Supplemental Data Items - *For Infants Born in 2019*
(For Expanded Data Submitting Centers)

Center Number: _____ **Network ID Number:** ☐☐☐☐☐ **Year of Birth:** _____

Previously Discharged Home: ☐ Yes ☐ No ☐ Unknown

Duration of Assisted Ventilation:
☐ None ☐ <4 hours ☐ 4-24 hours ☐ > 24 hours ☐ N/A
If > 24 hours, Total Days of Assisted Ventilation: _____

ECMO at your Hospital: ☐ Yes ☐ No ☐ N/A

Hypothermic Therapy at Your Hospital:
Was Hypothermic Therapy Performed at Your Hospital: ☐ Yes ☐ No
***If Yes*, Hypothermic Therapy Cooling Method**: ☐ Selective Head ☐ Whole Body ☐ Both

Hypoxic-Ischemic Encephalopathy: ☐ Yes ☐ No ☐ N/A
HIE Severity (check one): ☐ Mild ☐ Moderate ☐ Severe ☐ N/A

Meconium Aspiration Syndrome: ☐ Yes ☐ No

Tracheal Suction for Meconium Attempted during Initial Resuscitation: ☐ Yes ☐ No ☐ N/A

Seizures: ☐ Yes ☐ No ☐ N/A

Center Number:_____ **Network ID Number:** ☐☐☐☐☐

VERMONT OXFORD NETWORK
PATIENT DATA BOOKLET FOR INFANTS BORN IN 2019

This Worksheet contains protected health care information and must NOT be submitted to Vermont Oxford Network (VON). VON only accepts protected health care information in cases where members have both voluntarily elected to send this information to VON and have signed an appropriate Business Associate Agreement with VON.

Contents:

PATIENT IDENTIFICATION WORKSHEET

Patient's Name: _____

Mother's Name: _____

Patient's Medical Record Number: _____

Date of Birth: ____/____/____ (MM DD YYYY)

Date of Admission: ____/____/____ (MM DD YYYY)
For inborn infants, the date of admission is the Date of Birth.
For outborn infants, the date of admission is the date the infant was admitted to your hospital.

Date of Day 28: ____/____/____ (MM DD YYYY)

Date of Week 36: ____/____/____ (MM DD YYYY)

} Use the Calculation Charts for Date of Day 28 and Date of Week 36 for the infant's birth year.

Date of Initial Disposition: ____/____/____ (MM DD YYYY)

If Infant Transferred: Date Discharged Home, Died, or First Birthday (if still hospitalized), whichever is soonest: ____/____/____ (MM DD YYYY)

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

Center Number:_____ **Network ID Number:** ☐☐☐☐☐

LENGTH OF STAY CALCULATION WORKSHEET FOR INFANTS BORN IN 2019

Protected Health Care Information. *DO NOT SUBMIT this Worksheet to Vermont Oxford Network.*
Use items *Date of Admission*, *Date of Initial Disposition*, and *Date of Transfer/Discharge Home/Death/First Birthday* from the Patient Identification Worksheet when completing this form.
Find day numbers corresponding to dates using the Day Number Chart for 2019-20 (www.vtoxford.org/downloads).

Part A. Initial Length Of Stay

Enter Date of Initial Discharge, Transfer, or Death (Date of Initial Disposition): ____/____/____ ☐☐☐ Day #

Subtract Date of Admission to Your Hospital (Date of Admission): ____/____/____ **–** ☐☐☐ Day #

For inborn infants, the date of admission is the Date of Birth.
For outborn infants, the date of admission is the date the infant was admitted to your hospital. ☐☐☐

Add 1: **+** 1

INITIAL LENGTH OF STAY = ☐☐☐ **Days**

Note: the maximum value of Initial Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

Part B. Total Length Of Stay

Only For Infants Transferred From Your Hospital to Another Hospital.

