

Sunset Public Hearing Questions for
Perinatal Advisory Committee
Created by Section 68-1-803, *Tennessee Code Annotated*
(Sunset termination June 2015)

1. Provide a brief introduction to the Perinatal Advisory Committee, including information about its purpose, statutory duties, staff, and administrative attachment. Also describe the Perinatal Program, its major activities, and its staffing.

Statute: TCA 68-1-801-804

Legislative Mandates: The law required the Department to (1) develop a plan to establish a program for the diagnosis and treatment of certain life-threatening conditions present in the perinatal period; and (2) develop a regionalized system of care, including highly specialized personnel, equipment and techniques that will decrease the existing high mortality rate and the life-long disabilities in newborn infants.

The Commissioner is charged to appoint a perinatal advisory committee to consult with the Department in the administration of the legislative mandate.

The Department, with the advice of the committee, was charged with designing a program to include:

- Development of standards for diagnosis and treatment.
- Assistance in the development of regional perinatal centers for the diagnosis and treatment of high-risk pregnant women and infants.
- Extending financial assistance for diagnosis and treatment by providing necessary medical, surgical, hospital, outpatient clinic and ambulatory services.
- Development of a regional system of transportation and referral.
- Development of regional education and training activities.
- Development or expansion of a communications/consultation system.

PERINATAL ADVISORY COMMITTEE (PAC)

Purpose: The purpose of the Committee is to advise the Commissioner of Health on issues related to perinatal health and the operation of the regional perinatal system.

Statutory Duties: The statute states that the committee will consult with the Department on the administration of the perinatal program.

Staffing: Staff responsibility for the Perinatal Advisory Committee is with the Division of Family Health and Wellness of the Department of Health.

Membership of the Perinatal Advisory Committee: Categories of membership on the Committee are included in the statute: director or designee of each obstetrical and newborn unit

of each Regional Perinatal Center, and at least one representative from each of the following: medical schools, public health agencies, hospital administrators, medical specialists in obstetrical and newborn conditions, family physicians, obstetrical and neonatal intensive care nurses, and the general public. Total membership shall not exceed 21.

PERINATAL PROGRAM (REGIONAL PERINATAL SYSTEM)

Description of the Perinatal Program: The Tennessee Perinatal Regionalization Program was established in 1977 to provide for the diagnosis and treatment of certain life-threatening conditions of pregnant women, their fetuses, and newborn infants. The five Regional Perinatal Centers have made this specialized care available by providing a statewide mechanism to health care providers for 24-hour consultation and referral of high risk patients; transport of these patients as needed; personnel skilled in high risk perinatal care; professional education in high risk perinatal care for physicians, nurses, and other medical personnel; on-site consultation visits to local hospitals upon request, and post-neonatal follow-up.

Major Activities: The five Regional Perinatal Centers provide perinatal care for high risk pregnant women and newborns if no other appropriate facility is available to manage significant high risk conditions. Funding from the Bureau of TennCare/Department of Finance and Administration enables the availability of consultation and referral for facilities and health care providers within the respective perinatal region, professional education for staff of hospitals and other health care providers within the region, and maternal-fetal and neonatal transport.

Care is provided to high-risk pregnant women and Tennessee's most fragile and sick infants at the five centers across the state. Specialized care is available for women with complex medical conditions or with high risk pregnancies. Services support critically ill infants, including those born extremely premature or with serious conditions requiring medical or surgical care. In fiscal year 2013, over 45,100 consultations were performed by perinatal center staff. The Centers delivered 14,725 Tennessee pregnant women and admitted 4,346 infants to their neonatal intensive care units. Expert staff from the perinatal centers provided over 5,300 hours of professional education on high risk care throughout the state.

Staffing: Staff responsibility for the Perinatal Advisory Committee is with the Division of Family Health and Wellness of the Department of Health. The Bureau of TennCare/Department of Finance and Administration is fiscally responsible for program contracts.

2. Provide a list of current members of the committee. For each member please indicate who appointed the member, how the member's presence on the committee complies with Section 68-1-803, Tennessee Code Annotated, and the member's county of principal residence. Please indicate each member's race and gender and which members, if any, are 60 years of age or older. Are there any vacancies on the committee? If so, what is being done to fill those vacancies?

