

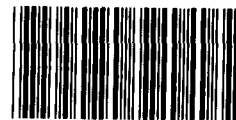
GAO

Report to the Chairman, Committee on
Veterans' Affairs, U.S. Senate

January 1992

VA HEALTH CARE
FOR WOMEN

Despite Progress,
Improvements Needed



145766

RELEASED

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Human Resources Division

B-246938

January 23, 1992

The Honorable Alan Cranston
Chairman, Committee on Veterans' Affairs
United States Senate

Dear Mr. Chairman:

This report responds to your request for information on the progress the Department of Veterans Affairs (VA) has made in improving health care services for women veterans. In 1982,¹ we reported that VA facilities were unable to meet the health care needs of women veterans to the same extent as that of men veterans. In September 1990, you asked that we determine (1) VA's progress, following our 1982 report, in providing needed health care services to women veterans and (2) the remaining barriers that restrict women's access to care.

Background

Women represent a small, but rapidly growing, segment of the nation's veteran population. At the time of our 1982 report, the number of women veterans was about 740,000. By 1990, that number was estimated to be over 1.2 million (4.5 percent of the veteran population). The percentage of veterans who are women is projected to increase steadily into the next century; by 2040, about 10.9 percent of veterans will be women.

The role of women in the military has also changed, as evidenced by the recent Persian Gulf conflict. In the past, most of the women serving in theater were nurses. During Operation Desert Shield and Desert Storm, however, women served in a wide range of combat support missions; approximately 6 percent of the 540,000 service members deployed were women. Thirteen women were killed and two held as prisoners of war. Although women have served in the military since at least World War I, they have not always gained recognition as veterans or received VA benefits equal to those of men. For example, women who served in the Women's Air Force Service Pilots during World War II were not legally eligible for VA benefits until 1979. Even women serving as nurses at combat hospitals in Vietnam have experienced problems in gaining recognition as veterans. Many of these inequities have been eliminated. But

¹ Actions Needed to Insure That Female Veterans Have Equal Access to VA Benefits (GAO/HRD-82-98, Sept. 1982).

the growing number of women who seek care presents VA with a challenge—meeting women patients' needs in a health care system historically oriented toward men. For example, as cited in the 1982 report, (1) limited privacy prevented women from being admitted to some specialized treatment programs, particularly in psychiatric and domiciliary programs, (2) physical examinations frequently did not include pelvic examinations, (3) gynecological care was sometimes unavailable to women patients with non-service-connected conditions, and (4) VA's facility-planning process did not adequately consider the needs of women veterans in planning renovation projects.

Scope and Methodology

Our work was conducted at the VA Central Office and eight VA medical centers: Bay Pines, Florida; Bronx, New York; Hampton, Virginia; Martinez, California; Richmond, Virginia; San Francisco, California; Tampa, Florida; and Wilkes-Barre, Pennsylvania. In selecting medical centers, we considered the size of the women veteran population, whether the medical center had a women's clinic, and whether the medical center had in-house mammography services.

In responding to your request, we

- interviewed VA officials, including medical center directors, chiefs of staff, women veterans and quality assurance coordinators, and other medical center and Central Office personnel;
- reviewed (1) VA policies, procedures, and guidance relating to women veterans, (2) internal and external reviews of VA's provision of health services to women, (3) medical records for random samples of women veterans at two medical centers, in order to determine whether thorough examinations were being performed, and (4) guidelines issued by professional health care organizations, such as the American College of Radiology (ACR) and American Cancer Society (ACS), that could be applied to women veterans' health care;
- toured seven of eight medical centers to identify any physical barriers that limit women's access to care; and
- sent a questionnaire to the 19 medical centers with in-house mammography, in order to determine their compliance with quality standards (see apps. I and II).

Our work was carried out from June 1990 through July 1991 in accordance with generally accepted government auditing standards.

Results in Brief

VA has made significant progress since 1982 toward ensuring women veterans' access to health care is equal to that of men veterans. The increased emphasis on identifying and correcting problems concerning care for women veterans followed both the creation of an Advisory Committee on Women Veterans at the Central Office and the appointment of a women veterans coordinator at each medical center.

Some problems remain, however:

- Physical examinations, including cancer screening for women veterans, continue to be sporadic.
- VA medical centers are inadequately monitoring their in-house mammography programs to ensure compliance with the ACR quality standards.
- Centers have inadequate procedures to ensure that patient privacy limitations affecting women patients are identified and corrected during facility renovations.

VA medical centers could improve compliance with physical examination requirements if the VA Central Office ensured that information about best practices is disseminated and, where appropriate, implemented throughout the system.

VA Has Taken Steps to Improve Care for Women Veterans

In April 1983, following issuance of our September 1982 report, VA established an Advisory Committee on Women Veterans in response to growing concerns that women were not receiving equal access to programs and benefits to which they were entitled.²

Beginning in 1983, to improve the provision of health services to women veterans, VA required that each medical center develop and implement a written plan outlining the provision of women's care. Each plan must provide at least two means for obtaining gynecologic services when such services are unavailable at VA medical centers. In addition to fee-for-service care, VA medical centers may offer these services through a consultant. Further, a 1989 survey showed that 90 of the 150 VA medical facilities responding (60 percent) now have women's clinics offering gynecologic care as well as preventive health and counseling services. In-house mammography services are also available at 19 VA medical centers.

²The most recent report is *Women Veterans—A Decade of Progress* (Report of the VA Advisory Committee on Women Veterans, July 1990).

To help improve women veterans' access to treatment programs, VA, in 1982, identified 28 medical centers with physical barriers that prevented them from accommodating women in all treatment programs; those with barriers were required to identify and develop plans for correcting them. For example, all domiciliaries are now able to accommodate women veterans; at the time of our 1982 study, 10 of the 16 domiciliaries could not admit women.

