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Preliminary Findings on
VA's Provision of Health
Care Services to Women
Veterans
Statement of Randall B. Williamson Director, Health Care

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Mr. Chairman and Members of the Committee:
I am pleased to be here today as the Committee considers issues related to the Department of Veterans Affairs' (VA) delivery of health care services to women veterans. Historically, the vast majority of VA patients have been men, but that is changing. As of October 2008, there were more than 1.8 million women veterans in the United States (representing approximately 7.7 percent of the total veteran population), and more than 102,000 of these women were veterans of the military operations in Afghanistan and Iraq, known as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). According to VA data, in fiscal year 2008, over 281,000 women veterans received health care services from VA—an increase of about 12 percent since 2006. Looking ahead, VA estimates that while the total number of veterans will decline by 37 percent between 2008 and 2033, the number of women veterans will increase by more than 17 percent over the same period.

The health care services needed by women veterans are significantly different from those required by their male counterparts. Women veterans are younger, in the aggregate, than their male counterparts. Based on an analysis conducted by the VA in 2007, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61. Women veterans seeking care at VA medical facilities need access to a full range of physical health care services, including basic gender-specific services—such as breast examinations, cervical cancer screening, and menopause management—and specialized gender-specific services such as obstetric care (which includes prenatal, labor and delivery, and postpartum care) and treatment of reproductive cancers. Women veterans also need access to a range of mental health care services, such as care for depression.

In addition, women veterans of OEF/OIF present new challenges for VA's health care system. Almost all of these women are under the age of 40— 58 percent are between the ages of 20 and 29. VA data show that almost 20 percent of women veterans of OEF/OIF have been diagnosed with post-traumatic stress disorder (PTSD).1 Additionally, an alarming number of them have

experienced sexual trauma while in the military.2 As a result, many women veterans of OEF/OIF have complex physical and mental health care needs.

Congress and others have raised concerns about how well VA is prepared to meet the physical and mental health care needs of the growing number of women veterans, particularly veterans of OEF/OIF. Traditionally, women veterans have utilized VA's health care services less frequently than their male counterparts. In fiscal year 2007, 15 percent of women veterans used VA's health care services, compared to 22 percent of male veterans. VA believes that part of this difference may be attributable to barriers that the current care models at many VA medical facilities present to women veterans. For example, women veterans have often been required to make multiple visits to a VA facility in order to receive the full spectrum of primary care services, which includes such basic gender- specific care as cervical cancer screenings and breast examinations. Because many of these women work or have child care responsibilities, multiple visits can be problematic, especially when services are not available in the evenings or on weekends.

VA has taken some steps to improve the availability of services for women veterans, including requiring that all VA medical facilities make the Women Veterans Program Manager (WVPM)—an advocate for the needs of women veterans—a full-time position and providing funding for equipment to help VA medical facilities improve health care services for women veterans. Additionally, in November 2008, VA began a systemwide initiative to make comprehensive primary care for women veterans available at every VA medical facility—VA medical centers (VAMC) and community-based outpatient clinics (CBOC). In announcing this initiative, VA established a policy defining comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, gender-specific care, and mental health care—from one primary care provider at one site.

You asked us to examine VA's health care services for women veterans. In my testimony today, I will discuss our preliminary findings, based on visits to selected VA facilities, regarding (1) the on-site availability of health care services at VA facilities for women veterans, (2) the extent to which VA
facilities are following VA policies that apply to the delivery of health care services for women veterans, and (3) some key challenges that VA facilities are experiencing in providing health care services for women veterans.

To examine the availability of health care services at VA facilities for women veterans and to determine the extent to which VA facilities are following VA policies that apply to the delivery of health care services for women veterans, we reviewed applicable VA policies3 and available VA data, and interviewed officials from VA headquarters, Veterans Integrated Service Networks (VISN),4 and VA facilities. In addition, we conducted site visits to a judgmental sample of nine VAMCs located in Atlanta and Dublin, Georgia; San Diego and Long Beach, California; Minneapolis and St. Cloud, Minnesota; Sioux Falls, South Dakota; and Temple and Waco, Texas. We also visited 10 VA CBOCs affiliated with these nine VAMCs, and eight Vet Centers, which are counseling centers that help combat veterans readjust from wartime military service to civilian life. We used VA data to select these sites based on several factors, including the number of women veterans using health care services at each VAMC and whether facilities offered

specific programs for women veterans, such as outpatient or residential treatment programs for women who have PTSD or have experienced military sexual trauma (MST). See appendix I for additional details on the selection criteria we used and information on the number of women veterans using health care services at each VAMC and CBOC we visited. To further examine the availability of services for women veterans, we obtained information from each VAMC and CBOC regarding the organization and availability of primary care services, basic gender- specific services, specialized gender-specific services, and mental health services in outpatient, residential, and inpatient settings; and the availability of specific clinical services such as prenatal care, osteoporosis treatment, mammography, and counseling for MST. When services were not available on site, we determined whether they were available through fee-for-service arrangements (fee basis), contracts, or sharing agreements with non-VA facilities. During our site visits we also toured each facility and documented observations of the physical space in each care setting. We examined how facilities were implementing VA policies pertaining to ensuring the privacy of women veterans in outpatient, residential, and inpatient care settings; and VA's model of comprehensive primary care for women veterans. Finally, to identify key challenges that VA facilities are experiencing in providing health care services for women veterans, we reviewed relevant literature; interviewed VA officials in headquarters, medical facilities, and Vet Centers; interviewed VA experts in the area of women veterans' health; and documented challenges observed during our site visits. The findings of our site visits to VA facilities cannot be generalized to other VA facilities. We shared the information contained in this statement with VA officials, and they generally agreed with the information we presented.

