

DSHS Grand Rounds

November 2

Caring for our Most Vulnerable: Levels of Neonatal Care

Presenter:

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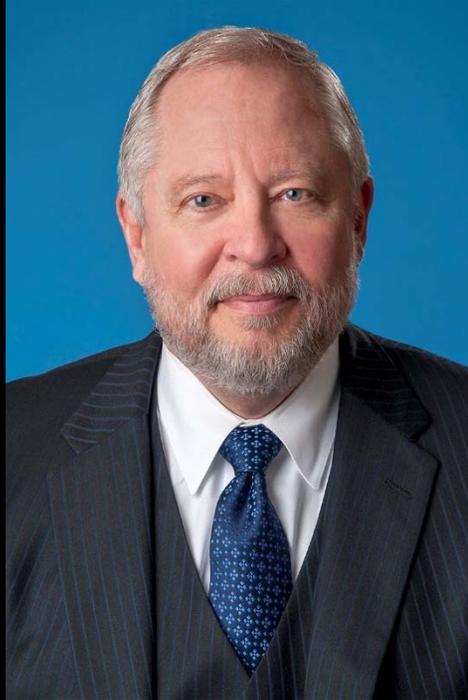
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Peer-reviewed Literature

1. American Academy of Pediatrics, Committee on Fetus and Newborn. Levels of neonatal care. *Pediatrics*. 2012 Sep; 130(3):587-97.
2. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village, IL: American Academy of Pediatrics and the American College of Obstetricians and Gynecologists; 2012.
3. Health and Human Services Commission. Perinatal Advisory Council, Report on Determinations and Recommendations. September 2016. Austin, TX : Health and Human Services Commission.
4. Lasswell SM, Barfield WD, Rochat RW, Blackmon L. Perinatal regionalization for very low-birth-weight and very preterm infants: a meta-analysis. *JAMA*. 2010 Sep 1; 304(9):992-1000.
5. Neonatal Intensive Care Unit Council. Annual Report. January 2013. Austin, TX : Health and Human Services Commission.



John Hellerstedt, MD
DSHS Commissioner

Introductions

John Hellerstedt, MD
DSHS Commissioner is pleased to
introduce our DSHS Grand Rounds speakers

Caring for Our Most Vulnerable: Levels of Neonatal Care



Eugene C. Toy, MD

Assistant Dean for Educational Programs, and Professor and Vice Chair of Medical Education, Department of Obstetrics and Gynecology, University of Texas Medical School at Houston

Working Together for our Most Vulnerable: Neonatal Levels of Care

Eugene C. Toy, MD
DSHS Grand Rounds
Austin, Texas
Nov 2, 2016



Disclosures

- **No relevant financial relationships with commercial interests related to the content of this presentation.**

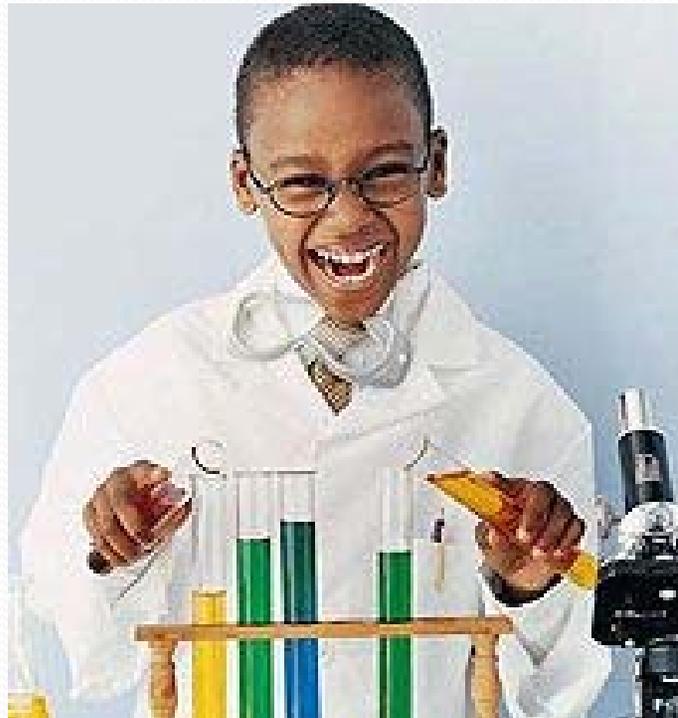




Objectives

- **Describe the scientific basis and evidence for designated neonatal levels of care**
- **Describe the basis of neonatal levels of care in Texas**
- **Apply the neonatal levels of care requirements to one's own hospital setting to improve the quality of care**
- **Describe the state designation process in Texas**

Part I: The Scientific Evidence for Neonatal Levels of Care



Neonatal Levels of Care

- **Concept since 1970's**
- **Well defined regional centers of neonatal ICU's provide best outcomes**
 - **For very low birth weight (VLBW [< 32 wks, <1500g])**
 - **Infants with complex problems**
 - **Place units in strategic locations to best serve the community (about 2-3% of births)**
 - **Concentrate expertise in these areas**

Causes of Infant Death in US 2011

Causes (8 of top 10)	%
Congenital malformations, deformations, chromosomal abnormalities	20.8
Disorders related to short gestation and low BW	17.2
Newborn affected by pregnancy complications	6.6
Newborn affected by complications of placenta, cord and membranes	4.1
Bacterial sepsis of newborn	2.2
Respiratory distress of newborn	2.1
Diseases of the circulatory system	2.1
Neonatal hemorrhage	1.9

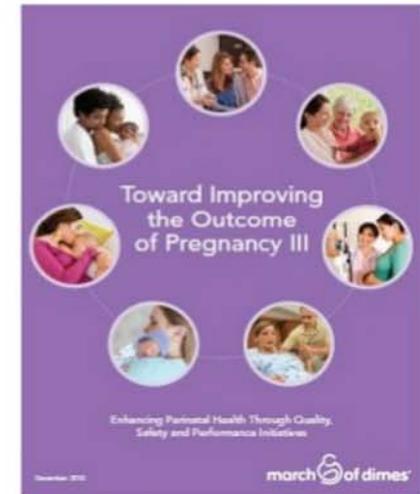


Levels of Neonatal Care

- General principles – continued
 - Each newborn should be delivered and cared for in a facility most appropriate for his or her needs
 - Further definitions of facility level should include requirements for equipment, personnel, ancillary services, training, and organization (including transport)

TIOP III: Regionalization Is Critical To Improved Perinatal Outcomes

- Organizes a coordinated continuum of perinatal services within a geographic area
- Increases survival of high risk newborns
- Concentrates relatively rare cases at a few locations
- Centralizes expensive technologies
- Provides opportunities for clinical teams to develop expertise

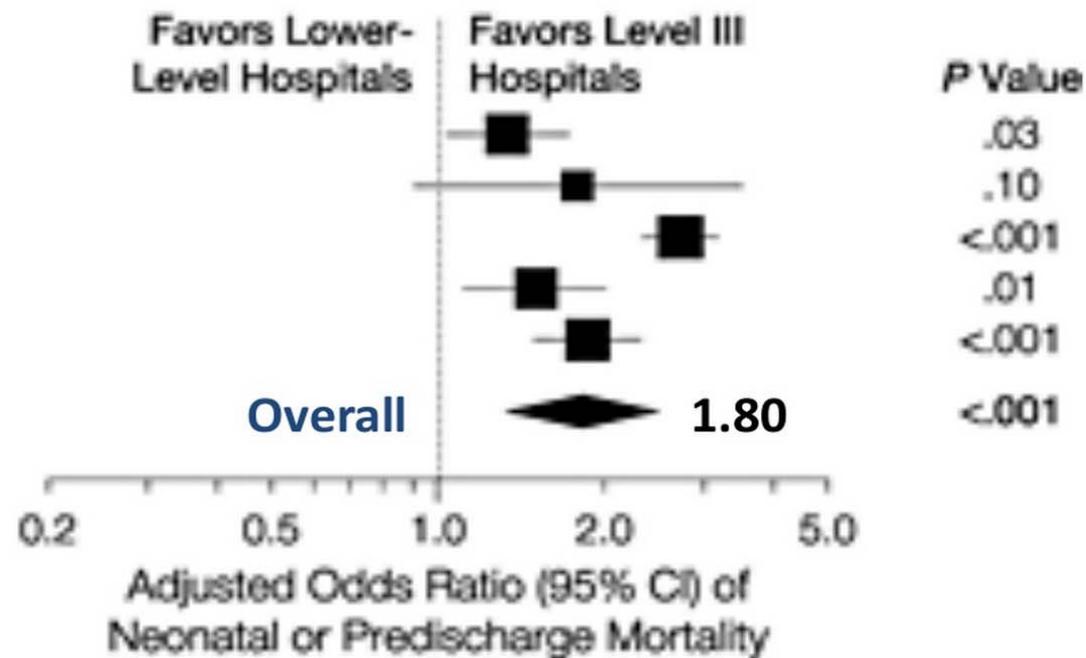




Preterm Infant Mortality is Increased by Birth Outside of Level III Hospital

- Review of 41 US and non-US studies from 1976 to 2010 – 104,944 very low birthweight infants
- **Risk of death is greater for infants born outside of level III hospitals**
 - VLBW (≤ 1500 g) infants (37 studies)(38 vs 23%)
 - OR 1.62, 95% CI 1.44-1.83
 - ELBW (≤ 1000 g) infants (4 studies)
 - OR 1.64 95% CI 1.14-2.36
 - Very Preterm (≤ 32 weeks) infants (4 studies)
 - OR 1.55, 95% CI 1.21, 1.98
- **No changes over 30 year period**

Extremely Low Birth Weight Mortality is Increased by Birth Outside Level III Hospital (59 vs 32%)



Lasswell S. JAMA 2010;304:992



Other Factors May Affect Outcome

- NICU volume - experience
- Obstetric characteristics – antenatal steroids
- Nursing staff
- Race or health insurance status
- Surveillance – how do we measure?
- Approach to aggressive resuscitation
- Congenital anomalies – typically not counted
- Practice issues

Risk of VLBW Mortality by NICU Level and Annual Volume

NICU Level	Volume	Odds Ratio (95% CI)
1	≤10	2.72 (2.37-3.13)*
	>10	2.39 (1.91-3.00)*
2	<10	2.53 (2.02-3.18)*
	11-25	1.88 (1.56-2.26)*
	>25	1.22 (0.98-1.52)
3A	≤25	1.69 (1.28-2.24)*
	26-50	1.78 (1.35-2.34)*
	>50	1.08 (0.96-1.21)*
3B,3C, 3D	51-100	1.19 (1.04-1.37)*
	>100	1.00 Reference

