Ohio Administrative Code

Rule 3701-22-21 Level I service standards.

Effective: August 31, 2025

(A) Obstetric license. A level I obstetric service will provide antepartum, intrapartum and postpartum care for obstetrical patients, including:

(1) Low-risk patients, such as patients with:

(a) Term deliveries;

(b) Singleton deliveries; and

(c) Deliveries with vertex presentation;

(2) Selected uncomplicated patients with higher-risk conditions, such as patients with:

(a) Term twin gestation;

(b) Trial of labor after cesarean delivery;

(c) Uncomplicated cesarean delivery; or

(d) Preeclampsia with severe features at term: A level I obstetrical service may provide care to patients with preeclampsia with severe features at term in the service if the service has appropriate staff, equipment, and training to care for both the mother and the neonate;

(3) The management of unanticipated complications of labor and delivery; and

(4) The management of emergencies.

(B) Obstetric transfers. A level I obstetric service will transfer to a level II, level III, or level IV

obstetric service, as appropriate, any pregnant woman for intrapartum care:

(1) With a complicated condition beyond those designated by the service; or

(2) At less than thirty-five weeks of her pregnancy.

Exception: A level I obstetric service may provide care where an emergency medical condition exists as defined by the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd (2012), and evidenced by the following:

(a) The mother is having contractions; and

(b) In the clinical judgment of a qualified obstetrical practitioner working under that practitioner's scope of practice:

(i) There is inadequate time to effect a safe transfer of the mother to an appropriate higher level hospital before delivery; or

(ii) The transfer will pose a threat to the health or safety of either the mother or the fetus.

(C) When considering a woman's condition and the likelihood of pregnancy-related complications, paragraphs (A) and (B) of this rule do not preclude the admission of:

(1) A less than thirty-five weeks gestation pregnant woman to the maternity unit for care or services for a non-obstetrical issue, but that may require monitoring of the health of the mother, the fetus, or both;

(2) Women with uncomplicated and complicated conditions for antepartum care where labor is not imminent;

(3) Non-infectious gynecologic patients; or

(4) Non-infectious female surgical patients in accordance with policies and procedures approved by

the service's director.

(D) Neonatal license. A level I neonatal care service will provide care to newborns, including:

(1) All low-risk newborns;

(2) Newborns with selected complicated conditions as identified by the service, such as newborns who are:

(a) Moderately ill with problems that are expected to resolve rapidly and are not anticipated to need specialty or subspecialty services on an urgent basis; and

(b) Convalescing that can be appropriately transferred from another service provider; and

(3) Newborns requiring emergency resuscitation or stabilization for transport.

(E) Newborn transfers. When a level I obstetrical service cannot timely transfer a pregnant woman pursuant to paragraph (B)(2) of this rule, the level I neonatal care service will transfer a newborn that is less than thirty-five weeks gestation to a neonatal care service or freestanding children's hospital licensed to provide the needed care, unless all of the following conditions are met:

(1) The level I neonatal care service has identified a neonatal transport program to facilitate the transport of the newborn to a higher level neonatal facility;

(2) The level I neonatal care service has in place a valid memorandum of agreement with one or more neonatal care services licensed to provide the needed care, providing for consultation on the retention of the infant between the level I neonatal care service attending physician and a neonatologist on the staff of the neonatal care service licensed to provide the needed care;

(3) The consultation with, and the concurrence of, the neonatologist on the staff of the neonatal care service licensed to provide the needed care is documented by the level I neonatal care service in the patient medical record and as otherwise may be determined by the service. Such documentation will be made available to the director upon request; and

(4) The risks and benefits to the newborn for both retention at the level I neonatal care service and transfer of the newborn to a neonatal care service licensed to provide the needed care, are discussed with the parent, parents, or legal guardian of the newborn and appropriately documented. Such documentation will be made available to the director upon request.

(F) Informed consent. When discussing transfer of a pregnant woman or a newborn to another facility in accordance with this rule, the transferring service will document and provide the patient or patient's legal guardian with:

(1) The recommendations from any consultations with a higher-level service;

(2) The risks and benefits associated with the patient's transfer or retention; and

(3) Any other information required by the hospital's policies and procedures.

(G) In the event the patient or patient's legal guardian refuses transfer to a recommended hospital, the service will document the refusal of transfer and provide treatment to the patient or patients in accordance with hospital policies and procedures. The service will update the patient or patient's legal guardian as the patient's condition warrants.

(H) Written service plan. Each provider will, using licensed health care professionals acting within their scopes of practice, develop a written service plan for the care and services to be provided by the service. The written service plan will be based on the "Guidelines for perinatal care" or other applicable professional standard and address, at minimum:

(1) The selected uncomplicated conditions for which care will be provided based on the:

(a) Patient population;

(b) Acuity of patients;

(c) Volume of patients; and

(d) Competency of staff.

