One More Conversation: Addressing Substance Use in Pregnancy Utilizing the Screening, Brief Intervention and Referral to Treatment Model

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September 20, 2021

Title of Program:	OB/GYN GRAND ROUNDS
Title of Talk:	"One More Conversation: Addressing Substance Use in Pregnancy Utilizing the Screening Brief Intervention and Referral to Treatment (SBIRT) Model
Speaker/Moderator:	Jody Kamon, PhD, Win Turner, PhD and Michelle Shepard, MD
Planning Committee Members:	Lauren MacAfee MD, George Till MD, Cheung Wong MD, Misty Blanchette Porter MD, Marjorie Meyer MD, Sandra Sperry RN
Date:	Tuesday, September 21, 2021
Workshop #:	22-117-003

Purpose Statement/Goal of this activity:
The participant should be able to discuss up to date standards of care and evidence-based practices in obstetrics and gynecology. The participant will be introduced to new research, technology and management strategies within the field of obstetrics and gynecology.

Learning Objectives:
By the end of this activity, the learners should be able to…..
1. identify reasons for implementing SBIRT within OB settings.
2. describe the SBIRT process.
3. describe the Brief Negotiated Interview, a key intervention within the SBIRT process.

All those with control of content (speakers, planners, moderators, reviewers, staff) who have relevant financial relationships with "ineligible companies" are listed below. (*An 'Ineligible company is defined as those whose primary business is producing, marketing, selling, reselling or distributing health care products used by or on patients.)*

Does the speaker or any of the planners have any relevant financial relationships with Ineligible Companies? Yes
If yes, please list their names (s), name of Ineligible Companies, and nature of relationship:
Lauren MacAfee, MD – Organon, Clinical Trainer
If yes, were all the relevant financial relationships mitigated: Yes

(CMIE staff members do not have any interests to disclose)
Did this activity receive any Ineligible Companies Support (grants or in-kind**)? No**
If yes, please list all o organizations and support type: n/a

In support of improving patient care, The Robert Larner College of Medicine at the University of Vermont is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

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INTERPROFESSIONAL CONTINUING EDUCATION

The University of Vermont designates this internet live activity for a maximum of _1__ *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program has been reviewed and is acceptable for up to _1_ Nursing Contact Hours

This activity was planned by and for the healthcare team, and learners will receive __1__ Interprofessional Continuing Education (IPCE) credit for learning and change.

Objectives

- Participants will be able to identify reasons for implementing SBIRT within OB settings.
- Participants will be able to describe the SBIRT process.
- Participants will be able to describe the Brief Negotiated Interview, a key intervention within the SBIRT process.

Why screen during pregnancy?

- Because VT has the best rate of prenatal care in the US!
  - VT adequate PNC 91%, US average 75%
  - VT 1st trimester PNC 89.5%, US average 77%

US National Vital Statistics 2016

- Good prenatal care makes a difference in infant outcomes including less premature births
  - VT preterm births: 5.6%, US average 7.6%
  - VT late preterm births: 7.3%, US average 10.1%

US National Vital Statistics 2020 Provisional Data

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Why screen during pregnancy?

- Vermonters use substances at rates higher than much of the country
- VT has some of the highest rates of substance use during pregnancy
- It’s the standard of care!

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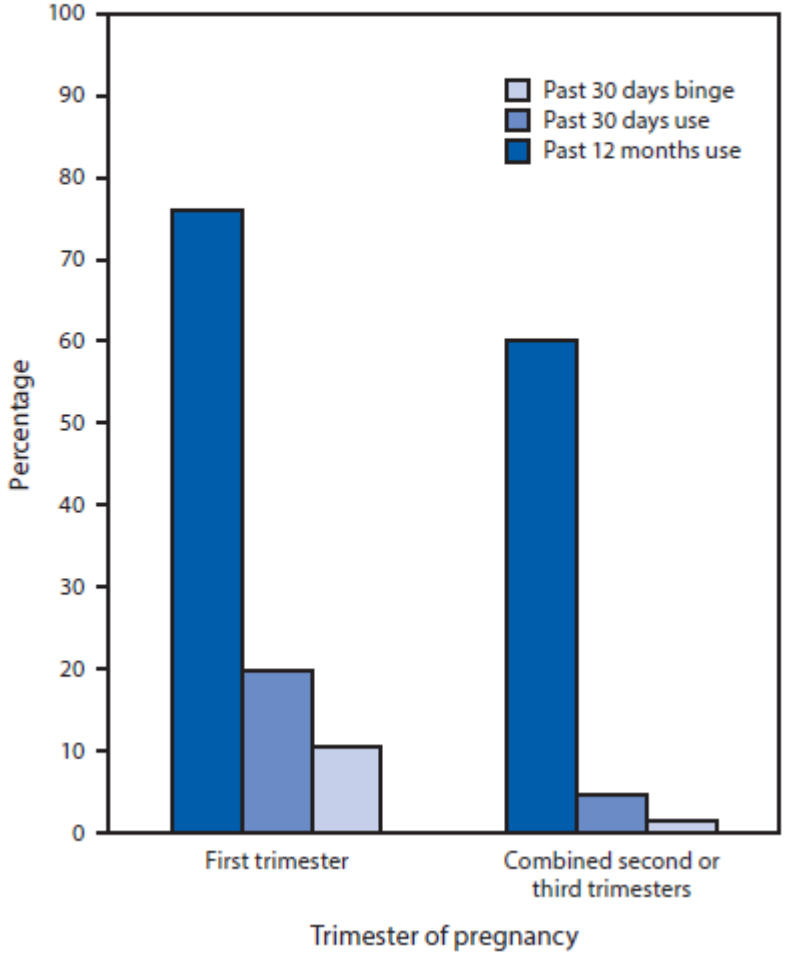
Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 69 / No. 31
August 7, 2020

Alcohol Use and Co-Use of Other Substances Among Pregnant Females Aged 12–44 Years — United States, 2015–2018

Lucinda J. England, MD[1]; Carolyne Bennett, MPH[1,2]; Clark H. Denny, PhD[1]; Margaret A. Honein, PhD[1]; Suzanne M. Gilboa, PhD[1]; Shin Y. Kim, MPH[1]; Gery P. Guy Jr., PhD[3]; Emmy L. Tran, PharmD[1,2]; Charles E. Rose, PhD[4]; Michele K. Bohm, MPH[5]; Coleen A. Boyle, PhD[4]

1 in 9 pregnant persons used alcohol, and
1/3 of those using reported binge drinking

FIGURE. Weighted prevalence of past 12 months drinking, past 30 days drinking, and past 30 days binge drinking* among pregnant females† aged 12–44 years (N = 3,006), by trimester — National Survey on Drug Use and Health, United States, 2015–2018



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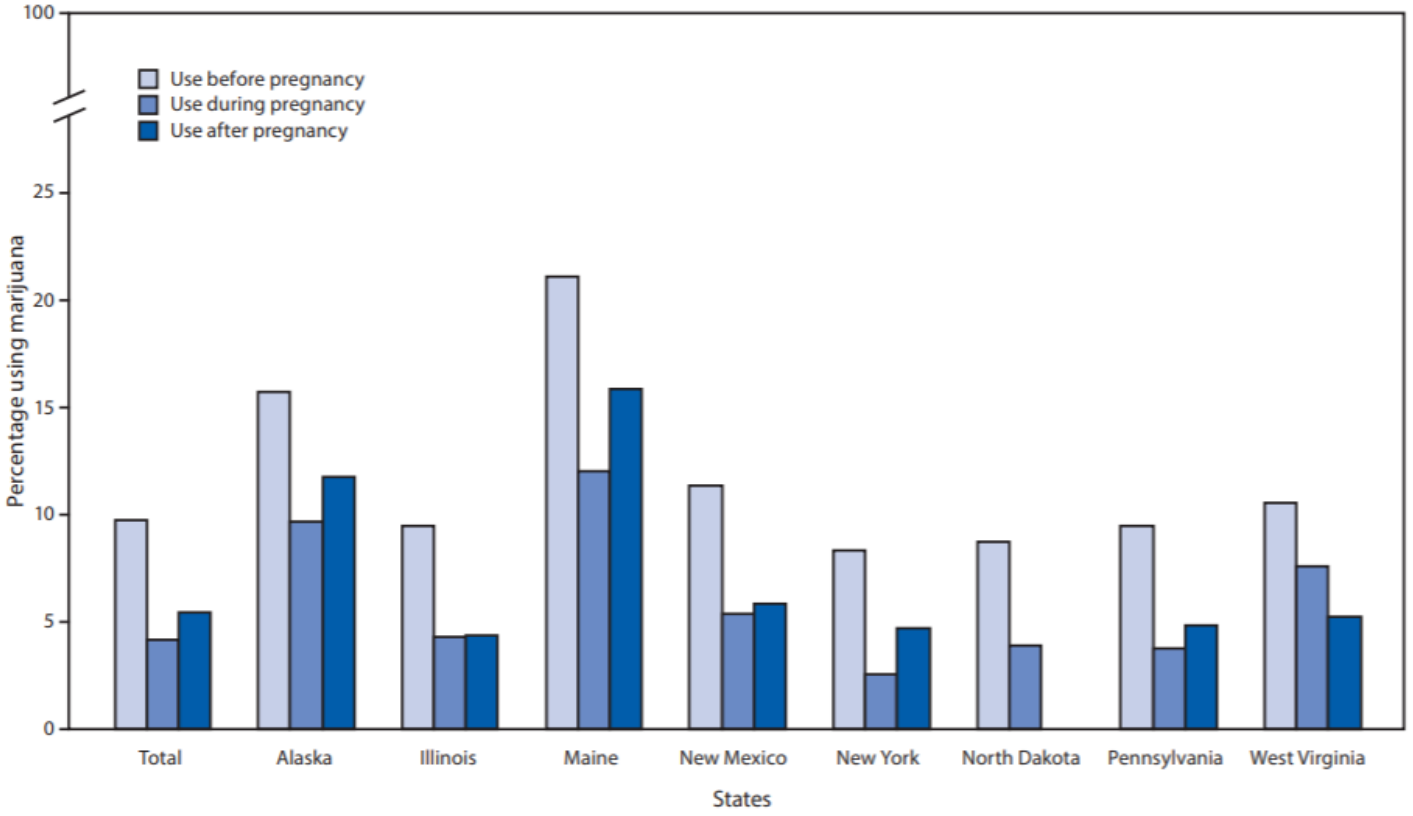
Morbidity and Mortality Weekly Report

Characteristics of Marijuana Use During Pregnancy — Eight States, Pregnancy Risk Assessment Monitoring System, 2017

Jean Y. Ko, PhD[1]; Kelsey C. Coy, MPH[1,2]; Sarah C. Haight, MPH[1]; Tamara M. Haegerich, PhD[3]; Letitia Williams, MPH[1]; Shanna Cox, MSPH[1]; Rashid Njai, PhD[4]; Althea M. Grant, PhD[4]

- 9.8% reported using marijuana before, 4.2% during, and 5.5% after pregnancy.

