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VA HEALTH CARE

VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes



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Highlights of [GAO-10-287](#), a report to congressional addressees

Why GAO Did This Study

In 2008, VA provided health care to over 281,000 women veterans, a fast growing subgroup of veterans. Women veterans seeking VA health care need access to an array of services and Congress has raised concerns about how well VA is prepared to meet the physical and mental health care needs of women. GAO was asked to examine (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 to women veterans, and (3) key challenges that VA facilities face in providing health care to women veterans and how VA is addressing these challenges. GAO reviewed applicable laws and VA policies, interviewed officials, and visited a judgmental sample of 9 VA medical centers (VAMC) and 10 community-based outpatient clinics (CBOC) chosen, in part, based on the number of women using services. GAO also visited 10 VA counseling centers (Vet Centers).

What GAO Recommends

GAO recommends that VA provide complete information on its external Web sites about specialized residential programs for women; verify the information facilities report on compliance with privacy policies; expedite action to update VA's design and construction policies; and clarify the roles and responsibilities of the Women Veterans Program Manager (WVPM). VA concurred with GAO's recommendations.

[View GAO-10-287 or key components.](#)
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VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes

What GAO Found

The VA facilities GAO visited provided basic gender-specific and outpatient mental health services to women veterans on site, and some facilities also provided specialized services for women. Seventeen of the 19 medical facilities GAO visited offered basic gender-specific services including pelvic examinations and cervical cancer screening on site, and 15 offered access to one or more female providers for gender-specific care. The availability of specialized gender-specific services—such as treatment of reproductive cancers—and mental health services for women varied by service and facility. While some VAMCs offered a broad array of specialized gender-specific care on site, smaller CBOCs referred women to other VA or non-VA facilities for many or most of these services. Nationally, 9 VAMCs have residential mental health programs that are for women only or have dedicated cohorts for women. However, information about all of these programs was not available on VA's external Web sites.

In July 2009, GAO reported in *VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans* ([GAO-09-884T](#)), that none of the facilities GAO visited were fully compliant with VA policy requirements related to privacy for women veterans. In response, VA has required facilities to report more information on their compliance with these policies. However, facility reporting on privacy policies has, in the past, been inaccurate, and VA's oversight process does not include a means to validate the information facilities report. The facilities GAO visited were in various stages of implementing a new VA initiative to provide comprehensive primary care—defined as complete primary care, including basic gender-specific services, and mental health care—to women veterans at all facilities. VA headquarters officials are working with Women Veterans Program Managers (WVPM) and facility leadership to help facilities implement this initiative.

In locations GAO visited, VA identified a number of key challenges in providing health care services to women veterans. For example, officials at VA medical facilities reported that space constraints have raised issues affecting the provision of health care services to women veterans, particularly related to ensuring their privacy and safety. According to VA officials, most VAMCs have planned renovation, construction, or relocation projects as part of their efforts to expand services and implement comprehensive primary care for women veterans. However, VA's design and construction policies have not been updated to reflect VA's privacy policies for women veterans. Moreover, the VA memorandum which established the WVPM as a full-time position outlined broad authority for the WVPM in facilitating changes in the delivery of services to women veterans, but some facilities have not modified the WVPM position as envisioned in VA's memorandum. For example, some WVPMs reported that they did not have sufficient authority and access to leadership to implement needed changes. Furthermore, VA's WVPM handbook, which defines the roles and responsibilities of the WVPM, has not been updated since the WVPM position was made full-time.

Contents

Letter		1
	Background	5
	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	10
	VA Medical Facilities Had Not Fully Implemented VA Policies Pertaining to the Delivery of Health Care Services for Women Veterans	19
	VA Has Taken Steps to Alleviate Space Constraints, Hire Trained Providers, and Expand the Role of the WVPM, but Challenges Remain	28
	Conclusions	41
	Recommendations for Executive Action	42
	Agency Comments and Our Evaluation	43
Appendix I	Information on the Selection of Department of Veterans Affairs Facilities Examined in This Report	46
Appendix II	Comments from the Department of Veterans Affairs	49
Appendix III	GAO Contact and Staff Acknowledgments	54
Tables		
	Table 1: On-site Availability of Selected Basic Gender-Specific Services for Women Veterans at Selected Department of Veterans Affairs (VA) Facilities	11
	Table 2: On-site Availability of Selected Specialized Gender-Specific Services for Women Veterans at Selected Department of Veterans Affairs (VA) Facilities	13
	Table 3: Veterans Affairs Medical Centers (VAMC) with Specialized Residential Mental Health Treatment Programs for Women Who Have Experienced Military Sexual Trauma (MST) or Other Trauma, as of August 2009	16

Table 4: Department of Veterans Affairs (VA) Facilities' Compliance with VA Privacy Requirements	20
Table 5: Women Veterans' Health Care Utilization at Selected Veterans Affairs Medical Centers (VAMC)	47
Table 6: Women Veterans' Health Care Utilization at Selected Veterans Affairs (VA) Community-Based Outpatient Clinics (CBOC)	48

Figures

Figure 1: Correct and Incorrect Placement of Exam Tables in Gynecological Exam Rooms at Department of Veterans Affairs (VA) Medical Facilities	22
Figure 2: Department of Veterans Affairs (VA) Outpatient Clinic Design Guide—Gynecologic Exam Room Guide Plate	32

Abbreviations

ACT	Acceptance and Commitment Therapy
CBOC	community-based outpatient clinic
CBT	Cognitive Behavioral Therapy
CPT	Cognitive Processing Therapy
HCS	health care system
MST	military sexual trauma
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PE	Prolonged Exposure
PTSD	post-traumatic stress disorder
VA	Department of Veterans Affairs
VAMC	Veterans Affairs medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WVPM	Women Veterans Program Manager

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United States Government Accountability Office
Washington, DC 20548

March 31, 2010

Congressional Addressees

Historically, the vast majority of patients who receive health care through the Department of Veterans Affairs (VA) have been men, but that is changing. As of September 2009, there were more than 1.8 million women veterans in the United States (representing almost 8 percent of the total veteran population). 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. Women veterans are younger, in the aggregate, than their male counterparts.¹ While almost all women veterans of OEF/OIF are under the age of 40—most between the ages of 20 and 29—VA also serves women veterans from other combat eras, who are typically over the age of 55. Looking ahead, VA estimates that while the total number of veterans will decline 37 percent by 2033, the number of women veterans will increase by more than 17 percent over the same period.

As more women veterans are seeking care at VA facilities, Congress and others have raised concerns about how well VA's health care system is prepared to meet the unique physical and mental health needs of these women, particularly women veterans of OEF/OIF. The health care services needed by women veterans are significantly different from those required by their male counterparts in several respects. Women veterans of all ages 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, management of contraceptive medications, 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 or post-traumatic stress disorder

¹On the basis of an analysis VA conducted in 2007, the estimated median age of women veterans was 47, whereas the estimated median age of male veterans was 61.

(PTSD).² VA data show that almost 20 percent of women veterans of OEF/OIF have been diagnosed with PTSD. Moreover, an alarming number of women veterans have experienced military sexual trauma (MST).³ VA data shows that in fiscal year 2008, 21 percent of women screened for MST, screened positive for having experienced MST.⁴

Women veterans also present unique challenges to VA. Traditionally, women veterans have utilized VA's health care services less frequently than their male counterparts, even though VA has found that women veterans have health burdens comparable to or greater than that of male veterans. 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 medical 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.⁵ Research has also shown that women veterans often do not

²PTSD may develop following exposure to combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who experience stressful events often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms can occur within the first few days after exposure to the stressful event but may also be delayed for months or years. If symptoms continue for more than 30 days and significantly disrupt an individual's daily activities, a diagnosis of PTSD is made.

³Federal law requires VA to provide services to help veterans overcome "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training," and further defines sexual harassment as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." See 38 U.S.C. § 1720D. VA developed the term military sexual trauma (MST) to refer to the sexual assault or sexual harassment experiences described in the law.

⁴Although women are much more likely to experience MST than their male counterparts—in fiscal year 2008, 1.1 percent of male veterans screened for MST screened positive—almost half of all veterans who experience MST are men.

⁵VA has determined that under existing law, the agency is not authorized to provide child care, or operate childcare facilities for VA patients.

identify themselves as veterans and are unaware of their eligibility for VA services.⁶

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 July 2009, we presented preliminary findings from our ongoing work to examine these services.⁷ In this report we provide our complete findings, based on visits to selected VA facilities, on (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, and how VA is addressing these challenges.

To examine the availability of health care services at VA facilities for women veterans and to determine the extent to which VA facilities are

⁶See 38 U.S.C. § 1710(a), 38 C.F.R. § 17.38 (2009). Any veteran who has served in a combat theater after November 11, 1998, including OEF/OIF veterans, and who was discharged or released from active service on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VA's health care system and receive VA health care services. See 38 U.S.C. § 1710(e)(1)(D), (e)(3)(C). Veterans who were discharged or released before January 28, 2003, and who did not enroll in VA's health care system before that date are eligible for these VA health care services for 3 years after January 28, 2008.

⁷See: GAO, *VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans*, [GAO-09-884T](#) (Washington, D.C.: July 14, 2009); and VA *Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans*, [GAO-09-899T](#) (Washington, D.C.: July 16, 2009).

following VA policies that apply to the delivery of health care services for women veterans, we reviewed applicable laws, VA policies,⁸ and available VA data and also interviewed officials from VA headquarters, Veterans Integrated Service Networks (VISN),⁹ and VA facilities. In addition, we conducted site visits to a judgmental sample of 9 VAMCs located in Long Beach and San Diego, California; Atlanta and Dublin, Georgia; Minneapolis and St. Cloud, Minnesota; Sioux Falls, South Dakota; and Temple and Waco, Texas.¹⁰ We also visited 10 VA CBOCs affiliated with these 9 VAMCs, and 8 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 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; 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

⁸The scope of services VA requires to be provided to women veterans, including requirements for ensuring the privacy of women veterans, is outlined in Veterans Health Administration (VHA) Handbook 1330.1, and the requirements for WVPM are outlined in VHA Handbook 1330.02 and in a July 2008 VA directive titled *Women Veteran Program Managers Full-Time FTEE Positions*.

