

# **GEORGIA STATE HEALTH PLAN**

## **COMPONENT PLAN**

# **PERINATAL HEALTH SERVICES**

**HEALTH STRATEGIES COUNCIL  
AND  
DEPARTMENT OF COMMUNITY HEALTH  
DIVISION OF HEALTH PLANNING  
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Planning area map for Basic and Intermediate Perinatal Services has been changed  
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## PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Division of Health Planning, which are funded through and operated within the authority of O.C.G.A. 31-6-1, et. seq.

The purpose of this Plan is to identify and address health issues, and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public, participatory process developed and monitored by the 27-member Governor-appointed Health Strategies Council. The Plan is effective upon approval by the Governor and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules, Chapter 272-1, 272-2 and 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the legal authority to implement. The Rules are reviewed by the Health Strategies Council (prior to their adoption) for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

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## I. INTRODUCTION

### A. PLANNING PROCESS

The Division of Health Planning (Agency), the Health Strategies Council (HSC), and the Council's predecessors have a long history of planning for perinatal health (including obstetric and neonatal) services in Georgia. The original perinatal plan and general hospital plan were developed in 1981 by the Statewide Health Coordinating Council (SHCC) and updated in 1983 by the Health Policy Council (HPC-successor to the SHCC). In 1988-89 a Perinatal Inpatient Hospital Services Technical Advisory Committee (Perinatal TAC) with a broad base of representation was convened by the HPC to evaluate the existing Component Plans and Certificate of Need Rules and to make recommendations to the Council and the Agency specifically about access and need issues.

Implementation of the 1989 Perinatal TAC report was delayed in anticipation of two events:

1. Convening of the Governor's Commission on Obstetrics in July 1990 to study all problems and conditions relative to the provision of obstetric care for citizens of the State; and
2. Convening of the Policy Council's Technical Advisory Committee on Short-Stay General Medical/Surgical Hospitals (Hospital TAC), to address hospital services including perinatal services.

In May of 1991 the Hospital TAC made recommendations regarding perinatal services in rural areas and asked the Perinatal TAC to reconvene. The Perinatal TAC met in May-July 1991 and revisited the recommendations regarding access in rural areas.

Another major event occurred in 1992 with the passage of SB 680 by the Georgia General Assembly giving the Agency sanctioning authority for perinatal providers not meeting certain Certificate of Need (CON) conditions. Under this law, the Agency is required to revoke a CON for perinatal

services if the new service fails to meet its commitment to provide indigent and charity care in at least one of the first three years of operation, or if the new service fails to achieve the Agency's established utilization standards within one year during the first three years of operation after the Agency issued the CON for the service.

To consider all previous work and accomplishments and to finalize revisions to the Component Plan and Certificate of Need Rules, the Health Strategies Council (HSC) convened its Specialized Care Standing Committee in December 1992. The HSC accepted the Committee's report in February 1993 to issue a Proposed Plan and Certificate of Need Rules for public comment.

The advent of managed care brought about many system-wide changes and further created the need to continue to critique the agency's planning functions. In January 1997 a Perinatal Technical Advisory Committee was convened and charged with determining whether Obstetrical Services should become a basic hospital service and determining the system implications of not regulating obstetrical services through the Certificate of Need Process. The TAC supported keeping CON for basic perinatal (OB and Neonatal) services but suggested that the agency (a) strengthen the infrastructure of the plan by licensing/regulating perinatal services by level of care; (b) assure financial access for indigent patients; and (c) establish outcome measures for hospitals that require data collection and reporting to support sound policy and planning decisions.

## **B. CONCEPTS, PRINCIPLES, CARE CONTINUUM**

Over the past twenty years, Georgia has built a strong base for a perinatal health system. Instrumental in this design is the Council on Maternal and Infant Health (M&I Council), which was created by the Georgia General Assembly in 1972 and is an advisory council to the Executive Branch through the Board of Human Resources. The primary focus of the M & I Council is to assure pregnant women in Georgia every opportunity to access comprehensive perinatal health care services appropriate to meet individual need.

The Council on Maternal & Infant Health is currently authoring a document entitled "Recommended Guidelines for Perinatal Care in Georgia" (Guidelines). These Guidelines delineate the following as core

components of the continuum of perinatal services: *Preconceptual Health Promotion*, the goals of which are to prevent unintended pregnancies, to identify risk factors and to intervene appropriately before pregnancy; *Antepartum Care*, to maintain and improve the mother's health status to result in a normal pregnancy; *Intrapartum Care*, to maintain and improve the mother's health status resulting in a normal birth of an intact, healthy newborn, without complications for the mother; *Postpartum Care*, to provide clinical care services consistent with antepartum and intrapartum care components.

The Guidelines primarily provide a framework for the provision of clinical perinatal services. Further, the M & I Council recommend the establishment of a State Perinatal Board and Regional Perinatal Boards to designate responsibility and accountability for all births. The Guidelines recommend a multi-disciplinary approach that addresses societal, environmental and health issues including the designation and certification of facilities for level and competence of care. In addition to these measures, the Council recommends the monitoring of statewide perinatal outcomes. The suggested monitoring system would allow for comparisons of clinical services among hospitals offering similar levels of perinatal care, health districts, perinatal regions. Some nationwide comparisons would also be possible.

One distinguishing feature of the Guidelines is the move away from the designation of hospitals as having "Level I, Level II and Level III" neonatal services, but conforming more to the standards of the American College of Obstetrics and Gynecology's nomenclature of basic, specialty and subspecialty perinatal hospital services. The regional perinatal centers will offer subspecialty perinatal services.

In 1995, the Division of Family Health/ Department of Human Resources contracted with the World Health Organization Collaborating Center for Perinatal Health & Health Services Research (WHO/CC). They were charged with evaluating the current status of the perinatal healthcare services in the state and suggesting ways to improve the outcome of pregnancy in Georgia. The WHO/CC is in its final phase of the assessment but have made five major recommendations. Central to all the recommendations is the concept of total cohort accountability. This concept operates under the axiom that "every pregnancy counts, so account for every pregnancy." The suggested recommendations support the concept of total cohort accountability and are as follows:

- Eliminate the "gaps" in infant mortality between groups as defined by race, age, level of education, and residence.
- Emphasize the community by changing the current centralized perinatal center-based program to one of Community-Based Regions (the 19 health districts) with a perinatal center;
- Redefine the concept of perinatal care to include the total spectrum of reproductive health, from before conception and to as long as two years after childbirth for women with high risk Conditions.
- Reorganize and refine the perinatal surveillance system to allow efficient management of the perinatal health care system at the level of the health district.
- Institute a fiscally sound policy with incentives to improve reproductive health and perinatal outcomes.
- Reestablish the role of the Division of Public Health as the central agency responsible for monitoring the reproductive health status of the community.
- Maintain and support the revitalized Council on Maternal and Infant Health.

The WHO/CC will forward its recommendations to a Task Force comprised of representatives across health, business and community sectors. The Task Force will review and forge the implementation of the recommendations of WHO/CC.

Several efforts that have been instituted in the State of Georgia have resulted in improved perinatal outcomes, particularly, better survival rates for high-risk infants. However, rates of improvement have not met expectations, requiring new, stronger strategies to address obstacles such as lack of insurance, shortage of providers particularly in rural and inner city areas, rise in unintended pregnancies, substance abuse and shortage of funding for the regional system.



