



NICU TRANSITION TO HOME INITIATIVE:



APPLICATION GUIDE



This application guide explains the objectives of the Homeward Bound Initiative to promote and improve the transition to home for infants in the NICU and their families. The guide also reviews our model for quality improvement, your role as a participant, the initiative timeline and activities, and proposed initiative measures.

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Initiative Overview

Comprehensive NICU care includes multidisciplinary, family-centered transition and discharge guidelines to ensure that discharge readiness and outcomes are optimized. Discharge readiness is defined as the “attainment of technical skills and knowledge, emotional comfort, and confidence with infant care by the infant’s primary caregivers at the time of discharge.” However, known social, environmental, economic, and mental health challenges impact NICU discharge readiness.ⁱⁱⁱ Neonatal intensive care unit (NICU) families can become overwhelmed by the discharge process and transition to home. Lack of parental emotional comfort and confidence can inhibit learning and contribute to poor infant outcomes and increased healthcare utilization after discharge. The quality of the discharge preparation is a strong predictor of discharge readiness.ⁱⁱⁱ Therefore, it is invaluable that NICUs develop a comprehensive, multidisciplinary, family-centered discharge preparation program. This includes 1) educating, equipping, and enabling new parents in the care of their premature or sick newborn, 2) addressing health-related social needs of the caregivers and family through referral and coordination with community resources, and 3) arranging for the infant health care and support services families will need once discharged. Comprehensive, consistent, and early discharge preparation can lead to more effective and efficient NICU discharge and transition to home as well as improve caregiver and family satisfaction. The Florida Perinatal Quality Collaborative (FPQC) aims to achieve the outcome of discharge readiness by improving the discharge preparation process through our NICU quality improvement initiative called Homeward Bound.

Through the initiative, FPQC will partner with Florida’s Level 2, 3, and 4 NICUs to promote comprehensive discharge preparation and ensure an optimized discharge and transition of the NICU baby to home through using three Key Drivers for improvement:

1. Family engagement and preparedness
2. Health-Related Social Needs
3. Transfer and coordination of care

Homeward Bound was developed with direct input and support of a Homeward Bound Advisory group consisting of health care team professionals, community leaders and family members. The initiative’s programs, trainings, materials, and data tracking are evidence-based using the recently published national interdisciplinary guidelines on NICU discharge preparation and transition planning.^{iv}

Initiative Foci

Standardization related to:

- Fostering family/caregiver engagement and participation in care from admission through discharge
- Developing a welcoming and supportive environment that is respectful of individual patient and family values
- Creating family-centered hospital and unit policies, guidelines and procedures through open collaboration and partnership with families
- Emphasizing the need for family education about medical care and clinical processes throughout admission to bolster family competence and confidence as independent caregivers
- Incorporating checklists and other appropriate tools to track family emotional discharge readiness
- Developing individualized transition plans for each patient, considering their unique medical needs, social support, and environmental factors
- Integrating an efficient referral system and clinician-to-clinician handoff to support families after discharge



Initiative Goal

Homeward Bound's primary aim is that, by 6/2025, each participating NICU will achieve a 20% increase in discharge readiness for NICU infants as measured by 1) Parental technical readiness checklist completion; and 2) Emotional readiness score by parent questionnaire. A secondary aim is that, by 6/2025, participating hospitals will achieve a 20% increase in the completion of a discharge planning tool upon discharge home.

Why Join the Initiative?

Homeward Bound offers an opportunity for your facility to implement change and improve the care provided to infants in the NICU and to engage your families in care, emphasizing preparation for discharge. The initiative's goal is to implement evidence-based tools and other potentially better practices to improve care for infants and their families in Florida hospitals, increasing readiness for discharge and care at home by the infant's caregivers. FPQC aims to support collaborating hospitals as they develop and implement multi-disciplinary teams and strategies with the ultimate goal of increasing readiness for discharge in their individual units. Hospitals will integrate families into a "Family-Centered" discharge process that encompasses all four components: Dignity & Respect, Participation, Communication, and Information Sharing. The process will begin on admission, empowering families to collaborate with the clinical interdisciplinary team throughout their baby's transition from NICU admission to discharge home.

Stakeholders across the state and the U.S. have begun to recognize the importance of implementing family-centered care strategies to improve infant health outcomes and help families be well-equipped to continue care after hospital discharge. Growing evidence demonstrates that a comprehensive and well-designed NICU discharge education and transition to home process improves the outcomes of NICU infants.

Participating in the initiative allows your hospital to work in a collaborative and have access to resources to help you implement evidence-based quality improvement recommendations centered on an improvement in discharge planning and transition to home. It also offers an environment to learn together with others on the best strategies, methods, and tools to adapt and implement in your hospital. Hospitals that participate in multi-organization quality improvement collaboratives achieve more positive gains in patient care and safety faster than those who go it alone. Past participants have found it useful to not have to "reinvent the wheel."

