PENNSYLVANIA Perinatal Action Collaborative

Actionable Strategies for **Supporting Behavioral Health and Substance Use Disorder Needs**

Goal: Improve detection of behavioral health risks during pregnancy and postpartum and improve referrals and uptake of treatment and supports.

Recommendation: Address wait times for referrals and warm handoffs from screenings for behavioral health and SDOH needs. Limit prior authorizations if possible and work to reduce wait times for appointments.*

*Updates to the recommendation were made to focus on wait times for mental health and SUD care.

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About the Perinatal Action Collaborative:

Over the past year, the PA Departments of Health, Human Services, Drug and Alcohol Programs and Insurance have been developing the PA Maternal Health Strategic Plan (MHSP).

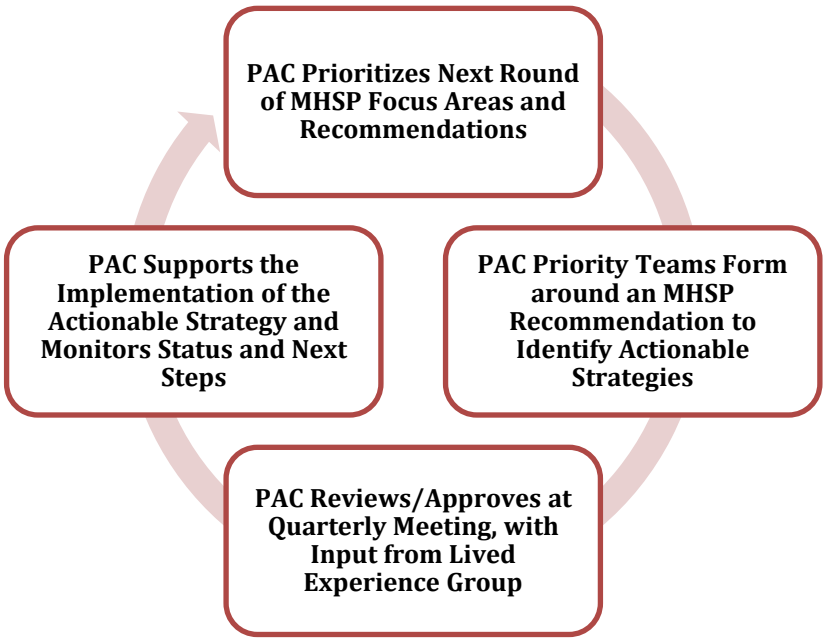
The MHSP includes goals and recommendations for the following focus areas: Increasing Access to High-Quality Care, Supporting Behavioral Health and Substance Use Disorder Needs, Improving Rural Health and Maternity Care Deserts, Addressing Health Related Social Needs (HRSN), and Expanding and Diversifying the Health Care Workforce.

The MHSP was informed by a statewide survey completed by over 700 Pennsylvanians and a series of listening sessions with stakeholders, including healthcare professionals, CBOs, people with lived experience, and health plans among others.

The Pennsylvania Department of Health also received a HRSA grant for the Maternal Health Innovation Program (MHIP) Program, which supports states in creating maternal health strategic plans, establishing task forces like the Perinatal Action Collaborative (PAC), and implementing interventions from the strategic plans.

The IMPLICIT Network is a primary care maternal child health learning collaborative focused on improving birth outcomes and promoting the health of women, birthing people, infants, and families. Founded in 2003 with support from the March of Dimes, the Network is a national leader in interconception health and is currently administered by the University of Pa. Health System (Penn Medicine). The IMPLICIT Network is an implementation partner of the PAC serving a dual mission to collect, analyze and improve data that furthers scientific knowledge of best practices, as well as to support the community of practice with tools, resources and trainings to improve quality and equity in maternal health care.

Figure 1: PAC's Process to Create and Implement Actionable Strategies for MHSP Recommendations



Background

Existing Programs and Initiatives
This is not an exhaustive list and additional programs or initiatives may exist.

