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| ILPQC MNO  **Neonatal** Data Collection Form  *Data will be submitted monthly for all infants discharged that month who meet the following definition. Data should be submitted by the 15th of the month for the previous month.* | |
| ***Neo 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.* | |
| Option to Report No Cases for a Month | |
| What MNO data are you submitting? | * I’m entering Neonatal Data * I have no mothers/newborns affected by opioids to report this month |
| If **NO** infants affected by opioids to report this month (MM/YYYY) | \_\_\_\_\_/\_\_\_\_\_\_ |
| REDCAP Identifiers | |
| REDCap Record ID | REDCap Record ID: \_\_\_\_\_\_\_\_\_ |
| Hospital ID Number | Hospital ID Number: \_\_\_\_\_\_\_\_ |
| 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. 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. Was maternal urine toxicology drug screen positive prenatally, prior to delivery admission?   *Please select all that apply*  *\*ON BOTH OB & Neo Monthly Data Form* | * Yes * No * Don’t Know * Never Done   IF YES, what detected drug classes:   * Amphetamines * Barbiturates * Benzodiazepines * Buprenorphine * Cannabinoids (marijuana or metabolite) * Cocaine or metabolite * Opiates * Methadone * Methamphetamine * Phencyclidine (PCP)   + Other (Specify: \_\_\_\_\_)   IF YES to Opiates AND/OR Buprenorphine AND/OR Methadone, was it prescribed:   * YES * No |
| 1. Was maternal urine toxicology drug screen positive during delivery admission, prior to maternal discharge?   *Please select all that apply*  *\*ON BOTH OB & Neo Monthly Data Form* | * Yes * No * Don’t Know * Never Done   IF YES, what detected drug classes:   * Amphetamines * Barbiturates * Benzodiazepines * Buprenorphine * Cannabinoids (marijuana or metabolite) * Cocaine or metabolite * Opiates * Methadone * Methamphetamine * Phencyclidine (PCP)   + Other (Specify: \_\_\_\_\_)   IF YES to Opiates AND/OR Buprenorphine AND/OR Methadone, was it prescribed:   * YES * No |
| 1. Outcome Measure: Is the mother on Medication-Assisted Treatment (MAT) at delivery?   ***Medication-Assisted Treatment (MAT) Definition:***  *Mother on prescribed Methadone, Buprenorphine/Subutex/Suboxone, or Other (e.g. Vivatrol, Naltrexone)*  *\*ON BOTH OB & Neo Monthly Data Form* | * Yes * No * 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. What were the maternal-fetal opiate exposures?  * *Check all that apply* * *Information can come from maternal self-report (maternal record), maternal tox screening, or neonatal tox screening* * *Do not include if exposure was clearly only in the first trimester* * *Buprenorphine includes Subutex and Suboxone* * *Other opioids include all agents that are not methadone, buprenorphine, or heroin; this includes fentanyl, codeine, oxycodone, hydrocodone, morphine, and hydromorphine (short and long-acting).* | * Methadone, prescribed * Methadone, illicit * Methadone, unknown source * Buprenorphine, prescribed * Buprenorphine, illicit * Buprenorphine, unknown source * Heroin * Other Opioids, prescribed * Other Opioids, illicit * No opioid exposure able to be determined |
| 1. What were other maternal-fetal exposures of note?  * *Check all that apply* * *Do not include if exposure was clearly only in the first trimester* * *Exposures could be from prescribed use or illicit use* | * Cocaine * Marijuana * Alcohol * SSRI * Benzodiazepine * Nicotine-only products (e-cigarettes, patch, gum) * Amphetamines/Methamphetamines * Tobacco Products (cigarettes, cigar, chewing tobacco) * Other (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| 1. Process Measure: Was infant urine, meconium, cord and/or other tissue drug screen used?   *Please* *select one* | * Yes * No * Unknown |
| 1. If YES, what was the result? | * Positive * Negative |
| 1. If POSITIVE, detected drug classes (check all that apply). If more than one test obtained (i.e. meconium and urine), select all that apply from both tests.   *Other opioids include all agents that are not methadone, buprenorphine, or heroin; this includes fentanyl, codeine, oxycodone, hydrocodone, morphine, and hydromorphine (short and long-acting).* | * Amphetamines * Barbiturates * Benzodiazepines * Buprenorphine * Cannabinoids (marijuana or metabolite) * Cocaine or metabolite * Opiates * Methadone * Methamphetamine * Phencyclidine (PCP)   + Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| 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. Process: ILPQC Infant Bedside Sheet   *Enter total Yes answers from Bedside Sheet*  *Enter total number of nursing shifts from Bedside Sheet* | Total number of Yes: \_\_\_\_\_\_\_\_  Total nursing shifts: \_\_\_\_\_\_\_\_ |
| 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. Was the non-pharmacologic bundle bedside checklist used every day for the infant? | * Yes * No |
| 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. |
| Was the first pharmacologic agent ordered in accordance with your hospital's NAS treatment guidelines? | * Yes * No * Unknown |
| 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. Was a second pharmacologic agent used for treatment of NAS? | * Yes * No * Unknown |
| 1. What was the second pharmacologic agent used for treatment of NAS?   *Please select one* | * Morphine * Methadone * Clonidine * Phenobarbital * Other (Specify: \_\_\_\_\_\_\_\_\_\_) * Unable to determine |
| 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 abuse 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. At the time of discharge to home, was the infant receiving medications for NAS? | * Yes * No * Unable to determine |
| 1. If yes, what medications was infant receiving at time of discharge to home?   *Please select all that apply* | * Morphine * Methadone * Clonidine * Phenobarbital * Other (Specify: \_\_\_\_\_\_\_) |
| 1. Was an official referral made by your hospital to Early Intervention (IL Child and Family Connections)? | * Yes * No * Unknown |
| 1. Was a Safe Discharge Plan made in partnership with the family, the hospital, and the community PCP? (ALL 4 elements must be satisfied in order to answer yes.)   *Safe discharge plan definition (all 4 must be yes):*  *MD to MD communication*  *Discharge safety bundle reviewed*  *DFS clearance/coordination*  *Official referral to Early Intervention (IL Child and Family Connections)* | * 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 |