



# NEWSLETTER

Winter 2006-2007

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## 2006 ANNUAL MEETING

The Vermont Oxford Network 2006 Annual Meeting was held in Washington, DC on December 2, 2006. Despite bad weather and delayed flights on the preceding day, the meeting was attended by over 600 individuals representing NICUs from around the world.

The meeting began with an update of Network activities by Jeffrey D. Horbar in which he reviewed the growth of the Network and its Database, and briefly discussed the broad range of Network projects. Since variation in both practices and outcomes is so clear a theme in the Database results each year, Dr. Horbar discussed the potential sources of variation among centers. He described how even after adjusting for differences in risk and case mix and accounting statistically for differences due to chance, there remain large unexplained differences in outcomes among NICUs. The potential sources of this variation include the following categories: people, practices, processes, technology, and organizational structure and culture. Each of these and their potential contributions was discussed.

Nigel Paneth provided a highly informative and insightful presentation, Historical Trends in Neonatal Outcomes: An Overview of the 20<sup>th</sup> Century, in which he addressed five eras of newborn care since 1900. These were the eras of: nutrition, hygiene and public policy (1900-1925), pediatric training and scientific discovery (1925-1950), progress for mothers but stagnation for babies (1950-1965), newborn intensive care (1965-1985), and simple interventions and incremental gains (1985-2000). Dr. Paneth discussed each era and reviewed perinatal and maternal mortality in each era. He concluded his presentation with some ideas for the Network related to merging the goals of neonatology and public health, suggesting that the Network Database be linked to public health records such as birth and death certificates.

The final session of the morning addressed the trend within Vermont Oxford for members to organize into regional collaboratives (see article describing services available to these groups). The session, moderated by George Little, included presentations by Jeffrey B. Gould representing the California Perinatal Quality Care Collaborative, Stanley Craig representing the NICORE group in Ireland and Northern Ireland, and a

distinguished panel discussion including members in the process of organizing local collaborative groups in the US and around the world. The panel included Roberto Bellu from Italy (Italian Neonatal Network), Josep Figueras from Spain (SEN 1500), Edward Donovan from Ohio, Martin McCaffrey from North Carolina, Clinton White from Mississippi, and Andrew Wilkinson from the United Kingdom. The presentations and discussion addressed a variety of models that members are exploring as they plan and organize local groups. We look forward to working closely with these groups and to learn from their pioneering efforts.

The afternoon session began with a presentation by Roger F. Soll addressing the Network's trials and follow up programs. Dr. Soll provided updates on the enrollment and progress of the Delivery Room Management Trial and the Heat Loss Prevention Trial. He discussed the results of the ELBW Follow Up project in which 3855 infants under 1000 grams born from 1998 to 2003 have now been followed up between 18 and 24 months of age. Dr. Soll also discussed the plans for the Parental Interview and Reporting Questionnaire (PIRQ), a tool that when perfected, will allow low cost simplified follow up of large numbers of infants. Finally, Dr. Soll discussed the possibility of a future Network trial on probiotic supplementation for very low birth weight infants. Additional details on Network trials and follow up are available in this Newsletter.

Robert Pfister discussed the Potentially Better Practices, PBPs, identified and tested over the past 10 years by teams in the Network's NICQ Improvement Collaboratives. The 369 PBPs cover a broad range of clinical, operational and organizational practices. They are referred to as "potentially better" rather than "better" or "best" to indicate that before they can be considered better for your unit, the strength and quality of the evidence, risks and benefits must be assessed and the practices adapted and customized to your local environment. Dr. Pfister reviewed the levels of evidence for the PBPs and provided selected examples of the PBPs and how different NICU teams tested and implemented them.

Following the plenary presentations, the meeting continued with members attending pre-selected breakout sessions. These sessions included: eUpdate (Joe Carpenter), Encephalopathy Registry (John

Barks, Jim Gray, Jeffrey Horbar), Multidisciplinary Advisory Committee (Maureen Reilly, Cathy Sawtell, and Committee), Global Neonatology (Steve Ringer, Le Thanh Hai), and Cochrane Review: HIFI Ventilation (Roger Soll).

The members reconvened in the plenary room with a general discussion of Network and database issues.

We thank all of the faculty and members for creating such a successful Annual Meeting.

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## 7<sup>TH</sup> ANNUAL QUALITY CONGRESS

The Vermont Oxford Network 7<sup>th</sup> Annual Quality Congress was held on December 3, 2006 in Washington, DC. The Congress was attended by over 600 health professionals from around the world. In addition to a series of excellent plenary presentations by internationally respected experts in health care quality, the Congress included a Learning Fair where members could share their personal improvement experiences with one another.

The morning session began with a presentation by Shoo Lee, Director of the Canadian Neonatal Network, in which he described the results of a cluster randomized controlled trial at 12 Canadian NICUs of quality improvement interventions designed to reduce BPD and nosocomial infection. Not only was each intervention successful in reducing its target outcome, but interventions targeting one of the outcomes may have resulted in improvements in other outcomes as well. This trial is an important new piece of evidence in the quest to understand the effectiveness of different approaches to quality improvement.

William Edwards and Gene Nelson presented a session on the NICU Value Compass: Pointing the Way to Better Outcomes. They described the four quadrants of the Value Compass (clinical, functional, cost, and satisfaction) and how the Value Compass can be used in the NICU to assess performance across a broad range of domains. Specific examples of how units have used the Value Compass in the Network's NICQ 2005 Improvement Collaborative were discussed.

Lou Halamek followed up on a critical topic that he had introduced at a previous Quality Congress in a presentation titled, Raising the Bar: Simulation Based Perinatal Team Training and Evaluation. He reviewed simulation based training for multidisciplinary teams, showed how to use video in debriefings of the simulations, and discussed how simulation can be used to evaluate team performance. Lou gave an

example from work he has done with several multidisciplinary teams in the Network's NICQ 2005 Improvement Collaborative. The focus of the simulation training was on communication between obstetric and neonatal teams in the delivery room. He showed how evaluation tools used to score simulations can also be used to score actual deliveries and presented preliminary data suggesting improved delivery room performance following simulation training. A key point of the presentation was that simulations can be performed without the need for high tech simulation rooms. The delivery room simulations were done without fancy technology and were highly effective.

Donald Goldmann, Senior Vice President at the Institute for Healthcare Improvement, IHI, discussed Bundles, Reliability, and the Pursuit of Perfection. He discussed the concept of bundles, a group of evidence-based practices that individually improve care, but when applied together result in substantially greater improvement. When assessing performance with respect to a bundle, success is "all or none". All components of the bundle must be performed to count as success. Dr. Goldmann presented the example of the Central Venous Catheter Bundle and how it has been successfully applied to reducing nosocomial infection. He concluded with a discussion of the IHI 100,000 Lives Campaign and challenged neonatology to develop a focused improvement campaign of its own.

The afternoon session began with a presentation by Jim Handyside and Margie Godfrey, two of the leaders of the Network's 2005 NICQ Improvement Collaborative. They explained the structure of the Collaborative and reviewed the improvement lessons learned by teams that participated. Their talk set the stage for the Learning Fair which followed.

