Illinois Department of PUBLIC HEALTH
Pat Quinn, Governor
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
STATEWIDE QUALITY COUNCIL
October 10, 2012
2:00 p.m. – 4:00 p. m.
James R. Thompson Center
100 West Randolph
Chicago, IL
9Th Floor - Room 034
Harold R. Bigger, MD, Chairman
MINUTES

Chair: Harold Bigger

Attendees: Cathy Gray, Cora Reidl, Patricia Bovis, Robyn Gude, Karen Callahan, Robin Jones, Pam Wolfe, Lenny Gibeault, Maripat Zeschke, Deb Rosenberg, Angela Rodriguez, Pat Prentice, Cindy Mitchell, Stephen Locher, Trish O'Malley, Elaine Shafer, Cora Reidl, Barb Prochnicki, Gary Loy, Robyn Gude,

Absent:, Ann Borders, Richard Besinger (excused)

Guests: Bonnie Paris, Patricia Garcia, Anne Statton, Laurie Ayala

IDPH Staff: Charlene Wells

1. **Review and Approval of Minutes-**
   The minutes were amended to correct ERM to EFM on page 5. ICAAP to ICAP. Stephen Locher moved approval, Barb Prochnicki seconded; the minutes were approved as amended

2. **Regional Quality Council Reports: Peoria and Springfield Perinatal Centers**

Peoria: Elaine Shafer

#1 To Eliminate Elective Deliveries < 39 Weeks Gestation

Data was presented that indicated that Later Preterm and Early Term deliveries admitted to NICU at the Perinatal Center decreased from 23 to 20 from 2008-2011. For infants transported to the Perinatal Center in the same category the decreased was from 57 to 52 for the same time period with increases in 2009 and 2010.

Barriers to closing the gap

- Physician autonomy

- Patient and physician desire for control that scheduled delivery offers
- Failure to appreciate risk of elective early term delivery (physicians and patients)
- Perceived risks (IUFD) of pregnancy continuation
- Individual physicians think their outcomes are different or better than everyone else's
- Nurses don't want to be put in the position to police our problem, and we have proven that we are not willing or able to correct

Patient perception of safety

- 650 recently delivered women surveyed
- All commercially insured
- Patients with high-risk maternal conditions were excluded
- At what GA do you believe the baby is considered full term?
  - 24% (34-36 weeks)
  - 50% (37-38 weeks)
- What is the earliest point in the pregnancy that it is safe to deliver the baby (electively)?
  - More than 50% (34-36 weeks)
  - 40.7% (37-38 weeks)
  - More than 90% (safe to deliver before 39 weeks)

Next Steps

- Review hospital data at Perinatal Case Review Meetings
- Encourage hospitals to stratify data by individual provider
- Monitor neonatal outcomes at 37 – 38 6/7 weeks
- Provide feedback to individual hospitals on elective deliveries < 39 weeks gestation and on neonatal outcomes
- Monitor proposed reimbursement strategies and educate hospital leadership
- Letter sent to Hospital Administration following Perinatal Case Review Meetings, identifying gaps between ideal performance and current performance
- March of Dimes
  - Billboards
  - Educational materials in physician offices
- Evaluate Reasons for Elective Deliveries
- Develop uniform definitions for:
  - Significant pre eclampsia
  - Chronic hypertension
  - Pregnancy Induced Hypertension
- Evidence for Thromobophilia/Lovenox
- Bishop Scoring

The Peoria Perinatal Center will involve families as parent pathfinders. The criteria for exclusion were discussed. Robin Jones indicated that standard ACOG definitions have not changed but that bulletins regarding the need for induction and the elimination of elective inductions are used as guidelines. Steven Locher described the Advocate methodology using data from their hospitals to evaluate cases in g M+M's .

HARD STOP means nursing personnel or others have a designated authority to take a conflict to and that person must assume the responsibility to maintain the policy. Schedulers need to be educated.
Susan Knight indicated that proactive steps must be taken to assure smooth implementation, and these need to include peer review.

