

BEFORE THE INDIANA STATE DEPARTMENT OF HEALTH

**AN ADMINISTRATIVE RULES HEARING
LSA DOCUMENT #18-416**

HEARING OFFICER REPORT

This matter came before the duly appointed Hearing Officer, Kelly MacKinnon, on the 19th day of February, 2019 at 10:00 a.m., at the Indiana State Department of Health (ISDH), 2 North Meridian Street, Indianapolis, Indiana.

Notice of time and place of the hearing was given as provided by law by publishing on January 23, 2019, in the *Indianapolis Star* and the *Indiana Register*. Proof of publication of this notice has been received by the ISDH and the notice and proof are hereby incorporated into the record of this cause by reference and placed in the official files of the ISDH. A transcript of this hearing is attached as Exhibit 1.

ORAL STATEMENT

Marissa Kiefer

Indiana University Health (IU Health) and Riley Children's Health

Ms. Kiefer testified at the hearing. She described IU Health and how it is structured, including a description of Riley Hospital for Children. IU Health anticipates applying for a wide range of levels, including a perinatal center. She applauded ISDH for establishing the certification program for perinatal hospital and birthing centers. IU Health will be submitting written comments as well as these statements.

She highlighted three key areas. The first is in the proposed rule, Section 4. There is inconsistent language within the obstetrical Level IV facility provisions pertaining to "onsite" and "readily available at all times." "Onsite" is not defined in the rule. 410 IAC 39-4-4(a) uses the term "onsite" when discussing the availability of "medical and surgical care of the most complex maternal conditions." However, later in the same section, the proposed rule uses "readily available at all times" when referring to "adult medical and surgical specialty and subspecialty consultants." She recommended changing "onsite" to "readily available at all times" to avoid undue confusion.

The second area was in 410 IAC 39-5-1 where there is concern that a formal relationship may exist between an affiliate hospital and other higher level-of-care facilities as it relates to transfer plans. To avoid conflict of the partnership agreement between affiliate hospital and perinatal centers, transfer agreements should only occur within the partnership agreement between the perinatal center and affiliate hospital. Transfer plans should not occur outside that agreement.

The third area is at 410 IAC 39-5-3(b)(1)(C), which requires pediatric surgeons and anesthesiologists with pediatric expertise to be readily available at all times, meaning available to be physically present onsite to perform neonatal surgical procedures. According to the Guidelines for Perinatal Care, 8th Edition, these providers should be at the site or at a closely related institution by prearranged consultative agreement. Further, the Guidelines state that prearranged consultative agreements can be performed using, for example, telemedicine technology or telephone consultation, or both, from a distant location. There are insufficient numbers of pediatric surgeons or anesthesiologists with pediatric expertise to require facilities to have them physically present at the Level III NICU in the State of Indiana. It would likely lead to more adult providers being used to fulfill this requirement, leading to poorer outcomes for the vulnerable, high-risk population. They suggest that “readily available at all times” be modified to “available at all times” to reflect the Guidelines for Perinatal Care.

She finished her testimony by thanking ISDH for the opportunity to speak on the rules and to thank ISDH for its leadership in improving the outcomes of mothers and babies in partnership with hospitals across Indiana.

Jeff Rothenberg

Chief Medical Officer and practicing OB-GYN

St. Vincent Indianapolis Hospitals

Dr. Rothenberg testified at the hearing. Dr. Rothenberg thanked ISDH as well as legislators in the State of Indiana for tackling this issue. He then described St. Vincent Hospitals and its organizations across the nation. While recognizing that it is important to hold birthing centers accountable, he wanted to point out that in other parts of the country that have done this, there have been unanticipated consequences of smaller centers closing. We live in a state where

30% of counties do not have a women's health care provider, so we do not want that to happen. We want to increase access so we need to keep an eye on that issue.

There will be some challenges to this, but we can accomplish things if we all work together. We need to keep our focus on healthier moms and healthier babies and doing it together instead of vulcanizing services.

Within the rule document there are multiple adjectives that are used like "expert" and "expertise" that they think will lead to ambiguity. They want the terms solidified so different people are not interpreting them very differently keeping in mind the goal of healthier moms and babies.

They have eight delivering hospitals in the state and they believe they will have one Level IV, two Level II, and three Level Is. This will come with inherent costs and they are willing to do that because they want to see the outcome of healthier moms and babies, but they want the state to realize the cost of this.

He next talked about the memorandum of understanding. He asked if it makes sense, knowing there's a temporal relationship, moms and babies may be transferred to places where they don't have memorandums of understanding. He spoke of the cost of these relationships to do the training and teaching, so maybe rethink the requirement because you might not get transferred to a Level IV in Indianapolis if you live in a border community.

He also spoke of a concern about relying on AWOHNN (Association of Women's Health, Obstetric and Neonatal Nurses) staffing guidelines because there may be discordance between those guidelines and something a hospital puts into place. He does not want to have places not participate because of the discordance between them.

He finished his statement by saying that this is an exciting time within the State of Indiana. Indiana is an outlier in women's health care in general and this is not a club we want to be in. He believes we can make it a better, safer place for moms to deliver babies and for babies to be born if we work together.

Jennifer Harrah
Nursing Care Manager of Newborn Intensive Care
Union Health System

Ms. Harrah testified at the hearing. She expressed Union Health's full commitment and support for all of the efforts the State of Indiana has made to make sure mothers and babies have the best care. They appreciate the effort to standardize care for pregnant women and newborns and believe these guidelines will result in better outcomes.

She stated that Union Health is the only Level III facility in the central southwest region and that partnering with ISDH in wrapping services around at-risk patients through perinatal navigation is paramount in continuing to support their region.

She requested that the rule for MFM (maternal fetal medicine) coverage for Level III designation mirror the 8th Edition of the American College of Obstetrics and Gynecologists (ACOG) Perinatal Levels of Care Guidelines definition on page 17 for clarity. Specifically, she stated that ACOG Level III OB facility MFM requirements as inpatient privileges in addition to availability at all times, either onsite, by phone, or by telemedicine.

She thanked ISDH and IPQIC (Indiana Perinatal Quality Improvement Collaborative) for their leadership in developing the proposed rule and that they look forward to continuing the collaboration to improve the health of all Hoosier women.

Paula Autry

Chief Executive Officer

Lutheran Hospital of Indiana

Ms. Autry testified at the hearing. She thanked state leadership who are attempting to address the issue of infant mortality. She noted that Lutheran Hospital of Indiana submitted comments through the Indiana Hospital Association and have provided similar comments related to standards, particularly the MFM standards.

She wanted to add that this will increase the cost to hospitals to implement, but that they are committed. She noted that they are the only dedicated children's hospital in the northeast part of the state (Fort Wayne). They believe there is going to be an additional cost to citizens, payers and without a clear impact of the understanding of the direct impact that it will have to benefit infant mortality. They are a physician-investor hospital so it is important to listen to their physicians and what they are hearing is that there is a need to make changes to the standards to make it more effective and make sure that they are compliant and improve the care to citizens.

She said they look forward to the partnership and that it has created an opportunity in the northeastern part of the state to partner with health systems across the state. This is an exciting opportunity and she appreciates the opportunity to comment.

Brennan Fitzpatrick

Medical Director for Perinatal Medicine and Ultrasound

The Women's Hospital, Newburgh, Indiana

Dr. Fitzpatrick testified at the hearing. Dr. Fitzpatrick stated that Women's Hospital applauds the grassroots approach that the ISDH is taking in its effort to improve the quality of maternal and neonatal care in Indiana. He is a member of the Perinatal Standards Committee and they have participated in the development and implementation of Indiana's perinatal standards. Their goal has been to implement evidence-based standards that improve quality by increasing access and reducing barriers to care.

Improving collaboration and sharing resources allows every hospital to provide the best possible care and the Women's Hospital has worked hard to maintain evidence-based standards to ensure patients at delivering hospitals receive the care and support they need. They have invested in human and physical infrastructure to meet the standards of a Level III perinatal center. They have made progress and continue to address the important challenges that still remain.

They are wary of any legislation that is biased in the direction of larger academic institutions despite data that suggests a long history of excellent perinatal outcomes. They are also concerned that they, as well as others like them, will be held to unrealistic standards when viewed through the lens of existing perinatal guidelines.

They are concerned about being downgraded due to legislation that emphasizes structural elements of a perinatal framework over functional ability of a perinatal center to deliver care when they meet and often exceed the functional requirements of a high-level perinatal center. While higher-tier center's physical infrastructure must be met, the standards should represent the hospital's available resources and the needs of its patient population. The currently proposed guidelines may relegate exceptional perinatal institutions to lower-tier centers and risk depriving patients of the best available care. One size does not fit all. The unintended consequence of

legislation that does not adequately address these concerns could be dire and lead to diminished access for most Hoosiers by virtue of lack of availability of higher-level centers and overcrowding of those centers that remain.

They are excited to participate in the process and have benefited from the challenge to review and improve policies, protocols, and processes. They are providing education and support to regional partners to improve outcomes. Being designated a perinatal center will ensure their ability to deliver the best quality of care and help them positively impact patient outcomes in Southern Indiana and their tri-state region.

They have a question on page 9, section 3, part B concerning critical care specialists being present at all times. They are seeking clarification with respect to critical care specialists; i.e. does that include physician and/or a PRN?

They also seek clarification with respect to IU Health’s comment about “readily available,” which is defined versus “available,” which is not.

He finished by thanking ISDH for the time to be heard.

Andy Van Zee

Indiana Hospital Association

Andy Van Zee testified at the hearing and provided written comments. He stated the Indiana Hospital Association’s support for the bill and thanked ISDH for its work on levels of care. He stated he would provide written comments.

He expressed concern for some inflexibility of the rules, which there is difficulty in providing updates and clarifications. He asked for flexibility within the rules with some of the changes that have been suggested where possible and to give itself authority to provide interpretive guidance with respect to the implementation of the rule.

WRITTEN STATEMENT

Indiana Hospital Association (IHA)

IHA’s comments provided extensive background on the process that lead to the development of the Perinatal Levels of Care rule. IHA supports the rule and asks for clarification in a few areas.

