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SMFM SPECIAL STATEMENT

Society for Maternal-Fetal Medicine Special Statement: Guidance to reduce racial disparities in substance use screening and biological testing in pregnancy at the delivery admission

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Abstract

Substance use complicates upward of 10% of US pregnancies. The Society for Maternal-Fetal Medicine, the American College of Obstetricians and Gynecologists, and the American Society of Addiction Medicine have jointly recommended universal screening for substance use during pregnancy using a validated tool, without recommending universal biological testing. Despite this recommendation, racial and ethnic differences in substance use screening and biological testing occur, representing disparate care and a quality gap. This Special Statement from the Society for Maternal-Fetal Medicine introduces a comprehensive strategy, grounded in principles of quality improvement, to address racial and ethnic disparities in substance use screening, with an emphasis on equitable and respectful care. Additionally, we propose a quality metric expressed as the percentage of patients who were screened for a substance use disorder using a validated tool during birth hospitalization, stratified by race, ethnicity, preferred language, and payor status. This quality metric and other related metrics could serve as the basis for quality improvement projects aimed at reducing racial disparities in substance use screening.

KEYWORDS

quality improvement, racial disparities, substance use disorder, substance use in pregnancy, substance use screening

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1 | CASE PRESENTATION

A Black pregnant individual arrives at the labor and delivery unit with vaginal bleeding concerning for placental abruption and undergoes emergency cesarean delivery. The patient is not screened for substance use using a validated verbal or written tool. Biological testing is ordered without patient notification or consent and returns positive for cannabinoids and negative for other substances. Child protective services (CPS) is contacted. The patient and neonate are discharged with a scheduled 1-week postoperative check and a 6-week postpartum visit in addition to CPS follow-up. The patient does not attend either visit and cannot be reached by phone.

Similarly, a White pregnant individual presents with vaginal bleeding concerning for placental abruption and undergoes emergency cesarean delivery. The patient is not screened for substance use using a verbal or written tool, nor is biological testing performed. The patient is discharged home on postoperative day 3 and presents, as scheduled, for the 1-week and 6-week postoperative and postpartum visits.

Despite both patients having vaginal bleeding and objective presentations concerning for placental abruption, their evaluations were disparate, with multiple issues identified. First, the patients presented with identical clinical scenarios, but were treated differently. Neither patient was screened using a validated screening tool, such as the National Institute for Drug Abuse's Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) tool [1]. Without this screening, the obstetrical team may have missed clinically significant risk factors for abruption that may not be present in a biological test, such as tobacco use. Additionally, if the patients had substance use related to placental abruption, there is a potential to miss substances based on the timing of use and the administration of the test. The Black birthing individual was subjected to biological testing without consent, which returned with positive results for a substance that was unlikely to be the underlying cause of a placental abruption. Despite the legalized recreational use of cannabis in the patient's state of residence, it remained an indication for referral to social services. The patient felt that biological testing was a breach of trust and avoided subsequent care in the setting of that mistrust. The White birthing individual, who was not screened, subsequently did not have social work consultation or CPS involvement and presented to follow-up visits as prescribed. Disparate care was thus present at the time of delivery and evolved into disparate postpartum care in response to a biased care delivery system.

2 | INTRODUCTION

The prevalence of substance use in pregnancy is challenging to estimate, given variable screening strategies among obstetrical providers and unreliable reporting of use by pregnant individuals. It is thought to complicate up to 10% of US pregnancies [2], although only 5% of pregnant individuals report using substances in pregnancy [3–6]. Reporting is, in part, limited by fear of stigma or consequences related to use [4–6]. Identifying substance use in pregnancy is an important public health consideration given the potential implications for the pregnant individual and fetus. To mitigate associated maternal and neonatal risks, appropriate screening strategies should be employed to identify pregnant individuals who may benefit from intervention. Efforts to target intervention must be balanced with the consequences that specific screening strategies may have on individuals. Depending on the state of residence, pregnant individuals with substance use disorder (SUD) may be at risk for arrest, loss of custody, or even forced commitment or confinement [7]. These laws may prevent pregnant individuals from pursuing substance use intervention or prenatal care, which can ultimately have a negative impact on the maternal-infant dyad [8].

The Society for Maternal-Fetal Medicine (SMFM), American College of Obstetricians and Gynecologists (ACOG), and American Society of Addiction Medicine (ASAM) have jointly recommended universal screening of all pregnant individuals with a validated screening tool, with recommendations for counseling and evidence-based treatment and intervention for those who screen positive [7]. Universal biological testing, such as urine toxicology screening, is not recommended due to the multiple shortcomings associated with biological tests. These recommendations are reiterated in the Alliance for Innovation on Maternal Health (AIM) core patient safety bundle on care for pregnant and postpartum people with SUD [9]. Although these recommendations have been in place since the ASAM, ACOG, and SMFM joint workshop special report was published in 2019, institutions vary in their substance use screening policies and practices. In addition to these variations, racial and ethnic disparities in urine toxicology screening have been demonstrated [10–12]. Non-Hispanic Black individuals are disproportionately more likely to undergo such screening than their White counterparts, even after adjusting for common indications for urine drug screening [10].

