ILPQC MNO-Neo Teams Call: Safe Discharge Planning and Linking to Community Resources

March 18th, 2019
Call Overview

- ILPQC Updates
- MNO-Data Review
- Safe Discharge Planning and Linking to Community Resources
- Team Talks
  - NorthShore University HealthSystem Evanston Hospital
  - SSM Health Cardinal Glennon Hospital, St. Louis
- QI Corner
- Next Steps for teams
**Aims**

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

**Primary Drivers**

- Identification and Assessment of OENs
- Treatment
- Safe Discharge

**Secondary Drivers**

- Strengthen Family/Care Team Relationships
- Improve pre-delivery planning
- Standardize identification, assessment, and monitoring of OENs
- Provide Family Education
- Improve infant nutrition and breastfeeding
- Optimize non-pharmacologic care
- Standardize pharmacologic treatment
- Coordinate safe discharge

**Change Ideas**

- Non-judgmental support
- Prenatal pediatric consultation
- Toxicology testing
- Assessment tools
- Feeding guidelines
- Non-pharmacologic care guidelines
- Pharmacologic treatment guidelines
- Safe discharge guidelines
- Social work consultation
- DCFS
MNO-Neo in 2019

Key Strategies

- Prenatal Consult
- Stigma/Bias
- Toxicology Testing
- Assessment of OENs

Strategies to review in 2019

- Non-Pharm Care
- Pharm treatment
- Safe Discharge Planning

Work towards goals in 2019

- Optimize non-pharm care
- Reduce pharm treatment
- Increase safe discharge plans

Covered in 2018

How do we begin to make progress?
## Key QI Strategies

1. Implement standardized identification of OEN with OB
2. Standardize assessment of NAS signs and symptoms for OENs
3. Implement non-pharmacologic bundle
4. Establish feeding guidelines for OENs including breastfeeding eligibility
5. Standardized pharmacologic treatment protocol
6. Standardize provider training - stigma & bias, OEN protocol
   - Standardize patient education
7. Implement standardized safe discharge planning
MNO-Neo OEN Protocol

Complete and document prenatal consult

Obtain toxicology testing, perform standardized assessment of NAS signs & symptoms for OENs

Initiate Non-pharmacologic treatment, document non-pharm care checklist in medical record

Determine maternal eligibility to breastfeed, encourage breastfeeding and determine/provide appropriate nutrition support

After optimization of non-pharmacologic care, initiate pharmacologic treatment protocol as needed

Activating the OEN protocol for every OEN

Complete and document safe discharge plan
Mothers and Newborns affected by Opioids- Neo Initiative

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
## MNO-Neo Patient-Level Data Entry Status

<table>
<thead>
<tr>
<th>Monthly Process/Outcome</th>
<th>Total Records</th>
<th># Teams with Patient Level Data Reported</th>
<th># Teams with No Newborns to Report</th>
<th># Teams Reporting</th>
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<tr>
<td>Baseline</td>
<td>276</td>
<td>62</td>
<td>12</td>
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<td>July 2018</td>
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<td>October 2018</td>
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<td>November 2018</td>
<td>51</td>
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<td>64</td>
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<tr>
<td>December 2018</td>
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<tr>
<td>January 2019</td>
<td>45</td>
<td>27</td>
<td>30</td>
<td>57</td>
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<tr>
<td>February 2019</td>
<td>28</td>
<td>18</td>
<td>18</td>
<td>36</td>
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</table>
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 Structure Measures: Standardized Prenatal Consult

Percent of hospitals that have implemented standardized protocols/guidelines for Prenatal Consult
All Hospitals, 2018-2019

- **Baseline (October - December 2017)**: 72%
- **Jul-18**: 50%
- **Aug-18**: 45%
- **Sep-18**: 33%
- **Oct-18**: 28%
- **Nov-18**: 20%
- **Dec-18**: 21%
- **Jan-19**: 19%
- **Feb-19**: 17%