410 IAC 39-4-1(b)(1)(E) – Obstetric Level I Facility Requirements concerning laboratory services concerning blood group and blood requirements. IHA suggests clarifying if it is an either/or or an either/and statement. Making the list a sub-bullet would make this more clear. There is concern with smaller facilities maintaining FFP at all times due to expiration and low usage rates. They recommend allowing facilities to maintain blood components appropriate to the usage and type of patients served.

410 IAC 39-4-1(b)(1)(F)(i) requires hospitals offering a trial of labor for patients with a prior cesarean delivery to have the physician physically present. This would limit Level I facilities to perform this procedure even when the provider is in close proximity, just not in the building. They then quoted the 2017 ACOG standard that a provider be readily available rather than physically on site.

410 IAC 39-4-3(c)(1)(B) requires an MFM specialist be readily available at all times. IHA requests that ISDH use the ACOG standards of “available at all times” onsite, which is defined as by telephone, or by telemedicine with inpatient privileges.

410 IAC 39-5-2(c)(1)(B) requires consulting relationships with certain providers. IHA requests clarification that the intent is that the hospital staff shall know whom to call for a specific issue, not that the hospital is required to have someone who is available to attend the patient in person.

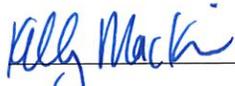
410 IAC 39-7-1(b) Inter-hospital Transfer Requirements. IHA requests that the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Indiana Perinatal Transport be updated to allow the Medical Director to have control in who he/she deems appropriate to send on transport. Specialty teams need to be adequately trained for the patient population the team is caring for. Properly trained Respiratory Therapists should be allowed to be part of the maternal team as the secondary provider; the Maternal RN being the expert in that population and the team leader overseeing the RT (or paramedic). For neonatal transport teams, NNP or a Neonatal RN should be allowed to be the primary staff.

IHA’s comments are attached and incorporated by reference as Exhibit 2.

The record was left open until February 20, 2019. ISDH received several written comments in addition to those in this report that are addressed in the Summary of Comments and Agency

Response document, which will be presented to the Indiana State Department of Health Executive Board.

Dated at Indianapolis, Indiana this 29th day of March, 2019.



Kelly MacKinnon
Hearing Officer



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

BEFORE THE INDIANA STATE
DEPARTMENT OF HEALTH

- - -

PUBLIC HEARING REGARDING
PERINATAL LEVELS OF CARE

LSA DOCUMENT #18-416

COPY

- - -

PROCEEDINGS

in the above-captioned matter, before Hearing
Officer Kelly MacKinnon, taken before me,
Lindy L. Meyer, Jr., a Notary Public in and for
the State of Indiana, County of Shelby, at the
Indiana State Department of Health, Rice
Conference Room, 2 North Meridian Street,
Indianapolis, Indiana, on Tuesday, February 19,
2019 at 10:01 o'clock a.m.

- - -

William F. Daniels, RPR/CP CM d/b/a
ACCURATE REPORTING OF INDIANA
12922 Brighton Avenue
Carmel, Indiana 46032
(317) 848-0088

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

APPEARANCES:

ON BEHALF OF ISDH:

Kelly MacKinnon, Hearing Officer

SPEAKERS PRESENT:

Marissa Kiefer
Jeff Rothenberg
Jennifer Harrah
Paula Autry
Brennan Fitzpatrick
Andrew Van Zee

- - -

1 10:01 o'clock a.m.
February 19, 2019

2 - - -

3 THE HEARING OFFICER: Okay.

4 Everyone, I think it is 10:00 o'clock, so we're
5 going to go ahead and get started with just a
6 little preliminary information. I think I heard
7 there are some questions about some of the timing
8 of this, so the rest of this process we're going
9 into.

10 So, our plan is to bring this before the
11 March 13th Executive Board meeting, so that would
12 be when our Executive Board were to vote on the
13 final adoption of the rule. And then from there,
14 there are some time lines before it would become
15 effective, but that's when we are looking to
16 present it --

17 AUDIENCE MEMBER: We can't hear.

18 THE HEARING OFFICER: -- to the
19 Executive Board. You can't hear?

20 AUDIENCE MEMBER: Can you speak up?

21 THE HEARING OFFICER: Okay. Is that
22 better?

23 AUDIENCE MEMBER: Yes.

1 THE HEARING OFFICER: Okay. So, I
2 will repeat, I guess. We're looking at -- our
3 plan is to try to bring this rule for final
4 adoption to our Executive Board on March 13th, so
5 that's the next step in the process moving
6 forward. As for today's hearing, this is really
7 for us to hear your questions and comments and
8 not for us to respond.

9 So, what we will do is we will take all of
10 your comments and questions and prepare a
11 document that we will present to the Executive
12 Board that will have the comments and the
13 Agency's response to the comments. That should
14 be available before the Executive Board, and
15 we'll post that on our Web site so you can see
16 any of our official responses to your questions
17 and comments at the time, as opposed to here
18 right now.

19 So, I will go ahead and officially start.
20 This is a public hearing before the Indiana State
21 Department of Health this 19th day of February,
22 2019 at 10:00 a.m. in the Indiana State
23 Department of Health, Rice Conference Room,

1 2 North Meridian Street, Indianapolis, Indiana,
2 and is docketed before the Executive Board of the
3 State Department of Health as LSA Document
4 No. 18-416, a rule to establish a program for the
5 certification of perinatal hospital and birthing
6 center levels of care for birthing centers,
7 obstetric units, neonatal units, and perinatal
8 centers, including transport rules.

9 Notice of time and place of this hearing
10 was given as provided by law by publishing on
11 January 23rd, 2019 in the Indianapolis Star and
12 in the Indianapolis -- or the Indiana Register.

13 Proof of publication of this notice has
14 been received by the Department, and the notice
15 and proof are now incorporated in the record of
16 this cause by reference and placed in the
17 official files of the Department. My name is
18 Kelly MacKinnon, and I have been appointed
19 Hearing Officer by the State Department of Health
20 to serve in this cause.

21 The sign-in sheet should be completed by
22 all individuals desiring to be shown as appearing
23 of record, and shall be completed by those

1 desiring to be heard. If you have not already
2 signed the sheet, please do so at this time.

3 You will also find in the back of the room
4 a copy of the Indiana Economic Development
5 Corporation's comments on the economic impact
6 statement, our small business economic impact
7 statement, and the proposed rule. You are
8 welcome to take a copy of each. Additionally,
9 the proposed rule and IEDC's comments are posted
10 on our Web site, isdh.in.gov, under Rules.

11 Oral statements will be heard, and written
12 statements may be handed to me, e-mailed to me at
13 rulepubliccomments@isdh.in.gov, or mailed to me
14 at 2 North Meridian Street, Section 3H-99,
15 Indianapolis, Indiana, 46204 by the end of day
16 February 20th, 2019, which is tomorrow. All
17 written and verbal comments will be reported in
18 my report on this hearing to the Executive Board
19 of the Indiana State Department of Health.

20 Each person who speaks for the record is
21 requested to clearly identify yourself by giving
22 your name, spelling it, and identifying who you
23 represent.

1 So, I think what we want to do is just --
2 I guess I'll start with a show of hands of who
3 wants to speak, and we'll just kind of move
4 through the room. So, we'll start kind of up
5 front, I think, and one -- I saw a hand. Go
6 ahead and -- you can come up.

7 MS. KIEFER: Okay. Marissa Kiefer,
8 from Indiana University Health and Riley
9 Children's Health.

10 THE HEARING OFFICER: Can you spell
11 that, please?

12 MS. KIEFER: M a r i s s a,
13 K i e f e r.

14 THE HEARING OFFICER: Thank you.

15 MS. KIEFER: On behalf of Indiana
16 University Health and Riley Children's Health, I
17 am Marissa Kiefer, Vice-President of Strategy at
18 Riley Children's Health. I appreciate the
19 opportunity to comment on LSA Document
20 No. 18-416.

21 IU Health is Indiana's largest safety-net
22 academic health center, and one of the busiest
23 hospitals in the United States. IU Health is

1 comprised of 16 hospitals located throughout the
2 State of Indiana, ranging from critical-access
3 hospitals in rural Indiana to an academic health
4 center in Downtown Indianapolis.

5 It is also home to the state's largest and
6 only comprehensive children's hospital, Riley
7 Hospital for Children, which offers the state's
8 only Level I pediatric trauma center, and is a
9 leader in pediatric health care, having been
10 regularly distinguished as Indiana's only
11 nationally ranking children's hospital by U.S.
12 News and World Report.

13 IU Health Hospitals, including Riley
14 Hospital for Children, anticipate applying for
15 the wide range of levels of care, including
16 Level IV OB and Level IV NICU, as well as
17 perinatal center.

18 First and foremost, IU Health and Riley
19 Hospital applauds Indiana State Department of
20 Health's efforts to establish a certification
21 program for perinatal hospital and birthing
22 center levels of care. We strongly believe that
23 the development and implementation of consistent

1 standards of service provided for each level of
2 care is essential to ensuring quality of care for
3 our moms and their babies, in an effort to reduce
4 Indiana's infant and maternal mortality.

5 We will be submitting our complete list of
6 written comments to ISDH. However, I would like
7 to highlight three key areas. In the proposed
8 rule, Section 4, there is inconsistent language
9 within the obstetrical Level IV facility
10 provisions pertaining to "onsite" and "readily
11 available at all times." Unlike "readily
12 available at all times," "onsite" is not defined
13 in the definitions of the proposed rule.

14 At 410 IAC 39-4-4(a), the term "onsite" is
15 used when discussing the availability of "medical
16 and surgical care of the most complex maternal
17 conditions." However, later in the same section,
18 the proposed rule utilizes "readily available at
19 all times" when referring to "adult medical and
20 surgical specialty and subspecialty consultants."

21 Consequently, we recommend the department
22 strike the use of "onsite" in this provision and
23 alternatively use the phrase "readily available

1 at all times" to avoid any undue confusion in the
2 application of the section.

3 In reading 410 IAC 39-5-1, this provision
4 seems to imply that a formal relationship may
5 exist between an affiliate hospital and some
6 other higher level-of-care facility as it relates
7 to transfer plan.

