Supporting your Perinatal Units During COVID-19: Evolving Guidance

August 21, 2020

CMQCC
California Maternal Quality Care Collaborative

CPQCC
california perinatal quality care collaborative
WEBINAR LOGISTICS

- Attendees are automatically muted upon entry
- The “chat” function has been disabled. **Please utilize the Q&A box if you are having technical difficulties and to submit any questions you have for the presenters.** We will answer a select number of questions relevant to the topics presented during the Q&A portion of the webinar. The remainder of the questions may be used to inform the topics of future webinars in this series.
- **The slides and webinar recording will be made available on www.CAperinatalprograms.org shortly after the webinar.** Due to the rapidly changing guidelines around COVID-19, the slides and recording may be taken down after two weeks.
• The information shared in this webinar series and on our resource site serve as examples of how hospitals, healthcare workers, and families in California are responding to COVID-19. We understand that each hospital is working with a different set of resources and constraints. As such, some of the recommendations presented may not apply to your hospital setting. Guidelines and recommendations should be adapted to fit your local needs.

• As this is a rapidly evolving public health situation, we encourage you to consider the most recently available local health department and CDC guidance when developing your internal protocols.
TODAY’S PRESENTERS

* Today’s presenters have nothing to disclose

• **Elliot Main, MD**, Clinical Professor of Obstetrics and Gynecology (Maternal-Fetal Medicine), Stanford School of Medicine and Medical Director, CMQCC

• **Tiffany McElvy, MSN, RN, CPPS, LHRM**, Director Maternal Child Health Services, Sutter Health Memorial Medical Center

• **Robert Altman, MD, MBA**, Medical Director for Specialty Care, Gould Medical Group

• **Jerasimos Ballas, MD, MPH, FACOG**, Associate Professor of Obstetrics, Gynecology, and Reproductive Sciences, University of California, San Diego

• **Jenny Quinn, PhD, APRN, NNP-BC**, NorthBay Medical Center, Department of Pediatrics and QI Specialist, CPQCC
California COVID-19 Update

Elliott Main, MD
As of June 2, 2020

New reported cases by day in California

3,000 cases

7-day average

New cases

Note: The seven-day average is the average of a day and the previous six days of data.

New reported deaths by day in California

150 deaths

7-day average

As of August 19, 2020

New reported cases by day in California

10,000 cases

5,000

1,000

0

March
April
May
June
July
Aug.

New reported deaths by day in California

200 deaths

100

50

0

March
April
May
June
July
Aug.

6.2.20

The content in these slides is current as of August 21, 2021.
As of June 2, 2020

New reported cases by day in California

3,000 cases

New reported deaths by day in California

150 deaths

Note: The seven-day average is the average of a day and the previous six days of data.

As of August 19, 2020

New reported cases by day in California

Because of a CDPH server failure on 7.25, ~300,000 test results were delayed

New reported deaths by day in California

6.2.20

The content in these slides is current as of August 21, 2021.
Los Angeles County

- Positive Patients: 1,378 (1 Day Δ: +9, +3.9%, 14 Day Rolling Avg.: 1,466)
- ICU Positive Patients: 433 (1 Day Δ: -2, -0.5%, 14 Day Rolling Avg.: 469)
- ICU Available Beds: 864 (1 Day Δ: +10, +1.2%, 14 Day Rolling Avg.: 345)

San Diego County

- Positive Patients: 238 (1 Day Δ: +9, +3.9%, 14 Day Rolling Avg.: 252)
- ICU Positive Patients: 85 (1 Day Δ: -12, -12.4%, 14 Day Rolling Avg.: 93)
- ICU Available Beds: 305 (1 Day Δ: -30, -9.0%, 14 Day Rolling Avg.: 205)

San Bernardino County

- Positive Patients: 440 (1 Day Δ: -1, -0.2%, 14 Day Rolling Avg.: 476)
- ICU Positive Patients: 125 (1 Day Δ: -5, -3.8%, 14 Day Rolling Avg.: 150)
- ICU Available Beds: 148 (1 Day Δ: +10, +7.2%, 14 Day Rolling Avg.: 131)

