ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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Meeting Minutes of:
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
Levels of Care Task Force Meeting (LOC)

January 21, 2016
1:00 p.m. until 3:00 p.m.

George W. Dunne Building
69 West Washington, 35th Floor
Conference Rooms 2 & 3
Chicago, IL

Chair: William Grobman, MD
Vice Chair: Raye-Ann O de Regenier

AGENDA

Attendees: William Grobman, Raye-Ann O de Regenier, Richard Besinger, Darlene Hammond, Jeff Jones, Jessica Kandel, Angie Reidner, Brent Ryherd, Kristin Salyards, Heather Stanley-Christian, Howard T. Strassner, Robyn Gude, Cindy Mitchell, Carol Rosenbusch, Pam Wolfe, Barb Haller

Absent: Beau Batton, Sandy Dennis, Sue Hesse, Jim Hocker, Stephen Locher, Timothy Pappoe, Deb Roski, Laura Smith, Jonathon Grieser

IDPH Staff: Amanda Bennett, Trishna Harris, Michelle Gentry-Wiseman, Andrea Palmer, Miranda Scott, Nirav Shah, Shannon Lightner, Tanya Dworkin

HFS Staff: Dan Jenkins

Guest: Patricia Prentice, Perinatal Network Administrator - Rush/AIMMC Perinatal Network

AGENDA

1. **Opening..... William Grobman, MD, MFM**

   The meeting was called to order by Chairman, William Grobman, MD, at 1:00 pm. He stated the Task Force's charge is to come up with a recommendation to the State regarding the perinatal levels of care. He stated the individual levels were reviewed at the last meeting and all in all, it was a very productive meeting.

2. LOCATe Tool – Preliminary Results ..... Amanda Bennett, PHD

The LOCATe Tool stands for Levels of Care Assessment Tool and is a CDC-developed survey for the hospitals. It is used to inquire about the availability of various maternal and neonatal services, and to compare the hospitals' provision of services and the availability of providers to the established guidelines set by the 2012 AAP neonatal levels of care and 2015 ACOG/SMFM maternal levels of care respectively. It was sent out to the Illinois Perinatal Hospitals in September 2015. 118 out of 120 hospitals participated which really impressed CDC.

The purpose of the survey was to obtain objective and comparable data to understand risk appropriate delivery and maternal levels of care. The tool has a great propensity to become a cross-state comparison tool as more states began to roll it out. However, it has not yet reached that point because not very many other states have utilized it. The value to the Levels of Care Task Force is that it can help us review what our hospitals are currently doing and how it relates to the professional guidelines set by the medical societies and the implications of changing the Rules in Illinois and what that means in aspect of the services provided. There was some discrepancy on the definition of "readily available" in terms of whether the providers are onsite, on call or available for consultation.

Neonatal Levels of Care – This survey was a 20 question survey with multiple choice type questions which were fairly simple and mostly consisted of yes/no answers. CDC developed the algorithm that translates the responses and how they lined up with the AAP and ACOG guidelines. When the responses are combined, in order to be classified as a higher level of care, you have to meet all of the criteria within the category of the higher level. For example, if you answered Level 4 for all of your questions, except for one response which matched Level 2 Criteria, you would be classified as a Level 2. One big difference in Level 3 and Level 4 neonatal levels of care is that Level 4 facilities are expected to have specialists onsite and not just available for consult.

The hospitals were asked to rate themselves under the AAP guidelines versus their current State designation. The responses were as follows:

- All nine Level 1 hospitals rated themselves as Level 1.
- Out of 59 Level 2 hospitals, the vast majority rated themselves as Level 2, 2 rated themselves as Level 1 and 3 stated they did not know.
- For the 23 Level 2Es, the majority (20) rated themselves as Level 2, 2 rated themselves higher as a Level 3 and only one stated they did not know.
- Of the 27 Level 3 hospitals, most (16) thought they were accurate as Level 3, 10 thought they should be higher as a Level 4 and 1 actually themselves as a lower Level 2.

The hospitals' responses were then compared to the LOCATe Tool's assessments and results. In summary, 61% of the hospitals matched the Tool's results while 36% felt their rating should be higher than the LOCATe results and 3% of the hospitals' ratings were lower than the Tool's results. Amanda stated the LOCATe Tool is meant to try and "capture the essence" of the AAP guidelines and to be a general self-assessment tool because it does not cover all of the AAP criteria. If the State does decide to adapt the AAP guidelines, the LOCATe Tool would not be appropriate to designate levels, because that process to assess the hospitals should be more comprehensive.

