TAKING CARE OF YOU: A PARENTAL SUPPORT PROGRAM

We are dedicated to supporting parents, guardians, and families experiencing a variety of stressors including mental health or substance use challenges during pregnancy and through the first year postpartum.

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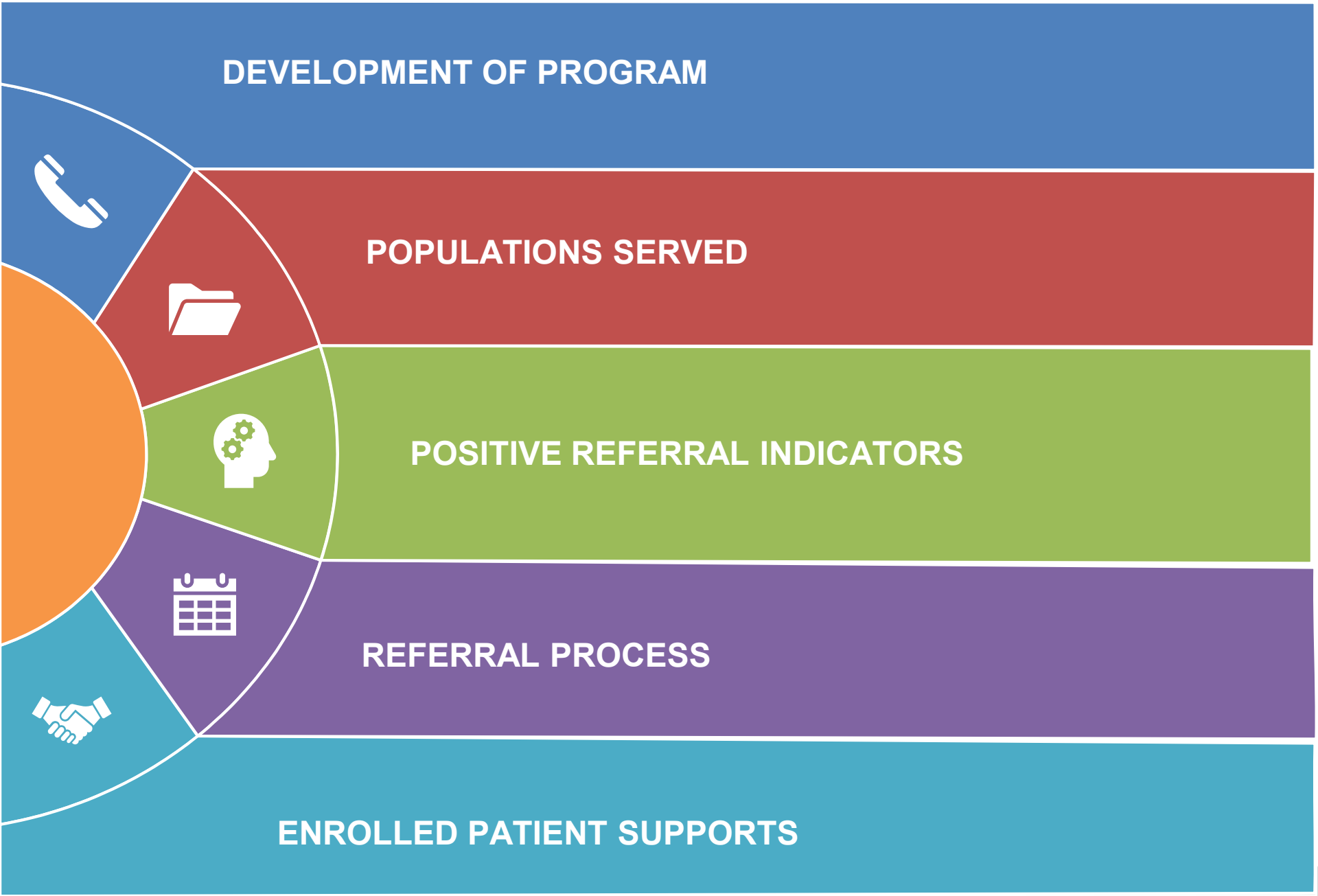

