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Report to Congressional Requesters

December 2016

VA HEALTH CARE

Improved Monitoring Needed for Effective Oversight of Care for Women Veterans

GAO-17-52

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GAO Highlights

Highlights of GAO-17-52, a report to congressional requesters

Why GAO Did This Study

In 2010, GAO found a number of weaknesses related to care for women veterans at VA medical facilities. GAO was asked to update that study. This report examines (1) the extent that VA medical centers complied with requirements related to the environment of care for women veterans and VHA's oversight of that compliance; (2) what is known about the availability of VHA medical providers who can provide sex-specific care for women veterans at VA facilities; and (3) VHA's efforts to provide and monitor access to sex-specific care for women veterans through Choice. To do this work, GAO reviewed VHA data on environment of care deficiencies; the number, location, and availability of VHA and Choice medical providers; women veteran enrollment; and Choice access-related performance measures. In addition, GAO inspected the environment of care for compliance with VHA policy at a nongeneralizable sample of six VA medical centers, which were selected to achieve variation in different care models, the size of the women veterans' population, and geographical locations. GAO also interviewed VHA Central Office and VA medical center officials.

What GAO Recommends

GAO recommends that VA (1) strengthen the policies and guidance for its environment of care inspection process and (2) monitor women veterans' access to sex-specific care under current and future community care contracts. VA concurred with GAO's recommendations.

View GAO-17-52. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) does not have accurate and complete data on the extent to which its medical centers comply with environment of care standards for women veterans. VHA policy requires its medical facilities, including VA medical centers, to meet environment of care standards related to the privacy, safety, and dignity of women veterans. VHA Central Office relies on medical centers to conduct regular inspections and to report instances of noncompliance, which are compiled in a VHA database. However, almost all the noncompliance GAO identified through inspections at six VA medical centers it visited had not been reported or recorded in the VHA database, and compliance rates ranged from 65 percent to 81 percent. For example, GAO found a lack of auditory privacy at check-in clerk stations and a lack of privacy curtains in examination rooms, as required by VHA policy. GAO also found weaknesses in VHA's oversight of the environment of care for women, including a lack of thorough inspections and limited verification of facility-reported data which results in inaccurate and incomplete data. As a result, the privacy, safety, and dignity of women veterans may not be guaranteed when they receive care at VA facilities. Federal internal control standards for monitoring call for management to establish activities to monitor the quality of performance over time and promptly resolve any identified issues.

GAO's analysis of VHA data shows that nationally the number of VHA full-time-employee equivalent gynecologists and the number of women's health primary care providers—VHA primary care providers specially trained in women's health care services, such as breast exams—increased by 3 percent and 15 percent respectively, from fiscal year 2014 through fiscal year 2015, and those percentages exceeded the 1 percent growth in women veteran enrollment during the same period. However, about 27 percent of VA medical centers and health care systems lacked an onsite gynecologist and about 18 percent of VA facilities providing primary care lacked a women's health primary care provider, according to VHA data. VHA officials said not all facilities require onsite gynecologists and facilities may authorize gynecological services from non-VA providers. They acknowledged a shortage of at least 675 women's health primary care providers and have a plan to train at least 535 providers by the end of fiscal year 2016.

The Veterans Choice Program (Choice) is a primary option for veterans to receive care from non-VA providers in the community if care cannot be provided at VA facilities. While the number of obstetricians and gynecologists under Choice has increased, some areas lack these providers, according to a VHA analysis. While VHA monitors access-related Choice performance measures (such as timely appointment scheduling) for all veterans, it does not have such measures for women veterans' sex-specific care, such as mammography, maternity care, or gynecology. VHA's data show poor performance on access-related performance measures for all veterans, and GAO found cases where women veterans' maternity care was significantly delayed, suggesting that veterans, including women, face challenges receiving timely access to care. Federal internal control standards for monitoring call for management to establish activities to monitor the quality of performance over time and promptly resolve any identified issues.

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Abbreviations

Choice	Veterans Choice Program
FTEE	full-time employee equivalent
PC3	Patient-Centered Community Care
TPA	third party administrator
VA	Department of Veterans Affairs
VAMC	Veterans Affairs medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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441 G St. N.W.
Washington, DC 20548

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Congressional Requesters

According to the Department of Veterans Affairs (VA), women are the fastest growing subpopulation of veterans. According to VA officials, in 2016, almost 10 percent of the total veteran population is female—over 2 million women—and by 2020, VA estimates that this proportion will rise to almost 11 percent.[1] Women veterans seeking care through VA's national health care system, which is operated by the Veterans Health Administration (VHA), are eligible to receive a full range of health care services—including services specific to their sex, such as breast examinations, cervical cancer screenings and treatment, and obstetric care. When these and other services are not available at VA medical facilities—including health care systems, VA medical centers (VAMC), and community-based outpatient clinics—or within required driving distances or time frames, VA may purchase care from non-VA providers through its care in the community programs, such as the Veterans Choice Program (Choice).[2]

Given the growth in the number of women veterans, in 2010 we examined the availability of VHA health care services for women.[3] We found variation in the types of sex-specific health care services available to women veterans at VA medical facilities.[4] We also found that none of the

[1]As of January 1, 2016, all positions and occupations in the armed forces are open to women, including previously closed combat positions, which could contribute to the increase in the women veteran population. See GAO, *Military Personnel: DOD Is Expanding Combat Service Opportunities for Women, but Should Monitor Long-Term Integration Process*, GAO-15-589 (Washington, D.C.: July 20, 2015).

[2]VA health care systems are made up of multiple VAMCs. Established under the Veterans Access, Choice, and Accountability Act of 2014, Choice authorizes care for eligible veterans through eligible non-VA providers under certain circumstances. Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-65 (2014).

[3]See GAO, *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 (Washington, D.C.: March 31, 2010). We provided preliminary findings in 2009; see 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).

[4]For example, while all VAMCs visited offered the full range of basic sex-specific services for women, some VA community-based outpatient clinics did not.

19 VA medical facilities we visited were in compliance with VHA's policies that govern the environment of care for women veterans.[5] These VHA policies require all VA medical facilities to adhere to certain standards intended to ensure women's privacy, safety, and dignity when they receive care. The standards relate to, for example, ensuring auditory privacy at check-in and in interview areas, the location of exam rooms, and the presence of privacy curtains in exam and inpatient rooms.[6]

In our 2010 report, we recommended that VA take several steps to strengthen VHA's provision and oversight of services for women veterans. VA agreed with our recommendations and has made progress in addressing issues raised. For example, VHA introduced a policy in 2010 requiring that all women veterans treated at VA medical facilities have access to a primary care provider specially trained in women's health care services, known as a women's health primary care provider. However, there are still concerns that VHA may not be fully meeting the health care needs of women veterans. For example, a Congressional hearing in April 2015 raised concerns about gaps in the services available for women veterans in VA medical facilities.[7] In addition, we and others have expressed significant concerns about VHA's management of its health care system, including VHA's ability to effectively provide timely access to health care for veterans. In 2014, a series of events called into question the ability of veterans to gain timely access to care from VHA medical facilities. As a result of these and other systemic problems, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.[8]

[5]The environment of care refers to the setting in which patients receive health care services. According to VHA Directive 1608, *Comprehensive Environment of Care Program*, VA medical facilities must provide a safe, clean, functional, and high quality environment for veterans, their families, visitors, and employees.

[6]The scope of services VHA requires to be provided to women veterans, including 46 requirements for the environment of care to ensure the privacy, safety, and dignity of women veterans, is outlined in a VHA handbook. See Department of Veterans Affairs, *Health Care Services for Women Veterans,* VHA Handbook 1330.01 (Washington, D.C.: May 21, 2010).

[7]See *Examining Access and Quality of Care and Services for Women Veterans: Hearing before the H. Comm. on Veterans' Affairs*, 114th Cong. (2015).

[8]See GAO, *High Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

We were asked to follow-up on our 2010 report and assess VA's progress in providing a full range of health care services for women veterans. This report examines:

1. the extent to which VAMCs complied with requirements related to the environment of care for women veterans, and VHA's oversight of medical facilities' compliance with these requirements;
2. what is known about the availability of VHA medical providers who can provide sex-specific care for women veterans at VA medical facilities; and,
3. VHA's efforts to provide and monitor access to sex-specific care for women veterans through Choice.

To examine the extent to which VAMCs comply with requirements related to the environment of care for women veterans, we reviewed VHA Central Office's database of VAMC self-reported instances of noncompliance in the environment of care for six selected VAMCs for fiscal years 2015 and 2016. We selected VAMCs located in Baltimore and Perry Point, Maryland; Gainesville and Lake City, Florida; Cincinnati, Ohio; and Cheyenne, Wyoming.[9] We chose these sites to represent different models of care for women veterans, diverse regions of the country, urban and rural locations, and a range in the percentage of the state population made up by women veterans.[10] For these selected VAMCs, we conducted site visits to inspect the environment of care in waiting areas as well as in procedure and examination areas across various outpatient, inpatient, and residential treatment units where women veterans can

[9]We limited our review to VAMCs because the VA Office of the Inspector General has been conducting similar inspections of women's health programs, including the environment of care, at VA community-based outpatient clinics. According to an official, the clinics that the VA Office of the Inspector General evaluates each year represent a randomized, generalizable sample, and 78 percent of the 93 clinics the VA Office of the Inspector General evaluated in fiscal year 2014 provided adequate privacy for women veterans.

[10]In accordance with VHA Handbook 1330.01, Health Care Services for Women Veterans, a VA facility may choose one or more of three primary care clinic models to meet the needs of women veterans. In one model, women veterans are seen by a women's health primary care provider within a sex-neutral primary care clinic. In a second model, primary care services for women veterans are offered by women's health primary care providers in a separate but shared space that may be located within or adjacent to mixed-sex primary care clinic areas. In a third model, primary care services are provided by a women's health primary care provider in an exclusive and separate space, including a separate entrance into the clinical area and a separate waiting room.

receive health care services.[11] We developed a standardized data collection instrument containing the VHA environment of care requirements we reviewed during our inspections to determine whether each requirement in every applicable setting was in compliance.[12] The findings of our site visits cannot be generalized to other VAMCs. To examine VHA's oversight of medical facilities' compliance with requirements related to the environment of care for women veterans, we reviewed VHA policies on the environment of care rounds process and related internal inspections. We also reviewed the findings from contracted evaluations of women's health programs at VA medical facilities.[13] Finally, we interviewed officials from the VHA administrative office that oversees compliance in the environment of care at VA medical facilities and from the selected VAMCs about VHA oversight and the implementation of environment of care policies. We examined this evidence in the context of federal internal control standards for monitoring and control environment.[14]

To examine what is known about the availability of VHA medical providers who can provide sex-specific care for women veterans, we analyzed available VHA data on the number, location, and the availability of women's health primary care providers and gynecologists in fiscal years 2014 and 2015. We also reviewed VHA data on women veteran

[11]Outpatient clinics are health care settings in which patients receive services without being admitted overnight, such as a primary care clinic. Inpatient units are health care settings in which patients are admitted and require at least one overnight stay. Residential treatment programs provide rehabilitative and clinical care to veterans for a wide range of illnesses or rehabilitative care needs which may include mental health and substance use disorders, co-occurring medical conditions, and psychosocial needs. The care through these residential treatment programs is provided 24 hours a day, 7 days a week.

