# The Family Dyad (plus*): The Postpartum Period, Future Reproductive Care, and Prevention

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# I have no disclosures

# Learning Objectives

- Describe a model of perinatal substance use disorder care centered around the family
- Outline the basic elements of preparing families for delivery and the postpartum period
- Discuss common challenges in the days and weeks after delivery, and strategies for support
- Imagine how advocacy and empowerment translate from the family to the community
- Brainstorming and questions

# “Vanessa is stable on buprenorphine at 28 weeks…”

- Vanessa is a 24 y/o G3P1011 at 28 0/7 wks GA status post buprenorphine induction at 16 wks
- Opioid use began 6 years ago with short-acting oral use, then used intravenously
- Was on methadone in later portion of previous pregnancy 3 years ago, stopped a month after delivery and had recurrence of active use, with periods of up to 5 months of abstinence since then.
- Mother has legal custody of 3 y/o daughter, but they all live together. Hx of IPV w/ daughter’s father, who is no longer involved.
- New partner this pregnancy, respectful relationship

# How can you help Vanessa prepare for delivery and postpartum?

# L&D-related plans:

- Identify a delivery support person
- Educate about doulas
- Discuss labor pain management options
- Plan post-op pain control, especially if operative delivery or tubal ligation anticipated
- Talk through any anticipated challenges related to prior sexual trauma
- Review expected roles of staff in the room

- Vanessa arrives at 37 5/7 wks GA in labor, 6cm/75%/-1, requests epidural. Fetal heart rate tracing is Category 1. Her mom is present for labor support.
- You have agreed to try to come to delivery, and so you are called and en route.
- Vanessa begins to feel pressure about 30 minutes after the epidural is dosed, just as you are arriving.
- She pushes twice for delivery of a vigorous baby Chloe, Apgars 8 and 9, weight 3620g. Baby is placed directly on the maternal abdomen, delayed cord clamping is performed as per Vanessa's wishes, and she also cuts the cord herself, also per her plan. No perineal lacerations are noted, and QBL is 350cc.

# Infant feeding plans

- Discuss by 20 weeks GA
- Promote breastfeeding for appropriate candidates:
  - HIV negative
  - No active polysubstance use
  - Hepatitis C acceptable if no bleeding from nipples
  - Ongoing participation in recovery program
- Talk honestly about your policy on marijuana and breastfeeding
- Document recommendations in chart for hospital providers
- Immediate skin-to-skin at delivery
- Plan to monitor infant if rapid weaning from breastfeeding occurs
- Consistent with guidelines of Academy of Breastfeeding Medicine

- Vanessa did not breastfeed her first due to not being in stable recovery at the time.
- At 20 weeks GA, you counseled Vanessa regarding the benefits of breastfeeding, and she planned to try, though she is still a little worried about her hepatitis C.
- Baby Chloe latches in the delivery room.
- Baby is on the breast hourly or more often after the initial 24 hours, and Vanessa is feeling a little anxious that she is not getting enough to eat, but you provided lots of education about colostrum and mature milk during prenatal visits, so she knows it's normal.

# Neonatal Opioid Withdrawal Syndrome (NOWS) education:

- Your patient treatment agreement/consent includes info re NOWS
- But your patient was in withdrawal when she signed that…
- Discuss NOWS at presentation to prenatal care, early-to-mid third trimester, and again just after delivery

# NOWS

- Babies can be "dependent" or "having withdrawal," but they are NOT "addicted"
- Signs/symptoms:
  - Autonomic dysfunction
  - Irritability
  - Poor feeding
  - Diarrhea
  - Weight loss
  - Seizures
- Historically, 70-95% of neonates of opioid-dependent pregnant patients required pharmacologic treatment of NOWS, but this is changing:
  - Buprenorphine
  - "Rooming in"
  - Breastfeeding
  - Eat, Sleep, Console
  - "PRN" morphine dosing

