

CALIFORNIA CHILDREN'S SERVICES PROGRAM

CHAPTER 3.25 – STANDARDS FOR NEONATAL INTENSIVE CARE UNITS Community NICU

CHAPTER 3.25.2 – COMMUNITY NEONATAL INTENSIVE CARE UNITS

A. Community Neonatal Intensive Care Units (NICU) – Definitions

1. For the purpose of the California Children's Services (CCS) Program, a Community NICU shall be defined as a nursery within a CCS-approved Pediatric Community Hospital, CCS-approved General Community Hospital, or CCS-approved Special Hospital that has the capability of providing a full range of neonatal care services (critical, intensive, intermediate, and continuing care as defined in Section 3.25.2/A.2.), for severely ill neonates and infants, and provides support to Intermediate NICUs that shall include, but not be limited to, professional education and consultation.
2. CCS categorizes care provided to severely ill neonates in a Community NICU as defined by the American Academy of Pediatrics (AAP):^{1,2}
 - a. Critical Care: The illness or the injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. The care provided involves high-complexity medical decision making to assess, manipulate and support vital system(s) function, to treat vital organ system(s) failure or to prevent further life-threatening deterioration of the patient's condition.
 - (1) Critical care requires the interpretation of multiple physiologic parameters or application of advanced technology(ies).
 - (2) Organ failure is the key to considering a patient critical.
 - (3) Any organ system can be involved.
 - (4) Nurse-to-patient ratio of one or greater.
 - b. Intensive Care: These patients do not require critical care but still require intensive services such as continuous monitoring, frequent adjustments of therapy, and constant observation by the healthcare team under the direct supervision of a physician. Such care entails:
 - (1) Nurse-to-patient ratio between one to one and one to two; and
 - (2) Continuous cardiopulmonary monitoring; and
 - (3) Other specialized care technology for their multisystem problems.
 - c. Intermediate care: Care which is provided to neonates and infants who require:

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- (1) Nurse-to-patient ratio between one to two and one to three; and
 - (2) Other medically-necessary support such as tube feeding, IV medications or IV fluids.
 - (3) Associated medical decision-making ranges from straightforward or low complexity – typically 30 minutes, to moderate complexity – typically 50 minutes, to high complexity – typically 70 minutes.
- d. Continuing care: Care which is provided to neonates and infants who require:
- (1) Nurse-to-patient ratio between one to three and one to four; and
 - (2) May have previously received intermediate or intensive care but who no longer require intermediate or intensive care.
 - (3) Associated medical decision-making ranges is straightforward or low complexity – typically 30 minutes.

B. Community NICU - General Requirements and Procedure for CCS Program Approval

1. A hospital with a NICU wishing to participate in the CCS Program as a Community NICU for the purpose of providing care to sick infants shall be licensed by the California Department of Public Health (CDPH), Licensing and Certification Division, as required by Health & Safety Code, Division 2, Chapter 2, and all implementing regulations as set forth in California Code of Regulations (CCR), Title 22, Division 5, Chapter 1, as an:
 - a. Acute general hospital; and
 - b. Intensive Care Newborn Nursery (ICNN).
2. To qualify as a CCS Program Community NICU, a NICU must satisfy the following criteria:
 - a. Shall be located in a hospital approved by CCS as a Pediatric Community Hospital, as per Chapter 3.3.2, CCS Standards for Pediatric Community Hospitals; or
 - b. Shall be located in a hospital approved by CCS as a General Community Hospital with licensed perinatal beds, as per Chapter 3.3.3, CCS Standards

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for General Community Hospitals; or

- c. Shall be located in a hospital approved by CCS as a Special Hospital which has licensed perinatal beds, as per Chapter 3.3.4, CCS Standards for Special Hospitals.
3. Common surgical procedures may be performed on stable neonates in a Community NICU that does not have CCS approval for Neonatal Surgery, as per Chapter 3.34, CCS Standards for Neonatal Surgery.
4. A Community NICU shall only perform neonatal surgery, including the performance of patent ductus arteriosus (PDA) ligation, if approved by CCS for Neonatal Surgery, as per Chapter 3.34, CCS Standards for Neonatal Surgery.
5. A Community NICU shall only perform PDA ligations in premature infants if approved by CCS for PDA Ligation for Premature Infants, as per, Chapter 3.34, Section E. CCS Standards for PDA ligation for Premature Infants.
6. A Community NICU shall have a Regional Cooperation Agreement as specified below:
 - a. A Community NICU shall enter into written Regional Cooperation Agreements, approved by the CCS program, with an affiliated CCS-approved Regional NICU(s), and may additionally enter into written Regional Cooperation agreements, approved by the CCS Program, with affiliated Intermediate NICUs. All Regional Cooperation Agreements shall specify mutual responsibility for at least the following:
 - (1) Joint education and training of perinatal health professionals;
 - (2) Joint development of guidelines for obtaining consultation by perinatal, neonatal, and other specialty disciplines as necessary;
 - (3) Joint development of guidelines for maternal and neonatal patient referral and transport to and from each facility/NICU;
 - (4) Joint identification, development and review of protocols, policies and procedures related to the care of the high-risk obstetric and neonatal patient, at least every two years; and
 - (5) Joint review of outcome data, as specified in section K.7., at least annually.
 - b. Prior to CCS approval of a Community NICU, the Regional Cooperation Agreement shall be developed, negotiated, dated and signed by at least the

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following persons from each hospital:

- (1) Hospital Administrator;
- (2) Medical Director of the NICU;
- (3) Medical Director, Maternal-Fetal Medicine, (hospitals without licensed perinatal beds are exempt from this requirement); and
- (4) Nurse Administrator.

c. It shall be the mutual responsibility of the Regional, Community, and Intermediate NICUs to review the Regional Cooperation Agreement terms annually and recommend any modifications of said agreement to reflect the evaluation of outcome data.

7. A CCS Program NICU shall meet and maintain CCS Standards for Community NICUs, as set forth in this Chapter. All NICUs shall conform to the most current edition of the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists (AAP/ACOG) Guidelines for Perinatal Care. Where there is a conflict with specific AAP/ACOG recommendations and CCS Standards, the CCS Standards for NICUs shall apply.
8. A hospital wishing to participate in the CCS Program for the purpose of providing care to sick infants that is in conformance with CCS NICU standards, may obtain from the CCS Facility Review team a CCS NICU application, and submit it to: CCS Facility Review Team, at: CCSFacilityReview@dhcs.ca.gov. Questions concerning the standards and the application process should be directed to the CCS Facility Review Team at the identified email address.
9. Review Process:
 - a. Upon receipt, the NICU application will be reviewed by the CCS Facility Review team. For new applications, a site visit will be scheduled if the documentation submitted by the hospital appears to meet the CCS Standards for Community NICUs. The CCS Facility Review team will advise the applicant of deficiencies and provide opportunity and assistance to remedy them.
 - b. The site review shall be conducted by a state CCS review team. CCS will describe the procedure for the visit in a letter to the hospital that also confirms when the visit will take place. The procedure will reflect the specific confirmatory objectives for the particular review

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- c. In deciding whether to approve the Community NICU's application, CCS will consider the applicant's compliance with the CCS Standards for Community NICUs, information gathered during the site review of NICU procedures, services provided, patient chart review, the demonstration of community need and NICU patient outcome data, and compliance with state and federal law, including but not limited to licensing and Medicaid/Medi-Cal requirements.
 - d. An application may be denied for reasons including, but not limited to, the following:
 - (1) If there is not a community need. The CCS Program may consult with other Departments, Divisions, or Branches, such as the Maternal and Child Health Branch of CDPH and/or Licensing and Certification Division and with other state and federal agencies to determine community need.
 - (2) Geographic considerations;
 - (3) Lack caseload sufficient to maintain proficiency in the care of critically ill neonates; and
 - (4) Lack of sufficient funding, including but not limited to Medicaid matching funds.
10. After the site visit, the following types of approval actions may be taken by the CCS Program:
- a. Full approval is granted when all CCS Standards, and all applicable licensing standards, and Medicaid/Medi-Cal requirements for Community NICUs are met.
 - b. Provisional approval may be granted when all CCS Standards for Community NICUs, as well as licensing and Medicaid/Medi-Cal requirements appear to be met, however, additional documentation or data confirming performance of recent process change is required by the CCS Program. This type of approval may not exceed one year.
 - c. Conditional approval, for a period not to exceed six months, may be granted when there are readily remediable discrepancies with program standards. The hospital must present a written plan for achieving compliance with program standards, and the plan must be approved by the CCS Program. If the discrepancies are not corrected within the time frame specified by the CCS Program, conditional approval shall be terminated.
 - d. An application may also be denied based upon failure of the hospital to meet CCS

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Program standards, licensing standards, Medicaid/Medi-Cal requirements, lack of sufficient state funding or federal matching funds, or it has been determined by CCS that there is a lack of community need.

