COVID-19 and Pregnant Health Care Personnel

Infectious Disease experts reviewed the information currently available on COVID-19 and pregnancy. Their answers to some frequently asked questions are included in this document for your information. Additionally, we want to provide colleagues guidance on how these recommendations will be managed through the McAlester Regional Health Center benefits program.

Our experts recommend that pregnant health care personnel should discontinue work and practice strict social isolation a minimum of two weeks prior to anticipated delivery, typically 37 weeks into the pregnancy. McAlester Regional Health Center supports these recommendations and encourages our pregnant health care colleagues to follow our experts' guidelines. Colleagues who wish to follow these recommendations can do the following:

- **If you want to self-isolate two weeks prior to the expected delivery date, you must notify your manager and you may determine the way in which you will receive pay and manage your leave of absence prior to delivery. Your options are:**
    a. Take available extended sick leave (ESL) or paid time off (PTO) for the period before your delivery and before your Family Medical Leave Act (FMLA) begins. If you select this option, you do not have to apply for FMLA or until your delivery and date of disability. Please note that if you select this option, your manager must enter PTO or ESL on your behalf.

- **What are my options if I am pregnant and my provider recommends that I be off work prior to 37 weeks of pregnancy?**
  You could qualify for the Family First Coronavirus Relief Act (FFCRA). This leave accounts for (80 hours) of leave outside of the FMLA time. Contact HR for this leave. You could qualify for time off through the Family Medical Leave Act (FMLA). If approved for FMLA you may will be paid according to the FMLA and Paid Time Off Policy.

  If you do not qualify for a leave of absence, you may request a reasonable accommodation or Non-FMLA. A reasonable accommodation could allow you to continue working, but in a modified role. You can request a reasonable accommodation by submitting a written request per the ADA policy. For Non-FMLA, please review the Non-FMLA policy. Accommodations are reviewed on a case-by-case basis as they are specific to your job duties and situation.

  Note: Infectious disease experts continue to emphasize that caring for a COVID-19 patients requires use of PPE and standard precautions, like other infectious diseases we treat. The health system will continue to provide appropriate PPE and employee safety continues to be a top priority

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Frequently-asked Questions: COVID-19 and Pregnant Health Care Workers

Currently, the information on COVID-19 and pregnancy is extremely limited. The answers to the following questions are based on expert opinion, national guidance documents and a few limited case series. As new data emerges these recommendations may be revised.

1. **Are pregnant women more susceptible to infection, or at increased risk for severe illness, morbidity or mortality with COVID-19, compared to the general public?**
   Pregnant women experience immunologic and physiologic changes that might make them more susceptible to viral respiratory illness. Pregnant women may also be at increased risk for complications compared to the general population as has been as observed in other coronavirus (SARS, MERS) and influenza. While the available literature is extremely limited, early reports suggest this may not be the case with COVID-19. Most infections in pregnancy have demonstrated mild symptoms typical of younger persons infected with a virus and have not required hospitalization.
2. **Are pregnant women with COVID-19 at increased risk for adverse pregnancy outcomes?**
   At this time there is very limited data regarding risks associated with infection in pregnancy. Data on the adverse effects of maternal fever is conflicting. Pregnancy loss, including miscarriages and stillbirth, was observed in other coronavirus infections (SARS, MERS). At this time the data on pregnancy outcomes is extremely limited, but there does not seem to be an increased risk of miscarriage, early pregnancy loss or adverse pregnancy outcomes.
3. **Can pregnant women with COVID-19 pass the virus to their fetus or newborn?**
   Transmission of viruses can occur either transplacentally with maternal viremia or can occur from exposure to maternal body fluids such as blood, saliva, respiratory droplets or breastmilk. Vertical transmission of other coronavirus such as MERS or SARS has not been reported. A small case series evaluating infants born to mothers with COVID-19 infection found none of the infants tested positive for the virus. The virus has not been detected in amniotic fluid or breastmilk, but the number of women evaluated in these studies was extremely limited.
4. **Are pregnant health care workers at increased risk for adverse events if they care for patients with COVID-19?**
   Studies of non-pregnant individuals suggest that appropriate use of personal protective equipment (PPE) can effectively prevent transmission of COVID-19. Pregnant women should adhere to all appropriate infection control practices to protect themselves from infection. As infection can be prevented by using the appropriate PPE and there does not appear to be an increased risk of adverse outcomes in pregnant women, there are no restrictions on pregnant health care workers' participation in care for suspected or defined COVID-19 patients.
5. **Can pregnant women who are approaching the end of their pregnancy continue to work?**
   Based on the recommendations of national and local experts, pregnant women should be instructed to discontinue work or begin working from home a minimum of two weeks prior to anticipated delivery (typically at 37 weeks). During this time, pregnant women should practice strict social isolation. The reason for this recommendation is to limit the risk of active COVID-19 illness at the time of delivery which would result in separation of the mother and infant for a prolonged period of time after birth. This has significant negative consequences for the child. Pregnant women should do all they can to avoid exposure around the time of delivery.

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Support for Question 5:

1. Guidance on Pregnant Health Care Workers:
    a. CDC and ACOG: "Based on limited data regarding COVID-19 and pregnancy, ACOG currently does not propose creating additional restrictions on pregnant health care personnel because of COVID-19 alone. Pregnant women do not appear to be at higher risk of severe disease related to COVID-19. Information on COVID-19 in pregnancy is very limited; however, facilities may want to consider limiting exposure of pregnant health care personnel to patients with confirmed or suspected COVID-19 infection, especially during higher-risk procedures (eg, aerosol-generating procedures), if feasible, based on staffing availability." https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics
    b. Society for Maternal and Fetal Medicine: "While pregnant HCP may continue to work, facilities may want to consider limiting their exposure to patients with confirmed or suspected COVID-19, especially during higher risk procedures (e.g., aerosol-generating procedures). However, in settings with a higher burden of disease or limited staffing, this may not be feasible." https://s3.amazonaws.com/cdn.smfm.org/media/2267/COVID19-_updated_3-17-20_PDF.pdf
    c. Royal College of Gynecology: "We encourage employers to seek opportunities for pregnant healthcare workers in their third trimester to work flexibly in a different capacity, to avoid roles where they are working directly with patients"
    d. Nebraska Medicine OB leadership recommends women nearing the time of birth (typically at or after 37 weeks) self-isolate until birth to avoid the issues of laboring while being a PUI or having defined COVID19. This saves PPE and avoids prolonged neonatal isolation (see below) and separation of mother and child.
    e. Other large facilities are recommending pregnant HCW "avoid all in-person patient contact after 37 weeks to decrease maternal infection risk and the chance of mother-infant separation after birth if mother is COVID-19+." (Stanford Health System)
2. Guidance on separating infants from infected mothers
    a. ACOG: "To reduce the risk of transmission of the virus that causes COVID-19 from the mother to the newborn, facilities should consider temporarily separating (eg, separate rooms) the mother who has confirmed COVID-19 or is a person under investigation from her baby until the mother's transmission based precautions are discontinued."
    b. ACOG: "Infants born to mothers with confirmed COVID-19 should be considered persons under investigation. As such, these infants should be isolated."
    c. CDC: "To reduce the risk of transmission of the virus that causes COVID-19 from the mother to the newborn, facilities should consider temporarily separating (e.g., separate rooms) the mother who has confirmed COVID-19 or is a person under investigation from her baby until the mother's transmission based precautions are discontinued"
    d. Recommendations from Nebraska Medicine NICU and OB leadership would be to separate mother and baby until COVID is ruled out in symptomatic mothers or if positive, the mother has reached end of infectious period.