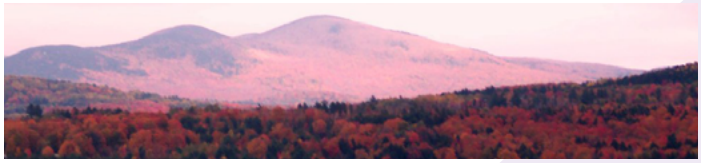
DATA SPOTLIGHT: PERINATAL HEALTH AND WELL-BEING



The foundation of child and family health and well-being starts before birth. The perinatal period, from pregnancy through one year after birth, is a key time for a child's long-term development and the well-being of the birthing parent, child, and family system. This period is a critical opportunity for providing access to concrete supports when interventions are particularly impactful. This chapter includes data and context on the current landscape and challenges as well as an overview of several long-standing and innovative opportunities for intervention, several of which are contained in the 2024 Policy Recommendations of Vermont's Early Childhood State Advisory Council. (See page 4 for the full slate of 2024 Policy Recommendations.)

Perinatal Mood and Anxiety Disorders (PMADs)

Perinatal mood and anxiety disorders (PMADs) are mental health conditions that develop at any time during pregnancy or after having a baby, through the year after delivery, adopting, or experiencing pregnancy or infant loss. Vermont has prioritized the screening, referral, treatment, training, support for families, and public awareness of PMADs for many years. **PMADs affected more than 25% of pregnant and postpartum people in Vermont in the 2018 to 2020 birth cohort[1], compared with a national prevalence of 11.5%.[2]** This may be in part due to increased public awareness, training, referrals, and higher screening rates, with 90% of pregnant people in Vermont screened for PMADs compared with 79% for the country as a whole.[1] PMADs are highly detectable and treatable, but when left untreated, PMADs have substantial impacts on the lives of those in the perinatal period, their families, and their communities. These include negative obstetric and non-obstetric physical health outcomes for both the birthing parent and child, productivity loss, and increased spending on social services resulting in an estimated cost of $36,000 per birthing parent and their child in Vermont.[1]

25% of pregnant and postpartum people in Vermont in the 2018 to 2020 birth cohort were affected by PMADS, compared with 11.5% nationally.[1]

More information is needed about the prevalence of PMADs in non-birthing partners and adoptive parents. For non-birthing partners, a recent meta-analysis showed a **global prevalence of 7.3% for paternal prenatal and postpartum depression and 10.7% for paternal prenatal and postpartum anxiety.[3]** PMAD screening for non-birthing and adoptive parents is inconsistent, as PMADs were historically thought to be linked to physiological changes only impacting the birthing parent.

Perinatal Substance Use

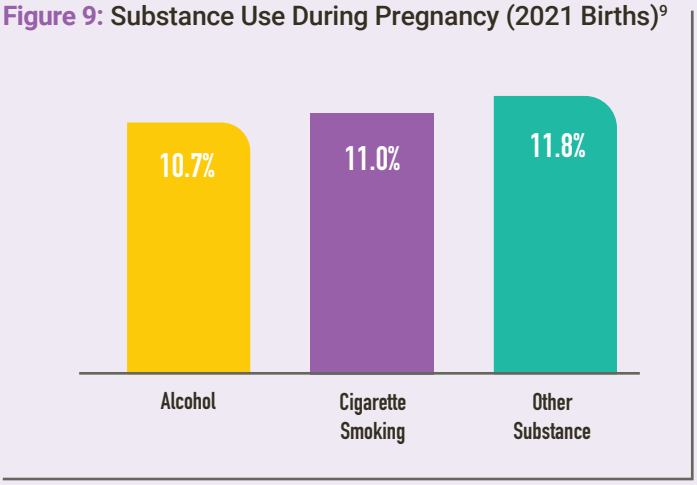
Substance use during the perinatal period can have lifelong effects on a child's ability to thrive. Vermont PRAMS (Pregnancy Risk Assessment Monitoring System) is an ongoing self-reporting survey of Vermont parents who recently gave birth. The most recent Vermont PRAMS data from 2021 births reported by the Vermont Department of Health (VDH) shows a moderate decrease in substance use among perinatal people.[4]

Substance Use During Pregnancy: Opioid use in Vermont continues to occupy the headlines, with a "third wave" of the opioid epidemic arriving with inexpensive and potent fentanyl. In 2021, **Vermont's rate of infants born with a diagnosis of drug withdrawal syndrome was 13.6 per 1,000 live births.[5]** However, the Vermont rate is down from 24 per 1,000 live births in 2018 and significantly decreased from a peak of 35.7 per 1,000 live births in 2014.[5]

