# *Outpatient Guidelines – Obstetric Services*

# *COVID19 Pandemic*

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**This document addresses obstetric outpatient medical guidelines during the current COVID19 global pandemic.**

*Mar 22, 2020, V3.0*

## 1. Objectives

- Reduce patient risk of COVID exposure in the healthcare setting.
- Reduce the public health burden of COVID transmission throughout the general population.
- Reduce obstetric provider and staff exposure to COVID in the outpatient setting.

## 2. Prenatal Visits

### Timing of Obstetric Visits

**Providers may increase or decrease timing of face-to-face antenatal visits and use of telehealth services as clinically indicated based on the patient's circumstances and comorbidities.*

- <u><9 weeks of gestation: New-to-Nurse (NTN) phone visit</u>
  - Schedule New OB visit, document "Phone visit" in Appointment Notes
    - Schedule face-to-face New OB visit if patient presents for care at >10 weeks EGA
  - Order 1st trimester ultrasound, to be performed beginning at 11w0d EGA******
  - Schedule Return OB visit (face-to-face) for 11-13 weeks gestation
  - Order Genetic Counseling consult, if patient is interested in aneuploidy screening
  - Assess for and encourage access to BP monitor for home monitoring; bring to clinic for validation at the time of face-to-face visit
- <u><10 weeks of gestation: New OB telehealth visit (phone or virtual)</u>
  - OB provider orders prenatal labs, referral for Genetic Counseling (if not already ordered)
- <u>11w0d – 13w6d of gestation: Face-to-face Return OB visit OR New OB visit if late to care</u>
  - Same-day dating/viability scan prior to OB visit
    - Anatomy scan scheduled while patient on site (ordered by US provider)
    - If an earlier viability/dating scan was clinically indicated, forgo repeat scan at 11w0d-13w6d
  - Prenatal labs including urine culture, Pap if needed
  - Carrier screening
  - Non-invasive prenatal screening (cell-free fetal DNA testing)
- <u>19-20 weeks of gestation: Face-to-face visit and anatomy ultrasound</u>
  - Anatomy ultrasound 19w0d-20w6d (ordered by MFM provider reading viability/dating scan at 11-13 weeks)
  - Cervical length (CL) screening – q2 weeks starting at 16-19 weeks at discretion of MFM and/or primary OB provider
    - Consider stopping CL screening after anatomy US if cervix >= 35 mm and prior preterm birth > 34 weeks
    - Consider spacing CL interval to Q3 weeks if cervix normal (MFM discretion)
- <u>28 and 32 weeks of gestation: face-to-face visits</u>
  - To coincide with ultrasound/antenatal testing as indicated
  - 28 weeks: glucola, labs, vaccines, RhoGam if indicated
- <u>36+ weeks</u>
  - Weekly face-to-face visits until delivery, in conjunction with ultrasound/antenatal testing as indicated.
    - Consider one face-to-face visit at 36 weeks and at 39-40 weeks for low-risk patients who own a validated at-home blood pressure monitor.
    - Routine labs (GBS, GC/CT) as indicated.

- 4-week Postpartum telehealth visit
    - In-person face-to-face visit as needed if patient desires LARC or has an acute issue.
    - Discontinue routine incision checks and perineal checks in asymptomatic patients.
    - Discontinue face-to-face mood and blood pressure check visits (for patients with access to BP monitor).

**If bleeding, pain, at risk for ectopic pregnancy, or *high-risk condition (e.g., elevated first-trimester Hgb A1c))* nurse or provider may order remote-read ultrasound prior to 11w0d by LMP.

**Table 1. Summary of antenatal visit timing in light of COVID19 pandemic.***

| Gestational Age | In person OB visit | Ultrasound | Comments |
|---|---|---|---|
| <11 weeks[1] | | | 1. Telephone OB RN intake<br>2. Telehealth NOB visit with provider re: weight, nutrition, aneuploidy options, etc. |
| 11-13 weeks | X | X (Dating/Viability) | Initial OB labs. Anatomy US ordered. |
| 20 weeks | x | X (Anatomy) | |
| 28 weeks | x | | Labs/Vaccines/RhoGam |
| 32 weeks | x | X (if indicated) | |
| 36 weeks | x | X (if indicated) | GBS/STD screen |
| 37 weeks – delivery | x | | Weekly |
| Postpartum | | | May be face-to-face as needed |