48,237 infants 1991-2000, no anomalies Phibbs CS N Engl J Med 2007; 356:2165

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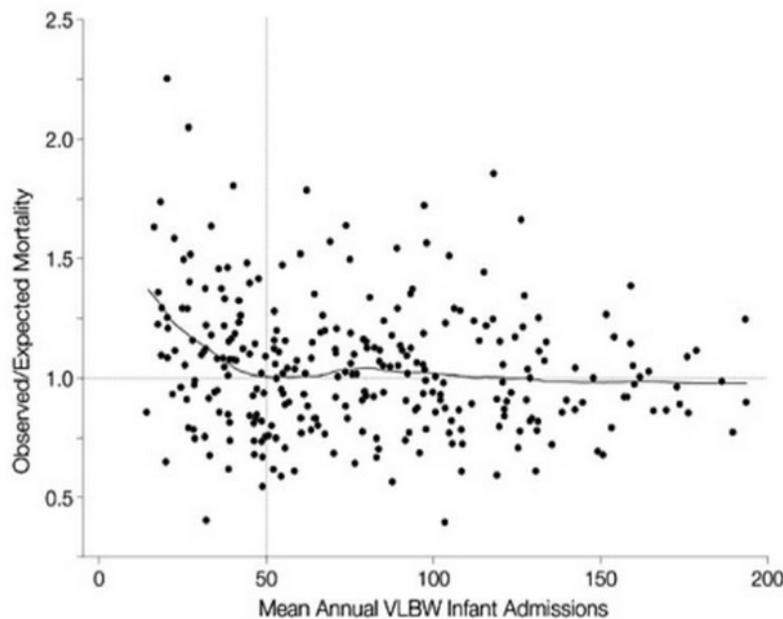
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Patient Volume Only Partly Explains NICU Quality

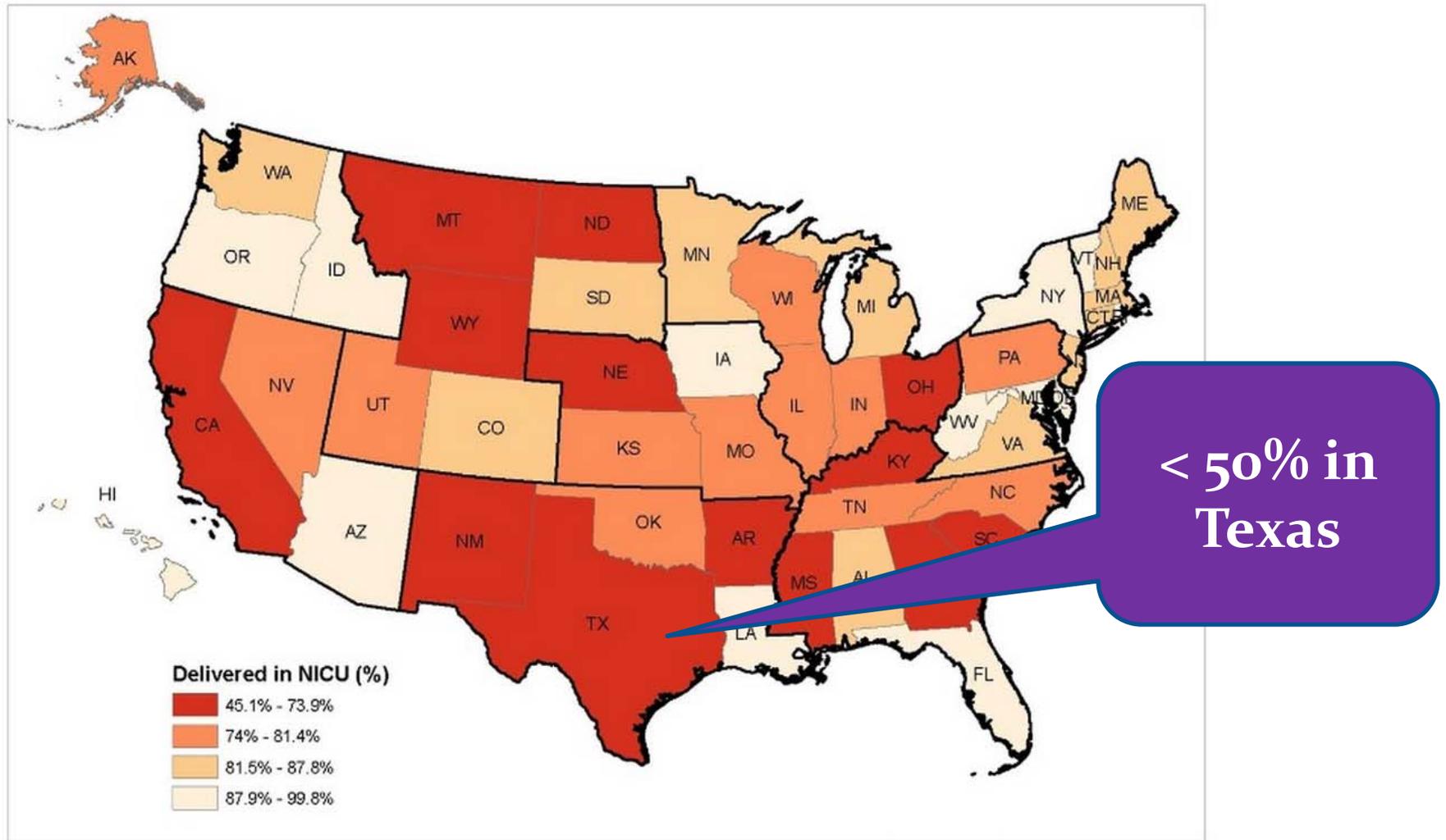
Mean standardized mortality ratio
(observed/expected deaths)



94,110 VLBW infants born
in 332 Vermont-Oxford
Network hospitals with
NICUs, 1995-2000

Volume of admissions
explained only 9% of
variation in mortality
rates, 7% other factors

Percent of VLBW Infants Delivered at Hospital with Level III NICU

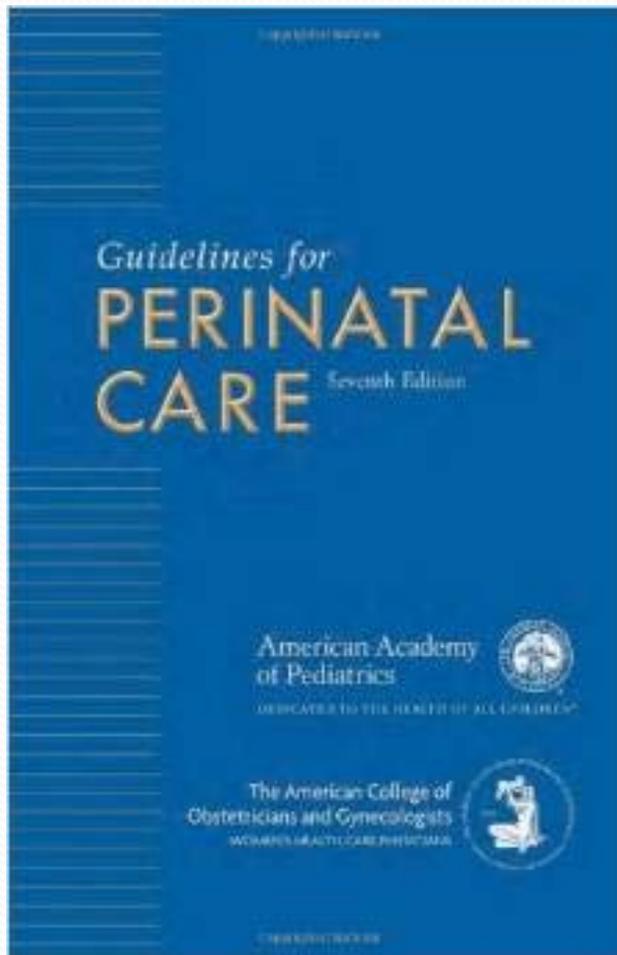


Source: MCHB, Title V Information System, 2009

National Observations

- Proliferation of NICU's without consistent relationship to high risk infants delivered
- Proliferation of small NICUs in same region as large NICUs
- Failure of states to reach Healthy People 2010 goal of 90% of VLBW infants delivered in level III units
- **BOTTOMLINE:** More money for lesser outcomes
- **AAP Response:** Simplify to 4 levels and eliminate Level III subcategories

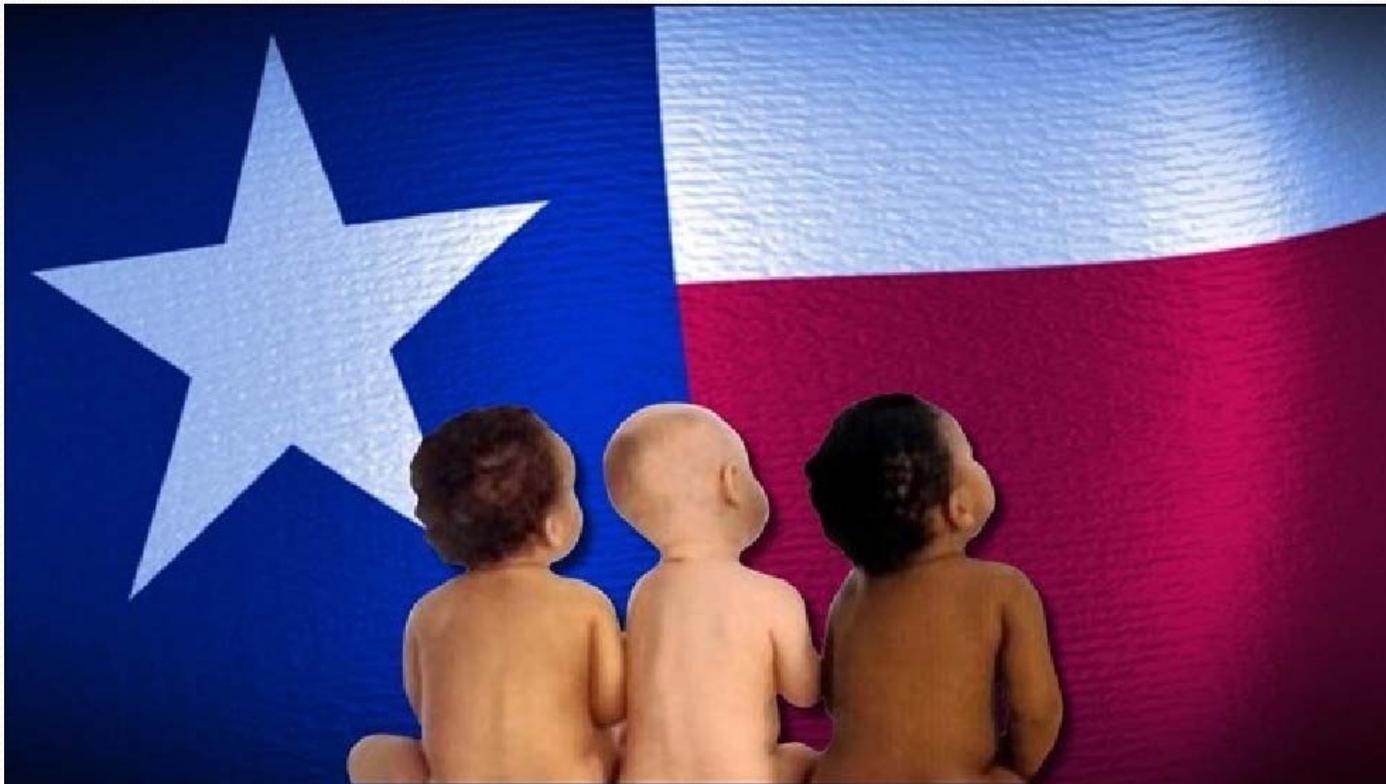
GUIDELINES FOR PERINATAL CARE 7TH EDITION (2012)