8 We would argue that to avoid any conflict
9 of the partnership agreement that must exist
10 between the affiliate hospital and the perinatal
11 center, any transfer plans between affiliate
12 hospital and some other higher level-of-care
13 facility should only occur within the context of
14 the partnership agreement between the perinatal
15 center and an affiliate hospital.

16 Transfer plans should not be developed
17 outside that agreement. To do so otherwise could
18 result in conflict between the affiliate hospital
19 and the perinatal center, as stated elsewhere in
20 the rule, in which perinatal centers may
21 affiliate with only one perinatal center.

22 At 410 IAC 39-5-3(b)(1)(C), every
23 Level III NICU must have pediatric surgeons and

1 anesthesiologists with pediatric expertise
2 readily available at all times, meaning available
3 to be physically present onsite to perform
4 neonatal surgical procedures.

5 According to the Guidelines for Perinatal
6 Care, 8th Edition, these providers should be at
7 the site OR at a closely related institution by
8 prearranged consultative agreement, Table 1
9 through 4, pages 29 through 30.

10 Further, on page 32 of the Guidelines, it
11 states prearranged consultative agreements can be
12 performed using, for example, telemedicine
13 technology or telephone consultation, or both,
14 from a distant location.

15 There are insufficient numbers of
16 pediatric surgeons or anesthesiologists with
17 pediatric expertise to require facilities to have
18 these providers physically present at the
19 Level III NICU in the State of Indiana. More
20 likely, adult providers would be utilized to
21 fulfill this requirement, leading to poorer
22 outcomes for this vulnerable high-risk
23 population.

1 Consequently, we would suggest for the
2 purposes of this subsection that "readily
3 available" will be -- "readily available at all
4 times" be modified to "available at all times,"
5 to reflect Guidelines for Perinatal Care.

6 Once again, thank you for the opportunity
7 to provide comment on this proposed rule, and
8 thank you for your leadership in improving the
9 outcomes of mothers and babies in partnership
10 with hospitals across Indiana.

11 THE HEARING OFFICER: You said you
12 had -- do you have written comments?

13 MS. KIEFER: I will provide them to
14 you.

15 THE HEARING OFFICER: Okay.
16 Who else? I think I saw --

17 MR. ROTHENBERG: Thank you. Thanks
18 so much.

19 Good morning, everybody. I'm Jeff
20 Rothenberg. I'm the Chief Medical Officer at the
21 St. Vincent Indianapolis Hospitals, and I'm still
22 a practicing OB-GYN, so I come by this naturally.
23 I actually delivered five babies this week, two

1 of whom were premies, and all babies and moms are
2 doing wonderfully. So, I'll start with that.

3 THE HEARING OFFICER: Can you -- I'm
4 sorry -- spell your name, please?

5 MR. ROTHENBERG: R o t h e n b e r g,
6 Jeff.

7 So, first and foremost, I'd like to, you
8 know, reiterate that we applaud both the
9 Department of Health as well as all of the
10 legislators in the State of Indiana for tackling
11 this. I think most of us in this room would
12 agree that we live in a state that has not paid
13 attention to this, and actually we have, you
14 know, numbers that are dismal. And so, anything
15 that we do to increase the health of both moms
16 and babies is really, you know, well appreciated
17 by all of us. So, thank you guys for doing that.

18 St. Vincent is part of the largest
19 not-for-profit health care system in the nation.
20 We have about 155 hospitals, maybe 2,500 sites of
21 care, and we're engaging in this work not just in
22 Indiana, but across the nation. So, you know,
23 we're excited about that, and we actually have

1 partners who can help us through this work as
2 well now, so that's a good thing.

3 We recognize that it's important to hold
4 birthing centers accountable. I would point out
5 that in other parts of the country where they've
6 done this, there have been unanticipated
7 consequences where smaller centers actually have
8 closed.

9 We live in a state where about 30 percent
10 of the counties don't have a women's health care
11 provider, and so, that is the last thing that we
12 want to see happen. We want to see actually
13 places get better and increase access, not going
14 the other direction. So, I do think that we have
15 to keep our eye on that as we move through this
16 work.

17 There will be some challenges to this, but
18 it's -- I think these are things that we can
19 accomplish if we all work together and not divide
20 the state. Again, I think we need to keep our
21 mission in focus that we want healthier moms and
22 healthier babies, and by doing it together
23 instead of vulcanizing our services, we're better

1 off.

2 Specifically within the documents, there's
3 multiple adjectives that are used, things like
4 "expert," "expertise." We will provide written
5 comments as well afterwards, but we think that
6 that leads to ambiguity and we need to kind of,
7 you know, solidify what those terms all mean so
8 different people are not interpreting them very
9 differently. Again, keep our mind on the goal,
10 which is getting healthier moms and healthier
11 babies.

12 We also know that for those places that
13 will be Level IV -- and we have eight delivering
14 hospitals in the state -- we'll have one Level IV
15 with the proposed rules, two Level II, two
16 Level III and three Level I's. This will come
17 with some inherent costs.

18 Systems likes ours are willing to do that
19 provided we're ensured that we see the outcome
20 that we want to see, and that is healthier moms
21 and healthier babies. But we do want the state
22 to realize that there will be costs associated
23 with it for the systems that embark on this.

1 Next, we heard a little bit about the
2 memorandums of understanding. You know,
3 especially with regards to border communities, we
4 have to ask, "Does it really make sense, knowing
5 that in reality, some of these babies, especially
6 if there's a temporal relationship, moms and
7 babies may be transferred to places where they
8 actually don't have memorandums of
9 understanding?"

10 You know, we have to put cost in to have
11 those relationships and to do training and
12 teaching, so we would just ask that we rethink
13 that, or at least discuss that, because the
14 reality is that if you live in a border
15 community, you might not get transferred back up
16 to a Level IV here in Indianapolis.

17 Lastly, another potential area of concern
18 is that some of the language follows things like
19 AI staffing guidelines. We need people to
20 understand that in this day and age, where
21 productivity and staffing are really issues for
22 hospitals and systems, that there may be
23 discordance between those staffing guidelines and

1 something that a hospital puts into place, and we
2 don't want places not to participate because of
3 discordance between them. And so, I think that's
4 an important point.

5 Lastly, I just want to reiterate that this
6 is an exciting time within the State of Indiana.
7 You know, we really are outliers in women's
8 health care in general. This is not a club that
9 we want to be in, and together if we work, I am
10 certain that we can make this a better, safer
11 place both for moms to deliver babies as well as
12 for babies to be born.

13 And we thank you, and we're excited to
14 engage with you guys in this work.

15 THE HEARING OFFICER: Thank you very
16 much.

17 Anyone else? Okay.

18 MS. HARRAH: Good morning. My name
19 is Jennifer Harrah, J e n n i f e r, H a r r a h.
20 I'm speaking on behalf of Union Health System, a
21 Level III OB facility and NICU. I'm the Nursing
22 Care Manager of the newborn Intensive Care, and
23 I've been at Union Hospital for 14 years.

1 I would like to express our organization's
2 full commitment and support for all of the
3 efforts the State of Indiana has made to make
4 sure our Hoosier mothers and babies have the best
5 possible care.

6 We applaud the state's effort in
7 standardizing care for pregnant women and their
8 newborns with the Perinatal Level of Care
9 Guidelines. We believe these Guidelines will
10 result in better outcomes for all pregnant
11 Hoosiers, and we stand fully committed to uphold
12 the standards outlined by continuing to serve our
13 patients who travel to our facility throughout
14 our region.

15 Our experience as the only Level III
16 facility in the central southwest region, in
17 partnering with the State Department of Health in
18 wrapping services around our at-risk patients
19 through our perinatal navigation is paramount in
20 continuing to support our region.

21 To better comply with the guidelines and
22 remove any ambiguity for compliance, we
23 respectfully request that the rule for the MSM

1 coverage for Level III designations mirrors what
2 the 8th Edition of the American College of
3 Obstetrics and Gynecologists Perinatal Levels of
4 Care Guidelines definition states on page 17.

5 Specifically, ACOG describes Level III OB
6 facility MSM requirements as inpatient privileges
7 in addition to availability at all times, either
8 onsite, by phone, or by telemedicine. Thank you
9 to the ISDH and IPQIC for their leadership in
10 developing the proposed rule as we look forward
11 to continuing this collaboration to improve the
12 health of all Hoosier women.

13 THE HEARING OFFICER: Thank you very
14 much.

15 Okay. Is there anyone else?

16 MS. AUTRY: Good morning. My name is
17 Paula Autry, P a u l a, A u t r y. I'm Chief
18 Executive Officer at Lutheran Hospital of
19 Indiana, and like the other health systems that
20 have been represented here, I also want to
21 applaud the state leadership, who are attempting
22 to address the issue of infant mortality to what
23 we would all agree are our most vulnerable and

1 our smallest citizens in the state.

2 We have provided comments from Lutheran
3 Hospital of Indiana through the Indiana Hospital
4 Association, so those are noted, and we've
5 provided similar comments related to some of the
6 standards, particularly the MSM standards.

7 Essentially, my additional comments that I
8 want to provide is it will increase costs to the
9 hospital it implement. We are committed at
10 Lutheran Hospital of Indiana. I should note that
11 we are in Fort Wayne, Indiana. We're the only
12 dedicated children's hospital in the northeast
13 part of the state. We're a regional provider for
14 the northeast part of the state.

15 We're committed to making those
16 investments to meet the requirements, but we know
17 there's going to be an additional cost to our
18 citizens, additional costs to payers, without a
19 clear understanding of the direct impact that it
20 will have to benefit infant mortality.

21 We are invest -- a physician investor
22 owned hospital. It's important for us to listen
23 to our physicians and to hear their concerns, and

1 what we're hearing from them is also that there
2 are changes to the standards that are needed to
3 make it more effective, to make sure that we're
4 compliant and improve the care to our citizens.

5 And last, I'd like to say that we look
6 forward to the partnership. It's created an
7 opportunity for us in the northern part of the
8 state to partner with health systems across the
9 state, so we think it's, again, an exciting
10 opportunity, and we appreciate the opportunity to
11 comment.

12 Thanks.

13 THE HEARING OFFICER: All right. Who
14 wants to go next? Anybody?

15 (No response.)

16 THE HEARING OFFICER: Is that
17 everyone who wants to speak?

18 (No response.)

