

**STATEMENT OF THE
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON "EXAMINING ACCESS AND QUALITY OF CARE
AND SERVICES FOR WOMEN VETERANS"**

APRIL 30, 2015

Mr. Chairman and Members of the Committee, thank you for the opportunity to provide information on the work of the Office of Inspector General (OIG) regarding the access to and quality of care and services for women veterans from the Department of Veterans Affairs (VA).

BACKGROUND

The National Center for Veterans Analysis and Statistics (NCVAS) estimates that as of September 30, 2014, women veterans made up 9 percent (2 million) of the total living veteran population (22 million).¹ NCVAS projects that by 2043, one in every six veterans will be a woman.² As both the population of and proportion of women veterans continue to grow, VA must anticipate ways to meet the rising demand to provide for the comprehensive and unique health care needs of women veterans. Since 2010, the OIG has reviewed various aspects of women's health care provided by VA through our national reviews and as part of our cyclical Community Based Outpatient Clinic (CBOC) reviews. Appendix A provides a list of OIG reports regarding women veterans. As part of the OIG's continued commitment to addressing issues of significance for women veterans, we also have two national reviews underway.

ONGOING REVIEWS

In March 2015, at the request of several Members of this Committee, we initiated a national review to determine how VA can better address the needs of women veterans using VA health care services. Specifically, our review will examine VA's ability to provide gender-specific care for women veterans and assess the efficacy of and compliance with privacy standards. We expect to complete this work by September 2015. We have also initiated another, more focused national review of military sexual trauma (MST) that will look at transitions from the Department of Defense (DoD) to VA and assess VA's outreach efforts to veterans who have experienced MST. We are working with DoD to obtain data so that we can examine VA medical care delivered to veterans with a history of military sexual trauma from DoD. We are currently working with DoD on a Memorandum of Agreement for data sharing; once signed, we anticipate

¹ Veteran Population Projection Model 2014 (VetPop2014), http://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/1L_VetPop2014.xlsx (accessed 4/23/2015).

² NCVAS data estimates that 2.4 million out of 14.5 million living veterans will be women. VetPop2014, http://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/1L_VetPop2014.xlsx (accessed 4/23/2015).

completing this work within 8 months. We will issue reports when our work is complete, and we will brief Members of Congress who have expressed an interest in these topics.

NATIONAL REVIEWS

The OIG has conducted two national reviews related to specifically women veterans. At the request of the Senate Veterans' Affairs Committee, we reviewed Veterans Health Administration (VHA) services available to women veterans who had experienced MST.³ We reviewed mental health services provided to 166 women with a history of MST treated at 14 residential and inpatient programs identified by the VHA MST support team website as resources for women veterans. We also reviewed patient electronic health records (EHR), VHA policy, and program self-assessments and conducted onsite visits at eight programs.

We found that patients were complex in terms of treatment, often with more than one mental health diagnosis. Ninety percent had received VHA mental health care within 3 months of program admission and largely from a female mental health provider. The programs reviewed provided evidenced-based psychotherapy techniques, gender-specific care, and same gender therapists. We also found that women were often admitted to programs outside their Veterans Integrated Service Network yet obtaining authorization for travel funding was frequently cited as a problem for patients and staff. We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. A decision on whether to change the travel policy is still pending with the Interim Under Secretary for Health.

As required by the *Conference Report to Accompany the Consolidated Appropriations Act of 2010* (Public Law 111-117), we assessed women veterans' use of VA health care for traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and other mental health conditions.⁴ Based on integrated data from VA and DoD, we characterized the population of nearly 500,000 veterans discharged from active military duty between July 1, 2005, and September 30, 2006, and we described their experience transitioning to VA and using VA health care and compensation benefits through March 31, 2010. We observed that, with variations in degree, female veterans generally were more likely to use VA health care than male veterans. They were also more likely to continue using VA health care services—even years after separating from active military service, and to use it more frequently.

