Indiana Department of Health

Division of **Maternal & Child Health**

Frequently Asked Questions Regarding Perinatal Centers

March 2021

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410 IAC 39-8-1 Qualifications for perinatal centers

Q 1. Is it required to have Maternal Fetal physically onsite 24/7 for consults versus being available 24/7 via virtual health consults?
As stated in 410 IAC 39-8-1 Sec. 1 (c)(1), All Perinatal Centers are required to have a Maternal Fetal Medicine specialist readily available at all times for onsite consultation and management with full privileges. Readily available is defined as available twenty-four (24) hours a day, seven (7) days a week for consultation and assistance, and able to be physically present onsite within a time frame that incorporates maternal and newborn risks and benefits with the provision of care. (Indiana State Department of Health;410 IAC 39-1-20)

Q 2. We currently offer transport reviews with all our referral hospitals, but some choose not to participate. Is this optional, or will this be required by the state for affiliate hospitals to participate? If required, who is responsible for communicating these new requirements to affiliate hospitals?
Perinatal Centers are responsible for conducting quality assurance review with the affiliate hospitals (410 IAC 39-8-1 (a)(2)). Details for responsibilities should be included in the Memorandum of Understanding.

410 IAC 39-8-3 Training for affiliate hospitals

Q 1. We currently offer an array of classes (Basic, Intermediate, and Advanced Fetal Monitoring, High Risk OB, ACLS OB, STABLE, NRP, and NRP instructor course) to affiliate hospitals as well as a yearly symposium. We currently do not offer a nursing exchange program, perinatal hospice/bereavement training, training for transport team personnel, or team training. Are the latter items suggestions, or are these required?
The language in the guidelines say, "topics may include but are not limited to." The committee's discussion was that the training topics would be negotiated between the center and the affiliate hospital. The agreement might be different from one hospital to the other depending on resources.

410 IAC 39-8-6 Back transport Sec. 6. Perinatal centers shall make every effort to transfer maternal-fetal or neonatal patients back to the affiliate hospital when risk appropriate and by mutual agreement with the affiliate hospital and family. *(Indiana State Department of Health; 410 IAC 39-8-6)*

Q 1. We continue to have issues with getting approval for back transfer from Medicaid. Maureen Greer had said to email her when this happens. Is this still the process?
Over the last number of years, conversation with OMPP has continued regarding payment approval for back transports. Each MCE establishes its own criteria for approval of payment for back transport. While we had hoped to have common criteria, we have asked for each MCE's criteria to support efficient use of hospital time seeking approval but have been unsuccessful to date. Maureen will continue to move examples forward as she receives them.

410 IAC 39-8-7 Neonatal intensive care unit transition and developmental follow-up

Perinatal centers shall use a valid and reliable standardized screening tool.

- (A) **The tool shall be administered at recommended intervals.**
- (B) **The developmental follow-up screening program shall serve high-risk infants including, but not limited to, those with the following conditions:**
  1) **Newborns weighing less than or equal to one thousand five hundred (1,500) grams at birth.**
  2) **Hypoxic-ischemic encephalopathy (HIE).**
  3) **Neonatal Seizures**
  4) **Hypoxic cardiorespiratory failure**
  5) **Complex, multiple congenital anomalies.**
  6) **Neonatal abstinence syndrome (NAS).**
  7) **All other high-risk infants with additional diagnoses at the discretion of the center.**

Q 1. How do we ensure that a standardized tool is being used by the medical home at the established intervals? Is this part of the MOU for each referral hospital? What if the medical home is not part of the medical staff?
At discharge from NICU, the neonatologist provides the discharge plan to the PCP and offers Developmental Clinic if there is no service in that community. If the provider is an affiliate from earlier discussions, the affiliate would provide the details and information that the baby followed appropriately.

Q 2. Can a baby who meets the criteria for screening be solely screened by the medical home, especially if traveling is a hardship, or do they have to come to the follow-up clinic? For example, a premature baby with birthweight <1500 grams.
We want to ensure the medical home manages the care of the baby as much as possible. Therefore, it is appropriate to allow the medical home to manage a premature birth weight neonate.

Q 3. If the medical home is unable to participate in the administration of the ASQ, the perinatal center should facilitate the completion of the questionnaire. Results should be shared between the center and the PCP with any recommended interventions done at a local level. How do we know this?
Every affiliate and center will be unique. A medical home's setup will allow them the ability to do the medical screening. Each facility and medical home should have a protocol that addresses this concern. The Help Me Grow and First Steps have developmental screening tools.

Q 4. From the Follow-Up algorithm – The neonatologists were wondering if there is a center that might be willing to share their approach when looking at this algorithm? The submitter was on the subcommittee with Dr. DeWeese but is unable to answer some of their questions. For example: "Point

person from Discharging Hospital contacts PCP to ensure screenings are occurring at the established intervals." Would it be a HIPAA violation to ask for this information from the medical home?
This would not be a HIPAA violation. Following up on the care of the neonate is a form of continuity of care. To help minimize any confusion, we recommend each facility place something in its policy to support follow-up and possibly a consent form to the family.