The approaches adopted for screening for substance use that underlie these racial disparities and social inequities represent a quality gap in screening and intervention and

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therefore represent an opportunity for improvement in care delivery. Outside of the recommendation for universal verbal screening with a validated tool and delivering a brief intervention for positive screens, followed by referral to treatment (i.e., SBIRT, short for screening, brief intervention, and referral for treatment) [13], there is limited guidance on implementation of these guidelines and a paucity of material on quality improvement (QI) initiatives to support their adaptation and refinement.

This SMFM Special Statement aims to establish a standardized approach to substance use screening and targeted biological testing upon birth admission, integrating best practices and principles of health equity. The goal is to optimize screening and intervention while eliminating racial and ethnic disparities. We propose introducing quality metrics that will enable institutions and other stakeholders to assess baseline screening rates, evaluate the equity of screening, monitor changes over time, and identify opportunities for improvement.

3 | DEFINING THE EVALUATION OF SUD IN THE CONTEXT OF CURRENT GUIDELINES

According to the Centers for Disease Control and Prevention, SUDs are defined as treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use [14]. In medicine, *screening* is defined as a strategy to identify as-yet unrecognized risk. Thus, the goal of screening for SUD in pregnant and birthing individuals should be to use a standardized and validated approach to identify patients and families who would benefit from medically appropriate care, allocation of resources, and the provision of services to support the successful transition of the parent-neonatal unit to home. As mentioned previously, the SMFM, ACOG, and ASAM joint workshop special report on SUD in pregnancy recommends universal SUD screening with a validated tool [7]. A detailed explanation of these validated screening tools is outside the scope of this review; however, the special report, *Substance Use Disorders in Pregnancy: Clinical, Ethical, and Research Imperatives of the Opioid Epidemic*, outlines the various recommended instruments, as well as their positive and negative attributes [7].

While universal substance use screening is recommended, universal biological testing is not. There may be clinical scenarios in which biological testing is an important next step in management, but it is important that we recognize that these biological evaluations are also screening tests and can yield misleading results, with the potential for false positives or false negatives. The results are further limited by the half-life of the substances, the route of ingestion, and the detection window specific to each substance. One study that examined universal biological testing had a positivity rate of 1.5% for urine drug screens using immunoassays, but between 32% and 57% of positive results were found to be false positives on confirmatory testing, highlighting the low yield and potential inaccuracy of biological testing results, especially when confirmatory testing is not performed [15]. Thus, biological testing has the potential to miss substances based on their rate of metabolism or frequency of use and may imply use when it is absent.

In contrast to biological testing, validated screening tools have high negative predictive value for substance use. They also offer a patient-centered approach, allowing clinicians to elicit clinically meaningful substance use histories while providing support. This approach contrasts with biological testing alone, which may miss clinically relevant use or report use that is not pertinent to patient care, thereby exposing the patient to legal and social ramifications.

As mentioned, biological testing may be useful in specific clinical scenarios in which results are necessary to guide medical management. SMFM, ACOG, and ASAM recommend *considering* biological testing in the following medical situations: [7]

- Obtunded or unconscious patient
- Patient showing signs of active intoxication (e.g., falling asleep midsentence)
- No prenatal care at the time of delivery
- Physical evidence of injection use, such as "track marks"
- Unexplained soft tissue infection or endocarditis
- Patient who is receiving medications for opioid use disorder to evaluate for any continued use
- At the time of delivery in patients with a history of illicit or inappropriate prescription medication use in pregnancy
- Acute clinical complications, such as placental abruptions or unexplained severe hypertension (from cocaine, amphetamines)

It is important to note that some of these suggested considerations have not been shown to be associated with a positive urine toxicology test [16]. Although Son and colleagues demonstrated an association between no prenatal care (defined as no prenatal visits) and a positive test result, lack of prenatal care alone may not be an appropriate indication for biological testing [16]. Providers should take into consideration barriers to access arising from structural and systemic racism, such as a patient expressing an inability to secure insurance or time off

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from work for prenatal care; having recently immigrated and being uncertain about how to navigate the healthcare system; or having received care in another institution, state, or country. Biological testing policies that rely on patient clinical history or engagement in prenatal care can be fraught with bias and result in disproportionate testing and criminalization of certain populations. In this publication, we advocate for the use of carefully selected, prespecified, objective criteria for biological testing in clinical scenarios in which the result could change medical management. Subjective criteria could perpetuate disparities in biological testing and are not recommended.

Additionally, biological testing should not be performed without informed patient consent outside of the rare instances when this is impossible, such as in the unconscious patient. Furthermore, a positive biological test should be followed by a confirmatory test, and, if positive, brief intervention and referral to treatment.

To improve processes and reduce disparities in substance use screening, the key drivers of disparities require exploration.

4 | DISPARITIES IN SUBSTANCE USE SCREENING IN PREGNANCY

The prevalence of SUD varies across racial and ethnic groups, with Asian and Hispanic individuals having the lowest rates of SUD, in contrast to higher rates in Black and White individuals [17]. Evidence shows that Hispanic women are diagnosed with opioid use disorder later in pregnancy than White women, leading to the largest contributor to racial and ethnic disparity in treatment with medication for opioid use disorder [18].

