

Guidelines for *Perinatal Services*



8th Edition

Iowa Department of Public Health

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GUIDELINES FOR PERINATAL SERVICES

EIGHTH EDITION, 2008

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II. PREFACE

This document represents the Eighth Edition of what formerly was called *Standards for Perinatal Centers*. Since then, the name has changed to *Guidelines for Perinatal Services*, because use of the term “standards” connotes an inflexibility of application that is not intended. As noted in the preface to an earlier edition, so-called standards that apply to major urban areas are not always practical in rural America. Unfortunately, when a bad outcome occurs and litigation ensues, the differences between urban and rural are frequently ignored. These guidelines are not meant to hold Iowa hospitals and Iowa perinatal professionals to an impractical ideal.

Although the *Guidelines for Perinatal Services* are clearly not intended to serve as standards, they do specify particulars when feasible. For example, specification of a designated level of care for a hospital should be clearly evident from the descriptions. In this regard, one of the changes from the earlier editions is a broader designation of levels of care. This was done to empower hospitals rather than to restrict them.

In the past, the Perinatal Guidelines Advisory Committee chose to keep the designation of levels of care as simple as possible, i.e., Levels I, II, and III. Levels II and III were designated only if the hospital was a referral center. All other hospitals were designated as Level I facilities. During the 1997 revision, the committee thought this approach was no longer reasonable. As a result, levels of care were designated by the functional capacity of the hospital. Thus, it may be possible to have a number of Level II and Level III perinatal centers in one city.

The Committee is very much aware of the need for organization of limited resources in a rural state. Accordingly, the *Guidelines for Perinatal Services Eighth Edition*, is designed to encourage and support the presence of a Level II Regional Center and Level II Regional Neonatal Centers where the area is not populous enough to support a Level III perinatal center.

This Eighth Edition also includes the new provisions from *Iowa Code Chapter 141 A* governing HIV testing during pregnancy which took effect on July 1, 2007.

The members of the Perinatal Guidelines Advisory Committee are commended and thanked for generously sharing their time and talent to compile the *Guidelines for Perinatal Services*. The contributions of the Committee, ex officio members as well as the Iowa Department of Public Health staff, were invaluable. A list of the committee members may be found on page v.

Comments or questions regarding the *Guidelines for Perinatal Services* may be addressed to:

Perinatal Guidelines Advisory Committee
Iowa Department of Public Health
Bureau of Family Health
321 East 12th Street, Lucas Building
Des Moines, Iowa 50319-0075
Telephone: 1-800-383-3826

Sincerely,



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The Perinatal Guidelines Advisory Committee would like to acknowledge the following individuals for their dedication and generous contributions of time and talents to the development of this Eighth Edition of the *Guidelines for Perinatal Services*.

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IV. BACKGROUND

A. History

In 1973, the Iowa Statewide Perinatal Care Program began under the auspices of the Regional Medical Program and the University of Iowa.

Iowa's first neonatal intensive care unit opened in Dubuque in 1971. This unit, located at Mercy Medical Center, was the result of private efforts representing Dubuque's entire medical community. Soon thereafter, in 1973, the Iowa Statewide Perinatal Care Program began under the auspices of the Regional Medical Program and the University of Iowa.

In 1974, the Regional Medical Program was incorporated into a joint Maternal and Child Health Program at the Iowa Department of Public Health and the University of Iowa. This statewide program continued to evolve through the joint efforts of the Iowa Department of Public Health and the University of Iowa.

The perinatal team of the Iowa Statewide Perinatal Care Program visited every hospital with an obstetrical service in Iowa during the first two years of the project. The information gained through these hospital visits identified those hospitals which could serve, or were already in the process of serving, as Level II Centers of care. With the assistance of the perinatal team, hospitals which had expanded their services were recognized by the Iowa Statewide Perinatal Care Program. Current level designation of hospitals in Iowa with an Obstetrical Service may be found on the Iowa Department of Public Health Web site: www.idph.state.ia.us/hpcdp/statewide.perinatal.care.asp, or by calling 1-800-383-3826 .

These guidelines were specifically created to address hospitals with obstetrical and neonatal services. They do not include hospitals that do not participate in obstetrical care and non-hospitals are not covered in these guidelines.

B. Process for Level Designation

In 1998, Iowa Administrative Code officially established the Iowa Regionalized System of Perinatal Health Care.

In 1977, the Iowa Department of Public Health established an Advisory Committee for Perinatal Standards which formulated the first edition of *Standards for Perinatal Centers*. A process for designation of centers was developed by this and subsequent standards committees. In 1998, the *Iowa Administrative Code* (Chapter 641, Section 150) established the Iowa Regionalized System of Perinatal Health Care, which defines the purpose and function of regionalized perinatal care for the state.

The issue of designation of level of care is potentially contentious and requires further clarification of the intent of designation. The primary purpose of designation is to ensure Iowa perinatal patients receive appropriate care as close to their homes as possible. In an ideal situation, no community hospital

would be more than 50 miles from a perinatal center. Unfortunately, Iowa's low population density precludes this. Accordingly, Iowa developed a network of regional perinatal centers. Based on well-documented outcome statistics, this system has served the state very well.

