

CALIFORNIA CHILDREN'S SERVICES PROGRAM

CHAPTER 3.25 – STANDARDS FOR NEONATAL INTENSIVE CARE UNITS Intermediate NICU

CHAPTER 3.25.3 – INTERMEDIATE NEONATAL INTENSIVE CARE UNITS

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

1. For the purpose of the California Children's Services (CCS) Program, an Intermediate NICU shall be defined as a nursery within a CCS-approved Pediatric Community, General Community or Special Hospital that has the capability of providing neonatal care services (intermediate and continuing care as defined in Section 3.25.3/A.2.), for sick neonates and infants who do not require intensive care but require care at a level higher than provided in a general nursery. Such infants may include, but are not limited to, infants requiring intravenous medication, exchange transfusion, feedings by nasogastric tube, parenteral nutrition, oxygen therapy and short term ventilatory assistance, as per the CCS Manual of Procedures, Chapter 2.17.1/A., Medical Eligibility for Care in a CCS-approved NICU.
2. CCS categorizes care provided to sick neonates in an Intermediate NICU as defined by the American Academy of Pediatrics (AAP):^{1,2}
 - a. After initial stabilization, "intermediate care" is that care which is provided to neonates and infants who require:
 - (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.
 - b. 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 no longer requires these levels of care.
 - (3) Associated medical decision-making ranges are straightforward or low complexity – typically 30 minutes.

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

1. A hospital with an NICU wishing to participate in the CCS Program, as an

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Intermediate NICU, for the care of sick infants shall be licensed by the California Department of Public Health (CDPH), Licensing and Certification Division under 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 Intermediate 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 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. An Intermediate NICU shall have a Regional Cooperation Agreement as specified below:
 - a. An Intermediate NICU shall enter into written Regional Cooperation Agreements, approved by the CCS Program, with an affiliated CCS-approved Regional NICU(s). The Intermediate NICU may additionally enter into a written Regional Cooperation agreement(s), approved by the CCS Program, with an affiliated CCS-approved Community NICU(s). All Regional Cooperation Agreements shall specify mutual responsibility for at least the following:
 - (1) Joint education and training of perinatal health professionals; and
 - (2) Joint development of guidelines for consultation by perinatal, neonatal, and other specialty disciplines, as indicated; and
 - (3) Joint development of guidelines for maternal and neonatal patient referral and transport to and from each facility/NICU; and

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- (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 sections K.2. and K.6., at least annually.

b. Prior to CCS approval of the Intermediate NICU, the Regional Cooperation Agreement shall be developed, negotiated, dated and signed by at least the following persons from each hospital:

- (1) Hospital Administrator; and
- (2) Medical Director of the NICU; and
- (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.

4. A CCS Program NICU shall meet and maintain CCS Standards for Intermediate NICUs, as set forth within 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.
5. A hospital wishing to participate in the CCS Program for the care of sick infants and meets NICU requirements, must complete a CCS NICU application and submit 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.
6. 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 Intermediate

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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 the CCS Facility 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
- c. In deciding whether to approve the Intermediate NICU's application, CCS will consider the applicant's compliance with CCS Standards for Intermediate 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 of 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.

7. 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 Intermediate NICUs are met.
- b. Provisional approval may be granted when all CCS Standards for Intermediate 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.

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- 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, approval shall be terminated.
- d. An application may also be denied based upon failure of the hospital to meet CCS 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.
8. 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.
9. 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 the CCS Standards for Intermediate 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.
10. 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. Intermediate 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.

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- c. Request prior authorization from the CCS Program, as per CCR, Title 22, Section 1770 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.
- e. Accept referral of CCS-eligible clients, Medi-Cal beneficiaries, and patients who are both CCS and Medi-Cal eligible.
- f. Serve patients regardless of race, color, religion, national origin, ancestry, or 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

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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.