## II. OVERVIEW

### Trends and Issues

The health of infants is a high priority for the State of Georgia and the nation as a whole. However, there exists a great disparity between the amount of resources expended and Georgia's national ranking of 45th in the nation for infant health and the state's dubious distinction as having one of the highest rates of low birth weight babies, those weighing less than 2,500 grams.

The State of Georgia is faced with alarming rates of teen pregnancies, unintended pregnancies and a great disparity between black/white infant health and survival rates. These indicators are suggestive of the need for improved perinatal health care services. Several factors contribute to poor infant health status. Among them is the lack of access to appropriate healthcare services, poor nutrition, poverty, lack of insurance, shortage of healthcare providers, rise in unintended pregnancies and substance abuse. Although medical technology in the United States today has far exceeded what was thought imaginable, many women still do not have access to the full range of perinatal services.

Three key indicators can be used to signal inadequate access to prenatal care and to predict and measure poor pregnancy outcomes. They are infant mortality, unintended pregnancy, and prenatal care utilization rates as measured by access and outcome at three different points along the continuum of perinatal health (March of Dimes, 1993). These indicators serve as the benchmark against which future progress may be measured. Unintended/unwanted pregnancies are more likely to result in adverse birth outcomes than are planned pregnancies. For women who experience an unwanted pregnancy, ambivalence or lack of awareness often leads to delayed entry into prenatal care.

In 1990, 76 percent of more than four million births were to women receiving prenatal care that began early. Since 1979, there has been virtually no increase in the proportion of women who began early prenatal care as recommended. Between 1970 and 1980 there was a significant trend toward increasing early entry into prenatal care. The proportion of mothers who initiated care late (after the sixth month of pregnancy) or had no prenatal care declined significantly during the late 1970's and early 1980's but remained at 6 percent from 1983 to 1989 (March of Dimes, 1993).

The national infant mortality rate in 1990 was 9.2 per 1,000 live births. Infant mortality rates are the starkest indicators of poor pregnancy outcomes. Of approximately four million infants born each year in the

United States, hundreds of thousands are at risk for death or disability, and nearly 40,000 die before their first birthday. The leading causes, birth defects, low birth weight-prematurity, respiratory distress syndrome, and Sudden Infant Death Syndrome (SIDS) account for over half of all infant deaths (March of Dimes, 1993). Directing appropriate prevention efforts in perinatal care at the main causes of infant mortality will result in the greatest reductions in numbers of infant deaths. Some state and nationwide perinatal health indicators follow:

## **PRENATAL HEALTH**

- In Georgia, the percentage of mothers who had no prenatal care began to decline in 1990 and has steadily decreased, falling from 2.5% in 1990 to 1% in 1995;
- In 1995, 83% of the more than 112,000 births in Georgia were to women receiving prenatal care that began in the first three months of pregnancy;
- A higher proportion of black and white women receive early prenatal care in Georgia than for the United States as a whole. Blacks, 71.6% and 68.3% respectively and Whites, 85.9% and 82.8% respectively;
- Some of the reasons that women have cited as reasons for not accessing early prenatal care include the following:
  - Didn't think that they were pregnant
  - Couldn't get an appointment with a health provider early in the pregnancy
  - Didn't have enough money or insurance to pay for a prenatal visit
  - Lack of transportation
  - Lack of child care

Source: *The Challenge of Change: A Mid-Decade Look at Maternal and Child Health in Georgia, 1997*

## **Infant And Maternal Mortality**

- Pregnancy complications require an average of 2 million hospital days of care per year at a cost of \$1 billion per year for hospital charges;
- The statewide infant mortality rate for 1990, 1994 and 1995 are 12.4; 10.2 and 9.4 respectively. The infant mortality rates for African-Americans during the same time period however are vastly different with rates of 18.5; 16.1 and 15.2 respectively.

The average cost of treatment in a neonatal intensive care unit is between \$20,000 and \$30,000. Based on data from Georgia's Department of Medical Assistance, the cost of care for a very low birth weight baby can reach \$500,000.00.

- In 1990, the neonatal mortality rate (cause of death in the first 27 days after birth) was 8.2 per 1,000 and the post-neonatal mortality rate was 4.2 per 1,000. By 1995, the comparable rates were 6.3 and 3.2 per 1,000;
- Between 1990 & 1992, the maternal mortality rate for the state was 22.2. The rate for white women was 12.1. The corresponding rate for African American women was 37.2. The targeted Year 2000 goal for maternal mortality is 3.3;
- The most common causes of pregnancy related deaths in Georgia are: hemorrhage, embolism, infection, cardiomyopathy, and hypertension
- In Georgia, African-American women have a 3.5 times higher risk of dying from pregnancy-related complications than white women. For each cause of death, the pregnancy-related mortality ratio was higher for African-American women than for white women.

Source: *(The Challenge of Change: A Mid-Decade Look at Maternal and Child Health in Georgia, 1997 & GA.DHR/Office of Perinatal Epidemiology)*

### **Early Discharge**

- Nationwide, there are approximately 4 million deliveries each year. (USGAO, 1996)
- In 1994, the national average length of stay for all newborns (including those delivered vaginally and by cesarean section) was 1.8 days, down from 3.2 days in 1980. (USGAO, 1996). Data from the SHPA indicated that in 1996, the average OB length of stay in Georgia was 2.3 days.
- Nationwide, for the first half of 1995, the longest newborn length of stay was 2.5 days in the mid-Atlantic and West South Central regions and the shortest length of stay was 1.6 days in the Pacific region. (USGAO, 1996)
- Nationwide, in 1994, 39.8 percent of newborns were discharged within 1 day, 33.7 percent at 2 days and the rest stayed longer. By contrast, only 8.9 percent of newborns had 1-day stays in 1980 (GAO, 9/96).
- Research studies in New York and New Hampshire hospitals found that the risk for hospital readmission within the first two weeks of life was 50 percent greater for infants discharged at less than 2 days of life. (Frank, J., National Health Policy Forum, 2/22/96).

## Caesarean Births

- Healthy People 2000, a Centers for Disease Control & Prevention Initiative has set the threshold for caesarean deliveries at 15 for every 100 births.
- Statewide caesarean rates are decreasing. Data reported by the Division of Health Planning (1995&6 Annual Hospital Questionnaire/Perinatal Services Addendum), indicated that of the total births in the state in 1995 and 1996, C-sections represented 22.4 % and 21.7% respectively.
- In the State of Georgia, the highest C-section rate was observed in the Southeast district of the state while the lowest rate was in the North district of the state. (1995 Facts, GHA).
- A source from the Georgia Hospital Association reported that in 1997, the average charge for an uncomplicated C-Section was \$6,905.00

## SYSTEM STATUS

### Health Care Personnel

- 15 of Georgia's 159 counties are above the Graduate Medical Education National Advisory Committee (GMENAC) standard of 191 physicians per 100,000 persons.
- Sixty-five (65%) percent of all physicians are located in the eight counties with a population greater than 150,000 (these 8 counties represent 43% of the state's population).
- The distribution of physicians in Georgia by specialty reveals an inadequate supply of medical specialists to meet the needs of the state's growing population.
- Nationwide, the projected growth in non-physician clinician supply between 1995 and 2005 is expected to double that of physicians. While the supply of non-physician clinicians is expected to grow from (87 per 100,000 to 132 per 100,000, physician supply will grow from 566,000 in 1995 to 756,000 in 2010 (24 per 100,000).
- The greatest density of non-physician clinicians (NPC) is found in the Northeast portion of the country, which has the greatest concentration of physicians. The lowest density of NPC's is in the Southern portion of the country, which has the lowest per capita number of physicians.
- Nationwide, the ratio of nurse-midwives to OB/GYNs is 1:6. By 2005 this ratio is expected to be 1:4.
- Nationwide, women are utilizing midwives for the provision of perinatal services. Between 1990 and 1992, the number of babies delivered in hospitals by certified nurse-midwives climbed 12 to 15 percent annually. During 1992, nurse-midwives delivered nearly 180,000 newborns in hospitals.

