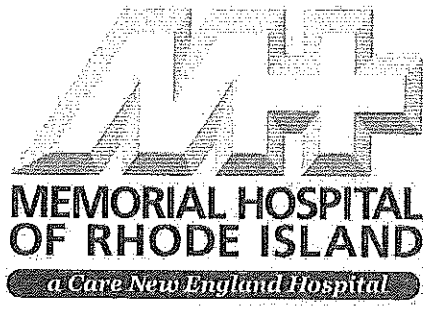


April 7, 2016

Mr. Michael K. Dexter, Chief
Center for Health Systems Policy and Regulation
Rhode Island Department of Health
Three Capitol Hill, Room 410
Providence, RI 02908-0597

Re: Memorial Hospital Inpatient Obstetrical Service

Dear Mr. Dexter:

Enclosed please find responses to your most recent questions regarding Memorial Hospital's inpatient obstetrical services and our reverse CON application.

Please also note a number of attachments that are included as part of our answers.

We appreciate all the efforts by the Department of Health in this matter. Please let us know of any additional information that is required.

Sincerely,

Michael J. Dacey, M.D.
President
Memorial Hospital of Rhode Island

MJD:ms

1.	For the 446 births at MHRI in fiscal year 2015, please provide a racial and ethnic breakdown of the mother. For the 214 pregnant patients contained in Attachment "C", please provide a racial and ethnic breakdown.

Please see attachments labeled "FY 15 Memorial Hospital by Race and Ethnicity" as well as Pregnant Patients Race and Ethnicity" that contain the requested information.

2.	Response #1: Please reconcile your comment that increases in patient volumes at Women & Infants and Kent Hospitals can be "supported by the current staffing. .....neither hospital anticipates changes to its existing staffing ratios" and your response in #6 that the 20.5 FTEs (including 17.5 registered nurses) will have opportunities to bid on similar obstetric positions throughout the CNE system.

Staffing ratios are maintained at all hospitals to ensure the proper staffing is available on the unit. Ratios are set for a range of patients (daily census). For example, on a large unit where daily census is between 16-20 patients, RN staffing level is set to 15 RN's for a 24 hour period. When census is above 20 patients or below 16 patients, staffing is adjusted as needed. Another example is on a unit with low volume, when daily census is between 1-4 patients, 4 RN's are needed to staff for the 24 hour period. The additional 1-2 patients at Kent and WIH can be absorbed within the staffing ratios.

To clarify our original response #6, staff affected by the reduction in force at Memorial will be invited to a job fair at which all operating units of CNE will be represented as well as other employers, and are encouraged to apply for similar positions throughout the CNE system. At the current time there are no open positions at Kent or WIH for OB units (LDR and Mother/Baby units) but with a turnover rate of 8% and RN population of 310 individuals (209 FTE's), we expect that positions will open in the future.

3.	Response 2(c): Please explain why refresher training programs are currently required for the anesthesia staff.

While awaiting the DOH decision on inpatient obstetrics services at Memorial Hospital we have worked to mitigate --- as best we can --- the potential risks that we perceive exist for obstetric patients and their infants who receive care in a low volume obstetrical unit such as Memorial's.

Despite good training, care givers at low volume obstetric units do not have the depth of daily experience with the uncommon obstetrical complications. We have focused on assessing and enhancing readiness for high risk/low frequency complication areas using proctoring, education, simulation and other tools. For example, we have asked the Chief of Anesthesia at Memorial to review one such high-risk/low frequency scenario with her staff and subsequently arrange for an outside expert, (who routinely works with higher volume obstetrical centers), to

come to Memorial and use education and simulation to refresh the skill set of the Memorial anesthesia department.

4.	Please describe in detail how the obstetrical service inpatient space will be utilized upon closure, if the plan is approved by the Director of Health. Will the space be re-purposed? If so, please estimate the amount of capital expenditures in this repurposing.

Currently, Memorial Hospital has 225,000 square feet of vacant and under-utilized space and the OB unit occupies 14,229 square feet. There are no specific plans for the space currently occupied by the OB service. Although we are searching for both medical and non-medical uses for the substantial amount of vacant space on the Memorial campus, there are no plans currently.

5.	Please explain how the closure of the obstetrical inpatient service, if the plan is approved by the Director of Health, will affect Condition #4 of the Director of Health's *Decision with Conditions* dated June 26, 2013 at page 69 (i.e., maintenance of an Accreditation Council for Graduate Medical Education-approved family medicine residency program "that is substantially similar in nature, scope, and purpose to the family medicine residency program presently offered at Memorial Hospital, including all academic, medical, and research components.")

The leadership of the Memorial Hospital Family Medicine program, the leadership of Women & Infants Hospital and clinical leaders from across Care New England have worked together to ensure that the closure of the Memorial Hospital inpatient obstetrical service will not affect the Memorial Family Medicine residency in terms of the quality or experience of training. An extraordinary degree of collaboration has resulted in a model that will see the Memorial Family Medicine residents doing their obstetrical rotations at Women & Infants Hospital. This will result in an enhancement of the Memorial Hospital Family Medicine residents' experience while training. The net result will be an enhancement of the educational experience.

6.	Please explain in detail how physician backup and support for home births will be altered if the MHRI obstetrical inpatient services are relocated to Women & Infants and Kent Hospitals, if the plan is approved by the Director of Health.

There are three community midwives who perform home births and have obstetric privileges at Memorial Hospital. They have an arrangement with a CNE Memorial-based obstetrician who provides obstetrical support for this midwife practice if these patients require hospital care. At the present time, only one of these midwives has sought privileges at another CNE hospital (WIH) and she is presently going through our credentialing and privileging process. The supporting obstetrician currently has privileges at Women & Infants and he is also seeking privileges at Kent. It is our intention to work with this midwife (and any others who seek to gain privileges at WIH or Kent) to determine together the best way to provide streamlined and effective care for their patients who require hospital-level care.

At the present time, pending applications and the cooperation of the midwives, it is difficult to offer a more specific plan other than our intention to work with them to help them find suitable supports for their community midwifery practice. In addition to working with these midwives to arrange mutually acceptable formal supportive relationships, we will continue our CNE-wide practice of readily evaluating and treating any woman presenting for obstetric care at one of our institutions. This will continue to be done regardless of with whom or where the patient received obstetrical care. And this will always be done in collaboration with any providers with whom the patient has already established a relationship.

7.	Response #6: Please indicate the minimum number of days of notice that will be provided to those staff whose positions will be eliminated. Please confirm that the 20.5 FTEs referred to in this response constitute the entirety of the "reduction of force of some magnitude" described in your March 2, 2016 correspondence.

The number of days notice that will be provided to staff whose positions are eliminated will range from a minimum of 7 to a maximum of 14. The 20.5 FTE's do constitute the entirety of the reduction in force required within the obstetrical unit itself.

~~8.~~	~~Please provide information on the Alternative Birthing Center (ABC) at Women & Infants Hospital,~~ including total number of deliveries in 2015, numbers of births utilizing midwives and/or doulas. Please also describe the criteria that would include and exclude a woman from delivering at the ABC. Please describe if other alternative birthing modalities are available.

In 2015, the WIH ABC included 125 deliveries and the total number of deliveries at Women & Infants by Certified Nurse Midwives (CNMs) was 902. In addition, our community CNMs were involved in the care of an additional 248 pregnant women and our hospital-based CNMs were involved in the care of an additional 350 pregnant women. Overall, this translates into involvement in the care of 1,500 pregnant women in labor. We do not have a record of the numbers of births utilizing doulas.

The policy with the full criteria for the Alternative Birthing Center is included as an attachment. (One Attachment)

In addition to the ABC, patients are offered other natural birthing modalities including ambulating during labor, access to aroma therapy, use of a birthing ball, rocking chair, hot and cold therapy, music therapy, hydrotherapy, freedom of movement, intermittent monitoring, acupuncture, acupressure, massage, birthing chair, birthing bar, and use of trained doula or other support persons as a woman desires.

9.	For MHRI, Kent, and Women & Infants Hospitals, please provide separately the most recent three years of data on Cesarean sections ("C" sections), Vaginal Birth After Cesarean ("VBACs") and "gentle C-sections."

Please see the table below, which displays the requested data. Neither Women and Infants nor Kent Hospital track their rates of "Gentle Cesarean" procedures.

TCS = Total C-section rate (Includes elective repeats)
PCS = Primary C-section rate (First C-section for a patient)
VBAC = Vaginal Birth after C-section

CNE CS Data (2013-2015)

2013

	TCS	PCS	VBAC
WIH	31.5%	21.6%	17.4%
KH	30.9%	19.2%	10.3%
MH	31.0%	21.8%	24.4%

2014

	TCS	PCS	VBAC
WIH	30.9%	21.0%	20.6%
KH	33.6%	21.0%	8.2%
MH	34.1%	23.3%	22.6%

2015 *(Jan-Jun NPIC)*

	TCS	PCS	VBAC
WIH	30.1%	19.8%	20.0%
KH	32.1%	19.9%	11.0%
MH	27.1%	16.4%	28.1%

10.	Response #13: Please clarify the response to question #13 where, on the one hand, it is stated that pre/post-natal care is provided at MHRI, yet, on the other hand, non-emergent pregnant patients will be transported from MHRI to Women & Infants and Kent Hospitals Monday – Friday 8:00 a.m. – 5:00 p.m., if transportation is a barrier to accessing care. Why would appointments be made at Women & Infants and Kent Hospitals when the services are provided at MHRI?

Care for the vast majority of pre and post natal patients is currently provided at Memorial Hospital and the plan is to continue to do so. However, like all medical specialties, there are situations where specialty consultations or testing is required that exceed local capabilities. In those specific situations, we will provide transportation to and from Women & Infants Hospital for Memorial patients. As is currently the case however, we anticipate that most outpatient care can be provided locally at Memorial.

11.	Please elaborate on arrangements CNE might make to provide the transportation. For example, will bus vouchers be provided? Taxi service? Uber? Please indicate if any out-of-pocket costs are anticipated for patients.

Care New England has developed a patient transfer process, to include immediately available ambulance service for patients requiring transport from Memorial to Kent, Women & Infants and Butler Hospitals, or to any other inpatient facility that might be needed. This includes emergency department, as well as Memorial's inpatient and observation patients who require transport for services that will not be provided at the Memorial Hospital campus going forward. In addition, an expanded shuttle transport service will be available with multiple scheduled stops at each Care New England facility to provide both patients and their families transportation to these CNE facilities. The ambulance service will be available 7 days per week around the clock. The need for the amount of shuttle service will be refined, but CNE will provide this service routinely during outpatient hours of operation at other campuses and on call outside of those service hours on an as-needed basis. We will also make a preferred arrangement with a taxi company and provide vouchers to patients to supplement the above service when necessary.

12.	Response #15: For the past three years, please provide the number of patients utilizing pre/post-natal services at MHRI. Please provide projected numbers of patients who will utilize pre/post-natal services at MHRI for the three years following the elimination of the obstetrical service, if approved by the Director.

Memorial Hospital estimates that it has provided pre- and postnatal services to the following number of patients over the past three years:

2013: 281
2014: 324
2015: 291

We would point out that the 2013 data was obtained from Memorial records and that CNE only had operational control over Memorial for one month of FY 2013.

The Family Care Center at Memorial and the Obstetrical practices at Memorial offer routine pre- and postnatal care and our plan is to continue to do so after the inpatient service transitions. While it is not expected that utilization of pre and post natal services at Memorial's Family Care Center will change after the inpatient service closes, it is not possible to project specific volumes.

13.	Attachment "C" contained in your March 14, 2016 response identifies 214 women who are in their second or third trimesters. For each of these 214 individuals, please identify the number of these individuals who are commercially insured. For each individual, please analyze their insurance status and determine their out-of-pocket costs. Based upon this analysis, please provide an average and a range of out-of-pocket costs for women who will access obstetrical services at each of Women & Infants and Kent Hospitals, in lieu of MHRI.

Approach:

1. Of 214 patients on Attachment "C" in the response of March 14, 2106, 69 have delivered or are not included in CNE's electronic medical record. These 69 patients are excluded from our analysis.
2. Of the remaining 145 patients, four (4) or 2% are insured through Medicare which carries no patient deductible or coinsurance liability. These 4 patients are excluded from our analysis.
3. For the remaining 141 patients, we:
   - Determined expected location for delivery in lieu of MHRI based on patient's obstetrician.
   - Searched internal databases for insurance policy id numbers for each patient.
   - From each insurance group, selected a sample of patients for which we found a valid insurance policy id.
   - Analyzed patient out-of-pocket liability per insurance policy for those patients in sample.
   - Estimated out-of-pocket expense per patient based on analysis of policy.
4. Extrapolated sample results to remaining patients on list based on type of insurance.

