PQCNC clOUDi 3.0 Participation Agreement

INTRODUCTION

Medicaid considers us their 'perinatal quality improvement arm' and that is both an honor and a responsibility that we take seriously, and in doing so must exemplify the best that quality improvement science has to offer in improving the care of the perinatal population. Medicaid expects us to share with them what works, what doesn't, and what's needed to help inform their policies and decisions, something we can only do by adhering to the best of quality improvement science.

The Agency for Healthcare Research and Quality in a report entitled *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies* undertaken to determine the effects of 'quality improvement strategies' on promoting adherence to interventions (categorized as) clinician education, patient education, audit and feedback, clinician reminders, and after looking at numerous hospital projects around CLABSI, SSI, CAUTI, HAI, and VAP, found no evidence to "consistently demonstrate the effectiveness of any specific strategy"

Education, policies, and reminders are not sufficient to move the needle, nor is one or two people working alone. Don Berwick - former president and CEO of the Institute for Healthcare Improvement (IHI) and led the organization's 100,000 Lives Campaign. Former administrator of the Centers for Medicare & Medicaid Services (CMS) who has served on the faculty for Harvard Medical School and Harvard School of Public Health – puts it this way:

> *"I think clinicians do feel they're doing their best because they are doing their best. They're really, they're normal human beings, flawed, frail people, in difficult context, trying as hard as they can. The quality improvement science says trying harder is the wrong plan. It can't work. You're already trying as hard as you can. The problem is you're in a context which doesn't allow you to be reliable.*
>
> *Most injuries to patients like most hazards in any situation are systemic. They're built into the way that the things flow. And this myth that somehow it all depends on the individual is a hard myth to break because I was trained in modern approaches to improvement systems thinking and ways to think about interdependency.*
> *I became able to see the problem of patient safety as a systemic issue, which can only be fixed through systemic changes. Those are very hard to achieve, but it's the only route.*
>
> *And so, the trick is to learn to think systemically, for clinicians to understand that they are citizens in complex environments, much bigger than themselves. And only when we get involved in... working in those interdependencies with the support of leaders can we make progress. It's really frustrating to try to be a hero all the time. It doesn't work."*

Clearly you need more than policies and education and a single person doing their best. We know that too many things are lumped together as 'quality improvement,' resulting only in 'old wine in new bottles' - actions and mindsets that will not get us where we want to go. We know what doesn't work, and we've known for quite some time.

We know what does work – you need a team and adherence to good QI methodology to make the systemic change necessary to improve patient outcomes. Don Berwick again:

> *"I think also, adhering to the science. (T)here are scientific foundations for making things better. Understanding systems and working at a systemic level, instead of, as I said, individual heroism, using data properly. We misuse data all the time in healthcare. We don't use it to help illuminate variation and how things are going. Information can really help unleash knowledge. And that's part of the plan. Part of it is learning to cooperate. (Y)ou can't improve patient journeys without high levels of respect and cooperation across many, many boundaries.*
>
> *And then, we refer to in our field, PDSA, Plan-Do-Study-Act. It's a mnemonic to help remember that you improve by trying things, you improve by getting… you learn to ride a bicycle by getting on the bicycle and healthy organizations are always, always trying new things, reflect on what they've learned from it. Everyone's involved. This is what I call the science of improvement. And it involves leadership who understand it and then allow it to thrive. That's probably the biggest problem is leadership focused on improvement."*

Building a team that can work across silos to address systems, talking to the population you're serving (nothing about me without me), mapping your current processes, devising SMART goals, devising PDSAs with rapid iteration, collecting and analyzing data to confirm improvement, and working to 'hardwire those improvements' – **this** is how improvement gets done.

So, for clOUDi 3 we will be making some adjustments to how we work, starting with the document you are reading now.

Teams will be divided into 'enrolled' and 'auditing' teams, based on organizational maturity (your ability to work across silos, have an effective team, deploy proven QI techniques during an initiative), ability to complete prerequisites and manage the work, and have a sense of urgency in improving patient care.

In this context, urgency refers to that fact that all 'hands on deck' working hard for a short period of time can really make an impact. Your team may not have the same urgency around this issue and this population, something you'll need to decide among yourselves.

While you and the patient populations you serve will get the most out of being an enrolled participant, there is much to be gained from auditing including: access to resources, newsletters, learning session content, potential best practices, and occasional coaching calls.

But there is also much you will miss out on including intensive hands-on mentoring on the latest tools/techniques, technical assistance calls with leading experts, and more as we continue to develop new resources for enrolled teams.

Not quite ready as an institution, or unsure how to address the issues that are preventing you from enrolling? Rest assured, we can, and will, help you with any of the issues that are preventing you from becoming enrolled - it's why we're here!

We are committed to having every facility that wants to provide the best possible care for their patients to join us as an enrolled team - it's the path to making North Carolina the best place to give birth and be born.

