Replaces VHA Manual M-2, Part I, Chapter 29, dated December 29, 1994

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA HANDBOOK 1330.1

May 2, 2001

VHA SERVICES FOR WOMEN VETERANS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook defines the scope of VHA services to women veterans.

2. SUMMARY OF MAJOR CHANGES:

a. Public Law 104-262 authorizes the Secretary to provide health care as determined to be medically needed. Maternity and infertility services, excluding in-vitro fertilization (IVF), are included as services provided by the medical benefits package.

b. Public Law 106-117 extends the Department of Veterans Affairs' (VA's) authority, to provide counseling and treatment for military sexual trauma, through December 2004.

c. The Military Sexual Trauma Software must be installed and implemented at each VA facility, including Community-based Outpatient Clinics (CBOCs) and independent clinics.

3. RELATED ISSUES: VHA Directive 1330 (to be published).

4. RESPONSIBLE OFFICE: The Director, Women Veterans Health Program (133) is responsible for the contents of this Directive. Questions may be referred to the Director, Women Veterans Health Program, at (202) 273-8577, or FAX at (202) 273-6136.

5. RESCISSIONS: VHA Manual M-2, Part I, Chapter 29, dated December 29, 1994, is rescinded.

6. RECERTIFICATION: This document will be recertified on or before the last working day of April 2005.

S/ by Tom Sanders for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

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VHA SERVICES FOR WOMEN VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines the Women Veterans Health Program within VHA. ***NOTE:*** *For purposes of this Handbook the acronym WVC refers to either the Women Veterans Coordinator or the Women Veterans Program Manager. For purposes of this Handbook "facility" refers to ALL free standing medical centers, primary and legacy facilities, and independent clinics, but does not include mobile clinics or Community-based Outpatient Clinics (CBOCs).*

2. AUTHORITY

a. Public Law (Pub. L.) 102-585, Veterans Health Care Act of 1992, Title I, enacted November 4, 1992, authorizes the Department of Veterans Affairs (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 same law authorizes VA to provide women veterans counseling services needed to treat sexual trauma experienced while serving on active duty.

b. Pub. 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 from four Regions to 22 Veterans Integrated Service Networks (VISNs), the position of Regional Women Veterans Coordinator is retitled Deputy Field Director (DFD), Women Veterans Health Program.

c. Pub. L. 103-452, Veterans Health Programs Extension Act of 1994, signed November 2, 1994, authorizes VA to provide appropriate care and services for sexual trauma. The law also made VA's authority to treat sexual trauma gender-neutral.

d. Pub. 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 medical benefits package.

e. Pub. L. 106-117, Veterans Millennium Health Care and Benefits Act, signed November 30, 1999, extends VA's authority to provide counseling and treatment for sexual trauma through December 2004.

3. SCOPE

It is a VHA mandate that each facility, independent clinic, mobile clinic, and Community-based Outpatient Clinic (CBOC) ensure that eligible women veterans have access to all necessary medical care, including care for gender-specific conditions, that is equal in quality to that provided to male veterans.

a. In their statement of work, each contract provider must address how gender-specific care will be provided, and how they will collect and track data on preventive medicine women's health indices.

b. All VHA facilities must develop written policies that describe how care provided to women veterans at mobile clinics and CBOCs is coordinated to ensure continuity of care.

c. Each facility, independent clinic, and CBOC must provide primary and basic gender-specific care.

d. Physical and psychosocial privacy must be provided to women veterans in all health care settings. Assessment and correction of physical and environmental barriers, which limit the access of women to care in VA facilities, independent clinics, and CBOCs, are an ongoing process.

4. PRIMARY HEALTH CARE

a. The plan for providing primary care must include:

(1) Intake and initial assessment, which will include screening for sexual trauma that may have occurred while the veteran was serving on active duty in the Armed Forces.

(2) Preventive health index measures, including cervical cancer and breast cancer screening.

(3) Acute and chronic biopsychosocial care.

(4) Referral coordination.

(5) Accessing all services and programs available to veterans.

(6) Follow-up care.

(7) Patient education.

b. Full-service women's primary care clinics and/or teams, which provide comprehensive care, including basic gender-specific care, are the optimal milieu for providing care to women veterans.

c. VHA policy requires that each patient enrolled for primary health care has a primary care provider and/or team, which assumes responsibility for planning, coordinating, and ensuring continuity of care, including the maintenance of health and treatment of illness.

d. Gender-neutral primary care teams need to be utilized when women's primary care clinics and/or women's primary care teams are not feasible. The assignment of women to gender-neutral primary care teams must take into consideration women's need for privacy, sensitivity, safety, emotional and physical comfort. When a facility serves only a small number of women

veterans, it is preferable to assign all women to one primary care team in order to facilitate the development and maintenance of the provider's clinical skills.

