FACILITY DATA SHEET

Date: _____

Facility Legal Name _____

Name of person supplying this data _____

Phone # for person supplying data _____

Email address for person supplying data _____

MATERNITY CARE SERVICES

Description of Facility Provided Prenatal Services:

1) Does the facility provide prenatal care or prenatal services? ☐ Yes ☐ No

2) If yes, what statement best describes these services:
   ☐ Prenatal care is provided by facility employees at facility owned property
   ☐ Prenatal care is provided by facility employees at property NOT owned by facility
   ☐ Prenatal care is provided by an independent health care group/physicians at facility owned property
3) How many locations are prenatal services offered by either facility employees or on facility owned property? _____

4) List the names, addresses, the approximate distance from your primary birthing facility and the approximate annual # of prenatal women served at each prenatal for of all of the above affiliated prenatal services.

NAME OF AFFIATED PRENATAL SERVICE	ADDRESS	DISTANCE IN MILES FROM PRIMARY BIRTHING FACILITY	# OF PRENATAL WOMEN SERVED ANNUALLY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10,			

5) Please provide an estimate of the percentage of women who deliver at the hospital and receive prenatal care provides by the facility? _____%

6) Please provide an estimate of the percentage of women who arrive at the facility without having any prenatal care? _____%

7) Does the facility offer any prenatal breastfeeding education classes? ☐ Yes ☐ No
   Please list:

8) Does the facility offer any prenatal breastfeeding education through tours or other alternative means? ☐ Yes ☐ No
Please list:

FACILITY CENSUS DATA:

Description of Facility Inpatient Birthing/Newborn Mother/Baby Services:

9) Total Beds in Hospital _____

10) Are all birthing and newborn mother/baby services operating under the facility license provided at a single location? ☐ Yes ☐ No

11) If no, how many locations are birthing and newborn mother/baby services operating under the facility license provided at? _____

12) LIST THE NAMES. ADDRESSES OF ALL BIRTHING AND NEWBORN MOTHER/BABY SERVICES OPERATING UNDER THE FACILITY LICENSE

NAME OF BIRTHING/POST PARTUM SERVICES	ADDRESS
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

13) **NUMBER OF BEDS** *(please complete all; enter 0 where applicable)*

_____ In LDRP Area
_____ In Labor and Delivery Area
_____ In Post Partum Area
_____ Mother/Baby Care (couplet care)
_____ Special Care/NICU (Level)

14) **NUMBER OF BIRTHS:**

Total deliveries in prior year (20_____) _____
_____ Were By Cesarean Section _____ % Cesarean

15) **NUMBER OF STAFF RESPONSIBLE FOR CARING FOR NEW MOTHERS AND BABIES** *(please complete all; enter 0 where applicable)*

_____ Nurses
_____ Midwives
_____ Dietitians/nutritionists
_____ Lactation consultants/counselors
_____ Pediatricians
_____ Obstetricians
_____ Family Practitioners
_____ Residents
_____ Advanced Practice RNs
_____ Physician Assistants
_____ _____

INFANT FEEDING INFORMATION

16) Data Obtained: Month_____ Year _____

17) Please indicate data collection method used to complete questions 18, 19 and 20. Check all boxes that apply.

☐ Records
☐ Birth Certificate
☐ Tally at Discharge
☐ Method estimated by _____
☐ Other _____

18) **Breastfeeding Initiation Rates**

A. _____ # All mother/infant pairs discharged in the past month.
B. _____ # All mother/infant pairs initiating breastfeeding in the past month
C. _____ % Breastfeeding initiation rate *(Will be automatically calculated online using B/A x 100)*

19) **Exclusive Breastfeeding Rates**
Calculate rates for D thru H in accordance with the eligibility criteria for exclusive breastfeeding and exclusive breast milk feeding (which includes acceptable medical reasons for exclusion) found on page 15 of the BFUSA Guidelines and Evaluation Criteria.

D. _____# Total infants that meet the eligibility criteria for exclusive breastfeeding as defined above in the past month.
E. _____# Mother/infant pairs exclusively breastfeeding from birth until discharge in the past month.
F. _____% Mother/infant pairs exclusively breastfeeding from birth until *discharge (Will be automatically calculated online using E/D*100)*

20) **Education Regarding Formula Supplementation**
G. _____# Infants who have been given formula in response to fully educated parental request in the past month.
H. _____% Infants who have been given formula in response to fully educated parental request *(Will be automatically calculated online using [G/(D-E) *100])*

21) **Are you Joint Commission Accredited?** ☐ Yes ☐ No *(Please note: this question is required. It is asked for statistical purposes only. Your answer does not impact your participation in the Baby-Friendly Hospital Initiative.)*

PLEASE NOTE: QUESTIONS 22-31 ARE ALL OPTIONAL

JOINT COMMISSION EXCLUSIVE BREAST MILK FEEDING RATE

22) Does the facility collect data that calculates the Exclusive Breastmilk feeding rate according to the Joint Commission? ☐ Yes ☐ No

A. If yes, what is that rate? _____ (*Use time period submitted in question #16 to determine rate)*

B. If no, what is that rate?_____
Please describe your calculation method (numerator/denominator):

MATERNITY PRACTICES IN INFANT NUTRITION AND CARE (mPINC) [1]

23) Has the facility submitted data to the CDC for the mPINC survey? ☐ Yes ☐ No

24) If yes, what was the facility mPINC score? _____
24b) What year does this score apply to? _____

HEALTHY PEOPLE 2020 GOALS[2]

25) **Does the facility collect data that compares to the Healthy People 2020 Goals?**
☐ Yes ☐ No

MICH-21 Increase proportion of Infants being breastfed (any breastfeeding at all)

26) _____# Mother/infant pairs with any breastfeeding at discharge in the past month
27) _____% Mother/infant pairs with any breastfeeding at discharge in the past month

MICH-23 Reduce the proportion of breastfed infants who receive formula supplementation within the first 2 days of life.

(This formula supplementation rate for your facility may be compared to CDC data)

28) _____# breastfed Infants discharged in the past month who had received at least 1 formula feed before 2 days old
29) _____% breastfed Infants discharged in the past month who had received at least 1 formula feed before 2 days old

PAYOR INFORMATON

30) Does the facility collect data about payer information for maternity care services?
☐ Yes ☐ No
31) If YES, please provide the number of births per insurance type: *(use time period submitted in question #16)*
_____ Medicaid
_____ Private Health insurance
_____ No Insurance
_____ Other

[1] mPINC is a national survey of maternity practices conducted with all birthing facilities throughout the US by the Center for Disease Control in partnership with Battelle Centers for Public Health Research and Evaluation. Individual reports are mailed to each participating facility. mPINC reports for each state may be found at http://www.cdc.gov/breastfeeding/data/mpinc/index.htm

[2] Healthy People 2020: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26