Colors:
- Green: In Place
- Yellow: Working On It
- Red: Have Not Started
MNO-Neo Structure Measures: Standardized Non-Pharm Care

Percent of hospitals that have implemented standardized protocols/guidelines for Non-Pharmacologic Care

All Hospitals, 2018-2019

<table>
<thead>
<tr>
<th>Month</th>
<th>In Place</th>
<th>Working On It</th>
<th>Have Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (October - December 2017)</td>
<td>3%</td>
<td>50%</td>
<td>65%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>14%</td>
<td>57%</td>
<td>32%</td>
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<td>Aug-18</td>
<td>8%</td>
<td>47%</td>
<td>42%</td>
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<td>18%</td>
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<tr>
<td>Nov-18</td>
<td>24%</td>
<td>57%</td>
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<tr>
<td>Dec-18</td>
<td>23%</td>
<td>58%</td>
<td>19%</td>
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<tr>
<td>Jan-19</td>
<td>35%</td>
<td>51%</td>
<td>14%</td>
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<tr>
<td>Feb-19</td>
<td>39%</td>
<td>52%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Legend:
- Green: In Place
- Yellow: Working On It
- Red: Have Not Started
MNO-Neo Structure Measures: Standardized Pharm Treatment

Percent of hospitals that have implemented standardized pharmacologic guidelines for OENs
All Hospitals, 2018-2019


- In Place
- Working On It
- Have Not Started

Graph shows progressive increase in the percentage of hospitals implementing the guidelines from the baseline to Feb-19.
MNO-Neo Structure Measures: Standardized Discharge Planning

Percent of hospitals that have implemented standardized protocols/guidelines for Safe Discharge Planning

All Hospitals, 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>In Place</th>
<th>Working On It</th>
<th>Have Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>60%</td>
<td>33%</td>
<td>7%</td>
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<tr>
<td>Jul-18</td>
<td>40%</td>
<td>43%</td>
<td>17%</td>
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<td>Aug-18</td>
<td>35%</td>
<td>45%</td>
<td>20%</td>
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<tr>
<td>Sep-18</td>
<td>28%</td>
<td>49%</td>
<td>23%</td>
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<tr>
<td>Oct-18</td>
<td>27%</td>
<td>60%</td>
<td>13%</td>
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<tr>
<td>Nov-18</td>
<td>21%</td>
<td>67%</td>
<td>12%</td>
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<tr>
<td>Dec-18</td>
<td>21%</td>
<td>65%</td>
<td>14%</td>
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<tr>
<td>Jan-19</td>
<td>14%</td>
<td>53%</td>
<td>23%</td>
</tr>
<tr>
<td>Feb-19</td>
<td>13%</td>
<td>65%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Note: Percentages reflect the percentage of hospitals that have implemented standardized protocols/guidelines for Safe Discharge Planning.
MNO-Neo Process Measures:
OENs Receiving Toxicology Testing

ILPQC MNO OB/Neo Initaitive
Percent of OENs (≥35 weeks) receiving a toxicology test (urine, cord, meconium) for NAS
All Hospitals, 2018-2019
ILPQC MNO-OB/Neo Initiative:
Percent of mothers with OUD/OENs (>35 weeks) who roomed together during infant hospitalization
All Hospitals, 2018-2019

- Baseline: 63%
- Jul-18: 69%
- Aug-18: 67%
- Sep-18: 65%
- Oct-18: 63%
- Nov-18: 70%
- Dec-18: 57%
- Jan-19: 66%
- Feb-19: 69%
MNO-Neo Outcome Measures:
Eligible OENs Receiving Maternal Breast Milk at Infant Discharge

ILPQC MNO OB/Neo Initiative
Percent of Eligible OENs (≥35 weeks) Receiving Maternal Breastmilk at Infant Discharge
All Hospitals, 2018

