Women's Health
Level III Referral Center Consultation Services

UNIVERSITY of MARYLAND
PRINCE GEORGE'S
HOSPITAL CENTER

Maternal and Neonatal consultations are oftentimes necessary when the primary clinical caregiver is faced with a situation that is beyond his or her level of expertise or when the referring facility does not have the proper equipment or staff to handle certain conditions. An effective consultative protocol helps to mitigate the risks associated with emergent, unexpected circumstances that may arise when caring for patients.

As a Level III Perinatal Referral Center, The University of Maryland Prince George's Hospital Center provides consultation and follow-up services to local referring hospitals.

Responsibilities of the Consultant[1]

The responsibilities of the consultant include:

1. Recognizing individual boundaries of expertise and providing only those medically accepted services and technical procedures for which they are qualified by education, training, and experience.
2. Providing timely consultation, regardless of the referring providers' specialty or qualifications.
3. Communicating findings, performed procedures, and recommendations to the referring provider effectively and timely.
4. Include a summary of the consultation in the medical record and send the summary in writing to the referring provider.
5. Developing a mutual agreement between the consultant, referring physician, and patient to determine how involved the consulting physician in the ongoing care of the patient. Sometimes the consulting physician will need to assume temporary primary clinical responsibility for the patient.
6. When the consultant does not have primary clinical responsibility for the patient, he or she should try to obtain concurrence for major procedures or additional consultants from the referring practitioner.
7. Respecting the relationship between the patient and the referring provider, not lessening the patient's confidence in her other caregivers.
8. Discussing with the referring provider who can best provide the agreed-upon care.
9. Recommending to the referring provider, and if necessary, to the patient that care be transferred to the consulting physician if the consultant feels the referring provider is not qualified to provide the appropriate level of continuing care.

Responsibilities of the Referring Practitioner[1]

The responsibilities of the referring practitioner include:

1. Requesting a consultation in a timely manner before an emergency arises.
2. Preparing the patient with an explanation of the reasons for consultation, the steps involved, and the name of the consultant.
3. Providing a summary of the history, results of the physical examination, laboratory findings, and any other information that may assist the consultant during evaluation and recommendations.
4. Documenting indications for the consultation in the medical record.
5. Discussing the consulting physicians report with the patient and give recommendations that are in the best interest of the patient.
6. Maintaining responsibility for the patient's care unless authority has been transferred.

The four categories of risk factors in which pregnancy can be placed are:

- Existing Health Conditions
- Age
- Lifestyle Factors
- Conditions of Pregnancy[2]

The following are examples of conditions which may necessitate transfer:

Maternal-fetal conditions:

- Preterm labor
- Preterm premature rupture of membranes
- Hypertensive disorders of pregnancy, including eclampsia
- Bleeding due to an obstetrical condition
- Multiple gestation
- Fetal anomalies
- Fetal condition outside the scope of care of the neonatal care unit

Maternal medical and surgical conditions:

- Trauma
- Diabetes
- Infection/sepsis
- Respiratory complications
- Cardiovascular disease, congenital or acquired
- Renal disease
- Connective tissue disorders
- Coagulopathy and complications of hemorrhage
- Neurologic abnormalities
- Liver disease
- Overdose
- Psychiatric emergencies
- Acute abdomen or peritonitis

Contraindications — Maternal transport may not be possible or advisable in the following situations:

- Lack of an appropriate modality for safe maternal and neonatal transfer
- Weather and road conditions too hazardous for safe travel
- Maternal condition insufficiently stabilized (eg, persistent hemorrhage, severe hypertension)
- Delivery is anticipated before transport completed
- Neonate with a lethal condition
- Unstable fetal condition threatening to deteriorate rapidly (delay in delivery would result in death or damage to the fetus)
- Patient declines transfer[3]

Response times:

- Emergent situations handled immediately
- Patients who are medically stable will be seen within 24 hours

