DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health Care in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01508-32 | DECEMBER 7, 2021

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Figure 1. *Veterans Affairs Building, Washington, DC.*
Source: https://www.gsa.gov/, accessed on June 24, 2021.

Abbreviations

CBOC	community-based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
PCP	primary care provider
VHA	Veterans Health Administration
WH	Women's Health

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected women's health care requirements for processes related to the provision of care, program oversight and monitoring of performance improvement data, and assignment of required staff.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[1]

Inspection Results

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with the

- provision of gynecologic care coverage 24 hours per day,
- assignment of at least two women's health primary care providers for each community-based outpatient clinic,
- women veterans health committees' inclusion of core members and reporting to clinical executive leaders,
- assignment of full-time women veterans program managers who are free of collateral duties, and
- designation of maternity care coordinators.

[1] Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

The OIG noted one repeat finding from fiscal year 2019 on women veterans health committees not including core members or reporting to executive leaders.[2] However, the OIG closed the associated recommendation on August 23, 2021. The OIG made no further recommendation.

Conclusion

The OIG conducted detailed inspections at 36 VHA medical facilities to ensure leaders implemented women's health processes. The OIG subsequently issued four recommendations for improvement to the Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to help guide improvements in operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

Comments

The Acting Under Secretary for Health agreed with the comprehensive healthcare inspection findings and recommendations (see appendix C, page 16, and the responses within the body of the report for the full text of the executive's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

[2] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report No. 20-01994-18, November 24, 2020.

Contents

Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' women's health (WH) care is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their levels of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with requirements for processes related to the provision of WH care, program oversight and monitoring of performance improvement data, and assignment of required staff.

Women represented 9.8 percent of the veteran population as of September 30, 2018.[2] According to data released by the National Center for Veterans Analysis and Statistics in May 2019, the total veteran population and proportion of male veterans are projected to decrease while the proportion of female veterans is anticipated to increase.[3] VA has made efforts to "better understand the needs of the growing Women Veteran population by examining health care use, preferences, and the barriers Women Veterans face in access to VA care."[4] Additionally, a VA *Forum* article on suicide trends among women veterans cited a 2016 VA report on veteran suicides that discussed the "importance of understanding suicide risk among women Veterans and developing gender-tailored suicide prevention strategies."[5]

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[1] Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).
[2] "Veteran Population," Table 1L: VetPop2018 Living Veterans by Age Group, Gender, 2018–2048, National Center for Veterans Analysis and Statistics, accessed August 23, 2021, https://www.va.gov/vetdata/Veteran_Population.asp.
[3] "Veteran Population," National Center for Veterans Analysis and Statistics, accessed September 16, 2019, https://www.va.gov/vetdata/docs/Demographics/VetPop_Infographic_2019.pdf.
[4] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care, Final Report*, April 2015.
[5] Claire Hoffmire, "Concerning Trends in Suicide Among Women Veterans Point to Need for More Research on Tailored Interventions," Suicide Prevention, *Forum*, Spring 2018, https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-5.

VHA requires that all eligible and enrolled women veterans have access to "timely, equitable, high-quality, [and] comprehensive health care services" in a "sensitive and safe environment."[6] Facilities must, therefore, ensure availability of appropriate resources, services, and staffing ratios.[7] VHA also requires "delivery of quality care to all women Veterans when accessing VA emergency services."[8] In addition, VHA requires facilities to establish a multidisciplinary women veterans health committee that "develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans."[9]

To determine whether VHA implemented and incorporated OIG-selected requirements to provide comprehensive healthcare services to women veterans, the inspection team reviewed relevant documents and interviewed selected managers and staff on the following requirements:

- Provision of care
  - Establishment of designated WH Patient Aligned Care Teams
  - Availability of Primary Care Mental Health Integration services
  - Availability of gynecologic care 24 hours per day
  - Designation of facility women's health primary care providers (PCPs)
  - Designation of community-based outpatient clinic (CBOC) WH PCPs
- Program oversight and monitoring of performance improvement data
  - Establishment of a women veterans health committee
    - Maintenance of quarterly meetings
    - Inclusion of core members
    - Collection and tracking of quality assurance data
    - Reporting to clinical executive leaders
- Assignment of required staff
  - Women veterans program manager
  - Women's health medical director or clinical champion

[6] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017, amended July 24, 2018. (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to emergency services for women veterans.)

[7] VHA Directive 1330.01(2).

[8] VHA Directive 1330.01(2).

[9] VHA Directive 1330.01(2).

- Maternity care coordinator
- Women's health clinical liaison at each CBOC

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews and may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.[10]

[10] Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

Methodology

The OIG evaluated compliance with selected women's health program requirements through comprehensive healthcare inspections of 36 VHA medical facilities during fiscal year 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks.