To improve outreach, VA required its regional offices to (1) identify and maintain rosters of veterans organizations with mostly women members and (2) maintain ongoing liaison with such organizations. In addition, VA surveyed the needs, attitudes, and experiences of women veterans. After the survey showed a need for greater awareness of benefits and services, VA regional offices and medical centers increased outreach activities through the use of pamphlets, audiovisual presentations, and exhibits. For example, VA developed pamphlets explaining VA benefits available to women veterans; created a traveling exhibit, "Benefits for Women Veterans—Same Service, Same Benefits," for display at conferences and medical center activities; and produced posters and other materials in recognition of the contributions of women veterans.

Finally, VA Central Office developed statistics on the women veterans population, including (1) projections by age and period of service, for 1990 through 2040, (2) use of VA hospitalization, and (3) demographic and socioeconomic data.

Need to Improve Thoroughness of Physical Examinations

VA has not effectively implemented plans to ensure that as part of their physical examinations, women veterans receive appropriate cancer screening. VA requires that medical centers provide each woman inpatient with a complete physical examination, including breast and pelvic examinations (to detect ovarian cancer) and Pap test (to detect cancers of the uterus and cervix) if these procedures have not been provided in the last year.³ VA also requires each medical center to provide mammograms, in accordance with the ACS standards⁴ or those of other health care organizations.

³VA policy acknowledges that there are legitimate reasons why these procedures should sometimes be deferred or not performed (for example, patient refusal or patient had a recent gynecological examination).

⁴ACS recommends a baseline mammogram for women between ages 35 and 39; a mammogram every 1 to 2 years for women between 40 and 49; and a mammogram every year for women aged 50 and over. These guidelines should be considered along with a woman's background and medical history.

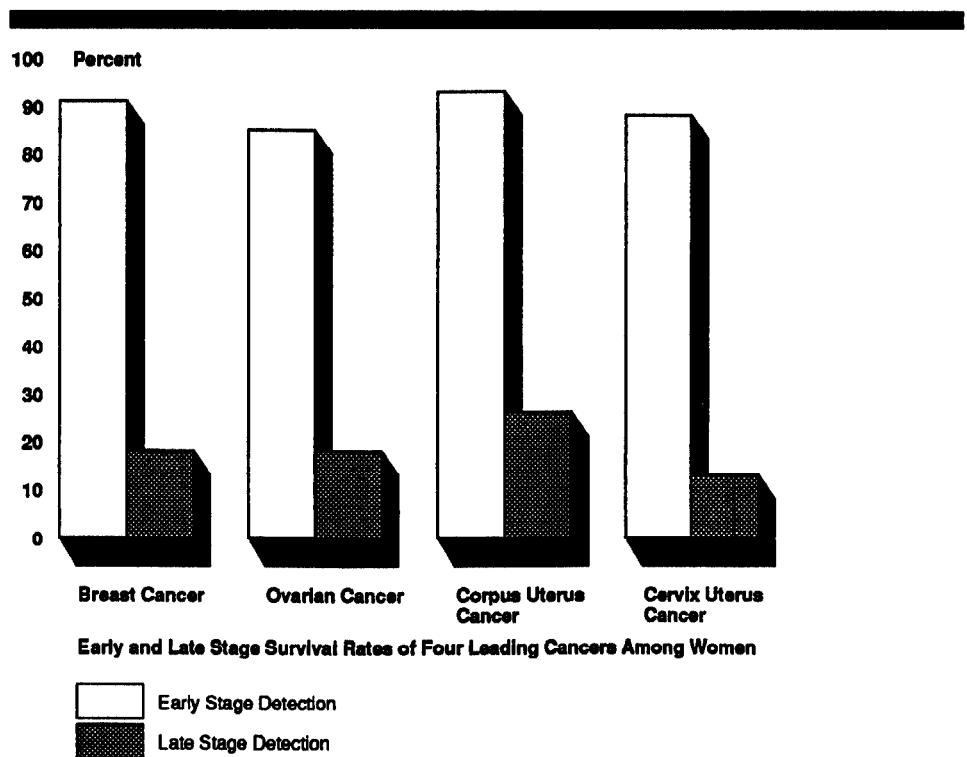
Some medical centers we visited did not consistently monitor women's care through their quality assurance programs. Periodic review of compliance with physical examination requirements should help ensure that opportunities for improvement are both recognized and adequately accomplished.

Complete Examinations Will Increase Chance for Early Cancer Detection

Women veterans experience an unusually high incidence of cancer. Cancer-screening programs are important at early stages, when treatment is more likely to be successful.

As shown in figure 1, early detection dramatically increases the 5-year survival rates of women with breast, ovarian, or uterine cancer.

Figure 1: Early Cancer Detection Increases 5-Year Survival Rates



Notes: (1) The rates, adjusted for normal life expectancy, are based on cases diagnosed in 1974-86; these rates represent the latest data available on survival by stage. (2) The corpus uteri (body of the uterus) and cervix uteri (opening of the uterus) are both uterine cancers.

Source: American Cancer Society, Cancer Facts & Figures— 1991.

For example, with early detection, the 5-year survival rate of women with cervical cancer is 88 percent, but in women whose cancers are not detected early, the 5-year survival rate is only 13 percent. Similarly, since the introduction of the Pap test—the principal method for early detection of cervical cancer—in the 1950s, there has been a 70 percent decline in the cervical cancer mortality rate.

High Incidence of Cancer in Women Veterans

VA's 1985 Survey of Female Veterans, conducted by Louis Harris and Associates, reported (1) nearly 9 percent of women veterans had cancer and (2) this lifetime prevalence of cancer among women veterans is nearly twice the rate of that in the total population of adult women (5 percent). In the survey, the most common types of cancer were uterine, ovarian, and cervical cancer, 43 percent; followed by breast cancer, 26 percent. In response to questions raised following the June 1989 congressional hearings, the Secretary of Veterans Affairs questioned the validity of the survey findings, but said that VA would treat them as a serious matter until this issue was resolved.⁵ Another indication of a high incidence of cancer among women veterans comes from a 1989 women veterans health inventory, conducted by a gynecologist at Bay Pines VA Medical Center. Nearly 50 percent of the 115 women included in the inventory had personal histories of cancer.

