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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Perceived Barriers in Coordinating Veteran Maternity Care

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) Maternity Care Coordinators' (MCCs') reported staffing, duties, and challenges.

Women are the fastest-growing demographic in the veteran population.¹ In fiscal year (FY) 2023, over 650,000 women veterans used VHA for health care, with approximately half being of reproductive age.² From FY 2011 through FY 2020, VA maternity benefits covered delivery hospitalizations for almost 40,000 veterans, with the number of veterans utilizing this service per year nearly doubling over the 10-year period.³ As the population of women veterans increases, so does the demand for VA healthcare services to address women's healthcare needs.

VHA purchases most pregnancy-related care through community providers. MCCs act as liaisons for patients, assisting in "navigating VA health care services and care in the community" to ensure continuity of care.⁴ Coordination of maternity care, including timely information sharing between VA and community providers, is "critical to patient safety."⁵

To better understand coordination of VHA maternity care services for women veterans, the OIG conducted a national survey of VHA MCCs. Responses received from 137 facilities' MCCs provide a frontline perspective on MCC staffing, maternity care access, and maternity care coordination in VHA. The OIG also reviewed relevant VHA policies and interviewed leaders from VHA's Office of Women's Health. The OIG did not independently assess the validity of the reported data.

¹ VA's 2020 Veteran Population Projection Model estimated a population of nearly 2,067,000 women veterans by the end of fiscal year 2023. A fiscal year is a 12-month period used for accounting purposes that in the federal government runs from October 1 through September 30. Public Law 93-344.

² For FY 2023, VHA provided health care for 323,512 women veterans, ages from 18 to 50 years old. "VA Maternity Outcomes – Quarterly Community Care Birth Report, FY 2023," VHA Support Service Center (VSSC), <https://vssc.med.va.gov/VSSCMainApp>. (This site is not publicly accessible.) The age range used to estimate women of reproductive age varies somewhat across sources, with commonly cited age ranges spanning from age 15 or 16 through age 44 or 49; VHA's Director of Reproductive Health advised that staff training and educational sessions offered by the VA Office of Women's Health have included a recommendation to consider potential for pregnancy when providing care for women veterans through age 52.

³ GAO, *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings*, GAO-24-106209, January 2024.

⁴ "Maternity Care Coordination," VHA Office of Women's Health SharePoint, [https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Maternity-Care-Coordinators-\(MCC\)-Guide.aspx](https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Maternity-Care-Coordinators-(MCC)-Guide.aspx). (This site is not publicly accessible.)

⁵ VHA Directive 1330.03, *Maternity Health Care and Coordination*, November 3, 2020.

Maternity Care Coordinator Staffing

While all VHA facilities had a designated MCC, survey responses showed variability in dedicated full-time equivalent (FTE) and caseloads for MCCs. Additionally, MCCs at more than 40 percent of facilities indicated not having enough time to perform duties associated with the position.

MCCs described FTE assignment, patient caseloads, and collateral duties as barriers to sufficient time. MCCs who reported patient caseloads within or below the Office of Women’s Health recommended guideline were more likely to report sufficient time for care coordination duties than those who reported caseloads higher than the recommended guideline.⁶ Analysis of MCCs’ free-text comments in the survey also highlighted concerns with collateral duties that left inadequate time for maternity care coordination activities. For example, the OIG noted that four MCCs reported also being the designated women veterans program manager, a position that VHA policy designates as “a full-time administrative position without collateral assignment,” and three of the four indicated having insufficient time for MCC duties.⁷

The findings above highlight the importance of ensuring VHA facilities provide adequate staffing and protected time for MCCs to perform assigned care coordination activities to address the needs of pregnant and postpartum patients.

Maternity Care Access

The OIG found that facility MCCs had a common concern about pregnant patients having timely access to maternity care.⁸

VHA policy requires “a streamlined process” for authorizing community providers to deliver maternity care and written processes to “expedite health care appointments for high-risk pregnant veterans or veterans initially presenting for maternity care during or beyond the second trimester.” VHA policy also requires providers to refer patients to prenatal care providers as soon as possible after pregnancy diagnosis.⁹

⁶ Assistant Under Secretary for Operations and Management, “Maternity Care Coordination (MCC) Program Expansion,” memorandum to Veterans Integrated Service Network Directors, January 18, 2023. The Office of Women’s Health recommends that for every 75–100 pregnant and postpartum patients per year, 1.0 FTE MCC is designated without collateral duties.

⁷ VHA Directive 1330.02, *Women Veterans Program Manager (WVPM)*, August 10, 2018.

⁸ Kristin Mattocks, et. al, “Factors Impacting Perceived Access to Early Prenatal Care among Pregnant Veterans Enrolled in the Department of Veterans Affairs,” *Women’s Health Issues*, no. 29-1 (2019): 56–63, <https://doi.org/10.1016/j.whi.2018.10.001>. A 2019 study funded by VA Health Services Research and Development found that almost one-third of the patients who received maternity care through the VA reported not receiving prenatal care as soon as they would have liked.

⁹ VHA Directive 1330.03.

MCCs at 50 percent of facilities reported barriers to scheduling pregnant patients for a routine initial prenatal care appointment with a community provider within the first trimester of pregnancy. Barriers to timely access for routine prenatal care were primarily attributed to community maternity care provider availability and delays related to facility community care processes.

MCCs at 38 percent of the facilities reported difficulties expediting maternity care for high-risk pregnant patients or patients presenting for initial maternity care during or beyond the second trimester of pregnancy. Descriptions of the difficulties were consistent with the concerns reported for routine appointments.

The OIG is concerned that half of MCCs reported challenges for scheduling routine prenatal visits within the first trimester, and more than a third cited difficulties expediting appointments for high-risk patients or those seeking care in later pregnancy.

Maternity Care Coordination

While MCCs generally reported compliance with coordination requirements, the OIG found that MCC responses provided some insights regarding opportunities for improvement in maternity care coordination.

All MCCs reported one or more methods for receiving notification of newly pregnant patients, and the majority (89 percent) indicated that facility processes resulted in timely awareness of patients with maternity care coordination needs.¹⁰ For the 11 percent who reported that facility processes did not ensure timely notification of pregnant patients, many cited the absence of automated electronic health record (EHR)-based notifications for relevant clinical events as a problem, and a few cited gaps in primary care teams' awareness of MCC services and initiation of manual notifications as a problem.

