OB Risk Management Webinar

May 16, 2024

Significantly Increased BMI in Pregnancy

Objectives

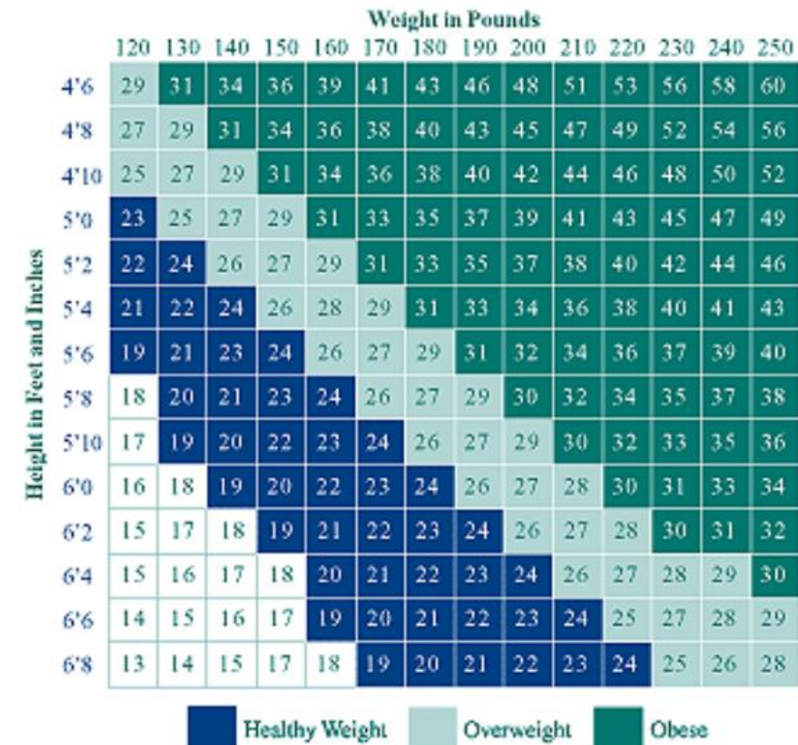
- Review the epidemiology and risks associated with increased BMI in pregnancy.
- Discuss implications for care of the laboring and postpartum patient with increased BMI.
- Apply a team-based, patient-centered approach to mitigate risks associated with increased BMI and provide safe peripartum care.

What is obesity and how do we measure it?

TABLE 12–1. Body Mass Index (BMI) Criteria for Classifying Weight Status in Adults

BMI formulas	
weight (kg) / height (m^2) or weight (lb) × 703 / height (in^2)	
Weight classification	**BMI (kg/m^2)**
Underweight	<18.5
Normal range	18.5 to 24.9
Overweight (preobese)	25.0 to 29.9
Obese	≥30
Obese class I	30.0 to 34.9
Obese class II	35.0 to 39.9
Obese class III	≥40

Adapted from National Heart, Lung, and Blood Institute. (2013). *Managing overweight and obesity in adults: Systematic evidence review from the obesity expert panel, 2013*. Washington, DC: National Institutes of Health; World Health Organization. (2000). *Obesity: Preventing and managing the global epidemic* (WHO Technical Report Series, 894). Geneva, Switzerland: Author. Retrieved from http://www.who.int/nutrition/publications/obesity/WHO_TRS_894/en/



$$BMI = \left\{ \frac{\text{WEIGHT (pounds)}}{\text{HEIGHT (inches)}^2} \right\} \times 703$$

Weight in Pounds

Height in Feet and Inches	120	130	140	150	160	170	180	190	200	210	220	230	240	250
4'6	29	31	34	36	39	41	43	46	48	51	53	56	58	60
4'8	27	29	31	34	36	38	40	43	45	47	49	52	54	56
4'10	25	27	29	31	34	36	38	40	42	44	46	48	50	52
5'0	23	25	27	29	31	33	35	37	39	41	43	45	47	49
5'2	22	24	26	27	29	31	33	35	37	38	40	42	44	46
5'4	21	22	24	26	28	29	31	33	34	36	38	40	41	43
5'6	19	21	23	24	26	27	29	31	32	34	36	37	39	40
5'8	18	20	21	23	24	26	27	29	30	32	34	35	37	38
5'10	17	19	20	22	23	24	26	27	29	30	32	33	35	36
6'0	16	18	19	20	22	23	24	26	27	28	30	31	33	34
6'2	15	17	18	19	21	22	23	24	26	27	28	30	31	32
6'4	15	16	17	18	20	21	22	23	24	26	27	28	29	30
6'6	14	15	16	17	19	20	21	22	23	24	25	27	28	29
6'8	13	14	15	17	18	19	20	21	22	23	24	25	26	28

Adverse Life Experiences

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5322988/

- https://developingchild.harvard.edu/media-coverage/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean/

Weight Bias

- Refers to negative stereotypes towards individuals with obesity or excess weight that leads to discrimination.
- When people experience weight stigma or discrimination, they are at higher risk for depression, anxiety, low self-esteem, and substance abuse.

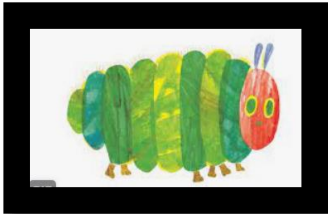
Identifying Bias

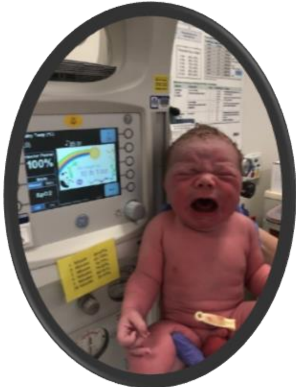
- Have you ever thought to yourself, this patient is:
  - Non-compliant
  - Dishonest
  - Lazy
  - Lacking self-control
  - Uneducated
- How do I feel when I work with patients of different body sizes?

Patient Perspective

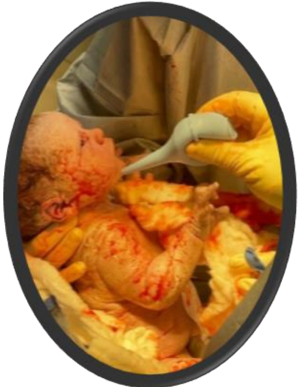
- Research indicates that 46 percent of women affected by obesity reported that small gowns, narrow exam tables and inappropriately sized medical equipment were barriers to receiving healthcare.
- In addition, 35 percent reported embarrassment about being weighed as a barrier to care.

Another Patient Perspective





40.0 weeks 10 lbs 1 oz



37.1 weeks 7 lbs 7 oz

Why does it matter that my pregnant patient is obese?

- Pregnancy can exacerbate obesity-related comorbidities as well as result in the development of additional maternal complications during pregnancy, labor, and birth (ACOG, 2015).
- Maternal morbidity and mortality increase with increasing BMI.

What does obesity put a pregnant person at higher risk for?

