Neonatal and Maternal Standards of Care

1. Draft Recommendation:
   a. The Division of Health Services Regulation should update the level of care neonatal service definitions ("Level I neonatal service", Level II neonatal service", "Level III neonatal service", and "Level IV neonatal service") in the **North Carolina Administrative Code 10A NCAC 14C. 1401 Criteria and Standards for Neonatal Services** to reflect the most recent Levels of Neonatal Care guidelines set forth by the American Academy of Pediatrics ("AAP"). DHSR should review the AAP Guidelines every 5 years and, if necessary, update the state standards accordingly.
   b. Notes:
      - ~~Include frequency in which they will be reviewed~~
      - Include language from previous recommendation that will allow for updates without having to go through legislation
        - Is this possible??

2. A) Draft Recommendation:
   a. The Division of Health Services Regulation should revise ("high-risk obstetric patients") the **North Carolina Administrative Code 10A NCAC 14C. 1401 Criteria and Standards for Neonatal Services** to include Levels of Maternal Care guidelines set forth by the American College of Obstetricians and Gynecologists ("ACOG") and the Society for Maternal-Fetal Medicine ("SMFM"). DHSR should review the AAP Guidelines every 5 years and, if necessary, update the state standards accordingly.
   b. Notes:
      - ~~Include frequency in which they will be reviewed~~
      - Include language from previous recommendation that will allow for updates without having to go through legislation
        - Is this possible??

   B) Draft Recommendation:
   a. The Division of Health Services Regulation should update the Hospital License Renewal Application under the **Facility Data** headline, **section C – Designations and Accreditations**, to include the following question:

      Does this facility comply with coded Level of Maternal Care guidelines set forth in the NCAC*? Highest Level of Designation met: _____

      **Maternal Service levels are designated in 10A NCAC 14C. 1401*

3. Draft Recommendation:
   a. The Division of Health Services Regulation should update **North Carolina Administrative Code 10A NCAC 14C. 1401 Criteria and Standards for Neonatal Services** to include a definition on birth centers that is consistent with the recommended capabilities of birth centers outlined in the *American College of Obstetricians and Gynecologists and Society for Maternal Fetal Medicine: Levels of Maternal Care* document. Additionally, the definition of birth centers should align with the *American Academy of Pediatrics guidelines* on neonatal care for a level 1 well newborn nursery with the exception that accredited free standing birth centers need to stabilize and provide care to infants born at or after 36 weeks gestation age who remain physiologically stable.

Commented [KJRP1]: Azzie: "10A NCAC 14C .1401 is a Certificate of Need Rule. There are several bills at the legislature that may impact CON. May 2 will probably not be enough time. I will follow up. Thank you."

Commented [KJRP2]: **Letter sent to:**
- Kellett Letson is the current NCOGS President, and his email is kellett.letson@hcahealthcare.com
- Elizabeth Livingston, who is the NCOGS President-Elect, as she was a key player along with me in developing this legislation. Her email is elizabeth.livingston@duke.edu
- Ami Goldstein is the NC ACNM President, and her email is amilenagoldstein@gmail.com
- Representative Greg Murphy, MD is the primary bill sponsor in the House.
- Senator Ralph Hise is the primary bill sponsor in the Senate.

Ami Goldstein Notes:
"I appreciate that you all are taking the time and effort to work on this. I suppose my only question or rather concern is that the birth centers should already be meeting the stated CABC regulations/guidelines. These fall not only within those of a level 1 nursery but in fact are stricter and require transfer earlier than the level 1 nursery. I'm wondering if there would be a way to word this so that it was more along the lines of the CABC regulations within the context both of the levels of care but also for the level 1 nursery. It feels like splitting hairs but the recommendations here really come from three bodies: ACOG, AAP and CABC.
Since CABC has the stricter guidelines it would seem appropriate that this would be included in the language of the bill."

NICU and Maternal Level of Care Verification

Recommendation to: NCHA? NC Birth Center Commission

Recommendation:

Hospitals that provide maternal and neonatal care should establish evaluation teams to review their maternal and neonatal care capabilities. These evaluation teams should include, at a minimum: Ob Provider, Neonatal Provider, OB Manager and Data Manager.

- One function of these evaluation teams will be to work annually with Perinatal and Neonatal Regional Coordinators, utilizing the CDC LOCATe tool to assess their facilities functional/appropriate levels of maternal and/or neonatal care.
- The functional/appropriate level of care (# of neonatal beds at each level and highest level of maternal care) determined by this team shall be the numbers reported on the annual hospital licensure form required by North Carolina.

Birth Centers that provide maternal and neonatal care should establish evaluation teams to review their maternal and neonatal care capabilities. These evaluation teams should include, at a minimum: (*Replace with appropriate professionals*).