Some of the major trends in each of the following specialty areas that directly impact the provision of perinatal care in the State of Georgia are outlined below:

## **Pediatrics**

- 82 of the state's 159 counties do not have a Pediatrician practicing full-time in the county;
- Of the top twenty counties by number for Pediatricians, only six counties are in rural areas;
- Applying the GMENAC standard of one Pediatrician per 8,000 persons, a total of 963 Pediatricians will be needed in Georgia by the year 2000. It is projected that we will have 1,252 Pediatricians or an excess of 289.

## **Obstetrics & Gynecology**

- Of the top twenty-one counties by number of OB/GYN, only six counties are in rural areas;
- 92 of the state's 159 counties do not have an OB/GYN practicing full-time;
- Applying the GMENAC standard of one OB/GYN per 10,000 persons, a total of 770 OB/GYNs will be needed in Georgia by the year 2000, by then the projected growth could produce an excess of 283 OB/GYNs;
- In 1996, the number of OB/GYN's exceeded the GEMENAC standard for the year 2000 by 121 physicians. By 2000, the projected growth could produce an excess of 283 OB/GYNs.

## **Family Practice**

- Family Practice physicians have increased by approximately 55 physicians per year over the last ten years (1986-1996);
- Of the 2,568 Family Practice physicians needed by the year 2000, 1,772 or 69% will be required in the metropolitan areas, an additional 796 (31%) will be needed in non-metropolitan statistical areas;
- To achieve a standard of one Family Physician per 3,000 persons, an additional 674 physicians will be needed by the year 2000. This is one of the few specialties where a deficit is projected by the year 2000;
- To meet the projected requirement (one Family Physician per 3,000 persons), the state would need 170 Family Practice physicians per year. Sixty-nine percent (69%) of Family Practice physicians are projected to be needed in metropolitan statistical areas; thirty-one percent (31%) in non-statistical areas.

## **Nurse Practitioners, Physician Assistants & /Nurse Midwives**

- Fifty percent (50%) of Nurse Practitioners in Georgia indicated OB/GYN as the major clinical practice area, while 15% cited the neonatal practice area;
- In 1995, the Georgia Board of Medical Examiners recognized 1,147 Physician Assistants (PAs) in active practice in Georgia, 16.3 per 100,000 population.
- The Georgia Department of Labor projects the addition of approximately 200 PAs in Georgia between 1995 and 2005, a 15% growth rate. This profession is projected to experience moderate growth over the next ten years.
- A major factor affecting the availability of perinatal providers is the rise in medical liability coverage.
- Georgia hospitals projected a 29% increase in the number of nurse midwife positions by the year 2000. Based on this data, three (3) or more Nurse Midwives will be needed each year to keep up with new openings and separations.

## **Expenditures for Perinatal Care**

- Hospital costs associated with perinatal care have drastically increased. Several factors contribute to this rise. Among them:
  - Inflation;
  - New technologies, including neonatal intensive care units;
  - The rising cost of malpractice insurance; and
  - The loss of revenue due to uncompensated medical care.
- Between 1990 and 1992, the number of babies delivered in hospitals by certified nurse-midwives climbed 12 to 15 percent annually; Nationwide, total maternity and infant care payments were \$25.4 billion; 15% for prenatal and postnatal care; 48% for obstetric delivery services; 17% for newborn inpatient care prior to discharge; and 20% for other care during the first year of life.
- Medicaid is currently the primary payor source for about one-half of all births in the state. A source from the Department of Medical Assistance (DMA) indicated that during fiscal year 1995, DMA paid for 57,500 deliveries, approximately 50% of all statewide deliveries. The Medicaid budget is now the fastest rising item in the state's budget.
- In 1995, there were 114,940 deliveries in the State of Georgia. The average charge for uncomplicated deliveries was \$2,910. In 1996 there were 117,006 with an average charge of \$3,023.00.
- Normal deliveries and newborns accounted for the highest number of cases in each payor category (except Medicare) in 1993. Together, DRGs 373 (Vaginal Delivery without Complicating Diagnosis)

and 391 (Normal Newborn) accounted for 14.5% of all discharges in the state.

### **Managed Care**

- In 1991, HMO enrollment was greatest in the West (25.3%) and Northeast (16.2%) moderate in the Midwest (12.9%) and lowest in the South (7.9%)
- Hospital costs in high managed care markets were approximately 11% below the national average and 19% below hospital costs in low managed care markets.
- Data from the Office of the Commissioner of Insurance indicates that as of June 1997, there are 16 licensed HMO's in Georgia. This number is expected to rapidly increase over the next few years.
- Effective managed care principles are expected to result in more preventive services, lowered use of specialty services, fewer hospitalizations and lower per patient revenue outlays while maintaining the same or higher level of services.

### **ALTERNATIVES TO TRADITIONAL HOSPITAL DELIVERIES**

- Approximately 30% of women opting to use birth centers in the United States are from low income families;
- Birth Centers have received 100% level of reimbursement for their charges and have been shown to reduce cost and increase access to care;
- The first birth centers were developed to serve rural communities;
- There are more than one hundred thirty (130) freestanding birth centers nationwide; thirty-eight of which are accredited by the National Association of Childbearing Centers (NCAA);
- Georgia has one licensed birth center located in Rincon, Georgia (Effingham County).

### **B. SUMMARY OF SERVICES IN GEORGIA**

Of the 159 hospitals in the State of Georgia 106 provide obstetrical services. Several trends in perinatal care are evident. Data from the Annual Hospital Questionnaire/ Perinatal Services Addendum indicate that there is a decreasing trend in the OB Average Length of Stay, which declined from 2.5 days in 1993 to 2.2 days in 1995. Also, the OB occupancy rate plummeted from 48.2% in 1993 to 42.4% in 1995.

One issue that is often addressed in planning for perinatal health services is the percent of births delivered by Caesarean section (C-section). Data from the 1996 Perinatal Services Addendum, indicate that nearly half of OB Health Planning Areas, (namely 4, 6, 7, 9, 10, 11, 13) showed C-section percentages significantly over the statewide average. The statewide average is 21.7%. Experience suggests many factors contribute to the wide variations in C-section rates nationwide including physician practice style, fear of malpractice and patient expectation. Education of both providers and patients seems to be the most effective approach to lowering C-section rates. Implications of this issue should be considered in planning perinatal programs.



### III. GUIDELINES FOR THE REVIEW AND DEVELOPMENT OF PERINATAL HEALTH SERVICES

#### A. USE OF THE GUIDELINES

The following criteria outline the guidelines for the delivery of Basic Perinatal and Neonatal Intermediate and Neonatal Intensive Care Services in the State of Georgia as recommended by the Health Strategies Council. For planning and Certificate of Need purposes, Basic Perinatal Services, Neonatal Intermediate Care Services (Level II/Specialty Care), and Neonatal Intensive Care Services (Level III/Subspecialty Care) will be defined as new institutional health services. Each service to be provided meets a distinct need within the service population and therefore should be evaluated independently.

