

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1330.03(1)
Transmittal Sheet
November 3, 2020

MATERNITY HEALTH CARE AND COORDINATION

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy and requirements for providing and coordinating maternity care for eligible pregnant Veterans in the Department of Veterans Affairs (VA) health care system.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Amendment dated January 23, 2025:

(1) Updates terms in paragraphs 3.h., 3.i., and 6.k.(4) from mother and breastfeeding to pregnant person and breast/chestfeeding, respectively.

(2) Adds responsibilities in paragraph 5.c., 5.e.(4), and 5.e.(5) for the Chief Officer, Office of Women's Health and the VA medical facility Director clarifying that onsite prenatal care must not be provided without a formal approval process and that care must be provided within the privileging and scope of practice of VA staff and health care providers to satisfy VA Office of the Inspector General (OIG, MCI #2022-02975-HI-1275) recommendation in OIG Report 22-02975-70.

(3) Updates the VA medical facility Chief of Emergency Medicine responsibility in paragraph 5.h.(2) to ensure testing is provided in accordance with relevant VHA directives.

(4) Updates the NOTE in paragraph 6.k. to reflect updated mechanisms for payment.

(5) Updates paragraph 8 to include exceptions for abortion coverage.

b. As published November 3, 2020, major changes included:

(1) Guidance for pregnant Veteran contact and follow-up.

(2) Guidance for the care of pregnant Veterans with mental health diagnoses.

(3) Clarification of newborn care, maternal mental health disorders, and postpartum interval.

(4) Emphasis on the importance of community partnerships to enhance parenting and lactation support groups, and education classes.

(5) Beneficiary travel and limitations.

(6) Terminology has been changed to reflect gender-neutral language that is more inclusive of transgender and intersex Veterans.

3. RELATED ISSUES: VHA Directive 1330.01(3), Health Care Services for Women Veterans, dated February 15, 2017, and VHA Directive, 1330.02 Women Veterans Program Manager (WVPM), dated August 10, 2018.

4. RESPONSIBLE OFFICE: The Office of Women's Health (10W) is responsible for the contents of this Veterans Health Administration (VHA) directive. Questions may be referred to the Director of Reproductive Health at VHACOREproductiveHealthTeam@va.gov.

5. RESCISSIONS: VHA Handbook 1330.03, dated October 5, 2012, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of November 2025. This VHA directive will continue to serve as national policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF THE
UNDER SECRETARY FOR HEALTH:**

/s/ Patricia Hayes, PhD
Chief Officer, Women's Health

DISTRIBUTION: Emailed to the VHA Publications Distribution List on November 10, 2020.

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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MATERNITY HEALTH CARE AND COORDINATION

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy and requirements for furnishing and coordinating maternity care of eligible Veterans. The directive establishes a VHA-wide standard of practice for maternity care and its coordination. **AUTHORITY:** 38 United States Code (U.S.C.) § 1710; Title 38 Code of Federal Regulations (C.F.R.) 17.38.

2. BACKGROUND

Maternity benefits are included in the VA Medical Benefits Package that is available to Veterans who are enrolled in VA's health care system. These benefits begin with the confirmation of pregnancy. A complete maternity standard episode of care continues through the postpartum period. Maternity care is typically provided by authorized health care professionals in the community. Some Veterans will continue to receive other health care and services through the VA health care system during their pregnancies, either for management of coexisting medical or mental health conditions, or for maternity-related laboratory tests or medications required during pregnancy. Coordination of maternity care and information sharing between all providers, including those at VA and in the community, is critical to patient safety, particularly in the area of medication management.

3. DEFINITIONS

a. **Approved Delivering Facility.** An approved delivering facility is:

(1) An accredited hospital with obstetric services; or

(2) An accredited birth center with established protocols to transfer patient care as necessary.

NOTE: Deliveries at hospitals and birth centers are covered when attended by a physician or certified nurse midwife at facilities accredited by The Joint Commission on Accreditation of Healthcare Organizations.

b. **Decision Support System.** Decision support system (DSS) is VA's Managerial Cost Accounting System. It is a derived database that is compiled through the merging of input from diverse sources of financial and workload data. DSS is VA's only system that provides full cost data at the product level using stop codes.

c. **Direct-Entry Midwife.** A direct-entry midwife, also known as lay midwife or certified professional midwife, is a midwife who has trained as midwife without being a nurse first. This category has several subcategories reflecting the varying legal status of direct-entry midwives in different states.

d. **DSS Identifier**. DSS identifier (ID), also referred to as a stop code, is a VHA term that characterizes VHA outpatient clinics by a six-character descriptor. The DSS ID value is transmitted to the National Patient Care Database (NPCD) with each separate outpatient encounter into the NPCD field DSS ID. A primary stop code and a secondary stop code comprise the DSS ID.

