Ohio Administrative Code

Rule 3701-22-22 Level II service standards.

Effective: August 31, 2025

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

(1) All low-risk patients;

(2) All uncomplicated patients with higher-risk conditions;

(3) Selected high-risk patients as identified by the service, such as patients with:

(a) Severe preeclampsia; or

(b) Placenta previa with prior uterine surgery in which a placenta accreta has been ruled out by ultrasound or magnetic resonance imaging;

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

(5) The management of emergencies.

(B) Obstetric transfer. A level II obstetric service will transfer to a level III or level IV obstetric service, as appropriate, any pregnant woman for intrapartum care:

(1) With a high-risk condition beyond those designated by the service; or

(2) At less than thirty-two weeks gestation or with a fetus expected to weigh less than one thousand five hundred grams.

Exception: A level II 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 is evidenced by the following:

(a) The mother is having contractions; and

(b) When, in the clinical judgment of a qualified obstetric 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 two 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, complicated, and high-risk 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 II neonatal care service will provide intermediate and routine care to newborns, including to:

(1) All low-risk newborns;

(2) All uncomplicated newborns;

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

(a) With physiologic immaturity such as apnea of prematurity;

(b) With an inability to maintain body temperature;

(c) With an inability to take oral feedings;

(d) Who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need sub-specialty services on an urgent basis; and

(e) Who are convalescing from intensive care.

(4) Newborns requiring mechanical ventilation for brief durations of less than twenty-four hours or continuous positive airway pressure, except the twenty-four hour period may be extended if the newborn is stable and improving, and the newborn does not require numerous interventions for time periods nearing twenty-four hours over the course of days; and

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

(E) Newborn transfer. When a level II obstetric service cannot effect a timely transfer of a pregnant woman pursuant to paragraph (B)(2) of this rule, the level II neonatal care service will transfer a newborn that is less than thirty-two weeks gestation or weighs less than one thousand five hundred grams to a neonatal care service licensed to provide the needed care unless all of the following conditions are met:

(1) The level II 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 II 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 II neonatal care service attending physician and a

neonatologist on the staff of that 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 II 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 II 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 high-risk 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) Ensures 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;

(c) A post resuscitation program that ensures that all 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 risks factors and clinical signs of sepsis;

(iv) Principles of assisted ventilation, continuous positive airway pressure, positive pressure ventilation, assisting and securing endo-tracheal tube insertion, and chest x-rays;

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

(vi) 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 low-volume, high-risk procedures consistent with the types of care provided in the obstetric and neonatal care services and includes education related to serious safety events; and

(iii) Nursing staff participation in annual simulation and skills verification, including low-volume, high-risk procedures consistent with 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 neonatal patients to ensure identification of appropriate consultation requirements for 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 clinical care, 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 or 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 II gestational age and weight restrictions, based on demonstrated capability to provide the appropriate services;

(21) Consultation for maternal-fetal medicine on a twenty-four hour basis;

(22) Developmental follow-up of at-risk newborns in the service or referral of such newborns to appropriate programs; and

(23) If the facility back transfers infants for convalescent care, the facility must have a process in place to appropriately identify infants at risk for retinopathy of prematurity to guarantee timely examination and treatment by having:

(a) Documented policies and procedures for the monitoring, treatment, and follow-up of retinopathy of prematurity; and

(b) The ability to perform, either on-site or by arrangement and referral, retinal examinations, or off-site interpretation of digital photographic retinal images, by a pediatric ophthalmologist or retinal specialist with expertise in retinopathy of prematurity, if needed.

(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, including;

(a) Blood typing, crossmatch, and antibody testing;

(b) Neonatal blood gas monitoring; and

(c) Analysis of small volume samples.

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

(3) A blood bank capable of providing blood, blood products, substitutes, blood component therapy and irradiated, leukoreduced or cytomegalovirus (CMV)-negative blood;

(4) Diagnostic imaging limited to x-ray;

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

(6) Respiratory therapy and pulmonary. The respiratory therapy service will:

(a) Have a full-time credentialed respiratory care practitioner, with education, training, or experience in neonatal and pediatric respiratory care who:

(i) Has sufficient time allocated to provide direction and guidance as needed, of the respiratory therapists who provide care in the level II neonatal care service; and

(ii) Provide oversight of an annual simulation and skills verification of staff, including neonatal respiratory care modalities and low-volume, high-risk neonatal respiratory procedures;

(b) Develop a written staffing plan for respiratory therapists that establishes flexibility for variable census and acuity. This plan and actual staffing will be based on allocating the appropriate number of respiratory therapy staff to a care situation, attend to a safe and high-quality work environment, and be operationally reviewed annually for adherence and to verify respiratory therapy staffing is adequate for patient care need;

(c) Maintain appropriate staffing ratios for infants receiving supplemental oxygen and positive pressure ventilation; and

(d) Ensure that respiratory therapy practitioners:

(i) Have documented education, training, or experience in the respiratory support of newborns and infants;

(ii) Will be on-site, in the same hospital building, twenty-four hours a day, seven days a week and remain available to supervise assisted ventilation, assist in resuscitation, and attend deliveries;

(iii) Are able to attend deliveries and assist with resuscitation as requested;

(iv) Are current on neonatal resuscitation program training;

(v) Have their credentials reviewed by the respiratory care leader annually; and

(vi) Participate in annual simulation and respiratory skills verification, including low-volume, high-risk procedures consistent with the types of respiratory care provided in the obstetric and neonatal care services.

