



FPQC Neonatal Abstinence Syndrome (NAS) Initiative Data Collection Sheet

INCLUSION CRITERIA													
NAS	<input type="checkbox"/> Infant w/ NAS signs	<input type="checkbox"/> Infant req. treatment in the hospital beyond observation period	Admit type					<input type="checkbox"/> Inborn	<input type="checkbox"/> Transfer in				
ON INFANT ADMISSION													
DOB	MM/DD/YY	DOA	MM/DD/YY	GA	Weeks	Days	BW	grams					
Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Mother's Race	<input type="checkbox"/> White	Barriers to visitation			<input type="checkbox"/> Incarcerated					
Type of insurance	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Private		<input type="checkbox"/> Black				<input type="checkbox"/> Inpatient MAT					
	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Unknown		<input type="checkbox"/> Asian				<input type="checkbox"/> Adoption					
Enrolled in MAT at delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Foster care	<input type="checkbox"/> Supervised visits req.	<input type="checkbox"/> None	<input type="checkbox"/> Other:					
MAT at delivery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Mother's Ethnicity	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:					
DRUG EXPOSURE													
<input type="checkbox"/> Mom / Infant +ve lab confirmation of opioid				<input type="checkbox"/> Mom +ve opioid history									
Select any of the following if there is a maternal history OR positive maternal lab confirmation OR positive infant lab confirmation													
<input type="checkbox"/> Methadone	<input type="checkbox"/> Subutex (Buprenorphine)	<input type="checkbox"/> Suboxone (Buprenorphine/Naloxone)	<input type="checkbox"/> Other opioid	<input type="checkbox"/> Benzodiazepine	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> PCP	<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Cocaine	<input type="checkbox"/> SSRI	<input type="checkbox"/> Tobacco	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Other:
DURING INFANT ADMISSION													
INFANT NUTRITION													
MOM contraindicated								<input type="checkbox"/> Yes	<input type="checkbox"/> No				
MOM by DOL 3	<input type="checkbox"/> Yes	<input type="checkbox"/> Transferred ≥DOL 3	<input type="checkbox"/> No	<input type="checkbox"/> Not documented	Any MOM at initial disposition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not documented					
PHARMACOLOGIC TREATMENT													
Pharmacologic treatment received								<input type="checkbox"/> Yes	<input type="checkbox"/> No				
		1st line	2nd line	3rd line	Start date	Stop date							
Morphine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Methadone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Phenobarbital		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Clonidine		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Initiation correct	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to admit	EACH weaning opportunity correct				<input type="checkbox"/> Yes	<input type="checkbox"/> No				
First dose correct	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Prior to admit					<input type="checkbox"/> Documentation inconclusive	<input type="checkbox"/> No wean before initial disposition				
Rooming-in (# of days where a caregiver was present for at least 6 hours per day): _____ days													
ON INITIAL DISPOSITION													
Discharged when medically cleared	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date medically cleared					MM/DD/YY					
			Date initial disposition					MM/DD/YY					
Reason for delayed discharge	<input type="checkbox"/> Caregiver related	<input type="checkbox"/> Hospital related	<input type="checkbox"/> DCF related	<input type="checkbox"/> Other:	Safe discharge plan								
					Caregiver education provided	<input type="checkbox"/> Safe sleep	<input type="checkbox"/> Postpartum depression	<input type="checkbox"/> Shaken baby syndrome	<input type="checkbox"/> Expectations of hospital stay				
Initial disposition	<input type="checkbox"/> Mother	<input type="checkbox"/> Father/family member	<input type="checkbox"/> Foster	<input type="checkbox"/> Adoption	<input type="checkbox"/> Transfer to another hospital	DCF report filed	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
						DCF discharge clearance determined	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
						Pediatrician appointment	<input type="checkbox"/> Scheduled	<input type="checkbox"/> Instructed					
Discharged outside FL	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Early Steps Referral	<input type="checkbox"/> Not offered	<input type="checkbox"/> Caregiver declined	<input type="checkbox"/> Referral made	Healthy Start Referral	<input type="checkbox"/> Not offered	<input type="checkbox"/> Caregiver declined	<input type="checkbox"/> Referral made			

FPQC Neonatal Abstinence Syndrome (NAS) Initiative Data Collection Definitions

Collect data on all infants with: 1) NAS signs AND 2) Infant requires treatment (nonpharmacologic or pharmacologic) > observation period

INCLUSION CRITERIA

NAS: Select all options that apply (Mom +ve history, Mom +ve drugs, Infant w/NAS signs, Infant req. treatment)

- **Infant w/NAS signs:** Infant has clinical signs not explained by another etiology (e.g., sepsis, intracranial hemorrhage, hypoglycemia). For details of symptoms, see FPQC NAS Definition algorithm located in the FPQC NAS toolkit.
- **Infant req. treatment:** Infant's severity of signs requires treatment for withdrawal with initial hospitalization for palliative non-pharmacologic care and/or pharmacologic treatment that extends beyond the facility's recommended observation period.