Robin Jones noted that scheduled cases are easier to analyze than the woman who walks in and says "my doctor says in labor".

#2 Congenital Heart Disease Screening

- March of 2011 & March of 2012
    - Conference for sonographers and Obstetricians
    - "Hands on," program
    - Z score measurement
    - Referral and follow-up
- Post natal Screening
    - Motion sensitive pulse oximeters
    - AAP Guidelines/Toolkit
    - Dr. Bramlet – RQC
    - All maternity service hospitals in Network stock PGE 1 and protocol for administration

Trade in program

Currently 20 out of 23 hospitals are actively participating

If there is a positive screen the Neonatologist at Perinatal Center gets the first call and decides about Pediatric Cardiology consultation.

#3 Promoting Breast Feeding

Project Status

- Leadership from Baby Friendly Hospital in Network is leading this project. (Darlene Hammond and Beth Siedel)
- Workshop held in May of 2012 to kick off project.
- Measure current practice of skin to skin contact.
    - Percent of patients receiving skin to skin with in first hour of life. (June –November of 2012)
    - Identifying barriers to skin to skin contact within first hour
- Promote "safe" rooming in
    - Adequate education for family regarding placing baby in crib when done feeding and mother is sleepy.
    - Assess mother for maternal fatigue
    - Cognizant of times when pain medication has been administered.
    - "No co-sleeping" policy. Baby is moved to crib when mother is drowsy or preparing for sleep
    - Hourly rounding
- Each hospital developing infant feeding policy supported by principles of the Baby Friendly Initiative.
- Standardizing discharge instructions to assure adequate and appropriate follow-up.

NICU

- Additional Lactation Consultants available to assist mothers with pumping and breast feeding.
- Videotaped mother's of near term or term babies in the NICU that had less than a positive experience with breast feeding in the NICU
    - Shared video with staff and developed plan with staff nurses to improve their support of breast feeding mothers

#4 Debriefing Select Transfers

PROJECT GOAL

- Debrief select transfers, within 48 hours of transport, with all staff involved in transport, both from the NICU and the network hospital.

- Identify opportunities for improvement in the stabilization and transfer process, for newborns with congenital anomalies, those requiring hypothermia therapy, and those weighing < 1500 grams
- Provide support to caregivers involved in stabilizing and transporting select cases of high-risk newborns.
- Utilize "systems thinking" principles in evaluating care delivery for transported newborns.
    - Learning from Defects Tool

OBJECTIVES

- Identify how teamwork effectiveness might have been improved during the stabilization and transport.
- Utilize "lessons learned," to test interventions, supported by best evidence, in improving the stabilization and transport process.
  Involve families in process…..

NEXT STEPS

- Kamlesh Macwan, MD provided overview of project at September 17, 2012, Regional Quality Council Meeting
- Finalize process for initiating debriefing and the process for generating and classifying the "lessons learned."
- Define unintended consequences that might arise from this process
- Initiate debriefings in January of 2013.

Springfield : Beau Batton, MD St. John's Children's Hospital

Outborn Births of Very Preterm Infants in Rural Illinois

- AAP and ACOG recommend that all preterm infants ≤ 32 weeks gestation be delivered at a Level III Perinatal Center
- It is not clear to what extent regionalized perinatal care has been effective in achieving this goal in rural portions of the United States
- The South Central Illinois Perinatal Network (SCIPN) serves 29 Hospitals in 37 Rural Counties
- The Level III Perinatal Center at St. John's Hospital receives maternal and infant transports from throughout the SCIPN

OBJECTIVES

- Identify the effectiveness of regionalized care for promoting delivery of infants ≤ 32 weeks GA at a Level III perinatal center
- Compare morbidity and mortality of very preterm infants born at a Level III Perinatal Center (inborns) versus those born at an outlying hospital (outborns) within a single rural perinatal network

