**Department of Veterans Affairs**                   **VHA DIRECTIVE 1101.05**
**Veterans Health Administration**                     **Transmittal Sheet**
**Washington, DC 20420**                           **September 2, 2016**

## EMERGENCY MEDICINE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes policy and procedures for VHA Emergency Departments (EDs) and Urgent Care Centers (UCCs).

**2. SUMMARY OF MAJOR CHANGES:** This directive replaces the previous VHA handbook establishing procedures for VA EDs and UCCs. The following major changes are included:

    a. Information on EDs, UCCs, diversion, Mental Health, sexual assault, temporary beds, ED/UCC staffing, and Emergency Department Integration Software (EDIS) was added.

    b. Information about the Intermediate Healthcare Technician Program.

    c. Information about the ED and Women's Health, Out of Operating Room Airway Management and Ensuring Correct Surgery and Invasive Procedures, and geriatric emergency care.

    d. Information about the Emergency Medicine Improvement Initiative and support resources.

**3. RELATED ISSUE:** None.

**4. RESPONSIBLE OFFICE:** The Office of Patient Care Services (10P), Specialty Care Services (10P4E), is responsible for the content of this VHA Handbook. Questions may be referred to the National Director for Emergency Medicine at 202-461-7120.

**5. RESCISSIONS:** VHA Handbook 1101.05, dated May 12, 2010; VHA Directive 1051, dated February 21, 2014; VHA Directive 1079, dated February 3, 2014; VHA Directive 2010-008, dated February 22, 2010; VHA Directive 2010-014, dated March 25, 2010; VHA Directive 1009, dated August 28, 2013; VHA Directive 2010-010, dated March 2, 2010; VHA Directive 2011-029, dated July 15, 2011; and VHA Directive 2009-069, dated December 16, 2009 are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of September 2021.

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

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## EMERGENCY MEDICINE

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## 1. PURPOSE

This Veterans Health Administration (VHA) directive establishes the minimum requirements to ensure all enrolled Veterans have access to quality emergency care. **AUTHORITY:** 38 U.S.C. 7301(b).

## 2. BACKGROUND

Universal access to appropriate emergency services is the cornerstone of basic health care in the United States. VHA is committed to providing timely and high-quality emergency care to the Department of Veterans Affairs (VA) patient population. While it is recognized that a wide spectrum of emergency services may exist among VA medical facilities, emergency care must be uniformly available in all VHA Emergency Departments (EDs) and Urgent Care Centers (UCCs). The level of emergency care available is always congruent with the capability, capacity, and function of the local VA medical facility.

a. The provision of emergency care includes detailed plans for the management of patients whose care needs may exceed the facility's capabilities, e.g., acute myocardial infarction needing emergent cardiac catheterization, major trauma, obstetrics and gynecology, pediatrics, and surgical subspecialty care.

b. This directive describes and delineates the resources and planning necessary to provide access to appropriate emergency medical and nursing care.

c. The practice of VA emergency medicine includes:

(1) Unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week at VA medical facilities with an ED, and during operational hours at VA medical facilities with a UCC. VA medical facilities with an ED or a UCC must have inpatient acute medical/surgical beds.

(2) Evaluation, management, and treatment provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care, including management of resuscitation, advanced airway management, emergency procedures and moderate sedation.

(3) Emergency care provided by an emergency physician and emergency nursing staff physically present in the ED and continuously available 24 hours a day and present and continuously available in the UCC during all hours of operation.

(4) An evaluation and emergency care provided to individual patients presenting to the ED or UCC that is consistent with all applicable standards and regulations, including compliance with the intent of the Emergency Medicine Treatment and Active Labor Act (EMTALA) 42 United States Code (U.S.C.) 1395dd. ***NOTE:*** *While not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for*

*Medicare and Medicaid Services (CMS), VA complies with the intent of EMTALA requirements regarding the transfer of acute patients among health care facilities.*

(5) Policies and procedures that allow for a smooth transition from the ED or UCC to the inpatient setting for definitive care, and to the outpatient setting for appropriate follow up.

(6) Support and participation by EDs in the existing EMS system and provision of medical direction for the patients in the pre-hospital setting, where appropriate.

(7) Supervision, teaching, and evaluation of the performance of medical and paramedical personnel including students, residents, and fellows in the ED or UCC.

(8) Participation in research and collaboration in research efforts at the clinical and basic science level, if possible, to identify and address gaps in evidenced based practice. ***NOTE:*** *All research efforts must be in compliance with all applicable VA requirements (see VHA 1200 and 1050 series directives and handbooks).* The Office of Research and Development may be consulted as needed.

(9) Administrative involvement in hospitals, medical schools, and outpatient facilities.

(10)  Emergent care that is congruent with the facility's capabilities.

(11)  EM practice that is consistent and in line with the American College of Emergency Physicians (ACEP) Model for the Clinical Practice of EM.

(12)  Geriatrics EM care that is consistent and in line with the Geriatric ED guidelines (2013) that have been endorsed by the ACEP, American Geriatrics Society (AGS), Emergency Nurses Association (ENA), and Society for Academic Emergency Medicine (SAEM).  These publically available guidelines can be found at:

(a) http://www.acep.org/geriEDguidelines/

(b) http://geriatricscareonline.org/

(c) https://www.ena.org/about/media/

(d) http://www.saem.org/education/

## 3.  DEFINITIONS

a.  **Advanced Practice Provider.**  An advanced practice provider is a licensed clinical medical professional (i.e., a nurse practitioner or physician assistant) who provides patient care under a scope of practice that includes the degree of physician supervision required.

(1) **Physician Assistant.**  A Physician Assistant (PA) provides patient care under a scope of practice that includes physician supervision.

(2) **Nurse Practitioner.**  A Nurse Practitioner (NP) provides patient care under a scope of practice that is defined by their state boards of nursing.

*NOTE:  PAs always require supervision.  In the majority of states there is no legal requirement for physician involvement in NP practice; however in some states "supervision" or "collaboration" is required.*

b.  __Diversion.__  Diversion is a situation in which all patients or a selected group of patients who would normally be treated by the VA medical facility cannot be accepted for admission and evaluation because the appropriate beds are not available; needed services cannot be provided; staffing is inadequate; and acceptance of another patient would jeopardize the ability to properly care for those already at the facility; or disaster has disrupted normal operations.

c.  __ED Fast Track.__  An ED fast track is a designated care area within the domain of the Emergency Department that may be a section within or close to the ED where lower acuity ED patients can be seen and is operated under the supervision of Emergency Medicine.  Like all ED patients, patients seen in fast tracks are scheduled and tracked on the Emergency Department Integration Software (EDIS) tracking software.  Fast tracks may be used at VA medical facilities with EDs and must use stop code 130 for patient workload capture.  Fast tracks may not be used by sites that have a UCC.

d.  __Emergency Department.__  An Emergency Department (ED) is a unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.  The ED is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and mental health disorders, regardless of the level of severity.  Emergency care is provided in a clearly defined area dedicated to this function and operates 24 hours a day, 7 days a week.

e.  __Encounter.__  An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition.  See VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, or subsequent policy issue, for further information.

f.  __Intensive Care Unit.__  An Intensive Care Unit (ICU) is a special care unit dedicated to the management of acute illnesses, injuries, or post-operative care in which life or organ function may be in jeopardy.  An ICU provides a higher level of medical services, medical technology, and staffing than other facility medical or surgical units.

g.  __Medical Officer of the Day.__  The inpatient provider (formerly known as the Medical Officer of the Day [MOD]) is the designated responsible physician or practitioner (with attending backup) who is physically present in an inpatient facility during periods when the regular medical staff is not on duty.  See VHA Handbook 1101.04, Medical Officer of the Day

h. **Observation Patient.** An observation patient is one with a medical, surgical, or mental health condition that needs to be monitored, provided with short-term treatment, and re-assessed while a decision is being made as to whether the patient requires further treatment in an acute care inpatient setting or can be discharged or assigned to care in another setting. A patient admitted to observation status can occupy a special bed set aside for this purpose, or may occupy a bed in any unit of a hospital, e.g., a hospital medical unit. If the ED has beds designated for use by observation patients, these beds are not designed to be a holding area in the ED. The length-of-stay (LOS) in an observation bed is not to exceed 47 hours and 59 minutes. *NOTE: Routine post-procedure recovery from ambulatory surgery is not observation. See VHA Directive 1036, Standards for Observation in VHA Medical Facilities for further details.*

i. **Observation Unit.** An observation unit is a designated area that can be either a virtual unit or bed located anywhere in the VA medical facility, or a unit located in close proximity to the ED or UCC where patients with medical, surgical, or mental health conditions can be kept for up to 47 hours and 59 minutes for extended monitoring, evaluation, and treatment. These units are designated as non-count wards and contain beds that can be used as observation beds.

j. **One-to-One Observation.** One-to-one surveillance is the constant observation of one patient by one staff member. Any staff member has the ability to initiate one-to-one surveillance, but only the ED attending physician or the psychiatric consultant can discontinue it. While under one-to-one surveillance, the patient is not to be allowed to leave the room for smoking or snacks, and any restroom visit requires an escort who can visually monitor the patient for suicidal behavior, provided that such restrictions on the patient's freedom are consistent with statutory and regulatory authority.

k. **Overflow Patient (Boarder).** An overflow patient is a patient who requires inpatient care due to a medical, surgical, or psychiatric condition but whom the facility is unable to accept on the designated unit due to a lack of available beds. An overflow patient may be held in a temporary bed location or be temporarily placed in a different level of care. Patients who wait in the ED or the UCC for an inpatient bed for 4 or more hours after the decision to admit is made are called "boarders" by current Centers for Medicare and Medicaid Services (CMS) definition.

l. **Psychiatric Intervention Room.** A psychiatric intervention room is a room where seriously disturbed, agitated, or intoxicated patients may be taken immediately on arrival. It provides an environment suitable for the rapid medical and psychiatric evaluation of dangerously unstable situations and the capacity to safely control them. When possible, it should be away from the waiting area and near the nursing station. While it is not a seclusion room, it should meet the standards for seclusion room construction outlined in the Mental Health Environment of Care Checklist found at: http://vaww.ncps.med.va.gov/guidelines.html. *NOTE: This is an internal VA Web site and is not available to the public.* If possible, all VA EDs and UCCs need to have one room meeting these requirements in the ED or UCC.

m. **Temporary Bed Location.** A temporary bed location is a designated place where a patient awaiting inpatient care can be cared for until a bed in the destination

unit is available.  Temporary bed locations may include, but are not limited to, the Post Anesthesia Care Unit for ICU overflow patients, the Observation Unit, and the ED or UCC for newly admitted patients.  It may also include short-term use of a higher level of care (e.g., an ICU bed for a telemetry inpatient admission) while awaiting the appropriate location.

n.  **Urgent Care Center.**  An Urgent Care Center (UCC) provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.  Urgent Care Centers shall not exist in VA medical facilities with an ED.  In general, an Urgent Care Center does not operate 24 hours a day, 7 days a week.  Should a VA medical facility with a UCC seek to continue or begin 24/7 care, that facility must seek a waiver from the National Director of Emergency Medicine to ensure safe patient care with proper staffing and support.  Further, Urgent Care Centers do not accept ambulances from the local or regional Emergency Medical Services (EMS) System.  ***NOTE:*** *Acute or urgent care can be provided in Patient Aligned Care Team (PACT) clinics by PACT providers at VA medical facilities without inpatient beds such as Community-based Outpatient Clinics (CBOCs) and Health Care Centers.*  See VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook.

o.  **Veterans Rural Access Hospital.**  A Veterans Rural Access Hospital (VRAH) is a VA medical facility providing acute inpatient care in a rural or small urban market in which access to health care is limited.  The VRAH is limited to not more than 25 acute medical or surgical beds.  Such facilities must be part of a network of health care that provides an established referral system for tertiary or other specialized care not available at the VRAH.

## 4.  POLICY

It is VHA policy to provide quality emergency care to all Veterans enrolled in VA health care.

## 5.  RESPONSIBILITIES

a.  **National Program Director for VA Emergency Medicine.**  The National Program Director for Emergency Medicine provides national leadership to and has advisory and consultative responsibility for all VA emergency medical services programs and initiatives.

(1) The Program Director for Emergency Medicine collaborates with VISN and VA medical facility leadership to assure that top quality emergency medicine services are made available, immediately accessible, and efficiently provided to all eligible Veterans as clinically indicated.

(2) Specific functions for the Program Director for Emergency Medicine include:

(a) Acting as the principal advisor to the Under Secretary for Health on emergency medicine policies and procedures pertaining to delivery of services.

(b) Collaborating and coordinating with other Patient Care Services (PCS) program offices, as well as other VHA or VA programs or offices such as the Network Support Team, Office of Public Health, Office of Quality and Performance, Office of Clinical Logistics, Office of the Medical Inspector, Office of Employee Educations, Office of Academic Affiliations, Office of Finance, Office of General Counsel, and the Office of Information.

1. In cooperation with the Office of Public Health, plans, develops, and participates in the development and oversight of programs relative to public health diseases and threats.

2. In cooperation with the Office of Employee Education, plans, develops, and actively participates in programs for patient and provider education.

3. In cooperation with Office of Academic Affiliations, participates in assessment, development and oversight of training programs for health care students and clinical staff.

4. In cooperation with the Office of Information, provides consultative services and input as it relates to data programs such as to the electronic medical record (CPRS), performance measures, and coding. Specific programs would also include the iMedConsent Forms and MyHealtheVet.

5. In cooperation with the Offices of the Medical Inspector and General Counsel, provides expert opinions on medical cases.

6. In cooperation with the Office of Clinical Logistics and the Business Office, provides input and business advice enabling reasoned "make or buy" decisions.

(c) Providing consultation and expert opinions as needed on clinical and administrative matters to the field and VACO program elements.

(d) Maintaining close association with professional organizations and the provider groups in affiliated institutions as well as other public and private organizations concerned with the delivery of Emergency Medicine in VHA.

(e) Leading the development of criteria and standards for Emergency Medicine programs and providers.

(f) Leading the development of clinical practice guidelines/protocols ("best practices") to be used in the analysis and management of Emergency Medicine programs.

(g) Developing and disseminating Emergency Medicine policies and clinical guidelines.

(h) Maintaining all directives, handbooks, and notices related to Emergency Medicine.

(i)  Reviewing and updating the Strategic Plans relative to Emergency Medicine and ensuring progress on the different elements within the plan.

(j)  Reviewing the adequacy of existing programs (including both redundant programs and gaps in available services.

(k) Providing information on new developments and technologies and being a source of advice and assistance to program managers and clinicians at field facilities on such issues.

(l)  Assuring that professional experts actively link with their specialty professional societies and provide liaison to other federal providers and professional groups concerned with the provision of Emergency Medicine Services.

(m)Participating as a member of the Professional Standards Board for Physicians.

(n) Participating as a member of various VACO and Network healthcare committees as assigned.

(o) Partnering with other program Directors within Specialty Care Services to ensure the success of Specialty Care Services.

b.  **VISN Director.**  The VISN Director or designee (normally the Chief Medical Officer) is responsible for ensuring that each facility in the VISN is appropriately designated as one having or not having an ED and/or a UCC and for appointing a VISN lead for EM.  This VISN EM leader is the Point of Contact (POC) for issues pertaining to EM practice in the VISN.

c.  **VA Medical Facility Director.**  The VA medical facility Director or designee (e.g., Chief of Staff, Associate Director Patient Care for Nursing Services) is responsible for ensuring that:

(1) Necessary space and resources (such as equipment, supplies, and support services) are provided to the Emergency Department and/or to the Urgent Care Center so that appropriate care can be consistently delivered in a timely fashion during all hours of operation.