Enter Date of Final Discharge or Death (Transferred/Home/Died/1st Birthday): ____/____/____ ☐☐☐ Day #

Subtract Date of Admission (Date of Admission): ____/____/____ **–** ☐☐☐ Day #

For inborn infants, the date of admission is the Date of Birth.
For outborn infants, the date of admission is the date the infant was admitted to your hospital. ☐☐☐

Add 1: **+** 1

TOTAL LENGTH OF STAY = ☐☐☐ **Days**

Note: the maximum value of Total Length of Stay is 366 (or 367 if leap day must be added), because tracking ends on the infant's first birthday.

SAMPLE CALCULATION OF INITIAL LENGTH OF STAY

Enter Date of Initial Discharge, Transfer, or Death: **02 / 26 / 2019** ☐5☐7 Day #

Subtract Date of Admission: **01 / 13 / 2019** **–** ☐1☐3 Day #

☐4☐4

Add 1: _____ **+** 1

INITIAL LENGTH OF STAY = _____ ☐4☐5 **Days**

Explanation: Date of 02/26/2019 is Day Number 57. Date of 01/13/2019 is Day Number 13. The day numbers for each date are found in the 2019-2020 Day Number Chart on the Network web site, **www.vtoxford.org/downloads**.

PLEASE DO NOT SUBMIT THIS WORKSHEET
Protected Health Care Information

Transfer & Readmission Data Items - *For Infants Born in 2019*

Center Number: _____ **Network ID Number:** ☐☐☐☐☐ **Year of Birth:** _____

Part A. Complete for ALL Transferred Infants

If an infant is transferred to another hospital, complete Data Items *Reason for Transfer*, *Transfer Code of Center to which Infant Transferred*, and *Post Transfer Disposition* (below). Post Transfer Disposition refers to the infant's disposition upon leaving the "transferred to" hospital.

Reason for Transfer: (Check Only One)
☐ Growth/Discharge Planning ☐ Medical/Diagnostic Services ☐ Surgery ☐ ECMO ☐ Chronic Care ☐ Other

Transfer Code of Center to which Infant Transferred: _____ (List available at https://www.vtoxford.org/tools/transferlist.aspx)

Post Transfer Disposition (check only one):

☐ Home	*Skip Parts B and C. Complete Part D.*
☐ Transferred Again to Another Hospital (2nd Transfer)	*Skip Part B. Complete Parts C and D when data are available.*
☐ Died	*Skip Parts B and C. Complete Part D.*
☐ Readmitted to Any Location in Your Hospital	*Complete Parts B and D (and C if applicable) when data are available.*
☐ Still Hospitalized as of First Birthday	*Skip Parts B and C. Complete Part D.*

Part B. Complete ONLY for Readmitted Infants

If a patient is readmitted to your center after transferring once to another hospital without having been home, answer Data Items *Disposition after Readmission* and *Weight at Disposition after Readmission* (below).

When infants are readmitted to your center, continue to update Items *Bacterial Sepsis and/or Meningitis on or before Day 3* through *PIH, Where First Occurred* and Items *Oxygen after Initial Resuscitation* through *Monitor at Discharge* based on all events at both hospitals until the date of Disposition after Readmission.

If your hospital participates in the Expanded Database and definition criteria are met, update Data Items *ECMO at your Hospital*, *Hypothermic Therapy at Your Hospital*, *Cooling Method*, *Hypoxic-Ischemic Encephalopathy*, *HIE Severity*, and *Seizures* based on events that occur following transfer and readmission.

Disposition after Readmission (check only one):

☐ Home	*Skip Part C. Complete Part D.*
☐ Died	*Skip Part C. Complete Part D.*
☐ Transferred Again to Another Hospital	*Complete Parts C and D when data are available.*
☐ Still Hospitalized as of First Birthday	*Skip Part C. Complete Part D.*

Weight at Disposition after Readmission: _____ grams

Part C. Complete ONLY for Infants Who Transferred More Than Once

Answer *Ultimate Disposition* if an infant transferred from your center to another hospital and was then either (1) transferred again to another hospital, or (2) readmitted to your center and then transferred again to another hospital.

