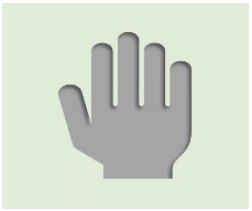
HOMEWARD BOUND

QI DATA TOOLS AND PROCESSES

WELCOME!

Please mute yourself



If you have a question, please enter it in the chat or raise your hand (Reactions)

This webinar is being recorded

FPQC

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

Vision: Integrate family into a "Family Centered" discharge process that encompasses Dignity & Respect, Participation, Communication, and Information Sharing. The process begins on admission, empowering families to collaborate with the clinical interdisciplinary team throughout their baby's transition from NICU admission to discharge home.

Aim

Primary Aim:
By June 2025, each participating NICU will achieve a 20 % increase in discharge readiness for NICU infants as measured by

- Parental technical readiness checklist
- Emotional readiness score by survey

Secondary Aim:
By June 2025, each participating NICU will achieve a 20% increase in the completion of a discharge planning tool upon discharge home

HOMEWARD BOUND

Primary Key Drivers

- Family Engagement & Preparedness
- Health Related Social Needs
- Transfer and Coordination of Care

Family-centered care is a universal component of every driver & activity

Data type and frequency of reporting

Patient-level data

- Aggregate SDOH data
- Patient demographics and SDOH
- Discharge Preparedness and Emotional Readiness Assessment

Hospital-level data

- Staff training
- Standardized documentation
- Policies and guidelines to support Homeward Bound

DEMOGRAPHICS

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

- Inform case composition and track population change overtime
- Disaggregate measures to identify differences between population groups

Discharge Preparedness

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			
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	☐	☐	☐	☐

Discharge Preparedness

Check all that was documented in the patient's chart:

- ☐ Complete technical readiness checklist
- ☐ Complete discharge planning tool
- ☐ Call to pediatrician/PCP (clinician-to-clinician hand-off)
- ☐ Follow-up phone call within 3 days after discharge
- ☐ None

- Tools available in **www.fpqc.org/homeward-bound-toolbox**

Technical readiness checklist

Table 1 Discharge education.

From: NICU discharge preparation and transition planning: guidelines and recommendations

DISCHARGE EDUCATION RECOMMENDATION	SUPPORTING REFERENCES
DISCHARGE EDUCATION CONTENT	
Communicate to the family the skills that need to be mastered prior to discharge and the expected timing of discharge.	[1, 2, 7, 14, 16–21]
Families need to have demonstrated appropriate technical infant care skills and knowledge prior to discharge. Common infant care topics that families need to understand prior to discharge include the following: • How they will safely feed their baby. ◦ How to support feeding at the breast and using a bottle. ◦ How to mix formula or increase calories in breast milk as indicated. ◦ How to pump and store breast milk. • How to bathe their baby. • How to dress their baby for the weather and for sleep.	[1–4, 6, 8, 14, 16, 22–24]

Complete technical readiness checklist

NICU Discharge Planning Worksheet for the Bedside Provider

During discharge meeting	Date	Completed by (initials)
Discharge meeting held		
Family given discharge packet		
Family obtained a car seat		
Family offered CPR class/video instruction		
Family received "Shaken Baby" brochure		
Pediatrician/PCP chosen		

No later than 1 week prior to anticipated discharge	Date	Completed by (initials)	Teach back date	Family declined	Comments
Provide Discharge Teaching on: Feeding /Nutrition guidelines					
Bowel and bladder patterns					
Bathing, skin care, cord care					
Temperature taking					
Circumcision care if needed					
Protection from infection					
Medication administration					

Table 1 Discharge education.

From: NICU discharge preparation and transition planning: guidelines and recommendations

- How they will safely feed their baby.
  - How to support feeding at the breast and using a bottle.
  - How to mix formula or increase calories in breast milk as indicated.
  - How to pump and store breast milk.

