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| **ILPQC MNO****Combined OB & Neonatal Monthly Sustainability Data Collection Form***Data will be submitted monthly for all women discharged from delivery that month who meet the following definition. Data should be submitted by the 15th of the month for the previous month.*  |
| Option to Report No Cases for a Month | * I have no mothers/newborns affected by opioids to report this month
 |
| If **NO** mothers and newborns affected by opioids to report this month (MM/YYYY) | \_\_\_\_\_/\_\_\_\_\_\_ |
| REDCAP Identifiers  |
| REDCap Record ID | REDCap Record ID: \_\_\_\_\_\_\_\_\_ |
| Hospital ID Number | Hospital ID Number: \_\_\_\_\_\_\_\_ |
| **OB Data Collection Form*****OB Data Collection:****Please complete OB data collection for all women with Opioid-Use Disorder (OUD) delivering at your hospital. This includes all women: with a positive self-report screen assessed to have OUD, or positive opioid toxicology test during pregnancy, or reporting opioid use disorder, or using any non-prescribed opioids during pregnancy, or using prescribed opioids chronically for longer than a month in the third trimester. In addition, please include if newborn (viable pregnancy ≥24weeks, 0 days) has an unanticipated positive neonatal cord, urine, or meconium screen for opioids or if newborn has symptoms associated with opioid exposure including NAS.* |
| 1. Demographics
 |
| 1. Maternal Age (XX, 12-50)
 | Maternal Age: \_\_\_\_\_\_\_\_ |
| 1. Maternal Race

*Please select all that apply* | * White
* Black
* Hispanic
* Asian
* Other
 |
| 1. Maternal Zip Code of Residence
 | Zip Code: \_\_\_\_\_ |
| 1. Date of Delivery (MM/DD/YYYY)
 | Date of Delivery \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| 1. Number of Infants
 | * Singleton
* Multiple\_\_\_\_\_\_
 |
| 1. Birth Weight *(grams)*
 | Birth weight: \_\_\_\_\_ |
| 1. Gestational age at delivery *(weeks, 0-44)*
 | Gestational age, weeks: \_\_\_\_\_ |
| 1. Gestational age at delivery *(days,0-6)*
 | Gestational age, days: \_\_\_\_\_ |
| 1. Infant Gender

*Please select one* | * Male
* Female
* Unknown
 |
| 1. Mother Treatment History
 |
| 1. Received prenatal care?
 | * Yes
* No
 |
| 1. When was maternal opioid use disorder (OUD) identified?

*Please select one* | * Prior to current pregnancy
* During current pregnancy
* Delivery Admission, prior to Delivery
* Post Delivery/Postpartum
* Unknown
 |
| 1. When was a pediatric/neonatal consult on OUD/NAS completed?
 | * Prenatally, before delivery admission
* During delivery admission, prior to delivery
* During delivery admission, consult completed but not able to be done before delivery
* No consult completed
* Unknown
 |
| 1. Outcome Measure: Was the mother receiving Medication Assisted Treatment (MAT) prenatally or by delivery discharge? (Updated 1/2019)

***Medication-Assisted Treatment (MAT) Definition:****Mother on prescribed Methadone, Buprenorphine/Subutex/Suboxone, or Other (e.g. Vivatrol, Naltrexone)*  | * Yes
* No
* Patient declined MAT
* MAT not available (box to address issue)
* MAT not indicated (box to indicate why)
* MAT counseling not provided
* Unknown
* Unknown
 |
| 1. If yes, when did the mother receive MAT?
 | MAT started prenatally, before delivery admissionMAT started during delivery admissionUnknown |
| 1. Outcome Measure: Was the mother connected to Behavioral Health Counseling/Recovery Services prenatally or by delivery discharge? (Updated 1/2019)

