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ILLINOIS DEPARTMENT OF PUBLIC HEALTH

PERINATAL HEALTH SYSTEM OF ILLINOIS

STATEWIDE QUALITY COUNCIL

June 12, 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, Pam Wolfe, Lenny Gibeault, Maripat Zeschke, Deb Rosenberg, Angela Rodriguez, Pat Prentice, Cindy Mitchell, Stephen Locher, Trish O'Malley, Elaine Shafer, Richard Besinger, Gary Loy, Susan Knight, Ann Borders, Pat Bovis, Phil Higgins, William Mackendrick,

Absent: Barb Prochnicki, Robyn Gude, (excused)

Guests: Dawn Reimann, Shirley Scott, Madiha Qureshi, Raye-Ann O. DeRegnier, Michael Socol,

IDPH Staff: Charlene Wells

I. Review of Minutes, April 10, 2013

The minutes of the April 10, 2013 were reviewed. Cora Reidl moved approval of the minutes, Lenny Gibeault seconded; the minutes were approved as written.

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

Dr. Rosenberg discussed the Region V CoIN (Collaborative Improvement and Innovation Network – to reduce infant mortality. The program for Region V was initiated in spring 2013 and is designed to reduce infant mortality and address the significant black-white disparities

Improving public health, one community at a time

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in infant death in Illinois.

In March a meeting was held with the federal facilitation team. The group chose topics to work on as a region.

Illinois has done extensive work with elective deliveries < 39 weeks using vital records to see if population level has changed. This initiative has served a double purpose- improving vital records process in the state. Dr. Sappenfield has developed an algorithm for measuring progress.

The updated Illinois Blueprint for Breastfeeding will be another focus.

Maternal mortality may be included through a grant that is currently being proposed.

A maternal child health agenda is being developed. Dr. Rosenberg recognized Dr. Brenda Jones for her work and support for the project. She also thanked all those working on related committees including the Perinatal Collaborative and CHIPRA,

The Illinois team is very strong. Clinical pieces are strong and there will be increased effort looking at social determinants of infant mortality.

CoIN is part of a bigger process by HRSA to improve health.

**III. Levels Of Perinatal Care: “Levels of Neonatal Care”, Pediatrics 2012; 130; 587
Raye-Ann O. DeRegnier, MD
Michael Socol, MD**

Dr. DeRegnier discussed information from a 2010 JAMA article combining 41 studies looking at regionalization of care. It was clear that infants less than 1500 grams born in Level III had a clear advantage.

She then referred to the “Levels of Neonatal Care” article and described the following as a proposal for Illinois:

Level II and Level II E – would allow vents up to 24 hours of age and late preterm infants to stay in the hospital where they were born. Stable infants greater than 32 weeks could be benefited by close family connections

Level III – would allow preterm infants and some surgical care – leaving that up to the state and institution. Needs flexibility for places to make the best decision for their patients

Level IV – specialty cases and complex surgeries, More expertise produces better data outcomes for congenital anomalies.

The article reviews all the reasons for these proposed designations.

Dr. Borders asked what the next steps should be. Currently each state makes its own rules. There are organizations to consider including the Illinois Hospital Association. The CDC and March of Dimes focus on Right Place/Right Time and have funded initiative to achieve this goal.

Discussion was held regarding the issue of required volume to maintain expertise in critical neonatal and maternal care modalities.

Discussion must include accessibility for the entire state and there are political considerations as well.

It would be timely to get professional groups, ACOG, AHWONN, AAP, and IHA together to work on this initiative.

Dr. Borders suggested this could be done through the emerging Perinatal Collaborative. Members discussed the importance of including maternal care in all discussions.

A motion was presented by Dr. Higgins and seconded by Dr. Locher:

MOTION#1: SQC will convene a task force to determine the best method to assess neonatal outcomes based on hospital level of care and volume.

