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.
TAKING CARE OF YOU: A PARENTAL SUPPORT PROGRAM

DEVELOPMENT OF PROGRAM

POPULATIONS SERVED

POSITIVE REFERRAL INDICATORS

REFERRAL PROCESS

ENROLLED PATIENT SUPPORTS
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
• 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
• 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
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:
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