Title 15: Mississippi Department of Health

Part 3: Bureau of Acute Care Systems

Subpart 4: Obstetrics (OB) System of Care

Chapter 1 Mississippi Obstetrics (OB) System of Care

Subchapter 1 General

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.1. 1. Legal Authority: The Mississippi State Department of Health (Department) is assigned the responsibility for developing, implementing and managing the statewide Obstetrics (OB) System of Care (SOC). The Department shall be designated as the lead agency for OB SOC development, implementation and management. The Department shall develop and implement the Mississippi OB SOC Plan and OB SOC standards, which include but are not limited to those having to do with maternal center and neonatal center designation, field triage of OB patients, inter-facility transfer of OB patients, OB care from initial medical contact through appropriate intervention, OB data collection, OB system evaluation and management of OB funding. The Department shall further promulgate specific regulations regarding the methods and procedures by which Mississippi licensed acute care facilities shall participate in the statewide OB SOC. These specific regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities.

2. Purpose: The purpose of these regulations is to establish separate criteria for four maternal and four neonatal levels of care and procedures by which a perinatal facility may request approval to be a designated facility which has achieved a particular Department designated level of care.

3. These regulations are not intended to prevent any facility from providing medical services to a woman or infant.

4. No facility shall hold itself out as or advertise itself to the public as having achieved a Department designated level of care as a maternal or neonatal center unless it has been designated by the Department.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.2. Mississippi OB SOC Advisory Committee: The Mississippi OB SOC Advisory Committee is created for the purpose of serving as an advisory body for statewide OB SOC development and shall provide support to the Department in all areas of OB SOC design, including the development and updating of SOC standards, SOC data collection and evaluation, SOC performance improvement, SOC funding, and evaluation of SOC programs.

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.3. Members of the OB System Advisory Committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities (membership list may be updated as needed based on participation):

1. Obstetrician Chair
2. Neonatologist, Co-Chair
3. Emergency Medicine Physician
4. Emergency Nurse
5. Family Medicine Physician
6. Neonatal Nursing Representatives from the Northern, Central and Southern Regions
7. Hospital Administration Representatives from the Northern, Central and Southern Regions
8. Obstetrician Representatives from the Northern, Central and Southern Regions Level 1 – IV Centers
9. Neonatologist Representatives from the Northern, Central and Southern Regions Level I – IV Centers
10. OB Nursing Representatives from the Northern, Central and Southern Regions
11. EMS Provider Representatives from the Northern, Central and Southern Regions
12. Regional OB Coordinators from the Northern, Central and Southern Regions
13. American College of Obstetricians and Gynecologists Representative

Source: Miss. Code Ann. § 41-3-15

Rule 1.1.4. The Mississippi OB SOC Advisory Committee shall meet at least Quarterly.
Source: Miss. Code Ann. § 41-3-15

Rule 1.1.5. **Definitions:** For the purpose of clarity and usage in the Mississippi OB SOC, the following abbreviations, acronyms, and terms shall be defined as follows:

1. ACLS – Advanced Cardiovascular Life Support. A resuscitation course that was developed and is administered by the American Heart Association.

2. ALS – Advanced Life Support, including techniques of resuscitation, such as intravenous access, and cardiac monitoring.

3. ALSO – Advanced Life Support Obstetrics

4. APP – Advanced Practice Providers – clinicians—such as nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives—who hold graduate-level education and advanced clinical training.

5. Available – Relating to staff who can be contacted for consultation at all times without delay.

6. Board-eligible – A physician who has completed a residency or fellowship and is eligible for board certification according to the applicable medical board.

7. CAP – Corrective Action Plan. A plan for the facility developed by the Department that describes the actions required of the facility to correct identified deficiencies to ensure the applicable designation requirements are met.

8. Department – The Mississippi State Department of Health

9. Designated facility – means a perinatal facility that has been inspected and approved by the Department pursuant to these regulations as meeting its established criteria for a particular maternal or neonatal level of care.

10. Designation – A formal recognition by the Department of a facility's maternal care capabilities and commitment for a period of three years.

11. Emergency Department (or Emergency Room) – The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care

12. EMS – Emergency medical services. Services used to respond to an individual's perceived need for immediate medical care.

13. Gestational age - The age of a fetus or embryo determined by the amount of time that has elapsed since the first day of the mother's last menstrual period or the corresponding age of the gestation as estimated by a physician through a more accurate method.

14. High-risk infant- A newborn that has a greater chance of complications because of conditions that occur during fetal development, pregnancy conditions of the mother, or problems that may occur during labor or birth.

15. Immediately--Able to respond without delay, commonly referred to as STAT.

16. Inclusive OB System of Care – an OB care system that incorporates every health care facility willing to participate in the mandatory system in order to provide a continuum of services for maternal or neonatal care.

17. Infant – A child from birth to one year of age.

18. Inter-facility Transport – Transfer of a patient from one healthcare facility to another healthcare facility.

19. Lactation Consultant – A healthcare professional who specializes in the clinical management of breastfeeding.

20. Levels of Care – All hospitals providing obstetric and newborn services will be designated a perinatal level of care by MSDH, based upon its functional capabilities to provide risk-appropriate care for pregnant women and neonates. The levels of care will be divided into four levels defined in accordance with the 2012 policy statement by the American Academy of Pediatrics, (PEDIATRICS Vol. 130, No. 3, September 2012) and maternal standards set forth by the American College of Obstetricians and Gynecologists with modifications approved by MSDH. The levels are:

    a. Level I – Basic Care
    b. Level II – Specialty Care
    c. Level III – Sub-specialty Care
    d. Level IV – Regional Care
    a. Level I - Well Newborn nursery
    b. Level II - Special Care nursery
    c. Level III - Neonatal Intensive Care nursery
    d. Level IV - Regional Care

21. Mississippi OB System of Care Plan – A formally organized plan developed by the Department, which sets out a comprehensive system plan for care and management of OB patients.

22. MFM – Maternal Fetal Medicine

23. MMD – Maternal Medical Director

24. MPM – Maternal Program Manager

25. MSDH – Mississippi State Department of Health

26. NCPAP-Nasal continuous positive airway pressure.

27. Neonatal Program Oversight-A multidisciplinary process responsible for the administrative oversight of the neonatal program and having the authority for approving the defined neonatal program's policies, procedures, and guidelines for all phases of neonatal care provided by the facility, to include defining the necessary staff competencies, monitoring to ensure neonatal designation requirements are met, and the aggregate review of the neonatal Performance Improvement (PI) initiatives and outcomes. Neonatal Program Oversight may be performed through the neonatal program's performance improvement committee, multidisciplinary oversight committee, or other structured means.

28. Neonate – An infant from birth through 28 completed days after.

29. NMD – Neonatal Medical Director

30. NPM – Neonatal Program Manager

31. NRP – Neonatal Resuscitation Program - A resuscitation course developed and administered jointly by the American Heart Association and the American Academy of Pediatrics.

32. OBSMD – Obstetrics System Medical Director

33. OEMSACS – The Office of EMS and Acute Care Systems

34. On-site – At the facility and able to arrive at the patient bedside for urgent requests.

35. Performance Improvement (PI or Quality Improvement) – A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on

individuals, but systems of patient care which might cause variations in patient outcome.

36. Perinatal – Of, relating to, or being the period around childbirth, especially the five months before and one month after birth.

37. Postpartum – the six-week period following pregnancy or delivery.

38. Privileged Care Provider – a healthcare provider with pediatric or neonatal specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies.

39. ROP – Retinopathy of Prematurity - is a potentially sight-threatening disorder in preterm infants caused by abnormal development of retinal blood vessels. It can range from mild, self-resolving changes to severe proliferative stages that may lead to retinal detachment and vision loss.

40. SHO – Mississippi State Health Officer

41. S.T.A.B.L.E. – an educational program for healthcare providers that focuses on the post-resuscitation and pre-transport stabilization of sick infants.

42. Urgent – Requiring action or attention within 30 minutes of notification.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 General Requirements

Rule 1.2.1. The Mississippi State Department of Health Office of EMS and Acute Care Systems (OEMSACS) shall review the applicant documents and approve the appropriate level of facility designation.

Rule 1.2.2. The Department shall determine requirements for the levels of maternal designation. Facilities seeking Levels II, III, and IV maternal designation must meet Department-approved requirements validated by Department-approved surveyors.

Rule 1.2.3. Facilities seeking Level I maternal designation must submit a self-survey and attest to meeting Department-approved requirements.

Rule 1.2.4. Each location must be considered separately for designation, and the Department shall approve the designation level for each location based on the location's ability to demonstrate designation criteria are met.

Rule 1.2.5. The four levels of maternal designation consist of:

1. Level I – Basic Care – The Level I maternal designated facility must:
   a. 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 specialty or sub-specialty care.
   b. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
   c. Mothers that are stable and likely to deliver before 35 weeks' gestation or have a fetus that is likely to require specialty services and mothers who themselves are likely to require specialty services should be transferred prior to delivery, when possible.
   d. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.
   e. Care of postpartum conditions.
   f. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.

2. Level II – Specialty Care – The Level II maternal designated facility must:
   a. Perform all Level I maternal services.
   b. Mothers that are stable and likely to deliver before 32 weeks gestation or have a neonate that is likely to require sub-specialty services, or mothers who themselves are likely to require sub-specialty services should be transferred prior to delivery, when possible.
   c. Access to maternal fetal medicine consultation and antenatal diagnosis technology including fetal ultrasound.

3. Level III – Subspeciality Care – The Level III maternal designated facility must:
   a. Manage complex maternal and fetal illnesses before, during and after delivery.
   b. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.

4. Level IV – Comprehensive Care – The Level IV maternal designated facility must:
   a. Provide all Level III capabilities as listed above.
   b. Maintain a full range of surgical and medical specialists including Maternal-Fetal Medicine specialists at the site.
   c. Facilitate maternal transport and provide outreach education.

Rule 1.2.6 The four levels of neonatal designation consist of:

1. Level I – Well Care – The Level I neonatal designated facility must:
   a. Provide neonatal resuscitation at every delivery.
   b. Evaluate and provide postnatal care to stable term newborn infants.
   c. Stabilize and provide care for infants born at 35-37 weeks gestation who remain physiologically stable.
   d. Stabilize newborn infants who are ill and those born at less than 35 weeks gestation until transfer to a facility that can provide the appropriate level of care.
   e. Maintain a staff of providers including pediatricians, family physicians, nurse practitioners with newborn training, registered nurses with newborn training, including being current with Neonatal Resuscitation Program Certification and S.T.A.B.L.E.

2. Level II – Special Care – The Level II neonatal designated facility must:
   a. Prove all basic care services of a Level I neonatal designated facility.
   b. Provide care for mothers and their infants of generally more than or equal to 32 weeks gestational age and birth weight more than or equal to 1500 grams who have physiologic immaturity or problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis.
   c. Provide care for infants' convalescent care after intensive care. Provide mechanical ventilation for brief duration (less than 24 hours) and/or continuous positive airway pressure.
   e. Stabilize infants born before 32 weeks' gestation and weighing less than 1500 grams until transfer to a Level III or Level IV neonatal intensive care facility.
   f. Maintain a staff of providers including pediatric hospitalists, neonatologists, and neonatal nurse practitioners.

g. Referral to a higher level of care for all infants when needed for pediatric surgical or medical subspeciality intervention.
h. Level II nurseries must have equipment (e.g., portable x-ray machine, blood gas analyzer) and personnel (e.g., physicians, specialized nurses, respiratory therapists, radiology technicians) to provide ongoing care of admitted infants as well as to address emergencies.

3. Level III – Neonatal Intensive Care – The Level III neonatal designated facility must:

a. Provision of all Level I and Level II services.
b. Level III NICUs are defined by having continuously available personnel (neonatologists, neonatal nurses, and respiratory therapists) and equipment to provide life support for as long as necessary.
c. Provide comprehensive care for infants born less than 32 weeks gestation and weighing less than1500 grams and infants born at all gestational ages and birth weights with critical illness.
d. Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists or anesthesiologists with experience in neonatal surgical care and pediatric ophthalmologists, on site or by prearranged consultative agreements.
e. Provide a full range of respiratory support and physiologic monitoring that may include conventional and/or high-frequency ventilation and inhaled nitric oxide.
f. Perform advanced imaging with interpretation on an urgent basis, including computed tomography, MRI and echocardiography.
g. Social and family support, including social services and pastoral care.
h. If geographic constraints for land transportation exist, the Level III facility should ensure availability of rotor and fixed-wing transport services to transfer infants requiring subspecialty intervention from other regions and facilities.
i. Consultation and transfer agreements with both lower-level referring hospitals and regional centers, including back-transport agreements.
j. Prompt diagnosis and appropriate referral of all conditions requiring surgical intervention. Major surgery should be performed by pediatric surgical specialists (including anesthesiologists with pediatric expertise) on–site within the hospital or at a closely related institution, ideally in close geographic proximity if possible. Level III facilities should be able to offer complete care, management, and evaluation for high-risk

neonates 24 hours a day. A neonatologist should be available either in-house or on-call with the capacity to be in-house in a timely manner, 24 hours a day.

k. Level III facilities should maintain a sufficient volume of infants less than 1500 grams to meet professionally accepted guidelines to achieve adequate experience and expertise.
l. Enrollment in the Vermont Oxford Network to report and monitor data regarding outcomes of infants born less than 32 weeks and weighing less than 1500 grams.
m. Participation in and evaluation of quality improvement initiatives.

4. Level IV – Advanced Neonatal Intensive Care – The Level IV neonatal designated facility must:

a. Provide all level III capabilities listed above.
b. Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions.
c. Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists and pediatric anesthesiologists at the site.
d. Facilitate transport and provide outreach education including community taught NRP and S.T.A.B.L.E. classes.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Designation of Maternal and Neonatal Facilities

Rule 1.3.1. Designation

1. A perinatal facility seeking Department designation as a maternal or neonatal center shall submit a written application to the Department through an application process and shall provide upon request such additional information, documents, or inspections as the Department may deem necessary.

2. A perinatal facility may apply for designation or re-designation as a maternal and a neonatal center or may apply for designation or re-designation separately as a maternal center or a neonatal center.

3. Designation shall be for a period of three years. The SHO may extend a designation for one year.

4. A designated facility shall be subject to periodic review by the Department and shall permit on-site inspection and submit data to the Department as may be required by the Department to evaluate whether the designated

center has maintained compliance with the requirements of these rules and regulations.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.2. Process for Initial Designation

1. The participation of acute care facilities in the OB SOC is mandatory; however, participating hospitals must be appropriately designated according to ability to care for maternal or neonatal patients – designation is a process of verifying that appropriate systems, staff, and resources are available

2. Once a completed application for maternal or neonatal center is received, the Department will work with hospital staff to schedule the date for the designation survey.

3. The Department shall provide for the survey of the applicant hospital, provided that its application has been formally approved by the Department, on the date scheduled and indicated in the Department's acceptance letter to the applicant hospital, unless the Department provides written notification with justification of change to the applicant hospital no later than 14 days prior to the survey date; or the applicant hospital provides written request with justification for a change in the survey date to the Department no later than 30 days prior to the survey date.

4. Results of facility surveys will be provided by the Department in writing to the applicant hospital. Details related to the hospital's survey will be considered confidential and will not be released

5. Maternal Centers currently verified by The Joint Commission Maternal Levels of Care Verification Program may request reciprocity for Department designation as a Maternal Center. The Department must receive the complete report from the accrediting organization, including any/all corrective action plans (CAP).

6. After completion of a designation survey, the team conducting the survey will make a recommendation to the Department for designation. The Director of the OEMSACS will present the survey report and the team’s recommendation to the state OB System Medical Director (OBSMD). OBSMD may seek advice or further recommendation from the Mississippi OB System of Care Advisory Committee during its executive session, if the OBSMD disagrees with the recommendations of the team; otherwise

the OBSMD may make direct recommendations to the State Health Officer.

