



ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
PERINATAL ADVISORY COMMITTEE MEETING

December 8, 2011

1:00 p.m. - 3:00 p. m.

Michael A. Bilandic Building

160 North LaSalle

Chicago, IL

5<sup>th</sup> Floor Room N505

**Chaired:** Howard T. Strassner, MD

**Attendees:** J. Roger Powell, Nancy Marshall, Barb Prochnicki, Dennis Crouse, Janet Hoffman, Cathy Gray, Harold Bigger, Lenny Gibeault, Edward Hirsch, Phyllis Lawlor-Klean, Janet Albers, David Schreiner, Robin Jones, Bruce Merrell, Susan Knight, Denis Crouse, David Crane, William Grobman, Omar LaBlanc, Kevin Rose, Janine Lewis, Bree Andrews

**Absent:** Richard Besinger,

**IDPH Staff:** Tom Schafer present, Charlene Wells, (excused)

**Guests:** Courtney Avery, Barb Haller, Pam Wolfe, Ray Spooner, Myra Sabini, Pat Prentice, Elaine Shafer, Maripat Zeschke, Robyn Gude, Cindy Mitchell, Anthony Bell, Robert Covert

**Minutes**

- 1. **Call to Order & Welcome.....Howard Strassner, MD**  
Dr. Howard Strassner welcomed the members and guests. He introduced Courtney Avery, member of the Health Facilities and Services Review Board and thanked her for her presence.
- 2. **Self Introduction of Members.....Howard Strassner, MD**  
Members and guests introduced themselves and
- 3. **Review and Approval of Minutes .....Howard Strassner, MD**  
The minutes of the October 5, 2011 were reviewed. Harold Bigger moved approval, Cathy Gray seconded; the minutes were approved as written.
- 4. **Old Business.....Howard Strassner, MD**

**Dr. Harold Bigger**

• **Prematurity Task Force Update**

Dr. Bigger gave an update on the progress of the Prematurity Task Force. The task force met on October 3 and November 10, 2011 and has discussed the responsibilities under HJR 111.

The Task Force has established that the report due to the legislature in November 2012 will contain the following elements:

- a) A description of the extent of prematurity. Dr. Bigger mention that the latest literature states that approximately 20% of births (births before 37 weeks gestation) in the United States are preterm.

Spontaneous preterm births account for 80% of that number and the remaining 20% are performed based on medical orders for a variety of reasons.

- b) A statement on the cost of prematurity to society, families and healthcare organizations
- c) A description of the challenges in attempting to reduce the incidence of prematurity
- d) Suggestions for the State of Illinois to reduce the incidence and to accurately report the causes of prematurity for the citizens of Illinois

Dr. Bigger also stated that additional legislators will be appointed to serve of the Task Force. Currently the Task Force has members from the PAC, the Illinois Department of Human Services, the Illinois Department of Healthcare and Family Services, the March of Dimes (an organization whose main focus is on preterm births) all as required in HJR 111.

Literature reviews have been held to assure the Task Force has access to the latest evidence based data regarding prematurity.

**5. IDPH Update.....Tom Schafer**

Tom Schafer reported that information regarding prematurity is up on the website, meeting the requirements of SB 3273. Mr. Schafer thanked Cindy Mitchell for her assistance on this project

Mr. Schafer announced that Dr. Damen Arnold, Director of the Illinois Department of Public Health has resigned and taken a position at Chicago State College. Craig Conover is now the senior medical advisor for IDPH.

Dr. Kenneth Soyemi is now Acting Director and Terri Garati is Assistant Director  
Stephan Kanye is the Administrative Director.

Mr. Schafer explained that the Acting Director may serve a sixty day term by statute. Dr. Bigger asked if the Acting Directors can rotate off and back on. Tom Schafer said he that persons in the Acting capacity can only serve for sixty days.

