

PROVIDING OB CARE FOR PATIENTS WITH SUBSTANCE USE DISORDER

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La Crosse

My Journey

- ▣ I burned out
- ▣ I came back
- ▣ I currently take care of 20-25 women with SUD at any one time
 - Opioids (pain pills and heroin users)
 - Methamphetamines
 - Benzodiazepines
- ▣ I have my waiver to prescribe buprenorphine
- ▣ I diagnose and treat a lot of psychiatric disorders
- ▣ Chronic pain and psychiatric patients

Know What Drugs are in Your Community

- ▣ Ask your local public health authorities
- ▣ Ask your police
- ▣ Ask your ER doctors
- ▣ Do a prevalence study
 - Get your hospital's foundation to pay for it
 - Get IRB approval
 - Send the urine down on 100 consecutive patients at the time of the new OB visit. Blind yourself so you don't need to get consents

Prevalence of Use in Pregnancy

First Author	Location	Date	Prevalence
Chasnoff	Florida	1990	14.8
Matti	Minnesota	1993	3.9
Dold	Wisconsin	1996	3.1
Buchi	Utah	2003	4.4
Ebrahim	US	2003	6.4
Chasnoff	Chicago	2005	9
Azadi	New Orleans	2008	19
Stitely	West Virginia	2009	19.2
SAMHSA	US	2013	5.4
Williams	South Africa	2014	8.8
Schauberger	Wisconsin	2014	13
Kreshak	San Diego	2016	14.2

Our Prevalence Study (2012)- LaCrosse, WI

- ▣ 13% of 200 patients (of 211)
 - 6.5% marijuana only
 - 6.5% other drugs
 - ▣ Pain pills
 - ▣ Heroin
 - ▣ Benzodiazepines
 - ▣ Methamphetamines

Goals for Therapy

- ▣ Improve outcomes for mother and newborn
 - Minimize prenatal risks
 - Increase participation in prenatal care
- ▣ Maintenance of custody
- ▣ Continuation in therapy
- ▣ Assist mother to transition to a safe and stable lifestyle- postpartum stabilization
- ▣ Effective family planning

Barriers to Care

- ▣ Housing insecurity
- ▣ Fear of custody loss
- ▣ No show rate
- ▣ Money
- ▣ Poor communications
- ▣ Transportation
- ▣ Food

