ILPQC COVID 19 Webinar 4/17/20: OB Questions/Answers

Answers represent experiences and strategies related to caring for patients during the COVID-19 pandemic from individual providers and institutions, these example strategies are not meant to be recommendations unless national or state guidelines are referenced.

Questions from the 4/17 webinar chatbox, the Info Account, and Registration

Antepartum

- In the presence of COVID PUI/+ patients in the antepartum setting, have there been any discussions around limiting or reducing the fetal monitoring for these patients when they're on the cusp of viability or when their issues aren't necessarily related to the mortality/morbidity of the baby? The first instinct seems to frequently be to place moms on continuous monitoring. However, in the suspicion/presence of COVID we should be limiting the amount that we are in and out of these rooms; not only to conserve PPE but also to protect staff. Particularly in cases where gestational age is low and/or mom's body habitus makes monitoring challenging. Of course, I'm not speaking of times when it's unavoidable or medically necessary. Just wondering if there has been any dialogue in regards to this.
    - At NorthShore, we have been trying to limit the frequency of fetal monitoring/heart tone assessment to those times that are medically necessary. An OB provider when rounding on the patient may obtain heart tones to avoid asking another individual to come to the room to do it. Monitoring around the time of periviability with a critically ill patient warrants an in-depth discussion of maternal/fetal risk and benefit of cesarean delivery for non-reassuring fetal status. Monitoring should be individualized accordingly.
    - Fetal monitoring procedures should be considered based on clinical circumstances. Very few clinical antepartum conditions (eg variable decelerations early preterm – velamentous insertion of the cord) requires continuous FHR monitoring. We agree to limiting the number of health care providers entering the COVID + patient's room.

- For a COVID + mom requiring an ICU admission and count EFM due to unstable O2 sats, any recommendations for monitoring that would avoid an LD nurse having prolonged exposure. We are considering using telemetry and moving the monitor to the glass window.
    - Telemetry is an excellent option to avoid prolonged exposure.
    - Similar procedures are implemented across the nation. Major obstacles have been absence of long cables and wireless technology availability.
    - At Loyola we have done exactly that for our ICU cases, moving the monitor to the window so that our nurse may remain outside the patient's room as feasible.

L&D

- second stage risk?
    - I think the question is asking about the recommendation for PPE / n95 and face shield in the 2nd stage. Given the 2nd stage and a cesarean delivery is potentially aerosolizing and the risk of asymptomatic patients. Hospitals have been moving to have all providers and staff in n95 masks and face shields for all 2nd stage, delivery and cesarean delivery.
    - At Rush, with Universal Screening for Covid we are only doing this for COIVD+ patients or those who refuse testing on admission. If a woman has no history of COVID, no symptoms and has a negative point of care test on admission, we are not using N95 at delivery.
    - The risk of not using n95 when have a negative rapid point of care test, is the risk of false negative cases, benefit is conserving PPE. The sensitivity of the rapid test and prevalence in the community is important to consider.

- What are other facilities doing about the significant other that is allowed in the room for delivery?
    - For known Covid patients, NorthShore does not allow a significant other as a visitor or in the delivery. For a person who becomes a PUI while in patient, the support person is treated like a PUI, is given a mask and is asked not to leave the room. If the support person leaves, he/she is not allowed to return.
    - Rush approach to visitors is based upon POC testing. If negative 1 support person is allowed. If a PUI/declines testing or is COVID + no visitor. We also do not allow visitors in triage to maintain appropriate social distancing
    - Per UI Health policy all visitors should wear masks and N95 during the second stage. Visitors are not allowed to leave the patients' room. Per our institutional policy visitors can visit the hospital cafeteria.
    - UCM allows one support person regardless of COVID or PUI status. The support person must wear a mask at all times when a provider or nurse is in the room. They ae not allowed to leave the room either.
    - Loyola does the same as UCM

- Review usage of O2 for Mom/Baby. What about for mother or baby with respiratory issue or low sats? NeoPuff vs Ambu bag
    - At NorthShore, we are not using supplemental oxygen for fetal resuscitation (ie during labor for nonreassuring fetal heart rate tracings), but we use it to treat maternal or neonatal respiratory symptoms.
    - At UI Health, Oxygen as part of the intra-uterine fetal resuscitation protocol was eliminated at our institution. Oxygen is still allowed for mothers who require oxygen for COPD, asthma and other maternal reasons for supplemental O2.

- Should we continue the use of supplemental oxygen therapy for fetal resuscitation during this pandemic (Intrapartum oxygen use for fetal heart rate decelerations)
    - See previous answers
    - Our institution, UI Health, eliminated the use of oxygen as part of the intra-uterine fetal resuscitation protocol.

