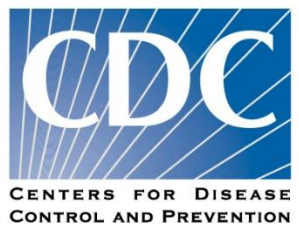




**THANKS TO OUR
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ILPQC Neonatal Breakout

A Discussion of ILPQC Newborn Initiatives

ILPQC Sixth Annual Conference
November 5, 2018

Overview



- Introduction
- Caring for Moms and Babies - Implementing MNO
 - Optimizing non-pharmacologic care (ESC as example)
 - Reducing stigma and bias
 - Planning a safe discharge
- ILPQC MNO-Neo Initiative
- Golden Hour Sustainability
- Survey Review
- Wrap up

ILPQC Central



- Patti Lee King, PhD, State Project Director
- Dan Weiss, MPH, Project Coordinator, MNO
- Autumn Perrault, RN, BSN, Nursing Quality Manager

Distinguished Guests



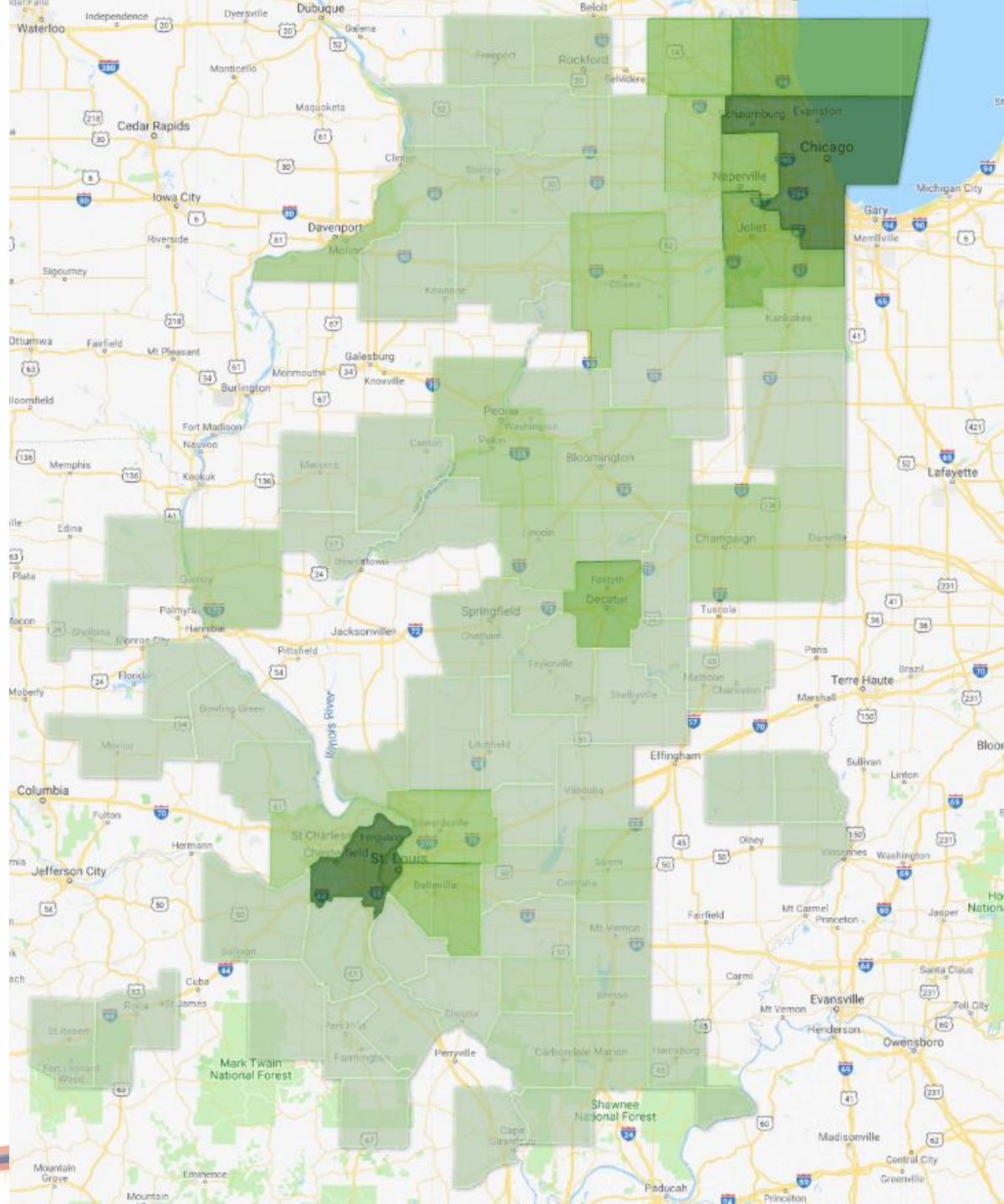
- Krisanna Deppen, MD (OPQC)
- Victoria Flanagan, RN, MS (NNEPQIN)
- Nora Harms-Pavelski, MSW (ILDCFS)

CARING FOR MOMS AND BABIES

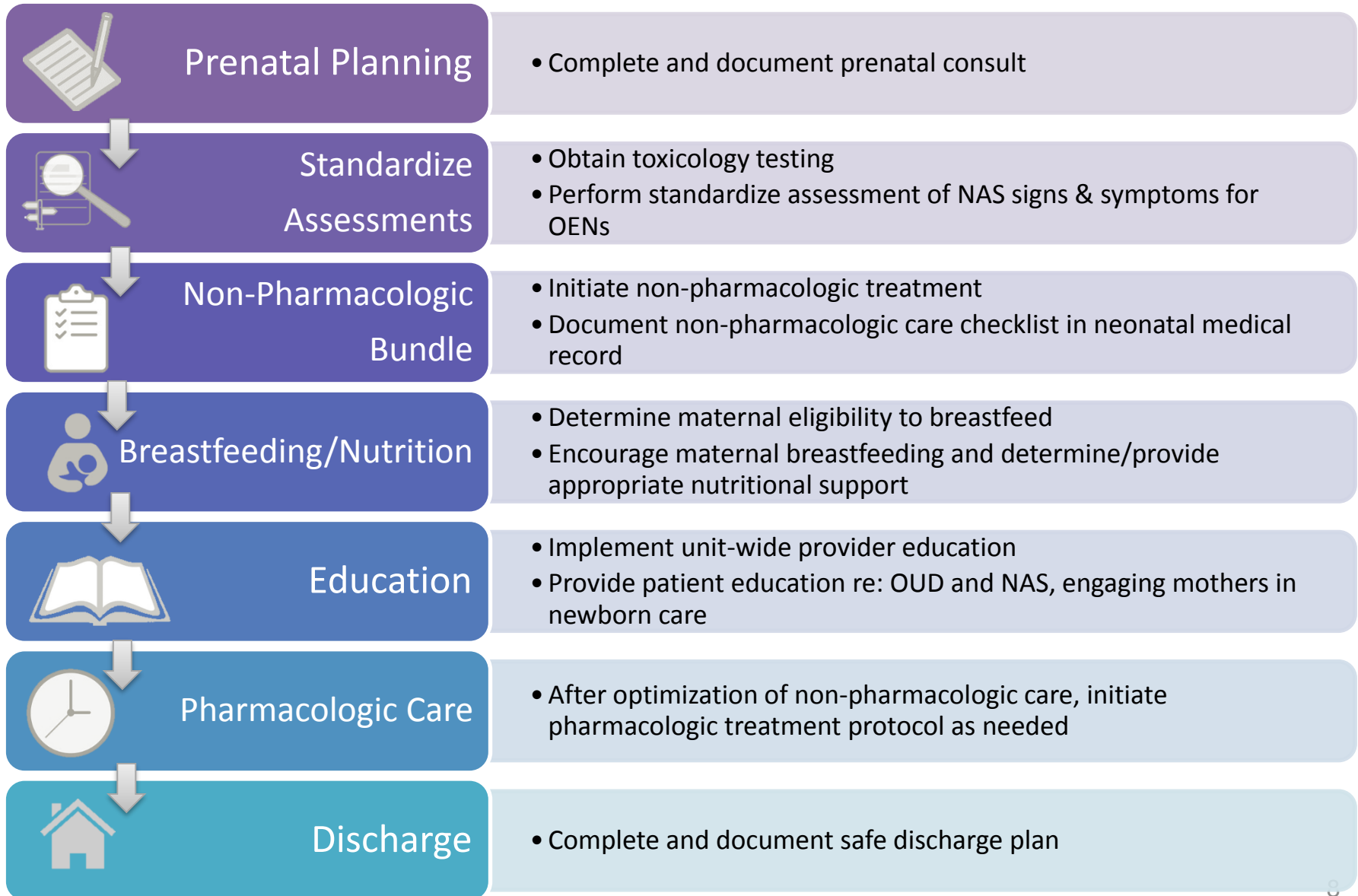
Implementing MNO

MNO Dyads

-Data submitted through October



Optimizing Care of OENs



MNO-Neo AIMS and Measures



AIMS:

- Decrease pharmacologic treatment in opioid-exposed newborns with NAS to 20%
- Increase safe and optimized discharge plans in opioid-exposed newborns to 95%
- Increase breastfeeding rates in opioid-exposed newborns at discharge to 70%

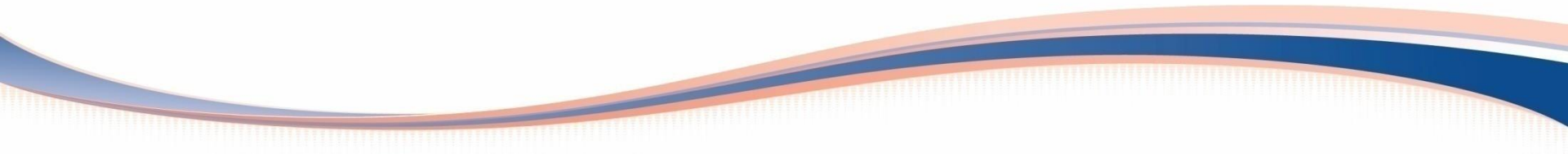
Measures:

- Percent of opioid-exposed newborns receiving a toxicology screen (urine/cord/meconium)
- Percent of opioid-exposed newborns requiring pharmacologic therapy for NAS
- Number of days of pharmacologic treatment for NAS
- Percent of mothers and newborns rooming together during infant hospitalization
- Percent of opioid-exposed newborns receiving maternal breast milk at neonatal discharge
- Percent of opioid-exposed newborns discharged with plan of safe care in place
- Average length of stay for opioid-exposed newborns

Optimizing Non-pharmacologic Care using the ESC approach



-



MINIMUM RECOMMEND MONITORING TIMES FOR OPIOID-EXPOSED INFANTS

2 days

- **Short-acting opioids:** Symptoms start on 1st day, usually peak by 24-36 hr, lessen by 48 hr
 - e.g., morphine, oxycodone, Percocet

4 days

- **Heroin**
- **Long-acting opioids:** Sx start on 2nd day, usually peak by 4 days
 - Buprenorphine (subutex, suboxone)
 - Methadone

*****Observe through peak in withdrawal sx*****



NAS/NOWS: WHAT TO EXPECT

- **55-94% infants develop some degree of NAS**
 - **Short-acting:** Sx start on day 1, peak by 36 hr, better by 48 hr
 - **Long-acting:** Sx start on day 2, peak by day 4, better by day 5
- **No relationship between dose of medicine and how severe NAS is or how long Rx is needed for baby**
- **May see symptoms earlier or differently if mom is:**
 - On SSRIs for depression / anxiety
 - Using other substances that also contribute to withdrawal Sx (e.g., other opiates, cigarettes, benzodiazepines, meth/amphetamines)

**** Stress importance of not using other substances ****

**** Do not start meds on DOL 1-2 unless short-acting exposure ****



EATING, SLEEPING, CONSOLING (ESC) CARE TOOL

- Review ESC behaviors with parents since last assessment 3-4 hours ago using Newborn Care Diary.
- If infant with Yes for any ESC item or 3 for Consoling Support Needed: Perform a Formal Parent/Caregiver Huddle to determine Non-Pharm Care Interventions to be optimized further and continue to monitor closely.
 - If not clear if infant's difficulties eating, sleeping or consoling are due to NAS, indicate Yes and continue to monitor closely while optimizing all Non-Pharm Care Interventions.
- If infant continues with Yes for any ESC item or 3 for Consoling Support Needed (or other significant concerns

See back of sheet for definition of items prior to performing assessment

ESC Care Tool 2.25.18

| | | | | | | | |
|-----------------------------------------------------------|--|--|--|--|--|--|--|
| TIME | | | | | | | |
| EATING | | | | | | | |
| Poor eating due to NAS? Yes / No | | | | | | | |
| SLEEPING | | | | | | | |
| Sleep \leq 1 hr due to NAS? Yes / No | | | | | | | |
| CONSOLING | | | | | | | |
| Unable to console within 10 min due to NAS? Yes / No | | | | | | | |
| Consoling Support Needed | | | | | | | |
| 1: Able to console on own | | | | | | | |
| 2: Able to console with caregiver support within 10 min | | | | | | | |
| 3: Unable to console with caregiver support within 10 min | | | | | | | |

| | | | | | | | |
|---------------------------------------------------------------------|--|--|--|--|--|--|--|
| 4: Other (please describe) | | | | | | | |
| PARENTAL / CAREGIVER PRESENCE | | | | | | | |
| 0: No parent present | | | | | | | |
| 1: < 1 hour | | | | | | | |
| 2: 1-2 hours | | | | | | | |
| 3: 2-3 hours | | | | | | | |
| 4: \geq 3 hours | | | | | | | |
| NON-PHARM CARE INTERVENTIONS | | | | | | | |
| Rooming-in: Increase / Reinforce | | | | | | | |
| Parent/caregiver presence: Increase / Reinforce | | | | | | | |
| Skin-to-skin contact: Increase / Reinforce | | | | | | | |
| Holding by caregiver / cuddler: Increase / Reinforce | | | | | | | |
| Safe swaddling: Increase / Reinforce | | | | | | | |
| Optimal feeding at early hunger cues: Increase / Reinforce | | | | | | | |
| Quiet, low light environment: Increase / Reinforce | | | | | | | |
| Non-nutritive sucking / pacifier: Increase / Reinforce / Not Needed | | | | | | | |
| Additional help / support in room: Increase / Reinforce | | | | | | | |
| Limiting # of visitors: Increase / Reinforce | | | | | | | |
| Clustering care: Increase / Reinforce | | | | | | | |
| Safe sleep / fall prevention: Increase / Reinforce | | | | | | | |
| Parent/caregiver self-care & rest: Increase / Reinforce | | | | | | | |
| Optional Comments: | | | | | | | |

DEFINITIONS

EATING

- Poor eating due to NAS: Baby unable to coordinate feeding *within 10 minutes* of showing hunger *OR* sustain feeding for *at least 10 minutes* at breast or with 10 mL by alternate feeding method (or other age-appropriate duration / volume) due to opioid withdrawal symptoms (e.g., fussiness, tremors, uncoordinated suck, excessive rooting).
- *Special Note:* Do not indicate Yes if poor eating is clearly due to non-opioid related factors (e.g., prematurity,

Indicate **Yes** if **Poor eating** (as defined below) is due to **NAS/opioid-withdrawal symptoms**:

- **Unable to coordinate feeding *within 10 minutes* of showing hunger *OR***
- **Unable to sustain breastfeeding for *at least 10 minutes* *OR***
- **Unable to feed with *at least 10 mL* by bottle or other feeding method (or other age-appropriate duration / volume)**

- *Special Note:* Do not indicate Yes if infant's inconsolability is clearly due to non-opioid related factors (e.g., caregiver non-responsiveness to infant hunger cues, circumcision pain).

Indicate **Yes** if **Sleep < 1 hour** is due to **NAS/opioid-withdrawal symptoms** (e.g., tremors, increased startle)

6. Caregiver offers a finger or pacifier for infant to suck, or a feeding if infant showing hunger cues.
 - *Parent/caregiver should offer CSIs to infant in manner that they feel is best at the time (e.g., feeding if infant*

Indicate **Yes** if **Unable to Console within 10 minutes** due to **NAS/opioid-withdrawal symptoms** (e.g., tremors, increased startle)

3. **Unable to console with caregiver support within 10 min:** Unable to console within 10 minutes despite caregiver or provider's effective implementation of all levels of consoling support.

PLAN OF CARE

- **Formal Parent/Caregiver Huddle:** RN bedside huddle with parent/caregiver to determine Non-Pharm Care Interventions to optimize ("Increase") further.
- **Full Care Team Huddle:** Bedside huddle with parent/caregiver, infant RN and physician or associate provider.

PARENTAL / CAREGIVER PRESENCE

- Time since last assessment that parent, or other caregiver, spent with infant in own room (or in Nursery for procedures).

OPTIMAL FEEDING:

- **Baby feeding when showing early hunger cues and until content**, on demand, without any limit placed on duration or volume of feeding. Baby should be offered feedings whenever showing the desire to suck.
- **Breastfeeding:** Baby latching deeply with comfortable latch for mother, and sustained active suckling for baby with only brief pauses noted. Staff assist directly with breastfeeding to achieve more optimal latch/position. Express colostrum and have baby feed on an adult finger first to organize suck prior to latching, as needed. Withhold pacifier use, as able.
- **Bottle feeding:** Baby effectively coordinating suck and swallow without gagging or excessive spitting up. Instruct parent to provide chin support, or modify position of bottle or flow of nipple if any feeding difficulties present.
- Consult lactation or feeding specialist if feeding difficulties continue despite above optimal feeding measures.

PLAN OF CARE

Recommend Formal Parent/Caregiver Huddle? Yes / No

Recommend Full Care Team Huddle? Yes / No

Management Decision

- 1: Continue/Optimize Non-pharm Care
- 2: Initiate Medication Treatment
- 3: Continue Medication Treatment
- 4: Other (please describe)

- **Formal Parent/Caregiver Huddle:** RN bedside huddle with parent/caregiver to determine Non-Pharm Care Interventions to optimize ("Increase") further.
- **Full Care Team Huddle:** Bedside huddle with parent/caregiver, infant RN and physician or associate provider.

- If infant with Yes for any ESC item or 3 for Consoling Support Needed: Perform a Formal Parent/Caregiver Huddle to determine Non-Pharm Care Interventions to be optimized further and continue to monitor closely.
 - *If not clear if infant's difficulties eating, sleeping or consoling are due to NAS, indicate **Yes** and continue to monitor closely while optimizing all Non-Pharm Care Interventions.*
- If infant continues with Yes for any ESC item or 3 for Consoling Support Needed (or other significant concerns are present) despite maximal non-pharm care: Perform a Full Care Team Huddle to determine if medication treatment is needed. Continue to follow infant closely, maximizing all Non-Pharm Care Interventions.