Assumptions:

- 2 day stay with normal uncomplicated delivery & normal newborn stay - 2 days.
- Extrapolation assumes same coinsurance % of allowable as per sample population.

Notes:

(1) Managed Medicaid plans are deemed commercial and may require a coinsurance payment; however we found none in the sample policies analyzed.

(2) Actual coinsurance may be lower depending on terms per patient specific plan policy.

Findings:

Change in Out-of-Pocket	# of Patients	% of all patients	Average	Range
Managed Medicaid (1)	76	54%	$0	$0
Other Commercial				
No change	6	4%	$0	$0
Decrease	39	28%	-$1,205	-$1,099 to -$1,287
Increase up to $1,000	17	12%	$682	$419 to $962
Increase over $1,000	3	2%	$1,433	$1,187 to $1,820
All Patients	**141**	**100%**	**$214**	-$1,287 to +$1,820

14.	Please indicate if the Pediatric Primary Care Center and Pediatric Specialty Clinics are still operational. If not, please provide the date that these units were closed. Please also provide separately the most recent three years of utilization data prior to closure, if applicable.

Yes, both the pediatric primary care clinics and the pediatric neurodevelopmental center are still operational. The physicians and providers are employed by Care New England. In fact, the neurodevelopmental center has seen increasing volume and is a regional referral center. We continue to be committed to providing these services going forward.

15.	Please provide one copy of each communication (emails, flyers, letters and any other written communication) that was directed to health care providers, employees, patients, and other interested parties related to MHRI's restructuring (including, but not limited to, the closure of the inpatient obstetrical unit at MHRI). If communication was made verbally to said parties, please indicate the date(s) and the nature of this verbal communication.

Please see attached a number of written communications sent to the interested parties referenced in the question. With respect to verbal communications and meetings, we have reviewed our records of meetings with interested parties and provide the following listing, which to the best of our knowledge, is complete:

1. On March 1, 2016, senior medical and administrative leaders from Care New England met at the Department of Health in Room 209 from 10:30 to 12:00. This meeting was at the request of Care New England. During the course of that meeting, we outlined the proposed restructuring plan for Memorial Hospital that had been approved by the Care New England Board of Directors several days prior. We asked the department to intervene as rapidly as possible, within the bounds of allowable regulations, to allow CNE to relocate the Memorial obstetrics inpatient service to Women & Infants and Kent Hospitals. We also informed Health Department staff that we would be relocating the obstetrical deliveries of our employed physicians to either Women & Infants or Kent as quickly as practicable. No objections were articulated by DOH staff at that time pursuant to this plan. At no time during this meeting, or anytime since, did any representative of CNE assert that we planned to close the Memorial inpatient obstetrical service without DOH approval.
2. Later that same day, CNE representatives and clinical leaders held a meeting at Memorial Hospital with providers of obstetrical services at Memorial to discuss the meeting earlier that day at the DOH. The providers were told of the desire to move the employed practices as soon as practicable to deliver at either Women & Infants or Kent Hospitals. The providers were also told that we had asked for the DOH to move as quickly as possible to allow the formal closure of the Memorial OB unit, but that the process does require a reverse CON and that public hearings on the matter would likely be necessary. Questions regarding attaining clinical privileges at the other hospitals were discussed and plans developed to assist the providers in obtaining the required privileges.
3. On March 3, CNE representatives had discussions with DOH representatives to re-verify that it was in fact acceptable to move the CNE employed OB practices from Memorial. Based on the number of patients involved, the DOH responded that they did not now believe this acceptable.
4. On March 4, CNE representatives and clinical leaders again met with the providers of OB services at Memorial from 7:30 to 8:30 a.m. and let them know that based on follow-up discussions with DOH, that the employed OB practices would not be moving as previously thought but that we still believed that the Department of Health would move very quickly on our reverse CON request, which had formally been submitted on 2 March. Issues regarding the obtaining of privileges at Women & Infants and Kent Hospitals were again discussed.

5. Also on March 4, CNE representatives held a meeting at Memorial Hospital from 8:00 to 9:30 a.m. with city officials from Pawtucket and Central Falls, as well as elected representatives from both cities to discuss the proposed restructuring plan and answer questions. A copy of the brief Power Point presentation is included in our submissions to this question.
6. On March 7, CNE representatives and clinical leaders again held a meeting at Memorial with providers of obstetrics services at 5:00 p.m. to provide updates and continue to discuss the privileging process at the other CNE hospitals and address barriers that needed to be overcome.
7. On March 14, March 16 and March 17, CNE representatives and clinical leaders attended all three community meetings called by the Department of Health. The comments submitted into the record by Angelleen Peters-Lewis, the CNE Chief Nursing Officer, are provided in response to this question.
8. On March 28, CNE officials and clinical leaders met with obstetrics providers based out of Memorial to discuss the current status of the reverse CON request and to answer questions regarding privileging at both Women & Infants and Kent.

16.	Please explain how the scope of practice and the day-to-day birthing activities of midwives differ separately at Women & Infants, Kent and MHRI. Please provide a copy of the midwifery practice protocols, including physician midwifery supervision protocols, in effect at MHRI, Women & Infants, and Kent Hospitals.

Please see the following attachments that also are part of our response to this question:

1. Kent Midwife Privilege Form
2. Kent Midwifery Service Protocol
3. MHRI Midwife Privileges
4. WIH ABC Admission Criteria
5. WIH Midwifery Practice Guidelines and Privileges

<u>Scope of practice at Care New England Hospitals:</u>

- Kent Hospital: Midwifery privileging criteria and guidelines (Two attachments) are in place. Currently, there are no CNMs practicing inpatient obstetrics at Kent.
- Memorial Hospital: Midwifery privileging criteria are included here (One attachment). Two Certified Nurse Midwives (CNMs) practicing in two of the community health centers deliver their patients at Memorial. An additional three CNMs have a home birth midwifery service and transfer patients to Memorial when indicated.
- Women & Infants Hospital: Midwifery privileging criteria and practice guidelines are well established (One attachment).
- Currently, 27 midwives hold privileges at Women & Infants. (This number changes month to month as new providers are added and other providers resign from the staff.)
    - 17 full time CNMs doing full scope practice
    - 1 part time doing full scope
    - 3 per diem CNMs

- 5 CNMs that are currently only doing office prenatal and gynecology
- 1 with privileges, however is practicing elsewhere

The mechanism for credentialing certified nurse midwives at Women & Infants, Kent, and Memorial are similar. The Memorial Hospital privileges include practices that are outside basic midwifery practice. WIH Privileging and Guidelines represent national standards of care with supplemental privileges included with specific criteria national guidelines (included as Appendix A-D in the WIH guideline) (American College of Nurse-Midwives document: http://site.blueskybroadcast.com/Client/ACNM_09/docs/expandedmidwiferypractice.pdf). The state of Rhode Island does not use supervisory language in the midwifery statute (http://sos.ri.gov/documents/archives/regdocs/released/pdf/DOH/7783.pdf). CNMs are considered independent practitioners. However, all midwives practice within a system for consultation, collaboration, and referral (ACNM standards of practice (http://www.midwife.org/ACNM/files/ACNMLibraryData/Standards_for_Practice_of_Midwifery_Sept_2011.pdf). These mutually agreed upon guidelines ensure safety and continuity for our patients. Each hospital guideline is similar in that there must be in-hospital consulting physician presence, however they do not need to attend a midwifery birth unless there is a change in the patient's risk status and indication to be present in the room.

17.	Please provide the total net patient service revenues and total operating expenses for FY 2013, 2014 and 2015 for the inpatient obstetrics unit at MHRI. In this response, please provide the components that comprise the total operating expenses (e.g., salaries and benefits, supplies, other expenses, etc.) for each FY.

It should be noted that the Memorial obstetrics unit does not stand by itself and requires substantial clinical and financial support from other components of Memorial, including the intensive care unit and multiple specialty support services. These in aggregate add to the losses shown below. Also, please note that the other components of the Memorial restructuring are dependent upon the transfer of the obstetrical service to our other hospitals.

	FY2013*	FY2014	FY2015
Net operating revenue	$ 3,730,615	$ 4,258,374	$ 3,845,311
Salaries & Wages	2,703,407	2,795,290	2,745,437
Benefits	854,885	877,039	868,007
Professional Fees	135,000	135,000	101,250
Medical supplies	135,881	231,013	159,944
Other Supplies	11,115	12,248	12,228
Insurance	116,709	123,174	89,384
Other Expenses	383,709	425,649	516,834
Operating expense	4,340,706	4,599,414	4,493,082
Net income over operating expenses	$ (610,090)	$ (341,040)	$ (647,771)

* Memorial became part of Care New England on September 3, 2013. Financial information presented for FY2013 was derived from records maintained by Memorial independent of CNE.

Memorial Hospital Births

Race	*FY15 Births*	*Percentage*
AMER_IND_ALASK	3	1%
ASIAN	7	2%
BLACK	40	9%
MULTI	18	4%
OTHER	61	14%
UNKNOWN	15	3%
WHITE	302	68%
Grand Total	**446**	**100%**

Hispanic	*FY15 Births*	*Percentage*
Y	80	18%
N	359	80%
U	7	2%
Grand Total	**446**	**100%**

Data Source: RI Department of Health, Center for Health Data and Analysis, KIDSNET

Memorial Hospital Pregnant Patients

Ethnic Group	*Total*	*Percentage*
Cape Verdean	4	2%
Colombian	2	1%
Dominican	5	2%
Guatemalan	1	0%
No, not Hispanic, Latino or Spanish	159	74%
Other Hispanic, Latino or Spanish	12	6%
Portuguese	2	1%
Puerto Rican	10	5%
Unavailable	19	9%
Grand Total	**214**	**100%**

Race	*Total*	*Percentage*
Asian	4	2%
Black or African American	26	12%
Multiracial: White & Black	3	1%
Multiracial: White & Some Other Race	2	1%
Other	19	9%
Unknown	24	11%
White or Caucasian	136	64%
Grand Total	**214**	**100%**

Women & Infants' Hospital

PATIENT CARE SERVICES

POLICY/ PROCEDURE
ABC: CRITERIA FOR ADMISSION

Policy Date: June 1996

Effective Date: February 2014

Revised Date: June 1996, June 2002, November 2003, October 2006, December 2009, February 2014

Reviewed Date:

POLICY: Patients may be admitted to Alternative Birthing Center if they meet the following criteria:

Criteria for Use:

1. Patient in labor after an uncomplicated pregnancy with singleton vertex presentation at 36 weeks or greater, not planning regional analgesia.
2. Patients with gestational diabetes that is well controlled by diet can be considered as candidates for the ABC provided they meet the following criteria:
   - Blood sugars performed at recommended times and results within required parameters
   - EFW of less than 4,000gms by both clinical assessment and Ultrasound (US) performed at 38 weeks gestation. If the patient is undelivered, US should be repeated at 40 weeks gestation.
3. Patients with a prior vaginal delivery of an infant greater than 4,500gms without complication and an EFW of less than 5,000gms with this pregnancy.
4. Patients with light meconium noted upon presentation to hospital.
5. Agreement by the attending obstetrician/ CNM and pediatrician is required if early discharge is planned.

Criteria for Exclusion:

1. Gestational Hypertension / Pre-eclampsia
2. Gestational Diabetes treated with oral agents or insulin (patient cannot have refused antenatal testing)
3. Documented gestational age of less than 36 weeks or greater than 42 weeks
4. Any other acute or chronic maternal illness which would increase risk to mother or infant
5. Moderate, thick or particulate meconium stained fluid prior to admission
6. Previous cesarean section
7. History of shoulder dystocia
8. Estimated Fetal Weight (EFW) greater than or equal to 4,500gms
9. Other co-morbidities

Procedure:

1. Patients are admitted to the Birthing Center on a first served basis.

2. Whirlpool bath may be used for relaxation/ pain relief during the first stage of labor. (See Policy/ Procedure: LDR/ ABC Whirlpool Therapy).

