EXPLORING POLICY SURVEILLANCE

Part 4 — Policy Surveillance for Research

April 9, 2019, 1:00 p.m.-2:30 p.m. ET
How to use WebEx Q&A

1. Open the Q&A panel by clicking the “…” button on the bottom of the screen and selecting “Q&A”
2. Select “All Panelists”
3. Type your question
4. Click “Send”
Moderator

Heidi Grunwald, PhD

Co-Director, Center for Public Health Law Research
Director, Institute for Survey Research
Presenters

Aaron Gilson, MS, MSSW, PhD

Health Policy Research Scientist, Senior Scientist
Sonderegger Research Center, University of Wisconsin-Madison School of Pharmacy
Kelli Komro, PhD, MPH

Professor, Behavioral Sciences/Health Ed.
Director at Large, RISE Center for Reproductive Health Research in the Southeast
Presenters

Sue Thomas, PhD

Senior Research Scientist, PIRE
State Laws and Other Regulatory Policies Related to Pain Care

Policy Surveillance Webinar
Policy Surveillance for Research

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April 9, 2019

Aaron M. Gilson, MS, MSSW, PhD
Health Policy Research Scientist / Senior Scientist
Policy Surveillance Project

Purpose

Compile, code, and analyze state-level laws and other regulatory policies that govern chronic pain treatment, including for palliative care and end-of-life care

- this is a legal content review based only on observable features (keyword search)
- all 50 states & DC
- policies effective through December 31, 2017
Policy Surveillance Project

Procedure

- Controlled Substances Acts & regulations
- Medical Practice Acts & regulations
- Medical Board guidelines
- Osteopathic Practice Acts & regulations
- Osteopathic Medical Board guidelines
- Pharmacy Practice Acts & regulations
- Pharmacy Board guidelines
- Practice standards for healthcare facilities
- Prescription monitoring programs statutes and regulations
Policy Surveillance Project

Procedure

- Conduct background research
- Use Lexis Academic to identify legal text
- Redundant coding (2 raters)
  - conducted in Batches (n=5)
- Calculate divergence rates
  - < 5% divergence (range = 0% to 4.00%; mode = 1.60%)
- Enter policy language into MonQcle
- Create Master Sheets
- Develop LawAtlas resources (e.g., Research Protocol, Landing Text, Codebook)
Model Policies Informing Coding Questions

- Federation of State Medical Boards *Essentials of a State Medical and Osteopathic Practice Act & Guidelines for the Chronic Use of Opioid Analgesics*
- the Joint Commission on Accreditation of Health Care Facilities facility standards
- National Alliance for Model State Drug Laws *Model Prescription Monitoring Program Act*
- National Association of Boards of Pharmacy *Model State Pharmacy Act* and *Model Rules & Model Prescription Monitoring Program Act*
- National Association of State Controlled Substances Authorities *Model Prescription Monitoring Program Act*
- National Conference of Commissioners on Uniform State Laws *Uniform Controlled Substances Act*
- current Federal statutes (Controlled Substances Act)
- current Federal regulations (Code of Federal Regulations)
## Coding Questions

### Domain 1: Policy Definitions

1. Does the practice of medicine include the treatment of pain?
   - Yes
   - No

2. Does the policy define addiction not based solely on physical dependence or tolerance?
   - Yes
   - No

2.1. Is there a statement that physical dependence or tolerance are not considered addiction?
   - Yes
   - No

3. Does the policy define a maximum amount for a prescription of a controlled substance?
   - Yes
   - No

3.1. What is the maximum amount for a prescription of a controlled substance?
   - 7-day supply
   - 30-day supply
   - 30-day supply, 100 MME
   - 31-day supply
   - 31-day supply or 100 dosage units, whichever is greater
   - 1 month supply
   - 34-day supply
   - 90-day supply

4. Does the policy define a duration for which a prescription for a controlled substance is valid?
   - Yes
   - No

4.1. What is the duration for which a prescription for a controlled substance is valid?
   - 3 days
   - 7 days
   - 14 days
   - 21 days
   - 30 days
   - 60 days
   - 90 days
   - 120 days
   - 6 months

5. Does the policy define "unprofessional conduct" to include excessive prescribing?
   - Yes
   - No

5.1. Does the policy include factors determining "excessive prescribing"?
   - Yes
   - No
Coding Questions

Domain 2: Establishing a Context for Pain Treatment

6. Does the policy state the need to reduce harms from controlled substances while maintaining patient care?
   - Yes
   - No

