

Midwives' Association of Washington State
in collaboration with the
Washington State Midwifery COVID-19 Response Coalition

Interim Guidelines for Community-Based Midwives During the COVID-19 Pandemic

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Community-based midwives include Licensed Midwives (LMs), Certified Professional Midwives (CPMs), Certified Nurse Midwives (CNMs), and Certified Midwives (CMs), among others, who are trained and prepared to care for low-risk clients and their newborns throughout the perinatal period. These professionals attend births specifically in, but not limited to, homes and freestanding birth centers. We believe that continuing to provide community-based care and options for healthy, low-risk families during the COVID-19 pandemic reduces their risk for exposure, and has the potential to alleviate the burden on hospitals by diverting low-risk reproductive families and newborn care to community-based care providers.

This document is a compilation and adaptation of current information and evidence as of March 28, 2020. It is intended to be used as an interim practice guideline for community-based midwives with the goal of promoting quality care throughout the perinatal period, and increasing the safety for providers, clients and their families, as well as people at increased risk of serious complications from COVID-19. Each midwife should make the most appropriate care plan based on their own clinical experience, training, and collaboration and/or consultation with additional providers (MDs, OBs, MFMs, pediatricians, neonatologists, ARNPs, NDs, etc.) as indicated. Every effort will be made to update this guideline as more relevant information becomes available and practice evolves.

A definition of terms used throughout this document can be found at:
<https://www.vox.com/science-and-health/2020/3/27/21190774/ventilator-respirator-quarantine-isolation-definitions-covid-19-pandemic-terms>

SPECIAL PRECAUTIONS AND CONSIDERATIONS DURING THE COVID-19 PANDEMIC:

SARS-COV-2 is the virus responsible for causing what is commonly known as COVID-19 or coronavirus. It is currently believed to spread primarily through respiratory droplet transmission, although it can also shed in feces, and has been documented to remain on surfaces for up to several days (van Doremalen, et al., 2020). Currently, there is limited data about the risks of contracting COVID-19 in pregnancy. To date, pregnant individuals do not appear to be at an increased risk for developing severe complications from COVID-19, nor do their fetuses (ACOG, 2020; Huijen et al., 2020). There is new research showing that vertical transmission may be possible, though the evidence is not conclusive (Dekker, 2020). It is not known how many pregnancies are affected or how infection in pregnancy impacts the fetus (Dekker, 2020). It has been suggested, however, that there may be an increased risk of miscarriage and preterm delivery, possibly due to iatrogenic effects (Dekker, 2020). There is a plethora of research demonstrating known embryonic complications of fever in the first trimester. There is not yet data about teratogenic effects specific to SARS-COV-2. Most expert recommendations about COVID-19 in pregnancy are extrapolated from that which is known about other viral infections in pregnancy; that pregnant people are considered immunocompromised and have shown increased risk for other upper respiratory tract infections such as SARS, MERS and influenza (CDC, 2020c). The one study available showed that children younger than 1 are at increased risk for severe COVID-19 in comparison to other age groups of children (Dong, 2020), although data on neonates less than 28 days was not published. Therefore, pregnant people and newborns should be treated as more vulnerable to severe COVID-19 and precautions should be taken to reduce the risk for their exposure.

Community-based midwives are prepared to care for healthy, low-risk pregnant people and their newborns, and usually do not have the resources or personal protective equipment (PPE) to provide care for people under investigation or diagnosed with COVID-19. Midwives are able to triage these patients, instruct them to self-quarantine or self-isolate, refer them to the appropriate providers as indicated for management of COVID-19, while continuing to provide telemedicine care, and to resume complete care once symptoms completely resolve and risk for viral shedding is no longer a concern. At this time, this professional association does not recommend midwives test clients for COVID-19 unless circumstances demand (as may be the case if there are no testing facilities), or the midwife is able to do so in full PPE, or simplified testing is developed that does not require full PPE (for example, patient-administered swabs performed at home). Community-based midwives are typically solo or small group practices who are currently unable to readily access COVID-19 test kits and PPE as those supplies are being directed to and reserved for higher-risk settings where they are needed most.

The following recommendations are intended to allow midwives to continue to provide quality, evidence-informed midwifery care and shared decision-making, while allowing for social distancing and reduction of transmission of SARS-COV-2 by combining in-person clinical care and telemedicine.