METHODS

- Retrospective review of prospective data
- All infants born between $23^{0/7}$ – $32^{6/7}$ weeks gestation between 1/1/2003 and 12/31/2009 within the SCIPN
- Demographic data, maternal risk factors, in-hospital outcomes
- Antenatal steroid exposure was defined as the administration of at least one dose of betamethasone prior to delivery

- Data Obtained from all participating hospitals
- Standard definitions used for all demographic data and morbidities (Vermont Oxford)
- Statistical Analysis
- Continuous Data Analyzed by ANOVA
- Categorical Data Analyzed by Pearson's Chi-squared
- Analysis performed with SPSS v17 software (Chicago, IL)

DEMOGRAPHICS

	Inborn Infants (n=619)	Outborn Infants (n=259)	P value
Gestational age (mean±SD)	28.4 ± 2.4	28.0 ± 2.6	0.051
Birth weight, g (mean±SD)	1162±408	1188±438	0.494
Cesarean Delivery	67%	66%	0.868
Multiple gestation	27%	24%	0.682
Received antenatal steroids	82%	37%	0.001

In-Hospital Outcomes

	Inborn Infants (n=619)	Outborn Infants (n=259)	P value
RDS	68%	79%	0.006
Received surfactant	55%	69%	0.002
Required ventilator	62%	73%	0.010
IVH (any grade)	20%	32%	0.001
IVH (grade III/IV)	9%	18%	0.004
PDA receiving treatment	44%	53%	0.05
NEC requiring surgery	4%	4%	0.845
Hospital days (survivors only) mean±SD	57 ± 39	62 ± 41	0.243

Survived to discharge*	88%	78%	0.001

CONCLUSIONS

- A large percentage (29%) of very preterm infants within the SCIPN are outborns
- The major difference in the care of outborn infants is that they are far less likely to receive antenatal steroids and this is associated with a marked increase in morbidity and mortality risks
- Outborn infants remain at a significantly greater risk of a large IVH even when steroids are administered and the reason for this is not clear
- It is likely that the prognosis for outborn infants could be improved with earlier maternal transport

The use of antenatal steroids was discussed. A study of antenatal steroid useage(7 year study period with 878 cases < 32 weeks or less) indicated that outborn infants were dramatically less likely to receive
Analysis found that steroid useage as the only factor that contributed to mortality was present in 25% out of 96 cases

The next step is trying to assist the outlying hospitals to improve maternal transport rates.

Dr. Bigger thanked both Perinatal Centers for their excellent reports. The membership recognized their efforts

3. Perinatal HIV Prevention Code: Suggested Amendments – Patricia Garcia, MD

At the last PAC meeting the SQC gave a report regarding the RUSH/AIMMC Co-Perinatal Centers' request from their RQC that the Perinatal HIV Prevention Code which is currently in the Second Period for Revision be clarified to address hospital concerns found in a Network Survey.

PAC asked that a meeting be held to include Dr. Pat Garcia regarding the requested revisions. The meeting was held on September 26, 2012 and included members from the Pediatric AIDS Chicago Prevention Initiative (PACPI), Pat Prentice, Pam Wolfe and the AIDS Legal Counsel of Chicago.

Dr. Garcia presented the following recommendations for changes to the Perinatal HIV Prevention Code with references and supportive information:

#1 Clarification of Settings for Testing

77 Ill. Adm. Code 699
Subpart B: HIV Perinatal Counseling and Testing
Section 699.100
IDPH Current Version:

- ***Every health care professional who provides health care services to a pregnant woman shall, unless she has already been tested during the current pregnancy, provide the woman with HIV counseling, as described in this Section, and shall test her for HIV as early in the pregnancy as possible, unless she refuses.***

Proposed Changes (PACPI, AIDS Legal Council of Chicago, Pat Prentice, Pam Wolfe):