Further, we noticed that VA generally diagnosed higher proportions of female veterans with mental health conditions after separation, but lower proportions were diagnosed with the specific mental health condition of PTSD or TBI. These patterns corroborated our findings from our data analysis and from our review of compensation claims files

³ *Healthcare Inspection - Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma* (December 5, 2012).

⁴ *Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits* (December 16, 2010).

that higher proportions of female veterans generally were awarded disability for mental health conditions other than PTSD, and a higher proportion of male veterans were generally awarded disability for PTSD or TBI. Our data analysis of the study population indicated that the Veterans Benefits Administration denied females more often for PTSD and denied male veterans more often for a mental health condition other than PTSD, although the denial rates for male and female veterans for all mental health conditions were almost the same.

COMMUNITY BASED OUTPATIENT CLINIC REVIEWS

In fiscal year (FY) 2009, the OIG began a systematic review of CBOCs. The purpose of the cyclical reviews is to assess whether CBOCs are operated in a manner that provides veterans with consistent, safe, high-quality health care in accordance with VA policies and procedures for selected clinical and administrative operations.

In 2010, VHA established minimum clinical requirements to ensure that all eligible and enrolled women veterans, irrespective of where they obtain care in VA, have access to all necessary services as clinically indicated.⁵ For FY 2012 through 2014, CBOC reviews focused in these areas:

- Women veterans' privacy and security
- Breast cancer screening
- Cervical cancer screening
- Proficiency of designated women's health providers (DWHP)

Women Veterans' Privacy and Security

The health care environment directly and indirectly affects the quality of care provided to women veterans. It affects their comfort and sense of security, as well as their perceptions of care received. VA policy requires that privacy be provided to women veterans in all health care settings, and measures must be taken to maintain and adjust care environments to support their dignity, privacy, and security.⁶ In the outpatient care setting, veterans must be provided adequate visual and auditory privacy at check-in and in the interview area. In the examination rooms, patient dignity and privacy must be maintained at all times during the course of a physical examination. Privacy curtains must be functional and shield the actual examination area. Placement of the examination table needs to minimize inadvertent exposure of the patient during a physical examination. Examination room doors must also have electronic or manual locks.

For FY 2013, of the 95 CBOCs we evaluated, 93 percent were compliant with women veterans' privacy and security standards. Of those that were noncompliant, deficiencies included lack of privacy curtains installed in the examination rooms and misplacement of examination tables where the patient's feet faced the entry door. We made recommendations in five local facility-based CBOC reports, improvements were made, and we closed all the recommendations.

⁵ VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.

⁶ VHA Handbook 1330.01.

For FY 2014, of the 93 CBOCs we evaluated, 78 percent provided adequate privacy for women veterans. Five CBOCs that had examination rooms designated for women veterans were not equipped with an electronic or manual door lock and one CBOC had no privacy curtains. We also noted 15 CBOCs with physical settings where gowned women veterans could not access gender-specific restrooms without entering public areas and no alternative measures were in place. Recommendations were issued in 15 local facility-based CBOC reports, improvements are being made, and 7 of the reports have been closed.

Breast Cancer Screening Through Mammography

Breast cancer is the second most common type of cancer among American women, with approximately 232,000 new cases in FY 2015.⁷ Timely screening, diagnosis, notification, interdisciplinary treatment planning, and treatment are essential to early detection, appropriate management, and optimal patient outcomes. Screening by mammography has been shown to reduce mortality by 20–30 percent among women age 40 and older.

VA requires that the Women Veterans Program Manager ensure that local policies and procedures guarantee proper and timely notification of gender-specific diagnostic study results. Each CBOC must also have a Women’s Health Liaison who collaborates with the Women Veterans Program Manager to coordinate women’s issues. All breast imaging and mammography results must be linked to the appropriate radiology breast study or mammogram order and entered into the Computerized Patient Record System (CPRS). The linking of the results to the orders is important because it enables providers and other clinical staff to find needed mammography results quickly and easily. Each VHA facility is also required to establish and document processes to track both the results of procedures performed offsite and the follow-up of abnormal results.