e. **Doula**. A doula, also known as a birth companion and post-birth supporter, is a non-medical person who assists before, during, and after childbirth by providing physical assistance and emotional support to the pregnant Veteran and their family.

f. **Ectopic Pregnancy**. An ectopic pregnancy is any pregnancy occurring outside the uterine cavity. These are never viable; care for ectopic pregnancies is covered under the Medical Benefits Package.

g. **Fetal Surgery**. Fetal surgery, also known as in-utero surgery, involves a broad spectrum of surgical procedures used to treat abnormalities of the fetus which, if left untreated, can lead to labor and delivery complications, or significant disability or death of the newborn. The fetus is operated on while in the uterus, either by opening the uterus or utilizing minimally invasive techniques with a fetoscope.

h. **High-Risk Pregnancy**. A high-risk pregnancy is one that threatens the health or life of the pregnant person or the fetus. It often requires specialized prenatal care from specially trained providers (e.g., Maternal Fetal Medicine specialists) due to the presence of identified risks or complications.

i. **Maternal Fetal Medicine**. Maternal-fetal medicine (MFM) (also known as perinatology) is a branch of medicine that focuses on managing health concerns of the pregnant person and fetus prior to, during, and shortly after pregnancy. An MFM specialist is a physician who has completed fellowship training in MFM after completing a 4-year residency program in obstetrics and gynecology. Fellowship training provides additional education and practical experience to gain special competence in managing medical and surgical complications of pregnancy.

j. **Maternity**. Maternity includes the following stages: preconception, pregnancy, intrapartum, postpartum, and lactation.

k. **Newborn Care**. Newborn care includes all post-delivery care/services, including routine care/services, that a newborn child requires on the date of birth plus seven calendar days after the birth of the child, provided the birth mother is a Veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA, and the child is delivered pursuant to a VA authorization for maternity care at VA expense. It may be provided for not more than 7 days after the date of birth of the newborn. See 38 U.S.C. 1786; 38 C.F.R. 17.38(a)(1)(xiv).

l. **Obstetrical Emergency**. An obstetrical emergency is a life-threatening medical condition or complication that occurs during pregnancy or during labor and delivery.

m. **Postpartum Period.** The postpartum period is usually 6–8 weeks following the delivery or when the Veteran is medically released from obstetric care.

n. **Qualified Provider.** For purposes of VA-authorized maternity care in the community, a qualified provider is a licensed medical practitioner operating within the scope of their license and not identified on the List of Excluded Individuals and Entities maintained by VA's Office of Community Care. **NOTE:** *Maternity care provided by doulas and direct-entry midwives is not covered.*

o. **Spontaneous Abortion.** A spontaneous abortion (SAB), also known colloquially as a miscarriage, is the spontaneous loss of a fetus before the 20th week of development. Types of spontaneous abortions are:

(1) Complete. Spontaneous expulsion of all fetal and placental tissue before 20 weeks of gestation.

(2) Incomplete. Passage of some, but not all, of uterine contents before 20 weeks of gestation.

(3) Inevitable. Intrauterine pregnancy with bleeding, cramping, and a dilated cervix.

(4) Missed. Spontaneous abortion with or without symptoms and with a closed cervical os (opening). A missed abortion might progress on its own to a complete abortion but might also require surgical or medical management.

(5) Threatened. Intrauterine pregnancy with bleeding and a closed cervix. Cramping pain may or may not be present.

p. **Teratogen.** A teratogen is any agent that may cause an abnormality, including miscarriage following fetal exposure during pregnancy. Classes of teratogens include radiation, maternal infections, chemicals, and drugs.

q. **Teratogenic Medication.** A teratogenic medication is any medication capable of acting as a teratogen.

4. POLICY

It is VHA policy that Veterans enrolled in VA's health care system have access to comprehensive maternity care; authorized VA maternity care must be provided by qualified providers. VA medical facilities are to promote seamless coordination of maternity care with other VA care provided to these Veterans. All maternity care furnished through the VA (in-house or by contract) must follow accepted evidence-based clinical standards.

5. RESPONSIBILITIES

a. **The Under Secretary for Health.** The Under Secretary for Health is responsible for making maternity care available to Veterans enrolled in the VA health care system.

b. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations, or designee, is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Services Network (VISN).

(2) Ensuring that each VISN Director has the resources required to support the fulfillment of the terms of this directive in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive.

c. **Chief Officer, Office of Women's Health.** The Chief Officer, Office of Women's Health, is responsible for reviewing and approving proposals submitted by VA medical facility Directors who are planning to provide onsite prenatal care.

d. **Veterans Integrated Services Network Director.** The VISN Director is responsible for ensuring that all VA medical facilities in the VISN appoint a maternity care coordinator (MCC). **NOTE:** Pursuant to VHA Directive 1330.02, Women Veterans Program Manager (WVPM), dated August 10, 2018, guidance has designated the position of the WVPM as a full-time administrative position without collateral assignment.

e. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Facilitating the process of developing contracts or sharing agreements between the local VA medical facility with maternity care providers in the community and ensuring these providers are part of the VA community care network.

