GRACE: Guiding Recovery and Creating Empowerment

A Replicable Hospital-Based Model for Addressing Substance Use in Pregnancy

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Contents

Executive Summary *1*

The Need for a New Model of Care *1*

Program Overview *2*

Core Model Design: The RN–SW Dyad **3**

The Nurse 3

The Social Worker 3

The Dyad 4

Care Across the Continuum **4**

Community Partnerships **6**

Treatment, Substance Use, and Behavioral Health Facilities 7

Shelters and Resource Centers 7

Transportation Services 8

Specialized Attorneys and Family Justice Centers 8

Adoption Services 8

Resource Banks 8

Primary Care Providers 9

Financial Model and Sustainability *9*

Getting Started 9

Sustained Funding 9

Services Provided per Service Label 10

Implementation Roadmap *12*

Defining the Target Population and Eligibility **12**

Establishing a Task Force Team **12**

Establishing & Maintaining Partnerships **13**

Community/External Partnerships 13

Internal Partnerships 13

Hospital Operational Changes **14**

EMR automation 14

Pharmacy 14

Program Oversight **15**

Program Scale and Operations *15*

Case Load Recommendation **15**

Staffing Recommendation **16**

Education and Workforce Development *16*

Outcomes and Evaluation *17*

Patient Success Story **17**

Challenges and Lessons Learned *18*

Conclusion *19*

References *21*

Appendices *23*

A. Referrals **24**

A1. Referral to GRACE Form 24

A2. Referral Feedback Form 25

B. Enrollment Forms **26**

B1. Consent for Treatment 26

B2. New Patient Information Form 27

B3. Final Notice of Privacy Practices 28

B4. Program Agreement Contract, Patient 34

B5. Notice Regarding Re-Disclosure 35

C. Screening/Assessment Forms **36**

C1. RN Intake Questionnaire 36

C2. Social Worker Assessment Form 37

D. Delivery Planning Checklist **43**

D1. Delivery Planning Checklist 43

D2. SBAR Example 44

E. Graduation Certificate **46**

E1. Woman's GRACE Graduation Certificate 46

F. Marketing **47**

F1. GRACE Marketing 1-Pager 47

F2. Handout/Poster 48

Executive Summary

Substance use during pregnancy remains a critical driver of maternal and neonatal morbidity and mortality across the United States. The GRACE program is a care navigation program that was developed to address these challenges through a coordinated, patient-centered model that integrates clinical care, behavioral health, and social support. Designed around a nurse (RN) case manager and social worker (SW) dyad, GRACE provides long-term care from pregnancy through the postpartum period up to one year. **This paper presents a comprehensive overview of the GRACE model and offers a practical roadmap for hospitals seeking to replicate it.**

The Need for a New Model of Care

Substance use disorder (SUD) during pregnancy has become an increasingly significant public health challenge in the United States. Between 2010 and 2017, opioid-related diagnoses at delivery hospitalization increased by more than 130%, reflecting a broader rise in substance use among reproductive-aged women (Centers for Disease Control and Prevention [CDC], 2024). This trend has been accompanied by increases in pregnancy-associated morbidity and mortality and adverse neonatal outcomes, including preterm birth, stillbirth, low birth weight, and neonatal abstinence syndrome (NAS) (CDC, 2024; American College of Obstetricians and Gynecologists [ACOG], 2017). Substance use has also emerged as a major contributing factor in pregnancy-associated deaths, underscoring the need for earlier identification and comprehensive intervention (ACOG, 2017).

Pregnant individuals with SUD frequently experience co-occurring mental health disorders and face substantial social and structural challenges that directly influence health outcomes. Housing instability, food insecurity, transportation barriers, intimate partner violence, involvement with child welfare or the legal system, and limited access to behavioral health services often coexist with substance use, creating complex care needs that extend beyond routine obstetric management (ACOG, 2017; Weber et al., 2021). Consequently, successful treatment requires simultaneous attention to medical, psychological, and social determinants of health. Traditional prenatal care models are generally organized around episodic medical encounters and referrals to external services. Although appropriate for many obstetric conditions, this approach often fragments care for patients with SUD by requiring them to independently navigate multiple healthcare, behavioral health, and community systems. These fragmented care pathways contribute to delays in treatment initiation, poor continuity of care, lower prenatal care utilization, and reduced retention in addiction treatment. In addition, stigma within healthcare settings and fear of punitive consequences, including child welfare involvement, criminalization, or loss of custody, can discourage disclosure of substance use and delay engagement with prenatal care (Weber et al., 2021; ACOG, 2011).

Recognizing these challenges, national organizations including the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) recommend integrated, multidisciplinary models of care that combine obstetric services with addiction medicine, behavioral health treatment, social work, patient navigation, and community-based resources (ACOG, 2017; Ecker et al., 2019). Evidence demonstrates that coordinated care models incorporating universal screening, timely referral to treatment, medication for opioid use disorder (MOUD), long-term care coordination, and recovery support improve treatment engagement, prenatal care utilization, and maternal and neonatal outcomes compared with fragmented systems of care (ACOG, 2017; Reddy et al., 2017; American Society for Addiction Medicine, 2026).

The GRACE Program was developed in response to this evidence. Rather than functioning as an additional referral service, GRACE serves as a centralized care coordination model that integrates obstetric care with addiction treatment, behavioral health services, and community partnerships. By addressing medical, behavioral, and social needs concurrently through a multidisciplinary team, the program seeks to reduce barriers to care, improve patient engagement, and promote healthier outcomes for both mothers and infants.

Program Overview

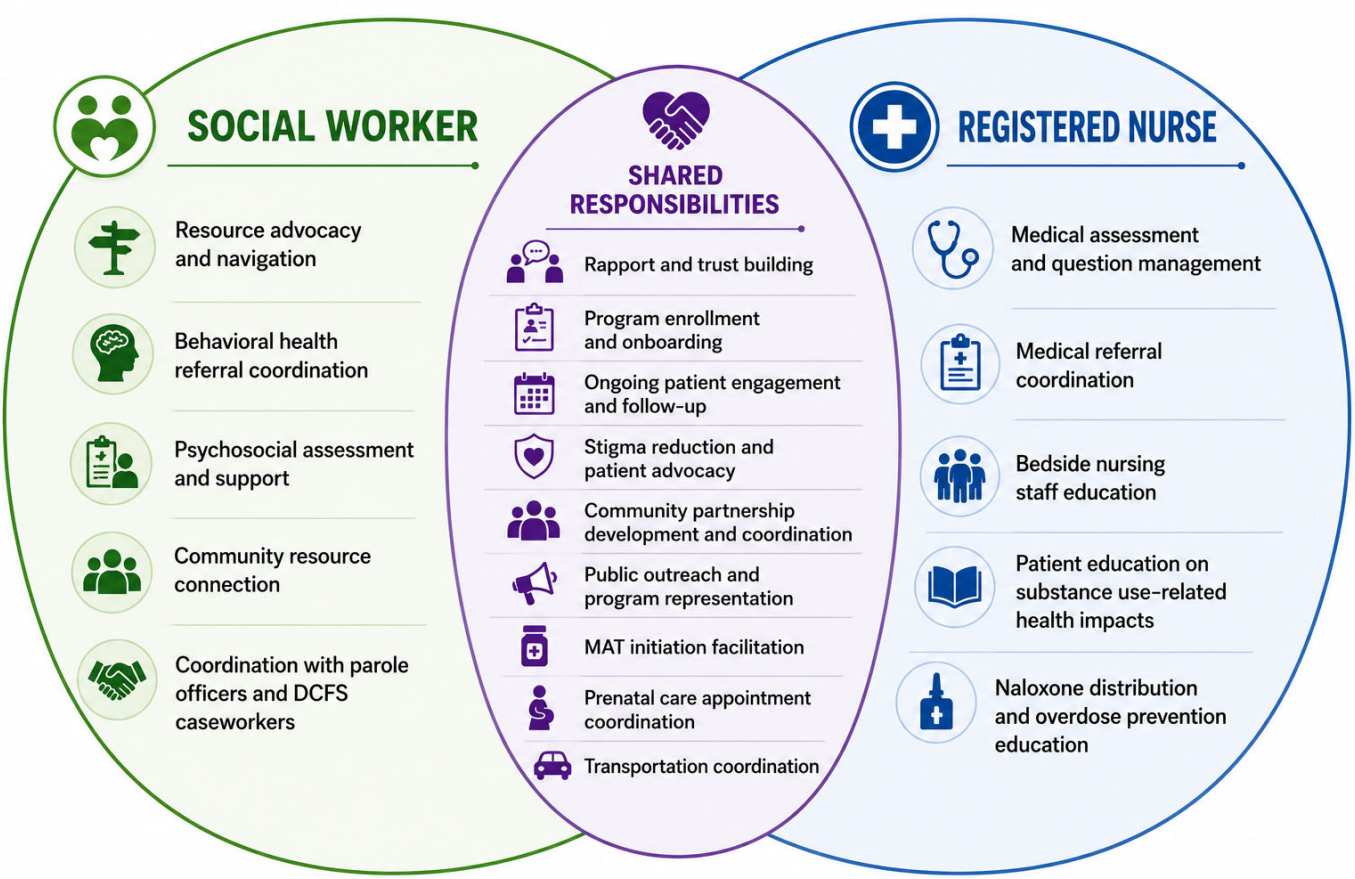
GRACE is a multidisciplinary care coordination program designed to support pregnant patients with substance use disorders throughout pregnancy and the up to one year postpartum. The program emphasizes early identification, continuous engagement, harm reduction, and coordinated transitions across healthcare and community settings. Patients are enrolled from intake through 12 months postpartum, with a dual focus on improving maternal recovery and infant health outcomes.

Upon enrollment, patients undergo a comprehensive assessment that includes evaluation of substance use history, medical history, mental health needs, and social determinants of health. Findings from these assessments inform the development of individualized care plans tailored to each patient's unique circumstances and goals. Care coordination services may include linkage to medication-assisted treatment (MAT), prenatal care, behavioral health services, and community-based resources that address social and practical barriers to care.

Central to the GRACE model is a commitment to building trust and fostering long-term engagement. Recognizing that sustained participation is critical to positive outcomes, the program prioritizes patient-centered, nonjudgmental support while providing continuous guidance and advocacy throughout the perinatal period.

Core Model Design: The RN–SW Dyad

At the center of the GRACE program is a nurse case manager and social worker (RN-SW) Dyad. This structure allows for simultaneous attention to clinical and psychosocial needs, ensuring that patients receive comprehensive, integrated care. The **social worker** addresses behavioral health, social determinants of health, and resource navigation while the **nurse** focuses on medical coordination, education, and treatment planning; however, constant collaboration between both parties remains essential.



The Nurse

The Registered Nurse (RN) serves as the clinical expert within the RN-SW Dyad and is responsible for addressing the medical and health education needs of patients. This role provides evidence-based education regarding substance use, pregnancy, treatment options, and harm reduction strategies while serving as a trusted source for medical information throughout the patient's care journey.

The RN conducts clinical assessments, answers patient questions related to health and treatment, coordinates medical referrals, and collaborates with healthcare providers to facilitate timely access to care. The RN also provides education to clinical staff to promote consistent, stigma-free care practices and distributes naloxone while providing overdose prevention education. Through clinical advocacy and patient education, the RN supports informed decision-making and promotes safe engagement in treatment and prenatal care.

The Social Worker

The Social Worker (SW) serves as the primary navigator for psychosocial, behavioral, and social determinants of health needs. This role focuses on identifying and addressing barriers that may interfere with a patient's ability to engage in treatment, prenatal care, and recovery services. Through comprehensive psychosocial

assessment, the SW evaluates factors such as housing instability, food insecurity, intimate partner violence, legal involvement, transportation challenges, and behavioral health needs.

