Agenda

- OPQIC’s New Staff Member: Maternal Peer Navigator
- OSDH Updates
- OHCA Updates
- State Maternal Health Innovation Program – HRSA Grant
- COVID-19 in Oklahoma
- OPQIC Updates
Sarah Johnson, OPQIC Maternal Peer Navigator
UPDATES FROM THE OKLAHOMA STATE DEPARTMENT OF HEALTH

Ashley Scott
Legislative Liaison
UPDATES FROM THE OKLAHOMA HEALTH CARE AUTHORITY

Traylor Rains
Deputy State Medicaid Director
STATE MATERNAL HEALTH INNOVATION PROGRAM (SMHIP)

Joyce Marshall, MPH
Director, Maternal And Child Health Service

Jill Nobles-Botkin, APRN-CNM
Administrative Program Manager
COVID-19 IN OKLAHOMA

ANSWERS TO REGISTRATION QUESTIONS
Approximately how many cumulative OB patients in your hospital have been/are under investigation for COVID-19?

20 OK Hospitals Responding
Approximately how many cumulative OB patients in your hospital have tested + for COVID-19?
Approximately how many OB patients do you have, or have you had, in the ICU with presumed or diagnosed COVID-19?

20 OK Hospitals Responding
Approximately how many newborns have you tested for COVID-19?

20 OK Hospitals Responding
Approximately how many newborns have you tested for COVID-19?

No hospitals reported a COVID-19 positive infant.
Has your site conducted any simulations specific to care of the COVID-19+ pregnant patient and/or her infant?

12 out of 20 hospitals reported “Yes”

- Some respondents specified that simulation included donning and doffing of PPE
- L&D and c-section “walk-through” of COVID-19 patient or PUI
OPQIC is committed to supporting perinatal healthcare workers, patients, and communities in Oklahoma by providing access to emerging information and guidance related to COVID-19. As this is a rapidly evolving public health pandemic, we encourage you to take into consideration the most recently available local health
COVID-19 in Oklahoma

Chad Smith, MD
Medical Director
OPQIC
VP Medical Affairs
Mercy Hospital OKC

LaWanna Halstead, MPH, RN
VP/Quality & Clinical Initiatives
OK Hospital Association

Stefanie Bryant, MD
Assistant Professor
OBGYN & Maternal Fetal Medicine
OU Medicine

Patricia Williams, MD
Assistant Professor
NICU Medical Director
OU Medicine

Clara Song, MD
Assistant Professor
Director of Education
Neonatologist
OU Medicine
Hospital resource use

6 days since peak resource use on
April 15, 2020
(April 6 - April 26)

Resources needed for COVID-19 patients on April 15:
- All beds needed: 369 beds
- ICU beds needed: 86 beds
- Invasive ventilators needed: 77 ventilators

Resources available:
- All beds available: 5,457 beds
- ICU beds available: 467 beds
- ICU bed shortage: 0 beds
- Invasive ventilators available: 0 ventilators

Graph showing the projection of resource needs and availability from February 1 to August 1.
After June 15, 2020, relaxing social distancing may be possible with containment strategies that include testing, contact tracing, isolation, and limiting gathering size.
Total deaths

359 COVID-19 deaths
projected by August 4, 2020
Factors/Issues that Remain

• Adequate PPE
  • Extended use
  • Repurposing techniques

• Testing Capability
  • Coronavirus 2 (SARS-CoV-2) PCR test
  • Serology tests (IgG, IgM, IgA)

