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VA Pregnancy-Related Primary Care Visits



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The primary care provider and maternity care coordinator play important roles in supporting and coordinating care during pregnancy for women Veterans.

To help meet these care coordination needs, VHA Handbook 1330.03 Maternity Care and Coordination requires two pregnancy-related primary care visits, one at the beginning of pregnancy and one after pregnancy ends.

Pregnancy Preventive Health Primary Care Visit

When:

- Positive pregnancy test and the patient confirms that she wants to be referred for maternity care services

Purpose:

- Identify and address general health and pregnancy risk factors that may impact maternal and fetal outcomes in a timely way, while the patient is establishing care with a maternity care provider
- Identify care coordination needs between the patient and her VA and non-VA providers, and establish mutual expectations about how this will occur

[Details of a Pregnancy Preventive Health Primary Care Visit](#)

VA Postpartum Follow-Up Primary Care Visit

When:

- After the 6 week postpartum visit with the maternity care provider
 - Within 2 months of delivery for women Veterans who have one or more chronic medical conditions
 - Within 3 months of delivery for women Veterans who have no chronic medical conditions

Purpose:

- Reintegrate the woman Veteran into the VA primary care system and routine health maintenance activities
- Update health record and ensure care is continuing with appropriate specialty care providers
- Provide additional support that may be needed following delivery (e.g. lactation support, WIC (Women, Infants and Children) eligibility/enrollment information, parenting support and resources)

[Details of Postpartum Follow-Up Primary Care Visit](#)

Pregnancy Preventive Health Primary Care Visit

Maternity care referral/ Maternity care coordination

Request maternity care referral if not already in system.

Inform patient about:

- The VA Maternity Care Coordinator
- Resuming care in primary care PACT/clinic following her postpartum visit with the maternity care provider
- Seeking care in the nearest emergency room if she experiences vaginal bleeding, abdominal pain or other complications

For patients with chronic medical or mental health conditions, encourage continued care with specialists during pregnancy.

Immunization status and vaccine update

Check immunization status for the following conditions:

- Influenza
- Tetanus, diphtheria, acellular pertussis (Tdap)
- Measles, mumps, rubella (MMR)
- Hepatitis B
- HPV

Vaccines recommended for all pregnant women:

During each pregnancy, recommend:

- Influenza vaccine (inactivated injectable form)
- Tetanus, diphtheria, acellular pertussis (Tdap) vaccine (regardless of timing of last vaccine)

Vaccines recommended for pregnant women with risk factors:

- Pneumococcal (polysaccharide – PCV13): 1 or 2 doses
- Meningococcal (conjugate – MCV4): 1 or more doses
- Hepatitis A (inactivated): 2 doses
- Hepatitis B (recombinant): 3 doses

[Risk factors for these conditions](#)

Vaccines to avoid during pregnancy:

Administer these vaccines postpartum:

- Live attenuated vaccines (MMR, varicella/zoster)
 - ✦ **Note:** Risk of fetal exposure to live, attenuated virus from these vaccines is theoretical, and inadvertent administration of these vaccines to a pregnant woman is not a reason for pregnancy termination.
- HPV vaccine

[More details about Vaccines during pregnancy](#)

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Psychosocial Risk Assessment

Arrange appropriate referrals based on screening results and ensure coordination of care among VA providers and the VA or non-VA maternity provider.

Intimate partner violence

- May occur in up to 20% of pregnancies
- Pregnancy may result in an escalation of violence against a woman
- Women who screen positive should be supported to seek care and services
- Advocacy and counseling services may increase a woman's safety
- Ask:
 - Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt or threatened by someone?
 - Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt or threatened by someone?
 - Within the last year, has anyone forced you to engage in sexual activities that made you uncomfortable?

Depression screening

- The two question Patient Health Questionnaire (PHQ-2) can be used as an initial screen for perinatal and postpartum depression
- A positive screen should be followed by a [PHQ-9 or the Edinburgh Postpartum Depression Scale](#) (EPDS, 10 questions)
- Refer patients who screen positive to VA Mental Health for further evaluation.

Homelessness

Housing situation:

- Where are the woman Veteran and her baby living?
- Is this living situation secure?

Refer to social work or homelessness coordinator at your facility for homelessness or housing security (or contact the 24/7 National Call Center for Homeless Veterans: 877-424-3838 to be connected to your local VA homeless program point of contact to assist further.)

Environmental/Occupational exposures

Ask and counsel about potentially harmful exposures at home and work:

- Toxic exposures (e.g., solvents and other chemicals, exhaust fumes, radiation)
- Physical stressors (e.g., heavy lifting)
- Infectious exposures (e.g., cat feces/toxoplasmosis, reptiles/salmonella)

Financial stressors

- Adequacy of food, housing, clothing, and access to healthcare for family members

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VA Postpartum Follow-Up Primary Care Visit

Pregnancy follow-up

- Complications during pregnancy or postpartum for mother
- Infant health
 - Care established with a pediatrician?
- Infant feeding method
 - If breastfeeding, any concerns or problems?
 - Refer to Maternity Care Coordinator or Women Veterans Program Manager for assistance with lactation consultant referral and/or breastfeeding supplies

Health update

- Contraceptive method (using correctly and consistently?)
- Chronic medical conditions (any change in status during or after pregnancy)
- Medications (update list)

Depression screening

- The two question Patient Health Questionnaire (PHQ-2) can be used as an initial screen for perinatal and postpartum depression
- A positive screen should be followed by a [PHQ-9 or the Edinburgh Postpartum Depression Scale](#) (EPDS, 10 questions)
- Support System

When to follow up for routine primary care

[More information about postpartum care and screening](#)

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Early Pregnancy Health Evaluation and Risk Factor Assessment

This risk assessment may be performed at or before the first prenatal visit by the maternity care provider or a clinical designee.

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Reasons for immediate referral to an Ob/Gyn or maternal fetal medicine specialist

Most relevant when the risk assessment is performed by a nurse prior to the first prenatal visit or when prenatal care is initiated with a provider who only cares for low risk pregnancies.

Current problems

- Vaginal bleeding
- Significant pelvic/abdominal pain or cramping

Obstetrical history

- Recurrent pregnancy loss (3 or more miscarriages)
- Ectopic pregnancy risk (history of ectopic, tubal surgery, current IUD, history of tubal infertility, history of PID)

Medical conditions

- Cardiovascular disease
- Cardiac abnormality
- Diabetes mellitus, type 1 or 2
- HIV
- Renal Disorder (including pyelonephritis)
- Transplant

Other risk factors

- Genetic disease history (self or family)
- Teratogenic medication exposure

Reasons for referral to other specialty care providers

Mental/behavioral health

- Major depressive disorder (moderate-severe)
- Suicide risk
- Other mental health condition

Nutrition

- Dietary restriction (for medical or personal reasons)
- Gastric bypass surgery

Public health

- Occupational exposures (including post-deployment exposures)
- Social services
- Homelessness
- Interpersonal violence

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Substance use/abuse

Tobacco

- Routine screen for tobacco use during pregnancy at the initial prenatal visit. For smokers, assess smoking status at each subsequent prenatal visit.
- Strongly recommend cessation and offer resources and counseling.
- For patients who are unable to quit on their own, discuss the risks and benefits of pharmacotherapy such as nicotine replacement therapy.

Alcohol

- While there is a clear dose-dependent effect, studies have failed to define a safe level of alcohol consumption during pregnancy.
- Screen for alcohol consumption using a standardized tool designed for use with pregnant women, such as the T-ACE, or TWEAK (See Pregnancy Tools and Resources for Providers for more information).
- Recommend abstaining from alcohol during pregnancy.
- If alcohol dependence is suspected, refer to mental health for further evaluation and possible treatment.

