HEALTH CARE SERVICES FOR WOMEN VETERANS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive 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 the VHA site of care.

2. SUMMARY OF MAJOR CHANGES:

a. This VHA directive updates the description of the 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 facility. The assignment of women Veterans to designated Women's Health Primary Care Providers WH-PCP is clarified and the requirements for designation and maintenance as a WH-PCP are defined in this directive.

b. Clarify that a physician, Nurse practitioner, or Physician Assistant can serve as Women's Health Medical Director or Women's Health Champion.

c. Merged Appendix C and D, Veterans Health Environmental Privacy and Security, and removed repetitive elements that are covered elsewhere on the Environment of Care survey tool.

d. Amendment, dated July 24, 2018:

(1) Paragraph 10: Added planning, design, and construction standards; revised language for door locking security, restroom/toilet room privacy, and curtain/screen privacy; and added mandatory availability of diaper changing tables.

(2) Appendix C: Revised general language from restroom to restroom/toilet room, added unisex restroom/toilet room, and clarified checklist items for readability and consistency with terms revised in paragraph 10 of the directive.

e. **Amendment dated June 29, 2020:** Updates Paragraph 6.d., to be consistent with VHA national policy requirements.

f. **Amendment dated January 8, 2021:** Updates Paragraph 6.i., to be consistent with VHA national policy requirements.

g. **Amendment dated August 25, 2022:** Removes language pertaining to the Veterans Health Care Act of 1992.

h. **Amendment dated September 9, 2022:** Removes reference to blanket exclusions on abortions and abortion counseling. Abortion counseling is no longer

excluded pursuant to 38 C.F.R. § 17.38(c)(1). Abortions are allowed under certain circumstances as set forth in 38 CFR § 17.38(c)(1). For more information, see 87 Federal Register (FR) 55287 (September 9, 2022).

3. RELATED ISSUES: VHA Handbook 1330.02 and VHA Handbook 1330.03.

4. RESPONSIBLE OFFICE: The Chief Officer, Women's Health Services (10P4W) is responsible for the contents of this VHA directive. Questions may be referred to 202-461-1070.

5. RESCISSIONS: VHA Handbook 1330.01, Health Care Services for Women Veterans, dated May 21, 2010 and VHA Memorandum, 2017-06-20, Requirements to be Designated as a Women's Health Primary Care Provider, dated June 23, 2017 are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2022. This VHA directive will continue to serve as national policy until it is recertified or rescinded.

/s/ David J. Shulkin, M.D.
Under Secretary for Health

DISTRIBUTION: Emailed to the VHA Publication Distribution List on February 16, 2017.

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HEALTH CARE SERVICES FOR WOMEN VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes the minimum requirements to ensure that all eligible and enrolled women Veterans, irrespective of where they obtain care in VHA, have access to all medically necessary services. **AUTHORITY:** 38 U.S.C. 501, 1710, 1720D, 7301(b).

2. BACKGROUND

The Department of Veterans Affairs (VA) is improving access, services, resources, facilities, and workforce capacity to make health care more accessible, more sensitive to gender-specific needs, and of the highest quality for the women Veterans of today and tomorrow. While women Veterans constitute a minority of Veterans, they deserve the same level of services provided to male Veterans. VHA Women's Health Services (WHS, 10P4W) works to ensure that timely, equitable, high-quality, comprehensive health care services are provided in a sensitive and safe environment at VA medical facilities nationwide. VA strives to be a national leader in the provision of health care for women, thereby raising the standard of care for all women.

a. 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.

b. P.L. 104-262, Veterans' Health Care Eligibility Reform Act of 1996, required VA establish and implement a national enrollment system to manage the delivery of health care services to eligible Veterans. VA subsequently established the medical benefits package in title 38, Code of Federal Regulations (CFR). See 64 FR 54217 (October 6, 1999); 38 CFR § 17.38. Maternity (pregnancy and delivery services) and infertility services, excluding in-vitro fertilization (IVF), are included in VA's Medical Benefits package. See § 17.38(a).

c. 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.

d. P. L. 108-422, Veterans Health Programs Improvement Act of 2004, granted VA permanent authority to provide counseling and treatment for conditions related to military sexual trauma and extended eligibility to Veterans who experienced sexual trauma while on active duty for training status.

e. P.L. 110-387, Veterans Mental Health and Other Care Improvements Act of 2008, 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.

f. P.L. 111-163, Caregivers and Veterans Omnibus Health Services Act of 2010, Pursuant to 38 U.S.C. § 1786, VA may provide newborn health care services, for up to but not more than, date of birth and 7 calendar days after the birth of the child, all post-delivery care services, including routine health care services that a newborn child requires, if the woman Veteran delivered the child in a VA medical facility or in another facility pursuant to a VA contract relating to such delivery. These services are part of VA's medical benefits package. ***NOTE:*** *See 38 CFR § 17.38 (a)(1)(xiv).*

g. P.L. 113-146, Veterans Access, Choice, and Accountability Act of 2014, Title III, Section 301 requires biennial reporting regarding staffing of medical facilities including workload, staffing and wait times for Women's Health.

h. P.L. 113-146, Veterans Access, Choice, and Accountability Act of 2014, Title IV, Health Care Related to Sexual Trauma expands eligibility for sexual trauma counseling and treatment to Veterans who experienced sexual trauma while on inactive duty training, permits (but does not require) VA to expand eligibility for sexual trauma counseling and treatment under Title 38 US Code 1720D to include Active Duty members of the Armed Forces, and updates VA reporting requirements.

i. VHA Handbook 1330.02, Women Veterans Program Manager, establishes the minimum requirements for health care professionals appointed as Women Veterans Program Managers (WVPMs). It outlines the duties, responsibilities, performance standards, and functional statements for Veterans Integrated Service Network (VISN) Lead WVPMs and VA medical facility WVPMs who are responsible for planning, executing, monitoring, and evaluating the Women Veterans Health Program services at the local level.

j. VHA Handbook 1330.03, Maternity Health Care and Coordination, establishes new VHA procedures for furnishing and coordinating the maternity care of eligible, enrolled, women Veterans. This includes women receiving their maternity care within VA or by a non-VA provider at VA expense through VA medical facilities. These procedures establish a VA-wide standard of practice for maternity care and its coordination.

3. DEFINITIONS

a. **Administrative Parent.** An administrative parent is defined as a collection of all the points of service that a leadership group (VA Medical Facility Director, Deputy VA Medical Facility Director, Chief of Staff, Associate or Assistant Director, and Nurse Executive) manages. The points of service can include any institution where health care is delivered. All of the data that originate from these points of service roll up to a single station number representing the administrative parent for management and programmatic activities.

b. **Co-Location.** Co-location means having primary care and gender-specific specialty care (i.e. mental health services, gynecology care) in the same physical location (clinic) in order to optimize care delivery.

c. **Comprehensive Primary Care for Women Veterans.** Comprehensive primary care for women Veterans is the provision of complete primary care and care coordination at one site by a Designated Women's Health Primary Care Provider (WH-PCP) and Women's Health Patient Aligned Care Team (WH-PACT) team. The WH-PCP and WH-PACT should, in the context of a longitudinal relationship, fulfill all primary care needs, including:

(1) **Care for Acute and Chronic Illness.** Care for acute and chronic illness is the routine detection and management of acute and chronic conditions commonly seen in primary care including, but not limited to: acute upper respiratory infection, headache and back pain, dizziness, urinary tract infection, high blood pressure, cardiovascular disorders, diabetes, osteoporosis, thyroid disease, kidney disease, gastrointestinal disease, lung disease, etc.

(2) **Gender-Specific Primary Care.** Gender-specific primary care is screening for breast and cervical cancer and referral of abnormal findings to specialty services for appropriate follow-up, and basic gynecology care including contraception counseling and basic contraceptive care; sexually transmitted infection (STI) treatment; management of menopause-related concerns; initial evaluation and treatment of conditions such as pelvic and abdominal pain, abnormal vaginal bleeding, vaginal infections, urinary incontinence, breast masses, mastitis, etc.

(3) **Preventive Services.** Preventive services include age-appropriate cancer screenings, nutrition counseling, STI and HIV screening and counseling, Intimate Partner Violence (IPV) screening, smoking cessation counseling and treatment, immunizations, etc.

(4) **Mental Health Services.** Mental health services include initial assessment and treatment, as needed, for a variety of mental health disorders which include mild depression, anxiety, substance abuse, and the appropriate referral to mental health as indicated.

(5) **Coordination of Care.** Coordination of care includes working across care settings, accessing health care providers and community programs, and communicating with patients, primary and specialty providers regarding evaluation and treatment plans both within and outside of the VA to ensure continuity of care.

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

a. **Chaperone.** A Chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.

b. **Designated Women's Health Primary Care Provider (WH-PCP).** Designated women's health primary care provider is a primary care provider who is trained, and experienced in women's health. A WH-PCP does not have to be of female gender. A WH-PCP is preferentially assigned women Veterans to their primary care patient panels. For the required qualifications of a WH-PCP, see paragraph 6 (d).

c. **Exclusive Space.** Exclusive space is a separate physical location for the delivery of comprehensive primary care to women Veterans and it is not shared by other services providing care to male Veterans.

d. **Military Sexual Trauma (as defined in 38 U.S.C. § 1720D).** Military sexual trauma (MST) is "physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while a Veteran was serving on active duty, active duty for training, or inactive duty training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

e. **Rights of Conscience.** Rights of conscience (ROC) refers to a request by a provider to opt-out of an aspect of clinical care because it violates the provider's conscience to provide that care, based on "the right to protect his or her moral integrity – to uphold the soundness, reliability, wholeness and integration of one's moral character."

f. **Separate Shared Space.** Separate shared space is a separate physical location for the delivery of comprehensive primary care to women Veterans that may be used by other services on days when women Veterans are not being seen.

g. **Specialty Gynecology Care.** Specialty gynecological care includes the management of gynecological conditions that require more advanced evaluation or management (medical or surgical) than can be provided through the gender-specific services offered by the primary care provider. Specialty gynecologic care includes, but is not limited to, evaluation and medical and/or surgical management.

h. **Women's Health Patient Aligned Care Team.** Women's Health Patient Aligned Care Team (WH-PACT) is a team or teamlet in which the provider is a WH-PCP. All members of the team or teamlet must be able to competently perform their roles related to providing comprehensive primary care for women. WH-PACT members must have sufficient training and expertise to care for women Veterans.

