Ensuring Access to a Continuum of Safe and High Quality, Patient Centered Care: Birth to Pediatric Care and Early Intervention

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Secretary's Advisory Committee on Infant Mortality
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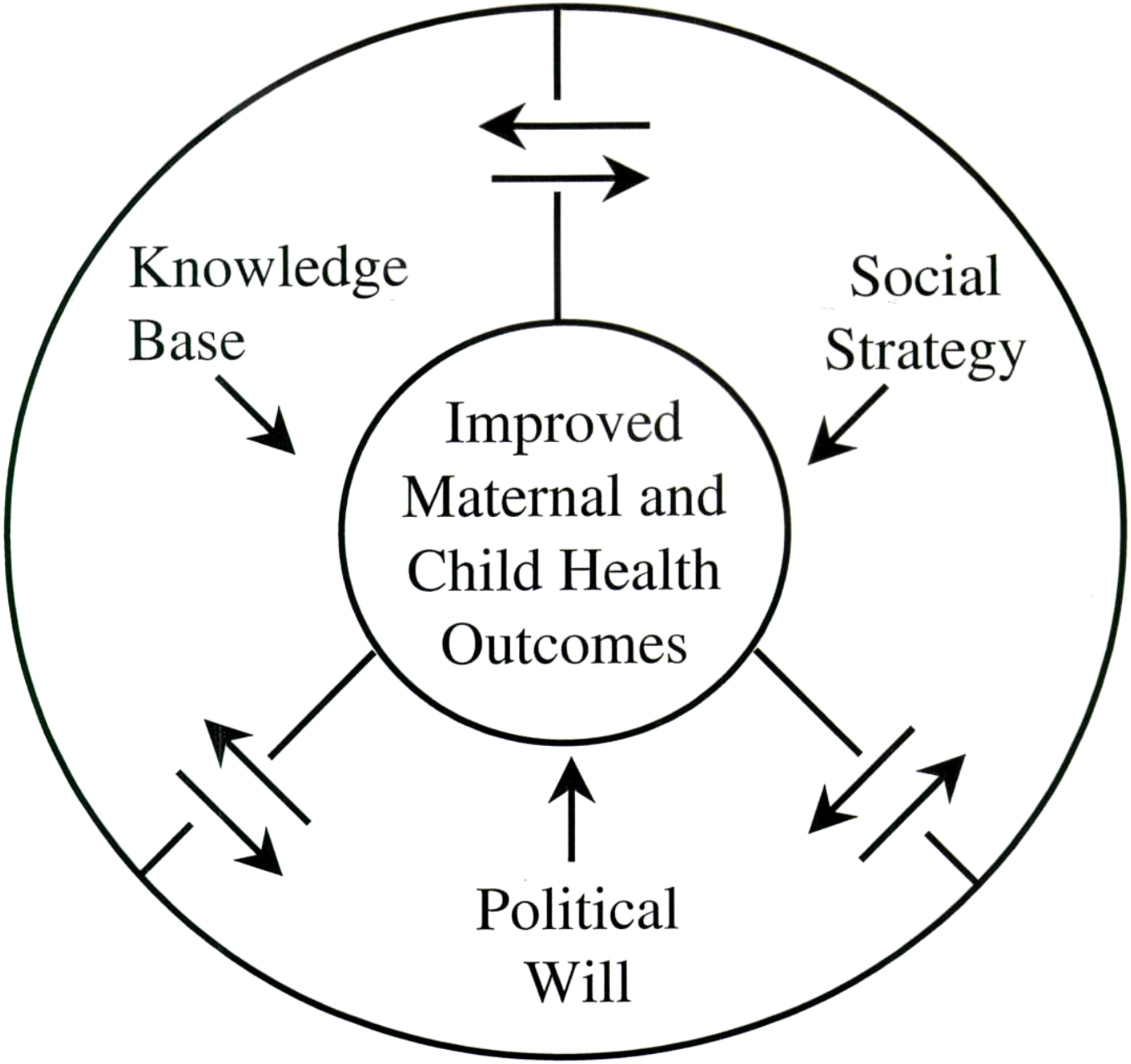