Drugs

- Screen for illicit drug use and prescription drug misuse using the National Institute on Drug Abuse (NIDA) screening tools (see Provider Resources for more info).
- For pregnant women abusing or misusing drugs, offer treatment and referral to an OB/Gyn.
- During pregnancy, inform neonatologists and pediatricians about the potential for infant drug withdrawal after delivery.
- Inform patient about potential neonatal intensive care unit admission and prolonged hospital stay if infant has withdrawal symptoms.

Sexually transmitted infections (STIs)

Ask all patients about past infections, risk factors, and any current symptoms.

- Chlamydia
- Gonorrhea
- Hepatitis B
- Hepatitis C
- Herpes Simplex Virus (HSV)
- HIV
- Syphilis

Review more information about [STIs during pregnancy and lactation and STI screening](#)

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Tuberculosis (TB) screening

Perform Mantoux test with purified protein derivative (PPD) in pregnant women with one or more high risk factors:

- HIV infection, close contact with TB-infected person, born in county with high TB prevalence, medically underserved, low income, alcoholic, IV drug user, long term care facility resident, healthcare professional in high risk facility, other medical risk factors that increases the risk of disease.

Women who screen positive should undergo chest radiograph with an abdominal lead shield.

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Psychosocial risk assessment

Assessment content

- [Intimate Partner Violence](#)
- [Depression](#)

Environmental/Occupational exposures

- Toxic exposures (e.g., solvents, other chemicals, exhaust fumes, radiation)
- Physical stressors (e.g., heavy lifting)
- Infectious exposures (e.g., cat feces/toxoplasmosis, reptiles/salmonella)

Financial stressors

- Adequacy for food, housing, clothing, and access to healthcare for family members.

Review the [Psychosocial Risk Assessment](#)

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Education and Risk Minimization

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Breastfeeding and maternal and infant health benefits

- Suggested question to ask patient: “What do you know about breastfeeding?”
- Breastfeeding offers maternal and infant health benefits. Optimal benefits with exclusive human milk feeding for the first 6 months of life and continued human milk feeding until at least 12 months of age.
- Human milk is the most nutritionally complete food for a human infant. Human milk fed infants have reduced rates of illness including otitis media, gastrointestinal disease, obesity and diabetes, and certain types of childhood cancers.
- Mothers who breastfeed have less postpartum bleeding, faster return to pre-pregnancy weight, and reduced risk for breast cancer.
- Review supplies and resources available through VA, including lactation consultation, breast pumps, breast pads, and nipple ointment.
- Discuss personal preferences, beliefs, and family support.

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Exercise during pregnancy

- Regular mild to moderate exercise 3 or more times per week recommended for pregnant women.
- Exercise program should be individualized based on level of pre-pregnancy activity (for example, pregnant women who ran before pregnancy, can continue running during pregnancy).
- Pregnant women should not participate in high-altitude activities (>10,000 feet), scuba diving, or contact sports.

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Genetic screening

- Ensure patient will see provider early enough in gestation to schedule and undergo first trimester screening (prior to 14 weeks gestation) if desired.
- All patients should be counseled about cystic fibrosis and offered screening.

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Minimizing reproductive risk of medications

- Review medications with the patient and discuss known and potential risks associated with the medication when used during pregnancy and lactation.
- When appropriate, consider appropriate alternative medications with less reproductive risk that offer the patient needed clinical benefit.
- Key risk/benefit considerations:
 - Failure to treat a serious maternal condition is often associated with greater embryofetal and maternal risk than the risk associated with the medication itself.
 - If fetal exposure to a known or potential teratogen has already occurred, medication change should not be initiated solely to reduce teratogenic risk, as maternal condition may worsen, and fetal exposure to a second medication may increase fetal risk.
 - Consider timing of medication exposure with regard to organogenesis and the risks of the particular medication.
- If fetal exposure to a known or potential teratogen occurs, counsel patient about:
 - Risks based on gestational age during exposure.
 - Risks of untreated disease.
 - Relative risks and benefits of continuing treatment, changing medications, or discontinuing treatment.

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Nutrition/weight management during pregnancy

Nutrition

- Multivitamin/prenatal vitamin supplements that contain at least 400 mcg folate for all pregnant women through the first trimester.
- Women who delivered a child with an open neural tube defect should supplement their diets with 4 mg folate daily until closure of the neural tube occurs, 28 days post-conception.
- Pregnant women taking nutritional supplements for a medical condition should continue the supplements throughout pregnancy.
- Obtain nutrition consultation for pregnant women on restrictive diets (e.g., vegetarians, history of bariatric surgery).

Weight

- Excessive weight gain may increase the risk for a macrosomic infant, shoulder dystocia, operative delivery, and postpartum obesity.
- Inadequate weight gain is associated with preterm delivery, intrauterine growth restriction, and low birth weight.
- Assess and document BMI for all pregnant women at the initial visit.
- Pregnant women with BMI < 20 kg/m² are at increased risk for fetal growth restriction and should be referred for nutrition counseling.
- Obese pregnant women (BMI ≥ 30 kg/ m²) are at increased risk for pregnancy complications and should be referred for nutrition counseling.

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Prenatal Care Timeline

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10-12 Weeks Gestation

🔑 Key Events:

1. First prenatal visit with maternity care provider
2. [12 week phone call with VA maternity care coordinator](#)
3. Ultrasound and Prenatal genetic screening

First visit with Maternity Care Provider

Note that this visit will include all elements of the Early Pregnancy Health Evaluation and [Psychosocial Risk Assessment](#) if this information was not collected prior to this visit.

Document gestational age: Typically based on most accurate criteria available for the pregnancy including:

- First day of last menstrual period (with adjustment for cycle length).
- Earliest obstetrical ultrasound:
 - More accurate at earlier gestational ages (first trimester ultrasound is accurate within 4 to 7 days).
- Known date of conception (e.g. assisted reproductive technology techniques).

Complete history (with attention to high risk pregnancy factors)

Obstetrical history

Including but not limited to:

- Gestational diabetes with a previous pregnancy
- Infant with macrosomia (large for gestational age)
- Second trimester fetal loss
- Preterm delivery
- Previous cesarean section

Gynecological history

Including but not limited to:

- Abnormal pap smears
- Previous cervical surgery (e.g. LEEP, cone biopsy)
- Known uterine anomaly or prior uterine surgery

Complete medical and surgical history

Including but not limited to:

- Asthma
- Cancer
- Cardiac anomaly or artificial valve
- Diabetes
- Mental health disorders
- Gastric bypass/bariatric surgery
- Hypertension
- Hypothyroidism
- Infections, including HIV, Hepatitis, Tuberculosis
- Obesity with or without gastric bypass surgery
- Periodontal disease and dental care
- Sexually transmitted infections
- Thyroid disorders
- Transplant

Complete physical examination

Including but not limited to:

- Weight/BMI
- Blood pressure
- Fetal heart tones by Doppler (normal rate is 120-160 beats/minute)
- STI screening as indicated (chlamydia, gonorrhea, HPV/cervical cancer)
- Uterine size and shape (check if consistent with expected gestational age)

Psychosocial Risk Assessment

- [Intimate Partner Violence screening](#)
- Other screening

Education/counseling

- **Prenatal screening** for fetal chromosomal genetic abnormalities
 - All pregnant women, regardless of age are offered prenatal screening for the most common clinically significant fetal anomalies.
 - Women presenting at appropriate gestational ages should be informed about available first trimester aneuploidy screening and diagnostic options and second trimester options.
- **Genetic screening**
 - Counsel all couples about cystic fibrosis screening.
 - Based on ethnicity, counsel about screening for sickle cell disease, other hemoglobinopathies, Tay-Sachs disease, and other relevant genetic conditions.
- **Breastfeeding education**
 - Suggested question to ask patient: “What do you know about breastfeeding?”

