

HEALTH CARE SERVICES FOR WOMEN VETERANS

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook defines the scope of health care services to women Veterans. It delineates essential components necessary to ensure that all enrolled women Veterans have access to appropriate services, regardless of VHA site of care.
- 2. SUMMARY OF MAJOR CHANGES.** This VHA Handbook incorporates the new standard requirements for the delivery of health care to women Veterans and specifies services that must be provided at each Department of Veterans Affairs (VA) Medical Center and Community-Based Outpatient Clinic (CBOC).
- 3. RELATED ISSUES.** VHA Handbook 1330.02.
- 4. RESPONSIBLE OFFICE.** The Chief Consultant, Women Veterans Health Strategic Health Care Group (13E) is responsible for the contents of this VHA Handbook. Questions may be referred to (202) 461-1070, or Fax at (202) 495-5961.
- 5. RECISSIONS.** VHA Handbook 1330.1, dated July 16, 2004, is rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled to be recertified on or before the last working day of May 2015.

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Under Secretary for Health

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VHA SERVICES FOR WOMEN VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes the minimum clinical requirements to ensure that all eligible and enrolled women Veterans, irrespective of where they obtain care in VHA, have access to all necessary services as clinically indicated.

2. BACKGROUND

a. While women Veterans constitute a minority of Veterans, they represent a “critical mass” deserving the same level of services provided to male Veterans. The Women Veterans Health Strategic Health Care Group (WVHSHG) works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VHA facilities nationwide. The Department of Veterans Affairs (VA) strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women.

b. The WVHSHG has adopted the following principles to provide the highest quality care for our women Veterans:

- (1) Comprehensive primary care.
- (2) Provided by proficient and interested primary care clinicians.
- (3) Focused on safety, dignity, and sensitivity to gender-specific needs.
- (4) Offering the right care in the right place at the right time.
- (5) Using state-of-the-art health care equipment and technology.

3. AUTHORITY

a. Public Law (P. L.) 102-585, Veterans Health Care Act of 1992, Title I, enacted November 4, 1992, authorizes VA to provide gender-specific services, such as Papanicolaou tests (Pap smears), breast examinations, management of menopause, mammography, and general reproductive health care services to eligible women Veterans. In addition, this law authorizes VA to provide women Veterans counseling services needed to treat conditions related to sexual trauma experienced while serving on active duty.

b. P. L. 102-585 also mandates that a VHA official in each region must serve as coordinator of women’s services with specific responsibility for assessing the needs of and enhancing services for women Veterans. As a result of the realignment of VHA the position of Regional Women Veterans Coordinator is re-titled Deputy Field Director (DFD), Women Veterans Health Program.

c. P. L. 103-452, the Veterans Health Programs Extension Act of 1994, signed

November 2, 1994, authorizes VA to provide appropriate care and services for conditions related to sexual trauma. The law also made VA's authority to treat sexual trauma gender-neutral.

d. P. L. 104-262, Veterans' Health Care Eligibility Reform Act of 1996, required VA to establish and implement a national enrollment system. Maternity and infertility services, excluding in-vitro fertilization (IVF), are included in VA's Uniform Medical Benefits package.

e. P. L. 106-117, Veterans Millennium Health Care and Benefits Act, signed November 30, 1999, extended VA's authority to provide counseling and treatment for conditions related to sexual trauma.

f. VA's Uniform Medical Benefits package includes pregnancy and delivery services as authorized by law and certain medically necessary infertility services. **NOTE:** *See Title 38 Code of Federal regulations (CFR) Sections 17.38(a)(1)(xiii) and 17.38(b) [care needed to promote, preserve, or restore health].* Abortions, abortion counseling, and in-vitro fertilization (IVF) are expressly excluded from the medical benefits package. **NOTE:** *See Title 38 CFR, Section 17.38(c)(1) & (2).*

g. Section 1720D of Title 38, United States Code, as amended by P. L. 108-422, Veterans Health Programs Improvement Act of 2004, grants VA permanent authority to provide counseling and treatment for conditions related to military sexual trauma and extends eligibility to Veterans who experienced sexual trauma while on active duty for training (ADUTRA) status.

h. P. L. 110-387 enhances domiciliary care for women Veterans, and requires that VA Domiciliary programs are adequate, with regard to capacity and safety, to meet the needs of women Veterans.

4. DEFINITIONS

a. **Co-Location:** Primary care and gender specific specialty care in the same physical location in order to optimize care delivery.

b. **Comprehensive Primary Care for Women Veterans:** The provision of complete primary care and care coordination by *one primary care provider at one site*. The primary care provider should, in the context of a longitudinal relationship, fulfill all primary care needs, including:

(1) **Care for Acute and Chronic Illness:** Routine detection and management of acute and chronic diseases commonly seen in primary care including, but not limited to: acute upper respiratory illness, cardiovascular disorders, screening for cancer of the breast and cervix, osteoporosis, thyroid disease, chronic obstructive pulmonary disease (COPD), etc.

(2) **Gender-Specific Primary Care:** Contraception counseling and care, sexually transmitted infection (STI) treatment, pharmacologic issues related to pregnancy and lactation, management of menopause-related concerns, initial evaluation and treatment of gender-specific conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, urinary incontinence, etc.

(3) **Preventive Services:** Age-appropriate cancer screening, nutrition counseling, weight management and fitness counseling, STI screening and counseling, smoking cessation counseling and treatment, immunizations, etc.

(4) **Mental Health Services:** Assessment and psychosocial treatment as needed for a variety of mental health disorders, which include depression and problem drinking, within the parameters of Mental Health-Primary Care integration.

(5) **Coordination of Care:** Coordinating care and communicating with specialty providers regarding evaluation and treatment plans to ensure care continuity.

***NOTE:** It is important to recognize that those women's clinics offering only gender-specific care (Pap clinic or gynecology care alone) do not meet the definition of comprehensive primary care given above). Primary Care may be delivered utilizing a team model, but it is expected that gender-specific primary care is provided by the same clinician that renders other routine Primary Care, preferably without multiple encounters or visits scheduled over different days.*

c. **Designated Women's Health Primary Care Provider (WH PCP):** A primary care provider who is interested and proficient in women's health. A designated WH PCP is preferentially assigned women Veterans within their primary care patient panels.

d. **Exclusive Space:** A separate physical location, for the delivery of primary care to women Veterans, not shared by other services providing care to male veterans.

e. **Facility:** Includes all freestanding medical centers, parent facilities and their divisions, Community-Based Outpatient Clinics (CBOCs), and independent clinics.

f. **Separate Shared Space:** A separate physical location for the delivery of primary care to women Veterans. This location may be used by other services on days when women Veterans are not being seen.

g. **Military Sexual Trauma (MST) (defined according to Title 38 U.S. Code 1720D):** "physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while a Veteran was serving on active duty or active duty for training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character." The location where the sexual trauma occurred, the genders of the people involved, and their relationship to each other do not matter.

5. SCOPE

Each VHA facility must ensure that eligible women Veterans have access to comprehensive medical care, including care for gender-specific conditions and mental health conditions, that is comparable to care provided for male Veterans.

a. All enrolled women Veterans need to receive comprehensive primary care from a designated WH PCP who is interested and proficient in the delivery of comprehensive primary care to women, irrespective of where they are seen (freestanding medical centers, primary facilities, community-based outpatient clinics (CBOCs), and independent clinics).

b. Each medical facility must have a designated full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health issues that improves the overall quality of care provided to women Veterans.

c. Privacy must be provided to women Veterans in all health care settings.