7. The Director of OEMSACS will prepare a memorandum detailing the recommendations of the team and signed by the OBSMD for the State Health Officer and will forward the memorandum and the designation letter to the State Health Officer for signature. Once signed, the letter will be sent to the hospital receiving the survey. The Department will inform the applicant hospital of the status of the application within 14 days of the advisory committee meeting.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.3. Re-Designation

1. Designated perinatal centers wishing to maintain current designation status shall submit a letter of intent to continue as currently designated no less than 30 days prior to the expiration of designation status.

2. Any designated perinatal center not submitting a letter of intent to continue as currently designated will be required to reapply through the initial application process.

3. Any Designated perinatal center that loses, either permanently or temporarily, patient care specialties required by this regulation, shall report that loss to the Department.

4. If the loss will result in the perinatal centers' inability to carry out the patient care activities associated with the current level of designation for a period longer than 30 days, the facility must submit a CAP that addresses how and when the facility will become compliant.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.4. Change in Designation Level for Maternal or Neonatal Centers

1. Maternal or Neonatal Centers will be permitted to change their designation if the following conditions are met in their entirety:

   a. The Maternal or Neonatal Center has been appropriately surveyed and designated by the Department, the designation is current, and the Center is in full compliance with Department, regulations, policies, procedures, and protocols

b. The request to change designation has been approved by the Mississippi OB System Advisory Committee

c. The State Health Officer (SHO) or designee issues the new designation

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.5. Designation Criteria for OB Centers

An OB Center must meet all standards applicable to the relevant level of care established by The Joint Commission Maternal Levels of Care Verification Program as amended, restated, supplemented, or otherwise modified from time to time.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.6. Designation Criteria for Neonatal Centers

A neonatal center must meet all standards applicable to the relevant level of care established by the American Academy of Pediatrics Standards for Neonatal Levels of Care as amended, restated, supplemented, or otherwise modified from time to time.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.7. Designation Suspension/Revocation

The SHO may suspend or revoke a designation for any hospital if the Department determines:

1. Documented conditions of serious threat or jeopardy to patients' health or welfare,

2. Failure to comply with these rules and regulations.

3. Failure to satisfactorily meet the minimum requirements as a Maternal/Neonatal Center as defined by regulations for the designation level;

4. Failure to complete a Corrective Action Plan (CAP) within the timeframe specified by the Department.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.8. Appeal Process

The Department shall use the following notice and hearing procedures:

1. The Department shall provide written notice to the perinatal facility of any suspension or revocation pursuant to this regulation.

2. All suspensions or revocations by the Department are effective twenty days after the perinatal facility's receipt of the Department's notice, unless the perinatal facility makes a written request for an administrative hearing within twenty (20) days of notification. In the event a timely request for a hearing is received, the action shall become effective upon the Department's final decision.

3. The Department shall provide an administrative hearing on the suspension or revocation if the perinatal facility's written request is delivered to and received by the Department no later than twenty days from the date the perinatal facility receives the notice of suspension or revocation.

Source: Miss. Code Ann. § 41-3-15

Rule 1.3.9. Hospitals having their designation suspended may reapply for designation only after:

1. Resolution of all issues that led to the suspension, as determined by the Department.

2. Submission of a complete new application for OB System of Care designation.

3. Successful completion of a Department-conducted survey verifying that all deficiencies have been corrected.

Upon satisfying these conditions, the facility's application for redesignation shall be processed in accordance with the standard designation timelines and procedures.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Performance Improvement and System Evaluation

Rule 1.4.1. Performance Improvement shall be an essential part of the OB System of Care. It shall be used to analyze proper functioning of the system and implement improvements in system operation. The PI program will be system-wide. Every designated perinatal center and neonatal center is required to participate in the system PI process. The appropriateness and quantity of all activities of the OB system must be continuously evaluated.

1. The OB PI Committee shall be responsible for the PI oversight of the OB System. Members of the OB PI Committee will be appointed by the State Health Officer for a term of three years and shall include representatives from the following entities (membership list may be updated as needed based on participation):

    a. One Obstetrician from each of the three regions

    b. One Neonatologist from each of the three regions

    c. One Emergency Medicine physician practicing at a maternal or neonatal center from each of the three regions

    d. The State EMS Medical Director or his physician designee

2. The OB PI Committee will be chaired by an obstetrician and the vice-chair shall be a neonatologist or emergency medicine physician of the committee as determined annually by a majority of the committee.

Source: Miss. Code Ann. § 41-3-15

Rule 1.4.2. Specific Performance Measures will be established by the OB PI committee

1. In general, the following performance improvement processes should be performed by each maternal and neonatal center. The results of these reviews shall be reported to the OB PI committee.

    a. Each maternal and neonatal center assigns a PI person to oversee the process

    b. Standards and measures established

    c. Determine audit filters

    d. Collect data

    e. Evaluate data

    f. Determine PI issues present

    g. Develop corrective action plan (CAP)

    h. Re-evaluate to document results/effectiveness of CAP

    i. The OB Performance Improvement Committee shall develop and maintain a comprehensive set of indicators, comprising both outcome

measures and process measures, to promote optimal maternal and neonatal health. Outcome measures shall be designed to assess clinical results for mother and baby, and process measures shall evaluate adherence to evidence-based practices. Examples of desired pregnancy outcomes include, but are not limited to:

i Ending preventable morbidity, mortality

ii Reducing infections

iii Reducing unnecessary procedures that may cause harm or risk to mother and baby

iv Increasing diagnosis of depression, substance use issues, and domestic violence during pregnancy

v Reducing late maternal death (42 days to 1 year due to cardiac disease)

vi Reducing postpartum hemorrhages

vii Administration of magnesium sulfate for seizure prophylaxis and IV antihypertensives (30-60 minutes from identification of severe hypertension >160/110)

viii Reducing ICU admission and readmission rates (within 30 days postpartum)

ix Neonatal specific: Infection

x Neonatal specific: intra-ventricular hemorrhage (IVH)

xi Neonatal specific: necrotizing enterocolitis (NEC)

xii Neonatal specific: hypothermia

xiii Additional indicators as identified by the state-wide PI Committee

Source: Miss. Code Ann. § 41-3-15

Rule 1.4.3 All designated OB and Neonatal facilities will actively engage in the process of data collection and retrieval.

Chapter 2 Maternal Program Requirements

Rule 2.1.1 Maternal Program Philosophy

Designated facilities must have a family-centered philosophy. The facility environment for perinatal care must meet the physiologic and psychosocial needs of the mothers, infants, and families. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants. The OB Center must ensure parent, sibling, and neonate visitation are supported and facilitated, following appropriate safety guidelines.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.2 Maternal Program Plan

The facility must develop a written maternal operational plan for the maternal program that includes a detailed description of the scope of services and clinical resources available for all maternal patients and families. The plan will define the maternal patient population evaluated, treated, transferred, or transported by the facility consistent with clinical guidelines based on current standards of maternal practice ensuring the health and safety of patients.

1. The written Maternal Program Plan must be reviewed and approved by Perinatal Multidisciplinary Committee and be submitted to the facility's governing body for review and approval. The governing body must ensure that the requirements of this section are implemented and enforced.

2. The written Maternal Program Plan must include, at a minimum:

    a. Clinical guidelines based on current standards of maternal practice, and policies and procedures that are adopted, implemented, and enforced by the maternal program;

    b. A process to ensure and validate that these clinical guidelines based on current standards of maternal practice, policies, and procedures are reviewed and revised a minimum of every three years;

    c. Written triage, stabilization, and transfer guidelines for pregnant and postpartum patients that include consultation and transport services;

d. Written guidelines or protocols for prevention, early identification, early diagnosis, and therapy for conditions that place the pregnant or postpartum patient at risk for morbidity or mortality;

e. The role and scope of telehealth/telemedicine practices if utilized, including:

   i. Documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care, or for inpatient consultation, including appropriate situations, scope of care, and documentation that is monitored through the PI Plan and process; and

   ii. Written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for compliance;

f. Written guidelines for discharge planning instructions and appropriate follow up appointments for all mothers and infants;

g. Written guidelines for the hospital disaster response, including a defined mother and infant evacuation plan and process to relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure maternal care can be sustained and adequate resources are available;

h. Requirements for minimal credentials for all staff participating in the care of maternal patients;

i. Provisions for providing continuing staff education, including annual competency and skills assessment that is appropriate for the patient population served;

j. A perinatal staff registered nurse as a representative on the nurse staffing committee; and

k. The availability of all necessary equipment and services to provide the appropriate level of care and support of the patient population served.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.3. Performance Improvement: The facility must have a documented PI Plan. The maternal program must measure, analyze, and track quality indicators and other aspects of performance that the facility adopts or develops that reflect processes of care and is outcome based.

1. The Chief Executive Officer, Chief Medical Officer (or Chief of Staff), and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven maternal PI Plan.

2. The facility must demonstrate that the Maternal PI Plan consistently assesses the provision of maternal care provided. The assessment will identify variances in care, the impact to the patient, and the appropriate levels of review. This process will identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.

3. Maternal facilities must review their incidence and management of placenta accreta spectrum disorder through the PI Plan and report the incidence and outcomes through the Perinatal Multidisciplinary Committee. (see guideline)

4. The Maternal Medical Director (MMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure maternal physician representation in the peer review process for maternal cases.

5. The MMD and the Maternal Program Manager (MPM) must participate in regional PI regional initiatives and submit requested data to assist with data analysis to evaluate regional outcomes as an element of their maternal PI Plan.

6. The facility must have documented evidence of maternal PI summary reports reviewed and reported by the Perinatal Multidisciplinary Committee that monitors and ensures the provision of services or procedures through telehealth and telemedicine, if utilized, is in accordance with the standard of care applicable to the provision of the same service or procedure in an in-person setting.

7. The facility must have documented evidence of maternal PI summary reports to support that aggregate maternal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through the Perinatal Multidisciplinary Committee, available for site surveyors, and submitted to the department as requested.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.4. Medical Staff. The facility must have an organized maternal program that is recognized by the facility's medical staff and approved by the facility's governing body.

1. The credentialing of the maternal medical staff must include a process for the delineation of privileges for maternal care.

2. The maternal medical staff must participate in ongoing staff and team-based education and training in the care of the maternal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.5 Medical Director. There must be an identified MMD. The MMD must be credentialed by the facility for treatment of maternal patients and have their responsibilities and authority defined in a job description. The MMD is responsible for the provision of maternal care services and:

1. Examining qualifications of medical staff requesting maternal privileges and making recommendations to the appropriate committee for such privileges;

2. Assuring maternal medical staff competency in managing obstetrical emergencies, complications and resuscitation techniques;

3. Monitoring maternal patient care from transport if applicable, to admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the PI Plan;

4. Participating in ongoing maternal staff and team-based education and training in the care of the maternal patient;

5. Overseeing the inter-facility maternal transport;

6. Collaborating with the MPM in areas to include developing or revising policies, procedures and guidelines, assuring medical staff and personnel competency, education and training; and the PI Plan;

7. Frequently leading the maternal PI meetings with the MPM and participating in Maternal Program Oversight and other maternal meetings as appropriate;

8. Ensuring that the PI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome-based;

9. Participating as a clinically active and practicing physician in maternal care at the facility where medical director services are provided;

10. Maintaining active staff privileges as defined in the facility's medical staff bylaws; and

11. Developing collaborative relationships with other MMD(s) of designated facilities within the applicable Perinatal Care Region.

Source: Miss. Code Ann. § 41-3-15

Rule 2.1.6. Maternal Program Manager (MPM). The facility must identify an MPM who has the authority and oversight responsibilities written in his or her job description for the provision of maternal services through all phases of care, including discharge and identifying variances in care for inclusion in the PI Plan and:

1. Be a registered nurse with perinatal experience;

2. Be a clinically active and practicing registered nurse participating in maternal care at the facility where program manager services are provided;

3. Have the authority and responsibility to monitor the provision of maternal patient care services from admission, stabilization, operative intervention(s) if applicable, through discharge, and inclusive of the PI Plan;

4. Collaborate with the MMD in areas to include developing or revising policies, procedures and guidelines; assuring staff competency, education, and training and the PI Plan;

5. Frequently leads the maternal PI meetings and participates in the Perinatal Multidisciplinary Committee and other maternal meetings as appropriate; and

6. Ensure that the PI Plan is specific to maternal and fetal care, is ongoing, data-driven and outcome based, including telehealth/telemedicine utilization, when used.

Source: Miss. Code Ann. § 41-3-15

Chapter 3 Maternal Designation Level I (Basic Care)

Subchapter 1 Hospital Organization

Rule 3.1.1. The Level I maternal designated facility shall provide care for low-to moderate risk pregnancies with the ability to detect, stabilize, and initiate management of unanticipated maternal-fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility at which specialty maternal care is available.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.
2. Compliance with the above will be evidenced by but not limited to:
    a. Governing authority and medical staff letter of commitment in the form of a resolution;
    b. Written policies and procedures and guidelines for the care of the maternal patient;
    c. Defined maternal team and written roles and responsibilities;
    d. Appointed Maternal Medical Director with a written job description;
    e. Appointed Maternal Program Manager with a written job description;
    f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.5. Maternal Program Manager (MPM): Level I OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 3.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

    b. Maternal Program Manager

    c. Obstetrics and Gynecology

d. Certified Nurse Midwife (if applicable)

e. Maternal Fetal Medicine

f. Anesthesia

g. Pediatrician/Family Physician/APPs

h. Labor and Delivery

i. Nursing

j. Laboratory

k. Radiology (Ultrasound)

l. Respiratory Therapy

m. Social Services/Pastoral Care

n. Dietary

o. Lactation Specialist (or equivalent)

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 3.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 3.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur with the consultation of Level IV, if needed. The program shall manage high-risk patients within its capabilities or initiate transfer protocols for those requiring advanced care. (see guidelines)

Source: Miss. Code Ann. § 41-3-15

Rule 3.2.4. Patient Education and Quality Improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 3.3.1 Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patients.

Source: Miss. Code Ann. § 41-3-15

Rule 3.3.2. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

Rule 3.3.3. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 3.4.1. Interdisciplinary Team: The Level I OB Center has an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The

interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation, at all times. *

2. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified birthing professional with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies. *

    a. must arrive at the patient's bedside within 30 minutes of an urgent request; and
    b. must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

* *A physician with privileges to perform emergency cesarean deliveries must be readily available at all times*.

3. Anesthesia: Anesthesia providers, such as anesthesiologists, nurse anesthetists, or anesthesiologist assistants working with an anesthesiologist for labor analgesia and surgical anesthesia must be readily available at all times. Anesthesia personnel with training and experience must be available at all times and arrive at the patient's bedside within thirty (30) minutes of an urgent request.

4. Nursing: Qualified labor, delivery, surgical, and recovery nursing personnel in adequate numbers to meet the needs of each patient are readily available at all times. Every birth must be attended by an appropriately trained and qualified RN with level-appropriate competencies as demonstrated by nursing competency documentation.

a. Nursing leadership must have level-appropriate formal training and experience in maternal care.

5. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to

determine blood type and Rh type, crossmatch blood and perform antibody testing. There must also be guidelines or protocols in place for:

a. initiation of massive blood component transfusion at all times with the process to obtain more blood and component therapy as needed;
b. Emergency release of blood components; and
c. Management of multiple blood component therapy.

6. Radiology and Ultrasound Support: Radiology and Ultrasound support services should be readily available at all times.

   Note: It is anticipated that the Level I center will have limited obstetric ultrasonography with interpretation capabilities readily available at all times.

7. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.

8. Support Staff:
   a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

   b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.

   c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.3. Physicians providing back-up coverage must arrive at the patient's bedside within thirty (30) minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. must operate under guidelines reviewed and approved by the MMD; and
2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:
   a. provide back-up and consultation; and
   b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.5. Level I Obstetrical Center requirements:

1. 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 specialty or sub-specialty care.
2. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
3. Mothers that are stable and likely to deliver before 35 weeks' gestation or have a fetus that is likely to require specialty services and mothers who themselves are likely to require specialty services should be transferred prior to delivery, when possible.
4. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.
5. Care of postpartum conditions.
6. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.
7. Capability to implement patient safety bundles for common causes of preventable maternal morbidity, such as management of maternal venous thromboembolism, obstetric hemorrhage, and severe maternal hypertension in pregnancy.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

2. obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

3. placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

5. sepsis or systemic infection in the pregnant or postpartum patient;

6. venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

7. shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

8. behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 3.4.7. Perinatal Education.

