From The National Perinatal Information Center: Caring for Patients and Care Teams during COVID-19

Elizabeth Rochin, PhD, RN, NE-BC

The National Perinatal Information Center (NPIC) is driven by data, collaboration and research to strengthen, connect and empower our shared purpose of improving patient care.

For over 30 years, NPIC has worked with hospitals, public and private entities, patient safety organizations, insurers and researchers to collect and interpret the data that drives better outcomes for mothers and newborns.

NPIC

National Perinatal Information Center

On January 23, 2020, the first reported laboratory-confirmed case of COVID-19 was described in Illinois (Ghinai et al., 2020). From that moment, life in the United States changed virtually overnight. By the end of March 2020, schools were closed across the nation, stay-at-home orders covered most of the country, and social media became the lifeline for clinicians and providers alike.

On the social media platform Twitter, the hashtag #MedTwitter has been utilized by healthcare teams across the nation in their quest for COVID-19 information. An overview of the Twitter analytics for #MedTwitter reveals the following during the time period March 22 – April 8, 2020 (Symplur Health Analytics, 2020):

- 376,753,000 Impressions
- 107,210 Tweets
- 71,785 Participants
- 272 Average Tweets per hour

In addition to #MedTwitter utilization, there has also been the utilization of #COVIDNeo to detail conversations surrounding COVID-19 and neonatology care. During the following timeframe of March 10 – April 9, 2020, the following analytics are provided (Symplur Health Analytics, 2020):

- 1,550,000 impressions
- 1,135 Tweets
- 578 Participants
- 2 Average Tweets per hour

Many of these Tweets have sought to connect clinicians and providers to one another as they care for patients on the front line of COVID-19. Most recently, these conversations have included the care of pregnant women with COVID-19, women who have COVID-19 and admitted for delivery, and women who are positive for COVID-19 and have a baby admitted to the NICU.

What are some of the overarching themes of these conversations?

1. Access to just-in-time and real-time information related to pregnancy, newborn, care of patients in the ICU (adult and neonatal)
2. Moral distress of the care teams when separating mother and newborn

As noted above for #MedTwitter and #COVIDNeo, providers and clinicians alike have detailed “Pre COVID-19” and “Post COVID-19.” And to what are these clinicians referring? They are referring to the thousands of clinical pearls that have been available through Twitter and Instagram platforms during this pandemic. There are prolific posts that include lamenting the return to “normal,” when publications no longer offer so many open access publications and papers that are requisite for treating a novel coronavirus. Data is free-flowing, and even the smallest inklings of data have meaning, and outcomes are described in virtually real-time. This analysis is an area that data scientists and those who utilize larger databases that take time to mobilize will need to think through carefully. The need for real-time data and outcome comparison in this pandemic environment has become a requisite approach, one that can be augmented by larger data lakes, platforms, and databases to further detail disparities and outcomes.

Dr. Yale Tung Chen (@yaletung) from Madrid, Spain, became a #MedTwitter celebrity as he journaled his chronicles with COVID-19, with daily signs, symptoms, and point of care ultrasound (POCUS) findings (he used his iPhone and personal portable ultrasound equipment) that helped to illustrate real-time the impact of the virus on the human body. Various clinicians have shared CT scans, MRI’s, blood gases, and the like, and Twitter has become a “living laboratory” for COVID-19 response and treatment.

AAP, SMFM, and ACOG began to rapidly develop guidelines and standards that could provide obstetric and neonatal teams with the information that they could use, knowing full well that information could change in a day, an hour, or a minute. Cynthia Gyamfi, MD, Maternal-Fetal Medicine, and colleagues at

Columbia and New York-Presbyterian published a case report of 43 women in New York City, which revealed that many women are asymptomatic at admission, and all neonates were negative for infection (Gyamfi et al., 2020).

However, the care of women and newborns has taken and will take a toll on providers and clinicians throughout perinatal care, including Labor and Delivery, Postpartum, and Neonatal Intensive Care. At press time of this publication, separation of mother and baby is recommended for women who are COVID-19 positive and delivering a newborn (American Academy of Pediatrics, Centers for Disease Control). While the development of these recommendations has been laborious, it also presents a conundrum for care teams, who have worked tirelessly to assure that mother and newborn can be connected immediately after birth. Separating mother and newborn is antithetical to care teams. Being a part of that separation can not only have an impact on the family cared for, but those also caring for the family. There have been those who are vocal opponents of this strategy but also vocal supporters, which creates additional stressors for care teams in applying the latest recommendations and emerging evidence surrounding COVID-19, pregnancy, childbirth, and neonatal care.

It is incumbent upon hospitals, professional associations, and others connected to healthcare that the mental health of providers and frontline staff is supported and maximized. A few items to note as you consider your facilities and resources available to your teams:

- How is your unit/organization assessing the needs of your frontline teams during COVID-19? How often do Executive level team members round on the frontline? Daily? Weekly? And how does that compare to "pre-COVID-19" rounding schedules?
- Is your organization assessing and measuring caregiver moral distress symptoms in your units? Are chaplains/support personnel available to your providers and clinicians?
- How often are your units performing debriefs at the end of shifts? Where are these occurring? Lounges? Units? And who is running these debriefs?
- Are mental health resources available to the families of providers and clinicians? Both providers and those at home can have very intense needs from a safety, stress, and mental health perspective
- Are your Employee Assistance Programs (EAP) staffed and able to handle a potentially higher volume of traffic? Have these resources been tested and affirmed for your teams?

Of course, caring for our vulnerable women and newborns is a priority for our healthcare system. The care and commitment to our frontline healthcare workers must be a priority as well. On behalf of NPIC, we are grateful to those caring for women, newborns, and their families and grateful to the families of frontline caregivers. You are our heroes.

References:

Breslin, N., Baptiste, C., Gyamfi, C., Goffman, D. (2020). COVID-19 infection among asymptomatic and symptomatic pregnant women: Two weeks of confirmed presentations to an affiliated pair of New York City hospitals. American Journal of Obstetrics and Gynecology, in press.

Ghiani, I., McPherson, T.D., Hunter, J.C…Layden, J.E. (2020). First known person-to-person transmission of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in the USA. Lancet, 395, 1137-1144.

The author has no conflicts of interests to disclose.

NT

Corresponding Author:

Elizabeth Rochin, PhD, RN, NE-BC
President
National Perinatal Information Center
225 Chapman St. Suite 200
Providence, RI 02905
401-274-0650
inquiry@npic.org