National Network of Perinatal Quality Collaboratives and IHI’s Better Maternal Outcomes Thematic Webinar:

**COVID-19: One Year In**

Dr. Carey Eppes  
Dr. Emily DeFranco  
Ashidah Baker  
Alisha Bird  
Gigi Bond

MARCH 31, 2021  
4:00-5:30PM ET
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Partnering for Improved Birth Outcomes

The Institute for Healthcare Improvement (IHI) Better Maternal Outcomes Initiative and the National Network of Perinatal Quality Collaboratives (NNPQC), coordinated by NICHQ, are partnering to provide participants with a valuable set of webinars on health equity, respectful care and other critical maternal health topics. This partnership recognizes the shared commitment of these two initiatives to improve hospitals and health systems by elevating and spreading evidence-based efforts and examples of improvement from across the country so that families experience better birth outcomes. By bringing all participants together to engage in shared learning, the NNPQC and the Better Maternal Outcomes Initiative will encourage collaboration and innovation among teams with a shared mission, and ultimately accelerate national improvement.
The IHI Better Maternal Outcomes Initiative aims to reduce maternal morbidity and mortality by supporting national efforts to implement reliable evidence-based care for women and newborns around the time of birth, and by facilitating locally driven, co-designed rapid improvements in four communities, targeting the interface of health care delivery, the experience of birthers, and community support systems.

The National Network of Perinatal Quality Collaboratives (NNPQC), coordinated by NICHQ, supports the development and enhances the ability of state perinatal quality collaboratives to make measurable improvements in statewide maternal and infant healthcare and health outcomes by providing resources and expertise to nationwide state-based perinatal quality collaboratives (PQCs).
Welcome from CDC

**Tiffany Colarusso, MD, MPH**
Lead, Perinatal & Infant Health Team
Acting Senior Scientist
Maternal and Infant Health Branch, Division of Reproductive Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
Carey Eppes, MD, MPH is a maternal fetal medicine physician at Baylor College of Medicine and is the Chief of Obstetrics and Maternal Medical Director at Ben Taub Hospital and co-director of the high-risk obstetrics infectious disease clinic. She attended medical school at the University of Texas Health Science Center, San Antonio, residency at Johns Hopkins Hospital, and received both her Masters in Public Health and maternal fetal medicine fellowship training from Northwestern University. Her clinical and research focus is on infectious diseases during pregnancy, obstetrical quality and safety and substance use disorder. In Texas, she is currently the Chair of the Texas Collaborative for Healthy Moms and Babies (the state PQC), and the medical director for TexasAIM. She has been the ACOG district XI patient safety and quality improvement chair for the past 4 years. She lives in Houston with her husband and 2 daughters (7 and 10 years old).
Texas Collaborative for Healthy Mothers & Babies
The Perinatal Quality Collaborative for Texas

Catherine Eppes, MD, MPH
Chair, TCHMB
Texas AIM Medical Director

March 30, 2021
Texas Collaborative for Healthy Mothers and Babies
TCHMB

- 224 Delivery Hospitals
- 22 “perinatal care regions”
- 5 AIM Cohort (219 Hospitals)
- Legislatively mandated maternal and neonatal levels of care
TCHMB and TexasAIM Initiatives at the time of the pandemic

• AIM PPH Bundle
  • 4/5 Implemented
  • 219 hospitals (99%) participating
  • Significant improvement in process, structure measures
  • Tentative reduction in SMM (15%)

• TCHMB MEWS project
  • All AIM hospitals
  • Focused support for 15 hospitals

• RAC/PCR system with well developed pediatric infrastructure
Impact of COVID-19
TCHMB Annual Summit
2021
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

Pre or Early-COVID
- Who needs testing?
- When should testing occur?

Today’s COVID

Future Pandemics
Detection of COVID-19 for Pregnant women

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 28 patients (67%) 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

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

Pre or Early-COVID
Universal testing maybe Indicated in some settings

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

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

- Pregnant women should be a prioritized population for testing
- L&D is a unique environment with high risk of exposures
- Access to testing is critical to diagnosis
Illness Severity and Management of COVID-19 in Pregnant women

- Do pregnant women have an increased risk of illness severity?
- Is there a risk of vertical transmission of COVID?
- What strategies can mitigate risk?
Detection of COVID-19 for Pregnant women

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

Pre or Early-COVID

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

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

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

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

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

**Hospitalization rate for COVID-19 in Washington state:**

<table>
<thead>
<tr>
<th>Pregnant women</th>
<th>Nonpregnant adults aged 20-39 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>2.8%</td>
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</tbody>
</table>

COVID Health Disparities

- Race/Ethnicity
- Social Distancing - food
- Social distancing – housing
- Transportation/Work From Home
- Medical co-morbidities

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

Vertical Transmission is possible, but rare.