TRANSMISSION PREVENTION AND REDUCTION PRECAUTIONS:

Midwives should follow CDC and county/state health department guidelines regarding infection reduction practices for healthcare providers, with proper hygiene, social distancing and appropriate PPE as is available and appropriate for their setting. WHO (2020a) currently advises that there is no benefit to healthcare personnel wearing a mask when caring for asymptomatic clients, though an expert review in AJOG MFM advised that “Given the risk of asymptomatic carriers and transmission, it should be the goal of every unit that every patient wear a surgical mask and every provider have a surgical mask for each patient encounter,” with N95 masks reserved for providers working “with suspected or confirmed COVID-19 or performing an aerosol generating procedures” (Boelig et al., 2020). At this time, this professional organization anticipates that the shortage in global PPE will impact the community-based midwife’s ability to acquire it. This guideline reflects the assumption that midwives will be working without access to some, if not most, PPE that until now has been the medical standard. We urge community-based midwives to consider methods to ensure that N95 masks are available to our most at-risk healthcare providers, such as anesthesiologists and ICU nurses, working with known COVID+ patients, and seek alternative methods of protection that reflect their lower risk status. Innovative solutions are expanding by the day, with some data starting to emerge on the effectiveness of "homemade" PPE alternatives.

We trust that Washington State midwives have the ingenuity, flexibility, and collaborative spirit to manage yet one more challenge to our ability to provide the most high quality, safe, and satisfying perinatal care as we always have. However, a community-based midwife may consider wearing a mask, in addition to their standard PPE, as they deem appropriate to their setting, client preferences and vulnerabilities, personal health considerations, or for other reasons. If so, they should follow the appropriate guidelines for wearing masks (cloth, surgical and N95).

Clients with known exposure to COVID-19 or any symptoms consistent with COVID-19 should be instructed to call their midwife and stay home for self-quarantine or self-isolation according to county health department guidelines. The midwife should use their own clinical judgment and refer the client to the appropriate care provider as indicated for testing and/or symptom management. All midwifery client care should be completed via telemedicine until the client and everyone in their home is cleared of concern for viral shedding.

MIDWIFERY CARE TEAM EXHIBITING COVID-19 SYMPTOMS:

- The midwifery care team and any administrative staff with client contact should self-screen at home before coming to work. This should include a symptom and temperature check. The midwifery care team and any administrative staff that are exhibiting symptoms should self-isolate, or who have known exposure to COVID-19 should self-quarantine, and follow-up with the appropriate care provider.
- Return to work strategy if staff tested positive for Covid-19 (*drawn from CDC guidelines: CDC, 2020d*):
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (eg., cough, shortness of breath) **and**
 - Negative result of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected >24 hours apart is currently the gold standard.
- Return to work strategy if staff was not tested for Covid-19 but had symptoms (*drawn from CDC guidelines: CDC, 2020d*):
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **and,**
 - At least 7 days have passed *since symptoms first appeared*
- Return to work strategy if staff was diagnosed with a different illness (e.g. influenza) should be as appropriate for that illness (CDC, 2020d).

MIDWIFERY CARE IN THE SETTING OF COVID-19:

One of the primary components of midwifery care is the relationship between the midwife and each client that develops through prenatal care and the shared decision-making process. Combining telemedicine visits with in-person visits can maintain this relationship and reduce viral transmission. **Because this is a newly introduced mode of communication for most midwives, they should obtain and document informed consent for telemedicine.**

In the spirit of shared decision-making, all informed choice discussions should now include considerations of the altered circumstances during the COVID-19 pandemic. This is relevant in discussing screening, such as ultrasound to confirm dating and normal fetal development/anatomy, or as clinically indicated. It is also relevant in the discussion of possible client refusal of standard testing (GDM, GBS, anemia) and/or possible client refusal of GBS antibiotic prophylaxis in labor, Vitamin K injection for the newborn, etc. As the COVID-19 pandemic evolves, it is possible that accessing more comprehensive medical care will become increasingly difficult and the client should understand this when making their informed decision about a procedure, medication, or screening. Additionally, given that comorbidities have been documented to increase the severity of

COVID-19 infections, midwives should review risks and CDC recommendations on vaccinations in pregnancy, and address client questions or concerns. Discussions regarding unpredictable, potential delays in transferring to a higher level of care if needed, both urgently and non-urgently, should also be included.

