Impact of COVID-19

Obstetric Implications

Carey Eppes MD MPH
Baylor College of Medicine
Chief of Obstetrics, Ben Taub Hospital
TCHMB Chair and TexasAIM Medical Director

Objectives

- Review obstetric considerations related to COVID-19
- Gain insights related to lessons learned during the pandemic that can be used for future infectious disease events

Detection of COVID-19 for Pregnant women

Detection of COVID-19 for Pregnant women

Original Research

Coronavirus disease 2019 infection among asymptomatic and symptomatic pregnant women: two weeks of confirmed presentations to an affiliated pair of New York City hospitals

Check for updates

Noelle Breslin, MD; Caitlin Baptiste, MD; Cynthia Gyamfi-Bannerman, MD, MPH; Russell Miller, MD; Rebecca Martinez, MD; Kyra Bernstein, MD; Laurence Ring, MD; Ruth Landau, MD; Stephanie Purisch, MD; Alexander M. Friedman, MD, MPH; Karin Fuchs, MD; Desmond Sutton, MD; Maria Andrikopoulou, MD; Devon Rupley, MD; Jean-Ju Sheen, MD; Janice Aubey, MD; Noelia Zork, MD; Leslie Moroz, MD; Mirella Mourad, MD; Ronald Wapner, MD; Lynn L. Simpson, MD; Mary E. D'Alton, MD; Dena Goffman, MD

Novel coronavirus disease 2019 is rapidly spreading throughout the New York metropolitan area since its first reported case on March 1, 2020. The state is now the epicenter of coronavirus disease 2019 outbreak in the United States, with 84,735 cases reported as of April 2, 2020. We previously presented an early case series with 7 coronavirus disease 2019—positive pregnant patients, 2 of whom were diagnosed with coronavirus disease 2019 after an initial asymptomatic presentation. We now describe a series of 43 test-positive cases of coronavirus disease 2019 presenting to an affiliated pair of New York City hospitals for more course of their delivery admission or early after postpartum discharge. Of the other 29 patients (67.4%) who presented with symptomatic coronavirus disease 2019, 3 women ultimately required antenatal admission for viral symptoms, and another patient re-presented with worsening respiratory status requiring oxygen supplementation 6 days postpartum after a successful labor induction. There were no confirmed cases of coronavirus disease 2019 detected in neonates upon initial testing on the first day of life. Based on coronavirus disease 2019 disease severity characteristics by Wu and McGoogan, 37 women (86%) exhibited mild

Pre or Early-COVID

- High rates of asymptomatic positivity in pregnancy
- Obstetric staff have a high rate of exposure and transmission
- Do Pregnant women have a higher chance of illness severity?

Detection of COVID-19 for Pregnant women

Figure 1. Symptom Status and SARS-CoV-2 Test Results among 215 Obstetrical Patients Presenting for Delivery.

Pre or Early-COVID

Universal testing maybe Indicated in some settings

Sutton et al. Universal Screening for SARS-CoV-2 in Women Admitted for Delivery. N Engl J Med 2020; 382:2163-2164

Detection of COVID-19 for Pregnant women

Today's COVID

- Almost 100% of Texas L&D Hospitals do universal screening on L&D
- Many are still challenged with access to timely COVID testing

Source: DSHS COVID Dashboard: https://txdshs.maps.arcgis.com/apps/opsdashboard/index.html#/ed483ecd702b4298ab01e8b9cafc8b83

Detection of COVID-19 for Pregnant women

Illness Severity and Management of COVID-19 in Pregnant women

Detection of COVID-19 for Pregnant women

Pre or Early-COVID

- Pregnant women have an increased risk of illness severity (ICU admissions, mechanical ventilation)

Ellington. Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020

Summary

What is already known about this topic?

Limited information is available about SARS-CoV-2 infection in U.S. pregnant women.

What is added by this report?

Hispanic and non-Hispanic black pregnant women appear to be disproportionately affected by SARS-CoV-2 infection during pregnancy. Among reproductive-age women with SARS-CoV-2 infection, pregnancy was associated with hospitalization and increased risk for intensive care unit admission, and receipt of mechanical ventilation, but not with death.

What are the implications for public health practice?

Pregnant women might be at increased risk for severe COVID-19 illness. To reduce severe COVID-19–associated illness, pregnant women should be aware of their potential risk for severe COVID-19 illness. Prevention of COVID-19 should be emphasized for pregnant women and potential barriers to adherence to these measures need to be addressed.

