



SECTION 4:

Tools to Support Patient Needs

Section 4: Tools to Support Patient Needs

Treatment of a pregnant patient with a substance use disorder goes beyond standard medication assisted treatment and recovery supports. This section provides an overview of the necessary tools to support the patient, including planning for the future beyond birth as well as addressing any underlying comorbidities and risk factors.

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1. Breastfeeding

Breastfeeding should be encouraged for pregnant and postpartum people on medication assisted treatment with either buprenorphine or methadone, in the absence of maternal or infant medical contraindications (World Health Organization, 2014; Kocherlakota, 2014).

- Breastfeeding is associated with decreased length and severity of neonatal abstinence syndrome (Abdel-Latif, 2006)
- Pregnant and postpartum people who have experienced sexual trauma may be reluctant to breastfeed and their wishes must be respected. The option to feed pumped breast milk may be more acceptable
- Breastfeeding may be complicated by NAS symptoms; therefore, support of a certified lactation consultant or other experienced provider is highly recommended
- Continued alcohol and non-prescribed drug use carry potential risk to both the birthing parent and the breastfeeding infant. However, substance use is not necessarily a contraindication to breastfeeding (WHO 2014). Therefore, a recommendation to abstain from breastfeeding should be made only if a person expresses intent to continue substance use and declines appropriate treatment (see [NNEPQIN Breastfeeding Guidelines for Women with a Substance Use Disorder](#) for discussion of risks associated with specific substances)
- Rapid urine drug screening is associated with a significant rate of false positives and confirmatory testing should be performed if results are inconsistent with what person reports

SUBSTANCES FOR WHICH ADVERSE EFFECTS ON THE BREASTFEEDING INFANT HAVE BEEN REPORTED

Adapted from: AAP COMMITTEE ON DRUGS. The Transfer of Drugs and Therapeutics into Human Milk: An Update on Selected Topics. *Pediatrics*. 2013. **Consult source for substance specific references.**

| Drug | Reported Effect or Reason for Concern* |
|--|---|
| Alcohol | Impaired motor development or postnatal growth, decreased milk consumption, sleep disturbances. Occasional, limited ingestion (0.5 g alcohol/kg/d; equivalent to 8 oz wine or 2 cans of beer per day) may be acceptable |
| Amphetamines | Hypertension, tachycardia, seizures. In animal studies of postnatal exposure, long term behavioral effects, including learning and memory deficits and altered locomotor activity, were observed |
| Benzodiazepines | Accumulation of metabolite, prolonged half-life; chronic use not recommended |
| Cocaine | Intoxication, seizures, irritability, vomiting, diarrhea, tremulousness |
| Heroin | Withdrawal symptoms, tremors, restlessness, vomiting, poor feeding |
| LSD | Potent hallucinogen, passes through blood/brain barrier easily; research limited |
| Methamphetamine | Potentially fatal, persists in breast milk for 48 h |
| Methylene dioxy-methamphetamine (ecstasy) | Closely related products (amphetamines) concentrated in human milk |
| Marijuana (cannabis) | Neurodevelopmental effects, delayed motor development, lethargy, less frequent and shorter feedings, high milk-plasma ratio in heavy users |
| Phencyclidine (PCP) | Potent hallucinogen, intoxication |
| Tobacco | Nicotine exposure, reduction in milk supply, second and third hand smoke exposure |

*In addition to effect of substance, alteration in maternal judgment or mood may impact ability to care for infant.

1.1 Provider Materials

1.1.1 AAP COMMITTEE ON DRUGS. THE TRANSFER OF DRUGS AND THERAPEUTICS INTO HUMAN MILK: AN UPDATE ON SELECTED TOPICS.

Pediatrics. 2013;132:3:e796-e809.



<http://pediatrics.aappublications.org/content/132/3/e796>.

1.1.2 LACTMED. DRUG AND LACTATION DATABASE



<https://www.ncbi.nlm.nih.gov/books/NBK501922/?report=classic>

1.2 Patient Materials

1.2.1 ASAM BROCHURE: CHILDBIRTH, BREASTFEEDING AND INFANT CARE: METHADONE AND BUPRENORPHINE



http://pcssmat.org/wp-content/uploads/2013/10/ASAM-WAGBrochure-Opioid-Labor_Final.pdf

2. Doula Services

What is Doula?

A doula is a “person trained and experienced in childbirth who provides continuous physical, emotional and informational support to the mother before, during and just after birth.” (Doula Organization of North America (DONA)).

A doula is not a midwife, but is instead a non-clinical support for pregnant and parenting people. A doula:

- Provides information and support during pregnancy and birth
- Provides guidance to navigate the healthcare system and in decision making
- Provides breastfeeding and newborn care support
- Provides postpartum care
- Provides partner and family support
- Refers to medical/health, social and community supports
- Advocates
- Provides care and models care for infant, encourage development of parenting skills
- Collaborates with health care team

There is no one national or statewide certifying body for doulas. However, certification for doulas typically covers childbirth education, postpartum care, and breastfeeding lactation. More comprehensive doula education includes trauma informed, culturally competent, antiracism and equitable healthcare delivery curricula.

Doula Benefits

| <i>Maternal Health</i> | <i>Emotional Health</i> | <i>Infant health</i> | <i>Public Health</i> |
|---|---|---|--|
| Decreases likelihood of cesarean deliveries ^{1,2} | Decreases chance of negative feelings about birth experience ^{2, 5} | Decreases risk of low Apgar scores ² | Can reduce racial disparities ^{4,5} |
| Shorter duration of labor ² | Increases sense of empowerment and efficacy during birthing process ^{1, 5} | Increases likelihood of breastfeeding ¹ | Reduces risk of interventions which may translate to cost savings ³ |
| Decreases likelihood of medical interventions like labor induction ² | | Decreases likelihood of low birth weight ¹ | |
| Decreases use of any analgesia ² | | | |

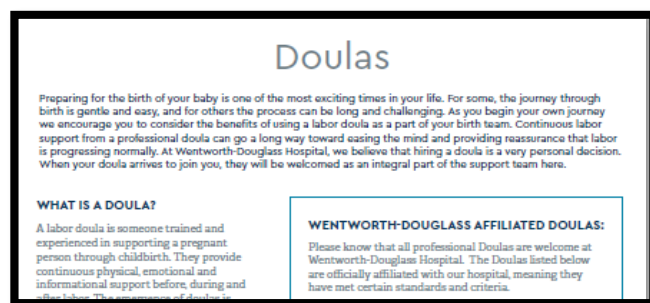
Potential Benefits for Pregnant/Parenting People Impacted by Substance Use

The emotional health benefits of a doula are a particularly compelling reason to connect them to a pregnant/parenting person impacted by substance use. This population may need extra social support and could especially benefit from having an advocate in the healthcare setting that could help reduce stigma and avoid traumatization. Barriers to obtaining doula services for a pregnant/parenting person center around cost as they currently are not a reimbursable service through Medicaid or commercial insurance carriers in NH. However, hospital based programs are emerging (see resources section for more information) that may offer low cost options.

2.1 PROVIDER MATERIALS

2.1.1 Wentworth-Douglass Hospital Doula Program

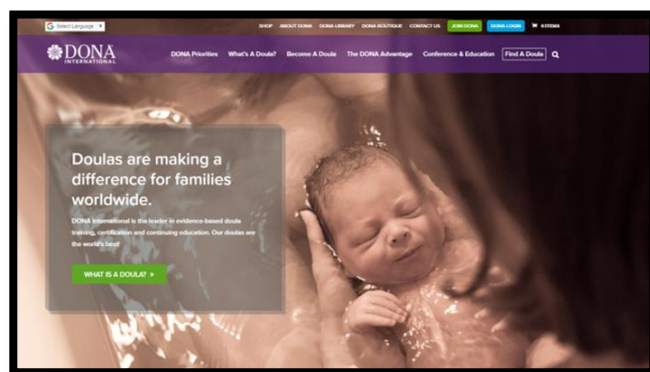
Can connect patients to a network of hospital-affiliated doulas. Low cost scholarships available.



https://www.wdhospital.org/files/4516/0132/8779/Doulas_2020.pdf

2.1.2 DONA International

Doula Organization of North America. Provides certification, education, and directory of doulas.



<https://www.dona.org/>

2.1.3 Birthing From Within

Childbirth educator and doula certification services. Also offers parent education.



<https://birthingfromwithin.com/>

References

1. Gruber, Kenneth J., PhD, Cupito, Susan H., MA, Dobson, Christina F., MEd (2013). Impact of Doulas on Healthy Birth Outcomes. The Journal of Perinatal Education. Vol 22 Issue 1, DOI: 10.1891/1058-1243.22.1.49
2. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. (2017). Continuous support for women during childbirth. Cochrane Database Syst Rev. Jul 6;7doi: 10.1002/14651858.CD003766.pub6.
3. Kozhimannil, Katy B., Rachel R. Hardeman, Fernando Alarid-Escudero, Carrie A. Vogelsang, Cori Blauer-Peterson, and Elizabeth A. Howell. (2016). Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. Birth 43, no. 1. 20–27. <https://doi.org/10.1111/birt.12218>.
4. Bey, A., Brill, A., Porchia-Albert, C., Gradilla, M., Strauss, N. (2019) Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities. Ancient Song Doula Services,

Village Birth International, and Every Month Counts. <https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf>

5. Taylor, J., Novoa, C., Hamm, K., Phadke, S. (2019) Eliminating Racial Disparities in Maternal and Infant Mortality- A comprehensive Policy Blueprint. Center for American Progress. <https://cdn.americanprogress.org/content/uploads/2019/04/30133000/Maternal-Infant-Mortality-report.pdf>

3. Harm Reduction

What is meant by harm reduction?