Neonatal Levels of Care (2012)

- **Level I – uncomplicated newborns, ≥ 35 weeks**
- **Level II – newborns > 32 weeks, 1500 g, need ventilatory support less than 24 hours**
- **Level III- newborns all gestational ages, complicated problems, access to specialist consultation**
- **Level IV- most complex, surgery for complicated congenital conditions**

Part II: Basis of Neonatal Levels of Care in Texas



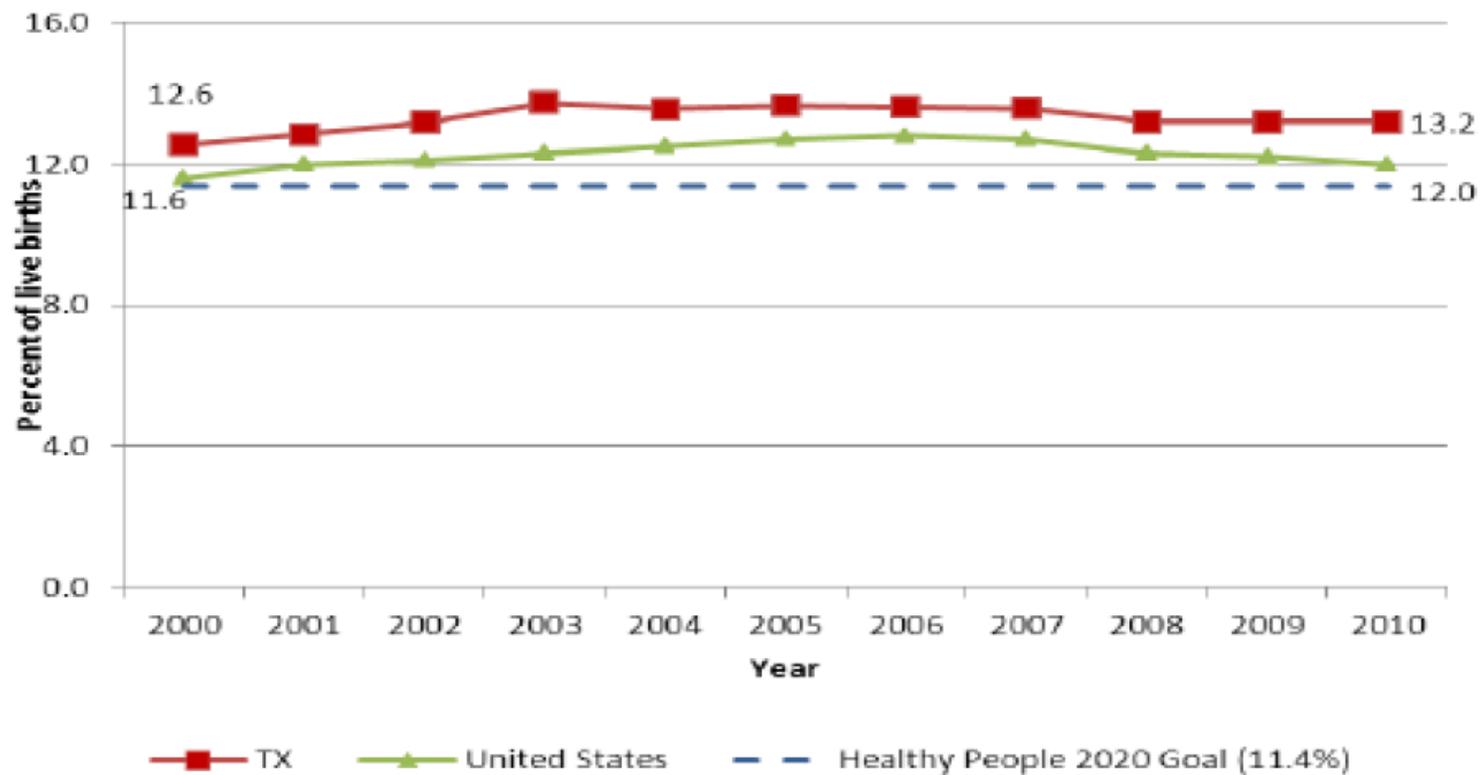
NICU Council (2012-2013)

- **HB 2636 (82 R) - Charge: Develop accreditation for NICU's, best practices and cost containment**
- **Implementation**
 - **Transparency – meetings open**
 - **Prioritizing patient quality**
 - **It's about the babies & pregnant moms!!**
 - **Evidence based**
 - **Listening to each other**
 - **Open to input**
 - **Developing consensus**
 - **Credibility**



Preterm Birth Rates

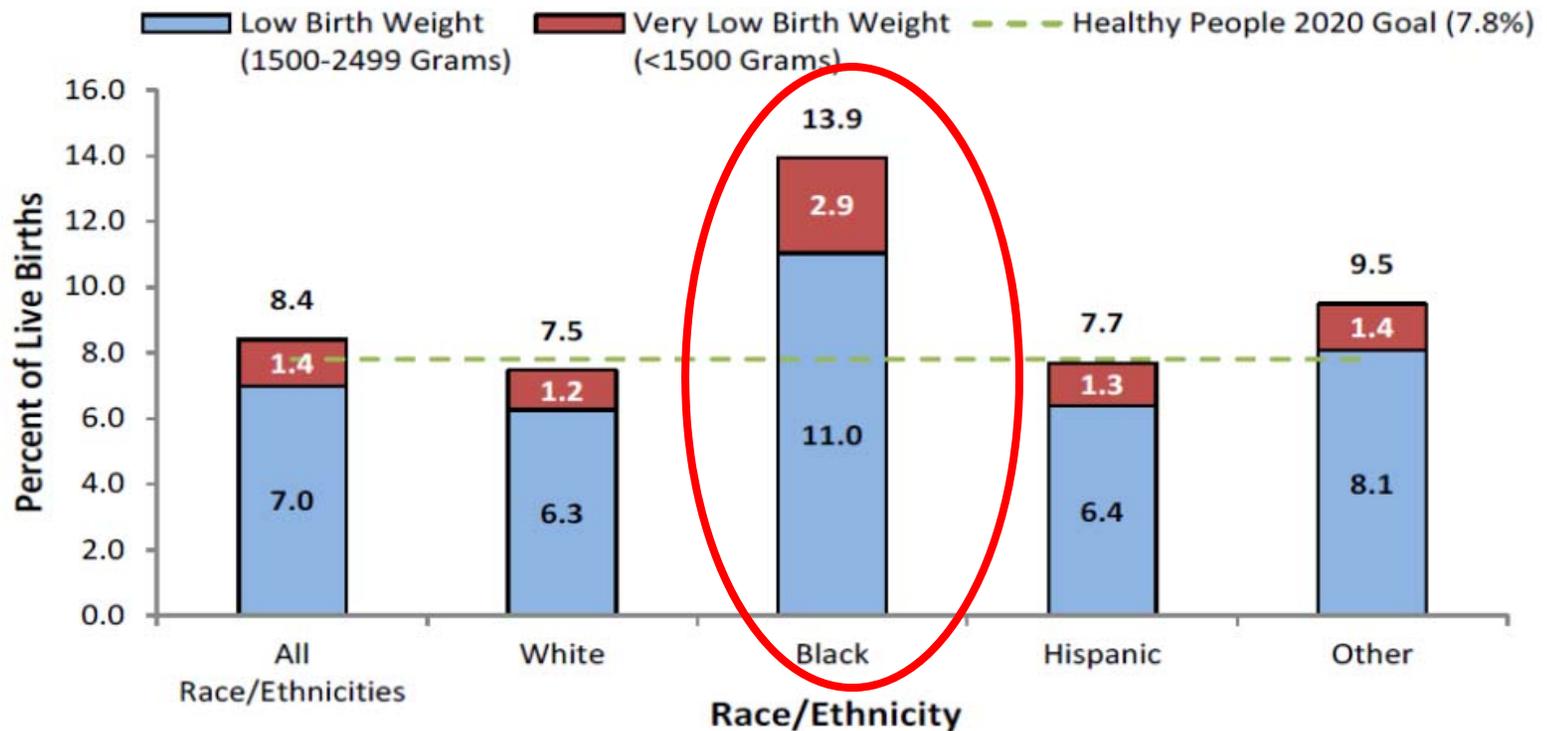
Figure 2 . Preterm Births for United States and Texas, 2000-2010



Source: Healthy Texas Babies Report, 2011.

Low BW by Race (Texas)

Figure 3 Low Birth Weight Births by Race/Ethnicity – Texas, 2010



Source: Texas DSHS 2011.

