Interim schedule for pregnant women and children during the COVID-19 pandemic

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The World Health Organization declared coronavirus disease 2019 (COVID-19) a global pandemic. Pregnant women, newborns, and children due for vaccinations still require care during the pandemic. Given that there is a need to reduce the number of visits to the clinic, and women and children and their caregivers might wish to reduce exposure to others, the timing and frequency of visits can be adjusted. Many health care providers are transitioning to virtual visits instead of in-person visits whenever possible. The goal of this guide is to propose an interim well-child and prenatal visit schedule that providers can use and adapt to their local settings.

Ideally, patients with symptoms of suspected COVID-19 or with exposures (travel or contact with someone who tested positive) should be separated from the rest of the practice or treated at a separate time and by a separate team.[1] At St Michael's Hospital Family Health Team in Toronto, Ont, we have designated protected time slots for our more vulnerable patients, including pregnant women, newborns, and children due for vaccinations. Another goal is to schedule in-person prenatal visits to coincide with ultrasounds and other investigations to reduce the number of visits to the hospital or outpatient office.

If well-child visits are converted to virtual appointments, questionnaires such as the Rourke Baby Record[2] and Nipissing District Developmental Screen[3] can be e-mailed to parents before the appointment. Patients should be called before attending all appointments to screen for COVID-19 symptoms or risk factors and screened once again on presenting to the hospital or clinic. Patients and families also need to be made aware of the hospital and clinic policies on visitors and support persons during the COVID-19 pandemic. The interim schedules provided in this article are suggestions that can be tailored to local needs and resources (**Figures 1** and **2**). The guidance on COVID-19 is rapidly changing; therefore, providers need to stay up to date on new information and provincial and hospital policies.

Well-child visits

Many health care providers in Canada follow the Rourke Baby Record for well-child visits.[2] During the COVID-19 pandemic, if resources allow and visits can be done safely (eg, adequate screening and physical distancing in waiting rooms), well-child visits that incorporate immunizations should be continued.[4-6] For all other well-child visits, providers can convert to virtual appointments (ie, telephone or video) or postpone the visit if there are no parental concerns.

Low-risk prenatal visits

For low-risk pregnancies, it is acceptable to adjust the routine prenatal visit schedule to align with the 2016 World Health Organization antenatal care model,[7] the Society of Obstetricians and Gynaecologists of Canada COVID-19 guideline,[8] Nova Scotia Interim Guidance,[9] and *American Journal of Obstetrics and Gynecology* maternal-fetal medicine guidance for COVID-19.[10] Ideally, in-person prenatal visits should coincide with ultrasounds and other investigations to reduce the number of visits to the hospital or clinic. For visits after 24 weeks' gestational age, perception of fetal movements can be used as a surrogate for fetal viability in lieu of a Doppler fetal monitor (ie, doptone). Instead of blood pressure measurement, providers can review with patients the clinical signs and symptoms of preeclampsia. If needed, providers can instruct patients to purchase a blood pressure monitor or to measure blood pressure at a local pharmacy. Maternal weight can be self-reported. Postpartum visits can also be done virtually.

At each visit, a responsible care provider must assess each woman to determine whether she is a candidate for an adjusted prenatal visit schedule as well as virtual care.[11]

Dr Bogler is a staff family physician and Chair of the Family Practice Obstetrics Group at St Michael's Hospital in Toronto, Ont. **Ms Bogler** is a fourth-year medical student at the University of Toronto who was taken off clinical duties owing to the COVID-19 pandemic.

Acknowledgment

We acknowledge the help of other members of the Family Medicine Obstetrics Group at St Michael's Hospital and members of the Obstetrics Department at St Michael's Hospital, including **Drs Filomena Meffe, Howard Berger,** and **Eliane Shore,** and members of the Pediatrics Department at St Michael's Hospital, including **Drs Tony Barozzino** and **Douglas Campbell**. We also acknowledge the suggestions provided by members of the Family Medicine Obstetrics Group at North York General Hospital, including **Drs Lara Rosenberg** and **David Eisen,** and suggestions from **Dr Allan Grill**, Chief of Family Medicine at Markham Stouffville Hospital.

Competing interests

None declared

Figure 1

INTERIM SCHEDULE FOR CHILDREN AND PREGNANT WOMEN DURING THE COVID-19 PANDEMIC

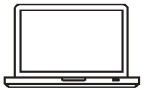
PROPOSED SCHEDULE FOR WELL-CHILD VISITS[1]

Newborn 0–2 weeks

- **In-person** for weight/jaundice/feeding issues[2]

1 month

- **VIRTUAL** (can be converted to in-person if concerns)[3]
  - Ask parents to check baby's weight at home if possible [(parent's weight with baby) – (parent's weight without baby) = rough estimate of baby's weight].
  - Can also be reassured by parents subjective report of weight gain/outgrowing diaper size and sleepers.