According to the Academy of Perinatal Harm Reduction, a simple way to define harm reduction is that this is “the acknowledgement that anything we choose to do carries risks - and that there are things we can do to minimize those risks.” From this premise, much of what we do in obstetrics is about harm reduction.

With regards to substance use during pregnancy, a harm reducing approach recognizes that legal and illegal substance use is part of our world, and that we should choose to work to minimize harmful effects rather than ignore them or punish pregnant or postpartum people who use substances. Furthermore, it is well established that getting prenatal care is the most important thing that a pregnant person can do to improve outcomes. Therefore, **providing welcoming and respectful care for all pregnant people, which encourages, rather than prevents, participation in prenatal care, is essential.**

The [National Harm Reduction](#) coalition provides the following definition for, “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs³.” The Academy for Perinatal Harm Reduction has published a [toolkit](#) and other harm reduction resources for families and providers.

Preventing maternal mortality

In New Hampshire, opioid overdose has become the leading cause of pregnancy associated death. The majority of these preventable maternal deaths are occurring during the postpartum year (New Hampshire Maternal Mortality reports 2018, 2020). An important harm reduction approaches include expanding access to the lifesaving drug [naloxone](#). The ***Alliance for Innovation in Maternal Health Care for Pregnant and Parenting People with Substance Use Disorders Patient Safety Bundle*** recommends distribution of naloxone to all postpartum people at the time of hospital discharge after childbirth.

State or community level harm reduction resources

- [NHHRC](#)
- [NH SSPs](#)
- [Academy for Perinatal Harm Reduction](#)
- [National Harm Reduction Coalition](#)
- [Resources for Safer Drug Use](#)

³ <https://harmreduction.org/about-us/principles-of-harm-reduction/>

4. Infectious Diseases

4.1 Hepatitis

4.1.1 HEPATITIS A

Hepatitis A is an acute viral infection of the liver. In 2019, an outbreak of hepatitis A in New Hampshire occurred initially among people who were homeless or using drugs. In order to prevent the development of an epidemic, immunization was therefore widely promoted in these two communities. Unlike hepatitis B and C, which are primarily blood born, hepatitis A is spread through fecal-oral or other close physical contact. It can persist for months outside the body and can be destroyed by washing surfaces with chlorine solution.

Hepatitis A has an average incubation period of 28 days and can last from weeks to months. Severe morbidity and rarely mortality are most likely to occur in those with co-occurring liver disease (hepatitis C or immune compromise. Unlike hepatitis C, infection is typically symptomatic, including the following:

- Fever
- Fatigue
- Loss of appetite
- Nausea
- Vomiting
- Abdominal pain
- Dark urine
- Diarrhea
- Clay-colored bowel movements
- Joint pain
- Jaundice

Immunization

The U.S. Centers for Disease Control (CDC) recommends immunization of members of high risk groups, including people who use drugs (whether by injection or not). Testing for immunity to hepatitis A is not required prior to vaccination, and vaccine may be after probable exposure to Hepatitis A. Both the hepatitis A vaccine and combination hepatitis A/B vaccine may be given during pregnancy when indicated. Please see the CDC adult vaccination recommendations and schedule for more information about indications, precautions and contraindications: <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-shell.html>

4.1.2 HEPATITIS B SCREENING & DIAGNOSIS

Patients with opioid use disorders, a history of injection drug use or inhalation (“snorting”), non- professional tattoos or piercings, or sexual or household contact with people with hepatitis B or injection drug history should be screened for hepatitis B virus (HBV).

Increased injection drug use has led to a rise in the prevalence of Hepatitis B due to injection drug use in some regions of the United States (see

<https://www.cdc.gov/hepatitis/statistics/2015surveillance/pdfs/2015HepSurveillanceRpt.pdf>)

Standard prenatal labs include screening for HBsAg (hepatitis B surface antigen, indicating the presence of active infection). Persons at risk for HBV infection should also be tested for anti-HBc (hepatitis B core antibody, indicating previous or current infection) and anti-HBs (hepatitis B surface antibody, indicating immunity from either disease or vaccination). This additional testing determines whether the person is vulnerable to infection and should be offered vaccination (CDC, 2017). Additional information about hepatitis B serologic testing, including clinical guidelines for perinatal management, see:

<https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>

Patients testing negative for HBsAb (Hepatitis B surface antibody) are not immune, and should be offered immunization. The combination Hepatitis-B/Hepatitis A vaccine has the advantage that it provides immunization against both, however, 3 doses are required to be fully effective. Immunization is recommended during pregnancy because the benefits in terms of averting infection outweigh hypothetical risks, see adult immunization schedule: <https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-shell.html>

Patients who test positive for HBsAg should be referred for further evaluation and management to an infectious disease specialist, gastroenterologist, or hepatologist.

Patients who test positive should receive the following information:

- Hepatitis B is a chronic disease of the liver which can cause permanent liver damage.
- Hepatitis B is highly contagious, and precautions are necessary to prevent transmission to partners and household members. All household members should be screened and offered immunization if non-immune.
- HBV is spread through contact with semen or vaginal secretions (CDC, 2016). Condoms should be used for sexual activity involving exposure risk.
- Avoid sharing razors, toothbrushes, etc. Hepatitis B is not spread through kissing an infected person, eating or preparing food, or via the respiratory route.
- Infants exposed to hepatitis B prenatally should receive hepatitis B immunoglobulin (HBIG) and HBV immunization immediately after birth. Without prophylaxis, an estimated 40% of exposed newborns will develop chronic hepatitis B. The need for treatment should be discussed prenatally and the delivery hospital notified in preparation (see algorithm: <https://www.cdc.gov/hepatitis/hbv/pdfs/PrenatalCareProviderPoliciesAndProcedures.pdf>).
- Breastfeeding is not contraindicated in the context of hepatitis B infection (CDC, 2016); however, breastfeeding is not recommended if nipples are bleeding, or open lesions present.

4.1.3 HEPATITIS C DIAGNOSIS & TREATMENT

KEY POINTS

- 1) All patients with opioid use disorders, history of injection drug use or inhalation (“snorting”), or non-professional tattoos or piercings should be screened for the hepatitis C virus (HCV). People who are HCV antibody positive should have follow-up viral load testing to determine whether chronic active disease is present. Testing for HCV *genotype* is optional during pregnancy, as it will not change perinatal management, but is useful to guide treatment after delivery.
- 2) Patients who are viral load positive should receive the following information:
 - a. Hepatitis C is a chronic disease of the liver which should be treated to avoid liver damage. New medications for HCV are highly effective and have minimal side effects. They are not currently recommended for use during pregnancy or lactation
 - b. A positive viral load indicates that Hepatitis C is contagious, and precautions are necessary to prevent transmission to partners and household members
 - c. The rate of sexual transmission of HCV is estimated to be about 15% (CDC, 2016). Condom use is recommended unless a partner is already infected with the same HCV genotype
 - d. Avoid contact with the blood of an infected person, including sharing razors, toothbrushes, etc.
- 3) The rate of vertical transmission from birthing person to fetus is around 6% (CDC, 2016), higher if the birthing person is also HIV positive. This rate is similar for vaginal and cesarean birth
- 4) There is no known case of transmission through breast milk (CDC, 2016). However, breastfeeding is not recommended if nipples are cracked or bleeding, or open lesions are present on the breast. CDC guidance is available at: <https://www.cdc.gov/breastfeeding/disease/hepatitis.htm>
- 5) Infants exposed to Hepatitis C prenatally should have follow up testing by their pediatric provider at 18 months of age (CDC, 2016)
- 6) People who have active Hepatitis C should be referred to a specialist or primary care provider with experience in hepatitis management

4.1.4 PROVIDER MATERIALS

4.1.4.1 The ABCs of Hepatitis

Centers for Disease Control (CDC)

| The ABCs of Hepatitis – for Health Professionals | | | |
|--|--|--|---|
| | HEPATITIS A is caused by the hepatitis A virus (HAV) | HEPATITIS B is caused by the hepatitis B virus (HBV) | HEPATITIS C is caused by the hepatitis C virus (HCV) |
| U.S. Statistics | • Estimated 6,700 new infections in 2017 | • Estimated 22,200 new infections in 2017 • Estimated 862,000 people living with chronic HBV infection in 2016 | • Estimated 44,700 new infections in 2017 • Estimated 2.4 million people living with HCV infection in 2016 |
| Routes of Transmission | Fecal-oral route. HAV is transmitted through: • Close person-to-person contact with an infected person • Sexual contact with an infected person • Ingestion of contaminated food or water Although viremia occurs early in infection, bloodborne transmission of HAV is uncommon. | Percutaneous, mucosal, or nonintact skin exposure to infectious blood, semen, and other body fluids. HBV is concentrated most highly in blood, and percutaneous exposure is an efficient mode of transmission. HBV is transmitted primarily through: • Birth to an infected mother • Sexual contact with an infected person • Sharing contaminated needles, syringes, or other injection drug equipment Less commonly through: • Needle-sticks or other sharp instrument injuries • Organ transplantation and dialysis • Interpersonal contact through sharing items | Direct percutaneous exposure to infectious blood. Mucous membrane exposures to blood can also result in transmission, although this route is less efficient. HCV is transmitted primarily through: • Sharing contaminated needles, syringes, or other equipment to inject drugs Less commonly through: • Birth to an infected mother • Sexual contact with an infected person • Unregulated tattooing • Needle sticks or other sharp |

<https://www.cdc.gov/hepatitis/resources/professionals/pdfs/abctable.pdf>

4.1.4.2 Hepatitis A Questions and Answers for Health Professionals

Centers for Disease Control (CDC)

Hepatitis A

Hepatitis B

Hepatitis C

Hepatitis D

Hepatitis E

Viral Hepatitis Home

Statistics & Surveillance

Overview and Statistics

What is the case definition for acute hepatitis A?

