



# MAMAs & SAPC

- **Pregnant and postpartum women needing SUD services**
  - Established a process for MAMAs to link SUD patients with SUD provider
- **Non-Pregnant women enrolled in SUD clinics needing FP/PCC**
  - Virtual Health Education classes, linkage with providers for FP/PCC
  - Asking RLP and refer clients interested in FP/PCC to MAMAs HE

# MAMA'S Neighborhood

Maternity  
Assessment  
Management  
Access and  
Service synergy  
throughout the  
Neighborhood for health



Women's Health Programs and  
Innovation (WHPI)



# Preterm Birth: Delivery < 37 weeks

- Leading cause of neonatal morbidity
- Primary reason for hospitalization during pregnancy
- History of spontaneous preterm delivery = 2x more likely for subsequent preterm deliveries
- Babies born before 33wks have higher rates of death & disability
  - Breathing problems
  - Feeding difficulties
  - Cerebral palsy
  - Developmental delay
  - Vision and hearing problems



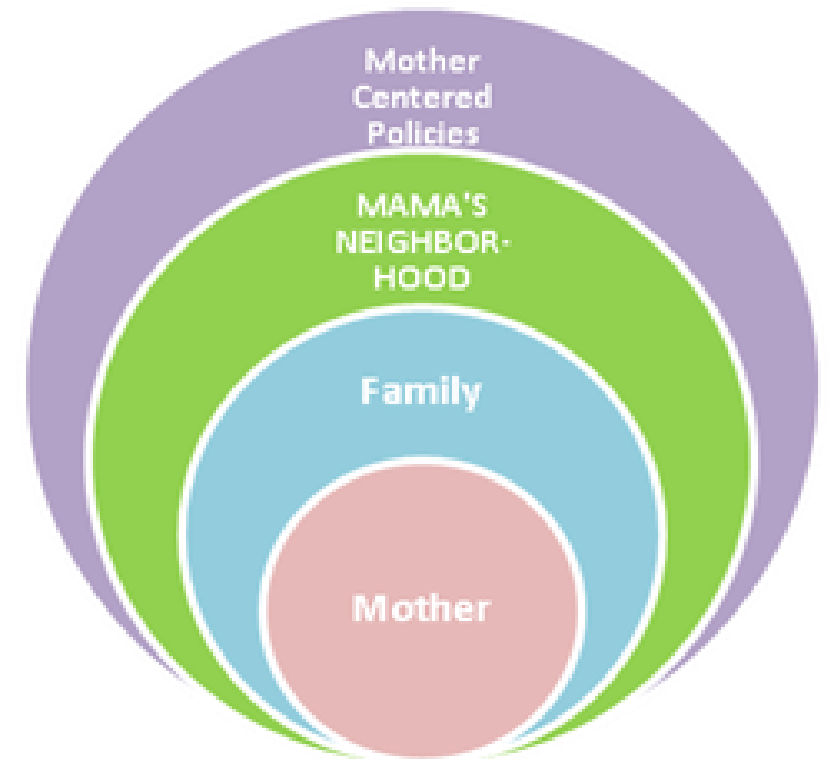
# MAMA'S Neighborhood

A comprehensive, coordinated approach to address 3 core pillars of health:

**Social**

**Physical**

**Mental**



# MAMA'S Care Domains: Prenatal Risk Assessment & Intervention

- ▶ **Substance Use** – smoking, alcohol, drug use
- ▶ **Social Insecurity** – food, housing scarcity, social support
- ▶ **Mental Health** – depression, anxiety, psychiatric dx, intimate partner violence
- ▶ **Biomedical Risk** – previous preterm birth, short cervix, infections, HTN, diabetes, obesity

# MAMA'S Services

- ▶ In-Clinic – MAMA'S Neighborhood
  - ▶ Adjunct wrap around psychosocial services during prenatal care and up to 10 weeks postpartum
  - ▶ **All patients qualify** with consent
- ▶ Home Visitation – MAMA'S Visits
  - ▶ **Specific Criteria:** high stress/risk factors
  - ▶ Women who qualify & consent
  - ▶ Post partum up to 12 months