(2) The ED and/or UCC is designed to be a safe environment for patients and staff.

(3) Appropriate signage at all entrances directs patients to the ED and/or UCC.

(4) A contingency plan is established for the provision of additional nursing, provider, and support staff in times of acute overload or disaster.

(5) A diversion policy is in force that provides clear indications for the use of diversion and limitations for the length of time spent on diversion without a re-evaluation of the situation.

(6) A credentialing and privileging process for ED/UCC physicians is in force that is consistent with VHA policy (see VHA Handbook 1100.19).

d.  **ED Medical Director.**  Every ED must have an ED Medical Director who is responsible for directing the medical care provided in the ED.  This person must:

(1) Be certified by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine (preferred), or be board certified in Internal Medicine, or Family Practice and possess comparable EM qualifications, training and experience as established by the VA medical facility credentialing and privileging policy.

(2) Have experience and competence in management and administration of clinical services in an ED.

(3) Ensure that quality, safety, and appropriateness of emergency care are continually monitored and evaluated.

(4) Be a voting member of the hospital Medical Staff Executive Committee (MSEC) or equivalent committee.

(5) Be knowledgeable about EMS operations and the local and regional EMS network.

(6) Represent or appoint a representative to serve as the VA medical facility liaison on the regional and local community EMS committees whenever possible, including participation in emergency preparedness activities.

(7) Assess and make recommendations to the facility's credentialing body regarding the qualifications and clinical privileges of ED physicians.

(8) Ensure the operation of the ED is guided by well-established national guidelines and local policies and procedures, as needed.

(9) Provide all new staff members working in the ED with a formal orientation to ED operating policy and procedures and to the responsibilities of each ED staff member.

(10)  Recruit and retain well-qualified ED physicians (see paragraph 9.a.(2)(b)).

(11)  Encourage the pursuit of academic affiliations with emergency medicine and other training programs wherever possible.

(12)  Oversee all academic affiliation agreements for emergency medicine and the ED to ensure the quality of teaching and supervision of all trainees in the ED.  *NOTE: In facilities with academic activities, the ED Medical Director is expected to provide academic and research opportunities to VA ED physicians qualified to teach and participate in other academic activities.*

(13)  Serve as a member of the Facility Peer Review Committee (or equivalent committee) or participate in the identification of a faculty member that can appropriately

assess EM practice and standards of care as it relates to cases being reviewed by this committee.

(14) Be intimately familiar and knowledgeable with EDIS and the EMMT and establish a culture of quality and safety within the facility.

e. **UCC Medical Director.** Every UCC must have a UCC Medical Director who is responsible for directing the medical care provided in the UCC. This person must:

(1) Be certified by the American Board of Emergency Medicine, the American Osteopathic Board of Emergency Medicine, or possess another Board certification, experience and a knowledge base of Emergency Medicine with comparable qualifications as established by the facility credentialing and privileging policy.

(2) Have experience and competence in management and administration of clinical services in a UCC or an ED.

(3) Ensure that quality, safety, and appropriateness of emergency care are continually monitored and evaluated.

(4) Be a voting member of the hospital MSEC or equivalent committee.

(5) Assume responsibility for assessing and making recommendations to the facility's credentialing body related to the qualifications and clinical privileges of UCC physicians.

(6) Ensure the operation of the UCC is guided by well-established National guidelines and local VA medical facility policies and procedures, as needed.

(7) Provide all new staff members working in the UCC with a formal orientation to UCC operating policy and procedures and to the responsibilities of each UCC staff member.

(8) Recruit and retain well-qualified UCC/ED physicians (see paragraph 9.a.(2)(b)).

(9) Be intimately familiar with and knowledgeable about EDIS and the EMMT and establish a culture of quality and safety within the UCC.

f. **ED/UCC Nurse Manager.** The ED/UCC Nurse Manager is responsible for overseeing the nursing care provided in the ED/UCC and must:

(1) Be a registered nurse and demonstrate evidence of substantial education, experience, and competence in emergency nursing. *NOTE: The Certified Emergency Nurse (CEN) credential is an excellent benchmark.*

(2) Show evidence of experience and competence in management and administration of ED/UCC clinical services.

(3) Ensure that the nursing and support staff are appropriately educated and qualified to perform the assigned duties in the ED/UCC.

(4) Collaborate with the ED/UCC Director on policy and procedure development.

(5) Monitor ED/UCC nursing staff competence and the nursing care that is delivered.

(6) Work in concert with the ED/UCC Director to ensure adequate tools are present to deliver quality patient care.

## 6. ED/UCC STAFFING

Appropriately educated and qualified emergency care professionals must be present in the Department to staff the ED/UCC during all hours of operation. This includes, at a minimum, 2 registered nurses with ED/UCC experience and/or current ED/UCC competencies and a licensed physician credentialed and privileged to work in the ED/UCC. ED/UCC volume, complexity, resources, and flow based on patient intake are necessary pieces of information to determine the appropriate number of staff members required. ED/UCC Nurse staffing should take into consideration the need for an additional staff member for triage in addition to the minimum requirement of 2 RNs. Use of a dedicated charge nurse within the ED/UCC is highly encouraged to assist with flow and communication needs between ED/UCC Nurse Manager, ED/UCC MD, ED/UCC Director and other leadership. VA medical facilities must have contingency plans in place to rapidly mobilize additional staff in cases where patient care demands exceed the current available physician and nurse staffing resources.

a. **Physician Credentialing and Privileging.**

(1) All physicians requesting emergency medicine privileges must be Board Certified/Board Eligible (BC/BE) in EM, IM, or FM. Physicians not meeting these criteria may be allowed to work in the ED/UCC if they have appropriate credentials, knowledge, and experience and are recommended by the Chief of Emergency or Urgent Care Services. The applicant must possess and maintain a current, full and unrestricted license to practice in any U.S. state or territory. *NOTE: Resident physicians cannot be credentialed and privileged as independent licensed practitioners for the purpose of staffing the Emergency Department unless they have completed all of the requirements of their training program.*

(2) All physicians granted emergency medicine privileges are afforded the following core privileges and core procedures: Applicants BC/BE in EM, IM or FM meet the requirements for appropriate training based on completion of an accredited residency program in any of these specialties within the last 5 years. Physicians who are 5 years removed from a training program or who are not BC/BE in these specialties must provide evidence of appropriate training and/or current competence to be granted these privileges (this listing is not meant to be inclusive):

(a) Core Privileges. Core privileges are the standard, usual, and customary nonprocedural activities appropriate in the diagnosis and management of the organ

systems and diseases encompassed by this specialty. Core privileges include the interview, evaluation, diagnosis, provision of treatment, rendering of opinion, completion of medical record, documentation of care, communication with patients and family regarding treatment, and communication with other care providers in accord with service privileges and with scope of licensure. These include requesting consultations and technical procedures to be performed by other physicians and qualified consultants/technicians.

   (b) <u>Core Procedures.</u>  Core procedures encompass those treatments and procedures granted to a practitioner in emergency medicine as a result of graduate training, postgraduate training and/or practice experience. Core procedures encompass the list in this section. The ED/UCC Director is responsible for determining if applicants meet the requirements necessary to be granted privileges to perform these core procedures and any other procedures that the local facility feels are necessary for standard emergency care in our acute care units (this listing is not meant to be inclusive):

   <u>1.</u>  Arterial punctures for blood testing and cannulation for blood pressure monitoring.

   <u>2.</u>  Emergency Vascular Access.

   <u>3.</u>  Non-emergent and emergent airway management including mechanical ventilation, subject to the requirements of VHA Directive 2012-032, Out of Operating Room Airway Management (OOORAM) or successor Directive.

   <u>4.</u>  Lumbar puncture.

   <u>5.</u>  Cardiopulmonary resuscitation including cardioversion/defibrillation and transcutaneous pacing.

   <u>6.</u>  Paracentesis.

   <u>7.</u>  Thoracentesis.

   <u>8.</u>  Gastric lavage.

   <u>9.</u>  Wound management including:

   <u>a.</u>  The use of local anesthesia.

   <u>b.</u>  Foreign body removal.

   <u>c.</u>  Incision and drainage.

   <u>d.</u>  Wound repair.

   <u>10.</u>  Foley catheter placement.

    11.   Epistaxis control.

    12.   Fracture/dislocation – initial management, including splints.

    13.   Cervical Spine immobilization.

    14.   Arthrocentesis.

    15.   Administration of thrombolytic therapy.

    (3) The Joint Commission and VHA Handbook 1100.19, Credentialing and
Privileging, mandate all physicians must have their clinical practice re-evaluated
periodically. All new hires must undergo a Focused Professional Practice Evaluation
within 60 days of being employed and all practitioners must be evaluated every 6
months with an OPPE. This evaluation will look at clinical practice during this time
frame to reaffirm competency and identify any gaps needing further training or
education.

    b. **Physician/Provider Staffing.** VA medical facilities with EDs or UCCs must have
a written policy designating minimum staffing requirements for EDs or UCCs during all
hours of operation. Each physician must be individually credentialed and privileged by
the VA medical facility in accordance with criteria contained in the facility policy on
physician credentialing.

    (1) All physicians who practice in a VA ED/UCC must possess training, experience,
and competence in emergency medicine sufficient to evaluate and initially manage and
treat all patients who seek emergency care, consistent with the physician's delineated
clinical privileges. *NOTE: Physicians board certified in emergency medicine are
preferred but not required for ED/UCC provider staff; however, all staff should be board
certified/board eligible in Emergency Medicine, Internal Medicine or Family Practice with
training and experience in emergency medicine practice.* All providers selected to
practice in the ED/UCC must be provided a supervised orientation program that
includes instruction on the proper utilization of the EDIS package.

    (2) Shift schedules must be completed and published in advance to all providers
working in the ED/UCC. Acceptable shifts lengths include 8-10 or 12-hour shifts. An
occasional 16-hour shift may be scheduled, (not more than two for each provider per
pay period). Departments utilizing 16-hour shifts must monitor this practice closely; to
be sure the staff members working these extended hour shifts are performing their
duties to the highest level. Providers working extended shifts more than 12 hours must
have available space to rest if the situation allows. There may be times when shift
length may be affected by a family emergency or an illness. In this situation an
extended shift may be used as long as the ED/UCC Director or designee approves the
extended tour.

    (3) Physician staffing guidelines must take into account physician abilities in terms of
the number of patients that can be seen and effectively managed per hour as well as
the number of hourly patient visits to the ED/UCC.

(a) Advanced Practice Providers can be used as additional providers in the ED/UCC, however they must have appropriate training, experience, and competence in emergency medicine sufficient to properly evaluate patients seen in these emergency care departments.

(b) Because of the complexity of the patient population being seen in VA EDs/UCCs, 2.0 patients per hour is currently recommended as the baseline for VHA practicing emergency medicine physicians. Midlevel providers (physician assistants and advanced practice nurses) are expected to be able to see anywhere from 50 percent to 75 percent of the physician work load per hour.

*NOTE: All VA ED and UCC facilities must have written provider staffing contingency plans that include a back-up call schedule to address situations where expedient mobilization of provider resources are needed. These plans need to empower ED nursing personnel to contact the ED Director or designee to discuss the need for implementation of the policy when provider staffing is deemed insufficient to handle patient demands.*

(4) ED patient volumes and hourly visits must be monitored to determine the ideal staffing pattern throughout the day. EDIS and the EMMT both provide access to patient intake reports that can be used to craft an appropriate schedule based on historical patient visits per hour.

(a) Periods when patient hourly visits consistently exceed the recommended patient per hour load for at least 4 hours must be staffed with additional providers to minimize delays in evaluation, treatment, and appropriate disposition.

(b) Additional providers may include physicians, physician assistants, or advanced practice nurses. If physician assistants and/or advanced practice nurses are utilized as additional providers, the acceptable ratio of physicians to midlevel providers must not exceed 1:2.

(c) Failure to provide additional providers will result in a compounding of the problem as the day progresses and additional factors come into play, such as lack of beds for admissions and delays in moving admitted patients to inpatient units. Information that must be used to determine appropriate ED/UCC staffing can be obtained from local reports available from the EDIS patient tracking software package or the EMMT national reporting tool discussed in paragraphs 6.d. and 6.e.

(5) Physician residents who are board certified or who have completed the training requirements for board eligibility may be privileged as independent practitioners for purposes of ED coverage in accordance with the provisions of VA Handbook 5007, and VHA Handbook 1400.01.

(6) Subspecialty residents, fellows, or Chief Residents who are appointed to work independently in the ED, outside the scope of their training program (i.e., in areas for which they are fully qualified by virtue of having completed core residency training in either internal medicine, emergency medicine, psychiatry, or general surgery), must be

fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for staff appointment and are subject to the provisions contained in VHA Handbook 1100.19.  Specialty or subspecialty privileges which are within the scope of the resident's current training program may not be granted.  ***NOTE:*** *"Moonlighting" in ED settings counts against duty hour restrictions as specified by the accrediting body.*

   c.  **Nursing Staff.**  Each nurse working in the ED/UCC is to:

   (1) Provide evidence of adequate previous ED, critical care experience or step down/intermediate care unit, or demonstrated competency in Emergency Nursing, or have completed an emergency care education program.  ***NOTE:*** *The CEN credential is an excellent benchmark.*

   (2) Demonstrate evidence of the knowledge and skills necessary to deliver nursing care in accordance with the Standards of Emergency Nursing Practice.  The Emergency Nurses Association (ENA) Emergency Nursing Scope and Standards of Practice, 2011 Edition, Sheehy's Manuel of Emergency Care 7th edition and ENA's Emergency Nursing Core Curriculum 6th edition are current resources that may be used as references.

   (3) Maintain Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS) and any other certifications deemed necessary by local VA medical facility policy.  (See VHA Directive 1177, Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff.)

   d.  **Pharmacy Staff.**  Dedicated Clinical Pharmacists have been proven to expand access, increase patient safety, and be cost-effective members of ED/UCC teams and are therefore strongly recommended for use in all EDs and UCCs.  Their assigned duties would include, but not be limited to:

   (1) The timely verification of all medication orders prior to the administration of such medications by nursing staff except in extremely urgent situations.  ***NOTE:*** *This process has been demonstrated to prevent medications errors which result from patient allergies, drug-drug interactions, over or under dosing and patient-medication contraindications.*

   (2) Medication reconciliation.  This is an important process to maintain and communicate accurate patient medication information.  Medical reconciliation entails identifying, addressing, and documenting medication discrepancies found in the VA electronic medical record as compared with the medication information supplied by the patient.  This information, along with any changes made during the episode of care, is communicated to the patient, caregiver or family member, and appropriate members of the health care team.  Pharmacists and Pharmacy Technicians can provide support for this process improving medication management, reducing harm, ensuring effective transitions, and engaging patients and caregivers which assures that all patients discharged from the ED / UCC to home have medications they need for the acute

treatment of their disease and are aware of what to take, when to take them, and how to avoid medication misadventures post discharge.

(3) Providing drug Information, education and support to the providers and nurses in the ED/UCC.

