MNO-Neonatal Teams Call: Addressing Stigma & Bias Education for Providers, Nurses, and Staff

August 20, 2018
1:00 – 2:00pm
Introductions

- Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  - Name
  - Role
  - Institution
- If you are only on the phone line, please be sure to let us know so we can note your attendance
Tips for Adding WebEx to your Calendar

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Conference Line Logistics

- Use the **MUTE** button on your phone or
- You can use *6 to place the call on **MUTE** and *6 to come off of **MUTE**
- Please do not place the call on hold!

Thank you!
Overview

• MNO-Neonatal Updates
• MNO-Neo Resources for Stigma & Bias Education
• NAS in the NICU
  • Lisa Jasin, DNP, NNP-BC; Dayton Children’s Hospital
• MNO-Neo Teams QI Corner
• Team Talks: Getting Started with MNO-Neo
  • Tonya Mangiaguerra, MSN, ACCNS-N, APN, RNC-NIC; NICU APN, Clinical Educator Edward Hospital
• Next Steps & Call Schedule
Calling all physicians, nurse midwives, APNs, NPs, RNs, quality leaders, administrators, payers, public health professionals, and all others interested in perinatal health!

You’re invited!

November 5, 2018
Check-in: 7-8am
Program: 8am-5:15pm

IL PQC
Westin Lombard
Yorktown Center,
Lombard, IL

6th Annual Conference

Join us to learn from state and national Perinatal Quality Collaborative leaders, leverage quality improvement success, and work together to improve outcomes for mothers and newborns.

Learn strategies for improving care for Mothers & Newborns affected by Opioids, increasing access to Immediate Postpartum LARC and sustaining gains in Severe Maternal Hypertension and Golden Hour.

Visit ilpqc.org for more information
Call for Volunteers!

• Annual Conference Planning Committee Volunteers Needed!

• Participation in planning committee includes:
  – Attend bi-weekly conference planning calls and provide input- Wednesdays 2-3pm
  – Review abstracts
  – Day of volunteer activities

• Interested in volunteering? Please email info@ilpqc.org
MNO-Neo Online Toolkit is Live!

http://ilpqc.org/node/115

MNO-Neo Neonatal Toolkit

1. MNO-Neo Neonatal Key Documents
   a. 11 Steps to Getting Started with the ILPQC Mothers and Newborns affected by Opioids (MNO) – Neonatal Initiative
   b. Mothers and Newborns affected by Opioids Aims and Measures
   c. MNO 6 Key Opportunities for Improvement
   d. Mothers and Newborns affected by Opioids Neonatal Data Form
   e. Mothers and Newborns affected by Opioids OB Data Form
   f. Mothers and Newborns affected by Opioids Neonatal Structure Measures Data Form
   g. Mothers and Newborns affected by Opioids Key Driver Diagram for Neonates
   h. Mothers and Newborns affected by Opioids Neo Readiness Survey
   i. Plan-Do-Study-Act Worksheet

2. Strengthen Family/Care Team Relationships

3. Improve Pre-Delivery Planning

4. Standardize Identification, Monitoring, and Assessment of SENs

5. Provide Family Education

6. Improve Infant Nutrition and Breastfeeding

7. Optimize Non-Pharmacologic Care

8. Standardize Pharmacologic Treatment

9. Coordinate and Communicate Safe Discharge

*Key Resource

The following material is an example only and not meant to be prescriptive. The resources provided in this toolkit are for informational purposes only. The exclusion of a resource, program or website does not reflect the quality of that resource, program or website. Note: websites and URLs are subject to change without advance notice.
MNO NEO-TEAMS UPDATES
MNO Neonatal REDCap Data Forms & Due Dates

MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form
- **Baseline**: October – December 2017 (DUE!)
- Recurrence: Monthly
- July 2018 Data Due: August 31\textsuperscript{st}
- Future Months Data Due: by 15\textsuperscript{th} of next month (i.e. September data due by Oct. 15\textsuperscript{th})

MNO Neo *Monthly* Structure Measures Data Form
- **Baseline**: October – December 2017 (DUE!)
- Recurrence: **NEW MONTHLY** (vs. quarterly)- tool for teams to track initiative progress (available online)
- July 2018 Data Due: August 31\textsuperscript{st}
- Future Months Data Due: by 15\textsuperscript{th} of next month (i.e. September data due by Oct. 15\textsuperscript{th})
MNO-Neonatal Data Collection

Monthly MNO-Neo Patient-Level Data Form (OENs):
• 56 teams have entered any baseline or July 2018 data so far (358 total records)

Monthly* MNO-Neo Structure Measures Data Form:
• 54 MNO-Neo teams have entered any baseline or June 2018 data so far (56 total records)

Don’t forget to submit your baseline and July 2018 Data!

