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**Meeting Minutes of:**

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
PERINATAL HEALTH SYSTEM OF ILLINOIS  
STATEWIDE QUALITY COUNCIL (SQC)**

**June 10, 2015  
2:00 p.m. – 4:00 p. m.**

**George W. Dunne Building  
69 W. Washington, 35<sup>th</sup> Floor  
Rooms 2 and 3  
Chicago, Illinois**

**Chair (Acting): Richard Besinger, MD**

**Attendees:** Roma Allen, Ann Borders, Jenny Brandenburg, Rita Brennan, Karen Callahan, Lenny Gibeault, Robyn Gude, Phil Higgins, Jodi Hoskins, Robin Jones, Stephen Locher, William MacKendrick, Cindy Mitchell, Trish O’Malley, Patricia Prentice, Madiha Qureshi, Angela Rodriguez, Deborah Rosenberg, Elaine Shafer, Bernadette Taylor, Pam Wolfe

**Absent:** Maripat Zeschke (excused)

**IDPH Staff:** Andrea Palmer, Brenda Jones, Amanda Bennett, Gregory Greer, Clark Jackson, Eduardo Alvarado

**Guests:** Jennifer Carlson, Linnette Carter, Harold Bigger, Debora Schy, Shirley Scott, Katherine Stowell, Anita Allen, Ann Schram

**AGENDA**

- 1. Call to Order & Welcome ..... Richard Besinger, MD**  
The meeting was called to order by Acting Chair, Dr. Richard Besinger. Members and guests introduced themselves.
- 2. Review/Approval of Minutes – April 15, 2015 Meeting..... Richard Besinger, MD**  
The minutes of the April 15, 2015 meeting were reviewed. **MOTIONS** were made to approve and seconded. The minutes were unanimously approved as written.
- 3. IDPH Updates..... Brenda Jones, DHSc, RN, MSN, WHNP-BC**  
In October 2012, Dr. Jones was hired and tasked with “re-designing” and aligning the Women’s Health program with Title V. IDPH was presented with the Perinatal Regionalization Program to align that with the overall vision of OWHFS. After assessing the RPP and the Title V Program, it was found that there were numerous opportunities for support. The Plan and the need for staff support were then presented to Dr. Shah. IDPH has now added 2 nurses: Dr. Trishna Harris, a certified nurse midwife, who is based in Chicago and Miranda Scott, who will start June 22, 2015 and be based in Springfield. IDPH’s Data Team is being led by Dr. Amanda Bennett, a senior level Epidemiologist, along with Eduardo Alvarado. IDPH has also been assigned State Counsel, Tanya Dworkin, who is dedicated specifically to this program. She typically attends the PAC Meetings and assists not only with legal matters/documents but also with ensuring the meetings and Committees run effectively and efficiently. Lastly, IDPH has been trying for the last 9 months to hire and is currently interviewing for a Quality Manager who will support the Team, the Network Administrators and Educators with some of the projects related to the Perinatal Strategic Plan.

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**3. IDPH Updates (continued)..... Brenda Jones, DHSc, RN, MSN, WHNP-BC**

OWHFS PERINATAL STRATEGIC PLAN: 2015-2020

Dr. Jones states OWHFS envisions “a future free of health disparities where all Illinoisans have access to continuous high quality healthcare.” The IDPH/OWHFS mission is to improve health outcomes of all Illinoisans by providing preventative education and services and increasing healthcare access, using data to ensure evidence-based practice and policy. But what is really important to IDPH/OWHFS is to empower families. To facilitate that they now have a obtained a Family Council to assist them with their issues, connection and communication with the Community, such as, how the programs are working, in what areas are they working the best, etc. When setting forth a strategic plan, it is very important to review the population of the communities we serve. We have 102 counties we cover of which 92 of them are rural. That fact alone makes Rural Healthcare a top priority.

