COVID-19 Obstetrical Guidelines for UW and UPH-Meriter

Scope:
- Part 1 of this document will cover obstetrical care guidelines for outpatient (UWHealth clinics) providing low risk OB care and the Center for Perinatal Care at UPH-Meriter providing management of high-risk pregnancy.
- Part 2 will cover all inpatient care done at UPH-Meriter

PART 1:

Guiding principles:

- The leanest schedule possible has been created to maintain provider access at each of our clinic sites.
- Each and every appointment have been reviewed to restrict face-to-face appointments as much as possible; face-to-face appointment will primarily be limited to obstetric appointments
- Face time of OB visits will be very limited: vitals, FHTs, weight. Provider will be phoning patients to have discussions.
- New OB appointments, nurses and physicians should be calling ahead to perform the OB education counseling and education to decrease the visit length.
- Each of our clinics will typically be staffed with no more than 1 physician and 1-2 APPs/CNMs. Patients who express concerns about respiratory illness or contacts will be triaged appropriately and screened as needed with a respiratory panel according to COVID IC guidelines.

Revised Ambulatory Testing Criteria (3/26/20): COVID-19 Symptomatic ADULT and PEDS

- In general, asymptomatic individuals should not be tested. There are certain patients who may need testing even if asymptomatic. Recommendations will be forthcoming.
- Pregnancy is a high-risk condition, therefore refer for testing if mild symptoms are present:
  - ACUTE onset of a respiratory illness with one or more symptoms below:
    - Fever 100 or higher
    - Cough—could be productive or not
    - Sore throat
    - Shortness of breath/ chest tightness
**LOW RISK CARE:**

**New OB Visit (NOB):**

| NOB Calls Clinic to Schedule NOB Appointments | • PSR: Schedule Dating Ultrasound AND Provider Telemed visit (2-3 days after Dating Ultrasound)  
• Appointment Notification is sent to Inbasket for RN to work |
| --- | --- |
| **RN NOB Call** | • RN will complete FULL history/intake over the phone prior to dating US appointment  
• RN will provide education and genetic screening counseling over the phone*  
• Order all New OB labs  
*To the best of our ability. If patient has further questions advise patient it will be discussed at provider telemed appt. RN would then follow up with provider to ensure patient has appropriate orders and her NP visit is within appropriate time frame |
| **Day of Dating Ultrasound** | • Ultrasound Tech: Obtains weight  
• MA: Obtains vitals, provides handouts, perform depression screen*  
*If screen is positive, for **self harm** pull in provider, otherwise send encounter with EDS score to primary OB  
• Patient will go to lab **after** ultrasound to complete NOB labs  
• If **nonviable** patient will be seen by in clinic provider |
| **Provider NOB Visit** | • TELEMEDICINE visit 2-3 days after dating scan + labs.  
• Review orders for completeness. Confirm genetic orders are in and anatomy US is ordered at the appropriate location  
• Review timing of NOB physical and communicate this to RN and Patient  
• Order any additional labs to be completed at next in clinic visit |
| **NP Physical** | • 12-14 weeks if patient is NOT doing genetic screening.  
• If patient desires first trimester screening: 15-16 weeks. AFP can be done the same day.  
• This appointment will be scheduled AFTER the provider telephone visit with the assistance of the RNs |

**Staffing:**

- **Inpatient:** teams now consist of L&D attending/Nocturnist, CNM attending, Triage CNM, Resident and Rounding NP and Service Attending (covers GYN team and back-up to L&D). These individuals will huddle at 0730 and 1930 at the Sim Lab on Meriter 5th Floor.
- **Outpatient:** 2 providers will staff each clinic site (1 physician and 1 APP (CNM or NP); residents will work in the PM at 20 SP on designated days; outpatient visits are primarily restricted to OB visits. To minimize the duration of the visit, patients are instructed that the visit is primarily to obtain vitals and perform essential physical exam (FHTs, FH); counseling can occur during a telemedicine visit.
  - See attached for the draft of the new NOB Workflow.
- **Reserve Physicians and APPs:**
  - A group of APPs and physicians are maintained in reserve to be prepared to work in the event that providers become ill/isolated/quarantined.
HIGH RISK OB (MFM CLINIC) AT THE CENTER FOR PERINATAL CARE UPH-MERITER:

Visitors/Support people

- The hospital has placed signs at each entrance, has placed the information on the website and on the news about the **NO visitors policy**.
- Letter added to the appointment reminder letters sent to patients.
- A call is placed to the patients with currently scheduled appts to inform them of the new practice.