Complete technical readiness checklist

NICU Discharge Planning Worksheet for the Bedside Provider

During discharge meeting	Date	Completed by (initials)
Discharge meeting held		
Family given discharge packet		
Family obtained a car seat		
Family offered CPR class/video instruction		
Family received "Shaken Baby" brochure		
Pediatrician/PCP chosen		

Date when demonstration of skill/teach back needs to be documented

No later than 1 week prior to anticipated discharge	Date	Completed by (initials)	Teach back date	Family declined	Comments
Provide Discharge Teaching on: Feeding /Nutrition guidelines					
Bowel and bladder patterns					
Bathing, skin care, cord care					
Temperature taking					
Circumcision care if needed					
Protection from infection					
Medication administration					

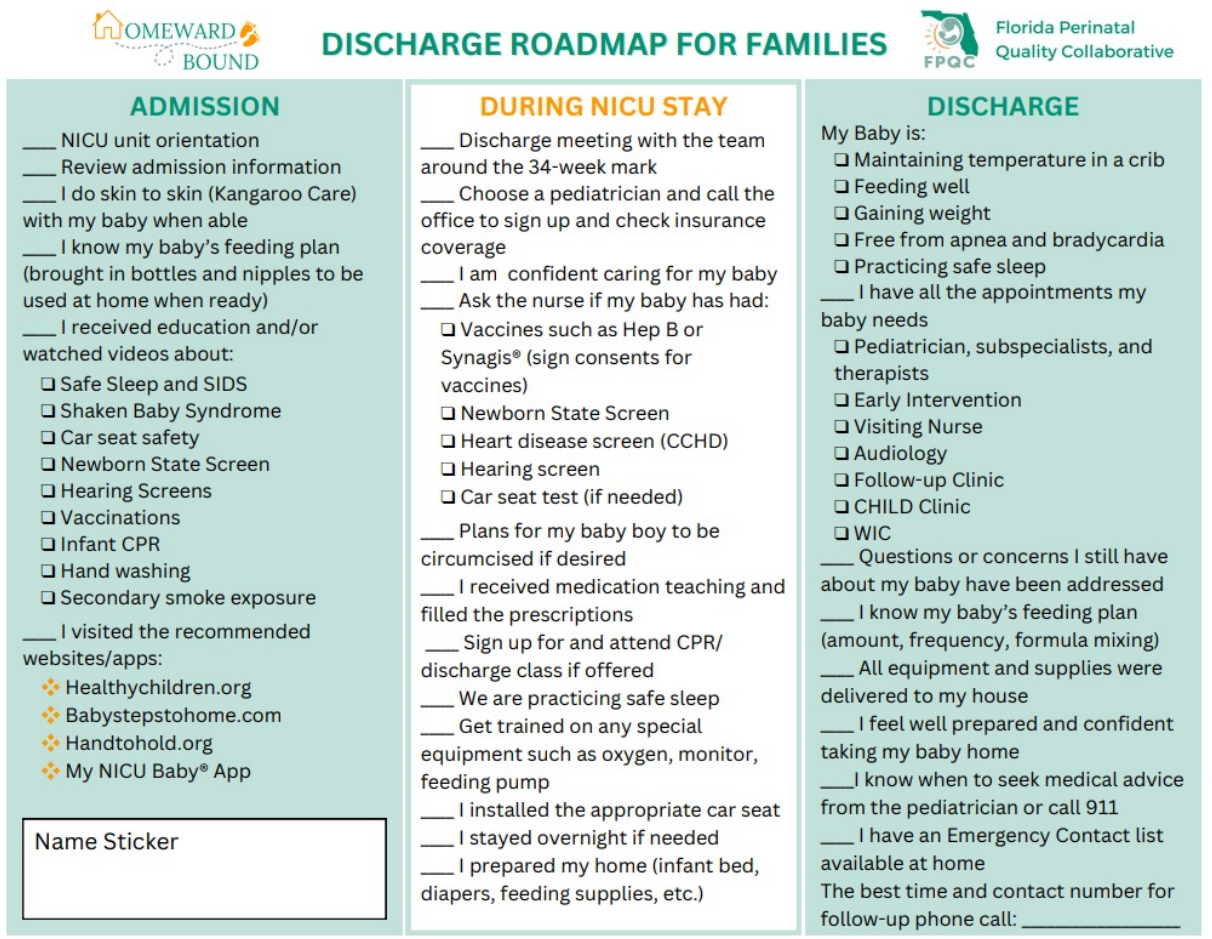
Discharge Preparedness

Check all that was documented in the patient's chart:

- ☐ Complete technical readiness checklist
- ☐ Complete discharge planning tool
- ☐ Call to pediatrician/PCP (clinician-to-clinician hand-off)
- ☐ Follow-up phone call within 3 days after discharge
- ☐ None