The Learning Fair was an interactive learning session organized into a series of topic focused learning stations. Meeting participants were provided with a map of the stations and note taking sheets to help them record ideas that they would like to take home and test in their own NICU. Each station was attended by someone who was knowledgeable about the work presented. The goal was to share practical ideas for improvement. There were a total of 38 learning stations including posters prepared by over 58 individual hospitals. There were learning stations from the teams in the NICQ 2005 Improvement Collaborative, stations representing regional groups of Network members (CPQCC, NICORE, Mississippi, NW Newborn, South Africa and Medi-Clinic South Africa, Italian Neonatal Network, and the United Kingdom), a station for the Value Compass with

posters from NICU teams that had participated in NICQ and iNICQ Collaboratives, stations devoted to simulation, as well as others. The feedback we received on the Learning Fair indicates most members found it very useful. We look forward to planning another exciting Learning Fair in 2007.

Thank you to all of the faculty and to the participants for creating such a successful Quality Congress in 2006.

**MARK YOUR CALENDAR!**

**NETWORK ANNUAL MEETING  
Saturday, 12/01/07**

**7th ANNUAL QUALITY CONGRESS  
Sunday, 12/02/07**

**Omni Shoreham Hotel  
Washington, DC**

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**iNICQ VALUE COMPASS COLLABORATIVE**

The Vermont Oxford Network is pleased to report that multidisciplinary teams from 44 neonatal intensive care units are participating in the current iNICQ Internet series, The NICU Value Compass: Pointing the Way to Better Outcomes. This collaborative is the sixth in a series of Internet collaboratives that have addressed a variety of topics aimed at improving the quality and safety of medical care for newborn infants and their families.

Under the direction of Jeffrey D. Horbar, MD, Eugene Nelson, DSc and William Edwards, MD, participating teams are learning to assess their unit's performance across important domains of outcomes to assess/improve quality and value of care. The clinical Value Compass, named to reflect its similarity to the NSEW compass rose, has at its four cardinal points (1) functional status and well-being, (2) costs, (3) satisfaction with care, and (4) clinical outcomes. The measures in each of these quadrants are driven by key underlying processes of care. Teams in this series are applying Value Compass thinking to their unit using tools and methods that have been tested by teams that have participated in the Network's intensive NICQ collaboratives.

This series includes six interactive, 90-minute Internet sessions. Each web conference provides formal teaching, interactive discussion and time for teams to work together. Prior to each conference, participating teams are provided with materials and prework assignments designed to prepare the team for action.

Collaborative members have access to a dedicated e-mail listserv as well as access to VON's private collaborative website [nicq.org](http://nicq.org), where participants have rapid access to tools, skills, information and resources designed to improve quality and safety of care. Free CME and Contact Hours are available for iNICQ Collaborative participants.

The topic areas of the iNICQ Value Compass are as follows:

**Introduction and Overview**

May 10, 2006: What is the Value Compass? How will it help us improve our NICU?

The use of the web causation to identify key processes is introduced.

**The Clinical Quadrant**

June 21, 2006: Key processes that drive clinical outcomes.

**The Satisfaction Quadrant**

September 13, 2006: Key processes that drive satisfaction outcomes. HowsYourBaby.com, an internet tool for families is introduced to participants. Parents discussed their NICU experience.

**The Cost Quadrant**

October 25, 2006: Value Compass Thinking in Action: Reducing Length of Stay.

A hospital CEO discussed his perspective on costs.

**The Functional Quadrant**

January 17, 2007: Measures of outcomes at 2-3 weeks and 18-24 weeks.

**Case Studies**

February 28, 2007: Case studies presented from participating centers.

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**iNICQ 2007**

**TESTING AND IMPLEMENTING POTENTIALLY  
BETTER PRACTICES FOR YOUR NICU  
BEGINNING MARCH 6, 2007**

This is the seventh in a series of Internet-based improvement collaboratives sponsored by the Vermont Oxford Network under the direction of Jeffrey D. Horbar. This collaborative will provide an introduction to the Potentially Better Practices identified and tested by teams that participated in the Network's NICQ 2005 Collaborative. In that Collaborative, 47 multidisciplinary teams from NICUs in North America worked with experts to identify and test Potentially Better Practices, PBPs, in a variety of NICU domains.

We refer to these practices as "potentially better" rather than "better" or "best" because we believe that until the practices are evaluated, customized, and

tested in your own NICU, you will not know whether they are truly “better” or “best”.

We do not expect you to agree with all of the PBPs. Some may be controversial. However, iNICQ will provide your multidisciplinary team with the opportunity to assess the strength and quality of the evidence for each PBP, and to decide which of the PBPs are appropriate to test and implement in your unit.

Prior to each session we will provide prework designed to prepare your team for the session. The prework will include resource kits with self-assessment tools as well as detailed descriptions and case studies of the PBPs.

The schedule for the iNICQ sessions is presented below. Each session will last 90 minutes. We ask each team to schedule an additional 30 minutes following the session to work together on a structured improvement exercise that we will provide related to the topic of the session.

#### **Session 1: March 6, 2007**

##### **Introduction to Potentially Better Practices**

This session will introduce the potentially better practices and how they were developed, and review how the strength and quality of the evidence is assessed.

#### **Session 2: June 6, 2007**

##### **PBPs for Nutrition**

This session will introduce the potentially better practices for nutrition of VLBW infants, and present case studies of how individual PBPs have been tested and implemented by NICU teams.

#### **Session 3: September 26, 2007**

##### **PBPs for Medication Safety**

This session will introduce the potentially better practices for medication safety, and present case studies of how individual PBPs have been tested and implemented by NICU teams. Attention will be paid to the JCAHO safety goals.

#### **Session 4: November 14, 2007**

##### **PBPs for Improving the NICU Environment**

This session will address how the NICU physical environment (sound, light, odor, space) affects the health and development of infants and their families. Case studies of how individual NICUs applied the PBPs for the NICU environment will be presented.

#### **Session 5: January 16, 2008**

##### **PBPs for Respiratory Care**

This session will review the PBPs for respiratory care and support of VLBW infants and present case studies of how individual NICUs have applied these PBPs.

#### **Session 6: March 19, 2008**

##### **Case Studies from iNICQ**

Participating teams will share case studies of how they have applied the PBPs in their own NICUs.

