COVID Primary Care Webinar: Bumps, Babies and Beyond: Prenatal and Child Care during COVID 19

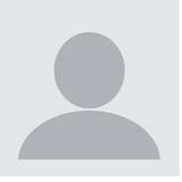
OBGYN Presenters:
Stephanie Cooper MD FRCSC
Jan Ooi MD CCFP

PED Presenters:
Natalie Forbes MD FRCPC
Christopher Lever MD FRCPC

Panelists:
J.A. Michelle Bailey MD FRCPC
Colin Birch MBBS FRCSC
Bonita Lee MD FRCPC
Kyle McKenzie MD FRCPC
Norma Spence MD CCFP
Wendy Wood R.M.

May 7, 2020

Moderators



Heather Armson MD CCFP FCFP

Professor and Assistant Dean, Personalized Learning, Continuing Medical Education and Professional Development, University of Calgary

Disclosure:

Tina Nicholson MB ChB MRCGP CCFP

Clinical Lecturer, Department of Family Medicine and Medical Director, Continuing Medical Education & Professional Development and Physician Learning Program (PLP), University of Calgary; Assistant Clinical Professor, University of Alberta; Medical Lead, HHC CFPCN; Faculty for CANREACH

Disclosure:

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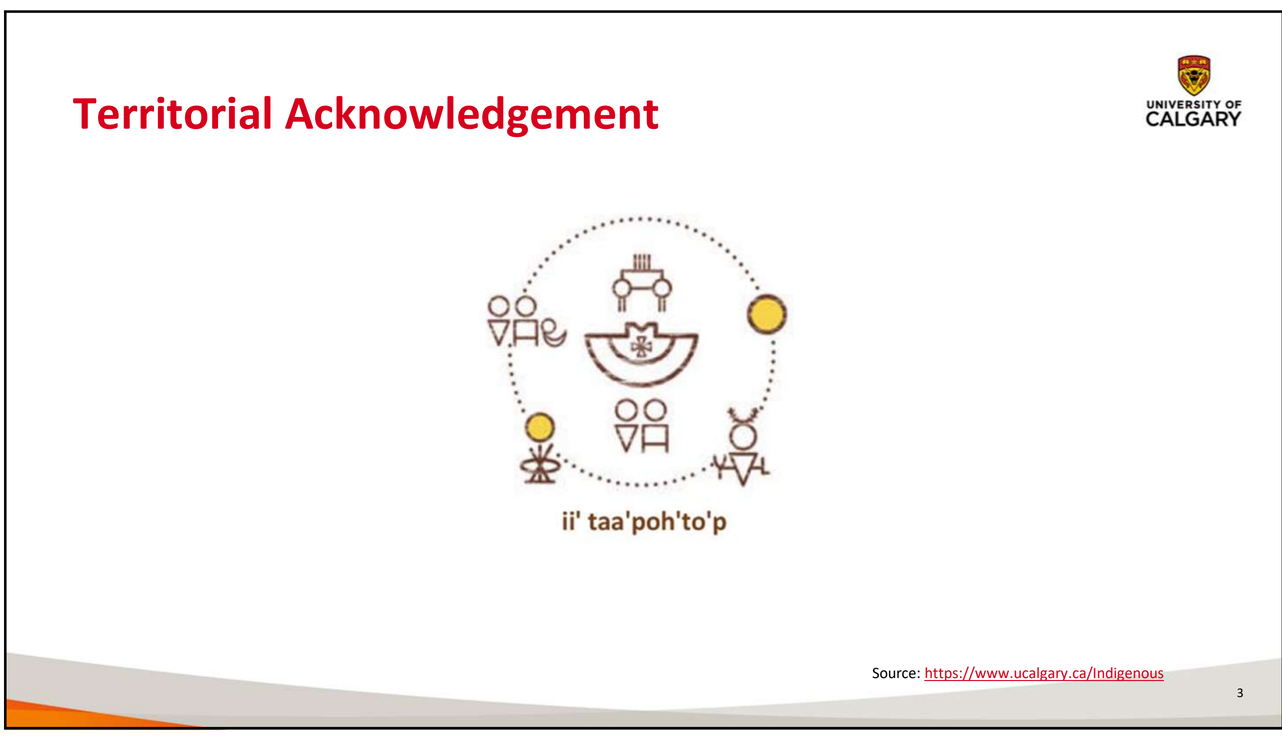

Disclosure of Financial Support

- The program was developed and planned to achieve scientific integrity, objectivity and balance
- This program has not received any educational grant, funding or in kind support.

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OBGYN Speaker

Stephanie Cooper MD FRCSC

Financial Disclosure:
Assistant Clinical Professor, University of Calgary;
OBGYN & Maternal-Fetal Medicine Specialist, AHS

COVID-19 in pregnancy

*What we know, what we don't know-
and where to go for help*

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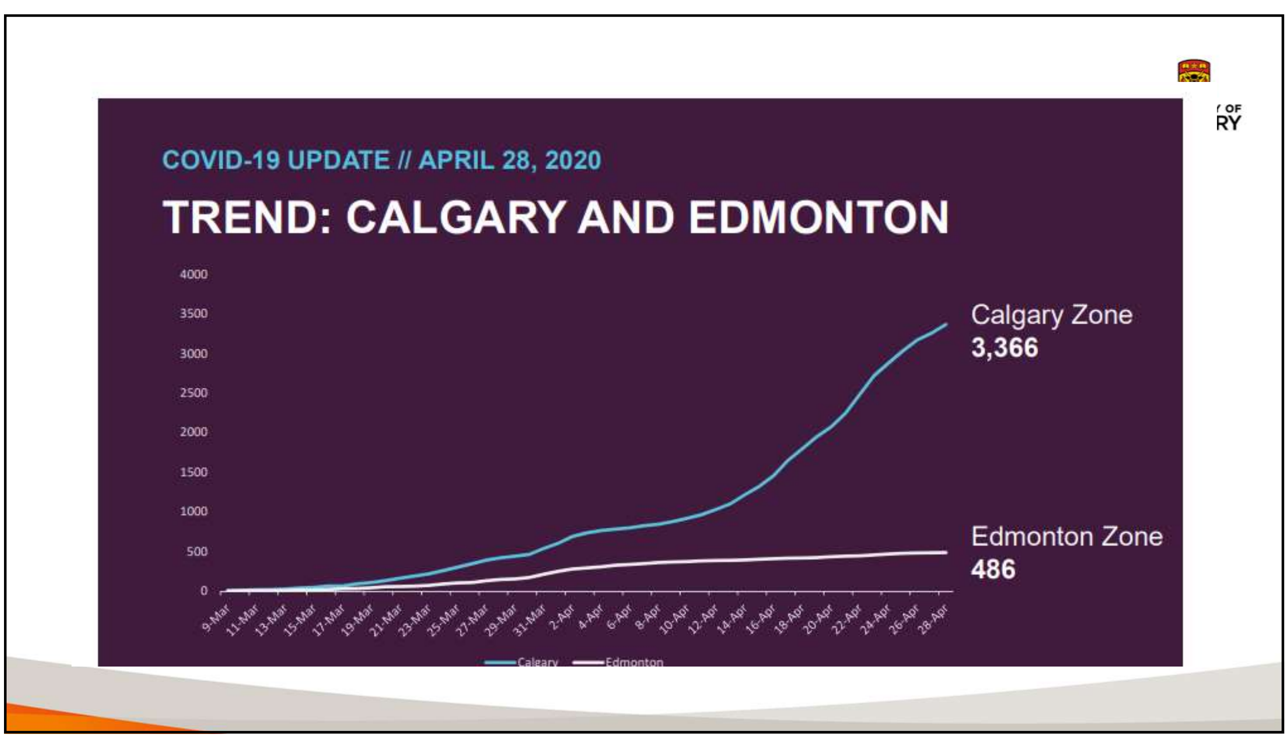

COVID-19 in pregnancy

- Limited information to guide care for COVID-19 infection in pregnancy
- Pregnant women are **not** more susceptible to acquiring infection
- Pregnant women present with similar signs and symptoms as the general population

