DEFENSE HEALTH AGENCY
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DHA-Policy Memorandum 25-002
January 24, 2025

MEMORANDUM FOR: SEE DISTRIBUTION LIST

SUBJECT: Risk Appropriate Maternal and Neonatal Care

Reference:
(a) DoD Directives 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency," September 30, 2013, as amended
(c) DHA-Procedural Instruction 5025.01, "Publication System," April 1, 2022
(d) Levels of Maternal Care. Obstetric Care Consensus No. 9. American College of Obstetricians and Gynecologists. *Obstetrics Gynecology* (2019)
(e) Levels of Neonatal Care. American Academy of Pediatrics. *Pediatrics* (2012)
(f) Standards for Levels of Neonatal Care: II, III, and IV. American Academy of Pediatrics. *Pediatrics* (2023)

This Defense Health Agency (DHA) Policy Memorandum, based on the authorities of References (a) and (b) and in accordance with the guidance of Reference (c) through (f), addresses risk-based stratification of the obstetric population, based upon the level of maternal and neonatal care offered at every military medical treatment facility (MTF). Multiple leading maternal and neonatal organizations advocate for implementation of levels of care to ensure delivery of risk-appropriate care, thereby minimizing severe maternal morbidity and mortality and improving neonatal outcomes.

MTFs offering obstetric and newborn services must ensure they self-assess their level of maternal and neonatal care, capabilities, and available health care providers in accordance with this memorandum, which incorporates standards published by the American College of Obstetricians and Gynecologists (Reference (d)) and the American Academy of Pediatrics (References (e) and (f)). This memorandum applies to MTFs that offer inpatient obstetric and newborn services as well as those that offer solely outpatient obstetric services with planned delivery of the newborn at community facilities through external resource sharing agreements.

Based upon resources available for their level of maternal and neonatal care, location, availability of transport, and coordination with other centers, MTFs will maintain a capabilities statement that lists maternal conditions, obstetric complications, and neonatal conditions and complications determined to exceed the capabilities of the facility. For MTFs that perform only outpatient obstetric care but require DHA personnel to perform deliveries for TRICARE beneficiaries at a community facility, the capabilities of the delivering facility should guide selection of the patient population cared for within the MTF.

The written capabilities statement will list conditions or complications that should prompt consultation from specialists or subspecialists as well as list conditions or complications that should result in referral for care in a higher-level facility. Every facility providing obstetric and neonatal care should have the personnel and resources to care for unexpected obstetric emergencies, judiciously apply a risk assessment, and consult or refer to higher-level care when indicated to optimize maternal and neonatal well-being. These facilities must also be aware of applicable travel authorities and have processes in place to ensure transfer can occur expeditiously when needed. An example capabilities statement is provided in the Attachment.

Every facility providing obstetric and neonatal care must also educate patients on the MTF's capabilities at the initial obstetric visit, including providing information as to conditions and complications which might prompt the patient to require a higher level of care. MTFs must also have formalized processes for conducting referrals to higher-level facilities.

Examples of maternal conditions or obstetric complications for which care may be provided at specific levels are available in Reference (d) and in the Attachment. These examples are listed as suggested conditions for consideration and not exhaustive or definitive. Some conditions present across a range or severity and depending on severity, location, and available resources, it may be appropriate to care for some patients at a level different than listed. Examples of gestational ages and neonatal complications optimally cared for based on the capabilities of a specific facility are available in References (e) and (f). Again, it is recognized that location and available resources may result in a determination that it is appropriate to care for some patients at a level different than listed.

This guidance is being provided to allow MTFs the time to begin to assess their current levels of care capabilities in alignment with the standardized information provided herein. DHA anticipates issuing formalized guidance via a DHA-Administrative Instruction in the coming months.

- This DHA Policy Memorandum is **cleared for public release** and available on the internet from the Health.mil site at https://health.mil/Reference-Center/Policies and is also available to authorized users from the DHA SharePoint site at https://info.health.mil/cos/admin/pubs/.

Please address questions regarding this DHA-Policy Memorandum to the DHA Women's Health Clinical Management Team at dha.ncr.j-3.mbx.whcmt@health.mil.

