Plans of Safe Care

Case Scenario 1

Panel Discussion *(4 minutes per panelist)*	
Maternity Care Provider: Daisy Goodman, DNP, MPH, CNM, CARN-AP Dartmouth College and Dartmouth-Hitchcock Medical Center	**How would you approach discussing this woman's concerns about neonatal opioid withdrawal?** ✓ Buprenorphine is a safe and effective medication for opioid use disorder during pregnancy. ✓ Prenatal exposure to buprenorphine can be associated with neonatal opioid withdrawal. ✓ Most of the time, this withdrawal can be managed through supportive measures, including skin to skin contact, breastfeeding, a quiet environment, without needing medication. ✓ Although more research is needed, exposure to buprenorphine prenatally does not appear to cause long term problems for babies or older children. ✓ The best way to support the health of her baby is to have a healthy pregnancy. Therefore, it is essential to treat her OUD effectively. ✓ Her history of relapse when she stopped MAT in the past is concerning. It is probably safer for her to remain on buprenorphine. We also do not recommend tapering off this medication during pregnancy, including in the first trimester. **How would you discuss her concerns regarding reporting to DCYF and our state's Plan of Safe Care requirements using a supportive and strength-based approach?** ✓ She is in long term recovery and simply having a remote history of substance use is not grounds for reporting to DCYF. ✓ Because she is on a medication which can cause withdrawal symptoms in her newborn, a Plan of Safe Care (POSC) is required per State and Federal law. ✓ The POSC is not equivalent to a mandated report. It is designed to help identify whether there are areas where she would benefit from additional support. ✓ Every hospital has a slightly different approach to mandated reporting and the POSC, therefore it is important to describe what the local policies are.

Social Worker: Lindsey Flynn, MSW Wentworth-Douglass	**How would you approach discussing the Plan of Safe Care with this patient during her first prenatal visit?** ✓ Identify purpose • A collection of resources, supports, strengths • Assists in identifying areas where mom/family could have more supports • Develop it throughout her prenatal care, if possible • Help identify follow up providers: pediatrician, home visiting, etc. • Encourage mom to own her document; foster empowerment **What supports would you offer her during the pregnancy? During the birth hospitalization?** During Pregnancy: ✓ Home visiting program to help prepare (i.e. Healthy Families America) ✓ Connection with further substance misuse resources – recovery coach; recovery centers; support groups ✓ Connecting them with WIC During Hospitalization: ✓ Early Intervention/Early Head Start referrals ✓ Home visiting referral, if not already connected ✓ Identifying supplies they still need for infant – Sound machine, especially! ✓ Setting up appointments for follow up ✓ Insurance/birth certificate information ✓ Support to family ✓ Very important: support to mom! • She's doing the right thing for herself and infant! • Encourage her to stay in MAR/MAT • Support around guilt/fear • Difficulty in different periods of 5 day stay • Encourage self-care • Education about post-partum depression/anxiety

Medication Assisted Treatment Provider: Molly Rossignol, DO Catholic Medical Center	**How would you approach discussing medication assisted treatment (MAT) with this patient?** The use of buprenorphine in women with an opioid use disorder has been shown to be effective in reducing cravings for opioids and stabilizes areas of the brain involved because of the characteristics of the medication itself. It is able to bind to the receptors, does not produce euphoria, and blocks other opioids if they are used. Thus this medication treats symptoms of opioid dependence and protects the patient from an overdose if she uses another opioid while on it. During Pregnancy: ✓ Pregnancy is a time of excitement, hopes, preparation and often stress. Buprenorphine is a reliable, effective medication that allows the patient to be able to focus on the issues at hand, participate in prenatal care, establish a support network of people and become active in recovery. ✓ Thus far we are aware of very few adverse side effects for the baby while exposed in utero to buprenorphine. We do know that there is about a 40-50% risk of neonatal withdrawal symptoms. We will be watching for these and assisting you and the baby to prevent and treat these if they arise. First Few Months After Pregnancy: ✓ Since having a newborn can be very stressful, being on buprenorphine allows a new mom to continue with stability in terms of avoiding craving, withdrawal and then the desire to seek other illicit opioids. Buprenorphine has little passage into the breast milk and thus we would not discourage breast-feeding. ✓ Postpartum is a time we also look for depression or other mood disorders and it will be important to talk to me and to your other providers about your emotions. These can be normal, but we want to be sure we don't miss something that goes out of bounds of normal and might need clinical intervention. 6 vs. 12 Months After Delivery: ✓ There is no evidence to arbitrarily recommend stopping this medication. In fact, to the contrary, we know people who stay on this medicine stay in treatment longer, have better outcomes and have less risk of relapse. Therefore 6 or 12 months postpartum would not be times to begin talking about discontinuing medication. If the patient is anxious to come of the medicine, I would encourage her to evaluate what her "recovery foundation" has in it. Does she participate in mutual support groups for recovery? Does she see a counselor regularly? Does she have stable housing, a stable support system socially? Has she been able to avoid using all illicit substances throughout her treatment thus far? This may be a time to make a plan to have all this in place. And it may be an opportunity to evaluate what has worked best and why. Often patients realize that the medication has made a big enough difference that it may be risky to stop it but we can revisit that over time. All through treatment for any use disorder I encourage connection with others who are support people ~ possibly those with lived experience, or those who one trusts implicitly, and it is important to build on a 'recovery foundation'. This can consist of a counselor, case manager, IOP 'classmates', mutual support group members, family members, sponsors. These activities also help to heal the areas of the brain affected by addiction. This person will always be at risk for relapse and thus having vigilance in their treatment in an office or in the community is important every day.

Recovery Coach: Cheri Bryer Dartmouth-Hitchcock Medical Center	**How would you support this patient during the pregnancy and birth hospitalization?** ✓ Meet her at the prenatal visit, introduce myself, say that I am in recovery myself and a mom. I would introduce my role as a recovery support person. ✓ Try to support her concerns about being on MAT. ✓ Offer her our Moms in Recovery (MORE) program at Dartmouth-Hitchcock, reviewing what it has to offer. ✓ Answer questions about weaning off MAT, and share that it is a dangerous time to wean off during pregnancy. Would discuss that relapse during pregnancy is much more dangerous than staying on MAT. ✓ Answer any questions she has about NAS, and/or would refer her to the right person if not able to answer questions. ✓ Talk about her concern regarding reporting – explaining that if you are in a MAT program and doing really well, not having any positive urines, then likely would not reported ✓ Check in at prenatal visits, see how she was doing, what supports she has, was she going to meetings, does she have a sponsor, recovery-related resources … ✓ Later in pregnancy, go over parent education "ESC folder", talking about NAS again ✓ In hospital: I would go visit her on the Birthing Pavilion. Ask her if she was having any triggers or cravings, and let her know that meds during birth may trigger these ✓ Talk about the potential for NAS symptoms in baby – tremors, stiff muscle tone, fussiness. Tell her how skin to skin, cuddling, having baby in a darkened room with you helps the baby. Tell her to have her visitors on the first day, as the 3rd to 4th days are the hardest. Keep it as quiet as possible, without a lot of stimulus in room. ✓ Share the eating sleeping consoling diary, saying that they will be the ones primarily seeing if their baby is having problems and can keep track of them. ✓ Parents really like that they have so much involvement in their child's care that makes them feel at ease. ✓ Would try to explain that haven't seen that many babies that have been treated for withdrawal symptoms using the ESC approach.