

## Massachusetts Moms Do Care Project:

An innovative and multipronged approach to supporting pregnant and parenting women with opioid use disorders



### Bureau of Justice Assistance and Comprehensive Opioid Abuse Program Webinar February 20, 2019

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## Moms Do Care: Introductions



**Massachusetts Department of Public Health,  
Bureau of Substance Addiction Services**  
*Amy Sorensen-Alawad, MSPH, MPA, Program Director*  
Leadership, funding administration, statewide resources

**Institute for Health and Recovery**  
*Laura Sternberger, LICSW, Program Manager*  
Leadership, coordination, training, technical assistance

**Advocates for Human Potential**  
*Amy Salomon, Ph.D., Lead Evaluator*  
Data collection and evaluation



# Webinar Agenda



## Introductions

### Project Background

- Program rationale
- Pregnancy, MAT, and NAS/NOWS
- Program and funding history

### Program Components

- Client-level services
- System change initiatives
- Care integration and sustainability
- Implementation strategy

### Performance Measurement

- Evaluation approach
- Outcomes
- Qualitative themes
- Lessons learned

## Questions



# The Massachusetts Department of Public Health, Bureau of Substance Addiction Services



**The Massachusetts Department of Public Health, Bureau of Substance Addiction Services (MDPH, BSAS) oversees the statewide system of prevention, intervention, treatment, and recovery support services for individuals, families, and communities affected by substance addiction and gambling**

**BSAS is the single state agency for substance use**

### Major Responsibilities

- Facilitates system development and funding—the full spectrum of prevention, intervention, treatment, recovery
- Licenses of SUD facilities and counselors and certification of recovery coaches
- Oversees provision of nonlicensed services including case management and recovery supports, naloxone distribution, SUD workforce development and training, media and communications, and state and federally funded pilot programs
- Provides content expertise, evidence-based and best-practice dissemination
- Oversees state SUD treatment and recovery support program data collection, analysis, and reporting
- Ensures access to treatment as the payer of last resort



## Institute for Health and Recovery Role: Leadership, Coordination, Training, and Technical Assistance



Mission statement: IHR is a statewide service, research, policy, and program development agency. IHR designs its services based on an understanding of the impact of trauma. IHR's mission is to develop a comprehensive continuum of care for individuals, youth, and families affected by alcohol, tobacco, and other drug use, violence/trauma, mental health challenges, and other health issues

IHR provides mental health and addiction licensed and CARF-accredited treatment for individuals, youth, and families struggling with addiction and mental health issues, many of whom have experienced violence, at several offices statewide. IHR also provides training, consultation, and technical assistance to state, local, and national organizations and funders to improve the integration of best practices and policies into prevention and treatment programs for families



## Advocates for Human Potential Role: Lead Evaluator



- AHP improves health and human services systems of care to help organizations and individuals reach their full potential
- AHP is the evaluator for a Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS) Moms Do Care grant to expand medical and behavioral health service systems' capacity to engage and retain pregnant and postpartum women in integrated medication-assisted treatment (MAT) and health care, addiction, and recovery support services
- The evaluation will provide critical information on implementing this type of complex intervention, as well as its impact at the client and system levels. As a new approach to engaging and serving a population of pregnant and parenting opioid-using women, the evaluation findings will help shape program development over time and help determine which components are most promising



## Project Background: Rationale



### Massachusetts rates of

- Neonatal abstinence syndrome
- Mothers with opioid use disorder
- Maternal overdose data

See citations below

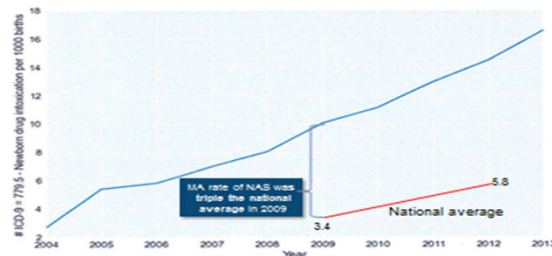


## Scope: NAS in Massachusetts



### The rate of NAS is increasing significantly in Massachusetts

From 2004 to 2013 the incidence of NAS increased from <3/1000 hospital births to >16/1000 hospital births per year



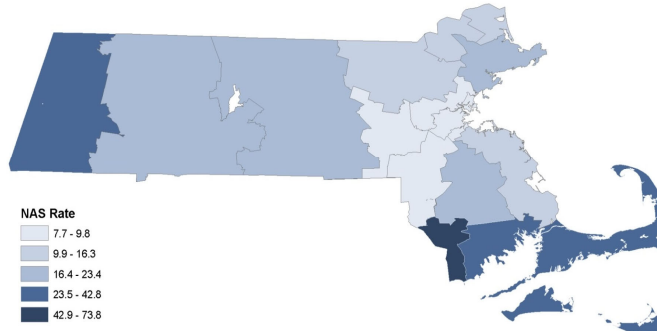
Sources:  
1. Gupte N and Riccio S. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. *pediatrics*. January 2012. Poster/Oral presentation.  
2. Renick S, Davis SS, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome. *United States*. 2008 to 2012. *Journal of Perinatology*. 2012; doi:10.1097/01.ppt.0000419101.2012.01.001