For patient notification, each certified VA Mammography Program and offsite non-VA mammography provider must establish a documented procedure to provide a summary of the written mammography report to the patient within 30 days from the date of the procedure. The VA ordering practitioner must communicate mammography results to the patient within 14 calendar days from the date on which the results were available to the ordering provider. When the mammography report assessment is “suspicious” or “highly suggestive of malignancy,” the summary results and recommended course of action should be communicated to the patient as soon as possible but no later than 5 business days after the mammogram. This may be achieved through documented verbal communication, but the provider is still required to provide written communication to the patient within 30 calendar days of the date of the mammogram.

When mammography services are outsourced, the site performing the mammogram is required to communicate the result directly to the patient. There is no additional requirement for the referring VA health care facility to provide written communication directly with the patient, unless local facility policy requires one. However, if additional

⁷ American Cancer Society, Cancer Facts & Figures 2015.

follow-up, treatment, or care is recommended, it is the responsibility of the ordering VA practitioner to attempt to contact the patient, continue the appropriate treatment regimen, and maintain continuity of care. Mammography studies that are completed by a fee provider, contract, or VA-certified mammography centers must also be linked to the provider order in CPRS to ensure that the study is complete and the patient receives the required notification.

During FY 2011, we evaluated the availability of assigned Women's Health Liaisons and the communication of mammography results to patients. We found 89 percent of the CBOCs had a Women's Health Liaison. We also found just over 11 percent compliance with the linking of mammogram results to the breast study order in CPRS. This compliance rate indicated to us that providers did not always have consistent access to comprehensive information needed to determine treatment plans for their patients. We noted that almost 73 percent of the patients were notified of their normal results, and approximately 96 percent of patients were notified of their abnormal results. We recommended that the Under Secretary for Health ensure that each CBOC has a Women's Health Liaison and that all breast imaging and mammography results are linked to the appropriate radiology mammogram or breast study order in CPRS. The Under Secretary for Health concurred with our recommendations, VHA completed their action plans for improvement, and we have closed the recommendations.

During FY 2012, we continued to evaluate the communication of mammography results to patients. We found about 93 percent with the documentation of mammography results in the radiology software package of CPRS. We also noted that 55 percent of the results of mammograms performed by a fee-basis or contract provider were linked to the provider order in CPRS and that 40 percent of the CBOC patients' EHRs contained documentation of patient notification of their mammogram results within 14 days. We recommended that the Under Secretary for Health ensure that CBOC managers establish processes to consistently link breast imaging and mammography results to the appropriate mammogram or breast study order for all fee basis and contract patients, to notify patients of mammogram results within the allotted timeframe, and document notification in the EHR. The Under Secretary for Health concurred with our recommendations, VHA completed their action plans for improvement, and we have closed the recommendations.

Cervical Cancer Screening through Papanicolaou Tests

Each year, approximately 13,000 women in the United States are diagnosed with cervical cancer.⁸ The first step of care is screening women for cervical cancer with the Papanicolaou test or "Pap" test. Screening by the Pap test is one of the most reliable and effective cancer screening tests available. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

Women should have cervical cancer screening at regular intervals. According to the

⁸ American Cancer Society, Cancer Facts & Figures 2015.

American Medical Association, “the American College of Obstetricians and Gynecologists recommended postponing Papanicolaou testing until age 21 years and extending the rescreening interval from 1 to 2 years, citing concern about harms.” In October 2011, the American Cancer Society and two pathology societies recommended that women reduce the lifetime number of Pap tests to ensure that they “receive the benefits of testing while minimizing the risks.”

VA outlines specific requirements that must be met by facilities that perform cervical cancer screening services for women veterans. The results of normal cervical pathology results must be reported to the ordering provider within 30 calendar days of the pathology report being issued. The interpreting physician must ensure the ordering provider is contacted with abnormal results within 5 business days. The cervical pathology report with normal results must be communicated to the patient in terms easily understood by a layperson within 14 days from the date of the pathology report becoming available. Documentation of a letter and/or verbal communication with the patient must be entered into CPRS. For any abnormal cervical pathology report, the results must be communicated within 5 business days of the report being issued.

