NPQIC Substance Use Screening and Toxicology Policy Recommendations

PURPOSE / OBJECTIVE: To describe evidence-based, equitable perinatal screening practices to identify substance exposure and subsequent obstetric toxicology screening, obstetric toxicology testing, and neonatal toxicology testing.

DEFINITIONS:

Substance Use Disorder	• Treatable chronic disease that affects a person's brain and behavior, leading to their inability to control their use of substances with continued use despite negative consequences or harms. Includes use of legal and illegal drugs, alcohol, and/or medications
Screening	• Process of gathering more information from patients about substance use, through use of a verbal, written, self-administered, or clinician-administered validated screening tool
Testing	• Collection of biological sample(s) to evaluate for presence of substances or their metabolites
Fetal Alcohol Syndrome	• Most serious type of Fetal Alcohol Spectrum Disorder, typically characterized by facial features including smooth upper philtrum, thin upper lip, wide-set and narrow eyes, growth problems (microcephaly, low birth weight, short height), and nervous system abnormalities

GENERAL INFORMATION:

1. In standardizing recommendations, this policy aims to guard against bias, discrimination, and variability in toxicology testing within obstetrics and neonatology while balancing the necessity of having accurate information regarding exposures to clinically manage infants and provide adequate support for families affected by substance use disorder.
2. Toxicology testing has benefits and harms and should not be used as a proxy for fitness for parenting nor as a sole data point in decision-making regarding referral to Child and Family Services (CFS). Indications for toxicology testing are driven by the need for a change in clinical management based on toxicology results or upon patient request.
3. The Nebraska Department of Health and Human Services has a standing order in place for Naloxone prescriptions. This order allows the public to have naloxone dispensed through a pharmacy without a prescription from a provider. The expanded availability of naloxone to friends, family, and bystanders increases the probability of administration in a timely manner and preventing death from an opioid overdose. Certain forms of naloxone, such as Naloxone nasal spray 4mg (brand name NARCAN Nasal Spray), are also available without a prescription for free at many Nebraska pharmacies. A list of participating pharmacies can be found on the Stop Overdose Nebraska website here. Online ordering is now available if an individual is not able to go to a participating pharmacy.

POLICY:

I. <u>Obstetrical Screening for Substance Use</u>

A. Universal Screening

1. Universal verbal or written screening with use of validated tool for all pregnant individuals presenting at the onset of outpatient obstetric care and during each inpatient obstetric admission and observation stay. Validated screening tools include the NIDA quick screen, 4Ps Plus, and the CRAFFT (for women and adolescents 12-26 years old).

a) Verbal screening results will be documented in the birthing individual's electronic medical record.

b) A **positive verbal screen** for substance use is an opportunity for further conversation with a pregnant individual and **does not automatically warrant or permit toxicology testing** without further discussion with the patient. This may be an opportunity to ask the patient if she is interested in doing a full assessment for a substance use disorder and provide an opportunity to engage in treatment. Toxicology testing may be helpful and warranted to identify additional information that would alter the course of medical care for the pregnant individual and/or their newborn.

c) Ideally, healthcare providers administering and responding to screening questions are trained in trauma-informed care.

B. Indications to Consider Ordering Obstetrical Toxicology Testing

1. Indications for toxicology testing are driven by the need for a change in clinical management based on toxicology results or upon patient request.

2. Signs and/or symptoms of intoxication, withdrawal, or altered mental status *with inability of the patient to provide accurate history regarding recent substance exposure*, including:

a) Unexplained disorientation or altered cognition (e.g. hallucinations, delusions) or confusion

b) Psychosis or manic symptoms

c) Ataxia or severe psychomotor agitation or retardation

d) Internal preoccupation

3. Physical evidence of alcohol or other illicit drug use, (i.e. "track marks")

4. Birthing person desires to chest/breastfeed AND:

a) Birthing person reports substance use or demonstrates positive toxicology test during the last trimester of pregnancy.

b) Birthing person has an active substance use disorder and is NOT engaged with treatment.

5. Toxicology testing desired by birthing individual

a) This may be to demonstrate sobriety, identify unintended exposure to substances, and/or safety of human milk provision.

C. Consent for Obstetric Toxicology Testing

1. Testing:

a) Healthcare providers will obtain verbal informed consent from all pregnant or postpartum individuals before toxicology testing.