Thank you to the 50+ teams who have entered data so far!
MNO Neonatal YOUR QI Data and the ILPQC Data System

• Entering your data into REDCap allows you to track your quality improvement data in the ILPQC Data System - a powerful tool to monitor your progress towards initiative goals on process, outcome, and structure measures on a monthly basis!

• The QI data you collect is a tool for your MNO-Neo QI team to drive quality improvement at your hospital!
MNO-Neonatal REDCap Reports

- Rapid-access to graphical representations of key process/outcome measures from the MNO-OB/Neo Monthly Mothers with OUD/OENs data form
- Allows teams to track their monthly progress, and compare to the collaborative overall!
# MNO-Neonatal REDCap Reports Development Timeline

<table>
<thead>
<tr>
<th>Week</th>
<th>Status of MNO-OB/Neo Patient-Level Monthly Data Reports (Process/Outcome Measures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Week of August</td>
<td>Internal Testing</td>
</tr>
<tr>
<td>3rd Week of August</td>
<td>Final Edits</td>
</tr>
<tr>
<td>4th Week of August</td>
<td>Reports go live</td>
</tr>
</tbody>
</table>
MNO-Neonatal Data:
“What day of life was infant final discharge to home?

- It is very important for MNO-Neo teams to provide a number for day of life infant was discharged
- First day of birth is considered day of life ZERO
- This can be from your hospital or receiving hospital
- If unable to determine, enter 999

Having a final date of discharge links the infant data to REDCap reports. Otherwise reports won’t be accurate
MNO-Neonatal Data Use Agreement (DUA)

• Data Use Agreement template available
  – MNO-Neonatal teams may complete a DUA to allow for sharing de-identified data with AIM for state comparison/national benchmarks.
  – MNO-Neonatal teams may still submit data without DUA and their de-identified data will not be submitted to AIM.

• **ILPQC is a leader in MNO QI Work** and AIM is a national initiative looking process/outcome measures for OENs in addition to mothers with OUD to allow national benchmarking and state comparisons

• Please email **info@ilpqc.org** for a DUA template!
Review the MNO-Neo REDCap Data Training Webinar

- Review the 1-hour data training calls to outline steps to submit data and answer questions from teams:

https://northwestern.webex.com/northwestern/ldr.php?RCID=f9cf18418f9e4d393db8088ffcc78ef8
ADDRESSING STIGMA & BIAS EDUCATION
Healthcare Providers
Stigma and Bias

“Substance Use Disorder is among the most stigmatized conditions in the US and around the world.”

SAMHSA “Words Matter”

Standardizing care through protocols and checklist create a space and provider openness to address stigma and bias.
We need to identify moms with OUD to help protect the babies. The members of the healthcare team are the best people to provide care to NAS babies.

New way of thinking

We need to identify moms with OUD, connect them to treatment, and provide resources to help put them in a position to be able to care for their own babies while coming alongside them.

Changing our thinking requires us to take an honest look at our own biases.
Addressing Stigma and Bias

FIRST STEP

Examine
HEALTHCARE STIGMA AND BIAS

- **Explicit attitudes** - Our conscious outlook and perspectives
- **Implicit attitudes** - Our unconscious perspectives and stereotypes

**RESHAPE method**

- Stigma reduction (primary outcome)
- Reduced negative biases
- Improved clinical knowledge
- Improved competence
- Higher quality of care
- Improved functioning and reduced symptoms

**Feedback pathways**

**Provider clinical competence**

**Quality of care**

**Patient outcomes**

RESHAPE method [citation]
Knowing the basics; Addiction

Opioid Addiction

• Primary **chronic disease** of brain reward, motivation, memory and related circuitry.
  – Dysfunction in these circuits leads to psychological, social and spiritual manifestations.