11. A hospital shall be notified in writing of the decision regarding approval status within 90 days after the site visit. A hospital whose application has been denied may appeal the decision by submitting a letter in writing to the Medical Director, Medical Operations and Policy Branch, Integrated Systems of Care Division (ISCD), within 30 days of receipt of the notification of denial.
12. Annually, or when requested as determined by CCS based on performance review, the hospital shall submit a list of staff who meet the qualifications as specified in these CCS Standards for Community NICUs to: CCSFacilityReview@dhcs.ca.gov. This list shall be accompanied by a copy of the most current hospital license. Any changes in the professional staff or facility requirements mandated by these standards shall be reported to the CCS Facility Review team at: CCSFacilityReview@dhcs.ca.gov within 30 days of occurrence.
13. Periodic reviews of CCS-approved NICUs may be conducted on an annual basis or as deemed appropriate by the CCS Program. If a NICU does not meet CCS Program requirements, licensing requirements, state or federal laws, or Medicaid/Medi-Cal requirements, the NICU is subject to losing CCS approval.

C. Community NICU - CCS Program Participation Requirements

1. Facilities providing services to CCS-eligible clients shall agree to abide by the laws, regulations, and policies of the CCS and Medi-Cal programs. Specifically, facilities shall agree to:
 - a. Refer all neonates/infants with potentially eligible CCS conditions to the CCS Program for review of CCS Program eligibility.
 - b. Assist families with the CCS referral and enrollment process by providing CCS application forms, phone numbers, and office locations.
 - c. Request prior authorization from the CCS Program, as per CCR, Title 22, Section 41770 and any applicable CCS Numbered Letters (N.L.).
 - d. Notify the local county CCS program office, before utilization, or within 72 hours of life-threatening emergency utilization, of specialized neonatal transport methods for potentially eligible neonates/infants to and from the facility/NICU.

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- e. Accept referral of CCS-eligible clients, Medi-Cal beneficiaries, and patients who are both CCS and Medi-Cal eligible.
- f. Serve all patients regardless of race, color, religion, national origin, ancestry, sexual orientation or gender identity of the patient or their caregivers.
- g. Bill client's private insurance, Medi-Cal or Medicare within six months of service prior to billing CCS, if the client is eligible for such coverage.
- h. Bill CCS within:
 - (1) Six months from the date of service if the client does not have third party insurance coverage; or
 - (2) Six months from the date of receipt of insurance payment/denial, including an explanation of benefits from the insurance carrier; or
 - (3) Twelve months from the date of service if insurance carrier fails to respond.
- i. Utilize electronic claims submission when available, upon CCS request.
- j. Accept CCS payment for authorized services in accordance with state regulations as payment in full.
- k. Provide electronic copies of medical records, discharge summaries, and other information as requested by the CCS Program within ten working days of request, or within fewer days as necessitated by the health and safety of the patient whose information is being requested.
- l. Provide annual reports as a component of CCS recertification.
- m. Provide services in a manner that is family centered and culturally competent, including the provision of translators and written materials. CCS defines family centered care as a partnership approach to health care decision making between the family and the health care provider. CCS equates cultural competency with the notion of cultural respect as articulated by the National Institutes of Health: cultural “elements influence beliefs and belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural respect has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients.”³

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- n. Permit CCS staff to visit and monitor facilities to assure ongoing compliance with CCS standards.
 - o. Assist and cooperate with CCS staff in the on-site utilization review by CCS staff of services provided to CCS-eligible clients and Medi-Cal beneficiaries.
2. Failure to abide by the regulations and procedures governing the CCS Program may result in retraction of CCS approval.

D. Community NICU - Exclusions

- 1. Hospitals that are excluded from participation in programs of federal and state agencies shall automatically be excluded from participation in the CCS Program.
- 2. A hospital may also be excluded by the CCS Program because of, but not limited to, the following:
 - a. Failure to successfully complete the CCS approval process;
 - b. Inadequate and/or untimely addressing of deficiencies identified during a CCS site visit;
 - c. Loss of external accreditation recognized by the Centers for Medicare and Medicaid Services; or
 - d. Failure to abide by the laws, regulations, standards, and procedures governing the CCS Program.

E. Community NICU - Organization

- 1. There shall be a separate and identifiable administrative unit for the NICU.
- 2. Medical care of the Community NICU shall be under the direction of a medical director:
 - a. Who shall meet the qualifications contained in Section 3.25.2/F.;
 - b. Whose primary responsibility shall be the organization and supervision of the Community NICU; and
 - c. Who shall not be the medical director of more than one NICU (Regional, Community, or Intermediate) other than at the same contiguous medical building complex.

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3. There shall be a Community NICU nurse manager:
 - a. Who shall have the responsibility on a 24-hour basis for the organization, management, supervision and quality of nursing practice and nursing care in the NICU;
 - b. Who shall not be a nurse manager of more than one NICU other than at the same contiguous medical building complex; and
 - c. Who shall meet the requirements contained in Section 3.25.2/F.
4. The Community NICU medical director and the Community NICU nurse manager shall have joint responsibility for the development and review of an ongoing quality improvement program.
5. The Community NICU medical director and the Community NICU nurse manager shall have joint responsibility for development and review of a Policies and Procedures Manual for the NICU which addresses, at a minimum, patient admission, patient care, discharge, and transfer criteria, as described in section I below.
6. There shall be an identified NICU multidisciplinary team:
 - a. Which shall have the responsibility for coordination of all aspects of patient care; and
 - b. Which shall consist of, at a minimum, a CCS-paneled neonatologist, a clinical nurse specialist (CNS), a respiratory care practitioner (RCP) and a CCS-paneled medical social worker (MSW) with current experience and practice in neonatal care and whose professional requirements are defined in Section 3.25.2/F. Optional members of the Community NICU multidisciplinary team may include, but are not limited to, the following: CCS-paneled clinical registered dietitian, CCS-paneled occupational therapist, and CCS-paneled physical therapist.
7. There shall be, at a minimum, weekly NICU multidisciplinary team conferences (rounds).
 - a. The NICU multidisciplinary team conference shall include representation from the NICU's medical, nursing, medical social service, RCP staff, and other specialists, i.e., the clinical registered dietitian, occupational therapist and physical therapist, when appropriate.
 - b. Minutes of these weekly team conferences which document attendance and

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discussion of plan(s) of care for the individual infants shall be included either in the infant's chart or in a binder that shall be available for review by CCS Program staff.

F. Community NICU - Professional Resources and Requirements

1. Community NICU Physician Staff

1.1. Community NICU Medical Director

a. There shall be a full-time CCS-paneled neonatologist as the medical director:

- (1) Who shall have overall responsibility for the quality of medical care for the infants admitted to the NICU; and
- (2) Who shall be certified by the American Board of Pediatrics in the subspecialty of Neonatal-Perinatal Medicine; and
- (3) Who shall have evidence of current successful completion of the Neonatal Resuscitation Program (NRP) course of the AAP and American Heart Association (AHA).

b. The responsibilities of the Community NICU medical director shall include, but are not limited to, the following:

- (1) Participation in the development, review and assurance of the implementation of NICU policies and procedures as specified in Section 3.25.2/I.
- (2) Approval of, at a minimum, written criteria approved by CCS that defines the following:
 - (a) Which infants admitted to the NICU require care to be provided by a neonatologist; and
 - (b) Which infants require consultation by a neonatologist; and
 - (c) Which infants require intermediate or continuing care who may be managed by a CCS-paneled pediatrician who has evidence of current experience and practice in neonatal medicine and who meets the requirements defined in Section 3.25.2/F.1.3.d.

