Year One Summary: Regional Opioid Consultation Initiative

Patient and Family-Centered Treatment and Care Coordination Model for Women Served by HRSA Programs

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HRSA
Office of Women's Health

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OFFICE ON WOMEN'S HEALTH

EXECUTIVE SUMMARY

In September 2018, the Health Resources and **Services Administration (HRSA), Office of Women's** Health and the U.S. Department of Health and Human Services (HHS)**, Office on Women's Health** began a 2-year-long collaboration in order to develop a care coordination model and toolkit for HRSA-funded health service settings that care for women with opioid use disorder (OUD). These settings include health care and social service organizations and providers at/within health centers; rural health clinics; Ryan White HIV/AIDS Program clinics; and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs. This document presents a new care coordination model framework, which includes select strategies to help women with OUD at different life stages. In addition, resources and tools are described for inclusion in the implementation toolkit. The toolkit is planned for release later in 2020.

> Care coordination **is the "deliberate** organization of patient care activities to facilitate the appropriate delivery of health **care services." It involves all of the patient's** providers as well as the patient (Agency for Healthcare Research and Quality 2014).
>
> Substance use disorder refers to the use of alcohol or drugs that results in health problems, disability, or functional impairments. (Substance Abuse and Mental Health Services Administration 2019).
>
> Opioid use disorder is a type of substance use disorder that involves the use of illegal (e.g., heroin) or prescription (e.g., oxycodone) opioids (Substance Abuse and Mental Health Services Administration 2015; National Institute on Drug Abuse 2018a).

Women and OUD

OUD is a public health crisis that disproportionately affects women. Deaths from opioid overdoses among women increased more than 471 percent from 1999 to 2015, compared with a 218 percent increase among men **(Mack et al. 2013; Office on Women's** Health 2017). Women are more likely than men to receive prescriptions for opioids, to use them chronically, to have prescriptions for higher doses, and to receive prescriptions from multiple doctors (Mack et al. 2013). Women who use opioids also progress to dependence more quickly than men, experience more cravings, and are more likely to relapse (Office on **Women's Health 2017; National Institute on Drug Abuse 2018b).**

OUD affects women of all ages including adolescence, middle age, and later years, and may also impact some women when they are pregnant and parenting. In 2015, more than half of the adolescents who reported misusing pain relievers in the prior year were female, and they were more likely than adolescent **males to become dependent upon the drugs (Office on Women's Health 2017).** Among non-pregnant women of reproductive age who participated in the National Survey on Drug Use and Health between 2007 and 2012, younger non-pregnant women were more likely to misuse opioids than older non-pregnant women (Smith and Lipari 2017). From 2000 to 2009, use and misuse of prescription opioids among pregnant women increased from 1.2 to 5.6 per 1,000 hospital live births; moreover, from 2009 to 2012, **neonatal abstinence syndrome rates increased nearly twofold (Jones et al. 2014; Office on Women's** Health 2017).

In addition, opioid use disportionately impacts women who are low income; who are pregnant or parenting young children; who live in medically undeserved areas (e.g., rural areas); and who have HIV/AIDS (Phillips et al. 2017; Waisel 2013). Because HRSA-funded service settings are on the front lines, they can provide critical support for women with OUD with treatment and recovery.

Approach

The Regional Opioid Consultation Initiative (ROCI) synthesized findings from information gathered during its first year via:

- A literature review of select peer-reviewed manuscripts and gray literature to understand the impact of the opioid crisis among women and to identify key strategies; and

- Individual stakeholder input on key care coordination strategies through three regional meetings with the Expert Review Workgroup (ERW) comprised of clinical and behavioral health experts and other relevant stakeholders

This document outlines key elements of care coordination in a new conceptual model. The model can help health care providers at HRSA-funded service settings and their partner social service organizations consider how to best deliver coordinated care to women with OUD. This document also references related strategies and provides examples of how organizations and providers can adapt key elements of the conceptual model to meet the needs of women with OUD in different life stages who receive care in HRSA-funded service settings. Lastly, this document describes considerations for the development of a care coordination toolkit.

