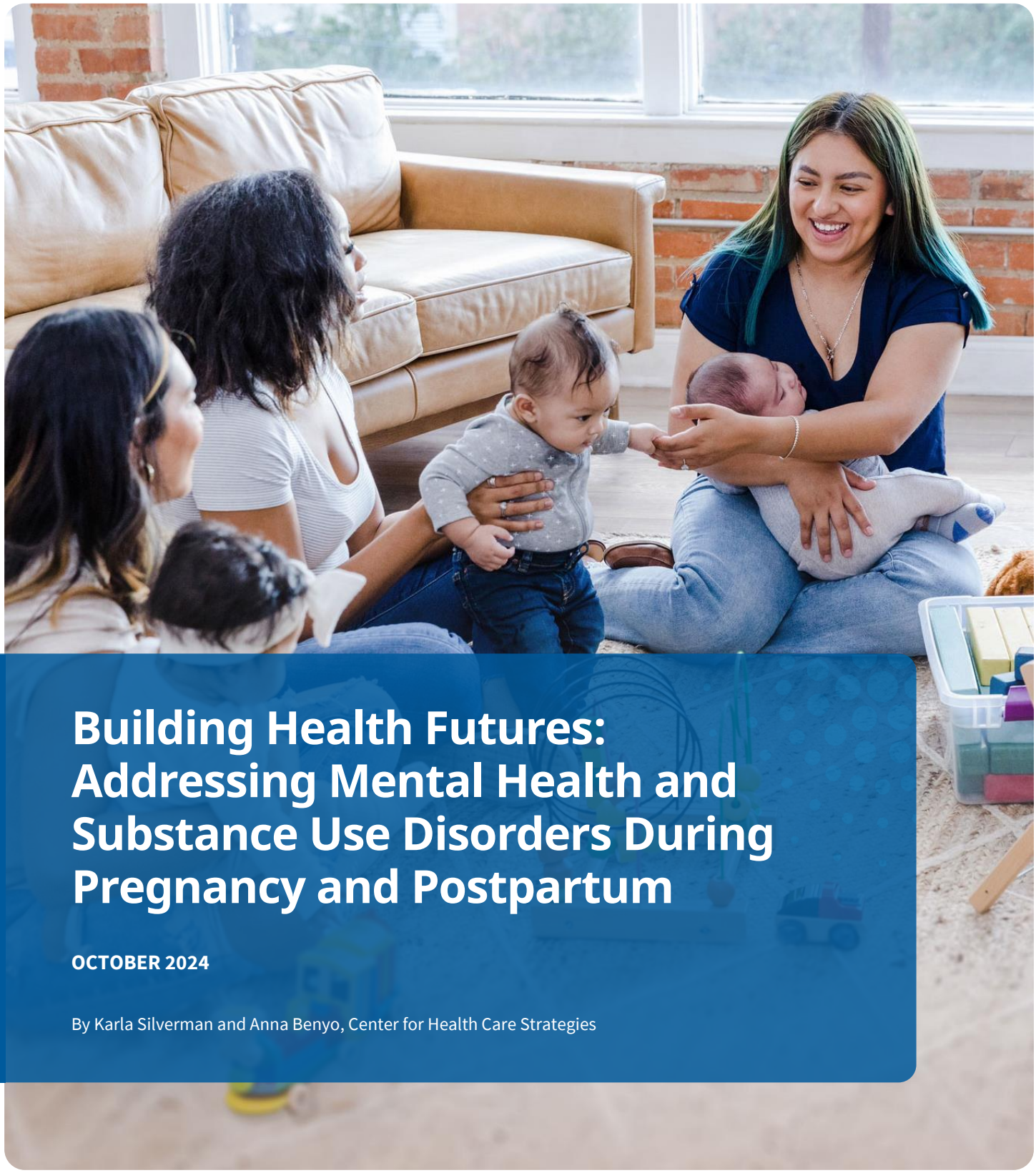
Center for Health Care Strategies



Building Health Futures: Addressing Mental Health and Substance Use Disorders During Pregnancy and Postpartum

OCTOBER 2024

By Karla Silverman and Anna Benyo, Center for Health Care Strategies

Contents

ACKNOWLEDGEMENTS

The Center for Health Care Strategies expresses gratitude to the following individuals and organizations who generously shared their expertise and knowledge with us:

- Anahi Collado, **The Alma Project**
- Ash Woods, **Harm Reduction Doula Collective**
- Ramya Dronamraju, **Association of States and Territorial Health Officials**
- Raquel Mazon and Wendy McWeeny, **Community Health Acceleration Partnership**
- Daisy Goodman, **Geisel School of Medicine at Dartmouth**
- Damali Campbell-Oparaji, **Rutgers New Jersey Medical School**
- Jessica Miller, **Jessica Fae Birthing Services**
- Elisabeth Wright Burak, Anne Dwyer and Nancy Kaneb, **Georgetown Center for Children and Families**
- Cat Livingston, Christine Bernsten, and Emily Wolff, **Health Share of Oregon**
- Bridget Talty, Todd Piorier, and Rashi Kumar, **Healthfirst**
- Elisabeth Johnson, **University of North Carolina Horizons Program**
- Josefa Scherer, **Moms Do Care EMPOWER**
- Joy Burkhard, **Policy Center for Maternal Mental Health**
- Karen Scott, **Foundation for Opioid Response Efforts**
- Kay Matthews, **Shades of Blue**
- Kimá Joy Taylor, **Anka Consulting** and **Urban Institute**
- Lisa Asare, **New Jersey Maternal and Infant Health Innovation Authority** and Christine Scalise, **New Jersey Division of Mental Health and Addiction Services**
- Viveka Prakash-Zawisza, Swathi Damodaran, and Sarah Hodin Krinsky, **MassHealth**
- Nastassia Harris, **Perinatal Health Equity Initiative**
- Gwen Zander, David Kelley and Laina Auletta, **Pennsylvania Department Health Services, Office of Medical Assistance Program** and Dale Adair, **Pennsylvania Office of Mental Health and Addiction Services**
- Pamela Taylor, **New Jersey Maternal and Infant Health Innovation Authority**
- Peg Wright, **Center for Great Expectations**
- Quinn Ingemi, **Southern New Jersey Perinatal Cooperative**
- Sarah Roberts, **Advancing New Standards in Reproductive Health, University of California, San Francisco**
- Dominika Seidman, **Zuckerberg San Francisco General Hospital and University of California, San Francisco**
- Elisabeth Tinker and Teresa Eltrich, **Washington State Health Care Authority**

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

TAKEAWAYS

- Improving outcomes for pregnant and postpartum individuals with mental health and substance use disorders (SUD) requires shifting from stigmatizing and harmful policies to evidence-based strategies.
- High-quality mental health and SUD care for pregnant and postpartum individuals is family-centered, prioritizes trusting relationships, and integrates services to effectively address medical, behavioral health, and health-related social needs.
- Promising models exist for pregnant and postpartum individuals with mental health disorders and SUD. These models provide integrated, trauma-informed, medical, behavioral health, and social care through dedicated care teams that include a community-based workforce and peer supports.
- Given new Medicaid coverage opportunities, this report presents evidence-based strategies to support pregnant and postpartum Medicaid members with mental health disorders and SUD, aiming to inform state policymakers, health systems, providers, and community-based organizations in promoting more effective, equitable care for this often-overlooked population.

Overview

The United States has one of the highest maternal mortality rates among high-income countries.[1] Less often recognized is the significant impact of mental health and substance use disorders (collectively referred to as behavioral health conditions) as drivers of this crisis, particularly during the postpartum period.[2,3] A substantial portion of maternal morbidity and mortality occurs in the weeks and months following childbirth, with suicide and substance-use disorder (SUD)-related overdoses accounting for over 20 percent of postpartum deaths.[4,5,6,7]

Limited care and treatment options exist for pregnant and postpartum individuals with mental health disorders and SUD that are easy to access, integrated, non-stigmatizing, and family centered. Unlike traditional models, family-centered mental health and SUD treatment prioritizes parenting support, bonding with children, and childcare during treatment.[8] These emerging models focus on integrated, team-based care, often collaborating with community-based organizations (CBOs) and incorporating input from people with lived experience.