(1) 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 rounds. **NOTE:** *It is recommended that at a minimum, rounds include Facilities Management/Engineering, the Associate Director or designee, and the Women Veteran Program Manager.*

(2) 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. **NOTE:** *See Appendix A for a checklist for minimum standards for environmental privacy and security.*

d. A female chaperone **must** be in the examination room during examinations, procedures, or treatments involving the breast and genitalia, regardless of the gender of the provider. In addition to breast examinations and pelvic examinations, and Pap smears, this may include procedures such as Urodynamic testing or treatments such as Pelvic Floor Physical Therapy.

(1) The following staff may function as female chaperones (health technicians, nurse's aides, Licensed Practical Nurses) for all gender specific examinations (breast, genitalia and rectal). Female chaperones need to be provided irrespective of whether the examination is being performed by a male or a female provider.

NOTE: *Female Volunteers may be used as chaperones when a specific position description outlining the duties and expectations has been written in collaboration with the Chief, Voluntary Services, the position description has been approved, and staff have been educated on the role limitations of the Volunteer chaperone (VHA Handbook 1620.1). Female Volunteer chaperones will have had prior experience working in a clinical health care environment (such as an RN, LPN or health technician).*

(2) A chaperone must be present at all gender specific exams, procedures, or treatments and when requested by a female Veteran for any visit. Chaperones help with the set up for Pap smears and Pelvic examinations; assist the Veteran with dressing and undressing, and provide gowns and other dressing apparel to the Veteran. If chaperones are utilized, duties should ***not*** be of a nature that would require credentialing/privileging.

6. RESPONSIBILITIES OF THE CHIEF CONSULTANT, WVHSHG

The Chief Consultant WVHSHG is responsible for the management, administration, technical aspects, program planning, policies, evaluations, integration and implementation of the national Program's activities. These programs include activities related to clinical services evaluation and coordination of women Veterans health care, women Veterans' health policy, epidemiology and research. It also includes other women Veterans' health issues as defined by VA on an evolving and as-needed basis.

- a. The Chief Consultant, in collaboration with Patient Care Services, develops and implements national directives, program initiatives, and VHA guidance related to women's health issues.
- b. The Chief Consultant initiates, promotes, and leads effective collaborations with Veterans Integrated Service Network (VISN) and facility Directors to integrate the delivery of comprehensive health care services to women Veterans across the national health care system and continuously evaluates and improves the delivery of health care to women Veterans.

7. RESPONSIBILITIES OF THE VISN DIRECTOR

Each VISN Director is responsible for:

- a. Ensuring that a Lead Women Veterans Program Manager (WVPM) is designated to serve as the VISN representative on women Veteran's issues and as a member of the WVHSHG Field Advisory Group.

(1) The VISN Lead WVPM needs to have direct access to top management in the VISN and serve on appropriate administrative and clinical boards or committees.

(2) It is highly recommended that the Lead WVPM also have VISN level funding and staff support for data analysis and project implementation, as well as money for travel to meetings with the facility-level WVPMs in the VISN.

- b. Ensuring that a planning and implementation team for comprehensive primary care for women Veterans has been established at every facility and that the requirements in this handbook are carried out.

- c. Ensuring that all staff members assume the responsibility of caring for women Veterans.

NOTE: VHA Handbook 1330.02, Appendices A and B describe work performed at the Network level.

8. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each Facility Director is responsible for:

- a. Ensuring that all staff members assume the responsibility of caring for women Veterans.
- b. Ensuring that a multi-disciplinary planning and implementation team for comprehensive primary care for women Veterans has been established.
- c. Appointing a clinical health care professional as full-time WVPM who is sensitive to the needs of women in VA health care facilities.
 - (1) VHA Handbook 1330.02 details the duties and responsibilities of health care professionals who perform the duties of the WVPM and provides in-depth detail for position descriptions and functional statements for the WVPM role.
 - (2) As of December 1, 2008, each facility must have a designated full-time WVPM.
 - (a) The position is mandated to be a full time administrative position with minimal allotment of clinical time (1/8 FTEE) to maintain clinical competency.
 - (b) The WVPM must be a health care professional such as a Registered Nurse (RN); Social Worker or Psychologist; Doctor of Medicine (MD/DO); Nurse Practitioner (NP); Physician Assistant (PA); Pharmacist; or other allied health care professional.
- d. Ensuring that the WVPM has direct access to top management in the facility and serves on appropriate administrative and clinical boards and/or committees.
- e. Ensuring that the name, location, and business telephone number of the WVPM is posted and appropriately publicized in each facility (e.g., on the facility website and accessible through the facility locator web tool).
- f. Ensuring that when a new full-time WVPM is appointed, the name, title, commercial telephone number, and e-mail address is submitted to the appropriate Deputy Field Director (DFD) and to the VISN Director within 10 working days. The DFD then notifies the VHA W VHSHG which maintains a listing of current WVPMs.
- g. Ensuring the appointment of a Women's Health Medical Director or a Women's Health Champion.
- h. Ensuring that an individual is designated at each facility to enter data from women Veterans' health care services provided by the facility into existing software packages or other formal mechanisms. **NOTE:** *This individual must be a clerical support staff member and not the clinical professional providing the care.*
- i. Ensuring support for data analysis and project implementation and sufficient resources to support quality and follow-up care.
- j. Ensuring that each Community-Based Outpatient Clinic (CBOC) has a Women's Health Liaison who collaborates with the WVPM at the parent facility.

9. RESPONSIBILITIES OF CLINICAL EXECUTIVE LEADERSHIP

Facility Clinical Executive Leadership is responsible for:

- a. Ensuring that clinical leadership, in Primary Care, Mental Health, and Specialty/Acute Care, plan and implement equitable, high quality, comprehensive healthcare services for women Veterans, including gender specific services, in a secure and sensitive environment in all areas of the facility.
- b. Ensuring excellent and equitable achievement on all clinical gender neutral and gender specific performance measures in the facility and CBOCs.
- c. Participating in a multidisciplinary planning and implementation team for comprehensive care of women Veterans.
- d. Working closely with the WVPM and Women's Health Medical Director/Clinical Champion.
- e. Holding Primary Care leadership accountable for identifying designated interested and proficient women's health primary care providers at each facility and CBOC.
- f. Ensuring the medical staff members providing women's comprehensive primary care are appropriately proficient, credentialed and privileged.

10. RESPONSIBILITIES OF PRIMARY CARE LEADERSHIP

Primary Care Leadership is responsible for:

- a. Excellent and equitable achievement on all primary care gender neutral and gender specific performance measures in the facility and CBOCs.
- b. Participating in a multidisciplinary planning and implementation team for comprehensive care of women Veterans.
- c. Working closely with the WVPM and Women's Health Medical Director/Clinical Champion.
- d. Ensuring that designated, interested and proficient comprehensive women's primary care providers are appointed at each facility and CBOC.

11. RESPONSIBILITIES OF THE WOMEN VETERANS PROGRAM MANAGER (WVPM)

The WVPM is responsible for:

- a. Executing comprehensive planning for women's health issues that improves the overall quality of care provided to women Veterans and achieves program goals and outcomes.