⁹The management of VAMCs and CBOCs is decentralized to 21 regional networks referred to as VISNs.

¹⁰We selected locations for our site visits using VA data on the numbers of various categories of women veterans using services at each VAMC in the United States. To assess the reliability of these data, we reviewed relevant documentation and interviewed agency officials knowledgeable about the data and the methodologies used to collect them. We determined that the data were sufficiently reliable for the purposes of this report.

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, and what VA is doing to address these challenges, we reviewed relevant literature; reviewed relevant VA policies and procedures; 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 conducted our performance audit from July 2008 through March 2010 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'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.¹¹ 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 mental health 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

¹¹In general, veterans must enroll in VA's health care system in order to receive most of VA's medical services.

social services to assist combat veterans in readjusting from wartime military service to civilian life.¹²

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.¹³ Specifically, VA facilities can make services available through

- referral of patients to other VA facilities or use of telehealth services,¹⁴
- 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

VA provides medically necessary health care services to eligible veterans, including women veterans, as authorized under federal law.¹⁵ VA provides health care services to veterans through its medical benefits package—health care services required to be provided are broadly stated in a regulation¹⁶ and further specified in VA policies. Through policies, VA requires its medical health care facilities to make certain services, including basic and specialized gender-specific services and primary care services, available to eligible women veterans.¹⁷ Examples of basic gender-

¹²All veterans who have served in a combat theater, including OEF/OIF veterans, are eligible for Vet Center services. See 38 U.S.C. § 1712A(a). As of September 2009, 39 additional Vet Centers had signed leases but had not formally begun operations. VA plans to open another 28 Vet Centers in fiscal year 2010.

¹³See 38 U.S.C. § 1703.

¹⁴Telehealth is the provision of health services from a distance using telecommunications technologies, such as videoconferencing.

¹⁵38 U.S.C. § 1710.

¹⁶See 38 C.F.R. § 17.38 (2009).

¹⁷These services are defined in: VHA Handbook 1330.1, *VHA Services for Women Veterans* (revised July 16, 2004); VHA Directive 2005-015, *Military Sexual Trauma Counseling* (revised Mar. 25, 2005); VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008); and VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)* (revised May 26, 2009).

specific services that would be provided under VA’s medical benefits package include, for example, cervical cancer screening, breast examination, and management of menopause. Examples of specialized gender-specific services that would be provided under VA’s medical benefits package include, for example, treatment after abnormal cervical cancer screening, mammography, obstetric care, and infertility evaluation.¹⁸

In December 2008, VA directed all VA medical facilities to establish a planning process and begin implementing comprehensive primary care for women veterans.¹⁹ 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.²⁰ 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; the availability of sanitary products in public restrooms at VA medical facilities; access to private restrooms in outpatient, residential, and inpatient settings of care; and access to separate and secured sleeping accommodations in residential and inpatient settings.

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. The WVPM position was outlined as a part-time collateral position in the Veterans

¹⁸In reviewing the services provided at VA medical facilities, we distinguished between “basic” and “specialized” gender-specific services. This distinction is based on the definitions included in VHA Handbook 1330.1 and the 2003 article by Elizabeth Yano and Donna Washington, “Availability of Comprehensive Women’s Health Care Through Department of Veterans Affairs Medical Center,” published in *Women’s Health Issues*, v. 13 (2003).

¹⁹See December 5, 2008, Memorandum from VA’s Deputy Under Secretary for Health for Operations and Management.

²⁰See VHA Handbook 1330.1, VHA Handbook 1160.01, and VHA Handbook 1162.02.

Health Administration's (VHA) *Women Veterans Program Manager Position Handbook*—last updated in March 2007²¹—but 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 Policy on Mental Health Services

In September 2008, VA issued its revised *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook,²² which specifies VA policies on the mental health services that must be provided at each VAMC and CBOC.²³ The purpose of these policies is to ensure that all veterans, wherever they obtain care in VA's health care system, have access to needed mental health services. The handbook lists the mental health care services that must be delivered on site or made available by each medical facility. The policies further state that mental health services must be delivered by qualified, trained, and competent staff, and that care should be provided by those with an appropriate level of training and clinical privileging.²⁴

Further, VA is required to provide mental health screening, counseling, and related treatment for eligible veterans who have experienced MST, which is much more common among women veterans than their male counterparts.²⁵ Research has shown that veterans who have experienced MST are at a high risk for developing a range of mental health conditions such as PTSD, major depression, anxiety, and panic disorder. MST victims may also struggle with other problems, including low self-esteem, difficulties with interpersonal relationships, and sexual dysfunction. VA

²¹VHA Handbook 1330.02.

²²VHA Handbook 1160.01.

²³The mental health services that must be provided in CBOCs differ according to the size of the clinics.

²⁴VA defines clinical privileging as the process by which a medical facility grants the practitioner permission to independently provide specified medical or other patient care services, within the scope of the practitioner's license and/or an individual's clinical competence.

²⁵Veterans who report experiencing MST, but who are otherwise deemed ineligible for VA health care benefits, may be eligible for free counseling and treatment for conditions related to MST.

research indicates that the psychological outcomes of sexual trauma that occurs in a military context are unique to the military and veteran population and may be more damaging than sexual trauma that occurs in civilian settings.²⁶ Federal law specifically requires VA to establish a program to provide these MST-related services and to provide for appropriate training of mental health professionals and such other health care personnel as the Secretary determines necessary to carry out the program effectively.²⁷

VA's MST-related policies require that VAMC directors appoint an MST Coordinator and that necessary staff education and training be provided.²⁸ The MST coordinators are responsible, among other things, for monitoring and ensuring that VA policies related to MST screening, education, training, and treatment are implemented at the facility. VA policy also requires that evidence-based²⁹ mental health care be available to veterans diagnosed with mental health conditions resulting from MST. VA's Office of Mental Health Services is responsible for oversight of MST-related services.

Starting in 2007, VA began rolling out a national program that offers intensive training in evidence-based psychotherapies for VA staff who treat patients with PTSD, depression, and serious mental illness. These 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, 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

²⁶According to VA researchers, sexual trauma in the military is unique, among other things, because the interpersonal trauma involves perpetrators that the victims know and are dependent on, such as a superior or someone they need to rely on for training or combat. VA researchers also said that MST victims may have an increased sense of distress, hopelessness, and powerlessness because escape from the situation is often difficult or impossible and there is increased risk of revictimization.

²⁷38 U.S.C. § 1720D.

²⁸VHA Directive 2005-015 and VHA Handbook 1160.01.

²⁹Psychotherapies that have consistently been shown in controlled research to be effective for a particular condition or conditions are referred to as "evidence-based."

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 generally provided basic gender-specific and outpatient mental health services to women veterans on site. All of the VAMCs we visited also offered at least some specialized gender-specific services on site, and six offered a broad array of these services. Among CBOCs 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

A full array of basic gender-specific services for women—such as pelvic examinations and osteoporosis treatment—were available on site at all 9 of the VAMCs and 8 of the 10 CBOCs that we visited. (See table 1.) One of the CBOCs we visited did not offer any basic gender-specific services on site and another offered some of these services, but did not offer pelvic examinations or cervical cancer screening. These CBOCs that provided limited basic gender-specific services referred patients to other VA facilities for this care, but had plans under way 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 1: On-site Availability of Selected Basic Gender-Specific Services for Women Veterans at Selected Department of Veterans Affairs (VA) Facilities

Service	Veterans Affairs Medical Center (VAMC), by number									Community-Based Outpatient Clinic (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	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⊙	⊙ ^a	●	●	●
Prescription of oral contraceptives	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⊙ ^a	●	●	●
Osteoporosis treatment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⊙ ^a	●	●	●
Menopause management	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	⊙ ^a	●	●	●

Source: GAO.

Key:

- Service available on site
- ⊙ Refer to another VA facility

Notes: 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 using a variety of clinical models. 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, facilities reported that 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 VA 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.

While All VAMCs Offered at Least Some Specialized Gender-Specific Services On Site, CBOCs Typically Referred Patients Needing These Services to Other VA or Non-VA Medical Facilities

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 2.) 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 screening, counseling, and treatment, only the largest CBOCs offered intrauterine device placement on site. 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 2: On-site Availability of Selected Specialized Gender-Specific Services for Women Veterans at Selected Department of Veterans Affairs (VA) Facilities

Service	Veterans Affairs Medical Center (VAMC), by number									Community-Based Outpatient Clinic (CBOC), by number									
	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9	10
Treatment of sexually transmitted diseases	●	●	●	●	●	●	●	●	●	●	●	●	●	●	● ^a	⊙	●	●	●
Treatment after abnormal cervical cancer screening	●	●	⊙ ^b	●	●	● ^c	● ^a	● ^{a,c}	● ^a	●	●	⊙	⊙	⊙ ^c	⊙	⊙ ^c	⊙	⊙	⊙
Intrauterine device placement	●	●	⊙ ^b	●	●	●	● ^a	●	●	●	●	⊙	⊙	⊙ ^c	⊙	⊙ ^c	⊙	⊙	⊙
Screening mammography	●	⊙ ^d	●	⊙	●	○	⊙	⊙	⊙ ^d	⊙	○	⊙	⊙	⊙	⊙	⊙ ^c	⊙	⊙	⊙
Obstetric care	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medical treatment of breast and reproductive cancers	● ^c	● ^{c,e}	● ^c	● ^c	●	⊙ ^c	⊙	● ^e	⊙	(Data about the availability of this service were not collected at CBOCs.)									
Reconstructive surgery after mastectomy	○	●	● ^c	●	●	○	○	⊙	⊙	(Data about the availability of this service were not collected at CBOCs.)									

Source: GAO.

- Service available on site
- ⊙ Refer to another VA facility
- ⊙ Refer to a contract provider
- Refer to a fee-basis provider

Note: 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 referred 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 had a mobile unit that offers screening mammography services on site at the VAMC a few days a month.

^eThis facility contracted for associated stereotactic biopsies.

Most CBOCs referred patients to VA medical facilities—sometimes as far as 130 miles away—for some specialized gender-specific services. For example, 8 of the 10 CBOCs we visited referred patients to another VA medical facility for treatment after abnormal cervical cancer screening test results. Four of these CBOCs typically referred their patients to a VAMC located 100 miles or more away for this care. 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.