The SW connects patients with community-based resources and coordinates referrals to behavioral health and supportive service providers. This role also facilitates communication with external agencies, including parole officers, child welfare agencies, and other social service organizations when appropriate with written consent from the patient. By addressing non-medical barriers to care, the SW helps create the conditions necessary for sustained engagement in treatment and improved maternal and neonatal outcomes.

The Dyad

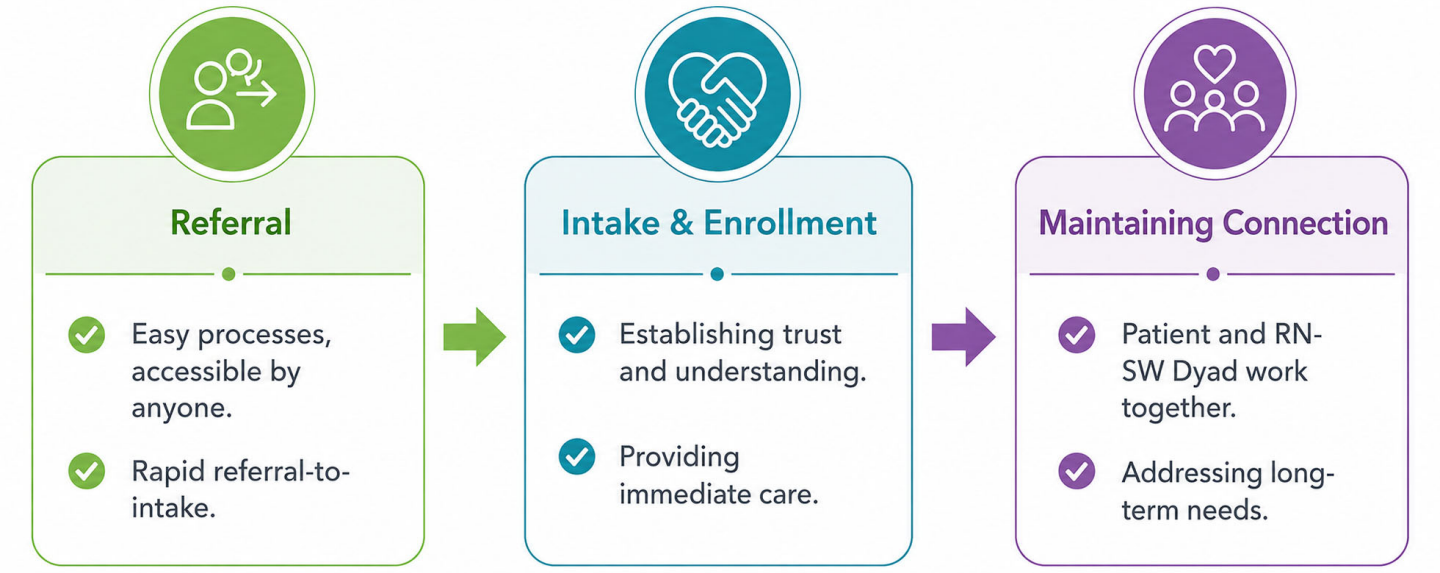
While each team member maintains distinct areas of expertise, the success of the model depends on close collaboration between the Social Worker and Registered Nurse. Together, the RN-SW Dyad serves as a consistent point of contact for patients, providing continuity of support throughout pregnancy and the postpartum period.

Shared responsibilities include building rapport and trust, enrolling patients into the program, maintaining ongoing communication and follow-up, coordinating transportation and prenatal care appointments, facilitating initiation of medication-assisted treatment (MAT), and advocating for patients in healthcare and community settings. The RN-SW Dyad also works collaboratively to reduce stigma, foster patient engagement, develop community partnerships, and represent the program through outreach and educational activities.

By combining clinical expertise with psychosocial support, the RN-SW Dyad model provides comprehensive, patient-centered care that addresses both medical and social needs. This integrated approach enhances care coordination, strengthens patient engagement, and improves access to treatment and supportive services.

Care Across the Continuum

GRACE provides long-term care that spans prenatal, inpatient, and postpartum settings. This section covers a step-by-step walkthrough of what the program looks like for the participant. At any point within this process, a patient can be transferred to a treatment facility or to treatment services.



1. **Every GRACE patient starts their journey with a referral.** Referrals can be made by anyone at any time. Referrals can come directly from the patient, an external provider, or an external care facility via phone call. Referrals can also be made within the hospital via phone call or via referral forms (Appendix A) that are built into the EMR system or via paper fax that immediately alert the GRACE team to a patient in need. If the GRACE Team is not immediately available, calls get routed to the hospital's 24-hour Social Worker line.
2. **First meetings with patients are navigated and scheduled with urgency to meet the patient's needs.** If a referral comes from within the hospital, a social worker meets the patient in the office/room that the patient is in at the time to offer the Program. Intake can be completed as soon as the patient is medically stable. If a referral comes from outside the hospital, an appointment is made at the earliest opportunity that is feasible for the patient. Transportation is arranged for those patients, if necessary, and intake appointments are held in the GRACE office.
3. **Intake and enrollment in the GRACE Program begins** with consenting using the Enrollment Forms (Appendix B) and patient education via the RN-SW Dyad.
    - Program and its process are explained to the patient by the RN-SW Dyad.
    - Patient education is always started by letting the patients ask whatever questions they have. The RN-SW Dyad navigates concerns, regardless of their topic, before moving forward.
    - Once all patient concerns are addressed, the team member begins the screening and assessment process using the provided Screening/Assessment Forms (Appendix C), and Release of Information forms (ROI) are signed by the patient so other providers can be contacted, and 42 part 2 CFR for substance use disorder (part of consent form) is reviewed.
    - Program documents (Appendix B4 & B5) are completed and it is ensured that there are at least 2 contact individual/people options documented.
    - Immediate concerns are addressed before the patient leaves the office, including Narcan distribution.

TRUST BUILDING TIP

Introduce the SW as a "team member." The term "social worker" often comes with a negative connotation for this population.

4. **Patients are contacted weekly by their RN-SW Dyad** via at least a phone call, and an office visit is available per the patient's request. During these visits, support, education, and delivery planning takes place (6 weeks out from delivery). Delivery planning is a key component, with coordinated strategies for pain management, medication continuation, and neonatal care. The patient and RN-SW Dyad create the plan together and discuss patient-specific needs related to childcare for delivery day, support person roles, treatment following discharge, and any other patient-specific needs. Delivery planning is guided by the Delivery Planning Checklist (Appendix D1).
5. **The GRACE Team is made aware of a delivery day in progress** by either the patient or the patient's team, but the delivery planning has already prepared the patient and hospital for her delivery. SBAR (Situation – Background – Assessment – Recommendation) is in the patient's Labor & Delivery medical record, and the hospital's Social Services ensures that L&D staff are aware of SBAR (Appendix D2). Opioid experienced order sets for the delivery day are premade and within the hospital system.
6. **Postpartum support begins after the patient delivers.** The GRACE team helps the patient navigate the early stages of the postpartum transition. If their baby goes to the Neonatal Intensive Care Unit (NICU), the GRACE team assists with this transition as well with a warm hand-off to the NICU social worker.
7. **Postpartum support while in the hospital and after discharge** additionally includes relapse prevention, infant care education, and transition to community providers. If appropriate, contraceptive counseling

is also provided. GRACE patients are typically contacted weekly, and the option for them to reach out to the GRACE team is always available.

8. **Patients graduate from the program after 12 months of active postpartum participation in the program.** Patients receive a certificate (Appendix E) for their completion.

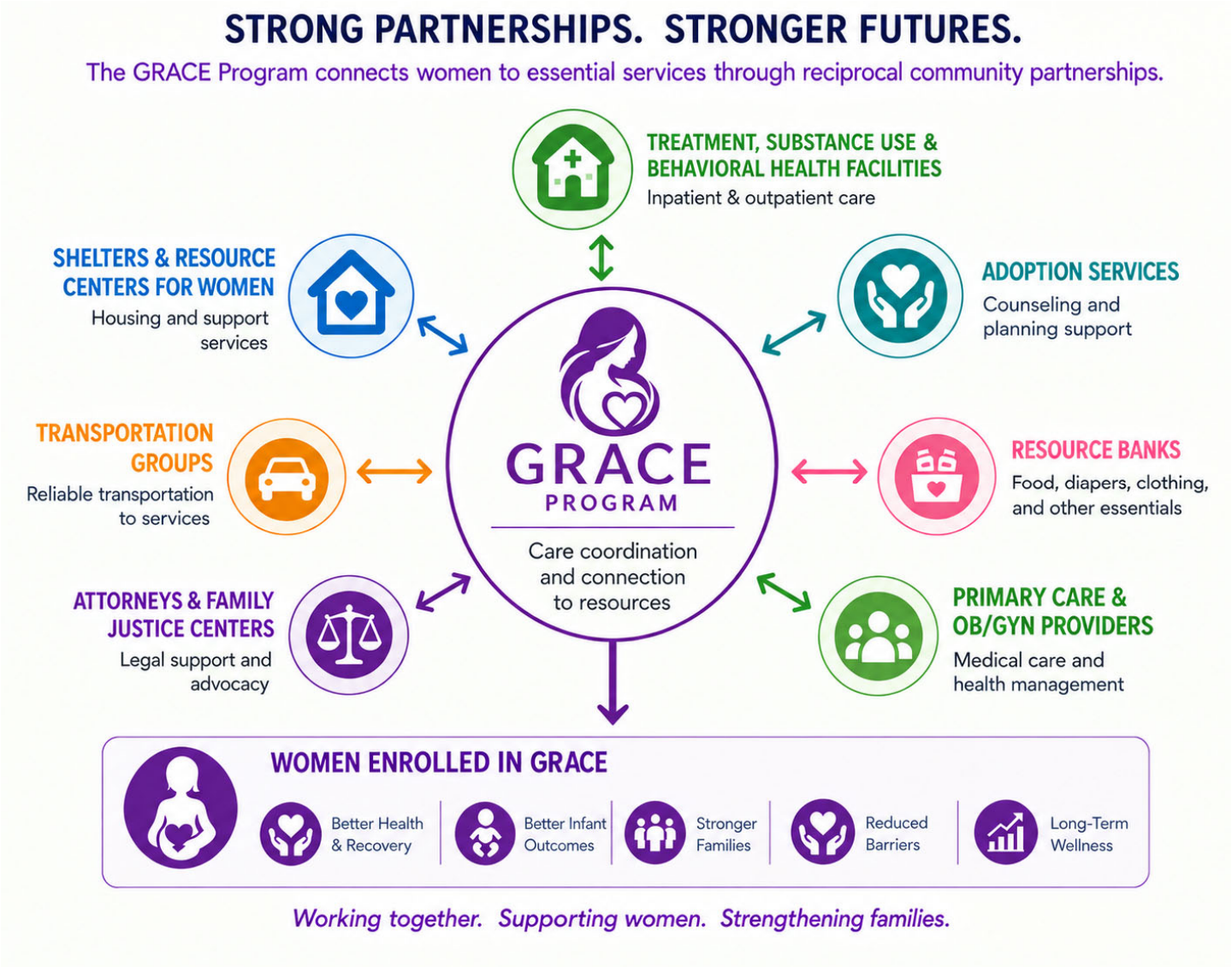
Community Partnerships

Pregnant patients with SUD often face multiple, overlapping barriers to care. Healthcare systems, social service agencies, criminal justice organizations, and community-based organizations are all critical gateways to treatment – no single organization can adequately address the complex medical, behavioral, social, and legal needs these patients experience (Choi et al., 2022).

Pregnant individuals with substance use disorders (SUDs) achieve better outcomes when care extends beyond medical treatment alone and incorporates coordinated partnerships that address behavioral health, housing, transportation, legal concerns, and other social determinants of health (Wouk et al., 2024; Townsel et al., 2023). Therefore, strong partnerships are essential to the GRACE model and creating a comprehensive care network for mothers enrolled in the program.