- b. Collaborating with and coordinate planning efforts with the WVHSHG.
- c. Attending national conference calls held monthly to learn about ongoing initiatives to improve women Veteran's care.
- d. Assessing the need for and implementation of services for women Veterans and providing oversight to ensure identified needs are met.
- e. Collaborating with primary care providers to ensure that the needs of women Veterans are met in a comprehensive manner.
- f. Working in coordination with diagnostic services to develop, implement and maintain a formal tracking mechanism to assure proper and timely notification of gender-specific diagnostic studies.
- g. Participating in the regular review of the physical environment, including formal review of all plans for renovation and construction, to identify potential privacy and safety deficiencies and facilitate availability and accessibility of appropriate equipment for the medical care of women.
- h. Partnering with the local Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Coordinators to ensure that OEF and OIF women Veterans have access to and receive priority, quality, comprehensive primary and gender-specific health care and services.
- i. Partnering with leaders from all other applicable programs such as the Military Sexual Trauma (MST) Coordinator, Homeless Coordinator and the Minority Veterans Coordinator at the facility.
- j. Working with acquisitions and contracting to have input on contracts that impact the delivery of services to women Veterans (e.g., contracts for radiology and mammography, maternity and infertility, gynecology, , grant and per diem, and CBOCs) .
- k. Working with CBOC liaisons to facilitate patient-related issues.
- l. Assuring that local policies and procedures guarantee proper and timely notification of gender-specific diagnostic study results.
- m. Conducting outreach activities such as: mailings, public speaking, public service announcements (PSAs), health fairs, recognition ceremonies, brochures, workshops, newsletters, newspaper articles, website maintenance, educational seminars, focus groups, and town hall meetings or forums where women Veterans have the opportunity to provide input and feedback to program staff and facility management.
- n. Organizing "Inreach" activities (internal marketing to Veterans already using the system and to facility staff). This may include educational seminars, in-service programs and workshops, new employee orientation activities, and customer feedback mechanisms.

12. RESPONSIBILITIES OF THE WOMEN'S HEALTH MEDICAL DIRECTOR OR CLINICAL CHAMPION

The Women's Health Medical Director or Clinical Champion is responsible for:

- a. Working closely with the WVPM, forming the foundation of the women's healthcare team.
- b. Serving as a clinical leader for women's health.
- c. Working in collaboration with Primary Care Leadership and participates in all Primary Care Leadership meetings at the facility level.
- d. Establishing priorities and direction for implementing quality improvement and is held responsible for excellent achievement on quality measures that apply to women's health.
- e. Developing or supervising clinical education programs for women's health providers and trainees.
- f. Participating in groups created for Women's Health Medical Directors.

13. RESPONSIBILITIES OF THE WOMEN VETERANS HEALTH COMMITTEE (WVHC)

- a. Each VHA facility must have a WVHC to assist the WVPM in carrying out duties and responsibilities of that position, and to provide recommendations to leadership for improving services and programs for women Veterans.
- b. The WVPM should chair the WVHC, but at a minimum must be a member of the committee.
- c. Membership on the committee may include, but is not limited to: representatives from clinical services such as primary care, specialty care (gynecology, radiology, oncology surgery), nursing services, pathology and laboratory services, pharmacy, extended care, prosthetics, domiciliary care, chaplain, social services, behavioral and mental health services, public and consumer affairs, OEF and OIF Team, Minority Veteran Coordinator, Patient Representative, member from management team office (Director or Chief of Staff), Readjustment Counseling Service (RCS), Veterans Benefits Administration (VBA), homeless programs. **NOTE:** *In compliance with the Federal Advisory Committee Act, 5 U.S.C. App., women Veteran consumers, representatives of Veteran Service Organizations (VSOs), and other non-Federal employees may only serve as consultants to the WVHC. Consultants do not regularly attend WVHC meetings and do not participate in any collective fact finding, dispensing of advice, or decision making. Consultants provide only individual advice and factual information as requested by the WVHC.*
- d. Minutes of the committee must be distributed to committee members with reporting requirements to include routing to the Clinical Executive Leadership and the medical facility Director.

e The WVHC needs to meet, at a minimum, quarterly. **NOTE:** *Monthly or bi-monthly meetings are more conducive to achieving productivity and outcomes.*

14. COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS

VHA policy maintains that the full scope of primary care is provided to all eligible Veterans seeking on-going health care. Therefore, regardless of the number of women Veterans utilizing a particular facility, all sites that offer primary care services must offer comprehensive primary care to women Veterans. The WVHSHG works in close collaboration with Primary Care, Mental Health, and Specialty and Acute Care to ensure: equal access to high quality health care services in all sectors for women Veterans; care is provided in a sensitive environment, and all necessary gender specific services must be available at every facility and CBOC.

a. **Patient Centered Medical Home (PCMH) Standards.** Comprehensive primary care is fully consistent with the principles of the PCMH. The PCMH standards of patient centeredness, access, continuity, and coordination of care in the setting of team based care must be applied in delivering primary care for women Veterans.

b. **Assignment to a Designated WH PCP.** Each woman Veteran enrolled for primary health care must be assigned to a WH PCP who assumes responsibility for providing, coordinating and ensuring continuity of care.

(1). All enrolled women Veterans must receive comprehensive primary care from a designated Women's Health Primary Care Provider (WH PCP) who is interested and proficient in the delivery of comprehensive primary care to women, irrespective of where they are seen (freestanding medical centers, primary facilities, (CBOCs), and independent clinics). **NOTE:** *An interested provider is one who is knowledgeable, concerned, engaged, and willing to participate in the primary care of women.*

(2) Women Veterans who are already assigned to a Primary Care Provider (PCP) who is not a designated WH PCP, must be offered the opportunity for reassignment to a designated WH PCP.

(3) To ensure that women Veterans receive equal opportunity to change PCPs, requests for PCP reassignment from women Veterans will be honored and processed according to facility standard procedure, even if the request is for a non-WH PCP.

(4) In all cases, arrangements must be made to provide this gender-specific care within the Primary Care setting.

(5) Designated WH PCPs must be preferentially assigned women Veterans within their primary care patient panels. **NOTE:** *This model allows these providers to maintain their clinical skills in delivering comprehensive primary care to female Veterans.*

(6) Each facility must ensure that an appropriate number of designated WH PCPs is available at every site to ensure that all VHA access goals are met for women Veterans.

c. **Mental Health Services.** A required component of comprehensive primary care involves receipt of basic mental health services in the same physical location as primary care, thus integrating services and improving the quality of care delivered to women Veterans. Patients requiring more intensive comprehensive and specialized mental health services will be referred to Mental Health Clinics.

(d) **Choice of Provider.** Facilities need to give women Veterans the option to designate their preference for a female or male provider. When a woman Veteran requests a female or male provider, accommodation must be made. Fee basis can be used if necessary to ensure the request but time/access measures should be suspended.

15. WOMEN'S HEALTH PRIMARY CARE PROVIDER PROFICIENCY

Proficiency in the core concepts of primary care women's health is required to provide comprehensive primary care for women. Essential components include, but are not limited to: pelvic/breast exams; contraception counseling and management; management of osteoporosis, menopause, pelvic pain, abnormal uterine bleeding, and sexually transmitted diseases; in addition to screening for breast and cervical cancer or, a history of sexual trauma. **NOTE:** *See Appendix B for a detailed list of provider competency standards which include primary care competency with gender specific manifestations and basic gender specific competencies.*

a. The designated WH PCP must be fully proficient in providing the complete range of primary care.

(1) Retraining of interested primary care providers may be required, as will recruitment of new primary care providers who are able to provide comprehensive primary care for both men and women.

(2). To maintain proficiency in women's health, each site must ensure that the patient panel of every designated WH PCP is comprised of at least 10% female patients. Each designated WH PCP will spend at least one-half day every week practicing or precepting in a women's health practice.

(3) For VHA facilities where women's health is integrated into primary care, a designated WH PCP must have a number of female patients assigned to them to ensure a practice experience equivalent to those participating in a women's clinic one-half day every week. This number needs to be 120 patients under the current PCMM guidelines. If insufficient numbers of female patients are available to maintain a panel inclusive of 10% women, an alternative plan to ensure ongoing proficiency must be implemented at a local level and may include:

(a) A provider being precepted at a VA women's clinic on a regularly scheduled basis, or

(b) Working with a contractor to hone practice skills.