# Finnegan Scale

| SYSTEMS | SIGNS AND SYMPTOMS | SCORE | AM 2 | 4 | 6 | 8 | 10 | 12 | PM 2 | 4 | 6 | 8 | 10 | 12 | DAILY WT. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CENTRAL NERVOUS SYSTEM DISTURBANCES | High Pitched Cry<br>Continuous High Pitched Cry | 2<br>3 | | | | | | | | | | | | | |
| | Sleeps < 1 Hour After Feeding<br>Sleeps < 2 Hours After Feeding | 3<br>2 | | | | | | | | | | | | | |
| | Hyperactive Moro Reflex<br>Markedly Hyperactive Moro Reflex | 2<br>3 | | | | | | | | | | | | | |
| | Mild Tremors Disturbed<br>Moderate Severe Tremors Disturbed | 2<br>3 | | | | | | | | | | | | | |
| | Mild Tremors Undisturbed<br>Moderate Severe Tremors Undisturbed | 1<br>2 | | | | | | | | | | | | | |
| | Increased Muscle Tone | 2 | | | | | | | | | | | | | |
| | Excoriation (specify area): _____ | 1 | | | | | | | | | | | | | |
| | Myoclonic Jerks | 3 | | | | | | | | | | | | | |
| | Generalized Convulsions | 3 | | | | | | | | | | | | | |
| METABOLIC VASOMOTOR/ RESPIRATORY DISTURBANCES | Sweating | 1 | | | | | | | | | | | | | |
| | Fever < 101°F (39.3°C)<br>Fever > 101°F (39.3°C) | 1<br>2 | | | | | | | | | | | | | |
| | Frequent Yawning (> 3-4 times/interval) | 1 | | | | | | | | | | | | | |
| | Mottling | 1 | | | | | | | | | | | | | |
| | Nasal Stuffiness | 1 | | | | | | | | | | | | | |
| | Sneezing (> 3-4 times/interval) | 1 | | | | | | | | | | | | | |
| | Nasal Flaring | 2 | | | | | | | | | | | | | |
| | Respiratory Rate > 60/min<br>Respiration Rate > 60/min with Retractions | 1<br>2 | | | | | | | | | | | | | |
| GASTROINTESTINAL DISTURBANCES | Excessive Sucking | 1 | | | | | | | | | | | | | |
| | Poor Feeding | 2 | | | | | | | | | | | | | |
| | Regurgitation<br>Projectile Vomiting | 2<br>3 | | | | | | | | | | | | | |
| | Loose Stools<br>Watery Stools | 2<br>3 | | | | | | | | | | | | | |
| SUMMARY | TOTAL SCORE | | | | | | | | | | | | | | |
| | SCORER'S INITIALS | | | | | | | | | | | | | | |
| | STATUS OF THERAPY | | | | | | | | | | | | | | |

Adapted from Finnegan L. Neonatal abstinence syndrome: assessment and pharmacotherapy. Neonatal Therapy: An update, F. F. Rubaltelli and B. Granti, editors. Elsevier Science Publishers B. V. (Biomedical Division). 1986: 122-146

# NOWS

- Non-pharmacologic treatment:
  - Rooming-in
  - Soothing environment
  - Skin-to-skin
  - Breastfeeding
  - Tobacco cessation during pregnancy
- Pharmacologic treatment:
  - Opioid wean is most common, using morphine or methadone
  - Newer concept of single doses given “prn”
  - Adjuncts include clonidine or phenobarbital
- Encourage families to:
  - Look at the Finnegan score with you/RN
  - Keep baby skin-to-skin, as long as caregiver is awake/alert
  - Keep room quiet, lights dim, voices and manner calm

# *MOTHER project* = Maternal Opioid Treatment: Human Experimental Research

- 2005-2008, comparing safety and efficacy of methadone and buprenorphine in pregnancy
- Randomized controlled trial: double-blind, double-dummy, flexible-dosing, parallel groups
- 175 opioid-dependent pregnant women

# MOTHER Project Study Findings--Neonatal

No significant differences between buprenorphine- and methadone-exposed newborns re:

- Percentage requiring tx for NOWS
- Peak withdrawal score
- Birth weight/length/head circumference
- Gestational age at delivery
- Apgars

But…buprenorphine-exposed neonates:

- Required ***89% less morphine*** (mean totals of 1.1 mg vs. 10.4 mg)
- Spent ***43% less time in hospital*** (10.0 vs. 17.5 days)
- Spent ***58% less time receiving morphine*** (4.1 vs. 9.9 days)

# Newer Data about NOWS Management

- Yale study published June 2017 in Pediatrics:  287 infants, non-pharmacologic therapies and simplified approach
- Key elements
  - Rooming-in, low-stimulation environment
  - Increase parent involvement in soothing/calming
  - Encourage breastfeeding
  - Triggers for pharmacologic tx (eat/sleep/console)
    - unable to breastfeed effectively/take at least 1 oz from a bottle
    - unable to sleep for one hour
    - unable to be consoled within 10 minutes
  - If morphine started, given 0.05mg/kg as **one time dose**
- Major findings
  - Decreased length-of-stay from 22 to 6 days
  - Decreased methadone-exposed infants who required tx w/ morphine from 98% to 14%

- Your hospital uses the Finnegan score, and Chloe's scores are mostly in the 2-5 range.
- At around 96 hours (4 days) of age, Chloe is given a score of 8 by a student nurse, however Chloe looks comfortable to Vanessa.  When Vanessa and the student nurse re-score Chloe together an hour later, they agree on 4.