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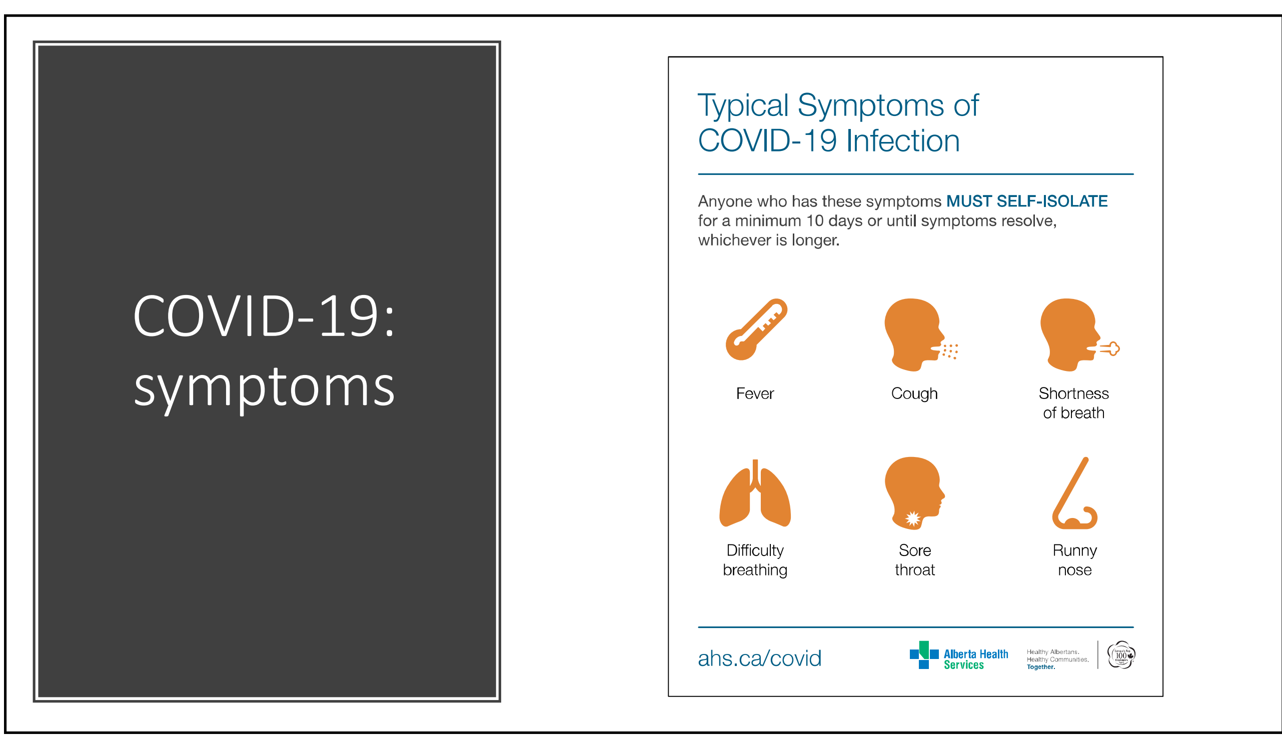
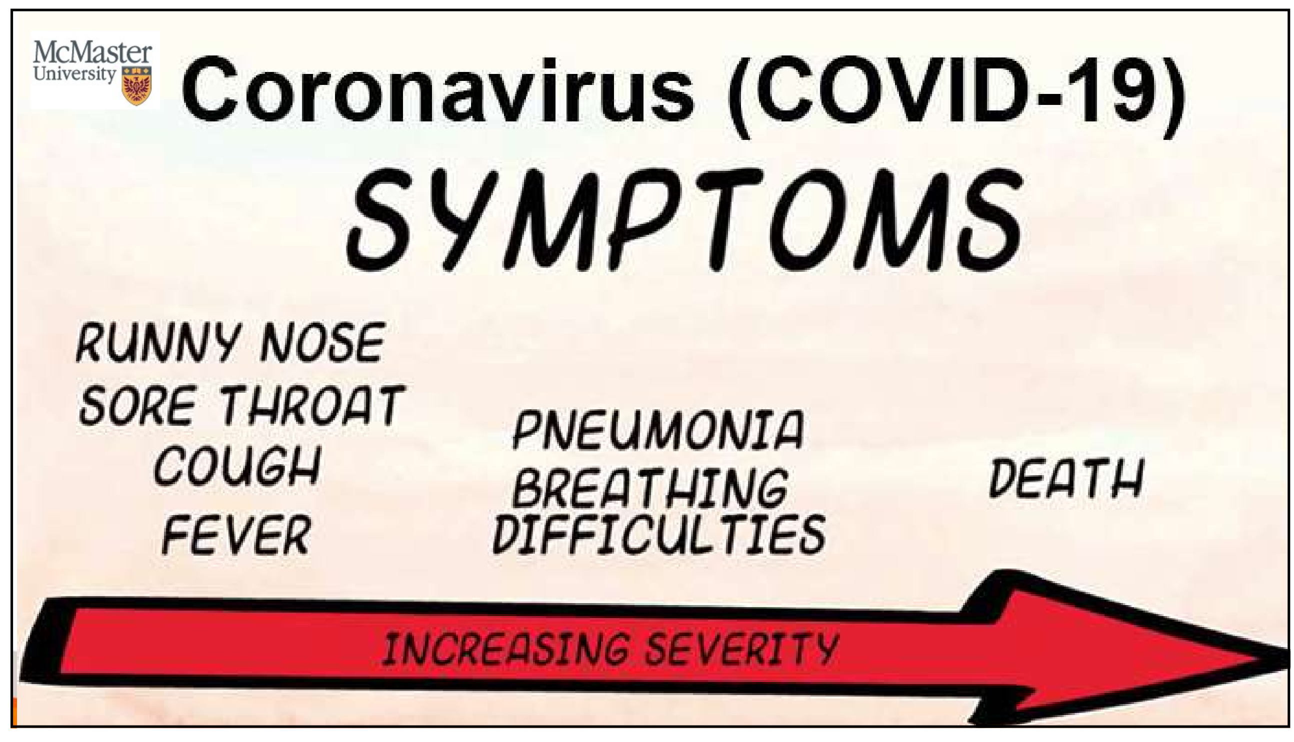
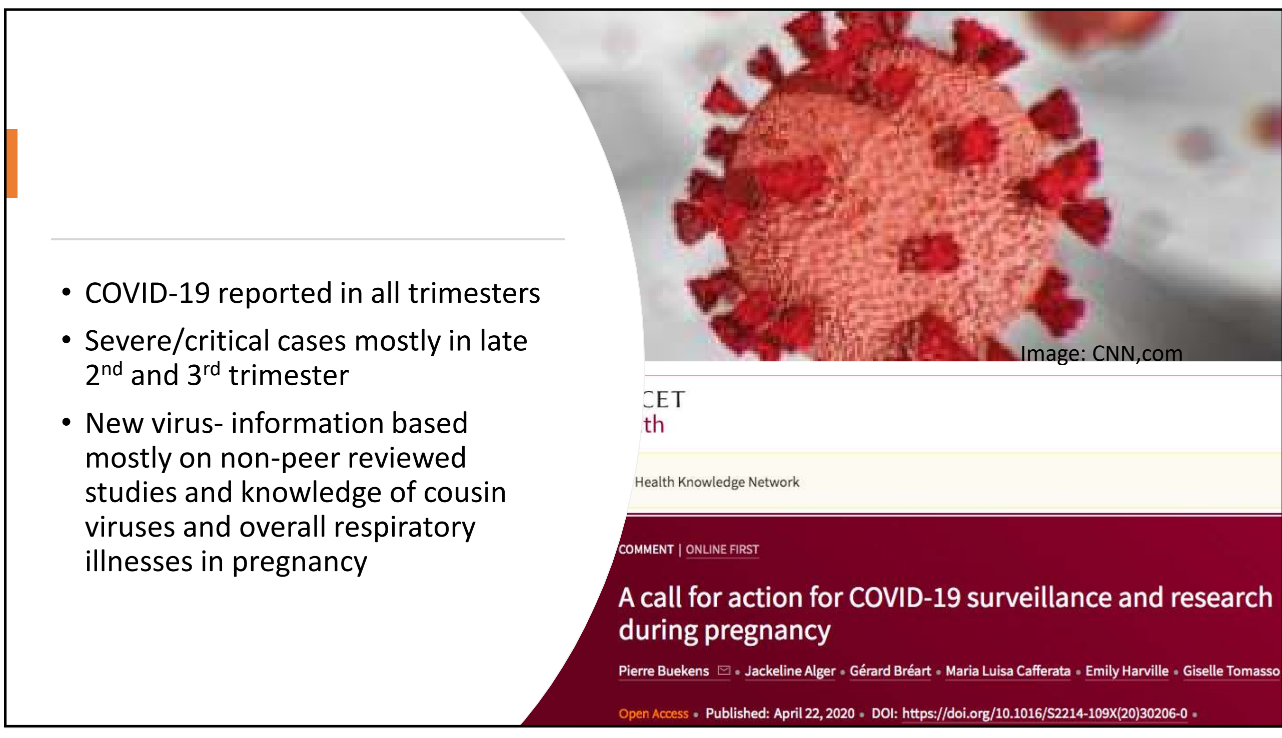

COVID-19: symptoms
Typical Symptoms of COVID-19 Infection
Anyone who has these symptoms MUST SELF-ISOLATE for a minimum 10 days or until symptoms resolve, whichever is longer.
Fever
Cough
Shortness of breath
Difficulty breathing
Sore throat
Runny nose
ahs.ca/covid
Alberta Health Services


McMaster University
Coronavirus (COVID-19)
SYMPTOMS
RUNNY NOSE
SORE THROAT
COUGH
FEVER
PNEUMONIA
BREATHING DIFFICULTIES
DEATH
INCREASING SEVERITY



Birth defects

- Unlikely to be associated with increased risk of birth defects
  - No viremia in 99% of cases
  - Risk of fever as a teratogen potentially overstated

Sass et al. BMC Pregnancy Childbirth. 2017; 17: 41 Drier et al. Pediatrics. 2014 Mar;133(3):e674-88

Risks to the Fetus

- Current available evidence does not suggest increased risk of averse perinatal outcomes in women with mild-moderate COVID-19.
  - No known increase in fetal growth restriction
  - No known increased risk of spontaneous preterm labour
  - No known increased risk of fetal demise in early or late pregnancy

Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol

Annemarie B Docherty, Ewen M Harrison, Christopher A Green, Hayley E Hardwick, Riinu Pius, Lisa Norman, Karl A Holden, Jonathan M Read, Frank Dondelinger, Gail Carson, Laura Merson, James Lee, Daniel Plotkin, Louise Sigfrid, Sophie Halpin, Clare Jackson, Carrol Gamble, Peter W Horby, Jonathan S Nguyen-Van-Tam, Jake Dunning, Peter JM Openshaw, J Kenneth Baillie, Malcolm Gracie Semple

doi: https://doi.org/10.1101/2020.04.23.20076042

- 55 (6% of admissions for reproductive age women) were pregnant - similar to the estimated proportion of pregnant women in the community

- Pregnancy is NOT an independent risk factor for mortality, in contrast with influenza.

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Breslin et al. AJOG (in press) (NY OB case series)

March 13-27, 2020 obstetrical admissions with COVID-19

- 43 patients (18 delivered)
- 86% mild disease
- 9.3% severe
- 4.7% critical

Non pregnant adults (Wu et al):

80% mild
15% severe
5% critical

Perinatal Outcomes

- Pregnant women with severe respiratory illnesses and hypoxia from *any cause* are at increased risk of adverse perinatal outcomes:
  - fetal demise, preterm labour, fetal growth restriction, intolerance to labour
- Preterm birth: likely iatrogenic
- Cesarean Section: increased rates of CS likely biased by earlier concerns of vertical transmission

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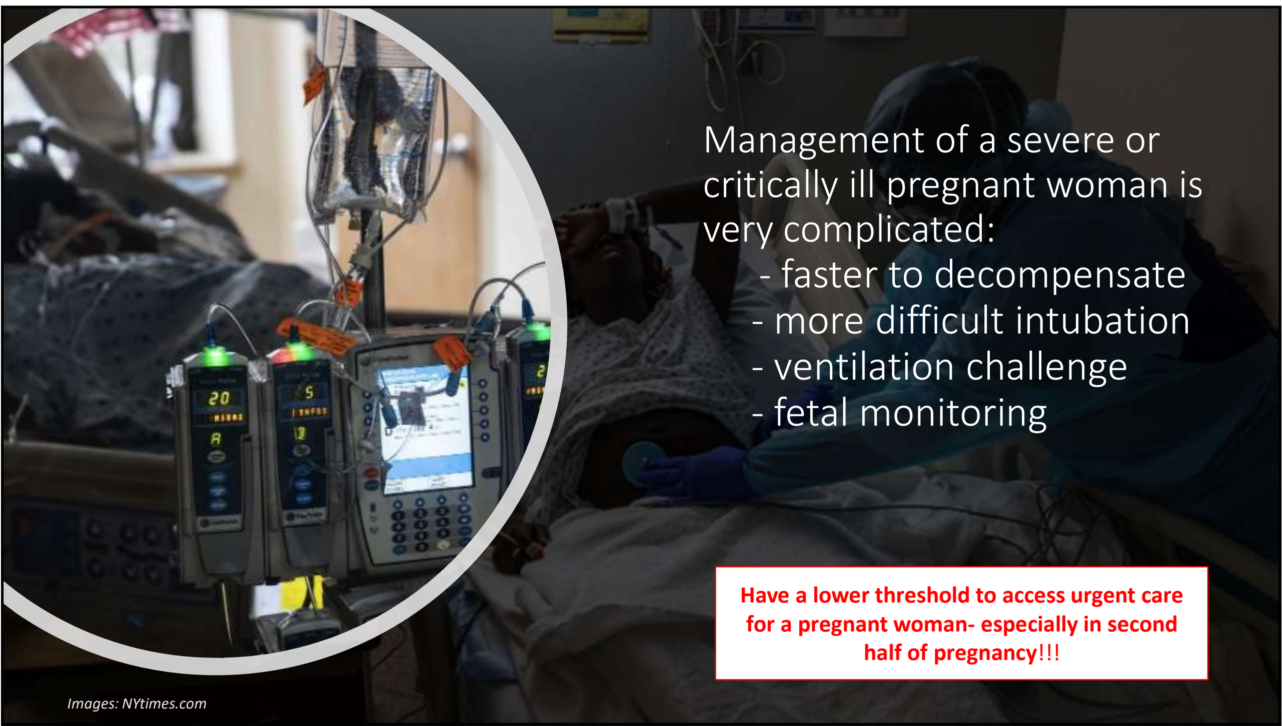
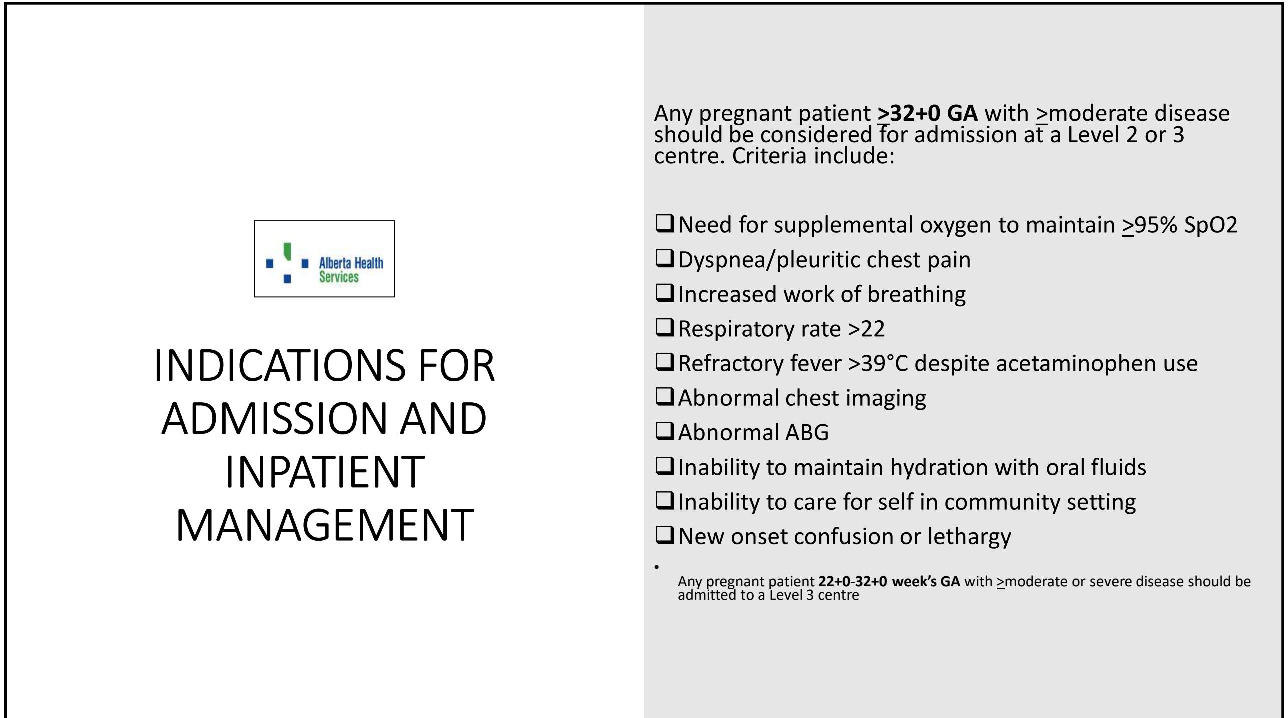
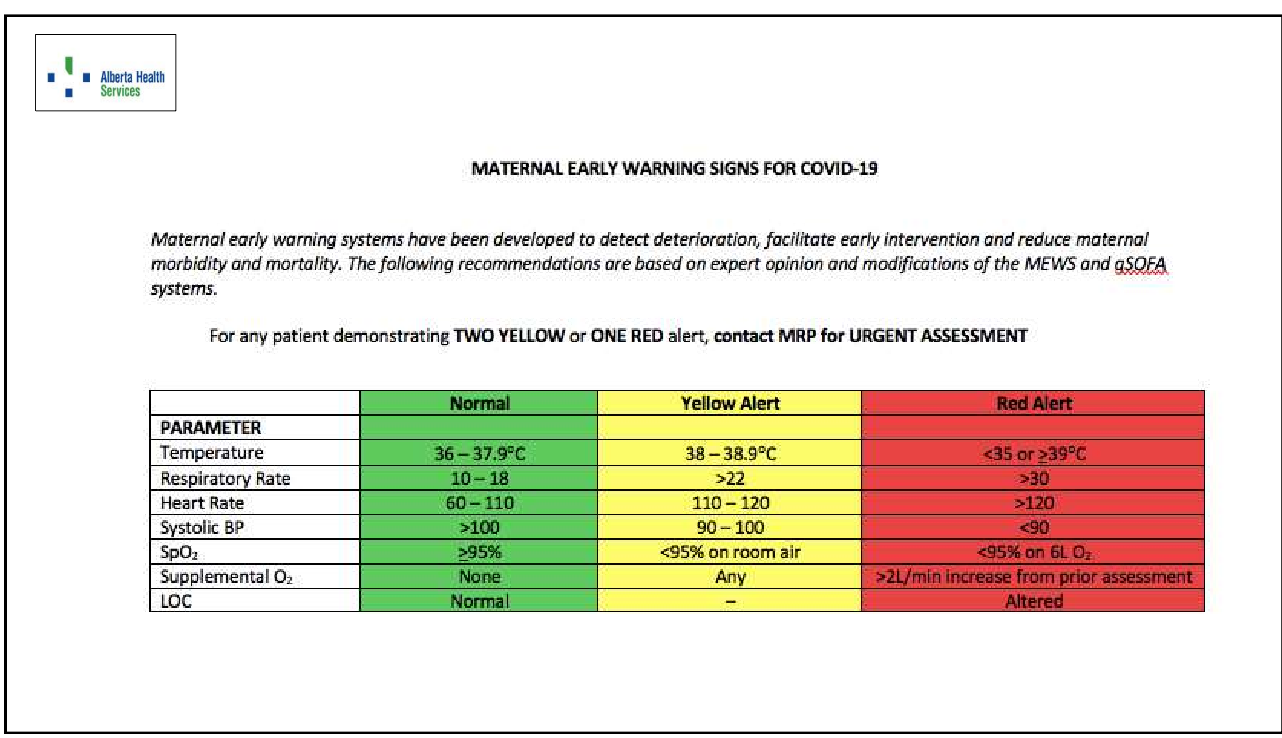


