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16 Mar 2020

Colleagues:

We have been receiving a number of questions, both from patients and providers, regarding the current Covid-19 outbreak. Fortunately, based on the **very** limited available evidence, this virus does not appear to affect pregnant women more severely than the general population. As we're sure you are aware, individuals over the age of 60 or those who are immunocompromised or have other serious health problems are the most likely to be severely affected.

After much thought, reviewing guidelines, and discussions with colleagues across the country, we plan to make changes to our clinic scheduling/flow to decrease the chance of transmission among patients, office staff, and ourselves.

Here are the changes we are making in our clinic – please modify them to meet the needs of your office:

- Pre-screen all patients visiting your clinic according to your institution's protocol. We have attached the ACOG/SMFM algorithm to this letter. Any positive screen should at least wear a mask, if not be rescheduled and/or tested prior to being seen.
- Cancel or reschedule any visit that can safely be postponed or canceled. See below for a list of necessary OB visits and consider canceling or postponing others.
- If feasible, consider using video conferencing, email, text message, and telephone to confer with patients regarding any conditions that do not require them to be physically present. Home BP cuffs and similar technologies may also be used to avoid some clinic visits.
- Many prescriptions (especially refills) can be safely called in without the patient coming to clinic. Most pharmacies are now accepting e-prescriptions even for controlled substances with appropriate two-factor authentication.
- Limit the number of visitors allowed to one visitor over the age of 18. Some offices nationwide are not allowing any visitors at all.
- Limit the number of patients in the waiting room. Our goal is zero to one patient (plus one visitor) waiting. Strategies to achieve this could include spacing out visits, utilizing unused clinic rooms for waiting patients, or having the patient call the office when they arrive but wait in their car until you are ready for them.
- Limit the number of office staff seeing an individual patient – ie the secretary checking the patient in should also check her out, and the MA checking vital signs should perform all necessary MA-level tasks until the patient leaves the clinic rather than handing a task off to another staff member of the same level of training.
- Avoid the use of paper charts or other fomites
- Completely wipe down any equipment in between each patient visit. Of note, we have also decided to remove all wipes and non-mounted bottles of hand sanitizer from our clinic rooms to decrease theft as missing supplies have been reported in many locations.

Evidence-based schedule for prenatal care

Most pregnant women end up seeing their provider at least 12+ times; however, the true number of *necessary* prenatal visits is likely fewer:

- 6-8 wk – Intake, education, labs, PNV (consider doing via phone/video conferencing)
- 10-12 wk – Physical, pap smear, fetal heart tones (FHT), offer genetic screening
- ~20 wk – fetal anatomic survey, weight, BP check, fundal height, FHT. Of note, an ultrasound in our office could likely be substituted for the 20-wk prenatal visit if that would be helpful to you.
- 24 wk – weight, BP check, fundal height, FHT
- 28 wk – weight, BP check, fundal height, FHT, glucola, Rhogam, TDAP, discuss fetal kick counts
- 32 wk – weight, BP check, fundal height, FHT, review fetal kick counts
- 36 wk – weight, BP check, fundal height, FHT, review fetal kick counts, GBS, labor precautions
- 38 wk and weekly thereafter – weight, BP check, fundal height, FHT, review fetal kick counts, labor precautions
- Postpartum examination – possibly postpone/skip in healthy women.

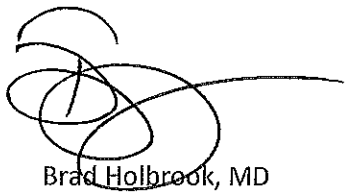
This is not meant to be an exhaustive or all-inclusive list of necessary changes, but is a list of the potential issues we have identified. We will be implementing these immediately in our practice; thus, we may schedule followup appointments differently from our routine. Please don't hesitate to contact either of us with questions regarding any of the above.

From an inpatient standpoint, limiting visitors is the most applicable of the above list. Additionally, we have a responsibility to ensure all resources are available to the critically ill. Thus, canceling elective surgeries would be appropriate. There have been some discussions about early inductions of labor now (ie at 37 wk) to ensure hospital beds are available over the next few weeks; our opinion is that even slightly early deliveries have a higher chance of NICU admission and thus could tax resources more than awaiting spontaneous labor. We still continue to support induction of labor any time after 39 wk and recommend it in everyone after 41 wk.

Our hope is that this information is helpful in keeping you, your office staff, and patients healthy, while also ensuring resources are available to those who unfortunately become infected by the Covid-19 virus. (We understand that some of these recommended changes may result in fewer office visits and/or RVUs but feel that these recommendations are important for the overall health of the community.)

Thank you for all of your work and efforts through these trying times. As always, please don't hesitate to contact us with questions or if we can be of assistance in any other way.