The GRACE partnership network should not be viewed as a collection of independent referral sources. Rather, it functions as an interconnected system of care in which each partner addresses a specific determinant of health, collectively reducing barriers to recovery and creating a comprehensive support structure for women and families throughout pregnancy, delivery, and 12 months postpartum.

It is important to note that utilization of these services is always voluntary on the patient's part but highly encouraged by the RN-SW Dyad.



Treatment, Substance Use, and Behavioral Health Facilities

Why it matters: Access to medication-assisted treatment (MAT) or MOUD (Medications for Opioid Use Disorder), counseling, psychiatric services, and recovery support is one of the strongest predictors of improved outcomes among pregnant individuals with substance use disorder. Integrated care models that coordinate prenatal care with addiction treatment and behavioral health services demonstrate higher treatment retention, improved engagement in care, and better birth outcomes (Debbink et al., 2026; Townsel et al., 2023; Nader et al., 2024). The GRACE program's partnerships with inpatient and outpatient treatment facilities ensure rapid referral pathways, facilitate continuity of treatment, and reduce delays that can lead to relapse or disengagement from care.

How it functions: When a GRACE patient experiences a need, a member of the RN-SW Dyad contacts an appropriate care facility with patient information. The physician provides clearance. The Dyad will check in regularly on the patient or when appropriate.

Shelters and Resource Centers

Why it matters: Housing instability is a major barrier to treatment engagement and healthy pregnancy outcomes. Homelessness and unsafe living environments increase stress, reduce healthcare utilization, and

complicate recovery efforts. Studies have identified stable housing and access to social supports as critical facilitators of treatment engagement and sustained recovery among pregnant women with SUD (Choi et al., 2022; Dailey et al., 2024). Partnerships with shelters and women's resource centers allow GRACE to address immediate safety concerns while connecting patients to longer-term housing and supportive services.
How it functions: A member of the RN-SW Dyad will directly contact the shelter or center that appropriately meets the needs of the patient and ensure that those partners are able and willing to meet the needs of the patient. Those connections are then shared with the patient to use as necessary.

Transportation Services

Why it matters: Transportation barriers are among the most commonly reported reasons patients miss prenatal visits, behavioral health appointments, and treatment sessions. In evaluations of multidisciplinary perinatal SUD programs, transportation assistance is consistently identified as a high-priority need and an important component of successful care coordination (Townsel et al., 2023; Wouk et al., 2024). Reliable transportation partnerships help ensure patients can access prenatal care, treatment services, and social support resources throughout pregnancy and the postpartum period.
How it functions: The RN-SW Dyad arranges for transportation of the patient via coordination between the patient and available Medicaid-covered transportation services. The RN-SW Dyad will assist and teach patients how to book transportation using their Medicaid insurance coverage. If no coverage is available, the program will assist with ride-share options for transportation for GRACE- or treatment-associated care.

Specialized Attorneys and Family Justice Centers

Why it matters: Fear of child welfare involvement, legal consequences, and custody concerns often discourage pregnant individuals from seeking treatment. Research has shown that legal and social system involvement can significantly influence treatment engagement and retention. Providing access to trusted legal resources helps patients navigate custody issues, protective orders, family law concerns, and interactions with child welfare agencies (Choi et al., 2022; Jäderholm et al., 2025). By partnering with attorneys and family justice centers, programs can reduce fear, improve trust, and help patients make informed decisions regarding their families and futures.
How it functions: The RN-SW Dyad locates attorneys and legal groups who provide pro-bono services that address patient needs. Based on those needs, the RN-SW Dyad will refer to/connect patients with appropriate professionals to aid in their case(s).

Adoption Services

Why it matters: For some patients, adoption may be considered as part of pregnancy planning.
How it functions: At the patient's request, the RN-SW Dyad will provide the patient with a list of adoption agencies.

Resource Banks

Why it matters: Food insecurity, lack of infant supplies, and financial hardship are common among families affected by SUD. Access to diapers, clothing, formula, food, and other necessities reduces immediate stressors that can interfere with treatment engagement and recovery (Choi et al., 2022; Dailey et al., 2024). Addressing these basic needs is consistent with evidence showing that social support and reduction of practical barriers improve treatment retention and maternal well-being.
How it functions: The RN-SW Dyad will provide the patient with resource information based on the needs of that patient (i.e., if food insecurity and transportation are major issues, the patient will be referred to a food

bank with delivery services or mobile units). The RN-SW Dyad will also assist with application processes or connecting the patient to pro-bono application assistance when needed.

Primary Care Providers

Why it matters: Although prenatal care is central during pregnancy, many patients have chronic medical conditions that require ongoing management before and after delivery. Integrated models that include primary care improve continuity, facilitate management of co-occurring medical conditions, and support long-term recovery and wellness beyond the postpartum period (Debbink et al., 2026).
How it functions: The RN-SW Dyad connect patients with primary care providers to address a range of conditions.

Financial Model and Sustainability

GRACE was initially supported through grant funding and is transitioning to a sustainable model supported by billing and reimbursement. Relevant billing opportunities may include care coordination codes, behavioral health integration codes, and evaluation and management services. Hospitals implementing similar programs should work closely with finance and compliance teams to identify appropriate insurance billing opportunities, optimize documentation, and ensure sustainability.

Getting Started

The grant funding was $1.2 million distributed evenly across 3 years ($400,000/year). Below is a table of suggestions for how to plan for expenditures in the first 3 years, based on GRACE's startup costs, which began in 2018.

	Year 1	Year 2	Year 3	Total
Salaries & Benefits	59%	60%	62%	60%
Consultant/Contract Services				
Psychiatrist-Addictionologist	11%	11%	11%	11%
Supplies & Materials				
Marketing Materials/Printing Costs	4%	4%	3%	3%
Office Supplies	1%	1%	1%	1%
Patient Educational Materials	2%	2%	2%	2%
Equipment				
Non-Capitalized (Minor)	4%	2%	1%	2%
Training & Conferences	9%	4%	4%	6%
Other Expenses				
Patient Vouchers for Travel	6%	9%	9%	8%
Patient Vouchers for Childbirth/Parenting Classes	1%	3%	3%	2%
Social Services Patient Fund (e.g., car seat, diapers, safe sleep)	1%	3%	3%	2%
Legal Fees	3%	3%	3%	3%

Sustained Funding

Upon proof-of-concept, the funding model transitioned to a combination of Hospital and Foundation funding assisted by Medicaid, where applicable. Medicaid coverage was possible through the introduction of an "In lieu

of" agreement. This agreement assisted with costs of intake, care coordination, and outreach, as outlined in the tables below through billable coding and services provided. This agreement was modeled for 20 months of care, including the 12 months of postpartum care and loss-to-follow-up cases, and it was additionally based in anticipated units of service per patient.

Code	Frequency of Use	Service Label	Service Description
H0002	1x per enrollment	Intake	Initial program application and description. Involves securing interest, obtaining consent, compiling medical, pregnancy, and psychosocial history, administering program assessments to find gaps in needed services to develop a care plan and referrals
H0006	1 unit = 1 month Maximum 20 units per enrollment	Care Coordination	Weekly check-ins to assess care plan progress, other risks, and support care needs, including polysubstance treatment, including MAT. Provides pathway to mitigate risks for delivery and through 12 months postpartum care needs for patient and infant.
H0023	1 unit = 1 month; Max 4 per enrollment: 2x prior to delivery, 2x postpartum; cannot be used in same month as H0006	Outreach for potentially disengaged	Targeted outreach to assess potential risk for disengagement. Includes monitoring call log, last contact, and missed appointments. Manages contact mapping document to outreach participant's expanded social circle to make contact. Initiates a "didn't keep appointment" process by attempting contact through preferred method (text, phone, email), family and friends, other providers and emergency contacts.

Services Provided per Service Label

Description	Unit	Services Provided
Intake, Assessment, Care Plan Development **Minimum Time Spent per unit billed 2.5 hours Face to Face and indirect work**	1	Initial Intake consists of • Pregnancy confirmation; referral to OB if needed • Explanation of services • Obtaining informed consent for treatment • Obtaining detailed medical and social history • Initiate assessment of unmet care needs for physical (medical and nutritional), behavioral and psychosocial needs. At a minimum, these assessments are completed: ○ 5 P's Screening tool ○ DSM-5 Opioid Use Disorder Screening ○ NIDA Substance Use Screen ○ PHQ9 Depression Screening ○ GAD-7 Generalized Anxiety Disorder Screening ○ HITS Intimate Partner Violence Screening **Additional screenings may be added, to include:** ○ Columbia Suicide Severity Rating Scale ○ Perinatal Posttraumatic Stress Disorder Questionnaire ○ PCL-C PTSD Checklist – Civilian version ○ ACE Adverse Childhood Experience Questionnaire

		• Review assessments to identify care needs and discussing results with patient • Develop treatment plan of patient-centered goals, including referral to MAT or SUD treatment • Assessing urgency of identified goals, prioritizing referrals based on needs, including housing referrals • Assessing Care Plan Adherence through teach back and other counseling methods Adjusting plan and referrals as needed. • Providing warm handoff to referral sources. • Create a mapping tool of contacts • Chart documentation of intake, program enrollment, assessment results, care plan development, contact mapping and referral activities.
Care Coordination[2] **Minimum time spent per unit billed as Face-to-Face, indirect and telephonic, 10 hours**	20	Weekly check ins with enrollee to perform any of the following activities: ***Prenatal*** • Confirmation of consent • Confirm and update birth plans • Confirm and update contact information • Assisting with benefit reinstatement, if indicated Care Coordination • Coordination of referrals identified from treatment plan • Review and revision of care plan, as needed • Visit preparation, navigation, and follow up for key OB services • Multidisciplinary long-term postpartum follow-up includes referrals for medical, developmental, and social support for mother and infant Risk Assessment • Reviewing patient history from referral source (if applicable) and medical charts • Reassess physical, mental and social needs; identifying gaps • Providing assistance to close gaps for physical, mental and social needs • Reassess risks identified during assessment and addressing those risks Alcohol/Substance Use Disorder Treatment • Interdisciplinary case conference with hospital care team • Participation at SUD Treatment Case Conference, if indicated • Providing referral and/or education for Naloxone Health Education and Promotion • Orientation to labor and delivery process, including pain management plan and discussion of postpartum family planning • Provide individualized education on pregnancy, childbirth, parenting, physical well-being, lactation support and information on Neonatal Abstinence Support, Eat Sleep Console, and other related topics Delivery Care • In-hospital, rooming in and assessment of NOWS • Lactation support and follow up education • Assessing baby safety needs • Navigating and educating mother for potential NICU admission, as needed • Assessment of care transition to home ***Postpartum Care*** Care Coordination • Identifying support system • Provide referrals for medical, developmental and social support • Visit preparation and follow up for pediatric visits • Identifying NOWS support by care partners Health Education and Promotion

		• Discussion of postpartum needs, including red flag warnings for postpartum hygiene, signs and symptoms of illness, sleep and nutritional needs. Risk Assessment • Reassessment for depression and anxiety screening with on-site treatment or referral as indicated • Health Chart documentation of activities and progress across all categories of care coordination activities
Outreach for Disengaged[3] (Prevalence is 60% of patient population) **Minimum time spent per unit billed: Telephonic and indirect work, 8 hours**	4	• Maintaining and reviewing call log for potential disengagement • Checking for missed physician or diagnostic appointments • Checking with SUD or MAT provider for missed appointments • Contact attempts made (x3) using preferred contact number when applicable • Escalating to listed emergency contact or treatment facility when applicable • Chart documentation of efforts made for outreach attempts

Implementation Roadmap

Successful implementation requires leadership support, interdisciplinary collaboration, and strong community partnerships. Hospitals should begin by defining their target population, establishing a Task Force, establishing vital partnerships, developing workflows, and integrating care across settings. Training and outcome tracking are essential to long-term success.

Defining the Target Population and Eligibility

The GRACE program serves women who are currently diagnosed with or have a history of substance use disorder (SUD). Women who are eligible include those who are in any gestation of pregnancy or within 1 year postpartum, regardless of where they delivered.