- ***Every health care professional who provides any health care services in an inpatient, outpatient or emergency room setting to any pregnant woman shall, unless she has already been tested during the current pregnancy, provide the woman with HIV counseling, as described in this Section, and shall test her for HIV as early in the pregnancy as possible, unless she refuses.***

#2. Promote Repeat Third Trimester Testing Prior to L+D

77 Ill. Adm. Code 699
Subpart B: HIV Perinatal Counseling and Testing
Section 699.100
IDPH Current Version:

- ***For women at continued risk of exposure to HIV infection in the judgment of the health care professional, a repeat test should be recommended late in the pregnancy or at the time of labor and delivery.***

Proposed Changes (PACPI, AIDS Legal Council of Chicago, Pat Prentice, Pam Wolfe):

- ***For women at continued risk of exposure to HIV infection in the judgment of the health care professional, a repeat test should be recommended performed late in the pregnancy and if not already done should be performed or at the time of labor and delivery unless the woman refuses.***

#3. Earlier Reporting to Ensure Medical Consultation for High-Risk Infants
77 Ill. Adm. Code 699
Subpart F: HIV Reporting
Section 699.500
IDPH Current Version:

- ***Health care facilities shall report a preliminary positive rapid HIV test in a delivering mother or her infant within 24 hours after birth by calling the 24/7 Perinatal HIV Hotline and by submitting a Preliminary Positive Data Collection Report.***

Proposed Changes (PACPI, AIDS Legal Council of Chicago, Pat Prentice, Pam Wolfe):

- ***Health care facilities shall report a preliminary positive rapid HIV test in a delivering mother or her infant within 24 12 hours after birth by calling the 24/7 Perinatal HIV Hotline and by submitting a Preliminary Positive Data Collection Report.***

Discussion was held regarding the recommended changes

MOTION #1 – That the Statewide Quality Council approve the recommended changes to the Perinatal HIV Code as presented by Patricia Garcia, MD

Steven Locher motioned approval, Lenny Gibeault seconded, the motion was unanimously approved.

Dr. Bigger will present this information to the PAC and if supported, will request a letter of comment to JCAR. The comment period is open until October 25, 2012. The Perinatal HIV Code is scheduled to go to JCAR in November.

4. Prematurity Taskforce Final Report - Harold Bigger

Dr. Bigger introduced the document with a thank you to Susan Knight, Mary Pat Zeschke, Arden Handler and Robyn Gabel.

All members received the complete document. Dr. Bigger focused on the summary and the following recommendations:

RECOMMENDATIONS

Because of the multi-factorial causes of preterm birth, recommendations to reduce preterm birth must incorporate a combination of clinical and public health interventions at every level including policy and system interventions. We also need consistent, coordinated approaches to collect and retrieve state

perinatal data for public health planning and community assessments, health policy research, quality assessment and performance improvement, public health surveillance and disease registries, and for informing public policy and legislation. What follows are seven recommendations, each with background, rationale, and required actions. Details about the recommendations may be found in the document.

I. CONSOLIDATE AND LINK DATA SYSTEMS T0 BETTER UNDERSTAND AND PREVENT PREMATURE BIRTHS IN ILLINOIS

Recommendation: Create a comprehensive dataset to enable a more systematic approach to understanding prematurity in Illinois

II. ELIMINATE ELECTIVE (NON-MEDICALLY INDICATED) DELIVERIES BEFORE 39 WEEKS GESTATIONAL AGE

Recommendation: Provide resources to ensure that Regional Perinatal Centers and all network hospitals implement a "hard stop" policy to eliminate elective, early term deliveries. Provide necessary clinician education to implement the change process and monitor progress through ongoing data collection and rapid return of data reports. Implement state-wide consumer awareness campaign directed to women of child-bearing age consistent with the message that "healthy babies are worth the wait."