- 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. Intermediate 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. Intermediate NICU - Organization

- 1. There shall be a separate and identifiable administrative unit for the NICU.
- 2. Medical care of the Intermediate NICU shall be under the direction of a medical director:

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- a. Who shall meet the qualifications contained in Section 3.25.3/F.;
- b. Whose primary responsibility shall be the organization and supervision of the Intermediate 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.

3. There shall be an Intermediate 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 3.25.3/F.
4. The Intermediate NICU medical director and the Intermediate NICU nurse manager shall have joint responsibility for the development and review of an ongoing quality improvement program.
5. The Intermediate NICU medical director and the Intermediate 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 or CCS-paneled pediatrician, and a CCS-paneled medical social worker (MSW) with current experience and practice in neonatal care and whose professional requirements are defined in Section 3.25.3/F. Optional members to the Intermediate NICU multidisciplinary team may include, but are not limited to, the following: neonatal nurse practitioner (NPP), physician assistant (PA), clinical nurse specialist (CNS), CCS-paneled clinical registered dietitian, respiratory care practitioner (RCP), CCS-paneled occupational therapist and CCS-paneled physical therapist.

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F. Intermediate NICU - Professional Resources and Requirements

1. Intermediate NICU Physician Staff

1.1. Intermediate NICU Medical Director

- a. There shall be a CCS-paneled neonatologist or CCS-paneled pediatrician with current experience and practice in neonatal medicine serving as the Intermediate NICU Medical Director, who shall have the overall responsibility for the quality of medical care for the infants admitted to the Intermediate NICU:
- b. A CCS-paneled neonatologist serving as the Intermediate NICU Medical Director shall:
 - (1) 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.
 - (2) Have evidence of current successful completion of the Neonatal Resuscitation Program (NRP) course of the AAP and American Heart Association (AHA).
- c. A CCS-paneled pediatrician serving as the Intermediate NICU Medical Director shall:
 - (1) Be certified by the American Board of Pediatrics with evidence of current experience and practice in neonatal medicine.
 - (2) Meet educational requirements defined in Section 3.25.3/K.; and
 - (3) Have evidence of current successful completion of the NRP course of the AAP and AHA.
- d. The responsibilities of the Intermediate 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 described in Section 3.25.3/I.
 - (2) Approval of, at a minimum, written criteria that define the following:

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- (a) Which infants shall be admitted to the Intermediate NICU;
- (b) Which infants require discharge and/or transfer out of the Intermediate NICU; and
- (c) Which infants require consultation by a neonatologist or pediatrician with evidence of current experience and practice in neonatal medicine.
- (3) Supervision of clinical performance evaluation and quality improvement 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 infant transport to and from the NICU.
- (8) Assuring maintenance of NICU database and/or vital statistics.

e. The facility shall maintain written documentation of the qualifications and responsibilities of the Intermediate NICU Medical Director.

1.2. Intermediate NICU Neonatologist/Pediatrician Staff

The Intermediate NICU Medical Director shall have one or more CCS-paneled associate neonatologists or pediatricians on staff who shall share the clinical care responsibilities of the NICU.

- a. A CCS-paneled neonatologist serving as the intermediate NICU Medical Director 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.

- b. A CCS-paneled pediatrician shall:

- (1) Be certified by the American Board of Pediatrics with evidence of current experience and practice in neonatal medicine; and

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- (2) Meet educational requirements defined in Section 3.25.3/K.; and
- (3) Have evidence of current successful completion of the NRP course of the AAP and AHA.

1.3 Intermediate NICU Additional Physician Staff

- a. The Intermediate NICU shall have a written Regional Cooperation Agreement with a CCS-approved Regional or Community NICU for obtaining telephone consultation with a neonatologist on a 24-hour basis as defined in Section 3.25.3/H.
- b. The Intermediate NICU shall have a written Regional Cooperation Agreement with a CCS-approved Regional NICU for obtaining telephone consultation on a 24-hour basis with all necessary specialties and disciplines as defined in Section 3.25.3/H. This does not preclude consultation agreements with Community NICUs.

