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

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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
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 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 CoIN 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 CollNs 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.....
Richmond & Kotelchuck, 1983

Knowledge Base

Social Strategy

Improved Maternal and Child Health Outcomes

Political Will