(3) Supervision of clinical performance evaluation and quality improvement

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activities (including morbidity and mortality reviews).

- (4) Assuring NICU staff competency in resuscitation techniques.
 - (5) Assuring ongoing NICU staff education.
 - (6) Participation in NICU budget preparation.
 - (7) Oversight of neonatal/infant transport to and from the NICU.
 - (8) Assuring maintenance of NICU database and/or vital statistics.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the Community NICU medical director.

1.2. Community NICU Neonatologist Staff

The Community NICU medical director shall have one or more full-time equivalent associate neonatologists on staff:

- a. Who shall be CCS-paneled neonatologists; and
- b. Who shall share the clinical care responsibilities of the NICU; and
- c. Each associate neonatologist shall be certified by the American Board of Pediatrics Sub-Board of Neonatal-Perinatal Medicine. Current policies of the American Board of Pediatrics for the subspecialty of Neonatal-Perinatal Medicine determine the time limit for eligibility for initial certification, for maintenance of certification, and for board status; and
- d. Who shall have evidence of current successful completion of the NRP course of the AAP and AHA.

1.3 Community NICU Additional Physician Staff

- a. A CCS-paneled pediatric cardiologist shall be on the hospital staff, on-call, and available on-site or via telemedicine to the NICU in less than one hour.

Telemedicine cardiology services must comply with current recommendations from the AHA and the following:

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- (1) Telehealth systems used to conduct the tele-cardiology consultation should conform to U.S. Food and Drug Administration (FDA) regulations and meet Medi-Cal telehealth rules.⁴
 - (2) At the “originating site,” a complete pediatric echocardiogram should be obtained by a Registered Diagnostic Cardiac Sonographer (RDCS).
 - (3) The RDCS (if not pediatric certified) must have additional training in obtaining infant, pediatric and adult congenital studies.
 - (4) Specific pediatric transducers must be available at the originating site.
 - (5) A complete echocardiogram should be available to the “distant site” CCS-paneled pediatric cardiologist on a Health Insurance Portability and Accountability Act (HIPAA) compliant platform (originating site, distant site, and/or cloud based) for review with options to review the entire study, and for review in standard quality, not in compressed or reduced quality.
 - (6) A CCS-paneled pediatric cardiologist at the “distant site” should be available and able to interpret echocardiograms and provide diagnostic data, per standard regulations, and within one hour on a 24/7 basis in urgent cases.
 - (7) In order to obtain a history, assess the status of the patient, and update family and providers at the “originating site,” a CCS-paneled pediatric cardiologist at the “distant site” should be able to provide face-to-face consultations to the primary medical team and/or family at the bedside within one hour of request, using high-definition telemedicine telecommunications (simultaneous audio and video).
 - (8) The cardiologist should be credentialed (by-proxy) at “originating site.”
 - (9) Documentation by the “distant” CCS-paneled pediatric cardiologist should be in place in the patient’s medical record within 24 hours.
- b. At a minimum, the following CCS-paneled pediatric subspecialists with neonatal expertise shall be readily available for consultation to the NICU: gastroenterologist, geneticist/dysmorphologist, endocrinologist, nephrologist, neurologist, pulmonologist, hematologist/oncologist, infectious disease specialist, immunologist, and pediatric surgeon. There shall be an agreement for Community NICU staff to obtain telephone consultation with those CCS-paneled pediatric subspecialists identified above who are not on hospital staff.

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- (1) Neurology telemedicine services must comply with current recommendations from the AAP,⁵ the Child Neurology Society,⁶ and the following:
 - (a) A CCS-paneled pediatric neurologist should be available within 24 hours and able to conduct a history from the family and physical examination of the patient using high-definition telemedicine telecommunications including simultaneous audio and video.
 - (b) A CCS-paneled pediatric neurologist should be available 24/7 to provide face-to-face consultations to the primary medical team and/or family at the bedside via standard telemedicine telecommunications referenced above in paragraph (a) with simultaneous audio and video.
 - (c) Documentation by the “distant” CCS-paneled pediatric neurologist should be in place in the patient’s medical record within 24 hours.
- (2) When neurology telemedicine services include electroencephalogram (EEG), continuous EEG (cEEG), or amplitude integrated EEG (aEEG), they must comply with the following:
 - (a) Telehealth systems used to obtain, transmit and present studies should conform to FDA regulations and meet Medi-Cal telehealth rules.⁴
 - (b) EEG should be placed by a certified EEG Technician with expertise in obtaining infant studies. Configuration and duration of the EEG should be determined in consultation with the CCS-paneled pediatric neurologist.
 - (c) The complete EEG should be available to the “distant” CCS-paneled pediatric neurologist on a HIPAA secure platform (originating site, distant site, and/or cloud based) with options to review the entire study, and for review in standard quality, not in compressed or reduced quality.
 - (d) At the “originating site,” aEEG should be placed and monitored by a bedside NICU registered nurse (R.N.) with an understanding of aEEG technology and principles; who has demonstrated qualifications for obtaining appropriate waveforms of diagnostic quality; and understands the clinical appearance of common abnormalities requiring immediate evaluation.
 - (e) Output from the aEEG should be reviewed in-person by the neonatologist and/or securely transmitted for review by a CCS-paneled neonatologist or pediatric neurologist.

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- (f) Review of the aEEG output by the appropriate physician should be available within one hour for urgent concerns on a 24/7 basis.
 - (g) cEEG should be placed by a certified EEG Technician with expertise in obtaining infant studies. The cEEG should be monitored remotely by a CCS paneled neurologist who can evaluate a patient within one hour for urgent concerns on a 24/7 basis.
 - (h) The bedside NICU R.N. should have the capacity to notify the neurologist of any clinical concerns and receive a response within one hour.
- c. There shall be a CCS-paneled ophthalmologist with expertise in the examination of the preterm infant on hospital staff. Those infants at risk for retinopathy of prematurity (ROP) and who require examination prior to discharge, shall have their examination performed by the CCS-paneled ophthalmologist.
- (1) Ophthalmology telemedicine services must comply with FDA regulations, meet Medi-Cal telehealth rules,⁴ and comply with current recommendations from the AAP's Section on Ophthalmology;⁷ American Association for Pediatric Ophthalmology and Strabismus;⁸ and with the following:
 - (a) Tele-ophthalmology must involve a CCS-paneled ophthalmologist who is qualified to diagnose ROP if the fundus images are limited in quality, provides documented feedback on retinal images within 24 hours, and can implement a plan for warranted treatment.
 - (b) The "originating site" must employ a wide-angle fundus camera suitable for pediatric retinal screening, operated by a technician who possesses knowledge and skills for independent imaging or with assistance and consultation, has basic understanding of ocular telehealth technology and principles, demonstrates qualifications for obtaining appropriate image fields of diagnostic quality, and understands the clinical appearance of common retinal diseases requiring immediate evaluation.
 - (c) Retinal image data sets should adhere to the Digital Imaging and Communications in Medicine Standard.⁹ Patient information, eye and retina characteristics, image type, and other data should be linked to image files as metadata.

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- d. CCS-paneled pediatricians may provide care to infants requiring intensive, intermediate and/or continuing care under the direct supervision of the Community NICU medical director or CCS-paneled neonatologist. The CCS-paneled pediatrician shall:
 - (1) Be certified by the American Board of Pediatrics with evidence of current experience and practice in neonatal medicine; and
 - (2) Meet continuing education requirements as specified in Section 3.25.2/K; and
 - (3) Have evidence of current successful completion of the NRP course of the AAP and AHA.