Problems in Providing Complete Physical Examinations Are Longstanding

We first identified the problems relating to physical examinations in 1982. Since then, over 50 reviews—by VA's Systematic External Review Program, Medical District Initiated Peer Review Organization (MEDIPRO), Inspector General, veterans service organizations, or internal quality assurance staff—have found that VA medical centers are not providing women patients with appropriate cancer-screening tests as part of their complete physical examinations. For example, MEDIPRO reviews in five districts found that from 20 to 86 percent of women patients did not receive breast and pelvic examinations, Pap tests, and mammograms when required (see fig. 2).⁶

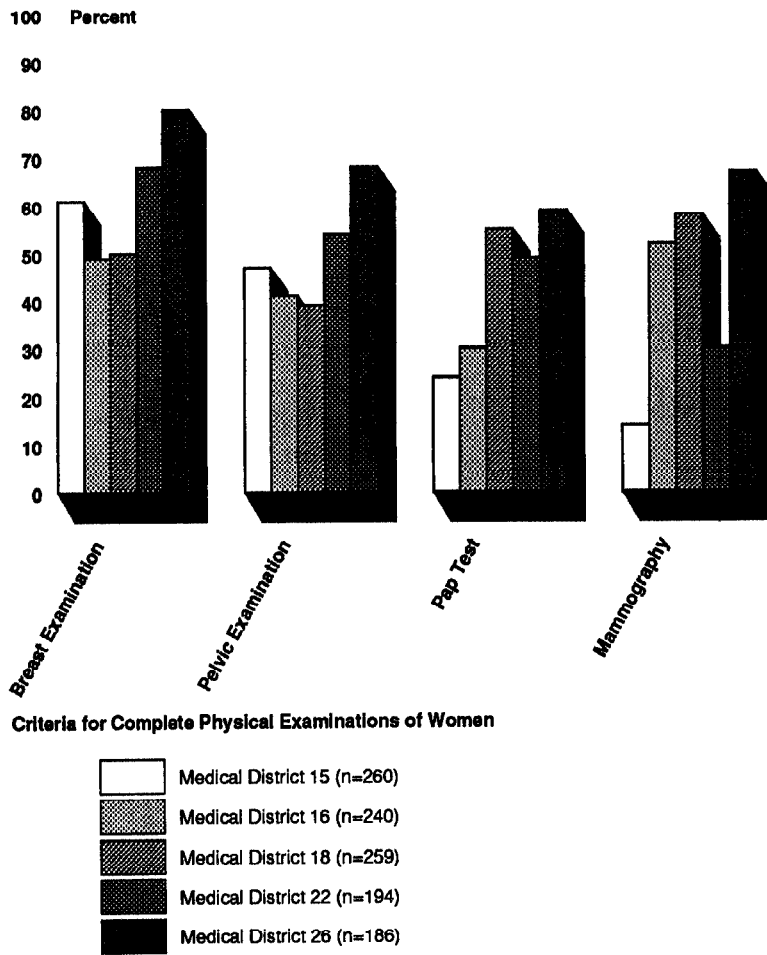
Despite these reviews, some VA medical centers still did not determine compliance with VA's physical examination requirements. These centers

⁵Status and Concerns of Women Veterans, U.S. Congress, House, Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, the 101st Cong., 1st sess., 1989. H. Rept. 101-20, pp. 121-30.

⁶These reviews covered care provided to women veterans during various time periods between June 1988 and September 1989.

did not regularly monitor women's health care as an integral element of their quality assurance activities.

Figure 2: Compliance Rates for Complete Physical Examinations of Women in Five VA Medical Districts



Note: The five VA medical districts include a total of 24 VA medical centers.
 Source: Compliance rates were taken from five Medical District Initiated Peer Review Organization (MEDIPRO) studies: 89-001, 89-006, 89-006(II), 89-009I, and the Medical District 26 report (number not indicated).

Innovative Efforts to Improve Compliance With Examination Requirements

Some VA medical centers have had little success in improving compliance. VA officials cited three primary factors as contributing to poor compliance with the examination requirements: (1) frequent rotation of the medical residents expected to perform the examinations, thus limiting knowledge of the requirements, (2) reluctance on the part of physicians to conduct breast and pelvic examinations when their specialties are in some other fields of medicine, (3) limited efforts by medical centers to monitor the thoroughness of women veterans' examinations. Three of the medical centers we visited, however, developed innovative efforts to improve compliance; these efforts may prove successful at other medical centers if information about such practices is made available.

The Martinez VA Medical Center improved compliance with the examination requirements by strengthening its quality assurance monitoring of women veterans' examinations. In 1988, medical center staff implemented a system to monitor the progress of health care services received by all hospitalized women veterans. As an integral part of the system, the nurse practitioner ensures that each woman veteran receives, is scheduled for, or (at a minimum) is offered the appropriate cancer-screening tests; this is documented in the veteran's medical record before discharge. In every category of gynecologic care, the compliance rates for Martinez improved dramatically between 1987 and 1989:⁷ compliance with VA requirements for pelvic examinations increased from 60.5 to 87.8 percent; breast examinations, from 73.7 to 92.7 percent; and Pap tests, from 50 to 82.9 percent. A quality assurance review, in January 1991, by the medical center indicates that the center was in 100 percent compliance with requirements for the provision of health care services to women veterans.

The San Francisco VA Medical Center similarly strengthened procedures for monitoring examinations of women veterans. Center staff developed a chart to facilitate documenting and identifying whether gynecological examinations have been performed. A designated nurse practitioner receives a daily list of women admitted to the medical center; she then initiates a chart, for use at the beginning of the medical record, to document the patient's history and monitor the status of physical examinations. The nurse practitioner visits with each woman inpatient and ensures that appropriate cancer-screening tests have been done or have been scheduled for a later date. These new procedures were implemented during August 1990. GAO found completed charts in all 13 of the

⁷The rates are based on the 1987 and 1989 MEDIPRO reviews.

medical records randomly reviewed for women veterans discharged between September and December 1990.