Richmond & Kotelchuck, 1983

Structure of talk

- Frameworks for SACIM's deliberations
- Broad Overview of Topic
  - Continuum of Care
  - Quality of Care
  - Access
  - Patient-Centered Care
- Alignment with national and professional initiatives and public-private partnerships
- Recommendations for Secretary of US DHHS

3. Frameworks

- How do we elaborate a framework for a perinatal medical home or for improving linkages between a child's medical home and a mother's medical home?
- How do we focus on a broad definition of patient-centeredness part of the medical home concept, beyond a strictly clinical definition?

- Life course continuities
- Triangulation of MCH life course services

MCH Life Course Continuities/Discontinuities of Care

- Vertical linkages
- Horizontal linkages
- Longitudinal linkages
- Holistic linkages

- Intergenerational linkages

(Enhancing) Intergenerational Continuity and Health

- Not Maternal or Child Health
- Intergenerational continuity or duality is the important concept
  - Impact of maternal (and paternal) health and well being on infant health [traditional risk factor/women as vessel perspective]
  - Impact of (pregnancy and) infant health on maternal health [our newer women's health perspective]
  - The health and well being of each directly impacts the other – we are bound together (our healths are bi-directional)
- Strengthening science base for intergenerational health
- Supports multiple interventions that impact both mothers/infants

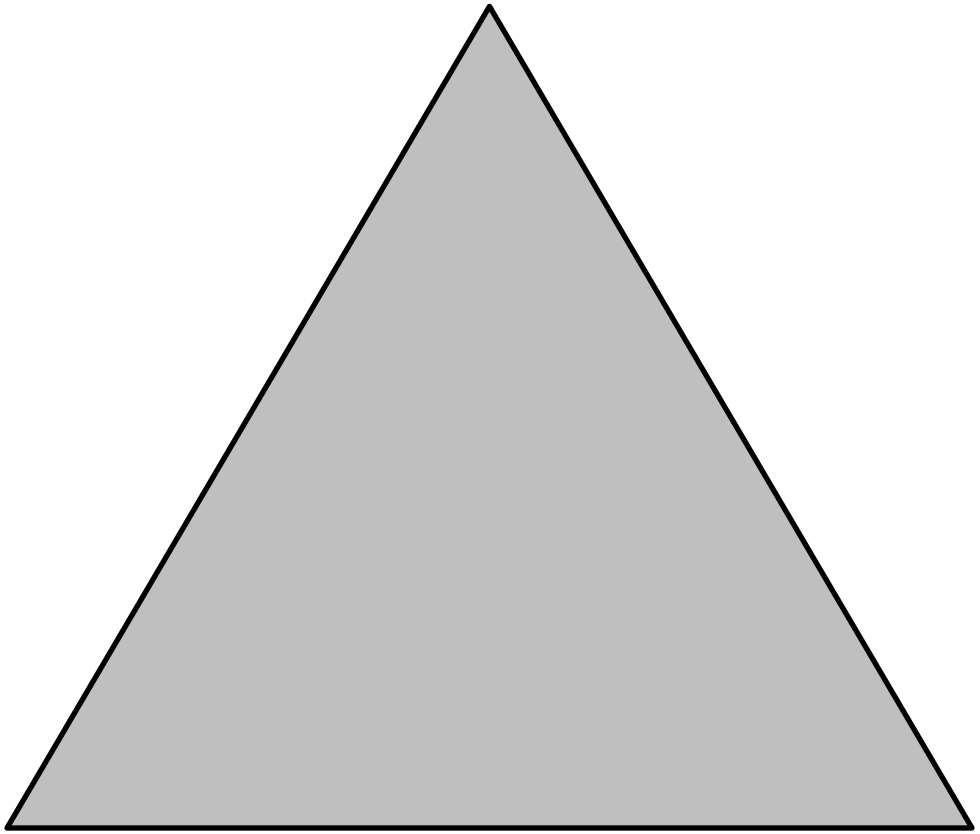
- Intergenerational health and continuity could serve as an important cross cutting theme/paradigm for the SACIM's work
  - Both conceptually and for generating Political Will