<table>
<thead>
<tr>
<th>Month</th>
<th>% of OENs</th>
<th>Goal</th>
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<tbody>
<tr>
<td>Baseline (2017)</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>56%</td>
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</tr>
<tr>
<td>Aug-18</td>
<td>74%</td>
<td></td>
</tr>
<tr>
<td>Sep-18</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Oct-18</td>
<td>69%</td>
<td></td>
</tr>
<tr>
<td>Nov-18</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Dec-18</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>Jan-19</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Feb-19</td>
<td>42%</td>
<td></td>
</tr>
</tbody>
</table>
MNO-Neo Outcome Measures: OENs Requiring Pharmacologic Treatment for NAS

ILPQC MNO OB/Neo Initiative
Percent of OENs (≥35 weeks) requiring pharmacologic treatment for NAS
All Hospitals, 2018
Median Days of Pharmacologic Treatment for OENs (≥35 weeks) with NAS symptoms

ILPQC MNO-Neo:
Median Number of Days of Pharmacologic Treatment for OENs (≥35 weeks) with NAS symptoms during infant hospitalization
All Hospitals, 2018-2019
MNO-Neo Outcome Measures: OENs Discharged with a Safe Discharge Plan

ILPQC MNO OB/Neo Initiative
Percent of OENs (≥35 weeks) Discharged with a Safe Discharge Plan
Made in Partnership with Family, Hospital, and Community PCP
All Hospitals, 2018

- Baseline (2017):
  - Jul-17: 38%
  - Aug-17: 33%
  - Sep-17: 49%
  - Oct-17: 54%
  - Nov-17: 55%
  - Dec-17: 39%
  - Jan-18: 47%
  - Feb-18: 45%

- Goal: 59%
MNO-Neo Outcome Measures: Average Length of Stay for OENs

ILPQC MNO-Neo:
Median Length of Stay (LOS) for All OENs with NAS Symptoms (≥35 weeks)
All Hospitals, 2018-2019
MNO Data Sharing Update

As with the Maternal Hypertension Initiative, ILPQC participates in the National ACOG Alliance for Innovation on Maternal Health (AIM) program. Our participation in this program allows for statewide comparisons of quality data across participating AIM states. For MNO, we will share aggregate de-identified hospital-level data (we will not share hospital name/ID and AIM will not be able to identify individual hospitals; patient level data will not be shared). MNO data will be shared with AIM by default (no DUA required). If you do not wish for us to share your hospital’s de-identified data please let us know in writing by March 31 via an email from the project lead and nurse lead and/or physician lead. As in the past, if your hospital would like a DUA with ILPQC, please contact us at info@ilpqc.org for a template. ILPQC does not require DUAs.
Safe Discharge Planning and Linking to Community Resources
Importance of Safe Discharge Planning

Discharge planning should ideally begin during the antenatal period. Safe discharge will focus on child vulnerability, adult protective capabilities, and safety factors. If withdrawal signs or symptoms are minimal, then a comprehensive discharge plan that addresses maternal substance use disorder treatment, a safe environment for both mother and baby, and parenting and community supports is essential.

A Safe Discharge Plan made in partnership with the family, hospital, and the community primary care provider includes these key components:

1. ILPQC MNO-Neo “Coordinating a Safe Discharge” Bundle Reviewed with family
2. MD to MD Communication
3. DCFS Clearance/Coordination
4. Official Referral to Early Intervention (IL Child and Family Connections)
Safe Discharge Planning: 4 Key Components

A Safe Discharge Plan made in partnership with the family, hospital, and the community primary care provider includes these key components:

1. ILPQC MNO-Neo “Coordinating a Safe Discharge” Bundle Reviewed with family
2. MD to MD Communication
3. DCFS Clearance/Coordination
4. Official Referral to Early Intervention (IL Child and Family Connections)
1. ILPQC MNO-Neo “Coordinating a Safe Discharge” Bundle Reviewed with family
This bundle of safe discharge criteria should be completed for every family in conjunction with the hospital and community primary care provider before infant discharge:

http://www.ilpqc.org/docs/toolkits/MNO-Neo/ILPQC_Coordinating-Safe-Discharge.pdf
ILPQC MNO-Neo
Coordinating Safe Discharge Bundle (cont.)

