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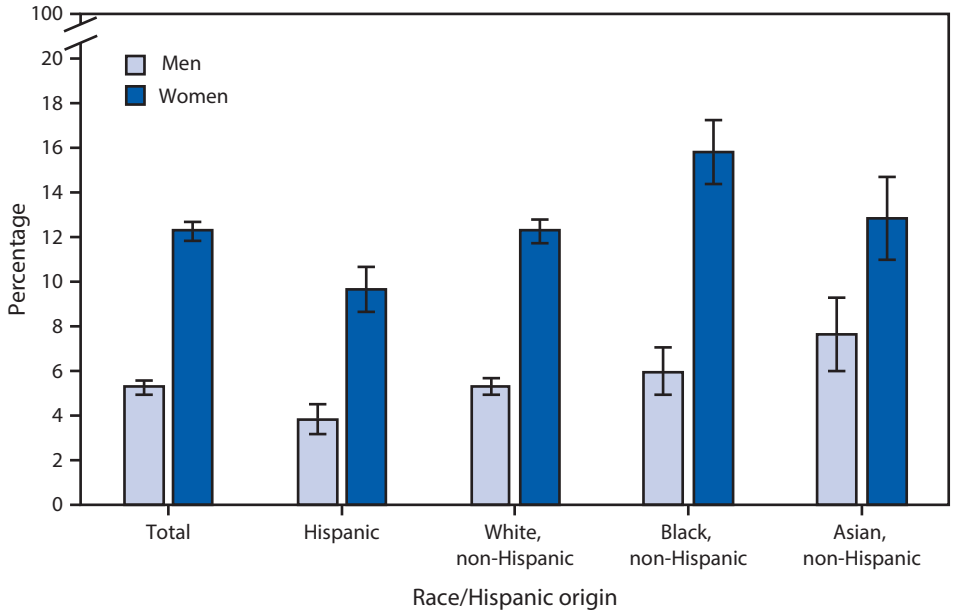
Percentage* of Adults Who Volunteered or Worked in a Hospital, Medical Clinic, Doctor's Office, Dentist's Office, Nursing Home, or Some Other Health Care Facility,† by Sex, Race, and Hispanic Origin§ — National Health Interview Survey, United States, 2016–2018¶



* With 95% confidence intervals shown with error bars.
† Based on responses to the question "Do you currently volunteer or work in a hospital, medical clinic, doctor's office, dentist's office, nursing home, or some other health-care facility? This includes emergency responders and public safety personnel, part-time and unpaid work in a health care facility as well as professional nursing care provided in the home. [This includes non-health care professionals, such as administrative staff, who work in a health-care facility.]"
§ Refers to persons who are of Hispanic or Latino origin and may be of any race or combination of races. "Non-Hispanic" refers to persons who are not of Hispanic or Latino origin, regardless of race.
¶ Estimates were based on household interviews of a sample of the noninstitutionalized U.S. civilian population and are derived from the National Health Interview Survey Sample Adult component.

During 2016–2018, women aged ≥18 years were more likely to volunteer or work in a hospital, medical clinic, doctor's office, dentist's office, nursing home, or some other health care facility (health care settings) than were men (12.3% compared with 5.2%). Non-Hispanic black (15.8%), Asian (12.8%), and white women (12.3%) were more likely to volunteer or work in health care settings than were Hispanic women (9.6%). Non-Hispanic Asian men (7.6%) were more likely to volunteer or work in health care settings than were black (6.0%), white (5.3%), and Hispanic men (3.8%).

Source: National Health Interview Survey, 2016–2018 data. https://www.cdc.gov/nchs/nhis.htm.

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Vital Signs: Prescription Opioid Pain Reliever Use During Pregnancy — 34 U.S. Jurisdictions, 2019

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Abstract

Background: Prescription opioid use during pregnancy has been associated with poor outcomes for mothers and infants. Studies using administrative data have estimated that 14%–22% of women filled a prescription for opioids during pregnancy; however, data on self-reported prescription opioid use during pregnancy are limited.

Methods: CDC analyzed 2019 data from the Pregnancy Risk Assessment Monitoring System (PRAMS) survey in 32 jurisdictions and maternal and infant health surveys in two additional jurisdictions not participating in PRAMS to estimate self-reported prescription opioid pain reliever (prescription opioid) use during pregnancy overall and by maternal characteristics among women with a recent live birth. This study describes source of prescription opioids, reasons for use, want or need to cut down or stop use, and receipt of health care provider counseling on how use during pregnancy can affect an infant.