#### B. DEFINITIONS FOR THE GUIDELINES

1. "Basic Perinatal Service" means Obstetric and Neonatal Newborn Care Services.
2. "Most recent year" means the most current twelve month period within a month of the date of completion of an application or within a month of the date of completion of the first application when applications are joined. If the Agency has conducted a survey within six months of the date of completion of the first application when applications are joined, the Agency may consider the most recent year to be the report period covered by the prior survey.
3. "Neonatal Intensive Care Service (Subspecialty/Level III)" means a hospital service, which meets the requirements for a Neonatal Newborn Care Service and meets the definition of a Subspecialty Perinatal Hospital Service as contained in the most recent edition of the *Recommended Guidelines for Perinatal Care in Georgia*, as published by the Council on Maternal & Infant Health.
4. "Neonatal Intermediate Care Service (Specialty/Level II)" means a hospital service, which meets the requirements for a Neonatal Newborn Care Service and meets the definition of a Specialty Perinatal Hospital Service as contained in the most recent edition of the *Recommended Guidelines for Perinatal Care in Georgia*, as published by the Council on Maternal & Infant Health.
5. "Neonatal Newborn Care Service" means a hospital service which meets the minimum standards contained in Chapter 290-5-6-.17 of the rules of the Department of Human Resources, such chapter being entitled "Newborn Service, Amended."
6. "Obstetric Service" means a hospital service which meets the minimum standards contained in Chapter 290-5-6-.16 of the rules of the Department of Human Resources, such chapter being entitled "Maternity and Obstetrical Service. Amended."
7. "Official Inventory" means the inventory for each hospital of Basic Perinatal Service and Neonatal Intermediate (Specialty) Care Services and Intensive (Subspecialty) Care Service beds maintained

by the Agency based upon responses to the Annual Hospital Questionnaire (AHQ) and/or its Perinatal Addendum and any Certificate of Need approved beds after the period covered by the AHQ and with the following provisions: (See Appendix A for Inventory of OB Services in Georgia)

(a) the official inventory for each facility will remain unchanged for the year following the last day of the report period on each hospital's completed AHQ and/or its Perinatal Addendum unless the Agency approves a change of bed capacity through the Certificate of Need process;

(b) the capacity of existing freestanding birthing centers will not be counted as part of the official inventory of available services when computing unmet numerical need for Basic Perinatal Services in a state service delivery region.

8. "Perinatal physician training program" refers to obstetrics and gynecology, family practice and pediatrics disciplines.

9. "Planning Areas" means fixed substate regions for reviewable services as defined in the State Health Component Plan for Perinatal Services. The State Service Delivery Region map is used in the determination of need for basic and intermediate perinatal services; Another map, consistent with the perinatal regions of the Council on Maternal & Infant Health is used for Intensive Care Perinatal Services.(See Appendix B)

10. "Regional Perinatal Center" (RPC) means those hospitals designated by the Dept. of Human Resources to serve a defined geographic area to provide the highest level of comprehensive perinatal health care services for pregnant women, their fetuses and neonates of all risk categories. The RPC accepts patients in need of these services from its region regardless of race, creed, religion, ability to pay or funding source. The RPC provides consultation and transport for patients requiring special services; coordination and assurance of follow-up medical care for maternal and neonatal patients requiring special care; educational support to ensure quality care in institutions involved in perinatal health care; compilation, analysis, and evaluation of perinatal data from the center and referring hospitals and coordination of perinatal health care within the region.

11. "Urban County" means a county with a projected population for the horizon year of 100,000 or more and a population density for that year of 200 or more people per square mile. All other counties are "rural".

12. "Perinatal Health Services" means the services pertaining to the pregnant woman, her fetus and newborn. These services include both inpatient hospital and outpatient obstetric, neonatal and postnatal services

## .C. GUIDELINES FOR CERTIFICATE OF NEED FOR PERINATAL HEALTH SERVICES

### AVAILABILITY

Standard 1 - Determination of Need: The need for perinatal hospital services should be determined through the application of a numerical need method and an assessment of the aggregate occupancy rate of existing services. A variance from this standard may be allowed when it is determined that unusual circumstances exist which justifies such action.

A. The numerical need for Basic Perinatal Services, Neonatal Intermediate Care (Specialty) and Neonatal Intensive Care Services (Subspecialty) should be determined through the application of a demand based forecasting model which considers historical service utilization, projected population, and the official inventory of existing services.

B. Determination of need should include an assessment of the aggregate occupancy rate of existing services.

Rationale for Standard 1: Before new or expanded bed capacity is approved, numerical need should be established. A comprehensive analysis of current and projected bed use should also be undertaken. Additional unused beds will result in increased costs to patients and could potentially remain unused if an aggregate review of current resources and some projections about future use are not taken into account.

The demand based forecasting model for each service for each planning area is based upon the following factors:

- < historical service utilization;
- < projected population; and
- < official inventory of service resources.

The resulting calculations are used to review the numerical need for new services and for expansion of existing services. There is a need to limit the unnecessary duplication of services and to provide incentives for the maximum utilization of existing beds/services. This limitation will increase the utilization of existing bed space. The need for services should be based on a desired occupancy rate for perinatal hospital services.

Standard 2- Exceptions to Need: Exceptions to numerical need may be considered by the Agency as follows: (1) to assure geographic access to Basic Perinatal Services in rural areas when the facility is the sole provider of general hospital services in the rural county; or (2) to allow expansion of any existing perinatal service (urban or rural) if the actual utilization of that service has exceeded 80% occupancy over the past two years.

Rationale for Standard 2: The distribution of perinatal health services and beds should closely correlate with patterns of population characteristics, distribution and growth. The need method for such services should distribute the supply of beds and services in a manner, which relates naturally with expansion of population growth and patterns of need. However, circumstances may exist in a community, which make it unique or where access to basic perinatal services for a specific segment of the population is limited. In these cases, individual community analysis and evaluation of access patterns may be necessary with an exception from numerical need standards even when the numerical need model indicates no or little unmet numerical need. Such an exception should apply to need only. All other applicable standards should be met. The exception for expansion recognizes the role of high volume providers.

Standard 3- Adverse Impact: In the development of new or expanded Basic Perinatal Care Services, Neonatal Intermediate Care Services (Specialty Care) or Neonatal Intensive Care Services (Subspecialty Care), the impact on existing and approved services in a planning area should be documented with the goal of minimizing adverse impact on the delivery system. Adverse impact should be evaluated from both a facility-specific and system-wide perspective.

Rationale for Standard 3: This standard addresses the issue of impact, or projected impact of the establishment of new or expanded services on existing and approved services. To the extent possible, the objective is to prevent the unnecessary duplication of these services so as to achieve and maintain a sufficient number of patients in all services, thus having a positive impact on quality of care, cost-effectiveness and the efficient use of personnel.

Additionally, new or expanded services should be established in a way, which creates and maintains a positive relationship between new and existing services, with consideration for system-wide implications. It is possible that system benefits might outweigh an adverse impact, short term or long term, on an individual provider. Therefore, projected impact, both system-wide and facility to facility, should include analysis of

factors such as, but not limited to, the following: costs, quality, accessibility, operating margin and availability of staff. In addition to the above adverse impact considerations, the Agency will also consider adverse impact on perinatal physician training programs, Georgia's nurse midwifery training program and the six regional perinatal centers.

