State of Connecticut

GENERAL ASSEMBLY

Medical Assistance Program Oversight Council
Women and Children's Health Committee

Recommendations from the Woman and Children's Sub-Committee Of the Medical Assistance Program Oversight Council's Workgroup on Maternity, Postpartum and Well-Baby Care During COVID-19 and Beyond

The Women and Children's Sub-Committee of the Medical Assistance Oversight Council

Presentation to the Medical Assistance Oversight Council

October 9, 2020

Agenda

1. Amy D. Gagliardi: Introduction and overview
2. Rep Jillian Gilchrest, MSW: Looking at Maternity Care through the Lens of Health Disparity, 4 Kara 4 Kids video
3. Veronica Pimentel, MD: Expansion of Medicaid during the Postpartum Year
4. Veronica Pimentel, MD: Coverage for Non-Invasive Pregnancy Testing
5. Donna Maselli, RN, MPH: Same Day LARC Placement at FQHCs
6. Annie Callamari, LCSW: Expansion of Perinatal Collaboratives at Birthing Hospital in Connecticut.
7. Amy D. Gagliardi, MA, IBCLC, RLC: Coverage of IBCLC Lactation Consultant Services
8. Sandra Carbonari, MD, FAAP, : Immunizations and well-Baby Care
9. Sandra Carbonari, MD, FAAP: Implementation of a Obstetric Provider to Provider Medication Consultation Line Based on the Access-Health Pediatric Medication Consultation Line

10: Representative Jillian Gilchrest: a. Continuation of coverage for both phone and video telehealth services.
b. Develop and implement a state wide web based resource listing which both providers and Medicaid members can access c. Secure coverage for BH groups through video telemedicine d. Telehealth for MAT

11. Q&A

Workgroup Members

Honorary Chair: Lieutenant Governor Susan Bysiewicz

Work Group Planning Committee and Chairs:

- Jillian Gilchrest, MSW, State Representative & Co Chair, MAPOC Subcommittee on Women & Children's Health
- Amy D. Gagliardi, MA, IBCLC, RLC, Community Health Center, Inc., Co-Chair Work Group Planning Committee:
- Donna Maselli, RN, MPH, Connecticut Department of Public Health

Workgroup Committee Members:

- Fatmata Williams, BSN, RN, MPH, CHES, Connecticut Department of Social Services
- Sandra Carbonari MD, FAAP, Medical Director, Connecticut Chapter of the American Academy of Pediatrics
- Ashley Starr Frechette, MPH, Connecticut Coalition Against Domestic Violence
- Monika L. Nugent, MPA, CT Maternal Mortality Review Board
- Mark Masselli, President/CEO Community Health Center, Inc.
- Traci McComiskey, LD/CE/PD, PMH-C, PE, IMH-E, Birth Support Education and Beyond
- Audrey Merriam, MD, MS, Assistant Professor at Yale Maternal-Fetal Medicine
- Shelly Nolan, MS, LPC. Connecticut Department of Mental Health and Addiction Services
- Donna Novella, RN, MSN, Connecticut Hospital Association
- Veronica Maria Pimentel, MD, MS, FACOG, Trinity Health/St. Francis Hospital
- Leigh-Anne Sastre, CNM, Midwifery Costal OBGYN & Midwifery LLC
- Jay Siklick, Esq. Center for Children's Advocacy
- Victor G. Villagra, MD, FACP, UConn Health Disparities Institute
- Catherine Campbell MD, MPH, Yale School of Medicine
- Annie Calamari, LCSW, Middlesex Hospital LCSW

