Maryland
DEPARTMENT OF HEALTH

Maryland Medicaid's MOM Program — Best Practices and Expectations for Case Management, Staffing and Workflow

Version 7.0 (28 April, 2023)

Version	Date	Change Log
1.0	1/25/21	N/A
2.0	4/14/21	Case management workflow timeline, self-report question list, and further Release of Information requirement information added; included guidance on data and document storage and case management appointment locations
3.0	6/9/21	Further guidance on CCM access, ROI completion, OUD diagnosis requirement and self-report template provided; eligibility checklist for MOM enrollment added
4.0	11/17/21	Updated OUD diagnosis requirement and related checklist; clarified expectations around substance use treatment engagement; added guidance on inpatient stays
5.0	5/31/22	Changed in-person requirement to preference; added additional timelines for documentation; added Maryland Prenatal Risk Assessment as a source of opioid use confirmation; removed limited to St. Mary's County; removed references to self-report template (now built into MOM CCM); updated case management documentation requirements
6.0	2/1/23	Removed references to cooperative agreement; updated information about CPRS; updated screenings; added Edinburgh, including screenshots of Edinburgh screening tool, removed PAM, PHQ-9, GAD-7, updated screening cadence, and self-report questions; updated consent requirements; updated eligibility requirements to reflect statewide expansion; and updated CCM screenshots
7.0	4/28/23	Updated to reflect changes to the MOM CCM

Executive Summary

The purpose of this document is to outline the accepted case manager provider types, staffing related needs and expectations, as well as workflow to fulfill the case management aspect of the Maternal Opioid Misuse (MOM) model. This document is meant to be used as a resource for MCOs to refer to while finalizing their staffing plans and planning case management

activities. Additionally, the case management workflow section of this document provides a detailed overview of the associated tasks required at various points during a participant's engagement in the model to fulfill the requirements needed to receive per member per month (PMPM) payments.

Background

The Maryland Department of Health (the Department) launched its MOM model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMS). The MOM model focuses on improving care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD). Substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid participants with OUD in Maryland per year. Maryland's MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid participants with OUD through collaborative efforts with its managed care organizations (MCOs), improved data infrastructure and strengthened provider capacity across the state. The MOM model aims to increase utilization of physical and behavioral health care services, such as medication for opioid misuse disorder (MOUD), as well as to address health-related social needs, for this population through enhanced MCO case management.

Best Practices

Case Management

The Substance Abuse and Mental Health Services Administration (SAMHSA) has described *case management* as a coordinated approach to the delivery of health and social services, linking clients with appropriate resources to address specific needs. SAMHSA notes that effective case management consists of the following set of functions: (1) assessment; (2) planning; (3) linkage; (4) monitoring; and (5) advocacy.[1] Similarly, *case manager* has been defined as an individual responsible for executing case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention, and case closure.[2]

[1] Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000. Retrieved from: https://store.samhsa.gov/system/files/sma15-4215.pdf

[2] New York State Department of Health AIDS Institute. Standards for HIV/AIDS Case Management. 2006. Retrieved from: https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/docs/casemanagementstandards.pdf

Case managers can serve as a single point of contact for participants who receive services from various entities. For the purposes of the Maryland MOM model, MOM case managers will serve as the "quarterback of care," ensuring participants enrolled in the MOM model not only receive needed health care services but also gain access to and remain connected to appropriate social services in the community. The overarching goal of comprehensive and coordinated case management is to reduce barriers that impede access to and/or compliance with treatment. Research has shown that retention in substance use disorder (SUD) treatment is more likely when other social needs are addressed concurrently.[3] Such needs include, but are not limited to: housing supports, food assistance, vocational services, educational resources, transportation, child care, legal assistance and peer support.[4]

Other best practices for case management through the MOM model involve:

- Developing and revisiting MOM care plans during case management encounters—preferably face-to-face meetings—and negotiating between MOM model participants and MOM case managers to encourage active participation and empowerment;
- Jointly developing measurable goals and activities—taking into consideration the participants' cognitive and physical abilities, available resources, support networks and motivations—that result in a more realistic, MOM model participant-specific care plan;
- Offering a copy of the MOM care plan to the participant, reinforcing participant ownership and involvement in the case management process;
- Documenting changes or updates to the MOM care plan as well as actual outcomes to track MOM model participant progress;
- Engaging family members and the participant's support network to assist in ensuring a MOM model participant receives needed service, including inclusion in the MOM care plan to carry out activities;
- Strengthening data-sharing and communication between MCOs and the Behavioral Health Administrative Services Organization (BH ASO); and
- Building relationships between MCOs, Local Health Departments (LHDs), and Local Behavioral Health Authorities (LBHAs) to leverage unique local opportunities and programs for MOM model participants.

[3] Substance Abuse and Mental Health Services Administration. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. Retrieved from: https://store.samhsa.gov/system/files/sma15-4426.pdf

[4] Center for Substance Abuse Treatment. Medication for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series No. 63. HHS Publication No. (SMA) 18-5063. Rockville, MD: Center for Substance Abuse Treatment, 2018. Retrieved from: https://medicine.yale.edu/edbup/quickstart/TIP_63_338482_42801_v1.pdf

Staffing

While MCOs must include one or more Medicaid-approved qualified provider type as the designated MOM case manager(s) in their staffing model (see below for eligible provider types); MCOs may enlist lay health workers, such as community health workers (CHWs) and Certified Peer Recovery Specialists (CPRSs), to support engagement and outreach activities. CHWs typically belong to the same communities as the individuals they serve and are a provider type that may be beneficial in improving the quality and cultural responsiveness of care.[5] Similarly, CPRSs offer non-judgmental, practical information for individuals with OUD and provide unique insights through their lived experiences.[6,7] Evidence demonstrates that utilization of peer recovery specialists and other paraprofessionals is a promising practice for continued engagement among individuals with OUD.[8] As an illustrative example, a CPRS could perform the following functions:

- Naloxone education and distribution;
- Referrals to community resources-ongoing, warm handoffs at discharge;
- Appointment reminders, follow up calls, and assisting with eliminating barriers to accessing care (*i.e.*, transportation, child care);
- Outreach to disengaged MOM model participants; and
- Accompany to clinician visits with MOM model participants.

With regard to staffing ratios, the Improving Mood: Providing Access to Collaborative Treatment (IMPACT) model utilized one full-time case manager for a caseload of 100-120 participants. IMPACT case managers include clinical social workers, master's level counselors/therapists, nurses, and psychologists.[9] Another, the Mental Health Integration Program (MHIP) had a typical caseload of 50-75 participants per one full-time case manager; however, larger caseloads were managed with support from community health workers. MHIP targets mental health and substance use conditions, and case managers include social workers and nurses.[10] The Collaborative Care Model (CoCM) varies the caseload per full-time case manager based on the target population characteristics. The CoCM has substantiated that a full-time case manager could have a lower caseload of 60-80 participants if they were Medicaid

[5] American Public Health Association. Community Health Workers. (n.d.). Retrieved from: https://www.apha.org/apha-communities/member-sections/community-health-workers

[6] Maryland Department of Health. Certified Peer Recovery Specialists. (n.d.). Retrieved from: https://bha.health.maryland.gov/Documents/CPRS%20Overview%20Guide_comms_030518.pdf

[7] Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). Partnering with patients and families to strengthen approaches to the opioid epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care.

[8] Ibid.

[9] Unützer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E., Harpole, L., Langston, C. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA, 288(22), 2836-2845.

