HOMEWARD BOUND INITIATIVE (HB) MEASUREMENT GRID

The Homeward Bound Initiative's vision is to integrate families 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.

Hospitals will report:

1. Monthly aggregate data of SDOH screening with a tool and referral to services for primary caregivers of NICU-admitted infants.

2. Monthly patient demographic, discharge, and referral data: for a sample of up to 20 qualifying infants. The sample should include five infants for each birth weight category: a) 2500 grams and above; b) 1500-2499 grams; c) 1499-750 grams; d) less than 750 grams.

If a category has more than 10 discharges per 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 there are fewer than 10 discharges in a specific category, report the first 5 discharges or as many as you have.

At the beginning of the initiative, your hospital can 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.

INCLUSION CRITERIA: All NICU admissions with minimal 2-day stay who are discharged home

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

3. Quarterly Hospital-level measures: report on the current implementation status of policies, procedures, or guidelines aimed at increasing hospital capacity to support HB and staff education and training

The measures listed in this document will be calculated and reported monthly to participating hospitals in a quality improvement data report so that facilities can track their progress. Key monthly measures will be disaggregated by the primary caregiver's race-ethnicity and language, infant insurance type, and birth weight. These data measures may be subject to change during the initiative as needed for QI purposes.

#	OUTCOME MEASURE	Description	Source
O1	Parental technical readiness checklist completion	Numerator: # of NICU primary caregivers that have completed the parental technical readiness checklist Denominator: # of qualifying NICU patients Note: The date when parents do teach back for appropriate items in the checklist must be documented to consider the checklist completed. Items in the checklist required for each infant must be defined per unit protocol. The parental technical readiness checklist is part of the NICU Discharge Planning Worksheet in the FPQC toolbox.	Medical chart
O2	Emotional readiness score by parent questionnaire	Numerator: # of NICU caregivers that report being "well prepared" on the emotional readiness questionnaire Denominator: # of NICU caregivers that complete the emotional readiness questionnaire Primary caregivers must complete the emotional readiness questionnaire within 24 hours of discharge. Bedside staff will ask 3 key questions and document their immediate responses (document the first response only, not reassessments). The emotional readiness questionnaire is part of the NICU Discharge Planning Worksheet in the FPQC toolbox.	Patient Survey
O3	Discharge Planning Tool	Numerator: # of completed discharge planning tools upon discharge Denominator: # of qualifying NICU patients The discharge planning tool should be initiated as early as possible after NICU admission and should be consistently updated throughout the admission according to the unit protocol.	Medical chart
#	**PROCESS MEASURES**		
P1	Perform Social Determinants of Health Screening (SDOH)	Numerator: # of NICU primary caregivers who were screened using a SDOH screening tool Denominator: # of qualifying NICU patients Data will be reported for both the sample and all NICU patients (aggregate)	Medical chart
P2	Provide resources for identified SDOH	Numerator: # of NICU primary caregivers who screened positive for SDOH who were referred to appropriate resources	Medical chart

		Denominator: # of qualifying NICU patients whose primary caregiver screened positive for Health-Related Social Needs Data will be reported for both the sample and all NICU patients (aggregate)	
P3	Schedule subspecialty and therapy appointments prior to DC	Numerator: # of patients with all appropriate subspecialty, therapy, follow-up and equipment appointments based on the patient-specific care plan scheduled prior to discharge Denominator: # of qualifying NICU patients	Medical chart
P4	Provide education to the primary caregiver about the patient-specific care plan	Numerator: # of primary caregivers that received education about the patient-specific care plan prior to discharge Denominator: # of qualifying NICU patients A patient-specific care plan should include appointments, referrals, immunizations, meds, diet, special needs/instructions, equipment orientations	Medical chart
P5	Provide education to the primary caregiver about the discharge summary	Numerator: # of primary caregivers who were verbally educated about the patient's discharge summary at discharge and provided with multiple copies as needed Denominator: # of qualifying NICU patients	Medical chart
P6	Identify and call PCP prior to discharge	Numerator: # of patients who had their primary care physician (PCP) contacted by the NICU physician for clinician-to-clinician hand-off prior to discharge Denominator: # of qualifying NICU patients	Medical chart
P7	Referral to community services	Numerator: # of primary caregivers who receive all appropriate referrals for community services based on the patient-specific care plan by service type prior to discharge Denominator: # of qualifying NICU patients Community services include: Early Steps, Healthy Start, Medicaid Managed Care, other community partners	Medical chart

P8	Follow-up call within 3 days after discharge	Numerator: # of primary caregivers who receive a follow-up call within roughly 3 days after discharge Denominator: # of qualifying NICU patients	Medical chart
P9	Engage care team to coach parents on infant care skills needed for transition to home	Numerator: # of bedside medical team members who demonstrated proficiency in coaching families in infant care skills Denominator: # of bedside medical team members	Hospital tally
P10	Train and commit the care team to dignity and respect in all family interactions	Numerator: # of Providers and Nurses that have completed dignity and respect training and completed the commitment letter Denominator: # of providers and nurses Include providers and staff that have completed dignity and respect training since October 2023. Commitment to implementing respectful care practices is expected only after completing the D&R training.	Hospital tally

Hospitals need to implement and/or reinforce key processes, guidelines, policies, and resources to support the Homeward Bound initiative. Quarterly, hospitals will report the current implementation status of the structural measures listed below until full implementation is achieved.

Report as follows:

- **Not started**
- **Planning**
- **Started Implementing** - started implementation in the last 3 months
- **Implemented** - less than 80% compliance after at least 3 months of Implementation (Not routine practice)
- **Fully Implemented** - at least 80% compliance after at least 3 months of Implementation (Routine practice)

#	STRUCTURAL MEASURES
S1	Policy, procedure, or guideline to administer a Social Determinants of Health screening tool
S2	Process map of key personnel, tools, information systems and timing to access SDOH from maternity units
S3	Policy, procedure, or guideline to supply breastfeeding trays and breast pumps
S4	Strategy to provide families with a list of Pediatricians who can manage NICU graduates and accept Medicaid
S5	Policy, procedure, or guideline to identify and call PCP prior to discharge for patients based on unit-specific criteria

S6	Patient-specific care plan for the family that includes appropriately scheduled subspecialty appointments, speech therapy, physical therapy, occupational therapy, home health services, NICU developmental follow-up programs, and appropriate community referrals
S7	Standardized format for the discharge summary, including medical history and comprehensive details of all care provided
S8	Policy, procedure, or guideline to provide multiple copies of the discharge summary for each referral and one for the family
S9	Policy, procedure, or guideline to call parents of patients based on defined unit criteria within 3 days after discharge
S10	Engage a family representative in the QI team
S11	Engage a community advisor in the QI team (e.g. Healthy Start representative, home visiting program representative)