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. These services 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 psychotherapies used to treat PTSD and depression and all had at least one female provider in outpatient mental health. All but one of the VAMCs we visited offered at least one women-only counseling group, and four VAMCs offered an outpatient group with a specific focus on sexual trauma. Two VAMCs offered an outpatient treatment program specifically for women who have experienced MST or other traumas. In addition, six 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 to non-VA providers for a veteran with an active eating disorder.

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. Two of the Vet Centers with sexual trauma counselors offered groups specifically for women veterans who had experienced 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. In general, we saw varying levels of mental health services and staffing in the smaller CBOCs. Only two of the eight smaller CBOCs offered women-only group counseling. Some had several mental health professionals, including staff with experience in working with victims of sexual trauma. Others relied upon one or two mental health providers and 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 who traveled to the CBOCs on specific days. Two of the CBOCs we visited did not offer mental health services every day of the work week. One CBOC offered extended hours, on Saturday mornings, for mental health services.

Most VAMCs Offered Residential or Inpatient Mental Health Services, but Few Had Specialized Women’s Programs and Information on These Programs Is Not Readily Available to Veterans

Most VAMCs offered mixed-gender inpatient mental health services or residential mental health treatment programs, but few had specialized programs for women veterans. Eight of the nine VAMCs we visited served women veterans in mixed-gender inpatient mental health units, mixed-gender residential treatment programs, or both. However, none of the VAMCs we visited had dedicated inpatient mental health units for women.³⁰ Two VAMCs we visited had specialized residential treatment programs specifically for women who have experienced MST and other traumas.

The two VAMCs we visited that had specialized residential treatment programs for women are part of a group of nine VAMCs nationally that have residential mental health programs that are for women only or have dedicated cohorts for women.³¹ The specific focus and structure of each program varies, but all of them offer intensive treatment in a residential setting. Some of the programs only admit women, while others admit both men and women but have specific tracks or cohorts for women. Some of the programs are focused on MST and others offer treatment focused on other traumas or disorders. The programs offer a mix of group and individual treatment options, but the types of psychotherapy offered in the programs also varies. For example, some programs offer CPT, some focus more on exposure therapy, and some provide a mix of these therapies or other treatment options. (See table 3 for more information on the locations, structure, and focus of these programs.) In addition to these facilities, five other VAMCs offer MST or sexual-trauma-specific mental health treatment programs for both men and women in a residential or inpatient setting, but do not have separate women only tracks.

³⁰While none of the facilities we visited had a dedicated inpatient mental health unit for women, according to VA’s Office of Mental Health Services the Houston VAMC recently opened a physically separate, 10-bed inpatient mental health unit exclusively for women. As of December 2009, this was the only such unit in VA’s health care system.

³¹One of these VAMCs offers two distinct programs.

Table 3: Veterans Affairs Medical Centers (VAMC) with Specialized Residential Mental Health Treatment Programs for Women Who Have Experienced Military Sexual Trauma (MST) or Other Trauma, as of August 2009

Facility	Program name	Structure of program ^a	Program focus
VA Boston Health Care System (HCS), Jamaica Plains Campus (Boston, Mass.)	Women Veterans' Therapeutic Transitional Residence Program	Women only. Rolling admissions. Ask for commitment to stay for at least 3 months, though prefer 1 year (18-month maximum).	PTSD. MST-related therapy provided through associated outpatient team at medical center.
VA Boston HCS, Brockton Campus (Brockton, Mass.)	Women's Integrated Treatment and Recovery Program	Women only. Rolling admissions. 8-week length of stay (can be extended).	Integrated treatment of trauma and substance abuse.
VA Western New York HCS, Batavia Campus (Batavia, N.Y.)	Women Veterans' Residential Program	Women only. 10-week mixed-trauma cohorts, with some flexibility.	All traumas.
VA New Jersey HCS (Lyons, N.J.)	Women's Residential MST Program	Women only. 7-week cohorts.	MST, with other traumas addressed as needed.
Bay Pines VA HCS (Bay Pines, Fla.)	Center for Sexual Trauma Services, Residential Program	Women and men, with a women-only track. Rolling admission. Variable length of stay depending on treatment needs.	MST, with other sexual trauma addressed as needed.
Cincinnati VAMC (Cincinnati, Ohio)	Residential Post-Traumatic Stress Disorder (PTSD) Program	Women and men, with a women-only track. 7-week cohorts.	PTSD.
Central Texas Veterans HCS (Temple, Tex.)	Women's Trauma Recovery Center	Women only. 7-week cohorts.	MST (sexual assault focused).
VA Palo Alto HCS, Menlo Park Division (Menlo Park, Calif.)	Women's Trauma Recovery Program	Women only. Rolling admissions. 2- to 3-month length of stay.	PTSD, but high prevalence of sexual trauma among veterans in program.
VA Long Beach HCS (Long Beach, Calif.) ^b	"Renew" and "Bridges"	Women only. Renew: 12-week cohorts. Bridges: rolling admission, 12-week residential and/or outpatient program.	Renew is sexual trauma focused. Bridges is a sexual trauma focused aftercare program consisting of 12 hours a week of community activity and support groups.

Source: GAO review of VA documentation.

^aCohorts are a size-limited group of individuals who begin a program at the same time and commit to completing the program.

^bThis facility offers two distinct programs: "Renew" and "Bridges."

Although the specialized programs offered at these nine facilities are all national VA resources—meaning that they serve veterans living nearby as well as veterans who live in other states—several VA providers told us that many veterans and VA providers alike did not know about VA's specialized programs for women and suggested that VA could do more to publicize the programs. One clinician running one of the programs noted that during the

first year of their program—which opened in July 2007 and has room for eight women in each cohort—they had space for additional patients in their cohorts but at the same time veterans in the region were being referred to programs across the country because VA providers in their region didn't know about the program. These providers told us that, while their cohorts have usually been full since the middle of 2008, many veterans still do not know about VA's specialized programs and other MST-related services that are available to them.

VA has taken some steps internally to make information about these programs more readily available to VA providers. Specifically, VA has conducted monthly, nationwide MST conference calls which have included basic information on the structure and focus of the various residential and outpatient programs offering MST or sexual-trauma-specific treatment, as well as detailed presentations by key providers from several programs. VA also has a list of the various programs on its internal Web site, which is accessible by VA providers.

However, VA has not made the same information accessible to veterans through VA's external Web sites. As of November 2009, the Web pages we reviewed from VA's national Web site did not provide complete lists of facilities that have MST-related treatment programs or specialized programs for women veterans. The sites that did list specific residential treatment programs usually listed a single program, while nine VAMCs have relevant programs.³² VA's national Web sites directed veterans to their local facilities for questions about available treatment options, but did not provide relevant contact information, instead linking veterans to a Web page that allows them to search for VA facilities in their area. Moreover, only three of the nine VAMCs that have these specialized residential programs for women provided detailed information about the programs on their facility-specific Web sites. Three of the nine VAMCs'

³²We found one VA Web page that linked to a "Frequently Asked Questions" document which listed four "special PTSD treatment centers," but did not provide contact information for those facilities. In November 2009, VA added a link on one VA Web page to a spreadsheet titled "PTSD Program List." This spreadsheet provided program names and contact information for over 160 programs or teams, 7 of which were labeled as "Women's" programs. Four of these women's programs corresponded to VAMCs that have specialized residential treatment programs for women veterans. The remaining 3 VAMCs in the spreadsheet were labeled as having a women's "team." The other 5 VAMCs that have specialized programs were not included in the spreadsheet. Separately, we found one Department of Defense site—within the agency's Sexual Assault Prevention and Response Office Web site—that identified 4 VA facilities.

Web sites mentioned their residential program briefly and the remaining three VAMCs did not mention their program at all. Several facility-specific Web sites mentioned that they provide specialized health care services for women or related to MST, but did not provide additional information about their programs.

This lack of accessible information on VA's residential mental health programs for women veterans is not consistent with VA's goals—referenced in its fiscal year 2010 Budget Submission—related to transforming the agency to serve veterans more effectively, including the goal of allowing veterans to “reach VA on their own terms (phone, web, in person) and gain quick and convenient access to information about all VA services from a single point of contact.” Moreover, research has shown that women veterans' lack of awareness about VA services available to them has been a barrier to their receiving care.

Officials in VA's Office of Mental Health Services acknowledged that the information on these residential programs on VA's external Web site is limited. They said that, in general, they would prefer that a veteran contact the WVPM or MST Coordinator at their local facility to get help identifying their unique treatment needs, finding the right program to meet those needs, and navigating the sometimes complicated process of enrolling in the programs. However, we found that contact information for WVPMs and the MST Coordinators was either missing or hard to find on most of the facility-specific Web sites for the nine facilities that have these programs. Three of these facilities' Web sites did not provide the WVPM's or the MST coordinator's contact information, and only two facilities provided contact information for both individuals. It is important that VA provide women veterans easy access to information about specialized VA programs for women as well as more complete information on key contacts at local facilities. Better access to this information could empower women veterans to have more informed conversations with VA staff about the available treatment options.

VA 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. None of the facilities were fully compliant with VA policies on privacy for women veterans, but all of them complied with at least some of the policies. The medical facilities we visited were in various stages of implementing VA's initiative to expand access to comprehensive primary care for women veterans.

None of the Facilities Were Fully Compliant with VA Privacy Policies for Women Veterans, and VA's Oversight Process Does Not Ensure Accurate Reporting on Compliance

None of the VAMCs or CBOCs we visited were fully compliant with VA policy requirements related to privacy for women veterans. Since July 2009, when we reported our preliminary findings on selected medical facilities' compliance with VA policies, VA has taken steps to implement a process that requires facilities to report more information on their compliance with these policies. However, the process VA is using relies on information reported by facilities, and VA does not have a process for ensuring that this information is accurate.

Medical Facilities Were Not Fully Compliant with VA Privacy Policies for Women Veterans

While none of the medical facilities we visited were fully compliant, all of the VAMCs and CBOCs we visited were compliant with at least some of VA's policy requirements related to privacy for women veterans in all clinical settings where those requirements applied. Table 4 summarizes the extent to which the medical facilities we visited complied with VA policy requirements related to privacy for women veterans.