**6. Committee Reports:**

**Statewide Quality Improvement Committee.....Harold Bigger, MD**

Dr. Bigger noted that two Perinatal Centers presented Regional Quality Council Reports

**Rockford Perinatal Center:** The RQC project report on Thermoregulation was presented. Eight hospitals reported positive outcomes using a variety of methods including food wrap, bags and chemical mattresses. The RQC felt that they needed more data and that the sample size was too small and plans are underway to expand the sample.

**St. Louis Perinatal Center:** The RQC is focusing on elective deliveries less than 39 weeks gestation. They have found that this is more common in rural areas where there are fewer Obstetric providers.

However, there are differences in institutions of similar characteristics. The RQC has obtained a grant to further this project.

The RQC is also addressing access to antenatal care and obesity.

Discussion was held regarding the interest of business and insurance companies in the less Reimbursement at less than 39 week deliveries. Some are suggesting that payments for OB and neonatal care be decreased or denied if the delivery was not indicated by medical conditions.

Dr. Bigger announced that the SQC Breastfeeding Task Force will meet on February 9 and present a draft plan with an estimate of costs to implement the measures needed to respond to the Illinois blueprint for breastfeeding.

Dr. Crouse mentioned that the March of Dimes BIG 5 project will finish data collection at the end of this year. Soon we will have data available to answer some of Prematurity Task Force's information needs. Dr. Grossman stated there should not be much discussion about less than 39 week elective deliveries, knowing that outcomes for infants are not acceptable. The "Hard Stop" method has been implemented in the study. Some states, including Ohio have analyzed costs and impacts and other have already stopped using public funds for these deliveries and outcomes. Kevin Rose confirmed that sometimes problematic issues arise and that data regarding a reason for early induction needs oversight.

Susan Knight indicated all hospitals in the BIG 5 project have been able to decrease the number of elective deliveries. Dr. Bigger asked if a zero rate is required. The March of Dimes does not expect a zero rate.

Dr. Strassner state a zero rate should be the goal and that PAC should endorse a zero rate that can be communicated to the Prematurity Task Force meeting in February.

Dr. Crouse described interest in this subject from Quality Quest, Leapfrog, and Midwest Business Alliance. These organizations are supporting a Statewide Program. We may be able to go into potential alliances with other states due to the recognition of these efforts

#### **Maternal Mortality Review Sub -Committee.....Robin Jones, MD**

Dr. Jones mentioned the difficulty that IDPH is having in getting complete records from hospitals and providers. The incomplete charts then result in a substandard preparation for MMRC review with an inability to analyze cases according to the expectations of the code. After much discussion; the following motion is proposed:

#### **MOTION #1**

- 1. A letter from Charlene will be sent out to all birthing hospitals with a copy of the Maternal Mortality Code and a list of required data to be sent to IDPH**
- 2. When a deficient chart is received, a follow-up letter from Mark Flotow will be sent to the provider or hospital (CEO and Director of Maternal Child Nursing) indicating the deficient elements with a requirement for producing the documents within 60 days.**
- 3. If the documents are not produced in 60 days. The Perinatal Advisory Committee will be informed and will request that the Director of IDPH communicate with the provider or hospital.**

Additional discussion was held. Comments included real consequences should be part of the Site Visit. Barb Haller asked that the hospital has opportunity to respond within 10 days. The members agreed.

Cathy Gray asked that the motion go to the Perinatal Administrators. The issue of discoverability was brought up. The Maternal Death Statute protects all data under the process and all abstracts are blinded for review by the MMRC.

Roger Powell motioned approval, Denise Crouse seconded, the motion was approved unanimously.

Dr. Jones indicated that the MMRC members requested cases involving pre-eclampsia and cardiac causes of death be reviewed. Many cases of cardiac caused included the diagnosis of cardiomyopathy as a cause of death. Of fourteen cardiac cases from 2008-2011 sent for review; 9 had obesity or morbid obesity as a co-morbidity. The MMRC will convene a workgroup on obesity to address this serious concern.

The Obstetric Hemorrhage Education Project Competency will be sent to all hospitals along with a data collection grid. The membership asked that IDPH allow the competency to be placed on the IDPH website to make it easy for hospitals that don't have electronic testing services to download.