[10] Vannoy, S., Mauer, B., Kern, J., Girn, K., Ingoglia, C., Campbell, J., Unützer, J. (2011). A Learning Collaborative of CMHCs and CHCs to Support Integration of Behavioral Health and General Medical Care. Psychiatric Services, 62(7), 753-758.

enrollees diagnosed with behavioral health conditions and had limited social supports. CoCM behavioral heath care managers include nurses, social workers, psychologists, and licensed counselors.[11,12]

MOM Model Provider Types and Staffing

Provider Types

The provider types that may provide case management and care coordination services in Maryland Medicaid for the MOM model are as follows: physician, physician assistant, nurse practitioner, nurse midwife, registered nurse, licensed clinical social worker, psychologist, certified professional counselor, and psychiatric nurse. It is important to note that Maryland Medicaid will begin reimbursing for CPRSs starting March 2023. CPRSs may provide secondary support to the client however they are not permitted to serve as a case manager.

Staffing Ratios

As described above, the Department identified several integrated health models to gain an understanding of an effective participant-to-case manager ratio. Findings from the review conducted determined that while ratios summarized for these cited models were higher than the Department's expectations for the MOM model, none of the models had the service delivery and care coordination activities that will be required for case managers to conduct on a monthly[13] basis. Due to this, MCOs should consider substantially lower staffing ratios to accommodate the case management level forecasted to ensure success of the model. It should also be noted that case management activities that will be required and outlined in this document represent a bundle of enhanced services different from those already offered to pregnant and postpartum MCO participants.[14,15]

Bridging the gap between primary care, behavioral health treatment, obstetric care, and other social service needs requires a dedicated full-time case manager. Each MCO should employ or contract with qualified case managers to render the services described in this document. The number of case managers per MCO needed to implement the MOM model depends largely on

[11] AIMS Center. Guidelines on Caseload Size for Behavioral Health Care Managers and Psychiatric Consults. University of Washington: 2017. Retrieved from: http://aims.uw.edu/sites/default/files/Behavioral%20Health%20Care%20Manager%20Caseload%20Guidelines_072120%20Final.pdf

[12] AIMS Center. Behavioral Health Care Manager. Retrieved from: http://aims.uw.edu/collaborative-care/team-structure/care-manager

[13] Unless otherwise stated, "month" refers to a "calendar month".

[14] COMAR 10.67.06.21: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.06.21.htm

[15] COMAR 10.67.04.08: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.04.08.htm

the number of eligible participants within each MCO. The Maryland MOM model proposes having a ratio of one MOM case manager per 30 MOM model participants (1:30) due to the substantial amount of care coordination and associated tasks required by MOM case managers to fulfill the requirements of the MOM model (outlined below) and to adequately address the myriad social and health needs for this vulnerable population.

Additionally, while MCOs are charged with providing the MOM model enhanced case management and care coordination services described in this document, MCOs may choose to partner with other entities, such as LHDs, to provide the MOM services on the MCOs' behalf.

Case Management Workflow - Associated Tasks and Timeline

MOM case managers will need to conduct certain tasks throughout a participant's engagement in the model and ensure the fulfillment of model requirements within a timely manner to receive PMPM payments.

It is imperative that MOM case managers document all MOM related tasks within the MOM Care Coordination Module (CCM), hosted by CRISP, in addition to documentation that would normally occur separately within their native electronic health record (EHR). MOM case managers will need Wi-Fi or cellular access to use the CCM, a web-based portal. Continually updating this information for all assigned MOM model participants within the MOM CCM, on at least a monthly basis by the final day of the month, will be vital for MCOs to receive PMPM payments. Documentation within the MOM CCM will also play an essential role in the monitoring and evaluation to measure the impact of MOM services. Please use this guide as a reference for associated tasks to be completed during the phases of participant engagement and the timeline to ensure compliance with the model. This document may be updated periodically with supplementary tasks (*e.g.,* screening requirements) as needed.

Pre-Enrollment: Referral Pathways and Eligibility Screening

- MCOs identify potentially eligible participants through the following avenues and forward referrals to MOM case managers:
    - *No wrong door referral from other agencies: LHDs, LBHAs, law enforcement, EDs, somatic and BH providers, DHS*
    - Screening, Brief Intervention and Referral to Treatment (SBIRT)
    - Maryland Prenatal Risk Assessment (MPRA)
    - MCO data mining and enrollment screening
    - Referral from the BH ASO
    - Referral from a community-based organization (CBO)

    - See also: Participant Engagement Strategies Brief
- MOM case managers receive referrals and contact identified potential participants to verify interest and confirm clinical eligibility (See Appendix A for an Eligibility Checklist)
    - Current MD state resident residing in a MOM service area
    - Current HealthChoice member
    - Currently pregnant (cannot enroll postpartum)
    - OUD Diagnosis - Must have a formal OUD diagnosis, at any point in participant's medical history, have responded positively to opioid use on the MPRA or be willing to attest to a current or previous history of OUD[16] before the participant enrolls into the model. (See Appendix B for additional guidance.)
- Schedule an intake appointment (preferably in-person)
    - Review approximate length of appointment and what to expect during session
    - In-person intake appointments could occur in the following locations, according to participant preference: MOM model participants' residence; private rooms in the local library; local health department; housing shelter or temporary housing (*e.g.*, motels); pregnancy centers; clinician offices; parks; unhoused encampments, or other locations as agreed upon by MOM participant and MOM case manager.
- Coordinate with the BH ASO to confirm Part 2 Release of Information completion

Participants must be enrolled during pregnancy prior to delivery as one aspect of eligibility. As part of a strategy for identifying participants, a goal of the MOM model will be to increase both the amount of MPRAs completed by providers in a timely manner as well as streamline the routing of MPRAs via ACCUs to MCOs to assist with identifying pregnant beneficiaries with OUD earlier in their pregnancy. Due to claims lag, the Department encourages MCOs to identify innovative ways other than data mining to identify and recruit potentially-eligible participants on the front-end as part of their staffing plans for the MOM model. If data mining is warranted, the following HCPCS codes are specifically related to prenatal care: H1000 and H1003. Please note the identification and use of these codes may not be a reliable method for identifying potentially eligible participants in a timely manner. Other approaches should be exhausted first.

It is important to note that, although the MOM model encourages participants to seek or maintain treatment for OUD, engagement in treatment is not a prerequisite for model eligibility and enrollment. Additionally, participants are welcome to continue in the model even if, over the course of their participation, they no longer have their infant for reasons such as adoption, CPS involvement and fetal demise.

[16] Self-attestation along with documented OUD screening will satisfy formal OUD diagnosis. This documentation must be captured in MOM CCM

To be considered eligible to participate in the MOM model, participants must have an OUD diagnosis before enrolling into the MOM model. To ascertain an OUD diagnosis, MCOs must look in their data for history of OUD-related codes for the potential participant; if no history is found, MCOs may consult with the BH ASO to look in its data. Appendix C outlines a list of ICD-9 and ICD-10-CM codes that constitute an OUD diagnosis for the purposes of the MOM model. The Department also accepts positive responses to the opioid use question on the MPRA as an OUD diagnosis for purposes of MOM model eligibility.