Orange County

- Positive Patients: 419 (1 Day Δ: +10, +2.4%, 14 Day Rolling Avg.: 452)
- ICU Positive Patients: 124 (1 Day Δ: +0, +0.0%, 14 Day Rolling Avg.: 147)
- ICU Available Beds: 215 (1 Day Δ: -10, -4.4%, 14 Day Rolling Avg.: 131)

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California COVID Deaths by Race as of 8.19.2020

<table>
<thead>
<tr>
<th>RACE/ETHNICITY</th>
<th>POSITIVE CASES</th>
<th>DEATHS</th>
<th>CA POPULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI AN</td>
<td>0%</td>
<td>0%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Asian</td>
<td>5%</td>
<td>12%</td>
<td>15%</td>
</tr>
<tr>
<td>Black</td>
<td>4%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Latino</td>
<td>59%</td>
<td>48%</td>
<td>39%</td>
</tr>
<tr>
<td>NH PI</td>
<td>1%</td>
<td>1%</td>
<td>0.3%</td>
</tr>
<tr>
<td>White</td>
<td>17%</td>
<td>30%</td>
<td>37%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1%</td>
<td>1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>13%</td>
<td>1%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Total Deaths: 11,523

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CMQCC California COVID OB Working Group

• Started in May with weekly then bi-weekly meetings to share OB data and current practices

• Health Systems
  • Kaiser North
  • Kaiser South
  • Sutter
  • Sharp
  • Scripps
  • Dignity (Common Spirit)
  • Providence
  • Adventist
  • Cedars Sinai

• Universities/ County Hospitals
  • UCSF
  • UC Davis
  • UCLA
  • UC Irvine
  • UC San Diego
  • UCSF Fresno /Community
  • Stanford
  • Loma Linda
  • Santa Clara Valley system
  • Los Angeles County system

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<table>
<thead>
<tr>
<th>Time</th>
<th>Region</th>
<th>Asymptomatic Positives</th>
<th>ICU cases</th>
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</thead>
<tbody>
<tr>
<td>May thru Early June</td>
<td>Bay Area</td>
<td>0.5% to 3%</td>
<td>~10, often antepartum, no deaths</td>
</tr>
<tr>
<td></td>
<td>Southern CA</td>
<td>&lt;0.5% to 1.5%</td>
<td>~15, largely lower income</td>
</tr>
<tr>
<td></td>
<td>Central Valley</td>
<td>&lt;0.5%</td>
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There are ~35,000 births every month in California

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</tr>
<tr>
<td>Mid-June thru Mid-July</td>
<td>Bay Area</td>
<td>1-3% concentrated in LatinX</td>
<td>~6</td>
</tr>
<tr>
<td></td>
<td>Southern CA</td>
<td>&lt;0.5% high income / 4% low income</td>
<td>~15</td>
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<td><strong>Mid-July Thru Mid August</strong></td>
<td>Bay Area</td>
<td>1-2% concentrated in LatinX</td>
<td>~5</td>
</tr>
<tr>
<td></td>
<td>Southern CA</td>
<td>&lt;0.5% high income / 10% low income</td>
<td>~40, ~5 on ECMO but OK</td>
</tr>
<tr>
<td></td>
<td>Central Valley</td>
<td>4-8%</td>
<td>~3</td>
</tr>
</tbody>
</table>

There are ~35,000 births every month in California

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Maternal Health & Covid-19
Memorial Medical Center
Modesto, CA

Tiffany McElvy, RN, MSN, CPPS
Robert Altman, MD, MBA
Surge Preparation/Testing/Staffing/ Management of Patient Flow
Our experience(s)

- 135 deliveries/month
- 250 outpatient visits/month

- 14 Covid-19 deliveries (since June)
  - approx. 5% of deliveries
    - 8 Vaginal deliveries
    - 6 C/S
  
  - 8 Symptomatic
    - 2 ICU admissions: both antepartum period @ 36 weeks
  
  - 6 Asymptomatic

- Late June – current day
  - Averaging 1-2 positive patients/week
Current workflow

