WORK GROUP #2 PARTICIPANTS

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WORKGROUP PURPOSE

Purpose: To determine in field triage and destination protocols for prehospital transfer (i.e. by EMS) and to determine transfer transport protocols between hospitals (i.e. ER to birth hospital, Level 1 hospital to higher level of care) including transport of maternal/fetal unit.

Perinatal Guideline Recommendation that applies

18. Work in collaboration with EMS/trauma system to thus assure that each perinatal patient “get to the right place in the right time.”

PERINATAL REGIONALIZATION & TIME DEPENDENT EMERGENCIES IN MICHIGAN

- The EMS has a system in place for pre-hospital transports and interfacility transports
- EMS operates under the Medical Control Authority
- Medical Control Authority has protocols (examples that pertain to perinatal period)
  - Obstetrical Emergencies
  - Pediatric Newborn Assessment, Treatment and Resuscitation
  - Inter-facility Transports of critical care patients
- Public Health Code authorization – see next slide
PUBLIC HEALTH CODE (ACT 368 OF 1978)
SECTION 209 – EMERGENCY SERVICES

Section 209(21)(5). Subsection (4) does not apply to the transportation of a patient by an ambulance if the patient is accompanied in the patient compartment of the ambulance by an appropriate licensed health professional designated by a physician and after a physician-patient relationship has been established as prescribed in this part or the rules promulgated by the department under this part.

Section 333.20932. (2) An aircraft transport operation shall not operate an aircraft transport vehicle unless it is staffed, with emergency medical services personnel or other licensed health care professionals as appropriate according to the written orders of the patient’s physician.

Inter-facility High Risk Maternal Transport

Identification of High Risk Women
(antepartum/intrapartum)

Are resources at current facility adequate according to the ACOG guidelines for Perinatal Care, to address patient needs?

Yes

No

Continue current management plan

Identified need to transfer for maternal or fetal indications*

Select receiving birth hospital facility (distance, resources, bed availability, patient preference)

Accept Maternal/Fetal Patient (based on OB and/or Nursery conditions or capacity)

Maternal/Fetal Patient Diverted (based on OB and/or Nursery conditions or capacity)

Follow local EMS High Risk Protocol+

Identification of High Risk Women (antepartum/intrapartum)

Are resources at current facility adequate according to the ACOG guidelines for Perinatal Care, to address patient needs?

Yes

Complete Transport Process per Protocol

Evaluate, collaborate in patient stabilization

Communicate and discuss plans with patient

No

When completed, evaluate transfer for quality improvement

Call made to receiving birth hospital facility. Identify and communicate with receiving physician

Maternal/Fetal Patient Diverted (based on OB and/or Nursery conditions or capacity)

Maternal/Fetal Patient Accepted at alternative birth hospital facility

Guiding Principle = Optimal safety for patient (mother and fetus)

*Consider Emergency Medical treatment in active labor act (EMTALA)

Each MCA shall identify a high risk obstetrical and newborn protocol in their region

Draft; 4/18/12
Identified need to transfer to higher level of care

Each neonatal transport program must identify their own guidelines and protocols for handling transport.

Definitions:

Neonatal Transport system – specialized transfer program for neonates by means of an ambulance (ground/air).

Neonatal transport team – a team of experienced, specialized multidisciplinary health care providers established and defined by a health care facility who are trained for, and immediately available, to respond to calls for high risk neonatal transports with the skill, knowledge and competency to provide neonatal care.
RECOMMENDATIONS

Hospitals should have a written policy for transport.
- Need to develop a process to assure this occurs consistently in the state
- May be a part of the designation/verification process and documents provided by the hospital as part of the process

RECOMMENDATIONS – CERTIFICATE OF NEED NICU STANDARDS

No recommended changes to the NICU CON standards related to transport were made.

- CON NICU Standards that apply:
  - Section 2 (u) Definition: “Neonatal Transport System” means a specialized transfer program for neonates by means of an ambulance pursuant to Part 209 of the Code, being Section 3333.20901 et seq.”
  - Section 11, (v) “If an applicant operates a NICU that admits infants that are born at a hospital other than the applicant hospital, an applicant shall develop and maintain a neonatal transport system”
  - Section 11, (xi) “An applicant shall develop and maintain plans for the provision of transferring infants discharged from its NICU to another hospital, as necessary for the care of an infant no longer requiring NICU services but unable to be discharged home.”