DISPLAY 12–1

Risks Associated with Maternal Obesity during Pregnancy, Labor, and Birth

Maternal	Fetal and infant
Spontaneous abortion	Congenital anomalies (neural tube defects, cardiovascular anomalies, diaphragmatic hernia, cleft lip and palate, anorectal atresia, hydrocephaly, limb reduction)
Antepartum hospitalization	Intrauterine growth restriction
Hypertensive diseases, both preexisting and gestational, preeclampsia	Prematurity related to medically indicated preterm birth due to maternal complications and comorbidities
Diabetes, both preexisting and gestational	Conditions associated with prematurity (intracranial hemorrhage, respiratory distress, vision, gastrointestinal, and cardiac problems)
Ischemic heart disease	Neonatal macrosomia
Sleep apnea	Fetal death
Multiple pregnancy	Stillbirth
Medically indicated preterm birth	Low Apgar scores
Postterm pregnancy	Birth trauma
Labor and birth abnormalities (labor dystocia, prolonged labor, labor induction and augmentation, unsuccessful vaginal birth after cesarean, fetal compromise, shoulder dystocia, operative vaginal birth, fourth-degree lacerations, postpartum hemorrhage, cesarean birth)	Neonatal acidemia
Labor anesthesia complications (difficult epidural catheter placement, inadvertent dural puncture, failure to establish regional anesthesia, insufficient duration of regional anesthesia, hypotension, postdural headaches)	Neonatal intensive care unit admission
Complications of cesarean birth (increased time from decision to incision, increased time from incision to birth, increased intraoperative time, general anesthesia, failed intubation, aspiration, intraoperative hypotension, increased blood loss, venous thromboembolism, surgical site infection, wound dehiscence)	Neonatal respiratory complications
Infection (urinary tract infection, episiotomy infection, endometritis, wound infection)	Childhood, adolescent, and adult obesity
Increased length of stay	
Breastfeeding difficulties	
Short duration of breastfeeding	
Postpartum maternal rehospitalization	
Maternal death	

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Simpson, 2019

Obesity-Related Peripartum Complications

Problem/Risk	Potential Intervention
Increased respiratory work and myocardial oxygen requirement	Epidural anesthesia, supplemental oxygen, lateral laboring position
Increased risk of general anesthesia	Anesthesia consult prior to 3rd trimester, epidural placement prior to any induction agents
Enhanced risk of PPH	Blood typed and crossed, ligate large subcutaneous vessels, meticulous surgical technique
Enhanced thromboembolic risk	Early postop ambulation, SCDs, Heparin until fully ambulatory
Enhanced risk of shoulder dystocia	Near term sonographic fetal weight, caution with operative delivery
Enhanced risk of infection morbidity	Thorough skin preparation, adequate antimicrobial prophylaxis, avoidance of submandibular incision, meticulous surgical technique, consideration of subcutaneous drain

From Gunatilake, R., & Perlow, J. H. (2011). Obesity and pregnancy: Clinical management of the obese gravida. American Journal of Obstetrics & Gynecology, 204(2), 106–119. doi:10.1016/j.ajog.2010.10.002.

Simpson, 2019

Anesthesia Consult

- Prior to 3rd trimester
- Evaluation of past medical history, OSA assessment, airway exam, visualization and palpation of the back, possible US of back
- Outlay risks associated with body habitus
- Explain need for epidural prior to any induction interventions
- Discuss risk/benefit of regional anesthesia over general anesthesia and implications in emergency situations

Obesity-Related Intrapartum Complications

- Women with obesity are more likely to have an induction or augmentation of labor.
- Excessive maternal weight and obesity have a negative effect on uterine contractility and can therefore, increase the length of the labor induction.
- Labor proceeds more slowly as BMI increases, as well as labor lengthens, suggesting that labor management be altered to allow longer time for these differences.

Simpson, 2019

Obesity-Related Intrapartum Complications

- Higher rate of C-section
- Increased risk of bleeding during C-section
- Increased risk of hypoxia
  - Olerich et al., 2022
- Increased risk of failed epidural (12-17%)
  - Taylor, Dominguez, & Habib, 2019

Nursing Interventions

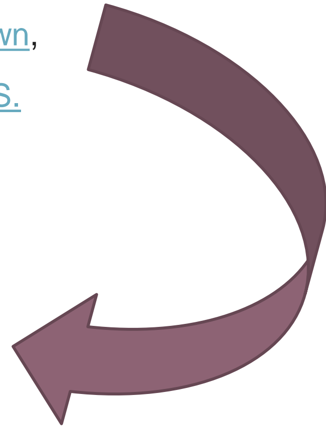
- EFM
  - Have the provider US the patient
  - Handheld doppler vs external monitor vs NOVII
- More Staff
  - 1:1 care for hand holding US
  - To position
  - To hold legs while pushing, or consider an alternate push position
  - To complete procedures
- If other risk factors are present, consider a second IV right away
  - May need US guided IV placement or IV team
- Cesarean Section
  - Extra Chlorhexidine, extra towels
- TALK TO YOUR PATIENT

Simpson, 2019

Nursing Interventions: Pitocin

Influence of Maternal Obesity on Labor Induction: A Systematic Review and Meta-Analysis

Jessica A. Ellis, CNM, MSN, Carolyn M. Brown, MLS, AHIP, Brian Barger, PhD, and Nicole S. Carlson, CNM, PhD



High alert medication

Half-life 10-12 min

- Requires 3-4 half lives to get to a steady state

Uterine response usually occurs within 3-5 min after initiation. Within 40-60 min there is a steady-state plasma concentration

90% of women at term will have labor successfully induced with 6mu/min or LESS of oxytocin

Complications

- **Too much Pitocin = irritability, coupling/tripling, tachysystole**
- **PPH**

D/C-14 min to resolve tachysystole

D/C & 500mL bolus-9 min to resolve tachysystole

D/C & Bolus & lateral position-6 min to resolve tachysytole

Nursing Interventions: Cuff Size

- Most common error is inappropriate cuff size
  - Cuff too small-overestimation of blood pressure
  - Cuff too large- small- underestimation of blood pressure
- If in doubt, measure arm
- Appropriate cuff size at least 1.5x length of upper arm circumference. Cuff bladder should encircle 80% of arm circumference

Figure 1: Recommended cuff sizes

Arm circumference (cm)	Cuff size
22–26	Small Adult: 12x22cm
27–34	Adult: 16x30cm
25–44	Large Adult: 16x36cm
45–52	Adult Thigh: 16x42cm

This figure is original content from the Improving Health Care Response to Preeclampsia: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2014; supported by Title V funds. © 2014 California Department of Public Health.

Gabel, 2013

Nursing Interventions: Position Matters

Patient Position

Cuff Size & Cuff Positioning

GE Healthcare,2022

Nursing Interventions: Your Safety

- Keep your own safety in mind
  - Avoid holding legs if you can
  - Know the weight limits of the footrests
  - Roll up blankets to help support
  - Use “Sara Steady” like equipment if you have it and know the weight limits

Nursing Interventions: The Patient's Safety

- Keep her safety in mind
  - Lower Extremity Nerve Injury (LENI)
    - Intrapartum
      - Avoid hyperflexion of the knees and thighs >90 degrees and abduction when using the stirrups
      - If the above is needed, say during a shoulder dystocia, reposition the patient's legs in a neutral position as soon as possible
      - Avoid deep and prolonged pressure from fingertips, especially at lateral knee and posterior thigh areas
    - Postpartum
      - Assess for pain, paresthesia, numbness, weakness or loss of function
      - Implement fall precautions and assist with ambulation

Wisner, 2021

Nursing Interventions: Infection Prevention

- Offer a shower
- If she is ruptured, keep a towel between her legs and change it often
- Educate, educate, educate

Why might it be helpful for these patients to deliver at a higher level of care?