• Rapid Test became available onsite April 2020
• Masking mandate for all staff AND patient/support person
  • Only 1 support person
  • Staying in room strongly encouraged
    • Change outs via approval by senior leadership
• Outpatient evaluation
  • No routine Covid testing
  • No visitors allowed
• Hospital triage for rapid testing:
  • All OB admissions
    • Rapid Test performed on arrival
    • Results within 1-2 hours

Ability to test created more specific workflow for PPE use

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Staffing

• Covid designated labor & postpartum rooms
  • Negative pressure room (both locations)
  • O.R. designated room identified in main O.R.
    • Upstairs, outside FBC
    • Positive airflow
• ICU patient admitted
  • ICU collaboration for care of pregnant patient in ICU
  • L&D RN to ICU
    • 2:1 care of Covid + mother with ICU RN
    • NST machine
• Covid + mom 1:1
• Covid Couplet requires 2 RN
  • 1 for + mom
  • 1 for PUI neonate

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Preparation and Training

Maternal Child Health surge prep

- SHEMS Clinical Advisory guidance
  - Regular calls and email updates
  - KnowDoShares (KDS)
  - Detailed workflows
- Staff PTO cancelled
- PPE Don/Doff Training
- Simulations
  - Table top and traditional

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Resource Considerations

Staffing

• Labor & Delivery RN highly specialized
  • No Labor and Delivery “close” equivalent in hospital
  • Hospital-wide nursing shortage
  • Traveler resources scarce
• Assessment of hospital employee resources
  • Within Maternal Health Service line
  • Outside service line (previous employees)

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Caregiver Support

- Frequent meetings with staff around morale building
- Weekly updates
- Frequent leader rounding
- Frequent rounding on MD
- Physician focus phone conferences
- Acknowledging the fear and keeping staff informed continuously!!

- Constant and consistent encouragement of safety measures outside of the hospital:
  - Traveling/Vacations
  - Social visits with friends/family
What we have learned:

- Reintroduced Simulation training in July
- Designating Doula as healthcare team member
- PPE needs and use during pushing increased
- Don’t forget key Quality Measures
  - NTSV
  - Preeclampsia
  - PPH
Challenges

• Surrogacy deliveries
• Staff fatigue & stress
  – varied behaviors outside of work
• Nursing Station social distancing ?
• Testing changes
  – Turnaround times
  – Method of collection
• Support person compliance with staying in room.
  – Denying entrance for noncompliance
• Patient/Support person compliance with masking
COVID-19 OB SCREENING/TESTING ALGORITHM

Last Update 8/04/20

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Acknowledgement

Kathleen Ortega, RN, Mgr of Labor & Delivery
Bethany Owings, RN, Mgr of Postpartum, NICU, Lactation
Sonja Loehr, RN, Clinical Educator MCH
Stacie Rariden, Svc Line Coordinator

All the dedicated physicians, nurses, techs, and unit clerks in the Family Birth Center at MMC.
They have put their lives on hold to care for our community at their greatest time of need.
We owe them and all the frontline a debt of gratitude.

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Prenatal care in the age of Covid

From surge planning to resuming care of recovered Covid patients

Jerasimos (Jerry) Ballas MD, MPH
Associate Clinical Professor, Maternal-Fetal Medicine
UC San Diego Health
San Diego, CA
Department of Obstetrics, Gynecology and Reproductive Sciences

• Approximately 3,500 deliveries annually
  • Two delivery hospitals:
    • Jacobs Medical Center in La Jolla
    • UCSD Hillcrest in San Diego.
• Mixture of private/public funded patients
  • Clinics throughout San Diego
    • La Jolla
    • Hillcrest
    • Rancho Bernardo
    • Encinitas
• Generalists, Hospitalists, Residents/Fellows, Midwives, Advanced Practitioners

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Current state of Covid-19 in San Diego County

The content in these slides is current as of August 21, 2021.
Timeline for Covid-19 Surge Planning

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Timeline for Covid-19 Surge Planning

- Late February/ Early March
  - Repatriated citizens at local military bases
  - First reports of community spread

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  - Screening and social distancing in patient care areas
  - Visitor policies
  - Converting clinic visits to telehealth visits
  - March 31st – First Covid+ OB patient flown in for ICU care

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- Early April
  - Routine screening for L&D patients

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Timeline for Covid-19 Surge Planning

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The time is now.

