
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-03303-206**

# Review of VHA Care and Privacy Standards for Women Veterans

**June 19, 2017**

**Washington, DC 20420**

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# Contents

# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate Veterans Health Administration's (VHA's) standards and care for women veterans upon receipt of a March 12, 2015 request from the following members of the House Veterans Affairs Committee of the 114th Congress: Ralph Abraham, Julia Brownley, Mike Coffman, Ryan Costello, Ann McLane Kuster, Beto O'Rourke, Kathleen Rice, Raul Ruiz, Mark Takano, Dina Titus, and Tim Walz. Specifically, we evaluated VHA's provision of care for women veterans, both general and gender-specific, the proficiencies of Designated Women's Health Providers (DWHPs), and VHA facilities' compliance with privacy standards for women veterans.

In response to Public Law 103-446, VHA has taken steps to meet the health care needs of the more than 1,578,000 women veterans who served in the U.S. military. This number accounts for more than 8.2 percent of the total veteran population. VHA projects this to increase to 15 percent of all living veterans by 2035. Public Law 102-585, Title I, authorizes VA to provide gender-specific care such as cervical and breast cancer screening, management of menopause, and general reproductive health care services to eligible women veterans.

In our analysis of VHA's provision of gender-specific care to women veterans, we found that 475,131 (82.5 percent) of these gender-specific care visits were performed at a VA facility while 100,789 (17.5 percent) of the visits were performed at a non-VA facility during FY 2014. We also noted that patients with pregnancy-related issues had the majority of their visits at non-VA sites rather than VA sites. This was the only subcategory of gender-specific care where we found this to be true.

We identified that as of September 2, 2015, there were 2,294 DWHPs. Some worked part-time, so that these 2,294 DWHPs represented the equivalent of 1,864.7 full time employees (FTEs). We found that 39.8 percent of those FTEs practiced at a VA medical facility, while 60.2 percent practiced in a VA community based outpatient setting.

Among the 2,294 DWHPs, 1,236 (53.9 percent) were shown to have women veteran populations of less than 10 percent of their total patient panel. We found that 547 of the 1,236 providers (44.3 percent) had documented proficiencies as required by VHA. We noted that VHA has appropriately identified those providers with a low percentage of women veterans as those who would need additional opportunities to maintain their practice skills; however, we could not verify that the provided documentation satisfied the proficiency requirements for all of these providers.

While VHA has defined various options to supplement experience for those providers with a small women veteran panel size, it is not clear whether such supplemental educational/experience opportunities are sufficient for proficiency. According to VHA, proficiency requirements would be considered satisfied if they managed a panel comprised of 50 percent or more women at any time in their practice outside VHA.

However, this option does not specify how remote that experience could be, nor does it address how a provider could verify the composition of his or her former patient panel.

VHA standards also allow proficiency to be assumed once a provider verifies completion of 20 continuing medical education hours specific to any women's health topic within the previous 3 years. Although this time frame requires providers to be more current in specific areas of WH than the previous guidance, whether this is sufficient for competency is unclear. Several alternative proficiency options remain vague in their wording and can lead to inconsistent interpretations and application of standards among DWHPs at different facilities.

We evaluated 93 CBOCs during FY 2014 and 56 CBOCs in FY 2015. We found that 20.4 percent of these representative clinics did not meet specific VHA requirements for protecting the privacy of women veterans in FY 2014. We continued to find lack of adequate privacy for women veterans in FY 2015, although some improvement was noted, as the percentage of CBOCs that did not meet privacy requirements for women declined from 20.4 percent to 14.3 percent. We issued recommendations for these clinics and corrective action plans were implemented. We have since closed all recommendations.

We recommended that the Acting Under Secretary for Health ensure that the Office of Women's Health Services routinely reviews and when appropriate, strengthens the requirements for women's health provider designation and facilitates the updating of requirements for all designated women health providers with supporting documentation that details how the requirements were satisfied.

**Comments**

The Acting Under Secretary for Health concurred with our recommendation and provided acceptable action plans. (See Appendix I, pages 23–26, for the full text of the comments.) We will follow up on the planned actions until they are completed.

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# Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate Veterans Health Administration's (VHA's) standards and care for women veterans upon receipt of a March 12, 2015 request from the following members of the House Veterans Affairs Committee of the 114th Congress: Ralph Abraham, Julia Brownley, Mike Coffman, Ryan Costello, Ann McLane Kuster, Beto O'Rourke, Kathleen Rice, Raul Ruiz, Mark Takano, Dina Titus, and Tim Walz. Specifically, we evaluated VHA's provision of care for women veterans, both general and gender-specific, the proficiencies of Designated Women's Health Providers (DWHP), and VHA facilities' compliance to privacy standards for women veterans.

# Background

VHA's mission initially focused primarily on health care for male veteran patients. VHA recognized that minimal services and a limited number of VHA providers with the necessary training and skills were available to deliver gender-specific care to women.[1] VHA is now challenged with healthcare system redesign to accommodate women veterans and meet the need for a vast array of gender-specific services. As a result, in 2010, VHA developed policies and processes to improve all aspects of primary care as it related to women veterans. The standard requirements for the delivery of health care to women veterans were updated in 2017.[2]

**VHA WH Services.** In response to Public Law 103-446, VHA has taken steps to meet the health care needs of the more than 1,578,000 women veterans in the United States.[3] This number accounts for more than 8.2 percent of the total veteran population.[4] VHA projects this to increase to 15 percent of all living veterans by 2035.[5]

Public Law 102-585, Title I, authorizes VA to provide gender-specific care, such as cervical and breast cancer screening, management of menopause, and general reproductive health care services to eligible women veterans.[6] It also mandates that a VHA official in each region serve as coordinator of women's services with specific responsibility for assessing the needs of and enhancing services for women veterans.

[1] VA, *Women Veteran Issues: A Historical Perspective*, 2014.
[2] VHA Handbook 1330.01, *Healthcare Services for Women Veterans*, May 21, 2010. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive has the same or similar language regarding development of policies and procedures to improve women veterans care.
[3] Public Law 103-446, *Section 509 Established the Center for Minority Veterans on November 2, 1994.* https://www.*Standards/role_and_authority_public_law_103_446_509.pdf*
[4] U.S. Census Bureau, 2016. *American FactFinder: 2014 American Community Survey 1-Year Estimates.* Retrieved February 12, 2016, from https://www.census.gov/acs/www/data/data-tables-and-tools/american-factfinder/.
[5] Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, November 23, 2011. *Military Service History and VA Benefit Utilization Statistics.*
[6] Public Law 102-585, *Summaries for the Veterans Health Care Act of 1992*, November 4, 1992. https://www.govtrack.us/congress/bills/102/hr5193/summary

