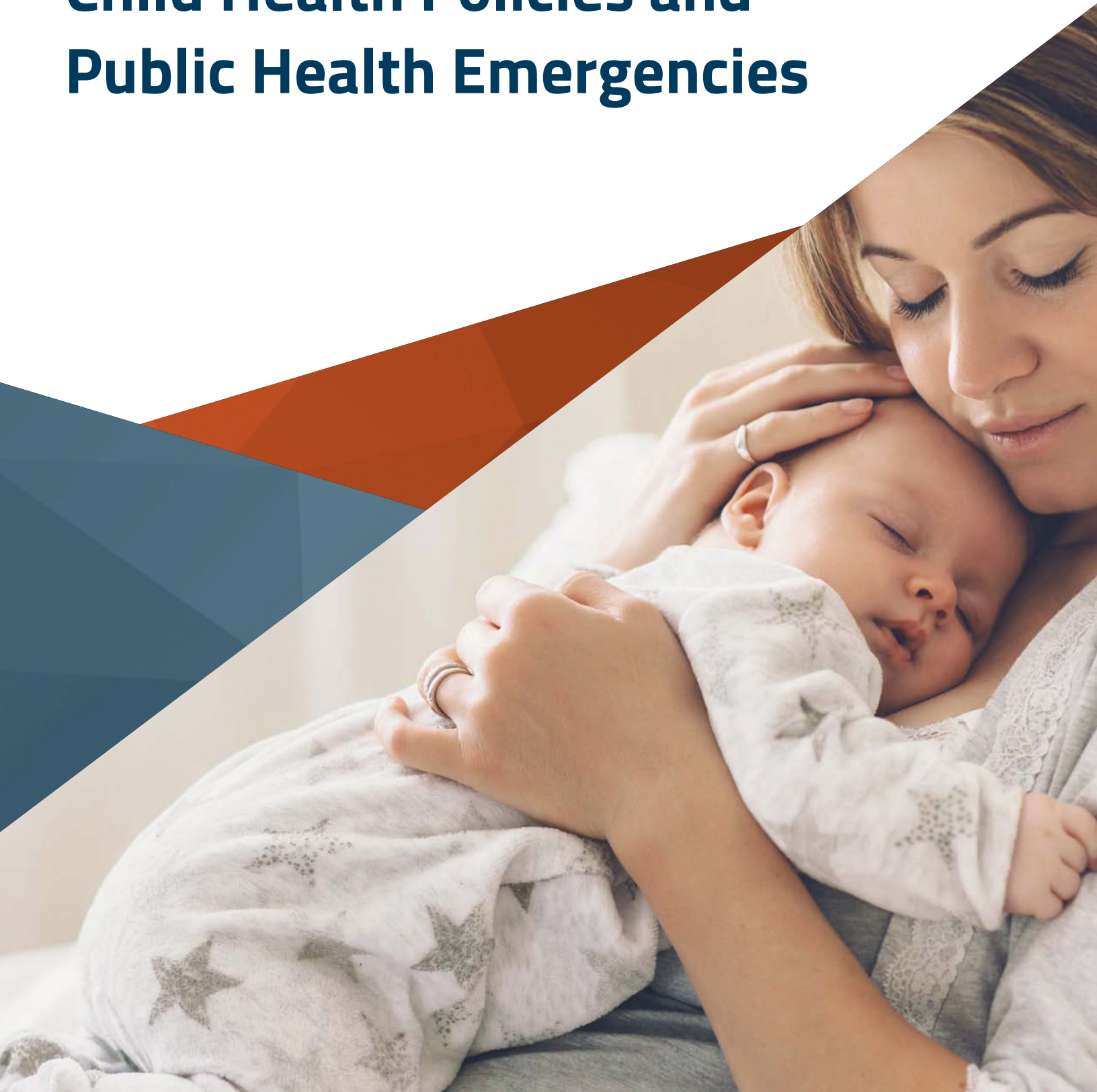


Considerations for Maternal Child Health Policies and Public Health Emergencies



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August 2022

Executive Summary

Access to care for pregnant people, neonates, and infants [can be interrupted during emergencies](#), including natural disasters such as hurricanes, wildfires, and floods. One category of public health risks following a natural disaster is [infectious disease outbreaks](#) following population displacement and changes to the environment resulting from the disaster. Public health emergencies caused by emerging infectious disease, whether precipitated by a natural disaster or resulting from an epidemic or pandemic, can disproportionately impact pregnant people, neonates, and infants as demonstrated by the [Zika virus epidemic](#) and [COVID-19 pandemic](#).

