Breakout Session	Reviewed	Discussed	Plan
Neonatal Abstinence Syndrome Co-Chair Jenny Fox, MD, MPH Co-Chair Jon Swanson MD, MSc	Reviewed data/hospitals enrolled from first audit in July	Discussed terms of what is "NAS" to ensure concurrence. Everyone agreed that any infant requiring pharmacologic treatment and substance exposed in-utero would qualify and the majority agreed that an illicit substance-exposed infant demonstrating symptoms would qualify. A small group of individuals felt an illicit-substance-exposed infant would qualify. New ICD-10 codes started 10/1/18 which may help in identifying these different cohorts. Few individuals knew these existed. Please see Appendix A: *2019 Additions and Revisions to NAS ICD-10 Codes*	Further discussion is needed with the work group to provide a more refined definition prior to next audit (Jan 2019) Next audit in January and we will be providing a more refined "timeline" (Jenny has developed from VON Congress) to all hospitals to develop their own AIM statement and driver diagram Action Items *** Plan to bring workgroup back for online/webinar meeting between Thanksgiving/Christmas holidays. **Complete Driver Diagram**
Antibiotic Stewardship Co-Chair Josh Attridge, MD Co-Chair Ann Heerens, MD, MBA	Reviewed plans to move forward with VON for Antibiotic Stewardship data iNICQ	Encouraged locations to begin to look at AUR data (utilizing connections with pharmacist to begin to find data) Data is usually available to pharmacy; there is a NHSN module in EPIC that collects this data monthly.	VON for Antibiotic stewardship data iNICQ with plans to start January 2019. Will need to know when module contract is complete Action Items *** Begin local hospital analysis of EONS adaptation in institution. - if adapted, how progressing, what measures following

			- if not adapted, what are challenges/barriers to adaptation **Complete Driver Diagram**
Obstetric Hemorrhage Co-Chair Christian Chisholm, MD	Reviewed AIM process and changes with the new HRSA funding.	Discussed resource-sharing system to system and hospital to hospital State participation in AIM > system participation. Discussed the benefits of AIM Data and the need for all centers to participate, may implement more than one bundle at once but need all to do hemorrhage bundle.	Plans to develop a toolkit and have it available on the VNPC web site 12/5 Ob Hemorrhage Webinar 3/15 Virginia PSO Safe table Action items*** Collected list of names/contact information for AIM enrollment, plans to onboard. **Complete Driver Diagram**
Maternal Opioid Use Disorder Co-Chair Shannon Miles, BSN, RN	Identified what other hospitals were doing related to the bundle.	The consensus was that most hospitals are not doing screenings. Additionally, most do not have referral sources for treatment so many are still practicing with “the don’t ask don’t know motto”.	Action items*** Reconvene the workgroup Potential for a webinar **Complete Driver Diagram**
Community Engagement Co-Chair Cornelia Deagle, PhD, MSPH Cee Ann Davis,	Introduced some initial discussion about definitions and the continuum of community engagement (provider driven, community placed, community based, community engaged, community leadership etc.).	There seemed to be three audiences or "targets" for our community engagement: 1. families 2. hospitals 3. community organizations This may be a result of who was present for the	Action items*** Put CBPR info as a resource on the VNPC website. Identify different resources for patients and professionals. Identify people, resources, and current

MD, MPH		discussion. 1. Priority of **family engagement** - interest in including families in the VNPC - specific roles were not determined. The challenge identified was in getting mothers and infants impacted by SUD but there remained the interest in developing strategies to include those professionals, paraprofessionals and others who do work with those families to bring them along until we can bring families into the group. 2. Identifying the individuals who are interested in the community engagement group and identify what communities they represent. Creating a map of where folks are as well as the types of organizations and populations they represent is important so we have baseline and can measure increased engagement. **Support engagement from people living and working within the communities we are trying to reach from all disciplines - providers, community based organizations, families etc...** 3. Working with Universities who conduct **service learning courses** to (A) use service learning as a model of outreach to communities facing the MCH issues we are looking at in the VNPC and use as models of communities identifying their own solutions/strategies to improve health(* side note my courses at VCU were service learning so I can follow up to see what "pilots" we could explore; (B) with service learning - work	efforts geographically. **Complete Driver Diagram**

		on developing a training pipeline for potential workforce development in the field of MCH across all disciplines (and with service learning in undergraduate programs we could expand community understanding and engagement throughout business, education, liberal arts and non-health fields). 4. Importance of having a **resource tool kit and library** and any other forms for all communities, families and professionals to have quick access. Perhaps a website and Facebook page (I think we need a strong social media presence for community engagement) 5. **Hospitals have family advisory boards** and this committee can link to them as a "win-win" for the triad hospital-family advisory boards-VNPC engagement committee. All three can have communication loops among and between them. Reaching out to hospitals to see what will work best for them and their family advisory Boards 6. The **hospitals have community assessments** that have included community engagement. The assessments could be data sources as well as reflections of community perspectives. Exploring how to use that data and that process to further the community engagement committee was a strategy to move forward. 7. **Best practices of current community-based groups** - there are ongoing community	