FIGURE 1. Prevalence* of marijuana use before, during, and after pregnancy (N = 6,236)† — eight states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2017§,¶



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NSDUH 2018-2019 Vermont Data Summary by Age Group

Prevalence and Quintile Rankings*

Substance and Age Group	Past Month	VT Quintile	Past Year	VT Quintile
Alcohol (12+) Consumption	60.9%	1		
12-17 Consumption	13.6%	1		
18-25 Consumption	67.7%	1		
12-20 Consumption	31.7%	1		
26+ Consumption	64.2%	1		
Alcohol (12+) Binge	26.1%	2		
12-17 Binge	7.5%	1		
18-25 Binge	45.2%	1		
12-20 Binge	21.2%	1		
26+ Binge	24.6%	4		
Marijuana (12+)	19.7%	1	27.0%	1
12-17	12.8%	1	21.1%	1
18-25	39.0%	1	52.2%	1
26+	17.1%	1	23.3%	1
Cocaine (12+)			3.1%	1
12-17			0.7%	1
18-25			9.1%	1
26+			2.3%	1
Heroin (12+)			0.5%	1
12-17			0.0%	N/A
18-25			0.6%	1
26+			0.6%	2
Pain Reliever Misuse (12+)			3.5%	4
12-17			2.4%	4
18-25			5.4%	3
26+			3.3%	4
Methamphetamine (12+)			0.7%	3
12-17			0.3%	1
18-25			1.1%	3
26+			0.7%	3
Alcohol Use Disorder (12+)			6.8%	1
12-17			2.6%	1
18-25			12.3%	1
26+			6.3%	1
Illicit Drug Use Disorder (12+)			4.0%	1
12-17			4.6%	1
18-25			10.0%	1
26+			2.9%	1

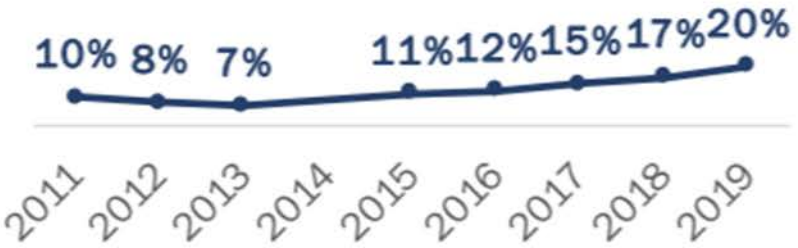
* Rank among 50 States and DC (1 = highest 10, 5 = lowest 10) - Quintiles more accurately reflect rankings due to instability in year-to-year individual ranks. Red in Rankings indicates VT in first quintile. Red in prevalence estimates indicates a significant increase from 2017-2018; green in prevalence estimates indicates a significant decrease from 2017-2018. Use of all substances is highest among those 18-25 years of age

Marijuana use in Vermont

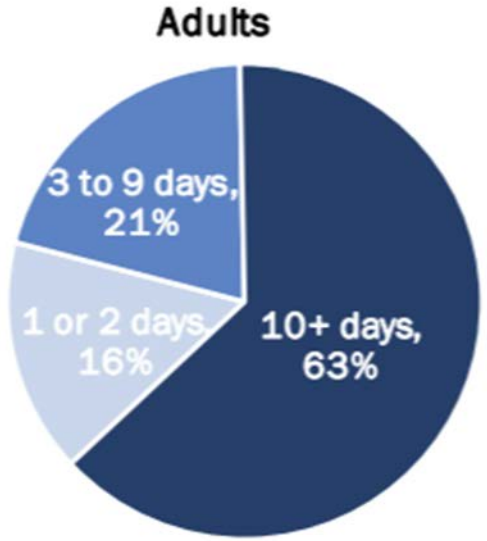
Marijuana Use Among Vermont Adults[iv]

Twenty percent of Vermont adults (18+) reported using marijuana at least once in the past 30 days in 2019. Past 30-day use has steadily increased since 2013, when 7% of adults reported using. Use in 2019 was significantly higher compared to 2018 (17%).

Past 30-day marijuana use among adults has nearly tripled since 2013.



Data source: Vermont Behavioral Risk Factor Surveillance System



Vermont Behavioral Risk Factor Surveillance System

https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Data_Brief_Marijuana.pdf

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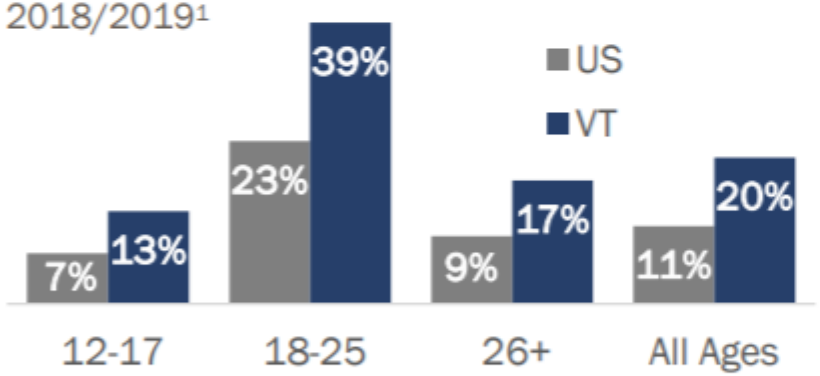
Vermont Marijuana Use Highlights

January 2021

Prevalence of Use

The percent of the Vermont population that used marijuana in the past month was higher than the US average, for all age groups.

2018/2019[1]



Vermont rates of use in the past month among people aged 12+ were highest in the country—at nearly twice the national rate.[1] Adult marijuana use has steadily increased in Vermont since 2013[2] and use among high school students increased significantly from 2017 to 2019[3].

Prevalence of Use During Pregnancy

The 2018 Pregnancy Risk Assessment Monitoring System shows that:

- 10% of people who are pregnant report using marijuana **during** their most recent pregnancy.[4]
- 17% of people who are pregnant report using marijuana in the month before pregnancy.[4]
- Marijuana was the most commonly used substance other than alcohol or tobacco.[4]

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Substance use in pregnant Vermonters

PRAMS data (2019)

- Tobacco: 15% smoking in the 3rd trimester (24% in 3 months prior to pregnancy)
- Alcohol: 11% drank during pregnancy (68% in 3 months prior to pregnancy)
- Cannabis: 10% used during pregnancy
- Prescription pain medications: 3% used during pregnancy
- 86% were asked about drug use!

https://www.healthvermont.gov/sites/default/files/documents/pdf/HS-Stats-PRAMS-Overview-2018.pdf

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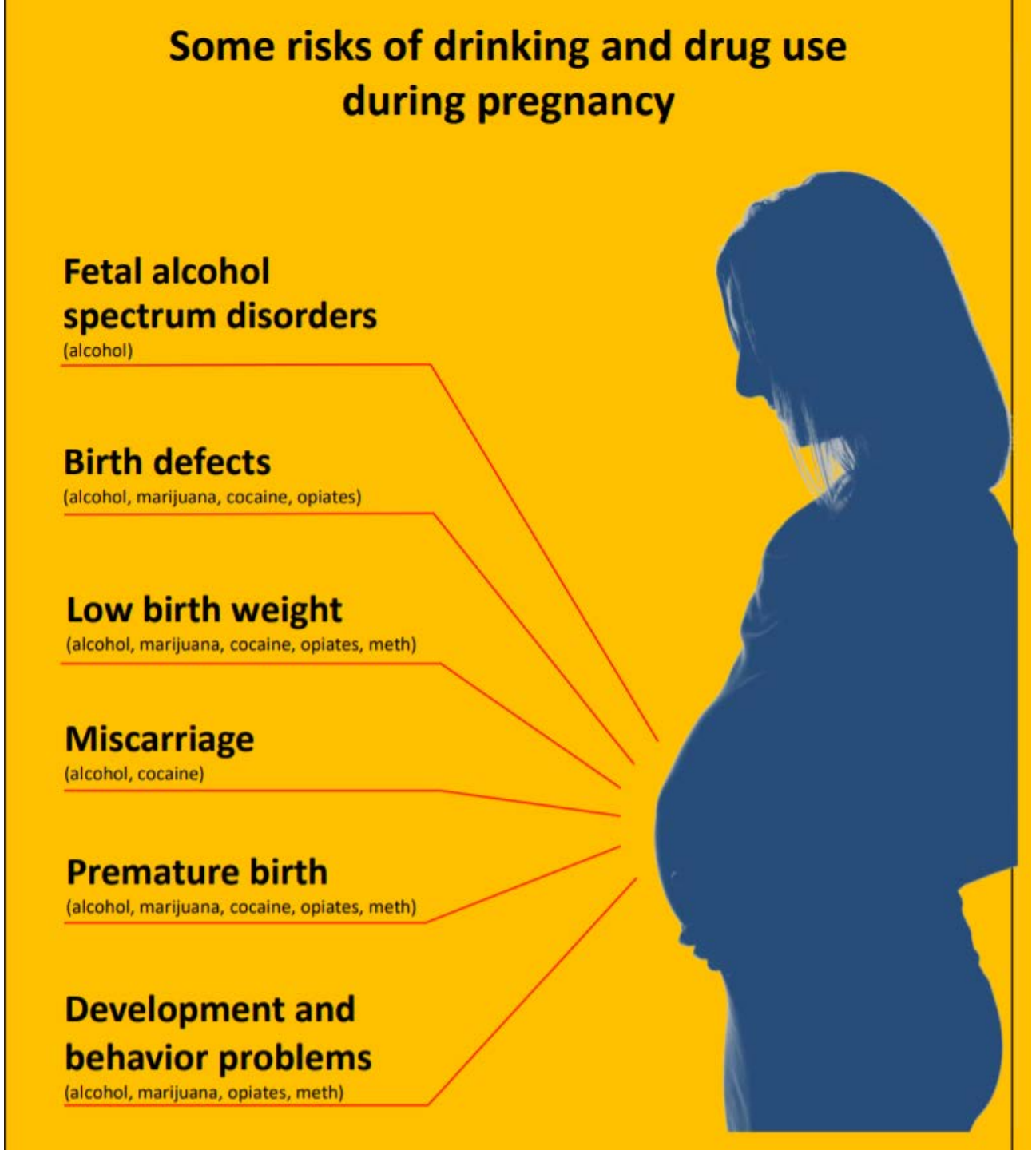
http://www.sbirtoregon.org/wp-content/uploads/Reference-sheet-pregnancy-English-pdf.pdf



The What and How of SBIRT

Presented by

Win C. Turner, PhD, LADC

Jody Kamon PhD.