# MAMA'S Neighborhood Team (In-Clinic)

## Care Coordinator (CC)/CHW

- ▶ Completes the Perinatal Services Intake form in ORCHID
- ▶ Formulates Care Plan & makes referrals & f/u per 3-2-1 Risk Stratification
- ▶ Provides support & health education

## Site Lead Nurse/OB clinic nurse

- ▶ Medical history
- ▶ Lab tests
- ▶ Health Education
- ▶ Coordination of care with CC, provider and SW

## Clinical Social Worker

- ▶ Ongoing cognitive behavior therapy
- ▶ Linkage to psychologist/psychiatry & other behavioral health services

## Health Educator

- ▶ Perinatal Resiliency Classes
- ▶ Individual health education
- ▶ Baby Boutique
- ▶ Hospital tours

## OB Provider/Maternal Fetal Medicine Specialist

- ▶ Clinical services





# MAMA's Neighborhood Services (In-Clinic)

## ▶ 1<sup>st</sup> OB Visit

- ▶ Meet with CC for perinatal intake
- ▶ Offer services/support to help with pregnancy & up to 10 weeks post partum
- ▶ Connect with supportive services within DHS & neighborhood community partners
  - ▶ Food, housing, transportation, counseling, education
- ▶ Clinician Visit within 2wks

## ▶ Follow Up Visits

- ▶ During prenatal apt & by phone
- ▶ Trimester reassessment of referrals
- ▶ Assist with new problems or challenges

## ▶ Prenatal Resiliency Classes

- ▶ Information on all aspects of pregnancy, labor & delivery, nutrition, yoga, tour of the hospital
- ▶ Nurse there to answer questions
- ▶ Can bring partner, friend or family member
- ▶ Receive free good for baby - diapers, clothes, toys, possibly car seats and strollers

## Collaborative Care Meetings

- ▶ Monthly/Biweekly
- ▶ Discussion of high risk patients to unify care with all care team members

# MAMA'S Visits Team: Home Visitation Program

## Care Coordinator (CC)/CHW

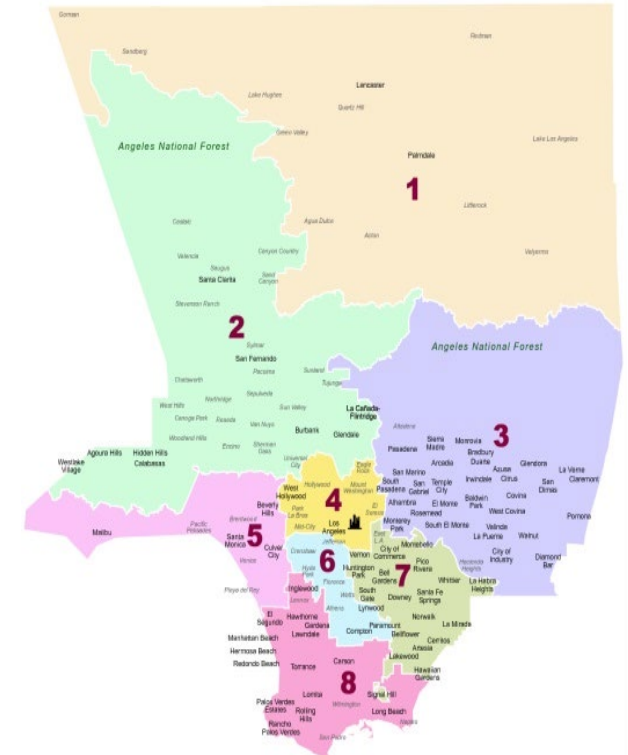
- ▶ Provides support & health education
- ▶ Formulate and follow comprehensive care plan
- ▶ Navigate into health and social services
- ▶ Health Education

## Psychiatric Social Worker

- ▶ Ongoing cognitive behavior therapy
- ▶ Linkage to psychologist/psychiatry & other behavioral health services

## Public Health Nurse

- ▶ Health assessments
- ▶ Follows complex medical needs
- ▶ Education and Support:
  - ▶ Mother-child bonding
  - ▶ Developmental Milestones
  - ▶ Routine Immunizations
  - ▶ Pediatric appointments
- ▶ Support other psychosocial needs