3. Patients who develop, including but not limited to, any of the following conditions are transferred from the ABC area to the Labor/ Delivery/ Recovery (LDR) area with provider consultation:
    - Any labor pattern or maternal/ fetal complications requiring additional diagnosis or treatment that is not available in the Birthing Center.
    - Moderate, thick, or particulate meconium stained amniotic fluid.
    - Temperature above 38.4° C (101.1° F) or above.
        - If the patient has a temperature of 38.0 to 38.3°C (100.4° to 100.9°F), hydration or other corrective measures may be undertaken with temperature repeated after 30 minutes
        - With the onset of this temperature elevation, the patient should be fully evaluated by the provider to rule out chorioamnionitis. This evaluation should include assessment of maternal and fetal heart rate and abdominal palpation to evaluate for fundal tenderness.
        - If reassessment after this 30 minute period continues to show a temperature of 38.0°C or above, the patient should be transferred.
    - Blood Pressure of ≥ 140 Systolic or ≥ 90 Diastolic on 2 occasions.
    - Vaginal bleeding requiring interventions.
    - Labor pattern requiring augmentation.
    - Prolonged labor.

4. The following guidelines for care shall be observed:

    A. Prolonged Rupture of Membranes (PROM) is defined as rupture of membranes greater than twenty-four (24) hours. Patients with PROM may remain in or be admitted to the ABC providing adequate contractions are present.

        1. Refer to the OB-GYN Guidelines (see attached) regarding recommendation that labor be induced at the time of presentation.
        2. On admission to the ABC or after twenty-four (24) hours past rupture if patient is already admitted:
            - Obtain 20 minute fetal heart rate tracing and evaluate based on Policy/ Procedure: Fetal Monitoring.
            - Monitor hourly temperature
            - Reassess the fetal heart rate with fetal heart rate tracing hourly.
        3. Transfer to LDR should occur thirty-six (36) hours after rupture of membranes.
        4. Any deviation from the norm will result in transfer to the LDR area.

B. For patients with light Meconium stained fluid noted at the time of admission:
   1. Continuous electronic fetal monitoring should be performed for at least twenty (20) minutes.
      - If fetal monitoring is interpreted as normal (Category I), the patient can be admitted to the ABC and followed as described in guideline C below.
      - If fetal monitoring is interpreted as indeterminant (Category II), the patient should be admitted to the LDR area and followed with continuous electronic fetal monitoring.

C. For patients with light Meconium stained fluid noted during labor:
   1. Continuous electronic fetal monitoring should be considered depending on risk assessment.
   2. Assess fetal heart with twenty (20) minutes of continuous fetal monitoring hourly.
      - If fetal monitoring is interpreted as normal (Category I) after this period of assessment, the patient may return to the intermittent auscultation protocol.
      - If fetal monitoring remains indeterminant (Category II), electronic fetal monitoring should be continued or the patient should be considered for transfer from ABC area to the LDR area.
   3. NICU is notified of meconium and called to attend delivery.
   4. Attending obstetrician is notified of meconium.
   5. Transfer to the LDR area occurs for moderate, thick, or particulate meconium.

D. Patients who are noted to have persistent indeterminant (Category II) fetal heart rate characteristics on intermittent auscultation should be placed on continuous electronic fetal monitoring to assess fetal status. These characteristics include but are not limited to:
   - Baseline < 110 or > 160 beats per minute
   - Irregular rhythm
   - Decelerations
   - Baseline that steadily increases toward a tachycardic rate

   If fetal monitoring is interpreted as normal (Category I) after a 20 minute period of assessment, the patient may return to the intermittent auscultation protocol.

   If fetal monitoring remains indeterminant (Category II), electronic fetal monitoring should be continued or the patient should be considered for transfer from ABC area to the LDR area.

E. **Requiring Pediatric presence at delivery** includes but not limited to:
   - Meconium
   - ROM > 24 hours
   - Maternal temperature $\geq$38.0°C

5. Document all assessments, interventions, and deviations in the medical record.

This [policy or procedure] is only intended to serve as a guideline to assist staff in the delivery of patient care; it **does not** *create standard(s) of care or standard(s) of practice.* The final decision(s) as to patient management shall be based on the professional judgment of the health care provider(s) involved with the patient, taking into account the circumstances at that time.

Approved By:

Date: 3/27/14
Angelleen Peters-Lewis, RN, PhD
Senior Vice President/ CNO, Patient Care Services

Date: 4/2/2014
Maureen G. Phipps, MD, MPH
Obstetrician & Gynecologist In Chief

Date: 4/7/14
James A. O'Brien, MD
Medical Director, InPatient Obstetrics

Date: 4/8/14
James F. Padbury, MD
Pediatrician In Chief

We've been talking about the new arena of health care for a long time – how on a national level the Accountable Care Act has shifted the industry's focus from treating patients in hospitals when they are sick to a more population-centric system that emphasizes primary care and other services in an outpatient setting. This trend is forcing health care facilities and systems to redefine themselves as the industry as a whole is made more streamlined, nimble and responsive to the needs of the people we serve.

That is where Care New England finds itself today – at the precipice of redefining how we deliver care at one of our operating units, Memorial Hospital, against the national landscape of change and what experts say is a 200-bed surplus of hospital beds in Rhode Island.

From the moment we affiliated with Memorial in 2013, we attempted to execute a thoughtful plan to improve the dire financial situation that existed there. We invested millions of dollars in upgrades to the physical plant and IT systems, and hiring new doctors. Yet, the situation has only worsened. We now believe that to continue to invest the system's very scarce dollars into the hospital as it is – while continuing to jockey for a dwindling inpatient market share with competitors on both sides - is not sound business strategy.

It is time to make significant changes to create a sustainable model of care at Memorial so we can continue to serve our community there in new and meaningful ways while maintaining the ongoing viability of the system as a whole.

These changes, approved at the February 26, 2016 Board meeting, will go into effect on April 4, 2016. They include:

- Transferring certain Memorial services to other CNE affiliates.
    - Obstetrical services will move to Kent and Women & Infants hospitals.
    - Medical/surgical and ICU units will be consolidated into the existing units at Kent.
- Eliminating duplicative positions across the system, which will result in approximately XXX layoffs.
- Consolidating lab services across the system.
- Eliminating all unfunded research programs system-wide.
- Moving Memorial's Internal Medicine Residency Program to Kent for access to the medical/surgical and ICU units.

It's important to note that these are only a fraction of the services offered at Memorial, which will remain open to serve its community in a newly defined way. The Board and senior leadership feel strongly that the system maintain a presence in northern Rhode Island, offering the programs and services Memorial does best. These include:

- Family medicine, including its residency program.
- Primary care practices, both family and internal medicine.
- Emergency Department, supported by a small in-patient unit.
- Operating room with support from the same in-patient unit.
- Center for Rehabilitation for inpatient care, as well as an outpatient clinic.

- Outpatient specialty services such as pulmonary and sleep medicine, nutrition, cardiology, The Cancer Center, The Endoscopy Center, New England Pediatric Institute of Neurodevelopment, and clinics for dermatology, cardiology, gastroenterology, rheumatology and X.

We know that change of this magnitude can be frightening. Memorial has a rich legacy of providing health care and many employees have worked there for decades. But the only way to stay relevant – and keep the doors open – is to be able to adapt to the needs of the health care environment. We hope that even in the face of fear, you can understand that and support the decisions we've outlined.

As we move forward with these changes, we promise to keep you informed through Town Hall meetings, all-user emails and by putting information on carenet. You can also reach out to XXXX with any questions you have at extension XXXX or XXX@carene.org.

Thank you for your ongoing commitment to the health and well-being of the people in our community.

Sincerely,

Dennis D. Keefe
President and CEO
Care New England

Care New England

TO: Care New England Staff
FROM: Dennis D. Keefe, President and CEO
DATE: February 29, 2016
SUBJECT: Memorial restructuring

As you know, Care New England has been engaged in an ongoing effort to redefine the way we deliver health care in order to meet the demands of an industry that is becoming more streamlined, nimble and responsive to patients. Today, we must make some very hard decisions that are designed to help right-size our organization in order to operate more effectively and efficiently so we are able to continue to provide quality health care to all Rhode Islanders.

From the moment that Care New England affiliated with Memorial Hospital in 2013, we attempted to execute a thoughtful plan to improve its dire financial situation. However, despite our collective best efforts and the investment of millions of dollars, the situation has not improved substantially. Memorial continues to struggle with declining inpatient volume, increasing competition and diminishing reimbursement rates.

These factors become more challenging in combination with the implementation of the Affordable Care Act of 2010, in which the traditional inpatient model of care has shifted to one that emphasizes primary care and outpatient services. This trend is forcing all health care facilities and systems, including Care New England, to reimagine how they deliver services and be more responsive to the needs of the people we serve.

That is where Care New England finds itself today – at the precipice of redefining how we deliver care at Memorial Hospital. So, it is time to make significant changes in order to create a sustainable model of care at Memorial. Though these changes are difficult, they are being made so Memorial can continue to serve its community in new and meaningful ways while maintaining the ongoing viability of the system as a whole.

These changes, which were approved at the February 26, 2016, CNE Board meeting, include:

- Transferring certain Memorial services to other CNE affiliates pending the required regulatory approvals:
  - Obstetrical services will move to Kent or Women & Infants hospitals.
  - Medical/surgical and ICU units will be consolidated into the existing units at Kent, with the exception of inpatient elective orthopedics and outpatient surgical patients who require an overnight stay.
- Moving the location of inpatient education for Memorial's Internal Medicine Residency Program to the Kent campus and continuing at the Providence VA Hospital.

Changes that will be made throughout the system include:

- Consolidating lab services.

- Eliminating duplicative positions, which will result in an undetermined number of layoffs.

Work on the restructuring plan begins immediately, and it will take several months to complete.

It's important to note that the changes at Memorial affect only a fraction of the services offered at the hospital. Memorial will remain open, serving its community in a newly defined way. The CNE Board and senior leadership feel strongly that the system should maintain a presence in northern Rhode Island and that Memorial should continue to offer the programs and services it does best.

These exemplary programs include:

- Family medicine, including its residency program.
- Primary care practices, both family and internal medicine.
- Emergency Department, supported by a small, in-patient unit.
- Operating room for orthopedic and outpatient surgery with support from the same in-patient unit.
- Center for Rehabilitation for inpatient care, as well as an outpatient clinic.
- Outpatient specialty services such as:
    - Pulmonary and sleep medicine
    - Nutrition
    - Cardiology
    - The Cancer Center
    - The Endoscopy Center
    - The New England Pediatric Institute of Neurodevelopment
    - Clinics for dermatology, cardiology, gastroenterology, geriatrics and rheumatology

We understand that change of this magnitude can be difficult. Memorial has a rich and deep legacy of meeting the health care needs of the people of northern Rhode Island and many employees have worked there for decades. However, the only way for Memorial to overcome these challenges is to adjust its service model. We hope that, in the face of this news, you will understand the realities of where Memorial has found itself and the critical importance of these changes.

As we move forward, be assured that CNE will keep you informed through Town Hall meetings, all-user emails and by putting information on **care**net. You can also reach out to your supervisor with your questions, and we will do our best to be responsive.

Thank you for your ongoing commitment to the health and well-being of the people in our communities.