We conducted our performance audit from July 2008 through July 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA Health Care System VA's integrated health care delivery system is one of the largest in the United States and provides enrolled veterans, including women veterans, with a range of services including primary and preventive health care services, mental health services, inpatient hospital services, long-term care, and prescription drugs.5 VA's health care system is organized into 21 VISNs that include VAMCs and CBOCs. VAMCs offer outpatient, residential, and inpatient services. These services range from primary care to complex specialty care, such as cardiac and spinal cord injury care. VAMCs also offer a range of mental health services, including outpatient counseling services, residential programs—which provide intensive treatment and rehabilitation services, with supported housing, for treatment, for example, of PTSD, MST, or substance use disorders—and inpatient psychiatric treatment. CBOCs are an extension of VAMCs and provide outpatient primary care and general mental health services on site. VA also operates 232 Vet Centers, which offer readjustment and family counseling, employment services, bereavement counseling, and a range of social services to assist combat veterans in readjusting from wartime military service to civilian life.6

When VA facilities are unable to efficiently provide certain health care services on site, they are authorized to enter into agreements with non-VA providers to ensure veterans have access to

medically necessary services.7 Specifically, VA facilities can make services available through
• referral of patients to other VA facilities or use of telehealth services,8
• sharing agreements with university affiliates or Department of Defense medical facilities,
• contracts with providers in the local community, or
• allowing veterans to receive care from providers in the community who will accept VA payment (commonly referred to as fee-basis care).

VA Policies Pertaining to Women's Health Federal law authorizes VA to provide medically necessary health care services to eligible veterans, including women veterans.9 Federal law also specifically requires VA to provide mental health screening, counseling, and treatment for eligible veterans who have experienced MST.10 Although the MST law applies to all veterans, it is of particular relevance to women veterans because among women veterans screened by VA for MST, 21 percent screened positive for experiencing MST. VA provides health care services to veterans through its medical benefits package—health care services required to be provided are broadly stated in a regulation and further specified in VA policies. Through policies, VA requires its health care facilities to make certain services, including gender-specific services and primary care services, available to eligible women veterans.11 Gender-specific services that are included in the VA medical benefits package12 include, for example, cervical cancer screening, breast examination, management of menopause, mammography, obstetric care, and infertility evaluation. See table 1 for a list of selected basic and specialized gender-specific services that VA is required to make available and others that VA may make available to women veterans.

Table 1: Selected Clinical Services That VA Is Required to Make Available and Others That VA May Make Available to Women Veterans, by Category

Services that VA medical facilities may make available to women veterans
Primary care/basic gender-specific servicesa • Intake and initial assessment, including screening for military sexual trauma (MST)b
• Routine physical exams
• Intimate partner violence screening
• Smoking cessation counseling
• Smoking cessation treatment
• Nutrition counseling
• Weight management and fitness
• Urgent/emergent gender-related care—normal hours
• Urgent/emergent gender-related care—evenings, weekends, and holidays
• Pelvic examinationb
• Clinical breast examinationb
• Education on performing breast self-examinationb
• Cervical cancer screeningb
• Menopause managementb
• Uncomplicated vulvovaginitis treatmentb
• Osteoporosis screeningb
• Osteoporosis treatmentb
• Hormone replacement therapyb

• Prescription of oral contraceptivesb
Specialized gender-specific servicesa • Treatment after abnormal cervical cancer screeningb
• Surgical sterilization—evaluationb
• Surgical sterilization
• Sexually transmitted disease (STD) screening
• STD counseling
• STD treatment
• Intrauterine device (IUD) placement
• Pregnancy test—urine
• Pregnancy test—serum
• Prenatal care
• Labor and delivery
• Postpartum care
• Infertility evaluationb
• Endometriosis treatment
• Evaluation of polycystic ovarian syndromeb
• Treatment of polycystic ovarian syndromeb

Services that VA medical facilities may make available to women veterans
Screening mammographyb
Diagnostic mammography
Surgical treatment of breast cancerb Surgical treatment of reproductive cancerb Medical treatment of breast cancerb Medical treatment of reproductive cancerb
Source: GAO review of VA data.
Notes: The data are from a review of VHA Handbook 1330.1 and VA's annual Plan of Care and Clinical Inventory Survey.
aThe distinction between "basic" and "specialized" gender-specific services is based on the definitions included in VHA Handbook 1330.1 and the 2003 article by Yano and Washington. Elizabeth Yano and Donna Washington, "Availability of Comprehensive Women's Health Care Through Department of Veterans Affairs Medical Center." Published by Donna Washington, et al., in Women's Health Issues, v. 13 (2003).

bDenotes a service that VA medical facilities are required to make available to women veterans, based on VHA Handbook 1330.1.

In November 2008, VA established a policy that requires all VAMCs and CBOCs to move toward making comprehensive primary care available for women veterans.VA defines comprehensive primary care for women veterans as the availability of complete primary care—including routine detection and management of acute and chronic illness, preventive care, basic gender-specific care, and basic mental health care—from one primary care provider at one site. VA did not establish a deadline by which VAMCs and CBOCs must meet this requirement.