IDPH Director, Dr. Shah stated that if we are to present a plan, we should also set forth our outcomes, i.e., what goals we are driving towards. In addressing the need for the new hires, we submitted a report to him on how very important it is for us to have a relationship with and to support the hospitals. As communicated by the results of the Survey completed, we had some deficiencies in that area. So, what we are trying to do now is to be more collaborative and share our vision with our State Partners, who need to hear about all the great work this Team is doing. This is just a context of where and why we are doing what we are doing.

We also have people visiting from other states who are reviewing our Maternal Mortality Review process, as maternal mortality is a top priority with the Director. There is still a huge black/white gap as it relates to infant mortality and it is not enough just to identify the disparity. We need to really address how we are going to tackle it.

OWHFS Divisions (3)

1. Division of Maternal, Child and Family Health Services. – Andrea Palmer is the Division Chief.
  - a. Regional Perinatal Health Program - Andrea Palmer is the Administrator.
  - b. Infant Mortality Reduction – Kelly Vrablic, the Infant Mortality Coordinator, has done an amazing job.
  - c. School Based Health Centers
  - d. Children w/Special HealthCare Needs (UIC)
  - e. Childhood Asthma Initiative
  - f. Teen Pregnancy Prevention
  - g. Chicago Mini-MCH Grant - 60% of our population is metro-Chicago. We have a great deal of support and money invested in the Chicago Department of Public Health, who we work with.
  - h. DHS-MCH Services
2. Division of Women’s Health
  - a. Illinois Breast & Cervical Cancer Program
  - b. Wise Woman – a “cohort” of the IBCCP Program. The focus of this group is to work with the women who have had breast cancer screenings and see if they will also be interested in other service such as nutrition counseling, cardiovascular health, hypertension education, and blood pressure screenings.
  - c. Family Planning – A lot of pre-conception and inter-conception health is being done with this program.
3. Division of Population Health Management
  - a. Women’s Health Hotline – will be outsourced and consequently, offer support in 16 languages.
  - b. Grant Monitoring – Monitors and ensures our grant monies are being spent appropriately.
  - c. Administrative Support
  - d. Quality Manager
  - e. Data Team

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**3. IDPH Updates (continued) ..... Brenda Jones, DHSc, RN, MSN, WHNP-BC**

GOALS

1. Improve Data Collection & Reporting - **Create a system for collecting and reporting perinatal data that is aligned with national metrics and used to drive performance improvement. *Main Points:*** Fill gaps to attain a comprehensive set of high-quality consensus measures, improve the availability and ease of collection of standardized perinatal data and create/implement a national system for public reporting.
2. Reduce Disparities in Access & Quality - **Decrease disparities in access to care and quality outcomes in perinatal care.** Not only are there some huge disparities in care access and quality between the races/ethnicities, there are also some serious geographical barriers as well. ***Main Point:*** We need to expand access to services that have been shown to improve the quality and outcomes of perinatal care for vulnerable populations.
3. Improve Coordination of Care - **Improve coordination of maternity care across time, settings and disciplines, with a focus on care provided in the community. *Main Points:*** Extend the health care home model to the full episode of maternity care. Develop local/regional collaborative quality initiatives and also develop consensus standards for care levels and risk criteria. We want to engage in strategic partnerships which help us reduce the redundancy of the services and improve our access and connectivity between them.
4. Establish a State-Wide Professional Curriculum - **Establish a statewide education curriculum for all health professionals providing perinatal care that is aligned with the state's goals for high quality, high value perinatal care. *Main Point:*** Develop a common core curriculum for all perinatal care provider disciplines that emphasizes health promotion and disease prevention. We would like to develop tool-kits for those hospitals that don't have infrastructure.

CROSS-CUTTING STRATEGIES

1. Empowering Women throughout the Lifespan.
2. Engaging the Community.
3. Building Improvement Capacity at the State Level
4. Creating Strategic Partnerships.

Dr. Jones stated some of the Strategic Partnerships IDPH is engaged in and with are: ILPQC, HRSA, AWHONN, ACOG, EverThrive Illinois, March of Dimes, AMCHP, US Military, Illinois Hospital Association and the Illinois Academy of Pediatrics. Many more partnerships are forthcoming.