Kotlyar et al. Vertical transmission of coronavirus disease 2019: a systematic review and meta-analysis. AJOG 2021
# Unscheduled Cesarean in PUI/COVID+

## Pre-Delivery Considerations

- **Notification Tree**
  - UnScheduled: OR (emergency)
  - Notify RN, OB emergency

- **OB MD 1**: contact attending
  - Discuss plan
  - Identity 2nd anesthesiologist
  - Inform attending to obtain N95, don PPE and prepare to transport patient

- **Anesthesiologist**: contact attending
  - Discuss plan
  - Identity 2nd anesthesiologist
  - Inform attending to obtain N95, go to OR and don sterile PPE

## Pre-Operative Briefing

- **Charge Nurse, OB MD, 2 Anesthesiologist and scrub tech**
  - Discuss timing of case, OR, plug 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, Anesthesiologist 2**
  - Obtain PPE bag and N95 from OR office
  - VWR: Display signage outside of OR and ante-room
  - Scrub tech, ORB and ORB: go to OR and don sterile PPE prior to patient arrival

## Anesthesia 3

- Review and Prepare OR for Anesthesia Management Guideline
- Call intubation team if needed

## Transfer from LDR to OR

### Transport Team:

- Nurse 2: don PPE
- Transporter: don "PPE"

### Sequence of Events in patient room

1. Place surgical mask on patient for transport
2. Nurse 1 and Anesthesiologist 1: gear up to transport in anteroom of patient room
3. Nurse 2 and Transporter: transport patient to OR

### Sequence of Events for Transport team

1. Nurse 2, Anesthesiologist 1, Nurse 1 and Anesthesiologist 3: transport patient to OR able
2. Nurse 2: carefully remove linen from labor bed and place in linen transfer to OR
3. Nurse 2 and Anesthesiologist 2: push bed of OR into transport
4. Transporter: sanitize bed with disinfectant wipes. Allow bed to fully dry and dress with linen

## In Operating Room

### Operating Room

- Scrub (OR): in preparation to patient arrival and remain scrubbed until end of case
- No delayed cord clamping

### Sequence of Events for Transport team

- Nurse 1: go to OR and don sterile PPE
- Transporter (RN): go to OR and don sterile PPE
- Transporter (RN or PCA): don sterile PPE

### Sequence of Events for Anesthesia 1

- Minimize contact to patient
- Transporter (RN or PCA): go to OR

## Post Delivery

### Operating Room

- Scrub (OR): in preparation to patient arrival and remain scrubbed until end of case
- No delayed cord clamping

### Sequence of Events for Transport team

- Nurse 1: go to OR
- Transporter (RN or PCA): go to OR

### Sequence of Events for Anesthesia 1

- Minimize contact to patient

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*PPE*: surgical gown, mask, gloves, eye shield

1. PPE: Second stage of cesarean: surgical gown, N95 mask, gloves, eye shield, long boots, bouffant
2. PPE: Birth for Cesarean: surgical gown and gloves, boots, bouffant

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<table>
<thead>
<tr>
<th>Role</th>
<th>Rule</th>
<th>Role</th>
<th>Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1 (primary nurse: intubation)</td>
<td>OR MD 1 (standing)</td>
<td>Anesthesiologist 1 (standing or briefly)</td>
<td></td>
</tr>
<tr>
<td>Nurse 2 (chambermaid or scrub tech)</td>
<td>OR MD 2 (standing)</td>
<td>Anesthesiologist 2 (standing)</td>
<td></td>
</tr>
<tr>
<td>Scrub Tech</td>
<td>Anesthesiologist 2 (standing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transporter (RN or PCA)</td>
<td>GB MD 3</td>
<td>COVID Airway Anesthesiologist</td>
<td>39883</td>
</tr>
</tbody>
</table>
Vaccination
Illness Severity and Management of COVID-19 in Pregnant women