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Attachments:
As stated

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Attachment
Example of Capabilities Statement

Obstetric and Neonatal Capabilities Statement for
[INSERT NAME OF MTF]

This capabilities statement is designed as guidance for maternal and neonatal capabilities available at [MTF NAME]. It is important to recognize this is not intended to provide a comprehensive or definitive list of conditions appropriate to manage, as each patient's care must be individualized with consideration of severity of the condition and availability of resources in the community. Ultimately, a pregnancy should be cared for at a facility that best meets the needs of both the pregnant person and fetus including consideration of postdelivery capabilities. If it is felt that [MTF NAME] cannot sufficiently meet a patient's needs, care should be transferred to a higher level with expanded capabilities to handle more complex levels of care. This instruction applies to all credentialed and licensed providers and personnel involved in patient care [MTF NAME].

1. DEFINITION OF MATERNAL LEVEL OF CARE

1.1. [MTF NAME] Labor and Delivery unit falls under the scope of a [Level I, II, III, or IV *(choose one)*] facility as defined by the American College of Obstetricians and Gynecologists (ACOG).

[The following list is reflective of a Level II maternal care facility. It should be modified as applicable]

1.1.1. Care of moderate- to high-risk antepartum, intrapartum, and postpartum conditions.
1.1.2. Capabilities that exceed those of a Level I obstetric facility.
1.1.3. Ability to perform emergency cesarean deliveries and perform them within a time interval that best incorporates maternal and fetal risks and benefits while remaining consistent with standard of care.
1.1.4. Imaging capabilities to include computed tomography, magnetic resonance imaging, non-obstetric ultrasound, and maternal echocardiography readily available daily.
1.1.5. Standard obstetric ultrasound imaging with interpretation readily available at all times.
1.1.6. Laboratory and blood bank available at all times.
1.1.7. Ability to initiate massive transfusion protocol at all times and process to obtain more blood and component therapy as needed.
1.1.8. Mechanism and procedure for transfer to a higher level of care when necessary.
1.1.7. Every birth attended by at least one qualified professional (i.e., midwife, family physician, or Gynecologic Surgeon and Obstetrician (GS&O)) and an appropriately trained/qualified RN.
1.1.8. Appropriately trained and qualified RNs with level-appropriate competencies, as demonstrated by nursing competency documentation, readily available at all times.
1.1.9. Nursing leadership with level-appropriate formal training and experience in maternal care.

1.1.10. GS&O or Family Medicine physician with surgical skills and credentials to perform a cesarean delivery readily available at all times.
1.1.11. Anesthesia providers (anesthesiologists, nurse anesthetist) readily available at all times for labor and surgical analgesia/anesthesia.
1.1.12. Anesthesiologist readily available at all times for consultation beyond routine labor and surgical analgesia/anesthesia or in support of nurse anesthetist.
1.1.13. Physician obstetric leadership is a board-certified GS&O, board eligible GS&O who has completed an obstetric residency, or physician board certified in another specialty with privileges and expertise in obstetric care including with surgical skill and privileges to perform cesarean delivery.
1.1.14. A Maternal Fetal Medicine provider is readily available at all times for consultation onsite, by phone, or by telemedicine as needed.
1.1.15. Internal or family medicine physicians and general surgeons are readily available at all times for obstetric patients.

1.2 Readily available refers to the availability of a person 24 hours a day, 7 days a week for consultation or assistance and able to be physically present in the hospital within a time frame that incorporates maternal and fetal or neonatal risks and benefits with the provision of care.

- In accordance with Reference (d), defining of this time frame should be individualized by facilities and regions with input from their obstetric care providers.
- With this consideration, [MTF NAME] requires members of the obstetric and neonatal care team, including members of the operating room team and anesthesia to be able to be physically present within ## minutes or sooner as clinical scenario dictates.[1]
  [Alternatively, the MTF may opt to require these members to be physically present at all times pending the level of care being offered, staffing, and other local considerations.]
- If referring to the availability of a service, the service should be available 24 hours a day, 7 days a week unless otherwise specified in References (d) through (f).