With increasing restrictions implemented to promote social distancing, every patient should be prepared to have increasing number of visits go virtual.

We must adjust our comfort level with virtual interaction because the risks of exposure for our us, our patients and our staff is growing exponentially.

Referring providers should be made aware that our consults may now be performed virtually so they can prepare patient.

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Short-term Goals of Telemedicine During the Current Pandemic

- Social distancing for patients, faculty and staff
- Attempt to decrease in-person clinic volume by 50% without canceling appointments
- Leverage technology to maintain the highest level of care while minimize financial losses from fallow sessions
- Educate patients to be more vigilant and involved in their care

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Long-term Goals of Telemedicine

- Increase access throughout the region
- Minimize cost and inconvenience across the course of a pregnancy
- Improve marketability to an increasingly virtual-oriented population.

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Blood pressure cuffs can be prescribed for all patients
- At first visit for all cHTN or patients at risk for Preeclampsia
- Second trimester for non-HTN patient in order to screen through third trimester

Telemedicine visits may be conducted by NPs, as appropriate.

Several studies have shown safety and efficacy of combining traditional in-person visits and TMVs in both low-risk and complicated pregnancies.

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Ultrasound and antenatal testing appointments may also serve as additional contact points for care.

- Plan in place to record weight and blood pressure at ultrasound appointments

- This is just a guide.

- If appointments can be reduced or spaced out, or a greater proportion converted to TMVs, then that should be the goal in the current situation

- There is going to be a degree of risk taken in order to benefit from greater social distancing

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<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>In Person OB Visit</th>
<th>Ultrasound</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 11 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>11-13 weeks</td>
<td>x</td>
<td>Dating / NT</td>
<td></td>
</tr>
<tr>
<td>16 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>20 weeks</td>
<td>x</td>
<td>Anatomy</td>
<td></td>
</tr>
<tr>
<td>24 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>28 weeks</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>32 weeks</td>
<td>x</td>
<td>As indicated</td>
<td></td>
</tr>
<tr>
<td>34 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>36 weeks</td>
<td>x</td>
<td>As indicated</td>
<td></td>
</tr>
<tr>
<td>37 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>38 weeks</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 weeks</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
<tr>
<td>40 weeks</td>
<td>x</td>
<td>Discuss IOL</td>
<td></td>
</tr>
<tr>
<td>Postpartum</td>
<td></td>
<td></td>
<td>TMV</td>
</tr>
</tbody>
</table>
Telemedicine Uptake at UC San Diego Health

<table>
<thead>
<tr>
<th>TelesPRINT Ambulatory Arrived Visit Volume</th>
<th>TelePRINT Start March 16, 2020 through August 17, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Arrived Visits</td>
<td>Total Telemedicine</td>
</tr>
<tr>
<td>36,741</td>
<td>5,189</td>
</tr>
<tr>
<td>14.12% of Total Visits</td>
<td>13.42% of Total Visits</td>
</tr>
</tbody>
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### Telemedicine Uptake at UC San Diego Health

#### TeleSPRINT Ambulatory Arrived Visit Volume

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<tr>
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<th>MyChart Video Visits</th>
<th>Telephone Visits</th>
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<td>5,189</td>
<td>4,929</td>
<td>260</td>
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<td>14.12% of Total Visits</td>
<td>13.42% of Total Visits</td>
<td>0.71% of Total Visits</td>
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Telemedicine Uptake for Women’s Health Service Line

• Highest rate of telemedicine visits: 31% by April 13th
  • Current rate: 9%

• Largest drop in clinic visits: 29.4% with nadir in April
  • Current clinic visit volume: 103% of pre-Covid volume

• Modest decrease in prenatal imaging and antenatal testing volume decreased modestly
  • Currently back to pre-covid volume
Challenges

Patient barriers

• Technology, language, health literacy
• High risk conditions necessitating closer monitoring

Provider uptake/acceptance

• Comfort with remote assessment
• Incorporating into daily schedule
• Billing

Institutional

• Video portal is suboptimal – bandwidth an issue; lobby to utilize more reliable platform/programs
• Ability to convert to same-day visits or evaluations if concerns arise

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Resuming Prenatal Care for Covid+ Patients
Resumption of Prenatal Care for Covid-19 Positive Patients

Developed in conjunction with UCSD Infectious Disease & Maternal-Fetal Medicine Divisions and are based on CDC Interim Guidance for Discontinuation of Isolation for Persons with Covid-19 Not in Healthcare Settings\(^1\) with modifications for pregnancy-specific issues.