1. The Level I OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.

2. Level I OB Centers must have a written perinatal education plan.

Source: Miss. Code Ann. § 41-3-15

Chapter 4

Maternal Designation Level II (Specialty Care)

Subchapter 1 Hospital Organization

Rule 4.1.1. The Level II maternal designated facility shall provide Level I facility level of care plus care of appropriate moderate- to high-risk antepartum, intrapartum, and postpartum conditions.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician with obstetrics training and experience and with privileges in maternal care or an obstetrics and gynecology physician. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.

2. Compliance with the above will be evidenced by but not limited to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;

b. Written policies and procedures and guidelines for the care of the maternal patient;

c. Defined maternal team and written roles and responsibilities;

d. Appointed Maternal Medical Director with a written job description;

e. Appointed Maternal Program Manager with a written job description;

f. Analysis and review of system perinatal outcome and quality data; and

g. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. Based upon available resources and facility determination of the most appropriate staffing, it may be acceptable for such leader to be board certified in another specialty with privileges and expertise in obstetric care including surgical skill and privileges to perform cesarean delivery. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.5. Maternal Program Manager (MPM): Level II OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 4.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

    b. Maternal Program Manager

    c. Neonatal Medical Director (if different from the MMD)

    d. Neonatal Program Manager (if different from the MPM)

    e. Pediatrician or Neonatologist

    f. Obstetrics and Gynecology

    g. Certified Nurse Midwife (if applicable)

    h. Maternal Fetal Medicine

    i. Anesthesia

    j. Labor and Delivery

k. Nursing

l. Laboratory

m. Radiology (Ultrasound)

n. Respiratory Therapy

o. Social Services/Pastoral Care

p. Dietary

q. Lactation Specialist (or equivalent)

r. General surgery

s. Internal Medicine

t. Family Medicine

u. Advanced Practice Provider

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 4.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 4.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-

risk patients within its capabilities or initiate transfer protocols for those requiring advanced care.

Source: Miss. Code Ann. § 41-3-15

Rule 4.2.3. Transfer Agreements and Continuity of Information: Written transfer agreements shall be maintained with higher-level referral centers. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

Rule 4.2.4. Patient Education and Quality Improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 4.3.1 Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 4.3.2. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities.

Source: Miss. Code Ann. § 41-3-15

Rule 4.3.3. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 4.4.1. Interdisciplinary Team: The Level II OB Center has an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation, at all times. *
   a. Based on available resources and facility determination of the most appropriate staffing, it may be acceptable for a family physician with obstetric fellowship training or equivalent training and skills in obstetrics, and with surgical skill and privileges to perform cesarean delivery to meet the criteria for being readily available at all times.

2. Obstetrics: An obstetrics provider must be readily available at all times.

3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies. *
   a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and
   b. Must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

   **A physician with privileges to perform emergency cesarean deliveries must be readily available at all times*.

4. Maternal-Fetal Medicine (MFM): A MFM specialist must be readily available at all times for consultation on-site. Availability may be through phone or telemedicine, if necessary.

5. Anesthesia: Qualified personnel with anesthesia privileges must be readily available at all times. Anesthesia personnel with training and experience must be available at all times and arrive at the patient's bedside within thirty (30) minutes of an urgent request.

6. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.

7. Nursing: Qualified labor, delivery, surgical, and recovery nursing personnel in adequate numbers to meet the needs of each patient are readily available at all times.

8. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must also be guidelines or protocols in place for:

    a. Massive blood component transfusion;

    b. Emergency release of blood components; and

    c. Management of multiple blood component therapy.

9. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:

    a. Computed tomography scans;

    b. Magnetic resonance imaging;

    c. Non obstetric ultrasound imaging

    d. Standard obstetric ultrasound imaging; and

    e. Maternal echocardiography.

10. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.

11. Support Staff:
    a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.

c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. Must operate under guidelines reviewed and approved by the MMD; and
2. Must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

   a. provide back-up and consultation; and

   b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.5. Level II Obstetrical Center requirements:

1. 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 specialty or sub-specialty care.
2. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.
3. Proper detection and supportive care of known maternal conditions and unanticipated maternal-fetal problems that occur during labor and delivery.
4. Care of postpartum conditions.

5. Maintain a staff of providers certified to perform normal and operative vaginal deliveries and cesarean sections including obstetricians and family physicians with advanced training in obstetrics, providers certified to perform normal vaginal deliveries including certified nurse midwives, and registered nurses with training in labor and delivery, post-partum care or inpatient obstetrics.
6. Mothers that are stable and likely to deliver before 32 weeks gestation or have a neonate that is likely to require sub-specialty services, or mothers who themselves are likely to require sub-specialty services should be transferred prior to delivery, when possible.
7. Access to maternal fetal medicine consultation and antenatal diagnosis technology including fetal ultrasound.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;

2. obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;

3. placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;

5. sepsis or systemic infection in the pregnant or postpartum patient;

6. venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

7. shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

8. behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 4.4.7. Perinatal Education.

1. The Level II OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.

2. Level II OB Centers must have a written perinatal education plan.

Chapter 5

Maternal Designation Level III (Subspecialty Care)

Subchapter 1 Hospital Organization

Rule 5.1.1. The Level III maternal designated facility must provide Level II facility level of care plus provide care of more complex maternal medical conditions, obstetric complications, and fetal conditions.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with

obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved. The program must provide perinatal system leadership if acting as a regional center in areas where Level IV facilities are not available.

2. Compliance with the above will be evidenced by but not limited to:

a. Governing authority and medical staff letter of commitment in the form of a resolution;

b. Written policies and procedures and guidelines for the care of the maternal patient;

c. Defined maternal team and written roles and responsibilities;

d. Appointed Maternal Medical Director with a written job description;

e. Appointed Maternal Program Manager with a written job description; and

f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care or a board-certified maternal-fetal medicine (MFM) physician that demonstrates administrative skills and oversight of the performance improvement

(PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.5. Maternal Program Manager (MPM): Level III OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 5.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

    b. Maternal Program Manager

    c. Neonatal Medical Director (if different from MMD)

    d. Neonatal Program Manager (if different from MPM)

e. Pediatrician or Neonatologist

f. Obstetrics and Gynecology *

g. Certified Nurse Midwife (if applicable)

h. Maternal Fetal Medicine (MFM)**

i. Anesthesia***

j. Labor and Delivery

k. Nursing

l. Laboratory

m. Radiology (Ultrasound)

n. Respiratory Therapy

o. Social Services/Pastoral Care

p. Dietary

q. Lactation Specialist (or equivalent)

r. General surgery

s. Internal Medicine

t. Family Medicine

u. Advanced Practice Provider

v. Intensive Care Unit

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

** The director of obstetric service shall be a board-certified OB-GYN or MFM.*

*** The director of the MFM program shall be a board-eligible or board-certified MFM physician.*

**** The director of obstetric anesthesia services shall be a board-certified anesthesiologist with obstetric* anesthesia fellowship training or experience in obstetric anesthesia.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 5.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-risk patients within its capabilities or initiate transfer protocols for those requiring advanced care.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.3. Transfer agreements and continuity of information: Written transfer agreements shall be maintained with higher-level referral centers. Mechanisms for timely exchange of medical records, orders, and status updates shall be established before and after patient transfer.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.4. Patient education and quality improvement: The program shall provide comprehensive education regarding available perinatal services and engage in

ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Rule 5.2.5. Leadership and accountability: A designated perinatal services leader shall be appointed, who is responsible for aligning staffing, resources, policies, and procedures with the organization's verified Maternal Level of Care and for continuous program oversight.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 5.3.1. The Level III OB Center must have the capability to accept maternal transports from lower levels of care for unanticipated high-risk pregnancies.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.2 Maternal transports from lower levels: The program shall maintain the capability to accept urgent maternal transports from lower-level facilities. Upon transfer request, the receiving team must confirm ETA, mobilize appropriate staff and resources, and prepare bed assignments to guarantee safe admission and continuity of care.

Rule 5.3.3. Identification and Management of Transfers: The program shall define criteria for maternal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. The program shall maintain documented mechanisms to facilitate and accept maternal transfers/transports. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patients.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.4. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities to address maternal care quality issues.

Source: Miss. Code Ann. § 41-3-15

Rule 5.3.5. Stabilization and Transfer Protocols: Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 5.4.1. Interdisciplinary Team: The Level III OB Center must have an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation at all times.

2. Obstetrics: A board-eligible or board-certified obstetrician must be physically present on site at all times.

3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend to all deliveries or other obstetrical emergencies.

    a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and

    b. Must complete annual continuing education, specific to the care of pregnant and postpartum patients, including complicated conditions.

4. Maternal-Fetal Medicine (MFM): A MFM specialist with inpatient privileges must be readily available at all times, either on site, by phone, or by telemedicine. Timing of the need to be on site is directed by the urgency of the clinical situation; however the provider must be able to be on site to provide direct care within 24 hours. The MFM specialist shall also be available at all times for consult for all pregnant or postpartum patients in the ICU.

5. Anesthesia: Board-certified anesthesiologist must be on site 24 hours a day, 7 days a week.

6. Intensive Care Unit (ICU): There must be the availability of an adult medical and surgical ICU that accepts pregnant women and women in the postpartum period. The ICU must be staffed by adult critical care providers on site 24 hours a day, 7 days a week.

7. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.

8. Nursing: Nursing leaders and qualified labor, delivery, surgical, and recovery nursing personnel who have special training and experience in the management of women with complex and critical maternal illnesses and obstetric complications in adequate numbers to meet the needs of each patient are readily available at all times.

9. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must be in-house availability of all blood components. There must also be guidelines or protocols in place for:

    a. Massive blood component transfusion;

    b. Emergency release of blood components; and

    c. Management of multiple blood component therapy.

10. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:

    a. Specialized obstetric ultrasound and fetal assessment (to include Doppler studies);

    b. Computed tomography scans;

    c. Magnetic resonance imaging;

    d. Standard non-obstetric ultrasound imaging

e. Standard obstetric ultrasound imaging;

f. Maternal echocardiography; and

g. Basic interventional radiology (capable of performing uterine artery embolization).

11. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.
    a. Appropriate equipment and personnel physically present at all times onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.

12. Support Staff:
    a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

    b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.

    c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

13. Subspecialists shall be readily available, per the facility's policy, for inpatient consultation, which include critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. must operate under guidelines reviewed and approved by the MMD; and

2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

    a. provide back-up and consultation; and
    b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.5. Level III Obstetrical Center requirements:

1. Manage complex maternal and fetal illnesses before, during and after delivery.
2. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. Massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. Obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;
3. Placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of

unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. Hypertensive disorders in pregnancy, including eclampsia and the postpartum patient to promote early diagnosis and treatment to reduce morbidity and mortality;
5. Sepsis or systemic infection in the pregnant or postpartum patient;
6. Venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;
7. Shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and
8. Behavioral health disorders, including depression, substance abuse and addiction that includes screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 5.4.7. Perinatal Education.

1. The Level III OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.

2. Level III OB Centers must have a written perinatal education plan.

Chapter 6

Maternal Designation Level IV (Regional Perinatal Health Care Centers)

Subchapter 1 Hospital Organization

Rule 6.1.1. The Level IV maternal designated facility must provide Level III facility level of care plus provide on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.2. Maternal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal and maternal care. The written commitment shall be in the form of a resolution at the time of application passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together

with the written commitment of the hospital's chief executive officer, to the establishment of a maternal care program may be sufficient. The maternal program must be established and recognized by the medical staff and hospital administration. The maternal program must come under the direction of a family medicine physician or an obstetrics and gynecology physician, with obstetrics training and experience, and with privileges in maternal care. The administrative structure must minimally include an administrator, Maternal Medical Director (MMD), Maternal Program Manager (MPM), and appropriate support staff. The Maternal Program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the departments involved. The Level IV facility must provide perinatal system leadership, including facilitation of collaboration with facilities in the region, analysis and review of system perinatal outcome and quality data, provision of outreach education and assistance with quality improvement as needed.

2. Compliance with the above will be evidenced by but not limited to:

   a. Governing authority and medical staff letter of commitment in the form of a resolution;

   b. Written policies and procedures and guidelines for the care of the maternal patient;

   c. Defined maternal team and written roles and responsibilities;

   d. Appointed Maternal Medical Director with a written job description;

   e. Appointed Maternal Program Manager with a written job description; and

   f. A written Maternal Performance Improvement plan.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.3. Maternal Service: The maternal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the perinatal patient. The maternal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Maternal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.4. Maternal Medical Director (MMD): The MMD must be a board-eligible or board-certified physician with obstetrics training and experience, and with privileges in maternal care or a board-eligible or board-certified maternal-fetal medicine physician that demonstrates administrative skills and oversight of the performance improvement (PI) plan and has completed annual continuing education specific to maternal care. The MMD must cooperate with nursing administration to support the nursing needs of the perinatal patient and develop treatment protocols for the perinatal patients. A qualified provider with obstetric privileges may be responsible for the management of the program's obstetric services.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.5. Maternal Program Manager (MPM): Level IV OB Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the MPM. Working in conjunction with the MMD, the MPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training.

Source: Miss. Code Ann. § 41-3-15

Rule 6.1.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

b. Maternal Program Manager

c. Neonatal Medical Director (if different from MMD)

d. Neonatal Program Manager (if different from MPM)

e. Pediatrician or Neonatologist

f. Obstetrics and Gynecology*

g. Certified Nurse Midwife (if applicable)

h. Maternal Fetal Medicine (MFM)**

i. Anesthesia***

j. Labor and Delivery

k. Nursing

l. Laboratory

m. Radiology (Ultrasound)

n. Respiratory Therapy

o. Social Services/Pastoral Care

p. Dietary

q. Lactation Specialist (or equivalent)

r. General surgery

s. Internal Medicine

t. Advanced Practice Provider

u. Family Medicine

v. Intensive Care Unit

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The OB Center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement (PI) program.

** The director of obstetric service shall be a board-certified OB-GYN or MFM*

***The director of the MFM program shall be a board-eligible or board-certified MFM physician.*

**** The director of obstetric anesthesia services shall be a board-certified anesthesiologist with obstetric anesthesia fellowship training or experience in obstetric anesthesia.*

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 Obstetric Service Provision

Rule 6.2.1. Patient-centered continuum of care shall be coordinated among all providers to ensure continuity, with prenatal assessments and care plans accessible at delivery sites and postpartum records shared with outpatient providers.

Source: Miss. Code Ann. § 41-3-15

Rule 6.2.2. High-risk pregnancy management: Early identification of high-risk pregnancies and appropriate risk-management shall occur. The program shall manage high-risk patients within its capabilities

Source: Miss. Code Ann. § 41-3-15

Rule 6.2.4. Patient education and quality improvement: The program shall provide comprehensive education regarding available perinatal services and engage in ongoing quality improvement activities, including review of outcomes from prenatal through postpartum care.

Source: Miss. Code Ann. § 41-3-15

Rule 6.2.5. Leadership and accountability: A designated perinatal services leader shall be appointed, who is responsible for aligning staffing, resources, policies, and procedures with the organization's verified Maternal Level of Care and for continuous program oversight.

Source: Miss. Code Ann. § 41-3-15

Subchapter 3 Transfer Guidelines

Rule 6.3.1. The Level IV OB Center must have the capability to accept maternal transports from lower levels of care for unanticipated high-risk pregnancies.

Source: Miss. Code Ann. § 41-3-15

Rule 6.3.2. Maternal transports from lower levels: The program shall maintain the capability to accept urgent maternal transports from lower-level facilities. Upon transfer request, the receiving team must confirm ETA, mobilize appropriate staff and resources, and prepare bed assignments to guarantee safe admission and continuity of care.