- Bariatric scale
- Bariatric bed with 1,000-lb weight capacity and an expandable frame
- Lift equipment
- A lateral transfer device to assist with transfer after regional anesthesia
- A commode and/or toilet that will support 500+ lb
- Weight limits of room furniture-chairs etc
- OR table with a 1,000-lb capacity, extension devices to increase the width of the table and extra long surgical instruments and retractors.
- Extra staff to help position, hold legs, assist in transfers, hold monitor pieces, etc
- IV access can be difficult
- Extra large gowns, pneumatic compression devices, wheelchairs

Statistics

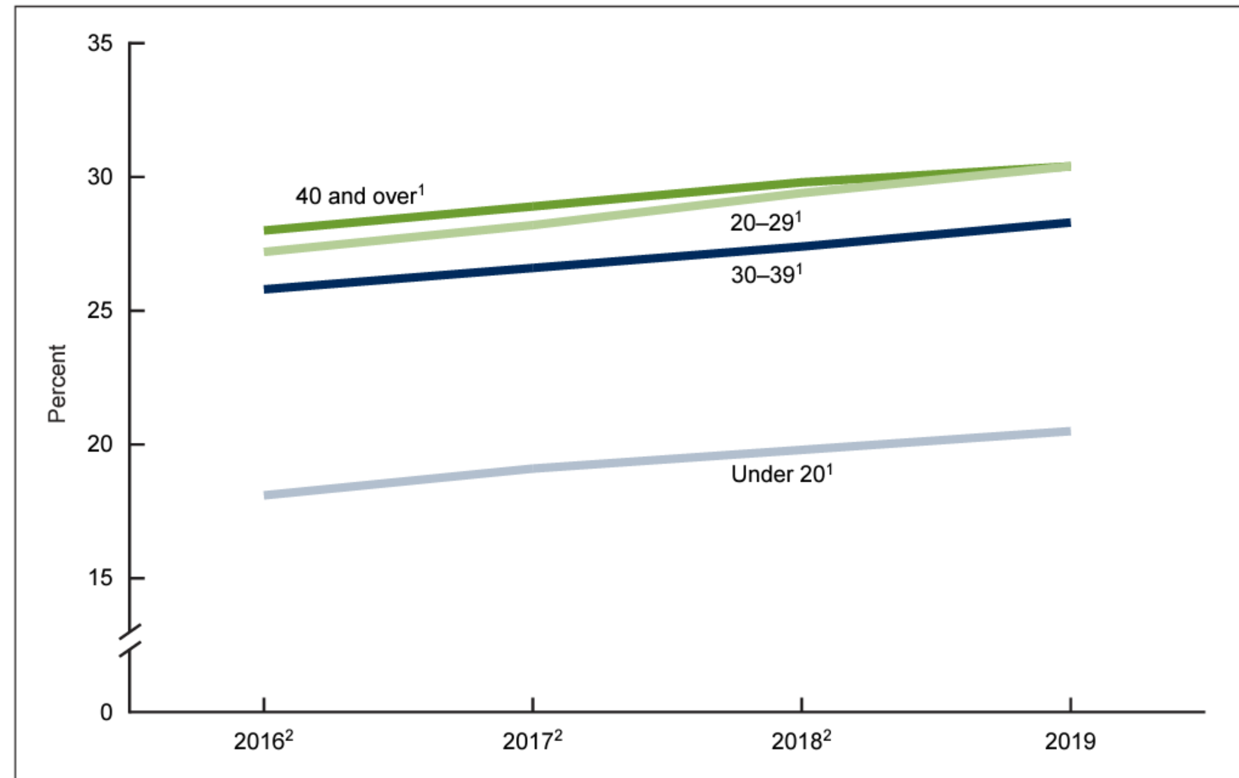
Pre pregnancy obesity rose from 2016 through 2019 for all age groups.

The percentage of women with pre pregnancy obesity rose:

13% for women under age 20
12% for women aged 20–29
10% for women aged 30–39
9% for women aged 40+

NCHS Data Brief

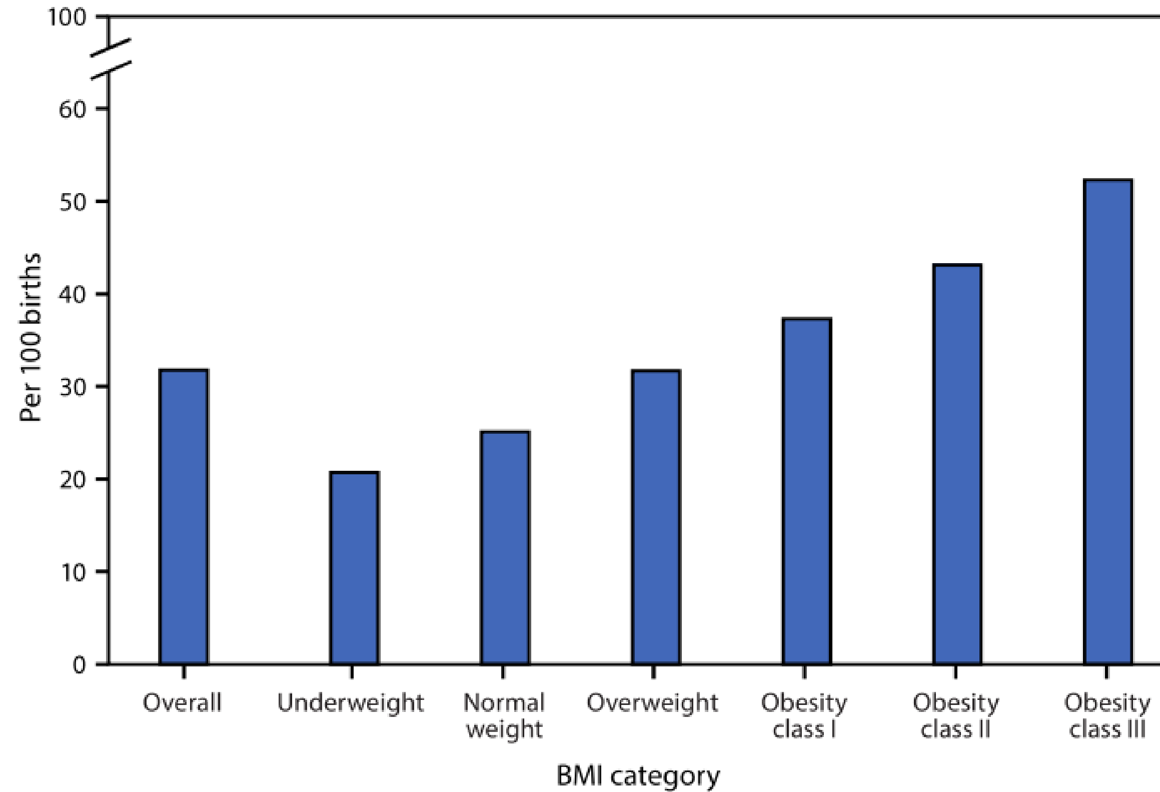
Figure 2. Prepregnancy obesity, by maternal age: United States, 2016–2019



[1]Significant increasing trend from 2016 through 2019 ($p < 0.05$).
[2]Significant difference between all age groups ($p < 0.05$).
NOTES: Obesity is a body mass index of 30.0 or higher. Total includes all race and Hispanic-origin groups. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db392-tables-508.pdf#2.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Natality file.