2. Intermediate 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 Intermediate NICU Nurse Manager

- a. There shall be a nurse manager of the NICU who shall direct the nursing administrative operation of the NICU, as per Section 3.25.3/E.3. and shall:
 - (1) Be a registered nurse (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; and
 - (3) Have at least three years of full-time clinical nursing experience one year of which shall have been in neonatal nursing in a NICU that is equivalent to a Regional, Community, or Intermediate NICU or in a facility providing pediatric critical care.

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- b. The responsibilities of the Intermediate 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 Intermediate 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 Intermediate NICU nurse manager.
- e. If the Intermediate 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.
- f. The Intermediate NICU nurse manager shall report directly to the administrative director of nursing or individual holding an equivalent position.

2.2 Intermediate NICU Nurse Supervisor

- a. The Intermediate 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 Intermediate 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, Community, or Intermediate 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).
- c. The Intermediate NICU nurse supervisor shall have 24-hour responsibility for:

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- (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 Intermediate NICU nurse supervisor.
- e. The Intermediate NICU nurse supervisor shall not be assigned direct patient care responsibilities.
- f. When there is no CNS as specified in Sections 3.25.3/F.2.3-F.2.4 below, the following are required:
 - (1) The Intermediate NICU nurse supervisor shall be responsible for the responsibilities of the CNS as specified in Sections 3.25.3/F.2.3-F.2.4; and
 - (2) The Intermediate NICU nurse supervisor position cannot be combined with the Intermediate NICU nurse manager position.

2.3 Intermediate NICU CNS (Optional, see Section 3.25.3/F.2.2.f. above)

- a. There may be a CNS for the Intermediate NICU and who shall:
 - (1) Be a R.N. licensed by the State of California, holding a master's degree in nursing;
 - (2) The CNS shall be certified by the State Board of Registered Nursing as a CNS, as per the California Business and Professions Code, Division 2, Chapter 6, Article 9, Sections 2838 through 2838.4;
 - (3) Have at least two years of full-time clinical experience in neonatal nursing care at least one of which shall have been in neonatal nursing in a NICU that is equivalent to a Regional, Community, or Intermediate NICU;
 - (4) Have current certification in Neonatal Intensive Care Nursing from a nationally recognized accrediting organization, i.e. the NCC; and
 - (5) Have evidence of current instructor status of the NRP course of the AAP and AHA.
- b. The Intermediate NICU CNS shall be responsible for:

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- (1) Directing the clinical nursing practice in the NICU;
- (2) Coordination and assessment of critical care educational development and clinical competency of the nursing staff in the NICU; and for ensuring continued neonatal critical care nursing competency through educational programs for both the newly-hired and experienced nursing staff;
- (3) Consultation with staff on complex neonatal critical care nursing issues;
- (4) Oversight of comprehensive parent and or primary caretaker education activities; and
- (5) Ensuring the implementation of a coordinated and effective discharge planning program.

c. The facility shall maintain written documentation of the qualifications and responsibilities of the Intermediate NICU CNS.

2.4 Intermediate NICU Nurse Practitioner (NNP) (optional)

- a. NNPs who provide care for infants in the NICU shall:
 - (1) Hold a master's degree in nursing; and
 - (2) Have current certification in Neonatal Intensive Care Nursing from a nationally recognized accrediting organization; and
 - (3) Have evidence of current successful completion of the NRP course of the AAP and AHA.

2.5 Intermediate NICU Charge Nurse

- a. There shall be at least one Intermediate 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;
 - (3) Demonstrate competency in the role of a charge nurse, as described by the

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International Scholarly Research Notices Nursing article published in the National Library of Medicine,⁴ and

- (4) Have evidence of current successful completion of the NRP course of the AAP and AHA.
- b. The responsibilities of the Intermediate NICU charge nurse during each shift shall include the following:
 - (1) Coordinating the patient care activities of 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 Intermediate NICU charge nurse.

