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VA HEALTH CARE FOR WOMEN

In Need of Continued VA Attention

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SUMMARY

In a limited follow-up to its January 1992 report on improvements needed in the Department of Veterans Affairs' (VA) provision of health care services to women veterans, GAO found that

-- VA's central office has repeatedly stressed the need for its facilities to improve services for women veterans and has issued guidance to its medical centers intended to address the problems identified in the January 1992 report.

-- VA's greatest success has come in improving privacy for women veterans. It has completed or funded 131 projects in this area at a cost of more than $672 million during the last three fiscal years. Another 205 projects, estimated to cost about $800 million, are planned; most of which will be funded before the turn of the century.

-- VA's central office has not effectively monitored field facilities to ensure that facilities improved services for women veterans. For example, even when medical centers submitted inadequate plans for improving women veterans' cancer screening examinations in response to one central office directive, the central office did not notify the medical centers of its findings. In addition, it has not followed through on plans to disseminate best practices for improving the thoroughness of examinations and monitor the provision of mammography services.

Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step, which is not dependent on implementation of health reform, should improve the thoroughness of women veterans' cancer screening examinations. But, real progress in improving services for women veterans depends on the leadership provided by individual VA medical center directors.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) long-standing problems in meeting the health care needs of women veterans and the implications the problems have for VA's role in a reformed national health care system. As you know, we first identified problems in VA's provision of health care services to women veterans in 1982 and identified continued problems in a 1992 follow-up report.[1]

Our January 1992 report focused on four problem areas: (1) patient privacy, (2) cancer screening examinations for women veterans, (3) dissemination of information on successful approaches for improving the thoroughness of the cancer screening examinations, and (4) quality assurance for mammography services. Our comments this morning will be based on limited follow-up at VA's central office to determine the extent to which VA followed through on the promises it made to improve health care services for women veterans. While our work focuses on central office actions, you will also be hearing this morning from VA's Inspector General on what progress is being made at the facility level.

Since issuance of our 1992 report and enactment of the Veterans Health Care Act of 1992 (P. L. 102-585), VA's central

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[1]Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits (GAO/HRD/82-98, Sept. 1982); VA Health Care for Women: Despite Progress, Improvements Needed (GAO/HRD-92-23, Jan. 23, 1992).

office has repeatedly stressed the need for its facilities to improve services for women veterans. In fact, it issued guidance to its medical centers intended to address the problems identified in our report.

VA's greatest success has come in improving privacy for women veterans. It has completed or funded 131 projects in this area at a cost of more than $672 million during the last three fiscal years. Another 205 projects, estimated to cost about $800 million, are planned; most of which will be funded before the turn of the century.

But, the VA central office has not effectively monitored field facilities to ensure that facilities improved services for women veterans. For example, even when medical centers submitted inadequate plans for improving women veterans' cancer screening examinations in response to one central office directive, the central office did not notify the medical centers of its findings. In addition, it has not followed through on plans to disseminate best practices for improving the thoroughness of examinations and monitor the provision of mammography services.

Under VA's health reform proposal, each veteran would be assigned a primary care physician. This step, which is not dependent on implementation of health reform, should improve the thoroughness of women veterans' cancer screening examinations.

But, real progress in improving services for women veterans depends on the leadership provided by individual VA medical center directors.

VA CENTRAL OFFICE ACTS TO IMPROVE SERVICES FOR WOMEN

Since issuance of our follow-up report, VA's central office has

-- issued directives to medical centers to develop action plans for improving services and privacy for women veterans;

-- established a newsletter on women veterans' health programs;

-- established a full-time women veterans coordinator in each of its four regional offices;

-- funded 15 full-time women veterans coordinator positions at medical centers, all but three of which are in place;

-- established a task force on sexual trauma;

-- established a Women Veterans Health National Training Program;

-- created a Women's Health Science Division in the National Center for Post Traumatic Stress Disorder (PTSD);

-- funded eight Women Veterans Comprehensive Centers; and

-- issued, in September 1993, Women Veterans Health Care Guidelines.

Clearly, these actions should result in improvements in services provided to women veterans. But a continuing problem limits the effectiveness of efforts to improve the quality of VA services: failure to monitor medical centers to ensure that corrective actions are taken. It is this problem--which we highlighted in our transition series report on VA--more than any other that threatens the success of VA's health reform plans and the quality of care likely to be provided under those plans.[2]

CORRECTION OF PRIVACY LIMITATIONS

One area in which VA appears to have made significant progress is correcting privacy limitations. When we first reported, in 1982, on VA's efforts to meet the health care needs of women veterans, many VA programs could not accommodate women because of the lack of private or semiprivate rooms with separate bathrooms. Problems were most evident in domiciliaries and psychiatric wards.

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[2]Veterans Affairs Issues, GAO/OCG-93-21TR, Dec. 1992.

Ten years later, we reported that women could be accommodated under all domiciliary programs, but were surprised to find that even a recently renovated facility paid little attention to the privacy of women patients.

