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Meeting Minutes of:

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)**

**June 11, 2015
9:30 a.m. until 12:00 p.m.**

**George W. Dunne Building
69 West Washington, 35th Floor
Chicago, IL**

HFDSC Attendees: Cindy Mitchell (**CHAIR**) - Howard T. Strassner – J. Roger Powell – Dennis Crouse - Robyn Gude – Donald Taylor – Ray Spooner – Urmila Chaudhry

IDPH Attendees: Brenda Jones – Andrea Palmer – Trishna Harris

Guests: Courtney DeSutter - Pamela Wolfe - Cecilia Lopez - Jenny Brandenburg - Jodi Hoskins - Elaine Shafer - Shirley Scott – Peggy Cowling – Jennifer Doerr – Mark Seaman

Review and Approval of Minutes from April 16, 2015 Meeting:

The meeting was called to order by Cindy Mitchell – The meeting minutes of April 16, 2015 were reviewed. There was one error which needed to be corrected: Ray Spooner was accidentally marked absent at the last meeting. **Motion** to accept the minutes with revisions to correct the absence of Ray Spooner and seconded with unanimous approval.

New Business:

CHAIR (Cindy Mitchell): Dr. Hirsch has relinquished his HFDSC membership and relocated to California. HFDSC is missing some critical positions of representation and has been for some time. There were 2 Family Practitioners and now there are none. A decision needs to be made on what types of disciplines are needed to make up the HFDSC Committee. **What types of specialties would be beneficial to HFDSC?** The Chair stated she has a Nurse Practitioner who works in Pediatric Surgery. Dr. Crouse suggested we may need an attorney and the Chair agreed. Dr. Jones of IDPH stated she will assist with obtaining some possible candidates. The Committee will continue to actively search out and recruit candidates with the required disciplines for the open positions.

IDPH Updates (Dr. Brenda Jones):

When the Perinatal Program was transferred to IDPH, Dr. Shah stated it needs to be aligned with Title V. Dr. Jones has been reviewing the Perinatal Program for the last year and a half and recently met with the Perinatal Administrators to ascertain what IDPH could do to support them. A survey was done to determine how and where IDPH was not meeting the needs of the State and the hospitals. Some of the barriers identified were: lack of communication, lack of support, unfunded mandates, etc.

In reviewing these barriers, Dr. Jones assessed that one of the main contributing factors was lack of staff. IDPH has since added Dr. Trishna Harris, a certified nurse midwife and also brought on Miranda Scott, an adjunct supporting IDPH and this Team who will start June 22, 2015. IDPH has a Data Team which Amanda Bennett is leading and additional support to the Perinatal Program has been provided by Alexander Smith and Berlinda Verges. Lastly, IDPH is currently interviewing for a Quality Manager. Dr. Jones and Andrea Palmer will continue to review the necessity for new positions, then interview and hire the appropriate staff in order to provide the support needed.

Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)
June 11, 2015
Page 2 of 6

IDPH Updates (Dr. Brenda Jones) continued:

PERINATAL STRATEGIC PLAN

Dr. Jones states our deliveries are dwindling nationally. We have 102 counties we cover and 92 of them are rural, which is very important when reviewing our population and setting forth a strategic plan.

OWHFS DIVISIONS (3)

1. Division of Maternal, Child and Family Health Services.
 - a. Regional Perinatal Health Program - Andrea Palmer is the Administrator for the Regional Perinatal Program, in addition to being the Division Chief. Some of her duties are reviewing and monitoring the budget, hiring the support, and working with eGrams, among others.
 - b. Infant Mortality Reduction - MMRC is aggressively addressing these issues. However, there is still a huge disparity in infant mortality cases between blacks and whites, which we will need to address.
 - c. School Based Health Centers
 - d. Children w/Special HealthCare Needs - Dr. Jones states there is a huge disconnect with Early Intervention Services and monitoring whether or not the children are returning for the appropriate care and how we are following up.
 - e. Childhood Asthma Initiative – There are still a high number of children returning back to the ER with asthma-related incidents. This is very high on the Medicaid radar.
 - f. Teen Pregnancy Prevention - Pregnancy is much higher downstate and STI is much higher down in the Southern Regions.
 - g. Chicago Mini-MCH Grant - 60% of our population is metro-Chicago.
 - h. DHS-MCH Services
2. Division of Women’s Health
 - a. Illinois Breast & Cervical Cancer Program
 - b. Wise Woman
 - c. Family Planning – A lot of pre-conception and inter-conception work is being done, as well as working with incarcerated women.
3. Division of Population Health Management
 - a. Women’s Health Hotline – In the process of outsourcing so we can get 16 languages covered.
 - b. Grant Monitoring
 - c. Administrative Support
 - d. Quality Manager
 - e. Data Team

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.** Dr. Jones stated we definitely want to use reported perinatal performance data to develop initiatives that foster improvement and quality for our hospitals.
2. Reduce Disparities in Access & Quality - **Decrease disparities in access to care and quality outcomes in perinatal care.** Dr. Jones stated it is not just a case of ethnicity or race; there are some serious geographical issues which contribute to the disparities, as well.

Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)
June 11, 2015
Page 3 of 6

IDPH Updates (Dr. Brenda Jones) continued:

PERINATAL STRATEGIC PLAN

GOALS (continued)

3. Improve Coordination of Care - **Improve coordination of maternity care across time, settings and disciplines, with a focus on care provided in the community.** Dr. Jones stated we need to work together in synergy. There is a database being created to assist with making these connections between the programs, the hospital, the doctor and patient. We want to develop local and regional collaborative quality improvement initiatives to improve care coordination. There is also a database being developed to assist with this.
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.** There are high-risk, vulnerable populations where physicians are practicing outdated medicine. We need to develop tool kits and educational support to counteract that.

CHAIR (Cindy Mitchell): We can educate the physicians and reiterate that these are the best practices all we want. Unfortunately, it still is not always done. The Site Visit needs to come into play.

Cross-Cutting Strategies

1. Empowering Women throughout the Lifespan.
2. Engaging the Community.
Dr. Jones stated we cannot keep building programs and bringing in the community after it is done.
3. Building Improvement Capacity.
4. Creating Strategic Partnerships

Dr. Jones stated that when we work with providers at the Perinatal Centers, sometimes there is not an understanding of things such as SDOH: Social Determinants of Health and Trauma Awareness. We really want to expose more of our Providers now. 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 other partnerships are forthcoming.

Dr. Jones met with the Chairs of each Committee (HFDSC, MMRC, PAC and SQC) and assigned "work flow" to each group. They are as follows:

- PAC: Perinatal Advisory Committee will be responsible for: NICU Levels of Care, Maternal Levels of Care, Appendix A suggested revisions and provide recommendations for the State Health Officer.
- SQC: Statewide Quality Council will be responsible for: the CoIIN Collaboratives: Hospital Safe Sleep, Perinatal Regionalization and SDOH Care Coordination, State Birth Certificate Project and provide linkage to IDPH and oversight of strategic partnerships.
- MMRC: Maternal Mortality/Morbidity Review Committee will be responsible for: implementing Severe Morbidity Hospital Form, revising and implementing Maternal Hospital Mortality Abstract Form, overseeing the Anesthesia Task Force and provide linkage to IDPH and oversight of strategic partnerships.
- HFDSC: Hospital Facilities Designation Sub-Committee will be responsible for: reviewing and revising the Site Visit Process, overseeing the Perinatal Statewide EMS Project, composing a Standardized Letter of Agreement and provide linkage to IDPH and oversight of strategic partnerships.

CHAIR (Cindy Mitchell): The Sub-Committee Meetings are Open Meetings and our Chair believes the PAC Members should be attending them. *(Dr. Jones stated this is an excellent idea.)*

Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)
June 11, 2015
Page 4 of 6

IDPH Updates (Dr. Brenda Jones) continued:

Dr. Jones stated our current PAC membership is not necessarily sufficient. There are disciplines required that are missing and some members are in the wrong positions. We really need the skill set that is legislatively required. She is going to be reviewing the positions for all of the Boards with the Director in order to obtain the mandated disciplines.

CHAIR (Cindy Mitchell): We have a good structure and we need to figure out a way to use it to our benefit. PAC oversees all of the Committees' issues and everything essentially goes thru PAC for approval. Nothing is able to be submitted to the Director without going thru PAC. So, it would be more beneficial to have the Sub-Committees with their assigned tasks/projects listed under PAC instead of as a separate entity. Accordingly, PAC will also need to provide the appropriate guidance and assistance as necessary.

IDPH (Brenda Jones): Dr. Jones made a point of stating that that guidance should be in the form of the appropriate expertise. For example, IDPH requires a PAC member to be present during Site Visits. However, it is counter-productive to have a PAC member attend who has no background in Site Visits and/or how they are conducted. They are welcome to attend to learn *how* to conduct one, but it should be jointly with a PAC member who does.

Site Visits: Process/Rules/Changes – Designations and Changes of Designations:

CHAIR (Cindy Mitchell): We talked a lot about this at the Perinatal Grantee Meeting. From what is in the Rules versus what we do in Site Visits, they essentially do not match/coincide. We reviewed some other States' Site Visit Process and we came away with the following questions:

CHAIR Question #1: *How do we make the Site Visit meaningful?*

CHAIR Question #2: *Who does the Site Visits?*

CHAIR Question #3: *What data do they collect?*

CHAIR Question #4: *What are our expectations?*

Arizona, Florida, Iowa and California have processes in place for Site Visits. So, we are going to try and get in contact with those States to review their processes.