If a potential participant does not have a claims history or MPRA response that indicates an OUD diagnosis, MOM case managers will be advised to coordinate with the potential participant for a verbal self-attestation of current or previous history of OUD before enrolling into MOM model services. The self-attestation process is meant to address barriers to enrolling participants in a timely manner. MCOs may proceed to setting up an intake appointment while simultaneously following the search procedures to verify or confirm a claims history of OUD on these participants. MCOs will need to document attempts to identify OUD diagnosis - in managed care encounters and behavioral health claims - in the MOM CCM by the time of enrollment following the guidance outlined below for these participants.[17]

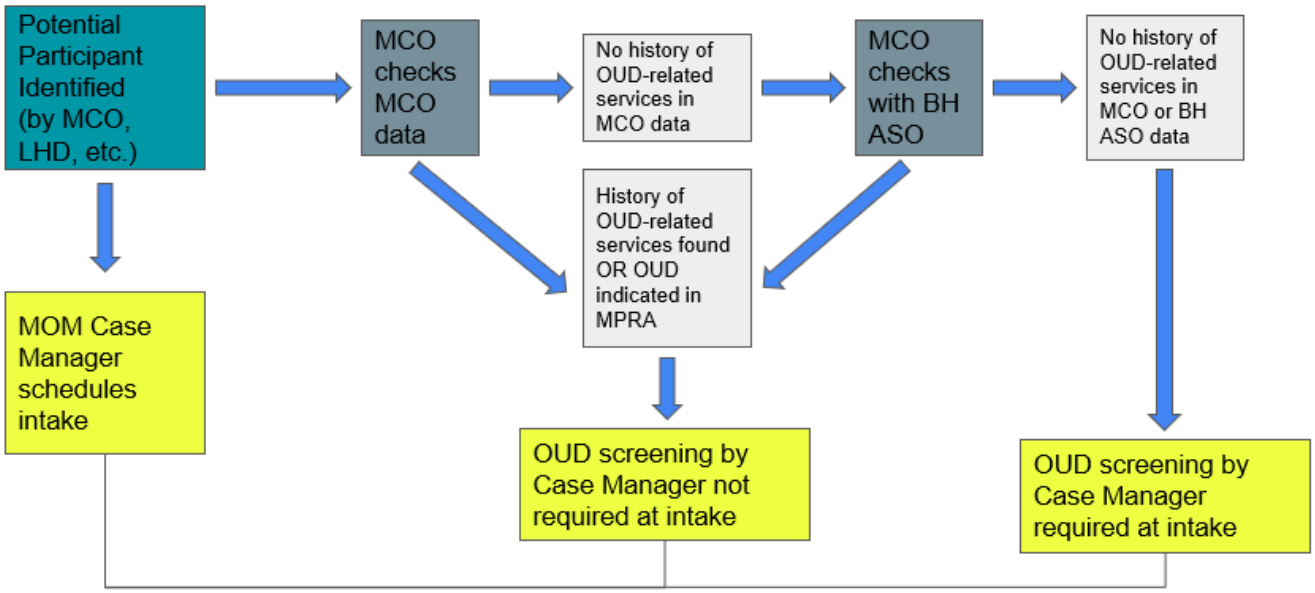
In the case that self-attestation is required, MOM case managers should administer the OUD screening tool (see Appendix B) with participants who self-report their OUD and document date screening was administered and level of severity to satisfy the formal OUD diagnosis requirement. In addition, if a MOM case manager is clinically licensed to provide a diagnosis, they should record that information into the MOM CCM, according to the clinical OUD diagnosis indicators in Appendix C.

Case managers may opt to conduct the self-attestation with participants upon intake, as it may help to indicate level of opioid use and inform the care planning process.

Figure 1 below displays the pre-enrollment workflow.

Figure 1. Pre-Enrollment Workflow

[17] Dates MCO checked their system and coordinated with Optum to verify OUD would be documented in the Medications and clinical conditions field of the MOM CCM intake form until an Other section can be built out in future enhancements



MCOs must also engage with the BH ASO and check for Part 2 release of information (ROI) to assist in verifying a participant's clinical eligibility during the pre-enrollment screening process. The BH ASO will collaborate with MOM case managers to ensure Part 2 ROIs are obtained for consenting MOM participants.

Table 1 below depicts a high-level summary of associated tasks and expectations throughout a participant's participation in the model. Additional detail follows the table.

Table 1. Case Management Workflow Timeline

	Pre-enrollment	**Intake**	**Ongoing Enrollment**				**Substantial outreach**	**Discharge**
Associated Activities	Enrollment Month 0/Referral	Initial Visit/ Enrollment Month 1	Enrollment Month 2	Enrollment Months 3-8 (Third Trimester)	Postpartum (up to 60 days)	60 Days Postpartum- Infant's 1st birthday	Anytime/Multiple Periods of up to 2 Months	Final Enrolled Month
Screenings	Confirm interest and clinical eligibility: Maryland resident, HealthChoice member, pregnant, formal OUD diagnosis (or self-attestation)	All required intakes, **HRSN(** incl. required alcohol screening), **Edinburgh**		*During third trimester:* **HRSN** (incl. required alcohol screening), Edinburgh Only re-administer these screenings if member enrolled prior to third trimester	**HRSN** (incl. required alcohol screening), **NIDA ASSIST SUD**	Every 3 months- **HRSN** (incl. required alcohol screening), Edinburgh	N/A	**HRSN** (incl. required alcohol screening), Edinburgh
Monthly in-person visits/contact	Schedule intake appointment Contact BH ASO to confirm Part 2 ROI completion		All Core Components	All Core Components	All Core Components (including providing naloxone post-delivery check-in)	All Core Components	At least 3 outreach attempts with two different methods, up to 2 months	All Core Components
Care plan and documentation	Document intake appointment date/time	New case development MOM CCM, Goal Creation (2-3 goals)	Goal Check In, MOM CCM documentation	Goal Check In, MOM CCM documentation	Goal Check In, MOM CCM documentation	Goal Check In, MOM CCM documentation	Document dates and outreach methods in MOM CCM	Review Goals, provide linkages, document activities and update discharged status in MOM CCM and send care alert

	Pre-enrollment	Intake	Ongoing Enrollment				Substantial outreach	Discharge
Associated Activities	Enrollment Month 0/Referral	Initial Visit/ Enrollment Month 1	Enrollment Month 2	Enrollment Months 3-8 (Third Trimester)	Postpartum (up to 60 days)	60 Days Postpartum- Infant's 1st birthday	Anytime/Multiple Periods of up to 2 Months	Final Enrolled Month
MOM Participant responsibilities	Answer OUD Dx screening (if applicable) and eligibility questions, confirm Medicaid ID, and sign Part 2 ROI (if outstanding)	Sign MOM Acknowledgement Form Have at least 1 BH or somatic visit	Have at least 1 BH or somatic visit	Have at least 1 BH or somatic visit	Have at least 1 BH or somatic visit	Have at least 1 BH or somatic visit	N/A	Have at least 1 BH or somatic visit

During Intake: First Month of MOM Participation

- MOM Acknowledgement Form
    - Explain program requirements and participant rights to voluntarily participate and withdraw, and answers any questions participants raise
    - Collect participant signature for MOM Acknowledgement Form and any other intake forms in addition to those required by the MOM model
- Initial Care Plan
    - Develop jointly during intake session
    - Confirm/collect participant contact information, denote preferred contact method, and emergency/secondary contacts
    - Confirm/collect information on all providers participant is currently under the care of and their contact information
    - Identify 2-3 goals based on participant identified areas of need, to be reviewed during every monthly meeting and updated as needed
- Screenings that must be completed within 7 days of model enrollment (The Department recommends these be conducted during the initial intake visit, as all components are required to enroll participants into the model and results of these screenings may influence the care plan.) (See Appendices C and D for additional detail.)
    - *HRSN screening* – Administer MOM model adapted AHC screening tool located within CRISP; domain-level results need to be recorded in the MOM CCM.
    - Depression and Anxiety screening – Administer Edinburgh assessment via separate document; result needs to be recorded in the MOM CCM.
    - *Alcohol screening* – captured through the HRSN screening tool; result needs to be recorded in the MOM CCM.
    - *Required Intake Questions* – administered by the MOM case manager to fulfill data collection requirements; the MOM CCM includes questions to be asked at intake.
    - *OUD screening* – required only for participants who self-attest their OUD, using the screening provided in Appendix B of this case management manual. Based on DSM-V criteria, specify if level of severity is mild, moderate, or severe and if in remission.
- Care coordination activities
    - Provide referrals based on identified areas of need
    - Ensure needed medical appointments are made for the upcoming month, such as prenatal care visits and specialty behavioral health care visits
    - Coordinate care and establish and/or increase communication between/among participant's providers across systems of care, including with the BH ASO's care coordinators, as needed

- Documentation
    - Create new case in MOM CCM for the participant and populate.
    - Log into CRISP ULP and access the patient snapshot where participants' providers and clinical conditions are captured and add relevant information.
    - Indicate that informed consent has been signed in Care Coordination Module
    - Save a hard copy of the signed consent, outside data template and Edinburgh assessment and OUD (if participant self-attests) screenings in a secure place
        - Note: The Edinburgh Assessment will be linked via PDF within the CCM but will also need to be administered and stored outside of the CCM.
    - Document completed tasks into the module (consent, initial MOM care plan, screenings provided, contact information, care team, patient visit and contact type)
    - If participant must self-attest to OUD: Document dates of MCO and ASO verification checks, date OUD screening tool administered and level of severity of OUD
        - Note: OUD screening will be stored outside of the CCM. All documentation related to this screening will be documented in the Medications & Clinical Conditions section of the MOM Initial Care Plan until otherwise specified.