CON NICU Standard
RECOMMENDATIONS
CERTIFICATE OF NEED AIR AMBULANCE

NO recommended changes to the Air Ambulance CON standards related to maternal or neonatal transport were made
- [Note EMS Ambulance Rules in part 209 of Public Health Code and EMS/Life Support Agencies and Medical Control Administrative Rules related to Ambulance Operation also apply]
- The group noted that there is no stipulation on the size of the aircraft. There is some federal legislation that may address aircraft size that is currently in committee.
- The number of NICU and maternal transfers by mode of transfer (air or ground) should be a recommendation from workgroup #3. The group cautions that inbound transports should be what is tracked so that there is not a double count of the same patient.

CON Review Standards for Air Ambulance

RECOMMENDATION –
FOUR COMPONENTS OF TRANSPORT
1) Standards/guidelines;
2) Effective communication
3) Feedback
4) Quality review and evaluation
COMPONENTS OF TRANSPORT STANDARDS/GUIDELINES

Published guidelines


There is not a similar document for maternal transports.

EMS Protocols

• Obstetrical Emergencies
• Pediatric Newborn Assessment, Treatment and Resuscitation
• Inter-facility Transports of critical care patients

RECOMMEND: Each MCA should identify high risk obstetrical and newborn protocols in their region (Example – Washtenaw/Livingston MCA – next page)

EXAMPLE MCA HIGH RISK PROTOCOL

Washtenaw/Livingston Medical Control Association
System Protocol: HIGH-RISK DELIVERY TRANSPORT GUIDELINES

Date: April 2011

High-Risk Delivery Transport Guidelines

The purpose of this policy is to establish guidelines for transport of women with pregnancy of more than 20 weeks and less than 34 weeks gestation in active labor, as these infants may require newborn intensive care.

1. In all cases where delivery is imminent, transport will be to the closest emergency receiving facility.

2. If labor is brought on by medical illness or injury of the mother, appropriate medical treatment of the mother is the first priority. This is also the most appropriate treatment of the infant.

3. If time allows, any woman in active labor with a gestational period of more than 20 weeks and less than 34 weeks, should be taken to St. Joseph Mercy Hospital or the C.S. Mott Children’s & Von Voigtlander Women’s Hospital in anticipation of delivery of a high risk infant.

Procedure:

A. All O&B transports to St. Joseph Mercy Hospital should be taken directly to Family Birth Center Triage. If delivery is imminent determine the destination in consultation with emergency department medical control.

B. All O&B transport to C.S. Mott Children’s & Von Voigtlander Women’s Hospital should be taken to the Birth Center via Labor and Delivery Triage entrance. If delivery is imminent determine the destination in consultation with emergency department medical control.
COMPONENTS OF TRANSPORT COMMUNICATION AND REFERRAL

The group explored some options such as EMR resource.
The group felt the referral/transport process is more complex than knowing bed status.

Recommendation: When a maternal/fetal patient or a neonate is diverted, based on OB and/or nursery conditions or capacity, the hospital diverting the patient will assist the referring hospital in finding an appropriate placement.
(Noted in flow charts)

COMPONENT OF TRANSPORT QUALITY ASSURANCE & EVALUATION

EMS-Life Support Agencies-Medical Control have a quality assurance and evaluation process in place through Administrative Rules 325.22207.

Rule 207

(1) Each MCA shall establish written protocols as defined in section 20919 of the code which shall include...

(h) Protocols that ensure a quality improvement program is in place. The quality improvement program shall include a requirement that each life support agency collects and submits data to the MCA. Data shall be reviewed by the MCA professional standards review organization.

Quality measures for transport are outlined in the Perinatal Guidelines: Implications for Michigan (2009)

Recommend: Look at quality transport measures at the regional level. This could be accomplished by a regional perinatal coordinator.
COMPONENT OF TRANSPORT FEEDBACK

Per the Perinatal Guidelines, a feedback mechanism is recommended.

These would be enforced through the designation-verification process.

ADDITIONAL RECOMMENDATIONS

1. The state shall support a perinatal outreach coordinator assigned for each region as defined by the Trauma Regions/Emergency Preparedness regions in the state.
2. The transport process needs oversight from some type of Peer Review team (to be determined)
   - This may interface through the professional Review Standards, the perinatal outreach coordinator or may tie in with recommendations from other workgroups.
UNRESOLVED ISSUES – TRANSPORT OVER STATE LINES

Local policy may be overridden by state. Michigan Medicaid goal is to keep care in Michigan, yet there are waivers to allow care outside of the state.

We did not have the time/resources to assess this situation.

Maternal and newborn care does happen outside of state boundaries for some Michigan residents – especially in our border states of Ohio, Indiana, Wisconsin and also in Minnesota.

Questions?
Comments?