- Breastfeeding offers maternal and infant health benefits. Optimal benefits with exclusive human milk feeding for the first 6 months of life and continued human milk feeding until at least 12 months of age.
- Human milk fed infants have reduced rates of illness including otitis media, gastrointestinal disease, obesity and diabetes, and certain types of childhood cancers.
- Human milk is the most nutritionally complete food for a human infant
- Mothers who breastfeed have less postpartum bleeding, faster return to pre-pregnancy weight, and reduced risk for breast cancer.
- Review supplies and resources available through VA, including lactation consultation, breast pumps, breast pads, and nipple ointment.
- Discuss personal preferences, beliefs, and family support.

[Prenatal laboratory assessments](#)

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What happens at every prenatal visit

- ☑ Listen for fetal heart tones
- ☑ Assess fundal height/uterine size
 - A discrepancy between fundal height and gestational age in weeks may suggest abnormal growth or amniotic fluid volume, especially between 20 and 36 weeks gestation.
- ☑ Assess maternal weight gain or loss
- ☑ Assess for potential complications (e.g. early labor, fetal movement, bleeding)
- ☑ Sitting blood pressure: screen for hypertensive disorders of pregnancy
 - **Gestational hypertension** is elevated (SBP \geq 140 mm Hg and/or DBP \geq 90 on 2 separate occasions) blood pressure in a pregnant woman without proteinuria and without a pre-pregnancy hypertension.
 - **Preeclampsia is elevated blood pressure** (SBP \geq 140 mm Hg and/or DBP \geq 90 on 2 separate occasions) accompanied by proteinuria that occurs after 20 weeks gestation. Other signs and symptoms may include edema, headache, and/or visual changes. If seizures occur, the condition is called **eclampsia**.

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16-28 Weeks Gestation

Key Events:

1. Obstetrical ultrasound with fetal anatomical survey
2. Gestational diabetes screening
3. Maternity Care Coordinator calls at [20 weeks](#) and [28 weeks](#)

18 to 22 weeks: Ultrasound to screen for fetal abnormalities and assess fetal growth

24 to 28 weeks: Screen for gestational diabetes, anemia, Rh isoimmunization

- **Complete blood count** – check for anemia, thrombocytopenia
- **Rh Isoimmunization screening and prophylaxis**
 - Screen all Rh negative women for anti-Rh antibodies. If screen is negative, administer anti-D prophylaxis, either 300 mcg of anti-D immunoglobulin at 28 weeks or 100 mcg of anti-D immunoglobulin at 28 and 34 weeks' gestation.
- **Gestational diabetes**
 - **Screening test: 50 g glucose load:** threshold value for proceeding to diagnostic glucose tolerance test is 130 to 140 mg/dL.
 - **Diagnostic test:** 100 g glucose 3-hour glucose tolerance test:

[Intimate Partner Violence screening](#)

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Approach	Criteria*	Fasting mg/dL	1-hour mg/dL	2-hour mg/dL	3-hour mg/dL
	Carpenter and Coustan	95 (5.3mm c/L)	180 (10.0mm d/L)	155 (8.6mm d/L)	140 (7.8mm d/L)
Two-Step (100g Load)	NDDG	105 (5.8mm d/L)	190 (10.6mm d/L)	165 (9.2mm d/L)	145 (8.0mm d/L)
	CDA	95 (5.3mm d/L)	191 (10.6mm d/L)	160 (8.9mm d/L)	

*NDDG = National Diabetes Data Group; CDA = Canadian Diabetes Association; WHO = World Health Organization; IADPSG = International Association of Diabetes and Pregnancy Study Groups.

28-36 Weeks Gestation

🔑 Key Events:

1. Patients with high risk factors monitor fetal movement
2. Family planning/postpartum contraception counseling
3. [Maternity Care Coordinator call at 36 weeks](#)

Daily fetal movements counts: From 28 weeks until delivery for high risk pregnancies

- Starting at 28 weeks, pregnant women with certain high risk factors may be instructed by their maternity care provider to assess fetal movement every day by performing “kick counts.”
- A decrease in fetal movement must immediately prompt the pregnant woman to seek further evaluation of fetal wellbeing.

Counseling for post-delivery family planning: Week 32

- Start a discussion at 32 weeks gestation about the pros and cons of different contraceptive methods, taking into consideration plans for lactation and child spacing.
- For women who desire tubal sterilization (postpartum or laparoscopic), discuss the permanence of the procedure and the availability of [highly effective reversible contraceptive methods](#) if she has any uncertainty about permanent sterilization.

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36-42 Weeks Gestation

🔑 Key Events:

1. **Group B Strep screening**
2. **Assess fetal presentation (cephalic versus other)**
3. **[Maternity Care Coordination call at 41 weeks](#)**

36 weeks: Screen for group B streptococcus (GBS)

- **35 to 37 weeks:** Screen all pregnant women for GBS at 35 to 37 weeks' gestation using a recto-vaginal culture and selective broth media to identify colonized women.
 - GBS infections are the leading cause of serious neonatal infections (i.e., sepsis, meningitis, and pneumonia) within the first seven days of life (early-onset infection).
- **Repeat screening** every four weeks until delivery.
- **Intrapartum IV chemoprophylaxis during labor for:** women who have a positive rectovaginal culture, a previous child with early-onset GBS infection, or have GBS bacteruria.

Assess fetal presentation: Weeks 36, 38-41

- Evaluate all pregnant women for fetal position/presentation at 36 weeks and at each visit thereafter until delivery.
- Ultrasound examination is possible to confirm fetal position/presentation. If non-cephalic presentation may be counseled about:
 - External cephalic version (manually turning baby) at or beyond 37 weeks gestation.
 - Cesarean delivery

Assess fetal well being

- **Antepartum fetal testing** with nonstress tests and biophysical profiles is performed to assess fetal well-being with a goal of preventing adverse fetal and maternal outcomes. The effectiveness of these tests in preventing or predicting adverse outcomes is debated by experts in the medical community.
- **Starting at 41 weeks gestation**, non-stress tests and a weekly amniotic fluid level assessment performed twice weekly until delivery.
 - Intrapartum fetal distress, meconium staining, postmaturity syndrome and primary cesarean section rates all increase after the 40th week of gestation.

Deliver by 42 weeks gestation

- Pregnancies continuing past 41 weeks gestation carry additional risks of perinatal morbidity and mortality.

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Postpartum Care and Care Coordination with VA

The postpartum period begins with delivery of the placenta and continues through six weeks after delivery.

Postpartum care

Inpatient postpartum care should include the following elements:

- **Lactation support and teaching for breastfeeding mothers**
 - Teaching correct technique starting in the delivery room
 - Lactation consult
 - Diaper counts to determine that baby is well hydrated
- **Breast care for formula-feeding women:**
 - Wear well-fitted bra to reduce engorgement (day and night).
 - Use of ice packs and analgesics as needed to minimize discomfort.
- **Pain management**
- **Prevention of Rh Isoimmunization:** Administer Rhogam 300 mcg dose within 72 hours of delivery to Rh negative women who delivered an Rh positive infant.
- **Vaccinations:**
 - **MMR:** for women who are rubella non-immune.
 - **Tdap:** for women who did not receive Tdap during pregnancy.
 - **Varicella:** offer to women who are non-immune.
 - **HPV:** offer to women who are not immunized and younger than 26 years of age.