Ultimate Disposition (check only one):

☐ Home	*Complete Part D.*
☐ Died	*Complete Part D.*
☐ Still Hospitalized as of First Birthday	*Complete Part D.*

Part D. Complete for ALL Transferred Infants

Complete *Total Length of Stay* when the infant has been discharged Home, Died, or is Still Hospitalized as of First Birthday, whichever comes first.

Total Length of Stay: _____day(s) (Data Item *Total Length of Stay* on Length of Stay Calculation Worksheet)

Coagulase Negative Staph Infection after Day 3: ☐ Yes ☐ No ☐ N/A

***If Yes*, Coagulase Negative Staphylococcal Infection after Day 3, Where Occurred:** ☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Fungal Infection after Day 3: ☐ Yes ☐ No ☐ N/A

***If Yes*, Fungal Infection after Day 3, Where Occurred:** ☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Cystic Periventricular Leukomalacia: ☐ Yes ☐ No ☐ N/A (See Manual of Operations, Part 2 for N/A criteria)

ROP, Retinal Examination ☐ Yes ☐ No

***If Yes*, Worst Stage of ROP** (0-5): _____

Congenital Anomaly: ☐ Yes ☐ No

***If Yes*, enter up to five Congenital Anomaly Codes:** ___ ___ ___ ___ ___ ___

See Manual of Operations, Part 2 – Appendix C for Congenital Anomaly Codes.

***If Yes*, as needed, include description(s) for Codes 100, 504, 601, 605, 901, 902, 903, 904, and 907:**

_____

_____

Enteral Feeding at Discharge:

- ☐ None
- ☐ Human Milk Only
- ☐ Formula Only
- ☐ Human milk in combination with either fortifier or formula

Oxygen, Respiratory Support, and Monitor at Discharge:

- **Oxygen at Discharge:** ☐ Yes ☐ No
- **Conventional Ventilation at Discharge:** ☐ Yes ☐ No
- **High Frequency Ventilation at Discharge:** ☐ Yes ☐ No
- **High Flow Nasal Cannula at Discharge:** ☐ Yes ☐ No
- **Nasal Ventilation at Discharge:** ☐ Yes ☐ No
- **Nasal CPAP at Discharge:** ☐ Yes ☐ No
- **Monitor at Discharge:** ☐ Yes ☐ No

Initial Disposition (check only one):

- ☐ Home
- ☐ Died
- ☐ Transferred to another Hospital (When this Disposition is chosen, also complete Transfer & Readmission Data Items)
- ☐ Still Hospitalized as of First Birthday

Weight at Initial Disposition: _____ grams

Head Circumference at Initial Disposition (in cm to nearest 10th): ☐☐.☐

Initial Length of Stay: _____ day(s) (Data Item *Initial Length of Stay* on Length of Stay Calculation Worksheet)

General Data Items - *For Infants Born in 2019*

Vermont Oxford Network

Center Number: _____ Network ID Number: ☐☐☐☐☐ Year of Birth: _____

Birth Weight: _____ grams

Gestational Age Weeks: _____ **Gestational Age Days (0-6):** _____

Died in Delivery Room: ☐ Yes ☐ No (***If Yes*, complete Delivery Room Death Data Items**)

Location of Birth: ☐ Inborn ☐ Outborn

If Outborn, Day of Admission to Your NICU (Range: 1 to 28. Date of Birth is Day 1): _____

If Outborn, Transfer Code of Center from which Infant Transferred: _____

(List available at http://www.vtoxford.org/transfers)

Head Circumference at Birth (in cm to nearest 10th): ☐☐.☐

Maternal Ethnicity/Race (Answer both Ethnicity and Race):

Ethnicity of Mother: ☐ Hispanic ☐ Not Hispanic

Race of Mother: ☐ Black or African American ☐ White ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Prenatal Care: ☐ Yes ☐ No