Significant racial disparities have been reported in the use of biological testing. Multiple studies have outlined the racial and ethnic disparities in biological testing, specifically identifying the increased rates of biological testing in Black and Hispanic pregnant individuals, as well as their neonates. Additionally, data show that the indications for testing are often less clearly associated with substance use [12]. Despite Black individuals having a higher likelihood of undergoing biological testing than their White counterparts, there is no difference in the likelihood of a positive test result as compared with other racial groups [10, 19, 20]. In addition, Ellsworth et al. demonstrated that neonates born to Black mothers are more likely than neonates born to White mothers to have screening performed, whether they met screening criteria (35.1% vs. 12.9%; $p < 0.001$) or not (5.3% vs. 1.2%; $p < 0.001$). Black race remained independently associated (odds ratio, 2.17; 95% confidence interval, 1.25–3.79) with drug screening even after controlling for standard screening criteria, income, insurance status, and maternal education [21].

Notably, in a single-institution QI project, implementing a standardized policy for urine drug testing in the labor and delivery setting was shown to reduce disparities in testing by race as well as the overall rate of drug testing without negatively impacting neonatal outcomes. The proportion of providers actively seeking informed patient consent before proceeding with testing also improved (93% vs. 68%; $p < 0.01$) [22].

Thus, while it is clear that relying solely on biological testing for substance use is fraught with problems, universal validated screening in addition to implementation of a standardized biological testing policy with clear criteria are critical elements of the solution to reducing disparities in substance use screening [23, 24].

5 | CONSIDERATIONS FOR CANNABIS USE IN PREGNANCY

When considering SUD in pregnancy, the use of cannabis in pregnancy warrants special consideration. According to the Controlled Substances Act of 1970, the use and possession of cannabis is illegal under US federal law [25]. However, in 2014, Congress passed the Rohrabacher–Farr amendment, prohibiting federal prosecution of individuals complying with state laws relating to cannabis [26]. While this amendment provides protection from federal prosecution, pregnant individuals are still at risk of being reported to local child protective agencies, even if the state in which they reside has laws legalizing cannabis use [27]. State- and institution-level policies can place obstetrical providers in challenging positions, requiring them to report pregnant individuals to legal and child welfare systems, even if the substance is legal in that state.

Both ACOG and the American Academy of Pediatrics advise avoiding cannabis during pregnancy and lactation, and they urge their members to work with state and local health departments to develop constructive, nonpunitive policies and education for families [28, 29]. These professional organizations emphasize how mandatory testing and reporting policies can undermine caregiver and infant health by discouraging pregnant people who use substances from engaging in prenatal care and SUD treatment to avoid punitive responses to their substance use [30]. The role of the obstetrical provider becomes even more important as more states legalize the use of recreational cannabis and the prevalence of its use in pregnancy rapidly increases [31, 32]. The true impact of fetal exposure to cannabis is not known and is confounded by the fact that patients have access to various potencies of this substance, with the potential for multiple chemicals present, and because

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there is a perception that there are minimal to no risks of use during pregnancy [33–35].

An additional confounder that obstetrical providers should be aware of is the differences in cannabis use among various racial and ethnic groups. While use has increased across all groups in the United States, use among Asian people is lower than the national average and slightly higher among Black, White, Hispanic, and Native Hawaiian/Pacific Islander populations. The highest rates of cannabis use are seen among American Indian/Alaska Native people, followed by Black individuals [36]. The increasing use among multiple racial and ethnic groups highlights the importance of standard, universal screening with a validated tool. In addition, these data and substance use patterns underscore the need for heightened sensitization by obstetrical providers to the vulnerability perceived by Black birthing individuals when justice system and child welfare system involvement occurs in the setting of isolated cannabis use even while living in states where this use is legal.

While it remains imperative that obstetrical providers offer education about the potential risks of prenatal cannabis use, they also need to remain cognizant of the consequences of using state reporting systems and the impact they may have on their patients. Providers are advised to seek guidance from their state medical boards, institutional case managers, social workers, or other authorities on the matter to arm themselves with knowledge about local rules and regulations, which in turn allows them to educate patients on the potential actions that they may encounter.

6 | IMPLEMENTATION OF QI PRINCIPLES TO IMPROVE SCREENING AND REDUCE RACIAL DISPARITIES

To address racial disparities in substance use screening and biological testing, multifaceted QI initiatives should be pursued. Key steps to a QI project include [37]:

- Defining the problem
- Determining the goal
- Delineating the measures of success
- Developing an intervention
- Implementation and measurement
- Analyzing the results
- Reflection and refinement
- Planning for long-term success

The following sections outline how to apply this approach to the recognized problem of inequitable substance use screening strategies in the clinical scenario and ways to mitigate these disparities.

6.1 | Define the problem

The disparities in substance use screening and intervention described above outline a universal problem that manifests differently at different locales. Each institution should evaluate the practices and processes unique to its location that lead to unique disparities. Baseline data are a key component to understanding this problem. Obtaining baseline data should be considered early in the QI process to determine how disparate substance use screening and biological testing manifests at your institution while identifying goals for improvement and strategies to achieve these goals.

6.2 | Assemble the team

A team is paramount to the success of any QI project. An interdisciplinary group will ensure representation of a variety of perspectives, engagement from all disciplines in your hospital, and promotion of a QI culture for the future. An ideal core QI team consists of five to eight members, all of whom should have a stake in improvement. Groups that should be considered for the formation of a QI team to address substance use screening in pregnancy, and their appropriate representatives, are listed in Table 1.

6.3 | Determine the goal

After considering the problem, it is important to develop an aim that you hope to accomplish—ideally one that is specific, measurable, attainable, relevant, time-based, inclusive, and equitable (SMARTIE). See Table 2 for an example that distinguishes a SMARTIE aim from its SMART (specific, measurable, attainable, relevant, and time-bound) counterpart.

