DEPARTMENT OF HEALTH

MPO Minnesota Perinatal ORGANIZATION

COVID-19 Town Hall

MN PQC MN Perinatal Quality Collaborative

MN Hospital Surge Planning Resource

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MN Hospital Perinatal Surge Planning

- Disaster Planning for OB Services (Stanford)

What is needed:

To accomplish a comprehensive obstetric disaster plan, there must be:
1) National adoption of a common triage and evacuation language including an effective patient tracking system to avoid maternal–neonatal separation
2) Stratification of maternity hospital levels of care
3) A collaborative network of obstetric hospitals, both regionally and nationally

Source: https://obgyn.stanford.edu/divisions/mfm/disaster-planning.html

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- Minnesota work to date:
  - A coalition of MN Health Systems organized by Dr. Lisa Saul to discuss best practices for COVID. Work subsequently supported by MN PQC.
  - Statewide NICU Resource meeting 4/14/20 facilitated by Chris Chell, Regional Healthcare Preparedness Coordinator from HCMC.
    - Topics: Will the metro have an increase in transfer of COVID+/PUI moms/babies? Bed monitoring capability? Will there be a system for notification of reduced capacity? Who owns it? Who is notified and what occurs?
  - Follow up discussion by coalition 4/21/20.

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Content removed due to confidentiality.
If you are a perinatal healthcare or allied professional, email MNPQC at info@minnesotaperinatal.org for a contact list of Minnesota hospitals with OB/L&D services to assist with COVID-19 surge planning/patient transfers.

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“Pertinent Negatives” (to date)

- MN TRAC
  - MN DHS
  - https://www.health.state.mn.us/communities/ep/coalitions/mntrac.pdf

- Minnesota Mental Health Access website
  - MHA + MN DHS
  - https://www.mnmhaccess.com/

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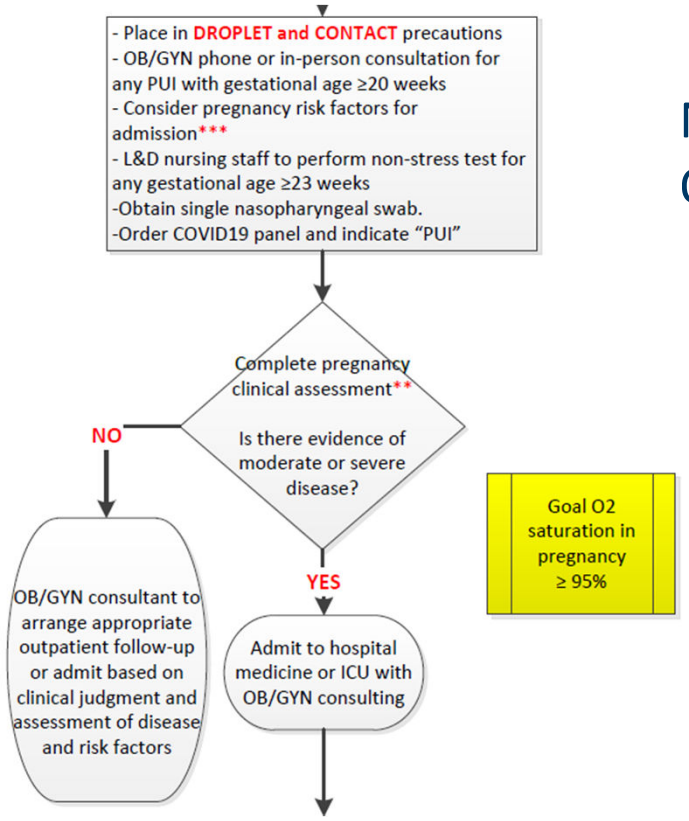

North Memorial OB COVID mgmt

****Pregnancy Clinical Assessment**

Any ONE of the following in a COVID PUI indicates at least moderate disease

- Requiring any supplemental O2 to maintain saturation ≥95% at rest or with ambulation
- RR ≥30 breaths/minute
- Chest XR with pneumonia or infiltrates involving >50% of lungs
- Abnormal ABG (for gestational age)****
- Temperature ≥39.0 despite antipyretics

*****Pregnancy Risk Factors to consider admission for a PUI**

- Uncontrolled hypertension (gestational or chronic)
- Inadequately controlled diabetes (gestational or chronic)
- Chronic renal or cardiopulmonary disease
- Immunosuppressed state (intrinsic or due to medication)

 Reference: https://s3.amazonaws.com/cdn.smfm.org/media/2336/SMFM_COVID_Management_of_COVID_pos_preg_patients_4-30-20_final.pdf

MN Hospital Perinatal Surge Planning

North Memorial Health

Newborn Discharge Guideline

Prompt Normal Newborn Discharge Guidelines

Assumption: Given the likelihood of community spread of COVID-19 and hospital resources, it is recommended that prompt newborn discharge is supported, provided the following criteria are met:

Criteria for prompt discharge—24 hours of life or older

1. Voiding and stooling confirmed.
2. Adequately feeding. For first time mom, latch score is >7 or bottle feeding/supplementation as per guideline.
3. Normoglycemia per algorithm.
4. Car seat evaluation completed. Suggested that this occur a few hours prior to 24 hours of life.
5. Newborn screen/CCHD completed—no change in requirement of 24 hours of age.
6. Discharge should not be delayed by a circumcision. In newborns who have met criteria #1 and #2, circumcision could be done as early as 18 hours as provider comfort allows.
7. Primary Care Provider or home care follow up is ensured.

Disqualifiers for early discharge (not comprehensive)

1. Newborns of mothers being ruled out or treated for chorioamnionitis.
2. Neonatal abstinence syndrome newborns.
3. Newborns inadequately treated for Group B Strep.
   a. Appropriate antibiotics not given within four hours of initiation or two doses completed as per care pathway.
4. Hyperbilirubinemia that precludes discharge as per current care pathway.
5. Child protective services/social work care plan not completed.

COVID-19+/PUI Couplets Discharge Guidelines

Assumption: Prompt discharge is acceptable if above criteria is met, with the following additions:

1. Ensure there is a healthy caregiver at home. Arrange for two droplet masks to be supplied at discharge for mom or caregiver.
2. Discharge with hand-off to PCP ensured.

Additional important points to communicate

- Breast milk—either expressed or at the breast—is still the best choice, even with COVID-19 + mom.
- MD to MD hand-off to PCP is especially important given current COVID-19 pandemic pressures on the health care system.
- Education for discharge should include how to care for your newborn if exposure is in question (no known vertical transmission).
- Social work planning is important to begin at the time of admission to Labor & Delivery to ensure adequate time for care planning.

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- Discharge at <24 hours?
  - MDH Guidance on newborn screening:

Newborn Screening and COVID-19

The life-saving work of newborn screening continues during the COVID-19 outbreak. All obligations, laws, and MDH policies regarding collection of screening samples and completing hearing & CCHD screenings remain in place. Bloodspot collection and shipping to MDH should continue as per protocol. Hearing and heart screening and reporting to MDH should continue as per protocol.

- All screenings should be done before discharge. If baby is discharged prior to 24 hours an additional bloodspot screen needs to be collected in clinic during the first week of life.
- Notification of abnormal lab or hearing refer results to primary physician/clinic by MDH staff will continue. When consultation with a specialist is advised, the primary physician should discuss with the specialist the best way to evaluate the baby given the community prevalence of COVID-19. Recommendations by MDH for seeking consultation and follow-up remain in place.
- MDH will continue to request:
  - Recollection of unsatisfactory specimens
  - Repeat screening after borderline bloodspot results