PRISM Policy Academy
Virtual Learning Session #1: Universal Screening/Testing

Thursday, May 16, 2019
Today’s Agenda

1:00pm  Welcome and Introductions

1:05pm  Universal Maternal Urine Drug Testing

1:20pm  Indiana’s Plan to Address Perinatal Substance Use

1:35pm  Protecting the Human and Civil Rights of Pregnant Women: Substance Use

1:50pm  Q and A

2:00pm  Adjourn
Objectives

• Describe the differences between universal screening and testing,

• Delineate the process by which Indiana developed and advanced legislation on universal screening, and

• Articulate possible ethical and legal concerns around universal screening implementation.
Please note:

The content, findings, and conclusions shared in this presentation are those of the speakers and do not necessarily reflect the official positions of or endorsements by ASTHO, AMCHP, or the PRISM project funder (HRSA).
• Scott L. Wexelblatt, MD
• Regional Director of Newborn Services, Perinatal Institute
• Assistant Professor, UC Department of Pediatrics
Universal Maternal Urine Drug Testing

Scott L. Wexelblatt, MD

• Medical Director Regional Newborn Services, Cincinnati Children’s Hospital Medical Center
• Associate Professor, Department of Pediatrics, University of Cincinnati College of Medicine
NAS/NOWS

• Signs and symptoms associated with opioid withdrawal.
• 55-95% will have signs of withdrawal
• 20-50% will need pharmacologic treatment for severe withdrawal.
• Average timing of treatment is 44 hours.
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2004 to 2008

Legend
- ADAMHS Board

Rate per 1,000
- 0.0 - 2.5
- 2.6 - 5.8
- 5.9 - 6.2

Map Information:
This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 2.2 discharges for NAS per 1,000 live births statewide between 2004 and 2008. Counties with the highest rates of NAS discharges were Athens (6.2), Scioto (6.0) and Madison (5.8). NAS discharge rates for 10 counties were at or close to zero during this time.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
- Data adapted by OhioMHAS from
- the Ohio Hospital Association &
- the Ohio Department of Health
- Map produced March 2014
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2005 to 2009

Legend

- ADAMHS Board
- Rate per 1,000
  - 0.0 - 2.5
  - 2.6 - 5.8
  - 5.9 - 9.0

Map Information:

This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 3.0 discharges for NAS per 1,000 live births statewide between 2005 and 2009. Counties with the highest rates of NAS discharges were Athens (9.0), Lawrence (8.5), Pickaway and Ross (both 7.7). NAS discharge rates for five counties were at or close to zero during this time.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from the Ohio Hospital Association & the Ohio Department of Health
Map produced March 2014
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2006 to 2010

Legend
- ADAMHS Board

Rate per 1,000
- 0.0 - 2.5
- 2.6 - 5.8
- 5.9 - 11.0
- 11.1 - 14.1

Map Information:
This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 777.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 3.9 discharges for NAS per 1,000 live births statewide between 2006 and 2010. Counties with the highest rates of NAS discharges were Pickaway (14.1), Athens (10.9) and Ross (9.5). NAS discharge rates for five counties were at or close to zero during this time.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OHMHAS from the Ohio Hospital Association & the Ohio Department of Health. Map produced March 2014
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2007 to 2011

Legend
- ADAMHS Board

Rate per 1,000
- 0.0 - 2.5
- 2.6 - 5.8
- 5.9 - 11.0
- 11.1 - 24.5

Map Information:
This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 5.3 discharges for NAS per 1,000 live births statewide between 2007 and 2011. Counties with the highest rates of NAS discharges were Scioto (24.5), Pickaway (18.4) and Pike (18.3). NAS discharge rates for four counties were at or close to zero during this time.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from the Ohio Hospital Association & the Ohio Department of Health
Map produced March 2014
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2008 to 2012