III. IDENTIFY MEDICAID-ELIGIBLE WOMEN AT RISK OF ADVERSE PREGNANCY OUTCOMES (e.g. women who have had prior preterm birth, perinatal loss, low birthweight infant, baby with birth defect, or present with multiple gestation). PROVIDE ENHANCED PRENATAL CARE WHICH LINKS THESE WOMEN TO A MEDICAL HOME AND CARE COORDINATOR AND PRENATAL EDUCATION

Recommendation: Create and implement a risk-assessment system for identifying early in pregnancy Medicaid-eligible women who are at risk for preterm birth. Provide coordinated, enhanced prenatal care with a maternity medical home provider and intensive care management. Integrate clinical care with nutritional counseling; social support; referrals to appropriate community resources; psychosocial counseling; and coordinated links to WIC, smoking cessation, substance abuse, or other relevant programs which may reduce risk.

IV. INCREASE NUMBER OF SITES AND ENHANCE IMPLEMENTATION OF CENTERINGPREGNANCY® GROUP MODEL OF PRENATAL CARE IN COMMUNITIES WHERE INCIDENCE OF ADVERSE PREGNANCY OUTCOMES IS HIGH

Recommendation: Pursue sources of funding to increase the capacity of current Centering Pregnancy® sites which have been approved by Centering Healthcare Institute (CHI), and expand number of sites to additional Illinois communities where incidence of adverse pregnancy outcomes is high. Consider augmenting content of Centering Pregnancy® groups for women at risk of preterm delivery such as women with gestational diabetes or hypertension. Monitor outcomes of pregnancies of women participating in this group model of care and compare with outcomes of comparable women in traditional care.

V. PRECONCEPTION, WELL-WOMAN AND INTERCONCEPTION CARE STRATEGIES

Recommendation: Provide well-woman preventive care for uninsured and underinsured women, and expand availability, access to, quality of, and utilization of a medical home for care during the pre and interconception periods.

VI. ENHANCE REGIONAL PERINATAL SYSTEM TO ENSURE THAT HIGH QUALITY CARE STANDARDS ARE CONSISTENTLY APPLIED IN ALL DELIVERING HOSPITALS AND THAT PREGNANT WOMEN DELIVER THEIR BABIES AT "THE RIGHT PLACE AND THE RIGHT TIME."

Recommendation: Provide additional support, personnel, resources, and expertise to develop, implement, and monitor perinatal quality improvement initiatives through the development of a Perinatal Quality Collaborative working in tandem with the Regional Perinatal System. Assess current perinatal system functioning to ensure that pregnant women deliver at the right place at the right time and that consistent, high quality perinatal care is provided to mothers and babies.

VII. ADVOCATE FOR INITIATIVES THAT PROMOTE SOCIAL EQUITY AND FOCUS ON REDUCING LONGSTANDING RACIAL AND ETHNIC DISPARITIES IN PREGNANCY OUTCOMES

Recommendation: Raise awareness in the health community of the effects of racism and marginalization on health outcomes. Ensure equal access to culturally sensitive, patient-centered medical homes coupled with social support and linkages to community resources. Collaborate with and build upon efforts across the state to invest in communities, provide job-skills training, adequate housing, access to nutritional food sources, and family-centered support services. Train healthcare workforce in culturally and linguistically appropriate service delivery. Invest research dollars in determining strategies which are effective in increasing healthy pregnancy outcomes in women of color.

The members thanked all who participated in the project for an excellent report. It is acknowledged that some elements may be difficult to implement in some locations in Illinois. ASCPO has a goal of reducing premature births by 8% by 2015. It is hoped that this report will make that goal a reality in Illinois

5. Quality Quest - Bonnie Paris

Bonnie Paris explained that Quality Quest is a 501C-3 Charitable Organization
Healthy Babies/Health Mom's Presentation
The Goal is to Eliminate Elective Inductions and Scheduled Cesarean Deliveries < 39 weeks
Strategy includes

- Measurement & Public Reporting
- Hospital Elective Delivery Policies
- Payment Reform
- Malpractice Relief
- Consumer Education