The Perinatal TiPS program was created to serve pregnant and postpartum individuals with mental health and SUD needs. Perinatal TiPS offers peer-to-peer consultation for providers caring for pregnant and postpartum individuals with behavioral health needs, resource referrals, educational services for perinatal providers, and telehealth and in-person bridge counseling for individuals with acute needs. The purpose of this program is to provide access to specialists in perinatal psychiatry and perinatal addiction medicine to individuals in need regardless of the location of their care. This service is available regardless of the patient's insurance status or payer type. This program operates on a regional basis with teams consisting of perinatal psychiatrists, perinatal addiction medicine specialists, and care coordinators. For example, if a family physician in a rural area of Pennsylvania has a patient with a prenatal or postpartum mental health condition or SUD, but does not have the training to treat the patient for their mental health condition or SUD, they can call their regional Perinatal TiPS program and receive peer-to-peer consultation on the appropriate treatment for their patient and begin that treatment. Additionally, doulas can also call the Perinatal TiPS line for guidance on perinatal depression and SUD.

Phia Health is a behavioral health platform that supports pregnant and postpartum individuals across Pennsylvania by providing evidence-based perinatal mental health screenings, continuous risk detection supported by AI, and rapid escalation to licensed clinicians and care coordinators. The platform proactively identifies behavioral health risks and ensures connection to treatment, rather than passive referral. The program will prioritize implementation in Philadelphia, Delaware, Montgomery, Lancaster, Erie, and rural northern counties identified as maternity care deserts or limited-access regions. Services will be delivered through both a secure web/app platform and SMS text messaging, ensuring accessibility for all individuals regardless of broadband, insurance type, or digital literacy. This website and app were developed in response to the education and screening actionable strategies identified in the first cycle of the priority team. During that cycle the priority team developed actionable strategies to improve screening and referral.

Additional initiatives identified by the Priority Team during the current cycle include:

- Workforce
    - The North American Board of Reproductive Psychiatry (NABRP) was formed by a group of reproductive psychiatrists, representing national organizations, who were selected by peers to explore and develop a pathway for board certification in reproductive psychiatry.
    - Several promising internship and practicum programs also exist in PA, such as Oshun Family Center's workforce programs.
    - DDAP's collaboration with universities is helping to strengthen the behavioral health workforce by helping students interested in the SUD field with educational expenses.
    - Funding HBCUs to shift their educational offerings to include BH programs has been a successful approach to attract diverse students and build a pipeline in North Carolina.

    - PA HB 2121 establishes a provisional licensure pathway for international medical graduates to practice in Pennsylvania under supervision, addressing physician shortages while maintaining patient safety, which could help to expand access to a culturally and linguistically diverse workforce.
- Care Integration
    - Trauma-Informed Care Training Resource – The Empowerment Equation is a resource to help women with histories of trauma prepare before delivery, to offer help for providers seeking to understand patient perspectives using first-hand narratives, and to provide evidence-based research on this topic.
    - Resources for Integrating Mental Health into Perinatal Care – The Alliance for Innovation on Maternal Health released a patient safety bundle for perinatal mental health conditions. ACOG released a Perinatal Mental Health Toolkit.
    - The IMPLICIT Network, which has 19 sites in PA, developed both an Interconception Care (ICC) model and a 4th Trimester Care Model that include BH screening in pediatric, family medicine settings and OB/GYN settings.
    - MFHS conducts mental health screenings and referrals during WIC visits.
- Support Workers
    - One example model is hiring impact workers—community members with lived experience who are trained to support patients through their mental health journey.
    - Many examples of successful home visiting, doula and perinatal peer support programs exist, such as Mabel Morris Family Program, Nurse-Family Partnership, Healthy Start, Early Head Start and Healthy Moms, Healthy Babies, the Diversifying Doulas Initiative and Newborns & Neighbors.

Data and Demographics

The Pennsylvania Insurance Department's Network Adequacy Study found the following based on secret shopper surveys in 2023 and 2024:[1]

- Adult callers were able to obtain appointments with Outpatient Behavioral Health Counselors in only 14% of cases due to the large number of unsuccessful contacts and inaccuracies.
- Even when successful, mean wait times for outpatient behavioral health counselors was 35.1 days for adults (median of 25.5 with a range of 1 to 609 days)
- Among simulated patients who completed up to 10 calls, 41.2% were successful in getting a psychiatry appointment and over 45% were successful in getting a psychology appointment, with wait times averaging about 50 days for psychiatry and 40 days for psychology.
- The most common problems experienced by callers were inaccuracies in provider directories (e.g., phone numbers, specialty, and network status) experienced by 47% of callers and provider capacity issues experienced by 15% of callers overall (about 24% for psychology and 20% for psychiatry)

[1] https://www.pa.gov/agencies/insurance/public-hearings-outreach-and-special-projects/network-adequacy-study

This is despite existing federal laws that require health plans to update and verify provider directories at least every 90 days.