Workgroup Recommendations

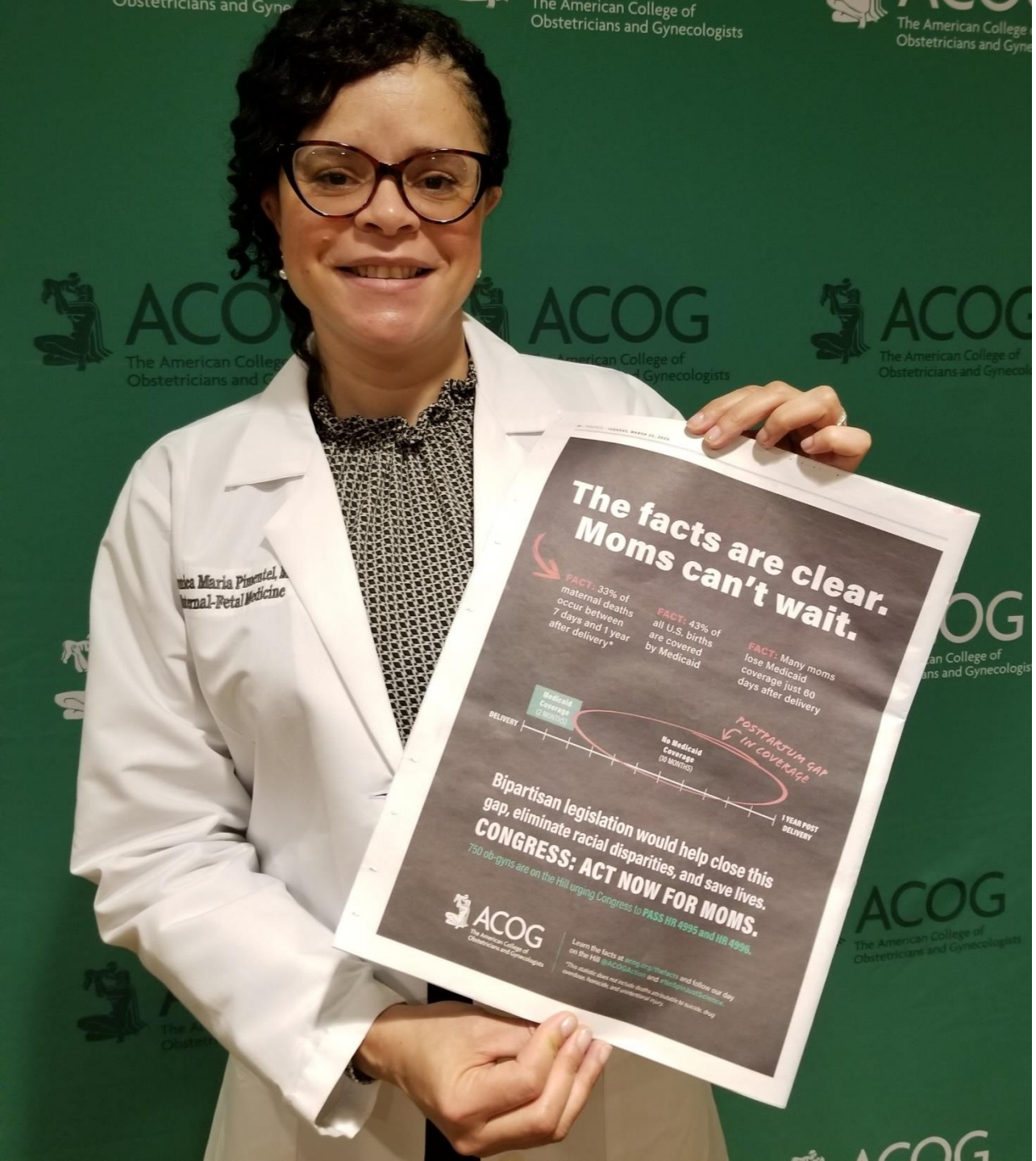
1. Expand Medicaid coverage for 12 months after delivery.
2. Cover Cell-free DNA for all pregnant women without a prior authorization and regardless of risk.
3. Allow FQHCs to provide same day LARC services by the ability to bill for service and device at time of visit.
4. Establishment of perinatal care collaboratives at CT birthing hospitals
5. Establish coverage for IBCLC lactation services through phone, video and in person visits.
6. Facilitate communication to parents and caretakers around the planning and safety of well childcare visits and immunizations.
7. Implement a tele medication consultation line for providers of prenatal and postpartum care, based on the ACCESS-Mental Health pediatric line
8. Continuation of coverage for both phone and video telehealth services
9. Develop and implement a statewide web-based resource listing which both providers and Medicaid members can access
10. Allow MAT services though telehealth
11. Secure coverage, expansion and facilitate access to BH groups through video telemedicine

Looking After the Health and Well-Being of our Most Vulnerable

https://youtu.be/05uBCBfrY4g

Extending Medicaid Coverage for Pregnant Women Beyond 60 Days Postpartum

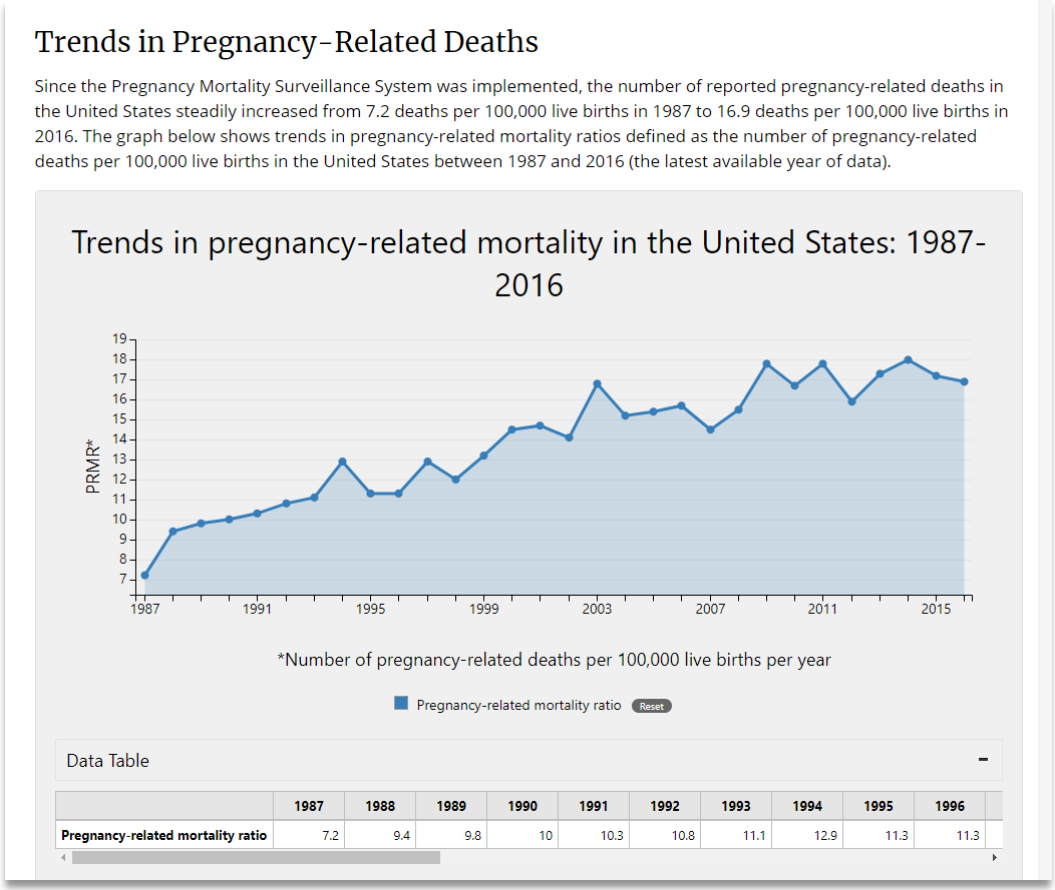
Dr. Verónica Maria Pimentel, MD, MS, FACOG