VA policies also outline a number of requirements specific to ensuring the privacy of women veterans in all settings of care at VAMCs and CBOCs.13 These include requirements related to ensuring auditory and visual privacy at check-in and in interview areas; the location of exam rooms, presence of privacy curtains, and the orientation of exam tables; access to private

restrooms in outpatient, inpatient, and residential settings of care; and the availability of sanitary products in public restrooms at VA facilities.

In 1991, VA established the position of Women Veteran Coordinator—now the WVPM—to ensure that each VAMC had an individual responsible for assessing the needs of women veterans and assisting in the planning and delivery of services and programs to meet those needs. Begun as a part- time collateral position, the WVPM is now a full-time position at all VAMCs. In July 2008, VA required VAMCs to establish the WVPM as a full- time position (no longer a collateral duty) no later than December 1, 2008. Clinicians in the role of WVPM would be allowed to perform clinical duties to maintain their professional certification, licensure, or privileges, but must limit the time to the minimum required, typically no more than
5 hours per week.

VA Mental Health Services

In September 2008, VA issued the Uniform Mental Health Services in VA Medical Centers and Clinics,14 a policy that specifies the mental health services that must be provided at each VAMC and CBOC.15 The purpose of this policy is to ensure that all veterans, wherever they obtain care in VA's health care system, have access to needed mental health services. The policy lists the mental health care services that must be delivered on site or made available by each facility. To help ensure that mental health staff can provide these services, VA has developed and rolled out evidence¬based16 psychotherapy training programs for VA staff that treat patients with PTSD, depression, and serious mental illness. VA's training programs cover five evidence-based psychotherapies: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE), which are recommended for PTSD; Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT), which are recommended for depression; and Social Skills Training (SST), which is recommended for serious mental illness. The training programs involve two components: (1) attendance at an in-person, experientially-based, workshop (usually 3-4 days long), and (2) ongoing telephone-based small-group consultation on actual therapy cases with a consultant who is an expert in the psychotherapy.

VA Facilities Provided Basic and Specialized Gender-Specific Services and Mental Health Services to Women Veterans, though Not All Services Were Provided On Site at Each VA Facility

The VA facilities we visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized gender-specific or mental health services specifically designed for women on site. All of the VAMCs we visited offered at least some specialized gender-specific services on site, and six offered a broad array of these services. Among CBOCs, other than the two largest facilities we visited, most offered limited specialized gender-specific care on site. Women needing obstetric care were always referred to non-VA providers. Regarding mental health care, we found that outpatient services for women were widely available at the VAMCs and most Vet Centers we visited, but were more limited at some CBOCs. Eight of the VAMCs we visited offered mixed-gender inpatient or

residential mental health services, and two VAMCs offered residential treatment programs specifically designed for women veterans.

Basic Gender-Specific Care Services Were Generally Available On site at VA Medical Facilities
Basic gender-specific care services were available on site at all nine of the VAMCs and 8 of the 10 CBOCs that we visited. (See table 2.) These facilities offered a full array of basic gender-specific services for women— such as pelvic examinations, and osteoporosis treatment—on site. One of the CBOCs we visited did not offer any basic gender-specific services on site and another offered a limited selection of these services. These CBOCs that provided limited basic gender-specific services referred
patients to other VA facilities for this care, but had plans underway to offer these services on site once providers received needed training. In general, women veterans had access to female providers for their gender-specific care: of the 19 medical facilities we visited, all but 4 had one or more female providers available to deliver basic gender-specific care.

Table 2: On-site Availability of Selected Basic Gender-Specific Services for Women Veterans at Selected VA Facilities

Service	VAMC, by number									CBOC, by number									
	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9	10
Pelvic exam and cervical cancer screening	•	•	•	•	•	•	•	•	•	•	•	•	•	c	ca	•	•	•	
Prescription of oral contraceptives	•	•	•	•	•	•	•	•	•	•	•	•	•	ca	•	•	•		
Osteoporosis treatment	•	•	•	•	•	•	•	•	•	•	•	•	•	ca	•	•	•		
Menopause management	•	•	•	•	•	•	•	•	•	•	•	•	•	ca	•	•	•		

Source: GAO.
Key:
• Service available on site c Refer to another VA facility
Note: We collected this information using a data collection instrument during site visits to VA medical facilities from October 2008 through April 2009. Some VA facilities reported that serious or complicated cases may be referred to other VA medical facilities.
aThis facility may also fee-base this service to an outside provider on a case-by-case basis.

The facilities we visited delivered basic gender-specific services in a variety of ways. Seven of the nine VAMCs and the two large CBOCs we visited had women's clinics. The physical setup of these clinics ranged from a physically separate dedicated clinical space (at five facilities) to one or more designated women's health providers with designated exam rooms within a mixed-gender primary care clinic. Generally, when women's clinics were available, most female patients received their basic gender-specific care in those clinics. When women's clinics were not available, female patients either received their gender-specific care through their primary care provider or were referred to another VA or non- VA facility for these services.