Table 4: Department of Veterans Affairs (VA) Facilities' Compliance with VA Privacy Requirements

Privacy requirement	Compliance with requirement																			
	Veterans Affairs Medical Center (VAMC), by number									Community-Based Outpatient Clinic (CBOC), by number										
	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	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	◐	○	◐	○	◐	○	
Adequate visual and auditory privacy in the interview area	●	◐	◐	●	●	◐	●	◐	●	◐	●	●	◐	●	●	●	●	●	●	
Exam rooms located so they do not open into a public waiting room or a high-traffic public corridor	●	●	◐	◐	◐	◐	◐	●	◐	●	●	●	●	●	●	●	●	●	●	
Privacy curtains present in exam rooms	●	●	●	◐	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●	
Exam tables placed with the foot facing away from the door (if not possible, placed so they are fully shielded by privacy curtains) ^a	◐	◐	○	○	◐	○	●	○	◐	○	●	○	○	○	N/A	N/A	○	●	○	
Changing area provided behind privacy curtain	●	●	●	◐	●	●	●	●	●	●	●	○	●	●	●	●	○	○	●	
Toilet facilities immediately adjacent to examination rooms where gynecological exams and procedures are performed	◐	●	○	●	◐	◐	○	○	◐	○	○	○	○	●	N/A	N/A	○	○	○	
Sanitary napkin and/or tampon dispensers and disposal bins in at least one women's public restroom	● ^b	○	○	○	○	○	○	○	● ^b	○	○	○	○	○	○	○	○	○	○	
Privacy curtains in inpatient rooms (exception: psychiatry and mental health units)	◐	●	●	●	●	●	N/A	●	○	(This requirement does not apply to CBOCs.)										
Access to a private bathroom facility (with toilet and shower) in close proximity to the patient's room (inpatient and residential units)	●	◐	●	●	●	◐	◐	◐	●	(This requirement does not apply to CBOCs.)										

Source: GAO.

- Facility was compliant with requirement in all clinical settings
- ◐ Facility was compliant with requirement in at least one—but not all—clinical settings
- 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

Note: 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.

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 were accessed by women veterans as required by VA policy. 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 heard. 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 CBOCs³³ we visited were fully compliant with VA's policy requiring exam tables to face away from the door.³⁴ 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.

³³We visited 10 CBOCs, but 2 of the CBOCs we visited did not offer gynecological exams.

³⁴According to VA policy, if it is not possible for exam tables to be placed with the foot facing away from the door, they may be placed so that they are fully shielded by privacy curtains. However, we did not observe any clinical settings where it was not possible to orient exam tables with the foot facing away from the door.

Figure 1: Correct and Incorrect Placement of Exam Tables in Gynecological Exam Rooms at Department of Veterans Affairs (VA) Medical Facilities



Source: GAO.

- **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.³⁵ 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.

³⁵We 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.

VA's Steps to Update Oversight of Medical Facilities' Compliance with VA Privacy Policies Lacks a Process to Ensure the Accuracy of Facilities' Reporting

- **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 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 communal 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 7 of the 9 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.

In response to preliminary findings we issued in July 2009 regarding VA medical facilities' lack of compliance with selected VA privacy policies,³⁶ VA took steps to increase how often facilities review and report on their compliance with these policies. Specifically, VA's Acting Deputy Under Secretary for Health directed all VA medical facilities to incorporate specific considerations related to the privacy, dignity, sense of security, and safety of all veterans into their facilities' environmental rounds processes, which are regular internal reviews of clinical spaces conducted to evaluate compliance with a range of VA policies.³⁷ The Acting Deputy Under Secretary also recommended that the WVPM should participate in the environmental rounds process. As part of environmental rounds processes, staff members at each facility assess whether the clinical spaces being reviewed are in compliance with the specified privacy, dignity, sense of security, and safety considerations and record their assessments in an online checklist.

³⁶See [GAO-09-884T](#) and [GAO-09-899T](#).

³⁷Environmental rounds are part of each facility's regular internal oversight responsibilities. On a monthly basis, the environmental rounds team, which includes representatives of facility leadership along with key clinical and operational staff, reviews a sample of clinical spaces in every VA medical facility to determine compliance with a range of VA policies—such as infection control, cleanliness of the environment, and staffing levels—and to identify deficiencies. VA's Office of the Deputy Under Secretary for Health for Operations and Management has oversight authority for the environmental rounds process, and for implementing any national changes to the process.

VA required that all VAMCs and CBOCs assess their compliance in all clinical settings with these considerations and submit the results from their reviews to VA's Office of the Deputy Under Secretary for Health for Operations and Management by August 31, 2009. According to VA, the initial round of these reviews identified some issues related to facilities' compliance with privacy policies for women, including finding exam rooms that lacked privacy curtains, limited availability of sanitary napkins, and improper orientation of exam tables. VA directed facilities to immediately address any compliance gaps that could be corrected immediately and submit a written action plan with a target completion date for addressing other deficiencies. VA's Office of the Deputy Under Secretary for Health for Operations and Management directed that facilities provide an update on the status of their efforts to address the identified deficiencies by October 30, 2009, with weekly updates thereafter until the deficiencies are addressed.

While incorporating privacy policies into VA's environmental rounds establishes a process for local oversight of compliance with these policies, it may not be enough, especially given that we identified inaccuracies in data that medical facilities had reported on their compliance with privacy policies under a prior system of self-reporting. Prior to the expansion of the environmental rounds process to include privacy issues, individual VAMCs reported, on an annual VA survey, whether their clinical spaces were in compliance with VA policies related to ensuring privacy for women veterans.³⁸ But at the facilities we visited, the information facilities had reported in their surveys for fiscal year 2008 often did not accurately reflect the conditions we observed during our site visits. For example, medical facilities consistently reported that they were in compliance with the privacy policy that requires that exam tables are oriented with the foot of the table facing away from the door. However, in most clinical settings we visited where gender-specific physical exams might be conducted, examination tables were not oriented correctly. At several facilities we visited, staff specifically pointed out that exam tables were not oriented

³⁸Each fiscal year, WVPs at each VAMC submit responses to this survey to VA's Women Veterans Health Strategic Health Care Group. Officials in this office are responsible for providing strategic and programmatic support to facilities as they implement programs for women veterans, particularly VA's initiative to provide comprehensive primary care for women veterans. In addition to collecting information on whether clinical settings are meeting VA's privacy standards for women veterans, the survey collects information on a range of topics related to the delivery of health care services to women veterans, such as the types of services available at each facility.

correctly, but in only one facility we visited did we observe that staff took action to address the issue.

Even though VA has strengthened its oversight of privacy policies, because it is still relying on a self-reporting process VA lacks independent validation that VA medical facilities are complying with VA policies related to ensuring privacy for women veterans. While the online checklist and facility action plans will allow VA headquarters officials to review deficiencies reported by facilities, the process relies on self-reported information that may not always be accurate.

Medical Facilities Were in Various Stages of Implementing VA's Initiative on Comprehensive Primary Care for Women Veterans, but Officials at Some Facilities Were Unclear about the Steps Needed to Implement VA's New Initiative

VA's initiative to expand access to comprehensive primary care for women veterans is a key element of the agency's efforts to address the needs of this population. In establishing the initiative, VA adopted as a fundamental goal that each woman veteran would have access to a VA primary care provider who is proficient, interested, and engaged and who meets all of her primary care needs, including gender-specific and mental health care, in the context of an ongoing patient-provider relationship. VA also expressly defined comprehensive primary care for women as the availability of these services through one provider at one site. Part of the intent of these goals is to address the fact that many VA medical facilities deliver general primary care services and basic gender-specific services to women veterans using different providers, in different settings, over multiple appointments. This shift towards providing comprehensive primary care for women veterans in this one visit model requires significant changes for many VA medical facilities, but VA believes it is important because this fragmented delivery of care interferes with continuity of care and increases barriers to accessing care. While VA has asked that all VAMCs and CBOCs implement this initiative, VA has not set a deadline by which facilities are required to have fully implemented it.

The VA medical facilities we visited reported that they were at various stages of implementing VA's new policy on comprehensive primary care for women veterans, but we also found that officials at some medical facilities were unclear about the steps needed to implement the initiative. Officials at six of the seven VAMCs and six of the eight CBOCs we visited after November 2008—when VA adopted the initiative—reported that they had at least one provider who could deliver comprehensive primary care services to women veterans. The models that facilities used to deliver comprehensive primary care varied. Some VAMCs and CBOCs we visited already offered comprehensive primary care services through designated women's health providers during a single visit, consistent with VA's vision

for a one-visit model of care. In contrast, some facilities were still working to adapt their existing model of care, as the following examples illustrate.

- 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. Officials at this facility said that they were in the process of determining whether they can 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 they would meet the new 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.
- Some of the medical facilities we visited reported that they still were not routinely assigning all new women veteran patients to providers who could deliver comprehensive primary care in one visit. Even facilities that had implemented the one-visit model reported that they still had female patients who had established relationships with their primary care providers and had elected to continue to receive their primary and gender-specific care in two different settings.³⁹

Another area of uncertainty facility officials highlighted was how to ensure that providers have and maintain the broad set of skills and knowledge that a provider would need to meet VA's comprehensive primary care standard, particularly at facilities that see relatively few women patients. 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, some VA medical facilities serve a low volume of women veterans. For example, three of the CBOCs we visited served fewer than 100 women veterans in fiscal year 2008, and each of these CBOCs had two or more providers who were delivering or were scheduled to be trained in delivering gender-specific care. Another CBOC that served

³⁹Facilities we visited reported that while they would offer established patients the option to be reassigned to a provider who could deliver comprehensive primary care services, they would not require these patients to switch if they preferred to stay with a provider with whom they had a relationship.

just over 100 women veterans in fiscal year 2008 did not offer gender-specific care at the time we visited the facility, but one provider had plans to obtain needed training in delivering gender-specific care. Some VA medical facility officials and providers told us they were unsure how providers, even those who already possessed the relevant skills, could maintain their competence in delivering the broad range of primary care and gender-specific services that VA envisions in facilities with a low volume of female patients given that opportunities to practice delivering these services are limited.