Detection of COVID-19 for Pregnant women

Pre or Early-COVID

- Pregnant women do not have an increased risk of illness severity

Figure. Flow Diagram of Pregnant Women Tested for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) Infection

Table 3. Illness Severity, Progression, and Hospitalization Among Delivered Women Diagnosed With SARS-CoV-2 Infection During Pregnancy

	Patients, No. (%)							
			Clinical progression among pregnant women diagnosed with SARS-CoV-2 infection					
COVID-19 illness severity at initial presentation	Total	Admitted within 14 d for obstetric indication[a]	Asymptomatic	Mild	Moderate	Severe	Critical	Admitted within 14 d for COVID-19 pneumonia[a]
Asymptomatic	107 (42)	99 (93)	98 (92)	7 (6)	0	0	2 (2)	1 (1)[b]
Mild	132 (52)	62 (47)	NA	126 (95)	2 (2)	4 (3)	0	4 (3)
Moderate	10 (4)	2 (20)	NA	NA	6 (60)	4 (40)	0	6 (60)
Severe	3 (1)	0 (0)	NA	NA	NA	1 (33)	2 (67)	3 (100)
Critical	0	NA	NA	NA	NA	NA	NA	NA
Total	252	163 (65)	98 (39)	133 (53)	8 (3)	9 (4)	4 (2)	14 (6)

Abbreviations: COVID-19, coronavirus disease 2019; NA, not applicable; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

[a] Denotes admission within 14 days of symptom onset or diagnosis (if asymptomatic).

[b] One asymptomatic woman developed critical COVID-19 illness while hospitalized for a non-COVID indication and is excluded from this group.

Adhikari et al. Pregnancy Outcomes Among Women With and Without Severe Acute Respiratory Syndrome Coronavirus 2 Infection. JAMA 2020

Detection of COVID-19 for Pregnant women

Pre or Early-COVID

- Pregnant women have an increased risk of illness severity (ICU admissions, mechanical ventilation)

Lokken EM, et al. Am J Obstet Gynecol.2021;doi:10.1016/j.ajog.2020.12.1221.

JAMA May 2020: (1) Yancy. COVID-19 and African Americans. (2) Webb-Hooper. COVID-19 Racial and Ethnic Disparities. (3) Williams et al. COVID-19 and Health Equity—A New Kind of "Herd Immunity"

Racial/Ethnic Disparities in COVID-19

- Rates of illness
- Illness severity at presentation

Fig. 1. Cumulative percentage of women reporting symptoms and testing positive for coronavirus disease 2019 (COVID-19) infection among the pregnant patient population. *Red and blue lines (solid and dashed)* are smoothed lines to fit the points.

Goldfarb. Ethnic Inequities in COVID-19 Prevalence and Severity. Obstet Gynecol 2020.

Vertical Transmission and COVID-19

Pre or Early-COVID

Vertical Transmission is possible, but rare.

FIGURE 3
Forest plot of meta-analysis of SARS-CoV-2 nasopharyngeal swab assessments of all case series and cohort studies

CI, confidence interval; *df*, degrees of freedom; *SARS-CoV-2*, severe acute respiratory syndrome coronavirus 2.

Kotlyar. Vertical transmission of COVID-19: a systematic review and meta-analysis. Am J Obstet Gynecol 2021.

Kotlyar et al. Vertical transmission of coronavirus disease 2019: a systematic review and meta-analysis. AJOG 2021

Baylor College of Medicine

Unscheduled Cesarean in PUI/COVID+

HARRISHEALTH SYSTEM

Pre-Delivery Cesarean

Notification Tree
Stat/Urgent: OB emergency
Unscheduled/Routine: Phone call

- **Primary RN 1**: contact CN
  - ☐ Request CD preparation items (SCDs, clipper, pre-op meds)
  - ☐ Ask CN to inform scrub tech and gets a transporter
  - ☐ Inform CN to obtain her N95, don PPE and prepare to transport patient
- **OB MD 1**: contact attending
  - ☐ Discuss plan
  - ☐ Identify 2nd surgeon
  - ☐ Inform attending to obtain N95, go to OR and don sterile PPE
- **Anesthesia 1:** contact attending
  - ☐ Discuss plan
  - ☐ Inform attending to obtain PPE and N95, don PPE and meet patient in OR