- 4-7 days of inpatient monitoring for infants who do not require pharmacotherapy
- 48 hours of inpatient monitoring after pharmacotherapy for infants who require pharmacotherapy
- The infant should feed well and gain weight over two consecutive days
- Consultation with social work completed
- *Coordination and clearance with Illinois Department of Children and Family Services (DCFS) completed
- *Communication and coordination with primary care provider completed
- Medication dispensing schedule and demonstration of ability to dose the infant, if applicable
ILPQC MNO-Neo
Coordinating Safe Discharge Bundle (cont.)

- Developmental follow-up appointment scheduled
- *Referral to Early Intervention completed
- Women, Infants, and Children (WIC) appointment scheduled, if applicable
- Home nurse visit scheduled including weight check scheduled for 1-3 days following discharge, if applicable
- Additional follow up appointments scheduled, including physical or occupational therapy
- Hepatitis B/Hepatitis C/HIV exposed infants – Pediatric infectious disease appointment scheduled or if preference is to follow infant in primary care, please refer to 2018 American Academy of Pediatrics Red Book for current recommendations.
ILPQC MNO-Neo
Coordinating Safe Discharge Bundle (cont.)

- Education provided regarding:
  - Importance and benefits of breastfeeding, unless contraindicated
  - Early Intervention
  - APORS
  - Increased risk of visual problems including strabismus
  - Developmental follow-up
  - Safe sleep practice
  - Non-accidental trauma
  - CPR

- Neonatal Abstinence Syndrome: What you need to know- A Guide for Families (booklet)
  - What to expect at home
  - How to soothe the baby
  - What to do if caregivers are stressed or need a break
2. MD to MD Communication
MD to MD Communication

- *Communication and coordination with primary care provider completed*
  - Discussion of medical and social information, including infant custody
  - Description of hospital course
  - Plan for outpatient medication wean, if applicable
  - Heightened need for vision screening for refractive errors/strabismus
  - Appointment scheduled for 24-48 hours after discharge
3. DCFS Coordination/Clearance
DCFS Coordination/Clearance: What You Should Know

- **Illinois Department of Children & Family Services (DCFS)**
  Website: [www2.illinois.gov/dcfs](http://www2.illinois.gov/dcfs)

- **DCFS Info and Assistance:** 800-232-3798 / 217-524-2029

- **To report suspected child abuse or neglect:** 1-800-25-ABUSE (252-2873)

- **Mandated Reporter Information:** Illinois state law requires that most professionals in education, health care, law enforcement and social work report suspected neglect or abuse. Any mandated reporter having reasonable cause to believe a child known to them in their professional or official capacity may be an abused child or a neglected child shall immediately report or cause a report to be made to the Department.

ILPQC is currently creating a “DCFS Quick Guide for Hospital Teams” to provide guidance on coordinating with DCFS.
DCFS Coordination/Clearance: What You Should Know

Linking mothers to Medication Assisted Treatment (MAT) / Behavioral Health Counseling / Recovery Services prenatally or by delivery admission is a key step in safe discharge planning

- **Abused and Neglected Child Reporting Act (325 ILCS 5/):** Neglected child means any child who is a newborn infant whose blood, urine, or meconium contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substances Act or a metabolite thereof, **with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.**
DCFS Coordination/Clearance: Importance of Plan of Safe Care

- **CARA- Comprehensive Addiction and Recovery Act 2016**
  - Amended 2010 CAPTA (Child Abuse Prevention and Treatment Act
  - Focused on prevention and treatment.
  - Specified data to be reported to by the States
  - Required Plan of Safe Care to include needs of both the infant and family/caregiver
  - Specified increased monitoring and oversight by States to ensure that Plans of Safe Care are implemented and families have access to appropriate services