(4) Assuring the rapid availability of any needed medications that may or may not be stocked in the ED/UCC and preparation of medications which require special handling and precautions.

(5) Medication Inventory Management, accountability, and formulary compliance.

(6) Participation in Medical Education and training in the ED/UCC; and

(7) Participation in Code Blues through ACLS training.

(8) For older adults who are at risk of polypharmacy, the likelihood of adverse drug events is even greater.  When possible pharmacist assistance and review of potentially inappropriate medications (Beers criteria) in older patients' current medications and those newly administered while in the ED, prescribed upon discharge, or associated with an ED-based hospital admission should be considered.

e. **Ancillary Staff.**

(1) The use of ancillary staff, such as paramedics, ED/UCC health care technicians, and transporters is encouraged to assist the nursing and provider staff.  Utilization of these types of staff members as provider/nurse extenders have been successful in assisting ED staff and improving ED flow, freeing up valuable time for providers and nurses to provide the care needed for the patients being evaluated and treated.  *NOTE: It is not intended that these additional staff members replace nursing or provider staff.*

(2) The use of NPs and PAs as additional staff is acceptable, as long as they work within their scope of practice and a physician is present at all times in the Department.

(3) The use of Intermediate Care Technicians has been demonstrated to be very useful at a number of sites across VHA and is strongly encouraged at VA medical facilities that feel they can be of service to the Department.

(4) Social work services provide a critical service function to the ED/UCC.  Each ED/UCC must have ready access onsite or on-call 24 hours a day, 7 days a week to social work services to assist in facilitating access to Veterans' benefits and referral to any clinical or non-clinical services needed by the Veteran.

(5) Sufficient support services for the ED and UCC must be available to ensure that necessary and appropriate care can be consistently delivered to patients in a timely fashion.  It is recognized that additional staff, such as licensed practical nurses (LPNs), nurses' aides, patient support assistants, clinical pharmacists, and clerical staff, provide important supportive roles in the ED.  *NOTE:  The use of such additional staff is supported and encouraged.*

(6) VA medical facilities must ensure sufficient provider staff and support services are available to cover the inpatient units so the ED/UCC providers do not have to leave the ED/UCC. ED/UCC physicians are allowed to respond to cardiopulmonary and respiratory emergencies on the inpatient units during off-tours and weekends at facilities that meet the requirements for a VRAH and facilities that have a level 4 Intensive Care Unit (ICU) and no more than 5 ICU beds if a waiver has been obtained to do so. These facilities must monitor this activity closely to ensure patient care in the ED/UCC is not being compromised because of this practice and this information needs to be sent to the National Program Director for Emergency Medicine quarterly.

(7) It is acceptable for ED/UCC providers to assist inpatient teams managing Out of OR Airway cases on the inpatient units in the case of identification of a difficult airway. This should not be the routine and if this situation should occur, the facility Chief of Staff, or designee, must conduct a Root Cause Analysis as to why this vulnerability existed and initiate appropriate system fixes to minimize a repeat occurrence.

## 7. RESIDENCY SUPERVISION IN THE ED/UCC

All residents seeing patients in the ED/UCC must be properly supervised.

a. The ED/UCC attending physician must be physically present in the ED/UCC and is the Attending of record for all patients. The ED/UCC attending physician must also be involved in the disposition of all ED/UCC patients.

b. Four types of documentation of resident supervision are allowed. These include:

(1) An attending physician progress note or other entry into the medical record.

(2) An attending physician addendum to the resident's note.

(3) A co-signature by the attending physician; this implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. *NOTE: Use of the Computerized Patient Record System (CPRS) function "Additional Signer" is not acceptable for documenting supervision.*

(4) Resident documentation of supervision by the attending physician. A resident progress note, or other chart entry, which includes a description of the involvement of the Attending, (for example, "I have seen and discussed the patient with my supervising practitioner Dr. X, and Dr. X agrees with my assessment and plan"). At a minimum, the responsible attending physician is to be identified, e.g., "The attending physician of record for this patient encounter is Dr. X."

c. Residents who are called to the ED/UCC as part of their assignment to a consulting service are supervised by the attending physician on the consulting service (not the ED/UCC attending physician). These residents are expected to be in contact with their supervising attending physician (who does not need to be physically present), as appropriate. However, the ED/UCC attending physician is still responsible for the

disposition of the patient and may request input from the consultation service attending physician, if necessary. If the Attending ED/UCC physician does not feel comfortable discharging a patient referred to a consultant or admitting team, the ED/UCC physician may ask the consultant to discharge the patient. The ED/UCC physician will provide assistance to the consultant in terms of proper completion of discharge paperwork if necessary.

## 8. ED/UCC REQUIREMENTS

a. **Safety and Access.** The ED/UCC must be designed to provide a safe environment for patients and staff while making access convenient and protecting visual and auditory privacy to the greatest extent possible. Appropriate signage must be displayed indicating convenient access for all individuals presenting for care. These signs need to be placed in areas serving as major points of entrance into the facility and need to clearly indicate directions to access the ED/UCC.

b. **Safety, Comfort, Mobility.** Environmental features that promote visual contrast, reduction of falls risk with handrails and non-slip, non-skid floor, ramps and accessibility for older adults with walkers or wheelchairs will promote greater safety.

c. **Equipment and Supplies.** The equipment and supplies necessary to care for patients expected to be seen in the ED/UCC must be readily available in the facility at all times (see Appendix B). A process for inspection and documentation of the proper functioning of all equipment must be in force (see VHA Handbooks 1761.1 and 1761.02 for further information).

d. **Support Services.** The specific services available at each VA medical facility need to be reviewed and determined by the onsite Medical Director in cooperation with the Chief of Staff, the Associate Director Patient Care and Nursing Services, and any other Directors of the departments providing services. Policies must be in place outlining access to support services during regular hours, off tours, weekends, and holidays. When these services are provided by on-call staff, 30 minutes is an acceptable time period to expect arrival of staff at the facility to perform the duties requested. Support services include, but are not limited to:

(1) **Laboratory.** All tests indicated in Appendix D need to be available 24 hours a day, 7 days a week to all EDs and during all operational hours for UCCs. There is to be onsite staff capable of performing critical tests 24 hours a day, 7 days a week, such as glucose and troponin studies. Individual sites may determine which tests are designated as critical. Non-critical tests can be performed by on-call laboratory staff. Please see Appendix D for additional information.

(2) **Pharmacy.** Medications need to be available 24 hours a day, 7 days a week in the ED or during operational hours for the UCC either through an in-house clinical pharmacist or use of a stocked pharmacy in the ED/UCC (see Appendix E).

(3) **Radiology.** Standard radiological studies including bone, soft tissues, standard and portable chest, Computerized Tomography (CT) scans and ultrasound exams for

time sensitive conditions such as testicular torsion, obstetric and gynecologic and other emergent conditions must be available during all hours of operation for EDs and UCCs.

(a) The ultrasound studies can be performed onsite or by a non-VA facility as long as there is an agreement in place that monitors turnaround times for these studies. Studies should be completed and a reading provided within 90 minutes of the order if referred to a non-VA facility for completion.

(b) Doppler venous ultrasound studies, dye contrast studies, nuclear studies, MRI and interventional radiology must be available on an urgent basis either onsite, by on-call staff or by contract (see Appendix C for the list of radiological procedures that need to be readily available 24 hours a day, 7 days a week by in-house or on-call staff at EDs and UCCs).

(4) **Consultative Services.**  The ED/UCC must be provided with a list of appropriate on-call social work and mental health staff, as well as specialty physicians, including radiologists, who are required to respond to assist the ED/UCC in caring for the patients seen.  A reasonable expectation for a call back from a consultant who is on call for the ED/UCC is 30 minutes with an expectation under normal circumstances of an onsite evaluation within 60 minutes of the call back.  Circumstances that might prevent evaluation during this time frame or conditions that might require a more emergent evaluation by the consultant must be discussed when the consultant returns the initial call.

(5) **Admission.**

(a) Appropriately qualified inpatient providers must be available 24 hours a day, 7 days a week and identified in advance to care for patients requiring admission and to manage the activities on the inpatient units.  Inpatient providers may be permitted to discharge patients from the ED according to local VA medical facility policy.  In such cases, the ED provider and inpatient provider should work together to ensure that documentation requirements and procedures are followed in accordance with applicable policy.

(b) VHA Handbook 1101.01, Medical Officer of the Day, establishes policy for physician or practitioner (with attending backup) coverage 24 hours a day, 7 days a week in all VA medical facilities with acute care inpatient beds.

(c) Controversies that may arise concerning which service is appropriate for admitting and treating patients need to be decided by the ED/UCC attending physician after consideration of all of the factors in the case.  ***NOTE:***  *Cases involving disputes such as these can be referred to the Emergency Medicine Director for review on the next business day.*

(d) ED/UCC physicians are not responsible for managing admitted patients on the inpatient services.  The Emergency Department Physician is not to write any orders that extend control and responsibility for the patient beyond the treatment given in the ED/UCC.

(6) **Follow-up Care.** A means of providing appropriate follow-up for patients seen and treated in the ED/UCC must be available. This can be provided by publishing, in advance, a comprehensive list of appropriately qualified primary care and specialty physicians available for follow-up visits, or by identifying the procedure for the utilization of primary care and specialty care clinics.

(7) **Transitions of Care.** Effective transition of care can facilitate outpatient care after ED evaluation. Discharge protocols to convey relevant information to the patient / caregiver and outpatient care providers, including nursing homes are important and may include the following:

(a) Presenting complaints,

(b) Test results and interpretation,

(c) ED treatment and clinical response,

(d) Consultation evaluation and recommendations,

(e) Working discharge diagnosis,

(f) ED clinician note,

(g) Newly prescribed medications or alterations in long-term medications, and

(h) Follow-up plan.

(8) **Patient Tracking.** All VA EDs and UCCs must fully implement and utilize the EDIS tracking program for data entry, to capture patient data including ED/UCC flow metrics and to utilize that information for flow improvement. National workload, metric and flow management data for every ED/UCC in VHA is available via the EMMT available at the following address: https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/Mgmt Reports/EDIS/EDIS_NationalReport_v2&rs:Command=Render.

(a) Additional information for productivity and operational risk for all sites is available on the EMMT ED Operations Dashboard available at the following address: https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fM gmtReports%2fEDIS%2fEMMTV2_Dashboard&rs:Command=Render.

(b) This dashboard provides National, VISN and facility options for viewing, allowing sites to see data from their own VISN as well as comparison data from facilities with the same complexity level designation.

## 9. GENERAL OPERATIONS REQUIREMENTS

Operations in the ED/UCC need to be governed by an organizational plan that is consistent with the medical facility bylaws and is guided by national and local practice guidelines, policies, and procedures necessary for efficient and safe emergency care.

In accordance with applicable laws, regulations, and standards, the medical screening examination on each patient who enters the VA medical facility seeking care must be performed by a physician, NP, or PA, in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) and local policies delineated in the medical staff bylaws. ***NOTE:*** *While not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for Medicare and Medicaid Services (CMS), VHA complies with the intent of EMTALA requirements.*

    a. **Patient Sign In.** All VA medical facilities registering patients in an ED/UCC must comply with the VHA policy for outpatient scheduling. All outpatient appointments meeting the definition of an encounter must be made in count clinics using VISTA Scheduling software. See VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, or subsequent policy issue, for additional information.

    b. **Triage.** VHA requires RN triage in all EDs/UCCs, consistent with the ENA position statement dated February 2011, Triage Qualifications, and the use of the Emergency Severity Index (ESI) as the sole triage tool. Triage Nurses should have orientation/educational training on use of the 5 tier ESI triage system and competency validation. The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups and provides a method for categorizing ED/UCC patients by both acuity and resource needs (see http://www.ahrq.gov/research/esi). Patients or caregivers must be furnished with the medication list for review to initiate the Medication Reconciliation process during triage. See VHA Directive 2011-012, Medication Reconciliation and Medication Management, or subsequent policy issue, for additional information.

    c. **Transfer Process.** All VA medical facilities must have a written policy for transfers when the ability to care for the patient exceeds the capabilities of the ED or UCC or when transfer is indicated for some other reason. This policy must also apply to patients being accepted for transfer from another VA or a non-VA site. See VHA Directive 2007-015, Inter-facility Transfer Policy, or subsequent policy issue, for additional information.

    d. **Discharge (Instructions).** All patients transferred or discharged from the ED must be given specific written or printed follow-up care instructions. These instructions must be legible, in large font and be reviewed with the patient and/or caregiver prior to discharge; and must include an updated medication list derived from the medication reconciliation process, relevant medication information and counseling to ensure effective self-care and follow-up, in language that patients will understand.

    e. **Diversion.** It is recognized that circumstances may dictate the need to go on diversion status from time to time in the ED. A diversion policy needs to be in force that provides clear indications for the use of diversion and limitations for the length of time spent on diversion without a re-evaluation of the situation. Local EMS policies and agreements may dictate some of the parameters for ED and medical facility diversion status. A VA patient being transported by ambulance has the right to request to go to a VA ED unless the assessment by a certified EMS provider (in direct radio or telephone contact with the VA ED provider) indicates that complying with the patient's request

could result in further harm to the patient from a delay in obtaining appropriate treatment, or the facility is on Internal Disaster; for example, trauma patients should go to the nearest trauma center in the area designated by local EMS protocol.

(1) **Advanced Life Support Diversion.** Advanced Life Support (ALS) Diversion is the diversion of ambulances caring for patients that require advanced life support or advanced monitoring. An example is the diversion of patients with acute myocardial infarction or unstable vital signs because of insufficient ICU or monitored beds in the facility and the ED.

(a) The ED may close to ALS ambulances only under one of the following circumstances:

1. When all but one of the available inpatient monitored beds are occupied and only one monitored bed remains in the ED.

2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients or there is not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or those already in the ED.

(b) While on ALS diversion, the ED can still receive ambulances under the following conditions:

1. The patient does not meet the criteria for ALS diversion, (i.e., the patient is a BLS patient).

2. All EDs in the community or local region are on diversion status.

3. The patient refuses to be transported to any other facility, i.e., the patient demands to be transported to a VA medical facility.

4. A patient has an immediate life-threatening emergency and VA is the closest medical facility capable of providing emergency care. *NOTE: This applies to all patients including those not eligible for VA care.*

(2) **ALS and BLS Diversion.** ALS and BLS Diversion is the diversion of all ambulances regardless of the need for monitoring; for example, the diversion of patients regardless of the level of care needed for treatment because facility beds are unavailable or there is an insufficient number of staff to care for additional patients. Patient demands are accepted.

(a) The ED may close to ALS or BLS ambulances under either of the following conditions:

1. When all but one of the available monitored hospital beds are occupied, all other inpatient beds are occupied, and only one unoccupied monitored bed remains in the ED.

2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients, or there are not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or to those already in the ED.

(b) While on ALS and BLS diversion, the ED can still receive ambulances under the following conditions:

1. All EDs in the community or local region are on diversion status.

2. The patient refuses to be transported to any other facility; i.e., the patient demands to be transported to VA.

3. A patient has an immediate life-threatening emergency and VA is the closest hospital capable of providing emergency care. ***NOTE:*** *This applies to all patients including those not eligible for VA care.*

(3) **Internal Disaster Diversion.** Internal Disaster Diversion is the diversion of all patients regardless of the level of care needed for treatment. The facility may have lost electricity or water, may have sustained physical damage to its structure, or be overwhelmed by current patient load. Patient demands are not accepted.