There is strong evidence that pregnant people are more likely to experience [increased disease severity for infections](#) such as influenza and malaria. Pregnant people [may be more susceptible to acquiring infectious disease](#), such as HIV and malaria. Determining why pregnancy is a risk factor for some infections or more severe disease is an evolving area of medical and public health research. Although greater research is needed to identify why pregnant people's immunology shifts during pregnancy, evidence indicates that [changes to the immune system](#) may increase a person's susceptibility to certain viruses, bacteria, and parasites. Additionally, infections during a pregnancy [may result in negative health outcomes](#) for the developing fetus. These negative outcomes could include pre-term birth, birth defects, or transmission of the infection to the infant.

Although exposure to some of these pathogens can be prevented through proper food handling and vaccines, healthcare providers need to know the existence of an infection—such as Echovirus or HIV—and provide treatment or alter birthing plans to prevent perinatal transmission. Public health officials can also mitigate the impact of disease outbreaks on pregnant people, neonates, and infants through a variety of policies, including policies related to preparing for, responding to, and recovering from a public health emergency.



Preparedness

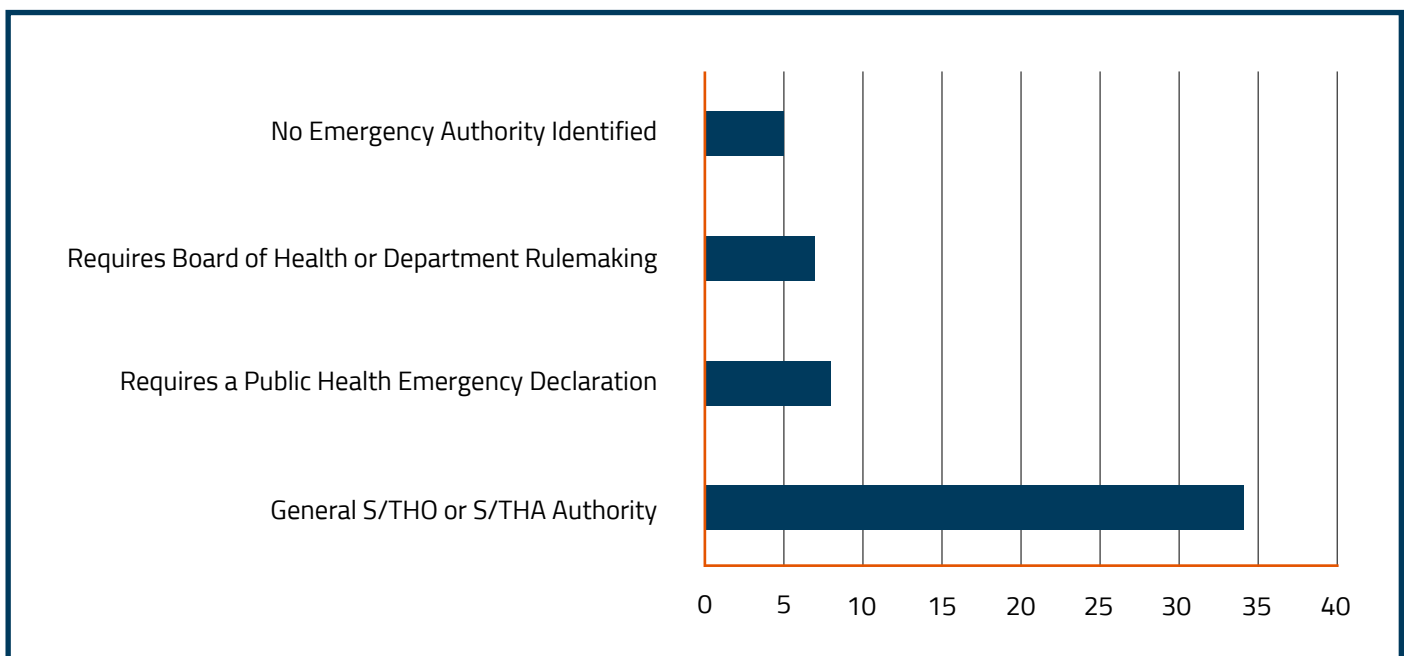
Disease surveillance is an essential public health tool that detects disease outbreaks, tracks occurrences of chronic conditions and birth defects, as well as other indicators of overall population health. The 50 states, Washington, D.C., Puerto Rico, and the United States Virgin Islands require certain diseases be reported to either local or state health departments by medical professionals such as physicians or pharmacists or medical laboratories.¹