DCFS Coordination/Clearance: Making a Call to DCFS

• When Does a Call to the Hotline Need to Be Made?
  – IF a child is born with positive toxicology test (blood, urine, or meconium contains any amount of a controlled substance as defined in the Illinois Controlled Substances Act) that is NOT the result of a prescribed medical treatment administered to the mother or the newborn infant → CALL DCFS
  – IF mother has positive toxicology test for controlled substance that is NOT prescribed → CALL DCFS
  – IF mother or child has positive toxicology test for controlled substance that is NOT prescribed and children are in the home → CALL DCFS

• What Happens When a Call is Made?
  – MCNRT – No report taken
  – Report – Evidence provided meets criteria (victim is under 18)
  – Child Welfare Referral – “Gentler” knock at door, linkage to community resource (caller can request)

• What Happens After a Call is Made?
  – Investigator will call to confirm what was reported
  – Investigator comes to hospital to interview and assess safety
  – Determination if protective custody and foster care is needed
  – Determination if infant/other children can remain in the home with supports
  – Plan of safe care/discharge planning *Refer to your hospital’s social services department for specific policies and procedures
DCFS Coordination/Clearance: About DCFS Protective Custody

• **DCFS Protective Custody of Substance Exposed Newborns:**
  - Child Protection Specialists shall not request that hospitals postpone discharge of infants who are medically ready for discharge.
  - Child Protection Specialists shall not take substance exposed infants into protective custody or accept a voluntary placement agreement just because the mother used illegal drugs during her pregnancy.
  - For protective custody of a substance exposed infant to be taken there must be other circumstances present that clearly demonstrate that leaving the infant in the care and custody of the mother presents an imminent danger to the infant’s life or well-being.
DCFS Coordination/Clearance: DCFS Resources

• **Agency and Community Resources for Mothers and Infants Affected by Opioids – Before DCFS Involvement:**
  – SPIDER Resource Locator: spider.dcfs.illinois.gov
  – Division of Specialized Care to Children: dssc.uic.edu
  – Safe Families: safe-families.org, safe-families.org/locations
  – Community Mental Health Centers: illinois.gov/hfs/MedicalProviders/behavioral/CommunityMentalHealthCenter/Pages/default.aspx
  – Community Substance Abuse: illinois.gov/dcfs/brighterfutures/healthy/Pages/Substance-Abuse-Services-and-Assistance.aspx
  – ILPQC Mapping Tool to map local resources: ilpqc.org/docs/toolkits/MNO-OB/Opioid-Use-Treatment-Mapping-Tool_5.11.18.docx
  – Illinois Opioid Assistance and Recovery Hotline (OARS): 1-833-2FINDHELP (234-6343)
  – Illinois Women’s Health Hotline: 1-888-522-1282
  – SAMHSA Treatment Hotline: 1-800-662-HELP (4357)
4. Early Intervention Referral (IL Child & Family Connections), APORS Reporting
Official Referral to Early Intervention (IL Child and Family Connections)

- IL Child and Family Connections serves families and children under the age of 3 with suspected developmental delays
- CFC provides a system point of entry into the IL Early Interventions System
- CFC provides service coordination of early intervention services including evaluations, connecting eligible families to therapies, community resources, and transition
IL Adverse Pregnancy Outcomes Reporting System (APORS)

- APORS collects information on Illinois infants born with birth defects or other abnormal conditions.
- Purpose of APORS:
  - Conduct surveillance on birth defects
  - Guide public health policy in reduction of adverse pregnancy outcomes
  - Identify and refer children who require special services to correct and prevent developmental problems and other disabling conditions
- All licensed Illinois hospitals are required to report adverse pregnancy outcomes to APORS (Note: APORS also receives reports from St. Louis Hospitals part of So. IL Perinatal Network)
Importance of Accurate Reporting of NAS in APORS

• According to a study in 2019:
  – The incidence of NAS in Illinois in 2016 and 2016 was 3.0 cases per 1,000 [link](https://www.cdc.gov/mmwr/volumes/68/wr/mm6807a3.htm?s_cid=mm6807a3_w)