Center for Behavioral Health Integration (C4BHI)

www.C4BHI.com

C4BHI

Thank you

Acknowledgments go out to mentors, researchers, programs:

People with lived experience
Substance Abuse & Mental Health Services Administration
JBS International
University of New Mexico
William Miller & Stephen Rollnick

C4BHI

Goals for today

Learn about	Explore	Watch
Background information related to WHY SBIRT for this population	Tools & strategies to engage & activate patients in a collaborative manner on the issue of alcohol and other drug use	See a demonstration of this approach in action

C4BHI

What is SBIRT?

A systematic & evidence based public health approach toward integrating medical and behavioral care in order to identify and intervene for persons with substance, mood, and other behavioral risks affecting their lives.

The heart and soul of all SBIRT interactions is to **generate patient motivation and actions toward seeking wellness**.

C4BHI

Why do we need SBIRT?

Because screenings and brief interventions work across settings and populations

- Even a 5-minute intervention reduces risky substance use.
- SBIRT in medical settings reduces costs, improves health-related diseases & consequences related to risky substance use.

C4BHI

SBIRT offers a systematized approach

Removes:	Introduces:
– Subjectivity	+ Predictability
– Inconsistency	+ Efficiency

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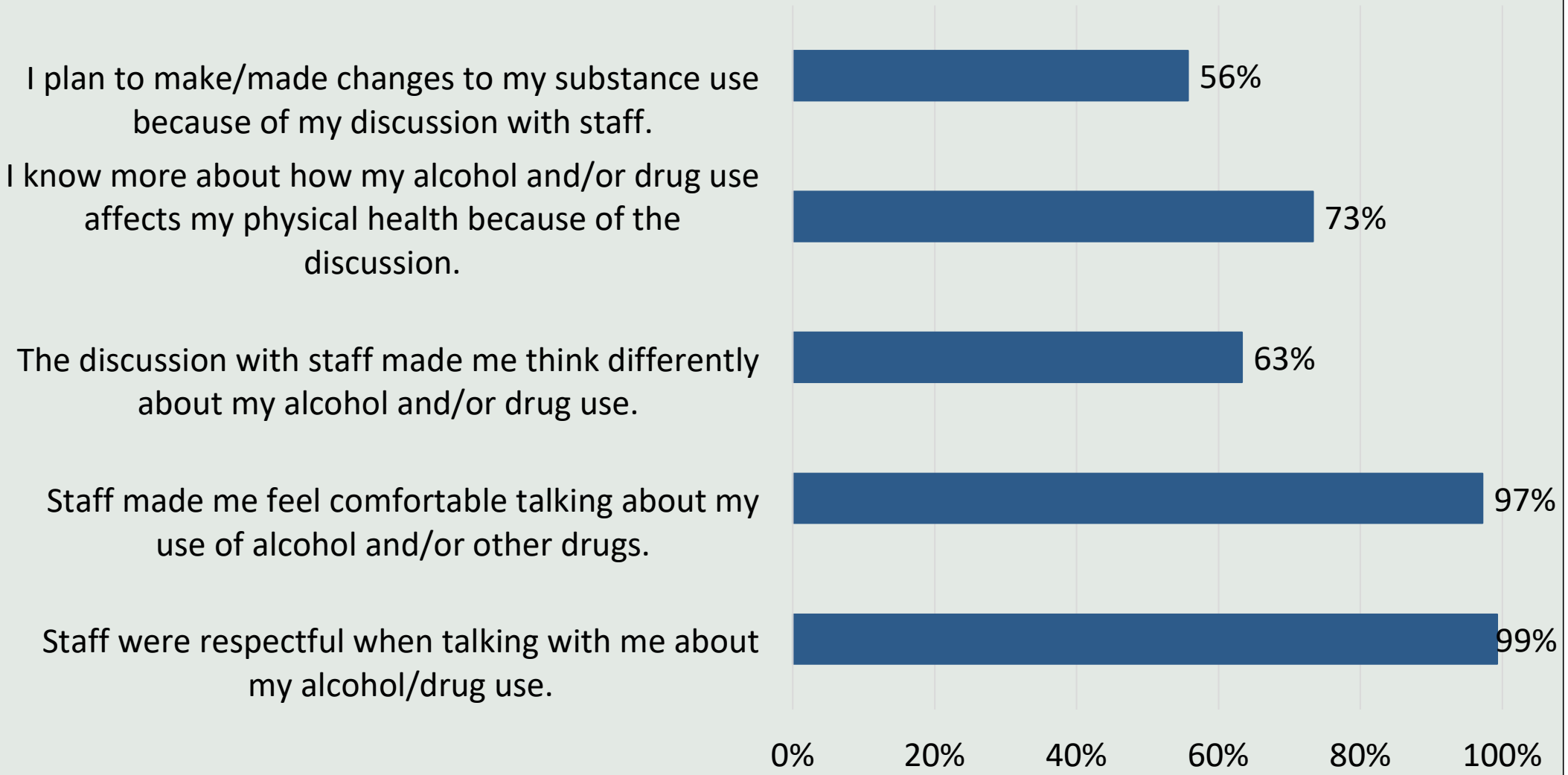
Patients' Satisfaction Rating of Initial Discussion



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"I felt supported and not judged or compared. I got good advice for next steps which I didn't follow right away, but a couple of months down the road I did. [Clinic name] is such a great place! They offer great support and help to people."

"The two different people I spoke to were very attentive. They listened open-minded with me. Based on my experience, they explained some things that I haven't been aware of. Getting another perspective [was helpful] so I could better understand myself."

"It gave me faith and hope - positive re-inforcement…that someone was listening and taking the time to listen. It was the start of a new era for me and definitely encouraging. Sticking to my guns and taking care of it!"

"My doctor, she talked to me like I was a real person and had respect for me and didn't talk down to me at all. It seemed like she understood what I was going through. She told me what I was going through doesn't make me a bad person; it's a disease. "

"It was helpful that they told me about the potential negative side effects of perpetual cannabis use."

"It was helpful because I learned that binge drinking is more harmful - it's better to drink one drink/day then binge drink."

C4BHI

Essential elements of SBIRT?

- Universal brief triage screening
- Risk stratification secondary screening
- Motivational matched brief interventions
- Embedded brief treatment
- Linkage to specialty care when needed

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Screening process & tools

- Universal brief triage screening
- Risk stratification secondary screening
- On average 9 of 10 will screen negative at universal phase.
- Risk = No, Low, Moderate or Severe
- Lots of validated screening tools to choose from

C4BHI

Motivational interviewing

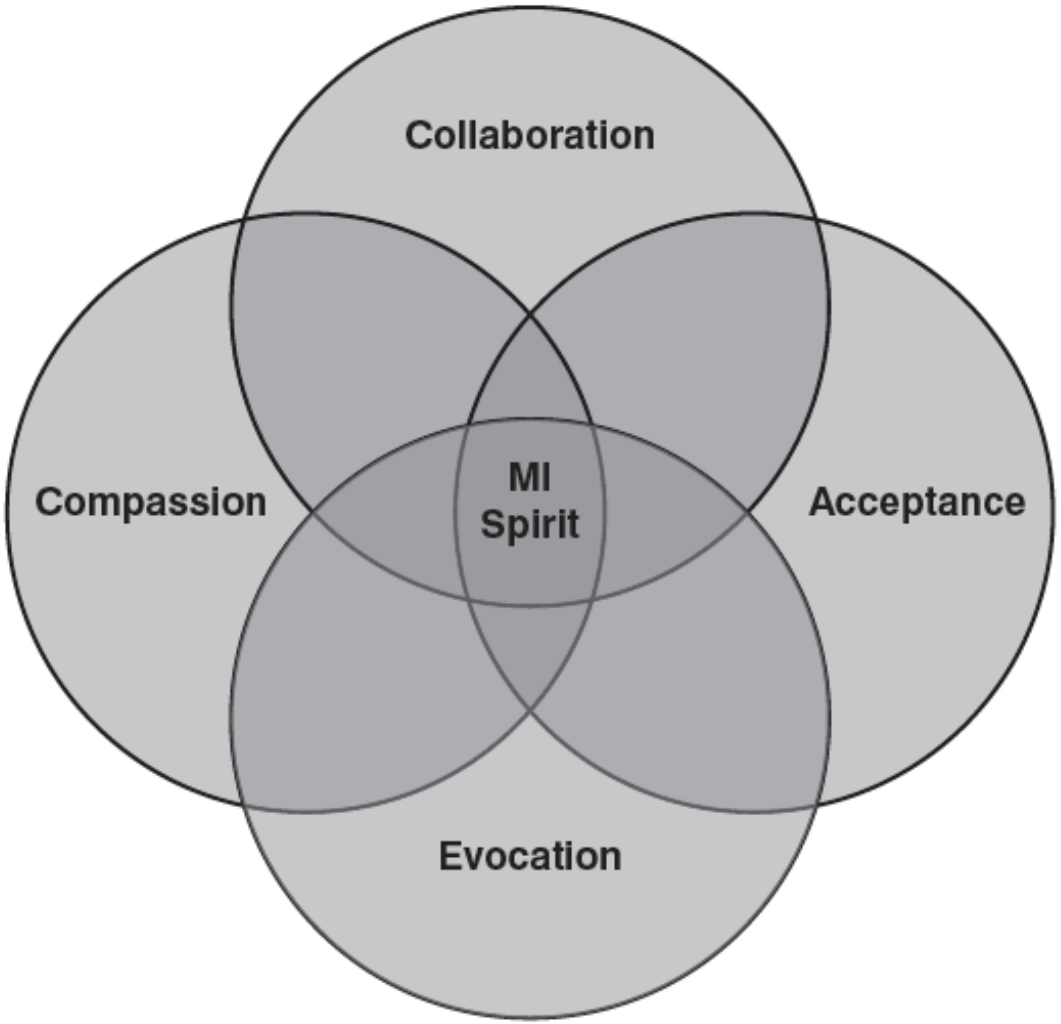
Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change.

Providing information, instruction, and advice

Good listener and also offers expertise where needed. **This is where MI lives -** between directing and following, incorporating aspects of each

Take an interest in what the other person has to say, seek to understand, and respectfully refrain from inserting their own material

C4BHI



Spirit of MI

MI Spirit is a way of being with patients that is…

1. Collaborative
2. Evocative
3. Accepting
4. Compassionate

5. *Respectful*
6. *Approach of Dual Expertise*

The feeling of the MI spirit is often expressed as <u>genuine curiosity</u>

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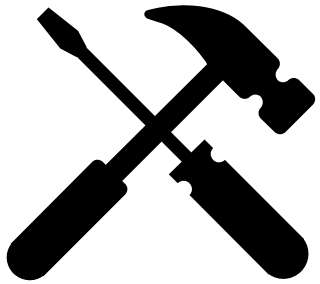

Brief Negotiated Interview

- Raise the subject
- Explore Pros and Cons
- Provide Feedback with Permission
- Readiness Ruler
- Negotiate a plan

Keys to successful BNI interactions

- Destigmatize = non-shaming, and not judging
- Focus on understanding the patient
- Meet them where they are at
- No advice (“you should”)
- Ask open questions
- Reflect more then ask questions
- Affirm self choice
- Hypothesize on core discrepancy(s) to promote and generate wellness activation

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Demonstration

C4BHI

Raise the subject

- Use a de-stigmatizing approach
- Normalize process, questions and topic
- We ask all patients because we care

- With screening results, ask permission to discuss:

“If its ok with you, can we take a minute to talk about the questions you answered when you checked in today?”