The Office of WH Services (WHS), in the Office of Patient Care Services, is responsible for addressing the health care needs of women veterans by working to ensure that timely, equitable, high-quality, and comprehensive health care services are provided in a sensitive and safe environment at VHA facilities nationwide. The Office of WHS is divided into three major sections: Comprehensive Health, Education, and Reproductive Health. Each healthcare system has a Women Veterans Program Manager and a WH Medical Director/Champion responsible for overseeing the delivery of services to women veterans. Each veterans integrated service network (VISN) has a Women Veterans Program Manager VISN Lead responsible for coordinating WH programs across the VISN.[7]

Reproductive health care addresses the reproductive processes, functions and system at all stages of life and includes care related to infertility, specialty gynecology, maternity, menopause, urogynecology and gynecologic cancers. VA's goal is to ensure that all women veterans consistently receive the highest quality reproductive health services.[8] The Office of WHS has also developed a new Maternity Health Care and Care Coordination policy to decrease fragmentation of maternity care services.[9]

On May 21, 2010, VHA published VHA Handbook 1330.01, *Health Care Services for Women Veterans*, which included requirements designed to ensure the privacy of women veterans receiving care at VHA facilities. A review to evaluate structural, environmental, and psychosocial patient safety and privacy must be conducted on an annual basis and incorporated into routine environment of care (EOC) rounds. Each VHA facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for women veterans.[10]

For WH history and physical examinations, the Handbook requires that patient dignity and privacy be maintained at all times during the course of a physical examination. Privacy curtains must shield the actual examination area. Placement of the examination table needs to minimize inadvertent exposure of the patient during a physical examination; for example, the foot of the table must be facing away from the door. Examination room doors must have locks. Gowns, sheets, and other appropriate apparel must be available to protect the patient's dignity and avoid embarrassment. The patient must never be asked to disrobe in the provider's immediate presence.[11]

[7] VHA, Office of Women Health Services. *About Women's Health Services*. Retrieved November 16, 2015 from http://vaww.infoshare.va.gov/sites/womenshealth/whsra/prog/PROGHome.aspx.
[8] VHA, Office of Women Health Services. *About Women's Health Services*. Retrieved November 16, 2015 from http://vaww.infoshare.va.gov/sites/womenshealth/whsra/prog/PROGHome.aspx.
[9] VHA Handbook 1330.03, *Maternity Health Care and Coordination*, October 5, 2012.
[10] VHA Handbook 1330.01, p. 4. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans*, February 15, 2017. The 2017 Directive has the same or similar language regarding environment of care requirements.
[11] VHA Handbook 1330.01, p. 24. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01. The 2017 Directive has similar language regarding exam tables, locks, privacy curtains and gowns.

Appropriate draping techniques must be used during the breast and pelvic examination or during examinations or procedures when these areas are exposed. The provider must explain the necessity of a complete physical examination or the components being performed during the examination and the purpose of disrobing in order to minimize the patient's anxiety and possible misunderstandings. Following a physical examination, the provider must discuss any positive findings with the patient and provide the opportunity for questions. The patient must be fully dressed during this discussion.[12]

**DWHPs.** The DWHP has a critical role in ensuring the quality of care provided to women veterans. Providers with experience and interest in WH care issues, as well as a willingness to maintain a higher percentage of women veterans on their panels, are assigned to be DWHPs. They provide access to primary care, gender-specific care, and referrals to specialty care (such as cardiology, endocrinology, and orthopedic surgery) and mental health care in the context of continuous patient-clinician relationships.[13]

The DWHP serves within the Primary Care Clinics as a Patient Aligned Care Team leader.[14] In most clinics, this provider manages the primary care needs of male veterans assigned to his/her panel while women veterans are also preferentially assigned to the DWHP. Women veterans previously assigned to a non-DWHP have the option to transfer to a DWHP.[15] In 2017, VHA clarified this option to allow women veterans who are already assigned to providers who are not Women's Health Primary Care Providers to continue assignment with these providers due to veteran preference if appropriate arrangements are made for the women veterans to receive gender-specific care from another provider at the same site of care.[16]

Although the number of women veterans served by VA is growing, they remain a minority within the veteran population. This presents many challenges to VHA as it strives to ensure that all DWHPs have access to caring for enough women veterans to maintain proficiency. Women veterans have unique and often complex needs that demand their providers have certain training and skill sets in order to deliver the required care or more importantly recognize abnormal findings that require specialty level evaluations. Implementation of the most current standards of care requires that providers remain updated on the latest diagnostic and treatment methods available.

[12] VHA Handbook 1330.01, p. 25. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive has similar language regarding physical examination privacy.
[13] VHA Handbook 1330.01. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive uses the term Women's Health Primary Care Provider (WH-PCP) and clarifies designation and maintenance requirements.
[14] Maisel NC, Haskell S, Hayes PM, et al. Readying the Workforce: Evaluation of VHA's Comprehensive Women's Health Primary Care Provider Initiative, *Medical Care*. 2015; 53: S39-S46.
[15] VHA Handbook 1330.01. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive uses the term Women's Health Primary Care Provider (WH-PCP) and clarifies women veterans' assignment to a WH-PCP.
[16] VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017.

In 2010, VHA required that DWHPs have patient panels comprised of at least 10 percent women veterans to maintain proficiencies. If a DWHP's patient panel is less than 10 percent, an alternate plan to ensure ongoing proficiency must be implemented at a local level.[17] In 2017, VHA updated their requirements for DWHP panels to be composed of at least 100 women veterans. To be initially designated as a DWHP, VHA accepts the following evidence of proficiency:

- Documentation of attendance at VHA's WH Mini-Residency within the previous 3 years
- Documentation of attendance at a WH continuing medical education (CME) or continuing education unit (CEU) training (approximately 20 hours) within the previous three years
- Documentation of prior experience—3 years in a practice of at least 50 percent women patients within the previous 5 years
- Completed Family Practice Residency, Internal Medicine Residency, WH Fellowship, or WH adult or Family Practice nurse practitioner or physician assistant training within the previous 3 years
- Documentation of a current preceptorship arrangement with a DWHP for at least 6 months
- Recognized as a known WH leader and subject matter expert[18,19]

In addition, in order to maintain the designation as a WH-PCP, a provider must complete at least 10 hours of CME or CEU in WH every 2 years.

Lastly, the Office of WHS has created comprehensive training programs to ensure VA's clinical workforce has the skills, knowledge, and competencies to provide the highest quality care to women veterans. The WH Mini-Residency training program was designed to target primary care, emergency medicine providers, and nurses since these clinicians are the entryway into the system for women veterans. More than 1,850 providers have been trained in the program since 2008.[20]

[17] VHA Handbook 1330.01. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive uses the term Women's Health Primary Care Provider (WH-PCP) and new recommendation that WH-Patient Aligned Care Team (PACT) are assigned a panel size of at least 100 women veterans.