VA headquarters officials report that they are taking several steps to help VA medical facilities implement comprehensive primary care for women veterans, including the following:

- VA has established an internal work group that, among other things, has developed draft written recommendations to more clearly define the professional competencies that a proficient women's health provider should have. This effort is being directed by leaders in VA's Office of Primary Care. According to officials from VA's Women Veterans Health Strategic Health Care Group, part of the work group's efforts involve looking at strategies to help address challenges associated with maintaining providers' competency at facilities with a low volume of female patients.
- All VAMCs were required to submit to VA headquarters by August 1, 2009, final implementation plans for providing comprehensive primary care for women veterans. These plans identify strategic goals and staffing, equipment, and other capital needs (such as resources for renovation or construction projects) to address gaps in services for women veterans at each VAMC. VA's Women Veterans Health Strategic Health Care Group is reviewing these plans to assess the status of medical facilities' efforts to implement the comprehensive primary care initiative. They are also reviewing the plans to identify the short- and long-term planning and budgetary needs identified by each facility, and to assess resource needs across VA's health care system. Officials from this group said that implementing comprehensive primary care for women veterans is an ongoing process that VA medical facilities should revisit during their annual strategic planning processes.

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- Officials from VA’s Women Veterans Health Strategic Health Care Group are working closely with individual WVPMs to help them gain access to and work with medical facility leadership to move facilities’ implementation plans forward.⁴⁰

VA Has Taken Steps to Alleviate Space Constraints, Hire Trained Providers, and Expand the Role of the WVPM, but Challenges Remain

VA facilities face challenges in providing health care services to women veterans, including alleviating space constraints that affect the provision of care, hiring providers who have specific experience and training in women’s health, and expanding the role of the WVPM. VA has taken steps to address some of these challenges, for example by implementing programs to educate VA providers in women’s health and evidence-based psychotherapies, creating a team to coordinate training and knowledge sharing on MST-related services, and working to educate facility leadership about the importance of ensuring that WVPMs have the ability to affect change at their facilities. However, these challenges have not been fully addressed. VA has not yet integrated its privacy policies for women into the agency’s design and construction standards, provided guidance on training that mental health providers working with MST patients should have, or updated its WVPM handbook to reflect the expanded full-time role it envisions for the position.

VA Facilities Plan Construction Projects to Alleviate Space Constraints That Affect the Provision of Services to Women Veterans, but VA’s Design Policies Do Not Address VA’s Privacy Policies Pertaining to Women Veterans

Officials at VA medical facilities we visited reported that space constraints have affected both their ability to provide comprehensive primary care services to women veterans and their ability to comply with VA’s privacy policies that pertain to women veterans. VA facility officials told us that space constraints have created challenges as they work to comply with VA’s new policy on comprehensive primary care for women and the policy requirements in the September 2008 *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook. For example, officials at one VAMC said that the limited numbers of primary care exam rooms at the facilities in their system—including CBOCs—made it difficult for providers to deliver comprehensive primary care services in an efficient and timely manner. Providers in this VAMC and at a large CBOC explained that they had only one exam room per primary care provider, and this

⁴⁰In addition, officials from the Women Veterans Health Strategic Health Care Group are conducting “coaching visits” for medical facilities that request their assistance. According to officials from the Women Veterans Health Strategic Health Care Group, these visits provide an opportunity for them to work directly with local WVPMs and facility leadership on how best to address the elements of their facility’s implementation plan and the potential challenges, and also to highlight the importance of supporting the plans.

prevented 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 large CBOC said that they often shared offices, which limited the number of counseling appointments they could schedule. At another VAMC, officials reported that because of substantial increases in demand for services, they no longer have adequate space in their women’s clinic and they have limited options for expanding the clinic.

Regarding the impact of space constraints on facilities’ implementation of privacy policies, 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 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 check-in stations, waiting rooms, and patient intake rooms limiting their ability to ensure the privacy of women, particularly those who have experienced MST and may not feel comfortable in a mixed-gender environment. For example, at one VAMC we visited the check-in station for the mixed-gender primary care clinic was located in a major hallway and near the medical center’s main elevator bank. At one large CBOC we visited—which saw almost 3,000 female patients in fiscal year 2008—the primary care clinic had only one patient intake room and providers sometimes had two patients separated by a curtain in that room during intake or screening processes, which involve sensitive questions about a patient’s medical history, including problems with substance use and whether a patient has experienced MST. Officials at another large CBOC said that space challenges that limited their ability to ensure privacy for women were among the factors that led to the relocation of mental health services to a separate off-site clinic.

VA providers at some facilities also expressed concerns about the privacy and safety of women veterans in mixed-gender residential programs, and cited space constraints as limiting their ability to address some of these issues. In May 2009, VA issued revised policies for residential mental health programs that require facilities with such programs to provide separate and secure sleeping arrangements for women veterans, including locks on bathroom and bedroom doors. In the residential treatment programs we visited, women veterans were placed either in a private room or a multibed room with other women, with bedrooms accessible using electronic keycards. Some residential programs placed women in secured bedrooms located at one end of a hallway, or near a nurses’ station. Other facilities had created a separate section of bedrooms for women only,

physically separated from other areas of the building and secured with a keyless entry system. However, given the available space in the buildings that house these programs, female residents shared common areas, such as the dining room, with male residents. Some providers expressed concerns that women who were victims of sexual trauma might not feel comfortable in such an environment. Further at one facility, a unit that housed a residential PTSD program had only one dormitory-style communal bathroom. Because it was a mixed-gender program, and although the bathroom was secured with a keycard entry system, staff had to allocate specific times of the day when women residents could use the showers and also had to stand guard at the door of the bathroom during the allocated time.

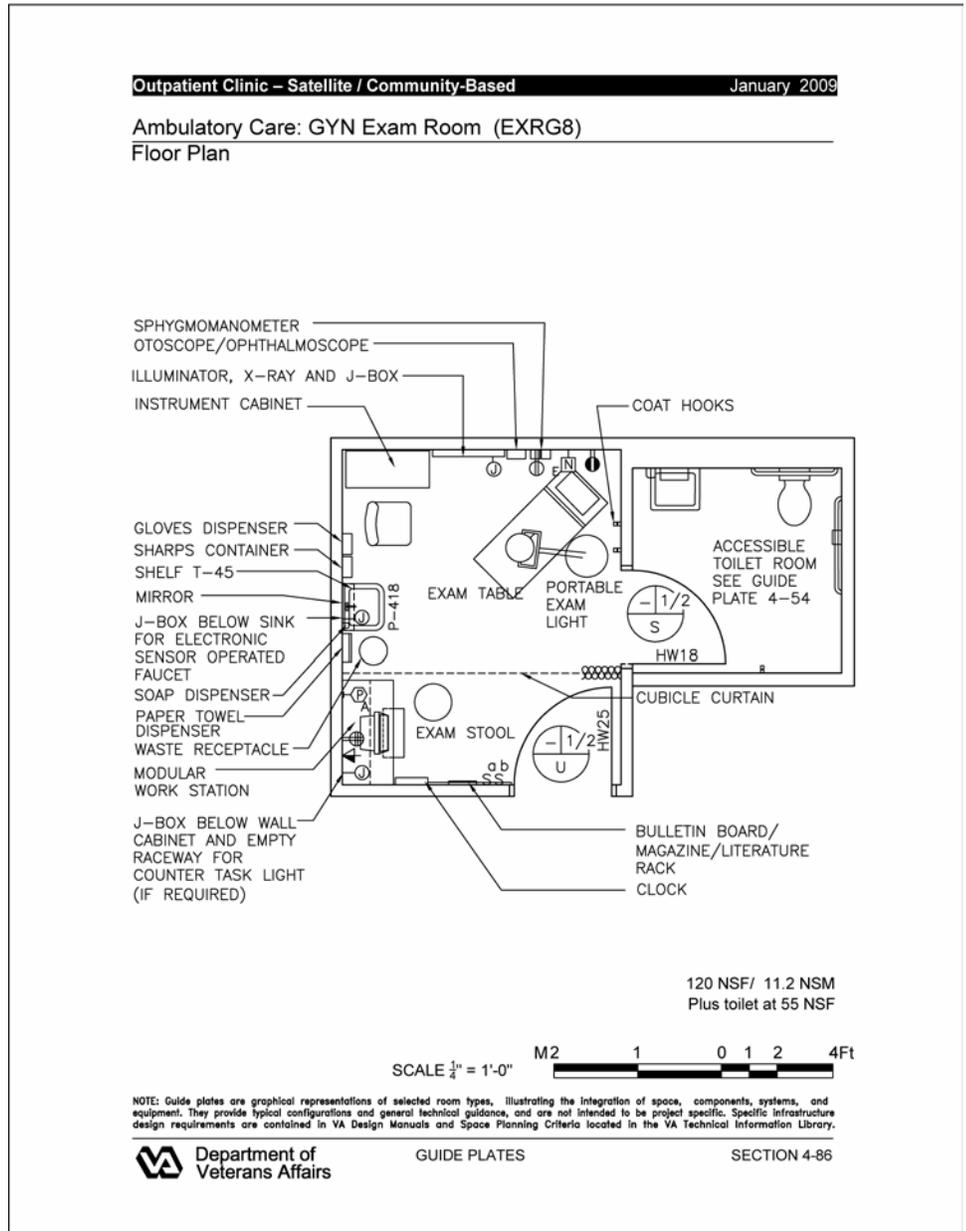
Finally, some VA providers highlighted space challenges that affected their ability to ensure the privacy and safety for women in inpatient environments. VA policy requires that all inpatient care facilities provide separate and secured sleeping accommodations for women and that mixed-gender units must ensure safe and secure sleeping arrangements, including, but not limited to, placing female patients in bedrooms that can be readily monitored from the nursing station. All of the inpatient mental health units we visited were mixed-gender units that had predominantly two- or four-bed bedrooms, with a limited number of private rooms. Providers told us they try to place women in private rooms, or if more than one woman is on the unit, they sometimes place these women in a two- or four-bed room near a nursing station. However, VA providers in two VAMC mixed-gender inpatient mental health units told us that some of the bedrooms that they usually designate for female patients were located where they could not be adequately monitored from the nursing station. Providers at several facilities told us that they had at times referred female patients to other VA or non-VA facilities when they felt they could not ensure the safety of those patients on their units. In one facility we visited, staff in the inpatient mental health intensive care unit had temporarily removed the doors to patient rooms and bathrooms as part of the facility's ongoing renovations to address updates in VA's suicide prevention and safety policies. However, this made it difficult to ensure safe and secure sleeping arrangements for women on the unit.