- One function of these evaluation teams will be to work annually with Perinatal and Neonatal Regional Coordinators, utilizing the CDC LOCATe tool, to assess their facilities functional/appropriate level of maternal and neonatal care.
- Not on the annual hospital licensure form – so where will this be reported? Licensure act have any language on this?

Recommendation to: NCGA

Recommendation:

The NCGA should legislate and require *external verification* of Level II – Level IV neonatal and maternal beds only.

- Level I Facilities: External Verification will be certified by Perinatal and Neonatal Regional Coordinators
- Level II – IV Facilities: External Verification will be certified by NC Created Group, or the AAP NICU/ACOG LoMC verification programs.
- External Verification for Level II – Level IV facilities will be required to be completed every 3 years

***The highest level of care determined by each facilities evaluation team + perinatal and neonatal regional coordinators, will be utilized to govern whether or not their facility requires an external evaluation.*

Commented [KJRP3]: Add in something about quality improvement development/assessment of regional needs role of this process.

Commented [KJRP4]: 1. Do we want to build as two step rec with volunteer moving to regulatory body over time

2.Steps? Start with self-designation and transition into an external recommendation process

3.Include PHAC/outreach program here to implement regular designation reviews?

Regional Perinatal Centers

Recommendation to: Department of Public Health, Women's and Children's Services Division

Recommendations:

1. DPH-WCSD should develop a map/system that ensures all Birth Centers, and Level I – Level III Neonatal and Maternal Level of Care facilities, are linked with one Level I hospital in the state of North Carolina. These Level IV facilities will be designated as Regional Perinatal Centers by DPH-WCSD if they meet and agree to provide all standards and duties by DPH_WCSD.
2. DPH-WCSD should create standards and duties expected of Regional Perinatal Centers. These standards and duties should include:
    a. The creation of a leadership team composed of, but not limited to, a physician, nurse, social worker who develop and provide education and best practice implementation support to referring hospitals, hospitals within their Medicaid region (i.e. mentorship to lower level hospitals, transport case review) and any other hospitals assigned to them by DPH.
    b. This team will also develop a tool to monitor outcomes from transports that will be utilized when providing training to their hospital and hospitals within the regional center's territory.
    c. Regional Perinatal Leadership teams should meet quarterly to share information with other regional perinatal center leadership teams, and to help shape health priorities

Reasoning:

- Regionalized systems of perinatal care are recommended to ensure that each newborn infant is delivered and cared for in a facility most appropriate for his or her health care needs, when possible, and to facilitate the achievement of optimal health outcomes. (AAP)

Commented [KJRP5]: May be hospital systems in regions where their Regional Perinatal Center is outside the system; this initiative must be built on the foundation of putting the patient(s) first.

An appropriate level of care facility should not be bypassed in an effort to keep the patient in the same hospital system.

Commented [KJRP6]: • Develop form with these standards? What their responsibilities will be if they sign on to be a RPC?

• Is this going to be voluntary – or do we want to make this legislated and add criteria that if you are a Level 4 you are going to be a RPC?

Commented [KJRP7]: Who are the OB & Neo champions?

Regional Perinatal Centers

Recommendation to: Department of Public Health, Women's and Children's Services Division

Recommendations:

3. DPH-WCSD should develop a map/system that ensures all Birth Centers, and Level I – Level III Neonatal and Maternal Level of Care facilities, are linked with one Level I hospital in the state of North Carolina. These Level IV facilities will be designated as Regional Perinatal Centers by DPH-WCSD if they meet and agree to provide all standards and duties by DPH_WCSD.
4. DPH-WCSD should create standards and duties expected of Regional Perinatal Centers. These standards and duties should include:
    a. The creation of a leadership team composed of, but not limited to, a physician, nurse, social worker who develop and provide education and best practice implementation support to referring hospitals, hospitals within their Medicaid region (i.e. mentorship to lower level hospitals, transport case review) and any other hospitals assigned to them by DPH.
    b. This team will also develop a tool to monitor outcomes from transports that will be utilized when providing training to their hospital and hospitals within the regional center's territory.
    c. Regional Perinatal Leadership teams should meet quarterly to share information with other regional perinatal center leadership teams, and to help shape health priorities

Commented [KJRP8]: • Develop form with these standards? What their responsibilities will be if they sign on to be a RPC?

• Is this going to be voluntary – or do we want to make this legislated and add criteria that if you are a Level 4 you are going to be a RPC?

Commented [KJRP9]: Who are the OB & Neo champions?

