



# *Indiana Emergency Department Guidelines for Pregnant Women*

## **CONSENSUS**

June 2010

### **POSITION**

Indiana Emergency Departments would benefit from written guidelines for evaluating and managing pregnant women to optimize outcomes for her and her fetus.

### **RATIONALE**

Evaluation of the pregnant patient presenting to the Emergency Department (ED) presents unique challenges since the presence of a fetus means that there are two patients potentially at risk, both of whom require evaluation and management.

Emergency departments may not possess adequate resources, personnel, or policies to address access and appropriate management of the obstetrical patient. Appropriately educated caregivers with access to proper resources are vital to providing the best care for the mother and fetus.

This consensus document has been developed as a resource for the healthcare professionals working in these clinical areas to provide guidance and support for establishing well-defined criteria to safely and effectively triage and care for pregnant women, those experiencing complications related to pregnancy, as well as the trauma patient who is pregnant.

### **OBJECTIVES**

1. Ensure timely and systematic maternal and fetal evaluation and stabilization.
2. Provide guidelines for the care of the obstetrical patient who presents to the Emergency Department.
3. Provide guidelines for prenatal referral to appropriate community agencies.
4. Increase the number of women beginning early prenatal care.
5. Increase the number of Emergency Departments that screen women for domestic violence and substance abuse.

### **BACKGROUND**

Nearly 90,000 babies are born in Indiana each year. Most of these pregnancies and births are low risk and uneventful. However, there are a significant number of women who know they are pregnant that have urgent events (trauma, preterm labor, bleeding), or present to the emergency department with a critical medical condition and may not know they are pregnant. During 2006, more than half a million ED visits in the US were related to obstetric/perinatal conditions.

As access to care and health care coverage becomes more limited, there are an increasing number of obstetrical patients in Indiana that present to ED's for primary obstetrical health care. Low-income patients make up one third of ED visits, the uninsured one fifth, and rural residents one fifth of all ED visits.

There is an association between the amount of prenatal care received and birth outcomes. (See Appendix A). Healthy People 2010 targets low birth weight (LBW), infant mortality and early prenatal care as areas that need improvement. Only 78.8% of pregnant women in Indiana receive first trimester (early) prenatal care; this is below the national average and well below the target for Healthy People 2010.

Progress in reducing Indiana's infant mortality rate and eliminating the racial and ethnic differences in pregnancy outcomes will occur with a community based commitment to improve birth outcomes and maintain healthy infants.

## RECOMMENDATIONS

Policies and procedures for the care of an obstetric patient presenting to the ED should address the following factors:

- nature of the complaint,
- availability of consultants and testing,
- gestational age of the fetus,
- need for fetal evaluation
- potential need for transfer of the patient between the ED and OB departments.

Open lines of communication and coordination between the OB and ED departments are vital to provide optimum care for both the mother and the fetus. Facilities that utilize an interdisciplinary team approach and promote the use of community resources may decrease use of the Emergency Department for non-emergent care, and foster more women obtaining early and adequate prenatal care.

A systematic approach to the ED triage and initial assessment of the obstetric patient is essential. It is important to ascertain whether:

- 1) the emergency problem is related to pregnancy
- 2) the problem is unrelated to but affected by the pregnancy
- 3) the problem affects the pregnancy, or
- 4) the problem neither affects the pregnancy or is affected by the pregnancy

1. All hospital policies should be in accordance with the Joint Commission and the Emergency Medical Treatment and Active Labor Act (EMTALA). (See Appendix B).

2. Screen all women between the ages of 12 – 50 for pregnancy:

- Evaluate the date of their last menstrual period (LMP)
- If uncertain of LMP, consider the possibility of pregnancy; confirm by lab test and/or ultrasound if needed
- If not pregnant, provide information for primary medical care and family planning services, if appropriate.
- If the woman is pregnant and not receiving prenatal care, provide her with a written referral for obstetric care options. (ED should identify local resources: Prenatal care coordinators, prenatal clinics, Social Services, Medicaid enrollment assistance, WIC sites, and any other agency that would meet an identified need of the patient.)
- Provide every pregnant woman with the Indiana Family Helpline number (1-800-433-0746) for additional referrals and to receive the IPN Baby First workbook with educational video (English and Spanish packets available).