7. Does the policy establish that a regulatory board will use individual case characteristics to judge the validity of pain treatment?
   - Yes
   - No

8. Does the policy establish an education course for practitioners or pharmacists to improve pain treatment?
   - Yes
   - No

9. Does the policy establish methods for healthcare facilities to improve pain treatment?
   - Yes
   - No
## Domain 3: Practitioner Expectations for Pain Treatment

<table>
<thead>
<tr>
<th>Question</th>
<th>Expected Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Are practitioners expected to consider <strong>integrative care</strong> during pain treatment?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>11. Are practitioners expected to provide <strong>individualized care</strong> during pain treatment?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>12. Are practitioners expected to assess patient <strong>functioning</strong> during pain treatment?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>13. Are practitioners expected to engage in <strong>shared decision-making</strong> with patients when considering pain treatment options?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>14. Are practitioners expected to assess or discuss <strong>patient benefits and/or risks</strong> before initiating pain treatment?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>15. Are practitioners expected to monitor patient <strong>benefits and/or risks</strong> during pain treatment?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
16. Does the policy require a timeframe in which dispensing data is submitted to the PMP after dispensing?
- Yes
- No

16.1. What is the timeframe in which dispensing data must be submitted to the PMP after dispensing?
- Real time
- 24 hours
- Daily
- 1 business day
- Next business day
- 72 hours
- 3 business days
- 7 days
- Weekly
- 8 days
- Monthly

17. Does the policy authorize the PMP to share data with other state PMPs?
- Yes
- No

18. Are practitioners required to register with the PMP?
- Yes
- No

19. Are practitioners required to check the PMP before initially prescribing a controlled substance?
- Yes
- No

20. Does the policy require teaching practitioner or pharmacist users about the PMP?
- Yes
- No

21. Does the policy require the PMP governing agency to review program information to identify inappropriate use of monitored medications?
- Yes
- No
Policies Affecting Pain Management

State Laws and Other Regulatory Policies Related to Pain Care

Healthcare practice in the United States is governed at the state level. All 50 states and the District of Columbia have laws and other regulatory policies that address pain management for patients. Policies related to pain care, palliative care, or end-of-life care provide standards of practice influencing the way pain management is provided for all patients with chronic diseases or conditions, including those with cancer and those who are now cancer-free but are experiencing other chronic painful conditions. These policies also have been used as a tool to curtail the opioid epidemic. As a result, the policies are often designed to maintain access to pain management services while also reducing medication misuse.

This dataset explores important features of state pain care-related laws and other regulatory policies. It includes laws and policies that address prescribing of controlled substances (specifically, Schedule II opioid analgesics), definitions creating parameters for healthcare practice; standards for evaluating and improving pain treatment, including practitioner expectations for treatment; practice requirements; and characteristics of state prescription monitoring programs (PMPs).

This map identifies and displays key features of more than 700 laws and other regulatory policies across all 50 states and the District of Columbia, in effect as of December 31, 2017.

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- Yes
- No
Research Protocol for State Laws and Other Regulatory Policies Related to Pain Care

Prepared by the Sonderegger Research Center, University of Wisconsin-Madison School of Pharmacy

December 2017
# Policies Affecting Pain Management Use by Others

## Prescription Monitoring Programs

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Requirement Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes timeframe for submitting dispensing data</td>
<td>( RED = \text{next business day after dispensing} )</td>
</tr>
<tr>
<td>Authorizes data sharing with other states PMPs</td>
<td>( \checkmark )</td>
</tr>
<tr>
<td>Requires practitioners to register with the PMP</td>
<td>( \checkmark )</td>
</tr>
<tr>
<td>Requires checking PMP before initially prescribing</td>
<td>--</td>
</tr>
<tr>
<td>Requires teaching practitioners</td>
<td>--</td>
</tr>
<tr>
<td>Requires review to identify inappropriate medication use</td>
<td>--</td>
</tr>
</tbody>
</table>

Domain points: 3
Vermont

Pain Policy in Vermont

Cancer patients, cancer survivors and other patients with serious illness often need pain treatment. State laws, policies and regulations can affect whether patients get the treatment they need, and the quality of that treatment. The American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACSCAN), working with the University of Wisconsin, have graded state pain policies as of December 31, 2017. The following are results for our state.