V. RQC Committee Updates
Rush
University of Illinois

Perinatal Center Representatives
Karen, Callahan RM, MS
Maripat Zeschke RNC-EFM, MSN

University of Illinois

Part 1. Hospital Assessment Data

Shirley Scott presented an in-depth analysis of the Hospital Assessment used in 2006 and 2009 as part of the Illinois Obstetric Hemorrhage Education Project. Each birthing hospital was required to produce data regarding the readiness of the hospital to perform in obstetric emergencies including lab resources and timing, blood bank resources and timing, rapid response team integration, policies and staff knowledge.

Major changes from 2006 to 2009 included:

- **Blood loss estimation responsibilities switched from Anesthesia to Nursing –**
- **Weighing declined in 2009**
- **Average length of time to get blood products decreased**
- **Mean times for lab results have decreased**
- **Medication changes in ER and OR have changes with grouping of hemorrhage drugs and equipment**

- **Specialty services increased both in location and time. There was an increase in the number of hospitals that had Obstetric providers in house 24/7.**
- **Vascular Surgeon and General Surgeons had a decrease in availability.**
- **Rapid Response Teams tend to be Hospital based fro Level I, II and II+ and unit based for Level III's.**
- **50% of hospitals are doing debriefing after hemorrhages and 61% debriefed 10 times or more.**

Benchmark Assessments: Pre and Post education scores were compared and it was determined that knowledge was sustained. Maternal fetal medicine specialists had the lowest degree of change and nurses the largest.

On-Going Requirements for the OBHEP include

- **All staff must complete all components within one year of hire**
- **Hemorrhage cases must be reported to the perinatal center monthly.**
- **Site Visit Process will continue to review progress on OBHEP including quality monitoring**

There has been a trending down with hemorrhage deaths since 2005-2006. Nancy Martin is identifying cases and noting a decline.

Project Outcomes include:

- **Synergistic effect between public health and private sector**
- **Knowledge gained during training was sustained greater than six months**
- **Increased collaboration and teamwork efforts**
- **Identification of workarounds**
- **Incorporating hemorrhage prevention and treatment protocols into the QA process has maintained awareness of ALL hospital staff**

Part II Network Breastfeeding Project

Maripat Zeschke described the following phases:

- **Phase 1**
 - Network discussion regarding data being collected
 - Network discussion regarding measureable elements
 - Breastfeeding Blueprint distributed
- **Phase 2**
 - Network Lactation Staff meeting
 - Developed and distributed survey
 - Discussed staff education and training
 - Illinois Hospital Breastfeeding Toolkit distributed
- **Phase 3**
 - Hospital Survey responses evaluated
 - Collection tool for data developed
 - Electronic Birth Certificate data evaluated

Phase 1 was a year ago and Phase 2 was six months ago

Breastfeeding meetings included lactation consultants with administrators and educators.

Prior to these meetings lactation consultants did not know the new questions on the birth certificate/Illinois Hospital Report Card

Level III's (5) Average lactation staff =3 FTE's, one hospital has 24 hr lactation coverage. 100 have done skin-to-skin training, Rates range from 74-96% but are not including Cesareans.

Level II E's (3) Average lactation staff =1.2 FTE's) one with no FTE, two did skin-to skin training and only one tracked with 60%

Level II (2) No lactation FTE's, both did skin-to-skin training and one tracked with an increase from 39% to 59.8% in six months

Skin to skin needs an avid MD champion

Future meetings will focus on uniform definitions and lactation meetings.

Perinatal Mortality Review

An analysis of causes of death for 1997-2003 and 2004-2009 was done indicating that Potentially Avoidable perinatal deaths is slightly increasing with about 25% with some factors, fetal death show about 15% factors while neonatal deaths show about 10% factors. Race was determined, Potentially Avoidable cases are about 60 % ascribed to the patient, with neonatal, systems, hospital of delivery, prenatal site and emergency room listed in descending order.