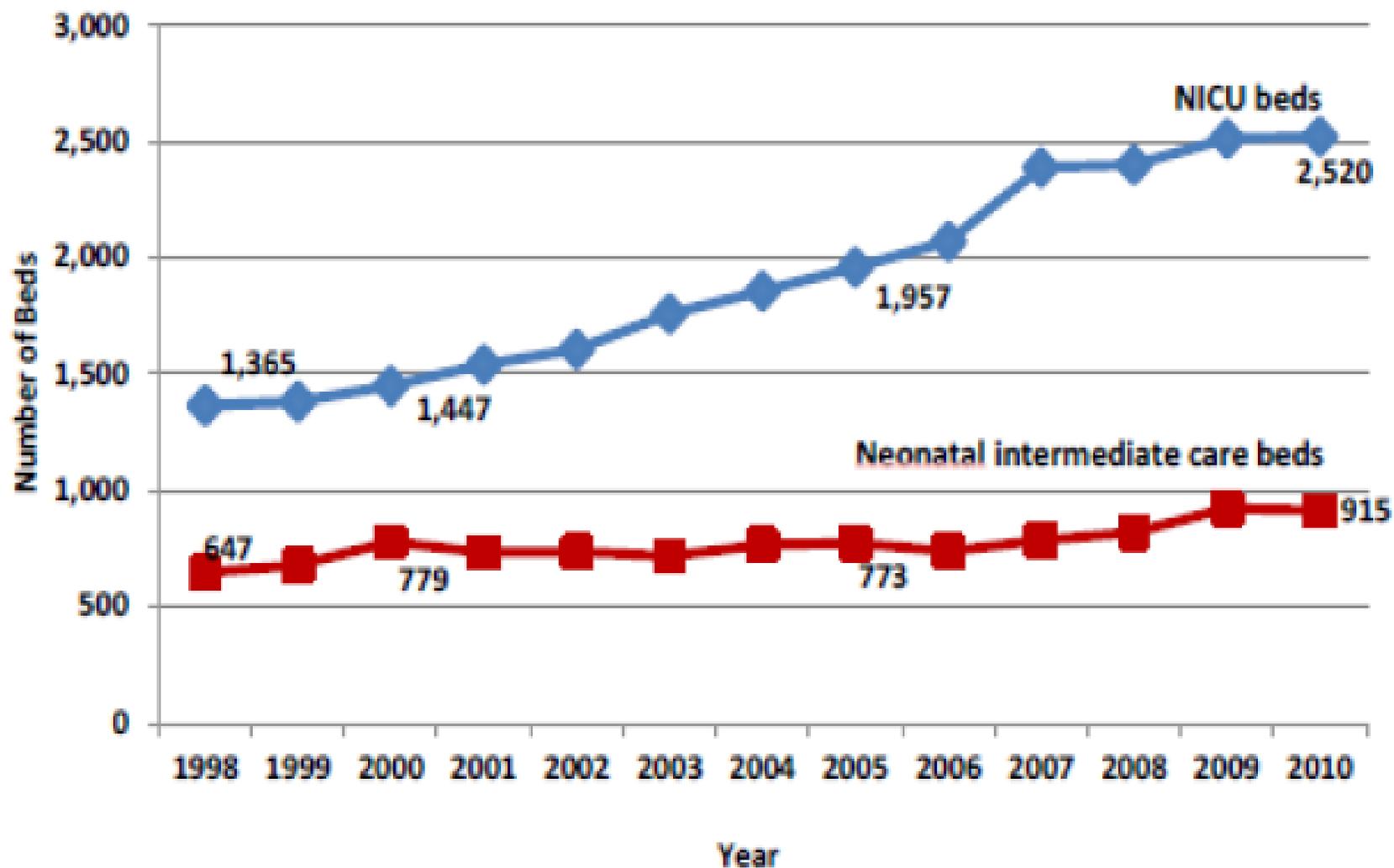
VLBW vs NICU Numbers

Table 2. Births, VLBW numbers, and NICU beds from 2000 to 2010

Category	2000	2010	Percent change
Total Births	363,300	385,700	6.2%
VLBW	4808	5400	12.3%
NICU (Level III) Beds	1447	2520	74.2%

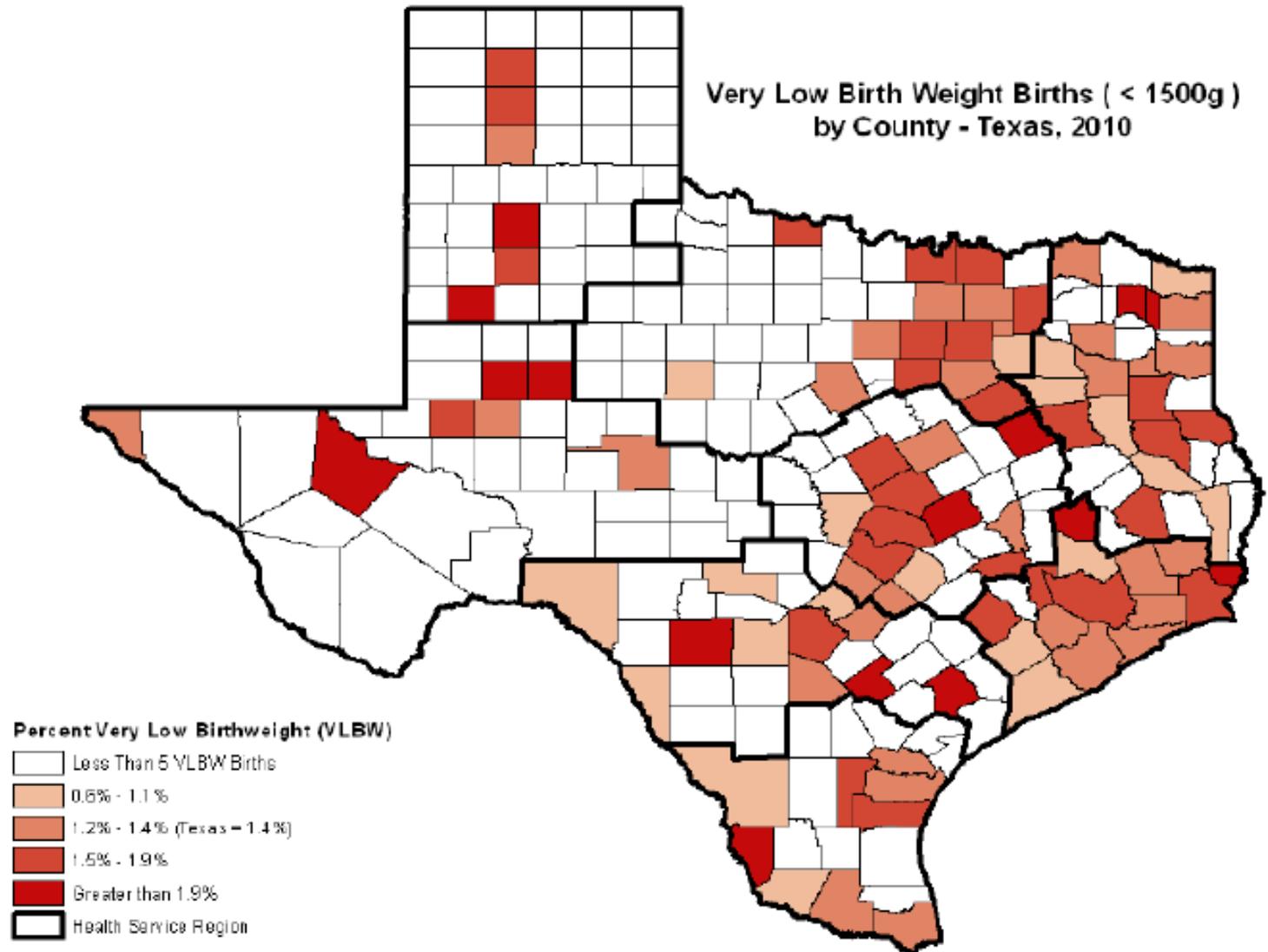
Source: Healthy Texas Babies Report, 2011; Dr. Rebecca Martin DSHS Report, 2012.

Figure 6 Number of Self-Reported NICU and Neonatal Intermediate Care Beds, Texas, 1998-2010



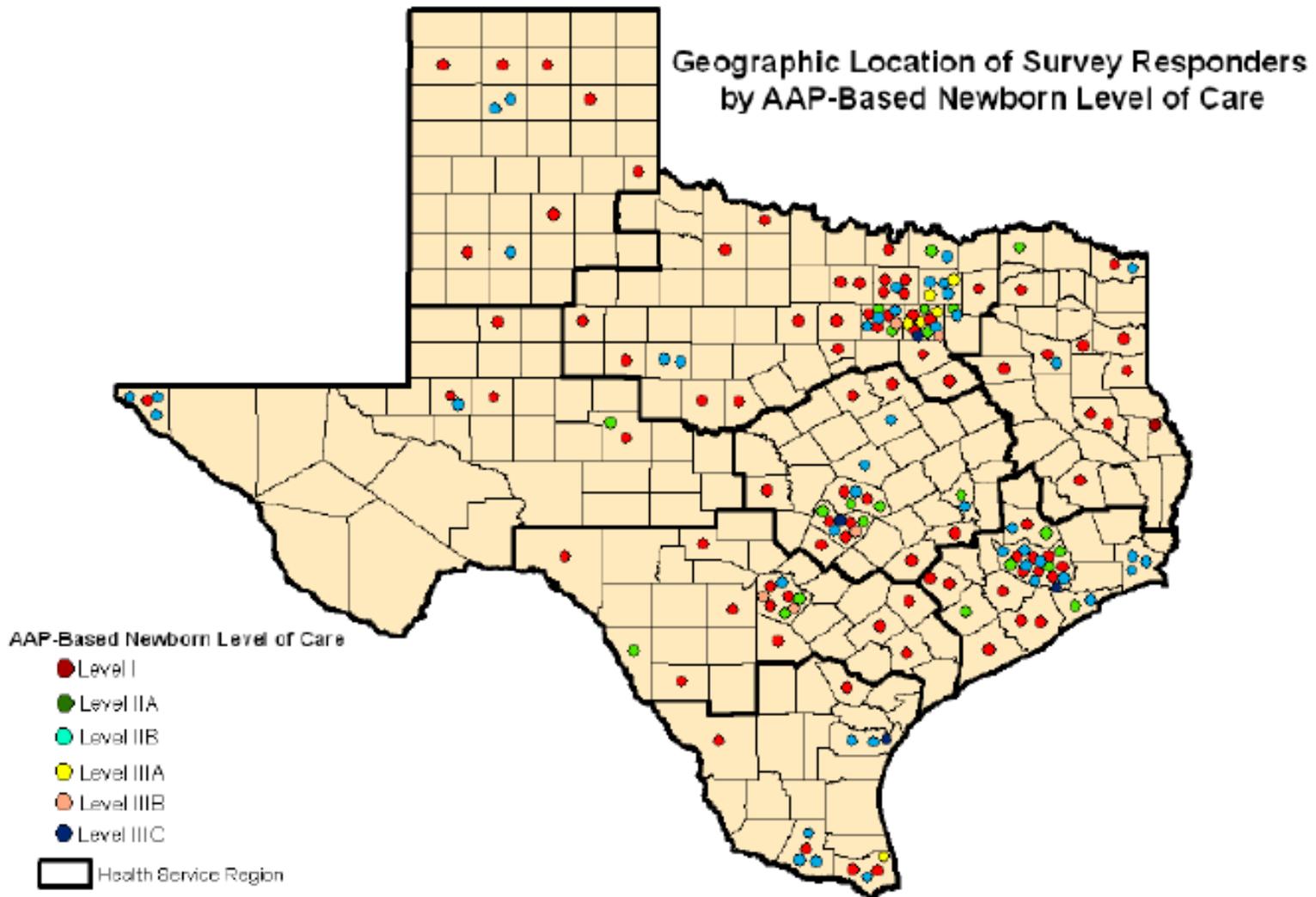
Source: Healthy Texas Babies Report, 2011