- Tools available in **www.fpqc.org/homeward-bound-toolbox**

Complete Discharge Planning Tool



HOMEWARD BOUND

DISCHARGE ROADMAP FOR FAMILIES

Florida Perinatal Quality Collaborative

ADMISSION

___ NICU unit orientation
___ Review admission information
___ I do skin to skin (Kangaroo Care) with my baby when able
___ I know my baby's feeding plan (brought in bottles and nipples to be used at home when ready)
___ I received education and/or watched videos about:
- ❑ Safe Sleep and SIDS
- ❑ Shaken Baby Syndrome
- ❑ Car seat safety
- ❑ Newborn State Screen
- ❑ Hearing Screens
- ❑ Vaccinations
- ❑ Infant CPR
- ❑ Hand washing
- ❑ Secondary smoke exposure

___ I visited the recommended websites/apps:
- Healthychildren.org
- Babystepstohome.com
- Handtohold.org
- My NICU Baby® App

Name Sticker

DURING NICU STAY

___ Discharge meeting with the team around the 34-week mark
___ Choose a pediatrician and call the office to sign up and check insurance coverage
___ I am confident caring for my baby
___ Ask the nurse if my baby has had:
- ❑ Vaccines such as Hep B or Synagis® (sign consents for vaccines)
- ❑ Newborn State Screen
- ❑ Heart disease screen (CCHD)
- ❑ Hearing screen
- ❑ Car seat test (if needed)

___ Plans for my baby boy to be circumcised if desired
___ I received medication teaching and filled the prescriptions
___ Sign up for and attend CPR/ discharge class if offered
___ We are practicing safe sleep
___ Get trained on any special equipment such as oxygen, monitor, feeding pump
___ I installed the appropriate car seat
___ I stayed overnight if needed
___ I prepared my home (infant bed, diapers, feeding supplies, etc.)

DISCHARGE

My Baby is:
- ❑ Maintaining temperature in a crib
- ❑ Feeding well
- ❑ Gaining weight
- ❑ Free from apnea and bradycardia
- ❑ Practicing safe sleep

___ I have all the appointments my baby needs
- ❑ Pediatrician, subspecialists, and therapists
- ❑ Early Intervention
- ❑ Visiting Nurse
- ❑ Audiology
- ❑ Follow-up Clinic
- ❑ CHILD Clinic
- ❑ WIC

___ Questions or concerns I still have about my baby have been addressed
___ I know my baby's feeding plan (amount, frequency, formula mixing)
___ All equipment and supplies were delivered to my house
___ I feel well prepared and confident taking my baby home
___I know when to seek medical advice from the pediatrician or call 911
___ I have an Emergency Contact list available at home
The best time and contact number for follow-up phone call: _____

- Tools available in **www.fpqc.org/homeward-bound-toolbox**

Discharge Preparedness

Check all that was documented in the patient's chart:

- ☐ Complete technical readiness checklist
- ☐ Complete discharge planning tool
- ☐ Call to pediatrician/PCP (clinician-to-clinician hand-off)
- ☐ Follow-up phone call within 3 days after discharge
- ☐ None

- Tools available in **www.fpqc.org/homeward-bound-toolbox**

Discharge Preparedness

Primary caregiver received the document(s) and verbal education on (check all that apply):

- ☐ Patient Specific Care Plan
- ☐ Discharge summary
- ☐ None

Word template available in
www.fpqc.org/homeward-bound-toolbox

Patient-Specific Care Plan Elements

1. Identification and preparation of the in-home caregivers
2. Formulation of a plan for nutritional care and administration of any required medications
3. Development of a list of required equipment and supplies and accessible sources
4. Identification and mobilization of the primary care physician, on-going specialty care physicians, and necessary and qualified home-care personnel and community support services
5. Dates of scheduled follow-up appointments
6. Assessment of the adequacy of the physical facilities within the home
7. Development of an emergency care and transport plan
8. Assessment of available financial resources to ensure the capability of caregivers to finance home-care costs and transportation to appointments

Florida Perinatal Quality Collaborative

FPQC.org/homeward-bound

Discharge Preparedness

Primary caregiver received the document(s) and verbal education on (check all that apply):

