Illinois Department of PUBLIC HEALTH

Pat Quinn, Governor
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PERINATAL HEALTH SYSTEM OF ILLINOIS

STATEWIDE QUALITY COUNCIL

April 7, 2010

2:00 P.M.
James R. Thompson Center
Room-025- Second Floor
100 West Randolph
Chicago, Illinois

Chaired: Harold Bigger, MD

Attendees: Trish O'Malley, Patricia Prentice, Karen Callahan, , Angela Rodriguez, Cathy Gray, , Barbara Prochnicki, Louise Simonson, Deborah Rosenberg, Ph.D., Robin L. Jones, MD, Cora Reidl, Richard Besinger, Myra Sabini (for Pam Wolfe), Stephen Locher, MD

Absent: Kevin Madsen, MD, (excused), Dasha Patel, MD, Gary Loy, MD, Stacie Geller, PhD., Lenny Gibeault,(excused) Cindy McDermith, (excused), Elaine Shafer, Robyn Gude,

IDPH STAFF: Charlene Wells, Mark Flotow

AGENDA

I. **Review and Approval of Minutes – December 9, 2009** Item #2 was changed to reflect Maternal Deaths at Level III hospitals – not Level II hospitals. Dr. Jones moved approval of the minutes as corrected and Cathy Gray seconded. The minutes were approved as amended.

II. **Report from IDPH** **Charlene Wells**
Charlene Wells discussed the fact that the Perinatal Program has been included in the IDPH budget at the same level as last year. Some Administrators and Educators met with Tom Schafer and expressed appreciation that the Perinatal Program received this level of support in a difficult fiscal environment.

Charlene also discussed current legislative initiatives including a toxoplasmosis bills, quality bills regarding late preterm deliveries and various forms of information on very low birthweight infants. IDPH has taken the position that current programs and committees can address these requests.

A bill by Raymond Poe is being proposed that will not allow sweeping of money for metabolic screening.

IDPH agrees that Legislative issues should stay on the PAC agenda

Increased access to information will be available to Administrators

III. Discussion regarding discrepancies in State of Illinois Statistics

Birthwieght categories, births under 37 weeks have been reviewed since 1996. The numbers reported from IDPH are very different from the numbers reported from the March of Dimes

Mark Flotow gave a presentation on this topic.

Preterm birth in Illinois is defined as <37 completed weeks of gestation.

37 completed weeks or gestational weeks is determined two different ways

- Using LMP – missing LMP varies from 2-25% and may be inaccurate
- COE – Clinical or obstetric estimate (not always early prenatal ultrasound) may have bias
  Dr. Bigger described that Dubowitz measurements can be inaccurate based on illness factors particularly in very early infants but are probably fairly accurate in late term infants.
  Past data shows bias toward full term births

NCHS uses LMP and MOD uses NCHS as the preterm data source

States use different data to impute LMP, COE by state. Oregon does not calculate it at all

The following are tables illustrating the differences

Percentage Preterm Births: 2006

	NCHS	State	Diff.
Florida	13.8	14.2	+0.6
Illinois	13.3	10.8*	-2.5
Kansas	11.8	9.4*	-2.4
Maryland	13.5	11.4*	-2.1

Massachusetts	11.3	9.0	-2.3
Missouri	12.8	13.2	+0.4
North Carolina	13.6	11.2*	-2.4
Ohio	13.3	13.1	-0.2
Pennsylvania	11.8	10.4	-1.4
Texas	13.7	13.6	-0.1
Utah	11.5		
Vermont	9.6	9.5	-0.1

* = COE only

Percentage Preterm Births: 2000-07

	NCHS	IDPH	Diff.
2000	12.1	9.9	-2.2
2001	12.5	9.8	-2.7
2002	12.5	10.0	-2.5
2003	12.8	10.3	-2.5
2004	13.0	10.7	-2.3
2005	13.1	10.7	-2.4
2006	13.3	10.8	-2.5
2007	13.1*	10.6	-2.5

* = based on preliminary data

NCHS is virtually impossible to duplicate because of the way they impute data – look at records with a similar profile. None of this was surprising

Which version is correct? If one wants to compare states by report card it is best to use data by March of Dimes. For cross tabulation use ILLINOIS data NCHS is still considering changing to the COE process.

