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Caring for women with substance use disorders through pregnancy and postpartum during the COVID-19 pandemic: Lessons learned from psychology trainees in an integrated OBGYN/substance use disorder outpatient treatment program

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ABSTRACT

Objective: This article presents a brief overview of the challenges and facilitators to the provision of substance use disorder (SUD) treatment for pregnant and parenting women during the COVID-19 pandemic. Specifically, we highlight the deployment of telepsychology services during the pandemic by an integrated, trainee-based women & addictions program that provides care via a multidisciplinary team, including an obstetrician, addiction medicine fellow, nurse, behavioral health trainees, violence prevention advocates, and pediatric provider.

Methods: We outline unique adaptations that the program made to shift from in-person psychology trainee services to telepsychology. Additionally, we describe supporting factors and barriers to success for continued treatment planning, service provision, and educational training.

Results: The program identified and addressed numerous opportunities for improvement to implement and continue telepsychology within an integrated women & addictions program during the COVID-19 pandemic. The program maintained the unique components of care integration with the proliferation of digital resources for patients and providers, as well as the flexibility of attending physicians and supervising psychologists.

Conclusions: Provision of telepsychology services within an integrated women & addictions program employing trainees is crucial during the COVID-19 pandemic. The program addressed barriers to care in creative ways, through the use of various technologies, to meet patients where they are. Continuing to have this option available requires adaptation to the maturing needs of the clinic.

1. Introduction

The COVID-19 pandemic has altered the delivery of substance use disorder (SUD) treatment. Guidelines encouraged providers to use telehealth to meet with patients when possible (CDC, 2020a; Nitkin, 2020; Stiepan, 2020; VHA, 2020) and new guidelines eliminated previous barriers to telehealth treatment provision: HIPAA Security and Privacy Rule requirements were waived, reimbursement changed to support telehealth, and the DEA and DMAS relaxed prescribing regulations for buprenorphine for treatment of opioid use disorder (DHHS, 2020a; DHHS, 2020b; DeAngelis, 2020; DEA, 2020). Though published data on the impacts of COVID-19 are in their early stages, individuals with SUD may be at an increased risk for more severe disease due to health status, and psychosocial and environmental factors (NIDA, 2020). It is important for patients to continue to remain engaged in treatment, including psychosocial support, especially individuals with SUD and complex circumstances, such as those who are pregnant and parenting.
### 1. Challenges specific to pregnant and parenting individuals with SUD

Although there is no current data that states that COVID-19 poses a greater risk to pregnant women, there is a documented higher risk for respiratory illnesses in general (CDC, 2020a). Stress and anxiety related to COVID-19 are also concerning, as worsened mood during pregnancy can have negative impacts on child and maternal outcomes (Field, 2011; Stewart & Vigod, 2016; Lindgren, 2001). CDC guidelines encourage pregnant women to continue regular care and deliver under the supervision of health care professionals (CDC, 2020b). COVID-19 may cause women to be both apprehensive about attending regular hospital appointments and avoid care when indicated (i.e., delivering outside of hospital). Thus, care teams should encourage treatment engagement, which can be facilitated via ongoing psychosocial support.

### 2. Methods: Women & addictions program at VCU

The women & addictions program at Virginia Commonwealth University Health System provides integrated women’s health services and SUD treatment. In 2019, the program expanded its team to include additional providers across specialties, specifically embedding psychology trainees who take part in the primary care psychology collaborative at VCU (see Perrin et al., 2020). Psychology trainees provide behavioral health (BH) services alongside medical care and onsite care coordination (inpatient and outpatient obstetrics care, pediatrics, anesthesia, psychiatry, addiction treatments, social work, domestic violence advocates). The integrated nature of the clinic supports multidimensional service provision for patients and vital educational services.

### Table 1. Clinic components and format, and subsequent adjustment to COVID-19 circumstance

| Program component | Workflow/setting pre-COVID-19 | Workflow/setting during COVID-19 |
|-------------------|-------------------------------|---------------------------------|
| Interdisciplinary plan of care (IPOC meeting) | In person, in hospital, Thursday afternoon | Weekly Zoom call for disciplines to participate in while at separate locations |
| Shared drive | No centralized location for resources, schedules, and patient tracking information. | OneDrive, HIPAA compliant shared folder created to house resources for patients and providers as well as schedules |
| Agenda for IPOC meeting | Presented in person during meeting by nurse coordinator | Outline saved in OneDrive in advance of meeting, individuals can update before meeting with patient case notes and clinic concerns |
| Patient scheduling | Completed in clinic by nurse coordinator and staff for behavioral health, follow ups discussed with BH trainees and scheduled by nurse | BH appointments: Completed by BH trainees by phone, text, or via patient portal. |
| Behavioral health schedule | Paper schedule for trainees in Behavioral Health | Documented scheduling and relevant information in shared scheduling document on OneDrive, should a patient see both MD and BH trainees in same clinic day (see below for more information). |
| Interdisciplinary care coordination and referrals | In clinic, during IPOC meeting | During IPOC meeting on ZOOM. |
| Nutrition, domestic violence advocates | In clinic, during clinic day | Via impromptu phone calls or messages in the EMR/skype during clinic time while staff work across settings. |
| Clinic visits | In clinic, each team member seeing patient as needed in same room | Medical visits take place both in person and via Doximity and phone. Behavioral Health visits |

