Newborn Bridge Clinic to Support Infant Transition Home

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Key words: premature; neurobehavioral; neonatal follow-up; transition; parent support

Background

High risk and premature infants are discharged from the newborn intensive care unit (NICU) when they; consistently gain weight, maintain their body temperature, are able to feed by mouth, have had their medical problems addressed with a plan of care, their parents and family are comfortable with their care required and the discharge teaching has been completed. The decision for discharge home is individualized to best meet the needs of the infant within the context of his or her family's readiness. Despite this, often parents feel this is an anxious and difficult time. The current follow up program, in collaboration with a nearby large hospital system, provides periodic developmental check-ups for infants discharged from the NICU. Parents can arrange for this service through their pediatrician or family medicine physician. The typical schedule begins at 3 months corrected age. For example, if an infant was born at 28 weeks gestation (three months early), their first visit with the Neonatal Follow-up Program may be when they are 6 months old in chronologic age. The majority of infants are discharged from the NICU by the time of their original due date and some are discharged even sooner, perhaps a month earlier if they are doing well and have met discharge criteria. This leads to a situation of families having experienced tremendous therapeutic support for weeks and months in the NICU being discharged home with a gap of three to four months before they may begin neonatal follow up.

Objectives

- Infants and families receive support during the transition from hospital to home and community.
- Parents gain greater understanding of their son or daughter's behavior with anticipatory guidance for caregiving to enhance maturation and development while strategizing ways to support the infant's vulnerability.
- The neurobehavioral assessment, the Assessment of Preterm Infant Behavior (APIB) will be performed every two to four weeks to monitor both the infant's emerging neurobehavioral organization and self-regulation as well as the parents' increasing degree of both competence and confidence in parenting.
- The infant's primary care provider supported with consultation and expertise to monitor the infant's transition.

Implementation

This Newborn Bridge Clinic is a new and innovative approach to "mind the gap" in order to support infants and families as they leave the hospital and transition to home during the three to four months before they will be seen in a neonatal follow up clinic. The Newborn Bridge Clinic will provide neurobehavioral assessment for screening and intervention and medical co-management of the infant's medical needs, in collaboration with the infant's primary health care

provider during the interim period between leaving the hospital and entering the typical neonatal follow up program.

The Bridge Clinic begins within the newborn intensive care with the formation of supportive relationships to be continued through the transition to home and the community. The physicians, clinical nurse scientist and nutritionist facilitate this transition and provide the crucial safety net for those with complex medical conditions. Infants born prematurely and/or who have special medical or social problems would be seen in the Bridge Clinic one to two weeks after discharge and at intervals ranging from one to four weeks depending on the specific needs until they enter the current neonatal follow up program in collaboration with the larger collaborative hospital.

Individualized care is provided through the multidisciplinary team assessing the infant's health, nutrition, growth, temperament and development as well as the parents' degree of comfort and ability to provide nurturing care especially around the issues of feeding, sleeping and crying. Parents are supported in gaining both confidence and competence in providing the sometimes very complex medical needs for these fragile infants. The provision of positive reinforcement of parenting and anticipatory guidance supports families in their transition from the newborn intensive care unit to their home and community.

The Bridge Clinic provides written summaries to communicate with the infants' primary medical care providers following each clinic visit and collaborate as needed to supplement their primary medical care. This may involve referrals for visiting nurses, early intervention and other programs within the family's community. Management of the special medical needs of these infants' (medications, feeding problems, chronic conditions such as lung disease, apnea monitor care, etc.) and ongoing developmental assessment and intervention assures the infant's best growth and development.

Summary

The success of the Bridge Clinic will be evaluated through statistics and measurements including:

- number of infants seen in the Bridge Clinic
- the rate of rehospitalization within the first six months following discharge from the NICU
- summary scores of the neurobehavioral evaluation (APIB) to show increasing maturation and neurobehavioral organization
- growth patterns of the infants
- parent engagement measured through the NICU Parent Risk Evaluation and Engagement Model and Instrument (PREEMI)
- successful entry into traditional neonatal follow up program at three months corrected age

Financial Support

The Newborn Bridge Clinic has received financial support from the Innovators' Circle Program of the Abington Health Foundation.