• Reflected in an individual pathologically pursing reward and/or relief by substance use and other behaviors.

• Like other **chronic diseases**, addiction often involves cycles of relapse and remissions

• Without treatment, addiction is progressive and can result in disability of death.
Physical Opioid Dependence

“Physical dependence is the physiological adaptation of the body to the presence of an opioid. It is defined by the development of withdrawal symptoms when opioid are discontinued, when the dose is reduced abruptly or when an antagonist (eg, naloxone) or an agonist-antagonist (eg, pentazocine) is administered.”

ILPQC Toolkit Resource:
“Understanding NAS as a Chronic Illness”

Adapted from ACOG Dist. II
Implicit and Explicit Attitudes

ILPQC Current Toolkit Resources

- SAMHSA Words Matter
  - How Language Choice Can Reduce Stigma
- OPQC Substance Abuse 101- Myth Busters

"Protest any labels that turn people into things. Words are important. If you want to care for something, you call it a ‘flower;’ if you want to kill something, you call it a ‘weed.’"
Perform a **language audit** of existing material for language that may be stigmatizing, then replace with more inclusive language.
Person-first Language to Reduce Stigma and Improve Treatment

**Words to Avoid**
- Addict
- Alcoholic
- Drug problem, drug habit
- Drug abuse
- Drug abuser
- Clean
- Dirty
- A clean drug screen
- A dirty drug screen
- Former/reformed addict/alcoholic
- Opioid replacement, methadone maintenance

**Words to Use**
- Person with substance use disorder
- Person with alcohol use disorder
- Substance use disorder
- Drug misuse, harmful use
- Person with substance use disorder
- Abstinent, not actively using
- Actively using
- Testing negative for substance use
- Testing positive for substance use
- Person in recovery, person in long-term recovery
- Medication assisted treatment

Implicit and Explicit Attitudes

We’ll help you get there!

AIM eModules in development

Possible ILPQC Custom Education if needed

MORE TO COME...

VON’s “Nurture the Mother, Nurture the Child”
NAS in the NICU
Lisa R Jasin DNP, NNP-BC
Phases

• Research: Jan 2012 – Sep 2013
  o Finnegan scoring education
  o Inter-observer reliability Oct 2012
  o Emphasis on non-pharmacologic treatment
  o Staffing changes to accommodate needs of babies with NAS
  o Standardized medication treatment protocol

• QI: OPQC Phase 1 Jan 2014-Jun 2016
• Phase 2: Orchestrated Testing (Oct 2015-Dec 2016)
  o Use of 22 cal vs 20 cal
  o Use of Low lactose vs Regular lactose formula
     • 4 groups – 22 cal LL, 22 cal reg lactose, 20 call LL, 20 cal reg lactose
• Phase 3: Sustain (Jan 2017-Jun 2018)
• Throughout had monthly webinars
• Twice per year in person “sharing seamlessly, stealing shamelessly”
Interobserver reliability began Oct 2012

Decreased average length of treatment to 38 days

Standardized treatment protocol initiated Jun 2013

Decreased avg length of treatment to 17 days (Jun 2013-Aug 2014)

Average length of treatment by Dec 2017: 11.5 days
Average length of stay: 15.6 days Calculated Jan-Dec
In the Beginning

• Length of treatment
  o >35 days
  o Everyone had an opinion
  o Everyone had their own way to treat based on where they had been trained
    • The art of medicine
  o Inconsistent and subjective use of Finnegan scoring tool
Building on Success
or
Things that Make you go Hmmm…

• Discussion of other facilities length of treatment which were much shorter than ours (OCHA data review)

• Get all physicians/NNPs on board with need to change practice
  o “Not just a nursing issue”
  o Concern for “cookbook medicine”
  o Skepticism that we could decrease days that drastically
  o Maybe our babies are different…exposure/poly drug etc…
First PDSA
Plan, Do