4. POLICY

a. It is VHA policy that all eligible and enrolled women Veterans have access to all medically necessary services in accordance with the procedures and guidelines specified in this directive.

b. The requirements in this directive apply to all sites of care that provide care directly and indirectly to women Veterans. Each VA medical facility must ensure that eligible women Veterans have access to high-quality, equitable, comprehensive medical

care which includes but is not limited to primary care, mental health, specialty care, spiritual and pastoral care, residential care, and urgent/emergent care in an environment that provides privacy, dignity and security. It is everyone's responsibility in a VA medical facility to care for all Veterans including women Veterans.

(1) Comprehensive primary care to women should be delivered by a WH-PCP and WH-PACT who are interested, trained, and experienced in the delivery of such care, irrespective of where patients are seen.

(2) Comprehensive primary care must be delivered using one, or any combination of, the comprehensive women's health models of care which best meet the needs of women Veterans in the health care system.

(3) All newly enrolled women Veterans must be assigned to a WH-PCP. Women who are currently receiving care at a VA medical facility must be offered the choice to receive their comprehensive medical care from a WH-PCP. The goal is that at least 85% of women Veterans should be assigned to a WH-PCP.

(4) Each Administrative Parent (Health Care System) must have a full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women's health care that ensures privacy, security, and dignity and improves the overall quality of care provided to women Veterans. WVPMs work collaboratively with administrative and clinical leaders, and the Women's Heath Medical Director (WHMD) to ensure that the needs of women Veterans are met across the health care system. (See VHA Handbook 1330.02).

(5) Each Administrative Parent (Health Care System) must have a WHMD or Women's Health Clinical Champion responsible for clinical oversight of the women's health program.

(6) Each medical facility must engage in an on-going, continual process to assess and correct physical deficiencies and environmental barriers to care for women Veterans. The use of the VHA Environment of Care (EOC) assessment and compliance tool will allow for management planning for correction of deficiencies. A review to evaluate structural, environmental, and psychosocial patient safety and privacy must be conducted on an annual basis, at a minimum, and be recorded through the EOC committee, including the plan for correction of deficiencies with a timeline for correction of deficiencies and an outline of budget commitment for corrections.

5. RESPONSIBILITIES

a. **WHS Chief Officer** The WHS Chief Officer is responsible for the management, administration, technical aspects, program planning, policies, evaluations, integration, and implementation of national women's health program's activities (e.g. comprehensive health, education, reproductive health and others). These activities include 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.

(1) The Chief Officer, in collaboration with Patient Care Services, is responsible for developing and implementing national directives, program initiatives, and VHA guidance related to women's health issues.

(2) Initiating, promoting, and leading effective collaborations with VISN and health care system 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.

b. **VISN Director.** Each VISN Director is responsible for:

(1) Ensuring that VA medical facilities have appropriate resources such as equipment, space, and staffing which includes gynecology and WH-PCP FTEE to ensure that comprehensive health care is delivered to women Veterans.

(2) Ensuring that all staff members assume the responsibility of caring for women Veterans.

(3) Ensuring that all Administrative Parents (Health Care Systems) provide gynecology care either on-site or through Care in the Community.

(4) Ensuring that all VA medical facilities have an appropriate number of WH-PCPs to provide care to their population of women Veterans.

(5) Ensuring that a Lead WVPM is designated to serve as the VISN representative on women Veterans' issues and as a member of the WHS Field Advisory Group.

(6) Ensuring that the Lead WVPM position maintains a minimum of .5 FTEE for job responsibilities and reports directly to the VISN Director or Chief Medical Officer (e.g. maintains a schedule of at least quarterly meetings and program updates with the Network Director or Chief Medical Officer). (VHA Handbook 1330.02).

(7) Ensuring that the VISN Lead WVPM has direct access to top management in the VISN and serves on appropriate administrative and clinical boards or committees.

(8) Ensuring that the VISN Lead WVPM has funding and staff support for data analysis and project implementation, as well as funding for travel to meetings with the WVPMs in the VISN.

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

c. **VA Medical Facility Director:** Each VA medical facility Director is responsible for:

(1) Ensuring that all staff members assume the responsibility of caring for women Veterans with dignity and sensitivity.

(2) Ensuring that Administrative Parents (Health Care Systems) have appropriate resources such as equipment, space, and staffing, including gynecology and an appropriate number of WH-PCP FTEE to ensure that comprehensive health care is delivered to all women Veterans at all sites of care in the health care systems including VA medical centers and CBOCs.

(3) Ensuring that all facilities provide all aspects of gynecology care including but not limited to office visits, surgical procedures, emergency department care, and consultations either on-site or through Care in the Community in accordance with Gynecology Policy. VA medical facilities with Surgical Programs are required to have on-site Gynecology.

(4) Ensuring that a Women's Health Medical Director (WHMD) is appointed to serve as the clinical leader for women's health in the Administrative Parent (Health Care System), and ensuring the WHMD has a minimum of 4 hours per week administrative time separate from clinical duties (see Appendix A). It is recommended but not required that the WHMD is a physician.

NOTE: *APRNs or PAs who are currently serving as WHMDs can continue in their current roles.*

(5) Ensuring that each Administrative Parent (Health Care system) must have a Women Veterans Health Committee (WVHC), comprised of appropriate facility leadership and program directors, which develops and implements a Women's Health Program strategic plan to guide the program and assist with carrying out improvements for providing high-quality equitable care for women Veterans. The WVHC must maintain an active charter, meet at a minimum quarterly and report to leadership with signed minutes at the Executive Quadrad level.

(6) Appointing a clinical health care professional as full-time WVPM. The position is mandated to be a full-time leadership and management position and free of collateral duties with a maximum of clinical time (1/8 FTEE) allotted only for purpose of maintaining credentialing. 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.

(7) Ensuring that the WVPM reports directly to the Chief of Staff or health care system Director and has direct access to top management in the health care system, serves on appropriate administrative and clinical boards and/or committees. (See VHA Handbook 1330.02).

(8) Ensuring that the name, location, and business telephone number of the WVPM is posted and appropriately publicized in each VA medical facility (e.g. on the Administrative Parent (Health Care System) website and accessible through the VA medical facility locator web tool http://www.va.gov/directory/guide/home.asp).

(9) Ensuring that appropriate administrative support staff is designated and available to assist the WVPM and WHMD with data and reporting requirements.

(10) Ensuring that each CBOC has appointed a women's health clinical liaison who collaborates with the WVPM at the parent health care system.

d. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff is responsible for:

(1) Ensuring that all staff members have sufficient training, experience, and access to clinical information resources to be able to provide high-quality comprehensive health care to women Veterans in all areas (e.g. primary care, specialty care, spiritual and pastoral care, ED, in-patient units, mental health, surgical care, nursing care, diagnostic services, and clinical pharmacy).

(2) Ensuring that clinical leadership in Primary Care, Mental Health, and Specialty/Acute Care plan and implement equitable, high-quality, comprehensive health care services for women Veterans, including gender-specific specialty services, in a secure and sensitive environment in all areas of the health care system.

(3) Holding primary care leadership accountable for identifying designated experienced, and proficient women's health primary care providers at each of the facility's sites of care. WH-PCPs must be trained or experienced in women's health care.

(4) Ensuring all women Veterans are offered assignment to a WH-PCP. All newly enrolled women Veterans must be assigned to a WH-PCP. Women who are already receiving care at a VA medical facility must be offered the choice to receive their comprehensive medical care from a WH-PCP.

(5) Ensuring that mental health providers have sufficient training, experience, and clinical information resources to provide high quality care to meet the specific mental health care needs of women Veterans.

(6) Assessing, developing, and maintaining services needed to deliver high-quality gynecologic care by incorporating gynecology service needs into facility strategic planning efforts.

(7) Ensuring processes and procedures are in place for 24 hours per day and 7 days per week (24/7) for ED and facility call coverage for gynecologic care. These local processes and procedures should be developed in collaboration with the ED Director, Chief of Nursing, and Chief of Gynecology (if available) and/or Chief of Surgery. Ensuring on-site care or off-site Non-VA Medical Care, when necessary, to accommodate these needs.

(8) Ensuring that adequate staffing is provided for all care coordination needs of women Veterans, including that the coordination of breast and cervical cancer

screening is assigned to appropriate support staff and not assigned as a collateral duty to the WVPM.

(9) Ensuring appropriate and timely breast and cervical cancer screening follow-up, tracking and reporting.

e. **Associate Director for Patient Care Service/Nurse Executive.** The Associate Director for Patient Care Services/Nurse Executive is responsible for ensuring that the primary care, emergency care, mental health, specialty care, spiritual and pastoral care, and inpatient and operating room nursing staff have the training, experience, and clinical information resources needed to provide high quality care for women Veterans.

f. **Primary Care Leadership (e.g. Chief of Ambulatory Care, Chief of Primary Care, etc.)** Primary Care Leadership is responsible for:

(1) Designating primary care representation on the Women Veterans Health Committee (WVHC).

(2) Working closely with the WVPM and WHMD on all matters affecting comprehensive primary care to women Veterans.

(3) Ensuring that WH-PCPs are designated at each site of care within each VA medical facility and that the number of WH-PCPs available is appropriate to the number of women Veterans accessing care, following primary care panel size recommendations. (VHA Handbook 1101.10, Patient Aligned Care Team (PACT), and VHA Handbook 1101.02, Primary Care Management Module).

(4) Ensuring that WH-PCPs have appropriate panel size reduction. (Appendix B)

(5) Ensuring that all newly enrolled women Veterans are assigned to WH-PCPs that all women already receiving care are offered assignment to WH-PCPs, with a goal of 85% of women Veterans are assigned to WH-PCPs.