Figure 7 Very Low Birth Weight Births by County – Texas, 2010



Source: Texas Vital Statistics Natality File, 2010, Texas Department of State Health Services
Prepared by: DSHS, Family and Community Health, Office of Program Decision Support, 04/23/2012

Figure 8 Geographic Location of Hospitals by AAP-Based Level of Care



Source: OPDS Newborn Level of Care Survey 2012

Prepared by: Texas Department of State Health Services, Family and Community Health - Office of Program Decision Support - 09/05/2012

Texas

- **More than half of VLBW babies being delivered in non-level III/IV facility**
- **Texas much worse than national average**
- **Hospital “self designation” by state survey found to be inaccurate 30-40% of time**
- **Bottomline: “It’s about our babies”**



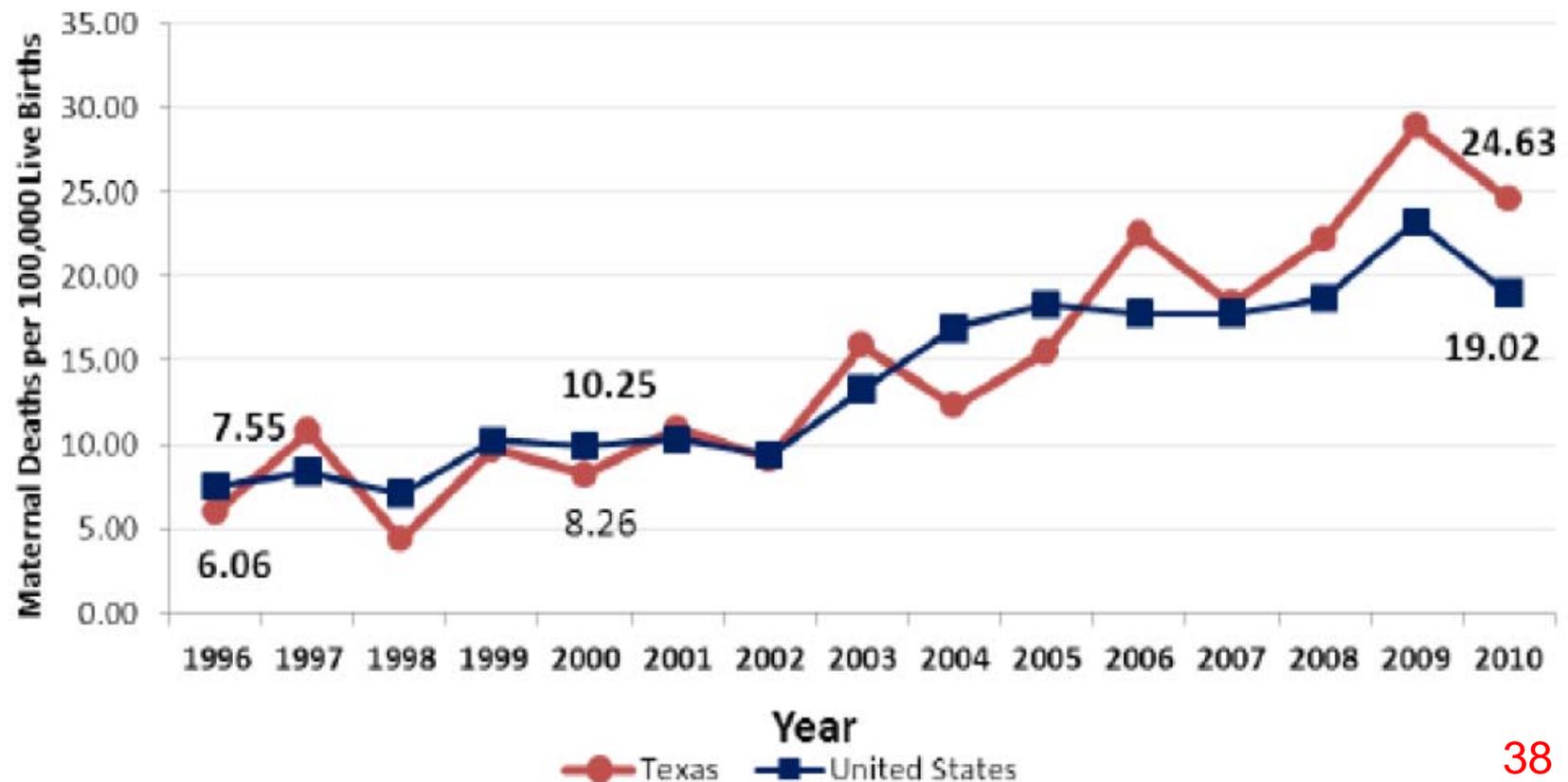


Texas: It's also about our moms!

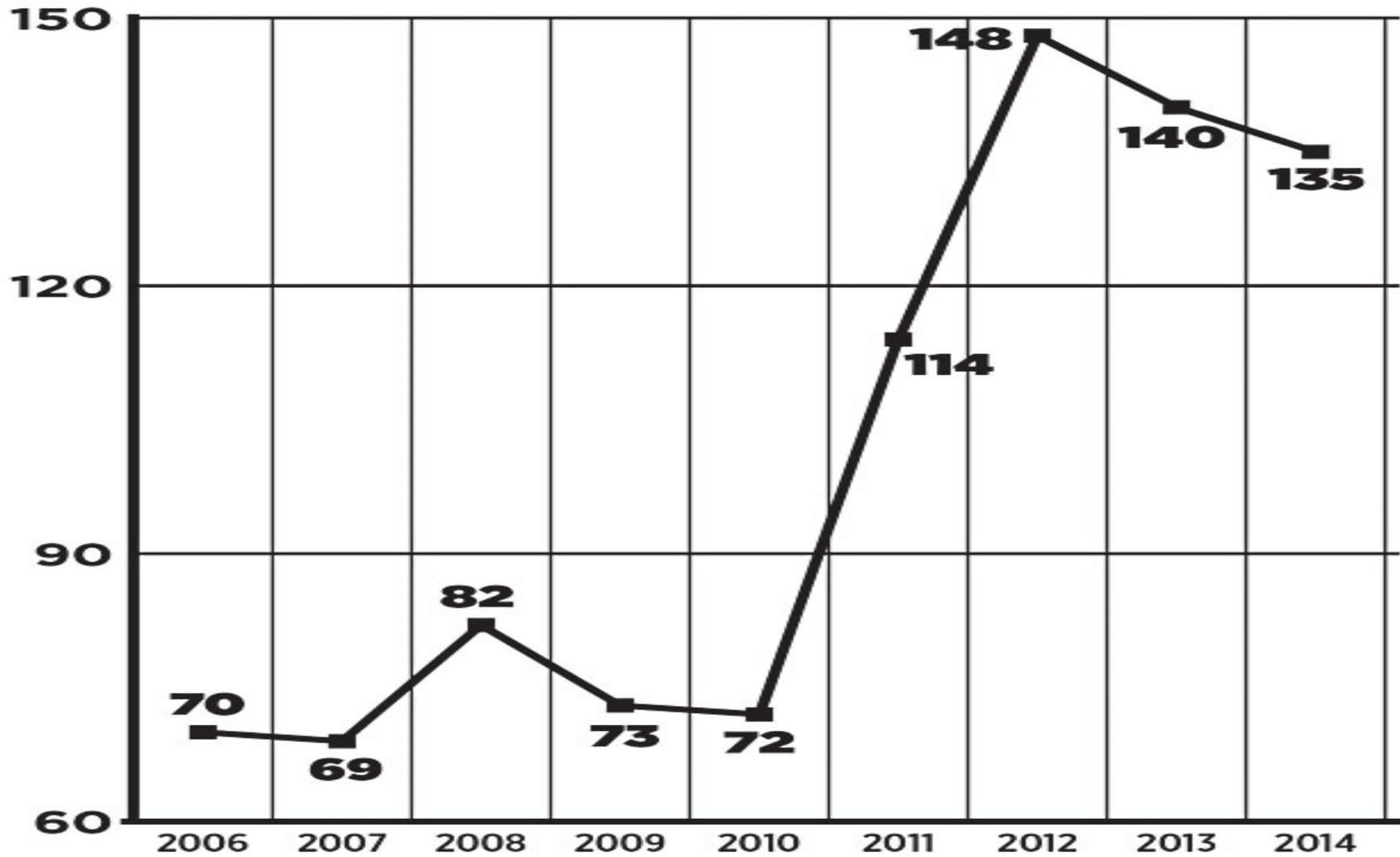
- **Beginning to recognize the increase in maternal mortality**
- **Understanding that to have a healthy baby, we need a healthy mom!**
- **Transfer of a pregnant woman to the right facility at the right time**

Maternal Mortality: ↑ 3x in 12 yrs

Figure 1 Maternal Mortality Ratio, United States and Texas, 1996-2010



Maternal Deaths in Texas, 2006-2014





www.hhsc.state.tx.us/reports/2013/NICU-council-report.pdf

**Neonatal Intensive Care Unit Council
Annual Report**

**As Required by
H.B. 2636, 82nd Legislature,
Regular Session, 2011**

**Health and Human Services Commission
January 2013**



NICU Council Recommendations

- 1. Recommend a Perinatal Council to develop designation process for both maternal and neonatal levels of care.**
- 2. Work together with DSHS to develop these designation criteria.**
- 3. Levels of care should be based on national standards and evidence.**
- 4. Develop a regional coordination and collaboration (but not affect transfers).**

Texas Perinatal Advisory Council

- HB 15 (83 R) authorized a state perinatal designation process for maternity and neonatal care
- Collaborative process of physicians, nurses, hospitals, and other stakeholders





Perinatal Council Philosophy

- **Each hospital can strive for the level of care it desires (no certificate of need)**
- **Each hospital works out its own transfer agreements (but look out for patients!)**
- **Even playing field – big city hospitals or academic hospitals not to make rules to dominate, take unfair advantage**
- **Look out for rural areas**



Taking Right Approach

- **Decisions through consensus**
 - **Stakeholder input**
 - **Sounding board**
 - **Allowing for abundant discussion**
 - **Prioritization for patients**
 - **Expanded to maternity standards**
 - **Statewide designation**
 - **Broad support, expanded representation**