PARENTAL / CAREGIVER PRESENCE

- Time since last assessment that parent, or other caregiver, spent with infant in own room (or in Nursery for procedures).

PARENTAL / CAREGIVER PRESENCE

0: No parent present

1: < 1 hour

2: 1-2 hours

3: 2-3 hours

4: \geq 3 hours

Parental / Caregiver Presence

We recommend documentation on the ESC Care Tool flowsheet of the presence of a parent (biological or foster) or other caregiver (e.g., family support person, cuddler) at the bedside when assessments are performed.¹² Documentation should reflect parental/caregiver presence with the infant (in their own room or in Nursery for procedures) since the last ESC assessment. The ESC Care Tool includes a rating code from 0-4 with increasing code number indicating *greater* parental/caregiver presence. If the infant is having eating, sleeping, or consoling difficulties and the parent's (or other caregiver's) presence is less than the time since last assessment, staff should encourage ways to optimize presence further to help the infant through their withdrawal more effectively.

| | | DATE AND TIME IN HOURS | | | |
|--------------------------------------------------------|-------------------------------------------------|------------------------|--|--|--|
| SYSTEM | SIGNS & SYMPTOMS | SCORE | | | |
| CENTRAL NERVOUS SYSTEM DISTURBANCES | High-Pitched Cry | 2 | | | |
| | Continuous High-Pitched Cry | 3 | | | |
| | Sleeps < 1 hour after feeding | 3 | | | |
| | Sleeps < 2 hours after feeding | 2 | | | |
| | Sleeps > 3 hours after feeding | 1 | | | |
| | Mild Tremors Disturbed | 1 | | | |
| | Mod-Severe Tremors Disturbed | 2 | | | |
| | Mild Tremors Undisturbed | 3 | | | |
| | Mod-Severe Tremors | 4 | | | |
| | Undisturbed | | | | |
| METABOLIC / VASOMOTOR / RESPIRATORY DISTURBANCES | Increased Muscle Tone | 2 | | | |
| | Excoriation (specify area) | 1 | | | |
| | Myoclonic Jerks | 3 | | | |
| | Generalised Convulsions | 5 | | | |
| | Fever (37.3°C – 38.3°C) | 1 | | | |
| | Fever (38.4°C and higher) | 2 | | | |
| GASTROINTESTINAL DISTURBANCES | Frequent Yawning (>3-4 times) | 1 | | | |
| | Nasal Stuffiness | 1 | | | |
| | Sneezing (>3-4 times) | 1 | | | |
| | Nasal Flaring | 2 | | | |
| | Respiratory Rate > 60 / min | 1 | | | |
| | Respiratory Rate > 60 / min with retractions | 2 | | | |
| | Excessive sucking | 1 | | | |
| Poor Feeding | 2 | | | | |
| Regurgitation | 2 | | | | |
| Projectile Vomiting | 3 | | | | |
| Loose Stools | 2 | | | | |
| Watery Stools | 3 | | | | |
| | Max Score: 41 | | | | |
| | TOTAL SCORE | | | | |
| | SCORER'S INITIALS | | | | |

| TIME | | | | |
|---------------------------------------------------------------------|--|--|--|--|
| EATING | | | | |
| Poor eating due to NAS? Yes / No | | | | |
| SLEEPING | | | | |
| Sleep < 1 hr due to NAS? Yes / No | | | | |
| CONSOLING | | | | |
| Unable to console within 10 min due to NAS? Yes / No | | | | |
| Consoling Support Needed | | | | |
| 1: Able to console on own | | | | |
| 2: Able to console with caregiver support within 10 min | | | | |
| 3: Unable to console with caregiver support within 10 min | | | | |
| PLAN OF CARE | | | | |
| Recommend Formal Parent/Caregiver Huddle? Yes / No | | | | |
| Recommend Full Care Team Huddle? Yes / No | | | | |
| Management Decision | | | | |
| 1: Continue/Optimize Non-pharm Care | | | | |
| 2: Initiate Medication Treatment | | | | |
| 3: Continue Medication Treatment | | | | |
| 4: Other (please describe) | | | | |
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| 0: No parent present | | | | |
| 1: < 1 hour | | | | |
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| 3: 2-3 hours | | | | |
| 4: ≥ 3 hours | | | | |
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| Skin-to-skin contact: Increase / Reinforce | | | | |
| Holding by caregiver / cuddler: Increase / Reinforce | | | | |
| Safe swaddling: Increase / Reinforce | | | | |
| Optimal feeding at early hunger cues: Increase / Reinforce | | | | |
| Quiet, low light environment: Increase / Reinforce | | | | |
| Non-nutritive sucking / pacifier: Increase / Reinforce / Not Needed | | | | |
| Additional help / support in room: Increase / Reinforce | | | | |
| Limiting # of visitors: Increase / Reinforce | | | | |
| Clustering care: Increase / Reinforce | | | | |
| Safe sleep / fall prevention: Increase / Reinforce | | | | |
| Parent/caregiver self-care & rest: Increase / Reinforce | | | | |
| Optional Comments: | | | | |



Pharm Rx if baby unable to eat, sleep, or console due to NAS/NOWS after optimal non-pharm care

Pharm Rx if severe symptoms (apnea, seizures) or other significant concerns present

**Review ESC behaviors q ~3 hr with parents
Educate re: Non-Pharm Care Interventions (NPIs)**

Poor eating

Sleep < 1 hr

**Unable to Console
within 10 min**

- 1. Are symptoms consistent with NAS / Neonatal Opioid Withdrawal (NOW)?**
e.g., excessive rooting and uncoordinated suck interfering with feeding, tremors and exaggerated startle waking baby, difficulty consoling due to significant fussiness, or inability to feed or sleep?
- 2. Is timing of withdrawal symptoms consistent with specific opioid exposure?**
- 3. Are NPIs maximized to their fullest possible in your clinical setting?**

Yes

No

Perform Full Care Team Huddle

**Perform Formal Parent/Caregiver Huddle
to review ESC symptoms and NPIs to be
increased / optimized further**

Pharm Rx if severe symptoms (apnea, seizures) or other significant NOW concerns present

**Review ESC behaviors q ~3 hr with parents
Educate re: Non-Pharm Care Interventions (NPIs)**

Poor eating

Sleep < 1 hr

**Unable to Console
within 10 min**

**Perform Formal Parent/Caregiver Huddle to review symptoms
and NPIs to be increased / optimized further**

**Continued difficulties with Eating, Sleeping, or Consoling *or*
other significant concerns present?**

Yes

No

**Perform Full Care Team Huddle to
review if symptoms are due to NAS /
Neonatal Opioid Withdrawal (NOW)
and ensure all NPIs maximized to fullest**

**Review ESC behaviors q ~3 hr
Reinforce & educate on additional NPIs
that can be increased further**

Pharm Rx if severe symptoms (apnea, seizures) or other significant NOW concerns present

Perform Full Care Team Huddle

1. **Are symptoms consistent with NAS / Neonatal Opioid Withdrawal (NOW)?**
e.g., excessive rooting and uncoordinated suck interfering with feeding, tremors and exaggerated startle waking baby, difficulty consoling due to significant fussiness, or inability to feed or sleep?
2. **Is timing of withdrawal symptoms consistent with specific opioid exposure?**
3. **Are NPIs maximized to their fullest possible in your clinical setting?**

Yes

No

Initiate medication treatment NOW, reassess ESC behaviors in ~ 3 hr and determine if further medication needed

Continue to educate on and reinforce effective implementation of NPIs

Determine etiology of symptoms and implement appropriate management

Reinforce & educate on additional NPIs that can be increased further

Continue to review ESC behaviors q ~3 hr

Pharm Rx if severe symptoms (apnea, seizures) or other significant NOW concerns present

NON-PHARM CARE INTERVENTIONS

Rooming-in: Increase / Reinforce

Parent/caregiver presence: Increase / Reinforce

Skin-to-skin contact: Increase / Reinforce

Holding by caregiver / ~~cuddler~~: Increase / Reinforce

Safe swaddling: Increase / Reinforce

Optimal feeding at early hunger cues: Increase / Reinforce

Quiet, low light environment: Increase / Reinforce

Non-nutritive sucking / pacifier: Increase / Reinforce / Not Nee

Additional help / support in room: Increase / Reinforce

Limiting # of visitors: Increase / Reinforce

Clustering care: Increase / Reinforce

Safe sleep / fall prevention: Increase / Reinforce

Parent/caregiver self-care & rest: Increase / Reinforce

Optional Comments:

RECOMMENDED NON-PHARM CARE INTERVENTIONS

- **Rooming-in** together and **parental (or other caregiver) presence** throughout baby's entire hospital stay
- **Skin-to-skin contact** as much as possible with parent/caregiver fully awake to help calm baby and promote neurobehavioral organization
- **Holding / gentle rocking / swaying**
- **Use of cuddler program**, if available, for additional holding and support in the room
- **Safe swaddling / flexed positioning**
- **Optimal feeding at early hunger cues**
- **Breastfeeding** unless there is concern related to continued substance use or other medical contraindication is present



RECOMMENDED NON-PHARM CARE INTERVENTIONS

- **Quiet environment** with low light stimulation in the room
- **Non-nutritive sucking** with finger or pacifier, as needed, ensuring baby is well fed first
- **Additional help / support** in room at all times with one caregiver napping while other caring for infant
- **Limiting visitors** to 1-2 at a time (and to those that will be quiet and supportive)
- **Clustering infant's care**, allowing for uninterrupted periods of rest/sleep for infant and caregivers

- **Safe sleep/infant fall prevention**
 - Ensure baby sleeps in own bassinet
 - Safely swaddle in thin blanket or safe sleep outfit, on back, without any additional items placed in bassinet
 - When holding infant, parent/caregiver should be fully awake
 - If parent sleepy, should place baby down in bassinet *OR* ask another caregiver, cuddler, or staff member to help with baby
 - Staff should encourage parent(s) to take a nap whenever baby is asleep, or being held by another caregiver, to help “refresh” and decrease likelihood of falling asleep with their baby

- **Encourage adequate parent/caregiver rest and self-care**
 - Staff/providers should acknowledge that infant’s symptoms and hospitalization may be stressful and challenging (e.g., baby needing to be held all of the time to stay calm) and that it is ok to ask for help and/or take a break, when needed



ESC Workshop Simulations



- Utilize a step-wise approach to assess the ability of an OEN to effectively eat, sleep, console
 - Will use ESC method of assessment, but overall approach will be similar
- Understand the purpose and indication of parent/care team huddles for NAS (NOW) management
- Learn how to adjust a care plan in response to the ESC management
- Recognize stigma and bias—Words Matter
- Utilize partnerships with community resources for a safe discharge

Focused Finnegan Scoring

Modified Finnegan Neonatal Abstinence Score Sheet¹

| System | Signs and Symptoms | Score | AM | | | | PM | | | |
|-------------------------------------|-------------------------------------------------|-------|----|--|--|--|----|--|--|--|
| Central Nervous System Disturbances | Excessive high-pitched (or other) cry < 5 mins | 2 | | | | | | | | |
| | Continuous high-pitched (or other) cry > 5 mins | 3 | | | | | | | | |
| | Sleeps < 1 hour after feeding | 3 | | | | | | | | |
| | Sleeps < 2 hours after feeding | 2 | | | | | | | | |
| | Sleeps < 3 hours after feeding | 1 | | | | | | | | |
| | Hyperactive Moro reflex | 2 | | | | | | | | |
| | Markedly hyperactive Moro reflex | 3 | | | | | | | | |
| | Mild tremors when disturbed | 1 | | | | | | | | |
| | Moderate-severe tremors when disturbed | 2 | | | | | | | | |
| | Mild tremors when undisturbed | 3 | | | | | | | | |
| | Moderate-severe tremors when undisturbed | 4 | | | | | | | | |
| | Increased muscle tone | 1 | | | | | | | | |
| | Excoriation (chin, knees, elbow, toes, nose) | 1 | | | | | | | | |
| | Myoclonic jerks (twitching/jerking of limbs) | 3 | | | | | | | | |
| Generalised convulsions | 5 | | | | | | | | | |

MNO Neonatal Key Drivers

Primary Drivers

Secondary Drivers

Change Ideas

Aims

- Decrease pharmacologic treatment in opioid exposed neonates
- Increase breastfeeding rates in opioid exposed neonates at discharge
- Increase safe and optimized discharge plans in opioid exposed neonates

Identification and Assessment of OENs

Strengthen Family/Care Team Relationships

Non-judgmental support

Improve pre-delivery planning

Prenatal pediatric consultation

Standardize identification, assessment, and monitoring of OENs

Toxicology testing

Provide Family Education

Assessment tools

Treatment

Improve infant nutrition and breastfeeding

Feeding guidelines

Optimize non-pharmacologic care

Non-pharmacologic care guidelines

Safe Discharge

Standardize pharmacologic treatment

Pharmacologic treatment guidelines

Coordinate safe discharge

Safe discharge guidelines

Social work consultation

DCFS

MNO Neonatal Key Drivers

Primary Drivers

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Non-pharmacologic care guidelines

Safe Discharge

Standardize pharmacologic treatment

Pharmacologic treatment guidelines

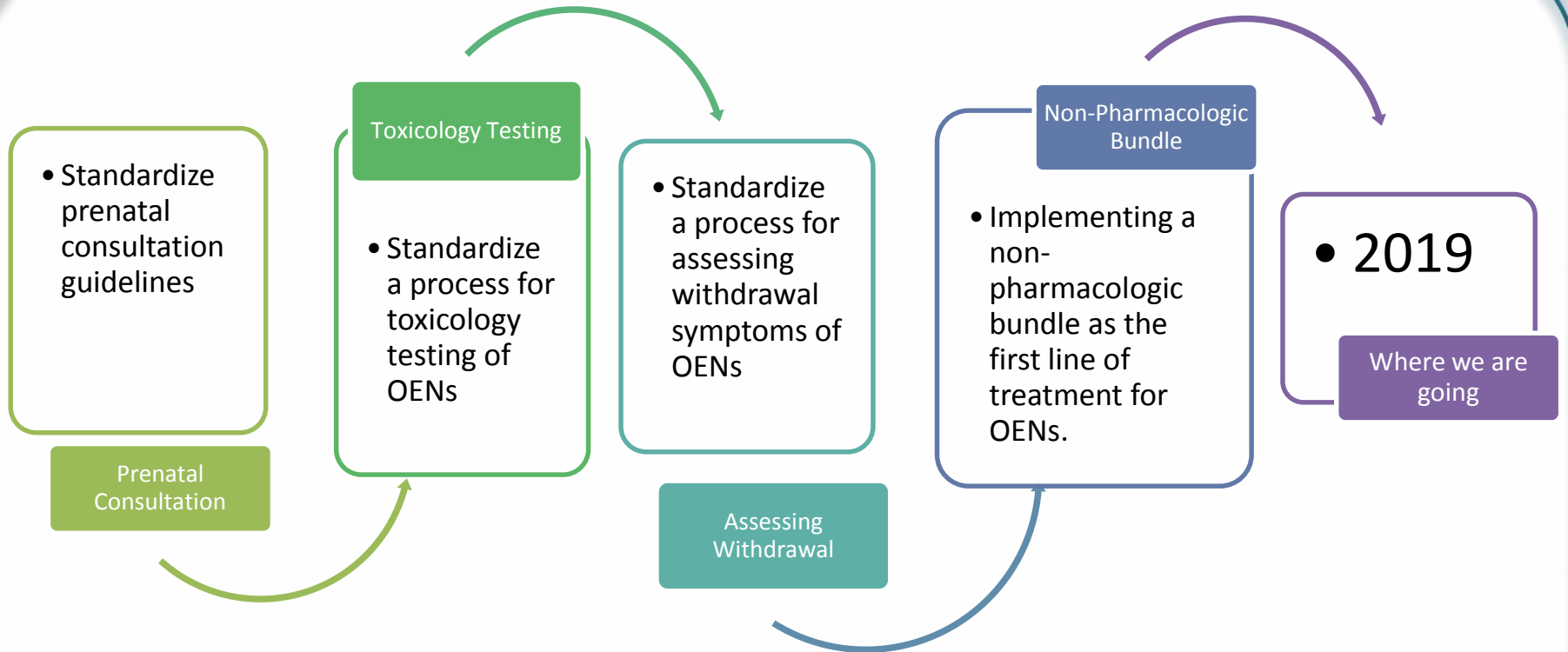
Coordinate safe discharge

Safe discharge guidelines

Social work consultation

DCFS

MNO-Neo work so far...