Legend
- ADAMHS Board

Rate per 1,000
- 0.0 - 2.5
- 2.6 - 5.8
- 5.9 - 11.0
- 11.1 - 52.6

Map Information:
This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 6.9 discharges for NAS per 1,000 live births statewide between 2008 and 2012. Counties with the highest rates of NAS discharges were Scioto (52.6), Lawrence (40.8) and Pike (38.9). Carroll (0.7), Holmes (0.5) and Auglaize (0.0) counties had the lowest rates of NAS discharges.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from the Ohio Hospital Association & the Ohio Department of Health
Map produced March 2014
Discharge Rates for Neonatal Abstinence Syndrome per 1,000 Live Births

Five-year Weighted Average from 2009 to 2013

Legend
- ADAMHS Board

Rate per 1,000
- 0.5 - 2.5
- 2.6 - 5.8
- 5.9 - 11.0
- 11.1 - 76.0

Map Information:
This map examines the discharge rates for neonatal abstinence syndrome (NAS; ICD-9 779.5) per 1,000 live births in Ohio by county of patient residence. On average, there were 8.8 discharges for NAS per 1,000 live births statewide between 2009 and 2013. Counties with the highest rates of NAS discharges were Scioto (76.0), Lawrence (96.7) and Pike (57.7). NAS discharge rates were lowest in Holmes (0.5), Carroll (0.7) and Auglaize (1.0) counties.

Note: Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards have black borders, and counties have white borders. Borders are black in cases where ADAMHS boards and counties have the same borders.

Data Source:
Data adapted by OhioMHAS from the Ohio Hospital Association & the Ohio Department of Health
Map produced June 2015
What a difference over the years...
Cincinnati Region is defined by patients being born at: Bethesda North, Christ, Fort Hamilton, Good Samaritan, Mercy Anderson, Mercy Fairfield, Mercy West, St. Elizabeth, and University Hospitals
Cincinnati Region: Opioid exposure rate per 1,000 births
Cincinnati Region (677% increase)
Cincinnati Region: NAS rate per 1,000 births
(NAS defined as requiring pharmacologic treatment)
Cincinnati Region (262% increase)

NAS (needing pharmacologic treatment) rates per 1,000 births

0 2 4 6 8 10 12 14

12% decrease
Cincinnati Region: Exposure to any substance per 1,000 births
Cincinnati Region (852% increase)
Screening vs Testing

• Difference between a Screen and a Test
Maternal Risk Based Screen

- ACOG Committee Number 711, August 2017.
- Updated replaces Committee Opinion Number 524, May 2012.
- Recommends universal screening at first visit.
- Recommends obtaining consent prior to testing.
Box 1. Clinical Screening Tools for Prenatal Substance Use and Abuse

4 P’s
Parents: Did any of your parents have a problem with alcohol or other drug use?
Partner: Does your partner have a problem with alcohol or drug use?
Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
Present: In the past month have you drunk any alcohol or used other drugs?

Scoring: Any “yes” should trigger further questions.

Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990.

CRAFFT—Substance Abuse Screen for Adolescents and Young Adults

C Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?
R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A Do you ever use alcohol or drugs while you are by yourself or ALONE?
F Do you ever FORGET things you did while using alcohol or drugs?
F Do your FAMILY or friends ever tell you that you should cut down on your drinking or drug use?
T Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more positive items indicate the need for further assessment.
# NIDA Quick Screen

## Quick Screen Question:

In the past year, how often have you used the following?

### Alcohol
- For men, 5 or more drinks a day
- For women, 4 or more drinks a day

### Tobacco Products

### Prescription Drugs for Non-Medical Reasons

### Illegal Drugs

#### Q1. In your *LIFETIME*, which of the following substances have you ever used?  
<table>
<thead>
<tr>
<th>Substance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis (marijuana, pot, grass, hash, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine (coke, crack, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine (speed, crystal meth, ice, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedatives or sleeping pills (Vallium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street opioids (heroin, opium, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription opioids (fentanyl, oxycodone [OxyConti, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Please record nonmedical use only: Non-medical use refers to using a substance either not prescribed to the patient or used in ways or amounts not prescribed by their doctor.