Policy Definitions & Prescription Limits 5 out of 6

Vermont does well in this category acknowledging that standard medical practice does include the proper treatment of pain but does have a maximum prescription validity period of 7 days in place which can be problematic for the elderly, the underserved and individuals who live in rural areas.

Efforts to Assess & Improve Pain Treatment 6 out of 6

Vermont does very well in this category recognizing the need to reduce potential medication harms while maintaining patient care. Individual case characteristics dictate pain care and practitioner education is in place to improve pain treatment.

Requirements for Treating Pain 6 out of 6

Vermont does very well in this category regarding integrative, individualized patient care while prioritizing the assessment of benefits/risks before treatment and monitoring benefits/risks during treatment.

Prescription Monitoring Programs (PMP) 5 out of 6

Vermont has become a leader in regards to state prescription monitoring programs requiring submission of data within 24 hours, or one business day, of dispensing. A state strategy to systematically review program data to identify inappropriate medication use could be beneficial.

Total points 22

Green – Matches model policy  Yellow – Making progress toward model policy  Red – Matches 50% or less of model policy
Policy Surveillance

Challenges

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities
Policy Surveillance

Future?

Depends on…

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities
Policy Surveillance
Future?

Needs…

- Enhanced awareness
- Impact policy decisions
- Funding opportunities
- Links to quantitative outcomes
  - Use of longitudinal policy data
Acknowledgements

This research was supported by the American Cancer Society and the American Cancer Society Cancer Action Network.
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Effects of EITC on Birth Outcomes: Research Findings

KA Komro, PhD, S Markowitz, PhD, MD Livingston, PhD, & AC Wagenaar, PhD
Emory University Rollins School of Public Health & Dept of Economics
S Burris, JD, & L Cloud, JD, Temple University Beasley School of Law
25 Years of Complex Intervention Trials: Reflections on Lived and Scientific Experiences

Kelli A. Komro

Figure A. Final form of the CSDH conceptual framework

WHO Commission on Social Determinants of Health (CSDH, 2010)

1. Minimum Wage Laws
2. Earned Income Tax Credit (EITC)
3. Unemployment Insurance
4. Temporary Assistance for Needy Families (TANF)

R01 funded by the National Institute on Minority Health and Health Disparities, 2015-2019

Initial policy surveillance and pilot studies funded by the Robert Wood Johnson Foundation
Understanding How Law Affects Health: Scientific Contributions from Multiple Disciplines

- Law
- Social & Behavioral Sciences
- Epidemiology
- Economics
- Statistics

Social Determinants of Birth Outcomes Conceptual Framework

Socioeconomic & Political Context

- Family Economic Security Policies

Socioeconomic Position

- Poverty
- Gender & Racial Discrimination

Mediators

- Health Behaviors
- Toxic Stress Weathering
- Health Care Access & Quality

Birth Outcomes

- Low Birth Weight
- Preterm Birth
- Infant Mortality
Effects of state-level Earned Income Tax Credit laws in the U.S. on maternal health behaviors and infant health outcomes

Sara Markowitz, Kelli A. Komro, Melvin D. Livingston, Otto Lenhart, Alexander C. Wagenaar
Contribution

1. Strong quasi-experimental and longitudinal design
   - state-level EITCs
   - multiple policy changes over 20 years

2. Presence and generosity of state EITCs
   - infant health outcomes
   - possible mechanisms via maternal health behaviors
State EITC

- In 1994, 5 states had an EITC → In 2013, 26 states had an EITC
- State-specific EITC ranges from 3.5% to 40% of the federal amount, varies by number of children and refundability

**EITC summary measure**

<table>
<thead>
<tr>
<th>States with no EITC</th>
<th>States with an EITC, nonrefundable payments, and payments less than 10% of the federal amount</th>
<th>States with an EITC, refundable payments, and payments less than 10% of the federal amount</th>
<th>States with an EITC, nonrefundable payments, and payments 10% or more of the federal amount</th>
<th>States with an EITC, refundable payments, and payments 10% or more of the federal amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>least generous</td>
<td>most generous</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Generosity of State EITCs
Families with One Child