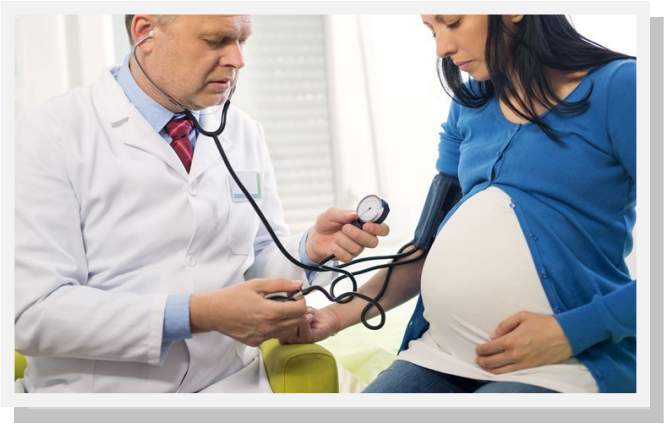
Level III (Subspecialty Care)[4]	
Definition	Level II facility (able to provide care to infants who are moderately ill with problems that are expected to resolve rapidly) **plus** care of more complex maternal medical conditions, obstetric complications, and fetal conditions.
Capabilities	Level II facility capabilities (can provide mechanical ventilation for brief durations -less than 24 hours- or continuous positive airway pressure.) They must have equipment (eg, portable chest radiograph, blood gas laboratory) **plus** Advanced imaging services available at all times. Ability to assist level I and level II centers with quality improvement and safety programs. Provide perinatal system leadership if acting as a regional center in areas where level IV facilities are not available (see level IV). Medical and surgical ICUs accept pregnant women and have critical care providers onsite to actively collaborate with MFMs at all times. Appropriate equipment and personnel available onsite to ventilate and monitor women in labor and delivery until they can be safely transferred to the ICU.
Types of health care providers	Level II health care providers (physician, specialized nurses, respiratory therapists, radiology technicians, and laboratory technicians) **plus** • continuous availability of adequate numbers of nursing leaders and RNs with competence in level III care criteria and ability to transfer and stabilize high-risk women and newborns who exceed level III care criteria, and with special training and experience in the management of women with complex maternal illnesses and obstetric complications. • ob-gyn available onsite at all times. • MFM with inpatient privileges available at all times, either onsite, by phone, or by telemedicine. • director of MFM service is a board-certified MFM. • director of obstetric service is a board-certified ob-gyn with special interest and experience in obstetric care. • anesthesia services available at all times onsite. • board-certified anesthesiologist with special training or experience in obstetric anesthesia in charge of obstetric anesthesia services. • full complement of subspecialists available for inpatient consultations.
Examples of appropriate patients (not requirements)	Any patient appropriate for level II care, plus higher-risk conditions such as suspected placenta accreta or placenta previa with prior uterine surgery, suspected placenta percreta, adult respiratory syndrome, expectant management of early severe preeclampsia at less than 34 weeks of gestation

Additional Level III and Level IV perinatal centers[5]

- University of Maryland Medical Center
- Shady Grove Adventist Hospital
- Holy Cross Hospital
- Anne Arundel Medical Center

Regional Perinatal Health Care Centers[4]	
Definition	Level III facility **plus** on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care
Capabilities	Level III facility capabilities **plus** • On-site ICU care for obstetric patients. • On-site medical and surgical care of complex maternal conditions with the availability of critical care unit or ICU beds. • Perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region, and analysis and evaluation of regional data, including perinatal complications and outcomes and quality improvement.
Types of health care providers	Level III health care providers **plus** • MFM care team with expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. This includes co-management of ICU-admitted obstetric patients. An MFM team member with full privileges is available at all times for on-site consultation and management. The team is led by a board-certified MFM with expertise in critical care obstetrics. • Physician and nursing leaders with expertise in maternal critical care. • Continuous availability of adequate numbers of RNs who have experience in the care of women with complex medical illnesses and obstetric complications; this includes competence in level IV care criteria. • Director of obstetric service is a board-certified MFM, or board-certified ob-gyn with expertise in critical care obstetrics. • Anesthesia services are available at all times onsite. • Board-certified anesthesiologist with special training or experience in obstetric anesthesia in charge of obstetric anesthesia services. • Adult medical and surgical specialty and subspecialty consultants available onsite at all times to collaborate with MFM care team.
Examples of appropriate patients (not requirements)	Any patient appropriate for level III care, plus higher-risk conditions such as • severe maternal cardiac conditions • severe pulmonary hypertension or liver failure • pregnant women requiring neurosurgery or cardiac surgery • pregnant women in unstable condition and in need of an organ transplant

The first step before initiating transfer is to determine whether the mother and fetus are stable. According to the Emergency Medical Treatment and Active Labor Act (EMTALA) statute, stability for transfer is determined by the physician or qualified medical provider evaluating the patient. Stability is a judgment that the patient's condition is not expected to deteriorate substantially during the transfer process.



According to the Centers for Medicare and Medicaid Services (CMS), a qualified medical provider may sign the certification that benefits of transfer outweigh the risks, in consultation with a physician, if the responsible physician is not physically present at time of transfer. Hospitals have the ability to designate non-physician medical providers to act as a qualified medical provider and provide medical screening examinations. If non-physicians will be screening patients, the hospital must indicate in their bylaws which non-physicians can perform this service; the written statute is not specific regarding whether the non-physician is a registered nurse, nurse practitioner, or certified nurse midwife. A clear process for phone consultation between the physician and non-physician provider and guidelines for when the physician must come in to assess the patient before transfer should be established. When a non-physician certifies the transfer, hospital bylaws should provide a means for physician signature to certify the transfer after the fact[6].

In the event the patient is unstable (ie, in active labor), the transferring physician must document that the benefits of transfer to another facility outweigh the risks for the mother and/or the fetus.

References:

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6. Centers for Medicare and Medicaid Services. (n.d.). *Certification and Compliance for the Emergency Medical Treatment and Labor Act (EMTALA).* Retrieved March 2018 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/EMTALA.pdf