REQUIREMENTS

Your hospital will need to agree to the following requirements for participation as an enrolled team in the Perinatal Quality Collaborative of North Carolina (PQCNC) clOUDi 3.0 initiative:

PREWORK

- Team full roster submitted prior to kickoff
- Snapshot completed prior to kickoff
- Prework Data completed prior to kickoff

MEETINGS

- Learning Sessions - Enrolled teams should bring their entire team, but will have at least two members in attendance for **all** clOUDi 3.0 Learning Sessions
- Enrolled teams will meet at minimum once a month following the start of the initiative to evaluate and move forward their clOUDi 3.0 work.
- Enrolled teams will meet at minimum with a PQCNC Clinical Initiative Manager once a quarter to review progress, discuss challenges, and receive support in accessing resources.
- Enrolled teams will provide relevant data and reports for discussion during all meetings

QUALITY IMPROVEMENT

- Enrolled teams will complete the PQCNC Quality Improvement Plan with the help and support of the PQCNC team during the January Kickoff,
- Enrolled teams will update the status of this plan throughout the duration of the initiative on the PQCNC Monthly Leadership Report.
- Enrolled teams will submit the updated PQCNC Monthly Leadership Report each month throughout the duration of the initiative.

DATA

- Enrolled teams will submit required initiative data to DELPHI throughout the duration of the initiative, within 60 days of the end of each month.
- If an enrolled team falls behind in their data submission, they will meet with a PQCNC Clinical Initiative Manager to create an action plan to bring submissions current.

*"**Quality without science and research is absurd. You can't make inferences that something works when you have 60 percent missing data**."*
— Peter Pronovost, world-renowned patient safety champion, innovator, critical care physician, a prolific researcher (publishing over 800 peer review publications)

APPENDIX

Items referred to above can be found in the Appendix which follows

NOTE: Versions of the Action Plan and Data Collection documents found in the appendix may be interim or draft versions

Final versions of these items will be found at pqcnc.org prior to the start of the initiative

Perinatal Quality Collaborative of North Carolina

cIOUDi

Comprehensively Lessening Opioid Use Disorder Impact Charter

CLOUDI CHARTER

Problem Statement:

The opioid epidemic is a profound public health crisis. In 2014, 92 million, or 37.8% of adults in the United States reported the use of prescription opioids. This and the availability of illicit narcotics fuels the crisis. Escalations in opioid use have been particularly profound among women of reproductive age. A greater prevalence of comorbid psychiatric disorders, gender-based violence, physical and sexual abuse, and chronic pain disorders likely contribute to disproportionate rates of opioid use and misuse among women compared with men. Collectively, a myriad of issues contribute to the rising prevalence of opioid use disorder among women and such issues continue during and after pregnancy.

Between 1999 and 2014, the prevalence of opioid use disorder during pregnancy increased from 1.5 to 6.5 per 1,000 hospital births per year. In 2017, there were 1,953 overdose deaths--- involving opioids in North Carolina—a rate of 19.8 deaths per 100,000 persons compared to the average national rate of 14.6 deaths per 100,000 persons.

Pregnancy-associated morbidity and mortality due to substance use is a major patient safety issue. Pregnancy is a unique opportunity to address the complex and often challenging health needs of women with opioid use disorder and provide interventions that can improve maternal and child health well beyond the perinatal period.

Each year, an estimated 15 percent of infants are affected by prenatal alcohol or illicit and prescription drug exposure. Prenatal exposure to alcohol, tobacco, and other drugs has the potential to cause a wide spectrum of physical and developmental challenges for these infants. There is also potential for ongoing challenges in the stability and well-being of infants who have been prenatally exposed, and their families if substance use disorders are not addressed with appropriate treatment and long-term recovery support.

Neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS) is a drug withdrawal syndrome in newborns following birth. The most recent data on the rate of babies born with NAS/NOWS in North Carolina is from 2014 hospital discharge data. From 2008 to 2014, the rate of NAS/NOWS increased from 1.8 cases per 1,000 hospital births to 8.2 cases per 1,000 hospital births.

The Perinatal Quality Collaborative of North Carolina will address this through an initiative that addresses issues relevant to the care of both moms and babies.

Perinatal Quality Collaborative of North Carolina

clOUDi

Comprehensively Lessening Opioid Use Disorder Impact Charter

CLOUDI CHARTER

FOR MOMS
Mission:

Provide the facilitation, support, and education necessary to deliver optimal (or evidence-based care) care for pregnant women with opioid use disorder

Aim:

Working with perinatal quality improvement teams and participating centers of maternal care we will assure an equitable and evidence based universal verbal screening recommendations for opioid use disorder in pregnant women during the antepartum and intrapartum periods.

We will develop procedures for all appropriate health care team members to be skilled in delivering non-judgmental and supportive brief assessment, timely intervention and referral to treatment/continued treatment delivery for all pregnant women with OUD.

We will introduce education, training, and ongoing quality assurance recommendations to reduce stigma and bias associated with maternal disclosure of any substance use, as well as how these stigma and biases may continue to impair access to clinical care after disclosure.

Scope:

We will work with perinatal quality improvement teams in participating sites, both outpatient and inpatient, caring for mothers with opioid use disorder in the antepartum, peripartum and postpartum period.