- ☐ Patient Specific Care Plan
- ☐ Discharge summary
- ☐ None

Word template available in
www.fpqc.org/homeward-bound-toolbox

Recommendations for NICU Discharge Summary

Discharge Summary Elements

- Infant's name in the hospital (and after discharge, if different)
- Admission indication, birthweight, head circumference, length and gestational age
- Maternal history including prenatal labs
- Discharge diagnoses
- Hospital course written by systems
- Physical exam at discharge including head circumference, length and weight percentiles
- Discharge physical exam findings (highlight any abnormal findings)
- Discharge medications and administration instructions
- Home feeding plan (breast milk fortification, formula type, recommended nipple, frequency and volume)
- Newborn hearing screen results and any follow up screening needed
- Newborn screening dates and abnormal results
- Car seat challenge results
- Immunizations administered and immunizations recommended that were not given
- Pending lab or test results that need follow up
- Prognosis (if guarded)
- If indicated, medical equipment needs
- Any known pertinent social, family, or medical history
- Community service referrals made or recommended and any counseling opportunities available to the family
- Any tasks to be completed (follow-up appointments or tests not yet scheduled)
- Interpreter or communication needs
- Any referrals to resources for specific diagnoses
- Community resources (counseling, mental health, substance dependency, visiting nurses, financial resources, etc.)

General Recommendations

- Discharge summary should be formatted from a structured template with section headings
- Discharge summary should be translated into the family's preferred language when possible
- Families should be provided with copies of the discharge summary and directions on how to get an official copy of the medical record, if interested
- Provide at least two copies of the discharge summary (one for the medical home and one for the family to share with home visiting or emergency services)
- Provide specialists with copies of the discharge summary directly or provide the family with copies to give to specialists

Social Determinants of Health (SDOH)

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

CMS required reporting timeline:

- Collection period: January 1, 2024 – December 31, 2024
- Submission deadline: May 15, 2025

FPQC

Social Determinants of Health (SDOH)

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

Further Assessment Completed: evaluation to assess the extent of adverse SDOH (social worker, case manager, patient navigator)

Appropriate Resources Provided: resources provided during the stay (e.g. Food Voucher, transportation assistance, etc.)

Appropriate Referrals Provided: referrals are arranged for the discharge process (e.g. WIC, Healthy Start, Early Start)

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Discharge Preparedness

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	☐	☐	☐	☐

Patient-specific based on unit criteria

Emotional Readiness Assessment

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	☐	☐	☐

Bedside nurse will ask 3 questions to the primary caregiver the day of discharge

Emotional Readiness Assessment

NICU Discharge Planning Worksheet for the Bedside Provider

Day of discharge	Date	Completed by (Initials)
Bedside staff conducted the emotional readiness assessment below~		
Ask the primary caregiver to rate the following statements:		
I feel confident that my infant's heart rate and breathing are safe	☐ Not at all confident ☐ Somewhat confident ☐ Very confident	
I feel confident that my infant is developing and growing now	☐ Not at all confident ☐ Somewhat confident ☐ Very confident	
I am ready for my infant to come home	☐ Not at all ready ☐ Somewhat ready ☐ Very ready	

Document the answers provided by the primary caregiver the **first** time the assessment is conducted

FPQC

Submitting data to FPQC

INCLUSION AND EXCLUSION CRITERIA

Include (qualifying infants):

NICU admissions with minimal 2-day stay who are discharged home

Exclude:

Infants who die or are discharged to other hospitals for escalation of care

REPORTING

Report up to 5 infants for each birth weight category:

- 2500 grams and above
- 2499-1500 grams
- 1499-750 grams
- less than 750 grams

up to 20 eligible patients total each month

At the beginning of the initiative, your hospital has the option to opt out of reporting information on smaller birth weight categories if the number of infants in a specific category is consistently less than 5 per quarter.

Sampling: Selection Process

If a category has more than 10 discharges in the month, report:

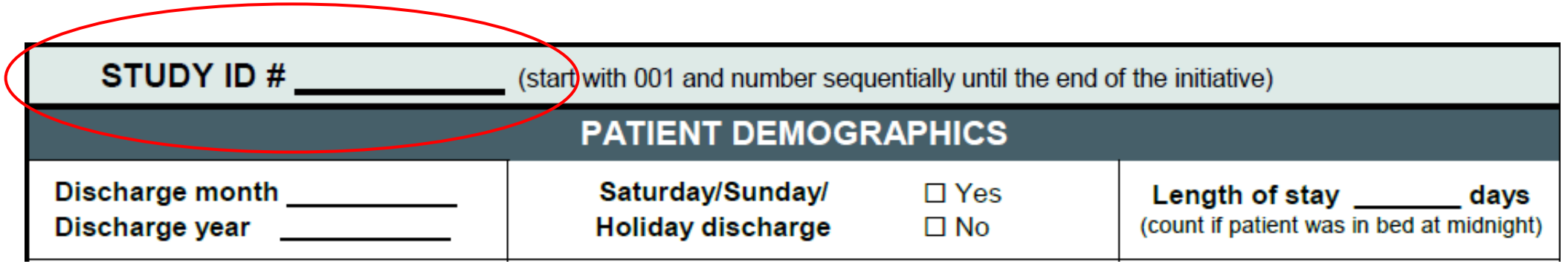
- The first discharge on each weekday for the first four weeks, and
- The first weekend discharge for the month, totaling 5 infants

e.g. Hospital X has 17 deliveries with a birth weight of 1500-2499. Reporting will include the first discharge on a weekday in the first, second, third and fourth week, as well as the first weekend discharge