Standard 4 - Protection of Perinatal Physician Training Programs: An existing training program should not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that the existing service could not sustain a sufficient number and variety of patients to maintain an appropriate number of providers and provider competencies and the training program's accreditation and funding status.

Rationale for Standard 4: Perinatal physician training programs provide an opportunity for resident physicians to develop competence in the provision of primary care services to women and children. They are expected to maintain an appropriate level of deliveries annually to support the number of residency slots for each discipline (Family Practice, OB/GYN and Pediatrics) to maximize the use of physician staff, to enhance provider competencies and to maintain accreditation.

*The Graduate Medical Education Directory (1996-7)*, of the American Medical Association stipulate that the patient population on which the educational program is based should be sufficient in size and composition (variety) so that the broad spectrum of experiences necessary to meet educational objectives will be provided. These stipulations also assure that the broad spectrum of experiences necessary to meet educational objectives will be provided and that a stable population of sufficient number and variety of patients to ensure comprehensiveness and continuity of experiences will be provided. As a result, training programs having an insufficient number of patients negatively impacts the training experience and jeopardizes the program's accreditation status.

Approximately twenty (20) perinatal training programs exist throughout the State of Georgia. These programs require some minimum number of residents and resident/patient contact hours per year in order to maintain their accreditation status. These hospital-based training programs are critical components of the healthcare delivery system and represent upwards of 75% of the care that is rendered to obstetric patients in teaching institutions. When planning for statewide perinatal services, every consideration should be given to protecting the accreditation status of the perinatal training programs (Pediatrics, Obstetrics & Gynecology and Family Practice).

The Georgia Board for Physician Workforce/Medical Education Advisory Committee is developing

state-specific guidelines for training programs. The most current edition of these requirements should be considered in the assessment of adverse impact.

Standard 5 - Protection of Nurse Midwifery Training Program: Georgia's existing nurse midwifery training program should not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that the existing service could not sustain an appropriate number of providers and provider competencies and sustain a sufficient number and variety of patients in order to maintain the training program's accreditation status.

Rationale for Standard 5: Delivery of safe and effective perinatal nursing care requires appropriately qualified nurses in adequate numbers to meet patient needs. Nursing responsibilities in individual hospitals vary according to the level of care provided, prescribed practice procedures, and the number of professional and ancillary staff.

Changing trends in medical management and technologic advances influence and may increase the nursing workload. It is important to be able to secure the appropriate complement of nursing staff to provide an optimum level of care to the patient and the newborn. Additionally, managed care and other organizational changes in health care delivery have sought to contain costs and, have increased the utilization of nursing personnel in both inpatient and community settings. Because future growth of this professional group is strong, a conscientious effort is needed to maintain and support these critical health care professionals. Furthermore, nurse midwifery training programs are expected to maintain an appropriate volume and variety of deliveries in order to maintain their accreditation status. In an assessment of adverse impact on this program, the most current edition of the *Criteria for Accreditation of Education Programs in Nurse-Midwifery and Midwifery with Guidelines for Elaboration and Documentation of Accreditation Criteria*, American College of Nurse-Midwives, should be considered.

Standard 6 - Protection of Regional Perinatal Centers: An existing regional perinatal center should not be adversely impacted by the establishment of a new or expanded perinatal service to the extent that it could not sustain a sufficient volume and case mix of patients including both low risk and high risk deliveries to maintain its regional center status.

Rationale for Standard 6: Regionalization is an attempt to ensure optimal availability of healthcare resources to

provide specialized and highly technical services to patients. Regionalization is focused on health system coordination, communication and collaboration to provide referral, consultation, and transport to those requiring perinatal services. There are six regional perinatal centers in the State of Georgia. These centers function at a high level of technological capability, providing the full range of services and expertise required for the management of complicated maternity or newborn conditions. Georgia's regional perinatal system has been credited for the statewide decline in infant mortality rates.

The regional designation process is based on regional need and available funding. Funding for the regional perinatal center (RPC) is predicated on a defined allocation formula that examines volume and case mix differences across each region. Each RPC is expected to maintain Level III (Subspecialty Care) status. In the assessment of adverse impact on these centers, the most current edition of the *Core Requirements and Guidelines for the Designated Regional Perinatal Centers in the State of Georgia* as developed by Georgia Department of Human Resources, should be considered.

## **COSTS**

Standard 1- Utilization of Existing Space: Hospitals planning to offer perinatal services should agree to provide services within the maximum evaluated bed capacity of the hospital.

Rationale for Standard 1: Perinatal health services are a part of the array of services provided by community hospitals. As part of the effort to control the supply of underutilized acute care medical/surgical beds in the state, the conversion of underutilized beds to Basic Perinatal Services may effectively reduce the oversupply of such beds while expanding access to a specific service. Every opportunity to contain healthcare costs including maximizing the use of existing resources is strongly encouraged and recommended.

## **UNIT SIZE**

Standard 2- Unit Size: Unit size for a new inpatient perinatal health service should reflect efficiency and cost effectiveness.

Rationale for Standard 2: To help ensure that an inpatient perinatal health service provides high quality services in an efficient and cost-effective manner, minimum bed complement may be suggested. Programs with bed complements below certain levels may be too small to provide a specialized staff and services at a reasonable cost and still maintain program integrity and quality. In certain circumstances, sound planning may

warrant a variance from the size standards. For example, if need in a planning area approaches but does not equal or exceed the suggested minimum bed size and there are no feasible alternatives for the delivery of services, the Agency may grant a variance from the size standard to allow development of a new program that is considered to be in the best interest of health planning.

## **QUALITY**

Standard 1 -Qualified Personnel/Staffing: Any perinatal service should be able to document that qualified personnel will be available to insure a quality service which meets appropriate licensure, certification, and/or accreditation requirements and which meets all of the standards outlined in the most recent edition of *Recommended Guidelines for Perinatal Care in Georgia*, a publication of the Council on Maternal & Infant Health.

Rationale for Standard 1: In an effort to promote improved outcomes for patients and families, providers must focus on staff. Ongoing attempts to control costs and to manage care has increased the demand for advanced practice nurses and other physician extenders (non-physician clinicians). Because these professionals are being utilized to provide front line care in both community and managed care settings, it is imperative that a program is implemented to assure that only those professionals with fine-tuned high functioning skills are in place to provide good quality care to patients. The applicant's ability to meet this standard should include, but not be limited to, the following: developing professional and direct care staff by offering continuing education and training, providing documentation that all staff who will provide the proposed services are state licensed or credentialed, where appropriate, have extensive experience and have ongoing training in their field of expertise.

Further, the perinatal service should demonstrate the intent to obtain appropriate levels and numbers of professional and paraprofessional staff to meet the requirements of the services proposed, and should assure that specified personnel are available in the proposed geographic service area.



Standard 2- Utilization Review Program: Each perinatal service should have a utilization review program consistent with state, federal and other accreditation standards.

Rationale for Standard 2: Utilization Review ensures the appropriate allocation of hospital resources without compromising the quality of patient care. A comprehensive quality improvement program should include, but not be limited to, measuring patient outcomes, outlining procedures and plans for staff training and monitoring the facility's overall performance. Further, evidence that the applicant has implemented a continuous quality improvement program should be provided.

Standard 3: Appropriate Licensure Requirements: A perinatal service should document its intent to comply with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources.

Rationale for Standard 3: The state has an interest in ensuring that all hospitals provide the highest quality of care to its patients. Compliance with licensure requirements, both state and national, correlates to the successful operation and management of hospitals and indicates that a facility has met certain performance standards. Healthcare facilities that meet these standards improve their ability to provide quality patient care.