Create a key driver diagram to understand the processes that could lead to disparate screening and to help you achieve your SMARTIE aim. A driver diagram is a visual display of a team's theory of what drives or contributes to the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to various stakeholders where a team is testing and working. A driver diagram shows the relationship between the overall aim of the project, the primary drivers (sometimes called *key drivers*) that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver. Primary drivers, of which you will only have a few, are the most important influencers on the aim; secondary drivers are influencers on (or natural subsections of) the primary drivers, and you may have many.

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TABLE 1 Sample interdisciplinary team makeup.

Clinical representatives	
Obstetrical providers	• Maternal-fetal medicine subspecialists • Obstetricians • Obstetrical trainees, including residents and fellows • Family medicine providers and trainees • Obstetrical leadership, including directors of labor and delivery and inpatient obstetrics units • Nonphysician providers: for example, midwives, physician assistants, and advanced practice providers
Pediatric providers	• Neonatology and general pediatrics physicians • Pediatrics trainees, including residents and fellows • Pediatrics leadership, including directors of inpatient pediatrics, newborn nursery, and neonatal intensive care units • Nonphysician providers: for example, physician assistants, advanced practice providers
Anesthesia providers	• Anesthesia providers, including obstetrical anesthesia providers • Anesthesia trainees, including residents and fellows • Nonphysician staff: for example, nurse anesthetists • Anesthesiology leadership
Nursing	• Nursing staff • Nursing leadership
Social work/other patient support	• Clinical social work staff • Social work leadership • Perinatal doulas
Other representatives	
Technical experts	• Information technology staff for the hospital's electronic medical records • Laboratory and pathology personnel
Process analysts	• Data architects and specialists • Quality specialists and administrators
Patients and community members	• Patient ambassadors and advocates • Interested community groups
Sponsors	• Quality administrators • Hospital chief quality officers or other quality leadership • Obstetrical, pediatric, anesthesia, and social work quality improvement groups

TABLE 2 Create a SMARTIE aim.

Example SMART aim	To increase screening with a validated tool to more than 90% and to reduce unindicated biological testing to less than 10% based on new institutional guidelines by December 2027 in all patients presenting to labor and delivery triage for evaluation or admission.
Example SMARTIE aim	To increase screening with a validated tool to more than 90% and to reduce unindicated biological testing to less than 10% based on new institutional guidelines by December 2027 in all patients presenting to labor and delivery triage for evaluation or admission *and to eliminate differences in testing according to the patient's race, ethnicity, payor status, or preferred language.*

Abbreviations: SMART, specific, measurable, attainable, relevant, time-bound; SMARTIE, specific, measurable, attainable, relevant, time-bound, inclusive, equitable.

As you identify each driver, establish a way to measure it. (See the Institute for Healthcare Improvement's *Quality Improvement Essentials Toolkit* [38].) This is an important first step for your organization in improving substance use screening while eliminating disparities in screening. Figure 1 is an example of a driver diagram for this purpose.

6.4 | Delineate the measures of success

The metrics to consider in a QI project include process measures, outcome measures, structural measures, and balancing measures. (For more details, see SMFM's *Primer on Patient Safety and Healthcare Quality for Maternal-Fetal Medicine Fellows* [39].) Process measures reflect the action of individuals within a process [37]. Outcome measures reflect the impact of a service or intervention on patients. Structural measures refer to a system's capacity or ability to provide care. Balancing measures refer to negative outcomes that may be downstream effects or direct results from QI interventions. The measures should evaluate mechanisms that underlie the aim as well as changes implemented by the intervention. From a health equity perspective, it is imperative to view all of the above rates after stratification by race, ethnicity, preferred language, and payor status to evaluate the disparities that may underlie the current screening and testing processes. Table 3 outlines the proposed family of measures for this project.

Mapping out the processes involved in substance use screening and biological testing can further elucidate the

