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# Screening for Substance Use in Pregnancy and Postpartum: Best Practices for Hospitals

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|---|
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# Objectives

- Review practical steps to establish a meaningful, evidence-based, stigma-free hospital policy to screen for substance use in pregnant and postpartum patients
- Understand the laws and national guidance for urine drug testing in pregnancy
- Become familiar with best practices for performing newborn toxicology testing

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# Best Practices for Screening for Substance Use in Pregnancy and Postpartum

# Why must we ensure that hospitals are following best practices in screening for SUD?

- Screening practices and protocols have the capability of promoting equity, autonomy and trust while screening practices done wrong have the real potential to cause long lasting harm.

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# Pros of Screening

- Opportunity to do brief intervention and referral to treatment
- Improved obstetric outcomes
- Improved neonatal outcomes
- Monitor for withdrawal in neonates
- Harm reduction
- Reduce barriers to care

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# Cons of Screening

- Fear
- Stigma
- Legal ramifications
- Incarceration
- Family surveillance or separation
- Implementation burden (cost, complexity, time)
- Insufficient capacity (where will you refer)
- Workforce limitations and training

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# National, evidence-based guidelines support screening for SUD in pregnancy/postpartum

- ACOG: Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in **partnership** with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be **universal**.

- AAFP, ACNM, SMFM, ASAM, CDC, USPSTF have similar guidance.

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# Screening for substance use IS:

- Evaluating for disease/risk of disease when people are asymptomatic
- Best carried out when standardized

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# Screening for substance use is NOT:

- Diagnosis of a condition
  - Substance use disorders are diagnosed using DSM criteria which establish physical dependence, risky use, social problems related to use and impaired control.
  - Diagnosis is done by providers, not labs or screening tools.
- Urine drug testing
  - There is no context to a negative or positive urine drug test.
  - There is an enormous potential for false positives and false negatives.
- Intended to “catch patients,” criminalize substance use, or share with non-healthcare entities without consent.
- Administered based on race/ethnicity, income, insurance status, compliance with prenatal care, etc

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# Best Practice #1: Use validated verbal screening tool

**Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle**

## Recognition & Prevention — Every Patient

| Recognition Element | Key Points |
|---|---|
| Screen all pregnant and postpartum people for SUDs using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission | **Providers screening for SUDs should:**<br>• Utilize validated screening tools to identify drug, alcohol, and polysubstance use.<br>• Incorporate a screening, brief intervention and referral to treatment (SBIRT) approach.<br>• Recognize that urine toxicology (urine drug testing) is not an appropriate method of screening for substance use or substance use disorders and this approach can discourage pregnant and postpartum people from seeking care. |

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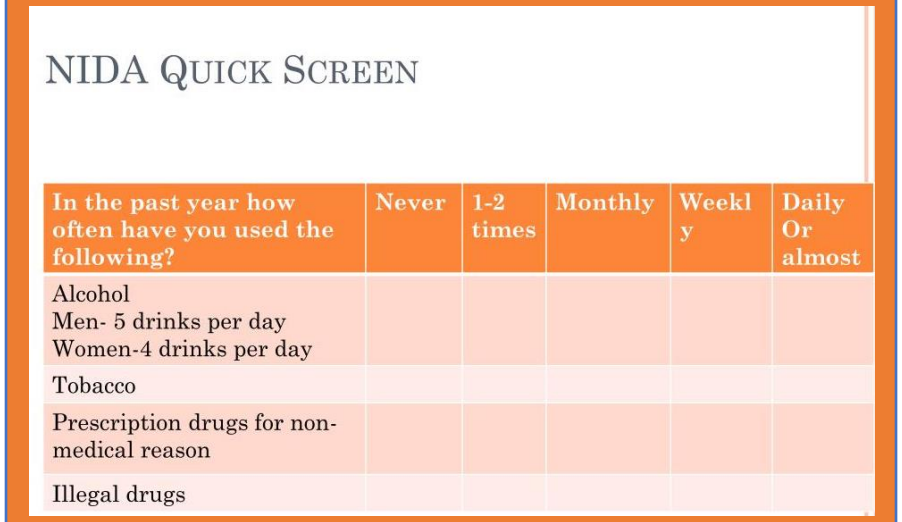
# Best Practice #1: Use validated verbal screening tool

