Data-Driven Improvement: Metrics Overview

Estefania Rubio, MD, MPH

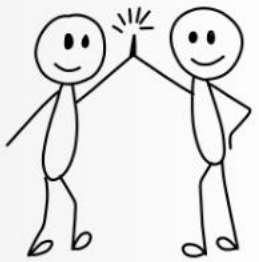
IS IT A RIPE TOPIC?

YES!

MEET THE EXPERTS

SPOT THE TALENT

RECRUIT THE DREAM TEAM



GAP between science + practice
EXAMPLES of great practice
Strong business case

CO-CREATION

PROCESS preceeds OUTCOME

CHANGE PACKAGE

Ideas with a Pedigree

CHARTER

Vision
Goals
Expectations

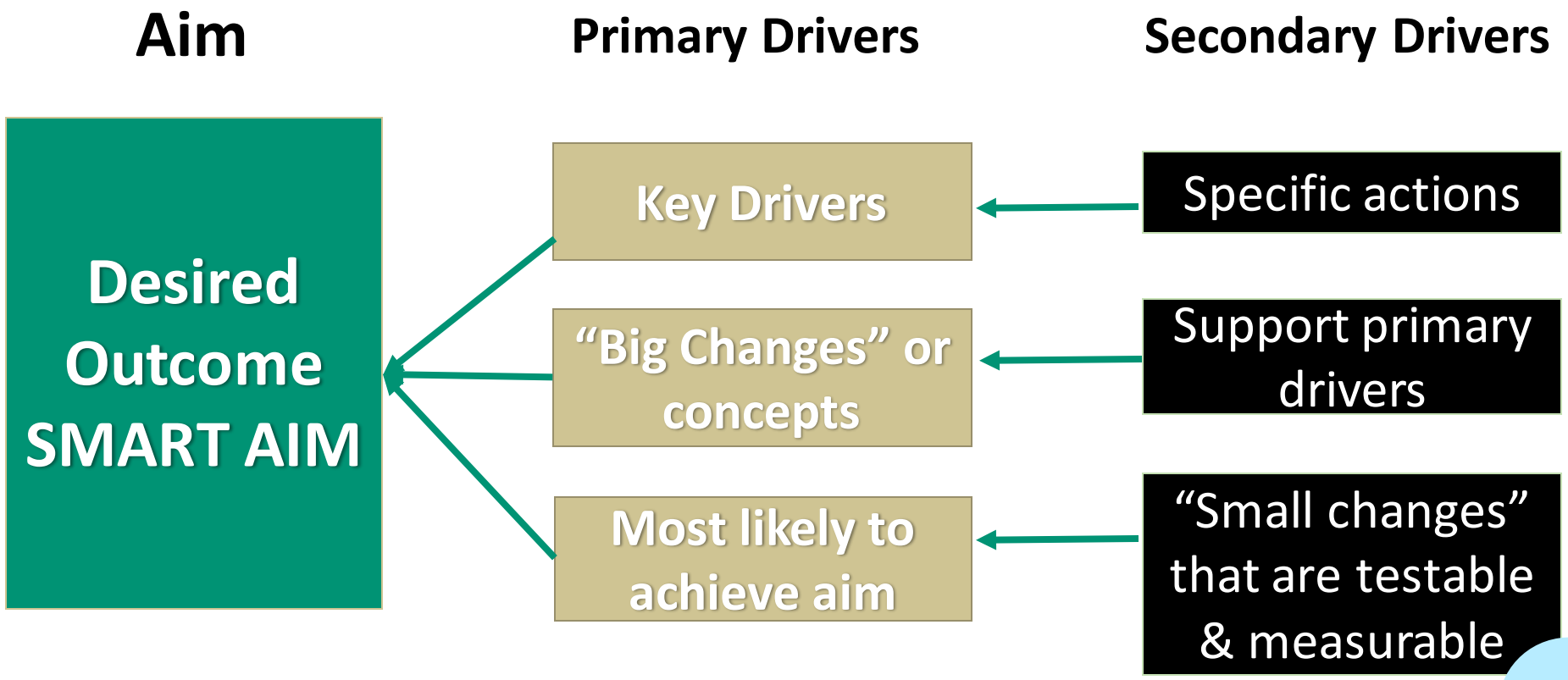
MEASURE STRATEGY

What?
Define
Collection

ME!
WE!
ME!
ME!
ME!