***Behavioral Health Counseling/Recovery Services Definition:*** *Received Behavioral Health Counseling/Recovery Services including:*Residential Treatment/Inpatient Recovery ProgramOutpatient Treatment Methadone Clinic/Treatment CenterBehavioral Health CounselingPeer Support Counseling/12-Steps Program | YesResidential Treatment/Inpatient Recovery ProgramOutpatient Treatment Methadone Clinic/Treatment CenterBehavioral Health CounselingPeer Support Counseling/12-Steps ProgramOther* No
* Patient declined
* Not available (box to address issue)
* Not indicated (box to indicate why)
* Behavioral Health Counseling/Recovery Services not offered
* Unknown

Unknown |
| 1. If yes, when was mother connected to services?
 | * Connected prenatally, before delivery admission
* Connected during delivery admission
* Unknown
 |
| 1. What medication was used for treatment for maternal opioid use disorder prenatally or during delivery admission, prior to maternal discharge?

*Please select all that apply* | * Methadone
* Buprenorphine/Subutex/Suboxone
* Other (e.g. Vivatrol, Naltrexone)
* None
* Unknown
 |
| 1. Is a substance use diagnosis included on the maternal problem list?
 | * Yes
* No
* Unknown
 |
| 1. Was standardized education for pregnant women with OUD given on the following topics prenatally or during delivery admission, prior to maternal discharge?

*Please select all that apply* | * Opioid use disorder and NAS
* Importance of breastfeeding for eligible opioid exposed infants
* Importance of mother’s participation in newborn care specific to babies with NAS
* Not Given
* Unknown
 |
| 1. Was an OUD clinical care checklist included in the patient’s pregnancy medical record?
 | * Yes, only in the prenatal record
* Yes, only in the labor and delivery admission record
* Yes, in both the prenatal record and the labor and delivery admission record
* No, it was not included
 |
| 1. If an OUD clinical care checklist was included in the patient's medical record, were all checklist items completed?
 | * Yes, prenatally, before delivery admission
* Yes, during delivery admission, prior to delivery
* Yes, during delivery admission, checklist completed prior to discharge
* Not completed
 |
| 1. Was Narcan counseling documented in the medical record prenatally or during delivery admission, prior to maternal discharge?
 | * Yes
* No
* Unknown
 |
| 1. Was contraception counseling and plan documented in the medical record prenatally or during delivery admission, prior to maternal discharge?
 | * Yes
* No
* Unknown
 |
| 1. Were HIV, Hepatitis B, and Hepatitis C screening completed and documented prenatally or prior to delivery?

*Please select all that apply* | * HIV Screening
* Hepatitis B Screening
* Hepatitis C Screening
* No screening
* Unknown
 |
| 1. Was a maternal behavioral health or social work consult regarding maternal follow-up/addiction services documented prenatally or during delivery admission, prior to maternal discharge?
 | * Yes
* No
* Unknown
 |
| 1. Maternal Discharge
 |
| 1. Does the patient have an appointment with an MAT provider/behavioral health counseling/recovery program scheduled at maternal discharge? (Updated 1/2019)
 | * Yes
* No
* Unknown
 |
| 1. Does the patient have navigator/social worker/case management coordinating MAT provider/behavioral health counseling/recovery services follow-up in the postpartum period? (Updated 1/2019)
 | * Yes
* No
* Unknown
 |
| **Neonatal Data Collection Form*****Neonatal Data Collection:****Please collect key data elements on all infants (≥35 gestational weeks- 35 weeks, 0 days) of mothers with opioid use disorder. This include newborns: with a mother that has a positive self-report screen assessed to have OUD, or positive opioid toxicology test before delivery, or reporting opioid use disorder, or using any non-prescribed opioids during pregnancy, or using prescribed opioids chronically for longer than a month in the third trimester. Please include newborns with an unanticipated positive neonatal cord, urine, or meconium screen for opioids or if newborn has symptoms associated with opioid exposure including NAS. Data collection should include mom / baby pairs. If infants delivered before 35 weeks, then OB data will be collected on mom with basic newborn data included on OB data form, neo data form will only be collected if the baby is born ≥ 35 weeks.* |
| 1. Basic Hospital Information
 |
| ***Note on Infant Transfers:****For infants transferred between hospitals, this form should be completed by that hospital that provided the majority of care during the acute period of risk. Typically, for mother this is during delivery and for infants this is approximately day 3 to day 10 of life. We are defining that hospital as the BIRTH hospital if the infant remains there for at least 5 days of life, and the RECEIVING hospital if the infant is transferred at day of life 5 or less. We believe this will capture the appropriate hospital in the vast majority of situations. If there is a situation that is vague, please contact one of the project leaders to discuss. For all mother/infants, this form should only be completed ONCE. Examples are listed below***Scenarios:*** Infant born at hospital A, remains at hospital A until discharge (Hospital A Completes Form)
* Infant born at hospital A, transferred to hospital B on day of life 20 for convalescent care, remains at hospital B until discharge (Hospital A Completes Form)
* Infant born at hospital A, transferred to hospital B on day of life 2 for acute care, remains at hospital B until discharge (Hospital B Completes Form)
* Infant born at hospital A, transferred to hospital B on day of life 2 for acute care, transferred back to hospital A on day of life 20 for convalescent care, remains at hospital A until discharge (Hospital B Completes Form)