Pre-Operative Team Briefing
Charge Nurse, OB MD 2, Anesthesia 2 and scrub tech
- ☐ Discuss timing of case, OR #, plan of care
- ☐ Review medications to be in room at time of delivery
- ☐ Review PPE order of events
- ☐ Designate supply personnel

Surgical Team
Scrub tech, OB MD 2, OB MD 3, Anesthesia 2
- ☐ **Anesthesia 2**: Obtain PPE bag and N95 from NM office
- ☐ **: Display signage outside of OR and ante-room
- ☐ **Scrub tech, OB2** and **OB3**: go to OG6 and don #PPE prior to patient arrival

Anesthesia 3
- ☐ Review and Prepare OR per Anesthesia Management Guideline
- ☐ Call intubation team if needed

Transfer from LDR to OR

Transport Team:
Nurse 2 dons #PPE
Transporter dons *PPE

Sequence of Events for team in patient room
- ☐ Place surgical mask on patient for transport
- ☐ **Nurse 1** and **Anesthesia 1**: pass bed to transport team in anteroom or outside room
- ☐ **Nurse 2** and **Transporter**: transfers patient to the OR
- ☐ **Nurse 1, Anesthesia 1** and **OB MD 1**:
  - doff gown and gloves in labor room, perform hand hygiene, doff masks outside labor room and obtain N95. Then proceed to OR.
  - don #PPE prior to entering OR if patient is in OR

STOP

*Prior to taking patient into OG 6 **Nurse 2** must confirm all required personnel are donned in #PPE*
Transporter does not go inside the OR

Sequence of Events for transport team
- ☐ **Nurse 2, Anesthesia 2, Nurse 1** and **Anesthesia 1**: Transfer patient to OR table
- ☐ **Nurse 2:** carefully remove linen from labor bed and place in linen hamper in OR
- ☐ **Nurse 2 and Anesthesia 2**: push bed out of OR to transporter
- ☐ **Transporter**: sanitize bed with Oxivir wipes. Allow bed to completely dry and dress with linen.

In Operating Room

Safe surgical checklist and appropriate timeout to always be followed

Team to call **Transporter** for any equipment needed that is outside of OR (do NOT leave OR enter sub-sterile room without doffing PPE)

Nursing
- ☐ **Nurse 1** to act as primary circulator
- ☐ **Nurse 2** to page NICU to attend delivery #16-#999 (OG6)

Anesthesia
- ☐ Regional
  - Confirm appropriate surgical level
- ☐ GETA
  - To be performed by COVID Intubation team
  - Add HMEF filter
  - All personnel not involved with intubation to step away from patient (> 6 feet)
  - Wait 10 minutes after intubation to prep patient (unless stat)

Operating Team
- Scrub ($PPE) in prior to patient arrival and remain scrubbed until end of case
- No delayed cord clamping
- Infant is given directly to NICU MD
- Placenta double bagged and sent immediately to pathology

NICU MD
- ☐ Take baby immediately out of OR and directly to NICU

Post Delivery

Postoperative Briefing required

Extubation Plan
Call COVID intubation team

Sequence of Events for team in patient room:
- **Nurse 1** and **Anesthesia 1**
  - ☐ Doff gown/gloves and long boots only
  - ☐ Put on new gloves (face masks stay in place)
  - ☐ Exit OR to retrieve clean bed
  - ☐ Move bed into OR
  - ☐ *Do not touch patient or assist with transfer*
  - ☐ Maintain current PPE
- **Anesthesia 2, OB MD 2, OB MD 3, Nurse 2**
  - ☐ Transfer patient from OR table to labor bed
  - ☐ Doff gown/gloves and long boots
  - ☐ Hand hygiene
  - ☐ Remove surgical mask and throw away
  - ☐ Remove bouffant once out of OR and throw away
  - ☐ Remove N95 respirator and implement reuse protocol
  - ☐ Hand Hygiene
- **Nurse 1** and **Anesthesia 1**
  - ☐ Transfer patient to LDR to her established patient room

End of Case – decontamination
- ☐ OR to remain empty for 60 min after patient leaves OR
- ☐ Scrub Tech to remove instruments and immediately send to SP; then remove trash and linen.
- ☐ EVS to perform terminal clean

*PPE: surgical gown, mask, gloves, eye shield
PPE (Second stage or cesarean): surgical gown, N95 mask, gloves, eye shield, long boots, bouffant
$ PPE (Sterile for Cesarean surgeons): N95, eye shield, surgical gown and gloves, boots, bouffant