2.6 Intermediate NICU R.N.

- a. R.N.s who are assigned direct patient care (intermediate and continuing care) responsibilities in the Intermediate 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 Intermediate NICU as per CCR, Title 22, Sections 70016.1, 70213 (c), 70217 (a), 70485.

3. Physician Assistants (PA) 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.

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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.

b. A supervising neonatologist must also meet the following requirements to delegate the provision of medical services to a NICU PA:

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- (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. Intermediate 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 an 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.
- c. The RCP shall be responsible, at a minimum, for the monitoring and application of respiratory equipment.

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- d. There shall be an identified RCP with expertise in neonatal respiratory care practice available at all times to the NICU.
- e. 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.
- f. All RCPs providing services in the NICU shall have evidence of current successful completion of the NRP course of the AAP and AHA.

5. Intermediate 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 Intermediate NICU.
- d. There shall be a written agreement with a CCS-approved Regional NICU with which the Intermediate NICU has a Regional Cooperation Agreement, for obtaining telephone consultation from a MSW, as specified in Section 3.25.3/H.
- e. The MSW shall conform to requirements contained in Section 3.25.3/H.10.

6. Intermediate NICU Pharmaceutical Services

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

7. Intermediate NICU Clinical Registered Dietitian

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- a. Nutritional consultation to the Intermediate 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 Intermediate NICU has a Regional Cooperation Agreement for obtaining telephone consultation from a clinical registered dietitian, as specified in Section 3.25.3/H.

G. Intermediate NICU - Facilities and Equipment

1. The Intermediate NICU shall be a distinct, separate unit within the hospital.
2. The Intermediate NICU shall meet the following bed requirements:
 - a. There shall be at least six licensed ICNN beds for providing intermediate and continuing care and:
 - (1) At least one of the six beds shall be utilized for infant stabilization and 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 70487 and 70489.
 - (2) There shall be at least five beds in the Intermediate NICU providing intermediate and/or continuing care which are not licensed under CCR, Title 22, Division 5, Article 6, Section 70489 but are approved under program flexibility, CCR, Title 22, Division 5, Chapter 1, Article 4, Section 70307. Those 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 six bed requirements of Sections 3.25.3/G.2.a.(1) and (2) in the Intermediate NICU 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.

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- 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. An Intermediate 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 1, Article 6, Section 70487, ICNN Service Equipment and Supplies, an Intermediate NICU shall have:
 - a. One bed used for infant stabilization that meets the following requirements:
 - (1) Monitoring equipment at each infant station in the NICU that have, at a minimum, the capability of:
 - (a) Heart rate and electrocardiogram (ECG);
 - (b) Respiratory rate;
 - (c) Temperature; and
 - (d) Oxygen saturation.
 - (2) Individual infant monitoring equipment shall 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;

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- (c) Routine testing and maintenance of all monitors; and
- (d) Two pressure monitor channels.

b. Beds used for intermediate care and are not used for infant stabilization that meet the following requirements:

- (1) Monitoring equipment at the infant station in the NICU that have, at a minimum, the capability to monitor:
 - (a) Heart rate and 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 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 continuing care that meet the following requirements:

- (1) Monitoring equipment at the infant station in the NICU that have the capability of:
 - (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:

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- (a) Visible and audible high/low alarms for heart rate and respiratory rate; and
- (b) Routine testing and maintenance of all monitors.

d. Equipment for infants, available 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;
- (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;

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- (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
- (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;

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- (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);
- (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.

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

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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 the transport of infants within the hospital and shall meet 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.