Standard 4: Uncorrected Operational Standards: There should be no uncorrected operational standards in any hospital in Georgia owned and /or operated by the proposed facility or by the facility's parent organization. Plans to correct all deficiencies should be provided.

Rationale for Standard 4: Georgia's hospitals should be held to the highest standards of patient care. Where deficiencies in the provision of patient care or in the operation of the facility are cited, a plan to correct such deficiencies should be outlined, along with an agreed upon time-frame in which to address and correct them. Evidence of intent to address all deficiencies must be provided

## CONTINUITY

Standard 1- Array of Services: Hospitals should provide access to an array of perinatal health services by submitting a plan whereby the hospital and its medical staff agree to provide a full array of perinatal health services to the community, including community education and outreach, prenatal, intrapartum, postpartum, newborn, and postnatal services.

Rationale for Standard 1: The provision of perinatal services should be part of a continuum of services that provide prenatal, intrapartum and postpartum care along with other support services. It is expected that Basic Perinatal Services predominantly will include normal deliveries to low risk mothers, except for some emergencies, and that any moderate to high risk patients will be identified and transferred in a timely manner to an appropriate level of care. A formal transfer agreement with at least one hospital, within reasonable proximity, that provides services to high risk mothers and babies is essential to the provision of good quality perinatal care.

Experience and research have proven that a hospital is only one point in the continuum of perinatal health care and that to impact infant mortality, morbidity and low birth weight, an array of services must be provided. For example, recent research has shown the importance of smoking cessation programs, alcohol abstinence, and prenatal nutritional education on expectant mothers. These services, along with adequate prenatal care and postnatal services, such as pre-pregnancy screening, parenting classes, newborn followup, (i.e. immunizations) and family planning education will enhance the effectiveness of a hospital perinatal service. To offer these services, a hospital may consider entering into a formal agreement with other providers of health care including the Public Health Department for provision of some services, e.g., community outreach and prenatal care. There also should be emphasis on outreach to underserved groups such as non-English speaking, the homeless, migrants and pregnant teenagers.

Standard 2 - Participation in the Regional Perinatal System: Hospitals offering perinatal services should provide evidence of an agreement to participate in the community based regional perinatal system. A Basic Perinatal Service should enter into a formal transfer agreement (as provided by COBRA) with at least one hospital that provides services for high-risk mothers and babies.

Rationale for Standard 2: Hospitals should assure continuity and quality of inpatient perinatal health services by strengthening the regional service system and referral network among providers, for safe and appropriate care for mothers and babies. The provision of quality perinatal health services is an essential element of any planning strategy. Increasing concerns with continuous quality improvement programs make it imperative that the Agency focus attention on coordinated and integrated systems at local and regional levels and quality of patient care as important aspects of planning.

## **FINANCIAL ACCESSIBILITY**

Standard 1 - Financial Accessibility: Hospitals providing Basic Perinatal Services, Neonatal Intermediate (Specialty Care) and Neonatal Intensive Care Services (Subspecialty Care) should foster an environment that assures access to services for those unable to pay regardless of payment source or circumstances. Hospitals should provide services to indigent patients and participate in the Medicaid program and other public reimbursement programs.

Rationale for Standard 1: Systematic comparison of the contribution of care for indigent members of the state's population is an essential component of the planning process. The equitable distribution of indigent care among providers is corollary to the equitable access to hospital and health care services for all citizens without regard to the ability to pay. It is characteristic of rational systems that the burden of the medically indigent be equitably distributed among all providers.

Assessment of a hospital's commitment to assure financial access to services should be multifaceted. The essential elements of the assessment for both past performance and future commitments may include, by are not limited to, the following:

1. Administrative policies and directives related to providing services on a non-discriminatory basis;
2. Provision of indigent care and charity care;
3. Provision of service to Medicaid recipients; and
4. Participation in Public Reimbursement Programs for perinatal services for which the hospital is eligible.

Assessment should encompass all aspects of a provider's healthcare delivery system (e.g., all corporate entities) including historical trends in the provision of care. The Agency should have the flexibility to factor in innovative approaches to service delivery. For example, outreach and primary care activities for the indigent population could be the most effective approach from a health planning perspective even if the aggregate expenditure is less than alternative approaches. Financial accessibility should also encompass consideration of catastrophic or unusual cases where free care is applicable to persons with higher incomes.

## **INFORMATION REQUIREMENTS**

Standard 1 - Data Collection: Any perinatal service should provide the Agency with requested information and statistical data related to operation and provision of perinatal services. The quality of a program should be supported by data, particularly outcomes data.

Rationale for Standard 1: Uniform data on perinatal healthcare services is important to assess the changing patterns and projected service needs relevant to this service. Such data allow more precise assessment of the level of services being provided as well as such important indicators as costs, charges, medical techniques and other factors important to health planning. Some measure of the quality of the perinatal service should be supported by outcomes data and up-to-date industry benchmarks that address, at the minimum, patient outcomes and patient satisfaction. Additionally, initiatives that encourage statewide reporting of perinatal data, (as outlined in the most recent edition of *Recommended Guidelines for Perinatal Care in Georgia*, Council on Maternal & Infant Health) would allow comparisons among similar perinatal hospitals, health districts, perinatal regions and other states. Where appropriate, perinatal providers and their corporate entities are strongly encouraged to participate in this data collection process.

## IV. GOALS, OBJECTIVES AND RECOMMENDED ACTIONS

### A. GOAL

Ensure the health and well being of women and their infants with access to needed services beginning before conception and extending through the first year of an infant's life.

### B. OBJECTIVES

1. Assure that perinatal hospital services, found to be in the public interest, are available and accessible to people in sufficient numbers and are compatible with local community needs;
2. Minimize adverse impact on the existing delivery system when establishing new perinatal hospital services;
3. Assure quality of perinatal hospital services by considering both staffing and personnel needs, utilization review, licensure requirements, uncorrected operational standards;
4. Improve the health status of women and babies by creating incentives to provide an array of perinatal services and to participate in the regional perinatal service system and referral network among providers, for safe and appropriate care for mothers and babies;
5. Assure financial access to appropriate perinatal hospital care by encouraging services to indigent patients and participation in Medicaid and other public reimbursement programs;
6. Contain costs in perinatal health care delivery by maximizing use of existing resources;
7. Assess availability, quality and effectiveness of services being provided through Agency information and statistical data.

### C. RECOMMENDED ACTIONS

1. Develop and implement Certificate of Need (CON) Rules for new or expanded perinatal health services consistent with this Component Plan.
2. Support the work of the Council on Maternal and Infant Health (M&I Council) to implement their definitions and guidelines for perinatal health services;
3. Monitor the implementation of recommendations pertaining to perinatal health services from groups such as the M&I Council and other appropriate state agencies and the World Health Organization Collaborating Center for Perinatal Health & Health Services and other appropriate agencies;
4. Strengthen the infrastructure of the plan by working with other state agencies to license/regulate perinatal services by level of care;
5. Work with state agencies and private organizations to establish outcome measures for hospitals that require data collection and reporting to support sound health policy and planning decisions.