- 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
Illness Severity and Management of COVID-19 in Pregnant women

- 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
- Anesthesia: medications, tackle boxes, epidural carts
- Create new labor board and sign-out
- Change OB emergency notification, add additional PPH kit
- Add emergency release and medications to pyxis
- Add 3 resuscitation stations, neo paging

COVID L&D

- Notify Incident Command
- Set up donning/doffing stations with infection prevention
- Change labor board to COVID Board
- Create neo paging system specific to COVID unit
- Cohort nursing/MD care
- Cohort patients
Surge Planning for L&D with emergencies

- 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
Surge Planning for L&D with emergencies

- Pre or Early-COVID
- Today’s COVID
- Future Pandemics
  - L&D specific emergency planning for pandemics and disasters
  - PPE allocations for women and infants
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
Emily DeFranco, DO, MS is a productive clinician scientist conducting clinical research at the University of Cincinnati College of Medicine. Her primary research interest is in the area of preterm birth, focusing on both clinical trials for prematurity prevention and epidemiologic studies evaluating genetic and environmental influences on preterm delivery. She has published over 100 peer-reviewed scientific studies and has given over 200 scientific presentations at national and international scientific meetings. She is a patent holder from her sentinel work on progesterone for the prevention of spontaneous preterm birth. Her additional research endeavors include stillbirth, infant mortality, birth spacing, and racial disparities in perinatal outcomes. She enjoys mentoring undergraduate students, medical students, and physicians in training in their acquisition of knowledge of hypothesis generation, study design, and application of clinical research. Dr. DeFranco joined the faculty at UC in the Department of OB/GYN in 2008. She received a Master’s Degree in Clinical and Translational research from the University of Cincinnati in 2010. She is the Director of the Division of Maternal-Fetal Medicine, Professor and Vice Chair of Obstetrics at UC. She is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine, and is a Fellow of the American College of Obstetricians and Gynecologists.
Pregnancy and the COVID 19 Vaccine: An Update

Emily DeFranco, DO, MS
Professor and Vice Chair, Obstetrics and Gynecology
Director, Maternal-Fetal Medicine
University of Cincinnati College of Medicine
Department of Obstetrics & Gynecology
• I have no relevant commercial or financial interests to disclose.

• Site Principal Investigator in several COVID-19 pregnancy vaccine research studies:
  • Pfizer clinical trial of SARS-CoV-2 vaccine in pregnant women
  • NIH DMID Observational, prospective cohort of women who receive SARS-CoV-2 vaccine during pregnancy or post-partum and their infants
Objectives

• Discuss the current recommendations for COVID vaccine in pregnancy, the postpartum period, and in women planning to become pregnant

• Review vaccine hesitancy among pregnant women
Pregnant Women with COVID-19 who were hospitalized, United States, January 22, 2020 - March 22, 2021

Data were collected from 80,590 women, but hospitalization data were only available for 64,784 (80.4%).

80,590 cases reported
17% Hospitalization rate
3% Hospitalized in ICU
0.6% Hospitalized on Vent
1-2/1000 Hospitalized on ECMO

HOSPITALIZED CASES

13,674

Pregnant women with COVID-19 admitted to the ICU, who required invasive ventilation, or who required ECMO, United States, January 22, 2020 - March 22, 2021

Data were collected from 80,590 women, but ICU admission data were only available for 11,496 (14.3%) women, invasive ventilation data were only available for 7,860 (9.8%) women, and ECMO data were only available for 8,500 (10.5%).

https://covid.cdc.gov/covid-data-tracker/#pregnant-population
COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine | Deliveries and Administration, Maps, charts, and data provided by CDC, updated daily by 8 pm ET†

Represents all vaccine partners including jurisdictional partner clinics, retail pharmacies, long-term care facilities, Federal Emergency Management Agency and Health Resources and Services Administration partner sites, and federal entity facilities.

