MNO-Neonatal Teams Call: Standardizing Toxicology Testing for Infants for or Showing Signs of NAS

July 16, 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 Accessing WebEx

• You must manually add the meeting to your calendar.
• WebEx is currently unable to add the meeting to your calendar if you are accepting the meeting on a mobile device.

Add to calendar by clicking either of these options.

Add to Calendar

When it's time, join the meeting.

Join by phone
+1-415-655-0002 US Toll
Global call-in numbers

Call-in info

Can't join the meeting?
MNO Teams Call Schedule & Communications

- Based on feedback and discussion after our trial of holding the June MNO-OB and MNO-Neo calls back to back, ILPQC decided to move back to two separate Monday calls:
  - MNO-Neonatal Teams - **3rd Monday of the month from 1pm - 2pm** (new call information and webinar link).
  - MNO-OB Teams - **4th Monday of the Month from 12:30pm – 1:30pm** (same call information and webinar link).
- ILPQC has posted updated call information on our website [www.ilpqc.org](http://www.ilpqc.org), and will include call information in team newsletters
- To accommodate the large volume of information for both the MNO-OB and MNO-Neonatal teams, ILPQC will be sending out separate monthly communications with unique information for both teams.
Overview

- MNO Updates
- MNO-Neo Resources for Standard Toxicology Testing
- Overview of Infant Toxicology Testing, Matthew Derrick, MD
- Quality Improvement Examples
- Team Talks: Getting Started with MNO-Neo
  - Roshena Lindsey & Meg Brough, Advocate Condell Medical Center
  - Brittany Ogrzewalla, SSM Health Cardinal Glennon Children’s Hospital- St. Louis
- Next Steps & Call Schedule
Incredible ILPQC Hospital Team Participation!

- 107 Hospitals across Illinois currently participating (rosters submitted & pending rosters) in Mothers and Newborns affected by Opioids (MNO):
  - 100 MNO-OB QI Teams
  - 88 MNO-Neo QI Teams
MNO-Neo Toolkit Next Steps

• 88 Neonatal Hospitals interested in MNO-Neonatal attended the Face-to-Face (includes currently participating teams & teams without a roster submitted)
  • 72 have rosters submitted (16 need to submit)
  • 12 have rosters submitted, but no toolkit yet
• If your hospital team has a Neonatal binder but no roster, please submit a roster to take full advantage of ILPQC resources
• ILPQC is following up with teams who have submitted Neonatal rosters since the Face-to-Face meeting to send them toolkit binders
• Living document- please share any relevant and timely resources that you come across that would help hospitals implement QI
MNO-Neo Online Toolkit is Live!

http://ilpqc.org/node/115

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<th>MNO-Neonatal Toolkit</th>
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<tr>
<td>1. MNO-Neonatal Key Documents</td>
</tr>
<tr>
<td>a. 11 Steps to Getting Started with the ILPQC Mothers and Newborns affected by Opioids (MNO) – Neonatal Initiative</td>
</tr>
<tr>
<td>b. Mothers and Newborns affected by Opioids Aims and Measures</td>
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<tr>
<td>c. MNO &amp; Key Opportunities for Improvement</td>
</tr>
<tr>
<td>d. Mothers and Newborns affected by Opioids Neonatal Data Form</td>
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<tr>
<td>e. Mothers and Newborns affected by Opioids OB Data Form</td>
</tr>
<tr>
<td>f. Mothers and Newborns affected by Opioids Neonatal Structure Measures Data Form</td>
</tr>
<tr>
<td>g. Mothers and Newborns affected by Opioids Key Driver Diagram for Neonates</td>
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<tr>
<td>h. Mothers and Newborns affected by Opioids Neo Readiness Survey</td>
</tr>
<tr>
<td>i. Plan-Do-Study-Act Worksheet</td>
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<tr>
<td>2. Strengthen Family/Care Team Relationships</td>
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<tr>
<td>3. Improve Pre-Delivery Planning</td>
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<td>4. Standardize Identification, Monitoring, and Assessment of SENs</td>
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<td>5. Provide Family Education</td>
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<td>6. Improve Infant Nutrition and Breastfeeding</td>
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<td>7. Optimize Non-Pharmacologic Care</td>
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<tr>
<td>8. Standardize Pharmacologic Treatment</td>
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<tr>
<td>9. Coordinate and Communicate Safe Discharge</td>
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*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 REDCAP DATA SYSTEM & TRAINING CALLS UPDATES
REGISTER NOW for MNO REDCap Data Training