Method:

Invite teams from antepartum, labor and delivery centers and postpartum care sites to participate in the collaborative. PQCNC will facilitate the collaborative structure to include learning sessions, web conferencing, coaching to support perinatal quality improvement teams (PQIT's), education regarding quality improvement strategies and development of data systems to support most effective implementation of the clOUDi action plan

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Comprehensively Lessening Opioid Use Disorder Impact Charter

CLOUDI CHARTER

Measurement Strategy includes:

1. 100% of pregnant women screened at initial prenatal visit and on entry to the hospital for delivery
2. 100% of positive screens receive a brief intervention
3. 75% of women receptive to a referral for treatment are assessed and evaluated for treatment
4. 100% of women with positive screens receive prenatal education regarding the risk for and treatment of neonatal abstinence syndrome
5. 100% of women with positive screens receive Safe Sleep education
6. 100% of women with positive screens receive depression screening
7. 100% of women with positive screens receive or are prescribed Naloxone prior to discharge

FOR BABIES
Mission:

Provide the facilitation, support and education necessary to deliver optimal care for infants with neonatal abstinence syndrome (NAS) in the hospital and for the first six months of the newborn period.

Aim:

- Create a multidisciplinary hospital and community-based team focused on providing a standardized approach to the identification, evaluation, treatment, discharge and follow up of the NAS infant.
- Hospitals will standardize the non-pharmacologic and pharmacologic care of the NAS infant using practices based either on Eat Sleep and Console (ESC) or the modified Finnegan scoring system.
- Hospitals will increase partnership with families or guardians in the care of NAS infants. Every infant with NAS will have the opportunity to participate in a Safe Plan of Care. At discharge NAS infants will be referred directly by the hospital based medical team to a community based medical team that will be responsible for ongoing newborn acute and routine care, and support for families or guardians.

Scope:

Working with participating perinatal quality improvement teams that include hospital (nurses, addiction specialists, physicians, pharmacists, social workers and practitioners) in the care of infants, mothers and families dealing with NAS.

Method:

Perinatal Quality Collaborative of North Carolina

clOUDi

Comprehensively Lessening Opioid Use Disorder Impact Charter

Invite teams from hospitals (NICU's and mother baby units) to participate in this collaborative. The formal structure will include learning sessions, web conferencing and coaching to support perinatal quality improvement teams (PQIT's) in using quality improvement strategies to implement elements of the action plan

Measurement Strategy includes:

1. Infants substance exposure (opioid, alcohol, tobacco, methamphetamine, cocaine, benzodiazepine)
2. Number of infants diagnosed as at risk for NAS
3. Number of infants diagnosed with NAS
4. % of infants diagnosed with NAS requiring pharmacologic treatment
5. % of infants diagnosed with NAS and non-pharm treated
6. % deviations from consistent use of a single primary designated medication in a facility
7. Length of stay for infants requiring pharmacologic treatment
8. For pharmacologic treated infants:
    a. If Finnegan scoring, % of infants receiving rescue dose of med
    b. If ESC, % of infants requiring scheduled med dosing
9. % of infants ever breastfed,
10. % of infants breastfeeding at DC
11. % of infants discharged home on withdrawal supporting medication
12. % of infants with follow up appointment arranged at discharge
13. % of infants with Plan of Safe Care offered at discharge
14. % of infants with Plan of Safe Care accepted at discharge
15. % of nurseries with guidelines for Safe Sleep practices
16. % of nurseries with demonstrated adherence to Safe Sleep practices

CLOUDI CHARTER

Perinatal Quality Collaborative of North Carolina

Decrease complications of OUD in pregnancy by optimizing the care for women through screening, education, resource mapping, access to treatment services, and protocols for all stages of pregnancy including postpartum care in all locations where care is received. Aim: *Working with perinatal quality improvement teams in participating centers of maternal care we will assure universal screening for opioid use disorder in pregnant women during the antepartum and intrapartum periods. *We will develop procedures for execution of a brief, timely intervention, referral and ongoing treatment for all pregnant women who screen positive *We will introduce interventions to reduce the stigma and bias associated with maternal disclosure of an opioid use disorder, as well as the stigma and bias which may impair the clinical care of mothers after their disclosure.

Secondary Aim	Primary Drivers	Secondary Drivers
1. SBIRT – Screening, Brief Intervention, Referral to OUD Treatment	1.1 Screening	1.1.1 Select and utilize validated screening tool with SBIRT approach 1.1.2 Screen all pregnant women for substance use
	1.2 Brief Intervention	1.2.1 Provide immediate support/counseling at time of identification using motivational interviewing techniques
	1.3 Referral to treatment	1.3.1 Map local resources 1.3.2 Utilize established path for referral to SUD treatment 1.3.3 Identify lead coordinators be responsible for women's care coordination between community and clinical partners 1.3.4 Establish Plan of Safe Care for women with OUD and their families 1.3.5 Ensure and follow OUD treatment engagement antepartum/intrapartum/postpartum
2. Optimizing Care	2.1 Develop protocols to optimize care	2.0.1 Develop protocols for universal screening / toxicology screening - how to introduce, implement, consent 2.0.2 Develop protocols to prevent acute opiate withdrawal by initiating MAT 2.0.3 Develop protocols for labor and delivery pain management 2.0.4 Develop protocols for breastfeeding 2.0.5 Develop protocols to provide lactation support 2.0.6 Develop protocols for referral 2.0.7 Develop clinical pathways for antepartum / intrapartum/ postpartum periods and in different settings - inpatient, outpatient, ED

