

Manual M-2, Clinical Affairs/Programs. Part I, General

Chapter 7, Outpatient Diagnosis and Treatment (Paragraphs 7.01 through 7.05)

Revises Chapter 7 dated September 9, 1959

This document includes:

Memorandum, dated **July 23, 1985**

Contents page for M-2, dated **June 1989**

Title page and title page verso for M-2, Part I, dated **February 9, 1990**

Contents page and Rescissions pages for M-2, Part I, dated **April 7, 1995**

Contents page for Chapter 7, dated **February 9, 1990**

Text for Chapter 7, dated **September 19, 1985** (Change 75)

Transmittal sheet located at the end of the document:

Change 75, dated **September 19, 1985**

Changes prior to 1985 located at the end of the document:

Change 12, dated **September 9, 1959**

Change 6, dated **January 15, 1958**



Veterans
Administration

Memorandum

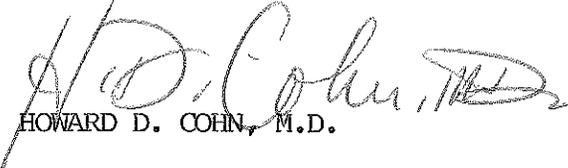
Date:

From: Actg. ACMD for Clinical Affairs (11)

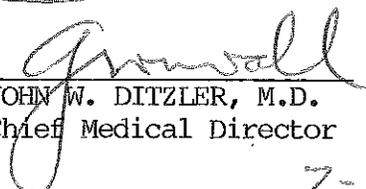
Subj: Redesignation of Manual M-2

To: Director, Regulations and Publications (10A1B)

VA Department of Medicine and Surgery Manual M-2, "Professional Services," has been redesignated as VA Department of Medicine and Surgery Manual M-2, "Clinical Affairs."


HOWARD D. COHN, M.D.

APPROVED/DISAPPROVED:


JOHN W. DITZLER, M.D.
Chief Medical Director

7-23-85

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07/29/85
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Regulations and Publications
Management Staff (10A1B)

June 1989

M-2 MANUALS

M-2

Part I General

Part II Chaplain Service

Part III Dietetic Service

Part IV Medical Service

Part IV Nuclear Medicine Service

Part V Nursing Service

Part VI Pathology & Allied Sciences Service

Part VI Drug Dependency Treatment Program

Part VII Pharmacy Service

Part VIII Physical Medicine & Rehabilitation Service

Part IX Prosthetic & Sensory Aids Service

Part X Psychiatry, Neurology & Psychology Service

Part XI Radiology Service

Part XII Social Work Service

Part XIII Medical & General Reference Library Staff - *Rees (see M-8, Pt III 8/14/87)*

Part XIV Surgical Service

Part XV Resc. by M-2, Part IV, Chg. 6(11-62) Pulmonary Disease (TB) Service

Part XVI Resc. by M-2, Part X (4-65) Vocational Counseling Service

Part XVII Voluntary, Service - *M-1, Pt I, Ch 3*

Part XVIII Audiology & Speech Pathology (II 10-66-20, 6-8-66)

Part XIX ~~Extended Care Service (Domiciliary)~~ *Replaced by M-5* ~~Spinal Cord Injury~~

XX Nuclear Medicine

XXI Vocational Counseling Service

XXII Prosthetic & Sensory Aids Service

XXIII *Blind Rehabilitation Service*

XXIV *Spinal Cord Injury*

**DEPARTMENT OF
VETERANS AFFAIRS**

PROGRAMS

**CLINICAL AFFAIRS
GENERAL**

**M-2, Part I
February 9, 1990**

**Veterans Health Services and
Research Administration
Washington, DC**

Department of Veterans Affairs
Veterans Health Services and
Research Administration
Washington, DC

February 9, 1990

Department of Veterans Affairs, Veteran Health Services and Research Administration
Manual M-2, "Clinical Affairs," Part I, "General," is published for the compliance of all
concerned.

John A. Gronwall, M.D.
JOHN A. GRONWALL, M.D.
Chief Medical Director

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Printing Date: 2/90

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RESCISSIONS

The following material is rescinded:

1. COMPLETE RESCISSIONS

a. Manuals

Par. 112f, M10-3.

Pars. 129f and 169, M10-6.

M-2, Part I, changes 2 through 5 through 9, 11, 12, 13, 14, 16, 18 through 21, 25, 30, 32 through 40, 41, 44, 45, 49, 50, 51, 52, 55, 57, 60.

VHA Supplement MP-1, Part I, Chapter 2, Section A and Appendices D and E, change 43, dated October 27, 1987 (Effective October 1, 1992).

VHA Supplement MP-1, Part I, Chapter 2, Section A, change 44, dated July 26, 1991 (Effective October 1, 1992).