Basic gender-specific services were typically available between 8:00 a.m. and 4:30 p.m. on weekdays. At one CBOC and one VAMC, however, basic gender-specific care was only available during limited time frames. At the CBOC, a provider from the affiliated VAMC traveled to the CBOC 2 days each month to perform cervical cancer screenings and pelvic examinations for the

clinic's female patients. In general, medical facilities
did not offer evening or weekend hours for basic gender-specific services.

The provision of specialized gender-specific services for women, including treatment after abnormal cervical cancer screenings and breast cancer treatment, varied by service and by facility. (See table 3.) All VA medical facilities referred female patients to outside providers for obstetric care. Some of the VAMCs we visited offered a broad array of other specialized gender-specific services on site, but all contracted or fee-based at least some services. In particular, most VAMCs provided screening and diagnostic mammography through contracts with local providers or fee- based these services. In addition, less than half of the VAMCs provided reconstructive surgery after mastectomy on site, although six of the nine VAMCs we visited provided medical treatment for breast cancers and reproductive cancers on site. In general, the CBOCs we visited offered more limited specialized gender-specific services on site. For example, while most CBOCs offered pregnancy testing and sexually transmitted disease (STD) screening, counseling, and treatment, only the largest CBOCs offered IUD placement on site. Most CBOCs referred patients to VA medical facilities—sometimes as far as 130 miles away—for some specialized gender-specific services. Because the travel distance can be a barrier to treatment for some veterans, officials at some CBOCs said that they will fee-base services to local providers on a case-by-case basis. At both VAMCs and CBOCs, specialized gender-specific services were usually offered on site only during certain hours: for example, four medical facilities only offered these services 2 days per week or less.

Table 3: On-site Availability of Selected Specialized Gender-Specific Services for Women Veterans at Selected VA Facilities

	VAMC, by number								CBOC, by number									
Service	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9	10
Treatment of sexually transmitted diseases (STD)	z	z	z	z	z	z	z	z	z	z	z	z	z	z	z	z	.a	®	z	z	z
Treatment after abnormal cervical cancer screening	z	z	®b	z	z	•c	•a	za,c	•a	z	z	®	®	€c	®	€c	€	€	€
Intrauterine device (IUD) placement	z	z	®b	z	z	z	•a	z	z	z	z	®	®	€c	®	€c	€	€	€
Screening mammography	z	od	z	o	z	o	®	®		d	®	o	o	®	o	®	€c				
Obstetric care	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o	o
Medical treatment of breast and reproductive cancers	•c	.c,e	•c	•c	z	®c	®	.e	®	[Data about the availability of this service were not collected at CBOCs.]									
Reconstructive surgery after mastectomy	o	z	•c	z	z	o	o	o	®	[Data about the availability of this service were not collected at CBOCs.]									

Source: GAO.
z Service available on site
® Refer to another VA facility O Refer to a contract provider o Refer to a fee-basis provider
Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.
aThis facility may refer this service to another VAMC.
bThis facility refers this service to a large CBOC located approximately 13 miles from this

facility. cThis facility may also fee-base this service to a non-VA provider on a case-by-case basis.
dThis facility provided screening mammography services through a contract provider. That contract provider has a mobile unit that offers screening mammography services on site at the VAMC a few days a month.
eThis facility contracts for associated stereotactic biopsies.

Outpatient Mental Health Services Were Widely Available at Most VAMCs and Vet Centers, but More Limited at Smaller CBOCs A range of outpatient mental health services was readily available at the VAMCs we visited. The types of outpatient mental health services available at most VAMCs included, for example, diagnosis and treatment of depression, substance use disorders, PTSD, and serious mental illness. All of the VAMCs we visited had one or more providers with training in evidence-based therapies for the treatment of PTSD and depression. All but one of the VAMCs we visited offered at least one women-only counseling group. Two VAMCs offered outpatient treatment programs specifically for women who have experienced MST or other traumas. In addition, several VAMCs offered services during evening hours at least 1 day a week. While most outpatient mental health services were available on site, facilities typically fee-based treatment for a veteran with an active eating disorder to non-VA providers. Similarly, the eight Vet Centers we visited offered a variety of outpatient mental health services, including counseling services for PTSD and depression, as well as individual or group counseling for victims of sexual trauma. Five of the eight Vet Centers we visited offered women-only groups, and six had counselors with training or experience in treating patients who have suffered sexual trauma. Vet Centers generally offered some counseling services in the evenings.

The outpatient mental health services available in CBOCs were, in some cases, more limited. The two larger CBOCs offered women-only group counseling as well as intensive treatment programs specifically for women who had experienced MST or other traumas, and two other CBOCs offered women-only group counseling. The smaller CBOCs, however, tended to rely on staff from the affiliated VAMC, often through telehealth, to provide mental health services. Five CBOCs provided some mental health services through telehealth or using mental health providers from the VAMC that traveled to the CBOCs on specific days.

While Most VAMCs Offer Mixed-Gender Residential or Inpatient Mental Health Services, Few Have Specialized Programs for Women Veterans While most VAMCs offer mixed-gender residential mental health treatment programs or inpatient psychiatric services, few have specialized programs for women veterans. Eight of the nine VAMCs we visited served women veterans in mixed-gender inpatient psychiatric units, mixed-gender residential treatment programs, or both. Two VAMCs had residential treatment programs specifically for women who have experienced MST and other traumas. (VA has ten of these programs nationally.) None of the VAMCs had dedicated inpatient psychiatric units for women. VA providers at some facilities expressed concerns about the privacy and safety of women veterans in mixed-gender inpatient and residential environments. For example, in the residential treatment programs, beds for women veterans were separated from other areas of the building by keyless entry systems. However, female residents in some of these programs shared common areas, such as the dinning room, with male residents, and providers expressed concerns that women who were victims of sexual trauma might not feel comfortable in such an environment.