*Please note that the hospital completing the form should attempt to contact transferring or receiving hospitals for information needed as outlined on the form. If an infant was transferred for acute care at day of life 5 or less, the receiving hospital should get information on the perinatal and birth history from the birth hospital. If the infant is transferred after day 10 for convalescent care, the transferring hospital should get information from the receiving hospital on eventual disposition and length of stay. If information is unable to be obtained, please indicate “unknown” or “unable to determine”.* |
| 1. Was the infant born in your hospital?
* *Please select one*
* *If infant transfer, complete all following fields based on all information available from your hospital as well as birth hospital. If information from birth hospital/transferring hospital is not available, indicate “unknown” or leave questions blank*
* *\*(Day of birth is considered day of life ZERO.)*
 | * Yes
* No (Transfer)

If transferred, from what hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If transferred, infant day of life when admitted: \_\_\_\_If transferred, was the reason for transfer related to management of NAS (feedings, withdrawal, etc.)?* Yes
* No
 |
| 1. Maternal-Fetal Drug Exposures and Neonatal Assessment
 |
| 1. Did infant have evidence of Neonatal Abstinence Syndrome (NAS)?

*IDPH NAS Definition:* *“Neonatal Abstinence Syndrome refers to the collection of signs and symptoms that occur when a newborn is prenatally exposed to prescribed, diverted, or illicit opiates experiences opioid withdrawal. This syndrome is primarily characterized by irritability, tremors, feeding problems, vomiting, diarrhea, sweating, and, in some cases, seizures.”* | * Yes
* No
 |
| 1. Which method of assessment for withdrawal symptoms was used?

*Please select all that apply* | * Modified Finnegan scoring
* Eat, Sleep, Console (ESC) method
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* None
 |
| 1. Non-Pharmacologic Treatment (at your hospital)
 |
| 1. Was mother engaged in non-pharmacologic bundle during infant hospitalization?
 | * Yes
* No
* Unknown

IF NO: Who was involved? \*check all that apply\** Family Member
* Nurse
* Volunteer
* Other
* Unknown
 |
| 1. Did the infant and mother room-in together during the infant’s hospitalization?

*Please* *select one****Rooming-In Definition**** *Check “Yes, during maternal hospitalization, but not after maternal discharge” if mother/baby care was provided in the same room at any time prior to mother’s discharge. Mother provided majority of infant care.*
* *Check “Yes, during maternal hospitalization and after maternal discharge” if infant in a private room where mother could sleep overnight until infant discharge. Mother provided majority of infant care for the duration of the infant’s hospitalization.*
* *Check “No” if neither mother did not room-in at any time during the baby’s hospitalization.*
 | * Yes, during maternal hospitalization, but not after maternal discharge.
* Yes, during maternal hospitalization and after maternal discharge
* Unable/ineligible to ‘room in’
	+ Mother not participating in newborn care
	+ Hospital does not have appropriate facilities for rooming in
	+ Infant transferred to NICU for advanced medical care (not NAS related)
	+ Other
* No
* Unknown