Pregnancy and birth are a vulnerable time and birthing people have the basic human right to have a support team surrounding them. In order to protect everyone during this pandemic, including the birthing person and their newborn, the number of in-person support people may need to be limited dependent on the setting of birth and risk for exposure to all persons in the room. Midwives should facilitate this discussion throughout care and, together with the client and their family, consider alternative and creative ways of including an extended support team.

SUGGESTED SCHEDULE OF CARE:

All in-person clinical care should take place only after screening as recommended in *SUGGESTED MODIFICATIONS TO CLINICAL MIDWIFERY CARE* below.

In-Person Care:

- Initial prenatal visit: 10-12 weeks gestation or sooner as clinically indicated. In addition to standard prenatal education, counseling and screening, initial visits should include:
 - Discussion regarding unpredictable, potential delays in seeking higher levels of care due to COVID-19 and transmission reduction procedures such as telemedicine.
 - Midwives may consider providing or instructing clients to procure a home automated blood pressure cuff, thermometer, adult scale, doppler/fetoscope, newborn weighing device and/or tape measure for self physical assessment during telemedicine visits. Clients could be instructed in palpating their symphysis pubis and fundus to complete fundal height measurements independently during telemedicine visits.
 - Client education should include:
 - Current COVID-19 precautions to reduce transmission
 - Current COVID-19 symptoms, and instruction to contact their midwife with positive symptoms or with known exposure to COVID-19.
 - Immune support and self-care practices.
 - Discussion regarding safety of OTC medications, herbs, etc.
 - Discussion and continued review of all indications where transfer to hospital based care would be recommended or required, as well as the risks/benefit analysis for exposure to COVID-19 in the hospital setting. It is acknowledged that risks based on reliable current local data may not be able to be precisely calculated.

- Routine prenatal visits: 20 (*if fetal survey ultrasound is performed, telemedicine visit may be offered instead), 28, 32, 36, 38, 39, 40, and 41 weeks.
 - Visits in the third trimester should be primarily in person, as health permits, in order for the midwife to assess and confirm low-risk status.
- Additional in-person visits may also be clinically indicated.
- Labor, birth, and the immediate postpartum
- Routine postpartum and newborn visits: 24-48 hours, 3-5 days, 1 week, and 6 weeks. Midwives may consider collaborating with or referring care to a lactation specialist for the 3-5 day postpartum visit.

Telemedicine: via phone or video platforms such as Zoom, Facetime, Skype, Google Hangouts, WhatsApp, etc. While HIPAA compliance has been relaxed to accommodate the unprecedented changes in healthcare during this time, midwives should continue good faith efforts to limit the risk of unintentionally revealing personal health information (PHI) of clients. To that end, midwives are urged to conduct telemedicine in a private space, remind clients to take care of their own needs for privacy on their end, and de-identify client information as much as reasonably possible. Because of the risk of lack of reasonable privacy, some platforms for telemedicine are not recommended, such as Facebook Messenger.

- Consultation visits and birth center tours.
- Routine prenatal visits: <12, 14 and/or 16, 20, 24, 30, 34, and 37 weeks.
- Routine postpartum/newborn visits: 2 weeks, 3-4 weeks.
- Other visits as deemed appropriate if the client has been exposed to or is ill with COVID-19 and is adhering to self-quarantine or self-isolation precautions.

LATE TRANSFERS TO MIDWIFERY CARE:

Some families may be nervous regarding the risk for exposure to COVID-19 in a hospital setting, and may be concerned regarding overburdening the strained hospital system, leading them to make the decision to transfer to community-based midwifery care late in pregnancy.

Late transfers should meet the following requirements:

- Must be low-risk and appropriate for the midwife's scope of practice, and must consent to a community-based, pain-medication free birth and midwifery care.
- The midwife should review the client's pregnancy records prior to accepting care.

Midwives should encourage clients to prepare for an unmedicated birth through counseling during prenatal visits, and referrals to online childbirth education classes or pre-recorded videos. Midwives support and encourage clients to have doulas, as feasible or desired, and suggest midwives have a robust referral list for doulas to share with clients.

