Illinois Department of PUBLIC HEALTH
Pat Quinn, Governor
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ILLINOIS DEPARTMENT OF PUBLIC HEALTH
PERINATAL ADVISORY COMMITTEE MEETING
October 11, 2012
1:00 p.m. – 3:00 p. m.
Michael A. Bilandic Building
160 North LaSalle
Chicago, IL
5Th Floor Room N505

Howard Strassner, MD, Chairman
Minutes

Chair: Howard Strassner

Attendees: J. Roger Powell, William Grobman , Jose Gonzalez, Dennis Crouse, Harold Bigger, Bree Andrews, Janet Albers, Bruce Merrill, Phyllis Lawlor-Klean, Cathy Gray, Nancy Marshall, Omar LaBlanc, Leonard Gibeault, Edward Hirsch, Robin Jones, Susan Knight, David Crane, Janine Lewis,, Barb Prochnicki, Janet Hoffman, Robin Jones

Absent: Richard Besinger, (excused)

IDPH Staff: Charlene Wells, Tom Schafer

Guests: Elaine Shafer, Pam Wolfe, Maripat Zeschke, Cindy Mitchell, Angela Rodriguez, Pat Prentice, Barb Haller, Cora Reidl, Jenny Brandenburg, Nancy Arnold, Robyn Gude, Chris Emmons, Ralph Kehl, Peggy Cowlin, Lori Beyer, Bonnie Paris, Doris DeMorst

1. Call to Order & Welcome……..Howard Strassner, MD
Dr. Strassner called the meeting to order and welcomed members and guests.

2. Self Introduction of Members……..Howard Strassner, MD
Members and guests introduced themselves.

3. Review and Approval of Minutes ……Howard Strassner, MD
The minutes of the June 14, 2012 meeting were reviewed. There was a request for an amendment to the wording of a motion from the Subcommittee on Facilities Designation. The amended motion is as follows:

MOTION #1

The hospital (Northwest Community) is not providing the expected surgical services for a Level III and therefore will need to implement the following:

- The hospital will submit a detailed surgical service implementation plan within 90 days to IDPH, outlining the timetable and actions needed to provide a full

scope of neonatal surgery services on-site, normally expected at a level III facility.
- If a neonatal surgical case cannot be performed at Northwest Community Hospital, the delivery of the neonate should occur at an institution with the appropriate resources
- In addition, adequate documentation of the unmet expectation requiring transfer of the mother should be outlined in detail
- Quarterly reports will be sent to the Administrative Perinatal Center and IDPH, detailing the listing of surgeries occurring at Northwest Community Hospital, a list of the mothers/neonates transfer out for surgery and the rationale and unmet expectations documented – updates on plan implementation will also be included
- Northwest Community Hospital will appear before the committee in 1 year

Dr. Gonzalez approved the amended motion, Dr. Powell seconded. The minutes were approved amended.

4. Old Business……..Howard Strassner, MD

- **Prematurity Task Force Final Report - Harold Bigger, MD**

Dr. Bigger thanked Susan Knight, Maripat Zechske, Arden Handler, Jeanine Lewis and all members of the Prematurity Task Force who worked to complete this complex document and bring it for review today.

Susan Knight presented the recommendations to the members and guests. She prefaced the recommendations with information regarding preterm birth.

She also indicated she appreciated the synergy of work throughout the past 18 months.

FACTS

- 1 in 8 babies born in Illinois are born preterm
- 12.4 % of all live births in Illinois were born preterm (NCHS, 2009)
- Highest rates for black infants (18.1%)
  - significant disparity between black and Caucasian infant mortality rates (2.4 times higher for black infants)
  - Reduction of racial disparities in health status a top priority in Illinois

COSTS

- Based on IOM's estimates, annual societal cost associated with preterm birth is $51,600 per infant born prematurely
- This means that the price Illinoisans paid to care for the 21,168 infants born too soon in 2009 amounted to over $1.09 billion
- Medicaid paid $890,364,285 in 2009 for prenatal care, delivery, post-partum care, and baby's first year of life (53% of all Illinois births)
- In 2009, over 53.9% of all births were paid for by Medicaid
- 40% of HFS-covered births that were non-normal (i.e. preterm, LBW, VLBW) accounted for 70% of the total birth costs covered

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.

Cathy Gray stated that the "right place, right time" recommendation may conflict with rules for 2E's and Level III.