## Scope: NAS in Massachusetts



Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015  
Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn)



## Ch. 55 Data Citations



- **An Assessment of Fatal and Nonfatal Opioid Overdoses in Massachusetts (2011–2015)**
  - August 2017
  - <https://www.mass.gov/service-details/chapter-55-overdose-report>
  - Pages 53–56 Section III F. Mothers with Opioid Use Disorder



## Ch. 55: Section III. F. Mothers With Opioid Use Disorder



- Background: Mothers with opioid use disorder (OUD) are a population of particular concern, since perinatal opioid use is not only associated with adverse health outcomes for the mother, but also with adverse health outcomes for her offspring (potentially) across the life course. While 2013 estimates of current illicit drug use among persons aged 12 and older are higher for men than for women (11.5% vs.7.3%), research indicates women progress more rapidly to problem use

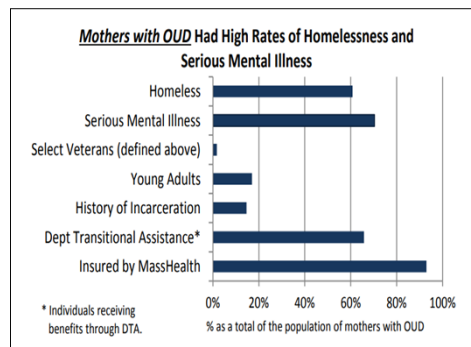
Source: Legislative Report: Chapter 55 Opioid Overdose Study—August 2017, MA  
Executive Office of Health and Human Services, MDPH



## Ch. 55: Key Findings



- A majority of mothers with OUD had interaction with the Department of Transitional Assistance, were insured by MassHealth, and had evidence of serious mental illness. One in six had a history of incarceration in Massachusetts prisons and jails



Source: Legislative Report: Chapter 55 Opioid Overdose Study—August 2017, MA  
Executive Office of Health and Human Services, MDPH



## Ch. 55: Key Findings



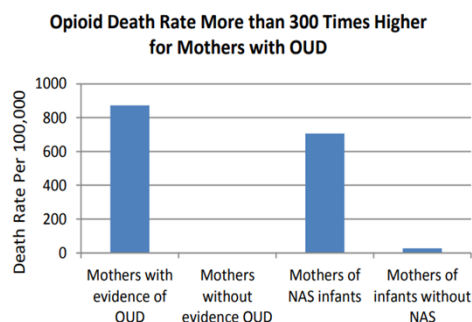
- Among women with OUD, women who delivered a live birth between 2011 and 2015 were 2.1 times **less** likely to have a fatal overdose compared with women who did not deliver a live birth



## Ch. 55: Key Findings



- The five-year opioid-related overdose death rate of mothers with evidence of OUD was 321 times higher than the rate among mothers without evidence of OUD, and the opioid-related overdose death rate among mothers delivering an infant with NAS was 27 times higher than the rate for all other mothers



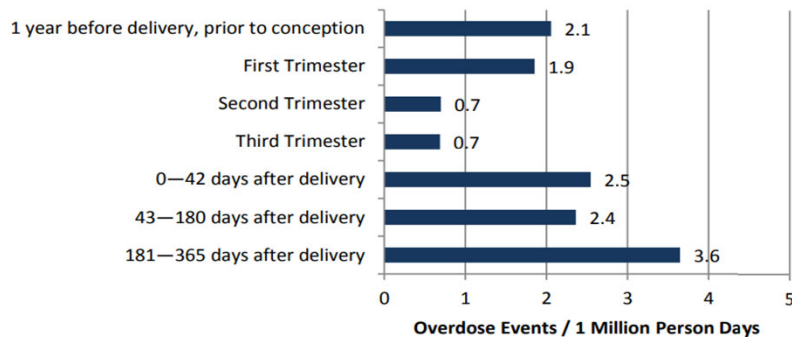
Source: Legislative Report: Chapter 55 Opioid Overdose Study—August 2017, MA Executive Office of Health and Human Services, MDPH



## Ch. 55: Key Findings



### Rate of Opioid Overdose Events Increase Sharply After Delivery for OUD Mothers



Source: Legislative Report: Chapter 55 Opioid Overdose Study—August 2017, MA Executive Office of Health and Human Services, MDPH



## Information About Pregnancy and MAT



### Abstinence therapy (detox) is not recommended

(Stewart, AJOG, 2013)

