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The Value of Integrating OB and Substance Use Disorder Treatment: Initial Findings

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Overview

Like much of the country, Colorado has seen a disturbing increase in substance use-related morbidity, mortality, and health care utilization in recent years. And like much of the country, reproductive-aged women are disproportionately affected.

To help address the need, the Integrated Care for Women and Babies (ICWB) pilot was established by the Colorado Department of Human Services, Office of Behavioral Health in partnership with the Practice Innovation Program at the University of Colorado. The pilot is helping six clinics integrate obstetric (OB) services with behavioral health and substance use treatment at the same location.

This brief summarizes the clinics' experiences, identifies best practices, and outlines several policy changes that can help advance integrated SUD and OB services.

Key Messages

- Substance use during pregnancy increases maternal and fetal death and contributes to other poor outcomes such as miscarriage, preterm labor, and low birth-weight.
- Six Colorado sites are making a difference for people with substance use issues and their babies by offering co-located and integrated substance use and obstetric (OB) services. In the first year, these sites have supported 530 pregnant and parenting people with substance use disorder.
- The sites have demonstrated success in reducing barriers to regular and consistent OB and SUD care and have also identified challenges and opportunities that can support other clinics as the pilot transitions to a full program.

Introduction

Pregnant people who misuse substances are at high risk for poor outcomes, including miscarriage, preterm labor, and delivery-related complications. Infants born to people who have misused substances during pregnancy also face negative outcomes and are more likely to have a low birth weight, be born early, and to need neonatal intensive care than unexposed infants. Mental health and substance use contribute to maternal death; in Colorado more than half of maternal deaths between 2014 and 2016 were to people experiencing one of these conditions.[1]

To help address these stark rates, the Integrated Care for Women and Babies (ICWB) pilot was established by the Colorado Department of Human Services, Office of Behavioral Health (OBH) in partnership with the Practice Innovation Program at the University of Colorado (PIP@CU).

1 Colorado Department of Public Health and Environment. (2020). Maternal mortality in Colorado, 2014- 2016. Retrieved from https://nursing.cuanschutz.edu/docs/librariesprovider2/newsroomdocuments/maternal-mortality-in-colorado-2014-2016.pdf?sfvrsn=209887b9_2 28

The pilot aims to measurably improve outcomes for pregnant and parenting people and their children by integrating OB, behavioral health (BH), and substance use disorder (SUD) treatment services.

ICWB OPERATES IN:

Four medical clinics that offer OB services:

- Denver Health Women's Clinic (Denver)
- San Luis Valley Health Women's Clinic (Alamosa)
- Sheridan Health Services (Denver)
- Sunrise Communtiy Health: Monfort Family Clinic (Evans)

Two opioid treatment programs (OTP) facilities:

- Addiction Research and Treatment Service (ARTS) at the Department of Psychiatry, University of Colorado School of Medicine (Denver)
- Mind Springs Health: The Women's Recovery Center (Grand Junction)

These clinical partners receive financial support and technical assistance from a practice facilitator and a clinical health information technology advisor. Support focuses on developing efficient workflows to integrate OB and SUD care, care coordination with peer support specialists, developing working community partnerships, and sustainability planning. Physician addiction specialists with extensive experience in perinatal SUD care and staff from Colorado Community Managed Care Network, Illuminate Colorado, and Signal Behavioral Health Network provide ongoing guidance and assistance.

IN THE FIRST YEAR THERE WERE:

530
patients served

127
with opioid use disorder

403
with a non-opioid use disorder (most frequently cannabis diagnoses)

176
total babies born

28
babies born with low birthweight

28
babies born prematurely

Originally authorized by Senate Bill 19-228 as a limited pilot, ICWB was recently expanded and made permanent by Senate Bill 21-137. The extension and expansion mean even more pregnant and parenting people will benefit from coordinated care and more practices can receive support and guidance to successfully implement this integrated model. In this brief we highlight the activities underway, key lessons learned and considerations for current practice partners and those who may participate in the future. We also identify several policy changes that could enhance the program's success.

