Appendix 1. Risk factors for Conditions that Require Early Ultrasound Screening

These risk factors, if present, should prompt earlier scheduling for in-person prenatal visit and ultrasound evaluation:

- Historical factors
  - History of ectopic pregnancy
  - History of bilateral tubal ligation
  - History of tubal reversal
  - History of pelvic inflammatory disorder
  - History of prior endometrial ablation
  - History of hydatidiform mole
  - Previous exposure to diethylstilbesterol
  - Intrauterine device in situ
  - Conception via assisted reproductive technologies
  - History of prior higher-order cesarean deliveries
  - History of early pregnancy loss
  - Maternal age over 40 or under 18 years old
  - Family history of genetic abnormalities
  - Family history of multifetal gestation
  - Significant maternal comorbidity
  - At risk for or history of intimate partner violence
- Symptoms
  - Abdominal or pelvic pain
  - Vaginal bleeding
  - Severe nausea/vomiting
  - Urinary symptoms suspicious for urinary tract infection

Duzyj CM, Thornburg LL, Han CS. Practice modification for pandemics: a model for surge planning in obstetrics. Obstet Gynecol 2020;136.
The authors provided this information as a supplement to their article.

Appendix 2. Recommended Elements of the Postpartum Comprehensive Telehealth Visit

The following screening questions should be a part of the comprehensive postpartum telehealth visit, to be held no later than 12 weeks post-delivery:

- Psychosocial evaluation
  - Mood and emotional well-being, including use of standardized postpartum depression screening questionnaires
  - Sleep and fatigue
  - Screening for intimate partner violence
  - Food and shelter security
- Infant care
  - Feeding modality
  - Breast health
  - Infant care
- Reproductive health
  - Sexuality
  - Contraception
  - Birth spacing
- Physical recovery
- Chronic disease management
- Planning for healthcare maintenance follow-up, including:
  - Pap smear, if indicated
  - Mammogram, if indicated
  - Vaccination plans
  - Follow-up for gestational diabetes, with plan for postpartum glucose testing (see Table 1)
  - Follow-up for preeclampsia, with referral for monitoring of blood pressure and cardiovascular health

Data from Optimizing postpartum care. ACOG Committee Opinion 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140-50.

Appendix 3: Summary of Elements of Routine Obstetrical Care, With Prepandemic Paradigm, Suggested Modifications, and Additional Precautions

Obstetrical care	Routine paradigm	Pandemic-adjusted modifications	Additional precautions
Early pregnancy care (1–9)			
Early prenatal visit and ultrasound screening	• Initial prenatal visit recommended to take place in the first trimester • Routine first-trimester imaging recommended to occur before 14 weeks GA	• Telehealth obstetrical intake at <11 weeks • Initial prenatal visit and ultrasound at 11-13 6/7 weeks GA • Early ultrasounds can be avoided in the low-risk patient	• Evaluate for risk factors for miscarriage, ectopic pregnancy, cesarean scar pregnancy, molar pregnancy, multifetal gestations • Patient's desire for continuation of pregnancy should be evaluated • Patients who are Rh-D unknown should have early confirmation of Rh-D status if bleeding is noted • Assess desire for telegenetics consultation
Comorbidities management	• History is taken at the first in-person prenatal visit • Patients at risk for pregnancy complications, including those with medical comorbidities are recommended to be seen "as early as possible"	• The first telehealth visit should occur as early as possible to evaluate for maternal comorbidities	• Medications should be adjusted to avoid teratogenicity • Appropriate subspecialist referrals should be made. These consultations can also be performed via telehealth

Family planning	• Family planning is an essential component of reproductive health care • Measures restricting abortions are in place in certain regions	• The first telehealth visit should occur as early as possible to evaluate for desire to continue the pregnancy.	• In areas of restricted abortion access, early ultrasound is of particular importance to afford the patient opportunities for intervention. • Telehealth can be applied for no-touch terminations • An additional referral network should be established to ensure that patients have adequate access to care