[18] Department of Veterans Affairs, Deputy Under Secretary for Health for Operations and Management Memorandum, *Health Care Services for Women Veterans, Veterans Health Administration (VHA) Handbook 1330.01; Women's Health (WH) Primary Care Provider (PCP) Proficiency*, July 8, 2013.

[19] VHA Directive 1330.01. The 2017 Directive uses the term Women's Health Primary Care Provider (WH-PCP).

[20] VHA, Office of Women Health Services. *About Women's Health Services*. Retrieved November 16, 2015 from http://vaww.infoshare.va.gov/sites/womenshealth/whsra/prog/PROGHome.aspx.

**Community Based Outpatient Clinic Reviews.** Since 2009, the OIG Community Based Outpatient Clinic (CBOC) reviews have been evaluating whether VHA clinics are operated in a manner that provides veterans with safe, consistent, and high-quality health care. We accomplish this through cyclical EOC inspections that involve a physical tour of the clinical space used to provide care. Whether located at the parent facility or in the community with VA-staffed or contract resources, all clinics are expected to comply with relevant VA policies and procedures, including those related to quality, patient safety, and performance. During fiscal year (FY) 2014, OIG incorporated an assessment of selected WH privacy requirements into the CBOC reviews.

**Recently Published Reports**. The 2010 Government Accountability Office[21] and the 2014 Disabled American Veterans reports[22] highlighted gaps, such as gender-specific preventive care and screening, breast care, gynecology specialty care, infertility services, and prenatal and obstetrical care, in VHA's provision of health care to women veterans.

On March 12, 2015, members of the House Veterans Affairs Committee of the 114th Congress: Ralph Abraham, Julia Brownley, Mike Coffman, Ryan Costello, Ann McLane Kuster, Beto O'Rourke, Kathleen Rice, Raul Ruiz, Mark Takano, Dina Titus, and Tim Walz, members of the House Veterans Affairs Committee requested the VA OIG to conduct "an inspection into VHA policies" designed to meet the needs of women veterans. This descriptive report seeks to specifically review VHA's compliance to privacy standards, which included physical requirements, and VHA's ability to provide gender-specific care for women veterans.

# Scope and Methodology

To examine VHA's provision of gender-specific care for women veterans, we integrated and analyzed VA's administrative data housed centrally in the Corporate Data Warehouse. Our study population included all VHA patients (ages 18 through 100) who received at least one episode of clinical care, including both inpatient and outpatient care, at VHA facilities in FY 2014.

We first compared disease diagnoses of male and female veterans in the study population, using the broad disease diagnostic categories of International Classification of Diseases, Ninth Revision (ICD-9) as well as the ICD-9 V-codes that indicated a psychosocial or behavioral problem, separately by whether the veterans were seen by VA or non-VA providers. If a patient was diagnosed with diseases in different categories, we counted the patient once in each of the disease categories. If a patient was diagnosed within the same disease category multiple times, we counted the patient once in the category. However, if a patient was diagnosed within the same disease

[21] The Government Accountability Office (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, March 2010. http://www.gao.gov/new.items/d10287.pdf.

[22] Disabled American Veterans (DAV), *Women Veterans: The Long Journey Home*, September 2014. Retrieved from http://www.dav.org/women-veterans-study/.

category by both VA and non-VA providers, we counted the patient once in the category. For example, if a patient was diagnosed with mental illness five times and hypertension eight times by VA providers as well as diagnosed with mental illness three times and hypertension one time by non-VA providers, we counted the patient once in the category of Mental Disorder, once in the category of Diseases of the Circulatory System for VA providers, and once in each of the two categories for non-VA providers.

We then examined the outpatient care utilization for women veterans in the gender-specific diseases categories. We adapted the gender-specific diseases categories from VHA's Women Health Service and the Medicare Code Editor Definitions of Medicare Code Edits 2013, after we manually reviewed these codes and removed those codes that were specific to men's health. If a woman veteran had multiple episodes of care concerning a same gender-specific diagnosis category on a single day, we counted the multiple episodes of care as a single visit per day. However, we counted the episodes of care in the same category provided by VA and non-VA on the same day once for VA and non-VA, separately.

To examine VHA's provision of selected gender-specific services, we interviewed VHA's WH leaders, reviewed VHA directives related to women veterans health care,[23] and requested and evaluated evidence of DWHPs' proficiencies. To ensure that DWHPs with limited exposure to women veterans were current with VHA requirements, we reviewed evidence of proficiencies for DWHPs whose proportion of women veterans were less than 10 percent of their total panel of patients.[24] We provided each VISN with a request detailing the required documentation needed to support the designation as a WH provider.

To evaluate VHA's compliance with stated privacy standards for women veterans (including physical requirements such as sound and vision barriers), we utilized a two-stage complex probability sample design to select CBOCs for the physical inspections of the EOC. We then collected data and analyzed EOC findings during FY 2014 and FY 2015 CBOC reviews.

In the first stage of sampling, we statistically selected 57 and 56 random VHA facilities, respectively, for FY 2014 and FY 2015 that were stratified by the 12 catchment areas of the OIG's Office of Healthcare Inspections regional offices. We compiled a list of eligible CBOCs that were assigned to the parent facility and had not been previously inspected for each of the selected VHA facilities for each fiscal year. This included all

[23] VHA Handbook 1330.01. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. VHA Handbook 1101.01, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

[24] VHA Handbook 1330.01. This Handbook was in effect during the time of the events discussed in this report; it was rescinded and replaced with VHA Directive 1330.01, *Healthcare Services for Women Veterans,* February 15, 2017. The 2017 Directive has new recommendation that WH-Patient Aligned Care Teams (PACT) is assigned a panel size of at least 100 women veterans. Deputy Under Secretary for Health for Operations and Management, "Health Care Services for Women Veterans, Veterans Health Administration (VHA) Handbook 1330.01; Women's Health (WH) Primary Care Provider (PCP) Proficiency" memorandum, July 8, 2013.

CBOCs in operation before March 31, 2013 for FY 2014 and October 1, 2014 for FY 2015.

In the second stage of sampling, we randomly selected one CBOC from each of the 57 and 56 random VHA facilities, respectively, for FY 2014 and FY 2015. If a VHA facility's CBOCs had all had a previous EOC physical inspection, then that parent facility was exempt from the EOC review. For FY 2015, we selected one CBOC from each VHA facility's set of CBOCs for a first EOC physical inspection; however, if all of its CBOCs had had a previous EOC physical inspection, then one CBOC was selected for a second EOC physical inspection. A resulting 93 CBOCs were selected for EOC site visits in FY 2014, and 56 CBOCs in FY 2015.

We conducted the review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

# Results

## Issue 1: Analysis of VHA Data for the Provision of Gender-Specific Care to Women Veterans

We found that 414,804 women veterans used VA care in FY 2014 in comparison to 5,338,858 male veterans. The age distributions of men and women VA patients were different as illustrated in Figure 1 (see appendix A) which demonstrated that men seen at VA tend to be older.