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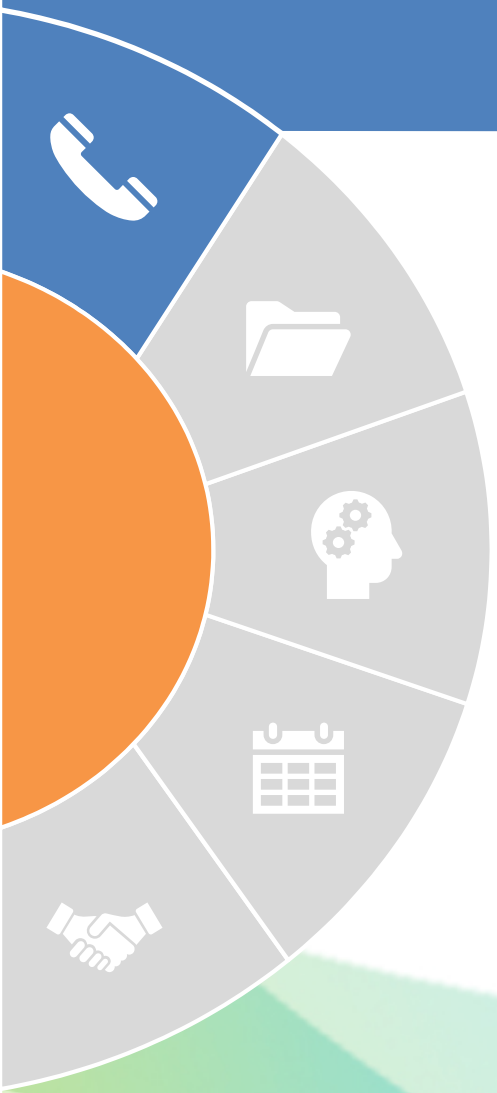
DEVELOPMENT OF PROGRAM



- Community health improvement plan identified three priority areas:
  - **Behavioral Health:** Education, awareness, screening and access to care;
  - **Early Childhood:** ACES/trauma-informed care, early care and education;
  - **System access and referral.**
- Primary Care RN Care Manager identification of pregnancy & postpartum population needing support
- Meadowlark funding through the Montana Healthcare Foundation
- Maternal Mental Health Task Force and community focus on supporting families in the perinatal period
- SPH building strong relationships with community partners serving this population
- AHRQ Award

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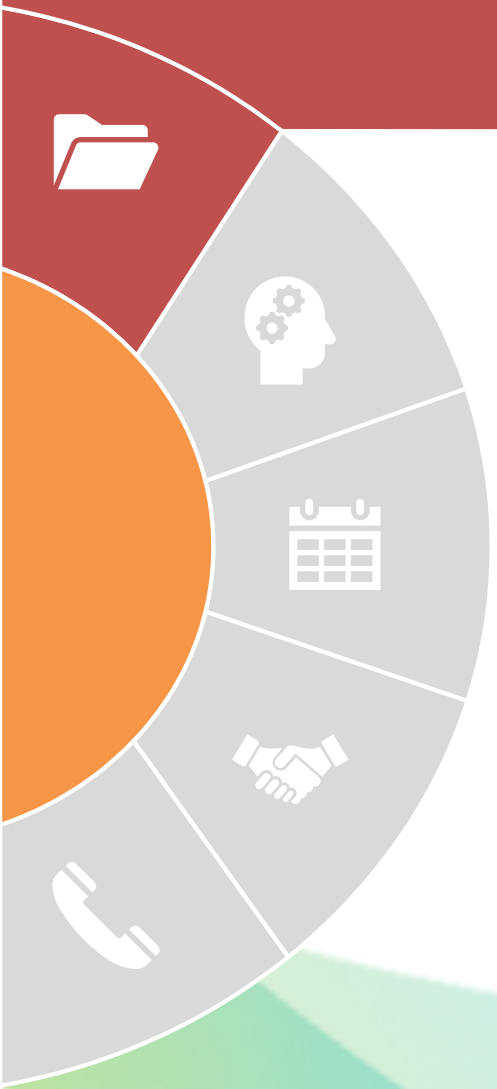
POPULATIONS SERVED