[12]See Appendix II for a list of the requirements we reviewed, which were a part of the data collection instrument. We selected a subset of 33 requirements from VHA Handbook 1330.01 Health Care Services for Women Veterans to ensure that there were no redundancies in our reporting and that we were reporting observations that we could verify. We inspected for 20 requirements in outpatient clinics, 6 requirements in inpatient units, and 7 requirements in residential treatment units.

[13]In fiscal year 2010, VHA Central Office contracted with Booz Allen Hamilton to conduct comprehensive independent evaluations of the women's health programs at all VAMCs and VA health care systems over 5 years. In fiscal year 2014, Atlas Research became the lead contractor, with Booz Allen Hamilton as the subcontractor.

[14]See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

enrollment and the number of completed VA women's health and gynecology appointments for fiscal years 2014 and 2015. We assessed the reliability of the data sources by reviewing relevant documentation, interviewing knowledgeable agency officials, or reviewing the data for missing values and outliers. Through these steps, we determined that the data were sufficiently reliable for the purposes of this reporting objective. In addition, we interviewed VHA Central Office and medical facility officials involved in coordinating and providing health care to women veterans, including women veterans program managers and clinicians at the six VAMCs we visited.

To examine VHA's efforts to provide and monitor access to sex-specific care for women veterans through Choice, we reviewed VHA data on the number of obstetricians and gynecologists in Choice networks from May 2015 through May 2016. We also reviewed the results of a 2016 VHA study analyzing the number and location of Choice obstetricians and gynecologists in Veterans Integrated Service Networks (VISN) 10 and 19 as of May 2016 and the VA medical facilities where gynecology is available in those VISNs.[15] For these two VISNs, we compared the reported number and location of Choice obstetricians and gynecologists in May 2016 with the number of non-VA community providers that VA medical facilities in these VISNs sent women veterans to for obstetrics or gynecology services in fiscal year 2014, prior to the introduction of Choice in November 2014.[16] We focused on VISNs 10 and 19 because, as a part of this study, we conducted site visits to VAMCs in these VISNs, located in Cincinnati, Ohio and Cheyenne, Wyoming.[17] In addition, these VISNs

[15]Carey, Evan; Paula Langner and Michael Ho. "VACA Spatial Evaluation of Specialty Care Relevant To Female Veterans: Quantitative Results (Version 2, updated 5/16/2016)." VISNs are regional networks containing individual VAMCs or groups of VAMCs, known as health care systems. VISNs oversee the day-to-day functions of VA medical facilities within their boundaries.

[16]We counted the number of providers that VA medical facilities disbursed payments to in fiscal year 2014 for obstetrics or gynecology care and used this as a proxy for availability of these services in the community.

[17]VA is currently in the process of reorganizing its VISNs. When we refer to VISNs 10 and 19 in this report, the boundaries of those VISNs as of fiscal year 2015 apply. In fiscal year 2015, VISN 10 included most of Ohio and parts of Indiana and Kentucky, and VISN 19 included most of Montana, Wyoming, Colorado; Utah; and parts of Idaho, Nevada, North Dakota, Nebraska, and Kansas. By the end of fiscal year 2018, VISN 10 is expected to contain most of Ohio and Indiana; Michigan; and a small portion of Kentucky; VISN 19 is expected to contain most of Montana, Wyoming, Colorado, and Oklahoma; Utah; and parts of Idaho, Nevada, Nebraska, and Kansas.

allow for comparisons of urban and rural areas. We also reviewed VHA data on women veteran enrollment in 2014 and 2016 and third-party administrator (TPA) performance data on Choice access to care and network adequacy from August 2015 through May 2016.[18] In addition, for illustrative purposes, we identified three examples of sex-specific care obtained by women veterans under Choice from a review of veteran medical records associated with an ongoing GAO study examining the implementation of Choice.[19] We assessed the reliability of these data sources by reviewing relevant documentation, interviewing knowledgeable agency officials or reviewing the data for missing values and outliers. Through these steps, we determined that the data were sufficiently reliable for the purposes of this reporting objective. We also interviewed VHA officials responsible for monitoring Choice and officials from the TPAs. We examined this evidence in the context of federal internal control standards for monitoring.[20]

We conducted our performance audit from October 2015 to December 2016 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 national health care system is one of the largest in the United States and provides enrolled veterans—including women veterans—with a full range of services including primary care, mental health care, inpatient care, and residential treatment. VA's national health care system is

[18]To implement Choice, VA modified contracts it had previously awarded to two TPAs to develop regional networks of community providers. These providers agree to treat veterans based on set payment rates and the terms of the agreement made between the provider and the TPA. The TPAs responsible for administering Choice are Health Net Federal Services and TriWest Healthcare Alliance. VA's performance data show the extent to which the TPAs met the performance standards associated with access to care and network adequacy measures.

[19]As a part of our ongoing review of Choice implementation, we are examining the extent to which veterans are able to access health care services through Choice within required time frames. We are reviewing records maintained by VHA and the TPAs for a random, nongeneralizable sample of 196 Choice authorizations for care between January and April 2016.

[20]See GAO-14-704G.

organized into regionally organized VISNs containing individual VAMCs and health care systems made up of multiple VAMCs. In addition, VAMCs operate VA community-based outpatient clinics that provide basic primary care services on site. VHA is responsible for oversight of the provision of health care at all VA medical facilities.

Women's Health Care at VA Medical Facilities

Through its medical facilities, VA provides a wide range of sex-specific health care services to women veterans. Basic women's primary care services are typically provided by women's health primary care providers who are trained in providing sex-specific primary care to women veterans.[21] Women's health primary care providers must maintain clinical competency through ongoing education and training and by having a certain percentage of women veterans on their patient panel.[22] Sex-specific primary care for women veterans includes breast examinations, cervical cancer screenings, management of contraceptive medications, and menopause management. More specialized sex-specific care for women is typically provided by a gynecologist. Services provided by a VHA gynecologist include treatment of menstrual disorders, fertility assessments, treatment of gynecological malignancies, and performance of gynecological procedures such as colposcopy.

[21]In 2010, VHA introduced a policy requiring that all women veterans treated at VA medical facilities have access to a women's health primary care provider. Typically, newly enrolled veterans are automatically assigned to women's health primary care providers unless they prefer to be assigned to a different primary care provider for a reason such as earlier scheduling availability. Women veterans enrolled in VA health care prior to 2010 may choose to remain with their longstanding primary care provider or ask to switch to a women's health primary care provider.

[22]A panel is a group of patients assigned to a given VHA provider, who is responsible for supervising the patients' care. According to VHA policy, the panel of a women's health primary care provider should have at least 10 percent women. VHA has established a baseline panel size of 1,200 patients for its primary care physicians. Nurse practitioners and physician assistants are generally assigned a panel of patients that is 75 percent of the physician panel size. To account for the unique needs of women veterans during appointments, VHA recommends that women's health primary care providers' panels be reduced by the number of unique patients equal to 20 percent of the total number of women veterans in the panel. For more information about VHA's use of panel sizes to manage its primary care workload, see GAO, *VA Primary Care: Improved Oversight Needed to Better Ensure Timely Access and Efficient Delivery of Care,* GAO-16-83 (Washington, D.C.: Oct. 8, 2015).

Environment of Care at VA Medical Facilities

VHA requires all facilities to follow certain standards related to the environment of care in accordance with agency policy and Joint Commission standards.[23] VHA policies specify privacy, dignity, sense of security, and safety considerations that all clinical spaces in VA medical facilities must meet.

To ensure compliance with environment of care standards, VHA directs VAMCs to conduct weekly inspections of the facility (known as environment of care rounds), and all patient care areas must be inspected twice every fiscal year.[24] An environment of care rounds team made up of representatives from various facility departments—such as nursing, police service, and environmental management—is responsible for identifying any instances of noncompliance. The women veterans program manager—a staff person at each VAMC or health care system who is responsible for helping to coordinate services for women veterans—is a member of the environment of care rounds team and is responsible for ensuring compliance with requirements related to women veterans. The environment of care rounds coordinator is responsible for examining rounds data and closing the inspection on an online tool, which then automatically sends a notification to the appropriate medical facility departments to address instances of noncompliance; this data then also becomes available to officials at VHA Central Office.[25] According to VHA policy, noncompliance must be addressed within 14 days, including developing an action plan, if necessary. VHA Central Office maintains a database that contains all noncompliance reports and periodically follows up with facilities to check on the status of open reports.

VA Care in the Community Programs

If veterans cannot receive timely care within VA or need care that a VA medical facility cannot provide, VHA is authorized to purchase care for veterans from non-VA providers, known as VA care in the community. Non-VA care is frequently used for women veterans because some VA

[23]The Joint Commission is an independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States. It is the nation's oldest and largest standards-setting and accrediting body in health care, and it is governed by a 32-member board that includes physicians, administrators, nurses, employers, quality experts, a consumer advocate, and educators.

[24]Department of Veterans Affairs, *Environment of Care (EOC) Assessment and Compliance Rounding Process Guide,* Version 0.7 (August 3, 2014).

[25]Some VAMCs record inspection information on handheld tablets with picture capabilities so instances of noncompliance may be documented.

medical facilities do not offer certain types of sex-specific health care, such as mammography or maternity care.[26] According to VHA, based on fiscal year 2014 data—the latest available data at the time of our review—women utilize more non-VA outpatient care than men. Veterans may be referred to a care in the community program by a VHA clinician, but VA medical facility staff must determine the veteran's eligibility before authorization for care is granted. Current VA care in the community options include:

- **Veterans Choice Program.** Choice was established in November 2014 under the Veterans Access, Choice, and Accountability Act of 2014. According to VHA policy, it typically must be the first option considered for providing care in the community to veterans. According to VHA data from March 2016, the majority of care in the community authorizations are for Choice.[27] After a veteran is authorized for Choice, the TPA that administers the relevant Choice network is responsible for (1) contacting the veteran to determine whether she would like to receive Choice care, (2) identifying community providers in the TPA's network who can meet the veteran's needs and asking the veteran if she wants to see a specific provider, (3) scheduling an appointment, and (4) ensuring that the veteran's appointment is within

[26]For example, a VA medical facility may not have sufficient demand for a provider to provide sex-specific services onsite. As of August 2016, according to VHA, 59 VA medical facilities provide mammography services, of which 56 provide diagnostic mammography. In addition, as of August 2016, two VA health care systems offer prenatal care. However, no VA medical facilities provide obstetrical care, that is, care related to the delivery of babies.