- Informed consent requires a clear explanation of why testing is necessary, the benefits of testing, such as understanding all known or unknown exposures and guiding medical management of the dyad, and the risks of testing, including the possible legal, criminal, or child welfare consequences. Informed consent should also include the risks and benefits of refusing consent for testing.

b) Verbal consent will be documented in the birthing individual's electronic medical record.

c) If toxicology testing is declined, document refusal of testing in electronic medical record and notify social work patient has declined testing to better inform discussion between patient and social worker during the consult.

d) If patient is unable to consent due to medical emergency (i.e. altered mental status), testing may be performed only if results are required for immediate medical care. Documentation of medical reason for testing without obtaining verbal consent to be documented in birthing individuals' electronic medical record.

II. <u>Neonatal Toxicology Testing</u>

A. Indications to Consider Ordering Neonatal Toxicology Testing

1. Indications for toxicology testing are driven by the need for a change in clinical management based on toxicology results.

2. Infants born to individuals at-risk for substance exposure based on obstetric verbal screening, obstetric toxicology testing, or documentation in health record, *may be appropriate* for meconium, urine, and/or umbilical cord testing sent to identify in-utero substance exposure.

3. Indications for Considering Neonatal Toxicology Testing

a) Infant born to individual who met criteria for obstetric toxicology testing, and results would alter medical management of the newborn.

b) Infant with signs and/or symptoms of intoxication (somnolence, jitteriness/irritability, depressed respiratory and/or cardiovascular status), or withdrawal (inconsolability, poor sleep, poor feeding) *which are otherwise unexplained*.

c) Newborn with physical features of Fetal Alcohol Syndrome (i.e. smooth philtrum, thin upper lip, upturned nose, flat nasal bridge and midface, epicanthal folds, small palpebral fissures, and small head circumference).

d) Other clinical situations may warrant neonatal toxicology testing. Additional indications must be documented in the electronic medical record with explanation of clinical judgement prior to ordering the test.

- Note: "Even objective medical criteria for determining who should have toxicology testing may be subject to inadvertent bias. For example, 'inadequate prenatal care' is a common, and often necessary, criterion for toxicology testing. If this criterion is used as a prompt for toxicology, providers and nurses must understand that a variety of factors other than substance use may influence whether a woman can remain in care, including lack of insurance, inability to take time off work, and lack of culturally appropriate care" (Crew et al., 2020).

4. Recommend consultation and discussion with social work and the multidisciplinary team prior to sending toxicology testing. First void, meconium, or cord may be collected and held until decision to test is made and discussed with family.

B. Consent for Neonatal Toxicology Testing

1. Informed consent will be obtained by the provider with the birthing individual and/or legal guardian(s) before toxicology testing is sent. If the birthing individual or legal guardian refuses testing, a discussion about the clinical importance of testing will occur, and that refusal will be respected.

a) Parental informed consent should include:

(1) A clear explanation of the indication for testing
(2) Potential benefits of testing
(3) Potential risks of testing including possible legal or child welfare consequences
(4) Risk and benefits of refusing testing
(5) How results may impact discharge or disposition

Parental consent should clarify the type(s) of toxicology testing that will be ordered and how the sample is obtained.

2. Document consent for toxicology testing in the infant's electronic medical record.

a) Documentation to include reason for obtaining toxicology test, how it will change medical management of the infant, and how the results may impact discharge and disposition.

b) In the case of medical emergency or if guardian lacks capacity, testing without birthing individual and/or legal guardian consent may be performed only if the results are required for the immediate medical care of the infant (see newborn indications for toxicology testing above). Documentation of medical reason for testing without consent to be documented in infant's electronic medical record.

III. Toxicology Test Interpretation

A. Immunoassays are challenging to interpret due to many potential false positive/false negative results. Other analytical techniques, such as high-performance liquid chromatography/tandem mass spectrometry (LCMS/MS), are much less prone to false positive/false negative results. Providers will assess for concurrent iatrogenic medication administration when interpreting tests and understand the limitations of toxicology testing before interpretation of the results.

B. Contact laboratory staff at the hospital for details regarding analytical techniques for the test in question and for details regarding interference or cross-reactivity with specific medications or substances.

C. If additional questions remain, contact Nebraska Regional Poison Center (1-800-222-1222) to speak with medical toxicologist regarding interpretation of maternal and neonatal toxicology results.

IV. Communicating Results of Toxicology Testing

A. Results of toxicology testing are communicated to the birthing individual by the clinical team and documented in the electronic medical record after collaborating with the multidisciplinary team caring for the birthing individual-newborn dyad.

B. Information obtained from toxicology testing will be used to counsel birthing individual and family regarding the perinatal effects of substance exposure, to obtain appropriate support, resources, and treatment for birthing individual and/or infant, if indicated.