Two out of every five births in the U.S., or 41 percent, are covered by Medicaid.[9] This presents significant potential to improve perinatal care for Medicaid members with mental health disorders and SUD, especially given the ongoing opioid epidemic. With nearly every state in the country now providing 12 months of postpartum Medicaid coverage, states, providers, and payers have a unique opportunity to

reduce maternal mortality and morbidity. This can deliver lasting improvements in the lives of parents, children, and families.

To identify ways to promote evidence-based, person-centered care and supportive policies for this population, the Center for Health Care Strategies (CHCS) conducted a literature review and interviews with partners across the country. Interviewees represented state Medicaid agencies, state health departments, Medicaid managed care organizations (MCOs), CBOs, foundations, researchers, physicians, midwives, doulas, people with lived experience, and behavioral and maternal health experts.

Drawing from CHCS' research, this report:

1. Examines the systemic challenges hindering pregnant and postpartum individuals' access to quality mental health and SUD care;
2. Provides examples of evidence-based solutions to inform the efforts of states, health plans, health systems, and CBOs in improving perinatal services for individuals with mental health disorders and/or SUD; and
3. Outlines critical elements of effective, integrated perinatal and behavioral health models to help health systems and CBOs replicate these best practices and guide state policymakers and payers in supporting these approaches.

Maternal Morbidity and Mortality, SUD, and Mental Health Conditions

While cardiovascular conditions drive a significant portion of pregnancy-related morbidity and mortality[10] (occurring during pregnancy, birth, and up to one year postpartum[11]), suicide and SUD-related overdose are the leading causes of death in the postpartum period.[12] Significant racial and ethnic mortality disparities exist in maternal health outcomes. Black and Indigenous women are three to four times more likely to die from pregnancy-related complications than white mothers, and postpartum depression rates are 80 percent higher for Black women.[13] Poverty, trauma, structural racism, and inadequate high-quality postpartum care all contribute to these disparities and poor outcomes.[14]

SUD in pregnant and postpartum individuals is typically associated with co-occurring depression, anxiety, post-traumatic stress disorder, panic disorder, and serious psychiatric conditions.[15,16,17,18] Experiencing intimate partner violence during pregnancy or the postpartum period is also closely linked with depression and SUD.[19]

Despite these challenges, mental health disorders and SUD can be treated and managed. Evidence-based approaches include psychiatric medications, medications for addiction treatment (MAT),[20] and individual and group therapy and supports.[21] Medications for opioid use disorder (MOUD), such as methadone and buprenorphine, are recommended for pregnant and postpartum individuals using opioids.[22,23] For pregnant and postpartum individuals with alcohol use disorder, there are also medications approved for use.[24] However, few providers prescribe these medications,[25] and nearly half of pregnant individuals with opioid use disorder (OUD) who receive care in publicly funded treatment centers do not receive MAT.[26] An estimated 75 percent of all birthing and postpartum individuals with co-occurring mental health and substance use conditions receive no treatment.[27]

Federal and State Initiatives Gaining Momentum

For many states, rising maternal morbidity and mortality rates have made addressing the behavioral health needs of postpartum individuals a strategic priority.[28] Recent changes in federal laws provide states with unprecedented opportunities to increase access to behavioral health care and social services from an array of providers, including and beyond maternal health providers.

Postpartum Medicaid coverage expansion to 12 months is now in effect nearly nationwide. As of August 1, 2024, 47 states are providing 12 months of coverage post-delivery, two are planning to implement 12-month postpartum coverage, and one is proposing a limited coverage extension.[29] More communication is needed to build awareness about this coverage expansion. Interviews with providers and CBOs revealed that many Medicaid members may not know they are now covered for the full postpartum year, and some providers and payers are still developing strategies to optimize this expanded coverage.

In June 2024, the CMS Innovation Center released a state funding opportunity for the Transforming Maternal Health (TMaH) model, a 10-year effort to support states in improving maternal health for Medicaid and Children's Health Insurance Plan enrollees by addressing physical, mental health, and social needs during pregnancy, childbirth, and postpartum.[30] Earlier in 2018, the Centers for Medicare & Medicaid Services launched the five-year Maternal Opioid Misuse (MOM) model to integrate maternity care with behavioral health and OUD treatment throughout pregnancy and the first-year postpartum. Participating states — Colorado, Indiana, Maine, New Hampshire, Tennessee, Texas, and West Virginia — are implementing strategies to improve care coordination, reduce stigma, and address social needs to reduce barriers to care.[31]

These are significant steps that states and the federal government are taking toward bringing resources, expertise, and focus to addressing the interrelated maternal health and behavioral health crises that exist today.

The Challenges

Based on CHCS' research and interviews, below is a summary of critical challenges for policymakers and providers in supporting the health and well-being of pregnant and postpartum people with mental health and substance use disorders.

> **Improving maternal and child outcomes requires us to understand and deconstruct our country's historically punitive policies towards pregnant and parenting people who use drugs.[32]**
>
> *– Kimá Joy Taylor, MD, MPH, Anka Consulting, and Non-Resident Fellow, Health Policy Center, Urban Institute*

- **Pervasive stigma drives silence and isolation.** Pregnant and postpartum individuals with SUD face stigma, discrimination, and poor health outcomes for themselves and their infants.[33] Experts interviewed, and the literature, cite shame, bias, and discrimination — perpetuated by punitive policies, the media, the community, and medical and social service providers — as primary reasons that pregnant and postpartum individuals with SUD do not seek help.[34,35] Seeking help during pregnancy can lead to separation from newborns, loss of custody of other children, and in some states, incarceration.[36,37] A pilot study found that after an individual admits substance use in a health care setting, they may be perceived negatively by staff and receive inadequate care.[38]

- **Poor systems alignment and misunderstanding of MAT drive harmful separation of families.** Infants and children of mothers with SUD are at high risk for early foster care placement, often leading to long-term adverse outcomes.[39] Keeping families intact, especially mother-infant dyads, can improve health outcomes and reduce disparities in postpartum outcomes.[40,41] Evidence suggests that keeping families together during MAT and mental health treatment decreases adverse childhood experiences and improves long-term health and well-being.[42] Aligning objectives between child welfare agencies, MAT providers, health departments, and Medicaid agencies can help support evidence-based models of care that aim to keep families together.[43] Lack of training among child welfare staff can also lead to unnecessary separations.

- **Traditional postpartum care is not designed to address the whole person.** High-quality postpartum care should address health-related social needs, behavioral health needs, and physical needs.[44] However, systemic challenges and a lack of integrated services hinder access to mental health and SUD treatment in the perinatal period. Historically, postpartum care was limited to a single visit at six to eight weeks, which many people miss due to barriers like transportation, childcare, and employment.[45,46,47] The American College of Obstetricians and Gynecologists

recommends viewing postpartum care as ongoing throughout the first post-childbirth year and not just a single visit.[48,49] However, providers, especially in low-resource areas, face challenges in improving postpartum care, including appointment scheduling difficulties, insurance limitations, and lack of provider continuity.[50]

- **Few OB/GYNs are trained in SUD care.** Studies show that OB/GYNs feel less confident treating opioid use disorder than tobacco use disorder and lack validated screening tools to assess substance use of pregnant and postpartum individuals.[51] Before the removal of X waiver requirements in 2023, less than two percent of 31,000 OB/GYNs surveyed could prescribe MAT.[52] One study showed that 40 percent of OB/GYN program directors did not prescribe MAT, citing a lack of trained faculty and interest.[53] Primary care providers also hesitate to screen for and treat SUD, noting a lack of training.[54,55] The lack of addiction treatment education for OB/GYNs and primary care providers results in missed opportunities for care.[56]
- **Behavioral health workforce shortages impede timely services**. The behavioral health workforce shortage is a significant barrier to care for pregnant and postpartum individuals. An estimated 122 million people in the United States live in mental health provider shortage areas.[57] Medicaid members are disproportionately affected by SUD and mental health conditions, with nearly 40 percent having a behavioral health condition compared to 31 percent of those privately insured or uninsured.[58] Lower provider reimbursement and inaccurate provider directories further hinder access to care for Medicaid members, especially in rural areas and communities of color.[59,60,61] The provider shortage also leads to higher hospitalization rates for behavioral health conditions.[62]

Potential Solutions

Despite the challenges, there is reason to be hopeful. CHCS' research and interviews with subject matter experts nationwide found that states, health systems, and CBOs are developing innovative approaches that support integrated, family-centered behavioral health care during the perinatal period. This section spotlights promising strategies and provides examples to guide efforts at various levels — including states and health plans, health systems and providers, and CBOs — in addressing the maternal mortality crisis and meeting the mental health and SUD needs of the people they serve.