PA DHS also tracks the following quality measures across their Physical HealthChoices Managed Care Organizations (MCOs).[2]

- Follow-Up on Positive Prenatal Depression Screening (53.52% in measurement year 2024 as a weighted average across the MCOs)

- Follow-Up on Positive Postpartum Depression Screening (61.23% in measurement year 2024 as a weighted average across the MCOs)

- Getting Appointment With Specialist (Usually or Always) (81% in measurement year 2023 as a weighted average across the MCOs)

For the above depression measures, HEDIS defines "follow-up" as receipt of any of the following within 30 days after the first positive screen: any type of follow-up visit with a diagnosis of a behavioral condition, a depression case management encounter, a behavioral health encounter, a diagnosis of encounter for exercise counseling, a dispensed antidepressant medication, or negative full screen on the same day.

PA DHS also tracks the following quality measures across their Behavioral HealthChoices MCOs:

- Initiation of Substance Use Disorder (SUD) Treatment (51.5% for 2023)[3]

PA DOH also reports the percent of pregnant women with OUD insured by Medical Assistance (MA) who are taking MOUD (e.g., 46.54 % in 2024 Q4) using PA DHS' data.[4]

In an April 2026 policy paper entitled *Improving Maternal Mental Health in Women With Serious Mental Illness*, SAMHSA identified gaps in systems for maternal mental health, including a lack of available providers who are able to treat mental health in the perinatal period, inadequate training in maternal mental health among existing providers, and access gaps in rural areas where there are fewer OB, addiction medicine, and psychology/psychiatry specialists. Additionally, opportunities identified in the paper align with strategies recommended by the PAC, both in previous cycles and in this document. These strategies include support for universal screening, training and consultation programs, integrated care, maternal mental health peer support, and home-visiting programs. [5]

The CHOP Research Institute identified significant barriers to care for SUD among pregnant and postpartum peopler relative to other populations. Identified barriers include siloed systems (i.e.

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[2] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/2025-hedis-performance-measures-rate-chart.pdf

[3] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/hc-services/documents/2024-omhsas-annual-technical-report.pdf

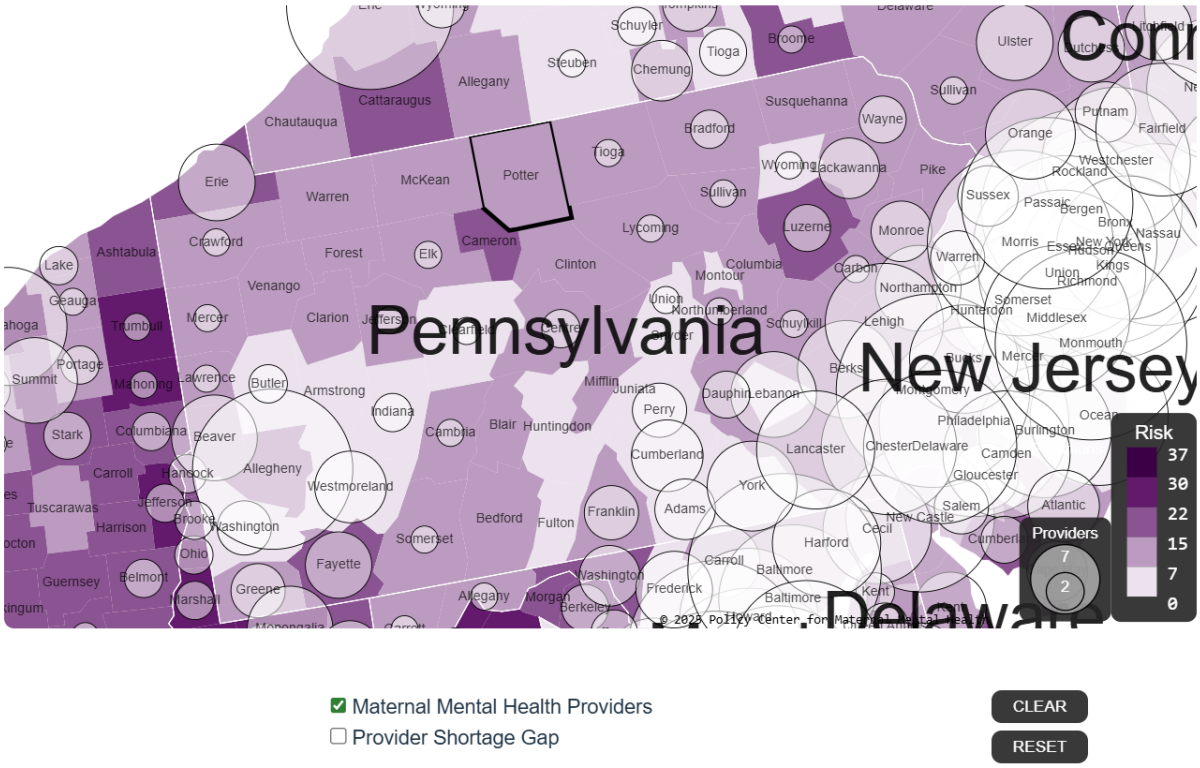
[4] https://data.pa.gov/stories/s/Pennsylvania-Opioids-Impact-on-Families-and-Childr/5jbf-sr7p/