### MAT in pregnancy goals

1. Decrease continued high-risk activity
2. Reduce the risk of relapse for the mother
3. Improve perinatal outcomes by preventing frequent withdrawal

Currently, methadone and buprenorphine are standards of care for pregnant women with OUD but there are several other emerging practice studies using naltrexone and injectable extended release naltrexone in the care of pregnant women with opioid use disorder

(Jones, C. W. and Terplan, M. *Obstet Gynecol* 2018 Oct.; 132(4): 923–925)





## Information on NAS or NOWS



- Experts in the field now recommend that Neonatal Abstinence Syndrome related to in-utero opioid exposure be referred to as **Neonatal Opioid Withdrawal Syndrome (or NOWS)**
- Signs and symptoms include altered sleep, high muscle tone, tremors, irritability, poor feeding, vomiting and diarrhea, sweating, tachypnea, fever, and other autonomic nervous system disturbances
- All opioids can cause withdrawal symptoms, including long-acting agents methadone and buprenorphine (Subutex, Suboxone) and short-acting agents such as oxycodone, heroin, and fentanyl, but the severity of these symptoms varies greatly
- The symptoms of NOWS are not dose-related
- Whenever possible, all infants should receive nonpharmacologic (nonpharm) care as first-line treatment: skin-to-skin contact, breastfeeding, low-stimulation environment, utilize the Eat, Sleep, Console method (ESC)
- Some infants also may require replacement opioids in addition to nonpharmacologic interventions. The American Academy of Pediatrics recommends that all opioid-exposed infants be monitored in the hospital for 4–7 days for signs of withdrawal that may require pharmacologic treatment. Without medication, symptoms typically resolve within 1–2 weeks

*Citation available upon request*



## Information About Postpartum Care



Statistics show that this is the most vulnerable time for mothers with OUD

Best practices for mother and baby

- Universal use of trauma-informed care
- Rooming in (mother and baby together as much as possible—implement skin-to-skin and breastfeeding as nonpharmacological interventions for NOWS)
- Eat, Sleep, Console approach as first-line intervention for NOWS



## Program History, Core Components, Implementation, and Outcomes



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## Moms Do Care History continued



### October 2018 to September 2021

SAMHSA awarded MA the next wave of Medication Assisted Therapy– Prescription Drug and Opioid Addiction (MAT-PDOA II) funding to implement a community-based model of the Moms Do Care Project on the Cape Region: Cape (rural community health center setting)

- Serving pregnant, postpartum and parenting women with a history of OUD (or at high risk of overdose); youngest child must be under the age of 36 months
- Service window: 12 months
- Target number: 150 women over three years



## Moms Do Care History continued



### SOR Funded Moms Do Care

#### October 2018 to September 2020

MDPH received State Opioid Response (SOR) funding. BSAS used a portion of the SOR funding to broaden the original Moms Do Care model to further support community-based medical and behavioral health homes for pregnant, postpartum, and parenting women (PPPW) with OUD. This model increases engagement through service integration, patient-centered scheduling, care navigation, and peer support in five more settings (urban and rural hospital and community health center settings)

This expanded MDC model seeks to further enhance seamless provider collaboration through the co-location or close integration of services

- Serving pregnant, postpartum, and parenting women with a history of OUD (or at high risk of overdose); youngest child must be under the age of 36 months
- Service window: 12 months
- Start-up phase: 11/2018 to 2/2019
- Target number: 250 women over two years



## Multipronged Approach: 1. Client-Level Services



**Goal:** Provide access to fully integrated clinical care (seamless continuum of care) including MAT, behavioral, obstetrical, pediatric, and primary health providers; early intervention; regional community providers; recovery support

- How: By utilizing peer recovery moms as mentors, coaches, and care navigators

**Goal:** Build client capacities

- How: Peer recovery moms help participants build a recovery plan, connect to concrete services (insurance, housing, transportation, food, behavioral, and MAT referrals), trauma groups (Seeking Safety), and parenting groups (Nurturing Parent Programs)



## 2. System-Level Services



### Capacity Building

**Goal:** Decrease stigma, increase access to care, develop and share best-practice resources

➤ How

- Regional buprenorphine waiver trainings and follow-up TTA for waived providers
- Universal training (for every provider in the arc of the continuum of care—prenatal through early childhood) in substance use disorders (SUDs) and trauma-informed care
- Develop ongoing regional, collaborative provider stakeholder groups to sustain the care integration and share best practices, resources, and lessons learned



## 3. Sustainability Activities



**Goal:** Replicate the MDC Project

- How: Health Policy Commission replication grants in two regions—Beverly and Lowell—with SOR funding in five more sites, and MAT-PDOA in another site
- Now implemented in ten sites

**Goal:** Reimbursement

- How: MDC is consulting with state and federal content experts around reimbursement (for peer mentor services and integrated MAT and OB services)