The issue of autopsy was again raised and the MMRC made the following motion:

**Motion #2 – That all clinically related maternity pregnancy deaths have a complete autopsy and that this request is communicated to the Perinatal Advisory Committee.**

Discussion by the PAC members indicated that the Coroner currently has the option of performing an autopsy

The members asked that the MMRC initially define the type of cases that would make a maternal death a coroner's case.

Dr. Grobman suggested that the definition be for a shorter time for coroners cases such as up to 90 days or 6 months.

Draft legislation may be required to do this. Tom Schafer recommended that a PAC member work with the legislature. Currently there are no formal arrangements with the legislature except for the prematurity task force.

Dr. Strassner asked if a PAC member could lobby legislators or should someone do it as individuals – then the PAC can make a motion.

Barb Haller suggested talking first with the coroners association.

Dr. Jones will reach out to the coroners and give a report in April. The motion was tabled.

**Subcommittee on Facilities Designation Report.....Cathy Gray, RN, MBA**

**A. Cathy Gray indicated that two motions were made at the Subcommittee:**

**1. Carle Clinic surgical services recommendation for Site Visit 6-9 months after the review.**

**A Motion that Carle Clinic was compliant with the requests of the Subcommittee was made and a Site Visit has been scheduled for May 9, 2012. Allow IDPH to send a formal letter that they have met the surgical requirements with the expectations of a Site Visit in May, 2012 - 6 accepted 2 abstained**

**2. St. Alexis Hospital was reviewed as a new Level III at 18 months. A letter of support from Rockford was received. The Subcommittee accepted the 18 month report and that they move into the regular rotation of Site Visits. - 6 accepted 2 abstentions**

**Motion #3: That the above mentioned Subcommittee on Facilities Designation motions be approved by the Perinatal Advisory Committee and be allowed to go forward.**

Leonard Gibeault made the motion, Harold Bigger seconded; the motion was approved with 17 ayes and 3 abstentions.

**B. Anesthesia Coverage: Anesthesia service availability for 24 hour coverage, that investigation will continue.**

▪ **Definition of Assisted Ventilation.....Denis Crouse**

Dr. Crouse discussed the recent letters between Perinatal Centers and hospitals temporarily giving hospitals the right to deal with head boxes and nasal prongs.

A Subcommittee on Facilities Designation workgroup including representative from those requesting change in the definition was convened.

The definition of assisted ventilation as stated in the Regionalized Perinatal Code was found to be outdated. As a modality used in every Level III and IIE, Dr. Goldsmith maintains a definition – the new definition unanimously approved will eliminate the issues of head boxes.

Dr. Goldsmith was consulted and the new definition accepted by the subcommittee based is

“Assisted ventilation can be defined as the movement of gas into and out of the lung by an external source connected directly to the patient. The external source may be a health care provider using mouth-to-mouth, mouth-to-mask, or a hand-operated resuscitation bag; the external source may be a mechanical device such as a continuous distending pressure device or a ventilator. Attachment of the device to the patient can be via a face mask, endotracheal tube, laryngeal mask airway, nasal prongs, or tracheostomy.” (Goldsmith 2010)

There is a need to look within the definition to clarify the issue of nasal prongs – all agree that nasal prongs provide positive pressure ventilation. Because we can't define which infants receive what pressure, for example:

2 liter flow in a 1000 gms. infant would probably indicate positive pressure; 2 liter flow in a 2600 infant would most likely not indicate positive pressure.

The Subcommittee did not decide – new definitions coming out for the future. If using a nasal prong in the future to provide positive pressure ventilation then it is assisted ventilation / if used to provide oxygenation only then not assisted ventilation. Each Perinatal Center needs to look at their Network Hospital practices.

**Motion #4: To accept the Goldsmith 2010 definition of assisted ventilation.**

Discussion continued. Kevin Rose asked if Dr. Crouse's explanation regarding nasal prongs could be included. IDPH requires a definition from a credible society. It would be in the hands of the Perinatal Center to explain the definition and establish trust with Network hospitals.

