ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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

March 10, 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, Beau Batton, Richard Besinger, Jeff Jones, Jessica Kandel, Stephen Locher, Timothy Pappoe, Angie Reidner, Deb Roski, Brent Ryherd, Kristin Salyards, Heather Stanley-Christian, Robyn Gude, Cindy Mitchell, Carol Rosenbusch, Pam Wolfe, Barb Haller

Absent: Sandy Dennis, Darlene Hammond, Sue Hesse, Jim Hocker, Laura Smith, Howard T. Strassner, Jonathon Grieser

IDPH Staff: Amanda Bennett, Trishna Harris, Andrea Palmer, Miranda Scott

HFS Staff: Dan Jenkins

Guests (Perinatal Network Administrators): Patricia Prentice, Jodi Hoskins, Bernadette Taylor, Elaine Shafer

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 charges are to determine if there should be maternal levels of care, should the neonatal levels of care in Illinois be altered and once those decisions are made, should maternal and neonatal levels of care be combined. Originally, the goal was to have a recommendation for the State by the third meeting. However, to do so has been more challenging than anticipated. He proposed to go over as much info and gather and review as much data as possible today, then determine what other questions needs to be answered to make a decision and/or if additional data is required. He would like to have a recommendation for the State as soon as possible.

2. Review .....

Maternal Levels of Care

The Chair stated ACOG/SMFM came out with a recommendation that in maternal levels of care neither the neonate nor the mother should be forgotten and some form of volume collection of patients based on acuity has value. This is based on the belief that the more volume of rare procedures a facility does, the better those patients will do. It is also stimulated by the fact maternal morbidity and mortality continues to climb in the United States.

Everyone has seen the four levels of care that were recommended and the basis for those. What we have been thinking about here is how we graft that onto our State, how does our State look, and what are the consequences of that.

Amanda Bennett of IDPH has done amazing work with the LOCATe Tool and in obtaining data to try and give us a sense of how things look and will look in the State. In addressing Barb Haller's question/inquiry about reaching out to and communicating with other states who may have similar issues with levels of care, Dr. Grobman stated he reached out to Kate Menard from UNC, Elliott Main in California and George Saade in Texas. In state health departments, the individual states are moving in different directions, however, ALL states are moving forward with the maternal levels of care. Texas actually passed a state law to implement them.

Data from LOCATe - Amanda Bennett

LOCATe is a CDC - developed survey tool based on the 2012 AAP Policy Statement on Levels on Neonatal Care, the 2012 AAP/ACOG Publication of Guidelines for Perinatal Care and the 2015 ACOG/SMFM Publication of Maternal Levels of Care. It was completed by nearly all of the Illinois perinatal hospitals in the fall of 2015. The goal of LOCATe is to serve as an objective tool for assessing neonatal and maternal levels of care in relation to these guidelines and matching them to the hospitals' responses to see how they are currently functioning. Hospitals were required to meet all of the required criteria and provide all of the requisite services to qualify for a specific level of care. For example, in addition to other services, a hospital is required to have eight sub-specialists on-site for inpatient consultations to meet the LOCATe Tool's criteria for a Level 4. However, if a facility meets every required service, but still only has seven sub-specialists onsite and not the entire 8, they will only be allowed a Level 3 classification according to LOCATe. There was also some discussion about the interpretation of 24/7 onsite availability.

There are now some changes in the numbers which were presented before because in the previous meeting, there were some questions about the requirement for ultrasound guided fetal procedures. Per committee comments, this was thought not to be an actual ACOG requirement, which is what the LOCATe survey is purportedly based upon. And because it may have been interpreted differently by each hospital and consequently caused some of the hospitals to be incorrectly downgraded to a lower level by the Tool, after consulting with CDC, they decided to change the algorithm of the survey by taking that requirement out.

Discussion

- It was addressed that between level 4's and level 3's the main difference is in the sub specialties of doctors. The feeling is that it would need to be clear cut in terms of the differences and extra requirements as a level 4 versus a level 3.
- Dr. Besinger noted to make the recommendation that the Department manage the geographic locations of the levels to make it is reasonably dispersed.

*Motion that the sub-committee makes a recommendation to the PAC that the state institute a system of designation maternal levels of care based off the ACOG SMFM Recommendations. Motion carried. No abstentions.

*Motion to approve the minutes from the January 2016 meeting. 1st Beau Batton, 2nd Pam Wolfe. Motion carried. No abstentions.

3. Neonatal Levels of Care.....Dr. Kandel

- Dr. Jessica Kandel gave a presentation on the surgical levels.
- Level III general requirements reflect an older system. Level IV is the highest for a nursery and Level I is the highest for the surgical care for children.
- It is important that surgical care of children is incorporated to the medical care. That is the major difference between the Level III and Level IV.
- Data is important for neonatal care's quality. If it is not collected according to national standards it will be very hard to improve that quality.
    - Q: The Department's stance on 640.43 Neonatal Surgical Services available for 24 hours a day?
    - A: Dr. Shah from the Illinois Department of Public Health has requested that the perinatal advisory committee give their input on the matter.
- State Comparisons:
    - Indiana – Pediatric Surgical and anesthesiologist sub-specialist maybe on site or at a closely located institution.
    - Arkansas – Level III NICU's have adopted the I, II, III, IV system.
    - Texas – A reasonable explanation for the transfer of a patient between one Level III to another Level III is that one has surgical capabilities and another does not.
    - Washington – Onsite surgery explicitly optional for Level III. If they decide to have one it is on par with the optimal resources document.
- There is a want for the neonatal guidelines should be consistent with the surgical guidelines.

4. **Next Steps .....**

- For the next meeting: What Recommendation to make to the PAC. And how to fold in surgical levels of care.
- Send Amanda Bennett any questions that will need to be addressed in terms of data.

5. Adjournment .....

*Motion to adjourn.

The next meeting is will be decided through a doodle poll.