Stigma, Bias, and Trauma Informed Care

Standardize a process to systematically educate providers, nurses and staff on stigma, bias and trauma informed care

MNO Patient-Level Data Entry Status



| Monthly Process/ Outcome | Total Records | # Teams with Patient Level Data Reported | # Teams with No Newborns to Report | # Teams Reporting |
|-------------------------------------|----------------------|---------------------------------------------------------|---------------------------------------------------|------------------------------|
| Baseline | 309 | 60 | 9 | 69 |
| July 2018 | 54 | 54 | 20 | 74 |
| August 2018 | 87 | 36 | 24 | 60 |
| September 2018 | 60 | 27 | 18 | 45 |

MNO Neo Structure Measures Data Entry Status

Monthly Structure Measures

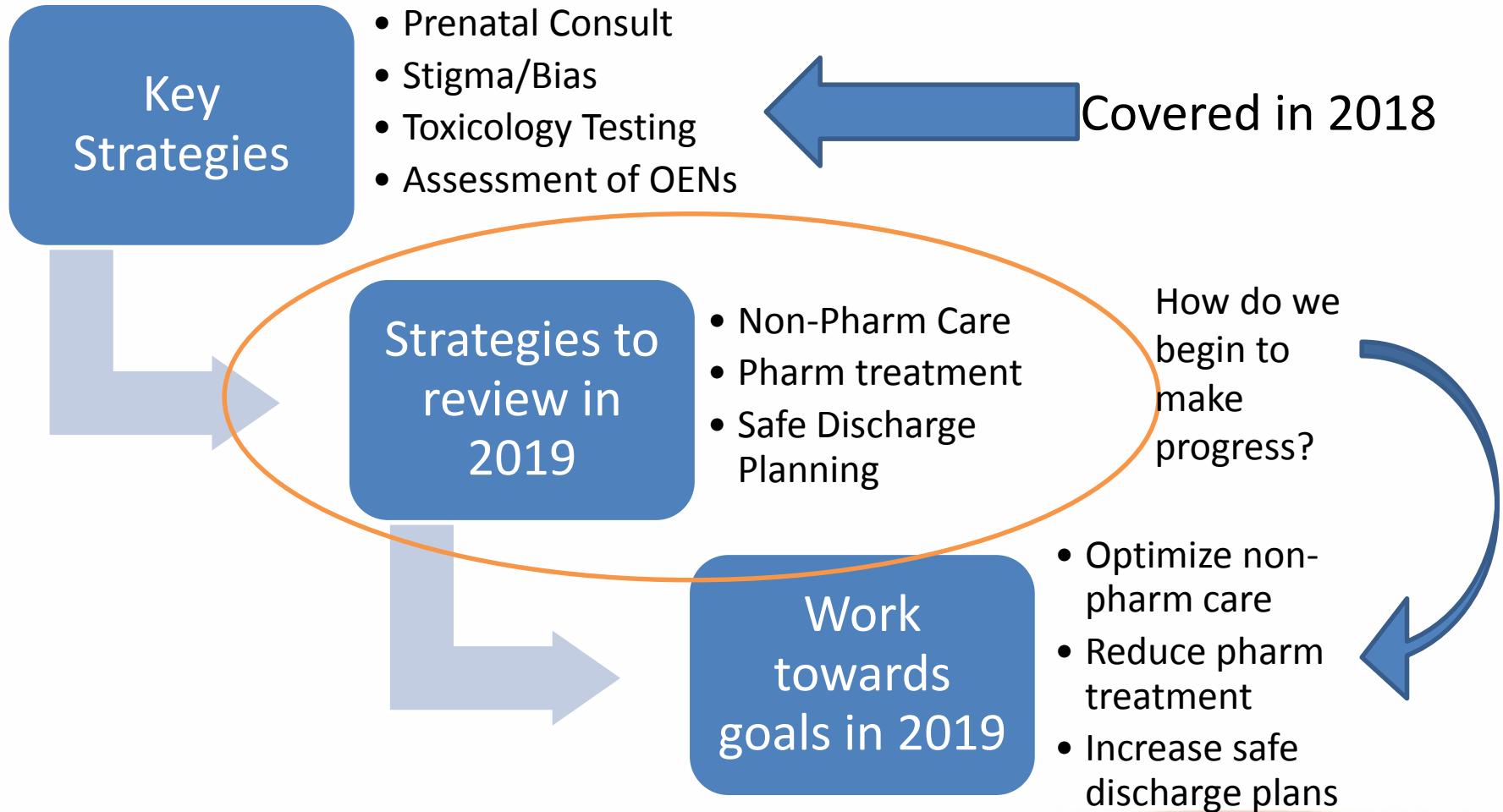
Teams with Data

| | |
|----------------|----|
| Baseline | 45 |
| July 2018 | 28 |
| August 2018 | 26 |
| September 2018 | 22 |

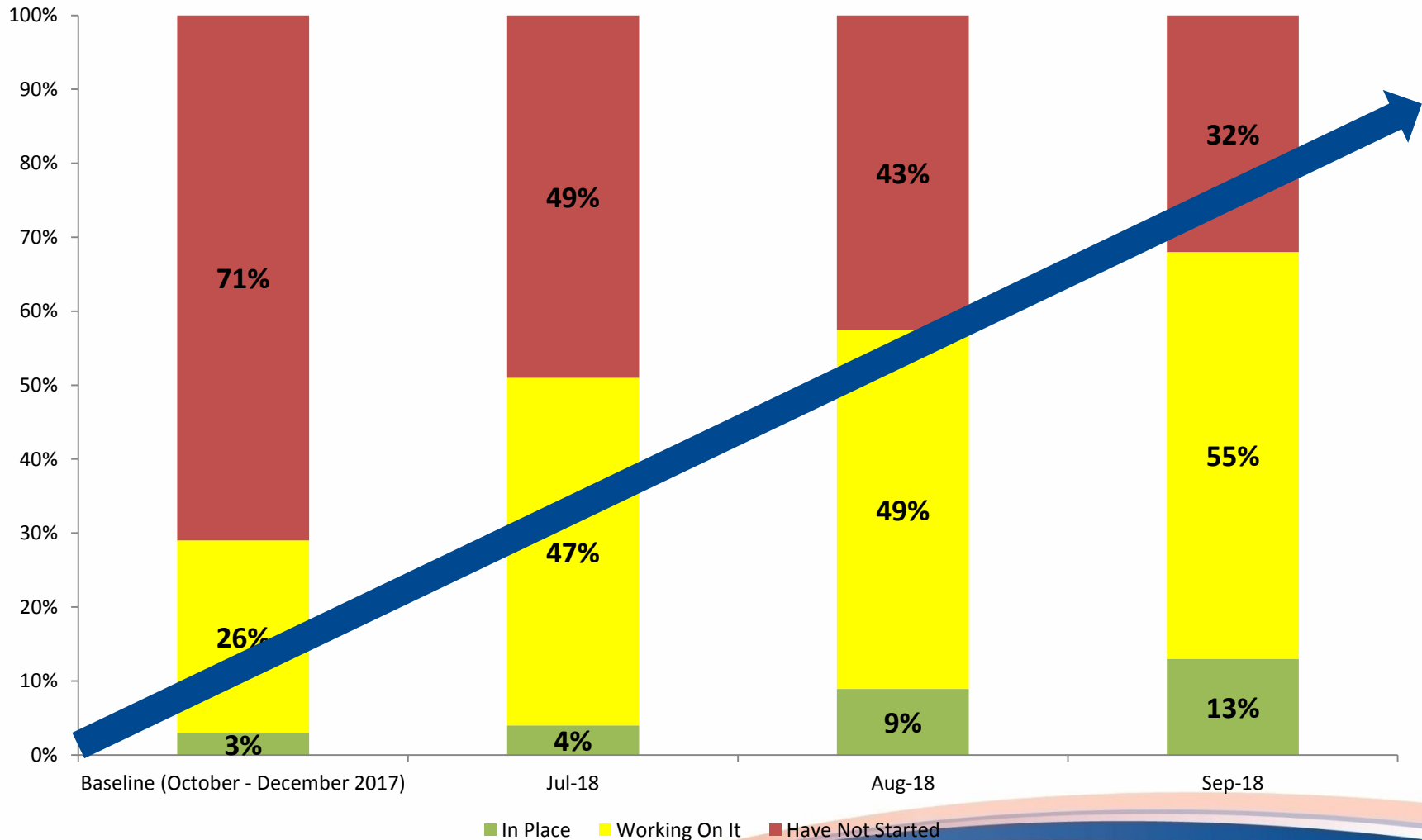
Structure measures are important tools to review with your team monthly to monitor your progress towards sustainable improvement

EVERYONE whether you see 1 to 100 infants / year your team can structure processes for success!

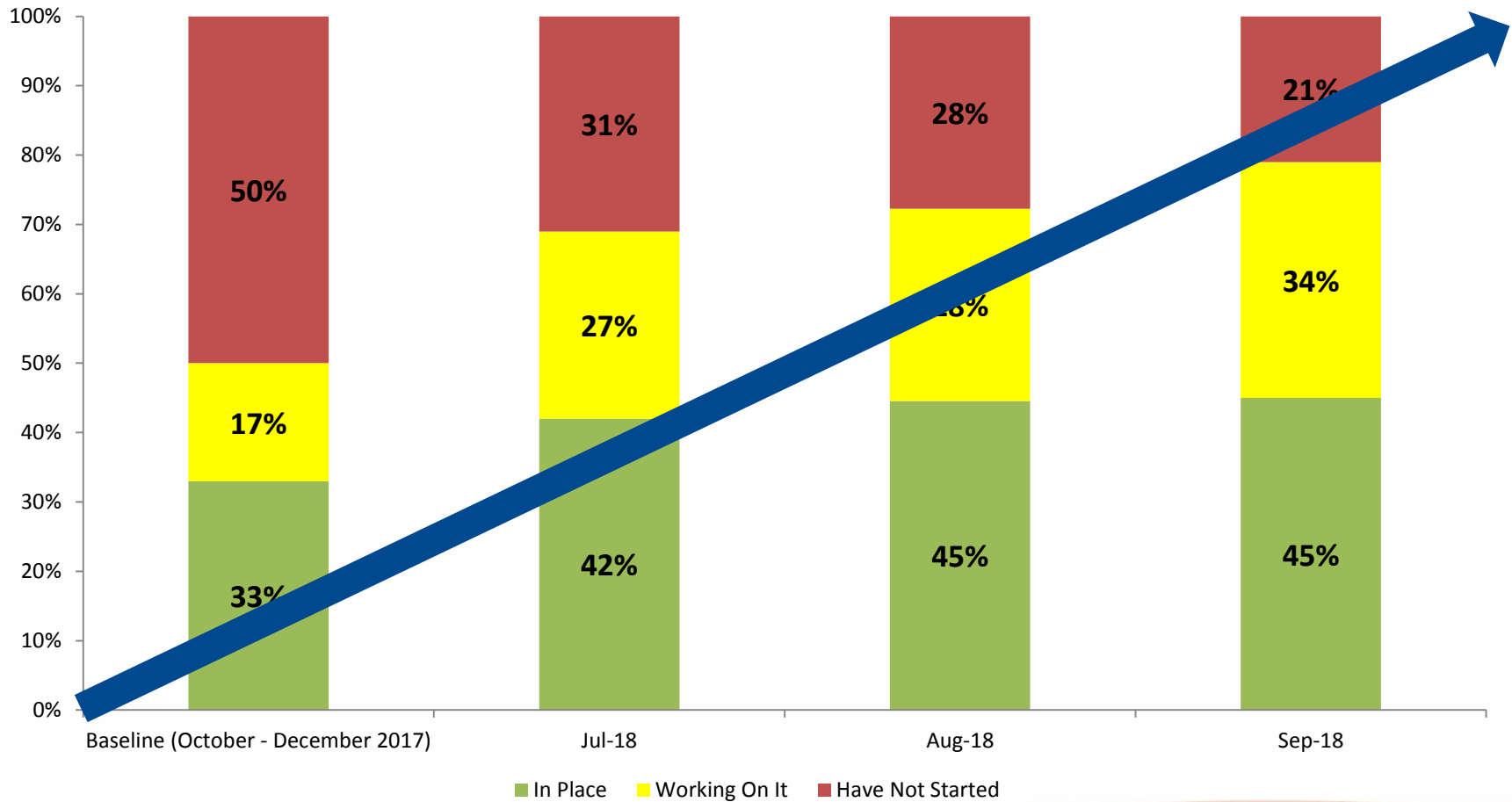
MNO-Neo in 2019



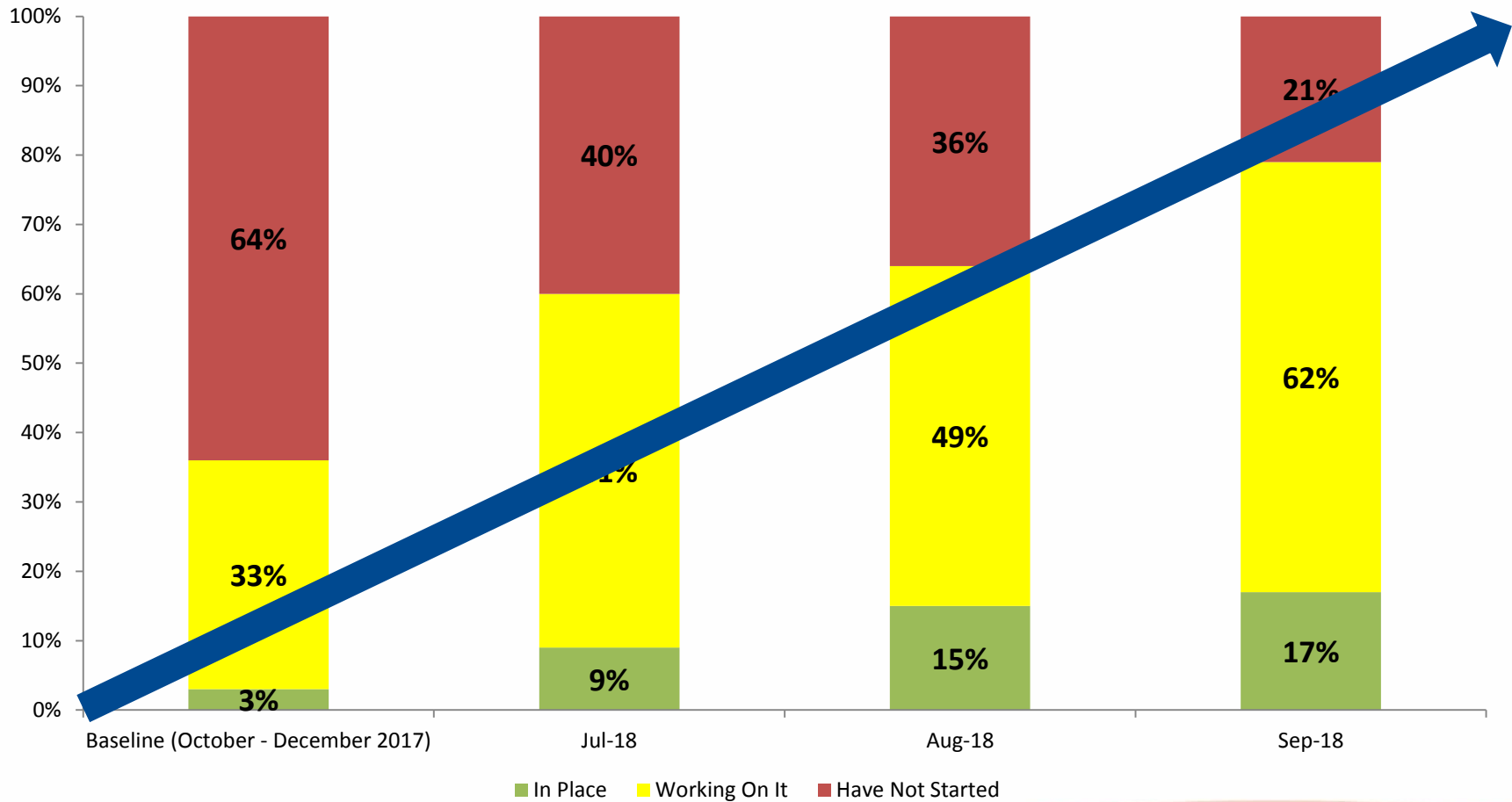
MNO-Neo Structure Measures: Standardized Prenatal Consult



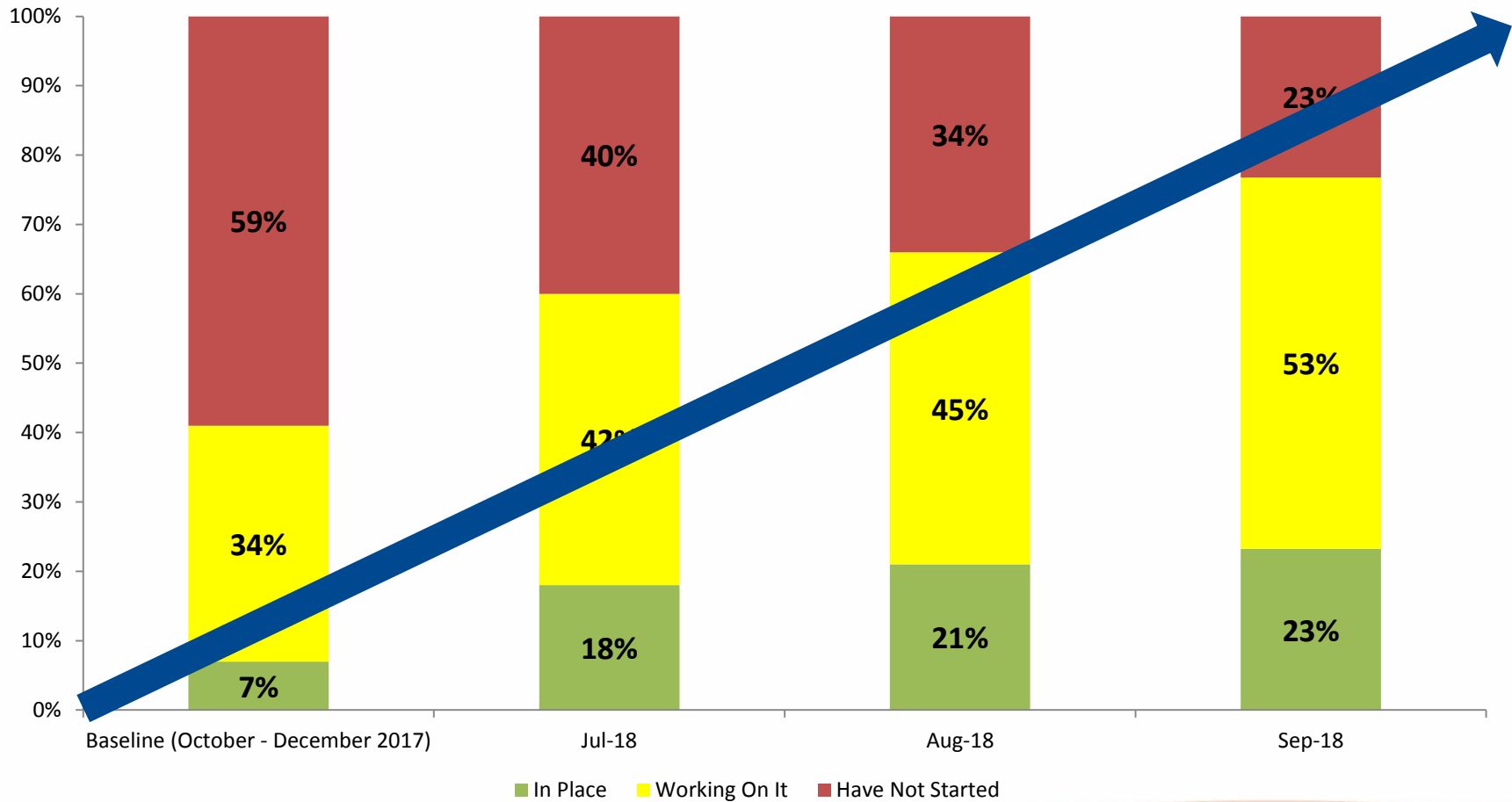
MNO-Neo Structure Measures: Standardized Pharm Treatment



