# MOMS+ Project
# Key Driver Diagram (KDD)

## Global Aim

Optimize the health and well-being of pregnant women with opioid use disorder and their infants

## SMART Aim

By June 30, 2019 we will:
Optimize maternity medical home to improve outcomes for pregnant women with opioid use disorder (OUD) as measured by:

- Increased identification of pregnant women with OUD
- Increased % of women with OUD during pregnancy who receive prenatal care (PNC), Medication Assisted Treatment (MAT) and Behavioral Health (BH) counseling each month
- Decreased % of full-term infants with Neonatal Abstinence Syndrome (NAS) requiring pharmacological treatment
- Increased % of babies who go home with mother

## Population

Pregnant women with opioid use disorder

## Key Drivers & Interventions

### Timely identification and tracking of pregnant women with opioid use disorders

- Complete a standardized screening tool on each patient to accurately identify and diagnose pregnant women with OUD (e.g. 5 P's, NIDA Quick Screen).
- Establish a coordinated referral system with BH providers, MAT providers, drug courts, prisons, homeless shelters, and ERs.
- Utilize a tracking system (e.g.. Database, spreadsheet) to follow pregnant women with OUD history/diagnosis and all babies with prenatal opiate exposure.
- Check OARRS per prescribing protocols.

### Compassionate and coordinated care

- Complete training in trauma informed care and addiction as a chronic illness to provide non-judgmental support for pregnant women with OUD
- Designate a care coordinator to arrange referrals and ongoing communication between the trans-disciplinary care team.
- Provide immediate support/counseling at time of identification by OB/FP by using standardized interviewing techniques.
- Implement a process to prevent acute opiate withdrawal by initiating MAT
- Implement a standardized process for referral to appropriate/necessary resources for women with a positive screen for OUD.
- Coordinate care between OB, BH, MAT, NICU/Pediatrics by regularly reviewing shared patients (e.g. multi-disciplinary care conference, huddle).
- Tailor counseling and support for healthy behaviors based on patient-specific situation/need during pregnancy (sobriety, smoking cessation, stable housing and birth spacing (LARC)), with referral to community resources as needed to augment medical resources.
- Consider implementing or referral to OUD specific Centering Pregnancy© program

### Empowerment of women through community based services

- Connect women to vocational training opportunities as applicable
- Involve community partners including referrals to faith-based organizations to support pregnant women with OUD (e.g. support groups, shelters, food pantries, etc.)

### Supported mother/infant dyad post delivery

- Coordinate Prenatal consultation for pregnant women with OUD with Neonatology/Pediatrics to discuss Neonatal Abstinence Syndrome (NAS)
- Ensure mom and baby have a Patient Centered Medical Home (post-delivery)
- Provide a warm handoff to pediatric care provider for infant post discharge (e.g. call/consultation and newborn/maternal summary)
- Provide lactation consultation (if applicable), post partum depression screening and contraceptive counseling
- Prenatal referral for pregnant women with OUD to Community Health Workers and/or home visitation programs (dependent on region)
- Postnatal referral or consideration to Help Me Grow and/or parenting classes
- Facilitate continuation and retention of OUD treatment and services during pregnancy and post-delivery occur (e.g. support of ongoing MAT maintenance services, training care providers to recognize signs of relapse and that mom is continuing in her treatment program)
- Coordinate with Department of Job & Family Services/Child Protective Services regarding reporting requirements and infant plan of safe care