The policies and procedures documents of a NICU must operationally define, at each level of care, such direct supervision by the neonatologist. All pediatricians providing such care and all neonatologists directly supervising such care must sign an agreement describing what constitutes direct supervision at each respective level of care. Pediatricians providing intensive care must be in-house and supported by the neonatologist as specified in section H.6. and H.7.

- e. A Community NICU approved for neonatal surgery shall meet all staffing requirements in the CCS Standards for Neonatal Surgery, CCS Manual of Procedures, Chapter 3.34.

2. Community NICU Nurse Staff

Nurse staff titles or positions listed in CCS Standards may differ from those used in a facility. For the purpose of CCS Standards for NICUs, the facility is allowed to have an individual whose staff title is not the same as that used in the CCS Standards, however, the individual shall meet the requirements described below.

2.1 Community NICU Nurse Manager

- a. The Community NICU nurse manager shall direct the nursing administrative operation of the NICU, as per Section 3.25.2/E.3. and shall:
 - (1) Be a R.N. licensed by the State of California holding a master's degree in nursing; or
 - (2) Be a R.N. holding a Bachelor of Science degree in nursing (BSN) and either a master's degree in a related field or certificate in nursing or health care administration from a nationally recognized accrediting organization;

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and

- (3) Have at least three years of full-time clinical nursing experience at least one year of which shall have been in neonatal nursing in a NICU that is equivalent to a Regional or Community NICU.
- b. The responsibilities of the Community NICU nurse manager shall include, at a minimum, personnel, fiscal and material management, and coordination of the quality improvement program for the NICU.
- c. The Community NICU nurse manager shall directly supervise the nurse supervisor(s) for the NICU.
- d. The facility shall maintain written documentation of the qualifications and responsibilities of the Community NICU nurse manager.
- e. If the Community NICU nurse manager is dedicated solely to the NICU and does not oversee more than 30 full-time equivalent positions or 50 NICU staff members, the position and responsibilities of the nurse manager and the nurse supervisor may be combined under the nurse manager position.

2.2 Community NICU Nurse Supervisor

- a. The Community NICU nurse supervisor shall directly supervise personnel and assure the quality of clinical nursing care of patients in the NICU at all times.
- b. The Community NICU nurse supervisor shall:
 - (1) Be a R.N. licensed by the State of California holding a BSN or master's in nursing degree;
 - (2) Have at least three years of full-time clinical experience, one year of which shall have been in neonatal nursing in a NICU that is equivalent to a Regional or Community NICU;
 - (3) Have evidence of current successful completion of the NRP course of the AAP and AHA; and
 - (4) Have current certification in Neonatal Intensive Care Nursing from a nationally recognized accrediting organization, i.e., the National Certification Corporation (NCC).

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- c. The Community NICU nurse supervisor shall have 24-hour responsibility for:
 - (1) The direct supervision of all clinical personnel who provide patient care; and
 - (2) The day-to-day coordination of and quality of clinical nursing care of patients in the NICU.
- d. The facility shall maintain written documentation of the qualification and responsibilities of the Community NICU nurse supervisor.
- e. The Community NICU nurse supervisor shall not be assigned direct patient care responsibilities.

2.3 Community CNS

- a. There shall be the equivalent of 0.5 full-time equivalent CNS for the Community NICU.
- b. The Community CNS shall:
 - (1) Be a R.N. licensed by the State of California holding a master's and/or doctoral degree in nursing.
 - (2) The CNS shall be licensed by the State Board of Registered Nursing as a CNS, pursuant to, Article 9, of Chapter 6, of Division 2, of the California Business and Professions Code.
 - (3) Have at least three years' full-time of clinical experience in neonatal nursing in a NICU that is equivalent to a Regional or Community NICU.
 - (4) Have current certification in Neonatal Intensive Care Nursing from a nationally accredited organization i.e., NCC or the American Association of Critical-Care Nurses (AACN); or certified by AACN as a Neonatal CNS.
 - (5) Have evidence of current instructor status by the NRP of the AAP and the AHA.
- c. The Community CNS shall be responsible for:
 - (1) Directing the clinical nursing practice in the NICU;
 - (2) Coordinating and assessing critical care education development and clinical competency of the nursing staff in the NICU; and ensuring continued

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competency through educational programs for both the newly hired and experienced nursing staff;

- (3) Consulting with staff on complex neonatal critical care nursing issues;
- (4) Oversight of comprehensive parent and/or primary caretaker education activities; and
- (5) Ensuring implementation of a coordinated and effective discharge planning program.

d. The facility shall maintain written documentation of the qualifications and responsibilities of the Community NICU CNS.

2.4 Community NICU Neonatal Nurse Practitioner (NNP) (optional)

a. NNPs who provide care for infants in the NICU shall:

- (1) Be a R.N. licensed by the State of California, as per CCR, Title 16, Division 14, Section 1482;
- (2) Have evidence of current successful completion of the NRP course of the AAP and AHA; and
- (3) Satisfy and comply with the Standards for Nurse Practitioners in accordance with CCR, Title 16, Division 14, Article 8, Sections 1480 through 1485.
- (4) The NNP shall provide medical and nursing care under the supervision of the medical director of the NICU or the CCS-paneled neonatologist and shall function in accordance with standardized procedures as per CCR, Title 16, Division 14, Article 7, Sections 1470 through 1474.

2.5 Community NICU Charge Nurse

a. There shall be at least one Community NICU charge nurse for each shift in the NICU who shall:

- (1) Be a R.N. licensed by the State of California;
- (2) Have education, training, and demonstrated competency in neonatal critical care nursing ; as per CCR, Title 22, Sections 70016.1, 70213 (c), 70217 (a), and 70485;

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- (3) Demonstrate competency in the role of a charge nurse , as described by the International Scholarly Research Notices Nursing article published in the National Library of Medicine;¹⁰ and
 - (4) Have evidence of current successful completion of the NRP course of the AAP and AHA.
- b. The responsibilities of the Community NICU charge nurse during each shift shall include the following:
- (1) Coordinating the patient care activities in the NICU; and
 - (2) Ensuring the delivery of quality patient care.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the Community NICU charge nurse.

2.6 Community NICU R.N.

- a. R.N.s who are assigned direct patient care (critical, intensive, intermediate, and continuing care) responsibilities in the Community NICU shall:
- (1) Be licensed by the State of California;
 - (2) Have education, training and demonstrated competency in neonatal critical care nursing as per CCR, Title 22, Sections 70016.1, 70213 (c), 70217 (a), and 70485.; and
 - (3) Have evidence of current successful completion of the NRP course of the AAP and AHA.
- b. R.N.s functioning in an expanded role shall do so in accordance with standardized procedures as per CCR, Title 16, Division 14, Article 7, Sections 1470 through 1474.
- c. The facility shall maintain written documentation of the qualifications and responsibilities of the R.N. staff which shall include, at a minimum, the standards of competent performance of the R.N. staff providing care in the Community NICU as per CCR, Title 22, Sections 70016.1, 70213 (c), 70217, 70485.

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3. Physician Assistants (PAs) Providing Patient Care in NICUs

- a. Consistent with Title 16, Division 13.8, Article 4, Section 1399.540 of CCR, neonatologists may delegate the provision of NICU care services to qualified PAs. A PA who meets all the following requirements in (1)-(5) below may provide delegated services to patients in the NICU under the supervision of a CCS-paneled attending neonatologist:

(1) Successful completion of either:

- (a) A PA program accredited by the Accreditation Review Commission on Education for the Physician Assistant and at least two years of NICU practice experience as defined below; or
- (b) A master's program in PA Studies and at least one year of NICU practice experience as defined below:

NICU practice experience is defined as full-time (at least 40 hours per week) clinical activities including professional mentoring, formally structured didactic teaching, skills training such as simulations followed by constructive feedback, and direct NICU supervised patient care, at a CCS Community level NICU, a CCS Regional level NICU, or an AAP level III or level IV NICU. Additional clinical experience settings must include all of the following:

- i. An obstetrical delivery room.
- ii. A well-baby nursery or similar area of the hospital.
- iii. An operating room.

(2) Certified by the National Commission on Certification of Physician Assistants.