Rule 6.3.3 Identification and Management of Transfers: The program shall maintain prearranged relationships for immediate consultation and patient relocation. The program shall maintain documented mechanisms to facilitate and accept maternal transfers/transports. All designated facilities will agree to provide service to the maternal patient regardless of their ability to pay. Written agreements should be in place for the transfer of perinatal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 6.3.4. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities to address maternal care quality care issues. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Clinical Components

Rule 6.4.1. Interdisciplinary Team: The Level IV OB Center must have an interdisciplinary team that includes individuals with expertise in and/or knowledge about the specialized care, treatment and services required for perinatal care. The

interdisciplinary team includes individuals and specialized services to support the care, treatment, and services provided by the program.

The following individuals and services are represented on the team:

1. Obstetrics and Gynecology physician: The Obstetrics and Gynecology physician with obstetrics training and experience must be available for consultation at all times.

2. Obstetrics: A board-eligible or board-certified obstetrician must be physically present on site at all times.

3. Qualified Physicians/Certified Nurse Midwife: Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies.

    a. Must arrive at the patient's bedside within thirty (30) minutes of an urgent request; and

    b. Must complete annual continuing education, specific to the care of pregnant and postpartum patient, including complicated conditions.

4. Maternal-Fetal Medicine (MFM): A board-certified MFM attending with full inpatient privileges must be readily available at all times, either on site, by phone, or by telemedicine for consultation and management. The need to be on site is directed by the urgency of the clinical situation; however, the provider must be able to be on site to provide direct care within 24 hours. The MFM specialist shall also be available at all times for consultation for all pregnant or postpartum patients in the ICU.

5. MFM Critical Care Team: The facility must have a MFM critical care team in place whose members have the expertise to manage highly complex, critically ill, or unstable maternal patients. This includes co-management for all pregnant or postpartum patients in the ICU.

    a. A MFM Critical Care Team member with full obstetrical privileges shall be available at all times for on-site consultation and management, and to arrive at the patient's bedside within thirty (30) minutes of an urgent request

b. A board-certified MFM physician with expertise in critical care obstetrics shall lead the team.

6. Anesthesia: Board-certified anesthesiologist with obstetric anesthesia fellowship training or experience must be physically present on site 24 hours a day, 7 days a week.

7. Medical/Surgical: On-site medical and surgical capabilities must be available for complex maternal conditions.

8. Intensive Care Unit: There must be the availability of an on-site adult medical and surgical ICU for obstetric patients who are primarily or co-managed by an MFM team. This includes the onsite provision of medical and surgical care for complex maternal and surgical care for complex maternal conditions, supported by the availability of critical care units or ICU beds. (Co-management includes at least daily rounds by an MFM specialist physician with interaction with the ICU team and other subspecialists with daily documentation.) The ICU must be staffed by adult critical care providers on site 24 hours a day, 7 days a week. In some settings, the ICU is in adjoining or connected building, which is acceptable as long as maternal-fetal medicine care is as noted above. If the woman must be transported by ambulance to the ICU, this is not considered onsite.

9. Internal medicine providers, family medicine providers, and general surgeons must be readily available at all times for obstetric patients.

10. At least one of the following adult subspecialties must be readily available for consultation and treatment as needed onsite: neurosurgery, cardiac surgery, or transplant. If the facility does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed services.

11. Nursing: The center shall have a continuous availability of adequate RNs who have experience in the care of women with complex medical illnesses and obstetric complications with close collaboration between critical care nurses and obstetric nurses with expertise in care for critically ill women.
    i. The Nursing Service Line leadership must have an advanced degree and national certification.

12. Laboratory and Blood Bank Services: Laboratory personnel must be immediately available to obtain and process appropriate samples and report urgent/emergent results. Blood bank services must be available at all times to determine blood type and Rh type, crossmatch blood and perform antibody testing. There must be in-house availability of all blood components. There must also be guidelines or protocols in place for:

    a. Massive blood component transfusion;

    b. Emergency release of blood components; and

    c. Management of multiple blood component therapy.

13. Radiology Support: Radiologic services with interpretation must be readily available at all times and include:

    a. Specialized obstetric ultrasound and fetal assessment (to include Doppler studies);

    b. Computed tomography scans;

    c. Magnetic resonance imaging;

    d. Standard obstetric ultrasound imaging;

    e. Maternal echocardiography; and

    f. Advanced interventional radiology (capable of performing uterine artery embolization).

11. Respiratory and Pharmacy: Respiratory care personnel and a registered pharmacist should be readily available at all times.

12. Support Staff:
    a. Lactation Specialists: Lactation Specialists or support staff with knowledge and skills in breastfeeding and lactation to meet the needs of maternal patients must be available at all times.

    b. Social services, pastoral care, or bereavement services must be provided as appropriate to meet the needs of the patient population served.

c. A dietician or nutritionist should be available with the appropriate training and experience for the population served.

13. Subspecialists shall be readily available, per the facility's policy, for inpatient consultation, which includes critical care, general surgery, infectious disease, hematology, cardiology, nephrology, neurology, gastroenterology, internal medicine, behavioral health, and neonatology.

    a. At least one of the following adult subspecialties must be available at all times, per the facility's policy, for consultation and treatment needed on site:

        i. Neurosurgery

        ii. Cardiac surgery

        iii. Transplant surgery

    Note: If the organization does not have all three subspecialties available, there should be a process in place to transfer women to a facility that can provide the needed services.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.2. An on-call schedule of providers, back-up providers, and provision for patients without a physician must be readily available to facility and maternal staff and posted on the labor and delivery unit.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.3. Ensure that physicians providing back-up coverage must arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.4. Certified nurse midwives, physician assistants and nurse practitioners who provide care for maternal patients:

1. must operate under guidelines reviewed and approved by the MMD; and

2. must have a formal arrangement with a physician with obstetrics training or experience, and with maternal privileges who must:

    a. provide back-up and consultation; and

    b. arrive at the patient's bedside within 30 minutes of an urgent request.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.5. Level IV OB Obstetrical Center requirements:

1. Manage complex maternal and fetal illnesses before, during and after delivery.
2. Maintain access to consultation and referral to Maternal-Fetal Medicine specialists.
3. Maintain a full range of surgical and medical specialists including Maternal-Fetal Medicine specialists at the site.
4. Facilitate maternal transport and provide outreach education.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.6. Guideline/Protocol Development

The facility must have written guidelines or protocols for various conditions that place the pregnant or postpartum patient at risk for morbidity or mortality, including promoting prevention, early identification, early diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must address a minimum of:

1. Massive hemorrhage and transfusion of the pregnant or postpartum patient in coordination of the blood bank, including management of unanticipated hemorrhage or coagulopathy;
2. Obstetrical hemorrhage, including promoting the identification of patients at risk, early diagnosis, and therapy to reduce morbidity and mortality;
3. Placenta accreta spectrum disorder, including team education, risk factor screening, evaluation, diagnosis, fostering telemedicine medical services and referral as appropriate, treatment and multidisciplinary management of both

anticipated and unanticipated placenta accreta spectrum disorder cases, including postpartum care;

4. Hypertensive disorders in pregnancy, including eclampsia and postpartum patients to promote early diagnosis and treatment to reduce morbidity and mortality;

5. Sepsis or systemic infection in the pregnant or postpartum patient;

6. Venous thromboembolism in the pregnant and postpartum patient, including assessment of risk factors, prevention, early diagnosis and treatment;

7. Shoulder dystocia, including assessment of risk factors, counseling of patient, and multidisciplinary management; and

8. Behavioral health disorders, including depression, substance abuse and addiction that include screening, education, consultation with appropriate personnel and referral.

Source: Miss. Code Ann. § 41-3-15

Rule 6.4.7. Perinatal Education.

1. The Level IV OB Center must have internal perinatal education programs including training for physicians, nurses, ancillary staff, and prehospital providers.

2. Level IV OB Centers must have a written perinatal education plan.

Source: Miss. Code Ann. § 41-3-15

Chapter 7 Neonatal Levels of Care

Subchapter 1 Neonatal Program Requirements

The neonatal levels of care establish a tiered framework—Level I through Level IV—to match facility resources, clinical expertise, and support services with the acuity of mothers and their newborns. Each ascending level builds on the previous one by defining progressively advanced requirements for infrastructure, staffing, specialized services, and quality-improvement activities, ensuring that every infant receives risk-appropriate, evidence-based care at the right place and time.

Rule 7.1.1. Designated neonatal facilities must have a family-centered philosophy. Parents must have reasonable access to their infants at all times and be encouraged to participate in the care of their infants. The facility environment for perinatal care must meet the physiologic, developmental, and psychosocial needs of the mothers, infants, and families.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.2 Designated neonatal facilities organized medical staff and institutional governing body must demonstrate an institutional commitment to the neonatal program and will

1. Include allocation of sufficient personnel and resources to attain optimal neonatal care;
2. Reaffirm the neonatal program at least every three (3) years; and
3. Verify the neonatal program description is current at the time of neonatal verification

Rule 7.1.3. Neonatal Program Plan. The facility must develop a written neonatal operational plan for the neonatal program that includes a detailed description of the scope of services and clinical resources available for all neonatal patients, mothers, and families. The plan must define the neonatal patient population evaluated, treated, transferred, or transported by the facility consistent with clinical guidelines based on current standards of neonatal practice ensuring the health and safety of patients. The plan must identify the resources used to develop the facility's neonatal policies and procedures for the neonatal services it provides.

1. The written Neonatal Program Plan must be reviewed and approved by Perinatal Multidisciplinary Committee and be submitted to the facility's governing body for review and approval. The governing body must ensure the requirements of this section are implemented and enforced.

2. The written Neonatal Program Plan must include, at a minimum:

   a. Clinical guidelines based on current standards of neonatal practice, and policies and procedures that are adopted, implemented, and enforced by the neonatal program;

   b. A process to ensure and validate these clinical guidelines based on current standards of neonatal practice, policies, and procedures, are reviewed and revised a minimum of every three years;

c. Written triage, stabilization, and transfer guidelines for neonatal patients that include consultation and transport services;

d. The role and scope of telehealth/telemedicine practices, if utilized, including:

   i. documented and approved written policies and procedures that outline the use of telehealth/telemedicine for inpatient hospital care or for consultation, including appropriate situations, scope of care, and

   ii. documentation that is monitored through the neonatal Performance Improvement (PI) Plan and process; and

   iii. written and approved procedures to gain informed consent from the patient or designee for the use of telehealth/telemedicine, if utilized, that are monitored for variances;

e. written guidelines for discharge planning instructions and appropriate follow-up appointments for all neonates/infants;

f. provisions to facilitate continuity of care for high-risk neonatal patients from delivery to discharge;

g. delineation of roles, responsibilities, and authority of the medical, nursing, and ancillary patient care directors;

h. physician, advanced practice nurse, and/or other medical care provider staffing plan for neonatal coverage;

i. plan for nurse staffing including provisions for flexibility and change in census and acuity;

j. written guidelines for the hospital disaster response, including a defined neonatal evacuation plan and process to relocate mothers and infants to appropriate levels of care with identified resources, and this process must be evaluated annually to ensure neonatal care can be sustained and adequate resources are available;

k. written minimal education and credentialing requirements for all staff participating in the care of neonatal patients, which are documented and monitored by the managers who have oversight of staff;

l. written requirements for providing continuing staff education, including annual educational needs assessment to evaluate the ongoing educational needs of all staff participating in the care of newborns, which are documented and monitored by the managers who have oversight of staff;

m. annual education plan for all staff participating in the care of newborns that includes didactic, education, simulation, competency, and skills validation;

n. measures to monitor the availability of all necessary equipment and services required to provide the appropriate level of care and support for the patient population served;

o. documented guidelines for consulting support personnel with knowledge and skills in breastfeeding and lactation, which includes expected response times, defined roles, responsibilities, and expectations;

p. Appropriate allocations for family-centered care including providing parents with reasonable access to their infants and encouraging advocacy, shared decision-making, and participation in their child's care; and

q. Assurance of equitable care for all neonatal patients and families and provisions for promoting an environment of cultural humility.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.4. Patient Safety and Quality Improvement. The facility must have a documented and approved Neonatal PI Plan. The Chief Executive Officer, Chief Medical Officer (or Chief of Staff), and Chief Nursing Officer must implement a culture of safety for the facility and ensure adequate resources are allocated to support a concurrent, data-driven Neonatal PI Plan.

1. The facility will have a system for identification and review of significant events that could indicate threats to patient safety, with a goal of learning from identified events and mitigating future risk of recurrence, including:

a. A list of specific triggers or safety indicators that warrant a record review, with the goal of identifying significant safety events such as errors, adverse events, near misses, complications, and mortalities;

b. A process for systematic multidisciplinary review of selected cases or safety events, using acceptable failure mode and effect analysis tools with a

goal of identifying interventions to improve systems and reduce future safety risks; and

c. A process for monitoring the implementation of identified interventions.

2. The facility will have a dashboard or equivalent that is used to summarize and track quality indicators relevant to newborn care, including:

   a. A list of selected quality measures relevant to the facility with a process for obtaining data needed for each selected neonatal quality measure;

   b. A platform to display performance on the selected quality measures, including a process for updating data with a frequency that allows for appropriate identification of performance concerns;

   c. Benchmarking of performance, when possible, with internal or external benchmarks; and

   d. A multidisciplinary forum for review of the dashboard or equivalent.

3. The facility will have a structured approach to quality improvement (QI) that seeks to improve care quality and outcomes. Quality outcomes include care that is safe, efficient, effective, timely, equitable, and patient centered. Approaches will include:

   a. A clear process for determining current QI initiatives, with a goal that the unit is engaged in at least 1 to 2 such initiatives at any given time;

   b. Identification of a multidisciplinary QI team for each initiative, with a designated team lead;

   c. Use of structured improvement methods or framework to guide improvement efforts; and

   d. A multidisciplinary quality committee that meets regularly to identify and review QI initiatives.

4. The facility will maximize efforts to standardize and improve care through the use of guidelines and policies that align with research-driven and evidence-based best practices, including:

   a. A process for identifying topics for guideline or policy development;

   b. A process for developing guidelines and policies that incorporate evidence-based recommendations;

   c. A platform for making guidelines and policies readily available to clinical providers; and

d. A process for periodic review of guidelines and policies to guarantee they remain updated, and evidence based.

5. The facility will have multidisciplinary involvement in quality and safety activities, including:

    a. Involvement of all disciplines represented in the neonatal quality and safety activities as appropriate and as described above; and

    b. For level IV facilities, involvement of subspecialty services with significant presence in the neonatal unit.

6. The neonatal-specific unit will coordinate with hospital quality and safety activities, including:

    a. Structured collaboration with the obstetrics and pediatric surgery departments, if applicable, to identify and implement opportunities for shared quality and safety efforts;

    b. Participation in hospital-level quality and safety activities to confirm alignment of neonatal quality goals with hospital priorities;

    c. Alignment with hospital activities and reporting of quality measures to national organizations; and

    d. Participation in efforts to guarantee everyday readiness for external assessments by regulatory organizations.

7. The facility will participate in larger communities of perinatal safety and quality, including:

    a. Collaboration between transferring and receiving hospitals to examine and improve population-level quality and safety through structured activities such as transport review and sharing of clinical protocols; and

    b. For level III and IV facilities, participation in regional, state, or national databases that allows benchmarking of performance.

1. The Neonatal Medical Director (NMD) must have the authority to make referrals for peer review, receive feedback from the peer review process, and ensure neonatal physician representation in the peer review process for neonatal cases.

2. The facility must have documented evidence of neonatal PI summary reports reviewed and reported by Perinatal Multidisciplinary Committee that monitor

and ensure the provision of services or procedures through telehealth and telemedicine, if utilized, is in accordance with the standards of care applicable to the provision of the same service or procedure in an in-person setting.

3. The facility must have documented evidence of neonatal PI summary reports to support that aggregate neonatal data are consistently reviewed to identify developing trends, opportunities for improvement, and necessary corrective actions. Summary reports must be provided through the Perinatal Multidisciplinary Committee, available for site surveyors, and submitted to the Department as requested.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.5. Medical Staff. The facility must have an organized, effective neonatal program that is recognized by the facility's medical staff and approved by the facility's governing body.