TimeLine

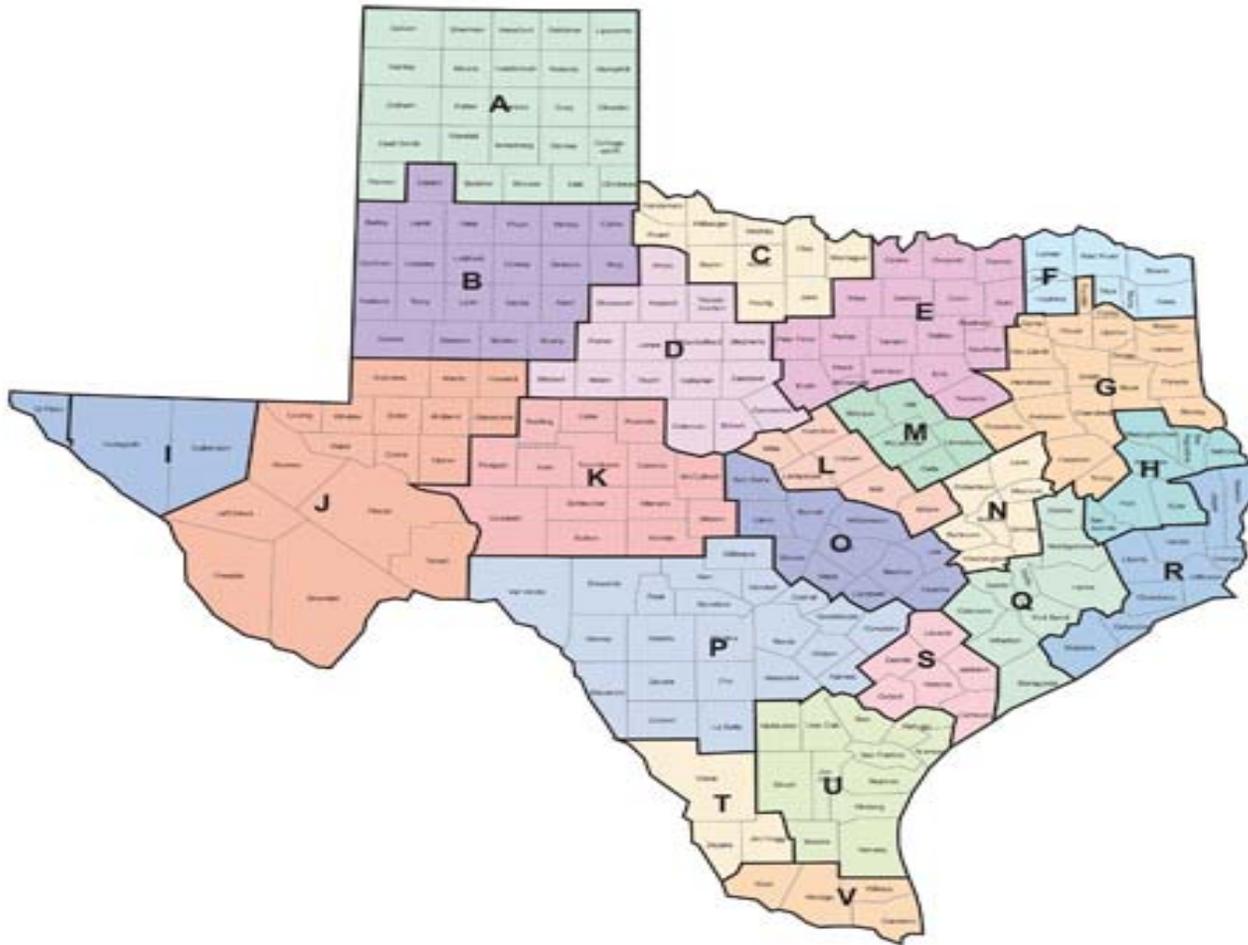
- From NICU Council (2012-13) recommended
- To Perinatal Advisory Council (2014-)
- HB15 (83rd Legislative Session)
 - Specifies Neonatal Levels of Care Designation by Sept 1, 2017 for Medicaid payments **(to 2018)**
 - Specifies Maternity Levels of Care Designation by Sept 1, 2019 for Medicaid payments **(to 2020)**
 - Divide state into regions (Regional Advisory Councils)
 - Transfer agreements

HB3433 (84th Leg Session)

Add 2 additional rural rep to Council

Add 1 year to Neo and Mat deadline (to 2018, and 2020)

Perinatal Regions: Same as Current Trauma Regions





**Perinatal Advisory Council
Report on Determinations and
Recommendations**

**As Required By
H.B. 15, 83rd Legislature (Regular Session, 2013) and
H.B. 3433, 84th Legislature (Regular Session, 2015)**

**Health and Human Services Commission
September 2016**

Neonatal Rules Filed June 3, 2016:

www.sos.state.tx.us/texreg/pdf/backview/0603/0603prop.pdf

ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 1. AGENCY ADMINISTRATION SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §1.6

The Texas Higher Education Coordinating Board (Coordinating Board) adopts amendments to §1.6 concerning Advisory Committees without changes to the proposed text as published in the February 12, 2016, issue of the *Texas Register* (41 TexReg 1083). Specifically, the amendment to §1.6(g) provides a nomination process for non-higher education institutional representatives on certain Coordinating Board advisory committees. This section is also amended to specify that the Board may replace a member who becomes unassociated with the nominating institution or entity.

There were no comments received concerning these amendments.

The amendments are adopted under the Texas Government Code, Chapter 2110, which provides the Coordinating Board with the authority to create advisory committees.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 17, 2016.

TRD-201602402

Bill Franz

General Counsel

Texas Higher Education Coordinating Board

Effective date: June 6, 2016

Proposal publication date: February 12, 2016

For further information, please call: (512) 427-8114

19 TAC §1.18

The Texas Higher Education Coordinating Board (Coordinating Board) adopts amendments to §1.18 concerning the status of the Education Research Center Advisory Board as a governmental body without changes to the proposed text as published in the February 5, 2016, issue of the *Texas Register* (41 TexReg 886). Specifically, the amendments to this section add Texas Education Code, §1.006(b), where the Education Research Center Advisory Board is considered to be a governmental body.

There were no comments received concerning the amendments to this section.

The amendments address the changes to Texas Education Code, §1.006(b), as amended by Senate Bill 685, 84th legislature.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 17, 2016.

TRD-201602403

Bill Franz

General Counsel

Texas Higher Education Coordinating Board

Effective date: June 6, 2016

Proposal publication date: February 5, 2016

For further information, please call: (512) 427-8114

SUBCHAPTER E. STUDENT COMPLAINT PROCEDURE

19 TAC §§1.110, 1.113 - 1.115

The Texas Higher Education Coordinating Board (Coordinating Board) adopts amendments to §§1.110, 1.113, 1.114, and 1.115 concerning the Student Complaint Procedure without changes to the proposed text as published in the February 12, 2016, issue of the *Texas Register* (41 TexReg 1084). The amended rules clarify and update the procedures for filing a student complaint against an institution of higher education. The new language provides for the use of a more efficient online student complaint form, updates the mailing address for complaints mailed to the Agency, and specifies that the evaluation of a student's academic performance is under the sole purview of the student's institution and its faculty.

There were no comments received concerning the amendments to these sections.

The amendments are adopted under the Texas Education Code, §81.031, which provides the Coordinating Board with the authority to adopt rules for handling student complaints concerning higher education institutions.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on May 17, 2016.

TRD-201602404

Part III: Neonatal LOC to One's Own Hospital to Improve Quality





Level I (Well Born Nursery)

- **The Level I neonatal designated facility will throughout the continuum, provide care for mothers and their infants of ≥ 35 weeks gestational age who have routine, transient perinatal problems; have skilled personnel with documented training, competencies and continuing education specific for the patient population served.**

Level II (Special Care Nursery)

- **Care for infants ≥ 32 wks GA and BW ≥ 1500 grams with physiologic immaturity or problems expected to resolve rapidly & not anticipated to require subspecialty services on urgent basis;**
- **May provide assisted ventilation on interim basis until infant's condition soon improves or infant can be transferred to a higher-level facility; delivery of CPAP should be readily available by experienced personnel, and mechanical ventilation can be provided briefly (< 24 hours);**
- **Have skilled personnel with documented training, competencies and continuing education specific for the patient population served.**



Level III

- **Care for mothers and comprehensive care of their infants of all gestational ages with mild to critical illnesses or requiring sustained life support;**
- **Access for consultation to a full range of pediatric medical and surgical subspecialists, and the capability to perform major pediatric surgery onsite or at a closely related institution by prearranged consultative agreements, ideally in geographic proximity;**
- **Have skilled personnel with documented training, competencies and continuing education specific for the patient population served;**
- **Facilitate transport and provide outreach education.**



Level IV (Advanced NICU)

- **Provide comprehensive care for infants of all gest ages with mild to complex medical problems, or requiring sustained life support;**
- **Comprehensive range of pediatric medical and surgical subspecialists immediately available for consultation;**
- **Capability to perform major pediatric surgery including the surgical repair of complex congenital or acquired conditions (eg, congenital cardiac malformations that require cardiopulmonary bypass with or without ECMO).**



Level IV (Advanced NICU)-2

- **Have skilled personnel with documented training, competencies and continuing education specific for patient population served; facilitates transports and provides outreach education to lower level designated facilities.**
- **Stand-alone children's hospitals that do not provide obstetrical services are exempt from obstetrical requirements.**



Examples:

Level I Neonatal Quality Indicators

- **Number of VLBW born in facilities**
- **Perinatal death rate**
- **Other ideas**
 - **Transfers and outcomes**
 - **Perinatal complications**
 - **Readmissions**
 - **% breast-fed**



Examples:

Level II Neonatal Quality Indicators

- **Number of VLBW born in facilities**
- **Perinatal death rate**
- **Fraction/number admitted to level II nursery**
- **Other ideas**
 - **Transfers and outcomes**
 - **Perinatal complications**
 - **Readmissions**
 - **% breast-fed**
 - **Developmental follow-up**