## V. REFERENCES

1. American Medical Association, Graduate Medical Education Directory, 1996-7, Chicago, Illinois
2. Georgia Kids Count Fact Book, Georgians for Children, Atlanta, Georgia, 1992 & 1993.
3. Health Insurance Association of America, *Managed Care, A Health Strategy for Today and Tomorrow*, 1993, Washington, D.C.
4. Georgia Department of Human Resources, Division of Public Health/Office of Perinatal Epidemiology, *Healthy People 2000, MCH Objectives: Georgia Indicators*, 1996.
5. Health Insurance Association of America, *The Cost of Maternity Care and Childbirth in the United States, 1989*, (Research Bulletin).
6. Dever, A.G.E., & Brantley, D.M., *Physician Profile, 1996: Toward the Year 2000*, Joint Board of Family Practice, Atlanta, Georgia.
7. Georgia Hospital Association, *1995 Facts*, Atlanta.
8. *The Challenge of Change: A Mid-Decade Look at Maternal and Child Health in Georgia, 1997*, Georgia Department of Human Resources, Epidemiology & Prevention Branch & March of Dimes Birth Defects Foundation, 1997
9. *Georgia's Nursing Workforce*, Office of Institutional Research & Information, Medical College of Georgia, June 1998
10. *Georgia's Health Professions: A Decade of Change, 1985-1995*, Morris & Little, 1996
11. "Current and Projected Workforce of Non-physician Clinicians", *Journal of the American Medical Association*, September 2, Vol. 280, No.9, 1998.
12. Frank, J., *National Health Policy Forum*, February 22, 1996

## VI. APPENDICES

**APPENDIX A**            Inventory of Obstetric Services in Georgia

**APPENDIX B**            OB Planning Areas



Georgia State Health Plan  
Perinatal Health Services Component Plan

# **APPENDIX A**

Inventory of Obstetric Services in Georgia  
(as of 5/2001)

## INVENTORY of OBSTETRIC SERVICES as of 5/31/2001

Page 1

GID	HOSPITAL	OBHPA	COUNTY
542	EMORY CARTERSVILLE MEDICAL CENTER	1	BARTOW
623	HUTCHESON MEDICAL CENTER	1	CATOOSA
413	FANNIN REGIONAL HOSPITAL	1	FANNIN
606	FLOYD MEDICAL CENTER	1	FLOYD
412	GORDON HOSPITAL	1	GORDON
451	MOUNTAINSIDE MEDICAL CENTER	1	PICKENS
415	HAMILTON MEDICAL CENTER	1	WHITFIELD
Total Hospitals with OB Services in HPA		1	= 7
211	COBB MEMORIAL HOSPITAL	2	FRANKLIN
414	HABERSHAM COUNTY MEDICAL CENTER	2	HABERSHAM
611	NORTHEAST GEORGIA MEDICAL CENTER	2	HALL
404	CHESTATEE REGIONAL HOSPITAL	2	LUMPKIN
545	STEPHENS COUNTY HOSPITAL	2	STEPHENS
248	UNION GENERAL HOSPITAL	2	UNION
Total Hospitals with OB Services in HPA		2	= 6
541	NORTHSIDE HOSPITAL - CHEROKEE	3	CHEROKEE
547	SOUTHERN REGIONAL MEDICAL CENTER	3	CLAYTON
546	WELLSTAR COBB HOSPITAL	3	COBB
615	WELLSTAR KENNESTONE HOSPITAL	3	COBB
720	DEKALB MEDICAL CENTER	3	DEKALB
368	EMORY NORTHLAKE REGIONAL MEDICAL CENTER	3	DEKALB
548	EMORY DUNWOODY MEDICAL CENTER	3	DEKALB
312	WELLSTAR DOUGLAS HOSPITAL	3	DOUGLAS
639	EMORY PARKWAY MEDICAL CENTER	3	DOUGLAS
630	SOUTH FULTON MEDICAL CENTER	3	FULTON
327	NORTH FULTON REGIONAL HOSPITAL	3	FULTON
631	SOUTHWEST HOSPITAL & MEDICAL CENTER	3	FULTON
705	CRAWFORD LONG HOSPITAL OF EMORY	3	FULTON
709	ATLANTA MEDICAL CENTER	3	FULTON
710	GRADY MEMORIAL HOSPITAL	3	FULTON
617	PIEDMONT HOSPITAL	3	FULTON
634	NORTHSIDE HOSPITAL	3	FULTON
722	WEST PACES MEDICAL CENTER	3	FULTON
366	GWINNETT MEDICAL CENTER	3	GWINNETT
534	EMORY EASTSIDE MEDICAL CENTER	3	GWINNETT
532	HENRY MEDICAL CENTER	3	HENRY
322	NEWTON GENERAL HOSPITAL	3	NEWTON
240	ROCKDALE HOSPITAL	3	ROCKDALE
Total Hospitals with OB Services in HPA		3	= 23
303	BARROW MEDICAL CENTER	4	BARROW
603	ATHENS REGIONAL MEDICAL CENTER	4	CLARKE
622	ST MARYS HOSPITAL	4	CLARKE
407	ELBERT MEMORIAL HOSPITAL	4	ELBERT
420	MINNIE G BOSWELL MEMORIAL HOSPITAL	4	GREENE
440	BJC MEDICAL CENTER	4	JACKSON
340	WALTON MEDICAL CENTER	4	WALTON
Total Hospitals with OB Services in HPA		4	= 7
244	TANNER MEDICAL CENTER/VILLA RICA	5	CARROLL
435	TANNER MEDICAL CENTER (CARROLLTON)	5	CARROLL

**INVENTORY of OBSTETRIC SERVICES as of 5/31/2001**

Page 2

<b>GID</b>	<b>HOSPITAL</b>	<b>OBHPA</b>	<b>COUNTY</b>
629	EMORY PEACHTREE REGIONAL HOSPITAL	5	COWETA
349	BAPTIST MERIWETHER HOSPITAL	5	MERIWETHER
508	SPALDING REGIONAL HOSPITAL	5	SPALDING
605	WEST GEORGIA MEDICAL CENTER	5	TROUP
523	UPSON REGIONAL MEDICAL CENTER	5	UPSON
Total Hospitals with OB Services in HPA		5	= 7
528	OCONEE REGIONAL MEDICAL CENTER	6	BALDWIN
266	MACON NORTHSIDE HOSPITAL	6	BIBB
636	COLISEUM MEDICAL CENTERS	6	BIBB
712	MEDICAL CENTER OF CENTRAL GEORGIA	6	BIBB
450	PERRY HOSPITAL	6	HOUSTON
439	HOUSTON MEDICAL CENTER	6	HOUSTON
540	WASHINGTON CO REGIONAL MED CENTER	6	WASHINGTON
Total Hospitals with OB Services in HPA		6	= 7
306	BURKE COUNTY HOSPITAL	7	BURKE
408	EMANUEL COUNTY HOSPITAL	7	EMANUEL
726	DOCTORS HOSPITAL of AUGUSTA	7	RICHMOND
620	ST JOSEPH HOSPITAL (AUGUSTA)	7	RICHMOND
719	MEDICAL COLLEGE OF GEORGIA HOSPITAL	7	RICHMOND
716	UNIVERSITY HOSPITAL	7	RICHMOND
526	WILLS MEMORIAL HOSPITAL	7	WILKES
Total Hospitals with OB Services in HPA		7	= 7
724	DOCTORS HOSPITAL (COLUMBUS)	8	MUSCOGEE
704	MEDICAL CENTER (COLUMBUS)	8	MUSCOGEE
602	SUMTER REGIONAL HOSPITAL	8	SUMTER
Total Hospitals with OB Services in HPA		8	= 3
405	CRISP REGIONAL HOSPITAL	9	CRISP
309	DODGE COUNTY HOSPITAL	9	DODGE
510	FAIRVIEW PARK HOSPITAL	9	LAURENS
519	TAYLOR REGIONAL HOSPITAL	9	PULASKI
Total Hospitals with OB Services in HPA		9	= 4
502	BULLOCH MEMORIAL HOSPITAL	10	BULLOCH
626	CANDLER HOSPITAL	10	CHATHAM
703	MEMORIAL HEALTH UNIVERSITY MED CTR	10	CHATHAM
448	EVANS MEMORIAL HOSPITAL	10	EVANS
355	LIBERTY REGIONAL MEDICAL CENTER	10	LIBERTY
443	MEADOWS MEMORIAL HOSPITAL	10	TOOMBS
Total Hospitals with OB Services in HPA		10	= 6
524	COLQUITT REGIONAL MEDICAL CENTER	11	COLQUITT
539	MEMORIAL HOSPITAL (BAINBRIDGE)	11	DECATUR
616	PHOEBE PUTNEY MEMORIAL HOSPITAL	11	DOUGHERTY
357	EARLY MEMORIAL HOSPITAL	11	EARLY
351	GRADY GENERAL HOSPITAL	11	GRADY
348	MILLER COUNTY HOSPITAL	11	MILLER
421	MITCHELL COUNTY HOSPITAL	11	MITCHELL
614	JOHN D ARCHBOLD MEMORIAL HOSPITAL	11	THOMAS
343	BAPTIST HOSPITAL WORTH COUNTY	11	WORTH