M-2, Part I, Chapter 35, dated August 7, 1992 and Supplements 1 and 2.

b. Interim Issues

II 10-156

II 10-161

II 10-184

II 10-188

II 10-270

II 10-292, pars. I, II, III, App. A

II 10-300

II 10-381

II 10-68-31

II 10-71-33

II 10-71-26 by M-2, part I, chg. 67

II 10-82-53 de facto by chg. 74

II 10-83-7 by chg. 74

c. Circulars/Directives

261, 1946, Sec.1

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10-86-37 by chg. 78

00-87-23

10-91-059

10-91-101

10-92-038

10-92-056

c. Circulars/Directives Continued

- 10-92-105 and Supplement 1
- 10-93-004
- 10-93-009
- 10-93-130
- 10-93-136
- 10-93-151

d. Regulations and Procedure

- R&P 6202
- R&P 6203
- R&P 6205
- R&P 6206

e. Technical Bulletins

- Par. 2, TB 10A-191
- Pars. 1b, 2 through 5, 6a and 9c, TB 10A-246
- TB 10A-256
- TB 10A-295 (except sec. XXI)
- TB 10A-359
- TB 10A-324 (This completes the rescission of TB 10A-324.)

f. AB Station Letters and Other Communications

<u>Date</u>	<u>Subject</u>
December 5, 1949	Officer of the Day Reports
March 3, 1952	Furnishing of Meals to Officers of the Day
April 8 1952	Domiciliary Care for Paraplegics
April 16 1952	Transfer of Quadriplegic Patients
April 17, 1952	Accomplishment of Recheck Examinations and Treatment of current Conditions Involving Paraplegics at VA Hospitals Other Than Paraplegia Centers.
June 23, 1952	Monthly Report of Service-Connected Blinded Veterans and Blinded Military Personnel
August 18, 1952	Proposals for Membership, American College of Physicians
September 19, 1952	Establishment of Paraplegia Organizational Segment
January 4, 1954	Certificate of Medical Feasibility, VA Form 4555b

g. Instructions (pertaining to Public Law 702, 80th Congress, as amended)

- Pars. 2d and 2e, Inst. 1-B
- Inst. 1C
- Inst. 1-D

2. LIMITED RESCISSIONS

The following material is rescinded insofar as it pertains to this manual.

a. Manuals

- M10-3, par. 115h

a. Manuals - Continued

M10-6, pars. 9b, 42e, 70c, 86, and 132h
M10-11, pars. 22b, 92e, 96d, 133b, and 172

b. Circulars

10-65-57, pars.2 and 3

c. Regulations and Procedure

R&P 6130

d. Technical Bulletins

TB 10A-324

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CHAPTER 7. OUTPATIENT DIAGNOSIS AND TREATMENT

7.01 POLICY

a. It is the policy of the VA to deliver the highest quality of health care in the most efficient mode to assure cost effective examination and treatment to the largest number of eligible veterans. To carry out this policy requires the full integration of all inpatient and outpatient health care services. Inpatient or outpatient care is a modality of health care to be utilized upon professional judgment in conjunction with the veteran's entitlement for service. For this policy to succeed, it is essential that local management assure that all outpatient services are fully integrated with inpatient services.

b. In keeping with currently accepted medical practice, the local Clinical Executive Board will develop criteria for which procedures, if any, are prohibited from being provided on an outpatient basis. While no specific procedures are contained in this chapter as being prohibited, such limitation may exist in currently published DM&S circulars or other appropriate VA directives. The Clinical Executive Board will conform with such directives when developing a local policy to present to the facility Director for approval.

c. Since outpatient diagnosis and treatment is only a modality of health care services, no separate service will be created to deliver admitting or outpatient services. The direct responsibility for the provision and quality of such services belongs to the appropriate service chief in a respective discipline.

7.02 PROGRAM DIRECTION

a. Each VA medical center will utilize the most efficient mode of health care which is appropriate for the service being provided (i.e., ambulatory surgery versus inpatient surgery, outpatient mental health care versus hospitalization, etc.).

b. Preadmission diagnostic testing should be utilized to reduce inpatient length of stay and to avoid unnecessary hospitalization.

c. Clinic hours should be scheduled to enable the highest cost effective utilization rate per examining room per day.

d. Diagnostic and consultative services (i.e., Radiology, Laboratory, Nuclear Medicine, etc.) should provide the appropriate support to the ambulatory care program so that physicians do not admit patients only to obtain timely services.