(6) Ensuring that all WH-PACT teamlets where the provider is a WH-PCP are designated in Primary Care Management Module (PCMM) as women's health teamlets.

(7) Ensuring that WH-PACT teamlets have appropriate staffing ratios as outlined in VHA Handbook 1101.10.

(8) Maintaining records of training or experience of WH-PCPs.

g. **Women Veterans Program Manager (WVPM).** See VHA Handbook 1330.02 for a detailed position description. Each VA medical facility must designate a full-time WVPM to assess the need for, and implementation of, services for eligible women Veterans, and to provide leadership and oversight to ensure that identified needs are met at the facility.

h. **Women's Health Medical Director (WHMD) or Women's Health Clinical Champion.** The WHMD is responsible for (See Appendix A):

(1) Serving as a clinical leader for women's health and functioning as the clinical subject matter expert for women's health issues in the health care system.

(2) Working closely with the WVPM, forming the foundation of the women's health program.

(3) Collaborating with primary care leadership and participating in all primary care leadership meetings at the health care system level.

(4) Working with other clinical services such as specialty care, surgery, radiology, mental health, laboratory, and emergency department to ensure appropriate clinical services are available to women Veterans.

(5) Collaborating with WVPM and facility leadership and primary care leadership to determine the appropriate model of care for Comprehensive Women's Health Care at all sites of care at the health care system, including the VA medical facility and CBOC's.

(6) Collaborating with the WVPM, VA medical facility leadership and primary care leadership to ensure that women Veterans are offered and assigned to WH-PCPs.

(7) Collaborating with Primary Care Leadership and the WVPM to ensure that WH-PCPs are given appropriate panel size reduction.

(8) Collaborating with WVPM and Primary Care/WH-PACT leadership and the WVPM to ensure that appropriate support staffing is provided to WH-PACT team.

(9) Collaborating with gynecology services to ensure appropriate services for women Veterans, including service line agreements, co-location in comprehensive women's clinics, ED coverage, urgent consultation, etc.

(10) Working with quality management team to monitor and review all clinical performance measures by gender. Establishing priorities and direction for implementing quality improvement on clinical quality measures that apply to women's health.

(11) Developing or supervising clinical education programs for women's health providers and trainees.

(12) Collaborating with VA medical facility Learning Officer to assess clinical women's health learning needs.

(13) Participating in groups created for Women's Health Medical Directors. Participates in monthly national Women's Health calls.

(14) WHMD/WHCC must have at least 4 hours of administrative time per week to perform the above duties.

(15) It is recommended that the WHMD be a WH-PCP.

i. **Women Veterans Health Committee (WVHC).**

(1) Each Administrative Parent (Health Care System) must have a WVHC that develops and implements a WH strategic plan at the local facility level to guide the women's health program and assists with carrying out improvements for providing high quality equitable care for women Veterans. The committee must maintain an active charter, meet quarterly at a minimum, and report to leadership with signed minutes at the Clinical Executive Board CEB level.

(2) The WVPM must either chair or co-chair the WVHC.

(3) Core members of the WVHC must consist of the following: WVPM, WHMD, representatives from primary care, mental health, medical and/ or surgical subspecialties, gynecology, pharmacy, social work and care management , nursing, ED, radiology, laboratory, quality management, business office/Non-VA Medical Care, and a member from executive leadership. Other members may include, but are not limited to, leadership support such as finance, strategic planning, engineering, EMS, and representatives from other services such as pathology services, extended care, prosthetic service, domiciliary care, chaplain, public and consumer affairs, VA Transition & Care Management, minority veteran coordinator, patient representative, Readjustment Counseling Service, nutrition services, MST coordinator, Community Living Centers, Veterans Benefits Administration, homeless programs.

NOTE: *In compliance with the Federal Advisory Committee Act, 5 U.S.C. App., women Veteran consumers, representatives of 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.*

6. COMPREHENSIVE CARE FOR WOMEN VETERANS

a. **Comprehensive Primary Care.** VHA policy requires that the full scope of primary care is provided to all eligible Veterans. Therefore, regardless of the number of women Veterans utilizing a particular health care system, all sites that offer primary care services must offer comprehensive primary care to women Veterans. The Women's Health Program 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, and that such care is provided in a sensitive environment. All necessary gender-specific primary care services must be available at every site of care in the health care system. Comprehensive primary care for women Veterans is patient centered and fully consistent with the principles of WH-PACT. The WH-PACT 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. All women Veterans receiving primary care must be offered assignment to a WH-PACT teamlet consistent with VHA Handbook 1101.10.

NOTE: *All primary care providers having completed training as internists, family physicians, NP or PA are credentialed to provide care to women Veterans. However, because women Veterans are still a minority population within VHA, to provide the highest quality care, it is required that all women Veterans are offered assignment to WH-PCPs and WH-PACTs who have received training and/or experience in the care of women Veterans. Primary care provided by WH-PCPs enhances women Veterans' satisfaction with care and enhances quality of gender-specific care.*

b. **Assignment to a WH-PCP.** All newly enrolled women Veterans must be assigned to WH-PCPs. Each woman Veteran already enrolled for primary health care must be offered assignment to a WH-PCP and a WH-PACT Team, who assume responsibility for providing, coordinating and ensuring continuity of care irrespective of where she is seen (VA medical facilities, CBOCs, outpatient clinics, etc.).

(1) If women Veterans are already assigned to providers who are not WH-PCPs, they may continue assignment with these providers due to Veteran preference if appropriate arrangements are made for the women to receive gender-specific care (from another provider) at the same site of care. Women Veterans should not be required to travel to appointments on separate dates or locations to receive routine primary care and gender-specific primary care.

(2) Requests for primary care provider reassignment from women Veterans will be honored and processed according to the VA medical facility's standard procedure, even if the request is for a non-WH-PCP.

(3) In all cases, arrangements must be made to provide gender-specific care within the primary care setting.

(4) Each VA medical facility must ensure that an appropriate number of WH-PCPs are available at each site of care to ensure that all VHA access goals are met for women Veterans. Cross-coverage for vacations and sick days must be provided by WH-PCPs. In addition each facility and CBOCs that treat more than 10,000 patients must ensure that comprehensive women's primary care is able to be provided by WH-PCPs during extended hours, after hours, and on weekends to the extent required by VHA Directive 2013-001, Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at VA Medical Centers and Selected Community Based Outpatient Clinics, or subsequent policy issue.

(5) Transgender Veterans requesting primary care in a Women's Health Clinic or a Designated Women's Health Provider (DWHP) in a mixed gender primary care clinic should be assigned to WHC or DWHP as requested. (VHA Directive 2013-003 Providing Health Care for Transgender and Intersex Veterans, or subsequent policy issue)

c. **WH-PACT**. Assignment of women Veterans preferentially to WH-PACT panels allows for women to be clustered in teams, where the provider and staff members can provide consistent experience and expertise in the care of women and maintain processes and procedures specifically tailored to women Veterans. These may include trained nursing staff members to triage gender-specific complaints or assist with gender-specific procedures; processes for ordering and tracking mammography and cervical cancer screening; ensuring chaperones and gender-specific equipment and supplies are readily made available.

(1) All PACT teamlets with a WH-PCP as the provider will be designated a WH-PACT teamlet. This must be entered into PCMM as a WH-PACT teamlet.

(2) WH-PACTs may function in gender integrated primary care clinics, or in women's clinics. WH-PACTs in integrated primary care clinics may be mixed gender. That is, a WH-PCP may care for both men and women Veterans on a WH-PACT teamlet panel.

(3) WH-PACT must be staffed according to WH-PACT guidelines (see VHA Handbook 1101.10) and requires enhanced staffing due to needs for chaperones and care coordination. All members of a WH-PACT should be experienced and knowledgeable in the care of women Veterans.

(4) The following staffing is recommended:

(a) Teamlet positions:

1. Primary care provider position: WH-PCP;

2. RN position: RN Care Manager;

3. License practical/vocational nurse (LPN/LVN) or health technician (HT) position: Clinical Associate;

4. Other Position: Chaperone (additional HT, LPN, etc.); and

5. Clerk position: Administrative Associate.

(b) Discipline-specific team members for WH-PACTs are assigned in PCMM as follows:

1. SW position: Social Worker;

2. Pharmacy: Clinical Pharmacy Specialist;

3. Dietitian Nutritionist: Registered Dietitian Nutritionist;

4. Other position: Gynecologist;

5. Other position: Military Sexual Trauma Coordinator;

6. Other position: Mental Health Provider; and

7. Other position: RN Mammogram/Pap/Maternity Care Coordinator.

Note: *Facilities may determine the extent of MST Coordinator involvement, but at a minimum, WH-PACT teamlets should establish a working relationship with the facility MST Coordinator and seek consultation or include their in discussion of specific cases as appropriate.*

d. **Requirements for Women's Health Primary Care Providers (PCP) and WH-PACT Teamlets.**

(1) It is recommended that women Veterans be clustered in teams where the provider and all team members have experience, knowledge and established systems of care to provide equitable, high-quality care to women Veterans.

(2) It is recommended the WH-PACT teamlets are assigned a panel size of at least 100 women Veterans, thus allowing all teamlet members to care for a volume of patients to support maintenance of expertise in the care of women.

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

(a) Documentation of attendance at a Women's Health Mini-Residency within the previous 3 years;

(b) Documentation of at least 20 hours of women's health continuing medical education (CME) or continuing education unit (CEU) within the previous 3 years;

(c) Documentation of at least 3 years in a practice with at least 50% women patients within the previous 5 years;

(d) Evidence of completion of an internal medicine or family practice residency; women's health fellowship; or women's health, adult, or family practice NP or PA training within the previous 3 years;

(e) Documentation of a current preceptorship arrangement with an experienced WH-PCP such as weekly meetings (for at least 6 months); or

(f) Evidence of being recognized as a known women's health leader and subject matter expert with experience practicing, teaching, and/or precepting women's health; and

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

(5) Documentation must be maintained by each provider. Ongoing records documentation of CME/CEU's in women's health education and training is part of the credentialing and privileging renewal process.

e. **Mental Health Services in Primary Care.** Forty-seven percent of women Veterans using VHA had a mental health or substance use disorder diagnosis in fiscal year 2014. A required component of comprehensive primary care involves receipt of integrated 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.

f. **Choice of Provider.** Facilities must give women Veterans the option to designate their preference for a female or male primary care provider. When a woman Veteran requests a female or male provider, accommodation must be made. VA Community Care Options and Non-VA Care can be used if necessary to ensure the request is satisfied.

g. **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 health care system 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.

