ILPQC COVID 19 Webinar 4/10/20: OB Questions/Answers

Answers represent experiences and strategies related to caring for patients during the COVID-19 pandemic and are considered guidance only, unless national or state guidelines are referenced.

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.

Testing

- **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 linked article published out of Medical College of Wisconsin regarding this topic; Protecting Labor and Delivery Personnel from COVID-19 during the Second Stage of Labor.
- **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.

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OB Questions from Chatbox:

L&D

- What do you do if you do not have a negative pressure room accessible? (During Julie's presentation). If the negative pressure rooms are not available we are using regular rooms (for both vaginal deliveries and CS).
    - All staff are wearing N95s for second stage and deliveries and the patient will wear a mask as well if unable to use a negative pressure room. The door should remain closed at all times except when staff/providers are going in and out. We are using 5 rooms which previously housed our antepartum patients and are in a separate hallway of the unit to give some physical space between PUI/COVID+ patients and asymptomatic patients.
- Are you allowing FOB or significant other in with the mom?
    - We are allowing one support person in the delivery room. The support person must be asymptomatic. If the support person is found to have symptoms they are asked to leave immediately and another support person may come. Once a support person is in the room with the patient they are required to stay in the room with the patient until discharge. Meal service is provided for the support person. We are not allowing support people in the OR for cesarean sections.
- When discharged is it recommended during the terminal cleaning to include replacing the curtain in the moms room with a clean one?
    - Our hospital wide cleaning SOP recommends hanging a new curtain.
- Do you have one anesthesiologist assigned for COVId/ PUI unit?
    - We don't have separate anesthesiologist for our COVID+/PUI patients on L&D. But they are also doing teams and 12 hour shifts to minimize cross over. Our hospital wide COVID unit is staffed by intensivist. If pregnant patients have no pregnancy issues and are only admitted due to being COVID+ and complications from COVID they would be admitted to that unit.

PPE on L&D

- What PPE is anesthesia wearing for neuraxials in "any" patient?

    - Our unit is currently practicing universal masking so all providers are wearing surgical masks at all times. When any patient is encountered all providers and staff are wearing surgical mask with googles or face shield, gown and gloves given our concern for upwards of 20% of patients being asymptomatic carriers for COVID.

- What are other area hospitals doing? What reference can I use to convince my hospital to adopt the HSHS PPE policy? Can you share how other hospitals are issuing out face shields or n95's. How do you avoid lack of access to the PPE especially in emergency OB cases?
    - We lobbied extensively to our Infection Control partners the ability to use N95s at each delivery which they were early to approve of. We have N95s stocked on L&D in a locked cabinet which the charge nurse has a key to. Prior to a delivery or the second stage providers and staff for that patient are given an N95. In an emergency situation there are N95s in the NICU tackle box which can be used. Face shields are also available on the unit

and are being wiped down and reused multiple times instead of being thrown away. However, we are messaging out to our providers and staff repeatedly that there is no emergency situation that should stop them from taking the extra time to properly don PPE. To conserve N95s our unit is piloting a program with the hospital to clean N95 masks using UV light.

PUI

- If just a fever, how would you distinguish from chorio?
  - This has been a challenging for us as well. We are sending swabs on patients with fever in labor and delivery. If the swab comes back negative and we suspect chorio as the cause of fever we can clear these patients as having an alternative diagnosis (chorio)
- What if a patient presents in labor without symptoms, but has had exposure to + Covid?
  - We are not treating COVID+ exposure patients differently and instead are assuming all patients could be asymptomatic for COVID so are using PPE for patient encounters assuming they are PUIs. Soon we will be doing a rapid COVID test on all patients presenting to L&D.

Postpartum

- Are centers expediting postpartum/post-C/S discharges and if so, what criteria are being used?
  - As long as medically cleared for the patient and infant we are discharging patients at day 1 for vaginal deliveries and day 2 for cesarean sections. Discharge is always at least 24 hours after delivery. Patients with gHTN or preE are being sent home with a BP cuff and getting a telephone call in a week for BP review.

Surge / Workforce

- If you only allow one OB provider for PUI/COVID+, does that mean that the resident does not participate in that delivery?
  - When COVID+ patients are delivering we are limiting to one provider when possible which means the resident would not participate in the delivery.
- Is everyone allowing pregnant associates to take care of PUI's or positive patients?

    - We are allowing pregnant staff and providers to care for these patients. However, a pregnancy accommodation can be submitted to HR to request to be moved to a non-COVID/PUI area.
- What is your view on OB staff, especially RN's floating to adult floors such as ICU/Telemetry/med-surg to function as a sitter or CNA then coming back to work on the OB floor?
    - We are not allowing any of our staff from the unit or providers to float or work in any other areas such as other floors, ED or outpatient. Providers who usually work at other hospitals are also not being permitted to "cross campuses" during this time without a certain amount of time between shifts.
- Have other units seen an increase in staff taking personal leave? What creative ways are you staffing your units?
    - We have all of our providers and nurses on a 3 day on 6 day off rotation and aligned with each other. This allows us to keep teams separated from each other. We are staffing each shift with less nurses then previously scheduled but have seen our volumes decrease especially with less triage visits.