Testing the Will

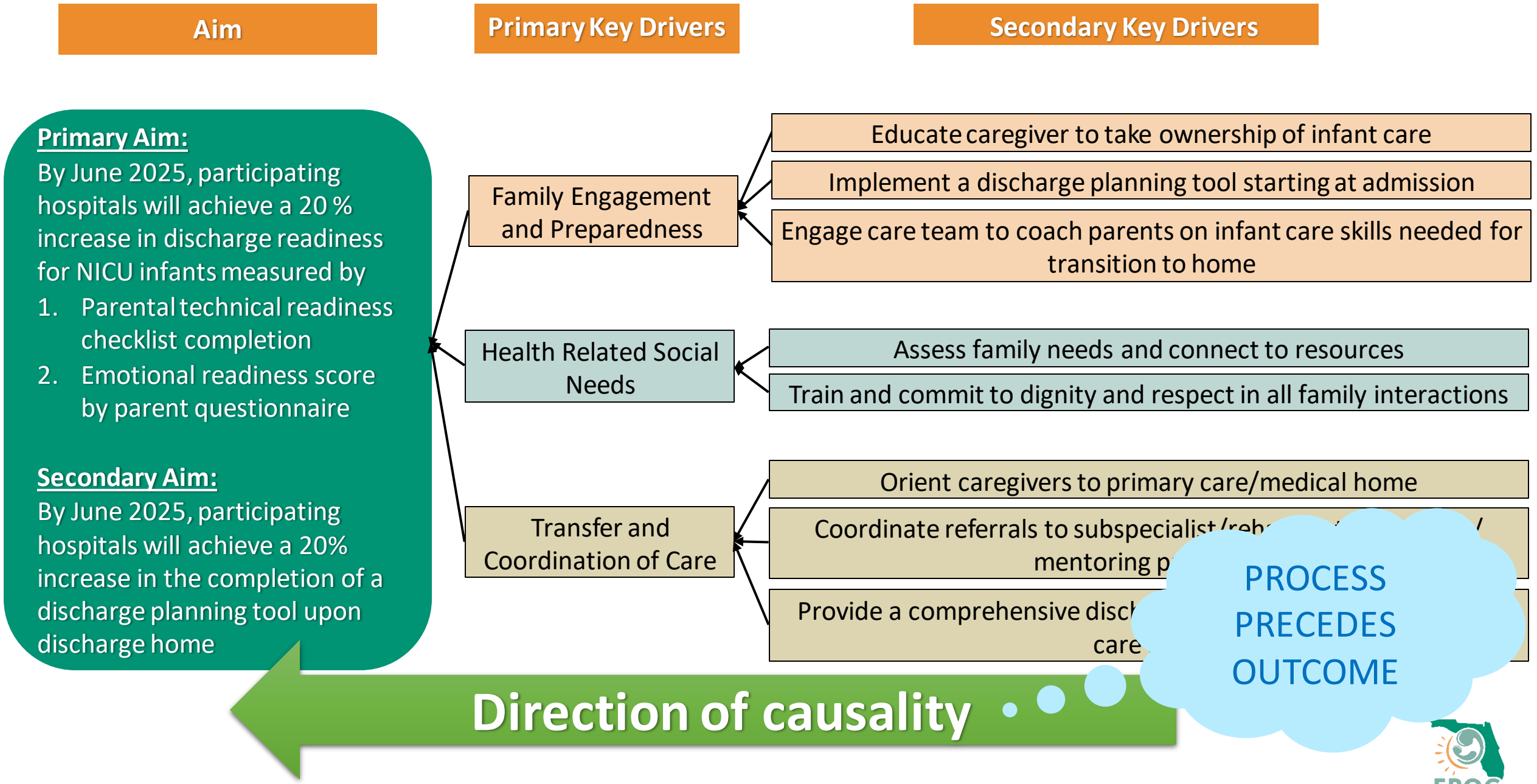
Key Driver Basic Concepts



Direction of causality

PROCESS PRECEDES OUTCOME

FPQC


Aim
Primary Key Drivers
Secondary Key Drivers
Primary Aim:
By June 2025, participating hospitals will achieve a 20 % increase in discharge readiness for NICU infants measured by
1. Parental technical readiness checklist completion
2. Emotional readiness score by parent questionnaire
Secondary Aim:
By June 2025, participating hospitals will achieve a 20% increase in the completion of a discharge planning tool upon discharge home
Family Engagement and Preparedness
Health Related Social Needs
Transfer and Coordination of Care
Educate caregiver to take ownership of infant care
Implement a discharge planning tool starting at admission
Engage care team to coach parents on infant care skills needed for transition to home
Assess family needs and connect to resources
Train and commit to dignity and respect in all family interactions
Orient caregivers to primary care/medical home
Coordinate referrals to subspecialist
mentoring
Provide a comprehensive disch
care
PROCESS PRECEDES OUTCOME
Direction of causality
FPQC

AIM

By 6/2025, participating NICUs will achieve a 20% increase in:

Discharge readiness for NICU infants measured by:

a. Parental technical readiness checklist completion

b. Emotional readiness score by parent questionnaire

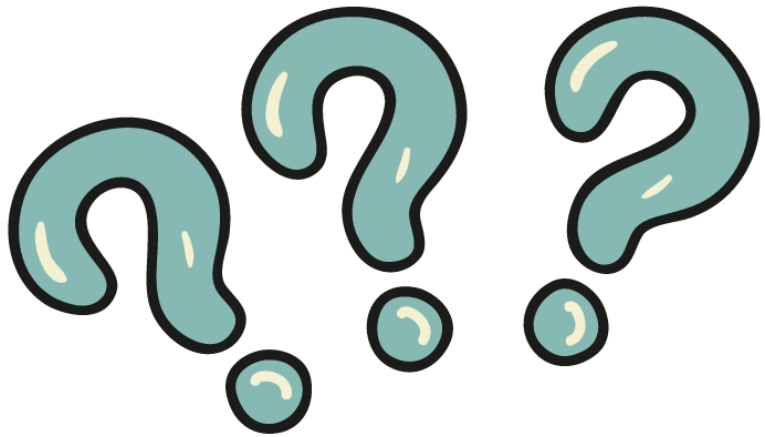
Completion of a discharge planning tool upon discharge home

* Baseline will be established with the first quarter of hospital data

FPQC

OUTCOME MEASURES