Admit type: Select one option that applies: **Inborn** (NAS infant is born in the hospital completing this data form) or **Transfer in** (NAS infant is transferred to the hospital completing this data form).

ON INFANT ADMISSION

DOB: Infant's date of birth. Collect in MM/DD/YY format.

DOA: Infant's date of admission to the unit managing NAS signs. Collect in MM/DD/YY format.

GA: Infant's birth gestational age. Collect in weeks and days. Infants must be ≥ 37 0/7 weeks to be included.

BW: Infant's birth weight. Collect in grams.

Type of insurance: Mother's insurance type as documented in the medical record.

MAT: Mother is enrolled in medication-assisted treatment (MAT) at the time of infant's birth.

Race & Ethnicity: Mother's race and ethnicity as documented in the medical record.

Barriers to visitation: Select any barrier that applies at any point in the infant's hospitalization. Mother is **incarcerated**, receiving **inpatient MAT**, **adoption**, **foster care** placement, or **supervised visits required**. Select and describe any other barriers to visitation that mother may have.

DRUG EXPOSURE

Mom / Infant +ve lab confirmation of opioid: Mom or infant have positive laboratory confirmation of opioid-containing drug(s).

Mom +ve opioid history: Mom has a positive history of recent use of opioid-containing drugs (prescription or illicit).

Select any that apply for the listed drugs (illicit or prescribed) based on maternal report or drug screen (mother, infant).

DURING INFANT ADMISSION

MOM contraindicated: Based on your hospital's policy or guideline, breastfeeding or mother's own milk (MOM) is contraindicated.

MOM by DOL 3: Infant received any mother's own milk (MOM) on day of life (DOL) 3. Day of birth is counted as DOL 0. MOM can be provided as expressed breast milk or breastfeeding. Skip this measure if breastfeeding or MOM is contraindicated, mother is incarcerated or inpatient MAT, infant is to be adopted or placed in foster care.

Any MOM at initial disposition: Infant received any mother's own milk (MOM) on initial disposition. Skip this measure if breastfeeding or MOM is contraindicated, mother is incarcerated or inpatient MAT, infant is to be adopted or placed in foster care.

Pharmacologic treatment: If no medication was administered for NAS management, skip this section.

- Check the box if any of the listed medications were administered to the infant for NAS management. Note if the medication was administered as a 1st, 2nd, or 3rd line medication, as well as the start and stop date(s) for each medication. If the infant is discharged on any of the listed medications, the stop date is the discharge date.

- **Initiation correct:** Infant was started on 1st line medication when treatment threshold was met, per your hospital's guideline. If infant was already started on medication prior to transfer to your hospital, select **prior to admit**.

- **1st dose correct:** Infant was started on 1st line medication at the correct dose, per your hospital's guideline. If infant was already started on medication prior to transfer to your hospital, select **prior to admit**.

- **EACH weaning opportunity correct:** Infant met ALL opportunities to be weaned per your hospital's guideline from "capture" to medication discontinuation or initial disposition (whichever comes first). Capture is defined as the time from peak dose of the the last added medication to 1st wean. Skip this measure if initial disposition happens before medication weaning occurs.

Rooming-in: Number of days during infant's hospitalization, when a parent, other caregiver, or hospital "cuddler" visits with the infant for greater than or equal to 6 hours per day. This may occur at the infant's bedside and does not require a private room.

ON INITIAL DISPOSITION

Discharged when medically cleared: Infant was discharged timely after medically cleared for discharge.

Date medically cleared: Date when the infant was medically cleared. Collect in MM/DD/YY.

Reasons for delayed discharge: If the infant was not discharged timely after medically cleared, select the reason related to the delay.

Date of initial disposition: Date of infant's initial disposition. Collect in MM/DD/YY format.

Initial disposition: This is the infant's initial disposition from the hospital completing this form. Select the option that applies.

Discharged outside FL: the infant is being discharged outside the state of Florida.

Outpatient NAS med: An outpatient medication for NAS was prescribed at hospital discharge.

Safe discharge care plan: Select all options that apply: **Education provided** to the caregiver on safe sleep, shaken baby syndrome, postpartum depression, NAS signs and nonpharmacologic techniques, and expectations of hospital stay; **DCF report filed**; **DCF discharge clearance determined**; **Pediatrician appointment made** within 3 business days of infant discharge prior to hospital discharge. **Early Steps referral status** made prior to hospital discharge; **Healthy Start referral status** made prior to hospital discharge.