Currently, many physicians and hospitals are operating in an environment quite removed from the era when the *Standards for Perinatal Centers* were first offered to the state. Now, physicians do not always have a choice of hospitals when admission is required. Rather, they are encouraged to admit to the hospital specified by the patient's health insurance policy. This may serve the patient's needs very well if the care available at the hospital is appropriate, but that is not always the case. Because of health insurance changes and because the state's rural character has not changed, the committee continues to strongly support the concept of regionalized perinatal services for Iowa.

The intent of *Guidelines for Perinatal Services* is to assure that when a hospital markets itself at a particular level of perinatal care, it is capable of providing that care. The public is entitled to know the level of functioning. A hospital having determined to participate in the regionalized system of perinatal care shall comply with the guidelines appropriate to the level of participation selected by the hospital and approved by the advisory committee for perinatal guidelines. The statewide parental health care program shall also perform periodic on-site verification surveys of established perinatal service programs to verify the continued ability of each hospital to meet the criteria for the level of designation selected by the hospital. The results of each survey shall be submitted to the Department, along with a recommendation to continue, suspend, or revoke the hospital's certification of verification. The *Guidelines for Perinatal Services* provides the framework to be used in defining and evaluating the level of perinatal services being offered.

In metropolitan areas, where Level III Centers are found, the natural evolution of competition is such that multiple centers can and will exist. The indigenous and referral bases are sufficient to warrant more than one Level III Center in these cities. In less populous communities, the referral resources will continue to be lower-level hospitals and centers.

Review and evaluation of a hospital's established or developed perinatal service program cannot be made without consideration of available resources sufficient to support that service at the level of designation being sought. Questions to ask may include:

- Are there sufficient numbers of transports to justify the need for another neonatal transport team?
- Does the community have sufficient pediatricians to adequately staff two neonatal intensive care centers?

These are only two illustrations of the many issues that will be considered in determining the appropriateness of a request.

The following steps describe the process for a hospital to be reviewed for a new designation:

1. Submit the following information to the Perinatal Guidelines Advisory Committee:
 - a) Description of the geographic area to be served
 - b) Identification of the target population to be served
 - c) Identification of Level I Hospitals to be served

- d) Identification of any overlap with existing higher level hospitals and/or centers
- e) Identification of unmet needs of the area to be served
- f) Demonstration of the ability to meet the most recent perinatal guidelines

2. Mail the package to: Perinatal Guidelines Advisory Committee
 Iowa Department of Public Health
 Bureau of Family Health
 321 East 12th Street, Lucas Building
 Des Moines, Iowa 50319-0075

Upon receipt of the information, the hospital's request will be reviewed by the Statewide Perinatal Care Program team members and the Perinatal Guidelines Advisory Committee to determine if all guidelines are met.

C. Regulatory Considerations

EMTALA regulations and interpretative guidelines relating to women in labor apply to all levels of hospitals.

EMTALA REGULATIONS

The Perinatal Guidelines Advisory Committee is aware of active enforcement of the Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA) law. EMTALA regulations and interpretative guidelines relating to women in labor apply to all levels of hospitals. Since 1986 the federal government enacted legal requirements detailing how Medicare-participating hospitals with emergency services must handle clients with emergency medical conditions or women who are in labor. Regulations relating to patient screening and transfer have undergone numerous changes since 1986.

They may be referenced in the following documents:

- the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA)
- related regulations at 42 CFR 489.24 and 42 CFR 489.20 (l)(m)(q)(r) and its related amendments
- the Social Security Act, section 1866, Agreements with Providers of Services, 42 U.S.C. §1395cc
- the Social Security Act, section 1867, Examination and Treatment for Emergency Medical Conditions and Women in Labor, 42 U.S.C. §1395dd
- Centers for Medicare and Medicaid Services position of the Born-Alive Protection Act as it relates to EMTALA. The Survey and Certification letter, S&C-05-26, can be found at the following Web site:

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf>

Hospitals must be aware of the requirements that pertain to EMTALA regulations.¹

For questions or further information, please contact:

Iowa Department of Inspections and Appeals
321 East 12th Street, Lucas Building
Des Moines, Iowa 50319
Telephone: (515) 281-4115

¹ American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2002). *Guidelines for Perinatal Care (5th Edition)*. Elk Grove Village, 2002, pgs 369-375 or <http://www.cms.hhs.gov/EMTALA/>

V. IOWA'S REGIONALIZED PERINATAL HEALTH SYSTEM

A. Purpose

This Guidelines for Perinatal Services addresses how various Iowa hospitals relate to the regionalized system and suggests a level of functioning which should identify the role each hospital plays in the system.

Iowa's regionalized perinatal health system helps practitioners in rural Iowa to rapidly access specialty services for their patients even though such services may not exist in the local community. This is predicated on several factors, including the willingness of certain hospitals in moderate-to-large Iowa cities to provide specialty services and the presence of a functional system of patient transportation.