Role	Role	Role
Nurse 1 (primary nurse /circulator)	**OB MD 1** (resident)	**Anesthesia 1** (senior or fellow)
Nurse 2 (charge or designee)	**OB MD 2** (attending)	**Anesthesia 2** (attending)
Scrub Tech		**Anesthesia 3** (junior)
Transporter (RN or PCA)	**OB MD 3**	**COVID Airway Anesthesia 39003**

Vaccination

INSIDER

Log in

HOME > HEALTHCARE

Fauci declares 'no red flags' from the 10,000 pregnant women in the US who have received a COVID-19 vaccine

Kate Duffy Feb 4, 2021, 5:18 AM

Dr. Anthony Fauci, director of the National Institute for Allergy and Infectious Diseases, speaks during a news conference

Ads by Google
Stop seeing this ad
Why this ad?

Covid-19 vaccines are likely safe during pregnancy. When will we know for sure?

People who are pregnant or breastfeeding in the US could choose to get the vaccines, or wait until more data comes out this spring.

By Katherine Harmon Courage | Feb 3, 2021, 2:30pm EST

SHARE

A health worker administers a dose of the Pfizer/BioNTech Covid-19 vaccine to a pregnant woman in Tel Aviv, Israel, on January 23. | Jack Guez/AFP via Getty Images

CONVENIENT COVID-19 TESTING
At-Home & Drive-Thru Options Available
ORDER NOW
QuestDirect™

Illness Severity and Management of COVID-19 in Pregnant women

Pre or Early-COVID

Today's COVID

- Pregnant women *likely* have an increased risk of illness severity
- Treatment can include many of those offered to non-pregnant women
- Vertical transmission is possible but rare
- Strategies like telemedicine may amplify healthcare inequities in OB
- Pregnant women *should* be offered COVID vaccination

Future Pandemics

Illness Severity and Management of COVID-19 in Pregnant women

Pre or Early-COVID

Today's COVID

Future Pandemics

- Consider prior evidence and experience in balancing MTCT and maternal risks
- Equity should be considered in developing all interventions
- Advocate for pregnant women to be included in research

Surge Planning for L&D with emergencies

Pre or Early-COVID

- Does L&D need its own surge plan?
- Should women and infants be included in pandemic planning?
- Does L&D need PPE?

Today's COVID

Future Pandemics

L&D COVID Surge Activation

Non-COVID L&D

Add labor beds/central monitoring to antepartum	01
Anesthesia: medications, tackle boxes, epidural carts	02
Create new labor board and sign-out	03
Change OB emergency notification, add additional PPH kit	04
Add emergency release and medications to pyxis	05
Add 3 resuscitation stations, neo paging	06

COVID L&D

01	Notify Incident Command
02	Set up donning/doffing stations with infection prevention
03	Change labor board to COVID Board
04	Create neo paging system specific to COVID unit
05	Cohort nursing/MD care
06	Cohort patients

Surge Planning for L&D with emergencies

Pre or Early-COVID

Today's COVID

- Surge planning looks different for L&D
- It is highly interdependent and collaborative
- L&D may surge with other high acuity units
- L&D is a high risk/high exposure area

Future Pandemics

Surge Planning for L&D with emergencies

Maternal Disaster Response in COVID

- Began COVID peer to peer learning via some PCR Regions
- Peer learning via literature reviews, simulations, checklists, tools, webinars with content experts via the TexasAIM platform

Perinatal SARS-CoV-2

What do we think we know?

J.B. Cantey, MD, MPH
Associate Professor of Pediatrics
Divisions of Neonatology and Allergy, Immunology, and Infectious Diseases
Director, OKAPI Program
University of Texas Health Science Center San Antonio
2021 Texas Collaborative for Healthy Mothers and Babies Virtual Summit

tchmb

OKAPI CLINIC
Ongoing Care of Congenital and Perinatal Infections

UT Health
San Antonio

Questions

- What are the risks for congenital and perinatal transmission?
  - What percentage of infants born to COVID+ mothers will be infected?
  - Can infants be infected transplacentally? And if so, what does that mean?
  - How can we safely deliver these infants?
  - Do we need to separate mother and baby?
  - Can mother breastfeed?
  - When does maternal antibody protect the baby?
  - How long does infant immunity last after maternal infection?
  - How long does infant immunity last after maternal immunization?

