NNEPQIN
NORTHERN NEW ENGLAND
PERINATAL QUALITY IMPROVEMENT NETWORK

Section 14:

POSTPARTUM CARE

The postpartum period is a particularly vulnerable time for women who have substance use disorders due to rapid physiologic changes, sleep deprivation, and family stress. Anxiety related to both internal and external factors is often high, and frequent visits for emotional support and problem solving are strongly recommended. The American College of Obstetricians and Gynecologists recommends a revised approach to postpartum care, including a postpartum visit within the first three weeks postpartum and a comprehensive exam at or before 12 weeks after delivery (ACOG, 2018). However, women with substance use disorders may benefit from additional support. Providers should consider scheduling an initial postpartum visit within 1-2 weeks after delivery, and biweekly until at least 6 weeks (SAMHSA, 2018; Alliance for Innovation in Maternal Health, 2018). A warm handoff to primary care should be made at the conclusion of postpartum care, whenever that occurs.

Postnatal visits may include usual obstetrical assessments, including healing from delivery itself and support for breastfeeding; as well as sequential screening for postpartum depression; intimate partner violence; assessment of material needs; and counseling for tobacco cessation if indicated. Pregnancy intention and need for contraception should be assessed at each visit unless a woman received immediate postpartum long acting reversible contraception (LARC). The traditional 6-week postpartum period should be extended for women with OUD/SUD as continuity of relationships is critically important and this is a vulnerable time (ACOG, 2018).

Postpartum screening

We recommend the use of validated screening instruments for depression, intimate partner violence, and social determinants of health at each postpartum visit, as described elsewhere in this toolkit.

Supporting breastfeeding

Methadone, buprenorphine, and naloxone are all compatible with breastfeeding, and breastfeeding is highly recommended for infants at risk for neonatal opioid withdrawal (NAS/NOWS). Please refer to the NNEPQIN Breastfeeding Guidelines for Women with Substance Use Disorders

Family Planning

Immediate post-placental long acting reversible contraception (LARC) is a convenient option for women desiring long-term contraception that is compatible with breastfeeding. Placement under epidural anesthesia or trans-cesarean is particularly attractive for women who have a history of sexual trauma or/and experience anxiety related to pelvic examination. Clinicians providing care for women with

substance use disorders should work to ensure that this option is available at the anticipated birth hospital, and offer it prenatally.

Whether prenatally or postpartum, conversation about pregnancy intention should always be conducted with respect and a shared decision-making approach which honors women's right to choose whether or not to use contraception. Using an approach which inquires about pregnancy intention, such as "One Key Question" https://powertodecide.org/one-key-question), rather than implying that a woman should use contraception, is respectful and aligned with the 10 best contraceptive practices included in this toolkit.

Transitions of care

Maternity care providers should ensure that women have access to medication assisted treatment for OUD and continuing SUD counseling as relapse risk is high and increases with time. If a woman leaves the SUD treatment program she had attended during pregnancy, it is important to help her find an alternate. Every effort should also be made to link women to a recovery-friendly primary care provider as well. Maternity care providers should continue to support for women's health needs at least until this transition has occurred. Finally, maternity care providers can play an important role both prenatally and postnatally in ensuring that women establish pediatric care for their infants.

Working with treatment providers

Maternity care providers should request written consent from mothers with SUD/OUD to communicate with their treatment providers prenatally, and to confirm this consent postnatally. Treatment providers may need reassurance that both methadone and buprenorphine/naloxone are compatible with breastfeeding (SAMHSA, 2018). Most antidepressant medications are also compatible with breastfeeding, but if started in the maternity care context, the SUD treatment provider should be advised as there are potential interactions with psychiatric medications and methadone.

Referral to specialty care

Women diagnosed with chronic Hepatitis C during pregnancy should be referred to Infectious Disease or Gastroenterology/Hepatology specialists after delivery, as treatment is indicated as soon as breastfeeding is concluded. Women receiving antiretroviral therapy for HIV should be supported in continuing treatment, and should not breastfeed. Women who do not respond as expected to antidepressants should be referred to a psychiatric provider if possible for assessment and management recommendations.

Referral for home visiting and other services

At each postpartum visit, providers should ask about and assist women to follow up on referrals to public health nursing and other child and family services available in the community

Additional resources for providers:

ACOG Committee Opinion #236, Optimizing Postpartum Care. Available from https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co736.pdf?dmc=1&ts=20180522T1442482827

SAMHSA Clinical Guidance for the Care of Pregnant and Parenting Women with Opioid Use Disorder and their Newborns. Available from https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf

Alliance for Innovation in Maternal Health: Patient Safety Bundle for Women with Opioid Use Disorder. Available from https://safehealthcareforeverywoman.org/wp-content/uploads/2017/11/Obstetric-Care-for-OUD-Bundle.pdf

Bedsider Birth Control Support Network: resources and educational materials for contraceptive practice. https://providers.bedsider.org/articles/changing-the-conversation-about-contraception

Resources for patients:

Bedsider Method Explorer: interactive site with digital patient education materials, available from https://www.bedsider.org/methods

References

American College of Obstetricians and Gynecologists. Opioid use and opioid use disorder in pregnancy. Committee Opinion no. 711. Obstet Gynecol 2017;130:e81-94.

American College of Obstetricians and Gynecologists. Optimizing postpartum care. Committee Opinion no. 736. Obstet Gynecol 2018.

Klaman SL, Isaacs K, et al. Treating women who are pregnant and parenting for opioid use disorder and the concurrent care of their infants and children: Literature review to support national guidance. J Addict Med 2017;11(3);178-190. doi: 10.1097/ADM.0000000000000308

Reddy UM, Davis JM, Ren Z, et al. Opioid use in pregnancy, neonatal abstinence syndrome, and Childhood Outcomes. Obstet Gynecol 2017;130:10-28. doi: 10.1097/AOG.0000000000002054

Substance Abuse and Mental Health Services Administration. Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. HHS Publication No. (SMA) 18-5054. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. Available at: https://store.samhsa.gov/shin/content/SMA18-5054/SMA18-5054.pdf. Accessed February 7, 2018

The Snuggle ME Guidelines: Tools for caring for women with addiction and their babies, Embracing drug affected babies and their families in the first year of life to improve medical care and outcomes Maine. Maine for Disease Control, Department of Health and Human Services. Available at: http://www.maine.gov/dhhs/SnuggleME/documents/SnuggleME-2018-GuidelinesFINAL.pdf. Accessed April 6, 2018.

Postpartum care (Outpatient)

- Close postpartum follow-up with frequent visits
  - ☐ Rescreen and brief intervention for return to substance use (SAMHSA Factsheet #16)
  - ☐ Postpartum depression screening
  - ☐ Monitor for relapse
  - ☐ Screen for intimate partner violence at 6 weeks and whenever indicated
  - ☐ Smoking cessation reinforcement or continued cessation counseling when indicated.
  - ☐ Consider providing support services for longer than the traditional 6 week postpartum period
  - ☐ Assess resource needs at each visit and coordinate with case worker/social service providers
  - ☐ Assist patient in scheduling appointments for infectious disease management where indicated
  - ☐ Facilitate transition for recovery-friendly primary care provider if not established
  - ☐ Breast-feeding support
  - ☐ Provide contraception and counsel on birth spacing