Table 1 (see appendix B) lays out the visits for veteran users of VHA services in 2014. The table breaks out the visits by gender, the site of the service, and the diagnostic category. The results demonstrate that a large majority of care for both genders is delivered at VA facilities. For most diagnostic categories, the proportion of visits in each category was similar for men and women.[25]

Of the 414,804 women veterans who used VA care in FY 2014, 195,100 had a gender-specific diagnosis code. Therefore, more than half of women veterans receiving VA care in FY 2014 were not specifically seeking work-up or management of a gender-specific diagnosis. Though access to gender-specific care is a necessary component to the care provided to women veterans, it is important to note that women veterans sought medical attention for non gender-specific concerns. This highlights the importance of provider experience and understanding of the variation of risk factors, presentation, and management of common conditions between men and women.

We found most visits for gender-specific care were delivered at VA facilities rather than non-VA facilities; 475,131 (82.5 percent) of these visits were performed at VA facilities while 100,789 (17.5 percent) of the visits were performed at non-VA facilities.

We noted that patients with pregnancy-related issues had the majority of their visits at non-VA sites rather than VA sites, and this was the only subcategory of gender-specific care where we found this to be true. Previous studies of pregnant veterans have noted that most care is delivered in community hospitals.

## Issue 2: DWHP Proficiencies

Based on the information that each VISN submitted, we identified that as of September 2, 2015, there were 2,294 DWHPs. Some worked part-time, so that these 2,294 DWHPs represented the equivalent of 1,864.7 full time employees (FTEs). We found that 39.8 percent of those FTEs practiced at a VA medical facility, while 60.2 percent practiced at a VA community based outpatient setting.

[25] The exceptions to this were diseases of the circulatory system; mental disorders; endocrine, nutritional and metabolic diseases, and immunity disorders; diseases of the nervous system and sense organs; and diseases of the musculoskeletal system and connective tissue.

Among the 2,294 DWHPs, 1,236 (53.9 percent) were shown to have women veteran populations of less than 10 percent of their total patient panel. Because these DWHPs had less than 10 percent women veterans in their panels of patients, they were required to establish an alternative plan to demonstrate proficiency in the care of women veterans' needs.

Among these 1,236 providers with less than 10 percent women veterans in their panels, 607 (49.1 percent) practiced at the parent facility and 629 (51.9 percent) practiced at a community based outpatient setting. We found that 547 of the 1,236 providers (44.3 percent) had documented proficiencies as required by VHA,[26] and 689 (55.7 percent) did not. The Chief of Staff at each VA medical center was responsible for assigning the designation of DWHP, and maintaining documentation related to the designation of each DWHP, including certificates of CME, prior experience, or precepting arrangements when appropriate.[27] We noted that VHA has appropriately identified those providers with a low percentage of women veterans as those who would need additional opportunities to maintain their practice skills; however, provider documentation did not satisfy the proficiency requirements.[28]

In addition, while VHA has defined various options to supplement experience for those providers with a small women veteran panel size, it remains unclear whether such supplemental educational/experience opportunities are sufficient for proficiency. According to VHA, proficiency requirements would be considered satisfied if they managed a panel comprised of 50 percent or more women at any time in their practice within the past 5 years. However, this option does not specify how a provider could verify the composition of his or her former patient panel.

Proficiency could, under current VHA standards, also be assumed once a provider verifies completion of 20 continuing medical education hours specific to any WH topic within the past three years. Although this time frame requires providers to be more current in specific areas of WH than the previous guidance, whether this is sufficient for such competency is unclear. Additionally, several of the alternative proficiency options remain vague in their wording, which can therefore allow for various interpretations at each facility and lead to inconsistent application of standards among DWHPs at different facilities. The two examples cited above illustrate the potential confusion in interpreting VHA guidance for validating practice and education experience. When questioned on these concerns, VHA officials acknowledged that current proficiency standards may not be sufficient and have recently updated the requirements.

[26] Deputy Under Secretary for Health for Operations and Management, "Health Care Services for Women Veterans, Veterans Health Administration (VHA) Handbook 1330.01; Women's Health (WH) Primary Care Provider (PCP) Proficiency" memorandum, July 8, 2013.
[27] Ibid.
[28] Either insufficient evidence or no evidence was submitted by the VISNs for these DWHPs. For example, a document may have been submitted as evidence of a continuing medical education activity, but we could only verify a fraction of the required hours. Some submissions were written statements describing previous experience providing care to female patients but were without any signature or attestation from a supervisor.

### Issue 3: Compliance with Privacy Standards

We found that 7 of the 93 CBOCs evaluated (7.9 percent) did not have manual or electronic door locks for the examination rooms used for women veterans. We also found that 16 of the 93 CBOCs (17.2 percent) had physical settings where gowned women veterans could not access gender-specific restrooms without entering public areas. No alternative measures were in place. Lastly, we found that VHA had made systemic improvements since the prior year, and only 1 of the 93 CBOCs (1.1 percent) had examination table positioning that did not facilitate privacy.

In FY 2015, we found that 3 of the 56 CBOCs evaluated (5.4 percent) did not have manual or electronic door locks for examination rooms used for women veterans. We also noted that 4 of the 56 CBOCs (7.1 percent) had physical settings where gowned women veterans could not access gender-specific restrooms without entering public areas. Again, no alternative measures were in place. Two CBOCs also had examination tables positioned in a way that did not facilitate privacy.

We issued recommendations in 15 facility CBOC reports during FY 2014 and in 8 facility CBOC reports during FY 2015. The clinics implemented corrective action plans. We have since closed all of the recommendations. Details are noted in Appendices G and H.

# Conclusions

In our analysis of VHA's provision of gender-specific care to women veterans during FY 2014, we found that there were visits with an associated gender-specific diagnosis code, and 475,131 (82.5 percent) of these gender-specific care visits were performed at a VA facility while 100,789 (17.5 percent) of the visits were performed at a non-VA facility. We also noted that patients with pregnancy-related issues had the majority of their visits at non-VA sites rather than VA sites, and this was the only subcategory of gender-specific care where we found this to be true.

As of September 2, 2015, we identified 2,294 DWHPs providing a total of 1,864.7 FTEs. We found that 39.8 percent of those FTEs practiced at a VA medical facility, while 60.2 percent of those FTEs practiced at a community based outpatient setting. This distribution of DWHPs provides access to gender-specific care in communities that may have limited WH providers.

Among the 2,294 DWHPs, 1,236 (53.9 percent) were shown to have women veteran populations of less than 10 percent of their total patient panel. We found that 547 of the 1,236 providers (44.3 percent) had documented proficiencies as required by VHA. We noted that VHA has appropriately identified those providers with a low percentage of women veterans as those who would need additional opportunities to maintain their practice skills; however, we could not verify that the provided documentation satisfied the proficiency requirements.