"You guys changed our lives." – Integrated Care Patient

"The peer support program has helped a lot. It has given me a person to listen to me when I have no one and someone to give me advice. Its nice to have that extra support." – Participant

Approach to Work

The ICWB program has five core components:

1. **Financial support for practices.** These funds provide resources for personnel, transportation, baby items, mom self-care items, technology upgrades and other infrastructure needs.
2. **Monthly practice facilitation.** A PIP@CU practice facilitator supports the practices as they adapt workflows to effectively integrate OB and SUD services, develop reliable processes for screening, establish consistent referral with BH professionals, engage pregnant and parenting people in treatment, and connect with their local recovery community.
3. **Monthly shared learning calls.** Hosted by the PIP@CU team, the calls are an opportunity for practices to learn from subject matter experts and to share with one another their successes, challenges and learnings.
4. **Measure reporting.** Practices report regularly on clinical quality measures, including numbers of patients: screened for SUD or pregnancy, served by integrated services, prescribed medications for opioid use disorder, and screened for postpartum mood and anxiety disorder. Practices also track total number of births and the percent of infants born at low birth weight or prematurely.
5. **Evaluation.** OBH oversees a robust evaluation of the project that includes the clinical quality measures mentioned above and rich qualitative data on patient stories and the challenges and successes of practices as they integrate care.

"The ICWB project has helped us to be creative in our service provision for pregnant women. The current integrated care model with telehealth services of both substance use treatment and prenatal care has greatly reduced barriers to treatment for those who need it most."
– ARTS/Sheridan Health Services Team

Lessons Learned for Practices

ICWB is designed to support continued learning and is an opportunity to assess best practices and challenges. Moving forward, as the pilot evolves into a larger program, it will be important to pay attention to the following lessons learned:

Key Lesson	Best Practices to Consider
Hiring and retention are continued challenges Challenges preceded recent and well-documented staff shortages in many industries. Challenges are particularly acute with peer support specialists whose unique combination of health care training and lived experience make them invaluable for both emotional support and coordinating services.	Engender a culture that recognizes and values the contributions of peers: • Competitive salaries • Flexibility with hiring requirements to ensure traditional hiring practices don't exclude people who could be effective (e.g. peers are atypical hires and have a greater likelihood of being unable to pass a background check than traditional health care professionals) • Intentionally support peer specialists with their own recovery Consider partnerships with substance use professional training programs as students need specified hours for their licensure. Develop succession plans even when there are no open peer recovery specialist positions.

Key Lesson	Best Practices to Consider
Keeping patients engaged is hard and requires creativity Population is often transient and many struggle with food, transportation, housing insecurity, and communication barriers (e.g. limited minute cell phone plans). When patients do leave treatment, strict data protections for SUD services pose legal barriers to coordinating care across settings.	Consider multiple approaches to ensure patients attend follow-up visits. To the extent funds are available, employ contingency management, which rewards participants that demonstrate positive behavior changes. Look to other providers for creative solutions
Fear and stigma can keep pregnant people from seeking care Many do not want to be screened because they fear a positive screen means child protective services will remove their child.	Educate providers and staff on guidance from the Colorado Department of Human Services and county-level child protective services explaining mandatory reporting requirements to support clear communicate with patients. Include peer support specialist in designing and delivering messages to patients
Data collection, cleaning and reporting are difficult	Leverage expertise of HIT partners to assist with clinical data collection and reporting.

Next Steps and Policy Implications

In addition to the solutions identified above, other actions that would help advance integrated SUD and OB services include:

- **Reviewing and amending any laws and regulations that are punitive for people seeking help for their substance use disorder**. As the state continues to invest in and transform our behavioral health, early childhood, and child welfare systems, it will be important to make sure there are multiple access points for supportive services for pregnant and parenting people with SUD – access points beyond law enforcement and child welfare.
- **Ensuring people are aware of recent changes to the law.** In particular, fear of child protective services can be a substantial barrier to engagement. Statute was recently changed to clarify that prenatal substance use alone is not child abuse and clear information for patients, mandatory reporters, and the general public should be developed and shared. Peers would be especially good messengers to patients.
- **Expanding use of bundles or sub-capitation payments.** These payments would ultimately give practices the most flexibility to implement initiatives and programs their patients most need.
- **Pursuing dedicated payment from payers for contingency management.** Contingency management is an evidence-based strategy that has shown great success in engaging people in SUD treatment but is not reimbursed by most payers.
- **Pursuing policies that facilitate alignment with other programs** such as Health First Colorado's Prenatal Plus and the Colorado Department of Policy and Financing's Maternal Opioid Misuse Model.
- **While opioid misuse is a growing problem in Colorado, it is not the predominant substance being misused by people in the ICWB pilot.** Funding and program design should be flexible such that providers can support all of their pregnant and parenting people regardless of the primary substance.