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### **iNICQ POTENTIALLY BETTER PRACTICES 2007 FACULTY**

#### **Betsi Anderson, RN, BSN, CPHQ**

Neonatal Intensive Care nurse, Children’s Mercy Hospital, Kansas City, MO  
Quality Improvement Coordinator for NICU, Children’s Mercy Hospital

#### **Wally Carlo, MD**

Edwin M. Dixon, Professor of Pediatrics, Univ. of Alabama  
Director of the Division of Neonatology, UAB and Children’s Hospital of Alabama  
Director of the Regional NICU at UAB and the NICU at the Children’s Hospital of Alabama

#### **Stanley Graven, MD**

Professor and Dean of the College of Public Health  
University of South Florida, Tampa FL

#### **James Handyside, B.Sc**

Co-Director NICQ 2007  
Quality Director NICQ 2005 and iNICQ 2005  
President, Improvisation – Ontario, Canada

#### **Jeffrey Horbar, MD**

Professor of Pediatrics, University of Vermont  
Chief Executive and Scientific Officer,  
Vermont Oxford Network, Burlington, VT

#### **Andrew Kairalla, MD**

Medical Director of Neonatology, Baptist Children’s Hospital  
Miami, FL

#### **Stuart Levine, Pharm.D**

Director of Pharmacy Services, Alfred I. DuPont Hospital for Children, Wilmington, DE  
Adjunct Professor, Temple University School of Pharmacy, Philadelphia, PA  
Informatics Specialist, Institute for Safe Medication Practices, Huntingdon Valley, PA;  
Chief Operating Officer, Pediatric Pharmacy Advocacy Group, Memphis, TN

#### **William Liu, MD**

Co-Medical Director of Newborn Services, Children’s Hospital of Southwest FL  
Chairman, Clinical Department of Children’s Hospital Southwest, FL

#### **Alfonso Pantoja, MD**

Associate Clinical Professor of Pediatrics, Univ. of Colorado, School of Medicine  
Medical Director of NICU, Exempla Saint Joseph Hospital, Denver, CO

**Roger Soll, MD**

Associate Professor of Pediatrics  
Director of Clinical Trials, Vermont Oxford Network  
Fletcher Allen Healthcare, Burlington, VT

**Eckhard Ziegler, MD**

Professor of Pediatrics, Director of the Fomon Infant  
Nutrition Unit  
Department of Pediatrics, Univ. of Iowa, Iowa City, IA

**PARTICIPATION IN THE  
QUALITY IMPROVEMENT SURVEY**

The Vermont Oxford Network conducted an on-line survey of VON members to assess participation in quality improvement activities. These activities include the iNICQ Internet based improvement collaboratives, the NICQ intensive face to face improvement collaboratives, and the Annual Quality Congress for Neonatology held each December in Washington, DC.

We received a 44% response rate to our survey. Of those who responded, 42% were from centers that had participated in an iNICQ Internet based improvement collaborative, 27% had participated in a Vermont Oxford NICQ improvement collaborative and 81% had attended the Vermont Oxford Annual Quality Congress for Neonatology. According to the survey results, the fee was a barrier to participation in collaboratives.

We asked centers to select the response that most closely described the impact the series had on their unit, using the Institute for Healthcare Improvement scale of:

- 1) No activity yet (non-starter)
- 2) Activities implemented, no improvement yet
- 3) Modest improvement
- 4) Significant improvement
- 5) Outstanding process ('best practice')

The majority of centers that participated in an iNICQ Internet collaborative reported making modest improvement, while the majority of centers that participated in the intensive face to face NICQ improvement collaborative reported significant improvement.

We appreciate your assistance in helping the Network improve QI offerings to our members.

**NIC/Q 2005 (YIN and YANG)  
QUALITY IMPROVEMENT COLLABORATIVE**

The NIC/Q 2005 Collaborative came to a successful conclusion in Philadelphia at the October 2006 meeting. Working in multicentered exploratory groups, the 42 YANG centers identified and implemented Potentially Better Practices in the following areas: Pharmacy, Hemodynamics, Surgery, Nutrition, Respiratory Care, Physical Environment, and OB-Perinatal Care. Applying Microsystems thinking under the guidance of expert improvement coaches, the YIN (Your Ideal NICU) centers worked to "idealize" processes and transform their NICUs.

The two year collaborative culminated with a Learning Fair where the YIN and YANG centers enthusiastically shared their improvement experiences and work products via case studies and posters.

The Philadelphia Learning Fair posters then made their way to Washington DC and were showcased in the well attended and lively Quality Congress Learning Fair which was open to all attendees. The feedback from the Quality Congress collaborative Learning Fair was very positive and will hopefully promote further collaboration among all Vermont Oxford Network members.

**NICQ 2007  
QUALITY IMPROVEMENT COLLABORATIVE**

NICQ 2007, beginning in January 2007, is the 5th in a series of intensive improvement collaboratives sponsored by the Vermont Oxford Network. Multidisciplinary teams from 47 institutions in North America will work together over two years to improve the quality and safety of medical care for newborn infants and their families. The faculty for the collaborative will include co-leaders Margie Godfrey, Jim Handyside, and Kathleen Iannacchino, an experienced group of skilled improvement facilitators, and respected experts in health care quality and safety. The aims of NICQ 2007 are:

- To make measurable improvements in quality and safety
- To engage families as team members for improvement
- To create a joyful and satisfying workplace that promotes personal & professional growth
- To develop new tools and resources for NICU improvement
- To disseminate the learning broadly in the neonatal community

Each year teams will attend two face-to-face meetings that will include interactive plenary presentations,

small and large group exercises, and learning fairs in which teams share their improvement stories.

Each team will also join one Learning and Improvement Community, a multi-hospital group that will focus on improving key NICU processes. Between meetings of the collaborative, teams will work together through conference calls and email discussion lists. In late summer and fall of 2006, the participating teams engaged staff in choosing their top 3 topics of interest for NICQ 2007. Based on these choices, the following Learning and Improvement Communities were created:

- Daily Care
- Staffing for Quality & Safety
- Design & Build a 21st Century NICU
- Transitions (admission, discharge & follow-up)

There are 7 major themes that we will encourage all of the Learning and Improvement Communities to address in their work. These themes are adapted from the Institute of Medicine principles first published in the influential Crossing the Quality Chasm: A New Health System for the 21st Century (National Academies of Science 2001). The themes are safe, effective, parent & family centered, timely, efficient, equitable and socially & environmentally responsible.

NICQ 2007 will also include a special leadership track under the direction of Deb Miller. NICU leaders from participating units will meet together for a half day prior to the main meetings of the collaborative to learn and apply new leadership skills.

An important element of NICQ 2007 will be engaging families as team members for improvement. Participating teams will be encouraged to include family representatives on their teams and to include them at the main meetings of the collaborative.

Twelve teams in NICQ 2007 have chosen to work closely with quality improvement coaches during the two years of the collaborative. Four of these teams will receive individual on-site visits from quality coaches. Nine teams will explore a new model of group coaching and round robin site visiting under the direction of their coaches.

The first meeting of NICQ 2007 will take place in St Louis March 22-25, 2007. We are looking forward to beginning this exciting new adventure in collaboration!

## **NICQ 2007 MEETING IS CARBON NEUTRAL!**

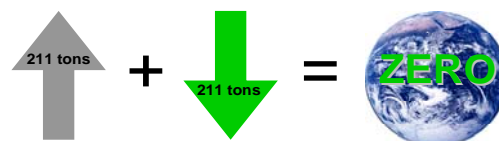
We are now all too aware of the inconvenient truth that our personal activities contribute to global climate change. Carbon emissions related to air travel are a significant contributor to this problem. The Vermont Oxford Network is pleased to announce that the NICQ

2007 Collaborative Meeting in St Louis, MO on March 22 to 25, 2007 will be carbon neutral. Over 300 individuals representing teams from 47 NICUs from around North America will be traveling to this 2 ½ day meeting. As a result of the travel and other energy use related to the meeting, 211 tons of carbon dioxide will be generated. The Vermont Oxford Network has purchased carbon offsets to help mitigate the effects of this carbon load. The money for the offsets will be used to support a sustainable energy project that would not otherwise be financially viable. In this case our offsets will be used to support the Rosebud Sioux Owl Feather War Bonnet Wind Farm on tribal lands near St. Francis, South Dakota. This is stage two of a tribal initiative to develop sustainable energy sources.