VA officials are aware of the space challenges that facilities face and VA is taking steps to address them, but the agency lacks a formal process to ensure that construction projects take into account the privacy needs of women veterans. According to VA headquarters officials, the majority of VAMCs have planned to undertake renovation, construction, or relocation projects as part of their efforts to implement comprehensive primary care

for women veterans. However, VA design policy documents—in particular VA’s Design and Construction Procedures and Design Guides—which lay out the detailed requirements that facilities will need to adhere to in undertaking these projects, do not explicitly address the policy requirements VA has outlined for ensuring the privacy of women veterans.⁴¹ For example, the Outpatient Clinic Design Guide, which includes detailed floor plans for a wide range of clinical spaces, does not note the need to ensure visual or auditory privacy at check-in, access to gender-specific restrooms, or the availability of a dispenser for sanitary products in at least one public restroom. Further, this Design Guide contains a detailed floor plan for an outpatient gynecological exam room that illustrates an incorrect placement of the examination table—the foot of the table is not facing away from the door, as VA’s privacy policies for women require. (See fig. 2.)

⁴¹VA’s Design and Construction Procedures specify the requirements that facilities must adhere to in designing new or renovated spaces, and state that these requirements “shall be utilized to the maximum extent practicable, commensurate with cost considerations.” Additionally, some of the design standards are required by laws or regulations.

**Figure 2: Department of Veterans Affairs (VA) Outpatient Clinic Design Guide—
Gynecologic Exam Room Guide Plate**



Source: VA Guide Plates, January 2009.

Note: This VA Guide Plate for a gynecological examination room is one of many in VA's Outpatient Clinic Design Guide, which lays out detailed specifications for a range of outpatient clinic spaces. The technical and medical terminology used in these Guide Plates is not directly relevant to this report. However, this Guide Plate contains several elements that are relevant to privacy for women veterans. Specifically, it specifies the need for a privacy curtain (labeled "cubicle curtain") and depicts a restroom immediately adjacent to the examination room, both of which comply with VA's privacy policies. However, the Design Guide also depicts the exam table with the foot of the table facing toward the door, which is contrary to VA's privacy policies. In addition the bathroom does not include a dispenser for sanitary products, which is required to be available in at least one public women's restroom, and would be expected to be available in a restroom attached to a gynecological examination room.

Although VA revised some of its design policy documents in April 2009, including Design Guides for outpatient clinics, those revisions did not include changes to explicitly address the privacy needs of women. At the time of the revisions, VA's Office of Construction and Facilities Management—which is responsible for developing VA's design and construction standards—was unaware of VA's privacy policies pertaining to women veterans. Consequently, officials from VA's Women Veterans Health Strategic Health Care Group were not consulted during the process of revising the design documents. Officials from both offices reported in November 2009 that they were working closely together to revise the current design policies to address VA's privacy policies and other needs of women. However, according to these officials, because of the many different types of clinical spaces in VA medical facilities, the process of making formal revisions to the design guides is a long and complex process that is conducted on a 3- to 5-year cycle, depending on the document. In order to get updated guidance to the responsible staff at the facility level as soon as possible, these offices are working together to develop "interim" design standards that better address the privacy needs of women veterans. According to these officials, the interim document covers the standards for women veteran's clinical services in an outpatient clinic setting. This document will be disseminated to facilities using VA's standard processes, which include online access to all current standards and a monthly report to engineering staff at VA facilities identifying that new standards have been released. Facilities will be asked to rely on the interim standards while the formal process of revising the design standards takes place. VA's Office of Construction and Facilities Management also said that they plan to work with the Women Veterans Health Strategic Health Care Group to help disseminate the interim standards through the Group's network of facility contacts. This office also reported that recent updates to the Design Guide for mental health services addressed the privacy and safety of women veterans, and that updates to Design Guides for certain other clinical settings—including medical/surgical units—were under way as of November 2009.

VA Facilities Face Challenges Hiring Providers with the Specialized Training and Experience Needed to Provide Services to Women Veterans, and VA Lacks Clear Guidance on the Training Appropriate for Providers Who Treat Victims of MST

VA facility officials reported difficulties hiring primary care and mental health providers with specialized training and experience in women’s health and MST-related conditions. In addition, while VA is providing mental health training for many of its existing providers, VA has not developed clear guidance on appropriate training for those mental health providers who treat victims of MST.

VA Medical Facilities Face Challenges Hiring Trained Primary Care Providers

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 a range of services to women veterans. This new policy requires that the 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.

However, a November 2008 VA 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.⁴² During our site visits, some VA medical facility officials discussed similar issues. For example, 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. 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 months 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 medical 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 hiring primary care providers with the required knowledge to meet their vision of delivering comprehensive primary care to women veterans. To help ensure they have sufficient primary care providers with knowledge of women’s health issues, 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 2-½ 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 officials reported that as of November 20, 2009, a total of 301 providers from 87 VAMCs and 100 CBOCs have attended the mini-residency training.

⁴²VA, Office of Public Health and Environmental Hazards, Women Veterans Health Strategic Health Care Group, *Report of the Under Secretary for Health Workgroup, Provision of Primary Care to Women Veterans* (Washington, D.C.: November 2008). This report attributed the insufficient number of primary care providers to the historical prevalence of male veterans in VA health care settings, which led to many providers having limited or no experience treating women veterans.

VA Facilities Face Challenges Hiring Mental Health Providers with Training and Experience in Treating MST-Related Conditions

VA medical facility and Vet Center officials we interviewed reported challenges attracting and hiring psychiatrists, psychologists, and other mental health staff with specialized training or experience in treating PTSD and other MST-related conditions. 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. For example, one VA medical facility official, who was responsible for training other mental health providers, both regionally and nationally, said that some VAMCs did not have staff with sufficient knowledge or training to provide adequate MST-related counseling services. Two officials, who both have experience as an MST coordinator, told us that many mental health providers at their facilities could use additional training in MST screening. In addition, two VA mental health 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 psychotherapies that are recommended for treating PTSD and other MST-related conditions, they often lack practical experience treating a challenging patient population. Some officials reported that shortages of trained and experienced providers limit the types of group or individual mental health treatment services that VA medical facilities and Vet Centers can offer.

Some CBOCs and one Vet Center we visited reported similar challenges. Officials at one VAMC, for example, 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 another CBOC, a licensed social worker reported providing individual counseling for about seven women who have experienced MST, but acknowledged having limited training in this area. The provider said that this situation was not ideal, and reported consulting with mental health providers at the associated VAMC on some of these cases. The provider also said that without these services some of these seven women might not receive any counseling. 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.

VA has taken steps to provide mental health training to its existing providers, including an agencywide training program to enhance its mental health providers' knowledge of clinically effective treatment methods. Specifically, VA is providing intensive training in CPT, PE, CBT, and ACT, which are evidence-based psychotherapies for treatment of PTSD and other conditions that are associated with MST.⁴³ According to VA, as of November 18, 2009, 3,426 VA providers had completed VA-provided training in evidence-based psychotherapies.

In addition to the broad mental health training efforts, VA has taken steps to provide specific MST-related training. VA's MST Support Team was created within VA's Office of Mental Health Services in fiscal year 2007, in part, to enhance MST-related training opportunities nationwide. According to VA officials, the team conducts monthly teleconference training for about 1-½ hours on a variety of MST-related topics, such as VA residential mental health treatment programs with specialized MST-related care, and how MST can affect veterans who served during different eras. The team is also responsible for an annual MST training conference on issues related to clinical care and program development and the development of a VA intranet Web site that contains MST-related resources.⁴⁴ VA officials also said that the MST Support Team provided MST-related materials for inclusion in the evidence-based psychotherapy training program.

VA Lacks Clear Guidance on the Training Appropriate for Mental Health Providers Who Treat Victims of MST

While VA is taking positive steps to provide MST training for its providers, it has not yet defined the appropriate training needed for treating victims of MST. MST-related law requires that VA provide for "appropriate training of mental health professionals and such other health care personnel" who deliver MST-related services.⁴⁵ VA policies require that all VA mental

⁴³VA officials told us that these therapies address the PTSD, depression, and generalized anxiety diagnoses commonly associated with sexual trauma.

⁴⁴The intranet Web site includes resources such as educational handouts, an independent study course on MST, providers' forums, veteran outreach materials, and sample treatment protocols.

⁴⁵38 U.S.C. § 1720D(b)(2)(A). On November 19, 2009, the Senate passed a bill that, among other things, would address training and certification requirements for mental health care providers who provide care to veterans suffering from MST. S. 1963, 111th Cong. § 204 (2009). The bill would amend the law to require VA to implement a program for education, training, certification, and continuing medical education for mental health professionals to specialize in the provision of counseling and care to eligible veterans; determine the minimum qualifications necessary for mental health professionals certified by the program to provide evidence-based treatment to veterans in VA facilities; and establish education, training, certification, and staffing standards for VA health-care facilities for full-time employees who are trained to provide treatment and care to veterans for sexual trauma.

health providers have appropriate training and that necessary staff education and training for treatment of MST-related conditions be provided, but do not specify what constitutes “appropriate or necessary” training for VA providers who work with victims of MST. VHA’s *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook states that VA should ensure that mental health services be provided by staff with an “appropriate level of training and clinical privileging” and that medical center directors should ensure that “necessary staff education and training is provided.” However, this handbook does not further specify the types of training that would meet this standard for mental health providers who treat MST-related conditions.

VA officials in headquarters told us that they have no plans to develop criteria that spell out in policy the specific training and experience needed for mental health providers that treat victims of MST. They said that all VA mental health providers who are licensed in their field and have appropriate clinical privileges are considered VA-qualified mental health providers and are qualified to work with victims of MST. They also confirmed that, beyond these standards, VA does not have specific training or experience requirements for providers who work with veterans who have experienced MST or other sexual trauma. However, some VA mental health providers told us there is a need for additional guidance on the types of training mental health providers should have to work effectively with veterans who have experienced MST. For example, two providers who have served as MST coordinators said that some minimum requirements for training on evidence-based psychotherapies for trauma-related conditions would be helpful for working with veterans who experienced MST.

