



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

PROPOSED SCHEDULE FOR WELL-CHILD VISITS¹

Newborn
0-2 weeks

- **In-person** for weight/jaundice/feeding issues²

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 vaccines⁴



9 month

- **VIRTUAL** visit⁵

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



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

PROPOSED SCHEDULE FOR LOW-RISK PRENATAL VISITS

- Pregnant women still require antenatal visits. Given that there is a need to reduce number of visits and women themselves might wish to reduce exposure to others, the timing and frequency of prenatal visits can be adjusted. Ideally, in-person prenatal visits would coincide with ultrasounds and/or blood work.
- Prior to attending appointment, patients should be called to screen for COVID-19. If patient is at-risk for COVID-19, please see separate hospital policy on how to proceed.
- For **low-risk pregnancies**, it is acceptable to adjust the prenatal visit to align with the WHO Antenatal Care Model (2016), SOGC COVID-19 guidelines, Interim Nova Scotia Guidelines, and American Journal of Obstetrics and Gynecology MFM Guidance for COVID-19.
- In lieu of dopplers, perception of fetal movements >24 weeks can be used as a surrogate for fetal viability when appropriate.
- For BP: review clinical signs/symptoms of preeclampsia. If needed, instruct patient to measure BP at local pharmacy/home. Maternal weight will be self-reported.
- Post-partum visits can 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 – 13
week

- Initial prenatal visit in clinic

- Combined dating/NT scan¹
- 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 bloodwork²
- If Rh negative, organize WinRho

30 week

- **Virtual visit** (as per ACOG 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 height³
- Book BPP/growth u/s for 2 weeks (if indicated)
- ADACEL

32 week

- Prenatal visit in clinic

- Routine prenatal care
- BPP/growth u/s same day if indicated
- Adacel, if not given

34 week

- **Virtual visit** (as per ACOG 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 height³

36 week

- Prenatal visit in clinic

- Routine prenatal care
- GBS swab⁴

37-38 week

- In-person OR **virtual visit**

- If virtual visit necessary: Review fetal movements and clinical signs of labour and preeclampsia; patient to self-report BP (if accessible at home/pharmacy) and weight
- Instruction regarding GBS management in labour

39-41 week

- Prenatal visit in clinic

- Routine prenatal care
- Stretch and sweep
- US as indicated

FOOTNOTES & REFERENCES

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.

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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