Triangulation of MCH Life Course Services

- New MK thinking about MCH practices (Social Strategies) to address (disparities in) reproductive health
  - Derived from LCRN essay
- All MCH Life Course interventions fall into one of three broad categories
  - Clinical; social determinants; maternal agency
- All are needed to address the complex, multi-sectorial issues involved in optimal maternal and newborn health

Triangulation of MCH Life Course Services

Maternal/family focused resiliency, agency and responsibility interventions



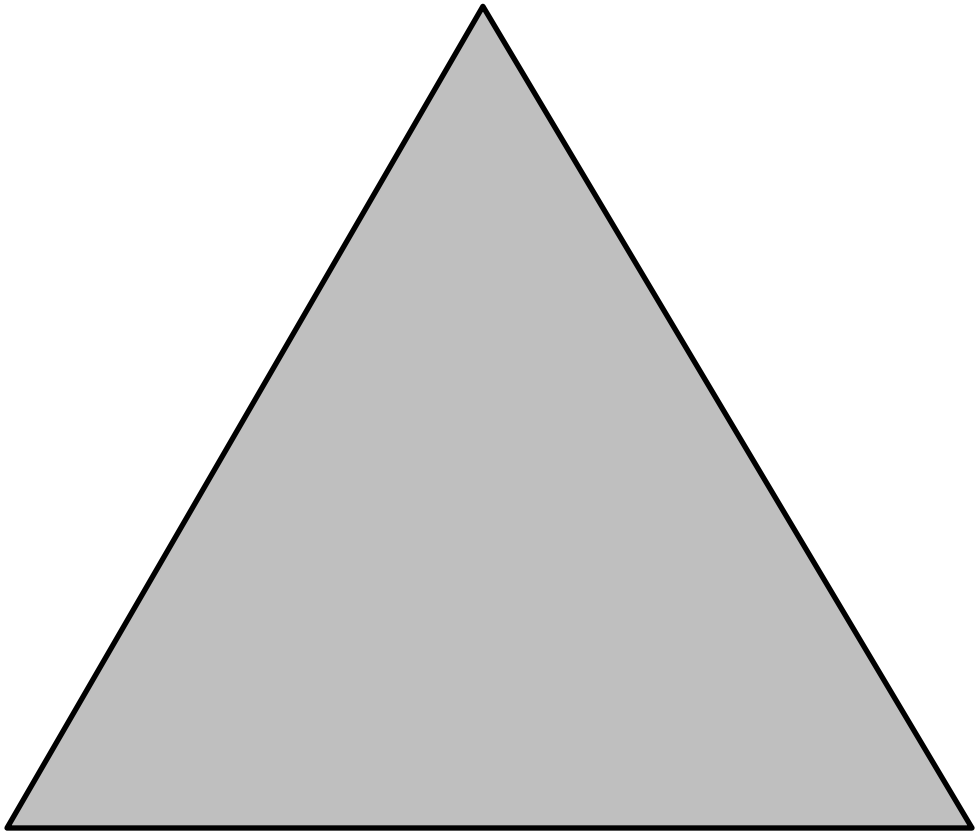
Clinical care and systems interventions

Social determinant interventions

Triangulation of MCH Life Course Services:

Strategy 2: Ensuring access (SD) to a continuum of safe and high quality (clinical), patient-centered (agency/resiliency) care