PERINATAL COMMITTEES

Dr. Jones met with the IDPH Director to assess the projects the Committee and Sub-Committees were working on and their direction. As we start talking to Legislators and hospitals, they want everyone to be on the same page. Chairs of each Committee (HFDSC, MMRC, PAC and SQC) and assigned "work flow" to each group. They are as follows:

PAC: Perinatal Advisory Committee: All of the Sub-Committees report to them. PAC will work with them and provide oversight. PAC is the Committee will provide recommendations to the State Health Officer and Director regarding such projects as the Levels of Care Task Force, which Raye-Ann O de Regnier did an excellent job with and the Maternal Levels of Care Task Force, which Dr. Grobman will lead. IDPH also would like for PAC to provide an official set of recommendations for Appendix A.

SQC: Statewide Quality Council will be responsible for the following CoIIN Collaboratives: Hospital Safe Sleep, Perinatal Regionalization (Risk Appropriate Care), SDOH Care Coordination, and the State Birth Certificate Project.

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**3. IDPH Updates (continued)..... Brenda Jones, DHSc, RN, MSN, WHNP-BC**  
PERINATAL COMMITTEES (continued)

MMRC: Maternal Mortality/Morbidity Review Committee will be responsible for: implementing Severe Morbidity Hospital Forms, revising and implementing Maternal Hospital Mortality Abstract Form and overseeing the Anesthesia Task Force for which Dr. Wong is the Chair. Lastly, AIM will be another initiative under this Committee.

HFDC: Hospital Facilities Designation Sub-Committee will be responsible for: reviewing and revising the Site Visit Process, overseeing the Perinatal Statewide EMS Project, and composing a Standardized Letter of Agreement (LOA).

Dr. Jones stated she really wants to beef up the role of the Perinatal Network Administrators in terms of justifying the dollars we use for Title V. We really want to help look at Perinatal Quality & Safety Projects and continue our current work with ILPQC. We want to work thru that to figure out the AIM Roll-Out. We are not changing the dates but we will be working together to figure that out. Trishna Harris will be your State contact on that.

Lastly, there is a State Action/Work Plan and 2015 Year-End Review included in today's hand outs. If you have any questions, comments, concerns or suggestions, you may forward them to Dr. Brenda Jones.

**IDPH Updates (continued).....Amanda Bennett**

LOCATe (Levels of Care Assessment Tool)

LOCATe is a CDC-developed survey instrument by their Maternal Child Health Epidemiology Team to gain info on maternal and neonatal practices and services. The Tool takes responses and classifies them into neonatal/maternal levels of care. Over the last year, some basic field testing has been completed in two states, with Illinois being one of them. Its purpose as described by CDC is "to obtain objective and comparable data to understand risk-appropriate delivery."

The survey is tied to established criteria of the 2015 ACOG maternal levels of care and 2012 AAP neonatal levels of care. LOCATe is a simple survey where hospitals answer a series of questions about their services and their answers are then applied to a series of logic trees to classify their neonatal and maternal levels of care.

Risk-Appropriate Care is a State and National priority and Illinois is one of 12 states focusing on it. In Illinois, RAC and the official Perinatal LOC designations we use do not match the current guidelines. The hospitals have maternal levels of care. However, they are not designated in the same way as the NICU LOC by the State.

LOCATe and its results in the field to gain more info on maternal and neonatal level of care and understand risk-appropriate delivery. It will NOT be used for regulation or designation or as a substitute for the Site Visit Process. The results will provide feedback during the Site Visits by: enhancing the conversations, providing feedback on services needing improvement within a geographic or regional area and/or a facility. LOCATe will also allow us to look at how the levels of care impact infant/maternal mortality and morbidity and neonatal and maternal outcomes. As Illinois has been only one of two states currently utilizing LOCATe, there is also an opportunity to participate in the national validation process by performing such tasks as sharing qualitative data on the results and comparing Site Visit assessments to determine LOCATe's competency.