- Share any changes to Resident physician involvement in Stage II delivery and Neo resuscitations when attending is readily available? FM/PEDS/OB
    - Currently at NorthShore resident physicians do not participate in the care of Covid patients or PUIs.
    - At UCM residents are not participating in COVID+ deliveries unless a second set of hands is needed.
    - Same at Loyola: Only Attendings at deliveries unless assistance is needed and a second Attending is not available

- Are you masking all patients that come on to L&D until screened
    - NorthShore has asked that anyone in the hospital wear a mask. All patients and support individuals are asked to don a mask whenever someone walks into the hospital room or if they walk in the hallways. The only time they may remove a mask is if no one else is in the room with them.
    - Rush: all patients and visitors are screened on presentation including temperature and are asked to wear a mask. All Rush employees are also screened upon entering the hospital and wear a mask.
    - UI Health – Yes
    - At UCM masks are handed out to patients and visitors at security check points or upon check in if they are not already wearing a mask.

- Are you seeing COVID positive patients presenting with preeclampsia/eclampsia/HELLP syndrome similar to what was seen in NY
    - We have not seen a sufficient number of Covid patients to assess the relationship between Covid and preelcampsia/eclampsia/HELLP yet, but some institutions have reported that they are screening HELLP patients for COVID 19.
    - Rush: at this time, we have not seen a clear relationship between other adverse outcomes including preeclampsia and COVID-19. However our sample size experience is too small to draw any conclusions one way or another.
    - The literature reports COVID patients presenting phenotypically resembling PE. At UI Health we do not have any experience at this time with such patients.
    - UCM has not seen this situation yet and are screening all patients.
    - The nonobstetric literature from China (see **W Guan et al. N Engl J Med 2020. DOI: 10.1056/NEJMoa2002032 for example) shows lab abnormalities,** particularly for those with worse outcomes, of thrombocytopenia, elevated transaminases and

elevated creatinine that mimic those seen in preeclampsia. In our own severely ill cases we have seen similar laboratory abnormalities. I am aware of two cases in my Healthcare System where initial presentation was assessed as a preterm severe preeclamptic based on lab abnormalities in chronic hypertensives who subsequently declared as CoVIDs.

Testing

- If limited # of Covid rapid tests for OBscreen in asympt pts, then who would you prioritize: PTL , sched cs, HR OB pts w/ comorb?
    - SMFM guidelines suggest prioritization of 3rd trimester patients or active labor.
    - The decision to test asymptomatic patients for SARS-CoV2 is individualized across hospitals. The pros/cons of testing need to be considered, the sensitivity of the test and the turn around time for test results, as well as for whom testing might be most beneficial (please see response from last week 4/10 webinar Q/A for a list of the Universal Testing Pros/Cons).
- should testing for COVID-19 be repeated on admission to the hospital for a woman diagnosed as COVID+ antenatally? (how do we determine resolution)
    - The CDC recommends 2 strategies—one is a test-based strategy (2 negative tests >24 hours apart) and the other is based on symptoms (resolution of fever without antipyretics/improvement in symptoms for 3 days or 7 days from start of symptoms whichever is longer). Some hospitals have added continued mask use for 14 days after onset of symptoms. It is still not entirely clear for how long someone may be infectious after experiencing Covid-19.
    - Rush: as we are using a universal point of care test on admission for all obstetric patients, we follow a test-based strategy of repeating their COVID-19 if they are more than 7 days from their last test. The time interval that can be used to safely say a patient no longer has evidence of COVID-19 is not clear.
    - We have had patients test positive > 7 days from resolution of symptoms and therefore need to be managed on a case by case basis, we chose to allow 14 days after resolution before the patient could be back in the hospital and would need to wear a mask.
    - Our new guidelines state > 7 days from positive test and > 72 hours from improvement in symptoms. Given patients not always clear when symptoms started.
    - At this point CDC guidelines dictate timing for lifting the precautionary measures. Clinical judgement should be used regarding the need of testing of a patient that tested COVID+ prior to her current episode of care. The answer is dependent of presence or absence of symptoms and the time passed since har last positive test result.
    - UCM is initiating respiratory precautions for 30 days all patients who have tested positive for COVID and present to the hospital. If the patient is admitted after the 30 days the patient is considered cleared of COVID unless symptoms have returned.

If the positive test results was less than 30 days prior but more than 7 days and the patient is asymptomatic repeat testing can be considered. Two tests 24 hours apart are then done and must both be negative to clear the patient.

- Should all patients that come to the unit (admissions and triage) be tested for the Coronavirus ?
    - Please see above and pros/cons for universal testing all patients from last week 4/10 webinar.
    - This is a controversial aspect that depends on hospital policies, availability of POC testing. At our institution only admitted patients are screened.

- Are hospitals testing pre-eclampsia patients for COVID-19 due to the unusual presentation in some patients? We have read about some pregnant women presenting with Pre-eclampsia or HELLP symptoms and they decompensate quickly, ending up being positive for COVID.
    - NorthShore has not yet adopted this testing strategy.
    - If POC is available it is possible will be good practice to test patients that display features of PE with severe features with particular focus on HELLP patients, early data has reported cases, but data is not conclusive.