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Explore pros and cons

- Explore both sides of the use:
    - I'm interested in getting to know more about what cannabis is like for you.
    - What are some of the good things about cannabis or ways that it is helpful?
    - What are some of the downsides or drawbacks?

Reflect: *"On the one hand, it helps reduce your nausea and on the other hand, you feel guilty because you worry about how it might be affecting your baby."*

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Provide feedback with permission

- Would it be ok if I share some information on cannabis use during pregnancy?

- *<u>Examples:</u>*

"There is some research to show that while cannabis can help anxiety in the moment, regular use over time can increase anxiety."

"We know that marijuana use during pregnancy can increase your risk of having a preterm birth, lower birth weight for your newborn, and a greater risk of long term brain development for your child."

C4BHI

Readiness ruler

- Given what we've been discussing, on a scale of 1 to 10 with 1 being not ready at all and 10 being completely ready, how ready are you to change some aspect of your cannabis use?
- If patient picks > 1 or 2, ask:

  "Why did you choose that number and not a lower number like a 1?"

  (This engages them in reasons for considering change)
- If patient picks a 1, ask:

  "What would it take to raise that number to a 2 or 3?" OR "How would your cannabis use need to impact your life in order for you to start thinking about making a change?"

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Negotiate a plan

- What steps can you take to cut back/reduce risk/stay health and safe?

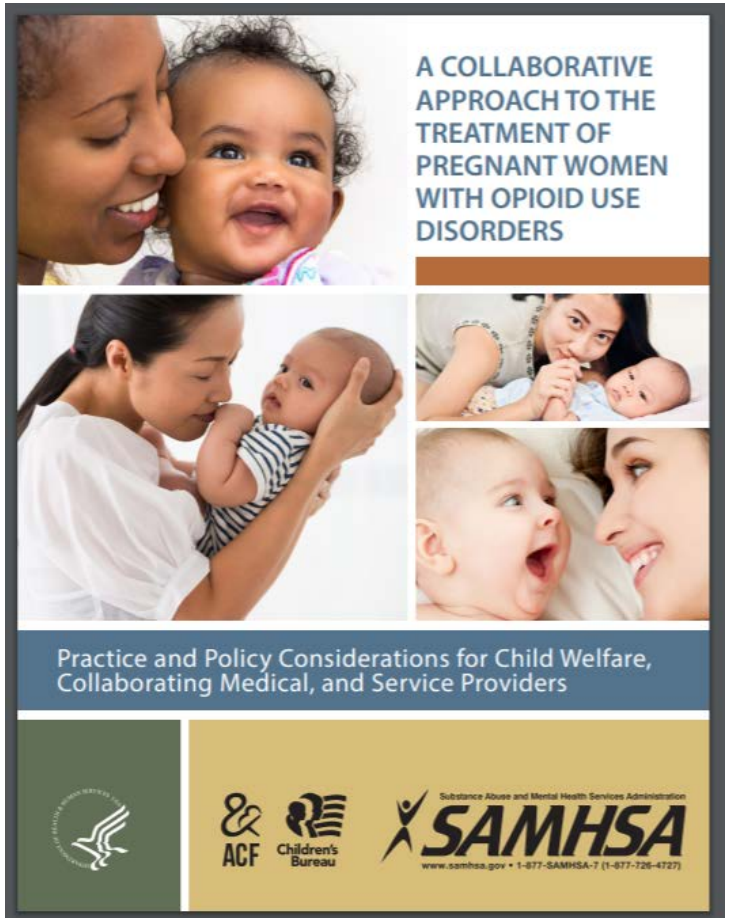
“It seems you have several options. You can choose to stop using, you can cut your use down, or you can choose to leave things as they are.”

- As they identify change steps:
    - Identify supports
    - Offer appropriate resources
    - Explore confidence
    - Have client write down action plan

C4BHI

C4BHI

We know how to do this in VT



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NNEPQIN

NORTHERN NEW ENGLAND PERINATAL QUALITY IMPROVEMENT NETWORK

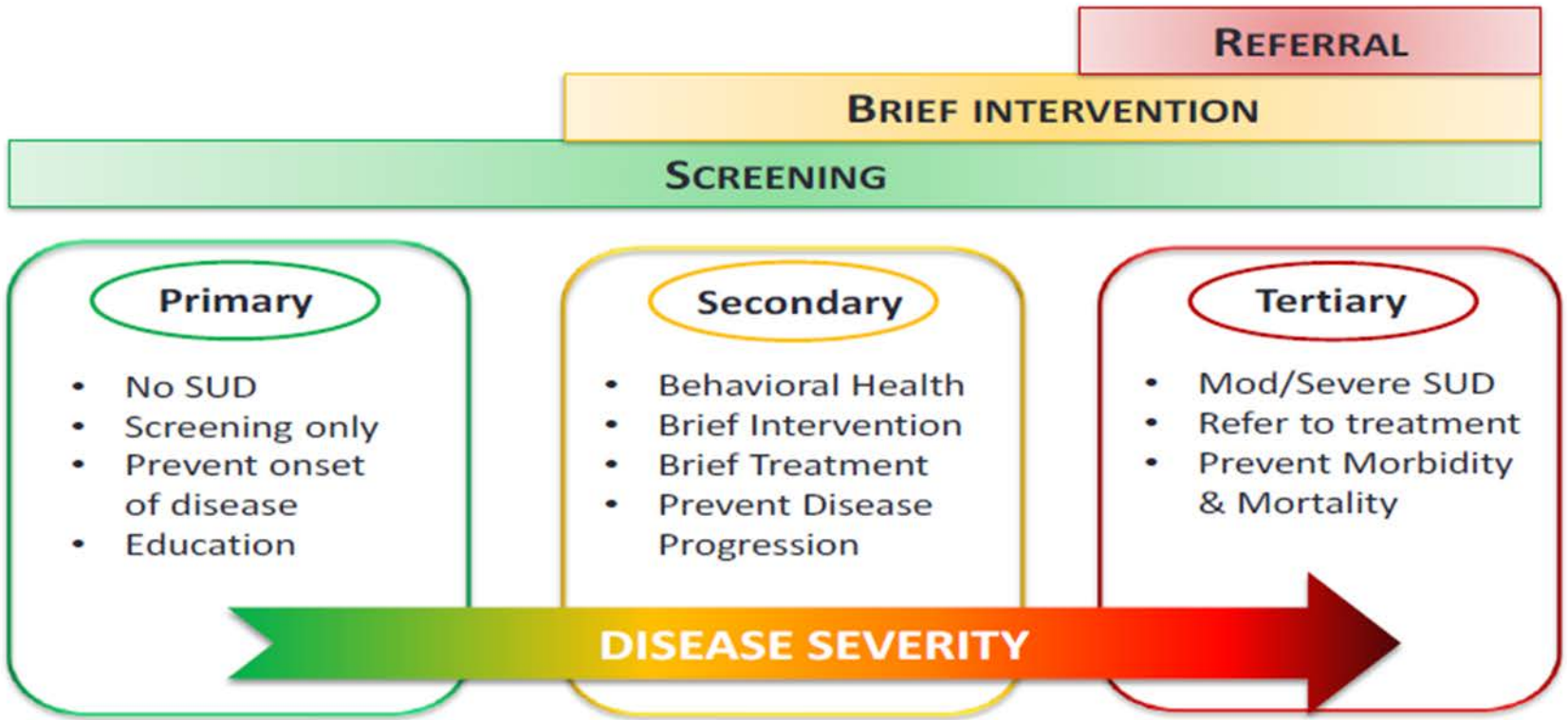
SCREENING FOR ALCOHOL, TOBACCO AND DRUG USE IN PREGNANCY - 2018 UPDATE

TOOLKIT FOR THE PERINATAL CARE OF WOMEN WITH SUBSTANCE USE DISORDERS - 2020 UPDATE

This toolkit was developed by a multidisciplinary group of obstetric, pediatric, neonatal, and addiction treatment providers and nurses to assist front-line perinatal care providers to improve the quality and safety of care provided to pregnant women with substance use disorders in northern New England.

- NNEPQIN_Toolkit_final
  - NNEPQIN_Toolkit_Section 1_Screening & Assessment
  - NNEPQIN_Toolkit_Section 2_By Substance
  - NNEPQIN_Toolkit_Section 3_Tools To Support Patients Needs
  - NNEPQIN_Toolkit_Section 4_QI & Best Practices
  - NNEPQIN_Toolkit_Section 5_Learning Opportunities
  - NNEPQIN_Toolkit_Section 6_Additional References

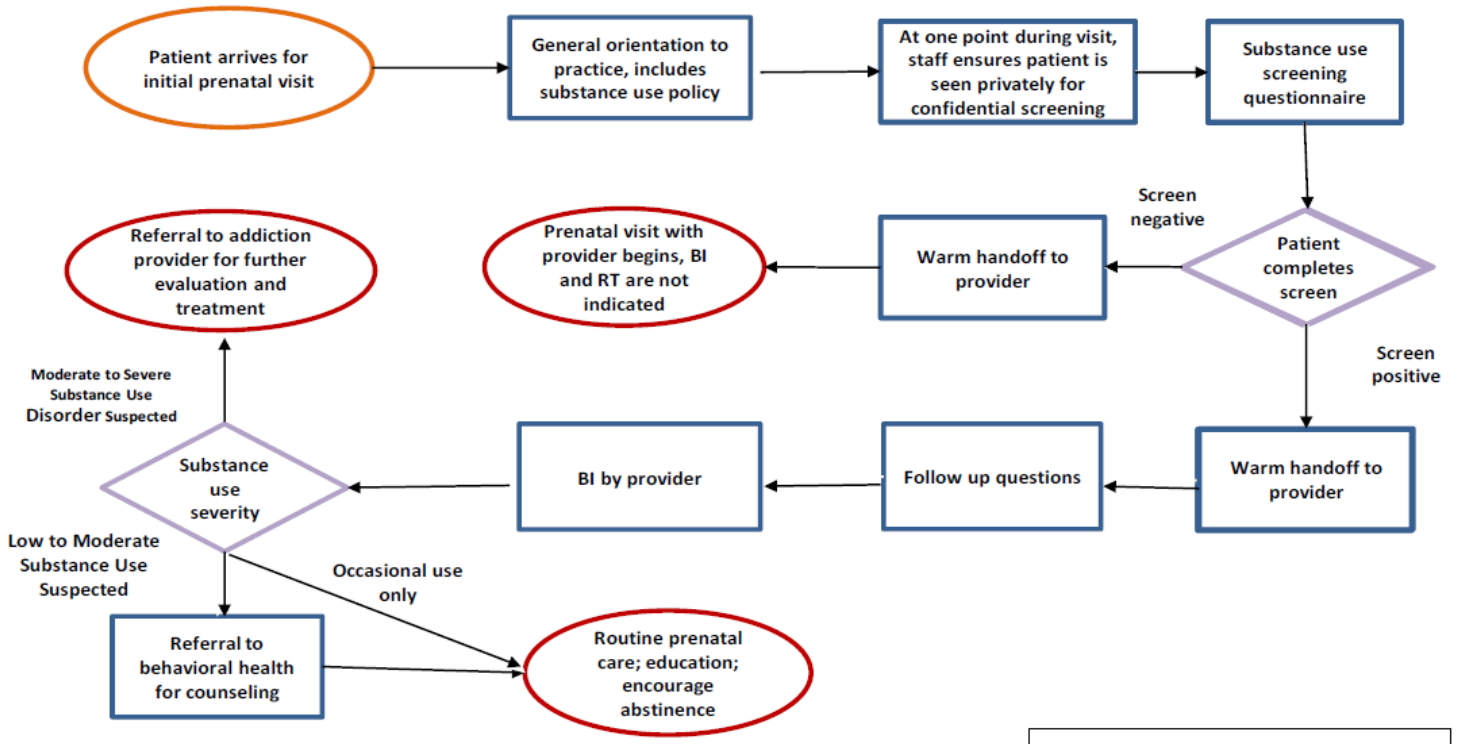
Universal screening and layered follow-up in the maternity care context