Most MCCs (92 percent) reported contacting pregnant patients, who received maternity care through Veterans Community Care Program, at a frequency of at least once per trimester, and most described providing education on required topics.¹¹ All MCCs reported that maternity and lactation supplies, such as breast pumps, maternity belts, disposable nursing pads, breast milk storage bags, lanolin cream, and nursing bras, were offered at their facilities. While a few MCCs (5 percent or fewer) described problems with availability of specific items or frequent delays in

¹⁰ The most common notification methods included (1) automated EHR alerts to the MCC triggered by specific clinical events such as a consult placed for maternity care or a positive pregnancy test result (~75 percent); (2) manual EHR-based communication, such as a provider adding the MCC as a co-signer on an EHR note for a pregnant patient (~68 percent); and (3) manual, non-EHR based communications, such as phone calls, e-mails, and instant messages to the MCC (~58 percent).

¹¹ VA Office of Women's Health, *VA MCC Telephone Care Program Manual*, September 2023. VHA guidance for MCCs details care coordination contacts during each trimester of pregnancy.

receiving ordered supplies, the majority of MCCs surveyed indicated that problems with receipt of supplies were infrequent.

While the majority of MCCs indicated monitoring that patients scheduled timely postpartum visits, responses suggested possible opportunities for improvement in VHA's maternity care coordination to ensure that all pregnant patients scheduled recommended postpartum care and re-establish with their VHA care teams timely.¹²

Based on the OIG's analysis of survey responses, VHA may consider additional assessments to ensure MCCs have the support and resources necessary for their duties. Approximately 80 percent of MCCs surveyed identified billing as an area for improvement, with some of the comments describing considerable time spent assisting patients with billing issues and lack of support from third-party administrators and facility community care staff to resolve the issues. Additionally, MCCs' comments in the survey referred to a lack of available patient education resources.

The OIG made two recommendations to the Under Secretary for Health related to MCC FTE assignments and timeliness of community care maternity care referrals.

VA Comments and OIG Response

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, VHA provided technical comments to the OIG during the draft phase. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to OIG findings and recommendations.

The Under Secretary for Health concurred with the recommendations and provided an acceptable action plan (see appendix A). The OIG will follow up on the planned actions until they are completed.



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¹² VHA Directive 1330.03. VHA policy requires MCCs to ensure that patients schedule a postpartum visit with their community care provider approximately six to eight weeks following delivery. MCCs are also responsible for ensuring that patients schedule a follow-up visit with their VHA women's health or primary care provider within three months post-delivery, or earlier if medically necessary.

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Abbreviations

EHR	electronic health record
FTE	full-time equivalent
FY	fiscal year
MCC	Maternity Care Coordinator
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) Maternity Care Coordinators' (MCCs') reported staffing, duties, and challenges. VHA MCCs "assist veterans in navigating VA health care services and care in the community" to ensure "continuity of care from conception through the postpartum period."¹

Background

Women are the fastest-growing demographic in the veteran population.² In fiscal year (FY) 2023, over 650,000 women veterans used VHA for health care, with approximately half being of reproductive age.³ Maternity benefits are included in the VA medical benefits package for veterans enrolled in VA's healthcare system, as mandated by federal regulation and required by VHA policy.⁴ From FY 2011 through FY 2020, VA maternity benefits covered delivery hospitalizations for almost 40,000 veterans, with the number of veterans utilizing this service per year nearly doubling over the 10-year period.⁵ As the population of women veterans increases, so does the demand for VA healthcare services to address women's healthcare needs.

¹ "Maternity Care Coordination," VHA Office of Women's Health SharePoint, [https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Maternity-Care-Coordinators-\(MCC\)-Guide.aspx](https://dvagov.sharepoint.com/sites/VHAWomensHealth/ReproductiveHealth/SitePages/Maternity-Care-Coordinators-(MCC)-Guide.aspx). (This site is not publicly accessible.)

² VA's 2020 Veteran Population Projection Model estimated a population of nearly 2,067,000 women veterans by the end of fiscal year 2023. A fiscal year is a 12-month period used for accounting purposes that in the federal government runs from October 1 through September 30. Public Law 93-344.

³ For FY 2023, VHA provided health care for 323,512 women veterans, ages from 18 to 50 years old. "VA Maternity Outcomes – Quarterly Community Care Birth Report, FY 2023," VHA Support Service Center (VSSC), <https://vssc.med.va.gov/VSSCMainApp>. (This site is not publicly accessible.) The age range used to estimate women of reproductive age varies somewhat across sources, with commonly cited age ranges spanning from age 15 or 16 through age 44 or 49. VHA's Director of Reproductive Health advised that staff training and educational sessions offered by the VA Office of Women's Health have included a recommendation to consider potential for pregnancy when providing care for women veterans through age 52.

⁴ 38 C.F.R. § 17.38. Veteran's Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, codified at 38 U.S.C. § 1710; VHA Directive 1330.03, *Maternity Health Care and Coordination*, November 3, 2020. The VA medical benefits package refers to the range of healthcare services that the VA covers and provides to eligible veterans. Maternity services have been included in the VA medical benefits package since its implementation in 1999.

⁵ GAO, *VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings*, GAO-24-106209, January 2024.

VA Maternity Care

VA maternity benefits begin with the confirmation of pregnancy and continue through the postpartum period.⁶ Clinical services covered under VA maternity benefits include

- an initial comprehensive medical assessment;
- evaluation and treatment consultations with clinically indicated specialist(s) and subspecialist(s);
- laboratory tests;
- prenatal screening for genetic disorders;
- diagnostic imaging;
- pregnancy-related education such as childbirth, parenting, nutrition, and breastfeeding classes;
- labor and delivery services;
- specified newborn care;⁷
- pharmacy services during pregnancy and postpartum period;
- management of miscarriages; and
- postpartum contraception.

VHA provides most pregnancy-related care through community care providers.⁸

Veterans Community Care Program

VA's Veterans Community Care Program provides care for eligible patients through community providers.⁹ Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VHA may authorize and pay community providers for healthcare services when the necessary care is not available at VHA, such as obstetric services;

⁶ VHA Directive 1330.03. The postpartum period refers to the six to eight weeks following delivery, when a patient is typically released from obstetric care.

⁷ VHA Directive 1330.03. VHA policy specified covered newborn care as including “all post-delivery care/services, including routine care/services, that a newborn child requires on the date of birth plus seven calendars 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.”

⁸ VHA Directive 1330.03. Some pregnant patients may receive maternity-related laboratory tests or medications required during pregnancy at their VHA facility in coordination with their community provider.