- Last chance to attend 1-hour data training calls to review steps to submit data and answer questions from teams
- Each hospital must have team members entering data attend one of the following calls
  - **Tuesday, July 17th:** 9-10am (Neonatal Focused Data)
  - **Wednesday, July 18th:** 12-1pm (OB Focused Data)
- Register for your preferred training call date/time
- Will be posting recordings of webinars online for future reference
ILPQC MNO-Neonatal Data Forms

✓ **MONTHLY:** MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form

✓ **QUARTERLY:** MNO-Neonatal Quarterly Structure Measures
Who to collect data on

*Monthly Data: Patient-Level

– All women with OUD / opioid exposed newborns process & outcome measures

All infants (≥35 gestational weeks- 35 weeks, 0 days) of mothers with opioid use disorder if mother has:

• positive self-report screen or positive opioid toxicology screen during pregnancy and assessed to have OUD, or

• Patient reports or reports misuse of opioids / opioid use disorder, or

• using non-prescribed opioids during pregnancy, or

• using prescribed opioids chronically for longer than a month in the third trimester, or

• if newborn has an unanticipated positive neonatal cord, urine, or meconium test for opioids per month.

• *If infants delivered before 35 weeks, OB data will be collected on mom with basic newborn data on OB data form, neo data will only be collected if the baby is born ≥35 gestational weeks*
What to collect data on?

• Hospitals policies, protocols, and educational curriculum for providers, staff, and patients

How to find the data

• Use baseline readiness survey to identify where your team is at to start

• Track quarterly structure measures at your hospitals monthly MNO-Neonatal QI team meetings to monitor progress
MNO-Neo Toolkit Resources for Toxicology Testing

- Neonatal Toxicology Testing Literature Review
- *DRAFT/IN PROGRESS* IDPH Neonatal Advisory Committee “Identifying Newborns At-Risk for Prenatal Substance Exposure” Decision Tree- will share when finalized

Will be available on [www.ilpqc.org](http://www.ilpqc.org) for download
MNO Neo Data Collection Timeline

1. Gain access to REDCap to submit data by submitting the [REDCap access form](#) by July 20 if you haven’t already (for ALL team members using system even if participated in past initiatives)

2. Baseline monthly and quarterly data (Oct – Dec 2017) submitted into REDCap by **August 15**th

3. Prospective monthly data collection begins **July 2018** and July data due into REDCap by **August 31**st and continues monthly (submit by 15th for previous month)

4. Prospective quarterly data collection begins **July 2018**. Submit Q2 by **August 31**st and continues quarterly (submit Q3 Oct 15, Q4 Jan 15, etc.)

5. Please reach out to [info@ilpqc.org](mailto:info@ilpqc.org) with any questions or to discuss special circumstances
STANDARDIZE TOXICOLOGY TESTING OF OPIOID-EXPOSED NEWBORNS (OENS)
Goals of Toxicology Testing

Adequate detection of opioids enables providers/hospitals to properly provide the best therapeutic intervention to the infant and support to the mom as soon as possible.
Aims
- Decrease pharmacologic treatment in substance exposed neonates
- Increase safe and optimized discharge plans in substance exposed neonates
- Increase breastfeeding rates in substance exposed neonates at discharge

Primary Drivers
- Identification and Assessment of SENs

Secondary Drivers
- Strengthen Family/Care Team Relationships
- Improve pre-delivery planning
- Standardize identification, assessment, and monitoring of SENs
- 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
- Social work consultation
- Toxicology Testing
- Assessment tools
- Feeding guidelines
- Non-pharmacologic care guidelines
- Pharmacologic treatment guidelines
- Safe discharge guidelines
- DCFS
Toxicology Testing

• Toxicology testing should be based on your individual’s hospital policies.
  – Develop an protocol for identifying high risk factors for testing.

