Maternity Designation Level III (Subspecialty Care)

(a) **Level III (Subspecialty Care)**

(1) The level III facilities will be well suited for pregnant women who have significantly complex medical, surgical, or obstetrical conditions that may pose high risk of maternal morbidity or mortality. These patients may be directly admitted or transferred from another facility.

(2) The Level III maternity designation facility will:

(A) Provide care of pregnant women with the ability to detect, stabilize, and initiate management of unanticipated maternal–fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until patient can be transferred to a facility at which a higher level of neonatal and/or maternity care is available

(B) Provide skilled personnel with documented training, competencies and annual continuing education specific for the patient population served

(C) Facilitate transports; and

(D) Provide outreach education to lower level designated facilities including assisting with quality and safety program.

(b) **Maternity Medical Director (MMD).** The MMD shall be a physician who:

(1) Is board certified in obstetrics and gynecology or maternal fetal medicine with experience and special interest in the care and delivery of pregnant women;

(2) Demonstrates effective administrative skills and oversight of the Quality Assessment and Performance Improvement (QAPI) Program;

(3) Has completed continuing medical education annually specific to maternity care including complicated conditions; and

(4) Is a member of the facility’s medical staff

(c) **If the facility has its own transport program, there shall be an identified Transport Medical Director (TMD).** The TMD or Co-Director shall be a physician who is a board eligible/certified maternal fetal medicine specialist or obstetrician-gynecologist with expertise and experience in maternal transport.

(d) **Director of Maternal Fetal Medical Service** is a board-certified maternal fetal medicine specialist who:

(1) Demonstrates effective administrative skills and oversight of the Quality Assessment and Performance Improvement (QAPI) Program;

(2) Has completed continuing medical education annually specific to maternity care including complicated conditions; and
(3) **Is actively practicing and a member of the facility’s medical staff**

(e) Program Function and Services

(1) Triage and assessment of all patients admitted to the perinatal service with:

(A) identification of pregnant women who are at high risk of delivering a neonate that requires a higher level of neonatal care than the scope of their neonatal facility shall be transferred to a higher level neonatal designated facility prior to delivery unless the transfer is unsafe

(B) identification of pregnant or postpartum women with conditions or complications that will likely require a higher level of maternity care will be transferred to a higher level maternal designated facility unless the transfer will be unsafe.

(2) Supportive and emergency care delivered by appropriately trained personnel for unanticipated maternal-fetal problems that occur until the patient is stabilized or transferred.

(3) Ensure the ability to begin emergency cesarean delivery including ensuring the availability of a physician with the training, skills, and privileges within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.

(4) Ensure adequate surgical assistance for cesarean deliveries commensurate to the complexity of the surgery.

(5) Ensure that a qualified physician or certified nurse midwife with appropriate physician back-up is available to attend all deliveries or other obstetrical emergencies.

(A) The primary provider caring for a pregnant or postpartum woman who is a family medicine physician or physician specializing in obstetrics and gynecology or maternal fetal medicine, or a certified nurse midwife with appropriate physician back-up whose credentials have been reviewed by the MMD and:

(i) Has completed continuing education annually, specific to the care of the pregnant and postpartum woman, including complicated conditions

(ii) Shall arrive at the patient’s bedside within a timeframe commensurate to the patient’s condition; for an urgent request, the timeframe may not be greater than 30 minutes and may be shorter for more critical circumstances

(iii) If not immediately available to respond or is covering more than one facility, shall have appropriate backup coverage available, documented in an on call schedule and readily available to facility staff; and the physician is providing backup coverage shall arrive
at the patient bedside within a timeframe commensurate to the
patient’s condition; for an urgent request, the timeframe may not
be greater than 30 minutes and may be shorter for some
circumstances
(B) Certified nurse midwives who attend patients
i. Shall operate under guidelines reviewed and approved
by the MMD
ii. Shall have through formal arrangement, a physician
providing back-up and consultation, whose credentials
reviewed by the MMD and shall be able to arrive at the
patient’s bedside within a timeframe defined in (S) (A)
(ii-iii)
(C) An obstetrician/gynecologist shall be available on site at all times
(D) An on-call schedule of providers, back-up providers, and provision for
patients without a physician should be posted on the labor and
delivery unit.
(E) During a delivery or cesarean, there will be separate provider who is
current with NRP immediately available to attend to the resuscitation
of the newborn including intubation and administrative of
medications if needed.
(F) Availability of appropriate anesthesia, laboratory, radiology,
ultrasonography and blood bank on a 24 hour basis as described in S
133.41(a), (h), and (s) of this title respectively. The facility will ensure:
(i) that the blood bank has the capability to provide ABO-
Rh specific or O-Rh negative blood, fresh frozen plasma
and cryoprecipitate, and platelet products at the
facility at all times;
(ii) Laboratory personnel are onsite at all times; and
(iii) Perinatal pathology services are available.
(6) Anesthesia personnel
(A) Anesthesia personnel with obstetrical experience or expertise shall
be provided to pregnant and postpartum women including labor
analgesia and surgical anesthesia, and available onsite at all times
(B) A board certified anesthesiologist with special training or experience
in obstetric anesthesia is in charge of obstetric anesthesia services.
(C) A board certified anesthesiologist with special training or experience
in obstetric anesthesia including critically ill obstetric patients will be
available for consultation at all times, and be able to arrive onsite for
urgent situations within 30 minutes
(7) Personnel appropriately trained in the use of x-ray equipment shall be available
on-site at all times. Advanced imaging including CT imaging available and MR
imaging, and echocardiography will be available 24/7 including interpretation,
which will be available within 1 hour on urgent requests on a 24 hours basis.
A radiologist with critical interventional radiology skills relevant to pregnant or postpartum women must be readily available at all times.