- 4 Ps, 5 Ps

- 1. Did any of your Parents have problems with alcohol or drug use?
- 2. Do any of your friends (Peers) have problems with alcohol or drug use?
- 3. Does your Partner have a problem with alcohol or drug use?
- 4. Before you were pregnant did you have problems with alcohol or drug use? (Past)
- 5. In the past month, did you drink beer, wine or liquor, or use other drugs? (Pregnancy)

NIDA QUICK SCREEN



NIDA QUICK SCREEN

| In the past year how often have you used the following? | Never | 1-2 times | Monthly | Weekly | Daily Or almost |
|---|---|---|---|---|---|
| Alcohol<br>Men- 5 drinks per day<br>Women-4 drinks per day | | | | | |
| Tobacco | | | | | |
| Prescription drugs for non-medical reason | | | | | |
| Illegal drugs | | | | | |

SURP-P

In the month before you knew you were pregnant, how many beers, how much wine, or how much liquor did you drink? Have you ever felt that you needed to cut down on your drug or alcohol use?

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# Best Practice #1: Use validated verbal screening tool

- Not all screening tools are equal or effective.
- This study suggests SURP-P and 4/5Ps is superior to NIDA quick screen because of higher sensitivity and negative predictive value.

Obstet Gynecol. 2019 Apr 9;133(5):952–961. doi: 10.1097/AOG.0000000000003230

**Accuracy of Three Screening Tools for Prenatal Substance Use**

Victoria H Coleman-Cowger [1,✉], Emmanuel A Oga [1], Erica N Peters [1], Kathleen E Trocin [1], Bartosz Koszowski [1], Katrina Mark [1]

Author information · Article notes · Copyright and License information

PMCID: PMC6485306 NIHMSID: NIHMS1522436 PMID: 30969217

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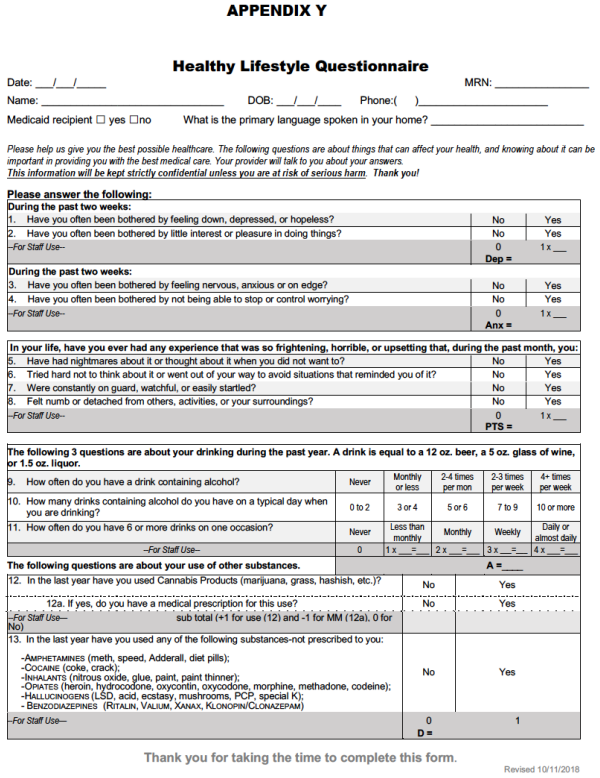
# Best Practice #1: Use validated verbal screening tool

SB42, which goes into effect July 1, suggests that any screening can be used to accomplish an SBIRT model, BUT only the HLQ screening tool is billable for Medicaid.