Clinical Criteria
An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine)

AND

a) jaundice or elevated total bilirubin levels ≥ 3.0 mg/dL, OR
b) elevated serum alanine aminotransferase (ALT) levels >200 IU/L,
AND
c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis
Confirmatory laboratory evidence:

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive,

OR

- Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

<https://www.cdc.gov/hepatitis/HAV/HAV/faq.htm#general>

4.1.4.3 Recommendations for Screening and Follow Up of Patients at Risk for Hepatitis B

Centers for Disease Control (CDC)

| Recommendations for Routine Testing and Follow-up for Chronic Hepatitis B Virus (HBV) Infection | | |
|--|--|---|
| Population | Recommendation | |
| | Testing | Vaccination/Follow-up |
| Persons born in regions of high and intermediate HBV endemicity (HBsAg prevalence $\geq 2\%$) | Test for HBsAg, regardless of vaccination status in their country of origin, including – Immigrants – Refugees – Asylum seekers – Internationally adopted children | If HBsAg-positive, refer for medical management. If negative, assess for on-going risk for hepatitis B and vaccinate if indicated. |
| US born persons not vaccinated as infants whose parents were born in regions with high HBV endemicity ($\geq 8\%$) | Test for HBsAg regardless of maternal HBsAg status if not vaccinated as infants in the United States. | If HBsAg-positive, refer for medical management. If negative, assess for on-going risk for hepatitis B and vaccinate if indicated. |

<https://www.cdc.gov/hepatitis/hbv/HBV-RoutineTesting-Followup.htm>

4.1.4.4 Interpretation of Hepatitis B Serologic Test Results

Centers for Disease Control (CDC)

Interpretation of Hepatitis B Serologic Test Results

Hepatitis B serologic testing involves measurement of several hepatitis B virus (HBV)-specific antigens and antibodies. Different serologic "markers" or combinations of markers are used to identify different phases of HBV infection and to determine whether a patient has acute or chronic HBV infection, is immune to HBV as a result of prior infection or vaccination, or is susceptible to infection.

| HBsAg | anti-HBc | anti-HBs | Interpretation |
|----------|----------|----------|---------------------------------------|
| negative | negative | negative | Susceptible |
| negative | positive | positive | Immune due to natural infection |
| negative | negative | positive | Immune due to hepatitis B vaccination |

Hepatitis B surface antigen (HBsAg):
A protein on the surface of hepatitis B virus; it can be detected in high levels in serum during acute or chronic hepatitis B virus infection. The presence of HBsAg indicates that the person is infectious. The body normally produces antibodies to HBsAg as part of the normal immune response to infection. HBsAg is the antigen used to make hepatitis B vaccine.

Hepatitis B surface antibody (anti-HBs):
The presence of anti-HBs is generally interpreted as

<https://www.cdc.gov/hepatitis/hbv/pdfs/SerologicChartv8.pdf>

4.1.4.5 Information on Pregnancy and HCV Infection

Centers for Disease Control (CDC)

Pregnancy and HCV Infection

Should pregnant women be routinely tested for anti-HCV?
At this time, pregnant women should be tested for anti-HCV if they have or are suspected to have risk factors for HCV infection (20, 25, 26). CDC is in the process of reviewing the evidence to determine if additional HCV screening recommendations, specific to pregnant women, are warranted.

What is the risk that an HCV-infected mother will spread HCV to her infant during birth?
The overall risk of an HCV-infected mother transmitting infection to their infant is approximately 4% to 7% per pregnancy. Transmission occurs at the time of birth, and no prophylaxis is available to prevent it. The risk is significantly higher if the mother has a high viral load or is coinfectd with HIV. Most infants infected with HCV at birth have no symptoms and do well during childhood. More research is needed to find out the long-term effects of perinatal HCV infection (27).

Should a woman with HCV infection be advised against breastfeeding?
No. There is no evidence that breastfeeding spreads HCV. While there is currently not enough information on the risks of transmission through breastfeeding by HCV-positive mothers with cracked or bleeding nipples, precautions may be considered (28).

When should children born to HCV-infected mothers be tested to see if they were infected at birth?

<https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#g1>

4.1.4.6 Interpretation of HCV Test Results

Centers for Disease Control (CDC)

Interpretation of Results of Tests for Hepatitis C Virus (HCV) Infection and Further Actions

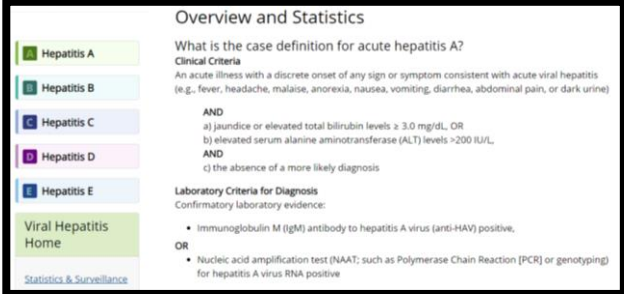
| TEST OUTCOME | INTERPRETATION | FURTHER ACTIONS |
|---|---------------------------|--|
| HCV antibody nonreactive | No HCV antibody detected | Sample can be reported as nonreactive for HCV antibody. No further action required. If recent exposure in person tested is suspected, test for HCV RNA.* |
| HCV antibody reactive | Presumptive HCV infection | A repeatedly reactive result is consistent with current HCV infection, or past HCV infection that has resolved, or biologic false positivity for HCV antibody. Test for HCV RNA to identify current infection. |
| HCV antibody reactive, HCV RNA detected | Current HCV infection | Provide person tested with appropriate counseling and link person tested to care and treatment.† |
| HCV antibody reactive, HCV RNA not detected | No current HCV infection | No further action required in most cases. If distinction between true positivity and biologic false positivity for HCV antibody is desired, and if sample is repeatedly reactive in the initial test, test with another HCV antibody assay. In certain situations,‡ follow up with HCV RNA testing and appropriate counseling. |

https://www.cdc.gov/hepatitis/hcv/pdfs/hcv_graph.pdf

4.1.5 PATIENT MATERIALS

4.1.5.1 Hepatitis A Factsheet

Centers for Disease Control (CDC)



The factsheet is titled "Overview and Statistics" and provides information about Hepatitis A. It includes a table of contents on the left with links to Hepatitis A, B, C, D, and E, as well as a link to the Viral Hepatitis Home page. The main content area defines the case definition for acute hepatitis A, listing clinical criteria (fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine) and laboratory criteria (elevated total bilirubin levels ≥ 3.0 mg/dL, OR elevated serum alanine aminotransferase (ALT) levels >200 IU/L, AND the absence of a more likely diagnosis). It also lists laboratory criteria for diagnosis, including immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive, OR nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive.

Overview and Statistics

What is the case definition for acute hepatitis A?

Clinical Criteria

An acute illness with a discrete onset of any sign or symptom consistent with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine)

AND

a) jaundice or elevated total bilirubin levels ≥ 3.0 mg/dL, OR
b) elevated serum alanine aminotransferase (ALT) levels >200 IU/L,
AND
c) the absence of a more likely diagnosis

Laboratory Criteria for Diagnosis

Confirmatory laboratory evidence:

- Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive,

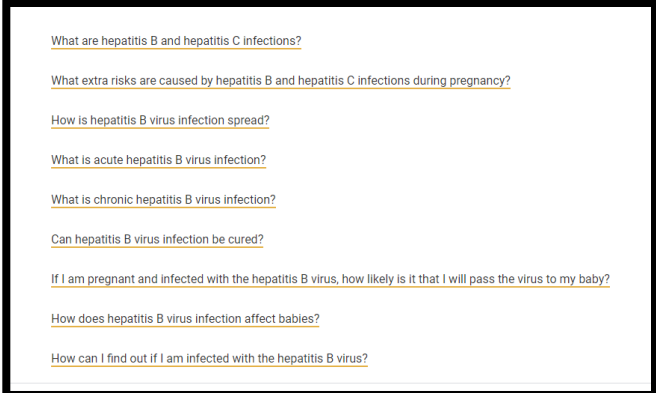
OR

- Nucleic acid amplification test (NAAT; such as Polymerase Chain Reaction [PCR] or genotyping) for hepatitis A virus RNA positive

<https://www.cdc.gov/hepatitis/HAV/HAVfaq.htm#general>

4.1.5.2. FAQ Hepatitis B and Hepatitis C

From the American College of Obstetricians and Gynecologists



The FAQ document lists several questions related to hepatitis B and C infections during pregnancy. The questions are: "What are hepatitis B and hepatitis C infections?", "What extra risks are caused by hepatitis B and hepatitis C infections during pregnancy?", "How is hepatitis B virus infection spread?", "What is acute hepatitis B virus infection?", "What is chronic hepatitis B virus infection?", "Can hepatitis B virus infection be cured?", "If I am pregnant and infected with the hepatitis B virus, how likely is it that I will pass the virus to my baby?", "How does hepatitis B virus infection affect babies?", and "How can I find out if I am infected with the hepatitis B virus?".

