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

October 29, 2015
1:00 p.m. until 3:00 p.m.

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

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

Attendees: William Grobman, Raye-Ann O de Regenier, Beau Batton, Richard Besinger, Sandy Dennis, Darlene Hammond, Sue Hesse, Jim Hocker, Jeff Jones, Jessica Kandel, Stephen Locher, Deb Roski, Brent Ryherd, Laura Smith, Heather Stanley-Christian, Cindy Mitchell, Robyn Gude, Carol Rosenbusch, Pam Wolfe, Barb Haller

Absent: Timothy Pappoe, Kristin Salyards, Howard T. Strassner, Jonathon Grieser

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

IHS Staff: Dan Jenkins

AGENDA

1. Opening Remarks ..... William Grobman, MD

The meeting was called to order by Chair, William Grobman, MD, at 1:00 pm.

Dr. Shah extended his thanks for everyone's participation on the LOC Task Force. He stated the report compiled by the group was tremendously enlightening, informative and very well done. The advice the Department will require from the Task Force particularly pertains to the Neonatal Levels of Care issue. He recognizes there is an issue with low-birth infants being born in inadequate facilities, etc. However, if it is decided to create a new Level 4 designation, the policy question is: W*ill it solve any of the impediments of babies being born with the incorrect care? What will happen that is not being done now?* The Assistant Director, Michelle Gentry-Wiseman and Dr. Shah have a principle interest in the neonatal levels of care. Nevertheless, the same analysis applies to the other levels of care in respect to the justification of proposing and/or introducing new levels of care.

2. Welcome and Introductions .....

Members and guests introduced themselves.

3. LOCATe Tool ..... Amanda Bennett, PHD

CoIIN Risk Appropriate Care Group is one of the CoIIN Infant Reduction Mortality Workgroups and co-chaired by Trishna Harris and Raye-Anne O de Regenier. This Group is going to facilitate a review process to look at some quantitative data to determine why VPT (Very Pre-Term) babies are being born outside of Level 3 hospitals. The review will focus on neonatal cases as those are more easily identifiable. They are aware of some of the reasons the babies are not being born in the appropriate hospital. However, it is not clear if the reasons are due to systems-based factors, patient factors, physician factors, or facility issues, etc.

LOCATe (*Levels of Care Assessment Tool*) is a CDC-developed perinatal survey tool used to gain info on maternal and neonatal practices and services. The Tool takes responses and according to an algorithm, classifies them into neonatal and maternal levels of care. The neonatal survey questions line up with the 2012 AAP guidelines and the maternal survey questions line up with the 2015 ACOG guidelines. 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." To update on the progress of the Tool, hospitals were given a deadline of October 31, 2015 to complete the Survey and as of today, 75 out of the 122 have already completed it. Although participation is not mandatory, in order to best assess the State's system, we need all Illinois hospitals to participate. So, those that have not participated may be given an extended deadline to do so.

On the maternal side, LOCATe is the very first tool which captures information on maternal Levels of care and classifies them, which is something we don't currently have. On the neonatal side, it will help us distinguish between the Levels. For example, it will give us insight to determine whether a 2E hospital is actually functioning more like a Level 3 or more like a Level 2. Still, the purpose of this assessment is not to use it for determining hospital designations. It is moreso to give us an idea of how our current system is lining up in relation to the new guidelines. We can get an overview of a hospital's current level of care as well as their specific services. Amanda stated she hopes to have some more descriptive data and info on the Tool by the next meeting in January 2016.

4. Pediatric Surgical Levels of Care .....

Jessica Kandel, MD

Dr. O de Regenier stated hospitals have different surgical levels of care where the surgeon may be able to complete a minor surgery to stabilize a baby for transfer but yet be unable to perform other high risk complicated surgeries with a surgical team. Dr. Kandel stated the Levels are usually hospital-defined. The surgical level is on a different spectrum of neonatology which is Level 4 while the surgery level is Level 1. It is not defined necessarily as a Level 3 or Level 4, but the total environment of care. In surgical literature, it is very clear that outcomes are tied to volumes. Surgical data collection is deemed essential for all the surgical levels of care for children. However, the methods of collection are defined differently. For Level 1, the defined data collection program is the ACS Pediatric NSQIP: National Surgical Quality Improvement Program.

5. Neonatal Levels of Care .....

Raye-Ann O de Regnier, MD

In reviewing the Neonatal LOC, it was found that if a Level 4 designation was added, it would involve the surgical care of newborns. Part of being a NICU would involve meeting these higher surgical levels for newborns. The overall idea and goal would be that as many babies that can be safely cared for near the mother's home should be. However, specialized resources for newborns are expensive and perhaps most effective when there is an adequate volume of patients requiring the care. So, it makes sense to provide the local care as best as possible for the majority of babies but for those highly specialized babies to be congregated in those centers where their needs can be fully met.