The offsets were purchased from Native Energy ([www.nativeenergy.com](http://www.nativeenergy.com)) whose Internet site includes additional information about carbon offsets in general and the wind farm we are supporting in particular.

The NICQ 2007 Meeting is one of the first national medical meetings to be carbon neutral. We are considering the use of carbon offsets for all future Network meetings including the Annual Meeting and Quality Congress. This will likely involve voluntary purchase of personal carbon offsets by meeting attendees, with the Network making up the difference for those who choose not to contribute. We would appreciate your ideas and suggestions related to this issue.

### **Carbon Neutrality** Offset (something that counterbalances)



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## **MULTIDISCIPLINARY ADVISORY COUNCIL**

The MDAC is a group of health professionals representing RNs, RRTs, NNPs, Dieticians, and Pharmacists who advise the network regarding the inclusion of a broad range of disciplines in VON activities and programs. The MDAC was organized to advise the VON faculty as well as to help meet the needs of the multidisciplinary teams who work in VON NICUs.

At the beginning of 2006 the MDAC elected Maureen Reilly, RRT from Sunnybrook Health Sciences Centre in Toronto and Cathy Sawtell, MSN, CRNP, from

Morristown Memorial Hospital in Morristown, NJ as co-chairs of the council. Along with the council's mandate to advise the network, the group decided its primary goal for the year would be to increase both the awareness of VON and the MDAC to the general membership. In order to help achieve this goal, a letter was sent to all the contact people at each participating VON site to request names and e-mail addresses of individuals at each site who would be interested in receiving general VON and MDAC information. This would only be general VON or MDAC information, never site specific. The council is continuing to collect names of individuals interested in being on a list serve. If you or someone you know is interested in being a part of this list serve, please send your name and e-mail to the address listed below.

The MDAC also held a break out session at the Annual VON meeting in Washington, DC. In addition to informing the group about many of the current VON projects, the group in attendance was informed about a Nursing Staffing Research Proposal that is being submitted to the NIH. The PI is Jeanette Rogowski who is working with VON. The study will look at the relationship between acuity adjusted nurse staffing and patient outcomes. The 5 sites that participated in the pilot said the acuity tool was very easy to manage. The study will take place during the course of a year, starting late in 2007. It should only take about 30 minutes/month. There were 50 sites that expressed an interest in participating at the 2005 meeting but Jeanette is looking for approximately another 50 units to participate. If you are interested in finding out about the study and possibly becoming a site, please send your information to: ([rogowsje@umdnj.edu](mailto:rogowsje@umdnj.edu))

This year the MDAC said good bye to 3 valued members Sharon Nelson, Betty Campbell, and Stephanie Howard. They will be missed and we thank them for their dedication to the MDAC. With their departure, the MDAC is looking for new members. We are specifically in need of a representative from Social Work, OT/PT, and a Dietician but welcome all applicants. If you are interested in becoming a member of the MDAC, please send your resume to Cathy Sawtell ([Cathy.sawtell@atlanticealth.org](mailto:Cathy.sawtell@atlanticealth.org)) or Maureen Reilly ([Maureen.reilly@sunnybrook.ca](mailto:Maureen.reilly@sunnybrook.ca)).

If you have any ideas on how the MDAC can help your multidisciplinary team become more active in VON please let us know.

Maureen Reilly: [Maureen.reilly@sunnybrook.ca](mailto:Maureen.reilly@sunnybrook.ca)

Cathy Sawtell: [Cathy.sawtell@atlanticealth.org](mailto:Cathy.sawtell@atlanticealth.org)

Bobby Bellflower, DNSc, NNP, Memphis, TN

Rosanne Buck, RN, MS, CNNP, Boston, MA

Dianne Charsha, RNC, MSN, CRNP, St. Louis, MO

Paula Delmore, RNC, MSN, Wichita, KA  
Diane Eastman, ARNP, MA, CPNP, Iowa City, IO  
Shirley Hargreaves, RN, MBA, Abu Dhabi, UAE

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## SURVEY AND ELIGIBILITY VERIFICATION PLAN

The *2006 Membership Survey*, the *Contact Information Report* and the *Eligibility Verification Plan for 2007* for your center were e-mailed to all Team Leaders in January 2007.

It is essential that we obtain the *2006 Membership Survey* information from each participant in the 2006 database before we complete the Annual Quality Management Report (QMR) later this year. We need this survey information to be as complete as possible so we can provide a detailed and accurate description of the membership.

The *Eligibility Verification Plan* is a form that each participating center is required to fill out and update each year. The Eligibility Verification Plan indicates the data sources your center uses to identify eligible infants for the VON Database and the frequency with which these sources are reviewed to make sure that all eligible infants have been included in data submissions to the Network. Every participating center must have submitted a completed Plan, signed and dated by the center's Team Leader, before they can be included in the Annual Quality Management Report.

The *Contact Information* report is a list of the contact information we have in our files for your center. This information should be updated each year so we can keep all center files as current as possible. Each center should choose one of the noted contacts as a Team Leader. The Team Leader is the person who will be responsible for leading and coordinating all VON activities at your center. Centers wishing to change the "Report Contact" must send the Contact Information Report back with a dated and signed letter, either from the outgoing Report Contact or an authorized agent of the hospital, requesting the change. If your center wishes to change or add new Nightingale Administrators, a completed Nightingale Administrator Change Form, signed by an authorized agent of the hospital, must be received by VON before the change can be made. Please contact Nancy Cloutier at [nancy@vtoxford.org](mailto:nancy@vtoxford.org) to receive a copy of the Nightingale Administrator Change Form.

Completed 2006 Membership Surveys, Contact Information Reports and Eligibility Verification Plans should be faxed to Lynn Stillman at 802-865-9613 by April 16, 2007. Please call Lynn Stillman at 802-865-4814, ext. 211 or email Lynn at [lynn@vtoxford.org](mailto:lynn@vtoxford.org) for another copy of these documents.

## 2006 DATA FINALIZATION

The Data Processing Team (DPT), which is made up of seven Account Managers, is gearing up for the finalization process of 2006 data. With 137 foreign centers and over 500 American centers, there is a lot of data yet to be finalized and we are counting on our member hospitals to be prompt in sending in their 2006 data. We also expect the completion of all outstanding 2005 records.

Our **Data Finalization Guidelines for Infants Born In 2006** and a **Checklist** will be sent to the Data Contact at each hospital and can also be downloaded on our website [www.vtoxford.org](http://www.vtoxford.org). Any questions on this information should be addressed to your Account Manager. Account Manager contact information can be found at the end of the Data Finalization Guidelines.

All of these efforts will enable Vermont Oxford Network to produce and deliver the 2006 Vermont Oxford Network Annual Quality Management Report to centers by the fall of 2007. We can't accomplish this goal without your help. Please review the Finalization Guidelines and comply with the deadlines to facilitate a smooth closing of your 2006 data.