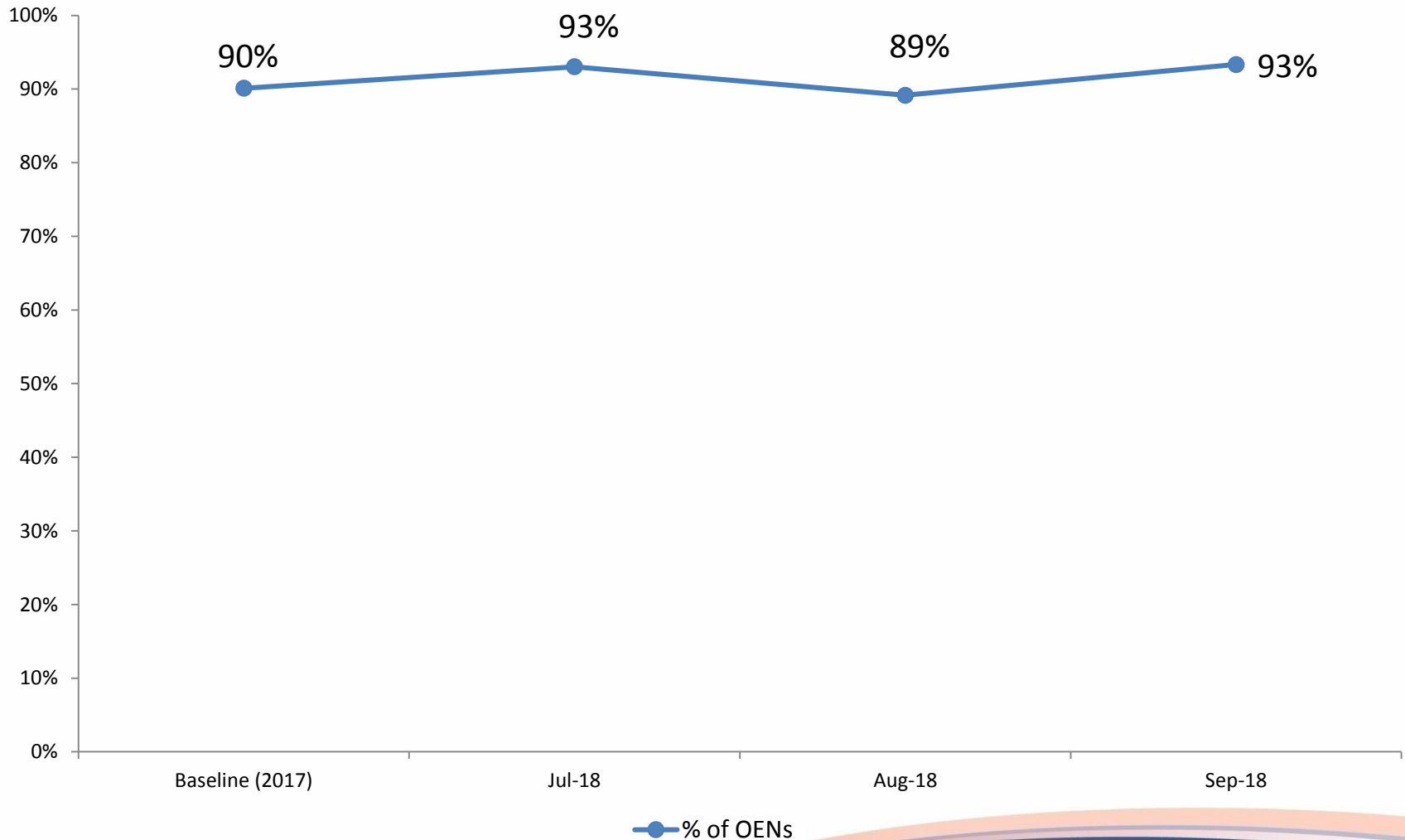
MNO-Neo Structure Measures: Standardized Non-Pharm Care



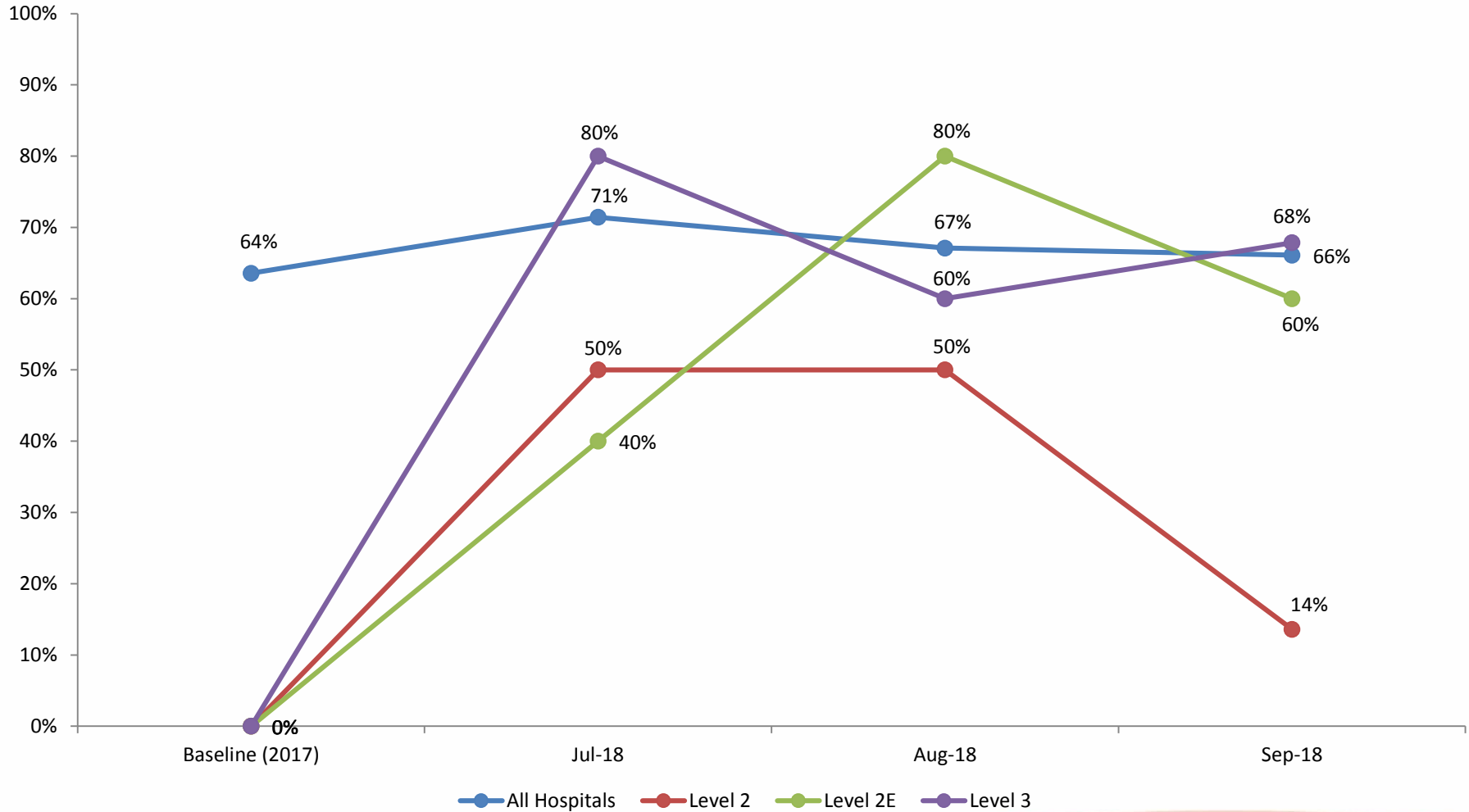
MNO-Neo Structure Measures: Standardized Discharge Planning



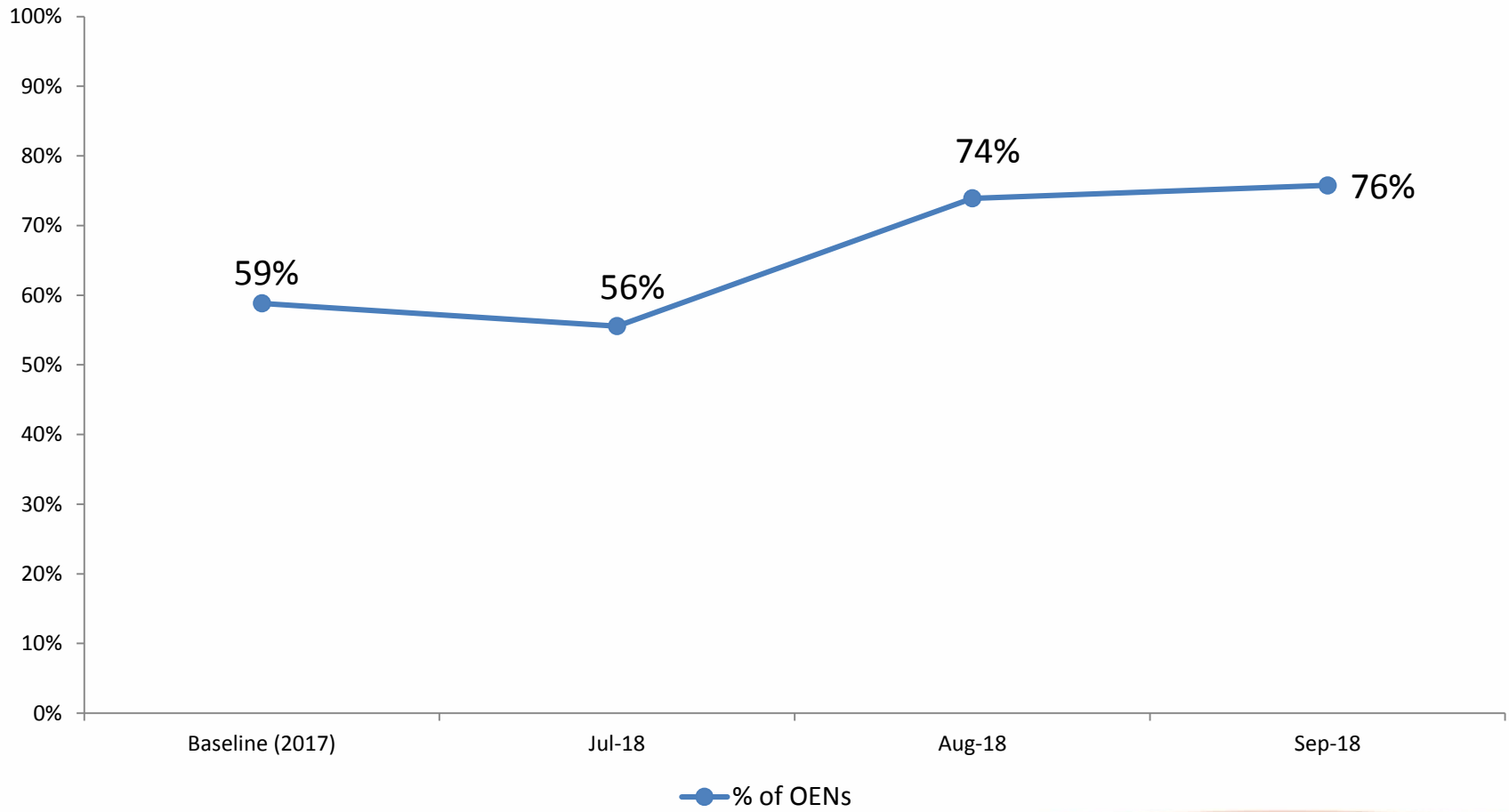
MNO-Neo Process Measures: OENs Receiving Toxicology Testing



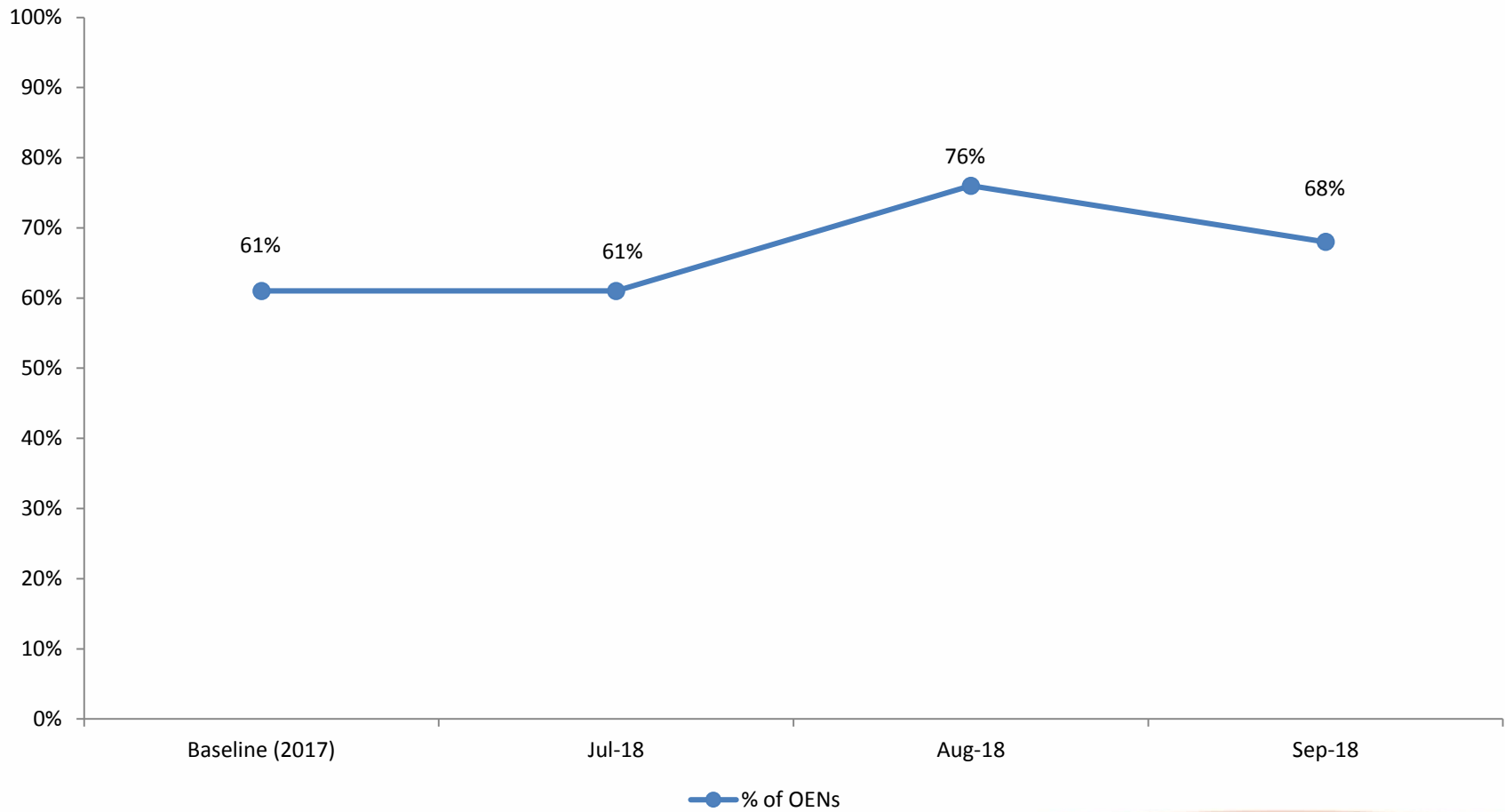
MNO-Neo Process Measures: Rooming In During Infant Hospitalization



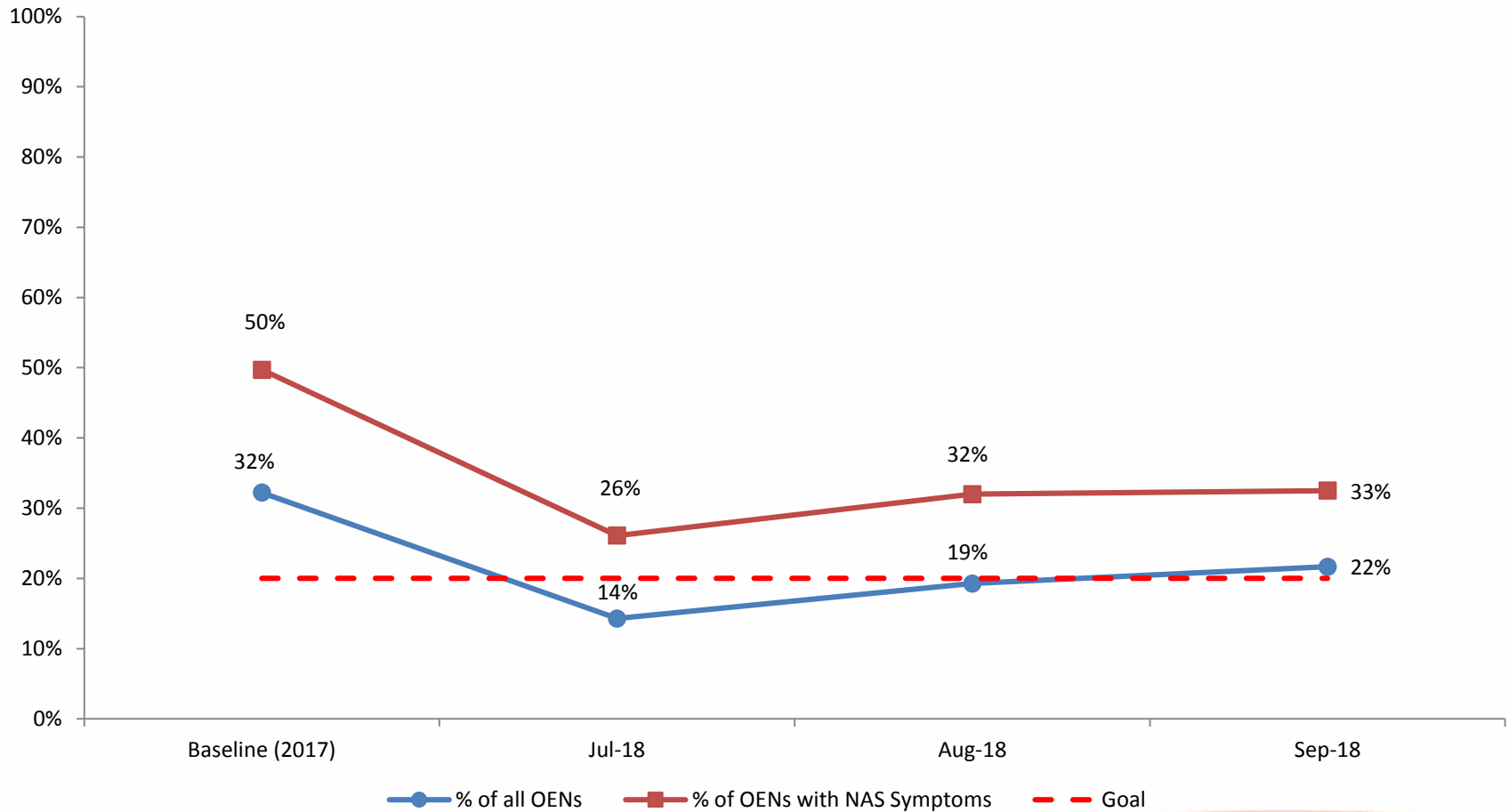
MNO-Neo Outcome Measures: Eligible OENs Receiving Maternal Breast Milk at Infant Discharge