Q 5. Could you provide further definition of hypoxic cardiorespiratory failure?
Additional information to come regarding this request. Once received, the FAQ will be updated and distributed.

410 IAC 39-8-8 Memorandum of understanding between perinatal center and affiliate hospitals.

Sec. 8. (a) Any facility not certified by the department as a perinatal center shall affiliate with a perinatal center. The department shall notify facilities when all initial perinatal centers have been certified. Facilities not certified by the department as perinatal centers will have twelve (12) months from notification to enter into a memorandum of understanding with a certified perinatal center.
(b) Nonperinatal centers may affiliate with only one (1) perinatal center.

Q 1. A request about the PC affiliation was sent by the PC committee. A follow-up email was sent to the birthing facility that did not respond to the initial email. Given the sensitive nature of these business transactions and partnerships, birthing facilities are rather hesitant to share future business strategies and confidential information regarding their plans. It is many of their understanding that they have until November of this year to secure a Perinatal Center partnership and that they would report such arrangement to the Department of Health.
It is accurate that final decisions regarding the center /affiliate relationship is not required until November. The leadership of the Perinatal Centers Task Force requested that the survey be conducted to assess status. All information gathered was held confidential and was only presented in aggregate because it is considered proprietary for the reasons noted. Response to a requestor survey from IPQIC is always optional. A reminder is always sent to ensure that individuals received the email. Individuals can always respond to the first email declining to respond and a second email will not be sent.

Q 2. Can you be a perinatal center without any affiliates?
No, you can be a Level III nursery, but you would not be considered a Perinatal Center.

Q 3. What constitutes a hospital as an affiliate hospital? Many of our maternal and newborn transports come from the same 13 hospitals, but occasionally we have a transport (once or twice a year) that chooses us due to special circumstances (family in the area, other NICUs closed, etc.). Must a formal agreement (MOU) be in place to accept transports?
No, you would not need to have an agreement for those special circumstances. You would need agreements with those hospitals with which you routinely deal.

General Questions

GQ 1. Are birthing centers required to sign Perinatal Transport Agreements with Perinatal Centers?
No, Prenatal Transport Agreements were developed for hospital-to-hospital transports.

GQ 2. How will birthing facilities with minimal high-risk patients maintain competency with managing high-risk conditions?
The birthing facilities should use the time they have with their prospective Perinatal Centers to discuss their individual needs. Discussing these needs should be a part of the birthing facility MOU agreements. Each party must come prepared to discuss all needs for the partnership to be successful.

GQ 3. Is it appropriate for a birthing center to use EMS services or their personal vehicles to transport maternal or neonatal patients to a higher level of care?
Birthing centers are not required to use a perinatal transport team to transport maternal or neonatal patients. The Commission for the Accreditation of Birthing Centers (CABC) requires that "birth centers have agreements and/or written policies and procedures for collaboration with other agencies, institutions or individuals for services to clients including, but not limited to… transport service" (Standard 2(9)(c)(9)(e)). CABC guidelines support the ability of birthing centers to use EMS services or personal vehicles to transport maternal or neonatal patients to a higher level of care to minimize the delay in care. Currently, the Indiana Code does not address this concern.

G Q4. How often will the state provide data?
The MCH Epidemiology team at the Indiana Department of Health (IDOH) commits to providing data to centers every six (6) months.

G Q5. Once it's provided, is there a timeline to meet with affiliates?
IDOH recommends that once that data is received, all perinatal centers review it and meet with their affiliates to discuss the data findings. Meetings should occur minimally twice a year to ensure ongoing data monitoring and that all needs are being met.

G Q6. Since data is provided to the state by each hospital, can we use our internal data for internal hospital affiliates (IUH affiliates) to meet with them prior to getting the data from the state? There is concern we will have to meet with everyone within the same month/quarter and would like to spread it out throughout the year.
The Indiana Department of Health (IDOH) encourages perinatal centers to discuss and explore any options of receiving data directly from their affiliated hospitals, if possible. The internal data directly from the affiliate will likely be in more "real time" than what the state can provide because the state must wait for birth record information to be submitted, certified, cleaned, and finalized prior to releasing it to centers.

G Q7. Are virtual meetings acceptable for data review, education, etc.? What does the documentation look like?

IDOH supports virtual platforms such as Teams, Zoom, WebEx, etc. to conduct meeting with affiliates. The center/affiliate should determine the educational offerings and methods of delivery. IDOH does not specify the method of delivering educational offerings.

IDOH continues to discuss how this documentation should reflect for each center. Please consider creating an Excel spreadsheet to track the encounters, goals, and needs of each affiliation.