(3) Maintains a current license from the California Physician Assistant Board.

(4) Maintains a current certification by the AAP and the AHA as a NRP Provider.

(5) Maintains a current written "Delegation of Services" agreement which specifies what medical services the PA may provide under the supervising neonatologist who is responsible for the patient's care. The "Delegation of Services" agreement authorizing the PA to provide delegated medical services must be signed and dated by both the PA and the supervising neonatologist.

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- b. A supervising neonatologist must also meet the following requirements to delegate the provision of medical services to a NICU PA:
 - (1) Provide to the CCS Facility Review Team, at: CCSFacilityReview@dhcs.ca.gov, a written “Delegation of Services Agreement” as required under Title 16, Division 13.8, Article 4, Section 1399.540 of CCR, and as referenced in section 3.a.(5). above. This document should specify the on-call schedule structure and services that may be provided, including: patient evaluations; problem formulations and care plans; care orders that a PA may write; procedures that a PA may perform; description of initial NICU orientation period preceptorship including duration, limitations, and patient load. This document also should describe requirements for continuing education, periodic review of clinical performance, and confirm agreement on complete scope of work by the hospital and medical group employing/supervising the PA.
 - (2) A supervising neonatologist who is a signatory to any PA delegation of services agreement must review and cosign, within 24 hours, all PA activity and medical record documentation performed by the PA.
 - (3) At each NICU which utilizes PA services, all policies and procedures governing PA NICU patient management and physician/PA communication must be approved by the CCS Facility Review team.

4. Community NICU RCP

- a. Respiratory care services shall be provided by RCPs who are licensed by the State of California and who have additional training and experience in neonatal respiratory care. Additional training in neonatal respiratory care shall be demonstrated by the following:
 - (1) Completion of a formal neonatal respiratory therapy course at an approved school of respiratory therapy that includes didactic and clinical course work; or
 - (2) Completion of a minimum of 20 hours of didactic and four weeks of precepted neonatal clinical experience in a hospital-based course at a facility with a NICU equivalent to a Regional or Community NICU.
- b. The facility shall maintain a written job description delineating the qualifications and duties of the RCP in the NICU which reflects the provision of practice in accordance with Business and Professions Code, Respiratory Care Practice Act, Division 2, Chapter 8.3, Article 1, Section 3702 and CCR, Title 16, Division 13.6, Articles 1 through 8.

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- c. The RCP shall be responsible, at a minimum, for the monitoring and application of respiratory equipment.
 - d. There shall be an identified RCP with expertise in neonatal respiratory care practice available at all times to the NICU.
 - e. RCPs shall be assigned solely to the NICU when supportive ventilation is being provided and the staffing level shall be such that immediate availability of the RCP to the NICU is assured at all times.
 - f. There shall be a system in place for ensuring continuing clinical respiratory care competency through educational programs both for the newly-hired and experienced RCP staff in accordance with CCR, Title 16, Division 13.6, Article 5.
 - g. All RCPs providing services in the NICU shall have evidence of current successful completion of the NRP course of the AAP and AHA.
 - h. RCP staffing shall be based on the level of required patient care, acuity, and number of patients in the NICU; all of which are determined by the attending neonatologist or physician designee.
5. Community NICU MSW
- a. Social work services shall be provided in the NICU by a CCS-paneled MSW holding a master's degree in social work who has expertise in psychosocial issues affecting the families of seriously ill neonates/infants.
 - b. For every 15 patients in the NICU, there shall be one full-time equivalent MSW.
 - c. The facility shall maintain a written job description defining the qualifications, responsibilities and functions of the MSW in the Community NICU.
 - d. There shall be 24-hour coverage by a MSW for the Community NICU.
 - e. There shall be a written agreement with a CCS-approved Regional NICU with which the Community NICU has a Regional Cooperation Agreement, for obtaining telephone consultation from a MSW, as specified in Section 3.25.2/H. The MSW shall conform to requirements contained in Section 3.25.2/H.11.
6. Community NICU Pharmaceutical Services

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- a. There shall be at least one licensed pharmacist holding a doctoral degree in pharmacy (Pharm.D.) with neonatal expertise available for consultation to Community NICU staff.
- b. Pharmacy staff and pharmaceutical services shall be available on a 24-hour basis to the Community NICU.
- c. Pharmacy staff shall provide neonatal unit doses including individual neonatal intravenous and parenteral nutrition solutions, and neonatal nutritional products, in clearly marked containers; and shall also provide continuous drug surveillance.

7. Community NICU Clinical Registered Dietitian

- a. Nutritional consultation to the Community NICU shall be provided by a CCS-paneled clinical registered dietitian who has clinical experience in pediatric and neonatal nutritional services.
- b. The clinical registered dietitian shall meet the requirements contained in Chapter 3.3.2 of the CCS Standards for Pediatric Community Hospitals.
- c. There shall be a written agreement with a CCS-approved Regional NICU with which the Community NICU has a Regional Cooperation Agreement for obtaining telephone consultation from a clinical registered dietitian, as specified in Section 3.25.2/H.

8. Community NICU Occupational Therapy Staff

There shall be a CCS-paneled occupational therapist available to the Community NICU who meets the requirements contained in Chapter 3.3.2 of the CCS Standards for Pediatric Community Hospitals. If available, speech language pathologists may consult for swallowing disorders.

9. Community NICU Physical Therapy Staff

There shall be a CCS-paneled physical therapist available to the Community NICU who meets the requirements contained in Chapter 3.3.2 of the CCS Standards for Pediatric Community Hospitals.

G. Community NICU - Facilities and Equipment

1. The Community NICU shall be a distinct, separate unit within the hospital.
2. The Community NICU shall meet the following bed requirements:

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- a. There shall be at least eight licensed ICNN beds for providing intensive, intermediate, and continuing care and:
 - (1) At least four of the licensed beds shall meet all requirements pertaining to space, equipment, supplies, and physical environment for intensive care as required in the ICNN regulations, CCR, Title 22, Division 5, Sections 70481 through 70489.
 - (2) There shall be at least four beds in the Community NICU providing intermediate and/or continuing care. These beds shall be licensed as required in Section 3.25.2/G.2.a.(1) above or approved under program flexibility, CCR, Title 22, Division 5, Chapter 1, Article 4, Section 70307. Beds approved under program flexibility shall not be used for intensive care and shall, at a minimum, have eight electrical outlets, two oxygen outlets, two compressed air outlets, and two suction outlets per patient station.
 - (3) Beds in addition to the eight required in Sections 3.25.2/G.2.a.(1) and (2) which provide only continuing care and are approved under program flexibility, CCR, Title 22, Division 5, Chapter 1, Article 4, Section 70307 shall at a minimum, have four electrical outlets, one oxygen outlet, one compressed air outlet and one suction outlet per patient station.
 - b. For the purpose of CCS Standards, program flexibility granted by Licensing and Certification for areas other than beds/patient stations, shall be superseded by the requirements in this document. CCS does not have authority to grant flexibility or exceptions to licensing and certification standards. The hospital must consult CDPH Licensing and Certification regarding such flexibility or exceptions.
3. A Community NICU shall have the following space/rooms available within, adjacent to, or in close proximity to the NICU:
 - a. An on-call physician's room/sleeping quarter(s);
 - b. A parent waiting room;
 - c. A separate room available for parent and infant interaction in privacy; and
 - d. A separate room for parent and physician/staff conferences, NICU multidisciplinary team conferences, case presentations, teaching/in-service education, and other staff meetings.
 4. In addition to meeting the requirements contained in CCR, Title 22, Division 5, Chapter

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1, Article 6, Section 70487, ICNN Service Equipment and Supplies, a Community NICU shall also have:

a. Beds licensed for intensive care, as required in the ICNN regulations, that meet the following requirements:

(1) Monitoring equipment at each infant station in the NICU that have, at a minimum, the capability to monitor:

(a) Heart rate and electrocardiogram (ECG);

(b) Respiratory rate;

(c) Temperature; and

(d) Oxygen saturation.