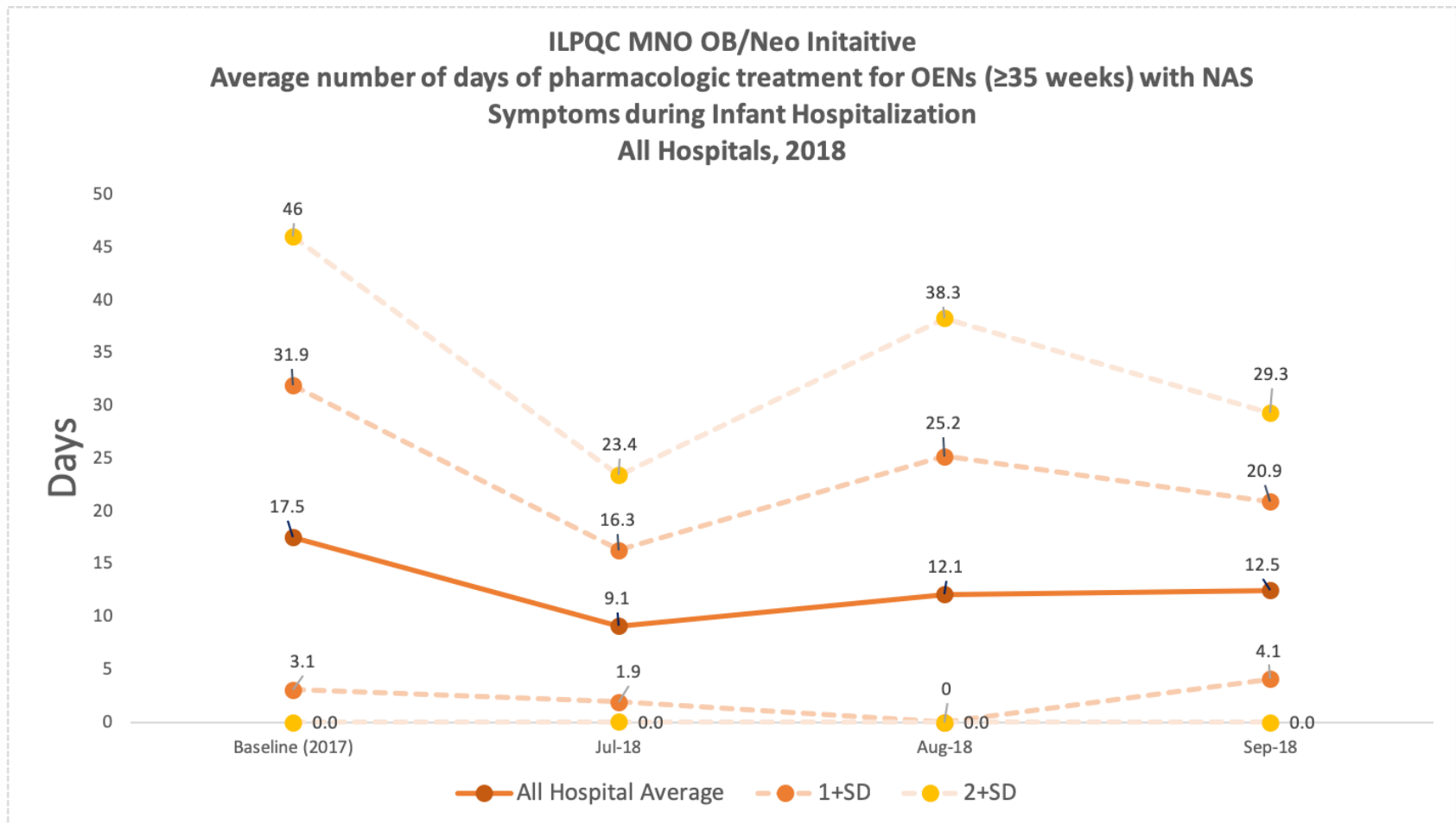
MNO-Neo Outcome Measures: All OENs Receiving Maternal Breast Milk at Infant Discharge



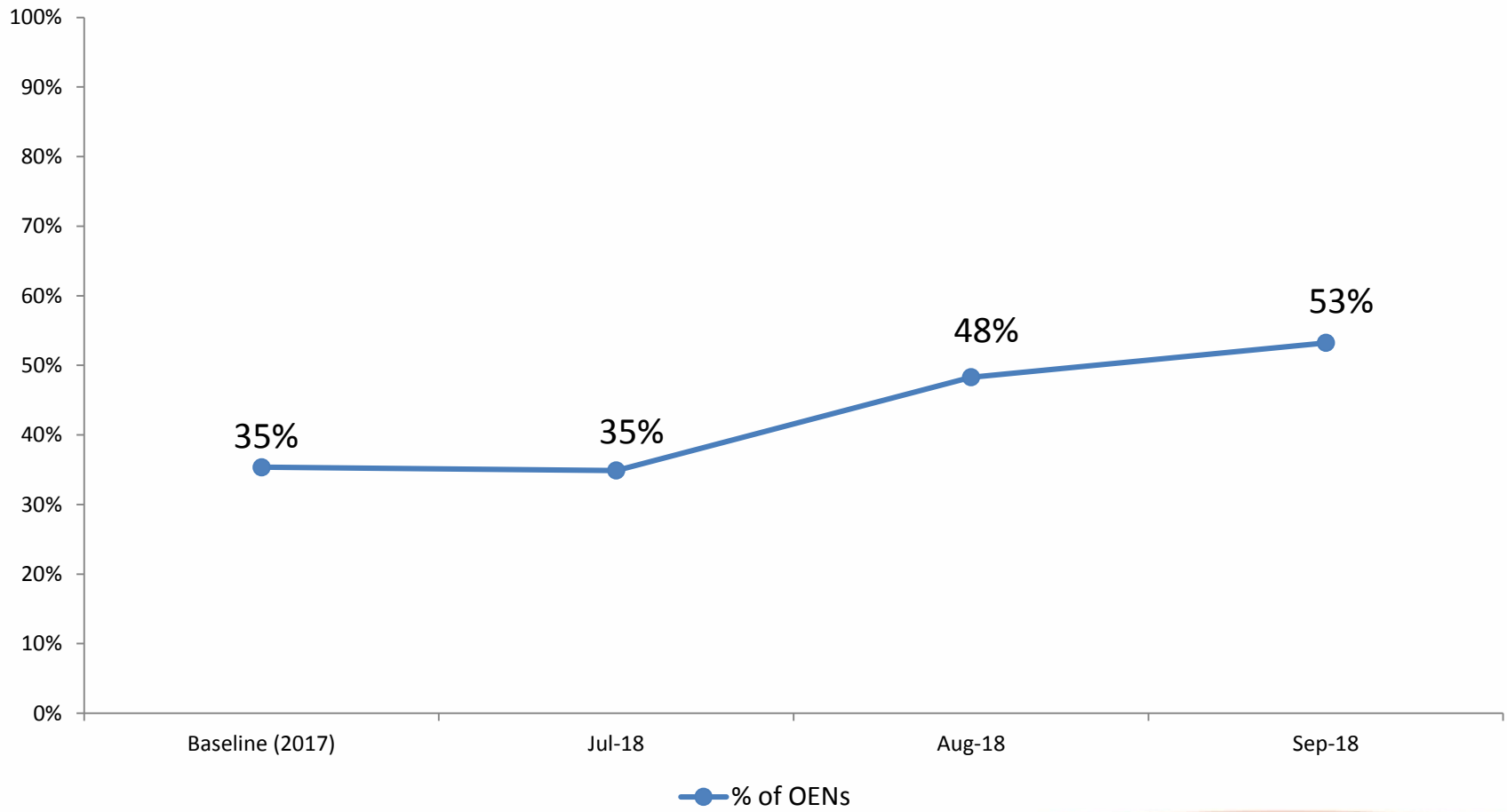
MNO-Neo Outcome Measures: OENs Requiring Pharmacologic Treatment for NAS



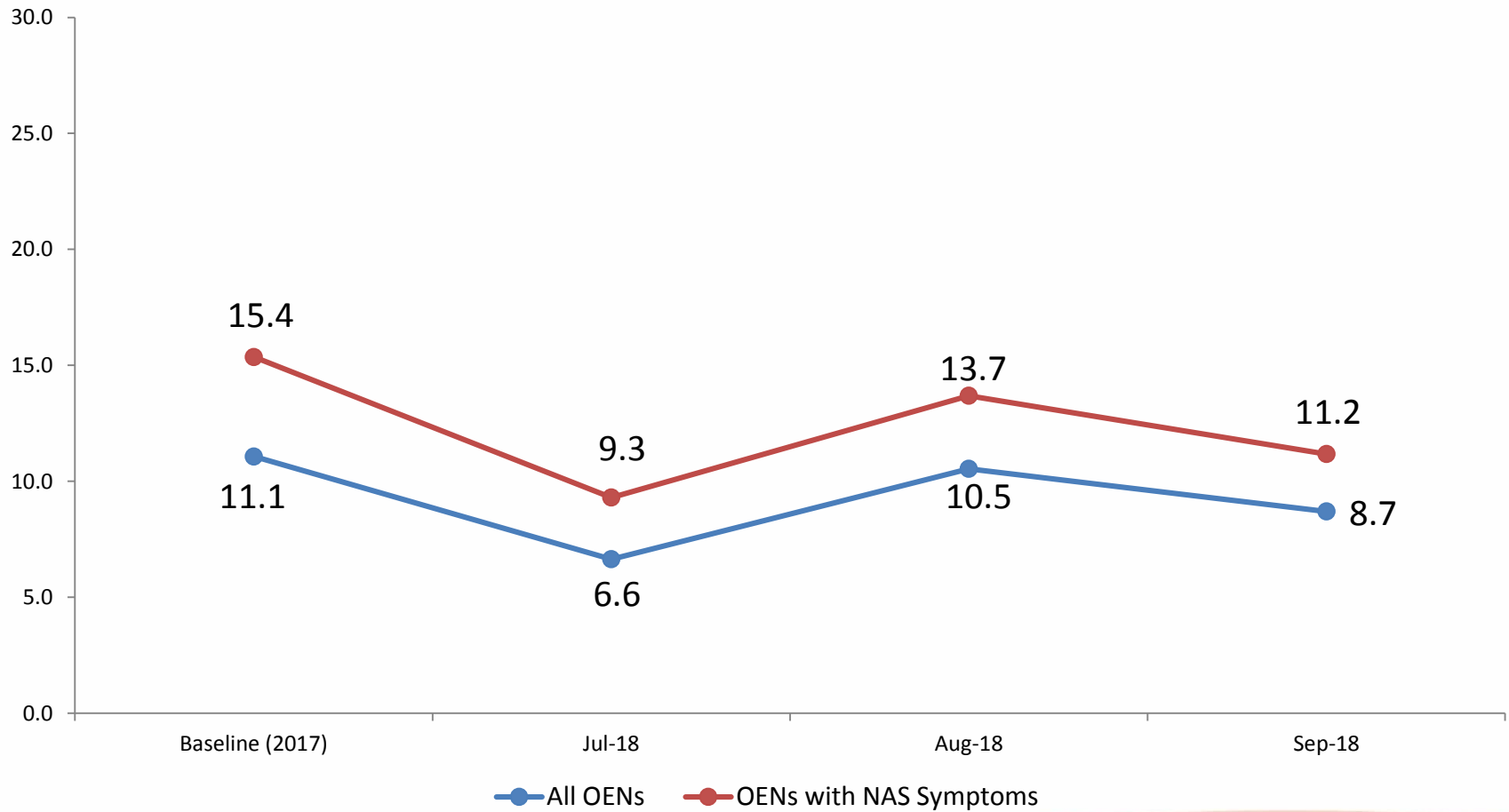
Mean Days of Pharmacologic Treatment for OENs (≥ 35 weeks) with NAS symptoms



MNO-Neo Outcome Measures: OENs Discharged with a Safe Discharge Plan



MNO-Neo Outcome Measures: Average Length of Stay for OENs



MNO-Neo in 2019

- Focus on non-pharmacologic care strategies
 - Improving rooming in after maternal discharge
 - Improving infant nutrition and optimize breastfeeding
 - Focusing on key withdrawal symptoms to drive pharm care rather than “Score”
- Implement standardized pharmacologic guidelines including PRN dosing as appropriate
- Standardize and implement safe discharge planning using checklist

CONGRATULATIONS

MNO-Neo OUTSTANDING QUALITY

IMPROVEMENT DATA AWARD WINNERS

ILPQC MOTHERS AND NEWBORNS AFFECTED BY OPIOIDS INITIATIVE



| | |
|------------------------------------------|---------------------------------------------------------|
| Advocate BroMenn Medical Center | Morris Hospital and Health Care Centers |
| Advocate Children's Hospital- Oak Lawn | Mount Sinai |
| Advocate Children's Hospital- Park Ridge | NM Central DuPage Hospital |
| Advocate Sherman Hospital | NM Delnor Hospital |
| Advocate South Suburban Hospital | NorthShore University Health System - Evanston Hospital |
| Alton Memorial Hospital | Northwestern Memorial Hospital |
| Belleville Memorial Hospital | OSF St. Francis Medical Center |
| Decatur Memorial Hospital | Riverside Medical Center |
| Edward Hospital | Rush-Copley Medical Center |
| HSHS St. Mary's Hospital - Decatur | SSM St. Mary's Hospital - St.Louis |
| Illinois Valley Community Hospital | SSM Health Cardinal Glennon Children's Hospital |
| Little Company of Mary Hospital | Swedish Covenant Hospital |
| Loyola University Medical Center | Vista Medical Center East |
| Memorial Hospital East | |

GOLDEN HOUR SUSTAINABILITY

CONGRATULATIONS



Golden Hour Quality Improvement Sustainability Champions and Compliance Monitoring Data Submission Awards

ILPQC GOLDEN HOUR SUSTAINABILITY

| |
|-----------------------------------------------------------------------------|
| Advocate Children's Hospital- Park Ridge |
| Advocate Good Samaritan Hospital |
| Amita Alexian Brothers Womens and Childrens Hospital at St. Alexius |
| AMITA Health Adventist Medical Center Hinsdale |
| Edward Hospital |
| NM Delnor Hospital |
| Northwestern Memorial Hospital |
| SSM Health St. Mary's Hospital with Cardinal Glennon Children's Hospital |

ILPQC Golden Hour

Aims:

- Delivery room team communication: Increase use of prebriefing, debriefing, and delivery room checklist prior to delivery to 80% or greater.
- Delivery room clinical practice: Increase use of delivery room continuous positive airway pressure (CPAP) trial to 70% or greater, timely administration of surfactant to 80% or greater, and utilization of delayed cord clamping to 80% or greater.
- Family engagement: Increase pre-delivery family contact, family presence during resuscitation, and family presence during neonatal intensive care unit (NICU) admission to 90% or greater.
- Neonatal intensive care unit (NICU) admission: Increase administration of intravenous glucose and antibiotics to within one hour of birth to 80% or greater and increase number of infants with a normothermic admission temperature between 36.5 - 37.5 degrees Celsius.