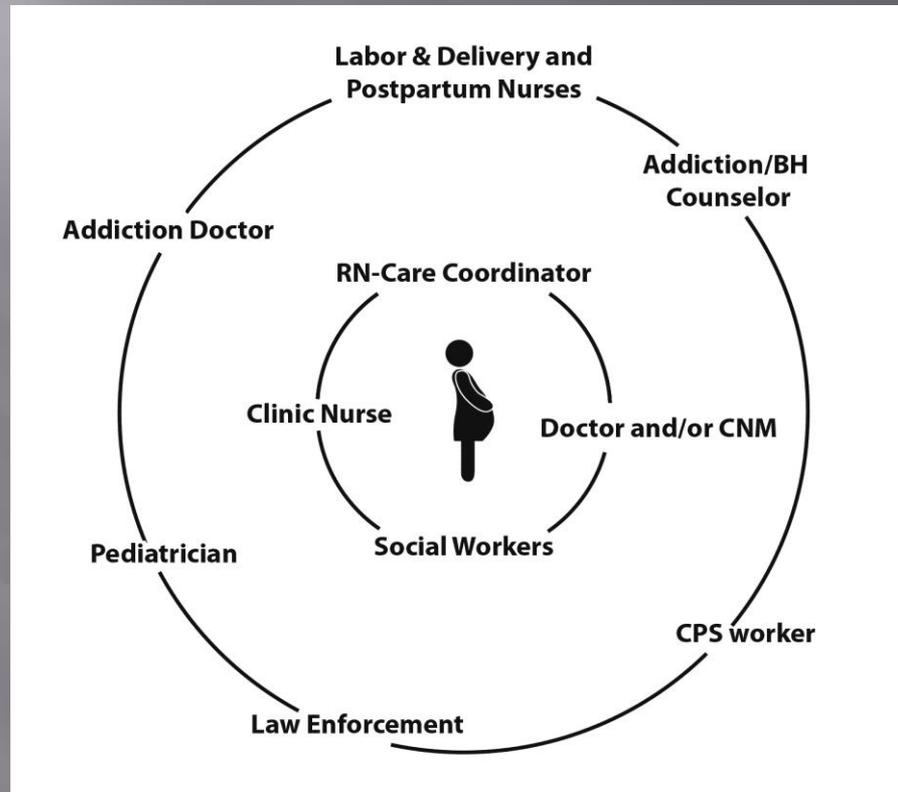
Our Team



How I Take Care of Women With Substance Use Disorder

Psychiatrist

Dentist &
Prostodont
ist



Dietitian

Communit
y College
counselor

Protocol

- Early entry into the system- open access
 - Review & modify medications
- Early Ultrasound
 - Date the pregnancy. 77% of our patients needed it
 - R/O miscarriage
 - Potential positive effects- drug use, IPV, others
- Work with the addiction clinics
 - 2/3rds of my patients are already in treatment
 - Maintain on Opioid Maintenance Therapy
 - Continued AODA counseling is important

32 Week Visit

- ▣ Pediatric Hospitalist consult
 - NAS talk
 - LOS
 - Follow-up
- ▣ Growth ultrasound
- ▣ Find a PCP to provide care
- ▣ Birth Plan
- ▣ Plan for pain medication in labor and delivery

Delivery

Labor and Post-partum Management for Patients on methadone or buprenorphine (OMT)

- Methadone, buprenorphine/naloxone (Suboxone), or buprenorphine (Subutex), can be continued in labor and postpartum. Be aware of the patient's usual dose and schedule and try to maintain. (However, withdrawal is unlikely if the patient is receiving opioids for pain control.)
- Fentanyl may be used for analgesia, but higher and more frequent dosing may be required.
- Do not use Nubain. It is a partial narcotic antagonist which may precipitate withdrawal.
- Epidurals and nitrous oxide are OK.
- Anticipate decreased FHR variability and fewer accelerations.
- Naloxone (Narcan) may be used as a life-saving measure in the mother. Opioid withdrawal seizures may occur if used during infant resuscitation.
- A trauma drug screen should be ordered to confirm the absence of other drugs that may affect management.

Postpartum Management

Vaginal delivery or cesarean section: continue methadone or buprenorphine. Maximize NSAIDs and other comfort measures. Lortab or Percocet may be used while on OMT. Watch the acetaminophen cumulative dose. Don't send them home with large prescriptions. Instead opt for quick follow-up in the clinic in 3-7 days.

Breastfeeding is encouraged, but not always recommended.

The baby will need to stay at least 72 hours. During the time from her discharge to the baby's discharge, the patient should have her own buprenorphine or methadone to take. Don't prescribe it.

Detoxification

- ▣ Acceptable, but not preferred, method of management
- ▣ Many communities don't have methadone clinics or buprenorphine prescribers
- ▣ Risk of miscarriage/stillbirth is no higher
- ▣ Risk of relapse is unacceptably high (15-95%)
- ▣ Risk of drug-related complications is unacceptably higher
- ▣ Use of MAT (methadone/buprenorphine) may enhance continued postpartum treatment, maintenance of custody

Very Few of My Patients:

- ▣ Request abortion
- ▣ Adopt out voluntarily
- ▣ Request permanent sterilization

- ▣ But I can get them to use LARCs

Reality Check for OB Providers

- ▣ The OB care is not particularly difficult
- ▣ High risk, but not a pattern of high risk most obstetricians/family practitioners can't manage
- ▣ Much more time and resource consuming. You can't manage these people by yourself
- ▣ You need to be compassionate
- ▣ You will build your reputation- not only for these patients, but other related disorders
- ▣ If you aren't on salary, you could starve

Why I Do It?