Perinatal Quality Collaborative of North Carolina

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2. Optimizing Care (cont)		2.0.8 Develop documentation standards for screening , assessment, referral
3. MMH SBIRT – Maternal Mental Health Screening, Brief Intervention, Referral Treatment	3.1 Screening	3.1.1 Select and utilize validated screening tool with SBIRT approach 3.1.2 Screen all pregnant women for MMH prior to discharge with appropriate confidentiality
	3.2 Brief Intervention	3.2.1 Provide immediate support/counseling at time of identification utilizing motivational interviewing techniques
	3.3 Referral to treatment	3.3.1 Map local resources 3.3.2 Utilize established path for referral to MMH treatment 3.3.3 Identify lead coordinators be responsible for women's care coordination between community and clinical partners 3.3.4 Ensure and follow MMH treatment engagement antepartum/intrapartum/postpartum

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4. Providing Education	4.1 Provider education	4.1.1 Develop and implement Staff / Provider Trainings on screening for OUD and MMH with validated tool 4.1.2 Develop and implement Staff / Provider Trainings on stigma related to OUD and MMH 4.1.3 Develop and implement Staff / Provider Trainings on MAT 4.1.4 Develop and implement Staff / Provider Trainings on reducing opioids used post delivery 4.1.5 Develop and implement Staff / Provider Trainings on intra and post partum management 4.1.6 Develop and implement Staff / Provider Trainings on state and local guidelines for maternal substance use and substance exposed infants 4.1.7 Develop and implement Staff / Provider Trainings on confidentiality around OUD and MMH
	4.2 Patient education	4.2.1 Develop and implement Patient education on OUD 4.2.2 Develop and implement Patient education on NAS 4.2.3 Develop and implement Patient education on treatment 4.2.4 Develop and implement Patient education on pain control after delivery 4.2.5 Develop and implement Patient education on care of MMH concerns
5. Providing Naloxone to Mothers with OUD	5.1 Provider education	5.1.1 Multiple materials available that discuss this best practice recommended by SAMSHA

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5. Providing Naloxone to Mothers with OUD (cont)	5.2 Patient education	5.2.1 Assess mothers' knowledge regarding risk factors for an opioid overdose, how to identify a suspected opioid overdose; how to respond in the event of a suspected opioid overdose 5.2.2 Address any gaps in client's knowledge regarding overdose risks and responses. 5.2.3 Educate patient regarding use of take-home naloxone. 5.2.4 Provide a naloxone information sheet.
	5.3 Prescription and Distribution	5.3.1 In NC naloxone available to all at risk for opioid use disorder 5.3.2 All mothers with SUD receive naloxone on discharge 5.3.3 Examine and refine process within your hospital for distribution

Perinatal Quality Collaborative of North Carolina

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Secondary Aim	Primary Drivers	Secondary Drivers
1 Proper Identification	1.1 Each nursery has a protocol that defines indications and procedures for screening for infants at risk for withdrawal	1.1.1 Identification of eligible infants for toxicology testing 1.1.2 Type of toxicology testing 1.1.3 Process for communicating results to mother or caregiver 1.1.5 Criteria for Referral to Social Work and CMARC 1.1.6 Criteria for CPS referral
	1.2 Each nursery develops criteria for toxicology testing and referral of infant to CHild Welfare for a Plan of Safe Care	1.2.1 Toxicology testing should be completed on all the following infants: • Known maternal history for substance use (inclusive of alcohol) • Positive maternal drug screen • And the following criteria: o No/late prenatal care (<4 visits or after 16 weeks) o Symptomatic infants o Unexplained abruption 1.2.2 A Plan of Safe Care referral to Child Welfare should be made for infants • Affected by Substance Abuse: 1. Positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standards. *Or* 2. The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth. • Affected by Withdrawal Symptoms: o The infant manifests clinically relevant drug or alcohol withdrawal. • Affected by Fetal Alcohol Spectrum Disorder(s) (FASD)
	1.3 Each nursery communicates activities to families	

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1 Proper Identification (cont)		1.3.1 Each nursery develops appropriate education to ensure staff competency and family understanding of NAS identification
	1.4 Each nursery identifies potential barriers to discharge on admission	1.4.1 Each nursery identifies: • PCP as early as possible after admission • Resources needed to support discharge of infant with mother/caregiver • As early as possible whether a report beyond referral for a POSC needs to be made to Child Welfare regarding infant safety or risk for neglect, whether CPS referral will be needed- differentiate between a notification to Child Welfare due to meeting critera in 1.2.2 or report to Child Welfare due to concern about infant being at risk for abuse or neglect prior to or upon discharge. See Title I of Child Abuse Prevention and Treatment Act; Public Law No: 114-198, The Comprehensive Addiction and Recovery Act of 2016
2. Proper Evaluation	2.1 Each nursery adheres to a standardized plan for the evaluation of infants at risk for or showing signs of withdrawal	2.1.1 Each nursery adopts either the Modified Finnegan assessment-scoring tool or Eat Sleep Console (ESC) Method 2.1.2 Each nursery develops evidenced based protocols for scoring to include but not limited to: • When to score • How to score • When to begin pharmacologic treatment