### 2006 DATA FINALIZATION DEADLINES REMINDER

**APRIL 1<sup>ST</sup> – COMPLETE**

**MAY 15<sup>TH</sup> – CONFIRM**

**JUNE 1<sup>ST</sup> – CORRECT**

**JUNE 15<sup>TH</sup> – CLOSE**

**IF ALL ITEMS ARE COMPLETE, CONFIRMED,  
CORRECT AND CLOSED BY JUNE 15<sup>TH</sup>, 2007,  
YOUR CENTER WILL RECEIVE THE 2006 NICU  
QUALITY MANAGEMENT REPORT (QMR) IN  
SEPTEMBER, 2007**

**PLEASE REFER TO THE VON DATA FINALIZATION  
CHECKLIST RECENTLY SENT TO DATA CONTACTS  
AT ALL PARTICIPATING CENTERS.**

## eNICQ SOFTWARE

### Over 300 Users!

As we go to press, there are more than 300 hospitals currently using **eNICQ** to collect and submit VON data. We expect this number to approach 350 by the end of 2007. Remember that **eNICQ** is free to members of the Network and includes technical support and free software upgrades.

### eNICQ versus Nightingale

There has been some confusion about these two systems. The **eNICQ** software is installed on your local computer(s) and allows your center to collect and submit VON data. Patient data is stored locally at your center, and only de-identified data is submitted to the Network. **Nightingale** is an Internet reporting system that allows you to view your center's practices and outcomes from a web browser in many different ways. The data in the Nightingale system consists of all of the data submitted by your center either in paper forms or electronically. With Nightingale, you can compare statistics at your center to the entire Network, to centers of the same NICU type and to other groups of which your center is a member. If you have questions or would like to sign up, please contact the VON Nightingale / eNICQ Coordinator, Nancy Cloutier, [nancy@vtoxford.org](mailto:nancy@vtoxford.org).

### Don't Forget to Upgrade!

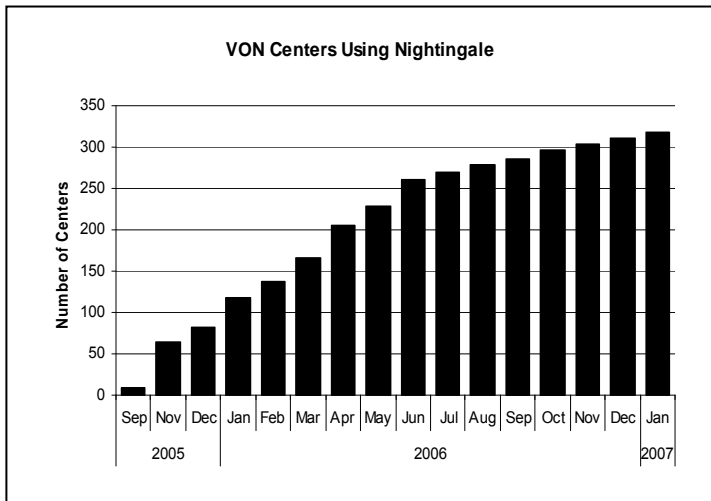
If your center uses **eNICQ** for data entry and submission, and you haven't already done so, you must upgrade your software to the latest version in order to submit data in 2007. To find the latest version, go to: <http://www.vtoxford.org/enicq/version.aspx>. Exported data files created in an **eNICQ** version less than 4.3.0 will be rejected.

### eNICQ.NET

During our Annual Meeting in December, we discussed plans to replace the current Microsoft Access version of **eNICQ** with a new version known as **eNICQ.NET**. This change is to implement features that users have requested and to provide a more flexible and stable application to meet the needs of the Network for collecting and submitting data. With **eNICQ.NET**, multiple users from your center will be able to enter data at the same time and users will be able to enter data for multiple centers from the same application. You will also have the choice of using your local SQL Server database or use the database that comes with the application. Look for the new version of eNICQ to be released in beta (test) in 2007 with full release in 2008. The plan is to support both the Access version of **eNICQ** as well as **eNICQ.NET** in 2008, with transition to **eNICQ.NET** by 2009.

## NIGHTINGALE

The number of centers using the Nightingale system continues to grow with almost 700 users from 300 + centers. We appreciate your comments and suggestions, so please let us know what you think!



A new version of Nightingale was released in January 2007 and provides several new features. Check your Nightingale home page for additional information.

- Centers participating in Nightingale groups can compare their center data to all centers in the group.
- Data on specific birth defects can be viewed in tables or charts.
- Collection of data on surgical procedures began in 2006. You can view data for surgery categories, e.g., Abdominal Surgery, Cardiac Catheterization, or you can chart or tabulate data for specific procedures.

If you would like to sign up for Nightingale please go to <http://www.vtoxford.org/tools/signup.aspx> or contact the VON Nightingale Coordinator, Nancy Cloutier, [nancy@vtoxford.org](mailto:nancy@vtoxford.org).

## WELCOME TO OUR NEWEST STAFF MEMBER!

**Jennifer Michelle** joined Vermont Oxford Network in October of 2006 as the new Reporting Specialist in the Information Technology Team. Her projects include the quarterly reports and Annual Quality Management Reports. Jennifer has a B.A. in Spanish and an M.P.H. in International Health and Epidemiology. Prior to moving to Vermont, Jennifer lived in the Dominican Republic, monitoring a health reform project. In her spare time, she plays with her dogs, Rocky and Madeleine, dances, and runs a fashion design business.

## VON GROUP REPORTING SERVICES

There is an increasing trend for members to join together in geographically and administratively based groups for the purpose of collaborative learning and improvement. Several states in the US as well as a number of countries around the world have already organized such groups. Others are exploring the possibilities or are in the process of planning. The Vermont Oxford Network is pleased to announce new reporting services to support members of such multi-hospital groups. The purpose of this article is to describe these services and explain the procedures for obtaining them.

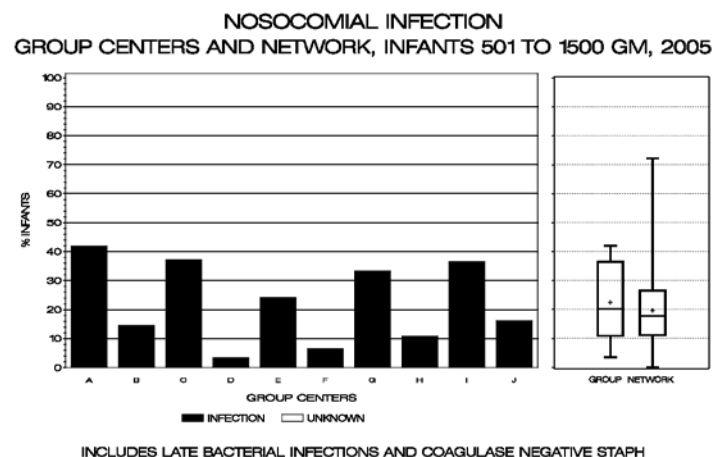
### A. Reporting Services

Once a VON group has been established, member centers will receive Detailed Group Reports and will be able to compare their center data to data at all group centers using the Nightingale Internet reporting system.

- Detailed Group Reports compare the individual centers in the group with each other, with the group, and with the Network. The reports are provided in print and/or as PDF files to each group center.