NOTE: *This recommendation is based on the fact that women veterans comprise less than 5 percent of VA's patient population, limiting VA primary care providers' exposure to women's health issues and routine gender-specific care. Rotating women veterans among a number of primary care teams further reduces the ratio of women in a VA practitioner's case load, making it even more unlikely that VA clinicians will gain the clinical exposure necessary to develop and maintain expertise in the area of women's health.*

e. Clinicians caring for women veterans in any setting must be knowledgeable about women's health care needs and treatments, participate in ongoing education about the care of women, and be competent to provide gender-specific care to women. Skills in screening for history of sexual trauma and working with women who have experienced sexual trauma are essential.

f. Primary Care teams are expected to provide basic gender-specific care. If basic gynecology care is provided in a separate specialty clinic, coordination of care remains the responsibility of the primary care provider.

g. The WVC works with <u>all</u> primary care providers and/or teams, where care is provided to women, to ensure that the needs of women veterans are met.

h. A complete primary care examination for women includes:

(1) **A Pelvic Examination.** A pelvic examination is performed, unless medically contraindicated or refused by the patient.

(2) **A Breast Examination.** Breast screening services offered include: clinical breast examination, education on performing breast self-examination, and mammography. Mammography is offered according to accepted screening standards. When mammography services are obtained through contractual arrangements or sharing agreements, the referring VA facility must ensure, prior to services being rendered, that the provider has current accreditation, <u>and</u> is certified by the Food and Drug Administration (FDA).

(3) **A Pap Smear.** Pap smears are offered according to accepted screening standards.

(4) **Basic Gender-specific Care.** Treatment of menopause, uncomplicated vulvovaginitis, osteoporosis, contraceptive needs, and hormone replacement therapy will be provided by the primary care provider and/or team.

NOTE: *If a pelvic, breast examination, and/or Pap smear are <u>not</u> included as a part of a complete physical examination, the reason(s) for deferring the examinations must be clearly documented in the medical record. When clinically unrelated to an acute hospitalization, the examination may be deferred to a competent provider to ensure that these examinations are provided at a later time. A follow-up appointment will be arranged for the completion of these examinations.*

5. GENDER-SPECIFIC CARE FOR WOMEN VETERANS

a. All VA health care facilities must provide gender-specific and gynecologic services to eligible women veterans. ***NOTE:*** *The goal is that these services will be provided in-house to the extent possible.*

NOTE: *If gynecology services are not available in-house, such services will be provided through fee-basis, consultants, sharing agreements, or academic affiliates.*

b. Gender-specific services will include:

(1) **Gynecologic.**

(a) Primary Care Teams, preferably in a women's health clinic, are expected to provide basic gynecology services that are part of primary care, such as: routine Pap smears and treatment of uncomplicated vulvovaginitis, fitting of diaphragms, prescription of oral or implantable contraceptives.

(b) A gynecologist will be available to both inpatients and outpatients for evaluation:

1. And treatment of complicated conditions.

2. And treatment of abnormal Pap smears.

3. Of certain contraceptive needs or surgical sterilization.

4. Of infertility.

(2) **Maternity.** VA is authorized to provide prenatal and postpartum care to eligible women veterans. At the present time, such care is best provided through contractual arrangements. VA is not authorized to provide newborn services, so it is essential that the mother be advised to make alternative arrangements for newborn care prior to delivery.

(3) **Infertility.** The Veterans' Health Care Eligibility Reform Act authorizes the Secretary to provide health care as determined to be medically needed. Since medical remedies for infertility exist, such services could be provided under Title 38 United States Code (U.S.C.) 1710, if the Secretary of Veterans Affairs determines that it is medically needed. 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 VA facilities. ***NOTE:*** *VA does not provide IVF.*

(4) **Mental Health.** Mental health services including substance abuse treatment.

(5) **Osteoporosis.** Osteoporosis screening and treatment.

(6) **Endocrinology.** This includes, but is not limited to, the evaluation and treatment of polycystic ovarian syndrome.