• Shelter-at-Home

• Elective Surgery
<table>
<thead>
<tr>
<th>Tiers</th>
<th>Definition</th>
<th>Locations</th>
<th>Examples</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 3a</td>
<td>High acuity surgery healthy patient</td>
<td>Hospital</td>
<td>Most cancers, Highly symptomatic patients</td>
<td>Not impacted by EO (allowable currently)</td>
</tr>
<tr>
<td>Tier 3b</td>
<td>High acuity surgery unhealthy patient</td>
<td>Hospital</td>
<td></td>
<td>Not impacted by EO (allowable currently)</td>
</tr>
<tr>
<td>Tier 2a</td>
<td>Intermediate acuity surgery healthy patient- Not life threatening but potential for future morbidity and mortality. Requires in hospital stay</td>
<td>HOPD, ASC, Hospital with low/no COVID-19 census</td>
<td>Low risk cancer, Non urgent spine, Ureteral colic</td>
<td>Allowable April 24</td>
</tr>
<tr>
<td>Tier 2b</td>
<td>Intermediate acuity surgery unhealthy patient</td>
<td>HOPD, ASC, Hospital with low/no COVID-19 census</td>
<td></td>
<td>Allowable April 24</td>
</tr>
<tr>
<td>Tier 1a</td>
<td>Low acuity surgery healthy patient- Outpatient surgery Not life-threatening illness</td>
<td>HOPD, ASC, Hospital with low/no COVID-19 census</td>
<td>Carpal tunnel release, prosthesis, EGD, Colonoscopy</td>
<td>Allowable May 1</td>
</tr>
<tr>
<td>Tier 1b</td>
<td>Low acuity surgery unhealthy patient</td>
<td>HOPD, ASC, Hospital with low/no COVID-19 census</td>
<td></td>
<td>Allowable May 1</td>
</tr>
</tbody>
</table>

HOPD – Hospital Outpatient Department ASC – Ambulatory Surgery Center
Oklahoma COVID-19
Hospital Surge Plan
Healthcare Surge Planning Committee

**Chairs:** Sec. Kayse Shrum, Sec. Jerome Loughridge, Sec. John Budd, Chief Michael Junk

**Executive Officer:** LTC Matt Stacy

**Staff Officer:** Deputy Secretary Carter Kimble

**Members:**
- Director Travis Kirkpatrick (OSDH)
- Tom Bates, JD (Legal)
- Gino DeMarco (PPE)
- Sec. Tim Gatz (Ventilators)
- Sec. Justin Brown/Designee (Alternative Care)
- Patti Davis, OHA President (Hospitals)
- LTC Steve Cheadle (Logistics)
- LTC Yolanda Gregory (Medical Facilities)
- COL Lance Frye, MD (Communications/Training)
Oklahoma Hospital Surge Plan Objectives

1. Protect the health and lives of Oklahomans by ensuring each patient goes to the closest most appropriate hospital in the right amount of time with the right treatment,

2. Ensure the stability of the health system for all patients,

3. Increase hospital capacity and capability to accommodate surge of critically ill patients,

4. Protect the wellness of all front-line workers.
IHME Projections and Oklahoma Capacity
Medical/Surgical + ICU beds

*Staffed beds minus specialty hospitals minus 30% for non-COVID patients

4,633 available beds*

882 projected bed need

*All resources specific to COVID-19 patients. Shaded area indicates uncertainty (1)
IHME Projections and Oklahoma Capacity

ICU Beds

*Staffed beds minus specialty hospitals minus 30% for non-COVID patients

671 available ICU beds*

218 projected ICU beds needed
IHME Projections and Oklahoma Capacity
Ventilators

1,794 available ventilators*

*Total ventilators, anesthesia machines, BiPaps; minus 20% for non-COVID patients

192 needed
192 needed
IHME Projections and Oklahoma Capacity
Ventilators
1,794 available ventilators*
*Total ventilators, anesthesia machines, BiPaps; minus 20% for non-COVID patients
Oklahoma Hospital Surge Plan Overview

(All healthcare facilities expected to provide care to COVID patient to their capability)

• There are COVID (+) patients in all regions of Oklahoma. All regions have hospitals with ICUs and ventilators;

• The goal: keep patients in regions unless a higher level of care is needed.

• In metro areas, cohort like-patients (i.e. cancer, OB, nursery, pediatrics, immunosuppressed) in one area;

• Contact TReC*, for referral of patient to the closest, most appropriate hospital within region, or to closest region with resources to care for the patient;

• Return patient to home region for recovery.