State and Health Plan Approaches

Beyond providing Medicaid coverage for postpartum individuals, states and health plans can play a significant role in supporting the health and well-being of this population. The following section spotlights innovative approaches in three states — **Massachusetts**, **New Jersey**, and **Oregon** — for improving mental health and SUD care for pregnant and postpartum individuals. These state and health plan approaches employ strategies that allow for:

- **Integrated Care and Supports:** Providing care across medical, behavioral health, and social services, with supports and training for providers to improve care for pregnant and postpartum individuals with mental health conditions and SUD.
- **Community-Based Workforce and Services**: Using a community-based workforce, including doulas, peer counselors, and community health workers (CHWs), along with nurse home-visiting services in the immediate postpartum period.
- **Evidence-Based Approaches**: Implementing harm-reduction, trauma-informed and other evidence-based approaches.
- **Cross-Sector Partnerships:** Fostering cross-sector alignment across state health and human service entities and other key partners to support pregnant and postpartum individuals and their families.
- **Value-Based Payment and Delivery**: Adoption of value-based payment and delivery to support team-based care.

Massachusetts

Massachusetts Medicaid (MassHealth) has adopted a multi-pronged strategy for improving the health and well-being of pregnant and postpartum individuals with mental health disorders and SUD.* MassHealth is embedding behavioral health supports and training for providers into their Medicaid accountable care organizations (ACOs), exploring payment levers to incentivize screening for behavioral health conditions beyond depression, and working with MCOs to support doulas to better support their clients. Massachusetts' approach includes:

- **Requiring Psychiatric Consultation Programs for Providers:** MassHealth has contractual requirements with MCOs in their Medicaid ACO program that pediatricians caring for pregnant teens enroll in the **Massachusetts Child Psychiatry Access Program (MCPAP) for Moms**. MassHealth hopes this requirement will help more providers feel comfortable screening, referring, or managing mental health and SUD for patients during the postpartum year.[63]
- **Exploring Payment for Behavioral Health Screening Beyond Depression:** MassHealth is exploring how to use all available payment levers to support screening and referral or provision of care for a wider range of mental health and SUD issues for pregnant and postpartum individuals, not just depression. Pediatricians are required to screen for postpartum depression at every well-child visit for the first six months postpartum and can also receive additional reimbursement for these screenings.
- **Enhancing Access to Doula Services and Community Supports through MCO Partnerships:** MassHealth covers doula services during pregnancy, delivery, and the 12-month postpartum period. Roughly 90 percent of the pregnant and postpartum individuals covered by MassHealth are in managed care. Managed care can connect members to the **MassHealth Community Partners Program** that provides behavioral health care services if needed. MassHealth ensures that doulas are aware of these resources and can connect their clients to them. They are also working with MCOs to educate members about doula access.[64]

Massachusetts Child Psychiatry Access Program (MCPAP for Moms), a program funded by the Massachusetts Department of Mental Health, supports primary care providers, OB/GYNs, and nurse-midwives with real-time access to perinatal psychiatric consultations and care coordination services. It is designed to help providers manage their pregnant and postpartum patients' mental health and substance use concerns. MCPAP for Moms delivers training and toolkits on evidence-based behavioral health guidelines and can link individuals and families to community-based services when appropriate.

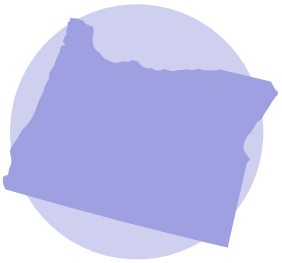
* Please note that some of the MassHealth policies mentioned in this report may have been updated or modified since the date of publication.

New Jersey

New Jersey has one of the widest racial disparities for both maternal and infant mortality in the country. Black mothers in New Jersey are almost seven times more likely than white mothers to die from maternity-related complications, and Black infants are over three times more likely than white infants to die before their first birthday.[65] In response, New Jersey Medicaid has adopted a multi-pronged approach that includes:

- **Creating a Statewide Strategy to Address Perinatal Health Involving All Sectors — Health, Education, Housing, Business, Government, and Justice**: Led by First Lady Tammy Murphy, **Nurture NJ** is a statewide campaign launched in 2019 to reduce maternal and infant mortality and morbidity, especially among women of color.[66] The statewide multi-agency approach involves a range of partners, such as doulas, health experts, mothers, families, providers, health systems, and government agencies, to create their strategic plan.[67] The plan centers on dismantling policies that reinforce structural racism and drive poor maternal health outcomes for women of color.[68]
- **Establishing a Maternal and Infant Health Innovation Center**: As work toward Nurture NJ's goals has gained momentum, the state passed legislation creating **the Maternal and Infant Innovation Authority**.[69] The Authority is similar to a governmental agency, and unlike previous initiatives, its objectives are codified by law, thus it will continue to operate beyond the current administration's term. The Authority established **the Maternal and Infant Health Innovation Center**,[70] which supports comprehensive efforts to provide equitable perinatal and infant care services.[71]
- **Closing the Care Gap for Postpartum Individuals in the Immediate Postpartum Period**: Under Nurture NJ, legislators passed a law in 2021 that establishes free, statewide postpartum nurse home-visiting services. The law requires all New Jersey hospitals and birthing facilities to schedule a free postpartum home visit within seven days of discharge for each birth.[72] The Department of Children and Families partners with Family Connects, which links parents with a home-visiting nurse.[73]
- **Removing Stigmatizing Language about SUD from State Institutions, Entities, and Laws**: In 2023, New Jersey became the first state to remove stigmatizing language about SUD from state institutions, entities, and when referenced in other laws. According to the new legislation, "the overall goal is to use person-first, non-stigmatizing language when referring to individuals with alcohol or substance use disorders."[74]

Health Share of Oregon



In 2012, Health Share of Oregon, a Coordinated Care Organization (CCO) accountable for health care quality and spending for more than 400,000 Medicaid members across three Portland-area counties, piloted an innovative approach for pregnant and postpartum individuals with SUD.[75,76] **Project Nurture** integrates maternity care, substance use treatment, and social service coordination.[77,78] The program has reduced foster care placements, increased prenatal visits, decreased C-section rates, and decreased child maltreatment.[79] Notably, of 238 participants served during the three-year pilot, 93 percent have remained in recovery and retained custody of their infants for one year after delivery.[80]

The model includes doulas and peer supports, who have lived experience with SUD, and connects clients to additional social supports.[81] As Project Nurture has grown, the CCO's health plan partners now finance the model, and Health Share of Oregon convenes participating organizations to address program needs and identify sustainability strategies. Model components include:

- **Providing Evidence-Based Integrated Maternity and Addiction Care Under One Roof**: The program offers outpatient addiction treatment, MOUD, and medical care during pregnancy and postpartum.[82] It engages women in prenatal care and drug treatment through low-barrier, drop-in weekly support groups.
- **Promoting Transparency and Collaboration with Child Protective Services**: Project Nurture clinicians prepare and support participants and act as a liaison and advocate during interactions with child protective services (CPS). Ongoing partnerships between clinicians and child welfare staff build trust and sustain professional rapport.
- **Facilitating Cross-Sector Partnerships through One Convening Organization**: Health Share of Oregon convenes providers and partners for quarterly Project Nurture meetings, facilitating peer-to-peer learning and troubleshooting. This convening role helps build connections between health and human services, housing, CPS, and behavioral health agencies.
- **Addressing Financial Challenges Created by Siloed Addiction and Physical Health Care**: Health Share of Oregon, their health plan partners, and the Project Nurture sites are exploring an enhanced maternity payment for its perinatal SUD care model to better support the extra care this model provides through the full postpartum year.