- This is a robust tool that screens beyond substance use.
- To my knowledge, not validated in pregnancy.



**APPENDIX Y**

**Healthy Lifestyle Questionnaire**

Date: ___/___/____ MRN: _____

Name: _____ DOB: ___/___/____ Phone:( )_____

Medicaid recipient ☐ yes ☐no What is the primary language spoken in your home? _____

*Please help us give you the best possible healthcare. The following questions are about things that can affect your health, and knowing about it can be important in providing you with the best medical care. Your provider will talk to you about your answers.*
*This information will be kept strictly confidential unless you are at risk of serious harm. Thank you!*

**Please answer the following:**

| **During the past two weeks:** | | |
|---|---|---|
| 1. Have you often been bothered by feeling down, depressed, or hopeless? | No | Yes |
| 2. Have you often been bothered by little interest or pleasure in doing things? | No | Yes |
| *–For Staff Use–* | 0 **Dep =** | 1 x ___ |
| **During the past two weeks:** | | |
| 3. Have you often been bothered by feeling nervous, anxious or on edge? | No | Yes |
| 4. Have you often been bothered by not being able to stop or control worrying? | No | Yes |
| *–For Staff Use–* | 0 **Anx =** | 1 x ___ |

| **In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, during the past month, you:** | | |
|---|---|---|
| 5. Have had nightmares about it or thought about it when you did not want to? | No | Yes |
| 6. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? | No | Yes |
| 7. Were constantly on guard, watchful, or easily startled? | No | Yes |
| 8. Felt numb or detached from others, activities, or your surroundings? | No | Yes |
| *–For Staff Use–* | 0 **PTS =** | 1 x ___ |

**The following 3 questions are about your drinking during the past year. A drink is equal to a 12 oz. beer, a 5 oz. glass of wine, or 1.5 oz. liquor.**

| | | | | | |
|---|---|---|---|---|---|
| 9. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times per mon | 2-3 times per week | 4+ times per week |
| 10. How many drinks containing alcohol do you have on a typical day when you are drinking? | 0 to 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| 11. How often do you have 6 or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| *–For Staff Use–* | 0 | 1 x ___=___ | 2 x ___=___ | 3 x ___=___ | 4 x ___=___ |
| **The following questions are about your use of other substances.** | | | | **A =** ____ | |

| | | |
|---|---|---|
| 12. In the last year have you used Cannabis Products (marijuana, grass, hashish, etc.)? | No | Yes |
| 12a. If yes, do you have a medical prescription for this use? | No | Yes |
| *–For Staff Use–* sub total (+1 for use (12) and -1 for MM (12a), 0 for No) | | |
| 13. In the last year have you used any of the following substances-not prescribed to you:<br>-Amphetamines (meth, speed, Adderall, diet pills);<br>-Cocaine (coke, crack);<br>-Inhalants (nitrous oxide, glue, paint, paint thinner);<br>-Opiates (heroin, hydrocodone, oxycontin, oxycodone, morphine, methadone, codeine);<br>-Hallucinogens (LSD, acid, ecstasy, mushrooms, PCP, special K);<br>- Benzodiazepines (Ritalin, Valium, Xanax, Klonopin/Clonazepam) | No | Yes |
| *–For Staff Use–* | 0 **D =** | 1 |

Thank you for taking the time to complete this form.

Revised 10/11/2018

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# Best Practice #2: Standardize a process

- Who to screen? everyone
- Who can screen? MA, nurse, provider, learners, peer support specialists
- What? embed validated tool into workflow and electronic medical record
- When? First visit, hospitalization, triage (please note SB42 suggests screening at every prenatal visit)
- Where? Prenatal care clinic, OB ED/triage, L&D, ED, primary care, SUD clinics, OTP/methadone clinic
- How? Create a system easy for your setting (tablet, verbally, paper, etc)

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# Best Practice #2: Standardize a process

- Once process is established > create a guideline > education > disseminate
- Recognize that pregnant people with substance use might not be engaged in prenatal care. How are you capturing them in other systems?