http://www.nnepqin.org/a-toolkit-for-the-perinatal-care-of-women-with-opioid-use-disorders/

Develop a workflow

Process Map for SBIRT at Initial OB Visit



BI=Brief intervention
RT= Referral to treatment

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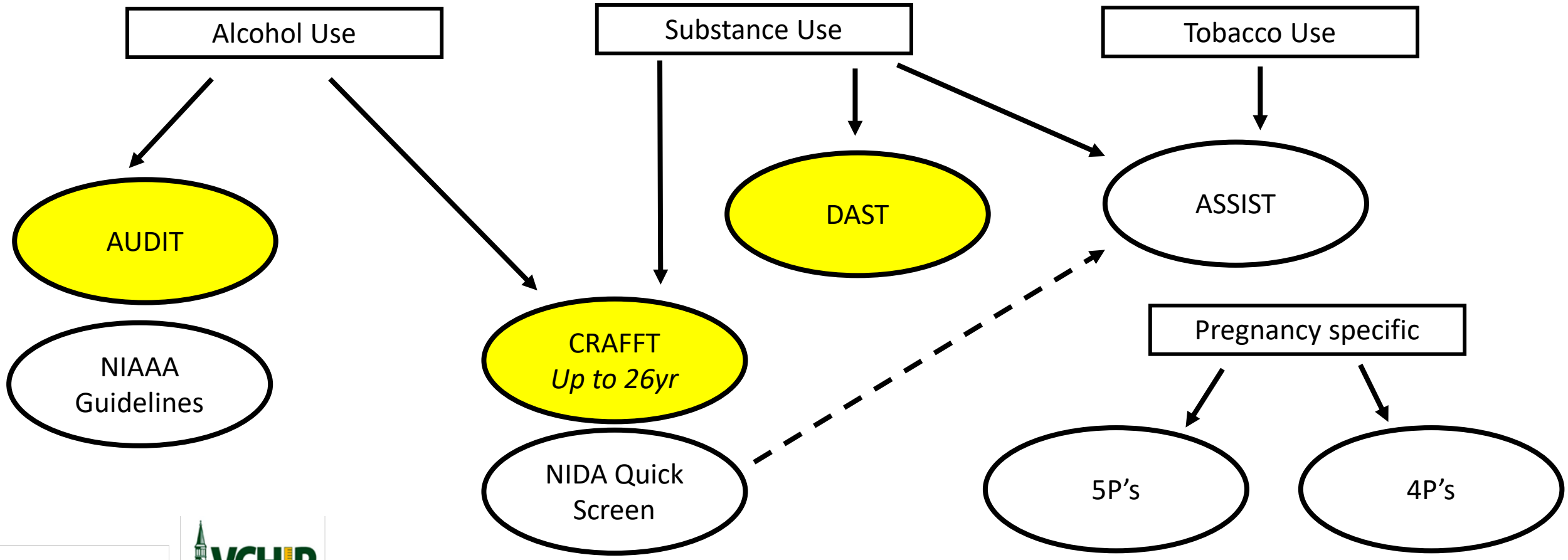
Identify a screening tool



Yellow= available in UVM HN Epic

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Leverage existing connections

- Women's Health Initiative
- Community Health Team
- Embedded behavioral health specialists
- Designated Agencies

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Identify new resources

- VT helplink

VT Helplink
Alcohol & drug support center

- Peer recovery coaches
- Clinic staff with interest in tobacco, alcohol or drug use

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One More Conversation

- Campaign by the VT Department of Health- Maternal and Child Health Division

- Aims to give both providers and pregnant people resources for discussing substance use

One More Conversation **Can** Make The Difference

One More Conversation

Patient educational materials reviewed and revised by healthcare providers on:

- Alcohol
- Cannabis
- Opioids
- Tobacco

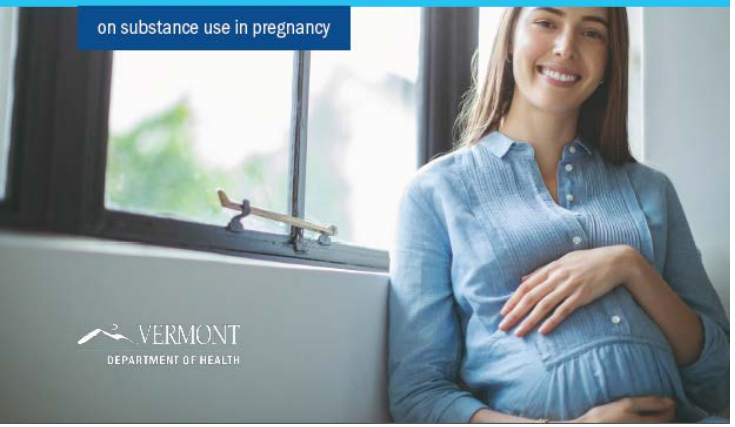
https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy

https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers

Tips and tools for

THE 9+ MONTH CONVERSATION

on substance use in pregnancy



WHAT'S THIS ALL ABOUT?

Recent research shows the prevalence of substance use in pregnancy is higher in Vermont than other, similar states. To help the healthcare professionals working to reduce those numbers, the Vermont Department of Health has created the One More Conversation Can Make the Difference campaign to encourage open, ongoing dialogue between professionals and their patients.

TIPS

Suggestions on how and when to talk substance use in pregnancy.

Make the conversation part of every visit or, at least, of every mental-health check in.
Remind patients about safe and effective treatments that improve pregnancy outcomes.
Take the stigma out of the conversation with open-ended, nonjudgmental language.
"We ask this of everyone." "Just checking in on this again." "Do you have any questions about substance use?" "Is there anything we can do to work on it?" "How do you feel about substance use?" "Is it okay to discuss the risks?"
Meet patients where they are in their relationship to substances to help build trust.
Look for the reason behind the use before jumping to negative outcomes.
Help them understand addiction is a treatable disease, not a character flaw.
When information is limited (e.g. marijuana) use questions or admission as an opportunity to discuss other substances.
Encourage the idea that there is "No Known Safe Amount" of substance use for a healthy pregnancy.
Empower patients to learn more with One More Conversation Can Make the Difference patient materials and webpage.
Try to tap into the patient's support system (especially when language barriers exist)
Share this information with other providers to help create one voice across Vermont.

TOOLS

Help encourage your patients to continue the conversation.

KEEP THE CONVERSATION GOING OUTSIDE THE OFFICE
with digitally shareable information.
Download Substance-Specific Fact Sheets

START THE CONVERSATION EARLY
with printable or email-able intake and discharge packet inserts.
Download Inserts/Rack Cards

TEXT OR TELL
patients about this easy to remember patient-centric page.

1MORECONVERSATION.COM

ENCOURAGE PATIENTS TO THINK ABOUT DISCUSSING SUBSTANCE USE BEFORE THEIR APPOINTMENT
with in-office digital screens.
Download Digital Screen Ads

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one more conversation
can make the difference

OTHER RESOURCES

Curated list of the latest information on substance use in pregnancy for easy access.

General Links & Research

Evidenced-based Screening Tool
A valuable resource that includes several evidence-based screening tools and other pertinent information.

JSI Research Report
2019 Report on Vermont Healthcare Provider's and Patient's Knowledge, Perceptions, and Attitudes of Substance Use and Pregnancy.

Vermont Pregnancy Risk and Management System (PRAMS) Report
provides data about pregnancy and the first few months after birth to help identify groups of women and infants at high risk for health problems.

Alcohol

NOFAS
Prevention organization focused on raising awareness as well as supporting families with FAS.

SAMHSA.gov Addressing FASD
Interventions for pregnant women and methods of Identification for people living with FASD.

CDC Choices Curriculum
A program for women about choosing healthy behaviors.

Tobacco

Vermont 802Quits
Incentives for counseling calls, custom quit plans, free text support, and nicotine replacement therapies with Rx.

CDC Perinatal Tobacco Risk
Understanding the Health Effects of Smoking and Secondhand Smoke on Pregnancies.

ACOG Tobacco Use and Women's Health
Epidemiology, Forms of Tobacco, Health Effects, Role of the Obstetrician, and Medications.

Cannabis

Maternal cannabis use in pregnancy and child neurodevelopmental outcomes
A 2020 study on the connection between maternal cannabis use and autism.

CDC Marijuana in Pregnancy
The potential health effects during pregnancy and breastfeeding – using marijuana in pregnancy.

NIH Marijuana Safety in Pregnancy or Breastfeeding
Statistics, the endocannabinoid system, health effects, the role of poly-drug use, perception of safety and recommendations.

Opioids

Alliance for Innovation in Maternal Health
Multidisciplinary groups of experts compile best practices around maternal health conditions and strategies.

SAMHSA.gov
Collaborative approach to the treatment of pregnant women with Opioid Abuse disorders.

SAMHSA Fact Sheet
Dos and don'ts, things to know and expect, and treatment.