***NOTE:*** *The ED/UCC must never turn away an ambulatory patient or a patient who has arrived by ambulance; a medical screening exam must always be performed in accordance with the provisions of EMTALA and implementing regulations at 42 Code of Federal Regulations (CFR) 489.24, 482.55. Patients, after being medically screened, may be referred to a clinic for further evaluation and treatment, if it is deemed appropriate.*

***NOTE:*** *While not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for Medicare and Medicaid Services (CMS), VHA complies with the intent of EMTALA requirements.*

f. **ED/UCC Observation.** All VA medical facilities with ED or UCC and acute care inpatient beds have a written policy to provide care for Observation patients. All patients must be assigned a treating specialty code of Observation, as applicable, and all services and costs associated with the Observation treating specialty must be captured and assigned to inpatient services. See VHA Directive 1036, Standards for Observation in VHA Medical Facilities for additional information.

## 10. STOP CODES

a. New stop codes 130 for ED and 131 for Urgent Care were developed to solve the problem related to capture of workload in the ED and UCCs.

b. All patients seen in an ED for treatment regardless of the severity of their illness or triage level must be coded as a 130. The intent is not to fragment the billing process for patients with differing acuities in the ED, such as whether they are seen in a fast track included as part of the ED or in the regular ED area. The reason for the visit has

no bearing on the stop code used, only on the level of service provided for billing purposes.  Patients that are seen in the ED are coded as a 130.

c.  The Urgent Care code 131 was developed to capture the workload in UCCs (see http://vaww.dss.med.va.gov/programdocs/pd_oident.asp).  ***NOTE:***  *This is an internal VA Web site and is not available to the public.*

## 11.  LOCAL AND REGIONAL EMERGENCY MEDICAL SERVICE (EMS) PARTICIPATION

a.  All VA medical facilities with an ED must:

(1) Establish a collaborative partnership with local EMS and officials.

(2) Participate in the community's emergency resources continuum.  This includes a discussion with local and regional EMS leaders about the capabilities of the VA medical facilities in the service area and arrangements for emergency transportations services when needed.

b.  VA medical facilities with an ED must also understand the responsibility to provide emergency care to Veterans, staff, and other non-Veterans who experience a medical emergency while in or near a VA facility.  This includes acceptance of requests by EMS for transport of unstable Veteran or non-Veteran patients to VA EDs when the VA medical facility is the closest capable facility.

## 12.  CLINICAL POLICIES

This section will highlight the important aspects of current VHA policy affecting ED/UCC practice and patient care which have not already been discussed in previous sections.

a.  **Pediatric Resuscitation.**  All VA medical facilities with EDs/UCCs must have Pediatric/Neonatal resuscitation equipment available for BLS in pediatric/neonatal emergencies, and all medical staff must be trained in its use.

(1) Although VA medical facilities with EDs/UCCs must have pediatric BLS equipment and ensure staff is trained in its use, it is not a mandate that VA EDs/UCCs provide training in Pediatric Advanced Life Support (PALS) or other comparable evidenced-based training programs to their employees unless they have pediatric ALS resuscitation equipment in the ED.

(2) It is necessary to have a plan in place for calling 911 immediately to summon EMS after recognition of a pediatric/neonatal code situation and for the provision of BLS by VA staff until EMS arrival on the scene.

b.  **Use of Anesthetic Agents for Moderate Sedation in the ED.**  VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers, requires individuals ordering, administering, or supervising moderate sedation in support of patient care must be

qualified and have appropriate credentials, privileges or scope of practice. (See VHA Directive 1073, Moderate Sedation by non-Anesthesia Providers for further information.)

c. **Rapid Sequence Intubation.** Emergency medicine providers may use anesthetic agents for Rapid Sequence Intubation, as long as they have documentation of appropriate training in airway management and management of hypotension due to these drugs. The credentialing and privileging process must include an assessment of airway management and management of hypotension prior to approval to use these drugs. Individuals performing emergency airway management within VA must meet the requirements found in VHA Directive 2012-032, Out of Operating Room Airway Management, or subsequent policy issue, which includes required demonstrated competencies and knowledge base, and a facility process for confirming such competencies.

d. **Treatment of Intoxicated Patients.** Intoxicated or otherwise cognitively impaired individuals may act in ways that are potentially injurious to themselves or others. VA medical facilities must act within Federal law provisions and prevailing standards of care to ensure that patients and society are adequately protected while maintaining the primacy of self-determination and 4th amendments rights against search, seizure and imprisonment. This section provides guidance on some specific and frequently occurring issues.

(1) An individual who is substantially impaired may be involuntarily retained for emergency treatment by the VA medical facility if incapacitated to such a degree that there is likelihood to result in harm to the person or others. That likelihood must be manifested by threats or attempts at suicide or serious bodily harm or other conduct that demonstrates a danger of self-injury or injury to others. Such detentions must be limited to truly imminent harm and not simply that an individual would be better off in a healthcare facility than outside of one.

(2) Federal law enforcement officers have no authority to independently detain individuals unless there is probable cause that the individual committed a crime or is about to commit a crime. Any requests for assistance restricting a patient from leaving the Emergency Department must be done under the direct guidance of a physician or Licensed Independent Practitioner (LIP).

(3) Consent for blood alcohol testing.

(a) Breathalyzer or blood alcohol testing may be used with the patient's informed consent to aid in making a determination of intoxication in the non-acute setting such as a CBOC or substance abuse clinic. Title 38 CFR 17.32(d) provides that signature consent is not required. The breathalyzer and blood alcohol test results must be made a part of the patient's electronic medical record.

(b) In medical emergencies, the patient's consent is implied by law. The practitioner may provide necessary medical care, including testing for blood alcohol levels without the consent of the patient, or a surrogate's express consent, when the following conditions are met:

    1. Immediate medical care is necessary to preserve life or avert serious impairment of the health of the patient or others and

    2. The patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting for the patient's surrogate would increase the hazard to the life or health of the patient or others. (See VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, for further information)

    (4) Duty to protect individuals and the public against operating a motor vehicle while intoxicated.

    (a) When an intoxicated patient (breath alcohol or blood alcohol greater than the local legal limit (typically.08) or showing clinically significant behavioral signs of intoxication) verbally or nonverbally demonstrates an intent to operate a motor vehicle, attempts need to be made to persuade (or assist) the patient to arrange other transportation or to remain for extended observation until additional testing shows the level has dropped below the local legal limit and the patient is not showing signs of impairment.

    (b) If the patient refuses the breathalyzer or blood test or is unwilling to remain for extended observation and the patient does not manifest truly imminent risk of immediate harm the patient may not be held against his or her will by clinical staff.  This must be documented in the medical record, with a witness if possible, i.e., that the patient was informed of any safety concerns and advised not to operate a motor vehicle.  If the patient refuses to make other arrangements or to remain for observation until no longer intoxicated, the patient needs to be informed that facility police will be contacted due to concerns related to public safety.

    (5) VA policy regarding disclosing patient alcohol information to police is found in VHA Handbook 1605.1, Privacy and Release of Information.  It states:  Requests by law enforcement officers or government officials for the taking of a blood sample from patients at VA health care facilities for analysis to determine the alcohol content must be denied.  In these situations, the requester must be advised that VA personnel do not have authority to withdraw blood from a patient, with or without their authorization, for the purpose of releasing it to anyone for determination as to its alcohol content.  See VHA Handbook 1605.1 for additional information.

    e. **ED/UCC Management of Mental Health Patients.**  All sites with EDs or UCCs must provide safe and secure mental health services during all hours of operation.  These policies must include the following elements:

    (1) All patients presenting to the ED or UCC are screened at some point during the visit for suicide and homicide risk.  Patients recognized on screening as being at-risk for suicide or homicide or who exhibit disruptive, aggressive, or violent behavior require one-to-one observation while in the ED or UCC until the time they are no longer deemed a risk by the ED or UCC attending physician or a psychiatric consultant.  Immediate treatment of life-threatening conditions always takes precedence over this

screening process.  ***NOTE:  The facility Suicide Prevention Coordinator must be informed of any patient presenting to the ED with suicidal ideation.***

(2) All patients admitted to the ED or UCC have appropriate physical and laboratory examinations to diagnose medical conditions that could be responsible for their psychiatric condition.  As part of that diagnostic process, patients are asked to wear a hospital gown or pajamas and an inventory of their belongings must be carried out by clinical or nursing staff.  These items must be safely placed in a bag, separated from the patient.  If during this process, weapons or contraband are discovered, facility police must be notified.  ***NOTE:  The question of whether a weapon found in the possession of a psychiatric patient can be returned to that patient is subject to Federal and state laws (see paragraph 15.e.(10)(c) below).***

(3) A policy is in place for appropriate transfer of the patient after stabilization to a facility that can provide a higher level of care, or provide an involuntary admission if it is deemed necessary and not available at the VA medical facility.  Transfers need to comply with applicable provisions of 42 CFR 489.24 that implement EMTALA.  ***NOTE: While not technically subject to EMTALA and the regulations implementing the Act issued by the Centers for Medicare and Medicaid Services (CMS), VHA complies with the intent of EMTALA requirements regarding the transfer of acute patients among health care facilities.***

(4) All VA EDs and UCCs must have mental health coverage available during all hours of operation either onsite or on-call.  This coverage is to be provided by an independent licensed mental health provider (i.e., a psychiatrist, psychologist, social worker, physician assistant, or advanced practice nurse).  Psychiatric residents or post-doctoral psychologists may also be used with appropriate supervision.

(a) During UCC non-operational hours, the telephone system must direct patients to the nearest ED that is able to provide appropriate emergency mental health service, and to provide the National Suicide Hotline number, 1-800-273-8255.

(b) Patients who arrive at UCCs when they are closed must be directed by appropriate signage to a VA or non-VA ED that will best serve their needs; this signage is to include the National Suicide Hotline number.

(5) For complexity Level 1a facilities, mental health coverage must at a minimum be onsite (based in the ED) from 7:00 a.m. to 11:00 p.m.  At other times, it may be onsite or on-call.  Mental health providers covering onsite from 7:00 a.m. to 11:00 p.m. may participate in activities throughout the VA medical facility; however, they must not undertake any medical facility activities that would prevent them from coming immediately to the ED if called.  Psychiatric residents and psychology postdoctoral fellows, where available, may provide ED coverage.  If that coverage is onsite, the psychiatry or psychology supervising attending must also be present in the ED. Psychiatry resident or psychology fellows who are on call and respond to requests for ED consultation are expected to contact their supervising practitioners while the patient is still in the EDto discuss the case and to develop and recommend a plan of

management.  For other VA medical facilities, coverage may be either onsite or on-call at all times.

(6) When a VA ED/UCC has on-call coverage for mental health, this requires a telephone response within 20 minutes and the ability to implement onsite evaluations within a period of time to be established on a facility-by-facility basis.

(7) All VA medical facilities with EDs are required to have resources that allow for extended observation or evaluation for up to 23 hours and 59 minutes for mental health patients.

(8) All ED and UCC staff including receptionists, nurses, nurse extenders, and physicians receive training in Suicide Prevention and training in Prevention and Management of Disruptive Behavior (PMDB).  ***NOTE:  PMDB is VHA's accepted training in verbal de-escalation, personal defense, and safety/physical containment for managing disruptive and potentially violent patients.***

(9) Refresher training in all aspects of PMDB and routine drills must be available on an annual basis.

(10)  A safe and secure area where patients seeking or needing mental health services can be evaluated and observed must be provided.

(a) All VA EDs and UCCs need to have at least one psychiatric intervention room.  A psychiatric intervention room is a room where seriously disturbed, agitated, or intoxicated patients may be taken immediately on arrival.  It provides an environment suitable for the rapid medical and psychiatric evaluation of dangerously unstable situations and the capacity to safely control them.

(b) The Mental Health Environment of Care Checklist from the VHA National Center for Patient Safety found at: http://vaww.ncps.med.va.gov/guidelines.html *(**NOTE:** This is an internal VA Web site and is not available to the public)* provides guidance in designing space used for the evaluation of patients presenting to EDs and UCCs with psychiatric issues.  New construction needs to take into account the requirement to care for both male and female Veterans, as well as the need to provide separate restroom facilities for men and women.

(c) Facilities may consider using metal detectors (magnetometers) to screen patients for weapons upon entering the ED and UCC.  Metal detectors provide some, but not absolute, assurance of safety with respect to detecting metal weapons.  When metal detectors are used, they are to be used for all individuals entering the ED and UCC and are not to be used selectively for psychiatric patients.  VA Handbook 0730, Security and Law Enforcement requires that two VA facility police officers be assigned to a magnetometer station for the safety of the officers and the public.  ***NOTE:  A protocol needs to be established for the management of patients screening positive when using a metal detector.***  Persons found to be in possession of weapons or other contraband during metal detector screening are subject to arrest and prosecution (see VA Directive

and Handbook 0730, and successor documents which address specific requirements for the use of metal detectors).

(11)  VA medical facility police must be trained and available to provide standby assistance when requested by ED and UCC staff.  Facility police are to be available when requested by the ED staff to provide standby assistance or intervention for the management of any patient who presents a danger to self or others, who is potentially violent, or who exhibits violent or agitated, unpredictable behavior.  Patients who have been determined by clinical staff to be a threat (or danger) to themselves or others are not to be allowed to voluntarily leave the ED or UCC until a discharge plan is in place. In these situations, facility police are to prevent their departure, consistent with applicable statutes, regulations, or departmental policies.  Whenever this occurs, the facility police are to use the minimum amount of force determined necessary to control the situation.

(12)  The level of mental health services provided by the ED and UCC must be congruent with the capabilities, capacity and function of that facility.  For patients who are discharged from the ED/UCC, a referral for mental health assessment and a follow-up appointment must be completed prior to discharge.

(13)  Appropriate employees must receive training in recognizing and responding immediately to the presence of all patient record flags.

(14)  Mental health providers in the ED and UCC are to be equipped with reliable cell phones or pagers.

(15)  Provisions are included for seeking advice from the VA General or Regional Counsel, and the local U.S. Attorney's Office, concerning the applicability of Federal, state, or local laws regarding weapon possession by a psychiatric patient.  Such advice must become a part of the local VA medical facility's established policy and procedures.

g.  **ED/UCC Management of Acute Sexual Trauma.**  EDs and UCCs must have plans in place to appropriately manage the medical and psychological assessment, treatment, and collection of evidence from Veterans, male and female, who are victims of alleged acute sexual assault.  Alleged acute sexual assault is defined as sexual contact with an alleged perpetrator within the last 72 hours.

(1) All VA medical facilities must assess the educational need and, when appropriate, develop plans for staff education that address the signs and symptoms of sexual assault, local reporting procedures, identification and treatment of sexual assault, institutional, local, state, and Federal reporting mandates, and instruction on maintaining and safeguarding evidence of alleged sexual assault.

(2) Informed consent for a physical examination, collection of evidence and treatment must be obtained from the alleged acute sexual assault patient by a licensed health care provider acting within the scope of the provider's practice.  In cases of alleged acute sexual assault, the patient who presents to a VA medical facility may need two types of health care services; an evaluation and treatment of medical and

mental health needs and a forensic examination to obtain all possible historical and physical evidence of the alleged sexual assault for possible future use by a law enforcement agency for purposes of investigation or prosecution.