OUTPATIENT MANAGEMENT suspected or confirmed COVID-19 in pregnancy

- Outpatient management and follow-up is appropriate for asymptomatic patients **OR** those with **mild** disease:
  - No shortness of breath at rest or with ambulation
  - Oxygen saturation >95% on room air
  - No evidence of disease on chest imaging
- Patient requires **in-person assessm**ent with MD/MRP (timing at discretion of care provider dependent on symptoms reported):
  - New or worsening shortness of breath
  - New chest pain
  - Orthopnea or paroxysmal nocturnal dyspnea (PND)
  - Fever >38°C despite use of acetaminophen
  - New onset confusion
  - Weakness limiting activities of daily living (ADLs)
  - Obstetrical complaints such as:
    - Regular uterine contractions
    - Ruptured membranes
    - Vaginal bleeding
    - Decreased fetal movement
- Urgent clinical concern from patient or MRP: Emergency Medical Services/911 should be activated per standard policy/practice.





PARAMETER	Normal	Yellow Alert	Red Alert
Temperature	36 – 37.9°C	38 – 38.9°C	<35 or >39°C
Respiratory Rate	10 – 18	>22	>30
Heart Rate	60 – 110	110 – 120	>120
Systolic BP	>100	90 – 100	<90
SpO_2	>95%	<95% on room air	<95% on 6L O_2
Supplemental O_2	None	Any	>2L/min increase from prior assessment
LOC	Normal	–	Altered

Case Examples:

38 year old G2P1 at 33 week's gestation w COVID-19. 7 day history of cough and fever.

On the phone, she describes increased shortness of breath

What now?

OUTPATIENT MANAGEMENT suspected or confirmed COVID-19 in pregnancy

- Outpatient management and follow-up is appropriate for asymptomatic patients **OR** those with **mild** disease:
  - No shortness of breath at rest or with ambulation
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  - No evidence of disease on chest imaging

Patient requires **in-person assessment** with MD/MRP (timing at discretion of care provider dependent on symptoms reported):

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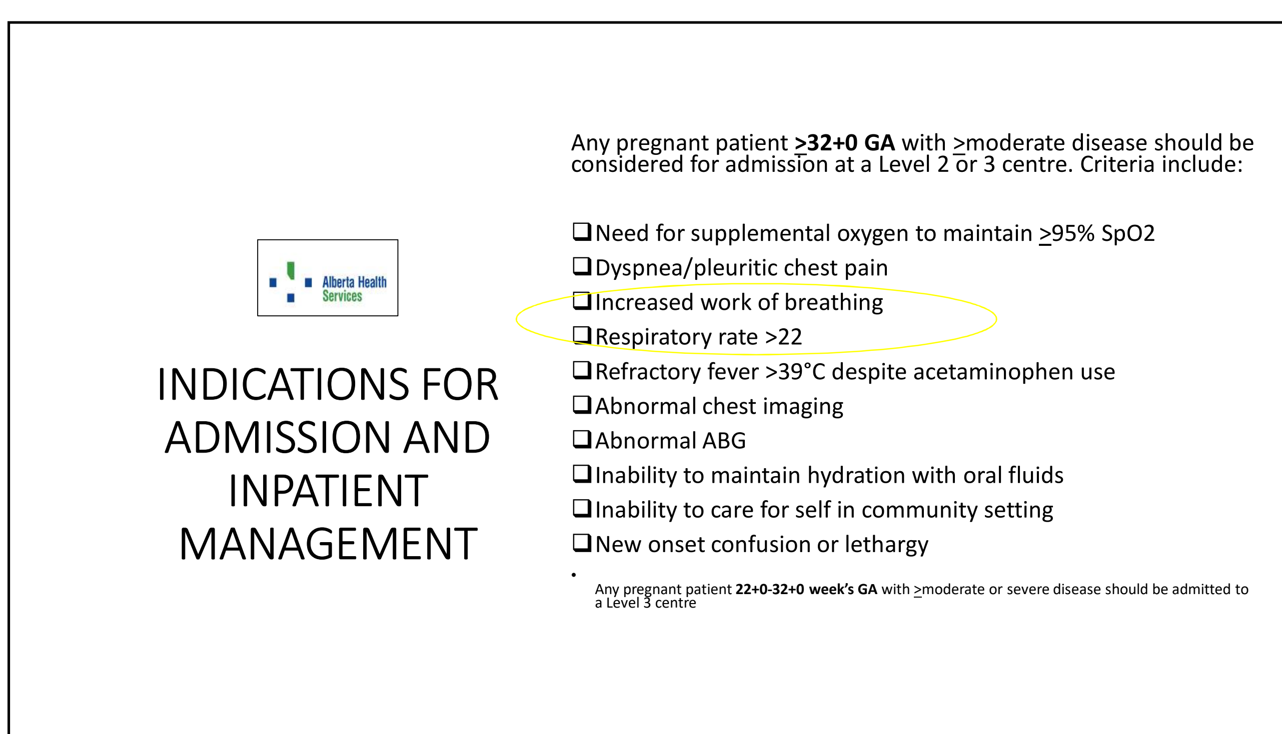
  - Ruptured membranes
  - Vaginal bleeding
  - Decreased fetal movement

- Urgent clinical concern from patient or MRP: Emergency Medical Services/911 should be activated per standard policy/practice.

Case example

38 year old G2P1 at 33 week's gestation w COVID-19. 7 day history of cough and fever, describes worsening shortness of breath

On assessment, respiratory rate is 23 bpm. Her temp is 38 degrees. Her breathing appears labored.



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Case example

38 year old G2P1 at 33 week's gestation w COVID-19. 7 day history of cough and fever, describes worsening shortness of breath

On assessment, respiratory rate is 23 bpm. Her temp is 38 degrees. Her breathing appears labored.

She is sent by EMS to a level 2 site for anticipated admission

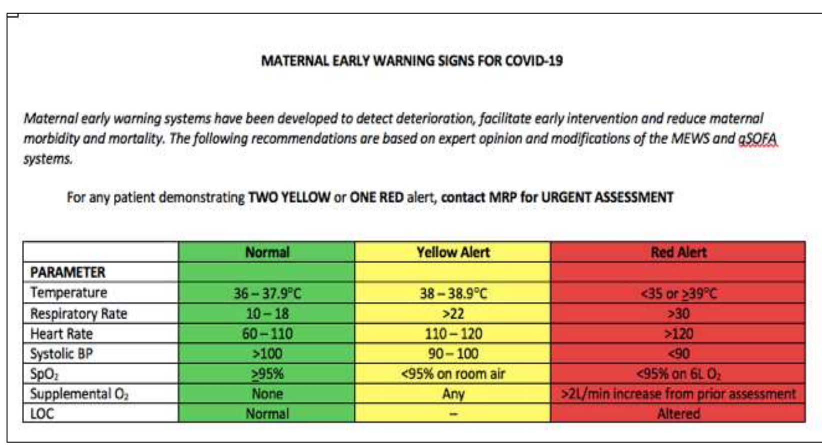
In the ER, her RR is now 26, O2 sat is 93% on room air, HR is 115 bpm.

In the ER, her RR is now 26, O2 sat is 93% on room air, HR is 115 bpm.

RR 26= yellow
O2 sat of 93%= yellow
HR 115= yellow

Call for help:

1. Most experienced provider for airway management
2. Obstetrics
3. Pediatrics
4. ICU



MATERNAL EARLY WARNING SIGNS FOR COVID-19

Maternal early warning systems have been developed to detect deterioration, facilitate early intervention and reduce maternal morbidity and mortality. The following recommendations are based on expert opinion and modifications of the MEWS and qSOFA systems.