Approach: 3 key goals

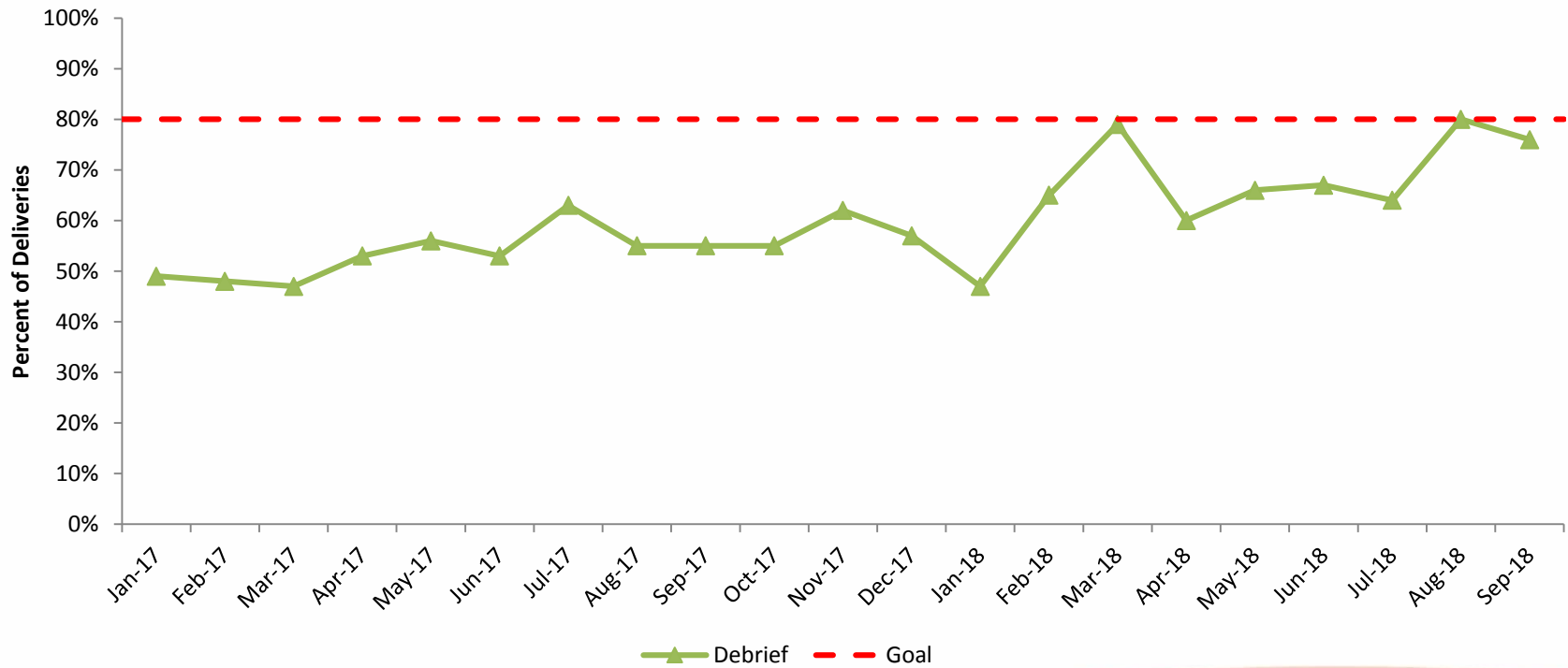
1. Increase delivery room team debriefs
2. Increase number of infants receiving delayed cord clamping in ≥ 30 seconds
3. Increase number of infants with temperatures between 36.5-37.5 on admission to NICU or SCN



- 23 hospital teams – April 2015 kick off to December 2017
- 23 Hospitals submitted data for over 8,000 infants
- Sustainability started January 2018
- 13 teams have submitted sustainability data
- 6 teams have submitted sustainability data for 5 months or more

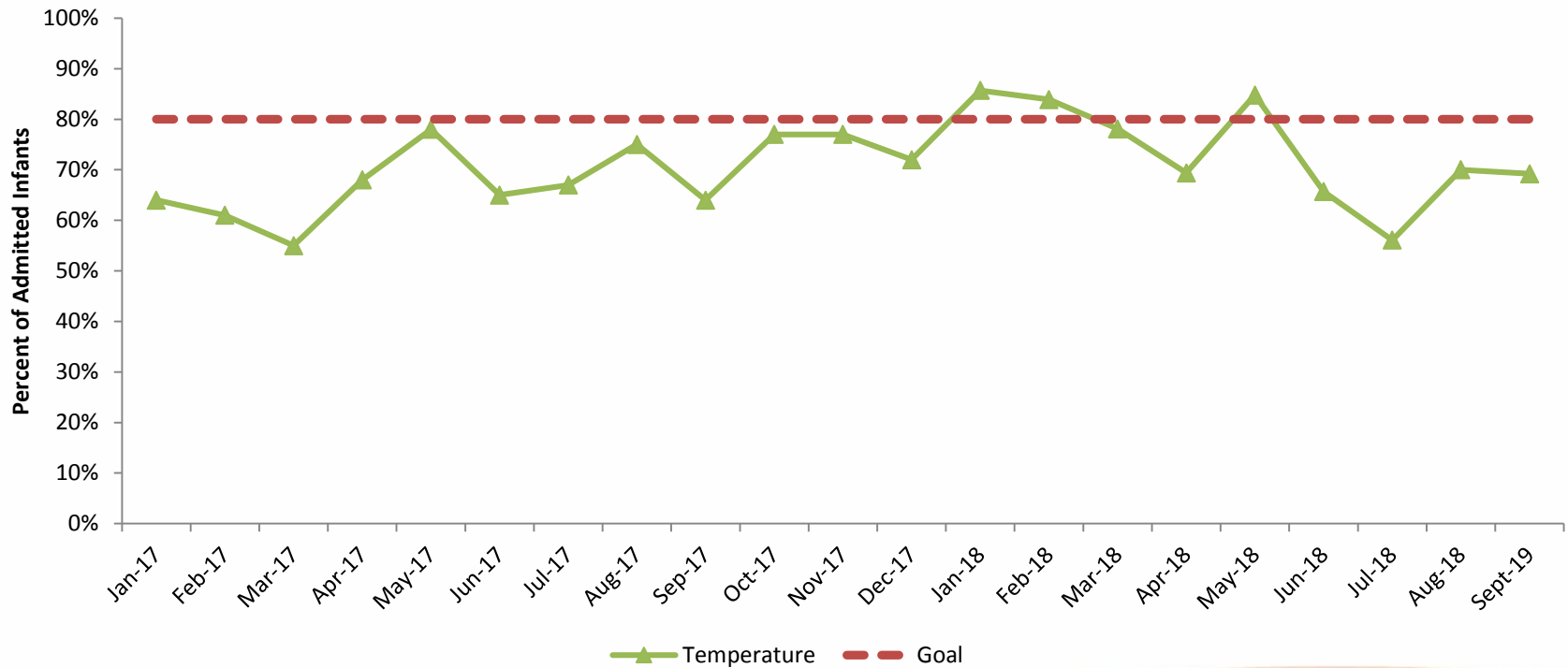
Golden Hour Sustainability Data: Team Debrief

ILPQC: Golden Hour Sustainability Communication Practices: Debrief All Hospitals, 2015-2018



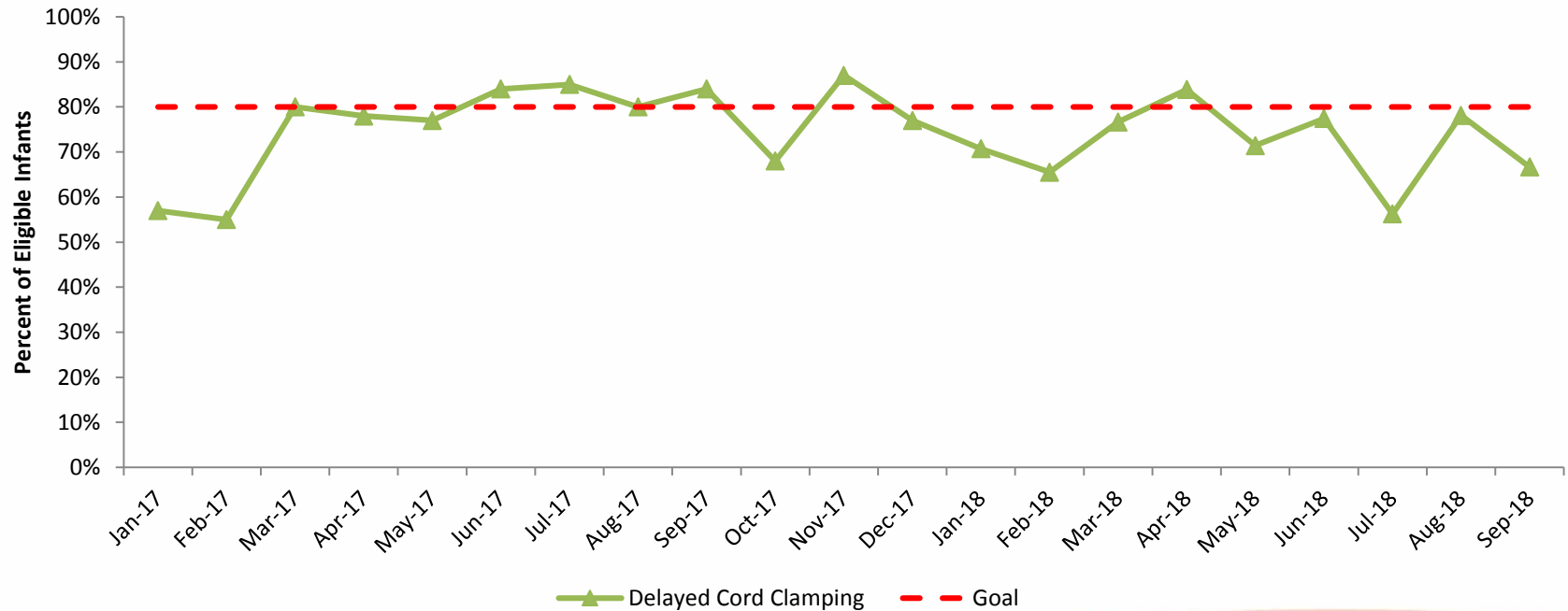
Golden Hour Sustainability Data: Temperature on Admission to NICU/SCN

ILPQC: Golden Hour Sustainability
**Admission Practices: Percent of Admitted Infants who are Between
36.5-37.5°C on Admission (<32 weeks) All Hospitals, 2015 - 2018**



Golden Hour Sustainability Data: Delayed Cord Clamping for 30+ Seconds

ILPQC: Golden Hour Sustainability
Delivery Room Practices: Percent of Eligible Infants with Delayed
Cord Clamping ≥ 30 Seconds
All Hospitals, 2015-2018



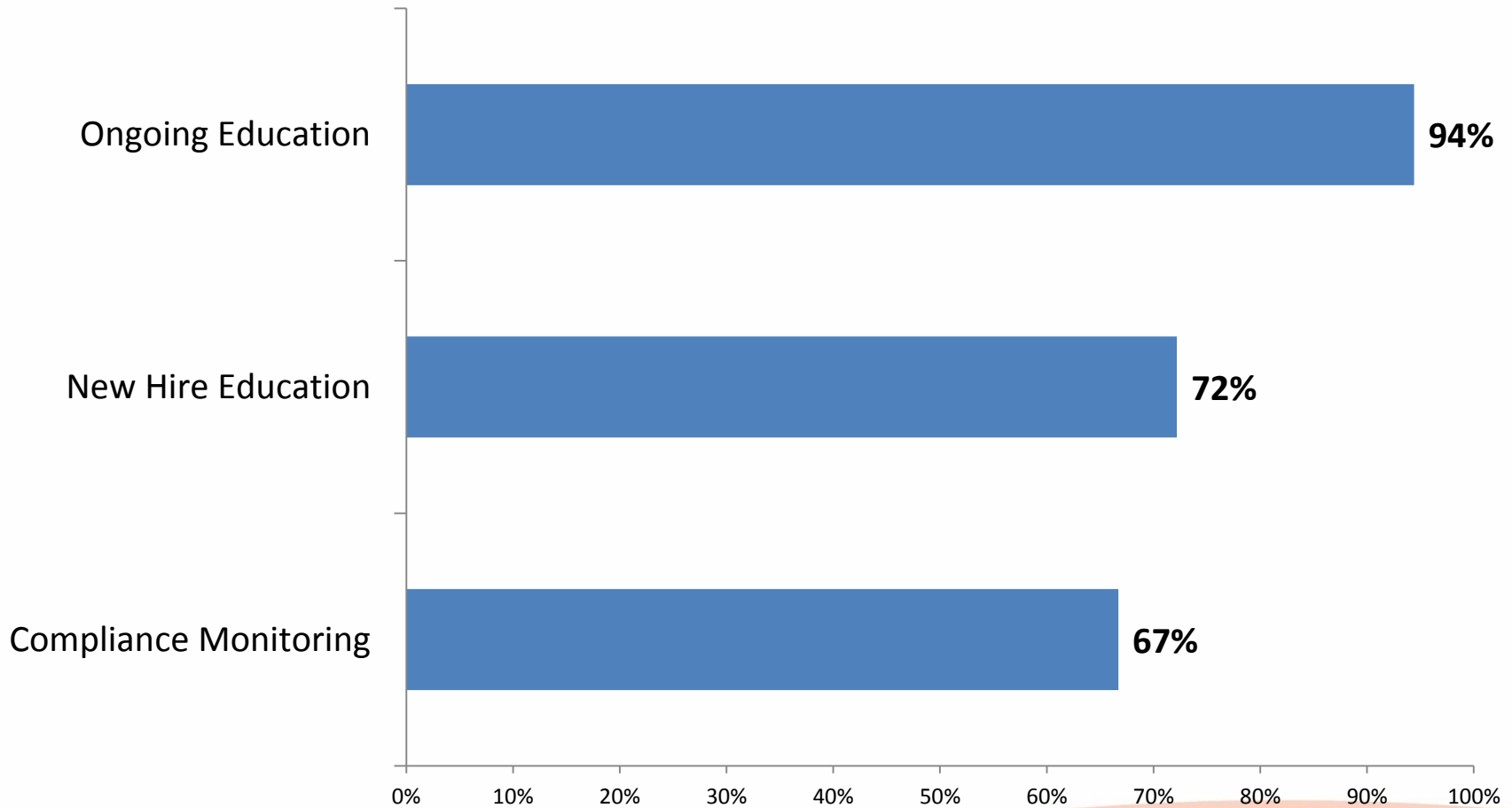
Next Steps for Golden Hour



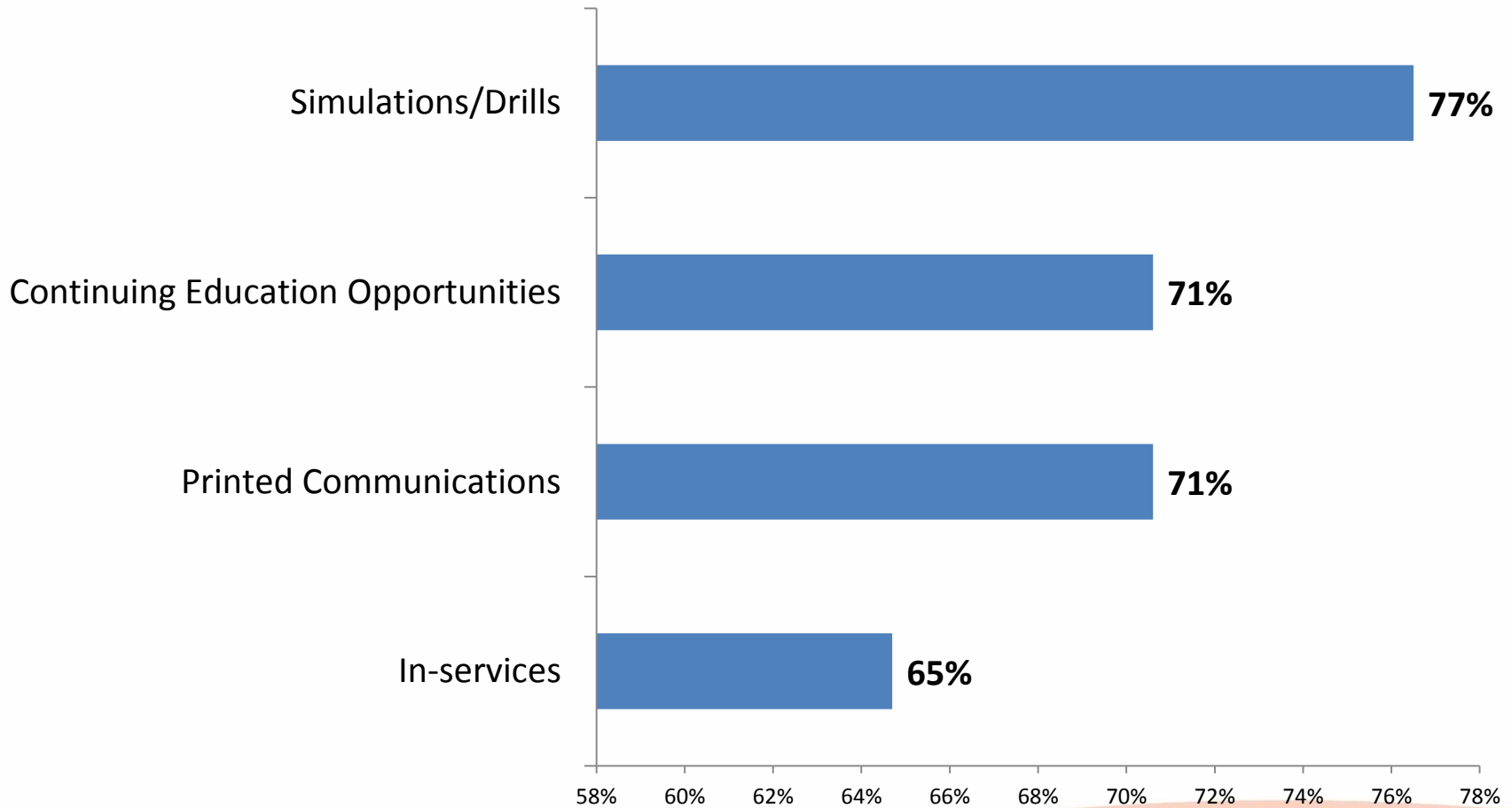
Golden Hour Teams identified the following supports they would like to have in 2019:

- Continued use of data system for compliance monitoring
- QI help desk available at ILPQC
- Team call check-ins

Sustainability



Educational Strategies



Recognition of YOUR hard work!