1994

2013
## Birth Outcome Results

<table>
<thead>
<tr>
<th>Dependent Variables</th>
<th>Birth Weight in Grams</th>
<th>Birth Weight &lt;2500g</th>
<th>Gestation Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low EITC No Refund</td>
<td>9.44</td>
<td>-0.003</td>
<td>0.05</td>
</tr>
<tr>
<td>Low EITC With Refund</td>
<td>16.85</td>
<td>-0.005</td>
<td>0.03</td>
</tr>
<tr>
<td>High EITC No Refund</td>
<td>12.68</td>
<td>-0.003</td>
<td>0.17</td>
</tr>
<tr>
<td>High EITC With Refund</td>
<td>27.31</td>
<td>-0.008</td>
<td>0.08</td>
</tr>
</tbody>
</table>
Quantile Regression Results

Fig. 2. Effects of EITC Generosity on Birth Weight Using Unconditional Quantile Regression at 5th through 95th Quantiles. Note: N = 30,780,950. Solid marker indicates point estimate is statistically significant at the 5% level.
Conclusions

• More generous EITCs associated with reductions in *probability of LBW*
  • 0.3 to 0.8 percentage-point reductions
  • 4% to 11% reductions
  • 4,300 to 11,850 fewer babies born LBW *every year* among women with high school education or less

• If Georgia implemented a refundable EITC at 10% or more of the federal, based on results we estimate
  • 1,047 fewer LBW babies per year in Georgia
Effects of Changes in Earned Income Tax Credit: Time-series Analyses of the Experience in Washington DC

Alexander C. Wagenaar, Melvin D. Livingston, Sara Markowitz, Kelli A. Komro

Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, 1518 Clifton Road, NE, GCR 556, Atlanta, GA 30322, USA
Department of Economics, Emory University, Atlanta, GA, USA
EITC in DC

- Four distinct policy changes over 8 year period
- Percentage of the federal EITC, fully refundable
Effects of EITC on Low Birth Weight
Bottom Line: Effects in DC

• 40% tax credit → 40% decrease in low birth weight births from baseline

• Prevents an estimated 349 low-weight births per year in DC
Effects of State-Level Earned Income Tax Credit Laws on Birth Outcomes by Race and Ethnicity

Kelli A. Komro, Sara Markowitz, Melvin D. Livingston, and Alexander C. Wagenaar
Health Inequities

- Health inequities in birth outcomes by mother’s income, education level and race
  - Percent low birth weight births (2016)
    - Hispanic women: 7% to 9.5%
    - non-Hispanic white women: 7%
    - non-Hispanic black women: nearly 14%
  - Caused by a complex set of social factors across the life course
    - income inequality
    - education achievement gaps
    - residential segregation
    - toxic environment exposures
Results

• Larger beneficial effect among black mothers compared with white mothers for the probability of low birth weight and gestation weeks

• No significant differences in birth outcomes between Hispanic and white mothers
Bigger State Earned Income Tax Credits Lead to Healthier Babies

Some 1,047 babies in Georgia a year can be saved from low birth weight if lawmakers pass a Georgia Work Credit, according to Emory University researchers. A new study finds that state tax credits to support low-income working families are linked to better health outcomes for babies.

The research builds on a robust body of evidence that already highlights many health and economic benefits from the federal Earned Income Tax Credit (EITC). Georgia lawmakers came close to passing a state tax credit to help working families earlier this year, and this move remains on the table for 2018. Lawmakers can still support working families and boost the health of babies statewide.

The Potential of State Earned Income Tax Credits

By Kelli Komro and Sara Markowitz  ·  March 14, 2019
Emory University

EITC Funders Network

GRANT MAKERS IN HEALTH

Sources: National Conference of State Legislatures, Center on Budget and Policy Priorities, Tax Policy Center

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1. Increase to 15% for families with children under 2.
2. The 45% rate applies to families with 1 child. EITC for Children, and EITC for Children.
3. Increased to 50% in 2016. The federal EITC can only be claimed under "taxable income" and "taxable income under the EITC.
4. Increase in income, which means the phase-in of the federal EITC triggers between 25% and 45%.
5. The effect of the federal credit for a 4-person family is a tax credit up to $7,050.
6. No EITC, No EITC

@EconoFact econofact.org
We Concur:
Gilson’s Policy Surveillance Challenges

- Resources
- Time-intensive
- Results outdate quickly
- Funding opportunities
We’re Just Getting Started

