Maternity Designation Level III (Subspecialty Care)

(a) 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

Comment [ET1]: Sections prior to Levels of Care include Purpose; Definitions; Program Requirements. Quality Programs, Program Scope, Formal transport plans and requirements will be in the Program Requirements

Comment [ET2]: Will define

Comment [ET3]: National Guidelines; education and outreach

(3) Is actively practicing and a member of the facility's medical staff

Comment [ET4]: Active practice & member of 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.

Comment [ET5]: Recommended by Dr. Saade

(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.

Comment [ET6]: From Perinatal Guidelines, 7ed, p24

(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 (5) (A) (ii-iii)

(C) An obstetrician/gynecologist shall be available on site at all times

Comment [ET7]: National guidelines

(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

Comment [ET8]: Is this enough? Actively practicing? Member of medical staff?

(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

Comment [ET9]: One OB anesthesiologist at a level III recommends "anesthesiologist onsite and available 24/7" for level III due to complexity of maternal conditions, and also recommends formal guidelines for who manages conditions

(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

(8) A radiologist with critical interventional radiology skills relevant to pregnant or postpartum women must be readily available at all times

(9) 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.

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

(11) Special equipment shall be available to accommodate the care and services for morbidly obese women

(12) Ensure the availability and interpretation of non stress testing and electronic fetal monitoring

(13) Hospitals offering a trial of labor for patients with prior cesarean delivery must have the immediate availability of anesthesia, cesarean delivery, and neonatal resuscitation capability during the trial of labor.

(14) Registered Pharmacist availability shall include:

(A) A registered pharmacist will be available onsite on 7 days a week, and on a 24 hour basis; and

(B) A **registered** pharmacist with experience and/or expertise in perinatal pharmacology shall be available for consultation on a 24 hour basis.

(C) If medication compounding is done by a pharmacy technician for obstetric patients, a pharmacist will provide immediate supervision of the compounding process.

(D) If medication compounding is done for obstetric patients, the pharmacist will develop checks and balances to ensure the accuracy of the final product.

(15) 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

Comment [ET10]: This is an important requirement, but is it practical?

Dr. Yeomans recommends delete (not necessary for interventional radiologist for level III)

(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

Comment [ET11]: National guidelines

(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 post partum patient

Comment [ET12]: This is in national guidelines

(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 [ET13]: The principle of active collaboration is in the National Guidelines

(20) 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.

(21) 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

(22) 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

Comment [WU14]: High risk and low frequency events,

(23) 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.

Comment [ET15]: Not in the guidelines, but this is an integral part of Maternity level III

(24) 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.

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

(26) A certified lactation consultant shall be available at all times

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

(28) Nutrition/Dietician?