Best,



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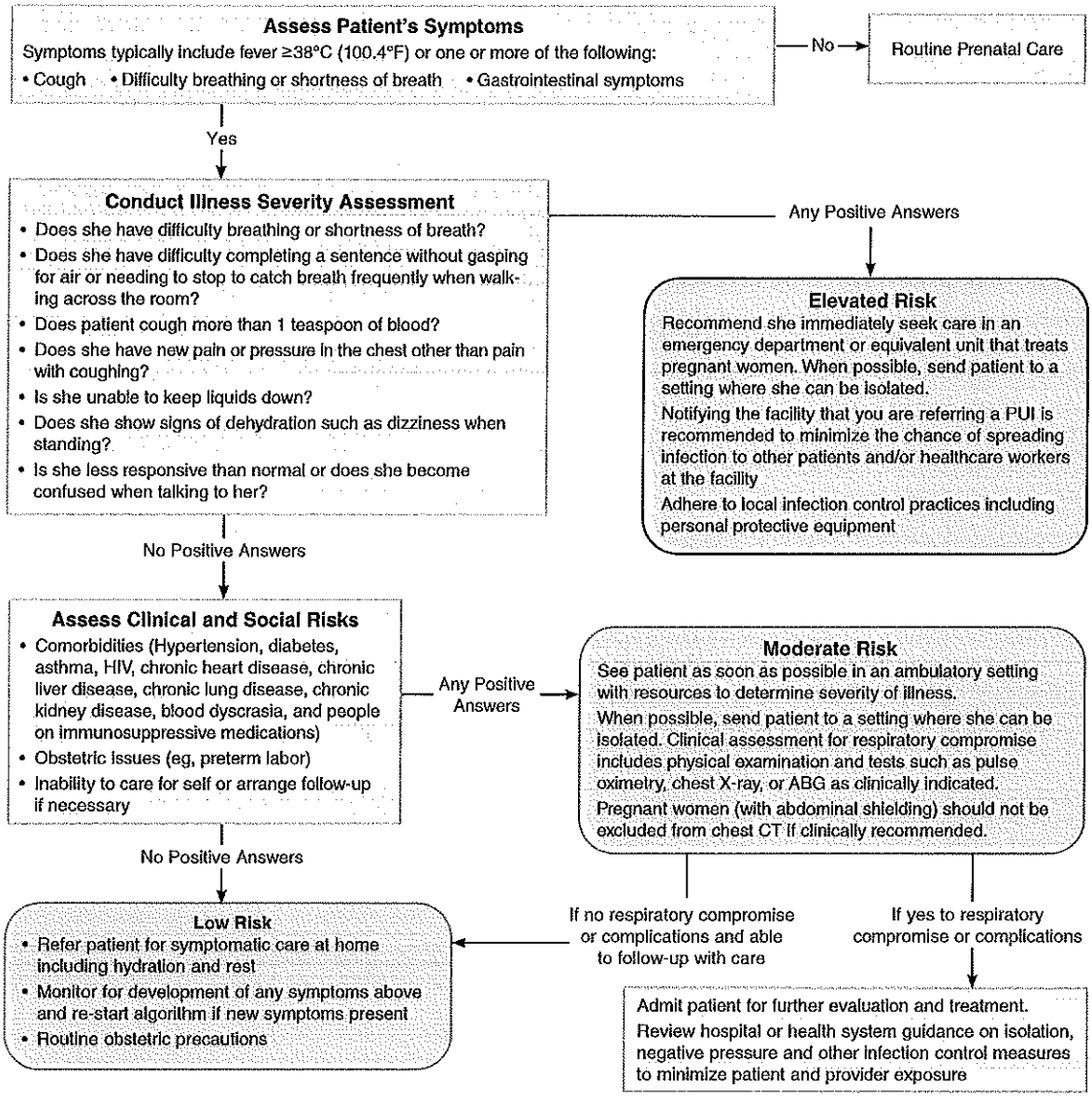
Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)

Unlike influenza and other respiratory illnesses, based on a limited number of confirmed COVID-19 cases, pregnant women do not appear to be at increased risk for severe disease. However, given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted.

This algorithm is designed to aid practitioners in promptly evaluating and treating pregnant persons with known exposure and/or those with symptoms consistent with COVID-19 (persons under investigation [PUI]). If influenza viruses are still circulating, influenza may be a cause of respiratory symptoms and practitioners are encouraged to use the ACOG/SMFM influenza algorithm to assess need for influenza treatment or prophylaxis.

Please be advised that COVID-19 is a rapidly evolving situation and this guidance may become out-of-date as new information on COVID-19 in pregnant women becomes available from the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/coronavirus/2019-nCoV/index.html



Abbreviations: ABG, arterial blood gases; CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus.

Healthcare providers should immediately notify their local or state health department in the event of a PUI for COVID-19 and should contact and consult with their local and/or state health department for recommendations on testing PUIs for COVID-19.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

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