Levels of Neonatal Follow-Up Care

The levels of neonatal follow-up should follow/be paired with NICU Levels of Care. This reference sheet provides details regarding the Neonatal Follow-Up Levels of Care, including admission criteria, the goals of each level of follow-up and recommended resources.

Refer to the **List of Assessment Tools** document for details on assessment tools that can be used to achieve the goals of each level of follow-up.

Level I IIa IIb (Primary/ Community Care): Low risk of neuro-developmental impairment

Admission Criteria	Goals	Recommended Resources
• GA 34+0-36+6 wks • BW >2000g • BW >3rd Percentile • Healthy infants • Uncomplicated neonatal course • No history of maternal drug use **OR** some drug exposure but no withdrawal and do not get treatment • Do not meet other criteria for regional or Level III follow-up • Exposure to selective serotonin re-uptake inhibitors (SSRI) (mother should be encouraged to stay on medication and be monitored for depression)	• All premature infants have the opportunity for early developmental screening • All low risk babies get screened by 18-months • Routine developmental care by primary care practitioner	• Primary care physician/nurse practitioner or general pediatrician (for screening) **Additional Notes:** • Level IIc NNFU consult is available for early concerns in infants under 8 months. • Referral to a paediatric consultant, to children's treatment centres or early intervention can be made depending on age and available resources. • Those with complex developmental issues that cannot be adequately assessed or who require multidisciplinary consultation could be considered for referral to a Level IIC and/or Level III NNFU.

Level IIc (Regional): Low-moderate risk of neuro-developmental impairment

Admission Criteria	Goals	Recommended Resources

• GA >30+0 to 33+6wks
• BW <3rd percentile or Head Circ <3rd percentile
• Hyperbilirubinemia exchange transfusion level
• Symptomatic Hypoglycemia <2.2mmol/l over 6 hours, requiring intensive care monitoring and treatment.
• Intrauterine death of one twin (if surviving twin is <36+6wks GA)
• Maternal drug use/Neonatal Abstinence Syndrome (NAS) requiring pharmacological treatment
• Meningitis, not requiring Level III care
• Multiples ≥ 3, >30wks GA
• Perinatal acidosis (pH<7 plus or Apgar <5 @ 10mins)
• Sarnat Level 1/Mild neonatal encephalopathy or Level 2 encepholapathy that does not require Level III NICU
• Periventricular leukomalacia >30wks GA, up to and including term
	• Screening, diagnosis, education, coaching (not intervention/treatment/ traditional therapy),
	• Linkage/referral/facilitation to community services, medical subspecialties, therapeutic interventions
		• Access to a physician/ pediatrician knowledgeable in early childhood development
		• Access to therapy support such as a motor-based therapist or interdisciplinary team, i.e. OT, PT, SLP, RN
		Additional Notes:
		• Focus on early assessment and major morbidities:
		  ○ Vision
		  ○ Hearing
		  ○ Cerebral Palsy/ Gross Motor Impairment
		  ○ Cognitive Impairment/ Global Developmental Delay
		  ○ Autism Spectrum Disorder

• Seizures – Any neonatal seizure • Twin-to-twin transfusion syndrome – requiring laser ablation, born between 30+0 to 36+6 wks GA • Moderate/late pre-term infant failing to establish full oral feed at term equivalent		
Level IIIa (Tertiary): Moderate-High risk of neuro-developmental impairment		
Admission Criteria	**Goals**	**Recommended Resources**
• GA <30 wks gestation • BW < 1250g • Bronchopulmonary dysplasia– oxygen dependence / respiratory support at 36 wks corrected GA • Hypoxic ischemic encephalopathy Sarnat Level 2 or 3/Moderate or severe encephalopathy • Therapeutic hypothermia • Intraventricular hemorrhage ≥ Grade III • Meningitis – Fungal or Bacterial (excluding staph epidermis) requiring Level 3 support • Necrotizing enterocolitis requiring surgery or penrose drain • Neonatal stroke • Periventricular leukomalacia <30 wks • Twin-to-twin transfusion syndrome – requiring laser ablation, born at <30 wks GA • Viral encephalitis requiring Level III NICU care • Other: Based on site specific capacity	• Developmental surveillance, screening and assessment • Diagnosis and intervention (referral, coaching, etc.) • Education • Research	• Developmental pediatrician/ pediatrician, neonatologist, nursing, therapists, psychologist, and potentially a psychometrist with expertise in early childhood and a behavioural therapist. **Additional Notes:** • Additional resources/ subspecialty consultations as needed • This level includes extreme-pre-terms and those Children at risk of school-aged issues/ learning disabilities Comprehensive assessments at 18-months and school age • Ability to collaborate with Level III providers
Level IIIb/ Children's Hospital (Quaternary): Moderate-High risk of neuro-developmental		
Admission Criteria	**Goals**	**Recommended Resources**
• Congenital diaphragmatic hernia • Omphalocele • Cyanotic congenital heart disease requiring pump or extracorporeal membrane oxygenation within the neonatal period • Extracorporeal membrane oxygenation • Children with medical complexity ≥ 3 subspecialists involved	• Same as Level IIIa • Linkage with sub-specialty services	• Sub-specialists • Interdisciplinary team associated with the diagnoses

Glossary

BW	Body Weight
GA	Gestational Age
NICU	Neonatal Intensive Care Unit
NNFU	Neonatal Follow-Up
OT	Occupational Therapist
PT	Physiotherapist
RN	Registered Nurse
SLP	Speech Language Pathologist
SSRI	Selective Serotonin Re-uptake Inhibitors