- SPHMG PCP patient who verbalize desire to become pregnant with positive referral indicator(s)
- Individual establishes OB care with SPHMG FP OB
- SPHMG PCP patient or partner with infant delivered/adopted/fostered in the past year
- SPHMG PCP patient who is a caregiver to child <12 mo. old
- SPHMG PCP patient who delivers a child at SPH (discharge call within 2 business days)
- Patient referred from Women & Children's unit
- Patient referred from CPS

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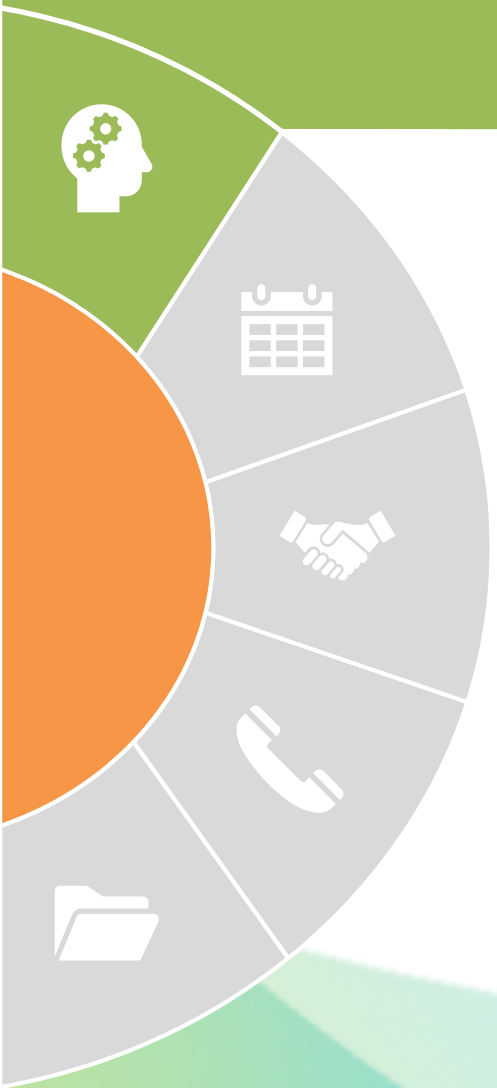
POSITIVE REFERRAL INDICATORS

REFERRALS CAN ORIGINATE FROM
OUTPATIENT OR INPATIENT SETTING



- Complex medical conditions present before pregnancy
- 1+ SDoH need
- PHQ9 or Edinburgh score 10+
- CPS involvement
- Substance use
- New mental health medication started
- Grief or loss
- NICU babies/parents
- Individual is stressed, overwhelmed & needing connection to parenting resources