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2. Proper Evaluation (cont)	2.2 Each nursery standardizes practices related to scoring that will improve inter-observer reliability and provide consistency in scoring of the infant at risk for or showing signs of withdrawal	2.2.1 Competency training for staff for either Finnegan assessment or ESC methods done at orientation and annually 2.2.2 Units adopt a dual observation requirement before infants are started on pharmacologic therapy.
	2.3 Each nursery recognizes the importance of consistency with caregivers	2.3.1 Each nursery prioritizes infants with NAS/NOWS for primary nursing
	2.4 Each nursery communicates activities to families	2.4.1 Daily contact at bedside or by phone with parent or guardian 2.4.2 Employ standardized materials that educate families regarding scoring for Finnegan or ESC method 2.4.3 Develop programs to allow family/guardian to participate in Finnegan scoring or decision to administer medication for ESC.
3. Proper Treatment	3.1 All nurseries employ non-pharmacologic treatment techniques prior to initiation of pharmacologic treatment	3.1.1 Non-pharmacologic supportive measures started immediately after identification of at risk 3.1.2 Minimizing environmental stimuli including low noise, low light, limiting visitors, cluster care 3.1.3 Consider best location for hospitalization (Private room?) 3.1.4 Swaddling 3.1.5 Encourage Maternal Presence 3.1.6 Encourage Skin to Skin 3.1.7 Encourage Kangaroo Care 3.1.8 Lactation Support

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3. Proper Treatment (cont)		3.1.9 Breastfeeding and the provision of expressed human milk should be encouraged if not contraindicated for other reasons
	3.2 Each nursery develops and adheres to a center defined standardized plan for the pharmacologic treatment of the infants at risk for or showing signs of withdrawal	3.2.1 Consider mother's substance exposure in selecting pharmacologic therapies 3.2.2 Hospitals identify standard first line medication: Morphine, Methadone or Clonidine. 3.2.3 Obtain pharmacy consultation when considering medical therapy 3.2.4 For Finnegan centers medications will be initiated based on the following process in scoring: Average of any 3 consecutive scores is >/=8 or average of any 2 consecutive scores is >/=12 3.2.5 Hospitals develop standard pharmacologic protocols whether ESC or Finnegan based. Includes weaning and escalation parameters, and drug to be used if a second medication required.
	3.3 Each nursery educates staff and parents on proper treatment	3.3.1 Develop standardized materials that educate families regarding ESC methodology 3.3.2 Routinely educates families on NAS treatment
4. Proper Discharge	4.1 Each nursery has a standardized minimum length of stay for all infants at risk for opioid withdrawal.	4.1.1 At risk is defined as including known antenatal drug exposure, a positive drug test or clinical signs or symptoms 4.1.2 Adhere to AAP length of stay standard of 4-7 days for all infants at risk for opioid withdrawal

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4. Proper Discharge (cont)	4.2 Each nursery adheres to a standardized plan for the discharge of infants and family/caregiver	4.2.1 Each center develops stability triggers for notification of proper organizations, family and PCP of pending discharge. 4.2.2 Each center includess infant and family/caregiver criteria for discharge to include but not limited to: • Identified caregiver • Medically stable with adequate weight nutrition • Clearance from all hospital or outside agencies (social work, CPS etc.) • Home situation reviewed • PCP identified and verbally updated with handoff • Follow-up appointments made or caregiver notified of needed follow-up appointments • Outpatient resources identified • Determine if outpatient meds/treatment (i.e. methadone) available in community pharmacy • Caretaker demonstrates normal infant care • Caretaker demonstrates ability to adequately feed infant • Caregiver demonstrates non-pharmacologic treatments • Caregiver provides return demonstration of medication administration • If caregiver is in recovery for opioid use disorder, have visiting nurse administer • Caregiver recognizes symptoms of withdrawal • Caregiver is educated as to when to notify PCP if concerned • CMARC referral
	4.3 Each nursery develops appropriate education to ensure staff competency and family understanding of discharge	4.3.1 Develop standardized materials that educate staff and families regarding discharge

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Provide the facilitation, support and education necessary to deliver optimal care for infants with neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS) in the hospital and for the first six months of the newborn period. Aim: • Create a multidisciplinary hospital and community-based team focused on providing a standardized approach to the identification, evaluation, treatment, discharge and follow up of the infant with NAS/NOWS / • Hospitals will standardize the non-pharmacologic and pharmacologic care of the infant with NAS/NOWS using practices based either on Eat Sleep and Console (ESC) or the modified Finnegan scoring system. / • Hospitals will increase partnership with families or guardians in the care of NAS infants. Every infant with NAS/NOWS will have the opportunity to participate in a Safe Plan of Care. At discharge infants with NAS/NOWS will be referred directly by the hospital based medical team to a community based medical team that will be responsible for ongoing newborn acute and routine care, and support for families or guardians.