Maternal/family focused resiliency, agency and responsibility interventions



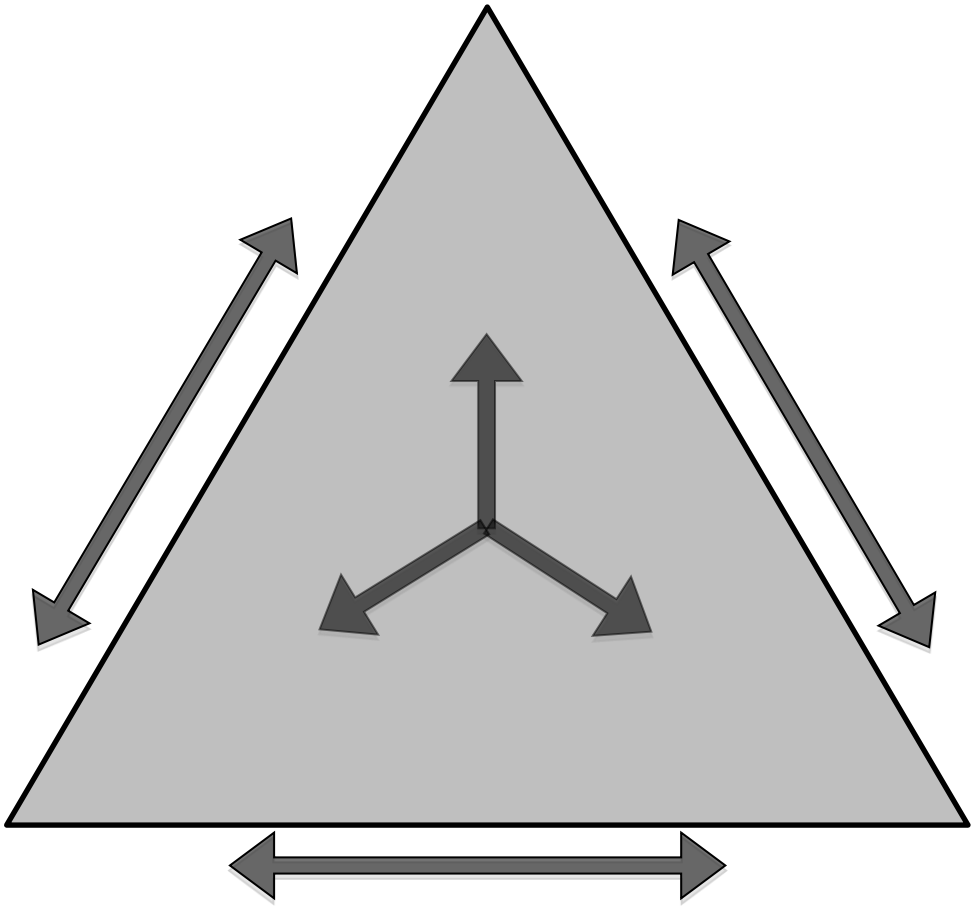
Clinical care and systems interventions

Social determinant interventions

Multi-sectorial interventions and programs

Successful initiatives need to address all three sectors; Single sectorial programs are less effective than multi-sectorial programs

Maternal/family focused resiliency, agency and responsibility interventions



Clinical care and systems interventions

Social determinant interventions

Ensuring Access to a Continuum of Safe and High Quality, Patient Centered Care: Birth to Pediatric Care and Early Intervention

1. Key Issues/Overview: Gaps in Continuum of Care

- Generally, birth to pediatric care (vertical) continuity or transitions are quite strong
  - though obstetrics and pediatrics are very distinct profession communities
- NICU availability/pediatric regionalization continues to expand
  - But new health system realignments may threaten existing regionalization arrangements
- Not all pediatric practices are full pediatric medical homes
  - Many pediatricians lack capacity for horizontal linkages to social service and allied health programs
  - Nor do many provide/conceptualize provision of maternal (intergenerational) health care
- Transitions of CSHCN to Early Intervention Programs are very uneven
  - Substantial variations by hospital, across states, and by child conditions
  - Newly emerging EI concerns ACT, NAS, ASD
- Transitions to (multiple) home visiting programs very disorganized
  - Absence of universal newborn (nurse) home visit programs in US