Renovation of one of the medical/surgical wards at the Tampa medical center had been completed shortly before our visit in December 1990. The renovated ward, however, retained the congregate showers for use by both male and female patients. Although the medical center had both a women veterans coordinator and a women veterans committee, neither was involved in the review and approval of renovation and construction projects.

Women at the Bay Pines medical center may similarly be required to use the same congregate showers as male patients. One of the women at the medical center when we visited explained that, when they wanted to take a shower, they used a magic marker to write "woman in shower" on a paper towel and taped it to the shower door. She said that while most male patients respected their privacy when the note was posted, male patients in some cases still entered the showers while women were using them.

We recommended that VA issue guidance to medical centers on (1) identifying privacy deficiencies in accommodations for women veterans and (2) instituting a mechanism for tracking corrective actions. We stated that the women veterans coordinator or women

veterans advisory committee or both should be involved in the approval process for construction and renovation projects to help address the privacy needs of women patients.

In March 1992, VA directed its medical centers to survey the privacy provisions of all clinical areas to identify those that might not respect women's privacy. The directive noted that the women veterans coordinator or a member of the facility's women veterans advisory committee should participate in the survey.

In response to the directive, medical centers identified 336 projects at 128 VA facilities which would improve privacy for women veterans. The estimated cost of the projects totaled almost $1.5 billion. Many medical centers, such as the Tampa and Bay Pines medical centers discussed above, submitted plans to quickly correct specific problems. Corrective actions range in cost from $1,000 to install privacy curtains around an examination table to $169 million for renovation and construction at the Philadelphia medical center. Among the most common projects were eliminating communal showers and improving privacy in examination rooms.

As of October 1993, 131 of the 336 planned projects had been completed or funded, at an estimated cost of over $672 million. Medical centers expect to fund most of the 205 additional projects before the turn of the century. Projects delayed until after the

turn of the century generally involve new construction or major renovation.

FURTHER ACTIONS NEEDED TO IMPROVE THOROUGHNESS OF CANCER SCREENING EXAMINATIONS

Cancer screening examinations are critically important for women veterans for two primary reasons. First, women veterans for some unknown reason experience an unusually high incidence of cancer. Second, treatment is more likely to succeed if the cancer is detected early. For example, early detection dramatically increases the 5-year survival rates of women with breast cancer. Additionally, with early detection, the 5-year survival rate of women with cervical cancer is 88 percent, but in women whose cancers are not detected early, the 5-year survival rate is only 13 percent. Similarly, since the introduction of the Pap test--the principal method for early detection of cervical cancer--in the 1950s, the cervical cancer mortality rate has declined by 70 percent.

Despite this strong evidence that cancer screening should be an important part of women veterans' health care, VA made little progress in improving the thoroughness of physical examinations during the 10 years between our 1982 and 1992 reports. For example, in reviews conducted in 1988 and 1989, VA's own Medical

District Initiated Peer Review Organization found that from 20 to 86 percent of women patients in the five districts reviewed did not receive breast and pelvic examinations, Pap tests, and mammograms when required.

Because of the limited progress in improving women's physical examinations during the 10 years between our two reports, our 1992 report contained a very specific recommendation: VA should require each medical center, as part of its quality assurance program, to develop and implement an action plan for improving compliance with the requirement that each woman inpatient receive a complete physical examination, including pelvic and breast examinations and a Pap test, at appropriate intervals. We stated that these action plans should, at a minimum, address (1) the use of nurse practitioners and gynecologists to perform physical examinations, (2) the education and training of medical center staff on the importance of women-specific services, and (3) quality assurance monitoring. Finally, we recommended that VA's central office review and approve the action plans.

VA followed through on its promise to require medical centers to submit revised plans for the care of women veterans, but did not analyze and provide feedback to medical centers on those plans. In March 1992, VA's central office directed its medical centers to revise their plans for the care of women veterans and to develop quality indicators to monitor compliance with the examination

requirements. Medical centers were required to submit their plans and quality indicators to the Director of the Women Veterans Program by August 1992.

We found no evidence of VA's central office review of 132 of the 155 plans obtained from VA. Our review of the 155 plans showed that

-- 34 addressed all three of the minimum requirements cited in our recommendation;

-- 69 discussed the use of nurse practitioners and gynecologists to perform the cancer screening examinations;

-- 62 cited staff education and training as an integral part of their plan; and

-- 150 mentioned quality assurance, but only 99 included quality indicators to monitor compliance with the examination requirements as required by the directive.

Frequently, the plans merely restated the requirements contained in the central office directive without outlining an action plan for improving compliance with the requirements.

Although VA promised, in response to our report, to provide feedback to the medical centers on their action plans, it did not notify the medical centers of the deficiencies in their plans. Nor did it do any monitoring to determine whether the thoroughness of examinations was improving.