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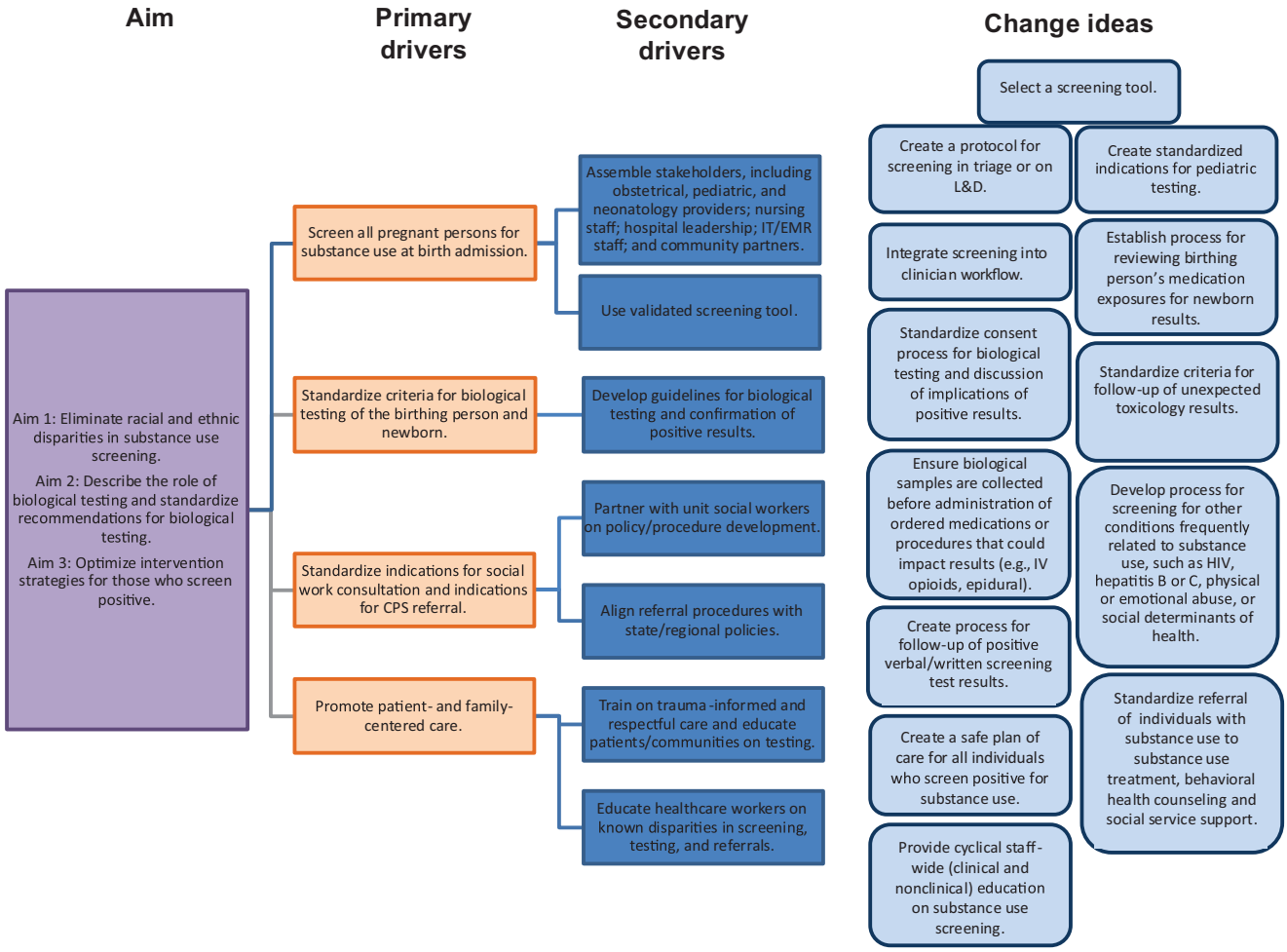

FIGURE 1 Key driver diagram example. CPS, child protective services; EMR, electronic medical record; IT, information technology; IV, intravenous; L&D, labor and delivery.

most effective measure to assess. Multiple modalities can be used, such as fishbone diagrams, process diagrams or flowcharts, and Pareto charts. A flowchart—also known as a process map—is a visual representation of the sequence of steps in a process. Understanding the process as it currently operates is an important step in developing ideas about how to improve it. Flowcharts are especially useful in the early phases of improvement work. To create a flowchart, teams brainstorm all the steps in the process as it currently exists. Teams write each process step in a box (or on a sticky note). In addition to the steps themselves, they use a diamond shape (or sticky note turned on its corner) to indicate points in the process where a decision needs to be made. For decision steps, the team writes a "yes/no" question describing the decision. Then they use lines to show the connections between the boxes and diamonds. Having a shared understanding of the current process helps teams identify problems or bottlenecks, focus discussions, and identify resources. For example, teams can identify steps in the process that do not add value, such as delays; unnecessary work, duplication, or expense; or breakdowns in communication. It is at these points where the improvement work can start [38]. Processes to consider for this QI project on disparities in SUD screening include a review of how the patients at your institution are currently being screened:

- Who screens the patients?
- When are the patients screened?
- What screening tool is being used?
- How are the patients being consented (i.e., is there a standardized consent process)?
- How are positive results followed up?
- Who receives a social work consultation?
- Who is referred to CPS?
- What is the follow-up for a positive screen?
- Are there systems in place to adhere to the SBIRT approach to care?

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TABLE 3 Proposed family of measures.

Structure	Process	Outcome	Balancing
Does your hospital have a policy/guideline on universal substance use screening using a validated tool?	Rate of substance use screening using a validated tool		
Does your hospital have a policy/guideline on indications and timing for performing biological testing during the birth admission?	Rate of adherence to hospital guidelines on indications for biological testing		Rate of false-positive biological testing results in birthing patient and newborn Rate of neonatal urine and/or meconium biological testing
Does your hospital have a policy/guideline on consent of the birthing patient to perform biological testing?	Rate of consent for biological testing		
Does your hospital have a policy/guideline on interventions after a positive screen using a validated tool?	Rate of documentation of SBIRT in all birthing patients with a positive screen using a validated tool Rate of social work consultation in all birthing patients with a positive screen using a validated tool Rate of sending biological sample for confirmatory test to rule out false-positive screening test results	Rate of maternal morbidity in a birthing patient with substance use disorder	Rate of neonatal abstinence syndrome

Abbreviation: SBIRT, screening, brief intervention, and referral for treatment.