3. Minors who are pregnant:

- Disclosure of pregnancy should be made first to the minor, then to the parent
- For all new diagnoses of pregnancy among adolescents, a provider should minimally address issues related to safety and disclosure to family and the father of the baby
- Screening and reporting child abuse is mandated for 12 and 13 year olds. Minor consent for pregnancy-related care can also be cumbersome (See Appendix C)
- If available, refer to adolescent-friendly reproductive health services, including comprehensive options counseling and OB care

4. The obstetrical patient in ED:
  - Because ectopic pregnancy remains the most common cause of maternal death and serious morbidity in the first trimester of pregnancy, it is essential to initially differentiate between an ectopic and intrauterine pregnancy.
  - Should have fetal heart tones, abdominal pain (with or without spotting) assessed, (may not be perceptible prior to 12 weeks gestational age) as well as uterine contraction status reported to or assessed by a qualified obstetric provider.
  - Involved in trauma should be first treated in the ED to stabilize the mother as the first priority with consistent communication between the ED and a qualified obstetric provider.
  - With a gestation of > 16-18 weeks, with active or suspected labor or obstetrical complications should be referred to a qualified obstetric provider (dependent upon institutional policies, procedures and resources).
  - In active labor should optimally be delivered in the Labor & Delivery (L&D) Department; however the care of the patient should take place in the area best prepared to meet the needs of the patient.
  - Should be stabilized with any emergency condition, whether or not the condition is OB-related, otherwise the effect on the fetus may be detrimental.
  
5. Every woman should be screened for domestic violence and substance abuse and provided with appropriate community referral resources.
  - Indiana Coalition Against Domestic Violence: [www.violenceresource.org](http://www.violenceresource.org)  
Use the forms below to help a client obtain a protective order.  
<http://www.violenceresource.org/popformcounsel.pdf>  
<http://www.violenceresource.org/POPformVictim.pdf>

## REFERENCES

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Agency for Healthcare Research and Quality

[http://hcupnet.ahrq.gov/Hcupnet.jsp?Id=EF060F78FC024DBB&Form=SelDB&JS=Y&Action=%3E%3ENext%3E%3E&\\_DB=NEDS06](http://hcupnet.ahrq.gov/Hcupnet.jsp?Id=EF060F78FC024DBB&Form=SelDB&JS=Y&Action=%3E%3ENext%3E%3E&_DB=NEDS06)

## APPENDIX A

### Indiana Statewide Select Perinatal Health Indicators

Perinatal Health Indicator	Indiana, 2006 <sup>1</sup>	U.S. Rank <sup>2</sup>	Healthy People 2010 Goal
Entry into Prenatal Care (first trimester)	78.8%	34	90.0%
Low Birth Weight (less than 2,500 grams)	8.2%	24	5.0%
<i>Among women with "adequate" PNC<sup>3</sup></i>	3.7%		
<i>Among women with "inadequate" PNC</i>	7.6%		
<i>Among women with no PNC</i>	24%		
Preterm Birth (less than 37 weeks gestation)	13.4%	37	7.6%
<i>Among women with "adequate" PNC</i>	4.1%		
<i>Among women with "inadequate" PNC</i>	12.4%		
<i>Among women with no PNC</i>	31.4%		
Infant Mortality Rate (per 1,000 births)	Total: 7.9 White: 6.4, Black: 18.1	40	4.5 total
<i>Among women who entered PNC during 1<sup>st</sup> trimester</i>	6.9		
<i>Among women who entered PNC during 2<sup>nd</sup> trimester</i>	7.6		
<i>Among women with no PNC</i>	29.5		

<sup>1</sup> Provisional data. Sources: Indiana State Department of Health Epidemiology Resource Center. (2008). *Trends in birth outcomes and maternal characteristics in Indiana: Statistics from the live birth data, 1990-2006*; *Draft Indiana Infant Mortality Report 1990-2006: Statistics from the period linked birth/infant death data set*; Indiana Natality Report, 2006, Table 6; Indiana Mortality Report, 2006, Table 8