(4) Each facility must participate in and support an ongoing staff and provider education plan to promote, improve, and maintain skills and proficiency in women's health to all interested primary care providers. All primary care providers must be encouraged to provide women's

health services. **NOTE:** *Incentives, such as inclusion of WH services in the provider performance pay, need to be strongly considered at a facility level.*

16. DELIVERY OF COMPREHENSIVE PRIMARY CARE FOR WOMEN VETERANS: CLINIC MODELS

All women Veterans must be assigned to receive comprehensive primary care conveniently located to their place of residence. A facility may choose one or more of the following Comprehensive Primary Care Clinic Models to best meet the needs of women Veterans and to achieve the standards for Comprehensive Primary Care for Women Veterans.

a. **Model 1. General Primary Care Clinics.** Comprehensive primary care for the women Veteran is delivered by a designated WH PCP who is interested and proficient in women's health. Women Veterans are incorporated into the WH PCP panel and seen within a general gender-neutral Primary Care clinic. Mental health services for women should be co-located in the general gender-neutral Primary Care Clinic in accordance with the Primary Care-Mental Health Integration. Efficient referral to specialty gynecology service must be available either on-site or through fee-basis, contractual or sharing agreements, or referral to other VA facilities within a reasonable traveling distance (less than 50 miles).

b. **Model 2. Separate but Shared Space.** Comprehensive primary care services for women Veterans are offered by designated WH PCP(s) in a separate but shared space that may be located within or adjacent to Primary Care clinic areas. Gynecological care and mental health services should be co-located in this space and readily available.

c. **Model 3. Women's Health Center (WHC).** VHA facilities with larger women Veterans populations are encouraged to create Women's Health Centers (WHC) that provide the highest level of coordinated, high quality comprehensive care to women Veterans.

(1) WHC offers comprehensive primary care services by a designated WH PCP(s) in an exclusive separate space. Whenever possible, a WHC needs to have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity and physical comfort.

(2) Specialty gynecological care, mental health and social work services must be co-located in this space.

(3) Other sub-specialty services such as breast care, endocrinology, rheumatology, neurology, cardiology, nutrition, etc., may also be provided in the same physical location.

(4) Women Veterans receiving comprehensive primary care through general primary care clinics in sites with WHC need to be referred to the WHC for gynecological care, mental health treatment, and other sub-specialty care.

NOTE: *Specialty gynecology clinics may not be utilized for routine breast and cervical cancer screening.*

17. SPECIAL CONSIDERATIONS IN THE DELIVERY OF COMPREHENSIVE PRIMARY CARE

a. Appointment Times

(1) Adequate appointment lengths for both new and follow-up visits are necessary to provide comprehensive primary care to women Veterans. It is recommended that appointment lengths for primary care visits be sufficient to allow time for gender-specific care during the primary care encounter.

(2) Appointment duration recommendations for all practice settings:

- | | |
|--|--------|
| (a) <u>New women's health appointment & Annual</u> | 60 min |
| (b) <u>Routine follow-up appointment</u> | 30 min |
| (c) <u>Urgent appointment</u> | 30 min |

b. Panel Sizes. Strong consideration should be given to adjusting panel sizes downward to accommodate the unique needs of women Veterans in the primary care setting.

(1) Providers who have women Veterans in their panel will have their maximum panel size reduced proportionate to the number of women Veterans that they serve.

(2) The modeled panel size will be reduced by the number of unique patients equal to 20% of the total number of women Veterans in the mixed gender panel. This reduction will be similar for a physician or a nurse practitioner or physician assistant (mid-level provider).

c. CBOCs

(1) All female patients seen at CBOCs must receive the same high quality comprehensive primary care that is received by female patients at the parent facility.

(2) CBOCs and independent clinics must designate a Women's Health clinical liaison to coordinate women's issues with the parent facility.

(3) The proficiency standards as stated above in Paragraph 15 shall apply to all WH providers providing services at the CBOCs.

d. Mobile Clinics. Mobile Clinics that offer primary care services must assure equitable access to comprehensive primary care services for both men and women. This includes the provision of gender-specific primary care to women Veterans.

18. PREVENTIVE CARE FOR WOMEN VETERANS

Preventive care for women Veterans must include age-appropriate screening for colon, breast and cervical cancer. Preventive services must also include: nutrition counseling; weight

management and fitness counseling; sexually transmitted infection screening and counseling; smoking cessation counseling and treatment; counseling to reduce alcohol use; and immunizations, etc. Special consideration needs to be given to breast and cervical cancer screening.

a. **Breast Cancer Screening.** Breast cancer screening includes mammography, with or without clinical breast examination.

(1) **Mammography Program Standards.** *NOTE: Refer to 38 U.S.C. 7319(b) and VHA Mammography Handbook 1104.1 for full details regarding Mammography Program Standards. See FDA Mammography Standards Guidance at www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Guidance/PolicyGuidanceHealthSystem/ucm135583.htm.*

(a) Every mammography program must develop and document procedures for preparing a written report of the results of each mammography examination performed under its certificate, consistent with 21 CFR 900.12(c) and its subsections.

(b) When mammography services are obtained through contractual arrangements or sharing agreements, the referring VHA facility must ensure, prior to services being rendered, that the provider is certified by the Food and Drug Administration (FDA), or a State that has been approved by FDA under 21 C.F.R. 900.21 to certify mammography facilities.

(c) A written Standard Operating Procedure (SOP) sufficient to meet the requirements of 21 CFR 900.12(g) is required to ascertain which patients have breast implants, and to provide proper care for patients with breast implants prior to mammography.

(2) Mammography Orders and Access

(a) All screening and diagnostic mammograms must be initiated via an order placed into the VistA Radiology package. This order must be entered regardless of where the Veteran will obtain the mammogram. Fee basis or contract agreements must be electronically entered as a CPRS radiology order. All breast imaging and mammography results must be linked to the appropriate radiology mammogram or breast study order.

(b) Mammograms must be accessible within a reasonable (less than 50 miles) distance. If the Veteran lives more than a reasonable distance from a facility with a mammography suite, the study should be provided off-site at the closest facility thru fee-basis, sharing agreement, or other contractual arrangements to the extent the Veteran is eligible.

(3) **Mammography Report Tracking.** The in-house VA Mammography Program is required to establish and maintain a mammography medical outcomes audit process in accordance with the provisions found in 21 C.F.R. 900.12(f).

(a) Each VHA facility will establish and document a process for tracking results from procedures performed off-site, ensuring that required data is captured and entered into the Computerized Patient Record System (CPRS) Radiology Package. In addition, there must be a

process established at each facility that ensures timely tracking and follow up of all abnormal mammogram results.

(b) All mammography reports, regardless of where they are performed, must be entered in the Radiology Reports section of Veterans Integrated System Technology Architecture (VistA.) If the study was interpreted elsewhere, for example through Fee Basis, the hardcopy report must be scanned into VistA and electronically filed using the Outside Reports option of the Radiology Package. This ‘electronic filing’ attests:

1. To the correct entry of the report into the VistA Radiology Package,
2. That the report is for the patient for whom the procedure was ordered, and
3. That the report is electronically released for access, review and action by the patient’s health care providers. The Final Assessment Category needs to be entered as a diagnostic code and will reflect the assessment category wording approved by FDA.

(4) Patient Notification of Mammography Results

(a) Each certified VA Mammography Program and off-site non-VHA mammography provider is required to establish a documented procedure to provide a lay summary of the written mammography report to the patient within 30 days from the date of the procedure. The documentation of letters, reports, and/or verbal communication with the patient in the patient’s medical record must be in accordance with VA or Mammography Quality Standards Act (MQSA) standards and guidelines (ref: 21 C.F.R 900.12(c), et.seq.).

(b) When the mammography report assessment is “Suspicious” or, “Highly Suggestive of Malignancy,” the lay summary results and recommended course of action should be communicated to the patient as soon as possible but no later than 5 business days after the mammogram. One way to achieve this is through documented direct verbal communication. However, prompt verbal communication does not obviate the need to also provide written communication to the patient within 30 calendar days of the date of the mammogram.