MFM Consults

- All consult should be done via telemedicine. If the patient declines, then it will be cancelled and rescheduled. All consults should be done at the scheduled appointment time. This includes NICU and peds surgery.

MFM Clinic Appointments

- New OB, follow up and postpartum visits deemed appropriate for telemedicine (non-essential) should be done that way
- Transition to once weekly antenatal testing with a full BPP, except for HTN or FGR if at high risk.
- Group classes will be do through telemedicine
- Diabetes group prenatal care has been canceled and the patients have been allocated to individual visits

Diabetes Care (April Eddy): Most visits will be done through telemedine unless not deemed appropriate.

Genetic Counseling: all done via telemedicine. No instant risk assessment offered.

Ultrasound

- See ultrasound rescheduling policy below.
- All patients seen in ultrasound for dopplers for FGR must have a BPP as part of the antenatal testing.

UWOB and UWFM patients

- In an effort to try to consolidate visits, some UW patients that are scheduled for ultrasound at the CPC and need an OB visit will get seen by a UW OB team at the FPMRS/CPC clinic after ultrasound.
MFM ultrasound and antenatal rescheduling guidelines

Ultrasounds:

- 24-week growths cancel for all except:
  - multiple gestation
  - FGR
- 28-32-36 week growths:
  - multiple gestation
  - FGR
  - GHTN, preeclampsia or CHTN on meds
  - pregestational diabetes mellitus
  - GDMA2
  - Chronic kidney disease
  - Lupus
  - Prior IUFD
  - Organ transplant
  - Maternal cardiac disease
- 32-week (once) growth for the following indications
  - Velamentous cord insertion
  - Single umbilical artery
  - Low PAPP-A or HCG
  - Elevated msAFP
  - Obesity
  - Chronic hypertension not on medications
  - Gestational diabetes class A1 (not on medications)
  - AMA
  - Thyroid disease
  - Placenta previa
  - Hx. Of severe preeclampsia or FGR

Antenatal testing:

- Changed to weekly 10-point BPP (US & NST) except:
  - Fetal growth restriction (see below)
  - Gestational hypertension, CHTN on meds or preeclampsia (2x weekly BPs)
  - Abnormal testing (prior BPP abnormal/ non-reactive)
  - For Fetal growth restriction patients GA 24-32 weeks with fetus EFW in 5-10% with Normal Dopplers and no- co-morbidities (diabetes, hypertension, lupus, etc.)
  - Do Dopplers every other week.
  - Begin antenatal testing at 32 weeks
  - If Dopplers & BPP are normal may have once weekly NST with BPP
- For Fetal growth restriction with EFW <5%
  - weekly Dopplers 24-28 weeks
  - Begin antenatal testing at 28 weeks
  - If Dopplers & BPP are normal may have once weekly NST with BPP
  - If Dopplers are elevated keep semiweekly NST with AFI/Dopplers
  - If Dopplers are absent or reversed diastolic flow perf MFM plan.
PART 2:

1. OB Triage
   - Patients presenting to OB Triage will be screened for fever, respiratory symptoms, travel and exposure by the HUC.
   - OB patients who are PUI will be masked at the HUC desk. The HUC will call the OB Triage RN to escort the patient immediately to the designated rooms in OB Triage 1-4 and 9-10 if needed. The RN will implement droplet and contact isolation. Screening will be initiated based on the Ambulatory Testing criteria algorithm.
   - If an OB patient presents with OB-related issues to the ER, they will be screened and if they have symptoms, masked and escorted to OB triage if OB related care and evaluation is needed.
   - Dedicated nursing staff and providers will be assigned to OB Triage rooms 1-4.
   - Labor inductions meeting case definition will be directly admitted to one of the 4Center designated labor rooms, 483-486 without going to triage.
   - Direct admission antepartum patients meeting case definition will be admitted to 3North rooms 392-393 without going to triage.
   - C/sections meeting case definition will have pre-op procedures completed in one of the designated OB Triage rooms 1-4 or 9-10.
   - OB OR # 3 will be designated for patients meeting case definition. Patient will be transported from OB Triage to OB OR #3. Staff must don a respirator during transport and observe hand hygiene per hospital policy. Patients must don a surgical mask during transport to OB OR #2. Limit to only necessary individuals in elevator during transport. Post-op c/section recoveries will occur on 6N in rooms 670-682. A portable cardiac monitor machine will be needed.
   - Dedicated staff would be assigned to all designated respiratory care areas in OB.