Dr. Bell stated that the workgroup did struggle with the intent to provide CPAP. The length of time, infant size, canula size all need to be clear that there should not be intending to give CPAP.

A child on positive pressure, prongs, canula, vent, CPAP after 6 hours must be at a Level II with exception facility or above.

Dr. Strassner said the exceptions need to be clearly stated in the Letters of Agreement. Legal discussions will have to take place, and Perinatal Centers may have to grant another exception until the rule is approved. Tom Schafer will take to the proposed definition to IDPH attorneys.

Dr. Strassner asked if it standard practice to indicate intent in the progress note and how does one evaluate this case by case. Dr. Bigger indicated that is not the standards practice now. Dr. Crouse states that they have selected a number but at some point a number had to be selected The AAP selected 2 liters for most infants and for tiny babies 1 liter.

Dr. Bigger said once flows above 2-3 liters it is possible to give unregulated CPAP.

**Motion #4: To accept the Goldsmith 2010 definition of assisted ventilation.**

**The motion was again brought to the floor: Dr. Crouse moved acceptance, Barb Prochnicki seconded. The motion passed unanimously**

Dr. Strassner asked that the letter accompanying the definition provide information and that education of the Level 2 and Level II with exceptions be provided.

Discussion continued:

A statement was made that there are two opposing views regarding the use of prongs and canula:

1. Adjust clinically based, flows, devices to size of the child to determine what is safe
2. If > 2 switch to CPAP

Dr. Crouse stated that until the literature defines this there is no evidence to support either one at this point

Dr. Bell indicated that Ram canula market is trying to put pressure readings on canulas. - Nancy Marshall asked if PAC can we say prongs are for CPAP only. Dr. Gonzalez disagreed. Dr. Strassner said this would not be appropriate in light of the motion.

**Grantee Committee Report.....Lenny Gibeault, MSW**

Lenny Gibeault provided the following report:

**The Chicago Department of Public Health/ Chicago Maternal Child Health Advisory (CMCHAC).**

Angela Rodriguez, CMCHAC chairperson, presented an initiative to assess the current status of patient access and appointments for inter-conceptual care. A survey process was presented and was endorsed by the Grantees. Hospitals who serve CDPH patients are asked to return the one page survey by January 15, 2012 to administrators who will forward to CMCHAC.

**The Perinatal Outreach Educators of Illinois - follow-up report on fetal monitoring survey.** The initial goal was to develop a standard program. Two options were shared but would involve significant hospital cost. The programs used must be multidisciplinary and interactive. POEI will be coming back in

April. Mr. Gibeault thanked Shirley Smith, Angela Rodriguez and all POEI EFM committee members for their work on this project.

**A legislative update on third trimester HIV** rapid testing was presented by Cathy Gray. This measure is supported by various groups. There are concerns over cost but she feels that this will eventually happen.

The Site Visit process has been reviewed and revised based on the recommendations of a Site Visit Workgroup. Thank to all administrators who participated. The changes made should streamline and make the process the same for all facilities of the same level of care.

A new standard database for PMR's is being implemented through e-Perinet..

Dr. Strassner asked about 3<sup>rd</sup> trimester HIV testing. Cathy Gray stated that the entire state is listed as a high risk HIV area. Illinois is all inclusive. There is a committee reviewing how to implement and whether all patients would be included, especially as cost is a concern. Cathy Gray stated that if a private physician or clinic did not do the test in the third trimester; the cost falls on the hospital which raises cost overall.

**7. New Business.....Howard Strassner, MD**

Mention was made that a Rule was coming up to increase the Newborn Screening fee by \$10 (\$88)

- **Illinois Health Facilities and Services Review Board**

Dr. Strassner recognized Ms. Courtney Avery who agreed to discuss the Certificate of Need (CON) process how Illinois Health Facilities and Services Review board evaluates and issues an application for a CON.

Ms. Avery described a Statutory Rule established the Illinois Health Facilities and Services Review Board to review requests for changes in health care facilities on behalf of the citizens of Illinois.