(1) **Model 1: General Primary Care Clinics.** Comprehensive primary care is delivered to women Veterans by WH-PCPs and WH-PACT teamlets within a gender-integrated primary care clinic. Mental health services for women should be co-located in the general primary care clinic in accordance with Primary Care-Mental Health Integration. Efficient referral to specialty gynecology care must be available within the health care system.

(2) **Model 2: Separate but Shared Space.** Comprehensive primary care is delivered to women Veterans by WH-PCPs and WH-PACT teamlets in a separate space that may be located within or adjacent to primary care clinic areas.

(a) This separate space is dedicated for women Veterans' use.

(b) It may be open part-time or full-time and may be used by other services when women Veterans are not being seen.

(c) This option may be selected by sites that choose to have a designated area for women Veterans' primary care but do not have facility space for a separate comprehensive women's clinic or do not have the women Veteran population to support a full-time women's clinic staff.

(d) Gynecological care and mental health services should be co-located in this space and readily available.

(3) **Model 3: Comprehensive Women's Health Center (WHC).** VA medical facilities with a large women Veterans population are encouraged to create WHCs that provide the highest level of coordinated, high-quality, comprehensive care to women Veterans. Comprehensive primary care is delivered to women Veterans by WH-PCPs and WH-PACT teamlets in an exclusive separate space:

(a) Whenever possible, a WHC should have a separate entrance into the clinical area and a separate waiting room with attention to privacy, sensitivity, safety and physical comfort.

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

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

NOTE: *Women's health centers require appropriate staffing above and beyond WH-PACT staffing ratios which are recommended for primary care teams. Appropriate Support Staffing must be provided for gynecology services and other specialty-care services within WHCs. Specialty gynecology clinics may not be utilized solely for routine breast and cervical cancer screening.*

h. **Special Considerations in the Delivery of Comprehensive Primary Care.**

(1) **Appointment Times.** 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.** Appointment duration recommendations for all practice settings:

(a) New women's health appointment–60 min;

(b) Comprehensive visit that includes a routine Pap smear--60 min;

(c) Routine follow-up appointment**–**30 min; and

(d) Urgent appointment**–**30 min.

(3) **Panel Sizes.** Panel sizes must be adjusted downward to accommodate the unique needs of women Veterans and higher utilization by women in the primary care setting which includes longer appointment time, increased numbers of visits, phone calls, and care coordination requirements compared to male Veterans. Panel size for WH-PCPs should be adjusted according to attached panel size guidelines (VHA Handbook 1101.10 and VHA Handbook 1101.01) (see appendix D).

(4) Community-Based Outpatient Clinics.

(a) All female patients seen at CBOCs must receive the same high-quality comprehensive primary care that is received by female patients at the parent health care system.

(b) All CBOCSs must have at least two WH-PCPs. (Because of small populations of women at most CBOCs, CBOC WH-PCPs will usually have mixed gender panels) It is necessary to have two WH-PCPs to provide full coverage for women during sick leave and vacation. In CBOCs with only one provider appropriate arrangements must be made for coverage during leave. This may include care at another VA site or Care in the Community.

(c) CBOCs and independent clinics must designate a women's health clinical liaison to coordinate women's health services with the WVPM at the main facility. The liaison is usually a nurse or social worker, but may be a provider. The role of the liaison is to be the point of contact who communicates with the WVPM about issues related to women's health care, environment of care and policy, and to communicate these messages to other staff at the CBOC.

(5) **Mobile Clinics.** Mobile clinics which 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.

(6) Chaperones.

(a) For Physical Examinations:

1. A female chaperone must be in the examination room during breast and pelvic exams; and

2. In addition to breast examinations and pelvic examinations, and Pap smears, this includes procedures such as urodynamic testing or treatments such as pelvic floor physical therapy.

(b) For Radiologic Procedures:

1. Mammography does not require a chaperone (all mammography technologists in VA are female);

2. Breast Ultrasound, Breast MRI, Pelvic Ultrasound, Pelvic or Femoral Vascular Ultrasound or any procedure that exposes the groin or pubic area: For the protection of both the patient and the radiologist or technologist, it is highly recommended that male radiologists or technologists have a chaperone present. Female radiologists and technologists should ask female patients if they want a chaperone and provide chaperones on request; and

3. Trans-vaginal ultrasound requires a chaperone regardless of the gender of the radiologist or technologist.

NOTE: In addition to these requirements a radiologist or technologist may request a chaperone for an imaging procedure according to their clinical judgment.

(c) For Electrocardiograms and Echocardiograms:

1. It is highly recommended for protection of both the patient and the RN or technologist that male nurses or technologists have a chaperone present. Female nurses or technologists should ask female patients if they want a chaperone and provide chaperones on request.

2. The following staff may function as female chaperones: MDs, RNs, HTs, LPNs and other clinical personnel such as radiology technologists.

NOTE: *Female volunteers who have had prior experience working in a clinical health care environment may be chaperones when a specific position description outlining the duty's position and expectations has been written in collaboration with the Chief of Voluntary Services, the description has been approved, and staff members have been educated on the role limitations of the volunteer chaperone (see VHA Handbook 1620.01, Voluntary Service Procedures). Female volunteer chaperones will have had prior experience working in a clinical health care environment as an RN, LPN, or HT.*

(7) **Transgender Veterans:** Patients will be addressed and referred to based on their self-identified gender. Room assignments and access to any facilities for which gender is normally a consideration will give preference to self-identified gender, or medical needs of the Veteran, irrespective of appearance and/or surgical history in a manner that respects the privacy needs of transgender and non-transgender patients.

i. **Preventive Care for Women Veterans.** Must follow VHA guidelines for Clinical Preventive Services http://vaww.prevention.va.gov/Guidance_on_Clinical_Preventive_Services.asp.. Preventive care for women Veterans must include but is not limited to age and risk appropriate screening for breast, and cervical cancer and osteoporosis screening. Screening for intimate partner violence and military sexual trauma must be completed as part of preventive care, with connection to recommended services in the case of a positive screen.

(1) Breast Cancer Screening.

(a) Breast cancer screening may be done onsite at VA facilities with in-house mammography programs, or offsite, through Non-VA Medical Care or contract mechanisms, or mobile mammography units.

1. VHA Mammography Program Standards. **NOTE:** Refer to 38 U.S.C. 7319(b) and VHA Handbook 1105.03, Mammography Program Procedures and Standards for full details.. See FDA Mammography Standards Guidance at *www.fda.gov\Radiation-*

EmittingProducts\MammographyQualityStandardsActandProgram\Guidance\PolicyGuidanceHelpSystem\ucm135583.htm.

2. When mammography services are obtained through contractual arrangements or sharing agreements, or through Non-VA Medical Care, the referring VA medical facility must ensure, prior to services being rendered, that the provider is certified by the FDA, or a state that has been approved by FDA under 21 C.F.R. 900.21 to certify mammography facilities.

3. Distance. Mammograms must be accessible within a reasonable distance (less than 50 miles or one hour from the Veteran's home). If the Veteran lives more than a reasonable distance from a medical facility with a mammography suite, the mammogram should be provided off-site via VA Community Care, non-VA care, contract, or other mechanisms.

(b) Breast Care: Orders, Reports and Records Management.

1. Orders. Requests for screening, and diagnostic mammograms, breast ultrasound (US) and MRI 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 onsite or via contract or non-VA care. Orders through Care in the Community including non-VA care or Choice must be electronically entered In the Radiology Package and also as a non-VA Care or VA Care in the Community consult request.

2. In-house mammography reports. Reports must be entered in the radiology package of Veterans Health Information Systems and Technology Architecture (VistA). The appropriate National Diagnostic Code corresponding to the Breast Imaging-Reporting and Data System(BI-RADS) assessment category must also be entered. FDA-approved language corresponding to the appropriate Breast Imaging-Reporting and Data System (BI-RADS) assessment category must be included in the impression section of the report.

3. Outsourced mammography reports received as hardcopy, must be scanned into VistA Imaging. Mammogram results (BI-RADS codes) must be entered and associated to a radiology order in Computerized Patient Record System (CPRS). Systems for tracking and management of mammography and breast cancer will not operate accurately without BI-RADS entered into CPRS and associated to a radiology order. All outsourced mammogram reports must be returned to VA ordering practitioner within 30 days as per Mammography Quality Standards Act and Program (MSQA). However, if future VA policy or contracts dictate shorter turn-around time for mammograms, those policies will take precedence.

(c) Notification of Results from the Radiologist.

1. Mammography Provider to the Patient.

a. All VHA and non-VA radiology and mammography programs are required to provide a report of the results of the mammographic examination to the patient within 30 calendar days, consistent with the requirements of 21 CFR Part 900.12(c). Furthermore, when the mammography report assessment is "Suspicious" or, "Highly Suggestive of Malignancy" (BI-RADS codes 4 or 5, respectively), the results and recommended course of action must be communicated as soon as possible. FDA guidance recommends the patient be notified of “Suspicious” or “Highly Suggestive of Malignancy” results within 3 to 5 days of interpretation.

b. It is the interpreting provider’s responsibility to interpret the images and communicate any positive findings, which are to be made known to the patient; however, it remains the responsibility of the practitioner ordering the study to discuss the meaning of the findings with the patient and the alternatives for further study, treatment, or referral.