Memorial Hospital Discussion with City and State Officials

Memorial Hospital Restructuring

4 March 2016
0800 – 0930
Sayles 1

Agenda

Call to order and opening comments	Mayor Grebien
Opening remarks	Dennis Keefe
Introductions	All
Memorial Hospital	Dr. Michael Dacey (20 min)

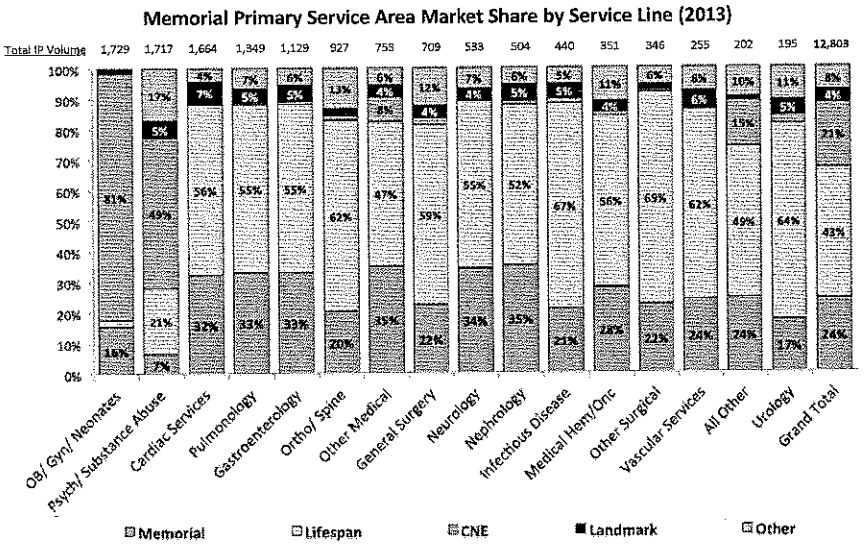
- Status prior to entering Care New England
- Utilization trends over past several years
- Financial performance
- Changes/investments made by CNE over past 3 years
- Re-organization plan
- Quality of care

Open discussion and questions	All (60 min)

Memorial Prior to CNE

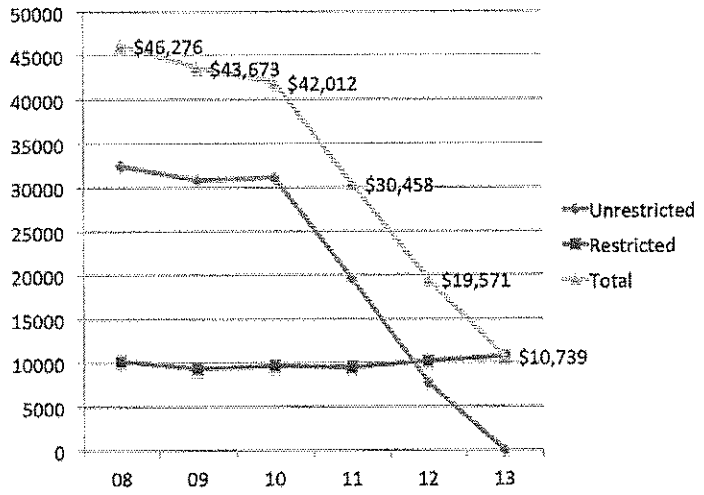
- Long reputation of service to the community and Brown affiliation were assets to MHRI for many years
- MHRI struggled mightily financially from 2008 until late 2013 when it became part of CNE
- Prior to joining CNE, MHRI was forced to spend most of its cash and unrestricted endowment to fund growing operating losses due to increased local competition
- Volumes in all areas showed a steady decline from the late 2000's onward
  - Competition from Lifespan (primarily Miriam but also RIH)
  - Loss of community based physicians to retirement or competition
  - Academic campus based practices unable to replace this shortfall in patient volume
  - Loss of specialty services such as orthopedics, urology, surgery and cardiology

Memorial Is Not Near 50% In Any Service Line In Its Own PSA



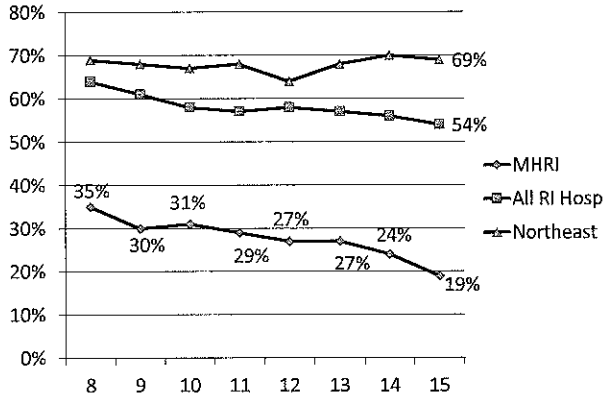
Source: Rhode Island Hospital data provided by CNE team

MHRI Endowment Assets ($000's)

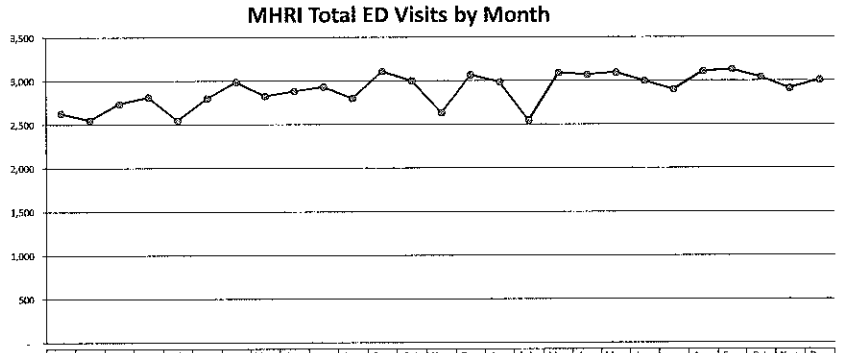


Volume and Utilization Trends

MHRI Occupancy *



* Based upon licensed beds



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
ED Visits	2,63	2,55	2,74	2,81	2,55	2,80	2,98	2,82	2,88	2,93	2,80	3,10	3,00	2,63	3,06	2,98	2,54	3,09	3,07	3,09	2,99	2,90	3,11	3,12	3,04	2,91	3,00

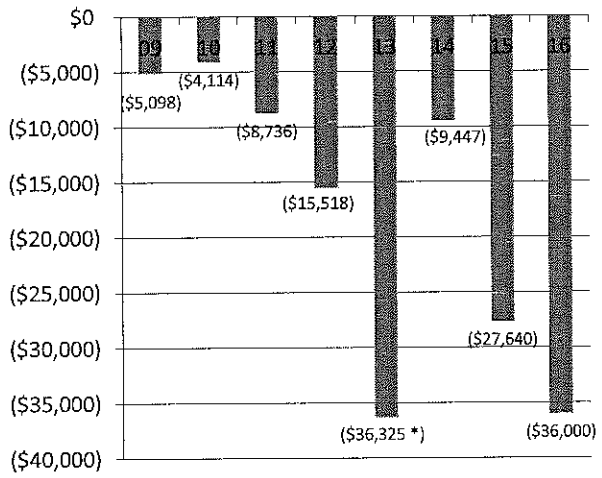
Includes IP and OP

Why Decline in Admissions?

- National trend --- 25% decrease over past 8 years
  - Newer outpatient treatments
  - Fewer readmissions to hospitals
  - Preventive care becoming effective
- Local competition intense
  - Arrival of for-profit hospitals in RI in areas around MHRI
    - Very aggressive at recruiting physician practices from local RI communities
  - Non-profits such as Miriam close to MHRI

Financial Performance

MHRI Operating Loss ($000's)



* 2016 Projected

Relationship Between Patient Volume and Clinical Quality

Care New England Investments in Memorial Since 2013

- Operating losses
- New inpatient electronic medical record system
- New outpatient electronic medical record system
- Pension funding
- New heating system for main hospital
- New radiology information system
- Numerous other capital items
- Physician recruitments

Total investments in excess of $120 million

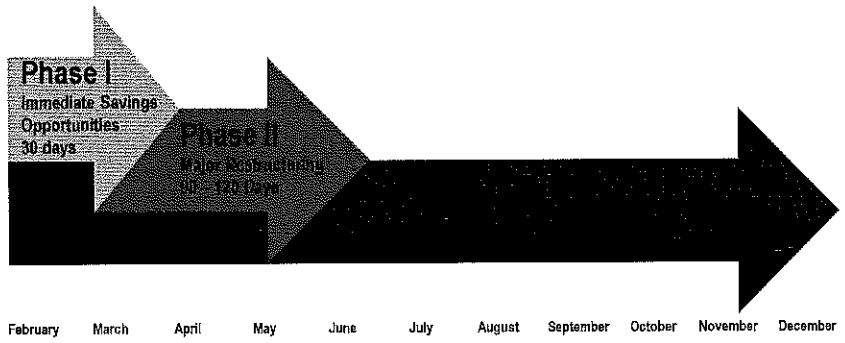
CNE HIRES INTO MHRI SINCE MHRI ACQUIRED

PHYSICIAN	SPECIALTY
1. Dino Messina	Medicine
2. Eduardo Cordova	General Surgery
3. Nicole Greenwood	Pediatrics
4. Zsolt Orban	Endocrinology
5. Carolinia Fonseca Valencia	Internal Medicine
6. Valeria Fabre	Internal Medicine
7. Nicole Siegert	Family Medicine
8. Kamran Manzoor	Pulmonary
9. Rene Goyal	General Surgery
10. Guy Nicastri	General Surgery
11. Ashish Shah	Cardiology
12. Victor Pinkas	Emergency Medicine
13. Laura Forman	Emergency Medicine
14. Katie Chapman	Emergency Medicine
15. Nicole Coleman	Emergency Medicine
16. Robert Shalvoy	Orthopedics
17. Richard Peloquin	Orthopedics
18. Razib Khaund	Internal Medicine
19. David Bica	Family Medicine
20. Andrew Tompkins	Urology (via 21st Century JV)
21. Joe Cambio Jr.	Urology (via 21st Century JV)
22. Angelo Cambio	Urology (via 21st Century JV)
23. Peter Gill	General Surgery
24. Christine Emmick	General Surgery
25. Marty Phillips	General Surgery
26. Jennifer Buckley	Family Medicine
27. Kate McCleary	Family Medicine

Memorial Restructuring Plan

Re-Purposing Plan Timeline

The MHRI re-purposing plan is a three-phase sequential approach where Phase I addresses immediate savings through facility, clinical service, and labor adjustments:



16

Major Elements of Phase II Restructuring

- 24/7 emergency department
- 10 bed observation unit
- 8 bed inpatient orthopedic unit for elective surgery
- Full outpatient surgery offerings
- Primary care and specialty outpatient clinics
- Inpatient rehabilitation unit
- Cancer center
- Infusion unit
- Obstetrical services transferred to W&I and Kent
- Two medical units consolidated into the above units
- ICU patients no longer cared for at Memorial
- Enhanced transportation services

Discussion and Questions

PUBLIC HEARING RELATED TO THE CLOSURE OF THE MEMORIAL HOSPITAL OBSTETRICAL UNIT
MARCH 14, 2016
ANGELLEEN PETERS-LEWIS, RN, PHD, CHIEF NURSING OFFICER, CARE NEW ENGLAND

Thank you for the opportunity to offer comments about the planned relocation of the obstetric unit at Memorial Hospital. My name is Angelleen Peters-Lewis, and I am the Chief Nursing Officer for Care New England. I am speaking on behalf the leadership of Memorial Hospital and Care New England. I am joined here by a number of Care New England Board members, executives and clinicians.

We realize this is a highly charged, emotional issue for the staff of the Memorial birthing service and its patient supporters. There is nothing that we would want more than to satisfy this call for the status quo at Memorial, but, sadly, we do not feel circumstances at Care New England allow this, nor do the conditions of our overall health care environment in Rhode Island where we know that there is an excess capacity of obstetric beds.

We at Care New England must weigh heartfelt and factual considerations. Yet, in the end, we believe we must follow a rational course that addresses the volume trends, the best standard of care, and the financial viability of sustaining the Memorial unit. All three of these areas are of critical importance to us, but none more so than our obligation to provide the highest possible quality of care to our patients.

First and foremost, we'd like to be clear, that in spite of the serious financial losses we have experienced, it remains our goal to keep a strong, but restructured Memorial Hospital serving the primary and outlying community. This includes an emergency room, a wide assortment of primary care and specialty services, orthopedic and outpatient surgical services, rehabilitation services and a small inpatient unit. This plan is in keeping with the goals of the Affordable Care Act and the principles of population health that force us to confront hard realities and redefine services in response to the true needs of the community. In our analysis, we were forced to take a hard look at the Memorial obstetric service.

The unit at Memorial, because of its geographic position, the socio-economic status of the population, and its appeal to those interested in a less interventional birth experience, represents a diverse universe of patients with a diverse set of needs. To serve the needs of these families and provide every opportunity for the healthiest possible birth outcome, the standard of care requires that we avail the mother and her newborn with the full array of services to assure a safe delivery. This means round-the-clock availability of fully trained and experienced obstetricians, 24-7 anesthesia coverage, and access to expert pediatricians who can treat a distressed baby in the event of a complicated delivery or newborn distress. Not all of these supports currently exist at Memorial.

Let's think about the size of our state and the fact that there are several obstetric services within 15 miles of the Memorial obstetric program, two of which reside within Care New England. In a general context, duplicating costly infrastructure, staff and support services is not

wise either from an economic or public policy standpoint. Duplicating services is particularly unwise for Care New England in that we are grappling with serious financial challenges at Memorial and across our health care system and we are already supporting two other high quality, high volume maternity programs. The choice for us was apparent: maintain the emergency room and other valuable primary care services and seek to relocate the obstetric program to Women & Infants Hospital, a national center of excellence in maternity care, and to Kent Hospital, a high quality community hospital known for its warm and personal women's care unit.