During Enrollment: Second month of MOM participation through 60 days postpartum

Participants will be engaged in MOM model services from the time of enrollment up to the infant's first birthday so long as the MOM model participant remains enrolled in Medicaid and continues to meet the following requirements to be considered active.

Requirement 1: Monthly Case Management Visits and Model Requirements

On a monthly basis, MOM case managers will be expected to fulfill each of the five core components of the Maryland MOM model in, at a minimum, the following ways:

1. Comprehensive Case Management
    - Initial needs assessment and SDOH screening
    - Development and periodic reassessment of MOM care plan
    - Supportive shared decision-making process to understand and select from the landscape of health-related social needs resources
2. Care Coordination
    - Appropriate linkages to somatic and behavioral health providers as identified within care plan for the MOM model participant
    - Following up on needed services and supports
    - Serving as the established MOM case manager for different providers and CBOs serving the MOM model participant
3. Health Promotion

- Discussing recurrence of symptoms and creating a safety plan
  - Providing naloxone to the participant and educating friends/family on use of naloxone
- Providing literature on Maryland Crisis Connect
  - Available 24/7 to people in need of crisis intervention, risk assessment for suicide, overdose prevention, support, guidance and information or linkage to community behavioral health providers
- Discussing options for family planning
- Nutritional counseling
- Wellness programs
- Education about STIs and other infectious diseases; e.g., viral hepatitis and HIV/AIDS Preventive healthcare education
- Assisting with medication adherence
- Educating family regarding appropriate infant developmental milestones and healthy attachment behaviors

4. Individual and Family Supports
   - With participant permission, involving partner and/or family in care activities
   - Training family about the role of recurrence of use and use of naloxone
   - Connecting families and children with needed supports such as parenting classes or family counseling
5. Linkages to Community and Support Services
   - Connecting participants to resources related to the SDOH screening by completing warm handoffs with programs embedded in LHDs as well as LBHAs and CBOs, such as disability benefits, social services, SUD treatment, housing, legal services, life skills training and educational/vocational training and using CRISP's envisioned referral and community resources platform

The MOM case manager will be responsible for at least one case management encounter per month. If conducting MOM case management via telehealth, the MOM case manager must document how they fulfilled each case management core components in the Care Coordination Module under the 'Monthly Contact' tab, by adding the date that each core component was addressed, plus a description in the text box. If a particular core component was not appropriate for a given month, the case manager must document the reason for not providing it.

Requirement 2: Monthly Health Service Utilization

MOM case managers will need to ensure MOM model participants receive at least one behavioral health and/or somatic health visit each month in addition to conducting monthly case management contacts. Examples of behavioral health and somatic health visits are included in Table 1 below.

Table 2. Qualifying Monthly Visits, by Behavioral and Somatic Health Categories

Behavioral Health Visits	Somatic Health Visits

Alcohol and/or drug assessment	Primary Care
SBIRT	Specialty Care
Individual Therapy and/or Group Therapy	Federally qualified health center (FQHC) or other clinic services
Family psychotherapy and psychoeducation	Family Planning
Medication Management	Dental services for pregnant individuals through date of delivery
Opioid maintenance therapy for individuals 18 years or over	Habilitation Services for Expansion Populations: (1) Physical therapy; (2) Occupation therapy; and (3) Speech therapy
Intensive Outpatient (ASAM Level 2.1)	OB/GYN Care- Prenatal, perinatal, and postpartum care visits
Partial Hospitalization (ASAM Level 2.5)	Labor and Delivery services
Ambulatory Detox	Newborn Care and Well Child visits

*Please note that provision of MOUD does not qualify as a behavioral health visit under the MOM model.

Periodic Re-assessments of Screenings and Care Plan

To identify early recurrence of use and prevent fatal overdose, MOM case managers will screen participants for both postpartum depression as well as SUD. Please refer to Appendix D for the frequency of re-assessments for each screening.

Documentation

- Document completed tasks into the module (re-assessment of participant goals and indicated barriers, screenings provided (including an indication substance use screening was administered postpartum), contact information, care team, patient visit and contact type)
- Store outside, SUD, and Edinburgh screenings in a secure location
- Document model core elements provided during visits including health promotion activities surrounding screening for SUD and naloxone distribution provided after delivery
- Document any contact attempts and type of outreach made when participant misses appointments and case management visits

During Enrollment: 60 days postpartum through infant's first birthday

Enhanced MOM model case management services will continue until the end of the month of infant's first birthday, unless the MOM participant elects to leave the model early.

Monthly CM Visits and Model Requirements

- MOM case managers will still need to ensure they are providing monthly case management visits and fulfilling the five core elements for the remainder of the participant's time in the MOM model. MOM case managers will need to ensure MOM model participants receive a minimum of one behavioral health or somatic health visit each month in addition to conducting monthly case management contacts.

Re-assessments of Screenings and Care Plan

- *Care Plan* – Re-assess participants needs and goals and revisit care plan on a monthly basis and update goals as needed
- *HRSN Tool* – Re-administer screening after 60 days postpartum every three months or as needed. Administered a final time during the last month of a participant's enrollment
- *Required Postpartum Questions* – administered by the MOM case manager to fulfill data collection requirements; the MOM CCM includes questions to be asked within 60 days of the postpartum period

Documentation

- Document tasks into the MOM CCM (consent, re-assessment of participant goals and indicated barriers, screenings provided, contact information, care team, patient visit and contact type)
- Store Edinburgh assessment screening in a secure location
- Document model core elements provided during visits
- Document any contact attempts and type of outreach made when participant misses appointments and CM visits

Disengaged Participants and Outreach Process

Multiple periods of up to two months if MOM model participants are lost to follow-up

Substantial outreach is a specific protocol for re-engaging MOM model participants that MOM case managers will follow in the event that MOM model participants become disengaged from care (e.g. miss a doctor's appointment or miss a monthly MOM case manager contact). With documentation logging the date and type of each contact attempt described in additional detail below, MCOs will receive a PMPM payment for providing substantial outreach for disengaged beneficiaries for up to two months. There are a variety of loss-to-follow-up activities that the Department will accept to continue the PMPM payment.

Highlight: Enrolled MOM participants who enter inpatient treatment

If an already-enrolled MOM participant enters inpatient treatment for a month or longer—and case management activities are not possible—MCOs are not eligible for PMPM payments for that month. Upon discharge, MOM participants may continue in the model without needing to re-perform intake activities but may conduct re-assessments to inform an updated care plan.