<sup>2</sup> Based on 2005 data. Sources: National Women's Law Center. (2008). *National report card on women's health*. Available at <http://hrc.nwlc.org/reports/state-report-card.aspx?stateID=INDIANA>; The Annie E. Casey Foundation. (2007). *KIDS COUNT state level data online*. Available at <http://www.kidscount.org/datacenter>; Martin JA, Hamilton BE, Sutton PD, Ventura SJ, et al. Births: Final data for 2006. National vital statistics reports; vol 57 no 7. Hyattsville, MD: National Center for Health Statistics. 2009; Heron MP, Hoyert DL, Murphy SL, Xu JQ, Kochanek KD, Tejada-Vera B. Deaths: Final data for 2006. National vital statistics reports; vol 57 no 14. Hyattsville, MD: National Center for Health Statistics. 2009, Table 32

<sup>3</sup> Italicized data source: Indiana State Department of Health Epidemiology Resource Center. (2007). *Trends in birth outcomes and maternal characteristics in Indiana: Statistics from the live birth data, 1990-2005*.

## APPENDIX B

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### EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) was included in the COBRA legislation of 1986. It was promulgated to combat the discriminatory practice of some hospitals transferring, discharging, or refusing to treat indigent patients coming to the emergency department because of the high cost associated with diagnosing and treating these patients with emergency medical conditions. While the Act applies to all Medicare participating hospitals, it protects anyone coming to a hospital seeking emergency medical services, not just Medicare beneficiaries. EMTALA imposes strict penalties including fines and exclusion from the Medicare program for violations of the Act. The Act imposes three primary requirements on Medicare participating hospitals that provide emergency medical services.

1. The hospital must provide an appropriate medical screening exam to anyone coming to the ED seeking medical care;
2. For anyone that comes to the hospital and the hospital determines that the individual has an emergency medical condition, the hospital must treat and stabilize the emergency medical condition, or the hospital must transfer the individual; and
3. A hospital must not transfer an individual with an emergency medical condition that has not been stabilized unless several conditions are met that includes effecting an appropriate transfer.

American Academy of Emergency Medicine [www.aaem.org/emtala](http://www.aaem.org/emtala)  
Centers for Medicare and Medicaid Services [www.cms.hhs.gov/emtala](http://www.cms.hhs.gov/emtala)

### Special Determination of Emergency Medical Conditions for Pregnant Women

The definition of an emergency medical condition also makes specific reference to a pregnant woman who is having contractions. It provides that an emergency medical condition exists if a pregnant woman is having contractions and "...there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or unborn child."

An emergency medical condition does not exist, even when a woman is having contractions, as long as there is adequate time to effect a safe transfer before delivery and the transfer will not pose a threat to the health or safety of the mother or the fetus. Labor is defined as "the process of childbirth beginning with the latent phase of labor or early phase of labor and continuing through delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor."

Under this definition, a qualified medical person must certify that a woman is in false labor before she can be released. It is important to note that, in the case of a pregnant woman, the health of the fetus also must be considered in determining whether an "emergency medical condition" exists.

American Academy of Pediatrics and The American College of Obstetricians and Gynecologists (2007). Guidelines for Perinatal Care, (6th edition). Washington, DC: AAP/ACOG. p. 407-408.

# APPENDIX C

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## Current Indiana Laws Regarding Consent & Confidentiality For Minors

### MINOR CONSENT & CONFIDENTIALITY—INDIANA LAW

#### I. Minor Consent

##### ***What is the age of majority/minority?***

The age of majority in Indiana is eighteen years. IC § 1-1-4-5. What is the age of consent for sexual activity? While no statute specifically establishes an age at which a minor legally may consent to sexual activity, there can be criminal penalties for consensual sexual activity with a minor 16 years of age or younger. See IC § 35-42-4-9. There also can be criminal penalties for consensual sexual activity with a minor under 18 years of age when certain circumstances exist. For example, it is criminal “child seduction” for an adult who is the guardian, parent or child care provider for a minor less than 18 years old to engage in any sexual activity with that minor, irrespective of consent. IC § 35-42-4-7

##### ***Who generally consents for health care for minors?***

Generally, a parent, guardian, or other person in loco parentis must consent for health care on behalf of a minor. IC § 16-36-1-5.