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### Ask the following questions for each drug mentioned in Question 1:

#### Q2. In the past 3 months, how often have you used [insert name of drug]?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

- If the answer to Question 2 is "never", skip to Question 6. Otherwise, continue with Questions 3

#### Q3. In the past 3 months, how often have you had a strong desire or urge to use [insert name of drug]?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Q4. In the past 3 months, how often have you used [insert name of drug] that led to health, social, legal or financial problems?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Q5. In the past 3 months, how often have you failed to do what was normally expected of you because of your use of [insert name of drug]?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
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<tbody>
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<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Ask Questions 6 & 7 for all substances ever used
(i.e., those mentioned in Question 1):

- NO
  - YES, but not in the last 3 months
  - YES, in the past three months

#### Q6. Has a friend or relative or anyone else ever expressed concern about your use of [insert name of drug]?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Q7. Have you ever tried and failed to control, cut down, or stop using [insert name of drug]?
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
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<td>5</td>
</tr>
</tbody>
</table>

**Instructions:** Ask Section 8 if patient mentions ANY drug that might be injected, including those that might be listed in the "Other" category (e.g., steroids). Circle appropriate response.

#### Q8. Have you ever used [any drug (including steroids)] by injection?  
- Indicate you are referring to non-medical use only.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
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<td>5</td>
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</tbody>
</table>
NIDA Quick Screen

**High Risk Score >27**
- Provide feedback on screening results
- Advise, Assess, Assist
- Arrange referral
- Offer continuing support

**Moderate Risk Score 4-26**
- Provide feedback
- Advise, Assess, Assist
- Consider referral based on clinical judgment
- Offer continuing support

**Lower Risk Score 0-3**
- Provide feedback
- Reinforce abstinence
- Offer continuing support

- **Advise** — Provide medical advice related to patient’s drug use
- **Assess** — Determine patient’s readiness to change
- **Assist** — Offer help based on patient’s readiness level
- **Arrange** — Refer patient for specialty assessment and/or drug treatment, if necessary
Toxicology Testing

• **Immunoassay:**
  • Positive or Negative as a result
  • False positive with diet/medications.
  • Immediate result

• **Mass spec:**
  • Absolute number as a result
  • CCHMC: Tests for 47 drugs of abuse on a drop of urine in a 6 minute analysis run.
    • If samples arrive in lab by 10:30AM then report by the end of the day.

Currently send out for meconium and cord which allows 14-20 weeks of detection
Self-reported and laboratory evaluation of late pregnancy nicotine exposure and drugs of abuse

- 8.6% self-reporting cigarette use.
- Mass spectrometry detected high-level nicotine exposures for 16.5% of the 708 women (P<0.001) and an additional 7.5% with low-level exposures.
Cincinnati Universal Testing Study

- We evaluated the efficacy of a universal testing protocol for all mothers in a community hospital setting that experienced a three-fold increase in neonatal abstinence syndrome (NAS) and compared it to the standard screening tool used in the community.

- In 2012 Mercy Hospital Anderson cared for 1,868 neonates born to 1,874 women of whom 96% were Caucasian, 52% were married, and 51% had private insurance.

Table I. Maternal risk-based screen used at Mercy Anderson Hospital before universal testing

- Documented, suspected, or acknowledged maternal history of drug use
- Insufficient prenatal care, defined as starting care after 12 weeks gestation
- Placental abruption
- Admission from a justice center
- Positive for HIV
- Positive for hepatitis B surface antigen
- Positive for hepatitis C virus
- Maternal history of gonorrhea or syphilis
Universal testing

- Number of Admissions: 2,995
- Number of Urine Drug test sent: 2,956
  - Number of Refused Test = 1
  - Test not done = 38
  - Positive Test Results: 159/2,956 (5.4%)
  - Negative Test Result: 2,797
Universal testing Pilot

Positive Test Results
159/2,956 (5.4%)