**Goal:** Ongoing integrated care

- How: Assist in building ongoing, collaborative, regional provider care groups that will continue to work together to maintain the care integration established through the work of the MDCP



## Implementation Approach



### Monthly site-based implementation team meetings

- Technical assistance, grant management, program design, and implementation support
- Ad hoc meetings to help develop and implement outreach and engagement strategies, trauma-informed care teams, systemwide and community training plans, and sustainability plans

### Systemwide trainings in SUD, trauma-informed care, and parenting

#### Peer workforce development support

- On-site technical assistance in developing policies and procedures for recruiting, hiring, training, supervising, supporting, and advancing this workforce; monthly statewide stakeholder and learning collaborative calls

#### Quarterly advisory meetings

- Guidance and support from statewide content experts



## Moms Do Care Peer Mentors



Working together with mothers and families (through the arc of the continuum of care) to build a plan for recovery and parenting

### Names

- Peer mentor mom
- Peer recovery mom
- Recovery coach\*

(\*Recovery coaching is just **one component** of this multifaceted MDCP role)



## Moms Do Care Peer Mentors



- Provide recovery and wellness coaching
- Perform outreach and engagement
- Assist in screening and referrals
- Assist in administering GPRA tool
- Provide care navigation and support
- Provide informal education, reduce stigma, and act as examples of hope to providers, participants, and families



## Evaluation and Outcomes



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**Outcomes presented today are from the first two sites: 2015–2018**



## Evaluation Approach



### Designed to improve program performance

- New and evolving service model
- Both process and outcome components, exploring the following
  - Who have we served?
  - What services were provided?
  - How successful were we in retaining clients in services?
  - What client outcomes were achieved and with what durability?
  - What, if anything, predicted change in outcomes?
  - How satisfied were clients with MDCP and treatment services?
- Evaluators integrated into program development team
- Continuous feedback of evaluation findings



## In Participants' Own Voices: Most Helpful Services and Why



Peer moms: Provide nonjudgmental, one-on-one, emotional support

*"She has been through what I was going through. I could trust her and talk to her."*

*"... Kind of like having a sponsor who also understands about MAT and pregnancy."*

Referral to treatment: Get the MH, SUD, MAT treatment needed

*"Them reaching out to other resources for you (calling for counseling, consulting with primary care ...). They really do the foot work for you ..."*

Wraparound services: Transportation critical, housing, clothing

*"I probably wouldn't have made at least half my appointments ..."*

*"She helped me with housing ... mailed housing apps, motivation, called for me."*

Groups: Connecting to others in similar situation

*"Hearing how people got through pregnancy and postpartum ... knowing I was not the only one going through it."*

Help with DCF, the courts, general advocacy: Help for those who do not know the system

*"... She went to court with me and supported me. This is my first baby and it really helped to have someone who knows the system well and can advocate for you."*

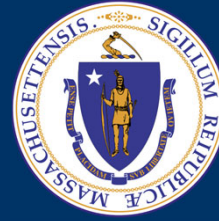
Help with the baby: Received information and support and help with baby's needs

*"Assistance with obtaining baby things I couldn't afford to get on my own."*

*"Attended baby appointments to be emotionally there for me so I was not alone."*



## Lessons Learned and Next Steps



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## Lessons Learned



- **Plan for a lengthy client engagement process.** Engaging pregnant women with OUDs was a lengthy process
- **Before hiring, prepare the system.** The peer-led model proved to be a radical departure from many medically based clinical service delivery models
- **Invest in the peer workforce.** When asked what was most helpful about MDC, participants roundly endorsed the peer component for providing instrumental and emotional support from women "who had been there." In our statistical model, the larger the dose of peer service, the better women did with respect to abstinence
- **Outreach early to MAT providers and ensure their ability to induct quickly.** Anecdotal information from site meetings indicates that the recipe for success here combines strong collaboration with community MAT providers, assurance that they will be able to begin induction quickly, and ongoing support from peers
- **Prepare for postnatal services to be more intense than services delivered during the prenatal period.** Analysis of service contact data reveals that the first month postpartum is the most intense period for services, but contacts remain relatively high through the fifth month postpartum
- **Trauma-informed care must be at the heart of the intervention and inform all practices.** Rates of trauma and trauma-related mental health disorders were extremely high in the MDC population. And because this model was a departure from the traditional clinical approach, MDCP continued to provide ongoing support and guidance to the site-based teams in implementing trauma-informed services, supervision, teams, policies, and procedures





## Next Steps



- Expand arc of the continuum of care to early-childhood providers (pediatrics, early intervention, child protective services)
- Expand parenting support services
- Develop reimbursement model for this multipronged, peer-led approach
- Continue building regional, ongoing, collaborative provider care groups
- Develop implementation toolkit



## Questions



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