Medical Facilities Had Not Fully Implemented VA Policies Pertaining to the Delivery of Health Care Services for Women Veterans

The extent to which VA medical facilities we visited were following VA policies that apply to the delivery of health care services for women veterans varied, but none of the facilities had fully implemented VA policies pertaining to women veterans' health care. In particular, none of the VAMCs or CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans. In addition, the facilities we visited were in various stages of implementing VA's new initiative on comprehensive primary care: most medical facilities had at least one provider that could deliver comprehensive primary care services to women veterans, although not all of these facilities were routinely assigning women veterans to these providers. Officials at some VA facilities reported that they were unclear about the specific steps they would need to take to meet VA's definition of comprehensive primary care for women veterans.

None of the Facilities Were Fully Compliant with VA Policies Related to Ensuring the Privacy of Women Veterans

None of the VAMCs and CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. Table 4 summarizes the extent to which the facilities we visited complied with VA policy requirements related to privacy for women veterans.

Table 4: VA Facilities' Compliance with VA Privacy Requirements

Compliance with requirement	VAMC, by number									CBOC, by number									
Privacy requirement	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9	10
Adequate visual and auditory privacy at check-in	o	o	o	o	o	o	o	o	oo	oo	oo	o	0	o	0	o	0		
Adequate visual and auditory privacy in the interview area	•	oo	••	o	•o	•	o	•	•	o	•	•	•	•	•				
Exam rooms located so they do not open into a public waiting room or a high-traffic public corridor	•	•	o	o	o	o	o	•o	•	•	•	•	•	•	•	•	•		
Privacy curtains present in exam rooms	•	•	•	o	•	•	•	•	•	0	•	•	•	•	0	0	•		
Exam tables placed with the foot facing away from the door (if not possible, placed so they are fully shielded by privacy curtains)[a]	o	o	0	0	o	0	•	0o	0	•	0	0	0	N/A	N/A	0	•	0	
Changing area provided behind privacy curtain	•	•	•	o	•	•	•	•	•	0	•	•	•	•	0	0•			
Toilet facilities immediately adjacent to examination rooms	o	•	0	•	o	o	0	0o	0	0	0	0	•	N/A	N/A	0	0	0	

where gynecological exams and
procedures are performed
Sanitary napkin and/or tampon • b 0 0 0 0 0 0 0 0 •b 0 0 0 0 0 0 0 0 0 0 0 0
dispensers and disposal bins in at least one women's public restroom
Privacy curtains in inpatient rooms o • • • • • N/A • 0 [This requirement does not apply to CBOCs.]
(exception: psychiatry and mental
health units)
Access to a private bathroom facility (with toilet and shower) in close proximity to the patient's room (inpatient and residential units) • o • • • o o o • [This requirement does not apply to CBOCs.]
Source: GAO.
• Facility was compliant with requirement in all clinical settings
o Facility was compliant with requirement in at least one—but not all—clinical settings 0
Facility was not compliant with requirement in any clinical settings
N/A We did not tour any clinical settings at this facility where this requirement must be applied
Notes: We collected this information using data collection instruments during site visits to VA medical facilities from October 2008 through April 2009.
aWe did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the doorway.
bAt this facility, sanitary napkins, tampons, or both were available free of charge in baskets that had been placed in public restrooms.

All facilities were fully compliant with at least some of VA's privacy requirements; however, we documented observations in many clinical settings where facilities were not following one or more requirements. Some common areas of noncompliance included the following:

• Visual and auditory privacy at check-in. None of the VAMCs or CBOCs we visited ensured adequate visual and auditory privacy at check-in in all clinical settings that are accessed by women veterans. In most clinical settings, check-in desks or windows were located in a mixed-gender waiting room or on a high-traffic public corridor. In some locations, the check-in area was located far enough away from the waiting room chairs that patients checking in for appointments could not easily be overheard. In a total of 12 outpatient clinical settings at six VAMCs and five CBOCs, however, check-in desks were located in close proximity to chairs where other patients waited for their appointments. At one CBOC, we observed a line forming at the check-in window, with several people waiting directly behind the patient checking in, demonstrating how privacy can be easily violated at check-in.

• Orientation of exam tables. In exam rooms where gynecological exams are conducted, only one of the nine VAMCs and two of the eight CBOCs17 we visited were fully compliant with VA's policy requiring exam tables to face away from the door.18 In many clinical settings that were not fully compliant at the remaining facilities, we observed that exam tables were oriented with the foot of the table facing the door, and in two CBOCs where exam tables were not properly oriented, there was no privacy curtain to help assure visual privacy during women veterans' exams. At one of these CBOCs, a noncompliant exam room was also located within view of a

mixed-gender waiting room. Figure 1 shows the correct and incorrect orientation of exam tables in two gynecological exam rooms at two VA medical facilities.