(2) Facilitating access to high-quality maternity care in the community that is coordinated by the facility's MCC; ensuring the effective coordination of care between the Veterans' VA providers and their maternity care providers in the community, particularly for those under concurrent VA care for co-morbidities.

(3) Promoting standard processes to facilitate communication between the authorized maternity care providers in the community and the Veterans' VA health care providers.

(4) Ensuring that all maternity services, including prenatal diagnostic and treatment services, provided to pregnant and postpartum Veterans at the local VA medical facility meet generally-accepted standards of care and are within the scope of practice of VA staff and VA health care providers. **NOTE:** See VHA Directive 1100.21(1), Privileging, dated March 2, 2023, and VHA Directive 1100.20(2), Credentialing of Health Care Providers, dated September 15, 2021.

(5) Submitting a proposal to the Chief Officer, Office of Women's Health if planning to provide onsite prenatal care; describing capacity and proposed onsite services for review and approval. **NOTE:** VA medical facilities rarely offer limited prenatal care; this is limited to care in the first trimester. For further information, see current VA/DoD

Clinical Practice Guideline for the Management of Pregnancy, available at <http://www.healthquality.va.gov/pregnancy.asp>.

(6) Ensuring there is support for the MCC to track maternity care and outcomes.

(7) Ensuring Veterans can receive supplies specific to maternity care (e.g., breast pumps, maternity belts, disposable nursing pads, breast milk storage bags, lanolin cream) from the local VA medical facility; supplies are available pursuant to local VAMC processes as discussed in paragraph 5.k.(16) of this directive.

(8) Ensuring the local VA medical facility has accommodations for nursing Veterans in inpatient or residential care. These accommodations include, but are not limited to, a private space (not the bathroom) to express breast milk, access to a portable or hospital grade pump, breastfeeding supplies and equipment, and an appropriate place to safely store breast milk.

(9) Ensuring that the local VA medical facility has a mechanism to monitor the prescription of high-risk or teratogenic medications which could be prescribed to Veterans with the potential to become pregnant.

f. **VA Medical Facility Chief of Staff**. The VA medical facility Chief of Staff is responsible for:

(1) Ensuring prescriptions written by the maternity care provider in the community can be filled by the Veteran at a VA pharmacy or through the consolidated mail outpatient pharmacy, consistent with 38 C.F.R. 17.4025(b).

(2) Ensuring that there is a process in place to enter a community care consult request for maternity care in the Computerized Patient Record System (CPRS), or an electronic health record (EHR), utilizing the community care standard episode of care (SEOC) template and that the MCC is alerted of newly pregnant Veterans.

(3) Ensuring maternity care coordination is integrated within a Patient-Aligned Care Team (PACT) as much as possible and in close collaboration with the MCC. Ensuring the effective coordination of care between authorized maternity care providers in the community and all relevant VA primary or specialist providers treating the Veterans.

(4) Using the appropriate decision support system ID (stop code) in the creation of VA outpatient clinics in which Veterans are provided treatment prior to and after childbirth.

(5) Ensuring that appropriate maternity care is provided if a pregnant Veteran is admitted either to a VA inpatient psychiatric unit or residential care program. If resources are unavailable within the VA health care system to provide medically appropriate surveillance or maternity care for currently known complications or comorbid conditions in this cohort, a written process must be in place to refer and authorize payment for the pregnant Veteran to be transferred to a facility in the community that will clinically manage both the patient's pregnancy and psychiatric

condition at VA-expense. **NOTE:** *The local VA medical facility must ensure the availability of fetal evaluation for pregnant Veterans at 20 or more weeks of gestation who are admitted to an inpatient psychiatric unit. If a pregnant Veteran is part of VA residential care program, the program should obtain a care plan from that Veteran's maternity provider which will detail frequency of fetal monitoring and maternity appointments. See Care of the Pregnant Patient referenced in VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023 and available at: <https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/VHA%20EM%20Official%20Document%20Library/Forms/AllItems.aspx?csf=1&web=1&e=JLUxvz&CID=38eee57d%2Dfa54%2D45bc%2D8cb9%2D3fa649bb1d40&FolderCTID=0x012000505431ECD7B47742B95D67ABFD0C33&id=%2Fsites%2FVHAEmergencyMedicine%2FVHA%20EM%20Official%20Document%20Library%2FPolicies%20Page%2FEM%20Directive%20Page%2FDocuments%20Referenced%20in%20EM%20Directive>. This in an internal VA website that is not accessible to the public.*

(6) Ensuring the availability of transvaginal or transabdominal ultrasound at the local VA medical facility in the case of an emergency (See VHA Directive 1101.14). If this is not readily available on-site, written processes (e.g., inter-facility transfers and agreements, contracts for hospital care and medical services in the community) must be in place to ensure the Veteran has access to these services, especially if this impacts the triaging of their care.