Levels of Care Task Force:

CHAIR (Cindy Mitchell): They are going to present an update to PAC. Details will be forthcoming.

Old Business – Hospital Opening Process:

Letters of Agreement

CHAIR (Cindy Mitchell): We talked about creating a standardized LOA for all of the networks to use for their hospitals. IDPH Legal has agreed to support that. A Draft will be forthcoming. The only question now is: *Is it something we should do now or should we focus on the Site Visit first?*

Committee Response(s): *It doesn't make sense to create a Template based on the current Rules, if they are not what we are going to be following.*

IDPH (Andrea Palmer): Ms. Palmer agreed and stated if we create a Template *not* based on the current Rules, Legal may reject it.

Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)
June 11, 2015
Page 5 of 6

Old Business – Hospital Opening Process (continued):

CHAIR (Cindy Mitchell): It does appear we should wait until we have the processes in order and the Rules updated. However, how long is it going to take to do that? We cannot wait and continue to function as we do.

Committee Response(s): *Tanya (Dworkin) of IDPH Legal stated it would take a minimum of 9 months to a year to get it implemented once request goes to the Department.*

CHAIR (Cindy Mitchell): Maripat Zeschke has started on the LOA. She put together this template which “mimics” the current LOA in the Rules. That template will be brought to the next meeting. She stated, as appropriate, in the LOA there will be references to where it coincides with the Code.

Committee Response(s): *For any recommendations submitted, the process will be the LOA needs to be approved by HFSDC, PAC and the Department, who will then make the final decision.*

Discussion of Work Plan:

Patricia Prentice: There is a Level 2-Plus hospital that needs to have an 18-month review done. The issue is that we do not have criteria in the Rule as to what that consists of and who must be there. At the Grantee Meeting, the Chair and I decided that this does not need to be a full Site Visit with IDPH, etc. there. However, we will need the following data from the Level 2-Plus after the 18-month review:

- An Appendix A
- Updated Resource Checklist
- In-depth review of all deliveries of less than 32 weeks and their outcomes
- In-depth review of all infants born less than 1250 grams and their outcomes
- In-depth review of all infants born between 1250 and 1500 grams and their outcomes
- In-depth review of all Neonatal and Obstetric Transports

Previously, we completed a full-scale Site Review and at the last meeting of HFDSC and the Grantees, it was felt that a full scale Site-Review was not reasonable for 18 months. The key issues with a Level-2 Plus are the ability to care for babies 30 weeks or more and those that are 1250 grams or more. The key provision is that they are not supposed to be delivering babies that are less than 32 weeks. That’s why in-depth reviews of those cases are being requested to see if there were issues or if there were any consultations completed. *Does that hospital need to present itself here for an 18-month approval? Who needs to come?*

IDPH (Andrea Palmer): The Rules states they are supposed to come back to assess compliance. *However, The Chair stated the Rules are unclear and the hospital needs somebody they feel is appropriate to present their case.*

Dr. Crouse stated if you look at the Code, there are normally three (3) people responsible for the perinatal care and service, the Perinatal Administrator and 2 Directors (Neonatal and Obstetric Nursing, as clarified by Pat Prentice). They are the core people who should be present. *The Chair stated she also has this issue on the calendar to revisit at our October 8, 2015 meeting.*

Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH - PERINATAL ADVISORY COMMITTEE
Hospital Facilities Designation Sub-Committee Meeting (HFDSC)
June 11, 2015
Page 6 of 6

*Per the **Open Meetings Act**, any time a hospital is being evaluated or CVs or resumes are being reviewed for admission onto a Committee or there is a discussion relating to a person's or an entity's personal, sensitive or confidential information, the meeting will need to be closed. If there is a conference line open, that will need to be closed as well. The callers may dial directly into the room, if they prefer.*

The discussion about any processes to be put in place is standard and the terms of changing centers or the leveling, are both open. Any specific discussions about hospitals are what should be closed. The specificity is the deciding factor. All voting should be outside.

Example: If there is a discussion of whether or not a specific hospital is "eligible" to change networks, the meeting should be closed. Discussions regarding the changing of networks in general don't have the same requirements.

Review of Material for Advocate Children's Hospital

- *Meeting should be closed per Open Meetings Act during discussion.*

Closing Comments/Adjournment:

The Chair stated there will be a meeting on August 13, 2015, in addition to the October 8, 2015 meeting. Motion to adjourn the meeting and it was seconded with unanimous approval.