1. The credentialing of the neonatal medical staff must include a process for the delineation of privileges for neonatal care.

2. The neonatal medical staff must participate in ongoing staff and team-based education and training in the care of the neonatal patient.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.6. Medical Director. There must be an identified NMD. The NMD must be credentialed by the facility for treatment of neonatal patients and have their responsibilities and authority defined in a job description. The NMD must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course. The NMD is responsible for the provision of neonatal care services and must:

1. Examine qualifications of medical staff and advanced practice providers requesting privileges to participate in neonatal/infant care and make recommendations to the appropriate committee for such privileges.

2. Ensure neonatal medical staff and advanced practice provider competencies in managing neonatal emergencies, complications, and resuscitation techniques;

3. Monitor neonatal patient care from transport, to admission, stabilization, and operative intervention(s), as applicable, through discharge, and review variances in care through the neonatal Performance Improvement (PI) Plan;

4. Participate in ongoing neonatal staff and team-based education and training in the care of the neonatal patient;

5. Oversee the inter-facility neonatal transport as appropriate;

6. Collaborate with the Neonatal Program Manager (NPM), maternal teams, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:

    a. written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;

    b. the Neonatal PI Plan, specific reviews, and data initiatives;

    c. criteria for transfer, consultation, or higher-level of care; and

    d. medical staff, advanced practice providers, and personnel competencies, education, and training;

7. Participate as a clinically active and practicing physician in neonatal care at the facility where medical director services are provided;

8. Ensure that the Neonatal PI Plan is specific to neonatal/infant care, is ongoing, data driven, and outcome based;

9. Frequently lead the neonatal PI meetings with the NPM and participate in the Perinatal Multidisciplinary Committee and other neonatal meetings, as appropriate;

10. Maintain active staff privileges as defined in the facility's medical staff bylaws; and

11. Develop and maintain collaborative relationships with other NMDs of designated neonatal facilities within the applicable region.

12. Collaborate with the transport team to develop, revise, and implement written policies, procedures, and guidelines, for neonatal care that are implemented and monitored for variances;

13. Participate in ongoing transport staff competencies, education, and training;

14. Review and evaluate transports from initial activation of the transport team through delivery of patient, resources, quality of patient care provided, and patient outcomes; and

15. Integrate review findings into the overall Neonatal PI Plan and process.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.7. Neonatal Program Manager (NPM). The facility must identify an NPM who has the authority and oversight responsibilities written in his or her job description, for the provision of neonatal services through all phases of care, including discharge, and identifying variances in care for inclusion in the Neonatal PI Plan. The NPM must be a registered nurse with defined education, credentials, and experience for neonatal care applicable to the level of care being provided. The NPM must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course. The NPM must:

1. Ensure staff competency in resuscitation techniques;

2. Participate in ongoing staff and team-based education and training in the care of the neonatal patient;

3. Monitor utilization of telehealth/telemedicine, if used;

4. Collaborate with the NMD, maternal program, consulting physicians, and nursing leaders and units providing neonatal care to include developing, implementing, or revising:

    a. written policies, procedures, and guidelines for neonatal care that are implemented and monitored for variances;
    b. the Neonatal PI Plan, specific reviews, and data initiatives;
    c. criteria for transfer, consultation, or higher-level of care; and
    d. staff competencies, education, and training;

5. Regularly and actively participate in neonatal care at the facility where program manager services are provided;

6. Consistently review the neonatal care provided and ensure the Neonatal PI Plan is specific to neonatal/infant care, data driven, and outcome-based;

7. Frequently lead the meetings and participate in Perinatal Multidisciplinary Committee and other neonatal meetings as appropriate; and

8. Develop and maintain collaborative relationships with other NPMs of designated neonatal facilities within the applicable PCR.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.8. Transfer Guidelines

The program shall define criteria for neonatal transfers to higher-level facilities and maintain prearranged relationships for immediate consultation and patient relocation. All designated facilities will agree to provide service to the neonatal patient regardless of their ability to pay. Written agreements should be in place for the transfer of the neonatal patient.

Rule 7.1.9 Stabilization and Transfer Protocols:

Patients requiring transfer shall receive prompt assessment, stabilization, and initiation of the transfer process. Follow-up reporting on patient status post-transfer shall be ensured.

Source: Miss. Code Ann. § 41-3-15

Rule 7.1.10. Communication and Documentation Requirements: Effective bidirectional communication protocols shall be employed, ensuring complete documentation and timely exchange of clinical information between transferring and receiving entities.

Source: Miss. Code Ann. § 41-3-15

Subchapter 2 General Program Requirements

Rule 7.2.1 Family Centered Care Core Components The facility will:

1. Allow all parents to have reasonable access to their infants at all times;
2. Have access to the services, personnel, and equipment needed to provide the appropriate level of care for all infants;
3. Support the physiologic, developmental, and psychosocial needs of infants and their families;

4. Have a process to screen every family for social determinants, depression, and cultural needs; and
5. Refer patients and families to appropriate resources as needed.

Family centered care additional best practices

1. Implement the utilization of primary nursing.
2. Involve family in daily and multidisciplinary patient care rounds.
3. Implement and support a family advisory council.
4. Establish a process to evaluate potential health disparities of the patient population served.
5. Implement a coordinated process to assess and address the emotional needs of families.
6. Engage in shared decision-making by involving family in discharge planning, including transport discussions.
7. Provider and staff training on shared decision making and how to engage in difficult and inclusive conversations.
8. Explicit efforts to support lactation and the needs of breastfeeding individuals.

Rule 7.2.2 Lactation and Neonatal Nutrition

1. The facility will:
    a. have personnel with the knowledge and skills to support lactation available at all times;
    b. have pumping equipment and secure human milk storage facilities available;
    c. have policies and procedures in place to support:
        i. the initiation and maintenance of lactation;
        ii. early initiation of milk expression;
        iii. safety, preparation, storage, and use of human milk and formula;
        iv. long-term pumping and transition to breastfeeding; and
        v. the utilization of donor human milk, if available.
    d. provide annual education to all direct care providers on the importance of, and support of lactation (i.e., pumping, mixing, safe storage, misappropriation, and proper identification); and
        i. all direct care providers have didactic education, skills verification, and competency on the proper mixing of human milk and formula;
    e. establish a program for breastfeeding and lactation support, including data collection.

Rule 7.2.3 Neonatal Resuscitation

The facility must have written policies and procedures specific to the resuscitation and stabilization of newborns based on current standards of professional practice.

1. At least 1 person with the skills to perform a complete neonatal resuscitation including endotracheal intubation, establishment of vascular access, and administration of medications must be immediately available on-site 24/7
2. A full range of neonatal resuscitative equipment, supplies, and medications must be immediately available at all times.
3. If the facility provides obstetrical delivery services:
    a. Each birth will be attended by at least 1 AAP Neonatal Resuscitation Program (NRP) trained provider whose only responsibility is the management of the newborn and initiating resuscitation.
    b. In the event of identified antepartum and intrapartum risk factors, at least 2 NRP trained providers should be present at birth and be responsible solely for the management and resuscitation of the newborn. Additional qualified providers should be available depending on the anticipated risk, number of newborns, and the obstetrical setting.
    c. If advanced resuscitation measures are anticipated, a fully qualified neonatal resuscitation team should be present at the time of birth.

Rule 7.2.4 Radiology

When obtaining imaging in neonatal and obstetrical patients, radiology services will incorporate the “as low as reasonably achievable” principle.

Rule 7.2.3 Policies and Procedures

The facility will have written:

1. neonatal, medical, and ancillary care guidelines, policies, and procedures that are established on evidence-based literature, and best-practice standards, that are monitored and tracked for adherence, reviewed at least every 3 years, and revised as needed;

2. a policy that mandates the escalation of concern and the urgent presence of a privileged care provider at the bedside, including a method to track adherence;

3. policies and procedures that define the criteria for neonatal team presence at a delivery and identify a method to track adherence, if applicable;

4. policies and procedures for the triage, stabilization, and transfer of obstetrical patients to the appropriate level of care, if applicable;

5. policies and procedures for consultation by telehealth and telephone, if applicable;

6. policies and procedures for intrafacility and interfacility neonatal transport;

7. policies and procedures for transfer to a higher level of neonatal care or for services not available at the facility, if applicable;

8. policies and procedures for car seat safety observation before discharge; and

9. policies and procedures for disaster response, including evacuation of obstetrical and neonatal patients to the appropriate level(s) of care.

Rule 7.2.4 Staff Privileges

The facility will have specified requirements for all privileged care providers participating in the care of neonatal patients, and have a credentialing process for delineation of privileges; a process to verify that all ancillary care services, clinical staff, and support staff have relevant neonatal training and expertise and a mechanism in place for medical, nursing, and ancillary care leadership to review and approve these credentials and track adherence.

Subchapter 3 Level I Neonatal Center (Well Care)

Rule 7.3.1. This Subchapter establishes the rules and regulations governing the organization, staffing, and delivery of neonatal care within Level I – Well Care facilities. It is intended to ensure that mothers and their newborns receive safe, effective, and timely clinical services in accordance with current standards of professional practice.

These requirements apply to all facilities designated as Level I – Well Care, which manage neonates of thirty-five (35) weeks gestational age or greater and may transiently retain infants of less than thirty-five (35) weeks gestational age. The Subchapter further mandates the implementation of a comprehensive Performance Improvement (PI) Plan to monitor outcomes and drive continuous improvement in neonatal services.

Rule 7.3.2. General Requirements

The Level I neonatal designated facility shall:

1. provide neonatal resuscitation at every delivery;

2. evaluate and provide postnatal care to stable term newborn infants;

3. stabilize and provide care for infants born 35-37 weeks gestational age who remain physiologically stable;

4. stabilize newborn infants who are ill and those born at < 35 weeks gestational age until transfer to a higher level of care ;

5. maintain a staff of providers including pediatricians, family physicians, nurse practitioners with newborn training, registered nurses with newborn training including being current with Neonatal Resuscitation Program Certification and S.T.A.B.L.E.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.

2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;

3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the departments involved.

4. Compliance with the above will be evidenced by but not limited to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;
    b. Written policies and procedures and guidelines for the care of the neonatal patient;
    c. Defined neonatal team and written roles and responsibilities;
    d. Appointed Neonatal Medical Director with a written job description;
    e. Appointed Neonatal Program Manager with a written job description;
    f. Analysis and review of system perinatal outcome and quality data; and
    g. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a currently practicing pediatrician, family medicine physician, or physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care. He/she must maintain a current status of successful completion of the Neonatal Resuscitation Program (NRP) or a department-approved equivalent course, while also completes annual continuing medical education specific to the care of neonates. The NMD must demonstrate effective administrative skills and oversight of the Neonatal PI Plan. The MMD may also serve as the NMD.

Rule 7.3.5. Neonatal Program Manager (NPM): Level I Neonatal Centers must have a registered nurse with documented perinatal nursing experience, working in the role of the NPM. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training. The MPM may also serve as the NPM.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
    b. Maternal Program Manager
    c. Neonatal Medical Director (if different from the MPM)
    d. Neonatal Program Manager (if different from the MPM)
    e. Pediatrician or Neonatologist
    f. Family Physician/APPs
    g. Obstetrics and Gynecology
    h. Certified Nurse Midwife (if applicable)
    i. Maternal Fetal Medicine
    j. Anesthesia
    k. Labor and Delivery
    l. Nursing
    m. Laboratory
    n. Radiology (Ultrasound)
    o. Respiratory Therapy
    p. Social Services/Pastoral Care
    q. Dietary
    r. Lactation Specialist (or equivalent)
    s. Pharmacist

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.3.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration

   a. The neonatal program shall collaborate with the maternal program , consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.

   b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.

2. On-Call Coverage The on-call physician, advanced practice nurse, or physician assistant shall:

   a. Possess documented special competence in neonatal care, with privileges and credentials formally reviewed and approved by the NMD.
   b. Maintain current certification in the NRP or department-approved equivalent.
   c. Complete annual continuing education specific to neonatal and infant care.
   d. Respond to an urgent request by arriving at the patient's bedside within thirty (30) minutes of notification.

e. Ensure documented back-up coverage where the on-call provider is unavailable or covering multiple facilities, with back-up call providers likewise responding within thirty (30) minutes of an urgent request.

3. Ancillary Services:

   a. The facility shall maintain written guidelines that define the twenty-four-hour availability of anesthesia, laboratory, radiology, respiratory therapy, ultrasonography, and blood bank services.

      i. Where preliminary interpretation of imaging studies is conducted pending formal radiologist report, such preliminary findings shall be documented in the patient's medical record.

      ii. The facility shall monitor and compare preliminary impressions with final interpretations under the radiology PI Plan, with summary activity reports presented to the Neonatal Multidisciplinary Committee.

   b. Pharmacy services shall ensure a pharmacist is available at all times.

      i. Where compounding of medications for neonates or infants is performed by a pharmacy technician, a pharmacist shall provide immediate and direct supervision of the compounding process.

      ii. The pharmacist shall implement and adhere to compounding guidelines designed to ensure the accuracy and safety of the final product. Such processes shall be monitored through the pharmacy PI Plan, and summary reports shall be presented to the Neonatal Multidisciplinary Committee.

4. Stabilization and Resuscitation

   a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.

   b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates, including those of less than thirty-five (35) weeks gestation, until safe to transfer to a higher level of care.

   c. Staffing requirements for neonatal resuscitation shall include:

i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.

ii. On-site availability of at least one individual skilled in complete neonatal resuscitation, inclusive on endotracheal intubation, vascular access establishment, and administration of emergency medication.

iii. Immediate availability of additional NRP-certified personnel for:

1. Multiple birth deliveries;
2. Unanticipated maternal-fetal complications during labor and delivery;
3. Deliveries identified or suspected to be high-risk.

iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.

v. Any deviations from these requirements must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Support Services

a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers.

b. The facility shall provide social services, spiritual care, and counseling resources, as appropriate, to address the holistic needs of the patient population served.

6. Staff Education

a. The facility shall designate a registered nurse with neonatal or perinatal care experience to oversee and coordinate staff education and competency assessments.

Source: Miss. Code Ann. § 41-3-15

Subchapter 4 Level II Neonatal Center (Special Care)

Rule 7.4.1. This Subchapter establishes the rules and regulations governing the organization, staffing, and delivery of neonatal care within facilities designated as Level II – Special Care. It is intended to ensure that mothers and their newborns receive safe, effective, and timely clinical services in accordance with current standards of professional practice.

These requirements apply to all facilities designated as Level II – Special Care, which manage neonates of thirty-two (32) weeks gestational age or greater and birth weight of at least fifteen hundred (1,500) grams, as well as those that may transiently retain more immature or lower–birth–weight infants. The Subchapter further mandates the implementation of a comprehensive Performance Improvement (PI) Plan to monitor outcomes and drive continuous improvement in neonatal services.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.2. General Requirements

The Level II neonatal designated facility shall maintain all Level I capabilities plus:

1. Provide comprehensive care for infants born ≥32 weeks of gestation and weighing ≥ 1500 grams who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.

2. Provide care for infants convalescing after intensive care.

3. Provide mechanical ventilation for brief duration (less than 24 hours) and/or continuous positive airway pressure for a condition expected to resolve rapidly or until transfer to a higher-level facility is achieved.

4. Stabilize infants born before 32 weeks gestation and weighing less than 1500 grams until transfer to a Level III or Level IV neonatal intensive care facility.

5. Maintain a staff of providers including those listed in Basic Care plus pediatric hospitalists, neonatologists, and neonatal nurse practitioners.

6. Referral to a higher level of care for all infants when needed for pediatric surgical or medical subspecialty intervention.

7. Level II nurseries must have equipment (e.g., portable x-ray machine, blood gas analyzer) and personnel (e.g., physicians, specialized nurses, respiratory therapists, radiology technicians and laboratory technicians) to provide ongoing care of admitted infants as well as to address emergencies.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.3. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application, passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.

2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;

3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.