While VHA has defined various options to supplement experience for those providers with a small women veteran panel size, it is not clear whether such supplemental educational/experience opportunities are sufficient for proficiency. According to VHA, proficiency requirements would be considered satisfied if they managed a panel comprised of 50 percent or more women within the previous five years in a practice outside the VA. However, this option does not specify how a provider could verify the composition of his or her former patient panel.

VHA standards also allow proficiency to be assumed once a provider verifies completion of 20 continuing medical education hours specific to any WH topic within the past three years. Several alternative proficiency options are also vague in their wording and can lead to inconsistent interpretations and application of standards among DWHPs at different facilities.

Lastly, we evaluated 93 CBOCs during FY 2014 and 56 CBOCs in FY 2015. We found that 20.4 percent of these representative clinics did not provide adequate privacy for women veterans in FY 2014. We continued to find lack of adequate privacy for women veterans in FY 2015, although some improvement was noted, as 14.3 percent of CBOCs had findings. We issued recommendations for these clinics and corrective action plans were implemented. We have since closed all recommendations issued in these CBOC reports.

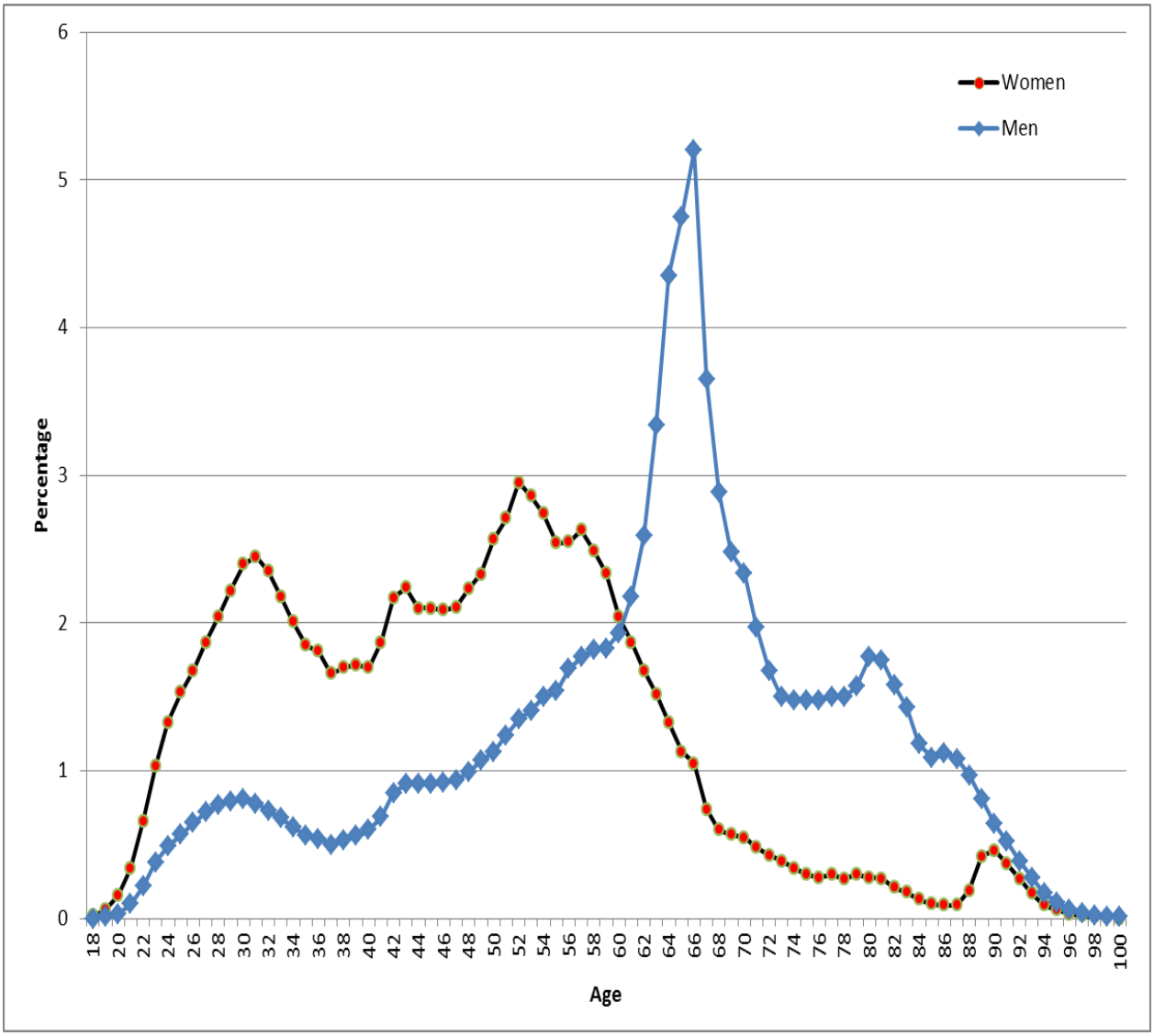
We made one recommendation for improvement.

# Recommendation

**Recommendation 1**. We recommended that the Acting Under Secretary for Health ensure that the Office of Women's Health Services routinely reviews and when appropriate, strengthens the requirements for women's health provider designation and facilitates the updating of requirements for all designated women health providers with supporting documentation that details how the requirements were satisfied.