H. Intermediate NICU - Patient Care

1. The care of CCS-eligible infants in the NICU shall be under the direct supervision of the Intermediate NICU medical director, CCS-paneled neonatologist or CCS-paneled pediatrician who meet requirements in Section 3.25.3/F.
2. Infants requiring care provided by a NNP shall have daily review, evaluation, and documentation of care by a CCS-paneled neonatologist or CCS-paneled pediatrician.
3. 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.
4. It shall be the responsibility of the CCS-paneled neonatologist or CCS-paneled pediatrician to ensure that information is provided, on an ongoing basis, to referring physicians regarding their patients.
5. There shall be a CCS-paneled neonatologist or CCS-paneled pediatrician who is on-call to the 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

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- c. Shall be notified of new admissions and adverse changes in the status of neonates in a timely manner as described in Section 3.25.3/H.6 below.
- 6. A neonatologist, pediatrician in postdoctoral training in neonatal-perinatal subspecialty medicine, 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. Whenever an unstable infant is in the NICU; and
 - b. When there is a major change an infant's condition which requires a reevaluation.
- 7. There shall be 24-hour in-house coverage by a professional staff member (physician, PA, NNP, 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.
- 8. Nurse staffing in the Intermediate NICU shall meet requirements contained in CCR, Title 22, Division 5, Article 6, Section 70485; Section 3.25.3/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.
- 9. Transfer of neonates for higher level of care:

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- a. A neonate in an Intermediate NICU who is receiving mechanical ventilation through either tracheal or nasal tubes (e.g. nasal IMV) shall be transferred to a Community or Regional NICU within the first 4 hours of initiating the care; such transfer may occur within the first 24 hours of initiating the care if all the following apply:
 - (1) ≥ 32 weeks gestation and weighing ≥ 1500 g with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis.
 - (2) FIO₂ requirement is not increasing; and blood pressure is normal and stable.
 - (3) No evidence of structural abnormality on physical exam and chest X-ray.
 - (4) pCO₂ is not persistently rising above 50 mm Hg.
 - (5) If surfactant was administered: subsequent FIO₂ remains ≤ 0.30 , and nasal continuous positive airway pressure (NCPAP) ≤ 5 cm. H₂O.
 - (6) A CCS-paneled neonatologist is the primary medical provider for the duration of the specified positive pressure respiratory support.
- b. A neonate who is receiving NCPAP or nasal cannula ≥ 2 Lpm flow, shall be transferred to a Community or Regional NICU within the first 24 hours of initiating the care, unless all the following apply:
 - (1) ≥ 32 weeks gestation and weighing ≥ 1500 g with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis,
 - (2) No evidence of structural abnormality on physical exam and chest X-ray,
 - (3) If surfactant was administered: subsequent FIO₂ requirement remains ≤ 0.30 , and NCPAP ≤ 5 cm. H₂O.
 - (4) A CCS-paneled neonatologist is the primary medical provider for the duration of the specified positive pressure respiratory support.
- c. For an infant in an Intermediate NICU who continues to receive NCPAP or ≥ 2 Lpm flow via nasal cannula beyond 48 hours after initiation of such support, transfer to a Community or Regional NICU must have occurred by 72 hours after initiation of support, unless significant clinical improvement including a decrease

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in support measures is seen during the period between 48 and 72 hours after initiation of support.

- d. An authorization to cover the actual transport of an infant shall also be issued when one of the following conditions is met:
 - (1) The infant who is CCS medically eligible is receiving care in a CCS approved NICU and now requires a higher level of care in an NICU that is CCS approved for the higher level of care.
 - (2) The infant who is CCS medically eligible requires a surgical procedure at a CCS NICU approved for neonatal surgery.
 - (3) The infant who is CCS medically eligible can be cared for at another CCS approved NICU providing a lower level of care and which is closer to the home of the infant.
 - (4) The infant is receiving care in a nursery that is not CCS approved and is being transferred to a CCS approved NICU.

Note: Other transport scenarios shall be referred for review to the local county CCS program Medical Consultant and/or the State CCS Program Medical Consultant.

