Systems to Transition the Premature & High Risk Infant Home: Development of the NICU Consortium

November 1, 2013
Systems to Transition the Premature & High Risk Infant Home: Development of the NICU Consortium

Speakers

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Care Coordinator/HCP Team Leader, Denver Health and Hospitals

Kathy Bolejack, RN, BSN
HCP (Health Care Program for Children with Special Needs), Tri–County Health Department

Paula Carrasco, RN, BSN
Special Infant Project (SIP), Tri–County Health Department

Carolyn Kwerneland, RN, BSN, CBIS
HCP Program Coordinator, Jefferson County Public Health

Lori McLean, RN
Children with Special Needs Coordinator, Boulder County Health Department
Disclosures

The following have no relevant financial relationships to disclose

Molly Benkert, MS, RN–BC, CBIS
Kathy Bolejack, RN, BSN
Paula Carrasco, RN, BSN
Carolyn Kwerneland, RN, BSN, CBIS
Lori McLean, RN
Objectives

1. Discuss the importance of assuring a coordinated transition home for high risk infants and their families.
2. Describe the purpose and efforts of the NICU Consortium
3. Present available local public health referral criteria and services for high risk infants
Did You Know?

- 7,000 – 8,000 preterm infants are born in Colorado every year.
- Preterm infants may be born to any mother, but are more likely to be born to mothers who experience health disparities in accessing health care services.
- Preterm infants have more regulatory problems due to their medical fragility. These result in hospital re-admissions and challenges for their parents.
- Preterm infants are more likely to re-admitted to the hospital after discharge. They require additional community support services, resulting in increased health and educational costs.
Purpose:

- To provide recommendations to optimize the health and developmental outcomes of premature and late premature infants through systems of care that support the medical home approach, and have the potential to reduce related health care system costs in Colorado.
Action Items from the Summit and Follow Up Meeting September 2012

1. Disseminate best practices and resources to health care providers in Colorado. (e.g. the Follow Up Tool Kit for Premature Infants).
2. Develop a data system about infants and toddlers with special health care needs.
3. Develop educational programs for health professionals regarding the needs of premature and high risk infants.
4. Increase awareness of the needs of premature/high risk infants and their families through policy development.
5. Develop and disseminate parent supports.
6. Follow-up with participants on progress towards Action Items.
NICHQ Neonatal Improvement Project
(National Institute for Children’s Healthcare Quality)

- Maternal Risk Reduction
- Antenatal Practices
- Immediate Postnatal Practices
- Neonatal Transfer Bundle
- Neonatal Intensive Care Unit Practices
- Proper Infection Control Practices
- Coordinating NICU discharge planning
- Optimizing follow-up care of high-risk infants
Vision:

- **Families of babies discharged from the NICU will be informed about appropriate health and community resources.**

Mission:

- **To promote a coordinated system of discharge and follow up for babies transitioning from the NICU to their community**
If parents are connected with community resources, including their primary care provider, we can reduce parent concerns. Infant morbidity and mortality may be decreased.
What is the NICU Consortium?

**Members**
- Public health staff
- NICU Staff
- Primary care providers
- Community partners
- Advocates

**Goal**
- Ensure that best practices are implemented as infants and their families transition home from the NICU.
A NICU Consortium member is assigned to each local hospital NICU to provide education and consultation about local community resources and assistance with referrals.

Care coordination and information about community resources is provided to families, based on the baby’s county of residence.
Benefits of Membership

- Opportunities to connect with local public health, community agencies, primary care providers, and NICU staff
- Opportunities for education and consultation
- Networking to learn about community resources and referrals
NICU Consortium Membership

- Membership is open at no charge to anyone working with premature and at risk infants.

- Quarterly educational and networking meetings are held on the 5th Wednesday of the month.
January 29, 2014  Follow Up and Resources for Infants and Their Parents with Substance Use Exposure  Kathryn Wells, MD

April 30, 2014  Safe Sleep: Special Considerations for High Risk Infants  Tentative: Marianne Neifert, MD Dr. MOM

July 30, 2014  To Be Announced

October 29, 2014  To Be Announced
Referral Criteria:
- Medically complex infants from the NICU

Services Offered
- Consultation and education on community resources to hospital staff

Contact: Molly Benkert
- Phone: 303-602-6765
- Fax: 303-602-8956
Referral Criteria:
- Preterm infants less than 36 weeks with an extended stay and/or babies with congenital anomalies

Services Offered
- Information, consultation or care coordination depending on infant’s/family’s needs

Contact: Carolyn Kwerneland
- Phone: 303–239–7014
- Fax: 303–239–7157
Referral Criteria:
- Preterm/full term infants with significant health conditions or who are at risk for developmental delay.

Services Offered
- Registered nurses provide information as well as care coordination support to link families to community resources and services. Our program also supports developmental monitoring through our ASQ developmental surveillance program.