*Trauma Transfer and Referral Center
The state of **Oklahoma** has been divided into eight (8) **regions** for the purpose of planning, protecting, providing funding and responding to an incident. Both the **Oklahoma Office of Homeland Security** (OKOHS) and the **Oklahoma State Department of Health** (OSDH) utilize these **regions**.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Vents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Francis Hospital</td>
<td>234</td>
</tr>
<tr>
<td>Hillcrest Medical Center</td>
<td>146</td>
</tr>
<tr>
<td>Ascension St. John Medical Center</td>
<td>88</td>
</tr>
<tr>
<td>OSU Medical Center</td>
<td>46</td>
</tr>
<tr>
<td>Hillcrest Hospital South</td>
<td>43</td>
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<tr>
<td>Bailey Medical Center</td>
<td>29</td>
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<tr>
<td>Oklahoma Surgical Hospital</td>
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<tr>
<td>PAM Specialty Hospital of Tulsa</td>
<td>19</td>
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<tr>
<td>Saint Francis South</td>
<td>25</td>
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<tr>
<td>Tulsa Spine &amp; Specialty Hospital</td>
<td>14</td>
</tr>
<tr>
<td>Ascension St. John Broken Arrow</td>
<td>11</td>
</tr>
<tr>
<td>Southwestern Regional Medical Center</td>
<td>10</td>
</tr>
<tr>
<td>Ascension St. John Owasso</td>
<td>5</td>
</tr>
<tr>
<td>PAM Rehabilitation Tulsa</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL** 700

**REGION 7 TULSA**

Region size: 570 sq miles
Total population: 651,552 (est 2019)
Population per sq miles: 1,142.6
EMS bases (ground/air): 7/1
Hospitals (acute/other): 10/11
REGION 8 OKLAHOMA COUNTY

Region size: 709 sq miles
Total population: 797,434 (est 2019)
Population per sq miles: 1,125.02
EMS bases (ground/air): 5/1
Hospitals (acute/other): 10/15

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Vents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integris Baptist Medical Center</td>
<td>228</td>
</tr>
<tr>
<td>OU Medicine</td>
<td>183</td>
</tr>
<tr>
<td>Mercy Hospital Oklahoma City</td>
<td>128</td>
</tr>
<tr>
<td>Integris Southwest Medical Center</td>
<td>86</td>
</tr>
<tr>
<td>SSM Health St. Anthony Hospital</td>
<td>75</td>
</tr>
<tr>
<td>Integris Health Edmond</td>
<td>24</td>
</tr>
<tr>
<td>AllianceHealth Midwest</td>
<td>22</td>
</tr>
<tr>
<td>Summit Medical Center</td>
<td>13</td>
</tr>
<tr>
<td>OneCore</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>761</strong></td>
</tr>
<tr>
<td>Operations</td>
<td>Logistics</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Med-Surg Beds</td>
<td>Cohort like-patients in one facility (i.e. peds, OB, nursery, oncology)</td>
</tr>
<tr>
<td>ICU Beds</td>
<td>Interfacility Transport</td>
</tr>
<tr>
<td>Alternative Care Models</td>
<td>Reassignment of healthcare workers to other facilities</td>
</tr>
<tr>
<td>Staffing</td>
<td>Healthcare Worker Wellness</td>
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</table>
# Defining Surge: A Tiered Action Plan

<table>
<thead>
<tr>
<th>Tier</th>
<th>Tier Action Plan Trigger</th>
<th>Tier Goals</th>
</tr>
</thead>
</table>
| Tier 1     | Preparing for Imminent Patient Surge                           | • Assessment of resources/needs  
• Estimation of resource needs  
• Procurement of resources (human, supply chain, equipment)  
• Data collection and logistics planning |
| Tier 2     | 60% Total Hospital Bed Capacity Reached (staffed beds, med-surg and ICU) | • Continued monitoring of surge data  
• Movement of resources into place  
• Ensure human resources positioned  
• Surge evaluation monitoring on EMResource |
| Tier 3     | 90 -140+% Hospital Bed Capacity Reached (staffed beds, med-surg and ICU) | • Full activation of clinical care and human resources  
• Continued monitoring of logistics (EMResource, TReC)  
• Utilizing alternative care sites |
| Tier 4     | 50% Hospital Bed Capacity                                      | • Normalizing to pre-COVID-19                                                                                                               |
Internal Hospital Considerations to Increase Staffing During Surge