**Appendix A**

**Figure 1. Age (as of October 1, 2014) Distribution of Veterans Using VA Care by Gender**




***Source: OIG Analysis of VA Corporate Data Warehouse data***

**Appendix B**

## Table 1. Veterans of Both Genders by ICD-9 Diagnosis for FY 2014 (Total and Percentage)

| Both Genders ICD-9 Categories | VA | | Non-VA | | Total* | |
|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female |
| Infectious and Parasitic Disease | 710,532 | 53,601 | 31,073 | 2,627 | 726,404 | 55,208 |
| | **13.3** | **12.9** | **0.6** | **0.6** | **13.6** | **13.3** |
| Endocrine, Nutritional and Metabolic Disease, and Immunity Disorders | 3,486,163 | 212,957 | 107,981 | 7,687 | 3,499,804 | 214,399 |
| | **65.3** | **51.3** | **2.0** | **1.9** | **65.6** | **51.7** |
| Diseases of the Blood and Blood Forming Organs | 495,463 | 37,009 | 27,146 | 2,527 | 509,439 | 38,522 |
| | **9.3** | **8.9** | **0.5** | **0.6** | **9.5** | **9.3** |
| Mental Disorders | 2,324,418 | 219,239 | 88,089 | 9,733 | 2,335,460 | 220,179 |
| | **43.5** | **52.9** | **1.6** | **2.3** | **43.7** | **53.1** |
| Diseases of the Nervous System and Sense Organs | 2,842,122 | 192,180 | 270,582 | 20,941 | 2,914,521 | 198,394 |
| | **53.2** | **46.3** | **5.1** | **5.0** | **54.6** | **47.8** |
| Diseases of the Circulatory System | 3,283,679 | 145,561 | 177,492 | 9,002 | 3,303,114 | 147,445 |
| | **61.5** | **35.1** | **3.3** | **2.2** | **61.9** | **35.5** |
| Diseases of the Respiratory System | 1,299,765 | 119,354 | 92,737 | 8,115 | 1,330,385 | 121,908 |
| | **24.3** | **28.8** | **1.7** | **2.0** | **24.9** | **29.4** |
| Diseases of the Digestive System | 1,750,176 | 130,544 | 131,795 | 12,839 | 1,786,389 | 133,968 |
| | **32.8** | **31.5** | **2.5** | **3.1** | **33.5** | **32.3** |
| Diseases of the Genitourinary System | 1,409,213 | 130,091 | 82,635 | 21,870 | 1,432,984 | 137,841 |
| | **26.4** | **31.4** | **1.5** | **5.3** | **26.8** | **33.2** |
| Diseases of the Skin and Subcutaneous Tissue | 1,098,757 | 85,256 | 48,481 | 4,016 | 1,116,882 | 86,896 |
| | **20.6** | **20.6** | **0.9** | **1.0** | **20.9** | **20.9** |
| Diseases of the Musculoskeletal System and Connective Tissue | 2,646,779 | 242,126 | 232,676 | 28,287 | 2,672,793 | 244,626 |
| | **49.6** | **58.4** | **4.4** | **6.8** | **50.1** | **59.0** |
| Congenital Anomalies | 100,457 | 8,406 | 4,831 | 669 | 104,366 | 8,954 |
| | **1.9** | **2.0** | **0.1** | **0.2** | **2.0** | **2.2** |
| Symptoms, Signs, and Ill-Defined Conditions | 2,613,459 | 217,814 | 254,714 | 34,262 | 2,667,517 | 225,816 |
| | **49.0** | **52.5** | **4.8** | **8.3** | **50.0** | **54.4** |
| Injury and Poisoning | 689,429 | 71,090 | 109,152 | 10,861 | 747,892 | 76,738 |
| | **12.9** | **17.1** | **2.0** | **2.6** | **14.0** | **18.5** |
| Benign Neoplasms | 595,453 | 43,961 | 51,175 | 5,789 | 627,697 | 47,358 |
| | **11.2** | **10.6** | **1.0** | **1.4** | **11.8** | **11.4** |
| Malignant Neoplasms | 581,648 | 18,582 | 66,975 | 3,514 | 595,146 | 19,351 |
| | **10.9** | **4.5** | **1.3** | **0.8** | **11.1** | **4.7** |
| Vcodes | 629,916 | 64,596 | 10,262 | 1,256 | 633,734 | 65,107 |
| | **11.8** | **15.6** | **0.2** | **0.3** | **11.9** | **15.7** |
| | | | | | **5,338,858** | **414,804** |

*Total numbers do not add up to the sum of VA and non-VA numbers because some patients may be seen in both VA and non-VA categories.

***Source: OIG Analysis of VA Corporate Data Warehouse data***

**Appendix C**

## Table 2. Women Veterans Patients by Gender-Specific Subcategories for FY 2014 (Total Number and Percentage)

| Female ICD-9 Subcategories | VA | Non-VA | Total |
|---|---|---|---|
| Pregnancy Related | 16,452 | 8,333 | 18,999 |
| | **4.0** | **2.0** | **4.6** |
| Female Infertility | 4,042 | 777 | 4,305 |
| | **1.0** | **0.2** | **1.0** |
| Menstrual Dis & Endometriosis | 33,552 | 3,905 | 35,385 |
| | **8.1** | **0.9** | **8.5** |
| Abnormal Cervical Screening | 7,496 | 629 | 7,969 |
| | **1.8** | **0.2** | **1.9** |
| Sexually Transmitted Disease | 9,224 | 146 | 9,339 |
| | **2.2** | **0.0** | **2.3** |
| Urinary Condition and Incontinence | 5,795 | 331 | 6,012 |
| | **1.4** | **0.1** | **1.4** |
| Gynecologic Cancer | 21,954 | 1,623 | 23,074 |
| | **5.3** | **0.4** | **5.6** |
| Benign Gynecologic Conditions | 1,911 | 429 | 2,266 |
| | **0.5** | **0.1** | **0.5** |
| Breast Cancer | 7,648 | 1,404 | 7,875 |
| | **1.8** | **0.3** | **1.9** |
| Infection-Related Conditions | 20,232 | 1,076 | 21,096 |
| | **4.9** | **0.3** | **5.1** |
| Reproductive Organ Disorders | 33,689 | 3,403 | 35,898 |
| | **8.1** | **0.8** | **8.7** |
| Menopausal Disorder | 29,886 | 781 | 30,358 |
| | **7.2** | **0.2** | **7.3** |
| Prolapse Female Genital Organ | 2,884 | 365 | 3,058 |
| | **0.7** | **0.1** | **0.7** |
| Contraceptive Care Mgmt | 24,457 | 1,464 | 25,524 |
| | **5.9** | **0.4** | **6.2** |
| Other | 87,565 | 7,009 | 92,237 |
| | **21.1** | **1.7** | **22.2** |

***Source: OIG Analysis of VA Corporate Data Warehouse data***

**Appendix D**

## Table 3. Outpatient Female Visits by Gender-Specific Subcategories for FY 2014 (Total and Percentage)

| Outpatient Female ICD-9 Subcategories | VA | Non-VA | Total |
|---|---|---|---|
| Pregnancy Related | 30,547 | 54,407 | 84,954 |
| | **7.4** | **13.1** | **20.5** |
| Female Infertility | 6,761 | 2,224 | 8,985 |
| | **1.6** | **0.5** | **2.2** |
| Menstrual Dis & Endometriosis | 65,388 | 5,978 | 71,366 |
| | **15.8** | **1.4** | **17.2** |
| Abnormal Cervical Screening | 11,666 | 866 | 12,532 |
| | **2.8** | **0.2** | **3.0** |
| Sexually Transmitted Disease | 12,428 | 196 | 12,624 |
| | **3.0** | **0.0** | **3.0** |
| Urinary Condition and Incontinence | 9,062 | 615 | 9,677 |
| | **2.2** | **0.1** | **2.3** |
| Gynecologic Cancer | 28,291 | 5374 | 33,665 |
| | **6.8** | **1.3** | **8.1** |
| Benign Gynecologic Conditions | 2,906 | 568 | 3,474 |
| | **0.7** | **0.1** | **0.8** |
| Breast Cancer | 37,408 | 12,350 | 49,758 |
| | **9.0** | **3.0** | **12.0** |
| Infection-Related Conditions | 27,349 | 1,515 | 28,864 |
| | **6.6** | **0.4** | **7.0** |
| Reproductive Organ Disorders | 50,150 | 4,771 | 54,921 |
| | **12.1** | **1.2** | **13.2** |
| Menopausal Disorder | 41,886 | 1,161 | 43,047 |
| | **10.1** | **0.3** | **10.4** |
| Prolapse Female Genital Organ | 5,105 | 943 | 6,048 |
| | **1.2** | **0.2** | **1.5** |
| Contraceptive Care Mgmt | 39,258 | 1,837 | 41,095 |
| | **9.5** | **0.4** | **9.9** |
| Other | 106,926 | 7,984 | 114,910 |
| | **25.8** | **1.9** | **27.7** |