19 THE HEARING OFFICER: Okay. Oh, do
20 you want to? Okay.

21 MR. FITZPATRICK: My name is Brennan
22 Fitzpatrick. I am the Medical Director for
23 Perinatal Medicine and Ultrasound at the Women's

1 Hospital in Newburgh, Indiana. The Women's
2 Hospital applauds the grassroots approach that
3 the ISDH is taking in its effort to improve the
4 quality of maternal and neonatal care throughout
5 the State of Indiana.

6 As a member of the Perinatal Standards
7 Committee, we have participated in the
8 development and implementation of our state's
9 perinatal standards. The Committee's goal has
10 been to implement evidence-based standards that
11 improve quality by increasing access and reducing
12 barriers to care.

13 Improving collaboration and sharing
14 resources allows every hospital to provide the
15 best possible obstetrical and neonatal care. The
16 Women's Hospital has worked hard to maintain
17 these evidence-based standards and employ
18 processes that ensure patients and delivering
19 hospitals in the Southern Indiana region receive
20 the care and support that they need.

21 We have actively invested in the human and
22 physical infrastructure necessary to meet all of
23 the functional requirements of a Level III

1 perinatal center. We've made incredible
2 progress, but recognize that important challenges
3 still remain. We will continue to address these
4 challenges by actively engaging in continuous
5 process improvement.

6 Moving forward, we remain wary of any
7 legislation that by virtue of the resources used
8 to create it is inherently biased in the
9 direction of larger academic centers, despite
10 ample data suggesting a long history of excellent
11 perinatal outcomes, we are concerned that our
12 institution, as well as others like it, will be
13 held to unrealistic standards when viewed through
14 the lens of existing perinatal guidelines.

15 We are concerned that excellent
16 institutions such as our own, which consistently
17 meet and often exceed the functional requirements
18 of a high-level perinatal center, will be
19 downgraded due to legislation that emphasizes the
20 structural elements of a perinatal framework over
21 the functional ability of a perinatal center to
22 deliver care.

23 Indeed, minimum standards for a

1 higher-tier center's physical infrastructure must
2 be met, but these standards should reflect the
3 hospital's available resources and the needs of
4 its patient population. The currently proposed
5 guidelines may relegate exceptional perinatal
6 institutions to lower-tier centers and risk
7 depriving patients of the best available care.

8 Put succinctly, one size does not fit all.
9 The unintended consequence of legislation that
10 does not adequately address these concerns could
11 be dire and lead to diminished access for most
12 Hoosiers by virtue of lack of availability of
13 higher-level centers and overcrowding of those
14 centers that remain.

15 The Women's Hospital is excited to
16 participate in the perinatal level of care
17 process. We've undoubtedly benefited from the
18 challenge to review and improve our policies,
19 protocols and processes. Our institution has
20 rededicated itself to providing education and
21 support to our regional partners to improve
22 perinatal outcomes, and employ the vision of the
23 Perinatal Standards Committee.

1 Being designated as a perinatal center
2 will ensure our ability to deliver the best
3 quality of care and help us positively impact
4 patient outcomes in Southern Indiana and our
5 entire tri-state region.

6 We had a couple of questions with respect
7 to the proposals, and the first of which is
8 page 9, I believe, Section 3, part (B), "An
9 onsite intensive care unit...should accept
10 pregnant women and have critical care specialists
11 physically present at all times." We would like
12 clarification with respect to critical care
13 specialists; i.e., does that include physician
14 and/or a PRN?

15 We would also like clarification with
16 respect to our colleagues at IU Health with
17 respect to the verbiage of "readily available"
18 versus "available." "Readily available" is
19 defined in the document, "available" is not.

20 We appreciate the opportunity to be able
21 to be heard today, and thank you for your time.

22 THE HEARING OFFICER: Thank you very
23 much. Is there anyone else that wants to speak?

1 MR. VAN ZEE: Hi. Andy Van Zee, with
2 the Indiana Hospital Association.

3 Yeah, we rise in support as well to this
4 legislation. This is eight years in the making
5 that the State of Indiana and the State
6 Department of Health have been working on levels
7 of care. You know, we will submit written
8 comments to you that, you know, take into account
9 many of the comments that the hospitals here
10 today have stated, along with several other
11 organizations that weren't able to be here today.

12 I think, you know, there's an opportunity.
13 You know, a lot of it talks about some of the
14 inflexibility of the rules. Any time to take
15 guidelines and place them into the kind of strict
16 constructs of the Administrative Code, there's
17 difficulty in providing updates and
18 clarifications.

19 And so, you know, I think that it's an
20 opportunity for the State Department of Health to
21 give itself authority to provide kind of
22 explanations and changes with the rules, allow
23 for flexibility within the rules with some of the

1 changes that have been suggested. So, we would
2 encourage the Department to -- wherever possible,
3 to add this flexibility, to give itself the
4 authority to provide interpretive guidance with
5 respect to implementation of this rule.

6 THE HEARING OFFICER: Okay.

7 So, anybody else?

8 (No response.)

9 THE HEARING OFFICER: Okay. I guess
10 then, seeing and hearing everyone who wants to be
11 heard at this time, I want to thank each of you
12 for your presentations. My report of the hearing
13 will be in writing to the Executive Board of the
14 Indiana State Department of Health for their
15 consideration before final adoption.

16 These proceedings pursuant to notice are
17 hereby concluded. The cause is therefore
18 adjourned until final order of the Executive
19 Board.

20 Thank you all for coming.

21 - - -
22 Thereupon, the proceedings of
23 February 19, 2019 were concluded
at 10:28 o'clock a.m.
- - -

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23

CERTIFICATE

I, Lindy L. Meyer, Jr., the undersigned Court Reporter and Notary Public residing in the City of Shelbyville, Shelby County, Indiana, do hereby certify that the foregoing is a true and correct transcript of the proceedings taken by me on Tuesday, February 19, 2019 in this matter and transcribed by me.



Lindy L. Meyer, Jr.,
Notary Public in and
for the State of Indiana.

My Commission expires August 26, 2024.

#	9			
#18-416 [1] - 1:6	9 [1] - 25:8	18:22	BEFORE [1] - 1:1	certain [1] - 17:10
1	A	American [1] - 19:2	BEHALF [1] - 2:2	CERTIFICATE [1] - 28:1
1 [1] - 11:8	a.m [4] - 1:17, 3:1, 4:22, 27:22	ample [1] - 23:10	behalf [2] - 7:15, 17:20	certification [2] - 5:5, 8:20
10:00 [2] - 3:4, 4:22	A1 [1] - 16:19	Andrew [1] - 2:7	benefit [1] - 20:20	certify [1] - 28:5
10:01 [2] - 1:17, 3:1	ability [2] - 23:21, 25:2	andy [1] - 26:1	benefited [1] - 24:17	challenge [1] - 24:18
10:28 [1] - 27:22	able [2] - 25:20, 26:11	anesthesiologists [2] - 11:1, 11:16	best [4] - 18:4, 22:15, 24:7, 25:2	challenges [3] - 14:17, 23:2, 23:4
12922 [1] - 1:22	above-captioned [1] - 1:10	anticipate [1] - 8:14	better [6] - 3:22, 14:13, 14:23, 17:10, 18:10, 18:21	changes [3] - 21:2, 26:22, 27:1
13th [2] - 3:11, 4:4	academic [3] - 7:22, 8:3, 23:9	APPEARANCES [1] - 2:1	between [7] - 10:5, 10:10, 10:11, 10:14, 10:18, 16:23, 17:3	chief [1] - 12:20
14 [1] - 17:23	accept [1] - 25:9	appearing [1] - 5:22	biased [1] - 23:8	Chief [1] - 19:17
155 [1] - 13:20	access [4] - 8:2, 14:13, 22:11, 24:11	applaud [3] - 13:8, 18:6, 19:21	birthing [4] - 5:5, 5:6, 8:21, 14:4	Children [2] - 8:7, 8:14
16 [1] - 8:1	accomplish [1] - 14:19	applauds [2] - 8:19, 22:2	bit [1] - 16:1	Children's [1] - 7:9
17 [1] - 19:4	according [1] - 11:5	application [1] - 10:2	board [8] - 3:11, 3:12, 4:4, 4:12, 4:14, 6:18, 27:13, 27:19	children's [5] - 7:16, 7:18, 8:6, 8:11, 20:12
18-416 [2] - 5:4, 7:20	account [1] - 26:8	applying [1] - 8:14	Board [2] - 3:19, 5:2	citizens [3] - 20:1, 20:18, 21:4
19 [4] - 1:16, 3:1, 27:22, 28:7	accountable [1] - 14:4	appointed [1] - 5:18	border [2] - 16:3, 16:14	City [1] - 28:4
19th [1] - 4:21	ACCURATE [1] - 1:21	appreciate [3] - 7:18, 21:10, 25:20	born [1] - 17:12	clarification [2] - 25:12, 25:15
2	actively [2] - 22:21, 23:4	appreciated [1] - 13:16	Brennan [2] - 2:7, 21:21	clarifications [1] - 26:18
2 [3] - 1:15, 5:1, 6:14	add [1] - 27:3	approach [1] - 22:2	Brighton [1] - 1:22	clear [1] - 20:19
2,500 [1] - 13:20	addition [1] - 19:7	area [1] - 16:17	bring [2] - 3:10, 4:3	clearly [1] - 6:21
2019 [7] - 1:17, 3:1, 4:22, 5:11, 6:16, 27:22, 28:7	additional [3] - 20:7, 20:17, 20:18	areas [1] - 9:7	business [1] - 6:6	closed [1] - 14:8
2024 [1] - 28:15	additionally [1] - 6:8	argue [1] - 10:8		closely [1] - 11:7
20th [1] - 6:16	address [3] - 19:22, 23:3, 24:10	associated [1] - 15:22	C	club [1] - 17:8
23rd [1] - 5:11	adequately [1] - 24:10	association [2] - 20:4, 26:2	captioned [1] - 1:10	CM [1] - 1:21
26 [1] - 28:15	adjectives [1] - 15:3	at-risk [1] - 18:18	Care [1] - 19:4	Code [1] - 26:16
29 [1] - 11:9	adjourned [1] - 27:18	attempting [1] - 19:21	care [33] - 5:6, 8:9, 8:15, 8:22, 9:2, 9:16, 10:6, 10:12, 11:6, 12:5, 13:19, 13:21, 14:10, 17:8, 17:22, 18:5, 18:7, 18:8, 21:4, 22:4, 22:12, 22:15, 22:20, 23:22, 24:7, 24:16, 25:3, 25:9, 25:10, 25:12, 26:7	collaboration [2] - 19:11, 22:13
3	Administrative [1] - 26:16	attention [1] - 13:13	CARE [1] - 1:5	colleagues [1] - 25:16
3 [1] - 25:8	address [3] - 19:22, 23:3, 24:10	AUDIENCE [3] - 3:17, 3:20, 3:23	Carmel [1] - 1:22	College [1] - 19:2
30 [2] - 11:9, 14:9	afterwards [1] - 15:5	August [1] - 28:15	center [14] - 5:6, 7:22, 8:4, 8:8, 8:17, 8:22, 10:11, 10:15, 10:19, 10:21, 23:1, 23:18, 23:21, 25:1	coming [1] - 27:20
317 [1] - 1:23	age [1] - 16:20	authority [2] - 26:21, 27:4	center's [1] - 24:1	comment [3] - 7:19, 12:7, 21:11
32 [1] - 11:10	Agency's [1] - 4:13	AUTRY [1] - 19:16	centers [9] - 5:6, 5:8, 10:20, 14:4, 14:7, 23:9, 24:6, 24:13, 24:14	comments [16] - 4:7, 4:10, 4:12, 4:13, 4:17, 6:5, 6:9, 6:17, 9:6, 12:12, 15:5, 20:2, 20:5, 20:7, 26:8, 26:9
32 [1] - 11:10	agree [2] - 13:12, 19:23	availability [3] - 9:15, 19:7, 24:12	central [1] - 18:16	Commission [1] - 28:15
39-4-4(a) [1] - 9:14	agreement [4] - 10:9, 10:14, 10:17, 11:8	available [16] - 4:14, 9:11, 9:12, 9:18, 9:23, 11:2, 12:3, 12:4, 24:3, 24:7, 25:17, 25:18, 25:19		committed [3] - 18:11, 20:9, 20:15
39-5-1 [1] - 10:3	agreements [1] - 11:11	Avenue [1] - 1:22		committee [2] - 22:7, 24:23
39-5-3(b)(1)(c) [1] - 10:22	ahead [3] - 3:5, 4:19, 7:6	avoid [2] - 10:1, 10:8		committee's [1] - 22:9
3H-99 [1] - 6:14	allow [1] - 26:22	B		communities [1] - 16:3
4	allows [1] - 22:14	babies [13] - 9:3, 12:9, 12:23, 13:1, 13:16, 14:22, 15:11, 15:21, 16:5, 16:7, 17:11, 17:12, 18:4		community [1] - 16:15
4 [2] - 9:8, 11:9	ambiguity [2] - 15:6,	barriers [1] - 22:12		complete [1] - 9:5
410 [3] - 9:14, 10:3, 10:22		based [2] - 22:10, 22:17		completed [2] - 5:21, 5:23
46032 [1] - 1:22		become [1] - 3:14		
46204 [1] - 6:15				
8				
848-0088 [1] - 1:23				
8th [2] - 11:6, 19:2				