Common postpartum discharge instructions and education:

- No sexual intercourse for 6-8 weeks.
- If delivered by cesarean section, no driving for at least 2 weeks (or more if still on narcotic pain medication) and no lifting anything heavier than the baby for 6 weeks.
- Contact provider for: fevers, increasing vaginal bleeding, increasing abdominal pain, increasing breast pain or redness, wound drainage, or depressed mood.
- Infant safety [Safe to Sleep](#), [avoiding second hand smoke](#), [shaken baby syndrome](#), [infant passenger safety](#)
- Watch for signs and symptoms of postpartum depression:

- All women should be screened for [postpartum depression](#) at their postpartum visit or sooner if symptoms occur.
 - Trouble sleeping when the baby sleeps
 - Feeling numb or disconnected from the baby
 - Worrying that she will hurt the baby
 - Feeling guilty about not being a good mom or ashamed that she cannot care for her baby
 - Feeling restless or moody
 - Feeling sad, hopeless, and overwhelmed
 - Crying a lot
 - Having no energy or motivation
 - Eating too little or too much
 - Sleeping too little or too much
 - Having trouble focusing or making decisions
 - Having memory problems
 - Feeling worthless and guilty
 - Losing interest or pleasure in activities she used to enjoy
 - Withdrawing from friends and family
 - Having headaches, aches and pains, or stomach problems that don't go away.

Resources for patient and MCC/provider:

[Depression during and after pregnancy fact sheet from women.gov](#)

[CDC – Depression among women of reproductive age](#)

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Postpartum Visits with the Maternity Care Provider

Timing of postpartum visits

Vaginal delivery

- 6 weeks if no complications.
- Sooner if patient experiences depression symptoms, increased bleeding, abdominal pain and fever, or other complications.

Cesarean delivery

- 2 weeks for incision check.
- 6 to 8 weeks for complete postpartum visit.
- Sooner if patient experiences depression symptoms, increased bleeding, abdominal pain and fever, or other complications.

Content of postpartum visit

Lactation support if breastfeeding

- Lactation consultant.
- Breastfeeding supplies (including lanolin-based nipple ointment, breast pads, nursing bras, breast pump and attachments, milk storage bottles and bags)
- Awareness of community resources (e.g. La Leche League).
- Educate patient about signs of mastitis.
- Review maternal medications (visit [LactMed](#)), (review [Education and Risk Minimization](#))

Family planning/contraceptive counseling

- Discuss relative effectiveness and pros/cons of different contraceptive methods based on patient preferences and reproductive life plan.
- For patients who are breastfeeding and interested in hormonal contraception, inform that estrogen containing contraceptives can reduce milk production.
- [CDC Medical Eligibility Criteria for Contraceptive Use](#)
- [Contraceptive Methods: Effectiveness and Features](#)

Postpartum depression screening

- Ten to 15% of women experience major depressive episodes after delivery - this is higher in women with a history of depression.
- Postpartum depression can result in impaired function, negative impacts on the child, and requires treatment.
 - This is different than “postpartum blues,” which occurs in 50-85% of women, resolves spontaneously within 2 weeks of delivery, and does not require treatment.
- [Edinburgh Postpartum Depression Scale](#) (EPDS), 10 questions

Effective treatment strategies:

- Nonpharmacologic: Interpersonal therapy, cognitive behavioral therapy, group therapy, support groups, psychoeducation of patient and family members, maximize social supports.
- Pharmacologic: Treatment with SSRIs (first line) and tricyclic antidepressants is highly effective and compatible with breastfeeding.
- Postpartum women with a history of depression or with other risk factors for postpartum depression (anxiety, life stress, lack of partner/social support, low self-esteem) should be followed regularly until at least 3 months postpartum and should be contacted or seen for depression screening prior to the traditional 6 week postpartum visit.

[Intimate Partner Violence screening](#)

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Postpartum Coordination with VA

VA Maternity Care Coordinator Postpartum Call

- [Six weeks post-delivery](#)

VA Postpartum Follow-Up Primary Care Visit

- By 2 months postpartum for women Veterans with a chronic medical or mental health condition.
- By 3 months postpartum for women Veterans with **NO** chronic medical or mental health condition.

VA Resources for Lactation (coordinate with maternity care coordinator)

- Breastfeeding Supplies to order through Prosthetics
 - Double electric and manual breast pumps
 - Nursing bras
- Breastfeeding supplies to order through Pharmacy
 - Lanolin based nipple ointment
 - Breast pads
- Patient support and lactation consultation
 - International Lactation Consultant Association (ILCA) – [Find a local lactation consultant](#)
 - [La Leche International – Resources](#)

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Resources

Topics

[VA Policy and Guidelines](#)

[Provider Resources](#)

[Patient Resources](#)



VA Policy and Guidelines

VA/DoD Clinical Practice Guideline, Management of Pregnancy: The guideline describes the critical decision points in the Management of Pregnancy and provides clear and comprehensive evidence based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. The guideline is intended to improve patient outcomes and local management of patients who are pregnant.

- [VA/DoD Clinical Practice Guidelines website](#)
- [VA/DoD Clinical Practice Guidelines Management of Pregnancy PDF](#)
- [VHA Handbook 1330.03 – Maternity Health Care and Coordination](#)

Provider Resources

[Breastfeeding and the Use of Human Milk. American Academy of Pediatrics – Section on Breastfeeding](#), Pediatrics 2012 Feb 27; 129(3):e827-41.

Depression screening

- [The Patient Health Questionnaire-2 \(PHQ-2\)](#)
- [The Patient Health Questionnaire-9 \(PHQ-9\)](#)
- [The Edinburgh Postnatal Depression Scale \(EPDS\) for Postpartum Depression \(EDPS\)](#)

Homelessness

How do I contact a coordinator for options for women veterans who are homeless with children?

- VA has a 24 hours a day, 7 days a week National Call Center for Homeless Veterans staffed by trained VA responders to help homeless Veterans or Veterans at-risk for homelessness. The call center can be reached by calling: **1-877-424-3838**
- Contact the local VA homeless coordinator (or point of contact), Social Work Services department, or Women Veterans Program Manager at your local VAMC.
- [VA's Homeless Veterans Program Coordinators page](#)

Immunization resources:

- [CDC vaccination schedule for adults](#)
- [CDC Pregnant women and vaccines](#)

[Intimate Partner Violence During Pregnancy, A Guide for Clinicians](#)

[LactMed at Toxnet](#) (National Library of Medicine): A database that provides available information about use of medications during lactation.

