Strategies 2 and 3

Continuum of Care

Effective Preventive Interventions

Summary

July 2014
Birth

Birth in quality, risk appropriate facility

NICU quality & safety

Newborn/neonatal

Well-child care based on Bright Futures

Immunization

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

Postneonatal

Intergenerational screening & treatment for mental health

Education and support for breastfeeding

Smoking cessation yielding smoke free environment for infant

Evidence-based home visiting

Better health for women

Women’s Clinical Preventive Services

Family Planning & Reproductive Life Plan

Well-woman visits & Pre/interconception Care

Better infant & child health outcomes

Reduced infant mortality

Improved survival for low birthweight & preterm infants

Reduced infant & child morbidity

Optimized health & developmental outcomes
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

Preconception

- Increase social support
- Well woman visits, with preconception risk screening
- Family planning

Prenatal

- Early and adequate, quality prenatal care
- Screening and treatment for medical & behavioral health

Birth

- Reduce preterm <39 weeks & repeat C-section
- Risk appropriate, quality care in regionalized perinatal system
- Support for breastfeeding
- Postpartum visit, with risk assessment and care plan for women with adverse outcome

Postpartum & Interconception

- Family planning
- Well woman visits
- Chronic disease management, including Medicaid health homes
- Support for breastfeeding
- Well woman visits
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
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