Read on to learn the kinds of support the FPQC can provide participating hospitals and what hospitals will be asked to commit in order to participate. If you have any questions about the information presented here, please email FPQC@usf.edu.

Hospital Participation Requirements

We plan to achieve improvements in supporting better family engagement and preparedness for discharge, addressing gaps in health-related social needs, and using a team approach to improve transfer and coordination of care. Participating hospitals will start the initiative together at the kickoff in October 2023, launch their initiatives in their local facilities in January 2024, and continue through the 18-month quality improvement initiative finishing in June 2025.

Participating hospitals and providers are expected to make a commitment to implementing change and reporting progress during the collaborative for the benefit of all neonatal services statewide.

Participating Hospitals are required to:

- Participate for the entire 18-month time period of the initiative.
- Assemble a strong and full committed QI team including physician, nurse, data and administrative champions and conduct regular team meetings to track progress throughout the initiative.
- Complete FPQC pre and post implementation surveys.

- Commit at least one team member to attend every Homeward Bound Initiative learning series coaching call/webinar.
- Schedule an onsite educational and technical assistance visit with FPQC advisors.
- Develop, add, or amend hospital or department policy to reflect recommended quality processes and procedure changes.
- Sign Data Use Agreement and document, submit, track, and report all required FPQC process and outcome measures on a monthly basis throughout the initiative.
- Notify FPQC of changes to the QI team.
- Send at least two members of your team to participate in the **in-person Kick-Off meeting on October 18, 2023** in Celebration, FL, and consistently attend Initiative face-to-face (mid-project only, September 2024) or virtual meetings throughout the project period.
- Participate in presenting during monthly learning coaching calls and webinars on sharing progress, overcoming challenges, seeking consultation, or other topics.

Hospital Administrator in Participating Hospitals:

- Promote the goals of the collaborative and develop links to hospital strategic initiatives.
- Provide the resources to support their team, including time to devote to this effort (team meetings, learning sessions, FPQC Homeward Bound Initiative virtual and in-person meetings and monthly coaching calls/webinars) and facilitate active senior leadership involvement as appropriate.
- Closely track initiative progress to assure adequate initiative support during the pilot and full initiative duration.

Neonatologist and Nurse Leaders in Participating Hospitals:

- Lead the hospital's quality improvement efforts, including convening regular team meetings.
- Develop a strategy for accountability among partners to help assure progress toward local goals.
- Attend Homeward Bound Initiative virtual and in-person meetings and monthly collaborative coaching calls/webinars.
- Share information and experiences from the initiative with fellow participants on coaching calls/webinars and at in-person meetings.
- Perform tests of change that lead to process improvements in the organization.
- Work with your peers to gain support and incorporate initiative components into practice.
- Spread successes across the entire hospital system where applicable.

Strategies will be adaptable to all hospital settings. Each facility can either adopt an existing set of protocols or guidelines and tools or develop/adapt protocols or guidelines and tools over time using the evidence-based elements.

FPQC will:

- Build a strong collaborative learning environment to support hospitals with driving change
- Coordinate experts and other resources to support the improvement process
- Offer content oversight and process management for the initiative
- Offer participants evidence-based information on the subject and information on applying that subject matter via medical and quality improvement experts
- Offer tools and resources to support hospitals in implementing process changes and improving documentation
- Develop/adapt/update useful materials and tools as needed by the initiative

- Host an online resource toolbox for hospital implementation
- Offer guidance and feedback to participating hospitals on executing improvement strategies
- Provide educational events and conduct on-site technical assistance consultations
- Convene regular learning session coaching calls and webinars to support hospitals in driving change
- Facilitate an online data submission process and provide monthly quality improvement data reports for participating hospitals as well as a baseline assessment report
- Communicate progress and deliverables to the stakeholders of FPQC
- Evaluate and report results in a fashion that does not publicly identify hospitals and providers

Homeward Bound Initiative hospitals will learn improvement strategies that include establishing goals and methods to develop, test, and implement changes to their systems with the goal of improving family discharge readiness. Sites will collect quantitative and qualitative data and submit monthly to FPQC using REDCap, a HIPAA-compliant, secure online interface. FPQC will regularly provide hospital teams with de-identified comparative data over time as a pdf file or an online data-secured portal using Power BI. A data use agreement will be established with hospitals prior to the start of the initiative.

Homeward Bound Initiative Timeline

Timeline is subject to change.

