NICU Graduates

Key Driver Diagram (KDD)

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Revision Date: 11/23/16

SMART Aim

By June 30, 2017, NICU infants with complex needs will successfully transition to care at home, as measured by:

- Decreased average time from initiation of medical intervention (trach/vent/g-tube) to care at home by 10%
  - *Decreased time from "medically ready for discharge" to care at home by X% (hospital & system sensitive)*
  - *Decreased time from "physiologically ready for discharge" to care at home by X% (system sensitive)*
- Decreased avoidable unplanned readmissions within 7 days of discharge by 10%
- Family/parent/caregiver measures TBD

Global Aim

Infants with complex needs will have optimal care and outcomes as a result of improved and sustained support for families during and after NICU stays, resulting in being successfully cared for at home.

Key Drivers

- Early identification of need for medical intervention (trach, vent, g-tube)
- Strengthened family capacity to care for infant during transition to home and long term
- Earliest and standardized process for transition to home
- Enhanced coordination of care through a prepared medical home and needed community resources
- Available and adequately trained home nursing workforce
- Collaboration among families, clinicians, hospitals and insurers to identify & address system barriers

Interventions

- **Identify, develop and implement standards to optimize decision to trach, including family readiness and infant's medical readiness**
  - Utilize shared decision making tools
- **Caregiver education during hospitalization**
  - Early, repeated education based on learning style assessment
  - Use of simulation technology, teach-back method, journey board
  - Provision of red flag action plan
- **Assessment of family's emotional needs**
- **Develop and activate peer social support and parent community**
- **Continuous support from sub-specialty team after transition to home**
  - Plan for and utilize technology to connect families & providers after transition to home, consider e-mail and telemedicine
- **Identify and communicate with Medicaid Care Manager/Case Manager**
- **Standardize roles and responsibilities of discharge point person at Children's hospital and Medicaid, and include family in communication**
- **Enhanced understanding of public resources**
  - Create tools to guide appropriate resource utilization (DME, home nursing, community support, etc.)
- **Identify eligibility for available resources (Managed Care Medicaid, Waiver) and early triggers for application process**
- **Work with Medicaid to ensure qualified home nursing**
  - Develop guidelines for home nursing care with individualized patient red flags
- **Create and standardize assessment/reassessment tools to match home nursing services to the child's needs**
- **Ensure seamless provision of Durable Medical Equipment and other emergency equipment**
  - Standardize checklists for DME with best practices
  - Establish early contact with DME providers
- **Standardize hand off between Children's Hospital and PCP, with standard communication including:**
  - Phone call prior to transition home with entire team including current provider (pulmonologist/neonatologist), family caregivers/parents, and PCP
  - Discharge notes and red flag action plan provided to PCP in timely manner