MOM case managers will need to follow outreach guidelines for enrolled participants when they first become disengaged from services. Before transitioning a participant to the substantial outreach phase of participation, MOM case managers will need to make three contact attempts, to be logged in CRISP-based care coordination module:

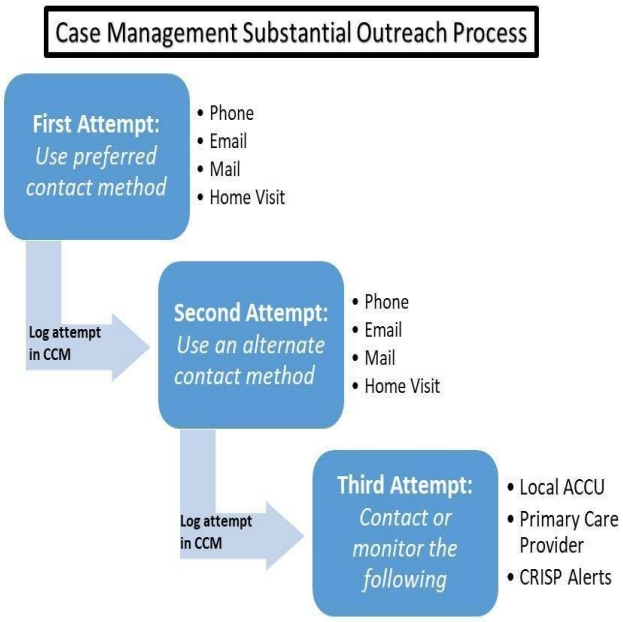
- First attempt using preferred method of contact as identified in the Maryland Health Connection
- Others may include phone, email, mail and home drop by visits

If participants can still not be re-engaged after following the above procedures, they will be considered lost to follow-up and provided two months' worth of substantial outreach. Potential outreach strategies may include the following:

- Use Healthy Families America and Nurse-Family Partnership home visiting model protocols;
- Contacting participants' family members, friends, partners, and emergency contacts via phone multiple times at different times of day;
- Sending mail correspondence to the participant's home or listed addresses;
- Deploying assigned MOM case manager or other assigned care plan team members (*i.e.,* CPRSs and/or CHWs) to the participant's home and/or community, including on evenings or weekends;
- Contacting participant's primary care provider and other providers to assist with reengagement;
- Connecting with local ACCUs or other connected departments and community programs participant is involved with (i.e. DPSCS; DHS);
- Monitoring CRISP hospital utilization alerts to check inpatient admissions and emergency encounters; and
- Log three attempts at minimum per month into the care coordination module. The three attempts should be at least two different types of follow-up, such as two phone calls and one letter in the mail. The third attempt could also involve other systems as demonstrated in the following visual.
- See also: Participant Engagement Strategies Brief

To qualify for a PMPM payment, substantial outreach activities must be conducted and documented during each month, for multiple periods of up to two consecutive months.

Figure 2. Case Management Substantial Outreach Process by Month



Discharge Planning

Last month before infant's first birthday or at case closure[18]

- Conduct final case management visit, providing the five core model components
  - Linkages (wrapping up connecting MOM model participant to social needs)
  - Health promotion (*e.g.,* providing naloxone; family planning materials)
  - Care coordination and warm handoffs
- Assess outstanding needs
  - *Care Plan* – Review developed goals, determine areas that may need continued support, and provide a discharge plan to participant upon the end of services
  - *HRSN Tool* – Final screening and referrals
  - *Depression and anxiety screening* – Provide linkages to ongoing supports if positive screening
- Documentation
  - Document all tasks and relevant screenings into the MOM CCM
  - Store any outside forms collected and Edinburgh assessment in a secure location
  - Indicate status of MOM enrollment and notate if participant was discharged due to loss to follow-up or if they completed services

[18] Discharge planning activities do not need to be completed if a MOM model participant is being discharged due to reasons other than completing services such as loss to follow-up. Ensure all outreach attempts are logged into the module and follow only the documentation section in these instances.

- Submit care alert indicating participant is no longer active

Appendix A: Eligibility Checklist for MOM Model Enrollment

For use by MOM case managers as needed to confirm clinical eligibility for potential participants before enrolling them in the MOM model.

- Confirm participant is a Maryland state resident
- Confirm participant is a current HealthChoice member
- Confirm participant pregnancy status is current
- Confirm participant has an Opioid Use Disorder diagnosis
  - Check historical records of MCO claims (see Appendix B in the Case Management Manual for ICD-9 and ICD-10 codes) ***or***
  - If not confirmed through MCO claims, engage in the BH ASO to confirm OUD diagnosis through BH ASO data ***or***
  - If not confirmed through either MCO or ASO data, OR indicated in the Maryland Prenatal Risk Assessment (MPRA), administer the OUD screening during intake (see Appendix B in the Case Management Manual for DSM-V criteria) and document in MOM CCM the following information:
    - Dates of data checks by MCO and BH ASO;
    - Date OUD screening tool administered
    - Level of severity of OUD
- Confirm with the BH ASO completion of the Part 2 Release of Information
  - If not completed, collaborate with the BH ASO to have the ROI signed
  - If refusal to sign, please contact the MOM team at MDH

Appendix B: OUD Diagnosis Criteria for Self-Report of History with OUD

These criteria should be applied for potential MOM participants who do not have a clinical history of an OUD diagnosis or have indicated opioid use in the Maryland Prenatal Risk Assessment. Complete screening tool and document level of severity into the MOM CCM. If clinically licensed to provide a diagnosis, MOM case managers should see Appendix C for clinical diagnosis codes.

DSM-V Criteria for Diagnosis of Opioid Use Disorder[19]

Diagnostic Criteria A. A problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12 month period:	
Check all that apply	
	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous.
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome

[19] Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

	(b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number of Boxes Checked: _____

Severity:

- **Mild:** 2-3 symptoms
- **Moderate:** 4-5 symptoms
- **Severe:** 6 or more symptoms

Specify if:

In early remission: After full criteria for OUD were previously met, none of the criteria for OUD have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

In sustained remission: After full criteria for OUD were previously met, none of the criteria for OUD have been met for at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use opioids," may be met).

Appendix C. OUD ICD-9 and ICD-10 Diagnosis Codes and Description

ICD-9 codes included, as the MOM model does dictate a historical timeline for OUD diagnosis without constraints to when a diagnosis occurred.

Code and Description	
ICD-9-CM codes	**Description**
30400	Opioid type dependence, unspecified
30401	Opioid type dependence, continuous
30402	Opioid type dependence, episodic
30403	Opioid type dependence, in remission
30470	Combinations of opioid type drug with any other drug dependence, unspecified
30471	Combinations of opioid type drug with any other drug dependence, continuous
30472	Combinations of opioid type drug with any other drug dependence, episodic
30473	Combinations of opioid type drug with any other drug dependence, in remission
30550	Opioid abuse, unspecified
30551	Opioid abuse, continuous
30552	Opioid abuse, episodic
ICD-10-CM codes	**Description**
F111	Opioid abuse
F1110	Opioid abuse, uncomplicated
F1112	Opioid abuse with intoxication
F112	Opioid dependence
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F1122	Opioid dependence with intoxication
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood Disorder
F1128	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F11921	Opioid use, unspecified, with intoxication Delirium
F1194	Opioid use, unspecified with opioid-induced

	mood disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication, unspecified
F1114	Opioid abuse with opioid-induced mood disorder
F1115	Opioid abuse with opioid-induced psychotic disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F1118	Opioid abuse with other opioid-induced disorder
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1125	Opioid dependence with opioid-induced psychotic disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F119	Opioid use, unspecified
F1192	Opioid use, unspecified with intoxication
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal

F1195	Opioid use, unspecified with opioid-induced psychotic disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F1198	Opioid use, unspecified with other specified opioid-induced disorder
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder

Appendix D. Screenings Frequency and Approach

Table D1. Overview

	Approach	Intake	90 Days	Third Trimester	Postpartum
HRSN	Modified AHC tool	X		X	X
Depression/ Anxiety	**Edinburgh**	X		X	X
Alcohol	Embedded in HRSN	X		X	X
SUD	NIDA-Modified ASSIST				X
Self-Report	Embedded in MOM CCM Screens	X		X*	X

*If not captured at intake.

Health-Related Social Needs (HRSN)

Administer modified Accountable Health Communities HRSN Tool accessed via CRISP.

***Timing*:** Administered within 7 days of model enrollment, a second time during the participant's third trimester, then a third time after the end of pregnancy within 60 days postpartum. Subsequent screenings administered every three months or as needed for participants who continue to be enrolled in Medicaid.