If the risk for COVID-19 transmission in the hospital increases, or if there are insufficient inpatient beds or staffing, hospital-based providers may need to divert patients out of the hospital system and into community-based care antenatally, during early labor, or within hours after birth. The hospital-based provider should consult with the midwifery practice for as warm a hand-off as possible while practicing social distancing and defer to the midwife's screening criteria in determining a client's risk status (AHRQ, n.d.).

SUGGESTED MODIFICATIONS TO CLINICAL MIDWIFERY CARE:

In-Person Office Visits:

- Office visits should be scheduled so there is no overlap among clients and should include additional time to adequately clean and sanitize commonly touched surfaces and medical equipment (including, but not limited to, computers, dopplers, BP cuffs, stethoscopes, beds, tape measures, bathrooms, doorknobs, pens, etc.) in-between visits. Consider replacing cloth surfaces such as chairs, couches and beds with office furniture that can be quickly and easily wiped down. Clients should be instructed to arrive exactly on time or to call from their vehicle or mass transit stop to ensure no interpersonal overlap depending on clinic structure.
- COVID-19 Screening before in person visits should include:
 - First tier screen:
 - Reminder phone-call placed 1-2 day before appointments.
 - Screen the client and all members of the household for COVID-19 symptoms as listed by the CDC and WHO.
 - Instruct the client to take their temperature the morning of their scheduled appointment, and contact midwife if anyone in the household has a temperature of 100° F or higher.
 - Second tier screen:
 - Signage posted on doors to the office that list the same symptoms, with instructions to not enter the building and instead contact their midwife immediately with any present symptoms.
 - Third tier screen:
 - Verbal and physical (e.g., temperature, lung auscultation, etc.) screening by the midwife to include the client and any support person(s) present.

If a symptomatic client presents in-person, they should be instructed to put on a mask or cover their mouth and nose, and immediately leave the building. The client should be referred for follow up with the appropriate provider to access COVID-19 testing. The clinic should be immediately disinfected and all other client visits should be rescheduled until exposure risk is resolved. The remainder of the symptomatic client's visit can be completed via telemedicine when appropriate. Any member of the care team exposed to the symptomatic client should self-quarantine for 14 days unless that client obtains a negative COVID-19 diagnosis. This will be challenging for solo practitioners; however, it is the safest practice and highlights the necessity of creating solid coverage plans during this time.

- Clients should be encouraged to attend in-person visits alone to minimize exposure, with the option to utilize phone or video platforms for family members who would like to be virtually present.
- Clients should sanitize their hands before entering the clinic and go directly to the bathroom to wash their hands per CDC guidelines (CDC, 2020a).
- In order to minimize exposure time, midwives may consider doing the educational and emotional check in piece of the visit virtually and only conduct hands-on assessment of the client in-person.
- All decorative, cloth, non-essential and hard to clean items (pillows, blankets, coffee table books, kids toys, etc.) should be removed from the clinic space.
- Commonly touched surfaces and everything the client and/or midwife touches should be cleaned with germicide before and after every visit.
- For clinics that provide additional services, all non-essential services should be deferred (CDC, 2020b).
- Administrative staff should work from home when possible.
- Midwives should aim to practice social distancing from other midwives, student midwives and birth assistants, and have contingency plans in place in the event one of their staff or care team becomes ill.
- Midwifery practices with multiple midwives and students/assistants might consider creating non-exchangeable pairs, so that if one pair becomes exposed and has to self-quarantine for 14 days, the other midwife and assistant pairs can continue to practice.

Home Visits:

Home visits should be reduced to only critical visits where no other option is feasible. Midwives can reduce the risk of exposure during a home visit by taking the following precautions:

- Prescreening with a telephone call to the family as previously described
- Asking clients to clean and disinfect areas of the home where the midwife will be, where the birth is planned to occur, and common areas such as bathrooms, doorknobs, light switches, kitchen, etc. These areas should be cleaned and maintained regularly until home visit care is discontinued.

- The midwife should practice appropriate hygiene, and bring only essential items into the visit, in a plastic container or washable bag.
- The midwife should bring a change of clothing, and consider changing clothes upon departure, or sit on a disposable pad in the client's house and/or in the midwife's car or other mode of transportation..
- All equipment (doppler, fetoscope, BP cuff, stethoscope, tape measure, computer, phone, etc.), and the plastic bin should be sanitized before placing them back in the car.
- To minimize exposure between a single family and multiple midwives, consider having the same midwife and student or assistant attend the prenatal home visit, the birth, and the postpartum home visit.