<table>
<thead>
<tr>
<th>People Vaccinated</th>
<th>At Least One Dose</th>
<th>Fully Vaccinated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>95,015,762</td>
<td>52,614,231</td>
</tr>
<tr>
<td>% of Total Population</td>
<td>28.6%</td>
<td>15.8%</td>
</tr>
<tr>
<td>Population ≥ 18 Years of Age</td>
<td>94,686,188</td>
<td>52,529,949</td>
</tr>
<tr>
<td>% of Population ≥ 18 Years of Age</td>
<td>36.7%</td>
<td>20.4%</td>
</tr>
<tr>
<td>Population ≥ 65 Years of Age</td>
<td>39,799,162</td>
<td>26,905,023</td>
</tr>
<tr>
<td>% of Population ≥ 65 Years of Age</td>
<td>72.8%</td>
<td>49.2%</td>
</tr>
</tbody>
</table>

View:
- Total Doses
- People

Show:
- Administered
- Delivered

Metric:
- Count
- Rate per 100,000

Population:
- Total Population
- Population ≥ 18 Years of Age
- Population ≥ 65 Years of Age

This shows the number of doses administered within the state or territory for every 100,000 people of the total population. It does not reflect the residency of the person receiving the vaccine, but where they received it.

https://covid.cdc.gov/covid-data-tracker/#vaccinations
Nearly 30% of US population has received at least one dose

- Range of rates of immunization categorized from <30% to >45% of the population immunized.
- Lowest rate in the South (Alabama)
- Highest rates in the North/ Midwest/ Eastern US.
Vaccines

**Pfizer-BioNTech mRNA vaccine** (BNT162b2): for use in individuals age 16 years and older as a 2-dose regimen given 3 weeks (21 days) apart.

**Moderna mRNA-1273 vaccine**: for use in individuals age 18 and older as a 2-dose regimen given 1 month (28 days) apart.


Several other large-scale (Phase 3) clinical trials are in progress or being planned for three additional COVID-19 vaccines:

- AstraZeneca’s COVID-19 vaccine
- Novavax’s COVID-19 vaccine
Pregnant women in COVID-19 trials

- These trial protocols specifically excluded pregnant and lactating women
  - 23 women in the Pfizer trial and 13 in Moderna’s became pregnant, n=36

- Trials began in summer 2020, lack of reported outcomes of live births
  - Completed studies have plans to follow-up outcomes on these women and their infants.

- Moderna, Janssen (J&J), and Pfizer have all expressed interest in testing their candidates on pregnant women.
  - Pfizer plans to enroll approximately 4000 pregnant women at 21 US sites in a phase 2/3 placebo-controlled COVID-19 trial of their vaccine.
  - Janssen will enroll 824 pregnant participants in a phase 2 placebo-controlled trial of its COVID-19 vaccine.

- It has been estimated that as many as 300,000 health care workers, members of the highest-priority group for vaccination are pregnant. Multiple ongoing registries.
Evidence based medicine

• Recommended versus Not Recommended
  • Something has been studied and benefit outweighs risk = recommend
  • Something has been studied and risk outweighs benefit = not recommend
  • Something has not been studied and we don’t know risk or benefit = not recommend

• Not recommended versus recommend not
  • Something has been studied and risk outweighs benefit = recommend not
  • Something has not been studied and we don’t know risk or benefit = not recommend or not withhold (expert opinion)
Including pregnant women in clinical trials

- Growing interest in the ethics of excluding pregnant women from clinical trials
- Historically considered a vulnerable population who needed protection from research
- This led to limiting access of important treatments to pregnant women
- Paradigm shift of “protection from” toward “protection through”
- Rather than consider pregnant women “vulnerable”, use term “scientifically complex”
SMFM on ethics of excluding pregnant women from vaccine trials

• Despite the categorization of pregnancy as a high-risk condition for severe COVID-19, hospitalization and mortality, pregnancy remains an exclusion for participation in vaccine trials.

• SMFM, ACOG, National Academy of Medicine advocate for the inclusion of pregnant and lactating women in vaccination trials, particularly when:
  (1) pregnancy poses increased susceptibility to or severity of a disease
  (2) the best approach to protect the infant is through passive placental antibody transfer, which provides the most efficient and direct protection to the newborn before an infant can be vaccinated, and
  (3) there is an active outbreak.

• Ultimately, the existing practice of "protection by exclusion" is harmful and has been characterized as clinical experimentation on pregnant women, as vaccines are distributed and administered without the safeguards of research protocols in place.

Why COVID Safe for I

The scantness of available data leaves though benefits

By MIREYA VILLARREAL

Pregnant women are concerned about whether to get the COVID vaccine due to lack of data

Lack of vaccine data on pregnant women fuels ...
Risks of COVID infection in pregnancy

- Risk of becoming infected is not known to be higher than non-pregnant individuals.
- The absolute risk for developing severe COVID-19 during pregnancy is low.