Having processes in place for identifying women in need is a necessity for ensuring that these women receive care. Implementing hospital-wide policies for use of validated screening tools for identifying these patients was a key component of setting up the hospital for GRACE. EMR automation with alerts and built-in referral processes additionally aids in ensuring that these women receive their needed care.

Establishing a Task Force Team

In order to develop an effective program with hospital-wide buy-in, creating an appropriate Task Force Team is necessary. The Team will ideally involve members of hospital leadership, care/subject matter experts, people responsible for funding the program (Financials), and other key project personnel.

Individuals included in the Woman's GRACE Task Force Included the following:

Hospital Leadership	Care Experts	Financials	Key Project Personnel
• Chief Medical Officer (CMO) • Chief Nursing Officer (CNO) • NICU Director • Mother-Baby Director • OB Services Director • Case Management Director	• CMO • CNO • Psychiatrist • Neonatologist	• Grant Writers • Foundation Members	• Marketing Team • Project Management Team

Establishing & Maintaining Partnerships

Strong internal and external partnerships are essential to the GRACE model. Key external collaborators include treatment centers, behavioral health providers, and social service organizations. Key internal collaborators are all portions of the hospital who potentially interact directly or indirectly with the patient and/or their care. Establishing these relationships and maintaining them are key to the success of the GRACE Program and the success of the patients who enroll.

Community/External Partnerships

Community partnerships include treatment, substance use, and behavioral health care facilities; primary care physicians; various shelters and resource centers, transportation services; attorneys and family justice centers; resource banks. These ensure a comprehensive care network for patients enrolled in GRACE.

Establishing partnerships with external partners begins a few different ways. Some community partners are contacted directly by the GRACE team. These partners are typically identified by the program as institutions within the community who could aid in care for the patients in need. Some partners are gained through attending local functions. These can include conferences, fairs, festivals, or local speaking engagements. These provide an opportunity for GRACE to advertise and educate as well as an opportunity for community partners to identify GRACE as a resource for them. The RN-SW Dyad typically serves as the "face" of the program in these events because they can speak directly to the needs of their patients.

To maintain a meaningful connection, community partners are contacted monthly to assess funding and/or programmatic changes. Facilities are also visited quarterly – this is particularly the case for shelters and resource centers where mothers are relying on those facilities for necessities. The quarterly visits offer opportunities for facility workers to meet the RN-SW Dyad and for the RN-SW Dyad to make sure their patients are getting what they need.

Internal Partnerships

GRACE was born within a hospital that specializes in women and infant care (Woman's Hospital, Baton Rouge, Louisiana). The hospital includes a retail pharmacy, hospital pharmacy, obstetrics and gynecology clinic, emergency department, labor and delivery unit, mother baby unit, perinatal mental health unit, operating rooms, NICU, and high-risk unit. Having a positive presence within the hospital allows for successful care of mom and baby throughout pregnancy, birth, and postpartum. This is because 1) the hospital staff know to refer moms in need to the GRACE program, and 2) when the GRACE program has a patient in care, the hospital staff respond well to measures put in place by the GRACE team – knowing that optimized care and good health outcomes are everyone's mutually shared goals.

Establishing partnerships with internal groups generally begins with administration support from various hospital departments and support for education of staff. Program development involved leaders from all impacted parts of the hospital (i.e. Chief Nursing and Medical Officers; directors of NICU, Mother-Baby Unit, and OB Services; Neonatologists; and marketing personnel) as well as project management. Involving the hospital in the establishment of the program allowed for buy-in as well as dissemination of information to necessary parties.

Maintaining connection is a somewhat naturally occurring process, given the presence of the program within the hospital. However, continuing education is a huge component of the program's success as well. New staff

are informed of the program and how to use the program during the onboarding process. The GRACE program is presented at every new employee orientation. The RN-SW Dyad attends "Transition to Practice" orientation for nurses, onboarding meetings for new physicians and residents, and various other staff meetings so that key personnel can get to know the team. These interactions ensure that all employees at the hospital are aware of the program's presence and their work in the hospital.

Hospital Operational Changes

Several hospital operational changes were instrumental in the success of the GRACE program. These changes were brought about via a myriad of catalysts but ultimately culminated into an ideal set of systems for making GRACE work.

EMR automation

Identifying patients in need of additional assistance in a timely and unbiased manner is critical to comprehensive care. Per hospital policy, all pregnant patients undergo the 5Ps SUD screening at all visits, regardless of visit type, reason for visit, additional diagnoses, and/or gestational age.

The EMR has an Our Practice Advisory (OPA) for SUD identification and treatment, which ties into this screening process in the ED, Outpatient, and Inpatient settings. Also, within the EMR is a built-in referral for patients who tell their doctor or nurse that they wish to receive GRACE services. This automation ensures that patients are not missing opportunities to receive care, and it makes the referral process for physicians easy and quick.

Built-in order sets for patients in the GRACE program are also incorporated into the EMR. These order sets reduce prescription errors and ensure that patients are receiving safe and adequate care. For opioid-experienced patients, there are specific order sets for epidural, labor and delivery admission, post anesthesia care, and postpartum for vaginal or c-section deliveries – alerting prescribing physicians to contraindicated medications and appropriate alternatives.

Pharmacy

Timely access to medication is a critical component of effective substance use disorder (SUD) treatment. Woman's Hospital supports this need through having both an inpatient pharmacy and an on-site retail pharmacy. Together, these pharmacies maintain a reliable inventory of commonly prescribed medications for opioid use disorder (MOUD), including **methadone, buprenorphine, and naltrexone**, as well as **naloxone (NARCAN®)**. Consistent medication availability enables clinicians to prescribe evidence-based treatment with confidence that patients can initiate therapy without unnecessary delays.

Pharmacy personnel also play an important educational role by providing immediate instruction on naloxone administration prior to discharge. This **point-of-care education** reinforces overdose prevention strategies and helps ensure patients and their support persons understand how to appropriately administer the medication in an emergency.

To further reduce barriers to treatment, Woman's Hospital utilizes a **Meds-to-Beds** program, through which discharge medications are delivered directly to patients before they leave the hospital. This service eliminates the need for patients to make a separate trip to a community pharmacy, reducing delays in treatment initiation and improving medication adherence. Additionally, bedside medication delivery offers greater privacy by

allowing medication counseling to occur in the patient's room, minimizing potential stigma and creating a more supportive, patient-centered experience.

Program Oversight

Strong leadership and a clearly defined chain of command are essential to successful implementation and sustainability of a multidisciplinary care coordination program. The GRACE program was designed, implemented, and optimized under the executive leadership of Woman's **Chief Nursing Officer**. Now, fully integrated into clinical care, the GRACE Program is administratively housed within the hospital and overseen by the **Chief Financial Officer** (CFO), with the Director of Care Management being a direct report to the CFO, and the RN-SW Dyad being direct reports to the Director.

The CFO provides executive sponsorship, strategic direction, and organizational support. Depending on the hospital's funding structure, another executive leader may serve in this role. The Director of Case Management oversees the day-to-day operations of the GRACE program, acting as the primary link between hospital leadership, the clinical team, and community partners. The Director ensures clinical workflows, quality improvement efforts, and program goals remain aligned while providing the operational framework needed for the program's long-term success. While the RN-SW Dyad manages direct patient care, the Director of Case Management supports the infrastructure and resources that allow the program to function effectively and sustainably.

Primary Responsibilities of Director of Case Management

- Provide administrative oversight of the GRACE program.
- Supervise and support the RN-SW Dyad.
- Monitor program performance, quality metrics, and patient outcomes.
- Develop and maintain program policies, procedures, and clinical workflows.
- Oversee regulatory compliance and documentation standards.
- Coordinate program evaluation, reporting, and continuous quality improvement initiatives.
- Manage relationships with hospital leadership and external stakeholders.
- Facilitate development and maintenance of community partnerships.
- Identify opportunities for program growth, funding, and sustainability.
- Lead staff education and implementation of evidence-based practices.

Program Scale and Operations

The GRACE model is built around a RN-SW Dyad that provides coordinated care for pregnant patients with substance use disorders (SUDs). The program emphasizes rapid referral-to-intake, comprehensive assessment, medication for opioid use disorder (MOUD) facilitation when appropriate, long-term engagement, and connection to community resources.

Case Load Recommendation

At the pilot site, the program receives approximately 50-60 referrals annually and is staffed by one nurse case manager and one social worker, who collectively manage a 20-25 patient active caseload at any given time. Intake visits average 1.5-2 hours, while follow-up interactions typically require 5-30 minutes depending on patient needs.

Staffing Recommendation

Below is a table of staffing ratio recommendations based on current GRACE workflow and RN-SW Dyad feedback on feasibility. Programs should reserve capacity for high-acuity patients who may require more frequent contact as well as consider time reserved for the RN-SW Dyad's additional duties beyond direct patient interactions.

Recommended Staffing Ratios	
Annual Referrals	**Recommended Staffing**
25-50	0.5 RN + 0.5 SW
50-80	1 RN + 1 SW
80-120	2 RN + 2 SW
200-250+	4-5 RN + 4-5 SW + Program Coordinator

Education and Workforce Development

GRACE incorporates structured training for staff, including substance use education, trauma-informed care, and bias reduction. Ongoing education ensures that providers are equipped to deliver compassionate, evidence-based care.

The GRACE Team directly provided two informational/training sessions for continuing education at the start of the program. The first was the "Program Presentation to Medical Staff," which covered performance metrics of the program. It demonstrated to clinical staff the importance of utilizing the program for their patients when the need arises. The second was the "Overdose Prevention and Education Training in Hospital," which covered the pharmacology of naloxone, how to identify patients who are indicated for naloxone opioid overdose, how to recognize and respond to opioid overdose, and how to make physician referrals in opioid use disorder.

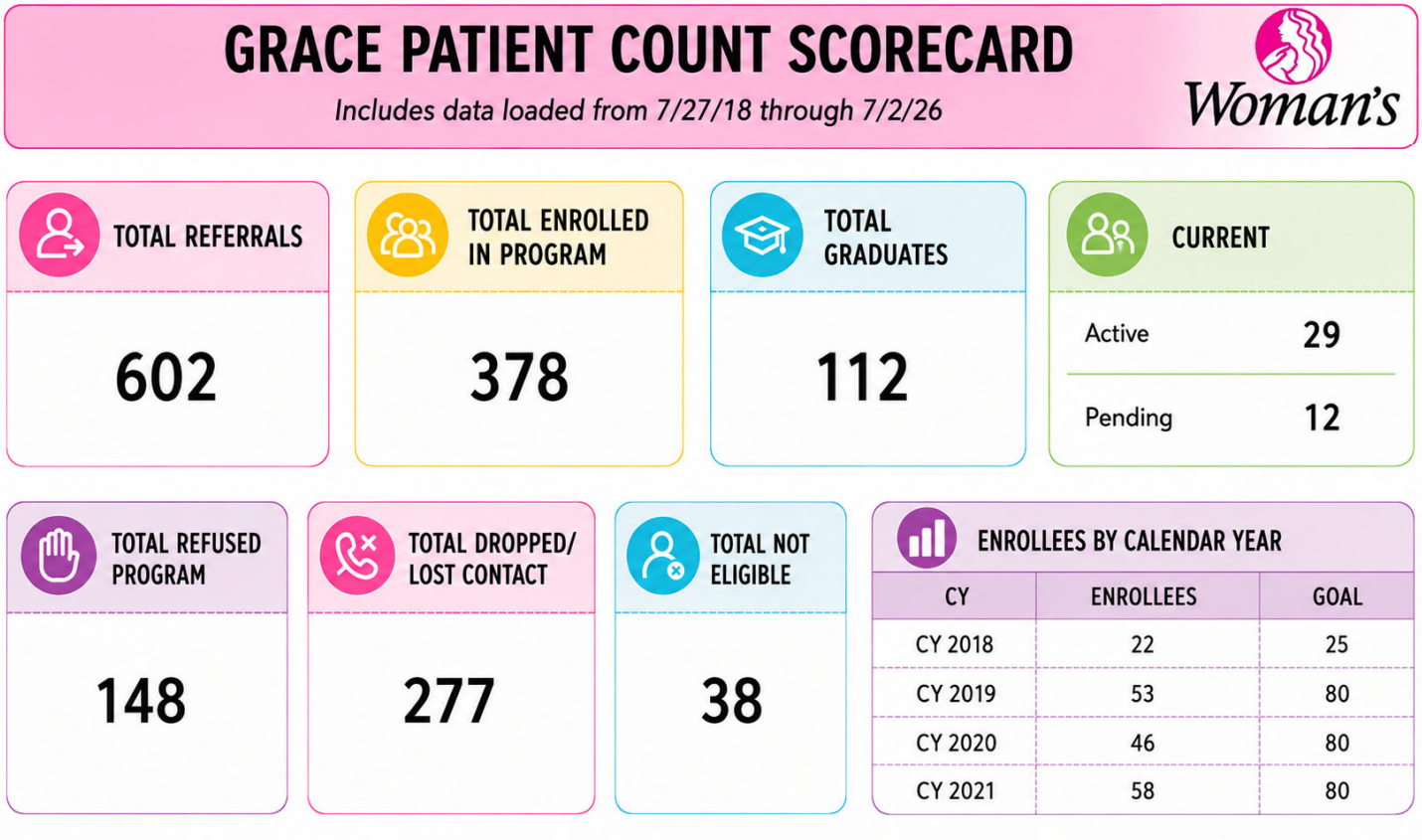
The GRACE Team additionally facilitates continuing education opportunities by locating trainings and disseminating information to medical staff. On an annual to biannual basis, the Team makes sure to distribute appropriate Webinars and In-Person trainings available across the country.