Further, as we work to reduce the footprint of Memorial's inpatient services, our concerns about the intrinsic link between volume and quality grow. It is well known, that the more you do something, the better you are. As we evaluated the future of the Memorial unit, we had to consider that a service with approximately 400 births was at the margins of viability not only in terms of economics, but also in terms of patient safety.

Clearly, as we have been reminded in recent days, there are undeniable strengths of the Memorial maternity program, not the least among these is a high level of patient satisfaction and patient loyalty. It is useful to keep in mind that we are nearing completion of the providers obtaining privileges at our other Care New England hospitals, so that if and when we receive approval on our plan, we will be ready. We hope that essence of the Memorial service is less about a place than it is about a philosophy of care and a personal approach to the patient and her family.

In addition, we believe we can go further in our community eliminating racial health disparities. Our commitment to undertake the journey to become a Baby Friendly organization at Women & Infants was grounded in the goal of raising the standard of care for all mothers and mitigating health disparities for the diverse populations we serve. If we are allowed to make this transition, we feel all members of the community will be well served.

We do not pretend to know it all. While Women & Infants is one of the leaders in the world advancing knowledge about the medical science of obstetrics, gynecology and newborn pediatrics, we know we can learn much by listening to the Memorial staff and to its patient community. We will continue to engage with our Memorial colleagues, and we are pleased that we had a very successful meet-and-greet and orientation session for the clinical staff. We will also continue to reach out to the advocates to begin a good faith effort to better understand their needs.

One way we have engaged with our community is through regular forums with patient and family advisory committees where we meet to share information and learn directly from our consumers about how we can enhance their experience. We invite members of the Memorial patient community to join with us and help us continue to strengthen and enhance the patient experience at our hospitals.

We all truly care about providing our patients a safe and happy birth experience. We will do everything possible to honor the trust that patients and families have placed in the Memorial program - and work our hardest to fulfill their expectations.

Thank you again for this opportunity to comment.

-x-

PUBLIC HEARING RELATED TO THE CLOSURE OF THE MEMORIAL HOSPITAL OBSTETRICAL UNIT
WOODLAWN COMMUNITY CENTER
MARCH 16, 2016
ANGELLEEN PETERS-LEWIS, RN, PHD, CHIEF NURSING OFFICER, CARE NEW ENGLAND

My name is Angelleen Peters-Lewis, Chief Nursing Officer for Care New England. In addition to the testimony I provided at the March 14 public hearing, I'd like to offer some brief comments in response to some of the concerns raised by the community.

First, we very much appreciate the strong loyalty and tremendous value so many have placed in the Memorial program. We certainly understand that the culture of care that was built over the years by the dedicated staff of Memorial's maternity service cannot be easily replicated. If our plan is approved, we are committed to transitioning the physician and provider staff and building on the foundation of the Memorial program. With this commitment comes our full support of patient and family-centered care – certainly this is not something that is new to us at Kent or at Women & Infants. For well over three decades, Women & Infants has offered midwife-assisted delivery, advanced new approaches to childbirth education, sponsored a free community WarmLine and four Centers for Health Education, in addition to being a worldwide leader and innovator in pioneering obstetrical, gynecologic and neonatal diagnoses and treatments. This hospital is a truly a national center of excellence and a valuable statewide resource.

For the public record and for those who may not have knowledge or recent experience with our other obstetrical services, please allow me to clarify a few points.

Patient and family-centered care: Both Women & Infants and Kent encourage rooming-in, skin-to-skin care and help mothers initiate breastfeeding within one hour of birth. In fulfilling all ten steps embraced by the World Health Organization toward Successful Breastfeeding, Women & Infants was named a Baby Friendly hospital. It is only the second hospital of its birth volume to receive such a significant honor nationally.

VBAC: Both Kent and Women & Infants support Vaginal Birth after Cesarean. Our VBAC rate at Women & Infants is xx percent which compares most favorably with the rate of xx percent at comparable perinatal centers. The VBAC rate at Memorial is xx percent.

Patient demographics of Memorial obstetric service: Approximately xx percent of the communities of Pawtucket and Central Falls now deliver their newborns at Women & Infants Hospital. In the current profile of second and third trimester pregnant women due to deliver at Memorial, 62 percent come from outside of the immediate area, mostly from outlying suburbs.

Transportation for patients in need: Care New England has committed to provide ambulance transportation to any maternity patient in need who shows up in the Memorial Emergency Department. We are also committed to working out a transportation plan for routine travel from Pawtucket to Women & Infants [?and Kent] in order to assure access to needed care.

Continuity of care: All Memorial obstetric may continue to receive their prenatal and postnatal care [?and their childbirth education] at Memorial. As their providers are in the process of becoming credentialed at Kent and Women & Infants, following approval of our plan, patients may choose to follow their doctors to one of the other Care New England facilities or we will facilitate a smooth transition to another obstetric hospital of their choice. Should they remain with Care New England, they should be assured that, because of our common information technology, their full medical record is readily accessible at any of our locations.

Again, we hope to work with the advocates to better understand their needs and do all we can to help assure them a positive birthing experience. We invite members of the Memorial patient community to meet with us and help us continue to strengthen and enhance the patient experience for all women at our hospitals.

Thank you again for this opportunity to comment.

-x-

Care New England

Dear Mom-to-Be,

I am writing to provide some information about your upcoming delivery. I know that you had planned to deliver your baby at Memorial Hospital, and we are sorry that these plans need to change at this point in your pregnancy. We will do everything we can to make this transition in your care as seamless and comfortable as possible.

In the next few weeks, you and your physician or midwife will need to decide together at which hospital you will deliver. Please know that the entire team at Care New England and at Kent and Women & Infants hospitals is here for you – to help you through the remainder of your pregnancy, to ease your labor and delivery, and to ensure that you and your baby get the healthiest start together.

To help make your decision, I encourage you to visit our Women & Infants (www.womenandinfants.org) and Kent Hospital (www.kentri.org) websites to learn more about our birthing services. Of course, you may also schedule a tour of either or both hospitals – call Women & Infants' Health Education at (401) 276-7800 or Kent Hospital's Labor and Delivery Unit at (401) 737-7010, ext. 31281 – we have made special arrangements so that you may be oriented to the hospital of your choice. You may also call the numbers listed for either hospital if you would like to receive a prenatal packet of information mailed to your home.

We know how important it is to support your birth preferences while maintaining a safe outcome and positive experience for you and your baby. Please take some time to fill out the enclosed birth worksheet with your birth partner and review it with your doctor or midwife during an upcoming prenatal visit. Please bring a copy of this worksheet with you to the hospital and give it to your labor nurse. We want to help make your birthing experience the best that it can possibly be.

I wish you congratulations on your pregnancy and offer you my personal assurance that our staff will be very attentive to you and your needs. Our goal is to meet your expectations and provide an emotionally satisfying and physically safe birth experience.

Sincerely,

Angelleen Peters-Lewis, RN, PhD
Chief Nursing Officer

CNE Op Ed – Providence Journal Version
Draft 2, 762 words (not including headline); Providence Journal maximum op ed length: 700 words

CHANGES AT MEMORIAL HOSPITAL ARE CRITICAL TO THE DELIVERY OF QUALITY HEALTH CARE

Difficult decisions are rarely popular and are often a challenge to fully comprehend. The recent announcement on the changes to service offerings at Care New England's Memorial Hospital in Pawtucket has raised many questions. All of them are valid. Not all of them are easily addressed as the issues that led to the determination to relocate Memorial's obstetrical unit, move its intensive care unit (ICU) and decrease the number of inpatient beds are complex and intertwined.

It's important as leaders in Rhode Island's health care system that we balance our assessments with both rational and heartfelt considerations. That is how the choices were made to best restructure Memorial and uphold our commitment to provide the right care, in the right place, at the right time – delivered to achieve high quality outcomes. These are not just words. This is the mandate of our health care organization.

Of particular concern recently is the relocation of Memorial's obstetric services. This decision was based on a thorough examination of volume trends, best standard clinical practices and the financial viability of sustaining the unit at Memorial. All three of these areas are important, but none more so than our obligation to provide the highest possible quality of care to our patients.

The service at Memorial has been referred to as a birth center. This, in fact, is a misnomer. A birth center is a specialized program with strict guidelines for ruling out patients for whom risk exists. The unit at Memorial, because of its geographic position, the socio-economic status of the population, and its appeal to a small cohort of natural birth advocates, represents a diverse universe of patients with a diverse set of needs. How do we best serve these families?

Considering that approximately 30 percent of births deemed no- or low-risk ultimately result in some type of unexpected complication, both medical expertise and common sense would suggest that you avail that mother and her newborn every possible opportunity for a safe delivery and a healthy baby. This means round-the-clock availability of fully trained and experienced obstetricians, 24-7 anesthesia coverage, and access to expert pediatricians who can be resuscitate the newborn in the event of a complicated delivery.

Enter the quandary for Care New England. As we grapple with a hospital whose flagging economics threatens the financial viability of an entire network of care, we know it is not wise or possible to maintain the full gamut of infrastructure, staff and support services for three obstetrical services less than 15 miles apart. Indeed, as we examined our choices, there was a compelling internal imperative to consolidate service and the external business reality that there is already excess capacity of obstetrical

beds in Rhode Island. We decided to relocate the Memorial service to our Providence obstetric flagship hospital and, to the south, our Warwick hospital.

It is not like we are leaving the community with poor choices. Women & Infants is recognized as one of the largest and most respected premier obstetric services across the globe, offering the full spectrum of options and specialty supports for low-risk pregnancy, high-risk pregnancy and for those with underlying medical complications. Kent Hospital offers a high-quality program with a well-established neonatal service staffed by Women & Infants neonatologists that is known for its community hospital atmosphere and its warm personal touch.

We know our decision in not uniformly popular. Indeed, the patient champions of the Memorial hospital maternity service rightly bring their case to the public discourse. We respect and admire their advocacy and their passion, and, with all of our hearts, we wish we could respond to their needs and wants with the preservation of a service they love. Unfortunately, the era of affordable care does not permit any hospital to maintain a duplicative service that no longer fulfills the public good with high quality and reasonable cost.

All of this means we must also be courageous and decisive in our decision-making - not for ourselves, but for those we serve. We are not giving up on Memorial, its staff, or our patients – quite the contrary. We're focusing our services to deliver high-quality care through a restructured program that best meets the needs of the neighborhood, the broader community and our entire region.

Meanwhile we are reaching out to the advocates to fully engage with them so that they can better understand our position - and we theirs. We believe we can offer them a birth experience that is at once medically safe and emotionally satisfying and gives their newborn baby the best opportunity for the healthiest start in life.

Care New England

March 29, 2016

Dear Care New England Staff:

As we have been reporting, Care New England has been grappling with some very challenging financial problems. In response, we have been working diligently to institute a variety of measures, including increased revenue generation, revenue cycle and supply chain improvements, and a wide array of expense management initiatives both in salary and non-salary areas.

Despite our focused efforts over the last six months, we still face unsustainable operating losses at Memorial Hospital and uneven results across our other operating units. Without significant improvement, we believe that our very mission across all of Care New England is now threatened.

Accordingly, we must take the painful step today of reducing our workforce by 58 positions, with the majority of these coming from Memorial Hospital in areas unrelated to the proposed restructuring plan. The remaining positions are from across all of our operating units where we have been working to improve efficiency or to consolidate across one or more of our organizations.

It has always been our goal to do everything possible to avoid these layoffs and to minimize the need for a greater number of workforce reductions. Yet, with labor representing 70 percent of expense in health care, it is challenging to reduce costs without touching people. Regrettably this is the position where we find ourselves today.

We realize this is extremely painful for all involved. We will be working with Care New England Human Resources and holding a job fair for the affected individuals and providing information about other job opportunities available at the system or organizational level as well as about support services available.

We also know that the hard work of expense management will need to continue here for some time. We ask for your support and understanding, knowing that we will ultimately get through this and emerge on the other side as stronger organizations.

Sincerely,

Dennis D. Keefe
President and CEO

KENT COUNTY MEMORIAL HOSPITAL

PRIVILEGE REQUEST FORM

PRACTICE AREA: NURSE MIDWIFE

To be eligible to use this form to request clinical privileges, the following minimum threshold criteria must be met:

1. Basic Education: B.S. in Nursing or R.N. with a minimum of 3 years obstetrical nursing experience.

2. Minimal formal training: Successful completion of a postgraduate educational program in Nurse Midwifery approved by the American College of Nurse Midwives or ACNM Certification Council. Certification by CNMN Certificate Council.