Antenatal Steroids: ☐ Yes ☐ No

Antenatal Magnesium Sulfate: ☐ Yes ☐ No

Chorioamnionitis: ☐ Yes ☐ No

Maternal Hypertension, Chronic or Pregnancy-Induced: ☐ Yes ☐ No

Maternal Diabetes ☐ Yes ☐ No

Mode of Delivery: ☐ Vaginal ☐ Cesarean Section

Sex of Infant: ☐ Male ☐ Female ☐ Unknown

Multiple Gestation: ☐ Yes ☐ No ***If Yes*, Number of Infants Delivered:** _____

Congenital Infection: ☐ Yes ☐ No

Congenital Infection, Organism(s): _____ _____ _____

(If *Congenital Infection* is *Yes*, enter up to three Congenital Infection codes from Manual of Operations, Part 2 – Appendix E)

APGAR Scores: **1 minute** _____ **5 minutes** _____

Initial Resuscitation:

- **Oxygen:** ☐ Yes ☐ No
- **Face Mask Vent:** ☐ Yes ☐ No
- **Laryngeal Mask Airway:** ☐ Yes ☐ No
- **Endotracheal Tube Vent:** ☐ Yes ☐ No
- **Epinephrine:** ☐ Yes ☐ No
- **Cardiac Compression:** ☐ Yes ☐ No
- **Nasal Vent:** ☐ Yes ☐ No
- **Nasal CPAP:** ☐ Yes ☐ No

Temperature Measured within the First Hour after Admission to Your NICU: ☐ Yes ☐ No ☐ N/A

***If Yes*, Temperature Within the First Hour after Admission to Your NICU:** ☐☐.☐

(In degrees *centigrade* to nearest 10th)

Died Within 12 Hours of Admission to Your NICU: ☐ Yes ☐ No

Center Number: _____ Network ID Number: ☐☐☐☐☐ Year of Birth: _____

Bacterial Sepsis and/or Meningitis on or before Day 3: ☐ Yes ☐ No

Bacterial Sepsis and/or Meningitis on or before Day 3, Pathogen(s): _____ _____ _____
(If *Bacterial Sepsis and/or Meningitis* is *Yes*, enter up to three Bacterial Pathogen codes from Manual of Operations, Part 2 – Appendix B)

Oxygen on Day 28: ☐ Yes ☐ No ☐ N/A (See Manual of Operations, Part 2 for N/A criteria)

Periventricular-Intraventricular Hemorrhage (PIH):
Cranial Imaging (US/CT/MRI) on or before Day 28: ☐ Yes ☐ No
If Yes, Worst Grade of PIH (0-4): _____
If PIH Grade 1-4, Where PIH First Occurred: ☐ Your Hospital ☐ Other Hospital

Respiratory Support (at any time after leaving the delivery room/initial resuscitation area):
Oxygen after Initial Resuscitation: ☐ Yes ☐ No
Conventional Ventilation after Initial Resuscitation: ☐ Yes ☐ No
High Frequency Ventilation after Initial Resuscitation: ☐ Yes ☐ No
High Flow Nasal Cannula after Initial Resuscitation: ☐ Yes ☐ No
Nasal Ventilation after Initial Resuscitation: ☐ Yes ☐ No

Nasal CPAP after Initial Resuscitation: ☐ Yes ☐ No
Nasal CPAP or Nasal Vent before or without ever having received ETT Vent: ☐ Yes ☐ No ☐ N/A

Surfactant during Initial Resuscitation: ☐ Yes ☐ No
Surfactant at Any Time: ☐ Yes ☐ No (*Surfactant at Any Time* must be *Yes* if *Surfactant During Initial Resuscitation* is *Yes*)
***If Yes*, Age at First Dose of Surfactant:** Hours _____ Minutes (0-59) _____