Dr. Pimentel Advocating for Extending Medical Coverage for Pregnant Women for 12-months Postpartum during ACOG's Congressional Leadership Conference

The United States is experiencing a maternal health crisis

- The United States is the only industrialized nation with a maternal mortality rate that is on the rise, increasing 26 percent between 2000 and 2014.
- Black women and American Indian/Alaska Native women are 3.3 and 2.5 times more likely, respectively, to die from pregnancy related causes than non-Hispanic white women.
- **More than half of these deaths are preventable**



Trends in Pregnancy-Related Deaths

Since the Pregnancy Mortality Surveillance System was implemented, the number of reported pregnancy-related deaths in the United States steadily increased from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. The graph below shows trends in pregnancy-related mortality ratios defined as the number of pregnancy-related deaths per 100,000 live births in the United States between 1987 and 2016 (the latest available year of data).

Data Table

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Pregnancy-related mortality ratio	7.2	9.4	9.8	10	10.3	10.8	11.1	12.9	11.3	11.3

The postpartum period is a time of vulnerability for new mothers

- The transition from pregnancy to full recovery is when many women experience unmet health needs.
- Nearly 70 percent of women describe at least one physical problem in the first year of the postpartum period.

The postpartum period is especially a vulnerable time for women on Medicaid

- Many women on Medicaid are at risk of losing their health insurance coverage just 60 days after the end of pregnancy.
  - Once this coverage ends, many women enter an unsafe period of uninsurance.
  - Compared to women with private insurance, women with Medicaid coverage are more likely to have had a prior preterm birth, low birthweight baby, and experience certain chronic conditions, putting them at higher risk of maternal morbidity and mortality.

Extending postpartum coverage can help

- Based on recent data from the Centers for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS), **roughly 29 percent of pregnancy-related deaths occur between 43 and 365 days postpartum.**
  - This is an underestimate as it does not include pregnancy-associated deaths or deaths to women over the age of 44.
  - These numbers are higher for black women, who represent a large portion of Medicaid beneficiaries.
- Extending coverage would also align the mom's coverage with that of her infant; infants born on Medicaid are guaranteed coverage through the first year of life.

Extending postpartum coverage is rooted in clinical evidence

- ACOG guidance notes that the postpartum period should be an ongoing process “with services and support tailored to each woman’s individual needs.”
    - This may include physical recovery from birth, an assessment of social and psychological well-being, chronic disease management, and initiation of contraception, among other services.
- The CDC defines the postpartum period as extending through 12 months after the end of pregnancy, and data demonstrate that women who have recently given birth have health needs that continue throughout an infant’s first year of life.
- Some of the most dangerous pregnancy-related complications – preeclampsia, blood clots, and heart problems such as cardiomyopathy – may not surface until weeks or months after delivery

Extending postpartum coverage is likely to save money

- Severe maternal morbidity costs billions of dollars every year.
  - Many of these costs could be avoided if women remain covered under Medicaid and have their conditions addressed before becoming progressively severe.
- Alternative payment models and other value-based payment and delivery system changes are more difficult if women are churning in and out of the system.

Extending postpartum coverage has wide support that continues to grow

- ✓Among the physician community:
  - ✓American Medical Association
  - ✓American Academy of Family Physicians
  - ✓American Academy of Pediatrics
  - ✓American College of Physicians
  - ✓American Osteopathic Association
  - ✓American Psychiatric Association
  - ✓Society for Maternal-Fetal Medicine
- ✓Among other stakeholders:
  - ✓March of Dimes
  - ✓Black Mamas Matter Alliance
  - ✓American Hospital Association
  - ✓Medicaid Health Plans of America
  - ✓America's Health Insurance Plans.