Positive for Opiates
96/2,956 (3.2%)

Positive for Others
63/2,956 (2.1%)

Positive Risk Based Screen
77/96 (80%)

Negative Risk Based Screen
19/96 (20%)

Positive Risk Based Screen
46/63 (73%)

Negative Risk Based Screen
17/63 (27%)

Number of Negative Risk based screen infants needing additional care for signs and symptoms of NAS
7/19 (37%)

Total Number of Positive tests with a Negative Risk Based Screen
36/159 (23%)

• Cincinnati region started universal maternal drug testing on Sept 1\textsuperscript{st}, 2013.
• Encourage consent at each hospital
• Recommend DAU 13 for mother and infant due to increase in buprenorphine availability.
• Send confirmation test (mass spec) for denial of use.
• 18 hospitals in our region now doing universal testing (2017)
  • ~25,000 deliveries/year
I (Date of Birth) give my informed consent to Dr. [Name] and other practitioners and persons needed to assist with the birth of my infant(s). I understand and agree that the birth and other care below will be provided by my physician/nurse or any licensed professional. This form has been explained to me, all my questions have been answered and I have been given no guarantee about the outcome of birth to myself, my infant or any other care determined to be medically necessary.

- the nature of the birth methods we intend to use
- the recommended method
- the risks involved
- the risks associated with birth and the risks associated with the method of delivery we have selected
- Normal vaginal delivery
- Cesarean Birth
- Trial of Labor After Cesarean Birth (TOLAC)
- Induction of Labor in combination with the above

I also understand that unknown circumstances at the time of my infant’s birth may require another method to be used for the safety of my infant or myself. Should that occur, I permit the physician/nurse to use alternative methods of birth that would be best, including use of vacuum extraction or forceps delivery. In addition, I understand that during the course of my birth medical necessity may require other care. Should that be necessary, I consent to the provision of other care for myself and my infant(s).

Blood and Blood Products
I give my physician permission to administer the blood or blood products that may be necessary during birth, after my birth and to the well-being of my infant. I understand that there is a risk of transmission of infections or adverse reactions and acknowledge that no guarantee has been given by the hospital, any blood bank or any person of the safety of blood components administered. I acknowledge that the risks, benefits, alternatives, and side effects related to seeking or refusing to receive blood and blood products have been explained to me. I further acknowledge that the risks, benefits, and side effects related to alternatives to receiving blood or blood products have been explained to me.

Consent
If a male infant is born, the physician/nurse has explained the risks, benefits, and alternatives of circumcision of my infant. I understand how the procedure is performed, if anesthesia of other pain relief medications will be used, and that circumcision can involve blood loss and infection. I understand that circumcision is not required by law. I understand the risks, benefits, and alternatives of not circumcising my infant. I understand that I may not have my baby circumcised at this time if my infant is born here. I understand that I may request circumcision at a later date and I understand that the hospital will not provide care for any condition that was not a normal part of the birth process.

Lab Testing
I understand that for my safety and that of my infant a blood and urine sample will be obtained that will be used for conditions including syphilis, presence of drugs or controlled substances, anemia and other blood disorders. If positive results are obtained, subsequent testing will be completed on my infant as necessary.

Lab testing
I understand that for my safety and that of my infant a blood and urine sample will be obtained that will be used for conditions including syphilis, presence of drugs or controlled substances, anemia and other blood disorders. If positive results are obtained, subsequent testing will be completed on my infant, as necessary.

I have read this form or had it read to me. I fully understand the material risks, benefits, and alternatives, and have all of my questions answered to my satisfaction.

Patient/Legal Representative Signature
Relationship of Legal Representative
Date
Time

Witness Signature
Witness Name
Date
Time

Practitioner Signature
Date
Time
Universal Testing

• Being able to start non-pharmacological bundle earlier, may lead to a decrease in percentage of infants requiring medications for NAS.