(7) **Oncology (surgical and medical oncology (breast and reproductive)).** Reproductive and breast oncology, and endocrinology may be addressed through network referrals, sharing agreements, academic affiliates, fee-basis, or in-house.

(8) **Counseling and Treatment for Sexual Trauma.** Sexual trauma counseling must be available at all VA health care facilities. In-house programs are recommended, but fee-basis may also be used when clinically advisable and because of geographical accessibility. Vet Centers are also an appropriate referral resource for sexual trauma counseling. All facilities must collect and maintain performance outcome data on sexual trauma screening and counseling services provided.

c. Each VA health care facility is responsible for the identification and monitoring of necessary gender-specific medical equipment, supplies, and pharmaceuticals.

6. WOMEN VETERANS COORDINATOR (WVC)

NOTE: *"Performance Model: Work Assignment of Women Veterans Program Managers (WVCs)," distributed in September 1999, provides guidance about specific performance results, best practices, and quality criteria.*

a. Each VHA facility must have an appointed WVC.

b. The name, location, and telephone number of the WVC is to be posted and appropriately publicized in each facility.

c. When a new coordinator is appointed, the name, title, commercial telephone number, and e-mail address will be submitted to the appropriate DFD and to the Veterans Integrated Service Network (VISN) Director within 10 working days. The DFD then notifies the VHA Women Veterans Health Program (WVHP) Office, VHA Headquarters. The WVHP office maintains a list of current WVCs.

d. The WVC is appointed by the medical center Director and should be a clinical health care professional sensitive to the needs of women in VA health care facilities, who is capable of working with both caregivers and patients to achieve a positive environment for care.

e. The WVC is a health care professional (Doctor of Medicine (MD), Nurse Practitioner (NP), and/or Physician's Assistant (PA), social worker, psychologist, pharmacist, or Registered Nurse (RN)) who provides health care services to women as a part of their regular responsibilities.

f. The WVC will be a member of the Women Veterans Primary Health Care Team.

g. The WVC participates in the regular review of the physical environment, to include the review of all plans for construction, for the identification of potential privacy deficiencies, as well as availability and accessibility of appropriate equipment for the medical care of women.

h. The WVC must have adequate time allocated to successfully perform program administrative activities including, but not limited to, patient education and case management. Outreach is an integral part of the WVC role. These responsibilities are to be considered in determining the amount of time allocated to the fulfillment of the responsibilities of this role. CBOCs and independent clinics must designate a WVC contact and/or liaison to:

(1) Coordinate women's issues with the parent facility; and

(2) Meet reporting requirements.

i. The WVC needs to have direct access to top management in the facility and should serve on appropriate administrative and clinical boards and/or committees.

j. Each VISN must designate a lead WVC who serves as the Network's representative on women veterans issues.

***NOTE**: Guidelines distributed to VISN offices in November 1999 provide recommended duties of this assignment.*

7. WOMEN VETERANS HEALTH COMMITTEE (WVHC)

Each VA facility should have a WVHC to assist the WVC in carrying out the duties and responsibilities of that position, and to provide recommendations for improving services and programs for women veterans.

a. The WVC should chair the WVHC, but at a minimum must be a member of the committee.

b. Membership on the committee may include, but is not limited to: representatives from clinical services such as primary care, specialty care, surgery, pathology and laboratory services, extended care, domiciliary care, chaplain, social services, behavioral and mental health services, public and consumer affairs, Readjustment Counseling Service (RCS), and the Veterans Benefits Administration (VBA).

c. Minutes of the committee should be distributed widely, with reporting requirements to include routing to the Chief Executive Officer and the Chief of Staff. ***NOTE:** Women veteran consumers, representatives of veterans service organizations (VSOs), and other stakeholders may only serve as consultants to the WVHC.*

8. THE HEALTH CARE ENVIRONMENT

a. The health care environment directly and indirectly affects the quality of care provided to women veterans, significantly impacts the patients' comfort and feelings of security, and invariably affects their perception of the care received. Annual reviews of the health care environment occur in all VA medical facilities to ensure that the environment promotes comfort, privacy, feelings of security, and a sense of welcome. The WVC and/or appropriate members of the facility's WVHC are to participate in these reviews.

b. Programs addressing attitudes and sensitivity toward women veterans are essential components of orientation and in-service education of employees and trainees.

c. Other elements within the environment that are of special concern to women veterans include, but are not limited to:

(1) The admissions process.

(2) Accommodations, with emphasis on privacy in examination rooms, restrooms, and bathing facilities.