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# Best Practice #3: Prepare for a positive screen

- Use SBIRT (Screen > Brief Intervention > Referral to Treatment
- Express concern about substance use.
  - “I know you want a health baby. It’s important to stop using X while pregnant.”
  - “I am worried about your health.”
  - “I am worried how this is affecting your relationship with your family.”
- Advise a women to stop use.
  - ”Thanks for trusting me with this information. I hope I can help you to stop using.”
  - “Stopping now can really benefit you and your baby.”
- Assess/validate reactions and discuss her feelings.
- Ask: “Would you like some help to using during your pregnancy?”
- Assist and refer.

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# Best Practice #3: Prepare for a positive screen

- Take a moment to map the resources in your area.
  - Leverage support and improve referral follow though using case managers, social workers, insurance care coordinators, doulas, peer support specialists, CARA navigators
- Tap into established resources:
  - Department of Health Clinics
  - FQHC or primary care offices
  - SUD providers
  - Behavioral health providers
  - Telehealth (WorkIt Health, Ideal Options)
  - OTP/methadone clinics
  - UNM Milagro/272-2000 PALS line for facility-to-facility transfers
- Mobilize resources to create internal system
  - Obstetric provider training and mentorship

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# Best Practice #3: Prepare for a positive screen

- Continue to provide care that is nonjudgemental and stigma-free.

| | | | |
|---|---|---|---|
| Avoid stigmatizing words (addict, user, junkie, alcoholic) | Use person first language (person with a SUD, person in recovery) | Instead of abuse, say “use” or “misuse” if referring to prescription medications | Avoid MAT, opioid substitution or replacement therapy and instead use MOUD |
| Avoid describing urine test as clean or dirty, but simply positive or negative | Never refer to a baby as addicted | Use careful documentation | Be aware of your body language. |
| Focus on health not blame. | Build trust through empathy. | Communicate hope and respect | Recognize SUD is a chronic condition and recovery is a process. |

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# Best Practice #3: Prepare for a positive screen

- Improve your entire team's knowledge and skills in caring for people with SUD.

Lead by example, recognize and correct bias.

Incorporate peer support specialists into your setting.

Hire individuals with lived experience.

Integrate prenatal and substance use care.

Improve readiness to meet patient's needs.

Staff wide trainings on stigma and bias.

Incorporate system level interventions and policy change.

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# Best Practices #4: Understand why screening fails

What if there are ongoing clinical concerns for substance use despite an initially negative screen:

- Interrogate your environment. How can you make your patient feel comfortable and safe, and create a stigma-free environment in which they will feel more able to provide this history?
- Consider verbally screening again.
- Explain your concerns and how eliciting this history can be helpful or would change management.

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# Best Practices #4: Understand why screening fails

Stigma and punitive policies can really impact a patient's readiness and desire to disclose their substance use. In states with policies that mandate CPS/CYFD referral for substance use in pregnancy and states that had automatic loss of parental rights for substance use, evidence has shown:

- Decreased screening
- Less engagement in prenatal care
- Less substance use treatment
- Higher rates of overdose
- Higher rates of neonatal opioid withdrawal syndrome
- Higher rates of congenital syphilis


•Weber A et al. Substance Use in Pregnancy: Identifying Stigma and Improving Care. *Substance Abuse and Rehabilitation*. 2021;12:105-121.
•C Margerison et al Changes in Racial and Ethnic Inequities in Pregnancy-Associated Death in the United States During the COVID-19 Pandemic, American Journal of Public Health, **114**, 7, (733-742), (2024).
•N Tabatabaeepour et al Journal of Substance Abuse Treatment, 2022-09-01, Volume 140, Article 108800,
•Haffajee RL, et alPregnant Women with Substance Use Disorders - The Harm Associated with Punitive Approaches. N Engl J Med. 2021 Jun 24;384(25):2364-2367. doi: 10.1056/NEJMp2101051. Epub 2021 Jun 19. PMID: 34161722.
•Faherty LJ, et al. Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome. JAMA Netw Open. 2019 Nov 1;2(11):e1914078. doi: 10.1001/jamanetworkopen.2019.14078. PMID: 31722022; PMCID: PMC6902764.