2. Mammography Provider to the Ordering Provider.

a. Facilities are strongly encouraged to negotiate report turnaround times consistent with VHA policy in their mammography contracts or non-VA care agreements.

b. Non-VA radiology mammography programs must provide a signed written report to the ordering practitioner within 30 calendar days of the examination date. If the assessment is “suspicious” or “highly suggestive of malignancy” the results and recommended course of action must be communicated to the ordering practitioner or designee as soon as possible. FDA guidance recommends no more than 3-business days (see VHA Handbook 1105.3) for notification of abnormal results.

3. Communication of Results from the Primary Care Provider (or Other Ordering Provider) to the Patient.

a. The ordering provider or designee must communicate the results of normal mammograms completed in-house or through contract or non-VA care to the patient within 14-calendar days of receiving the results.

b. All mammogram results requiring action must be communicated by the ordering provider or designee to patients no later than 7-calendar days from the date the results are available to the ordering provider.

c. Communication must be documented in CPRS.

d. If indicated, 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.

e. Significant abnormalities may require review and communication in shorter timeframes and 7 calendar days represents the outer acceptable limit. For abnormalities

that require immediate attention communication needs to occur in the timeframe that minimizes risk to the patient.

(2) Cervical Cancer Screening.

(a) Cervical cancer screening must be performed in accordance with VHA guidelines. The results of normal (no evidence of malignancy (NEM)) cervical pathology must be reported to the ordering provider within 30-calendar days of the pathology report being completed. The interpreting pathologist must ensure the ordering provider is contacted with abnormal results within 5-business days.

(b) The cervical pathology report of normal NEM results must be communicated to the patient in terms easily understood by a layperson within 14-calendar days from the date of the pathology report and the Human Papilloma Virus (HPV) report becoming available to the ordering provider. Documentation of a letter and/or verbal communication with the patient must be entered into CPRS. If using the United States Postal Service, confirmation of the receipt of these results is not required. For any abnormal cervical pathology report, the results must be communicated within 7-calendar days of the report (including cytology and HPV) becoming available to the ordering provider.

(3) Tracking and Care Coordination.

(a) Each facility must have a process in place to ensure tracking and timely follow-up of findings from breast and cervical cancer screening. All Administrative Parents (Health Care Systems) must have in place standard operating procedures that specify the tracking process and assign breast, maternity, and gynecological care coordination duties to specific individuals. These duties may be assigned to individuals such as a WH-PACT RN Care Coordinator, Oncology Care Coordinators Mammogram Coordinators or Maternity Care Coordinators (see VHA Handbook 1330.03). These duties should not be assigned to the WVPM who fills a leadership and management role for the Women's Health Program.

(b) Breast and gynecological care coordination includes but is not limited to the following duties:

1. Tracking of breast and cervical cancer screening, including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care;

2. Ensuring communication between patient and providers such as answering and triaging patient questions and phone calls, and ensuring that all results are communicated to patients;

3. Ensuring coordination of breast and gynecological cancer care within VA including assisting patient with navigating appointments and services, and ensuring communication between VA providers;

4. Facilitating access to non-VA providers when needed and ensuring communication between VA and non-VA providers;

5. Ensuring that pertinent copies of all non-VA medical records are obtained and entered into the VA medical record; and

6. Ensuring travel resources are available when needed for eligible Veterans.

j. **Gender-Specific Specialty Care.** Gender-specific specialty services must include:

(1) **Gynecological Care.**

(a) Specialty and Subspecialty Gynecologic Care must be provided either on-site or through Care in the Community. Large sites with surgical programs will be required to provide Specialty Gynecology Care on-site. Please see Gynecology policy for site specific requirements.

(b) Specialty gynecological care includes the management of gynecological conditions that require more advanced evaluation or management (medical or surgical) than can be provided through the gender-specific services offered in the primary care setting. Please note that there may be overlap between care provided by primary care providers and gynecologists for certain conditions.

(c) Specialty gynecology care can be provided by a gynecologist. In addition, physician extenders such as credentialed gynecology NP can provide some gynecological services.

(d) The facility must ensure staffing is sufficient to provide needed gynecologic care (e.g. assisting with office procedures, chaperone, etc.).

(2) **Sub-Specialty Gynecologic Care.**

(a) Reproductive endocrinology and infertility: Care of women who have hormonal or infertility problems.

(b) Gynecologic oncology: Care of women with cancers of the reproductive system.

(c) Female pelvic medicine and reconstructive surgery (subspecialty sometimes referred to as urogynecology): Care of urinary tract dysfunction and disorders stemming from loss of support of pelvic structures.

(d) Maternal-fetal medicine: Care of high-risk pregnancy.

(e) A gynecologist can be considered a discipline-specific team member for WH-PACTs and is assigned in PCMM as a gynecologist (see VHA Handbook 1101.10).

NOTE: *The VHA goal is that gender-specific specialty services 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 non-VA medical care, contractual or sharing agreements, academic affiliates, or other VA medical facilities within a reasonable traveling distance (less than 50 miles). In some cases (i.e. subspecialty care), there may not be a non-VA provider within 50 miles and health care systems can document and make accommodations as possible.

NOTE: *When a women Veteran requests a female or male gynecology provider, accommodation must be made. In order to satisfy the patient request, referral to network sites or use of Choice or non-VA medical care may be utilized. In cases of emergent delivery of care, the accommodation may not be possible and this can be documented in CPRS as such.*

(3) **Pregnancy Testing.**

(a) All VA medical facilities including VA medical facilities and CBOCs must have access to stat pregnancy tests within 1 hour.

(b) All Administrative Parents (Health Care Systems) must have “stat” qualitative (urine and/or serum) and quantitative human chorionic gonadotropin (hCG) testing available 24 hours per day and 7 days per week (24/7) with results available to the ordering clinician stat or within 1 hour of order.

(c) Immediate access to point of care qualitative urine pregnancy testing at the time of the visit is ideal for initial assessment in women of child-bearing age. VA CBOCs or outpatient clinics that do not have access to on onsite stat pregnancy testing must use point of care pregnancy testing.

(d) Women of child bearing age should be counseled about pregnancy testing prior to anesthesia, sedation, radiological procedure, or surgery. Based on the patient’s indication for surgery or type of procedure, medical history, menstrual history, and method of contraception, a pregnancy test should be offered. However, a patient who refuses a pregnancy test will not be denied appropriate care and treatment. If a pregnancy test is positive, the patient, surgeon, and anesthesia provider will discuss whether to proceed with the surgery or radiological procedure.

(4) **Maternity Care and Newborn Care.**

(a) VHA is authorized to provide comprehensive prenatal, intra-partum, and postpartum 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. Each Administrative parent (Health Care System) must have a designated maternity care coordinator (see VHA Handbook 1330.03). A maternity care coordinator functions as a liaison between the patient, the non-VA provider and the VA medical facility. This person is responsible for monitoring the delivery of care, coordinating such care, and tracking outcomes of services that have been furnished through maternity purchased care.

(b) Several health care systems across the country provide on-site prenatal care. If sites are planning to enhance capacity and provide onsite prenatal care, they must submit a proposal to WHS and the Office of Clinical Operations and Management (10NC) describing capacity and proposed onsite services for review.

(c) Newborn care is available for Veterans enrolled in VA care and receiving VA maternity benefits. All medically necessary and appropriate post-delivery services (including transfer) are included in this benefit (see 38 CFR § 17.38 (a)(1)(xiv)) for seven days post-delivery.

(d) Abortion counseling is available to enable eligible and enrolled Veterans to make informed decisions about their health care, just as counseling is offered or covered by VA regarding any other health care decision. Abortion counseling is available for both covered (see paragraph 6.j.(4)(e) below) and non-covered abortions.

(e) Abortions are excluded from the medical benefits package except when:

1. The health or life of the pregnant Veteran would be endangered if the pregnancy were carried to term; or

2. The pregnancy is the result of an act of rape or incest. ***NOTE****: Self-reporting from the pregnant Veteran constitutes sufficient evidence that an act of rape or incest occurred.*

See 38 CFR § 17.38(c)(1). The decision of whether an abortion is covered under one of these exceptions is made on a case-by-case basis by the appropriate VA health care professional pursuant to the promote, preserve, restore standard in the medical benefits package (see 38 CFR § 17.38(b)). In all but the most unusual circumstances, when the pregnancy is the result of an act of rape or incest, an abortion sought by a pregnant Veteran would be considered needed to promote, preserve, or restore their health.

(5) **Infertility.**

(a) Consistent with VA's goal of improving Veterans' health and the quality of their lives, VA health care includes infertility treatment. Refer to current infertility policies for guidance on what treatments VA covers, in line with clinical standards of care.

(b) Infertility services can be provided on-site, through network referrals, negotiated comprehensive contract packages with consultants, contractual or sharing agreements, or through non-VA care to the extent the Veteran is eligible. VA and non-VA provider care must be coordinated in order to ensure delivery of high-quality care consistent with evidence-based standards.

(6) **Gender-Specific Oncological Services.**

(a) Gynecologic oncology and breast oncology care may be provided on-site or through network referrals, negotiated comprehensive contract packages with consultants, contractual or sharing agreements, or through non-VA care to the extent

the Veteran is eligible. When these services are provided on-site, appropriately trained and experienced providers and adequate resources must be available.

(b) The care of a woman with a suspected or diagnosed gynecologic cancer or breast cancer should be coordinated by a health care provider or team with multidisciplinary training in the care of women with gynecologic or breast cancer.

1. This multidisciplinary care involves the gynecologic or breast oncologist and other professionals including but not limited to radiation oncologists, medical oncologists, pain and palliative care specialists, pathologists, radiologists, primary care providers, oncology nurses, oncology pharmacists, genetic counselors, physical therapists, surgical oncologists, obstetrician-gynecologists, trainees and additional supportive care providers.

2. Care for women with gender specific cancers must be highly coordinated and seamless. Support services must be readily available and include pre- and post-hospitalization services.

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

k. Mental Health.

(1) Mental Health for Women Veterans.

(a) Mental health services must be provided to women Veterans according to VHA Handbook 1160.01, Uniform Mental Health Services in VA medical facilities and clinics.