The overall plan discussed by Dr. Jones and Amanda is for Dr. Shah, IDPH Director, to send out an introduction letter to the hospitals outlining several perinatal initiatives, such as the AIM Project and the Perinatal Strategic Plan. Then, Dr. Jones will send out a second introductory letter with the exact specifics of the Survey adding a web link to the Perinatal Administrators who will distribute it to their hospitals. The data would be analyzed and the survey results and would then be tallied into a web-based data system. Nothing has been finalized; however, IDPH hopes to get all hospitals to participate so IDPH can better determine where the deficiencies are. If you have recommendations, feedback or suggestions, feel free to email Amanda.

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**3. IDPH Updates (continued).....Amanda Bennett**

LOCATe (Levels of Care Assessment Tool) (continued)

Dr. Jones states that Dr. Shah's initial letter has a tentative mailing date of two weeks. That is not set in stone because of other pressing matters, i.e. the State Budget. After the Survey goes out, we would like for it to be completed within a timeframe of 2-3 months, with reminders being sent out at different time points. Again, we would like to reiterate that this Survey Tool is NOT to be used as a punitive tool or in place of the Site Visit Process. It is only being used to for the State to complete some statewide analyses and to *enhance* the Site Visit Process.

- **Committee Question:** *Will there be a way to track the responses?*

**IDPH (Amanda Bennett):** IDPH will be able to track which hospital completed the Survey and the party who completed it on their behalf, which will allow us to make inquiries to that party should we have additional questions or obtain inconsistent responses which need additional clarification.

**IDPH (Andrea Palmer):** Ms. Palmer stated it might be helpful to have a webinar detailing exactly what the Survey will entail and why it is it being utilized, and what the info will and will NOT be used for.

**SQC MOTION:** *Motion made to request that the Perinatal Advisory Committee (PAC) review and recommend that IDPH implement the LOCATe Tool as soon as possible.* **MOTION APPROVED AND SECONDED WITH UNANIMOUS APPROVAL.**

Severe Maternal Morbidity among Delivery Hospitalizations in Illinois – 2011 thru 2013

This analysis actually came from an online course which Deb Rosenberg is teaching and designed for State Epidemiology Teams to be able to analyze and use claim space data for State monitoring and surveillance. This was the first project we worked on and 12 States are currently actively participating. Illinois specifically has an interest in implementing a Severe Morbidity review in addition to Maternal Mortality.

**BACKGROUND:** Severe complications during pregnancy and delivery affect thousands of women each year and pregnancy-related morbidity is about 100 times more common than maternal mortality. Nationally, severe maternal morbidity (SMM) rates have been steadily rising over the last decade.

**STUDY PURPOSE:** Use hospital discharge data to identify delivery hospitalizations when an SMM event is/was present, analyze SMM rates by patient characteristics and quantify racial/ethnic disparities in SMM.

Amanda worked with the IDPH Division of Patient Safety & Quality on the study and used the combined data from 2011-2013 from all discharge records of women ages 15-44 which were coded with the pre-determined 15 diagnosis codes and 9 procedure code field

**METHODS:** The delivery hospitalizations were identified using a standard algorithm utilizing the following criteria: DRG (Diagnosis Related Group), Diagnosis Codes and Procedure Codes. To identify conditions and procedures that are likely to indicate severe maternal complications with a high fatality rate, an algorithm published by Bill Callaghan of CDC was used. It utilized 19 specific DX (diagnoses) codes and 9 specific procedure codes. Then once the SMM cases were identified, a recode process was applied to find the most severe SMM cases. To maintain a classification of severe, there needed to an applicable extended stay, i.e. 90<sup>th</sup> percentile LOS by delivery method.

The SMM rate = the number of SMM events per 10,000 delivery hospitalizations. These rates were calculated for the whole state and then stratified by the patient characteristics of: Age, Race/Ethnicity and Geographical Residence. The Joinpoint Regression Program was used to look at age-specific trends in the SMM rate.

