Guidelines for Obstetrics and Gynecology Care during COVID-19

May 4, 2020

Note: Audio-video visits may be conducted. Document in the EHR as if the telehealth visits were an in-person visit. Include the time spent and any deviation in the service because the visit was not performed in-person. All care provided via telehealth should be documented in the EHR. Coding and billing for tele-video visits are to follow current processes for in-person visits per current payer guidance.

Guideline for OB/GYN and Prenatal Care During COVID-19

- **Purpose:** To provide OB/GYN and maternal-fetal medicine (MFM) providers with a suggested alteration to routine gynecological and prenatal care processes during the COVID-19 pandemic to limit exposure to patients and mitigate the spread of the virus. This document includes guidance on the following:
  - Gynecologic visits appropriate for telehealth visits
  - An altered schedule for prenatal care that includes the use of telehealth, telephone and in person visits for:
    - Low Risk Pregnancy
    - High Risk Pregnancy
- **Guideline:** OB/GYN and MFM providers should continue with gynecological care and prenatal care visits at a safe distance and use telehealth as appropriate per the CDC COVID-19 guidance. As a public health action to preserve staff, personal protective equipment and patient care supplies, and to ensure safety for patients and health care teams, facilities should encourage the appropriate transition of elective ambulatory provider visits to the implementation of alternative service delivery models such as Telehealth.
- A recent publication by the *American Journal of Obstetrics & Gynecology MFM* (as cited here) addresses the COVID-19 global pandemic and provides guidance for maternal-fetal medicine providers with two goals:
  - Reduce patient risk through healthcare exposure, understanding that asymptomatic health systems/healthcare providers may become the most common vector for transmission
  - Reduce the public health burden of COVID-19 transmission throughout the general population.
  
- The prenatal recommendations that follow are based on this article and should be viewed as suggestions, which can be adapted to local needs and capabilities. Please consult the CDC and other reputable sources for updates as guidance is changing rapidly.
- The altered schedule for prenatal visits during the COVID-19 pandemic is designed to reduce the frequency of in-person visits and optimize tele-visits for a low risk pregnancy. This is a guideline; it is for the clinician to determine appropriate frequency and type of visit for each patient.
Additional Notes:
- Defining “low risk pregnancy” - a provider should use clinical judgement regarding who would fall into low-risk and high-risk categories
- Patient spacing guidelines refer to recommendations for waiting rooms and rooming patients

General Gynecological and Obstetric/MFM COVID-19 Recommendations
- Prevention of spread should be the top priority: encourage patients and visitors to wear a mask to all visits and carry hand sanitizer.
- Upon arrival to the ambulatory clinic, patients and visitor should be provided with a mask and use hand sanitizer.
- Social distancing of at least 6 feet should be pursued; If this is not feasible, use extended dividers or other precautions
- Elective and not-urgent in-person visits should be postponed and appropriate televisits considered
- Each patient should be contacted to decide on the need for next in-person visit and/or test
- **Any visit that can be done by telehealth should be**
- No support person should accompany a patient to outpatient visits unless they are an integral part of patient care
- Testing specific recommendations:
  - **Symptomatic patients are best triaged via telehealth** in order to assess their need for inpatient support or supplemental testing; they should be presumed infected, and self-isolate for 14 days. In-person evaluation is not indicated if symptoms are mild.
  - Utilize drive-through testing or stand-alone testing rather than in office testing
  - Symptomatic patients who nonetheless arrive to hospital or office should be managed as if they are COVID-19 positive and be immediately properly isolated in designated areas, with appropriate mask on
  - *Note: During Influenza Season: Pregnancy in the setting of new-flu like symptoms and a negative influenza assay is enough to warrant COVID-19 testing; testing is especially important if additional risk factors (e.g. advanced age, immunocompromise, advanced HIV, homeless, hemodialysis, etc.) are present*
- Designated separate areas should be created at each office site for suspected COVID-19 patients. If medically feasible, known positive cases of COVID-19 or persons under investigation should wait in their vehicle until exam room is ready. In such areas, sanitization should be increased. Masks and hand sanitizer should be made available at front desk and throughout waiting area. Patient rooms should be wiped down after each patient visit. If a waiting area is used, chairs should be wiped down after each patient use.