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one more conversation
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Let's have a conversation about

CANNABIS DURING PREGNANCY

and beyond

VERMONT DEPARTMENT OF HEALTH

WHETHER YOU SMOKE, VAPE, DRINK OR EAT IT

if you are pregnant, trying to get pregnant or breastfeeding you're encouraged to not use cannabis for the health of you and your baby. The chemical in cannabis called THC that gives you the feeling of being "high" can be transferred to your baby while you are pregnant or breastfeeding. To some, pot being "natural" (and now legal) mean it's safe. But that's not necessarily true. Any time you introduce chemicals (or other toxins that come from how it's manufactured or how you ingest it), they can be harmful to a baby's development. While nothing beats an open, honest conversation with your healthcare professional, here are some answers to your most common questions, both to give you the truth about cannabis use and pregnancy risks and to inform that next conversation with your provider.

IS ANY AMOUNT SAFE?

There is no known safe amount of cannabis use during pregnancy. Currently, there isn't as much research on the effects of THC during pregnancy as other substances. But that doesn't mean it's safer. Federal classification of Cannabis as a Schedule 1 substance makes research more difficult. But there are some studies that show cannabis use during pregnancy has negative outcomes.

HOW CAN IT AFFECT MY BABY?

Research shows that cannabis can affect a baby's birth weight, making children more prone to health issues–especially in the critical first year of growth. Cannabis use during pregnancy may increase the risk of stillbirth, and THC may also negatively affect a baby's brain development, leading to longer-term behavioral and learning issues. Supporting this, a 2019 study showed a connection between prenatal cannabis use and autism.

I USED CANNABIS BEFORE I KNEW I WAS PREGNANT. WHAT NOW?

Moderate cannabis use before you know you are pregnant is unlikely to cause harm. But, now that you know, it's important to stop. Weeks three through eight are the most sensitive time for causing birth defects.

WHAT ABOUT EDIBLES, VAPING AND OTHER CONCENTRATES?

While edibles, vaping and other concentrates may remove the potentially harmful effects of smoking, THC in your system is still passed from you to your baby. Plus, many of these alternative methods of using cannabis have higher levels of THC, increasing its negative effects.

ISN'T IT A NATURAL SUBSTANCE?

Yes, but so is tobacco. So is opium. And those aren't safe during pregnancy either. Plus, as more states have legalized or decriminalized its use, cannabis has become a big business. With that come newer cultivating methods and higher levels of THC and it isn't clear how these higher strains may increase the negative effects.

WHAT IF I SLIP UP?

It happens. If you do use cannabis while pregnant, the best thing to do is be honest–both with yourself and with your healthcare professional. Together, you can work to understand why and the best course of action to be sure you move forward in the healthiest way possible for both you and your baby.

ARE THERE ANY SUGGESTIONS FOR SELF CARE?

Depending on your reason for using cannabis, there are ways to help you help yourself avoid using while pregnant. Exercise–even just taking a walk–releases endorphins to make you feel better and can help you sleep. OTC medications can help with morning sickness. Meditation reduces stress hormones. Talk to your healthcare professional about these and methods for self care.

HOW ABOUT BREASTFEEDING?

Breastfeeding is important to your baby's health and cannabis use is not recommended. THC is present in breast milk and upwards of 3 percent of the what you get can be transferred to your baby. It seems small, but so are they.

HOW LONG IS THC IN MY BREAST MILK?

Tests have shown THC can be present in breast milk within 20 minutes of consumption and is present at least 24 hours after. THC is stored in fat cells, so it can stay in the body longer than other substances, so pump and dump doesn't really work. Your best option to avoid issues is to not use cannabis while breastfeeding.

WHERE CAN I FIND HELP?

Call 2-1-1, visit VTHelpLink.org or 802.565.LINK (5465) or talk to your healthcare professional.

For more information, there's no better resource than your healthcare professional. Remember, they're not there to judge. They're there to help you have the healthiest pregnancy possible. Keep the conversation going.

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Let's have a conversation about

TOBACCO DURING PREGNANCY

and beyond

VERMONT DEPARTMENT OF HEALTH

PEOPLE WHO ARE PREGNANT, TRYING TO GET PREGNANT OR BREASTFEEDING

are encouraged not to use tobacco products for their health and the health of their baby. But quitting smoking can be one of the most difficult things a person can do. Despite all the information and all the advertising and social pressures, sometimes it can seem nearly impossible. But if you're pregnant, trying to be, or have just had a baby, you have the strength to do anything. Sometimes you just need a little help, some good information, or someone to talk to to take that important step for the health of you and your baby.

While nothing beats an open, honest conversation with your healthcare professional, here are some answers to your most common questions, both to give you the truth about tobacco and pregnancy risks and to inform that next conversation with your provider.

IS ANY AMOUNT SAFE?

Almost everyone has heard that there is no known safe amount of tobacco use during pregnancy. Smoking lowers the amount of food and oxygen your baby gets. The less you smoke, the lower the risk of problems for both you and your baby. So while cutting back helps, quitting as soon as possible is always the best way to a healthy pregnancy.

HOW CAN IT AFFECT MY BABY?

People who smoke have a higher risk of miscarriage and ectopic pregnancy (a dangerous complication where the embryo grows outside the uterus). Smoking increases your chances of premature delivery, placental problems, lower birth weight, stillbirth and sudden unexpected infant death (SUIDs). It increases your baby's risk for asthma and respiratory illnesses. Babies born to people who smoke can suffer from nicotine withdrawal. Studies have shown the link between smoking while pregnant and behavioral problems in childhood, like attention deficit hyperactivity disorder (ADHD) and even a higher likelihood of being overweight.

I SMOKED BEFORE I KNEW I WAS PREGNANT. WHAT NOW?

The chances are, if you smoked before you knew you were pregnant, that no harm was done. But the longer you wait to quit, the higher those chances grow– especially during the 3-8 week period where rapid development occurs.

WHAT ABOUT VAPING?

While vaping may expose your baby to fewer toxins than smoking, it is not a safe alternative. Your baby will still be exposed to nicotine, flavorings and other dangerous chemicals found in e-cigarettes.

WHAT ABOUT REPLACEMENT THERAPIES?

Cigarette smoke contains thousands of chemicals, so anything that reduces smoking is better than continuing to smoke. But nicotine, present in all replacement therapies, by itself can harm a baby's development. Some therapies, like the patch, feed a constant stream into the body, so nicotine levels never reduce. Talk to your healthcare professional about nicotine replacement therapies and what may be the best choice for you personally.

HOW ABOUT BREASTFEEDING?

Smoking can reduce the production of breast milk making breastfeeding more difficult. And nicotine and other harmful chemicals from tobacco are found in breast milk, so it's best to not smoke while breastfeeding.

HOW LONG IS NICOTINE IN MY BREAST MILK?

Nicotine remains in breast milk for at least three hours after smoking, and traces may be present much longer. If you must smoke, it's best to do so after breastfeeding and, of course, away from your baby.

WHERE CAN I FIND HELP?

Visit 802quits.org for more information or help quitting, call 1-800-QUIT-NOW (1-800-784-8669) or talk to your healthcare professional.

For more information, there's no better resource than your healthcare professional. Remember, they're not there to judge. They're there to help you have the healthiest pregnancy possible. Keep the conversation going.

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Let's have a conversation about

ALCOHOL DURING PREGNANCY

and beyond

VERMONT DEPARTMENT OF HEALTH

PEOPLE WHO ARE PREGNANT, TRYING TO GET PREGNANT OR BREASTFEEDING

are encouraged to not drink alcohol for the health of their baby. But not drinking is sometimes harder than just deciding to quit, and quitting. And when you hear stories about how "my mother drank and I'm fine" and "so and so says a glass of wine is okay" it only gets more confusing. While nothing beats an open, honest conversation with your healthcare professional, here are some answers to your most common questions, both to give you the truth about cannabis use and pregnancy risks and to inform that next conversation with your provider.

IS ANY AMOUNT SAFE?

There is no known safe amount of alcohol use during pregnancy–no matter what your aunt or friend or anyone says. And a child is developing throughout pregnancy, so any alcohol use–even later in a pregnancy–can cause problems.

HOW CAN IT AFFECT MY BABY?

Drinking during pregnancy can cause miscarriage, stillbirth and lifelong physical, behavioral, or intellectual issues. Among them are difficulty in learning and attention span, hyperactivity, low IQ, speech difficulties, and poor reasoning skills. One of the most serious disorders is called Fetal Alcohol Spectrum Disorder (FASD). A baby born with FASD will have a small head, low weight and distinctive facial features.

I DRANK BEFORE I KNEW I WAS PREGNANT. IS THAT A PROBLEM?

If you drank alcohol in the first month of your pregnancy, it is unlikely any harm was done. It's important to note that the next few weeks (weeks 3-8) are the most sensitive to causing birth defects. If you did drink before you knew, it's best to let your healthcare professional know.

WHAT IF I HAVE A DRINK?

The best thing you can do if you do drink is talk about it. Understanding why you drank and finding alternatives can go a long way to being sure it's a one-time mistake. The more you drink, the greater the risks of doing harm so being honest about the slip up and avoiding another one is the best way to avoid issues.

IF I DRINK WINE AND NOT LIQUOR IS IT OKAY?

Alcohol is alcohol. It's the same chemical with the same negative effects no matter what form it's in. One glass of wine is no different than one cocktail or one beer. And none of them are good for a healthy pregnancy.

ARE THERE ANY SUGGESTIONS FOR SELF CARE?

If you drink when you know you shouldn't, alcohol may be a bigger problem than you know. Programs like Alcoholics Anonymous can help you develop the support you need to stop. VTHelpLink.org has other treatment options. But your greatest asset is your healthcare professional who can help find a care method that works for you.

HOW ABOUT BREASTFEEDING?

Drinking alcohol can make it more difficult for your body to produce breast milk. Alcohol passes very easily into breast milk, and roughly the same level of alcohol in a your blood is present in breast milk. Studies have shown drinking alcohol while breastfeeding can lead to a baby eating less, changes in sleep patterns and problems with motor development.

HOW LONG IS ALCOHOL IN MY BREAST MILK?

It takes between 2 and 2 1/2 hours for a standard drink to clear breast milk and an additional 2-2 1/2 hours for each additional drink. And nothing–not pumping and dumping, not drinking water, not drinking caffeine–can hurry this process.

WHERE CAN I FIND HELP?

Call 2-1-1, visit VTHelpLink.org or 802.565.LINK (5465) or talk to your healthcare professional.

For more information, there's no better resource than your healthcare professional. Remember, they're not there to judge. They're there to help you have the healthiest pregnancy possible. Keep the conversation going.

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Let's have a conversation about

OPIOIDS DURING PREGNANCY

and beyond

VERMONT DEPARTMENT OF HEALTH

PEOPLE WHO ARE PREGNANT, TRYING TO GET PREGNANT OR BREASTFEEDING

are encouraged to not use opioids for the health of their baby. Opioids are often prescribed for pain management and, when not taken as prescribed are highly addictive substances. Before taking opioids, talk to your healthcare professional about the risks, benefits and if you may be or are planning to be pregnant. While this conversation is critical for anyone taking opioids, it's also good to know some of the facts so you can go in well informed. To help, here are some answers to your most common questions. This way you have the latest information about opioids and pregnancy risks to inform that next conversation with your provider.