(3) Patient apparel.

(4) Availability of personal hygiene products.

(5) Canteen services, including hair care services and products.

(6) Recreational and social programs.

(7) Long-term care facilities.

9. PERFORMANCE IMPROVEMENT

As part of VHA's program to assess and improve the quality of health care, systematic data collection must be designed to collect information related to women veterans' health care services. In addition to data about key performance measures and standards, the development of critical pathways, flowcharts, and other performance improvement tools are needed for standardization and improved outcomes of care.

a. An individual will be designated at each facility to perform data entry of women veterans' health care services furnished by the facility into existing software packages. Effective and accurate data management is an integral component of the WVHP. ***NOTE:*** *The individual designated should be a clerical support staff member and not the clinical professional providing the care.*

b. The Women's Health Software must be installed and implemented at each VA facility, and at each CBOC and independent clinic.

(1) Pap smears and mammography data must be entered into Veterans Health Information Systems and Technology Architecture (VistA) using the Women's Health Software. This includes notification of test results and plans for follow-up care. Additional data can be entered to assist in performance improvement activities.

(2) Reports can be generated using the software. Such reports are used to assess and improve outcomes in cervical and breast cancer screening.

c. Expansion of performance improvement activities needs to include areas such as:

(1) Screening and follow-up for sexual trauma.

(2) Complete physical examination in all facilities.

(3) Customer satisfaction initiatives and outcomes.

(4) Research plays a vital role in the improvement of services provided in VHA. ***NOTE:*** *Research in women's health care issues should be encouraged at each VA facility, and women must be included in all appropriate studies.*

d. The Women Veterans Health Program, Primary Care, and Mental Health and Behavioral Sciences Service must track and document treatment for Military Sexual Trauma (MST). All providers in these areas must screen veterans for MST and utilize the MST software for tracking.

e. Each VA facility must have an interdisciplinary Implementation Support Team (IST) to oversee the effective use of this software. ***NOTE:*** *The WVC should be a member of this team.*

10. OUTREACH

Outreach to women veterans is an integral part of the Women Veterans Health Program, since women veterans tend to be less aware of their veteran status and eligibility for benefits than male veterans.

a. Outreach can include activities such as: mailings, public speaking, public service announcements (PSAs), health fairs, recognition ceremonies, brochures, workshops, newsletters, newspaper articles, educational seminars, and focus groups.

b. In planning outreach activities, assistance may be available from a number of resources such as Public and Consumer Affairs, Social Work Service, volunteer staff, members of the WVHC, Vet Centers, VSOs, and VBA staff.

11. INREACH

"Inreach" is a term that describes internal marketing, both to women veterans already using the system and to other facility staff. Examples may include: educational seminars, in-service, workshops, orientation activities, and customer feedback.

GUIDELINES FOR WOMEN VETERANS' PHYSICAL EXAMINATION

1. Allegations of sexual misconduct are among the most sensitive and difficult areas to investigate and resolve. The episodes leading to such allegations are rarely witnessed and often lead to great public distress for both the provider and the patient. As in many areas of health care, prevention is usually the best remedy. The following guidelines for Department of Veterans Affairs (VA) physicians and other health care providers are similar to those promulgated by a number of state medical boards to prevent misunderstandings and protect both provider and patient.

2. Patient dignity must be maintained during the course of a physical examination with adequate privacy at all times. The examination room should be safe, clean and well maintained and should provide both auditory and visual privacy. Privacy curtains should shield the actual examination area and the placement of the examination table should also minimize any inadvertent exposure of the patient during a physical examination. Gowns, sheets and/or other appropriate apparel should be available to protect the patient's dignity and decrease embarrassment. The patient should never be asked to disrobe in the provider's immediate presence.

3. A third party should be readily available at all times during a physical examination. A third party should actually be present when the provider performs an examination of the sexual or reproductive organs or rectum. The provider must inform the patient of the option to have a third party present regardless of the provider and/or patient gender.

4. Due to past sexual trauma, some women veterans may have a heightened sense of vulnerability when receiving medical care, in particular, during invasive procedures such as pelvic and/or rectal examinations and endoscopic procedures. Full and complete discussion with the patient in advance of procedures helps both the provider and the patient to anticipate difficulties that might arise and to develop strategies for alleviating anxiety and fear. ***NOTE:*** *Further information on specific interventions may be found on the internet site for the National Center for PTSD at http://www.ncptsd.org/facts/specific/fs_female_primary.html.* The provider needs to explain the necessity of a complete physical examination or the components being performed during the examination, as well as the necessity for various diagnostic studies, and the purpose of disrobing, in order to minimize the patient's anxiety and possible misunderstandings.