Gynecological Conditions Appropriate for Telehealth Video Visits
- **Appropriate for telemedicine**
  - Contraceptive counseling or refills
  - Preconception counseling or infertility counseling
  - Postoperative visits (if no pelvic exam required)
  - Postpartum visits (if no pelvic exam required)
  - Mood checks (postpartum or otherwise), PMDD
  - Menopausal symptoms / HRT management
  - Counseling visits (follow up of labs/ discussion of management options, etc.)
  - Abnormal uterine bleeding in adolescent (initial evaluation where pelvic exam is not planned)
  - Preop Instructions
- **Not appropriate for telemedicine**
  - OB patients (including pregnancy confirmation)
  - Annual exam
Procedures or ultrasounds
- IUD string check
- Pelvic pain (initial evaluation)
- Abnormal bleeding (initial evaluation other than adolescents)
- Prolapse/ pessary check

Outpatient Obstetric Prenatal Visits
All new obstetrical intake visits should be completed by telehealth unless the patient describes an urgent problem in which case she will be appointed as an urgent in-person visit.

Scheduling of Outpatient Ultrasound
In addition to modifying ultrasound timing, the routine practice of face to face counseling for ultrasounds should be adjusted. Aside from major anomalies or new diagnoses (i.e. fetal growth restriction), in most cases ultrasound findings can be reviewed either over the phone or via telehealth, or in the setting of a normal routine ultrasound, by the OB provider at the next visit.

- **Dating Ultrasound:**
  - Combine dating/NT to one ultrasound based on LMP
  - If the performance of an ultrasound earlier in the first trimester (e.g., less than 10 weeks) is indicated due to threatened abortion, pregnancy of unknown anatomic location, the provider may consider foregoing NT ultrasound and offering cell free DNA screening for those desiring early aneuploidy screening
  - For patients with unknown LMP or EGA>14 weeks, ultrasound may be schedule as “next available”

- **Anatomy Ultrasound (20-22 weeks)**
  - Consider follow up views in 4-8 weeks rather than 1-2 weeks**
  - Consider stopping serial cervical length assessments after anatomy u/s if transvaginal cervical length ≥35mm or prior preterm birth at >34 weeks
  - BMI>40: schedule at 22 weeks to reduce risk of suboptimal views/need for follow up

- **Growth Ultrasounds**
  - Perform single fetus third trimester growth ultrasound at 32 weeks
  - Follow up ultrasound on previa/low lying placenta at 34-36 weeks

*Or earlier if desired based on state-specific termination laws;**

Consider forgoing follow-up ultrasound for one or two suboptimal views (e.g., l/s spine not seen well due to fetal position but posterior fossa normal)

Scheduling of Non-Stress Tests
Antenatal surveillance with NST/BPP may be modified in setting of the COVID19 pandemic and increased risk patients may be confronted with office visits involving 30+ minutes of testing. In general, we suggest the following principles:

- Twice weekly NSTs only for intrauterine growth restriction (IUGR) with abnormal umbilical artery Doppler
- Limit NSTs initiated at <32 weeks
- If concurrent with ultrasound, perform a BPP rather than an additional NST visit
- In lower risk patients, such as advanced maternal age 35-39 or BMI>40 with no other comorbidities, consider kick counts instead of NST.

For patients with gestational hypertension/preeclampsia, plan weekly visits in the office with daily blood pressure checks at home. Weekly visits will include antenatal testing, blood pressure check, and lab work drawn in the office to minimize the need for additional visits. These changes should be relayed to patients with a discussion of the altered risk/benefit balance of presenting to the office for testing in the setting of a global pandemic.
Visitor Policy for Obstetric Office

- NO additional family/friend/partner should attend any outpatient appointment unless
  - Visitor is required for supporting patient including activities of daily living such as assisting with ambulation
  - Visitor has power of attorney or is court appointed for care of the patient
- Patients should be asked NOT to bring children to office visit
- Visitor with symptoms at front desk check in SHOULD NOT be allowed in patient care areas and SHOULD be asked to return home.
- Patients may be asked to reschedule non-urgent care if they or their visitor are symptomatic

Involvement of Students/Trainees
In setting of a COVID-19, we suggest that all nonessential clinical personnel remain at home, including nursing, medical, and sonography students. In an academic setting where an attending physician is supervising residents or fellows, the number of providers providing face to face counseling should be limited.