- Universal testing considerations when not every hospital has the resources.
    - Please see Pros/Cons from last week 4/10 webinar Q/A. Many locations do not have testing capacity for Universal Testing, or they do not have a rapid test with fast enough turn-around time, or the sensitivity of their test is not high enough. When thinking how to best manage the risk of asymptomatic patients or patients with mild symptoms we can consider universal PPE (n95 masks in 2nd stage, delivery and cesarean delivery) and low threshold for PUI testing for mild symptoms.

- One of our providers is asking about confirmatory toxicology testing on maternal urine. We haven't done that here and I am wondering if that is a common practice in other facilities. Also, does it require a separate consent?
    - We have not seen that done at our institution
    - UCM has not been doing this.

- Should universal screening be done on L&D- if so and an asymptomatic mother is positive do you test the father of the baby?
    - We have not opted to test spouse/partner at NorthShore. If the spouse developed any symptoms, testing would be considered at that time.
    - We would consider if mom is positive, father is likely positive but would not do testing unless partner showed symptoms. For Covid+ women their partner is not

allowed. For PUI's their partner or support person can be in the room with a mask on, if they leave the room they then have to leave the hospital.

    - Rush: we are screening all visitors for symptoms and with a temperature evaluation and require a mask be worn. We are not currently testing visitors that do not have symptoms or other evidence of COVID-19 with universal point of care testing
    - This is a controversial aspect that depends on hospital policies, availability of POC testing. At our institution only admitted patients are screened.
    - UCM is not testing the support person of COVID+ patients but we are assuming that the support person is also likely positive.

- Where do patients go for testing prior to scheduled procedures
    - Some hospitals are asking patients to present for testing 24-48 hours prior to scheduled procedures and the time frame is based on the turn-around time for the test. Testing can occur at outpatient testing centers.
    - At UI Health, walk-through testing center or outpatient clinics that made the RT-PCR based tests available.

Resolution / Guidance for when patients are no longer considered infectious

- What are you saying for patients who are + in pregnancy- how long until we consider them negative. ID at NorthShore told me 2 weeks (RUSH)
    - Please see above question/answers on when patients are no longer considered an infectious risk.
    - Rush: also addressed above.
    - CDC guidelines suggest a test and a non-test-based approach. If a test-based approach is taken 2 consecutive negative tests taken 24 h ours apart are sufficient in the absence of symptoms to suggest patient is COVID -.

- Are you testing employees for 2 negative results before they return to work?
    - NorthShore for the most part is using a symptom strategy for return to work although there may be specific instances when the test-based strategy is used to allow a specific provider to return to work earlier (see previous answers to CDC link).
    - CDC guidelines suggest a test and a non-test-based approach. If a test-based approach is taken 2 consecutive negative tests taken 24 h ours apart are sufficient in the absence of symptoms to suggest patient is COVID -. Every institution is different. Consult Employee Health Services at your institution. Our institution is not testing employees returning back to work. Yet, all employees are temperature screened every AM prior to entering the OB units.

Visitors

- Are positive patient being allowed a visitor in your facility?
    - Not at NorthShore
    - For Rush - See answer above. Patients that are PUI or Covid+ are not allowed a visitor

- What are your visitor guidelines for COVID+ mothers
    - Visitors are not allowed for Covid + patients at NorthShore.
- Is there any thought for testing spouses of patients as well? Given that the neonate will be discharged to that household
    - We have not opted to test spouse/partner at NorthShore. If the spouse developed any symptoms, testing would be considered at that time.
    - Rush: see above. We are not performing universal visitor/spouse/partner testing

PPE

- What is the recommended PPE during placement of an epidural (for both RN and anesthesia). Often the nurse is the person "holding" the patient, which places them within close proximity.
    - At NorthShore, masks, gloves and goggles are utilized for all patient contacts, including CLE. During the second stage or cesarean delivery, airborne precautions are added (gown, N95 and face shield).
- PPE during second stage.
    - See above
- With universal masking of all patients and providrs, are they brining their own? Or is your organization providing them with masks
    - NorthShore provides a mask for patients who do not bring their own. PUIs or partners of PUIs are provided with a mask.
    - Rush: patients, visitors and employees are provided a mask upon entrance to the hospital
- Growing concern about asymptomatic cases of COVID+. And worldwide data showed 10-20% of COVID cases are health care worker. My concern is that it might have a chance that one of us don't know they are infected and might unintentionally pass the virus to their colleagues or their patients. Any comment for this regard.
    - It is difficult to know with certainty the answer to this question. However, it does provide further support for universal masking to prevent infection of others—colleagues and patients-- as well as to protect ourselves. The concern with asymptomatic spread also underscores the importance of vigilant hand hygiene with every interaction, social distancing as possible, promotion of telehealth visits and consideration of platoon model for OB care with fewer OB providers utilized. From the experiences cited in Atul Gawande's New Yorker article (posted on ILPQC Covid site), the application of strict respiratory precautions in every patient interaction and airborne precaution for known Covid patients, resulted in very few infections among health care workers.