The Detailed Group Reports include tables and figures in which each center is represented by a code letter. All members of the group receive the reports, but each hospital's individual code is only known to that hospital. It is up to the hospitals to decide whether or not to disclose their code to others in the group. These reports allow members of a group to begin identifying common opportunities for improvement and participate in regional improvement efforts.

Below is an example of the data display for a 10 hospital group (labeled A to J). On the right of the figure, the Group and Network data are shown in box plots for comparison.



## 2. Nightingale Group Comparison Feature

Nightingale provides members with secure access to their hospital's data via the Internet. Hospitals choose the comparison group for Nightingale tables using a pull-down menu that lists all of the groups to which they belong. This customized menu allows hospitals to compare their data with the entire Network, with hospitals of the same NICU Type, with all US hospitals (US members only), and with hospitals in any group to which they belong. The group comparison data displayed in Nightingale includes the group mean as well as 25<sup>th</sup> and 75<sup>th</sup> percentiles for hospitals in the group. The logo for the group can be displayed on Nightingale when any member of the group logs on. This customized screen view with group logo will appear at the right side of the header on each Nightingale page. It will be seen only by members of the group.

Below is a screen shot from Nightingale showing how your group would appear in the Comparison Group menu. When selected from the menu, your group data would appear in the three right hand columns replacing the network data.

Measure	Center (2007)		Network (2005)		
	N	%	N	%	(Q1, Q3)
Early Bacterial Sepsis ?	0		41,710	2.2%	(0.0%, 3.3%)
Late Bacterial Infection ?	0		39,773	11.9%	(5.5%, 15.4%)
Coagulase Negative Staph ?	0		39,744	12.8%	(4.8%, 16.6%)
Nosocomial Bacterial Infection ?	0		39,754	21.2%	(11.6%, 26.3%)
Fungal Infection ?	0		39,722	2.3%	(0.0%, 3.3%)
Any Late Infection ?	0		39,738	22.0%	(12.5%, 27.9%)

## B. Establishing a Group

### 1. Permissions

Groups must arrange with Vermont Oxford Network to establish the group reporting features. Each hospital that will be included in the group will be required to provide the Network with written permission to be included in the group reports.

### 2. Group fees for 2007 and 2008

Groups of 5 or fewer hospitals: \$3750 per year  
 Groups of 6 to 10 hospitals: \$7500 per year  
 Groups of 11 or more hospitals: \$7500 per year + \$500 per hospital per year for hospitals over 10  
 (example: fee for 15 hospitals would be \$7500 + \$2500)

We are pleased to discuss the possibility of discounted fees for new groups to help them get started.

## NEONATAL ENCEPHALOPATHY REGISTRY UPDATE

The Vermont Oxford Network Neonatal Encephalopathy Registry was established in 2006. The Registry is now enrolling infants 36 weeks gestation or more with evidence of neonatal encephalopathy within 3 days of birth defined as presence of seizures, altered consciousness (stupor or coma), or 5 minute Apgar score of three or less. Infants who receive hypothermic therapy are also eligible for the Registry, regardless of gestational age at birth. Infants with central nervous system malformations are excluded.

Participation in the Registry is open to all members who are submitting expanded data and using the Network's free eNICQ software. eNICQ includes a special data module for the Registry with forms for neurological exam findings, neuro-imaging results, EEG/CFM monitoring results, seizures, anticonvulsant medication, and hypothermic therapy.

The Registry will allow us to characterize the population of infants with encephalopathy, evaluate variations in current practice, monitor the introduction and dissemination of new neuroprotective therapies, assess selection criteria for neuroprotective therapy, identify opportunities for improvement in the quality and safety of care for infants with encephalopathy, define important questions for clinical research, and plan prospective research and randomized trials.

Currently 44 centers have signed up and received IRB approval. Thirty-five centers have submitted data on nearly 14,000 infants born in 2006 and admitted to their NICUs. Of these, 164 infants (1.2%) meet the eligibility criteria for encephalopathy. Thirteen infants have been treated with hypothermia (6 selective head cooling, 7 whole body cooling). Of interest, 53% of the 164 infants with encephalopathy are outborn and of these outborn infants, 60% were admitted more than 6 hours after birth. Given that hypothermic treatment in the trials began within six hours of birth, there will be significant systems issues to address if outborn infants are to receive treatment within the recommended timeframe. These data are very preliminary and do not yet include all infants from participating centers. When the data for infants born in 2006 have been finalized we will do a more complete descriptive analysis of the Registry cases.

We would like to thank those centers currently participating in the Registry.

We also welcome new participants. If your center is submitting expanded data using eNICQ and would like to begin participating in the Registry in 2007, please

contact Nancy Cloutier, Registry Coordinator, for information (email: [nancy@vtoxford.org](mailto:nancy@vtoxford.org), or call Nancy at 802-865-4814, ext 208).

We view 2006 and 2007 as the pilot years for the Registry. Based on the pilot experience we will make any necessary changes and then open up enrollment to all Network members. We hope that the Registry will be a valuable resource to the neonatal community.

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### WELCOME TO OUR NEWEST MEMBERS!

Vermont Oxford Network welcomes the 89 new members who have joined the Network since February, 2006:

Adventist Hinsdale Hospital, Hinsdale, IL  
All Children's at Sarasota Memorial, Sarasota, FL  
Arlington Memorial Hospital, Arlington, TX  
Arwyp Medical Centre, Kempton Park, South Africa  
Athens Regional Medical Center, Athens, GA  
Azienda Ospedaliera Cardinale Panico, Lecce, Italy  
Azienda Ospedaliera Umberto I, Siracusa, Italy  
Centinela Freeman Reg Medical Ctr, Inglewood, CA  
Christiaan Barnard Mem. Hosp, Cape Town, So. Africa  
Clinton Hospital, Alberton, South Africa  
Community Regional Medical Center – Fresno, CA  
Constantiaberg Medi-Clinic, Plumstead, South Africa  
Christus Spohn Hosp, Corpus Christi, FL  
Evangelisches Waldkrankenhaus Spandau, Berlin, Germany  
Femina Women's Hospital, Pretoria, South Africa  
Ferncrest Hospital, Rustenburg, South Africa  
Fountain Valley Regional Hospital & Medical Center, Fountain Valley, CA  
Garden City Clinic, Mayfair West, South Africa  
George Medi-Clinic, Stellenbosch, South Africa  
Golisano Children's Hospital at Strong, Rochester, NY  
Hamot Medical Center, Erie, PA  
Henry Medical Center, Stockbridge, GA  
Hospital San Jose', Santiago, Chile  
Innovis Health, Fargo, ND  
Jeff Anderson Regional Medical Center, Meridian, MS  
Johannesburg Hospital Neonatal Unit, Johannesburg, South Africa  
King/Drew Medical Center, Los Angeles, CA  
Kingsbury Hospital, Cape Town, South Africa  
Krugersdorp Hospital, Krugersdorp, South Africa  
Kuopio University Hospital – NICU, Kuopio, Finland  
Lake Charles Memorial Hospital - Gauthier, Lake Charles, LA  
Le Bonheur Children's Medical Center, Memphis, TN  
Liverpool Women's Hospital, Liverpool, United Kingdom  
Massachusetts General Hosp. for Children, Boston, MA  
Maury Regional Hospital, Columbia, TN  
Mayo Foundation, Rochester, MN  
Neonatologia e TIN AO V. Cervillo, Palermo, Italy  
Neonatologia Ospedaliera - TINO ASO Oirm, Turin, Italy