3. Required previous experience: The successful applicant must be able to demonstrate that he/she has performed at least 50 uncomplicated vaginal deliveries during the past 24 months (maternity leave excepted).

If you meet the criteria above, you may request privileges as specified below. Any special requests you make will be considered only if you meet the threshold criteria for each request.

I hereby request core NURSE MIDWIFERY privileges as follows:

The management of normal obstetrical care throughout the maternity cycle in association with a physician. Included in this core of privileges are the evaluation of labor status, the evaluation of the status of membranes, admission and management of an uncomplicated patient in labor, providing appropriate pain relief and performing the appropriate examinations related to a normal vaginal delivery and everything that is included in the attached **Midwifery Service Protocol**.

Special requests in this practice:

_____

_____

_____

I understand that in making this request I am bound by the applicable bylaws or policies of the hospital and medical staff and hereby stipulate that I meet the threshold criteria for each request.

CNM Signature_____ Date_____

Privileges:
a) Recommended _____
b) Not Recommended _____
c) Recommended as Modified _____

Chief's Signature_____ Date_____

CNO Signature_____ Date_____

word:h:\privileges\nurse midwife.doc
(Revised 11/94)

MIDWIFERY SERVICE PROTOCOL

INTRODUCTION:

Kent County Memorial Hospital located in Warwick, Rhode Island is a progressive facility which strives to integrate scientific advances and consumer demands into high quality care for the community it services.

One link in this chain of community care is the utilization of the skills of a licensed midwife. Through the midwife's role in client management and education during the childbearing cycle she is expected to make a valuable contribution to the health care team's efforts.

Midwifery practice is the care of essentially normal women and newborns during the childbearing cycle which includes the areas of antepartum, intrapartum, post-partum and well-woman gynecology. This practice is regulated by state licensure, the American College of Nurse-Midwives and the following midwifery protocols. Within these parameters, the midwife may independently manage the care for her client and her family. If the management goes outside that of normal, consultation and collaborative management will be sought with the physician or referral to the physician with the midwife present to provide continuity of care and support for the client.

PHILOSOPHY AND OBJECTIVES:

Midwifery is a service to clients and their families during the childbearing year and is directed toward the promotion and maintenance of health and general well-being. It is based on the concept that the midwife, because of her educational preparation and involvement in all areas of the maternity cycle, can offer the client and her family highly personalized care.

The midwife, in keeping with the philosophy of Kent County Memorial Hospital, is committed to the concept of a single class of health care for all. The objectives of the service include continuity of educational supports, guidance to the expectant parents, and emotional support of the woman through all phases of the childbearing year. This kind of direct care from the same individuals encourages a more comprehensive and supportive follow-through of each patient's medical, educational and emotional needs.

In addition, the midwifery philosophy promotes the principles of family-centered maternity care as adopted by the medical, administrative and nursing staffs of Kent County Memorial Hospital.

STATEMENT OF RESPONSIBILITIES:

All midwives granted privileges according to the Bylaws at Kent County Memorial Hospital will function in accordance with the Midwifery Service Protocol which has been approved by the Department of Obstetrics and Gynecology. The protocol acts as a guide in individualizing the care of clients and defines the limits of midwifery management. The protocol will be reviewed annually by a representative of the midwives currently holding privileges, her physician consultant and the current Chief of the OB/GYN Department.

The midwife will assume responsibility for the management of the medically-uncomplicated client as defined by the Department of OB/GYN at Kent County Memorial Hospital and her consultant physician. In the course of the patient management, the midwife will report any deviation from established criteria to the consultant physician who has ultimate responsibility for the patient care.

Physicians employing or associating with midwives shall hold Class 1 privileges in the Department of OB/GYN at Kent County Memorial Hospital. The midwife will render services in accordance with the Policies and Procedures as established by the Department of OB/GYN and will not have admitting privileges. Privileges will be terminated if a midwife leaves the employment of her consultant physician.

STATEMENT REGARDING MIDWIFERY ORDERS:

Any order by a midwife, if written according to and within the listings of the approved Midwifery Orders (as described in the Midwifery Protocol) will receive the same attention by the nursing staff as if written by a staff physician. Any order not within this listing must be obtained from a staff physician first by a nurse or the midwife before the nurse is expected to carry out the order.

REQUIREMENTS FOR PRACTICE:

1. Current certification by the American College of Nurse-Midwives or ACNM Certification Council.
2. Rhode Island Midwifery License
3. Medical Staff appointment
4. Liability insurance consistent with the Rules and Regulations of the Medical Staff

The credentials of the midwives seeking appointment to the staff must be submitted to the Medical Staff Credentials Committee.

CLINICAL RESPONSIBILITIES:

A. ANTEPARTUM SERVICE:

All midwives with privileges will be expected to provide antenatal care according to protocols jointly developed by the midwife and the consultant physician. These protocols should be based upon and be reflective of the Guidelines and Standards established by the American College of Nurse-Midwives (ACNM) and the American College of Obstetricians and Gynecologists (ACOG).

All midwives will observe the routine antepartum standing examination and treatment protocols as outlined in the Medical Policy and Procedure manual including:

NEW PATIENT:

1. Interview and History
    a. medical history
    b. surgical history
    c. previous obstetrical history
    d. menstrual history, including LMP
    e. previous contraceptive history
    f. family history (parents, siblings and other first or second degree relatives)
    g. patient's attitude toward pregnancy and sense of well being
    h. desire to attend prepared childbirth classes
    i. expected method of infant feeding

2. Physical Examination:
   a. assesses general condition of client, noting appearance and manner of motion, gross physical abnormalities, skin, hair growth pattern, eyes, teeth, neck for masses and legs for varicosities and edema, BP determination
   b. palpates breasts, noting size, shape and consistency of breast masses and colostrum
   c. heart and lung evaluation
   d. abdominal evaluation for presentation and position of the fetus, FHR location, EFW
   e. pelvic examination:
      visual examination of the external genitalia, pubic hair growth pattern and presence of varicosities, speculum examination for visualization of vaginal discharge, taking of Pap smear and GC cultures, noting changes in the area of the Bartholins glands and/or exudate from the Skene's glands, evaluating the tone of musculature of the pelvis, bimanual palpation of the pelvic organs, evaluation of the size, shape and position of the uterus, clinical examination of the bony pelvis, rectal examination and GC culture

3. Diagnostic Testing:
   a. any/all baseline diagnostic laboratory studies appropriate in the evaluation of the client's condition including but not limited to CBC, UA/C&S.
   b. in addition the midwife may also order ultrasound testing, non-stress testing, glucose-tolerance testing, x-rays and serum estriol levels.

4. Health supervision and education on an individual basis.

5. Medical specialty referral after appropriate consultation with the physician.

6. Interdisciplinary referrals including nutrition, social service and VNA referrals may be initiated by the attending midwife.

B. INTRAPARTUM SERVICE:

Policies:

All midwives at Kent County Memorial Hospital will observe the routine intrapartum pre-printed orders as outlined in the Medical Policy and Procedure manual.

The midwife will examine and attend only clients from her own practice who are in labor. All other patients will be examined and admitted by the responsible physician or his/her designee.

I. Criteria for Selecting Clients for Midwifery Management in Labor/Delivery:

1. Clients who have been attended by the midwife during the antenatal period.

2. Clients who have co-existing medical conditions and whose obstetrical history is negative may be designated by the consultant physician for co-management status with the attending midwife.

II. Labor/Delivery Requirements:

1. The attending midwife assumes the responsibility for the management of the medically-uncomplicated patient throughout the labor/birth process.

2. The midwife will consult with the responsible physician whenever there are any deviations from the normal during labor, birth or the immediate post-partum period.

3. Clients requiring oxytocin induction/augmentation or epidural anesthesia may be managed by the midwife provided that her physician consultant is in the hospital or in his/her office in accordance with the established OB/GYN Department policies and procedures.

4. The physician consultant shall be on the hospital grounds at the time of the anticipated delivery.

5. The midwife may do whatever emergency measures are indicated until the consultant arrives, including but not limited to manual exploration of the uterus and manual removal of the placenta.

III. Admitting Procedure:

1. Take and record client history.
2. Perform and record physical findings.
3. Initiate appropriate orders.
4. Report abnormal findings to the consultant physician when appropriate.

IV. Management and Support of the Client:

1. Continuous assessment of the labor progress, noting physical, psychosocial reactions and diagnostic results.
2. Amniotomy when indicated.
3. Medication order when indicated.
4. Vaginal examinations when indicated.
5. Supportive breathing and relaxation techniques utilized through the labor/birth process.
6. Application of the internal FECG or IUPC as is deemed necessary by the attending midwife.

V. Anesthesia by the Midwife:

1. Local infiltration of the perineum or vaginal tissues.
2. The midwife will not give pudendal blocks.
3. The midwife may request the Anesthesia Department to report to the LDR for client assessment and management. Epidural/general anesthesia and/or saddle block anesthesia may not be administered unless the consultant physician is present in the LDR.

VI. Episiotomy:

1. Median or medio-lateral episiotomies may be performed by the midwife.

2. The physician must be consulted for all 3rd and 4th degree lacerations. He/she may elect to repair the laceration until it qualifies as a 2nd degree and then allow the midwife to complete the repair. An experienced midwife may defer consultation for a 3rd degree laceration with a letter from the physician consultant confirming adeptness at repair of 3rd degree lacerations.

VII. Delivery:

1. Normal spontaneous vaginal deliveries may be performed by the midwife.
2. With vacuum extractions, once MD has facilitated delivery of the vertex, midwife may complete birth.

Third Stage:

1. Delivery and examination of placenta, membranes and cord vessels.
2. Order oxytocic medications per approved orders.
3. Inspection of introitus, vagina, cervix and perineum for lacerations.
4. Repair of lacerations/episiotomy as indicated.

Newborn:

1. The midwife will notify the pediatrician and her physician consultant if there are any indications for or anticipation of fetal asphyxia.

2. Clear airway by suction and gentle tactile stimulation.

3. Promote establishment of ventilation by positive airway pressure with face mask when such measures are necessary but only when a physician to perform such measures is unavailable.

4. Initial screening and appraisal of newborn.

5. Completion of birth certificate, including signature.

Fourth Stage:

1. Assess fundal height, lochia, bladder status and vital signs prior to the midwife leaving the LDR area.

2. Complete charting and documentation in the progress notes and midwifery log.

3. The midwife will report to the consultant physician any unusual findings, complications and/or if additional medications are necessary.

Postpartum Management:

1. The midwife assumes the responsibility for the management of the medically uncomplicated client in the postpartum period. This includes daily postpartum rounds, charting in the progress notes area and the writing of orders as needed to facilitate the provision of care.

2. Under the direction of the physician consultant, the midwife may provide postpartum care to the high-risk postpartum client who has been followed by the midwife during the antepartum/intrapartum period.

3. The midwife will consult with the physician whenever there are deviations from the normal during the postpartum hospital stay.

4. The midwife may initiate any medication, treatment or procedure that is within the approved postpartum protocols or listed under postpartum medication orders.

5. The midwife will coordinate client discharge to appropriate community agencies as indicated.

APPENDIX A

Approved Intrapartum Medication Orders:

Meperidene (Demerol)
IM up to 100 mgs. Q 3-4 hrs.
IV not to exceed 25 mgs. Per IV dose

Stadol
IM 2 / 4 mgs IM q 3-4 hrs.
IVP 1 or 2 mgs. q 2 hrs.

Vistaril
IM up to 100 mgs. in single or divided doses q 3-4 hrs.
PO up to 100 mgs. in single or divided doses q 6-8 hrs. – prn

Secobarbital
100-200 mg. po for sedation in prodromal labor

Promethazine – Phenergan
25-50 mg. IM May be combined with Meperidene

Lidocaine – 1%
Up to 30cc for perineal infiltration in the repair of lacerations/episiotomies

Ergonovine (Ergotrate) or Methylergonovine (Methergine)
0.2 mgs IM if necessary to control 4th stage bleeding

Oxytocin
10 u IM following delivery of placenta or 10-20 u added to the IV solution

Morphine Sulfate – 10-15mg. sc for sedation in early labor

Prepidil Gel (PG2 Gel) as indicated by OB/GYN Policy

Ferrous Sulfate 300 mg po for anemia

Cervidil placement for cervical ripening

MOM 30 cc po

All other medications not listed may be used only after consultation with the responsible physician.