PUI

- Laboring patients, postpartum patients with elevated temperatures (>,= 38 C) treated as PUI?
    - Some hospitals have adopted the screening criteria that any fever >100 F is an indication for PUI status. Other hospitals have adopted an approach that if a patient does not have localizing symptoms/ strong support for an alternative diagnosis, then the individual should become a PUI and undergo testing. Other hospitals evaluate on a case-by-case basis in consultation with their Covid team.
    - When a Triple I diagnosis (chorio) is made the patient will become automatically a PUI. This status will be lifted once he POC testing will suggest COVID – status.

- When a patient spikes a fever after delivery, at what point should she be placed in isolation and considered a PUI?
    - See above.

Postpartum

- How are any facilities reacting to patients who refuse testing and/or separation at delivery? In many instances a refusal of care requires the patient to sign a form attesting to the refusal with associated risks. Has anyone inquired to their risk/ethics departments to adopt this practice of a refusal form for COVID testing/newborn separation or, is this a moot point because AAP recommendations differ from those of the WHO & CDC on this?
    - We have opted for a shared-decision making model in which separation is an option and if declined, an alternative strategy of respiratory/droplet precaution is applied during the hospital stay. This model is supported by the alternate strategies discussed in the AAP guidelines.
    - UCM has also opted for a shared-decision making. We are doing universal screening and have had patients decline to be screened. They are NOT then treated like a PUI or COVID positive patient and offered separation etc but full PPE is worn during encounters with the patient and N95 at delivery.

Transports

Data / Registry

- Is there systematic data being collected about perinatal outcomes, particularly morbidity and mortality data?

    - See response re: PRIORITY study national registry information from last week. On the ILPQC Covid 19 webpage, please click on OB/Neonatal Covid 19 registries and this will bring you to the registries and all information needed to enroll.
- What is happening with 'the curve' of new events in Illinois and in Chicago?
    - Governor Pritzker spoke to this topic today, April 21. https://www.nbcchicago.com/news/local/when-will-coronavirus-cases-peak-in-illinois-models-now-predict-mid-may-pritzker-says/2259420/

- Can you provide OB number/percentage breakdown of mild symptoms, severe symptoms and those requiring ICU care?
    - Our data are limited but from the Columbia study (Breslin article posted on ILPQC Covid site), of the 43 women with Covid, 86% had mild disease, 9% severe disease and 5% critical disease.

Materials Requested

- second stage/universal testing ob admits
- Is there a need to change the bottles she expressed milk into from a mom with a positive/PUI COVID?
- I think a hand out for all new parents- including non-exposed with FAQs on it. For instance: should I have visitors
- what are the guidelines to say an OB patient has cleared COVID and no longer needs isolation from baby?

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OB Panelist Questions:

Questions from chatbox and into ILPQC info email account for all OB panel

OB Registry

- Registry for OB - We are asked to send to APC are we to add our own patients to the national registry. Will IDPH use the through the national registry?
    - Yes, every OB clinical team should try to report positive pregnant women and exposed newborns to the national registries. They are very important for gathering information quickly to best care for pregnant women and newborns with Covid 19.
    - The national registries are separate from IDPH and we do not information that they would share information with the national registry. The national registries are voluntary but a great idea and each patient who has Covid is encouraged to participate.
    - To refer a patient, please go to PRIORITY.UCSF.EDU

L&D

- **Northshore had discussed not utilizing supplemental O2 for fetal resuscitation. Is that for all laboring patients or just your Covid/ Person of Interest patients?**
    - The restriction applies to all women. Given the emerging data that have re-framed the risk/benefit ratio for supplemental O2 for fetal resuscitation, the potential for aerosolization, and the potential for asymptomatic community prevalence, many hospitals are avoiding this practice for all parturients.
    - I can relay at Loyola we are no longer using O2 supplement for fetal indication in any patient whether PUI or coVID positive. Treating all as potential CoVIDS given the 30% asx presentation rate.

- **Discuss recommendation to not use O2 for fetal indications during labor seen in the literature.**
    - The following 2 articles argue that O2 for fetal indications may have no benefit and actually be of harm:
        - Hamel MS, Anderson BL, Rouse DJ. Oxygen for intrauterine resuscitation: of unproven benefit and potentially harmful. Am J Obstet Gynecol 2014; 211:124-127.
        - Raghuraman N, Wan L, Temming LA, et al. Effect of Oxygen vs Room Air on Intrauterine Fetal Resuscitation: A Randomized Noninferiority Clinical Trial. JAMA Pediatr. 2018; 172:818–823.