(5) Ordering Provider Notification of Mammography Results

***NOTE:** Separate VHA policies may set standards regarding communication of results for specific tests. When separate VHA policies exist that set standards for communication of specific test results, the shorter standard (of the separate policy or the 14-day standard of this policy) takes precedence. Communication must be documented in the medical record. The VHA ordering practitioner is expected to also communicate and document a follow up diagnostic or treatment plan. The fact that an outside Radiologist may discuss findings with the Veteran patient does not remove the obligation of the VHA ordering practitioner to discuss the findings and a follow-up plan with the patient.*

(a) Facilities are strongly encouraged to negotiate report turnaround times consistent with VHA policy in their mammography contracts. Current VHA turnaround timeliness is within 48 hours of the imaging study performance. In any case, the off-site (non-VHA) mammography

facility must supply mammography reports to the referring VA facility within 30 days of the date of the procedure. Electronic entry of the mammography report into the Radiology Package is sufficient notification to the ordering provider. Responsibilities for VHA on-site provider notifications may be found in VHA Handbook 1104.1.

(b) The off-site contracted mammography facility's interpreting physician must ensure the referring VHA practitioner or surrogate is contacted for results of "Suspicious" or, "Highly Suggestive of Malignancy," as soon as possible but no later than 3 business days after the mammogram procedure. Responsibilities for VHA on-site provider notifications may be found in VHA Handbook 1104.1.

(6) Documentation of Breast Imaging Findings in CPRS

The VHA ordering practitioner communicates the results of Breast Imaging Reporting and Data System (BI-RADS) Codecategories 0, 3, 4, 5 findings to the patient within 14 calendar days from the date on which the results are available to the ordering practitioner. Significant abnormalities may require review and communication in shorter timeframes and 14-days represents the outer acceptable limit. For abnormalities that require immediate attention, the 14-day limit is irrelevant, as the communication needs to occur in the timeframe that minimizes risk to the patient.

b. Cervical Cancer Screening

(1) Cervical cancer screening includes a speculum examination and cervical pathology evaluation performed by the primary care provider in accordance with VHA guidelines. The results of normal (NEM-No Evidence of Malignancy) cervical pathology must be reported to the ordering provider within 30 calendar days of the pathology report being issued. The interpreting physician must ensure the ordering provider is contacted with abnormal results within 5 business days.

(2) The cervical pathology report of Normal (NEM-No Evidence of Malignancy) results must be communicated to the patient in terms easily understood by a layperson within 14 days from the date of the pathology report becoming available. Documentation of a letter and/or verbal communication with the patient must be entered into CPRS. If using the United States (U.S.) Postal Service, confirmation of the receipt of these results is not required. For any abnormal cervical pathology report, the results must be communicated within 5 business days of the report being issued.

c. Tracking and Timeliness

The Quality Management team for each VHA facility, in collaboration with the Women Veterans Program Manager, Radiology Service, Pathology Service, and Primary Care Service will oversee the tracking and timeliness of follow-up of findings from breast and cervical cancer screening.

19. GENDER-SPECIFIC SPECIALTY CARE FOR WOMEN VETERANS

Gender-specific specialty services must include:

a. Gynecological Care

(1) A gynecologist will be available to both inpatients and outpatients for evaluation and treatment of:

(a) Gynecological conditions such as abnormal cervical pathology, uterine fibroids, endometriosis, polycystic ovarian syndrome, abnormal uterine bleeding, pelvic pain, and gynecological malignancies.

(b) Contraceptive needs such as implantable contraceptives, IUDs or surgical sterilization.

(c) Infertility (see inclusions and exclusions below).

(2) For VHA facilities that offer emergency care, a gynecologist needs to be available for consultation either on-site or via telephone.

NOTE: A female chaperone must be in the examination room during examinations or procedures involving the breast and genitalia, regardless of the gender of the provider (see Subparagraph 5d).

(3) The patient needs to be evaluated within 30 days for a routine referral and within 7 days for an urgent condition. VHA facilities with a separate WH Center must co-locate gynecological services for women Veterans to the WH Center.

(4) The co-payment fee for routine Gynecology visits was changed from a specialty visit to basic co-pay effective FY 2008.

(5) Abortion and abortion counseling are excluded from the medical benefits package [38 CFR § 17.38(c)(1)]. With the decision to exclude abortions from the medical benefits package, VA also made a policy decision to no longer perform therapeutic abortions. RU 486 (mifepristone) is an abortifacient not available through VA pharmacies.

(6) Levonorgestrel (Plan B) Emergency Contraception is not an abortifacient and is available in VA pharmacies. A process must be implemented at the local or VISN level to ensure availability of emergency contraception to patients in a timely manner (same day).

NOTE: The VHA goal is that gender-specific specialty services need to be provided in-house to the greatest extent possible. If gender-specific specialty services are not available in-house, such services must be provided through fee-basis, contractual or sharing agreements, academic affiliates, or other VA facilities within a reasonable traveling distance (less than 50 miles).

NOTE: When a women Veteran requests a female or male gynecologist, accommodation must be made. In order to satisfy the patient request, referral to Network sites or use of fee basis may be utilized.

b. **Maternity Care**

(1) VHA is authorized to provide comprehensive pre-natal, intra-partum and post-partum care to eligible women Veterans. Maternity benefits begin with the confirmation of pregnancy, preferably in the first trimester, and continue through the final post-partum visit, usually at 6-8 weeks after the delivery, when the Veteran is medically released from obstetric care.

(2) Each VHA facility must have a policy to identify the process for assessing pregnant women; identifying care that could be provided by VHA in conjunction with the Obstetrician (e.g., mental health, provision of medications, maintenance of chronic conditions, etc); identifying mechanisms for co-management of care, identification of risk factors, and change to high risk pregnancy status.

(3) VHA facilities may use the enhanced sharing authority (Title 38 United States Code (U.S.C.) 8153) to contract for services including pre-natal, intra-partum and post-partum care of the mother. If contracting for services is required, competitive bid is the first option to be considered. VHA facilities may negotiate non-competitive contracts with VHA affiliates or with practice groups associated with the affiliate when the services of affiliate faculty members are required to perform services under the contract. **NOTE:** See VA Handbook 1663.

(4) High-risk pregnancies and outpatient services may require individualized referrals using fee-basis, contractual or sharing agreements to the extent the Veteran is eligible.

(5) To furnish women Veterans with needed outpatient services on a fee basis, the Veteran must meet the eligibility criteria of Title 38 CFR Section 1703.

(6) Fee basis care is routinely used to provide maternity care within a reasonable distance of a Veterans' home, even when a contract is otherwise available. Maternity care must be provided within 50 miles or one hour of the Veterans' home.

(7) In the case that a pregnant Veteran needs immediate hospitalization prior to the establishment of a contract, fee basis can be used for this under the authority of Title 38 U.S.C. §1703(a)(4) and 38 CFR §17.52(4).

(8) The co-payment fee for Obstetric visits was changed from a specialty visit to basic co-pay effective FY 2008. Fee basis rules apply to co-payment rates for both individual visits and bundled billing of routine obstetric care. Additionally, the patient has no payment responsibility to the provider of non-VHA maternity benefits care for services that have been authorized in advance by VHA. Regulations prohibit "balance billing" of the difference between the providers' billed charges and VHA allowable payment for the services.

NOTE: VHA should utilize the updated *Management of Uncomplicated Pregnancy in the Primary Care Setting* released in 2009 by the VA/DoD Evidence Based Clinical Practice Guideline Working Group as a reference to manage maternity care.

(9) Maternity care needs to include appropriate (community standard) education and tools such as:

- (a) Genetic consultation with a physician when clinically indicated,
- (b) Childbirth preparation,
- (c) Parenting education,
- (d) Breastfeeding support and lactation classes, and
- (e) Breast pumps.