1. Key Issues/Overview: Gaps in Quality of Care

- Quality of Care is an issue of high importance and sustained efforts of the obstetric, neonatology and pediatric communities
- New methodologies have dramatically transformed approaches to address and improve quality and safety of perinatal care
  - Recent growth and acceptance of continuous quality improvement (CQI) initiatives
  - Development of new State Perinatal Quality Care Collaboratives/VON
- Specific new topical areas are emerging as quality of care challenges for continuity among these professional communities
  - ACT (Antenatal Corticosteroid Treatment) for premature infants
  - NAS/Opioid epidemics (detection, tx, referrals to EI)
  - Newborn screening for developmental, genetic, and metabolic disorders
  - Nutritional continuity (micronutrients, breastfeeding, microbiome, obesity)
  - Parental psycho-social issues (maternal depression, IPV, substance use)
  - Longitudinal Data bases (OB to Community Pediatricians to EI/HV)

Antenatal Corticosteroid Therapy

- ACT is an effective secondary prevention intervention for premature infants of 24-34 weeks gestational age
- ACT reduces RDS, decreases severe IVH; and reduces neonatal mortality RR =.69
- Needs 48 hours for optimal effectiveness
- ~75% ACT initiation in tertiary hospitals; estimated 50% nationally – and these are for initiating only, not optimal doses
- ACT is the national standard for care –since 1994
- ACT is a quintessential intergenerational issue
- Key OB transition to neonatal/pediatric care issue
- Key issues - Getting women to hospital in optimal time; knowing when to administer doses; measurement challenges
- Now starting to be adopted as potential PQCC issue, but it will requires all three sectors involvement

Neonatal Abstinence Syndrome

- ~1.7% of births have NAS, and rising with opioid epidemic in U.S.
- NAS requires addressing all three MCH life course sectorial issues
- Quintessential intergenerational issue
- Critical OB transition to pediatric care issue
- Key issues - early and systematic SUD assessment, proper treatment for NAS, lack of SUD services for women (especially pregnant and post-partum women), child welfare and legal involvement, linkage to mental health and other behavioral issues, and l measurement issues
- Maternal substance use is a mandated EI referral since 2004– but recent MA study (by Derrington) showed only 66% NAS referrals to EI, and strong referral bias by insurance status (80% public vs. 55% private), and low and varied hospital rates of referrals (17%)
- Substance use is also a very difficult topic for home visitors, EI programs
- Some VON PQCC initiatives underway, but complex continuity issues remain
- MGH CQI initiative story – concern but lack of continuity

1. Key Issues: Gaps in Access

- Access to infant pediatric (clinical) care is strong in the US – reflecting the gains of SOBRA, CHIPRA, and ACA initiatives
  - Though some newborns/infants lack health insurance leaving birthing hospital (support universal coverage of all newborns by making temporary coverage available to those who are uninsured)
- Paid Maternity Leave is key to intergenerational health care in the perinatal period, for access to early pediatric and postpartum care, early bonding, BF, ...
  - Only available in three states, now being encouraged by President Obama
  - Paid leave & maternal/childhood allowances key to European maternity insurance policies and their lower rates of LBW infants
- At local community level, many families lack sufficient and high quality pediatric (and other medical) care resources (a placed-based problem)
- Access to EI programs is available in all states, but often limited state funding limits availability or restricts eligibility for EI services
- Available Home Visiting programs do strongly emphasize access to and utilization of pediatric clinical care, plus access to entitled social services resources and empowerment of families; but insufficient HV programs, especially universal newborn programs

1. Key Issues: Gaps in Patient Centered Care

- Patient centered involvement in transition to Pediatric Care mixed
  - Parental choice of pediatrician or hospital assignment
  - Growth of hospitalists limits pediatric newborn rounding
- Virtual absence of maternal empowerment training programs
  - Limited group prenatal or pediatric care
  - Insufficient mothers (or parents) groups/clubs, parent cafes
- PCORI has not yet devoted sufficient attention to perinatal health issues
- EI/CSHCN advocates/MCHB and AAP do actively foster patient centered care orientation
- Prevention training enhances patient centered health care/agency
- Increased use of social media for parent-centered care communications and clinician/parent (preventive) health communications
- Home visiting programs can and do address empowerment of families, as well as clinical care and access to entitled social services resources
- Father involvement initiative reflect a patient centered perspective