“Provide feedback on whether changes are having the desired impact on patient outcomes.”



AIM

QI Outcome Measures

By 6/2025, participating NICUs will achieve a 20% increase in:

Discharge readiness for NICU infants measured by:

a. Parental technical readiness checklist completion

b. Emotional readiness score by parent questionnaire

Completion of a discharge planning tool upon discharge home

* Baseline will be established with the first quarter of hospital data

FPQC

PROCESS MEASURES

Indicate what a provider does to maintain or improve health

“Are the parts/steps in the system performing as planned?”

STRUCTURAL MEASURES

“Assesses features of a healthcare organization or clinician relevant to its capacity (infrastructure) to provide healthcare.”

Policies / Processes / Guidelines

Primary Key Driver

Family Engagement and Preparedness

Secondary Drivers

Educate caregivers to take ownership of infant care

% of infants with a complete technical readiness checklist

Implement a discharge planning tool starting at admission

% of infants with a complete discharge planning tool

Engage care team to coach caregivers on infant care skills needed for transition to home

% of RNs and providers provided training on processes to coach caregivers

Primary Key Driver

Health Related Social Needs

Secondary Drivers

Assess family needs and connect to resources

% of primary caregivers screened for HRSN and referred to appropriate services

Train and commit to dignity and respect in all family interactions

% of RNs and providers that attended a Respectful Care Training since October 2023