Opioids are not the only substances used during pregnancy. As can be seen in Figure 9, **non-exclusive categories show the use of alcohol, cigarettes, and other substances ranging from 10.7% to 11.8% for children born in 2021, meaning that one or more substances were used during more than 1 in 10 pregnancies.[4]**

Perinatal Mortality and Substance Use Disorder (SUD): Since 2012, Vermont has had an average of two to three perinatal deaths per year from any cause (from pregnancy through the first year postpartum for the birthing individual). In 2022, Vermont saw a sharp increase in overall number of maternal deaths with a total of six deaths.[6]

Figure 9: Substance Use During Pregnancy (2021 Births)[9]



In 2023, the Vermont Maternal Mortality Review Panel (MMRP) reviewed seven perinatal deaths occurring between 2021 and 2023. **All the deaths reviewed for this time period were either from accidental overdose or from infection resulting from intravenous drug use. Most of the accidental overdose deaths involved polysubstance use.** In addition, all deaths reviewed occurred in the postpartum period and in the home or in the community. The MMRP has identified the period from 3 to 12 months postpartum as particularly vulnerable for perinatal people. In their 2024 legislative report, the MMRP issued multiple recommendations for the state, many of which were related to improvements to screening, support, and care coordination for those with SUD.[7]

100% of perinatal deaths reviewed were directly related to substance use disorder.[7]

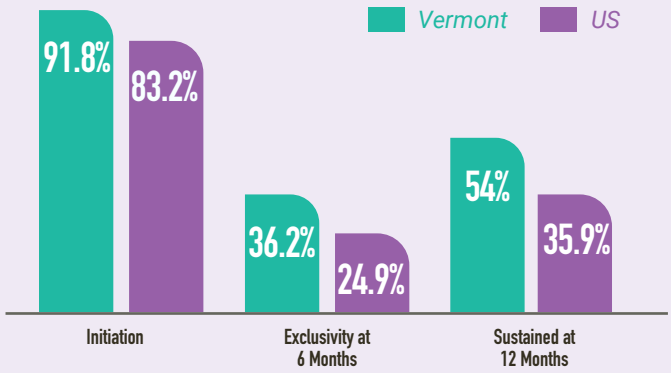
Opportunities for Intervention and Health Promotion Strategies

There are numerous long-standing and innovative approaches to supporting birthing parents, children, and family systems during the perinatal period. It is well known that prevention is more effective and less expensive than treatment, and the perinatal period is a key time for intervention. A partnership between the Vermont Child Health Improvement Project and the Family and Child Health Division at the Vermont Department of Health, the Perinatal Quality Collaborative Vermont (PQC-VT), mobilizes state networks to implement quality improvement efforts and improve care for perinatal people. The mission of the PQC-VT is to optimize health access, treatment, and outcomes in the perinatal period and infancy through collaboration and continuous quality improvement. There are many additional regionally run initiatives to support birthing families, many of which are collaborations among providers, community partners, perinatal health organizations, and other organizations focused on well-being.

Prenatal and Postpartum Visits: Prenatal and postpartum care is an essential tool for supporting healthy pregnancies and long-term outcomes. **Of the 5,379 Vermont babies born in 2021,[8] 86.7% of birthing parents had adequate prenatal care (early entry and regular visits), and 94.4% had a postpartum visit. Of birthing parents, 79.6% had a visit with a health care provider in the year before pregnancy.[4] Of births in 2021, 72% of pregnancies were intended,** surpassing the Healthy Vermonters 2030 goal of 65%.[4]

Care and Feeding of Infants: Families make the best choice for their unique situation with recommendations from their health care providers about the feeding of their infants. Breastfeeding and chestfeeding may not be available or may not be the right choice for all families for a multitude of reasons. For those who are able, breastfeeding/chestfeeding is associated with preventing obesity and diabetes in children, and puts birthing parents at lower risk for breast and ovarian cancer, diabetes, hypertension, and cardiovascular disease. Across the board, when compared to the whole U.S., **Vermont has higher rates of breastfeeding/chestfeeding initiation (91.8% vs. 83.2%), exclusive breastfeeding/chestfeeding through 6 months (36.2% vs. 24.9%), and sustained breastfeeding/chestfeeding through 12 months (54% vs. 35.9%); and lower rates of infants receiving formula before two days of age (9.5% vs. 19.2%) among infants born in 2019.**[9]

Figure 10: Breastfeeding/Chestfeeding Rates for 2019 Births, Vermont and U.S.[9]