[What are hepatitis B and hepatitis C infections?](#)

[What extra risks are caused by hepatitis B and hepatitis C infections during pregnancy?](#)

[How is hepatitis B virus infection spread?](#)

[What is acute hepatitis B virus infection?](#)

[What is chronic hepatitis B virus infection?](#)

[Can hepatitis B virus infection be cured?](#)

[If I am pregnant and infected with the hepatitis B virus, how likely is it that I will pass the virus to my baby?](#)

[How does hepatitis B virus infection affect babies?](#)

[How can I find out if I am infected with the hepatitis B virus?](#)

<https://www.acog.org/Patients/FAQs/Hepatitis-B-and-Hepatitis-C-in-Pregnancy>

4.1.5.3 Prenatal Exposure to Hepatitis B (Educational Slide Show)

Centers for Disease Control (CDC)



The slide show is titled "Hepatitis B and Your Healthy Baby" and is described as "An Educational Slide Set for Women Who Have Hepatitis B". It features a photograph of a smiling woman holding a baby.

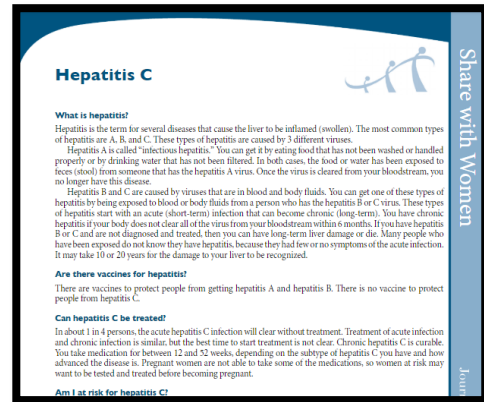
Hepatitis B and Your Healthy Baby

An Educational Slide Set for Women Who Have Hepatitis B

https://www.cdc.gov/hepatitis/Partners/Perinatal/Presentations/HealthyBaby/HepB_And_YourHealthyBaby-eng.pdf

4.1.5.4 Hepatitis C Factsheet

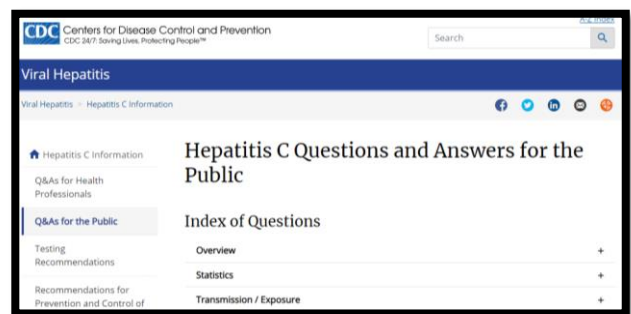
American College of Nurse Midwives



<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.12623>

4.1.5.5 Hepatitis C-Q&A for the Public

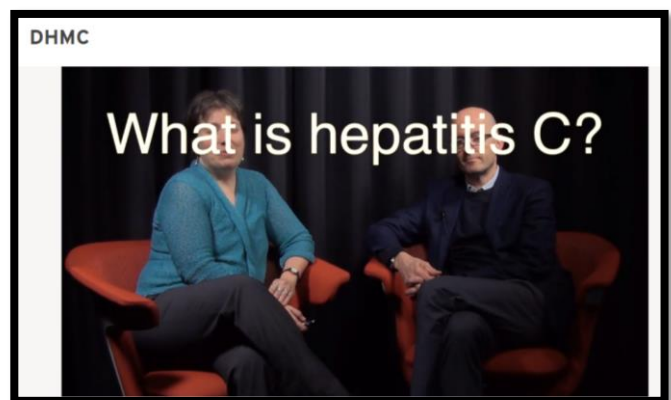
Centers for Disease Control (CDC)



<https://www.cdc.gov/hepatitis/hcv/cfaq.htm>

4.1.5.6 Hepatitis C in Pregnancy Video

A conversation with Dr. Tim Lahey, Infectious Disease



<https://dhmc.wistia.com/medias/dhsjkydhv1>

4.2 HIV Resources for Providers & Patients

All pregnant people should be screened for HIV at the onset of prenatal care. People with risk factors for infection, including recent injection drug history, a partner who uses injection drugs, or are incarcerated, should also be screened in the third trimester. Because it is difficult to be sure who has ongoing risk, NNEPQIN recommends that all people with opioid use disorder should be re-screened for HIV towards the end of pregnancy. Screening at the time of delivery is acceptable if expedited results are obtainable within one hour at the delivery hospital, although earlier screening is preferred as it allows time to confirm results, initiate antiretroviral therapy during pregnancy, and develop a follow up plan for the newborn (<https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0>).

Pregnant and postnatal people testing positive for HIV should be referred to an infectious disease specialist experienced in the treatment of HIV during pregnancy, and consent to disclose information to their infants' pediatric providers should be incorporated in the care plan to ensure appropriate follow up. Maternal Fetal Medicine consultation should be obtained and/or care transferred.

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis helps people avoid infection with HIV and should be offered to anyone at risk, including people who use injection drugs or exposed through sexual contact with an HIV positive partner. PrEP consists of HIV medication taken daily to proactively lower risk of infection. When taken daily, PrEP reduces the risk of HIV transmission through sexual contact by greater than 90%, and from injection drug use by greater than 70% (<https://www.hiv.gov/hiv-basics/hiv-prevention/using-hiv-medication-to-reduce-risk/pre-exposure-prophylaxis>).

PrEP must be prescribed, and is covered by many insurance plans. A medication assistance program is available if PrEP is not covered by a specific insurance plan: <https://www.gilead.com/purpose/medication-access/us-patient-access>

4.2.1 PROVIDER MATERIALS

4.2.1.1 AIDSinfo

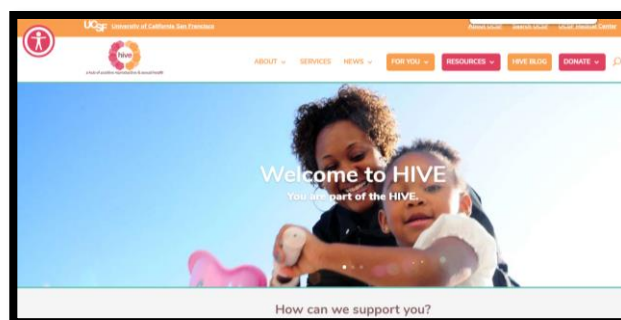
The U.S. Department of Health and Human Services site, a comprehensive resource for clinical guidelines, factsheets, and infographics to facilitate evidence-based care for people living with HIV



<https://aidsinfo.nih.gov/>

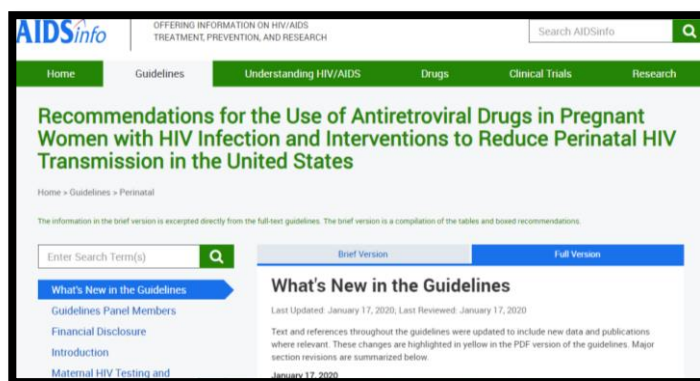
4.2.1.2 UCSF HIVE

University of California-San Francisco



<https://www.hiveonline.org/>

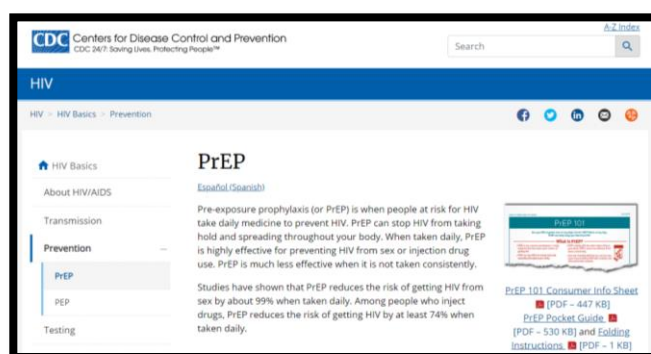
4.2.1.3 NIH Perinatal Treatment Guidelines