4. Proper Discharge (cont)		4.3.2 Education for families on NAS discharge includes: • Normal infant care • Feeding infant • Non-pharmacologic treatments • Medication administration if applicable • Symptoms of withdrawal • When to notify PCP if concerned
	4.4 Each nursery assures every family receives education regarding all elements of safe sleep for newborns	4.4.1 A discussion of safe sleep practices and the risks of unsafe sleep practices is conducted with the mother/parents/caregivers prior to discharge 4.4.2 Standardized materials are given to mother/parents/caregivers prior to discharge as a reference 4.4.3 Consider incorporating the safe sleep calculator into discharge discussions regarding safe sleep
5. Safe Sleep Practices	5.1 Each hospital models all elements of safe sleep for newborns	5.1.1 AAP 2022 safe sleep recommendations are incorporated into policy 5.1.2 Annual training updates include review of AAP 2022 safe sleep recommendations 5.1.2 AAP 2022 safe sleep recommendations are incorporated in to practice and measured via safe sleep audits which include: • Infant in supine position • Infant in a crib, or bassinet with a firm flat mattress; the head of bed should be flat • Sleeping space free of extra items, including loose blankets, pillows, bumpers, and stuffed toys • Infant sleeps in their own sleep space and not with another person

Provide the facilitation, support and education necessary to deliver optimal care for infants with neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS) in the hospital and for the first six months of the newborn period. Aim: • Create a multidisciplinary hospital and community-based team focused on providing a standardized approach to the identification, evaluation, treatment, discharge and follow up of the infant with NAS/NOWS / • Hospitals will standardize the non-pharmacologic and pharmacologic care of the infant with NAS/NOWS using practices based either on Eat Sleep and Console (ESC) or the modified Finnegan scoring system. / • Hospitals will increase partnership with families or guardians in the care of NAS infants. Every infant with NAS/NOWS will have the opportunity to participate in a Safe Plan of Care. At discharge infants with NAS/NOWS will be referred directly by the hospital based medical team to a community based medical team that will be responsible for ongoing newborn acute and routine care, and support for families or guardians.

5. Safe Sleep Practices (cont)		• modifiers for care in the unit are acceptable and explained 5.1.3 Consider partnering with Cribs for Kids' National Safe Sleep Hospital Certification program
	5.2 Each hospital assures a discussion with all mothers/parents families regarding the importance of safe sleep practices (100%)	5.2.1 Use of crib cards affirming safe sleep practices 5.2.2 Documentation of safe sleep counseling in all infant charts at discharge 5.2.3 Use of safe sleep calculator
	5.3 Each hospital assures mothers/parents receive reference materials regarding the importance of safe sleep	5.3.1 Distribution of Safe Sleep sheet information discussing reasons for safe sleep and recommended safe sleep practices

PQCNC AIM clOUDi Roster Form

1. Our facility's name and address are below:

	Name of Facility	Address	City	State	
1					

Please fill out the positions that you know, leaving blank those about which you are unsure, and submit to ensure that you begin receiving emails/newsletters/etc. and are kept up-to-date on the initiative. You may return as frequently as necessary to complete the roster for your team

2. Our team contact information is below:

	Last Name	First Name	Email	Phone
Hospital Executive Champion				
Project Team Leader				
Physician Champion - Maternal				
Physician Champion - Newborn				
Nurse Manager Champion - Maternal				
Nurse Manager Champion - Newborn				
Social Work Contact				
Pharmacy Contact				
Data Entry Contact				
IT Support				
Pt/Family Team Liasion (staff member who will work closest with pt/family member)				
Team Member				
Team Member				

Submit

0%

PQCNC AIM clOUDi Team Snapshot 2023

PQCNC clOUDi Team Snapshot 2023

1. Your facility: *

2. Date of Snapshot: *

3. Your name: *

4. Your email: *

5. Your 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
- DON'T KNOW

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

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

24. Does your facility provide staff-wide education on best practices for shared decision making? *

- Yes
- No

25. Does your facility provide staff-wide education on implicit bias? *

- Yes
- No

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

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

28. Has your facility established a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect? *

- Yes
- No

29. Does your facility ensure a timely and tailored response to each report of inequity or disrespect? *

- Yes
- No

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

31. Do you currently screen mothers screen positive for SUD for depression? *

- Yes
- No

32. Do mothers who screen positive for SUD receive or are prescribed Naloxone prior to discharge? *

- Yes
- No

33. Are mothers who screen positive for SUD educated on Safe Sleep prior to discharge? *

- Yes
- No

Thank You!

Thank you for completing the snapshot!

PQCNC AIM clOUDi Team Prework 2023

PQCNC clOUDi Team Prework 2023

1. Your facility: *

2. Date of Prework: *

3. Your name: *

4. Your email: *

5. Your role: *

Instructions: Choose any date prior to December 10, 2022 and, working backwards chronologically, use the next 10 charts to answer the 3 questions that follow. You will not need to enter every chart, just a count of the total out of 10. Due no later than January 1, 2023.

6. Of the 10 mothers with OUD whose charts were reviewed how may were screened for depression? *

0
1
2
3
4
5
6
7
8
9
10

7. Of the 10 mothers with OUD whose charts were reviewed how may were provided Safe Sleep education? *

0
1
2
3
4
5
6
7
8
9
10

8. Of the 10 mothers with OUD whose charts were reviewed how may received or were prescribed Naloxone prior to discharge? *

0
1
2
3
4
5
6
7
8
9
10

Thank You!

Thank you for completing the snapshot!

PQCNC Quality Improvement Plan

Please answer the following questions

1. Problem Statement
   - Explain the problem and why it is important with reference to the Charter.

2. Goal & SMART Objectives
   - List the directional goal statements and the Specific, Measurable, Actionable, Realistic, and Time bound (SMART) objectives for the problem with reference to the Action Plan.