Dr. Strassner asked about cost and if the cost listed is what Medicaid paid for mom and baby during first year of baby's life. Susan Knight stated that his assumption was correct

Dr. Bigger asked Tom Schafer what to do next with the report. Tom Schafer said IDPH will be happy to distribute to the legislature. He appreciated the input from many agencies and was pleased that the Task Force received the requested data. The report will be delivered from IDPH to the General Assembly –

Susan Knight indicated the document will be shared with March of Dimes Prematurity Caucus and the Illinois Maternal Child Health Coalition.

Tom Schafer asked that it get to the General Assembly first before November 1, 2012; then it can be distributed to others.

MOTION #1: That the Perinatal Advisory Committee approve the report presented by the Prematurity Task Force

Ed Hirsch moved approval, J Roger Powell seconded. The motion was unanimously approved.

5. IDPH Update……..Charlene Wells

Charlene Wells indicated that Dr. Strassner has extended an invitation to December PAC meeting to the Director, Dr Hasbrouck, MD, MPH. Dr. Hasbrouck has responded and plans to attend the December meeting.

Perinatal Grant Applications need to be signed by the Centers and returned to Charlene. Once fully executed, payments to Centers will begin.

6. Committee Reports

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

Dr. Bigger indicated that the report will address agenda item except Quality Quest as there will be a presentation by Quality Quest under "New Business".

The Perinatal HIV Prevention Code – Amendments

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:

#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 <u>in the judgment of the health care professional</u>, a repeat test should be <u>recommended</u> late in the pregnancy <u>or at the time of labor and delivery.</u>***

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

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

Dr. Strassner discussed the reach of the changes regarding "any health professional" people who are Family Medicine, Pediatricians, Internists, Emergency Room staff and others could be held responsible. Members asked if the changes would apply to dentists, therapists, lab technicians, radiology staff, optometrists and other.

Dr. Hirsch suggested that #1 be reworded to include primary, urgent and emergent care providers.

Motion #2 PAC suggests an amendment to the first proposed change to the Perinatal HIV Prevention Act regarding settings for testing. That the scope of health care providers be narrowed down and made more specific. PAC supports the third trimester testing request and earlier reporting.

Dr. Strassner asked for clarification regarding the use of "shall" and "should".

A letter will be sent from IDPH to JCAR outlining the PAC position. If changes in the Perinatal HIV Prevention Act are mad, the PAC requests that all involved health care professionals receive a letter outlining responsibilities.

RQC REPORTS

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

#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

#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 Birth 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

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

Maternal Mortality Review Sub -Committee……Robin Jones, MD

Dr. Jones reported on the following agenda items:

#1 Direct Causes of Death Review 2002-2011
Nancy Martin prepared a gave a report of 597 cases reviewed- 2002-2011
Direct Causes 111, Hemorrhage 27 Direct Causes 24%
Jehovah Witness cases increasing Dr. Cynthia Wong indicated that Northwestern had an educational program to update those who care for Jehovah's Witness patients and will share it with the MMRC.

The MMRC requested that Nancy Martin attend the December meeting to address the statistics

Total Maternal Deaths
Total Reviewed 1st Completed
Breakout of Regions
Total number of live births
Total of indirect causes
Total of Jehovah Witness cases
Look at number of hemorrhages 2009 -2010-2011

#2 Obesity Workgroup
Obesity Workgroup Update: Statistics regarding patient weight were shared and Dr. Boyle and Michelle Dr Kominiarek. A report is planned for December.

#3 CDC / AMCHP Maternal Mortality Review Initiative
Dr Robin L. Jones, Dr Hasbrouck, MD, MPH, Glendean Sisk are attending a program to address the need for national standards for maternal mortality committees in Atlanta in November. A report will be presented in December.

#4 Chart Checklist
After presentation to the PAC in June, the MMRC revised the checklist and established guidelines for chart preparation and mailing to IDPH per the Maternal Death Review Act.