<https://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0>

4.2.1.4 CDC Information About PrEP

Available in Spanish as well



<https://www.cdc.gov/hiv/basics/prep.html>

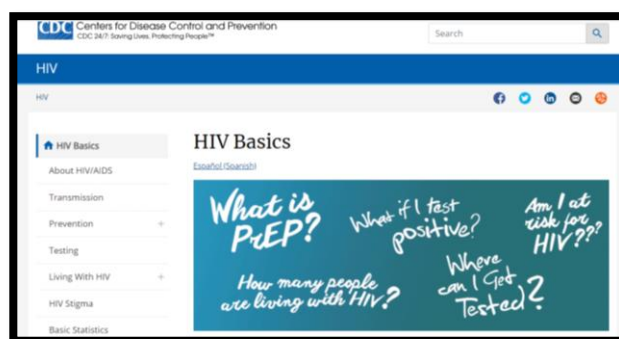
4.2.1.5 CDC Information on HIV and Pregnancy (Provider)



<https://www.cdc.gov/hiv/group/gender/pregnantwomen/>

4.2.2 PATIENT MATERIALS

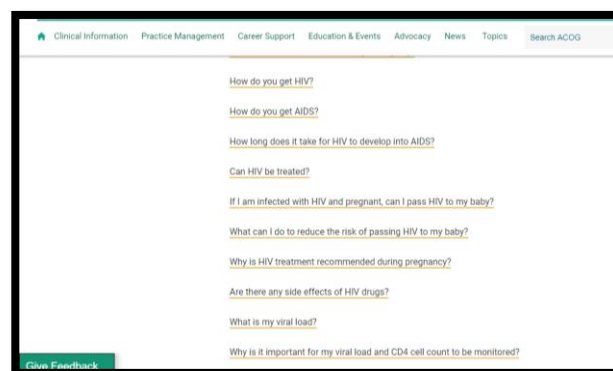
4.2.2.1 CDC Information on HIV



<https://www.cdc.gov/hiv/basics/index.html>

4.2.2.2 FAQs About HIV and Pregnancy

American College of Obstetricians and Gynecologists



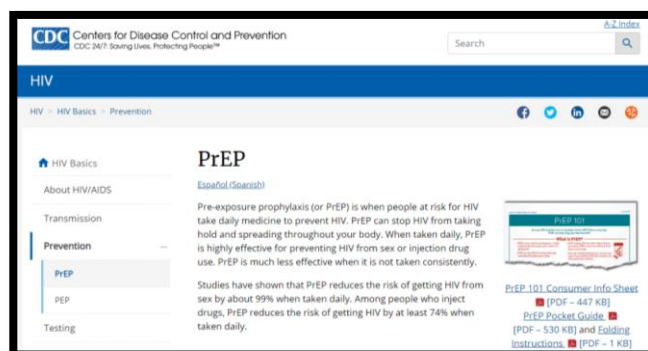
<https://www.acog.org/Patients/FAQs/HIV-and-Pregnancy>

4.2.2.3. What Women Need to Know about Pregnancy and HIV Treatment



<https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/hiv.html>

4.2.2.4. CDC Information About PrEP



<https://www.cdc.gov/hiv/basics/prep.html>

5. Plans of Safe Care (POSC) / Family Care Plans

5.1 Federal Legislation

Federal law requires that all infants determined to be affected by prenatal substance use must have a Plan of Safe Care in place at the time of discharge. As amended in 2010, the Child Abuse Prevention and Treatment Act (CAPTA) requires states to include in their state plans an assurance that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program relating to child abuse and neglect that includes the development of a plan of safe care for the infant born and identified as “being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder”.

Title V, Section 503, “Infant Plan of Safe Care,” of S. 524, “Comprehensive Addiction and Recovery Act of 2016” was signed into law on July 22, 2016. The bill amends CAPTA to address the health and substance use disorder treatment needs of the infant and affected family or caregiver; and to ensure the development and implementation by the State of monitoring systems regarding the implementation of plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

The Comprehensive Addiction and Recovery Act of 2016 (CARA):

<https://www.congress.gov/bill/114th-congress/senate-bill/524>

Key points

- The required elements of the Plan of Safe Care (POSC) vary from state to state
- This requirement applies to exposure to substances that are both prescribed and not prescribed
- Includes neonatal withdrawal from buprenorphine or methadone prescribed for treatment of opioid use disorder
- Some states (NH, VT) have developed a template for the POSC which can be shared with pregnant and parenting people

The goal of the POSC is to list existing supports and coordinate referrals to new services to help infants and their families after hospital discharge. The POSC is developed by a birthing person and their family's care team. How the POSC is intended to be used subsequent to discharge varies by state and institution.

Federal legislation requires notification by states regarding the number of infants born with prenatal substance exposure (aggregated) and the proportion of these for whom a POSC was created. This is not equivalent to making a mandated report about any individual to child protective services, and the fact that an infant is born with prenatal exposure to drugs or alcohol does not itself require a mandated report *per federal law*, although state laws differ in this regard.

Both Vermont and New Hampshire have developed a dual pathway by which a hospital-based care team determines for any infant whether (1) a POSC is required due to prenatal substance exposure, and (2) whether a mandated report is also required. Details about these requirements and how to determine need can be found on the relevant state websites:

Vermont

- Information about the VT POSC process (patient-facing): <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Safe-Care-Mothers.pdf>
- Flowchart describing the VT POSC process: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/CAPTA-Flowcharts.pdf>
- VT POSC template: <https://dcf.vermont.gov/sites/dcf/files/FSD/Docs/Hospital-Plan-Safe-Care.pdf>

New Hampshire

- State Law: <https://legiscan.com/NH/text/SB549/id/1728560>
- Guidance Document: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/12/POSC_GuidanceDocument_8-15-19.pdf
- Information about the NH POSC process: <https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>
- Frequently Asked Questions about the NH POSC: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_FAQ_v.6-1.pdf
- NH POSC template: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/POSC_Template_v.14_FillableForm-2.pdf

Maine

- Maine has not passed legislation regarding the care of substance affected infants since 2013. This law, LD 257, includes the following language:
- For each infant whom the department determines to be affected by illegal substance abuse or, to be suffering from demonstrating withdrawal symptoms resulting from prenatal drug exposure or to have fetal alcohol spectrum disorders, develop, with the assistance of any health care provider involved in the mother's or the child's medical or mental health care, a plan for the safe care of the infant and, in appropriate cases, refer the child or birthing person or both to a social service agency or voluntary substance abuse prevention service (HP 194- LD257, June 4, 2013)
- This is currently accomplished through notifying the Maine Office of Child and Family Services about the birth of an infant meeting the criteria described above.

5.2 Provider Materials

5.2.1 PROVIDER LETTER



http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/FINAL_POSC_ProviderLetter_7-15-19.pdf

5.2.2 POSC TEMPLATE

The POSC includes private health information. For electronic versions of this form, visit:

<https://nhcenterforexcellence.org/governors-commission/perinatal-substance-exposure-task-force/plans-of-safe-care-posc/>.

English version- [MS Word Format](#), [PDF Format](#)

Spanish version – [MS Word Format](#), [PDF Format](#)

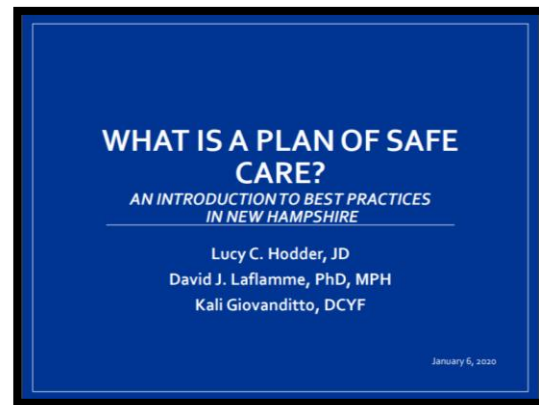
5.2.3 GUIDANCE DOCUMENT

This document provides general guidance about Plans of Safe Care (POSCs)¹ as well as answers to questions received from professionals related to Plans of Safe Care.

http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/08/POSC_GuidanceDocument_8-15-19.pdf

5.2.4 WEBINAR

POSC 101



Recording: https://jsi.zoom.us/rec/play/7Jlkdr-rqDM3GdWU4wSDAPd4W9W_Lq6s0SNL86UOmkm0ACMDNAWkM-RBZfuhwYg-if33-m_iWiX2TgM?continueMode=true

Slides: <http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/POSC101Webinar.pdf>

5.2.5 IMPLEMENTATION CHECKLIST

Implementing a new process requires quality planning to systematically design a process that will work for your specific practice or site. Use the following checklist to identify and monitor activities to plan and implement Plans of Safe Care.

| New Hampshire Plan of Safe Care (POSC) Implementation Checklist | | | | |
|---|--|-----------------------|------------|----------|
| Implementing a new process requires quality planning to systematically design a process that will work for your specific practice or site. Use the following checklist to identify and monitor activities to plan and implement Plans of Safe Care. | | | | |
| Category | Activity | Implementation Status | | |
| | | Planning | In Process | Complete |
| Staffing | Determine members of POSC implementation team. | | | |
| | Determine the responsibilities of each team member. | | | |
| | Determine a decision making process for the team. | | | |
| | Determine the timeline for POSC implementation. | | | |
| Template | Determine if this POSC template will be used, or if a practice-specific form will be used. | | | |
| | Determine if an electronic or paper form will be used. | | | |
| | Determine where the forms will be stored. | | | |
| | Establish a process for updating the form and maintaining form versions. | | | |
| Workflow | Determine the specific "who," "what," "when," and "where" the POSC will be completed. | | | |
| | Establish and document a protocol for the flow of how the POSC will move between staff or offices. | | | |
| Referrals | Develop an inventory of community service providers and contact information. | | | |
| | Establish internal referral mechanisms. (If appropriate) | | | |
| | Establish external referral mechanisms. | | | |
| | Develop and foster community provider partnerships. | | | |
| Follow Up | Develop protocol for organizing how referrals will occur, and to whom. | | | |
| | Establish protocol for patient follow up, method of follow up, and frequency of follow up. | | | |

http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/FINAL_Implementation_Checklist-PRINTED-380.docx