The speed of these reports varies based on the type of disease identified, with many jurisdictions creating tiers of diseases to report within timeframes ranging from immediately to within 72 hours. At least ten states require certain infections to be reported to public health officials if they are acquired by a pregnant person, including HIV, syphilis, and Zika.² Additionally, at least three states require infectious disease reports to note a patient's pregnancy status regardless of the reportable infection.³

Leveraging Disease Reporting Requirements for Outbreaks and Emerging Infectious Disease

When a novel disease emerges in a community or there is an outbreak of disease that doctors are not required to report to public health officials, most jurisdictions have a clear mechanism to require healthcare professionals to report the infection on an emergency basis. In at least 34 state and territorial jurisdictions, the public health department or designated health official has authority to require reporting for certain disease outbreaks or novel disease.⁴ Similarly, in at least eight jurisdictions the department can require additional reporting for a disease that is the basis for a declared public health emergency.⁵ In at least seven jurisdictions, the Board of Health or department must initiate emergency rulemaking procedures to add a new disease to the reporting requirements.⁶

Number of States/Territories with Authority to Add New Infection/Outbreak to Disease Reporting Requirements



Pregnant people, neonates, and infants are often at higher risk for emerging infectious diseases and novel diseases circulating in the population. A robust disease reporting system can provide public health officials and healthcare providers critical information about disease risks within the population. When informed of novel diseases identified in a jurisdiction, or early indications of an outbreak, public health officials and healthcare leaders are better positioned to implement a timely response effort with the unique needs of pregnant people, neonates, and infants in mind.

KEY CONSIDERATIONS

- Public health officials and their professional associations should be aware of how their jurisdiction is able to add new diseases to the required reporting list, work with their policy and legal teams to identify the most efficient way to do so while maintaining patient confidentiality, and to inform those who are required to report the information of the addition.
- Although many jurisdictions require health agencies to review disease reporting requirements at least annually, all jurisdictions can assess which diseases must be reported and by whom at any time.
- Public health leaders can work with healthcare professionals—including OB/GYNs and pediatricians—to inform them of the risks of certain infectious diseases during pregnancy and early infancy and the best way to notify the health department if they observe unusual or unique symptoms in a patient.

Disease Surveillance for Birthing-Parent and Infant Dyads

Within existing disease reporting requirements, some jurisdictions also monitor birthing-parent and infant dyads for negative public health outcomes. The integration of data using the birthing parent-infant dyad can help determine the potential risk of disease or infection to pregnancy and infants, including severe illness and adverse pregnancy outcomes. Since 2019, CDC has been collaborating with state, local, and territorial health departments to [create the infrastructure](#) to monitor pregnant people and infants for potentially negative pregnancy and/or birth outcomes linked to an infectious disease. Thanks to annual federal funding and COVID-19 supplemental federal funding for this program, the [Surveillance for Emerging Threats to Mothers and Babies Network](#) (SET-NET), 24 states, five cities, and two territories have dedicated support to participate in the program.

SET-NET [collects general data](#) on birthing parent--infant dyads for all health threats, including the pregnant person's age, any pregnancy complications, and the infant's height and weight. Additional data points are collected depending on the specific exposure being studied, such as COVID-19, hepatitis C, or syphilis. These exposure specific modular variables enable the program to adapt to new diseases and emerging public health threats. SET-NET uses existing disease reporting forms and laboratory reporting, synthesizing the information with existing health records, and birth and death records. Medical information collected in SET-NET is protected by [CDC's Assurance of Confidentiality](#).

KEY CONSIDERATIONS

- When considering whether to implement pregnancy-infant linked surveillance approaches, jurisdictions should factor in how data are entered into current syndromic surveillance and disease reporting systems to minimize the need for additional data entry from healthcare providers.
- Jurisdictions can explore joining the program to gather longitudinal data on birthing parent-infant dyads, including assessing interoperability of existing disease surveillance systems and considering interoperability for procuring future systems and data exchanges.





