West Virginia Perinatal Partnership – 2007

Committee on Perinatal Consultation, Transport, and Outreach Education

Key findings of the committee[1] revealed that West Virginia needs to improve the emergency transport system for high risk mothers and babies. Surveys of small hospitals showed that they were not always able to get these mothers and babies to one of the state's three Neonatal Intensive Care Units (NICUs). Last year the perinatal partnership transport committee made recommendations to improve transport for high risk mothers and babies.

COMMITTEE RECOMMENDATIONS:

Recommendations for Improving Perinatal Transport and Outreach Education in West Virginia

1. Maternal and infant transport should be available 24-hours, seven days a week for all level I and Level II facilities in the state. West Virginia should insure that reliable, accurate, comprehensive communication systems between referring hospitals and between the transport teams and hospitals, regarding response times, capabilities, and facilities be continuously up to date.

2. West Virginia should investigate the implementation of a single call system for perinatal transport. The characteristics of this center should include:
    a. Daily knowledge of all NICU and high risk maternal beds (Bedboard) available in the West Virginia and surrounding states
    b. Ability to immediately connect referring physicians with the appropriate neonatal or obstetrical specialists for consultation and care recommendations while awaiting transports
    c. The ability to find available beds and arrange the transports of mothers or babies.
    d. The ability to (whenever possible) arrange transports to tertiary centers closest to the homes of mothers and babies.
    e. A centrally maintained website with evidence-based guidelines for maternal-fetal and neonatal care including:
        i. resuscitation, stabilization and transport guidelines for mothers and infants
        ii. general care for mothers and infants
        iii. development of these guidelines should take place in collaboration with perinatal care providers across West Virginia

3. Until a single call system is in place, the committee recommends the following:

    a. Interagency collaboration and communication should be fostered through monthly communication meetings of representatives from the three tertiary centers.
    b. Special attention should be given to ways for tertiary centers to communicate with each other for back-up when a small hospital is in crisis and a transport is not available in the hospital's region.
    c. Ability of tertiary centers to rely on each other for help in finding NICU beds. (Some systems of care have a daily regional **NICU bedboard** posted on a multi-user website. Every morning, each tertiary care center enters the number of beds available)
    d. Investigation of the feasibility of developing a centrally maintained website with evidence-based guidelines for maternal-fetal and neonatal care including:
        i. resuscitation, stabilization and transport guidelines for mothers and infants
        ii. general care for mothers and infants
        iii. development of these guidelines should take place in collaboration with perinatal care providers across West Virginia

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[1] The full committee report is available online or by request: Call Ann Dacey, RN at 293-8891

e. Education of all personnel who may take calls at tertiary centers regarding the following:
    i. Referring pediatricians need to be caring for the sick infants not making calls looking for beds
    ii. No hang-up should occur until the hospital/physician feels it has been helped

4. West Virginia should investigate the possibility of making emergency maternal transport available to all community hospitals in the state. The model developed by Cabell-Huntington Hospital should be evaluated for relevance to the entire state.

5. Advanced Life support in Obstetrics (ALSO) courses should be made available for EMS personnel, transport nurses, and hospital perinatal nurses.

6. Emphasis on keeping mothers/fathers and babies together should be promoted. Systems for the mothers to return to their communities when appropriate, without undue financial stress should be insured.

7. Tertiary centers should keep logs of all requests for transports whether they are turned down or not. Assistance given to declined requests for transfer should be noted.

8. Community hospitals should keep logs of all requests for transports and their dispositions

9. Referring providers should receive frequent updates and information on mothers and babies that they have referred. Obstetric providers should also receive information on the health status of the infants of mothers born after being transported to tertiary centers.

10. Referring hospitals should receive frequent updates, information to in order to support separated families in times of stress and grief;

11. West Virginia should establish an organized perinatal outreach education program coordinated by each of the three Level III Perinatal facilities for each of their referral hospitals**.** State funding for an office and a coordinator for these activities in each level III perinatal center is vital as well as reimbursement for teaching time by healthcare professionals. Special attention and support should be given to those hospitals that deliver less than 750 babies per year. Results of the outreach education survey should be taken into consideration when scheduling these programs. All birthing hospitals should be offered a yearly review of the following programs:

    i. Transport/perinatal case reviews specific to each hospital
    ii. NRP, Neonatal Resuscitation Certification
    iii. STABLE, (Sugar, Temperature, Assisted Breathing, Blood Pressure, Lab Work, and Emotional Support to Family), a program is designed to provide healthcare professionals with knowledge on how to stabilize patients during the post-resuscitation/pre-transport period
    iv. Electronic Fetal Monitoring
    v. Advanced Life support in Obstetrics
    vi. Hospital data reviews with individual hospitals and opportunities for quality improvement

12. A special outreach education program should be developed for staff at those hospitals that have agreed to take babies back for convalescent care after NICU admissions.

13. Plans for a perinatal transport summit, inviting all stakeholders to discuss implementation of the above recommendations, should be made for sometime early in 2008.