6.5 | Develop the intervention

An intervention aimed at improving substance use screening and intervention in pregnancy while simultaneously reducing inequitable screening and testing strategies will require a multi-faceted approach. Using your SMARTIE aim, the gaps and opportunities for improvement that you identified from the process map or diagram of your current process, and the change ideas from your key driver diagram, you can begin to construct your interventions into plan-do-study-act (PDSA) cycles. The AIM bundle, *Care for Pregnant and Postpartum People With Substance Use Disorder Patient Safety Bundle*, provides important, relevant resources you can use to design your intervention [9].

The first consideration involves universal screening using a validated tool. Validated screening tools recommended include the TAPS tool, the Drug Abuse Screening Test (DAST-10), the 4Ps screen, the Substance Use Risk Profile-Pregnancy, the CRAFFT Screening Tool for Adolescent Substance Abuse (validated in young adults), and the Wayne Indirect Drug Use Screener [7]. The electronic medical record (EMR) can be adapted to incorporate validated tools in clinical documentation—structured as best practice alerts—to document the results of screening and also provide an opportunity to query data on a recurring basis to evaluate the measures described in Table 3. A QI initiative may address each of these measures. For example, once a patient screens positive for substance use, brief intervention and referral to treatment should occur (i.e., the SBIRT approach). The QI initiative could include developing a counseling statement and referral order to address the need for brief intervention and treatment. Deciding whether to obtain patient consent verbally or in writing should be determined locally; however, patients should be counseled and their consent obtained in a standardized way.

The second consideration should include developing a protocol in which biological testing should be pursued. In theory, applying a protocol uniformly to individuals could reduce variation in biological testing and result in a reduction of racial disparities in testing. How patients will be informed of the indication for biological testing based on the established protocol should be considered and outlined in your QI projects. In addition, patient consent is integral and requires standardized, universal consent, whether written or verbal. A protocol should also be established for individuals who test positive, given that biological testing can be complicated by false-positive results. Consult with local laboratory experts to identify a

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TABLE 4 Medications associated with false-positive results [40].

Medications associated with false-positive results	Positive substance in urine drug test						
	Amphetamine or methamphetamine	Phencyclidine	Methadone	Opiates	Benzodiazepines	Cannabinoids	Barbiturates
Antihistamines/decongestants							
Brompheniramine	X						
Diphenhydramine			X				
Doxylamine			X				
Phenylpropanolamine	X						
Nonprescription nasal inhaler	X						
Antidepressants							
Bupropion	X						
Clomipramine			X				
Sertraline					X		
Trazodone	X						
Venlafaxine		X					
Antibiotics							
Quinolones				X			
Analgesics							
Ibuprofen		X				X	X
Naproxen						X	X
Antipsychotics							
Chlorpromazine	X		X				
Promethazine	X						
Quetiapine			X				
Thioridazine			X				
Antihypertensives							
Labetalol	X						
Other agents							
Dextromethorphan		X					
Ranitidine	X						
Verapamil			X				

Note: Adapted from [40].

standardized approach to confirm positive results or to identify any confounding medications. See Table 4 for medications associated with false-positive drug test results. Once a protocol has been devised, it is important to measure appropriate adaptation of the protocol.

Given that positive screening and biological testing results can be met with disparate intervention and follow-up, it is important to include this aspect of care in the QI initiative. Standardized processes that result in social work consultation for individuals with positive screening should be considered. Additionally, the number of social work referrals and resultant referrals to CPS based on substance use screening results should also be considered as a process measure to evaluate whether patients with different demographic characteristics yet similar results have identical referral patterns.

6.6 | Analyze, reflect, and refine through PDSA cycles

The previously described key steps to a QI project can be executed through PDSA cycles, which are iterative processes designed to make rapid changes and assess for improvements. A PDSA cycle is a method for incrementally introducing a small change, evaluating whether

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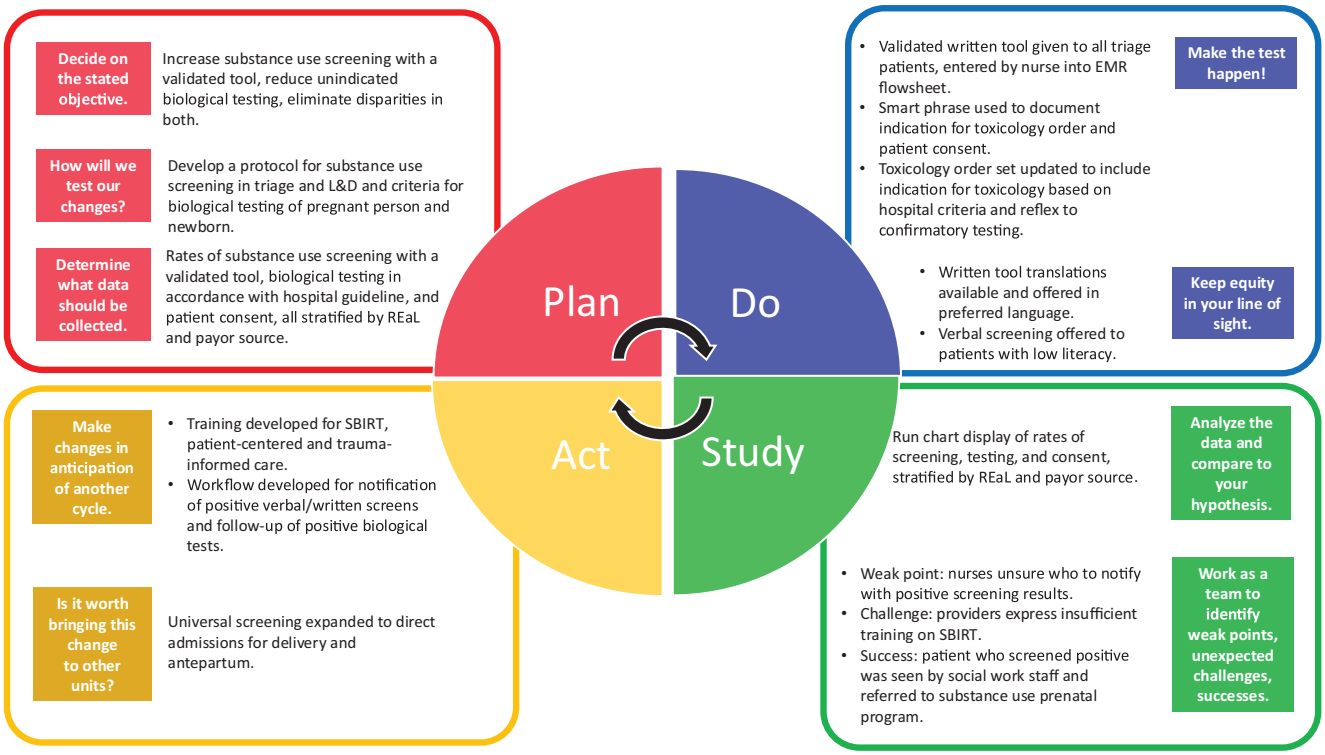