Primary Key Driver

Transfer and Coordination of Care

Secondary Drivers

Orient caregivers to primary care/medical home

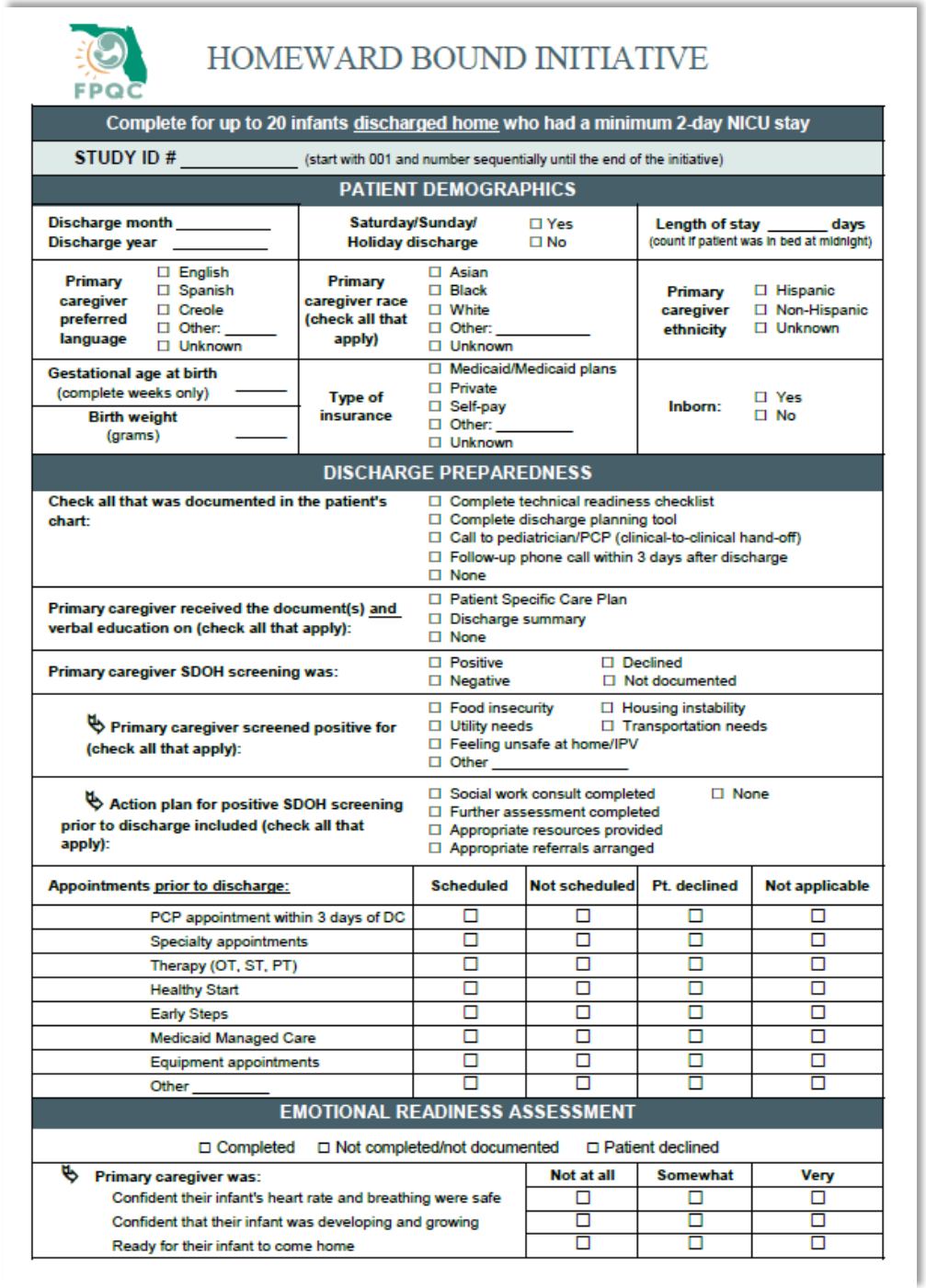
% of infants whose PCP was identified and a clinician-to-clinician handoff call took place prior to NICU discharge