(2) Individual infant monitoring equipment that have features including, at a minimum, the following:

(a) Visible and audible high/low alarms for heart rate, respiratory rate, and all pressures;

(b) Hard-copy capability for the rhythm strip;

(c) Routine testing and maintenance of all monitors; and

(d) Two pressure monitor channels.

b. Beds licensed for intermediate care, and are not used for intensive care, that meet the following requirements:

(1) Monitoring equipment at the infant station in the NICU that have, at a minimum, the capability to provide:

(a) Heart rate and ECG;

(b) Respiratory rate;

(c) Temperature; and

(d) Oxygen saturation.

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- (2) Individual infant monitoring equipment that have features including, at a minimum, the following:
 - (a) Visible and audible high/low alarms for heart rate, respiratory rate, and pressures;
 - (b) Routine testing and maintenance of all monitors; and
 - (c) One pressure monitoring channel per every two beds.
- c. Beds licensed for continuing care, and are not used for intensive care or intermediate care, that meet the following requirements:
 - (1) Monitoring equipment at the infant station in the NICU that have the capability to monitor:
 - (a) Heart rate and ECG;
 - (b) Respiratory rate; and
 - (c) Oxygen saturation.
 - (2) Individual infant monitoring equipment that have features including, but not limited to, the following:
 - (a) Visible and audible high/low alarms for heart rate and respiratory rate and
 - (b) Routine testing and maintenance of all monitors.
- d. Equipment available for infants in the NICU that includes, but is not limited to, the following:
 - (1) Emergency ("code" or "crash") cart with emergency drugs with size/weight appropriate neonatal unit doses and a defibrillator;
 - (2) Neonatal surgical cut-down trays (including equipment for umbilical vessel catheterization, thoracostomy, chest and pericardial tube placement, peripheral vessel cut down, and exchange transfusion);
 - (3) Chest tube drainage, collection, water seal, and suction devices;
 - (4) Incubators;

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- (5) Radiant heat device;
- (6) Heart rate/respiratory rate/blood pressure monitors;
- (7) Blood pressure transducers;
- (8) Automated noninvasive blood pressure apparatus;
- (9) Pulse oximeter;
- (10) Bedside glucose monitor;
- (11) Neonate scale(s), 10 kilogram;
- (12) 500 gram scale(s), with one gram increments;
- (13) Infusion pumps (with microinfusion capability);
- (14) Intravenous stands;
- (15) Suction pressure regulators;
- (16) Suction/drainage bottles;
- (17) Vascular access equipment;
- (18) Suction catheters in a range of sizes, (i.e. 10, 8, 6 French [Fr]);
- (19) Feeding tubes # 5 and # 8 Fr;
- (20) Nasogastric tubes# 10 Fr;
- (21) Stethoscopes, infant size appropriate;
- (22) Otoscopes and ophthalmoscopes;
- (23) Neonate laryngoscope with # 00, # 0, and # 1 laryngoscope blades, spare batteries, and bulbs (for reusable blades);
- (24) Endotracheal tubes, sterile and disposable, sizes 2.0, 2.5, 3.0, 3.5, 4.0 mm with malleable stylets;
- (25) Colorimetric Carbon Dioxide Detector;

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- (26) Oral airways;
 - (27) Laryngeal masks;
 - (28) Portable surgical illumination/procedure lamp;
 - (29) Wall clocks indicating elapsed seconds and minutes; and
 - (30) Portable transilluminator.
- e. Equipment for infants available to the NICU that includes, but is not limited to, the following:
- (1) ECG machine;
 - (2) Central venous catheters, both temporary and permanent;
 - (3) Phototherapy lights;
 - (4) Refrigerators;
 - (5) Ice maker;
 - (6) Surgical tray stands;
 - (7) Supply carts;
 - (8) Blood warming apparatus;
 - (9) Plastic wrap and heating mattresses;
 - (10) Electric breast pump; and
 - (11) Freezer for storage of breast milk.
- f. Respiratory equipment for infants available in and/or to the NICU that includes, but is not limited to, the following:
- (1) Oxygen-air blenders;
 - (2) Gas flow meters (oxygen and air);

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- (3) Continuous oxygen analyzers with alarms;
 - (4) Oxygen humidifier/nebulizer with heater;
 - (5) Oxygen temperature detectors with alarms;
 - (6) Oxygen hoods or other indicated delivery device;
 - (7) Ventilation bag, 500 ml flow-through with adjustable pop-off valve capable of generating pressure of 40-50 cm H₂O and/or T-piece resuscitator;
 - (8) Face masks in appropriate sizes for neonates;
 - (9) Mechanical ventilators;
 - (10) Continuous positive airway pressure capability either via ventilator or separate units;
 - (11) Aerosol medication administration equipment;
 - (12) Chest physiotherapy and suctioning equipment; and
 - (13) Inhaled nitric oxide.
5. Oxygen and compressed air, supplied from a central source, shall supply 50 pounds per square inch (psi) with an alarm system to warn of a critical reduction in line pressure. Reduction valves and blenders shall produce concentrations of oxygen from 21 percent to 100 percent at atmospheric pressure for head hoods and 50 psi for mechanical ventilators. Oxygen monitoring for inspired concentrations shall be available in the NICU.
 6. Transport equipment with provisions for temperature control, ventilation, and cardiopulmonary monitoring shall be available for transport of infants within the hospital. Transport equipment shall meet the conditions in CCR, Title 22, Division 5, Chapter 1, Article 6, Section 70487(b).
 7. Diagnostic imaging procedures and consultation services necessary for the level of care provided shall be available on a 24-hour basis as specified in Chapter 3.3.2 of the CCS Standards for Pediatric Community Hospitals.
 8. Laboratory services and consultation services necessary to the level of care provided shall be available on a 24-hour basis. There shall be the capability for a ten minute turnaround time for pH and blood gas determinations.

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H. Community NICU - Patient Care

1. CCS-eligible infants in the Community NICU requiring intensive care shall be under the direct supervision of the Community NICU medical director or CCS-paneled neonatologist.
2. A CCS-paneled pediatrician who meets the requirements contained in Section 3.25.2/F., under direct supervision of a CCS-paneled neonatologist at the NICU, as specified in section F.1.3.d, may provide care to infants requiring intensive, intermediate or continuing care.
3. Infants requiring critical or intensive care provided by a NNP shall have daily review, evaluation, and documentation of care by a CCS-paneled neonatologist. Infants requiring intermediate or continuing care provided by a NNP shall have daily review, evaluation, and documentation of care by a CCS-paneled neonatologist or CCS-paneled pediatrician.
4. A CCS-paneled neonatologist or CCS-paneled pediatrician shall review, evaluate, and document the clinical management of each infant, on-site, at least on a daily basis.
5. It shall be the responsibility of the CCS-paneled neonatologist to ensure that information is provided, on an ongoing basis, to referring physicians regarding their patients.
6. There shall be a CCS-paneled neonatologist on-call to the Community NICU on a 24-hour basis who:
 - a. Shall be in the hospital or be no more than 30 minutes away from the NICU at any time; and
 - b. Shall not be on-call for more than one hospital at the same time; and
 - c. Shall be notified of new admissions and adverse changes in the status of neonates in a timely manner as described in Section 3.25.2/H.7 below.
7. A neonatologist, pediatrician in postdoctoral training in neonatal-perinatal subspecialty medicine training, a NNP, and/or a physician who has completed more than two years of a postgraduate pediatric residency training program with experience and training in neonatology shall be in-house and called:
 - a. To evaluate every infant on admission; and

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- b. Whenever an unstable infant is in the NICU; and
 - c. When there is a major change an infant's condition which requires a reevaluation.
8. There shall be 24-hour in-house coverage by a professional staff member (physician, NNP, PA, and/or R.N.):
- a. Who has evidence of current successful completion of the NRP course of the AAP and AHA; and
 - b. Who is proficient in needle aspiration for pneumothorax and intubation for resuscitation.
9. Nurse staffing in the Community NICU shall meet the requirements contained in CCR, Title 22, Division 5, Article 6, Section 70485; Section 3.25.2/F.2.; and shall also include the following:
- a. The nurse supervisor or designee shall be present in the NICU at all times.
 - b. There shall be at least one nurse supervisor assigned to the NICU for every 30 full-time equivalent NICU positions or 50 NICU staff members to be supervised, whichever is less.
 - c. There shall be a R.N. assigned to each patient in the NICU.
 - d. There shall be no less than two R.N.s physically present in each area of care of the NICU at all times, when a patient is present.
 - e. A NNP assigned to the NICU may not be included in the calculation of nurse staff to infant ratio in the NICU.
10. There shall be a MSW assigned to all patients upon admission to the NICU; and:
- a. A social work assessment shall be completed within two working days of admission.
 - b. The social work assessment shall include an interview of at least one of the infant's parents or primary caretaker(s). The parent(s) or primary caretaker(s) shall be included as early as possible in the decision-making process(es) relating to the care of their infant.
 - c. A preliminary case service plan shall be developed with the parent(s) or primary

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caretaker(s) within five working days of admission to the NICU which shall include, but not be limited to, assessment of the following: significant family stress factors, environmental factors, mental health factors, and any other psychosocial factors, and how these factors in the family will be addressed.