If a category has less than 10 discharges in the month, report:

- The first 5 discharges or as many as you have

STUDY ID



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)

- Assign Study ID # 001 to the first patient whose data will be submitted to FPQC
- Number consecutively all patients submitted to FPQC throughout the initiative

KEEP TRACK OF YOUR CASES

Please keep a log of the patients whose data is submitted to FPQC.

Hospital Name: _____

Medical Record #	Study ID #	Survey Return Code	Data lead name

PROCESS TO COLLECT AND SUBMIT YOUR DATA

1

Identify Cases

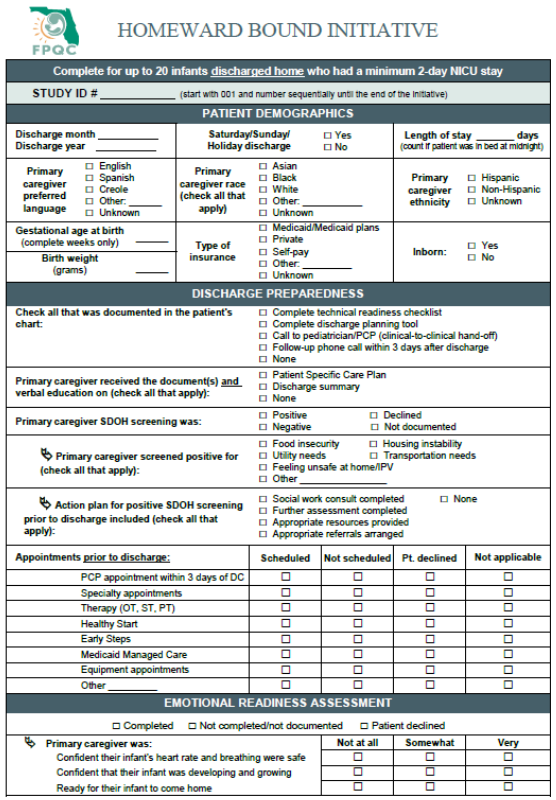
Number of discharges/month

If category has 10 or more : 5 systematically selected infants

If less than 10 discharges: First 5 infants

2

Abstract medical record



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 _____	☐	☐	☐	☐

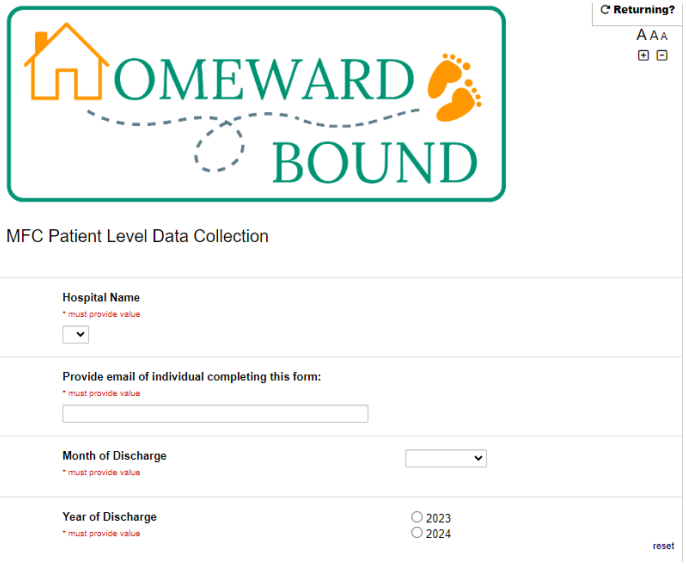
EMOTIONAL READINESS ASSESSMENT

☐ 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	☐	☐	☐

3

Enter data in the REDCap data portal



HOMEWARD BOUND

Returning?