- ▣ Stay relevant. Instead of being marginalized as the old guy who is practicing medicine like it's 1987, I'm recognized for taking care of a high-risk population that frankly no one else wants. Job security.
- ▣ It's a cure for burn-out.
- ▣ This is a service to my profession, my community, and the world at large. I've had a long and successful career, yet, I hope my legacy is my care of women with substance use disorder.

Changes You May Wish to Make in Your Practice

- ▣ Know what drugs are in your community
- ▣ Learn to treat psychiatric comorbidities, especially anxiety
- ▣ Hire a high-risk nurse care coordinator
- ▣ Give some serious thought to making this a focus of your last 10 years of your practice

Questions or Comments?

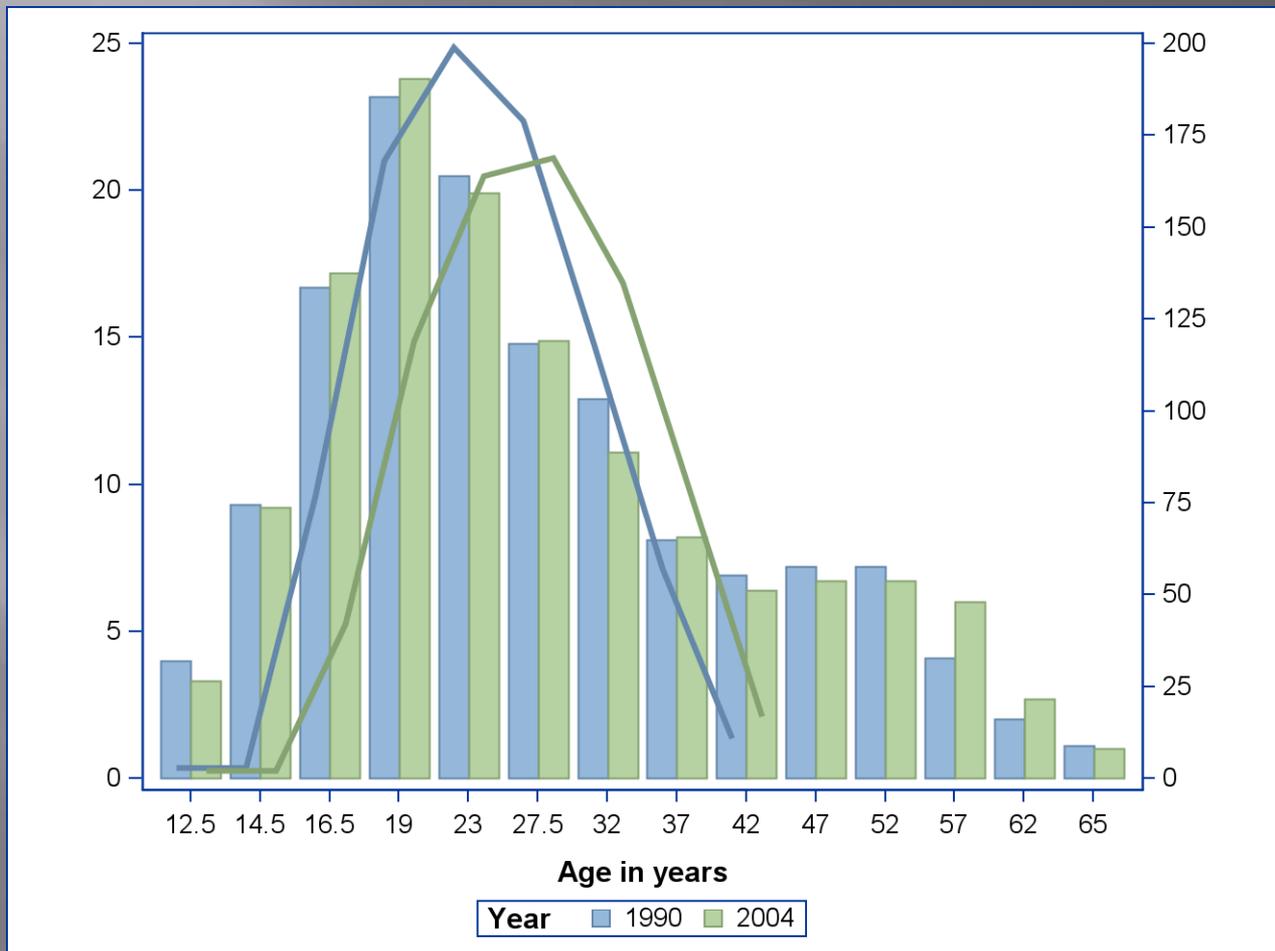
- ▣ Charles.schauburger@gmail.com

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Obstetric Care

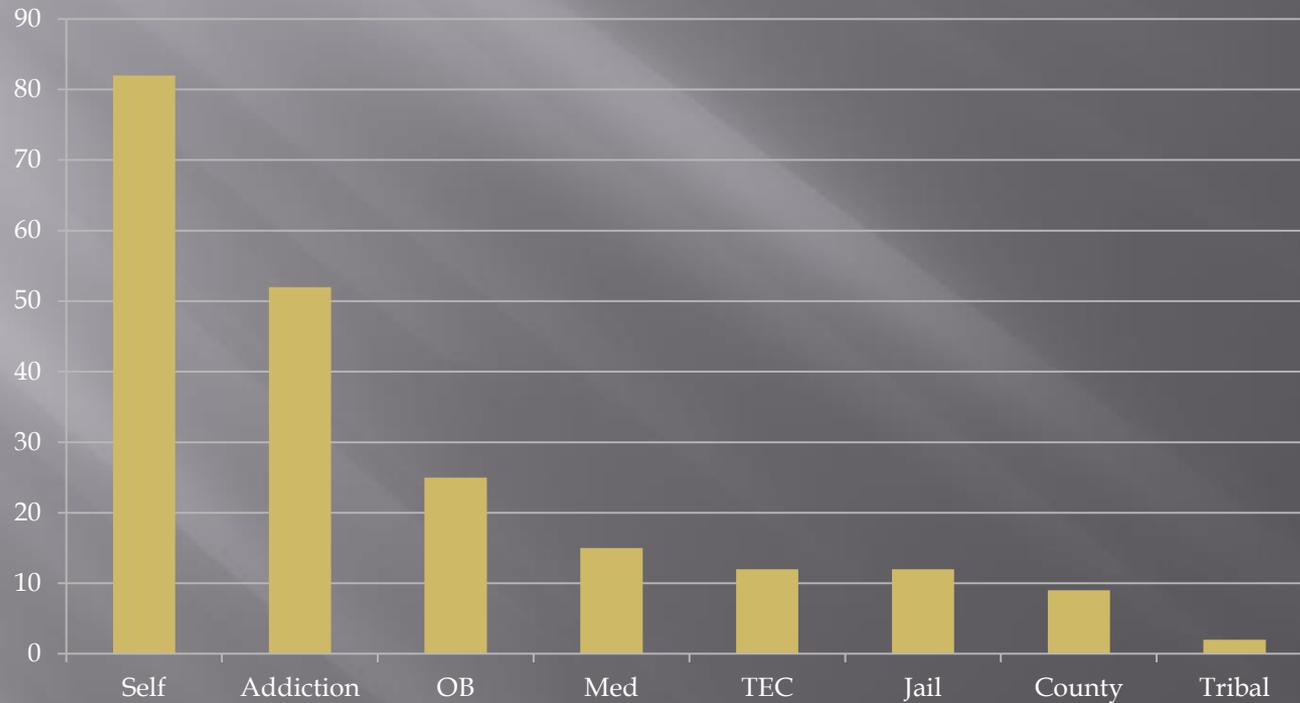
- ▣ Patient numbers: 210 patients
- ▣ Demographics
 - Median Age 25
 - Parity median 1. Mean 1.37
 - Racial
 - ▣ 193 White
 - ▣ 4 African-American
 - ▣ 8 Native American
 - ▣ 5 Asian
 - Payer status
 - ▣ 73% Medicaid
 - ▣ 13% Insurance/health plan
 - ▣ 13% Self-pay