• IDPH APORS identified 944 infants with NAS, admitted to 110 different hospitals (2015 – 2016):
  – Only 27.1% of the cases were reported to APORS with NAS
  – An additional 61.0% of the cases were reported with drug exposure but not NAS
  – 28.4% of babies with NAS were not reported to APORS with any drug-associated condition

• This is a problem for statewide monitoring of NAS & also that families could not be offered the services that might be of benefit to them
Accurate Reporting of NAS IN APORS

- **IDPH/ILPQC: Accurate Reporting of NAS in APORS Fact Sheet:**
  - Fact sheet to provide guidance for APORS abstractors on accurate documentation of NAS in APORS

Accurately reporting NAS into APORS

Helping ensure newborns with NAS and their families are connected to IL CFC/Early Intervention
Team Talks
How Many Social Workers Does it Take…

A Team Approach to Supporting Patients with OUD

Peggy Healy, LCSW
Janet Winslow, LCSW
Perinatal Family Support Center
Dr. Matthew Derrick, Neonatologist

March 18, 2019
Who We Serve

• Services provided to pregnant patients: north of Chicago to the Wisconsin border, at two hospitals
  – 3500 deliveries per year
  – Level III NICU with 42 beds
• High-risk obstetric clinic
• Maternal Fetal Medicine group
• Community based obstetric practices
Perinatal Family Support Center
Program Overview

- Relationship based hospital care model serving approximately 1500 patients/year
- 9 Masters-level clinicians, equivalent 5.5 FTE’s
- In-house weekdays, 24 hour pager/phone coverage
Scope of Program

- Psychosocial assessments, including perinatal mood assessment for all referrals
- Participate in perinatal consults
- Referral to community based resources (Illinois MOM’s hotline 866-364-6667)
- Patient advocacy (mother and baby)
- Interdisciplinary collaboration
- Concrete services
Prior to Delivery

• Referrals from physicians when OUD has been identified
• PFSC Specialist assigned to each patient
• Collaborate with treatment providers
• Neonatology consultation
  – Anticipatory guidance for evaluation and treatment of baby
  – Birth planning
  – Safe discharge planning
At/After Delivery

- Toxicology screening (per hospital Perinatal Drug Screen Policy)
  - Maternal: urine
  - Baby: umbilical cord
- Neonatal Abstinence Scoring protocol
  - Observation on postpartum unit
  - NICU admission if medically indicated
NorthShore OEN Progress

Prenatal Consult prenatally (if possible) with a Neonatologist & Perinatal Family support

Birth

Cord Toxicology Sent

Neonate sent to Normal Newborn (and Peds if mother discharged)

If Neonate NAS signs severe

Non–Pharmacological bundle

• Nursing education related to non-pharm bundle and stigma bias training for ISCU Normal Newborn and Peds nurses

• Simulation training for stigma and bias for the physicians

ISCU and Pharmacological Care

Observe 3-5 days

Discharge with PFSC input re discharge plan
Discharge Planning
DCFS and/or internal High-Risk Infant Discharge agreement

• Ongoing assessment of parental involvement in care of infant, adherence to treatment, maternal mental health assessment
• Determine need for DCFS reporting vs High-Risk Discharge
• Facilitate multi-disciplinary family meetings
• Provision of resources, ongoing support to facilitate transition after discharge
Recommendations for Best Practice

For Unit-Based Care Models

Develop work-flow to identify stakeholders from pregnancy to baby’s discharge

- Identify patients with OUD during pregnancy
- Warm hand-off between unit social workers to ensure continuity of care
- Ongoing documentation of assessment, treatment, and discharge planning
- Develop materials to educate mothers/families about perinatal mood disorders
Process for Social Work Involvement

- Reminders / disclaimers
- Reality vs. expectation of discharge
- Referral for SW assistance or involvement
- Consult with family
- Call to MOCD / ILDCFS
- Contact with MOCD / ILDCFS investigator
- Establishing a safe discharge plan
Receiving Referral