• Various options are available including:
  ◦ Infant Urine Toxicology
  ◦ Meconium Toxicology
  ◦ Umbilical Cord Sample
  ◦ Infant Blood Toxicology
  ◦ Infant Hair Sample
Current Toxicology Testing in Illinois

Types of Toxicology Testing Commonly being used for NAS by Hospitals

- Urine - 89% (42)
- Serum - 2% (1)
- Meconium - 85% (40)
- Hair - 0% (0)
- Cord Blood - 6% (3)
- Umbilical Cord - 27% (13)
Hospitals with Written Policies or Guidelines for:

Toxicology testing for infants at risk for or showing signs of NAS

48 Teams Reporting

- Yes: 83%
- No: 17%
Standardizing Toxicology Testing Tools

Matthew Derrick, MD
NorthShore University Health Systems
Options available for Opiate Detection

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Neonatal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>Urine</td>
</tr>
<tr>
<td>Hair</td>
<td>Hair</td>
</tr>
<tr>
<td>Amniotic fluid</td>
<td>Meconium</td>
</tr>
<tr>
<td>Blood</td>
<td></td>
</tr>
<tr>
<td>Umbilical Cord</td>
<td></td>
</tr>
</tbody>
</table>
Urine/Blood Toxicology Testing

• Widely established in Adult Testing Programs

• Problems in Neonates
  – Dilute Urine
  – Sample Volume low
  – Rapid Clearance resulting in false negative results
  – 1st Void can be missed and failure/missed sample decreases the likelihood of a positive test
Meconium Toxicology Testing

- Meconium formation starts about the 12th week of gestation and continues to term.
- Drugs are deposited in meconium
- Problems:
  - If first usage just prior to delivery, there will not be time to pass into meconium.
  - It may be tricky in premature infants or if the collections is started after meconium has been passed.
    - 99% of neonates will have passed meconium within 48hr of birth
Infant Hair Sample Toxicology Testing

- Able to be tested until approx. 3 months after birth
- Not all neonates will have sufficient hair growth to allow for an adequate specimen sample.
Umbilical Cord Sample Toxicology Testing

• All babies have one 😊
  – Water Soluble drugs accumulate in amniotic fluid and then into the umbilical cord

• Needs to be collected

• Positive for about 20 weeks from the time of drug exposure
Cord Collection Process

• A 6-8 inch segment of umbilical cord should be cut and drained of blood.

• Rinse, dry and place specimen in a sterile container with a patient identifier.

• Specimen is logged by the LD team and stored in a dedicated refrigerator
Work Flow

• **Mother:**
  – Urine testing done by LD team

• **Neonates:**
  – **ALL** babies have a cord segment collected by the delivery team and stored in a dedicated refrigerator for 7 days.
  – Any infant where there is a clinical suspicion of drug exposure, the specimen is sent to reference lab.
  – Turn around time is approximately 48 hours.
  – Meconium collection is backup for transports where cord has not been saved or when the cord cannot be found.
### Recap of Information

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine</td>
<td>• Non-invasive • Quick Results</td>
<td>• Shortest window of detection <em>(Cotton, 2012)</em> • Rapid clearance resulting in false negatives • Failure to catch 1(^{st}) void decreases likelihood of a positive result.</td>
</tr>
<tr>
<td>Need 1-10mL (Varies by lab)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meconium</td>
<td>• Non-invasive-easier to collect than urine • Wide window of detection <em>(2(^{nd}) &amp; 3(^{rd}) Trimester)</em> • High sensitivity for opiates and cocaine</td>
<td>• Collection can be missed if meconium is discarded by parent or late identification of risk factors. • Difficult to obtain adequate sample in pre-term infant • Requires storage during collection</td>
</tr>
<tr>
<td>Need 0.5-4g sample</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair</td>
<td>• Able to test until approximately 3 months after birth</td>
<td>• Collection is considered invasive because quantity may be limited • Not all neonates have sufficient sample quantity available at birth</td>
</tr>
<tr>
<td>Need 20-50mg hair sample</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Umbilical Cord</td>
<td>• Non-invasive- easy collection • No risk for missed specimen-stored • Wide window of detection <em>(similar to meconium)</em> • Can be sent when symptoms are present after meconium is passed</td>
<td>• Must be stored in a refrigerator • Need for delivery provider and team to collect specimen.</td>
</tr>
<tr>
<td>Need 6-8 in sample</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
QI EXAMPLES
Applying the IHI model and PDSA Cycle to Improve Identification of OENs