⁹ VHA Notice 2022-19, *Veterans Community Care Program*, December 27, 2022.

when the necessary care is not available in a timely manner at a VHA facility; or when the patient meets certain criteria, such as distance to a VHA facility.¹⁰

To initiate a community care referral for a pregnant patient, a VHA provider enters a consult in the electronic health record (EHR) requesting maternity care. Community care staff at the facility receive the consult, confirm eligibility, perform a clinical review for the requested services, and determine which services to authorize based on the clinically indicated services specified in the provider's consult. Once care is authorized, community care staff send the referral to a provider in the VA community care network with an authorization specifying the approved services.¹¹ Once the referral is sent to the community provider, an appointment can be scheduled.¹² Facility community care staff coordinate with the community provider for any additional service needs and obtain clinical documentation associated with the episode of care. Once received, the clinical documentation is scanned into the patient's EHR.

Maternity Care Coordination

VHA acknowledges that “coordination of maternity care and information sharing between all providers, including those at VA and in the community, is critical to patient safety.”¹³ In 2012, VHA issued a policy with procedures for “providing and coordinating maternity care for pregnant women veterans” receiving care in VHA and established the MCC position to function as “a liaison between the patient, the non-VA provider, and the VA facility.”¹⁴ VHA policy

¹⁰ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703. “Community Care Overview,” VA Community Care, accessed September 25, 2023, <https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp>. VHA provides healthcare services through community providers based on “specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans.”

¹¹ VHA's Office of Community Care utilizes “standardized episodes of care” (SEOCs) to authorize services when possible. SEOCs provide a standardized list of “allowable health care services customary for a specialty or sub-specialty that fall under the VA medical benefit” and are used to authorize the services “needed to render the clinically necessary care based on the request in the consult/referral order” and decrease “the administrative burden on VA staff and community providers.” VHA utilizes a SEOC for authorizing maternity care. When there is a need for care that falls outside of the customary SEOC, the community provider must submit a request for additional services to the facility community care office for clinical review and approval.

¹² Depending on the type of care and available options, the veteran may schedule an appointment directly with the community provider or appointment scheduling may be managed by VA staff or VA's third-party community care network administrator.

¹³ VHA Directive 1330.03.

¹⁴ VHA Handbook 1330.03, *Maternity Health Care and Coordination*, October 5, 2012; VHA Directive 1330.03. The most recent update to the policy included a change in terminology from “pregnant women veterans” to “eligible pregnant veterans” to reflect more inclusive, gender-neutral language.

requires that all medical facilities appoint an MCC and ensure support and resources necessary for effective care coordination.¹⁵

VHA's MCC program was expanded in FY 2023, extending the period of follow-up to 12 months post-delivery.¹⁶ This expansion was in response to concerns about heightened maternal mortality and risks in the pregnant veteran population compared to the general population, and legislation intended to enhance support for pregnant and postpartum patients.¹⁷

VHA MCCs' designated duties include

- collaborating with facility community care staff for community care referrals;
- ensuring effective coordination of care between relevant VHA and community maternity care providers involved in the patient's treatment;
- making regular telephone contacts while the patient is in the care of the community provider;
- providing patient education;¹⁸
- assisting patients in obtaining maternity and lactation supplies;¹⁹
- ensuring referrals to appropriate specialists for pregnant and postpartum veterans who screen positive for mental health or behavioral concerns such as depression, intimate partner violence, military sexual trauma, and posttraumatic stress disorder;

¹⁵ VHA Directive 1330.03. "Care Coordination," Agency for Healthcare Research and Quality, accessed January 16, 2024, <https://www.ahrq.gov/ncepcr/care/coordination.html>. Care coordination may be defined as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."; "Care Coordination Measures Atlas Update Chapter 2. What is Care Coordination?" Agency for Healthcare Research and Quality, accessed January 16, 2024, <https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html>. Failures in care coordination may be perceived by patients in terms of "unreasonable levels of efforts" required on the part of the patient or caregiver in order to meet care needs. Failures in care coordination may be perceived by healthcare providers or care team members in terms of misdirection of patient care or poor health outcomes resulting from inadequate information exchange or poor handoffs, or in terms of "unreasonable levels of effort" required on the part of the provider or care team members to accomplish necessary levels of coordination during transitions in care.

¹⁶ Assistant Under Secretary for Operations and Management, "Maternity Care Coordination (MCC) Program Expansion," memorandum to Veterans Integrated Service Network Directors, January 18, 2023. As of October 1, 2023, VA facilities were required to expand the MCC program to provide "post-delivery contacts for 12 months after delivery," noting that MCCs "identify mental and behavioral risks and other social determinates of health and connect Veterans to resources as needed."

¹⁷ Protecting Moms Who Served Act of 2021, Pub. L. No. 117-69, 135 Stat. 1495 (2021).

¹⁸ Patient education includes providing information about local and community resources, advance guidance about seeking emergency obstetric care, and the scope and limits of VA's newborn care benefits.

¹⁹ *Merriam-Webster.com Dictionary*, "lactation," accessed January 31, 2024, <https://www.merriam-webster.com/dictionary/lactation>. Lactation refers to the production and secretion of milk by the mammary glands, or the period extending from around the time of birthing to weaning, when this occurs.

- coordinating maternity care for pregnant patients on inpatient psychiatric units or in residential care programs;
- ensuring the EHR accurately reflects the patient’s pregnancy or lactation status;
- monitoring the provision of services and tracking maternal and fetal outcomes; and
- ensuring continuity of follow-up care, including timely postpartum visits with the community provider and with the patient’s VHA women’s health or primary care provider.²⁰

Prior OIG Reports

An OIG report was published on September 28, 2023, that found VHA facilities reviewed generally reported being able to provide reproductive health services through on-site and community resources. Facility leaders most frequently reported challenges to the provision of reproductive health services that were consistent with recognized broader challenges for health care. Such challenges included access to care in rural areas, including travel distances, community care provider availability, and shortages in VHA staffing. These challenges were more likely to impact care that requires timely access to specialty providers, such as obstetrician-gynecologists. No recommendations were made based on that review.²¹

An OIG report was published on December 7, 2021, that included one recommendation related to ensuring each VHA facility has a designated MCC. The recommendation was closed on January 4, 2023.²²

Scope and Methodology

The OIG initiated the review on June 14, 2022, to better understand MCCs’ perspectives on coordination of VA maternity care services for women veterans. The OIG reviewed relevant VHA policies and guidance documents related to maternity care coordination and interviewed leaders from VHA’s Office of Women’s Health. The OIG conducted a national survey of VHA MCCs, with the period for responses spanning from December 19, 2022, through January 23, 2023. The OIG did not independently assess the validity of the reported data.