(3) Informed consent for both medical evaluation and treatment and for forensic examination must be obtained by the practitioner as specified in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

(a) Medical evaluation and treatment may be provided in emergency situations without the patient or surrogate's consent only under the limited specific conditions stipulated in VHA Handbook 1004.01.

(b) The practitioner must always obtain informed consent for a forensic examination. A forensic examination is not an emergency since the examination is not necessary to preserve a patient's life or avert serious impairment to her or his health.  Informed consent to an examination for evidence of sexual assault (forensic exam) must be obtained by a practitioner trained in conducting forensic evidentiary examinations. *NOTE: Alleged acute sexual assault victims must, as part of the informed consent discussion, be made aware of the applicable limits to confidentiality in the relevant state(s).  VHA complies with state law concerning mandatory reporting of sexual assault only to the extent that it can do so consistent with Federal records confidentiality statutes, the Privacy Act at 5 U.S.C. 552a and 38 U.S.C. 5701 and 7332.  Refer to VHA Directive 2012-022, Reporting Cases of Abuse and Neglect.  Consult with Regional Counsel as needed.*

(c) If the patient is unable to provide informed consent because the patient lacks decision-making capacity, an authorized surrogate needs to be identified in accordance with VHA Handbook 1004.01.

*NOTE:  The informed consent for medical treatment and the consent for forensic evaluation must be separately documented in the health record.*

(4) **Patient Rights.**  The patient has the right to accept or refuse any aspect of the medical evaluation and treatment or forensic evidentiary examination which may include: examination for the presence of injuries sustained as a result of the assault; evidence of sexual assault and collection of physical evidence; photographs of injuries; and, further examination and collection as provided for by state law.  Refusal of the forensic examination for evidence of sexual assault is not a ground for denial of treatment for injuries and for possible pregnancy and sexually transmitted diseases, if the person wishes to obtain treatment.  Refusal of any recommended treatment or procedure must be documented in the health record and those treatments or procedures must not be provided.  *NOTE:  Patients have the option to have forensic evidence collected anonymously in the event they choose to pursue prosecution at a later date.  Regional Counsel should be consulted regarding state laws.*

(5) **Collection and Safeguarding of Evidence.**  The collection and safeguarding of evidence must be done in accordance with VA Office of Security and Law Enforcement Model Medical Center Standard Operating Procedure (SOP) Evidence/Property

Collection, Documentation and Processing Procedures and in consultation with Rape Crisis Centers, SANE unit, or other organizations having knowledge and experience in the issues of sexual assault as needed. ***NOTE:*** *A SANE is a registered nurse who has advanced education and clinical preparation in forensic examination of sexual assault victims and a SANE unit can be located at http://www.sane-sart.com/.*

(a) VA Police must be notified to assist in the proper collection, sealing, and labeling of the evidence.

(b) In all cases in which the patient has consented to the examination and collection of evidence of sexual assault, VA Police must be notified to safeguard and secure the evidence collected.

(6) **Report of Incident.** VA Police must be notified to refer the report of the incident to law enforcement in the appropriate jurisdiction after consultation with Regional Counsel when the victim consents to report the incident to law enforcement. ***NOTE:*** *VA regulations require prompt notification to the Office of Inspector General (OIG) about possible criminal matters involving felonies related to VA programs and operations. The OIG must be notified of sexual assaults when the crime occurs on VA premises or by VA employees in connection with VA treatment or services. Refer to 38 CFR Section 1.204.*

(a) Reports of alleged sexual assault are made pursuant to valid state laws which provide for, or require that such reports be made. In the absence of a prior written consent of the victim, a report of sexual assault by VA may be made only in response to a letter prepared by the qualified representative of the civil or criminal law enforcement instrumentality charged with the protection of the public health or safety. ***NOTE:*** *Refer to VHA Directive 2012-022, Reporting Cases of Abuse and Neglect, or subsequent policy issue, and Regional Counsel for information about what qualifies as a law enforcement instrumentality and the responsibilities of VA medical facilities concerning these instrumentalities.*

(b) Reports of sexual assault are limited to providing the name and address of the victim and that information specifically permitted or required by state statute to be in compliance with the reporting provisions of the applicable state law. ***NOTE:*** *In no event shall information protected under 38 U.S.C. 7332 that pertains to treatment for drug and alcohol abuse, sickle cell anemia, or to testing for or infection with human immunodeficiency virus (HIV) be disclosed to comply with a state request, unless the Veteran signs a prior written special consent or there is a valid court order.* If the state agency that has received a report of sexual assault seeks additional information, such information may be provided only with the patient's authorization or in response to a letter prepared by the law enforcement agency charged with the investigation in accordance with the provisions of 5 U.S.C. 552A (b)(7).

(7) **Treatment and Support Services.**

(a) VA medical facilities without a local, non-VA facility with staff providers experienced in the care of victims of alleged acute sexual assault must have

appropriately trained staff available 24 hours a day, 7 days a week for the examination, treatment, and collection of evidence that fully meets patient needs and is conducted in consultation with Rape Crisis Centers, a SANE unit, or other appropriate organizations having knowledge and experience in the issues of sexual assault.  This may include local law enforcement with the consent of the patient or the patient's surrogate when the patient lacks decision making capacity.

(b) Providers caring for victims of alleged acute sexual assault must provide emergency treatment for the physical and emotional trauma, address the collection of evidence to properly care for the patient and maintain the chain of evidence.

(c) Appropriate prophylaxis for sexually transmitted disease and pregnancy must be offered when clinically indicated.

(d) A referral for psychological counseling (including an immediate electronic consult to Mental Health) must be offered immediately.  Initial contact from a mental health provider must occur within 24 hours.

1.  Alleged acute sexual assault victims may have an immediate need for mental health counseling, although a victim's decision to decline or defer mental health services must be respected.

2.  For those patients who want to seek mental health care immediately, an initial appointment with the mental health clinic must be scheduled as soon as clinically indicated, but not later than 7 days.  Those who choose to decline or defer mental health services should be contacted again 1 week later to assess current desire for services.

(e) VA medical facilities are not required to provide complete care onsite as indicated above if the following procedures are implemented.

1.  Emergency evaluation to stabilize and/or treat any acute medical or psychological problems must be provided with subsequent transfer to an appropriate local, non-VA facility with trained and experienced providers in the examination, treatment and the collection of evidence of patients suffering from alleged acute sexual assault.  An agreement with a local, non-VA facility needs to be arranged in advance and agreed to in a contract to provide this service 24 hours a day, 7 days a week at VA expense.

2.  VA medical facilities unable to provide full care to alleged acute sexual assault victims that transfer patients to a local non-VA facility for additional treatment and collection of evidence must comply with the intent of the provisions of 42 CFR 489.24 (EMTALA) and VHA Directive 2007-015, Inter-Facility Transfer Policy, or subsequent policy issue.

3.  A non-VA consult must be entered in the Computerized Patient Record System (CPRS) to obtain authorization for payment of services rendered at the non-VA facility.

 4. The sending facility assumes full responsibility for the alleged acute sexual assault patient during travel.  If appropriately trained VA staff is not available to accompany the patient, arrangements will be made with the local Rape Crisis Center, SANE or other private or public community agencies for appropriately trained staff to be available on demand.

 (f)  A detailed Report of Contact of all actions taken to provide treatment and support must be provided to the Chief of Staff.

 (g) All emergency departments, urgent care clinics, and inpatient sites must have rape evaluation kits available for use by the consulting organizations if needed in the event that a victim is too unstable for transfer and the collection process needs to occur on site.  In this situation, a protocol must be in place for the collection of evidence that is based on the VA Office of Security and Law Enforcement Model Medical Center SOP Evidence/Property Collection, Documentation and Processing Procedures and in consultation with the appropriate agencies, including Rape Crisis Centers, SANE unit, or local non-VA facility to assist in the proper collection process.  Staff needs to be familiar with state law examination and collection requirements in the event the alleged acute sexual assault victim seeks to pursue legal action against the alleged perpetrator.

 h. **ED/UCC Acute Ischemic Stroke Management.**  All VA medical facilities with inpatient acute care medical or surgical beds must have a written policy to provide appropriate care to patients presenting with Acute Ischemic Stroke.   Each VISN Director is responsible for assessing the capability of each facility in the VISN and assigning an appropriate designation for stroke care to each.  See VHA Directive 2011-038, Treatment of Acute Ischemic Stroke, or subsequent policy issue, for further information.

 i. **ED/UCC Boarding and Temporary Bed Activation.**  Patients requiring hospitalization must be provided the highest level of care in the unit most appropriate for their clinical condition and written procedures must be in effect to ensure optimal care is uniformly and expediently delivered even when patients must be managed in temporary bed locations due to lack of bed availability in the destination unit.  All VA medical facilities must have written policies that address the placement of overflow patients in temporary bed locations.  These policies must include:

 (1) Established processes for prioritization and decision-making to ensure safe patient care during periods of high demand for inpatient beds.

 (2) Designation of a "Bed Flow Coordinator" (a staff member with clinical background) to coordinate inpatient admissions and bed assignments.  This Bed Coordinator will be responsible for activation of the Temporary Bed Location Protocol and to notify the Chief of Staff or designee if the determination is made that no inpatient beds will be available within 4-6 hours and the ED/UCC is in danger of going on diversion.

 (a) The initial action should be to identify patients with an impending or imminent discharge who are stable and attempt to discharge these patients as soon as possible.

*NOTE: If barriers to discharge exist, such as inability to find transportation, efforts could be directed towards providing transport. VA medical facilities could also institute the use of a discharge lounge for temporary use by patients awaiting transportation home.*

(b) The primary goal is to accommodate a sufficient number of admitted patients to relieve some of the stress on the ED or UCC and delay or avoid diversion status. It is not expected or required that all admissions waiting for beds in the ED or UCC be accommodated by the early discharge of inpatients.

(3) Plans to provide the appropriate number of qualified physicians, nurses, and support staff to meet established The Joint Commission, ACEP, and ENA Standards of Practice, regardless of the location of the admitted patient.

(4) Established ongoing performance improvement activities designed to improve patient flow and reduce the need for temporary bed placements.

(5) Written local policies and procedures that address the following issues as they relate to overflow patients who are placed in temporary bed locations:

(a) Identification of the location of temporary beds for overflow patients (e.g., ED, UCC, Post-Anesthesia Care Unit (PACU), Observation Unit), and for admitted patients awaiting an inpatient bed.

(b) Patient right to privacy is protected.

(c) Upholding the standard of care for a patient admitted to an inpatient area in all temporary bed locations. *NOTE: When a patient requires admission to a critical care unit and no Intensive Care Unit (ICU) bed is available, it is an absolute requirement that the patient receive ICU-level care in an alternative location including monitoring, staffing, and treatment consistent with ICU standards.*

(d) Medication administration and provision of meals is appropriate.

(6) Statements indicating that the ED or the UCC is not utilized as the primary temporary bed location for patients awaiting admission.

(7) Identification of the Chief of Staff, or designee, at each VA medical facility as the person responsible for establishing local policy to guide practice that clearly defines who will determine the final disposition and bed status assignment (i.e., unit bed vs. telemetry bed) in the rare instance when there is a disagreement between the ED or UCC provider and the appropriate admitting physician.

(a) The maximum number of patients that the ED or UCC is expected to hold as boarders including patients requiring ICU or telemetry services must be outlined in the local VA medical facility policy for managing patients placed in temporary bed locations.

(b) After this limit has been reached, additional patients requiring admission must be transferred to alternate temporary bed locations in the facility or to another health care facility depending on available resources in the ED or UCC, the overall ED or UCC

patient volume, the medical condition of the patient, and the availability of community resources.

(c) The maximum number of overflow patients each unit can receive must be outlined in the local VA medical facility policy for the handling of patients placed in temporary bed locations.

(d) Application of a prioritization matrix for inpatient admissions which includes all sources of referral for inpatient beds.

1. Patients kept in temporary bed locations outside of the ED must be prioritized over the ED and UCC boarders and/or new admissions for movement to the first available bed on any unit where nursing competencies meet patient needs.

2. Patients placed in temporary bed locations must be admitted to a virtual inpatient bed so they can receive medications, food service, etc. during their stay on the unit on which they are boarding.

(8) Transfer of the responsibility for the patient's care from the ED or UCC attending physician or from an outpatient physician to an inpatient provider must be completed in an appropriate and timely manner, even if the patient is not physically located on the destination unit.  The ED, UCC, or other outpatient provider and staff are responsible for the care of the patient until this transfer of responsibility occurs.  Once a patient is admitted, (admission order is placed by admitting service) and verbal and documented handoff is given, the ED, UCC, or other outpatient physician is no longer responsible to care for these admitted patients.

(9) A plan and procedure for safe transfer of patients to other VA or non-VA facilities when beds are not expected to be available.  This may require contracts and/or Memorandums of Understanding (MOU) with local non-VA facilities.

(10)  Appropriate policies are in force to implement the high-impact solutions to reduce ED and UCC boarding and diversion.  These include:

(a) Procedures to manage the care of admitted patients who are not in temporary bed locations should be in place, paying particular attention to appropriate length of stay (LOS) for the patient's condition, appropriate discharge time based on patient needs and scheduling of the discharge appointment as early in the admission as possible.  Concentrated efforts should be made to discharge patients as soon as possible every day to allow for the placement of new admissions in patient rooms in a timely manner.

(b) Policy for coordination of elective and surgical patients.  This can be enhanced by collecting data on average ED and UCC admissions and scheduled surgeries for each day of the week and using that data to predict bed utilization for emergency patient care needs to allow appropriate scheduling of elective admissions.

(c) Policy to ensure the Bed Flow Coordinator or designee notifies the appropriate chain of command regarding the status of the beds when patients are being held in temporary bed locations.

(11)  Monitoring organizational performance improvement, this includes evaluation of patient flow throughout the organization and includes at a minimum:

(a) Monitoring of episodes of diversion status and the frequency of patient placement in temporary bed locations.

(b) Monitoring of the number of admissions, LOS, as well as admission and discharge times, and where appropriate, transition time for transfer to a lower level of care, to evaluate workload and throughput.

(c) Reviewing a sample of patient medical records to ensure the appropriate standard of care has been delivered to patients in overflow status.

(12)  The ED or UCC Attending Physician on duty is not to accept transfers from other facilities, including off-site VA clinics during the times that the Temporary Bed Location protocol is activated.

(a) On-site clinic transfers are not to be accepted unless they are critical or unstable.

(b) Policy must exist that guides the referring physician who must transfer clinic patients needing acute care admission who are not critical or unstable to another health care facility.

j.  **Women's Health and the ED/UCC.**

(1) VA is providing health care to increasing numbers of women Veterans.  Previous work has shown that many VA EDs have limited resources for female gender-specific medical conditions, such as access to specialty consultation.  When resources are not available onsite, they are often provided off-site (i.e., through Non-VA Medical Care or contracting agreements).  This may impact timely access, care coordination, and follow-up care.  ED Directors, ED Women's Health (WH) Champions, Women Veterans Program Managers (WVPM) and, when applicable, Maternity Care Coordinators (MCC), Patient Aligned Care Team (PACT) Coordinators, and Associate Chiefs of Staff for Mental Health, or their designees, should work together to develop processes to assist VA ED and UCC in providing and arranging care for women Veterans.