(b) Primary care mental health integrated services must be co-located and provide same-day availability for women Veterans in women's clinics and gender integrated primary care clinics (see VHA Handbook 1160.01). In some smaller facilities with insufficient workload to justify full time staffing, same day access to a visit (either in person in the clinic or virtual) must be available.

(c) Clinicians must be proficient in meeting the mental health needs of women Veterans.

(d) Other mental health services including psychiatry, psychology and social work services may be co-located in comprehensive women's clinics. When clinically indicated, alternatives options to mixed gender groups such as individual therapy or tele-mental health must be provided. Staff members must take full responsibility to address gender issues, such as safety and security, within mixed gender groups. The care environment is an integral component of the design of the outpatient mental health, inpatient psychiatry and residential milieu. All efforts must be made to make the inpatient mental health environment a secure and healing one. The WVPM must participate in routine environmental rounds with special emphasis on improving privacy and security.

(e) Mental health program staff members should 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.

l. **Care for Conditions Related to Military Sexual Trauma (MST).** Full requirements for services for conditions related to MST are found in VHA Directive 2010-033, Military Sexual Trauma (MST) Programming.

m. **Emergency Department Care/Urgent Care Centers (UCC).** VHA has an obligation to ensure quality emergency medical services for all Veterans including women Veterans.

(1) **Emergency Department Gynecology Care.** VA medical facilities must develop and implement written policies and standard operating procedures for managing obstetric and gynecologic emergencies. These policies must clearly describe on-site capabilities and processes/protocols for emergent patient transfer which are consistent with VHA Directive 2007-015, Inter-facility Transfer Policy, or subsequent policy issue. Processes for addressing obstetric and gynecologic emergencies will differ by facility depending on the availability of:

(a) Obstetricians and gynecologists (on-site, off-site, through transfer to another facility, or via tele-gynecology consultation).

(b) On-site diagnostic and treatment resources (e.g. pelvic ultrasound, operating room capacity).

(2) Emergency and Urgent Care.

(a) All VA medical facilities offering urgent care treatment for 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, STI kits, urine pregnancy tests, speculums, medications, etc.). All emergency departments and UCC must have a mechanism in place to diagnose and treat, and/or triage and consult on patients with breast issues such as mastitis, breast mass, nipple discharge etc.

(b) Appropriate supplies must be available to make accurate and efficient diagnosis of vaginal and sexually transmitted infections at the point of care.

1. All VA emergency departments and UCC should have the ability to perform a gynecologic examination at all times and should have at least one gynecologic examination table or a stretcher that is adaptable for a gynecologic exam (i.e. stirrup availability).

2. Necessary gynecologic examination supplies should be available 24/7. All VA emergency department and UCC should stock an obstetric delivery kit.

3. Although, fetal heart monitors are an important tool used by obstetric consultants to assess the state of the fetus in a pregnant patient they are not an expected standard of care in every emergency department nation-wide or a mandated competency for all emergency department providers. It is not an expectation that VA medical facilities have fetal heart monitors on site and if they choose to have them on site, they must have local policy to support their use to evaluate fetal heart rates by obstetric consultants.

(c) Competencies. All staff members providing emergent/urgent care treatment to women Veterans should have sufficient training and expertise to care for women presenting with issues such as, but not limited to, abdominal/pelvic pain, acute vaginal bleeding, vaginal bleeding and/or pelvic pain in early pregnancy, acute sexual assault, recognizing and assessing the presence and impact of interpersonal violence and appreciating gender differences in the presentation of acute coronary syndromes.

(d) Pregnancy Testing.

1. All women Veterans of child-bearing age (age ≤ 52 years) triaged in VA emergency department or UCC should be asked about pregnancy status and last menstrual period. Nursing triage documentation should include this information.

2. VA emergency department and UCCs must have “stat” qualitative (urine and/or serum) and quantitative human chorionic gonadotropin (hCG) testing available 24 hours per day and 7 days per week (24/7) with results available to the patient’s emergency department or UCC clinician stat or within 1 hour of order. Immediate access to point of care qualitative urine pregnancy testing at triage is ideal for initial assessment in women of child-bearing age. Quantitative serum pregnancy testing is critical for managing certain cases (e.g. possible ectopic pregnancy).

3. All women Veterans of child-bearing age (≤ 52 years) who come to the emergency department or UCC should have a pregnancy test (urine or serum) if evaluation of the presenting complaint and any potential treatment could be affected by pregnancy or could adversely affect the well-being or outcome of a pregnancy.

4. Blood type evaluation (i.e. Type and Screen). Blood type evaluation must be part of the evaluation of every pregnant woman who presents to an emergency department or UCC with vaginal bleeding. Locally, VA medical facilities must develop a process to ensure availability of Rho (D) Immunoglobulin to prevent Rh Isoimmunization in female patients who are pregnant, Rh negative, and have a bleeding event (i.e. miscarriage). These processes should be in place in advance of need.

(e) Telephone Triage. VA medical facilities must ensure that the 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.

7. ADDITIONAL SERVICES FOR WOMEN VETERANS

a. **Pharmacy Services.**

(1) It is strongly recommended that Women's Health Program officials (WVPMs, WHMDs) ensure that the unique medication needs of women Veterans are clearly communicated at the local, VISN and national levels.

(2) Emergency contraception (e.g. Levonorgestrel (Plan B) etc.) must be available to all women Veteran patients in a timely manner (same day of their appointment). A process must be implemented at the local or VISN level to ensure availability of emergency contraception to patients in a timely manner (same visit) even if a provider has requested to opt out from providing emergency contraception to the patient because of a Rights of Conscience (ROC) Claim.

(3) All VA medical 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. An informed discussion with the Veteran must cover the risks and benefits of such prescriptions and documentation of patient counseling must be recorded in CPRS.

b. **Telehealth Programs.**

(1) Women's health specific telehealth programs, also known as Tele-Women's Health programs, are defined as telehealth clinics or programs that are designed to treat women only. Providers should be experienced in women's health or knowledgeable about how certain gender-specific conditions, chronic disease states, medications or symptoms impact women. Examples of Tele-Women's Health programs include but are not limited to women's primary care (teleconsultation or telemedicine), gynecology (teleConsultation, or telemedicine), telepharmacy, care coordination (e.g. maternity care, specialty care coordination), and mental health.

(2) When developing or implementing a women's health-specific telehealth program, VA medical facilities should consult the TeleWomen's Health Specialist Supplement (see VHA Telehealth, http://vaww.telehealth.va.gov/clinic/wmn/twmnh/index.asp) that provides recommendations for the operational and clinical standards for TeleWomen's Health programs and identifies the resources required to support safe, quality care.

(3) TeleWomen's Health programs can increase capacity to serve women Veterans, especially those living in rural areas.

(4) Targeted goals for enrollment of women Veterans in VHA telehealth programs based on local need must be set annually at the health care system and VISN levels, and should be addressed in the strategic planning cycle.

(5) TeleWomen's Health programs should be assigned the four character (also known as CHAR4, alpha, or national) code WCQC by the facility Managerial Cost Accounting (MCA) staff members.

(6) Utilization of TeleWomen's Health programs (e.g. uniques, encounters) should be monitored at the health care system and VISN levels at minimum on an annual basis.

c. **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.

d. **Prosthetics Services.** WVPMs need to work closely with the Prosthetics and Sensory Aid Services (PSAS), 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 and lactation supplies, shoes, eyeglasses, compression stockings, etc.). If a request is denied at the facility level, prosthetics staff members must refer the decision through the appropriate channels for review.

e. **Polytrauma Centers.**

(1) Services in polytrauma centers must be tailored to the unique needs of women Veterans. This includes ordering and stocking equipment and supplies that are the correct designs, sizes, and fit.

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

(3) Women Veterans must be assured basic and routine gender specific care in addition to the highly specialized care that they receive at polytrauma centers.

(4) Gender-specific specialty care in breast care, gynecology, uro-gynecology, mental health, oncology, neurology, etc. must be available within the polytrauma center Administrative Parent (Health Care System).

f. 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 1176.01, Spinal Cord Injury and Disorders (SCI/D) 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, arrangements must be made for this care during the annual evaluation or when issues requiring such care arise. Alternatively, arrangements may be made with WH-PCPs to provide the services within the SCI/D examination rooms, or through fee basis with an appropriately trained provider with accessible health care office space and equipment.

8. WOMEN'S HEALTH EDUCATION, TRAINING, AND CULTURAL COMPETENCY

a. Each Administrative Parent (Health Care System) must participate in and support an education plan to promote, improve, and maintain proficiency in women's health care for all clinical staff members, and in cultural competency for all employees. WH-PCP and WH-PACT training: refer to Comprehensive Care for Women Veterans (Section 15).

c. Emergency and Urgent Care training: refer to Emergency Department Care/Urgent Care Centers (section 6(m)).

d. All clinical staff members providing care to women Veterans must have knowledge and skills to provide care to women for conditions that are unique to women, more common in women, or have gender-specific manifestations.

e. All staff members providing or dispensing medication, or administering diagnostic testing involving teratogenic medications or substances, must have appropriate knowledge about risks and benefits of potentially teratogenic medications to provide safe and high-quality care to women of childbearing age.

f. In order to increase awareness of all staff members regarding women Veterans, all VA medical facilities should:

(1) Include a training needs assessment about women Veterans as part of any facility-wide learning needs assessment.

(2) Ensure all training programs and internal events and outreach events are inclusive of women Veterans.

(3) Represent women Veterans with images throughout the VA medical facility.

(4) Include information about women Veterans as part of new employee orientation.

(5) Ensure all employees have access to educational programs addressing recognition of women as Veterans and sensitivity to issues of women Veterans including but not limited to awareness of women's military experiences, awareness of sexual trauma and interpersonal violence, roles of caregivers and parents, and rights to privacy, dignity, and security.