- **For hospitals with limited number of labor/postpartum rooms and inability to send off to another floor of the hospital- what are your thoughts on starting to cohort postpartum mom/baby (do we cohort healthy people- i.e. 2 mom/baby healthy pairs in a room, or cohort PUI/COVID patients)**
    - (I wonder if this is more for peds since I think it is about putting mom/baby together)
    - We at Loyola have limited space also but moving a viable pregnancy off our unit was not logistically felt the safest option unless the patient required ICU level care. Each unit should walk through their layout in a multidisciplinary fashion – walk through with Nurse

Manager & OB Director, Neo team rep doc and nurse, as well as OB Anesthesia before finalizing the plan. We developed a step-wise plan based on CoVID volume as to which rooms we would use, as well as which OR we would use. It is also critically important your Peds/NICU team be involved in any decisions re baby care/logistics.

- **Would it be prudent to recommend delivery of the TERM SARS-CoV-2 positive patient that is presenting with only mild symptoms?**
    - The decision to deliver in the setting of SARS-CoV2 must balance the risk of clinical deterioration and the gestational age (if <39 weeks). It also must balance the recommendations in many hospitals against having a support person in labor and for neonatal separation in the setting of SARS-CoV2 which often is lifted with symptom resolution. Thus, while prudent in many cases to move toward delivery, this decision must be individualized.
    - That should be based on gestational age at presentation and individualized. For an early term patient for example that would be a very reasonable decision. Whereas for a patient who is 30 weeks given 80% of infection will resolve following a minor course immediate delivery would not be advised.

- **Why cannot doulas be considered part of the health team, so patient can have them in the room with the husband or other partner?**
    - Doulas are a highly valued contributor to the birth of many women and the decision to limit their presence must be balanced against that benefit. The decision to limit extra people in the LDR (support people and HCW included) is made to mitigate exposure and to minimize PPE utilization. Exposure occurs in two directions. Any additional person present in the hospital represents a potential exposure to other HCWs. In addition, as a higher risk exposure, deliveries pose a risk of SARS-CoV2 to all people in the room. As doulas are often support persons for multiple pregnant women, this poses a heightened risk of augmenting community spread. To mitigate these risks, PPE would be recommended (including, potentially, an N95 at delivery). The extant shortages in PPE faced in many healthcare systems underscore the concerns of having additional people in the room and have lead many health systems to limit the number of HCW present at any delivery.
    - The reason for limitation on support person number is not based on title of that support person it is based on limiting exposure.

<u>Testing</u>

- **Is it recommended that screening of both the expectant mom and her support person be performed?**

- There are no clear national guidelines to recommend universal testing of parturients and their support people, although two case series from Columbia suggest that in areas of high community spread, a high prevalence of asymptomatic positive tests are common. These decisions must be made based on community prevalence and any testing supply concerns. This decision should also incorporate the sensitivity and anticipated negative predictive value of the testing platform utilized as well as the turn-around-time for the test.

- **Should we screen all patients being admitted to L&D for labor for COVID?**
  - As above, the decision to test asymptomatic women must take into account many factors, including how the hospital plans to differentially manage asymptomatic women and their newborns with a positive test. In addition, the sensitivity of the test and turn-around time for results. The availability of testing is also important to consider and sufficient testing supplies.
  - Both pros/cons of this argument were presented during the webinar.
    - For pro universal testing – we discussed the high rate of asymptomatic positive tests from the first cohort of pregnancy cases from NY. Taking into consideration the risk on L&D with large numbers of HCW with possible prolonged interaction with asymptomatic positive patients, as well as safety of all laboring women and their newborns.
    - For con universal testing –
      - 1) Worry the sensitivity is lower in an asymptomatic population.
      - 2) It is not uncommon for patients to test negative early, and then test positive later in the disease course.
      - 3) A false negative test could provide a false sense of security.
      - 4) Must consider the level of community spread and the incidence of positives in the population.
      - 5) Must consider if testing resources or PPE is more scarce resource, not all sites have ability to perform that number of tests.
      - Must consider the test turn-around time and the lab capacity.

- **For universal testing, are all mothers considered PUI until results are received**
  - A PUI is, by definition, someone with symptoms suggestive of COVID-19 who is awaiting test results. There is no clear guidance on how to categorize asymptomatic women with pending test results.

- **With universal testing of all L&D patients, are you concerned about false negatives**
  - **The current gold standard for the diagnosis of SARS-CoV2 infection is the CDC testing platform. Several of the platforms currently in use have similar sensitivities when validated in the laboratories of individual hospitals. The rapid tests, however, may not have as high a sensitivity as the CDC test.**

    - **A false negative can arise if a test with lower sensitivity is used or if sampling error occurs (an insufficient sample is obtained) or if a patient is tested early in his/her disease course. It is not yet known what the sensitivity of these tests are in asymptomatic patients but early data suggest that it may be lower than in symptomatic patients.**
    - One example discussed on the call, Northwestern has focused on the negative predictive value of the test-- what is the probability of an asymptomatic patient being negative for SARS-CoV2 when the test performed is negative. This can be estimated using the presumed prevalence of SARS-CoV2 along with the tests sensitivity and specificity. Currently, the negative predictive value is high and Northwestern has made the decision to *not* use aerosolizing precautions (N95 masks) at delivery for those patients with negative SARS-CoV2 testing. .