PDSA Worksheet

**AIM**

*What are we trying to accomplish?*

**MEASURES**

*How will we know that a change is an improvement?*

**CHANGES**

*What changes can we make that will result in improvement?*

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*available for review on ilpqc.org*
Applying the IHI Model and PDSA Cycles continued

1. Do initial PDSAs on smallest scale possible
   - A “cycle of one” usually best: one patient, one doctor, one day
   - “Failed” cycles are good learning opportunities, particularly when small

2. Test under as many conditions as possible
   - Think about factors that could lead to breakdowns, supports needed, “naysayers”

3. Always identify the prediction/hypothesis before testing the change
   - Allows improved learning from “failures” and refinement of your theory

4. Use a “study measure” specific to the PDSA
   - Usually not one of the project measures
   - Is a measure specific to the small test of change
   - Qualitative results are very valuable in early PDSAs
PDSA: Plan

The Power of “ONE”

Conduct your test with...

• ONE day
• ONE physician
• ONE patient
PDSA WORKSHEET

Team Name: Quality Collaboration Health
Date of test: July 15th, 2018
Test Completion Date: July 21st, 2018

Overall team/project aim: Improve identification of SENs through standardized toxicology screening

What is the objective of the test? To implement standardized toxicology screening for newborns.

**PLAN:** After discussing how hospital currently identifies SEN, we reviewed toxicology tools provided in the ILPQC MNC-Neo Toolkit. After reviewing the evidence, we selected cord segment testing because we found it to be the least invasive and most accurate form of toxicology testing and hospital administration supported the decision based on our recommendation. Our next step is to determine the workflow of the cord segment collection as a toxicology tool to use before implementing at our hospital.

**Briefly describe the test:** Test cord segment collection as a screening option to determine the best fit for implementation as standardized toxicology screening.

**How will you know that the change is an improvement?** Feedback from providers on toxicology tool, format, and seamless transition to brief intervention after use –with one patient.

**What driver in the initiative key driver diagram does the change impact?** "Identification and assessment of SENs".

**What do you predict will happen?** We predict the provider champions will recommend changes to streamline our process.
### Plan

<table>
<thead>
<tr>
<th>List the tasks necessary to complete this test (what)</th>
<th>Person responsible (who)</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prepare and gather needed supplies for the cord screening for Dr. Derrick.</td>
<td>Autumn</td>
<td>July 13</td>
<td>L&amp;D</td>
</tr>
<tr>
<td>2. Meet with Dr. Derrick and Dr. Delivery to review tool cord screening tools.</td>
<td>Autumn</td>
<td>July 14</td>
<td>Dr. Derrick's Office</td>
</tr>
<tr>
<td>3. Test the screening tool once with the first patient admitted to L&amp;D</td>
<td>Dr. Derrick and Dr. Delivery</td>
<td>July 15</td>
<td>L&amp;D</td>
</tr>
<tr>
<td>4. Debrief with QI team to discuss feedback</td>
<td>Autumn, Dr. Derrick, Dr. Delivery</td>
<td>July 20</td>
<td>Staff meeting room</td>
</tr>
<tr>
<td>5. Develop subsequent PDSA cycle/other action.</td>
<td>Autumn, Dr. Derrick, Dr. Delivery</td>
<td>July 20</td>
<td>Staff meeting room</td>
</tr>
</tbody>
</table>

Plan for collection of data: Notes from toxicology screening tool format, workflow, storage and ease of collection on 1 patient each and qualitative discussion of experience using the tool.
DO: Test the changes.

Was the cycle carried out as planned?  X Yes □ No

Record data and observations. Dr. Derrick and Dr. Delivery tested the screening tools with one patient admitted in L&D. The collection was easy and it was non-invasive with a wide window of detection. The LD workflow of the toxicology tool will need to be adapted for a larger sample quantity in the LD setting.

What did you observe that was not part of our plan?
We didn’t expect the additional work/time needed by the LD team at the time of delivery (ex; draining the cord segment of blood and logging the specimen appropriately.)
PDSA: Study

**STUDY:**

Did the results match your predictions?  X Yes  □ No

Compare the result of your test to your previous performance:
First test. Standardized toxicology screening not currently in place.