  |
| 1. Was infant admitted to a NICU or SCN?
 | * Yes
* No

IF YES, what was the reason for transfer:* Management of NAS sequela
* Respiratory distress
* Other: \_\_\_\_\_\_\_\_\_\_
 |
| 1. Was infant eligible to breastfeed at infant discharge?

*Current guidelines: ACOG CO, #711, August 2017: Breastfeeding should be encouraged in women who are stable on their opioid agonists, who are not using illicit drugs, and who have no other contraindications, such as human immunodeficiency virus (HIV) infection. Women should be counseled about the need to suspend breastfeeding in the event of a relapse.* | * Yes
* No
* Unknown

IF NO: what feeding received* Donor breast milk or Formula
* Unknown
 |
| 1. IF Yes- eligible to breastfeed: Specify what infant received at **infant** discharge

*Please select one* | * Breastmilk only
	+ Exclusive breastfeeding
	+ Breastfeeding or pumped breastmilk through bottle
* Breastmilk/breastfeeding with formula supplementation
* Formula only
* Unknown
 |
| 1. Pharmacologic Treatment (at your hospital)
 |
| 1. Did infant receive pharmacologic agents for NAS?

*Please select one* | * Yes
* If Yes, what was the first pharmacologic agent used for treatment of NAS?
	+ Morphine
	+ Methadone
	+ Clonidine
	+ Phenobarbital
	+ Other (Specify: \_\_\_\_\_\_\_\_)
	+ Unable to determine
* No
	+ If no, 🡪 skip to question 36 as the remaining questions do not apply.
* Unknown
	+ If unknown, 🡪 skip to question 36 as the remaining questions do not apply.
 |
| 1. What day of life was **first** pharmacologic agent initiated? *(Day of birth is considered day of life ZERO.)*
 | Day of Life: \_\_\_\_\_\_ |
| 1. How was the first pharmacologic agent ordered?
 | * Scheduled (i.e. on a q3h schedule)
* PRN only (not scheduled)
	+ Was this agent EVER ordered on a scheduled basis (i.e. on a q3h schedule)?
		- Yes
		- No
		- Unknown
 |
| 1. What day of life was **last** pharmacologic treatment dose given?

*Day of birth is considered day of life ZERO**If unable to determine, enter 999* | Day of Life: \_\_\_\_\_\_\_\_\_ |
| H. Discharge and Postpartum Information: *If infant was transferred from your hospital to another hospital, answer the following questions based on information from your hospital as well as the receiving hospital. Day of birth is considered day of life ZERO.*  |
| 1. Was the mother receiving treatment for substance use disorder at discharge of newborn?
 | * Yes, MAT
* Yes, other addiction treatment services
* No
* Unknown
 |
| 1. What day of life was infant final discharge to home? *Day of birth is considered day of life ZERO.*

*This could be from your hospital or receiving hospital**If unable to determine, enter 999* | Day of Life: \_\_\_\_\_\_\_\_\_ |
| 1. Was an official referral made by your hospital to Early Intervention (IL Child and Family Connections)?
 | * Yes
* No
* Unknown
 |
| 1. Was the MNO Discharge Checklist completed by infant discharge?

Key elements of the MNO Discharge Checklist include:1. Clinical Readiness - infant meets clinical discharge criteria2. Family Preparedness - mother/family received education and anticipatory guidance3. Transfer of Care - MNO Collaborative Discharge Plan completed and care handed off to PCP | * Yes
* No
* Unknown
 |
| 1. To whom was infant discharged home?

*Please select one* | * Mother
* Father (but not mother)
* Other family member
* Non-family foster
* Infant died in hospital
* Infant transferred
* Unknown
 |