- Minimum wage and EITC interactive effects
- Minimum wage and EITC optimum legal constructions
- TANF effects on maternal, infant and child outcomes
- Exploring differential effects by race/ethnicity
- Additional health outcomes
- Additional policies affecting social determinants
- Continued monitoring and coding of legal changes

Thank You! Kelli
(kkomro@emory.edu)
Substance Use During Pregnancy Policy


Sue Thomas
Senior Research Scientist, PIRE
Project Objectives

- Status and trends of state policies targeting alcohol and drug use during pregnancy
- Assess effects of state-level policies targeting alcohol use during pregnancy as measured by prenatal care use and birth outcomes
- Assess effects of alcohol use based on SES and race
Extant research lacks quantitative, longitudinal data/analysis on the effects of policies, their specifics & whether they accomplish their purposes.

Understanding the effects of these policies is crucial to our ability to adopt/implement policies to improve health.
For this research, we use:

- An original dataset (based on NIAAA’s APIS) that covers 1970 - 2016 - the entirety of state-level legislation in this policy domain (46 years)
- More than 30 years of alcohol use during pregnancy survey data from the Behavioral Risk Factor Surveillance System (57,955 pregnant women between 1985-2016)
- More than 40 years of birth outcomes and prenatal care data from Vital Statistics records (148,048,208 singleton births between 1972-2013)
The Alcohol Policy Information System (APIS) provides detailed information on a wide variety of Alcohol-Related Policies in the United States at both State and Federal levels, as well as policy information regarding the Recreational Use of Cannabis. The information and resources available on this site are geared towards alcohol policy researchers and others interested in alcohol.

Alcohol Policy Topics
Detailed state-by-state information is available for the following alcohol policy topics, or you may browse all topics.

- Alcohol Beverages Pricing
  - Drink Specials
  - Wholesale Pricing Practices and Restrictions
- Alcohol Beverages Taxes
  - Beer
- Pregnancy and Alcohol
  - Civil Commitment
  - Legal Significance for Child Abuse/Child Neglect
  - Limitations on Criminal Prosecution
  - Priority Treatment
  - Reporting Requirements

Cannabis Policy Topics
Detailed policy information is available on the Recreational Use of Cannabis.

In addition, APIS has developed the Cannabis Policy Taxonomy (CPT), an inventory and taxonomy of cannabis policies.

Recently Adopted
Information is available on states that have recently adopted laws legalizing the
Data from APIS & original legal research

- Identified relevant statutes and regulations on each of six alcohol/pregnancy policy topics tracked in APIS
- Identified effective dates for each statute and regulation not available on APIS – HeinOnline, StateScape
- Coded statutes and regulations, including ensuring inter-rater reliability
- Quality control steps to compare results to those available from secondary sources
Legal Methods- Drug Dataset

Data from APIS & original legal research

- Relied on Westlaw, HeinOnline, and StateScape
- Started with relevant statutes and regulations from alcohol/pregnancy database (derived from APIS) including effective dates data
- Searched Westlaw for additional drug/pregnancy statutes and regulations on each policy topic
- Coded drug/pregnancy statutes and regulations, including inter-rater reliability checks
- Quality control step to compare results to those available from secondary sources – Guttmacher Institute data
Data Gathering Challenges

- Tools – databases
- Longitudinal data gathering for regulations
- Recodifications and tracking back to a single (new) effective date.
- Comprehensive session laws
- Lack of redlining in session laws
- Staff training
- Quality control
<table>
<thead>
<tr>
<th>Mandatory warning signs</th>
<th>Require that notices about alcohol/cannabis use during pregnancy are posted in medical/recreational marijuana dispensaries as well as retail outlets selling or serving alcohol. The warning language must warn of the risks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority treatment</td>
<td>Mandate priority access to substance abuse treatment for pregnant + postpartum women.</td>
</tr>
<tr>
<td>Prohibitions against criminal prosecution</td>
<td>Prohibits use of results of medical tests, such as prenatal screenings or toxicology tests, as evidence in the criminal prosecutions of women who may have caused harm to a fetus or a child.</td>
</tr>
<tr>
<td>Reporting requirements</td>
<td>Mandated or discretionary reporting of suspicion of or evidence of alcohol/drug use or abuse by women during pregnancy to either CPS or to a health authority. Evidence: screening and/or toxicological testing of pregnant women or of infants after birth. Reporting may be for child abuse/neglect investigation, provision of health services or for data gathering.</td>
</tr>
<tr>
<td>Child abuse/child neglect</td>
<td>The legal significance of a woman’s conduct prior to birth + of damage caused in utero. In some cases, defines alcohol/drug use during pregnancy as child abuse or neglect.</td>
</tr>
<tr>
<td>Civil commitment</td>
<td>Mandatory involuntary commitment of a pregnant woman to treatment or mandatory involuntary placement in protective custody of the state for the protection of a fetus from prenatal exposure to alcohol/drugs.</td>
</tr>
</tbody>
</table>
Policy Categories