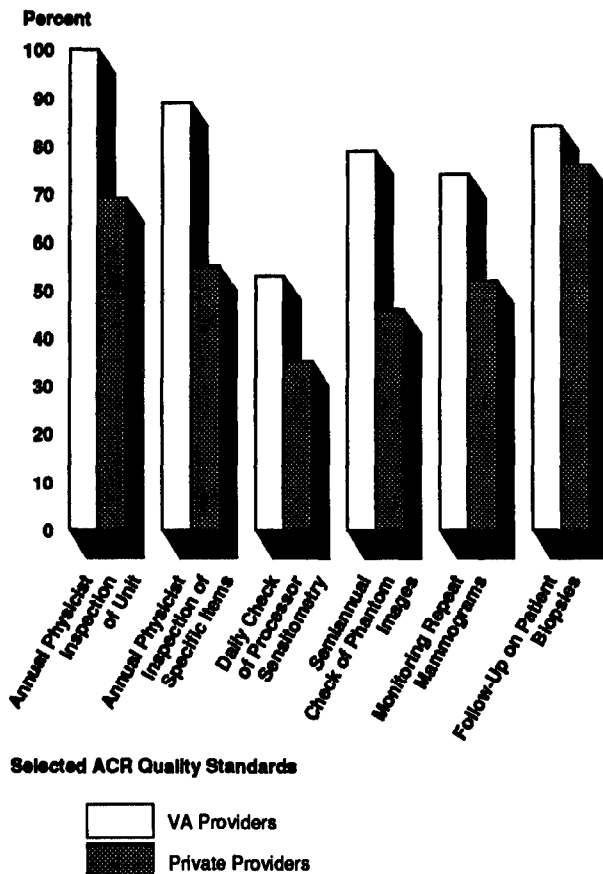
The San Francisco and Martinez efforts focus exclusively on improved quality assurance monitoring. But the Wilkes-Barre VA Medical Center developed an approach that also addressed (1) the problem of some physicians not performing gynecological examinations and (2) the lack of awareness that the cancer-screening tests are required. In January 1988, the Wilkes-Barre VA Medical Center established a women's health care clinic, based on the concept of women caring for women. Nurse practitioners operate the women's clinic and provide routine gynecological care, including the cancer-screening examinations. Additionally, the medical center, as part of its quality assurance program, began monitoring the thoroughness of examinations for women. Two internal quality assurance reviews (Dec. 1988 and May 1990) of medical records showed that the medical center's compliance with VA's requirements for cancer-screening examinations ranged between 75 and 100 percent.

VA Compliance With Mammography Standards Generally Exceeds That of Private Providers, but Some Improvements Needed

The 19 VA medical centers with in-house mammography services generally exceeded private providers for compliance with selected ACR quality standards for mammography (see app. I),⁸ but some improvements are needed. The ACR quality standards can be divided into two groups—service delivery and quality assurance. Service delivery standards include the process of providing mammographic services to patients; quality assurance standards include those associated with evaluating equipment and staff performance. For service delivery, performance was essentially comparable with that of private providers; we found few problems in how the 19 VA medical centers deliver mammography services. For quality assurance, although exceeding the performance of private providers, some improvements are needed in many medical centers' programs for ensuring the accuracy of their mammography equipment and the tests conducted. (See fig. 3 for a comparison of VA and private provider compliance with selected ACR quality assurance standards.)

⁸Two additional systems for mammography services had been purchased, but were not yet operational at the time of our review.

Figure 3: Comparison of VA and Private Providers of Mammography With Selected ACR Quality Standards



Notes: (1) The annual physicist inspection of specific items includes the inspection of beam quality, average glandular dose, and phantom image quality. (2) ACR has modified its standard for the frequency of checks of phantom image quality, from semiannual to monthly. To allow comparisons with private provider responses, we used the old standard from our 1990 report on mammography. (Screening Mammography—Low-Cost Services Do Not Compromise Quality [GAO/HRD-90-32, Jan. 1990].)

Sources: Private providers' responses were obtained from the GAO 1990 report and VA providers' responses were obtained from our survey.

The key problem GAO found with VA medical center inspection of mammography equipment was with the frequency of the inspection. Fifteen of 19 medical centers (79 percent) did not meet at least one of the ACR-recommended time periods for inspecting items of the mammographic equipment we measured. For example, ACR requires that a radiologic technologist conduct a weekly check of the screens, which helps to ensure the quality of the images produced. Only eight (42 percent) reported doing such weekly checks. And two VA medical centers—Miami

and Allen Park—were not in compliance with five (of seven) quality assurance standards. A summary of each VA medical center's compliance with selected ACR standards is provided (see fig. 4).

On September 12, 1991, VA published a circular requiring medical centers to follow ACR guidelines for performing mammography. In part, the circular requires that medical centers establish an adequate quality assurance program that includes inspecting items such as equipment and film quality. However, VA does not monitor VA medical centers' in-house mammography programs to ensure compliance with ACR quality standards. In fact, VA Central Office was unaware that 9 of the 19 medical centers had mammography equipment until we brought it to the office's attention in April 1991.

Figure 4: Noncompliance With Selected ACR Quality Standards at VA Medical Centers Surveyed

Use of ACR Standards in Medical Centers	Service Delivery Standards						Quality Assurance Standards					
	Dedicated Mammography Equipment	Taking Recommended Breast Views	Licensed/Certified Operator	Interpretation of Mammograms by Radiologist	Reporting Results of Abnormal Mammograms	Retention of Mammograms, 5 Years or More	Annual Inspector by Radiological Physicist	Annual Physicist Inspection of Specific Items	Weekly Check of Screens	Daily Check of Processor Sensitometry	Semi Annual Check of Phantom Images	Follow Up on Patient Biopsies
Allen Park, Mich.							●	●	●	●	●	
Bay Pines, Fla.								●				●
Boston, Mass.							●	●				●
Brockton/W. Roxbury, Mass.								●	●	●		
Bronx, N.Y.								●				
Buffalo, N.Y.								●				
Denver, Colo.	●											
Erie, Pa.		●								●	●	●
Hines, Ill.								●				
Iowa City, Iowa												
Long Beach, Calif.								●				●
Louisville, Ky.				●					●			
Martinez, Calif.								●				
Miami, Fla.								●		●	●	●
Minneapolis, Minn.									●			
Philadelphia, Pa.												
Portland, Ore.									●			
Tampa, Fla.								●	●			
West Los Angeles, Calif.												