5.2.6 FACT SHEET

Key Facts about Perinatal Substance Exposure

Supporting Mothers & Infants:
Key Facts about Perinatal Substance Exposure

- Substance use disorders including opioid use disorders are a chronic recurring brain disease. As with other chronic diseases, proper ongoing treatment is essential for recovery and good health outcomes.
- Medication Assisted Treatment (MAT) with methadone or buprenorphine, along with evidence-based behavioral interventions, is the standard of care for pregnant women with opioid use disorder. Insufficient clinical research is available to support the safety of extended-release injectable naltrexone during pregnancy. Breastfeeding while on MAT is safe and is strongly encouraged for maternal-child health and bonding, unless medical contraindications are present (such as HIV or use of substances).
- Sustaining MAT after birth of a baby helps women maintain recovery, prevents return to use of substances, and reduces risk of overdose death. The duration of time a person needs to be on MAT to sustain recovery varies.
- Neonatal Abstinence Syndrome (NAS) describes a group of symptoms an infant may experience when withdrawing from in-utero exposure to opioids. It is treatable and can be managed safely in a non-intensive care setting. It is not an addiction.
- Many infants with NAS can be managed effectively and safely with the Eat Sleep Console (ESC) approach, which encourages parental presence, rooming-in, skin-on-skin contact, swaddling, "on demand" feedings, and other comfort measures. This often eliminates the need for opioid replacement medication for the newborn, and has been shown to substantially shorten the time infants spend in the hospital.
- Tobacco exposure is harmful to both the pregnant woman and her fetus. There is conclusive evidence of lasting harms to infants from in-utero exposure including premature birth, small for gestational age (SGA), and increased risk for Sudden Infant Death Syndrome (SIDS). Pregnant and newly parenting women should be offered support to reduce or stop use of tobacco products through nicotine replacement therapy and behavioral treatment.

Language Matters

Use encouraging and supportive approaches, including nonjudgmental, person first language to encourage women to seek and continue care for themselves and their children.

Refer to the person's disease in clinical terms. Examples include:

- Women with an opioid use disorder
- Infant with neonatal abstinence syndrome

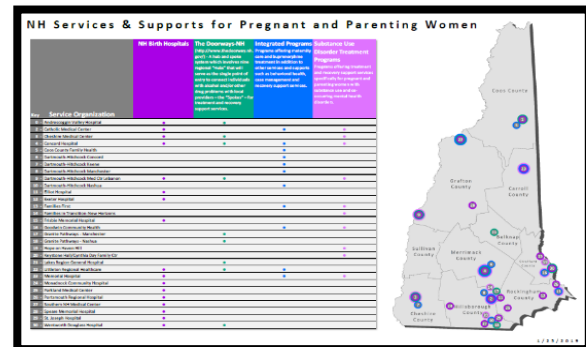
Refer to back page for additional facts.

http://1viuw040k2mx3a7mwz1lwa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/01/FINAL-POSC_FactSheet.pdf

5.2.7 POSC SERVICES LIST AND MAP

[illegible]

https://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/PregnantParentingServicesList_6-20-19.pdf



http://1viuw040k2mx3a7mwz1lwaa5-wpengine.netdna-ssl.com/wp-content/uploads/2019/02/FINAL_MAP_ServicesSupports_PregnantParenting_11x17.pdf

5.3 Patient Materials

5.3.1 POSC PATIENT BROCHURE (ENGLISH AND SPANISH)



English

Word format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/02/FINAL_POSC_PatientBrochure_English_Word-2.docx

PDF Format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/POSC_PatientMaterial_1-10-20.docx.pdf

Spanish

Word format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/02/FINAL_POSC_PatientBrochure_Spanish_Word-3.docx

PDF Format: http://1viuw040k2mx3a7mwz1lwva5-wpengine.netdna-ssl.com/wp-content/uploads/2020/01/SPANISH_POSC_PatientBrochure_1-14-20.pdf

6. Postpartum Care

The postpartum period is a particularly vulnerable time for birthing people who have substance use disorders due to rapid physiological 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, birthing people 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 birthing person received immediate postpartum long acting reversible contraception (LARC). The traditional 6-week postpartum period should be extended for birthing people with OUD/SUD as continuity of relationships is critically important and this is a vulnerable time (ACOG, 2018).

NNEPQIN/AIM Checklist for Post-Discharge Care

- Close postpartum follow-up with frequent visits
 - Review relevant portions of the *Plan of Safe Care* made at hospital discharge
 - Rescreen and brief intervention for return to substance use
 - Postpartum depression screening
 - Monitor for relapse
 - Screen for intimate partner violence at 6 weeks and when indicated
 - Smoking cessation reinforcement or continued cessation counseling when indicated
 - Rescreen for social determinants of health and assess resource needs at each visit,
 - coordinate with case worker/social service providers
 - Assist patient in scheduling appointments for infectious disease management when indicated
 - Facilitate transition for recovery-friendly primary care provider if not established
 - Breast-feeding support
 - Provide contraception and counsel on birth spacing (10 Best Contraceptive Practices; Postpartum Contraceptive Access Initiative (PCAI))
 - Consider providing support and services for longer than the traditional 6 week postpartum period (ACOG Committee Opinion #236)

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 section on breastfeeding in this toolkit

Family Planning

Immediate post-placental long acting reversible contraception (LARC) is a convenient option for birthing people desiring long-term contraception that is compatible with breastfeeding. Placement under epidural anesthesia or trans-cesarean is particularly attractive for birthing people who have a history of sexual trauma or/and experience anxiety related to pelvic examination. Clinicians providing care for birthing people 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 pregnant people'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 pregnant person 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 pregnant people have access to medication assisted treatment for OUD and continuing SUD counseling as relapse risk is high and increases with time. If a pregnant person leaves the SUD treatment program they had attended during pregnancy, it is important to help them find an alternate. Every effort should also be made to link pregnant people to a recovery-friendly primary care provider as well. Maternity care providers should continue to support pregnant people'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 pregnant people establish pediatric care for their infants.

Working with treatment providers

Maternity care providers should request written consent from birthing people with SUD/ODU 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

People 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. Pregnant people receiving antiretroviral therapy for HIV should be supported in continuing treatment, and should not breastfeed. Pregnant people 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 birthing people to follow up on referrals to public health nursing and other child and family services available in the community. *Please see additional references sections for literature.*



10 Best Practices in Contraceptive Counseling

Background

Origin

The 10 Best Practices in Contraceptive Counseling were developed to improve contraceptive use and help families prevent unintended pregnancies through a partnership between the Center for Latino Adolescent and Family Health at the NYU Silver School of Social Work and Planned Parenthood Federation of America.

In 2011, almost half of pregnancies nationwide were unintended, and 41% of those unintended pregnancies were due to inaccurate or inconsistent use of a birth control method. An additional 54% of unintended pregnancies were due to nonuse of any contraceptive method.¹ The 10 Best Practices in Contraceptive Counseling provides an evidence-based framework for healthcare providers to use in discussing birth control options with patients, supporting them to use the method of their choice consistently and correctly so their reproductive life plans can be achieved.

Application for Women with SUDs

This framework is especially needed for women who use substances. Among women with opioid use disorders, nearly 9 out of 10 pregnancies (86%) are unintended.² For providers who are supporting women with substance use disorders (SUDs) through an existing pregnancy and birth, both the prenatal and post-partum periods are a crucial window to implement these practices and discuss future reproductive intentions and birth control options.

This protocol was created through a lens of reproductive justice, and is designed to maximize patient choice and autonomy. It is especially important to maintain this lens in counseling women with SUDs, who represent a marginalized population that has faced a history of contraceptive coercion.

Framework Design

The 10 Best Practices in Contraceptive Counseling were designed to be implemented in a healthcare setting that offers the full range of contraceptive options, including IUDs and implants, and can be delivered by a variety of staff, including healthcare assistants, nurses, doctors, etc. In cases in which the medical practice does not offer certain methods of contraception, the 10 Best Practices can still be delivered, along with a referral to someone who can provide the patient's chosen method.

Further Training

The following summary was adapted by Planned Parenthood of Northern New England (PPNNE) from an extensive full-day training protocol, and is not intended to replace the more in depth program. To inquire about receiving training on the 10 Best Practices in Contraceptive Counseling, please contact Whitney Parsons at PPNNE (whitney.parsons@ppnne.org).

¹ Guttmacher Institute. (2016, September). Fact Sheet: Unintended Pregnancy in the United States. Retrieved from https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us_0.pdf

² Heil SH, Jones HE, Arria A, et al. Unintended Pregnancy in Opioid-abusing Women. *Journal of substance abuse treatment*. 2011;40(2):199-202. doi:10.1016/j.jsat.2010.08.011.