- OSH
  - Drug screen obtained
  - Concerns regarding behavior or prior history
  - Communication with SW and medical team
- Urine, Meconium and umbilical drug screens
  - Urine: must be first void
  - Meconium: sending enough; waiting for transition
  - Umbilical: sending with prior history, current or past use or concerns
Consult with Family

- Importance of level of detail gathered
- Discuss NICU SW role
- Obtain current demographics
- Talk about medical needs and concerns with baby
  - Progress and needs
  - Discharge plan and process
- Discussion of social history
  - Drug use: current, past
  - Involvement (current or past) with MOCD / ILDCFS
  - Other social concerns: homelessness, limited resources, mental illness, limited functioning, addiction, treatment, etc…
  - Treatment
MOCD/ILDCFS Involvement

• OSH hotlined
• CG SW to hotline
• Work with investigator ongoing (long term vs. short term)
  • Difference with 25 wk. vs. 38 wk.
• Discuss concerns or needs as discharge approaches
• Affidavit
• ILDCFS to petition the court or discuss other options or level of involvement
• Discharge plan for safe placement
Affidavit

- Documentation of needs and concerns
- Expressing concerns with discharge plan
- Concerns of discharge with safe plan or no treatment in place
- Submit directly to court and to MOCD / ILDCFS
Safe Discharge

- ILDCFS involvement
  - Contact with family
  - Home visit
  - Considering risk or other concerns
  - Parent(s) in treatment
  - Drug testing

- Petitioning the court
  - ILDCFS
    - Taking custody at time/day of discharge
    - Placement
    - Discharge

- Services in the home
  - Follow up once discharged
Success in Discharge Planning

**Successful**

- Team approach
- Open communication
  - Medical team
  - MOCD / ILDCFS
- Willing to work with the hospital
- Understanding of hospital constraints
- Supporting the family: Resources
- Actively working the case
Emily Johnson
Emily.Johnson@ssmhealth.com
MNO QI Corner
Quality Improvement Tools

Past Tools and Resources:

- 30/60/90 day plans
- PDSA Worksheets
- Process Flow Diagrams
  - High Level
  - Detailed
- Inner-Rater Reliability
  - A performance measurement tool that compares responses (RN scores on ECS) against a standard (a Super User RN) to determine the validity* of the assessment (ESC).

*The tool measures what is aims to measure
Using QI to implement a “ILPQC Coordinating a Safe Discharge Checklist:”

- Review at MNO-Neo QI team meeting to identify what areas are not currently being implemented/in place and create 30/60/90 day plans
- Create process flow for your individual hospitals discharge guidelines for all providers and staff to reference
- PDSA- Test with 1 nurse, 1 provider for the first patient with NAS, discuss, adjust accordingly, retest
- Create a safe discharge simulation for hospital providers and staff or use the ILPQC Eat Sleep Console Simulations and practice filling out a safe discharge plan for one of the cases with hospital providers and staff
Team Support for MNO-Neo Teams in 2019

- **REDCap Reports Overview** and Using Data to Drive QI Webinars for teams coming soon
- Developing **Stigma & Bias training modules** from the Stigma & Bias Plenary and Neo Breakout session at the Annual Conference- Available for teams SOON!
- Developing **Eat Sleep Console simulation training** modules from the Neo Breakout session at the Annual Conference- Available for teams SOON!
## Upcoming MNO-Neo Teams Calls

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>Empowering mothers to participate in their newborn's care</td>
</tr>
<tr>
<td>May</td>
<td>Nutrition and Breastfeeding + Face-to-Face Meeting</td>
</tr>
<tr>
<td>June – December</td>
<td>To Be Determined</td>
</tr>
</tbody>
</table>
2019 FACE-TO-FACE MEETING
You’re Invited!