Reasoning:

- Regionalized systems of perinatal care are recommended to ensure that each newborn infant is delivered and cared for in a facility most appropriate for his or her health care needs, when possible, and to facilitate the achievement of optimal health outcomes. (AAP)
- South Carolina Language:
    - *Perinatal Regionalization provides for a statewide system development of a regional cooperative, cohesive and structured risk-appropriate approach to perinatal care for all pregnant women and infants. Each RPC must provide professional expertise, communication, coordination and education. Key system components include Regional System Development, Obstetric Outreach Education, Neonatal Outreach Education, Transport Coordination, Back-Transports, Consultation and Follow-up with Referring Physicians and Hospitals, and Data Collection and Evaluation. Each RPC is contracted by the SC Department of Health & Environmental Control (DHEC) to provide the above services and grant funding is provided for the most part by the state, with a small portion of federal funds. Quarterly Reports are required with specific detailed transport & education components.*

Recommendation to: **DPH? NCHA? Both?**

Recommendation:

Each regional perinatal center should have a perinatal and neonatal outreach coordinator. The roles and duties of the Perinatal and Neonatal regional outreach coordinators will be set forth by the DPH. The following should be included:

- Regional Coordinators will develop and foster relationships between regional perinatal centers and referring hospitals/providers, including referring hospitals located outside of North Carolina
- Regional Coordinators will be responsible for planning and facilitating **outreach education** between regional perinatal centers and the lower level of care facilities assigned to their regions.
    - Outreach Education includes:
        - Best practices/Rehearsed transfer patters
- Regional Coordinators will work with each facilities evaluation team, in their region, to guide their level of care designation through the utilization of the CDC LOCATe tool.
- Regional Coordinators from across the state will convene **quarterly?** to review, share and assess all neonatal and maternal transfer cases. This will allow for best practices to be shared, but also a review of transfers that ended with negative outcomes.

*Job duties and responsibilities will be completely outlined in Regional Coordinator contracts

Commented [KJRP10]: SC has a "Regional Manager" at each RPC as well. Would we want to add this 3rd role, or just have one person that would head the Org chart of all Perinatal & neonatal Outreach coordinators?

Someone to focus the initiatives, compile the data – be a program manager.

South Carolina Neonatal and Perinatal Outreach Coordinator Job Structure:

- Prisma Health Richland is the RPC for the 16 counties in the Midlands Region and we have 11 referral delivering hospitals. My OB Outreach Educator, Michelle Flanagan, and my Neo Outreach Educator, Cathy White, both work 32 hours/ week, exclusively for Perinatal Systems. They are Prisma Health employees, salaries are paid through the DHEC grant, and they report to me.
- In addition to their Core education classes (see attached brochure), we also hold an annual Midlands Perinatal Conference, hold on-site educational offerings as requested, and provide education in conjunction with our MFM & the Simulation Center team for the Birth Outcomes Initiative SimCOACH™ on-site visits to the Midlands delivering hospitals. There were a total of 50 educational offerings and 823 professionals educated during this past fiscal year.
- We maintain a fairly extensive database of all of the OB and Neo transports to Prisma Health Richland and send brief Admission and D/C Summaries to the referral physicians and hospitals.
- The Perinatal Systems office also receives consultation requests from the region in the form of requests for Education, Resource, Research, Protocol, Quality Initiative, and Patient Safety. There were 221 consultation requests last fiscal year.

Recommendation to: DPH, NCHA, Payers, GA?

Recommendation:

Funding for Perinatal and Neonatal Regional Outreach Coordinators should be sustainable and come from Medicaid, other 3rd party payers, DPH, Regional Perinatal Centers and/or the GA.

Regional Perinatal Centers:

- ACOG Level IV [Required] Capabilities:
    - *"Perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region, and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement as part of collaboration with lower-level care facilities in the region."*
    - *"Community outreach and data analysis and evaluation will require additional resources in personnel and equipment within these facilities."*
- AAP Level IV [Required] Capabilities:
    - *"Facilitate transport and provide outreach education."*
    - *"Regional organization of perinatal health care services requires that there be coordination in the development of specialized services, professional continuing education to maintain competency, facilitation of opportunities for transport and back-transport, and collection of data on long-term outcomes to evaluate both the effectiveness of delivery of perinatal health care services and the safety and efficacy of new therapies. These functions usually are best achieved when responsibility is concentrated in a single regional center with both perinatal and neonatal subspecialty services."*

DPH:

- CA – Uses Title V MCH Grant; possibility to re-allocate any of these funds to Perinatal and Neonatal Regional Outreach Coordinators?

Medicaid:

- Over 50% of births in NC are Medicaid Births

3rd Party Payers:

- Medicaid Transformation

GA:

- Funded Perinatal and Neonatal Outreach Coordinator pilots
- Use reports//available data to recommend a funding of all regions

DHHS Create Perinatal Advisory Committee

- Hospital System Representative
- Include nonhospital system representatives i.e. consumers, community based organizations.
    - Etc. – did one of the other states have a list of included people?
- Include: purpose, type of members, who is financially responsible for it – Medicaid 50/50 match as a potential starting point? Mix of hospitals, Medicaid, etc.