• Our 14 hospitals have a 28-31% of opioid exposed infants need pharmacologic treatment vs. 42% OPQC statewide data.
  • One hospital with 4,000 deliveries has 22% Rx rate.
Current Universal Maternal Testing
2016 Women in OH

Rate per 100,000

- Hep B: 19.1
- Syphilis: 4.8
- HIV: 3.4
Current Universal Maternal Testing
2016 Women in OH

Rate per 100,000

- Hep B: 19.1
- Syphilis: 4.8
- HIV: 3.4
- Opioid: 3,300
JFS Children in Custody / Foster Home Rising
Total 43% Increase / New 52% Increase
Questions?

"The problem with quotes on the Internet is that no one can confirm their authenticity."

—Abraham Lincoln
• Kristina Box, MD, FACOG
  State Health Commissioner of Indiana
Indiana’s Plan to Address Perinatal Substance Use

ASTHO Webinar, May 16, 2019
How It Started

Intersection of two top Indiana health priorities: Infant mortality and opioid epidemic

- Indiana has 7th highest infant mortality rate in U.S., at 7.3 per 1,000 live births
- 44% of Indiana overdoses occurred among women of peak childbearing years
- Drug epidemic contributes to infant mortality in our state
  - Women who use substances in pregnancy are 3-4 times more likely to experience fetal or infant death
44% female opioid overdose deaths were among women who were in prime child-bearing age.
Public Health Response vs. Punitive Approach to SUD in Pregnancy

• Preventing unintended pregnancies
• Universal verbal screening for alcohol and drugs for all women of childbearing age
• Universal verbal / targeted lab screening for all pregnant women, and improved access to SUD treatment in pregnancy.
• Improved funding and support for social services and child welfare
Perinatal Substance Use Task Force and Pilot Program

- Task force launched in 2014
- NAS definition, uniform process, educational materials in 2015
- Launched in 2016 with 4 pilot hospitals
- Expanded to 21 hospitals in 2017
- 30 hospitals currently participating
- Goal is to better understand prevalence of babies born drug-exposed
NAS Revised Definition

• Symptomatic; tremors/jitteriness, difficult to console, poor feeding, or abnormal sleep and

• Have one of the following:
  1) A positive toxicology test, or
  2) A maternal history with a positive verbal screen or toxicology test.
OB / Pediatric Provider Protocol

• Destigmatization of SUD in pregnancy
• Validated verbal screen
• Urine toxicology screening (opt out)
• Obstetrical team able to provide MAT
• Wrap around services in the same clinic with:
  o Mental health professional
  o Patient care coordinator/OB navigator
• Inpatient Care / like Fresh start of Fayette regional
• Transition to recovery housing
• Standardize definition of NAS/treatment
• Discharge planning and follow-up for babies/families
• Maternal LARC
Indiana Using 10 Panel Screen of Umbilical Cord

- Amphetamine
- Cocaine
- Cannabinoids
- Barbiturates
- Methadone
- Benzodiazepine
- Oxycodone
- Buprenorphine
- Opiates
- Fentanyl

Alcohol blood spot test
## Screening Report

**1/1/17 - 3/31/19**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of births</td>
<td>69,716</td>
</tr>
<tr>
<td>Number of cords tested</td>
<td>12,626 (18% of births)</td>
</tr>
<tr>
<td>Number of positive cords</td>
<td>4,681 (37.1% of cords tested) (6.7% of births)</td>
</tr>
<tr>
<td>Number of NAS diagnoses</td>
<td>842 (6.6% of cords tested) (1.2% of births)</td>
</tr>
<tr>
<td>Rate of positive cords per 1,000 cords tested</td>
<td>370.7</td>
</tr>
<tr>
<td>Rate of positive cords per 1,000 live births</td>
<td>67.1</td>
</tr>
<tr>
<td>Rate of NAS diagnosis per 1,000 cords tested</td>
<td>66.7</td>
</tr>
<tr>
<td>Rate of NAS diagnosis per 1,000 live births</td>
<td>12.1</td>
</tr>
</tbody>
</table>
Data reflects the 26 hospitals using USDTL for cord tissue testing.
2019 Legislative Efforts