Report cards are designed to stimulate action. Deb Rosenberg indicated that if NCHS changes to COE will still look just as bad. Illinois is using COE.

Most of the research community to date uses LMP based estimates, Deb brought two articles stating early infants have the most difference as stated earlier.

Dr. Mrytis Sullivan has on her agenda to begin looking at late preterm infants.

NCHS – uses the hot tech method single imputation method. Suggestion is to look at birthweight and gestational age together.

Louise Simonson presented a document from a conversation with Vickie Williams regarding questions from the University of Illinois. She thanked Ms. Williams for her participation.

There were other definitions that caused concern.

Dr. Bigger asked that the definition of resuscitation – it is a process – what you need to know is how many infant are depressed to require help.

What is CPAP or O2 delivery – ambu bag or intubation IS resuscitation. On VLBW infant some will be intubated because of pulmonary disease not because they were depressed.

Resuscitation can be operator dependent – is it really predictive. Birth certificate clerks sometimes have a difficult time compiling the information for the certificates

IV. Data Sharing :

A. **University of Chicago/University of Illinois**: The IRB passed through the University of Illinois in July. They received a letter from IDPH approving the program. The purpose of the study is to assess preventability. Informed consent was waived as all data is retrospective. If there is under a certain number in one area zip codes will be combined.

B. **MMRC – Level III maternal deaths** – A proposal has been approved by PAC that another Level III center would review the death to avoid inherent bias. IDPH suggested after legal consultation, that it will be necessary to amend that section in the proposed Rule that deals with M+M's.

C. **Perinatal and Maternal Deaths that involved more that one facility** A proposal was approved that facilities can review cases together at M+M's. This proposal is being reviewed by the legal department at IDPH.

V. Late Preterm Infants:

A. Many sources are looking at this issue. The March of Dimes Big Five Initiative, Joint Commission core measures, IHI bundles include the < 39 weeks cases and IDPH. Discussion was held on how to respond. The more uniform the recommendation the better data collection will be.

Hospitals will have to report deliveries and reason behind <39 weeks. In Ohio this was implemented and the late preterm rate decreased 30% just by enforcing reporting.

California has a huge tool kit - < 39 weeks non-medically indicated are put into a system for documentation. This is mandatory for all hospitals.

Von and the PQCI want to accomplish this objective.

There needs to be a meeting of the minds. PQCI wants Level III hospitals– MOD wants five hospitals.

PQCI may want to get together IDPH, DHS and Healthcare and Family services.

OB and Pediatric data will be needed. Pediatric data collection will be complex. OB data may include soft diagnoses. Data use issues must go through IDPH. The process will continue until late preterm infants born electively is no longer a problem.

Once it is determined what needs to be done – resources are available from MOD. Senator Pam Altoff wants IDPH to put information about late preterm infants on the IDPH website.

Louise Simonson suggested that a uniform project throughout the state be established.

It is possible to start with the one preventative piece and use the awareness gained by the OPHEP project to move this initiative forward. The fist step may be to approach the OB objectives.

IHI has bundles but no policies about deliveries less than 39 weeks.

MOTION #1: That Chair will ask that Regional Quality Councils conduct a survey of all Network hospitals to ascertain current practices in evaluating late preterm deliveries and data from Birth Certificate reports to determine frequency.

The motion was made by Cathy Gray and seconded by Angela Rodriguez. The motion passed unanimously.

A motion to adjourn was made by Richard Besinger and seconded by Pat Prentice. The meeting was adjourned at 4:03 pm.