Vermont-Oxford
2018 Annual Quality Conference

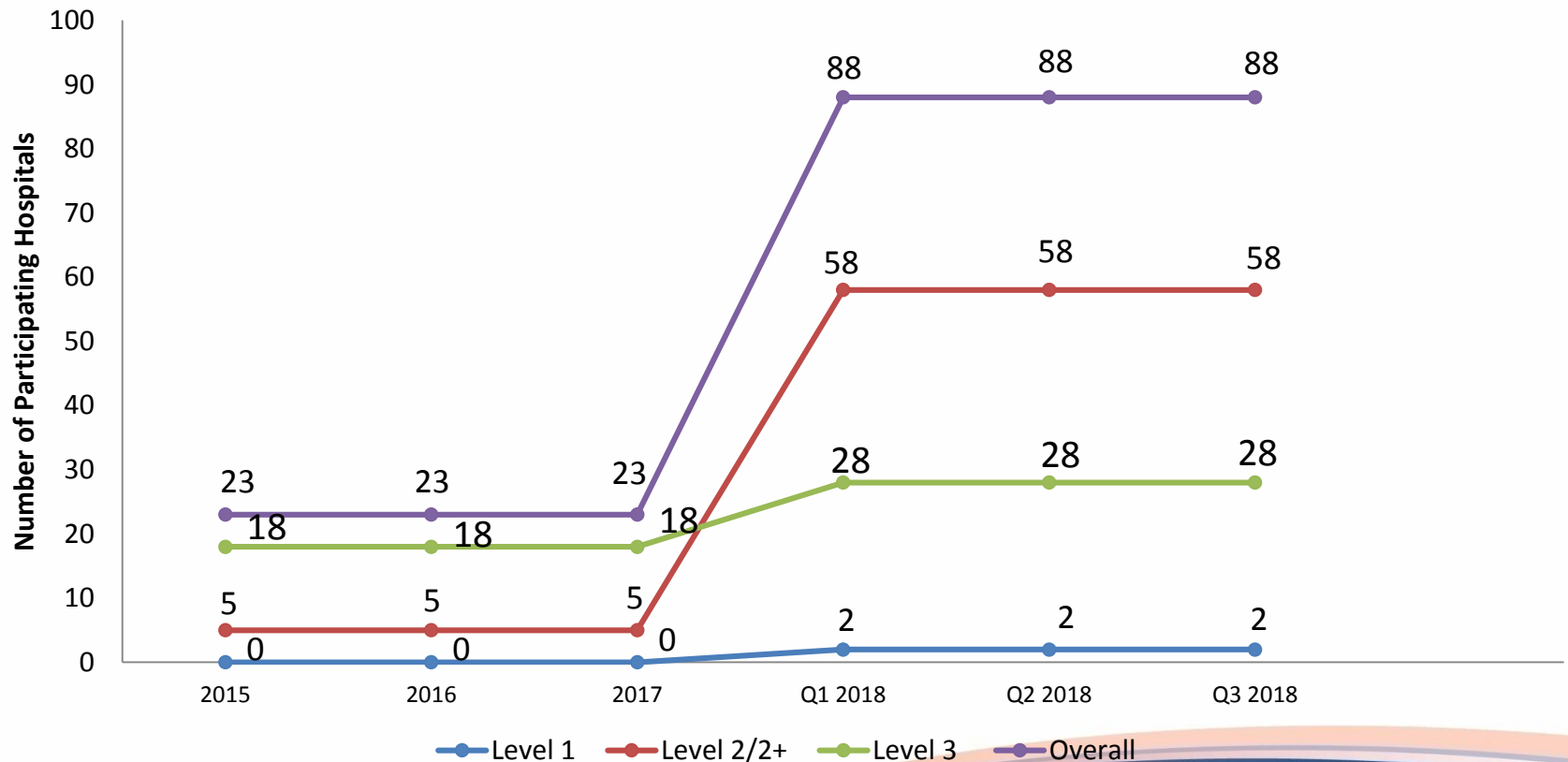
Growing Statewide Capacity



- Participation of Level 1, 2, and 2E hospitals increased from 5% to 66%
- Participation of neonatal hospital teams increased from 23 to 88 reaching 73% of Illinois birthing hospitals
- Recruitment of the new hospitals led to an increase in the percent of:
 - Rural hospitals - 15% to 19%
 - Low to low-moderate birth volumes - 14% to 19%
 - Hospitals with a high proportion of patients on Medicaid - 32% to 42%

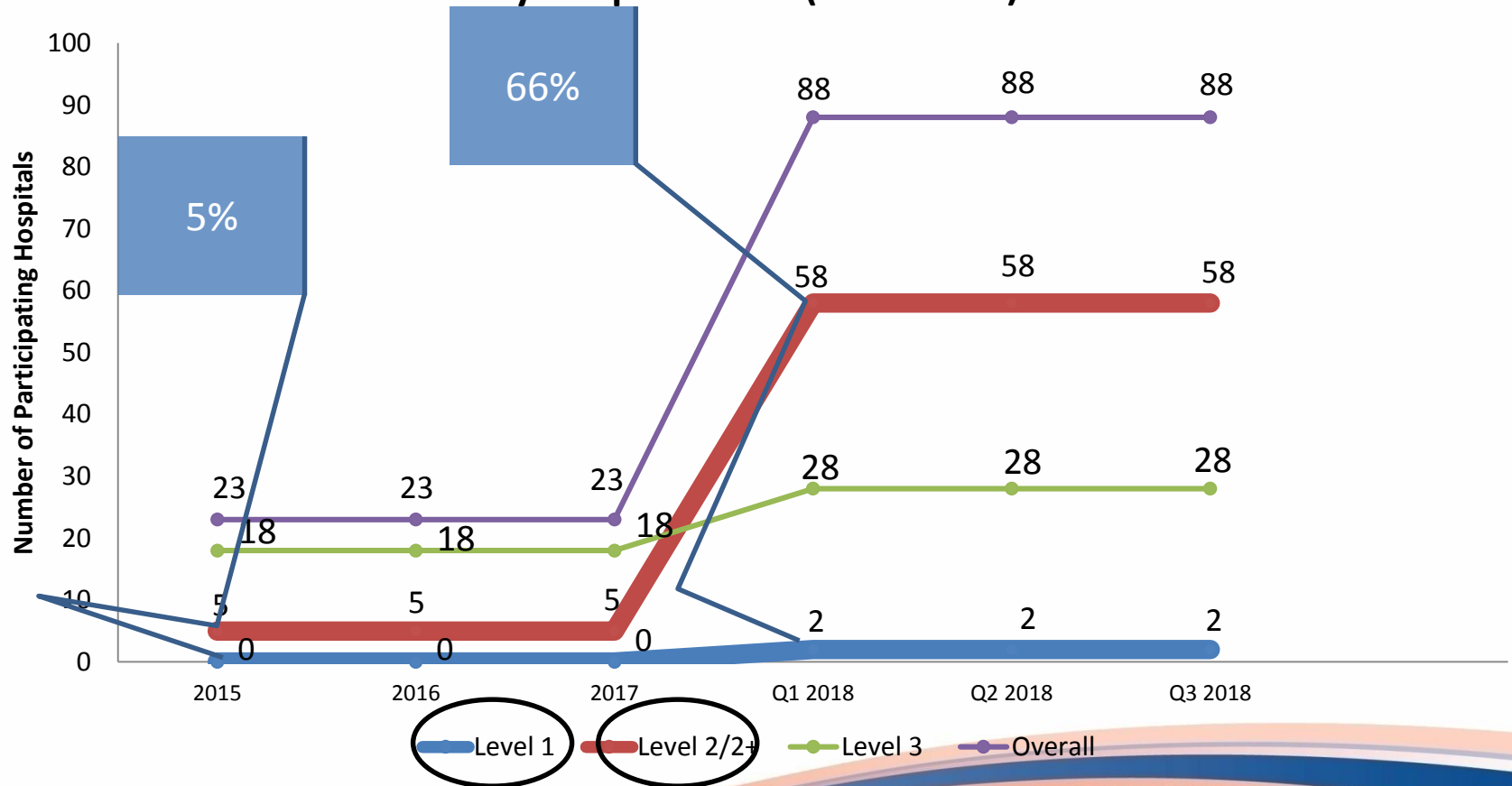
Growing Neonatal Quality Improvement Capacity Statewide

Number of Neonatal Hospital Teams Participating in ILPQC Quality Improvement Initiatives By Hospital Level (2015-2018)



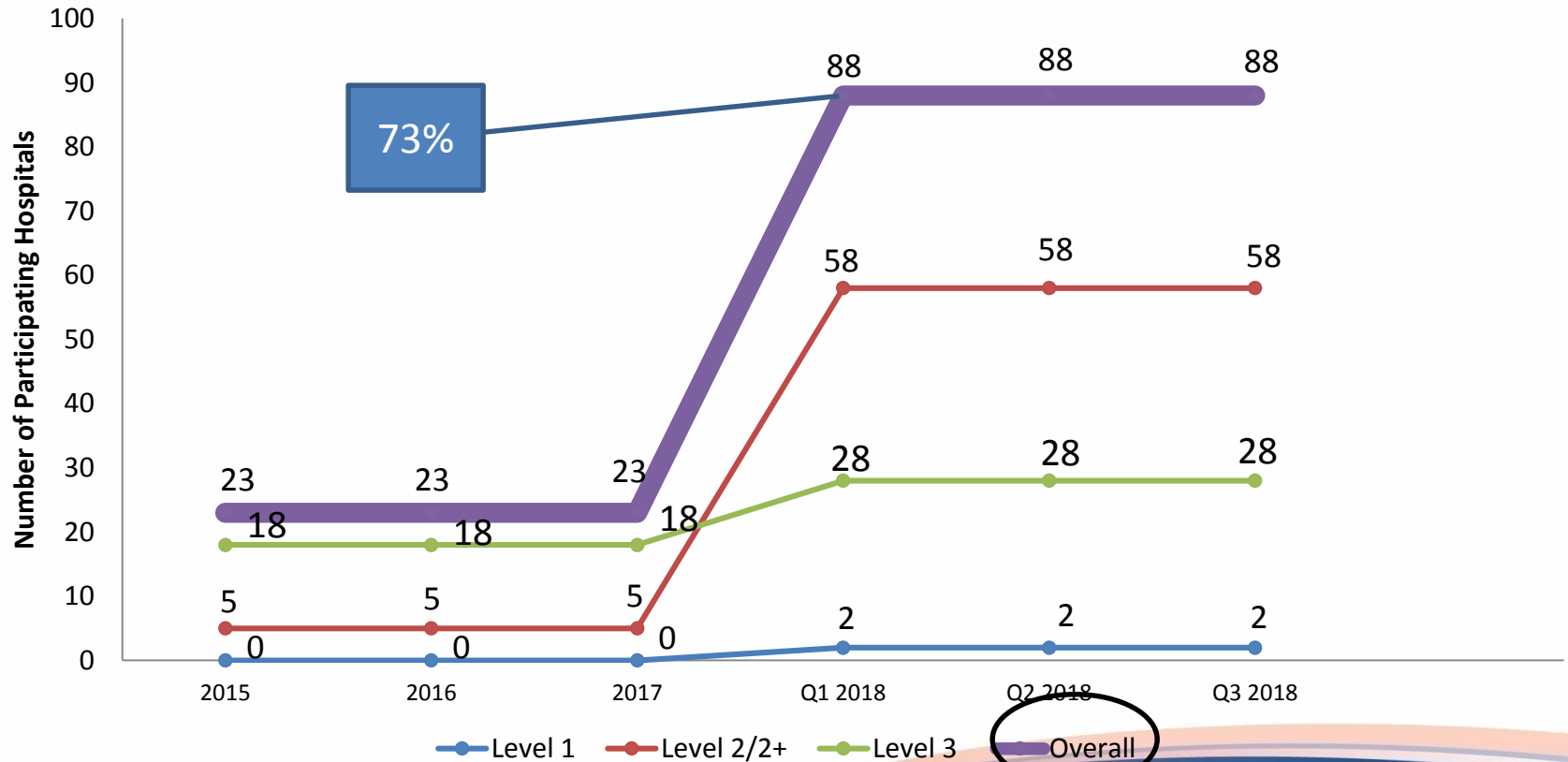
Growing Neonatal Quality Improvement Capacity Statewide

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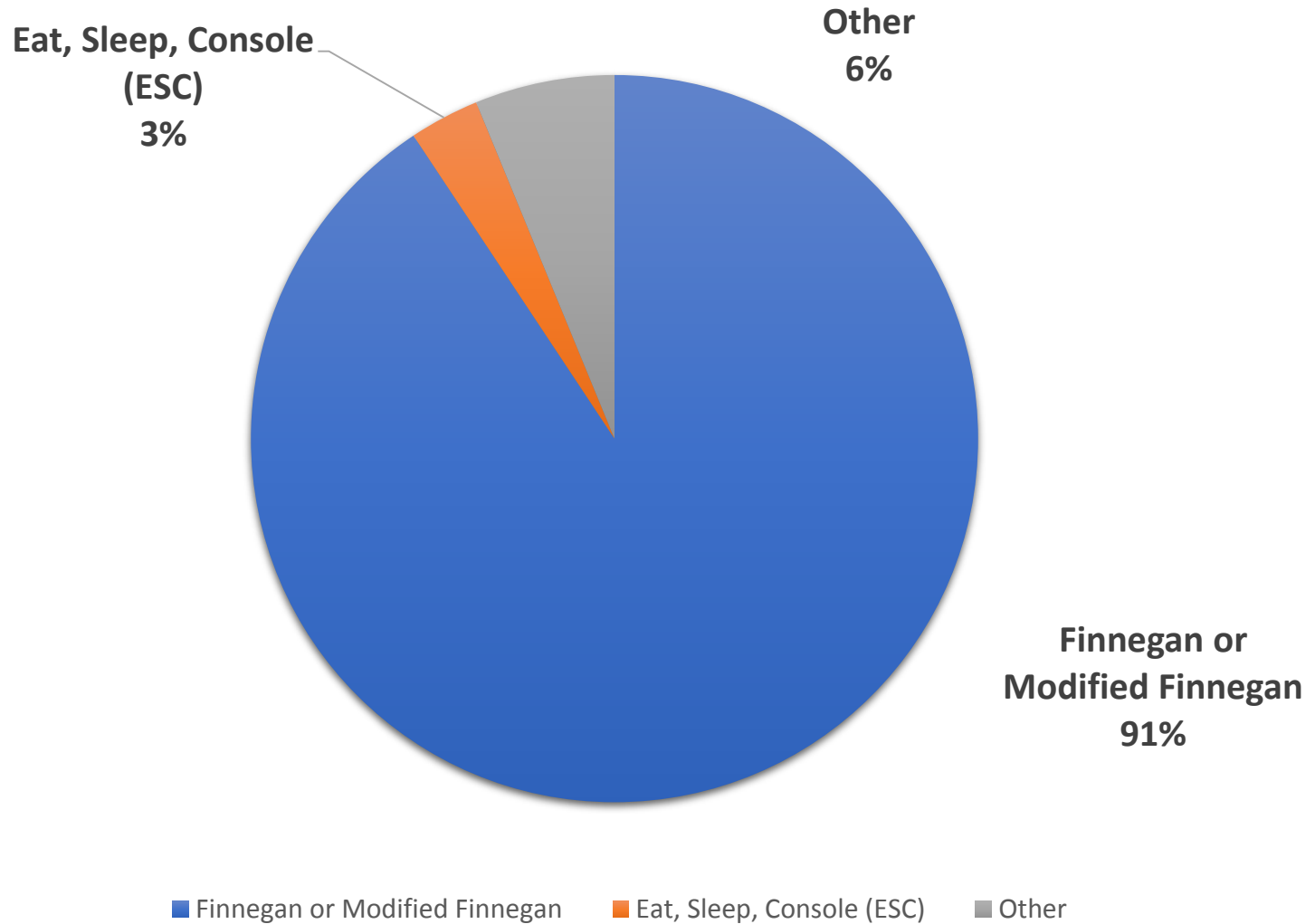
Growing Neonatal Quality Improvement Capacity Statewide

Number of Neonatal Hospital Teams Participating in ILPQC Quality Improvement Initiatives By Hospital Level (2015-2018)