²⁰ VHA Directive 1330.03.

²¹ VA OIG, [Review of Veterans Health Administration Reproductive Health Services](#), Report No. 22-03931-226, September 28, 2023.

²² VA OIG, [Comprehensive Healthcare Inspection Summary Report: Evaluation of Women’s Health Care in Veterans Health Administration Facilities, Fiscal Year 2020](#), Report No. 21-01508-32, December 7, 2021.

The OIG identified MCCs assigned to each facility via the Office of Women’s Health MCC Directory.²³ The OIG distributed the survey to the primary MCCs listed for the 140 VHA facilities and re-directed the survey to the appropriate respondent if the identified recipient was no longer serving as the MCC. The survey was completed by 137 (98 percent) of the 140 MCCs.²⁴

The MCC survey requested information regarding time served as the MCC, full-time equivalent (FTE) assigned to the position, and patient caseload. MCC questions focused on care coordination activities and challenges to care coordination.²⁵ The OIG also inquired about perceived areas for improvement and resource needs.

The OIG analyzed survey responses by calculating the frequency of closed-ended responses to questions to determine respondents’ perspectives on select aspects of the MCCs’ responsibilities. The OIG also analyzed free-text responses to further understand the MCCs’ perspectives related to barriers to timely access to maternity care, challenges performing MCC duties, areas for improvement in maternity care coordination, and need for additional resources. The OIG categorized the individual responses into one or more themes.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

²³ The OIG selected a single MCC representative for sites that had more than one MCC. For all Veterans Integrated Service Networks (VISNs) except VISN 1, MCCs were assigned at the facility level. VISN 1 assigned MCCs at the VISN level, with three coordinators sharing duties across eight facilities. As such, the same MCC completed surveys for more than one facility.

²⁴ The OIG attempted to contact facility MCCs who did not respond to the survey and extended the survey deadline to maximize responses. For two facilities, the designated MCCs were on extended leave, with anticipated return to duty falling beyond the time frame allotted for survey response, and for one facility, the MCC reported being temporarily assigned to the position in an acting role shortly prior to the survey distribution. The OIG noted that staff assigned to temporarily cover MCC duties in the MCCs’ absences may not have sufficient experience or familiarity to provide reliable and accurate information. Therefore, survey responses were not gathered for these three facilities.

²⁵ US Executive Office of the President (EOP), Office of Management and Budget (OMB), *Preparation, Submission, and Execution of the Budget*, August 2023, <https://www.whitehouse.gov/wp-content/uploads/2018/06/a11.pdf>. See Sections 85.2 and 85.5 (c). FTE employment refers to the total number of hours worked divided by the number of compensable hours in the fiscal year. FTE is used to quantify employment as a function of hours worked rather than by the number of individual employees. For example, 2080 hours worked per year (equivalent to 40 hours worked per week), would be calculated as 1.0 FTE, while 1,040 hours worked per year (equivalent to 20 hours worked per week) would be calculated as 0.5 FTE.

The OIG conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

MCCs' survey responses provided frontline perspectives on MCC staffing, maternity care access, and maternity care coordination.

1. Maternity Care Coordinator Staffing

The OIG found that MCC survey responses showed variability in dedicated FTE and workload with many MCCs reporting not having enough time to perform MCC duties.

VHA policy requires that all VA medical facilities in each Veterans Integrated Service Network (VISN) appoint an MCC.²⁶ Facility directors are required to facilitate “access to high-quality maternity care in the community that is coordinated by the facility’s MCC” and ensure there is “support for the MCC to track maternity care and outcomes.”²⁷

Demand for maternity-related care varies across facilities. The number of reproductive-age women veterans enrolled for health care differs across VHA facilities, as does the distribution of reproductive-age women veterans residing in states across the country.²⁸ While VHA policy does not specify the MCC FTE required for maternity coordination, the Office of Women’s Health recommends that for every 75–100 pregnant and postpartum patients per year, 1.0 FTE MCC is designated without collateral duties.²⁹

Maternity Care Coordinator Designation

At the time of this review, 100 percent of VHA facilities had a designated MCC. For the 137 facilities with MCCs who responded to the survey, the average time serving in the position was approximately 3 years, with a range of approximately one month to over 10 years.

²⁶ VHA Directive 1330.03.

²⁷ VHA Directive 1330.03.

²⁸ “Women Veterans Profile”, VHA Support Service Center (VSSC), <https://pyramid.cdw.va.gov/direct/?id=d095d018-3e47-40ae-825d-f88ac42fe73b>. (This website is not publicly accessible.) VA data on women veterans by age group from the end of FY 2023 showed that the number of reproductive age women veterans enrolled in VA varied across facilities, ranging from 282 to 14,177. The OIG calculated the number of enrolled reproductive aged women by combining VHA data on the number of enrolled women veterans in the following age categories: <25, 25–29, 30–34, 35–39, 40–44, and 45–49. “Veteran Population Projection Model, VetPop2020,” VA Analytics Service, accessed December 19, 2023, https://www.va.gov/vetdata/Veteran_Population.asp. By end of FY 2023, Vermont was projected to have the smallest population of reproductive age women veterans, estimated at approximately 1,000, and Texas was projected to have the largest population, estimated at approximately 105,000.

²⁹ Assistant Under Secretary for Operations and Management, “Maternity Care Coordination (MCC) Program Expansion,” memorandum to Veterans Integrated Service Network Directors, January 18, 2023.

Responding facility MCCs reported between 0.1 to 1.0 FTE dedicated to the position. The majority of them (84 percent), reported being the only designated MCC for their facility.³⁰ The remaining (16 percent) reported one to two other staff designated as an MCC for the facility but did not specify additional dedicated FTE.³¹

Maternity Care Coordinator Workload

MCCs' at more than 40 percent of facilities indicated not having enough time to perform MCC duties. Patient caseloads, dedicated FTE, and collateral duties were reported as barriers to sufficient time.