9. DATA COLLECTION AND QUALITY ASSURANCE

a. In order to assure the highest quality of care for women Veterans, all VHA data collections must include the ability to analyze the data by gender. 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, access, enrollment

projections and utilization, new clinical guidelines, flowcharts, and other performance improvement tools are needed to standardize and improve outcomes of care.

b. The Administrative Parent (Health Care System) quality team should oversee performance improvement activities to address areas such as;

c. Understanding and designing interventions to address any differences in quality measures for women Veterans compared to male Veterans;

d. Appropriate follow-up of abnormal mammograms and abnormal cervical cytology reports and the timeliness with which treatment for breast and cervical cancer is initiated;

e. Customer satisfaction initiatives and outcomes; and

f. Tracking of access, wait lists, non-VA care utilization, and clinic no-show rates as facilities implement comprehensive primary care and specialty care for women Veterans.

10. THE HEALTH CARE ENVIRONMENT

a. **Environment of Care (EOC).**

(1) The health care environment affects the quality of care provided to all Veterans, including environments specifically addressing Women Veterans' needs. The health care environment affects Veterans comfort, their sense of security, and their perceptions of care received. All VA medical facilities must ensure that these environments support Veterans' dignity, privacy, safety, and security, whether in planning new construction, remodeling older facilities, or improving the environment supporting patient care programming. The Women Veterans Program Manager (WVPM) shall act as the consultant representing Veterans in planning of new, renovation, and improvement projects.

(a) Planning, design and construction standards which establish a basis for compliance with this directive in the built-environment are found on the VA Technical Information Library (TIL) https://www.cfm.va.gov/til/, specifically PG-18-12 Design Guides https://www.cfm.va.gov/til/dGuide.asp and Design Alerts https://www.cfm.va.gov/til/alert.asp.

(2) Regular EOC assessments of the health care environment occur in all VA medical facilities to ensure that the environment promotes these goals. The WVPM or designee, and appropriate members of the health care system EOC must participate in these reviews on a routine basis.

(3) Each health care system must engage in an on-going, continual process to achieve and maintain full EOC compliance.

(4) Required environmental elements include, but are not limited to:

(a) Accommodations, with emphasis on privacy in all examination rooms, procedure rooms, sleeping areas, toilet rooms, bathing/shower facilities, and other areas such as radiology, physical medicine and rehabilitation therapy rooms, cardiac stress test areas, laboratory services etc., Women Veterans must have women-only or unisex toilet rooms and bathing/shower facilities.

(b) Appropriately locking door hardware with locking mechanisms providing for privacy, safety, security, and utility (allowing staff members to have key or code access in case of emergency) are required for all toilets, baths and showers.

(c) A female Veteran must not share a single bathroom between rooms with a male patient in the adjoining room (ie: Jack 'n Jill), even if the toilet room is locked. A female in both adjoining rooms sharing the bathroom is acceptable in both outpatient and inpatient environments.

(d) Personal hygiene products shall be available in public female, unisex, and family toilet rooms at no charge.

(e) Diaper changing tables shall be available in designated public male, female, unisex, and family toilet rooms. Diaper changing tables shall be placed at least one per floor in male, female, and unisex toilet rooms, and no more than 300 feet from areas accessible to a patient. Rooms with changing table must be identified, and toilet rooms without changing tables should include signage directing users to the nearest changing table.

(f) Residential, domiciliary and community living centers (CLC) must adhere to same privacy, dignity, and security standards as inpatient areas. See VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP). Fisher Houses are excluded from this requirement. (See section c.(1) below)

(g) Recreational and social programs including pool areas, gymnasiums, and recreation/multipurpose rooms are included in EOC.

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

(1) Veterans must be provided adequate visual and auditory privacy at check-in, interview, and clinical areas. Patient names shall not be posted or enunciated in corridors/hallways or patient care clinic areas.

(2) Patient-identified information must not be visible in corridors/hallways including charts where names are visible. Restrict unnecessary access to hallways by patients and staff members who do not work in that clinic area.

(3) The examination rooms must be located in a space where they do not open into a public waiting room or a public corridor. Appropriate locks which allow staff members to have emergency key or code access are required for all examination room doors. Locks must be installed in all examination rooms in all clinics and outpatient testing or

procedure areas, not only those clinical areas primarily serving women. All locks must be designed to always allow a safe exit from locked rooms without a key or code.

(4) Privacy curtains/screens must be present and functional in examination rooms. Curtains/screens are to ensure privacy from incidental door openings, and from view of others in the room that are not taking part in the examination. Curtains/screens must fully shield the patient while dressing/undressing, during examination, and offer sufficient work space for the provider to perform the examination. Rooms where a patient would not be expected to disrobe within a private room are exempted from this requirement. Examples include dental, audiology, ophthalmology/optometry.

(5) All examination tables must be placed in such a way that the genital area is not visible from the doorway**.** Treatment/Procedure bays are exempted from bed orientation requirements. Examples include PACU, ED, Dental, Chemotherapy/infusion.

(6) Toilet rooms should be located in close proximity to the examination room. Patients who are undressed or wearing examination gowns must have access without going through public hallways or waiting rooms.

(7) Sanitary napkin and tampon dispensers and disposal bins must be available in women's, unisex, and family public restrooms at no cost. Tampons and sanitary pads must be provided to patients where pelvic examinations are performed, and in toilet rooms within close proximity.

(8) Cameras (telehealth, computer, teaching) must be shielded/ covered/in locked cabinet/room when not in use.

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

(1) Privacy curtains/screens must be placed in all inpatient rooms, exam rooms, and procedure rooms except for mental health inpatient rooms and isolation/infection control rooms. In these cases, alternate privacy barriers must be provided, e.g. disposable privacy curtains (not for mental health), anteroom in patient isolation room with integrated blinds-in-glass. (See section a.(4)f. above)

(2) Female patients must have a private and secure toilet/shower room in their room or access to the women's bathroom facilities with shower within the patient care unit. A private and secure bathroom must have an appropriate locking mechanism (allowing staff members to have key or code access in the case of emergency). The toilet/shower room must also provide for the patient to signal for hospital staff members if they are in distress. ***NOTE:*** *It is not* allowed *to have a group shower room with a sign on the door when it is utilized by women.*

(3) Appropriate clothing types and sizes must be stocked and provided on all inpatient units.

11. REFERENCES

a. P.L. 103-452.

b. P.L. 104-262.

c. P.L. 106-117.

d. P.L. 108-422.

e. P.L. 110-387.

f. P.L. 111-163.

g. P.L. 113-146.

h. 38 U.S.C § 501.

i. 38 U.S.C § 1710.

j. 38 U.S.C § 1720D.

k. 38 U.S.C § 7301 (b).

l. 5 U.S.C. app.

m. 38 C.F.R. § 17.38.

n. 21 C.F.R. § 1.1.

o. VHA Directive, 2010-033, Military Sexual Trauma (MST) Programming, dated July 14, 2020.

p. VHA Directive 2013-001, Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at VA Medical Centers and Selected Community Based Outpatient Clinics, dated January 9, 2013.

q. VHA Directive 1608, Comprehensive Environment of Care, dated February 1, 2016.

r. VHA Handbook 1330.02, Women Veterans Program Manager (WVMP), dated May 23, 2012.

s. VHA Handbook 1330.03, Maternity Health Care and Coordination, dated October 5, 2012.

t. VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

u. VHA Handbook 1101.02, Patient Primary Care Management Module (PCMM), dated April 21, 2009.

v. VHA Handbook 1105.03, Mammography Program Procedures and Standards, dated April 28, 2011.

GUIDANCE FOR THE DEVELOPMENT OF THE WOMEN'S HEALTH MEDICAL DIRECTOR POSITION IN VHA HEALTH CARE SYSTEMS

1. DESIGNATION OF A WHMD

Each Administrative Parent (Health Care System) must designate a Women's Health Medical Director (WHMD) or a Women's Health Clinical Champion (WHCC). (Smaller sites e.g. those with less than 1000 women Veterans may prefer the title WHCC although responsibilities are the same). The designated person works closely with the Women Veteran Program Manager (WVPM) to form the foundation of the Women's Health Program. The WHMD or WHCC serves as the clinical leader for the Women's Health Program at the facility level. In collaboration with the WVPM, the WHMD or WHCC works to develop clinical leadership for the Women's Health Program, including participation in strategic planning, administration, quality improvement, and educational initiatives. The WHMD or WHCC must maintain an active clinical practice in Women's Health. It is recommended that the WHMD or WHCC is a Designated Women's Health Primary Care Provider (WH-PCP).

2. CLINICAL ACTIVITIES

The WHMD or WHCC provides clinical expertise in the area of women's health care. The WHMD promotes best practices and functions as the clinical subject matter expert for women's health issues in the health care system.

3. ADMINISTRATIVE RESPONSIBILITIES

Since there is a wide variation in the women Veterans' population and the model of care for structure and provision of women's health services among different VA medical facilities/health care systems, it is recognized that the duties and responsibilities of the WHMD or WHCC may be adjusted to fit the needs of the facility. The following are suggested duties and responsibilities of the WHMD or WHCC:

a. Performs as the clinical leader for comprehensive women's health care at the Administrative Parent (Health Care System).

b. Participates in key clinical governance committees at the Administrative Parent (Health Care System).

c. Collaborates with the WVPM and facility leadership to determine the appropriate model of care for comprehensive women's health care at all sites of care at the health care system, including the main VA medical facility and Community-Based Outpatient Clinics (CBOC).

d. Collaborates with primary care leadership and the WVPM to assure that WH-PCPs are assigned at all sites of care.

e. Collaborates with primary care leadership at all sites of care in the Administrative Parent (Health Care System) to ensure that all women Veterans are offered assignment to WH-PCPs in the VA medical facility and CBOCs.

f. The WHMD or WHCC is a leader for implementation of Women's Health Patient Aligned Care Team (WH-PACT) at the Administrative Parent (Health Care system). Participates in WH-PACT implementation leadership team meetings to ensure the needs of women Veterans are met within WH-PACTs.

g. The WHMD or WHCC collaborates with primary care Primary Care Management Module (PCMM) coordinator to ensure that WH-PACT teams are assigned appropriately in PCMM at all sites of care within the health care system including the medical center and all CBOCs.

h. The WHMD or WHCC collaborates with gynecology services to ensure appropriate services for women Veterans.

i. The WHMD or WHCC works with other clinical services such as specialty care, surgery, radiology, mental health, laboratory, emergency department to ensure appropriate comprehensive clinical services are available to women Veterans at the health care systems including main facility and CBOCs.

j. The WHMD or WHCC collaborates (or has input) with leadership in supervision and performance evaluation of women's health providers at their facility and CBOCs.

k. The WHMD or WHCC collaborates (or has input) with nurse management in supervision and performance evaluation of staff members assigned to women's health teams, including clerks, health technicians and nurses.

l. The WHMD works with the clinic coordinator to review provider schedules and assure appropriate access for women Veteran patients.

m. The WHMD and WVPM hold weekly meetings to discuss progress/issues within the Women's Health Program.