Antepartum care			
Preeclampsia and Gestational Hypertension (10–11)			
Diagnosis	• In office blood pressure (BP) and urine screening • Inpatient or outpatient diagnostic confirmation if the suspicion arises • USPSTF has found no increase in adverse outcomes related to preeclampsia among patients with fewer prenatal visits	• Home screening via BP logs and symptoms can be used in lieu of frequent prenatal visits. Low-risk patients should perform checks on a weekly basis, and high-risk patients on a daily or as needed basis. • Home screening should be augmented by occasional telehealth or in-person prenatal visits • Diagnostic confirmation can be made on an outpatient basis,	• Home sphygmomanometers should be pre-calibrated. Upper arm cuffs are recommended, but wrist cuffs can be considered if upper arm measurements are not feasible, the monitor is directly over the radial artery, and the wrist is in neutral position at the level of the heart. • A report of abnormal BP or symptom should trigger an in-person visit to confirm BP cuff accuracy, laboratory evaluation, and fetal assessment.

		unless the patient has severe features	
Management	• In preeclampsia without severe features, expectant management is used until 37 weeks GA. • In preeclampsia with severe features, inpatient management to 34 weeks GA is recommended, followed by delivery. • ACOG recommends serial growth ultrasound, weekly antepartum testing, close monitoring of BPs, and weekly laboratory tests.	• In preeclampsia without severe features, expectant management can be used until 37 weeks GA.(unchanged) • In preeclampsia with severe features, *outpatient* management can be considered up to 34 weeks if clinically stable. • Frequency of surveillance and timing of delivery may be adjusted as needed based on the clinician's risk assessment	• In-person visits and fetal surveillance may be staggered on alternate days with telehealth reviews of BP logs and symptoms • The utility of weekly laboratory studies for preeclampsia in decision-making regarding delivery has also been called into question • Written and detailed instructions on calling guidelines should be provided. Patients must have access to a direct communication line. Patients must be reliable, understand potential risks, and have rapid hospital access.
Delivery	• Intrapartum and 24-hour postpartum magnesium sulfate seizure prophylaxis	• If clinically stable, outpatient cervical ripening protocols can be considered in the appropriate candidate to minimize the duration of admission. • Limitation of postpartum magnesium to 6-12 hours in clinically stable patients	• Elimination of magnesium sulfate for seizure prophylaxis has been advocated among patients without severe features.
Fetal Growth Restriction (12–18)			

Diagnosis	• In low-risk patients, fundal height screening is performed during prenatal visits after 24 weeks GA • In high-risk patients, regular sonographic growth assessments are recommended, with frequency not specified • Diagnostic criteria for FGR is set at EFW or AC <10th percentile	• Tailor frequency of sonographic growth assessment (ever 4-8 weeks) to associated relative risk of stillbirth • Consider use of more stringent criteria for FGR to determine entry into additional surveillance	• No study has demonstrated effectiveness of home fundal height evaluation
Management	• Growth assessments at 2-4 week intervals. • Weekly antenatal testing with Doppler, to be initiated when intervention would be performed	• Growth assessments at 3-4 week intervals. • Surveillance and umbilical artery Doppler studies at 1-3 week intervals, if Dopplers remain normal • If Dopplers become elevated, recommend twice weekly Dopplers.	• Telemedicine review of fetal movement logs may be used in alternating intervals with in-person surveillance
Delivery	• Delivery at 38-39 6/7 weeks GA for isolated FGR • Delivery at 32-37 6/7 weeks GA for FGR with additional risk factors for adverse outcome	• Delivery may be shifted to the latter part of the recommended gestational age ranges to promote cervical ripening and decrease in-hospital duration of induction, using clinician judgment on a case-by-case basis	• FGR is not an automatic indication for cesarean delivery, particularly as this has the potential to prolong hospitalization. • The threshold for recommending a cesarean delivery during labor with non-reassuring fetal status remote from delivery may be lowered in order to

			avoid the need for emergent conversion to cesarean. Emergent patient transport and intubation can increase the risk viral aerosolization and healthcare worker exposure.
Preterm Labor (19–21)			
Diagnosis	• Preterm contractions with cervical change	• Preterm contractions with cervical dilation 2cm or greater	• Fetal fibronectin may be used in triaging patients to outpatient management
Management	• Tocolysis until completion of antenatal steroid administration	• Consider outpatient management after completion of steroids if clinically stable without further or advanced cervical dilation	• Patients must be reliable, understand potential risks, and have rapid hospital access.
Preterm premature rupture of membranes (22–24)			
Management	• Inpatient expectant management if delivery not otherwise indicated	• Inpatient expectant management until completion of latency antibiotics • Consideration of outpatient expectant management after latency antibiotics with daily telehealth visits	• Patients should conduct q6-8 hour temperature and heart rate assessments, fetal movement logs • Written and detailed instructions on calling guidelines should be provided. Patients must have access to a direct communication line. Patients must be reliable, understand potential risks, and have rapid hospital access.

