No One Recovers Alone

Group Prenatal & Postpartum Care
for Women in Recovery

KY Overdose Prevention Summit

Frontier Nursing University | Integrative Care Models in SUD Treatment

Speaker Information

Disclosures: No relevant financial relationship(s) to disclose with ineligible companies who's primary business is producing, marketing, selling, reselling, or distributing healthcare products used by or on patients

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The Crisis We Face

#1

cause of pregnancy-associated death in the US

2×

higher overdose risk in the postpartum period

80%

of maternal overdose deaths are preventable

12mo

extended postpartum period now recognized by ACOG

Sources: CDC, ACOG, SMFM — Substance use disorder is the leading driver of pregnancy-associated mortality in Kentucky and nationally.

Learning Objectives

01

Describe maternal & infant risks associated with untreated SUD during pregnancy and postpartum — including overdose risk, maternal mortality, neonatal complications, and disruptions to maternal–infant bonding.

02

Identify common barriers to SUD treatment engagement in the postpartum period: stigma, fragmented care, fear of child welfare involvement, mental health comorbidities, and limited trauma-informed services.

03

Evaluate innovative group prenatal and postpartum care models and examine how integrated, peer-supported, trauma-informed approaches improve engagement, continuity, and outcomes.

Maternal & Infant Risks of Untreated SUD

MATERNAL RISKS

- Overdose death --highest risk postpartum
- Severe maternal morbidity (sepsis, cardiac events)
- Preeclampsia, preterm labor, placental abruption
- Co-occurring mental health disorders (depression, PTSD, anxiety)
- Disengagement from healthcare after delivery
- Disrupted maternal–infant bonding & caregiving capacity
- Housing instability, intimate partner violence, poverty

INFANT & NEONATAL RISKS

- Neonatal Opioid Withdrawal Syndrome (NOWS/NAS)
- Preterm birth & low birth weight
- Neurodevelopmental delays
- Elevated risk for child welfare involvement
- Disrupted attachment & early relational trauma
- Breastfeeding challenges
- Long-term behavioral and developmental impacts

Barriers to Treatment Engagement

Stigma & Shame

Judgment from providers, family, and community silences women seeking help

Fear of Child Welfare

Fear of CPS involvement prevents disclosure and engagement with services

Fragmented Care Systems

OB, behavioral health, and SUD treatment rarely communicate or co-locate

Mental Health Comorbidities

Untreated depression, PTSD, and anxiety amplify barriers and dropout risk

Social Determinants

Transportation, childcare, housing instability, and poverty limit access

Trauma & Mistrust

Histories of medical trauma and marginalization reduce trust in healthcare

"Women don't fail treatment. Treatment fails women." — SAMHSA

The Postpartum Cliff

Why the overdose risk spikes after delivery

Traditional postpartum care ends at 6 weeks; but overdose risk peaks in months 1–12 postpartum

Medicaid coverage gaps and insurance transitions disrupt medication-assisted treatment (MOUD) access

New parenting demands, sleep deprivation, and isolation increase relapse vulnerability

Perinatal loss, NICU stress, or separation from infant compound grief and trauma responses

OB providers discharge patients without warm handoffs to SUD or behavioral health services

ACOG now recommends 12-month postpartum care , yet most programs stop at 6 weeks

Closing this gap is a matter of life and death.

Group Care: A Different Kind of Medicine

TRADITIONAL PRENATAL MODEL

- 15-minute individual appointments
- Provider-centered interaction
- Siloed OB, mental health & SUD care
- Reactive, crisis-driven engagement
- Limited peer connection
- High no-show & dropout rates
- Fragmented, rushed care experience

GROUP PRENATAL CARE MODEL

- 90-minute facilitated group sessions
- Relationship-centered & peer-supported
- Integrated medical, behavioral & SUD care
- Proactive, continuity-based engagement
- Community & shared lived experience
- Significantly higher retention rates
- Trauma-informed, strength-based approach

Model Spotlight: Project Nurture — Oregon

Project Nurture is a statewide Oregon Health Authority initiative embedding SUD treatment within prenatal and postpartum care using integrated, trauma-informed, peer-supported groups. The program serves Medicaid-enrolled pregnant and postpartum individuals with SUD. Project Nurture Panel- Integrated Care

CORE COMPONENTS

- Co-located prenatal & SUD care
- Weekly group prenatal visits (CenteringPregnancy model)
- Peer recovery support specialists embedded in teams
- Integrated MOUD management
- Postpartum groups extending to 12 months

OUTCOMES ACHIEVED

- Higher rates of prenatal care initiation
- Reduced NOWS severity & NICU length of stay
- Improved MOUD retention
- Increased breastfeeding rates
- Reduced child welfare involvement

KEY LESSONS

- Peer support is **irreplaceable** — not a nice-to-have
- Trust-building precedes behavior change
- Flexible attendance policies improve retention
- Trauma-informed systems training required for all staff
- Sustainability requires Medicaid billing reform

Model Spotlight: UK PATHways — Lexington, KY

The University of Kentucky PATHways (Perinatal Assistance and Treatment Hope) program is a Kentucky-based integrated care model providing comprehensive prenatal and postpartum services for women with OUD, embedded within UK HealthCare's Women's Health service.