Summary

The 10 Best Practices in Contraceptive Counseling:

| | |
|-----|---|
| #1 | Demonstrate the “key three” attributes of an effective counselor –trustworthiness, expertise, and accessibility (TEA) |
| #2 | Use active as opposed to passive learning strategies to engage the patient in learning and remembering important points |
| #3 | Ask about pregnancy plans and offer resources |
| #4 | Simplify choice process |
| #5 | Make a plan for accurate use |
| #6 | Make a plan for side effects |
| #7 | Address lifestyle and broader context (POISE) |
| #8 | Make a plan for method switching |
| #9 | Talk about condoms for STI protection |
| #10 | Mention use of quick start |

Key Points:

- Through contraceptive counseling, providers can help patients prevent unintended pregnancy by helping them:
 - Choose a method that is best for them and their lifestyle,
 - Be consistent and correct in the use of their chosen method, and
 - Make a plan for switching methods if they choose to in the future.
- A year-long study of over 1,300 women at three Planned Parenthood Health Centers evaluated the effectiveness of the 10 Best Practices in Contraceptive Counseling. Compared to those patients who did not receive the new counseling protocol, those who did receive the 10 Best Practices were:
 - More likely to use birth control,
 - More likely to use condoms plus another method of birth control,
 - More likely to choose an IUD or implant because they decided it was the best method for them, and
 - More positive about the person who provided the counseling, the process, and the health center itself.
- Providers must be cognizant of potential for reproductive coercion, and respect and support patient autonomy and decision-making.
 - Minority and low-income women are more likely to report being pressured to use a birth control method and limit their family size.³
 - Providers are more likely to recommend IUDs to low-SES black and Latina women than to low-SES white women.⁴
- Patients will remember information and instructions better when they talk more and the provider talks less.

³ Dehlendorf, C., Rodriguez, M. I., Levy, K., Borrero, S., & Steinauer, J. (2010). Disparities in Family Planning. *American Journal of Obstetrics and Gynecology*, 202(3), 214–220. <http://doi.org/10.1016/j.ajog.2009.08.022>

⁴ Dehlendorf, C., Ruskin, R., Grumbach, K., Vittinghoff, E., Bibbins-Domingo, K., Schillinger, D., & Steinauer, J. (2010). Recommendations for Intrauterine Contraception: A Randomized Trial of the Effects of Patients' Race/Ethnicity and Socioeconomic Status. *American Journal of Obstetrics and Gynecology*, 203(4), 319.e1–319.e8. <http://doi.org/10.1016/j.ajog.2010.05.009>

How and Why to Implement 10 Best Practices in Contraceptive Counseling:

1 – Demonstrate the “key three” attributes of an effective counselor – trustworthiness, expertise, and accessibility (TEA)

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| Research says | <p>Patients who see their provider as accessible are more likely to contact that provider and are less likely to experience gaps in protection when switching methods. Research also shows that patients do not automatically think that counselors have expertise or are looking out for their patient's best interests. Counselors are more effective if they are seen as trustworthy, expert, and accessible.</p> | What to say & do | <ul style="list-style-type: none"> • “We want to help you find the birth control method that's best for you.” (trustworthiness) • “I have dealt with this before.” (expertise) • “We are here for you. Call us anytime and I or one of my co-workers will get back to you. Here's a card with my name on it and the health center's contact info.” [Write your name on the card in front of the patient and give to patient.] (accessibility) |
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2 – Use active as opposed to passive learning strategies to engage the patient in learning and remembering important points

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| Research says | <p>People are more likely to remember important information when they actively process it as opposed to passively listen to it. For example, remembering how to accurately use a method is critical. Active processing of such information will help them recall it later.</p> | What to say & do | <ul style="list-style-type: none"> • Ask open-ended questions: <ul style="list-style-type: none"> ○ What questions do you have about this chart? ○ How will you make sure that you...? ○ Tell me more about that... ○ So am I understanding you correctly that you want...? • Ask patient to repeat important information back to you in their own words. |
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3 – Ask about pregnancy plans and offer resources

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| <p>Research says</p> <p>Pregnancy ambivalence—including among women who want to leave the prospect of having a baby to “chance”—is associated with gaps in protection, less accurate and consistent use of birth control, more method switching, and extended periods without using contraception.</p> | <p>What to say & do</p> <p>Ask the One Key Question®: “Would you like to become pregnant in the next year?”</p> <ul style="list-style-type: none"> • If “no,” discuss preventing pregnancy • If “yes,” discuss preconception care • If patient is unsure, here are key points to communicate: <ul style="list-style-type: none"> i. Pregnancy is healthiest when planned. ii. Being unsure can lead to gaps in protection. iii. Making a Reproductive Life Plan is a great way to reflect on goals of having or not having children and to identify steps to take to reach those goals. iv. Continue counseling as usual |
| <p>Additional Resources:</p> <ul style="list-style-type: none"> • One Key Question® - https://powertodecide.org/select360 consulting. • Main, M. (2016). One Key Question: Would You Like to Become Pregnant in the Next Year? <i>Northwest Bulletin: Family and Child Health</i>, 30. Center of Excellence in Maternal and Child Public. Retrieved from https://depts.washington.edu/nwbfch/archives/one-key-question-would-you-become-pregnant-next-year. • Delaware Health and Social Services- Division of Public Health. Adult Life Plan Brochure. Retrieved from http://dhss.delaware.gov/dhss/dph/chca/dphfp services1c.html. • U.S. Department of Health and Human Services: Office of Population Health. Preconception Health and Reproductive Life Plan. https://www.hhs.gov/opa/title-x-family-planning/preventive-services/preconception-health-and-reproductive-life-plan/index.html. | |

4 – Simplify choice process

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| <p>Research says</p> <p>There are about a dozen methods of birth control and each method differs on about a dozen different dimensions. Patients must therefore wade through about 150 pieces of information to make a choice—an overwhelming task. Research shows that in situations where people are faced with information overload, they “jump around” from one piece of information to another and make decisions based on what is salient (what happens to come to mind at that particular moment), not what is important.</p> | <p>What to say & do</p> <p>→ SHOW: Star Chart of birth control options “This is a chart of all the birth control options. They are organized into three groups:</p> <ul style="list-style-type: none"> • <u>Group A</u> methods are the best at preventing pregnancy and most convenient. They are inserted here at the health center by a clinician. • <u>Group B</u> methods require some sort of action to work, like taking a pill every day, but are also very good at preventing pregnancy when used accurately. • <u>Group C</u> methods still work to prevent pregnancy as long as you use them every time you have sex.” <p>“Are there any methods you would like to learn more about?”</p> |
| <p>Additional Resources</p> <ul style="list-style-type: none"> • See Appendix 1: Star Chart | |

5 – Make a plan for accurate use

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| Research says | Using a method inaccurately or inconsistently undermines the efficacy of many methods. For example, the perfect use effectiveness rate of the pill is greater than 99% but the typical use effectiveness rate is 91%. This disparity is because of inaccurate and inconsistent use of the pill and translates into thousands of unintended pregnancies. Issues of use accuracy and consistency are critical to address | What to say & do | <ul style="list-style-type: none"> • “How will you remember to take your method as described?” • “What will you do if you make an error using your method?” • “How will you remember to pick up your refills?” <p>→ Discuss common errors made when using method the patient is considering.</p> |
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6 – Make a plan for side effects

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| Research says | Switching methods is often associated with gaps in protection or switches to less effective methods. Side effects are one of the most common reasons patients give for switching methods. | What to say & do | <ul style="list-style-type: none"> • “Most side effects are temporary, usually lasting 2-3 months. • I’m going to share a few common side effects. Tell me which, if any, might be hard for you and I’ll help you make a plan to deal with them.” <p>→ Discuss common side effects for the method the patient is considering</p> |
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7 – Address lifestyle and broader context (POISE)

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| Research says | In addition to the attributes of a given contraceptive method, you need to make sure that the chosen method fits with the lifestyle and life circumstances of the patient, more generally. It is not enough to just talk about effectiveness, side effects, and other method characteristics. A good choice considers broader considerations as well. | What to say & do | <ul style="list-style-type: none"> • Pros and Cons: “What are the positives and negatives for you using this method?” • Others’ Views: “How would people important to you feel about you using this method?” • Image: “How does this method fit with how you see yourself?” • Self-Efficacy: “If you decided to use this method, how easy or hard do you think it would be for you to use it correctly?” • Emotions: “What positive and/or negative feelings do you have about this method?” |
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8 – Make a plan for method switching

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| Research says | Switching to a less effective method increases the risk of an unplanned pregnancy, sometimes substantially so. Research shows that if people have “action plans” ahead of time for what to do when encountering unanticipated difficult situations, they are more likely to cope with and resolve those situations effectively – in this case, by avoiding a gap in protection. | What to say & do | <p>“If you decided you wanted to switch, how would you switch to another method?”</p> <p>[Call the health center and continue taking a method of birth control.]</p> |
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9 – Talk about condoms for STI protection

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| Research says | STIs are widespread, far more than most people realize. There are over 8,000 new, serious infections in the United States every day. Some STIs, like herpes, are incurable and others, like HIV, are deadly. Some STIs do not show symptoms, but left untreated, can have serious health consequences. The methods most effective at preventing pregnancy offer no protection against STIs. | What to say & do | <p>“This method doesn’t prevent STIs so if you are concerned about that it’s a good idea to use condoms.”</p> |
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10 – If possible, begin patient on chosen method that same day