[27]Certain categories of care are not provided through Choice, such as dental care, chronic dialysis treatments, long-term care, and hospice care, and may be provided through other community care arrangements. A veteran is eligible for Choice care if he or she is enrolled in the VA health care system and any of the following apply: the veteran attempts, or has attempted, to schedule an appointment with a VHA provider, but VHA is unable to schedule an appointment within 30 days from the veteran's preferred date or the date such care or services are deemed clinically necessary, if such period is shorter; the veteran lives more than 40 miles driving distance from the nearest VA facility with a full-time primary care physician; the veteran lives in a state or territory without a full-service VA medical facility and resides more than 20 miles from such a facility; the veteran resides in a location other than one in Guam, American Samoa, or the Republic of the Philippines, and must travel by air, boat, or ferry to the VA facility that is closest to his or her home; the veteran faces an unusual or excessive burden in traveling to a VA facility based on geographical challenges, environmental factors, or a medical condition that affects the ability to travel; or other factors as determined by the Secretary of VA, such as the nature or simplicity of the care required, the frequency that such care is needed, or the need for the veteran to travel with an attendant.

specified time frames.[28] Specifically, after the TPAs have confirmed veterans would like to receive Choice care, the TPAs are contractually required to, among other things:

- schedule appointments within 5 business days (for routine care) from the time the veteran agrees to participate in Choice or within 2 business days (for urgent care) of accepting the authorization from the referring VA medical facility;
- ensure that veterans receive care within 30 days of scheduling an appointment for routine care or within 2 business days (for urgent care) of accepting the authorization from the referring VA medical facility;[29]
- return authorizations to the referring VA medical facility when appointments cannot be scheduled within required time frames; and
- track the number of authorizations for which they did not schedule appointments for veterans and the reasons why.

- **Patient-Centered Community Care (PC3).** In September 2013, VHA awarded contracts to two TPAs to develop regional networks of community providers of specialty care, mental health care, limited emergency care, and maternity and limited newborn care when such care is not feasibly available from a VA medical facility. VHA and the TPAs began implementing the PC3 program in October 2013, and it was fully implemented nationwide as of April 2014. In August 2014, VHA expanded the PC3 program to allow community providers of primary care to join the networks. PC3 is a program VHA created

[28]In addition, after the completion of each episode of Choice care, the TPAs must obtain medical documentation from the veteran's community provider and return it to VA so that the documentation can be added to the veteran's VHA electronic health record for care coordination purposes.

[29]The TPAs' contracts permit routine Choice appointments to take place outside this 30-calendar-day time frame if VA documented that the veteran's preferred date (that is, the date the veteran wants to be seen) was outside the 30-day time frame. Additional exceptions exist for (1) veterans who were referred to Choice because the next available appointment with a VA provider was more than 30 days from the clinically indicated date or the veteran's preferred date, and (2) veterans who live more than 40 miles driving distance from a VA facility with a full-time primary care physician. For the veterans who are referred to Choice due to wait times for appointments with VA providers, the TPAs must ensure that Choice appointments for routine care take place within 30 calendar days of the clinically indicated date on the authorization VA sent. For the veterans who are referred to Choice due to the 40 mile driving distance, the TPAs must ensure that Choice appointments for routine care take place within 30 calendar days of the veteran's preferred date.

under existing statutory authorities, not a program specifically enacted by law, like Choice. Currently, the two TPAs that administer PC3 also administer Choice. The regional networks built for PC3 provided a basis upon which the Choice networks were established.

- **Individually authorized care.** VA medical facilities may approve individual authorizations for care in the community from providers who agree to see VA patients. Historically, individually authorized care was the primary means by which VHA provided care in the community to veterans.

Choice is scheduled to expire in August 2017, or when appropriations for the program are expended, whichever occurs first. The upcoming expiration of Choice does not extend to VHA's other care in the community programs, which VHA has proposed to consolidate into a single program.[30]

VHA Lacks Complete and Accurate Data on VAMC Compliance with Environment of Care Requirements for Women Veterans and Does Not Consistently Identify or Address Noncompliance

VHA Central Office lacks complete and accurate data on the extent to which VAMCs are in compliance with environment of care requirements. VHA relies on VAMC staff to self-report their facilities' level of compliance with environment of care requirements; however, almost all of the noncompliance that we identified at the six VAMCs we visited was not reported to VHA Central Office. In addition, during site visits, we found that levels of compliance with VHA's environment of care requirements for women veterans varied.

[30]According to VA, VHA's proposal to consolidate its community care programs will require congressional legislation in order to implement.

VHA Lacks Complete and Accurate Data on VAMC Compliance with Environment of Care Requirements for Women Veterans

VHA Central Office does not have complete and accurate information on VAMCs' compliance with the environment of care requirements for women veterans and, as discussed later, does not verify the data it receives from facilities. Based on our inspections, we observed 155 instances of noncompliance at six VAMCs we visited, and almost all (152) of these instances had not been reported to VHA Central Office and entered into its database, according to our analysis of VHA data. For four of the VAMCs we visited, none of the instances of noncompliance we observed had been reported to VHA Central Office. Because VHA Central Office uses this database to track facility compliance, the accuracy of the data is vital for the agency to perform its oversight duties effectively.

Among the six VAMCs we visited, based on our inspections, we observed varying levels of compliance with selected VHA requirements related to the environment of care for women veterans, ranging from 65 percent to 81 percent.[31] Across all six VAMCs, outpatient clinics had lower rates of compliance than inpatient units and residential treatment programs. Specifically, outpatient clinics complied with 74 percent of selected VHA requirements related to the environment of care for women veterans; in comparison, inpatient units and residential programs across the six VAMCs each complied with 96 percent of selected VHA requirements. (See table 1.) The number of instances where requirements were applicable varies by facility, due to facility size and types of services available. In addition, at the time of our inspections, circumstances may have precluded us from observing each requirement in every instance; for example, some exam rooms may have been occupied or some clinics were not open. VHA requires VAMCs to comply with its environment of care requirements in all instances where they are applicable. (See appendix III for VAMC compliance rates by each individual requirement we inspected.)

[31]While VHA policy requires 100 percent compliance, the rates of compliance among the six selected VAMCs we inspected between December 2015 and March 2016 were generally higher than the rates of compliance among the 19 VA medical facilities we reviewed in 2010. See Appendix II for a full list of selected VHA requirements that we inspected for compliance. None of the six VAMCs we visited for this review were included in the sample of sites we visited for our 2010 review. See GAO-10-287.

Table 1: Compliance Rates with Selected Veterans Health Administration Environment of Care Requirements across Six Veterans Affairs Medical Centers (VAMC), December 2015 – March 2016

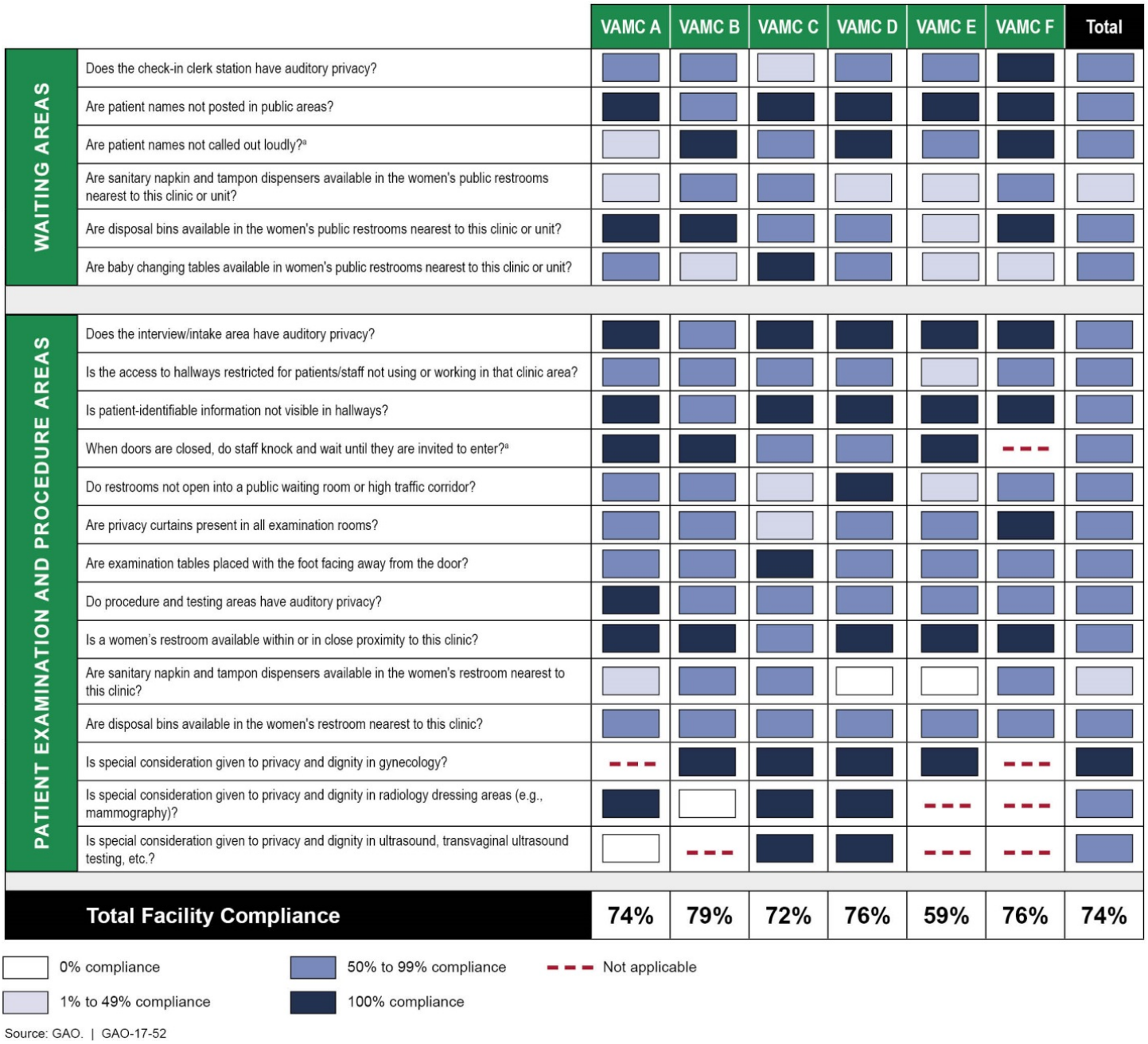
	Outpatient Clinics	Inpatient Units	Residential Programs
Total number of requirements GAO inspected for compliance	567	81	48
Total number of requirements GAO found in compliance	417	78	46
Rate of compliance	74 percent	96 percent	96 percent

Source: GAO | GAO-17-52

Note: We collected this information using a data collection instrument during site visits to VAMCs from December 2015 through March 2016.