(continued)
opportunities for trainees across disciplines.

2.1. Training model before and during COVID-19

COVID-19 created some unique barriers for our clinic due to the program’s embedded training. Before COVID-19, our clinic director had no training or experience in clinical teaching using telehealth. Thus training was initially compromised, as trainees across the health system were removed from providing in person services in clinic in March 2020. BH trainees immediately began providing services via telepsychology, with no gap in treatment for patients. We identified several potential issues with remote work: it limits trainee ability to consult with other providers across disciplines, to receive warm handoffs, and to provide patient education alongside medical providers (ensuring consistent messaging). Additionally, BH trainees employ a peer supervision model wherein advanced trainees support new clinicians in clinical decisions in real time, which was difficult to replicate with remote work. We had to make creative adjustments to maintain the benefits of our model and training standards.

3. Results: COVID-19 clinic changes, integrated care at a distance

The switch to telehealth allowed for the utilization of digital resources to support training and services (Table 1). New tools including a shared drive that allows trainees to communicate patient status in a HIPAA protected manner. The ability to check patient status in real-time via shared documents has helped our team to discuss patients’ issues that have potentially catastrophic health outcomes (i.e., interpersonal violence, suicidal ideation, substance use recurrence) in a timely manner to ensure proper support. We established protocols for BH trainees to operate remotely, including remote peer consultations, supervisions, and integrated clinic meetings to discuss points of education and patient status outside of clinic.

3.1. 3.2 Challenges and advantages to telepsychology services within an integrated care model for pregnant/parenting individuals

There have been challenges to the telepsychology transition. Some patients do not have consistent access to resources (i.e., a phone) that support telepsychology services. For others, clinic visits may be the only patients do not have consistent access to resources (i.e., a phone) that support telepsychology services. For others, clinic visits may be the only experience at which patients receive the support they need. In our clinic, many patients are unable to access childcare and either have to parent during or no-show to telehealth appointments due to COVID constraints and lack of resources. This issue has pushed providers to be more flexible with appointment times; however, dense scheduling can interfere with our ability to provide flexibility. Another driver of the decreased telepsychology attendance is likely related to compromised ability to engage patient-provider trust and relationships. Many women with SUD note high level of mistrust of the health care system related to repeated prior stigmatizing interactions with health care providers related to substance use (Cockcroft et al., 2019). Not being able to perform “warm handoffs” between medical and BH providers in the clinic limits the ability for clinical team members to gradually gain patients’ trust, which then likely compromises their uptake of telepsychology services with a new team member who they have not been able to meet yet in person.

Although COVID-19 has presented challenges, there have been some relative advantages to using telehealth. Telehealth allows us to reach our patients where they are. Transportation is no longer a barrier for patients who do not have a vehicle. Though not ideal, parenting patients are not required to find childcare during appointments, which was even more critical during COVID visitor restrictions in the clinic. Overall, telehealth services are more acceptable to some, but not all, patients. For example, telehealth allows us to reach those who may have missed appointments due to extenuating factors or those who may feel more comfortable starting with BH services via virtual rather than in-person care.

4. Conclusion: Is this the new normal? Considerations for integrated SUD care

As a multidisciplinary, trainee-based program, we hope to continue to use these cross-discipline communication tools and to offer telehealth when appropriate. In the context of ongoing uncertainty, our role will focus on supporting patients in their progress toward and maintaining recovery while also continuing our training. These changes may help the clinic to grow; evidence-based psychology treatment for pregnant and parenting individuals with SUD includes addiction treatment (e.g., medication for OUD) and medical services (e.g., prenatal care), preferably in one location. An anticipated benefit of using telehealth is increased flexibility to connect patients with other disciplines, such as psychiatry, and to integrate wrap-around services. These positive changes can help other programs to reach the quality of care that evidence base supports (SAMHSA, 2018). Current circumstances, though unfortunate, may provide an opportunity to continue to improve and better serve our patients.

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Declarations of competing interest

None

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