What did you learn?
Ease of collection is valued by all team members and workflow will need to be adjusted to optimize LD workflow.
**PDSA: Act**

**ACTION MODULE:**

**ACT:** Decide to Adopt, Adapt, or Abandon.

- **Adapt:** Improve the change and continue testing plan.
  
  Plans/changes for next test: **We would like to trial the toxicology testing with different providers for a minimum of 5 deliveries/babies to better determine the best work for the delivery room providers.**

- **Adopt:** Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

- **Abandon:** Discard this change idea and try a different one

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**PDSA WORKSHEET**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**DO:**

- **None**

**STUDY:**

- **None**

**ACT:**

- **None**

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**Plan:** None

**Do:** None

**Study:** None

**Act:** None

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**Notes:**

- We would like to trial the toxicology testing with different providers for a minimum of 5 deliveries/babies to better determine the best work for the delivery room providers.
Collect 6-8 inches of an umbilical cord at every delivery.

Store cord segment for 7 days in designated area.

Label and log cord segment specimen appropriately.

Suspicion of drug exposure and need for toxicology analysis.

Yes

Sign out the specimen and send to lab with appropriate orders.

No

Discard cord segment per bio-hazard protocol.

Initiate NAS protocol
MNO-NEO TEAM TALKS
Advocate Condell Medical Center

- Located in Lake County, IL.
  - Population of 703,462 residents
- Level 2+ Special Care Nursery
  - Highest level nursery for Lake County
- 25 Special Care Staff Nurses
- 1827 deliveries in 2017
  - 11 of these infants were exposed to drugs in utero
- As of July 2018, 6 cases of IUDE identified and treated in our special care nursery
Current State

- *December 2016: Umbilical Cord Drug Testing was implemented*
  - Ease in collection
  - Faster results
    - 3-4 days versus 5-7+ days with mec collection and send out
  - Expeditious monitoring and treatment of infants who tested positive
  - Possible decreased length of stay
Current State Cont.

- **Intrauterine Drug Exposure Testing Guideline**
  - Consistently identifies and tests both mom and baby per listed risk factors
    - Ex: Maternal risk factors- inadequate prenatal care, poor maternal weight gain, placental abruption, STD’s, previous positive toxicology screen for illicit or prescribed medications (Opioids).
    - Neonatal risk factors- IUGR, S&S of NAS, unexplained preterm delivery <35weeks
  - Collection process for umbilical cord drug testing
  - Admission criteria to special care nursery
MNO Team Members

• Neonatology, Nurses, Special Care Nursery Educator, Assistant Clinical Manager, Lactation, Social Work, and Pharmacy

• Recent addition of Gateway Foundation
  – Treatment services for substance abuse disorder
  – Community Linkage to Care that begins in the hospital and continues after discharge
Timeline

May
Planning Meetings
Face to Face

June
Educate Staff
Individual Team Meetings

July
Develop Non pharmacologic bundle
Educate Staff ESC & Bedside tools
Project AIMS

• Increase Maternal Participation in Care
  – ESC
  – Breastfeeding

• Decrease Pharmacologic Use in OEN
  – Neonatology
  – Pharmacy
Education

• ESC PowerPoints
• Training Videos with case studies
• Develop and educate on the use of bedside tools
• Gateway Foundation Education
• Use of predelivery checklist
Education & Development
30 Day Plan

• 30 Day Plan
  – Education
    • Addiction Education
    • ESC
  – Development of a nonpharmacologic care bundle
    • Develop contract for mothers rooming in specific to OEN
    • Bedside Diary
  – Neonatology to review predelivery checklist and pharmacologic interventions
60 Day Plan

Plan

Act

Study

Do

Modify materials/tools as necessary, adopt as guideline

Development of bedside tools

Test use of pre-delivery checklist, contract and bedside diary

Obtain Feedback from mothers, staff and neonatology

Advocate Children’s Hospital
90 Day Plan

• Evaluation of bedside tools, ESC, feedback
• Continue implementation of non-pharmacologic bundle
• Evaluate Gateway’s role in linkage to care
About CGCH…