<p>complex [1] - 9:16 compliance [1] - 18:22 compliant [1] - 21:4 comply [1] - 18:21 comprehensive [1] - 8:6 comprised [1] - 8:1 concern [1] - 16:17 concerned [2] - 23:11, 23:15 concerns [2] - 20:23, 24:10 concluded [2] - 27:17, 27:22 conditions [1] - 9:17 conference [1] - 4:23 Conference [1] - 1:15 conflict [2] - 10:8, 10:18 confusion [1] - 10:1 consequence [1] - 24:9 consequences [1] - 14:7 consequently [2] - 9:21, 12:1 consideration [1] - 27:15 consistent [1] - 8:23 consistently [1] - 23:16 constructs [1] - 26:16 consultants [1] - 9:20 consultation [1] - 11:13 consultative [2] - 11:8, 11:11 context [1] - 10:13 continue [1] - 23:3 continuing [3] - 18:12, 18:20, 19:11 continuous [1] - 23:4 copy [2] - 6:4, 6:8 corporation's [1] - 6:5 correct [1] - 28:6 cost [2] - 16:10, 20:17 costs [4] - 15:17, 15:22, 20:8, 20:18 counties [1] - 14:10 country [1] - 14:5 County [2] - 1:13, 28:4 couple [1] - 25:6 Court [1] - 28:3 coverage [1] - 19:1 create [1] - 23:8 created [1] - 21:6 critical [3] - 8:2, 25:10, 25:12</p>	<p>critical-access [1] - 8:2</p> <hr/> <p style="text-align: center;">D</p> <hr/> <p>d/b/a [1] - 1:21 Daniels [1] - 1:21 data [1] - 23:10 dedicated [1] - 20:12 defined [2] - 9:12, 25:19 definition [1] - 19:4 definitions [1] - 9:13 deliver [3] - 17:11, 23:22, 25:2 delivered [1] - 12:23 delivering [2] - 15:13, 22:18 department [7] - 4:21, 5:17, 8:19, 9:21, 13:9, 27:2, 27:14 DEPARTMENT [1] - 1:1 Department [9] - 1:14, 4:23, 5:3, 5:14, 5:19, 6:19, 18:17, 26:6, 26:20 depriving [1] - 24:7 describes [1] - 19:5 designated [1] - 25:1 designations [1] - 19:1 desiring [2] - 5:22, 6:1 despite [1] - 23:9 developed [1] - 10:16 developing [1] - 19:10 development [3] - 6:4, 8:23, 22:8 different [1] - 15:8 differently [1] - 15:9 difficulty [1] - 26:17 diminished [1] - 24:11 dire [1] - 24:11 direct [1] - 20:19 direction [2] - 14:14, 23:9 Director [1] - 21:22 discordance [2] - 16:23, 17:3 discuss [1] - 16:13 discussing [1] - 9:15 dismal [1] - 13:14 distant [1] - 11:14 distinguished [1] - 8:10 divide [1] - 14:19 docketed [1] - 5:2 DOCUMENT [1] - 1:6 document [3] - 4:11, 7:19, 25:19</p>	<p>Document [1] - 5:3 documents [1] - 15:2 done [1] - 14:6 downgraded [1] - 23:19 downtown [1] - 8:4 due [1] - 23:19</p> <hr/> <p style="text-align: center;">E</p> <hr/> <p>e-mailed [1] - 6:12 economic [3] - 6:4, 6:5, 6:6 Edition [2] - 11:6, 19:2 education [1] - 24:20 effective [2] - 3:15, 21:3 effort [3] - 9:3, 18:6, 22:3 efforts [2] - 8:20, 18:3 eight [2] - 15:13, 26:4 either [1] - 19:7 elements [1] - 23:20 elsewhere [1] - 10:19 embark [1] - 15:23 emphasizes [1] - 23:19 employ [2] - 22:17, 24:22 encourage [1] - 27:2 end [1] - 6:15 engage [1] - 17:14 engaging [2] - 13:21, 23:4 ensure [2] - 22:18, 25:2 ensured [1] - 15:19 ensuring [1] - 9:2 entire [1] - 25:5 especially [2] - 16:3, 16:5 essential [1] - 9:2 essentially [1] - 20:7 establish [2] - 5:4, 8:20 evidence [2] - 22:10, 22:17 evidence-based [2] - 22:10, 22:17 example [1] - 11:12 exceed [1] - 23:17 excellent [2] - 23:10, 23:15 exceptional [1] - 24:5 excited [3] - 13:23, 17:13, 24:15 exciting [2] - 17:6, 21:9 executive [7] - 3:11, 3:12, 4:4, 4:11, 4:14,</p>	<p>6:18, 27:13 Executive [4] - 3:19, 5:2, 19:18, 27:18 exist [2] - 10:5, 10:9 existing [1] - 23:14 experience [1] - 18:15 expert [1] - 15:4 expertise [3] - 11:1, 11:17, 15:4 expires [1] - 28:15 explanations [1] - 26:22 express [1] - 18:1 eye [1] - 14:15</p> <hr/> <p style="text-align: center;">F</p> <hr/> <p>facilities [1] - 11:17 facility [7] - 9:9, 10:6, 10:13, 17:21, 18:13, 18:16, 19:6 February [6] - 1:16, 3:1, 4:21, 6:16, 27:22, 28:7 files [1] - 5:17 final [4] - 3:13, 4:3, 27:15, 27:18 first [3] - 8:18, 13:7, 25:7 fit [1] - 24:8 FITZPATRICK [1] - 21:21 Fitzpatrick [2] - 2:7, 21:22 five [1] - 12:23 flexibility [2] - 26:23, 27:3 focus [1] - 14:21 follows [1] - 16:18 foregoing [1] - 28:5 foremost [2] - 8:18, 13:7 formal [1] - 10:4 Fort [1] - 20:11 forward [4] - 4:6, 19:10, 21:6, 23:6 framework [1] - 23:20 front [1] - 7:5 fulfill [1] - 11:21 full [1] - 18:2 fully [1] - 18:11 functional [3] - 22:23, 23:17, 23:21</p> <hr/> <p style="text-align: center;">G</p> <hr/> <p>general [1] - 17:8 given [1] - 5:10 goal [2] - 15:9, 22:9 grassroots [1] - 22:2</p>	<p>guess [3] - 4:2, 7:2, 27:9 guidance [1] - 27:4 guidelines [10] - 11:5, 12:5, 16:19, 16:23, 18:9, 18:21, 23:14, 24:5, 26:15 Guidelines [2] - 11:10, 19:4 guys [2] - 13:17, 17:14 GYN [1] - 12:22 gynecologists [1] - 19:3</p> <hr/> <p style="text-align: center;">H</p> <hr/> <p>hand [1] - 7:5 handed [1] - 6:12 hands [1] - 7:2 hard [1] - 22:16 HARRAH [1] - 17:18 Harrah [2] - 2:6, 17:19 health [22] - 4:23, 6:19, 7:8, 7:16, 7:18, 7:21, 7:22, 7:23, 8:3, 8:9, 13:9, 13:15, 13:19, 14:10, 17:8, 17:20, 18:17, 19:12, 19:19, 21:8, 25:16 HEALTH [1] - 1:1 Health [10] - 1:14, 4:21, 5:3, 5:19, 7:9, 8:13, 8:18, 26:6, 26:20, 27:14 health's [1] - 8:20 healthier [6] - 14:21, 14:22, 15:10, 15:20, 15:21 hear [4] - 3:17, 3:19, 4:7, 20:23 heard [6] - 3:6, 6:1, 6:11, 16:1, 25:21, 27:11 HEARING [18] - 1:4, 3:3, 3:18, 3:21, 4:1, 7:10, 7:14, 12:11, 12:15, 13:3, 17:15, 19:13, 21:13, 21:16, 21:19, 25:22, 27:6, 27:9 hearing [8] - 4:6, 4:20, 5:9, 5:19, 6:18, 21:1, 27:10, 27:12 Hearing [2] - 1:10, 2:2 held [1] - 23:13 help [2] - 14:1, 25:3 hereby [2] - 27:17, 28:5 hi [1] - 26:1 high [2] - 11:22, 23:18</p>
--	---	--	--	--

