Introducing Peer Recovery Services into the Maternal Opioid Misuse (MOM) Model: Lessons Learned

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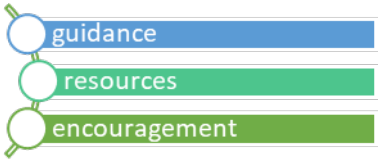
Overview

- 8 States designed MOM Model interventions to improve quality of care for Medicaid beneficiaries with opioid use disorder (OUD) and their infants and reduce costs.
- Interventions integrated OUD treatment with prenatal and postpartum care.
- 6 MOM Models* integrated peer recovery services during implementation Year 1 (July 1, 2021 – June 30, 2022).

What are Peer Recovery Services?

Peer recovery services consist of nonclinical support to recovery. Individuals in this role have lived experience of addiction recovery and are trained to support others through their recovery process. Though peers' responsibilities vary throughout the models, their core role is the same. They provide:



*MOM Models in Maine, Maryland, New Hampshire, Tennessee, Texas, and West Virginia.

Key Findings

Peer recovery specialists (PRSs) have been key to implementation success. Staff and beneficiaries interviewed believed their PRSs provide unparalleled social and emotional support.

> *"[Our hospital] built out a network of people to do the work and be accessible to MOM patients in real ways. Provider teams and clinicians will say this is an invaluable team member."*
>
> *—Case study key informant*

State Models faced challenges recruiting and retaining PRSs with appropriate qualifications. They struggled finding peers who matched model needs and turnover was high due to burnout. Model staff provided additional support to meet PSRs' social-emotional needs.

Specialized training and capacity building for PRSs and collaborating staff mitigated challenges related to introducing PRS into clinical settings. Despite initial friction in some models, increased communication, training, and the addition of in-house mental health services for PRSs helped address differences in professional training, lived experience and perceptions of OUD treatment .

State Models used varied approaches to incorporate PRSs into programs. Some models included PRSs in care coordination huddles to provide context on beneficiaries' needs, while in other models PSRs remained separate from clinical teams to promote privacy.

> *"When I receive information that does not come directly from the person, it creates a rift in that relationship. I know something about them that they have not [personally] disclosed to me, and that puts me in a position of power over them. I am not more powerful; I am just another human being who has had a similar experience."*
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> *—Peer Recovery Specialist*

Conclusion

Support from someone with lived experience is critical to recovery. Key informants in each State noted the importance of peer recovery services. Some called it the "most important component" of the MOM Model. Despite States' peer staffing challenges, Models that offered peer support appeared to succeed in encouraging people with OUD to seek help in their recovery and persevere through that journey.

Implications

- Including PRSs in program designs could increase positive outcomes and strengthen beneficiaries' support system.
- Awareness of potential barriers and mitigation strategies may help programs overcome PRSs staffing challenges.

Disclaimer: The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
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