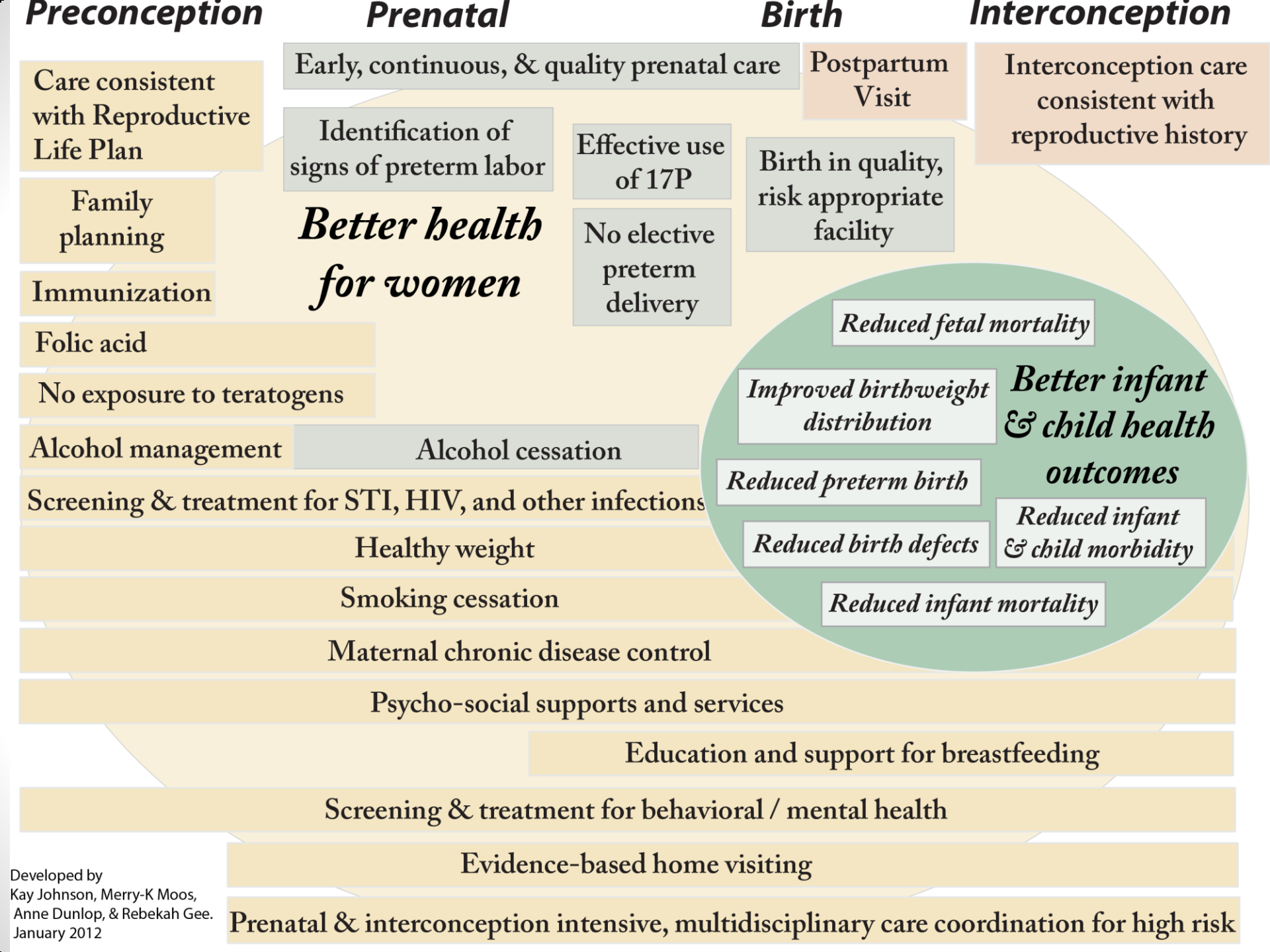
Strategies 2 and 3

Continuum of Care

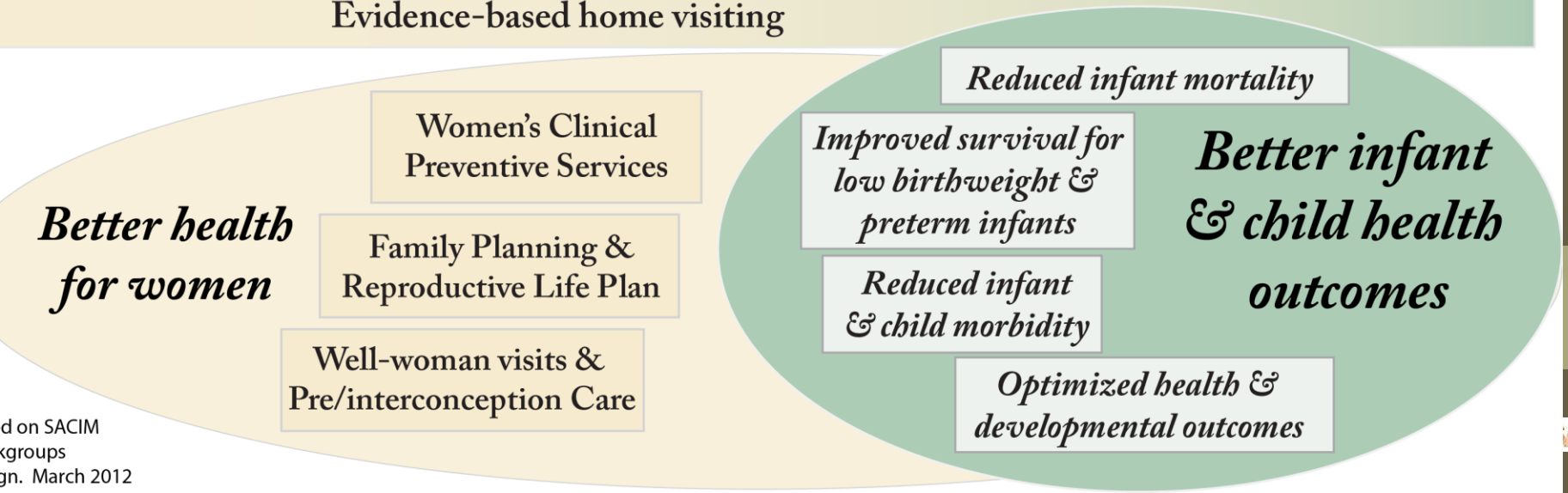
Effective Preventive Interventions

Summary

July 2014


Preconception
Prenatal
Birth
Interconception
Early, continuous, & quality prenatal care
Postpartum Visit
Interconception care consistent with reproductive history
Care consistent with Reproductive Life Plan
Identification of signs of preterm labor
Effective use of 17P
Birth in quality, risk appropriate facility
Family planning
Better health for women
No elective preterm delivery
Immunization
Folic acid
No exposure to teratogens
Reduced fetal mortality
Improved birthweight distribution
Better infant & child health outcomes
Alcohol management
Alcohol cessation
Reduced preterm birth
Screening & treatment for STI, HIV, and other infections
Reduced infant & child morbidity
Reduced birth defects
Healthy weight
Smoking cessation
Reduced infant mortality
Maternal chronic disease control
Psycho-social supports and services
Education and support for breastfeeding
Screening & treatment for behavioral / mental health
Evidence-based home visiting
Prenatal & interconception intensive, multidisciplinary care coordination for high risk
Developed by
Kay Johnson, Merry-K Moos,
Anne Dunlop, & Rebekah Gee.
January 2012

Birth	Newborn/neonatal	Postneonatal
Birth in quality, risk appropriate facility	Well-child care based on Bright Futures	
	Immunization	
NICU quality & safety	Diagnostic & treatment services	
	Education on child development and parenting	
	Injury & SIDS prevention	
	Protection from violence, home and community safety	
	Quality early care and education	
	Newborn screening with appropriate follow up	Intergenerational screening & treatment for mental health
Education and support for breastfeeding		
Smoking cessation yielding smoke free environment for infant		
Evidence-based home visiting		