Inhaled Nitric Oxide: ☐ Yes ☐ No
***If Yes*, Inhaled Nitric Oxide, Where Given:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Respiratory Support at 36 Weeks (See Manual of Operations, Part 2 for N/A criteria):
Oxygen at 36 Weeks: ☐ Yes ☐ No ☐ N/A
Conventional Ventilation at 36 Weeks: ☐ Yes ☐ No ☐ N/A
High Frequency Ventilation at 36 Weeks: ☐ Yes ☐ No ☐ N/A
High Flow Nasal Cannula at 36 Weeks: ☐ Yes ☐ No ☐ N/A
Nasal Ventilation at 36 Weeks: ☐ Yes ☐ No ☐ N/A
Nasal CPAP at 36 Weeks: ☐ Yes ☐ No ☐ N/A

Steroids for CLD: ☐ Yes ☐ No
***If Yes*, Steroids for CLD, Where Given:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Indomethacin for Any Reason: ☐ Yes ☐ No

Ibuprofen for PDA: ☐ Yes ☐ No

Acetaminophen (Paracetamol) for PDA: ☐ Yes ☐ No

Probiotics: ☐ Yes ☐ No

Treatment of ROP with Anti-VEGF Drug: ☐ Yes ☐ No

Caffeine for Any Reason: ☐ Yes ☐ No

Intramuscular Vitamin A for Any Reason: ☐ Yes ☐ No

General Data Items - *For Infants Born in 2019*

Center Number: _____ Network ID Number: ☐☐☐☐☐ Year of Birth: _____

ROP Surgery: ☐ Yes ☐ No
***If Yes*, ROP Surgery, Where Done:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Surgery or Interventional Catheterization for Closure of PDA: ☐ Yes ☐ No
(*If Yes*, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

Surgery for NEC, Suspected NEC, or Bowel Perforation: ☐ Yes ☐ No
(*If Yes*, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

Other Surgery: ☐ Yes ☐ No
(*If Yes*, a Surgery Code, Location of Surgery, and an answer to Surgical Site Infection are required below)

If *Yes* to *Surgery for Closure of PDA, Surgery for NEC*, or *Other Surgery*, enter up to 10 Surgery Codes, Locations of Surgery, and check Yes or No for Surgical Site Infection following Surgery at Your Hospital:
See Manual of Operations, Part 2 – Appendix D for Surgery Codes.
If *Surgery for NEC* is *Yes*, one or more of the following codes is required: S302, S303, S307, S308, S309, S333.
Indicate *Location of Surgery* for each surgery code.
If a surgical site infection is present, indicate "Yes" for the one surgical code that resulted in the surgical site infection.

Surgery Code 1: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 2: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 3: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 4: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 5: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 6: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 7: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 8: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 9: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No
Surgery Code 10: _____	☐ Your Hospital	☐ Other Hospital	☐ Both	Surgical Site Infection:	☐ Yes ☐ No

Include description for Surgery Codes S100,S200,S300,S400,S500,S600,S700,S800,S900,S1000, and S1001:

_____

_____

_____

Respiratory Distress Syndrome: ☐ Yes ☐ No

Pneumothorax: ☐ Yes ☐ No
***If Yes*, Pneumothorax, Where Occurred:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Patent Ductus Arteriosus: ☐ Yes ☐ No

Necrotizing Enterocolitis: ☐ Yes ☐ No
***If Yes*, NEC, Where Occurred:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Focal Intestinal Perforation: ☐ Yes ☐ No
***If Yes*, Focal Intestinal Perforation, Where Occurred:** ☐ Your Hospital ☐ Other Hospital ☐ Both

Sepsis and/or Meningitis, Late (after day 3 of life) (See Manual of Operations, Part 2 for N/A criteria):
Bacterial Sepsis and/or Meningitis after Day 3: ☐ Yes ☐ No ☐ N/A
***If Yes*, Bacterial Sepsis and/or Meningitis after Day 3, Where Occurred:**
☐ Your Hospital ☐ Outside Your Hospital ☐ Both

Bacterial Sepsis and/or Meningitis after Day 3, Pathogen(s): _____ _____ _____
(If *Bacterial Sepsis and/or Meningitis* is *Yes*, enter up to three Bacterial Pathogen codes from Manual of Operations, Part 2 – Appendix B)