**Section 640.90 State Perinatal Reporting System**

a) Purpose

The Department will maintain a State Perinatal Reporting System to follow selected high-risk perinatal patients to ensure that those patients are assessed at appropriate intervals, receive intervention as needed, and are referred for needed support services.

b) Identification and Referral of High-Risk Maternal Patients

1) Each designated APC and Level III hospital that provides obstetrical care shall establish criteria and procedures for identifying high-risk pregnant and postpartum patients. A statement describing the criteria and procedures shall be on file and shall be provided to the Department on request.

2) The hospital's Perinatal Review Committee, or other committee established for the purpose of internal quality control or medical study for the purpose of reducing morbidity or mortality or improving patient care, shall collect and submit the information required in subsection (b)(1) to the Department. These data will be considered confidential under Section 8-2101 of the Code of Civil Procedure.

c) Identification of Perinatal Patients

1) All Illinois hospitals licensed to provide obstetrical and newborn services shall report information on all perinatal patients. The Department requests, but does not require, reports on perinatal patients from hospitals outside Illinois.(The Department does request reports from the St. Louis APCs or hospitals maintained by the federal government or other governmental agencies within the United States.)

2) Each hospital shall prepare a Perinatal Report record (see Appendix I), to be provided by the Department, for patients meeting one of the following conditions:

A) Live-birth; or

B) Diagnosed prior to discharge from newborn hospitalization as a perinatal or neonatal death.

3) Women who present with spontaneous abortion, ectopic pregnancy or hydatidiform mole are perinatal patients and shall be reported. The products of induced abortions shall not be reported to the State Perinatal Reporting System.

4) Fetal death (gestation greater than 20 weeks) is considered a reportable perinatal outcome. These fetal deaths do not have to be reported through the State Perinatal Reporting System, because they are already reported and compiled in the Department's Vital Records database.

5) Every hospital shall provide representatives of the Department with access to information from all medical, pathological, and other records and logs related to reportable registry information. The mode of access and the time during which this access will be provided shall be by mutual agreement between the hospital and the Department.

6) The State Perinatal Reporting System also will be complemented with information from the Department's Vital Records live birth database under the Vital Records Act, the Adverse Pregnancy Outcomes Reporting System under the Illinois Health and Hazardous Substances Registry Act and other Maternal and Child Health Reports and submissions.

7) The State Perinatal Reporting System consists of two forms of reporting. This reporting shall be on the forms provided by the Department or through electronic means that meets the exact specifications of the Department's data processing system. Complete perinatal reporting information shall be reported to the Department within 14 days after infant discharge, regardless of the method of reporting.

d) Availability of Information

1) The patient and hospital-identifying information submitted to the Department or certified local health department under the Act and this Part shall be privileged and confidential and shall not be available for disclosure, inspection or copying under the Freedom of Information Act or the State Records Act, except as described in this Section. These data shall also be considered confidential under Section 8-2101 of the Code of Civil Procedure.

2) Aggregate summaries and reports of follow-up activities may be provided upon request to hospitals, to APCs, and to the certified local health department designated by the Department to provide follow-up services to the patients. These reports may contain information provided by the referring hospital and information provided by the follow-up certified local health department. Patient or hospital specific data provided to the appropriate designee under this Section are confidential and shall be handled in accordance with the Illinois Health Statistics Act and Section 9 of the Hospital Licensing Act. These data shall also be considered confidential under Section 8-2101 of the Code of Civil Procedure.

3) All reports issued by the Department in which the data are aggregated so that no patient or reporting hospital may be identified shall be available to the public pursuant to Access to Public Records of the Department of Public Health and the Freedom of Information Act.

e) Quality Assurance and Continuous Quality Improvement

1) Reporting entities (i.e., hospitals, certified local health departments and managed care entities (MCEs) shall be subject to review by the Department to assess the timeliness, correctness and completeness of the reports submitted by the entity.

2) Reporting entities (i.e., hospitals, certified local health departments and MCEs shall supply additional information to the Department at the Department's request when additional information is needed to confirm the accuracy of reports previously submitted, or to clarify information previously submitted. The Department will not request data that are more than two years old.

(Source: Amended at 35 Ill. Reg. 2583, effective January 31, 2011)