The House Passes H.R. 4996 – Helping MOMS ACT

H.R. 4996 allows states to provide one year of postpartum coverage under Medicaid and the Children's Health Insurance Program (CHIP)

Extending Medicaid Coverage for Pregnant Women Beyond 60 Days Postpartum

- THE PROBLEM: The United States is experiencing a maternal health crisis. Unsafe gaps in health insurance coverage, particularly for women on Medicaid, are contributing to poor maternal health outcomes.
- THE SOLUTION: Extending Medicaid coverage for postpartum women will help ensure new moms have continuous, uninterrupted access to care to address their ongoing health needs, including those unrelated to pregnancy.
- THE BOTTOM LINE: Moms can’t wait. It’s time to extend Medicaid coverage for pregnant women beyond 60 days postpartum.

Dr. Verónica Maria Pimentel, MD, MS, FACOG

Screening for Fetal Chromosomal Abnormalities

ACOG
The American College of Obstetricians and Gynecologists

Society for Maternal•Fetal Medicine
High-risk pregnancy experts

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 226

(Replaces Practice Bulletin 163, May 2016, Reaffirmed 2018)

Committee on Practice Bulletins—Obstetrics, Committee on Genetics, and Society for Maternal-Fetal Medicine. This Practice Bulletin was developed by the American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics and Committee on Genetics, and the Society for Maternal-Fetal Medicine in collaboration with Nancy C. Rose, MD, and Anjali J. Kaimal, MD, MAS, with the assistance of Lorraine Dugoff, MD, and Mary E. Norton, MD, on behalf of the Society for Maternal-Fetal Medicine.

Screening for Fetal Chromosomal Abnormalities

Prenatal Testing for Chromosomal Abnormalities

- Prenatal testing for chromosomal abnormalities is designed to provide an accurate assessment of a patient's risk of carrying a fetus with a chromosomal disorder.
- Each patient should be counseled in each pregnancy about options for testing for fetal chromosomal abnormalities.
- All patients should be offered both screening and diagnostic tests, and all patients have the right to accept or decline testing after counseling.

Table 1. Chromosomal Abnormalities in Second-Trimester Pregnancies Based on Maternal Age at Term

	Trisomy 21	Trisomy 18	Trisomy 13	Sex Chromosome Aneuploidy (XXX, XY, XYY, 45, X)	Microarray or Rare Chromosomal Abnormality	All Chromosomal Abnormalities
Age 20	8 per 10,000 1 in 1,250	2 per 10,000 1 in 5,000	1 per 10,000 1 in 10,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	82 per 10,000 1 in 122
Age 25	10 per 10,000 1 in 1,000	2 per 10,000 1 in 5,000	1 per 10,000 1 in 10,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	84 per 10,000 1 in 119
Age 30	14 per 10,000 1 in 714	4 per 10,000 1 in 2,500	2 per 10,000 1 in 5,000	34 per 10,000 1 in 294	37 per 10,000 1 in 270	91 per 10,000 1 in 110
Age 35	34 per 10,000 1 in 294	9 per 10,000 1 in 1,111	4 per 10,000 1 in 2,500	35 per 10,000 1 in 285	37 per 10,000 1 in 270	119 per 10,000 1 in 84
Age 40	116 per 10,000 1 in 86	30 per 10,000 1 in 333	14 per 10,000 1 in 714	51 per 10,000 1 in 196	37 per 10,000 1 in 270	248 per 10,000 1 in 40

Data from:

Srebniak MI, Joosten M, Knapen MF, Arends LR, Polak M, van Veen S, et al. Frequency of submicroscopic chromosomal aberrations in pregnancies without increased risk for structural chromosomal aberrations: systematic review and meta-analysis. Ultrasound Obstet Gynecol 2018;51:445–52.

Hook EB. Rates of chromosome abnormalities at different maternal ages. Obstet Gynecol 1981;58:282–5.

Gravholt CH, Juul S, Naeraa RW, Hansen J. Prenatal and postnatal prevalence of Turner's syndrome: a registry study. BMJ 1996;312:16–21.

Snijders RJ, Sebire NJ, Nicolaides KH. Maternal age and gestational age-specific risk for chromosomal defects. Fetal Diagn Ther 1995;10:356–67.

Snijders RJ, Sundberg K, Holzgreve W, Henry G, Nicolaides KH. Maternal age- and gestation-specific risk for trisomy 21. Ultrasound Obstet Gynecol 1999;13:167–70.

Forabosco A, Percesepe A, Santucci S. Incidence of non-age-dependent chromosomal abnormalities: a population-based study on 88965 amniocenteses. Eur J Hum Genet 2009;17:897–903.

