Improving Infants' Overall Health and Access to Care

Problem Statement

In 2022, only 31.6% of Nebraska children aged 9-35 months received a developmental screening using a parent-completed screening tool in the past year.[1]

The American Academy of Pediatrics recommends that all children have a developmental screening during their regular well-child checks at 9, 18, and 24 or 30 months.[2]

When children do not receive preventive health visits, they also do not have opportunities to be screened for developmental delays.

According to 2022 data from the National Survey of Children's Health, 16.7% of Nebraska's children (aged 0-5) received **NO PREVENTIVE HEALTH VISITS** during the past 12 months from a doctor, nurse, or other health care professional.[1]

The American Academy of Pediatrics recommends a newborn evaluation, six well-child visits within the first year, and seven additional visits for children aged 1-4.[3]

Criterion 1: Disproportionate Outcomes Exist Among Subgroups of the Population

One of Healthy People 2030's five overarching goals is specifically related to social determinants of health (SDOH): "**Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all."** Examples of SDOH include safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; polluted air and water; language and literacy skills.[4]

When data are examined by race/ethnicity in Nebraska, some disparities are evident, beginning with the percent of infants in households with incomes below 100% of the federal poverty level (FPL) (Figure 1).[1]

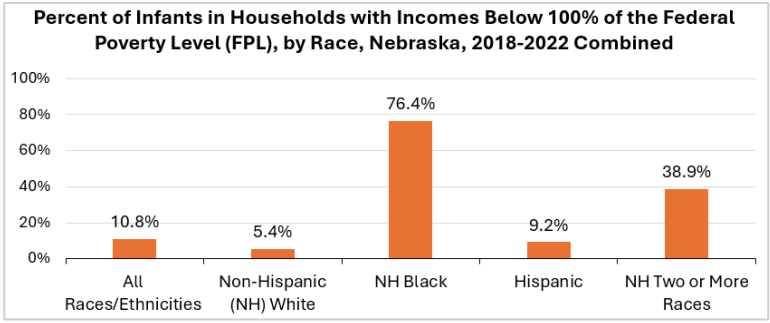

Figure 1. Source: Nebraska Department of Health and Human Services.[1]

The combined 2021-2022 National Survey of Children's Health data show racial/ethnic differences in the percentage of children aged 0-1 who were reported to be in excellent or very good health (Figure 2). **Non-Hispanic Black children** aged 0-1 **were least likely to be in excellent or very good health** (48.1%), compared to non-Hispanic White children (97.3%).[1]

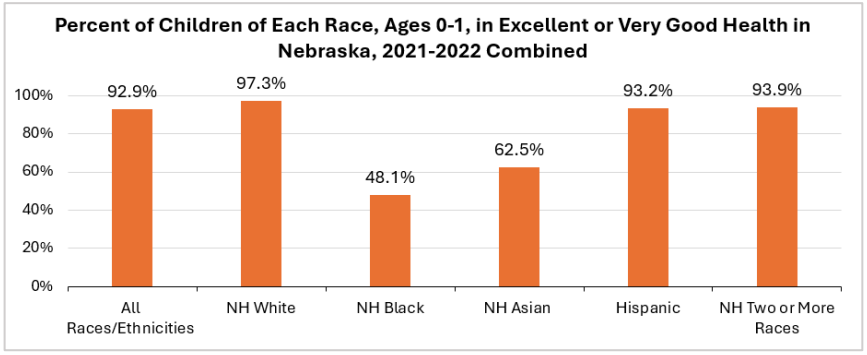

Figure 2. Source: Nebraska Department of Health and Human Services[1]

Disparities in early term births (37-38 weeks gestation) are evident in Nebraska. The percentage of early term births in Nebraska increased from 26.9% in 2019 to 30.9% in 2023.[1] However, when examining racial/ethnic disparities over the combined period (2019-2023), non-Hispanic Native American/American Indian (34.9%) and non-Hispanic Asian infants (32.0%) were more likely to be born in the early term period compared to non-Hispanic White infants (28.0%).[1]

Criterion 2: Strategies Exist to Address the Problem/An Effective Intervention is Available

A multifaceted approach is needed to address disparities in children's preventive health visits, considering the state's diverse community capacities. As the community landscape differs significantly among urban areas and rural regions, it is critical to adapt strategies to local needs and resources. The MCH Evidence Center identified the latest strategies and practices to address the issue of low access to preventive and primary care services for infants. Among racially/ethnically diverse populations and underserved communities, a number of strategies, such as shared care coordination with home visiting and policies that promote medical homes, have emerged from studies in scientific literature.

The concept of ***medical homes*** has been widely recognized as an effective model for improving infants' overall health and access to care. A medical home, characterized by comprehensive, continuous, and coordinated care provided by a primary care team, has shown significant benefits particularly in terms of increasing access to preventive services, early screenings, and timely referrals.[5] Furthermore, medical homes reduce health care disparities by providing equitable access to care for underserved populations. Medical homes are particularly effective in connecting families to community resources and specialists.

A promising strategy to address these disparities is the use of ***bundled measures***, including immunizations, lead screening, and screening tools, combined with staff education and targeted outreach. A quality improvement study demonstrated that the development of patient registries, reminders, and visit tracking, can increase the completion of well-child visits. Following the implementation of these strategies, the rate of bundle completion by 14 months of age improved from 58% to 77%.[6] An integrated approach of combining staff education, using staff to reschedule missed appointments, and outreach strategies can improve the delivery of essential preventive care services in communities with poor health outcomes.[6] This approach targets both the promotion of well-child visits and overcoming barriers to access, especially in communities with historically low rates of preventive care.