Coordinate referrals to subspecialist/ rehabilitation services/mentoring programs

% of infants for whom all necessary appointments were scheduled prior to discharge

Provide a comprehensive discharge summary to caregivers and care team

% of infants provided with copies of their Discharge Summary and Patient Plan of Care prior to discharge



HOMEWARD BOUND INITIATIVE

Complete for up to 20 infants discharged home who had a minimum 2-day NICU stay

STUDY ID # _____ (start with 001 and number sequentially until the end of the initiative)

PATIENT DEMOGRAPHICS

Discharge month _____ Discharge year _____	Saturday/Sunday/ Holiday discharge ☐ Yes ☐ No	Length of stay _____ days (count if patient was in bed at midnight)
Primary caregiver preferred language ☐ English ☐ Spanish ☐ Creole ☐ Other: _____ ☐ Unknown	Primary caregiver race (check all that apply) ☐ Asian ☐ Black ☐ White ☐ Other: _____ ☐ Unknown	Primary caregiver ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
Gestational age at birth (complete weeks only) _____ Birth weight (grams) _____	Type of insurance ☐ Medicaid/Medicaid plans ☐ Private ☐ Self-pay ☐ Other: _____ ☐ Unknown	Inborn: ☐ Yes ☐ No

DISCHARGE PREPAREDNESS

Check all that was documented in the patient's chart:	☐ Complete technical readiness checklist ☐ Complete discharge planning tool ☐ Call to pediatrician/PCP (clinical-to-clinical hand-off) ☐ Follow-up phone call within 3 days after discharge ☐ None
Primary caregiver received the document(s) and verbal education on (check all that apply):	☐ Patient Specific Care Plan ☐ Discharge summary ☐ None
Primary caregiver SDOH screening was:	☐ Positive ☐ Declined ☐ Negative ☐ Not documented
Primary caregiver screened positive for (check all that apply):	☐ Food insecurity ☐ Housing instability ☐ Utility needs ☐ Transportation needs ☐ Feeling unsafe at home/IPV ☐ Other _____
Action plan for positive SDOH screening prior to discharge included (check all that apply):	☐ Social work consult completed ☐ None ☐ Further assessment completed ☐ Appropriate resources provided ☐ Appropriate referrals arranged

Appointments prior to discharge:	Scheduled	Not scheduled	Pt. declined	Not applicable
PCP appointment within 3 days of DC	☐	☐	☐	☐
Specialty appointments	☐	☐	☐	☐
Therapy (OT, ST, PT)	☐	☐	☐	☐
Healthy Start	☐	☐	☐	☐
Early Steps	☐	☐	☐	☐
Medicaid Managed Care	☐	☐	☐	☐
Equipment appointments	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

EMOTIONAL READINESS ASSESSMENT

☐ Completed ☐ Not completed/not documented ☐ Patient declined

Primary caregiver was:	Not at all	Somewhat	Very
Confident their infant's heart rate and breathing were safe	☐	☐	☐
Confident that their infant was developing and growing	☐	☐	☐
Ready for their infant to come home	☐	☐	☐

PATIENT-LEVEL DATA

Report on up to 20 infants per month; 5 per birth weight category

Disaggregate by race, ethnicity, insurance type, LOS

PATIENT-LEVEL DATA

Aggregate Monthly Report of infants **discharged home** with a minimum 2-day NICU stay		
# of eligible infants discharged home	_____	
# of eligible infants whose primary caregivers had SDOH screening documented using a SDOH screening tool	_____	☐ Unknown
# of eligible infants whose primary caregiver declined SDOH screening	_____	☐ Unknown
# of eligible infants whose primary caregiver screened positive for SDOH	_____	☐ Unknown
# of eligible infants whose primary caregiver screened positive for SDOH, and was connected to appropriate services/resources	_____	☐ Unknown