Screening and Psychiatric Consultation for Perinatal Mood and Anxiety Disorders: When an individual is diagnosed with a PMAD, clinicians in Vermont have the opportunity to consult with the Perinatal Psychiatric Consultation Service about medication treatment plans, therapeutic needs, and appropriate referrals. The Perinatal Psychiatric Consultation Service also provides training and technical assistance to medical and mental health providers. **Financial cost savings from this program are estimated at $200,000 per year at current staffing and $650,000 per year with expanded capacity and coordination. In addition, it is estimated that 47% of individuals who receive this support will achieve remission from a PMAD.**[10]

Developmental Understanding and Legal Collaboration for Everyone (DULCE): DULCE is implemented in pediatric practices and proactively addresses social determinants of health, promotes the healthy development of infants, and provides support to their parents during the first six months of life. **DULCE programs are currently offered at six sites across Vermont and served 350 babies between January and October of 2023.**[11] Three new sites will launch in 2024 serving Burlington, St. Albans and St. Johnsbury.[12] DULCE embeds into the pediatric care team a Family Specialist, employed by the region's Parent Child Center (PCC), who attends well-child visits with families and providers. Trained in child development and relational practice, the Family Specialist connects families to the concrete supports and resources they need. DULCE implementation includes collaboration among the medical practice, the PCC as the early childhood sector lead, and a legal partner to universally support families by addressing the accumulated burden of social and economic hardship.

HIGH-QUALITY AND INCLUSIVE PHYSICAL AND MENTAL HEALTH SERVICES (VECAP GOAL 3)

Invest in Perinatal Supports

- Invest in statewide strategies that center early relational health to ensure families are supported across clinical and community settings during the critical perinatal period, including after experiencing the loss of a child or loss of a caregiver.
  - Fund the expansion of Developmental Understanding and Legal Collaboration for Everyone (DULCE) approach sites.
  - Invest in peer- and community-based strategies such as multiagency collaboration teams, like regional CHARM/Community Response teams, to ensure families have the supports they need through a strength-based approach and in recognition that Vermont's maternal mortality incidences have a concerning overlap with substance use disorders (SUD).
  - Ensure continuity of care and high-quality services are available for the perinatal population. Expand Children's Integrated Services (CIS) supports past the 8-week postpartum period to the full year postpartum for the birthing person, in alignment with postpartum Medicaid expansion.
  - Pursue strategies that center equitable services and birth-related outcomes for parents/caregivers of color, including expanding Medicaid coverage to doula services.

Home Visiting: The transition to parenthood is a time of celebration as well as potential stress. Home visiting programs provide new and expectant parents with information, support, and referrals to community resources and services.

Strong Families Vermont Home Visiting offers two evidence-based home visiting programs, the Maternal Early Childhood Sustained Home Visiting (MECSH program and Parents as Teachers (PAT)). The MECSH program just completed its fifth year of implementation across the state. **During program year 2022, MECSH served 421 families and 393 children with a total of 3,175 visits.**[13] The PAT program is in the development phase, with nine PAT affiliate programs across Vermont. **Initial engagement for the development year of PAT has included 21 families with 21 children served for a total of 315 visits.** The program will shift to full implementation next year with a full staff and integration into affiliate programs, which will increase capacity.[13]

Home-based Early Head Start and Head Start home visiting served 308 infants and pregnant individuals during program year 2023.[14]

Paid Family and Medical Leave: Access to paid family and medical leave is associated with improved physical and mental health for new parents, decreased infant mortality, financial security for caregivers in the short and long term, and improved connections to the workforce, particularly for women, who are more likely than men to be caregivers for children and older adults.[15] Nationally, 27% of workers have access to a paid family leave policy through their employer and more than 90% have access to unpaid family leave.[16] **In Vermont, 47% of birthing parents returning to work after having a child do not have paid leave.** Birthing parents returning to work in Vermont after paid leave are more likely to have private insurance (72%), while only 26% of birthing parents with access to paid leave are on Medicaid.[17] **Access to paid family leave has been associated with birthing parents being more likely to be working (18.3% higher probability) one year following birth and an average increase of $3,400 in household income among birthing parents of 1-year-olds.**[18]

47% of birthing parents returning to work after having a child do not have paid leave in Vermont.[18]

Additional physical and mental health access and utilization data can be found beginning on page 16, and related recommendations can be found on page 4.

ACCESS TO BASIC NEEDS (VECAP GOAL 1)

Paid Family and Medical Leave Insurance

- Enact a Paid Family and Medical Leave Insurance program for Vermonters seeking to take time off to care for a family member or themselves while welcoming a new child into the family, while navigating an illness or injury, or after experiencing a loss. Ensure that the benefit through this program covers all caregivers in the case of a two-parent household, and that the benefit is generous enough that loss of income is not a barrier for those looking to utilize the program.