Ultrasound Availability. The facility will ensure:

(A) Basic ultrasonographic imaging for maternal or fetal assessment including interpretation available on a 24 hour basis.

(B) A portable ultrasound machine will be available in the labor and delivery and antepartum unit for urgent bedside examination.

A respiratory therapist with experience or expertise in pregnant or postpartum women will be immediately available on-site 24/7.

Special equipment for cardioversion and defibrillation shall be available for ACLS including intubation, cardioversion or defibrillation, and direct the administration of medications for cardiopulmonary arrest.

Resuscitation – The facility shall have appropriately trained staff, policies and procedures for the stabilization and resuscitation of pregnant or postpartum women based on current standards of professional practice, including:

(A) ensuring the availability of personnel who can stabilize pregnant or postpartum women until transfer is possible

(B) having at least one person on site at all times who can be immediately available to provide ACLS including intubation, cardioversion or defibrillation, and direct the administration of medications for cardiopulmonary arrest.

(C) Having current guideline or protocols specifically addressing the resuscitation of the pregnant woman, and ensure that resuscitation equipment for pregnant and postpartum women is readily available at the labor and delivery area, including:

(i) Equipment for cardioversion and defibrillation

(ii) Resuscitation equipment and medications
(iii) Intubation equipment including fiber optic scopes for awake
intubation
(D) Appropriate equipment and personnel available onsite to ventilate and
monitor women in labor and delivery until they can be safely transported to
the ICU

(16) Consultants available include:
(A) A physician specializing in maternal fetal medicine:
   (i) Shall have in-patient privileges at the facility and shall be available on
       site, by phone, or by telemedicine as needed.
   (ii) Shall be able to arrive onsite for an urgent request within 30 minutes
(B) A full complement of adult medical and surgical subspecialists readily
available for inpatient face to face onsite consultation
(17) Stabilize obstetrical patients who have been admitted to the facility or
transferred from other facilities
(18) Shall have the availability of Medical and Surgical Intensive Care Units
    that are able to accept pregnant and postpartum women and have critical care
providers onsite to actively collaborate with Maternal Fetal Medicine and
Obstetrician specialists at all times
(19) The facility shall have written guidelines or protocols for various
    conditions that place the pregnant or postpartum woman at risk for morbidity
    and/or mortality, including promoting prevention, early identification, early
diagnosis, therapy, stabilization, and transfer. The guidelines or protocols must
address a minimum of:
    (A) Massive hemorrhage and transfusion of the pregnant or postpartum
        patient in coordination of the blood bank, and including management
        of unanticipated hemorrhage and/or coagulopathy
    (B) Obstetrical hemorrhage including promoting the identification of
        patients at risk, early diagnosis, and therapy to reduce morbidity and
        mortality.
    (C) Hypertensive disorders in pregnancy including eclampsia and the
        postpartum patient to promote early diagnosis and treatment to
        reduce morbidity and mortality
    (D) Sepsis and/or systemic infection in the pregnant or postpartum
        woman
    (E) Venous thromboembolism in pregnant and postpartum women, and
        to assessment of risk factors, prevention, early diagnosis and
        treatment
    (F) The management of the morbidly obese pregnant and postpartum
        patient
    (G) Management of critically ill pregnant or postpartum women,
        including fetal monitoring in the ICU, respiratory failure and ventilator
        support, procedure for emergency cesarean, coordination of nursing
        care, and consultative or co-management roles to facilitate
        collaboration

Comment [ET11]: National guidelines
Comment [ET12]: This is in national guidelines
Comment [ET13]: The principle of active collaboration is in the National Guidelines
The facility shall have a continuous availability of adequate number of nursing leaders and RN’s:

(A) with competence in level III maternity care criteria and ability to stabilize and transfer high-risk women and newborns who exceed their designation criteria; and

(B) with special training and experience in the management of women with complex maternal illnesses and obstetric complications.

The facility shall have nursing leadership and staff with formal training and experience in the provision of perinatal nursing care and should coordinate with respective neonatal services.

Shall have a QAPI process and policies aimed to reduce maternal morbidity and mortality including:

(A) Measuring key outcomes and making improvements on outcomes that are less than optimal;

(B) The facility will ensure that drills for high risk events such as shoulder dystocia, emergency cesarean delivery, eclampsia, clinical coagulopathy, respiratory failure, and maternal hemorrhage will occur at regular intervals to help medical, nursing, and ancillary staff prepare for these emergencies.

(C) ensure regular team training on an ongoing basis in the perinatal areas to promote staff communication and effectiveness in working together.

Shall have a program for genetic diagnosis and counseling for these disorders, or have a policy and process for consultation referral to a closely related facility.

Perinatal Education. A registered nurse with experience in maternity care including complex and critically ill patients shall provide the supervision and coordination of staff education.

Ensures the availability and support personnel with knowledge and skills in breastfeeding to meet the needs of mothers.

A certified lactation consultant shall be available at all times.

Social services and pastoral care shall be provided as appropriate to meet the needs of the patient population served, including bereavement services.

Nutrition/Dietician?