(2) VHA has an obligation to ensure quality emergency medical services for all Veterans including women Veterans.  VA medical facilities must have robust policies in advance of need to facilitate rapid transfer of patients with potentially catastrophic conditions that cannot be managed at the local VA site of care.  For example, onsite stabilization and treatment strategies for patients presenting to a VA ED in hemorrhagic shock due to a ruptured ectopic pregnancy should be developed in advance.

(a) Initial Screening.  All women Veterans of child-bearing age (age ≤ 52 years) triaged in VA ED or UCC should be asked about pregnancy status and last menstrual

period.  Nursing triage documentation should include this information.  Screening for Domestic Violence (DV)/Intimate Partner Violence (IPV) is also recommended for women Veterans at high risk (see https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx for additional tools and references).  ***NOTE:*** *This is an internal VA Web site, not available to the public.*  This screening can be done in triage or at some point during the visit so as not to hinder expeditious ED/UCC triage.

(b) Staff Education.  All staff providing emergent/urgent care treatment to women Veterans should have the opportunity to receive ongoing professional education/training in women's health to maintain proficiency in topics such as, but not limited to, documenting a menstrual and obstetric history; evaluation of acute abdominal/pelvic pain; evaluating gender-based differences in presentation (i.e., myocardial infarction presentation), vaginal bleeding in early pregnancy, acute sexual assault, and DV/IPV. Simulation equipment and training materials have been made available to VA medical facilities for training.

(c) Order Sets and Pathways.  VA EDs and UCCs should consider using care coordination tools and resources (e.g., clinical order sets, clinical pathways, note templates, clinical guidelines) to standardize and efficiently manage the evaluation and treatment of gender-specific clinical presentations (e.g., vaginal bleeding).

(d) Pregnancy Testing in VA ED and UCC Facilities.  VA EDs and UCCs should have "stat" qualitative (urine and/or serum) and "stat" quantitative human chorionic gonadotropin (HCG) testing available 24 hours a day and 7 days a week with results available to the patient's ED or UCC clinician 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).

1.  All women Veterans of child-bearing age (≤ 52 years) who come to the ED 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.  See Appendix F for common obstetrics and gynecology (Ob/Gyn) related presentations to VA ED and UCC.

2.  Blood type evaluation (i.e., Type and Screen) should be part of the evaluation of every pregnant woman who presents to an ED or UCC with vaginal bleeding.  In EDs that treat pregnancy related vaginal bleeding; Rho (D) immune globulin (e.g., Rhogam) should be available 24 hours a day and 7 days a week.

(e) Equipment and Supplies.

1.  Every VA ED 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).  Necessary gynecologic examination supplies should be available 24 hours a day and 7 days a week.

2. All VA EDs and UCCs should stock an obstetric delivery kit.

3. Fetal heart rate hand held dopplers. Fetal heart rate assessment is an important tool used by obstetric consultants (e.g., obstetricians/gynecologists, certified nurse midwives, family practitioners, or those trained in obstetric care) to assess the state of the fetus in a pregnant patient. This, however, is not an expected standard of care in every ED nation-wide or a mandated competency for all ED providers. VA medical facilities should not have hand held fetal heart rate dopplers available without local policy to support their use to evaluate fetal heart rates by obstetric consultants.

(f) Obstetrics and Gynecology Emergencies.

1. VA EDs should ensure that processes (including local policies and agreements) are in place to provide standard emergency care to all pregnant women Veterans including stabilization and preparation for emergent maternal transport when facility capabilities are exceeded.

2. VA medical facilities should develop and implement written policies and processes (i.e., standard operating procedures) for managing obstetric and gynecologic emergencies that clearly describe onsite capabilities and processes/protocols for emergent patient transfer.

3. Processes for addressing obstetric and gynecologic emergencies will differ by facility depending on the availability of:

a. Obstetricians and gynecologists onsite, off-site through transfer to another facility, or via tele-gynecology consultation;

b. Onsite diagnostic and treatment resources (e.g., pelvic ultrasound, operating room capacity); and

c. Other community resources.

4. VA medical facilities should have a process in place to follow-up on cases transferred off-site to ensure appropriate quality assurance and integration of that care with ongoing care in VA.

(g) Special Considerations for Pregnant Women Veterans.

1. Pregnant women Veterans may present to a VA medical facility for routine care; for a pregnancy-related issue or for a medical issue not directly related to pregnancy. VA medical facilities should have information available that providers (e.g., Primary Care, PACTs, etc.) can give to pregnant women Veterans in advance. Such information should outline the patient's plan for their prenatal care and other medical care over the course of their pregnancy, and clearly define the offerings and limitations of the VA medical facility's ED or UCC as it pertains to the pregnant patient.

2. The MCC or their designees (e.g., PACT Coordinators, WVPM, etc.) should be involved in assisting pregnant women Veterans with arrangements for prenatal care and

for providing resources to help them obtain the care they need (VHA Handbook 1330.03). This should also include information related to non-VA maternity care.

3. Resources for pregnant women Veterans receiving maternity benefits through VA should include guidance describing where the pregnant Veteran should go in case of an emergency during her pregnancy (which is typically not to a VA ED or UCC).

(h) Care of the Pregnant Patient. A systematic approach to ED or UCC triage and initial assessment of the pregnant or potentially pregnant patient is essential. In particular, it is fundamental to ascertain clinically whether the presenting emergency problem:

1. Is due to the pregnancy (e.g., vaginal bleeding, abdominal/pelvic pain, preeclampsia);

2. Is unrelated to the pregnancy (e.g., sprained ankle, ear infection); or

3. Could affect the pregnancy (e.g., asthma, seizure, pyelonephritis, and hypertension).

*NOTE: See Appendix G for an example of a planned approach to these patients.*

(i) Transvaginal Pelvic Ultrasound. Transvaginal pelvic ultrasound is an essential diagnostic tool to provide comprehensive and safe care of women Veterans presenting with a myriad of pelvic conditions, especially ovarian torsion and ectopic pregnancy.

1. VA medical facilities caring for pregnant patients onsite should have:

a. Pelvic ultrasound (transvaginal) capability;

b. A radiologist skilled to interpret transvaginal ultrasound;

c. Quantitative and qualitative pregnancy testing; and

d. Access to specialty care providers (i.e., Ob/Gyn) available through consultation to assist with diagnosis and treatment.

2. Focused ultrasonography performed by duly credentialed emergency physicians to diagnose an intrauterine pregnancy is acceptable only if the interpretation of the results is formally entered into the medical record of the patient, and an appropriate quality assurance process is in place consistent with the American College of Emergency Physicians policy on ED Ultrasonography http://www.acep.org/clinicalpolicies/.

3. VA medical facilities must have a written plan that describes when these ultrasonography services are available onsite (i.e., 24 hours a day and 7 days a week, during normal business hours, nights, and weekends) and options for providing care when these services are not available onsite.

(j) Medication Availability.

1. Emergency contraception should be available to women Veterans at the time of the patient's visit to the VA ED and UCC when indicated 24 hours a day and 7 days a week.

2. Locally, VA medical facilities should develop a process to ensure availability of Rho(D) Immunoglobulin to prevent Rh Iso-immunization 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.

3. Methotrexate and misoprostol are medications that are commonly used to manage complications of early pregnancy such as ectopic pregnancy and miscarriage. VA medical facilities systems should have processes in place to make these medications available to appropriate specialty providers (i.e., consulting Ob/Gyn) when caring for pregnant women Veterans in the ED or UCC. Written policies or processes should also identify how care will be provided when emergent surgical management is needed for the conditions these medications treat, such as ruptured ectopic or incomplete miscarriage.

k. **Clinical Laboratory Improvement Amendments Testing and the ED/UCC.**

(1) VHA Directive 1106, Pathology and Laboratory Medicine Service, outlines the requirements that must be met to perform Clinical Laboratory Improvement Amendments (CLIA) Waived Laboratory Testing in EDs and UCCs.

(2) These tests should be performed under the purview of the facility laboratory, the local Laboratory Chief and the ancillary testing coordinator to ensure the processes comply with all regulatory requirements. EDs and UCCs should not apply for their own CLIA certificates. All testing performed is under the direct or indirect oversight of the Chief or Director of Pathology and Laboratory Medicine at the VA medical facility even if that facility has its own CLIA certificate. *See VHA Directive1106, Pathology and Laboratory Medicine Service, for additional requirements for CLIA testing.*

l. **Emergency Care of the Older Adult.**

(1) With the aging population, and an even greater representation of older Veterans using the VA health care system, the ED is uniquely positioned to play a role in improving care to the geriatric population. The expertise that the ED staff can bring to an encounter with a geriatric patient can not only meaningfully impact a patient's condition but also decisions about inpatient or outpatient care treatments. Effective emergency care of older Veterans can result in more cost effective care and ultimately better patient outcomes. (2013 GED Guidelines, pg. 3)

(2) VA is providing health care to increasing numbers of aging Veterans. ED Directors, GEC Chiefs or their designees, when applicable, Patient Aligned Care Team (PACT) Coordinators, and Associate Chiefs of Staff for Mental Health, or their

designees, should work together to develop processes to assist VA ED and UCC in providing and arranging care for aging Veterans.

(a) Staffing and administration for older adults:  EDs provide interdisciplinary care focused on the varying needs of the geriatric patient.  Staffing protocols should be considered and include geriatrics-trained providers, when available, and provide educational/training opportunities for all staff to ensure high-quality geriatrics care.

(b) Transitions of care:  Hospitalizations for older adults are associated with risk of delirium, nosocomial infections, iatrogenic complications, and functional decline.   For these reasons, reduction of avoidable admissions of the older Veteran is recommended.  Ensuring timely follow up and transition of care to facilitate continuity with outpatient care after discharge from the ED is important.

(c) Education about geriatric patients:  Improving the quality of care that older adults receive in the ED setting is predicated on education about care and approaches to elder patients directed toward the needs of the geriatric population.  Education content should be assessed and implemented based on specific policy and procedure initiatives tailored to individual department needs.  Recommended content includes the following:

1. Atypical presentations of disease

2. Trauma (including falls and hip fracture)

3. Cognitive and behavioral disorders

4. Modifications for older patients of emergency interventions

5. Medication management

6. Transitions of care and referrals to services

7. Pain management and palliative care

8. Effect of comorbid conditions

9. Functional impairments and disorders

10. Weakness and dizziness

11. Iatrogenic injuries

12. Elder abuse and neglect

13. Cross-cultural issues involving older patients in the ED

14. Ethics and advance directives

(d) Quality improvement initiatives:  For sites with geriatric emergency medicine expertise initiatives to improve the quality of geriatric emergency care are encouraged. Possible QI initiatives could monitor implementation and impact of the programs in a manner conducive to staff education and program success.  Specifically for older adult QI initiatives, the following items might be considered:

1.  Completion rates of at-risk screening tools

2.  Geriatric ED visit volume

3.  Geriatric admission rate

4.  Geriatric readmission rate

5.  Geriatric ED return visits within 72 hours

6.  Completion of follow up reevaluation for discharged patients

7.  Geriatric deaths

8.  Suspicion of geriatric abuse or neglect

9.  Geriatrics transfers to another facility for higher level of care

10.  Geriatric admission requiring upgrade of level of care to ICU within 24 hours of admission

11.  Other disease specific measures related to falls, urinary catheters, use of high risk medications, and delirium.

(e) ED equipment and supplies to care for older patients:  The physical plant should focus on structural modifications that promote improvements in safety, comfort, mobility, memory cues, and sensorial perception (both vision and hearing) for elders in the ED.

(f)  Policies, procedures, and protocols:  It is recommended that policies, procedures, and protocols be considered as part of routine care for geriatric patients in the ED and for syndromes associated with older adults.  These include screening of geriatric patients at risk of adverse outcomes, additional needs assessment, consultation and/or interventions.  Clinical order sets, clinical pathways, and/or note templates may be useful to standardize and efficiently manage certain geriatrics-specific conditions.  The suggested list is recommended as a comprehensive, directed, although not exhaustive list of challenges involved in the care of geriatric patients in the ED that may benefit from specific policies, procedures, and protocols:

1.  Triage and initial evaluation

2.  Initial screening tool to recognize and evaluate at-risk seniors

3.  Patient safety

4. Suspected elder/dependent adult abuse and neglect

5. Sedation and analgesia in the geriatric patient

6. Assessment and evaluation of delirium / agitation

7. DNR / MOLST (Medical orders for life-sustaining treatment) / Palliative care

8. Patient death

9. Urinary catheter placement guidelines

10. Falls risk assessment and management

11. Wound assessment and management

12. Transitions of care and follow up

13. Medication reconciliation, polypharmacy, potentially inappropriate medications in older adults

m. **Out of OR Airway Management.**

(1) Each VA medical facility with an ED/UCC must have a written policy in place regarding out-of-operating-room airway management (OOORAM) and a process for ensuring the competency of staff performing this task in responding to respiratory compromise events, including cardiopulmonary arrest, during all hours when patient care is provided. Please see VHA Directive 2012-032, Out of Operating Room Airway Management, or subsequent policy issue, for additional information.

(2) The OOORAM policy must include a statement that in extraordinary circumstances, where an individual with the demonstrated competency in airway management per the requirements of this policy is not available, clinicians, including clinical trainees, may exercise their judgment as to the appropriate response with the overarching goal being the care and safety of the patient. If this situation should occur, the facility Chief of Staff, or designee, must conduct an RCA as to why this vulnerability existed and initiate appropriate system fixes to minimize a repeat occurrence. In this situation, in rare instances it would be appropriate to ask the ED/UCC provider to assist if it is safe for him/her to leave the department. Arrangements must be made for ED/UCC coverage by a LIP during the ED/UCC provider's absence.

n. **Ensuring Correct Surgery and Invasive Procedures.** Any VHA health care provider performing a surgery or invasive procedure must complete specific steps to ensure that the procedure is performed on the correct patient, at the correct site, and with the correct implant, if applicable. Refer to VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures, for additional information.

o. **Program Restructuring and Inpatient Bed Change Policy.**

(1) All proposals to restructure programs or make changes to authorized or operating beds or program capacity must be entered into the web-based VA National Bed Control Database, and receive approval from the Under Secretary for Health and the VISN Director.