For any patient demonstrating **TWO YELLOW** or **ONE RED** alert, **contact MRP for URGENT ASSESSMENT**

	Normal	Yellow Alert	Red Alert
PARAMETER			
Temperature	36 – 37.9°C	38 – 38.9°C	<35 or ≥39°C
Respiratory Rate	10 – 18	>22	>30
Heart Rate	60 – 110	110 – 120	>120
Systolic BP	>100	90 – 100	<90
SpO_2	≥95%	<95% on room air	<95% on 6L O_2
Supplemental O_2	None	Any	>2L/min increase from prior assessment
LOC	Normal	–	Altered

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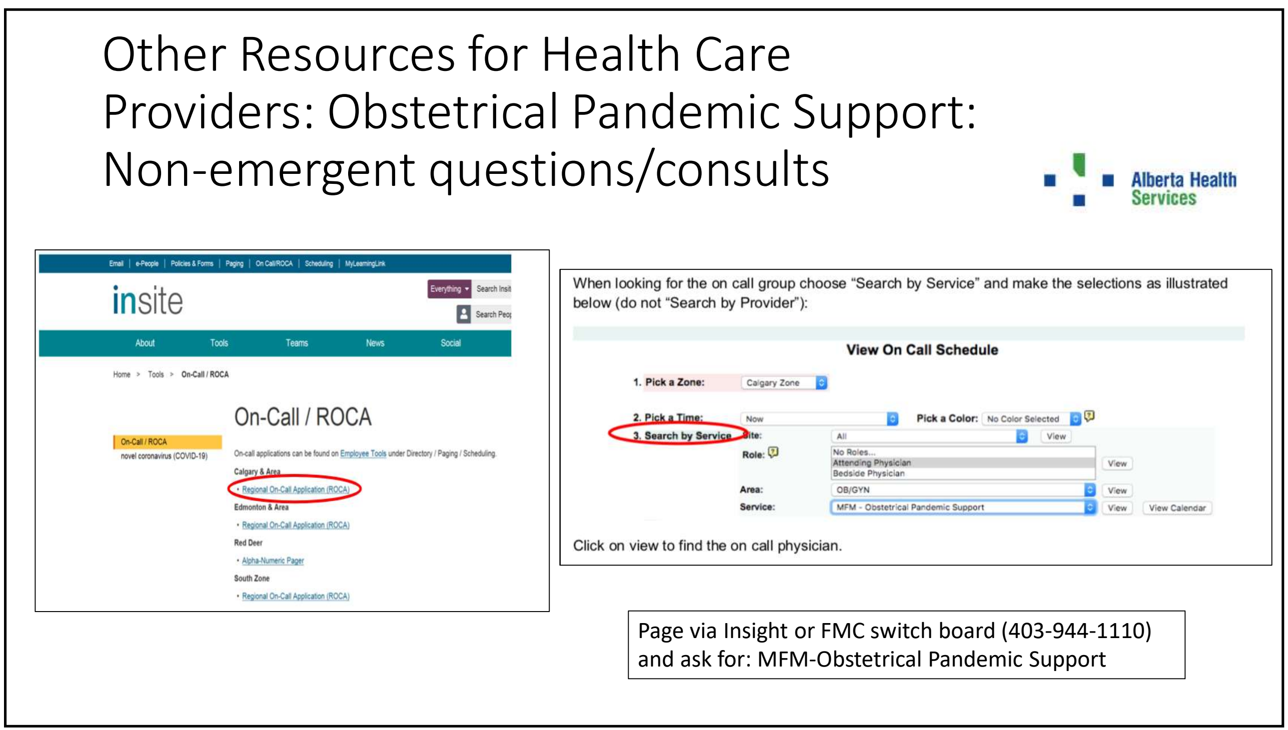
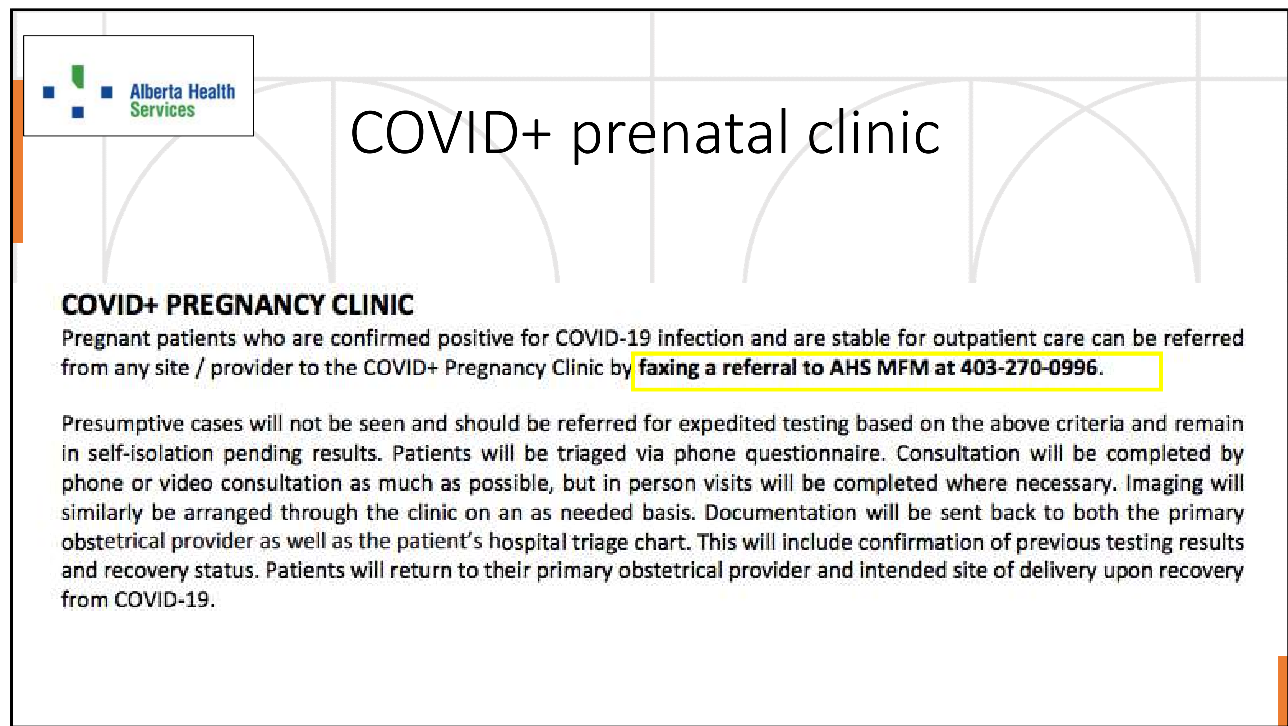
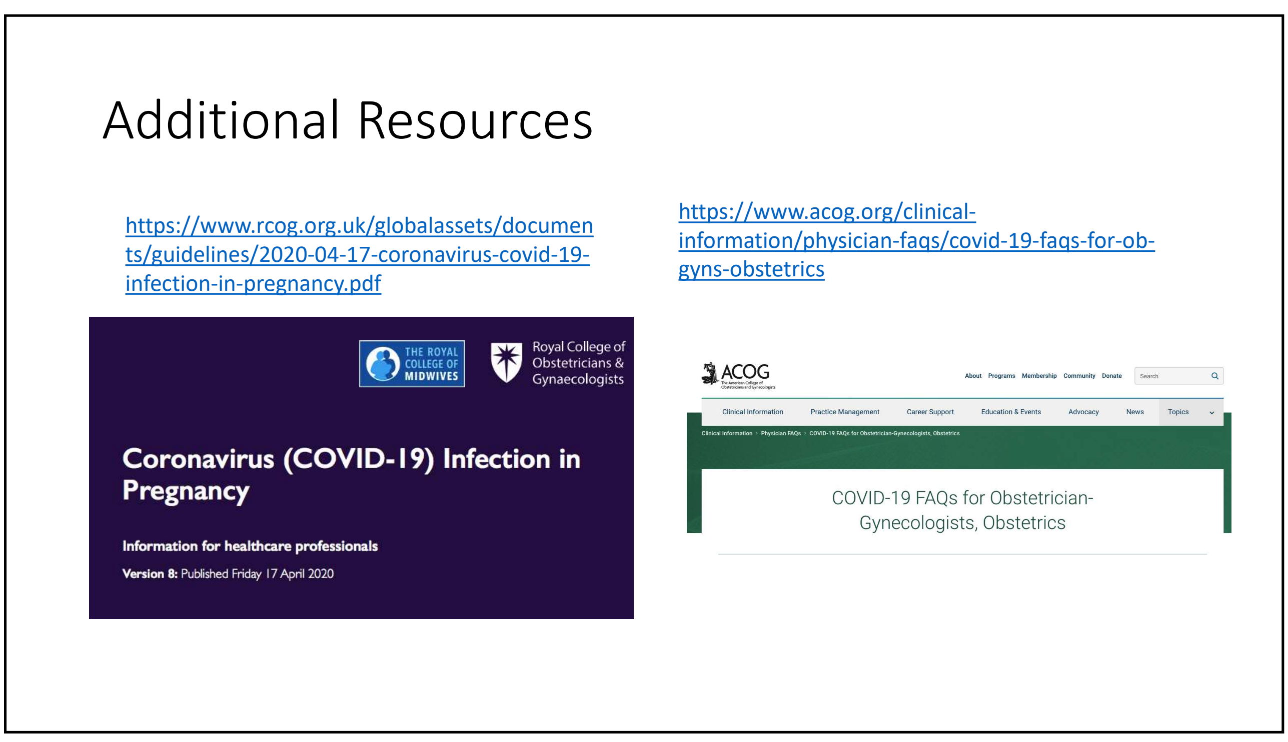
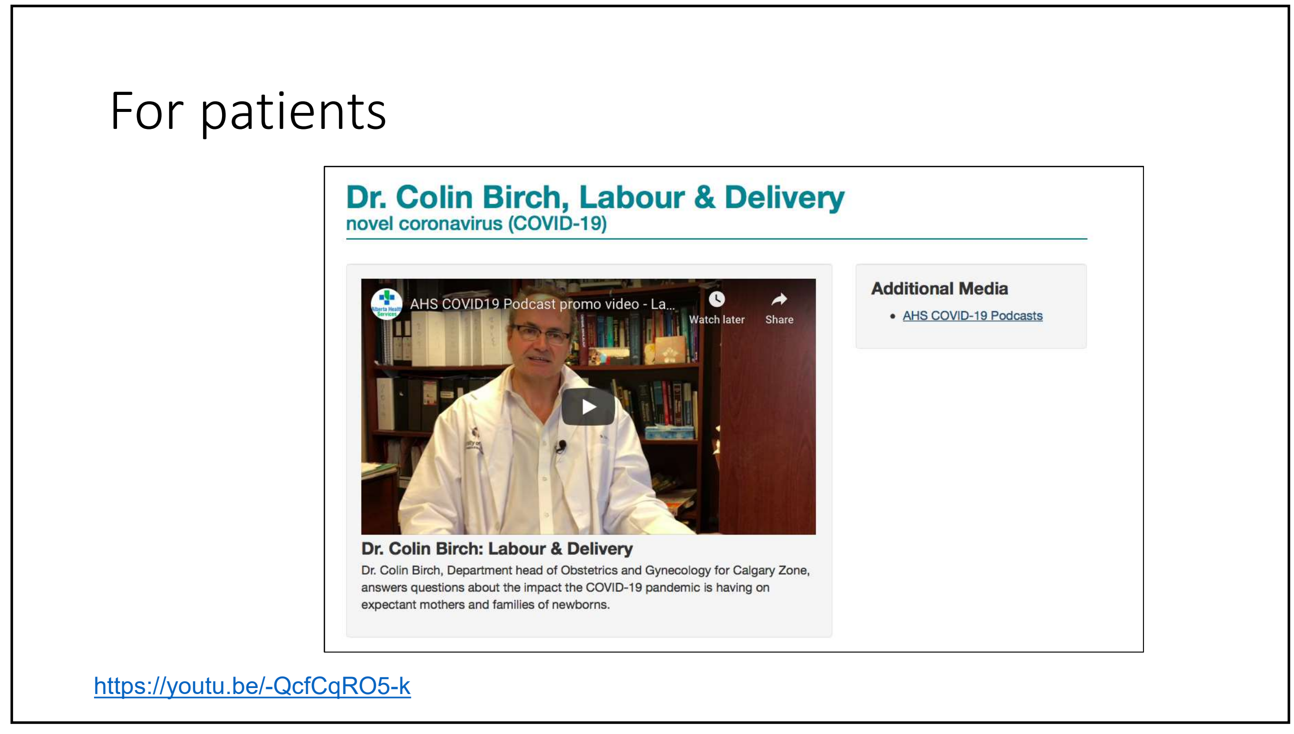

Other Resources for Health Care Providers: Obstetrical Pandemic Support: Non-emergent questions/consults
Alberta Health Services
insite
On-Call / ROCA
When looking for the on call group choose "Search by Service" and make the selections as illustrated below (do not "Search by Provider"):
View On Call Schedule
1. Pick a Zone:
2. Pick a Time:
3. Search by Service
MFM - Obstetrical Pandemic Support
Click on view to find the on call physician.
Page via Insight or FMC switch board (403-944-1110) and ask for: MFM-Obstetrical Pandemic Support


Alberta Health Services
COVID+ prenatal clinic
COVID+ PREGNANCY CLINIC
Pregnant patients who are confirmed positive for COVID-19 infection and are stable for outpatient care can be referred from any site / provider to the COVID+ Pregnancy Clinic by faxing a referral to AHS MFM at 403-270-0996.
Presumptive cases will not be seen and should be referred for expedited testing based on the above criteria and remain in self-isolation pending results. Patients will be triaged via phone questionnaire. Consultation will be completed by phone or video consultation as much as possible, but in person visits will be completed where necessary. Imaging will similarly be arranged through the clinic on an as needed basis. Documentation will be sent back to both the primary obstetrical provider as well as the patient's hospital triage chart. This will include confirmation of previous testing results and recovery status. Patients will return to their primary obstetrical provider and intended site of delivery upon recovery from COVID-19.