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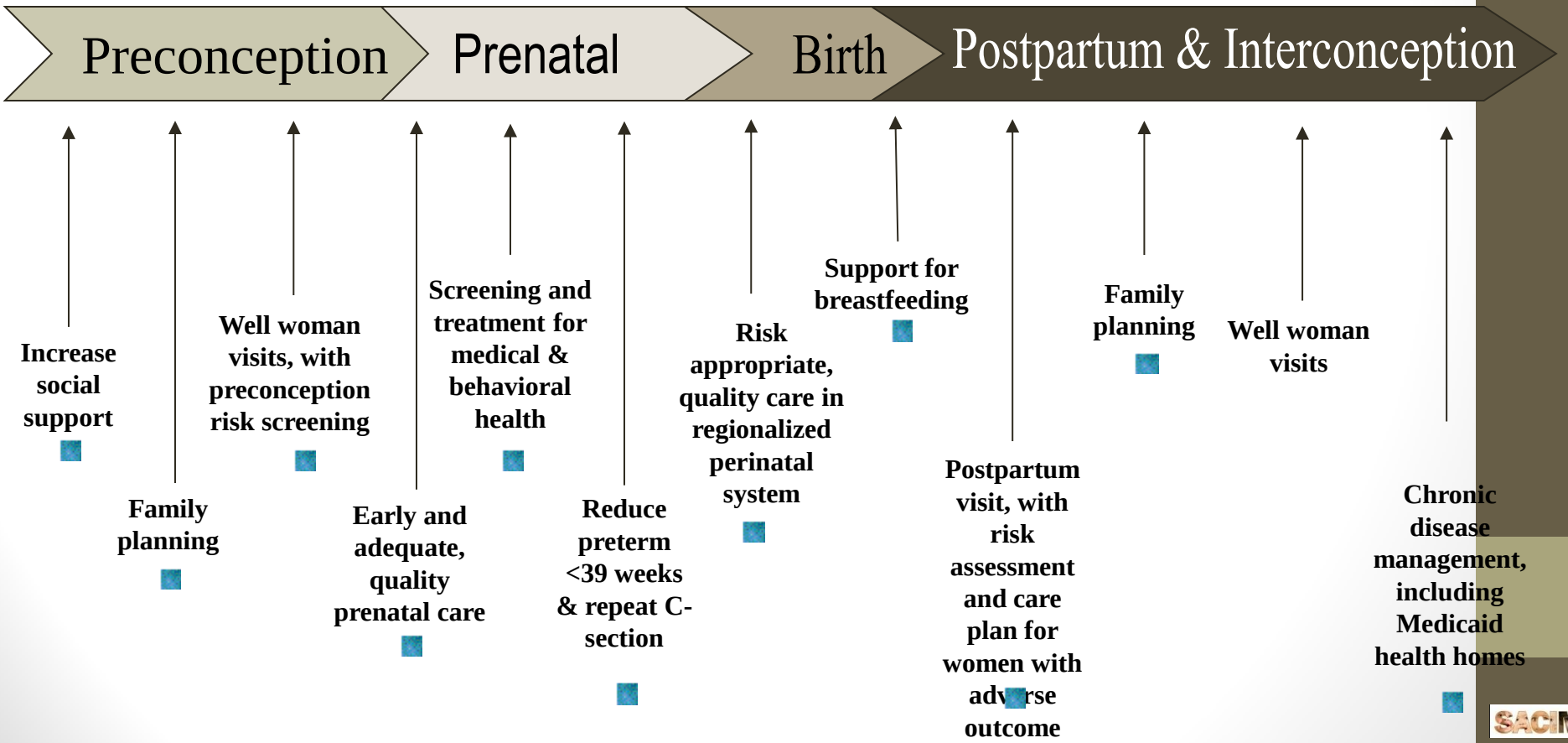
SACIM Strategic Directions: *6 Big Ideas*

1. **Improve the health of women before, during and after pregnancy.**
2. **Ensure access to a continuum of safe and high-quality, patient-centered care.**
3. **Redeploy key evidence-based, highly effective preventive interventions to a new generation.**
4. **Increase health equity and reduce disparities by targeting social determinants of health through investments in high-risk communities and initiatives to address poverty.**
5. **Invest in adequate data, monitoring, and surveillance systems to measure access, quality, and outcomes.**
6. **Maximize the potential of interagency, public-private, and multi-disciplinary collaboration.**

Strategic Direction 2. Ensure access to a continuum of safe and high-quality, patient-centered care

- **2.A. Strengthen state capacity to reduce infant mortality through the HRSA-MCHB COIIN.**
- **2.B. Use Medicaid to drive quality.**
- **2.C. Support quality improvement activities through other agencies, including AHRQ and CDC.**
- **2.D. Support coverage for all newborns**
- **2.E. Maximize the ACA investments in community health centers and workforce capacity.**

Continuum of Women's Health Interventions to Improve Birth Outcomes



Linkages Across the Perinatal Spectrum

- **A time of many transitions**
  - NICU, lost to follow up, postpartum, breastfeeding babies, etc.
- **Closing the gaps among platforms for care delivery, providers, systems**
  - What do linkages need to look like?
  - What are metrics for success in linkages?
- **What do we expect/deliver in first days following birth?**

Continuum: Linkages

- **Within and between health system and other systems of care/services in the community**
- **What are the costs of failed linkages in perinatal period?**
  - "Readmission" costs
- **Continuity that is**
  - Horizontal, vertical, longitudinal, intergenerational, and holistic

How can Medicaid drive quality across the continuum of care?