7.03 GENERAL PRINCIPLES

a. There will be a qualified staff physician who is at least 5/8 time (7/8 for Associate Chief of Staff for Ambulatory Care and Chief Medical Officer) designated to be responsible for the administrative management of all ambulatory health care activities.

b. The physician responsible for the administrative management of the outpatient program will spend the majority of regular duty hours in the ambulatory care area.

c. Physicians working in the outpatient unit should be involved with the activities of the inpatient service. Inpatient physicians should also be involved with the delivery of outpatient health care activities.

d. Every attempt should be made to assure the necessary physician coverage to foster continuity of patient care.

e. Each general and specialty clinic must be attended or supervised by a staff practitioner (including Consultant and Attending) who has clinical privileges in the discipline represented by the clinic.

f. There needs to be a master multidisciplinary staffing plan that clearly defines the number, type, and level of personnel assigned to each clinical service/program in the outpatient area.

g. The evaluation of outpatient services must be fully integrated into the facility's overall quality assurance program.

h. For a minimum of 90 percent of the scheduled outpatients, the medical record should be available when the patient is seen in the clinic.

i. Ninety-five percent of all walk-in patients should be evaluated by a health care professional within 10 minutes of initial contact. This evaluation must include a determination of the patient's health condition (including vital signs) and a decision regarding the appropriate level of care (emergency/nonemergency) needed.

7.04 ADMINISTRATIVE COORDINATION OF OUTPATIENT ACTIVITIES

a. As stipulated in paragraph 7.03a, the day-to-day medical direction of outpatient health care activities must be assigned to a specific physician. At medical centers, this individual is either an ACOS/AC (Associate Chief of Staff for Ambulatory Care), or a staff physician who performs this responsibility in addition to other duties. At a satellite clinic, this individual is typically the CMO (Chief Medical Officer). At an independent clinic, this individual is the Chief of Staff.

b. The major responsibilities performed by either an ACOS/AC or a staff physician, who has been designated administratively responsible for coordinating and/or directing ambulatory care activities in addition to other duties, include such facets as staffing patterns, space utilization, patient flow, equipment acquisition and maintenance, evaluation of patient care quality, education, and research.

c. The Ambulatory Care arena functions in a matrix setting that requires the skillful interaction of a number of administrative and clinical disciplines. Whether directed by an ACOS/AC or not, it is incumbent upon the physician administratively in charge of the outpatient activities to ensure compliance with facility requirements. This physician is functioning in a management role and in that role is responsible for ensuring that administrative and reporting requirements are complied with. In this regard, it is crucial that the various elements of the Medical Administration Service work with this individual to ensure both accurate and timely clinical and administrative reporting systems.

d. The position of ACOS/AC:

(1) This position is centralized to the Chief Medical Director. The day-to-day operation of the program has been delegated to the ACMD for Clinical Affairs.

(2) VA medical centers may apply to VA Central Office (10BA__/11) for the approval to establish this position if they meet the following criteria:

(a) At least 50,000 outpatient visits per year; and

(b) Outpatient clinics are held in at least three of the following clinical disciplines: medicine, surgery, neurology and psychiatry.

(3) The ACOS/AC candidates will:

(a) Be a Doctor of Medicine or Osteopathy.

(b) Be board-certified in a medical specialty and be recognized by peers for clinical competence.

(c) Have extensive clinical experience and have developed a good understanding of the relationships between the various patient-care providers and the problems they encounter.

(d) Have a history of increasingly successful medical administrative accomplishment.

(e) Hold a reasonably high academic rank and be an acceptable teacher for medical students and physician residents if the facility is affiliated.

(4) Criteria for processing ACOS/AC candidates are:

(a) If the candidate is a current VA physician, the facility should submit a letter of recommendation for appointment signed by the facility Director, a current curriculum vitae, a statement of endorsement from the Deans Committee (if affiliated), and a statement that the individual is, or will be, employed a minimum of 7/8 VA time.

(b) If the candidate is not currently a physician within the VA, the facility, after completing and documenting all credentialing and privileging requirements, must submit in addition to the above, a VA Form 10-2850, Application for Physicians and Dentists, four reference letters from peers who have personal knowledge of the candidate's clinical and administrative abilities, and a statement by the facility as to a recommended grade and step rate for appointment.

e. The position of CMO:

(1) This position is centralized to the Chief Medical Director. The day-to-day operation of the program has been delegated to the ACMD for Clinical Affairs.

(2) VA medical centers may apply to VA Central Office (10BA___/11) for the approval to establish this position if they meet the following criteria:

(a) They are assigned responsibility for a satellite ambulatory care clinic not located on the grounds of the medical center.

(b) The satellite clinic offers a multiplicity of health care activities which include a significant medical and surgical presence.

(3) The qualifications for CMO and the criteria for processing candidates are the same as those in subparagraph d(3) and (4) for ACOS/AC.

