COORDINATING OUTPATIENT CARE FOR PREGNANT AND POSTPARTUM WOMEN WITH OPIOID USE DISORDER: LESSONS FROM THE COACHH PROGRAM

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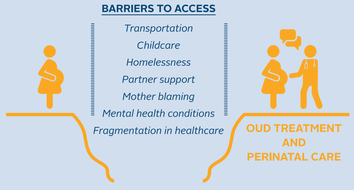
INTRODUCTION

With the rise of opioid use disorder (OUD) among women of childbearing age, care providers for this population increasingly encounter complex and intersecting medical and social needs.[1] Effective care for pregnant women with OUD must go beyond the bounds of traditional prenatal care and address pregnancy, substance use, and socio-economic challenges, such as housing instability and partner violence.[2,3] While pregnant women with OUD are especially in need of both prenatal care and medication assisted treatment (MAT) for their substance use, as recommended by the American College of Obstetrics and Gynecology, they are also likely to face barriers when accessing both types of care.[4] Lack of specialized substance use disorder (SUD) treatment resources for pregnant women, lack of education and training among providers, limited financial resources and social support, and stigma are barriers to accessing integrated and effective care.[5,6,7,8,9]

PREGNANT WOMEN WITH OUD HAVE COMPLEX AND INTERSECTING SOCIAL AND MEDICAL NEEDS



However, pregnancy can also present an opportunity for providers to engage women through prenatal care and SUD treatment.[10,11] The extant literature highlights the importance of building strong relationships between pregnant women with OUD and their care team in order to improve outcomes for the mother and baby.[12,13,14] Collaborative care teams offer such an approach to holistically address and coordinate the specialized and time-intensive care for this population. The purpose of this qualitative case study is to share experiences, promising practices, and lessons learned from a program designed to coordinate outpatient care for pregnant and postpartum women with OUD.

SETTING

CHART
Administered by the Massachusetts Health Policy Commission, the Community Hospital Acceleration, Revitalization, and Transformation (CHART) investment program provides phased grants to certain Massachusetts community hospitals for clinical transformation projects. Hallmark Health System (HH) used its CHART Phase 2 award to develop the Collaborative Outreach and Adaptable Care at Hallmark Health (COACHH) program.[15]

COLLABORATIVE OUTREACH AND ADAPTIVE CARE AT HALLMARK HOSPITAL (COACHH)

TARGET POPULATION
Pregnant women with opioid use disorder (OUD)

TEAM
Executive Director (LICSW), social work supervisor (LICSW), nurse practitioner and a community health worker

SETTING
In the home, coffee shops, other community settings, and at Hallmark Health

COACHH
Although the COACHH program serves multiple populations, this case study focuses on the component serving pregnant and postpartum women with OUD.[16] After referral from providers within HH (primarily from OBGYNs or following a presentation to the ED), the team works with patients to develop a care plan, connects them with resources, and provides informational and emotional support as patients navigate their OUD during pregnancy and postpartum.

METHODS

A series of in-person, semi-structured interviews were conducted on a voluntary basis with COACHH team members who work directly with pregnant and postpartum women with OUD: the Executive Director, Social Work Supervisor, NP, and CHW. The interviews were coded, with a subset of interviews independently coded by three authors to compare and validate the code list. As themes emerged from the data, codes were grouped into five primary areas: patient-provider relationship building, service delivery, building a care team, outcomes, and structural challenges.

FINDINGS

RELATIONSHIP BUILDING

Supportive and nonjudgmental relationships between the COACHH team and patients are central to the success of the program. Through in-depth patient relationships and home visits, COACHH team members develop a holistic understanding of patients' lives in a way that is not feasible in a brief medical appointment. As a result, the team has a more vivid and encompassing sense of a patient's social determinants of health, strengths and challenges, and unmet needs. The team emphasizes "sticking by" patients and providing emotional support, especially as many of these patients have experienced shame, fear, anxiety, and stigma.

> *"We develop close relationships with [the moms, and become] someone they can rely on... We are judgement free. We are open and honest."*
>
> –SOCIAL WORKER

COLLABORATING WITH PATIENTS

Once patients are enrolled in COACHH, the team and patients engage in a collaborative needs assessment to "meet women where they are" and develop a care plan guided by patients' goals. The NP helps patients develop a pregnancy plan and/or explore alternatives. The Social Work Supervisor plays a central role in identifying and building relationships with other providers and federal, state, and community resources. Leveraging these connections, the CHW enrolls patients in services. The COACHH program functions as a communication hub, providing updates and sharing appropriate details with other health care providers or involved agencies, as well as for patients who often have questions about how to navigate the care system.

> *"[We] don't come in with a list of things [we] want them to do. It's hard but it's really important for them to want to do things for themselves and know that you are there to help, not tell [them] what to do."*
>
> –COMMUNITY HEALTH WORKER

BUILDING A CARE TEAM

Responsibilities and tasks are apportioned among the professionally diverse team in order to make the most of each team member's capacity and expertise. For example, the CHW dedicates time to maintaining regular communication with patients, which allows the NP to focus on clinical needs and patient education. All team members must be open-minded, understand addiction and pregnancy, and be familiar with the resources available in the community. Other skills, experiences, and traits are more role-specific. The team meets regularly, avoiding burnout by adjusting patient caseload and processing emotions. Despite the challenges, the team finds it rewarding to work with pregnant and postpartum women, noting the high potential for impact.

> *"[The social worker] can identify social issues and knows a lot about community resources... That's great because it doesn't take away from my time. [As a nurse practitioner,] I can focus on health and do an assessment in the home."*
>
> –NURSE PRACTITIONER

STRUCTURAL CHALLENGES

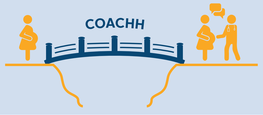
Despite repeated outreach efforts, the program was not able to enroll as many patients as originally anticipated. The COACHH team speculates that broader awareness of OUD across the health care system could increase referrals, since OBs and other clinicians who are more familiar with OUD may be better able to build trusting relationships so that patients feel comfortable disclosing their SUD. Moreover, clinicians might be more likely to screen and/or provide timely referrals, especially for patients who appear to be high-functioning and may otherwise slip through the cracks. However, the team is concerned that other care providers may not have the time to gain a holistic understanding of this patient population, limiting their ability to identify and address underlying challenges. In addition, there is a lack of a central repository for information about best practices or resources for this population.

> *"Women aren't coming forward and there's not a strong referral system."*
>
> –NURSE PRACTITIONER

SIGNALS OF CHANGE

Identifying appropriate outcome measures for this type of program requires thoughtful ongoing consideration. Given the complexity of patients' lives and myriad factors that impact outcomes, quantitative outcome measures are not likely to be reliable for the small patient population served in this time frame. Accordingly, the team measures success in holistic and qualitative terms, stressing relationships, engagement, and openness as signals of change.

> *"Some of the moms have long term goals that they thought they couldn't accomplish... [COACHH] has given them the ability to see that there's a second chance at life and to pursue those opportunities."*
>
> –NURSE PRACTITIONER



IMPLICATIONS

- Specialized, patient-centered programs for pregnant women with OUD are valuable
- Care teams must have relevant and person-centered skills to address individuals' needs
- Community health workers play a central role in relationship building
- Better integration of COACHH services in OB offices may increase referrals
- Ongoing provider education and dissemination of best practices should be adopted across disciplines

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