(2) Criteria for determining those conditions that can be routinely managed by the service;

(3) Admission to the service;

(4) Discharge from the service;

(5) Patient care in accordance with accepted professional standards;

(6) Referrals for obtaining public health, dietetic, genetic, and toxicology services not available in-house;

(7) Minimum competency requirements for staff in accordance with recognized national standards and ensure that all staff are competent to perform services based on education, experience and demonstrated ability;

(8) Administration of blood and blood products;

(9) Provision of phototherapy;

(10) Provision of respiratory therapy;

(11) Unit-based surgeries and surgical suite-based surgeries;

(12) Post-mortem care;

(13) A formal education program for staff, including, at minimum:

(a) A nursing orientation that incorporates didactic education, simulation, skills verification, and competency and is tailored to the individual needs of each nurse based on clinical experience;

(b) The neonatal resuscitation program. The service will ensure all labor and delivery registered nurses and any other practitioner likely to attend to a neonate at a high risk delivery receive training in the neonatal resuscitation program; and

(c) A post resuscitation program. The service will ensure individuals caring for newborns receive training in a post resuscitation program to include, at minimum:

(i) The identification and treatment of signs and symptoms related to hypoglycemia, hypothermia, and pneumothorax;

(ii) Blood pressure (normal ranges, factors that can impair cardiac output);

(iii) Lab work, including perinatal and postnatal risk factors and clinical signs of sepsis;

(iv) Emotional support to parents with sick infants; and

(v) Quality improvement to identify problems and the importance of debriefing to evaluate care in the post-resuscitation period; and

(d) Ongoing continuing education that includes:

(i) An annual educational needs assessment to determine the educational needs of the clinical nursing staff and ancillary team members;

(ii) Annual nursing education that addresses the annual needs assessment and incorporates simulation and skills verification of the types of care provided in the obstetric and neonatal care service and includes education related to serious safety events; and

(iii) Nursing staff participation in annual simulation and skills verification of the types of care provided in the obstetric and neonatal care services.

(14) Provision of care by direct care staff to individuals in other areas of the hospital, including, but not limited to the emergency department and the intensive care unit;

(15) Risk assessment of obstetric and newborn patients to ensure identification of appropriate consultation requirements for or referral of high-risk patients;

(16) A formal process for the on-site provision of services or the referral of patients to follow-up services, as appropriate, for the following:

(a) Developmental screening;

(b) Ophthalmology;

(c) Audiology;

(d) Child life specialist;

(e) Lactation education and support;

(f) Neonatal therapists to address the six core practice domains of environment, family or psychosocial health support, sensory system, neurobehavioral system, neuromotor and musculoskeletal systems, and oral feeding and swallowing by providers with neonatal experience, including:

(i) Physical therapy;

(ii) Occupational therapy; and

(iii) Speech therapy.

(17) Education for mothers regarding personal care and nutrition, newborn care and nutrition, and newborn feeding;

(18) Infection control, consistent with current infection control guidelines issued by the United States centers for disease control and prevention;

(19) Consultation for and referral of both obstetric and neonatal transports;

(20) Criteria for the acceptance of both obstetric and neonatal transports from other services, which may include the reverse transport of newborns who otherwise do not meet the level I gestational age restriction, based on demonstrated capability to provide the appropriate services; and

(21) Developmental follow-up of at-risk newborns in the service or referral of such newborns to appropriate programs.

(I) Each provider will, in accordance with accepted professional standards, develop and follow written policies and procedures to implement the written service plan required by paragraph (H) of this rule.

(J) Each provider will have the ability to perform all of the following:

(1) An emergency cesarean delivery in accordance with facility policy, but no later than thirty minutes from the time that the decision is made to perform the procedure;

(2) Fetal monitoring; and

(3) Resuscitation and stabilization of newborns and emergency care for the mother and newborn in each delivery room.

(K) Support services (on-site). Each provider will have the staff and support services to meet the needs of patients and have the following staff and services on-site on a twenty-four hour basis:

(1) Clinical laboratory capable of providing any necessary testing; and

(2) Blood, blood products and substitutes.

(L) Support services (on-call). Each provider will have the following services on-site on a twenty-four hour basis, with staff necessary to provide the services on-call:

(1) Diagnostic x-ray capable of providing portable x-ray services;

(2) Portable ultrasound visualization equipment for diagnosis and evaluation;

(3) Pharmacy; and

(4) Anesthesia, except that when a patient or patients are receiving a labor epidural, an anesthesiologist or certified registered nurse anesthetist acting within their scope of practice and under the supervision of a physician, will remain in attendance with a patient until it is determined the patient is stable, but for at least thirty minutes. After it is determined the patient is stable, an anesthesiologist or certified registered nurse anesthetist may be on-call, but is obligated to remain available to return in accordance with facility policy, but no longer than thirty minutes.

(M) Unit management. Each provider will have qualified individuals on-staff appropriate for the services provided including:

(1) Co-directors of the obstetric and neonatal care service responsible for the overall operation of the respective care service;

(a) One co-director will be a board certified obstetrician or board certified family physician with experience in obstetrics; and

(b) One co-director will be a board certified pediatrician or a board certified family physician with experience in pediatrics.