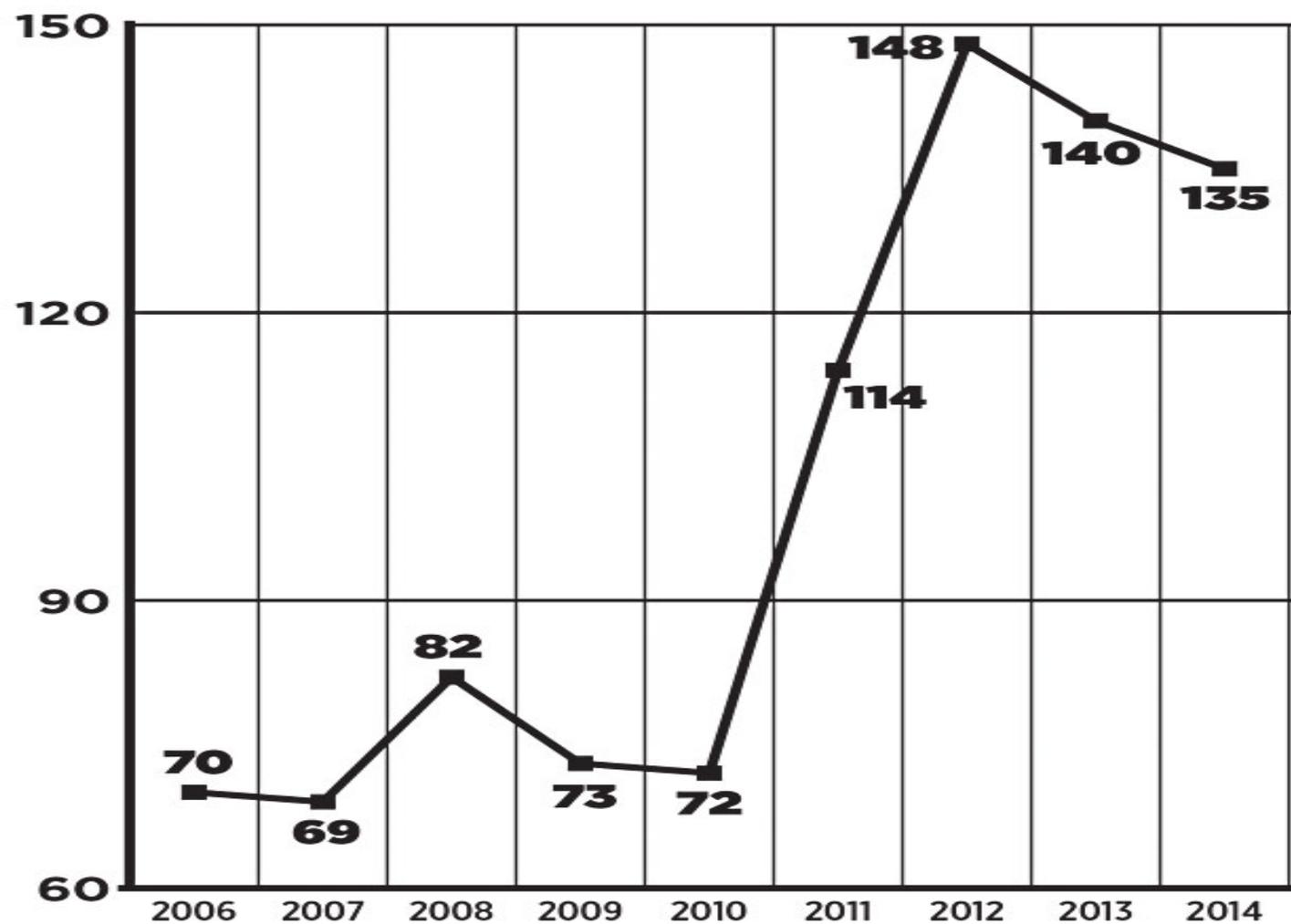
Examples:

Level III/IV Neonatal Quality Indicators

- **Number of VLBW born in level III/IV facilities**
- **Perinatal death rate**
- **Transfers out and outcomes**
- **Some other ideas:**
 - **Chronic lung disease**
 - **Intraventricular hemorrhage**
 - **Nosocomial infection**
 - **Hearing loss**
 - **Severe retinopathy of prematurity**

MATERNAL MORTALITY IN TEXAS

Maternal Deaths in Texas, 2006-2014





Maternal Quality: Maternal Mortality & Serious Morbidity

- Each hospital and each region should review how to monitor and improve its maternal complications
- Recall causes of maternal death in TX
 - #1: Cardiac
 - #2: Opioid overdose
- Work on guidelines for hypertension in pregnancy
- Guidelines for PP hemorrhage

Part IV: Texas' Neonatal Designation Process





How Does State Designation Work?

- **Each hospital that provides neonatal and/or maternity care will need to undergo state designation process to receive Medicaid funds**
- **Neo designation by Sept 1, 2018**
- **Maternity designation by Sept 1, 2020**



What Is Involved in Designation?

- **Hospitals will need to ensure they meet the requirements for the level of care they seek**
- **Submission to state: application, policies (QI, triage, transfer, etc.), ID key personnel**
- **Site visit for levels 2, 3, 4**
 - **Level 1 = no site visit needed**
- **State will approve or not approve application (duration = 3 yrs)**



Who Regulates Designation?

- **The Dept. of State Health Services (DSHS) Office of Trauma developing rules and process**
 - Same place as trauma and stroke designation
- **Health and Human Services Commission (HHSC) Perinatal Advisory Council**
 - 19 member appointed committee (2 rural reps) makes recommendations to DSHS
 - Physicians, nurses, hospital administrators

Is Designation Optional?

- **Yes, but hospital requirement for Medicaid funds**
- **Neonatal and maternity designation is governed by statute (HB 15 from 83R legislative session; and HB3433 from 84R)**
- **The designation will be housed in Title 25, Chapter 133 of Texas Administrative Code (Hospital Licensing)**

How Will Designation Affect Me?

- All hospitals providing Neo or OB services will need state designation for Medicaid funding
- QI process a strong part of designation process



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Neonatal System Development



The purpose of the Neonatal Levels of Care Designation is to comply with House Bill 15, 83rd Legislature, Regular Session, 2013, which added Health and Safety Code, Subchapter H, Hospital Level of Care Designations for Neonatal and Maternal Care, Sections 241.181 - 241.187. House Bill 3433, 84th Legislature, Regular Session, 2015 amended Health and Safety Code, Chapter 241 requires the development of initial rules to create the neonatal / maternal level of care designation by March 1, 2018. Currently only the neonatal level of care designation rule has been developed and is in the rule adoption process, expected to become effective on or about May 20, 2016. The designation for neonatal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2018.

Neonatal Designation Applications Now Available

Rule

The neonatal designation rule, effective June 9, 2016 is found at the Texas Administrative Code, [Title 25, Chapter 133, Subchapter J](#)

Related Programs

Survey Sites

[American Academy of Pediatrics NICU Verification Program](#)

[TETAF NICU Services and Consultation](#)

Resource Documents

Provider training webinars were held throughout the month of June for introduction and review of the new requirements. Recordings of the training are listed below. Each link will take you to a page where you must enter your name and email address to access the video.

Webinar recordings:

[Level I Designation – June 13, 2016](#)

[Level II Designation – June 14, 2016](#)

[Level III and IV Designation – June 16, 2016](#)

[Level III and IV Designation – June 20, 2016](#)

[Level I Designation – June 21, 2016](#)

[Level II Designation – June 24, 2016](#)

[View System Requirements](#)

PowerPoint presentations from webinars:

[Level I PowerPoint presentation](#)

[Level II PowerPoint presentation](#)

[Level III PowerPoint presentation](#)

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Advanced

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- Texas EMS & Trauma Registries
- Reference Center**
- Apply Online
- DSHS Regulatory Philosophy (40kb pdf)

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Neonatal System Development

Sign up for e-mail updates

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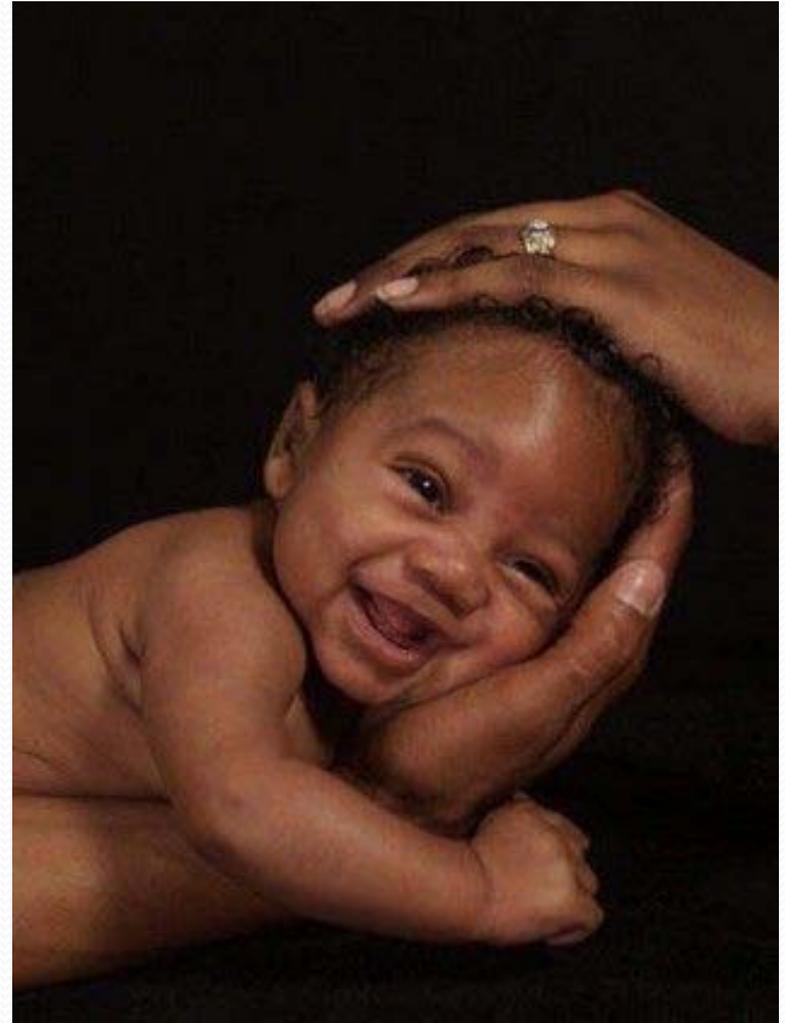


Bottom Line

- All Texas hospitals that provide neonatal care will need neonatal state designation (1-4) by Sept 1, 2018 to receive Medicaid funding
- All Texas hospitals that provide maternity care will need maternity state designation (1-4) by Sept 1, 2020 to receive Medicaid funding
- **CAVEAT: HB 3433 extended deadlines by 1 year (2018- neo, 2020 -maternal)**

Bottom Line-2

- **Children's hospitals exempt from OB (maternity) requirements**
- **Hospitals may have different levels of care between maternity and neonatal care**
 - **Example: Level II maternity and level III neonatal**



Guestimate of # of Hospitals

- 240 providing OB/Neo services & children's hospitals in Texas
 - Level I (80) } **Written affidavit (no site visit)**
 - Level II (80) }
 - Level III (73) } **160 hospitals (site visit)**
 - Level IV (7) }

If Level I exempt from site visit (submit application with data, documents), **160 hospitals need site visits.**

Neonatal Facility Designation Application Levels II, III, and IV

INSTRUCTIONS AND HELPFUL INFORMATION

General Information

1. Where to call for information or guidance while completing the application:

For technical assistance, call or email the Neonatal Program Specialist:

- Jewell Potter - (512) 834-6743
- Jewell.Potter@dshs.state.tx.us

For process or rule clarification, please contact the following:

Neonatal Designation Coordinator

- Debbie Lightfoot, RN – (512) 834-6700 Ext. 2032
- Debra.Lightfoot@dshs.state.tx.us

Designation Program Manager

- Elizabeth Stevenson, RN – (512) 834-6794
- Elizabeth.Stevenson@dshs.state.tx.us

2. When should the application be submitted? Title 25 Texas Administrative Code (TAC) §133 Subchapter J, provides the guidelines for submission of designation application packets. According to TAC¹, a designation application packet shall be submitted to our office within 120 days of the facility's survey date.
3. Need more information relating to the designation process? Call your assigned Designation Coordinator (above) or refer to the "Process for Neonatal Facility Designation Application" at the following Office of EMS/TS website:
www.dshs.state.tx.us/emstraumasystems/neonatal.aspx

TAC¹ §133.184. Designation Process.