VA's Assistant Chief Medical Director for Environmental Medicine and Public Health acknowledged that many of the plans were inadequate--the plans frequently reiterated the requirements cited in the central office directive--and told us that VA developed, and disseminated to medical centers in September 1993, women veterans health care guidelines to provide additional guidance to the medical centers. The guidelines encourage medical centers to establish women's clinics and women veterans primary health care teams. These teams would include a core group made up of a physician, nurse, or nurse practitioner, social worker, and the women veterans coordinator.

We believe these teams, if established by the medical centers, could improve the thoroughness of the cancer screening examinations. VA central office has not, however, required medical centers to establish such teams. VA is currently gathering data on the number of medical centers that have established women veterans primary health care teams.

The VA guidelines state that "quality indicators should be developed to monitor aspects of women veterans health care" but provide no further elaboration on quality assurance monitoring.

INNOVATIVE PRACTICES NOT DISSEMINATED

Our report noted that some of the VA medical centers visited had developed innovative efforts to improve compliance with the examination requirements. Although VA agreed with our recommendation that it identify, disseminate, and, where appropriate, require systemwide implementation of such innovative approaches, it has not implemented the recommendation.

VA initially planned to disseminate innovative practices through a November 1992 information letter to its medical centers but later decided that it would be more appropriate to disseminate such information through a quarterly women veterans health programs newsletter. This type of periodic newsletter would, in our opinion, be a good forum for disseminating information on best practices. Neither of the first two issues of the newsletter (July and December 1993), however, contained any information on innovative approaches for improving compliance with the physical examination requirements.

The December 1993 newsletter did contain data on the number of pap smears, mammograms, and gynecologic examinations performed at

each VA medical center. The data are of minimal use in assessing how well the medical centers are following the examination requirements, however, because they do not include data on the numbers of women who should have received the services. In addition, the reliability of the data appears questionable, with some large medical centers reporting no services.

MONITORING QUALITY OF MAMMOGRAPHY SERVICES

In our January 1992 report, we noted that VA medical center's compliance with mammography standards generally exceeded that of private providers. We noted, however, that some improvements were needed and recommended that VA, as part of its quality assurance activities, monitor centers' compliance with its September 1991 circular on mammography services.

VA agreed and said that it would (1) review plans for provision of breast screening services submitted by VA medical centers and (2) develop periodic monitoring of quality control and quality assurance aspects of mammography services and equipment.

VA, however, did not follow through on this recommendation. As I mentioned earlier, VA did not review and provide feedback to the medical centers on their plans for providing breast screening services. And, we identified no VA central office efforts to monitor medical centers' compliance with quality control and

quality assurance aspects of mammography services. Central office officials told us that they lack the resources to conduct such monitoring.

IMPLICATIONS OF HEALTH REFORM

Before closing, I would like to discuss the implications of health reform on the women veterans' program. Under VA's health care reform proposal, the most critical deficiency in the women's program--failure of facilities to provide appropriate cancer screening examinations--may largely be overcome through primary care. Each woman veteran would have a primary care physician and be entitled to a comprehensive set of health care services. Under such an arrangement, a doctor/patient relationship should develop in which physicians will no longer be reluctant to perform the examinations. While VA's planned move to primary care is linked to the President's health reform proposal, VA does not need to wait for health reform to implement a primary care system.

One of the factors VA's officials frequently cite as contributing to poor compliance with cancer examination requirements is physicians' reluctance to conduct breast and pelvic examinations when their specialties are in some other field of medicine. Mr. Chairman, this is another example of the types of problems created by the current hospital-based VA health care eligibility system. The focus of cancer screening examinations

should not be on inpatients, but on outpatients. Focusing on providing cancer screening services to inpatients undoubtedly causes VA to miss cancers in women veterans who may go 5 years or more without an inpatient episode of care--well beyond the recommended screening periods. Under a managed care plan, women veterans would no longer need to be hospitalized to receive routine cancer screening tests.

In the future, VA will rely even more than it does now on individual facilities to ensure the quality of care to both male and female veterans. Consequently, the long-standing problems in getting many VA medical centers to implement corrective actions to improve women veterans health care services may continue.

The final point on health care reform I would like to discuss this morning is coverage of a routine pregnancy. Currently, women veterans of child-bearing age may be reluctant to rely on VA for their health care because routine pregnancies are not covered. While VA would be required to cover routine pregnancies under a managed care plan, women may still be reluctant to sign up for care from a VA health plan that does not ensure continuity of care in private-sector hospitals. In other words, the VA gynecologist/obstetrician would need to have admitting rights to the hospital contracted to provide maternity care.

In summary, Mr. Chairman, VA's central office continues to stress the need to improve services for women veterans. Real improvements, however, depend more on the commitment of medical center directors than on directives from central office. The absence of complete, comprehensive action plans to improve services to women raises serious doubts about the potential for VA health plans to attract women veterans.

Mr. Chairman, that concludes my statement. We will be glad to answer any questions that you or members of the Subcommittee may have.