Overview of findings

Key care coordination strategies

As a result of the literature review and stakeholder input, a conceptual model was developed to illustrate the key care coordination strategies for delivering coordinated care to women with OUD (Figure ES.1). Women with OUD and their families are at the center of the model. The rings around the center of the model list the key elements of care coordination that organizations and providers can use to consider how to deliver coordinated care to women and their families. The items listed below the rings are external **conditions outside of organizations' and providers' control that affect the delivery of care coo**rdination to women with OUD. A brief description of these factors and strategies follows in the body of this report.

Figure ES.1. Care coordination model strategies for women with OUD in HRSA-funded service settings

This model provides a framework to guide health care and social service organizations and providers in determining where to focus their efforts to improve care coordination for women with OUD.

Organizations and providers can choose which strategies to implement. Characteristics that affect selection and implementation include, but are not limited to: organizational leadership, population served, provider beliefs about OUD, client risk and protective factors.

Organizational strategies

Provider strategies

Form provider support systems

Provide transportation support to women and providers

Develop and maintain partnerships with other agencies

Build trusting relationships with women

Engage a peer navigator as an essential member of the care team

Help women develop support systems

Give women options for accessing services

Women and their families

Educate women about OUD

Conduct screening to identify OUD and to assess women's needs and strengths

Refer women to referral partners

Develop and maintain shared care plans

Develop policies regarding treatment and support of women with OUD

Create a trauma-reducing and family friendly environment

Invest in workforce development and training

Create system to track OUD and care coordination activities

External Conditions

- Service deserts
- Regulation governing client privacy
- Fear among pregnant and parenting women of losing child custody
- Peer navigator workforce
- Limitations in healthcare financing
- Shortage of OUD treatment services in states
- Greater stigma for women than men
- Criminalization of addiction

Examples of how care coordination strategies may be adapted

Key elements of care coordination strategies identified in the conceptual model may be adapted to meet the needs of women with OUD in different life stages who receive care in varied HRSA-funded service settings. The provider strategy of building trusting relationships with women may be adapted to meet the needs of women with OUD in different HRSA-funded service settings based on the need of the client or service setting. For example, provider strategies focused on building trusting relationships with women with OUD and their families may include adjusting the number of chairs in consultation rooms to ensure privacy. Further, a home visitor in an MIECHV session may collaborate with a client to identify meeting times when abusive partners are not home.

Considerations for toolkit development

During the second year of the ROCI project (2020), the HRSA **Office of Women's Health and HHS Office on Women's Health** will develop a care coordination toolkit to support the delivery of coordinated care for women with OUD receiving services in HRSA-funded service settings. It will build upon existing resources and reflect the input of administrators and providers who are target users of the toolkit. Resources in the toolkit will be easily adaptable to the range of HRSA-funded service settings and will include tips for customizing the resources to be trauma-reducing and gender and culturally responsive.

KEY CARE COORDINATION FACTORS, STRATEGIES, AND EXTERNAL CONDITIONS

Provider characteristics

Health care and social service providers—including physicians and other health care providers, care coordinators, social workers, and peer navigators, and other program staff—are positioned to identify women with OUD, recommend a range of treatment and supports, and assess the strengths women can draw on during treatment and recovery. Providers can connect women to other staff and resources to help address their needs and leverage their strengths. Examples of provider characteristics influencing how they deliver care coordination include:

> Beliefs about OUD. **Providers may have beliefs that support or interfere with a woman's treatment** and recovery or may be unaware of the challenges women with OUD face when seeking treatment and maintaining recovery. Some providers may be unaware of evidence-based treatment practices for women with OUD which may delay the delivery of coordinated care and the ability to build trusting relationships with their clients.

> Training and qualifications. Providers may differ in the training they have received on the unique treatment and recovery needs of women with OUD and on evidence-based treatment for OUD. This variation may lead to assumptions that providers are fully trained and qualified to work with all types of people and conditions, which is not the case. Providers may also receive conflicting information through training(s) and may thus be uncertain about how to help women address their health needs in conjunction with OUD. Linguistic and cultural competencies can influence the quality of care provided as well.