Depression/Anxiety

Captured using the Edinburgh assessment.

***Timing*:** Administered within 7 days of model enrollment, at least once during the first trimester (if participant is enrolled in the model at this time), at least once during the third trimester, and at the end of pregnancy within six weeks postpartum (or at first postpartum visit).

Alcohol

Capture through HRSN screening tool.

***Timing*:** Administered at a minimum within 7 days of model enrollment, during the participant's third trimester, and after the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid.

SUD (NIDA-Modified ASSIST)

Administered through the NIDA-Modified ASSIST screening tool (stored separately), document completion and any interventions offered as a result of the participant's score into Care Coordination Module.

***Timing*:** Administered once within 60 days after the end of pregnancy.

Self-Report Questions

Administered by the MOM case manager, document for data collection purposes.

Timing: Administered as part of intake screen, as well as postpartum in an ongoing screen, both of which are located in the CCM .

Appendix E: Health-Related Social Needs, Depression, Anxiety, Self-Report Questions and SUD Screenings

Health-Related Social Needs

(Accessed via CRISP)

Question	Response
Domain: Living Situation	
What is your living situation today?	I have a steady place to live
	I have a place to live today, but I am worried about losing it in the future
	I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Pests such as bugs, ants, or mice
	Mold
	Lead paint or pipes
	Lack of heat
	Oven or stove not working
	Smoke detectors missing or not working
	Water leaks
	None of the above
Domain: Food	
Some people have made the following statements about their food situation. Please answer whether these statements were OFTEN, SOMETIMES OR NEVER true for you and your household in the last 12 months. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true
	Sometimes true
	Never true
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true
	Sometimes true
	Never true

Domain: Transportation	
In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?	Yes
	No
Domain: Utilities	
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes
	No
	Already shut off
Domain: Safety ** A score of 11 or more when the numerical values for answers to the following questions posed in this domain are added indicates a positive result that the person might not be safe.*	
Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions. How often does anyone, including family and friends, physically hurt you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, insult or talk down to you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, threaten you with harm?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, scream or curse at you?	Never (1)
	Rarely (2)
	Sometimes (3)

	Fairly often (4)
	Frequently (5)
Domain: Financial Strain	
How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is…	Very hard
	Somewhat hard
	Not hard at all
Domain: Employment	
Do you want help finding or keeping work or a job?	Yes, help finding work
	Yes, help keeping work
	I do not need or want help
Domain: Education	
Do you speak a language other than English at home?	Yes
	No
Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	Yes
	No
Domain: Substance Use ** Additional questions may be added pending CMMI requirements and other new data elements. Please refer separately to SUD screening during the postpartum period to monitor for risk and provide health education.*	
During the last month, how many alcoholic drinks did you have in an average week? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.	I Didn't Drink in the Last Month
	Less than 1 Drink a Week
	1 to 3 Drinks a Week
	4 to 7 Drinks a Week
	8 to 13 Drinks a Week
	14 Drinks or More a Week
	Did Not Answer/Unknown

How many times in the past 12 months have you used tobacco products (not including electronic cigarettes)?	Never
	Once or twice
	Monthly
	Weekly
	Daily or almost daily
On average, how many cigarettes do you smoke per day?	(free text)
Domain: Mental Health ** Note: The AHC mental health questions are equivalent to the PHQ-2 depression screening. To meet the MOM depression screening requirement, if a MOM participant initially screens positive (3 or above on the first two questions posed in this section), MOM case managers will conduct the full PHQ-9 with the participant. After completing this section, please administer and score the GAD-7 separately.*	
Over the past 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things?	Not at all (0)
	Several days (1)
	More than half the days (2)
	Nearly every day (3)
Feeling down, depressed, or hopeless?	Not at all (0)
	Several days (1)
	More than half the days (2)
	Nearly every day (3)
Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?	Not at all
	A little bit
	Somewhat
	Quite a bit
	Very much
Domain: Family and Community Support	

If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?	I don't need any help
	I get all the help I need
	I could use a little more help
	I need a lot more help
How often do you feel lonely or isolated from those around you?	Never
	Rarely
	Sometimes
	Often
	Always
Domain: Maternal Child Health	
Who can you count on for help/support during this pregnancy?	(Free text)
Who can you talk to about stressful things in your life?	(Free text)
Do you need daycare for your child?	Yes
	No
If yes, would you like help finding it?	Yes
	No
	Maybe later

Depression/Anxiety

Edinburgh Postnatal Depression Scale (EPDS)

Patient Label

Mother's OB or Doctor's Name:

Doctor's Phone #: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time __✔__ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶

Thank you for completing this survey. Your doctor will score this survey and discuss the results with you.

Verbal consent to contact above mentioned MD witnessed by:

_____

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long term effects on the family.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the "blues" (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Patient Label	OB de la madre o el nombre del médico Número de teléfono del médico

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:
Sí, todo el tiempo ____ 0
Sí, la mayor parte del tiempo ✔ 1
No, no muy a menudo ____ 2
No, en absoluto ____ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:
   Tanto como siempre he podido hacerlo ____ 0
   No tanto ahora ____ 1
   Sin duda, mucho menos ahora ____ 2
   No, en absoluto ____ 3

2. He mirado al futuro con placer para hacer cosas:
   Tanto como siempre ____ 0
   Algo menos de lo que solía hacerlo ____ 1
   Definitivamente menos de lo que solía hacerlo ____ 2
   Prácticamente nunca ____ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   Sí, casi siempre ____ 3
   Sí, algunas veces ____ 2
   No muy a menudo ____ 1
   No, nunca ____ 0

4. He estado ansiosa y preocupada sin motivo alguno:
   No, en absoluto ____ 0
   Casi nada ____ 1
   Sí, a veces ____ 2
   Sí, muy a menudo ____ 3

5. He sentido miedo o pánico sin motivo alguno:
   Sí, bastante ____ 3
   Sí, a veces ____ 2
   No, no mucho ____ 1
   No, en absoluto ____ 0

6. Las cosas me oprimen o agobian:
   Sí, la mayor parte del tiempo no he podido sobrellevarlas ____ 3
   Sí, a veces no he podido sobrellevarlas de la manera ____ 2
   No, la mayoría de las veces he podido sobrellevarlas bastante bien ____ 1
   No, he podido sobrellevarlas tan bien como lo hecho siempre ____ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   Sí, casi siempre ____ 3
   Sí, a veces ____ 2
   No muy a menudo ____ 1
   No, en absoluto ____ 0

8. Me he sentido triste y desgraciada:
   Sí, casi siempre ____ 3
   Sí, bastante a menudo ____ 2
   No muy a menudo ____ 1
   No, en absoluto ____ 0

9. Me he sentido tan infeliz que he estado llorando:
   Sí, casi siempre ____ 3
   Sí, bastante a menudo ____ 2
   Ocasionalmente ____ 1
   No, nunca ____ 0

10. He pensado en hacerme daño:
    Sí, bastante a menudo ____ 3
    A veces ____ 2
    Casi nunca ____ 1
    No, nunca ____ 0

Total Score: _____

Consentimiento verbal para contacto arriba mencionado MD presenciada por:

_____

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry,* Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items 3, 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals in detecting mothers suffering from postpartum depression (PPD); a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery), but less severe than puerperal psychosis.