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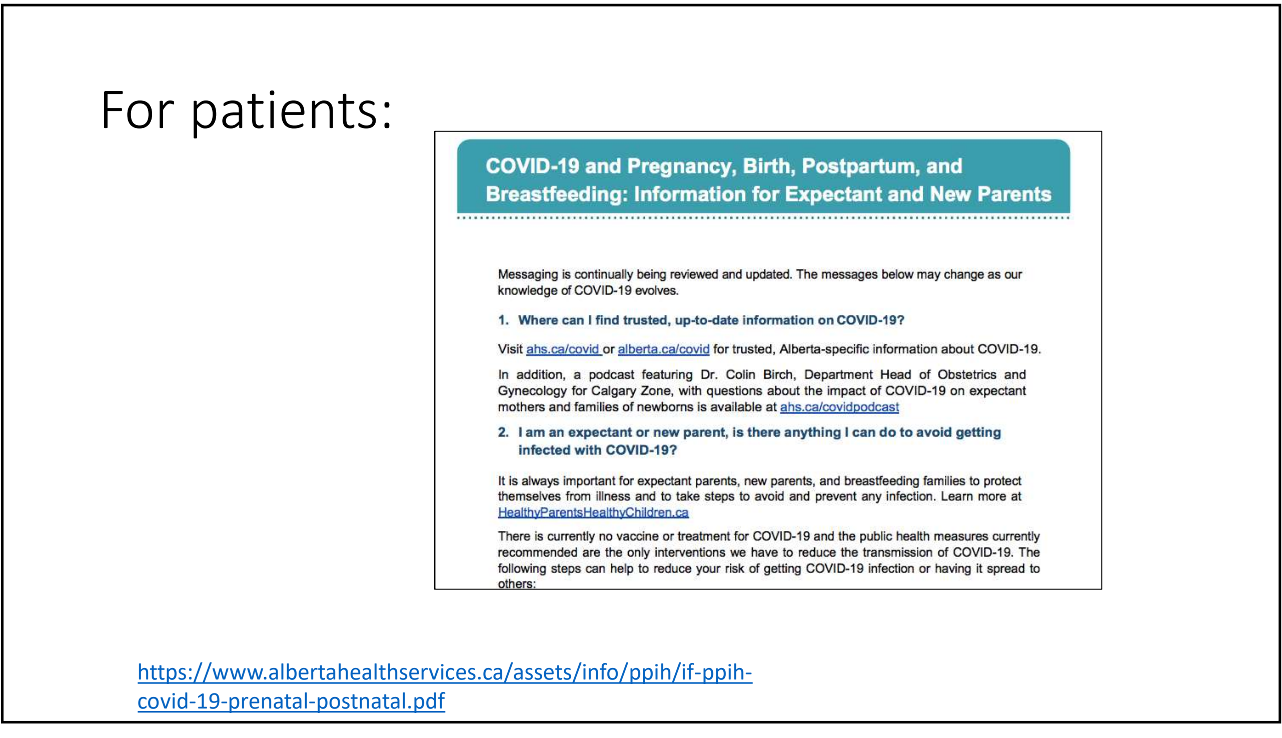
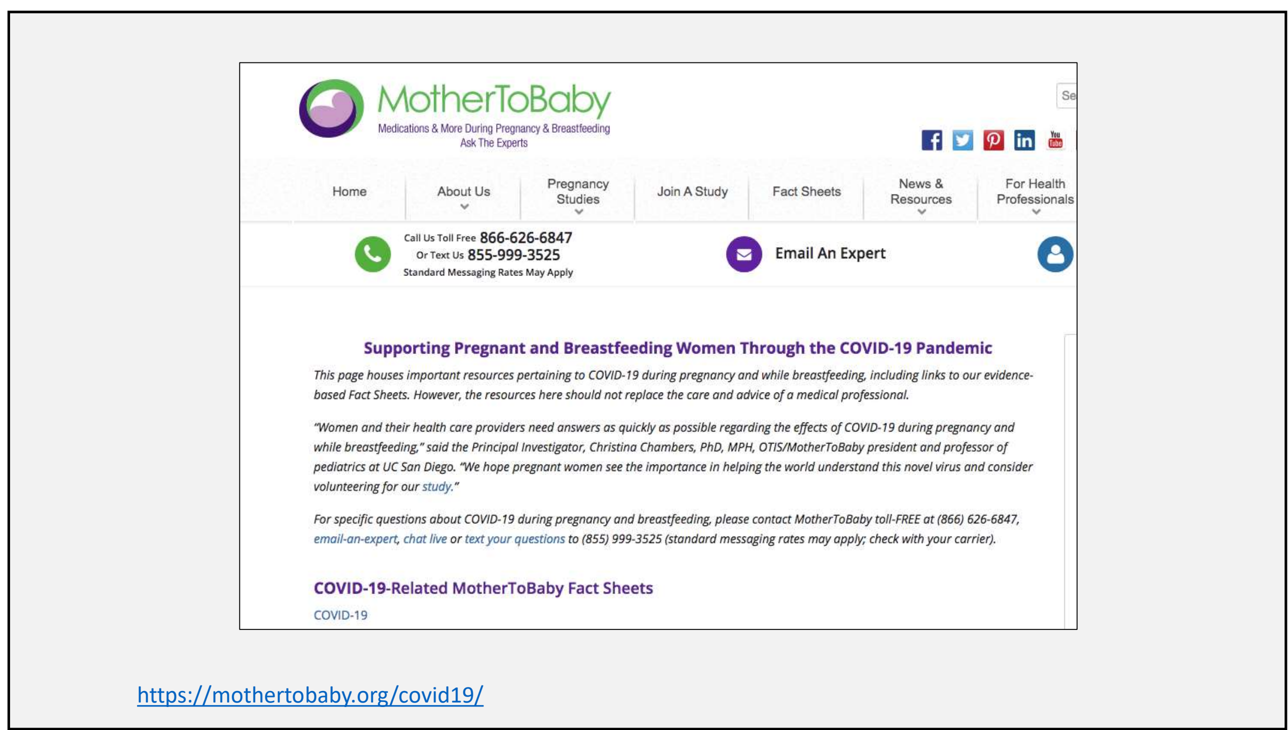

For patients:
COVID-19 and Pregnancy, Birth, Postpartum, and Breastfeeding: Information for Expectant and New Parents
Messaging is continually being reviewed and updated. The messages below may change as our knowledge of COVID-19 evolves.
1. Where can I find trusted, up-to-date information on COVID-19?
Visit ahs.ca/covid or alberta.ca/covid for trusted, Alberta-specific information about COVID-19.
In addition, a podcast featuring Dr. Colin Birch, Department Head of Obstetrics and Gynecology for Calgary Zone, with questions about the impact of COVID-19 on expectant mothers and families of newborns is available at ahs.ca/covidpodcast
2. I am an expectant or new parent, is there anything I can do to avoid getting infected with COVID-19?
It is always important for expectant parents, new parents, and breastfeeding families to protect themselves from illness and to take steps to avoid and prevent any infection. Learn more at HealthyParentsHealthyChildren.ca
There is currently no vaccine or treatment for COVID-19 and the public health measures currently recommended are the only interventions we have to reduce the transmission of COVID-19. The following steps can help to reduce your risk of getting COVID-19 infection or having it spread to others:
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-prenatal-postnatal.pdf


MotherToBaby
Medications & More During Pregnancy & Breastfeeding
Ask The Experts
Home
About Us
Pregnancy Studies
Join A Study
Fact Sheets
News & Resources
For Health Professionals
Call Us Toll Free 866-626-6847
Or Text Us 855-999-3525
Standard Messaging Rates May Apply
Email An Expert
Supporting Pregnant and Breastfeeding Women Through the COVID-19 Pandemic
This page houses important resources pertaining to COVID-19 during pregnancy and while breastfeeding, including links to our evidence-based Fact Sheets. However, the resources here should not replace the care and advice of a medical professional.
"Women and their health care providers need answers as quickly as possible regarding the effects of COVID-19 during pregnancy and while breastfeeding," said the Principal Investigator, Christina Chambers, PhD, MPH, OTIS/MotherToBaby president and professor of pediatrics at UC San Diego. "We hope pregnant women see the importance in helping the world understand this novel virus and consider volunteering for our study."
For specific questions about COVID-19 during pregnancy and breastfeeding, please contact MotherToBaby toll-FREE at (866) 626-6847, email-an-expert, chat live or text your questions to (855) 999-3525 (standard messaging rates may apply; check with your carrier).
COVID-19-Related MotherToBaby Fact Sheets
COVID-19
https://mothertobaby.org/covid19/

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OBGYN Speaker
Jan Ooi BSc MD CCFP
Disclosure:
Clinical Lecturer, School of Medicine, University of Calgary;
Medical Lead, Riley Park Maternity Clinic, Calgary, AHS

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My Babies

- Prenatal and Post-Partum care can be altered but not delayed during a pandemic.
- Prenatal care, labour and delivery involve multiple and significant interactions with healthcare workers.
- Many tools are available to allow for virtual care and the pregnant population is, in general, technology savvy.

Timing of Visits - Re-thinking our routines

WHO - New guidelines on antenatal care for a positive pregnancy experience

Nov 2016 https://www.who.int/reproductivehealth/news/antenatal-care/en/

This model recommends pregnant women to have their first contact in the first 12 weeks' gestation, with subsequent contacts taking place at 20, 26, 30, 34, 36, 38 and 40 weeks' gestation.

NICE - Antenatal care for uncomplicated pregnancies

Feb 2019 https://www.who.int/reproductivehealth/news/antenatal-care/en/

A schedule of antenatal appointments should be determined by the function of the appointments. For a woman who is nulliparous with an uncomplicated pregnancy, a schedule of 10 appointments should be adequate. For a woman who is parous with an uncomplicated pregnancy, a schedule of 7 appointments should be adequate.