The GRACE Team also locates educational teams and programs that come to the hospital or are already within the hospital, when available. These typically focus on harm reduction strategies, updated information on treating opioid use in pregnancy, and stigma-reduction activities, such as poverty simulations.

Outcomes and Evaluation

The program tracks outcomes related to maternal engagement, substance use, birth outcomes, and neonatal health. A forthcoming peer-reviewed publication will provide detailed results and further validate the model.

As of June 2026, the Woman's GRACE Program has received 602 referrals, 378 patients have been enrolled, and 112 patients have graduated the program.



Patient Success Story

Positive patient impact is always a goal for the GRACE team. Success stories demonstrate the ways in which the GRACE Program has been successful and impactful at each stage of the program, not only for moms, but for clinical staff as well.

Navigating Initiation of MAT

A pregnant patient contacted the GRACE program seeking outpatient treatment after experiencing opioid withdrawal symptoms. Although her obstetric provider instructed her to seek evaluation in the emergency department, she was reluctant due to fear of hospital admission.

The GRACE social worker (SW) initially connected the patient with an outpatient provider who could prescribe medication for opioid use disorder (MOUD). The GRACE SW later encouraged the patient to present to the emergency department, reassuring her that evaluation did not necessarily mean admission and emphasizing the importance of assessing both maternal and fetal well-being. Upon the patient's arrival, the GRACE SW met her in the Woman's emergency department and collaborated with the ED nurse to successfully advocate for initiation of buprenorphine based on current clinical guidelines.

Working alongside the emergency department nurse, the GRACE registered nurse provided just-in-time education on buprenorphine initiation, available electronic order sets, adjunctive medications, and outpatient follow-up procedures to the ER provider. The team also coordinated confirmation of the patient's prior buprenorphine dose, addressed a lapse in treatment caused by insurance barriers, arranged a bridge prescription through the Meds-to-Beds program, and ensured the patient was discharged with naloxone and a scheduled follow-up plan.

Within 48 hours of discharge, the GRACE registered nurse contacted the patient to confirm successful linkage to outpatient MOUD services. This case demonstrates how proactive care coordination, provider education, and multidisciplinary collaboration can overcome barriers to treatment, facilitate evidence-based management of opioid withdrawal during pregnancy, and ensure a seamless transition from acute care to ongoing recovery services.

Challenges and Lessons Learned

Implementation of the GRACE program has yielded several important lessons that may assist other institutions seeking to establish a multidisciplinary care coordination program for pregnant patients with substance use disorders. Several overarching principles have emerged from our experience of GRACE. **First**, relationship-building is as important as clinical expertise; trust between the patient with both the RN-SW Dyad and community partners is foundational to successful engagement. **Second**, standardized workflows and EMR integration improve efficiency while reducing variability in care. **Third**, implementation should be viewed as an organizational culture change rather than simply the addition of a new service line. **Finally**, flexibility is essential. Successful care coordination programs continually adapt to evolving patient needs, healthcare systems, and community resources while maintaining a patient-centered, non-judgmental approach.

Addressing Stigma Through Intentional Communication

The Challenge: One of the earliest challenges encountered in the GRACE Program was the stigma associated with Social Workers. Patients were generally receptive to working with the registered nurse but were often hesitant when introduced to a "Social Worker," a title that some associated with child protective services or punitive interventions.

The Solution: The SW member of the RN-SW Dyad was initially introduced to patients by describing his/her role rather than emphasizing the professional title – often opting for “My Colleague” or “My Teammate” when introduced by the RN or other personnel. Once rapport was established, patients were typically much more receptive to ongoing engagement. This experience reinforced the importance of trauma-informed, person-centered communication from the first patient interaction.

Embedding the Program Within the Electronic Medical Record

The Challenge: Early program evaluation relied on manual tracking systems that required duplicate documentation. These systems were tedious, time consuming, and increased the potential for data entry errors.

The Solution: Having patient screenings and evaluation, referrals, and order sets built into the EMR have streamlined the program. The program is also transitioning into using the EMR’s data tracking features to optimize outcome tracking for the program. Integrating program workflows, patient tracking, and outcome measures directly into the electronic medical record (EMR) is anticipated to substantially improve efficiency, enhance data quality, and simplify reporting of program metrics. Hospitals implementing similar programs should prioritize development of EMR infrastructure early in implementation.

Creating a Culture Shift Within the Health System

The Challenge: Stigma surrounding substance use in pregnancy often impedes patients from seeking help for fear of being judged in a negative light. This stigma exists within the patients' social circles and can also exist with physicians, nurses, and ancillary staff.

The Solution: Reducing stigma surrounding substance use in pregnancy required consistent education for physicians, nurses, and ancillary staff regarding SUD as treatable chronic medical conditions. Sharing patient success stories, reviewing challenging cases, and incorporating standardized communication tools such as SBAR during labor and delivery handoffs helped increase staff confidence, improve interdisciplinary communication, and reinforce consistent, evidence-based care practices.

Standardizing Identification Through Universal Screening

The Challenge: Reliance on individual provider judgment to identify patients in need of services may unintentionally introduce bias and contribute to missed opportunities for intervention.

The Solution: Integrating universal screening and automated EMR alerts into routine prenatal care normalized the referral process, reduced stigma, and increased consistency in identifying patients who could benefit from the GRACE program. System-level identification strategies also reduced the perception that patients were being singled out because of personal characteristics or provider assumptions.

Using Patient-Centered Messaging

The Challenge: The language used to describe the program significantly influenced patient engagement because the language being used signals the safety of the program.

The Solution: Marketing materials (Appendix F) and patient education resources intentionally avoided stigmatizing terminology and instead emphasized support, health, and connection to resources. Neutral, welcoming messaging—for example, focusing on "getting help" rather than "substance abuse treatment"—encouraged self-referral and reinforced the program's role as a supportive partner rather than a punitive service.

Maintaining a Dynamic Community Resource Network

The Challenge: Community partnerships require ongoing maintenance. Behavioral health providers, treatment facilities, shelters, and other community organizations frequently experience changes in services, staffing, funding, or operational status.

The Solution: GRACE team routinely verifies community resources through direct communication, in-person visits, virtual tours, and review of educational materials. Maintaining an up-to-date resource directory and continuously identifying new community partners has proven essential to sustaining seamless patient navigation.

Conclusion

Substance use disorder (SUD) during pregnancy comes with complex clinical, behavioral, and social challenges. Traditional models of care alone struggle to address the various concerns and needs of patients with SUD diagnoses. As rates of substance use and associated maternal and neonatal complications continue to rise, healthcare systems must adopt innovative approaches that prioritize coordination, accessibility, and patient-centered support.

The GRACE program demonstrates how a multidisciplinary care coordination model can bridge gaps between obstetric care, addiction treatment, behavioral health services, and community resources. Through the

collaborative efforts of a Registered Nurse-Social Worker Dyad, strong community partnerships, and a commitment to reducing stigma amongst hospital staff, the program provides comprehensive support that addresses the full spectrum of patient needs throughout pregnancy and the postpartum period.

GRACE was designed as a scalable and sustainable model. Its success illustrates that meaningful improvements in care are possible through intentional collaboration, standardized workflows, and a commitment to meeting patients where they are. By integrating medical care with behavioral health services and community-based resources, healthcare organizations can promote healthier outcomes for both mothers and infants.

As healthcare systems seek solutions to the growing impact of substance use disorders in pregnancy, the GRACE model offers a practical framework for replication. Through continued investment in comprehensive care, hospitals can create supportive environments that foster recovery, improve maternal and neonatal outcomes, and strengthen the health of families and communities.

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Appendices

All Appendix items are available within this document. If you would like to download Appendix items, please visit this link: https://redcap.link/grace-program.

Disclaimer
The forms provided are sample forms only and are intended to be adapted to conform to your organization's specific policies and practices. Woman's makes no representations or warranties as to the accuracy or fitness for use of the sample forms provided.

A. Referrals

A1. Referral to GRACE Form

GRACE PROGRAM

GRACE Program Referral Form

Phone: ___-___-____ • Fax: ___-___-____

Date: _____

☐ AUTHORIZATION FORM HAS BEEN SIGNED (please complete before submitting referral)

☐ CONFIRMED PREGNANCY

Estimated Gestational Age (EGA): _____(how many weeks pregnant)

Estimated Date of Confinement (EDC):_____

CLIENT'S/PATIENT'S NAME: _____,_____

(Last Name) (First Name)

D.O.B.: _____

PHONE:_____

ALTERNATE PHONE:_____

PRIMARY LANGUAGE: _____

*Please attach demographic/face sheet if available

REFERRAL INDICATION(S) (check all that apply):

☐ Current use of opioids ☐ Currently in Medication Assisted Treatment Program

☐ Currently in Rehab/Recovery Program ☐ Historical use of opioids

REFERRING MD/AGENCY/CLINIC Date:_____

Name:_____

Phone:_____ Fax:_____

Comments:_____

_____

Signature:_____

Please fax completed form to: ___-___-____

FOR OFFICE USE ONLY:

Intake Appt. Date/Time:_____

Referral Feedback Form Sent ☐

A2. Referral Feedback Form

GRACE Program Referral Feedback

Thank you for your referral to the GRACE Program. Please see below feedback regarding your referral.
If you have any questions or concerns, feel free to call the GRACE team @ ___-___-____

- **Patient was assessed and accepted into the GRACE program on _____**
- **Patient was scheduled for assessment; however, patient did not show** *(Please discuss with patient at next visit).*
- **Patient has been called for assessment, however, GRACE was unable to make contact for the following reason:**

___ Left message, no call back

___ No answer after 3 attempts

Not an active number

Refused services at this time

GRACE worker signature: _____Date:_____

BARCODE

BARCODE #

B. Enrollment Forms

B1. Consent for Treatment

GRACE: Consent for Use and Disclosure of SUD Records for Treatment, Payment, and Health Care Operations

Patient Name: _____ Birthdate: _____

Address: _____ Account#: _____

_____

I _____, understand that my substance use disorder treatment records are protected under federal law, including 42 CFR Part 2 and HIPAA, and any applicable state law.