MFC Patient Level Data Collection

Hospital Name
* must provide value

Provide email of individual completing this form:
* must provide value

Month of Discharge
* must provide value

Year of Discharge
* must provide value
2023
2024

reset

Link will be sent to the project and data lead once DUA is fully executed

FPQC

Data type and frequency of reporting

Patient-level data

- Patient demographics and SDOH
- Discharge Preparedness and Emotional Readiness Assessment
- Aggregate SDOH data

Hospital-level data

- Staff training
- Standardized documentation
- Policies and guidelines to support Homeward Bound

Aggregate Social Determinants Of Health 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

CMS required reporting timeline:

- Collection period: January 1, 2024 – December 31, 2024
- Submission deadline: May 15, 2025

Data type and frequency of reporting

Patient-level data

- Aggregate data
- Patient demographics
- Discharge Preparedness and Emotional Readiness Assessment
- Social Determinants of Health

Hospital-level data

- Staff education
- Standardized documentation
- Policies and guidelines to support Homeward Bound

Structural Measures

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)	☐	☐	☐	☐	☐

What are Structural Measures?

Structural Measures help us to assess where your facility is on implementation within our Initiative.

How are we Measuring this?

Implement and/or reinforce key processes, guidelines, policies, and resources to support Homeward Bound.

Report as follows:

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)

Staff Training

- Report cumulative percent

Staff Training		
Please add the percentage of staff and NICU providers who have been educated on the following topic and have attended the Respectful Care training		
***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	_____ %	_____ %

HOSPITAL-LEVEL DATA

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)	☐	☐	☐	☐	☐

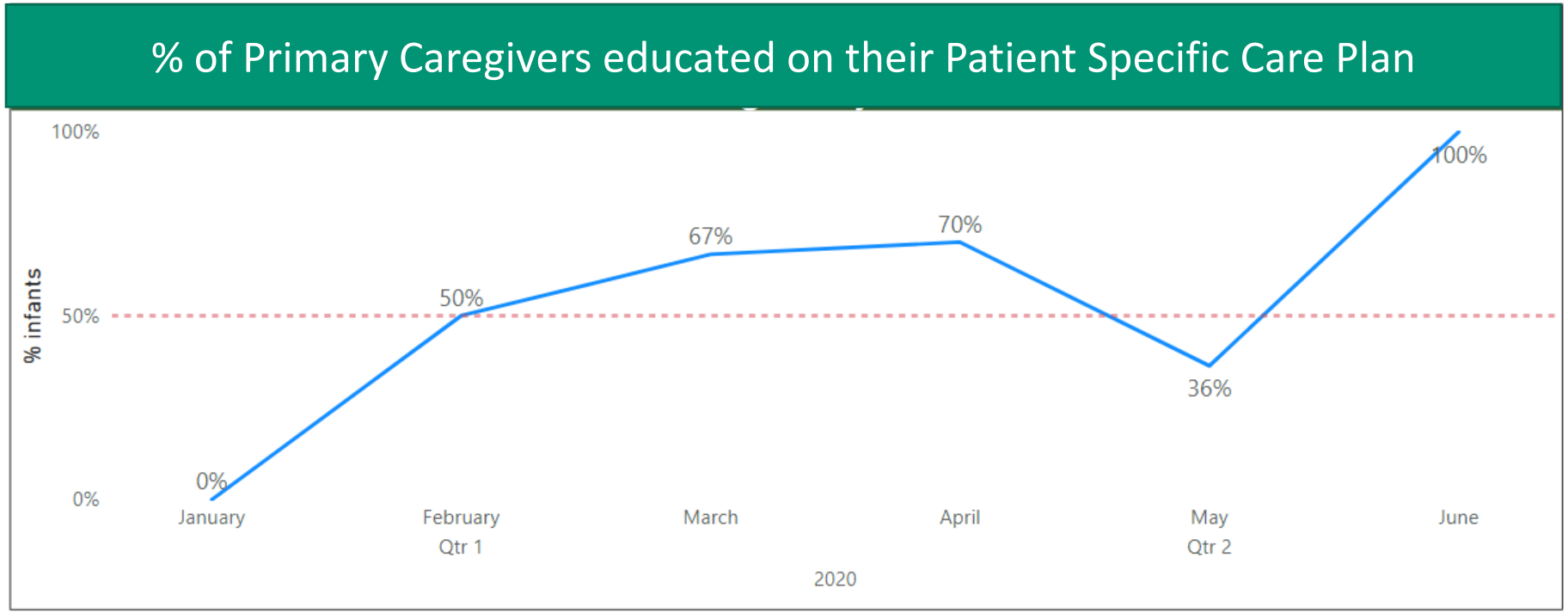
Staff Training		
Please add the percentage of staff and NICU providers who have been educated on the following topic and have attended the Respectful Care training		
***Has your Staff been trained on*:**	**Nurses**	**NICU providers**
A process to engage the care team in coaching parents on infant care 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	_____ %	_____ %