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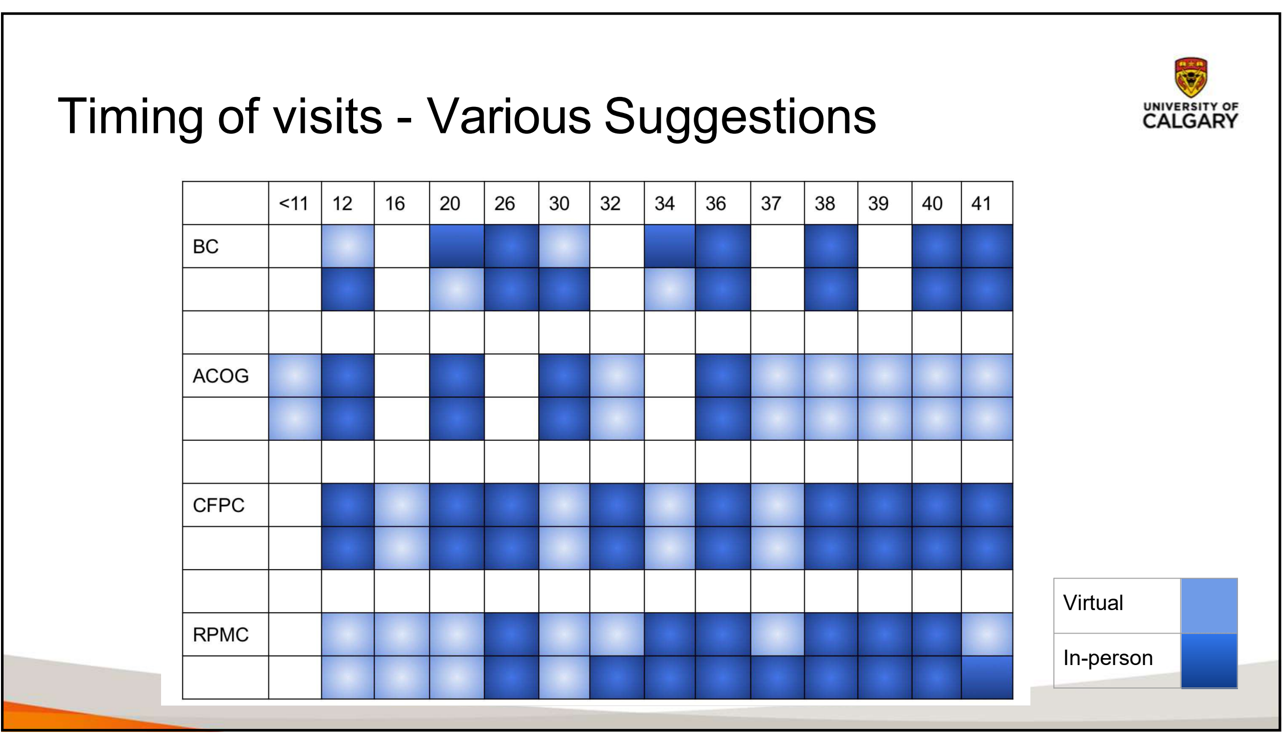


Timing of Visits - General Considerations

- Group investigations with in-person visits as much as possible
- Virtual and in-person visits do not necessarily have to alternate
- Fetal movement is a surrogate for fetal heart auscultation after 24 weeks
- Considerations:
  - Consider the patient's blood pressure history
    - parity, previous hypertensive disorders of pregnancy, BP trend in this pregnancy
  - If a patient has an ultrasound booked or recently done this may allow you to stretch the time until their next office visit. A third trimester ultrasound (done for increased BMI, previous SGA, advanced maternal age etc…) will allow the patient to have a growth assessment and possibly a BP recorded if done at MFM
  - Look at the patient's SFH curve and most recent measurement to help determine whether an office visit would be beneficial
- TIP: If the patient is seen in triage record their vitals and a SFH, this may allow you to do a virtual visit next time

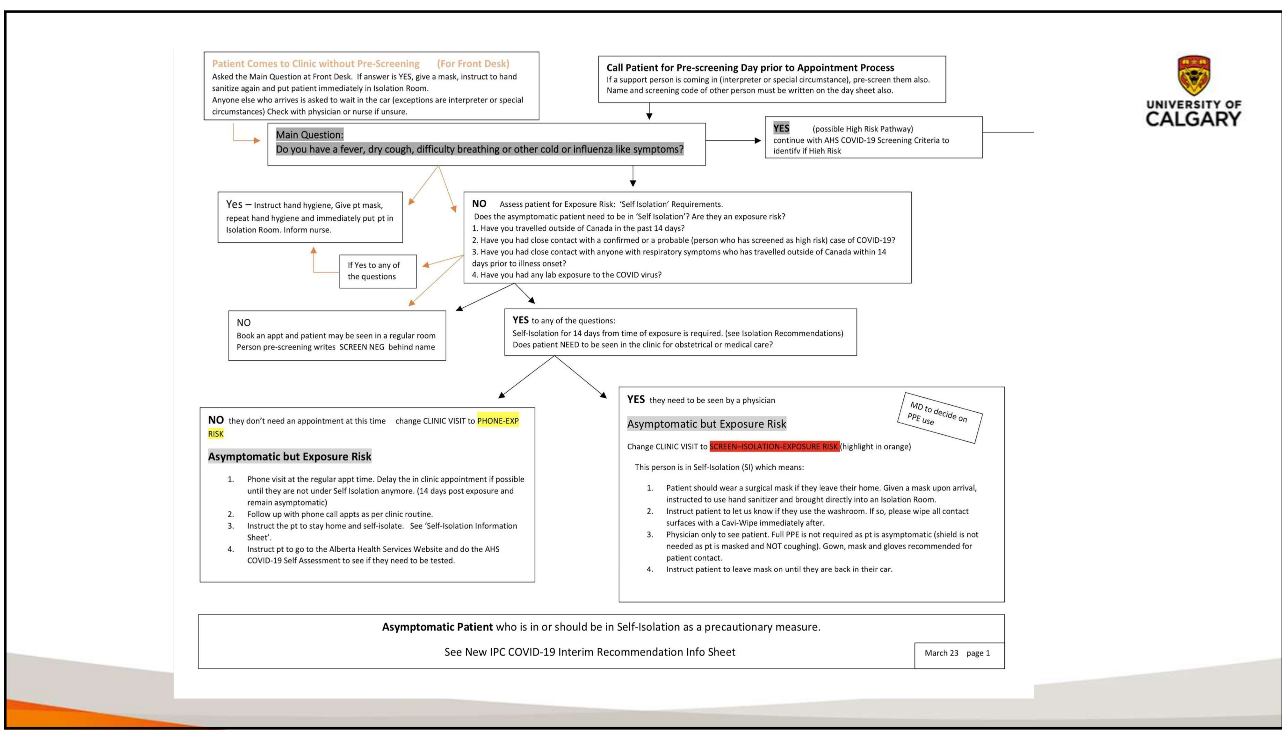
Timing of Visits - What Works for Us

- 14 contacts
- 6-9 of those in-person

Gestational Age	Investigations	Office Visit	Phone Visit
11-13 weeks	Dating/FTS US, Labs	X (if need labs)	X (if labs done)
14-18 weeks			X
19-21 weeks	Anatomical US		X
21-26 weeks			X
26-28 weeks	Labs, Pertussis booster	X	
30 weeks			X
32 weeks	US prn	X (if no US)	X (if US)
34 weeks			X
36 weeks	GBS, bedside scan	X	
37 weeks		X (if pt prefers)	X
38 weeks-Delivery		X weekly	

Decrease Exposure in Clinic

- Screen all patients entering your clinic


Patient Comes to Clinic without Pre-Screening (For Front Desk)
Asked the Main Question at Front Desk. If answer is YES, give a mask, instruct to hand sanitize again and put patient immediately in Isolation Room.
Anyone else who arrives is asked to wait in the car (exceptions are interpreter or special circumstances) Check with physician or nurse if unsure.
Call Patient for Pre-screening Day prior to Appointment Process
If a support person is coming in (interpreter or special circumstance), pre-screen them also. Name and screening code of other person must be written on the day sheet also.
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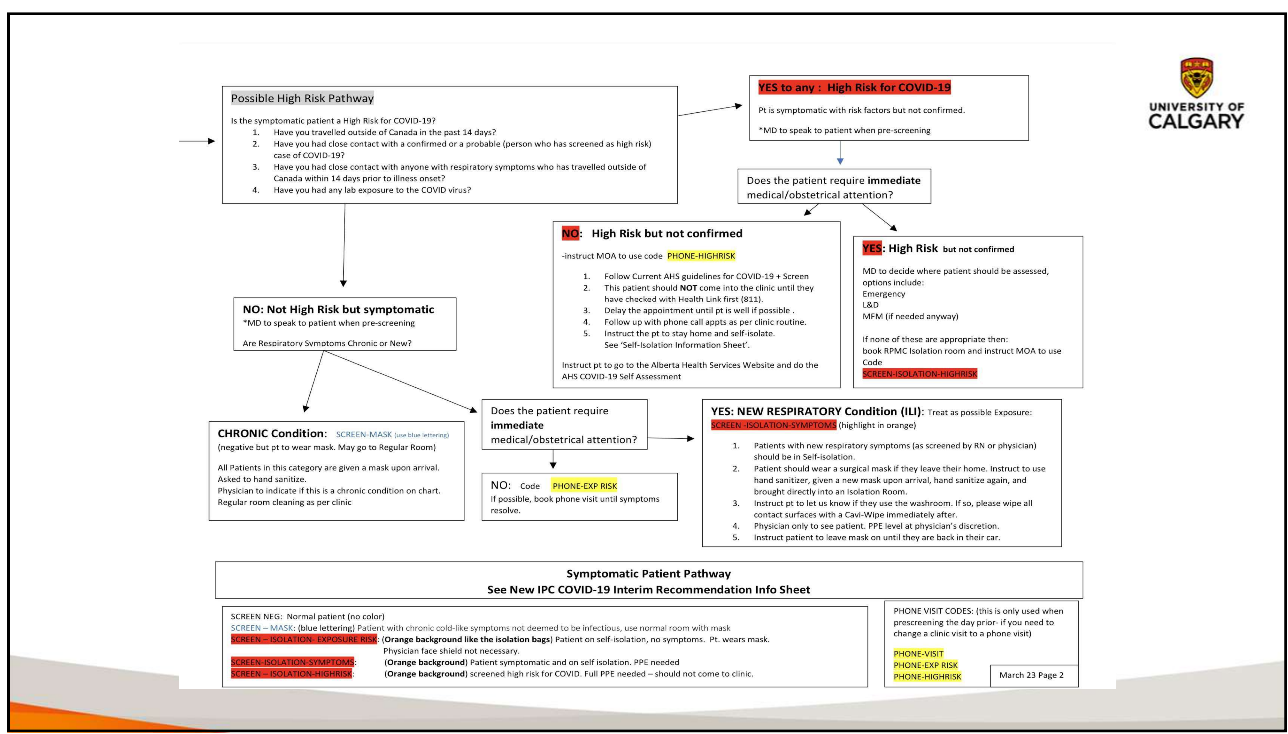
Main Question:
Do you have a fever, dry cough, difficulty breathing or other cold or influenza like symptoms?
YES (possible High Risk Pathway)
continue with AHS COVID-19 Screening Criteria to identify if High Risk
Yes – Instruct hand hygiene, Give pt mask, repeat hand hygiene and immediately put pt in Isolation Room. Inform nurse.
If Yes to any of the questions
NO Assess patient for Exposure Risk: 'Self Isolation' Requirements.
Does the asymptomatic patient need to be in 'Self Isolation'? Are they an exposure risk?
1. Have you travelled outside of Canada in the past 14 days?
2. Have you had close contact with a confirmed or a probable (person who has screened as high risk) case of COVID-19?
3. Have you had close contact with anyone with respiratory symptoms who has travelled outside of Canada within 14 days prior to illness onset?
4. Have you had any lab exposure to the COVID virus?
NO
Book an appt and patient may be seen in a regular room
Person pre-screening writes SCREEN NEG behind name
YES to any of the questions:
Self-Isolation for 14 days from time of exposure is required. (see Isolation Recommendations)
Does patient NEED to be seen in the clinic for obstetrical or medical care?
NO they don't need an appointment at this time change CLINIC VISIT to PHONE-EXP RISK
Asymptomatic but Exposure Risk
1. Phone visit at the regular appt time. Delay the in clinic appointment if possible until they are not under Self Isolation anymore. (14 days post exposure and remain asymptomatic)
2. Follow up with phone call appts as per clinic routine.
3. Instruct the pt to stay home and self-isolate. See 'Self-Isolation Information Sheet'.
4. Instruct pt to go to the Alberta Health Services Website and do the AHS COVID-19 Self Assessment to see if they need to be tested.
YES they need to be seen by a physician
MD to decide on PPE use
Asymptomatic but Exposure Risk
Change CLINIC VISIT to SCREEN–ISOLATION-EXPOSURE RISK (highlight in orange)
This person is in Self-Isolation (SI) which means:
1. Patient should wear a surgical mask if they leave their home. Given a mask upon arrival, instructed to use hand sanitizer and brought directly into an Isolation Room.
2. Instruct patient to let us know if they use the washroom. If so, please wipe all contact surfaces with a Cavi-Wipe immediately after.
3. Physician only to see patient. Full PPE is not required as pt is asymptomatic (shield is not needed as pt is masked and NOT coughing). Gown, mask and gloves recommended for patient contact.
4. Instruct patient to leave mask on until they are back in their car.
Asymptomatic Patient who is in or should be in Self-Isolation as a precautionary measure.
See New IPC COVID-19 Interim Recommendation Info Sheet
March 23 page 1