(4) The CMO is responsible for seeing that quality health care services are fully integrated with the parent VA medical center. To do this, the CMO must be an active member of the Clinical Executive Board. The CMO should participate fully in all decisions affecting the operation of the satellite clinic. This critical interfacing with the parent VA medical center is primary and essential to the success of the satellite's program and to the professional credibility of the CMO.

(5) The precise organizational alignment of the CMO position is a responsibility of the parent medical center. This position should report to either an ACOS/AC or the Chief of Staff.

(6) To help assure appropriate coordination between the satellite and the parent medical facility the following should take place:

(a) The CMO should meet on a regular basis with the physician who has administrative responsibility for the hospital based ambulatory care activities.

(b) There should be periodic onsite visits to the parent facility by the CMO. Such visits should also take place at other VA facilities if there exists an active pattern of patient referrals between the facilities. A written policy should be established regarding the referral of patients between the satellite clinic, the parent facility, and any other facility where there exists an active pattern of patient referrals.

(c) There should be periodic (no less than one each quarter) onsite visits to the satellite clinic by one of the parent facility's top management (Director, Chief of Staff, Associate Director) officials. At least once every 6 months, all service chiefs who have employees working at the clinic should visit the clinic.

(d) The satellite clinic must carry out a quality assurance program that is both clinic specific and integrated with the facility's overall quality assurance program.

(e) A clearly defined policy for treating clinic patients after normal duty hours should be published and publicized to all patients.

7.05 INDEPENDENT OUTPATIENT CLINICS

As appropriate, independent outpatient clinics should follow the intent and provisions of this chapter.

DEC 6 1985

Department of Medicine and Surgery
Veterans Administration
Washington, DC 20420

M-2, Part I
Change 75

September 19, 1985

Part I, "General," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is redesignated Part I, "General," VA Department of Medicine and Surgery Manual M-2, "Clinical Affairs." Chapter 7, "Treatment and Diagnostic Procedures in Outpatient Clinics" has been retitled "Outpatient Diagnosis and Treatment" and is changed as indicated below:

NOTE: The purpose of this change is to provide a total revision of the previous chapter and to include the provisions of expired Circular 10-82-215. Due to the nature of this change, brackets are not being used.

Page iii, paragraph 1

Subparagraph d: Add "Cir. 10-82-215".

Subparagraph f: Add changes "6" and "12".

Pages v and vi: Remove these pages and substitute pages v and vi attached.

Pages 7-1 and 7-2: Remove these pages and substitute pages 7-1 through 7-3 attached.

RESCISSIONS: Changes 6 and 12, part I, M-2.



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Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

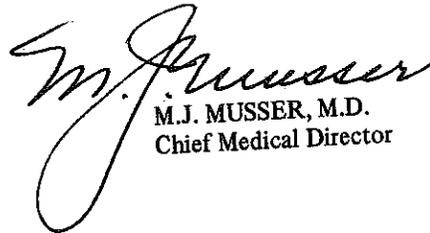
M-2, Part I
Change 47

February 8, 1971

Part I, "General," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as indicated below:

NOTE: The purpose of this change is to clarify and revise procedures to be followed on proposals for endorsement of full-time VA physicians for membership in the American College of Physicians. The VA physicians now have the option of having their proposals endorsed by the ACP Governor having jurisdiction over the geographic area in which the candidate is located or to the ACP Governor for the VA.

Page 5-1: Remove this page and substitute page 5-1 attached. (Ch. 5 revised.)



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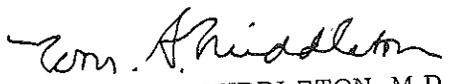
Department of Medicine and Surgery
Veterans Administration
Washington 25, D.C.

M-2, Part I
Change 12

September 9, 1959

Part I, "General," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

Pages 7-2 and 8-1: Remove these pages and substitute pages 7-2 and 8-1 attached. (Ch. 8 revised. The formal designation of certain VA hospitals to serve as diagnostic centers is canceled. In the future, any suitably staffed and equipped VA hospital may be selected under procedures prescribed in this change to perform special diagnostic studies and examinations for adjudicative purposes which heretofore were referred to the diagnostic centers.)


WILLIAM S. MIDDLETON, M.D.
Chief Medical Director

Distribution:

Same as M-2, Part I

Department of Medicine and Surgery
Veterans Administration
Washington 25, D. C.

M-2, Part I
Change 6

January 15, 1958

Part I, "General," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is changed as follows:

NOTE: The purpose of this change is to clarify the certification procedure in connection with veterans' applications for specially adapted housing.

✓ Pages 6-1 and 7-1: Remove these pages and substitute pages 6-1 and 7-1 attached.
(Par. 6.02 changed.)



WILLIAM S. MIDDLETON, M. D.
Chief Medical Director

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Same as M-2, Part I