		coalitions, Community Action Networks (CANS in Home Visiting), coalitions that understand unique communities, know the families we are working with as well as know the resources (or lack thereof) within their communities. Understanding who those groups are and where they are can establish Virginia best practices as well as be resources to add to # 4 above.	
17-OH Progesterone Co-Chair Marie Pokraka, MS, RN Co-Chair Cathleen McCoy, MD, MFM	Reviewed what the workgroup has been working on, successes to date, and provided an update regarding what is happening in the community in the past few weeks.	Participants were engaged, there were some good questions and discussion.	Action items *** Re-visit 17OHP usage data for VA **Complete driver diagram** Establish redcap data system Initiate data collection from participating clinics Provide guidance on best practice
QI Essentials Joan Williamson, RN, MN	Reviewed PDSA cycles and Driver Diagrams	Discussed the several hospitals that have Perinatal QI teams already in place.	Action items*** Identify which hospitals have QI teams in place. Identify champions
VNPC 101 Shannon Pursell, MPH	Q&A in follow-up from the presentation about the VNPC structure and year in review from the morning session.	Discussion on how to get involved with the advisory committees and project workgroups. There was also several questions about family engagement and lived experience individuals to participate in the VNPC. A couple of the challenges and barriers	Action items*** Start looking for people with lived experiences. Perhaps creating a panel of families to create an informed advisory board.

		mentioned for individuals to participate is compensation for their time, childcare and/or not having the amount of time to invest in participation. Overall, the group was very energized and encouraged to learn more and get involved with the VNPC and bring this information back to their respect organization. The VNPC website was the one take away that everyone was happy to know that it existed and would be sure to check back to see additional updates. Discussion about VON, the process, and the data.	Create implementation workbook to help walk hospitals through the process of VON and other QI projects.
Safe Sleep Shannon Pursell, MPH	Reviewed the AAP Safe Sleep guideline and Thomas Jefferson Health District (TJHD) presented what they are doing in their community to promote safe sleep practices and ensure access to a pack-n-play for families in need of a safe sleep location for baby.	The TJHD discussed their community engagement specific to safe sleep education, dissemination of the pack-n-plays and how they have evaluated their program. Also the website www.safesleepVA.com was discussed and will be linked to the VNPC website for easy reference. A couple of questions discussed how this program/project varies from a hospital setting and the discussed turned to understanding of how parents often model what they see in the hospital setting when baby is on monitors and how that translate to the home setting. There was interest in the room to look into a QI project specific to Safe Sleep as a potent future project workgroup.	Potential for Safesleep as future QI Projects Action items*** Put the safesleepVA.com link on the website under resources.

Appendix A

2019 Additions and Revisions to NAS ICD-10 Codes

P96 codes- Other Conditions Originating in the Perinatal Period

UNCHANGED:

P96.1- Neonatal withdrawal symptoms from maternal use of drugs of ADDICTION

Drug withdrawal syndrome in infant of dependent mother

Neonatal abstinence syndrome

Excludes: reactions and intoxications from maternal opiates and tranquilizers during labor and delivery

P96.2- Withdrawal symptoms from therapeutic drugs in newborn

P04 codes- Newborn Affected by Noxious Substances Transmitted via Placenta or Breast Milk

REVISED:

P04.1 – Newborn affected by other maternal MEDICATION

Code first – withdrawal symptoms from maternal use of drugs of addiction, if applicable (P96.1)

Excludes: maternal use of drugs of addiction (P04.4)

NEW:

P04.11- newborn affected by maternal antineoplastic chemotherapy

P04.12- newborn affected by maternal cytotoxic drugs

P04.13- newborn affected by maternal use of anticonvulsants

P04.14- newborn affected by maternal use of OPIATES

P04.15- newborn affected by maternal use of ANTIDEPRESSANTS

P04.16- newborn affected by maternal use of AMPHETAMINES

P04.17- newborn affected by maternal use of SEDATIVE HYPNOTICS

P04.18- newborn affected by OTHER MATERNAL MEDICATION

P04.19- newborn affected by MATERNAL USE OF UNSPECIFIED MEDICATION

P04.1A- newborn affected by maternal use of ANXIOLYTICS

P04.4- Newborn affected by maternal use of drugs of ADDICTION
P04.40- newborn affected by maternal use of UNSPECIFED DRUGS OF ADDICTION
P04.41- newborn affected by maternal use of COCAINE
P04.42- newborn affected by maternal use of HALLUCINOGENS
Excludes- newborn affected by other maternal medication (p04.1)
P04.49- newborn affected by maternal use of other drugs of addiction
Excludes- newborn affected by anesthesia and analgesia (P04.0)
Withdrawal symptoms from maternal use of drugs of addiction (P96.1)
Includes – METHAMPHETAMINE

REVISED:
P04.8- Newborn affected by other maternal NOXIOUS SUBSTANCES
NEW:
P04.81- newborn affected by maternal use of CANNABIS
P04.89- newborn affected by OTHER MATERNAL NOXIOUS SUBSTANCES

UNCHANGED:
P04.2- newborn affected by maternal use of tobacco
Newborn affected by exposure in utero to tobacco smoke
Excludes- newborn exposed to environmental tobacco smoke (P96.81)
P04.9- Newborn affected by maternal noxious substance, unspecified

Z05 codes- Encounter for observation and evaluation of newborn for suspected diseases and conditions:

RULED OUT

To identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study NOT to be present.

This category is to be used for newborns, within the neonatal period (the first 28 days of life), who are suspected of having an abnormal condition but without signs or symptoms, and which, after examination and observation, is ruled out.

DO NOT use a Z05 code when the patient has identified signs or symptoms of a suspected problem: in such cases code the sign or symptom

UNCHANGED:

Z05.8- observation and evaluation of newborn for other SPECIFIED suspected condition ruled out
Z05.9- observation and evaluation of newborn for UNSPECIFIED suspected condition ruled out