Recommended Frequency of Prenatal Visits for "Low Risk Pregnancy" including Ultrasound and Labs during COVID-19

<table>
<thead>
<tr>
<th>Gestational Age</th>
<th>Visit type</th>
<th>Ultrasound</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Confirmation</td>
<td>In Person</td>
<td></td>
<td>Confirmation that pregnancy is in the uterus. Note: Consideration can be given to foregoing this visit</td>
</tr>
<tr>
<td>8-10 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-12 wks</td>
<td>Telephone (RN)</td>
<td></td>
<td>Encourage patient to complete labs on the day of her next visit for genetic screening discussion.</td>
</tr>
<tr>
<td>New OB Visit</td>
<td>In Person</td>
<td></td>
<td>Discuss genetic screening further if needed</td>
</tr>
<tr>
<td>12-14 weeks</td>
<td></td>
<td>RHM to designate location</td>
<td>BP is not assessed at this visit. This is only for the screening ultrasound.</td>
</tr>
<tr>
<td>19-20 weeks</td>
<td>In Person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 weeks</td>
<td>Tele-Video</td>
<td></td>
<td>Discuss 3rd trimester lab orders and review reasons to call the office.</td>
</tr>
<tr>
<td>28 weeks</td>
<td>In Person</td>
<td>RHM to designate location</td>
<td>Visit includes 3rd trimester labs and administration of Rhogam &amp; Tdap Note: If patient has low lying placenta will need to schedule a follow up ultrasound</td>
</tr>
<tr>
<td>32 weeks</td>
<td>In Person</td>
<td></td>
<td>Recommend in-person visit Note: Could be a video visit if patient has home doppler and BP cuff</td>
</tr>
<tr>
<td>36 weeks</td>
<td>In Person</td>
<td></td>
<td>Group B Streptococcus (GBS) screening</td>
</tr>
<tr>
<td>37 weeks to delivery</td>
<td>In Person</td>
<td></td>
<td>Consideration for weekly visits starting at either 37 or 38 weeks</td>
</tr>
<tr>
<td>1-2 week post-partum mood check</td>
<td>Tele-Video</td>
<td></td>
<td>Perform GAD 7 and PHQ 9 screening Note: If patient does not have a home BP cuff, the visit will need to be in person.</td>
</tr>
<tr>
<td>1-2 week blood pressure check</td>
<td>RN visits or In Person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-8 wk final post-partum visit</td>
<td>Video</td>
<td></td>
<td>Visit includes GAD-7/PHQ 9, contraceptive counseling, closure of pregnancy episode in EHR and updating of EHR problem list Note: Order labs (TSH/PPGDM testing) as needed</td>
</tr>
</tbody>
</table>
• **Considerations:**
  o The discussion in the alteration of the patient’s scheduling will occur at their next in person visit with a provider. This may not align perfectly with the grid above. Use clinical judgement when determining when it will be best to see the patient back in the office.
  o Keep in mind that this is not “black and white” and should be individualized to each patient
    ▪ Consider the patient’s willingness to undergo an altered schedule. Please use shared decision making. If the patient is highly anxious and does not want to undergo an altered schedule, work to accommodate something that will minimize the patient’s anxiety
  o This guideline refers to “low risk pregnancies”. However, spacing may also be appropriate for patients with a history of high-risk conditions or with high risk conditions that are well controlled, and these should be assessed on a case by case basis.
  o Encourage the patient to obtain a home BP cuff. This will allow the ability to assess BP at the time of a virtual visit. This will also allow the patient to monitor during times of “spaced” visits.
    ▪ Please see the AMA Home BP Monitoring Infographic for use as a patient education tool:
  o Ensure that you have documented your discussion with the patient in your note and the rationale for altering their prenatal visit schedule

**Recommended Guidelines for High Risk Pregnancy**

• **Purpose:** To provide maternal fetal medicine providers and obstetrical providers with a suggested alteration to “high risk prenatal care” during the COVID-19 pandemic to limit exposure to patients and mitigate the spread of the virus

• **Visit Frequency for High Risk Patients**
  o High risk patients should be seen at 12, 20 and 34 weeks by Maternal Fetal Medicine
    ▪ Ultrasound and consult should be performed at these visits
    ▪ The 20- and 34-week appointments should be scheduled at the initial consult
    ▪ A biophysical profile (BPP) combining a non-stress test with ultrasound examination should be included at the 34-week appointment if antenatal testing is needed
  o Mo/Di (Monochorionic/Diamniotic) twins – shared placenta with own amniotic sacs
    ▪ Continue twice monthly (every 14 days) ultrasound examination
  o Di/Di twins (Dichorionic/Diamniotic) twins – own amniotic sacs and placenta
    ▪ Continue to monthly ultrasound examination for growth
  o IUGR (Intrauterine Growth Restriction) fetuses
    ▪ Continue weekly BPP/ dopplers/AFI (Amniotic fluid index)
  o Fetuses with need for MCA (middle cerebral artery) Dopplers
    ▪ Continue weekly ultrasounds