[1]*Earlier scan may be indicated if at risk (pain, bleeding, history of ectopic, high-risk condition (e.g., elevated first-trimester Hgb A1c)).*

## *Telehealth Encounters*

*Every obstetric patient must be enrolled in MyChart and Telehealth services when feasible for patient.*

### Maternal-Fetal Medicine (MFM) Consultation/Co-management Visits

- Many MFM consultations (for example - preconception counseling, prior preterm birth history, chronic hypertension, etc.) can be done via telemedicine.
- In-person consultation scheduling must be reviewed with a designated physician prior to scheduling by the PAC.
- Any follow-up consultation/co-management visit for a pregnant patient seen in the office by another provider in the past 4 weeks should be converted to Telehealth, especially when not in conjunction with an ultrasound.

### Other Visits that Are Appropriate for Telehealth Encounters

- Genetic Counseling
- Nutrition consultation
- Perinatal psychiatry
- Discussion of abnormal ultrasound findings
- Trial of labor after cesarean (TOLAC) consultations
- Diabetes care

- Mastitis
- Cesarean wound checks (MyChart photo; virtual e-visit when video available)

## 3. Antenatal Testing

### OB Ultrasounds

**Providers may increase or decrease timing of ultrasound visits, as clinically indicated, based on the patient's circumstances and maternal/fetal comorbidities.*

- Dating/viability ultrasound will occur at 11w0d-13w6d of gestation in conjunction with first face-to-face visit in clinic.
- Cervical length (CL) screening will occur Q2 weeks starting at 16-19 weeks at discretion of MFM and/or primary OB provider
    - Consider stopping CL screening after anatomy US if cervix >= 35 mm and prior preterm birth > 34 weeks
    - Consider spacing interval to Q3 weeks if CL is normal (MFM discretion)
- Anatomy ultrasounds will occur at 19w0d-20w6d (ordered by MFM provider reading viability/dating scan).
    - Earlier ultrasounds may be scheduled for cervical length screening, as clinically indicated
    - Schedule follow-up anatomical scans in 6 weeks rather than 3-4 weeks.
    - Forgo follow-up ultrasound for one or two suboptimal views in an otherwise low-risk patient (e.g., L/S spine not seen well due to fetal position, but posterior fossa normal).
- Fetal ECHO scans will occur at 24w0d-24w6d according to AIUM (American Institute of Ultrasound in Medicine) guidelines.
- Initiate growth ultrasounds for medical indications at 32 weeks of gestation, unless clinically indicated sooner (e.g., history of early-onset fetal growth restriction).
    - Schedule serial growth ultrasounds Q6 weeks rather than Q3-4 weeks based on clinical judgment and comorbidities.
- Follow-up placenta previa/low-lying placenta ultrasounds at 34-36 weeks of gestation.
    - Consider earlier follow-up ultrasounds in the setting of concern for placenta accreta spectrum, previa with bleeding/contractions, or need to aid in timing of delivery.

**Table 2. Outline of indications for outpatient follow-up ultrasounds and frequency/timing in light of COVID19 pandemic.**

| Diagnosis | Initiation | | | | Frequency |
|---|---|---|---|---|---|
| | 24 weeks | 28 weeks | 32 weeks | 36 weeks | |
| Pre-gestational diabetes | | | X | | Q4 weeks |
| Chronic HTN | | | | | |
| Not on meds | | | X | | Once |
| On meds-controlled | | | X | | Q6 weeks |
| On meds-poorly controlled | | X | | | Q4 weeks |
| Preeclampsia/gestational HTN | | | | | Initiate at diagnosis – Q4 weeks |
| History of FGR/SGA | | | X | | Or at time of previous diagnosis – Q4-6 weeks |
| Current FGR | | | | | Initiate at diagnosis – Q4 weeks |
| Without abnormal UAD | | | | | Q4 weeks |
| With abnormal UAD[1] | | | | | Individualize |