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

Cumulative Percent

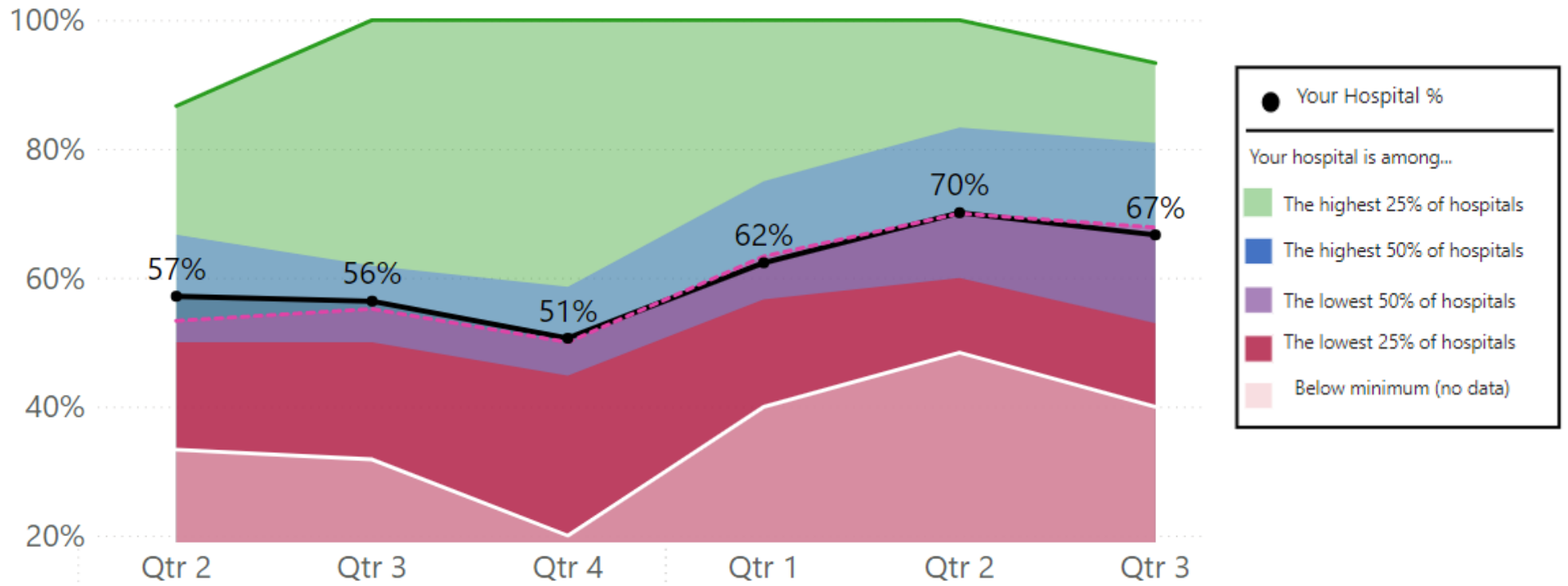
Sample Report

HOSPITAL-SPECIFIC



Sample Report

HOW DOES YOUR HOSPITAL COMPARE TO OTHERS



Why we collect data for QI?

- Informs progress and outcome of your work
- Identify areas of opportunity and strength