- **For those hospitals that are covid testing all of their laboring patients, how are they doing this? Are they screening them in triage and if so are their triage rooms private? I'm trying to figure out the best way to do this at our institution while maintaining isolation for these patients.**
    - At Northwestern, we are testing either in their LDR (if need to be admitted) or in triage (if obstetrically appropriate to delay admission until the result).

- **Who does the Coronavirus testing in your labor and delivery units? Where is the testing done? Are their enough test kits available at your institutions to test all laboring patients or those going for cesarean?**
    - L&D nurses are performing the SARS-CoV2 swabs. Imperfect specimen acquisition is a large contributor to the imperfect sensitivity of a test, so it is important that whomever is obtaining the NP swab has undergone specific training to optimize the specimen collection.
    - Some hospitals have sufficient testing capacity to test all obstetric patients and other hospitals do not have sufficient capacity.

- **Are you testing all OB patients for NCov in order to avoid possible 2nd Stage exposure?**
    - **Northwestern has adopted a universal testing strategy for all obstetric patients to assess the negative predictive value of the test and is currently not using N95 masks during the second stage in those asymptomatic women who have tested negative for SARS-CoV2.**
    - **Other hospitals have opted to universally screen asymptomatic patients and used that information to prevent community or household spread for mothers, newborns and their families. Some sites continue to use universal PPE if available given risk of false negative, including sample collection error or negative result from testing too early in virus course.**
    - **Other hospitals are testing only symptomatic patients, but given risk of asymptomatic positive patients in labor, using universal PPE on L&D including n95 masks for all**

patients for 2nd stage and OR, and low threshold to test women in labor for mild symptoms and consider PUI.

PPE on L&D

- What is Level 2 PPE
    - Level 1PPE: cap, gown, gloves, surgical mask. These are also called droplet precautions.
    - Level 2 PPE: cap, gown, gloves, N95mask, face shield. These are also called airborne precautions.
- **Should the second stage of labor be considered an aerosol generating procedure? Should PPE (N95) be provided in the second stage for COVID positive patients or all patients?**
    - Yes for ALL patients for many institutions. Many institutions are prioritizing n95 for 2nd stage labor and cesarean delivery given the risk of asymptomatic laboring patients on L&D can be high per the data from NYC.
    - The CDC and ACOG guidelines to date are not specific in addressing this, however given most SARS-CoV2 transmission is by respiratory droplet, the filtration of a standard surgical mask versus an N95 mask (75% versus 99%), and the close proximity providers are in during the second stage of a vaginal delivery and during a Cesarean delivery, many hospitals have moved to use of N95 masks in these circumstances to protect their personnel. Additionally, given that approximately 30% of SARS-CoV2 presents in an asymptomatic fashion, adoption of universal Level 2 PPE for these circumstances is also appropriate.
    - Please see attached article published out of Medical College of Wisconsin regarding this topic.
- **The use of masks for patients and staff in OB areas**
    - All staff wears eye protection and masks for all patients. All patients and significant others wear masks throughout admission.
    - At our hospital, all staff are required to wears masks and eye shields when caring for patients and gown, gloves, N95 and face shields during the second stage of labor or cesarean delivery.
    - Our anesthesiologists have been wearing N95 masks and face shields during epidural placement.

PUI

Screening criteria for a pui, covid testing - when should we be doing it

- Many hospitals have developed their own screening algorithms based on input from their infectious disease, infection control and clinical teams that reflect availability of testing and patient symptoms.
- Our hospital system posts updated guidelines at the following link along with commonly asked questions and the corresponding answers

https://www.northshore.org/healthy-you/novel-coronavirus-2019/

- PUI criteria on OB Unit for NU (before universal testing) and for Loyola as of 4/3:
  - All scheduled and unscheduled patients and their support person will be routinely screened for signs/symptoms of COVID19 prior to entry in to our unit if:

    Fever > 100.4 without another clear etiology, or

    New cough or Shortness of breath

    -or two of the following-

    body aches, chills, new onset vomiting after 1st trimester, diarrhea

    loss of sense of taste or smell, or itchy/painful/red eyes (unrelated to seasonal allergies)
- If above, placed in designated COVID room & in absence of a clear alternative diagnosis patient will be swabbed for COVID19 and treated as a PUI.

Postpartum

- Document to show discussion has been had with a mom re: recommendation to separate? Just documenting in progress note or using a consent type document?
  - Our hospital has adopted a shared decision model in which the neonatology team has a discussion regarding the options of isolation versus newborn rooming with mom with appropriate precautions
  - This conversation is currently documented in the chart in a progress note
  - At UCM we are having a discussion with the parents regarding recommendation to separate as soon as the test comes back positive and documenting the conversation in a standard way in a progress note. We discussed having a consent form but decided there didn't seem to be enough evidence to mandate a consent form given that we are still sending the patient and infant home together in a 48 hours or so.