C. Place social work consult for all positive obstetrical or neonatal toxicology testing results if not already ordered.

1. Social work team will meet with treating provider(s) to determine indication for and risks and benefits of referral to CFS, if indicated.

D. Child abuse and/or neglect as it relates to substance-exposed newborns is defined as a child "born *affected* by alcohol or substance exposure… *and* the newborn child's health or welfare is *threatened* by substance use." **Positive toxicology testing alone no longer mandates a report for child abuse/neglect.**

1. A child is born affected by alcohol or substance exposure when it impacts the child's physical, developmental, and/or behavioral response.
2. The newborn child's health or welfare is threatened by substance use when the medical, physical, and/or developmental needs of the newborn child are likely to be inadequately met or likely unable to be met by parents and/or caregiver.

E. Nebraska's Protocols to Address Requirements for CARA:

1. Healthcare providers involved in the delivery or care of a substance-affected infant shall notify the child protective services system using one of the following two pathways:

a) **Report:** If child abuse and/or neglect is suspected, notify the Nebraska Child Abuse and Neglect Hotline (1-800-652-1999).

(1) The DHHS Children and Family Services Specialist will request a copy of the Plan of Safe Care to support the health and treatment needs of the infant and family.

b) **Notify**: If child abuse and/or neglect is not suspected, complete the Comprehensive Addiction and Recovery Act (CARA) Notification Form, and submit it according to the directions. The Notification form is available at https://dhhs.ne.gov/Pages/Comprehensive-Addiction-and-Recovery-Act.aspx. This notification does not contain identifying information.

(1) The following criteria require a notification to DHHS:

(i) Mother is stable and engaged in opioid medication-assisted treatment with a licensed physician.

(ii) Mother is being treated with opioids for chronic pain by a licensed physician.

(iii) Mother is stable and engaged in treatment for other non-opioid substance use, including alcohol, with a licensed provider, physician and/or stable recovery program.

(iv) Infant is at risk for Fetal Alcohol Spectrum Disorder.

(v) Mother is engaged in substance use or misuse, (including Marijuana) that does not rise to the level of abuse/neglect requiring a report. This is up to the physician's judgement.

F. Plan of Safe Care

1. For all infants affected by prenatal substance use or misuse, complete a Plan of Safe Care before the infant's discharge from the hospital and forward it to the infant's primary care provider.

2. A Plan of Safe Care can include a discharge summary or other documentation. It must address the health and substance use disorder treatment needs of the infant and affected family or caregiver.

3. A Plan of Safe Care example template is available at https://dhhs.ne.gov/Pages/Comprehensive-Addiction-and-Recovery-Act.aspx. The template was developed in partnership with the Nebraska Perinatal Quality Improvement Collaborative.

V. Ethical Considerations

A. Practice variation in both maternal and newborn toxicology testing during the birth hospitalization exists across institutions and legal jurisdictions. While testing can provide important medical benefits, non-standardized testing approaches have been shown to perpetuate health care inequities. Evidence demonstrates that selective or risk-based testing strategies often disproportionately impact women from racial and ethnic minority groups, leading to inequitable rates of CPS referrals for these already marginalized populations.

B. Punitive approaches and criminalization of substance use in pregnancy creates barriers to essential healthcare access. Research demonstrates that in states with punitive policies regarding substance use during pregnancy, women are more likely to disengage from prenatal care and avoid disclosing substance use to healthcare providers, missing critical opportunities for intervention and support.

1. Policies should undergo scheduled reviews and timely revisions to reflect current best practices.

2. Regular audits should be conducted to ensure consistent and appropriate policy implementation across all patient care.

3. When ethical questions or concerns arise regarding testing decisions, treatment approaches, or family separation, providers should promptly consult their institutional or local ethics committee or consultation service

C. Separation of mother and infant when Child Protective Services (CPS) becomes involved can have profound negative impacts on both the child and mother. These impacts include disruption of critical early bonding, potential long-term emotional and developmental harm, and increased family stress. Such separations can be especially harmful to vulnerable populations and families facing socioeconomic challenges.

1. When mothers and children enter treatment together, parent-child bonds are maintained:

   a) Research demonstrates higher program completion rates and improved custody outcomes when women enter residential treatment with their children.

   b) Nebraska has created initiatives to support family-based treatment. These recovery homes are designed to allow parents to stay with their children or, if the children have been removed, to work toward reunification.

c) The Family First Prevention Services Act of 2018 enables states to utilize Title IV-E foster care funds for placing children with parents in licensed residential family-based treatment facilities

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