● Noncompliance with Selected ACR Standard

Notes: (1) A brief description of each standard is outlined in appendix I. (2) Blank space indicates compliance.

Further Actions Needed to Identify and Correct Privacy Deficiencies

In our 1982 report, we recommended that VA revise its privacy standards and ensure that future construction or renovation projects correct privacy deficiencies that limit women's access to facilities and treatment. VA has made significant progress in eliminating such structural problems: for example, at the eight medical centers we visited, we identified no program unable to accommodate women patients. But some

barriers still exist because VA has not established adequate procedures to ensure that privacy deficiencies are identified and corrected during renovation projects.

Inadequate Identification and Follow-Up for Privacy Deficiencies

After issuance of our 1982 report, VA, in the same year, surveyed its medical centers to identify those programs that could not accommodate women patients. The survey was inadequate in several respects, however. First, VA provided little guidance on when a medical center should report that it could not accommodate women patients: for example, a medical center might accept women patients in a treatment program, but have to house them in a location separate from the program. VA did not indicate, however, whether such a medical center should report that it could—or could not—accommodate these patients. This lack of guidance on what to report resulted in some of the privacy deficiencies (identified in our 1982 report), found during the VA survey later that same year, not being recognized as problems by the medical centers. For example, we reported that the North Chicago VA Medical Center did not accept women in some of its psychiatric treatment programs, but the medical center did not report this problem in the VA survey.

Second, the VA survey identified the specific treatment program—such as medical, surgical, or psychiatry—that could not accommodate women patients. VA medical centers did not give an adequate description, however, of the specific deficiencies (such as lack of private rooms or toilets) that prevented the accommodation of women. This made it difficult to determine the status of corrective actions.

Finally, the VA survey identified 28 medical centers with one or more programs unable to accommodate women patients, but VA has not adequately followed up to determine whether corrective actions have been completed. VA identified, at our request, all major renovation projects at the 28 medical centers reporting that women could not be accommodated in one or more programs. Since 1982, most of the medical centers had completed renovation projects or moved into newer facilities better able to accommodate women patients. For example, all domiciliaries that were unable to accommodate women patients in 1982 now accept women. From the information VA gathered, however, neither VA nor GAO could determine whether renovations at many of the medical centers had corrected the privacy deficiencies that had limited women patients' access to treatment programs in 1982. This was because neither the original survey nor the summary of renovation projects gave details of the specific deficiencies limiting women veterans' access.

Further Action Needed to Eliminate Communal Showers and Toilets

One type of privacy deficiency not reported in VA's 1982 survey was the use of communal showers and toilets. None of the eight medical centers GAO visited had identified communal showers as a privacy limitation in 1982; four of the medical centers have communal showers on their medical or surgical wards.

While communal showers do not prevent women from being accommodated, communal showers are inconsistent with VA policy to provide patients adequate privacy, especially in showers and toilets. For example, one woman patient at the Bay Pines Medical Center told GAO about having to place handwritten signs on the door of the communal shower when women were using it and about intrusions by men patients.

Since 1982, VA has revised its facility planning standards to allow the use of communal showers and toilets in newly constructed or renovated space only when space or structural barriers prohibit private or shared accommodations. Adequate procedures do not exist, however, to ensure that standards are followed during renovation projects. For example, the Tampa VA Medical Center renovated one of its medical and surgical wards—and planned to renovate the remaining wards—without subdividing the existing communal showers or establishing private showers to accommodate women patients. The medical center has both a women veterans coordinator and a women veterans committee, but neither is involved in the review and approval of construction and renovation projects. Increased involvement of women veterans coordinators in the planning for renovation projects might help ensure that the privacy needs of women patients are adequately considered.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Chief Medical Director to carry out these actions:

- Require each medical center, as part of its quality assurance program, to develop and implement an action plan, acceptable to the Chief Medical Director, for improving compliance with the requirement that each woman inpatient receive a complete physical examination, including pelvic and breast examinations and a Pap test, at appropriate intervals. These plans should, at a minimum, address (1) the use of nurse practitioners and gynecologists to perform physical examinations, (2) the education and training of medical center staff as to the importance of women-specific services, and (3) quality assurance monitoring.

- As part of VA's quality assurance activities, monitor centers' compliance with the September 1991 circular on mammography services.
- Issue guidance to medical centers on (1) identifying privacy deficiencies in accommodations for women veterans and (2) instituting a mechanism for tracking corrective actions. The latter should include a center's women veterans coordinator or a representative of the women veterans committee or both in the approval process for facility renovation and construction projects, thus helping to ensure that the privacy needs of women patients are adequately addressed.
- Ensure that innovative practices for improving health services to women veterans are identified, disseminated, and, where appropriate, implemented throughout the system.

Agency Comments

In a letter dated December 6, 1991, the Secretary of Veterans Affairs concurred with our recommendations and acknowledged that more can be done to improve services to women veterans (see app. III). The Secretary further provided details on the actions planned by the Veterans Health Administration (VHA) during 1992 to implement the recommendations:

- Publish a circular to improve compliance with existing policy and to incorporate quality management principles in auditing compliance. (The circular will require each medical center to (1) develop a plan for monitoring compliance with VA policy on physical examinations, (2) address quality assurance monitors and roles of nurse practitioners, internists, and gynecologists, and (3) address the required education of clinicians in gender-specific services.)
- Review plans for provisions of breast-screening services submitted by VA medical centers and, in coordination with regional offices, develop periodic monitoring of quality control and quality assurance aspects of mammography services and equipment.
- Publish a circular with guidance on identifying and correcting privacy deficiencies, establish a subcategory for female patient privacy in the VHA data base for minor and nonrecurring maintenance projects, and develop weights for privacy construction projects with female privacy considerations, incorporating these into its prioritization methodologies.
- Incorporate new and innovative preventive services for women veterans into the VHA preventive medicine policy for VA medical centers. (An "Information Letter" will disseminate innovative approaches to compliance with VHA's policy on health care to women veterans.)