APPENDIX B

1. Total medical management by the physician would be indicated with the following complications detected during the antepartum/intrapartum period.

    a. Transverse presentation/Breech presentation
    b. Cardiac Disease (Class II through Class IV)
    c. Placental abnormalities – i.e. Abruptio, complete previa.
    d. Anticipated fetal abnormality ex. Hydrocephaly.

Midwifery Privileges Eligibility Criteria (2014-2015)

All Midwives must have a physician designee on the active staff of Memorial Hospital of RI, and possess clinical privileges in OB/GYN and/or Family Medicine with Maternal Health in order to be granted Midwife privileges.

Core Privileges Requirements:

- Successful completion of a accredited certified nurse-midwifes (CNM) or certified midwives (CM) program
- Certification by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board (AMCB)
- License to practice midwifery in Rhode Island
- Letter of reference from the applicant's training program director
- Letter(s) of reference from the hospital where applicant has been most active for the last two years
    - For obstetric privileges: chief of OB
    - For newborn care privileges: chief of Pediatrics
- Maintenance of certification as required by the ACNM or AMCB
- Certification in ACLS and Neonatal Resuscitation (NRP)

Class I: Care of the Childbearing Woman: includes assessment of the progress of pregnancy and fetal well-being, confirmation of labor and its progress, assessment of maternal and fetal status during labor, management and facilitation of physiologic labor progress, management of spontaneous vaginal delivery, third stage management and repair of first and second degree lacerations. Also includes care of women during the postpartum period, and instruction on newborn care and feeding.

Class I procedures include:

1. First assistant for cesarean delivery
2. Limited obstetrical ultrasound
3. Augmentation and induction of labor

Class II: Care of the Neonate during the extra-uterine transition period: providing immediate stabilization, evaluation, and management of the newborn, including resuscitation of the depressed neonate. Also includes initial gestational age assessment and physical assessment.

Class III: Care of the Newborn Infant: independent management of the well infant's medical needs during the hospital stay. This includes assessment of maternal and fetal risk factors on the newborn, primary health screening, and feeding and nutrition assessments. Also includes screening for and recognition of abnormal physiological states. Medical care provided will be in compliance with the hospital's policy on level of care for the neonate.

Reappointment Requirement:

- Documentation and results of performance improvement and peer review.
- For NMs and CNMs who are inactive at Memorial Hospital of RI and have no PI findings, a letter from the chief of service of the hospital where they are most active must be provide making specific reference to performance improvement results at that hospital.

Select class(es) for which you meet eligibility requirements:

	Granted	Denied	Chief Sign
____ Class I	____	____	_____
____ Class II	____	____	_____
____ Class III	____	____	_____

Special Procedures:

	Document # in past year	Granted	Denied	Chief Sign
1) _____	____	____	____	_____
2) _____	____	____	____	_____

I have not requested privileges for which I am not qualified by either training or experience and understand that by making this request I am bound by the applicable bylaws and policies of the hospital and herby stipulate that I meet the minimum criteria for this request.

_____ Date

_____ Signature (Applicant)

_____ Name

_____ Date

_____ Signature - Chief of OB/GYN

_____ Date

_____ Signature - Chief of Pediatrics

Women & Infants' Hospital

PATIENT CARE SERVICES

POLICY/ PROCEDURE
ABC: CRITERIA FOR ADMISSION

Policy Date: June 1996

Effective Date: February 2014

Revised Date: June 1996, June 2002, November 2003, October 2006, December 2009, February 2014

Reviewed Date:

POLICY: Patients may be admitted to Alternative Birthing Center if they meet the following criteria:

Criteria for Use:

1. Patient in labor after an uncomplicated pregnancy with singleton vertex presentation at 36 weeks or greater, not planning regional analgesia.
2. Patients with gestational diabetes that is well controlled by diet can be considered as candidates for the ABC provided they meet the following criteria:
   - Blood sugars performed at recommended times and results within required parameters
   - EFW of less than 4,000gms by both clinical assessment and Ultrasound (US) performed at 38 weeks gestation. If the patient is undelivered, US should be repeated at 40 weeks gestation.
3. Patients with a prior vaginal delivery of an infant greater than 4,500gms without complication and an EFW of less than 5,000gms with this pregnancy.
4. Patients with light meconium noted upon presentation to hospital.
5. Agreement by the attending obstetrician/ CNM and pediatrician is required if early discharge is planned.

Criteria for Exclusion:

1. Gestational Hypertension / Pre-eclampsia
2. Gestational Diabetes treated with oral agents or insulin (patient cannot have refused antenatal testing)
3. Documented gestational age of less than 36 weeks or greater than 42 weeks
4. Any other acute or chronic maternal illness which would increase risk to mother or infant
5. Moderate, thick or particulate meconium stained fluid prior to admission
6. Previous cesarean section
7. History of shoulder dystocia
8. Estimated Fetal Weight (EFW) greater than or equal to 4,500gms
9. Other co-morbidities

Procedure:

1. Patients are admitted to the Birthing Center on a first served basis.

2. Whirlpool bath may be used for relaxation/ pain relief during the first stage of labor. (See Policy/ Procedure: LDR/ ABC Whirlpool Therapy).

3. Patients who develop, including but not limited to, any of the following conditions are transferred from the ABC area to the Labor/ Delivery/ Recovery (LDR) area with provider consultation:
   - Any labor pattern or maternal/ fetal complications requiring additional diagnosis or treatment that is not available in the Birthing Center.
   - Moderate, thick, or particulate meconium stained amniotic fluid.
   - Temperature above 38.4° C (101.1° F) or above.
     - If the patient has a temperature of 38.0 to 38.3°C (100.4° to 100.9°F), hydration or other corrective measures may be undertaken with temperature repeated after 30 minutes
     - With the onset of this temperature elevation, the patient should be fully evaluated by the provider to rule out chorioamnionitis. This evaluation should include assessment of maternal and fetal heart rate and abdominal palpation to evaluate for fundal tenderness.
     - If reassessment after this 30 minute period continues to show a temperature of 38.0°C or above, the patient should be transferred.
   - Blood Pressure of ≥ 140 Systolic or ≥ 90 Diastolic on 2 occasions.
   - Vaginal bleeding requiring interventions.
   - Labor pattern requiring augmentation.
   - Prolonged labor.

4. The following guidelines for care shall be observed:

   A. Prolonged Rupture of Membranes (PROM) is defined as rupture of membranes greater than twenty-four (24) hours. Patients with PROM may remain in or be admitted to the ABC providing adequate contractions are present.

      1. Refer to the OB-GYN Guidelines (see attached) regarding recommendation that labor be induced at the time of presentation.
      2. On admission to the ABC or after twenty-four (24) hours past rupture if patient is already admitted:
         - Obtain 20 minute fetal heart rate tracing and evaluate based on Policy/ Procedure: Fetal Monitoring.
         - Monitor hourly temperature
         - Reassess the fetal heart rate with fetal heart rate tracing hourly.
      3. Transfer to LDR should occur thirty-six (36) hours after rupture of membranes.
      4. Any deviation from the norm will result in transfer to the LDR area.

B. For patients with light Meconium stained fluid noted at the time of admission:
   1. Continuous electronic fetal monitoring should be performed for at least twenty (20) minutes.
      - If fetal monitoring is interpreted as normal (Category I), the patient can be admitted to the ABC and followed as described in guideline C below.
      - If fetal monitoring is interpreted as indeterminant (Category II), the patient should be admitted to the LDR area and followed with continuous electronic fetal monitoring.

C. For patients with light Meconium stained fluid noted during labor:
   1. Continuous electronic fetal monitoring should be considered depending on risk assessment.
   2. Assess fetal heart with twenty (20) minutes of continuous fetal monitoring hourly.
      - If fetal monitoring is interpreted as normal (Category I) after this period of assessment, the patient may return to the intermittent auscultation protocol.
      - If fetal monitoring remains indeterminant (Category II), electronic fetal monitoring should be continued or the patient should be considered for transfer from ABC area to the LDR area.
   3. NICU is notified of meconium and called to attend delivery.
   4. Attending obstetrician is notified of meconium.
   5. Transfer to the LDR area occurs for moderate, thick, or particulate meconium.

D. Patients who are noted to have persistent indeterminant (Category II) fetal heart rate characteristics on intermittent auscultation should be placed on continuous electronic fetal monitoring to assess fetal status. These characteristics include but are not limited to:
   - Baseline < 110 or > 160 beats per minute
   - Irregular rhythm
   - Decelerations
   - Baseline that steadily increases toward a tachycardic rate

   If fetal monitoring is interpreted as normal (Category I) after a 20 minute period of assessment, the patient may return to the intermittent auscultation protocol.

   If fetal monitoring remains indeterminant (Category II), electronic fetal monitoring should be continued or the patient should be considered for transfer from ABC area to the LDR area.

E. **Requiring Pediatric presence at delivery** includes but not limited to:
   - Meconium
   - ROM > 24 hours
   - Maternal temperature $\geq$ 38.0°C

5. Document all assessments, interventions, and deviations in the medical record.

This [policy or procedure] is only intended to serve as a guideline to assist staff in the delivery of patient care; it **does not** *create standard(s) of care or standard(s) of practice.* The final decision(s) as to patient management shall be based on the professional judgment of the health care provider(s) involved with the patient, taking into account the circumstances at that time.

Approved By:

Date: 3/27/14
Angelleen Peters-Lewis, RN, PhD
Senior Vice President/ CNO, Patient Care Services

Date: 4/2/2014
Maureen G. Phipps, MD, MPH
Obstetrician & Gynecologist In Chief

Date: 4/7/14
James A. O'Brien, MD
Medical Director, InPatient Obstetrics

Date: 4/8/14
James F. Padbury, MD
Pediatrician In Chief

Policy: ABC-Admiss
/mml

Women & Infants

Name: #Name_FML_T#
Term:

DEPARTMENT OF OBSTETRICS/GYNECOLOGY
MIDWIFERY CLINICAL PRACTICE GUIDELINES

I. BACKGROUND/SCOPE OF PRACTICE

Midwives with hospital privileges at Women and Infants Hospital function in accordance with the Midwifery Clinical Practice Guidelines formulated by the Midwifery Clinical Practice Guidelines Committee and approved by the Obstetrician/Gynecologist-in-Chief. These define the scope of midwifery management and are reviewed and updated periodically.

The hospital-based Academic Midwifery Section functions within the Department of Obstetrics and Gynecology. These midwives are medically and administratively responsible to the Obstetrician/Gynecologist-in-Chief and/or his or her designate. Their duties are determined by the Obstetrician/Gynecologist-in-Chief in collaboration with the Director of the Academic Midwifery Section within the Department of OB GYN in accordance with accepted midwifery standards and practices.

The community-based midwife functions within guidelines set by their affiliated community practices and alliances.

II. QUALIFICATIONS

Current Rhode Island Midwifery License
Current Certification by the American Midwifery Certification Board
Current DEA Registration
Allied Health Professional Staff Appointment
Malpractice insurance coverage in an amount established by the hospital

Midwives seeking privileges at Women and Infants Hospital must be credentialed in accordance with Medical Staff Bylaws.

III. GENERAL RESPONSIBILITIES

Midwives are authorized to practice the independent management of cases of normal childbirth, including prenatal, intrapartum, postpartum, normal newborn care, and well woman gynecologic care with evidence of prearranged provision for collaboration with a physician. This practice is in accordance with standards established by the American College of Nurse-Midwives and American College of Obstetrics and Gynecology (Reference 1).

Midwives are regulated in Rhode Island by the state department of health and have their own Rules and Regulations for the Licensing of Midwives and a separate Board (R23-13-MID). A list of definitions, per the state regulations, can be found in the rules and regulations governing the licensure of midwifery (Reference 2). Section 10.0 of the State Rules and Regulations promulgates prescriptive privileges.