IS ANY AMOUNT SAFE?

There is no known safe amount of opioid use during pregnancy. Opioids are strong narcotics and use always carries a risk. However, patients prescribed medication or who may have a substance use disorder should always speak with their healthcare professional for the safest way to manage opioid use during pregnancy.

HOW CAN IT AFFECT MY BABY?

Opioid use during pregnancy can cause miscarriages, premature birth, preeclampsia, respiratory depression, low birth weight and neurobehavioral problems. Newborns can also suffer withdrawal symptoms, including hypersensitivity and hyper irritability, tremors, vomiting, respiratory difficulties, poor sleep, and low-grade fevers. Newborns with this neonatal abstinence syndrome (NAS) often require hospitalization and treatment, including medication (usually morphine) as their bodies adapt to being opioid free.

I USED BEFORE I KNEW I WAS PREGNANT, IS THAT A PROBLEM?

If you used opioids in the first weeks of pregnancy, chances are good that no harm was done. But if you're having trouble not using, you should seek help.

WHAT IF THEY WERE PRESCRIBED?

If your doctor has prescribed opioids for pain maintenance and you follow prescription instructions, you shouldn't just stop taking them when you become pregnant. Talk to your healthcare professional to be sure you still need the prescription and any risks associated with stopping.

ARE MAINTENANCE TREATMENT PROGRAMS SAFER?

When combined with prenatal care and a drug treatment program, Methadone and other maintenance programs can improve many of the negative effects associated with opioid addiction and the chances of a healthy birth.

ARE THERE ANY SUGGESTIONS FOR SELF CARE?

With opioids, self care is not recommended. The risks associated with withdrawals is too great for both you and your baby. Seek help from a healthcare professional.

HOW ABOUT BREASTFEEDING?

A person with an opioid substance use disorder who breastfeeds exposes the infant to increased risk to harmful effects, including respiratory depression, lethargy, trouble feeding and withdrawal symptoms such as tremors and high-pitched screaming. However, if medication was prescribed for pain moderation– as in the case of a Caesarian birth or other issue– and is taken exactly as directed, these risks are fairly low. Patients in treatment for opioid use are also encouraged to breastfeed as breastfeeding has shown improved outcomes for infants with NAS.

WILL OPIOIDS BE IN MY BREAST MILK?

Opioids are transferred to a baby through breast milk. This can cause lethargy and respiratory depression. But breastfed infants with NAS have a decreased need for pharmacological treatment and tend to have shorter hospital stays than formula-fed infants with NAS.

WHERE CAN I FIND HELP?

Call 2-1-1, visit VTHelpLink.org or 802.565.LINK (5465) or

For more information, there's no better resource than your healthcare professional. Remember, they're not there to judge. They're there to help you have the healthiest pregnancy possible. Keep the conversation going.

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You have a captive audience

- Pregnancy is an accepted time to seek healthcare and many pregnant people are not otherwise accessing primary care

- Pregnant people may be more interested in changing their lifestyle habits for the sake of the infant

What happens after birth?

- Discuss plans for managing anxiety and sleep after pregnancy, nausea should no longer be a factor
- Harm reduction: use less often, decrease amount, avoid breastfeeding in the 1-2hr after use
- SAFE SLEEP! Infants of parents that use substances, including cannabis are at an increased risk of SIDS

Clear communication is key!

- Marijuana use in pregnancy is not recommended, decreasing or stopping use should be encouraged
- In Vermont, marijuana use does not lead to a DCF report, but that may not be the case in neighboring states (NY)
- In VT a Plan of Safe Care must be completed with the family and a de-identified notification is sent to DCF for reporting to the Children's Bureau annually in accordance with federal law (CARA/CAPTA)

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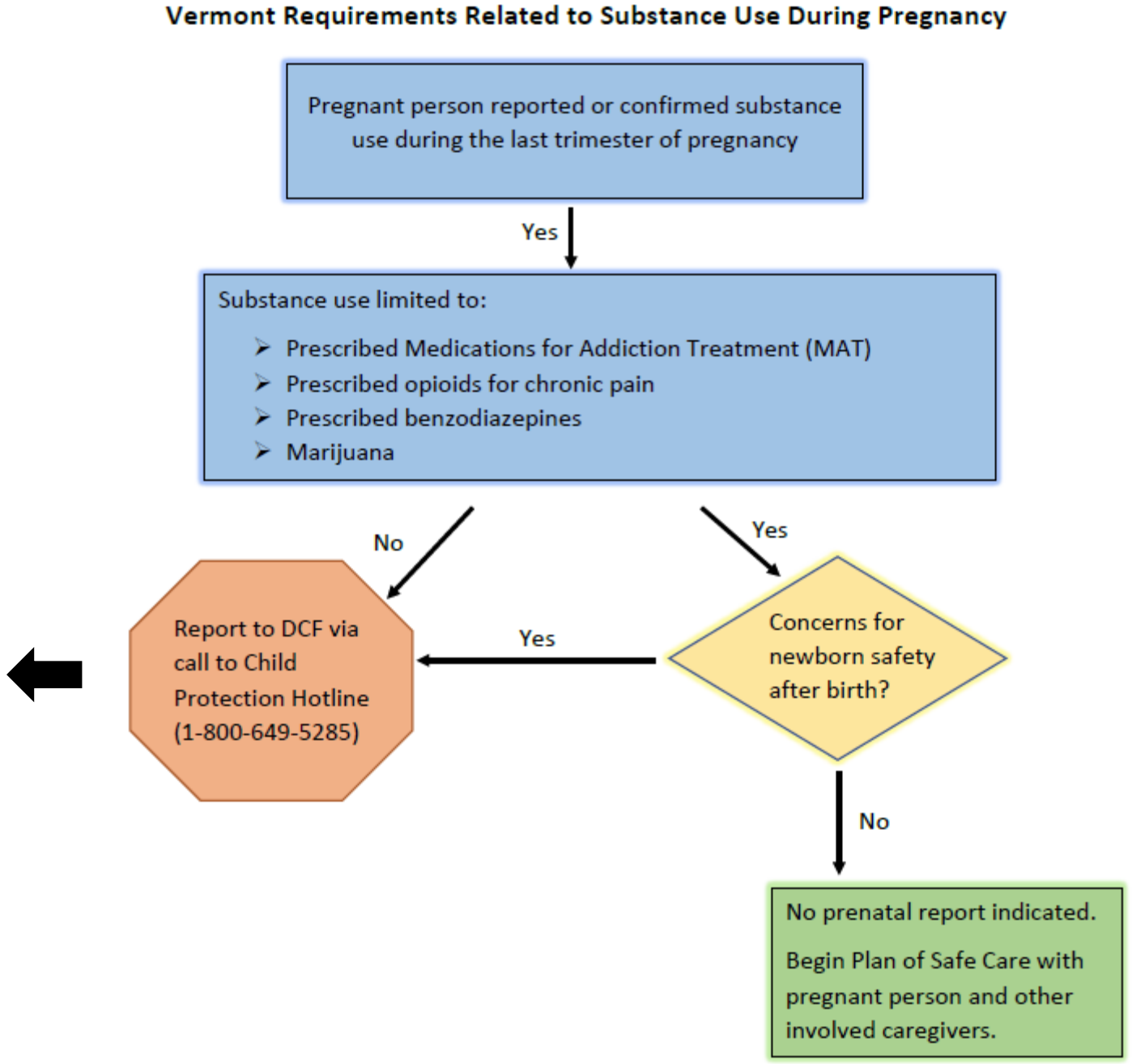
Prenatal reports:
Since January 2007, VT DCF is able to accept a report and open an assessment during pregnancy within 30 days of the estimated delivery date

Prenatal report acceptance criteria:
Use of an illegal substance or non-prescribed medication, or misuse of prescription medication during the last trimester of pregnancy.

And/or:
Concern for infant's health or safety related to ANY substance use (with the goal to address the safety concerns prior to birth).

Flowchart available on the DCF POSC Website:
https://dcf.vermont.gov/fsd/partners/POSC



DCF policy on marijuana use:
Effective November 1, 2017, if there are no other child safety concerns, marijuana use during pregnancy will not be accepted as a report.

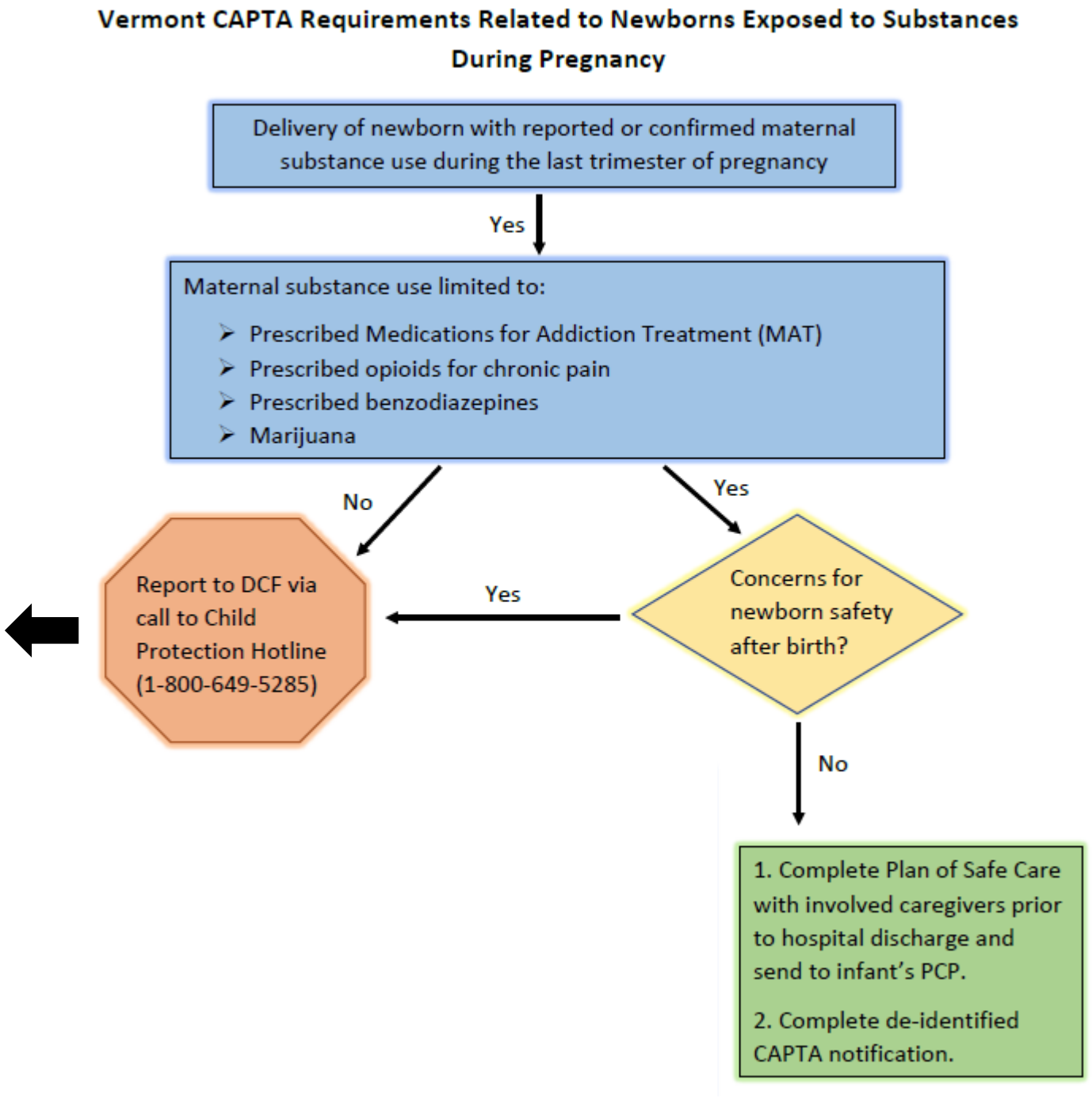
Update 2021: POSC and CAPTA notification for marijuana use after the 1st trimester

Newborn report acceptance criteria:

Positive toxicology screen or diagnosis of Neonatal Abstinence Syndrome related to maternal use of illegal substances or non-prescribed medication.