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# Best Practice #5: Screening should not be confused with drug testing

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# Best Practices for Urine Drug Testing in People who are Pregnant and Postpartum

# Urine drug testing in pregnant/postpartum patients

- It is our duty to use urine drug testing wisely, sparingly and equitably.
- We will review best practices to guide your hospital's use of urine drug testing.

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# Best Practice #1: Understand the limitations of UDT.

- There is no data to suggest urine drug testing improves outcomes or treatment of substance use.
- There is a lot of data demonstrating harm of urine drug testing.
- Urine drug testing often used for nonmedical reasons.
- Urine drug testing often replaces conversations and trust building.

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- **Advantages**
  - Negative Urine Drug tests can “measure success”
  - Patient desires
  - Monitor medication usage
  - Ensure safety of MOUD initiation
  - Help treat life threatening ingestions or overdoses
  - Guide medical management
  - Can help create reward systems
  - Demonstrate breastfeeding safety

- **Advantages**
  - Negative Urine Drug tests can "measure success"
  - Patient desires
  - Monitor medication usage
  - Ensure safety of MOUD initiation
  - Help treat life threatening ingestions or overdoses
  - Guide medical management
  - Can help create reward systems
  - Demonstrate breastfeeding safety

- **Disadvantages**
  - **Disproportionately affect people of color**
  - **Inaccurate provider interpretation or failure to use confirmatory testing when indicated**
  - **Centers abstinence as opposed to harm reduction and patient centered care**
  - Expensive
  - Redundant
  - Time consuming, may delay care
  - Delayed Clearance
  - Do not capture occasional use
  - Failure to capture all substances
  - False Positive and Negative
  - Inadequate training and support
  - Many collection practices are dehumanizing
  - Results can have grave consequences
  - Coercive
  - Discourage people from participating in care

# Limitations of urine drug testing:

Centers Abstinence

People of color are disproportionately affected by drug testing.

Clinical proficiency is lacking.

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› Am J Obstet Gynecol MFM. 2022 Jan;4(1):100453. doi: 10.1016/j.ajogmf.2021.100453.
Epub 2021 Aug 2.

# Racial differences in indications for obstetrical toxicology testing and relationship of indications to test results

Nicola C Perlman [1], David E Cantonwine [2], Nicole A Smith [2]

Affiliations + expand

PMID: 34352428 DOI: 10.1016/j.ajogmf.2021.100453





Reisfield, G. M., Bertholf, R., Barkin, R. L., Webb, F., & Wilson, G. (2007). Urine drug test interpretation: what do physicians know? Journal of Opioid Management, 3(2), 80–86. https://doi.org/10.5055/jom.2007.0044
Moeller, K. E., Kissack, J. C., Atayee, R. S., & Lee, K. C. (2017). Clinical Interpretation of Urine Drug Tests: What Clinicians Need to Know About Urine Drug Screens. Mayo Clinic Proceedings. Mayo Clinic , 92(5), 774–796. https://doi.org/10.1016/j.mayocp.2016.12.007
Suzuki, J., Garayalde, S., Dodoo, M., & Rodriguez, C. (2018). Psychiatry residents' and fellows' confidence and knowledge in interpreting urine drug testing results related to opioids. Substance Abuse: Official Publication of the Association for Medical Education and Research in Substance Abuse , 39(4), 518–521. https://doi.org/10.1080/08897077.2018.1469105
Sunshine, I., & Jatlow, P. I. (1975-1985). Methodology for analytical toxicology 1 . CRC Press. https://search.worldcat.org/title/1253991
Eskridge, K. D., & Guthrie, S. K. (1997). Clinical issues associated with urine testing of substances of abuse. Pharmacotherapy , 17(3), 497–510. https://www.ncbi.nlm.nih.gov/pubmed/9165553