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. 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 caretaker(s) within five working days of admission to the NICU which shall include but not be limited to, the 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 on implementation and results of the service plan and plans to continue contact with the family for ongoing support.

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- e. MSW reports and notes shall be recorded in the infant's chart and 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 Intermediate 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 Intermediate 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. There shall be, at a minimum, weekly NICU multidisciplinary team conferences (rounds).

- a. The NICU multidisciplinary team conferences shall include representation of the NICU's medical, nursing, medical social service, and other specialists, such as the clinical registered dietitian, RCP staff, occupational therapist and physical therapist, when appropriate.
- b. Minutes of these weekly team conferences which document attendance and 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.
- 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 Intermediate 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.

15. The Intermediate NICU shall ensure that parents of all infants who are provided care in the NICU are offered screening for critical congenital heart disease (CCHD) as currently specified by the California Department of Health Care Services N.L. 04-0314.

I. Intermediate NICU - General Policies and Procedures

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1. There shall be an Intermediate 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 Intermediate NICU; and
 - b. Readily available in the NICU for all NICU staff.
2. The written Policies and Procedures Manual for the Intermediate NICU shall address/include, but not be limited to, the following:
 - a. Criteria delineating the privileges granted to attending CCS-paneled physicians and criteria as to when consultation by a neonatologist is required;
 - 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 of infants in the NICU;
 - e. Pain management and sedation for operative/medical procedures;
 - f. Criteria for when NICU staff are called 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 agencies, 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

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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.
- (3) Provision of interpretive services for all parent(s) or primary caretaker(s) either in person or remotely.

- 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 retinopathy of prematurity, 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 ophthalmology examination shall be performed by a CCS-paneled ophthalmologist with experience in the examination of preterm infants.
- o. Any Intermediate level nursery shall offer to parents of an admitted newborn, prior to discharge, a pulse oximetry test on their newborn for the identification of CCHD.

J. Intermediate NICU - Discharge Planning Program

Discharge of infants from an Intermediate 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 SCCs, Medi-Cal ISCD, and the Early Start Program whose services may be required

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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 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 a 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 an Intermediate 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
 - 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. Intermediate NICU - Performance Evaluation and Quality Improvement

1. There shall be an ongoing performance evaluation and quality improvement program specific to the patient care activities in the Intermediate NICU that is coordinated with the hospital's overall performance evaluation and quality improvement program.

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- 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 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 a joint conference 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 (as defined in section C.1.m.) approach 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 Intermediate NICU medical director and nursing leadership to confirm on an annual basis, that all professionals who are required to successfully complete the NRP course of the AAP and AHA as described in Section 3.25.3/F, have done so.
5. There shall be a formalized method for the 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).⁵
6. Infant morbidity and mortality data concerning birth weight, survival, transfer,

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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.

7. Assurance of continuing education for staff providing services in the NICU shall include at least the following:
 - a. There shall be a written plan for an 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 a written plan 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 intermediate or continuing care shall document a minimum of 36 hours of continuing education in neonatal medicine every three years.
 - c. The Intermediate 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 review 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 3.25.3/B.3.
 - 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.
8. 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;

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- 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 3.3, CCS Standards for Hospitals;
- g. Current listing of CCS medically eligible conditions; and
- h. An annually updated Policies and Procedures Manual of the Intermediate NICU.

L. Intermediate NICU - High Risk Infant Follow-up Program

- 1. The medical director of the NICU shall have the responsibility for ensuring the follow-up at a CCS-approved HRIF program of neonates and infants 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 high risk infant follow-up programs by another hospital or agency, including High Risk Infant Follow-up SCCs.
- 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

4 Charge Nurse Perspectives on Frontline Leadership in Acute Care Environments
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3236392/>

5 Needle Aspiration of the Pneumothorax

<https://publications.aap.org/neoreviews/article-abstract/15/4/e163/91549/Needle-Aspiration-of-the-Pneumothorax?redirectedFrom=fulltext>