• **Supportive policies:** provide information, early intervention, and treatment or services to pregnant women

• **Punitive policies:** seek to control pregnant women’s behavior by civilly committing them, mandating reporting to law enforcement and/or child welfare agencies, and initiating child welfare proceedings or using the threat of such actions to compel behavior change
<table>
<thead>
<tr>
<th>Policies by Category</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Abuse/Child Neglect</strong></td>
<td>Punitive</td>
</tr>
<tr>
<td><strong>Civil Commitment</strong></td>
<td>Punitive</td>
</tr>
<tr>
<td><strong>Reporting Requirements</strong></td>
<td>Punitive if referral to CPS</td>
</tr>
<tr>
<td><strong>Reporting Requirements</strong></td>
<td>Supportive if for data gathering purposes or referral to treatment</td>
</tr>
<tr>
<td><strong>Mandatory Warning Signs</strong></td>
<td>Supportive</td>
</tr>
<tr>
<td><strong>Prohibitions Against Criminal Prosecution</strong></td>
<td>Supportive</td>
</tr>
<tr>
<td><strong>Priority Treatment – Pregnant Women &amp; with Children</strong></td>
<td>Supportive</td>
</tr>
</tbody>
</table>
# of states with at least 1 alcohol/pregnancy policy &/or at least 1 drug/pregnancy policy – dramatic increase since 1970.

Most states have at least 1 alcohol/pregnancy or drug/pregnancy policy:

- **More common**: Mandatory Warning Signs (MWS) for alcohol, Reporting Requirements- Data & Treatment & CPS, Child Abuse/Neglect

- **Less common**: Civil Commitment, Priority Treatment, Prohibitions on Criminal Prosecution, MWS- drugs

With exception of MWS, policies related to alcohol/pregnancy also address drugs/pregnancy

Alcohol/pregnancy & drug/pregnancy policy environments are becoming increasingly punitive.
Individual Policy Trends

Figure 1. Drug and Pregnancy Policies by Year
Policy Environmental Trends

Figure 2. Drug and Pregnancy Policy Environments Over Time

- No policy
- Punitive
- Supportive
- Mixed
Findings: Alcohol

- Most policies targeting alcohol/pregnancy – MWS, CACN, CC, PCP, RR-DATA, and PT-PREG appear associated with increased adverse birth outcomes.
- State-level policies targeting alcohol use during pregnancy at best do not improve birth outcomes and, at worst, associated with increases in adverse birth outcomes and can lead women to avoid prenatal care.
- Generally applicable policies that lead to decreased population-level consumption might improve birth outcomes.
Overall, findings indicate that policies punishing alcohol use during pregnancy are associated with increased adverse birth outcomes and may lead to avoidance of prenatal care.

Findings do not support hypotheses that the more supportive policies – including Mandatory Warning Signs – are associated with decreased adverse birth outcomes.
Explanations of Findings

Pregnant women report:

• Bureaucratic and logistical barriers
• Fear of having harmed baby
• Belief that it is necessary to stop using before going to the doctor
• Fear of being reported to Child Protective Services, losing children, and going to jail
Partial List of Project Publications


# Project Team

<table>
<thead>
<tr>
<th>UCSF - ANSIRH (Advancing New Standards in Reproductive Health)</th>
<th>Alcohol Research Group</th>
<th>Pacific Institute for Research and Evaluation</th>
<th>San Jose State University</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Roberts</td>
<td>Bill Kerr</td>
<td>Sue Thomas</td>
<td>Laurie Drabble</td>
</tr>
<tr>
<td>Kevin Delucchi</td>
<td>Mina Subbaraman</td>
<td>Ryan Treffers</td>
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<tr>
<td>Nancy Berglas</td>
<td>Priscilla Martinez</td>
<td></td>
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<td>Amy Mericle</td>
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