2. LOCATe Tool – Preliminary Results (*continued*) ..... Amanda Bennett, PHD

Neonatal Levels of Care (*continued*) – In comparing the State designations to the LOCATe results, there were some significant differences, mainly the downgrading of many hospitals to lower levels. The number of hospitals being shifted to Level 1 had not been anticipated in previous discussions or had it been discussed in depth how the AAP guidelines would affect the lower level hospitals. It also highlights the big differences between our current State guidelines and what AAP requires in their guidelines. The comparison is as follows:

- There were 9 hospitals with Level 1 state designations but the LOCATe results indicated there should be 45 which is a significant increase.
- Of the 59 State designated Level II hospitals, only 51 hospitals were classified as Level 2 by LOCATe.
- There were no Level 2E hospitals classified by LOCATe but yet there are 23 State designated Level 2E hospitals.
- Over half of the 27 Level 3 hospitals designated were considered accurate by LOCATe which had the total at 15.
- In the State designations, there are no Level 4 hospitals. However, in the Neonatal LOCATe results, there were 7 hospitals deemed as such.

There were some specific factors which played a major part in the hospitals being deemed a lower level by LOCATe than what they were designated or what they thought they should be designated as. The biggest issues were with the specialty providers of Neonatologists, Pediatric Surgeons and Pediatric Ophthalmologists and their availability, as in on staff versus available for consult and 24/7 availability versus daytime hours only. The potential timing of access to the specialists was not incorporated into the analysis. However, this issue is still prevalent in a lot of the hospitals.

Per Committee Inquiry of Brent Ryherd: Do we have communication with the individual hospitals who may have thought they were a higher level than what they were deemed to be?

Amanda stated they would like to give feedback to those individual hospitals. However, the process or mechanism in which it will be done has not yet been determined. She stated she needs to have additional discussions with the State Perinatal Staff and the Administrators. She also has started to reach out to some of the facilities to ensure they did not make any mistakes when completing the survey so that they don't consequently receive an unjust rating.

Committee Member, Richard Besinger, made a recommendation that Amanda bring her plan for dissemination of the LOCATe results before the IDPH Perinatal Advisory Committee (PAC) for consensus. He stated he believes that way the information is presented could impact the way the issues are ultimately dealt with.

Andrea Palmer, IDPH, stated that when LOCATe was introduced, assurance was given that it would not be a punitive measure or for reviewing anything negative about any one particular facility, but only to be utilized as a process to identify where we stand. Chair, William Grobman, also reiterated that none of the information gathered will be used for designation or redesignation purposes.

2. LOCATe Tool – Preliminary Results (*continued*) ..... Amanda Bennett, PHD

Committee Member, Richard Besinger, requested that Amanda differentiate between metropolitan and rural areas in her future analyses. He stated it would assist with the decisions made in the metropolitan are and how those decisions will impact the rural ones. She agreed to do so.

There was an inquiry placed to Dr. Shah on whether or not there is a different financial reimbursement between the different levels of care, i.e. level 2 versus level 1. He stated, in general, the answer is no and reimbursements are not necessarily driven by the designation level of the hospital. The HFS Representative stated Medicaid reimbursements are based on the severity of the illness, severity of the care and the acuity of the care provided. However, there is an enhanced payment for perinatal Level 3 facilities which applies only to those facilities that meet that designation and only for neonatal and O/B claims, per State of Illinois policy. There is not an enhanced payment for and between the lower level facilities.

Chair, William Grobman, asked Amanda whether or not in her discussions did the lower level hospitals state why they were not accepting convalescent neonates. She stated she did not query individual hospitals on their response to the questions. But, she did pose a general question to several of the administrators. There were a variety of responses and some of the issues stated were insurance payment barriers or maybe the parents refuse the transport because they liked the care better at one facility. With that being said, if Level 3 hospitals are being filled with babies that could potentially be transported to lower a level of care and they are not, it prevents the babies who need that higher level of care from getting in. If we are looking at revising our Rules, we need to look at what other system-wide solutions we can put in place to overcome some of these barriers. Andrea Palmer stated one of the next steps could be having discussions with not only our public payors but some of our problem payors, as well.

Maternal Levels of Care – Since the hospitals don't have state designations, they were asked to rate themselves under the ACOG/SMFM guidelines versus the LOCATe results. The responses were as follows:

- 2 hospitals (2%) thought they were considered a Birthing Center.
- 13 hospitals or 11% thought they were a Level 1.
- 58% or 67 hospitals thought they were a Level 2
- 18 hospitals or 16% thought they were a Level 3.
- 11 hospitals or 9% thought they were a Level 4
- 5 hospitals (4%) stated they did not know.

The survey was generally filled out by the Directors of Women & Children Services and the ACOG/SMFM guidelines were not provided to the facilities beforehand. They were instructed to consult with the OB Chair and Neonatology if they were unsure how to answer. In comparing the self-assessments to LOCATe results, 43% of the hospitals' responses matched LOCATe. However, in the same scenario as the LOCATe results for the neonatal levels, many hospitals were downgraded to a lower level that what they thought they should be. Over half (56%) of the facilities over-rated their levels by a least one level. 1% under-rated them. This demonstrates there is not a lot of understanding of the maternal levels of care.