- I have a patient with COVID and had a c-section. The OBGYN wants to remove the staples after 14 days of quarantine. Can we have her come earlier.
  - It would be reasonable to adopt the IDPH guidance that an individual could be removed from home isolation after 7 days since onset of symptoms or after resolution of fever for 72 hours, whichever is longer. Health care workers are asked, in addition, to wear a mask for 7 days in the health care system. The patient could be asked to wear a mask when she receives care during the 14 day window after onset of symptoms to prevent community spread within the healthcare system.
  - (http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/personal-guidance-and-testing)
  - IDPH offers the following guidance for patients to discontinue home isolation followed by guidance for health care workers:

- If you have tested positive for COVID-19, you should remain under home isolation precautions for a minimum of 7 days and until your symptoms are resolving and you have had no fever (without taking fever-reducing medication) for at least 72 hours.
- If you have a fever with cough or shortness of breath but have not been exposed to someone with COVID-19 and have not tested positive for COVID-19, you should also stay home and away from others for a minimum of 7 days and until your symptoms are resolving and you have had no fever (without taking fever-reducing medication) for at least 72 hours.
- If you are a health care worker, testing may be required before you return to work in some circumstances. If a non-test-based strategy is used, healthcare workers with possible or confirmed COVID-19 may return to work when at least 3 days (72 hours) have passed since recovery, defined as the resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) and at least 7 days have passed since symptoms first appeared.
- After returning to work, health care workers should
- Wear a facemask at all times while in the healthcare facility until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer
- Be restricted from contact with severely immunocompromised patients (e.g., transplant, hematology-oncology) until 14 days after illness onset
- Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

- What is considered a 'dedicated' breast pump recommended for COVID positive moms who are pumping? Can it be cleaned and reused for other patients?
    - Each patient with COVID has their own breast pump and thorough cleaning between each pumping session is recommended. After the patient is discharged the pump is being cleaned in accordance with our hospital wide policy for cleaning equipment of COVID patients.

- If have known positive Covid-19 and she has delivered with significant other in room- and the hospital has plan in place to separate mom and baby in separate rooms- the significant other goes to see baby in PPE and now goes back to mom. Is there a recommendation for back and forth with the significant other.
    - Our hospital has adopted a policy that significant others of SARS-CoV2 positive women who choose to stay during the labor, delivery and post-partum course are expected to stay with the mother and are not allowed to leave mother's room. They are provided meals and are asked to not go to the cafeteria or visit other rooms (including the

newborn). If they leave the room, they are not allowed to return and are asked to leave the hospital.
    - The topic of where the newborn stays (in isolation versus with mom) and the implications for the significant other would ideally be discussed by the neonatologist as part of a shared decision model prior to delivery.
    - If parents choose to separate, we are not allowing any visitors to the separated infant during the separation period. Instead, we are offering ipads so parents can "video chat" with the infant.

- What about moms who are breastfeeding?
    - IDPH offers the following guidance for moms who are breastfeeding
    - http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/pregnancy-children

    - Can women with COVID-19 breastfeed?
    - Yes. Women with COVID-19 can breastfeed if they wish to do so. They should:
    - Practice respiratory hygiene during feeding, wearing a mask where available;
    - Wash hands before and after touching the baby; and
    - Routinely clean and disinfect surfaces they have touched.
    - Can women touch and hold their newborn baby if they have COVID-19?
    - Yes. Close contact and early, exclusive breastfeeding help a baby to thrive. You should be supported to:
    - Breastfeed safely, with good respiratory hygiene;
    - Hold your newborn skin-to-skin, and
    - Share a room with your baby
    - You should wash your hands before and after touching your baby and keep all surfaces clean.

Equity / Disparities

- What are providers in Illinois doing to address the equity/disparities issues with COVID & patient communication?
    - Here are links with examples from MGH in Boston of approaches to address Birth Equity and COVID 19 (also posted on ILPQC COVID 19 webpage):
    - Mass General OB/GYN: Equity in the Time of COVID-19 – what can we do? (4.8.2020)
    - 1) As we design new models of care, attention to how they might work or need to be modified for vulnerable communities
        - – Telehealth visits • Use interpreter services or consider having virtual visits conducted with a colleague fluent in your patient's primary language • If you have facility in languages other than English and are willing to use them to provide care,• For some, initial communications by text messaging (e.g. Google Voice) may be preferred • Consider increased frequency of "touches" in the postpartum period