Report aggregate data on SDOH screening and referral each month

FPQC

Homeward Bound
Hospital-Level Data Collection Form

Guidelines, Policies, and/or Processes

1- Not Started
2- Planning
3 -Started Implementing – Started implementation in the last 3 months
4- Implemented – Less than 80% compliance after at least 3 months of Implementation (Not routine practice)
5- Fully Implemented – At least 80% compliance after at least 3 months of Implementation (Routine practice)

To what extent is your hospital:	Not started 1	Planning 2	Started to implement 3	Implemented 4	Fully implemented 5
Implementing a policy, guideline, or procedure to administer a Social Determinants of Health (SDOH) Assessment tool	☐	☐	☐	☐	☐
Developing process maps of key personnel, tools, information systems and timing to access SDOH from maternity units	☐	☐	☐	☐	☐
Implementing a guideline, policy, or procedure to supply food vouchers and breast pumps.	☐	☐	☐	☐	☐
Creating a strategy to provide families with a list of Pediatricians who can manage NICU graduates and accept Medicaid	☐	☐	☐	☐	☐
Implementing a guideline, policy, or procedure to identify and call PCP prior to discharge for patients based on unit specific criteria	☐	☐	☐	☐	☐
Creating a patient-specific care plan for the family that includes needed subspecialties, ST, PT, OT, home health services, equipment, and NICU developmental follow-up programs	☐	☐	☐	☐	☐
Creating a standardized format for DC summary including history and all care provided	☐	☐	☐	☐	☐
Implementing a guideline, policy, or procedure to provide multiple copies of DC summary for each appointment	☐	☐	☐	☐	☐
Implementing a guideline, policy, or procedure to call parents of patients based on unit criteria within 3 days after discharge	☐	☐	☐	☐	☐
Engaging a family advisor in the QI team	☐	☐	☐	☐	☐
Engaging a community advisor in the QI team (e.g. Healthy Start representative, home visiting program representative)	☐	☐	☐	☐	☐

Staff Training

Please add the percentage of nurses and NICU providers who have been trained on the following:

Has your Staff been trained on:	Nurses	NICU providers
A process to engage the care team in coaching parents on infant care skills needed for the transition to home	_____ %	_____ %
Has your Staff attended:	**Nurses**	**NICU providers**
A Respectful Care training since October 2023 and committed to Respectful Care practices	_____ %	_____ %

Questions? Please contact FPQC@usf.edu

10/11/2023

HOSPITAL-LEVEL DATA

- ❑ Not started
- ❑ Planning
- ❑ Started to implement
- ❑ Implemented
- ❑ Fully Implemented