Previous studies have shown that PPD affects at least 10 percent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of 10 short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother felt during the previous week, and in doubtful cases it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

INSTRUCTIONS FOR USERS

1. The mother is asked to underline the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at six to eight weeks to screen postnatal women or during pregnancy. The child health clinic, postpartum check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Substance Use Disorder

NIDA-Modified ASSIST V2.0[20]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- If the patient indicates that the drug used is not listed, please mark '**Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.** If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

[20] The NIDA Quick Screen was adapted from a single-question screen for drug use in primary care by Smith et al. 2010 and the National Institute on Alcohol Abuse and Alcoholism's Helping Patients Who Drink Too Much: A Clinician's Guide Updated 2005 Edition. The NIDA-Modified ASSIST (NM ASSIST) was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

Question 2 of 8, NIDA-Modified ASSIST 2. <u>In the past three months</u>, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

<u>In the past 3 months</u>, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Nev	On Tw	Mon	Wee	Dail Dai
Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
Cocaine (coke, crack, etc.)	0	3	4	5	6
Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6

Street Opioids (heroin, opium, etc.)	0	3	4	5	6
Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
Other – Specify:	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

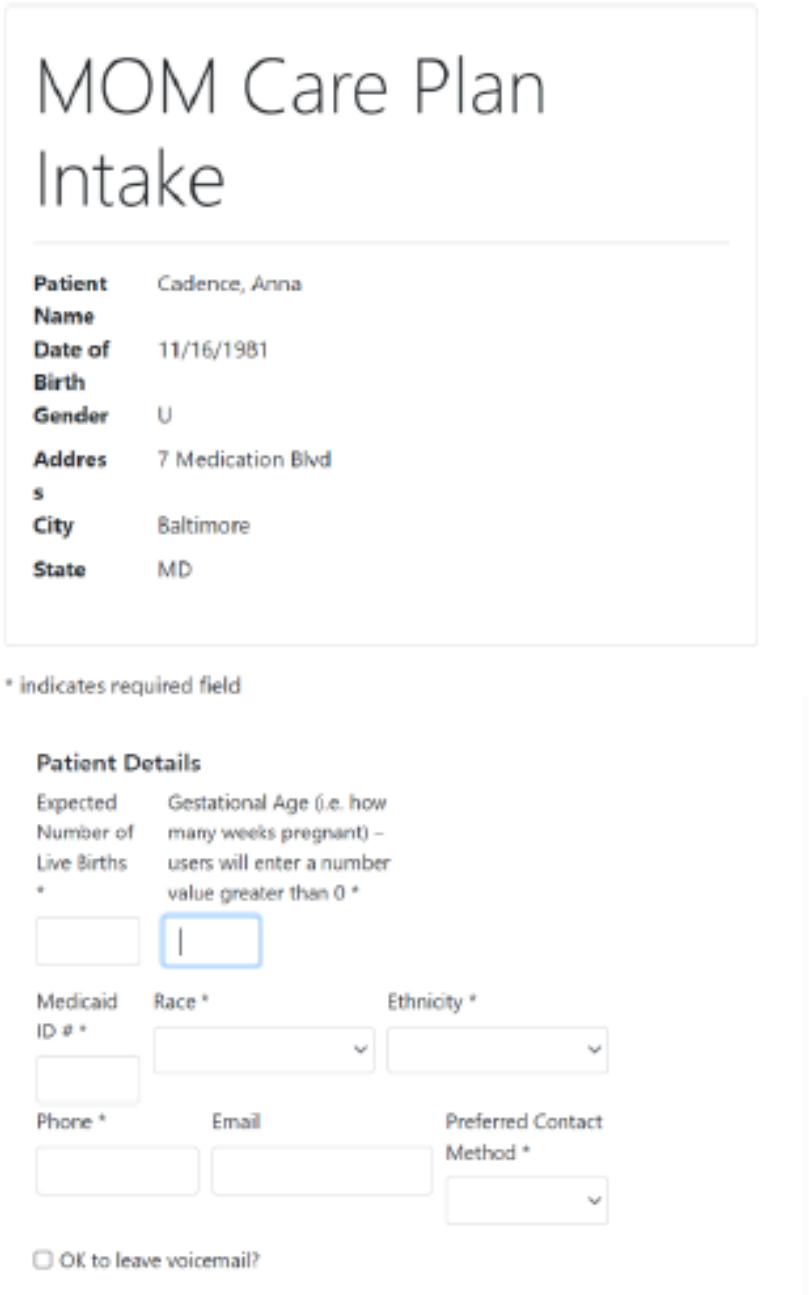
Substance Involvement Score	Total (SI SCORE)
Cannabis (marijuana, pot, grass, hash, etc.)	
Cocaine (coke, crack, etc.)	
Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
Methamphetamine (speed, crystal meth, ice, etc.)	
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
Street Opioids (heroin, opium, etc.)	
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
Other – Specify:	

To determine patient's risk level based on his or her SI Score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

Appendix F: MOM Care Coordination Module Screenshots

Intake Screen



Emergency Contact

Name *

Phone *

Consent

Date Completed *

mm/dd/yyyy

Enrollment

Enrollment Date *

mm/dd/yyyy

Assessment Completed *

mm/dd/yyyy

Managed Care Organization

MCO *

Case Manager

Name *

Phone *

Email *

Medications & Clinical Conditions

Screenings

SDOH *

Date Completed

mm/

Need Indicated

(Please check all that apply)

- ☐ Living Situation
- ☐ Food
- ☐ Transportation
- ☐ Utilities
- ☐ Safety
- ☐ Indicated Financial Strain
- ☐ Employment
- ☐ Education
- ☐ Substance Use
- ☐ Mental Health
- ☐ Family and Community Support
- ☐ Maternal Child Health

Depression/Anxiety *

Date Completed

mm/

Depression/Anxiety Screening Result *

Please note that for the Edinburgh Screening, a score of 10 or greater indicates possible anxiety/depression. If the participant scores lower than a 10 but you feel they meet the criteria, please select "Yes" for the question "Depression/Anxiety?" and indicate the actual score under "Depression/Anxiety Screening Results

Alcohol *

Date Completed

mm/

Participant Goals & Identification of Barriers

Goal 1 *

Barriers to goal

- [ ] Lack of transportation
- [ ] Travel time
- [ ] Lack of childcare
- [ ] Provider Shortage
- [ ] Low health literacy
- [ ] Lack of timely access to care
- [ ] Limited appointment availability
- [ ] Lack of nutritional food access
- [ ] Unstable housing
- [ ] Lack of culturally responsive care
- [ ] Lack of social support

Other

Self Report

Is the beneficiary receiving pharmacotherapy treatment (for OUD); if so what type of medication? *

If medicat on is not listed, please enter the medication name manually.

Did the beneficiary use any of the following substances in the last year? Check all that apply. *

- [ ] Alcohol
- [ ] Cannabis
- [ ] Amphetamines
- [ ] Opioids
- [ ] Benzodiazepine
- [ ] None