• Let’s try a change on just one patient…
  o We’ll see what happens with length of treatment/LOS
    • Might shorten a little bit
  o Review of medication protocol
    • With NNPs, Residents and Attending physician
    • No patient needed it, felt like a non-issue

• Finally the patient arrived
  o “Quick” review of previous information with providers
  o Increased anxiety about the change in dose frequency
  o Questions from RNs at bedside about changing of dose frequency
  o Multiple discussions on rounds and throughout day
  o Quick wean of Methadone over less than 20 days
  o Social services in the baby’s county were unprepared for the baby to be ready for discharge
First PDSA Study

• Did the results match our prediction?
  o Exceeded our expectations
  o Decreased length of treatment
  o Skepticism…will it work again?

• What did we learn?
  o We didn’t do a good job reviewing change in protocol with the nursing staff
    • Made it difficult on night shift when residents in house on call.
  o Social work needs to be involved in changes to protocol…
  o Need to keep social work updated on progress and anticipated discharge
First PDSA Act

• Did we Adapt, Adopt or Abandon

• We adopted albeit with some skepticism
  ○ Would it really work that way again???
Second Verse (PDSA)
Same as the First

• The next patient arrived and we repeated the protocol with the same result
• Fully adopted the protocol
Education for Culture Change

- All staff received about 90 minutes of trauma informed, non-judgmental care
- Emphasis on how women entered the world of substance use
- Nurture the Mother Nurture the Child video – watched first chapter (5 min), had a facilitated discussion of trauma and barriers to care
- Review of organized vs disorganized infant, mother and support system.
  - Facilitated discussion of how NICU staff can encourage organization
- Pre and post education attitude surveys
## Dayton Children’s Hospital Attitude Survey Results: Pre and post education

Answers range from 1 (Not at all) to 5 (Very) on a Likert scale

<table>
<thead>
<tr>
<th>Question</th>
<th>Average score pre education</th>
<th>Average score post education</th>
<th>Desired direction of change</th>
<th>Percent change</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent are adverse life circumstances likely to be responsible for a woman’s problematic substance use?</td>
<td>3.8</td>
<td>4.2</td>
<td>Increase</td>
<td>9%</td>
</tr>
<tr>
<td>To what extent is an individual personally responsible for their problematic substance use?</td>
<td>4.3</td>
<td>3.8</td>
<td>Decrease</td>
<td>11%</td>
</tr>
<tr>
<td>To what extent do you feel angry towards women who use drugs and alcohol while they are pregnant?</td>
<td>3.5</td>
<td>2.8</td>
<td>Decrease</td>
<td>21%</td>
</tr>
<tr>
<td>To what extent do you feel disappointed towards women who use drugs and alcohol while they are pregnant?</td>
<td>3.8</td>
<td>3.5</td>
<td>Decrease</td>
<td>1%</td>
</tr>
<tr>
<td>To what extent do you feel sympathetic towards women who use drugs and alcohol while they are pregnant?</td>
<td>2.7</td>
<td>3.4</td>
<td>Increase</td>
<td>11%</td>
</tr>
<tr>
<td>To what extent do you feel concerned towards women who use drugs and alcohol while they are pregnant?</td>
<td>3.9</td>
<td>4.4</td>
<td>Increase</td>
<td>13%</td>
</tr>
<tr>
<td>To what extent do women who use drugs and alcohol while pregnant deserve the same level of health care as people who don’t use drugs?</td>
<td>4.5</td>
<td>4.8</td>
<td>Increase</td>
<td>6%</td>
</tr>
</tbody>
</table>
How Culture Change was Possible

• Process change came first
  o Finnegan scoring was optimized – interobserver reliability with champions and objective data decreased “waffling” about a score
  o Standardized, score based medication protocol improved decision making
  o Education and emphasis on non-pharmacologic care provided tools for care
  o All of the above decreased length of stay and nurse’s frustration
How Culture Change was Possible

Decreased frustration with care of the babies allowed time for education and openness to culture change. Decreased frustration and increased time enabled the nursing and physician staff to concentrate on family centered care specifically for this population.
Facilitators