The four most common reasons for death are

- Extreme immaturity
 - Abruptio
 - Sepsis
 - Chorioamnionitis
-

RUSH/AIMMC Co-Perinatal Center

Karen Callahan presented the following on the EBBHI project for the second year:
Complete Network Breastfeeding Practice Survey

1st Quarter

Identify Hospital Champions
Create a breastfeeding committee
Complete Baby Friendly Assessment
Report Baseline Quality Outcomes
Establish Data Collection Process Report Status (RQC Network Report)

2nd Quarter

Create a work plan

Breastfeeding policy development
or revision

Report Status (RQC Network Report)

3rd Quarter

Implement work plan

Educate staff and providers

Report Status

(RQC Network Report)

4th Quarter

Report Quality Outcomes

Complete Network Breastfeeding

Practice Survey

Report Status (RQC Network Report)

Five network hospitals are on the Baby Friendly pathway.

Progress on the steps for the Breastfeeding Blueprint include:

- **Step 1 Policy – all hospitals (Level III 6; Level II E 4, Level II 4) have completed the Infant Feeding policy and shared it at the Annual Meeting**
- **Step 2 Staff Training all but one hospital has initiated training. The five hospitals on Baby Friendly Pathway have on-line or didactic training. Talking point have been developed for staff**
- **Step 3 Patient Education on the Benefits and Management of Breastfeeding. All hospitals provide educational materials and include in prenatal classes and inpatient lactation consultants. Some have brought materials to physician offices and three have focused breastfeeding classes**
- **Step 4 Skin to Skin and Initiate within 60 minutes: all hospitals have initiated and some have 90% + rates, vaginal and Cesarean**
- **Step 5 Educate on breast pumping: All hospitals are educating on breast pumping**
- **Step 6 promote exclusive breastfeeding. All hospitals educate mothers on risks of supplementation and many have developed scripts to ensure consistency in education**
- **Step 7 promote 24 hour rooming-in: All hospitals have encouraged rooming-in and many have eliminated newborn nurseries**
- **Step 8 Facilitate Breastfeeding on demand: All hospitals teach and encourage breastfeeding on demand**
- **Step 9 Pacifiers and Artificial Nipples: more work needs to be done to educate staff to eliminate this practice unless medically indicated**
- **Step 10 Breastfeeding Support Groups: Five hospitals have established.**

All Network hospitals submit a Revised Quarterly report on the progress on the steps.ve.

Problems have included lack of support from some physicians, some negative patient satisfaction with 24 hour rooming in, visitors, and the need to improve staff communication skills.

A lending library is available in the Network and a subcommittee is forming measureable quality monitors for the steps to be used by all Network Hospitals

VI. IDPH Update

Charlene Wells

Charlene Wells described the budget process for the Perinatal Grant for fiscal year 2014. All grants have been submitted and the process will be streamlined this year. Grants will be close to last year's level with a reduction of \$1100 per Perinatal Center.

VII. New Business

Susan Knight

Susan Knight described the Preliminary Findings of Illinois Hospital Survey Regarding Progress Toward the Elimination of Elective Early Term Deliveries.

The survey was developed by the Florida Perinatal Quality Collaborative with Support from the March of Dimes and the HRSA CoIN States.

The purpose of the survey is to:

- Obtain information that will support Illinois efforts to improve care and reduce costs by eliminating elective, early term deliveries prior to 39 weeks gestational age.
- Better understand Illinois hospitals current Quality Improvement processes
- Provide tools to hospitals that may benefit from toolkits, Grand Rounds, Consumer education materials and sample policies to support QI efforts

The survey was done in partnership with IDPH, ACOG, IHA and March of Dimes

The Perinatal Centers distributed the surveys to Network Hospitals and achieved a 88% return rate.

Most surveys were completed by nurse managers. Over 84% of hospitals have policies regarding elective inductions and scheduled Cesarean deliveries less than 39 weeks.

The policies are strongly enforced by 77% of hospitals, 62% said the scheduling guideline is strictly enforced, 78% have a "hard stop" and 68% said they have strong hospital support for the program.

Only 58% have had Grand Rounds or other physician education

Recommendations include:

- The creation of a Speakers Bureau and offering of Grand Rounds
- Compare the survey with Birth certificate findings
- Support the Statewide CQI project with data collection and monitoring over time.

Meeting adjourned at 4:22 PM.
Next Meeting October 9, 2013