Schedule of Home Visits may include:

- 36 weeks for families planning a home birth (the midwife may determine this is not necessary with repeat clients whose home is already familiar to the midwife)
- Labor, birth, and immediate postpartum
- 24-48 hour postpartum and newborn visit
- Other visits as clinically indicated

Every effort should be made to ensure that the 24-48 hour visit and the 1 week postpartum/newborn visit be completed in person due to the necessary assessment and timing of critical tests/procedures.

INTRAPARTUM CARE:

Clients should be encouraged to labor at home with their support team until active labor. Labor triaging should be done via telemedicine to limit potential exposure time unless clinically indicated. Labor triaging should include assessment for COVID-19 in the pregnant person, their support team and all persons in the home.

- Any signs/symptoms of COVID-19 in the pregnant person, or a member of their care team, should be considered high risk and transfer into hospital based care will be recommended.

The rationale for transferring suspected and confirmed COVID-19 cases in labor is twofold. First, exposure to COVID-19 puts community-based midwives at risk and removes their ability to continue to provide care for their other clients for a minimum of 14 days at a time when their presence for clients and the healthcare system are needed. Secondly, COVID-19 has the potential to lower the birthing person's oxygen saturation levels and require critical care suddenly, which increases the risk to both the birthing person and the fetus, making labor in the hospital the most appropriate choice. In the event that transfer doesn't occur, the care team should put on masks and know that waterbirth is currently not recommended for laboring people with or under investigation for COVID-19.

- Consider having a stricter standard on when to admit clients in labor and consider utilizing cervical exams for all consenting clients whose membranes are intact to help determine their dilation of 6 cm or more to confirm active labor.
- Active Management of the Third Stage of Labor (AMTSL) should be considered and discussed with the client as there may be a significant delay in emergency medical support and limited blood supply. If shortages of antihemorrhagic medications occur, active management should be reserved for people with antenatal or intrapartum risk factors for postpartum hemorrhage or hemorrhagic shock.
- Midwives should consider a lower threshold for intrapartum transfer due to anticipated unpredictable delays in EMS support and availability in the hospital. Discussions regarding transfer should be started earlier when possible and shared decision making should occur regarding the risks/benefits of staying at the community-based birth versus transferring into the hospital as many clients may be concerned regarding the increased risk for exposure to COVID-19 in a hospital setting.

Intrapartum Transmission Reduction:

- Birth support people should be limited:
 - BIRTH CENTER: Two (2) support people who should remain within the birth suite.
 - HOME BIRTH: Two (2) support people in the birthing space at home. Other family members/friends, including children, who live in the home or who are providing childcare to the older siblings, should be encouraged to stay in another part of the home to reduce risk for exposure to the midwifery team.
- Clients should be counseled to continue social distancing following their birth and avoid introducing in-person introductions of their newborn to extended family and friends.
- The midwifery team should screen themselves for symptoms before attending a birth and will not attend if any symptoms are present. A substitute team will be called in, or if one is not available, the client will be counseled to accept a referral to an available birth center or to a hospital.
- The midwifery team should practice social distancing during intrapartum care to the extent it is possible and reasonable.
- Consider abbreviating the immediate postpartum care to 2-4 hours, when clinically appropriate, to limit potential exposure time.
- The birth team should practice the same precautions regarding clothing, hygiene and personal protection as described above for home visits.

- For home birth:
 - Midwifery equipment:
 - Supplies designated for one birth should be placed in washable containers such as: plastic bins, hard-shell suitcase, zip-lock bags or washable bags (duffel, reusable grocery, wet bags, etc.).
 - Individual containers for IV start kits (including the IV bag), GBS prophylaxis kits, suture kits, postpartum hemorrhage kits, emergency medication kits, newborn exam kits, etc. should all be individually packaged into to plastic containers or ziplock bags so that if they are not opened at a birth, they can remain in the kit and the outside can be sanitized.
 - Non-sterile gloves could be packaged into reusable diaper wipe containers or small ziplock bags in smaller quantities for easy access.
 - Birth bags and extra supplies that cannot be sanitized should remain accessible in the midwife's vehicle unless the midwife has access to UV-C lights and follows the proper guideline for decontaminating the entire surface of each bag.
 - Upon leaving the home, all supplies and bins used at the birth should be taken outside and sanitized. The midwife should change clothes if possible, placing birth clothes into a plastic bag. Prior to loading sanitized supplies into the vehicle, the midwife should wash hands. Take special considerations for sanitizing car keys, phone, watch, jewelry (or ideally not be worn), computer, and oxygen tank. If the midwife is unable to change clothes in a separate area, the midwife should place a towel over the car seat which should be washed along with birth clothes upon arrival home or to the clinic.
 - Consider leaving the sling used to weigh the baby at the home for the follow-up home visit(s).