3. Understanding the Current State: Description or Diagram of the Current Process
   - Describe the current process that relates to the problem statement (i.e., who does what and when) with visual diagrams (e.g., process maps).
   - Next, identify what is working well in the current process, what is not working well in the current process (improvement opportunities), and the root causes.

4. Identifying Improvement Opportunities
   - In response to the improvement opportunities and root causes, identify key interventions you want to implement (with reference to the Action Plan) in a new, improved process (i.e., the future state).

5. 7-14-30-60-90 Day Plan to Implement or Improve the Key Interventions
   - Create a plan to implement the key intervention and new process (e.g., identify a lead person who is responsible for task, describe the task, and set a due date), and track the status of the 7-14-30-60-90 day plan

Plan for the first 7 Days
List who will do the work, what they will be working and by when

Plan for the first 14 Days
List who will do the work, what they will be working and by when

Plan for the first 30 Days
List who will do the work, what they will be working and by when

Plan for the first 60 Days
List who will do the work, what they will be working and by when

Plan for the first 90 Days
List who will do the work, what they will be working and by when

6. Plan to Measure Process and Outcomes Measures

- Identify the relevant measures you will be tracking using the operational definitions of the PQCNC measures to analyze and track the metrics that relate to the key intervention that is being implemented.

7. Current Progress and Results Over Time
   - Trend the results from the measures the relate the QI work by month (e.g., Run and Control Charts)

Monthly Leadership Report

clOUDi

Hospital Name, Date 2023

Charter

Aim: *(include your numeric goals)*

Why is this important? - (facility elevator speech)

A

Team Members

Team names and roles
Key Stakeholders

B

Lessons Learned / Anecdotes

E

Changes

Proposed (P), Tested (T), Implemented (I)

C

Graphs of Measures

Insert data graph to highlight

D

Senior Role / Recommendations / Next Steps

F

G

Patient / Family Engagement

0 1 2 3 4 5 6 7 8 9 10

(Share examples of parent involvement)

H

IHI Rating Scale

1 2 3 4 5

Patient / Family Engagement

0 Have not prioritized PFE

0.5 Committed to moving forward with PFE

1 Selected a team member to lead PFE for the initiative

2 Identified a strategy for incorporating the patient/family perspective

2.5 Received one-time feedback (interview, survey, focus group) from patients/family members

3 Incorporated feedback from patients/family members into initiaitive efforts

4 Recruited a patient/family member to provide ongoing support to the initiative

5 With the leadership of patients/family members, completed a realistic self-assessment of current PFE practices

6 With the leadership of patients/family members, analyzed gaps and opportunities for improvement reflected in the self-assessment and used analysis to develop an action plan that prioritizes key opportunities for improvement

7 With the leadership of patients/family members, identified at least 1 new or expanded PFE practice that addresses priorities or opportunities for improvement identified by the self-assessment

8 With the leadership of patients/family members, developed an implementation plan for at least 1 new or expanded PFE practice

9 With the leadership of patients/family members, implemented at least 1 new or expanded PFE practice using performance improvement methods

10 With the leadership of patients/family members, tracked and shared progress on implementation within organization and among initiative members

IHI Rating Scale

Reviewing Initiative through Progress Scores

Based on a self-assessment scale developed by the Institute for Healthcare Improvement (IHI), progress scores allow you to track your initiative progress over time using a scale between 0.5 - 5.0. 0.5 defined as being 'signed up to participate' and 5.0 'showing outstanding sustainable results'

The progress scores defined:

0.5 - Intent to Participate - Signed on to participate, but the team charter has not been reviewed nor team formed.

1.0 - Charter and Team Established - A charter has been reviewed and accepted. Individuals or teams have been assigned, but no work has been accomplished.

1.5 - Planning for the Initiative has begun - Organization / structural has begun (such as: what resources or other support will likely be needed, where will focus first, tools/materials need gathered, meeting schedule developed).

2.0 - Activity, but no changes - Initial cycles for team learning have begun (project planning, measurement, data collection, obtaining baseline data, study of processes, surveys etc.).

2.5 - Changes / tests, but no improvement - Initial cycles for testing changes have begun. Most project goals have a measure established to track progress. Measures are graphically displayed with targets included.

3.0 - Modest Improvement - Successful test of changes have been completed for some components of the change package related to the action plan. Some small-scale implementation has been done. Anecdotal evidence of improvement exists. Expected results are 20% complete.

3.5 – Improvement - Testing and implementation continues and additional improvement in project measures towards goals is seen.

4.0 - Significant Improvement - Expected results achieved for major subsystems. Implementation (training, communication etc) has begun for the project. Project goals are 50% or more complete.

4.5 - Sustainable Improvement - Data on key measures begin to indicate sustainability of impact of changes implemented in system.

5.0 - Outstanding Sustainable Results - Implementation cycles have been completed and all project goals and expected results have accomplished. Organizational changes have been made to accommodate improvements and to make the project changes permanent.