What percentage of infants will be infected?

- What we thought we knew:
  - Worst case scenario: *Listeria* (>50% attack rate)
  - Untreated HIV – 25-30%
  - Hepatitis C – 5%
  - Best-case scenario: ~0.5-1% (minimal rate for most viral pathogens)

  - Probably depends on viral load/shedding and whether or not infection can be spread hematogenously or just perinatally

Current knowledge: Incidence

- Based on AAP collaborative (294 sites, 7168 dyads, ~1 year):
  - 1.5-2%
  - Primary risk factor seem to be timing of maternal infection (more later) and severity of maternal infection
  - Sort of best-case scenario!

Can infants be infected transplacentally?

- What we thought we knew:
  - Almost certainly, since SARS-CoV-2 can be detected in blood and any pathogen that can reach the maternal bloodstream can theoretically infect the fetus
  - Late congenital infection probably looks like perinatal/postnatal disease
  - Early congenital infection???

Current knowledge: Transplacental infection

- Congenital infection with immediate separation, positive placenta, positive infant has been reported
  - England
  - France
  - Dallas

Current knowledge: Transplacental infection

- No evidence so far of 1st trimester teratogenicity (as in congenital rubella syndrome, cytomegalovirus infection, etc)
- Continued surveillance needed to see if there are late effects of this respiratory viral infection during pregnancy (eg, influenza's controversial association with schizophrenia)

How can we safely deliver these infants?

- What we thought we knew:
  - SARS-CoV-2 is transmitted by both droplets (~6 feet) and aerosols (which diffuse into the shared airspace and can float for hours)
  - Sustained vocalization and higher volume increases droplet shedding
  - Increased intrathoracic and intra-abdominal pressure increases droplet shedding

Current Knowledge – Delivery

- Current CDC guidance states that “forceful exhalation during the second stage of labor would not be expected to generate aerosols to the same extent as procedures more commonly considered to be aerosol generating (such as bronchoscopy, intubation, and open suctioning)”
- However, the CDC does recommend airborne precautions (including N95 mask and eye protection) for clinicians delivering COVID+ mothers

Do we need to separate mother and baby?

- What we thought we knew:
  - If mother is COVID+, it <u>might protect the infant</u> to separate the infant during immediate postnatal care and, if possible, the nursery stay
- However
  - No evidence of benefit in separation with seasonal OR pandemic influenza
  - Real concerns about maternal/infant bonding, breastfeeding
  - Real concerns about workflow in hospitals that do not have a 24/7 newborn nursery (eg, would separation require NICU admission?)

Current Knowledge - Separation

- AAP and CDC recommendations changed several times
- AAP Perinatal Collaborative ultimately demonstrated that there was **NO DIFFERENCE** in neonatal infection rate (~1.5-2%) regardless of whether infant was separated or not
- Current recommendations:
  - **Do not separate** mother and baby unless mother is too sick to care for infant
  - Hand hygiene should be encouraged before and after handling baby
  - Until she has recovered (>10 days from positive test AND symptoms improved/resolved), mother should mask while directly caring for baby

Can mother breastfeed?

- What we thought we knew:
  - SARS-CoV-2 virus can be detected in breast milk
  - MERS-CoV can be detected in fresh milk and unpasteurized camel milk was a significant source of transmission during MERS epidemic
- As a result:
  - WHO always recommended breastfeeding
  - CDC had interim recommendations that offered “pump-and-dump” as an interval strategy
  - Separation of infant was often a barrier to breastfeeding regardless

Breastfeeding

- Chambers C, et al. Evaluation of SARS-CoV-2 in breast milk from 18 infected women. *JAMA* 2020. 324(13): 1247-48.
  - 64 samples from 18 COVID19+ mothers
  - 63 of 64 samples negative by PCR
  - The one positive sample did not grow in viral culture
- Tam PC, et al. Detectable SARS-CoV-2 in human breast milk of a mildly symptomatic patient with COVID-19. *Clin Infect Dis* 2021. 72(1): 128-130.
  - 6 samples from 1 mother
  - 1 sample positive by PCR
  - No recovery in culture
- Kumar J, et al. SARS-CoV-2 detection in human milk: a systematic review. *J Mat Fetal Neonatal Med*. 2021; February 8th.
  - Review of 34 studies including 116 lactating women
  - RNA detection was ~2% of samples, no culturable virus
- Conclusion: **No infectious virus shed in breast milk**