[Smoking and Tobacco Use Mini-Clinic](#)

[VA SUD \(VA Substance Use Disorder Treatment Programs\)](#)

Patient resources

[CDC Pregnancy Page for Patients – Healthy Pregnancy Tips for Women](#)

[CDC Reproductive Health - Maternal and Infant Health](#)

[La Leche League](#)

[U.S. Department of Health and Human Services Office of Women's Health - Violence Against Women](#)

[VA Women's Health Services website](#)

VA-DoD pregnancy and childbirth: A goal-oriented guide to prenatal care (Purple Book)

How to order

- Log onto TMS
- In Catalog box type "Pregnancy"
- Select – Pregnancy and Childbirth: A Goal-Oriented Guide to Prenatal Care
- Select – "Related Documents"
- Select – Order this product
- Complete Order Form and Submit (there is no charge to order)
- [Download VA-DoD Pregnancy and Childbirth PDF](#) (232 pages)

[Women, Infants and Children \(WIC\) website](#)

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

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Immunization Status and Vaccine Update

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Vaccines recommended for all pregnant women	31
Vaccines recommended for pregnant women with high risk factors	32
Vaccines to avoid during pregnancy	33
Immunization Resources	33



Check immunization status for the following conditions:

- Influenza
- Tetanus, diphtheria, acellular pertussis (Tdap)
- Measles, mumps, rubella (MMR)
- Hepatitis B
- HPV

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Vaccines recommended for all pregnant women:

- **Influenza vaccine**

- **(inactivated injectable form):**

- All pregnant women should receive influenza vaccine during the epidemic season (October through May).

- Pregnant women who acquire influenza are at increased risk of morbidity and mortality compared to nonpregnant individuals.¹
 - Vaccination during pregnancy provides important protection for the woman and infant during the first 6 months of life.
 - Nasal spray is a live, attenuated vaccine and is contraindicated during pregnancy.

- **Tetanus, diphtheria, acellular pertussis (Tdap) vaccine:**

- All women should receive the Tdap vaccine during each pregnancy. Can be administered at any time during pregnancy, but 28-36 weeks gestation is the ideal time to maximize infant immunity.

- Maternal vaccination provides passive pertussis immunity for the infant during the first 6 months of life until the infant can be vaccinated.
 - Recommend vaccination of family members who will be in contact with the newborn (e.g. partner, caregivers).

¹ Pregnant women and influenza. Centers for Disease Control and Prevention.
<http://www.cdc.gov/flu/protect/vaccine/pregnant.htm>

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Vaccines recommended for pregnant women with risk factors²:

- **Pneumococcal (polysaccharide – PCV13): 1 or 2 doses**

Risk Factors:

- Decreased immune function from disease or medications
- Functional or anatomic asplenia
- Chronic heart, pulmonary (including asthma), liver, or renal disease
- Smoking cigarettes
- Cerebrospinal fluid leak

- **Meningococcal (conjugate – MCV4): 1 or more doses**

Risk Factors:

- Age 11 to 18 years
- College freshman living in a dormitory
- Complement component deficiency
- Functional or anatomic asplenia
- Microbiologist routinely exposure to *Neisseria meningitidis*
- Traveling to or residing in country where disease is common (e.g. SubSaharan Africa)

- **Hepatitis A (inactivated): 2 doses**

- Working with Hepatitis A (HAV)-infected primates or with HAV in a research laboratory setting
- Chronic liver disease
- Treated with clotting factor concentrates
- Traveling to or working in countries with a high or intermediate rate of HAV.
- Household or occupational close personal contact with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediated rates of HAV infection

- **Hepatitis B (recombinant): 3 doses**

Risk Factors:

- Sexually active but not in a long term, monogamous relationship
- Sexual partner is HBsAg positive
- Household contact is HBsAg positive
- Current or recent IV drug user
- Resident or staff of facility for developmentally disabled
- Health care or public safety worker with anticipated exposure to blood or blood-contaminated body fluids
- End stage renal disease (predialysis and dialysis patients)
- Chronic liver disease
- HIV
- International travelers to regions with high or intermediate levels of HBV infection (HBsAg prevalence $\geq 2\%$).

² Vaccines and Immunizations. Centers for Disease Control and Prevention.
<http://www.cdc.gov/vaccines/>

Vaccines to avoid during pregnancy:

- **Live attenuated vaccines**

Live, attenuated vaccines should be administered to non-immune women in the immediate postpartum period (usually before discharge from the hospital):

- MMR (measles, mumps, rubella)
- Varicella/zoster

✦ Note: Risk of fetal exposure to live, attenuated virus from these vaccines is theoretical, and inadvertent of these vaccines to a pregnant woman is not a reason for pregnancy termination.

- **HPV vaccine**

- For women who initiated the 3-dose vaccine series before pregnancy, delay the remainder of the doses until pregnancy completion.
- Report vaccine exposure during pregnancy to the [Cervarix pregnancy registry](#).
- The Gardasil registry study is complete and found no increase in the risk for birth defects among women exposed to Gardasil during pregnancy.

Immunization Resources:

- [CDC vaccination schedule for adults](#)
- [CDC Pregnant women and vaccines](#)

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Psychosocial Risk Assessment

Topics

[Intimate partner violence](#)

[Depression](#)

[Environmental/Occupational exposures](#)

[Financial stressors](#)

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A psychosocial risk assessment should be performed:

- By the VA primary care provider at the Pregnancy Preventive Health Primary Care visit
- By the maternity care provider at the initial prenatal visit, at 28 weeks gestation, and postpartum.

In addition, the VA Maternity Care Coordinator provides intimate partner violence, depression, and smoking assessments via phone calls to pregnant women Veterans at multiple times during pregnancy and the postpartum period.

Providers should arrange appropriate referrals in response to positive screening results and ensure coordination of care among VA providers, and the VA or non-VA maternity provider.

Intimate partner violence

- May occur in up to 20% of pregnancies.
- Pregnancy may result in an escalation of violence against a woman.
- Women who screen positive should be supported to seek care and services.
- Advocacy and counseling services may increase a woman's safety
- Ask:
 - Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt or threatened by someone?
 - Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt or threatened by someone?
 - Within the last year, has anyone forced you to engage in sexual activities that made you uncomfortable?
- Intimate Partner Violence screening by VA Maternity Care Coordinator:
 - At first contact.
 - 20, 36 weeks gestation and 1 week post due-date if delivered.
 - Six week postpartum call.

Depression

- The [PHQ-2](#) can be used as an initial screen for perinatal and postpartum depression.
- A positive screen should be followed by a PHQ-9 or the Edinburgh Postpartum [Depression Scale](#) (EPDS, 10 questions).
- Depression screening by VA Maternity Care Coordinator at:
 - First contact.
 - 20, 28, 36, and 41 weeks gestation.
 - Six week postpartum call.

Environmental/Occupational exposures

Ask and counsel about potentially harmful exposures at home and work:

- Toxic exposures (e.g., solvents and other chemicals, exhaust fumes, and radiation).
- Physical stressors (e.g., heavy lifting).
- Infectious exposures (e.g., cat feces/toxoplasmosis, reptiles/salmonella).

Financial stressors

- Adequacy of food, housing, clothing, and access to healthcare for family members.

Homelessness

Housing situation:

- Where are the woman Veteran and her baby living?
- Is this living situation secure?

Refer to social work or homelessness coordinator at your facility for homelessness or housing security (or contact the 24/7 National Call Center for Homeless Veterans: 877-424-3838 to be connected to your local VA homeless program point of contact to assist further.)

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Sexually Transmitted Infections (STIs), Pregnancy and Lactation Risk, and STI Screening

Topics

[Chlamydia](#)

[Gonorrhea](#)

[Hepatitis B \(HBV\)](#)

[Hepatitis C \(HCV\)](#)

[Herpes](#)

[HIV](#)

[Syphilis](#)



Ask all pregnant patients about past infections, risk factors, and any current symptoms.