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow up until VHA leaders complete corrective actions. The comments and action plans submitted by the Acting Under Secretary for Health in response to the report recommendations appear within the report.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[11] 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.

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

[11] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[12] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[13] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, efficiency, and patient experience."[14] In keeping with VHA's goal of delivering quality care to women veterans, the OIG evaluated compliance with requirements for the provision of WH care, program oversight and monitoring of performance improvement data, and assignment of required staff.

Findings and Recommendations

The OIG found general compliance with many of the selected requirements. However, across the facilities inspected in fiscal year 2020, the OIG identified weaknesses in the

- provision of gynecologic care coverage 24 hours per day,
- assignment of at least two WH PCPs for each CBOC,
- women veterans health committees' inclusion of core members and reporting to clinical executive leaders,
- assignment of full-time women veterans program managers who are free of collateral duties, and
- designation of maternity care coordinators.

VHA requires facilities to have processes and procedures "in place for 24 hours per day and 7 days per week (24/7) for ED [Emergency Department] [care] and facility call coverage for gynecologic care."[15] The OIG determined that 7 of 35 facilities (20 percent) did not provide 24/7 coverage for gynecological care, potentially resulting in limited access to quality comprehensive

[12] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.
[13] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.
[14] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.
[15] VHA Directive 1330.01(2). (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to processes and procedures for coverage of gynecologic care.)

women's health care.[16] Reasons for noncompliance included managers' beliefs that facility efforts met requirements.

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that each facility has processes and procedures in place for emergency care 24 hours per day, 7 days per week and facility call coverage for gynecologic care.

VHA concurred.

Target date for completion: February 2022

VHA response: Not all VA medical facilities will have adequate numbers of gynecology providers to provide 24/7 call coverage for gynecologic care. However, VA medical facilities must develop and implement written policies and standard operating procedures for managing obstetric and gynecologic emergencies 24 hours per day, 7 days per week. These policies must clearly describe on-site capabilities and processes/protocols for emergent consultation or patient transfer when needed. Processes for addressing obstetric and gynecologic emergencies will differ by facility depending on the availability of: (a) Obstetricians and gynecologists (on-site, off-site, through transfer to another facility, or via tele-gynecology consultation) and (b) On-site diagnostic and treatment resources (e.g., pelvic ultrasound, operating room capacity).

The Office of Women's Health, in collaboration with Emergency Medicine, and VHA Operations, will ask that all VA medical facilities attest that they have written policies and processes (i.e., standard operating procedures (SOPs)) for managing obstetric and gynecologic emergencies 24/7 that clearly describe onsite capabilities and processes/protocols for emergent consultation and patient transfer when required.

If the VA medical facility cannot attest that they have such written policies and processes in place, they will be required to submit an action plan for completion.

VHA requires that each CBOC has at least two designated WH PCPs or arrangements for leave coverage in place when CBOCs have only one designated WH PCP.[17] The OIG found that 16 of 36 facilities (44 percent) had at least one CBOC with only one designated WH PCP and no plans for leave coverage. Inadequate staffing of WH PCPs may limit facilities' ability to provide

[16] One facility did not have an emergency department or urgent care center (Tuscaloosa VA Medical Center in Alabama) and was not included in this element.

[17] VHA Directive 1330.01(2). (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to designated WH PCPs or that arrangements for leave coverage are in place when CBOCs have only one designated WH PCP.)

comprehensive healthcare services to women veterans. Reasons for noncompliance included staffing issues and managers believing that facility efforts met requirements.

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that each community-based outpatient clinic has at least two designated women's health primary care providers or arrangements for leave coverage.

VHA concurred.

Target date for completion: February 2022

VHA response: VHA concurs that each community-based outpatient clinic (CBOC) must have at least two Women's Health Primary Care Providers (WH-PCP). VHA policy requires that the full scope of primary care is provided to all eligible Veterans. Therefore, regardless of the number of women Veterans utilizing a particular health care system, all sites that offer primary care services must offer comprehensive primary care to women Veterans. To provide the highest quality care, it is required that all women Veterans are offered assignment to WH-PCPs and Women's Health-Patient Aligned Care Teams (WH-PACT) who have received training and/or experience in the care of women Veterans. Primary care provided by WH-PCPs enhances women Veterans' satisfaction with care and enhances quality of gender-specific care. Each VA medical facility must ensure that an appropriate number of WH-PCPs are available at each site of care to ensure that all VHA access goals are met for women Veterans.

All CBOCs must have at least two WH-PCPs. (Because of small populations of women at most CBOCs, CBOC WH-PCPs will usually have mixed gender panels) it is necessary to have two WH-PCPs to provide full coverage for women during provider leave and vacation. In CBOCs with only one overall in the CBOC, appropriate arrangements must be made for coverage during leave. This may include care at another VA site or Care in the Community.