Figure 1: Correct and Incorrect Placement of Exam Tables in Gynecological Exam Rooms at VA Medical Facilities

• Restrooms adjacent to exam rooms. Only two of the nine VAMCs and one of the eight CBOCs we visited were fully compliant with VA's requirement that exam rooms where gynecological exams are conducted have immediately adjacent restrooms.19 In most of the outpatient clinics we toured, a woman veteran would have to walk down the hall to access a restroom, in some cases passing through a high-traffic public corridor or a mixed-gender waiting room.

• Access to private restrooms in inpatient and residential units. At four of the nine VAMCs we visited, proximity of private restrooms to women's rooms on inpatient or residential units was a concern. In one

19We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams, so this requirement was not applicable at those 2 CBOCs.

mixed-gender inpatient medical/surgical unit, two mixed-gender residential units, and one all-female residential unit, women veterans were not guaranteed access to a private bathing facility and may have had to use a shared or congregate facility. In two of these four settings, access to the shared restroom was not restricted by a lock or a keycard system, raising concerns about the possibility of intrusion by male patients or staff while a woman veteran is showering or using the restroom.

• Availability of sanitary products in public restrooms. At seven of the nine VAMCs and all 10 of the CBOCs we visited, we did not find sanitary napkins or tampons available in dispensers in any of the public restrooms.

VA has not set a deadline by which all VAMCs and CBOCs are required to implement VA's new comprehensive primary care initiative for women veterans, which would allow women veterans to obtain both primary care and basic gender-specific services from one provider at one site. Officials at the VA medical facilities we visited since the comprehensive primary care for women veterans initiative was introduced reported that they were at various stages of implementing the new initiative. Officials at 6 of the 7 VAMCs and 6 of the 8 CBOCs we visited since November 2008—when VA adopted this initiative—reported that they had at least one provider who could deliver comprehensive primary care services to women veterans. However, some of the medical facilities we visited reported that they were not routinely assigning women veterans to comprehensive primary care providers.

Officials at some medical facilities we visited were unclear about the steps needed to implement VA's new policy on comprehensive primary care for women veterans. For example, at one VAMC, primary care was offered in a mixed-gender primary care clinic and basic gender-specific services were offered by a separate appointment in the gynecology clinic, sometimes on the same day. The new comprehensive primary care initiative would require both primary care

and basic gender specific services to be available on the same day, during the same appointment. Officials at this facility said that they were in the process of determining whether they can adapt their current model to meet VA's comprehensive primary care standard by placing additional primary care providers in the gynecology clinic so that both primary care services and basic gender- specific services could be offered during the same appointment, in one location. Facility officials were uncertain about whether it would meet VA's comprehensive primary care standard if primary care and basic gender-specific services were still delivered by two different providers.

However, VA's comprehensive primary care policy is clear that the care is to be delivered by the same provider. Another area of uncertainty is the breadth of experience a provider would need to meet VA's comprehensive primary care standard. Officials from VA headquarters have made it clear that it is their expectation that comprehensive primary care providers have a broad understanding of basic women's health issues—including initial evaluation and treatment of pelvic and abdominal pain, menopause management, and the risks associated with prescribing certain drugs to pregnant or lactating women. However, in one location, we found that the only provider who was available to deliver comprehensive primary care may not have had the proficiency to deliver the broad array of services that are included in VA's definition, because the facility serves a very low volume of women veterans and opportunities to practice delivering some basic gender-specific services are limited.

VA Officials Identified Key Challenges Related to Space, Hiring Staff with Specific Experience and Training, and Establishing the WVPM as a Full-time Position VA officials at medical facilities we visited identified a number of key challenges in providing health care services to women veterans. These challenges include physical space constraints that affect the provision of care, including problems complying with patient privacy requirements, and difficulties hiring providers that have specific experience and training in women's health, as well as hiring mental health providers with expertise in treating veterans with PTSD and who have experienced MST. Officials at some VA medical facilities also reported implementation issues in establishing the WVPM as a full-time position.

VA Facility Officials Identified Space Constraints as a Challenge Affecting the Provision of Health Care Services to Women Veterans

Officials at VA medical facilities we visited reported that space constraints have raised issues affecting the provision of health care services to women veterans. In particular, officials at 7 of 9 VAMCs and 5 of 10 CBOCs we visited said that space issues, such as the number, size, or configuration of exam rooms or bathrooms at their facilities sometimes made it difficult for them to comply with some VA requirements related to privacy for women veterans. At some of the medical facilities we visited, officials raised concerns about busy waiting rooms and the limited space available to provide separate waiting rooms for patients who may not feel comfortable in a mixed-gender waiting room, particularly women veterans who have experienced MST. Officials at one CBOC said they received complaints from women veterans who preferred a separate waiting room. At this facility, space challenges that affected privacy were among the factors that led to the relocation of mental health services to a separate off-site clinic. VA facility officials told us that some of the patient bedrooms at two VAMC mixed-gender inpatient psychiatric units

that were usually designated for female patients were located in space that could not be adequately monitored from the nursing station. VA policy requires that all inpatient care facilities provide separate and secured sleeping accommodations for women and that mixed-gender units must ensure safe and secure sleeping arrangements, including, but not limited to, the ability to monitor the patient bedrooms from the nursing station.