NOTE: Breast pumps and related supplies, when clinically indicated, can be obtained through a Prosthetics Consult at least two weeks in advance of the women Veteran's estimated date of confinement (EDC).

(11) VHA is not authorized to pay for newborn services. It is essential that the Veteran be advised to make alternative arrangements for newborn care coverage prior to delivery. WVPs are available to assist with information on Medicaid, State Child Health Insurance Programs, and other sources of newborn health insurance coverage.

c. **Infertility**

(1) Because medical remedies for infertility exist, medically necessary infertility services may be provided. Limited infertility services, such as assessment of reproductive capacity and treatment or correction of some obvious abnormalities, such as endometriosis or varicocele, are available at VHA facilities. Surgical reversal of tubal ligation is a covered benefit for treatment of infertility.

(2) VHA is not authorized to provide advanced reproductive in-vitro fertilization technologies.

(3) Infertility services, excluding in vitro fertilization, can be provided locally or through network referrals and negotiated comprehensive contract packages with consultants, contractual or sharing agreements, or through fee basis to the extent the Veteran is eligible. The package can be tailored to meet individual facility needs based on local expertise and resources. A very close relationship with the reproductive endocrinologist needs to be established to ensure that diagnostic results and efforts are not duplicated.

d. Breast and Reproductive Oncology

(1) Reproductive and breast oncology, and associated endocrinology, referrals need to be addressed through Network referrals, sharing agreements, academic affiliates, fee-basis, or in-house when available.

(2) Genetic testing is authorized when needed to make diagnostic, management, and secondary prevention decisions.

e. Mental Health

(1) Mental health services must be provided to women Veterans according to VHA Handbook 1160.01.

(2) VHA facilities that have a separate WHC should co-locate mental health services for women Veterans to the WHC. *NOTE: The privacy of the WHC space makes it an ideal location for such services.* If a WHC is not available, such as in CBOCs, it is strongly recommended that mental health services be provided in the same area that comprehensive primary care is offered.

(3) VHA facilities are strongly encouraged to provide Veterans being treated for conditions related to MST (women and men) the option of being assigned a same-sex mental health provider, or opposite-sex provider if the trauma involved a same-sex perpetrator.

(4) VHA facilities are strongly encouraged to make gender separate therapy groups available where needed. Staff must take full responsibility to address gender issues, such as safety and security, within mixed gender groups.

(5) The care environment is an integral component of the design of the outpatient mental health, in-patient psychiatry and residential milieu. The WVPM must participate in routine environmental rounds with special emphasis on improving privacy and security.

(6) Mental health program staff needs to collaborate with the WVPM in the design and implementation of VA residential and transitional housing programs as they relate to the privacy and security of women Veterans.

(7) Evidence based practices need to be provided in individual and group counseling.

f. Care for Conditions Related to Military Sexual Trauma (MST)

(1) All primary care providers must screen all women patients for military sexual trauma and appropriately refer for counseling and treatment as clinically indicated. Mental health services for conditions related to MST must be available at all VHA facilities. Referral to the local Vet Center may be an appropriate alternative.

(2) Full requirements for mental health services for conditions related to MST are found in VHA Handbook 1160.01. All VHA facilities must use the CPRS Clinical Reminder for MST to document screening and the encounter form checkbox for MST to indicate MST-related care, as

delineated in VHA Handbook 1160.01. **NOTE:** *This helps to ensure the accuracy of the facility's MST-related screening and treatment data and allows monitoring of MST-related care on a national level.*

NOTE: *VHA acknowledges the gender-neutrality of sexual trauma experiences, and requires that all male veterans with a history of military sexual trauma have access to comparable standards of sexual trauma counseling programs and services.*

20. URGENT/EMERGENT CARE

a. It is required that all VHA facilities have a mechanism in place whereby urgent and emergent care needs of women Veterans are met in an appropriate, timely manner with the highest quality of care during normal hours as well as during evenings, weekends and holidays.

b. All VHA facilities offering urgent care treatment for women Veterans during business and expanded business hours (i.e., same-day clinic appointments, urgent care appointments) are required to have the necessary equipment to treat female patients (tables, lights, Sexually Transmitted Infections (STI) kits, urine pregnancy tests, speculums, medications, etc) and to have appropriate supplies to make accurate and efficient diagnosis of vaginal and sexually transmitted infections at the point of care. This includes microscopes, slides, Potassium Hydroxide (KOH) solution, litmus paper, etc.

c. Point of care testing (CLIA waivers) should be considered as needed. **NOTE:** *Point of care testing may be accomplished online through www.medtraining.com.* VHA facility laboratories must assign a point of contact to track provider's completion of annual online training.

d. It is required that urine pregnancy tests be available at all sites (including CBOCs and mobile clinics). Additionally, every VHA facility laboratory must have the ability to perform a quantitative beta Human Chorionic Gonadotropin (HCG) level on a blood sample. Urine pregnancy and wet preps need to be processed within 15 minutes of delivery to the lab.

e. VHA facilities must ensure that all staff who provide urgent care treatment to Veterans receive regular training in women's health to maintain proficiency in topics such as, but not limited to: documenting a menstrual and obstetric history; evaluation of acute abdominal pain; vaginal bleeding in early pregnancy; and gender-based differences in the presentation of myocardial infarction and other disease processes.

f. VHA facilities must ensure that the 24 hour a day, 7 days a week (24/7) telephone triage system is staffed by professionals trained in and aware of the health care needs of female patients. The triage system needs to ensure that procedures are in place so that women Veterans are triaged and cared for according to the urgency of their condition.

g. VHA facilities with an Emergency Department that provides urgent and emergent care for Veterans after business hours must properly equip the Emergency Department to provide urgent and emergency care for women Veterans. Requirements include equipment and staff to treat female patients during normal business hours, as well as nights, weekends, and holidays. If

urgent care treatment is not available for certain conditions such as sexual assault evaluation, vaginal bleeding, or acute abdominal pain in a pregnant patient, or a pregnant patient in labor, these sites must have arrangements in place with a local or regional community facility that is able to provide the requisite care. VHA will transfer patients to such facilities safely and in accordance with VHA policy.

21. ADDITIONAL SERVICES FOR WOMEN VETERANS

a. Prosthetics Services

WVPMs need to work closely with the Prosthetics Service and Supply, Purchase and Distribution Department to ensure that supplies specific to women's health are properly stocked, easily requested, and provided in a timely manner (e.g., intra-uterine devices (IUDs), breast pumps, compression stockings, etc.).

b. Tele-Health Programs

(1) Women Veterans have specific health care needs that must be considered as Tele-health programs expand; services must be tailored to meet their needs.

(2) Consideration must be given to include women Veterans as part of these programs. Targeted goals need to be set to increase the enrollment of women Veterans in VHA proportional to the population of women Veterans.

(3) The Tele-health Program must develop specific training modules to update clinical providers in health care issues specific to women.

c. Poly-Trauma Centers

(1) It is necessary to ensure that services are tailored to the unique needs of women Veterans including ordering and stocking equipment and supplies that are the correct designs, sizes and fit for women Veterans.

(2) Staff needs to be trained to understand the unique needs of women and maintain privacy and security for women Veterans.

(3) Gender-specific specialty care in gynecology, uro-gynecology, mental health, oncology, neurology, etc., must be available within the polytrauma center or within the medical facility for women Veterans.