- However, compared with nonpregnant individuals, those who contract COVID-19 while pregnant are at increased risk of intensive care unit admission, invasive ventilation and death.

- It is hypothesized that pregnant women have an altered immune response to infection that is exaggerated, resulting in marked inflammatory response and subsequent adverse outcomes related to inflammation. Similar to higher morbidity from influenza infection in pregnancy.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6944e3.htm
Available Safety Information Related to the use of COVID-19 Vaccines in Pregnancy

- Pregnant women were not included in COVID-19 vaccine clinical trials. Observational data from vaccinated pregnant individuals is being collected by CDC and manufacturers.

- Based on limited self-reported information, no specific safety signals have been observed in pregnant people enrolled in CDC’s v-safe pregnancy registry. Early data show side effects and adverse events in pregnant individuals did not indicate any safety concerns.

- Data from Developmental and Reproductive Toxicity (DART) animal-model studies for the Pfizer-BioNTech, Moderna, and Janssen (Johnson & Johnson) COVID-19 vaccines have not demonstrated any safety concerns in pregnancy.

- Based on the mechanism of action of these vaccines and the demonstrated safety and efficacy in Phase II and Phase III clinical trials, it is expected that the safety and efficacy profile of the vaccine for pregnant individuals would be similar to that observed in non-pregnant individuals.

Statements regarding use of COVID-19 vaccine in pregnancy

- Initial recommendations from ACOG and SMFM advocated for pregnant women to have access to COVID-19 vaccines.
- Initial recommendations from WHO differed from this guidance and recommended withholding the vaccine from most pregnant women.
- WHO later revised its statements to be more in line with ACOG and SMFM:
  “…we don’t have any specific reason to believe there will be specific risks that would outweigh the benefits of vaccination for pregnant women. For this reason, those pregnant women at high risk of exposure to SARS-CoV-2 (e.g. health workers) or who have comorbidities which add to their risk of severe disease, may be vaccinated in consultation with their health care provider.”
ACOG

• ACOG recommends that COVID-19 vaccines should not be withheld from pregnant individuals who meet criteria for vaccination based on recommended priority groups.

• COVID-19 vaccines should be offered to lactating individuals similar to non-lactating individuals when they meet criteria for receipt of the vaccine based on priority groups.
ACOG

- Individuals considering a COVID-19 vaccine should have access to available information about the safety and efficacy, including information about data that are not available. A conversation between the patient and their clinical team may assist with decisions regarding the use vaccines for the prevention of COVID-19 by pregnant patients.

- Important considerations include:
  - the level of activity of the virus in the community
  - the potential efficacy of the vaccine
  - the risk and potential severity of maternal disease, including the effects of disease on the fetus and newborn
  - the safety of the vaccine for the pregnant patient and the fetus
• Clinicians should review the available data on risks and benefits of vaccination with pregnant patients, including the risks of not getting vaccinated in the context of the individual patient’s current health status, and risk of exposure, including the possibility for exposure at work or home and the possibility for exposing high-risk household members.

• Conversations about risk should take into account the individual patient’s values and perceived risk of various outcomes and should respect and support autonomous decision-making.
ACOG

• While a conversation with a clinician may be helpful, it should not be required prior to vaccination, as this may cause unnecessary barriers to access.

• Pregnancy testing should not be a requirement prior to receiving any approved COVID-19 vaccine.
Vaccination Considerations

- Pregnant women with fever following vaccination should be counseled to take acetaminophen. Acetaminophen considered safe for use in pregnancy and does not appear to impact antibody response to COVID-19 vaccines.
- There is currently no preference for the use of one COVID-19 vaccine over another except for 16-17 year olds who are only eligible for the Pfizer-BioNtech vaccine.
- Those receiving a 2-dose series should use the same vaccine product.
- COVID-19 vaccines should not be administered within 14 days of receipt of another vaccine. For pregnant individuals, vaccines including Tdap and influenza should be deferred for 14 days after the administration of COVID-19 vaccines.
- Anti-D immunoglobulin (i.e. Rhogam) should not be withheld from an individual who is planning or has recently received a COVID-19 vaccine as it will not interfere with the immune response to the vaccine.
Postpartum, Lactating and Individuals Planning Pregnancy

- ACOG recommendations for these groups align with those for pregnant women.