(2) Changes in ED or UCC status must follow the same process.  Contact with the Emergency Medicine Program Office should be the first step for any VA medical facility wishing to make changes to services being provided due to staffing or other challenges that are creating difficulty in meeting the needs of the Veterans trying to access emergency care.  For further information see VHA Handbook 1001.01, Inpatient Bed Change Program and Procedures.

p. **Ordering and Reporting Test Results.**  All test results must be communicated to the ordering provider or surrogate practitioner, within a timeframe allowing prompt attention and appropriate clinical action to be taken.  The ordering practitioner is responsible for communicating these results to the patient so they may participate in health care decisions. *NOTE: The Emergency Department should not be given primary responsibility for test results that are not life threatening.  For further details see VHA Directive 1088, Communicating Test Results to Providers and Patients.*

## 13.  REFERENCES

a.  VHA Directive 1036, Standards for Observation in VA Medical Facilities.

b.  VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, or subsequent policy issue.

c.  VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures.

d.  VHA Directive 1117, Utilization Management Program.

e.  VHA Directive 2012-032, Out of Operating Room Airway Management, or subsequent policy issue.

f.  VHA Directive 2007-015, Inter-Facility Transfer Policy, or subsequent policy issue.

g.  VHA Directive 1073, Moderate Sedation by Non-Anesthesia Providers.

h.  VHA Directive 2011-038, Treatment of Acute Ischemic Stroke (AIS), or subsequent policy issue.

i.  VHA Directive 2011-012, Medication Reconciliation, or subsequent policy issue.

j.  VHA Directive 2012-022, Reporting Cases of Abuse and Neglect.

k.  VHA Directive 1106, Pathology and Laboratory Medicine Service.

l.  VHA Directive 1088, Communicating Test Results to Providers and Patients.

m. VHA Handbook 1400.01, Resident Supervision.

n. VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures.

o. VHA Handbook 1100.19, Credentialing and Privileging.

p. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures.

q. VHA Handbook 1605.1, Privacy and Release of Information.

r. VHA Handbook 1000.01 Inpatient Bed Change Program and Procedures.

s. VHA Handbook 1101.04, Medical Officer of the Day.

t. VHA Handbook 1761.02, VHA Inventory Management.

u. VHA Handbook 1330.01, Health Care Services for Women Veterans.

v. VHA Handbook 1101.10, Patient Aligned Care Team (PACT) Handbook.

w. VHA Handbook 5007, Part II, Appendix F, Compensation of Consultants, Attending's and Others Employees on a Fee Basis Under 38 U.S.C. 7405.

x. VHA Handbook 5011/12, Part II, Appendix I, page II-I-10, Prescheduled Part-Time Tours and the Utilization of Adjustable Work Hours) Title 38).

y. VHA Handbook 0730, Security and Law Enforcement.

z. American College of Emergency Physicians (ACEP), October 2013, "Geriatric Emergency Department Guidelines".

aa. American College of Emergency Physicians (ACEP) Policy Statement, April 2014, "Emergency Department Planning and Resource Guidelines."

bb. Gilboy N., Tanabe P., Travers D.A., Rosenau A.M., Eitel D.R. Emergency Severity Index, Version 4: Implementation Handbook. AHRQ Publication No. 05-0046-2. Rockville, MD: Agency for Health care Research and Quality. May 2005.

**SUPERVISION OF PHYSICIAN RESIDENTS PROVIDING EMERGENCY CARE COVERAGE**

1. **Emergency Department Physician (sometimes called the Admitting Officer of the Day).** Physicians providing <u>independent</u> Emergency Department (ED) coverage must be credentialed, privileged, and fully licensed. ***NOTE:*** *Post-graduate year (PGY)-3 and above residents are normally subject to the same supervisory requirements as specified in paragraph 10 of this directive.* However, in a critical staffing emergency situation, permission to use a PGY-3 and above, non-board-eligible resident for sole, unsupervised coverage may be requested from the respective Veterans Integrated Service Network (VISN) Director. When such an emergency exists, the VISN Director may approve the use of a PGY-3 and above, non-board-eligible resident on a short-term, time-limited basis. In these rare instances, the resident must be appropriately credentialed and privileged and be an approved provider of Advanced Cardiac Life Support (ACLS) (see VHA Handbook 1100.19).

2. **Supervision of PGY-4 and above Board-Certified or Board-Eligible Residents**

    a. Physician residents who are board-certified or board-eligible may be privileged as independent practitioners for purposes of ED coverage. Privileges sought and granted may <u>only</u> be those delineated within the general category for which the resident is board-certified or board-eligible.

    b. Residents who are appointed as such, outside the scope of their training program (i.e., non-VA care), must be fully licensed, credentialed, and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for appointment, and they are subject to the provisions contained in VHA Handbook 1100.19, Credentialing and Privileging. Specialty privileges, which are within the scope of the resident's training program, may not be granted.

    c. Regarding documentation of attending supervision for ED care:

    (1) **Physical Presence.** The supervising practitioner for the ED must be physically present in the ED.

    (2) **ED Visits.** Each new patient to the ED must be seen by or discussed with the supervising practitioner. ***NOTE***: *Documentation of supervising practitioner involvement must be in accordance with paragraphs 15.a., 15.b.(1)-(4), and 15.c. of this directive.*

    (3) **Discharge from the ED.** The supervising practitioner, in consultation with the resident, ensures that the discharge of the patient from the ED is appropriate. ***NOTE:*** *Any of the four types of documentation referenced in paragraphs 15.b.(1)-(4) of this directive.*

## RECOMMENDED EQUIPMENT FOR THE ED/UCC

### I. General Equipment

a. Central station monitoring capability
b. Physiological monitors
c. Electrocardiogram (EKG) machine with automatic loading into EMR
d. Infusion pumps to include blood pumps
e. Intravenous (IV) poles
f. Linens, e.g., pillows, towels, wash cloths, gowns, blankets, blanket warmers, etc.
g. Medication dispensing system with locking capabilities
h. Nebulizer
i. Nurse-call system for patient use
j. Patient belongings or clothing bag
k. Peak flow meters
l. Personal protective equipment, e.g., gloves, eye goggles, face masks, gowns, head and foot covers
m. Access to PPE for disaster preparedness
n. Portable oxygen tanks
o. Security needs, including restraints
p. Separately wrapped instruments (specifics vary by department or service)
q. Stretchers
r. Tape measure
s. Thermometers, Routine and those capable of monitoring core temperature
t. Vascular Doppler
u. Weight scales
v. Wheelchairs

### II. Critical Care

a. Cardioverter/Defibrillator with monitor, battery and conductive pads
b. Adult "code" cart including carbon dioxide ($CO_2$) detectors or other esophageal detection devices
c. Pulse oximetry

### III. Basic Airway

a. Bag Valve Mask adult and pediatric size masks
b. Oxygen source
c. Clear Face masks (Various)
d. Oropharyngeal airways
e. Nasopharyngeal airways
f. Yankauer suction
g. Suction source
h. Pulse oximeter
i. Tongue Blades
j. Lubricants

**IV. Advanced Airway / Moderate Sedation (addition to basic)**

a. Endotracheal tubes various sizes
b. 10 ML syringe
c. Water-soluble lubricant
d. Wire Stylet (malleable)
e. Laryngoscope handles
f. Laryngoscope Batteries
g. Laryngoscope blades various styles and shapes
h. Benzoin adhesive
i. Tape
j. Commercial endotracheal tube holder
k. End tidal $CO_2$ monitor

**V. Difficult Airway**

a. Video-assisted Laryngoscopy equipment
b. Supraglottic airway device
c. Surgical Airway device
d. Other supplies as determined by local staff and consultants

**VI. Devices and kits**

a. Nasogastric tubes and suction supplies; Gastrostomy tubes for replacement
b. Paracentesis kit
c. Thoracenteseis kit
d. Self-contained Urinary catheters kits
e. Intraosseous Insertion device and needles
f. Lumbar puncture kits with Manometer
g. Central Line Access Bundle (CLAB) kits
h. Lumbar Puncture kit with manometer
i. Basic Wound closure kits
j. Needle driver
k. Scalpel
l. Iris scissors
m. Suture Scissors
n. Forceps
o. Metzenbaum
p. Hemostats
q. Skin closure tapes
r. Benzoin solution swabs or sprays
s. Skin Stapler
t. Staple remover
u. Gauze
v. Suture removal kit
w. Tissue Adhesive closure (Cyanoacrylates)
x. Additional equipment for plastic surgery or hand surgery cases
y. Obstetrical Delivery kit

**VII. Orthopedic casting and splinting supplies**

    a. Cotton padding various widths
    b. Stockinet various
    c. Elastic Bandage various
    d. Slings various
    e. Plaster strips or rolls various sizes
    f. Fiberglass strips or rolls various sizes
    g. Heavy scissors
    h. Cast cutter unless readily available for orthopedic service
    i. Splints
    j. Plaster and commercial finger splints, ankle stirrups, knee immobilizer
    k. Ring cutters
    l. Crutches various sizes
    m. Canes
    n. Knee immobilizers
    o. Ankle Stirrups

**VIII. Ophthalmology/ENT**

    a. Slit lamp
    b. Tonometer
    c. Fluorescein
    d. Acuity chart
    e. Epistaxis kit
    f. Cerumen removal kit

**IX. Ultrasound Machine and probes**

    a. Coupling gels and reprocessing set-up
    b. Probes
    c. Vascular Linear Sequenced High Frequency
    d. Abdominal Curved Sequenced low frequency
    e. Endovaginal Microcurved High Frequency
    f. Cardiac Low-frequency Phased array

**X. Business and Administrative function**

    a. Capability to display EDIS board on large screens
    b. Triage Station
    c. Professional Staff work station
    d. Social work supplies
    e. Registration and Update
    f. Communication with local Emergency Medical System ambulances
    g. Wrist Band printer
    h. Conference Room
    i. Resident space as needed
    j. Access to electronic and paper resource material

## RADIOLOGIC, IMAGING, AND OTHER DIAGNOSTIC SERVICES

*NOTE:* The specific services available for emergency patients in an individual facility Emergency Department (ED) or Urgent Care Center (UCC) needs to be determined by the Medical Director of the ED/UCC in collaboration with the directors of the diagnostic services and other appropriate individuals.

**1. The following are to be readily available 24-hours a day for emergency patients and during hours of operation for UCC patients:**

   a.  Standard radiologic studies of bony and soft-tissue structures.

   b.  Standard and Portable chest radiographs for acutely ill patients and for verification of placement of endotracheal tube, central line, or chest tube.

   c.  Computed Tomography with reconstruction.

   d.  Emergency ultrasound services for the diagnosis of obstetric or gynecologic, cardiac, and hemodynamic problems and other emergent conditions.

**2. The following services are to be available on an urgent basis. They are to be provided by staff in the medical facility, or by staff to be called in to respond within a reasonable period of time, or by facility agreement:**

   a.  Venous Doppler.

   b.  Interventional radiology (IR).

   c.  Magnetic resonance imaging (MRI).

   d.  Contrast arteriography.

**RECOMMENDED LABORATORY CAPABILITIES**

The facility Medical Director of the Emergency Department (ED) or Urgent Care Center (UCC) and the Director, Laboratory Services need to develop guidelines for availability and timeliness of services for an individual hospital's ED/UCC.  The following laboratory capabilities are suggested for medical facilities with 24-hour EDs and for UCCs during operational hours.  ***NOTE:***  *This list may not be comprehensive.*

## 1.  Blood Bank

  a.  Bank products availability and
  b.  Type and cross-matching capabilities.

## 2.  Chemistry

  a.  Ammonia;
  b.  Amylase;
  c.  Anticonvulsant and other therapeutic drug levels;
  d.  Arterial blood gases;
  e.  Bilirubin (total and direct);
  f.  Calcium;
  g.  Carboxyhemoglobin;
  h.  Cardiac iso-enzymes;
  i.  Chloride (blood and cerebrospinal fluid (CSF);
  j.  Creatinine;
  k.  Electrolytes;
  l.  Ethanol;
  m. Glucose (blood and CSF);
  n.  Hepatic panel;
  o.  Lipase;
  p.  D-Dimer;
  q.  Osmolality;
  r.  Protein (CSF);
  s.  Serum magnesium;
  t.  Troponin;
  u.  Urea nitrogen; and
  v.  Lactate.

## 3.  Hematology

  a.  Cell count and differential (blood, CSF, and joint fluid analysis);
  b.  Coagulation studies;
  c.  C-reactive protein (CRP);
  d.  Erythrocyte sedimentation rate;
  e.  Platelet count;
  f.  Sickle cell preparation.

4. **Microbiology**

   a. Acid fast smear or staining;
   b. Chlamydia testing;
   c. Counter immune electrophoresis for bacterial identification;
   d. Gram staining and culture or sensitivities;
   e. Strep screening;
   f. Viral culture;
   g. Wright stain;
   h. Influenza A PCR;
   i. HIV Rapid Test; and
   j. Urine Legionella and Streptococcus Antigen.

5. **Other**

   a. Hepatitis screening;
   b. Human Immunodeficiency Virus (HIV) screening;
   c. Joint fluid and CSF analysis;
   d. Toxicology screening and drug levels;
   e. Urinalysis;
   f. Mononucleosis spot;
   g. Serology (syphilis, recombinant immunoassay);
   h. Pregnancy testing (qualitative and quantitative); and
   i. Herpes testing.

6. **Point of Care Testing (if Needed)**

   a. Glucose monitoring;
   b. Cardiac marker (Minimally troponin);
   c. Urine pregnancy;
   d. Urine dipstick;
   e. Fecal occult blood;
   f. Arterial Blood gas analysis with Lactate (results available to the ED within 10 minutes);
   g. Hemoglobin Co-oximetry; and
   h. IStat chemistry.

## SUGGESTED PHARMACOLOGICAL AND THERAPEUTIC DRUGS FOR EMERGENCY DEPARTMENTS (EDs)

The facility Medical Director of the Emergency Department or the Urgent Care Center (UCC) (ED), representatives of the medical staff, and the facility Director, Pharmacy Service, need to develop a formulary of specific agents that is consistent with VHA's general formulary for use in an individual medical facility ED.  These include:

1.  Analgesics, both narcotic and non-narcotic;

2.  Anesthetics including topical, infiltrative, and general anesthetics;

3.  Anticonvulsant;

4.  Antidiabetic agents;

5.  Antidotes including antivenins, if applicable;

6.  Antihistamines;

7.  Anti-infective agents (systemic and topical);

8.  Anti-inflammatories both steroidal and non-steroidal;

9.  Bicarbonates;

10.  Blood modifiers such as anticoagulants to include fibrinolytics, anti-platelet and anti-thrombin agents, and hemostatic, i.e., systemic, topical, plasma expanders, or extenders;

11.  Burn Preparations;

12.  Cardiovascular agents as:  ace inhibitors, adrenergic blockers, adrenergic stimulants, Alpha and Beta blockers, antiarrhythmic agents, calcium channel blockers, digoxin antagonist, diuretics, vasodilators, and vasopressors;

13.  Cholinesterase inhibitors;

14.  Diagnostic agents such as blood contents, stool contents, testing for myasthenia gravis, and urine contents;

15.  Electrolytes, such as cation exchange resin, electrolyte replacements, and parenteral and oral fluid replacement solutions;

16.  Gastrointestinal agents such as antacids, anti-diarrheals, emetics and anti-emetics, anti-flatulent, anti-spasmodics, bowel evacuants and laxatives, histamine receptor antagonists, and proton pump inhibitors;

17.  Glucose elevating agents;

18.  Hormonal agents such as oral contraceptives, steroid preparations, and thyroid preparations;

19.  Hypocalcemia and hypercalcemia management agents;

20.  Lubricants;

21.  Migraine preparations;

22.  Muscle relaxants;

23.  Narcotic antagonist;

24.  Nasal preparation;

25.  Ophthalmologic preparations;

26.  Otic preparations;

27.  Oxytocics;

28.  Psychotherapeutic agents;

29.  Respiratory agents such as antitussives, bronchodilators, decongestants, leukotriene antagonist;

30.  $Rh_0$ (D) immune globulin;

31.  Salicylates;

32.  Sedatives and hypnotics;

33.  Vaccinations; and

34.  Vitamins and minerals.

**SUGGESTED VA ED/UCC GYNECOLOGY EQUIPMENT, TESTS AND SUPPLIES**

***NOTE:*** *It is recommended that all gynecologic examination supplies are stored together (i.e. assembled into a kit, on a dedicated cart, or in a designated supply location). Most commonly used supplies and instruments (e.g., speculums, ring clamp, 4x4 gauze pads, large cotton applicators) can be assembled into pre-packaged kits. A focused light source for speculum examinations is essential.*

**1. EQUIPMENT:**

   a.  Mobile cart to hold equipment and supplies for easy provider access during exam.

   b.  Table/stretcher with footrests.  The stretcher should have a bottom that lowers or footrests at the end.  ***NOTE:*** *The exam table/stretcher should face away from the door or area of foot traffic.*

   c.  Focused standing light source:

   (1) Standing or

   (2) Speculum light.