[5] https://library.samhsa.gov/sites/default/files/tac-maternal-mental-health-pep26-01-006.pdf

child welfare, healthcare, medical insurance) and stigma related to having an SUD when pregnancy/parenting, as well as stigma about providing MOUD treatment. Other provider-level barriers include being uncomfortable with, improperly trained in, or afraid of the legal consequences of providing MOUD to pregnant and postpartum patients.[6]

The Policy Center for Maternal Mental Health's map below shows the maternal mental health risk and and number of mental mental health providers in each county. The risk factor is based on known factors associated with poor maternal mental health and over two dozen datasets were collected and standardized. [7]

Map 1. 2025 U.S. Maternal Mental Health Risk and Resources Maps

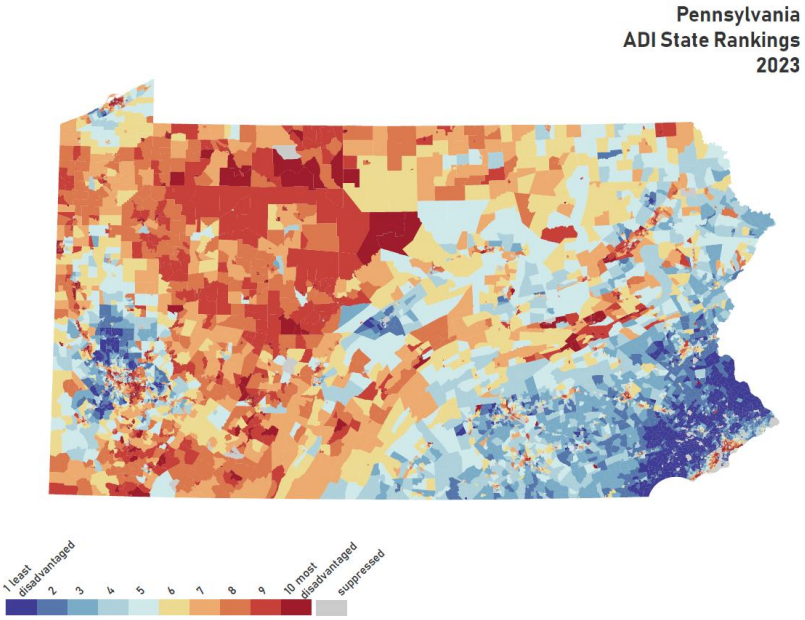


[6] https://www.research.chop.edu/cornerstone-blog/what-prevents-pregnant-postpartum-people-with-opioid-disorder-from-accessing-care