FIGURE 2 Example plan-do-study-act cycle. EMR, electronic medical record; L&D, labor and delivery; REaL, race, ethnicity, and language; SBIRT, screening, brief intervention, referral to treatment.

the change resulted in an improvement, and then introducing another small change. The QI team develops a plan to implement each change, carries out a test, observes and learns from the consequences by analyzing data, and determines what other improvements should be made. QI teams use successive PDSA cycles until they reach the desired results [37]. Not all changes may be pursued during the same PDSA cycle, and changes may require multiple PDSA cycles to accomplish. The Pareto principle, which states that 80% of problems come from 20% of causes, can be helpful to determine which problems should be addressed first [37]. The highest-frequency problems should be prioritized for QI intervention. Figure 2 is an example of an initial PDSA cycle for a QI project on substance abuse screening in pregnancy.

7 | RESEARCH IN QUALITY

As you perform these QI processes, consider adapting a research component to your projects. There are multiple gaps in the literature surrounding evidence-based practices to successfully reduce racial and ethnic disparities in substance use screening, including evidence-based ways to incorporate community stakeholders into obstetrical substance use screening projects or effective strategies to standardize screening, such as best practice alerts in the EMR or audit and feedback mechanisms. There is a paucity of research about how local laws and policies influence the ability to successfully reduce disparities. Research should be pursued to identify the best practices to reduce disparities in substance use screening.

8 | DESCRIPTION OF THE PROPOSED QUALITY MEASURE

Inequitable substance use screening processes are a major quality issue and therefore warrant quality metrics to standardize evaluation to hold stakeholders, institutions, and providers accountable for the role their structured processes play in perpetuating racial and socioeconomic disparities in substance use screening.

Of the metrics outlined in Table 3, we describe the specifications of one of the proposed process measures, which is expressed as a simple rate: the percentage of patients who were screened for SUD during hospitalization for delivery. The full definition is given in Table 5. The denominator defines a childbirth hospitalization by American Medical Association Current Procedural Terminology (CPT®) codes for various types of birth procedures and definitions.

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TABLE 5 Measure specification.

Characteristic	Description	Notes
Brief title	Substance use disorder screening during delivery hospitalization	
Narrative description	The percentage of patients who were screened for SUD using a validated instrument, documented during the birth admission	
Denominator	Number of patients during the measurement period who had a delivery hospitalization (defined by the CPT codes listed below)	
Numerator	Number of patients during the measurement period who had a delivery hospitalization (defined by the CPT codes listed below) and who were screened for SUD using a validated instrument (defined by documentation in the EMR)	ASAM, ACOG, and SMFM current guidance recommends universally screening all pregnant patients with a validated screening tool and offering evidence-based treatment and intervention as necessary. *Universally screening all pregnant patients minimizes the potential for implicit bias that can occur* when subjective risk factors are used.
Measure calculation	Numerator divided by denominator, expressed as a percentage	
Type of measure	Process	
Ideal performance	100%	
Evidence of improvement	Increasing percentage	
Suggested measurement period	Hospitalization for delivery occurring in a calendar month, quarter, or year (same period for both the numerator and the denominator)	
Suggested level of evaluation	Individual hospital or birthing center	Group practices or individual providers could be assessed in "drill-down" reports
Exclusions from denominator	Patients who died during delivery hospitalization	
Exclusions from numerator	None	
CPT codes qualifying for denominator [41]	Any one or more of the following: Vaginal delivery: 59400, 59409, 59410 Cesarean delivery: 59510, 59514, 59515 VBAC: 59610, 59612, 59614 Cesarean after TOLAC: 59618, 59620, 59622	Excludes the following: Management of spontaneous abortion: 59812, 59820, 59821, 59830 Management of induced abortion: 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866 Management of hydatidiform mole: 59870, 59100 Management of ectopic pregnancy: 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151

Abbreviations: ACOG, American College of Obstetricians and Gynecologists; ASAM, American Society of Addiction Medicine; CPT, American Medical Association Current Procedural Terminology; EMR, electronic medical record; SMFM, Society for Maternal-Fetal Medicine; SUD, substance use disorder; TOLAC, trial of labor after cesarean; VBAC, vaginal birth after cesarean.