I authorize _____ Grace Program (the "Program") to use and disclose my substance use disorder treatment information as described below:

DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

For purposes of facilitating treatment and medical care of the Patient named above, payment for such care, and hospital health care operations, as defined by HIPAA, I consent to the Program disclosing the Treatment Records and Billing Records (as defined below) to _____ and Medical Staff, my treating healthcare providers, health plans, third-party payers, and organizations helping to operate this program.

"Treatment Records" covered by this consent will include all substance use disorder records maintained by the Program relating to the Patient, including all admission forms and information, medication information, medical history information, physician orders, clinical testing information and other information, including information obtained from other entities and providers. "Billing information" will include all records and information maintained by the Program relating to the Patient, including, without limitation, admission information, medication information, medical history information, physician orders, clinical testing information, and other information.

REDISCLOSURE OF INFORMATION

I understand that information disclosed pursuant to this consent may be redisclosed in accordance with HIPAA. Federal law prohibits the use or disclosure of these records for civil, criminal, administrative, or legislative proceedings against me. I further understand that once disclosed, these records may be redisclosed by the recipient and may no longer be protected by 42 CFR Part 2.

RIGHT TO REVOKE

I understand that this consent is voluntary and may be revoked at any time, except to the extent that _____ or any other lawful holder of patient identifying information permitted to make the disclosure has already acted in reliance on it. I understand that any request to revoke this consent must be submitted in writing to the Health Information Management Department.

EXPIRATION

This consent will expire on the following date, event, or condition if not revoked before then:

_____ (list the date, event or condition upon which you wish for this consent to expire).

If no date, event or condition is listed, this consent will expire one (1) year from the date of signature below.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship of Legal Representative to Patient Signature of Witness (Include Date)

B2. New Patient Information Form

GRACE New patient Information

Today's Date:_____

Patient Name:_____DOB:_____

Primary Phone number:_____(cell, home, work, other)

Secondary phone number:_____(cell, home, work, other)

E-mail address:_____

Current Physical Address:_____

_____

Marital status (circle one): Never married Married Divorced Separated Widowed

Emergency contact (Name):_____

(Relationship)_____(Phone#)_____

Due Date:_____OB:_____

Health Insurance Type: Medicaid None Private/Commercial_____

Medicaid Type: Health Blue Amerihealth Caritas United Health Care Louisiana Health Connections Aetna

In substance abuse treatment currently? Where:_____

_____

Current Medications:_____

_____

Where did you hear about GRACE Program?

_____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective date: _____

Who Will Follow This Notice

This notice describes the practices of [redacted] and that of:

- All healthcare professionals authorized to enter information into your medical record;
- All departments, clinics, and units of the hospital, including all hospital-owned physician practices;
- All employees, staff, volunteers, contractors and other hospital personnel;
- Members of volunteer groups who assist you while you are in the hospital;
- Physicians who are members of [redacted] medical staff and any allied health professional involved in your care;
- Any hospital personnel who provide healthcare services for you at any satellite locations.

In addition, satellite locations may share your medical information with each other as needed for treatment, payment, or healthcare operations, as described in this notice.

This notice applies to all records of your care generated by the hospital, whether made by hospital personnel or your personal physician, including billing-related information. Your personal physician may have different policies or notices regarding the use and disclosure of your medical information created in his or her office or clinic.

Notice of Organized Healthcare Arrangement

In addition to the uses and disclosures described below, there may be instances where the hospital will share your health information with members of our Organized Health Care Arrangement (OHCA). This means that the Hospital may share your health information with other healthcare providers who are part of the OHCA when it is necessary for treatment, payment, or healthcare operations. Sharing information in this way helps us coordinate your care and improve the services you receive. Members of the OHCA agree to follow the privacy practices described in this Notice and may use or disclose your information as permitted by HIPAA and applicable state law.

Our Pledge Regarding Your Medical Information:

We understand that medical information about you and your health is personal, and we are committed to protecting it. This Notice explains how we may use and disclose your medical information and describes your rights under federal and state law.

Your Rights Regarding Medical Information About You

Although your medical record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. As provided by federal and state law, you have the right to:

- request a restriction on certain uses and disclosures of your information.

You may ask the hospital to limit how we use or disclose your medical information for treatment, payment, or healthcare operations. In some cases, it may not be feasible or possible for us to agree to the requested restrictions. The hospital will agree to restrict disclosure of your health information to a health plan if the disclosure is for payment or healthcare operations, and the information relates only to a service that you, or another person on your behalf has paid the hospital for in full.

- obtain a paper copy of the Notice of Health Information Practices by request from the hospital's Health Information Management Department, even if you agreed to receive it electronically.

• inspect and obtain a copy of your health record as also provided for in Louisiana law (R.S. 40:1299.96). You may request an electronic copy if your records are maintained electronically. Reasonable fees may apply as allowed by law.

• request an amendment to your health record. You have the right to ask us to change your health information related to treatment or billing if you think that there is a mistake or that information is missing.

• obtain an accounting of disclosures of your health information.

• request communications of your health information by alternative means or at alternative locations.

• revoke, in writing, your authorization to use or disclose health information except to the extent that action has already been taken.

• be notified, in the event that we (or one of our business associates or business associate subcontractors) discover a breach of unsecured, protected health information involving your medical information.

[redacted] **Responsibilities**

[redacted] is required to:

• maintain the privacy and security of your health information;
• provide you with this Notice, describing our legal duties and privacy practices;
• follow the terms of this Notice;
• notify you promptly if a breach occurs that compromises the privacy or security of your unsecured health information;
• Inform you if we are unable to agree to a requested restriction or amendment;
• accommodate any reasonable request to communicate with you in a specific way or at a specific location.

[redacted] will not use or disclose your health information without your authorization, except as required by law or as described in this Notice.

Revisions to Privacy Practices

Federal Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164 is effective on or after April 14, 2003. [redacted] reserves the right to change our practices and to make new provisions effective for all individually identifiable health information we maintain. Should our information practices change, we will make the new version of this Privacy Practices Notice available to you upon request.

For More Information or to Report a Problem

Requests for restrictions, or to inspect, copy, or amend medical information must be made in writing and submitted to the Director of Health Information Management[redacted]. Requests for an accounting of disclosures must also be submitted to the Director of Health Information Management. If you have questions and would like additional information, you may contact th[redacted] Patient Relations Coordinator at[redacted]. If you believe your privacy rights have been violated, you can file a formal complaint with the Patient Relations Coordinator or with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

How [redacted] May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose your health information. For each category, we explain the purpose of the use or disclosure and provide examples to help illustrate how your information may be shared. We have not listed every use or release of information within the categories, but all permitted uses will fall within one of the categories.

Pursuant to State and Federal Law, [redacted] will use Your Health Information for:

Treatment. We may use your medical information to provide you with appropriate medical treatment or services. This includes sharing information about you with physicians, nurses, technicians, medical students, or other hospital personnel who are

involved in your care. For example, if you are scheduled for surgery or admitted for delivery, your care team may need to know if you have diabetes so they can plan for the right medications, monitoring, or meals. Different hospital departments may also share information with one another to coordinate services such as prescriptions, laboratory testing, imaging, and other aspects of your treatment. We may also participate in various secure health information exchanges that allow your healthcare providers to access your health information when needed to support your care.

Payment. We may use or disclose your health information to obtain payment for the healthcare services you receive. This may include sharing information with your health plan to confirm coverage, obtain prior authorization, or determine whether a service, treatment, or prescription will be paid for by your plan. If payment is not made, we may disclose limited information to collection agencies, attorneys, credit reporting agencies, or other authorized organizations as needed to collect payment for services provided.

Healthcare Operations. We may use and disclose your health information for activities that support the hospital's operations and help us provide safe, high-quality care. These activities include reviewing the care you receive, evaluating outcomes, and working to improve the quality and effectiveness of our services. We may also use your information for staff training, accreditation, licensing, auditing, and other administrative functions that allow the hospital to operate efficiently and meet regulatory requirements.

Business Associates. Some services we use to support hospital operations are provided by outside companies or individuals known as business associates. These may include consultants, record storage providers, accreditation organizations, claims processing administrators, and vendors who maintain our software or equipment. We may disclose your health information to our contracted business associates so that they can perform the services we've contracted them to provide. Each business associate is required, by law and by contract, to protect your information and to use it only as permitted to carry out their duties.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication, for the same health condition. All research projects must go through a formal review and approval process to ensure that patient privacy and safety are protected. We may also disclose limited medical information to researchers who are preparing a study, as long as the information they review is necessary for developing the research project.

Coroners and Funeral Directors. We may release medical information to a coroner or medical examiner when necessary, such as to identify a deceased person or to determine the cause of death. We may also share relevant information with funeral directors to help them carry out their authorized duties.

Contacting You. We may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also reach out to invite you to special events, programs, or celebrations offered by the hospital.

Appointment Reminders. We may contact you to remind you of an upcoming appointment for treatment or medical care at the hospital. We may also reach out when it is time to schedule a follow-up visit.

Fundraising. We may use limited information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, hospital service information, treating physician information or outcome information) to contact you as part of a fundraising effort. We may also share this information with a foundation associated with [redacted] to work on our behalf. Each fundraising communication will give you the option to opt out of receiving future fundraising messages.

Public Health. As authorized by law, we may disclose medical information about you for public health activities. For example, we may disclose your health information in certain circumstances: to prevent or control disease, injury or disability; to report births and deaths; to report child or elder abuse or neglect; to report reactions to medications or problems with products to the FDA; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; and to notify the appropriate government authority if we believe a patient has been

the victim of abuse, neglect or domestic violence. We will make these disclosures only when required or authorized by law, or when you agree.

Correctional Institution. If you are an inmate of a correctional institution, we may disclose your health information to the facility or its authorized agents when necessary for your own health and safety, or for the health and safety of others.

Legal Proceeding. We may disclose your health information in response to a court order, valid subpoena, or other lawful process. We may also share information with our attorneys when needed to defend the hospital or respond to a complaint or claim related to the services we provide.

Law Enforcement. We may disclose your health information for law enforcement purposes as required by law. Federal law also allows us to release health information to an appropriate health oversight agency, public health authority, or attorney if a workforce member or business associate believes in good faith that the hospital has engaged in unlawful conduct, violated professional or clinical standards, or may be placing one or more patients at risk.

As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law.

To Prevent a Serious Threat to Health or Safety. We may use or disclose your medical information when necessary to prevent a serious threat to your health or safety, or the health and safety of another person or the public. Any disclosure would be made only to someone who is able to help reduce or prevent the threat.

Special Situations

Organ and Tissue Donation. We may disclose medical information to organizations involved in organ, eye, or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may disclose your medical information as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may disclose your medical information as required to comply with workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Other Permitted Uses and Disclosures that May be Made, with the Opportunity for You to Object

Patient Directory. We may include certain limited information about you in the patient directory. This information may include your name, your location in the hospital, your general condition, and your privacy status. The directory information may also be released to people who ask for you by name. If you are unable to express your preference about being included in the directory due to an emergency or your medical condition, you will be provided the opportunity to object when it is feasible to do so.

Notification. We may use or disclose your information to notify, or help notify, a family member, personal representative, or another person responsible for your care of your location and general condition. We may also share information with organizations assisting in disaster relief efforts so your family can be informed of your condition, status, and location.

Communication with Family. Health professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. If you do not want hospital personnel to communicate with your family or others involved in your care, you may let us know at any time.

Other Uses Of Medical Information Requiring Patient Authorization

Uses and disclosures of your health information for marketing or for disclosures that involve the sale of protected health information require your written authorization.

Any other use or disclosure of your medical information not described in this notice, or not permitted or required by law, will be made only with your written authorization. If you authorize us to use or disclose your medical information, you may revoke hat authorization at any time by written request. Once you revoke your authorization, we will no longer use or disclose your information for the purposes covered by the authorization; however, we cannot undo any disclosures that were made before your revocation, and we must continue to maintain records of the care we provided.