**INVENTORY of OBSTETRIC SERVICES as of 5/31/2001**

Page 3

<b>GID</b>	<b>HOSPITAL</b>	<b>OBHPA</b>	<b>COUNTY</b>
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Total Hospitals with OB Services in HPA 11 = 9

501	DORMINY MEDICAL CENTER	12	BEN HILL
317	MEMORIAL HOSPITAL OF ADEL	12	COOK
314	IRWIN COUNTY HOSPITAL	12	IRWIN
529	LOUIS SMITH MEMORIAL HOSPITAL	12	LANIER
333	SMITH HOSPITAL	12	LOWNDES
618	SOUTH GEORGIA MEDICAL CENTER	12	LOWNDES
521	TIFT GENERAL HOSPITAL	12	TIFT

Total Hospitals with OB Services in HPA 12 = 7

301	APPLING HOSPITAL	13	APPLING
302	BACON COUNTY HOSPITAL	13	BACON
441	CAMDEN MEDICAL CENTER	13	CAMDEN
406	COFFEE REGIONAL HOSPITAL	13	COFFEE
507	SOUTHEAST GEORGIA REGIONAL MED CTR	13	GLYNN
442	JEFF DAVIS HOSPITAL	13	JEFF DAVIS
627	SATILLA REGIONAL MEDICAL CENTER	13	WARE
538	WAYNE MEMORIAL HOSPITAL	13	WAYNE

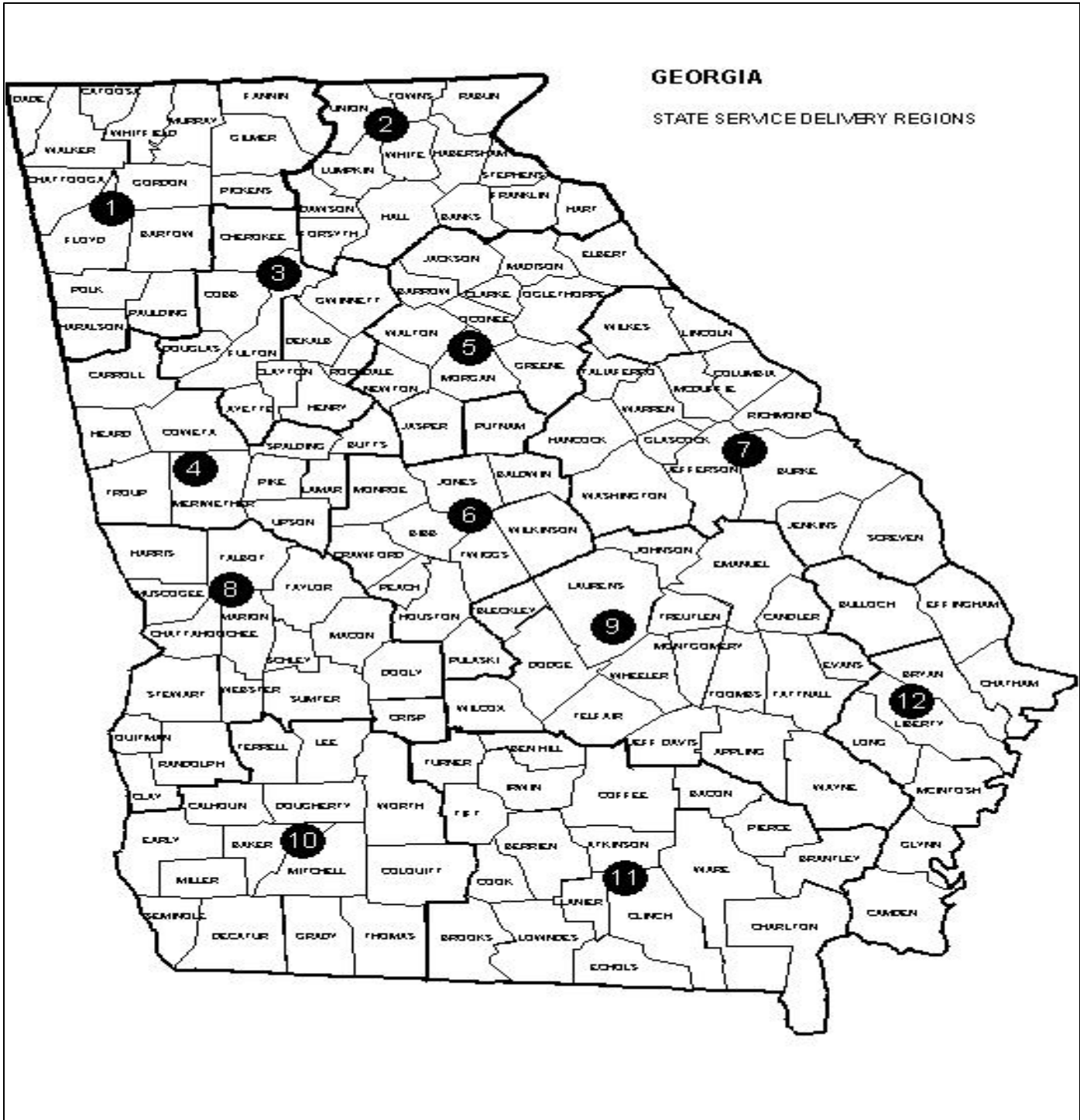
Total Hospitals with OB Services in HPA 13 = 8

**TOTAL OF 101 HOSPITALS WITH OB SERVICES**

**Georgia State Health Plan**  
**Perinatal Health Services Component Plan**

**APPENDIX B**

**OB PLANNING AREAS**



Planning areas for Basic Perinatal Services and Neonatal Intermediate Care Services

Effective April 1, 2003

# GEORGIA

## PLANNING AREAS FOR NEONATAL INTENSIVE CARE SERVICES

CONSISTENT WITH PERINATAL REGIONS OF THE MATERNAL AND INFANT HEALTH COUNCIL