Tasks	Target Completion Date
Recruit Leadership Team and Submit Hospital Application to Participate	August-September 2023
Attend in-person Hospital Kick Off in Celebration, FL	October 18, 2023
Establish Local Team Meeting Schedule	October – December 2023
Individual Hospital Kick-Offs of HB Initiative	January 2024
Regular Learning Session Webinars for training and collaboration (including at least one presentation from each facility on your progress) Hold regular local team/department meetings	January 2024-June 2025
Ongoing Data Collection and Technical Assistance upon request	January 2024-June 2025
In-person mid-initiative meeting	Fall 2024
Full initiative hospital post-implementation survey	May 2025
Full Initiative Completion	June 2025

Homeward Bound Initiative Recommended Key Practices

1. Form a multi-disciplinary team to address potentially better practices that improve the transition to home
2. Encourage family/caregiver engagement in the discharge process beginning early in the NICU stay
3. Develop or revise hospital guidelines and policies that support and promote transition to home
4. Provide family education throughout NICU admission to optimize infant outcomes and transition to home
5. Identify health related social needs and make referrals that support family needs

6. Develop with the family a patient- and family-specific care plan as needed for primary care, specialty care, rehabilitative care, other health services, equipment, and community services, and make all of the necessary arrangements prior to NICU discharge.

A key driver diagram that visualizes factors that impact outcomes in order to assist in prioritizing strategies and actions to improve outcomes is included in Appendix A.

Initiative Core Measures

Data collection and analysis are a key components of quality improvement. What gets measured gets managed! Participants will focus on improving practice metrics for their institution relative to their baseline assessment (aggregate and de-identified data will be submitted by participating sites). We will provide metric outcomes de-identified by hospital to allow each hospital to compare itself to other participating sites.

Participating hospitals will be asked to collect and submit data to support outcome, process, and structural measures. Please see the Measurement Grid in Appendix B for more information on each measure.

How to Apply

To be involved in the Homeward Bound Initiative, please complete the online application at this link: https://usf.az1.qualtrics.com/jfe/form/SV_1WSsYwHMQ1WJ20C. The deadline for submitting an application is October 2, 2023.

It is important that you coordinate with your entire department to ensure everyone is aware that you are submitting an application and your hospital does not submit more than one application with different champions. A minimum of 3 team leaders are required. We will contact all team members by email to confirm commitment; **a response from all team members will be required to complete your application.**

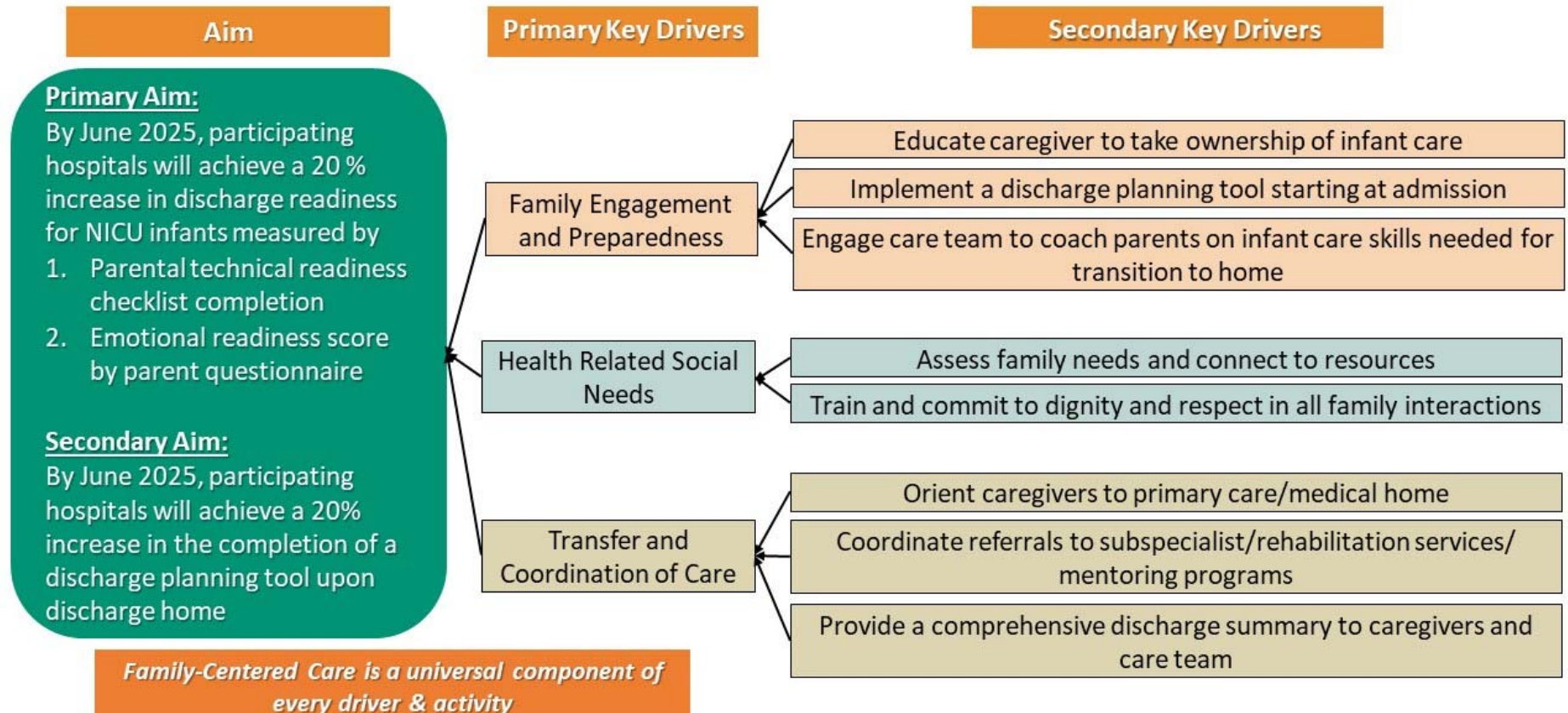
If accepted, a Hospital Commitment Letter signed by an appropriate authorizing hospital executive will be required. A Data Use Agreement will be provided to accepted hospitals.