##### ***What exceptions allow minors or others to consent for health care?***

##### **Emancipated Minors:**

“[A]n individual may consent to the individual’s own health care if the individual is: a minor and ...is emancipated.” IC § 16-36-1-3. While no statute specifically defines emancipation for this purpose, for the purposes of determining child support, a court will find a minor emancipated if the court finds that the child: (1) has joined the United States armed services; (2) has married; or (3) is not under the care or control of: (A) either parent; or (B) an individual or agency approved by the court.” IC § 31-16-6-6

##### **Independent Minor Living Separate and Apart, Financially Independent:**

“[A]n individual may consent to the individual’s own health care if the individual is: (1) a minor and (2) is: (i) at least fourteen (14) years of age; (ii) not dependent on a parent for support; (iii) living apart from the minor’s parents or from an individual in loco parentis; and (iv) managing the minor’s own affairs.” IC § 16-36-1-3

##### **Married or the Military:**

“[A]n individual may consent to the individual’s own health care if the individual is: a minor and (1) is or has been married; [or] (2) is in the military service of the United States.” IC § 16-36-1-3

*For all three of these exceptions, minors may not consent if “in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care.” IC § 16-36-1-4.*

##### **Title X Family Planning, including Pregnancy Testing, Contraception:**

Federal regulations establish special access rules for family planning services funded through Title X. Federal law requires that Title X funded services be available to all adolescents, regardless of their age, without the need for parental consent. 42 C.F.R.59.5(a)(4); see *Does 1-4 v Utah Dept. of Health*, 776F.2d253 (10th Circ. 1985).

Providers delivering services funded in full or in part with Title X monies must comply with the federal regulations. Thus, minors of any age may consent to family planning services when those services are funded in full or in part by Title X monies.

##### **Sexually Transmitted Diseases:**

“An individual who has, suspects that the individual has, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment of the individual.” IC §16-36-1-3.

**HIV/AIDS Testing & Care:**

For services funded in full or in part by Title X, federal law requires the services be available to all adolescents, regardless of age.

For services not funded in full or in part by Title X, state consent law applies: “[A] person may not perform a screening or confirmatory test for the antibody or antigen to HIV without the consent of the individual to be tested....” IC § 16-41-6-1

**Emergency:**

“This section does not require consent to health care in an emergency.” IC § 34-18-12-9.

**Emergency Sexual Assault Services:**

“A hospital licensed under IC §16-21-2 that provides general medical and surgical hospital services shall provide emergency hospital services, in accordance with rules adopted by the victim services division of the Indiana criminal justice institute, to all alleged sex crime victims who apply for hospital emergency services in relation to injuries or trauma resulting from the alleged sex crime.”

“For the purposes of this chapter, the following crimes are considered sex crimes:

- (1) Rape (IC § 35-42-4-1)
  - (2) Criminal deviate conduct (IC § 35-42-4-2)
  - (3) Child molesting (IC § 35-42-4-3)
  - (4) Vicarious sexual gratification (IC § 35-42-4-5).
  - (5) Sexual battery (IC § 35-42-4-8); and
  - (6) Sexual misconduct with a minor (IC § 35-42-4-9).”
- IC § 16-21-8-1.

The Indiana Attorney General has concluded that a parent’s or guardian’s consent is not required prior to rendering emergency medical treatment to a minor who is an alleged rape victim. 1978 Op.Atty.Gen. No. 19.

*Adapted from “Minor consent, confidentiality and Child Abuse Reporting in Title X Funded Family Planning Settings.” National Center for Youth Law, [www.youthlaw.org](http://www.youthlaw.org).*