Cumulative Percent

Individual Hospital Levels of Participation are Required by FDOH

Attendance and Engagement

Coaching Call (CC) Attendance

Attendance: 100%

# of CCs your hospital attended	Total # of Coaching Calls
3	3

Patient-Level Data Submitted every month on the 21st

Patient-Level Data Last Submitted on: February 2023

# of Months your hospital reported	Total # of Reporting Months
2	3

Hospital-Level Data (Quarterly) submitted every quarter

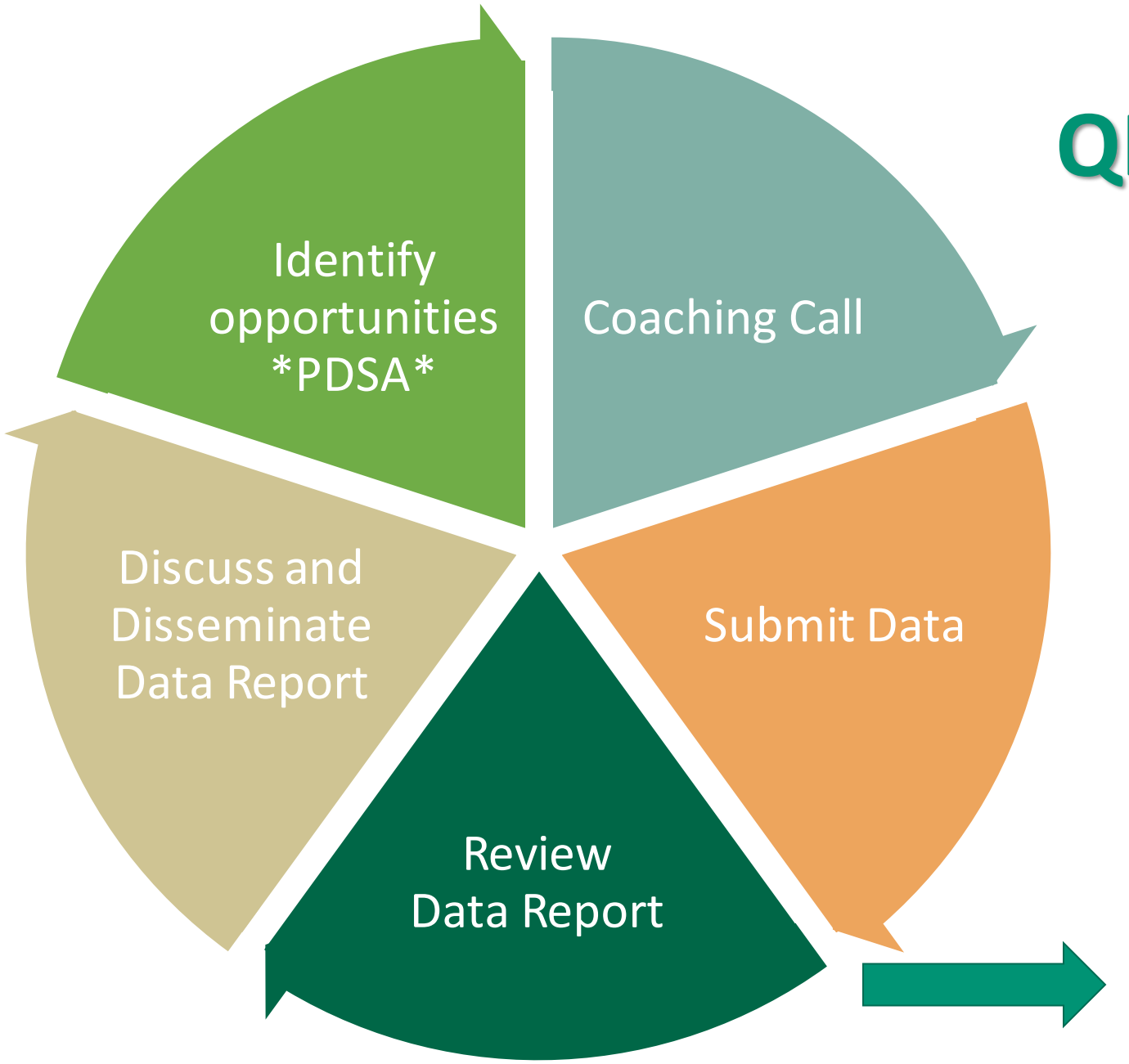
Hospital-Level Data Last Submitted on: December 2022

# of Quarters your hospital reported	Total # of Reporting Quarters
1	2

HB Hospitals will receive a star for each of the metrics

Data Without Action is Just Numbers on Paper

QI MONTHLY CYCLE



QI REPORTS

- Aim
- Run Charts
- Track Process, Structural, and Outcome Measures
- Add your PDSAs

IMPORTANT REQUESTS

- ❑ Track completion of your hospital's Data Use Agreement (DUA)
- ❑ Let us know of any changes in your HB team: data lead resources
- ❑ Attend the data webinar
- ❑ Submit your hospital-level data by December
- ❑ Patient-level data collection starts in January

HB DATA WEBINAR

Date: Tuesday, October 24, 2023
2:00 PM – 03:00 PM EDT

- Importance of data for the HB initiative
- Data definitions, inclusion criteria
- Data tools - data collection sheets
- Processes to submit data
- Review of a sample report
- Using your report to guide improvement

Questions?

erubio l @usf.edu

fpqc@usf.edu

www.fpqc.org

"To improve the health and health care of all Florida mothers & babies"