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 when “infant is medically ready for discharge” to care at home by X%
- 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