Statistics

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS



QuickStats, 2020

Cesarean Sections

- Women who are obese and have cesarean birth are at increased risk of significant operative and postoperative complications, including increased blood loss, anesthesia complications, surgical technical difficulties, prolonged time from incision to birth of the baby, and wound infection and healing complications.
  - ACOG, 2015; Gunatilake & Perlow, 2011
- Why might decision to incision times & incision to baby times be longer?
- More antibiotics needed.
- Increased risk of wound breakdown & dehiscence.
  - Depth of incision a major determinate of wound issues
  - Maintain normothermia

Airway Concerns

- Compared with normal-weight women, the parturient with severe obesity is at increased risk of cesarean delivery, emergency cesarean delivery, failed epidural, and difficult intubation (see "Obesity in pregnancy: Complications and maternal management"). In one study of parturients over 300 pounds (136.4 kg), 6 of 17 women who required general anesthesia had difficult intubations, four of which were unanticipated [21].

- The airway can worsen during the course of labor, so patients should be re-examined prior to airway management if significant time has elapsed since the initial airway evaluation. In particular, the size of the tongue and uvula should be noted for women in prolonged labor or who are pre-eclamptic (picture 1).

Airway Concerns

- Always have video laryngoscopy equipment available
- Educate nursing staff on ways they can help facilitate intubation i.e., holding cricoid, helping ventilate, reducing breast mass, positioning patient, providing additional equipment
- Consider use of LMA if unable to intubate or ventilate
- Increase dosing of paralytic, 1 mg/kg actual body weight to provide optimal conditions

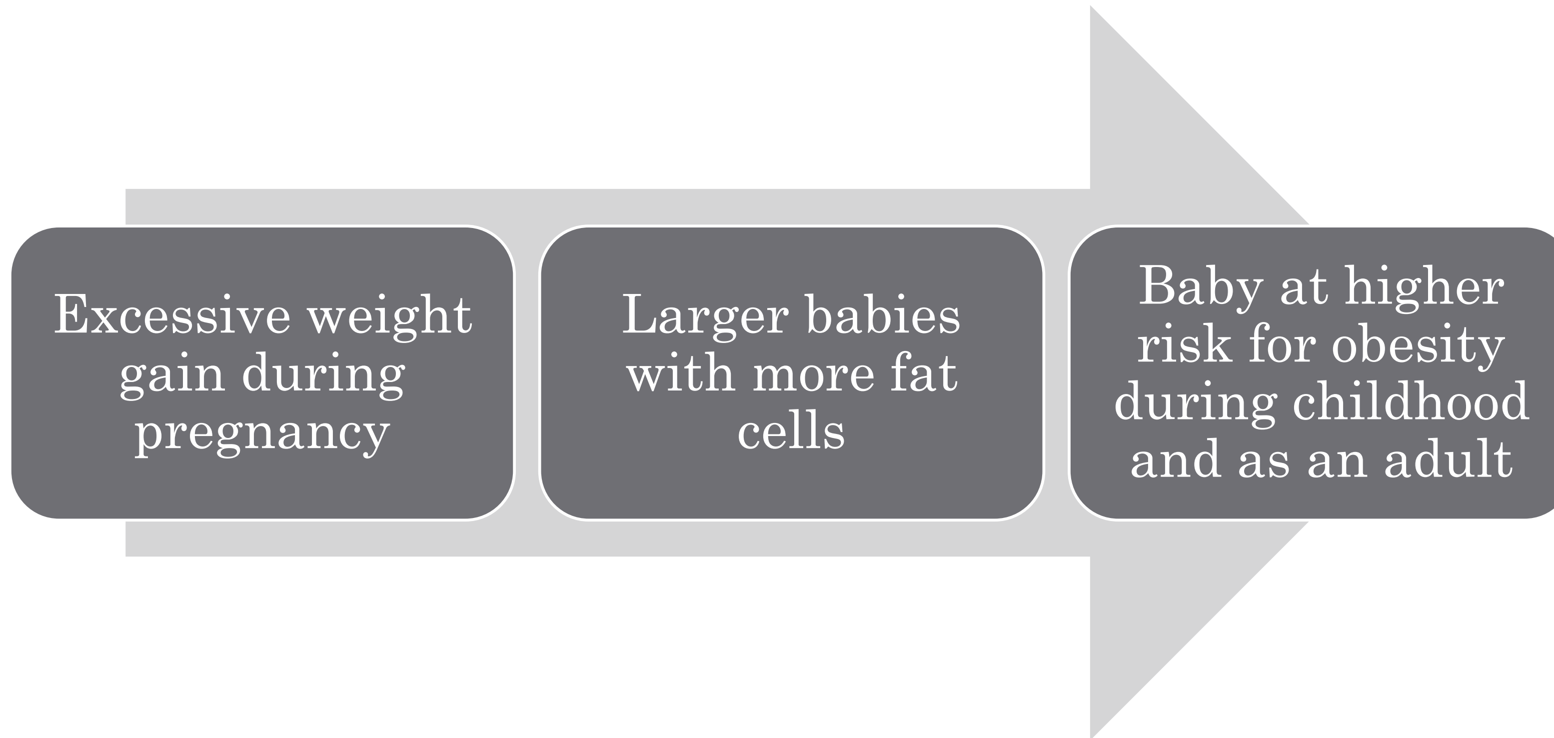
Moral Dilemmas

- The mother has a right to decisions about her care. This includes whose life should be a priority.
- During the beginning of COVID, it was decided that there would be no crash C-sections on COVID + patients.
  - Can/should this case be made in the case of severe morbid obesity?
- Multidisciplinary communication is key to the safe and smooth care of these patients.

Postpartum Care

- Postpartum obese mothers at an increased risk for
    - Respiratory complications: Atelectasis, Pneumonia, Hypoxemia
    - Cardiac complications: Postpartum cardiomyopathy
    - Surgical site infections
    - Venous thromboembolism (VTE)
    - Uterine atony & postpartum hemorrhage
    - Sleep Apnea
        - Close monitoring, awareness of opioids
- Careful assessment of fundus, lochia, and signs of infection
- After cesarean delivery get the patient moving, encourage IS use, take foley out as soon as possible, keep the wound dry.

Effect of Obesity on Newborns



Children born to obese mothers are twice as likely to develop obesity at 2 to 4 years of age.

Simpson, 2019

In Conclusion

- We need to have honest and compassionate conversations with our patients.
- Interdisciplinary communication, especially with anesthesia is vital.
- Patients with an increased BMI are more likely to be induced and more likely to have a cesarean section.
- Change your patient's position often, be patient with monitoring, use good body mechanics, be aware of her safety and know weight restrictions.
- Help decrease postpartum complications by monitoring her bleeding, her respiratory status, and watching for infection.

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Perinatal Mental Health and Substance Use Disorders

Kate Austman, MD, FASAM

Addiction Medicine/FP/OB

Gibson Recovery Optimizing Wellness

Epidemiology in the US

- Cystic Fibrosis: 0.03% (1 in 3200 live births in US)
- Gestational Diabetes: 7%
- Pre-eclampsia: 4%
- Anemia: 5%
- Illicit drug use: 5%

Epidemiology cont.