# Contraceptive plans

- Discuss during prenatal care
- Determine an interim plan, even if undecided re longer term use
- Long-acting reversible contraception (LARCs) have high rates of patient satisfaction and low rates of method failure:  copper or progesterone IUD, progesterone implant
- If considering tubal ligation, usually recommended to sign federal consent at 28 weeks (Medicaid requires at least 30 days before the EDD, except 72 hours in case of emergency abdominal delivery). Patients can change their minds anytime before the procedure.
- Some providers avoid estrogen-containing methods during breastfeeding, but evidence is not clear.

- Vanessa used oral contraceptives after her last delivery but became pregnant due to missed pills.
- She has decided to use the etonogestrel implant (Nexplanon), and this is inserted prior to discharge from the hospital

# Postpartum depression

- Screen for depression at presentation to prenatal care
- Some anhedonia initially is common when switching from short-acting opioids to buprenorphine, and usually improves with time.
- If patient has discontinued antidepressant during pregnancy, can plan to restart immediately postpartum, rather than waiting for symptoms.
- Most SSRIs are acceptable in breastfeeding, with preference for sertraline
- Be aware of QT-prolonging agents with methadone
- Plan frequent follow-up visits postpartum for all patients with OUD in pregnancy—usually q 2 weeks
- Coordinate with baby's checkups (or see them both yourself!)

# MOUD management postpartum

- Discourage patients from weaning off MOUD immediately postpartum
- May need to decrease methadone dose slightly in the postpartum period, given decreased metabolism—10mg initially is often enough
- Individuals on MOUD should not co-sleep with their babies
- Make sure patients are informed about plans for postpartum buprenorphine prescribing—transfers to a new program or provider often take weeks to months.

# Discuss fears openly

- What do patients worry about before birth?:
  - Can I handle the pain?  Will anyone care about my pain?
  - Will I be judged?
  - Will DCS take my baby away?
  - Will I relapse?
  - Who will take care of my other children while I am in the hospital with my baby for 5 days?
  - What if my baby needs medicine for withdrawal?
  - Will I be able to protect my baby from the things I've experienced?

# What else can we do to help pregnant and postpartum patients overcome barriers?

- Comprehensive care provided at one site is cost-effective and produces better outcomes for both the birthing parent and child
- Screen early and often for co-morbid conditions
  - Depression, anxiety, and other mental health disorders
  - Intimate partner violence and abuse
  - Psychosocial support system
- Encourage partner and support-person involvement in prenatal care and addiction treatment

- Vanessa has been seeing you for her buprenorphine management and primary care and bringing Chloe to you for pediatric care.
- A month after her delivery, Vanessa's partner schedules an appointment with you to discuss MOUD, and then starts buprenorphine.
- At 18 months postpartum, Vanessa feels ready to wean Chloe and start treatment for hepatitis C , which the pharmD who comes to your clinic weekly provides.

# Features of a Multidisciplinary, Longitudinal, Family-Centered Approach

- Prenatal visits at primary care clinic locations
- Maternal Fetal Medicine and Psychiatry consultation available
- Substance use disorder counseling on-site
- Buprenorphine management for pregnant patient (or coordination of care with methadone clinic) and partner or support person, if desired
- Postpartum services, including contraception management, with emphasis on LARCs
- Ongoing primary care for adults and children, including developmental support, MOUD management, hepatitis C treatment, etc.

# Circle of Recovery for Families

***Team-Based Care for Families Affected by Substance Use Disorder During and After Pregnancy***

A new pregnancy can be an exciting time filled with new possibilities. It may also bring up questions or worries for moms and their families.

Receiving care during pregnancy is important for the health of mom and baby. When a woman is living with an opioid or other substance use disorder, special care can help her deliver a healthy baby and achieve better personal health.

Eskenazi Health Circle of Recovery for Families provides a family-centered approach to prenatal, primary and substance-related care. Services are ongoing throughout pregnancy and beyond, building long-term relationships between families and their health care providers that are based on respect and compassion.

**Services include:**

- Prenatal and postpartum care
- Medication for opioid use disorder (buprenorphine [Suboxone/Subutex] or methadone)
- Primary care and substance-related care
- Pediatric care for baby and siblings
- Counseling for a woman and her partner including treatment for depression, anxiety, PTSD and other mental health conditions

To make an appointment or to learn more about this program, please call Eskenazi Health Connections at 317.880.5950.

ESKENAZI HEALTH

www.EskenaziHealth.edu

# How can we create an integrated network of care?

- Break down silos:  nurses, midwives, advanced practice providers, family physicians, OBs, MFMs, pediatricians, psychiatrists, pharmacists, social workers, therapists, peer recovery coaches, community outreach workers, etc.
- Educate professionals, communities, and families to decrease stigma
- Develop local expertise that ensures all patients have access
- Provide mentorship and support for those developing new services across the state
- Advocate for adequate funding
- Fight mass incarceration, overt and insidious racism, institutionalized sexism, and poverty
- As we lift them up, pregnant and postpartum patients and their families become part of the team for advocacy and change

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