NICU - Istituti Ospitalieri di Cremona, Cremona, Italy  
NICU - Ospedali Riuniti, Foggia, Italy  
NICU A.O.U. G. Martino Messina, Messina, Italy  
NICU- Azienda Ospedaliera St. Croce e Carle, Cuneo, Italy  
NICU Carlo Poma Hospital, Mantua, Italy  
NICU Ospedale Cardarelli, Campobasso, Italy  
NICU Ospedale Evangelico Villa Betania, Naples, Italy  
NICU Pediatric Department, Univ. of Padua, Padua, Italy  
North Devon District Hospital, Barnstaple, Devon, UK  
O'Connor Hospital - San Jose, CA  
Olivedale Clinic, Randburg, South Africa  
Ospedale Infermi Di Rimini U.O. TIN, Rimini, Italy  
Ospedale Niguarda Ca Granda, Milan, Italy  
Ospedali Riuniti Di Bergamo, Bergamo, Italy  
Paradise Valley Hospital, National City, CA  
Park Lane Clinic, Johannesburg, South Africa  
Parkview Community Hosp. Med. Ctr, Riverside, CA  
Patologia Neonatale, Camposampiero, Italy  
Patologia Neonatale Ca Foncello, Treviso, Italy  
Perrino Hospital, Neonatology, Brindisi, Italy  
Portneuf Medical Center, Pocatello, ID  
Pretoria East Hospital, Pretoria, South Africa  
Providence St. Joseph Medical Ctr, Burbank, CA  
Regional Medical Ctr of San Jose, San Jose, CA  
RMCH at Loyola University Medical Ctr, Maywood, IL  
Royal Cornwall Hosp. NHS Trust, Truro, Cornwall, UK  
Royal Devon & Exeter NHS Found. Trust, Exeter, UK  
Saddleback Memorial Medical Center, Laguna Hills, CA  
San Raffaele Hospital, Milan, Italy  
Santa Rosa Memorial Hospital, Santa Rosa, CA  
Scripps Mercy Hospital, San Diego, CA  
Singleton Hospital Neonatal Unit, Swansea, UK  
South Shore Hospital, South Weymouth, MA  
Southwest Washington Medical Center, Vancouver, WA  
St. Augustines Hospital, Durban, South Africa  
St. Bernardine Medical Center, San Bernardino, CA  
St. George Hospital, Port Elizabeth, South Africa  
St. Louis Children's Hospital, St. Louis, MO  
St. Luke's Regional Medical Center, Sioux City, IA  
Sunninghill Hospital, Rivonia, South Africa  
The Bay Hospital, Richards Bay, South Africa  
Torbay Hosp. So. Devon Healthcare NHS, Torquay, UK  
Tri-City Medical Center, Oceanside, CA  
Tripler Army Medical Center NICU, Honolulu, HI  
Unitas Hospital, Pretoria, South Africa  
University Hospital of Wales – NICU, Cardiff, UK  
Univer. of Miami - Jackson Memorial Hospital, Miami, FL  
USA Children's & Women's Hospital, Mobile, AL  
Vereeniging Medi-Clinic, Vereeniging, South Africa  
Watsonville Community Hospital, Watsonville, CA  
Windsor Regional Hospital, Windsor, Ontario, Canada

**For Quick Links to eNICQ, Nightingale, project information, downloads and much more, visit our website:**  
**[www.vtoxford.org](http://www.vtoxford.org)**

## CLINICAL TRIALS AND FOLLOW-UP PROJECTS

There is a great deal of activity to report, both in clinical trials and in our follow-up projects. The Delivery Room Management Trial continues to actively enroll infants, the Heat Loss Prevention Trial is in full swing, The Extremely Low Birth Weight Follow-up Project begins the eighth year of data collection, and the revised Parental Interview and Reporting Questionnaire survey has been tested on 400 infants.

A short summary of each of these projects follows:

### CLINICAL TRIALS

#### Delivery Room Management (DRM) Trial

As most of you know, the Delivery Room Management (DRM) Trial is perhaps the most ambitious clinical trial we have undertaken. The DRM Trial evaluates three distinct approaches to stabilization and support of premature infants at high risk of respiratory distress syndrome: intubation and surfactant treatment, intubation, surfactant treatment and rapid extubation to nasal continuous positive airway pressure (NCPAP), or NCPAP alone. Participating centers have received extensive training in NCPAP and trials methodology via web conferences prior to beginning the trial. Currently, we have 23 centers actively participating. Two new centers have joined the trial over the past year. We are nearing our next data and safety monitoring review as we enroll our 500th infant later this month.

Enrollment has been difficult for this trial, but there is a firm commitment both from VON and the participating centers to continue with enrollment. Several centers with experience in NCPAP have stepped forward and asked if they could join these efforts. We welcome new centers and are arranging for appropriate educational materials and support for those interested in joining.

Our upcoming web conference will feature Professor Colin Morley discussing the results of the recently completed COIN Trial, a study of NCPAP delivered to spontaneously breathing premature infants in the delivery room.

With these new centers and a strong commitment from our existing centers, we anticipate the DRM Trial to continue through 2007. Any center that is interested in joining this trial and has experience in Bubble CPAP please contact Karla Ferrelli at [karla@vtxford.org](mailto:karla@vtxford.org).

Congratulations and many thanks to all the centers that have progressed and are participating in this trial – this is an important but difficult and challenging

study and we appreciate your efforts and continued commitment!

#### Heat Loss Prevention Trial (HeLP)

Prevention of hypothermia is thought to be critical to survival of the smallest premature infants. The Heat Loss Prevention Trial (HeLP) is an international randomized control trial that evaluates whether polyethylene occlusive wrap applied immediately after delivery has an impact on mortality and morbidity in infants born between 24 and 28 weeks gestation. Interested participating centers are also enrolling infants born at less than 24 weeks gestation as part of a separate pilot study. The HeLP Trial is a collaborative project led by Sunnybrook Health Sciences Center in Toronto and the University of Alberta (Co-Principal Investigators, Maureen Reilly and Sunita Vohra) and coordinated by the Vermont Oxford Network. Study enrollment began in November 2004. To date over 400 infants have been enrolled.

The HeLP Trial is still looking for participating centers. If you would like more information or would like to join the HeLP Trial, please contact Maureen Reilly at [Maureen.reilly@sunnybrook.ca](mailto:Maureen.reilly@sunnybrook.ca) or 416-323-6400, ext 4598.

Issues of patient enrollment affect all of these urgent delivery room intervention studies. One approach to improving enrollment is to consider institutional consent. Institutional consent is where the institution rather than the parents grant consent to participate in the trial. Institutional consent is used in emergency situations when there is no time to approach the family for consent. The institutional consent process seems well suited for a trial such as the HeLP Trial, where the intervention, though potentially meaningful, represents a relatively small deviation from the standard of care, needs to be applied urgently, and appears to be at low risk for the treated infant. In fact, during the past year, three US NICUs applied and were granted Waiver of Consent or Institutional consent for the trial.