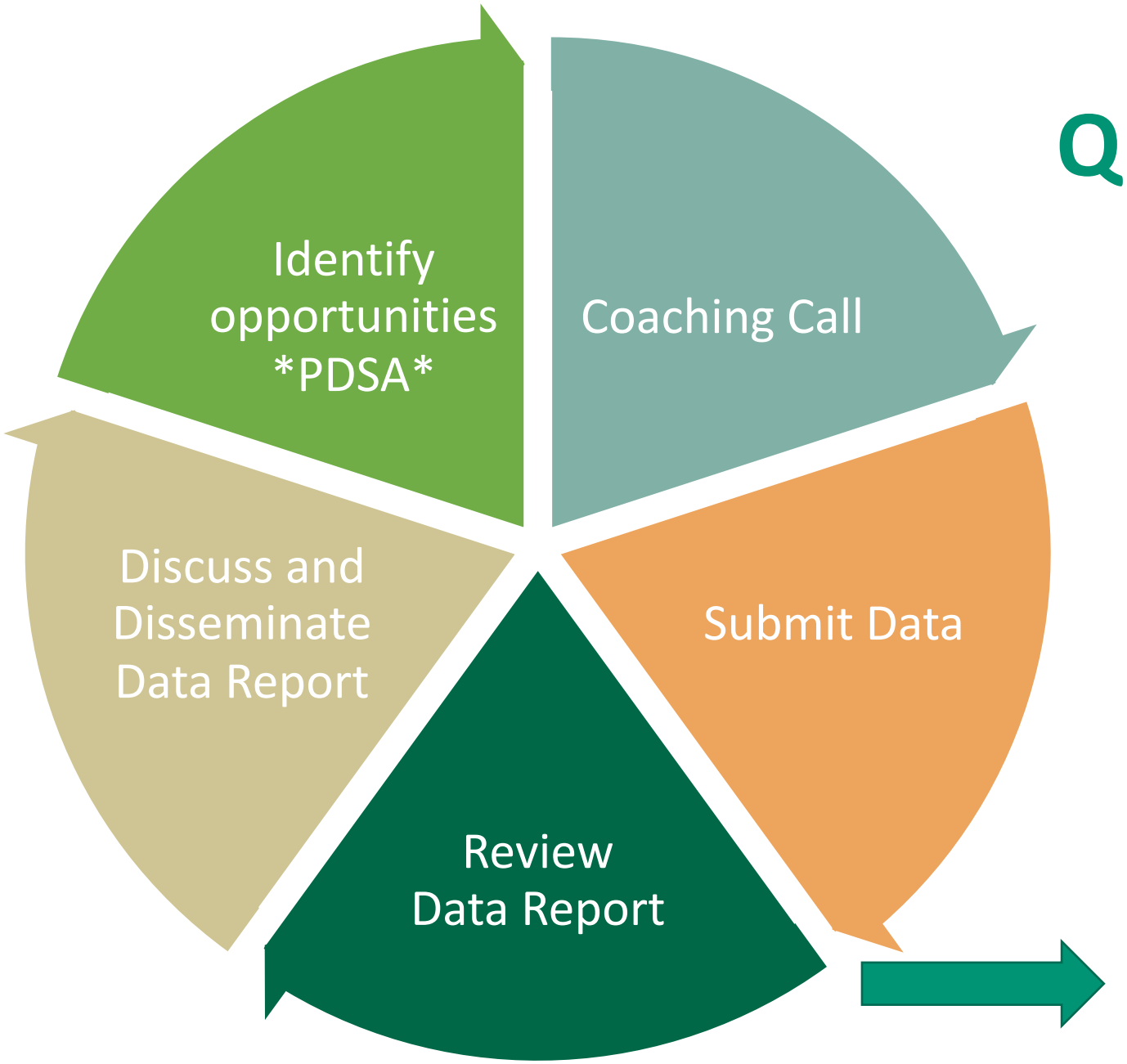
Data for learning not for judgment- Maximize learning

How to use your data for improvement?

- Initial data points will be a surrogate baseline
- Review your data every month for evaluating and guiding improvement. Use it to prompt discussion and action!
- Create a system that can be maintained long after the project ends: check if you are holding your gains overtime!

Data need to be strong, detailed and actionable!

QI MONTHLY CYCLE



QI REPORTS

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

Homeward Bound

Vision: Integrate family into a "Family Centered" discharge process that encompasses Dignity & Respect, Participation, Communication, and Information Sharing. The process begins on admission, empowering families to collaborate with the clinical interdisciplinary team throughout their baby's transition from NICU admission to discharge home.

Aim

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-Centered Care is a universal component of every driver & activity

Primary Key Drivers

Secondary Key Drivers

- Family Engagement and Preparedness
  - 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
- Health Related Social Needs
  - Assess family needs and connect to resources
  - Train and commit to dignity and respect in all family interactions
- Transfer and Coordination of Care
  - Orient caregivers to primary care/medical home
  - Coordinate referrals to subspecialist/rehabilitation services/ mentoring programs
  - Provide a comprehensive discharge summary to caregivers and care team

Important requests/dates

- ❑ Track completion of your hospital's Data Use Agreement
- ❑ Let us know of any changes in your HB team: Data Lead resources
- ❑ Submit your Hospital-Level Data in December
- ❑ **Patient-level data collection starts in January** – (January data is due February 15th)

Questions?

erubiol@usf.edu

gessnerb@usf.edu

www.fpqc.org

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