**2. INSTRUMENTS:**

   a.  Speculums in several sizes (small, medium, large, and pediatric size).

   (1) The speculums should be of several types and styles (e.g., Pedersen, Graves, and pediatric).

   (2) Lighted speculums are recommended however, if unavailable, an external focused standing light source is necessary.

   b.  Forceps (Ring, Kelly, Adson; long alligator; long, curved uterine dressing).

   c.  Scissors (regular and long Mayo).

   d.  Suture kit (needle driver, curved and straight hemostats, forceps with teeth).

   e.  Single and or double tooth tenaculum.

   f.  Word catheters (for management of Bartholin cyst).

   g.  Scalpels (blades #15, #10, and #11).

3. **TESTS:**  DNA probe for gonorrhea and chlamydia testing:

   a.  Probe or wet prep (Clinical Laboratory Improvement Amendment (CLIA) waived) for evaluation of vaginitis (e.g., Affirm®).

b.  Point of care pregnancy test kits (CLIA waived).

**4.  SUPPLIES:**

a.  Sterile boxes of 4x4 gauze.

b.  Betadine and non-iodine antimicrobial solutions.

c.  Silver nitrate sticks.

d.  Dermal biopsy punches (various sizes).

e.  Chux pads or equivalent.

f.  Feminine pads and tampons (regular and super-size).

g.  Lubricant (e.g., in packets, water-based lubricant as Surgilube®).

h.  Extra-large cotton applicators (e.g., Phoenix Rayon Swabs).

i.  Single cotton tip applicators.

j.  Female patient gowns (regular and large sizes).

**5.  MEDICATIONS THAT REQUIRE ACCESS 24 HOURS PER DAY AND SEVEN DAYS PER WEEK:**  Access is possible via dispenser in ED and UCC or an onsite pharmacy.

a.  Emergency contraception, at least one: Levonorgestrel (e.g., Plan B One-Step® and equivalents) or uliprisal (e.g., ella®).

b.  Misoprostol and/or Methergine.

c.  Rho(D) immune globulin (e.g., Rhogam) from Blood bank for Rh-negative pregnant women who have vaginal bleeding or abdominal/pelvic trauma (if not available onsite, design process for obtaining).

d.  Hormones to treat dysfunctional uterine bleeding.

e.  Antibiotics.

f.  If applicable, processes should be established for methotrexate use for ectopic pregnancy.

**6.  SUPPLIES IN OBSTETRIC DELIVERY KIT:**

a.  Bulb syringe.

b.  Sterile scissors.

c. Cord clamps (four on hand at all times).

d. Container for placenta.

e. Infant/baby warmer.

## SUGGESTED PLANNED APPROACH TO CARE FOR PREGNANT PATIENTS

1.  The following treatment algorithm outlines a suggested planned approach to care for pregnant patients:

     a.  Pregnant patients who present to the Emergency Department (ED) or Urgent Care Center (UCC) at less than 20 weeks gestation, by dates or by history, should be evaluated by the Department of Veterans Affairs (VA) ED or UCC provider, and either treated in the ED or UCC or assessed for potential transfer for treatment, if appropriate.

     b.  Pregnant patients who present to the ED or UCC at 20 or more weeks gestation, by dates or by history, with pregnancy-threatening symptoms such as abdominal/pelvic pain, vaginal bleeding, or lack of fetal movement should be evaluated by the emergency physician (EP) immediately.  These patients should be taken directly to OB triage, if it exists at the VA medical facility, or transferred emergently to a facility that can manage such cases.  The patient must be stabilized prior to transfer unless delays would result in more significant problems.

     c.  Pregnant patients who present to the ED or UCC at 20 or more weeks of gestation, by dates or by history, with a life-threatening event including trauma-induced events, should be evaluated by the EP immediately and stabilized.  The EP should consult with an obstetrics provider (in person or by phone) to determine whether or not the patient should be transported to a facility that can provide appropriate emergent obstetrical management and other necessary emergent care.  Stabilization of the pregnant patient is critical in a life-threatening situation.

     d.  Pregnant patients who present to the ED or UCC with a non-obstetrical complaint that is non-threatening to maternal/fetal well-being (e.g., broken arm, laceration requiring stitches) should be evaluated and treated in the ED or UCC.

     e.  Consultation with the patient's obstetric provider is important in all cases to assist in care management and arrange timely outpatient follow-up.  Such consultation should be used if there are questions about the safety and/or appropriateness of particular tests or treatments.

     f.  Pregnant patients may present to a VA ED or UCC facility in labor, some with imminent delivery.  Most VA ED and UCC facilities do not have labor and delivery capabilities.  However, they may need to provide emergency care during the delivery (i.e., precipitous delivery) and prepare for transfer of the patient and infant as soon as possible post-delivery.  Transfer processes for such should be in place in advance.

2.  ED and UCC providers should ensure that all pregnant patients who present to the ED or UCC have appropriate follow-up arrangements.  Processes for notifying the Maternity Care Coordinators, or their designee, or Patient Aligned Care Team Coordinators to facilitate care coordination and follow-up needs should be identified.

## EMERGENCY MEDICINE IMPROVEMENT (EMI) INITIATIVE

The EMI Initiative is a strategic initiative of the VA National Director of Emergency Medicine to improve emergency care services provided by VHA to Veterans.

a.  The EMI Initiative has emerged from multiple initiatives underway since 2007 specifically to improve the reliability, efficiency, and quality of emergency care services provided by VA.  The standardization of ED and UCC operations around best practices across VA has been a key focus for maturing the program.  Increased efficiency, safety, and quality of care through improvements in the flow of patients into, thru, and out of EDs and UCCs has been another key focus.  In addition, the deployment of evidence-based emergency care delivery protocols and pathways is a focus for improving the quality of care delivered in EDs and UCCs.  The EMI Initiative is intended to provide a logical framework for planning, communicating and managing these activities.

b.  Emergency services are currently being provided by VA through EDs or UCCs located at VA medical facilities.

c.  EMI Goals and Objectives.

(1) The goal of the EMI Initiative is to improve the quality of emergent and urgent care provided to Veterans through VA EDs and UCCs.  Its scope includes operations performed and clinical services provided in all EDs and UCCs.  The quality improvement focus has, as its foundation, VA's overall commitment to patient–centered care and includes a focus on responsiveness to Veteran's needs, operational efficiency and reliability, and clinical service quality.

(2) The EMI Initiative is a formalization of activities and projects that began within Emergency Medicine to improve operations through the implementation of patient tracking software.  As those activities and projects have evolved and the focus of activity has shifted from initial IT system implementation (i.e., "means") to the design and implementation of improvement metrics and strategies (i.e., "ends") a more formal approach to planning, managing, and communicating is required.  The EMI Initiative provides that framework.

(3) Four initial objectives have been defined to guide activities carried out through the EMI Initiative to accomplish this goal:

(a) <u>Objective 1.</u>  Reduce elapsed time of ED/UCC visits by eliminating delays and time patients spend waiting for service.

(b) <u>Objective 2.</u>  Reduce missed opportunities to provide care to patients who choose to leave the ED/UCC without being treated because of delays and time required to obtain service.

(c) <u>Objective 3.</u>  Standardize ED/UCC operations to maximize efficiency across the system by improving the ability to compare performance and share best practices.

(d) <u>Objective 4.</u>  Standardize emergency care services around evidence-based protocols to ensure high-quality care across the system.

(4) The EMI Initiative is following an improvement strategy that recognizes the important role IT can play in accomplishing EMI Initiative goals and objectives if appropriately integrated into broader operational and clinical solutions, and guided by a focus on performance improvement.

**EMERGENCY MEDICINE NATIONAL SUPPORT RESOURCES**

a. **Emergency Medicine Field Advisory Committee.** The Emergency Medicine Field Advisory Committee (EMFAC) is the principal advisory body for emergency medicine in the Office of Specialty Care Services (SCS) and the Office of Patient Care Services (PCS). This Committee is made up of four to eight field-based representatives from across the country each serving a 3-year term with possible reappointment. Reappointment terms may be less than 3 years, as noted in the following paragraphs. All EMFAC members must be VA employees.

(1) The EMFAC Manager (the National Director for Emergency Medicine) is responsible for appointing the EMFAC Chairperson and Vice Chairperson with the concurrence of the Chief Consultant, SCS, in the Office of Patient Care Services. These two appointments come from the active committee members of the EMFAC and may serve an additional 3 years.

(2) The EMFAC Manager and Chairperson are responsible for selecting and appointing the general committee membership.

(3) Approximately one-third of the EMFAC membership is replaced each year after the first 3-year appointment.

(4) Appointments may be terminated and replacements added by the EMFAC Manager or Chief Consultant, SCS, at any time.

b. **Veterans Integrated Service Network EM Committees.** The EMFAC strongly encourages the formation of Veterans Integrated Service Network (VISN)-level EM committees composed of EM providers and EM nurses to facilitate communication among the EM providers in the VISN and to enhance communication with this group's EMFAC representative and the VA National Director for EM. These committees should meet monthly and identify a lead to report to the VISN EMFAC representative prior to the monthly EMFAC meeting. *NOTE: It is expected that all VISNs will have some facilities willing to participate; however, participation is strongly encouraged by all members of the VISN EM/UCC community. Each VISN EM Committee should select a Chairperson who summarizes committee discussions and reports a summary of these discussions to their respective EMFAC member on a monthly basis.*

c. **EM Electronic Site Directory.** The EM Electronic Site Directory has been developed to provide a single source of information about VHA ED and UCC sites.

(1) The EM Electronic Site Directory provides three kinds of information:

(a) Facility Information—information about VA medical facilities in which Emergency Medicine operates EDs and/or UCCs.

(b) ED/UCC site information—key contacts and characteristics about Emergency Medicine operations.

(c) ED/UCC site resources—identifying the number of ED beds in use and provider and nursing coverage hours at each site.

(2) The EM Site Directory also provides capabilities for updating that information and managing access to updating tools.   Updates must be performed by EMFAC members and/or the National Director only.

(3) Access to the EM Site Directory is provided through the Emergency Medicine Improvement Initiative (EMI) SharePoint site: https://vaww.rtp.portal.va.gov/OQSV/10A4C/SRD/cfmprogram/EmMedII/SitePages/Home.aspx and https://secure.vssc.med.va.gov/HSIPC/EM_SITE_DIR.aspx. ***NOTE:*** *These are internal VA Web sites that are not available to the public.*

d.  **Emergency Department Integration Software.**  EDIS is a software package that incorporates several Web-based views that extend the current Computerized Patient Record System (CPRS) to help health care professionals track and manage the flow of patient care in the ED and UCC setting.  EDIS views are based on a class-three application developed by the Upstate New York Veterans Health Care Network (VISN 2).  Most views are site-configurable.

(1) EDIS enables users to:

(a) Add ED patients to the application's display board.

(b) View detailed information about patients on the display board.

(c) Edit patient information.

(d) Remove patients from the display board.

(e) Search, edit and restore patients to the display board.

(f)  Create administrative reports.

(2) The application also includes views for entering patients' dispositions, removing patients from the display board, and configuring the display board.  Data captured during the course of patient care in the ED/UCC populates reports that are available on both EDIS and the Emergency Medicine Management Tool (EMMT), discussed below. Proper implementation and utilization of EDIS for patient tracking and data capture is mandated by VHA Directive 2011-029, Emergency Department Integration Software (EDIS) for Tracking Patient Activity in VHA EDs and UCCs, or subsequent policy issue. EDIS can be accessed at:  https://vaww.edisprod2.med.va.gov/main/login/login.jsp. ***NOTE:***  *This is an internal VA Web site that is not available to the public.*

(3) Clicking on the greyed out circular tab with a question mark inside it in the upper right corner of the EDIS desktop on any page will take users to the index for further assistance.

    e. **Emergency Medicine Management Tool.**

    (1) EMMT is a process analysis and reporting tool that provides information about the operational performance of VA EDs and UCCs.  It uses data collected from utilization of the EDIS tracking software program to generate daily patient flow and productivity metrics for each ED/UCC and provides access to those metrics through standard reports, performance dashboards, and a process analysis tool.

    (2) The EMMT supports the Emergency Medicine Improvement initiative.  EDIS data derived from the use of EDIS, and the EMMT are key tools for accomplishing EMI initiative goals.

    (3) EMMT provides a National roll-up of EDIS data that allows users to see how their site is performing on key metrics in comparison to other EDs/UCCs.  EMMT also provides access to standard reports that mirror reports available on EDIS today with additional patient-level information provided.  These reports will eventually replace EDIS reports and will also provide access to new National reports for tracking productivity and EDIS adoption metrics.  Additional national reports will be added in the future.

    (4) Additional Information on EMMT can be obtained by accessing the EMMT User Manual from the tab located in the upper section of the management tool.

    (5) The EMMT site is accessed via the VSSC's intranet site at http://vssc.med.va.gov/  EMMT is found under the VSSC Quality & Performance section and is classified as a Utilization Management product.

## EMERGENCY MEDICINE DEPARTMENT ADMINISTRATION

EM/UCC Department Status:

a.  Whenever and wherever possible, a facility Emergency Medicine Department must be designated to manage and oversee the ED and associated teaching, research, and other administrative programs and activities.  VA medical facilities with EDs that have an Emergency Medicine academic affiliation in place, or in the planning phase, must have a designated department to parallel the medical school organization and to comply with Residency Review Committee (or equivalent committee) requirements.

b.  VA medical facilities whose mission, staffing, and resources limit the ability to support the ED in the manner described in paragraph 7.a.(1) above should establish as much ED autonomy and authority as possible.  For example, if a well-organized ED is currently administered by Medicine-Ambulatory Care Services, an ED Medical Director who has experience and an understanding of emergency medicine practice must be designated and given primary authority to manage the ED operations and related programs.

c.  Oversight and management of the ED should be the primary responsibility of the ED Medical Director and he/she should report directly to the Chief of Staff.  In addition, this ED Medical Director must be given membership on the Medical Staff Executive Committee (or equivalent committee) and be provided with dedicated administrative support to assist in monitoring reports, completion of Ongoing Professional Practice Evaluations (OPPE), and other administrative duties important and necessary to manage the ED efficiently.  ***NOTE:***  *As available resources and capabilities improve in these facilities, evolution towards implementation of the full Emergency Medicine model described in paragraph 7.a.(1) is expected.*

d.  The EMFAC and the VISN Emergency Medicine Committee serve as a resource to VA medical facilities as they develop and evolve these emergency medicine and ED initiatives.

e.  It is expected that similar arrangements will be made for UCCs as described in paragraphs 7.a.(1)-(4) above.  A UCC Medical Director who has experience and an understanding of emergency medicine practice must be designated and given primary authority to manage the UCC operations and related programs, have some degree of administrative support, and report directly to the Chief of Staff.