When asked about having enough time to perform MCC duties, 13 percent of facility MCCs responded "always," 45 percent responded "usually," 26 percent responded "sometimes," and 15 percent responded "never."³²

MCCs reported patient caseloads varied, both in the type and number of patients followed. Nearly all (98 percent) of facility MCCs responded that pregnant patients utilizing VHA maternity care were "always" followed by the coordinator. However, for pregnant patients who did not plan to utilize VHA maternity care, 37 percent of facility MCCs indicated these patients were "always" followed by the coordinator and 39 percent reported "sometimes" following those patients.³³ When asked "how many patients do you follow on your [current] MCC caseload?" MCCs responses varied widely, ranging from 1 to 420 patients.³⁴

³⁰ For VISN 1 facilities, three 1.0 FTE MCCs shared coverage across the eight VISN 1 facilities. Because MCCs were designated at the VISN level for VISN 1, the OIG excluded VISN 1 facilities from this calculation.

³¹ Twenty-one facility's MCCs reported having more than one person designated as an MCC for the facility. However, the FTE reported was for the respondent only and did not include any additional FTE contributed by the other assigned MCCs. For the eight VISN 1 facilities, three MCCs were assigned at the VISN level and shared coverage across the facilities. VISN 1 respondents reported being assigned to the VISN MCC position at 1.0 FTE, but did not specify the percentage of FTE designated to each facility. Therefore, the OIG could not calculate total facility MCC FTE for those 29 sites with more than one designated MCC.

³² The OIG considered responses of "always" and "usually" as indicating sufficient time to perform MCC duties and responses of "sometimes" and "never" as indicating insufficient time. Percentages were rounded to the nearest whole number; therefore, reported percentages do not total 100 percent.

³³ The OIG's survey did not query MCCs about differences in the scope of duties provided by the MCC for those patients who opted to utilize VHA maternity care versus those who did not. However, some free text responses in the surveys offered additional information about MCC follow-up for pregnant patients who did not opt to use VHA maternity care, including references to offering maternity and lactation supplies, ensuring awareness of available services or resources, and completing screenings.

³⁴ VISN 1 did not provide facility-specific MCC FTE and was therefore excluded from the analysis of FTE and caseload.

To compare caseloads across MCCs, the OIG used reported FTE and patient caseload to calculate an estimated equivalent caseload per 1.0 FTE.³⁵

The OIG found that MCCs who reported having higher patient caseloads did not necessarily report having more time designated to the position than those who reported having lower patient caseloads. Sixty-six percent of MCCs who reported patient caseloads within or below the Office of Women’s Health recommended guideline of 75–100 patients per 1.0 FTE, reported having sufficient time to perform maternity care coordination duties.³⁶ In comparison, 37 percent of MCCs who reported caseloads higher than the Office of Women’s Health recommendation reported having sufficient time to perform maternity care coordination duties.³⁷

Some MCCs also described that, regardless of assigned FTE, time demands associated with collateral duties impacted the actual time available to perform maternity care coordination. For example, a respondent reported serving as the facility’s mammogram coordinator, cervical cancer screening coordinator, and MCC, and indicated that the time demands across the multiple assignments did not allow enough time to effectively perform MCC duties. Another MCC, who also identified serving as the facility’s mammography coordinator and covering cervical cancer screening, reported that the time demands for mammography coordination at the facility left little time for other duties. The time demands from collateral roles were echoed in comments by another respondent, who similarly reported that the “overwhelming” amount of work associated with serving as the facility’s mammography coordinator was a barrier. The OIG noted that four MCCs reported also being the designated women veterans program manager, a position that VHA policy designates as “a full-time administrative position without collateral assignment.”³⁸ Another MCC reported that covering the facility’s vacant women veterans program manager position as a collateral duty was a barrier.

³⁵ For example, if an MCC reported a caseload of 50 patients and reported being assigned 0.5 FTE, the estimated equivalent caseload for 1.0 FTE would be 100 patients. Calculation: $(1.0 \text{ FTE} / \text{reported FTE}) * \text{reported caseload} = \text{estimated equivalent caseload}$.

³⁶ The average of estimated equivalent 1.0 FTE coordinator caseloads was 63 patients for MCCs who reported “always” having enough time for MCC duties, and 95 patients for MCCs who reported “usually” having enough time. VISN 1 facilities were excluded from the analysis of FTE and caseload. For VISN 1, responding MCCs reported assignment to the position at 1.0 FTE, but shared coverage across the eight VISN 1 facilities. Therefore, the OIG could not calculate an estimated 1.0 FTE equivalent caseload per facility for the VISN 1 facilities.

³⁷ The average of estimated equivalent 1.0 FTE coordinator caseloads was 118 patients for MCCs who reported “sometimes” having enough time for MCC duties, and 169 patients for MCCs who reported “never” having enough time. VISN 1 facilities were excluded from the analysis of FTE and caseload. For VISN 1, responding MCCs reported 1.0 FTE assignment to each facility; however, three MCCs shared coverage across the eight facilities. Therefore, the OIG could not calculate an estimated 1.0 FTE equivalent caseload per facility for the VISN 1 facilities.

³⁸ VHA Directive 1330.02, *Women Veterans Program Manager*, August 10, 2018. Three of the four MCCs who reported also being the designated women veterans program manager indicated not having sufficient time for MCC duties.

In response to an open-ended question regarding resource needs, nearly one in five of the MCCs described a need for additional staff, relief from collateral duties, or more designated time to perform MCC duties.

The findings above highlight the importance of ensuring VHA facilities provide adequate staffing and protected time for MCCs to perform assigned care coordination activities to address the needs of pregnant and postpartum patients.

2. Maternity Care Access

The OIG found that facility MCCs had a common concern about pregnant patients having timely access to maternity care.

VHA policy requires “a streamlined process” for authorizing community providers to deliver maternity care and written processes to “expedite health care appointments for high-risk pregnant veterans or veterans initially presenting for maternity care during or beyond the second trimester.” VHA policy also requires providers to refer patients to prenatal care providers as soon as possible after pregnancy diagnosis.³⁹

Guidance from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists indicates that the first prenatal visit typically occurs during the first trimester of pregnancy.⁴⁰ During the initial prenatal visit, the provider evaluates the individual needs of the patient, assesses risks, and offers education, including specialized counseling on topics of importance during early pregnancy. The provider’s evaluation informs plans for appropriate surveillance, screening, and treatment, as well as the recommended frequency of follow-up visits.⁴¹

A 2022 report referenced concerns about “maternity care deserts,” noting that approximately 2.2 million women of childbearing age are affected across the United States.⁴² A 2019 study funded by VA Health Services Research and Development found that almost one-third of the

³⁹ VHA Directive 1330.03.