(2) Nurse leader: A single, designated registered nurse with a bachelor's degree in nursing (Individuals employed in this position prior to October 1, 2019, who remain in this position do not need to comply with the degree requirement) with demonstrated expertise in obstetric care, responsible for leading the organization and supervision of nursing services in the obstetric and newborn care services to:

(a) Coordinate with respective newborn care, pediatric, and obstetric care services, as appropriate;

(b) Provide oversight of annual obstetric and newborn care specific education;

(c) Collaborate with multidisciplinary team members, facility leadership, and higher-level facilities to create a diverse, equitable, and inclusive environment focused on the quality of care and patient care outcomes; and

(d) If the nurse leader is involved with providing care to the neonatal patient, the nurse leader must be current on neonatal resuscitation.

(N) For every anticipated low risk delivery or uncomplicated delivery with higher-risk condition, each provider will have an:

(1) Obstetrician, physician, or certified nurse midwife acting within their scope of practice and under a standard care arrangement with a collaborating physician, in attendance; and

(2) Individual who has successfully completed the neonatal resuscitation program and who can initiate and complete full resuscitation on-site. This requirement may be met by a team of individuals who have successfully completed the neonatal resuscitation program, one of whom can initiate resuscitation, and one of whom can complete full resuscitation.

(O) For every anticipated high-risk delivery as that term is used in paragraph (A)(3) of rule 3701-22-22 of the Administrative Code, each provider will have in attendance:

(1) An obstetrician or physician;

(2) A second physician, a certified nurse practitioner acting within their scope of practice and under a standard care arrangement with a collaborating physician, or a physician assistant acting within their scope of practice and under a supervisory agreement with a physician, to care for the neonate; and

(3) An individual who has successfully completed the neonatal resuscitation program and who can initiate and complete full resuscitation. This requirement may be met by a team of individuals who have successfully completed the neonatal resuscitation program, one of whom can initiate

resuscitation, and one of whom can complete full resuscitation.

For an unanticipated delivery of a high-risk delivery, every attempt shall be made to secure a second physician, a certified nurse practitioner acting within their scope of practice and under a standard care arrangement with a collaborating physician, or a physician assistant acting within their scope of practice and under a supervisory agreement with a physician, to care for the neonate.

(P) Each provider will have qualified staff on-duty appropriate for the services provided including, at minimum:

(1) Registered nurse staffing to include:

(a) At least two registered nurses competent in obstetric and neonatal care for labor and delivery;

(b) A registered nurse with obstetric and neonatal experience for each patient in the second stage of labor;

(c) A registered nurse to circulate for the cesarean birth deliveries;

(d) Additional registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of obstetric patients; and

(e) Additional registered nurses with the appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of newborns; and

(2) At least one member of the nursing staff to attend to newborns when they are not with the mother or her designee.

(Q) Other disciplines. Each provider will have the following practitioners on-staff:

(1) A licensed social worker with knowledge of obstetric and neonatal psychosocial and family

support services;

(2) A licensed dietitian; and

(3) Personnel with the knowledge and skills to support lactation including:

(a) A certified lactation consultant, as defined in rule 3701-22-01 of the Administrative Code, available for on-site consultation on weekdays and certified lactation consultant services will be accessible by telehealth or telephone twenty-four hours a day, seven days a week. After-hours and weekend consultation can be provided by free services available to healthcare providers and their patients through other avenues such as a hotline. Individuals employed in this position on the effective date of these rules who do not meet the qualifications of this rule shall have five years from the effective date of this rule to come into compliance with the certification requirement;

(b) Lactation support may be provided under the direction of the certified lactation consultant by lactation counselor/educator staff or registered nurse staff educated and trained on how to provide lactation support to the mother and neonate; and

(c) The provider will ensure that lactation support staff maintain continuing education and certification requirements, as applicable, and ensure adequately trained lactation coverage is available based on the specific need and volume of the neonatal population served.

(R) If the provider utilizes licensed practical nurses (LPNs) or nonlicensed direct care providers to support the clinical nursing staff, the facility will:

(1) Have written criteria that define the LPN's or nonlicensed direct care provider's scope of obstetric or neonatal care;

(2) Provide annual education specific to the care of the obstetric and neonatal population served; and

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

(S) If the provider utilizes physician assistants (PA):

(1) Physician supervision for the PA will be provided by a neonatologist or a board-certified pediatrician with special interest and experience in neonatal medicine;

(2) The PA will have appropriate education and demonstrated competence, commensurate with the acuity and volume of patients served, to provide direct supervision of newborns;

(3) The PA is responsible for maintaining clinical expertise and knowledge of current therapy by participating in continuing medical education and scholarly activities;

(4) The PA will maintain national certification, including one hundred hours of continuing medical education every two years and a recertification exam given by the "National Commission on Certification of Physician Assistants" every ten years; and

(5) The level I service will maintain written criteria that define the PA's scope of obstetric or neonatal care.