- **Triple Aim: pt experience, improved population health, reduced cost**
  - Regionalization
  - Transitions
  - Postpartum visits (content, safety)
  - Maternal depression screening
  - Breastfeeding standard of care, provider qualifications/trained support
  - FP/LARCs
  - Interconception care/chronic disease care

“Churning” as Risk Factor

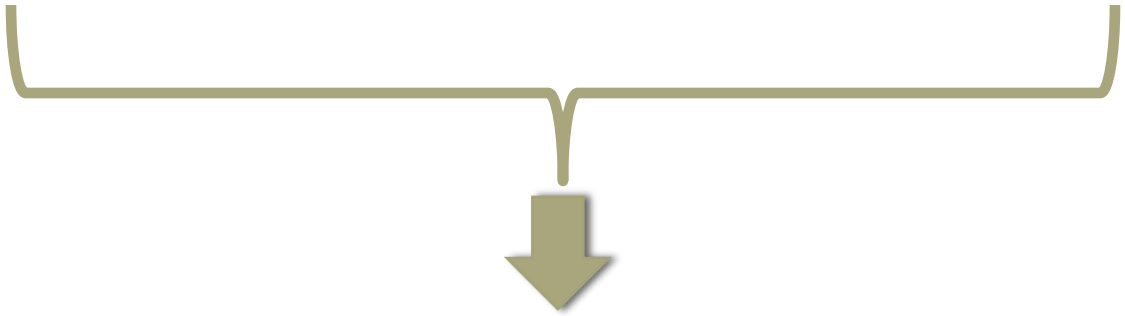
- **ACA exchange coverage**
  - Variation in state implementation of ACA and Medicaid expansion
  - Potential for churning in coverage between Medicaid and exchanges
  - Negative impact on transitions, continuity of care, patient-provider relationships

PCMH for Perinatal Care

- **Integrated framework necessary**
  - Medical home for woman and child may be different
  - Women have to go to many places to put it together, especially those most at risk in psycho-social terms
- **Move beyond clinical orientation**
  - Many providers involved
    - Ob-gyn, family physicians, nurse-midwives, neonatologists, pediatricians
  - Other critical providers in perinatal period
    - Lactation consultants, family planning, home visitors, behavioral health, child development, case managers, community health workers, nutrition (WIC)
  - Community integration/connection essential
- **Transitions are complicated**
  - Improve hand offs
  - Information sharing, active referral and follow up

What is Already Happening?

- **Quality and safety**
- **“Value based purchasing”**
- **ACOs and integrated systems**



What can we learn from these (adult care) and bring to Perinatal Care Continuum

What are best practices?

- Home visiting
- Integrated systems with community connections (accountable care communities)
- Health centers and workforce
- California quality monitoring system
- Continuity of coverage
- Retooling postpartum visit
- Interconception care – disease management approach
- FP/LARC shortly after delivery, inpatient
- Early elective delivery

Strategic Direction 3. Redeploy key evidence-based, highly effective, preventive interventions to a new generation

- **3.A. Give emphasis through social marketing, health education, and access to preventive services for five key preventive interventions.**
  - **Breastfeeding**
  - **Family planning**
  - **Immunizations**
  - **Safe sleep to prevent SIDS/SUID**
  - **Smoking cessation**

Health Centers/Workforce

- **Role in improving the health of women, infants, children, and families**
- **Opportunities with ACA expansion**
- **Equity, diversity, and quality in workforce**
- **Primary care incentives**
- **OB/GYN and primary care**

Presentations

For each of the themes of* health equity, medical home, linkages and communication, *discuss:

1) Current gaps related to the continuum of care and quality of care issues

2) Overlap/ alignment with other federal/state initiatives or public-private partnerships

3) Framework for a perinatal medical home or for improving linkages between a child's medical home and a mother's medical home, with a broad definition of patient-centeredness

4) Specific concrete recommendations for the Secretary, within HHS purview

Topics (equity, medical home, linkages, communication)

- **Delivery → Postpartum visits → well woman care + FP (Arden Handler)**
- **Perinatal regionalization (Joann Petrini)**
- **Hospital to community (Raymond Cox)**
- **Mental health/ depression (Fleda Jackson)**
- **Delivery to pediatrics / early intervention (Milt Kotelchuck)**
- **Breastfeeding (Miriam Labbok)**
- **Home visiting (Joanne Martin)**

Goals

- Look at transition points, look for similarity and alignment in gaps/need/recommendations related to continuity
- Define key issues and recommendations
- Develop a SACIM checklist for continuum of care
- Letter to the Secretary by July 31