| | | | | | |
|---|---|---|---|---|---|
| Sickle cell disease | | | X | | Once |
| Chronic kidney/End-stage renal disease | | | X | | Q4-6 weeks |
| Multiples | | | | | |
| Di/Di | X | | | | Q4 weeks |
| Mono/Di | | | | | Q2 weeks TTTS surveillance 16-32 weeks |
| Mo/Mo | X | | | | Q4 weeks |
| A2 GDM | | | X | | Q4-6 weeks |
| Lupus, no end-organ dysfunction | | | X | | Once |
| Lupus, end-organ dysfunction | | | X | | Q4 weeks |
| Prior unexplained 3rd trimester fetal demise | | | X | | Once |
| Organ transplant | | | X | | Once |
| Maternal cardiac disease | | | X | | Q4 weeks |
| Thyroid disease, uncontrolled | | | X | | Q4 weeks |
| Current tobacco/substance use | | | X | | Once |
| AMA (>=40) | | | | X | Once |
| Placenta previa | | | | | Once at 34-36 weeks |
| Large uterine fibroids | | | X | | Once |
| Decreased fetal movement | | | | | Once at time of patient report |
| Fetal anomaly | | | | | Individualize |
| HIV | | | X | | Once |
| Alloimmunization | | | | | Individualize |
| BMI>=40 | | | X | | Q6 weeks |

[1]Elevated (>95%), absent, or reverse

HTN, hypertension; FGR, fetal growth restriction; SGA, small for gestational age; UAD, umbilical artery Dopplers; GDM, gestational diabetes mellitus; AMA, advanced maternal age; HIV, human immunodeficiency virus; BMI, body mass index.

## *Non-Stress Tests (NST) and Biophysical Profiles (BPP)*

**Providers may increase or decrease timing of antenatal testing (NST/BPP), as clinically indicated, based on the patient's circumstances and maternal/fetal comorbidities.*

- Reserve twice-weekly antenatal testing (BPP and/or NST) for fetal growth restriction with abnormal umbilical artery Dopplers (S/D >95th percentile, absent end diastolic flow).
- Limit amount of antenatal testing in lower risk patients (e.g., AMA>=40).
- Limit antenatal testing to once weekly in patients with gestational hypertension/preeclampsia, in conjunction with face-to-face blood pressure check, lab work, and prenatal visit.

**Table 3. Outline of indications for outpatient antenatal testing and frequency/timing in light of COVID19 pandemic.**

| Diagnosis | Initiation | | Frequency |
|---|---|---|---|
| | 32 weeks | 36 weeks | |
| Pre-gestational diabetes | X | | Weekly, unless suspected macrosomia or polyhydramnios |
| Chronic HTN | | | Weekly |
| Not on meds | | X | |

| | | | |
|---|---|---|---|
| On meds-controlled | | X | Weekly |
| On meds-poorly controlled | X | | Weekly |
| Preeclampsia/gestational HTN | | | Initiate at diagnosis – Weekly |
| FGR | | | |
| Without abnormal UAD | | | Kick counts only |
| With abnormal UAD[1] | | | Initiate at diagnosis – Weekly |
| Sickle cell disease, well controlled | | | Kick counts only |
| Sickle cell disease, end-organ dysfunction or active | X | | Weekly |
| Chronic kidney/End-stage renal disease | X | | Weekly |
| Multiples | | | |
| Di/Di | | | Weekly only if other risk factors |
| Mono/Di | X | | Weekly (BPP) |
| A2 GDM | X | | Weekly, unless suspected macrosomia or polyhydramnios |
| Lupus, no end-organ dysfunction | | | Kick counts only |
| Lupus, end-organ dysfunction or active disease | X | | Weekly |
| Organ transplant | | X | Weekly |
| Maternal cardiac disease | X | | Weekly |
| Thyroid disease, uncontrolled | X | | Weekly |
| AMA (>=40) | | | Kick counts only |
| Decreased fetal movement | | | Once (BPP) |
| Fetal anomaly | X | | Weekly |
| Alloimmunization | X | | Weekly |
| BMI>=40 | | X | Kick counts only, unless suspected macrosomia |

[1]Elevated (>95%), absent, or reverse. HTN, hypertension; FGR, fetal growth restriction; SGA, small for gestational age; UAD, umbilical artery Dopplers; GDM, gestational diabetes mellitus; AMA, advanced maternal age; HIV, human immunodeficiency virus; BMI, body mass index.

## *4. Telephone Triage Guidelines*

Below is an overview of nursing phone triage concerns that may prompt an in-person visit:

- Severe nausea/vomiting
- Abdominal pain/contractions
- Vaginal bleeding
- Leakage of fluid
- Decreased fetal movement (>28-32 weeks)
- Headache unrelieved by acetaminophen
- Right upper quadrant abdominal pain
- Visual disturbances