Response

After public health officials identify a potential disease or condition that could result in a public health emergency for their jurisdiction, there are several policy options that could benefit pregnant people, neonates, and infants so they can access safe and supportive medical care while minimizing their risk for exposure. Several policies were implemented during the COVID-19 pandemic to promote social distancing, a disease mitigation [effort shown to successfully minimize the spread of COVID-19](#).

While social distancing lowers the risk of infection, the pandemic also highlighted the need to balance the risk of transmission with the social and emotional needs of pregnant and postpartum people. Below are three policies to consider during a public health emergency response to lower the risk of disease transmission while also providing safe and supportive healthcare for pregnant people, neonates, and infants.

Leveraging Telehealth

[Telehealth uses technology](#) to facilitate communication between a patient and a healthcare practitioner through remote monitoring and provision of healthcare services, rather than a traditional face-to-face interaction. During a public health emergency, transitioning to telehealth appointments minimizes a patient's exposure to the disease by limiting their interactions with other people outside of the home, while still providing care.

The American College of Obstetricians and Gynecologists (ACOG) [recommends using telehealth](#) during public health or environmental disasters to provide pregnant and postpartum people access to care while lowering the risk of overwhelming medical facilities. Additionally, [ASTHO issued a brief](#) outlining how telehealth can be used to provide pregnant people care during the COVID-19 pandemic.

In addition to emergencies, a 2020 [Kaiser Family Foundation report](#) found that increased use of telehealth for prenatal and postpartum care may reduce disparities in maternal morbidity and mortality experienced by people living in rural settings. A pregnant person could have close to [14 in-person visits during pregnancy](#) under a traditional prenatal care model, with some of these visits able to be safely conducted virtually rather than in-person. These telehealth visits, coupled with at home monitoring of a pregnant person's health, can provide high rates of patient satisfaction, reduce costs, and minimize a pregnant person's exposure to disease.

During the COVID-19 pandemic, the federal government loosened telehealth restrictions in certain areas while almost all states [temporarily expanded telehealth services available under Medicaid](#). In addition to expanding access, hospitals across the nation instructed patients exhibiting COVID-19 symptoms to [schedule a telehealth appointment prior to visiting](#) the emergency room or urgent care.

With the success of leveraging telehealth for maternal and postpartum care, several states are codifying the emergency provisions to their Medicaid programs into law. For example, in 2021 Nebraska enacted [LB 400](#) to include audio-only services for mental and behavioral health services under its Medicaid program.

KEY CONSIDERATIONS

- When a public health emergency is imminent or declared, public health officials should assess whether there are medical services that could safely be provided virtually and make the appropriate recommendations to providers in their jurisdiction.
- To support using telehealth during an emergency, state leaders should assess existing payment mechanisms for telehealth services. To the extent permitted under state law, public health officials should work with other agency leaders to expand access to telehealth via increased Medicaid coverage or requiring coverage of certain services under private health insurance.

Access to Supportive Persons During Medical Treatment

In the early months of the COVID-19 pandemic, many healthcare facilities restricted visitor access based on [early recommendations](#) to limit gatherings as a way to reduce the spread of disease. These limitations included many hospitals only [permitting one adult visitor](#) for a patient in a labor and delivery unit, with some early public health orders prohibiting visitors in labor and delivery all-together. While the total prohibitions were short-lived, the overall effect of visitor restrictions to limit the spread of disease has [not been widely researched](#).

At least one study assessing COVID-19 positive patients who were not permitted visitors during labor and delivery reported greater pain and stress than COVID-19 positive patients that were permitted visitors. Additionally, some research indicates that supportive postnatal environments may be related to parents meeting their breastfeeding goals.

In response to concerns of visitors unable to access loved ones in healthcare facilities during the COVID-19 pandemic, several states enacted laws prohibiting visitor restrictions during public health emergencies.

Alabama enacted [HB 521](#) in 2021 to prohibit blanket visitor restrictions during a public health emergency, although the law permits facilities to initiate infection control policies such as requiring visitors to wear personal protective equipment while visiting. Similarly in 2021, North Carolina enacted [SB 191](#), which prohibited healthcare facilities from prohibiting visitors and requires facilities to provide patients information on their visitation rights.