The numerator is based on the number of patients who had a delivery hospitalization and who were screened for SUD using a validated instrument. Universal screening of all pregnant patients using a validated tool minimizes the potential for implicit bias that can occur when subjective risk factors are used.

If the measure is used to track progress of a QI initiative, monthly and quarterly reporting will provide relatively rapid information for the QI project team to evaluate.

9 | STRENGTHS AND CRITIQUE OF THE MEASURE

A quality measure that assesses SUD screening among pregnant patients plays a crucial role in ensuring comprehensive obstetrical healthcare. One of the primary strengths is the ability to screen and identify substance use with a standardized validated tool. The quality measure helps to promote healthcare provider adherence

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TABLE 6 ICD-10-CM codes for specific substance use disorders [42].

Substance	ICD-10-CM code
Opioids	F11.10, F11.11, F11.120, F11.121, F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19, F11.20, F11.21, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F11.920, F11.921, F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99
Sedatives	F13.10, F13.11, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.21, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F13.90, F13.920, F13.921, F13.929, F13.930, F13.931, F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.97, F13.980, F13.981, F13.982, F13.988, F13.99
Cocaine	F14.10, F14.11, F14.120, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.21, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F14.90, F14.920, F14.921, F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980, F14.981, F14.982, F14.988, F14.99
Amphetamines/ stimulants	F15.10, F15.11, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.21, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F15.90, F15.920, F15.921, F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980, F15.981, F15.982, F15.988, F15.99

Abbreviations: ICD-10-CM, International Classification of Diseases, 10th Revision, Clinical Modification.

to established guidelines and protocols for SUD screening among pregnant patients. This compliance promotes consistency in care and aligns healthcare practices with evidence-based recommendations. The quality measure generates data that can be used for performance evaluation and improvement. Healthcare systems can analyze the screening rates, identify trends, and implement targeted interventions to enhance screening rates and overall quality of care. By establishing a metric for SUD screening, the quality measure holds healthcare providers accountable for the delivery of comprehensive and evidence-based care using a standardized process. This accountability can drive continuous improvement in healthcare practices.

One of the challenges of the metric is that the numerator assesses whether a patient underwent SUD screening on the basis of EMR documentation. Hospitals may experience challenges reporting the SUD measure due to a lack of data capture in structured fields, difficulty accessing data from EMRs, and resistance from stakeholders. Developing standardized documentation, such as a smart phrase or flowsheet, and having the screening tool embedded within the admission history and physical note contributes to consistency, decreases potential bias, reduces administrative burden, and creates a transparent location for identification. Building and using structured data fields in EMRs will mitigate the barrier to capturing SUD screening data by enabling data extraction from EMR using a healthcare data analytics approach.

Consistent SUD screening in pregnancy can help reduce disparities in screening, counseling, and intervention, as well as in who is ultimately reported to social services. A more uniform application of screening protocols can help ensure that decisions about reporting are based on consistent criteria, rather than being influenced by subjective judgments or biases. At the same time, increased standardized screening can also better connect individuals with the care they need. By identifying SUDs earlier, healthcare providers can refer patients to appropriate treatment services more quickly. This can lead to better health outcomes and potentially prevent situations that might otherwise lead to external reporting. However, it is important to note that the effectiveness of increased screening in achieving these goals depends on a variety of factors, including using a validated screening tool, the training and biases of the individuals conducting the screenings, and the availability and accessibility of treatment resources.

The measure should be calculated and reported at the level of the hospital or birthing center. The determination of the percentage of patients who are screened will allow hospital quality teams to determine the effect of hospital programs and the amount of allocated resources needed to improve screening rates. The metric will also provide the impetus to pursue further metrics and collaborative efforts with nursing, obstetrics and gynecology, maternal-fetal medicine, anesthesia, pediatrics, social work, and hospital staff and administration. Other possible metrics for hospital quality teams to consider are outlined in Table 3. In addition, perinatal quality collaboratives can reference these metrics as a potential focus of statewide efforts. The core data collection plan described in AIM's *Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle* can be referenced in these endeavors [9]. The data will fuel QI initiatives moving forward at the level of the individual provider, hospital, and even state. Additional *International Classification of Diseases, 10th Revision, Clinical Modification* codes for specific SUDs are listed in Table 6.

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10 | CONCLUSION

While ACOG, SMFM, and ASAM recommend universal screening using a validated SUD screening tool and restricted use of biological testing, racial and ethnic disparities exist in substance use screening and biological testing. QI principles are needed to eliminate these disparities in care. This Special Statement outlines the key considerations that underlie racial disparities in substance use screening and principles that can be employed to identify these disparities locally, develop QI initiatives to improve substance use screening in pregnancy, and eliminate racial disparities in screening. This Special Statement advocates for a national focus on the immediate need for change in local practices based on underlying bias and racism that lead to disparities in substance use screening and the related downstream sequelae. This Special Statement further provides a structured approach to the steps that should be taken to expeditiously address this national crisis. In addition, the proposed quality metric provides a means to measure the rate of substance use screening stratified by important drivers of disparity to evaluate the local impact of QI initiatives and respond to opportunities for improvement.

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