In the absence of VA criteria on MST-specific training required for its providers, we found that some facilities were applying their own criteria or judgment on what constitutes appropriate training for mental health providers who deliver MST-related treatment. For example, at one VAMC, the Director of Mental Health Services told us the facility only allows providers who have received training and supervision in a relevant evidence-based psychotherapy, such as CPT or ACT, to work with victims of MST. MST coordinators at several other VAMCs told us that they try to ensure that providers who work with victims of MST have had some formal training in evidence-based psychotherapy. Similarly, VA’s Readjustment Counseling Service, which oversees the Vet Centers, has established specific training and experience requirements that its counselors must meet before being permitted to provide unsupervised counseling services to victims of sexual trauma. Vet Center policy

specifies, among other things, that sexual trauma counselors must have 120 hours of specialized training and 50 supervised hours of treatment experience with a minimum of five sexual trauma cases. According to Vet Center officials, these requirements were established to ensure that providers are adequately trained to meet the unique needs of veterans who have experienced MST or other sexual trauma.

Some Facilities Have Not Implemented the Full-time WVPM Position as VA Envisioned, and VA Has Not Updated Its Policy to Clarify the WVPM's Roles and Responsibilities

Some medical facilities have not implemented the full-time WVPM position with the broad responsibilities, authority, and access to senior facility leadership that VA envisioned in creating the position. VA's July 8, 2008, memorandum that directed all VAMCs to establish the full-time WVPM position broadened the role and responsibilities of the position with the intent that WVPMs be empowered to work across a facility's various clinical services in order to implement needed changes, particularly related to VA's efforts to expand comprehensive primary care for women veterans. The memorandum further directed facilities to "ensure that the WVPM has full access to facility leadership." The memorandum specified that the role of the full-time WVPM was to strategically plan, coordinate quality of care, evaluate delivery of care, and increase outreach to women veterans.

While VA's July 2008 memorandum establishes the key aspects of VA's vision for the full-time WVPM position, it also cites VHA's WVPM handbook—which has not been revised since March 28, 2007, when the WVPM was still a collateral duty—for additional guidance on the duties and responsibilities of the WVPM.⁴⁶ We found that although the handbook addresses many responsibilities encompassed in VA's July 2008 memorandum, it is not fully consistent with VA's new vision for the full-time WVPM position. For example, the handbook discusses a range of responsibilities for the WVPMs including evaluating delivery of care (involving reviews of the physical environment, construction plans, and privacy and safety policies), and increasing outreach to women veterans, among others. However, the handbook does not explicitly mention or fully discuss other key responsibilities cited in VA's July 2008 memorandum related to strategic planning and coordination of quality of care. In addition, the handbook states that facility directors should ensure that WVPMs have direct access to top management in the facility and serve on appropriate clinical and administrative committees, but does not give clear

⁴⁶VHA Handbook 1330.02.

guidance about the level of reporting authority that the position should have. Instead, the handbook states that the responsibilities of the WVPM must be negotiated between the WVPM and the WVPM's supervisor and be tailored to the local circumstances.

During our site visits and reviews of position descriptions for the WVPMs at the facilities we visited, we found differences between the responsibilities some facilities had assigned to the full-time WVPM and those envisioned in VA's July 2008 memorandum. The differences we found related primarily to responsibilities for strategic planning, reviews of compliance with privacy policies, and reporting authority. For example, five of six position descriptions we reviewed⁴⁷ did not explicitly mention strategic planning as one of the WVPM key responsibilities. We also found that two position descriptions did not discuss the WVPM's responsibilities for monitoring or participating in reviews of facility compliance with privacy policies that affect women veterans. Similarly, while VA's July 2008 memorandum urged facilities to make certain the WVPM "has the support and reporting chain necessary to effectively carry out the rapid changes required at the facility level," none of the WVPMs at the facilities we visited reported directly to a member of the facility's senior leadership.⁴⁸

The inconsistencies we observed between VA's vision for the WVPM and how facilities are implementing the position can limit individual WVPMs' effectiveness in implementing changes needed at the facility level to improve care for women veterans. Some WVPMs told us about situations where their ability to affect changes to improve care for women veterans sometimes had been limited by a lack of authority to directly exercise their judgment or report directly to senior facility leadership to discuss issues that affected women veterans. For example, one WVPM reported not being included in key initiatives, such as the environmental rounds or reviewing construction plans. Another WVPM told us that efforts to expand gender-specific services for women at a CBOC were rebuffed by her supervisor, and did not move forward until someone else who was committed to addressing the needs of women veterans took over the supervisory position. Officials from VA's Women Veterans Health Strategic Health Care

⁴⁷One VAMC did not provide a position description and one VAMC provided a sample position description from a different facility.

⁴⁸The WVPMs that we reviewed reported to various other officials, such as the Chief of Primary Care, Service Line Medical Director, or the Chief of Social Work Service.

Group also told us they have heard from WVPMs that their supervisors have sometimes prevented them from communicating with facility leadership about steps they believe are needed to implement changes to improve services for women veterans. Officials from this group said that they are working to educate facility leadership on the importance of ensuring that WVPMs have the ability to affect changes across the spectrum of services and clinical settings in their facilities, and are also working with WVPMs to help them be proactive in gaining access to facility leadership. These officials acknowledged that VA could update the WVPM handbook to better reflect the agency's current vision for the roles, responsibility, and authority of the WVPM position.

Conclusions

The number of women veterans using VA health care services has increased substantially in recent years and this trend is going to continue over the coming decades. VA has taken important steps to address the needs of women veterans, including efforts to expand comprehensive primary care for women veterans. However, our review also identified some gaps in services available to women, including several medical facilities that did not routinely offer basic gender-specific services on site. While most facilities we visited offered a variety of mental health services, VA has not made information accessible on its external Web sites about all VA specialized residential mental health programs for women veterans who have experienced MST or other traumas. Without ready access to such information, women veterans who need treatment may face unnecessary challenges to accessing VA programs.

To address our preliminary findings that medical facilities were often not complying with VA's privacy policies for women veterans, VA has increased its oversight of compliance with these policies by incorporating privacy, dignity, sense of security, and safety considerations into facilities' existing environmental rounds processes. However, we found that facilities' prior reporting on their compliance with privacy policies often did not accurately reflect the conditions that we found on site, and as a result continuing to rely solely on self-reported information may not provide sufficient assurance that facilities are complying with these policies.

VA has also taken steps to address some of the challenges that facilities have identified in delivering services to women veterans, but has not updated some key policies. Many medical facilities have planned renovation, construction, or relocation projects to help expand comprehensive primary care for women veterans. However, VA's recently

revised design and construction policies do not accurately reflect VA's privacy policies for women. Given that facilities are actively planning construction projects, it is important that facilities have access to design policy documents that reflect VA's privacy policies so that plans for new and renovated clinical spaces do not fall short of addressing the needs of women. VA would also benefit from utilizing the expertise of the staff from the Women Veterans Health Strategic Health Care Group to help ensure that any revisions to VA's policies take into consideration other unique needs of women veterans. To address challenges related to training of mental health providers, VA has taken decisive action to expand its national training program in evidenced-based psychotherapies. However, VA policies require appropriate training for mental health professionals in general, but have not clearly specified what constitutes appropriate or necessary training for VA mental health professionals who work with victims of MST or other sexual trauma. In the absence of clear guidance from VA, some medical facilities we visited had established their own criteria on the training and experience their providers needed to have in order to work with this population. Finally, VA has directed that VAMCs make the WVPM a full-time position with broad responsibilities and authority to transform the delivery of health care to women veterans. However, VA has not revised its WVPM handbook since the time that the position was a collateral duty, and we found some inconsistencies between VA's expressed vision for the position and the responsibilities, level of authority, and access to leadership that facilities were assigning to individual WVPMs. The lack of clear and consistent policies at the national level about the role of the WVPM position may hamper the effectiveness of individual WVPMs in taking a leadership role in facility efforts to improve and expand the services offered to women veterans.

Recommendations for Executive Action

To better ensure that women veterans have access to health care services that meet their unique needs and to strengthen oversight of the services delivered to women veterans at VA facilities, we recommend that the Secretary of Veterans Affairs direct the Under Secretary of Health to implement the following five recommendations:

- provide complete information on VA's external Web sites on the specialized residential mental health treatment programs VA offers for women veterans who have experienced MST or other traumas;
- establish a process to independently validate self-reported information by VA medical facilities' on compliance with privacy policies that pertain to women veterans;

-
- expedite action to ensure that VA’s design and construction policies explicitly address the needs of women veterans in all health care delivery settings in VA medical facilities;
 - clarify VA’s policies by describing specifically what constitutes “appropriate and necessary training” for mental health professionals who provide services to veterans who have experienced MST; and
 - update VA’s policies to clarify the roles and responsibilities of the full-time WVPM position, in particular with respect to the level of reporting authority and access to senior facility management.

Agency Comments and Our Evaluation

VA provided written comments on a draft of this report, which we have reprinted in appendix II. In its comments, VA generally agreed with our conclusions and concurred with our recommendations, and also described the agency’s planned actions to implement each of the recommendations. VA did not provide separate technical comments on the draft report.

Specifically, VA agreed that it is important that the agency’s external Web sites provide appropriate information about specialized residential mental health treatment programs for women veterans, and stated that the agency is conducting a systematic review of VA’s national Web sites to identify sites that contain limited or inadequate information. However, it is unclear from VA’s comments whether this review will include VA’s facility-specific Web sites. Given our finding that only three of the nine VAMCs that have specialized residential programs for women provided detailed information about those programs on their Web sites, we believe it is important that VA include facilities’ Web sites in its review. VA also plans to emphasize with facilities the importance of ensuring that local MST coordinators’ contact information is readily available at key entry points to the VA system. We commend this effort and encourage VA to include WVPMs’ contact information in its plans, given the agency’s stated goal that women veterans work with their local WVPMs or MST coordinators to identify programs to best meet their unique treatment needs. Separately, VA plans a collaborative effort to develop, by March 30, 2010, a process to validate facilities’ self-reported information on compliance with privacy policies.

