December 14, 2010

To: Members, Legislative Council Special Study Committee on Infant Mortality

From: Ann E. Conway, Executive Director, Wisconsin Association for Perinatal Care and Perinatal Foundation

Subject: Perinatal regionalization

*The issue*: Perinatal regionalization is an issue that is best dealt with on a statewide level. It is not necessarily a BadgerCare issue, but one of structuring a system of care. While perinatal regionalization was included in the minutes of our November meeting, it is not obvious in the current proposals. Therefore, I request that time be allocated for discussion of legislation related to perinatal regionalization at the December 16, 2010, meeting.

*Perinatal regionalization is significant because* it could directly affect the numbers of neonatal deaths due to congenital anomalies/birth defects, disorders related to preterm birth and low birth weight, maternal complications of pregnancy, newborn complications of placenta/cord/membranes, and respiratory distress.

Perinatal regionalization is a system of designating hospitals in which infants are born or are transferred based on the amount of care that they need at birth. In regionalized systems, very ill or very small infants are born in or referred to hospitals that are able to provide the most appropriate care with high-level technology and specialized health providers. Regionalized systems define hospitals at risk-appropriate levels—Level 1 being the most basic and Level IIIC being the most specialized. The goal of a regionalized system is to reduce infant deaths.

In a September 1, 2010, report on perinatal regionalization in the *Journal of the American Medical Association* (Vol. 304, No. 9), the authors conclude that for very low birth weight and very preterm infants, birth outside of a Level III hospital is significantly associated with increased likelihood of neonatal or pre-discharge death.

The percent of very low birth weight infants born in Level III facilities is a federal maternal and child health performance measure that Wisconsin must report.

Wisconsin has a voluntary system in which hospitals complete a self-assessment of their level of care based on the recommendations of the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists. To view the list of hospitals that have completed the self-assessment process, go to http://www.perinatalweb.org/index.php?option=content&task=view&id=244

The Wisconsin Collaborative for Healthcare Quality provides public information about high risk deliveries, which is a Leapfrog measure. According to their Web site: "Infants are typically cared for in a Neonatal Intensive Care Unit (NICU) following births in which the baby was predicted to weigh less than 1500 grams at birth, is born before 32 weeks of pregnancy, or has correctable major birth defects. These babies usually have better outcomes

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if they are treated in a hospital with an NICU where an average of at least 15 infants is cared for per day ("average daily census of neonatal ICU"). This is a measure of how close each hospital is to meeting The Leapfrog Group's volume and quality standard for this procedure."

Six of the 10 birth hospitals that voluntarily report volume (of approximately 25 possible hospitals) report fully implementing this measure. While this is a good start at publicly reporting data, viewers do not know

- The level of care offered by the 100 birth hospitals
- The number of Level III hospitals in Wisconsin
- The average daily census for all Level III hospitals
- The outcomes of the infants born in Level III hospitals

Not having these data for all hospitals allows adverse selection. Complete and accurate data for all hospitals could be used to allocate funds to providers/facilities that are meeting standards of excellence, similar to the current Medicaid medical home OB project.

*The ideal outcome* is for Wisconsin to form a perinatal collaborative to design, designate, and support a regionalized system of perinatal care. This collaborative should be organized by a multidisciplinary non-profit organization and include major stakeholders—providers, payers, and consumers. The purpose of the collaborative is to decrease infant mortality and morbidity by addressing hospital-based health care delivery. This can be achieved by designating levels of care, establishing criteria for admission to an NICU through collaboration with key industry stakeholders, and reporting the census of the NICUs.

*Relevant background information*: From 1970 to 1990, Wisconsin had a highly effective regionalized perinatal care system. With the advent of managed care, new referral patterns emerged. When "certificate of need" was no longer necessary, hospitals could build NICUs where they had established need. By 2003, the number of NICUs in Wisconsin increased 300% from six to 18. The Wisconsin Association for Perinatal Care is working with hospitals to determine the number of Level III hospitals. There is no other system in place to determine the level of care.

The Legislative Council Special Study Committee on Infant Mortality has the opportunity to take action to improve perinatal outcomes by re-establishing a regionalized structure of perinatal care. It can do this by:

- Establishing a mechanism to publicly report the level of care a birth hospital provides
- Setting criteria for NICU admissions
- Requiring reporting of the daily census of NICUs in Level III hospitals
- Requiring that Level III hospitals provide additional data about infant care and outcomes
- Providing an annual report of the above to the public.

The leadership of the Wisconsin Association for Perinatal Care (Dr. Paul Neary, pediatrician) and the Perinatal Foundation (Dr. Carol Browning, retired neonatologist) stand ready to work with the committee to write a legislative proposal that will meet Wisconsin's needs.