- **Outpatient setting.** Across the six selected VAMCs, rates of compliance with the selected outpatient environment of care requirements varied. Figure 1 shows how frequently each of the VAMCs was in compliance with the applicable environment of care requirements in the outpatient areas we reviewed.

Figure 1: Outpatient Compliance Rates of Six Veterans Affairs Medical Centers (VAMC) with Selected Environment of Care Requirements for Women Veterans, December 2015-March 2016



Source: GAO. | GAO-17-52

Notes: We collected this information using a data collection instrument during site visits to VAMCs from December 2015 through March 2016. Not applicable indicates either that the requirement was

not applicable to any units within the facility or that we were unable to observe the requirement in any of the facility units given the circumstances at the time of our inspection.

[a]At the time of our inspections, circumstances in the clinic environment may have precluded us from observing this requirement in every applicable instance. For example, some exam rooms or restrooms may have been occupied by patients at the time of our inspection, or some clinics may only be open on certain days of the week and were closed at the time of our inspection.

Some common areas of noncompliance that we observed in outpatient clinics included the following:

- **Lack of auditory privacy at check-in clerk station**. VHA policy requires that check-in clerk stations must be positioned in a way that protects the privacy of patients who are checking in. However, over one-third (14 out of 40) of all check-in stations we observed across the selected VAMCs were located in such close proximity to the waiting room area that conversations between the patient and the check-in clerk could be heard by other patients. Only one of the six VAMCs we visited ensured adequate auditory privacy at the check-in clerk station in all outpatient clinical settings.
- **Lack of auditory privacy in procedure and testing areas**. VHA policy requires that patients be assured auditory privacy while they are in procedure and testing areas to help protect the confidentiality of their health conditions and treatments. However, in over one-third (11 out of 32) of all outpatient clinics in the selected VAMCs, we observed at least one examination room from which conversations between a patient and provider could be heard from the hallway despite a closed door. Only one of the six VAMCs that we visited was fully compliant with VA's requirement of auditory privacy in all procedure and testing areas.
- **Privacy curtains not present in all examination rooms**. VHA policy requires that all examination rooms be equipped with a privacy curtain. However, in over one-quarter (8 out of 28) of all outpatient clinics that we observed where this requirement was applicable, at least one examination room where women veterans could be asked to disrobe was missing a privacy curtain. Additionally, in many exam rooms where privacy curtains were present, the curtains were positioned in a way that did not adequately shield adjustable exam tables. Figure 2 (right) shows an example of an examination room we inspected that was missing a privacy curtain.[32] In addition, the examination room

[32]The upper left hand corner of the figure shows the upper portion of the curtain, which connects to the ceiling track, but the bottom portion, which provides the layer of privacy for the patient, is not present.

featured an adjustable exam table placed with the foot facing the door. Both of these are inconsistent with VHA policy.

Figure 2: Examples of Examination Rooms For Women Veterans at Department of Veterans Affairs Medical Centers (VAMC)

Privacy curtain present and adjustable exam table faces away from the door.

Privacy curtain not present and adjustable exam table faces the door.

Source: GAO. | GAO-17-52

Notes: We collected this information during site visits to VAMCs from December 2015 through March 2016. For the incorrect example, the upper left hand corner of the figure shows the upper portion of the curtain, which connects to the ceiling track, but the bottom portion, which provides the layer of privacy for the patient, is not present.

- **Sanitary products not available in all women's restrooms.** According to VHA policy, sanitary napkins and tampons must be made available in all women's restrooms. However, in over half (40 out of 69) of all women's restrooms that we inspected across the six selected VAMCs, there were no sanitary napkins or tampons provided. One facility official stated that she places sanitary products only in the restrooms that are most frequently used by women, but this is inconsistent with VHA policy.
- **Unrestricted access to examination and procedure areas.** According to VHA policy, access to clinic examination and procedure areas must be limited only to authorized clinic staff and patients with appointments. However, 38 percent (15 out of 39) of the examination and procedure areas that we observed across the selected VAMCs either had unlocked doors that allowed for unrestricted access or were adjacent to other unrestricted clinic

hallways, potentially allowing non-clinic staff or individuals that are not patients into the exam area.

- **Inpatient setting.** The only instances of noncompliance that we observed in inpatient units were the following:
  - Two out of the 12 units we visited did not have privacy curtains available in every examination room.
  - While visiting one unit, we observed a staff member entering a patient room without knocking.
- **Residential treatment programs.** The only instances of noncompliance that we observed in residential treatment programs were the following:
  - One out of the seven programs we visited did not have appropriate private space for women veterans to visit with children.
  - While visiting one program, we observed a staff member entering a patient room without knocking.

VHA's Oversight Processes Do Not Consistently Identify or Address Noncompliance Due to Weaknesses in Environment of Care Rounds and Related Policies

We found weaknesses in VHA's oversight processes of the environment of care rounds and related policies. Specifically, we identified the following weaknesses:

- **Environment of care rounds not always conducted in a thorough manner.** VHA requires all patient care areas in a medical facility to be inspected twice per fiscal year. According to an official at one facility, when environment of care rounds are conducted at a time of day when care is being provided, the rounds team will not inspect examination rooms and other areas that are being used. As a result, the environment of care rounds team may not inspect every room in a facility twice per fiscal year, as required. Additionally, we found that the checklist—which was developed by an environment of care field advisory committee and is used across VAMCs to conduct the environment of care rounds—lists only 22 requirements for the environment of care, while VHA's women's health handbook contains 46 requirements.[33] For example, the checklist does not require inspection teams to examine whether clinical procedure and testing areas have auditory privacy. In our review of the six selected VAMCs, we found that all six exhibited noncompliance with women's health

[33]VHA Handbook 1330.01, *Health Care Services for Women Veterans.*

handbook requirements that are not included on the environment of care rounds checklist.

- **Responsibility for addressing noncompliance not always clear.** At three of the selected VAMCs we visited, facility staff were unable to identify the medical center department, such as engineering or building maintenance, responsible for correcting identified instances of noncompliance with certain environment of care policies. Without clearly delineated roles and responsibilities, instances of noncompliance are not addressed in a timely manner. For example, at one selected VAMC, we observed a privacy curtain missing from a primary care exam room. The provider who uses this room explained that she reported this noncompliance to the facility's maintenance department but was told that the replacement of the curtain was not the responsibility of the maintenance department. When we spoke with the provider, it had been 6 months since she had reported the noncompliance, and the issue had still not been addressed. Furthermore, this instance of noncompliance was also among those that the VAMC had not reported to VHA Central Office.
- **No systematic process to verify that medical facilities conduct thorough reviews and fully report noncompliance issues**. VHA Central Office does not have a systematic process to independently verify the compliance information it receives from VAMCs. According to an agency official, VHA is largely dependent on the environment of care rounds coordinator at each facility to report information on instances of noncompliance to VHA by entering this information into VHA's data system. However, VHA does not verify the accuracy and completeness of this information. VHA Central Office officials told us that they do conduct periodic site visits to VAMCs to review the work done by facilities' maintenance departments, and that one component of these reviews is examining the VAMCs' compliance with environment of care standards. According to VHA officials, only 4 of these visits were conducted in fiscal year 2015, and 9 of the 12 visits scheduled for fiscal year 2016 were conducted by June 2016. In addition, the sites to be reviewed are not selected randomly but instead are selected based on a request from VAMC or VISN leadership.[34]

[34]According to VHA officials, sites are usually chosen for review based on a request from the site itself or from VISN leadership as a proactive measure to gauge strengths and weaknesses and to obtain guidance on how to improve.

In our 2010 report, we found similar problems with data accuracy and a lack of clarity in delegated responsibilities.[35] Specifically, none of the medical facilities we visited had fully reported their noncompliance, and we recommended that the agency establish a process to independently validate facilities' self-reported compliance with environment of care requirements for women veterans. At the time, VA agreed with our recommendation, and agency officials told us that VHA Central Office directed VAMCs to report, on a quarterly basis, information on their noncompliance with the environment of care standards. Agency officials also told us that VHA Central Office directed VISNs to verify this information by conducting separate environment of care rounds as part of the VISNs' oversight of VAMCs. However, our current findings suggest that there are weaknesses in the operational effectiveness of these actions. Additionally, according to VHA Central Office officials, as of July 2016, VISNs are not conducting these rounds and verifying the extent of compliance among VAMCs. We have previously expressed significant concerns about inadequate oversight and accountability within VA, including that VHA's oversight efforts have been impeded by the agency's reliance on facilities' self-reported data, which lack independent validation and are often inaccurate or incomplete.[36]

This failure to verify reported information is inconsistent with federal internal control standards for monitoring, which call for management to establish activities to monitor the quality of performance over time and promptly resolve the findings of audits and other reviews.[37] Additionally, the lack of thorough inspections and of clearly delegated responsibilities is also inconsistent with federal internal control standards for control environment, which require management to establish an organizational structure, assign responsibility, and delegate authority to achieve agency objectives and to evaluate performance and hold individuals accountable for their internal control responsibilities. By not acting in accordance with federal internal control standards, VHA does not have reasonable assurance that its facilities are meeting the agency's standards when delivering care to women veterans.

[35]See GAO-10-287.

[36]See GAO, *VA Health Care: Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care*, GAO-14-808 (Washington, D.C.: September 30, 2014).

[37]See GAO-14-704G.

While the Number of VHA Gynecologists and Women's Health Primary Care Providers Has Increased Overall, Availability Was Limited in Some Locations

The Number of VA Gynecologists Has Increased Over Time, but More than a Quarter of VAMCs and VA Health Care Systems Did Not Have an Onsite Gynecologist

Our analysis of VHA data shows that the number of VHA gynecologists increased about 3 percent nationally from fiscal year 2014 to fiscal year 2015. Specifically, in fiscal year 2014, there was the equivalent of about 75 full-time gynecologists, and in fiscal year 2015, the number increased to the equivalent of about 77 full-time gynecologists.[38] While the increase in gynecologists exceeded the rate at which women veterans enrolled in VA's national health care system for the same time period, it remains unclear whether the number of current VHA gynecologists is sufficient to meet demand and whether the distribution of these gynecologists across VA medical facilities is optimal.[39] Thirty-nine of 145 VAMCs or VA health care systems in fiscal year 2015 (about 27 percent) did not have an

[38]These data reflect only the clinical time that gynecologists spent seeing patients. In addition, many gynecologists do not work full time at VA medical facilities, indicating that the count of VHA gynecologists is higher than the number of full-time employee equivalents. While VHA gynecologists may have been trained in obstetrics, VA medical facilities do not provide obstetrical care, that is, care related to the delivery of babies. As of August 2016, two VA health care systems offer prenatal care.