Health System/Hospital Approaches

Integrated, team-based care can ensure that pregnant and postpartum individuals with mental health disorders and SUD receive individualized care that considers their specific physical and behavioral needs and pays attention to health-related social needs.[83] Models embodying these principles are emerging in health systems and hospitals across the U.S., supported by forward-thinking clinicians, administrators, and health system leadership. Below are two examples of integrated, family-centered care models centered within a health or hospital system.

Dartmouth Hitchcock Perinatal Addiction Treatment Purple Pod Program

Purple Pod is a team-based, trauma-informed, person-centered care model located within the **Perinatal Addiction Treatment program** in the OB/GYN department at Dartmouth Hitchcock Medical Center in Lebanon, New Hampshire.[84] The program provides enhanced support for patients with mental health disorders, SUD, and/or health-related social needs that interfere with their ability to access and engage in care.

Purple Pod is led by a certified nurse-midwife and staffed by medical residents. The midwife trains and oversees residents as they rotate through Purple Pod. OB/GYN residents are also trained in addiction medicine, perinatal psychiatry, medications for OUD and alcohol use disorder, trauma-informed care, and intimate partner violence.

Purple Pod seeks to build bridges between the community and the health system through its community ambassadors' program. Community ambassadors, who are CHWs trained as doulas and certified recovery support workers, spend time in the community connecting with pregnant individuals with SUD who may not be receiving care. They are reimbursed as CHWs connected to a licensed provider's visit. Through grant funding, they are able to provide free phones to pregnant and postpartum individuals who are homeless or using substances to increase care engagement, allowing them to schedule appointments, telehealth visits, and Medicaid-covered transportation. In 2025, New Hampshire Medicaid will begin reimbursing doulas, and community ambassadors will be able to bill independently under Medicaid.

Nursing staff receive training in addiction medicine, understanding addiction as a chronic disease, and stigma reduction. A key aspect of this integrated model's success is the introduction of doulas/community ambassadors to labor and delivery and postpartum nurses. By attending select nursing staff meetings, the doulas/community ambassadors build trust with the nursing staff. This collaboration leads to nurses working closely with doulas, bringing them in as needed for extra support or care for pregnant patients with mental health and/or SUD who present at the hospital.[85]

Team Lily at Zuckerberg San Francisco General Hospital

Team Lily is a trauma-informed, team-based, person-centered care model located at Zuckerberg San Francisco General Hospital.[86] The program provides medical care and wrap-around services to pregnant and postpartum individuals with a focus on those experiencing homelessness, intimate partner violence, incarceration, substance use, and/or a mental health condition. Training inpatient hospital staff is a key component of Team Lily's approach to shift away from punitive cultural attitudes toward pregnant and postpartum individuals with SUD. All clinical staff who work on labor and delivery and the postpartum floor are trained, and nurses are paid to attend trainings.[87]

Team Lily partners closely with street medicine providers and runs an open-access clinic where patients can arrive at any time on a specific day and see their designated provider. An OB/GYN provider who prescribes MAT, and a therapist, social worker, navigator, and psychiatrist are available. Patients can stay with a provider they trust, and patients set the agenda for their visits. For example, if a patient wants to spend their prenatal visit discussing their need for housing or they want to talk about their mental health and not have a traditional prenatal visit, they can do that. This builds trust with patients and allows them to feel in control of their visit.

> **We did a lot of training with triage nurses on labor and delivery about instead of saying, '*Why are you here?*' starting with, '*We're so glad you're here. Let's get you settled in a room. Would you like some food?*'**
>
> – *Dominika Seidman, MD, MAS, Team Lily, Zuckerberg San Franciso General Hospital*

Team Lily has developed "dyadic care coordination timeouts," which are called whenever anyone on the team mentions or considers calling CPS. During this timeout, providers and clinical staff involved in the parent's care pause and come together to decide on a course of action. Team Lily has found that this process allows the team to hear from other providers and team members who may know the parent and family better, providing a fuller picture of the patient's situation. It ensures that calling CPS is the best course of action for both mother and infant or allows the team to avoid calling CPS and take another course of action.

Community-Based Approaches

CBOs and a community-based workforce — employing doulas, CHWs, and/or peers — are crucial in supporting pregnant and postpartum individuals with mental health disorders or SUD through effective community engagement and connections. Below are examples of community-based approaches with positive results.

Moms Do Care EMPOWER at Baystate Franklin Medical Center, Massachusetts

The Moms Do Care EMPOWER program, funded by State Opioid Response Funds from the Substance Abuse and Mental Health Services Administration through the Bureau of Substance Addiction Services at the Massachusetts Department of Public Health, operates several sites. The program supports pregnant and postpartum individuals using substances, those using MAT for OUD, and their families.[88]

The Moms Do Care EMPOWER site in Greenfield, Massachusetts provides a team-based approach committed to person-centered care. At the center of the team are doulas and peer recovery coaches who have lived experience with addiction and recovery. Doulas and peers are connected to a multidisciplinary team, including obstetricians, midwives, and care coordinators. The team has flexibility to support clients' autonomy and self-defined goals, ranging from low-barrier/low-threshold care and harm reduction-based interventions to abstinence-based treatment goals.[89]

The organization's ability to retain a peer workforce with low turnover is key to its success. The program respects peers' lived experience by elevating their unique strengths and qualifications through equitable compensation, flexible scheduling, and clear opportunities for professional development.

Shades of Blue Project, Texas

Some individuals feel more comfortable finding support outside the health care system. The **Shades of Blue Project** supports individuals of color before, during, and after pregnancy by providing maternal mental health advocacy, treatment, community resources, and support groups.[90] The project has a team of CHWs and doulas, many who share lived experiences with clients. They also refer to social workers and psychiatrists.

Although based in Texas, Shades of Blue serves women and families in 42 states. The program's virtual support groups focus on restoring people's mental health in part by restoring their dignity and self-respect. No one is turned away from the program. The project offers a variety of groups including for pregnant and postpartum, teen moms, single moms, general mental health, LGBTQ+, and a pregnancy loss grief support group. Shades of Blue also provides free new clothing for mothers and babies, diapers, and other supplies.

> **We often say in the maternal mental health and substance use space that there are not enough people to help, not enough providers. That's because we don't look beyond clinicians. If you widen the lens, you see all these other support mechanisms. Not everybody needs to go to therapy … Maybe I just want to talk to another mom who identifies with how I'm feeling, and she can make me feel better about myself and know that I'm not alone.**
>
> – *Kay Matthews, LCSW, Founder, Shades of Blue Project*

Key Recommendations

Innovative programs are emerging nationwide to reduce maternal mortality and morbidity and ensure healthier outcomes for infants and their parents, particularly individuals with mental health and SUD needs. These patient-centered initiatives, often rooted in the community or local health systems, typically offer seamless integration of perinatal and behavioral health services through a no-wrong-door, stigma-free approach.

This section outlines key elements essential for models that effectively integrate perinatal and behavioral health services. These six elements, detailed below, can guide health systems, CBOs, state policymakers, and payers in designing successful programs and supporting coordinated evidence-based care for this population.

1. Support Dedicated Care Teams

2. Center People with Lived Experience to Drive Health Equity

3. Normalize Substance Use Care

4. Train All Staff on Bias and Stigma

5. Expand the Community-Based Workforce

6. Use Harm Reduction and Street Medicine Approaches

Interviewees and subject matter experts CHCS spoke with emphasized that even small changes in supporting the policy and care delivery approaches outlined in the following recommendations can benefit mothers and families.