Criterion 3: Capacity to Address the Problem

Community capacity to address disparities in well-child visits in Nebraska relies heavily on organizations, programs, and initiatives outside of the traditional clinical and medical environment. Infrastructure ***already exists*** to build upon and implement strategies. This established structure of organizations and leadership promote the medical home model and preventive care, including well-child checks. Examples are further described below and under Criterion 5.

Addressing infant needs requires community-based and culturally-appropriate solutions. Nebraska has established programs and initiatives across the state that are tailored by location and community need. These programs were developed with input from parents and other local leaders that can assist the medical community in addressing this issue, for example, community-owned collaborations, supported in all counties statewide by Bring Up Nebraska, engage nonprofit organizations, health care providers, educators, local governments, churches, businesses, and, most importantly, families and youth. The knowledge that exists in the established programs, initiatives, and networks can be leveraged to assist in building the capacity of local leaders, especially parents, to support effective programs.

Nebraska leverages state resources to support infant health through Medicaid, public health programs, and home visitation initiatives. Partnerships between public and private organizations in some communities could be expanded for broader impact. Leaders in Nebraska include local health departments, Health Center Association of Nebraska (HCAN), Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP), Nebraska's Home Visitation Network Partners, Bring Up Nebraska, First Five Nebraska, Nebraska Early Childhood Collaborative, Society of Care, Nebraska Urban Indian Health Coalition, Winnebago Health System, and Ponca Health Services. Head Start and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) currently have programs that focus on preventive care, well-child visits, and other screeners.

Criterion 4: Problem is Worse than the Benchmark or Worsening

In 2019, only 307 board certified pediatricians were practicing in Nebraska.[7] While many provider types can provide care to infants and children, they may not have any additional specialized training and education. The majority of pediatricians are located in larger communities leaving the rural counties without this specialized care.[7] Reaching out to family practice doctors and mid-level clinicians in rural areas is critical to address the lack of children's preventive care.

Nebraska's demographics are varied and comprise a small number of large urban areas and many small rural communities, which are several miles away from larger towns or cities. It is noted that **51.6% of counties in Nebraska are considered maternity care deserts compared to 32.6% of all United States counties**.[8] The lack of health care access negatively impacts the health of mothers and children. The National Survey of Children's Health (2022) showed that 16.7% of Nebraska's children aged 0-5 **had no preventive care** during a 12-month period compared to the national average of 8.8%.[1]

Nebraska faces challenges of not only distance and accessibility to health care but also poverty. In 2022, 11.6% of Nebraskan households with infants had incomes below 100% of the federal poverty level (FPL).[1] When analyzing 2018-2022 combined data, significant racial/ethnic disparities emerge, with 76.4% non-Hispanic Black infants and 38.9% of non-Hispanic Two or More Race infants living in poverty.[1]

For combined 2021-2022 data, racial disparities were noted among children aged 0-1, with non-Hispanic Black children the least likely to report excellent or very good health (48.1%), and non-Hispanic Asian children also less likely to report excellent or very good health (62.5%) compared to non-Hispanic White children (97.3%).[1] There was no linear trend from 2018-2022 in the percent of Nebraskan children aged 0-1 with excellent or very good health.[1]

Criterion 5: Community Readiness to Address the Problem

Nebraska has strong groups, collaboratives and communities of partners who ***represent and include representation from*** communities they serve. The missions of these groups prioritize access to care for overall better health by promoting preventive care and well-child checks and directing resources to improve outcomes for children and families. Some of these partners are listed below.

- Health Center Association of Nebraska (HCAN)
- Local city and county health departments

- Health care providers who serve Native populations (i.e. Ponca Health Services, Nebraska Urban Indian Health Coalition, Northeastern Tribal Health Services, Winnebago Healthcare System, and others through the DHHS Office of Health Disparities)
- The Nebraska Early Development Network
- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Home visiting networks (Nebraska-Maternal, Infant, and Early Childhood Home Visiting Program (N-MIECHV), Early Head Start, Sixpence Family Engagement/Home Visitation)
- Lutheran Family Services, Catholic Social Services, and Refugee Empowerment Center focus on resettling refugees to Nebraska and provide outreach to populations with higher disparities.

State and national partners support a collective impact model of collaboration, use data to inform the work, focus on a two-generational approach, build upon prevention of adverse childhood experiences (ACEs), and actively promote protective factors so families and communities thrive. Examples of organizations engaged in this work include the Children & Family Coalition of Nebraska (CAFCON) and Nebraska Children and Families Foundation. *Monthly facilitated calls between engaged organizations are one avenue for engaging a wide range of stakeholders to increase preventive care and well-child checks for Nebraska infants.*

If this issue is selected as one of the Title V MCH priority needs in 2025, what do you expect this issue to look like five years from now? What kind of progress can you expect for the next five years?

In five years, we would expect to see:

- An increase in the percentage of Nebraska's children (ages 0-5) who have had one or more preventive health visits in the past 12 months.
- Reduced disparities between non-Hispanic Black and non-Hispanic White infants in reported excellent or very good health.
- Materials developed and utilized for promoting the importance of well-child visits, and strategies implemented that incentivize preventive care that are specifically designed to reach populations who face disparities in health already evident in the first year of life.

To accomplish this, the state needs to focus on funding **outreach, educational campaigns, and health services for populations with higher disparities and those living in underserved areas.** Another consideration is to **incentivize healthcare providers** to offer services within these communities. Progress can be made as Nebraska builds upon existing collaboratives, braids funding with other partners, and establishes more public-private partnerships to address prioritized needs.

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