Perinatal mental health conditions

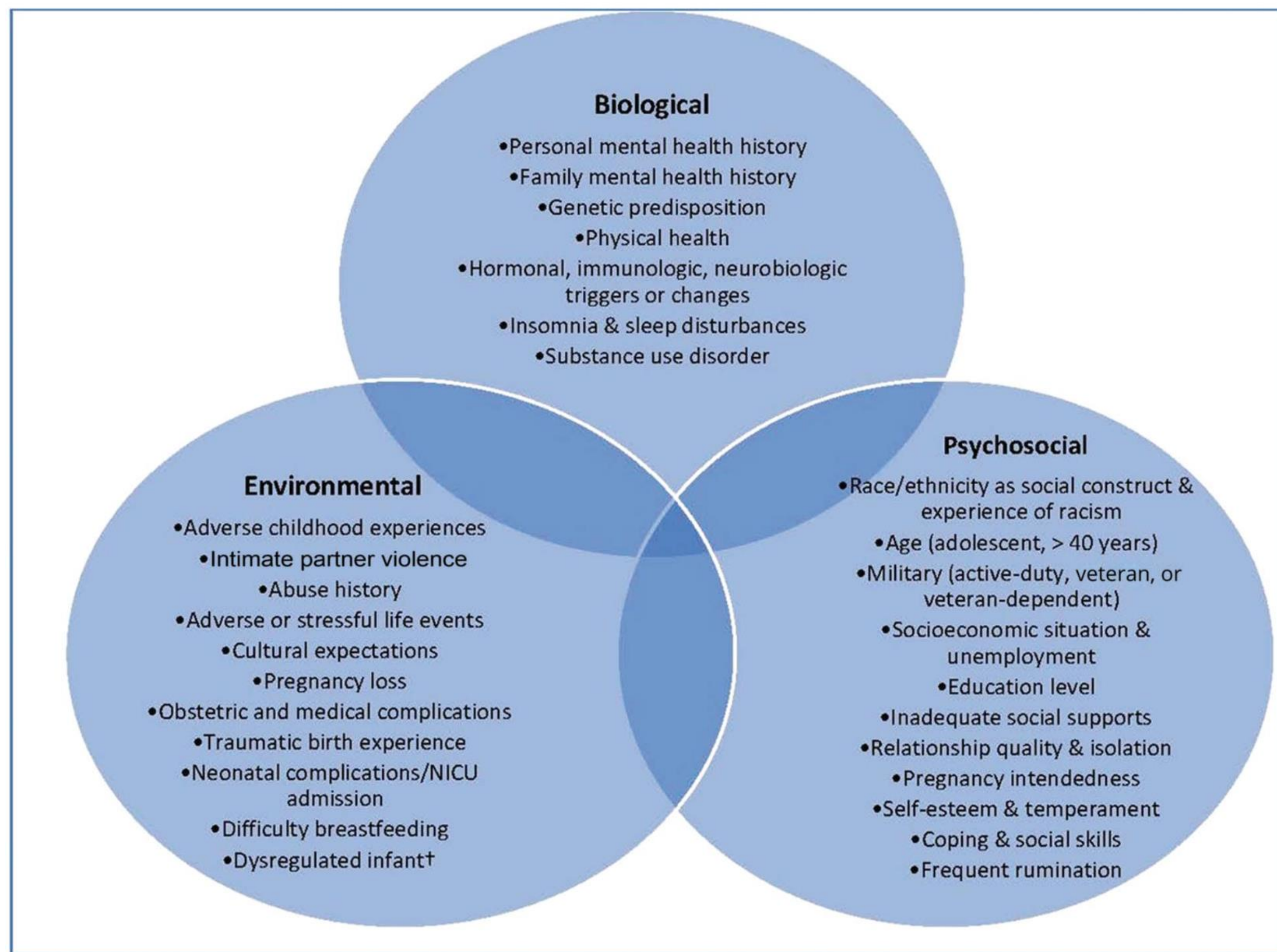
- Affect more than 1 in 5 perinatal individuals
- One of the most common complications of pregnancy and the year after childbirth

ACOG Clinical Practice Guideline June 2023

Perinatal Mental Health

ACOG Clinical Practice Bulletin June 2023

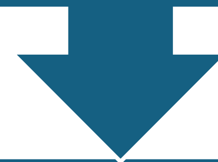
Risk Factors Associated with Perinatal Mental Health Conditions



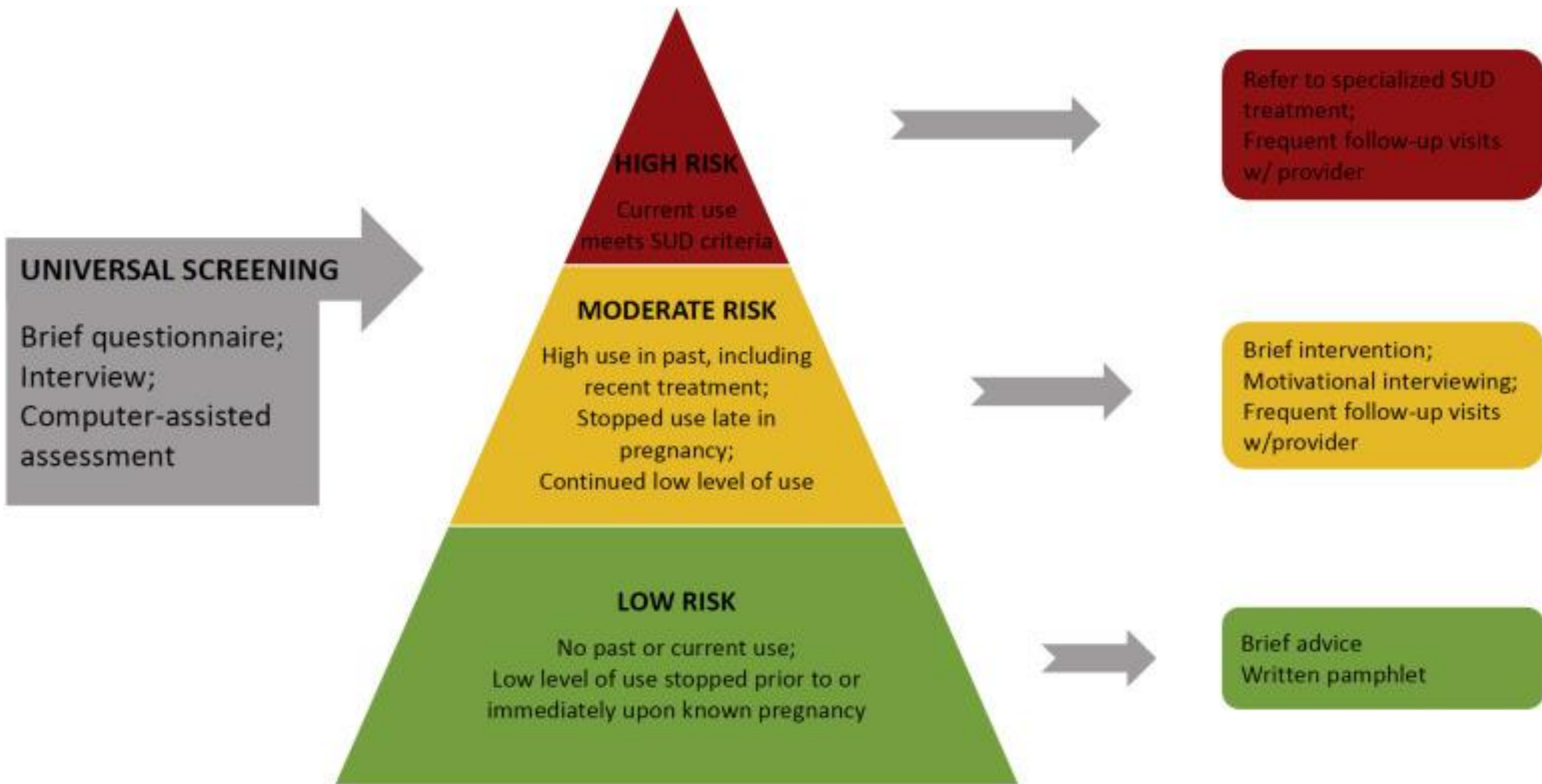
Where can I find SBIRT?