<p>high-level [1] - 23:18 high-risk [1] - 11:22 higher [4] - 10:6, 10:12, 24:1, 24:13 higher-level [1] - 24:13 higher-tier [1] - 24:1 highlight [1] - 9:7 history [1] - 8:5 home [1] - 8:5 Hoosier [2] - 18:4, 19:12 Hoosiers [2] - 18:11, 24:12 hospital [23] - 5:5, 8:6, 8:7, 8:11, 8:21, 10:5, 10:10, 10:12, 10:15, 10:18, 17:1, 17:23, 19:18, 20:3, 20:9, 20:12, 20:22, 22:1, 22:2, 22:14, 24:15, 26:2 Hospital [4] - 8:14, 8:19, 20:10, 22:16 hospital's [1] - 24:3 hospitals [11] - 7:23, 8:1, 8:3, 8:13, 12:10, 12:21, 13:20, 15:14, 16:22, 22:19, 26:9 human [1] - 22:21</p>	<p>22:13 include [1] - 25:13 including [3] - 5:8, 8:13, 8:15 inconsistent [1] - 9:8 incorporated [1] - 5:15 increase [3] - 13:15, 14:13, 20:8 increasing [1] - 22:11 incredible [1] - 23:1 indeed [1] - 23:23 INDIANA [2] - 1:1, 1:21 Indiana [36] - 1:13, 1:14, 1:16, 1:22, 4:20, 4:22, 5:1, 5:12, 6:4, 6:15, 6:19, 7:8, 7:15, 8:2, 8:3, 8:19, 11:19, 12:10, 13:10, 13:22, 17:6, 18:3, 19:19, 20:3, 20:10, 20:11, 22:1, 22:5, 22:19, 25:4, 26:2, 26:5, 27:14, 28:4, 28:13 Indiana's [3] - 7:21, 8:10, 9:4 Indianapolis [8] - 1:16, 5:1, 5:11, 5:12, 6:15, 8:4, 12:21, 16:16 individuals [1] - 5:22 infant [3] - 9:4, 19:22, 20:20 inflexibility [1] - 26:14 information [1] - 3:6 infrastructure [2] - 22:22, 24:1 inherent [1] - 15:17 inherently [1] - 23:8 inpatient [1] - 19:6 instead [1] - 14:23 institution [3] - 11:7, 23:12, 24:19 institutions [2] - 23:16, 24:6 insufficient [1] - 11:15 intensive [2] - 17:22, 25:9 interpreting [1] - 15:8 interpretive [1] - 27:4 invest [1] - 20:21 invested [1] - 22:21 investments [1] - 20:16 investor [1] - 20:21 IPQIC [1] - 19:9 ISDH [4] - 2:2, 9:6, 19:9, 22:3</p>	<p>isdh.in.gov [1] - 6:10 issue [1] - 19:22 issues [1] - 16:21 itself [3] - 24:20, 26:21, 27:3 IU [5] - 7:21, 7:23, 8:13, 8:18, 25:16 IV [6] - 8:16, 9:9, 15:13, 15:14, 16:16</p>	<p>15:14, 15:15, 15:16, 16:16, 18:8, 18:15, 19:5, 23:18, 24:13, 24:16 Level [4] - 8:16, 17:21, 19:1, 22:23 level-of-care [2] - 10:6, 10:12 levels [5] - 5:6, 8:15, 8:22, 19:3, 26:6 LEVELS [1] - 1:5 likely [1] - 11:20 Lindy [3] - 1:12, 28:2, 28:11 lines [1] - 3:14 list [1] - 9:5 listen [1] - 20:22 live [3] - 13:12, 14:9, 16:14 located [1] - 8:1 location [1] - 11:14 look [2] - 19:10, 21:5 looking [2] - 3:15, 4:2 lower [1] - 24:6 lower-tier [1] - 24:6 LSA [3] - 1:6, 5:3, 7:19 Lutheran [3] - 19:18, 20:2, 20:10</p>	<p>28:11 might [1] - 16:15 mind [1] - 15:9 minimum [1] - 23:23 mirrors [1] - 19:1 mission [1] - 14:21 modified [1] - 12:4 moms [8] - 9:3, 13:1, 13:15, 14:21, 15:10, 15:20, 16:6, 17:11 morning [3] - 12:19, 17:18, 19:16 mortality [3] - 9:4, 19:22, 20:20 most [4] - 9:16, 13:11, 19:23, 24:11 mothers [2] - 12:9, 18:4 move [2] - 7:3, 14:15 moving [2] - 4:5, 23:6 MR [4] - 12:17, 13:5, 21:21, 26:1 MS [6] - 7:7, 7:12, 7:15, 12:13, 17:18, 19:16 MSM [3] - 18:23, 19:6, 20:6 multiple [1] - 15:3 must [3] - 10:9, 10:23, 24:1</p>
I			M	N
<p>I's [1] - 15:16 i.e [1] - 25:13 IAC [3] - 9:14, 10:3, 10:22 identify [1] - 6:21 identifying [1] - 6:22 IEDC's [1] - 6:9 II [1] - 15:15 III [6] - 10:23, 11:19, 15:16, 17:21, 18:15, 19:1, 19:5, 22:23 impact [4] - 6:5, 6:6, 20:19, 25:3 implement [2] - 20:9, 22:10 implementation [3] - 8:23, 22:8, 27:5 imply [1] - 10:4 important [4] - 14:3, 17:4, 20:22, 23:2 improve [6] - 19:11, 21:4, 22:3, 22:11, 24:18, 24:21 improvement [1] - 23:5 improving [2] - 12:8,</p>		<p>January [1] - 5:11 Jeff [3] - 2:5, 12:19, 13:6 Jennifer [2] - 2:6, 17:19 Jr [3] - 1:12, 28:2, 28:11</p>	<p>MacKinnon [3] - 1:11, 2:2, 5:18 mailed [2] - 6:12, 6:13 maintain [1] - 22:16 manager [1] - 17:22 March [2] - 3:11, 4:4 Marissa [3] - 2:5, 7:7, 7:17 maternal [3] - 9:4, 9:16, 22:4 matter [2] - 1:10, 28:7 mean [1] - 15:7 meaning [1] - 11:2 medical [3] - 9:15, 9:19, 12:20 Medical [1] - 21:22 Medicine [1] - 21:23 meet [3] - 20:16, 22:22, 23:17 meeting [1] - 3:11 member [1] - 22:6 MEMBER [3] - 3:17, 3:20, 3:23 memorandums [2] - 16:2, 16:8 Meridian [3] - 1:15, 5:1, 6:14 met [1] - 24:2 Meyer [3] - 1:12, 28:2,</p>	<p>name [6] - 5:17, 6:22, 13:4, 17:18, 19:16, 21:21 nation [2] - 13:19, 13:22 nationally [1] - 8:11 naturally [1] - 12:22 navigation [1] - 18:19 necessary [1] - 22:22 need [4] - 14:20, 15:6, 16:19, 22:20 needed [1] - 21:2 needs [1] - 24:3 neonatal [4] - 5:7, 11:4, 22:4, 22:15 net [1] - 7:21 newborn [1] - 17:22 newborns [1] - 18:8 Newburgh [1] - 22:1 News [1] - 8:12 next [3] - 4:5, 16:1, 21:14 NICU [4] - 8:16, 10:23, 11:19, 17:21 north [2] - 5:1, 6:14 North [1] - 1:15 northeast [2] - 20:12,</p>
L				

20:14
 northern [1] - 21:7
 not-for-profit [1] - 13:19
 Notary [3] - 1:12, 28:3, 28:12
 note [1] - 20:10
 noted [1] - 20:4
 notice [4] - 5:9, 5:13, 5:14, 27:16
 numbers [2] - 11:15, 13:14
 nursing [1] - 17:21

O

o'clock [4] - 1:17, 3:1, 3:4, 27:22
 OB [4] - 8:16, 12:22, 17:21, 19:5
 OB-GYN [1] - 12:22
 obstetric [1] - 5:7
 obstetrical [2] - 9:9, 22:15
 Obstetrics [1] - 19:3
 occur [1] - 10:13
 OF [4] - 1:1, 1:5, 1:21, 2:2
 offers [1] - 8:7
 officer [2] - 5:19, 12:20
 Officer [3] - 1:11, 2:2, 19:18
 OFFICER [17] - 3:3, 3:18, 3:21, 4:1, 7:10, 7:14, 12:11, 12:15, 13:3, 17:15, 19:13, 21:13, 21:16, 21:19, 25:22, 27:6, 27:9
 official [2] - 4:16, 5:17
 officially [1] - 4:19
 often [1] - 23:17
 ON [1] - 2:2
 once [1] - 12:6
 one [5] - 7:5, 7:22, 10:21, 15:14, 24:8
 onsite [7] - 9:10, 9:12, 9:14, 9:22, 11:3, 19:8, 25:9
 opportunity [8] - 7:19, 12:6, 21:7, 21:10, 25:20, 26:12, 26:20
 opposed [1] - 4:17
 OR [1] - 11:7
 oral [1] - 6:11
 order [1] - 27:18
 organization's [1] - 18:1
 organizations [1] - 26:11

otherwise [1] - 10:17
 outcome [1] - 15:19
 outcomes [6] - 11:22, 12:9, 18:10, 23:11, 24:22, 25:4
 outliers [1] - 17:7
 outlined [1] - 18:12
 outside [1] - 10:17
 overcrowding [1] - 24:13
 own [1] - 23:16
 owned [1] - 20:22