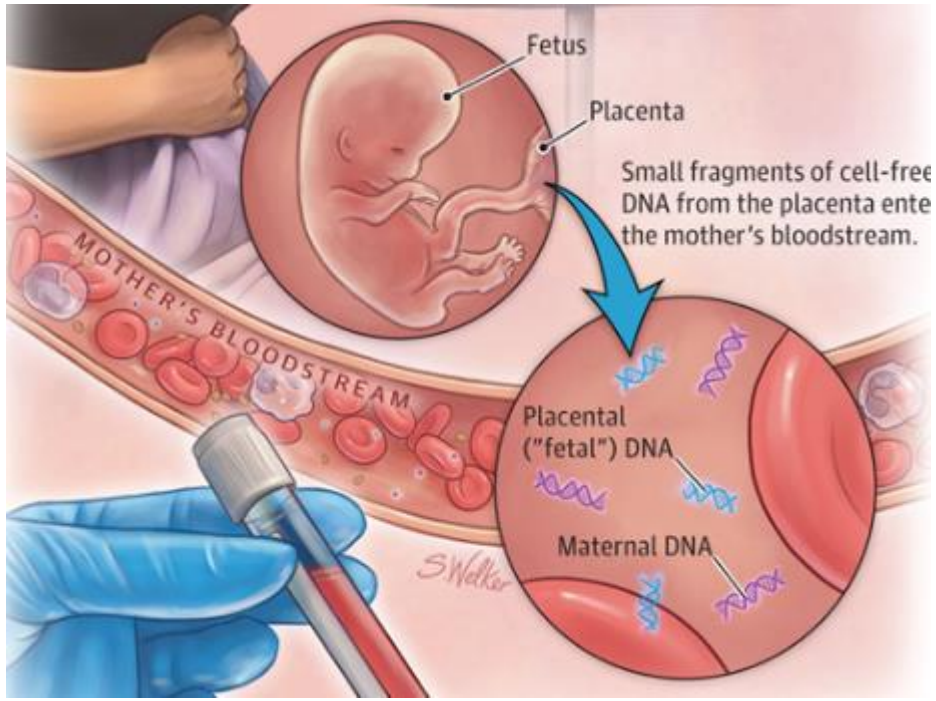
Crider KS, Olney RS, Cragan JD. Trisomies 13 and 18: population prevalences, characteristics, and prenatal diagnosis, metropolitan Atlanta, 1994–2003. Am J Med Genet A 2008;146A:820–6.

Irving C, Richmond S, Wren C, Longster C, Embleton ND. Changes in fetal prevalence and outcome for trisomies 13 and 18: a population-based study over 23 years. J Matern Fetal Neonatal Med 2011;24:137–41.

Cell-free DNA

- Cell-free DNA screens for aneuploidies using the analysis of cell-free DNA fragments in the maternal circulation starting at about 9–10 weeks of pregnancy

- The fetal component of cell-free DNA is derived from placental trophoblasts that are released into the maternal circulation from cells undergoing programmed cell death.



Cell Free DNA

Cell-free DNA is the most sensitive and specific screening test for the common fetal aneuploidies

Table 2. Characteristics, Advantages, and Disadvantages of Common Screening Tests for Chromosomal Abnormalities

Screening Approach	Approximate Gestational Age Range for Screening (Weeks)	Detection Rate (DR) for Trisomy 21 (%)	Screen Positive Rate* (%)	Advantages	Disadvantages	Method
Cell-free DNA†	9–10 to term	99	2–4% Includes inability to obtain results, which is associated with increased risk†	1. Highest DR 2. Can be performed at any gestational age after 9–10 weeks 3. Lowest false-positive rate	Results may reflect underlying maternal aneuploidy or maternal disease	Several molecular methods
First trimester‡	10–13 6/7§	82–87‖	5	1. Early screening 2. Single time point test	Lower DR than tests with first and second trimester component NT required	NT+PAPP-A, free beta hCG, +/− AFP¶
Sequential#: stepwise	10–13 6/7§, then 15–22	95	5	1. First-trimester results provided 2. Comparable performance to integrated, but FTS results provided	Two samples needed NT required	NT+ free beta hCG + PAPP-A, +/− AFP¶, then quad screen
Contingent screening**		88–94	5	First-trimester test result: Positive: diagnostic test or cell-free DNA offered Negative: no further testing Intermediate: second-trimester test offered Final: risk assessment incorporates first- and second-trimester results	Possibly two samples needed NT required	NT+hCG+ PAPP-A, +/− AFP¶, then quad screen

Cell-free DNA

- Has the potential for false-positive and false-negative results
- Is not equivalent to diagnostic testing
- Patients with a positive cfDNA screening test should undergo genetic counseling and a comprehensive ultrasound evaluation with an opportunity for diagnostic testing to confirm results
- Patients with a negative screening test result may choose diagnostic testing later in pregnancy, particularly if fetal anomalies identified on ultrasound examination

Genetic Counseling at St. Francis Hospital and Medical Center

- We are counseling patients the available genetic screening and diagnostic test options for fetal chromosomal abnormalities.
- We review their risks, benefits performance characteristics, and limitations.
- Patients receive an educational handout entitled “Prenatal Screening Options for Chromosome Disorders.”

Access to long-acting reversible contraception (LARCs)

Donna C. Maselli, RN, MPH
Public Health Services Manager
Department of Public Health (DPH)
Women's Health & Prevention Unit
Maternal Mortality Review Committee DPH Co-chair

What are LARCs?

Long-acting reversible contraceptives (LARC) are methods of birth control that provide effective contraception for an extended period without requiring user action. They include injections, intrauterine devices (IUDs) and subdermal contraceptive implants.

Source: https://en.wikipedia.org/wiki/Long-acting_reversible_contraception#

Background

- 85% of all pregnancies in the U.S. are unintended[9].

- Unintended pregnancy disproportionately affects women with lower incomes and those from racial and ethnic minority groups[1].
  - The rate of unintended pregnancy for women with incomes below the federal poverty level (FPL) is more than **5 times higher** than the rate for women with incomes greater than 200% of the FPL[1].

