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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PERINATAL HEALTH SYSTEM OF ILLINOIS

STATEWIDE QUALITY COUNCIL

October 9, 2013

2:00 P.M.

Michael Bilandic Center
160 North LaSalle Street
Room N502
Chicago, Illinois

MINUTES

Chair: Harold Bigger

Attendees: Cora Reidl, Bernadette Taylor, Karen Callahan, Robin Jones, Pamela Wolfe, Lenny Gibeault, Maripat Zeschke, Deborah Rosenberg, Angela Rodriguez, Pat Prentice, Cindy Mitchell, Trish O'Malley, Elaine Shafer, Gary Loy, Ann Borders, Pat Bovis, Phil Higgins, Barb Prochnicki, Robyn Gude, Shirley Scott, Bernadette Taylor,

Absent: William Mackendrick, Stephen Locher (excused) Richard Bessinger

Guests: Madiha Qureshi, Lynne Barnes, Jenny Brandenburg, Nancy Martin, Roma Allen

IDPH Staff: Charlene Wells, Brenda Jones, Ivonne Sambolin

I. Review of Minutes – June 12, 2013 Meeting:

The minutes were reviewed. Angela Rodriguez motioned approval, Lenny Gibeault seconded, and the minutes were approved as written.

II. Region V CoIIN to Reduce Infant Mortality Deborah Rosenberg, PhD

Deb Rosenberg presented an update on the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality which is a public-private partnership to reduce infant mortality and improve birth outcomes. She is working with Brenda Jones and HRSA with five

other staffs including representatives from HFS, the University of Illinois at Chicago (Arden Handler and Deborah Rosenberg).

The CoIN reviews issues such as social determinants, < 39 weeks deliveries, Safe Sleep, interconception and preconception and their impact on infant mortality and birth outcomes.

Federal participants include Dr. Michael WU – Director of the Maternal- Child Health Bureau

The first 18 months focused on Regions 4+6 south and southwest first, having the highest incidence of infant mortality. The project for Region V is active for 6 months and has 18 months to go. Region V has the worst black/ white gap in infant mortality in the nation.

CoIN will galvanize the regions and will propel the Federal Government in certain directions.

Monitors must have timely data which requires improved access and use of state vital records and systems.

The first project is to focus on early elective with the objective of having no non-medically indicated deliveries. Region 4 and 6 will use an algorithm developed by Dr. William Saffield. The CoIN will be meeting with the Midwest Business Group on Health.

IDPH has called another meeting regarding the process.

Four tables were presented for dissemination:

#1 By network total births and Medicaid births

#2 Preterm delivery and VLBW by network and Medicaid

#3 Early Elective Deliveries: Different denominators what's the comparison % of all term births excluding women with medical indications. The denominator is all term births the range is 4-8% for Early Elective Deliveries and this includes just women who deliver between 37-38 weeks. Data is now hospital specific for Illinois.

The project is not clear yet on what the rules and boundaries will be. Data will be able to look hospital by hospital in Illinois.

The project is using provisional vital statistics data. The good news is the data will be able to identify gaps by hospital. In Illinois the problem for white rural women may be more than anywhere else.

IDPH wants all hospitals to have this data. The Perinatal Quality Collaborative is supported by Illinois regionalization. Other states are working toward regionalization.

Dr. Higgins asked how the CoIN differs from Leapfrog data. Leapfrog is like a hospital report card but is self reported and many hospitals do not report. Every hospital has a unique identifier. Higgins said more consumers are going to go on line and the information is going to get out anyway.

Things are changing and data will be more readily available.

III. CHIPRA Update

Ann Borders, MD, MSC, MPH

The Prenatal Quality Tool, previously presented, had grant funding available. CHIPRA is looking for prenatal clinics and hospitals who would like to pilot the tools. Grant will help with implementation and quality data. Will let us know then the announcements are set out.

Dr. Bigger said how CHIPRA will track results to make sure the tools make a difference. The Prenatal minimal electronic data set will capture data so all hospitals will have access to it.

Prenatal records will review how the tool was implemented and if the appropriate things done. Chart audits will be done and this will be in the application document.

Dr. Higgins asked where CHIPRA expects the tool to have the most effect. Clinics and midlevels will be used and specific outcomes will be available.

Dr. Borders has talked with Dr. Mora Quinlin and questioned how this will be implemented for general OB physicians.

Members may e-mail questions to Dr. Borders. CHIPRA needs to get HFS data and clinic data.

Dr. Deborah Rosenberg offered to work with Dr. Borders. This will allow more perspective to get accurate data and determine cost effectiveness.

ILHE and Governors Office – Health Information Exchange – data repository on the health exchange for the prenatal data sets. Will query places that currently have electronic data records and key information will be available to labor and delivery.

The pilot will take place in clinics that have the capacity to move data. A series of clinics associated with hospitals both hospital and clinic agrees to participate.

Phase 2 will work with clinics that don't have electronic records and pull them in. Grant funding is available. Arden Handler and Janine Lewis have involvement in toolkit and prenatal care and interconceptual care, prenatal and post-partum checklists for patients.

The Kick-off conference for the ILQPC (Illinois Quality Perinatal Collaborative) will be November 21, 2013 and will be held at Northwestern Memorial Hospital – Next year there will be a meeting downstate. Morning will be sharing data about perinatal collaborative. Dr. Jay Iams will be the keynote speaker.

Different projects which have or on going in the State include:

- Breastfeeding
- Line Infection

- < 39 week deliveries

Shannon Allen from the Ohio Perinatal Collaborative will discuss the science of case studies from their Perinatal QI. The next Q-I project for the will be the < 39 weeks for OB what has been accomplished and what has been done. The ILQPC will be partnering with vital statistics to determine how to use the data we have. The group will determine ways to support data collections from different networks and will provide one statewide form and help everyone move forward.