(7) Ensuring that each VA health care provider fulfills the responsibilities in paragraph g. below.

g. **VA Health Care Provider.** The VA health care provider is responsible for:

(1) Performing a vesting exam which will include a full physical exam, whenever an enrolled Veteran presents to a VA facility to initiate maternity care.

(2) Referring the Veteran to an authorized routine or high-risk prenatal care provider (e.g., MFM) as early as possible after the pregnancy is diagnosed.

(3) Ensuring that all pregnant Veterans are screened for depression, intimate partner/ domestic violence (IPV/DV), military sexual trauma (MST), posttraumatic stress disorder (PTSD), anxiety, substance use, and postpartum depression, and that referrals and authorizations for care of any confirmed conditions are made, as appropriate.

(4) Using an appropriate tool to screen all pregnant and postpartum Veterans for depression. Positive screening results require subsequent referrals to mental health or social work for comprehensive assessment (e.g., psychosocial), accurate diagnosis, implementation of treatment, and follow-up. **NOTE:** *Veterans with symptoms of depression during or after pregnancy, with a previous history of depression or bipolar disorder, medical complications at birth, lack of strong emotional support from their spouse, partner or friends, or with alcohol or other drug abuse are at greater risk of developing postpartum depression. Postpartum depression can affect any Veteran regardless of sociodemographic characteristics.*

(5) Screening all pregnant and postpartum Veterans for the presence of IPV/DV using the recommended VA screening tool consistent with the Intimate Partner Violence Assistance Program (IPVAP) screening program which also screens for sexual assault. See VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019. Positive screening results require further risk assessment to determine immediate course of action. Additionally, VA health care providers must ensure that all pregnant Veterans are provided with education and resources on IPV/DV to include the VA medical facility's IPVAP coordinator, or designee, contact information and the National Domestic Violence Hotline number and website.

(6) Referring all pregnant Veterans determined to be at high-risk of IPV/DV to the facility's IPVAP coordinator, or designee, for further assessment, safety planning and/or treatment. **NOTE:** *The United States Preventative Services Task Force recommends screening all women of childbearing years for intimate partner violence. IPV/DP can affect any Veteran regardless of age, race, ethnicity, or economic status.* See VHA Plan for Implementation of the DV/IPV Assistance Program at <https://dvagov.sharepoint.com/sites/VHACMSWS/IPV/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FVHACMSWS%2FIPV%2FShared%20Documents%2F02%2DGeneral%20IPVAP%20Info%20and%20Resources%20%5BXX%5D%2FVHA%20PIan%20for%20Implementation%20of%20the%20Domestic%20Violence%20%20Intimate%20Partner%20Violence%20Assistance%20Program%2Epdf&parent=%2Fsites%2FVHACMSWS%2FIPV%2FShared%20Documents%2F02%2DGeneral%20IPVAP%20Info%20and%20Resources%20%5BXX%5D>, Intimate Partner Violence Assistance Program at <https://dvagov.sharepoint.com/sites/VHACMSWS/ipv/sitepages/home.aspx> **NOTE:** *These are internal VA websites that are not available to the public.*

(7) Ensuring that mental health conditions and trauma history are considered during service provision and that care is adapted as needed.

(8) Ensuring the Veteran is up-to-date on relevant screenings and receives prenatal prescriptions.

(9) Facilitating the coordination of care such that pregnant Veterans with pre-existing psychiatric diagnoses, as well as pregnant Veterans who screen positive for psychiatric symptoms during pregnancy and/or postpartum, have a psychiatric evaluation and/or a review by a clinical pharmacist. Ensuring the effective coordination of care between authorized maternity care providers in the community and all other relevant VA and community specialist providers treating the pregnant Veteran.

(10) Recording in CPRS, or EHR, informed consent discussions, and medication counseling with the Veteran about the risks and benefits of high-risk and teratogenic medications; and collaborating with the VA medical facility's clinical pharmacy services for medication review when appropriate. **NOTE:** *VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009, Appendix A, requires a separate signature-informed consent for each of the following: treatments using hazardous drugs, and use of high-risk imaging procedures where there is no other*

appropriate alternative diagnostic approach such as pregnant women receiving intravascular contrast agents or x-radiation to the fetus.

h. **VA Medical Facility Chief of Emergency Medicine.** The VA medical facility Chief of Emergency Medicine is responsible for:

(1) Establishing written mechanisms or processes in the local VA medical facility's emergency department or urgent care center to ensure that processes are in place to provide standard emergency care to pregnant patients, including stabilization and maternal transport. See Care of the Pregnant Patient referenced in VHA Directive 1101.14 and available at:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/VHA%20EM%20Official%20Document%20Library/Forms/AllItems.aspx?csf=1&web=1&e=JLUxvz&CID=38eee57d%2Dfa54%2D45bc%2D8cb9%2D3fa649bb1d40&FolderCTID=0x012000505431ECD7B47742B95D67ABDFE0C33&id=%2Fsites%2FVHAEmergencyMedicine%2FVHA%20EM%20Official%20Document%20Library%2FPolicies%20Page%2FEM%20Directive%20Page%2FDocuments%20Referenced%20in%20EM%20Directive> and VHA Directive 1094(1), Inter-Facility Transfer Policy, dated January 11, 2017. **NOTE:** *This is an internal VA website that is not available to the public.*

(2) Ensuring the local VA medical facility (e.g., emergency department (ED) or urgent care center) has quantitative and qualitative testing as defined in VHA Directive 1330.01(3), Health Care Services for Women Veterans, dated February 15, 2017, and otherwise care for pregnant patients as outlined in VHA Directive 1101.14 and VHA Directive 1101.13, VHA Urgent Care, dated March 20, 2023.

i. **VA Medical Facility Chief of Community Care.** The VA medical facility Chief of Community Care is responsible for:

(1) Ensuring standardized criteria are in place for the approval of maternity care benefits as part of a complete maternity SEOC. The maternity SEOC will generally consist of the maternity care services set forth in paragraph 6 of this directive.

(2) Ensuring a streamlined process for authorizing a community provider to furnish a pregnant enrolled Veteran with the maternity SEOC using relevant current procedural terminology (CPT) codes, diagnostic related groups (DRG), or International Classification of Diseases (ICD) codes.

(3) Ensuring written processes are in place to expedite health care appointments for high-risk pregnant Veterans or Veterans initially presenting for maternity care during or beyond the second trimester.

(4) Collaborating with the local VA medical facility's Enrollment Services staff and the MCC to ensure Veterans, upon notification of prenatal care benefits, also understand newborn medical care benefits and processes. See 38 U.S.C. § 1786 and <https://www.womenshealth.va.gov/WOMENSHEALTH/OutreachMaterials/GeneralHealthandWellness/maternity.asp>.

(5) Providing guidance regarding the filling of prescriptions from providers in the community, consistent with 38 C.F.R. 17.4025(b). Medications prescribed by a provider in the community, when authorized by VA to provide care, can be dispensed by a VA pharmacy. **NOTE:** See 38 C.F.R. 17.4025(b); VHA Handbook 1108.05(2), *Outpatient Pharmacy Services*, dated June 16, 2016, and VHA Directive 1108.08(1), *VHA Formulary Management Process*, dated November 2, 2016.

(6) Providing a letter to the Veteran and the authorized community provider explaining the scope of the authorization and instructions on how to seek amendments of the authorization to include any additional services, including treatment for medical emergencies that arise during the course of the Veteran's pregnancy. Instructions are to explain how the community provider must notify VA within 72 hours of a medical emergency for VA to be able to authorize and pay for the provision of the community provider's furnishing of emergency treatment. See 38 C.F.R. 17.4020(c)(2). Otherwise, the provider will have to seek reimbursement of these costs under the applicable VA reimbursement statute, i.e., 38 U.S.C. § 1725 or 1728.

(7) Ensuring that a process is in place to obtain, in collaboration with the MCC, and scan the health records associated with maternity care into Veterans Information Systems and Technology Architecture (VistA) Imaging and CPRS, or another EHR.

(8) Ensuring pregnancy records include, but are not limited to, a summary of treatment, pregnancy and delivery outcomes, complete hospital discharge summary, and any additional pertinent clinical information.

j. **VA Medical Facility Chief of Social Work.** The VA medical facility Chief of Social Work is responsible for ensuring that at-risk pregnant Veterans referred for social work services have an updated and comprehensive psychosocial assessment, and that an intervention plan is developed in collaboration with the Veteran's health care and treatment team.

k. **Maternity Care Coordinator.** The MCC is responsible for:

(1) Ensuring the effective coordination of care between VA and maternity care providers in the community, and all relevant VA and community specialist providers treating the pregnant Veteran.

(2) Working with the local VA medical facility Office of Community Care to collaborate on referrals for care in the community.

(3) Ensuring coordination of care among relevant VA providers and the VA facility's WVPM and Women's Health Medical Director.

(4) Facilitating coordination of maternity care for pregnant Veterans on inpatient psychiatric units or in residential care programs.

(5) Monitoring the provision of services and tracking of maternal and fetal outcomes.