(4) Women Veterans must be assured basic and routine care in addition to the highly specialized care that they receive at Poly-trauma Centers.

d. **Physical Medicine and Rehabilitation**

It is necessary to ensure that services are tailored to the unique needs of women Veterans including ordering and stocking equipment and supplies that are the correct size and fit for women Veterans.

e. **Care for Women Veterans with Spinal Cord Injury/Disorders (SCI/D)**

(1) Women veterans with SCI/D must be followed as outlined in VHA Handbook 1176.1, Spinal Cord Injury and Disorders System of Care. Care may be provided within a women's health clinic or an SCI Clinic. The designated SCI primary care providers must provide or arrange for timely women's health care and gender specific screenings during the Veteran's annual evaluation. **NOTE:** *Veterans with SCI/D have difficulty accessing health care services due to mobility, transfers, and positioning, and often travel long distances for their health care.*

(2) When the SCI primary care provider or Veteran chooses to have these screenings done in a women's health clinic or by a WH PCP, pre-arrangements for this care during the annual evaluation (or when issues arise) must be made, or arrangements with Women's Health to provide the services within the SCI/D examination rooms, or through fee basis to an appropriately trained provider with accessible health care office space and equipment will be made.

f. **Pharmacy Services**

(1) It is strongly recommended that Women's Health Program officials (WVPM's, WH Medical directors, WH champions) assure that the unique medication needs of women Veterans are clearly communicated at the local, VISN and National levels.

(2) A process needs to be in place at the local or VISN level, to include CBOCs, to ensure availability of levonorgestrel (Plan B) emergency contraception to patients the same day of their appointment.

(3) All VHA facilities must have a mechanism to monitor the prescription of high risk **teratogenic** medications (FDA class D or X) which could be prescribed to women with the potential to become pregnant. Women need to be counseled on the risks and benefits of such prescriptions and documentation of patient counseling must be recorded in CPRS.

22. DATA COLLECTION

a. As part of VHA's program to assess and improve the quality of health care, a systematic data collection process must be initiated to collect information related to women Veterans' health care services. Identification of sources (data bases) to retrieve reliable data is essential. In addition to data about key performance measures and standards, new clinical guidelines, flowcharts, and other performance improvement tools are needed to standardize and improve outcomes of care.

b. Performance improvement activities need to include areas such as:

(1) Understanding and designing interventions to address the differences in quality measures for women Veterans compared to male Veterans.

(2) Screening and follow-up for military sexual trauma.

(3) Appropriate follow-up of abnormal mammograms and abnormal cervical cytology reports as well as timeliness to initiate treatment for breast and cervical cancer.

(4) Customer satisfaction initiatives and outcomes.

(5) Tracking of access and no-show rates as facilities implement comprehensive primary care for women Veterans.

23. GUIDELINES FOR WOMEN VETERANS' HISTORY & PHYSICAL EXAMINATION

a. The primary care provider must document a detailed history of the woman Veteran including; current and past medical and surgical history; a gynecologic and obstetric history; history of allergies; family history of disease; a psycho-social history including military service; and an occupational history.

b. Military service history must include: the branch and length of military service; location and period of deployment(s); type of work done for the military; possible exposures; and injuries or trauma experienced.

c. The initial intake history must include screening for military sexual trauma and must be done prior to the physical examination while the patient is fully dressed.

d. When clinically indicated, the primary care provider must also perform a complete physical examination that includes the head and neck, cardiovascular, respiratory, abdominal, musculoskeletal, and neurological systems. A complete primary care examination for women also includes a breast and genital examination.

e. If a patient is due for a cervical cancer screening examination and this is not included as a part of a complete physical examination, the reason(s) for deferring the examinations must be clearly documented in the medical record.

NOTE: A female chaperone must be in the examination room during examinations or procedures involving the breast and genitalia, regardless of the gender of the provider. (See Subparagraph 5d).

f. Patient dignity and privacy must 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 i.e. 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.

g. Appropriate draping techniques must be used during the breast and pelvic examination or during examinations or procedures when these areas are exposed (e.g., EKG, chest auscultation).

h. 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.

i. 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.

j. VHA has experienced increased use of camera and computer-based video technology for tele-health, resident training, security observation, etc. When establishing and reviewing these services, attention must be given to the privacy needs of Veterans. Veterans must be informed that cameras are in use before entering an active camera area. Consideration must be given to balancing the clinical activity with maintaining privacy and dignity. Active cameras must not be utilized while a Veteran is dressing or undressing for examinations, bathing, toileting, or engaging in similar activities. Installed cameras must be covered or shielded when not in use, even when turned off.

k. When medical students, Nurse Practitioner students, or Physician Assistant students participate in the provision of comprehensive primary care or gender-specific specialty care to women Veterans, they must be appropriately supervised as defined by relevant handbooks.

24. THE HEALTH CARE ENVIRONMENT

a. The health care environment directly and indirectly affects the quality of care provided to women Veterans. It affects their comfort and sense of security, as well as their perceptions of care received. Measures must be taken to maintain and adjust care environments to support their dignity, privacy, and security.

b. The privacy and security needs of women Veterans must be addressed when planning new construction, remodeling older facilities, or improving patient care programming. Annual reviews of the health care environment must occur in all VHA facilities to ensure that the environment promotes dignity, privacy, safety and security. The WVPM and appropriate members of the facility must participate in these reviews on a routine basis.

c. Each VHA facility must engage in an on-going, continual process to assess and correct physical deficiencies and/or environmental barriers to care for women Veterans. **NOTE:** *See appendix A for a checklist for minimum standards for environmental privacy and security.*

d. Other elements within the environment that are of special concern to women Veterans and require the input of the WVPM including, but are not limited to:

- (1) Inpatient admissions and patient flow.
 - (2) Accommodations, with special emphasis on privacy in all examination rooms, sleeping areas, restrooms, bathing/shower facilities, and other areas such as physical medicine and rehabilitation therapy rooms when needed, cardiac stress test areas, etc. Women Veterans must have women only restrooms and bathing/shower facilities.
 - (3) Availability of personal hygiene products, female pajamas and robes, and hair care services and products.
 - (4) Diaper changing stations need to be available in designated male and female restrooms.
 - (5) Residential, domiciliary and long-term care facilities.
 - (6) Recreational and social programs including pool areas, gyms, and recreation halls.
 - (7) Separate rooms with appropriately locking doors (allowing staff to have key or code access in the case of emergency) are required for toilets, baths and showers.
- e. Educational programs addressing attitudes and sensitivity toward women Veterans are essential components of orientation and in-service education of employees and trainees. Education needs to focus on, but not be limited to; sensitivity regarding women's military experiences; caregiver and parenting roles; intimate partner violence; sexual trauma; and sexual orientation.

f. **Ambulatory Care Dignity, Respect and Security**

- (1) Veterans must be provided adequate visual and auditory privacy at check-in. Patient names are not posted or called out loudly in hallways or clinic areas.
- (2) Veterans must be provided adequate visual and auditory privacy in the interview area.
- (3) Patient-identified information must not be visible in the hall including charts where names are visible. Every effort should be made to restrict unnecessary access to hallways by patients and staff who do not work in that clinic area.
- (4) The examination rooms must be located in a space where they do not open into a public waiting room or a high-traffic public corridor. Appropriate locks (either electronic or manual) for examination room doors are required (allowing staff to have key or code access in the case of emergency). When doors are closed, all healthcare personnel must knock, WAIT, and enter only after invited in.
- (5) Privacy curtains must be present and functional in examination rooms. Privacy curtains must encompass adequate space for the healthcare provider to perform the examination unencumbered by the curtain. A changing area must be provided behind a privacy curtain.

(6) Examination tables must be placed with the foot facing away from the door. If this is not possible, tables must be fully shielded by privacy curtains.

(7) Patients who are undressed or wearing examination gowns must have proximity to women's restrooms that can be accessed without going through public hallways or waiting rooms.

(8) If toilet facilities cannot be located in close proximity to the examination room, the woman must be discreetly offered the use of a toilet facility before she disrobes for the exam.

