



Opioid Exposed Newborn Project Initiative --- Checklist ---

Please contact Brenda Barker, TIPQC Executive Director, with any questions:
Brenda.Barker@tipqc.org or 615-343-8536.

- Complete & return Enrollment Form
- Execution of Data Use Agreement between your facility and/or practice
- Encourage OB colleagues to join the project
- File IRB (if applicable)
- Report QI measures
- Implement OEN bundle in conjunction with the state collaborative
- Attend Quality Improvement webinars, face-to-face learning sessions, coaching calls

TennesseeAIM Initiative

--- Enrollment Form ---

To enroll your birthing hospital, please complete this Enrollment Form and return to Brenda Barker, TIPQC Executive Director, via FAX at 615-936-8766 or scan to Brenda.Barker@tipqc.org. Please contact Brenda Barker with any questions at 615-343-8536.

Basic Hospital Information

Hospital Name: _____

Type of Hospital (check all that apply):

Non-Profit Profit Public Specialty

Is your hospital a teaching hospital? No Yes

Annual Delivery Volume: _____

Percentage of Deliveries Covered by TennCare: _____

NICU Level of Care: _____

Is this a joint project with your OB Team participating in the AIM OUD Project? No Yes

Your Hospital Team

IMPORTANT: By being listed below, the individual acknowledges their expected participation in this project.

For more information on forming your team please visit <https://tipqc.org/jit-developing-a-team/>.

Day to Day Leader (Key Contact Person)

Name: _____

Title: _____

Telephone: _____

Email: _____

Physician Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Nursing Champion

Name: _____

Title: _____

Telephone: _____

Email: _____

Data Contact

Name: _____

Title: _____

Telephone: _____

Email: _____

Senior Leader (Project Sponsor)

Name: _____

Title: _____

Telephone: _____

Email: _____

Patient/Family Member

Name: _____

Telephone: _____

Email: _____

Acknowledgment of Local Medical Oversight & Approval

This project seeks to effectively and efficiently implement evidence-based practice in an active clinical care setting. QI tests of change that introduce new processes or modify existing processes require assurance of local medical oversight of the work of the improvement team. This application requires identification of the physician champion who will be responsible for medical oversight of your institution or practice's implementation of this project. The Physician Champion is also responsible for gaining approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical Office (as appropriate) for participation in this project. *Please have the Physician Champion complete this section (initial and signature).*

_____ I agree to provide medical oversight for the work of the improvement team in my facility or practice.

_____ I have gained approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical Office (as appropriate) for participation in this project.

Signature of *Physician Champion*: _____

Print Name: _____ Date: _____

Senior Leader Authorization and Support

Please have your Senior Leader confirm the following (using initials) and sign.

_____ This hospital grants permission for the Tennessee Hospital Association to use UB-04 claims data to calculate and report required measures for participation in this project. THA, as a partner to the TIPQC project, has permission to submit data quarterly to the ACOG AIM national database on behalf of the hospital. Hospitals are identified by name in the dataset. Project leaders from THA, TIPQC and ACOG will have access to view the data reports.

_____ This hospital grants permission for TIPQC to aggregate data they capture in TIPQC's instance of REDCap, maintained by the Tennessee Department of Health. TIPQC has permission to submit data quarterly to the ACOG AIM national database on behalf of the hospital. Hospitals are identified by name in the data set. THA and TIPQC will use the same hospital identifiers. Project leaders from TIPQC and ACOG will have access to view the data reports.

_____ I will support the team and will work with them to remove any barriers and/or provide the resources necessary for them to achieve success.

Signature of *Senior Leader*: _____

Title: _____

Print Name: _____ Date: _____