Screening

Brief Intervention

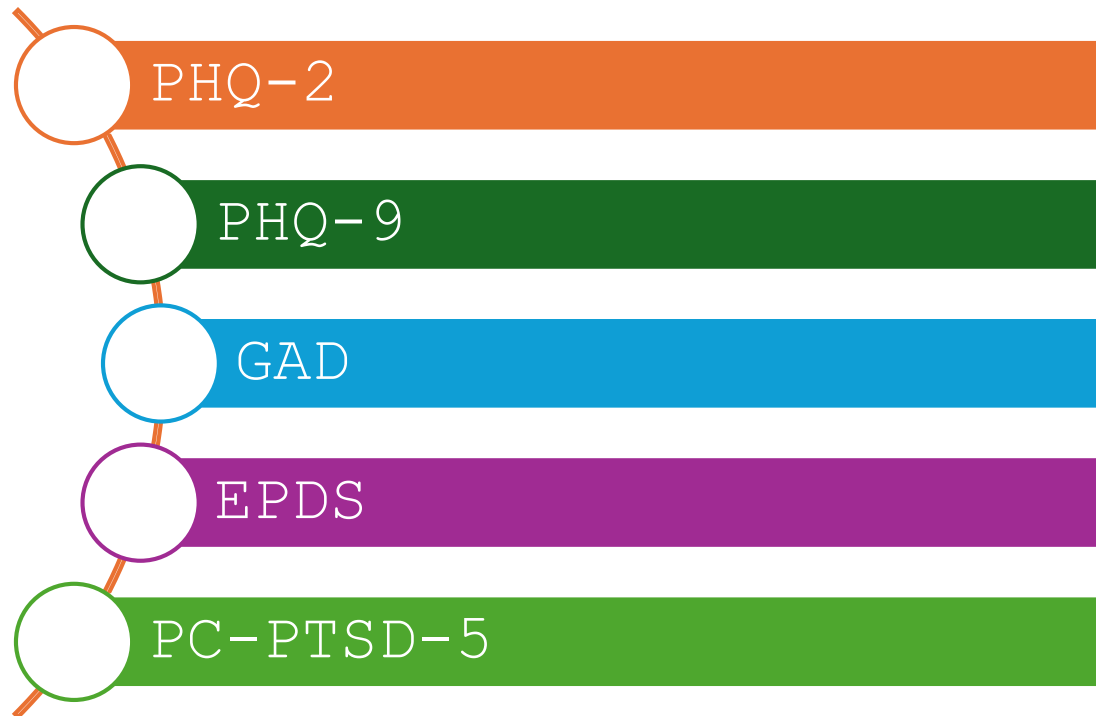


Referral to Treatment



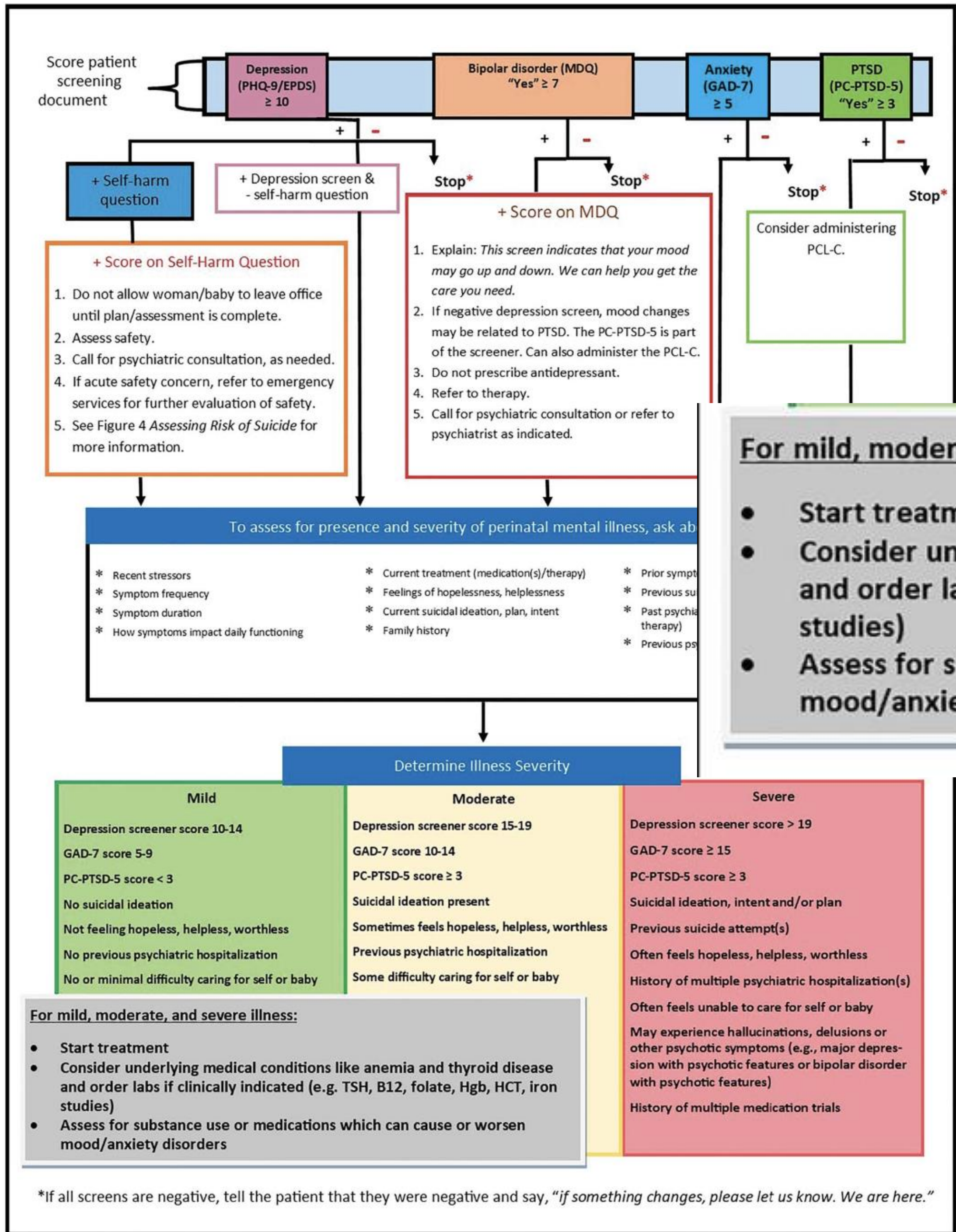
https://sites.education.miami.edu/sbirt/w