APPENDIX A: KEY DRIVER DIAGRAM

A key driver diagram (KDD) is intended to assist in identifying factors that impact outcomes, and in prioritizing actions and strategies to be undertaken to improve outcomes.

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.



APPENDIX B: MEASUREMENT GRID

HOMeward BOUND INITIATIVE (HB) MEASUREMENT GRID

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.

Hospitals will report:

1. Monthly aggregate data for all NICU admission whose primary caregiver was screened for HRSC with a tool and referred to services

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, as follows: a) 2500 grams and above; b) 1500-2499 grams; c) 1499-750 grams; d) less than 750 grams. Hospitals can choose at the start of the initiative not to report information on smaller birthweight categories for QI purposes if having too few infants in a specific category for tracking purposes (roughly fewer than 5 infants per quarter)

If there are fewer than five infants for any specified birth weight category per month, report all the available records for that category.

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

#	OUTCOME MEASURE	Description	Source
O1	Parental technical readiness checklist completion	<p>Numerator: # of NICU caregivers that have completed the parental technical readiness checklist</p> <p>Denominator: # of qualifying NICU patients</p> <p>Note: The date when parents do <u>teach back</u> for appropriate items in the checklist must be documented to consider the checklist completed.</p> <p>Items in the checklist required for each infant must be defined per unit protocol.</p>	Medical chart

O2	Emotional readiness score by parent questionnaire	<p>Numerator: # of NICU caregivers that report being “well prepared” on the emotional readiness questionnaire</p> <p>Denominator: # of NICU caregivers that complete the emotional readiness questionnaire</p> <p>The emotional readiness questionnaire should be completed by the primary caregiver prior to discharge via FPQC survey.</p>	Patient Survey
O3	Discharge Planning Tool	<p>Numerator: # of completed discharge planning tools upon discharge</p> <p>Denominator: # of qualifying NICU patients</p> <p>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.</p>	Medical chart
#	PROCESS MEASURES		
P1	Perform Health-Related Social Needs Assessment	<p>Numerator: # of NICU primary caregivers who were screened using the Health-Related Social Needs Assessment tool</p> <p>Denominator: # of qualifying NICU patients</p> <p>Data will be reported for both the sample and all NICU patients (aggregate)</p>	Medical chart
P2	Provide resources for identified Health-Related Social Needs	<p>Numerator: # of NICU primary caregivers who screened positive for Health-Related Social Needs who were given available resources</p> <p>Denominator: # of qualifying NICU patients whose primary caregiver screened positive for Health-Related Social Needs</p> <p>Data will be reported for both the sample and all NICU patients (aggregate)</p>	Medical chart
P3	Schedule subspecialty and therapy appointments prior to DC	<p>Numerator: # of patients with all appropriate subspecialty, therapy, follow-up and equipment appointments based on the patient-specific care plan scheduled prior to discharge</p> <p>Denominator: # of qualifying NICU patients</p>	Medical chart
P4	Provide education to the primary caregiver about the patient-specific care plan	<p>Numerator: # of primary caregivers that received education about the patient-specific care plan prior to discharge</p> <p>Denominator: # of qualifying NICU patients</p> <p>A patient-specific care plan should include appointments, referrals, immunizations, meds, diet, special needs/instructions, equipment orientations</p>	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 families 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 families 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 the Health-Related Social Needs Assessment tool
S2	Policy, procedure, or guideline to offer free parking for all NICU Caregivers
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 community advisor in the QI team (e.g. Healthy Start representative, home visiting program representative)

Questions? Please contact FPQC@usf.edu
v. 7/24/2023

ⁱ Smith V.C. NICU discharge preparation and transition planning: introduction.

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