4. Compliance with the above will be evidenced by but not limited to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;

    b. Written policies and procedures and guidelines for the care of the neonatal patient;

    c. Defined neonatal team and written roles and responsibilities;

d. Appointed Neonatal Medical Director with a written job description;

h. Appointed Neonatal Program Manager with a written job description;

i. Analysis and review of system perinatal outcome and quality data; and

j. A written Neonatal Performance Improvement (PI) Plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.4. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.5. Neonatal Medical Director (NMD). The NMD must be a physician who is a is a board-eligible/certified neonatologist or board-certified pediatrician with sufficient training and expertise to assume responsibility of care for infants who require Level II care, including endotracheal intubation, assisted ventilation, and CPAP management, or equivalent. and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) and completes annual continuing medical education specific to neonatology. If the neonatologist or pediatrician is certified by the American Board of Pediatrics, they will meet maintenance of certification requirement.

The NMD must demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

If the NMD and/or on-site provider is not a neonatologist, the privileged care provider must maintain a consultative relationship with a board certified or eligible neonatologist at a higher-level neonatal facility; and the facility must have a written policy or guideline that defines the criteria for neonatologist consultation at a higher-level neonatal facility.

Privileged Care Providers with pediatric- or neonatal-specific training qualified to manage the care of infants with mild to moderate critical conditions, including emergencies, will be continuously available, on-site or on-call and available to

arrive on-site within an appropriate time frame as defined by the facility's policies and procedures.

1. If the on-site or on-call provider is not a physician, a written policy will be in place that defines the criteria for notification and time frame for on-site physician presence, and a tracking mechanism for compliance is required;

2. If an infant is maintained on a ventilator, a pediatric- or neonatal-specific privileged care provider who can manage respiratory emergencies will be immediately available on-site;

3. Continuously provided neonatal care for the last consecutive two years and has experience and training in the care of neonates/infants, including assisted endotracheal ventilation and NCPAP management;

4. Maintains a current status of successful completion of the NRP or a department-approved equivalent course; and

5. Must complete annual continuing medical education specific to the care of neonates.

The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for onsite presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

The MMD may also serve as the NMD.

Rule 7.4.6. Neonatal Program Manager (NPM): Level II Neonatal Centers must have a registered nurse with a Bachelor of Science in Nursing with documented perinatal nursing experience and nursing certification preferred, working in the role of the NPM. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care The NPM will:

1. demonstrate a current status of NRP completion;
2. have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require level II care;
3. be responsible for inpatient activities in the level II facility and, as appropriate, obstetrical, well newborn, and/or pediatric units;

4. coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate;
5. provide oversight of annual neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the level II; and
6. foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment focused on the quality of care and patient care outcomes.

Rule 7.4.7. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:
   a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
   b. Maternal Program Manager
   c. Neonatal Medical Director (if different from MMD)
   d. Neonatal Program Manager (if different from MPM)
   e. Pediatrics
   f. Pediatric Hospitalist
   g. Neonatology
   h. Obstetrics and Gynecology
   i. Certified Nurse Midwife (if applicable)
   j. Maternal Fetal Medicine

k. Anesthesia

l. Labor and Delivery

m. Nursing

n. Laboratory

o. Radiology (Ultrasound)

p. Respiratory Therapy

q. Pharmacy

r. Social Services/Pastoral Care

s. Dietary

t. Family Medicine

u. APPs/Neonatal Nurse Practitioner

v. Lactation Specialist (or equivalent)

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.4.8. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration

a. The neonatal program shall collaborate with the maternal program, consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.

b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.

2. On-Call Coverage - The on-call physician, advanced practice nurse, or physician assistant shall:

   a. Possess documented special competence in neonatal care, with privileges and credentials formally reviewed and approved by the NMD.

   b. Maintain current certification in the NRP or department-approved equivalent.

   c. Complete annual continuing education specific to neonatal and infant care.

   d. Respond to an urgent request by arriving at the patient's bedside within thirty (30) minutes of notification.

   e. Ensure documented back-up coverage where the on-call provider is unavailable or covering multiple facilities, with back-up call providers likewise responding within thirty (30) minutes of an urgent request.

   f. Where neonatal surgery is performed, a surgeon privileged and credentialed to operate on neonates/infants shall be on-call and shall arrive at the patient's bedside in a timeframe consistent with current standards of professional practice. Surgeon response times shall be monitored and reviewed through the Neonatal PI Plan.

3. Ancillary Services:
   a. Anesthesia

      i. Anesthesia services shall be provided by practitioners with demonstrated pediatric experience and competence.

b. Laboratory and Transfusion Services

   i. Laboratory services shall ensure personnel are on-site at all times, as defined by written management guidelines, including when a neonate/infant is maintained on endotracheal ventilation. The ability to determine blood type, crossmatch, and perform antibody testing and the ability to perform analysis on small volume samples.
   ii. Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to verify timely and direct communication of all critical value results.

   iii. The facility's blood blank shall be capable of providing blood and blood component therapy and irradiated, leukoreduced or cytomegalovirus negative blood within the timelines established and approved transfusion guidelines.

c. Pharmacy – Pharmacy services must ensure a registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times and completes continuing education requirements specific to pediatric and neonatal pharmacology.

   i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.

   ii. The pharmacy will have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the level II SCN; and must implement policies and procedures to verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan, and present summary reports at Perinatal Multidisciplinary Committee meetings.

d. Radiology – must adhere to the "As Low as Reasonably Achievable" (ALARA) principle for neonatal imaging and provide the following:

   i. Personnel trained in neonatal x-ray and ultrasound operation, including cranial ultrasonography, must be on-site and able to respond to urgent requests within 30 minutes.

Appropriately trained staff must remain continuously available to meet routine diagnostic imaging needs and to manage emergencies .

ii. Interpretation of neonatal and perinatal studies must be available at all times; any preliminary reads pending final interpretation must be documented in the medical record.

iii. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to the Perinatal Multidisciplinary Committee.

e. Respiratory Therapy

i. The respiratory care leader will:
   1. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
   2. have sufficient time allocated to oversee the respiratory therapists (RTs) who provide care in the level II facility;
   3. provide oversight of annual simulation and skills verification, which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
   4. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
   5. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

ii. Respiratory care practitioners assigned to the special care nursery will
   1. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal or pediatric respiratory care certification preferred;
   2. be on-site 24/7 and immediately available when an infant is supported by assisted ventilation or CPAP;
   3. be able to attend deliveries and assist with resuscitation as requested;
   4. demonstrate a current status of NRP completion;
   5. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the SCN; and

6. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.

iii. The facility shall maintain neonatal/infant blood gas monitoring capabilities to support the management of respiratory function and acid–base status in acutely ill neonates.

f. Therapy services – A speech, occupational, or physical therapist with neonatal expertise must be engaged to meet the developmental and functional needs of the patient population.

i. Therapy services should be individualized based on gestational age, clinical status, and family goals.
ii. At least one individual skilled in the evaluation and management of neonatal feeding and swallowing concerns, with neonatal therapy certification preferred.

iii. Therapists must document competencies in neonatal care and participate in the Neonatal PI Plan for therapeutic interventions.

g. Nutrition
   i. Nutrition services shall be provided by a registered dietitian or a nutritionist trained in neonatal nutrition who will
      1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
      2. establish policies and procedures to verify proper preparation and storage of human milk and formula; and
      3. have policies and procedures for dietary consultation for patients.

   ii. The facility will:

      1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;

      2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and

3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

4. Stabilization and Resuscitation
   a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.

   b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates, including those of less than thirty-five (35) weeks gestation, until safe to transfer to a higher-level of care.

   c. Staffing requirements for neonatal resuscitation shall include:
      i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.

      ii. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.

      iii. Immediate availability of additional NRP-certified personnel for:

         1. Multiple birth deliveries;

         2. Unanticipated maternal-fetal complications during labor and delivery;

         3. Deliveries identified or suspected to be high-risk.

      iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.

      v. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Neonatal Transport

The facility will have policies and procedures in place to identify a local neonatal transport program to facilitate transport to a higher-level neonatal facility.

6. Pediatric Medical Subspecialists and Pediatric Surgical Specialists
   Policies and procedures will be in place for referral to a higher level of neonatal care when pediatric medical subspecialty or pediatric surgical specialty consultation and/or intervention is needed.

7. Support Services

   a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. Breastfeeding support activities are reviewed periodically through the Neonatal PI Plan.

   b. The facility shall provide social services, spiritual care, and counseling resources, as appropriate, to address the holistic needs of the patient population served. Referrals to community resources and follow-up support are coordinated through the neonatal team.

      i. The Level II social worker will be a Master's prepared medical social worker with perinatal and/or pediatric experience.
      ii. The facility will:
         1. Provide 1 social worker for every 30 beds providing Level II neonatal care and/or specialty and subspecialty perinatal care
         2. Have a written description that clearly identifies the responsibilities and function of the social worker and
         3. Have social services available for each family member with an infant in the special care nursery as needed.

8. Retinopathy of Prematurity

   If the facility back transfers infants for convalescent care, the facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity and the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal

images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity, if needed.

9. Discharge Planning and Follow-Through Care

    a. The Neonatal Program must develop and implement discharge plans for infants at high risk of neurodevelopmental, medical, or psychosocial complications.

        i. Plans include referrals to specialty care, early intervention programs, and community-based services.
            1. The facility will have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; and have a written referral agreement with a developmental follow-up clinic or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

        ii. Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

10. Nurse Education and Orientation
    Level II Neonatal Centers nursing orientation will incorporate didactic education, simulation, skills verification, and competency and shall be tailored to the individual needs of the nurse based on clinical experience. The facility must document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members. Annual nursing education will address the annual needs assessment and incorporate simulation and skills verification of low-volume, high-risk procedures consistent with the types of care provided in the level II centers and include education related to serious safety events.

11. Clinical Nurse Educator

    a. be an RN, with nursing certification specific to the care environment preferred;
    b. have at least a Bachelor of Science in Nursing, Master's preferred;
    c. demonstrate a current status of NRP completion;
    d. cultivate collaborative relationships with the neonatal nurse leader and facility leadership to improve the quality of care and patient care outcomes5; and

e. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level II neonatal care.9
f. The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the clinical nurse educator.

The *Source: Miss. Code Ann. § 41-3-15*

Subchapter 5 Level III Neonatal Center (Intensive Care)

This Subchapter establishes the rules governing the organization, staffing, and delivery of intensive neonatal care within facilities designated as Level III – Neonatal Intensive Care Centers. Its purpose is to ensure that mothers and their neonates—ranging from mild to critical illness or requiring sustained life support—receive safe, effective, and timely clinical services in accordance with current professional standards.

Rule 7.5.1. General Requirements

The Level III neonatal designated facility shall maintain all Level I and II capabilities as well as the following:

1. Level III NICUs are defined by having continuously available personnel (neonatologists, neonatal nurses, and respiratory therapists) and equipment to provide life support for as long as necessary.

2. Provide comprehensive care for infants born less than 32 weeks gestation and weighing less than1500 grams and infants born at all gestational ages and birth weights with critical illness.

3. Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists or anesthesiologists with experience in neonatal surgical care and pediatric ophthalmologists, on site or by prearranged consultative agreements.

4. Provide a full range of respiratory support and physiologic monitoring that may include conventional and/or high-frequency ventilation, inhaled nitric oxide delivery, and/or therapeutic hypothermia or have policies and procedures in place to facilitate neonatal transfer to a higher level of care.

5. Perform advanced imaging with interpretation on an urgent basis, including computed tomography, MRI and echocardiography.

6. Social and family support including social services and pastoral care.

7. If geographic constraints for land transportation exist, the Level III facility should ensure availability of rotor and fixed-wing transport services to transfer infants requiring subspecialty intervention from other regions and facilities.

8. Consultation and transfer agreements with both lower-level referring hospitals and regional centers, including back-transport agreements.

9. Prompt diagnosis and appropriate referral of all conditions requiring surgical intervention. Major surgery should be performed by pediatric surgical specialists (including anesthesiologists with pediatric expertise) on–site within the hospital or at a closely related institution, ideally in close geographic proximity if possible. Level III facilities should be able to offer complete care, management, and evaluation for high-risk neonates 24 hours a day. A neonatologist should be available either in-house or on-call with the capacity to be in-house in a timely manner, 24 hours a day.

10. Level III facilities should maintain a sufficient volume of infants less than 1500 grams to meet professionally accepted guidelines to achieve adequate experience and expertise.

11. Enrollment in the Vermont Oxford Network to report and monitor data regarding outcomes of infants born less than 32 weeks and weighing less than 1500 grams.

12. Participation in and evaluation of quality improvement initiatives.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a

neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.

2. The neonatal program must come under the direction of a practicing pediatrician, family medicine physician or a physician specializing in obstetrics and gynecology with experience in the care of neonates/infants and with privileges in neonatal care;

3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature, and the performance improvement evaluation of this care must be extended to all the departments involved.

4. Compliance with the above will be evidenced by but not limited to:
   a. Governing authority and medical staff letter of commitment in the form of a resolution;

   b. Written policies and procedures and guidelines for the care of the neonatal patient;

   c. Defined neonatal team and written roles and responsibilities;

   d. Appointed Neonatal Medical Director with a written job description;

   e. Appointed Neonatal Program Manager with a written job description; and

   f. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible or board-certified neonatologist with neonatal or infant care

experience and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or Department-approved equivalent. The NMD is responsible for the oversight of neonatal transport protocols, staff competencies, safety standards and performance review. The NMD must also complete annual continuing medical education specific to the care of neonates, as well as demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

Rule 7.5.5. Neonatal Program Manager (NPM): Level III Neonatal Centers must have a registered nurse with at least a Bachelor of Science in Nursing (Master's preferred) with documented neonatal nursing experience and nursing certification preferred, working in the role of the NPM. The NPM must maintain a current NRP certification or equivalent. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and training. The NPM must have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require Level III NICU care, be responsible for inpatient activities in the NICU and, as appropriate, obstetric, well newborn, and/or pediatric units; and coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate. The NMD must provide oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level III NICU and foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes

Rule 7.5.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)
b. Maternal Program Manager
c. Neonatal Medical Director
d. Neonatal Program Manager
e. Pediatrics
f. Neonatology
g. Obstetrics and Gynecology
h. Certified Nurse Midwife (if applicable)
i. Maternal Fetal Medicine
j. Pediatric surgery / pediatric ophthalmology
k. Anesthesia/pediatric anesthesia
l. Labor and Delivery
m. Nursing
n. Laboratory
o. Radiology (Ultrasound)
p. Respiratory Therapy
q. Social Services/Pastoral Care
r. Dietary
s. Family Medicine
t. APPs/Neonatal Nurse Practitioner
u. Lactation Specialist (or equivalent)

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration
   a. The neonatal program shall collaborate with the maternal program, consulting physicians, and nursing leadership to ensure that pregnant patients identified as high risk for requiring higher-level neonatal care are transferred to a higher-level facility prior to delivery, unless such transfer is deemed clinically unsafe.

   b. The facility shall ensure the provision of appropriate, supportive, and emergency care by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.

2. On-Site Clinical Coverage - The on-call physician, advanced practice nurse, or physician assistant shall:
   a. At least one neonatal provider (pediatric hospitalist, neonatologist, neonatal nurse practitioner, or neonatal physician assistant) must be on-site at all times with documented competence and privileges reviewed by the NMD.

   b. Neonatologists

   1. The NICU neonatologists will:
      i. be a board eligible or certified neonatologist or equivalent
      ii. complete annual CME specific to neonatology
      iii. demonstrate a current status of NRP completion

ii. Have credentials that are reviewed by the NMD at least every two (2) years; and

i. Preferably be on-site and immediately available 24/7, a written policy will be in place that defines the criteria for notification and timeframe, as defined by the facility's policies and procedures.

3. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and timeframe for on-site presence, and a tracking mechanism for compliance is required.

c. Privileged Care Providers

Privileged Care Providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on site 24/7 and:

i. Maintain current NRP certification or equivalent.

ii. Complete annual continuing education in neonatal care; and review of credentials at least every two years by the NMD.

iii. If no neonatologist on-site, have a board-certified neonatologist available for consultation and on-site, arrival within thirty (30) minutes of urgent requests.

iv. Ensure back-up neonatologist coverage (documented on-call) if covering multiple facilities, with the same 30-minute response time. The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

d. Pediatric Medical Subspecialists

i. The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to: cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism.

ii. The pediatric medical subspecialists must be readily accessible for on-site consultation, have credentials to consult at the facility, including documented training, certification, competencies, and CME specific to their subspecialty and document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

e. Neonatal Surgical Program – Optional for Level III

i. Pediatric surgeons and pediatric surgical specialists will be available on-site or at another closely related NICU facility.

1. If pediatric surgery is not offered on-site at the facility, policies and procedures will be in place with a facility that provides surgical care to facilitate transfer of an infant when needed.

ii. Infants requiring cardiovascular surgery or extracorporeal membrane oxygenation (ECMO) will be transferred to a facility that provides these services.

1. If pediatric surgery is accessible on-site, the surgeons will:

a. be available at the bedside within 1 hour of request or identified need;
b. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty;
c. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
d. report neonatal surgical and anesthesia care back to the PI Committee.

3. Ancillary Services:

a. Anesthesia

i. If pediatric surgery is performed on-site, anesthesia providers with pediatric expertise must:

1. be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need;
2. serve as the primary responsible anesthesia provider for all infants <24 month of age and should serve as the primary anesthesiologist for children 5 year of age based on the American Society of Anesthesiologists (ASA) physical status classification; and

3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.

b. Laboratory and Transfusion Services
   i. Laboratory services shall ensure personnel are on-site at all times.
   ii. Laboratory services will have the ability to determine blood type, crossmatch, and perform antibody testing.

   iii. Pediatric pathology and intra-operative frozen section services must be available in the operative suite at the request of the operating surgeon.

   iv. The facility's blood blank shall be capable of providing blood and blood component therapy and irradiated, leukoreduced or CMV-negative blood within the timelines established and approved transfusion guidelines.

      1. Policies and procedures will be in place to facilitate emergency access to blood and blood component therapy so that the NICU can provide hematologic interventions, if applicable.

   v. The laboratory will have the ability to perform analysis on small volume sample and access to perinatal pathology services, if applicable.

      1. Low-volume specialty laboratory services may be provide by an outside laboratory, but the facility will have policies and procedures in place to maintain timely and direct communication of all critical value results.

c. Pharmacy – Pharmacy services must ensure at least one registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times, completes continuing education requirements specific to pediatric and neonatal pharmacology and participates in multidisciplinary care, including participation in patient care rounds.
   i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.
   ii. The pharmacist must implement guidelines to address drug shortages, verify medications are appropriately allocated to the Level III NICU

and verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan,

iii. Total parenteral nutrition (TPN) tailored for neonates/infants must be readily available upon request.

1. The facility will have a written policy and procedure for the proper preparation and delivery of TPN.

d. Radiology – must adhere to the "As Low as Reasonably Achievable" (ALARA) principle for neonatal imaging and include the following:

i. Personnel trained in neonatal x-ray equipment must be on-site and available at all times to address emergencies.

ii. Personnel appropriately trained in ultrasound, computed tomography, including cranial ultrasound, computed tomography (CT), and magnetic resonance imaging (MRI) equipment and available on-site within a time period consistent with current standards of professional practice.

iii. Fluoroscopy must be available at all times.

1. If fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care.

iv. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;

v. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;

vi. Pediatric-trained radiologists must be available at all time for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.

vii. Pediatric echocardiography with pediatric cariology interpretation and consultation within professional timeframes.

viii. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to Perinatal Multidisciplinary Committee.

e. Respiratory Therapy

The respiratory care leader will:

i. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
ii. have sufficient time allocated to oversee the RTs who provide care in the level III NICU;
iii. provide oversight of annual simulation and skills verification which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
iv. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
v. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

Respiratory care practitioners assigned to the NICU will:

i. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
ii. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;
iii. demonstrate a current status of NRP completion;
iv. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
v. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
vi. provide neonatal/infant blood gas monitoring capabilities to support the management of respiratory and metabolic management.

Therapy Services – The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family and psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served. The facility will have on-site access to the

following neonatal therapists who have dedicated time allocated to serve the NICU:

1. an occupational and/or physical therapist with neonatal expertise, and neonatal therapy certification preferred; and
2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.

    i. If swallow studies are not offered on-site at the facility, policies and procedures will be in place to facilitate neonatal transfer to a higher level of care.

    ii. The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.

f. Nutrition

i. At least one registered dietician or nutritionist who has specialized training in neonatal nutrition will have dedicated time allotted to serve the NICU and will:
    1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
    2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
    3. participate in multidisciplinary care, including participation in patient care rounds; and
    4. have policies and procedures for dietary consultation for infants in the NICU.

Neonatal Nutrition

ii. The facility will:
    1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;
    2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for

human milk, donor human milk, fortification of human milk and formula; and

3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

g. Clinical Nurse Staffing

i. A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

h. Clinical Nurse Staff

i. Each clinical nurse will:

1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and
4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

ii. If the facility utilizes LPNs or non-licensed direct care providers to support the clinical nursing staff, the facility must:

1. have written criteria that define the LPNs' or non-licensed direct care providers' scope of neonatal care;

2. provide annual education specific to the care of the neonatal population served; and

3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

i. Clinical Nurse Specialist

The clinical nurse specialist will:

a. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred;

b. have at least a Bachelor of Science in Nursing, Master's or Doctorate preferred;
c. demonstrate a current status of NRP completion;
d. foster continuous quality improvement in nursing care;
e. develop and educate staff to provide evidence-based nursing care;
f. be responsible for mentoring new staff and developing team building skills;
g. provide leadership to multidisciplinary teams;
h. facilitate case management of high-risk neonatal patients; and;
i. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes;
j. The roles and responsibilities of the NICU clinical nurse specialist can be allocated to multiple individuals to perform this role.

4. Stabilization and Resuscitation
   a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.

   b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates.

   c. Staffing requirements for neonatal resuscitation shall include:

      i. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.

      ii. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.

      iii. Additional personnel who maintain a current status of successful completion of the NRP or a Department-approved equivalent must be on-site and immediately available upon request for the following:

         1. Multiple birth deliveries;

2. Unanticipated maternal-fetal complications during labor and delivery;

3. Deliveries identified or suspected to be high-risk.

iv. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.

v. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee.

5. Neonatal Transport

If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services. The director of neonatal transport services can be the NMD or another physician who is a pediatrician, board-eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.

Responsibilities of the director of neonatal transport services include the following:

i. Train and supervise staff;
ii. Provide appropriate review of all transport records;
iii. develop and implement policies and procedures for patient care during transport;
iv. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence;
v. establish policies and procedures to provide transport updates and outreach education;
vi. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
vii. report neonatal transport data and neonatal-specific reviews back to the PI committee.

viii. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.

The facility will:

i. establish minimum education, experience, and training requirements for all transport team members
ii. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have the ability to provide a level of care that is similar to that of the admitting unit; and
iii. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.

6. Support Services

The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers at all times. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. An IBCLC should be available for on-site consultation on weekdays and accessible by telehealth or telephone at all times. IBCLC personnel should be operationally reviewed on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.

a. Social Worker

i. The NICU social worker will:
    1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.
ii. The facility will:
    1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care;
    2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
    3. have social services available for each family with an infant in the NICU as needed.

b. Pastoral Care

Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.

Rule 7.5.8 Retinopathy of Prematurity

The facility must have process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity, and the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.

Rule 7.5.9 Discharge Planning and Follow-Through Care

1. Systems will be in place to establish preparation for NICU discharge, including post-discharge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

   The facility must have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; as well as provide developmental follow-up services or have written referral agreement with a developmental follow-up clinical or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

   a. Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.10 Nursing Orientation and Education

1. Level III NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.
2. The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.
3. Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk

procedures consistent with the types of care provided in the level III NICU and include education related to serious safety events.

4. Clinical Nurse Educator

a. The NICU clinical nurse educator will:
    i. Be an RN, with nursing certification specific to the care environment preferred;
    ii. Have at least a Bachelor of Science in Nursing, Master's preferred;
    iii. Demonstrate a current status of NRP completion;
    iv. Cultivate collaborative relationships with the NPM and facility leadership to improve the quality of care and patient care outcomes; and
    v. have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.

b. The facility will have a dedicated individual with sufficient time allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Source: Miss. Code Ann. § 41-3-15

Rule 7.5.11 Neonatal Outreach

The Level III facility will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities, if applicable.

Subchapter 6 Level IV Neonatal Center (Advanced Neonatal Intensive Care)

This Subchapter establishes the rules governing the organization, staffing, and delivery of the highest-level neonatal care within facilities designated as Level IV – Advanced Neonatal Intensive Care Centers. Its purpose is to ensure that mothers and neonates with the most complex medical and surgical conditions benefit from multidisciplinary expertise, evidence-based practices, and continuous quality improvement aligned with current professional standards.

Rule 7.6.1. General Requirements: The Level IV neonatal designated facility shall maintain all Level III capabilities and shall also:

1. Provide care for infants of all gestational ages and birth weights, with mild to complex critical conditions or medical problems requiring sustained life support, hemodynamic support, conventional and high frequency mechanical ventilation, iNO delivery, and/or therapeutic hypothermia.

2. Be located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions.

3. Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists and pediatric anesthesiologists at the site.

4. Have the ability to provide ECMO or policies and procedures in place to facilitate neonatal transfer to another unit or facility that provides ECMO.

5. Facilitate transport and provide outreach education including community taught NRP and S.T.A.B.L.E. classes.

6. Have sufficient experience based on patient volume and a systematic process to assess the quality of care provided, including a method to track specific quality indicators and clinical diagnoses, review aggregate data using accepted methodology, and develop action plans as needed to improve patient outcomes.

Source: *Miss. Code Ann. § 41-3-15*

Rule 7.6.2. Neonatal Program

1. There shall be a written commitment on behalf of the entire facility to the organization of neonatal care. The written commitment shall be in the form of a resolution at the time of application passed by appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a neonatal care program may be sufficient. The neonatal program must be established and recognized by the medical staff and hospital administration.

2. The neonatal program must come under the direction of neonatologist;

3. Neonatal Medical Director (NMD), Neonatal Program Manager (NPM), and appropriate support staff. The Neonatal Program must be multidisciplinary in nature and the performance improvement evaluation of this care must be extended to all the departments involved.

4. Compliance with the above will be evidenced by but not limited to:
   i. Governing authority and medical staff letter of commitment in the form of a resolution;

   ii. Written policies and procedures and guidelines for the care of the neonatal patient;

iii. Defined neonatal team and written roles and responsibilities;

iv. Appointed Neonatal Medical Director with a written job description;

v. Appointed Neonatal Program Manager with a written job description;

vi. Analysis and review of system perinatal outcome and quality data

vii. A written Neonatal Performance Improvement (PI) plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.3. Neonatal Service: The neonatal service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the neonatal patient. The neonatal service will vary in each organization depending on the needs of the patient and the resources available. The service shall come under the organization and direction of the Neonatal Medical Director.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.4. Neonatal Medical Director (NMD). The NMD must be a physician who is a board-eligible or board-certified neonatologist with neonatal or infant care experience and maintains a current status of successful completion of the Neonatal Resuscitation Program (NRP) or Department-approved equivalent. The NMD is responsible for the validation of neonatal transport protocols, staff competencies, safety standards, and performance review. The NMD must also complete annual continuing medical education specific to the care of neonates, as well as demonstrate effective administrative skills and oversight of the Neonatal PI Plan.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.5. Neonatal Program Manager (NPM): Level IV Neonatal Centers must have a registered nurse with at least a Bachelor of Science in Nursing (Master's preferred) with documented perinatal nursing experience, working in the role of the NPM. The NPM must maintain a current NRP certification or equivalent. Working in conjunction with the NMD, the NPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of maternal care, as well as developing or revising policies, procedures and guidelines, assuring staff competency, education, and

training. The NPM must have sufficient experience and expertise to create, and/or support, a program that provides care to infants who require Level IV NICU care, be responsible for inpatient activities in the NICU and, as appropriate, obstetrical, well newborn, and/or pediatric units; and coordinate with respective neonatal, pediatric, and obstetric care services, as appropriate. The NMD must provide oversight of annual neonatal-specific education which includes low-volume, high-risk procedures consistent with the care provided in the level IV NICU and foster collaborative relationships with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment to improve the quality of care and patient care outcomes. In conjunction with the NMD, he/she shall conduct monthly case reviews, analyze transport outcomes and report variances through the PI process.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.6. Perinatal Multidisciplinary Committee

1. The purpose of the committee is to provide oversight and leadership to the entire maternal program. Each perinatal center may choose to have one or more committees as needed to accomplish the task. One committee must be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

    a. Maternal Medical Director (Chairman – must be present at greater than 75% of all meetings.)

    b. Maternal Program Manager

    c. Neonatal Medical Director

    d. Neonatal Program Manager

    e. Pediatrics

    f. Pediatric Hospitalist

g. Neonatology

h. Obstetrics and Gynecology

i. Certified Nurse Midwife (if applicable)

j. Maternal Fetal Medicine

k. Pediatric surgery / pediatric ophthalmology

l. Anesthesia/pediatric anesthesia

m. Family Medicine

n. APPs/Neonatal Nurse Practitioner

o. Labor and Delivery

p. Nursing

q. Laboratory

r. Radiology (Ultrasound)

s. Respiratory Therapy

t. Social Services/Pastoral Care

u. Dietary

v. Lactation Specialist (or equivalent)

w. Pharmacist

2. The clinical managers (or designees) of the departments involved with maternal care must play an active role with the committee.

3. The Neonatal Center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee must handle peer review independently from department-based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital PI program.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.7. Clinical Components

The clinical components outlined below form the foundation for delivering integrated, high-quality maternal and neonatal care. They ensure seamless collaboration, timely availability of skilled providers, access to essential support services, and standardized stabilization and resuscitation protocols.

1. Maternal – Neonatal Collaboration
   a. The neonatal program must collaborate with the maternal program , consulting physicians, and nursing leadership to ensure that pregnant patients who are at high risk of delivering a neonate that requires specialized care are transferred to a facility with specialized care capabilities before delivery unless the transfer would be unsafe.

   b. The facility shall ensure the provision of appropriate, supportive, and emergency care delivered by qualified personnel for unanticipated maternal-fetal or neonatal complications arising during labor and delivery, continuing through patient disposition.

2. On-Site Clinical Coverage
   a. Neonatologists
      The NICU neonatologists will:
      i. be a board eligible or certified neonatologist or equivalent;
      ii. Complete annual CME specific to neonatology;
      iii. Demonstrate a current status of NRP completion;
         1. Have credentials that are reviewed by the NMD at least every two (2) years; and
      iv. Preferably be on-site and immediately available 24/7, a written policy will be in place that defines the criteria for notification and timeframe, as defined by the facility's policies and procedures.
         1. If a neonatologist is not on-site 24/7, a written policy will be in place that defines the criteria for notification and timeframe for on-site presence, and a tracking mechanism for compliance is required.

3. Privileged Care Providers
   Privileged Care Providers with neonatal-specific training qualified to manage the care of infants with mild to complex critical conditions, including emergencies, will be on site 24/7 and:

   i. Maintain current NRP certification or equivalent;

ii. Complete annual continuing education in neonatal care; and review of credentials at least every two years by the NMD.

iii. If no neonatologist on-site, have a board-certified neonatologist available for consultation and on-site, arrival within thirty (30) minutes of urgent requests.

iv. Ensure back-up neonatologist coverage (documented on-call) if covering multiple facilities, with the same 30-minute response time. The facility will establish a written policy for backup privileged care provider coverage that establishes flexibility for variable census and acuity. This policy will document the criteria for notification and time frame for on-site presence, be based on allocating the appropriate number of competent medical providers to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

4. Pediatric Medical Subspecialists

The facility must have on-site access to a broad range of pediatric medical subspecialties including, but not limited to;

i. cardiology, pulmonology, infectious disease, neurology, ophthalmology, endocrinology, hematology, gastroenterology, nephrology, and genetics or metabolism; and

ii. the pediatric medical subspecialists must:

1. be readily accessible for in-person consultation;
2. have credentials to consult at the facility, including documented training, certification, competencies, and continuing education specific to their subspeciality; and
3. document consultations in the medical record within an appropriate time frame and as defined by the facility's policies and procedures.