***Source: OIG Analysis of VA Corporate Data Warehouse data***

**Appendix E**

## LIST OF WH PROVIDER COMPETENCY STANDARDS[29]

### Primary Care Competencies with Gender-Specific Manifestations:
***Care practiced should be evidenced-based and adhere to current standards of care.***

Nutrition Counseling
Obesity &Weight Management Counseling
Exercise & Fitness Counseling
Smoking Cessation Counseling & Nicotine Replacement
Screening for Alcohol and Substance Use/Abuse
Screening for Depression
Screening for PTSD
Post-Deployment Readjustment Issues
Endocrine disorders including:
-Thyroid disorders
-Diabetes
Genitourinary tract disorders including:
-Cystitis
-Urinary Tract Infection
-Pyelonephritis
-Urinary incontinence
Respiratory Illnesses including:
-COPD
-Bronchitis/common cold/acute upper respiratory illness
Hyperlipidemia (due to gender quality disparities)
Screening for Military Sexual Trauma
Diagnosis and prevention of Osteoporosis/Osteopenia
Cardiovascular Disorders
-Chest pain
-Hypertension
Fibromyalgia
Connective Tissue Disease
Headaches
Hirsutism
Acne
Anemia
Gastrointestinal disorders including:
-Irritable Bowel Syndrome
-Diarrhea/Constipation
-Gastroenteritis
Assess risks for cancers (e.g. lung, breast, ovary, colon and skin)

[29] VHA Handbook 1330.01, *Healthcare Services for Women Veterans,* May 21, 2010, pages B-1 and B-2.

## WH PROVIDER COMPETENCY STANDARDS (continued)

**"Basic"/"Minimal" WH Competencies:**
Assess and manage reproductive concerns including:
-Contraception counseling
-Emergency contraception
-Sexually transmitted disease screening, counseling and treatment
-Basic diagnostic evaluation and tests for infertility

Cervical Cancer Screening
Assessment of abnormal cervical pathology
Breast Cancer Screening
Evaluation and management of Breast Symptoms (Mass, Fibrocystic Breast Disease, Mastalgia, Nipple Discharge, Mastitis, Galactorrhea, Mastodynia)
Evaluation and management of Acute and Chronic Pelvic Pain
Evaluation & Treatment of Vaginitis
Evaluation of Abnormal Uterine Bleeding
Amenorrhea/Menstrual Disorders
Menopause Symptom Management
Crisis Intervention; Evaluate psychosocial well being and risks including issues regarding abuse
Violence in women & Intimate Partner Violence Screening
-Personal and physical abuse
-Verbal/Psychological abuse
Diagnosis of pregnancy and initial screening tests
Recognition and management of Postpartum Depression and Postpartum Blues
Pharmacology in Pregnancy & Lactation
Preconception Counseling
-medical assessment
-vaccination evaluation
-genetic history
-supplement recommendations
-awareness of terotogenic medications
Recognize presentation of Ectopic Pregnancy

**Procedures:**
**"Basic"/"Minimal"**
Breast Examination
Pelvic Examination
Rectal Examination
Pap Smear
Wet Mount
Removal of Foreign Body from Vagina

## WH PROVIDER COMPETENCY STANDARDS (continued)

**Interpreting Test Results:**
**" Basic"/"Minimal"**
Bone densitometry
Colposcopy & Biopsy
Cervical Cytology Report
Endometrial Biopsy
CT of Abdomen & Pelvis
Pelvic Ultrasound
Pregnancy Test
Mammography
Infertility workup
Basic Urodynamic Testing

**Appendix F**

## List of OIG WH Reviews

Published Fiscal Year Summary Reports:

*Healthcare Inspection — Evaluation of Community Based Outpatient Clinics Fiscal Year 2011*," Report No. 11-01406-247, August 16, 2012. The report included results of:

- CBOC compliance with selected VHA requirements for the provision of mammography services for women veterans, including:
  - Assignment of WH liaisons.
  - Linkage of results (of mammograms ordered by fee-basis or contract providers) to the provider order in the electronic health record.
  - Patient notification of normal results within 30 days.
- Comparison of CBOC and parent facility performance measures for breast cancer screening for women ages 50-69.

*Healthcare Inspection — Evaluation of VHA Community Based Outpatient Clinics Fiscal Year 2012* (Mammography Compliance), Report No. 13-00090-346, September 30, 2013. The report included results of:

- CBOC compliance with selected VHA requirements for the provision of mammography services for women veterans, including:
  - Availability of results in the radiology software package.
  - Linkage of results (of mammograms ordered by fee-basis or contract providers) to the provider order in the electronic health record.
  - Patient notification of normal results within 30 days.

*Community Based Outpatient Clinic Summary Report — (FY13) Evaluation of CBOC Cervical Cancer Screening and Results Reporting*, Report No. 14-02198-284, September 23, 2014.

- A consistent process was established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification was documented in the electronic health records.
- A consistent process was established for notifying women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification was documented in the electronic health record.

**Table 4. FY 2014 WH Privacy Findings in Individual Facility Reports**

| FY 2014 Published CBOC Reports | | | | |
|---|---|---|---|---|
| **Privacy Element Evaluated** | **Parent Facility** | **CBOC Location(s)** | **Recommendation** | |
| | | | **Date Issued** | **Date Closed** |
| Door Locks for Exam Room Designated for Women Veterans | Columbia, MO | Osage Beach, MO, and Mexico, MO | 2/27/14 | 12/9/2014 |
| | Tucson, AZ | Casa Grande, AZ | 4/28/14 | 10/13/2015 |
| | Topeka, KS | Garnett, KS | 6/26/14 | 4/23/2015 |
| | Wichita, KS | Parsons, KS | 7/8/14 | 1/29/2015 |
| | Big Spring, TX | Fort Stockton, TX | 7/23/14 | 2/11/2015 |
| | Milwaukee, WI | Cleveland, WI | 8/12/14 | 9/16/2014 |
| Gowned Women Veterans' Access to Gender-Specific Restrooms | Columbia, MO | Mexico, MO | 2/27/14 | 1/6/2015 |
| | Salt Lake City, UT | Roosevelt, UT | 2/28/14 | 12/3/2014 |
| | San Juan, PR | Arecibo, PR | 3/13/14 | 10/31/2014 |
| | Tucson, AZ | Casa Grande, AZ; Green Valley, AZ; and Safford, AZ | 4/28/14 | 10/13/2015 |
| | Altoona, PA | Johnstown, PA | 5/13/14 | 11/6/2014 |
| | Saginaw, MI | Bad Axe, MI | 5/22/14 | 12/23/2014 |
| | Huntington, WV | Prestonsburg, KY | 6/10/14 | 4/8/2015 |
| | Fort Meade, SD | Scottsbluff, NE | 7/2/14 | 2/5/2015 |
| | Topeka, KS | Garnett, KS | 6/26/14 | 4/23/2015 |
| | Wilmington, DE | Dover, DE | 6/26/14 | 6/26/2014 |
| | Walla Walla, WA | Yakima, WA | 7/7/14 | 7/27/2015 |
| | Wichita, KS | Parsons, KS | 7/8/14 | 6/3/2015 |
| | Big Spring, TX | Fort Stockton, TX | 7/23/14 | 8/12/15 |
| | Miami, FL | Hollywood, FL | 11/10/14 | 3/19/2015 |
| Examination Table Positioning | Miami, FL | Key Largo, FL | 11/10/14 | 3/19/2015 |