2019 OB & Neonatal Face-to-Face Meetings

Nurses, Providers, & Staff join us for an interactive day of collaborative learning for current ILPQC initiatives!

OB Teams: May 29, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - OB (MNO-OB)
Immediate Postpartum LARC (IPLARC)
Improving Postpartum Access to Care (IPAC)

Neonatal Teams: May 30, 2019
Check-in: 8:00a-9:00a
Meeting: 9:00a-3:30p
Mothers and Newborns affected by Opioids - Neonatal (MNO-Neonatal)

Register now! https://ilpqc.eventbrite.com

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. (OBN-001-91)

Abraham Lincoln DoubleTree Hotel, Springfield, IL

Illinois Perinatal Quality Collaborative
633 N. St. Clair, 20th Floor
Chicago, IL 60611
FACE-TO-FACE REGISTRATION OPEN!

Visit www.ilpqc.eventbrite.com to register today!
Storyboard Template for 2019 Illinois Teams
Storyboard Instructions

- **Storyboards must fit into a space approximately 28 x 40 inches.** It may be created from a collection of letter-sized sheets (print outs of your power point slides or word documents) that are convenient for carrying while traveling. About six 8x10 inch sheets can fit in the available space. Large post-it sheets and tape will be provided at the meeting.

- **Share your story:** about your hospital, about your team, describe your goals for this initiative, include process flow diagram draft, can include any barriers you have identified and opportunities for improvement, describe next steps or action items for your team.

- **Keep it simple:** the Storyboard is not meant to be an extremely time-consuming project.

**Display Tips**

- Be creative- there is no wrong way!
- Use fewer words and more pictures and graphics
- Include photos, collages, and illustrations (including a photo of your team)
- Use the largest font size as possible for readability
- Use color to highlight key messages (If you don’t have a color printer, use bright highlighters)
- Clear titles and labels if you use graphs (X and Y axes, dates, brief explanation of what it shows)
Storyboard Instructions: Participating in Multiple Initiatives?

- Your hospitals may be participating in multiple OB & Neonatal initiatives at in 2019. We encourage teams to bring **one OB and one NEO** storyboard addressing the active initiatives they are participating in:
  - **OB Teams:**
    - MNO- OB
    - IPLARC Wave 1 or 2
  - **Neonatal Teams:**
    - MNO- Neonatal
OB & Neonatal Teams
Shared Content

• Describe your hospital and demographics
• List team members and their roles (add a team photo if available)
• List identified barriers and strategies for addressing them across initiative
• Describe any PDSA cycles and their results
Initiative Specific Content

- **MNO-OB:**
  - Process flow for OUD protocol
  - Progress on structure measures and key process measures including MAT at delivery and OUD clinical care checklist in chart

- **MNO-Neo:**
  - Process flow for OEN protocol
  - Progress on structure measures and key process measures including breastfeeding, pharmacologic treatment, and safe discharge

- **IPLARC/IPAC:**
  - Wave 1: Include information about comprehensive contraceptive counselling & documentation (prenatally and on L&D), process flow, and GO LIVE date.
  - WAVE 2/IPAC: Include team goals, next steps, draft process flow, 30-60-90 day plan-where are you starting, what do you want to accomplish next?
Example: Team participating in 2 initiatives

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>MNO-Neo</th>
<th>MNO-Neo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Demographics</td>
<td>Identified MNO-Neo Team goals and successes</td>
<td>Hospital OEN process flow</td>
</tr>
<tr>
<td>Neo MNO Qi Team Composition</td>
<td>30-60-90 Day plan</td>
<td>Non-pharm care strategies</td>
</tr>
<tr>
<td>Pictures/data sharing</td>
<td>Identified barriers &amp; strategies to address</td>
<td>Process flow for non-pharm and pharm care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safe Discharge Process and LOS data</td>
</tr>
</tbody>
</table>
Sample Layouts

With 4 portrait oriented sheets in the middle panel

With 3 landscape oriented sheets in the middle panel
THANKS TO OUR FUNDERS