Classification of Covid-19 Illness

- **Mild**: Identifiable signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) **without** shortness of breath, dyspnea, or abnormal chest imaging.

- **Moderate**: Evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air.

- **Severe**:
  - Respiratory rate >30 breaths per minute,
  - SpO2 <94% on room air (or, if history of chronic hypoxemia, baseline decrease >3%)
  - PaO2/FiO2 <300 mmHg
  - Lung infiltrates >50%

- **Critical**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
  - Special consideration for severely immune compromised: Bone marrow transplants, active chemotherapy, AIDS (CD4<200 or CD4 percentage <15%), and patients on heavy immune suppression (biologics, prednisone > 20mg/d, immune therapy).


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### Symptom-based strategy for discontinuing transmission-based precautions/isolation

<table>
<thead>
<tr>
<th>Asymptomatic and not Severely Immune Compromised:</th>
<th>Mild to Moderate Illness and not Severely Immune Compromised:</th>
<th>Asymptomatic and Severely Immune Compromised</th>
<th>Severe to Critical Illness or Severely Immune compromised:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>o</strong> At least 10 days have passed since the date of their first positive viral diagnostic test <strong>AND</strong></td>
<td><strong>o</strong> At least 10 days have passed since symptoms first appeared <strong>AND</strong></td>
<td><strong>o</strong> At least 20 days have passed since symptoms first appeared <strong>AND</strong></td>
<td><strong>o</strong> At least 20 days have passed since symptoms first appeared <strong>AND</strong></td>
</tr>
<tr>
<td><strong>o</strong> Asymptomatic throughout their infection</td>
<td><strong>o</strong> At least 24 hours have passed since last fever without using fever-reducing medications <strong>AND</strong></td>
<td><strong>o</strong> At least 24 hours have passed since last fever without using fever-reducing medications <strong>AND</strong></td>
<td><strong>o</strong> At least 24 hours have passed since last fever without using fever-reducing medications <strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td><strong>o</strong> Symptoms (e.g., cough, shortness of breath) have improved</td>
<td><strong>o</strong> Asymptomatic throughout their infection</td>
<td><strong>o</strong> Symptoms (e.g., cough, shortness of breath) have improved</td>
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### Pathway for resuming in-person prenatal care & ongoing management considerations

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<tr>
<td>• Home isolation</td>
<td>• Home isolation, if possible</td>
<td>If hospitalized, criteria to be met prior to discharge:</td>
</tr>
<tr>
<td>• Phone follow-up by COVID Nurse to assess for symptoms.</td>
<td>• Phone follow-up by COVID Nurse to assess for symptoms.</td>
<td>• No immediate need for clinic visit, antepartum testing or ultrasound. If patient’s condition warrants such short interval follow-up, then patient should remain in-house.</td>
</tr>
<tr>
<td>o If symptoms develop, refer to ID Clinic^2</td>
<td>• Refer to Covid-19 ID Clinic^2</td>
<td>• MFM Consultation scheduled</td>
</tr>
<tr>
<td>If &gt; 10 days from positive PCR and remains asymptomatic:</td>
<td>If &gt; 10 days from onset of symptoms and 24 hours have passed since last fever without using fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved:</td>
<td>• Referral to COVID-19 ID Clinic^2</td>
</tr>
<tr>
<td>• Patient may resume ambulatory care with primary OB provider</td>
<td>• Patient may resume ambulatory care with primary OB provider</td>
<td>If &gt; 20 days from onset of symptoms and 24 hours have passed since last fever without using fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved:</td>
</tr>
<tr>
<td>• Consider referral for MFM Telehealth consult</td>
<td>• Refer for MFM consult (Telehealth or at MOS)</td>
<td>• MFM consultation &amp; HROB care</td>
</tr>
<tr>
<td>• Follow-up growth ultrasound +/- BPP depending on GA</td>
<td>• Follow-up growth ultrasound</td>
<td>• Patient may return to primary OB once cleared by MFM</td>
</tr>
<tr>
<td>• Antepartum testing if there are other indications that warrant it</td>
<td>• Antepartum testing</td>
<td>• Serial ultrasounds</td>
</tr>
<tr>
<td>• Obtain CBC, CMP, urine PC ratio</td>
<td>• Obtain CBC, CMP, urine PC ratio</td>
<td>• Antepartum testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain CBC, CMP, urine PC ratio</td>
</tr>
</tbody>
</table>