2, 4, 6 months

- **In-person** for vaccines[4]

→ **9 month**

- **VIRTUAL** visit[5]

12, 15 months

- **In-person** for vaccines[6,7]

→ **18 month**

- **In-person** for developmental assessment and vaccine (could consider virtual)[8]

4–6 year

- Consider **postponing**

NOTE: At each visit, a responsible care provider must assess each child to determine whether the child is a candidate for an adjusted well-child visit schedule as well as virtual care

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FOOTNOTES

PROPOSED SCHEDULE FOR WELL-CHILD VISITS

1. If well-child visits are converted to virtual appointments, questionnaires such as the Rourke Baby Record and Nipissing District Developmental Screen can be emailed to parents prior to the appointment.
2. The neonatal period is a critical time to assess weight, feeding issues, and jaundice and therefore should be an in-person assessment.
3. The 1-month visit does not require immunizations and therefore can be converted to a virtual visit.
4. If possible, an in-person assessment with vaccinations should take place. Delaying vaccines puts children at risk for common and serious childhood infections. Therefore, we recommend continuing vaccines during COVID-19, in accordance with the Canadian Paediatric Society (CPS) COVID-19 guidelines. Although risk of transmission in clinic is low with adequate screening and infection control, providers still need to engage in shared-decision making with parents in order to balance the relative risks. Need to consider:
    i. Risk of exposure with travel to the clinic (many patients might not have a private vehicle)
    ii. Clinical screening processes are not foolproof as they are often based on self-report
    iii. Health care providers (HCPs) might expose patients (although this might be improved with mandated masks for HCPs during clinical encounters, which is now in effect in many hospitals and has been recommended for outpatient community family practice offices) (5)
5. The 9-month visit according to the Rourke schedule is optional and does not require immunizations and therefore should be converted to a virtual visit.
6. If possible, the 12-month visit should be an in-person assessment with vaccinations as this visit incorporates the measles, mumps, and rubella vaccine and is an important vaccination given recent outbreaks of measles (6).
7. If possible, the 15-month visit should be an in-person assessment with vaccinations, as this visit incorporates the varicella vaccine.
8. The 18-month visit can be in-person or virtual. The virtual visit would be a surrogate for an in-person developmental assessment. Developmental questionnaires can be sent to parents prior to the appointment. Although the 18-month vaccine is a booster, it should still be given as close to its routine schedule as possible.

Figure 2

INTERIM SCHEDULE FOR CHILDREN AND PREGNANT WOMEN DURING THE COVID-19 PANDEMIC

PROPOSED SCHEDULE FOR LOW-RISK PRENATAL VISITS

11 – 13 week	• Initial prenatal visit in clinic	• Combined dating/NT scan[1] • Full history and risk assessment • Laboratory tests (including genetic screening) as needed
16 week	• **Virtual visit**	• Discuss screening and laboratory results • Initiate iron supplementation if needed • Book anatomy scan for next visit
20 week	• Prenatal visit in clinic	• Full anatomical scan • Give requisition for glucose challenge test and CBC, Ferritin and G&S (if RH negative) ○ G&S often needs to be done at lab no more than 4 weeks prior to administration of WinRho
26 – 28 week	• Prenatal visit in clinic	• Coincide with T2 bloodwork[2] • If Rh negative, organize WinRho
30 week	• **Virtual visit** (as per AJOG MFM guideline)	• Consider virtual visit if appropriate • If virtual: Review fetal movements and clinical signs of preterm labour and preeclampsia; patient to self-report BP (if accessible at home/pharmacy) and weight; consider self-symphysis fundal height[3] • Book BPP/growth u/s for 2 weeks (if indicated) • ADACEL

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FOOTNOTES

PROPOSED SCHEDULE FOR LOW-RISK PRENATAL VISITS

1. Can combine dating/NT to one ultrasound. There is a potential risk of being outside the window period for measuring NT if inaccurate dating by 'Last Normal Menstrual Period.' Earlier ultrasounds might also be needed for threatened abortion or if risk factors for an ectopic pregnancy etc. If completing initial prenatal blood work and a dating ultrasound prior to the first prenatal visit, this can be organized virtually over the telephone.
2. For GCT, write on the requisition to allow the patient to wait in a car or in a private room in the clinic. If there are significant disruptions to lab testing and treatment due to COVID-19 and/or patient refusal, please review the temporary alternative screening strategy for gestational diabetes at your institution (i.e. A1c & non-fasting, random plasma glucose as per SOGC April 2020) (11).
3. Can consider instructing patient on self-symphysis fundal height (SFH) measurement:
   a. youtube video: https://www.youtube.com/watch?v=LLse4MV0J4M
4. If the 36-week visit is not in person, consider coordinating with the lab for the patient to drop off a GBS self-swab if possible.
   a. Instructions to provide patient:
      https://www.cdc.gov/groupbstrep/downloads/gbs_swab_sheet21.pdf

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