Demographic characteristics. **A provider's own individual demographic characteristics, such as** race, ethnicity, and primary language spoken, can also impact care delivery.

Characteristics of HRSA-funded service settings

Organizational characteristics within HRSA-funded service settings may influence the delivery of care coordination to women with OUD. These characteristics include the following:

Organizational leadership. Identifying an individual within the organization to serve as a **"champion" to support the implementation of a ca**re coordination model for women with OUD may be effective in some settings. Without a champion, other organizational priorities may hinder efforts to maintain a focus on the structures and processes necessary to coordinate care.

Population served in the setting. Women with OUD and other co-occuring conditions access care in different HRSA-funded service settings. Partnerships with primary care organizations, specialty departments, and behavioral health practices can support care coordination efforts. For example, Ryan White HIV/AIDS Program clinics focus on treating people with low income who are living with HIV. Given the prevalence of co-occurring physical health conditions, including OUD, Ryan White HIV/AIDS Program clinics may need to develop partnerships with primary care organizations, specialty departments, and behavioral health providers to coordinate care.

Financing. Financial structures that support the delivery of care coordination, including the ability to reimburse—and therefore incentivize—provider time to coordinate care for women and to serve women who have limited or no medical insurance can impact care coordination.

External Conditions

External conditions are influences outside of organizations' and providers' immediate control that affect the delivery of care coordination to women with OUD. These can include limitations in health care financing, shortages of OUD treatment services, service deserts, peer navigator workforce availability and capacity, regulation governing client privacy, custody fears, greater stigma for women than men, and the criminalization of addiction.

Organizational and provider strategies to coordinate care for women with OUD

Through the literature review and ERW meetings, nine organizational strategies and seven provider strategies for care coordination were identified.

Organizational strategies include:

- Develop organizational policies regarding treatment and support of women with OUD
- Invest in workforce development and training
- Create a trauma-reducing environment
- Create a family-friendly environment
- Form provider support systems
- Develop and maintain partnerships with other agencies
- Create a system to track OUD and care coordination activities

- Provide transportation support to women and providers
- Give women options for accessing services, including traditional in-person office visits, telehealth visits, mobile van and street outreach services, services in integrated care settings, and home-based services

Provider strategies include:

- Build trusting relationships with women
- **Conduct screening to identify OUD and to assess women's needs and strengths**
- Help women develop support systems
- Educate women about OUD
- Engage a peer navigator as an essential member of the care team
- Refer women with OUD to referral partners
- Develop and maintain shared care plans

Strategies can have important interplay. For example, including a peer navigator as an essential member of the care team may allow for stronger, more trusting relationships between women and their providers, more opportunities to screen women with OUD for their needs and to assess their strengths, and greater dissemination of education to women with OUD. The final toolkit will include resources for providers and their organizations to implement these sorts of strategies.

Next steps

In 2020, the HRSA **Office of Women's Health and HHS Office on Women's Health** will convene a series of meetings with stakeholders to solicit input on resources that should be developed or adapted for inclusion in the care coordination toolkit. A care coordination toolkit will be developed based on this input and guided by the conceptual framework summarized here. Input on sections of the draft toolkit will come from various stakeholders including administrators and providers who work in HRSA-funded service settings.

The toolkit will provide new and existing resources for HRSA-funded service settings and their social service partners to use as they strive toward trauma-reducing, coordinated care for women with OUD. Resources may also include attention to other co-occuring conditions including but not limited to poly-substance use, chronic illnesses, and experiences with violence. Each resource in the toolkit will be configured to be able to stand alone, if necessary.

Once complete, the HRSA **Office of Women's Health and HHS Office on Women's Health** anticipate testing the care coordination toolkit with grantees working to address OUD. These grantees will help contribute to the evidence base around care coordination and identify additional promising practices and ways to implement key elements of care coordination highlighted in the toolkit. While designed with HRSA-funded care settings in mind, elements of the toolkit may be applicable in other settings serving women with OUD.

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