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2. EPIC Order: “Consult/referral to Infectious Disease – COVID-19”

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**The content in these slides is current as of August 21, 2021.**
Special Considerations

• If patient has not attained the necessary time for Discontinuing Transmission-Based Precautions, and requires either maternal or fetal evaluation, patient should be sent to triage with the following stipulations:
  • Scheduled in advance, if possible.
  • L&D Charge Nurse must be notified in order to coordinate patient’s path of travel into the hospital, up to L&D and into a negative pressure room.

• Repeat COVID-19 PCR testing is not routinely advised, unless otherwise directed by Infectious Disease, or if > 3 months from initial infection.
  • Test Based Strategies for Discontinuing Transmission-Based Precautions can be considered for select patients and should only be done with consultation with the Infectious Clinical COVID-19 Hotline
  • Healthcare personnel should use Droplet Precautions. If there are procedures which may expose providers to Contact (e.g. Pelvic Exams), Droplet and Contact Precautions are recommended.

• Patient is not a candidate to deliver in the Birth Center.

• For patients with ongoing symptoms who otherwise qualify for resuming prenatal care and need antenatal testing, assure that there is appropriate distancing for NSTs or consider single-occupancy rooms.

• The placenta should be sent to pathology. They are NOT eligible to be taken home by patient.

• All patients should be referred to The PRIORITY Study (http://priority.ucsf.edu). All that is needed is patient’s willingness to be contacted by study personnel. All consenting and enrollment will be performed by research team.

The content in these slides is current as of August 21, 2021.
Lessons Learned

- Patients are adaptable
  - Be up front and direct with rationale for changes
  - Take time to introduce new technology
  - Be flexible and have a sense of humor

- Physicians (and administrators) can be least adaptable
  - Identify champions and recruit trainees
  - Alleviate anxiety about billing, technology and liability

- All staff members need to feel safe and know they are being listened to
  - Set aside time to present protocols to each distinct team (ie. Front desk, MAs, sonographers)
Lessons Learned

• **Create telemedicine-only sessions/templates**
  • Interspersing in-person visits with telemedicine visits is inefficient
  • Create workflow that includes front desk, assistants, nurses and provider

• **Fatigue is inevitable**
  • As with quarantine and lockdown fatigue, providers simply want to “go back to normal”
  • Have long term vision for new paradigm

• **Invest in technology for the long term**
  • Frustration arises with aging technology or insufficient IT services
  • Create incentives to utilize telemedicine
Thank you!
Positive Maternal COVID Cases and Newborn Management

Jenny Quinn, PhD, NNP-BC
NorthBay Medical Center
Department of Pediatrics
The content in these slides is current as of August 21, 2021.
The content in these slides is current as of August 21, 2021.
NorthBay Medical Center Setting

• Solano County’s community hospital
  – Opened in 1959

• 16 bed, Community Level III NICU
  – Open Bay
  – One isolation room
  – Overflow room (cohort COVID/PUIs)
  – ADC ~ 8
NorthBay Medical Center Setting

- 2019 – 1108 deliveries
- Private Neonatology/Pediatric Group
  - Contracted with NorthBay and another Level I nursery
  - 3 neonatologists, 1 NNP, 1 pediatrician, and 1 per diem neonatologist
NorthBay Medical Center Process

- ALL staff wear surgical masks inside hospital
- High risk areas wear goggles
  - ED & ICU, aerosol generating procedures
  - Recommend all healthcare professional wear goggles
- Patients and support person (if allowed)
  - Temperature check
  - Health screening questions
NorthBay Medical Center Process