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to interested parties and make copies available to others on request. If you have any questions about this report, please call me at (202) 275-6207. Other major contributors to this report are listed in appendix IV.

Sincerely yours,

Edward A. Hensmore

for

David P. Baine
Director, Federal Health
Care Delivery Issues

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Abbreviations

ACR	American College of Radiology
ACS	American Cancer Society
VA	Department of Veterans Affairs
MEDIPRO	Medical District Initiated Peer Review Organization

Explanation of ACR Quality Standards

The following selected ACR quality standards were used in our study for (1) comparing VA mammography services with those of private providers and (2) determining the extent to which those VA medical centers are complying with ACR quality standards. These standards do not represent all of ACR's quality standards for mammography.

Use of Dedicated Equipment

The mammographic equipment should be designed especially for mammography and should include a compression device and removable grid. Conventional radiographic equipment that has been adequately modified can be used with xeroradiography.

Taking of Breast Views

The examination should ordinarily be limited to craniocaudal and mediolateral oblique views of each breast.

Licensed/Certified Operator

Certification by the American Registry of Radiological Technologists or state licensure or both required.

Interpretation of Mammograms by Radiologist

The radiologist must (1) interpret mammograms on a regular basis, with a recommended minimum of 480 mammograms per year (it is understood that in low population areas, this number may not be achievable), and (2) regularly participate in continuing education programs for mammography (it is recommended that, initially, the radiologist should have 40 hours of continuing medical education [CME] credits in mammography and, thereafter, 15 hours of CME credits in mammography every 3 years).

Reporting Results

The report should be rendered as soon as reasonably possible. Description of abnormalities detected by screening and recommendations for subsequent follow-up studies should be included in the report. All reports in the high-probability category should be communicated to the referring physician or his or her designated representative by (1) telephone, (2) certified mail, or (3) in such a manner that receipt of the report is assured and documented.

Record Retention	Original mammograms should be retained by a facility or made available to the patient for a period of at least 5 years or, if required by state or federal acts, longer.
Annual Inspection by Radiological Physicist	An annual inspection by a radiological physicist.
Annual Physicist Inspection of Specific Items	Annual inspection (including beam quality, average glandular dose, and phantom image quality) by a medical physicist.
Check of Screens	Weekly check for screen cleanliness by a radiologic technologist.
Check of Processor Sensitometry	Daily quality control of processor by a radiologic technologist.
Check of Phantom Images	Monthly inspection by a radiologic technologist.
Follow-Up on Patient Biopsies	Systems for reviewing outcome data from mammography should be established. Included should be follow-up on the disposition of positive mammograms and correlation of surgical biopsy results with mammogram reports. It is understood that in some situations, follow-up information on all positive mammograms will be unobtainable.
Monitoring Repeat Mammograms	The radiologic technologist should do a quarterly analysis of mammograms that were required to be repeated.

GAO Questionnaire on Mammography

United States General Accounting Office



SURVEY OF DVA HOSPITALS' MAMMOGRAPHY PROCESS

The U.S. Congress has asked the General Accounting Office (GAO) to conduct a follow-up study on DVA's health care services for female veterans. As part of our study, we are collecting information about current mammography practices at DVA medical centers.

This questionnaire should take about 15 minutes to complete. It was designed to collect information from medical centers that have in-house mammography capabilities. Specifically, we are requesting information about the mammography process and quality assurance procedures conducted at your DVA medical center.

This questionnaire should be completed by the person(s) most familiar with your mammography process. Please provide the name, title, and telephone number of the primary person responsible for completing the questionnaire in the event that we need to contact him or her for additional information or clarification.

Medical Center: _____

Name of primary person to call:

Official title:

Telephone number (Non FTS): () _____

HRD/SLS/2-91 (406000)

Appendix II
GAO Questionnaire on Mammography

BACKGROUND

1. Is mammography performed at your facility? (CHECK ONE.)
 - a. Yes
 - b. No -->(Stop! PLEASE RETURN THIS QUESTIONNAIRE. IT IS IMPORTANT THAT YOU RETURN THIS QUESTIONNAIRE.)

2. Does your facility provide mammography to -- (a) symptomatic patients, (b) asymptomatic patients, or (c) both symptomatic and asymptomatic patients? (CHECK ONE.)
 - a. Symptomatic patients only
 - b. Asymptomatic patients only
 - c. Both symptomatic and asymptomatic patients

3. Approximately during what month and year did your facility begin providing mammography services?

_ _ _ _	19	_ _ _ _
(Month)		(Year)

4. Does your facility provide mammography services to patients from other DVA medical centers?
 - a. Yes --> How many other DVA facilities? _____
 - b. No

**Appendix II
GAO Questionnaire on Mammography**

5. For each federal fiscal year (FY) listed below, please indicate in:

Column 1: Total number of mammograms performed at your facility.

Column 2: Total number of mammograms provided through a fee basis or contract arrangement.

	Column 1 Total Mammograms Performed at <u>Your Facility</u>	Column 2 Total Mammograms Provided Through Fee Basis/ Contract <u>Arrangement</u>
a. FY 1988	_____	_____
b. FY 1989	_____	_____
c. FY 1990	_____	_____

6. During a normal week, how many symptomatic and/or asymptomatic mammograms does your facility perform?

- a. _____ Number of symptomatic mammograms
- b. _____ Number of asymptomatic mammograms

7. Listed below are various pieces of information which might be collected from a patient as part of the mammography process. Indicate the information you usually collect. (CHECK ALL THAT APPLY.)