• Support of Administration/Management – Senior leadership
• Nurse and Physician Champion
• Super-Users – helped with inter-observer reliability
• Education of ALL staff
  o PCAs, NICU and House floats, Attendings, Residents, NNPs and administrators/managers
• Staff Buy-in
  o Unit Councils
• QI Board in Staff Lounge
• “The Team”
  o Lisa Jasin NNP, David Yohannan MD, Karen Beekman CNS, Erin Kichline RN (data collection), Kara Pierce RN (staff education), Kerri Scott RN (staff education), Jen Morris RN (manager)
Successes

• Decreased length of treatment
• Agreement by providers
• Improved attitude scores
• Education of resident staff paid off

• Length of treatment now an average length of treatment 11.5 days
Failures

• Focused primarily on providers for protocol change
• Didn’t focus enough on the nurses
  o RNs have now had education on the protocol
• Didn’t anticipate the need for such frequent social work updates
  o Brought our social worker into the team
• Didn’t have enough faith that we would succeed in decreasing length of treatment
QI Work Recap: MNO July 2018
Applying the IHI model and PDSA Cycle to Improve Identification of OENs

PDSA Worksheets

The Model for Improvement

1. AIM
What are we trying to accomplish?

2. MEASURES
How will we know that a change is an improvement?

3. CHANGES
What changes can we make that will result in improvement?

*available for review on ilpqqc.org
Process Flow for Implementing Stigma and Bias Education

- Create a Stigma & Bias Council including a patient representative to work alongside QI Team
- Review Baseline MNO RedCap Data from ILPQC
- Define needs and goals for the unit after reviewing data.
- Review MNO RedCap Data
- Team meets and debriefs
- Implement Stigma and Bias Curriculum on unit to staff.
- Administration approval needed?
  - Yes: Administration approval granted?
    - Yes: Add Stigma and Bias Curriculum to new staff orientation education.
    - No: Address administration concerns and get approval
  - No: Add Stigma and Bias Curriculum to new staff orientation education.
Want to improve and build your QI knowledge set?

Hear from FPQC quality expert **Dr. Maya Balakrishnan**
and learn new strategies for your team!

- **WHO**: Any and all teams that wish to build their QI knowledge
- **WHEN**: September 18th at 2:00
- **WHAT**: Build your team’s QI capacity by adding skills on Pareto charts and prioritization matrices to your QI toolkit.

Maya Balakrishnan, MD, CSSBB
Healthy Driven
Edward-Elmhurst
HEALTH

ILPQC MNO Initiative
Edward Hospital

- Community Magnet recognized hospital
- ~3,250 deliveries with almost 100 multiples per year
- Level III NICU
- ~425+ admissions per year
- 37 private rooms
Elmhurst Hospital

- Community Magnet recognized hospital
- ~2200+ deliveries per year
- Level IIE SCN
- over 250 admissions per year
- 10 private rooms
30 Day Plan

• Formal education of nursing staff

Process for Creation of Education Plan:

1. Reviewed: MNO-Neo Toolkit, NAS journal articles, VON NAS initiative, ESC study
2. Created power point presentation: Overview of NAS, slides from ILPQC face-to-face meeting, goals of the project, new assessment tool- ESC, non-pharm bundle, engaging mothers/family in the care
3. Obtained CE hours for presentation
4. Printed handouts on Eat-Sleep-Console documentation
5. Provided three mandatory education sessions at both Edward (June) and Elmhurst (July)
Perspectives- Nurses and Mothers


Mother’s Perspective: “So I would go in and—you just feel that ugly feeling—that weight on your shoulder—because it’s so unwelcoming from the nurses. I think they don’t want us to come. They would rather just take care of [the baby] and not have to deal with us.”