Additional Rights and Privacy Protections for Substance Use Disorder Programs

Additional privacy protections apply to substance use disorder records ("Part 2 records") created by a [redacted] clinic ("Part 2 Program").

This section supplements the rest of this Notice and describes:

- How your Part 2 records may be used and disclosed;
- Your rights regarding your Part 2 records; and
- How to file a complaint if you believe your privacy or security rights related to your Part 2 records have been violated.

These protections are required by federal law and are designed to give you greater control over the confidentiality of your substance use disorder treatment information.

Uses and Disclosures of Part 2 Records

[redacted] may use and disclose your Part 2 records only as described in this section or with your written consent.

Permitted Uses and Disclosure of Part 2 Records Without Consent

We may use or disclose your Part 2 records without your written consent in the following situations, as allowed by federal law:

- **Within the Part 2 Program.** To staff members who need the information to provide diagnosis, treatment, or referral for treatment.
- **To qualified service organizations.** To organizations that provide services on our behalf and that agree in writing to protect your information as required by Part 2.
- **Crimes on Program Premises or Against Program Personnel.** To law enforcement agencies or officials if you commit, or threaten to commit, a crime on our premises or against our staff.
- **Child Abuse or Neglect Reporting.** To report suspected child abuse or neglect, consistent with state law.
- **Medical Emergencies.** To medical personnel in a medical emergency, when necessary, to treat a condition that poses and immediate threat to your health.
- **Research.** For research approved by an Institutional Review Board or other applicable oversight body.
- **Audit and Evaluation.** To qualified personnel conducting audits or program evaluations, who agree to protect the information.
- **Public Health.** To a public health authority, but only if the information has been deidentified in accordance with federal standards.

Permitted Uses and Disclosures that Require Consent

Your written consent is required for most other uses and disclosures for your Part 2 Records including:

- **Treatment, Payment, and Healthcare Operations.** [redacted] will ask you to sign a single consent allowing future uses and disclosures of your Part 2 records for treatment, payment, and health care operations. This consent helps ensure coordinated, high-quality care. Once your Part 2 records are disclosed to a HIPAA covered entity (such as another health care provider or your health plan) or to a business associate, the recipient may redisclose your information consistent with HIPAA and this Notice of Privacy Practices.

Even with a general consent, you must sign a separate, specific consent before your Part 2 records may be used in a civil, criminal, administrative, or legislative proceeding against you.

Revoking Consent

You may revoke your consent at any time by submitting a written request to your provider. After you revoke your consent, [redacted] will no longer use or disclose your Part 2 records, except to the extent we have already relied on your prior authorization.

Using or Disclosing Part 2 Records in Legal Proceedings

Your Part 2 records or testimony relaying the content of such records may not be used or disclosed in any civil, criminal, administrative, or legislative proceedings against you unless you provide specific written consent or a court issues an order permitting the disclosure. A court may issue such an order only after you and/or [redacted] have received notice and an opportunity to be heard. Any court order must be accompanied by a subpoena or similar legal mandate before the records may be used or disclosed.

Your Rights Regarding Part 2 Records

As a patient in a [redacted] l Part 2 Program, you have the rights listed in this Notice, along with the right to a list of disclosures by an intermediary for Part 2 Records. If you consent to share your Part 2 records through an intermediary, such as a research organization, you may request a list of any disclosures that intermediary has made during the past 3 years. Requests for this list must be submitted directly to the intermediary.

How to File a Complaint About Your Part 2 Privacy Rights

If you believe your rights related to your Part 2 records have been violated, you may file a formal complaint with the [redacted]s [redacted] Patient Relations Coordinator at [redacted], or with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

[redacted]

B4. Program Agreement Contract, Patient

PROGRAM NAME
PROGRAM ADDRESS
P: ___-___-____ • **F:** ___-___-____

GRACE Program Agreement

I, _____, agree to participate in the GRACE Program.

Participation may include:

- GRACE assessment and evaluation completed by GRACE team
- Follow up visits in person or by phone with GRACE team
- Compliance with Medication Assisted Treatment (if applicable)
- Honest information regarding your medical and social history, including substance use
- Collaboration with GRACE team, your care provider(s) and identified support person(s)
- Communication between GRACE team and your patient care provider(s)
- Mutual respect between you, the GRACE team and your care provider(s)

I understand my information may be used for research, and, if so, privacy and confidentiality research policies will be followed.

I understand that participation in the GRACE program is voluntary. I understand that I may withdraw at any time:

o **One year from the date of signature; Specify Month, Day and Year** _____ **or**

o **Specify date, event or condition** _____

Signature: _____ Date: _____

Witness signature: _____ Date: _____

BARCODE

##BARCODE##

B5. Notice Regarding Re-Disclosure

NOTICE REGARDING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION

This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies:

I. Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.
II. You are a covered entity or business associate and have received the record for treatment, payment, or health care operations, or
III. You have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E.

A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).

42 CFR part 2 prohibits unauthorized use or disclosure of these records.

C. Screening/Assessment Forms

C1. RN Intake Questionnaire

Intake RN Questions

OB-GYN: Gravida ___ Para ___ Term ___ Preterm ___ AB ___ Living ___ SAB ___ IAB ___ Ectopic ___

EDC _____ Age at first period? ___(regular/irregular)

Medical History:

Mental Health History:

Surgical History:

Significant Family History:

Current medications:

Substance Use:

ETOH? _____ How often _____

Drugs? _____ How often_____

Cigarettes? _____ How many a day? _____

Vape? _____ Substance? _____ How often? _____

Are you married? ____ Spouse or SO name_____

Year of education? _____ Highest level of education? _____

Preferred language? _____

Preferred learning style? _____

Complete Nursing Intake Note:

- Do you have an OB-GYN? Y/N _____ PCP? Y/N _____ Dentist? Y/N
- Document any Education or Referrals
- Pain management following delivery
- Support persons & emergency contact
- Breastfeeding questions/options
- Safe Sleep review (Nothing in bed except for baby, tight fitting sheet & pacifier)
- Community contacts given to patient (OB-GYN, MAT, IOP, Inpatient Treatment, Behavioral Health, Residential)
- Handouts or pamphlets given
- NICU tour depending on gestational age Y/N
- Narcan offered/received from Pharmacy

Patient questions?_____

C2. Social Worker Assessment Form

Assessment

OB:_____ **Next OB Visit:**_____

Mood:_____

EGA Calculation

EDD:_____

⊙ **Psychosocial Assessment**

OB History:

Gravida (# of times been pregnant)_____

Para (# of deliveries after 20 weeks)_____

Term (# of deliveries 37+ weeks)_____

Abortions-Spontaneous:_____
Abortions- Elective:_____
Abortions-Ectopic:_____
Living:_____

Prenatal Care:

Pregnancy Plan: □Planned □Unplanned
Feelings regarding Pregnancy: □Happy □Unhappy □Unsure □Other:_____

⊙ **Family**

Family Status: □Married □Living with a partner □Separated □Divorced □Widowed □Never married □ Declined to answer

Employment: □Employed for wages □Student □Self-employed □Retired □Unemployed less than a year □ Unemployed greater than a year □Retired □ Unable to work □Declined to answer

Yearly household income: □ less than $10,000 □$10,000 to $15, 000 □$15,000 to $20,000 □$20,000 to $25,000 □$25,000 to $35,000 □$35,000 to $50,000 □Unknown □Declined to Answer

People supported by household income: □ Adults less than 18 years old □Children greater than 17 years old □Unknown □Decline to answer

List number of adults 18 years of age or older:

_____

_____

List number of children 17 years of age or younger -

_____

_____

List names/ages of other children cared for by mother if primary caregiver:

_____

_____

⊙ **Nutrition**

Food situation in the past 12 months: □always afford nutritious meals □always afford enough to eat, not necessarily nutritious □sometimes we could not afford enough to eat □often we could not afford enough to eat □decline to answer

Housing:

Housing : □ own/shares home □ rents/shares home □public housing/with rental assistance □with parent/family member □homeless □other □declined to answer

Other(describe)_____

Housing Concerns: □eviction notice □ rent past due □ unable to pay future rent □unable to pay utilities □Utilities turned off □housekeeping concerns □housing condemned □friend/family eviction □threat of abuse □discharged/service terminated □personal conflict with others □health/safety concerns □lease violations □ declined to answer □other_____

⊙ **Trauma History**

Event:

Natural disaster: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Fire or explosion: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Transportation accident: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Serious accident work, home or during recreational activity: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Exposure to toxic substance: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Physical assault: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Assault with a weapon: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Sexual assault: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Other unwanted/uncomfortable sexual experience: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Combat/exposure to a war-zone: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Captivity: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Life threatening illness/injury: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Severe human suffering: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Sudden violent death: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable

Serious injury, harm or death caused to someone else: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable
Any other very stressful even/experience: □ happened to me □witnessed □learned about it □part of my job □ unsure □ not applicable
Other (describe):

_____
_____

Supplement:
Experienced suicidal or homicidal ideation: □ past attempt(s) □plan □ means □ access to guns
Describe:_____
_____
_____

Self harm: □ completed □ thoughts
Describe (frequency, when, where, how):_____
_____
_____

Current thoughts of self-harm: □Yes □No

Has Department of Children and Family Services ever been involved with family □ yes □no
Describe:_____
_____

Criminal Justice: □ Arrests □Probation □ Parole
Describe:_____
_____

⊙ Stress and Discrimination
Events:
Stressors in the past 12 months: □ Family member hospitalized □divorced □Separated □Moved □homeless □ loss of job/family member □loss of job □cut in pay/work hours self/family member □increase in arguments with family member □family member disapproves of pregnancy □difficulty paying bills □family member jailed □drug/alcohol abuse family/friend □ death

Experience:
Treated with less courtesy/respect than others: □ Almost every day □at least once a week □a few times a month □a few times a year □less than once a year □never □declined to answer
Receive poorer service than others: □ Almost every day □at least once a week □a few times a month □a few times a year □less than once a year □never □declined to answer
People act as if you are not smart: □ Almost every day □at least once a week □a few times a month □a few times a year □less than once a year □never □declined to answer
People act as if they are afraid of you: □ Almost every day □at least once a week □a few times a month □a few times a year □less than once a year □never □declined to answer
Threatened or harassed: □ Almost every day □at least once a week □a few times a month □a few times a year □less than once a year □never □declined to answer
Reason for experiences: □ ancestry/nationally □gender □race □age □religion □height □weight □physical appearance □sexual orientation □education □ income level □ skin color □ physical disability

□unknown □declined to answer □Other
(describe)_____

⊙ Personal Safety

Partner Violence:

Frequency of abuse

Physically hurt: □never □rarely □sometimes □fairly often □frequently
Insulted/talked down to: □never □rarely □sometimes □fairly often □frequently
Threatened by harm: □never □rarely □sometimes □fairly often □frequently
Cursed/screamed at: □never □rarely □sometimes □fairly often □frequently

Service and Assistance History:

History

Previously received mental/behavioral health treatment □yes □no
Describe treatment (physician, facility, timeframe, inpatient/outpatient_____

_____

_____

_____

Previous diagnosis

_____

_____

Current diagnosis

_____

_____

Psychiatric medications □ yes □no
List names of medications

_____

_____

Describe medication regime

_____

_____

Other Medications/Supplements □ yes □no
Record ALL medications in Clinical Data

Services:
Childcare voucher: □Receiving □Applied □Need □Not applicable □Declined to answer
Emergency aid (EAEDC): □Receiving □Applied □Need □Not applicable □Declined to answer
Food stamps: □Receiving □Applied □Need □Not applicable □Declined to answer
Heating assistance: □Receiving □Applied □Need □Not applicable □Declined to answer
Immigration assistance: □Receiving □Applied □Need □Not applicable □Declined to answer
Legal services: □Receiving □Applied □Need □Not applicable □Declined to answer
Public Housing: □Receiving □Applied □Need □Not applicable □Declined to answer
Section 8 Voucher: □Receiving □Applied □Need □Not applicable □Declined to answer
Social Security: □Receiving □Applied □Need □Not applicable □Declined to answer
Disability Insurance (SSDI): □Receiving □Applied □Need □Not applicable □Declined to answer
Social Security Income (SSI): □Receiving □Applied □Need □Not applicable □Declined to answer