In its comments, VA further concurred with the need to expedite action to update VA’s design and construction standards to explicitly address the needs of women veterans in all health care delivery settings. VA said that these standards have been upgraded for some clinical settings, and cited the design guides and standards for ambulatory care and outpatient

clinics, among others, as examples. However, as of March 25, 2010, the current Ambulatory Care and Outpatient Clinic Design Guides—last updated in April 2009—were the same documents that we reviewed in our draft report and found to be inadequate. VA also commented that an interim document focusing on “women’s issues” is scheduled to be issued in late spring 2010, which our draft report mentioned VA was working on in November 2009. We urge VA to expedite updating of design and construction standard documents—which are typically updated on a 3- to 5-year cycle—for all clinical settings to ensure that the renovation, construction, or relocation projects that many VA facilities are planning adequately address the needs of women veterans.

VA concurred that mental health professionals must be skilled to provide MST-related care, and said that the agency will specify what constitutes adequate training for these clinicians in an action plan to be delivered by March 30, 2010. Finally, VA has tasked a work group to revise the current WVPM handbook to ensure that it aligns with the expanded mission of the full-time WVPM position. VA noted that the work group will examine and define the reporting authority, access to senior facility management, and the program management responsibilities of the position. VA anticipates the handbook will be revised and submitted for internal review within VA by June 1, 2010.

We are sending copies of this report to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



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United States Senate

The Honorable Tim Johnson
Chairman
The Honorable Kay Bailey Hutchison
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Chet Edwards
Chairman
The Honorable Zach Wamp
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
and Related Agencies
Committee on Appropriations
House of Representatives

The Honorable Michael H. Michaud
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

The Honorable Russell D. Feingold
United States Senate

Appendix I: Information on the Selection of Department of Veterans Affairs Facilities Examined in This Report

We selected locations for our site visits using Department of Veterans Affairs (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. To assess the reliability of these data, we reviewed relevant documentation and interviewed agency officials knowledgeable about the data and the methodologies used to collect them. We determined that the data were sufficiently reliable for the purposes of this report. In addition to these data, 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 medical facilities of interest:

- total number of unique women veteran patients who used the VAMC;
- total number of unique OEF/OIF women veteran patients who used the VAMC;
- proportion of unique women veterans who used the VAMC who were OEF/OIF veterans;
- proportion of unique OEF/OIF women veterans who used 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 used VA health care and lived in rural or highly rural areas; and
- availability of on-site programs specific to women veterans, such as inpatient or residential treatment programs that offered specialized treatment for women veterans with PTSD or who have experienced MST, including programs that were for women only or that had an admission cycle that included 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

**Appendix I: Information on the Selection of
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Vet Centers, we focused on selecting facilities that represented a range of sizes, in terms of the number of women veterans they served. 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 Veterans Affairs 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)
VAMC 1 ^a	6,464	19.5	8.5
VAMC 2	6,360	22.4	12.8
VAMC 3	4,497	8.2	7.3
VAMC 4	3,588	19.4	10.2
VAMC 5	2,324	11.7	4.8
VAMC 6	1,846	20.2	3.9
VAMC 7	1,841	19.8	5.1
VAMC 8	999	12.5	1.0
VAMC 9	995	22.5	6.9

Source: VA data and GAO analysis.

^aBecause VAMC 1 is part of the same health care system as VAMC 7, some of these veterans may also have received services at VAMC 7, and vice versa.

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Table 6: Women Veterans' Health Care Utilization at Selected Veterans Affairs (VA) Community-Based Outpatient Clinics (CBOC)

CBOC, 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 unique 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 10 ^a	42	not applicable ^a

Source: VA data and GAO analysis.

^aThis facility opened in 2007, so percentage increase since fiscal year 2006 does not apply.

Appendix II: Comments from the Department of Veterans Affairs



Department of Veterans Affairs
Office of the Secretary

March 19, 2010

Mr. Randall B. Williamson
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***VA HEALTH CARE: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes (GAO-10-287)*** and generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department. The enclosure specifically addresses each of GAO's recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,


John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***VA HEALTH CARE: VA Has Taken Steps to Make Services
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(GAO-10-287)***

GAO Recommendation: To better ensure that women veterans have access to health care services that meet their unique needs and to strengthen oversight of the services delivered to women veterans at VA facilities, we recommend that the Secretary for Veterans Affairs direct the Under Secretary of Health to implement the five following recommendations:

Recommendation 1: Provide complete information on VA's external Web site regarding the specialized residential mental health treatment programs VA offers for women veterans who have experienced Military Sexual Trauma (MST) or other traumas.

VA Response: Concur in principle. The Veterans Health Administration (VHA) policy is to establish connections between Veterans and their local VA medical centers (VAMCs) to enable the best decisions regarding residential care issues, rather than rely on posting of detailed information on Web sites. This ensures that Veterans are connected with the residential/inpatient program (or other care) that best meets their unique treatment needs and that they receive adequate support and aftercare once they have completed the programs.

However, VHA agrees that providing information on external Web sites is also important so that Veterans and others have appropriate information about specialized residential mental health treatment programs for women Veterans. To ensure that existing Web site information concerning the availability of specialized treatment in residential and inpatient programs, including materials relative to MST, is appropriately communicated, the Office of Mental Health Services (OMHS) is currently conducting a systematic review of VA's National Web sites. If information is limited or inadequate, the MST Support Team will follow-up to request that more appropriate MST-related materials and information be posted.

To further emphasize the importance of addressing MST issues, the MST Support Team has initiated a campaign to highlight communications about the availability of programs as a key motivator for this year's theme for Sexual Assault Awareness Month (April 2010), "Making Connections to Help Survivors of MST." Initiatives such as these will help further publicize the availability of specialized residential and inpatient care programs VA offers for women Veterans and provide improved access to MST coordinators. In the weeks leading up to this event and throughout the month of April, MST Coordinators will

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receive periodic e-mails providing suggestions on various ways their names and contact information can be publicized throughout their facilities. Emphasis will be placed on the importance of ensuring that this information is available at key entry points to the system (e.g., with telephone operators; at information desks; and on facility Web sites). The MST Support Team will evaluate the effectiveness of the campaign, including periodic test calls to various facilities in an attempt to reach the MST Coordinator. Expected completion date is June 2010.

Recommendation 2: Establish a process to independently validate self-reported information by VA medical facilities on compliance with privacy policies that pertain to women veterans.

VA Response: Concur. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will collaborate with VHA's Office of Primary Care and the Women Veterans Health Strategic Health Care Group (WVHSHCG) to develop a process to validate medical facilities' self-reported information on compliance with privacy policies by March 30, 2010. Medical facilities will develop action plans to implement this process. These may include unannounced site visits by Veterans Integrated Service Network (VISN) Environment of Care Teams, random site visits and records reviews by VHA's Office of Environmental Programs Service, as well as System-wide On-going Assessment and Review Strategy site visits. Action plans will be maintained and tracked by the DUSHOM Environmental Programs Service to ensure compliance.

Recommendation 3: Expedite action to ensure that VA's design and construction policies explicitly address the needs of women veterans in all health care delivery settings in VA medical facilities.

VA Response: Concur. VA's Office of Construction and Facilities Management (CFM) is responsible for developing VA's design and construction standards. CFM has been meeting directly and regularly for over a year with the Chief, Consultant Women's Health Office and members of her staff to expedite the update of VA design and construction standards (VADCS) to address needs of women Veterans. These standards have been upgraded in a number of VA design guides and standards, to include ambulatory care, outpatient clinics, MRI, radiology, etc. The Women's Health Office will continue to be an essential element of the process that involves VHA program officials, consultants, and

2

Enclosure

Department of Veterans Affairs (VA) Comments to
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CFM staff for the update of VADCS for state-of-the-art VA facilities. Women's issues are included within many VADCS documents which are all continuously updated in cycles that vary from 3 to 5 years. An interim document specifically on women's issues is scheduled to be issued in late Spring 2010.

Recommendation 4: Clarify VA's policies by describing specifically what constitutes "appropriate and necessary training" for mental health professionals who provide services to veterans who have experienced MST.

VA Response: Concur in principle. VHA concurs that clinicians must be skilled to provide MST care. As noted in the report, all VA mental health providers who are licensed in their fields and have appropriate clinical privileges are considered VA qualified mental health providers with appropriate and necessary training to be qualified to work with victims of MST.

Specific plans for what constitutes adequate training will be prepared in an action plan to be delivered by March 30, 2010.

Recommendation 5: Update VA policies to clarify the roles and responsibilities of the full-time WVPM position, in particular with respect to the level of reporting authority and access to senior facility management.

VA Response: Concur. VA understands that it is critical to define the roles and responsibilities of Women Veteran Program Managers (WVPM) in implementing facility Women's Comprehensive Health Implementation Plans and ensuring a positive impact on the quality of women Veterans health care. In 2008, VHA directed the appointment of a WVPM as a full time position in every VAMC and broadly outlined their roles for facilitating changes in the delivery of services to women Veterans. In response to this change, VHA Handbook 1330.02, Women Veterans Program Manager (WVPM) Position, that describes the duties and responsibilities of the health care professionals that perform the duties of the WVPM, now needs updating to further clarify enhanced roles and responsibilities of the full-time WVPM.

A workgroup has been tasked to review and revise the current Handbook to ensure alignment with the expanded mission of the WVPMs. In consultation with human resources experts and field advisors, the workgroup will examine and define the reporting authority of the WVPMs and their access to senior facility

3

Enclosure

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Government Accountability Office (GAO) Draft Report
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management as well as describe the program management responsibilities of full-time WVPMs. In addition, specific duties for full-time VISN Lead WVPMs (approximately 10 of the 21 positions) and their roles in coordination of activities throughout VISNs need to be identified. The Handbook is anticipated to be revised and submitted for concurrence by June 1, 2010.

4

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; Susannah Bloch; Chad Davenport; Alexis MacDonald; Kaitlin McConnell; Carmen Rivera-Lowitt; and Michael Zose made key contributions to this report.

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