Special considerations regarding intrapartum and immediate postpartum transfer of care:

- In the event of an intrapartum transfer, midwives will complete the Birthing Person or Newborn Transfer Report and send it with the clients/EMS. Documentation of COVID-19 symptoms (present or absent) should be included on the form.
- The decision of whether the midwife will accompany the client will be a collaborative decision between the midwife, EMS transport team (when indicated by mode of transport), and the accepting provider, to reduce risk for viral transmission. If the midwife does not accompany the client, the midwife will facilitate the transfer via telephone or video conference to ensure the safe

- transition of the family. Records will be sent with the clients or faxed as soon as possible.
- Midwives should minimize time spent at hospital and take precautions to reduce risk for transmission of COVID-19.
 - Midwives should carry a copy of their midwifery license with them. Midwives should make an effort to be aware of their local hospital(s) capacity and preferences to facilitate transfer of care as needed.
 - Midwives should reserve use of the EMS system for urgent/emergent transfers knowing that they may be overwhelmed caring for ill people and their availability may be limited.
 - Transfer of newborn may need to take place in a private vehicle, observed continuously and monitored by the midwife in a car seat, if EMS wait-time might endanger neonatal well-being.

SPECIAL CONSIDERATIONS FOR COUNSELING CLIENTS UNDER INVESTIGATION OR DIAGNOSED WITH COVID-19 TRANSFERING INTO HOSPITAL BASED CARE.

- When making arrangements for transferring clients due to concern for COVID-19, the midwife should counsel the clients regarding the variable recommendations for separating these parents from their newborns: ACOG and the CDC recommend separation, whereas the WHO and RCOG recommend the birthing parent and newborn stay together. Families should be counseled to speak to the accepting care team regarding the risks and benefits of such a separation in making their decision regarding separation between birthing parent and newborn.
- Breastfeeding/chestfeeding is considered safe and should be encouraged, with the precaution of the breast/chestfeeding parent wearing a mask and practicing scrupulous hygiene (WHO, 2020b). The CDC and ACOG recommend that all lactating patients under investigation or diagnosed with COVID-19 should express colostrum/milk and a well caregiver should feed the newborn when possible.
- Support people will be limited as hospitals evolve policies to reduce the risk for transmission.
- There may be an increased risk for intervention such as induction of labor (early or at term) or cesarean section in people under investigation for or diagnosed with COVID-19 due to clinical concerns or iatrogenic causes (Dekker, 2020).

COVID-19 SPECIFIC CHARTING RECOMMENDATIONS

- Documentation should include assessment of COVID-19 signs and symptoms in the client, their family members and housemates, support team and midwifery staff.
- Documentation regarding midwife recommendations and any client disagreements- especially if midwife recommends transfer and client declines due to concern for increased risk of COVID-19 exposure in the hospital.

- Unusual circumstances and deviations from the standard of practice could arise and should be charted thoroughly, including the midwife's rationale for significant variance from usual practice.

These recommendations for interim practice guidelines are intended to assist community-based midwives in continuing to provide the Midwives Model of Care™ in order to meet community health needs in the shifting landscape of information and best practices during the COVID-19 pandemic. These recommendations should not be interpreted to be all-inclusive or as a strict standard of care. Each midwife will retain independent professional judgment as informed by their own training and experience, the particulars of the client, resources available, local health system personnel and logistics, and county or state public health recommendations.

Sample COVID-19 Screening Algorithms:

- ACOG: Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)
- Roanoke Birth and Perinatal Center: COVID-19 Community Birth Algorithm.

Additional Resources:

American Academy of Family Physicians. (n. d.). Checklist to prepare physician offices for COVID-19. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/public_health/COVID-19-office-prep-checklist.pdf

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