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

(1) Diagnostic imaging, including:

(a) Computed tomography;

(b) Magnetic resonance imaging;

(c) Fluoroscopy;

(d) Personnel appropriately trained in ultrasonography to perform advanced imaging as requested; and

(e) The ability to provide timely imaging interpretation by radiologists with pediatric expertise as requested.

Cranial ultrasonography may be provided on-site or by arrangement.

(2) Pharmacy:

(a) Each provider will have at least one registered pharmacist with experience in neonatal and/or pediatric pharmacology who will:

(i) Complete continuing education requirements specific to pediatric and neonatal pharmacology;

and

(ii) Participate in multidisciplinary care, as needed.

(b) Have policies and procedures in place to address drug shortages and to verify medications are appropriately allocated to the neonatal care service; and

(c) Have policies and procedures in place to verify neonatal competency for pharmacy staff supporting and preparing medications for neonatal patients.

(3) A pediatric/neonatal trained hospital pharmacist available by telephone or telehealth on a twenty-four-hour day basis. This requirement can be provided directly or by an agreement with a children's hospital.

(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; and

(5) Biomedical engineering.

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

(1) A board-certified obstetrician and a board-certified pediatrician as co-directors of the obstetric and neonatal care service. The co-directors will establish procedures for patients and integrate and coordinate a system for consultation, in-service education and communication with referring obstetric and neonatal care services;

(2) A neonatologist or a pediatrician in consultation with an on-staff neonatologist, to manage the care of newborns and to provide for:

(a) A system for consultation and referral;

(b) Continuing education programs;

(c) Communication and coordination with the obstetrical service; and

(d) Defining and establishing appropriate policies, protocols, and procedures for the unit nursery or nurseries and neonatal follow-up as may be indicated;

(3) A director of anesthesia services who is a board eligible or board certified anesthesiologist;

(4) Nurse leader: A single, designated, full-time registered nurse with at least a bachelor's degree in nursing, with demonstrated expertise in obstetric care, or neonatal care, or both responsible for leading the organization and supervision of nursing services in the neonatal care service and the obstetrical service to:

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

(b) Provide oversight of annual obstetric and neonatal-specific education, which includes low-volume, high-risk procedures consistent with the care provided in the obstetric and neonatal care services;

(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.

(5) Nurse educator: A registered nurse with at least a bachelor's degree in nursing and are current on neonatal resuscitation, to act as the clinical nurse educator or perinatal nurse educator with the experience and expertise to:

(a) Evaluate the educational needs of the clinical staff, develop didactic and skill-based educational tools, oversee education and skills verification, and evaluate retention of content, critical thinking skills, and competency relevant to the obstetric and neonatal care services; and

(b) Collaborate with the obstetrical nurse leader, neonatal nurse leader, and facility leadership to improve the quality of care and patient care outcomes;

(c) If the nurse educator is involved with providing care to the neonatal patient, the nurse educator must be current on neonatal resuscitation; and

(d) The nurse educator may be performed by a single designated registered nurse in addition to their other duties.

(N) Specialists. Each provider will have medical, surgical, radiological and pathology specialists on-call based upon the medical needs of the patients and policies and procedures will be in place for referral to a higher level of neonatal care when pediatric medical subspecialty or pediatric surgical specialty consultation and/or intervention is needed.

(O) Sub-specialists. Each provider will have a maternal-fetal medicine sub-specialist available for consultation.

(P) Deliveries:

(1) For every low risk delivery or uncomplicated delivery with higher-risk conditions, each provider will have an obstetrician, physician, or certified nurse midwife acting within their scope of practice and under a standard care arrangement with a collaborating physician, in attendance; or

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

(Q) For every anticipated high-risk delivery, each provider will have in attendance:

(1) An obstetrician or physician;

(2) A second physician, certified nurse practitioner acting within their scope of practice and under a standard care arrangement with a collaborating physician to care for the neonate, 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) Members of the multi-disciplinary team required by paragraph (S) of this rule, one of whom can initiate resuscitation, and one of whom can complete full resuscitation. This can be the same individual.

(R) Each provider will ensure every newborn requiring mechanical ventilation or continuous positive airway pressure has an initial evaluation by a physician, certified nurse practitioner, or physician assistant acting within their scope of practice. If stable, qualified staff with experience in newborn airway management and diagnosis and management of air leaks will be on-site to care for such newborns.

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

(1) Registered nurse staffing, including:

(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 section 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 newborns; 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 obstetric patients;

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

(3) A multi-disciplinary team, each of whom have successfully completed the neonatal resuscitation program and can initiate resuscitation. One member of the multi-disciplinary team shall be capable of completing full resuscitation.

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

(1) A licensed social worker to provide psychosocial assessments and family support services. Additional social workers will be provided based upon the size and needs of the patient population;

(2) A licensed dietitian with knowledge of maternal and newborn nutrition and knowledge of parenteral/enteral nutrition management of at-risk newborns; 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 certified lactation consultant 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.

(U) 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.

(V) 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;

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

(6) If the PA is involved with providing care to the neonatal patient, the PA must be current on neonatal resuscitation.