• Redeployment of staff in surgical and procedures areas, and closed physician offices
• Develop team models of care
• Partnering experienced nurses with lesser experienced nurses to increase the ability to care for an increased number of patients
• Adjust nurse:patient staffing ratios upward to accommodate increased number of patients in ICU and med-surg areas
• Utilize anesthesiologists and CRNA’s as part of the ventilation care team;
• Cross-train non-professional staff to work in supplies or housekeeping
External Hospital Actions to Increase Staffing During Surge

• Identify nurses and other health professionals from other medical facilities (such as surgical specialty hospitals and ambulatory surgical centers)
• Utilize nurses and other health professionals from ambulatory surgery centers
• Utilize staffing agencies for healthcare professionals
• Identify resources from Medical Reserve Corp, public health, and military
• Expedite licensing for healthcare professionals, newly graduated nurses and other allied health care providers (*in progress*)
• Coordinate with licensure boards to utilize additional persons granted expedited temporary licensure (*done*)
Tiered Surge Plan

Alternative Care Sites
- USACE
- Staffing, PPE, Equipment, Transport
- 520+ beds

COVID Flex Sites
- Acute Care-OSUMC, OKC Location TBP (260+ beds)

Hospital Surge up to 40%
- Self-supporting with supplementation
- 40% staff augmentation, PPE, Equipment, Transport
- 4633 Available Beds

SAFETY NET*
Not intended to displace patients
Your collaboration is appreciated during this time of uncertainty!

Let’s hope for the best but be prepared for the worst
MFM COVID 19 Response
OU Medical Center/TCH

Stefanie Bryant, MD
Assistant Professor
OBGYN & Maternal Fetal Medicine

The UNIVERSITY of OKLAHOMA
Pregnancy and COVID 19

• Not as severe as other Coronaviruses (SARS, MERS)
• No increased risk of SAB – need more data
• PTB and PPROM increased
• Anomalies not increased
• No definitive evidence of vertical transmission

DiMascio et al, AJOG 2020
Screening: Who, What, When, Where, How:

Outpatient

• Upon arrival to the hospital/clinic building by hospital staff (RN)
  • Limited access points
  • Universal masking
  • Questionnaire and Temp
  • Visitors + patient
• Confirmation on arrival to clinic
• Screen + evaluation in clinic
Screening: Who, What, When, Where, How

**Inpatient**

- Upon arrival to the hospital/clinic building by hospital staff (RN)
  - Limited access points
  - Universal masking
  - Questionnaire and Temp
  - Visitors + patient
- Confirmation on arrival to unit
- Screen + eval in OB Emergency Department or L&D COVID rooms
Testing: Where?

Outpatient
• Prenatal care clinics
  • Resident Clinic
  • OU Physician’s OB-GYN
  • Prenatal Diagnostic Center (MFM)
• Respiratory Clinic
  • Run by Family Medicine

Inpatient
• OB Emergency Department
• L&D
Testing: Who? When?

Outpatient
• Prenatal care clinics
  • Outpatients who call in with symptoms + OB complaints
  • Patients with appointments who screen +
• Respiratory Clinic
  • Outpatients who call in or present with symptoms without OB complaints
Testing: Who? When?

**Inpatient**
- Screen positive for COVID symptoms
- Present for COVID symptoms
- Develop symptoms during admission or work up for OB complaint
Testing: How?