The Office of Women's Health, in collaboration with VHA Operations, will ask that all VA medical facilities attest that CBOCs have at least two WH-PCPs, or if there is only one PCP at the CBOC, there is a written standard operating procedure for coverage for the WH-PCP during leave.

If the VA medical facility cannot attest that they have two WH-PCP or an SOP for coverage for the WH-PCP during leave, then they will be required to submit an action plan for completion.

VHA requires that women veterans health committees meet quarterly, have core members, and report to executive leaders. Core members include a women veterans program manager; a WH medical director; "representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED

[Emergency Department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership."[18]

The OIG reviewed documentation of core membership in women veterans health committees for the two quarters prior to the CHIP visit. The OIG found inconsistent member representation from[19]

- medical and/or surgical subspecialties for 10 of 35 committees (29 percent),[20]
- gynecology for 8 of 30 committees (27 percent),[21]
- pharmacy for 4 of 36 committees (11 percent),
- emergency department for 10 of 30 committees (33 percent),[22]
- radiology for 9 of 36 committees (25 percent),
- laboratory for 9 of 36 committees (25 percent),
- quality management for 9 of 36 committees (25 percent),
- business office for 13 of 36 committees (36 percent), and
- executive leadership for 11 of 36 committees (31 percent).

Further, the OIG found that 8 of 36 committees (22 percent) did not report to executive leaders. This resulted in a lack of expertise and oversight in the review and analysis of data as committees planned and implemented improvements for quality and equitable care for women veterans. Reported reasons for noncompliance included staffing issues and managers being unaware of the requirement.

Women veterans health committees not including core members or reporting to executive leaders was a repeat finding from the *Comprehensive Healthcare Inspection Summary Report for Fiscal*

[18] VHA Directive 1330.01(2). (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to women veterans health committee core membership.)

[19] A facility was not included in the specific review element if it did not provide the service(s) or if, at the time of the review, the position was vacant.

[20] One facility did not provide the services and was excluded (Tuscaloosa VA Medical Center in Alabama).

[21] Six facilities were not included because there was no gynecologist on staff (Battle Creek VA Medical Center in Michigan; Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri; John J. Pershing VA Medical Center in Poplar Bluff, Missouri; Roseburg VA Health Care System in Oregon; Tomah VA Medical Center in Wisconsin; and Tuscaloosa VA Medical Center in Alabama).

[22] Six facilities were not included because they had no emergency department (Battle Creek VA Medical Center in Michigan; Chillicothe VA Medical Center in Ohio; VA Illiana Health Care System in Danville, Illinois; Carl Vinson VA Medical Center in Dublin, Georgia; Aleda E. Lutz VA Medical Center in Saginaw, Michigan; and Tuscaloosa VA Medical Center in Alabama).

Year 2019. However, the OIG closed the associated recommendation on August 23, 2021, and therefore, made no further recommendation.[23]

VHA requires facilities to have a women veterans program manager who is full-time and free of collateral duties.[24] The OIG found 8 of 36 designated women veterans program managers (22 percent) were not full time or were assigned collateral duties, which could negatively affect the ability to deliver quality healthcare services to women veterans. Facility managers reported believing efforts met the requirements or cited staffing issues as the reason for noncompliance.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that each facility has a women veterans program manager who is full-time and free of collateral duties.

[23] VA OIG, *Comprehensive Healthcare Inspection Summary Report for Fiscal Year 2019*, Report #20-01994-18, November 24, 2020.

[24] VHA Directive 1330.01(2). (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to the women veterans program manager.)

VHA concurred.

Target date for completion: February 2022

VHA response: VHA concurs that each facility must have a Women Veteran Program Manager (WVPM) who is full-time and free of collateral duty.

Each VA medical facility must designate a full-time WVPM to assess the need for, and implementation of, services for eligible women Veterans, and to provide leadership and oversight to ensure that identified needs are met at the facility. The responsibilities of the WVPM are broad and include leading the overall delivery of care and services for the growing population of women Veterans, including through program management, strategic planning, advocating for women Veterans, cultural transformation, policy on women Veterans, business planning, staff training, environment of care and capital assets, outreach, partnerships with special populations, contracting review, care in the community, and collaboration with services (including diagnostic, emergent and urgent care, primary care, and specialty care).

Because of the nature of the work, overseeing the delivery of care and services to women Veterans, responsibilities for program development, outreach, quality, construction and design elements, the position cannot be constrained by the addition of collateral duties. The Office of Women's Health supports the WVPM, as part of their executive programmatic duties, in managing human resources for the Women's Health Program; and these roles and duties are not considered a collateral duty. The management role includes selecting qualified staff in collaboration with the WH Medical Director/Champion, orienting and mentoring the staff, promoting staff development and professional growth to ensure competency.

