

PERINATAL QUALITY COLLABORATIVE OF NORTH CAROLINA
Comprehensively Lessening Opioid Use Disorder Impact Snapshot



1. Your facility _____
2. Date of snapshot _____
3. Your name _____
4. Your email _____
5. Your title / role _____
6. How many outpatient obstetric (FP, PH, OB offices, hospital based practice) clinics send patients to deliver at your hospital? _____
7. What percent of your referral clinics universally screen all pregnant women for OUD?

8. Do you know what screening tool is used for maternal verbal screening? YES / NO
9. What percent of deliveries at your hospital are complicated by maternal OUD? _____
10. What percent of mothers with identified opioid use were NOT identified prior to hospital arrival? _____
11. Does your hospital universally verbally screen all women admitted for delivery care?
YES / NO
12. Who verbally screens mothers at admission? _____
13. Does your hospital use a validated screening tool? YES / NO / DON'T KNOW
14. Is there policy to guide providers if a verbal screen is positive? YES / NO / DON'T KNOW
15. Is there education for pregnant women with OUD admitted for delivery regarding the risk for NAS and care of infants with withdrawal symptoms? YES / NO / DON'T KNOW
16. Does your hospital policy encourage breastfeeding of all infants born to mothers with OUD according to AAP criteria (or if mother in a treatment program)? YES / NO / DON'T KNOW
17. Is your hospital care for newborns at risk for NAS based on Finnegan scoring or ESC?
Finnegan scoring / ESC?

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18. Is rooming of mother and baby after delivery standard practice? YES / NO / DON'T KNOW
19. Where are newborns experiencing NAS hospitalized? _____
20. Do you usually transfer infants with NAS requiring pharmacologic treatment to another facility? YES / NO / DON'T KNOW
21. Does a social worker or case manager consult on every mother with OUD? YES / NO / DON'T KNOW
22. Is a CC4C referral made for every infant born to a mother with OUD in order to create a plan of safe care? YES / NO / DON'T KNOW

Thinking about equity:

23. Does your facility provide staff-wide education on peripartum racial and ethnic disparities and their root causes? YES / NO / DON'T KNOW
24. Does your facility provide staff-wide education on best practices for shared decision making? YES / NO / DON'T KNOW
25. Does your facility provide staff-wide education on implicit bias? YES / NO / DON'T KNOW
26. Does your facility engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams? YES / NO / DON'T KNOW
27. Has your facility built a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture? YES / NO / DON'T KNOW
28. Has your facility established a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect? YES / NO / DON'T KNOW
29. Does your facility ensure a timely and tailored response to each report of inequity or disrespect? YES / NO / DON'T KNOW

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30. Has your facility developed a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership? YES / NO / DON'T KNOW