



# COVID-19: Considerations for Provider Rotations and Obstetric Patients

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## What Does It Mean?

With hospitals slowly reopening, providers must have the right systems in place to treat both COVID and non-COVID patients. Segmenting patients and providers by COVID and non-COVID treatment areas and continuing to screen patients and providers prior to entry into a facility are two key ways to minimize the spread of infection. Additional considerations are being made for specific patient populations, such as pregnant women admitted for delivery, to further facilitate maternal, neonatal, and staff safety.

As hospitals continue to treat both COVID-19 and non-COVID-19 cases, adjusting staff workflows to ensure the safe delivery of care without cross-contamination is critical to prevent the spread of infection across a facility. In addition, some organizations are following special precautions for certain patient populations, such as obstetric patients, since the effect of COVID-19 on these patient populations is still being researched at this time.

According to the study “Placental Pathology in COVID-19” published in the July 2020 issue of the *American Journal of Clinical Pathology* ([click here](#)), the placentas of pregnant women that tested positive for COVID-19 showed evidence of injuries, such as higher rates of decidual arteriopathy and other maternal vascular malperfusion features, and may be associated with adverse outcomes. While further research is warranted on the topic, the study indicates the need for increased clinical monitoring and care of pregnant women during the pandemic to ensure maternal and neonatal safety.

## Provider Rotation Across the Hospital

With COVID-19 stretching staff workloads, several organizations have been redistributing their workforce as a means to better manage the surge in patient cases, limit exposure, and reduce employee burnout. Particularly as cases began to rise in U.S. facilities in early 2020, the CDC and CMS recommended the segmentation of patient flow with separate zones established for the care of COVID-19 patients. While cases have started to abate in many places, most hospitals continue to see some patients with the novel coronavirus. Thus, many organizations have continued with the segmentation approach so that safe treatment of COVID and non-COVID patients can be achieved.

### Current Recommendations

- According to CMS recommendations that were last updated on June 8, 2020, on reopening facilities to provide non-emergent non-COVID-19 healthcare ([click here](#)), organizations should establish separate non-COVID care (NCC) zones within facilities with dedicated staff. **Rotation or movement of these staff to COVID-19 care zones is limited unless absolutely necessary.** For staff rotating into COVID-19 care areas, appropriate PPE and sanitation protocols must be adhered to ensure their safety.

- Furthermore, the forming of **dedicated teams** for specific floors and areas to reduce or prevent the exposure risk of patients and staff has been done by some hospitals. In cases where providers move across different floors to perform daily consults on patients, it is advisable to have a designated person doing consults on each floor, with an advanced practice provider or nurse assisting the consulting physician through telehealth capabilities if required.
- Especially if hospitals must move providers throughout floors or areas for a longer period (more than a week at a time) either due to staffing shortages or to prevent physician burnout, it is recommended to continue screening providers' temperatures daily. If adequate staffing capacity is available, it is also advisable to provide the healthcare staff a **two-week administrative period between switching floors or areas**. Providers can isolate during this period and help with charts, notes, telehealth, and other activities prior to resuming in-person care services.
- Similar guidelines are mentioned in the American Medical Association's resources for healthcare leadership ([click here](#)) last updated on June 5, 2020, which includes an example of the Atlantic Medical Group's plans for **splitting their workforce into teams of staff and physicians rotating in and out of the office**. Physicians not working on-site are involved in telehealth and testing center operations to help maintain workflows while reducing the chances of infection spread or burnout.



### Featured Resource: COVID-19 Staffing Projections Calculator

[Click here to access the full version of the tool at covidstaffing.org](https://covidstaffing.org)

## Special Considerations for Obstetric Providers and Patients

According to CDC guidelines ([click here](#)) last updated on May 18, 2020, **all healthcare personnel should be screened** at the beginning of their shift for fever and symptoms of COVID-19. Following these guidelines, many organizations are consistently screening their staff—including providers in departments of obstetrics and gynecology—for the presence of COVID-19 symptoms prior to entry into their facilities.

### Testing Obstetric Patients

With research on the impact of COVID-19 on pregnant women and newborns still underway, establishing precautions to ensure the safety of all obstetric patients is critical to prevent adverse outcomes. The most recent CDC guidelines ([click here](#)) from May 20, 2020, recommend prioritizing pregnant women with suspected COVID-19 for testing during hospitalization, with testing of asymptomatic pregnant women left at the discretion of individual facilities.

For another perspective, the May 2020 letter to the editor "Universal Screening for SARS-CoV-2 in Women Admitted for Delivery" in *The New England Journal of Medicine* ([click here](#)) reported the symptom status of COVID-19 in obstetrical populations presenting for delivery at Columbia University Irving Medical Center. The authors recommend the application of **universal testing for all pregnant women presenting for delivery** to ensure the prompt identification of asymptomatic patients with COVID-19. Several health systems are similarly implementing universal screening of all pregnant women prior to delivery to ensure the safety of patients, neonates, and staff. The following are a few examples of obstetrical guidelines implemented by health systems:

- Guidelines developed by Intermountain Healthcare on obstetrical and neonatal COVID-19 operations highlight universal screening of pregnant women prior to delivery ([click here](#) to automatically download guidelines).
  - For all patients scheduled for induction of labor and cesarean sections, COVID-19 testing is carried out 24 to 28 hours before the procedure.
  - For unscheduled asymptomatic patients at less than 37 weeks gestation being admitted for labor or postpartum care, universal screening is carried out, and providers are recommended to order rapid test status after review with the local facility lab director.
  - For unscheduled asymptomatic patients at more than 37 weeks gestation, standard COVID-19 testing is performed.
  - For unscheduled symptomatic patients or patients screened positive for exposure risk within the past 14 days, a rapid test is recommended.
- COVID-19 obstetric screening guidelines from Nebraska Medicine ([click here](#)) also recommend universal screening of all patients upon their admission to labor and delivery, with symptomatic patients triaged in a negative pressure room until testing is completed.

Have a question about this topic or another altogether? HBI's research team is on the case. Send a message to [contact@hbinsights.com](mailto:contact@hbinsights.com) with your questions!

## About the Analyst

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Vyshnavi is a research analyst at HBI with an educational background in pharmaceutical biotechnology. She has worked on a diverse range of cost and quality topics, including infection control, immunotherapy, behavioral health, obstetric and neonatal care, patient safety, and process improvement.