Possible High Risk Pathway
Is the symptomatic patient a High Risk for COVID-19?
1. Have you travelled outside of Canada in the past 14 days?
2. Have you had close contact with a confirmed or a probable (person who has screened as high risk) case of COVID-19?
3. Have you had close contact with anyone with respiratory symptoms who has travelled outside of Canada within 14 days prior to illness onset?
4. Have you had any lab exposure to the COVID virus?
YES to any : High Risk for COVID-19
Pt is symptomatic with risk factors but not confirmed.
*MD to speak to patient when pre-screening
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Does the patient require immediate medical/obstetrical attention?
NO: High Risk but not confirmed
-instruct MOA to use code PHONE-HIGHRISK
1. Follow Current AHS guidelines for COVID-19 + Screen
2. This patient should NOT come into the clinic until they have checked with Health Link first (811).
3. Delay the appointment until pt is well if possible .
4. Follow up with phone call appts as per clinic routine.
5. Instruct the pt to stay home and self-isolate. See 'Self-Isolation Information Sheet'.
Instruct pt to go to the Alberta Health Services Website and do the AHS COVID-19 Self Assessment
YES: High Risk but not confirmed
MD to decide where patient should be assessed, options include:
Emergency
L&D
MFM (if needed anyway)
If none of these are appropriate then:
book RPMC Isolation room and instruct MOA to use Code
SCREEN-ISOLATION-HIGHRISK
NO: Not High Risk but symptomatic
*MD to speak to patient when pre-screening
Are Respiratory Symptoms Chronic or New?
CHRONIC Condition: SCREEN-MASK (use blue lettering)
(negative but pt to wear mask. May go to Regular Room)
All Patients in this category are given a mask upon arrival.
Asked to hand sanitize.
Physician to indicate if this is a chronic condition on chart.
Regular room cleaning as per clinic
Does the patient require immediate medical/obstetrical attention?
NO: Code PHONE-EXP RISK
If possible, book phone visit until symptoms resolve.
YES: NEW RESPIRATORY Condition (ILI): Treat as possible Exposure:
SCREEN -ISOLATION-SYMPTOMS (highlight in orange)
1. Patients with new respiratory symptoms (as screened by RN or physician) should be in Self-isolation.
2. Patient should wear a surgical mask if they leave their home. Instruct to use hand sanitizer, given a new mask upon arrival, hand sanitize again, and brought directly into an Isolation Room.
3. Instruct pt to let us know if they use the washroom. If so, please wipe all contact surfaces with a Cavi-Wipe immediately after.
4. Physician only to see patient. PPE level at physician's discretion.
5. Instruct patient to leave mask on until they are back in their car.
Symptomatic Patient Pathway
See New IPC COVID-19 Interim Recommendation Info Sheet
SCREEN NEG: Normal patient (no color)
SCREEN – MASK: (blue lettering) Patient with chronic cold-like symptoms not deemed to be infectious, use normal room with mask
SCREEN – ISOLATION- EXPOSURE RISK: (Orange background like the isolation bags) Patient on self-isolation, no symptoms. Pt. wears mask. Physician face shield not necessary.
SCREEN-ISOLATION-SYMPTOMS: (Orange background) Patient symptomatic and on self isolation. PPE needed
SCREEN – ISOLATION-HIGHRISK: (Orange background) screened high risk for COVID. Full PPE needed – should not come to clinic.
PHONE VISIT CODES: (this is only used when prescreening the day prior- if you need to change a clinic visit to a phone visit)
PHONE-VISIT
PHONE-EXP RISK
PHONE-HIGHRISK
March 23 Page 2

Decrease exposure in clinic

- In scheduling your day consider alternating virtual visits with in-person visits to decrease the time patients spend in the waiting room
- Have a plan for patients who screen positive on arrival
  - isolation room with donning and doffing stations
  - enhanced cleaning protocols
- Support people accompany patient only if necessary
  - ex.translation, mental health reasons, difficult decisions/discussions

Decrease exposure in clinic

- Consider using secure email messaging to be able to exchange documents with patients
  - lab and ultrasound requisitions, doctor's notes, prescriptions and forms (ex. attending physician statements)
- Ensure adequate physical distancing of staff
  - lunchroom limits, spacing at nursing station, using exam rooms for charting and phone calls, physicians with remote EMR access can do virtual visits from home)
- Fax prenatal record to the hospital rather than giving a copy to the patient
- Remove unnecessary items from exam rooms

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PPE in the Office

- Masks for all healthcare workers providing patient care within 2 meters
  - If support staff are within 2 meters of patients OR co-workers they should also be wearing masks

- Consider requesting patients wear a mask to the office and provide one if they don't
  - Surgical masks for patients who are symptomatic or discharged from hospital within the past 14 days
  - Cloth masks for all other patients (Mask Makers YYC)

- Consider wearing scrubs and changing prior to leaving the clinic

Virtual Care

- The AMA has a Virtual Care Toolkit
  - https://www.albertadoctors.org/e-health/ab-virtual-care-toolkit.docx
- Get consent
  - verbal is ok, document it
- Ask the patient to consider buying or borrowing a BP cuff
  - may be covered by insurance, can be purchased online
- Ask the patient to check their weight if they have a home scale
- Consider video visits for:
  - First maternity visits
  - Mental health visits
  - Post-Partum visits

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Challenges

- Childcare
  - to be able to attend office visits alone
  - planning for labour
- Language barriers
  - affects ability to pre-screen/screen
  - video visits may be a good option, phone visits more difficult than in-person visits

Challenges

- Low Socio-economic Status
  - affects ability to pre-screen/screen
  - often helpful to see the patient - video preferred over phone visits

Emerging data indicate disproportionate rates of COVID-19 infection, severe morbidity, and mortality in some communities of color, particularly among Black, Latinx, and Native American people. Social determinants of health, current and historic inequities in access to health care and other resources, and structural racism contribute to these disparate outcomes. (ACOG 2020)

Essential Investigations - Labs

Goals are to decrease patient outings/exposure at the lab and decrease the workload for Alberta Precision Labs

- Alternate GDM Screening (replacing GDS/GTT)
  - Random glucose (>11.1) OR HbA1C (>/= 5.7%)
- No need for repeat type and screen in Rh negative mothers and primips
  - WinRho for all Rh negative mothers
- Still doing: routine prenatal bloodwork and GBS swabs
  - If a patient chooses to do a first trimester screen aim to group that bloodwork with their routine prenatal labs

Essential Investigations - Ultrasounds

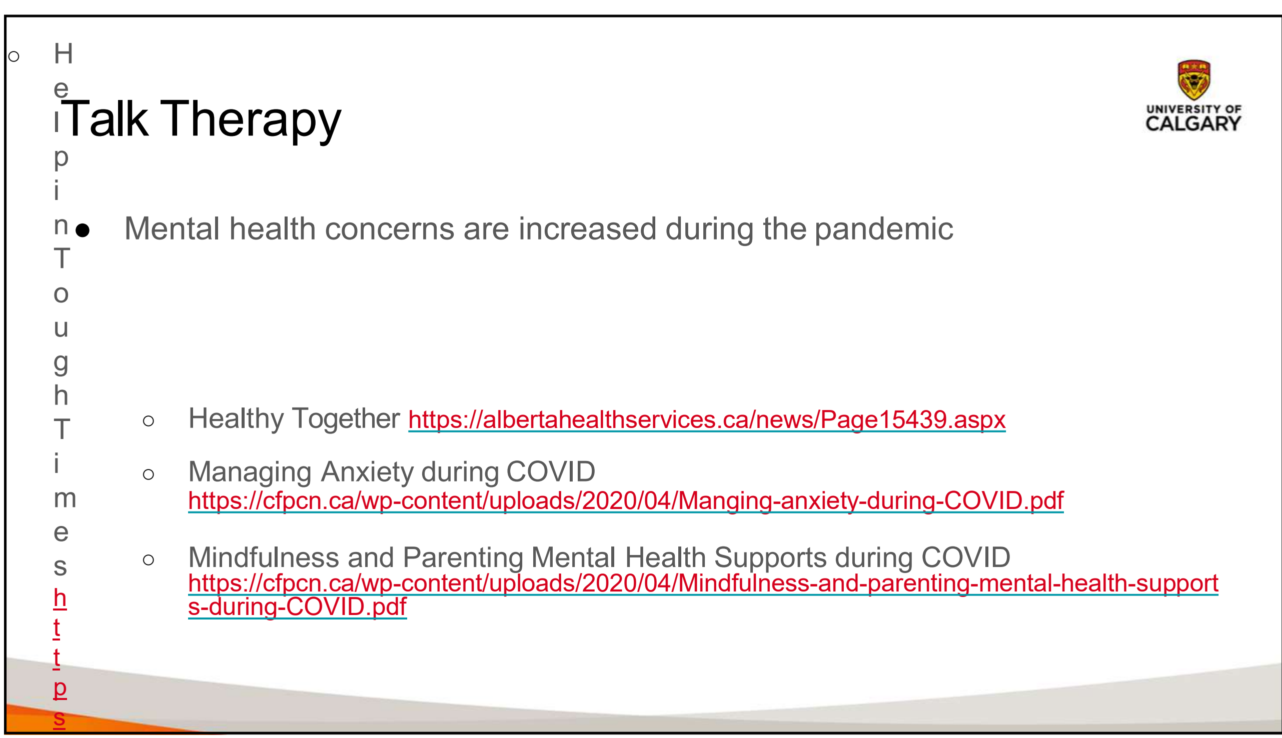
Goal is to minimize patient outings/exposure

- A single first trimester ultrasound between 11-14 weeks, including first trimester screen if the patient chooses, no need for earlier dating ultrasound
- Routine anatomical scan can be shifted to 20-22 wks, closer to 22 weeks for BMI >40; consider follow up views in 4-8 rather than 1-2 weeks
- Indications for further scans in the third trimester remain unchanged with growth ultrasounds done at 32-34 weeks

Talk Therapy

- Expect patients to have questions about COVID 19 and how it will impact their care.
  - AHS Information for Expectant and New Parents
    https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-prenatal-postnatal.pdf

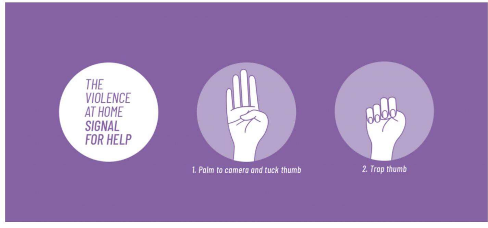
- AHS Prenatal Classes are being offered online



Talk Therapy

- Intimate partner violence is increased during pandemic lockdown
  - https://www.cmaj.ca/content/cmaj/early/2020/05/01/cmaj.200634.full.pdf
  - Calls to the Vancouver Battered Women's Support Service have tripled.
  - Specialized crisis lines for IPV in Alberta have seen a 30-50% increase in calls.

- Tools for physicians are available
  - dveducation.ca
  - https://realtalk.sagesse.org/
  - https://www.facs.org/about-acs/statements/115-partner-violence



Preparing Patients for Delivery

- Strict self-isolation recommended from 37 weeks onwards to decrease the chance of patient or support person developing symptoms

- Preparing patients for hospital care
  - Patient screening and PPE
  - No Entonox
  - Limit going out of labour room/walking in hallways
  - Minimize personal effects brought to the hospital

Preparing Patients for Delivery

- Support people are considered part of the dyad, not the same as visitors
  - One person, same throughout
  - Must screen negative (temperature, symptoms and exposure)
  - Discuss with patients and have them consider a potential backup
  - They need to be in a mask and temperature checked q4h
  - Pack/Prepare to stay for the duration of hospitalization

What to Expect Post-Partum

- Early Discharge from Hospital
  - Considered if:
    - No post-partum hemorrhage or easily controlled hemorrhage with no hemodynamic compromise and minimal increased blood loss.
    - No need for increased monitoring of the infant in terms of hypoglycemia testing, monitoring for GBS positive mothers, meconium during delivery, SGA infant.
    - Patient and staff fairly comfortable with infant feeding, ideally with good supports at home.
  - Midwives and Public Health Nurses doing NMS collection and TsB testing at home

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What to Expect Post-Partum

- Infant Feeding
  - Potential for formula shortages
  - Provide resources for antenatal colostrum expression and collection
    - https://cfpcn.ca/wp-content/uploads/2018/08/CollectingColostrumWhileYourePregnant_August2018.pdf
  - Teach and encourage ways to supplement that support breastfeeding
    - Paced bottle feeding, Low-flow bottle nipples (Dr Brown's preemie)
  - LC clinics offering virtual (phone and video) visits
  - Consider donor breastmilk
    - https://www.northernstarmilkbank.ca/

What to Expect Post-Partum

- Office Follow-up
  - Virtual care
    - ideal in the 14 days after discharge
    - BUT you must decide whether BP and baby weight must be determined and, if so, how
  - Mental health
  - Counsel about Physical Distancing
    - window visits with baby's grandparents

Considerations Newborns of COVID-19+ Mothers

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- Skin-to-skin after delivery
  - Mask, clean hands and chest

- Infant Feeding
  - Breastfeeding encouraged
    - Mask, clean hands and chest
  - Avoid coughing or sneezing on baby
  - Hand hygiene prior to pumping and handling pump and other feeding equipment

Timing of Referral to OB/Maternity Clinics

- All Obstetrics/FP Obstetrics/Midwifery practitioners are happy to answer questions over the phone

- Can transfer as early as first trimester
  - Maternity clinics have been running as usual over the last 8 weeks - we potentially have a higher level of comfort with virtual care in this patient population (but we don't know your patients as well as you do!)