P

page [3] - 11:10, 19:4, 25:8
 pages [1] - 11:9
 paid [1] - 13:12
 paramount [1] - 18:19
 part [5] - 13:18, 20:13, 20:14, 21:7, 25:8
 participate [2] - 17:2, 24:16
 participated [1] - 22:7
 particularly [1] - 20:6
 partner [1] - 21:8
 partnering [1] - 18:17
 partners [2] - 14:1, 24:21
 partnership [4] - 10:9, 10:14, 12:9, 21:6
 parts [1] - 14:5
 patient [2] - 24:4, 25:4
 patients [4] - 18:13, 18:18, 22:18, 24:7
 Paula [2] - 2:6, 19:17
 payers [1] - 20:18
 pediatric [6] - 8:8, 8:9, 10:23, 11:1, 11:16, 11:17
 people [2] - 15:8, 16:19
 percent [1] - 14:9
 perform [1] - 11:3
 performed [1] - 11:12
 perinatal [27] - 5:5, 5:7, 8:17, 8:21, 10:10, 10:14, 10:19, 10:20, 10:21, 11:5, 12:5, 18:19, 19:3, 21:23, 22:6, 22:9, 23:1, 23:11, 23:14, 23:18, 23:20, 23:21, 24:5, 24:16, 24:22, 24:23, 25:1
 PERINATAL [1] - 1:5
 Perinatal [1] - 18:8
 person [1] - 6:20
 pertaining [1] - 9:10

phone [1] - 19:8
 phrase [1] - 9:23
 physical [2] - 22:22, 24:1
 physically [3] - 11:3, 11:18, 25:11
 physician [2] - 20:21, 25:13
 physicians [1] - 20:23
 place [4] - 5:9, 17:1, 17:11, 26:15
 placed [1] - 5:16
 places [4] - 14:13, 15:12, 16:7, 17:2
 plan [3] - 3:10, 4:3, 10:7
 plans [2] - 10:11, 10:16
 point [2] - 14:4, 17:4
 policies [1] - 24:18
 poorer [1] - 11:21
 population [2] - 11:23, 24:4
 positively [1] - 25:3
 possible [3] - 18:5, 22:15, 27:2
 post [1] - 4:15
 posted [1] - 6:9
 potential [1] - 16:17
 practicing [1] - 12:22
 prearranged [2] - 11:8, 11:11
 pregnant [3] - 18:7, 18:10, 25:10
 preliminary [1] - 3:6
 premies [1] - 13:1
 prepare [1] - 4:10
 PRESENT [1] - 2:4
 present [5] - 3:16, 4:11, 11:3, 11:18, 25:11
 presentations [1] - 27:12
 President [1] - 7:17
 privileges [1] - 19:6
 PRN [1] - 25:14
 procedures [1] - 11:4
 PROCEEDINGS [1] - 1:9
 proceedings [3] - 27:16, 27:21, 28:6
 process [4] - 3:8, 4:5, 23:5, 24:17
 processes [2] - 22:18, 24:19
 productivity [1] - 16:21
 profit [1] - 13:19
 program [2] - 5:4, 8:21

progress [1] - 23:2
 proof [2] - 5:13, 5:15
 proposals [1] - 25:7
 proposed [9] - 6:7, 6:9, 9:7, 9:13, 9:18, 12:7, 15:15, 19:10, 24:4
 protocols [1] - 24:19
 provide [7] - 12:7, 12:13, 15:4, 20:8, 22:14, 26:21, 27:4
 provided [5] - 5:10, 9:1, 15:19, 20:2, 20:5
 provider [2] - 14:11, 20:13
 providers [3] - 11:6, 11:18, 11:20
 providing [2] - 24:20, 26:17
 provision [2] - 9:22, 10:3
 provisions [1] - 9:10
 public [1] - 4:20
 PUBLIC [1] - 1:4
 Public [3] - 1:12, 28:3, 28:12
 publication [1] - 5:13
 publishing [1] - 5:10
 purposes [1] - 12:2
 pursuant [1] - 27:16
 put [2] - 16:10, 24:8
 puts [1] - 17:1

Q

quality [4] - 9:2, 22:4, 22:11, 25:3
 questions [5] - 3:7, 4:7, 4:10, 4:16, 25:6

R

range [1] - 8:15
 ranging [1] - 8:2
 ranking [1] - 8:11
 readily [9] - 9:10, 9:11, 9:18, 9:23, 11:2, 12:2, 12:3, 25:17, 25:18
 reading [1] - 10:3
 reality [2] - 16:5, 16:14
 realize [1] - 15:22
 really [5] - 4:6, 13:16, 16:4, 16:21, 17:7
 receive [1] - 22:19
 received [1] - 5:14
 recognize [2] - 14:3, 23:2
 recommend [1] - 9:21

record [3] - 5:15, 5:23, 6:20
 rededicated [1] - 24:20
 reduce [1] - 9:3
 reducing [1] - 22:11
 reference [1] - 5:16
 referring [1] - 9:19
 reflect [2] - 12:5, 24:2
 REGARDING [1] - 1:4
 regards [1] - 16:3
 region [5] - 18:14, 18:16, 18:20, 22:19, 25:5
 regional [2] - 20:13, 24:21
 Register [1] - 5:12
 regularly [1] - 8:10
 reiterate [2] - 13:8, 17:5
 related [2] - 11:7, 20:5
 relates [1] - 10:6
 relationship [2] - 10:4, 16:6
 relationships [1] - 16:11
 relegate [1] - 24:5
 remain [3] - 23:3, 23:6, 24:14
 remove [1] - 18:22
 repeat [1] - 4:2
 report [3] - 6:18, 8:12, 27:12
 reported [1] - 6:17
 Reporter [1] - 28:3
 REPORTING [1] - 1:21
 represent [1] - 6:23
 represented [1] - 19:20
 request [1] - 18:23
 requested [1] - 6:21
 require [1] - 11:17
 requirement [1] - 11:21
 requirements [4] - 19:6, 20:16, 22:23, 23:17
 residing [1] - 28:3
 resources [3] - 22:14, 23:7, 24:3
 respect [5] - 25:6, 25:12, 25:16, 25:17, 27:5
 respectfully [1] - 18:23
 respond [1] - 4:8
 response [4] - 4:13, 21:15, 21:18, 27:8
 responses [1] - 4:16

rest [1] - 3:8
result [2] - 10:18, 18:10
rethink [1] - 16:12
review [1] - 24:18
Rice [1] - 1:14
rice [1] - 4:23
Riley [6] - 7:8, 7:16, 7:18, 8:6, 8:13, 8:18
rise [1] - 26:3
risk [3] - 11:22, 18:18, 24:6
Room [1] - 1:15
room [4] - 4:23, 6:3, 7:4, 13:11
Rothenberg [2] - 2:5, 12:20
ROTHENBERG [2] - 12:17, 13:5
RPR/CP [1] - 1:21
rule [13] - 3:13, 4:3, 5:4, 6:7, 6:9, 9:8, 9:13, 9:18, 10:20, 12:7, 18:23, 19:10, 27:5
rulepubliccomments@isdh.in.gov [1] - 6:13
rules [5] - 5:8, 15:15, 26:14, 26:22, 26:23
Rules [1] - 6:10
rural [1] - 8:3

S

safer [1] - 17:10
safety [1] - 7:21
safety-net [1] - 7:21
saw [2] - 7:5, 12:16
section [4] - 9:8, 9:17, 10:2, 25:8
Section [1] - 6:14
see [5] - 4:15, 14:12, 15:19, 15:20
seeing [1] - 27:10
sense [1] - 16:4
serve [2] - 5:20, 18:12
service [1] - 9:1
services [2] - 14:23, 18:18
several [1] - 26:10
shall [1] - 5:23
sharing [1] - 22:13
sheet [2] - 5:21, 6:2
Shelby [2] - 1:13, 28:4
Shelbyville [1] - 28:4
show [1] - 7:2
shown [1] - 5:22
sign [1] - 5:21
sign-in [1] - 5:21

signed [1] - 6:2
similar [1] - 20:5
site [3] - 4:15, 6:10, 11:7
sites [1] - 13:20
size [1] - 24:8
small [1] - 6:6
smaller [1] - 14:7
smallest [1] - 20:1
solidify [1] - 15:7
sorry [1] - 13:4
southern [2] - 22:19, 25:4
southwest [1] - 18:16
SPEAKERS [1] - 2:4
speaking [1] - 17:20
speaks [1] - 6:20
specialists [2] - 25:10, 25:13
specialty [1] - 9:20
specifically [2] - 15:2, 19:5
spell [2] - 7:10, 13:4
spelling [1] - 6:22
St [2] - 12:21, 13:18
staffing [3] - 16:19, 16:21, 16:23
stand [1] - 18:11
standardizing [1] - 18:7
standards [13] - 9:1, 18:12, 20:6, 21:2, 22:6, 22:9, 22:10, 22:17, 23:13, 23:23, 24:2, 24:23
Star [1] - 5:11
start [4] - 4:19, 7:2, 7:4, 13:2
started [1] - 3:5
STATE [1] - 1:1
state [20] - 4:20, 5:3, 6:19, 8:19, 13:12, 14:9, 14:20, 15:14, 15:21, 18:17, 19:21, 20:1, 20:13, 20:14, 21:8, 21:9, 25:5, 26:5, 26:20, 27:14
State [12] - 1:13, 1:14, 4:22, 5:19, 8:2, 11:19, 13:10, 17:6, 18:3, 22:5, 26:5, 28:13
state's [4] - 8:5, 8:7, 18:6, 22:8
statement [2] - 6:6, 6:7
statements [2] - 6:11, 6:12
states [2] - 11:11, 19:4
States [1] - 7:23

step [1] - 4:5
still [2] - 12:21, 23:3
Strategy [1] - 7:17
Street [3] - 1:15, 5:1, 6:14
strict [1] - 26:15
strike [1] - 9:22
strongly [1] - 8:22
structural [1] - 23:20
submit [1] - 26:7
submitting [1] - 9:5
subsection [1] - 12:2
subspecialty [1] - 9:20
succinctly [1] - 24:8
suggest [1] - 12:1
suggested [1] - 27:1
suggesting [1] - 23:10
support [5] - 18:2, 18:20, 22:20, 24:21, 26:3
surgeons [2] - 10:23, 11:16
surgical [3] - 9:16, 9:20, 11:4
system [2] - 13:19, 17:20
systems [5] - 15:18, 15:23, 16:22, 19:19, 21:8