Other

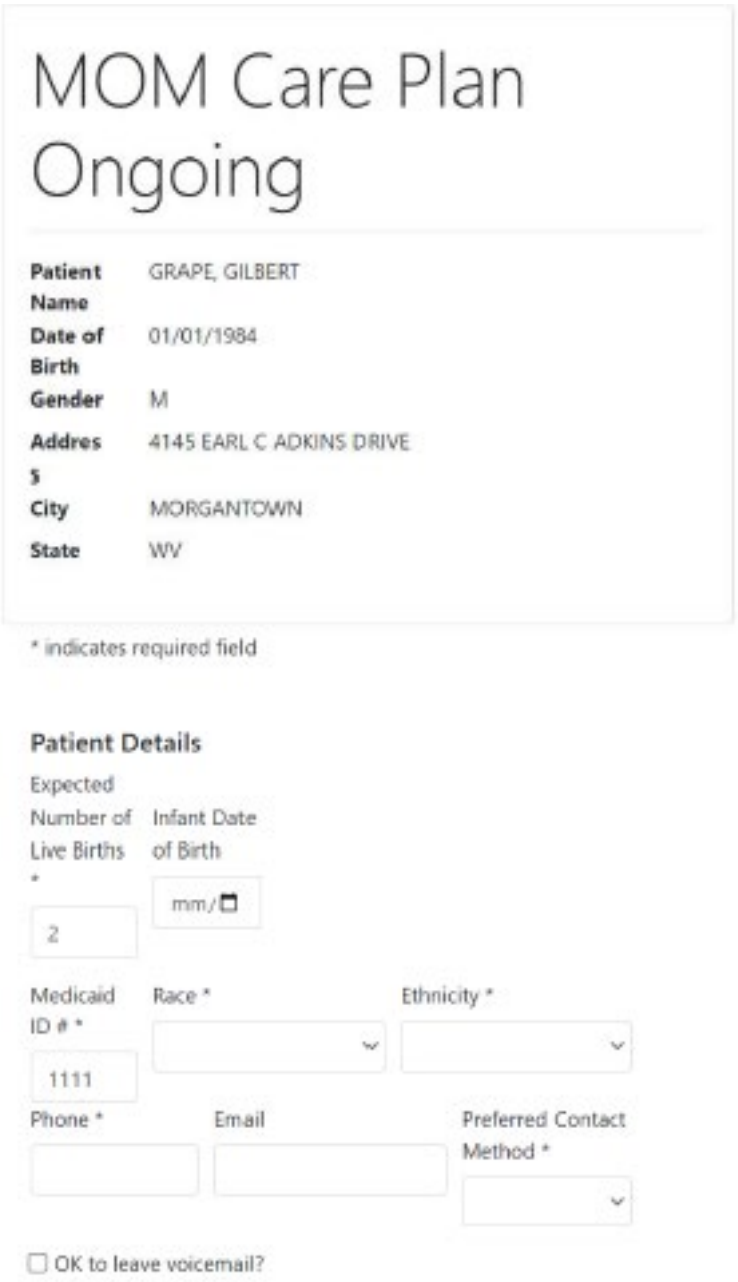
What is the beneficiary's current HIV status? *

What is the beneficiary's current Hepatitis C status? *

Has the beneficiary ever experienced any of the following outcomes from a prior pregnancy? Check all that apply. *

- [ ] Premature (less than 37 weeks)
- [ ] Low Birthweight (less than 2500g)
- [ ] Stillborn infant
- [ ] Infant diagnosed with NAS
- [ ] Unknown
- [ ] None
- [ ] Not applicable

Ongoing Screen



MOM Care Plan Ongoing

Patient Name	GRAPE, GILBERT
Date of Birth	01/01/1984
Gender	M
Address	4145 EARL C ADKINS DRIVE
City	MORGANTOWN
State	WV

* indicates required field

Patient Details

Expected Number of Live Births *

2

Infant Date of Birth

mm/

Medicaid ID # *

1111

Race *

Ethnicity *

Phone *

Email

Preferred Contact Method *

OK to leave voicemail?

Emergency Contact

Name *

Phone *

MCO Contact

Status *

MCO Case Manager Monthly Contact Attempted *

Yes No

MCO Case Manager Monthly Contact Completed *

Yes No

Case managers must provide detail on how all five case management pillars were addressed in the corresponding notes section.

Contact Date *

m

Method of Contact *

Contact Type (select at least one) *

- Comprehensive Case Management
- Health Promotion
- Linkages to Community and Support Services
- Care Coordination
- Individual and Family Support
- Contact attempted but not successful

Additional Notes

Add Contact

Screening Reassessment

Please see MOM Case Management Manual for frequency of screenings

SDOH

Date Reassessed

mm/

Need Indicated
(Please check all that apply)

- ☐ Living Situation
- ☐ Food
- ☐ Transportation
- ☐ Utilities
- ☐ Safety
- ☐ Indicated Financial Strain
- ☐ Employment
- ☐ Education
- ☐ Substance Use
- ☐ Mental Health
- ☐ Family and Community Support
- ☐ Maternal Child Health

Depression/Anxiety

Date Reassessed

mm/

Depression/Anxiety Screening Result

Please note that for the Edinburgh Screening, a score of 10 or greater indicates possible anxiety/depression. If the participant scores lower than a 10 but you feel they meet the criteria, please select "Yes" for the question "Depression/Anxiety?" and indicate the actual score under "Depression/Anxiety Screening Results

NIDA-Modified ASSIST (postpartum only)

Date

mm/

NIDA-Modified ASSIST Result

Alcohol

Date Reassessed

mm/

Encounter Type *

Select at least one of the following

Behavioral Health Visit

- ☐ Alcohol and/or drug assessment
- ☐ SBIRT
- ☐ Individual Therapy and/or Group Therapy
- ☐ Family psychotherapy and psychoeducation
- ☐ Medication Management
- ☐ Intensive Outpatient (ASAM Level 2.1)
- ☐ Partial Hospitalization (ASAM Level 2.5)
- ☐ Ambulatory Detox

Somatic Health Visit

- ☐ Primary Care
- ☐ Specialty Care
- ☐ Federally qualified health center (FQHC) or other clinic services
- ☐ Family planning
- ☐ Dental services for pregnant individuals through date of delivery
- ☐ Habilitation services for expansion populations: physical therapy; occupation therapy; and speech therapy
- ☐ OB-GYN care - prenatal, perinatal, and postpartum care visits
- ☐ Opioid maintenance therapy for individuals 18 years or over

Care Coordination Activities/Milestones *

Select at least one of the following

- ☐ Shared relevant information with at least one other provider involved in the beneficiary's care
- ☐ Assessed beneficiary needs and goals
- ☐ Discussed self-management goals with beneficiary
- ☐ Reviewed beneficiary's medications
- ☐ Consulted other providers involved in the beneficiary's care
- ☐ Other care coordination activity
- ☐ None of the above

Model Engagement Services *

Select at least one of the following

- ☐ Care management telephonic visits or contacts
- ☐ Management of medications or laboratory tests
- ☐ Breastfeeding support
- ☐ Education about OUD treatment
- ☐ Self-management care
- ☐ Health promotion: other
- ☐ Parenting classes
- ☐ Child care support
- ☐ Housing support
- ☐ Individual and family support: other
- ☐ Coaching or consultation to support adherence to treatment or care plan
- ☐ Home visitation
- ☐ Care management and navigation
- ☐ Education about prenatal or postpartum care
- ☐ Education about infant care (including NAS treatment)
- ☐ Recovery skills
- ☐ Peer coaching or support
- ☐ Family counseling services
- ☐ Tranreportation support
- ☐ Other ancillary services
- ☐ Provision of naloxone
- ☐ None

Milestones/Additional Notes

Participant Goals

Goal 1

Goal Completed

mm/

Goal 2

Goal Completed

mm/

Goal 3

Goal Completed

mm/

Add Goal

Recurrence of Use

Date of Recurrence of Use

mm/dd/yy

Referral Made for Recurrence of Use

Add recurrence of use

Self Report

This should be assessed at the first postpartum visit.

How many weeks gestation was the infant at the time of birth?
Please express your response in number of weeks.

Did the beneficiary receive pharmacotherapy treatment (for OUD) at the time of delivery; if so what type of medication?

If medication is not listed, please enter the medication name manually

Did the infant receive pharmacotherapy treatment (for NAS)?

Did the beneficiary receive any of the following during labor to manage pain?

Do you intend to use family planning following birth? If so, which of the following do you plan to use?

Model Exit

Model Exit Date

yyyy

Exit Treatment Plan

- ☐ Pharmacotherapy
- ☐ Behavioral health counseling and therapy
- ☐ Health and behavior interventions for OUD
- ☐ Psychotherapy: individual and group
- ☐ Social work services related to OUD treatment
- ☐ Crisis intervention
- ☐ Recreational therapy related to OUD
- ☐ Psychosocial rehabilitation services
- ☐ Community psychiatric supportive treatment
- ☐ None

Submit | Save Progress

Substantive Outreach Screen

Contact Attempts

Enter custom text if correct option is not listed.

Contact Attempt 1

Date

mm/

Contact Attempt 2

Date

mm/

Contact Attempt 3

Date

mm/

Additional Notes

Submit | Save Progress