Contact: Lori McLean
- Phone: 303–678–6137
- Fax: 720–864–6494
Referral Criteria:
  ◦ Preterm/full term infants with complex medical needs & developmental delays

Services Offered
  ◦ Care Coordination—for support, resources and referrals and to coordinate services between multiple agencies.

Contact: Kathy Bolejack
  Phone: 303–783–7139
  Fax: 303–761–1528
Tri-County SIP Program

- Referral Criteria:
  - Preterm infants or infants at risk for developmental delays

- Services Offered
  - Provide families information on infant development. Monitor growth and development. Provide resources

- Contact: Paula Carrasco, BSN, RN
  - Phone: 303–363–3022
  - Fax: 303–341–8043
### NICU Consortium Local Public Health County Contacts

**Referral Criteria and Services**

Most families need some type of support after they are discharged from the NICU; however, families with fewer resources and late preterm infants are often less likely to access available support services and need extra assistance in making needed connections. Eligibility criteria generally includes preterm (<37 weeks gestation), low birth weight (<2500 grams), or discharge from the NICU. Listed below are the specific criteria for referrals and the services provided through the local county Health Care Program for Children with Special Needs (HCP) and local public health nursing.

<table>
<thead>
<tr>
<th>County</th>
<th>HCP Coordinator Contact</th>
<th>Phone Number</th>
<th>Additional Referral Criteria</th>
<th>Services Provided</th>
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</thead>
<tbody>
<tr>
<td>Boulder</td>
<td>Lori McLean, BSN, RN</td>
<td>Phone: 303-678-6137</td>
<td>Preterm/full term infants with significant health conditions or who are at risk for developmental delay.</td>
<td>Registered nurses provide information as well as care coordination support to link families to community resources and services. Our program also supports developmental monitoring through our ASQ developmental surveillance program.</td>
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<td>Fax: 720-864-6494</td>
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<td>Broomfield</td>
<td>Missy Smith, BSN, RN</td>
<td>Phone: 720-887-2221</td>
<td>Preterm/full term infants and children with complex medical needs and/or at risk for developmental delays.</td>
<td>Registered nurse can provide information, community resources, assist with referrals and care coordination for families based on individual need. Services are provided free of charge.</td>
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<td>Helane Lanzer, BSN, RN</td>
<td>Fax: 720-887-2229</td>
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<td></td>
<td></td>
<td>Phone: 720-887-2264</td>
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<td>Wendy Taylor, BSN, RN</td>
<td>Phone: 720-887-2247</td>
<td>Broomfield clients from pregnancy to a child's 2nd birthday, can enroll at any time, does not have to be a first-time parent, free, high risk, preterm/full term infants.</td>
<td>Registered nurse coordinates home visitation program with each client based on individual need. Program provides nursing assessments, developmental screenings using ASQ, parenting support and education, care coordination with other providers, referrals, resources.</td>
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<td>Fax: 720-887-2229</td>
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<td>Denver</td>
<td>Molly Benkert, MS, RN-BC</td>
<td>Phone: 303-602-6765</td>
<td>Medically complex infants from the NICU</td>
<td>Consultation and education on community resources to hospital staff</td>
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<td>Fax: 303-602-8956</td>
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<td>Jefferson</td>
<td>Carolyn Kwerneland, BSN, RN</td>
<td>Phone: 303-239-7014</td>
<td>Preterm infants less than 36 weeks with an extended NICU stay, babies with congenital anomalies, and/or significant medical needs</td>
<td>Information, consultation or care coordination depending on infant's/family's needs</td>
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<tr>
<td>Tri-County (Adams, Arapahoe, Douglas County)</td>
<td>HCP Kathy Bolejack, BSN, RN</td>
<td>Phone: 303-783-7139</td>
<td>Preterm/full term infants with complex medical needs &amp; developmental delays</td>
<td>Care Coordination—for support, resources and referrals and to coordinate services between multiple agencies.</td>
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<td>Fax: 303-761-1528</td>
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<td>**SIP Paula Carrasco, BSN, RN</td>
<td>Phone: 303.363.3022</td>
<td>Preterm infants or infants at risk for developmental delays</td>
<td>Home visitation by registered nurses who provide families information on infant development and behavior and monitor growth and feeding. Nurse are able to provide resources/referrals to health care services and community resources.</td>
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<td>Fax: 303.341.8043</td>
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*HCP—Health Care Program for Children with Special Needs  
**SIP—Special Infant Project

11-1-13
Questions
What are the concerns you hear most often from parents?

What programs are you thinking about, beginning, or have underway to support parents as they transition home from the NICU?

What would you like to see the NICU Consortium focus on in the next year?
Next NICU Consortium Meeting
We Hope You will Join Us

Wednesday, January 29, 2014
9:00 AM to 11:30 AM

“Follow Up and Resources for Infants and Their Parents with Substance Use Exposure”

Kathryn Wells, MD
Thank you for coming