Committee membership is detailed on the table attached to this report. At this time, there are no vacancies on the Committee.

3. How many times did the committee meet in fiscal years 2013 and to date in 2014, and how many members were present at each meeting?

The Perinatal Advisory Committee is required to meet at least once a year or as frequently as the Commissioner deems necessary. For FY 2013, the Committee met two times, and for FY 2014, the Committee met one time. The next meeting will be July 23, 2014.

Schedule and Attendance – Perinatal Advisory Committee

Date	Members Present	GUESTS & Staff PRESENT
December 17, 2012	14	9
June 4, 2013	15	7
January 31, 2014	14	14

4. What per diem or travel reimbursement do members of the committee receive? How much was paid to committee members during fiscal years 2013 and to date in 2014?

Members do not receive per diem. Travel reimbursement is paid in accordance with the Comprehensive State Travel Regulations for reimbursement of travel for committee members. For FY 2013, travel expenses for the meetings were \$752.15; for FY 2014, travel reimbursement for the meeting was \$831.76.

5. What were the committee’s revenues (by source) and expenditures (by object) for fiscal year 2013? Does the committee carry a fund balance and, if so, what is the total of that fund balance? If expenditures exceeded revenues, and the committee does not carry a fund balance, what was the source of the revenue for the excess expenditures?

The Perinatal Advisory Committee generates no revenues. The only expenditures for the committee are for travel to the meetings and related supplies for the meetings. These expenditures are charged to the budget for the Division of Family Health and Wellness of the Department of Health, specifically to the Maternal and Child Health Block Grant.

The Committee has no fund balance.

6. Is the committee subject to Sunshine law requirements (Section 8-44-101 et seq., Tennessee Code Annotated) for public notice of meetings, prompt and full recording of minutes, and public access to minutes? What procedures does the committee have for informing the public of its meetings and making its minutes available to the public?

The Perinatal Advisory Committee is subject to Sunshine law requirements. A meeting notice is posted to the State of Tennessee web site in the month prior to the meeting (tn.gov) on the Public Participation Calendar. The notice has date, place, time of the meeting, and major agenda items. The minutes are distributed to members, guests, and staff, are kept on file in the program office, and are available to anyone upon request.

7. Describe the nature and extent of the committee's activities and any major accomplishments of the past two years. Specifically, describe the committee's actions to advise the department in the areas outlined in Section 68-1-804.

The Perinatal Advisory Committee conducts its work through the committee members and through ad hoc work groups. During the past two years, there were four active work groups comprised of experts from across the state which addressed specific areas of perinatal care. Activities included:

- Revised the *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities*, 7th edition, March 2014 [TCA 68-1-804 (1)].
- Revised the *Guidelines for Transportation*, 2014, 6th edition [TCA 68-1-804 (4)].
- Revised the *Educational Objectives in Medicine for Perinatal Social Workers* (final document will be presented to the Perinatal Advisory Committee for approval at the next meeting) [TCA 68-1-804 (5)].
- Work in process to revise the *Educational Objectives for Nurses, Levels I, II, III, Neonatal Transport Nurses*. The final document will be presented to the Perinatal Advisory Committee for approval at the next meeting. [TCA 68-1-804 (5)].
- Revised the quarterly data reports for both obstetrics and neonatal.
- A representative from the Committee serves on the federal CoIIN (Collaborative Improvement and Innovation Network) work group on perinatal regionalization – a federal tri-regional effort to reduce infant mortality.
- Members were asked to review and provide comments on two Certificate of Need applications related to perinatal care.
- The outreach educators from all five Regional Perinatal Centers conducted training for staff at all their birthing facilities on implementation of critical congenital heart disease screening of all newborns. These trainings occurred in a few short months and were the key to successful and statewide implementation.

8. Has the committee set goals and measured its performance compared to the goals? What performance indicators or goals does management use to measure the effectiveness and efficiency of the committee? How well has the committee performed based on those performance indicators?