2. LOCATe Tool – Preliminary Results (*continued*) ..... Amanda Bennett, PHD

Some of the common things which shifted the facilities to the lower maternal levels of care were the 24/7 availability of specialty providers, such as, OB Anesthesiologist Specialists, Critical Care Specialists, etc. and the availability of certain ultrasound services. The general question put forth to the hospitals in the survey was, "Are ultrasound guided fetal procedures provided in your facility?" However, per committee comments, this may not be an actual ACOG requirement, which is what the LOCATe survey is purportedly based upon. But because this ultrasound requirement may have been interpreted differently by each hospital and consequently caused some of the hospitals to be incorrectly downgraded to a lower level, Amanda stated she would get clarification from CDC on the question of its requirement and why it was included in the survey.

In comparing the LOCATe results of the neonatal versus the maternal, 62% of the hospitals responses matched up. For the vast majority of those that did not match, the neonatal level was coming out higher than the maternal level in the survey. Amanda stated as we continue our discussions, she will continue to make notes of other questions we need answered. Per committee member inquiry, anything about the maternal conditions or care was not incorporated into the LOCATe survey. It was strictly neonatal. Amanda stated in the CoIIN Group chaired by Raye-Ann, there was a discussion to determine how to look at the data on risk-appropriate care. There is a discrepancy between the mom's gestational age where she comes in before the baby is delivered and the neonatal care for the baby after it is delivered. Lastly, to answer the Illinois Medicaid reimbursement question as previously in relation to the neonatal levels, the HFS rep stated because there is no maternal designation at this point, there is no enhanced reimbursement specifically for maternal services.

Dr. Besinger stated the good news is that this comparison of maternal and neonatal is pretty much going to fall between Level 3 and Level 4 because there are not going to be many Level 4 facilities which have Level 2 neonatal designations. You are going to want to have Level 3 facilities to be able take of premature babies because you can take care of moms who are undelivered and sick. Dr. Grobman stated being a Level 4 for maternal care essentially means you are taking care of the sickest of the sick moms with extensive services and it is not possible for that Level 4 to not at least have a Level 3 NICU.

Dr. Grobman clarified the objective of the Task Force is to decide how hospitals should be designated with regard to perinatal obstetric maternal levels of care and then make a recommendation to the State in that regard. He stated it seems there is a regulatory issue of how do we want to regulate things and there is a second issue of how does that regulation get operationalized to optimize. Hopefully, we have some cognizance in that we wouldn't ever make a recommendation that couldn't be operationalized but there could be some sort of straggling underperformance that we need to resolve once we know what our goal instruction is.

At the last meeting Andrea Palmer agreed to follow-up with Dr. Shah by providing clarification of the Rules in regards to some Level IIIs interpreting the current rules to mean they are required to do surgery. That follow-up is still pending. Dr. Shah stated if clarification after discussion with our lawyers resulted in this surgical requirement is not in fact valid, are we raising the possibility that some Level 2 facilities might try to call themselves Level 3 and/or facilities try to upgrade their status and as a result of that, actually put babies in jeopardy?

Per Committee response, it might be. However, what should be thought about is whether or not that can be best addressed by clearly defining a Level 3 because we don't want to use the surgery requirement as a filter for Level 3 if it does not result in the best care for the children. There is a larger need for the facilities to take care of preemies than there is for facilities to do surgery. So, we should allow facilities that can take care of preemies that are as close to the baby's home as possible to be an appropriate level of care to do that. And, centralize the more expensive and less frequently used surgical care. That would be aligned with the goal of giving babies the best care as close to home as possible.

Dr. Besinger asked Tanya Dworkin, IDPH Legal, if it is legally permissible to add a geographic requirement or exception into the Rules. Tanya stated she would have to research it further and review the way it was being proposed before she could provide a definitive answer.

Dr. Strassner inquired of Chair, Dr. Grobman, on whether or not neonatal redesignation is a part of the charge for this Committee. Dr. Grobman stated he believes it is and also includes figuring out how do we set up the systems from a designatory perspective for moms and babies so that it serves our citizens well. The recommendations would then go to PAC and from there to the Director.

Next Steps .....

Dr. Grobman stated the first meeting was setting the framework and the second meeting was obtaining information and data about what is going on with the State. The next meeting should be dealing with these proposed questions. A couple of actions items introduced were understanding the surgical regulations and understanding our capacity to make regulations different based on health professional shortage, such as Legal. We also want to address the following the questions:

A. What should neonatal levels of care be based upon? Should we continue with the regulatory system we have in place now or should we transition over to other guidelines, i.e. AAP?
B. What should we adopt in addition at a statewide level for a maternal level of care designation? What should it be based on?
C. How do these designations interact with each other?
D. What does the final system look like?

The next meeting is March 10, 2016.

Adjournment.....