(6) Retrieving statistical data on maternity care and utilization at their local VA medical facility using VHA Support Services Center (VSSC) or other VA databases. Statistical data on maternity care and utilization includes, but is not limited to:

(a) Veterans demographics.

(b) Number of Veterans being managed for maternity care.

(c) Pregnancy outcomes (e.g., maternal complications, neonatal complications, method of delivery and medications).

(d) Lactation status.

(7) Making regular telephone contact (i.e., based on the Veteran's needs) while the Veteran is in the care of the VA authorized provider in the community and documenting the call(s) in the electronic health record. The nature and frequency of calls are based on the Veteran's needs and should include assessment of the impact of mental health problems and/or trauma history in the pregnancy and postpartum period, as appropriate.

(8) Providing the Veteran with information in advance about seeking obstetric emergency care at the closest emergency department or at the approved facility the Veteran will be using for delivery. Also inform Veteran of the need for the Veteran or the Veteran's provider to notify VA within 72 hours of the emergency in order for VA to be able to authorize payment for the emergency treatment (see 38 C.F.R. 17.4020(c)(2)).

(9) Informing the Veteran of VA's authority to furnish newborn care and the need for other non-VA payment options (e.g., Medicaid) to be in place to cover any newborn care required beyond VA's authorization.

(10) Providing the Veteran with information about local and community resources (e.g., Women, Infants, and Children Program).

(11) Ensuring that the EHR accurately reflects a Veteran's pregnancy or lactation status.

(12) Ensuring that each pregnant Veteran receives a copy of the Patient Resource Manual "Purple Book" titled *Pregnancy and Childbirth: A Goal Oriented Guide to Prenatal Care*.

(13) Documenting contact information of the obstetric provider in the EHR.

(14) Ensuring that the Veteran schedules a postpartum care visit with the VA-authorized provider in the community at approximately 6–8 weeks post-delivery date (or earlier if recommended by that provider).

(15) Ensuring that the Veteran schedules an appointment with the women's health clinic or VA primary care provider within 3 months post-delivery date. The appointment

may be scheduled earlier when medically necessary due to the Veteran's co-morbid condition(s), or for bereavement support and counseling.

(16) Providing the Veteran with information about the local VA medical facility's process to obtain maternity care and health supplies (e.g., breast pumps, maternity belts, disposable nursing pads, breast milk storage bags, lanolin cream, intra-uterine devices).

(17) Ensuring that Veterans with positive screening results for depression, IPV/DV, MST, and PTSD during their pregnancies or postpartum are referred to the appropriate specialists. The MCC must ensure that follow-up care for depression is completed and that Veterans receive information about the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), press 1.

6. CLINICALLY-APPROVED CRITERIA: MATERNITY SERVICES

Approved maternity services include, but are not limited to:

a. **Comprehensive Assessment.** An initial comprehensive assessment is to be completed and must include the pregnant Veteran's medical history; physical examination; preventive services (e.g., screenings, vaccines); and care as approved on the referral.

b. **Standard and Special Laboratory Tests.** The VA/DoD Management of Pregnancy Clinical Practice Guideline, Pregnancy Management, www.healthquality.va.gov/pregnancy.asp, recommends standard and special laboratory tests and procedures that must be performed at the appropriate gestational age.

c. **Maternity Prenatal Screening for Genetic Disorders.**

(1) VA covers genetic screenings as part of maternity care. Coverage includes identifying fetal abnormalities and genetic problems consistent with the standard of care and as determined necessary by the prenatal care provider. This includes, but is not limited to, screening for radiation and teratogenic chemical (e.g., chemotherapy) exposure; genetic disorders based on racial and ethnic background such as hemoglobinopathies (e.g., sickle cell, α -thalassemia, β -thalassemia); Tay-Sachs disease; Canavan disease; familial dysautonomia; cystic fibrosis; and other genetic disorders based on personal and family history.

(2) Genetic counseling must be made available to all eligible Veterans (pregnant or considering pregnancy; Veterans of advanced maternal age; positive family history for genetic disorders; or due to their pregnant partners' non-VA acquired screening results). Availability of genetic counseling is an important component of prenatal and preconception care. If the pregnant non-Veteran partner of a Veteran has a positive abnormal genetic screening test that puts them in a higher risk category for a genetic abnormality, then the Veteran must be provided access to genetic screening as recommended by the partner's prenatal care provider. This testing can be provided within VA, if available, or through VA Community Care.

d. **Gestational Dating Ultrasounds.** Ultrasound for gestational dating is recommended in the first trimester, when date of last menstrual period is uncertain or there is a size-date discrepancy. Additional diagnostic studies that are deemed medically necessary by the provider in the community and consistent with standard of care can be included in the authorization.

e. **New Specialty Consultations.**

(1) New specialty consultations directly related to the pregnancy may be required. These consults (e.g., high-risk care) must be referred by the VA provider or routine prenatal care provider to specialists in the community with expertise in maternity care, such as MFM specialists.