Chlamydia

- Test for chlamydia at the first visit using urine or swab specimens from the endocervix or vagina. Treat if positive.
- Women who test positive or have a new partner, should have repeat testing in the 3rd trimester.
- Chlamydia during pregnancy increases the chance for intrauterine infection, preterm birth, and preterm premature rupture of the membranes (PPROM). Prompt treatment may reduce these risks.
- Babies born to mothers with untreated chlamydia have significant risk of neonatal conjunctivitis (25-50%) or pneumonia (5-30%).

Gonorrhea

- Test for gonorrhea at the first visit using urine or swab specimens from the endocervix or vagina.
- Neisseria gonorrhea can cause ophthalmia neonatorum in infants born to mothers with untreated gonorrhea, which can cause localized skin infections, blindness, perforation of the globe of the eye, sepsis, arthritis, and meningitis.

Hepatitis B (HBV)

- Screen for hepatitis B surface antigen at the initial visit.
- Vaccinate pregnant women with hepatitis risk factors who have not been previously vaccinated.
- Women at risk for HBV infection in pregnancy should be counseled concerning additional methods to prevent HBV infection.
- HBV can be transmitted through breast milk. Women with HBV infection should not breastfeed.

Hepatitis C (HCV)

- Pregnant women with known HCV risk factors should be offered counseling and testing.
- About six of every 100 infants born to HCV-infected woman become infected. Cesarean delivery does not reduce the risk of infection, and no maternal or infant treatment decreases this risk.
- Infants born to HCV-positive mothers should be tested for HCV infection.
- HCV is not transmitted through human milk. Women with HCV may breastfeed but should not breastfeed when nipples are cracked and bleeding.

Herpes

- Pregnant women with herpes symptoms or lesions, and seronegative patients who have infected partners should be tested and counseled.
- Pregnant women with clinical and/or serological evidence of herpes simplex, type 2 or a history of genital lesions with herpes simplex, type 1, should be counseled about starting suppressive anti-viral prophylaxis with acyclovir or valacyclovir at 36 weeks gestation and continue prophylaxis through delivery in order to reduce transmission to the infant.
- Pregnant women with herpes outbreak symptoms and/or lesions at the time of labor should be delivered by cesarean section to prevent infant infection at delivery.

HIV

- At initial prenatal visit, recommend routine testing for HIV infection.
- Early 3rd trimester: Retest all pregnant women with high risk factors early in the 3rd trimester and offer testing to patients who refused testing earlier.
- Pregnant women who test positive: refer for treatment and counseling.
- Pregnant women with HIV infection should have a consultation with an infectious disease specialist to ensure treatment follows current recommendations for antiretroviral treatment during pregnancy and delivery in order to reduce transmission to the infant.
- Do not discontinue antiretroviral therapy in HIV-infected women already receiving treatment.
- Physiological changes during pregnancy increase the risk for acquiring and transmitting HIV. Counsel on safe sex practices.
- HIV is transmitted through human milk.

Syphilis

- Screen for syphilis using serologic testing (i.e., RPR or VDRL) at the initial prenatal visit.
- Treat confirmed syphilis with penicillin G (desensitization may be needed for penicillin allergic women).
- Untreated syphilis can cause non-immune hydrops in the fetus and jaundice, hepatosplenomegaly, skin rash, and/or pseudoparalysis of an extremity in the newborn.
- Comply with state reporting requirements for pregnant women screening positive.

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Prenatal Laboratory Assessments

Topics

[Urinalysis and urine culture](#)

[Chlamydia and gonorrhea screening](#)

[Blood type \(ABO, Rh factor\) and antibody screen](#)

[Rubella titer](#)

[Varicella titer](#)

[Complete blood count \(anemia/hemoglobinopathy screen\)](#)

[Hepatitis B surface antigen](#)

[HIV](#)

[Sickle cell screen](#)

[Hemoglobin electrophoresis](#)



Urinalysis and urine culture

- Bacteriuria occurs in 2 to 7% of pregnant women. Asymptomatic bacteriuria during pregnancy is a risk factor for pyelonephritis, preterm delivery, and low birth weight.
- Women with positive cultures should be treated with 3 to 7 days of an appropriate antibiotic based on drug sensitivity of the bacteria taking into consideration the relative reproductive risk of antibiotic treatment alternatives.

Chlamydia and gonorrhea screening (urine or vaginal or cervical swab)

Blood type (ABO, Rh factor) and antibody screen

- Testing and identification of pregnant women with non-anti-D antibodies allows for early treatment of infants with isoimmunization, which may improve fetal outcomes.
- Rh negative pregnant women need prophylaxis with RhoGam (anti-D immune globulin injection) to prevent exposure of the mother's immune system to fetal cells that could trigger antibody development and a risk of isoimmunization with subsequent pregnancies.

Rubella titer

- Women who are non-immune to rubella should be counseled about the potential risk for congenital rubella syndrome and the importance of vaccination after delivery.

Varicella titer

- Pregnant women who are non-immune to varicella should be vaccinated after delivery.
- If exposure to varicella occurs during pregnancy, consider treatment with varicella zoster immune globulin given the increased risk for varicella complications during pregnancy if infection occurs.
 - 10-20% of pregnant women who get chickenpox will develop pneumonia, and varicella pneumonia has a mortality rate up to 40%.
 - Chickenpox during the first or early second trimester is associated with a 0.4 to 2.0% risk for congenital varicella syndrome in the newborn.
 - Newborns born to mothers who develop a chickenpox rash between 5 days prior to delivery and 2 days after delivery have an increased risk for chickenpox after birth, which has a mortality rate up to 30%.

Complete blood count (anemia/hemoglobinopathy screen)

- For pregnant women with anemia, perform further evaluation to define the cause of the anemia and provider appropriate nutrient supplementation to address the deficiency (e.g. iron, B12, or folate).

Hepatitis B surface antigen

- Screen for hepatitis B surface antigen at the initial visit.

HIV

- At initial prenatal visit, recommend routine testing for HIV infection.

Sickle cell screen

- For individuals with African, Mediterranean, and /or Southeast Asian heritage American (if positive, then Hgb electrophoresis).

Hemoglobin electrophoresis

- Perform Hgb electrophoresis in patients of African, Southeast Asian, and Mediterranean descent to screen for sickle cell disease, Sickle-C disease, and alpha and beta thalassemias.

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Contraceptive Methods: Effectiveness and Features



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Relative risks of contraceptive use 46

Among 100 sexually active women who use no contraception for a year, 85 will get pregnant.

Contraceptive method effectiveness is described as the number of women out of 100 who will become pregnant during one year with “typical use” of the contraceptive method.

In the birth control method tables, effectiveness is labeled “PPY” for “pregnancies per year”.

Extremely effective methods

Method	PPY*	Features	Where at VA?
Hormone implant (e.g. Nexplanon, Implanon)	<1	One rod, single insertion. Rapid return of fertility upon removal.	Prosthetics
IUD – levonorgestrel (e.g. Mirena, Skyla)	<1	Use up to 5 years. May have lighter, infrequent, or absent menses. Rapid return of fertility after removal.	Prosthetics
IUD – Copper T (e.g. ParaGard)	<1	Use up to 10 years. May have heavier, more painful menses initially. Rapid return of fertility after removal.	Prosthetics
Tubal sterilization	<1	Permanent. Requires surgical procedure.	Gynecology
Partner’s vasectomy	<1	Permanent with that partner. Ineffective with other partners.	Urology
Lactational amenorrhea for first 6 months after birth	1-2	Requires exclusive breastfeeding during first 6 months after delivery. Effectiveness declines thereafter.	Instruction through primary care or gyn clinic

*PPY = pregnancies per year that occur among 100 women with typical use of the method.