(a) Designation application packet. The applicant shall submit the packet, inclusive of the following documents to the Office of EMS/Trauma Systems Coordination (office) within 120 days of the facility's survey date:

- (1) an accurate and complete designation application form for the appropriate level of designation, including full payment of the designation fee as listed in subsection (d) of this section;
- (2) any subsequent documents submitted by the date requested by the office;
- (3) a completed neonatal attestation and self-survey report for Level I applicants or a designation survey report, including patient care reviews if required by the office, for Level II, III and IV applicants;
- (4) a plan of correction (POC), detailing how the facility will correct any deficiencies cited in the survey report, to include: the corrective action; the title of the person responsible for ensuring the correction(s) is implemented; how the corrective action will be monitored; and the date by which the POC will be completed; and

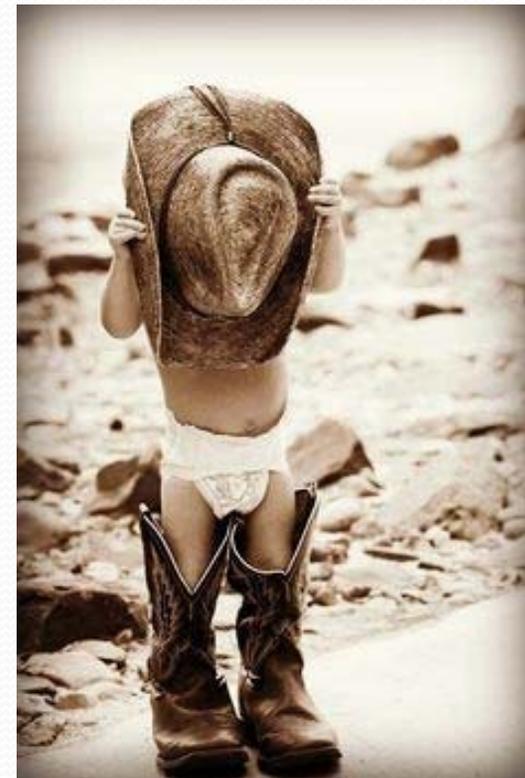
Site Visits

- **SITE VISIT (levels II/III/IV)**
 - After application is submitted
 - Need to also interview staff, physicians, etc.
 - View physical facility
 - Write up site visit report
 - Cost of site visit paid by hospital



DSHS Websites

- Applications for neonatal designation:
- www.dshs.texas.gov/emstraumasystems/neonatal.aspx
- **Surveys: AAP and TETAF**





AAP NICU Verification Program

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Advocacy & Policy

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NICU Verification

Transitions

NICU Verification Program

American Academy of Pediatrics

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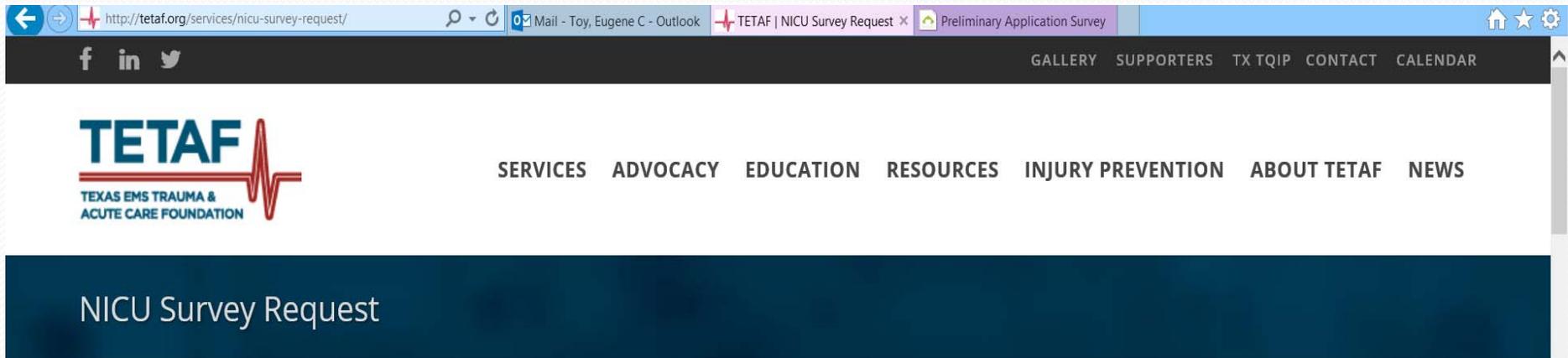


The mission of the AAP NICU Verification Program is to improve outcomes for high-risk newborns by supporting a system that ensures that every high risk newborn receives care in a facility with the personnel and resources appropriate for the infant's needs and condition.

About

The Committee on Fetus and Newborn 2012 policy statement, *Levels of Neonatal Care*, reaffirmed in 2015, and the *Guidelines for Perinatal Care*, published by the AAP and the American College of Obstetricians and Gynecologists, delineate the personnel and resources needed for four levels of Neonatal Intensive Care Units (NICUs) appropriate for newborns with increasingly complex needs. The AAP NICU Verification Program was created to achieve the best possible outcomes by ensuring that every high risk newborn is cared for in a facility with the personnel and resources appropriate for the infant's needs and condition. Program development was supported in part by a grant from the Centers for Disease Control and Prevention.

http://tetaf.org/services/nicu-survey-request/



NICU Survey Request



Utilizing experienced neonatal medical directors and neonatal nurses that actively practice in Texas, TETAF will provide NICU survey services for Level I, II, III and IV Texas hospitals.

TETAF credentialed surveyors will provide the hospital with the required report for submission to the Texas Department of State Health Services, Office of EMS/Trauma for designation or re-designation. The TETAF survey experience offers an educational opportunity with experienced, knowledgeable neonatal medical staff and neonatal program management.

Once the request for survey application form is received, the TETAF NICU survey coordinator will contact the requesting hospital regarding potential survey dates.

Surveys will occur after *January 1, 2017*.



Maternity Levels of Care

- Published in Feb 2015 (Joint ACOG & SMFM)
- Perinatal Council is finalizing its maternity LOC

Maternity Levels 1 – 4

- Level 1 – uncomplicated
- Level 2 – moderately complicated
- Level 3 – complicated, high risk
- Level 4 – very complicated, critically ill



What Can You Do?

- Visit the DSHS websites for Neo Designation application, site visit info, webinars
- Get engaged with the state process (Perinatal Advisory Council + state rulemaking) – **next mtg Nov 28, 2016 (Monday) at 10:30am in Austin**
- Make sure your facility meets requirements for your level of care
- Make sure your hospital has a QI process to look for key outcomes (get it ready for application process)



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Perinatal Advisory Council

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The Perinatal Advisory Council, created by House Bill 15 of the 83rd Texas Legislature (Regular Session), develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation and a process for the assignment of levels of care to a hospital, makes recommendations for dividing the state into neonatal and maternal care regions, examines utilization trends in neonatal and maternal care, and recommends ways to improve neonatal and maternal outcomes.

House Bill 3433 of the 84th Texas Legislature (Regular Session) amended House Bill 15 by adding two new members to the Perinatal Advisory Council and extended the date of its report.* The council must submit a report with its recommendations to the Health and Human Services Commission and the Department of State Health Services by September 1, 2016*.

Members

- Dr. Eugene Toy, Chair, Obstetrics-gynecology, Houston
- Dr. Emily Briggs, family medicine physician who provides obstetrical care in a rural community, New Braunfels
- Dr. Elly Xenakis, maternal fetal medicine, San Antonio
- Dr. Frank Cho, neonatologist in Level III or IV NICU, Austin
- Dr. Sanjay Patel, Rural Hospital Representative, Odessa
- Barbara Greer, RN, nurse with expertise in perinatal health, Benbrook
- Dr. Charleta Guillory, pediatrician, Houston
- Allen Harrison, representative from a hospital with Level II NICU, Austin
- Dr. John Harvev. neonatologist from rural area. Amarillo

Events

October 25, 2016

- [Perinatal Advisory Council \(webcasting available\)](#)
Austin - 10:30 am



Resources

- **NICU Council Report**
- **Perinatal Advisory Council Report**
- **Guidelines for Perinatal Care, 7 th ed, 2012**
- **Laswell, Barfield, et al. JAMA 2010**
- **Barfield et al., AAP. Levels of Neonatal Care. Pediatrics 2012**



Resources

- <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/perinatal-advisory-council>
- www.dshs.texas.gov/emstraumasystems/neonatal.aspx
- www.marchofdimes.org/baby/levels-of-medical-care-for-your-newborn.aspx
- www.aap.org
- www.tetaf.org

For More Information

- **Neo Designation (DSHS):**
 - Debra.Lightfoot@dshs.state.tx.us
 - Elizabeth.Stevenson@dshs.state.tx.us
- **HHSC Perinatal Advisory Council website**
www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/pac/
- **Eugene Toy, Chair, Perinatal Advisory Council**
 - eugene.c.toy@uth.tmc.edu
- **David Williams**
 - david.williams@hhsc.state.tx.us
 - Handles the administrative aspects of the Perinatal Advisory Council

Questions and Answers



Evelyn Delgado
Q & A Moderator

*Associate Commissioner
for Family and Community Health*

Remote sites can send in questions by typing in the *GoToWebinar* chat box or email GrandRounds@dshs.state.tx.us.

For those in the auditorium, please come to the microphone to ask your question.

November 9

Zika: Looking Ahead

Presenter:
John Hellerstedt, MD
Commissioner, Texas Department of
State Health Services