Delivery	• Delivery at 34 weeks GA	• Expectant management to 36 6/7 weeks GA in the well-selected patient may improve obstetric outcomes	• Delivering in the late preterm period may decrease the length of hospital stay for the maternal-neonatal dyad
Diabetes mellitus in pregnancy (25–29)			
Diagnosis (Gestational Diabetes Mellitus [GDM])	• Stepwise laboratory screening via 1-hour 50-gram and reflex 3-hour 100-gram glucose load	• One step assessment among patients with risk factors.	• Options for alternate testing modalities include the 2-hour 75-gram glucose load, or the 1-hour 50-gram load without reflexing to the 3-hour confirmatory test
Management	• Serial in-person glucose log evaluation • A2GDM and pregestational DM: Serial fetal growth assessment. • A2GDM and pregestational: Weekly or twice weekly surveillance after 32 weeks GA.	• Frequent telehealth visits for diabetic education, nutritional and glucose monitoring. • A2GDM and pregestational DM: Surveillance schedule should be tailored to glucose control. If a patient is well-controlled, antenatal testing may be delayed beyond 32 weeks GA. • No additional surveillance is necessary for A1GDM.	• If the patient is diagnosed with "GDM" using the alternate screening modalities, but glucose logs are within normal limits after testing for a period of time, fingerstick testing can be stopped or decreased in frequency. • Group prenatal care via teleconferencing can be considered for diabetes education. In-person group prenatal care should be halted during social distancing.
Delivery	• A1GDM: Expectant management until 41 weeks GA. • A2GDM or pregestational DM: Delivery at 39 weeks GA, or	• Unchanged, but can consider delivering towards the latter part of the recommended range.	• Delivery planning should be made to decrease the length of hospital stay for the maternal-neonatal dyad

	37-38 6/7 weeks GA with poor glucose control		
Postpartum	• Postpartum screening for persistent DM with fasting blood glucose and 2-hour glucose after a 75-gram glucose load, performed at 4-12 weeks postpartum	• Can consider a 75-g oral glucose tolerance test during the delivery hospitalization	• Measurement of hemoglobin A1c alone is not a sensitive test to detect abnormal glucose tolerance in postpartum period.
Antenatal bleeding			
Management	• Inpatient expectant management if hemodynamically stable with reassuring fetal status. • Can consider outpatient management after prolonged observation. • Steroids can be considered if GA is appropriate.	• Outpatient management if medically stable. Patients should have frequent virtual assessments of symptoms and fetal movement logs, alternating with in-person fetal evaluation. • Steroids should be considered with caution (Table 3)	• Outpatient management should be considered only with absence of bleeding or evidence of preterm labor. • Patients must be reliable, understand potential risks, and have rapid hospital access. Providers must provide access to a direct provider line and strict calling guidelines.
Delivery	• Expectant management until bleeding recurrence or planned preterm delivery.	• Planned preterm delivery may be indicated if safe expectant management cannot be performed.	• Timing of delivery remains per ACOG recommendations on medically indicated deliveries, but providers can err on the latter part of the GA range if the patient is stable