- Federally Qualified Health Centers (FQHCs) serve our most vulnerable population. In 2018, 52.7% of all CT pregnancies were Medicaid clients.[7]

Support for increasing access to LARC

- Centers for Disease Control & Prevention (CDC)
  - Increasing access to long-acting reversible contraceptives was listed as **one of the CDC's top public health priorities** for reducing teen pregnancy and unintended pregnancy in the United States[3].
- National Quality Forum
  - Contraceptive recommendations- **Access to LARCs** are stewarded by the US Office of Population Affairs [10].
- American College of Obstetrics and Gynecology (ACOG)
  - Intrauterine devices and the contraceptive implant **should be offered routinely** as safe and effective contraceptive options for nulliparous women and adolescents[4].
  - Unintended pregnancy persists as a **major public health problem** in the U.S.
    - OB-Gyns may contribute by increasing access to contraceptive implants and intrauterine devices (IUDs) for their patients[5].
  - Advocate for **coverage and appropriate payment** and reimbursement for every contraceptive method by all payers in all clinically appropriate circumstances[5].
- CT Maternal Mortality Review Committee
  - Committee recommendation to **increase access to same day LARCs** in FQHCs [6]

Benefit of LARC

- Long-lasting, convenient
  - Can be inserted same day, after confirming no pregnancy[1].
- Most effective method of contraception in preventing unplanned pregnancies[1].
  - Failure rates are less than 1% per year (IUDs and implants), about the same as 'perfect use' failure rates[2].
- Very cost effective
  - Over a 5-year period saves each patient thousands of dollars as compared to oral contraceptives of condoms[1].
- Reduces teen pregnancy
  - Compared with national statistics, the CHOICE Project (which provided no-cost, same-day access to contraception) was associated with a 79% reduction in teen pregnancy, an 80% reduction in teen births, and a 76% reduction in abortions[8].

Economic Benefit of LARC

- *Cost Minimalization Analysis of Same Day Long Acting Reversible Contraception for Adolescents (JAMA, Sept. 2019)*
  - Same-day LARC placement was associated with overall lower costs per patient over one year compared with placement at a subsequent visit. **Cost** was more **than doubled** per patient for multiple visits.
  - In addition to cost saving, numbers of **unintended pregnancies** decreased with providing same-day LARC placement.
    - 14% unintended pregnancy with same day LARC vs 48% multiple visit LARCs

- Evaluation findings suggest that providing same-day LARC placement may save payers money by preventing unintended pregnancy, and efforts to make this model of care feasible in all clinical settings should be undertaken[8].

Current status, risk & solution for CT

- Status
  - Same day LARC access
    - CT Department of Social Services adjusted Medicaid reimbursement for same day LARC access for Planned Parenthood Centers, private MD offices, and hospitals.
  - Multiple visits
    - **CT FQHCs do not offer same day access to LARC** and multiple appointments are needed**.**
- Risk
  - Increased risk for unintended or repeat pregnancies if same day access is limited.
    - More than half of the women fail to return for the second visit, and many engage in unprotected intercourse during this period[8].
  - Barrier to access can be greater during the postpartum period and can increase the risk of a short interpregnancy interval (<18 months), which has known associations with adverse birth outcomes, such as preterm birth and low birth weight[8].
- Solution
  - CT DSS adjust Medicaid reimbursement for same day LARCs in FQHCs

References

1. Stoddard, A.; McNicholas, C.; Peipert, J. F. (2011). "Efficacy and Safety of Long-Acting Reversible Contraception". *Drugs*. **71** (8): 969–980. doi:10.2165/11591290-000000000-00000. PMC 3662967. PMID 21668037

2. *Blumenthal, P. D.; Voedisch, A.; Gemzell-Danielsson, K. (2010). "Strategies to prevent unintended pregnancy: Increasing use of long-acting reversible contraception". Human Reproduction Update. **17** (1): 121137. doi:10.1093/humupd/dmq026. PMID 20634208.*

3. *"Public Health Priorities". Centers for Disease Control and Prevention. 20 September 2011.*

4. *https://www.acog.org/clinical/clinical-guidance/practice-bulliten/articles/2017/11/long-acting-reversible- contraception-implants-and-intrauterine-devices*

5. *https://www.acog.org/clinical/clinical-guidance/committeeopinion/articles/2015/10/increasing-access-to-contraceptive-implants-and-intrauterine-devices-to-reduce-unintended-pregnancy*

6. CT Maternal Mortality Review Committee Recommendations, Sept. 8, 2020

7. National Governor's Association Survey, 2020, Email communication from DSS 10/1/2020

8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6739899/

9. https://www.ajmc.com/view/supplying-sameday-longacting-reversible-contraception-associated-with-major-cost-savings-study-shows

10. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=2904&print=0&entityTypeID=1

Perinatal Health Collaborative

Annie Calamari, LCSW
Middlesex Health
Middletown, CT

“Clinical-Community Integration”

Clinical-community integration is an approach that values the importance of collaboration between clinicians and those working in the community.