An antenatal steroid project may also be considered.

Next Steps after the kick off will include outreach and developments of Memorandums of Understanding with hospitals and partnering with MOD, IHA, and Midwest Business. IHA has virtual models from HEN project

The ILQPC will bring in leaders from around the State and will produce interactive webinars. These have been very well used by the HEN hospitals. There will be Champions and teams at each hospital. The goal is to have enough folks at the table to get information out.

IV. SQC Outcomes Task Force Report Charlene Wells/Harold Bigger

Dr. Crouse, Dr. Locher, Dr. DeRegnier, Dr. Bigger and Charlene Wells met to further discuss the Outcomes Task Force project. The task force discussed using birth certificates to see if outcomes are reflected by the numbers of cases in a hospital. Birth Certificate data needs to be correct to accomplish validity in reporting.

The objectives may morph into definitions of care as well as definition of designations. Volume as outcome measures is legitimate. The next meeting will be October 31, 2013. Any member can have input. If anyone wants to join let Dr. Bigger know.

This is not a group to change levels of care. Charlene said the purpose of the group was to address the possible four levels of care.

V. RQC Committee Updates Perinatal Center Representatives Loyola Trish O'Malley RN, MS, APN

Obesity in the Perinatal Population: Pat Bovis and Roma Allen

CDC slides indicate that in 2010, 28.2% of the population of Illinois is obese. This problem is consuming healthcare dollars which are much higher (\$1429 in 2006) for those with a BMI 30 or higher. No state has a rate < 20%.

CDC leaves pregnant women out of statistics but the 2011 Pregnancy Nutrition Surveillance indicated that 59.2% of mothers were overweight and 55.8% were obese.

Loyola did education in Network hospitals outlining the risks and complications. Obesity data was collected from Network hospitals on Three Classes of Obesity:

Class I BMI 30-34.9
Class II BMI 35-39.9
Class III BMI 40+

Few patients had BMI documented on initial Visit.

Pre-Pregnant BMI =N 450 deliveries
Labor Admission BMI =N 541 deliveries

Of significance was Labor Admission showed 50% patients have Class 1-2-3 obesity

No formal toolkit is in place at present. A data collection tool has been developed to review management:

1. Antepartum
 - a. Diabetes
 - b. Preterm Labor
 - c. PRE-eclampsia
 - d. Nutrition Gastric Bypass and Lapband
2. Intrapartum with factors such as
PTD
Cesarean
Airway Management
Blood Clots
Infection (Systemic and Incisional)
Vaginal
Should Dystocia
Operative Deliveries
3. Postpartum
4. Neonatal

The results will determine the primary area of focus and the best opportunities for improvement. The goal will be to engage stakeholders in conversations with recommendations from experts. Members asked what motivated the Network to do this study. High rates of morbidity associated with obesity were being observed. Partners include MD's, MD champion for each site and anesthesia participating.

The study will avoid only focusing on the mother; will look at babies with hypoglycemia and other neonatal complications. The members complimented Loyola on this project.

VI. St. Louis Robyn Gude, RN, MSN

The Study on Evidenced Based Breastfeeding was prompted as there was no consistent data on the quality of breastfeeding in the Network Hospitals

1st Quarter

- Questionnaires were sent out in January 2013
- The Online toolkit was reviewed at a Network Meeting
- Data Collection was discussed
- Established a Minimum Data Collection
- Review policies for compliance with the Infant Feeding Act

87% of Network Hospitals had Breastfeeding Policies

94% had some type of lactation support

25% had a Breastfeeding Committee

37% has skin-to skin

56% had 24 hour rooming in

94% had breastfeeding within 60 minutes but only 36% monitored

Monitoring was weak for all areas

2nd Quarter

- Quality Indicators determined – maternal reports via questionnaires, monthly summary report
- Breastfeeding policy developed or revised to comply with Infant Feeding Act
- Begin Staff education

Survey asked:

- Total del
- 23/24/ hours back to Nursery
- Pumping within 6 hours for mothers
- Mixed or actual

3rd Quarter hoping to start data collection July 1 – Started September 1, 2013

Successes:

- 4 hospitals on baby Friendly pathway

Issues

Having trouble about 24 hour rooming in – back to the nursery for exams

- Difficult explaining changes to MD's
- Skin to Skin with Cesarean – getting Anesthesia to cooperate.
- OR staff not always cooperative.
- Problems with low staff and education, no lactation consultants
- Culture change difficult
- 60 minutes don't want to get skin-to-skin right away
- Early pumping
- Quality Indicators hard to select
- Nursing Manager also does staffing.

Questions

Dr. Bigger suggested monitoring and completing the birth certificates on discharge. IDPH Report Card is will come from that data.

Cultural Shift will be assisted when the general public gets used to changes. They will work on practitioners. Hospitals must make Breastfeeding a priority for it expectations.

Karen Callahan indicated that grants are still available to assist with the project.

The Network will continue this program until the next major SQC project comes up.

VII. IDPH Update

Charlene Wells

The Perinatal Program is in the Office of Women's Health. Dr. Brenda Jones is the Deputy Director for the Office of Women's Health. Dr. Bigger introduced Dr. Jones and explained to the membership that her role includes Title V and should benefit the Perinatal Program to have the opportunity to work in the Department of Women's Health. Dr. Jones is a nurse practitioner and familiar to the workings of the medical field

A group from the Grantees was convened to correct the discrepancies in the appendices of the Perinatal Rule.

Mediha Qureshi has volunteered to take Susan Knight's place on the MMRC. Charlene Wells motioned approval, Pat Prentice seconded. The SQC approved unanimously, The request will go to the Perinatal Advisory Committee tomorrow.

Meeting adjourned 3:58