4. QUALITY

The WHMD reviews EPRP performance and works with the VA medical facility quality team, the WVPM and the women's health team to implement clinical quality improvement. The WHMD is held responsible for excellent achievement on all measures that apply to women's health, both gender-specific and gender-neutral measures. The WHMD or WHCC is responsible for working with the quality team, the WVPM and the women's health team to eliminate gender disparities in performance.

5. EDUCATION

The WHMD or WHCC develops or supervises development of local educational initiatives for women's health providers and trainees, including those in CBOCs. The

WHMD or WHCC actively supports participation in on-going nationally developed educational programs such as Women's Health Mini-Residency, emergency care modules, provider audio calls and use of women's health simulation equipment.

6. STRATEGIC PLANNING

The WHMD or WHCC should collaborate with the WVPM on strategic planning for the Women's Health Program and implementation of national and Veterans Integrated Service Network initiatives. The WHMD or WHCC is an active participant in the Women's Health Committee.

7. PARTICIPATION IN GROUPS FOR WHMDS

The WHMD or WHCC is expected to participate in national calls and meetings developed for WHMDs. The WHMD is expected to utilize references, tools and materials on the WHS SharePoint site.

8. PROTECTED TIME

The WHMD or WHCC must be given a minimum 10-20 percent (1/2-1 full day) day per week protected administrative time. The amount of protected time may be greater depending on size and complexity of the healthcare system and model of care of the Women's Health Program.

9. PANEL SIZE REDUCTION

It is recommended that the WHMD of WHCC be given panel size reduction appropriate to the protected administrative time, in addition to the required panel size reduction for WH-PCPs.

10. ORGANIZATIONAL STRUCTURE/REPORTING

Reporting and organizational structure may vary by facility. The WHMD or WHCC may report to the Chief of Staff, Chief of Medicine, Chief of Surgery, or Chief of Primary Care or others.

DESIGNATED WOMEN'S HEALTH PRIMARY CARE PROVIDER (WH-PCP) AND WOMEN'S HEALTH PATIENT ALIGNED CARE TEAM (WH-PACT) SUGGESTED COMPETENCY DOMAINS

1. Background: The following topic domains were identified by subject matter experts as conditions that are more common in women, unique to women, or have gender specific manifestations. It is recommended that Designated Women's Health Providers have experience and/or training in these areas.Domains with Possible Gender Specific Presentations, Manifestations, and/or Management Issues:

a. **Cardiovascular Health, Disorders, and Symptoms:**

(1) Chest Pain and Cardiovascular Disorders;

(2) Hypertension;

(3) Hyperlipidemia; and

(4) Stroke.

b. **Endocrine Disorders:**

(1) Diabetes; and

(2) Thyroid Disorders.

c. **Gastrointestinal Disorders:**

(1) Irritable Bowel Syndrome; and

(2) Diarrhea/Constipation.

d. **General Health and Wellness:**

(1) Exercise & Fitness Counseling;

(2) Nutrition Counseling;

(3) Obesity &Weight Management; and

(4) Smoking Cessation.

e. **Mental Health:**

(1) Alcohol and Substance Use/Abuse;

(2) Depression and Anxiety Disorders;

(3) Intimate Partner Violence;

(4) Posttraumatic Stress Disorder; and

(5) Suicide Risk.

(f) **Military Service-related:**

(1) Military Sexual Trauma; and

(2) Post-Deployment and Readjustment Issues.

(g) **Pulmonary Disorders:**

(1) Chronic Obstructive Pulmonary Disease; and

(2) Asthma.

(h) **Rheumatologic, Bone, and Joint Disorders:**

(1) Fibromyalgia (Chronic Widespread Pain Syndrome);

(2) Connective Tissue Disease;

(3) Arthritis – Osteo- and Rheumatoid-; and

(4) Chronic Pain.

(i) **Urinary Tract Disorders:**

(1) Urinary Tract Infection (Including Cystitis and Pyelonephritis); and

(2) Urinary Incontinence.

(j) **Miscellaneous Disorders and Symptoms:**

(1) Acute and Chronic Pelvic Pain;

(2) Acne;

(3) Anemia;

(4) Headaches;

(5) Hirsutism;

(6) Interpersonal Violence;

(7) Osteoporosis/Osteopenia;

(8) Obesity; and

(9) Traumatic Brain Injury.

3. Gender Specific Domains ("Basic"/"Minimal"):

a. **Breast Issues:**

(1) Breast Cancer Screening; and

(2) Evaluation and Management of Breast Symptoms (Masses, Fibrocystic Breast Disease, Mastalgia, Nipple Discharge, Mastitis, Galactorrhea, etc.).

b. **Gynecology and Obstetrics:**

(1) Abnormal Uterine Bleeding/Menstrual Disorders;

(2) Amenorrhea;

(3) Basic Infertility Evaluation;

(4) Cervical Cancer Screening, Managing Abnormal Pap and Human Papillomavirus Tests;

(5) Contraception and Emergency Contraception;

(6) Diagnosis of Pregnancy and Provision of Early Prenatal Care;

(7) Preconception Care and Assessment (Including Medical Assessment, Vaccinations, Genetic History, Supplement Recommendations, etc.);

(8) Recognition and Initial Management of Postpartum Depressive Disorders;

(9) Recognition and Management of Gynecology Emergencies (such as Ovarian Torsion or Acute Uterine Bleeding);

(10) Recognition and Management of Early Pregnancy Emergencies (such as Ectopic Pregnancy); and

(11) Vaginitis and Sexually Transmitted Diseases.

(13) Other:

(a) Medication Use in Pregnancy & Lactation;

(b) Menopausal Symptoms; and

(c) Teratogenic Effects of Medications.

c. **Physical Examination/Skills ("Basic"/"Minimal"):**

(1) Breast Exam Including Axillary Exam;

(2) Cervical Cancer Screening;

(3) Collection of Specimens for Cervicitis and STI Diagnosis;

(4) Pelvic Examination (Speculum and Bimanual);

(5) Rectal/Recto-Vaginal Exam;

(6) Removal of Foreign Body from Vagina; and

(7) Wet Mount and/or Other Vaginitis Specimen Collection.

d. **Interpretation and Utilization of Reported Test Results to Determine a Plan of Care ("Basic"/"Minimal"):**

(1) Bone Densitometry;

(2) Breast Ultrasound;

(3) Breast Magnetic Resonance Imaging;

(4) Breast Biopsy Report;

(5) Cervical Cytology;

(6) Colposcopy Report & Colposcopic Biopsy;

(7) CT Scan of Abdomen & Pelvis;

(8) Endometrial Biopsy;

(9) Mammogram (Screening and Diagnostic);

(10) Pelvic Ultrasound;

(11) Pregnancy Test (Serum and Urine; Quantitative and Qualitative);

(12) Transvaginal Ultrasound;

(13) Urinalysis; and

(14) Urodynamic Testing.

VETERANS HEALTH ENVIRONMENTAL PRIVACY AND SECURITY

1. 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 of privacy and dignity during environmental rounds.

a. **Ambulatory Care Setting:**

(1) **Public Areas:**

(a) Is a family or unisex restroom/toilet room available?

(b) Are sanitary napkin and tampon dispensers (or any other way to provide, ie basket, etc) and disposal bins in ALL women's/unisex public restrooms/toilet rooms, at no cost?

(c) Are changing tables available in public restrooms/toilet rooms?

(2) **Examination, Procedure and Testing Areas:**

(a) Do exam rooms open into public waiting rooms or corridors?

(b) Do exam rooms have locks?

(c) Do individual restrooms/toilet rooms have locks?

(d) Can gowned patients access sex-specific or unisex restrooms/toilet rooms without entering public areas?

(e) Are privacy curtains/screens present and functional in all examination rooms?

(f) Do privacy curtains/screens fully shield the patient during examination, while dressing/undressing, and provide sufficient work space for the provider to perform the examination?

(g) Are examination tables placed in such a way that the genital area is not visible from the doorway?

(h) Are cameras (telehealth, computer, teaching) shielded/covered/in locked cabinet/room when not in use?

b. **Inpatient, Residential, Domiciliary, and Hoptel Facilities**

(1) Do women have access to women-only/unisex toilets and showers in close proximity to their room? (At a minimum, needs to be in the same subunit where their assigned room is located)

(2) Is there a system in place to obtain appropriate clothing sizes at all times?

(3) Do individual restrooms/toilet rooms have locks?

(4) Do all women have separate and secured sleeping accommodations?

(5) Do mixed gender units ensure safe and secure sleeping and bathroom/toilet room arrangements, including, but not limited to door locks and proximity to staff?

PANEL MANAGEMENT

1. Women's Health PACT teamlets should be adjusted to allow for more frequent and longer visits made by Women Veterans.

2. Panel sizes should be reduced by twenty percent of the proportion of the panel that is female. Recommended WH-PACT patient panel size is calculated according to the following equation:

a. $X = Y - 0.2(Z)$; and

b. X = modeled panel size adjusted for number of women Veterans; Y= panel size unadjusted for women Veterans; Z= number of women Veterans assigned to the WH-PACT.