Of interest to centers participating in the HeLP Trial, the recently updated NRP guidelines discuss the use of wrapping premature infants immediately after delivery. The guidelines state: "if the baby is born at less than 28 weeks gestation, consider placing him, below the neck, in a reclosable polyethylene bag". The HeLP Trial was designed to examine the impact of wrapping premature infants on mortality. The trial also includes an 18 month follow up assessment to determine long term morbidity. At this point in time, we believe that there is insufficient evidence to justify the

universal adoption of this strategy. For this reason the NRP guidelines do not recommend the intervention be instituted in all infants as part of standard of care. The HeLP trial will answer this important question and will determine whether wrapping should or should not be routinely recommended for use in infants less than 28 weeks gestation.

Again, thanks to all of our participating centers for their efforts and hard work! We welcome any inquiries regarding joining the trial. A more detailed description of the study can be accessed on the VON website: <http://www.vtoxford.org/home.aspx?p=research/help/index.htm>

### **Extremely Low Birth Weight (ELBW) Infant Follow-up**

The Extremely Low Birth Weight (ELBW) Follow-up project has been collecting data on ELBW infants over the past seven years! Data collection is currently being completed on infants born during 2003 with birth weight between 400 and 1001 grams. There are 36 centers currently participating in this project. The database now contains the survival status at two years adjusted age on 5151 infants born between 1998 and 2003.

A brief snapshot of the survival status at two years adjusted age on 5,151 infants born during 1998 through 2003 is noted below. Here's what our ELBW infants look like:

Of the 5,151 surviving infants, 3,855 had neurodevelopmental evaluations conducted.

- 75% came from two-parent households
- 63% of parents had some college education
- 41% were rehospitalized after discharge
- 30% required support after discharge
- 30% required surgery

- 32% had poor weight gain
- 12% had microcephaly
- 1% had bilateral blindness
- 2% had hearing impairment requiring amplification

8% had cerebral palsy  
35% had severe disability: defined as having one of the following: cerebral palsy, inability to walk, cognitive delay, hearing loss requiring amplification, or visual impairment of bilateral blindness.

Centers with high reporting rates of follow-up (>=60%) had slightly more infants with severe disabilities 35.6% vs. 34.7% compared to centers with low reporting follow-up rates (<60%).

Want to know more? A summary of the data from the ELBW Infant Follow Up Project will soon be available to all on our Nightingale site!

Also, look for a publication on the "Neurodevelopmental Outcomes of Extremely Low Birth Weight Infants from the Vermont Oxford Network: 1998-2002" in the near future. It was recently submitted for publication. In addition, we hope to present data on the "Changes in Postnatal Steroid Use and Neurodevelopmental Outcome of Extremely Low Birth Weight Infants" at the upcoming PAS meeting in Toronto.

### **Parental Interview and Reporting Questionnaire (PIRQ)**

Current neurodevelopmental follow up of all high risk infants is difficult, incomplete and expensive. The Parental Interview and Reporting Questionnaire (PIRQ) represents an effort to create a simple questionnaire that could identify infants with serious disability. In order to test the validity of this tool, we are comparing parental perception of their child's health and developmental status (as reflected in the PIRQ) with information gained from formal medical evaluation. The questionnaire has been revised and the current interview tool has 20 structured questions and one open ended question. The PIRQ does not require a health care provider to administer. To date, we have close to 800 completed PIRQs to compare to formal neurodevelopmental evaluation. Hopefully, this tool will allow for large scale, inexpensive follow up of high risk infants that will identify the major medical and developmental issues these children encounter. Results from this revised questionnaire were presented at the VON Annual Meeting in 2006, and have been submitted for presentation at the upcoming PAS Meeting in Toronto.

#### **CONTACT US!**

**For more information on Clinical Trials and the Extremely Low Birth Weight (ELBW) Follow Up Project, the DRM Trial or the PIRQ, please contact Karla Ferrelli at 802-865-4814, ext. 212 or email [karla@vtoxford.org](mailto:karla@vtoxford.org).**

## OPPORTUNITY TO JOIN INTERNATIONAL RCT

### **Safety and efficacy of pentoxifylline in preventing progression of definite necrotising enterocolitis in preterm neonates – A randomised controlled trial (pilot phase)**

*Trial acronym: POINT*

*Registry ID: ACTRN012606000257561*

#### Inclusion criteria:

- (1) Gestation <32 weeks
- (2)  $\geq$  Stage II NEC
- (3) Informed parental consent

#### Exclusion criteria:

- (1) Failure to obtain informed parental consent
- (2) Major congenital malformation/s
- (3) Chromosomal aberration/s

Treatment groups: Standard management plus either IV pentoxifylline (study group) or placebo (control group)

#### Outcome measures:

Primary outcome for the pilot phase: Safety (significant adverse events such as death) and efficacy (reduction in plasma TNF- $\alpha$  levels) of pentoxifylline in preventing the progression of definite NEC ( $\geq$ Stage II) to Stage III and/or death.

Secondary outcomes include: Extent of bowel resection at surgery, Duration of hospital stay and total parenteral nutrition support, Time to restart and reach full enteral feeds (150mL/kg/day) after NEC

#### **Principle investigator:**

Dr Sanjay Patole

Department of Neonatal Paediatrics,

KEM Hospital for Women

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Email: Sanjay.Patole@health.wa.gov.au]

## eNICQ ONLINE SERVICES

### **The eNICQ Upgrade Center**

To obtain the most current version of the Vermont Oxford Network eNICQ Software, go to the eNICQ Upgrade Center. The Upgrade Center can be reached through the button on the version tab found in eNICQ versions 3.1.0 or greater, or directly through the following link: [www.vtoxford.org/enicq/version.aspx](http://www.vtoxford.org/enicq/version.aspx)

Instructions for performing an upgrade are available in a PDF document at the bottom of that page and can also be found in the eNICQ Online Help Files.

### **Online Help Files**

The Online Help Files contains the latest release of the eNICQ help files which are very useful in providing general user information as well as in diagnosing and resolving eNICQ user problems. Although the eNICQ software contains useful help files, the most up-to-date information is available online as the online help files are updated with new information on a regular basis. These Online Help Files can be accessed at: [www.vtoxford.org/enicq/help/enicq\\_guide.htm](http://www.vtoxford.org/enicq/help/enicq_guide.htm)

### **On-Line Support Request**

The Support Request can be submitted and processed through the following link: [www.vtoxford.org/enicq/supportrequest.aspx](http://www.vtoxford.org/enicq/supportrequest.aspx) Users will have to log in using their center number and their EDS password. The password can be found on the Administrative Form in eNICQ, listed in the 'Encryption Password' field. Requests filed through the online service will be responded to at the same speed as any other request, such as email or voicemail messages. We encourage eNICQ users to place their support requests online giving as much detail of the problem or question as possible.

**Sign up for the Nightingale Internet Reporting System and have access to view your center's data and the ability to create tables and figures similar to those in the annual Quality Management Report!**

Go to: [www.vtoxford.org](http://www.vtoxford.org) for more information and to sign up  
or email Nancy Cloutier at: [nancy@vtoxford.org](mailto:nancy@vtoxford.org)

*Nightingale*