[39]From fiscal year 2014 to fiscal year 2015, the number of women veteran enrollees increased about 1 percent, from about 670,000 to about 680,000. VHA medical appointment wait times may be one indicator of demand. We did not examine wait times data because we have previously found issues related to their reliability. See GAO, *VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care*, GAO-16-328 (Washington, D.C.: Mar. 18, 2016); *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, GAO-16-24 (Washington, D.C.: Oct. 28, 2015); GAO-14-808; and *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012). According to a VHA official, some VA medical facilities without an onsite gynecologist may provide telemedicine gynecology through a gynecologist based at a neighboring VA medical facility.

onsite gynecologist. VHA Central Office officials said that, based on workload, not all VA medical facilities need an onsite gynecologist, and women veterans may receive necessary gynecological services through a care in the community program.[40]

At facilities where onsite gynecology was available, the number of VHA gynecologists available to treat women veterans varied. In fiscal year 2015, the number of full-time equivalent gynecologists (for VAMCs or VA health care systems that had them) ranged from 3.18 (Gainesville, Florida) to 0.02 (Dayton, Ohio), which corresponds to less than 1 hour per week. VA data also show that the number of completed gynecology appointments increased across VA, from about 81,000 in fiscal year 2014 to about 85,000 in fiscal year 2015—an increase of about 5 percent. The increase in completed gynecology appointments suggests a greater overall utilization of gynecology services in VA medical facilities. (See appendix IV for more information on the number of full-time equivalent gynecologists by VISN and the number of completed gynecology appointments by VISN.)

The Number of VHA Women's Health Primary Care Providers Has Increased Over Time, but Almost One-Fifth of VA Clinics Offering Primary Care Lacked Such a Provider

Our analysis of VHA data indicates that the number of women's health primary care providers increased by almost 15 percent from fiscal year 2014 through fiscal year 2015. Specifically, in fiscal year 2014, there were 2,130 providers, and in fiscal year 2015, there were 2,439 providers.[41] The increase in providers significantly outpaced the increase in women veteran enrollment (1 percent) during the same time period. In addition, VHA data show that the number of completed women's health appointments increased across VHA, from about 304,000 in fiscal year 2014 to about 331,000 in fiscal year 2015—an increase of about 9 percent.

[40]We contacted eight locations that did not have an onsite gynecologist, according to the data, and received responses from five locations. Women veterans program managers from two of the five locations said their facilities continued to lack an onsite gynecologist as of August 2016 because the demand for such services did not warrant an onsite provider. According to the women veterans program managers, these facilities typically refer women veterans to neighboring VA medical facilities, or to Choice or another care in the community program.

[41]This is a count of women's health primary care providers and does not reflect their clinical availability to see patients.

VHA data show that a women's health primary care provider was available to see veterans about 31 clinical hours per week, on average, at the end of fiscal year 2015.[42] However, that availability included any clinical time women's health primary care providers spent seeing male veterans.[43] Because women's health primary care providers see both men and women, according to VHA, it is highly likely that a typical women's health primary care provider was available for less than 31 hours per week to see women veterans. When VHA adjusted clinical availability data by the proportion of women veterans seen for primary care at each VA medical facility, the data show that a women's health primary care provider's availability was estimated at about 6 hours per week, on average, at the end of fiscal year 2015.[44] Fiscal year 2015 was the first year for which VHA collected and validated data on the clinical availability of women's health primary care providers, and according to VHA officials, the data are considered preliminary and not yet robust enough to compare with the demand for services.[45]

Despite the increase in providers nationally, VHA data show that 17 percent of VA community-based outpatient clinics that provide primary care and 3 percent of VAMCs or VA health care systems lacked a

[42]According to VHA, primary care clinics, including women's health clinics, run in half-day clinic sessions (made up of 4 clinical hours), with two half-day clinic sessions making up a full-day clinic session (8 clinical hours). In any given week, the maximum number of clinic sessions is 10 and the maximum number of clinical hours is 40.

[43]According to VHA policy, the panel of a women's health primary care provider should have at least 10 percent women. VHA has established a baseline panel size of 1,200 patients for its primary care physicians. Nurse practitioners and physician assistants are generally assigned a panel of patients that is 75 percent of the physician panel size. To account for the unique needs of women veterans during appointments, VHA recommends that women's health primary care providers' panels be reduced by the number of unique patients equal to 20 percent of the total number of women veterans in the panel.

[44]This calculated estimate assumes that a women's health primary care provider sees women veterans proportionate to the number of women seen for primary care (traditional primary care or a women's health clinic) at a given VAMC or VA health care system.

[45]Whether the clinical capacity of women's health primary care providers at a VA medical facility is sufficient depends, in part, on the number of women veterans enrolled at a VA medical facility and the full-time employee equivalency of those providers. A VHA official said a clinical capacity goal for a women's health primary care provider would be approximately 40 clinical hours for every 1,000 women veterans, or the equivalent of one full-time provider with a full panel size.

women's health primary care provider at the end of fiscal year 2015.[46] Specifically, 151 out of 881 outpatient clinics that provide primary care and 4 out of 155 VAMCs lacked a women's health primary care provider at the end of fiscal year 2015.[47] (See appendix V for more information on the number of outpatient clinics that provide primary care lacking a women's health primary care provider.) At least 1 of the 4 VAMCs lacking a women's health primary care provider also lacked an onsite gynecologist based on VHA fiscal year 2015 data.[48]

The fact that nearly 18 percent of VAMCs and outpatient clinics providing primary care lacked a women's health primary care provider in fiscal year 2015 suggests that VHA may face challenges ensuring that all women veterans have timely access to these providers, as required under VHA policy.[49] Specifically, each VA medical facility must ensure that eligible women veterans have access to comprehensive medical care that is comparable to care provided to male veterans, and veterans should not wait more than 30 days from either the date an appointment is deemed clinically appropriate by a VA provider or, if no such clinical determination has been made, the date a veteran prefers to be seen for care. A VHA official told us that if a women's health primary care provider is not available at a veteran's local facility, women veterans can seek sex-specific care at other VA medical facilities, though in these cases women veterans may face longer wait times and potentially longer driving

[46]VHA also monitors the percentage of women veterans assigned to women's health primary care providers. The percentage of women veterans assigned to women's health primary care providers has increased nationally from 68 percent in fiscal year 2014 to about 70 percent in fiscal year 2015, representing a percentage point increase of about 2 percent. This increase can be explained, in large part, due to automatic assignment of new women veteran enrollees to women's health primary care providers. According to VHA officials, the overall goal is assignment of 85 percent of women veterans to these providers. VA officials said they do not expect 100 percent of women veterans to be assigned to women's health primary care providers because previously enrolled women veterans may prefer to stay with their existing primary care provider and receive sex-specific care separately from a women's health primary care provider, if desired.

[47]These VAMCs are located in Perry Point, Maryland; St. Louis (John Cochran), Missouri; San Antonio, Texas; and, Fort Meade, South Dakota.

[48]The Fort Meade, South Dakota VAMC had no gynecology full-time equivalents. In addition, as of February 2016, the Perry Point, Maryland VAMC did not have an onsite gynecologist, according to facility data.

[49]*See* VHA Handbook 1330.01, *Health Care Services for Women Veterans* and VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*.

distances.[50] Eligible women veterans may also receive care through Choice or another care in the community program.

In our interviews with VHA officials, they acknowledged a shortage of women's health primary care providers at VA medical facilities. A VHA official told us that facilities have difficulty recruiting and retaining primary care providers who are interested and proficient in caring for women veterans, particularly in rural areas. According to an agency memo, VHA needs at least 675 additional women's health primary care providers, under a guiding principle that each VA medical facility—VAMCs and community-based outpatient clinics—should have, at a minimum, two women's health primary care providers. In addition, according to the agency memo, VA medical facilities with 2,000 or more women veteran enrollees should have the equivalent of an additional one full-time women's health primary care provider for every 1,000 women veteran enrollees or fraction thereof. According to the memo, these providers do not all have to be new hires, but could be drawn from VHA's existing pool of primary care providers and trained to provide sex-specific care. According to VHA, existing providers may participate in a VHA-sponsored women's health training to become women's health primary care providers, unless providers already possess the necessary training and experience.[51]

While VHA has taken steps to hire and train additional women's health primary care providers, these efforts have not yet yielded a sufficient number of such providers. According to VHA, as of August 2016, using funding from the Veterans Access, Choice, and Accountability Act of 2014, VHA had hired 45 women's health-specific providers, including 11 gynecologists, since September 30, 2015.[52] However, due to subsequent turnover in staff as well as growth in the demand for services, VHA reported that the number of women's health primary care providers needed to meet VHA's criteria of a minimum of two per VA medical facility has remained approximately the same. A VHA official told us that the

[50]See GAO-16-328; GAO-16-24; GAO-14-808; and GAO-13-130.

[51]According to VHA policy, providers who had seen female patients in a sufficient volume in previous and recent work experiences would be exempt from VHA training and could be designated as women's health primary care providers.

[52]In addition, under the Veterans Access, Choice, and Accountability Act of 2014, VHA hired 3,532 primary care medical professionals since September 30, 2015, according to officials. This number includes physicians (469), physician assistants, and nurses.

agency has a plan to train existing VHA providers so that there will be at least 500 additional women's health primary care providers in fiscal year 2016. According to VHA documents, 305 providers attended the agency's national training program in the spring and summer of 2016, and a VHA official said an additional 230 providers will be trained by the end of fiscal year 2016 at nine different VA locations across the country.

While the Number of Obstetricians and Gynecologists Participating in Choice Networks Has Increased, VHA Does Not Have Performance Measures for Monitoring Access to Sex-Specific Care under Choice

Obstetricians and Gynecologists Participating in Choice Networks Have Increased Nationally, though Some Geographic Areas Lack These Types of Providers

Our analysis of VHA data show that the number of obstetricians and gynecologists participating in Choice networks nationally increased significantly from about 6,200 in May 2015 to 10,100 in May 2016, an increase of about 64 percent.[53] While the number of obstetricians and gynecologists increased, some geographic areas lacked these types of providers, which provided access challenges for women veterans seeking care. For example,

- our analysis of VHA data for VISN 19 indicated that as of May 2016, there were almost 33 percent more community obstetricians and gynecologists participating in Choice (615) compared to the number of

[53]VHA data on the number of women veterans authorized under Choice for obstetrical and gynecological services are not readily available due to limitations of VHA's electronic health record and due to differences in how the TPAs counted authorizations.