5. Neonatal Surgical Program – Required for Level IV

Pediatric Surgeons

Pediatric surgeons and pediatric surgical specialists will:

a. Be available at the bedside within one hour of request or identified need and be capable of performing major pediatric surgery, including surgery for complex conditions;

b. If transplant or cardiac surgery is not offered on-site at the facility, policies and procedures will be in place to facilitate

neonatal transport to a facility that provides appropriate surgical care;

c. provide consultation to a broad range of pediatric surgical specialists including, but not limited to:
d. general pediatric surgery, neurosurgery, urology, ophthalmology, otolaryngology, orthopedics, and plastic surgery;
e. have credentials to provide care at the facility, including documented training, certification, competencies, and continuing education specific to their pediatric surgery specialty;
f. establish a program for evaluating surgical performance by accurately tracking data, identifying trends, and implementing quality improvement initiatives to address surgical performance in a coordinated systematic approach within a culture of safety, equity, and prevention; and
g. report neonatal surgical and anesthesia care back to the PI Committee.

6. Ancillary Services:
   a. Anesthesia
      1. Pediatric anesthesiologists must be on the medical staff and promptly available 24/7 to respond to the bedside within 1 hour of request or identified need;
      2. serve as the primary responsible anesthesia provider for all infants <24 mo. of age and should serve as the primary anesthesiologist for children ≤ 5 y of age or based on the ASA physical status classification; and
      3. be physically present for all neonatal surgical procedures for which they serve as the primary responsible anesthesia provider.

   b. Laboratory and Transfusion Services
      1. Laboratory services shall have:
         1. laboratory personnel on-site 24/7;
         2. the ability to determine blood type, crossmatch, and perform antibody testing;
         3. a blood bank capable of providing blood component therapy and irradiated, leukoreduced or CMV-negative blood;
            a. policies and procedures will be in place to facilitate emergent access to blood and blood component therapy

so that the NICU can provide a full range of hematologic interventions;

4. the ability to perform neonatal blood gas monitoring;
5. the ability to perform analysis on small volume samples;
6. the capability to process biopsies and perform autopsies; and
7. access to perinatal pathology services, if applicable.

2. Low-volume specialty laboratory services may be provided by an outside laboratory, but the facility will have policies and procedures in place to

maintain timely and direct communication of all critical value results.

c. Pharmacy – Pharmacy services must ensure at least one registered pharmacist experienced in neonatal/pediatric pharmacology is available at all times, completes continuing education requirements specific to pediatric and neonatal pharmacology and participates in multidisciplinary care, including participation in patient care rounds.

i. If a pharmacy technician compounds medications for neonates/infants, a pharmacist must provide immediate, direct supervision of the process.

The pharmacist must implement guidelines to address drug shortages, verify medications are appropriately allocated to the Level III NICU and verify the accuracy of each compounded product, monitor compounding activities through the pharmacy PI Plan,

ii. Total parenteral nutrition (TPN) tailored for neonates/infants must be readily available upon request.

1. The facility will have a written policy and procedure for the proper preparation and delivery of TPN.

c. Radiology – must adhere to the "As Low as Reasonably Achievable" (ALARA) principle for neonatal imaging and include the following:

1. Appropriately trained radiology personnel continuously available on-site to meet routine diagnostic imaging needs and to address emergencies.

2. Fluoroscopy available on-call 24/7;

3. Personnel appropriately trained in the following techniques will be on-call and/or available on-stie to perform advanced imaging as requested:
   a. ultrasonography, including cranial ultrasonography,
   b. computed tomography (CT), and
   c. magnetic resonance imaging (MRI)

4. the ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested;

5. The facility will provide pediatric echocardiography and have the ability to consult with a pediatric cardiologist for timely echocardiography interpretation as requested.

   a. If fluoroscopy is not offered on-site at the facility, policies and procedures will be in place to facilitate transfer of an infant to a higher level of care.

6. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;

7. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;

8. Pediatric-trained radiologists must be available at all time for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.

9. Pediatric echocardiography with pediatric cariology interpretation and consultation within professional timeframes.

10. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to Perinatal Multidisciplinary Committee.

11. Personnel trained in neonatal x-ray equipment must be on-site and available at all times.

12. Personnel appropriately trained in ultrasound, computed tomography, and cranial ultrasound equipment available on-site within a time period consistent with current standards of professional practice.

13. Fluoroscopy must be available at all times.

14. Neonatal diagnostic imaging studies and radiologists with pediatric expertise to interpret the neonatal diagnostic imaging studies, available at all times;

15. A radiologist with pediatric expertise to interpret images consistent with the patient condition and within a time period consistent with current standards of professional practice with monitoring of variances through the Neonatal PI Plan and process;

16. Pediatric-trained radiologists must be available at all times for interpretation of neonatal and perinatal studies; any preliminary reads pending final interpretation must be documented in the medical record.

17. Pediatric echocardiography with pediatric cariology interpretation and consultation within professional timeframes.

18. The radiology PI Plan must compare preliminary and final readings, with summary reports submitted to the Perinatal Multidisciplinary Committee.

d. Respiratory Therapy

The respiratory care leader will:

i. be a full-time respiratory care practitioner, with neonatal and pediatric respiratory care certification preferred;
ii. have sufficient time allocated to oversee the RTs who provide care in the level III NICU;
iii. provide oversight of annual simulation and skills verification which includes neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;
iv. develop a written RT staffing plan that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RTs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care needs; and
v. maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation.

Respiratory care practitioners assigned to the NICU will:

i. be a respiratory care practitioner with documented experience and training in the respiratory support of newborns and infants, with neonatal and pediatric respiratory care certification preferred;
ii. be on-site 24/7 and immediately available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;
iii. demonstrate a current status of NRP completion;
iv. participate in annual simulation and respiratory skills verification, which includes low-volume, high-risk procedures consistent with the types of respiratory care provided in the NICU; and
v. have their credentials reviewed by the respiratory care leader annually for adequacy and adherence.
vi. provide neonatal/infant blood gas monitoring capabilities to support the management of respiratory and metabolic management.

e. Therapy Services
   1. The facility will provide on-site consultative services by qualified neonatal therapists to address the 6 core practice domains (environment, family or psychosocial support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing) and to provide the appropriate care for the neonatal population served.
   2. The facility will have on-site access to the following neonatal therapists who have dedicated time allocated to serve the NICU:
      1. an occupational and/or physical therapist with sufficient neonatal expertise, and neonatal therapy certification preferred; and
      2. a speech language pathologist with neonatal expertise, skilled in the evaluation and management of neonatal feeding and swallowing concerns, and neonatal therapy certification preferred.
   3. The facility will operationally review neonatal therapist personnel on an annual basis to maintain adequate multidisciplinary neonatal therapist coverage based on the specific need and volume of the neonatal population served.

f. Dietician

   The NICU will have at least 1 full-time NICU-dedicated registered dietitian or nutritionist available on-site who has specialized training in neonatal nutrition and will:

1. collaborate with the medical team to establish feeding protocols, develop patient-specific feeding plans, and help determine nutritional needs at discharge;
2. establish policies and procedures to verify proper preparation and storage of human milk and formula;
3. participate in multidisciplinary care, including participation in patient care rounds; and
4. have policies and procedures for dietary consultation for infants in the NICU.

i. Neonatal Nutrition

The facility will:

1. provide a specialized area or room, with limited access and away from the bedside, to accommodate mixing of formula or additives to human milk;
2. develop standardized feeding protocols for the advancement of feedings based on the availability of, and family preference for human milk, donor human milk, fortification of human milk and formula; and
3. have policies and procedures in place for accurate verification and administration of human milk and formula, and to avoid misappropriation.

ii. Lactation and Breastfeeding Support

The facility will:

1. have personnel with the knowledge and skills to support lactation available at all times;
2. have an IBCLC available for on-site consultation on weekdays and accessible by telehealth or telephone 24/7; and
3. operationally review IBCLC personnel on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.

iii. Clinical Nurse Staffing

A written nurse staffing plan is in place that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of competent RNs to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adequacy and adherence.

iv. Clinical Nurse Staff

Each clinical nurse will:

1. be an RN, with nursing certification specific to the care environment preferred;
2. demonstrate a current status of NRP completion;
3. participate in annual simulation and skills verification, which includes low-volume, high-risk procedures consistent with the types of care provided in the level III NICU; and

4. promote a family-centered approach to care, including but not limited to skin-to-skin care, appropriate developmental positioning based on gestational age, lactation and breastfeeding support, and engagement of families in their infant's care.

If the facility utilizes LPNs or non-licensed direct care providers to support the clinical nursing staff, the facility must:

1. have written criteria that define the LPNs' or non-licensed direct care providers' scope of neonatal care;

2. provide annual education specific to the care of the neonatal population served; and
3. have a written staffing plan that establishes collaborative work assignments in accordance with the facility's policies and procedures.

v. Clinical Nurse Specialist

The clinical nurse specialist will :

1. be an RN, with neonatal nursing certification and clinical nurse specialist certification preferred;
2. have at least a Master of Science in Nursing, Doctorate preferred;
3. demonstrate a current status of NRP completion;
4. foster continuous quality improvement in nursing care;
5. develop and educate staff to provide evidence-based nursing care;
6. be responsible for mentoring new staff and developing team building skills;
7. provide leadership to multidisciplinary teams;
8. facilitate case management of high-risk neonatal patients; and

9. cultivate collaborative relationships with multidisciplinary team members and facility leadership to improve the quality of care and patient care outcomes.

The facility will have a dedicated full-time equivalent (FTE) allocated to perform the roles and responsibilities of the NICU clinical nurse specialist.

7. Stabilization and Resuscitation

a. The facility shall develop, maintain, and enforce written policies, procedures, and guidelines for the stabilization and resuscitation of neonates, in accordance with current standards of professional practice.

b. The facility shall ensure the availability of trained personnel capable of stabilizing distressed neonates.

c. Staffing requirements for neonatal resuscitation shall include:

1. Attendance by at least one individual, at the time of each birth, who holds current NRP certification (or Department-approved equivalent) and whose primary responsibility is neonatal management and resuscitation.

2. At least one additional provider with full neonatal resuscitation skills - including endotracheal intubation, vascular access establishment, and administration of emergency medication – must be immediately available on-site.

3.Additional personnel who maintain a current status of successful completion of the NRP or a Department-approved equivalent, must be on-site and immediately available upon request for the following:

4. Multiple birth deliveries; to care for each neonate;

5. Unanticipated maternal-fetal complications during labor and delivery;

6. Deliveries identified or suspected to be high-risk for the pregnant patient or the neonate.

4. Immediate on-site availability of all necessary resuscitative equipment, supplies, and medications.

5. Any deviations from these standards must be monitored through the Neonatal PI Plan, with reporting of variances to the Perinatal Multidisciplinary Committee

7. Neonatal Transport
   If the facility has a neonatal critical care transport program, it will have an identified director of neonatal transport services. The director of neonatal transport services can be the NMD or another physician who is a pediatrician, board-eligible or certified neonatologist, pediatric hospitalist, or pediatric medical subspecialist with expertise and experience in neonatal and infant transport. If the facility does not have its own transport program, the facility must have policies and procedures in place to identify a local neonatal transport program to facilitate transport.
   Responsibilities of the director of neonatal transport services include the following:
   i. Train and supervise staff;
   ii. Provide appropriate review of all transport records;
   iii. develop and implement policies and procedures for patient care during transport;
   iv. develop guidelines for determining transport team composition and medical control and establish a mechanism to track adherence;
   v. establish policies and procedures to provide transport updates and outreach education;
   vi. establish a program for evaluating performance by tracking data, identifying trends, and implementing quality improvement initiatives to address transport performance in a coordinated systematic approach within a culture of safety, equity, and prevention5; and
   vii. report neonatal transport data and neonatal-specific reviews back to the PI committee.
   viii. The director of neonatal transport services may delegate specific requirements to other person(s) or group(s) but retains the responsibility of certifying that these functions are addressed appropriately.

The facility will:

   i. establish minimum education, experience, and training requirements for all transport team members;
   ii. select transport team members based on their experience and competence in the care of neonates and the transport team must collectively have

the ability to provide a level of care that is similar to that of the admitting unit; and

iii. provide annual transport education to all transport team members that incorporates equipment training, didactic education, simulation, and skills verification of low-volume, high-risk procedures consistent with the types of care provided during neonatal transport.

8. Support Services
   a. The neonatal program shall ensure the availability of personnel with specialized knowledge and skills in breastfeeding and lactation, to provide assistance and counseling to mothers at all times. Services shall include latch assessment, milk supply evaluation, and coordination with nutrition teams. An IBCLC should be available for on-site consultation on weekdays and accessible by telehealth or telephone at all times. IBCLC personnel should be operationally reviewed on an annual basis to establish adequately trained lactation coverage based on the specific need and volume of the neonatal population served.
   b. Child Life Services

      Child life services, or the equivalent, will be available for on-site consultation to support patient-and family-centered care by establishing and maintaining therapeutic relationships between patients, family members, multidisciplinary team members, and community resources.

   c. Social Worker

      The NICU social worker will:

      1. be a Master's prepared medical social worker with perinatal and/or pediatric experience.

      The facility will:

      1. provide 1 social worker for every 30 beds providing level III neonatal care and/or specialty and subspecialty perinatal care;
      2. have a written description that clearly identifies the responsibilities and functions of the NICU social worker; and
      3. have social services available for each family with an infant in the NICU as needed.

   d. Pastoral Care

      Personnel skilled in pastoral care will be available as needed and by family request, and will represent, or have the ability to consult, multiple religious affiliations representative of the population served.
   e. Retinopathy of Prematurity

The facility must have process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity, and the ability to perform on-site retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.8 Discharge Planning and Follow-Through Care

1. Systems will be in place to establish preparation for NICU discharge, including post-discharge follow-up by general and subspecialty pediatric care providers, home care arrangements and community service resources, and enrollment in a developmental follow-up program as needed.

The facility must have written medical, neurodevelopmental, and psychosocial criteria that automatically warrant high-risk neonatal follow-up with appropriate developmental follow-up services; as well as provide developmental follow-up services or have written referral agreement with a developmental follow-up clinical or practice, when possible, to provide neurodevelopmental services for the neonatal population served.

Follow-up outcomes are monitored via the Neonatal PI Plan to ensure continuity of care.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.9. Nursing Orientation and Education

1. Level IV NICU nursing orientation will incorporate didactic education, simulation, skills verification, and competency and will be tailored to the individual needs of the nurse based on clinical experience.
2. The facility will document an annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members.
3. Annual nursing education will address the annual needs assessment and incorporate simulation and skill verification of low-volume, high-risk

procedures consistent with the types of care provided in the Level IV NICU and include education related to serious safety events.

Clinical Nurse Educator

a. The NICU clinical nurse educator will:
    i. Be an RN, with nursing certification specific to the care environment preferred;
    ii. Have at least a Bachelor of Science in Nursing, Master's preferred;
    iii. Demonstrate a current status of NRP completion;
    iv. Cultivate collaborative relationships with the NPM and facility leadership to improve the quality of care and patient care outcomes; and
    v. Have experience and expertise to evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to level III neonatal care.
b. The facility will have at least one dedicated FTE allocated to perform the roles and responsibilities of the NICU clinical nurse educator.

Source: Miss. Code Ann. § 41-3-15

Rule 7.6.10. Neonatal Outreach

The Level IV Neonatal Center will provide multidisciplinary outreach education to referring facilities by assessing educational needs and evaluating clinical care and outcomes, including transport data, as part of collaboration with lower-level neonatal facilities.

Source: Miss. Code Ann. § 41-3-15