Dr. Shah stated he required additional clarification and input on the Level 4 neonatal designation to understand what the merits and demerits are by introducing it. *"Why is it or is it not necessary?"*

Dr. Batton stated it would not change their care of pre-term infants or their surgical approach because they do not do ECMOs or deal with congenital heart disease and they are not interested in delving into them. However, for those hospitals that do provide those types of services, he believes the L4 designation would give some value provided there is some volume. It would also provide some commitment to that type of patient as you cannot do ECMOs once a year and still be considered a Level 4 hospital.

Dr. O de Regnier stated it is more crucial for the Level 4 surgical levels of care because the resources and the volume require that designation which right now is not a State designation. It is a voluntary designation. She can see where they only have these 3 levels of care for these newborns but they also have these surgical levels of care where the Level 3 hospital might or might not have the surgical requirement because essentially, meeting the surgical requirements makes them a Level 4.

Dr. Kandel stated some service requirements for only Level 4 hospitals are being performed in Level 3 hospitals. Establishing the new designation would provide a guideline stating that the Level 4 hospital is the best place for certain services to be performed. Nurseries that want maintain their Level 3 designation hold on to babies and insist on doing surgeries when they do not have a high volume. Any facility that does 10 or 20 surgeries per year should not be doing them because they do not have the appropriate resources and staff for them. It is certainly possible they will have VPT infants who will benefit from their expertise, but they simply do not have the surgical volume or can't invest in the resources to do the surgery correctly. You need to have a clear understanding that Level 3 hospitals are not obligated to do surgery in order to retain their ability to take care of very small infants. With the release of the obligations from the Level 3s, then you will regionalize care for those babies who require those higher surgical care resources in a Level 4. The Level 4 designation will kind of formalize that. If you combine the concept of a Level 4 nursery which does everything and has high volumes with the idea that the obligation of a Level 3 Nursery is to take care of very small babies but not do surgery on site, the combination of these 2 factors would result in these babies being sent to Level 4 hospitals when they require complex interventions. Then, as they recuperate and their conditions improve be transferred back to nurseries closer to their home. Also, in response to the general agreement of the group that some Level IIIs interpret the current rules to require the Level III to do surgery, Dr. Shah said that the pertinent section of the rules must be clarified. He requested for Andrea Palmer to follow-up with him on that issue.

5. Maternal Levels of Care .....

William Grobman, MD

Maternal Levels of Care are not about moms at risk of premature delivery. That is really more about what happens to the neonates. They are in response to the trend that severe maternal morbidity and mortality in our country is rising. There are many different reasons but one reason is that babies are being born to sick moms and there is no standard framework in place. In the maternal levels of care, there are 5 Levels of Care. There is one Level which is a birthing center and Levels 1-4 which don't necessarily correspond to the neonatal levels of care. It is very unlikely there will be a Level 1 maternal center that will also be a Level 3 neonatal center. Dr. Shah stated he understands that sick moms are not getting the care that is calibrated for them. However, he asked "What would this 4 or 5 level system solve?" Dr. Grobman stated he believes it makes everyone safer even though it may not be necessarily problem free. It will give everyone some guidance to rely on as opposed to having to do things in ad hoc fashion. From a policy perspective, it has the opportunity to make a big impact on bad outcomes without a lot of disruption.

Dr. Jeff Jones, who currently practices at a Level IIE in downstate Illinois, states he believes the introduction of new levels would give them a framework to operate in. In a common scenario, when discussing the transfer of a patient, the nurses or the family may come back and state they were under the impression the hospital could handle the required level of care. Being able to separate the issues of the mom and the issues of the baby where everyone understands that maternal complications can turn severe very quickly and as a result, putting the pressure on the hospital to have the foresight to say the condition may get worse, gives the hospital the freedom to transfer these patients without feeling like the care which they can provide is insufficient and assure the family that the transfer is standard practice because the condition is recognized as requiring a higher level of care.

Dr. Shah stated that if the geographical location is one of the predominating factors for the patient's family's choice of facilities (as in they want the patient(s) to receive care locally or close to home), he agreed the introduction to the maternal level of care might be persuasive to the family. The hospital would be able to have a reference for the family and say they are not designated to handle the type of care required. When Dr. Shah asked what the barriers of transfer were, as establishing a new LOC would mean that they are not practicable at most times, Dr. Batton stated money and distance are barriers. For example, if a mom is transferred 2 hours away from her home, a lot of times she is from a small community with limited financial resources and does not have a car or mode of transportation. So that separates her from her family in a meaningful way because of the how far away she is and the fact she is unable to get back to the transferred hospital/facility.

6. Next Steps .....

Dr. Grobman stated the next proposed meeting dates are January 21, 2016 and March 10, 2016 from 1:00 p.m. until 3:00 p.m. Info will be disseminated within the next week. Amanda Bennett of IDPH will have some data to share on the maternal and neonatal levels of care at that meeting to see where our State systems are.

Dr. Grobman stated before the Committee gets into determining and assigning different designations, as they review each different Level of Care (Maternal, Neonatal, Surgical), they first need to decide how they will classify the hospitals.

Adjournment .....