1. Support Dedicated Care Teams

Almost all states have now extended Medicaid coverage to 12 months postpartum.[91] This creates an unprecedented opportunity to rethink care delivery for postpartum individuals and their families, particularly those with mental health disorder and SUD diagnoses. One promising first step would be to support dedicated multi-disciplinary teams where medical and behavioral health providers, a community-based workforce, and people with lived experience are integrated. A full year of postpartum Medicaid coverage makes this multi-disciplinary approach possible not just for pregnant individuals but also for those who need behavioral health care for up to a year after they give birth.

States, payers, health systems, and providers can increase "no wrong door" access to mental health and SUD services for postpartum individuals over the full postpartum year by focusing on the multiple entry points where individuals will likely access care (i.e., OB/GYN offices, primary care offices, pediatrician's offices, emergency departments, or non-clinical settings like shelters). States can make team-based care easier to provide by developing perinatal episode payments or other bundled payment models that are inclusive of behavioral health and health-related social needs. Coverage of a community-based workforce, such as doulas, can also support teams in employing these team members. Payers can extend their support beyond just financing screening and treatment. They can incentivize team coordination by aligning incentives with desired outcomes, such as providing bonus payments for implementing care coordination processes and multi-disciplinary case conferencing. Additionally, payers can reward reductions in disparities and assist in data sharing and measuring outcomes for patients engaged with these teams.

Hospital-based maternal health and OB/GYN departments are also key entry points for care since care delivery infrastructure is already in place. Like Purple Pod at Dartmouth-Hitchcock and Team Lily at Zuckerberg San Francisco General, hospital-based providers can consider creating dedicated teams within their departments that integrate behavioral health providers, a community-based workforce, and OB/GYNs, midwives, and nurses. These providers can be trained in SUD treatments and trauma-informed practice.

2. Center People with Lived Experience to Drive Health Equity

The maternal mortality crisis, driven in part by behavioral health issues, disproportionately impacts people of color.[92] Peer support from people with lived experience is an evidence-based strategy for helping pregnant and postpartum individuals with mental health disorders and SUD.[93,94] However, many communities, especially those experiencing the greatest disparities, lack the robust community-based workforce with lived experience needed to implement these strategies effectively. For example, a New Jersey study found that in most community-based perinatal programs, people of color made up less than 10 percent of CHWs, doulas, and peer recovery coaches.[95] Similarly, studies show racial and ethnic disparities in the use of mental health and SUD services, with communities of color accessing these programs less than their white counterparts.[96] When interviewed, mental health and SUD program administrators cited a range of barriers, including mental health stigma, lack of family support, fears of disclosing mental health issues, limited language options, social determinants (namely transportation barriers), and limited awareness of the programs and services available.[97]

Systemic and structural racism and historical and current bias within the health care and social service systems against mothers of color and families are complex, interrelated factors that compound the likelihood of experiencing postpartum mental health distress and SUD. These factors may also dissuade women of color from seeking effective treatment.[98] People with lived experience working as CHWs, peers, and doulas can play a critical role in supporting these individuals and their families.

> **For me, it's about what we need to do to get people to put compassionate care back into this care delivery system that we are in.**
>
> – *Kay Matthews, LCSW, Founder, Shades of Blue Project*

Health systems, providers, CBOs, as well as states, payers, and funders should consider:

- Investing in the capacities of community-based programs to identify equity gaps, increase staff diversity and peer workforce, and address barriers to seeking care; and
- Including people with lived experience in the design and delivery of care and support for pregnant and postpartum mothers with mental health and SUD.

3. Normalize Substance Use Care

Today, high-quality, evidence-based treatment exists that can help people with SUD diagnoses. However, many providers and clinical staff are either unaware of these treatments, uncomfortable with them, or have not received training to provide effective care. A systemic review identified the most common reasons physicians are reluctant to provide addiction care as "lack of institutional support, knowledge, skill, and cognitive capacity."[99] Normalizing SUD care requires more clinical professionals who care for pregnant and postpartum individuals to understand current evidence-based SUD treatments and receive training to deliver them.[100] States, MCOs, and health systems can play an important leadership role by requiring or funding this training.

Pregnant and postpartum individuals may seek SUD treatment from any of the following providers and staff, all of whom could benefit from training in perinatal SUD treatment options:

- Maternal and reproductive health providers, including OB/GYNs, midwives, hospital labor and delivery and postpartum nurses;
- Primary care providers, including internal medicine, family physicians, pediatricians, nurse practitioners, and physician assistants;
- Emergency department providers and staff;
- Behavioral health providers, addiction specialists, social workers, care managers/care coordinators;
- CHWs, doulas, peer navigators and counselors; and
- Child protective services staff.

4. Train All Staff on Bias and Stigma

When pregnant or postpartum individuals seek help for mental health disorders or SUD, they often face feelings of shame or stigma during encounters with the health care system. This can happen at any point of interaction, whether it is the tone of the person answering the phone or the doctor's attitude during a medical visit. Postpartum individuals with SUD diagnoses may be judged more harshly by both clinical and non-clinical staff members than non-parents, leading to punitive and shaming approaches that may deter them from seeking care.[101] Postpartum individuals may also have legitimate fears that seeking help will lead to police or child welfare involvement.[102]

To address this, it is essential to provide training on bias and stigma to a wide range of clinical and non-clinical staff, including administrators, security, and janitorial staff. This type of training, a core principle of trauma-informed care, is critical for changing the culture of care for pregnant and postpartum individuals with mental illness and SUD.[103] Postpartum individuals seeking help may be as likely to go to an emergency department or ask for treatment in the pediatrician's office as they would at a postpartum visit. This highlights the need for training on bias and stigma across the array of provider types that postpartum individuals interact with. Addressing stigma and bias at the systems level requires widespread education across locations and staff.

5. Expand the Community-Based Workforce

Doulas, CHWs, peer coaches, and recovery specialists are fundamental assets in bridging the gap between the community and traditional health care-based settings. They often excel at building trust with patients, and a positive, supportive relationship can increase patient engagement in care. Evidence supports the use of peer interventions and a community-based workforce to prevent or reduce the harms of perinatal depression, as well as the use of peers for SUD recovery support.[104,105]

Integrated care models at health systems and hospitals can incorporate a community-based workforce, including peers, doulas, perinatal CHWs, recovery coaches, and peer specialists. These care models recognize that having team members who have a community presence — able to reach people where they are, in their homes and communities — is vital for serving pregnant and postpartum individuals with mental health and substance use disorders, especially if there are other issues such as unstable housing and lack of childcare. Having a community-based workforce as part of the care team also helps the clinical staff have more awareness of the behavioral health and social needs of patients.[106] Payment models are key to helping health systems support a community-based workforce, and many states have already moved or are moving to expand coverage of CHWs and doulas through Medicaid.[107,108]

6. Use Harm Reduction and Street Medicine Approaches

Many successful programs for pregnant and postpartum individuals use innovative approaches such as street medicine, drop-in clinics where patients are guaranteed to see their preferred provider, and care models that provide medical care and SUD treatment and connect patients to housing, transportation, and domestic violence services if needed. Many interviewees spoke of "low barrier to entry" care or support groups that minimize rules around who can attend, highlighting these as core parts of their models. Additionally, many successful programs brought care directly to pregnant and postpartum individuals with SUD instead of waiting for them to come into hospitals and clinics. These programs focus on building trust and relationships, allowing pregnant and postpartum individuals to feel in control over their care and treatment choices. These approaches are based on harm reduction strategies.[109]

Conclusion

Suicide and overdose are the leading causes of death in the postpartum period, and the impact on families and the community is tragic and profound.[110] It should not be difficult for pregnant and postpartum individuals with mental health disorders and SUD who are seeking help to find it. However, these individuals often face shame and stigma and an array of challenges in accessing the family-centered, trauma-informed, team-based care and support they need.