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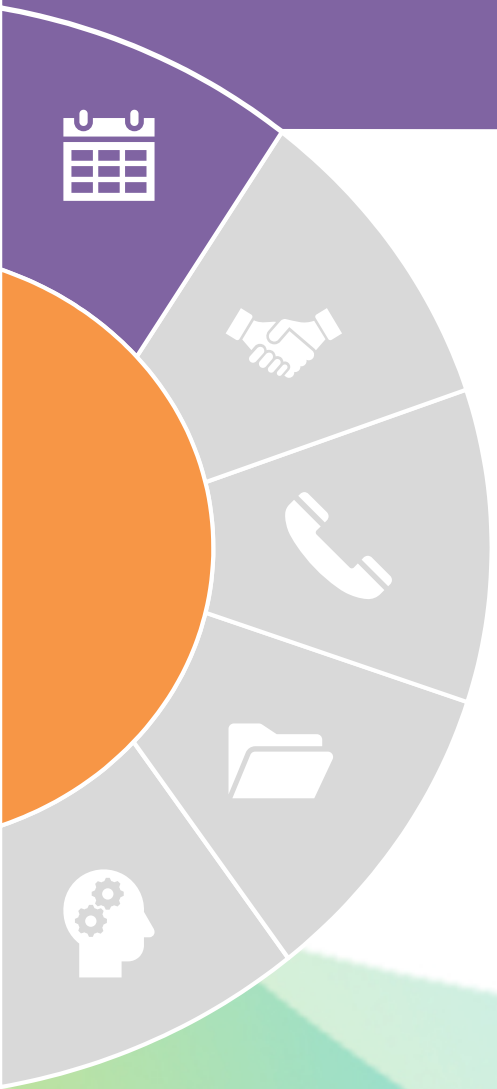
REFERRAL PROCESS



- Warm handoff with Parental Mental Health RN Care Manager &/or Social Worker/Social Services Coordinator (otherwise outreach within 2 days)
- Via CONNECT from CPS
- Women & Children's Unit
- SPHMG FP OB (future goal to include high-risk individuals with community OB and SPHMG PCP)
    - Outreach at 2 weeks postpartum with Edinburgh screening
    - Outreach at 4 months postpartum with Edinburgh screening
    - Outreach at 9 months postpartum

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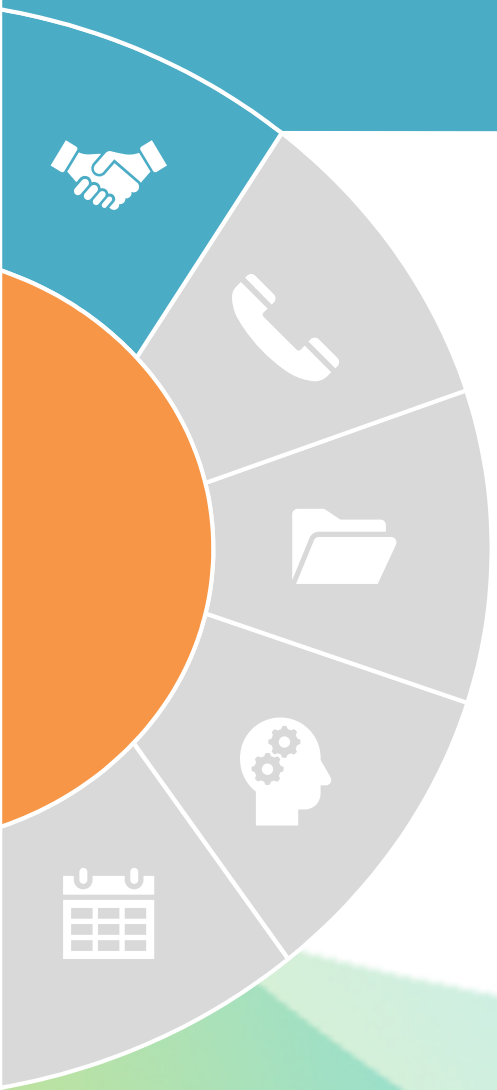
ENROLLED PATIENT SUPPORTS



- Outreach every 1-4 weeks, based on preference and risk.
- Program duration is pregnancy through 1 year postpartum. Potential for longer duration on case-by-case basis.
- Assistance with:
  - Goal setting to decrease symptoms
  - Referrals to community supports
  - Referrals to Primary Care behavioral health professional/community therapist/Psychiatry if indicated
  - Connection to PCP for medication & symptom discussion
  - Rescreening at least monthly

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For more information contact:

TakingCareOfYou@sphealth.org

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