• **Guidelines for altered antenatal testing**
  o Consider the patient’s willingness to undergo an altered scheduled. Please use shared decision making. If the patient is highly anxious and does not want to undergo an altered schedule, work to accommodate something that will minimize the patient’s anxiety
  o Ensure that you have documented your discussion with the patient in your note and the rationale for altering their antenatal testing schedule.
  o Review recommendations that are outlined by the MFM providers as they will also be making individualized plans for “co-managed” patient’s (ex: patients with Mo/Di twins, pre-gestational diabetes, Chronic Kidney Disease (CKD), poorly controlled chronic hypertension, etc.)
  o Use clinical judgement as there may be patients who need antenatal testing and are not included on the grid below
### Recommended Guidelines for Antenatal Testing - Alternative to Non-Stress Test

<table>
<thead>
<tr>
<th>Indication for Non-Stress Test (NST)</th>
<th>COVID-19 Suggested Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Maternal Age</td>
<td>Consider Fetal Kick Counts instead of Non-Stress Test</td>
</tr>
<tr>
<td>Cholestasis</td>
<td>Weekly at time of diagnosis</td>
</tr>
</tbody>
</table>
| GDMA2 Gestational Diabetes Classification A2 (Abnormal glucose tolerance test with abnormal fasting or postprandial glucose levels treated with diet and insulin) | Well controlled weekly at 32 weeks with weekly Amniotic fluid index (AFI)  
Poorly controlled twice per week at 32 weeks with weekly AFI |
| Chronic Hypertension (CHTN)          | If no anti-hypertensives, in office visit once per week at 36 weeks with weekly AFI  
If on anti-hypertensives, in office visit twice a week at 36 weeks with weekly AFI  
Difficult to control blood pressure – follow Maternal Fetal Medicine (MFM) recommendations |
| Gestational Hypertension (GHTN)      | Twice per week at time of diagnosis with weekly AFI |
| Pre-eclampsia                       | Twice per week at time of diagnosis with weekly AFI |
| Intrauterine Growth Restriction (IUGR) | Weekly biophysical profile (BPP)/doppler/AFI  
Weekly Non-Stress Tests (3-4 days after BPP) |
| Abnormal dopplers                   | Weekly Non-Stress Tests |
| Di-Di twins                         | Additional visits and testing only if there are other indications |
| Obesity/BMI<40                       | Fetal kick counts instead of Non-Stress Tests |
| Oligohydramnios (Too little amniotic fluid) | Twice per week at time of diagnosis |
| Polyhydramnios (Excessive amniotic fluid) | If > 32 weeks and AFI >30, then see once week with weekly AFI |
| Prior Intrauterine Fetal Death (IUFD) | Additional visits and testing customized to patient need |
| Sickle Cell Disease                 | Kick counts if disease is well controlled |
Pre-gestational Diabetes | Twice per week at 32 weeks with weekly AFI per Maternal Fetal Medicine recommendations
---|---
Mo-Di Twins | Maternal Fetal Medicine recommendations
Systemic Lupus Erythematosus (SLE) | Office visit every 1-2 weeks at 32 weeks per Maternal Fetal Medicine recommendations
Chronic Kidney Disease | Office visit twice per week at 32 weeks or per Maternal Fetal Medicine recommendations

**Recommended Guidelines for Outpatient Foley Balloon Placement**

**Purpose:** Evidence suggests that the patient experience is enhanced when cervical ripening occurs in the home as opposed to the inpatient setting. During COVID-19 consider outpatient Foley balloon placement as a strategy to shorten the time the patient is in the hospital setting for induction.