- a. () Demographic data (e.g., age, marital status, ethnic background)
- b. () Current breast symptoms (e.g., breast tenderness, pain, lump, or nipple discharge)
- c. () Previous mammography information (e.g., date, where performed)
- d. () Surgical history -- breast surgery
- e. () Family history of breast cancer
- f. () Current medication history (e.g., hormone)
- g. () Other (PLEASE SPECIFY.) _____
- h. () Do not collect information

Appendix II
GAO Questionnaire on Mammography

8. When a patient has a mammogram at your facility, is a breast physical examination (palpation) routinely conducted? (CHECK ALL THAT APPLY.)
- a. Yes, prior to scheduling the mammogram
 - b. Yes, as part of the mammogram process
 - c. Yes, sometime after the patient has completed the mammogram process
 - d. No, a physical examination is not conducted
 - e. Don't know

9. Indicate what mechanism(s) is used by your facility to inform the patient about breast self-examination. (CHECK ALL THAT APPLY.)
- a. Video
 - b. Pamphlet
 - c. Staff person instructs the patient
 - d. Other (PLEASE SPECIFY.) _____
 - e. No information provided

MAMMOGRAPHY PROCESS

10. For mammography, indicate if your facility performs mammograms using (a) dedicated mammography equipment (i.e., equipment manufactured for the sole purpose of mammography or general radiographic equipment that is modified for mammography only and cannot be used for general radiographic purposes), (b) general purpose radiographic equipment, or (c) both dedicated mammography and general purpose radiographic equipment? (CHECK ONE.)
- a. Dedicated mammography equipment only (i.e., equipment manufactured or modified for mammography only)
 - b. General purpose radiographic equipment
 - c. Both dedicated mammography and general purpose radiographic equipment

Appendix II
GAO Questionnaire on Mammography

11. Indicate the type of mammography your facility uses. (CHECK ONE.)

- a. Screen-film mammography
- b. Xeromammography
- c. Both screen-film and xeromammography

12. Which views does your facility usually do for a bilateral mammogram?
(CHECK ALL THAT APPLY.)

- a. Cranio-caudal or Cephalo-caudal (1 view per breast)
- b. True Lateral (1 view per breast)
- c. Oblique--Mediolateral (1 view per breast)
- d. Other (PLEASE SPECIFY.) _____

13. Listed below are various categories representing individuals who might perform mammography. Indicate the one category which represents the individual at your facility who usually performs the mammograms. (CHECK ONE.)

- a. ARRT registered radiologic technologist
- b. State licensed radiologic technologist
- c. Both ARRT registered and state licensed radiologic technologist
- d. Other (PLEASE SPECIFY.) _____

Appendix II
GAO Questionnaire on Mammography

14. Listed below are categories representing individuals who might interpret mammograms. Indicate the category which represents the individual at your facility who usually does the final interpretation of the mammograms. (CHECK ONE.)

- a. Radiologist
- b. Other physician
- c. Nurse
- d. Technologist
- e. Other (PLEASE SPECIFY.) _____

15. When a patient has a negative mammogram, what is usually done with the mammogram report? (CHECK ONE.)

- a. Report sent to the patient
- b. Report sent to patient's physician
- c. Report sent to the patient and patient's physician
- d. Report not sent, but patient telephoned about the results
- e. Report not sent, but patient's physician telephoned about results
- f. Report not sent, but patient and patient's physician telephoned about the results
- g. Report not sent, but filed at the facility
- h. Other (PLEASE SPECIFY.) _____

**Appendix II
GAO Questionnaire on Mammography**

16. When a patient has a positive mammogram, what is usually done with the mammogram report? (CHECK ONE.)

- a. () Report sent to the patient
- b. () Report sent to patient's personal physician
- c. () Report sent to the patient and patient's physician
- d. () Report not sent, but patient telephoned about the results
- e. () Report not sent, but patient's personal physician telephoned about results
- f. () Report not sent, but patient and patient's physician telephoned about the results
- g. () Report not sent, but filed at the facility
- h. () Other (PLEASE SPECIFY.) _____

17. For each item listed below, check in:

Column 1: Whether your facility keeps the item as part of the patient's record.

Column 2: If yes, how long the item is kept. (CHECK ONE FOR EACH ITEM.)

Item	Column 1			Column 2				
	Item kept?			How long is the item kept? (CHECK ONE FOR EACH ITEM.)				
	No	Yes		1 Yr	2-4 Yrs	5 Yrs	6-10 Yrs	Over 10 Yrs
a. Mammogram report			If Yes -->					
b. Original mammogram images			If Yes -->					
c. Patient information provided at the time of the mammogram			If Yes -->					
d. Other (SPECIFY.) _____			If Yes -->					

**Appendix II
GAO Questionnaire on Mammography**

QUALITY ASSURANCE

18. Does your facility periodically have someone inspect all or part of your mammography system? (CHECK ONE.)

- a. Yes
- b. No —>(SKIP TO QUESTION 22.)

19. Listed below are various individuals who might inspect a mammography system. Indicate in:

- Column 1: Whether your mammography system is inspected by each individual.
- Column 2: If yes, how frequently each individual inspects your system. (CHECK ONE.)

Individual	Column 1 Does Inspect?		Column 2 How frequently mammography system inspected. (CHECK ONE.)					
	No	Yes	Every 6 Months	Every Year	Every 2 Years	Every 3-5 Yrs	Over 5 Years	
a. Staff Radiological Physicist								If Yes—>
b. Consultant Radiological Physicist (i.e., physicist not at the facility)								If Yes—>
c. Other (SPECIFY.) _____								If Yes—>

**Appendix II
GAO Questionnaire on Mammography**

20. For each of the items listed below, check in:

Column 1: Whether the staff radiological physicist, consultant radiological physicist, or an other individual you identified in question 19 inspects the item.

Column 2: If yes, which individual(s) inspects the item.
(CHECK ALL THAT APPLY.)

Item	Column 1 Inspect item?				Column 2 Who inspects item? (CHECK ALL THAT APPLY)		
	No	Yes	N/A		Staff Radiological Physicist	Consultant Radiological Physicist	Other
a. Beam quality (Half value layer)				If Yes—>			
b. Focal spot size				If Yes—>			
c. Average glandular dose				If Yes—>			
d. Phototimer				If Yes—>			
e. Consistency of mA station				If Yes—>			
f. KVP				If Yes—>			
g. Phantom image quality				If Yes—>			
h. Other (SPECIFY.) _____				If Yes—>			

Appendix II
 GAO Questionnaire on Mammography

21. Listed below are additional items that might be inspected as part of your facility's quality assurance program. Check in:

Column 1: Whether each item is inspected as part of your quality assurance program.