T

table [1] - 11:8
tackling [1] - 13:10
talks [1] - 26:13
teaching [1] - 16:12
technology [1] - 11:13
telemedicine [2] - 11:12, 19:8
telephone [1] - 11:13
temporal [1] - 16:6
term [1] - 9:14
terms [1] - 15:7
THE [18] - 1:1, 3:3, 3:18, 3:21, 4:1, 7:10, 7:14, 12:11, 12:15, 13:3, 17:15, 19:13, 21:13, 21:16, 21:19, 25:22, 27:6, 27:9
therefore [1] - 27:17
Thereupon [1] - 27:21
they've [1] - 14:5
three [2] - 9:7, 15:16
throughout [3] - 8:1, 18:13, 22:4
tier [2] - 24:1, 24:6
timing [1] - 3:7
today [3] - 25:21, 26:10, 26:11

today's [1] - 4:6
together [3] - 14:19, 14:22, 17:9
tomorrow [1] - 6:16
training [1] - 16:11
transcribed [1] - 28:8
transcript [1] - 28:6
transfer [3] - 10:7, 10:11, 10:16
transferred [2] - 16:7, 16:15
transport [1] - 5:8
trauma [1] - 8:8
travel [1] - 18:13
tri [1] - 25:5
tri-state [1] - 25:5
true [1] - 28:5
try [1] - 4:3
Tuesday [2] - 1:16, 28:7
two [3] - 12:23, 15:15

U

U.S [1] - 8:11
ultrasound [1] - 21:23
unanticipated [1] - 14:6
under [1] - 6:10
undersigned [1] - 28:2
undoubtedly [1] - 24:17
undue [1] - 10:1
unintended [1] - 24:9
union [2] - 17:20, 17:23
unit...should [1] - 25:9
United [1] - 7:23
units [2] - 5:7
university [1] - 7:16
University [1] - 7:8
unlike [1] - 9:11
unrealistic [1] - 23:13
up [4] - 3:20, 7:4, 7:6, 16:15
updates [1] - 26:17
uphold [1] - 18:11
utilized [1] - 11:20
utilizes [1] - 9:18

V

Van [1] - 2:7
VAN [1] - 26:1
van [1] - 26:1
verbal [1] - 6:17
verbiage [1] - 25:17
versus [1] - 25:18
Vice [1] - 7:17

Vice-President [1] - 7:17
viewed [1] - 23:13
Vincent [2] - 12:21, 13:18
virtue [2] - 23:7, 24:12
vision [1] - 24:22
vote [1] - 3:12
vulcanizing [1] - 14:23
vulnerable [2] - 11:22, 19:23

W

wants [5] - 7:3, 21:14, 21:17, 25:23, 27:10
wary [1] - 23:6
Wayne [1] - 20:11
Web [2] - 4:15, 6:10
week [1] - 12:23
welcome [1] - 6:8
wide [1] - 8:15
William [1] - 1:21
willing [1] - 15:18
women [3] - 18:7, 19:12, 25:10
Women's [4] - 21:23, 22:1, 22:16, 24:15
women's [2] - 14:10, 17:7
wonderfully [1] - 13:2
world [1] - 8:12
wrapping [1] - 18:18
writing [1] - 27:13
written [6] - 6:11, 6:17, 9:6, 12:12, 15:4, 26:7

Y

years [2] - 17:23, 26:4
yourself [1] - 6:21

Z

Zee [2] - 2:7, 26:1
ZEE [1] - 26:1

On behalf of the almost 170 member facilities within the Indiana Hospital Association (IHA), we appreciate the opportunity to provide comment on Rule #18-416. This effort supports the Governor's agenda to establish Indiana for best in the Midwest with respect to Infant Mortality by 2024. IHA commends Dr. Box and the team at the State Department of Health for their commitment to improving public health.

This rule provides a framework to establish standards of care for infant and maternal care across the state. As you know, this has been a long process which goes back to October 2010 when the Indiana State Department of Health's (ISDH) Division of Maternal and Child Health created the Hospital Levels of Care (LOC) Task Force. The LOC concept came before the Indiana Perinatal Quality Improvement Collaborative - IPQIC - which is co-chaired by the ISDH Commissioner and IHA's President. While the individuals in these roles have changed, the commitment to collaboration on this and many other topics impacting public health remains strong. IPQIC's Governing Council endorsed the LOC framework in January 2013, and years of work began that has included education, consultation, and surveying almost 100 hospitals by IDSH's staff. Our members greatly appreciate the efforts of the Department and its partners throughout this process. Thanks to the thoughtful and value-added approach taken by ISDH, the system of care for Indiana newborns is being strengthened. The process has been inclusive, and we were proud to support Senate Enrolled Act 360 in 2018. This legislation formalized the initiative and made Indiana the third Midwestern state to codify in law a perinatal LOC structure.

We support Rule #18-416 and ask for clarification in just a few areas. We recognize that there can be challenges when converting guidelines or best practices into regulations, and look forward to ongoing dialogue on how updates and new guidance will be incorporated into LOC. Some of our members may comment individually, but our comments also reflect feedback from some hospitals who could not be here today.

410 IAC 39-4-1 Obstetric Level I Facility Requirements

Sec. 1. (b) (1) (E) Access to the hospital's laboratory services including twenty-four (24)-hour capability to provide blood group, Rhesus factor (Rh) type, cross-matching, antibody testing and basic emergency laboratory evaluations, and either ABO-Rh-specific or O- Rh-negative blood and fresh frozen plasma and cryoprecipitate at the facility at all times.

Comment: Suggest clarifying whether the section regarding blood requirements is an either/or statement or an either/and. Making the last line a sub-bullet would make this more clear. If this is an either/and statement, there is concern with smaller facilities maintaining FFP at all times due to expiration and low usage rates. IHA would recommend allowing facilities to maintain blood components appropriate to the usage and type of patients served.



410 IAC 39-1-18 “Physically present at all times” defined

Sec. 18. “Physically present at all times” means onsite in the building where the perinatal care is provided, twenty-four (24) hours a day, seven (7) days a week. Comment: IHA requests further clarification on the definition of physically present at all times. The unique nature of hospital buildings and campuses creates an environment where a provider can be in close proximity of the patient while not being physically located in the same building with the L&D department. IHA would suggest physically present extend to all building located immediately adjacent to the main hospital building in which the L&D services are provided.

410 IAC 39-4-1 Obstetric Level I Facility Requirements

Rule 4, Sec. 1(b)1.(F)(i)) which states the provider to be “physically present” for hospitals offering a trial of labor for patients with a prior cesarean delivery. Comment: Complying with this rule will limit the ability of Level 1 to do TOLAC even though the provider could be located in close proximity – just not “in the building”. This rule could potentially increase repeat cesarean section rates and/or cause women to unnecessarily travel greater distances to find a facility that meets this criteria. ACOG states in its Practice Bulletin Number 184, published in November 2017 that a provider should be readily available as opposed to physically on site.

“Trial of labor after previous cesarean delivery should be attempted at facilities capable of performing emergency deliveries. The American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine’s jointly developed Obstetric Care Consensus document, *Levels of Maternal Care* (which introduced uniform designations for levels of maternal care), recommends that women attempting TOLAC should be cared for in a level I center (i.e., one that can provide basic care) or higher (151). Level I facilities must have the ability to begin emergency cesarean delivery within a time interval that best considers maternal and fetal risks and benefits with the provision of emergency care (151).”

410 IAC 39-4-3 Obstetric Level III Facility Requirements

Sec. 3 (c) (1) (B) which states MFM specialist readily available at all times. Comment: The Guidelines for Perinatal Care provided by the American Academy of Pediatrics and the American Academy of Obstetricians and Gynecologists lists in Table 1-2 of Chapter 1 that MFMs are to be available at all times onsite, defined as by telephone, or by tele-medicine with inpatient privileges. The Indiana State Department of Health defines “Readily available” to require MFM services to be available twenty-four (24) hours a day, seven (7) days a week for consultation and assistance, and able to be physically present onsite within a time frame that incorporates maternal and newborn risks and benefits with the provision of

care. This was a change from the previous standard available prior to the final rules stated (in regard to MFM coverage) which said: "A provider (or providers) board-certified or board eligible in maternal-fetal medicine shall be: Available at all times onsite, by phone or by telemedicine with inpatient privileges." The final rule changes this definition and in doing so, is no longer congruent with the published Guidelines for Perinatal Care.

410 IAC 39-5-2 Neonatal Level II Facility Requirements

Sec. 2 (c) (1) (B) "The hospital shall have consulting relationships in place with a pediatric cardiologist, a surgeon, and an ophthalmologist..."

Comment: Please consider adding a definition of "consulting relationship" to clarify that the intent is that the hospital staff shall know whom to call for a specific issue, not that the hospital is required to have someone who is available to attend to the patient in person.

410 IAC 39-7-1 Inter-hospital Transfer Requirements

Sec 1. (b) references Indiana Perinatal Transport Standards issued by the Indiana Perinatal Quality Improvement Collaborative (IPQIC) dated October, 2018.

Comment: Specialty teams need to be adequately trained for the patient population the team is caring for. Properly trained Respiratory Therapists should be allowed to be part of the maternal team as the secondary provider; the Maternal RN being the expert in that population and the team leader overseeing the RT (or paramedic). For neonatal transport teams, NNP or Neonatal RN should be allowed to be the primary staff. We request that the guidelines be updated to allow the Medical Director to have control in who he/she deems is appropriate to send on the transport.