States are now providing Medicaid coverage for a full postpartum year. To make the most of this coverage, states, payers, and providers can act strategically to promote evidence-based care that works and reduces the inequities and disparities that currently exist. Positive change is within reach by collaborating across sectors, creating integrated teams of medical, behavioral health, and social service providers, and embracing a community-based workforce and individuals with lived experience in designing and delivering care.

Policy change, new payment strategies, and integrated, person-centered, trauma-informed, non-punitive team-based care can help. There is no order in which these changes should occur, and there is no mandate to do everything all at once. Whether through participation in innovative new efforts like the CMS Innovation Center's TMaH model, or through incremental approaches at the state or local level, there are critical opportunities to significantly improve care for new birth parents and their babies across the United States.

ENDNOTES

[1] The White House. (2024, July 10). Blueprint for addressing the maternal health crisis: Two years of progress.[News Release]. https://www.whitehouse.gov/briefing-room/statements-releases/2024/07/10/the-white-house-blueprint-for-addressing-the-maternal-health-crisis-two-years-of-progress/

[2] U.S. Department of Health and Human Services. (2023). *The task force on maternal mental health's report to Congress*. [Report]. https://www.samhsa.gov/sites/default/files/mmh-report.pdf

[3] The Joint Commission. (2023, January 6). Quick Safety 67. *Mental health conditions leading cause of pregnancy-related deaths*. [Newsletter]. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-67/

[4] Dol, J., Hughes, B., Bonet, M., Dorey, R., Dorling, J., Grant, A., Langlois, E., Monaghan, J., Ollivier, R., Parker, R., Roos, N., Scott, H., Shin, H. D., & Curran, J. (2022, September). Timing of maternal mortality and severe morbidity during the postpartum period: a systematic review. *JBI Evidence Synthesis*, *20*(9), 2119–2194. https://doi.org/10.11124/JBIES-20-00578

[5] Declercq, E., & Zephyrin, L. (2020, December 16). The Commonwealth Fund. *Maternal mortality in the United States: A primer*. [Report] https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer

[6] Chin, K., Wendt, A., Bennett, I., & Bhat, A. (2022). Suicide and maternal mortality. *Current Psychiatry Reports*, *24*(4), 239–275. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8976222/

[7] Centers for Disease Control and Prevention. (2022, September 19). *Four in 5 pregnancy-related deaths in the U.S. are preventable.* [Press release]. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

[8] Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA). (2007). *Family-centered treatment for women with substance use disorders: History, key elements, and challenges*. [Report]. https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

[9] Valenzuela, C., & Osterman, M. (2023, May 24). *Characteristics of mothers by source of payment for the delivery: United States, 2021*. NCHS Data Brief, no 468. [Data brief]. https://www.cdc.gov/nchs/products/databriefs/db468.htm

[10] Hill, L., Artiga, S., & Ranji, U. (2022, November 1). *Racial disparities in maternal and infant health: Current status and efforts to address them*. KFF. [Issue brief]. https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

[11] Trost S., Beauregard J., Njie F., Harvey, A., Berry, J., Beauregard J., Chandra, G., & Goodman, D. (2024, May 30). *Pregnancy-related deaths: Data from maternal mortality review committees in 36 U.S. states, 2017–2019*. Centers for Disease Control and Prevention. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc-2017-2019.html

[12] Association of American Medical Colleges (AAMC). (n.d.). *Maternal mental health*. https://www.aamc.org/about-us/mission-areas/health-care/maternal-mental-health

[13] Policy Center for Maternal Mental Health. (2023, December). *Black maternal mental health*. [Report]. https://www.2020mom.org/blog/issue-brief-black-maternal-mental-health

[14] Foster, V.-A., Harrison, J., Williams, C., Asiodu, I., Ayala, S., Getrouw-Moore, J., Davis, N., Davis, W., Mahdi, I. K., Nedhari, A., Niles, P., Peprah, S., Perritt, J., McLemore, M., & Mask Jackson, F. (2021, October). Reimagining Perinatal Mental Health: An Expansive Vision for Structural Change: Commentary describes changes needed to improve perinatal mental health care. *Health Affairs*, *40*(10), 1592–1596. https://doi.org/10.1377/hlthaff.2021.00805

[15] Prince, M., Daley, S., & Ayers, D. (2024). Substance use in pregnancy. *StatPearls*. http://www.ncbi.nlm.nih.gov/books/NBK542330/

[16] Agency for Healthcare Research and Quality. (n.d.). *Pregnant and postpartum women and behavioral health integration*. [AHRQ Integration Academy topic brief] https://integrationacademy.ahrq.gov/products/topic-briefs/pregnant-postpartum-women

[17] Weiss, N., Kiefer, R., Goncharenko, S., Raudales, A., Forkus, S., Schick, M., & Contractor, A. (2022, January 1). Emotion regulation and substance use: A meta-analysis. *Drug and Alcohol Dependence*, *230*, 109131. https://doi.org/10.1016/j.drugalcdep.2021.109131

[18] Substance Abuse and Mental Health Services Administration (SAMHSA). (2024, April 11). *Medications for substance use disorders*. https://www.samhsa.gov/medications-substance-use-disorders

[19] Soper, R., & Jones, H. (2018). Intimate partner violence, pregnancy and substance use disorder. In T. E. Wright (Ed.), *Opioid-use disorders in pregnancy: Management guidelines for improving outcomes* (pp. 41–48). Cambridge: Cambridge University Press. https://www.cambridge.org/core/books/opioiduse-disorders-in-pregnancy/intimate-partner-violence-pregnancy-and-substance-use-disorder/62824438764C169D9B2527B51E5A1C7A

[20] Substance Abuse and Mental Health Services Administration (SAMHSA), 2024, April.

[21] National Institute on Drug Abuse (NIDA). (2011, July). *Drugs, brains and behavior: The Science of addiction: Treatment and recovery.* https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

[22] Centers for Disease Control and Prevention. (2024, May 15). *Treatment of opioid use disorder before, during, and after pregnancy*. https://www.cdc.gov/opioid-use-during-pregnancy/treatment/index.html

[23] Miele, K., Kim, S., Jones, R., Rembert, J., Wachman, E., Shrestha, H., Henninger, M., Kimes, T., Schneider, P., Sivaloganathan, V., Sward, K., Deshmukh, V., Sanjuan, P., Maxwell, J., Seligman, N., Caveglia, S., Louis, J., Wright, T., Bennett, C., … Gilboa, S. (2023). Medication for opioid use disorder during pregnancy - maternal and infant network to understand outcomes associated with use of medication for opioid use disorder during pregnancy (MAT-LINK), 2014-2021. *Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, D.C.: 2002)*, *72*(3), 1–14. https://www.cdc.gov/mmwr/volumes/72/ss/ss7203a1.htm

[24] DeVido, J., Bogunovic, O., & Weiss, R. D. (2015, March - April). Alcohol use disorders in pregnancy. *Harvard Review of Psychiatry*, *23*(2), 112–121. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4530607/

[25] Kelty, E., Terplan, M., Greenland, M., & Preen, D. (2021, May). Pharmacotherapies for the treatment of alcohol use disorders during pregnancy: Time to reconsider? *Drugs*, *81*(7), 739–748. https://pubmed.ncbi.nlm.nih.gov/33830479/

[26] Bello, J., Dell, N., Laxton, A., Conte, M., & Chen, L. (2024, June 11). Prevalence and predictors of medication for opioid use disorder among reproductive-aged women. *Drug and Alcohol Dependence Reports*, *11*, 100239. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11070671/

[27] Martin, C., & Parlier-Ahmad, A. (2021, September). Addiction treatment in the postpartum period: an opportunity for evidence-based personalized medicine. *International Review of Psychiatry 33*(6), 579–590. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8490333/

[28] Gunja, M., Gumas, E., & Williams II, R. (2022, December 1). The U.S. maternal mortality crisis continues to worsen: An international comparison. [Blog post]. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison

[29] Kaiser Family Foundation (KFF). (2024, August 1). *Medicaid Postpartum Coverage Extension Tracker*. [Issue Brief]. https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/

[30] Centers for Medicare & Medicaid Services. (2024). Transforming maternal health (TMaH) model. https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model