Outpatient
• Nasopharyngeal swab
• In-house lab
  • TAT 2-8 hours

Inpatient
• Nasopharyngeal swab
• In-house lab
  • TAT 2-8 hours
Universal Screening on L&D

• Not implemented at OU…yet
• Why/benefits?
  • Preserve PPE, limit HCW exposure, planning for newborn care, epidemiologic information (ie: incidence of asymptomatic test)
• Why not?
  • Testing availability and TAT, delay in cases, false neg rates of test (~30%)
• Other concerns: where and when to screen, refusal or inability to get testing, partner testing
Universal Screening on L&D

• Several other L&Ds in OKC are universally testing
  • No data reported yet
• Nationally, many L&Ds are trying to move toward the policy but are limited in testing availability
  • Very limited reported data
  • Columbia
Universal Screening on L&D

- Columbia published two reports of asymptomatic COVID+ rates
  - 3/13-3/27 – 32% COVID cases asymptomatic on presentation (Breslin et al)
  - 3/22-4/4 – 13.5% of universally screened patients asymptomatic positive (Sutton et al)

Breslin et al, AJOG MFM 2020

The UNIVERSITY of OKLAHOMA

Sutton et al, NEJM, 2020
COVID+ / PUI Patient Flow

• If needs inpatient monitoring for COVID or OB complaint
  • Specified isolation rooms on L&D
  • < 20 weeks to COVID floor/ICU in Adult tower
• Specified L&D OR if needed
COVID+/PUI Patient Flow

- Prefer outpatient management with home quarantine
  - Specific OB admission criteria
  - Phone/telehealth follow up in 24-48 hours and q2-3 days
  - Reschedule outpatient appts as able/indicated
  - Limit OBED/ER visits
L&D Care for COVID+/PUI

• Patient and visitor with surgical mask at all times
• Aerosolizing procedures: N95, gown, eye protection, hair covering, gloves
  • ALL deliveries have potential for aerosolization
• Routine patient care (contact + droplet): surgical mask, eye protection, hair covering, gloves
L&D Care for COVID+/PUI

• Vaginal deliveries: N95, gown, eye protection, hair covering, gloves for 2\textsuperscript{nd} and 3\textsuperscript{rd} stage
  • Delivering physician(s) or provider, OB nurse, newborn nurse

• Cesarean deliveries: N95, gown, eye protection, hair covering, gloves
  • Surgeon(s), scrub tech, circulating OB/OR nurse, newborn nurse
PPE: Surgical masks and N95s

- Universal surgical masks for patients, visitors and all HCW and hospital staff
- Reuse unless visibly soiled or deformed, unable to breathe through or when used for known COVID+ patient or aerosolizing procedure
- **N95s for ALL deliveries**
- Storage in paper bags
- Process to use UV light to clean N95s rolling out
L&D Management for COVID+ / PUI

- Early epidural
- Neuraxial anesthesia recommended to avoid GETA
- No maternal O2 for fetal resuscitation
- No nitrous oxide
L&D Management for COVID+/PUI

- Mode of delivery per routine obstetric indications
- Avoid emergent CDs
- Move to OR early (if indicated)
  - Vaginal twins or breech extraction, hemorrhage risk, operative vaginal delivery, etc
L&D Management for COVID 19/PUI

- Antenatal steroids
- Tocolysis
- Magnesium
- NSAIDs
L&D Management for COVID 19/PUI

- Preeclampsia/HELLP association
- Isolated fever/other infections
- Treatment of COVID – consult with ID
  - Hydroxychloroquine
  - Azithromycin
  - Antivirals and cytokine blockade
Postpartum COVID+ / PUI

- Stay in L&D room for postpartum care
- Newborn separation
  - Recommended
  - If pt refuses, bassinet ≥ 6 ft away in room
  - Well care-giver
Postpartum COVID+/PUI

- Breastfeeding
  - Pumping and bottle feed preferred
  - Direct breastfeeding with appropriate hygiene and mask
- Caution with early discharges
- Ideally well care giver at home as well
Postpartum BTLs

• Postpartum BTLs on case by case basis
  • Done with concomitant CD
  • Generally delayed except with high risk maternal conditions
• Increase LARC use
COVID-19 and the Neonate