5. Following a physical examination, the provider should discuss any positive findings with the patient and give the patient a chance to ask questions. During this discussion, the patient should be fully dressed.

SAMPLE FORMAT FOR FACILITY SELF-ASSESSMENT AND/OR PROGRAM EVALUATION

NOTE: *The following list represents basic elements needed for a Department of Veterans Affairs (VA) facility's Women Veterans Health Program (WVHP) and more advanced elements for those applying for special programs and/or recognition in Women's Health. Each Women Veterans Coordinator (WVC) should be able to describe the facility's program using the following information:*

1. Women Veterans Health Clinic and/or Women Veterans Health Team

a. **Schedule.** Days per week and hours of operation.

b. **Workload**

(1) Average number of women seen per clinic.

(2) Unique women veterans seen in previous fiscal year.

(3) Total number of outpatient visits by women veterans in previous fiscal year.

(4) Total number of women enrolled at each health care site (facility, independent clinic, and Community-based Outpatient Clinic (CBOC)).

(5) Total number of Full-time Employee Equivalent (FTEE) assigned to WVHP.

c. **Program Staff**

(1) Physician and/or Medical Director.

(2) WVC (needs to function as a women's health primary care team member with time allotted for program administration versus clinical practice provided).

(3) Nurse.

(4) Social Worker.

(5) Nurse Practitioner.

(6) Physician Assistant.

(7) Other support staff.

(8) Clerical support.

d. **Space**

(1) Waiting areas: separate versus common waiting areas.

(2) Offices and/or examination rooms.

(3) Privacy and/or safety concerns:

(a) Privacy curtains,

(b) Table facing away from the door, and

(c) Proximity to women's restrooms that can be accessed without going through public hallways or waiting rooms.

2. Clinical Care

a. **Primary Care**

(1) Mechanisms for provision of primary care.

(2) Mechanisms for assignment of women veterans to primary care.

(3) Percentage of women veterans who receive primary care in the women's health clinic.

(4) Mechanisms for coordination of care.

b. **Gynecology**

(1) In-house versus contract.

(2) Full-time or part-time provider status.

(3) Referral process for inpatient and outpatient gynecological services.

c. **Cytology**

(1) In-house.

(2) Contract.

(3) Percentage of women under 65 years of age who have a uterus, and who have been offered and declined a Pap smear, or had a Pap smear within the past 3 years.

d. **Mammography**

(1) In-house versus contract.

(2) Certification of in-house or contract providers.

(3) Referral processes.

(4) Individual(s) responsible for mammography, including follow-up and notification.

(5) Percentage of women 52-69 years of age who have been offered and declined or had a mammogram within the last 2 years.

e. **Military Sexual Trauma Counseling and Treatment**

(1) In-house versus contract.

(2) Referral processes.

(3) Screening processes.

(4) Percentage of women veterans seen in primary care who are screened for sexual trauma.

(5) Percentage of women veterans receiving sexual trauma counseling and/or treatment.

f. **Other Gender-Specific Services**

(1) Medicine.

(2) Surgery.

(3) Mental Health and Behavioral Sciences.

(4) Pharmacy.

(5) Other.

3. <u>Data Collection</u>

a. **Women's Health Software**

(1) Individual(s) responsible for entry of data.

(2) Current data reports.

(3) Performance improvement measures and outcomes.

(4) Productivity, efficiency, cost-effectiveness measures.

(5) Preventive health measures and outcomes.

(6) Customer satisfaction measures and outcomes.

b. **Military Sexual Trauma Software**

(1) Individual(s) responsible for entry of data.

(2) Screening processes.

4. Structures and Processes

a. Changes and/or innovations leading to improvements in clinical services and/or clinical outcomes in the past year.

b. Programs or processes developed that could be considered "best practice models" for the WVHP.

5. Education and Research

a. Grants, publications and/or awards obtained through the facility's WVHP.

b. Educational programs developed for staff on women's health.

c. Educational programs developed for patients.

6. WVC

a. Name(s).

b. Professional designation(s).

c. Hours available for WVC activities.

d. Hours spent in clinics or direct services.

e. Hours spent for administrative duties.

f. Other duties.