WVPMs may supervise program support assistants, assistant WVPMs or other care or outreach coordinators that would not be considered a collateral duty. Additionally, WH supports the WVPM in having active programmatic oversight of other positions that may report administratively to another service line.

Some examples of activities or duties that would be considered a collateral duty are supervising nursing clinic staff, performing the day-to-day duties of Maternity Care Coordinator or other care coordination roles such as mammogram coordinator.

The Office of Women's Health, in collaboration with VHA Operations, will ask that all VA medical facilities attest that they have a full-time WVPM without collateral duties.

If the VA medical facility cannot attest that they have a full time WVPM without collateral duties, they will be asked to provide an action plan for completion.

VHA requires facilities to "have a designated maternity care coordinator" who "functions as a liaison between the patient, the non-VA provider and the VA medical facility."[25] The OIG found 5 of 36 facilities (14 percent) did not have a designated maternity care coordinator. The absence of a liaison in this role for expectant women veterans poses a risk of fragmented care and an inability to coordinate maternity care or track outcomes. Reported reasons for noncompliance included managers believing facility efforts met requirements, lack of funding, and staffing issues.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that each facility has a designated maternity care coordinator.

[25] VHA Directive 1330.01(2). (This directive was in place for the time frame reviewed for this report. The directive was amended on June 29, 2020 (1330.01(3)), and again on January 8, 2021 (1330.01(4)). The directives contain the same or similar language related to a designated maternity care coordinator.)

VHA concurred.

Target date for completion: February 2022

VHA response: VHA requires that each facility has a designated Maternity Care Coordinator (MCC). The MCC position cannot be fulfilled as a collateral duty of the WVPM, as per VHA Directive 1330.02, Women Veterans Program Manager. Maternity benefits are included in the VA Medical Benefits Package that is available to Veterans who are enrolled in VA's health care system. Maternity care is typically provided by authorized health care professionals in the community. Some Veterans will continue to receive other health care and services through the VA health care system during their pregnancies, either for management of coexisting medical or mental health conditions, or for maternity-related laboratory tests or medications required during pregnancy. MCCs maintain contact with women Veteran by regular phone calls throughout their pregnancies and ensure VHA support, mental health and intimate partner violence screening, coordination of care, lactation support and tracking of maternal and fetal health outcomes.

Coordination of maternity care and information sharing between all providers, including those at VA and in the community, is critical to patient safety, particularly in the area of medication management.

The Office of Women's Health, in collaboration with VHA Operations, will ask that all VA medical facilities attest that they have a designated MCC. They will attest that the MCC is not a collateral duty of the WVPM and that there is a coverage plan in place for the MCC responsibilities when the MCC is not available.

If the VA medical facility cannot attest that they have a designated MCC, who is not a WVPM, and that they have a coverage plan in place for the MCC responsibilities when the MCC is not available, then they will be required to submit an action plan for completion.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The intent is for VHA leaders to use these recommendations as a road map to help guide improvements in operations and clinical care. The recommendations address findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
Women's Health: Comprehensive Care.	• Provision of care • Program oversight and monitoring of performance improvement data • Assignment of required staff	• Each facility has processes and procedures in place for emergency care 24 hours per day, 7 days per week and facility call coverage for gynecologic care. • Each CBOC has at least two designated WH PCPs or arrangements for leave coverage. • Each facility has a women veterans program manager who is full-time and free of collateral duties. • Each facility has a designated maternity care coordinator.	• None

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)

Names	City
Ann Arbor VA Medical Center	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Clement J. Zablocki VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI

Names	City
VA Puget Sound Health Care System	Seattle, WA
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: October 26, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health in Veterans Health Administration Facilities, Fiscal Year 2020 (2021-01508-HI-1152) (VIEWS 6124180)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, "Comprehensive Healthcare Inspection Summary Report: Evaluation of Women's Health in Veterans Health Administration Facilities, Fiscal Year 2020". The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan 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:)

Steven L. Lieberman, M.D.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Krista Stephenson, MSN, RN, Team Leader Rachel Agbi, DBA, MSN Erin Allman, MSN, RN Daisy Arugay, MT Lisa Barnes, MSW Keri Burgy, MSN, RN Patricia Calvin, MBA, RN Cynthia Hickel, MSN, CRNA Miquita Hill-McCree, MSN, RN Carrie Jeffries, DNP, FACHE Rowena Jumamoy, MSN, RN Barbara Miller, BSN, RN Donna Murray, MSN, RN Jennifer Reed, RN, MSHI Simonette Reyes, BSN, RN Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN
Other Contributors	Melinda Alegria, AuD, CCC-A, F-AAA Elizabeth Bullock Shirley Carlile, BA Kaitlyn Delgadillo, BSPH Ashley Fahle Gonzalez, MPH, BS Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN-BC Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Joy Smith, BS, RDN Caitlin Sweany-Mendez, MPH

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