CLARA SONG, MD & PATRICIA WILLIAMS, MD
OU CHILDREN’S NEONATOLOGY
COVID 19

* Transmission routes involving a combination of hand & surface = indirect contact.
Vertical Transmission – Chinese studies show no evidence

**Chen et al** (Lancet 2020) – 6 women/6 infants, **positive maternal NP swabs**, amniotic fluid negative, cord blood negative, neonatal NP swabs negative

**Liu et al** (Preprints 2020) – 3 women/3 infants, **maternal OP positive**, Breast milk, vaginal mucus and placenta negative, Neonatal swabs negative (urine, OP, feces, blood) at birth, OP negative DOL 1

**Wang X et al** (Clin Infect Dis 2020) – 1 woman/1 infant, **maternal sputum positive**, amniotic fluid and placenta negative, newborn cord blood, gastric aspirate, throat swab at delivery negative, testing negative at DOL 3, 7 and 9

**Wang S et al** (Clin Infect Dis 2020) – 1 woman/1 infant, **maternal NP swab positive postpartum**, placenta and breast milk negative, cord blood negative, newborn NP swab positive at 36h but negative at 15 days of age
Vertical Transmission – Ongoing questions

**Zeng H et al. (JAMA 2020)** – 6 women/6 infants, mothers with positives, newborns with negative throat swabs, serum. Elevated IgG in 5 infants (expected) but 2 infants had elevated IgM. All infants were asymptomatic.

**Dong et al (JAMA 2020)** – 1 woman/1 infant – Maternal NP swab positive (1 month prior to delivery), Neonate with elevated IgG and IgM, 5 NP swabs were negative, Infant was asymptomatic.

**Zeng L et al (JAMA Pediatr 2020)** – 33 women/33 infants – Maternal NP positive, 3 infants (1 preterm) with positive NP swabs on DOL 2 and 4, negative by DOL 6.
## No studies show Transmission via Breast Milk

### GOOD NEWS

Many benefits to mom and baby of breast milk
- Nutritional
- Immunologic
- Bonding

### CONCERNS

Risk of transmission during direct breastfeeding
- Use of mask by mom
- Meticulous hand and breast hygiene

Risk of transmission during bottle feeding
- Clean breast pump with disinfectant wipes
- Clean components with hot, soapy water

No guidance to avoid Donor Breast Milk
- Holder pasteurization (62.5°C for 30 min)
  - [https://www.hmbana.org/file_download/inline/1a0ef462-6185-4f2c-9115-433a676b8548](https://www.hmbana.org/file_download/inline/1a0ef462-6185-4f2c-9115-433a676b8548)
COVID 19 in the Neonate

Rare – majority of neonates born to COVID positive moms are negative
- Breslin (Sutton NEJM letter 2020) – Columbia, NY experience: 43 COVID positive pregnant women, often asymptomatic. No positive newborns

If positive – majority are asymptomatic
- Case reports

If symptomatic - non-specific, mild symptoms
- Case reports – emesis, fever, tachypnea
- Media stories of infant deaths: 6 week old in Connecticut, Infant in Chicago,
Care Considerations

Prenatal

Postnatal

Delivery
INITIAL GUIDANCE:

Management of Infants Born to Mothers with COVID-19

Date of Document: April 2, 2020

Karen M. Puopolo, M.D. Ph.D., Mark L. Hudak, M.D.,

David W. Kimberlin, M.D., James Cummings, M.D.

American Academy of Pediatrics Committee on Fetus and Newborn, Section on Neonatal Perinatal Medicine, and Committee on Infectious Diseases
AAP Section on Neonatal-Perinatal Medicine website

https://services.aap.org/en/community/aap-sections/sonpm
Review of practices at US Institutions
1/3 census in our NICU now filled with COVID rule outs. Some reunited with mothers, other times moms too sick or no caregiver. Some babies positive on testing. All healthy. Discharge planning and family communication a big ordeal for all. Superb teamwork.
1/3 census in our NICU now filled with COVID rule outs. Some reunited with mothers, other times moms too sick or no caregiver. Some babies positive on testing. All healthy. Discharge planning and family communication a big ordeal for all. Superb teamwork.