# Best Practice #2: Obtain consent.

- “Routine urine drug screening is controversial. ACOG recommends testing be performed only with the patient’s consent and a positive test not be a deterrent to care, a disqualifier for coverage under publicly-funded programs, or the sole factor in determining family separation.” – ACOG
- “The pregnant woman should be asked to provide informed consent for urine, blood, or saliva screenings for substance use. Although oral informed consent is used in many labor-and-delivery clinics, a signed paper or electronic form is preferred.” -SAMHSA
- ”Given that many pregnant women do face consequences if substance use is detected, providers who treat pregnant patients should be knowledgeable about federal- and state-level laws pertaining to confidentiality and reporting requirements. ASAM recommends that, with the exception of emergency situations, pregnant women should provide explicit written consent for drug testing including during labor and delivery. This informed consent should include an understanding of the possible consequences of test results.” - ASAM

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# Best Practice #2: Obtain consent.

- Informed consent must include risks of testing, benefits of testing, alternatives, and the right to decline.
- Create guidelines and a process for consent.
  - Paper, electronic
  - How will it be documented?
  - Who can obtain consent?

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# Sample consent

Your healthcare team is recommending urine drug testing. The following substances are commonly checked- amphetamines, barbiturates, benzodiazepines, buprenorphine, methadone, cocaine, heroin, opioids, synthetic opioids like fentanyl. THC/Cannabinoids is not routinely tested at UNM. You have the right to decline urine drug testing and to get information on how urine drug testing might affect you or your baby. Please read carefully and indicate whether or not you given permission to do urine drug testing.

Reason(s) for testing:

- ☐ You have requested urine drug testing.
- ☐ You used substances that were not prescribed to you during your pregnancy.
- ☐ You are taking a prescribed opioid medication that might result in newborn opioid withdrawal.
- ☐ Your clinical care team has concerns that you may be impaired, intoxicated, or not thinking clearly.
- ☐ You desire to breastfeed and confirmation of safety is needed.
- ☐ You are initiating medications for opioid use disorder (buprenorphine or methadone).

Benefits of Testing:

- Identify a substance you might be exposed to that you did not know was in your system that can be harmful to your or your pregnancy
- Confirm use of prescribed medications like buprenorphine, methadone, benzodiazepines.
- Provide information that might help guide your care or your baby's care, especially in the setting of overdose or life-threatening symptoms
- Helpful tool for your recovery

Risks of testing:

- False positives- you test positive even when you have not taken the substance
- *Understand your hospital's policies for CYFD involvement.*
- *Understand your policies for who might access this information.*

Additional information:

- A provider will discuss the results with you. You can request confirmation testing on any result that is unexpected.
- If you decline to have urine drug testing, your care will not be delayed.
- Your baby may still need to be tested at time of delivery.

☐ I authorize my providers to test my urine for drugs.
☐ I **do not** authorize my providers to test my urine for drugs.

