WELCOME to the
Planning and Clinical Management of Perinatal COVID-19 cases

Session will start in less than 15 minutes
Punctuated Equilibrium

Rethinking Prenatal Care and Regional Collaboration
Conflict of Interest Disclosure Statement

No Conflicts of Interest
“...Gould posits, most species have originated during punctuated geologic moments, and persisted through the periods of stasis that followed. Just as, more than a century ago, quantum theory proved that in physics, things sometimes moved forward in spurts, Gould intuited that this was also true for aspects of evolutionary biology.” — The Atlantic
Objectives

1. Describe a hybrid (telehealth and in-person) prenatal care schedule.
2. Review the evidential basis for hybrid, lower-frequency prenatal care.
3. Describe a regional response to obstetric surge planning, including strategies for ongoing assessment and communication.
Cheshire Medical Center DHH: Clinic (Ambulatory) Initial Response Goals

To maintain high standards of quality care.

To protect staff and patients by reducing in-person contact.

To grow and evolve by adopting new practices which further our mission even beyond the pandemic response.
Immediate Actions

• Postponement of elective surgery and procedures

• Schedule Sorting:
  • Urgent/Critical
  • Routine
  • Prenatal Care

• Implementation of telehealth, including telephone office visits, telehealth with video, and group activities (Centering Pregnancy, Childbirth Education)

DHH: https://med.dartmouth-hitchcock.org/connected-care.html
Redesigning Prenatal Care: Assessment

• Hospital L&D Closures: Patients (and providers) are burdened by travel, national data indicates PNC utilization will decrease.

• Patient Satisfaction: Good satisfaction with providers, poor satisfaction with process. Good satisfaction with Centering Pregnancy.

• Inconvenient Hours: Travel is increasingly a factor. Mitigation through evening Centering.

• Clinical Practice Guidance: The structure, schedule, and components of “best practice” prenatal care are not well defined.
Redesigning Prenatal Care: Ideas

• “Location-independent” care that happens where the patients are, not where the clinic/hospital is.

• Leveraging technology to increase access: Already use telemed for GDM, neonatology, MFM, and genetic counseling.

• Creation of a protective social presence in prenatal care. SUD and behavioral health problems are prevalent.

• Consideration of patient values: travel, convenience of hours, home dopplers, asynchronous communication.

• **Immediate need: Reduce visit frequency especially for low-risk patients.** Implement a hybrid, lower frequency model.
Published Prenatal Care Guidance: Ob NEST

• Study protocol published in 2015, single center RCT, results 12/2019 in AJOG.

• Test arm
  • Pregnant women, aged 18–36 years
  • 8 onsite appointments with an obstetric provider
  • 6 virtual visits consisting of phone or online communication with RN
  • Home monitoring with fetal Doppler and BP cuff
  • Access to an online community of pregnant women.

• Outcomes: no perceived difference in quality of care. Both control and test arms adhered to ACOG standards to PNC. Ob outcomes similar.
Published Prenatal Care Guidance: WHO

• “Antenatal Care for a Positive Pregnancy Experience.” High quality, comprehensive clinical practice guideline for prenatal care.

• Assessed methodological rigor and transparency of development via AGREE II instrument.

• Updated visit frequency, more aligned with ACOG/ common practice in USA.

• This provided the visit structure, overlaid with local best practice (genetic screening, SUD screening, behavioral health assessment, WHO Baby Friendly).

<table>
<thead>
<tr>
<th>WHO FANC model</th>
<th>2016 WHO ANC model</th>
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<tbody>
<tr>
<td><strong>First trimester</strong></td>
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<tr>
<td>Visit 1: 8-12 weeks</td>
<td>Contact 1: up to 12 weeks</td>
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<tr>
<td><strong>Second trimester</strong></td>
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<tr>
<td>Visit 2: 24-26 weeks</td>
<td>Contact 2: 20 weeks Contact 3: 26 weeks</td>
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<tr>
<td><strong>Third trimester</strong></td>
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<tr>
<td>Visit 3: 32 weeks</td>
<td>Contact 4: 30 weeks Contact 5: 34 weeks</td>
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<tr>
<td>Visit 4: 36-38 weeks</td>
<td>Contact 6: 36 weeks Contact 7: 38 weeks Contact 8: 40 weeks</td>
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<tr>
<td>Return for delivery at 41 weeks if not given birth.</td>
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Cheshire Medical Center DHH WHO CarePath