[31] Centers for Medicare & Medicaid Services. (2018). Maternal opioid misuse (MOM) model. https://www.cms.gov/priorities/innovation/innovation-models/maternal-opioid-misuse-model

[32] Taylor K. J. (2023, December). A different vision: Centering love not punishment for families affected by substance use. *Maternal and Child Health Journal*, *27*(Suppl 1), 182–186. https://pubmed.ncbi.nlm.nih.gov/37955838

[33] Stringer, K., & Baker, E. (2018, January). Stigma as a barrier to substance abuse treatment among those with unmet need: An analysis of parenthood and marital status. *Journal of Family Issues*, *39*(1), 3–27. https://doi.org/10.1177/0192513X15581659

[34] Substance Abuse and Mental Health Services Administration (SAMHSA). (2018, August). *Treatment episode data set (TEDS): 2016. Admissions to and discharges from publicly funded substance use treatment.* [Data set.] https://www.samhsa.gov/data/sites/default/files/2016_Treatment_Episode_Data_Set_Annual.pdf

[35] Substance Abuse and Mental Health Services Administration (SAMHSA). (2024, March 29). *The task force on maternal mental health's report to Congress*. U.S. Department of Health and Human Services. [Report to Congress]. https://www.samhsa.gov/sites/default/files/mmh-report.pdf

[36] Stone, R. (2015, December). Pregnant women and substance use: fear, stigma, and barriers to care. *Health & Justice*, *3*, 2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/

[37] Coleman, E. (2019, December 5). *Many states prosecute pregnant women for drug use. New research says that's a bad idea.* Route Fifty. https://www.route-fifty.com/management/2019/12/pregnant-women-drug-use/161701/

[38] Dahl, R., Vakkalanka, J., Harland, K., & Radke, J. (2022). Investigating healthcare provider bias toward patients who use drugs using a survey-based implicit association test: Pilot study. *Journal of Addiction Medicine*, *16*(5), 557–562. https://doi.org/10.1097/ADM.0000000000000970

[39] John McConnell, K., Kaufman, M., Grunditz, J., Bellanca, H., Risser, A., Rodriguez, M., & Renfro, S. (2020, April). Project Nurture integrates care and services to improve outcomes for opioid-dependent mothers and their children. *Health Affairs*, *39*(4), 595–602. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01574

[40] Choy, C., McAdow, M., Rosenberg, J., Grimshaw, A., & Martinez-Brockman, J. (2024). Dyadic care to improve postnatal outcomes of birthing people and their infants: A scoping review protocol. *PLOS ONE*, *19*(4), e0298927. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC11020692/

[41] Sakala, C., & Corry, M. (2008). *Evidence-based maternity care: What it is and what it can achieve*. Milbank Memorial Fund. [Report]. https://nationalpartnership.org/wp-content/uploads/2023/02/evidence-based-maternity-care.pdf

[42] Briscoe, H., Murthy, S., & Vais, S. (2021, October). *Do no harm: Rebuilding trust & keeping families together*. California ACEs Aware. https://www.acesaware.org/wp-content/uploads/2021/12/DoNoHarmFinal.pdf

[43] Radel, L., Baldwin, M., Crouse, G., Ghertner, R., & Waters, A. (2018, November). *Medication-assisted treatment for opioid use disorder in the child welfare context: Challenges and opportunities*. U.S. Department of Health and Human Services ASPE. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/185086/MATChildWelfare.pdf

[44] Gresh, A. (2024, May 22). Strengthening maternal and child health: redefining and reimagining postpartum care. *Johns Hopkins Nursing Magazine*. https://nursing.jhu.edu/magazine/articles/2024/05/strengthening-maternal-and-child-health-redefining-and-reimagining-postpartum-care/

[45] The White House. (2022, June 22). *White House blueprint for addressing the maternal health crisis*. [White House Report]. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf

[46] Rodin, D., Silow-Carroll, S., Cross-Barnet, C., Courtot, B., & Hill, I. (2019, October 6). Strategies to promote postpartum visit attendance among Medicaid participants. *Journal of Women's Health, 28*(9), 1246–1253. https://doi.org/10.1089/jwh.2018.7568

[47] Henderson, V., Stumbras, K., Caskey, R., Haider, S., Rankin, K., & Handler, A. (2016, June 24). Understanding factors associated with postpartum visit attendance and contraception choices: Listening to low-income postpartum women and health care providers. *Maternal and Child Health Journal*, *20*(Suppl 1), 132–143. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5290059/

[48] The American College of Obstetricians and Gynecologists. (2018, May). *Optimizing postpartum care (committee opinion no. 736)*. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

[49] The American College of Obstetricians and Gynecologists, 2018.

[50] Ruderman, R., Dahl, E., Williams, B., Davis, K., Feinglass, J., Grobman, W., Kominiarek, M., & Yee, L. (2021). Provider perspectives on barriers and facilitators to postpartum care for low-income individuals. *Women's Health Reports*, *2*(1), 254–262. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8310741/

[51] Ko, J., Tong, V., Haight, S., Terplan, M., Stark, L., Snead, C., & Schulkin, J. (2020). Obstetrician-gynecologists' practices and attitudes on substance use screening during pregnancy. *Journal of Perinatology: Official Journal of the California Perinatal Association*, *40*(3), 422–432.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7047638/

[52] Penn Medicine. (2020, December 11). *Fewer than 2 percent of OB-GYN doctors can prescribe life-saving opioid treatment.* [News Release]. https://www.pennmedicine.org/news/news-releases/2020/december/fewer-than-2-percent-of-obgyn-doctors-can-prescribe-life-saving-opioid-treatment

[53] Penn Medicine, 2020.

[54] Campopiano Von Klimo, M., Nolan, L., Corbin, M., Farinelli, L., Pytell, J., Simon, C., Weiss, S., & Compton, W. (2024, July 17). Physician reluctance to intervene in addiction: A systematic review. *JAMA Network Open*, *7*(7). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2821497

[55] Short, V., Hand, D., MacAfee, L., Abatemarco, D., & Terplan, M. (2018). Trends and disparities in receipt of pharmacotherapy among pregnant women in publicly funded treatment programs for opioid use disorder in the United States. *Journal of Substance Abuse Treatment*, *89*, 67–74. https://doi.org/10.1016/j.jsat.2018.04.003

[56] Campopiano von Klimo M., Nolan L, Corbin M, et al., 2024.

[57] Health Resources & Services Administration. (2024, September 19). *Health workforce shortage areas*. [Data Dashboard]. https://data.hrsa.gov/topics/health-workforce/shortage-areas

[58] Saunders, H., & Rudowitz, R. (2022, June 6). Demographics and health insurance coverage of nonelderly adults with mental illness and substance use disorders in 2020. Kaiser Family Foundation (KFF). [Issue Brief]. https://www.kff.org/mental-health/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/

[59] Mark, T., Parish, W., Zarkin, G., & Weber, E. (2020, July 24). Comparison of Medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*, *71*(9), 947–950 https://psychiatryonline.org/doi/10.1176/appi.ps.202000062

[60] Zhu, J., Charlesworth, C., Polsky, D., & McConnell, K. (2022, July). Phantom networks: Discrepancies between reported and realized mental health care access in Oregon Medicaid. *Health Affairs*, *41*(7), 1013–1022. http://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00052

[61] Rural Health Information Hub. (2024, September 10). *Healthcare access in rural communities overview*. https://www.ruralhealthinfo.org/topics/healthcare-access

[62] Raven, M., Billings, J., Goldfrank, L., Manheimer, E., & Gourevitch, Marc. N. (2009). Medicaid patients at high risk for frequent hospital admission: Real-time identification and remediable risks. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *86*(2), 230–241. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2648879/

[63] Prakash-Zawisza, V., Damodaran, S., Krinsky, S.H., (2024, May 7). [Virtual interview with MassHealth].