Measurement & Public Reporting

- Recommend use of the National Quality Forum (NQF) endorsed measure #0469 PC-01 Elective Delivery from the Joint Commission perinatal measure set and in use by the Leapfrog Group
- Evaluated potential sources of data on early elective deliveries

- ePerinet system (JEMM Technologies) – Currently not feasible
- Compdata system (IHA) – Currently not feasible
- Leapfrog Group data – Feasible and in use
- **NEXT STEPS:** Develop a recommendation statement to ask every hospital providing maternity care service publicly report their early elective delivery rate

Hospital Elective Delivery Policies

- Reviewed policies from participating hospitals and March of Dimes Toolkit
- Developed essential characteristics for a best-practice standard policy
  - *A "good" Hospital Elective Delivery Policy provides a **hard-stop** for early elective (non-medically indicated) deliveries but **does not delay** early medically-indicated deliveries.*
  - Key domains of a "good" Hospital Elective Delivery Policy:
    - Informed Decision-Making
    - Scheduling Process
    - Clarity of Policy
    - Authority for Policy
- NEXT STEPS: Develop a Hospital Elective Delivery Policy Toolkit with links to existing resources and a grading scale for hospital policies

Payment Reform

- Recognize payment reform as a way to align financial incentives with best practice, so that clinicians and hospitals are not financially penalized for "doing the right thing"
- Developed a survey for health plans to ascertain what is being done throughout Illinois and across the nation
  - This will be used as a frame of reference for which direction this workgroup should take
  - Survey has been drafted, reviewed by the workgroup, and will be distributed soon

Payment Reform – align financial incentives to reward best practices. NICU's have a higher profit rate than other units. NICU has a lot of fixed costs. By improving quality the NICU could adversely affect the hospital financially. The team is looking for ways to avoid that outcome.

Malpractice Relief

Consumer Education

- In process of developing an Employer Toolkit
  - Toolkit will be distributed to employers, ACOG, Leapfrog and hospitals for pilot testing
    - Electronic
    - 2-pocket folder
- NEXT STEPS:
  - Finish the Employer Toolkit
  - Pilot test

Distribute broadly

Hospital Engagement Networks. Some hospitals have signed on. IHA is providing grant support to hospitals.

Issues to consider include:

- How to organizationally address, any violations of the policy should it be taken into the M+M
- How to enforce
- How to create new pt information – referencing websites
- How to providing information to employers.

ISMIE – Dr. Locher will speak with the current president for thoughts on a position.

Quality Quest is regional quality collaborative with funding from Corporate Sponsorship – including Caterpiller and OSF Healthcare System.

Private and Grant Funding is present through participation of the March of Dimes and Midwest Business Group on Health. There is no cost to collaborate or participate in the project. Charlene Wells commented on the number of agencies with the same objective and asked if they could we join as one. Hospitals and hospitals systems must develop their own policies for < 39 weeks deliveries, using the ACOG standards that are in place.

Harold Bigger had questions on how the project is going to be monitored. Until that focus is in place the project is not complete and personnel will need to be paid for monitoring to assure objectivity.

Leapfrog Data for 2011: Illinois had 68 hospitals reports – over 64% did not make goal of < 5% 70% showed improvement

Members advised against assigning a grade to the policy and agreed with development of tools to help improve policies.

Dr. Bigger thanked Bonnie Paris for bringing the Quality Quest program to the SQC

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6. **IDPH Update – Charlene Wells**

- The Prematurity Task Force created by PAC as a result of HJR 111 will present their report to the PAC.
- Nine Perinatal Grant applications have been received. When all are complete the review committee will meet
- Meet with Congressman Jesse Jackson – bill to allow APN's to provide medical equipment – not going anywhere. Support for the Perinatal Program –

7. **Adjournment –** Pat Prentice motioned for adjournment, Angela Rodriguez seconded. The meeting was adjourned at 4:23pm.