Mental Health Screening



Recommedations

- USPSTF: screen every pregnant person for depression with EPDS or PHQ-9; if positive screen for BPD with Mood Disorder Questionnaire
- ACOG: screen with EPDS or PHQ-9
- AAFP: screen with EPDS or PHQ-9
- AAP: screen with EPDS or PHQ-9



For mild, moderate, and severe illness:

- Start treatment
- Consider underlying medical conditions like anemia and thyroid disease and order labs if clinically indicated (e.g. TSH, B12, folate, Hgb, HCT, iron studies)
- Assess for substance use or medications which can cause or worsen mood/anxiety disorders

ACOG Clinical Practice Guideline June 2023

IllinoisDocAssist (866) 986- | Antidepressants-Risks-in-Pr | Perinatal-Antidepressant-Al | SLU Medical Center Library | A register study of the impa | Neonatal Discontinuation Sy

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Answering your child, adolescent, and perinatal mental health questions

Start a Consultation | Access Provider Resources | Schedule an Educational Event | Take a Webinar

Illinois Doc Assist

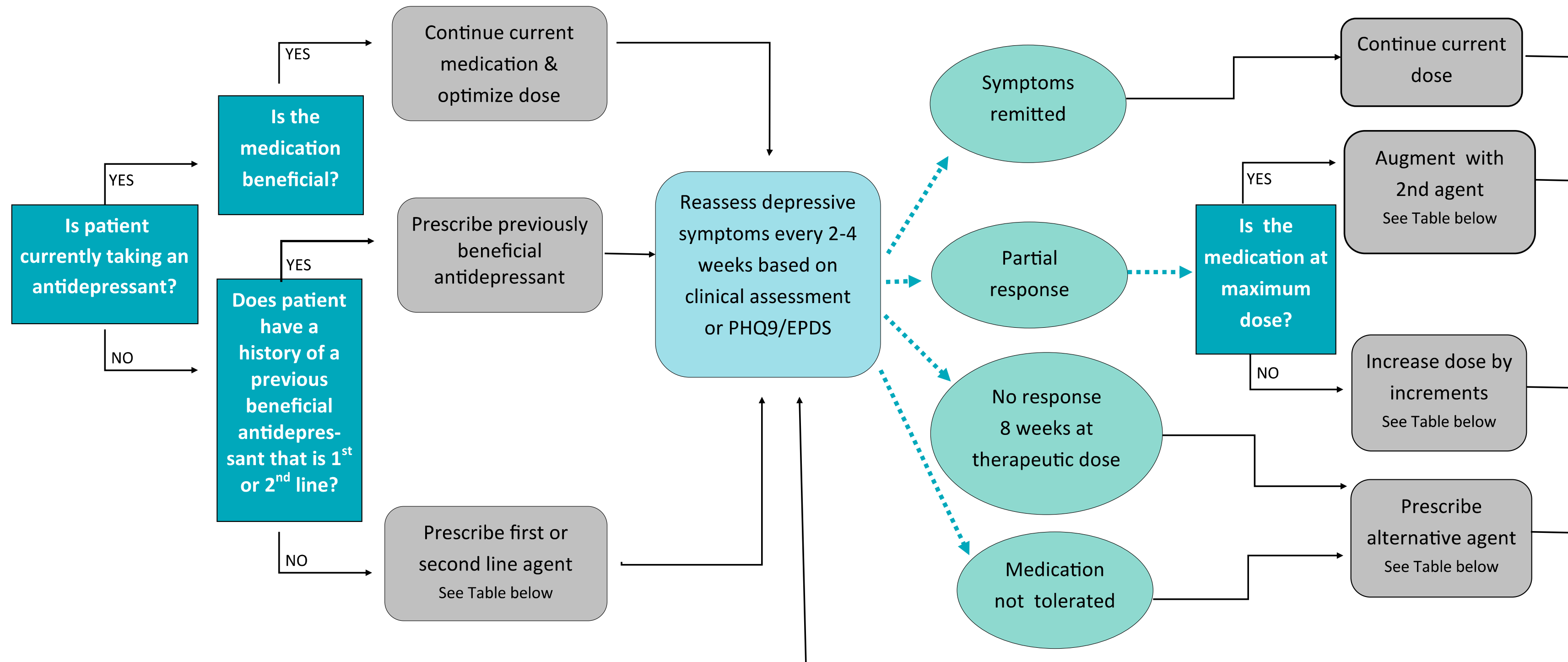
Illinois DocAssist

Call for questions or a consultation

Perinatal Antidepressant Algorithm

This information is produced by the University of Illinois at Chicago (UIC) by Illinois DocAssist as a summary of research on antidepressants in human pregnancy

866-986-2778



First line Treatment			
Sertraline (Zoloft) Start: 25mg x4days Increase by: 25-50mg TR: 50-200mg	Escitalopram (Lexapro) Start: 10mg Increase by: 5-10mg TR: 10-20mg	Citalopram (Celexa) Start: 20mg Increase by 10mg TR: 20-40mg	Fluoxetine (Prozac) Start: 20mg Increase by 10-20mg TR: 20-80mg

Second Line Treatment				
Buproprion XL (Wellbutrin) Start: 150mg Increase by: 150mg TR: 150-450mg	Venlafaxine XR (Effexor) Start: 37.5-75mg Increase by: 37.5-75mg TR: 75-225mg	Duloxetine (Cymbalta) Start: 30-40mg Increase by: 20mg TR: 60-120mg	Mirtazapine (Remeron) Start: 15mg Increase by: 15mg TR: 15-45mg	Paroxetine (Paxil) Start: 20mg Increase by: 10mg TR: 20-60mg

Augmentation Agents	
Buproprion XL (Wellbutrin) 150-450mg	Aripiprazole (Abilify) Start: 2-5mg/ TR: 2-15mg

TR = Treatment range

Clinical Pearls

1. Screen all women with depressive symptoms for a history of bipolar disorder or hypomanic/manic symp-toms. If present, antidepressant monotherapy is NOT recommended. Refer to mental health specialist.
2. To minimize GI side effects, start sertraline at 25mg x 4 days then increase to 50mg daily. If GI symptoms per-sist for >1 week they are unlikely to resolve; consider switching medication.
3. Evidence shows Cognitive Behavioral Therapy and Interpersonal Therapy to be effective for treating peri-natal depression. Consider therapy alone for mild depression, or as an adjunct to medications for moder-ate/severe depression.