2. Alignment with other federal/state programs and public private partnerships

- Birth to Pediatrics is an area of strong public health and clinical practice programs, and public-private partnerships
  - A positive legacy of the 100+ year efforts to reduce infant mortality, both neonatal and post-neonatal mortality
- Virtually all federal agencies (CDC, ARHQ, MCHB/HRSA, NICHD, CMMS, USDA,…) are concerned to improve infant outcomes and reduce disparities, as are professional organizations (ACOG, AWOHNN, AAP…) and public-private organizations (MOD,….)
- Several national programs explicitly address access to high quality safe maternity and post-birth clinical care CoIINs (MCHB), Strong Start (CMMS), National Quality Forum, CHIPRA National Quality demonstrations; SUID prevention (CDC),…
- We don't have to create new national or state programs or institutions, but to strengthen the existing MCH organizations and agencies to address newly emerging and existing challenges

Core Recommendations

- Encourage and fund Perinatal Quality Care Collaboratives in every state
- Strengthen (and maintain vigilance about) Perinatal Regionalization under ACO/ACA reforms
- Increase funding for Early Intervention programs, and strengthen/develop national quality standards for EI services
- Initiate national campaigns around two specific perinatal continuity issues – ACT and NAS
- Strengthen the Medical Home capacity of Pediatricians
- Initiate new national campaign/program for Paid Maternity Leave
- Strengthen longitudinal capacity and linkage of clinical care and public health of MCH data systems

Concrete Recommendations 1

- Continuity
- Encourage newborn universal (nurse) home visiting programs, as the basis for system of early childhood care
- Increase funding for EI programs
- Support more Pediatric Medical Homes (horizontal continuity) through statewide MD support programs (e.g., Help Me Grow) and enhanced CMMS reimbursement
- Encourage greater pediatrician involvement in Home Visiting programs
- Maintain vigilance (and strengthen) State maternal and newborn regionalization in era of ACO

- Quality
- Expand CDC funds for Perinatal Quality Care Collaboratives into all states, require that they have both perinatal and pediatric quality component
- Support a national ACT campaign (to assure that 100% of mothers of premature infants receive timely treatment); encourage ACT initiatives in CoINNs
- Support perinatal CoIIN and maternal safety initiatives (MCHB) and development of further obstetric quality standards (National Quality Forum)
- Strengthen/establish standards for EI programs, especially create incentives for NAS referrals to EI
- Develop new NAS CQI programs – and provide additional funding for OSEP maternity and early family care initiatives
- Support more Pediatric Medical homes (and explore pediatric reimbursement for maternal care as pilot programs)