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Highly effective methods

Method	PPY*	Features	Where at VA?
Hormone shot	3	Repeat doses every 3 months. Delayed return of fertility. Discontinue 18 months prior to desired pregnancy. Amenorrhea common. Causes some women to gain weight.	Pharmacy

*PPY = pregnancies per year that occur among 100 women with typical use of the method.

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Very effective methods

Method	PPY*	Features	Where at VA?
Estrogen/progestin oral contraceptive pill	8	Daily compliance required. More effective with consistent and correct use.	Pharmacy
Estrogen/progestin vaginal ring	8	Worn in vagina for 3-4 weeks. If withdrawal bleed desired, remove for 1 week each month. Can remove and immediately replace after intercourse or leave in place.	Pharmacy
Estrogen/progestin patch (e.g. Ortho Evra)	8	Replace patch weekly. Less effective for women who weigh > 200 lbs. Higher systemic estrogen exposure than with ring or low dose oral contraceptive pills	Pharmacy
Progestin oral contraceptive pill	8	Higher effectiveness when pill taken within 3 hours of the same time each day.	Pharmacy

*PPY = pregnancies per year that occur among 100 women with typical use of the method.

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Effective and less effective methods

Method	PPY*	Features	Where at VA?
Male condom	15	Latex and synthetic products provide STI protection	Prosthetics
Diaphragm with spermicide	16	Fitted by a trained provider. Have patient demonstrate proper insertion and removal. Insert prior to intercourse; leave in for at least 4 hours afterwards. Extra spermicide in vagina for additional acts of intercourse.	Prosthetics
Withdrawal	18	Requires high level of partner awareness and control.	Prosthetics
Female condom	21	Some protection from STIs	Gynecology
Cervical cap with spermicide (e.g. FemCap)	14 (29 if prior vaginal delivery)	Fitted by a trained provider. Have patient demonstrate proper insertion and removal. Insert prior to intercourse. Leave in at least 4 hours after intercourse.	Urology
Contraceptive sponge (contains spermicide)	16 (32 if prior vaginal delivery)	Nonprescription (OTC) product	Instruction through primary care or gyn clinic
Fertility awareness methods (e.g. calendar, cervical mucus)	25	More effective for women with consistent menstrual cycles.	
Spermicide (foam, gel, suppository, film)	29	Nonprescription (OTC) products	

*PPY = pregnancies per year that occur among 100 women with typical use of the method.

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Emergency contraception

For use following unprotected intercourse or when regular contraception fails (e.g. condom breaks, diaphragm not positioned correctly).

Method	Features	Where at VA?
Copper-T IUD insertion after unprotected intercourse	The most effective form of emergency contraception is placement of a copper IUD within 7 days of unprotected sex. More than 99% effective	Prosthetics
Emergency contraception (e.g. Ella (ulipristal acetate) Plan B One-Step, Next choice)	Next most effective option is oral ulipristal acetate, which requires a prescription and can be used within 5 days of unprotected sex. Levonorgestrel EC is available OTC; it is less effect for obese women and the longer it has been since intercourse, but can be used up to 5 days after unprotected sex.	Pharmacy

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Relative risks of contraceptive use

- Each method of contraception has different risks. Therefore, it is important to read the FDA approved drug or device labeling to understand these risks and counsel patients.
- Pregnancy itself has risks (e.g. increased risk of thrombosis, risks for bleeding and infection, etc) that generally are greater than the risks of preventing pregnancy with contraception.

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☐ Introduction

- ☐ Introduce self and role
- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ VA Coverage of Maternity/ Newborn Care

- ☐ Letter and Purple book received? (If no, send)
- ☐ Located OB & hospital? (If no OB, follow-up q 1-2 weeks, appt. before end of first trimester)
 - ☐ Obtain OB contact information
- ☐ Review benefits
 - ☐ Written VA authorization for maternity benefits = insurance card
 - ☐ Routine Prenatal Care
 - ☐ If OB refers for additional care, verify coverage with MCC or VA first
 - ☐ If Emergency, go to nearest ED
- ☐ Obtaining medications and medical supplies from VA
- ☐ VA newborn care coverage and obtaining non-VA newborn health insurance coverage
- ☐ VA-provided dietician & weight management and Non-VA pregnancy-related classes
- ☐ Assess interest in VA Authorization for Tubal Ligation and Intrauterine Device
- ☐ Patient response to receiving a bill from Non-VA Maternity Care provider

☐ Health Problems

- ☐ Update health problems, advise patient to tell OB about all problems
- ☐ Ask about new medications

☐ Smoking

- ☐ Assess/Verify smoking status (complete clinical reminder if not done)
 - ☐ If smoker, assess readiness to quit
 - ☐ If contemplating quit or recently quit, offer resources/referral
 - ☐ If not contemplating quitting, educate on importance for baby
- ☐ If non-smoker, assess/educate on second and third hand smoke

☐ Alcohol

- ☐ Verify alcohol use status (complete clinical reminder if not done)
- ☐ Educate: Danger of alcohol to fetal development. No amount of alcohol is safe

☐ Depression & Suicide

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ Interpersonal Violence

- ☐ Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
- ☐ Within the last year, has anyone forced you to engage in sexual activities?
 - ☐ Refer to resources as appropriate

☐ Contact Information & End Call

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related question
- ☐ Re-iterate to call OB with pregnancy-related question, go to ED for emergencies

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☐ *Introduction*

- ☐ Re-introduce self and role
- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ *VA Coverage of Maternity/Newborn Care*

- ☐ Verify receipt of VA Maternity/Newborn Care Materials (if not verified on call #1)
- ☐ Resend any items not received
 - ☐ VA Authorization for maternity benefits
 - ☐ Remind patient to carry with them like an insurance card
 - ☐ Describe local processes for correcting situation when patient receives bill
 - ☐ Letter describing benefits
 - ☐ Purple book
- ☐ Located OB? (If no, troubleshoot follow-up in <1 week-patient must be seen ASAP)
- ☐ Ask for questions regarding getting prescriptions or medical supplies filled at the VA

☐ *Health Problems*

- ☐ Update health problems, advise patient to tell OB about new problems
- ☐ Ask about new medications

☐ *Smoking (Only if active smoker or recently quit)*

- ☐ Assess current smoking status
- ☐ If currently smoking, assess readiness to quit
- ☐ If contemplating quit or recently quit, offer resources/referral
- ☐ If not contemplating quitting, educate on importance for baby
- ☐ If recently quit, congratulate, reinforce importance, offer resources/referrals, and educate about second and third-hand smoke

☐ *Contact Information & End Call*

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related questions
- ☐ Re-iterate to call OB with pregnancy-related questions, go to ED for emergencies

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☐ *Introduction*

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ *VA Coverage of Maternity/Newborn Care*

- ☐ Ask about questions or problems with VA maternity care benefits, help problem-solve
- ☐ If previously interested in TL/IUD, ask if patient had opportunity to discuss with OB

☐ *Pregnancy-related Classes*

- ☐ Refresh patient's memory about childbirth preparation class benefits and assess interest
- ☐ If delivered previously and took course previously, mention refresher course
- ☐ If not interested, assess reasons and answer questions as appropriate
- ☐ Describe mechanism for VA payment for these classes

☐ *Health Problems*

- ☐ Update health problems, advise patient to tell OB about new problems
- ☐ Ask about new medications