**RESULTS:** **450,212 delivery hospitalizations were identified from 2011 to 2013**, with the majority being identified by DRG Codes (99.8%) and a small percentage by only diagnosis or procedure codes. That averaged out to 150,000 deliveries per year. Of the 150,000 deliveries, **7239 were SMM (severe) Cases.** That averaged out to **160.8 cases per 10, 000.** The National Average published by Bill Callaghan (CDC) is **120 per 10,000.** So, Illinois' rate is higher.

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**3. IDPH Updates (continued).....Amanda Bennett**

*Severe Maternal Morbidity among Delivery Hospitalizations in Illinois – 2011 thru 2013 (continued)*

**RESULTS (continued):** The top 10 SMM Conditions/Procedures were: Transfusion, Disseminated Intravascular Coagulation (DIC), Hysterectomy, Heart/Pericardium Operations, Respiratory Distress, Mechanical Ventilation, Renal Failure, Shock and Eclampsia. By far, the vast majority of the SMM Cases were **Blood Transfusion-related**. In this study, it accounted for over 5000 of the 7000 events. There were 2,599 cases that had some other code other than Transfusion. If we took the Transfusion-related cases out of the SMM calculations, the rate would be 57.7 per 10,000.

The SMM rates based on race/ethnicity were right at the national average of 120 per 10,000 for Caucasian females at 122.2. However, the cases are higher for minorities/other nationalities, with the highest being for African-American women at 270.7 which is over twice the Caucasian rate **and** the national average. Although the cases for Latina women at 177.2 and Asian women at 161.0 were not as high as the cases for African-American women, they too were higher than the national average.

The SMM Rates categorized by county/city of residence were the highest in Chicago at 197.7, Suburban Cook County (156.6) and in a compilation of *Other* (Non-Chicago Metro) Urban Counties (159.2). The lowest rate was in Collar County at 139.7 with Rural Counties being next lowest at 145.2.

Based on the results from the Joinpoint Analysis, the SMM rates had a predictable trend of being higher in women aged 15-19 (134.5), then decreasing with the 20-24 age group (94.4) and decreasing even more in the 25-29 group (88.4). The rate begins to rise again with the 30-34 age group (91.9) and increases with the 35-39 age group (129.0) with the most significant rate of SMM Cases being for women over 40 (206.3). In summary, the SMM decreases significantly at a rate of 10 per 10,000 for every 1 year of age for women under 25 and significantly increases at 22 per 10,000 for every 1 year of age for women 35+. For women aged 25-35, the cases appear to be within the SMM rate level.

In regards to the SMM rates and black/white disparity, at the youngest ages, the SMM rates for white women decrease until age 27, while there is no decrease in SMM rates in black teens thru the early 20's. In white women, the rates are level until age 36 and level until 32 with black women. This is also the same age difference found for the SMM rates in the advanced maternal ages. The SMM rates increase significantly at age 36 for white women and the rise in SMM rates for black women increase earlier at aged 32. The overall black/white SMM disparity ratio is 2.2.

**SUMMARY:** SMM affects about 1.6% of mothers during delivery hospitalizations. The most common condition leading to an SMM classification is blood transfusion. SMM disparities exist by race/ethnicity, geography and age. And although thousands of Illinois women are affected each year, SMM events/rates are higher for minority women, specifically black women. Compared to white women, black women experience elevated SMM at all ages and with advancing age, the increase is more pronounced. In order to eliminate the black/white gap in the disparity in SMM rates/case/events, we will need to address the root cause of early deterioration among black women.

**4. ILPQC Update.....Ann Borders, MD, MSC, MPH**

Currently, there are over 100 hospitals actively working on the Birth Certificate Project and 26 hospitals on the Neonatal Project with ILPQC. They have monthly calls with Rahm Emanuel and with representatives from California, Ohio, New York, North Carolina and Massachusetts. They also received the CDC Grant to fund the Collaborative.

Dr. Borders stated a couple of reasons why Illinois is able to achieve such great results in such a short period of time is because of an excellent Regional Perinatal System and the ability to work with the Perinatal Educators, Perinatal Administrators, IDPH and March of Dimes.

