

DHCS' Pregnancy and Postpartum Transitional Care Services (TCS): Member Journeys

High-Intensity TCS: Benita

Benita's Experience:

- Newly diagnosed with uncontrolled diabetes at early prenatal visit; scheduled for planned hospital admission for glucose control

Key TCS Care Manager (CM) Responsibilities:

- Assigns a single point of contact/TCS Care Manager (Gary)

Perinatal Provider/TCS CM Coordination:

- OB office refers Benita to MCP for high-intensity TCS and Medically Tailored Meals
- MCP sends OB office an email with TCS CM name and contact information (and confirms with Benita via text)

Benita's Experience:

- Admitted and discharged from hospital
- Attends appointments with OB and endocrine teams; connected to Medically Tailored Meals, paid family leave (PFL), and a doula

Key TCS CM Responsibilities:

- Coordinates with hospital during admission
- Follows-up within seven days post discharge; reviews discharge instructions
- Provides support for needed Birthing Supports Checklist items.

Perinatal Provider/TCS CM Coordination:

- Gary ensures OB and endocrinologist receive discharge summary
- Gary exchanges information with OB, ensuring completion and non-duplication of Checklist items.

Benita's Experience:

- Delivers healthy baby and discharged with recommended follow-ups
- Talks to Gary five days after discharge

Key TCS CM Responsibilities:

- Receives notification of admission from MCP; coordinates with hospital during admission
- Follows-up with Benita within seven days of discharge; reviews discharge instructions; ensures Benita receives recommended follow-ups, including connection to endocrinologist

Perinatal Provider/TCS CM Coordination:

- Gary ensures OB and endocrinologist receive discharge summary

Benita's Experience:

- Attends postpartum appointments and well-child visits

Key TCS CM Responsibilities:

- Ensures postpartum visit, two-month well-child, any recommended follow-ups, and Checklist items are complete

Perinatal Provider/TCS CM Coordination:

- Gary reviews OB records and ensures completion and non-duplication of Checklist items

Initial Interaction to Trigger TCS

Pregnancy Continues

Delivery

First Two Months Postpartum

Moderate-Intensity TCS: Alex

Alex's Experience:

- Attends prenatal visit at certified nurse midwife (CNM) practice; referred to a Licensed Clinical Social Worker (LCSW) for anxiety
- Enrolled in WIC and home visiting

Key Care Coordination Entity Responsibilities:

- CNM practice helps connect to needed services on the Birthing Supports Checklist

Key MCP Responsibilities:

- Assesses criteria for high- vs moderate-intensity TCS and confirms CNM practice is contracted to provide moderate-intensity TCS
- Notifies CNM practice that they will deliver TCS; shares information about TCS call line with Alex via text

Alex's Experience:

- CNM practice provides routine prenatal care
- Connected to nonmedical transportation (NMT), breast pump, and paid family leave (PFL)

Key Care Coordination Entity Responsibilities:

- CNM practice helps connect to needed services on the Birthing Supports Checklist
- Coordinates with MCP via TCS call line for needed supports (e.g., NMT)

Key MCP Responsibilities:

- Reevaluates criteria for moderate-intensity TCS
- Supports CNM practice via TCS Call Line
- Ensures access to MCP-provided services (e.g., NMT)

Alex's Experience:

- Delivers healthy baby and discharged with recommended follow-ups
- Discusses discharge instructions with CNM

Key Care Coordination Entity Responsibilities:

- RN from CNM practice calls Alex within 21 days post-delivery to ensure she is doing well and receiving needed services

Key MCP Responsibilities:

- Reevaluates criteria for moderate-intensity TCS after delivery and ensures CNM practice will provide TCS through two months postpartum

Alex's Experience:

- Attends postpartum OB, LCSW, well-child and PCP visits

Key Care Coordination Entity Responsibilities:

- Ensures postpartum visit, two-month well-child, any recommended follow-ups, and Checklist items are complete

Key MCP Responsibilities:

- Conducts routine evaluation and monitoring of CNM practice as care coordination entity