VA facility officials also told us they have struggled with space constraints as they work to comply with VA's new policy on comprehensive primary care for women and the requirements in the September 2008 Uniform Mental Health Services in VA Medical Centers and Clinics, as well as the increasing numbers of women veterans requesting these services. For example, officials at a VAMC said that limitations in the number of primary care exam rooms at their facilities made it difficult for providers to deliver comprehensive primary care services in an efficient and timely manner. Providers explained that having only one exam room per primary care provider prevents them from "multitasking," or moving back and forth between exam rooms while patients are changing or completing intake interviews with nursing staff. Similarly, mental health providers at a medical facility said that they often shared offices, which limits the number of counseling appointments they could schedule, and primary care providers sometimes have two patients in a room at the same time separated by a curtain during the intake or screening process. In addition, at one VAMC, officials reported that the facility needed to be two to three times its current size to accommodate increasing patient demand.
VA officials are aware of these challenges and VA is taking steps to address them, such as funding construction projects, moving to larger buildings, and opening additional CBOCs. However, some of these projects will not be finished for a few years. In the interim, officials said, some facilities are leasing additional space or contracting some services to community providers.

VA facility officials reported difficulties hiring primary care providers with specific training and experience in women's health. VA's comprehensive primary care initiative requires that women veterans have access to a designated women's health primary care provider that is "proficient, interested, and engaged" in delivering services to women veterans. The new policy requires that this primary care provider fulfill a broad array of health care services including, but not limited to
detection and management of acute and chronic illness, such as osteoporosis, thyroid disease, and cancer of the breast, cervix, and lung;

• gender-specific primary care such as sexuality, pharmacologic issues related to pregnancy and lactation, and vaginal infections;
• preventive care, such as cancer screening and weight management;
• mental health services such as screening and referrals for MST, as well as evaluation and treatment of uncomplicated mental health disorders and substance use disorders; and
• coordination of specialty care.

Officials at some facilities we visited told us that they would like to hire more providers with the required knowledge and experience in women's health, but struggle to do so. For example, at one VAMC, officials reported that they had difficulty filling three vacancies for primary care providers, which they needed to meet the increasing demand for services and to replace staff who had retired. They said it took them a long time to find providers with the skills required to serve

the needs of women veterans. Similarly, at one CBOC, officials reported that it takes them about 8 to 9 months to hire interested primary care physicians. Further, officials at some facilities we visited said that they rely on just one or two providers to deliver comprehensive primary care to women veterans. This is a concern to the officials because, should the provider retire or leave VA, the facility might not be able to replace them relatively quickly in order to continue to provide comprehensive primary care services to women veterans on site.

VA officials have acknowledged some of the challenges involved in training additional primary care providers to meet their vision of delivering comprehensive primary care to women veterans. A November 2008 report on the provision of primary care to women veterans cites insufficient numbers of clinicians with specific training and experience in women's health issues among the challenges VA faces in implementing comprehensive primary care.20 To help address the knowledge gap, VA is using "mini-residency" training sessions on women's health. These training sessions—which VA designed to enhance the knowledge and skills of primary care providers—consist of two and one-half days of case-based learning and hands-on training in gender-specific health care for women. During the mini-residency, providers receive specific training in performing pelvic examinations, cervical cancer screenings, clinical breast examinations, and other relevant skills.

VA medical facility and Vet Center officials reported challenges hiring psychiatrists, psychologists, and other mental health staff with specialized training or experience in treating PTSD and MST. Medical facility officials often noted that there is a limited pool of qualified psychiatrists and psychologists, and a high demand for these professionals both in the private sector and within VA. In addition, two officials reported that because it is difficult to attract and hire mental health professionals with experience in treating the veteran population, some medical facilities have hired younger, less experienced providers. These officials noted that while younger providers may have the appropriate education and training in some evidence-based psychotherapy treatment methods that are recommended for treating PTSD and MST, they often lack practical experience treating a challenging patient population.

Some officials reported that staffing and training challenges limit the types of group or individual mental health treatment services that VA medical facilities and Vet Centers can offer. For example, officials at one VAMC said that they had problems attracting qualified mental health providers to work at its affiliated CBOCs. The facility posted announcements for psychiatrist and psychologist positions, but sometimes received no applications. Because the facility has not been able to recruit mental health providers, it relies on contract providers and fee-basing to deliver mental health services to veterans in its service area. At one Vet Center, officials told us that because none of their counselors have been trained to counsel veterans who have experienced MST, patients seeking counseling for MST are usually referred to the nearby CBOC or VAMC. At one CBOC, a licensed social worker reported that he provides individual counseling for about seven women who have experienced MST, even though he has limited training in this area. He said that this situation was not ideal, but said that he consults with mental health providers at the associated VAMC on some of these cases, and that without his services some of these women might not receive any counseling.

VA officials told us that they are aware of the challenges involved in finding clinical staff with specialized training and experience in working with veterans who have PTSD or have experienced MST. A VA official told us that as part of a national effort to enhance mental health providers' knowledge of clinically effective treatment methods and make these methods available to veterans, VA has developed evidenced-based psychotherapy training for VA mental health staff. In particular, CPT, PE, and ACT are evidence-based treatment therapies for PTSD and also commonly used by providers who work with patients who have experienced MST.21 A VA headquarters official who is responsible for these training programs told us that as of May 4, 2009, 1,670 VA clinicians
had completed VA-provided training in evidence-based therapies. Although VA is providing training in these evidence-based therapies, VA officials stated that this training is not mandatory for VA mental health providers who work with patients who have PTSD or have experienced MST.