Transitional aid to families with dependent children (TAFDC): □Receiving □Applied □Need □Not applicable □Declined to answer
Temporary assistance to needy families (TANF): □Receiving □Applied □Need □Not applicable □Declined to answer
Tribal housing: □Receiving □Applied □Need □Not applicable □Declined to answer
Utility assistance: □Receiving □Applied □Need □Not applicable □Declined to answer
Nutrition Supplemental program for Women/Infants/Children (WIC): □Receiving □Applied □Need □Not applicable □Declined to answer
Describe other services/status

_____

_____

Education
Information/education provide: □ Childcare voucher □Emergency aid to elderly/disabled/children (EAEDC) □Food stamps (SNAP) □Heating assistance □Immigration services □Legal services □Public housing □Section 8 voucher □Social security disability Insurance (SSDI) □Social Security income (SSI) □Transitional aid to families with dependent children (TAFDC) □Temporary assistance to needy families (TANF) □ Trial housing □Utility assistance □Nutrition supplemental program for woman/infant/children (WIC) □*Other
(Describe other*)

_____

_____

Referral
Referrals: □ Childcare voucher □Emergency aid to elderly/disabled/children (EAEDC) □Food stamps (SNAP) □Heating assistance □Immigration services □Legal services □Public housing □Section 8 voucher □Social security disability Insurance (SSDI) □Social Security income (SSI) □Transitional aid to families with dependent children (TAFDC) □Temporary assistance to needy families (TANF) □ Trial housing □Utility assistance □Nutrition supplemental program for woman/infant/children (WIC) □Other
(describe)_____

_____

Θ Substance Use
Opioids:
Describe use (first experience, attempts to quit/reduce use, hospitalizations)

_____

_____

_____

_____

_____

Smoking:
Rules □Not allowed in home □allowed in home □allowed in designated areas □allowed in home some times □Declined to answer

Alcohol:
Use during pregnancy: □Drink alcohol regularly/no change in use with pregnancy □Drink alcohol regular/decreased amount with pregnancy □ occasionally □Quit alcohol with pregnancy □no alcohol prior/during pregnancy □don't know □declined to answer

Drug/alcohol abuse family/friend: □Peers □Partner □Parents
Parents with mental health history: □ Yes □ No
Comments:_____

_____

⊙ **Neighborhood and Community**

Neighbors:
Help each other: □ Agree □Don't know □Disagree □Declined to answer
Watch out for others children: □ Agree □Don't know □Disagree □Declined to answer
Feel safe in neighborhood/community: □ Never □ Sometimes □ Usually □ Always □ Declined to answer
Describe contributing factors to feeling unsafe:

_____

_____

_____

Clinical Information:
Summary
Clinical Summary (include: goals, current stage of change):

_____

_____

_____

Preliminary Diagnosis:

_____

_____

D. Delivery Planning Checklist

D1. Delivery Planning Checklist

Pt Name:

Delivery Planning Checklist– Social Worker

- ☐ Pregnancy App?
- ☐ Bags packed for you and baby and partner?
- ☐ Arrangements for other children when you are in the hospital?
- ☐ Who do you want with you in the room?
- ☐ Do they know about your substance use history and current treatment?
- ☐ Are you ok with GRACE team visiting you while you are here?
- ☐ Do you have any fears or concerns about taking baby home?
- ☐ Discuss DCFS reporting criteria
- ☐ Discuss possibility of DCFS investigation and what to expect
- ☐ How do you think you will feel if baby has to go to the NICU?
- ☐ PMAD information + Mom Group
- ☐ Plan for mental health treatment after delivery?
- ☐ Will you have help when you get home? (with baby, food prep, laundry, etc.)
- ☐ Do you have the baby supplies? Carseat, safe sleep, diapers, bottles, clothes, etc.
- ☐ Do you have a pediatrician picked out?
- ☐ Post-partum OB visit scheduled?
- ☐ Who will drive you and baby to your appointments?
- ☐ Do you think you want more children?
- ☐ Birth Control
- ☐ Plan for returning to treatment
- ☐ Plan for someone to hold your meds
- ☐ Staying sober when you are stressed and losing sleep
- ☐ Self-care and coping
- ☐ Safe place for you and baby to live?
- ☐ People in home who use?
- ☐ Contacting GRACE about your delivery

D2. SBAR Example

Patient: Jane Doe

DOB: 1/1/19xx

EDC 01/01/20XX

Scheduled C-section 01/09/20XX

Situation:

- Referral source: referred by Provider
- Lives with: spouse and 4 children
- Support System:
- Patient reports she is sober and lives in a safe environment.
- MAT Program: No

Background:

- 33 y.o.
- G2P1001
- OB History: G2P1T1. First baby was adoption case.

Past Medical History:

- ADHD
- Anemia
- Anxiety
- Arthritis (Reported by patient)
- Borderline personality disorder (Sees Dr. Flechas & LCSW at WH BH)
- Depression
- Fibromyalgia
- Herpes simplex
- Hypertension
- Panic attack
- PONV (postoperative nausea and vomiting)
- Prediabetes
- PTSD (post-traumatic stress disorder)
- Self-injurious behavior (hx of cutting as a teenager)
- Sleep difficulties
- Substance abuse (sober x 4.5 years)
- H/O suicide attempts

Social History: Patient with history of intimate partner violence. Currently lives with her spousee. Patient denies any domestic violence in current relationship. Patient reports she has been sober from methamphetamines for 4 years, last use of marijuana 05/2025, and last use of ecstacy in 01/2025. Patient reports she uses nicotine patches prn.

Assessment:

- Patient has been cooperative while engaged with GRACE program. Patient advocates well for herself and is motivated to continue treatment and remain sober.
- Patient states she is nervous for delivery.
- Patient is happy about pregnancy.
- Patient wants to use Formula.
- GRACE staff explained infant will need to be observed for 72 hours or longer for NAS with possible NICU stay. Patient has not toured the NICU.
- GRACE staff explained hospital policy for DCFS notification if infant meconium drug screen is positive.

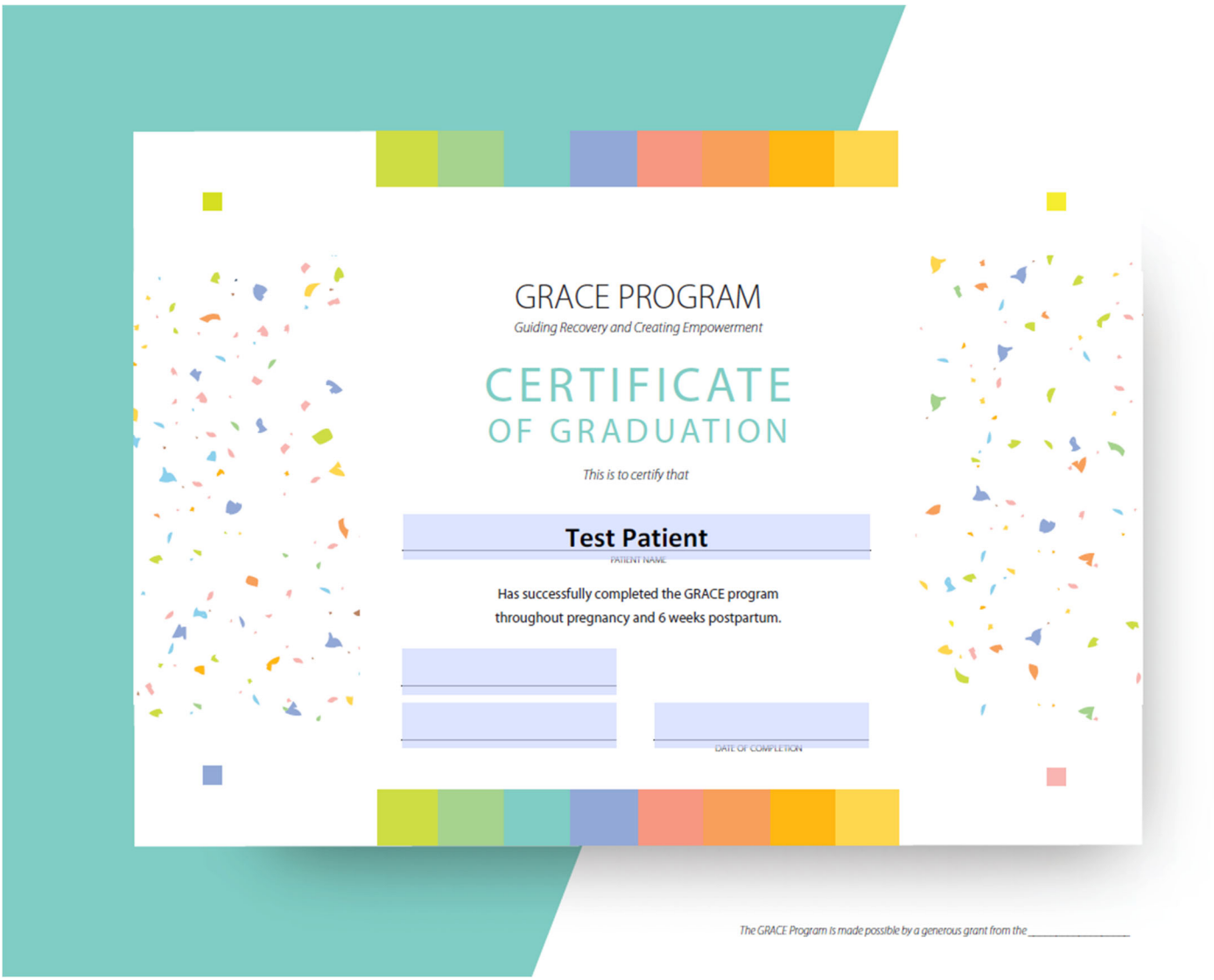
Recommendation:

Contact GRACE staff when patient is admitted for delivery.

All information included is subject to change.

E. Graduation Certificate

E1. Woman's GRACE Graduation Certificate



F. Marketing

F1. GRACE Marketing 1-Pager



YOUR LOGO HERE

GRACE PROGRAM

Guiding Recovery and Creating Empowerment

GRACE is a FREE program that provides non-judgmental support and resources to women who need help with substance misuse during pregnancy.

Who can participate in GRACE?

The GRACE Program provides support for women in the Baton Rouge area suffering from the following addictions during pregnancy:

- Opioids
- Alcohol
- Tobacco
- Illicit substances

How can GRACE help?

- A nurse and social worker support women through pregnancy up until one year after giving birth.
- Women are provided with education on substance use and the safest treatment options during pregnancy.
- The GRACE team will connect participants to resources in the community to aid in treatment and recovery.
- GRACE helps women and their babies receive the best care possible.

What is the cost to participate?

The program is free of cost to participants and open to any pregnant woman in the Baton Rouge area, regardless of where she is receiving prenatal care.

Is participant information kept private?

- All phone calls and appointments are private and confidential.
- A participant's private health information is protected by federal laws and regulations and cannot be shared without her permission.
- [redacted] will not report drug use for patients enrolled and participating in the GRACE Program. Information regarding health history and treatment also will not be given as evidence for criminal drug charges.

KNOW SOMEONE WHO NEEDS HELP?

CALL YOUR PHONE #

Refer yourself or another woman in need today.

ARE YOU PREGNANT AND STRUGGLING WITH ADDICTION? IF SO, **WE CAN HELP.**

Take the first step toward recovery and call GRACE today. All calls are confidential.

Call YOUR PHONE # **or visit** YOUR WEBSITE HERE

YOUR LOGO HERE

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Guiding Recovery and Creating Empowerment