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**4. ILPQC Update (continued) .....Ann Borders, MD, MSC, MPH**

*Birth Certificate Initiative (with Cindy Mitchell)*

- 106 hospitals out of 122 are participating
- The main focus is Quality Improvement
- Submitted year 1 progress report and year 2 work-plan to CDC in March 2015.
- An incredible amount of time went into developing a Guide Book for each hospital and it currently contains over 200 definitions. IHA contributed quite a bit of funding and we were able to develop a Key Variables Guide focusing on the 17 variables: WIC, Prenatal Care, LMP: Last Menstrual Period, Infant Feeding, SSN, Antibiotics, Gestation at Delivery, Augmentation, Fetal Intolerance, Induction, Previous Pre-Term Delivery, Assisted Ventilation, Payment, ANS, Maternal Transfusion, HTN and NICU Admission.
- A face-to-face meeting held with 230 attendees that included all of the Perinatal Network Administrators, most of the Perinatal Network Educators, nurse, physicians, and birth certificate clerks was successful. Cindy Mitchell agreed. However, she stated, based on the emails she has received, there was more of a need for info on the definitions and that that presentation may have been cut short prematurely.
- As a follow-up to the face-to-face meeting, month to month audits are being done to make sure the data from the birth certificates match the medical records.
- Monthly QI Reports are also required to be turned in by the Teams to the Perinatal Network Administrators detailing their progress, activities and problems. Team Talks are being held 3 times a month.
- It has been quite a bit of a challenge to disseminate the BC definitions because some hospitals use EMR systems and some don't. This will cause some initial "downgrading" of the results, but as time goes on, they should return to normal and be more consistent.

*Hypertension Initiative*

- Meetings started in January 2015 and are now held as a part of and to coincide with the OB Advisory Work Group meeting, which meets the second Monday of every month. The OB Advisory Work Group consists of nurses, physicians, mid-wives, OB anesthesiologist; they are working on obtaining an ER doctor.
- GOAL: Reduce pre-eclampsia maternal morbidity. AIM: Reduce the rate of severe morbidities in women with severe preeclampsia, eclampsia, or preeclampsia superimposed on pre-existing hypertension by 20% over the course of the initiative. These goals were established after reviewing the California data.
- Our outcome measure is severe maternal morbidity which the AIM initiative also uses as their outcome measure.
- Process measures are *Appropriate Medical Treatment*: Severe hypertension treated in less than 60 minutes, the number of women treated at different time points after elevated BP is identified and the number of women with a new onset of severe hypertension....*Debriefs of All New Onset Severe Hypertension Cases.....Discharge Education and Follow-Up*: Outpatient follow-up of all severe hypertension women on meds within 72 hours.

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**4. ILPQC Update (continued) .....Ann Borders, MD, MSC, MPH**

Neonatal Initiative (Golden Hour)

- Golden Hour launched April 20, 2015
- 26 teams are currently participating
- Toolkit is finalized and available to the Teams via Google Drive
- Data Form is finalized

ILPQC Annual Meeting

- NIU Naperville was the last location where it was held. However, there may be some issues due to the size. The Birth Certificate Initiative Meeting was the last meeting held there and with 230 participants, they essentially reached capacity.
  - Pros: Costs are covered entirely by \$50 fee per attendee and there is free parking.
  - Cons: 250 max capacity. They will not allow a large number of posters to be displayed in the lobby
- UIC Forum may be an optional location.
  - Pros: 300+ attendees may be accommodated, city of Chicago location/easily accessible as opposed to suburban Naperville (SQC members affirmed that a larger, downtown location may be preferable). There is ample space for posters to remain accessible in main room.
  - Cons: Costs are not covered by \$50 fee, parking in nearby lots for \$10-13 and they can be located up to 2 blocks from venue.

**Adjournment .....Richard Besinger, MD**

**Motion to adjourn the meeting was ACCEPTED AND SECONDED.**

***Wherein, the meeting was adjourned.***