Dr. Strassner indicated that PAC would like to inquire about the CON Board's view of the need for NICU beds in the State of Illinois.

Cathy Gray says there is currently an 80% occupancy level, indicating many vacant beds. The HAN inventory which indicates how many vacant beds by type; completed daily at each Illinois hospital was used to confirm the rates.

Members stated there has been a large increase in the number of Level III facilities approved, some of which are in a close geographic approximation to another Level III.

Ms. Avery described some recent requests for additional hospital that were not approved by the Board.

Dr. Crouse quoted experts that stated that the most cost effective way of giving high risk perinatal care is in NICU units over 24-25 average daily census. Smaller facilities must have all necessary services and can diluting the overall timely availability; surgical services is an example.

Some Level III facilities have an average census of 4-6 in the NICU. When Perinatal Centers only have the sickest infants the academic nature of NICU training is affected. This scenario is unfolding and is causing problems.

It was mentioned that Michigan has reduced the number of Level III's from 10 to 6. Cathy Gray voiced concerned about low volume and the ability to maintain expertise.

Ed Hirsch indicated the process of defining need should include the PAC, the CON board and Hospital Licensure.

Dr. Grobman stated that need defined by a two dimensional measure. Multiple Perinatal Centers have empty beds. How is it that there is a need for more Level III's. It could be that there is benefit to the individual hospital at the expense of the public.

Cathy Gray said the excuse has been given that more Level III's can keep the patient in the community. Currently most new CON request involves communities overlapping. However, high volumes of Medicaid patients are often not served by these newer Level III's.

Ms. Avery stated that the Board does look at and make decisions based on payor mix, charity care etc.

Denis Crouse stated that currently every hospital in the state has NICU vacancies and suggested that PAC and the CON Board work together.

Cathy Gray stated in the late 80's to late 90's there was a moratorium on new Level III's. Ms Avery stated that the Board has not received a request for a moratorium. She indicated that a moratorium could be requested by sending a letter to the CON Board chairman. The request would go through public hearings and reviews.

Dr. Crouse mentioned that eliminating elective deliveries is already decreasing NICU admissions by up to 20%.

Dr. Strassner asked if there is an opportunity for the Perinatal Group to be elicited whenever a request is received.

Ms. Avery replies that the CON must be done in the context of the public hearing and analysis of the need presented. The CON could solicit input from the PAC.

Cathy Gray stressed the bigger public health view. Ms. Avery stated that CON Board always accepts outside comments.

The time being 3:00pm, Dr. Strassner suggested that the time be extended until 3:15pm. Members agreed.

Denis Crouse stated that the groups need to communicate for the greater good. HE mentioned that the Illinois Section of the American Academy of Pediatrics, Committee on Fetus and Newborn asked for an American College of Obstetrics and Gynecology member. He asked if the CON Board have an ad-hoc person at meetings from the PAC and vice versa.

Ms. Avery stated that the process could be done through public comments, hearings or prior to the meeting. Board members only see each other every 45 days.



Ms. Avery also mentioned that all requests for CON processes are posted.

Dr. Grobman stated that the Con Board is doing what they are supposed to do but this doesn't take into account the concept of Perinatal Regionalization. He asked if there a way to look at this. Illinois currently has as many NICU's. He also mentioned SB 1905- that stipulated legislation center for comprehensive health planning as a possible way to address concerns.

Dr. Bigger stated that a previous member, John Paton, predicted the current situation in 1990.

Ms. Avery stated that the CON is working on the rule, and there is the opportunity to suggest language that works with the Perinatal Rules.

Dr. Strassner and members thanked Ms. Avery again for her time and attention to PAC concerns and pledged to work together in the future to further cooperation with the CON Board.

**8. Adjournment .....Howard Strassner, MD**

**Motion to adjourn by Phyllis Lawlor-Kleen, motion seconded by Kevin Rose.  
Adjournment at 3:19 pm.**

**Next Meeting April 12, 2012 at 1:00 PM  
James R. Thompson Center – 9<sup>th</sup> Floor Room 034**