- If an individual becomes pregnant after the first dose of the COVID-19 vaccine series, the second dose should be administered as indicated.

- Routine pregnancy testing is not recommended prior to receiving any COVID-19 vaccine.

- It is not necessary to delay pregnancy after completing both doses of the vaccine.
Pregnant patients who decline vaccination should be supported in their decision. Remind patients about the importance of other prevention measures such as hand washing, physical distancing, and wearing a mask.

- Expected side effects should be explained as part of counseling patients.
MEMORANDUM

TO: Patients, Obstetric Providers, and Employers of Pregnant Healthcare Personnel (HCP)

We suggest that pregnant women, including pregnant health care workers, who opt to receive the COVID-19 vaccine should be prioritized for vaccination in a similar manner to other non-pregnant individuals.

The FDA has encouraged pharmaceutical companies studying COVID-19 vaccines to track and report observational data on safety and efficacy among pregnant and lactating women. Plans for several COVID-19 vaccine trials in pregnant women are underway and are anticipated to begin enrollment as soon as early 2021.

A CDC advisory committee is expected to meet soon to make further recommendations. As new evidence and recommendations emerge, guidance may change over time.

Sources:
“We reviewed approaches that help to prevent spread and the risk of acquiring the virus such as wearing a mask, frequent hand washing, staying a safe distance from others, avoiding close contact with people who are sick, and getting vaccinated. ....

Considering the risk to the mother if she were to become infected with COVID-19 during pregnancy, and the growing availability of the COVID-19 vaccine in the community, many pregnant women have begun to question whether the vaccine is safe and effective if given during pregnancy. Although the currently available COVID-19 vaccines have not been specifically studied for safety and effectiveness in pregnant women, there is no known risk. ...

Comparing the risk of serious pregnancy complication if a pregnant mother were to fall ill with COVID-19 in pregnancy, many leading pregnancy experts and agencies feel that the risk to benefit ratio favors vaccinating pregnant women. Overall, the obstetric community supports a woman’s choice to receive the COVID19 vaccine during pregnancy despite the current lack of definitive safety data.”
As Covid-19 Vaccinations Ram
Survey shows decline in reluctance, driven by increasing will among Black Amer

By Randy Yeip
March 30, 2021 5:30 am ET

A shrinking percentage of Americans are expressing reluctance to get a Covid-19 vaccine, a positive sign for the efforts to get shots to enough people to reach herd immunity.

U.S.

Globally, most pregnant women and mothers would get COVID-19 vaccine and vaccinate their children; acceptance in U.S. and Russia lags

For immediate release: Monday, March 1, 2021

Boston, MA—Most pregnant women and mothers of children younger than 18 years old say they would receive a COVID-19 vaccine and vaccinate their children, according to a survey conducted by researchers at Harvard T.H. Chan School of Public Health. The research indicated that vaccine acceptance was highest in India, the Philippines, and all sampled countries in Latin America, and it was lowest in Russia, the U.S., and Australia.

Report yesterday indicated COVID vaccine hesitancy in pregnant women globally showed that just decreased from 22% to 17%, mostly attributed to lower hesitancy rates among African Americans, especially in the South. Rates were 43% acceptance rate
Evidence based medicine

• Recommended versus Not Recommended
  • Something has been studied and benefit outweighs risk = recommend
  • Something has been studied and risk outweighs benefit = not recommend
  • Something has not been studied and we don’t know risk or benefit = not recommend

• Not recommended versus recommend not
  • Something has been studied and risk outweighs benefit = recommend not
  • Something has not been studied and we don’t know risk or benefit = not recommend or not withhold
Summary

- Lack of knowledge and fear lead to higher rates of vaccine hesitancy in pregnancy, especially in groups at highest risk of adverse outcomes from COVID.
- Patient education and support for vaccine use in pregnancy are important to address drivers of hesitancy that may not be founded.
- Minimize barriers for pregnant women who choose to become vaccinated.
- Encourage enrollment in registries, observational studies, and clinical trials.
Guest Speakers

Facilitated by Nicole Purnell

- Ashidah Baker
- Alisha Bird
- Gigi Bond
Q&A

Please feel free to type questions for any of today’s speakers into the chat box
Evaluation

Please take a moment to complete the evaluation survey. We value your feedback so we can continue to improve!
Thank you!