Parkland Memorial Hospital in Texas and Oregon Community Health are two examples of grant-funded pilot programs that have seen great successes for patient outcomes, simultaneously creating best practices for using technology to link clinical care and community services.

References: Villagra VG. Clinical-Community Integration: The Role of Health Information Technology. CT Health Foundation April 2018.
Allen A. The ‘frequent flier’ program that grounded a hospital’s soaring costs. Politico. December 2017.
Ackermann RT. Bridging the why and the how of clinical-community integration. Am J Prev Med. 2013;45(4):526-529.

Perinatal Health Collaborative at Middlesex Health

- What is PHC?

We are a group of collaborating agencies in the Middletown area with a focus on healthy physical and social-emotional outcomes for vulnerable, pregnant moms and their babies.

  - Our objective is to provide early intervention to improve engagement in prenatal care. To establish goals for that mom and baby for a health birth outcome and to preserve family unity whenever possible.
  - Our core belief is that community collaboration is necessary to improve health outcomes and our core understanding is that psycho-social problems are community problems, no one entity alone can effectively improve outcomes for this population.

- Moms identified as best served by the collaborative are:
  - Experiencing domestic violence, treated or untreated mental health issues, substance abuse/use/addiction, homelessness, and those that may have experienced previous significant perinatal mood and anxiety disorders.

What does PHC do?

We work to improve the quality of life:

- Sobriety
- mental health stabilization
- stable housing
- re-connection with family
- Safety
- linking moms to care such as OB/GYN or primary care, psychiatry, other specialists
- supportive housing

Coverage of Lactation Services

Amy D. Gagliardi, MA, IBCLC, RLC
Community Health Center, Inc.
Instructor of Medical Sciences, Frank H. Netter MD School of Medicine, Quinnipiac University

Current Status of Breastfeeding

- Since the onset of COVID-19 there has been a reduction in breastfeeding with NGOs suggesting as much as 40 to 50% in some areas
- Non- Hispanic black dyads are 15% less likely to ever breastfeed than non-Hispanic white or Hispanic dyads
- According to the CDC breastfeeding disparities exist among:

  Race, Income, Age and Payer types (Medicaid lowest)
- Breastfeeding Saves our Healthcare System Money and Lives https://www.ncbi.nlm.nih.gov/pubmed/27647492
- Suboptimal breastfeeding as we have in the US is associated with increased health care costs and maternal and infant morbidity and mortality (The majority of the excess death and medical costs -- nearly 80 percent -- were maternal)

Breastfeeding… Who Cares?

- American Academy of Pediatrics (AAP) states human milk is a uniquely superior food for infant growth and development.
- AAP recommends that infants be exclusively breastfed for six months
- Continue to receive breastmilk throughout the first year of life and beyond.
- Breastfeeding enhances the health and well being of both women and their infants
- Breastfeeding is endorsed by multiple professional organizations including ACOG, ACNM, AAFP, CDC, HHS and more

Child Health Benefits Associated With Breastfeeding

Decrease in the incidence of infectious and non-infectious diseases:

- Urinary track infections
- otitis media
- Necrotizing enterocolitis
- Respiratory track infections
- Diarrhea
- Neurodevelopmental enhancements including improved performance on cognitive tests
- Bacteremia
- Bacterial meningitis
- Reduced incidence of sudden infant death syndrome
- Reduction in both insulin and non-insulin-dependent diabetes
- Diabetes mellitus,
- Cancers such as lymphoma
- Leukemia and Hodgkin disease
- Overweight and obesity
- Asthma
- Hypercholesterolemia

****AAP suggests infant mortality rates in the United States are reduced by 25% in breastfed infants.**

Health Benefits For Preterm Infants

Research Suggests Human Milk is critical for the health and developmental outcomes of preterm infants

- Decreases the incidence of necrotizing enterocolitis (a life-threatening gastrointestinal disorder)
- Meningitis
- Blood infection
- Retinopathy of prematurity (a severe eye condition that may lead to blindness)
- Significantly improves neurodevelopmental outcomes including IQ
- Late onset sepsis

Breastfeeding Enhances Maternal Health

- Premenopausal breast cancer
- Ovarian Cancer
- Osteoporosis
- Type 2 Diabetes
- Enhanced weight loss
- Decreased postpartum bleeding
- More rapid uterine involution
- Enhanced bonding
- Reduction of cardio- vascular risk (hypertension, myocardial infarction)

“Breastfeeding provides unmatched health benefits for babies and mothers. It is the clinical gold standard for infant feeding and nutrition, with breast milk uniquely tailored to meet the health needs of a growing baby. We must do more to create supportive and safe environments for mothers who choose to breastfeed.”
(Dr. Ruth Petersen, director of CDC’s Division of Nutrition, Physical Activity, and Obesity)

Surgeon General's Action Steps To Support Breastfeeding
(including standard overage for IBCLCs as "covered providers")

- Ensure access to services provided by International Board Certified Lactation Consultants – Action Step 11 Health Care
- Include support for lactation as an essential medical service for pregnant women, breastfeeding mothers and children:
- "Third party payers typically define a standard package of health benefits for women and children. Including standard coverage for IBCLCs as "covered providers" when they perform services within their scope of their certification would ensure that mothers and children have access to these services through insurance maternity benefits. Federally funded health benefit programs, such as Medicaid, the Children's Health Insurance Programs, Tricare and the Federal Health Benefit Program, could serve as models for such a standard benefit package."