# Best Practice #3: Consider the indication for testing and how it will impact clinical decision making and care.

- Before ordering a urine drug test, always ask what clinical question am I trying to answer?
- Can you obtain this information from the patient?
- Will this change medical management?
- Situations in which UDT might be helpful:
  - Patient desires
  - Contingency management
  - Overdose
  - Acute psychosis
  - Unexplained seizures
  - Elicit contaminants in drug supply
  - Potential drug interactions
  - Breastfeeding safety

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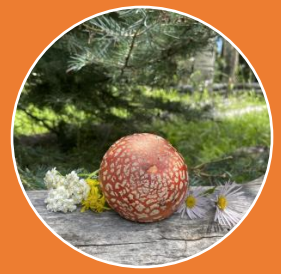
# Examples of common UDT pitfalls



Preterm labor

Placental abruption

Limited prenatal care

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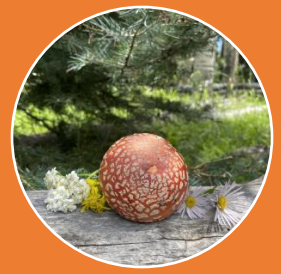
# Examples of common UDT pitfalls



Preterm labor

-disproportionately implemented

-*some* studies suggests PTL is associated with a negative UDT

Placental abruption

-a placental abruption caused by cocaine is managed the same as an abruption caused by high blood pressure

Limited prenatal care

-this may be associated with substance use, but this information can also be obtained through verbal screening using a validated tool

Son, S et al 2018
Chin et al 2022

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“The U.S. Supreme Court has ruled that it is unconstitutional to use the results of drug testing obtained in the guise of medical care for law enforcement purposes without informed specific consent to a search for evidence of a crime.”

Ferguson v. City of Charleston, 532 U.S. 67 (2001); Id. on remand, 308 F.3d 380 (4th Cir. 2002)Cited in National Advocates for Pregn ant Women policy statement: Clinical Drug Testing of Pregnant Women and Newborns March 2019

# Best Practice #4: Know which test to order.

Can you test for a single substance?

Does the study your ordering check for the substance of concern?

If you have a low pretest probability, you have higher rates of false positives.

Best practices often exclude THC given legal status and reduced clearance.

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# Best Practice #5: Discuss results with patient.

- Give the patient an opportunity to discuss what might be seen in their urine drug test in advance of testing.
- Discuss your patients concerns about urine drug testing.
  - What do you want to know about blood or urine tests used to screen for substance use as part of your prenatal care?
  - What are your concerns about toxicology testing?
- Discuss results with patients, especially if not concordant with their report.

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# Best Practice #6: Perform diagnostic testing when indicated.

- Rapid urine drug tests can frequently result in false positives.
- If patient's reported substance use does not match urine drug testing results, order diagnostic testing.
  - Diagnostic testing is gas chromatography/mass spectrometry.
  - Rapid testing is ELISA testing.
  - Methamphetamines has MANY substances that cause false positives. Labetalol and many over the counter medications have been demonstrated to cause false positive.
- Do not assume your patient is being dishonest.
- Recognize limitations in your test. For example, delayed clearance of substances.
  - Consider quantitative study.
- Consult your local laboratory.

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# Limitations in Urine Drug Testing

AJOG Global Reports
Volume 4, Issue 2, May 2024, 100313

Original Research

## Prolonged detection of urine norfentanyl in individuals enrolled in a medication for opioid use disorder in pregnancy and postpartum program: a case series

Miranda K. Kiefer DO [1], Jamie Cowen BA [2], Katherine A. Hinely RN [1], Kara M. Rood MD [1]

[1] Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, The Ohio State University College of Medicine, Columbus, OH (Dr Kiefer, Ms Hinely, and Dr Rood)

[2] The Ohio State University College of Medicine, Columbus, OH (Ms Cowen)

Available online 19 January 2024, Version of Record 16 March 2024.

- Fentanyl is converted to norfentanyl in the liver.
- Metabolism of fentanyl can be delayed with liver dysfunction, obesity, genetic polymorphism, and chronic opioid use.
- This study looked at norfentanyl levels in 3 pregnant/postpartum people who were stable on MOUD with weekly participation and negative UDT for fentanyl. Norfentanyl levels remained in their system for up to 294 days!
- All 3 of these cases were referred for child protection services because of a positive norfentanyl test.
- Detection and clearance is poorly understood in pregnancy and postpartum but has enormous consequences for family separation. More discretion is needed when using UDT for clinical decision making. UDT should not guide CPS involvement.

