LINKAGE TO COMMUNITY SERVICES

Overview:

Implementation of a warm handoff process at the time of discharge, when key information can be easily lost or forgotten, will reduce the risk of communication breakdowns that compromise patient safety and jeopardize a smooth and cohesive transition to care.

Why We Recommend this Best Practice

Providing adequate transitions of care pre- and postnatally that include outpatient support structures with expertise in addressing the needs of both the pregnant individual with opioid use disorder (OUD) or substance use disorder (SUD) and their exposed newborns can improve outcomes and support the development of protective factors that reduce or mitigate the effects of adverse life experiences for children and their families. Early interventions like home visits are a prime example of this.

Strategies for Implementation

Step 1: Identify community care resources for the mother and newborn

- Step 1a: Involve the pregnant patient and newborn in outpatient support programs as early as possible, ideally prenatally for the pregnant individual.
- Step 1b: Each unit should maintain an updated list of outpatient resources (federal, state, and local) that families can access including home visitation *(Note: WA DOH is developing a county-by-county resource guide to distribute to hospitals in summer/fall 2022)*
- Step 1c: Arrange a system to refer the pregnant patient and newborn to outpatient OUD/SUD treatment and recovery programs. The system should clarify who refers (physician, social worker, etc.) and when to refer (upon admission or discharge). Consider a default referral on admit orders
- Step 1d: Inform and educate pregnant patietns on these referrals and highlight the benefits of these programs.

Step 2: Schedule all follow-up appointments before discharge

Appointments should include, but are not limited to:

- Recommended routine postpartum appointments at one to two and six weeks postpartum.
- Public health and/or home health home visit within three days of discharge.
- Recommended routine newborn appointments within 24-72 hours after discharge.

Step 3: Implement a warm handoff strategy to follow at time of discharge

Warm handoff standard work should:

- Be in person (whenever possible) and in front of the patient and/or family.
- Include an introduction by the discharging team member to the next care provider.
- Include pertinent details related to prenatal care and the acute care stay.
- Include a review of the discharge goals and plan.
- Include a review of next steps and who is responsible.
- Include a review of what is important to the patient/family.
- Provide an opportunity for all participants, including patient and family, to question, clarify, and confirm information.

Additional Resources

- Perinatal Support Washington for connection to Perinatal Mental Health Services (not specific to addiction services)
- Eat, Sleep, Console Patient-Centered Video - Spokane Regional Health District