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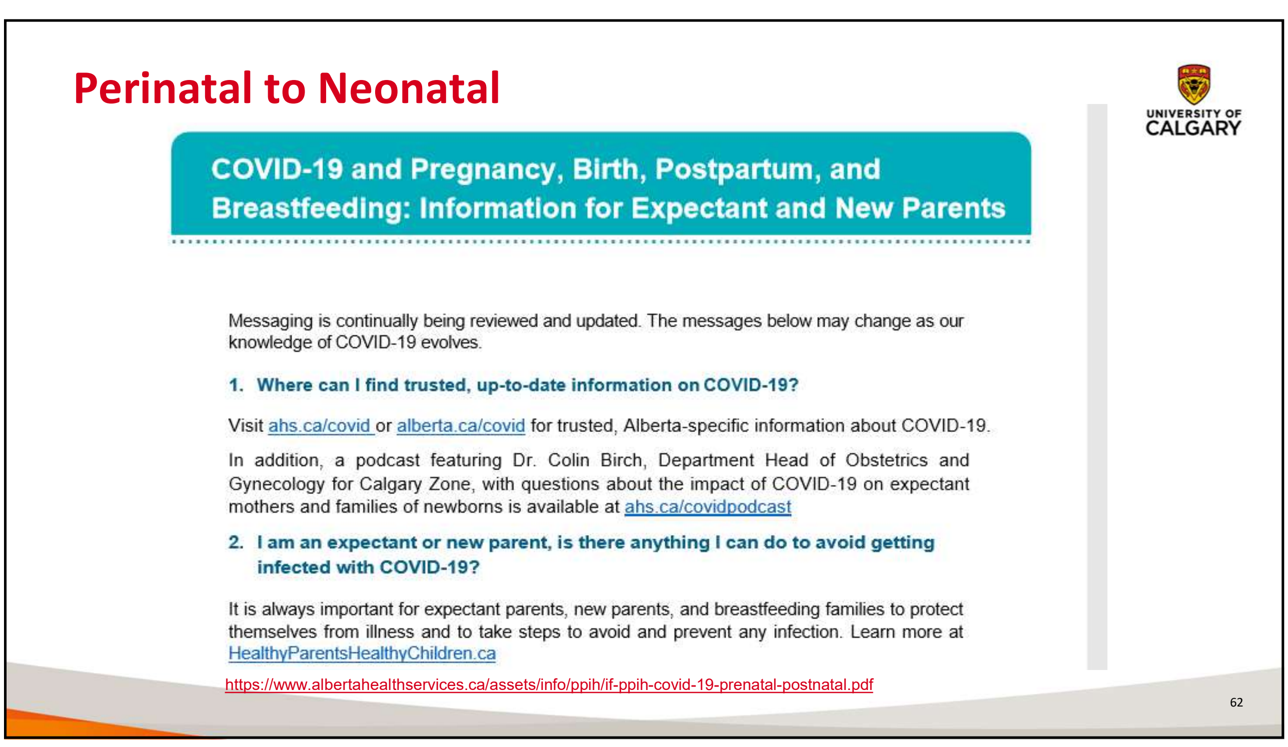
Pediatric Speaker
Chris Lever MD FRCPC
Disclosure:
Community Pediatrician;
Associate Clinical Professor, University of Calgary;
Foothills Medical Centre Site Lead for Newborn Nursery;
Chair of Normal Newborn Care Committee


Perinatal to Neonatal
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COVID-19 and Pregnancy, Birth, Postpartum, and Breastfeeding: Information for Expectant and New Parents
Messaging is continually being reviewed and updated. The messages below may change as our knowledge of COVID-19 evolves.
1. Where can I find trusted, up-to-date information on COVID-19?
Visit ahs.ca/covid or alberta.ca/covid for trusted, Alberta-specific information about COVID-19.
In addition, a podcast featuring Dr. Colin Birch, Department Head of Obstetrics and Gynecology for Calgary Zone, with questions about the impact of COVID-19 on expectant mothers and families of newborns is available at ahs.ca/covidpodcast
2. I am an expectant or new parent, is there anything I can do to avoid getting infected with COVID-19?
It is always important for expectant parents, new parents, and breastfeeding families to protect themselves from illness and to take steps to avoid and prevent any infection. Learn more at HealthyParentsHealthyChildren.ca
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-prenatal-postnatal.pdf
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Perinatal to Neonatal - Key Concepts

- Babies will be born to COVID 19 positive or suspect mothers
- Vertical transmission has not been proven to occur
- Neonates can be contaminated but are not clearly a transmission risk. Full PPE is required for the resuscitation team when in a birthing room with an infected or suspect mom, but N95 masks are only required when there is an aerosol generating procedure (ventilation)
- Cord care does not need to be delayed
- Delayed bathing is still in the best interest of babies, but may be forgone if there is transfer to an NICU

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Perinatal to Neonatal - Post Delivery Hospital Care

- Maternal fever in labour makes her case suspect for COVID. All neonates of suspect or COVID positive moms will have a test at 24hr
- Mom and baby can stay together, but . . . Increased distance, hand & chest washing, masking, regular cleaning of hard touch surfaces
- Breast feeding is not contraindicated. EBM acquisition needs to be done properly.
- Respiratory symptoms in babies are common. Test baby, in addition to standard investigation.

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Perinatal to Neonatal - After Discharge Care

- Public health is amazing. Nurses are equipped with PPE and still work every day of the year
- Public Health Nurses [PHN] attempt to contact and see all neonates after 24-48 discharged from hospital. Rural areas are not quite so lucky due to travel. Second COVID NP swab will be done by PHN
- Masks are not provided to breast feeding moms. Cloth barriers are not perfect but are clearly better than no barrier.
- Primary care follow up: In person care, delayed visits, virtual visits. The choice will be determined by the circumstance of the child and her family.

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Perinatal to Neonatal – Virtual visit

- The baby is low risk, the caregivers are the risk
- In person: standard questionnaire for risk, one caregiver per visit if at all possible, mask for caregivers, direct patient to a cleaned exam room, modified PPE or Full PPE (with face shield) if Suspected or COVID positive caregiver/infant
- Virtual visit : phone or video for caregiver questions, input, output, sleep pattern, and parental questions. Pictures can be used for selected issues.

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In-person protocols

- Pre-screen patients & families for COVID symptoms.
- Always wear a mask and gloves when seeing patients (even asymptomatic ones).
- If you have PPE and can see sick patients:
  - Give patients / caregivers a mask
  - Schedule sick patients at a separate time of day from non sick
- Eliminate your waiting room if possible.
- Escort patient + 1 caregiver directly into an exam room upon arrival.
- Thoroughly clean your exam beds, surfaces, door handles (both sides), pens, etc., after each patient visit.
- Provide prescriptions & requisitions in the exam room.
- Ask your patients to phone the office to schedule follow-up appointments

CPS: Providing virtual care during a pandemic: A guide to telemedicine in the paediatric office, March 2020

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Neonate to 3 months

In-person vs Virtual

Please see in person!
Growth assessment at 1 to 2 weeks of age is critical.
Thorough physical exam important.
Psychosocial screening

COVID Considerations

Physician / NP to assess growth
Laminated 'Clean' / 'Dirty signs for scales
Remember to clean tape measures
Baby and her belongings are fomites

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Pediatric Speaker
Natalie Forbes MD FRCPC
Clinical Lecturer, Faculty of Medicine, University of Calgary; Community Pediatrician, Calgary, AHS

Disclosure:

> 3 months to 12 months

In-person vs Virtual

Developmental follow up can be virtual
Please see in-person for:
Poor growth
Developmental regression
Injuries / illness* that would not require ED /Urgent care visit
* See patients with COIVD-like symptoms only if you have PPE

COVID Considerations

History is still almost everything
Observation as Px is possible over video – baby should be there!
Have parent weigh baby at home
Developmental questionnaires sent pre-visit can save time
Routine vaccinations continue

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1 year to 5 years

In-person vs Virtual

Virtual should be fine for well child visits
In-person visits for:
Developmental regression
Injuries / illness that would not require ED /Urgent care visit

COVID Considerations

For video visits ask that child have toys to play with
Try engaging the child
Ask about new behaviour issues
SLP, OT, PT services limited to private sector
Did I mention vaccines?

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Psychosocial Considerations

- Virtual visits may lack privacy
- Patients may lack the tech
- Ask about:
  - Job loss
  - Food and shelter security
  - Social connections
  - Household composition
- Consider
  - Increased risk for child abuse
  - Increased risk for IPV

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And even though this isn't "about" COVID. . .

- Most kids have mild disease and may be asymptomatic
- < 1 year are most likely to have severe or critical disease
- 75% present with typical respiratory symptoms
- Comorbidities increase risk

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Resources

For Physicians

- Specialists Link, Calgary
- Connect MD, Edmonton

- CPS: COVID-19 information and resources for paediatricians
- Child Abuse Physicians
- PCN Social Workers
- Children's Services
- Pediatric Infectious Disease COVID specialist link

For Families

- Caring For Kids: COVID-19 and your child
- COVID-19 Health Literacy Project
- CBC Kids COVID
- Kids Help Phone
- Crisis Line
- YWCA
- PCN Social Workers

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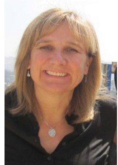
OBGYN Panelists

Colin Birch MBBS FRCSC

Disclosure:
Associate Professor, Department Head Obstetrics and Gynaecology, Faculty of Medicine, University of Calgary; Obstetrician, Foothills Medical Centre, AHS

Norma Spence MD CCFP

Disclosure:
Clinical Assistant Professor, Faculty of Medicine, University of Calgary; Maternal Newborn Section Chief, AHS



Wendy Wood R.M.

Disclosure:
Clinical Midwifery Director, Calgary & South Zones, AHS

Pediatric Panelists

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J.A. Michelle Bailey MD FRCPC

Disclosure:
Clinical Associate Professor, Faculty of Medicine, University of Calgary; Department of Pediatrics Medical Director, Quality and Practice Improvement, PLP and CME, Cumming's School of Medicine; Quality and Safety Lead, Hospital Pediatrician, Alberta Children's Hospital

Kyle McKenzie MD FRCPC

Disclosure:
Clinical Lecturer, Faculty of Medicine, University of Calgary; Assistant Clinical Professor, Pediatrics, Univeristy of Edmonton; Pediatrician Red Deer, AHS

Bonita Lee MD FRCPC

Disclosure:
Associate Professor, Department of Pediatrics, University of Alberta; Medical Lead, Infection Prevention Control. Stollery Children's Hospital, Edmonton

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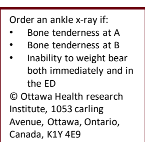

Order an ankle x-ray if:
- Bone tenderness at A
- Bone tenderness at B
- Inability to weight bear both immediately and in the ED

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Evaluation Survey

- Your feedback is essential; please make sure you complete the online evaluation survey https://survey.ucalgary.ca/jfe/form/SV_73abUIJgr2n5EqN

You will receive an email with the link tomorrow.

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