During FY 2013, we evaluated the communication of cervical cancer screening results to both providers and patients. We found 99 percent compliance with the documentation of test results in the laboratory package of CPRS and about 91 percent compliance with provider notification of normal results as documented in CPRS. We also noted 81 percent compliance with the provider notification of abnormal results within 5 business days, 84 percent compliance with patient notification of normal results within 14 days of pathology report availability, and about 68 percent compliance with patient notification of abnormal results within 5 business days of the pathology report availability. We recommended that the Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal screening results within the required timeframe and that notification is documented in the EHR. We also recommended that the Under Secretary for Health ensure that a consistent process is established for notifying patients of normal and abnormal screening results within the required timeframe and that notification is documented in the EHR. The Under Secretary for Health concurred with our recommendations, and as of April 2015, VHA was still implementing their action plans.

Designated Women’s Health Providers’ Proficiency

VA requires designated women’s health providers (DWHP) to maintain proficiency in the core concepts of women’s health so that comprehensive primary care may be provided to women veterans. DWHPs must be fully proficient in providing the complete range of primary care. This may involve retraining of primary care practitioners (PCPs) or the hiring of new PCPs who can provide comprehensive primary care to both men and women veterans. To maintain proficiency in women’s health, VA requires that the DWHPs’ patient panels comprise at least 10 percent female patients so that they will spend at least one-half day every week (or its equivalent) practicing or precepting (i.e. training a less experienced provider and overseeing the care he or she provides) in a women’s health practice. Facility Chiefs of Staff must also ensure that DWHPs are

designated with the “WH” indicator in the Primary Care Management Module, the software program that tracks and reports on health care team assignments and the assignment of patients to providers.⁹

During FY 2014, we evaluated the proficiencies of VA’s DWHPs. We found that 91 percent in the CBOCs and primary care clinics at the parent health care systems had maintained proficiency requirements as established by VA. We also noted that 89 percent of these providers were designated with the “WH” indicator in VA’s Primary Care Management Module as required. We made recommendations at nine facilities to ensure DWHPs maintain proficiency and that DWHP providers are designated with the “WH” indicator. As of April 2015, seven facilities had taken appropriate actions, and we closed the recommendations. Two facilities were still implementing actions to address the recommendations.

CONCLUSION

According to VA data, the number of women veterans served by VA will continue to grow, and VA continues to explore ways to enhance health care for women veterans. Through our national reviews and ongoing cyclical reviews, the OIG has recognized the importance of ensuring women veterans have access to high-quality health care in a safe and dignified manner. Since 2010, the OIG has made recommendations to the Under Secretary for Health regarding women’s health care delivery processes. It is critical that VHA remains vigilant in maintaining improvements in the provision of examination room and restroom privacy, the designation of a Women’s Health Liaison at each CBOC, the linking of all breast imaging and mammography results to the appropriate radiology mammogram or breast study order in CPRS, and the timely patient notification of mammogram results within the allotted timeframe with documentation in CPRS. We will also continue to monitor VHA’s action plans for improving provider notification of abnormal cervical cancer screening results and patient notification of both normal and abnormal cervical screening results with documentation in CPRS until the open recommendations in our reports are fully implemented.

The OIG will maintain its commitment to provide independent oversight of various aspects of care delivery, access, safety, privacy, and quality. We look forward to sharing with the Committee the results of our current work on significant women’s health care issues in several months. Thank you, Mr. Chairman, for the opportunity to submit this statement.

⁹ VHA Handbooks 1330.01 and 1101.02, *Primary Care Management Module*, April 21, 2009.