Current Knowledge - Breastfeeding

- RNA detection of virus is scant, and no one has been able to recover viable (eg, culturable) virus from breastmilk
- Translational data demonstrating that anti-SARS-CoV-2 IgA appears in breastmilk along with virus, suggesting a protective effect
- Strictly from a viral standpoint, benefit of breastfeeding exceeds risks (never mind all the other benefits too!)
- Data from the AAP collaborative support these conclusions – no increased risk for infants who are breastfeeding versus formula-fed
- In addition, higher rates of postpartum depression for women prevented from breastfeeding during pandemic!

- **Conclusion: Breastfeeding should be encouraged and supported**

When does maternal antibody protect the baby?

- What we thought we knew:
  - Based on our experience with other perinatal viral infections, especially varicella, we assumed that maternal infection >7 days before delivery would equate to infant protection

Current Knowledge – Maternal Antibody

YUP		Maternal symptoms		
		Hospitalized for COVID	Symptomatic at home	Asymptomatic
Maternal testing date	≥8 days before	0%	0.9%	0.4%
	7-4 days before	9.1%	4.1%	5.2%
	3 days before to 3 days after	0%	3.8%	2.2%

How long does infant immunity last?

- What we think we know:
  - Maternal immunization against influenza, pertussis lasts up to 4-6 months on average
  - Timing of immunization matters; immunization in the 2nd trimester seems to be optimal (as opposed to 3rd trimester or postpartum)

Current Knowledge – Duration of Antibody

Pfizer

moderna
messenger therapeutics

AstraZeneca

Johnson & Johnson

Summary

- What percentage of infants born to COVID+ mothers will be infected? → **~1-2% overall, with risk peaking at 5-10% for infection 4-7 days before delivery**
- Can infants be infected transplacentally? And if so, what does that mean? → **Yes, and TBD**
- How can we safely deliver these infants? → **PPE as per any other positive patient**
- Do we need to separate mother and baby? → **NO – do not separate**
- Can mother breastfeed? → **YES – breastfeed!**
- When does maternal antibody protect the baby? → **Probably as early as 7 days after infection – and in breast milk too!**
- How long does infant immunity last after maternal infection? → **Probably 6-ish months??? Prospective study needed**
- How long does infant immunity last after maternal immunization? → **Probably 6-ish months??? Prospective study needed**

Questions?

Email: cantey@uthscsa.edu
Twitter: @InfectiousNeo

OCAPI CLINIC

Ongoing Care of Congenital and Perinatal Infections

UT Health
San Antonio

COVID-19: Laboring from the Bedside

CHEYANNE HARRIS, MSN, RNC-OB
WOMEN'S & CHILDREN'S CLINICAL OPTIMIZATION SPECIALIST
TITUS REGIONAL MEDICAL CENTER

Preparation & Staffing

- Proactive to best practices
  - Seeking CDC, TexasAIM, ACOG, and AAP guidance
  - Policy Formation
- "Awaiting the wave"
  - Preparation of staff (PPE, infection control training)
  - Downplaying the myths
  - Promoting the realities/Surge planning
    - COVID LDRs & NICU Rooms

- Staffing Surge to Staffing Crisis
  - Preparation Hiring
  - Exposure Management
  - Sick employees/sick families
  - Staff Leaving
    - PPE Shortages
    - Staffing Constraints
    - Fear

Patient Care: Then & Now

Testing Availabilities/Algorithms
Positive patients
PPE

Family-Centered Care
Mental Health
Review of Care
Patient Follow-Up
Health Education & Promotion

"Our Wave" and "Our 2nd Wave"

"Wait, Wave #3?"

Safety & Simulation

- COVID Huddles
  - Multidisciplinary
  - Team Leaders
- Virtual Education
- Simulations
  - Initial hesitation, but..

"Emergencies won't stop for a pandemic, so neither will we."

Sustainability

Reducing Fear & Raising Awareness

Do your part

Bring light to COVID-19 & the pandemics hidden beneath it

Don't forget the mama, don't forget the baby

Thank You

CheyAnne Harris, MSN, RNC-OB

Women's & Children's Clinical Optimization Specialist

Titus Regional Medical Center – Mt. Pleasant, Texas

Cheyanne.harris@titusregional.com

(903) 855.9255