⁴⁰ American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*, Eighth Edition, September 2017.

⁴¹ American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*.

⁴² March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S. 2022 Report*, accessed December 4, 2023, https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf. “Maternity care deserts are counties where there is a lack of maternity care resources, where there are no hospitals or birth centers offering obstetric care and no obstetric providers.”

patients who received maternity care through the VA reported not receiving prenatal care as soon as they would have liked.⁴³

MCCs at 50 percent of the facilities surveyed reported barriers to scheduling pregnant patients with a community provider for a routine initial prenatal care appointment within the first trimester of pregnancy. Barriers to timely access for routine prenatal care were primarily attributed to community maternity care provider availability and delays related to facility community care processes. The MCCs reported insufficient maternity care providers, increased wait times for appointments, and an inadequate number of maternity care providers enrolled in the VA community care network or accepting VA referrals or payment.⁴⁴ Descriptions of facility community care process delays included timely completion of community care referral steps such as authorizations, communication with community providers, and patient scheduling. Insufficient staffing in facilities' community care programs was also cited as a barrier.

MCCs at 38 percent of the facilities surveyed reported difficulties expediting maternity care for high-risk pregnant patients or patients presenting for initial maternity care during or beyond the second trimester of pregnancy. Difficulties expediting care for these patients were primarily attributed to community maternity care provider availability and delays associated with facility community care processes. Descriptions of the barriers related to community maternity care provider availability were consistent with the concerns reported for routine appointments, but also included reports of difficulty finding community maternity care providers who would accept high-risk patients or who would accept patients referred for care late in their pregnancy. Descriptions of the challenges related to facility community care process delays were consistent with the issues reported for routine appointments. Additionally, a couple of MCCs reported delays associated with processing requests for subsequent referrals, such as referring the patient to a maternal-fetal medicine specialist, for high-risk patients following the initial community maternity care referral.

⁴³ Kristin Mattocks, et. al, "Factors Impacting Perceived Access to Early Prenatal Care among Pregnant Veterans Enrolled in the Department of Veterans Affairs," *Women's Health Issues* 29, no. 1 (2019): 56-63, <https://doi.org/10.1016/j.whi.2018.10.001>.

⁴⁴ VA utilizes contractors, known as third-party administrators, to develop networks of community providers as a mechanism to purchase care in the community for veterans.

Ensuring early and regular access to prenatal care is important to promote healthy pregnancies and manage health conditions that increase risks for adverse outcomes in pregnancy.⁴⁵ The OIG is concerned that half of MCCs reported challenges for scheduling routine prenatal visits within the first trimester, and more than a third cited difficulties expediting appointments for high-risk patients or those seeking care in later pregnancy.

3. Maternity Care Coordination

While MCCs generally reported compliance with coordination requirements, the OIG found that MCC responses provided some insights regarding opportunities for improvement in maternity care coordination.

Coordination of care is a recognized challenge for healthcare systems.⁴⁶ Coordinating care between VHA and community providers presents increased risk for patients when communication is lacking and care becomes fragmented. MCCs help mitigate these risks by “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.”⁴⁷

To ensure effective coordination, MCCs

- need reliable processes for notification regarding newly pregnant patients,
- must establish ongoing patient contact to assess needs and provide relevant information,
- must advise patients on facility processes for obtaining maternity and lactation supplies, and
- must ensure scheduling for timely postpartum care and transition of care back to the patient’s VHA primary care provider or women’s health team.⁴⁸

⁴⁵ “Prenatal care,” US Department of Health and Human Services, Office on Women’s Health, accessed January 30, 2024, <https://www.womenshealth.gov/a-z-topics/prenatal-care>; “Maternal Morbidity and Mortality: What do We Know? How are We Addressing It?” National Institutes of Health (NIH), Office of Research on Women’s Health, accessed January 17, 2024, https://orwh.od.nih.gov/sites/orwh/files/docs/ORWH22_MMM_Info_Factsheet_508.pdf; Elizabeth A. Howell, “Reducing Disparities in Severe Maternal Morbidity and Mortality,” *Clinical Obstetrics and Gynecology* 61, no. 2 (June 2018): 387-399, <https://doi.org/10.1097/grf.0000000000000349>. Adequate access to care early in pregnancy allows providers to screen for health conditions that could impact pregnancy or maternal health and to manage risks or initiate treatment promptly. Early prenatal care also offers opportunities to educate patients on health-related behaviors to support their pregnancy. Women who do not receive prenatal care are more likely to die from pregnancy-related complications.

⁴⁶ Institute of Medicine, “Crossing the Quality Chasm: A New Health System for the 21st Century,” The National Academies Press, <https://doi.org/10.17226/10027>.

⁴⁷ VHA Directive 1330.03.

⁴⁸ VHA Directive 1330.03.

Notification of Pregnant Patients

Facility chiefs of staff must ensure that processes are in place to alert MCCs to newly pregnant patients.⁴⁹

All MCCs reported one or more methods of receiving notification of newly pregnant patients. The most common notification methods included

- automated EHR alerts to the MCC triggered by specific clinical events such as a consult placed for maternity care or a positive pregnancy test result (~75 percent);
- manual EHR-based communication, such as a provider adding the MCC as a co-signer on an EHR note for a pregnant patient (~68 percent); and
- manual, non-EHR-based communications, such as phone calls, emails, and instant messages to the MCC (~58 percent).

The majority of MCCs (89 percent) reported that the processes at their facilities resulted in timely notification of pregnant patients. For the 11 percent who reported that facility processes did not ensure timely notification of pregnant patients, many cited absence of automated EHR-based notifications for relevant clinical events as a problem, and a few cited gaps in primary care teams' awareness of MCC services and initiation of manual notifications as a problem. For example, one MCC reported having requested that automated alerts be set up to notify the MCC of community care maternity consults but indicated not receiving the requested alerts. Another MCC described receiving timely alerts for all community care maternity consults but reported that sometimes pregnancies "get missed" because the MCC was not notified of all positive pregnancy tests.⁵⁰ That MCC also reported that the facility's women's health providers consistently placed maternity care consults, but primary care providers outside of women's health and emergency department providers did not always place a consult or alert the MCC of new pregnancies.

The majority of MCCs reported being notified of pregnant patients through multiple methods and indicated that facility processes resulted in timely awareness of patients with maternity care coordination needs.

⁴⁹ VHA Directive 1330.03.