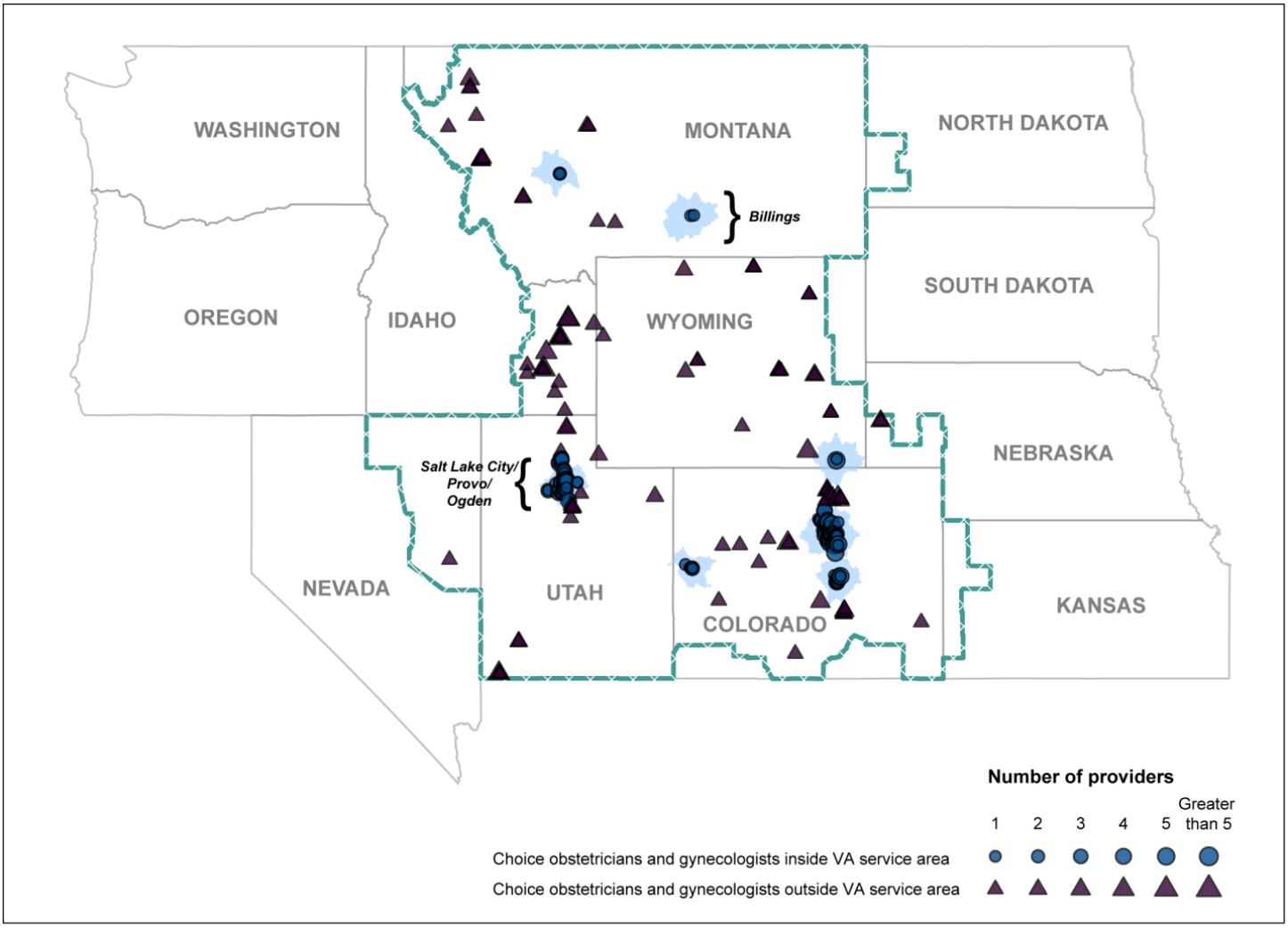
these providers (464) who delivered care to women veterans through individually authorized care prior to the implementation of Choice in fiscal year 2014.[54] However, according to a VHA analysis of VISN 19 based on May 2016 data, certain areas within VISN 19 lacked these providers. (See fig. 3).[55] Specifically, VHA's analysis found that two VA medical facilities in Montana offered gynecology services, and there were no VHA or Choice obstetricians and gynecologists located north and east of Billings, Montana.[56] Parts of central Utah also lacked VHA or Choice obstetricians and gynecologists. The Salt Lake City/Provo/Ogden area was the only area in Utah that offered VHA gynecology services, and Choice providers were also concentrated in this area. According to the analysis, the areas lacking Choice obstetricians and gynecologists generally had fewer veterans (male and female) relative to other areas of these states.

[54]In fiscal year 2015, VISN 19 included most of Montana, Wyoming, and Colorado; Utah; and parts of Idaho, Nevada, North Dakota, Nebraska, and Kansas. About 67 percent of Choice obstetricians and gynecologists were within VA medical facility service areas where gynecology was available through VA, suggesting, in theory, that 33 percent were extending potential access to veterans living outside of VHA's gynecology service areas. From fiscal year 2014 through fiscal year 2016, women veteran enrollment in VISN 19 increased by about 5 percent.

[55]Carey, Evan; Paula Langner and Michael Ho. " VACA Spatial Evaluation of Specialty Care Relevant to Female Veterans: Quantitative Results (Version 2, updated 5/16/2016)."

[56]According to VHA, VA medical facilities do not provide obstetrical care, that is, care related to the delivery of babies. As of August 2016, two VA health care systems offer prenatal care.

Figure 3: Location and Concentration of Veterans Choice Program (Choice) Obstetricians and Gynecologists as of May 2016 and Department of Veterans (VA) Locations Providing Gynecology as of September 2015, Veterans Integrated Service Network (VISN) 19



Source: VA and GAO. | GAO-17-52

Notes: VISNs are regional networks containing individual VA medical centers (VAMC) or groups of VAMCs, known as health care systems. VISNs oversee the day-to-day functions of VA medical facilities within their boundaries. VA service areas are roughly the 40 miles surrounding a VA medical facility. Urban areas indicated are approximate. While the Choice provider data used are from fiscal year 2016, the boundaries of VISN 19 as depicted are as of fiscal year 2015. VA is currently in the process of reorganizing its VISNs. By the end of fiscal year 2018, VISN 19 is expected to contain

most of Montana, Wyoming, Colorado, and Oklahoma; Utah; and parts of Idaho, Nevada, Nebraska, and Kansas.

- Our analysis of VA data for VISN 10 showed that there were 4 percent fewer non-VA community obstetricians and gynecologists participating in Choice as of May 2016 (431) than there were providers who delivered care to women veterans through individually-authorized care prior to the implementation of Choice (451).[57] According to a VHA analysis of VISN 10 based on May 2016 data, 15 percent of Choice obstetricians and gynecologists in VISN 10 are located outside of VHA's gynecology service areas—the roughly 40 miles surrounding a VA medical facility—suggesting that most Choice obstetricians and gynecologists in VISN 10 are not extending significant access to veterans living outside of VHA's gynecology service areas.

VHA Does Not Have Performance Measures for Monitoring Access to Sex-Specific Care under Choice

VHA lacks performance measures for the availability under Choice of sex-specific care, such as mammograms, maternity care, or gynecology. In contrast, for another VA care in the community program, PC3—a program that the Choice TPAs also administer—VHA has performance measures to evaluate women veterans' access to mammography and maternity care, sex-specific services that are not routinely provided at most VA medical facilities.[58] Specifically, as part of PC3, VHA monitors women veterans' driving distances to obtain mammograms and maternity care services as a measure of network adequacy.[59] One VHA official responsible for monitoring the TPAs' performance on Choice contract requirements told us that the PC3 performance measures specific to sex-

[57]In fiscal year 2015, VISN 10 included most of Ohio and parts of Indiana and Kentucky. From fiscal year 2014 through fiscal year 2016, women veteran enrollment in VISN 10 decreased by almost 1 percent.

[58]VHA awarded contracts in September 2013 to Health Net Federal Services and TriWest Healthcare Alliance to administer PC3. These contracts required each TPA to develop a regional network of providers, including physicians, to deliver care to veterans when care cannot be delivered at a VA medical facility, among other reasons. VHA modified the PC3 contracts it had previously awarded to these TPAs in 2014 to implement Choice.

[59]In addition, under PC3, VHA monitors the driving time all veterans experience to access care. According to a VHA document, the network adequacy standard to enable access is a maximum commute time of 45, 100, and 180 minutes for urban, rural, and highly rural dwellers, respectively.

specific care were simply overlooked in the haste to implement Choice.[60] VHA could monitor driving distances for women veterans to receive mammograms and maternity care services delivered through Choice, as the TPAs currently collect these data as part of PC3, according to VHA officials.

While VHA doesn't have performance standards for sex-specific care under Choice, it does have performance standards for all care delivered through Choice. For example, VHA's contracts with the two TPAs require the timely scheduling and completion of appointments, and VHA also monitors the rates at which the TPAs return Choice authorizations to VHA medical facilities without appointments. However, VHA data show that the TPAs did not meet VHA's performance standards for providing timely access for veterans, including women veterans.[61] See table 2 for TPA average monthly performance under Choice for certain access-related performance measures.

Table 2: Veterans Choice Program Third-Party Administrator (TPA) Average Monthly Performance on Select Veterans Health Administration (VHA) Access-Related Performance Measures, August 2015-May 2016

Percentage

VHA Performance Measure	TPA 1	TPA 2	VHA Performance Standard
Routine appointments scheduled within 5 days	70	69	100
Urgent appointments scheduled within 48 hours	47	49	N/A[a]
Routine appointments taking place within 30 days	82	70	90 or greater

[60]In August 2014, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, which created Choice. The act required VA to issue interim final regulations on the implementation of Choice within 90 days of enactment, and VHA began referring veterans to Choice in November 2014. VHA officials also said that after reviewing information from sources such as veteran surveys and feedback from regional VA business improvement managers, they did not think driving time for women veterans to mammography and maternity care appointments was a concern.

[61]In response to these issues, VHA has directed the TPAs to submit action plans detailing the steps they will take to improve veterans' access to care. Additional evaluation of TPA performance and VHA oversight of Choice is being further examined in an ongoing GAO review, due to be released in the late winter of 2017.

Percentage			
VHA Performance Measure	**TPA 1**	**TPA 2**	**VHA Performance Standard**
Urgent appointments taking place within 48 hours	14	24	100[b]
Authorizations that are unable to be fulfilled and are returned to VHA[c]	4	4	2 or less

Source: GAO analysis of VHA data. | GAO-17-52

Notes: Since the Veterans Choice Program was implemented, contract requirements have been modified over time. The measures and standards listed in this table are as of May 2016.

[a]According to a VHA official, effective June 2016, VHA established a performance standard of 97.5 percent for this measure.

[b]According to a VHA official, effective June 2016, VHA modified this performance standard to 97.5 percent.

[c]According to a VHA official, the TPAs count authorizations that are returned for the following reasons: (1) no network provider was available for the requested service; (2) the provider requested by VHA or the veteran was outside of the network; (3) the veteran declined the provider because the provider was outside of established commute standards; (4) VHA requested a return because of TPA inactivity; (5) the veteran was scheduled with the incorrect provider or type of care.