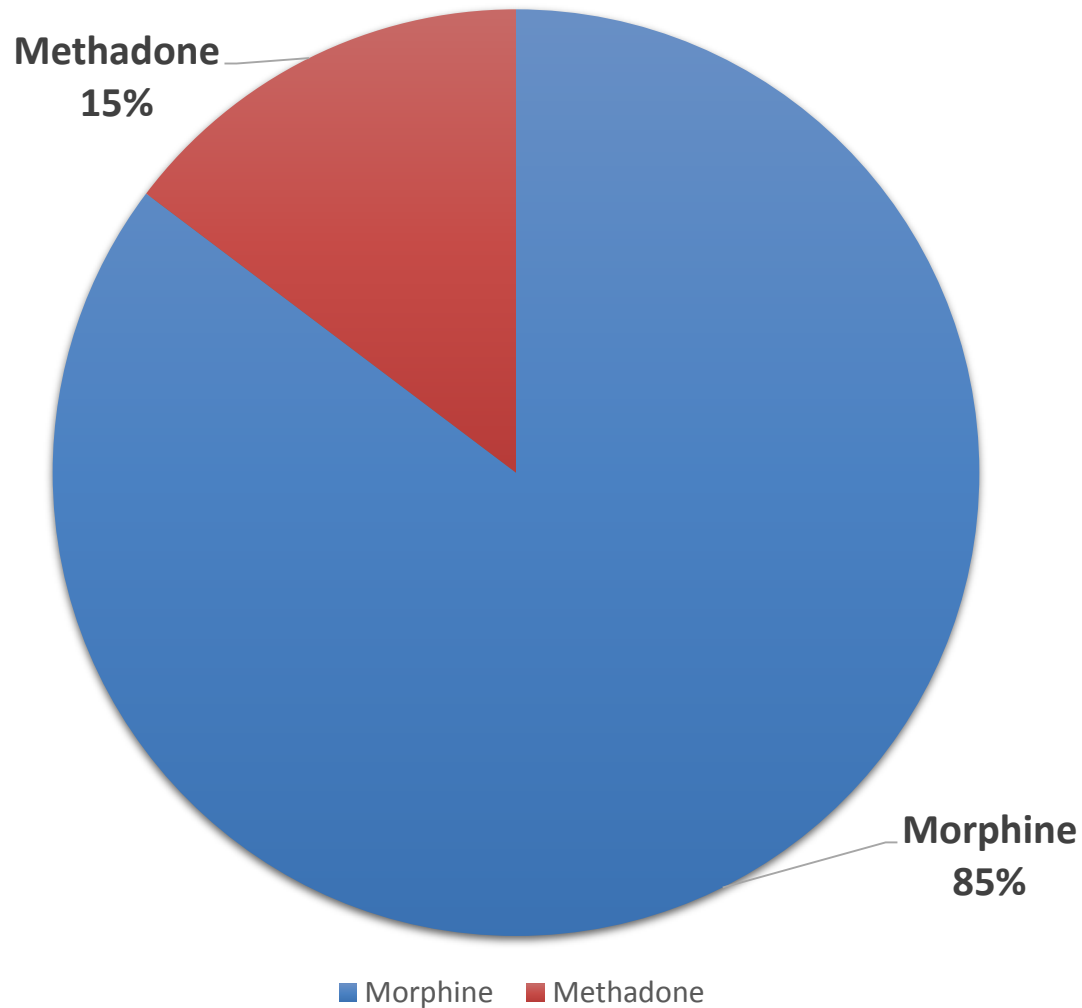


Neonatal Abstinence Syndrome: Variations in Care in Illinois Hospitals

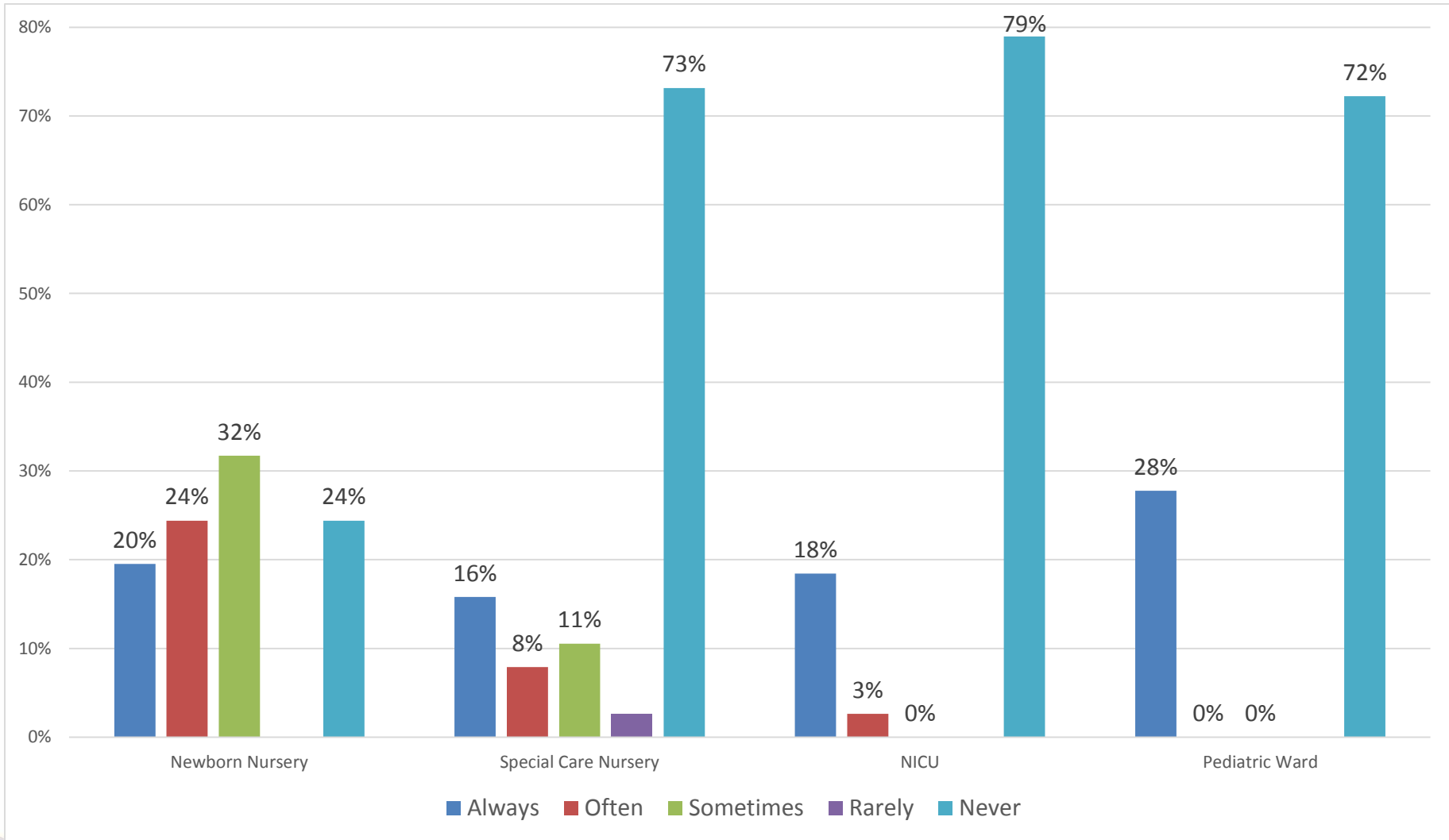
NAS Assessment Tools



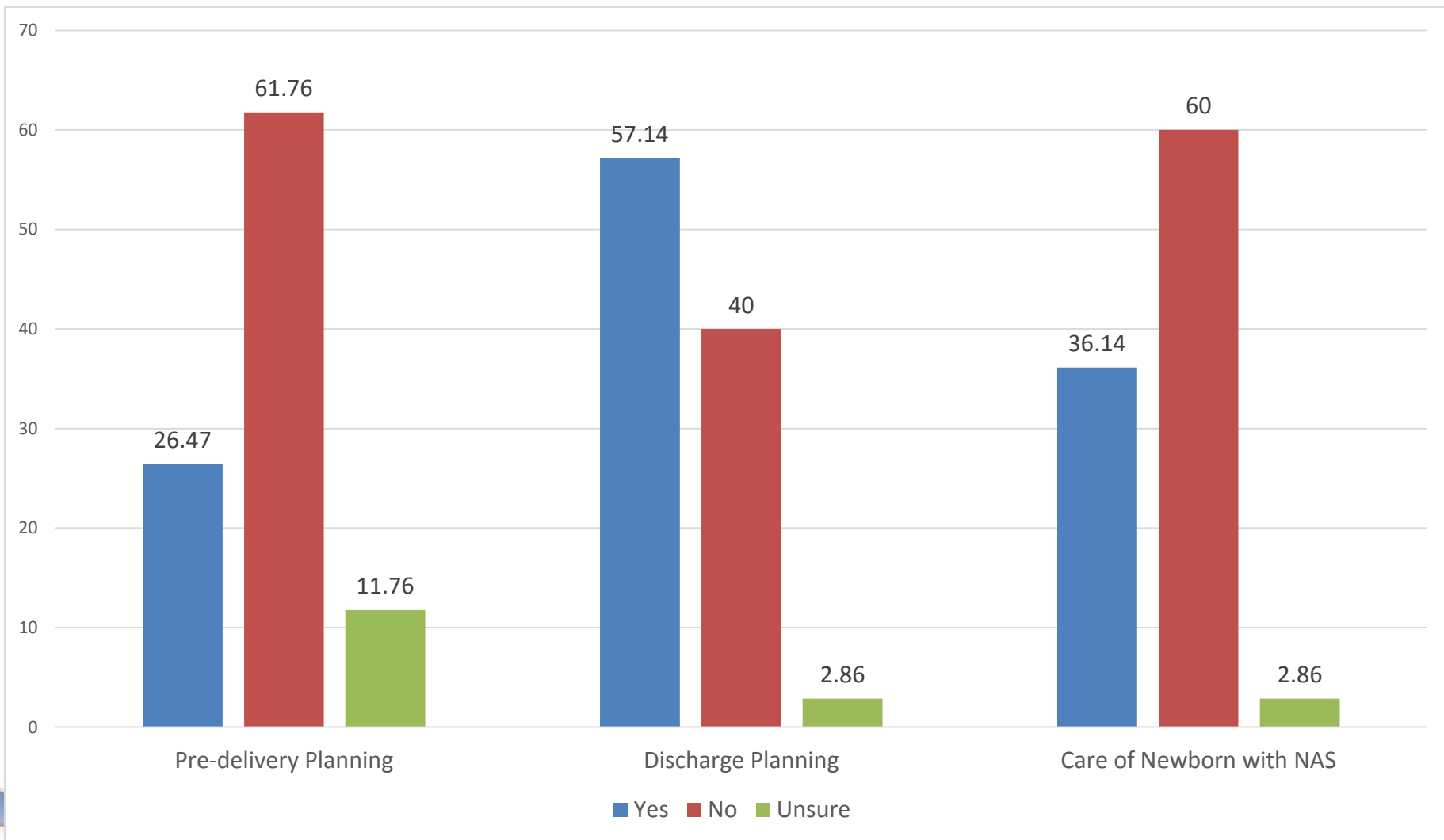
NAS Pharmacologic Treatment



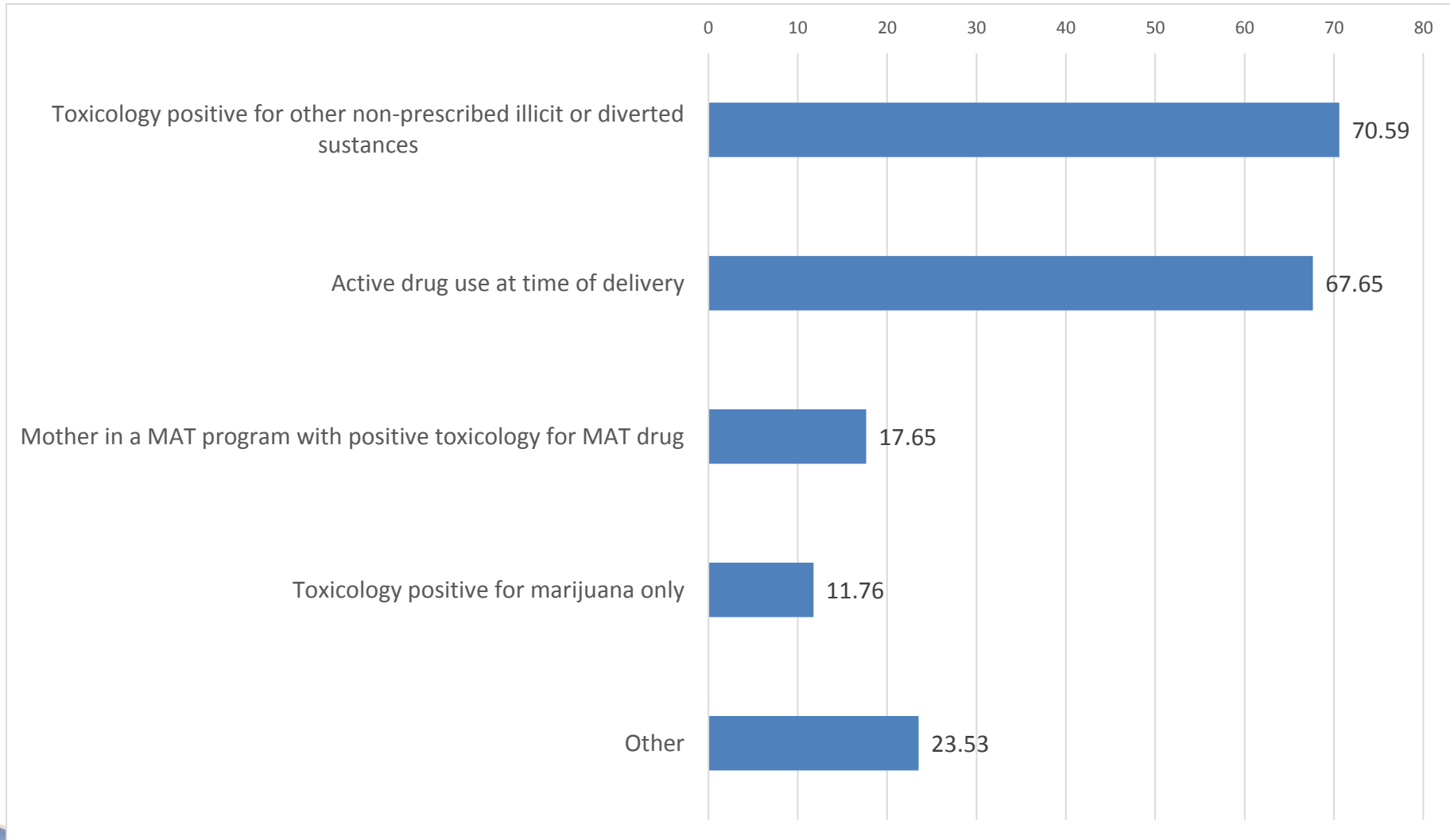
Rooming-In After Maternal Discharge



Engaging Mother & Family in Care of Opioid-Exposed Newborns

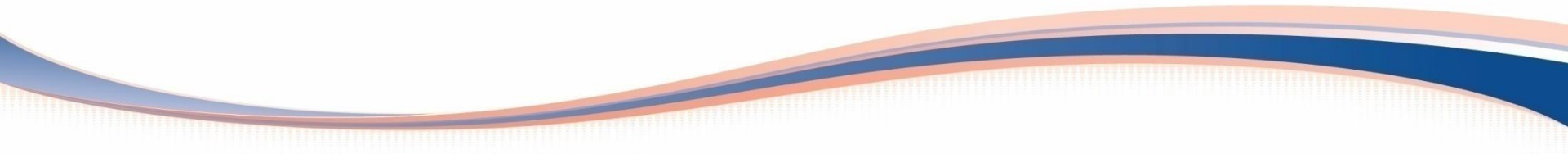


Breastfeeding





2018 ILPQC Annual Conference Survey



MNO Barriers

- Facilitating buy-in and
- Providing stigma and bias education
- Accessing resource to facilitate rooming-in
- Changing culture with a limited patient population

MNO Successes



- Engaging interdisciplinary providers
- Implementing non-pharmacologic interventions
- Facilitating monthly communication between Neo/OB teams
- Learning from collaborative webinars

MNO 2019 Topics



MNO Team Calls

Informative
speakers
hear one
experiences
Team
time
information
due
talks
Others
Hospital
speakers
Hearings
topic
hospitals
helpful

MNO Team Call Improvements



- Including focused topics to ensure time for discussion
- Offering more frequent, optional, calls to address specific topics

Toolkit Improvements

- Non-pharmacologic care policies, protocols, strategies
- ESC Training videos
- Additional stigma & bias education
- Additional copies of patient education handouts
- Sample Newborn Care Diary for parents
- Strategies to collaborate with OB team
- Bilingual materials

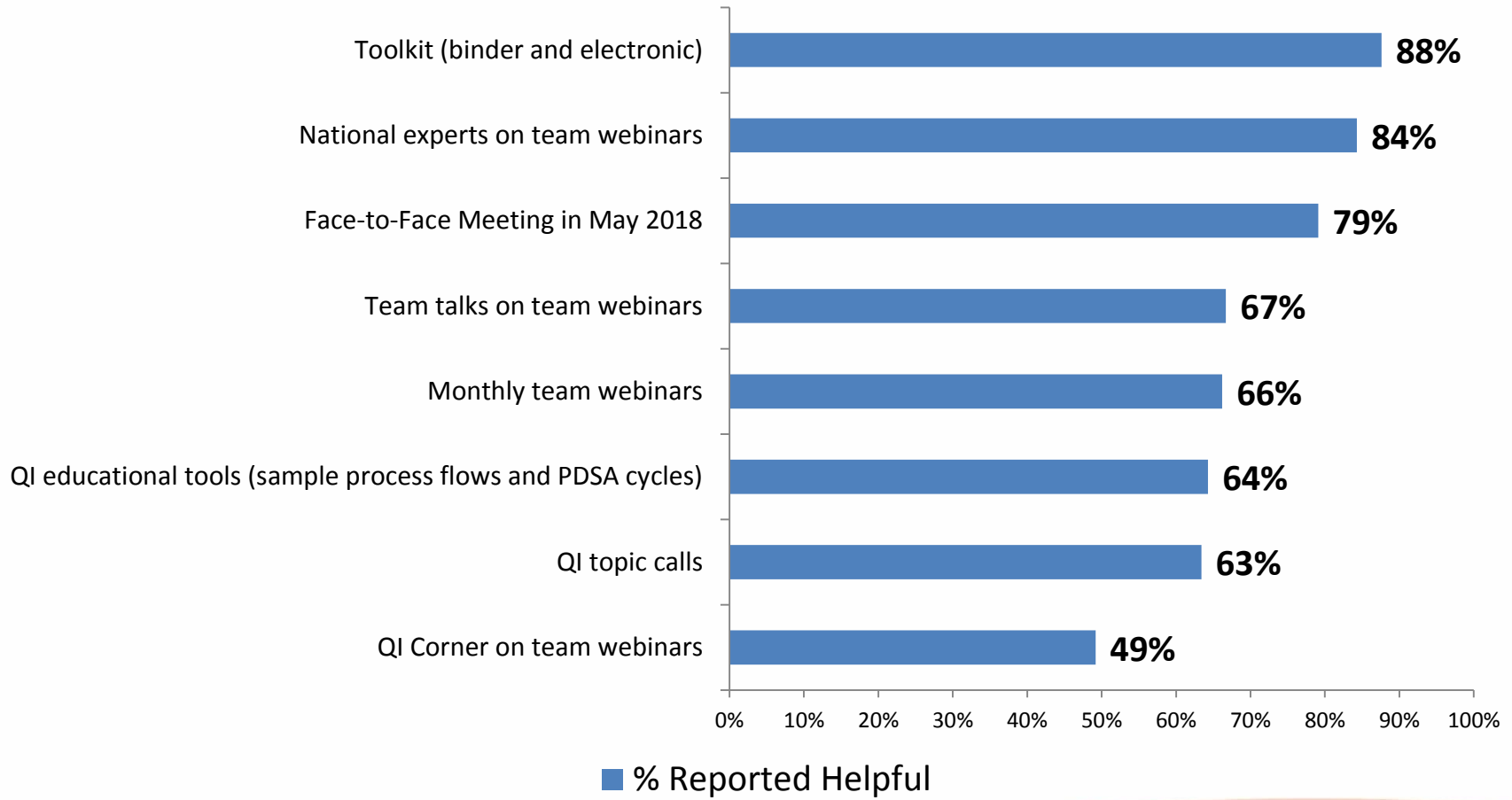
Team Support

- MNO-Neonatal Grand Rounds- education for providers & nurses
- QI Support Calls/Site Visits to assist with MNO-Neo implementation
- Data collection/submission clarifications
- ESC Training
- Stigma & Bias training
- Support for engaging the broader MNO-Neo QI team at a hospital

Patient/Family Advisors

- 97% of MNO-Neonatal teams do not have a patient/family advisor on their QI Team
- MNO is an excellent opportunity to engage patients and families in your QI Team
- Contact ILPQC for resources or to share with us what resources would be helpful to support your efforts.

Helpful ILPQC Resources



MNO-Neonatal QI Support



- If your team is interested in receiving individualized MNO-Neonatal QI support for any piece of the initiative please reach out to us! We would be happy to set up a time to provide information and strategies.
- Dweiss@northshore.org or info@ilpqc.org

Possible future initiative for 2020?

| | Future Initiative | % of support from Neo Teams Survey |
|-----------|-----------------------------------------------------------------------------------|-------------------------------------------|
| 1. | Care of late preterm infant | 69.9% |
| 2. | Antibiotic stewardship | 54.8% |
| 3. | Safe Sleep Initiative | 42.5% |
| 4. | Family-integrated transitions in care | 38.4% |
| 5. | Supporting optimal breastfeeding/breastmilk in NICU | 31.5% |
| 6. | Improvement of neuro-developmental follow-up after discharge of high-risk infants | 19.2% |
| 7. | Preventing chronic lung disease | 15.1% |

Wrapping up

Neonatal MOC Part IV Opportunities



Neonatal Teams- Approved by ABP for 25 Part IV MOC Credits **DUE NOV 15th, 2018**

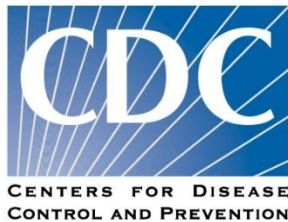
- Pediatricians must have an active role-attest to all of the following to get the credits
 - Be intellectually engaged in planning and executing the project
 - Participate in implementing the project's interventions
 - Review data in keeping with the project's measurement plan
 - Collaborate actively by attending team meetings, whether in person or virtually
- MNO-Neo AND/OR Golden Hour Sustainability will **BOTH** qualify!
- **EMAIL** INFO@ILPQC.ORG with any questions!

Next

- Get your raffle tickets ready!
- Move to main ballroom



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