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Postpartum Dyad Care with Maternal Substance Use-OB

Dyad care in context of SUD

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Disclosures

No relevant disclosures

Birth with SUD

Imagine giving birth again. Remember how difficult it was with a sometimes-unhappy baby, the challenge of latching a hungry baby, the vast lack of sleep, all in the context of engorgement and the natural roller coaster of emotions and shifting hormones.

But now add in:

- The worst flu ever (opioid WD) or overwhelming medical sedation (stimulant WD)
- A system or providers and workers who don't trust you, and think you might be using every time you act differently
- The reality that the government may take your newborn from you
- A partner who is struggling with their own use, being less present as a result
- Houselessness
- The possibility of being forced into an unfamiliar residential program where you may have not enough help, and you will need to do their treatment program during the day while caring for your baby night and day
- The sudden need to face your PTSD, depression, severe anxiety, or trauma without the substances that have helped you survive through that
- Being told that you shouldn't breastfeed, or you should pump and dump, when breastfeeding may be incredibly important to you
- Feeling like your newborn's withdrawal is your fault

Objectives

- Learn best practices for maternal and newborn care in the context of SUD, with special focus on dyad
- Maternal care: screening for SUD, pain management, MOUD
- Newborn care: NOWS and ESC
- Dyad care: lactation, setting of care, breastfeeding, support team, documentation and peer role
- Dyad discharge plans

General concepts when meeting patients with SUD

- Welcome patients (hospital setting is scary)
- Universal verbal screening with appropriate tool
- Written consent for UDS
- Support (peer, friends, family, etc). PEERS!!!
- Build trust (transparency; trauma informed care, for example discuss NOWS management ahead of time; pain management)
- Ask about breastfeeding goals (and understand your hospitals guidelines)
- Safety of SUD discussion (if others involved)
- Check in re partner (how can we help?)
- Useful approach: ask permission, normalize, avoid stigma/judgment
- Understand: This hospital stay will likely be the best chance for dyad to remain together and for your parent to stop using (if that is their goal)

Screening

- ACOG recommends universal verbal screening
- 5 P's is probably most complete screening tool that has been validated in pregnancy (ex: 5 P's) 80-88% sensitive.
- Advantage of 5 P's: creates the possibility of a foundation of respect and understanding a person's context, builds trust
- How is this different from just walking into a room with a positive drug test?

Intrapartum care

OUD:

- Epidurals do work. Fentanyl 100 mcg doesn’t
- High dose opioids might help. But we are generally fearful of providing the dose that will help treat their pain
- For opioid withdrawal in labor- don’t fear long-acting opioids, may even help with NOWS

StUD:

- Anticipate withdrawal and 36-hour window of somnolence
- Can we avoid delivery before that time?

Pain Management Postpartum

- Vaginal- no changes. Provide (or start) MOUD
- Cesarean- multimodal pain management
  - Continue MOUD but give additional PRN opioids for pain
  - NSAIDs and APAP
  - **Blocks: TAP block vs 24 hr epidural**
  - Topical lidocaine?
  - If necessary: PCA, ketamine?
  - Gabapentin HAS been studied- **not helpful** for PP pain.
  - Not the time to argue with patient about opioid dosages, most patients take what they need

MOUD- medications for opioid use disorder

- The best opportunity to stabilize a dyad
  - Withdrawal management (“detox”) units will not take newborn, and most new parents will not stabilize without their newborn
  - Difficult to get into treatment without “detox unit” or stabilization in hospital
- Methadone or buprenorphine- advantages of both. Buprenorphine probably blocks opioids so more difficult to start post-op. Consider:
  - A) patient goals
  - B) community resources
  - C) type and quantity of opioid
- If pain mgmt necessary, all MOUD options provide better pain control if dosed TID or QID
- It takes 4-6 days (average) to stabilize someone off fentanyl onto MOUD

Buprenorphine

Advantages:

- more easily available, less barriers, less sedation, less respiratory depression

Risks:

- Underpowered to match strength of fentanyl. Max doses still associated with persistent withdrawal symptoms for weeks
- Risk of precipitated withdrawal if started too quickly

Initiation:

- Microdose vs macrodose- generally we microdose over several days
- Methadone/opioids to get them through microdosing
- Will need more support for ongoing withdrawal symptoms (ie safe family, residential treatment, sober living, more adjunct medications)