- **OB Navigators**
  - Identify high-risk Medicaid OB patients as early in pregnancy as possible and deploy services in communities with limited access to care
  - Connect an OB Navigator to each patient to address issues that contribute to infant mortality:
    - Lack of prenatal care in first trimester
    - Smoking, substance use disorder, prior preterm birth, diabetes, high blood pressure, etc.
    - Socio-economic factors that prevent women from seeking and following through with care

- **Universal verbal screening for substance use disorder in pregnant women**
  - 44% of Indiana’s female overdose deaths were women aged 20-40 years
  - Women more motivated to seek treatment when pregnant or have a newborn at home
  - Requires providers to connect women with positive screen to treatment
  - An estimated 578 babies born exposed to opioids in 2016, 140 percent increase since 2003

- **2019 budget request includes $6.6 million over two years for these efforts**
Questions?

Kris Box, MD, FACOG
Indiana State Health Commissioner
kbox@isdh.in.gov
• Indra Wood Lusero, JD
• Staff Attorney for National Advocates for Pregnant Women (NAPW)
Protecting the Human and Civil Rights of Pregnant Women: Substance Use

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Overview

• Value of law
• Context of the Perinatal Health Care System
• Drug screening/testing
• Mandatory Reporting
• Innovations and Opportunities
The Value of Law

• The law anticipates conflicts
• The law allows you to get perspective
• The law clarifies roles/power - due process
• The law makes you check your impulses
Context of the Perinatal Health Care System


*Early Release / May 7, 2019 / 68

How hospitals are failing new moms, in graphics

Why thousands of moms are needlessly injured, and some die, giving birth every year in the U.S.
Over the last 40 years, state policy environments related to alcohol use during pregnancy have become increasingly punitive.
Drug Screening/Testing

• Pregnant and postpartum women and their newborn babies are often drug tested in medical settings without their knowledge or explicit, informed consent.
  • This undermines the doctor-patient relationship and violates human and civil rights.
• Drug testing practices further discrimination and racial profiling.
  • Universal screening doesn't necessarily reduce disparities.
• Drug tests may be conducted improperly or produce inaccurate results.
  • Clinical results are not reliable, but even when they are, what are they used for?
  • Consequences to families can be devastating.
Mandatory Reporting

• There is no evidence that it works.
  • And the focus on investigations takes resources away from families who could benefit from help.
• It puts providers in conflict with their duties and their patients.
  • Undermines therapeutic relationship, keeps pregnant women in particular away from prenatal care.
• There is confusion about what to report.
  • CAPTA does not require an abuse report for babies who test positive.
  • Providers often defer to the agency - costing families & the agencies.
  • Abuse = substance use is a relic from the “crack baby” myth.
• A positive test does not equal abuse.*
Screening/Testing/Reporting Has Risks

Sarah C. M. Roberts and Amani Nuru-Jeter, Universal screening for alcohol and drug use and racial disparities in Child Protective Services reporting, J Behav Health Serv Res. 2012 Jan; 39(1): 3-16.
Recap

• The law anticipates conflicts
• The law allows you to get perspective
• The law clarifies roles/power - due process
• The law makes you check your impulses
Innovations and Opportunities

• Use your power with discretion.
• Improve things for pregnant people who use substances by improving things for pregnant people in general.
  • Improve postpartum care.
  • Assess patient-provider interactions - MOR tool.
• Improve things for pregnant people with SUD by improving things for anyone with a SUD.
  • Privacy and confidentiality = good care.
• Oppose punitive policies (and don’t participate in them).
• Seek solutions that don’t just satisfy the law: improve or exceed it (NM example).
Thank you

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For more info:
http://advocatesforpregnantwomen.org
Please send us your technical assistance requests!

ASTHO and AMCHP are happy to help answer questions, find resources, and facilitate connections.

• Thank you!