[7] https://mmhmap.com/

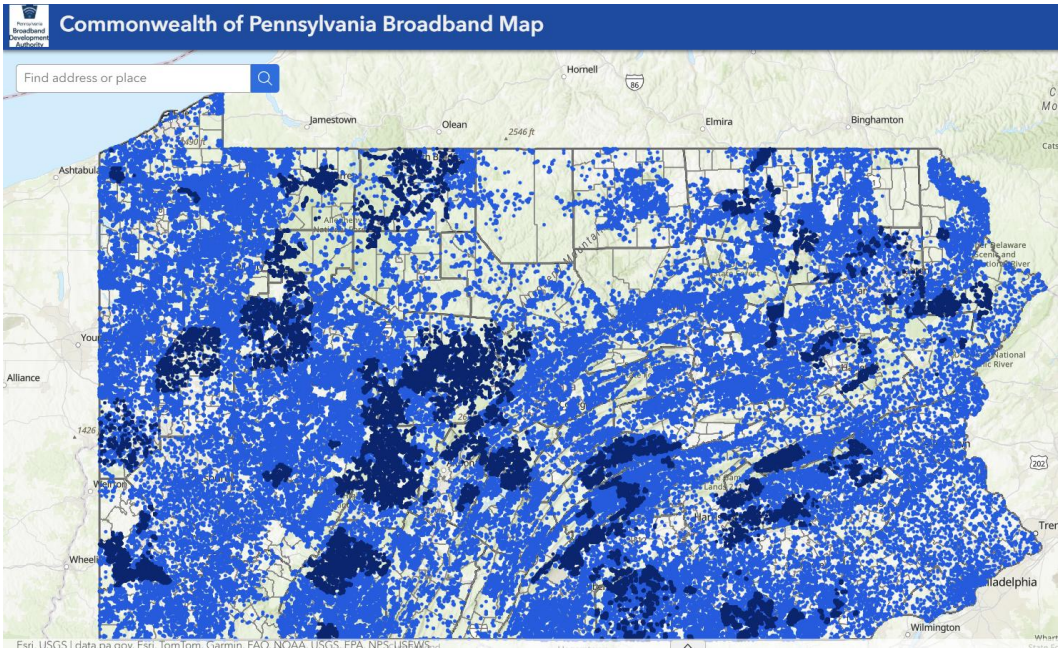
Map 2. Pennsylvania Area Deprivation Index

The map to the right shows neighborhood disadvantage by census block, calculated using a scientifically validated measure. This includes gaps related to socioeconomic status, education and housing.[8] This map illustrates areas where residents may have higher SDOH needs that could increase barriers to accessing care.



Map 3. Commonwealth of Pennsylvania Broadband Map

The map below shows broadband connectivity across the state.[9]



[8] https://www.neighborhoodatlas.medicine.wisc.edu/
[9] https://broadband.pa.gov/maps-data/

Description of the Actionable Strategies

For the purposes of this document, "perinatal" refers to the time during pregnancy and up to one year postpartum/after the end of a pregnancy. "Behavioral health" (BH) refers to both mental health (MH) and substance use disorders (SUD).

1. Integrated Care

To reduce wait times for perinatal MH and SUD care, outpatient obstetric providers (e.g., midwives, OB/GYNs, family medicine OB) should offer co-located (fully integrated or contracted) trauma-informed perinatal BH treatment. Primary care clinics often provide faster connections to BH than obstetric settings. However, patients report a higher level of comfort seeking BH support from obstetric providers due to the frequency of contact during pregnancy. Meanwhile, some clinicians feel uncomfortable discussing MH/SUD with patients due to stigma, which limits referrals.

To address these barriers, the **PAC BH Priority Team recommends to pilot an integrated care model at an outpatient obstetric clinic (with a champion at the clinic) located in Philadelphia County.** This pilot would increase the skills, competencies, and comfort levels of whole person care at the clinic. Philadelphia County was selected as an ideal location due to the population density and diversity, allowing for discoveries that could inform implementation throughout the state with varying populations. Additionally, although Philadelphia is an urban area, many patients from surrounding rural counties with limited maternity care, such as Delaware County, travel to Philadelphia for OB care. This could generate lessons for care connections in other urban areas where individuals have to travel for care. A second pilot in a rural area should be considered to explore solutions to unique barriers to care (i.e. transportation, internet access), followed by dissemination of best practices for both urban and rural settings to all OB providers throughout the state.

The PT recommends focusing on integrating co-located MH and SUD care due to the common co-occurrence between the two. It is important to have a one-stop shop for whole-person care as a best practice (including both MH and SUD care) to help transform what perinatal care will look like in Pennsylvania. It will also be important to create the financial structures and incentives to support this model, including for patients receiving Medicaid.

Two examples of evidence-based models of care include Screening, Brief Intervention, and Referral to Treatment (SBIRT) and Collaborative Care Management. Research has shown that SBIRT has a return on investment ranging from $3.20-$4.40 for every dollar spent. Collaborative Care Management has been shown to have a four-year cost-difference of $3,363 less per patient. Project components recommended by the PT include:

1. **Establish connections to Perinatal TiPS**. In addition to provider-to-provider consultation and referral assistance, the Perinatal TiPS teams could provide training on addressing stigma related to perinatal BH, how to integrate BH care in obstetric settings and offer bridge therapy. Trainings should help obstetrics providers with scripting on follow-up/referrals, increase the capacity of the obstetrics team to assess and prescribe for

depression and anxiety, use stepped care treatment models with psychiatrists (e.g., treating mild/moderate symptoms and referring complex cases to psychiatry).

