Neonatal Couplet Care in the U.S.

A Provider's Perspective

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Outline

- Psychosocial barriers to couplet care
- Practical barriers to couplet care
- Our practice at CMC: where we came from, where we are going, and where we want to be

Establishing Couplet Care

- Shifting the focus from standard NICU care to couplet care– where do our priorities lie?
- “Buying in” to the concept
- Supporting the concept practically
- Giving up control
- Lack of standard procedure/precedent to follow
- Lack of evidence to support practice on a hands-on level
- Gaining parental support of the model

Medical Practice "To Order"

Social Barriers in the U.S.

- U.S.-4.2 million births, 8.2% LBW, 12% preterm

- Sweden- 109,000 births, 4.4% LBW, 6% preterm

- U.S.: no guaranteed paid leave, option of 12 weeks of job protection under Family Medical Leave Act

- Sweden: 480 days of paid leave for a family unit, 664 days unpaid, job protected for each parent to work part-time for 6.5 years

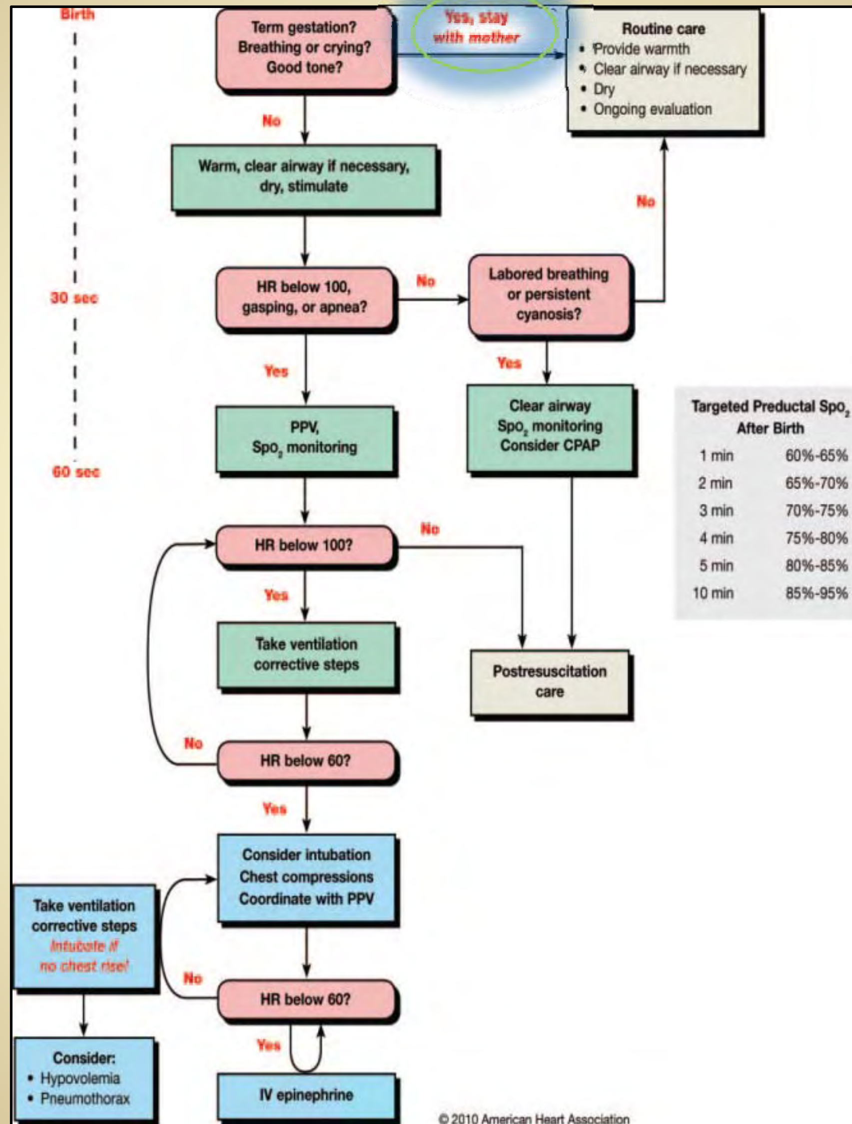
Parental Barriers

- Expectations of recovery from birth
- Physical discomfort of living in the hospital
- Time constraints
- Financial constraints
- Childcare issues, both at home and in the hospital
- High percentage of mothers with history of drug use

Practical Issues

- Once psychological and social barriers have been overcome, how do we practically shift the focus from standard NICU care to couplet and family-centered care?
- How do we ensure quality medical care outside our comfort zone and still support families to provide true couplet care?
- Do families in the US truly want this model?

New NRP Guidelines



Putting Couplet Care Into Practice

- Offering portable respiratory support
- Performing the physical exam on an infant while in the mother's arms
- Stabilizing and initiating treatment in the parents' room, including lab work, oxygen delivery, monitoring of vital signs, IV fluids, medications
- Exclusive breastfeeding
- Central monitoring

Practical Barriers

- Patient access and evaluation
- Central monitoring and response
- Staffing
- Physical layout of the Unit

Where We Started

- Standard western medical training
- Clinical background of the standard NICU model
- Trying to apply our old ways of approaching patients to the new model
- Reevaluating old approaches with a new mindset

Where We Are

- In flux…
- Trying to let go of our preconceived notions regarding where we care for patients, how we monitor patients, and when a patient is “too sick” to be with the parents
- Developing creative staffing solutions
- Transitioning to a place where couplet/family care is our primary goal, and where we are as flexible as is medically allowable to support this goal.
- Creating protocols and practice guidelines that reflect this goal

Where We Are, cont'd

- Educating and supporting our colleagues to create an environment where the couplet care model can be carried out
- Anecdotal evidence of shorter hospital stays, especially for late-preterm and infants with NAS
- Greater access to provider by families; much greater family attendance at rounds and length of time spent daily in the unit
- Happier families

Where We Want to Be

- A model for NICU couplet care across the country
- Parents are not separated from their infants as a rule
- Skin-to-skin from birth and for as many hours of the day as possible subsequently
- Management of airway, fluid, glucose, infectious, bilirubin, and other medical issues occurs primarily in the parents' arms, and nearly always in the parents' room.
- All procedures done with parent present
- Exclusive breastfeeding is supported and encouraged
- Parent as primary caregiver; staff as facilitator
- Transition from hospital to home is purely a geographical change, not a psychological one