Diagnosis of Fetal Alcohol Spectrum Disorder.

Flowchart available on the DCF POSC Website:
https://dcf.vermont.gov/fsd/partners/POSC



Vermont POSC Parent Handout- revised for 2021

Vermont Plan of Safe Care for Families

What is a Plan of Safe Care?

The Plan of Safe Care is a document created with your help listing current supports and strengths your family has and any new community resources or referrals you may need after your baby is born. This plan will help your family and the infant's primary care provider communicate and be sure you have all the supports and services you need.

Who needs a Plan of Safe Care?

In Vermont, a Plan of Safe Care is developed when certain prescription medications or substances are used during pregnancy including:

- Prescribed medications for addiction treatment (MAT)
- Prescribed opioids for chronic pain
- Prescribed benzodiazepines
- Prescribed or recreational marijuana use continuing after the first trimester

What will be in your plan?

- Information about your current supports and services
- Information about new resources or referrals placed after the baby is born.
  Examples include: home health/nurse home visiting, parenting and recovery supports, financial or housing supports, and medical or developmental referrals.

Who keeps the plan?

You'll get a copy and one will be sent to your baby's primary care provider. A copy will also be stored in your baby's medical record.

Will the hospital provide information about me or my newborn to DCF?

- The use of prescribed MAT, opioids, or benzodiazepines as directed by a health care provider and/or marijuana use during pregnancy are not reported to DCF when there are no child safety concerns.
- The federal government requires states to track the number of babies exposed to substances. In Vermont, a de-identified notification form was made. This form has no names, birth dates, or other identifying information and is sent to the Family Services Division for tracking purposes only.
- A report containing information is made to the Vermont Department for Children and Families (DCF) only if:
  - There are concerns for your infant's safety.
  - There was use of illegal substances, non-prescribed medications, or misuse of prescribed medications during the third trimester of pregnancy (reported, found on screening tests, or infant has withdrawal)
  - Your baby is suspected of having Fetal Alcohol Spectrum Disorder or there was active alcohol use disorder in the third trimester of pregnancy.

Where can I get more information?

Talk to your obstetrical care provider if you have any questions about the Plan of Safe Care.

Frequently Asked Questions: Marijuana Use in Pregnancy

Q: When should healthcare providers ask pregnant individuals about marijuana use?

Conversations about substance use including marijuana, alcohol, tobacco, and other drugs should occur at every prenatal visit in an open, non-judgmental fashion.

Q: How should healthcare providers ask about marijuana use?

Prenatal providers should develop a work-flow for universal screening of pregnant individuals for substance use using questionnaires or verbally. Results should be documented to allow follow-up at subsequent visits.
For more information and resources, visit the Vermont Department of Health's One More Conversation campaign website: https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers

Q: What should I do if a pregnant individual discloses marijuana or other substance use?

First, thank them for their honesty. Then ask about reasons for using and whether they have interest in cutting back or stopping use. Discuss any concerns they have around effects on their baby and provide both verbal and written information about the impact of substance use on development. Consider referring for substance use counseling or treatment if indicated.

Q: How are infants affected by marijuana use during pregnancy and breastfeeding?

Current data suggests marijuana use during pregnancy may impact fetal growth and development. Some studies also show long-term effects on attention and behaviors in school age children exposed to marijuana during pregnancy. Tetrahydrocannabinol (THC), the active ingredient in marijuana is concentrated in fat cells, easily passing into breastmilk and may cause sedation, poor feeding and problems with weight gain of infants who are breastfed.

Q: Marijuana use is legal in Vermont, what about federal laws regarding marijuana use in pregnancy?

Under federal law, each state must provide the Children's Bureau with certain data regarding substance-exposed newborns. In addition, this legislation states a Plan of Safe Care (POSC) should be developed for all infants exposed to substances during pregnancy. Each state created their own process, in Vermont the de-identified Child Abuse Prevention and Treatment Act (CAPTA) notification form was developed. Please see "Frequently Asked Questions: Vermont Plan of Safe Care" and "Frequently Asked Questions: Vermont CAPTA Notifications" for more information.

Q: When is a Plan of Safe Care (POSC) and CAPTA notification required?

When there are no child safety concerns, a POSC and CAPTA notification form is required if a pregnant individual:

- Was treated by a healthcare provider with any of the following: medications for addiction treatment (MAT), prescribed opioids for chronic pain, or prescribed benzodiazepines.
- And/or used prescribed or recreational marijuana after the first trimester.

Q: What if a pregnant individual stopped using marijuana after discovering they are pregnant?

If a pregnant individual stops using marijuana in the first trimester a POSC and CAPTA notification are not required. If use continues into the second or third trimester of pregnancy a POSC and CAPTA notification should be completed.

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FAQs: Marijuana Use in Pregnancy (continued)

Q: In what situations is a DCF report made based on substance use during pregnancy?

The following situations meet Vermont's report acceptance criteria:

- A pregnant individual reports (or a healthcare provider certifies) the use of an illegal substance, use of non-prescribed prescription medication, or misuse of prescription medication during the last trimester of pregnancy.
- Concern that the pregnant individual's substance use constitutes a significant threat to an infant's health or safety (with the goal to address the safety concerns prior to birth).
- A newborn has a positive confirmed toxicology result (urine, meconium or cord) for an illegal substance or non-prescribed medication.
- A newborn develops signs or symptoms of withdrawal (neonatal abstinence syndrome) as the result of exposure to an illegal substance, use of non-prescribed medications, misuse of prescribed medication, or due to undetermined exposure.
- A newborn is suspected to have fetal alcohol spectrum disorder, or the pregnant individual had active alcohol use disorder during the last trimester of pregnancy.

Q: Why isn't the use of marijuana during pregnancy a DCF report?

Effective November 1, 2017, DCF no longer accepts reports where the sole concern is regarding marijuana use during pregnancy. While some studies have suggested that prenatal exposure to marijuana may be harmful, there is lack of sufficient evidence to warrant a child protection intervention.

Q: What if hospital staff believe a pregnant individual's use of marijuana is impacting their ability to safely parent their newborn?

A report to DCF should be made via the child protection hotline at 1-800-649-5285 in any situation where there is a concern for infant safety.

Q: Where can prenatal providers go for more information and educational materials on marijuana use during pregnancy?

- The Vermont Department of Health Substance Use in Pregnancy Information for Providers:
  One More Conversation https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers
- Centers for Disease Control and Prevention: https://www.cdc.gov/marijuana/factsheets/pregnancy.htm

Q: Where can hospital staff find the POSC and CAPTA notification forms?

The DCF Family Services Division website has the most updated version of these forms and supporting documents.
https://dcf.vermont.gov/fsd/partners/POSC

Q: Who can hospital staff contact if they have questions?

Questions can be emailed to AHS.DCFFSDCAPTA@vermont.gov or call 802-760-0476 and ask to speak with DCF's Policy and Planning Manager.

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Thank you!

If you are interested in perinatal healthcare and quality improvement consider joining the Perinatal Quality Collaborative Vermont (PQC-VT)

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The Perinatal Quality Collaborative – Vermont (PQC-VT)

PERINATAL QUALITY COLLABORATIVE VERMONT

The Perinatal Quality Collaborative-Vermont (PQC-VT) is a formal partnership of long standing Vermont Child Health Improvement Program projects that have joined forces to become Vermont's resource for perinatal care. In partnership with the Maternal and Child Health Division at the Vermont Department of Health, the PQC-VT will mobilize state networks to implement quality improvement efforts and improve care for mothers, babies and their families.

Goal: The PQC-VT will improve care and health outcomes of Vermont's pregnant people, newborns and their families by:

- **Setting Perinatal Outcome Priorities:** Actively engage perinatal health care professionals, maternal and child health public health experts and community-based partners in developing a common agenda by highlighting current successes and gaps in perinatal care and identifying specific pregnancy and infant health outcomes to focus on across the state.
- **Providing Outreach and Education:** Build relationships across sectors including hospitals, outpatient practices, community-based organizations, state health programs, and families to address current and emerging perinatal issues, and provide opportunities for collaborative learning on the latest best practices.
- **Advancing Quality Improvement Efforts:** Mobilize perinatal health care teams in continuous quality improvement efforts for better health outcomes, and disseminate successful system approaches throughout the state. Develop quality metrics appropriate for perinatal health care.
- **Monitoring Health Care Outcomes:** Efficiently analyze available perinatal and public health datasets to gage quality improvement work and opportunity, evaluate program implementation, and perform surveillance of health outcomes.

The PQC-VT Mission: Optimizing care and health outcomes in pregnancy and infancy through collaboration and continuous quality improvement.

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Resources: One More Conversation

Links for Providers:

- https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy-information-providers

- https://www.healthvermont.gov/sites/default/files/documents/pdf/adap_1MC_ProviderTipSheet.pdf
-

Link for patients:

- https://www.healthvermont.gov/family/pregnancy/substance-use-pregnancy

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Resources:

- https://vthelplink.org/app/Pregnant_and_Parenting
- NIDA quick screen: https://archives.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
- National Center on Substance Abuse and Child Welfare: https://ncsacw.samhsa.gov/topics/pregnant-postpartum-women.aspx
- https://www.samhsa.gov/marijuana/marijuana-pregnancy
- https://www.ok.gov/health2/documents/UP_Marijuana_Pregnancy_Fact_Sheet_2020.pdf
- https://mothertobaby.org/fact-sheets/marijuana-pregnancy/pdf/

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- National vital statistics: https://www.cdc.gov/nchs/nvss/births.htm

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