- d. Social work progress notes shall be completed at least on a weekly basis, or more often as indicated, and shall include psychosocial data, significant changes in the infant's family, updates and results of the implementation of the service plan and plans to continue contact with the family for ongoing support.
 - e. MSW reports and notes shall be recorded in the infant's chart and shall be readily available to other NICU team members.
 - f. The authorizing CCS Program shall have access, as needed, to social work reports in order to coordinate services.
11. The Community NICU shall obtain physician, nursing, MSW, and clinical registered dietitian consultation on a 24-hour basis from the CCS-approved Regional NICU with which the Community NICU has a Regional Cooperation Agreement.
12. Physicians, nurses, MSW, and clinical registered dietitian shall be available for consultation to community practitioners and facilities who refer patients to the NICU.
13. The Community NICU medical director shall ensure, either directly or through written agreements with another NICU or agency that a mechanism for neonatal transport exists.
- a. The Community NICU neonatal transport team program or the written neonatal transport agreement for the provision of transport services of infants by another NICU or agency requires CCS Program approval. The neonatal transport agreement shall be updated and signed annually by the medical directors of NICUs involved in the agreement.
 - b. The medical director of the neonatal transport program shall be responsible for a written neonatal transport plan which shall include, but is not limited to, the following:
 - (1) A summary of the neonatal transport training program; and
 - (2) Annual evaluation and documentation of competency in neonatal transport of the neonatal transport team members by the Community NICU medical director or CCS-paneled neonatologist designee; and

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- (3) Requirement of a minimum number of neonatal transports by new neonatal transport team members that are directly supervised by existing neonatal transport team members specifically approved for this role by the transport program medical director; and
 - (4) Maintenance of written records of each neonatal transport completed shall be available for review by CCS program staff.
 - c. The NICU shall agree to accept, on a space and staff available basis, any infant requiring a level of care beyond that which can be provided by a hospital with which the NICU has transport agreements.
14. The medical director of the NICU, or a CCS-paneled neonatologist designee providing the neonatal transport, shall be responsible for:
 - a. Selecting the method of transport to be used;
 - b. The medical care of infants during transport; and
 - c. Designating neonatal transport team members to be utilized for transport of unstable, potentially unstable and stable infants.
- (1) The transport team for unstable and potentially unstable infants shall:
 - (a) Include a physician, a NNP, or a R.N. functioning under standardized procedures in accordance with CCR, Title 16, Division 14, Article 7, Sections 1470 through 1474 who:
 - i. Shall have advanced skills which include, but are not limited to, endotracheal intubation, needle aspiration, and placement of an umbilical venous catheter; and
 - ii. Shall have evidence of current successful completion of the NRP course of the AAP and AHA and shall function under standardized procedures in accordance with CCR, Title 16, Division 14, Article 7, Sections 1470 through 1474.
 - (b) Also include at least one other professional who may be a physician who has completed three or more years of a postgraduate pediatric residency training program, a NNP, a NICU P.A., a neonatal R.N. with advanced neonatal skills and/or a RCP. Transport team members shall be determined by the neonatologist. The composition of the team shall be balanced to provide all required skills.

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- (c) The transport team shall be in attendance during the entire transport procedure.
 - (2) A stable infant may be transported by a NICU P.A. or R.N. who has NICU experience and who shall have evidence of current successful completion of the NRP course of the AAP and AHA.
15. The Community NICU shall ensure that all infants who are provided care in the NICU receive a hearing screening test prior to hospital discharge, in accordance with the California Newborn Hearing Screening Program (NHSP) and as mandated by California Health and Safety Code, Section 123975.
16. The Community NICU shall ensure that all infants who are provided care in the NICU receive screening for critical congenital heart disease as currently specified by the California Department of Health Care Services N.L. 04-0314.

I. Community NICU - General Policies and Procedures

1. There shall be a Community NICU Policies and Procedures Manual which shall be:
 - a. Updated, reviewed, and signed at least every two years by the medical director and nurse manager of the Community NICU; and
 - b. Readily available in the NICU for all NICU staff.
2. The written Policies and Procedures Manual for the Community NICU shall address/include, but not be limited to, the following:
 - a. Criteria delineating the clinical privileges granted to attending CCS-paneled physicians other than neonatologists. Criteria shall include definitions of:
 - (1) Those infants requiring intensive, intermediate or continuing care who may be managed by a CCS-paneled pediatrician; and
 - (2) Those infants requiring consultation by a neonatologist;
 - b. Criteria for admission of infants to the NICU;
 - c. Criteria for infant discharge from the NICU and infant transfer to/from the NICU;
 - d. Criteria for monitoring infants in the NICU;

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- e. Pain management and sedation for operative/medical procedures;
- f. Criteria for NICU staff to provide neonatal resuscitation in the delivery room and written protocol for the provision of skilled neonatal resuscitation in the delivery room;
- g. Mechanism for bioethical review of neonatal patients when indicated;
- h. Mechanism for infection surveillance, prevention, and control in the NICU;
- i. Discharge planning process which includes the roles of the designated coordinator for discharge planning and the NICU multidisciplinary team members with the parent or caretaker and the referring physician, primary care physician, and any specialized follow-up agency, including CCS Special Care Centers and the Early Start Program;
- j. Parent visitation in the NICU;
- k. Mechanism for the referral to the hospital's child abuse and neglect team or Child Protective Services on a 24-hour basis;
- l. A written plan that facilitates a family-centered and culturally competent approach to NICU care by the professional staff which includes, but is not limited to, the following:
 - (1) A system that will encourage and provide for inclusion of the parent(s) or primary caretaker(s) in the decision-making process relating to the care and interventions of their infant as early as possible; and
 - (2) A method for the parent(s) or primary caretaker(s) to provide input and feedback to the NICU multidisciplinary team members regarding their infant's care and experiences in the NICU.
- m. A system to ensure that all infants who are provided care in the NICU receive a hearing screening test prior to hospital discharge, in accordance with the California NHSP and as mandated by California Health and Safety Code, Section 123975.
- n. A system to ensure that an ophthalmology examination is performed on infants at risk for ROP, as defined by the most recent joint statement of the AAP, the American Association for Pediatric Ophthalmology and Strabismus, and the American Academy of Ophthalmology. The

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ophthalmology examination shall be performed by a CCS-paneled ophthalmologist with experience in the examination of preterm infants.