Lock box: safety for others at home

Methadone

Advantages:

- Can match power of fentanyl effectively BUT needs gradual titration

Risks:

- More sedation, respiratory depression, drug interactions, cardiac risks

Initiation:

- Consider rapid initiation protocols
- Add additional opioids and adjuncts if still symptomatic
- Dose BID. This honors faster metabolism in pregnancy and postpartum

Discharge:

- Take outs with 72-hour rule (hard to wait in line at OTP clinic first day home)
- Care with sedating medications
- Ensure follow up
- EKG

NOWS

Newborns withdraw from opioids if extensive in-utero exposure from all opioids

Eat/Sleep/Console is the model of care definitively associated with shorter length of stay yet with equal outcomes, but it requires:

- Presence of actively supportive big humans (family/friends/volunteers/hospital workers at times). Ideally newborns are rooming together with families
- Attention to environment (quiet, dark)
- Attention to nutrition
- PRN dosing opioids when necessary
- Ability to feed using NG tube if necessary

Dyad Care

- Length of stay
- Location of stay
- Breastfeeding
- It takes a village
- DHS/CPS
- Peers
- Notes
- Sedating medications

Length of Stay

- It probably needs to be longer than usual
- Swedish, in WA, has started a project called Compassion, which creates a 5-day postpartum stay for families affected by SUD
- Social workers, peers, CADC, MOUD, lactation team
- It is demonstrating better outcomes, saving money, reducing NICU stays, DHS involvement

Location of Care

- Rooming in, always
- If possible: FBC better than NICU
- Why? In NICU:
  - Parents are no longer the expert for their newborn
  - Parents can leave if they want
  - Less likely that they will give breastmilk
  - Newborns are attached to lines
  - Policies that might exclude family (like illness, somnolence, behavior)
  - Pediatric vs Adult care

Breastfeeding

- Most recent guidelines exclude breast milk until most of the substance has dissipated, but to encourage expression if that is a goal
- Based on length of time we expect substances to remain in human milk; but ignores fact that these infants have been exposed to these substances in utero for much of their lives
- No actual studies looking at harm in this scenario and ignores benefit (to both parts of dyad).
- Consider SDM
- Breast feeding is a human right
- DO NOT base it on UDS results- many substances remain in urine for a long time (fentanyl, cannabis)

It Takes a Village

- Parents are often tired/somnolent after delivery when they come from less supportive environments
- We are not treating partner's SUD (if present)
- NOWS is challenging, and infants often need to be held 24 hrs, which a single person cannot do
- Consider supports:
  - Intrinsic (family, partner, friends)
  - External (PEERS, volunteers, hospital staff)

CPS/DHS

- Ask about family history with DHS (understanding/expectation)
- Consider timing of visit and call; there may be no good time
- Designated team to call DHS (social work team?)
- Transparency: offer to call DHS with family
- Support patient during DHS visits
- Some hospitals are exploring models of a team huddle before making a DHS call- has found it reduces calls without increase in harm



Peers

Hospital Notes

- Our notes can be subpoenaed and presented in court
- They can also be read by our patients
- Be neutral
- Or consider calling out positives when you see them

Safe discharge planning

- Pain management- closer follow up visit (often high doses opioids)
- Peer- not limited to hospital
- 72 hr take-out methadone to reduce need for immediate trip to OTP
- Safety planning with family
- Caution with sedating medications
- Home visiting programs (RNs, support teams)
- Lockboxes for older kids
- Rx naloxone (even when StUD)
- Follow up treatment for SUD

Conundrums

- When a partner is using
- When a patient might be using
- Smoking
- Urine drug screens
- Somnolent patients
- Less safe discharge plans due to lack of available treatment beds

We can dream...



Coordination for residential beds in this era of not enough

Compassion project for Oregon

More volunteers

A step-down unit in hospital or acute withdrawal unit for pregnancy

A place for boarding dogs

Simultaneous treatment of partners



Take home messages

- This is hard, yet important work, and nobody else is better designed to do it
- Birthing parents and newborns do better together
- Think critically about processes we have, not everything is evidence-based, nor are all protocols and policies effective, some may be harmful
- (re)Consider length of stay
- Engage a peer
- Offer MOUD (and naloxone!)

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