At a recent request of Committee members, the Department of Health has begun to routinely compile very low birth weight births by delivering facility, by level of neonatal care, and by perinatal region. These births will be tracked by the Perinatal Centers' directors and members of the Committee, as well as by Department staff, allowing for monitoring of outcomes on these infants. Critical to improving birth outcomes in Tennessee is assuring that pregnant women identified with high risk conditions be delivered at a facility with the appropriate staff and equipment to care for her and her baby.

Committee members recently decided to focus on outcome of follow-up care; the specific metric will be decided at a future meeting.

The federal Maternal and Child Health Block Grant to the Department of Health has an indicator which tracks very low birth weight infants delivered in Level III or IV facilities. The State has been tracking this indicator for a number of years. Infant mortality is also tracked for each state in the nation.

The federal CoIIN Initiative to reduce infant mortality is reviewing or re-establishing regionalization in the participating states; one indicator being tracked is the very low weight births by level of care for each state. Tennessee is participating in this initiative and submitting data on our births. Since the early days of establishing the perinatal regionalization system in Tennessee, the structure with its Perinatal Centers and readily available consultation with all health care providers on high risk patients, Tennessee's infant mortality rate has decreased from 13.4 in 1980 to 7.2 in 2012. Most of this decrease in the 1970s and 1980s was directly related to improvements in high risk care and the availability of the regionalization system.

The Committee serves to provide advice and assistance to the Department of Health on high risk perinatal care. A number of process measures are tracked by the Centers and reported quarterly to the Department of Health. These include deliveries, NICU admissions, transports, follow-up visits, and educational hours provided, among others. The Committee is also charged with assuring that all four perinatal manuals are reviewed on a regular basis and revised when national guidelines are released or medical practice changes.

9. How does the committee ensure that its members and staff are operating in an impartial manner and that there are no conflicts of interest? If the committee operates under a formal conflict of interest policy, please attach a copy of that policy.

The Committee does not have a formal conflict of interest policy. Staff (state employees) are required to sign a conflict of interest statement which is kept in the personnel files. Committee members are requested to sign a conflict of interest form for committees; copies are kept in the program office.

10. Describe any items related to the committee that need legislative attention and your proposed legislative changes.

No legislative action is being proposed.

11. Should the committee be continued? To what extent and in what ways would the absence of the committee affect the public health, safety, or welfare?

It is recommended that the Perinatal Advisory Committee be retained as an advisory committee to the Department of Health.

Specifically, the Committee impacts public health, safety and welfare in the following ways:

- The Perinatal Advisory Committee members provide the Department ready access to persons with a high level of expertise in the field of high risk obstetrical and neonatal care. The ten members who are the directors of the Regional Perinatal Centers are persons trained at the highest level in maternal-fetal medicine and neonatology. Other representatives on the Committee provide the Department additional expertise from the perspective of the community, the private sector, and hospitals.
- The Perinatal Advisory Committee assists the Department in monitoring the statewide systems of perinatal care and makes evidence- and needs-based recommendations for change.
- The Perinatal Advisory Committee and its work groups provide the expertise to develop and revise the four manuals regularly used by health care providers statewide.

The absence of this level of expertise could affect the quality of perinatal care and the availability of the perinatal regionalization system in this state. The expertise is not available within the Department of Health, and the lack of access to the members of the committee would create a void in the areas of high risk neonatal and obstetrical care. The committee provides a valuable service and should be continued. The consistent trends in improved birth outcomes (such as infant mortality) would likely stagnate or even reverse without this strong system of regionalized care.

12. Please list all committee programs or activities that receive federal financial assistance and, therefore are required to comply with Title VI of the Civil Rights Act of 1964. Include the amount of federal funding received by program/activity.

The Committee does not operate any programs. The Committee does not receive federal financial assistance.

[Federal financial assistance includes:

- (1) Grants and loans of Federal funds,
- (2) The grant or donation of Federal Property and interests in property,
- (3) The detail of Federal personnel,
- (4) The sale and lease of, and the permission to use (on other than a casual or transient basis), Federal property or any interest in such property without consideration or at a nominal consideration, or at a consideration which is reduced for the purpose of assisting the recipient, or in recognition of the public interest to be served by such sale or lease to the recipient, and
- (5) Any federal agreement, arrangement, or other contract which has as one of its purposes the provision of assistance.