**VA Office of Inspector General
Reporting on VA Care for Women Veterans**

National Reports

- December 5, 2012 Healthcare Inspection – Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma
<http://www.va.gov/oig/pubs/VAOIG-12-03399-54.pdf>
- December 16, 2010 Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits
<http://www.va.gov/oig/52/reports/2011/VAOIG-10-01640-45.pdf>

CBOC Summary Reports

- September 23, 2014 Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting
<http://www.va.gov/oig/pubs/VAOIG-14-02198-284.pdf>
- September 30, 2013 Healthcare Inspection – Evaluation of VHA Community Based Outpatient Clinics Fiscal Year 2012
<http://www.va.gov/oig/pubs/VAOIG-13-00090-346.pdf>
- August 16, 2012 Healthcare Inspection Evaluation of Community Based Outpatient Clinics Fiscal Year 2011
<http://www.va.gov/oig/pubs/VAOIG-11-01406-247.pdf>

Individual CBOC Reports

- November 10, 2014 Community Based Outpatient Clinic and Primary Care Clinic Reviews at Miami VA Healthcare System, Miami, Florida
<http://www.va.gov/oig/pubs/VAOIG-14-00939-27.pdf>
- August 12, 2014 Community Based Outpatient Clinic and Primary Care Clinic Reviews at Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin
<http://www.va.gov/oig/pubs/VAOIG-14-00923-237.pdf>
- July 23, 2014 Community Based Outpatient Clinic and Primary Care Clinic Reviews at West Texas VA Health Care System, Big Spring, Texas
<http://www.va.gov/oig/pubs/VAOIG-14-00916-218.pdf>

July 8, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Robert J. Dole VA Medical Center, Wichita, Kansas http://www.va.gov/oig/pubs/VAOIG-14-00915-206.pdf
July 7, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington http://www.va.gov/oig/pubs/VAOIG-14-00910-205.pdf
July 2, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Black Hills Health Care System, Fort Meade, South Dakota http://www.va.gov/oig/pubs/VAOIG-14-00909-191.pdf
June 26, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilmington VA Medical Center, Wilmington, Delaware http://www.va.gov/oig/pubs/VAOIG-14-00235-195.pdf
June 26, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Kansas Health Care System, Topeka, Kansas http://www.va.gov/oig/pubs/VAOIG-14-00914-190.pdf
June 10, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Huntington VA Medical Center, Huntington, West Virginia http://www.va.gov/oig/pubs/VAOIG-14-00905-182.pdf
May 22, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Aleda E. Lutz VA Medical Center, Saginaw, Michigan http://www.va.gov/oig/pubs/VAOIG-14-00231-158.pdf
May 13, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at James E. Van Zandt VA Medical Center, Altoona, Pennsylvania http://www.va.gov/oig/pubs/VAOIG-14-00236-153.pdf
April 28, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at Southern Arizona VA Health Care System, Tucson, Arizona http://www.va.gov/oig/pubs/VAOIG-14-00240-129.pdf
March 13, 2014	Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Caribbean Health Care System, San Juan, Puerto Rico http://www.va.gov/oig/pubs/VAOIG-14-00233-96.pdf

- February 28, 2014 Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Salt Lake City Health Care System, Salt Lake City, Utah
<http://www.va.gov/oig/pubs/VAOIG-13-03420-85.pdf>
- February 27, 2014 Community Based Outpatient Clinic and Primary Care Clinic Reviews at Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri
<http://www.va.gov/oig/pubs/VAOIG-13-03424-74.pdf>
- December 5, 2013 Community Based Outpatient Clinic Reviews at James H. Quillen VA Medical Center, Mountain Home, TN
<http://www.va.gov/oig/pubs/VAOIG-13-00026-24.pdf>
- September 18, 2013 Community Based Outpatient Clinic Reviews at James A. Haley Veterans' Hospital, Tampa, FL
<http://www.va.gov/oig/pubs/VAOIG-13-00026-314.pdf>
- August 19, 2013 Community Based Outpatient Clinic Reviews at Charlie Norwood VA Medical Center, Augusta, GA
<http://www.va.gov/oig/pubs/VAOIG-13-00026-285.pdf>
- May 31, 2013 Community Based Outpatient Clinic Reviews at North Florida/South Georgia Veterans Health System, Gainesville, FL
<http://www.va.gov/oig/pubs/VAOIG-13-00026-207.pdf>
- February 20, 2013 Community Based Outpatient Clinic Reviews at John J. Pershing VA Medical Center, Poplar Bluff, MO
<http://www.va.gov/oig/pubs/VAOIG-12-03851-102.pdf>