2. APPROPRIATE OBSTETRIC PATIENTS

2.1 Conditions which [MTF NAME] has the capability to care for include:

[The following list should be modified as applicable based upon the level of maternal care at the facility and facility capabilities. The below serves only as an example.]

- Uncomplicated dichorionic diamniotic twin gestation
- Trial of labor after cesarean
- Uncomplicated cesarean delivery or anticipated complicated cesarean delivery.
- Preeclampsia
- Gestational diabetes
- Placenta previa with no previous uterine surgery or with one prior uterine surgery and no evidence of placenta accreta spectrum on imaging

[1] Timeframes should incorporate maternal and fetal or neonatal risks and benefits with the provision of care. The timeframe should be individualized by the facility and region, with input from OB providers in accordance with references (a) through (c).

- Maternal medical conditions that require additional monitoring included well-controlled pregestational diabetes, poorly controlled asthma, poorly controlled or complicated chronic hypertension, uncomplicated systemic lupus erythematosus.

2.2 Conditions for which transfer to a higher-level facility should be considered include:

[The following list should be modified as applicable based upon the level of maternal care at the facility and facility capabilities. The below serves only as an example.]

- Monochorionic monoamniotic twins or monochorionic diamniotic twins
- Moderate or severe maternal cardiac disease
- Systemic lupus erythematosus associated with restrictive lung disease, heart failure, chronic renal failure, active renal disease, stroke within the previous 6 months or severe flare within the previous 6 months.
- Current BMI of 50kg/m2 or pre-pregnancy BMI of 45kg/m2 with excessive weight gain
- Suspected placenta accreta or placenta previa with more than one uterine scar
- Suspected placenta percreta
- Adult respiratory distress syndrome or other conditions that require ventilatory support antepartum or postpartum.
- Acute fatty liver of pregnancy
- Coagulation disorders
- Complex hematologic or autoimmune disorders
- Expectant management of preeclampsia with severe features remote from term
- Moderate to severe pulmonary hypertension
- Pregnant women who require neurosurgery or cardiac surgery
- Pregnant women in unstable condition and in need of an organ transplant.
- Any other condition where the obstetric and neonatal providers feel the neonate is likely to require NICU care.

3. DEFINITION OF NEONATAL LEVEL OF CARE

3.1. [MTF NAME] falls under the scope of a [Level I, II, III, or IV *(choose one)*]) as defined by the American Academy of Pediatrics (AAP).

[The following list is reflective of a Level I neonatal care facility should be modified as applicable]

3.1.1. Provide neonatal resuscitation at every delivery.
3.1.2. Evaluate and provide postnatal care to stable term newborn infants.
3.1.3. Stabilize and provide care for infants born after 35 weeks gestation and anticipated to weight more than 2000 grams who remain physiologically stable.
3.1.3. Stabilization of newborn infants who are ill or those born at less than 35 weeks gestation until transfer to a higher-level care can be arranged.

2. APPROPRIATE NEONATAL PATIENTS

2.1 Conditions which [MTF NAME] has the capability to care for include:

[The following list should be modified as applicable]

- Uncomplicated twin gestation born after 35 weeks gestation.
- Fetal choroid plexus cyst with normal genetic screening
- Small atrial or ventricular septal defects
- Hyperbilirubinemia requiring light therapy.

2.2 Conditions for which delivery at or postnatal transfer to a higher-level facility should be considered include:

[The following list should be modified as applicable based upon the level of maternal care at the facility and facility capabilities. The below serves only as an example.]

- Any condition for which delivery is anticipated prior to 35 weeks gestation.
- Fetal growth restriction with fetal weight at delivery estimated to be <2000g.
- Fetal anomalies likely to require NICU support or immediate neonatal surgery including significant cleft lip/palate, abdominal wall defects, congenital diaphragmatic hernia, cardiac defects other than small atrial or ventricular septal defects.
- Severe polyhydramnios
- Positive Anti-Ro/SSA or Anti-La SSB antibodies with concern for fetal heart block.
- Respiratory distress post-delivery with no improvement within 6 hours.
- Any other condition where the obstetric and neonatal providers feel the neonate is likely to require NICU care.