J. Community NICU - Discharge Planning Program

Discharge of infants from a Community NICU shall be the responsibility of the CCS-paneled neonatologist or CCS-paneled pediatrician responsible for the care of the infant. Discharge planning, at a minimum, shall include but not be limited to the following:

1. Designation of a coordinator for discharge planning who shall be responsible for:
 - a. Ensuring collaboration between the NICU multidisciplinary team members and communication with the primary care physician, community agencies, CCS Programs, CCS Special Care Centers, Medi-Cal ISCD, and the Early Start Program whose services may be required and/or related to the care needs of the infant after hospital discharge. This includes the provision of pertinent medical records, including test results and discharge summaries informing determination of CCS eligible diagnoses, and authorization of sub-specialty care services, including High Risk Infant Follow-up (HRIF).
 - b. Ensuring that each infant discharged from the NICU shall have follow-up by a primary care physician and a program specialized in the follow-up care of the high-risk infant.
2. Identification of the responsibilities and involvement of the NICU multidisciplinary team members in discharge planning activities on an ongoing basis.
3. Ensuring culturally and linguistically appropriate (as defined in section C.1.m.) written discharge information shall be given to the parent(s) or primary caretaker(s) participating in the infant's care at the time of discharge and shall include, but are not limited to, the infant's diagnoses, medications, follow-up appointments, including community agencies and HRIF program appointments and instructions on any medical treatment(s) that will be given by the parent(s) or primary caretaker(s). A copy of this written discharge information shall be sent to the primary care physician and as applicable, agencies involved in providing follow-up care.
4. Ensuring that infants, determined by a neonatologist to be ready for discharge from a Community NICU to a facility closer to the home of the parent or primary caretaker shall:
 - a. Be transferred to a CCS-approved NICU for those who continue to require NICU care, or

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- b. Be transferred to a CCS-approved hospital appropriate for those who no longer require NICU care but require continued hospitalization for the CCS-eligible condition.
5. Provision for teaching the parent, legal guardian, and/or primary caretaker about the medical needs of the infant, including the use of necessary technology to support the infant in the community, when appropriate.

K. Community NICU - Performance Evaluation and Quality Improvement

1. There shall be an ongoing performance evaluation and quality improvement program specific to patient care activities in the Community NICU that is coordinated with the hospital's overall performance evaluation and quality improvement program.
 - a. Documentation shall be maintained of the performance evaluation and quality improvement activities provided.
 - b. Documentation shall include utilization review and medical records review which shall be available for on-site review by CCS Program staff.
2. There shall be morbidity and mortality conferences held at least quarterly to discuss neonatal care issues. These conferences shall be held conjointly with professionals in obstetrics and/or perinatal subspecialties.
 - a. CCS encourages multidisciplinary participation, including primary care physicians, as well as participation by outside consultants on a regular basis.
 - b. A hospital without licensed perinatal beds is exempt from having joint conferences but shall have neonatology staff morbidity and mortality conferences.
 - c. Meeting agendas, lists of attendees, and minutes of such conferences shall be maintained and available for on-site review by CCS Program staff.
3. There shall be a written plan that facilitates a family-centered and culturally competent approach (as defined in section C.1.m.) to NICU care by the professional staff. This plan shall include, but not be limited to, a mechanism for the parent(s) or primary caretaker(s) to provide input and feedback to NICU multidisciplinary team members regarding their infant's care and experiences in the NICU. This may be in the form of a patient/family satisfaction questionnaire.
4. There shall be a formalized method for the Community NICU medical director and nursing leadership to confirm, on an annual basis, that all professionals who are

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required to successfully complete the NRP course of the AAP and AHA as described in Section 3.25.2/F, have done so.

5. There shall be a formalized method for reviewing and documenting, on an annual basis, the skills of professionals responsible for 24-hour in-house coverage of the following:
 - a. Neonatal resuscitation and intubation. This review shall be based on maintaining evidence of current successful completion of the NRP course of the AAP and AHA; and
 - b. Needle aspiration for pneumothorax as described in the most recent edition of AAP guidance (reference cited below at the time of this writing).¹¹
6. There shall be annual reviews of the neonatal transport program and an evaluation of the members making up the neonatal transport team by the medical director and nursing leadership of the NICU or CCS-paneled neonatologist designee.
7. Infant morbidity and mortality data concerning birth weight, survival, transfer, incidence of certain conditions, and other information as required, shall be compiled in a CCS-approved format (available from the CCS Facility Review team) and shall be submitted to CCS Facility Review Team at: CCSFacilityReview@dhcs.ca.gov; annually and are due on the first day of June for the data of the preceding calendar year. Alternatively, a NICU may submit this data via the California Perinatal Quality Care Collaborative, which then submits the data directly to CCS.
8. Assurance of continuing education for staff providing services in the NICU shall include, at a minimum, the following:
 - a. There shall be a written plan for orientation of all newly-hired professionals who will be providing care in the NICU and an ongoing evaluation of the program. This written plan shall include the competencies required of the professional staff and documentation of successful demonstration of these competencies.
 - b. There shall be written plans for the continuing education of all professionals involved in neonatal care.
 - (1) The continuing education program shall include, but is not limited to, a neonatal/perinatal in-service education program for all professionals, held at least monthly.
 - (2) CCS-paneled pediatricians providing care to infants requiring intensive, intermediate, or continuing care shall document a minimum of 36 hours of

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continuing education in neonatal medicine every three years.

- c. The Community NICU shall have in-house educational programs which are based on the standards of practice for all professionals responsible for providing care in the NICU as demonstrated by peer reviewed journal articles and current professional reference books. These programs shall be provided as specified in the requirements for the Regional Cooperation Agreement, as per Section 3.25.2/B.6.
 - d. The hospital shall document, and make available to CCS on request, attendance of all professionals involved in neonatal care at the monthly continuing education programs.
9. The latest editions of the following texts and documents shall be kept in the NICU, in either physical copy or immediately available online:
- a. Red Book: Report of the Committee on Infectious Diseases, Committee on Infectious Diseases, AAP;
 - b. Guidelines for Perinatal Care, AAP/ACOG;
 - c. Two current reference books pertaining to the care of the high risk infant;
 - d. One current reference book pertaining to critical care nursing of the high-risk infant;
 - e. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units;
 - f. CCS Manual of Procedures, Chapter 3.34, CCS Standards for Neonatal Surgery;
 - g. CCS Manual of Procedures, Chapter 3.3, CCS Standards for Hospitals;
 - h. Current listing of CCS medically eligible conditions; and
 - i. An annually updated Policies and Procedures Manual of the Community NICU.

L. Community NICU - HRIF Program

1. The medical director of the Community NICU shall have responsibility for ensuring referral to follow-up at a CCS approved HRIF program of neonates and infants

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discharged from the NICU who have high risk for neurodevelopmental delay or disability, as specified by the HRIF program.

2. There shall be an organized HRIF program in the NICU's facility or there shall be a written agreement for the provision of services provided in HRIF programs by another hospital or agency, including HRIF Special Care Centers.
3. The HRIF program shall conform to the CCS high risk infant eligibility criteria and components of service, as per the CCS Manual of Procedures, Chapter 2.17.2, CCS Medical Eligibility Criteria.

¹ Martin, G.I. and Molteni, R., Quick Reference Guide to Neonatal Coding and Documentation. American Academy of Pediatrics. 2009.

² American Academy of Pediatrics Guidelines for Perinatal Care, 8th Edition.

³ Cultural Respect

<https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect>

⁴ Medi-Cal & Telehealth

<https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>.

⁵ The Current Pediatric Telehealth Landscape

<https://pediatrics.aappublications.org/content/141/3/e20172334>

⁶ Resource Tool kit for the Child Neurologist in the midst of the COVID-19 Pandemic

[https://www.childneurology.org/docs/default-source/2020-cns-/cns-toolkit-for-telemedicine-\(apr-5\).pdf?sfvrsn=1a5065b8_2](https://www.childneurology.org/docs/default-source/2020-cns-/cns-toolkit-for-telemedicine-(apr-5).pdf?sfvrsn=1a5065b8_2)

⁷ Telemedicine for Evaluation of Retinopathy of Prematurity

<https://pediatrics.aappublications.org/content/135/1/e238>

⁸ COVID-19 Resources

<https://aapos.org/members/covid-19-resources>

⁹ Digital Imaging and Communications in Medicine

www.dicomstandard.org

¹⁰ Charge Nurse Perspectives on Frontline Leadership in Acute Care Environments

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3236392/>

¹¹ Needle Aspiration of the Pneumothorax

<https://neoreview.s.aappublications.org/content/15/4/e163>