Some VAMC Officials Reported That
Establishing the WVPM as a Full-time Position Has Raised Implementation Issues Some VA officials expressed concerns that certain aspects of the new policy making the WVPM a full-time position may have the unintended consequence of discouraging clinicians from applying for or staying in the position, potentially leading to the loss of experienced WVPMs. One concern that some WVPMs raised during our interviews was that they were interested in performing clinical duties beyond the minimum required to maintain their professional certification, but would not be able to do so under the new policy. The new policy limits a WVPM's clinical duties to the minimum required to maintain professional certification, licensure, or privileges, typically no more than 5 hours per week. Another concern was that the change to full-time status could result in a reduction in salary for some clinicians because the position could be classified as an administrative position, depending on how the policy is implemented at the VAMC. At two VAMCs we visited, such concerns had discouraged the incumbent WVPM from accepting the full-time position.

VA headquarters officials told us that they are aware of and have expressed their concerns to VA senior headquarters officials about unintended consequences of the new policy. VA headquarters officials provided VISN and VAMC leadership with some options that they could use to help avoid or minimize the potential loss of experienced WVPMs. For example, one option that could be approved on a case-by-case basis is to use a job-sharing arrangement that would allow the incumbent WVPM and another person to each dedicate 50 percent of their time to the WVPM position, performing clinical duties the other 50 percent, in order to transition staff into the full-time position or as a succession planning effort. VA headquarters officials said that action on this issue was important because VA does not have the time or resources to train new staff to replace experienced WVPMs who may leave their positions.

Mr. Chairman, this completes my prepared remarks. I would be happy to respond to any questions you or other Members of the committee have at this time.
For further information about this testimony, please contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made major contributions to this testimony are listed in appendix II.

Appendix I: Information on the Selection of
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VA Facilities Examined in This Report
We selected locations for our site visits using VA data on each VA medical center (VAMC) in the United States. Our goal was to identify a geographically diverse mix of facilities, including some facilities that provide services to a high volume of women veterans, particularly women veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF); some facilities that serve a high proportion of National Guard or Reserve veterans; and some facilities that serve rural veterans. We also considered whether VAMCs had programs specifically for women veterans, particularly treatment programs for post-traumatic stress disorder (PTSD) and for women who have experienced military sexual trauma (MST). For each of the factors listed below, we examined available facility- or market-level data to identify facilities of interest:
• total number of unique women veteran patients using the VAMC;
• total number of unique OEF/OIF women veteran patients using the VAMC;
• proportion of unique women veterans using the VAMC who are OEF/OIF veterans;
• proportion of unique OEF/OIF women veterans using the VAMC who were discharged from the National Guard or Reserves;
• within the VA-defined market area for the VAMC, the proportion of women veterans who use VA health care and live in rural or highly rural areas; and
• availability of on-site programs specific to women veterans, such as inpatient or residential treatment programs that offer specialized treatment for women veterans with PTSD or who have experienced MST, including programs that are for women only or have an admission cycle that includes only women; and outpatient treatment teams with a specialized focus on MST.
We selected a judgmental sample of the VAMCs that fell into the top 25 facilities for at least two of these factors. Once we had selected these VAMCs, we also selected at least one community-based outpatient clinic (CBOC) affiliated with each of the VAMCs and one nearby Vet Center, which we also visited during our site visits. In selecting these CBOCs and Vet Centers, we focused on selecting facilities that represented a range of sizes, in terms of the number of women veterans they served.

Appendix I: Information on the Selection of VA Facilities Examined in This Report
Tables 5 and 6 provide information on the unique number of women veterans served by each of the VAMCs and CBOCs we selected for site visits.
Table 5: Women Veterans' Health Care Utilization at Selected VA Medical Centers (VAMC)

VAMC, by number	Number of unique women veterans served in fiscal year 2008	Percentage increase between fiscal year 2006 and fiscal year 2008 in the number of women veterans served	Percentage increase between fiscal year

2006 and fiscal year 2008 in the total number of veterans served (both men and women)

6,464
19.5 8.5
6,360 22.4 12.8
4,497 8.2 7.3
3,588 19.4 10.2
2,324 11.7 4.8
1,846 20.2 3.9
1,841a 19.8 5.1a
999 12.5 1.0
995 22.5 6.9

Source: VA data and GAO analysis.
aThis VAMC is part of the same health care system as VAMC 1. Some of these veterans may also have received services at VAMC 1.

Appendix I: Information on the Selection of VA Facilities Examined in This Report
Table 6: Women Veterans' Health Care Utilization at Selected Community-Based Outpatient Clinics (CBOC)
Percentage increase between Number of unique fiscal year 2006 and fiscal year
women veterans served in 2008 in the number of unique
CBOC, by number fiscal year 2008 women veterans served
CBOC 1 2,926 12.5
CBOC 2 1,750 27.0
CBOC 3 599 90.2
CBOC 4 554 51.0
CBOC 5 224 13.1
CBOC 6 115 8.5
CBOC 7 103 21.2
CBOC 8 88 54.4
CBOC 9 48 9.1
CBOC 10a 42 not applicablea
Source: VA data and GAO analysis.
aThis facility opened in 2007, so percentage increase since fiscal year 2006 does not apply.

Appendix II: GAO Contact and Staff
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