Maternal Mental Health

Resources for Workflow  5.22
Patient’s perspective

*Every door can be a connection to access help.*

Provider’s perspective

*Every provider is responsible to ensure that patients are screened and connected with treatment that they choose.*
CRISIS
If patient is in active crisis, follow hospital protocol for managing psychiatric crisis, notify social work and on-call OB.

EPDS <10 and negative #10.

EPDS 10-12 and negative #10.

EPDS 13-30 and/or positive #10.

No/Low Suicide Risk
Provide pt. education. Make warm handoff to social work. Offer to facilitate referral for outpatient psych care. Notify on-call OB.

Medium/High Suicide Risk
Request assistance from behavioral health crisis team and request mental health exam. Notify attending OB.

Follow-Up
For all patients scoring between 10-30: Follow up within 48 hours of discharge via phone. Re-screen using the EPDS at this time and request an update of follow-through with any referrals made before discharge.

Additional Info
Does the patient...
Have a current mental health provider? An appointment set up with that provider? Have adequate family/partner support? Concerns about DV? Have basic needs met (housing, food)?
**Postpartum Discharge Referral Workflow**

**Birthing Facility Discharge**

Screening for:
- Medical conditions
- Mental health
- Substance use
- Breastfeeding
- Family planning
- Structural and social drivers of health

Provide standardized discharge summary

**Outpatient Care**

Direct referral

- Refer to navigator and/or directly to needed services
- Connect patient to outpatient postpartum visit

**Postpartum Care Team**

- Primary OB/Peds/Medical Specialty Care
- Breastfeeding Support
- WIC
- Home Visiting
- Behavioral Health
- Housing, Transportation, Insurance, etc.
Postpartum Discharge Referral Algorithm

**Birthing Facility Discharge**
Screening for:
- Medical conditions
- Mental health
- Substance use
- Breastfeeding
- Family planning
- Structural and social drivers of health

Provide standardized discharge summary

**Are any needs emergent?**

- Yes
  - Connect to immediate specialty care

- No
  - Connect to outpatient postpartum care

**AND**

- Schedule postpartum visit
- Refer to community resources (home visiting, community navigator, etc)
Spotlight: Geary Community Hospital

Geary Community Hospital

Screening for:
• Medical conditions
• Mental health
• Substance use
• Breastfeeding
• Family planning
• Structural and social drivers of health

Provide standardized discharge summary

Delivering Change

• Navigator follows-up on positive screens/needs
• Provides breastfeeding support

Refer all patients

Refer to needed services

Loop closure

Primary OB/Peds/Medical Specialty Care

WIC

Home Visiting

Behavioral Health

Housing, Transportation, Insurance, etc.

Postpartum Care Team