2. **Establish connections with the OUD Centers of Excellence**. The OUD Centers of Excellence program includes expectations for the physical and behavioral health COEs to coordinate care with obstetrics providers and either provide or refer to MOUD for pregnant women.

3. **Conduct comprehensive screenings and referrals**. Beginning conversations and universal screenings for MH/SUD early in pregnancy, and continuing them throughout pregnancy/postpartum visits, can help to educate patients and make difficult conversations easier if and when more serious needs arise. SDOH screenings and strong, coordinated connections to primary care and community-based support services, including domestic violence help centers, should also be included to ensure other health (i.e. chronic disease management) and social needs are met.

4. **Partner with perinatal support workers.** Support workers, such as home visitors, CHWs, doulas, peer navigators, and case managers can provide early and ongoing, trauma-informed support outside of clinical settings throughout the postpartum period—helping to address barriers such as transportation, childcare, language access, and housing instability; reinforcing education on perinatal MH/SUD; facilitating communication and warm handoffs between providers and community services; and offering continuous care and navigation support throughout pregnancy, the postpartum period, and beyond.

5. **Support BH workers**. Fostering a sense of belonging and shared purpose when integrating BH workers into the care team, providing sufficient pay and balancing patient loads.

6. **Reduce no-show rates**. Effective scheduling tactics, should be implemented in order to increase show rates and support justification for additional BH staffing. Examples include having a nurse or case manager do warm handoffs to the scheduler and using trauma-informed communication practices (i.e. explaining who you are, asking permission to discuss the details of an appointment, not leaving messages to protect patient privacy, explaining what will happen at the appointment, grounding prior to the call, and making sure the patient is comfortable.)

7. **Offer telehealth and other flexible service delivery options**. For patients with barriers to accessing in-person care (i.e. disability, transportation, childcare) or for whom receiving BH care outside of the clinical setting is preferred (i.e. patients who have experienced medical/birth trauma), tele-behavioral health can increase their access and likelihood of attending appointments. Other options such as home-based care and evening or weekend hours can also increase access to care.

8. **Implement an accessibility policy**: To ensure equitable access to care, develop and implement standards that address accessibility needs (i.e. language access, disability accommodations, culturally responsive care, and technology access), including protocols for providing interpreters (spoken language and ASL), plain language materials, and preferred communication formats/platforms (verbal, written, texting, app-based).

2. Cross-sector Perinatal MH/SUD Collaborative

Health systems should establish a cross-sector collaborative infrastructure with obstetrics providers, perinatal MH/SUD care providers, and nonclinical perinatal support organizations to reduce wait times for the communities they serve. Primary challenges to integration of nonclinical supports include siloed communication between health systems, screening services and community service providers, including crisis services. For community service providers, navigating the health system and knowing who to reach out to remains a barrier to connecting patients to appropriate care.

Supportive workers offering services outside of the clinical context (i.e. doulas, CHWs, home visitors, peer navigators) can create an essential bridge with the healthcare system, as doulas and CHWs often have more frequent contact with, and are more trusted by, patients. These individuals can help to close the communication gap between health care providers and patients, and reduce barriers due to stigma.

To address persistent barriers due to siloed communication between perinatal support workers community service providers (i.e. BH services, crisis services), people with lived experience, and health systems—**the PAC Behavioral Health Priority Team recommends funding a health system or community-based organization, with the capacity to serve as a convener, in a community with a high ADI ranking and large Medicaid population to establish a cross-sector collaborative, including the following steps**:

1. **Conduct a regional ecosystem mapping and gap analysis**. Identify all relevant stakeholders across the perinatal MH/SUD continuum (health systems, OB/GYN and primary care practices, MH/SUD care teams, telehealth providers, community-based organizations, home visiting programs, crisis services, and payors). Map referral pathways, existing partnerships, and breakdown points where patients are lost to follow-up.
    a. Consider individuals/organizations that support patients with physical and cognitive disabilities, insurance barriers, limited English proficiency, immigrant status, or those experiencing housing instability (i.e. traveling and ASL interpreters, "mommy clubs", CHWs, peer mentors)
    b. Include organizations addressing common perinatal concerns (i.e. breastfeeding support, transportation, childcare services)

2. **Establish a cross-sector Perinatal MH/SUD Collaborative.** Institute a regionally anchored group and hold regular cross-sector check-ins (e.g., monthly or quarterly) with representation from clinical providers (including in-person, telehealth, Medicaid), community-based organizations, and individuals with lived experience. The health system

should take responsibility for initiating and resourcing this table to reduce the burden on community partners to navigate outreach independently. Review referral patterns, troubleshoot breakdowns, and assess partnership effectiveness. Use these forums to continuously refine workflows and ensure accountability across partners.