Column 2: If yes, how frequently the item is inspected. (CHECK ONE.)

Item	Column 1 Inspect Item?			Column 2 How frequently is the item inspected? (CHECK ONE.)					
	No	Yes		Daily	Weekly	Monthly	Every 6 Months	Annually	Less Often Than Annually
a. Grids			If Yes—>						
b. Screens			If Yes—>						
c. Processor Sensitometry			If Yes—>						
d. Phantom image quality			If Yes—>						
e. Other (SPECIFY.) _____			If Yes—>						

Appendix II
GAO Questionnaire on Mammography

22. A facility might include some of the following procedures as part of its quality assurance program. Which procedures, if any, does your facility usually perform. (CHECK ALL THAT APPLY.)

- a. Review film quality
- b. Perform a second reading of mammograms within the facility
- c. Submit mammograms for second reading by radiologist(s) outside the facility
- d. Follow up on patient biopsies
- e. Monitor number of repeat mammograms due to equipment, patient, and/or technologist problems
- f. Other (PLEASE SPECIFY.) _____
- g. No procedures performed

23. Does your facility provide any mammography services using a mobile van? (CHECK ONE.)

- a. Yes
- b. No

24. If you would like to provide additional information about your mammography program or make comments regarding this questionnaire, please use the space provided below.

**** THANK YOU FOR YOUR COOPERATION ****

Comments From the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

DEC 6 1991

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
Human Resources Division
U.S. General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Baine:

This is in response to your draft report, VA HEALTH CARE FOR WOMEN: Despite Progress, Improvements Needed (GAO/HRD-92-23). We are pleased that the GAO report recognizes the significant progress the Department of Veterans Affairs (VA) has made toward assuring women veterans' access to health care is equal to that of men veterans. This progress is the direct result of the increased emphasis we have placed on identifying and correcting problems concerning care for women veterans.

We agree with the GAO recommendations and recognize that more can be done to improve service to women veterans. In this regard, the Veterans Health Administration (VHA) staff is working in concert with the U. S. Preventive Services Task Force to keep apprised of new issues to improve health services to women veterans.

The enclosure details actions taken or planned to implement GAO's recommendations. I appreciate the opportunity to comment on this report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Edward J. Derwinski".

Edward J. Derwinski

Enclosure
EJD/vz

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO GAO
DRAFT REPORT, VA HEALTH CARE FOR WOMEN:
DESPITE PROGRESS, IMPROVEMENTS NEEDED
(GAO/HRD-92-23)

GAO recommends that I direct the Chief Medical Director to:
-- Require each medical center, as part of their quality assurance program, to develop and implement an action plan, acceptable to the Chief Medical Director, for improving compliance with the requirement that each woman inpatient receive a complete physical examination, including pelvic and breast examinations and a Pap test, at appropriate intervals. These plans should, at a minimum address (1) the use of nurse practitioners and gynecologists to perform physical examinations, (2) the education and training of medical center staff as to the importance of women-specific services, and (3) quality assurance monitoring.

CONCUR - By February 1992, VHA will publish a circular to improve compliance with existing policy and to incorporate quality management principles in auditing compliance with that policy. The circular will require each VHA medical center to develop a plan for monitoring compliance with VA policy on physical examinations and submit it to VA Central Office for approval. The facility's quality assurance office will coordinate the plan requiring input from a variety of offices reporting to the Chief of Staff, most significantly, the Assistant Chief of Staff (ACOS) for Ambulatory Care and the ACOS for Education. The circular will require that the facility's plan specifically address quality assurance monitors, roles of nurse practitioners, internists, and gynecologists. It will also address the required education of clinicians in gender specific services. The VHA's Office of Environmental Medicine and Public Health will analyze plans and provide feedback to all facilities in the form of an Information Letter. We anticipate publishing this Information Letter by November 1992.

-- As part of VA's quality assurance activities, monitor centers' compliance with the September 1991 circular on mammography services.

CONCUR - VHA's Office of Environmental Medicine and Public Health will review plans for provisions of breast screening services submitted by VA medical centers in accordance with VHA Circular 10-01-101, dated September 12, 1991. We anticipate completion of this review by May 1992.

Appendix III
Comments From the Department of
Veterans Affairs

In coordination with its regional offices, VHA will also develop periodic monitoring of quality control and quality assurance aspects of mammography services and equipment. We will complete these plans by July 1992.

-- Issue guidance to medical centers on (1) identifying privacy deficiencies in accommodations for women veterans and (2) instituting a mechanism for tracking corrective actions. The letter should include the women veterans coordinator or women advisory committee or both in the approval process for facility renovation and construction projects, thus helping to ensure that the privacy needs of women patients are adequately addressed.

Concur - In February 1992, VHA will publish a circular with guidance on identifying and correcting privacy deficiencies. As an ongoing process, VHA is encouraging submission of privacy construction projects. VHA will also establish a subcategory for female patient privacy in the Office of Facilities data base for minor and nonrecurring maintenance projects by November 1992. Also by November 1992, VHA will assign a task force/working group to develop weights for privacy construction projects with female privacy considerations, and incorporate these into its prioritization methodologies.

-- Insure that innovative practices for improving health services to women veterans are identified, disseminated, and, where appropriate, implemented throughout the system.

Concur - While we concur with the general thrust of this recommendation, we believe the recommendation is somewhat vague, and it is unclear what is meant by "innovative". The report cites three "innovative" efforts to improve compliance with examination requirements. Two, however, are fairly classic examples of quality assurance monitoring, and the third is loosely based on a model clinic established at another VAMC. In addition, similar clinics exist in at least 90 VAMCs around the country.

VA is also taking additional action in this area. VHA's Preventive Medicine Program is closely associated with the U. S. Preventive Services Task Force, the group that issued the "Guide to Clinical Preventive Services" under the auspices of the Public Health Service. As new and innovative preventive services for women veterans are identified, VHA will incorporate them into its preventive medicine policy for VA medical centers. The Information Letter cited in recommendation 1 above to be issued in November 1992 will also disseminate innovative approaches to compliance with VHA's policy on health care to women veterans.

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