Source: https://www.hhs.gov/sites/default/files/breastfeeding-call-to-action-executive-summary.pdf

What is an IBCLC?

- Board Certified by the International Board of Lactation Consultant Examiners
- National Commission for Certifying Agencies (NCCA) of the Institute of Credentialing Excellence (ICE)
- Nationally registered allied health professionals
- Are the only lactation professionals who have rigorous training, clinical hours and board certification by a standardized certifying agency allowing them to be eligible for reimbursement
- IBCLCs are licensed in several states including Rhode Island
- Studies demonstrate enhanced breastfeeding outcomes with IBCLC support
- Lack of access to IBCLCs due to lack of coverage contributes to health disparities in breastfeeding initiation and duration rates and maternal-infant health outcomes
- IBCLCs considered the “gold standard” for lactation professionals

References

1. Effect of Primary Care Intervention on Breastfeeding Duration and Intensity
Karen Bonuck, PhD,corresponding author Alison Stuebe, MD, MSc, Josephine Barnett, MS, Miriam H. Labbok, MD, MPH, Jason Fletcher, PhD, and Peter S. Bernstein, MD, MPH
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4011096/

2. Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs
Melissa C. Bartick1,2, Eleanor Bimla Schwarz3, Brittany D. Green4, Briana J. Jegier5, Arnold G. Reinhold6, Tarah T. Colaizy7, Debra L. Bogen8, Andrew J. Schaefer9, Alison M. Stuebe
https://onlinelibrary.wiley.com/doi/pdf/10.1111/mcn.12366

3. AAP Breastfeeding Policy and other policy references
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/AAP-Policy-on-Breastfeeding.aspx

4. Newborns of COVID-19 mothers: short-term outcomes of colocating and breastfeeding from the pandemic's epicenter Uday P Patil , Sheela Maru , Parvathy Krishnan, Rachel Carroll-Bennett , Joselito Sanchez, Lawrence Noble , Randi Wasserman
Journal of Perinatology volume 40, pages1455–1458(2020)

Impact of COVID-19 Pandemic on Children

Sandra Carbonari, M.D. FAAP

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CT Chapter of the American Academy of Pediatrics

The Concern

With the initial shutdown order it quickly became clear to pediatricians that the health care of children would be severely impacted.

The national American Academy of Pediatrics developed guidelines regarding this concern including:

1. Schedule well visits and sick visits at different times of the day.

2. Do as many in person WCC visits for children under 2 years. There was a wide variety of implementations of these recommendations in CT. Some practices were seeing only newborns in person initially, but most expanded this to older children as soon as possible.

The National Data

New data from the Centers for Medicare & Medicaid Services (CMS) highlight a decline in services used by children covered by Medicaid and the Children's Health Insurance Program (CHIP) in March through May this year compared to the same period last year.

The agency found:

- 69% fewer (7.6 million) dental services rendered,
- 44% fewer (3.2 million) child screening services that assess physical and cognitive development,
- 44% (6.9 million) fewer outpatient mental health services and
- 22% fewer (1.7 million) vaccinations up to age 2.

The Barriers

Parental Fears of exposure of the child to infection.

Transportation Issues

- Limited bus service
- Other children not in school or daycare so need to go along increasing exposure risk

Limited access:

- Some practices closed for a prolonged period of time
- Fewer patients can be seen per day
- Practices have had to lay off staff because of financial constraints so outreach limited
- Provider Relief Funds have not effectively reached pediatricians

Some Solutions

American Academy of Pediatrics:

- Developed a national campaign “Call Your Pediatrician” during the summer
- Tool kit available with many resources
- Recently produced six 30-second PSAs in English and Spanish urging parents to call their pediatricians to get their children caught up on vaccines and other important health care, and to check in with their pediatrician if their child or teen is struggling emotionally.

In Connecticut:

- An ad hoc task force convened to address the problem of decreased well child visits and immunizations.
- Many organizations, state agencies, community groups including CT AAP, DPH, CHNCT, OEC, Dept of Education, Home Visitors, Libraries, Hospital Association, Community Health Centers, School Based Health Centers, CHDI, InfoLine
- Goal was to find a way to communicate this message in a single format from many sources trusted by families
- Adapted a flyer with CT specific information translated into 10 languages that was widely distributed through the involved groups and their contacts

PeriPartum Mental Health Issues

The COVID-19 pandemic has caused widespread emotional distress and increased risk for psychiatric illness according to a recent article in the New England Journal of Medicine.

A recent MMWR found that “Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019.” Almost 41% of responders had at least one adverse mental or behavioral health condition that was related to the viral pandemic.

Obstetricians need assistance with caring for mothers with these issues

Recommendation to adapt the ACCESS MH model for this population.

Additional Recommendations

Rep. Jillian Gilchrest

Additional Recommendations

1. Continuation of coverage for both phone and video telehealth services
2. Develop and implement a statewide web-based resource listing which both providers and Medicaid members can access
3. Allow MAT services though telehealth
4. Secure coverage, expansion and facilitate access to BH groups through video telemedicine

Q&A