KEY CONSIDERATIONS

- During a public health emergency necessitating social distancing, public health leaders should consider guidance to minimize disease spread and allows a birthing parent to have a supportive person during labor, delivery, and post-partum care to support physical and mental health.
- State policy makers should consider enacting laws or policies requiring visitation rights for pregnant people, neonates, and infants receiving in-person care.



Considerations During Crisis Standards of Care

When a healthcare system experiences resource shortages—such as limited space, supplies, or staff—medical providers must make difficult decisions in allocating scarce resources. During these times of scarcity, facilities and jurisdictions may implement [Crisis Standard of Care](#) (CSC) to guide resource allocation decision making.

[Pregnant people and children](#) are sometimes prioritized in the development of CSCs, particularly when the prioritization of resources considers the total potential lives saved as well as potential years of life. However, [HHS’s Office for Civil Rights \(OCR\) issued guidance](#) in March 2020, clearly stating that all treatment decisions under CSC “should be based on an individualized assessment of the patient based on the best available objective medical evidence.”

Throughout the waves of COVID-19 experienced in 2020, two states—[Arizona](#) and [New Mexico](#)—activated CSCs statewide. In 2021, [Idaho](#) activated its crisis standards of care for hospitals in the northern part of the state, using a rule adopted by the [Idaho Department of Health and Welfare in December 2020](#). Under Idaho’s rule, the department convened an advisory committee with representatives from healthcare facilities and public health leaders to make recommendations on the CSCs. While these standards did not particularly address pregnant people, the [New Mexico patient care strategies](#) highlighted special considerations for pediatric patients.

ASTHO identified four states with statutes related to CSCs: Arizona, Idaho, Utah, and Oregon. These statutes ranged from authorizing the state department of public health to initiate rulemaking to establish CSCs (Utah) to directing the department to waive nursing staffing requirements in facilities experiencing scarce resources and moving to CSCs (Oregon).

KEY CONSIDERATIONS

- Jurisdictions undergoing CSC planning should consider the specialized needs of pregnant people, neonates, and infants when assessing resources.
- The allocation of resources must be based on individual medical assessments and objective medical evidence, which includes considerations for a birthing person’s plan for delivery without pressure to change their plan based solely on scarcity of resources.

Recovery

After a public health emergency, policy makers and public health leaders have an opportunity to adjust existing policies or create new ones incorporating best practices and lessons learned during the response. For example, the foundation of SET-NET—a valuable preparedness tool for pregnant people and infant surveillance—were the lessons learned and [systems built during Zika](#) response. Similarly, states are incorporating lessons learned from the COVID-19 pandemic in establishing visitor rights for patients during a public health emergency and reassessing their CSC planning efforts.

KEY CONSIDERATIONS

- Executive Orders and Public Health Orders issued during an emergency response that improved care, such as expanding telehealth access, should be assessed by policy makers and considered for codification in statute or rule.
- Programmatic systems developed during a response should be evaluated by public health leaders for use in future public health emergencies and included in preparedness plans.



Conclusion

Public health leaders should consider ways to promote the health and safety of pregnant people, neonates, and infants when developing emergency preparedness, response, and recovery plans. The evidence-based and promising policy considerations outlined above can be incorporated into emergency plans to better support care for this population before, during, and after an emergency.