Age of Maximal Drug Use and Pregnancy



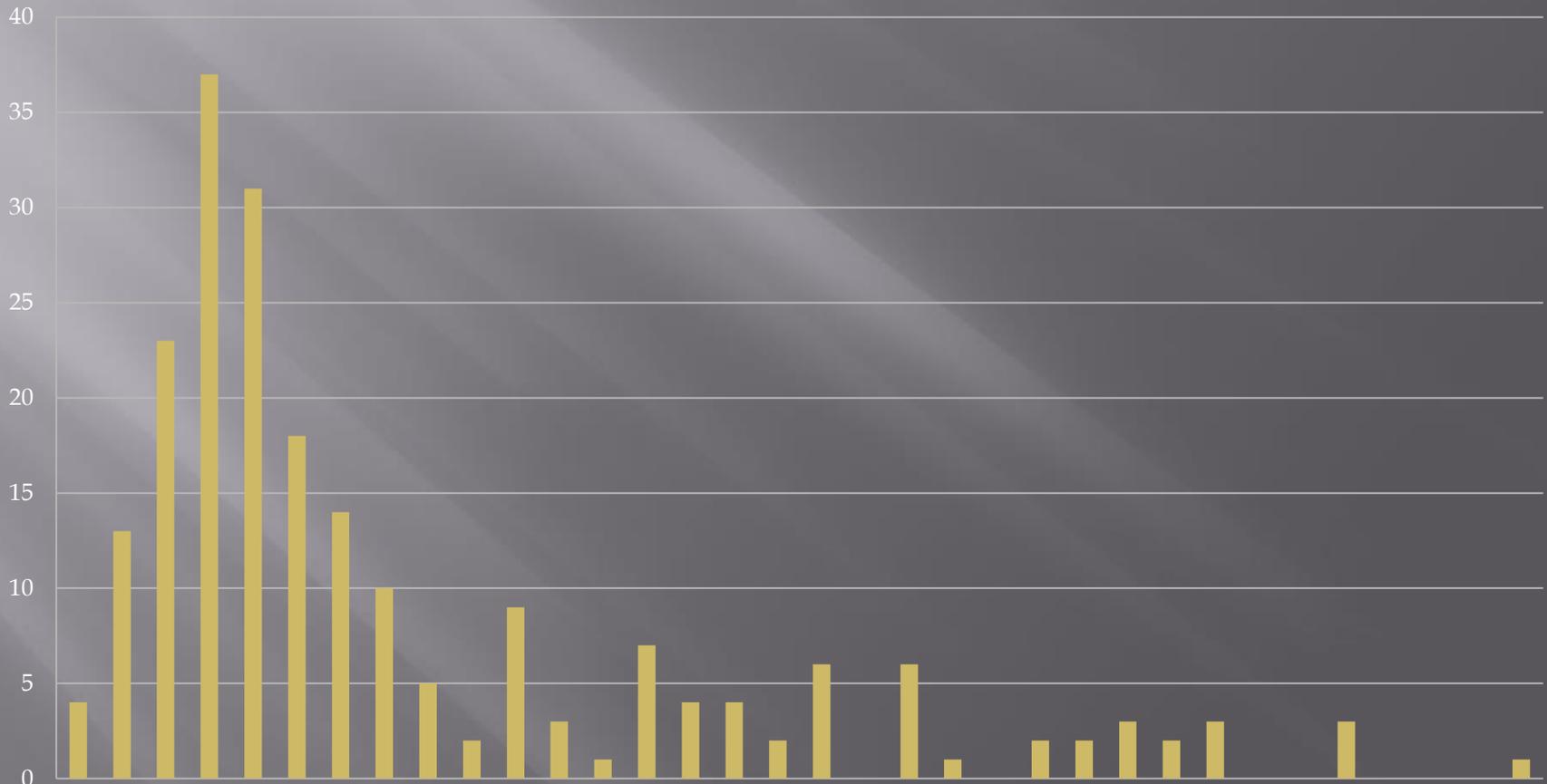
How Patients Get into the System

Source of Referral



Most Patients Begin Care Early

Gestational Age at First Contact



Why Early Care is Important

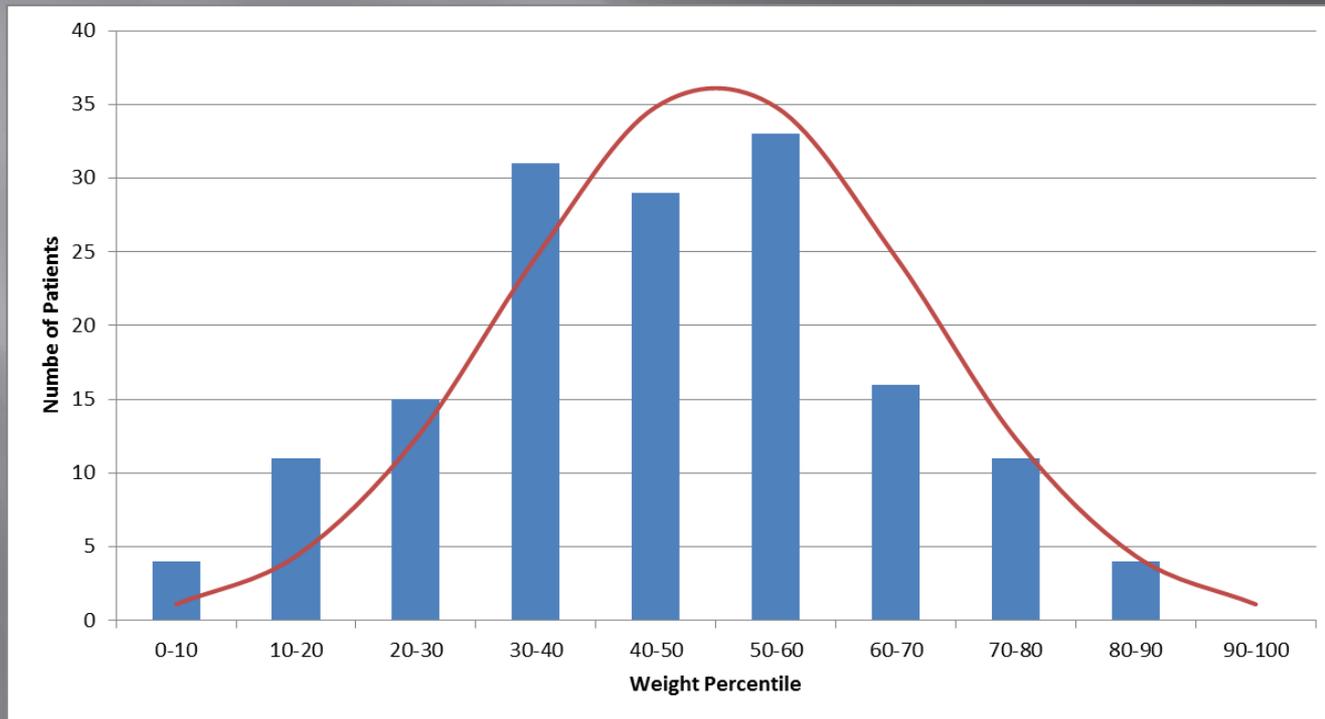
- ▣ Determine safety of medications
- ▣ Dating the pregnancy successfully
 - High risk for PTL, IUGR
 - Manage miscarriages (20% of all pregnancies)
 - Other benefits
 - Our research shows 77% have unreliable dates
- ▣ Initiate Care Coordination
- ▣ Identify and manage barriers to care

Frequent Contact

- ▣ Number of prenatal visits: 1-22, median: 10
- ▣ Number of no-shows and cancelled visits: 852 (31% of all visits)
- ▣ ER visits:
 - N = 124 visits for 68 patients
 - Range: 0-15
- ▣ Urgent Care visits:
 - N = 96 visits for 56 patients
 - Range 0-4

3rd Trimester

- ▣ Pediatric Hospitalist visit- NAS education
- ▣ Ultrasound for growth:



70.3% of our patients are still smoking at time of admission to L & D

Delivery Statistics

- ▣ Prematurity Rate- **14.1%**
 - Gundersen: 10.4% (including this population)
 - Wisconsin 9.4%
 - Almario et al 2009 for women on methadone: 29%
 - Dose-response curve?
- ▣ C-section rate- **24.2%**
- ▣ Birth weight (of those over 37 weeks): **3157g**
 - Gundersen BW >37wks: 3476g

NAS

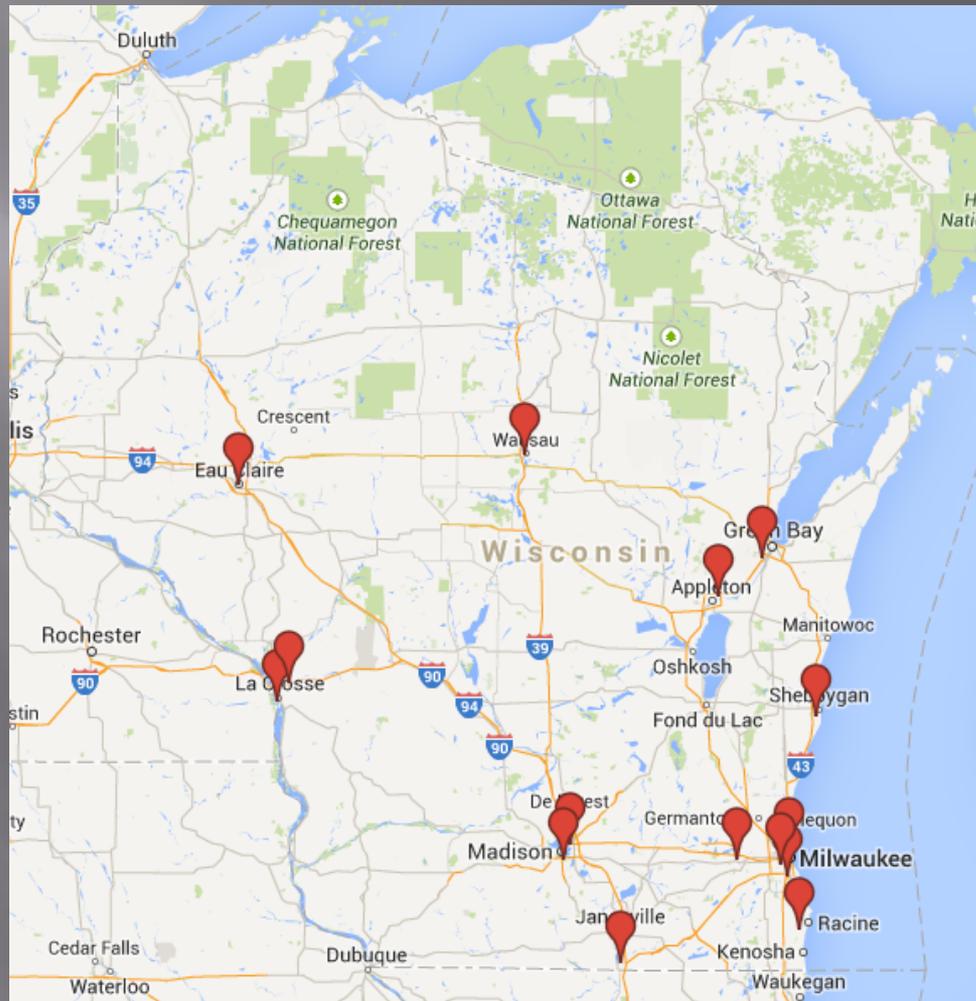
NAS Rates			
Drug	N AS	Population	% NAS
Methadone	14	23	61*
Buprenorphine	12	50	24*
Other	1	36	3*
Chronic pain	2	27	7
			* p <0.0001

GunderKids

A Model of Care for Socially Complex Families



Wisconsin OTPs



Courtesy WAPC
2015

Wisconsin buprenorphine providers and programs

Courtesy, WAPC
2015, SAMHSA