***Source: OIG FY 2014 Published CBOC Reports***

**Table 5. FY 2015 WH Privacy Findings in Individual Facility Reports**

| FY 2015 Published CBOC Reports | | | | |
|---|---|---|---|---|
| **Privacy Element Evaluated** | **Parent Facility** | **CBOC Location(s)** | **Recommendation** | |
| | | | **Date Issued** | **Date Closed** |
| Door Locks for Exam Room Designated for Women Veterans | West Palm Beach, FL | Delray Beach, FL | 3/31/2015 | 11/24/2015 |
| | Madison, WI | Baraboo, WI | 9/28/2015 | 3/10/2016 |
| | Battle Creek, MI | Muskegon, MI | 10/22/2015 | 4/4/2016 |
| Gowned Women Veterans' Access to Gender-Specific Restrooms | Tomah, WI | Wausau, WI | 1/15/2015 | 6/30/2015 |
| | Memphis, TN | Savannah, TN | 1/15/2015 | 5/21/2015 |
| | Erie, PA | Warren, PA | 2/11/2015 | 6/23/2015 |
| | Dayton, OH | Lima, OH | 3/30/2015 | 3/30/2015 |
| Examination Table Positioning | Memphis, TN | Savannah, TN | 1/15/2015 | 5/21/2015 |
| | Phoenix, AZ | Gilbert, AZ | 6/4/2015 | 10/29/2015 |

***Source: OIG FY 2015 Published CBOC Reports***

**Appendix I**

# Acting Under Secretary for Health Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** April 14, 2017

**From:** Acting Under Secretary for Health (10)

**Subject:** OIG Draft Report – National Review – Review of the VHA Privacy Standards and Provision of Care for Women Veterans (Project No. 2015-03303-HI-0606) (VAIQ 7778734)

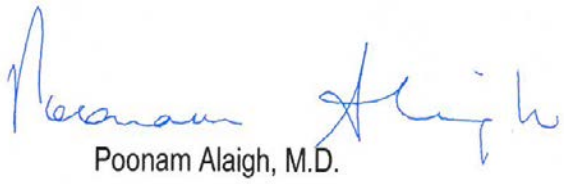
**To:** Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the draft report, Review of the VHA Privacy Standards and Provision of Care for Women Veterans. I concur with the draft report content and OIG's recommendation. I provide the attached action plan to address the recommendation.

2. Women's Health Services (WHS) is improving access, services, resources, facilities, and workforce capacity to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. Security and privacy for women Veterans is a high priority for VA. VA is training providers and other clinical staff, enhancing facilities to meet the needs of women Veterans, and reaching out to inform women Veterans about VA services.

3. In 2016 VA Implemented a breast care registry to improve patient safety and health outcomes, launched an *e*-chat enhancement at the Women Veterans Call Center, created a preconception care counseling template in the CPRS, and trained over 550 primary care providers in women's health mini-residency.

4. The recommendation in this report applies to GAO high risk areas 1 and 4. VHA's actions will serve to address ambiguous policies and inconsistent processes and inadequate training for VA staff.



Poonam Alaigh, M.D.

## VETERANS HEALTH ADMINISTRATION (VHA)

### Action Plan

### OIG Draft Report – National Review – Review of the VHA Privacy Standards and Provision of Care for Women Veterans

**Date of Draft Report: February 27, 2017**

| Recommendations/ Actions | Status | Completion Date |
|---|---|---|

**OIG Recommendations**

**Recommendation 1.** We recommended that the Acting Under Secretary for Health ensure that the Office of Women's Health Services routinely reviews and when appropriate, strengthens the requirements for women's health provider designation and facilitates the updating of requirements for all designated women health providers with supporting documentation that details how the requirements were satisfied.

**VHA Comments**: Concur

VHA will routinely review requirements for designation as a women's health primary care provider (WH-PCP). VHA Directive1330.01, Health Care Services for Women Veterans, has recently been revised and released. It clarifies the guidance for obtaining and maintaining WH-PCP status. The new guidance in policy is:

In order to be initially designated as a WH-PCP, a provider must have at least one of the following:

(a) Documentation of attendance at a Women's Health Mini-Residency within the previous 3 years;
(b) Documentation of at least 20 hours of women's health continuing medical education (CME) or continuing education unit (CEU) within the previous 3 years;
(c) Documentation of at least 3 years in a practice with at least 50 percent women patients within the previous 5 years;
(d) Evidence of completion, within the previous 3 years, of any of the following: an internal medicine or family practice residency; women's health fellowship; or women's health, adult, or family practice Nurse Practitioner or Physician Assistant training.
(e) Documentation of a current preceptorship arrangement with an experienced WH-PCP such as weekly meetings (for at least 6 months); or
(f) Evidence of being recognized as a known women's health leader and subject matter expert with experience practicing, teaching, and/or precepting women's health; and

In order to maintain the designation as a WH-PCP, a provider must complete at least 10 hours of CME, Continuing Nursing Education (CNE) or CEU in women's health every 2 years.

Women's Health Services is communicating the revised Directive 1330.01 to the field through presentation on national women's health calls, facility director's call, and national primary care call.

Women's Health Services will send a memo through the Deputy Under Secretary for Health for Operations and Management to the field delineating requirements to be designated as a WH-PCP and ongoing continuing education required to maintain designation as a WH-PCP according to the revised policy and documentation to be maintained at the facility level via Credentialing and Privileging renewal process.

At completion of this action, Women's Health Services will provide the dates of presentation on national calls and a copy of the Memo and Date of release to field.

| Status: | Target Completion Date: |
|---|---|
| In Process | June 2017 |

**Appendix J**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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**Appendix K**

# Report Distribution

## VA Distribution

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## Non-VA Distribution

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Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
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