28 C.F.R. Sec. 42.102(c)

[The term recipient means any State, political subdivision of any State, or instrumentality of any State or political subdivision, any public or private agency, institution, or organization, or other entity, or any individual, in any State, to whom Federal financial assistance is extended, directly

or through another recipient, for any program, including any successor, assign, or transferee thereof, but such term does not include any ultimate beneficiary under any such program.

28 C.F.R. Sec. 42.102(f)]

If the committee does receive federal assistance, please answer questions 13 through 20. If the committee does not receive federal assistance, proceed directly to question 19.

13. Does your committee prepare a Title VI plan? If yes, please provide a copy of the most recent plan.

14. Does your committee have a Title VI coordinator? If yes, please provide the Title VI coordinator's name and phone number and a brief description of his/her duties. If not, provide the name and phone number of the person responsible for dealing with Title VI issues.

15. To which state or federal agency (if any) does your committee report concerning Title VI? Please describe the information your committee submits to the state or federal government and/or provide a copy of the most recent report submitted.

16. Describe your committee's actions to ensure that committee staff and clients/program participants understand the requirements of Title VI.

17. Describe your committee's actions to ensure it is meeting Title VI requirements. Specifically, describe any committee monitoring or tracking activities related to Title VI, and how frequently these activities occur.

18. Please describe the committee's procedures for handling Title VI complaints. Has your committee received any Title VI-related complaints during the past two years? If yes, please describe each complaint, how each complaint was investigated, and how each complaint was resolved (or, if not yet resolved, the complaint's current status).

19. Please provide a breakdown of current committee staff by title, ethnicity, and gender.

The Perinatal Advisory Committee has no staff solely dedicated to its activities. Two central office staff support the work of the committee as needed. They are the Director of Family Health and Wellness who serves as Chair of the Committee and a Public Health Program Director 3. Both are white; one is male, one is female.

20. Please list all committee contracts, detailing each contractor, the services provided, the amount of the contract, and the ethnicity of the contractor/business owner.

The Committee has no contracts for which it is responsible.

Supplemental Questions

1. What are your key measures for ensuring that your organization is meeting its goals?

- Infant mortality rate (monitored at the state, regional, and county levels)
- Delivery at appropriate facility (very low birthweight births delivered at level III or IV facility)

2. What are the statistical reliability and accuracy (for objective measures) or validity and repeatability (for subjective measures) of your key measures?

Both of the measures above are objective and are deemed reliable and accurate.

The infant mortality rate is derived using a standard formula (infant deaths per 1,000 live births), with “live birth” being defined in TCA. The rate is calculated by staff in the Tennessee Department of Health’s Division of Policy, Planning and Assessment using a consistent method each year (allowing for reliability). Information on all vital events (e.g., births and deaths) in Tennessee are collected by the Tennessee Department of Health’s Office of Vital Records using standardized birth and death certificates as required by law. Because of this completeness and standardization in data collection, measurement bias, and hence inaccuracy, are unlikely. In addition, infant mortality rates can be displayed using 95% confidence intervals. In general, a confidence interval is a range of values that describes the level of certainty (or precision) surrounding an estimate. In the case of a 95% CI, we can be 95% certain that the interval contains the true population mean. A narrow interval indicates a more precise estimate, while a wide interval indicates a less precise estimate.

The percent of infants delivered at the appropriate facility uses a standard formula (number of very low birthweight infants delivered at level III/IV facilities divided by the total number of very low birthweight infants). The hospital levels of care are defined in detail in the latest edition of the *Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities* (available on the Department’s website). This metric is calculated by staff in the Tennessee Department of Health’s Division of Policy, Planning and Assessment using a consistent method each year (allowing for reliability). Information on all births in Tennessee (including birthweight and delivery hospital) are collected by the Tennessee Department of Health’s Office of Vital Records using a standardized birth certificate as required by law. Because of this completeness and standardization in data collection, measurement bias, and hence inaccuracy, are unlikely. In addition, percentages can be displayed using 95% confidence intervals. In general, a confidence interval is a range of values that describes the level of certainty (or precision) surrounding an estimate. In the case of a 95% CI, we can be 95% certain that the interval contains the true population mean. A narrow interval indicates a more precise estimate, while a wide interval indicates a less precise estimate.