Perinatal Quality Collaborative of North Carolina

clOUDi 3.0 Infant Patient Data Collection Form

(Inclusion criteria: all infants evaluated for NAS)

(updated August 29, 2022)

clOUDi Infant Data

1. Patient Number: _____

2. Month/Year: _____

3. Infant is being cared for in:
_____Newborn Nursery
_____NICU

4. Did infant have substance exposure? (click all that apply):

_____ a Methadone
_____ b Buprenorphine (Suboxone, Subutex)
_____ c Morphine
_____ d Heroin
_____ e Other opiates (codeine, fentanyl, opium, oxycodone, meperidine, hydromorphone, hydrocodone, Propoxyphene)
_____ f Marijuana
_____ g Cocaine
_____ h SSRIs
_____ i Fetal Alcohol Syndrome / Alcohol Related Birth Defects
_____ j Tobacco
_____ k Other
_____ l Methamphetamine
_____ m No exposure

5. Was infant ever breastfed?
_____Yes
_____No

6. Was infant discharged home or transferred?
_____Discharged home
_____Transferred

If discharged home continue to 7, if transferred skip to 12

7. Was infant breastfeeding / receiving mother's milk at discharge?
_____Yes
_____No

8. Was follow-up appoint scheduled prior to discharge?
____ Yes
____ No

9. Was plan of safe care offered at discharge?
____ Yes
____ No

10. Was plan of safe care accepted at discharge?
____ Yes
____ No

11. Was infant discharged home to biological mother?
____ Yes
____ No

12. Was infant at risk for NAS?

_____Yes (continue form)
_____No (skip to 17)

13. Was infant diagnosed with NAS?

_____Yes
_____No

14. How was infant cared for?

_____Eat, Sleep, and Console (ESC)
_____Modified Finnegan Scoring System

15. Did infant require pharmacological treatment?

_____Yes
_____No

If no, skip to question 17:

15a. Was a medication used other than the primary designated medication?

_____Yes
_____No

If ESC

15b. Did infant require scheduled medication dosing?
_____Yes
_____No

If Finnegan

15c. Did infant receive rescue dose of medication
_____Yes
_____No

16. Was infant discharged home or on withdrawal supporting medication?
_____Yes
_____No

17. What was length of stay of infant in days? _____

18. Infant is:

_____White
_____Asian American
_____Black or African American
_____Hispanic or Latino
_____Native Hawaiian and Other Pacific Islander
_____American Indian or Alaska Native
_____Multiracial
_____Refused

19. Payor:

_____Medicaid
_____BCBS/State
_____Uninsured
_____Other

20. Infant evaluated for NAS due to
_____Maternal history
_____Infant's clinical presentation

21. Was mother in a treatment program?
_____Yes
_____No

22. Have parents/caregivers been counselled about safe sleep practices?
_____Yes
_____No

Perinatal Quality Collaborative of North Carolina

clOUDi 3.0 Mom Patient Data Collection Form

clOUDi Mom Data

1. Month/Year: _____

2. Patient Number: _____

3. Patient is:

_____White
_____Asian American
_____Black or African American
_____Hispanic or Latino
_____Native Hawaiian and Other Pacific Islander
_____American Indian or Alaska Native
_____Multiracial
_____Refused

4. Payor:

_____Medicaid
_____BCBS/State
_____Uninsured
_____Other

5. Was patient verbally screened at a prenatal visit for OUD using a validated verbal screening tool?

_____Yes
_____No
_____Unknown
_____Patient already in a treatment program

6. Was patient verbally screened for OUD on entry to the hospital using a validated verbal screening tool?

_____Yes
_____No
_____Unknown
_____Patient already in a treatment program

7. Did patient screen positive?

_____Yes (continue form)
_____Patient already in a treatment program (continue form)
_____No (stop here and enter result)
_____Unknown (stop here and enter result)

8. Was patient referred for SUD assessment?

_____Yes
_____No
_____Patient already in a treatment program

9. Was patient referred to Social Work?

_____Yes
_____No

10. Did patient receive education regarding the risk for Neonatal Abstinence Syndrome and the treatment of Neonatal Abstinence Syndrome prior to delivery?

_____Yes
_____No

11. Was patient screened for maternal depression/anxiety during the delivery stay?
_____Yes
_____No

12. Did patient screen positive for maternal depression/anxiety?
_____Yes
_____Patient already in treatment
_____No
_____Unknown

13. If screened positive for maternal depression/anxiety and not in treatment, was a referral for treatment made?
_____Yes
_____No

Perinatal Quality Collaborative of North Carolina

clOUDi Mom Quarterly Data Collection Form

clOUDi Mom Quarterly Data

1. How many perinatal care sites are associated with your hospital? _____

2. How many perinatal care sites associated with your hospital perform screening for OUD with all pregnant patients? _____

3. Has your hospital implemented a universal screening protocol for OUD?

   Yes: _____
   No: _____

4. Has your hospital implemented post-delivery and discharge pain management prescribing practices for routine vaginal and cesarean births focused on limiting opioid prescriptions?

   Yes: _____
   No: _____

5. Has your hospital implemented specific pain management and opioid prescribing guidelines for OUD patients?

   Yes: _____
   No: _____

Perinatal Quality Collaborative of North Carolina

clOUDi Infant Monthly Data Collection Form

1. Total Admissions: _____
2. Month/Year: _____
3. Total Patients Entered: _____

clOUDi Infant Data

Perinatal Quality Collaborative of North Carolina

clOUDi Mom Monthly Data Collection Form

1. Total admissions: _____
2. Month / Year: _____
3. Total Patients Entered: _____

clOUDi Mom Monthly Data