(2) Fetal surgery that is not considered experimental, investigational, or unproven must involve a multidisciplinary approach and be consistent with standards of care. Under these conditions, fetal surgery is a covered medical benefit.

f. **Comorbid Conditions.**

(1) The Veteran already under the care of VA specialists (e.g., mental health, physical medicine and rehabilitation, neurology, cardiology, endocrine) may continue treatment for other medical conditions during pregnancy unless the VA specialist or community maternity provider determines that a different specialist within the context of pregnancy and the postpartum period is needed. The VA specialist would submit a consult for a relevant specialist in the community to the local VA Office of Community Care for approval and authorization.

(2) Chronic pain management during pregnancy must be coordinated and managed by the service providing the care to the Veteran (e.g., primary care, physical medicine and rehabilitation clinic, complimentary medicine) in collaboration with the MCC and any VA-approved maternity care provider in the community. Chronic opiate or substance abuse treatment during pregnancy creates special considerations and requires mandatory referral to substance abuse or addiction treatment programs in the community that have expertise with pregnancy if expertise is not available at the local VA medical facility.

g. **Postpartum Contraception.**

(1) All clinically indicated contraceptives, excluding elective sterilization, are a covered medical benefit during the postpartum period. Contraception must be made available through the Veteran's VA medical facility after the postpartum period is completed, or when medically appropriate, by the maternity care provider in the community.

(2) The community care obstetrics/ maternity authorization includes elective sterilization (e.g., tubal ligation or resection), a covered benefit at the time of delivery hospitalization only. This does not preclude the Veteran from requesting such service at

a later date either from a VA provider or a later authorization to care in the community, if eligible.

h. **Newborn Care.**

(1) Newborn care is furnished for the date of birth plus the 7 calendar days after the birth of the child. Newborn care includes, but is not limited to, inpatient care, outpatient care, medications, immunizations, circumcision, well-baby office visits, neonatal intensive care, and other appropriate post-delivery services.

(2) Pursuant to 38 C.F.R. 17.38(a)(1)(xiv), the Veteran must be enrolled in VA care and receiving VA maternity benefits, and the child must be delivered in a non-VA facility pursuant to a VA authorization for maternity care at VA expense.

i. **Pharmacy Prescriptions during Pregnancy and Postpartum.** VA pharmacies are authorized by 38 C.F.R. 17.4025 to fill prescriptions that are written by VA-approved providers in the community in accordance with VHA Handbook 1108.05(2). When appropriate, arrangements may be made for emergency prescription services utilizing a pharmacy in the community. In these instances, the Veteran must not incur additional expense. These arrangements are to be made on an individual basis, after careful determination of the type and recurring nature of the prescription.

j. **Beneficiary Travel.** Pursuant to 38 U.S.C. § 111 and 38 CFR part 70, VA, in limited circumstances, is authorized to provide certain Veterans mileage reimbursement, common carrier (e.g., plane, train, bus, taxi, light rail), or when medically indicated, special mode transport (e.g., ambulance, wheelchair van) for travel to and from VA medical facilities, or VA-authorized care in the community. Beneficiary travel is generally available only in connection with care or services provided by VA. In addition, the Veteran must meet eligibility criteria stated in 38 C.F.R. 70.10, and must complete the application process specified in 38 C.F.R. 70.20. For detailed information of beneficiary travel, see VHA Handbook 1601B.05, Beneficiary Travel, dated July 21, 2010. *NOTE: Newborns are not currently eligible for beneficiary travel. However, when an inter-facility transfer is required, check with the local VA Office of Community Care about such transfer request. The Office of Member Services (15MEM) is another resource for beneficiary travel inquiries. See 38 C.F.R. part 70; VHA Handbook 1601B.05., and VHA Directive 1094.*

k. **Pregnancy-Related Education.** Pregnancy-related education and tools, consistent with the generally accepted standards of medical practice, must be provided. These include, but are not limited to:

- (1) Childbirth preparation classes.
- (2) Parenting classes.
- (3) Nutrition counseling.
- (4) Breast/chestfeeding support and lactation classes.

NOTE: *The original community care obstetrics/maternity authorization includes pregnancy-related education classes as a covered benefit; therefore, an additional consult is not necessary. However, the classes must be billable, as all other medical education, to include a diagnosis and Health Care Financing Administration/Current Procedural Terminology codes.*

I. **Management of Spontaneous Abortion (Miscarriage)**. Medically necessary procedures for the management of spontaneous abortion are covered medical benefits.