If VHA monitored access to sex-specific Choice care for women veterans, it is possible that delays in care would be identified and actions could be taken to minimize future occurrence. For example, if VHA were monitoring sex-specific Choice care, it might have identified the three cases of delayed maternity care through Choice we found as part of an ongoing review of 196 Choice authorizations for care (of both men and women) from early calendar year 2016. In one case, almost a month and a half elapsed from the time of the veteran's initial pregnancy confirmation appointment at VA (when she was 6 weeks pregnant) to when the Choice authorization was sent by the VA facility to the TPA for scheduling. It then took two additional weeks for the TPA to attempt to schedule a prenatal appointment; by that point, she was almost 15 weeks pregnant. At 18 weeks pregnant, she finally scheduled her initial prenatal appointment herself, almost 3 months after her pregnancy was confirmed at VHA. In another case, about a week and a half elapsed from the time the veteran's Choice authorization was created (when she was 6 to 7 weeks pregnant) to when the VA facility sent it to the TPA for scheduling. It then took the TPA nearly a month to reach the veteran and determine if she wanted to participate in Choice. After the veteran agreed to participate in Choice, it took more than 2 weeks for the TPA to schedule an appointment. The veteran was about 14 weeks pregnant by the time her first appointment was scheduled.

Federal standards of internal control for monitoring call for management to establish activities to monitor the quality of performance over time and promptly resolve the findings of audits and other reviews. VHA does not currently have performance measures for sex-specific care under Choice. While VA does monitor access to Choice care for all veterans, the past performance of TPAs on access-related measures highly suggests that veterans have problems obtaining timely access to these services as required under Choice. Since women are more likely to use non-VA care than male veterans, according to VHA, the lack of timely access to Choice care may affect women veterans more so than male veterans. In addition, we found instances where women veterans' care under Choice was significantly delayed and we found a lack of participating obstetricians and gynecologists in some areas, both of which further underscore the importance of VHA's ability to monitor access to sex-specific care for women veterans. Without performance measures, VHA does not have reasonable assurance that women veterans can obtain timely access to sex-specific care.

Conclusions

Our review shows that, despite some progress since 2010, VHA still has a significant problem ensuring that its medical facilities are complying with VHA's environment of care requirements, which are intended to protect the privacy, safety, and dignity of women veterans when they receive care. This lack of oversight reflects long-standing weaknesses in the policies and guidance for the environment of care rounds inspections process, including how data is collected by facility staff and what information is reported to VHA Central Office. For example, facility staff do not inspect all applicable areas within the facility and the list of requirements they inspect does not include all requirements in the VHA women's health handbook. In addition, responsibilities for addressing noncompliance are not clearly delegated, and VHA does not verify the noncompliance information it receives from its facilities. These weaknesses are similar to those we identified in our 2010 report, and the problems have persisted even though VHA agreed with our previous recommendations to strengthen oversight of its environment of care standards. These findings further underscore the agency's continued lack of adequate oversight and accountability, which resulted in our adding VA health care to our High Risk List in 2015.[62] If VHA does not strengthen its environment of care inspections policies, it will remain unable to provide

[62]See GAO-15-290.

reasonable assurance that it is protecting the privacy, safety, and dignity of women veterans who receive care at VA medical facilities.

Our review also suggests that VHA faces challenges ensuring that women veterans have access to sex-specific care at its own medical facilities and through community providers participating in Choice. VHA has acknowledged that there are an insufficient number of women's health primary care providers across the national health system, and some services, such as mammography, maternity care, and gynecology, are not offered at many VA medical facilities. To the extent that VA medical facilities cannot deliver sex-specific services, women veterans will need to receive these services through Choice or other care in the community programs. However, VHA does not monitor access for women to sex-specific care through Choice. Unless VHA establishes performance measures that monitor access to sex-specific services, VHA will not have reasonable assurance that women veterans have adequate access to these services.

Recommendations for Executive Action

To improve care for women veterans, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

- Strengthen the environment of care inspections process and VHA's oversight of this process by expanding the list of requirements that facility staff inspect for compliance to align with VHA's women's health handbook, ensuring that all patient care areas of the medical facility are inspected as required, clarifying the roles and responsibilities of VA medical facility staff responsible for identifying and addressing compliance, and establishing a process to verify that noncompliance information reported by facilities to VHA Central Office is accurate and complete.
- Monitor women veterans' access to key sex-specific care services—mammography, maternity care, and gynecology—under current and future community care contracts. For those key services, monitoring should include an examination of appointment scheduling and completion times, driving times to appointments, and reasons appointments could not be scheduled with community providers.

Agency Comments

We provided a draft of this report to VA for review and comment. While VA was reviewing a draft of this report, the agency requested further

clarification on the scope of our second recommendation; as a result, we revised the recommendation to be more clear and specific. In its written comments, which are reproduced in appendix I, VA concurred with our recommendations. VA stated it will charter a workgroup to examine issues related to VA facility compliance with environment of care requirements for women veterans. VA also said it is focused on providing community care to all eligible veterans and will ensure that future community care contracts incorporate areas for improvement based on lessons learned. VA also provided technical comments, which we incorporated as appropriate.

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

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

Randall B. Williamson
Director, Health Care

List of Congressional Requesters

The Honorable Johnny Isakson
Chairman
The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
The Honorable Mark Takano
Acting Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Dean Heller
United States Senate

The Honorable John McCain
United States Senate

The Honorable Corrine Brown
House of Representatives

The Honorable Mike Coffman
House of Representatives

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

November 15, 2016

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: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans"*** (GAO-17-52).

The enclosure provides our general and technical comments and sets forth the actions to be taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans"
(GAO-17-52)

GAO Recommendation: To improve care for women veterans, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

Recommendation 1. Strengthen the environment of care inspections process and VHA's oversight of this process by expanding the list of requirements that facility staff inspect for compliance to align with VHA's women's health handbook, ensuring that all patient care areas of the medical facility are inspected as required, clarifying the roles and responsibilities of VA medical facility staff responsible for identifying and addressing compliance, and establishing a process to verify that noncompliance information reported by facilities to VHA Central Office is accurate and complete.

VA Comment: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability). Strengthening the environment of care inspections process and improving oversight of this process will allow the Veterans Health Administration (VHA) to ensure Veterans Affairs Medical Centers (VAMC) comply with requirements related to the environment of care for women Veterans as well as increase VHA's oversight of VAMCs compliance with the requirements.

VHA is committed to strengthening oversight and accountability across VHA's facilities. In response to this recommendation, the Deputy Under Secretary for Health for Operations and Management will charter a workgroup to address Recommendation 1 of this GAO report. The charter will designate a responsible program office to lead the workgroup and will require membership that includes, at minimum, representation from VHA's Women's Health, Environmental Programs Service, and Veterans Integrated Service Networks.

The estimated timeframe for the workgroup to complete aligning the environment of care requirements with VHA's women's health handbook; ensuring inspection of all patient care areas; clarifying roles and responsibilities; and addressing, reporting, and verifying non-compliances is approximately one year. Target Completion Date: November 2017.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Improved Monitoring Needed for Effective Oversight of Care for Women Veterans"
(GAO-17-52)

Recommendation 2. Monitor women veterans' access to care in the community providers for sex-specific care, such as mammography, maternity care, and gynecology. Monitoring access to sex-specific care could include examining appointment scheduling and completion times, driving times to appointments, or analyzing the reasons for unfulfilled authorizations of key services for women veterans.

VA Comment: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability). VHA is committed to ensuring women Veterans have adequate access to necessary sex-specific care in the community when not available from a VA facility. To this end, VHA is focused on providing community care to all eligible Veterans.

VHA's current Patient Centered Community Care/Choice contract requires the contractors to maintain an adequate network to ensure Veteran access to care. Measures of the contractors' performance include appointment scheduling timeliness, appointment scheduling within Veterans' clinically indicated date, and appointment distance. These measures apply to all types of community care, including sex-specific care such as mammography, maternity care, and gynecology. In addition to standard scheduling requirements for all Veterans regardless of type of care, the contract specifically requires access to these specialties within a maximum of 50 miles distance or a 60 minute commute (whichever is lesser) for the Veteran.

Finally, VHA will ensure that future community care network contracts incorporate areas for improvement based on lessons learned to provide for continued network adequacy and performance. Target Completion Date: July 2017.

Appendix II: Veterans Health Administration (VHA) Environment of Care Requirements Inspected by GAO

Table 3: Selected VHA Environment of Care Requirements Inspected by GAO for Compliance, 2015-2016

Outpatient Clinics	Inpatient Units	Residential Programs
Does the check-in clerk station have auditory privacy?	Is patient-identifiable information not visible in hallways?	Are client records not left unattended?
Are patient names not posted in public areas?	Are patient records not left unattended?	Are female bathrooms either private or lockable if accessible from unit hallways or other public spaces?
Are patient names not called out loudly?	When doors are closed, do staff knock and wait until they are invited to enter?	Are female bedrooms located in a separate and secured area of the unit or located near main staff offices or nursing stations?
Are sanitary napkin and tampon dispensers available in the women's public restrooms nearest to this clinic or unit?	Are privacy curtains present in all rooms (mental health units are exempt)?	Is there appropriate private space available for female veterans to visit with children?
Are disposal bins available in the women's public restrooms nearest to this clinic or unit?	Are rooms assigned either to only one client or to same-sex clients (except in facilities where spouses share rooms)?	When doors are closed, do staff knock and wait until they are invited to enter?
Are baby changing tables available in women's public restrooms nearest to this clinic or unit?	Do women patients have access to women-only toilet and shower facilities in close proximity to the patients' rooms?	Are rooms assigned either to only one client or to same-sex clients (except in facilities where spouses share rooms)?
Does the interview/intake area have auditory privacy?		Do women have door locks, access bar codes, or controlled access ID card scanners?
Is the access to hallways restricted for patients/staff not using or working in that clinic area?		
Is patient-identifiable information not visible in hallways?		
When doors are closed, do staff knock and wait until they are invited to enter?		
Do restrooms not open into a public waiting room or high traffic corridor?		
Are privacy curtains present in all examination rooms?		
Are examination tables placed with the foot facing away from the door?		
Do procedure and testing areas have auditory privacy?		
Is a women's restroom available within or in close proximity to this clinic?		
Are sanitary napkin and tampon dispensers available in the women's restroom nearest to this clinic?		
Are disposal bins available in the women's restroom nearest to this clinic?		

Outpatient Clinics	Inpatient Units	Residential Programs
Is special consideration given to privacy and dignity in gynecology?		
Is special consideration given to privacy and dignity in radiology dressing areas (e.g., mammography)?		
Is special consideration given to privacy and dignity in ultrasound, transvaginal ultrasound testing, etc.?		