2. Inpatient Unit Placement

   Direct Admission screening
   - HUC will screen all direct admit patients to OB in the same manner as OB triage. If the patient has positive symptoms the HUC will provide a mask for the patient and call the OB RN to escort the patient to the designated room (see below).
   - Staff must don a surgical mask and face shield mask during transport and observe hand hygiene per hospital policy.

   The following rooms in OB are designated for PUI or positive COVID-19 patients:
   - Antepartum – rooms 393-394
   - Labor & Delivery – rooms 483-486
   - Postpartum – rooms 670-682

3. General Considerations

   - All direct care staff is to wear a surgical mask when caring for all patients.
   - All staff caring for PUI or COVID-19 positive patients follow the PPE guidelines on the Meriter HUB:
     - Contact/droplet isolation in one of the designated rooms
     - Surgical mask and face shield are to be worn.
Isolation gown
Gloves
- PUI or COVID-19 positive patient undergoing aerosol-generating procedure
  - Airborne and droplet isolation
  - Negative pressure room. If not available, use a room with recirculating HEPA filter and door closed
  - N 95 mask and face shield or PAPR
  - Isolation gown
  - Gloves
- Expedite discharge. Guidelines for all mother/baby couplets discharge – after 24 hours for a vaginal delivery and after 48 hours for a c/section

4. Labor & Delivery care during labor in patients meeting case definition or confirmed COVID-19
- Laboring patients (4 beds) – rooms 483, 484, 485, 486
- Patient should wear surgical mask
- Do not use supplemental O2 for non-reassuring FHR tracing unless patient is hypoxic
- For aerosolizing procedure to support mother respiratory status
  - If High-flow O2 or intubation are needed -> staff must wear N95 respirator with face shield or PAPR
  - Consider moving patient to negative pressure room: 476 or OB OR #3
  - HEPA filtration will need to be brought to the room if unable to move patient to a negative pressure room

5. Newborn/NICU team for delivery
- Appropriate care for newborn on radiant warmer.
- Expedite transfer of baby out of room directly from warmer to isolette when clinically appropriate
6. Mother-baby separation

Management of the Infant born to COVID+ /PUI Mother

**Breast Feeding:** Breastfeeding is encouraged and is a potentially important source of antibody protection for the infant. The CDC recommends that during temporary separation, women who intend to breastfeed should be encouraged to express their breast milk to establish and maintain milk supply. If possible, a dedicated breast pump should be provided. Before expressing breast milk, women should practice appropriate hand hygiene. After pumping, all parts of the pump that come into contact with breast milk should be thoroughly washed, and the entire pump should be appropriately disinfected per the manufacturer’s instructions. Expressed breast milk should be fed to the newborn by a healthy caregiver (10).

In the case that the mother declined temporary separation, and the woman wishes to feed at the breast, she should put on a facemask and practice hand hygiene before each feeding (4).


**Disposition**
Discontinuing Contact + Droplet isolation, and COVID-Risk Infection Status (if applicable) for mother and baby and discharge from the hospital will be undertaken in coordination with the Infection Control and evolving guidelines.
CDC Home Isolation Discontinuation Criteria

- COVID-19 patients can stop home isolation under the following conditions
  - **If test not planned** to determine if patient still contagious, patient can leave home after these **three** following criteria are met:
    - Patient has no fever for at least 72 hours (without the use of antipyretics) **AND**
    - Other symptoms have improved (for example, cough or shortness of breath have improved) **AND**
    - At least 7 days have passed since symptom onset
  - **If test planned** to determine if patient still contagious, patient can leave home after these **three** following criteria are met:
    - Patient no longer has fever (without the use of antipyretics) **AND**
    - Other symptoms have improved (for example, cough or shortness of breath have improved) **AND**
    - Patient received two negative tests in a row, 24 hours apart (per CDC guidelines)*


Special clinical management consideration for COVID-19 or PUI patients:
- Late preterm steroids for fetal lung maturity are not recommended
- Considering prophylactic management of PPH with misoprostol 400mcg and TXA
- Delayed cord clamping is not recommended if overexposing the infant to possible aerosolize particles.

Donning PPE, per CDC

- Important to follow proper sequence of donning and doffing PPE
- All PPE should be donned outside of the patient’s room
Doffing PPE, per CDC

- Important to follow proper sequence of donning and doffing PPE
- Remove gown and gloves in room and perform hand hygiene
- The remainder occurs in the hallway outside the patient room (or in anteroom)

Unless soiled, used PPE can be disposed of in a non-biohazard waste container.

The content in these slides is current as of March 24, 2020.