7. MATERNITY SERVICES THAT WILL NOT BE PROVIDED BECAUSE THERE IS INSUFFICIENT CLINICAL EVIDENCE TO SUPPORT VA PAYMENT FOR THESE OPTIONS

- a. Home deliveries.
- b. Services by Doulas.
- c. Deliveries by direct-entry midwives.

8. EXCLUDED MATERNITY SERVICES

a. Experimental procedures and medical procedures not consistent with the standard of care (excluded under the Medical Benefits Package regulation at 38 C.F.R. § 17.38(b);(c)(3)).

b. Abortions are excluded from the medical benefits package, except when:

(1) The life or health of the pregnant Veteran would be endangered if the pregnancy were carried to term; or

(2) The pregnancy is the result of an act of rape or incest. **NOTE:** *Self-reporting from the pregnant Veteran constitutes sufficient evidence that an act of rape or incest occurred.*

9. TRAINING REQUIREMENTS

There are no training requirements associated with this directive.

10. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. If you have any questions regarding any aspect of records management, you should contact your facility Records Manager or your Records Liaison.

11. REFERENCES

- a. 38 U.S.C. § 1710; 38 C.F.R. 17.38(a)(xiii).

- b. 38 U.S.C. § 1786; 38 C.F.R. 17.38(a)(xiv).38 U.S.C. §§ 111, 1703, 1725, 1784A, 7301, and 8153.
- c. 38 CFR §17.38; 38 C.F.R. part 70; 38 C.F.R. 17.120 et seq.; 38 C.F.R. 17.1000 et seq; 38 C.F.R. part 17.4000 et seq.
- d. VHA Directive 1094(1), Inter-Facility Transfer Policy, January 11, 2017.
- e. VHA Directive 1100.20(2), Credentialing of Health Care Providers, dated September 15, 2021.
- f. VHA Directive 1100.21(1), Privileging, dated March 2, 2023.
- g. VHA Directive 1101.13, VHA Urgent Care, dated March 20, 2023.
- h. VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023.
- i. VHA Directive 1108.08(1), Formulary Management Process, November 2, 2016.
- j. VHA Directive 1330.01(3), Health Care Services for Women Veterans, February 15, 2017.
- k. VHA Handbook 1004.01(3), Informed Consent for Clinical Treatments and Procedures, August 14, 2009.
- l. VHA Handbook 1108.05(2), Outpatient Pharmacy Services, June 16, 2016.
- m. VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019.
- n. VHA Directive 1330.02, Women Veterans Program Manager (WVPM), August 10, 2018.
- o. VHA Handbook 1601B.05, Beneficiary Travel, July 21, 2010.
- p. VHA Handbook 1907.01, Health Information Management and Health Records, March 19, 2015.
- q. VA OIG Report 22-02975-70.
- r. American College of Nurse-Midwives <http://www.midwife.org/>.
- s. Centers for Disease Control and Prevention: Reproductive Health <http://www.cdc.gov/reproductivehealth/index.htm>.
- t. Department of Health and Human Services, List of Excluded Individuals and Entities <https://exclusions.oig.hhs.gov/>.

- u. VA Intimate Partner Violence Assistance Program.
<https://dvagov.sharepoint.com/sites/VHACMSWS/ipv/sitepages/home.aspx>. **NOTE:** This is an internal VA website that is not available to the public.
- v. National Institutes of Health, What Is a High-Risk Pregnancy?
<https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/high-risk>.
- w. Pharmacy Benefits Management Services <http://www.pbm.va.gov/>.
- x. The American College of Obstetricians and Gynecologists <http://www.acog.org/>.
- y. United States Preventive Services Task Force. Screening Recommendations for IPV & Elderly.
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening>.
- z. VA/DOD Clinical Practice Guidelines for Mental Health
<https://www.healthquality.va.gov/HEALTHQUALITY/guidelines/MH/index.asp>
- aa. VA/DOD Clinical Practice Guideline for the Management of Pregnancy
<http://www.healthquality.va.gov/pregnancy.asp>.
- bb. VHA Plan for Implementation of the DV/IPV Assistance Program:
[https://dvagov.sharepoint.com/:b:/r/sites/VHACMSWS/IPV/Shared%20Documents/02-General%20IPVAP%20Info%20and%20Resources%20\[XX\]/VHA%20Plan%20for%20Implementation%20of%20the%20Domestic%20Violence%20Intimate%20Partner%20Violence%20Assistance%20Program.pdf?csf=1&web=1&e=v0YyDG](https://dvagov.sharepoint.com/:b:/r/sites/VHACMSWS/IPV/Shared%20Documents/02-General%20IPVAP%20Info%20and%20Resources%20[XX]/VHA%20Plan%20for%20Implementation%20of%20the%20Domestic%20Violence%20Intimate%20Partner%20Violence%20Assistance%20Program.pdf?csf=1&web=1&e=v0YyDG). **NOTE:** This is an internal VA website that is not available to the public.