• Covid testing at Urgent Care Centers, ED, all admissions and pre-procedure
  – As of 8/13: 8,400 patients tested with 602 positive cases
  – 7% positivity rate

• Universal Covid testing in L&D started on 6/15/20
  – As of 8/14: 218 deliveries with 10 positive cases
  – ~ 5% positivity rate
  – Asymptomatic
Maternal Management

• All admissions PUIs and tested
  – Full PPE (N95, faceshield, gown, gloves)
  – COVID results ~ 1 hour
• Mothers can have one support person
  – Doula if pre-arranged
• Recommend support person wears mask when staff in room
Maternal Positive Cases

- FOC/Support person tested through ED
- One infant temporarily separated
- Couplet care is done in L&D room
  - Full PPE
  - Cluster care
  - Doffing assist
- Promote breastfeeding
  - Baby Friendly organization
- Nursing staff provides initial education
  - Maintain 6 feet separation when not directly caring for infant
  - Wear a mask
  - Frequent hand washing
Maternal Positive Cases

- Newborn healthcare provider reviews AAP/CDC recommendations and standard discharge teaching
  - Handouts from AAP website
    - 2019 Novel Coronavirus
    - Breastfeeding During the COVID-19 Pandemic
    - Is it OK to call my pediatrician during COVID-19?
  - Review CDC timeframe for self quarantine in home and measures to reduce spread

- Newborn testing at 24 and 48* hours

- Circumcisions done in the room
Newborn Follow-up

- Newborn appointments scheduled as usual
- Staff provides notification to local outpatient clinic of positive maternal case

POP appt.

- Weekend appointments
- Post discharge & community pediatricians
  - TcB/TSB, weight, feeding assessments
- Lactation consultants or nursing
POP appointments - COVID+ moms

• Protocol developed
• Family drives to a closed wing and calls up to post-partum floor
• Nurse brings supplies (scale, transcutaneous bilimeter and registration paperwork)
• Nurse in full PPE (N95, face shield, gown, gloves)
• Conducts POP appointment
• Room and supplies cleaned/sterilized per COVID protocol
NICU Management

• Visitation hasn’t changed, just limited number
  – MOC and FOC/Support person
  – 24/7 visitation hours

• Surgical masks and hand hygiene

• For intubation procedure, Neo/NNP wear N95 and eye protection
NICU Management

• Inborn Admission COVID+
  – Placed in isolation room
  – 24 and 48-hour Covid testing

• Back Transports
  – Prior to pandemic, all back transports admitted to and discharged from isolation room
  – Full PPE until results of Covid test (done on admission)
NICU Management

• 2 positive maternal case
  – LPTI w/hypoglycemia
  – Term infant born via C/S, initial respiratory distress
    – Weaned to room air by 2 HOL
    – Roomed in with mom on DOL#2
  – MOC; FOC/support person not allowed to visit
  – Nursing staff and Neo provided updates daily via FaceTime or phone
  – Both discharged home on DOL#3
Travis AFB Airman Meets Daughter for 1\textsuperscript{st} time 3 weeks after birth

The content in these slides is current as of August 21, 2021.
Q&A

Moderated by
Christina Oldini, MBA, RN, CPHQ and
Courtney Nisbet, RN, MS
Closing

Christina Oldini, MBA, RN, CPHQ
• The information shared in this webinar series and on our resource site serve as examples of how hospitals, healthcare workers, and families in California are responding to COVID-19. We understand that each hospital is working with a different set of resources and constraints. As such, some of the recommendations presented may not apply to your hospital setting. Guidelines and recommendations should be adapted to fit your local needs.

• As this is a rapidly evolving public health situation, we encourage you to consider the most recently available local health department and CDC guidance when developing your internal protocols.
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All Stanford Accredited CME on COVID-19 is available at:
covid19cme.stanford.edu

Questions? Email: stanfordcme@stanford.edu
COVID-19 RESOURCE SITE
www.CAperinatalprograms.org

The slides and webinar recording will be made available on our resources site later today. Due to the rapidly changing guidelines around COVID-19, they may be taken down after two weeks.

For more information email: info@CAperinatalprograms.org