Results: An estimated 6.6% of respondents reported prescription opioid use during pregnancy. Among these women, 21.2% reported misuse (a source other than a health care provider or a reason for use other than pain), 27.1% indicated wanting or needing to cut down or stop using, and 68.1% received counseling from a provider on how prescription opioid use during pregnancy could affect an infant.

Conclusions and Implications for Public Health Practice: Among respondents reporting opioid use during pregnancy, most indicated receiving prescription opioids from a health care provider and using for pain reasons; however, answers from one in five women indicated misuse. Improved screening for opioid misuse and treatment of opioid use disorder in pregnant patients might prevent adverse outcomes. Implementation of public health strategies (e.g., improving state prescription drug monitoring program use and enhancing provider training) can support delivery of evidence-based care for pregnant women.

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Introduction

During 2017–2018, 42.5% of opioid-related overdose deaths among women in the United States involved a prescription opioid (*1*). Long-term use of prescription opioids is associated with increased risk for misuse (i.e., use in larger amounts, higher frequency, longer duration, or for a different reason than that directed by a prescribing physician) (*2*), opioid use disorder, and overdose (*3*,*4*). According to commercial insurance (*5*) and Medicaid (*6*) claims for reimbursement of pharmacy dispensing, an estimated 14%–22% of women filled at least one opioid prescription during pregnancy (*5*,*6*). Opioid use during pregnancy has been associated with poor infant outcomes, such as neonatal opioid withdrawal syndrome (*7*), preterm birth, poor fetal growth, and stillbirth (*8*). PRAMS* and two additional jurisdictions' maternal and infant health surveys conducted during 2019 were used to describe population-based, self-reported estimates of prescription opioid pain reliever (prescription opioid) use during pregnancy.

Methods

PRAMS is a jurisdiction-specific and population-based surveillance system designed to monitor self-reported behaviors and experiences before, during, and shortly after pregnancy among women with a live birth in the preceding 2–6 months. Detailed PRAMS methodology is published elsewhere (*9*). Supplementary questions on prescription opioid use during pregnancy were asked in 32 jurisdictions participating in PRAMS and on maternal and infant health surveys in two jurisdictions that do not participate in PRAMS.† Data were weighted to adjust for sample design and nonresponse, representing the total population of women with a live birth in each jurisdiction during an approximately 4-month§ or 5-month¶ period in 2019.

Women were asked, "During your most recent pregnancy, did you use any of the following prescription pain relievers?" Use of prescription opioid pain relievers (prescription opioids) during pregnancy was indicated by selection of any of the following: hydrocodone, codeine, oxycodone, tramadol,

* PRAMS currently requires that jurisdictions meet a response rate threshold of 55% for publication. However, because of the critical need to report surveillance data related to the opioid crisis, a response rate threshold was not used to determine inclusion in the analysis. Therefore, data in this report are from all PRAMS jurisdictions participating in the opioid supplement (response rate noted): Alabama (57.6%), Arizona (41.9%), Colorado (59.7%), Connecticut (52.6%), District of Columbia (48.4%), Florida (46.1%), Georgia (53.6%), Illinois (62.6%), Indiana (46.4%), Iowa (56.7%), Kansas (66.0%), Kentucky (61.5%), Louisiana (55.9%), Maryland (47.8%), Massachusetts (61.2%), Missouri (56.5%), Nevada (43.5%), New Hampshire (51.0%), New York (51.4%), North Dakota (57.3%), Oregon (69.6%), Pennsylvania (55.6%), Puerto Rico (81.1%), Rhode Island (57.1%), South Carolina (38.3%), South Dakota (69.4%), Tennessee (55.0%), Utah (71.9%), Vermont (61.6%), Washington (60.6%), West Virginia (42.7%), and Wyoming (56.3%).

† California (response rate: 59.3%) and Ohio (response rate: 34.2%).

§ California collected data during a 4-month period; the weight was adjusted for this analysis to represent mothers giving birth in this approximately 4-month data collection period in 2019.

¶ For PRAMS jurisdictions and Ohio, 5 months of data were weighted to represent women having a live birth during approximately 5 months in 2019.

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