☐ *Smoking (Only if active smoker or recently quit)*

- ☐ Assess current smoking status
 - ☐ If currently smoking, assess readiness to quit
 - ☐ If contemplating quitting or recently quit, offer resources/referral
 - ☐ If not contemplating quitting, educate on importance for baby
 - ☐ If recently quit, congratulate, reinforce importance, offer resources/referrals, and educate about second and third hand smoke

☐ *Depression & Suicide Assessment*

- ☐ In the past 2 weeks, how often have you been bothered by little interest or
- ☐ pleasure in doing things?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ *Interpersonal Violence Screening*

- ☐ Since we last talked, have you been hit, slapped, kicked, or otherwise physically
- ☐ Hurt by someone?
- ☐ Since we last talked, has anyone forced you to engage in sexual activities?
 - ☐ Refer to resources as appropriate

☐ *Contact Information & End Call*

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related questions
- ☐ Re-iterate to call OB with pregnancy-related questions, go to ED for emergencies

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☐ *Introduction*

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ *VA Coverage of Maternity/Newborn Care*

- ☐ Ask about questions/problems with VA maternity care benefits, help patient problem-solve

☐ *Pregnancy-Related Classes*

- ☐ If patient previously expressed interest in taking classes, assess enrollment status
- ☐ If difficulty finding a class, help patient problem-solve
- ☐ Describe mechanism for VA payment for classes

☐ *Breastfeeding Supplies*

- ☐ Assess patient interest in breastfeeding, clarify misinformation
- ☐ Provide overview of breastfeeding and benefits
- ☐ Inform patient regarding lactation support services provided by hospitals
- ☐ Provide information on nursing supplies and breast pump, order breast pump as needed

☐ *WIC (Nutrition Program for Women, Infants, and Children)*

- ☐ Inform patient that WIC provides low-income families with healthy food, breast feeding support, and connections to community resources.
- ☐ Encourage patient to discuss with OB if would like more information
- ☐ Provide WIC contact information: 1-888-WIC-WORKS (1-888-942-9675) or website <http://www.fns.usda.gov/wic>

☐ *Family Planning (Contraception)*

- ☐ Assess if patient has discussed family planning with OB. If not, encourage patient to discuss with OB. (If previously requested authorization for TL or IUD, ask if patient has discussed TL/IUD.)
- ☐ Clarify misconceptions: When resuming sexual relations after having a baby, you can get pregnant - No safe period - breastfeeding does not prevent pregnancy

☐ *Health Problems*

- ☐ Update health problems, advise patient to tell OB about new problems
- ☐ Ask about new medications

☐ *Depression & Suicide Assessment*

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things? [Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless? [Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
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☐ *Introduction*

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ *VA Coverage of Maternity/Newborn Care*

- ☐ Ask about questions/problems with VA maternity care benefits, help patient problem-solve

☐ *Breastfeeding Supplies Only if patient intends to breastfeed)*

- ☐ Offer to order nursing supplies (nipple cream, pads, nursing bra)
- ☐ If breast pump previously ordered, confirm receipt. (If no, follow-up)
- ☐ If pump not ordered previously, re-offer to order
- ☐ Advise patient to call if ordered items not received in expected time period

☐ *Family Planning (Contraception) (Only if patient did not previously indicate discussing topic with OB)*

- ☐ Assess whether or not patient has discussed family planning with OB. If not, encourage patient to discuss with OB.

☐ *Health Problems*

- ☐ Update health problems & advise patient to tell OB about health problems
- ☐ Ask about new medications

☐ *Depression & Suicide Assessment*

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things? [Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless? [Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ *Interpersonal Violence (Tab 16)*

- ☐ Since we last spoke, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
- ☐ Since we last spoke, has anyone forced you to engage in sexual activities?
- ☐ Refer to resources as appropriate

☐ *Contact Information & End Call*

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related questions
- ☐ Re-iterate to call OB with pregnancy-related questions, go to ED for emergencies

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☐ *Introduction*

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ *VA Coverage of Maternity/Newborn Care*

- ☐ Ask about questions/problems with VA maternity care benefits, help patient problem-solve

☐ *Health Problems*

- ☐ Update health problems, advise patient to tell OB about new problems
- ☐ Ask about new medications

☐ *Depression & Suicide Assessment*

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ *Breastfeeding Supplies (Only if breastfeeding supplies/pump ordered)*

- ☐ Confirm breastfeeding supplies and/or pump delivered. (If not, follow-up)

☐ *Contact Information & End Call*

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related questions
- ☐ Re-iterate to call OB with pregnancy-related questions, go to ED for emergencies

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☐ Introduction

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ VA Coverage of Maternity/Newborn Care

- ☐ Ask about questions/problems with VA maternity care benefits, help patient problem-solve

☐ Health Problems

- ☐ Update health problems
- ☐ Inquire specifically about pregnancy-related diabetes & hypertension
- ☐ Ask about new medications

☐ Depression & Suicide Assessment

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ Interpersonal Violence

- ☐ Since we last talked, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
- ☐ Since we last talked, has anyone forced you to engage in sexual activities?
 - ☐ Refer to resources as appropriate

☐ Breastfeeding & Supplies

- ☐ Assess for difficulties with breastfeeding, answer questions, refer to pediatrician as needed
- ☐ As needed, confirm breast pump and supplies delivered. (If not, follow-up)
- ☐ If received breast pump/supplies, assess for difficulties with use, answer questions, and provide support.

☐ Family Planning (Contraception)

- ☐ If patient previously verbalized contraceptive plan, verify patient obtained contraception. Troubleshoot as needed.

☐ Post-Partum Visit

- ☐ Assess if patient has scheduled post-partum visit. If not, encourage patient to do so.
 - ☐ Offer VA PCP visit if patient not planning to return to OB for this visit.
- ☐ Review importance and purpose of post-partum visit

☐ Contact Information & End Call

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and timing of next call
- ☐ Provide MCC & VA PCP contact information, encourage calls for VA-related questions
- ☐ Re-iterate to call OB with pregnancy-related questions, go to ED for emergencies

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☐ Introduction

- ☐ Ask if patient free to discuss private topics, and available to speak for 10-15 minutes

☐ VA Coverage of Maternity/Newborn Care

- ☐ Ask about questions/problems with VA maternity care benefits, help patient problem-solve

☐ Health Problems

- ☐ Update health problems
- ☐ Ask about new medications

☐ Breastfeeding & Supplies

- ☐ Assess for difficulties with breastfeeding, answer questions, refer to pediatrician as needed
- ☐ Assess for difficulties/Answer questions regarding use of breast pump and/or supplies, provide support as needed.

☐ Depression & Suicide Assessment

- ☐ In the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
- ☐ In the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?
[Not at all (0); Several Days (1); More than half the days (2) Nearly every day (3)]
 - ☐ Suicide screen and referral to resources if total score = 3 or more

☐ Post-Partum Visit

- ☐ Assess if patient has had post-partum visit with OB, or has one scheduled. If not, encourage patient to do so and/or encourage/assist with scheduling appointment with VA PCP.
- ☐ If patient has had post-partum visit, assess if patient has remaining questions or issues. If yes, refer patient to VA PCP

☐ VA Primary Care Provider Follow-up Care (Only if patient does not have visit already scheduled)

- ☐ Encourage and assist patient to make appointment with PCP:
 - ☐ If patient has medical/mental health conditions, within 2 months
 - ☐ If patient does not have medical/mental health condition(s), within 3 months
- ☐ If patient declines to make appointment with PCP, determine reasons

☐ Contact Information & End Call

- ☐ What questions can I answer for you?
- ☐ Summarize call, next steps and tell patient that this will be your last call to them.
- ☐ Provide VA PCP contact information.

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