Nurses Perspective: “I do have a really hard time ethically… sending these babies home with those mothers. Because you can see when they come that they’re high; …that they’re still using. I don’t know how they get through the system […] if you can’t take care of yourself without using drugs on a daily basis, how in the world are you going to take care of a child who is more difficult than most children?”
Bias, Prejudices, Myths

• Dr Ron Abrahams- Vancouver
  ▪ [https://vimeo.com/89878159](https://vimeo.com/89878159)
  ▪ VON LMS- NAS Collaborative- Family Centered Care- “Nurture the Mother- Nurture the Child”

• Substance Abuse 101: Mythbusters
  ▪ ILPQC MNO-Neo toolkit
## 30-60-90 Day Plan

<table>
<thead>
<tr>
<th>Period</th>
<th>Plan</th>
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</thead>
</table>
| **30 days** | • Team meeting  
| | • Review MNO toolkit- June  
| | • Re-educate on non-pharm bundle- June/July  
| | • Educate staff on Eat-Sleep-Console (ESC) Assessment Tool and Engaging families in care- June/July  
| | • Build ESC into EMR- July  
| | • Begin revisions of current NAS policy- June  
| | • Cuddler Program- May |
| **60 days** | • Team meeting  
| | • Begin using ESC Assessment tool- PDSA cycle- August  
| | • Continue revisions of NAS policy- July/August |
| **90 days** | • Team meeting  
| | • Expand Cuddler Program- August  
| | • Complete revisions to NAS policy  
| | • Standardize pharmacologic treatment  
| | • Standardize toxicology testing  
| | • Develop/Revise safe discharge plan  
| | • Continue PDSA cycle |
WRAP-UP
Q: **Who enters data on an infant if transferred to another hospital?**

A: ILPQC suggests that maternal data is collected by the MNO-OB hospital where the mother delivered. For the infant, ILPQC has provided this guidance:

- 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

Q: **Do any hospitals have tools and resources to help implement a cuddler program at our institution?**

A: Yes! With much generosity, Mary Hope and SSM Health Cardinal Glennon Children’s Hospital have developed and are sharing their cuddler program tools and resources with other hospitals to use as an example. Please see ilpqc.org for the materials!
Q: If a mom has screened positive for a substance other than opioids (i.e. marijuana, cocaine, etc.) do we include her and her infant in the data set?
A: No. ILPQC is asking teams to only track data in REDCap for mothers and newborns with opioid exposure (see Data Forms for data collection definitions).

Q: Are teams expected to implement Eat-Sleep-Console as part of the ILPQC MNO Initiative?
A: No. ILPQC and the MNO Initiative is not promoting ESC as the only method for assessing OENs for pharmacologic treatment. We ask that teams work to have a standardized approach to assessing infants, whether it is Modified Finnegan or ESC. The ILPQC MNO-Neo toolkit has resources if teams are interested in adopting ESC at their institution.

ANY OTHER QUESTIONS? Please ask in the webinar or email info@ilpqc.org!
NEXT MNO-NEO TEAMS CALL

Monday, September 17th, 1-2pm

MNO-Neo Teams Call
Optimize Non-Pharmacological Bundle
### MNO Data Collection

<table>
<thead>
<tr>
<th>Data Collection Form(s) Name</th>
<th>Monthly Data Patient-Level</th>
<th>Quarterly Data Structure Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form</td>
<td>MNO Neonatal Quarterly Structure Measures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baseline Time Period</th>
<th>October – December 2017</th>
<th>October-December 2017 (Quarter 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Due Date</td>
<td>August 15</td>
<td>August 15</td>
</tr>
<tr>
<td>Prospective Data Collection Start</td>
<td>July 2018</td>
<td>July 2018</td>
</tr>
<tr>
<td>Prospective Data Due Date</td>
<td>July 2018 due August 31&lt;sup&gt;st&lt;/sup&gt;, 15&lt;sup&gt;th&lt;/sup&gt; of the month for future months</td>
<td>July 2018 due August 31&lt;sup&gt;st&lt;/sup&gt;, 15&lt;sup&gt;th&lt;/sup&gt; of the month for future months</td>
</tr>
<tr>
<td>Who/what are we collecting data on?</td>
<td>All women with OUD / Opioid exposed newborns collect process and outcome measures</td>
<td>Track your QI work: patient and provider education, protocol implementation, mapping resources, process flow etc.</td>
</tr>
</tbody>
</table>
OB & Neonatal MOC Part IV Opportunities

Neonatal Teams- Approved by ABP for 25 Part IV MOC Credits DUE NOV 1st, 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@ILPQCC.ORG** with any questions!
Contact

• Email  info@ilpqc.org
• Visit us at  www.ilpqc.org
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