
Care Coordination Team Tree

Return to Model Map