⁵⁰ During an interview with the OIG, leaders in VHA's Office of Women's Health noted that MCCs should receive automatic alerts when a community care consult for maternity care is placed. Leaders also explained that, while the use of automated alerts for positive pregnancy tests might be utilized at some facilities, there were drawbacks associated with that approach, as it may result in the MCC receiving alerts for patients who do not need maternity care. For example, a positive pregnancy test might be obtained for a patient presenting for management of a miscarriage. Also, certain tumors can cause false positive results on a pregnancy test. Additionally, during the COVID-19 pandemic, a requirement for lab confirmation of pregnancy prior to initiating a consult for maternity care was removed.

Patient Contacts

VHA policy specifies that MCCs are responsible for making regular telephone contacts with pregnant patients while they are receiving pregnancy-related care from a VA authorized community care provider.⁵¹ During these contacts, MCCs provide pregnant patients with information and resources relevant to their maternity care needs, with VHA policy specifying information that must be furnished.⁵² VHA policy states that “the nature and frequency of calls are based on the veteran's needs,” with maternity care coordination guidance detailing expectations for at least one contact during each trimester of pregnancy, and an initial postpartum contact to occur within approximately six weeks of delivery.⁵³

All MCCs reported routinely providing education for pregnant patients regarding covered VA maternity care benefits. Nearly all MCCs indicated providing patients with required information per VHA directive on

- advance instructions for seeking obstetric emergency care in the community (97 percent),
- the requirement to notify VHA within 72 hours of seeking emergency care to ensure payment authorization (93 percent), and
- local facility processes for obtaining maternity and lactation supplies (99 percent).⁵⁴

Seventy-nine percent of MCCs reported provision of required information on newborn care benefits.⁵⁵

Following initial contact to establish maternity care coordination services, the majority of MCCs (85 percent) reported the typical frequency of contacts with pregnant patients as occurring every two to three months. Reports of the typical frequency for postpartum contacts was more varied,

⁵¹ VHA Directive 1330.03.

⁵² VHA Directive 1330.03.

⁵³ VHA Directive 1330.03; Assistant Under Secretary for Operations and Management, “Maternity Care Coordination (MCC) Program Expansion,” memorandum. As of September 30, 2023, VA facilities were required to expand maternity care coordination to 12 months post-delivery. VA Office of Women’s Health, *VA MCC Telephone Care Program Manual*, September 2023, provides guidance regarding expectations for quarterly postpartum contacts.

⁵⁴ VHA Directive 1330.03. Nearly all of facility MCCs also reported providing patient education regarding a range of covered maternity care benefits, including prenatal screening for genetic disorders (99 percent), diagnostic and screening obstetric ultrasounds (96 percent), pharmacy services for prescriptions during pregnancy (99 percent), postpartum contraception (99 percent), and tubal ligation (100 percent).

⁵⁵ VHA Directive 1330.03.

with 43 percent reporting postpartum contact every two to three months, 26 percent reporting more frequent contacts, and 31 percent reporting less frequent contacts.⁵⁶

The OIG found that most MCCs (92 percent) reported contacting pregnant patients receiving maternity care through Veterans Community Care Program at a frequency of at least once per trimester, and most surveyed reported providing education on required topics.

Coordination of Maternity and Lactation Supplies

VHA policy requires that facility directors ensure pregnant and postpartum patients can receive supplies specific to their maternity care needs through the local VHA facility. MCCs are responsible for advising patients of facility processes for obtaining maternity care and lactation supplies.⁵⁷

All MCCs reported maternity and lactation supplies, such as breast pumps, maternity belts, disposable nursing pads, breast milk storage bags, lanolin cream, and nursing bras, were offered at their facilities. While a few MCCs (5 percent or fewer) reported problems with availability of specific items or frequent delays in receiving ordered supplies, the majority of MCCs surveyed indicated that problems with receipt of supplies were infrequent.⁵⁸

Ensuring Scheduling for Postpartum Care Visits

VHA policy requires MCCs to ensure that patients schedule a postpartum visit with their community care provider approximately six to eight weeks following delivery.⁵⁹ MCCs are also

⁵⁶ The time frame for the OIG's survey of MCCs preceded the required expansion of MCC contacts to 12 months post-delivery by the end of FY 2023.

⁵⁷ VHA Directive 1330.03.

⁵⁸ For example, one facility's MCC indicated that most supplies were available but noted "The prosthetics department does not supply such items as milk storage bags. The outpatient pharmacy does not supply these either." Another reported delay in receipt of supplies occurred due to the facility's prosthetics department "not approving and processing the items in a timely manner." One facility's MCC noted that "Due to supply demands and shipment delays over the past year many orders were delayed." Another MCC described "having issues all the time but our VA changed vendors and are doing better."

⁵⁹ VHA Directive 1330.03; American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, *Guidelines for Perinatal Care*. Guidance from the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommends that "[a]ll women should undergo a comprehensive postpartum visit within the first 6 weeks after birth."

responsible for ensuring that patients schedule a follow-up visit with their VHA women's health or primary care provider within three months post-delivery, or earlier if medically necessary.⁶⁰

When queried about coordination to ensure patients scheduled postpartum appointments with their community maternity care provider six to eight weeks after delivery, 85 percent of MCCs reported "yes," 9 percent reported "sometimes," and 5 percent reported "no."⁶¹ When queried about coordination to ensure patients scheduled visits with their VA women's health or primary care provider within three months after delivery, 76 percent of MCCs reported "yes," 19 percent reported "sometimes," and 5 percent reported "no."⁶²

While the majority of MCCs reported ensuring that patients were scheduled timely for postpartum visits, responses suggested possible opportunities for improvement in VA's maternity care coordination to ensure that all pregnant patients have scheduled recommended postpartum care, and re-establish care timely with their VHA care teams.

Reported Areas for Improvement

Based on the OIG's analysis of survey responses, VHA may consider additional assessments to ensure MCCs have the support and resources necessary for their duties. When asked "What, if any, barriers do you experience to performing your duties as a Maternity Care Coordinator?" 62 percent identified one or more challenges. Staffing, facility community care processes, and community care provider availability were most frequently identified as barriers by the MCCs, as noted in earlier sections of this report addressing workload and access concerns.