# Eligibility into MAMA'S

## In-Clinic

- ▶ Health Net or LA Care Managed Care Medi-Cal assigned to DHS
- ▶ Restricted Medi-Cal assigned to DHS
- ▶ Willing to receive prenatal care at DHS MAMAs clinic
- ▶ Consent to MAMA'S services during pregnancy and up to 10 weeks postpartum

## Home Visitation

- ▶ High Stress & Chronic Disease: Score on Intake
  - ▶ Homelessness, ER use, bipolar/schizophrenic/Psych apts >4x/yr, chronic dx, substance use, justice involvement, African American
- ▶ Must have custody of newborn
- ▶ Consent during pregnancy or up to 3 months postpartum

# Referrals Into MAMAs and WHPI

Office of Patient Access  
Call 1-844-37-MAMAS

Fill out form on WPC-LA website:

<https://dhs.lacounty.gov/whole-person-care/perinatal-high-risk/>

**If Pregnant:**

Patient will receive an initial prenatal appointment

**If 10 weeks to 3 months postpartum:**

Patient will be referred to a MAMA'S visits staff

dhs.lacounty.gov/wps/portal/dhs/lut/p/b/1/hc1NC4JAGATgXtVvO6r23GNwVSSy1yL-EhRPDJEv3-CjrEQj3gWcYctSsAg6UIFoBF3Tez279pHP0\_18Okuuu0AmDI5CRwPIXRtk63JKuzvEHZCxQXCTQklyqVwYaxtL-Q8wjLcDo\_W2tq

Home > More DHS > Departments > Whole Person Care > Perinatal High-Risk

## Whole Person Care - Los Angeles (WPC-LA)

Whole Person Care
Overview
Homeless High-Risk
Re-entry High-Risk
Mental Health High-Risk
Substance Use Disorder High-Risk
Medically High-Risk
<b>Perinatal High-Risk</b>
Juvenile Aftercare
Medical-Legal Partnership
Frequently Asked Questions
Newsletters
Contact Us

### Perinatal High-Risk Programs

**Overview:** MAMA'S Visits is a healthcare and support program for pregnant and parenting mothers. MAMA'S Visits, an extension of MAMA'S Neighborhood, uses a Mobile Care Team (MCT) to offer comprehensive, coordinated and compassionate home- or community-based care management that is personalized to support low income pregnant and parenting mothers who have complex, stressful life issues. These stressful issues can make a mother's pregnancy difficult, a baby be born too early or too small, it hard for a mother and baby to recover after birth, and it slower for a baby to grow and develop normally. With regular and supportive doctor and care coordinator visits, a mother and baby can work with their MCT to have a healthy pregnancy and be empathically supported during the baby's first years of life. The MAMA'S Visits program can be reached at 1-844-37-MAMA'S.

**Services Provided:**

- Home or community-based care and support visits conducted by a Mobile Care Team (MCT) made up of nurses, counselors and care coordinators
- Educational guidance on healthy pregnancies, recovery after birth and attachment and development with baby
- Group educational classes to learn about pregnancy, stress reduction, breastfeeding, parenting and baby bonding, and a baby development
- Linked prenatal care with a doctor at a MAMA'S Clinic and birth planning at a MAMA'S Hospital
- Community referrals to assist with getting WIC, housing, a new job, training or enrolling in school, childcare or preschool, legal support, transportation and other life needs
- Linked connection to advanced health services like psychiatry, substance use support, violence counseling, and high-risk doctors who see pregnant and postpartum mothers that have diabetes and high blood pressure
- Family planning education, support and contraception, if desired
- Mothers' meet-up socials to celebrate motherhood and build a family

**Inclusion Criteria:**


- Pregnant
- Medi-Cal eligible or low-income
- Experiencing complex, stressful life circumstances

**Length of Program:** 12-18 months

The average length of stay for MAMA'S Neighborhood program is 12-18 months.

For more information, [click here](#) or please call 1-844-37-MAMAS, your local clinic, or e-mail [mamas@dhs.lacounty.gov](mailto:mamas@dhs.lacounty.gov). If you would like to refer a patient, or yourself on our secure portal, please [click here](#).

Be healthy. Call MAMA'S.





Questions?