Source: VHA Handbook 1330.01: Health Care Services for Women Veterans | GAO-17-52

Note: We developed a standardized data collection instrument with the above requirements to inspect for compliance on site visits to Veteran Affairs medical centers from December 2015 through March 2016.

Appendix III: Veterans Affairs Medical Center (VAMC) Compliance with Environment of Care Requirements

Table 4: Selected VAMC Compliance with Selected Veterans Health Administration (VHA) Requirements Related to the Outpatient Environment of Care for Women Veterans, December 2015-March 2016

Percentage							
	VAMC A	**VAMC B**	**VAMC C**	**VAMC D**	**VAMC E**	**VAMC F**	**Total**
Waiting areas							
Does the check-in clerk station have auditory privacy?	80	64	33	67	60	100	**65**
Are patient names not posted in public areas?	100	91	100	100	100	100	**98**
Are patient names not called out loudly?[a]	33	100	67	100	50	100	**84**
Are sanitary napkin and tampon dispensers available in the women's public restrooms nearest to this clinic or unit?	25	70	67	29	20	50	**47**
Are disposal bins available in the women's public restrooms nearest to this clinic or unit?	100	100	83	86	40	100	**86**
Are baby changing tables available in women's public restrooms nearest to this clinic or unit?	50	40	100	50	40	25	**51**
Patient examination and procedure areas							
Does the interview/intake area have auditory privacy?	100	83	100	100	100	100	**96**
Is the access to hallways restricted for patients/staff not using or working in that clinic area?	80	73	67	56	20	67	**62**
Is patient-identifiable information not visible in hallways?	100	91	100	100	100	100	**97**
When doors are closed, do staff knock and wait until they are invited to enter?[a]	100	100	67	75	100	n/a	**86**
Do restrooms not open into a public waiting room or high traffic corridor?	60	73	33	100	40	67	**65**
Are privacy curtains present in all examination rooms?	75	71	40	86	75	100	**71**

Percentage

	VAMC A	VAMC B	VAMC C	VAMC D	VAMC E	VAMC F	Total
Are examination tables placed with the foot facing away from the door?	50	83	100	83	67	50	**75**
Do procedure and testing areas have auditory privacy?	100	60	67	71	50	50	**66**
Is a women's restroom available within or in close proximity to this clinic?	100	100	83	100	100	100	**97**
Are sanitary napkin and tampon dispensers available in the women's restroom nearest to this clinic?	40	64	50	0	0	50	**36**
Are disposal bins available in the women's restroom nearest to this clinic?	80	91	50	67	60	50	**73**
Is special consideration given to privacy and dignity in gynecology?	n/a	100	100	100	100	n/a	**100**
Is special consideration given to privacy and dignity in radiology dressing areas (e.g., mammography)?	100	0	100	100	n/a	n/a	**83**
Is special consideration given to privacy and dignity in ultrasound, transvaginal ultrasound testing, etc.?	0	n/a	100	100	n/a	n/a	**67**
Total VAMC compliance	**74**	**79**	**72**	**76**	**59**	**76**	**74**

Source: GAO | GAO-17-52

Notes: We collected this information using a data collection instrument during site visits to VAMCs from December 2015 through March 2016. n/a indicates either that the requirement was not applicable to any units within the facility or that we were unable to observe the requirement in any of the facility units given the circumstances at the time of our inspection.

[a]At the time of our inspections, circumstances in the clinic environment may have precluded us from observing this requirement in every applicable instance. For example, some exam rooms or restrooms may have been occupied by patients at the time of our inspection, or some clinics may only be open on certain days of the week and were closed at the time of our inspection.

Table 5: Selected VAMC Compliance with Selected VHA Requirements Related to the Inpatient Environment of Care for Women Veterans, December 2015-March 2016

Percentage

	VAMC A	VAMC B	VAMC C	VAMC D	VAMC E	VAMC F	Total
Is patient-identifiable information not visible in hallways?	100	100	100	100	100	100	**100**
Are patient records not left unattended?	100	100	100	100	100	100	**100**
When doors are closed, do staff knock and wait until they are invited to enter?[a]	100	100	n/a	100	100	50	**89**
Are privacy curtains present in all rooms (mental health units are exempt)?	100	100	100	100	33	100	**83**
Are rooms assigned either to only one client or to same-sex clients (except in facilities where spouses share rooms)?	100	100	100	100	100	100	**100**
Do women patients have access to women-only toilet and shower facilities in close proximity to the patients' rooms?	100	100	100	100	100	100	**100**
Total VAMC compliance	**100**	**100**	**100**	**100**	**88**	**91**	**96**

Source: GAO | GAO-17-52

Notes: We collected this information using a data collection instrument during site visits to VAMCs from December 2015 through March 2016. n/a indicates either that the requirement was not applicable to any units within the facility or that we were unable to observe the requirement in any of the facility units given the circumstances at the time of our inspection.

[a]At the time of our inspections, circumstances in the clinic environment may have precluded us from observing this requirement in every applicable instance. For example, some exam rooms or restrooms may have been occupied by patients at the time of our inspection, or some clinics may only be open on certain days of the week and were closed at the time of our inspection.

Table 6: Selected VAMC Compliance with Selected VHA Requirements Related to the Residential Treatment Program Environment of Care for Women Veterans, December 2015-March 2016

Percentage

	VAMC A	VAMC B	VAMC C	VAMC D[a]	VAMC E	VAMC F	Total
Are client records not left unattended?	100	100	100	—-	100	100	**100**
Are female bathrooms either private or lockable if accessible from unit hallways or other public spaces?	100	100	100	—-	100	100	**100**
Are female bedrooms located in a separate and secured area of the unit or located near main staff offices or nursing stations?	100	100	100	—-	100	100	**100**
Is there appropriate private space available for female veterans to visit with children?	100	100	67	—-	100	100	**86**
When doors are closed, do staff knock and wait until they are invited to enter?[b]	100	100	100	—-	0	n/a	**83**
Are rooms assigned either to only one client or to same-sex clients (except in facilities where spouses share rooms)?	100	100	100	—-	100	100	**100**
Do women have door locks, access bar codes, or controlled access ID card scanners?	100	100	100	—-	100	100	**100**
Total VAMC compliance	**100**	**100**	**95**	**—-**	**86**	**100**	**96**

Source: GAO | GAO-17-52

Notes: We collected this information using a data collection instrument during site visits to VAMCs from December 2015 through March 2016. n/a indicates either that the requirement was not applicable to any units within the facility or that we were unable to observe the requirement in any of the facility units given the circumstances at the time of our inspection.

[a]There is no residential treatment program at VAMC D.

[b]At the time of our inspections, circumstances in the clinic environment may have precluded us from observing this requirement in every applicable instance. For example, some exam rooms or restrooms may have been occupied by patients at the time of our inspection, or some clinics may only be open on certain days of the week and were closed at the time of our inspection.

Appendix IV: Veterans Health Administration (VHA) Gynecologist Availability

Table 7: VHA Gynecologist Clinical Care Full-Time-Employee Equivalent (FTEE) per 1,000 Women Veteran Enrollees and Completed Gynecology Appointments, Nationally and by Veterans Integrated Service Network (VISN), Fiscal Years 2014 and 2015

	Clinical care FTEE per 1,000 women veteran enrollees			Completed gynecology appointments		
Location	Fiscal year 2014	Fiscal year 2015	Percent change (percent)	Fiscal year 2014	Fiscal year 2015	Percent change (percent)
VISN 1	0.09	0.11	26	2,288	2,636	15
VISN 2	0.10	0.14	38	1,130	1,339	18
VISN 3	0.19	0.26	36	4,215	4,553	8
VISN 4	0.12	0.12	0	2,354	2,131	-9
VISN 5	0.03	0.03	-9	1,116	1,169	5
VISN 6	0.09	0.11	19	7,474	8,912	19
VISN 7	0.07	0.09	33	6,922	7,632	10
VISN 8	0.22	0.22	0	14,284	14,167	-1
VISN 9	0.10	0.09	-14	2,874	3,285	14
VISN 10	0.26	0.15	-41	1,871	1,944	4
VISN 11	0.09	0.07	-21	2,557	2,405	-6
VISN 12	0.15	0.16	6	3,271	2,997	-8
VISN 15	0.05	0.09	89	1,285	1,579	23
VISN 16	0.10	0.07	-24	5,984	5,785	-3
VISN 17	0.06	0.05	-24	4,407	2,992	-32
VISN 18	0.08	0.07	-22	2,472	3,856	56
VISN 19	0.10	0.06	-38	2,977	3,563	20
VISN 20	0.08	0.05	-42	2,576	2,860	11
VISN 21	0.16	0.16	0	2,887	2,826	-2
VISN 22	0.14	0.15	6	6,246	6,750	8
VISN 23	0.05	0.06	16	1,809	1,914	6
Total	**0.11**	**0.11**	**-1**	**80,999**	**85,295**	**5**

Source: GAO analysis of VHA data. | GAO-17-52

Notes: VHA gynecologist clinical care FTEE data reflect only the clinical time that was spent seeing patients. Clinical care FTEE per 1,000 women veteran enrollees figures were rounded to 2 decimal places and percent change calculations were rounded to the nearest whole number. Some calculations may not add up due to rounding.

Appendix V: Veterans Affairs (VA) Clinics Without a Women's Health Primary Care Provider

Table 8: Number and Percentage of VA Community-Based Outpatient Clinics that Provide Primary Care Lacking a Women's Health Primary Care Provider and Women Veteran Enrollment, Nationally and by Veterans Integrated Service Network (VISN), Fiscal Year 2015

Location	Number (percentage) of clinics without a women's health primary care provider	Women veteran enrollment
VISN 1	7 (16)	20,109
VISN 2	6 (18)	12,093
VISN 3	4 (14)	14,791
VISN 4	10 (20)	25,479
VISN 5	4 (24)	29,908
VISN 6	2 (7)	54,568
VISN 7	9 (20)	62,690
VISN 8	10 (18)	54,296
VISN 9	15 (28)	27,190
VISN 10	3 (9)	19,839
VISN 11	2 (6)	23,544
VISN 12	0 (0)	21,094
VISN 15	12 (20)	22,049
VISN 16	5 (8)	58,278
VISN 17	5 (14)	47,707
VISN 18	8 (18)	30,791
VISN 19	5 (12)	24,593
VISN 20	13 (30)	35,241
VISN 21	11 (26)	27,317
VISN 22	4 (13)	38,919
VISN 23	16 (26)	24,353
Total	**151 (17)**	**678,517**

Source: GAO analysis of Veterans Health Administration data. | GAO-17-52

Note: Women veteran enrollment total includes enrollees not associated with a specific VISN.

Appendix VI: 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), Stella Chiang (Analyst-in-Charge), Carolyn Fitzgerald, Arushi Kumar, and Alexis MacDonald made key contributions to this report. Also contributing were Krister Friday, Jacquelyn Hamilton, Emily Wilson, and Vikki Porter.