**Appropriate candidates for outpatient cervical ripening:**

- Post due date
- Advanced Maternal Age
- Well controlled GDMA1 (Gestational Diabetes Classification A1 – diet controlled) and no contraindications

**Contraindications to outpatient cervical ripening include:** GA < 37 weeks, pre-eclampsia, gestational HTN, ruptured membranes, VBAC, IUGR, low lying placenta, oligohydramnios, uncontrolled pre-gestational diabetes, anticoagulant therapy, uterine tachysystole unresolved by fluids & position changes on pre-insertion NST

**Guideline and Workflow:**

- Physician initiates intracervical balloon procedure by informing check out staff that, at patient’s next appointment, the provider will be inserting an intracervical balloon catheter.
- Receptionist will then schedule patient’s next appointment with the provider requesting intracervical balloon placement. Put in the details: “ROB/Intracervical balloon insertion”. This is a 20-minute provider appointment.
- Reception will then also schedule patient for pre-insertion NST 20 minutes before insertion and a 20-minute NST immediately after procedure.
- Provider should confirm category 1 tracing prior to insertion of Foley bulb for cervical ripening.
- Patient should have reactive NST after placement.
- Confirm induction on L&D scheduled for the following morning. (need to make sure that Ob surgery scheduling template states patient is getting an outpatient Foley)
- Patient should call L&D 2 hours prior to induction time to confirm availability (as per usual procedure).
- Patient should be warned it is possible they may need to present to triage for evaluation and possible Foley bulb removal, with admission to L&D delayed dependent on hospital availability.
- Provide patient instructions in “Wrap Up”
- Offer to provide patient with Rx for medication to assist with pain and sleep.
- Advise patient to call office number and speak with on-call provider for any questions or concerns after placement.
Procedure Supplies for MA room set up

1. Foley catheter with 30-40 ml inflation volume, latex free if necessary
2. 30-40 ml of sterile normal saline or sterile water
3. Vaginal speculum (large)
4. Sponge forceps / tenaculum
5. Vaginal swab / 4x4 sponges
6. 30-100 ml syringe
7. Antiseptic solution

Suggested Standardized Documentation and EHR Dot Phrases

Kick Counts

Instructions on Counting Your Baby's Movement:

A simple way to check your baby's well-being is to pay attention to how much your baby is moving. Most babies move at least ten (10) times within two hours. Count your baby's movements once a day, at the same time each day:

- Choose a time when your baby is usually the most active. Eat or drink cold water, milk, or juice before monitoring. After dinner is often a good time.
- Lie down on your side or sit in a comfortable chair. The first time your baby moves, write down the time.
- Count each movement the baby makes until the baby has moved ten (10) times. A movement may be a kick, turn, stretch, twist, swish, roll, jab or a flip of the baby. Hiccups do not count as movements.
- Write down the time you feel the tenth (10th) movement. If you have counted ten (10) movements in less than two (2) hours, stop counting until tomorrow.
- If your baby does not move at least ten (10) times in two (2) hours or if there is a sudden decrease in movement, call our office to report this to us.

Antenatal testing

- In an abundance of caution, and in the setting of COVID-19 pandemic, we discussed spacing out the patient's antenatal testing visits. We reviewed kick counts and the importance of monitoring fetal kick counts on a regular basis. The patient was in complete agreement with this plan.

COVID Spacing Note

- In an abundance of caution, and in the setting of COVID-19 pandemic, we discussed spacing out the patient's routine prenatal visits. We reviewed that at any time if the patient has concerns, she should call the office. We reviewed reasons to call the office including but not limited to the following: regular painful contractions, leaking of fluid, vaginal bleeding, and decreased fetal movement. The patient was in complete agreement with this plan.

Blood Pressure Monitoring Instructions without Known Hypertensive Problems

- You have been asked to monitor your blood pressure at home with a home blood pressure cuff. Please take your blood pressure around the same time every day. **Please call the office if either of the following occurs:**
  - Your top number (systolic blood pressure) is > 140
  - Or
  - Your bottom number (diastolic blood pressure) is > 90
• You should also call the office if you develop any of the following symptoms:
  o Headache
  o Bright or dark spots in your vision
  o Pain in your upper abdomen
  o Nausea or vomiting

Blood Pressure Monitoring Instructions for Patients with Known Hypertensive Problems
• You have been asked to monitor your blood pressures at home because you have a blood pressure condition in pregnancy. **Please call the office if either of the following occurs:**
  o Your top number (systolic blood pressure) is > 160
  Or
  o Your bottom number (diastolic blood pressure) is > 110
• Please call the office if you have any of the following symptoms:
  o Headache
  o Bright or dark spots in your vision
  o Pain in your upper abdomen
  o Nausea or vomiting

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>Document</th>
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