Women&Infants

Name: #Name_FML_T#
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A. Core Privileges

Core privileges for midwives include evaluation and diagnosis of conditions through antepartum, intrapartum, and postpartum in collaboration with a physician who holds privileges at the hospital in their specialty area. Midwifery core privileges include, but are not limited to:

- Taking histories and performing physical examinations
- Ordering laboratory and diagnostic imaging studies
- Collecting specimens for pathological examination
- Initiating management of obstetric emergencies with immediate consultation
- Performing the following procedures:
  - Fetal surveillance
  - Amniotomies
  - Midline/mediolateral episiotomies
  - Repair of midline/mediolateral episiotomies
  - Uterine exploration and manual removal of placenta and/or placental fragments
- Providing care to mothers and infants in the postpartum period
- Providing well woman gynecology

B. Consultation/Medical Conditions for Consultation

Women who have a history of or who are currently experiencing certain medical or obstetric conditions/complications will require consultation. These conditions include, but are not limited to:

Antepartum/Intrapartum/Triage

- 3rd stage lasting longer than 30 minutes
- Anemia < 9 mg/dl hemoglobin
- Cholestasis of pregnancy
- Chorioamnionitis
- Chronic HTN – stable
- Controlled seizure disorder
- Documented fetal anomalies
- Documented IUGR
- Drug addiction
- Face presentation
- Gestational diabetes diet controlled or insulin treated
- Intrauterine fetal demise (IUFD)
- Trial of labor after Cesarean (TOLAC)
- Multiple gestation (vaginal births anticipated)
- Non-severe pre-eclampsia (PEC)
- Oligohydramnios
- Pitocin induction or augmentation
- Placenta previa
- Preterm labor < 35 weeks
- Regional anesthesia
- Significant abdominal trauma

Postpartum

- Abdominal pain unresponsive to analgesia
- Anemia HCT<27%
- Mastitis
- Maternal fever >100.4
- Persistent urinary retention
- Postpartum hemorrhage

C. Medical Conditions for Referral

Conditions which require **referral** for medical management include, but are not limited to the following:

For all midwives practicing at Women and Infants' Hospital, the following referral list includes:

Antepartum/Intrapartum

- Acute abruption
- Active seizure disorder
- Category 3 fetal heart tracing
- Decision for Cesarean section
- Essential HTN – unstable
- HSV lesion, active, in labor
- Malpresentation, except for face presentation
- Medical complications that severely affect the pregnancy
- Placenta previa in labor
- PPROM <34 weeks
- Rh sensitization
- Severe pre-eclampsia (PEC)
- Thromboembolic disorder on anticoagulants/DVT
- Type 1 or Type 2 Diabetes

Postpartum

- DVT
- Endometritis
- Episiotomy or laceration breakdown/infection
- Hematoma increasing in size

Such referral does not preclude continued involvement of the midwife.

Specifically for the Academic Midwifery Section within the Department of OB GYN, the most current list of conditions designated by the Maternal Fetal Medicine Service for transfer to the High Risk Service are noted in Appendix A.

Appendix A: Patients Transferred to Maternal Fetal Medicine Service

Women & Infants

Name: #Name_FML_T#
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IV. INCORPORATING PROCEDURES BEYOND MIDWIFERY CORE COMPETENCIES INTO PRACTICE

Midwifery practice may be expanded beyond core competencies to incorporate new procedures that improve care for women and families. When incorporating a new procedure into practice, the midwife will demonstrate knowledge and competency.

Current expanded procedures include, but are not limited to: 1st Assisting at C-Sections, Manual Vacuum Aspiration and Ultrasound Scanning. The midwife seeking to become credentialed in these expanded procedures will follow the steps outlined by the Credentialing Committee and approved by the Chairperson of the Department of Ob-Gyn.

V. EXPANDED PRACTICE GUIDELINES

Appendix B: 1st Assist at C-Sections
Appendix C: Manual Vacuum Aspiration
Appendix D: Ultrasound Scanning

VI. AUTHORITY

This agreement is in accordance with the delineation of privileges approved by the Department of Obstetrics and Gynecology, the Medical Staff and the Board of Trustees of Women and Infants' Hospital.

REFERENCES:

1. Joint Statement of Policy. American College of Nurse Midwives and the American College of Obstetricians and Gynecologists. Joint Statement of Practice Relations between Obstetrician-Gynecologists and Certified Nurse Midwives/Certified Midwives, February 2011.

2. Rules and Regulations for Licensing of Midwives. State of Rhode Island and Providence Plantation. Department of Health, October 2008.

Request		Grant	Withdrawn
[ ]	**Core Privileges** – As outlined in the Scope of Practice above	[ ]	[ ]
[ ]	**Supplemental** – 1st Assist at C-Sections	[ ]	[ ]
[ ]	**Supplemental** – Manual Vacuum Aspiration	[ ]	[ ]
[ ]	**Supplemental** – Ultrasound Scanning	[ ]	[ ]

SIGNED: _____ DATE: _____
#Name_FML_T#

RECOMMENDED: _____ DATE: _____
Elisabeth D. Howard, PhD, CNM
Interim Director – Department of Midwifery

RECOMMENDED: _____ DATE: _____
Maureen Phipps, MD, MPH – Acting Chief
Obstetrics/Gynecology Department

Women&Infants

Name: #Name_FML_T#
Term:

APPENDIX A

GUIDELINE NO. 65 – Amended, October 2010

GUIDELINES FOR TRANSFER OF PATIENTS FROM TEAM SERVICE TO MATERNAL FETAL MEDICINE (MFM) SERVICE

The following represent guidelines to be used in determining which patients are best managed on the Maternal-Fetal Medicine service (High Risk) rather than the team (Low Risk) service. The issue is not whether the resident in the low risk setting is competent to care for such patients, but rather whether the support system is in place to provide the team approach needed by patients with such problems. If a patient does need to be transferred to the MFM service for acute management while in the hospital, this does not necessitate that the rest of her prenatal care will be managed by the MFM service once she is discharged. For outpatient transfer guidelines, see the Women's Primary Care Center Guideline.

Inpatient Transfers Low Risk to High Risk

Respiratory compromise
- Acute severe asthma i.e.
  - Intravenous steroids
  - FiO_2 of 50% to maintain 20_2 >95%
  - PCO_2 of >40%
- Impaired oxygenation
  - FiO_2 of 50% to maintain $S0_2$ >95%

Cardiovascular compromise
- New onset arrhythmia
  - Atrial Fib/flutter
  - SVT
- Cardiac arrest
- Myocardial Infarction
- Hypertensive crisis (non-preeclamptic)
  - DBP > 110 mmHg
  - SBP > 160 mmHg
- Cardiomyopathy
- Endocarditis
- Shock, any cause

Thromboembolic Disease
- Pulmonary embolus
- Superior sagital sinus thrombosis
- Deep vein thrombosis

Women & Infants

Name: #Name_FML_T#
Term:

Neurologic disease
- Intracranial hemorrhage
- CVA
- Status epilepticus
- Diabetes insipidus
- Eclampsia
- Coma
- Papilloedema

Trauma
- Penetrating abdominal trauma
- Significant head trauma

Gastrointestinal disease
- Acute fatty liver
- Hepatic hemorrhage
- Hepatitis requiring hospitalization
- Acute pancreatitis
- Hypermesis requiring TPN
- Acute inflammatory bowel disease

Renal disease
- Acute renal failure

Endocrine disease
- Diabetic ketoacidosis
- Thyroid storm
- Pheochromocytoma
- Addisonian crisis

Hematologic disease
- Sickle cell crisis
- Acute leukemia
- Aplastic anemia
- DIC

Obstetric disorders
- Severe complicated preeclampsia
  - Blood pressure >160/110 refractory to multiple medications
  - Oliguria
  - Eclampsia
  - Pulmonary edema
  - Creatinine greater than 1.2
  - Platelets <80,000
- Severe fetal anomaly
- Fetal hydrops
- Refractory preterm labor requiring multiple tocolytic agents
- Fetal arrhythmia
- Oligohydramnios remote from term
- Anticipated delivery between 22-27 weeks

Women & Infants

Name: #Name_FML_T#
Term:

APPENDIX B

Midwifery Guideline
1st Assist at C-Section
Department of OB/GYN

Qualifications:

- Meet requirement for credentialing as a midwife.
    1. Current Rhode Island Midwifery License
    2. Current DEA Registration
    3. Current Certification by the American Midwifery Certification Board
    4. Allied Health Professional Staff Appointment
    5. Malpractice Insurance Coverage in an amount established by the hospital

- This is an advanced midwifery practice skill and requires advanced training.

Training:

- Acquire the knowledge of risks, benefits, patient selection, etc., by attendance at a formal program of education for first assisting at Cesarean Sections. This course should at least be one full day and be approved by the American College of Nurse Midwives.

- To acquire the required skills, the certified nurse midwife/certified midwives will:
    a. Second assist in at least five (5) C-Sections under the supervision of one or more physicians with or without a previously qualified CNM
    b. First assist in at least ten (10) Cesarean Sections under the supervision of one or more physicians with or without a previously qualified CNM.
    c. Clinical skills competency shall be documented by means of a checklist to be completed by the supervising physician/midwife for each case.

Maintenance of Privileges:

To maintain privileges for the procedure, the CNM will need to perform five (5) 1st assists within the past year or have a FPPE initiated. This FPPE would also be triggered for a new hire with prior 1st assist experience to document competency and proficiency.

Recommendation:

These checklists will be kept on file, along with a case list. The checklists will then be reviewed by the Chief of OB/GYN and the midwife cleared to first assist.

6/22/2012 – Diane Angelini, CNM
Adapted from 1st assist requirements for CNMs in midwifery approved protocol, 2006.

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Name: #Name_FML_T#
Term:

Appendix C
Credentialing for Providers to perform a
Manual Vacuum Aspiration in WIH Triage OB/GYN Department

In order to perform a Manual Vacuum Aspiration in WIH Triage, a provider must demonstrate specific MVA credentials as follows.

A provider may be credentialed in one of the following ways:

1. A hospital credentialed physician who has performed Manual Vacuum Aspirations in another setting and is certified as having performed MVAs to competency by the Medical Director of Triage and the Chief of OB/GYN

OR

2. A hospital credentialed physician who has completed the MVA in-service **AND** who has performed the procedure under direct observation of an already credentialed provider to the level of competency. The competency checklist will be reviewed by the Medical Director of the Triage and the Chief of OB/GYN, who will certify MVA credentials.

OR

3. A certified nurse midwife or nurse practitioner, with specialized training and subsequent demonstration of knowledge of indications, patient eligibility, alternative options, potential complications, and treatment of complications. The CNM or nurse practitioner must also perform a minimum of five procedures under direct observation of an already credentialed provider to the level of competency. The competency checklist will be reviewed by the Medical Director of Triage and the Chief of OB/GYN, who **will** certify MVA credentials.

For the credentialing and performance of MVAs:

- A credentialed certified nurse midwife or nurse practitioner may only perform an MVA in Triage in conjunction with a credentialed an identified and available collaborating attending physician who is credentialed to perform MVAs.
- An in-service must be scheduled with any **credentialed provider** in triage. The in-service consists of a demonstration of the IPAS aspirator and the cannulas, how they attach and how they operate.
- In order to maintain credentialing, a previously credentialed provider must perform an average of two MVA procedures per year over three years, or, in the absence of that number performed, a provider must demonstrate ongoing competency through simulation with the Director of Triage.
- Each provider will be responsible to confirm that his/her credentials to perform MVAs are intact prior to performance of each procedure.

(See attached competency checklist.)

Credentials Committee Approval: 01/04/2012
Medical Executive Committee Approval: 01/10/2012
Board of Directors Approval: 01/26/2012

Women&Infants

Name: #Name_FML_T#
Term:

APPENDIX D

Midwifery Guideline
Ultrasound Scanning
Department of OB/GYN

Qualifications:

- Meet requirement for credentialing as a midwife.
    1. Current Rhode Island Midwifery License
    2. Current DEA Registration
    3. Current Certification by the American Midwifery Certification Board
    4. Allied Health Professional Staff Appointment
    5. Malpractice Insurance Coverage in an amount established by the hospital

- This is an advanced midwifery practice skill and requires advanced training.

- It is not necessary for midwives to achieve competency in all aspects of ultrasound, and they may tailor their education and training to the specific type of ultrasound examination they wish to perform.

Purpose:

Limited, third trimester ultrasound in hospital setting (in OB triage) used primarily to evaluate amniotic fluid index and biophysical profile status.

Training:

- Acquire the knowledge and skills necessary to perform basic or limited ultrasound in the obstetric setting (either transvaginal or transabdominal, depending on setting, or both) by attendance at a formal or continuing education (structured curriculum) program in Limited or OB Ultrasound (including AFI, BPP, assessment).

- To acquire the required skills, the certified nurse midwife/certified midwife will:

- Perform at least ten (10) ultrasounds under the supervision of someone qualified to perform ultrasound in this obstetric setting to ensure competency with each specific ultrasound skill (including AFI, BPP and any other limited ultrasound assessment skills).

- Ultrasound skills competency shall be documented by means of a checklist to be completed by the supervising physician/midwife for each case.