7 In Person Visits
- 10-12 weeks, 20 weeks, 26-28 weeks, 30-32 weeks, 36, 38, 40.

4 Telehealth Visits
- Intake <12 weeks, review 20 week ultrasound, 28 weeks, 34 weeks.

Lab visit 14-16 weeks if necessary
- For serum screen part 2, MSAFP, or quad

Rule-outs include HTN, multiples, insulin-requiring diabetics, hx IUFD or IUGR, immunosuppression, anticoag, HIV... many more, which can be found here: https://clinicaltrials.gov/ct2/show/NCT02082275

“Clinical judgement that determines that the pregnancy is at high risk for complications.”
Objectives

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2. Review the evidential basis for hybrid, lower-frequency prenatal care.

3. Describe a regional response to obstetric surge planning, including strategies for ongoing assessment and communication.
Cheshire Medical Center DHH: Regional Response Goals

To maintain high standards of quality care.

To coordinate information sharing and strategies for cohorting patients, providers, and staff across our region’s three community hospitals and one freestanding birth center.

To grow and evolve by adopting new practices which further our mission even beyond the pandemic response.
Regional Practice Landscape
Regional Strategic Planning

- Freestanding Birth Center: Cohorting well patients, information-sharing, policy alignment (visitors), status of staffing and PPE. Daily check-in.

- Community Hospitals: Cohorting well patients, “disaster” privileges for providers, nursing resources, PPE resources, downtime charting, diversion planning, information sharing, census and transfer information.

- Agreement in concept: We will maintain awareness of each others’ status. We will help each other out, and we clarified how to communicate a status change or ask for help.
The Daily/Weekly Checklist

- Patient Census
- Staff and Provider Status
- Any changes to:
  - Screening policy
  - Visitor policy
- Any Clinical Guidance Changes (Information Sharing)
- Review Transfers (Between Practices)
- Review Transfers (From Away)
Key Points

1. The Ob NEST RCT demonstrates feasibility and acceptability of a low frequency prenatal care model in a population of low risk, urban patients.

2. There is opportunity to test a similar model in rural Northern New England.

3. The WHO provides robust guidance for prenatal care, and includes a lower-frequency visit schedule.

4. Hospitals and clinics may wish to organize surge planning around geography, instead of organizational affiliation.
Appendix A: Cheshire Medical Center DHH WHO CarePath

- Intake < 12 Weeks: TELEPHONE/TELEHEALTH Visit with Prenatal Care Coordinator. Intake surveys, genetic counseling referral, early GDM screen, PN labs, obtain BP cuff & scale, order dating ultrasound.

- 10-12 Weeks: IN PERSON Visit with Provider. H&P, BP cuff calibration/teaching, draw labs, paperwork for genetic screening, immunizations, FHT or bedside ultrasound, serum screen only or NIPT part 1, order morphology ultrasound.

- 14-16 Weeks: LAB VISIT ONLY (if necessary for serum screen part 2, MSAFP, or quad) PHONE CALL to review results and check in.

- 20 Weeks: IN PERSON Morphology Ultrasound, PHONE CALL to review results and start Plan of Supportive Care, lab visit for integrated screening part 2, QUAD, MSAFP if NIPT.


- 26-28 Weeks: IN PERSON Visit with Provider. GTT same-day, T&S and RhoGam if indicated, repeat syphilis and HIV if indicated, sign tubal consent, sign VBAC consent, TDaP.

- 28 Weeks: TELEPHONE/TELEHEALTH Visit with Prenatal Care Coordinator, Preterm labor precautions, Breastfeeding education.

- 30-32 Weeks: IN PERSON Visit with Provider. Review birth plan, fundal height, schedule PRCS if indicated.

- 34 Weeks: PHONE VISIT with Provider. Postpartum planning, Breastfeeding and infant care education, Plan of Supportive Care, Review PTL precautions and kick counts.

- 36 Weeks: IN PERSON Visit with Provider. GBS, Fundal height, repeat HIV/GCCT for high risk, labor precautions.


- 40 Weeks: IN PERSON Visit with Provider. Schedule IOL or postdates testing.