3. **Produce a standardized "who-to-contact" infrastructure guide**. Define roles, workflows, and points of contact across systems, including clear points of entry for referrals, warm handoffs, and crisis escalation. This should include designated liaisons within clinical settings and community organizations to streamline communication and reduce navigation barriers.

4. **Establish data-sharing agreements and privacy protocols.** Proactively address HIPAA, confidentiality, and consent barriers by developing a common understanding of the current state/federal policies and standardized agreements and workflows that enable appropriate information sharing while protecting patient privacy. Provide technical assistance to partners unfamiliar with healthcare compliance requirements.

5. **Engage in cross-training.** Provide support workers (i.e. doulas, CHWs) with training in trauma-informed approaches (i.e. PSI maternal health training), perinatal mood and anxiety disorders and SUDs so they can provide pregnant and postpartum individuals with critical education and interim support until they are able to make a connection to MH/SUD treatment. Provide clinical teams with training on SDOH to expand understanding of barriers to care and reduce stigma around perinatal mental health and substance use.

6. **Create shared accessibility policies and processes.** To ensure equitable access to care, develop and implement cross-system standards that address accessibility needs (i.e. language access, disability accommodations, culturally responsive care, and technology access), including protocols for providing interpreters (spoken language and ASL), plain language materials, and flexible service delivery options (i.e. telehealth, home health, extended hours). Ensure these policies are consistently applied across clinical and community-based partners to reduce disparities and support equitable engagement in perinatal MH/SUD services.

7. **Advocate for financial incentives.** To help ensure sustainability, incentives are needed to support these types of collaborations through policy or through payor-driven incentives.

3. Tele-behavioral Health Services

In order to reduce wait times for individuals in areas with limited provider availability, trained perinatal MH and SUD treatment providers should expand trauma-informed tele-behavioral health services. In Pennsylvania, poor bandwidth in rural areas and Social Determinants of Health (SDOH) remain significant hurdles to accessing and prioritizing tele-behavioral health visits. Many patients also lack the safe, private spaces required for telehealth visits. Recent policy changes allowing Medicaid providers and patients to conduct visits from home will help to increase access to telehealth.

In response to these barriers, the **PAC Behavioral Health Priority Team recommends to fund pilot sites for tele-behavioral health expansion, focusing on counties with the most the limited access to MH/SUD care.** The Priority Team identified Fayette/Somerset, Luzerne/Sullivan, and Cameron Counties as those with the greatest disparities in number of BH providers and lack of broadband access in PA.

Note: The Pennsylvania Broadband Development Authority is working to close this digital divide. Maps can be accessed on their website to assess a community's access to internet.

The Priority Team suggests the following components for demonstration projects:

1. **Expand Perinatal TiPS to also offer telehealth as bridge therapy.** Offer telehealth (bridge therapy) in these areas through Perinatal TiPS and help link patients to longer-term therapy/psychiatry in their communities. The telehealth providers (e.g., expanded Perinatal TiPS teams) would identify safe, private spaces required for telehealth visits (e.g., in their homes) and also safe community spaces (e.g., schools, municipal buildings, libraries, and pharmacy consultation rooms).

   "Expanded Perinatal TiPS" should also identify a "trusted network" of perinatal psychiatrists who provide telepsychiatry and perinatal SUD providers (e.g., OUD COEs and bridge clinics that offer telehealth), including those who accept Medicaid.

   **Note: This trusted network could potentially help prepare for the Regional Maternal Health Hubs in the PA Rural Health Transformation Program.*

2. **Expand provider training.** To further build out the "trusted network," Expanded Perinatal TiPS could also offer provider trainings and technical assistance to enhance provider competency in providing tele-behavioral health care for pregnant and postpartum individuals, building comfort and technical skills for tele-behavioral health. Topics should include common barriers to care and social determinants of health, strategies for enhancing accessibility for individuals with disabilities, integrating trauma-informed care into digital platforms, addressing perinatal MH/SUD stigma, and streamlining administrative and electronic billing processes to reduce barriers.