# Best Practice #7: Standardize a protocol to ensure equity.

JAMA Network | Open.

Original Investigation | Equity, Diversity, and Inclusion

Racial Equity in Urine Drug Screening Policies in Labor and Delivery

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- RESULTS: Of 9396 female patients, 4305 [45.8%] were Black, 4277 [45.5%] White, and 814 [8.7%] other race. There was a small but statistically significant decrease in the number of Black patients before vs after the intervention (2210 [47.6%] vs 2095 [44.0%], P = .005); there were no significant differences in other race groups, median age, or multiparity. Before the intervention, 513 (23.2%) and 228 (11.1%) Black and White patients, respectively, had UDS (P < .001) compared with 95 (4.5%) and 79 (3.6%) Black and White patients, respectively, after the intervention (P = .40). **Before the intervention, an association between Black race and CPS report was observed (249 [11.3%] Black and 119 [5.8%] White patients, P < .001); there was no association between race and CPS report after the intervention (87 [4.2%] Black and 78 [3.5%] White patients, P = .67).** There was no association between the intervention and the percentage of UDS results that were positive for nonprescribed, non-cannabis substances (107 [2.5%] preintervention vs 88 [2.0%] postintervention; P = .14). There was no significant association between the intervention and any measured neonatal outcomes.
- CONCLUSIONS AND RELEVANCE In this quality improvement study, removal of isolated cannabis use and limited prenatal care as UDS indications, coupled with clinical decision support, was associated with improved racial equity in UDS testing and CPS reporting. The intervention was not associated with a significant change in UDS positivity for nonprescribed, noncannabis substances.

# Best Practice #8: Review your screening practices.

- Create systems that are measurable.
- Disaggregate data to ensure equitable screening practices.
- Have ongoing learning and feedback opportunities.
- Elicit feedback from the frontline!
- Ask your patients with lived expertise about their experience being screened in your setting.

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# SB42 Guidance for urine drug testing

- Historically federal and state legislation has not mandated urine drug testing in pregnancy.
- Former CARA legislation stated “reported use” was sufficient to create CARA referral.
- Awaiting final rules to be published in June or July.

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# Toxicology Testing in Newborns

# Best Practice #1: Drug testing should be clinically actionable.

- Meconium, umbilical cord, and placental drug tests rarely have clinical utility.
  - Delayed results.
  - Do not represent recent use.
- When maternal substance use is well documented, neonatal testing rarely provides additional clinical information.
- Consider the indication.
  - Few studies exist to guide utility. Possible indications: signs/symptoms of neonatal opioid withdrawal and parent declines opioid use/exposure, unexplained seizure of neurologic abnormality, FASD?
  - Understanding the cause of prematurity rarely changes the clinical course.

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# Best Practice #2: Drug testing should not replace conversations, verbal screening and education.

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# Best Practice #3: If testing is indicated, gestational parent should be tested rather than newborn.

- Negative urine drug testing in the gestational parent has been demonstrated to be a reliable predictor of negative urine drug test in the newborn after accounting for medications administered during the intrapartum course.
- Newborn testing is often redundant.
- Drug testing practices can cause harm.
- Meconium, umbilical cord, and placental drug tests rarely have clinical utility.

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# Best Practice #4: If safety concerns arise, drug testing alone is not a reliable tool to establish a person's ability to safely parent.

- Drug tests do not quantify use.
- Drug tests do not suggest timing of use.
- Drug tests to not measure impairment.
- Drug tests do not take into account other safety measures put in place.
- Drug tests rarely check for alcohol.
- Drug tests done prior to day of delivery, do not predict use postpartum.
- Drug tests disproportionately affect mothers.

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# Email me for support implementing a guideline or sample protocol.

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