The checklist was finalized and will be presented to Mark Flotow and a letter sent to all Directors of Maternal Child Services in Illinois birthing hospitals with a change in procedure as follows:

- Notifications will be sent to the Director of Maternal Child Services not Medical Records
- The Director of Maternal Child Services or designee will assure that the chart components are in place, that they are in order, are legible and are able to be viewed and abstracted by section

- The Director of Maternal Child Services will sign and approve the mailing within 30 days of the death

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

1. Carle Foundation Hospital came before the committee to request a change in network from the South Central Network, Springfield to the North Central Network, Peoria. Carle Foundation Hospital was give 10 minutes to state the reasons why they desired this network change. Stephanie Beever, VP of Strategic Development, spoke for Carle, stressing their current positive working relationship with Peoria as related initially to their surgical services but has expanded beyond just surgery. She shared her concerns for lack of communication and direction from their current administrative center.
   Cindy Mitchell, Network Administrator from the South Central Network, was also given 10 minutes to state their opinions. Cindy supported the idea that communication could be improved between institutions. She shared her concern that if Carle were in a different network, data collections, patient tracking, and M&M coordination would be disrupted.
   Subcommittee Motion
   MOTION: A motion was presented by Roger Powell, MD and seconded by David Crane that: "Carle be allowed to move to the North Central Network"– the results of the vote was 3 yea, 3 abstain and 5 no – Hal Bigger, MD, the rules expert felt because we did not have a full majority, we could not address the motion – this will be referred to the IDPH legal department.

2. Advocate South Suburban Hospital came before the committee asking to move from a Level II perinatal institution to a Level II with extended neonatal capabilities. Leadership presented their case and discussed their forward progress since their site visit. Questions from the committee were answer by the hospital representative. The main concern of the committee was the fact that deliveries had decreased over the past few years and how could staff maintain their competencies. The hospital administration described a new initiative with Aunt Martha's clinic, which is expected to increase the deliveries by several hundred over the next two year.
   MOTION: A motion was presented by Lenny Gibeault and seconded by Roger Powell, MD that: "Advocate South Suburban Hospital be approved as a level II perinatal institution with extended neonatal capabilities and present itself to the committee in 18 months for a follow-up review". The motion was supported unanimously

3. A Site Visit is scheduled in November for a Missouri Hospital wishing to become a Network member. IDPH states there is no restriction as long as they are willing to follow the IDPH Perinatal Rule

Members suggested a procedure be developed under the 640 Rules that will include how much will it cost to admit an out of state hospital. A process will be developed to address this.

A suggestion was made that all Networks would have the same charge.

4. Election of Vice Chair for Facilities is on hold if anyone is interested please notify Cathy Gray. The individual needs to be a member of PAC.

Charlene Wells mentioned that persons are going to be trained to do Site Visits. PAC members and Administrators need to be expanded to deal with changes in the Network Administrator composition and to meet the Perinatal Rule requirement.

Grantee Committee Report……..Lenny Gibeault, MSW

1. Stacey Rogers updated the group on National Children's Study. The study contains a cross section of the US and will study preconception through 21 years. The study will include all social-economic, racial and educational levels. Currently 4000 families are enrolled.

2. The CHIPRA demonstration project is an advocacy group working together to improve children's health, control cost, and set minimum standards for prenatal care to improve quality. Key goals are :
   (1)To improve interconceptual care
   (2) To provide coordination between hospitals and obstetric provider sites
   (3) To have sustainable quality projects

3. Site Visit Workgroup: A workgroup will be formed to focus on streamlining visits and using resources wisely.
4. The Medical Studies Act was discussed, there should be no minutes taken at Morbidity and Mortality conferences.
5. Maternal Death Chart preparation: the Administrators were informed of the MMRC and PAC recommendations and asked for suggestion to the form
6. Starved Rock Committee will review the purpose and future of this meeting
7. Charlene indicated that nine out of ten grants had been submitted. Quarterly Reports and billing must be on file to authorized payment and are due on the 30th of the month after the quarter has ended.

New Business……Howard Strassner, MD

- 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

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

SQC advised against assigning a grade to the policy and agreed with development of tools to help improve policies.
Once the toolkit has a finalized draft; Quality Quest will ask PAC for input.

If your organization is wanting to participate let QQ know

Plan to distribute through Midwest Business Group on Health Wants PAC's opinion.

Dr. Grobman- Malpractice reform is on hold. He cautioned against duplication of programs.

The Joint Commission may mandate these objectives.

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.

A template letter was proposed, making it easier for people to tap into those resources.

Dr. Strassner thanked Bonnie Paris and Quality Quest and said the PAC will take the information under advisement

7. Adjournment ……..……Howard Strassner, MD

A motion to adjourn was made by Lenny Gibeault and seconded by Denis Crouse

Next Meeting December 13, 2012 at 1:00 PM
James R Thompson Center – 9th Floor Room 034