7:45 PM · 4/10/20 · Twitter for iPhone

44 Retweets 304 Likes
Management of Neonates born to Suspected/+ COVID-19 Mothers in Delivery Room
NICU COVID-19
Intubation

Take Home Points

1. Pre-medicate for intubation when possible
2. Connect viral HEPA filter, mask and self-inflating bag PRIOR to procedure
3. Prepare ventilation circuit tubing with in-line suction catheter PRIOR to procedure
4. Properly dispose of all materials immediately after intubation procedure

• [https://youtu.be/tNiuRSFeb2c](https://youtu.be/tNiuRSFeb2c)
Close Collaboration with OB/MFM colleagues

Communication around patients

Collaboration in developing care guidelines for mom and baby

Communication with parents around care for mom and baby
OU NICU Guidelines for Care of Neonates born to Suspected or Confirmed COVID-19 Mothers

Mother with Symptoms (Testing for COVID-19 by OB)
- Admit to OB under isolation
- Infection control and ID consult
- Dedicated delivery team (see document for details)
- PPE (N95 mask or surgical mask, +/- face shield, gown & gloves)
- Admit to NICU room 8 or designated PICU COVID-19 rooms.
- Notify ID and infection control.
- Bath when stable.
- Test for COVID-19 at 24 hours or ID recs.
- Dedicated staff with PPE until test is negative.
- Keep in isolation until test is negative
- Limit visitors to one healthy > 18 years.

Baby requires NICU admission or mother clinically unstable and/or with confirmed COVID-19
- Admit to OBSCU under isolation (CDC recs)
- Bath when stable
- Test for COVID-19 per ID
- Family and staff to wear PPE at all times.

Baby asymptomatic & doesn't require NICU
- If mother refuses isolation
  - Baby stays with mom, crib 6 ft away & curtains drawn.
  - Mother should wear a mask at all times
- Direct BF not recommended until negative testing
- If still desired by mother will need PPE while BF.

Donor milk/ formula/ EBM fed by healthy provider

Feeding/Nutrition
# Postnatal Care - Collaboration

<table>
<thead>
<tr>
<th>Peds ID</th>
<th>Peds Anes</th>
<th>Outpt Peds</th>
</tr>
</thead>
</table>
| • Testing strategies  
  • Swab at 24h and 48h of life | • COVID intubation team  
  • NICU specific protocol | • Infant status communication  
  • Appropriate follow up |
Ongoing Open Questions

Best practices for testing in neonates (NP, throat, stool, & sensitivity of testing)

Vertical transmission?

Risk to perinatal complications, like PTL?

Follow-up in neonates and for how long? (24H, 48H, 14 days?)

Risk of postnatal transmission via close contact, human milk feeds, etc- what is the risk: benefit ratio?

Risk of re-admission due to asymptomatic PUI contact

Risk of re-admission due to early discharge (also increases risk of neonatal COVID-19 admissions)
Stay Safe & Healthy!

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Director of Advocacy & Innovation

patricia-k-williams@ouhsc.edu
Director of Clinical Operations
COVID-19 Maternal/Neonatal Registries

- PRIORITY: Pregnancy Coronavirus Outcomes Registry (UCSF)
  National registry of pregnant women with COVID-19

- National Perinatal COVID-19 (NPC-19) Registry (AAP Section on Neonatal Perinatal Medicine)
  National registry of mothers with COVID-19 and their infants

- Neonatal COVID-19 Impact Audit (Vermont Oxford Network)
  Data tool to help newborn care teams understand the impact of COVID-19 in their units
OPQIC Updates

- Save the Date – OPQIC 7th Annual Summit – October 2, 2020

- Future Meeting Dates
  - October 20, 2020
  - January 19, 2021
THANK YOU FOR YOUR PARTICIPATION!

https://opqic.org

info@opqic.org

Facebook | Twitter | YouTube | Instagram