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| Research says | For some birth control methods, women who start a method on the day of the clinic visit, instead of waiting for the next menstrual cycle or for another appointment, are more likely to start the method, use it correctly, and continue to use the method. | What to say & do | <p>“We can start you on this method today so that you don’t have any gaps in protection.”</p> |
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Choosing a Method of Birth Control

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| Group A (Low-maintenance; health center sets it and you forget it) | Implant | ★★★★ |
| | IUD (Hormonal) | ★★★★ |
| | IUD (Non-hormonal) | ★★★★ |
| | Sterilization (Vasectomy, Tubal Ligation, Essure) | ★★★★ |
| Group B (Once every 3 months, monthly, weekly, daily) | Shot (Depo) | ★★★ |
| | Vaginal Ring | ★★★ |
| | Patch | ★★★ |
| | Pill | ★★★ |
| Group C (Must use every single time) | Male Condom | ★★ |
| | Female Condom | ★★ |
| | Diaphragm | ★★ |
| | Sponge | ★★ |
| | Cervical Cap | ★★ |
| | Fertility Awareness Method | ★ |
| | Withdrawal | ★ |
| | Spermicides | ★ |

Approximate effectiveness: ★★★★★ = 99% ★★★★★ = 91% ★★★ = 85% ★ = 75%

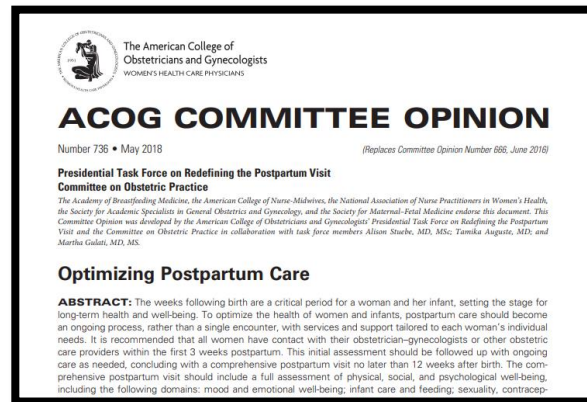
Remember, most of these methods do not protect against STDs.
 Use a condom to lower your chances of getting an STD.



www.nnepqn.org/clinical-guidelines/

6.2 Provider Materials

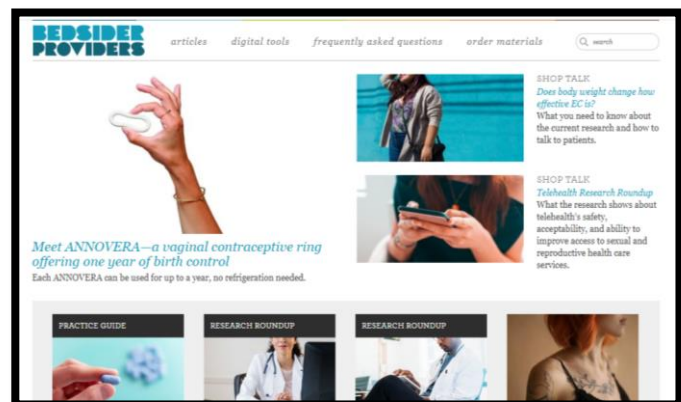
6.2.1 ACOG COMMITTEE OPINION #736, OPTIMIZING POSTPARTUM CARE



<https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>

6.2.2 BEDSIDER BIRTH CONTROL SUPPORT NETWORK

Resources and educational materials for contraceptive practice

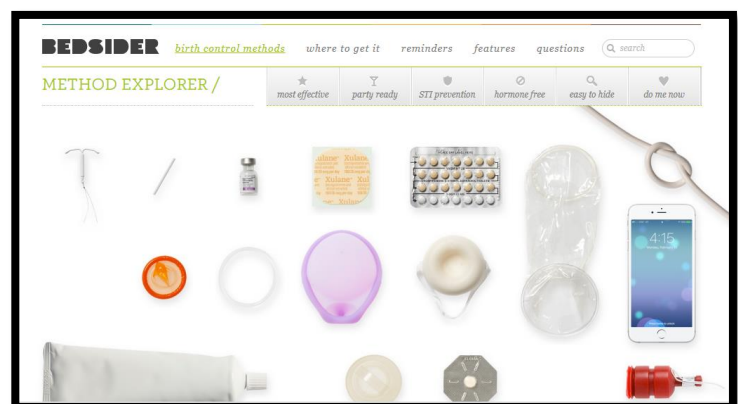


<https://providers.bedsider.org/>

6.3 Patient Materials

6.3.1 BEDSIDER METHOD EXPLORER

Interactive site with digital patient education materials



<https://www.bedsider.org/methods>

7. Supporting LGBTQIA and Gender Diverse Patient Health

Maternal and obstetric care for Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit + (LGBTQIA2S+) and gender diverse people is critical and necessary, but has gained visibility in the medical community only recently. There are many ways to provide affirming care to all patients including: asking a patient for their pronouns, offering psychosocial support, providing hormone therapy and other practices that aim to align a person's physical experiences with their gender identity. Provider education in this area is critical. People in the LGBTQIA2S community have historically experienced discrimination especially in healthcare setting. This is partly due to underreported and under researched experiences with pregnancy for this population and the prominence of the heteronormative framework of most maternal and obstetric care. Many unique considerations exist for maternal and obstetric care of gender diverse patients.

Considerations for Perinatal Care

Supporting all patients' physical and mental health is critical, especially for those who are trans, non-binary or gender diverse as they have historically faced higher rates of discrimination. For pregnant and parenting people this may look like affirming the person's pregnancy in a way that is safe such as calling ahead for certain services to assure they are inclusive or ensuring that all clinic staff use gender affirming language in the workplace and providing them with education around gender, sex and sexuality. Affirming the identity of a patient is the first step to providing proper care. Simply asking how a person would like to be referred to can create safety and trust between patient and provider.

Education around trans inclusive medical care is also crucial. This may look like systems-level and/or interpersonal interventions. Hormone therapy and other practices that aim to align a person's physical experiences with their gender identity are areas where patient education are crucial. Providing resources for pregnant and parenting people about gender affirming parenting may also be helpful.

As an example of affirming medical interventions for a transgender man's pregnancy, Hahn et al., 2019¹ found the following teaching points:

- Testosterone should not be considered a contraceptive. Testosterone may lead to amenorrhea and cessation of ovulation. However, although testosterone may reduce fertility, fertilization is possible despite prior or active use of testosterone and while amenorrheic from testosterone use.
- Testosterone is not currently recommended during pregnancy owing to possible irreversible fetal androgenic effects. An optimal interval between discontinuing testosterone and conceiving is unknown at this time.
- Although transgender and gender-diverse people previously on testosterone may adjust well to pregnancy, lack of testosterone use during fertilization and pregnancy may lead to or exacerbate gender dysphoria.
- Testosterone may be excreted in small quantities in human milk and may affect milk production. Currently, it is not recommended to use testosterone while chestfeeding, until more information is known about the effects of testosterone use on human milk.

7.1. Provider Materials

7.1.1 MOTHERS AND OTHERS: THE INVISIBILITY OF LGBTQ PEOPLE IN REPRODUCTIVE AND INFANT PSYCHOLOGY

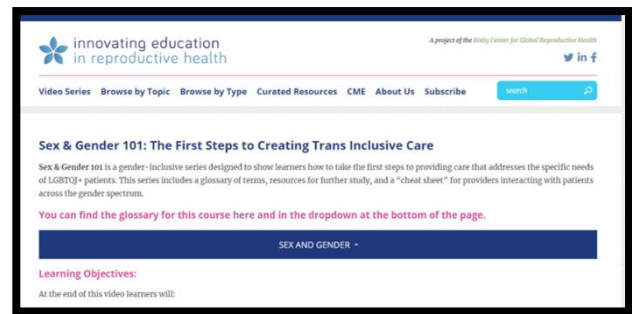
Editorial article

Zoe Darwin & Mari Greenfield (2019). Journal of Reproductive and Infant Psychology, 37:4, 341-343, DOI: 10.1080/02646838.2019.1649919



<https://www.tandfonline.com/doi/full/10.1080/02646838.2019.1649919/>

7.1.2 SEX & GENDER 101: THE FIRST STEPS TO CREATING TRANS INCLUSIVE CARE



<https://www.innovating-education.org/course/gender-inclusive-care/>

7.2 Patient Materials

7.2.1 PREPARING FOR PREGNANCY AS A NON-BINARY PERSON

Resource from Family Equality



<https://www.familyequality.org/resources/preparing-for-pregnancy-as-a-non-binary-person/>

7.2.2 SUPPORT RESOURCES FOR FAMILIES OF GENDER DIVERSE YOUTH

Resource from HealthyChildren.org



<https://www.healthychildren.org/English/ages-stages/gradeschool/Pages/Support-Resources-for-Families-of-Gender-Diverse-Youth.aspx>

References

1. Hahn M, Sheran N, Weber S, Cohan D, Obedin-Maliver J. Providing patient-centered perinatal care for transgender men and gender-diverse individuals: A collaborative multidisciplinary team approach. *Obstetrics and gynecology*. 2019 Nov;134(5):959.