• Licensed Beds: 195
• Admissions per year: 7,585
• Level I Pediatric Trauma Center
• Level IV Neonatal Intensive Care Unit
About the NICU…

• 65 beds
  61 private rooms including 4 twin rooms
• ~700 admissions per year
• 200 staff RNs, 32 NNPs, 20 Neonatologists
Introducing: Our Neonatal MNO Team

- **Multi-disciplinary team**
  - Staff RNs
  - Neonatologists
  - Neonatal Nurse Practitioners
  - Lactation Consultant
  - Social Work
  - Parent Support Coordinator
  - Discharge Coordinators
  - Child Life
Current Status

• Introducing ESC—live May 2018
  Mandatory Education for all staff
• Recruiting for Cuddler Program (beginning with current volunteers)
• Looking into saving umbilical cords in lab for testing (system-wide)
• Establishing a formal guideline for using ESC on our patients
• Instituting ESC and focus on non-pharmacologic treatment throughout our hospital system
How did we get here?

- VON NAS initiative—Center of Excellence
- NAS taskforce—in place for 2+ years
  Finnegan vs. ESC
  Pilot Trial-guidelines/policy
- Grand Rounds with Dr. Matt Grossman
  September 2018
- Formal education created for staff
  April-June 2018
- Addiction Medicine Conference
  May 2018
- Buy in—the word about NAS and the care involved has spread like wild fire.
Going Forward

• **30 days:**

  By mid-August…
  
  …we will have trained our first group of cuddlers.
  
  …we will have gathered and entered our pre-data from 2017 into REDCap
  
  …we will have initiated education with our community hospitals (including Pediatricians) on ESC
  
  …we will have worked with EPIC to improve charting on NAS and ESC
• **Cuddler Program (THANK YOU ST. MARY’S!):**

Is the cuddler training appropriate for the volunteers and patient population at Cardinal Glennon?

Current volunteers will attend the training and begin the program in the NICU on August 2.

Staff RNs from the NICU will become the champions.

Child Life Specialist will help with recommendations.

What adaptations are necessary for our patient population?

Re-evaluate monthly
Going Forward

• 60 days

By mid/end of September…
…we will have rolled ESC out at all community hospitals in the St. Louis region
…we will have established the Cuddler Program at Cardinal Glennon
• ESC for the community

How can we roll out education to the community hospitals and pediatricians so ESC can be established in well baby nurseries?

Standardized education from roll out at St. Mary’s and Cardinal Glennon

Education team going to each facility to teach

Fine-tuning EPIC charting

What adaptations are needed for the community hospitals?

What kind of buy in and education is necessary for the physicians?
• 90 days:

By mid/late October…

…we will have a WELL UTILIZED, standardized non-pharmacologic and pharmacologic guideline for treatment of opioid-exposed newborns

…we will be working on a standardized safe discharge process that expands on what is currently required.

-Crisis Plan
-How to Calm Your Baby
-Calendar with follow up appointments and phone numbers
MONTHLY CALLS, UPCOMING TRAININGS AND MOC PART IV OPPORTUNITIES
NEXT MNO-NEO TEAMS CALL

Monday, August 20th, 1-2pm

MNO-Neo Teams Call

Patient/Provider Education: Addressing Stigma & Bias
NEXT STEPS FOR MNO-NEO TEAMS

1. Gain access to REDCap to submit data by submitting the REDCap access form by **July 20**th if you haven’t yet

2. REGISTER NOW for MNO REDCap Data Training
   **Tuesday, July 17**th: 9-10am (Neonatal Focused Data)

3. Baseline monthly and quarterly data (Oct – Dec 2017) submitted into REDCap by **August 15**th

4. Prospective monthly data collection begins **July 2018** and July data due into REDCap by **August 31**st and continues monthly
Learn more about the data forms in the Data Toxicology Testing in REDCap Data Training Sessions

**Maternal-Fetal Drug Exposure and Neonatal Assessment**

What were the maternal-fetal opiate exposures?
Check all that apply.
* must provide value

- 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

Information can come from maternal birth report (maternal record), maternal toxic screening, or neonatal toxic 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, hydromorphone, and hydrocodone (short and long acting).