3. **Offer "telehealth gift baskets."** Telehealth providers could consider offering gift baskets for patients without in-home broadband containing necessary equipment and supplies that could help new parents prioritize these visits. Given that an internet connection or access to data is required to operate the equipment and participate in telehealth appointments, partnerships should be explored to help cover the costs of data or internet for program participants.

4. **Integrate non-clinical support workers.** Telehealth providers could integrate CHWs, doulas, peer navigators, interpreters and home visitors into tele-behavioral health models to improve engagement and continuity of care—supporting patients in preparing for

telehealth visits, identifying or accessing safe/private spaces, reinforcing education on perinatal MH/SUD, facilitating communication with providers, and providing ongoing, trusted touchpoints between virtual visits, particularly for patients with physical and cognitive disabilities, as well as those facing transportation, language, or other access barriers.

5. **Implement an accessibility policy**: To ensure equitable access to care, develop and implement standards that address accessibility needs (i.e. language access, disability accommodations, culturally responsive care, and technology access), including protocols for providing interpreters (spoken language and ASL), plain language materials, and preferred communication formats/platforms (verbal, written, texting, app-based).

Equity

The Priority Team identified the following equity considerations to center in the implementation of the above actionable strategies:

- Stigma is a significant barrier to care for individuals with mental health and substance use disorders, especially during the perinatal period.
- Counties in rural areas as well as outlying areas in some urban/suburban counties disproportionately lack access to care (before and after pregnancy) including OB care, perinatal care, and BH care. Resource gaps include transportation and significant lack of internet access.
- Waiting times can vary by insurance type, including Medicaid, due to lack of in-network BH providers.
- Providers sometimes lack awareness that SDOH barriers are preventing patients from attending appointments.
- People with disabilities experience barriers accessing psychiatrists and often experience quality of care issues when those services are accessed. Lack of availability of accessible offices can increase wait times.
- There is a lack of support for how to navigate the system prenatally and postpartum, especially for those with language barriers and for immigrant populations.
- Lack of providers with specialized training to support perinatal behavioral health needs, especially beyond an initial intake appointment.

Appendix – Cycle 1 Actionable Strategies

Excerpt from Cycle 1 Behavioral Health Priority Team Actionable Strategies Document, reinforcing the need for specialized residency programs for perinatal psychiatry:

"As screening and referral occur, care is only successful if there are trained providers that can provide specialized care that is needed for perinatal psychiatric and perinatal addiction medicine treatment. Education for the perinatal workforce is needed to increase the number of qualified personnel available to care for this patient population. Studies show that Ob/Gyns and Psychiatrists are not likely to receive the necessary training in perinatal psychiatry and perinatal SUD to treat these conditions. An increase in trained providers is needed to address the current resource barrier and reduce delays and admissions in care.

Approaches for educating medical and non-medical providers are needed. Education is needed at all levels, from master's and doctoral education through residency to current practice. In the past the PA DOH worked with medical schools in Pennsylvania to include addiction as a core competency for medical students' education. Medical schools could ensure that maternal SUD information is included in current addiction core competency curriculum, which would ensure that all medical students graduating in Pennsylvania would have some knowledge of maternal SUD. This concept could be applied to maternal mental health. If there is an existing core competency for mental health, add maternal mental health to the curriculum. If this does not exist, the state should work with the medical schools to establish a core competency in mental health with education on maternal mental health. Additionally, the state could work with nursing and midwifery programs to ensure these areas are part of their student's curriculum.

The commonwealth, through its networks and relationships with health systems, could encourage medical residency programs, especially in psychiatry, Ob/Gyn and family medicine, as well as midwifery programs, to require clinical rotations in perinatal psychiatry. In lieu of, or in addition to this requirement, supplemental education could be required at a variety of levels. There is a national effort to mandate that OBGYN residency programs in the future include perinatal psychiatry as part of their training programs."

To read the full document, visit: https://perinatalactioncollaborative.org/content/rfp/36-bh-and-sud-actionable-strategies-plan-2-25-26/file

See the Cycle 1 Rural Health Priority Team Actionable Strategies Document for information on virtual care expansion: https://perinatalactioncollaborative.org/content/rfp/38-rural-and-maternity-care-deserts-actionable-strategies-plan-2-25-26/file