(9) Sanitary napkin and tampon dispensers and disposal bins must be available in women's public restrooms. Tampons and sanitary pads should also be available in examination rooms where pelvic examinations are performed and in bathrooms within close proximity.

g. **Inpatient Care Dignity, Respect and Security**

(1) When clinically unrelated to an acute hospitalization, a screening pelvic and breast examination may be deferred. Upon discharge from the acute hospitalization, a follow-up appointment needs to be arranged to complete these examinations if clinically indicated.

(2) If a pelvic or breast examination is necessary during an inpatient admission, adherence to all privacy and security standards is required as delineated in the physical examination guidelines for women Veterans. Patient dignity and privacy must be maintained at all times.

(3) VHA facilities must ensure that sufficient inpatient medical and surgical rooms are available to accommodate female patients with plans for increases as the population of women Veterans expands. Capacity for women Veterans must be, at a minimum, equivalent to the current proportion of the women Veteran utilization rates or the specific VISN utilization rate for that site, whichever is greater. Plans for new inpatient medical/surgical space must project a 15% minimum utilization rate for women Veterans.

(4) The number of inpatient rooms assigned for females needs to be at a minimum equivalent to the current proportion of the women Veterans enrolled at the facility or the specific VISN utilization rate for that site, whichever is greater.

(5) Privacy curtains must be placed in all inpatient rooms, with the exception of Psychiatry and Mental Health units.

(6) Female patients must have access to private and secure women's bathroom facilities (toilet and shower) in close proximity to their room. A private and secure bathroom must have an appropriate locking mechanism (allowing staff to have key or code access in the case of emergency) while also allowing the patient to signal for the hospital staff if they are in distress.

NOTE: *It is not sufficient to have a group shower room with a sign on the door when it is utilized by women.*

(7) Female pajamas and robes must be stocked and provided on all inpatient units.

(8) Nursing intake and assessment forms need to be modified to capture gender-specific data such as last menstrual period and current pregnancy or breastfeeding status.

h. **Mental Health Residential Rehabilitation Treatment Program (MH RRTP)**
Dignity, Respect, and Security

(1) Residential and domiciliary facilities must ensure safe and secure sleeping arrangements for women Veterans including but not limited to door locks, access bar codes, or controlled access ID card scanners. All locking arrangements must be in compliance with National Fire Protection Association (NFPA) 101, Life Safety Code.

(2) All inpatient and residential care facilities must include separate and secure sleeping arrangements (unit or wing) for women Veterans.

(3) Mixed gender units must ensure safe, private, and secure sleeping and bathroom arrangements for women Veterans including, but not limited to, proximity to staff, door locks and gender-specific personal care and hygiene products.

(4) The Annual Safety and Security Assessment must be conducted jointly with the facilities Management/Engineering, the Associate Director or designee, and the WVPM. The WVPM must also participate in regular environmental rounds with special emphasis on improving privacy and security.

VETERANS HEALTH ENVIRONMENTAL PRIVACY AND SECURITY**AMBULATORY CARE SETTINGS**

The Veterans Health Administration (VHA) is dedicated to ensuring the dignity, privacy, sense of security, and safety of every Veteran in all care settings. A review of structural, environmental, and psychosocial patient security and privacy issues will be conducted in VHA ambulatory care settings on an annual basis by the Women Veterans Program Manager and incorporated into monthly environment of care rounds. Each facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for all Veterans, particularly women Veterans. This Checklist is to be utilized as a guide for assessing minimum standards during environmental rounds.

Public Areas:

Yes	No	N/A	
			Check-in clerk station has auditory privacy.
			Interview area has auditory privacy.
			Clinic waiting area has auditory privacy.
			Patient names are not posted.
			A “family” or “unisex” restroom is available where a patient or visitor can be assisted.
			Sanitary napkin and tampon dispensers and disposal bins in women’s public restroom
			Baby Changing Tables in women’s and men’s public restrooms
Notes:			

Examination, Procedure, and Testing Areas:

Yes	No	N/A	
			Patient names are not called out loudly.
			Access to hallways by patients/staff who do not work in that clinic area is restricted.
			Patient-identifiable information is not visible in hallways (chart notes/patient names).

			When doors are closed, staff <u>knock and WAIT</u> until they are invited to enter.
			Rooms do not open into a public waiting room or a high-traffic corridor.
			Room doors have locks, either electronic or manual.
Notes:			

Yes	No	N/A	
			Gowned patients can access sex-specific restrooms without entering public areas.
			Privacy curtains are present in all examination rooms <input type="checkbox"/> yes <input type="checkbox"/> no Privacy curtains allow adequate space for providers to perform physical exams. <input type="checkbox"/> yes <input type="checkbox"/> no Privacy curtains are located so patients can undress behind them.
			Examination tables are placed with the foot facing away from the door.
			Examination tables are shielded from view when the door is opened.
			If not... <input type="checkbox"/> yes <input type="checkbox"/> no Examination tables are fully shielded by privacy curtains.
			Cameras are not exposed when not in use (removed or mounted in locked cabinet).
			Trash collection/routine maintenance is scheduled when patients are not present.
			Draping techniques are used to shield intimate body parts during exams/procedures.
			Procedure and testing areas have auditory privacy.
			Special consideration is given to privacy and dignity in areas that involve exposure: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Colonoscopy. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Gynecology, urology, and proctology. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Cardiac treadmill testing. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A EKG testing. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Radiology dressing areas. <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Ultrasound, trans-vaginal ultrasound testing.
Notes:			

INPATIENT, RESIDENTIAL, DOMICILIARY AND HOPTEL FACILITIES

The health care environment directly and indirectly affects the quality of care provided to Veterans. It affects their comfort and sense of security, as well as their perceptions of care received.

The Veterans Health Administration (VHA) is dedicated to ensuring the dignity, privacy, sense of security, and safety of every Veteran in all care settings. A review of structural, environmental, and psychosocial patient security and privacy issues in VHA inpatient care settings will be conducted on an annual basis by the Women Veterans Program Manager and incorporated into monthly environment of care rounds. Each facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for all Veterans, particularly women Veterans. This Checklist is to be utilized as a guide for assessing minimum standards during environmental rounds.

Inpatient Facilities:

Yes	No	N/A	
			Patient-identifiable information is not visible in hallways (chart notes/patient names).
			Patient records are not left unattended.
			When doors are closed, staff <u>knock and WAIT</u> until invited to enter.
			Privacy curtains are present in all rooms (mental health units are exempt).
			Rooms are assigned to same-sex patients (except in facilities where spouses share rooms).
			Women patients have access to women-only toilet and shower facilities in close proximity to the patient's room.
			Male and female patient pajamas, gowns, robes, etc. are stocked in all sizes.
			If not... <input type="checkbox"/> yes <input type="checkbox"/> no An equitable system is in place to obtain appropriate clothing.
Notes:			

Residential and Hoptel Facilities:

Yes	No	N/A	
			Client records are not left unattended.
			Female bathroom doors are lockable if accessible from unit hallways or other public spaces.
			Female bedrooms will be located in a separate and secured area of the unit or located near main staff offices or nursing station
			Appropriate private space is available for female Veterans to visit with children.
			When doors are closed, staff <u>knock and WAIT</u> until invited to enter.
			Rooms are assigned to same-sex clients (except in facilities where spouses share rooms).
			Women have safe and secure sleeping arrangements: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Door locks <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Access bar codes <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> N/A Controlled access ID card scanners
Notes:			

WOMEN'S HEALTH PROVIDER COMPETENCY STANDARDS

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)

"Basic"/"Minimal" Women's Health 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 teratogenic medications
- Recognize presentation of Ectopic Pregnancy

Procedures:

"Basic"/"Minimal"

- Breast Exam
- Pelvic Examination
- Rectal Exam
- Pap Smear
- Wet Mount
- Removal of Foreign Body from Vagina

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