        - – Early hospital discharge • Consider patient resources and self-efficacy when determining optimal discharge timing
    - 2) Continue screening for social determinants of health, IPV and depression
        - – Consider asking “do you feel safe at home?” at all in-person visits – Keep in mind that SDoH may have changed from beginning to end of pregnancy with this crisis – Familiarize yourself with SW, community health, spiritual care and HAVEN referral processes •
    - 3) Adhere to principles of Reproductive Justice – Enable women’s reproductive choices • Offer – but don’t coerce – all women PP LARC other other contraceptive methods that can be administered during the inpatient stay • For women with desire for sterilization, at high risk of unplanned repeated pregnancy (ideally, as documented by primary OB provider) and no other threats to safety, accomplishing postpartum TL on L&D is appropriate • Continue access to abortion care as an essential service
    - 4) Consider how our our own implicit biases may contribute

    - https://www.apa.org/topics/covid-19-bias
    - https://implicit.harvard.edu/implicit/featuredtask.html
    - https://www.dropbox.com/sh/zvg12qp7g477un9/AADAndcUeK1QzjYzwtGnhSqda?dl=0 (Multilingual COVID resources)
    - https://en.contracovid.com

- How are you responding to suspected cases of domestic violence toward birthing women and/or their children?
    - For any woman who has Covid-19 and is a victim of domestic violence, an individualized treatment plan to prioritize her and her children’s health and safety would be required.
    - It is important when performing prenatal telehealth visits or postpartum telehealth visits to try to ask if women feel safe at home, understanding that women may not be free to talk, if concern try to see women in person for care, provide women information on where to call for concerns for domestic violence, mental health concerns, food insecurity and other issues that women may be facing during the COVID 19 crisis.

- **How does Covid-19 impact incarcerated pregnant/birthing women? How can hospitals meet needs for safety & emotional support?**
    - At Logan Correctional Center, 8 months ago we created a separate Pregnancy Housing Unit for non-violent justice-involved individuals. This unit is completely removed from the general population and includes a library, exercise room, and refrigerator for snacks. Since COVID-19, the pregnant women have remained in this unit, even for meals, and the entire institution has been placed on Level 1 lockdown. Therefore, the pregnant incarcerated women are isolated to minimize the risk of exposure and spread.

Surge / Workforce

- **What are the guidelines for personnel dedicated to caring for moms and babies to float to other areas with COVID + patients? Would they be able to return to the unit?**
    - IDPH provides guidance for return of health care workers to return to work based on the risk related to the Covid-19 exposure
    - http://www.dph.illinois.gov/covid19/community-guidance/healthcare-professional-return-to-work
- **How is IDPH/ILPQC addressing hosp who have closed or anticipating closing their OB units to care for non-preg COVID+ and PUIs.**
    - Would work with perinatal network and IDPH to address how to best meet the needs of pregnant/postpartum women in the community for access to care.
- **Guidance for smaller, rural hospitals**
    - For any questions or guidance, rural hospitals are encouraged to contact their respective Perinatal Center.

Transports

- **Should we be transporting patients that are PUI or COVID + and no other risk factors? Are there guidelines on when transporting is warranted vs not - what if a community only has 1 OB provider - should the patient be moved to limit that providers exposure?**
    - Answered during webinar, see below. This was discussed on the webinar that it should be managed on a case by case basis.
- I am very interested in the different Perinatal Centers' perspective on accepting transports of COVID+ patients who have no obstetrical issues. Should these patients stay at their respective hospitals in order to minimize exposure, or should they come to the Level III hospital? I've heard pros/cons for both sides. And if they are truly sick, would transporting them pose more risks than benefits?
    - Similar to non-SARS-CoV2 positive patients, our perinatal center will accept all SARS-CoV2 positive patients who require care at a Level 3 perinatal center. For those women for whom we do not anticipate care at a Level 3 perinatal center will be needed (previable gestation, appropriate gestational age for the hospital), we do not recommend transfer to our center. Healthcare workers with sufficient PPE would be at low-risk for contracting SARS-CoV2.

Recovery

- Those patients that recover do they then become carries of COVID 19 and once you recover do you then become immune to COVID-19?
    - We do not have very much data on SARS-CoV2 and whether immunity is attained. Currently, trials are underway to test if antibodies derived from recovered patients can be given to symptomatic patients to speed their recovery. If those antibodies prove to be an effective treatment, it would suggest that individuals develop immunity to SARS-CoV2. We do not know how long this immunity might last. We also don't know if the

virus might change over time. If the virus changes enough, the prior immune reaction may no longer be sufficient to fight the disease.

Additional patient/provider Resources requested:

- C-section planning
- guidance on PPE during vaginal deliveries
- COVID-19 breastfeeding guidance
- a "1-sheet" page of recommendations regarding pregnancy/labor & birth/NICU
- Workflow/Diagram template of what to do when a COVID patient is admitted to labor and delivery
- A checklist for the surge planning documents. What is most needed. Will each surge plan be reviewed with suggestions offered?
- OB Antepartum Covid-19 positive discharge instructions
- Delivery timing recommendations.
- Pamphlet for patients educating them regarding how we are protecting them during their labor and delivery experiences.
- How to manage fetal distress in a pregnant mother with progressive COVID infection.