¹ Ala. Admin. Code r. 420-4-1-.04; 7 Alaska Admin. Code 27.005; A.A.C. § R9-6-206; 007 26 CARR 001; 2008 CA Regulation Text 18517; C.R.S. 25-1-122; Regs., Conn. State Agencies § 19a-36-A4; CDR 16-4000-4202; CDCR 22-B202; Fla. Stat. § 381.0031; O.C.G.A. § 31-12-2; HAR 11-156; IDAPA 16.02.10.20; 77 Ill. Adm. Code 690.200; 410 IAC 1-2.5-75; Iowa Code § 139A.3; K.S.A. § 65-118; 902 KAR 2:020; LAC 51:11.105; CMR 10-144-258; Md. HEALTH-GENERAL Code Ann. § 18-201; ALM GL ch. 111, § 111; MICH. ADMIN. CODE R 325.173; Minn. R. 4605.7030; CMSR 15-002-001; 19 CSR 20-20.020; ARM 37.114.204; Nebraska Admin. Code Title 173, Ch. 1; NV ADC 441A.225; N.H. Admin. Rules, He-P 301.03; N.J.A.C. 8:57-1.6; 7.4.3.8 NMAC; 10 NY ADC 2.10; N.C. Gen. Stat. § 130A-135; ND ST 23-07-02.1; OAC Ann. 3701-3-02; OK ST T. 63 § 1-503; OR ADC 333-018-0000; 35 P.S. § 521.4; 24 L.P.R.A. § 352; 216 RICR 030-05-1; S.C. Code Regs. 61-20; ARSD 44:20:02:02; Tenn. Comp. R. & Regs. R. 1200-14-01-.02; Tex. Health & Safety Code § 81.042.; Utah Code Ann. § 26-6-6; CVR 13-140-007; CVIR 19-001-000, Sec. 1-3; 12 VAC 5-90-90; Rev. Code Wash. (ARCW) § 70.05.090; W. Va. CSR § 64-7-3; Wis. Adm. Code DHS 145.04; WCWR 048-0046-11.

² Arkansas (007 15 CARR 008); Florida (64D-3.029, F.A.C.); Hawaii (HAR 11-156); Kansas (K.A.R. § 28-1-2); Minnesota (Minn. R. 4605.7044); Mississippi (CMSR 15-002-001); Missouri (19 CSR 20-20.020); New Hampshire (N.H. Admin. Rules, He-P 301.02) Rhode Island (216 RICR 030-05-1); Utah (U.A.C. R386-702-3)

³ Iowa (Iowa Code § 139A.3); Kentucky (902 KAR 2:020); Nebraska (Nebraska Admin. Code Title 173, Ch. 1)

⁴ Alaska (Alaska Stat. § 18.15.360); California (Cal Health & Saf Code § 120130); Connecticut (Regs., Conn. State Agencies § 19a-36-A7); Florida (Fla. Stat. § 381.0031); Hawaii (HAR 11-156); Iowa (641 IAC 1.3); Kansas (K.A.R. § 28-1-2); Louisiana (LAC 51:11.105); Maryland (COMAR 10.06.01.03); Massachusetts (105 CMR 300.133); Minnesota (Minn. R. 4605.7050); Nebraska (Nebraska Admin. Code Title 173, Ch. 1); Nevada (NAC 441A.260); New Hampshire (N.H. Admin. Rules, He-P 301.02); New Jersey (N.J.A.C. 8:57-1.5); New Mexico (7.4.3.13 NMAC); New York (10 NYCRR § 2.1); North Carolina (N.C. Gen. Stat. § 130A-141.1); North Dakota (N.D. Cent. Code, § 23-07-02.3); Ohio (OAC Ann. 3701-3-02); Oklahoma (O.A.C. § 310:515-1-6); Oregon (OAR 333-018-0015); Pennsylvania (35 P.S. § 521.2); Rhode Island (216 RICR 030-05-1); South Carolina (S.C. Code Regs. 61-20); Tennessee (Tenn. Comp. R. & Regs. R. 1200-14-01-.02); Texas (25 TAC § 97.3); Utah (U.A.C. R386-702-3); Vermont (CVR 13-140-007); Virginia (12 VAC 5-90-80); Washington (WAC § 246-101-510); and Wisconsin (Wis. Adm. Code DHS 145 Appx. A).

⁵ Delaware (CDR 16-4000-4202); Georgia (O.C.G.A. § 31-12-2); Illinois (77 Ill. Adm. Code 690.100); Kentucky (902 KAR 2:020); Maine (22 M.R.S. § 802); Michigan (MICH. ADMIN. CODE R 325.172); Puerto Rico (24 L.P.R.A. § 359c); and West Virginia (W. Va. CSR § 64-7-3).

⁶ Alabama (Ala. Admin. Code r. 420-4-1-.03), Arkansas (007 26 CARR 001), Colorado (6 CCR 1009-1), Indiana (410 IAC 1-2.5-75), Mississippi (CMSR 15-002-001), Missouri (§ 192.020 R.S.Mo.), and Montana (50-1-202, MCA)

⁷ A.R.S. § 36-791; Idaho Code § 56-1706; Utah Code Ann. § 26-1-45; and ORS § 441.165