Intrapartum care

Labor and Delivery (30–31)			
Bed management	• Admission in active labor	• Unchanged	• Leadership team must ensure adequate staffing to maintain mother:nurse ratios
Anesthesia	• Upon request for pain management	• Upon request • Early regional analgesia if increased likelihood of cesarean	• Avoid nitrous oxide in some pandemics (see Table 3)
Induction of labor (32)			
Bed management	• Elective induction permissible at 39 weeks or as medically indicated	• Medically indicated inductions only. Minimize elective inductions. • Outpatient cervical ripening protocols can be considered.	
Blood products	• Available as per unit protocol	• Continual assessment for hemorrhage risk for early intervention and minimization of blood product usage.	
Complex surgical deliveries: such as placenta accreta spectrum; previous abdominal surgery; previous transplant; large fibroids; refusal of blood products			
Bed management	• Delivery timing as indicated by the pathology	• Delivery timing balancing risk of 1) emergent presentation and delivery, 2) resource availability on unit, and 3) reduction in duration of	• Delivery should not be delayed beyond the recommended GA range for each pathology, but can be moved towards the latter part if the patient is clinically stable.

		maternal and neonatal hospitalization	
Anesthesia	• In person anesthesia consults as indicated	• Use of telehealth anesthesia consults • Multidisciplinary team preparations via teleconference • Consideration of likelihood of conversion to general anesthesia in pre-operative anesthetic planning	• Appropriate PPE should be donned per pandemic-specific recommendations
Blood products	• Available as per unit protocol	• Preoperative optimization of hemoglobin • Use of cell salvage, vascular occlusion/embolization, and transexamic acid in patients without pro-thrombotic risks, (Table 3) • Rapid escalation to hysterectomy if indicated	• The decreased blood blank supply chain during pandemics can significantly affect blood product availability. Open lines of communication is recommended with the blood bank to prepare for upcoming complex deliveries.

Postpartum care			
Postpartum hemorrhage (33–34)			
Anesthesia	• Awareness of high-risk patients	• Early anesthesia consultation in high risk patients • Ensure vascular access	

Blood products	• Available as per unit protocol	• Early utilization of tranexamic acid (in patients without pro-thrombotic risks; Table 3), balloon compression, or vascular embolization • Rapid escalation to hysterectomy if indicated	• The decreased blood blank supply chain during pandemics can significantly affect blood product availability. Open lines of communication is recommended with the blood bank to prepare for upcoming complex deliveries.
Post-cesarean delivery monitoring (35–39)			
Postoperative recovery	• Enhanced recovery after surgery (ERAS) protocols are being increasingly adopted	• ERAS protocol should be encouraged to decrease duration of hospital stay	
Incision monitoring	• In-person follow-up at 1-3 weeks for wound check	• Telehealth based evaluation at 1-3 weeks	• Ideally, a visual component to the telehealth visit (via still image of the incision or video capabilities) is recommended. • It is important to note that not all patients will be able to self-evaluate their incision. • Calling guidelines need to be reviewed.
Postpartum care of Hypertensive disorders (40–44)			
Blood pressure monitoring	• BP care and symptoms assessment at 1-3 weeks	• Telehealth based evaluation • Provision of home-based pre-calibrated sphygmomanometer.	• More frequent home BP checks may be necessary if the patient is discharged early or requires antihypertensive medications.

			• Written and detailed instructions on calling guidelines should be provided. Patients must be reliable and have rapid hospital access.
Postpartum depression and mood disorders (45–52)			
Depression screening	• Screening for postpartum depression throughout the postpartum period	• Screening should be performed via telehealth • Referral to tele-mental health services as indicated	• Risk of mood disorders significantly increased during pandemics and requires additional surveillance • Obstetricians should partner with pediatricians to expand screening, as this can effectively be incorporated into well-child checks • Assure referral and treatment services are available for those with positive screening results
Contraception access (53–54)			
Contraception	• LARCs are often placed at postpartum outpatient visits	• Post-delivery LARC should be offered to decrease need for another in-person visit	• Antepartum and postpartum counseling regarding long-acting reversible contraceptives (LARC) increases acceptance. LARC improves optimal pregnancy spacing nearly 4 times over barrier contraception • Those starting other types of contraception (even in 4-6 weeks) should be provided these medications on discharge to avoid need to return to

			office or pharmacy and to avoid delayed starts
Postpartum bilateral tubal ligations	• Routinely performed postpartum in some centers	• Access becomes limited in some centers, as it is felt to be a non-essential by some organizations • If unavailable, alternative contraception should be encouraged and arranged	

Obstetrical care is divided into four blocks: early pregnancy care, antepartum care, intrapartum care, postpartum care). The overall goal is to balance community mitigation protocols with ensuring adequate screening.

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