What were other maternal-fetal exposures of note?
Check all that apply.
* must provide value

- Cocaine
- Marijuana
- Alcohol
- SIBI
- Benzodiazepine
- Nicotine-only products (e-cigarettes, patch, gum)
- Amphetamines/Methamphetamines
- Tobacco Products (cigarettes, cigar, chewing tobacco)
- Other
- Unknown

Do not include if exposure was clearly only in the first trimester. Exposures could be from prescribed use or illicit use.

**Was infant urine, meconium, cord and/or other tissue drug screen used?**
* must provide value

- Yes
- No
- Unknown

If yes, what was the result?
* must provide value

- Positive
- Negative

If positive, select the detected drug classes.
If more than one test obtained (i.e. meconium and urine), select all that apply from both tests.
* must provide value

- Amphetamines
- Barbiturates
- Benzodiazepines
- Buprenorphine
- Cannabinoids (marijuana or metabolite)
- Cocaine or metabolite
- Opiates
- Methadone
- Methamphetamine
- Phencyclidine (PCP)
- Other

Other opioids include all agents that are not methadone, buprenorphine, or heroin. This includes fentanyl, codeine, oxycodone, hydrocodone, morphine, and hydromorphone (short and long acting).
MNO-Neonatal Data Collection
Strategies for Monthly Patient-Level Form

• Strategies for identifying infants of mothers with opioid use disorder at risk/have Neonatal Abstinence Syndrome:
  – Chart review or key word searches in EMR
  – Data tracked via bedside checklist/logs
  – Diagnostic code (ICD-10) (Ex: Search for IDC-10 code O99.32 on problem list, or neonatal log of opioid exposed babies or babies with NAS)

• FOR BASELINE: Some teams may have only a small # across 3 months:
  – 3 months (Oct-Dec 2017 baseline data)
  – If less than 5 newborns, go one month earlier up to 6 months until 5 newborns are identified (Sept, August, July 2017)
Linking mom and baby data

• Strategies to collect data from mom/baby pairs
• All moms with OUD documented - collect data each month for all moms delivered that month
• Opioid exposed newborns - collect data for all babies (OEN) discharged each month
• Keep log of Moms with OUD they enter and share with Neo team to confirm mom/baby pairs have data entered to complete mom/baby record
Newborn ICD-10 Codes & Changes in Oct 2018

- ICD-10 Opioid Related Disorders (changes coming in Oct 2018):
  - NAS: P96.1 Neonatal withdrawal symptoms from maternal use of drugs of addiction
  - "Newborn affected by Maternal use of opiates"
    - Current: P04.49 Newborn affected by maternal use of other drugs of addiction
    - New in Oct 2018: P04.14 Newborn affected by maternal use of opiates
## MNO Data Collection

<table>
<thead>
<tr>
<th></th>
<th>Monthly Data Patient-Level</th>
<th>Quarterly Data Structure Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Collection Form(s) Name</td>
<td>MNO OB/Neo Monthly Mothers with OUD and Opioid-Exposed Newborns Data Form</td>
<td>MNO Neonatal Quarterly Structure Measures</td>
</tr>
<tr>
<td>Baseline Time Period</td>
<td>October – December 2017</td>
<td>October-December 2017 (Quarter 4)</td>
</tr>
<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>Q2 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>Q2 2018 due August 31&lt;sup&gt;st&lt;/sup&gt;, 15&lt;sup&gt;th&lt;/sup&gt; of first month of the next quarter (i.e. Q3 data due Oct 15)</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>

*Who/what are we collecting data on?* All women with OUD / Opioid exposed newborns collect process and outcome measures
OB & Neonatal MOC Part IV Opportunities

**Obstetric Teams** - **NEW** ACOG MSPP (OB-Gyns and Multi-Specialty Physicians)-
DUE NOV 1st, 2018

- Step 1: Participating physicians complete [Physician Attestation Survey](#)
- Step 2: On-site project leads complete [Project Lead Attestation Survey](#)
- MNO-OB AND/OR Severe Maternal Hypertension will **BOTH** qualify!

**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@ILPQC.ORG](mailto:INFO@ILPQC.ORG) with any questions!
SAVE THE DATE
ILPQC 6th Annual Conference
Monday, November 5, 2018
Westin Lombard
Contact

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