This *Guidelines for Perinatal Services* addresses how various Iowa hospitals relate to the regionalized system and suggests a level of functioning which should identify the role each hospital plays in the system.

The following pages present a description of the levels of care among Iowa perinatal hospitals. The levels are as follows:

- Level I Hospital
- Level II Hospital
- Level II Regional Center
- Level II Regional Neonatology Center
- Level III Center

To be effective, the system must have complete cooperation. For example, although Level III Perinatal Centers will assist with responsibility for coordinating transfer of patients among the hospitals, each hospital with transport capability must be willing to assist when the transport capabilities of the Level III Perinatal Centers are overtaxed. This situation has happened in the past. However, the emergence of managed care networks could draw allegiances away from the state system and into a more restricted regional focus. The Iowa Department of Public Health recognizes its responsibility for monitoring changes in the health care delivery system and preserving the capabilities of the regionalized perinatal system for all Iowans

B. Level I Hospitals

DEFINITION

Level I Hospitals provide basic inpatient care for pregnant women and newborns without complications; manage perinatal emergencies, including neonatal resuscitation; provide leadership in early risk identification before and after birth; seek consultation or referral for high-risk patients; and provide public and professional education.¹

FUNCTIONS

Level I Hospitals have a family-centered philosophy regarding sibling visitation. Parents have reasonable access to their newborns 24 hours a day within all functional units and are encouraged to participate in the care of their newborns. Generally, parents can be with their newborns in the mother's room. Noninfectious siblings may visit in the mother's room or in a designated space.²

Level I Hospitals have the capability to:

- Provide surveillance and care of all patients admitted to the obstetric service with an established triage system for identifying high-risk patients who should be transferred to a facility that provides Level II or higher care, prior to delivery
- Provide proper detection and supportive care of unanticipated maternal-fetal problems that occur during labor and delivery
- Perform emergency cesarean sections as soon as possible after the decision to do the operation has been made
- Provide transfusions of blood and fresh frozen plasma on a 24-hour basis
- Provide anesthesia, pharmacy, radiology, respiratory support, electronic fetal heart-rate monitoring, and laboratory services on a 24-hour basis
- Provide care of postpartum conditions
- Evaluate the condition of healthy neonates and their continuing care until discharge
- Resuscitate all neonates using the neonatal resuscitation program guidelines as established by the American Heart Association/American Academy of Pediatrics
- Stabilize all neonates, including unexpectedly small or sick neonates, before transfer
- Consult and arrange transfers in conjunction with the obstetrician, pediatrician or neonatologist at the referral center
- Maintain a nursery for normal term or near-term newborns

PHYSICAL FACILITIES

Physical facilities for perinatal care in hospitals should be conducive to care that meets the normal physiologic and psychosocial needs of mothers, neonates, fathers, and families. Special facilities should be available when deviations from the norm require uninterrupted physiologic, biochemical, and clinical observations of patients throughout the perinatal period. Labor, delivery, and newborn care facilities should be located contiguously.

The following recommendations are intended as general guidelines and are meant to be flexible enough to meet local needs. It is recognized that individual limitations of physical facilities for

perinatal care may impede strict adherence to the recommendations. Furthermore, not all hospitals will have all the functional units described. Provisions for individual units should be consistent within the framework of a regionalized perinatal care system and the state and local public health regulations.³

For more specific guidelines for new construction or remodeling, refer to the current edition of *Guidelines for Construction and Equipment of Hospital and Medical Facilities*. To order this book or request a catalog, call The American Institute of Architects Press in Washington, D.C. at 1-800-365-2724 or visit the Web site at <http://www.archINFORM.net/info/index.htm>.

Obstetric Functional Units

Labor

Areas used for women in labor are equipped with the following components:

- Adequate space for support persons, personnel, and equipment
- Adequate ventilation and temperature control
- A labor or birthing bed
- A storage area for the patient's clothing and personal belongings
- Adjustable lighting that is pleasant for the patient and adequate for examinations
- An emergency signal and an intercommunication system
- A sphygmomanometer and stethoscope
- Mechanical infusion equipment
- Fetal monitoring equipment
- Oxygen, ventilation bag and mask and suction outlets
- Access to at least one shower for use of labor patients
- Storage facilities for supplies and equipment

Delivery

Delivery rooms should be close to the labor rooms in order to afford easy access and to provide privacy to women in labor. A waiting area for families should be adjacent to the delivery suite, and restrooms should be located nearby.

Traditional delivery rooms and cesarean birth rooms are similar in design to operating rooms. Vaginal deliveries can be performed in either room, whereas cesarean birth rooms are designed especially for that purpose and are thus larger. Each type of birthing room is well lighted and environmentally controlled to prevent chilling of the mother and neonate.

It is desirable that cesarean deliveries be performed in the obstetric unit. However, if this is not possible due to cost and space, equipment for neonatal stabilization and resuscitation must be available during delivery.