When asked "What aspects of VA Maternity Care do you think need improvements?" almost all MCCs (97 percent) identified one or more areas for improvement. MCCs most often identified the following areas:

- Billing issues (~80 percent)
- Community care provider access (~66 percent)

⁶⁰ VHA Directive 1330.03. The follow-up visit re-establishes care with the veteran's VA care team following the episode of community care and transitions primary responsibility for ongoing care to the veteran's VA provider. The American College of Obstetricians and Gynecologists, *Optimizing Postpartum Care*, ACOG Committee Opinion, no. 736, May 2018. Communication between the obstetrician-gynecologist (community care provider) and the patient's primary care provider (VA provider) should ensure awareness of any pregnancy-related complications that may have implications for the veteran's continuing health or treatment needs. This is important for continuity of care.

⁶¹ The OIG's survey asked MCCs "Do you ensure patients have a 6–8 week scheduled postpartum appointment with the community maternity care provider?" The survey did not gather data on the reasons why not when an MCC responded "no" or "sometimes" to this question. Percentages were rounded to the nearest whole number; therefore, reported percentages do not total 100 percent.

⁶² The OIG's survey asked MCCs "Do you ensure patients have a scheduled appointment within 3-months postpartum with the VA women's health clinic or VA primary care provider?" The survey did not gather data on the reasons why not when an MCC responded "no" or "sometimes" to this question.

- Community care processes (~38 percent)
- Pharmacy coordination for filling prescriptions from community care providers (~36 percent)
- Postpartum contraception (~29 percent)

Within the Veterans Community Care Program, VA’s third-party administrators pay claims submitted by the community providers within the administrator’s network and send invoices for the payments directly to VA for reimbursement. Some MCCs’ free-text comments described spending considerable time assisting patients with billing issues. They also reported a lack of support from third-party administrators and facility community care staff to resolve billing issues.

When asked “What, if any, additional resources are needed to support maternity care coordination?” approximately one in five MCCs described needs for patient education resources, including childbirth preparation, lactation support, and parenting classes.

VHA policy requires that “pregnancy-related education and tools” be provided, including childbirth preparation classes, parenting classes, nutritional counseling, and breastfeeding support and lactation classes.⁶³

Review of MCCs’ free-text comments noted references to lack of available resources in the community or VA community care network. Comments also expressed interest in developing internal VA resources for patient education needs, such as requesting funding and training to enable MCCs to offer lactation consultation.

Conclusion

While the OIG found that all VHA facilities had a designated MCC, MCCs at 40 percent of VHA facilities reported having insufficient time for MCC duties. Patient caseloads, dedicated FTE, and collateral duties were reported as barriers to sufficient time.

Timely access to maternity care was a common concern. MCCs at 50 percent of the facilities reporting barriers to scheduling pregnant patients with a community provider for a routine initial prenatal care appointment within the first trimester of pregnancy. Similarly, MCCs at 38 percent of the facilities surveyed reported difficulties expediting maternity care for high-risk pregnant patients or patients presenting for maternity care during or beyond the second trimester of pregnancy. Access concerns were primarily related to availability of maternity care providers in the community and delays associated with facilities’ community care processes.

⁶³ VHA Directive 1330.03.

The majority of MCCs reported being notified of pregnant patients through multiple methods and indicated that their facility's processes resulted in timely awareness of patients with maternity care coordination needs. Most MCCs (92 percent) reported contacting pregnant patients receiving maternity care through Veterans Community Care at a frequency of at least once per trimester. All facility MCCs reported routinely providing education for pregnant patients, and nearly all those surveyed indicated covering topics required within VHA policy. While a few MCCs (5 percent or fewer) reported problems with availability of specific items or frequent delays in receiving ordered supplies, the majority indicated that problems with receipt of maternity and lactation supplies were infrequent. While most MCCs indicated monitoring that patients scheduled timely postpartum visits, responses also suggested opportunities for improvement in VA's maternity care coordination to ensure that all pregnant patients have timely access to recommended postpartum care.

Billing was the top area identified for improvement in VA maternity care, identified by approximately 80 percent of the MCCs surveyed. Some comments described considerable time spent assisting patients with billing issues, lack of support from third-party administrators, and lack of facility community care staff to resolve the issues.

When asked about additional resource needs, approximately one in five MCCs identified patient education resources, including childbirth preparation, lactation support, and parenting classes. MCCs' comments reflected that some facilities lacked available community resources, and some expressed interest in supports to develop these services at their facilities.

Recommendations 1–2

1. The Under Secretary for Health requires facilities to review designated time for Maternity Care Coordinator caseload, and assigned collateral duties, to determine if additional staffing resources are needed to support Veterans Health Administration Maternity Care Coordination, and takes action as appropriate.
2. The Under Secretary for Health reviews timeliness of facility community care maternity care referrals to ensure timely access for routine and expedited (high-risk and late term) referrals, and takes action as appropriate.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: May 2, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Review of Perceived Barriers in Coordinating Maternity Care (VIEWS 11688585)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on Veteran maternity care. The Veterans Health Administration (VHA) concurs with recommendations 1 and 2. VHA provides action plans in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Review of Perceived Barriers in Coordinating

Veteran Maternity Care

(OIG Project Number 2022-00900-HI-1236)

Recommendation 1. The Under Secretary for Health requires facilities to review designated time for Maternity Care Coordinator caseload, and assigned collateral duties, to determine if additional staffing resources are needed to support Veterans Health Administration Maternity Care Coordination and takes action as appropriate.

VHA Comments: Concur

To ensure that facility senior leaders review the time designated for Maternity Care Coordinators (MCC) to perform their MCC duties, including their caseload and assigned collateral duties, and determine if additional staffing resources are needed to support, the Office of Women's Health (WH) and the Office of the Assistant Under Secretary for Health for Operations will develop an operational memorandum to reiterate requirements within applicable Maternity Health Care Directives and in previously released guidance from WH. The Memo will require Facility leaders to attest that they have reviewed their MCC caseloads, determined whether additional staffing resources are needed to support VHA Maternity Care Coordination, share any relevant trends or barriers detected, and take action as appropriate.

Status: In Progress

Target Completion Date: November 2024

Recommendation 2. The Under Secretary for Health reviews timeliness of facility community care maternity care referrals to ensure timely access for routine and expedited (high-risk and late term) referrals and takes action as appropriate.

VHA Comments: Concur

VHA Office of Integrated Veteran Care (IVC) will develop and execute a plan to review the timeliness of scheduling community care referrals for routine and expedited maternity care and will review available Community Care Network data resources to identify potential areas of improvement for maternity care scheduling. The review will utilize data extracts currently available to VHA.

IVC will review the data in collaboration with WH. IVC and WH will work together to take appropriate action as warranted.

Status: In Progress

Target Completion Date: July 2024

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