Concrete Recommendations 2

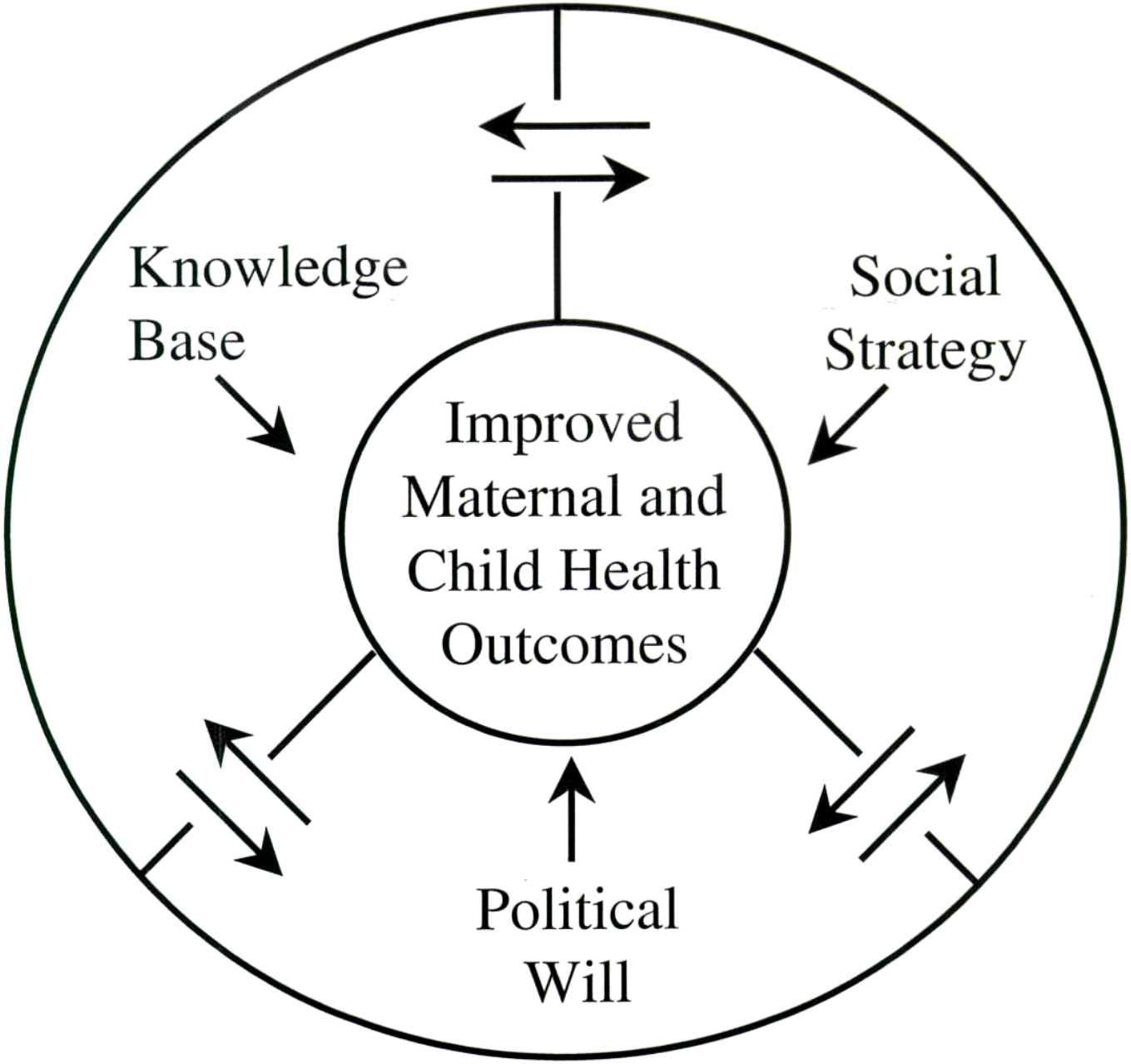
- Access
- Encourage paid maternity leave program experimentation (Obama's recommendation)
- Increase neighborhood health centers
- More placed base initiatives (and collective impact approaches) to improve area resources
- More EI funding; national EI standards
- Encourage newborn universal (nurse) home visiting programs, as the basis for early system of child-care including clinical care

- Patient Centered Care
- Support innovations in social media, group pediatric/health care, resource mothers/block captains to empower mothers
- More support for PCORI initiatives/grants addressing perinatal care
- Encourage more father's involvement in perinatal care

- Programmatic/structural interventions
- Encourage better clinical to early life longitudinal data bases, and more joint clinical and public health data bases
- Encourage CoIINs to think about leaving a legacy in every state in addition to its short-term gains

Discussion

- Converting birth to pediatric/EI continuities ideas into concrete recommendations for the Secretary
- Using intergenerational and MCH Triangulation frames across this topic and all SACIM deliberations
- Your thoughts and comments…..



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