3. What is the record (over time) of those key measures in relation to what they should be to accomplish the goal of the organization? (I would like to see charts that have a performance mean and 3-standard deviation limits marked on them for these measures. Note: if these cannot be provided, I would like a valid explanation and a plan for future implementation.)

See attached chart.

4. Explain any excessive variation in your key measures.

The infant mortality rate has consistently declined in Tennessee over the past decade, consistent with public health efforts focused on improving women's health and perinatal/infant health.

5. What unique events or special causes have driven your key measures beyond 3 standard deviations from the mean in the past and what have done about them?

N/A. It is important to note that this key measure is not directly within the control of the Tennessee Department of Health. The Department can provide resources, education, and infrastructure that should support the reduction of the infant mortality rate. However, the Department does not provide traditional "prenatal care" or delivery services.

6. What impediments, if any, prevent you from driving those key measures to the desired point?

A major contributor to Tennessee's high infant mortality rate is preconception health—mother's health before she ever becomes pregnant. High rates of chronic disease (such as obesity and diabetes) and health risk behaviors (such as smoking) are major impediments to a woman of childbearing age being at optimal health before she ever becomes pregnant.

7. How are you addressing/correcting the impediments, if any, that prevent you from driving those key measures to the desired point?

While these impediments are not under the direct control of the Tennessee Department of Health, a number of public health initiatives include efforts to improve the health of women of childbearing age. Examples include:

- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Tobacco Prevention and Control Program (including the Tobacco QuitLine)
- Project Diabetes
- Chronic Disease Prevention and School Health Promotion (CDC-funded grant)
- Title X/Family Planning Services

Members of the Perinatal Advisory Committee

Name	Representation	County of Residence	Race	Gender	Age 60 or over
David Adair, M.D.	Regional Obstetrical Center	Hamilton	White	Male	No
Alison Asaro, M.D.	Public Health Agency	Davidson	White	Female	No
Woods Blake, M.D.	Regional Newborn Center	Hamilton	White	Male	Yes
Frank Boehm, M.D.	Regional Obstetrical Center	Davidson	White	Male	Yes
Michael DeVoe, M.D.	Regional Newborn Center	Washington	White	Male	Yes
Ramasubareddy Dhanireddy, M.D.	Regional Newborn Center	Shelby	Other (Indian/South Asia)	Male	Yes
Mark Gaylord, M.D.	Regional Newborn Center	Knox	White	Male	No
Kitty Cashion, R.N.-B.C., M.S.N.	Obstetrical Intensive Care Nurse	Shelby	White	Female	Yes
Susan Guttentag, M.D.	Regional Newborn Center	Davidson	White	Female	No
Bobby Howard, M.D.	Regional Obstetrical Center	Knox	White	Male	No
Kimberly Howerton, M.D.	Family Physician	Madison	White	Female	No
Gwinnett Ladson, M.D.	Medical School	Davidson	African American/Black	Female	No
Cheryl Major, R.N.C., B.S.N.	Newborn Intensive Care Nurse	Davidson	African American/Black	Female	Yes
Giancarlo Mari, M.D.	Regional Obstetrical Center	Shelby	White	Male	No
Marta Papp, M.D.	Specialist in Newborn Conditions (private practice)	Davidson	White	Female	No
Marilyn Robinson, M.D.	General Public	Shelby	African American/Black	Female	Yes
Karen Schetzina, M.D.	Medical School	Washington	White	Female	No

Name	Representation	County of Residence	Race	Gender	Age 60 or over
Lenita Thibault, M.D.	Specialist in Obstetrical Conditions (private practice)	Sullivan	White	Female	Yes
Selman Welt, M.D.	Regional Obstetrical Center	Washington	White	Male	Yes
Jeff Whitehorn	Hospital Administrator	Williamson	White	Male	No