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March, 23, 2023

Perinatal Substance Use Disorders

VS

- According to the October 2023 Illinois Maternal Morbidity and Mortality Review Report, substance use disorders are the leading cause of pregnancy associated deaths in Illinois
- Deaths reviewed: 263
- 2018-2020

How to Screen

- ACOG and ASAM, along with other major medical associations recommend that all women should be screened using a validated screening test, and not biomechanical measures
- Normalize screening
- Ask every patient

Screening Tools Validated in Pregnancy

- T-ACE
- TWEAK
- 4 P’s (5 P’s)
- Substance Use Profile-Pregnancy
- AUDIT-C

Screening Tools Not Validated in Pregnancy but still often used

- CAGE
- NIDA
- TAPS

Screening and Assessment Tools Chart

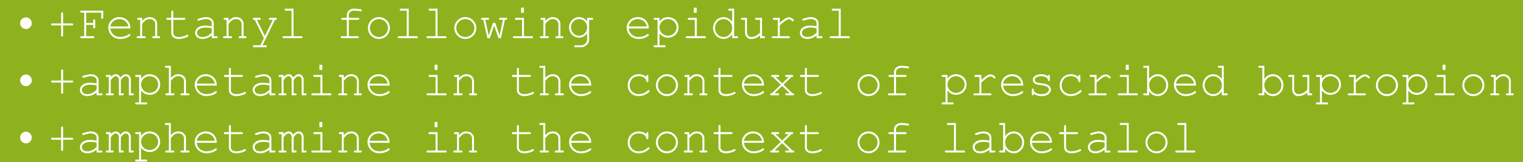
Screening tools

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Opioid Risk Tool – OUD (ORT-OUD) Chart		X	X		X	

Tool	Substance type		Patient age		How tool is administered	
	Alcohol	Drugs	Adults	Adolescents	Self-administered	Clinician-administered
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
CRAFFT	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)* *For use of this tool - please contact Dr. Harvey Skinner*		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version)* *For use of this tool - please contact Dr. Harvey Skinner*		X		X	X	X
NIDA Drug Use Screening Tool (NMASSIST) *(discontinued in favor of TAPS screening above)*	X	X	X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X

Nida.nih.gov

UDS is only a moment in time, it does not determine use disorder


False positives
+Fentanyl following epidural
+amphetamine in the context of prescribed bupropion
+amphetamine in the context of labetalol

False negatives
Do you know if your hospital has POC fentanyl testing?

Why is the test being ordered?

(biochemical) testing should only be ordered for clinical purposes and to guide quality medical care

Often tests are ordered for reasons that are not clinically actionable, but ordered for punitive purposes

The Benefit of Protocols

- Can reduce inequality
- Makes decision making for team members simpler
- Support of birthing patient
- Support of infant

Legal Issues

- APORS form → IDPH
- Positive toxicology of non-prescribed substance → DCFS
- Different responses in different regions
- Illinois does not have laws that outline which infants should receive testing
- Supreme court: must have informed consent or a valid warrant in order to do UDS on pregnant patient (Gottlieb, 2001)

Why would someone who uses drugs want to be pregnant?

Don’t they know they are harming the baby?

Illinois Perinatal Quality Collaborative

ilpqc.org

Home | About | Current Initiatives | Past Initiatives | Events | Perinatal Resources | Contact Us

IL PQC
Illinois Perinatal Quality Collaborative

Get Involved | ILPQC Data System

Making Illinois the Best Place to Give Birth and be Born

Over 95%
Birthing hospitals participating in one or more statewide quality improvement initiatives.

99%
Percent of births covered by hospitals participating in ILPQC initiatives.

100%
Neonatal intensive care units participating in ILPQC initiatives.

2024 ILPQC Face-to-Face OB and Neonatal Meetings

Calling all nurses, providers, staff, and public health professionals: Registration is now OPEN for the ILPQC OB & Neonatal Face-to-Face meetings in Springfield, IL!

helplineil.org/app/home

Get Help Now with MAR NOW (Medication Assisted Recovery) - immediate recovery assistance with opioids or alcohol use.

Call 833-234-6343 or text "HELP" to 833234 Español

GET HELP HELP SOMEONE STAY SAFE STOP OVERDOSE ABOUT PROVIDE

Help is here

If you or a loved one
is struggling with substance
use,
we're here for you.

Call Text Chat

[Illinois Helpline](https://helplineil.org/app/home)

Opioid Use Disorder

Medications for Opioid Use Disorder

Methadone

Buprenorphine

- Suboxone
- Subutex
- Sublocade
- Brixadi

Naltrexone

"Comfort" meds

Tobacco Use Disorder

Offer treatment: varenicline, bupropion, NRT

There is benefit in reducing use

Newborn withdrawal from nicotine can look similar to early opioid withdrawal

Difference is that nicotine withdrawal occurs earlier

Cannabis

- Just because it’s legal, doesn’t make it safe
- Harmful effects to newborn
- May worsen hyperemesis
- May worsen anxiety
- N-acetylcysteine – safe in pregnancy

Alcohol Use Disorder

- No safe amount has been established
- Leading cause of preventable birth defects
- Value in brief intervention and education by health care provider

Stimulants

- Cocaine
- Methamphetamine
- Adderall, Ritalin, etc
- CBT
- Difficult to treat due to acute and chronic withdrawal symptoms
- Adulteration of supply

Neonatal Withdrawal Symptoms

Newborns are not born addicted to a substance

Addiction requires cravings, loss of control, compulsions and adverse consequences

Be thoughtful about documentation

?Finnegan scoring

Eat, Sleep, Console

For longer acting opioids (methadone, fentanyl) monitor baby for 4-7 days

Benefits of Breastfeeding in Substance Exposed Dyads

- Same benefits for breastfeeding as in general population
- Breastfeeding known to reduce the severity of NOWS
  - Decreased pharmacologic treatment
  - Decreased length of stay for infant
- Help mothers bond with their infant, which can reduce stress and support their recover

Harris et al, 2023

Concerns About Breastfeeding in Individuals Actively Using Non-prescribed Substances

- Reduced parental response to infant feeding cues
- Infant substance exposure through breast milk
- Reduced breastfeeding ability
- Potential alterations in neonatal brain development

Harris et al, 2023

Timing of Breastfeeding Initiation

- 2015 ABM guidelines → wait 30-90 days from last use
- 2023 ABM guidelines → it's more and less complicated!
  - Predictive value of continued use post-partum based on 3rd trimester UDT: 36%
  - UDT at delivery has strongest association with ongoing substance use postpartum
  - Most substances eliminated in hours to days (not days to weeks)
  - Women who discontinue use by or during delivery should be supported in breastfeeding

- Rooming-in and skin-to-skin positioning should be encouraged regardless of breastfeeding status

IDHS/SUPR Drug Overdose Prevention Program

About the Drug Overdose Prevention Program (DOPP)

Naloxone is a safe and effective opioid overdose reversal medication that **saves lives**. The Illinois Department of Human Services, Division of Substance Use Prevention and Recovery (IDHS/SUPR) aims to reduce the number of opioid overdoses through the expansion of community-based Overdose Education and Naloxone Distribution (OEND) services. IDHS/SUPR manages the Drug Overdose Prevention Program (DOPP), as legislated in the Substance Use Disorder Act, which allows organizations to order free Narcan (a form of naloxone) through our Access Narcan program to distribute within their communities. These programs are essential to ending the overdose crisis in Illinois by making sure that anybody who may witness an opioid overdose is equipped with naloxone and the knowledge they need to save a life.

All organizations (except pharmacies) that use the Illinois Department of Public Health Naloxone Standing Order must enroll in DOPP. IDHS/SUPR encourages all other organizations to enroll even if they conduct OEND services under their own standing order.

What if I'm looking for naloxone or fentanyl/xylazine testing strips without enrolling in DOPP?

If you are seeking no-cost naloxone for your first-aid kits or fentanyl/xylazine testing strips, there are funded OEND service organizations responsible for all counties who can provide these resources. OENDs can also provide larger quantities if the interested organization decides that they do not want to enroll in DOPP.

- To find the program designated by IDHS/SUPR to serve your county: Illinois Overdose Education and Naloxone Distribution (OEND) Programs funded by IPDO and SOR grants, by County.
- To find a Drug Overdose Prevention Program provider near you, visit the Illinois Helpline.

Who can register to be part of DOPP?

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Questions