[64] Mass.gov. (2024, April 16). *MassHealth doula services program: Information for MassHealth members*. https://www.mass.gov/info-details/masshealth-doula-services-program-information-for-masshealth-members

[65] Hogan, V., Lee, E., Asare, L., Banks, B., Benitez Delgado, L., Bingham, D., Brooks, P., Culhane, J., Lallo, M., Nieves, E., Rowley, D., Karimi-Taleghani, P., Whitaker, S., Williams, T. & Madden-Wilson, J. *The Nurture NJ strategic plan.* (2021). The State of New Jersey. https://nurturenj.nj.gov/wp-content/uploads/2021/01/20210120-Nurture-NJ-Strategic-Plan.pdf

[66] Hogan, V., Lee, E., Asare, L., et al., 2021.

[67] Hogan, V., Lee, E., Asare, L., et al., 2021.

[68] Hogan, V., Lee, E., Asare, L., et al., 2021.

[69] New Jersey Maternal and Infant Health Innovation Authority. (2023, July 17). *N.J. Stat. § 26:18-20*. https://casetext.com/statute/new-jersey-statutes/title-26-health-and-vital-statistics/chapter-2618/section-2618-20-new-jersey-maternal-and-infant-health-innovation-authority-established

[70] Maternal and Infant Health Innovation Authority. (n.d.). The State of New Jersey. https://www.nj.gov/njmihia/about/authority/

[71] New Jersey Economic Development Authority (NJEDA). *Maternal and infant health innovation center*. (n.d.) https://www.njeda.gov/maternal-and-infant-health-innovation-center/

[72] New Jersey Assembly Bill 4530, No. A4530 (2020). https://pub.njleg.state.nj.us/Bills/2020/A5000/4530_I1.PDF

[73] Family Connects NJ. (n.d.). https://www.familyconnectsnj.org/

[74] New Jersey Legislature. Bill A5096 Sca (1R). Session 2022-2023. https://pub.njleg.state.nj.us/Bills/2022/A5500/5096_I2.PDF

[75] McConnell, K., Renfro, S., Wallace, N., Cohen, D., Lindrooth, R., & Chernew, M. (2017). Oregon's Medicaid reform and transition to global budgets were associated with reductions in expenditures. *Health Affairs* , *36*(3), 451–459. https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1298

[76] Health Share of Oregon. (n.d.). *Our story*. https://www.healthshareoregon.org/about/our-story

[77] Project Nurture. (2024). *All sites flyer*. https://www.healthshareoregon.org/storage/app/media/uploaded-files/proj-nurt-all-sites-flyer-2024-v2-1.pdf

[78] McConnell, K., Kaufman, M., Grunditz, J., et al., 2020.

[79] McConnell, K., Kaufman, M., Grunditz, J., et al., 2020.

[79] McConnell, K., Kaufman, M., Grunditz, J., et al., 2020.

[80] Livingston, C., Bernsten, C., Wolff, E., (2024, May 14). [Virtual interview with Health Share of Oregon].

[81] Livingston, C., Bernsten, C., Wolff, E., (2024, May 14). [Virtual interview with Health Share of Oregon].

[82] Project Nurture. (2024). *All sites flyer*.

[83] National Council for Mental Wellbeing. (2024, July 23). *Advancing perinatal health care integration*. https://www.thenationalcouncil.org/resources/advancing-perinatal-health-care-integration/

[84] Northeast Node: The National Drug Abuse Treatment Clinical Trials Network. (2018, January 30). *Node investigators launch Purple Pod to augment care for pregnant women on Buprenorphine*. https://www.ctnnortheastnode.org/node-investigators-launch-purple-pod/

[85] Goodman, D., (2024, April 24) [Virtual interview with Geisel School of Medicine at Dartmouth]

[86] Zuckerberg San Francisco General Obstetrics and Gynecology. (n.d.). *Team Lily for patients*. https://obgyn.ucsf.edu/san-francisco-general-hospital/team-lily-patient-information-0

[87] Seidman, D., (2024, April 30). [Virtual interview with Team Lily at Zuckerberg San Francisco General].

[88] Scherer, J., (2024, July 2). [Virtual interview with Moms Do Care EMPOWER]

[89] Scherer, J., (2024, July 2). [Virtual interview with Moms Do Care EMPOWER]

[90] Shades of Blue Project. (n.d.). *Shades of Blue: Breaking maternal mental health barriers*. https://www.shadesofblueproject.org

[91] Kaiser Family Foundation (KFF), 2024.

[92] Rokicki, S., Patel, M., Suplee, P., & D'Oria, R. (2024). Racial and ethnic disparities in access to community-based perinatal mental health programs: Results from a cross-sectional survey. *BMC Public Health*, *24*(1), 1094. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-18517-7

[93] Fallin-Bennett, A., Elswick, A., & Ashford, K. (2020). Peer support specialists and perinatal opioid use disorder: Someone that's been there, lived it, seen it. *Addictive Behaviors*, *102*, 106204. https://doi.org/10.1016/j.addbeh.2019.106204

[94] Substance Abuse and Mental Health Services Administration. (2024, May 29). Peer support workers for those in recovery. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers

[95] Rokicki, S., Patel, M., Suplee, P., et al., 2024.

[96] Grooms, J., & Ortega, A. (2022, April 29). Racial disparities in accessing treatment for substance use highlights work to be done. *The Evidence Base* [USC Schaeffer Center for Health Policy and Economics blog]. https://healthpolicy.usc.edu/evidence-base/racial-disparities-in-accessing-treatment-for-substance-use-highlights-work-to-be-done/

[97] Rokicki, S., Patel, M., Suplee, P., et al., 2024.

[98] Dwarakanath, M., Hossain, F., Balascio, P., Moore, M., Hill, V. & De Genna, N. Experiences of postpartum mental health sequelae among black and biracial women during the COVID-19 pandemic. *BMC Pregnancy Childbirth* 23, 636 (2023). https://doi.org/10.1186/s12884-023-05929-3

[99] Campopiano von Klimo M., Nolan L, Corbin M, et al., 2024.

[100] Scott, K. A., Shogren, M., & Shatzkes, K. (2023). Reducing fear to help build healthy families: Investing in non-punitive approaches to helping people with substance use disorder. *Maternal and Child Health Journal*, *27*(Suppl 1), 177–181. https://doi.org/10.1007/s10995-023-03772-8

[101]Weber, A., Miskle, B., Lynch, A., Arndt, S., & Acion, L. (2021). Substance use in pregnancy: Identifying stigma and improving care. *Substance Abuse and Rehabilitation*, *12*, 105–121. https://doi.org/10.2147/SAR.S319180

[102] Stone, R., 2015.

[103] Menschner, C., & Maul, A. (2016, April). *Key ingredients for trauma-informed care implementation*. Center for Health Care Strategies. https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/

[104] Huang, R., Yan, C., Tian, Y., Lei, B., Yang, D., Liu, D., & Lei, J. (2020). Effectiveness of peer support intervention on perinatal depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, *276*, 788–796. https://doi.org/10.1016/j.jad.2020.06.048

[105] Substance Abuse and Mental Health Services Association (SAMHSA). (2017). *Value of peers infographics: Peer recovery*. [Infographic]. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-substance-use-disorders-2017.pdf

[106] Centers for Medicare & Medicaid Services. (2021, April). *On the front lines of health equity: Community health workers* [Report]. https://www.cms.gov/files/document/community-health-worker.pdf

[107] Haldar S. & Hinton, E. Kaiser Family Foundation. (2023, January 23*). State policies for expanding Medicaid coverage of community health worker (CHW) services.* [Issue brief]. https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/

[108] Medicaid and CHIP Payment and Access Commission (MACPAC). (2023, November). *Doulas in Medicaid: Case study findings* [Issue brief]. https://www.macpac.gov/wp-content/uploads/2023/11/Doulas-in-Medicaid-Case-Study-Findings.pdf

[109] Puccio J. (2023, December 27). They will never forget how you made them feel: Implementing harm reduction in the perinatal setting. *Maternal and Child Health Journal*. 122-127. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10692246/

[110] Chin, et al., 2022.