Program Structure	Weekly multidisciplinary team visits integrate midwifery/OB care, addiction medicine, behavioral health counseling, social work, pharmacy, and peer support in one visit. Group and individual care are blended based on patient preference and acuity.
Postpartum Extension	PATHways continues postpartum care well beyond 6 weeks, offering structured follow-up at 2 weeks, 6 weeks, 6 months, and 12 months postpartum. MOUD continuation, infant development, and maternal mental health are all addressed in the extended window.
Outcomes	Participants show significantly reduced neonatal abstinence severity scores, higher breastfeeding initiation, improved MOUD retention, and lower rates of emergency department utilization compared to standard care controls.

ukhealthcare.uky.edu/pathways

Extending Postpartum Care: The 4th Trimester & Beyond

1	2	3	4	5
Birth – 2 wks	**2–6 Weeks**	**2–4 Months**	**4–8 Months**	**8–12 Months**
MOUD stabilization Pain & wound care Breastfeeding support Peer check-in MH/SDOH screening ESC/newborn care cues	Traditional postpartum visit Mental health screen Contraception counseling SUD treatment plan review	Group postpartum sessions Infant bonding & development Trauma-informed therapy Housing & social needs	Peer recovery groups Parenting skills support Community re-integration Chronic disease management/preg complication FU (GDM/Hypertension /Cardio, Hep C)	Transition planning Long-term recovery support Primary care handoff Annual wellness visit

ACOG recommends postpartum care as an ongoing process — not a single visit — through 12 months.

Pillars of Trauma-Informed, Peer-Supported Care

Safety

Physical and emotional safety is established first. Consistent providers, predictable environments, and clear boundaries create conditions for healing.

Trustworthiness

Transparent communication, follow-through, and honest disclosure build the therapeutic alliance essential for women with histories of betrayal.

Peer Support

Lived experience is a clinical asset. Peer recovery coaches and group members provide connection, hope, and practical wisdom no provider can replicate.

Collaboration

Power-sharing between patient and provider. Shared decision-making respects autonomy and centers the woman's goals, not only clinical outcomes.

Empowerment

Strengths-based language, skill-building, and celebrating milestones shift identity from 'addict' to 'person in recovery.'

Community-based

Recognizing that individual behavior is impacted by available community resources. When care is delivered in community, by people who are part of the same community outcomes improve.

Practical Strategies: What You Can Do Now

For Peer Support, CHWs & Care Navigators	• Conduct warm handoffs • Assess and address transportation, childcare, and housing barriers before first appointment • Follow up within 48–72 hours of delivery • Connect patients to peer recovery support before discharge
For Clinicians	• Screen all patients with validated tools (5Ps, AUDIT-C) without judgment • Continue MOUD through the full postpartum year • Use trauma-informed language: 'person with SUD,' not 'addict' • Reimagine Postpartum care based on needs
For Programs & Systems	• Advocate for extended postpartum Medicaid coverage (Kentucky 12-mo postpartum expansion) • Co-locate behavioral health, SUD, and perinatal services or provide real-time e-consult • Train all staff in trauma-informed care (front desk to clinical team) • Build peer recovery support roles into staffing models and billing structure

Recovery Patient-Centered Care

Effective care for SUD requires identifying and breaking down of systemic barriers that prevent women from accessing dignified, effective treatment.

Marginalization

Women with SUD face surveillance, CPS involvement, punitive responses and internal/external stigma which decreases ability to access healthcare.

Rural Access in KY

Many Kentucky counties lack any OB provider, addiction specialist, or mental health clinician. Telehealth-integrated group models and mobile care units are critical for rural equity.

Criminalization vs. Care

Punitive approaches increase maternal and infant harm. Decriminalization of drug use in pregnancy and mandated reporting reform improve engagement with care and reduce mortality.

Family Preservation

Fear of losing custody is the #1 barrier to disclosure. Family-centered programs that keep mothers and infants together produce better outcomes for both.

Kentucky Resources & Next Steps

Resources for innovation in perinatal SUD treatment (not an exhaustive list).

UK PATHways Program

Lexington, KY — Integrated perinatal SUD care

ukhealthcare.uky.edu

MOST Program, Norton

Louisville, KY--Hospital stabilization, co-located pregnancy & recovery services

MOST Program

KY Postpartum Medicaid Extension

12-month continuous coverage — effective 2022

chfs.ky.gov/Medicaid

SAMHSA Maternal & Infant Resources

National guidelines, provider tools, and SUD treatment locator

samhsa.gov/find-help/national-helpline

Project Nurture (Oregon model)

Replication resources & implementation guides available

projectnurture.org

MOMs+ (Maternal Overdose Matters)

Colorado quality improvement initiative with resources/tools for birthing hospitals and clinicians

momsplus.us

No One Recovers Alone.

Recovery is possible.
With the right support, every mother deserves the chance to heal — and to thrive.

Questions & Discussion

Presented at the KY Overdose Prevention Summit

Thank you for your commitment to maternal recovery and health equity.