

CONTENTS

CHAPTER 34. RELEASE OF INFORMATION CONCERNING HEALTH CARE PROFESSIONALS TO STATE LICENSING BOARDS AND TO PROSPECTIVE EMPLOYERS

PARAGRAPH **PAGE**

SECTION I. GENERAL

34.01 Purpose	34-1
34.02 Authority	34-1
34.03 Philosophy	34-1
34.04 Definitions	34-2
34.05 Entering Agreements That Would Prohibit or Restrict Disclosure	34-2
34.06 Responsibility	34-2
34.07 Reporting to State Licensing Boards, Quarterly Report RCS 10-0849	34-3

SECTION II. VA INITIATED REPORTING OF SEPARATED HEALTH CARE PROFESSIONALS TO STATE LICENSING BOARDS

34.08 Policy	34-3
34.09 Required Procedures and Time Standards for VA Initiated Reporting	34-4a
34.10 Effect of Deadlines	34-5
34.11 Evidence File	34-5
34.12 Notice Letter	34-7
34.13 Review Process	34-8
34.14 Reporting Letter to State Licensing Board(s)	34-10

SECTION III. RESPONDING TO INQUIRIES FROM STATE LICENSING BOARDS AND PROSPECTIVE EMPLOYERS

34.15 Policy	34-10
34.16 Signed Release Form	34-10
34.17 Subpoena	34-10
34.18 Non-practitioner Specific Request From State Licensing Board	34-10
34.19 Interim Response to State Licensing Board Inquiry When VA Is Considering Reporting On Own Initiative	34-11
34.20 State Licensing Board Inquiry Must Meet Privacy Act Requirements	34-11
34.21 Determining Information to be Disclosed in Response to State Licensing Board In Response To State Licensing Board Inquiry	34-11

APPENDIXES

34A Systems of Records	34A-1
------------------------------	-------

Chapter 34

Change 3

34B Guidelines for Collecting Evidence on Clinical Practice 34B-1

34C Examples -- Listings of Failure to Meet Generally Accepted Standards 34C-1

34D Reporting to State Licensing Boards, Quarterly Report RCS 10-0849. 34D-1

34E Sample Notice Letter to Separated Health Care Professional 34E-1

34F Sample Cover Letter from VA Health Care Facility Director (00)
to General Counsel (024) 34F-1

34G Sample Reporting Letter to State Licensing Board 34G-1

34H Sample Follow-up Letter from State Licensing Board Requesting
Evidence File 34H-1

34I Sample Letter of Inquiry from State Licensing Board 34I-1

34J Sample Alert Letter to State Licensing Board 34J-1

RESCISSIONS

The following material is rescinded:

1. Manuals

Partial Rescission

M-2, Part I, Chapter 34, Change 1, pages 34-3 and 34-4, dated October 4, 1994.

M-2, Part 1, Chapter 34, Change 2, pages 34-3 and 34-4, dated December 16, 1994.

2. VHA Circulars

10-87-42

**CHAPTER 34. RELEASE OF INFORMATION CONCERNING HEALTH CARE PROFESSIONALS
TO STATE LICENSING BOARDS AND TO PROSPECTIVE EMPLOYERS**

SECTION I. GENERAL

34.01 PURPOSE

a. This chapter sets forth policies and procedures to be carried out by VHA (Veterans Health Administration) health care facilities for releasing information concerning:

(1) Separated licensed health care professionals to State licensing board(s) as a VA (Department of Veterans Affairs) initiative in the absence of a State licensing board inquiry;

(2) Currently employed or separated VA health care professionals to State licensing board(s) and to prospective employers in response to written inquiries;

b. It is important to note that policy and procedures for VA initiated reporting to State licensing boards (disclosing information regarding licensed health care professional to State licensing boards in the absence of a State licensing board inquiry) in this chapter do not apply to licensed health care professionals still employed by VA.

c. Reference can be made to VHA policies and procedures governing reporting to the NPDB (National Practitioner Data Bank) and State licensing boards regarding malpractice cases involving licensed health care practitioners and clinical privileges actions that adversely affected the clinical privileges of a physician or dentist for greater than 30 days.

34.02 AUTHORITY

The Health Care Amendments Act of 1985, Public Law 99-166, Section 204, authorizes the VA to conduct a program for reporting any separated health care professional to State licensing boards who:

a. Was fired or who resigned following the completion of a disciplinary action relating to such individual's clinical competence;

b. Resigned after having had such individual's clinical privileges restricted or revoked; or

c. Resigned after serious concerns about such individual's clinical competence have been raised but not resolved.

34.03 PHILOSOPHY

a. VA is responsible for ensuring that its patients receive appropriate and safe health care. In a like manner, VA has the obligation to alert those entities charged with licensing health care professionals when there is serious concern with regard to a licensed health care professional's clinical practice. This obligation includes notifying State licensing boards of VA's concern with regard to the clinical practice of former employees and responding to inquiries from State licensing boards concerning the clinical practice of current and former employees. Further, VA has the obligation of responding honestly to inquiries from prospective employers regarding the clinical practice of current and former employees.

b. Equally important, VA has a responsibility to its current and former employees to protect their personal rights. VA will ensure such protection by conforming to due process requirements and requirements of various Federal information laws enacted for the express purpose of protecting the rights of the individual.

34.04 DEFINITIONS

a. Generally Accepted Standards of Clinical Practice. Competence in the clinical aspects of one's responsibilities, as well as the moral and ethical behavior necessary to carry out those responsibilities.

b. Licensed Health Care Professional. An individual appointed or utilized under Title 5 U.S.C. (United States Code) or Title 38 U.S.C. on a full-time, part-time, intermittent, on-station fee basis; and those utilized in an on-station contract basis, or on-station sharing agreement basis; either permanent or temporary, whether paid or without compensation, who is licensed as a physician, dentist, podiatrist, optometrist, nurse, physician assistant, expanded-function dental auxiliary, physical therapist, practical or vocational nurse, pharmacist, occupational therapist, or certified or registered respiratory therapist. It includes licensed residents, consultants and attendings. As used in this chapter, the term "licensed health care professional" also refers to a licensed health care provider appointed to a position in an occupation where appointment in VA does not require licensure, such as a social worker, speech pathologist, psychologist, or audiologist. As used in this chapter, it also refers to licensed individuals working outside their licensed occupation, such as a registered nurse appointed to a Title 5 U.S.C. position.

c. Licensure. The official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration.

d. Separated Licensed Health Care Professional. Any licensed health care professional no longer on VA rolls and who left VA for any reason. This includes both voluntary and involuntary reasons, including disability retirement.

35.05 ENTERING AGREEMENTS THAT WOULD PROHIBIT OR RESTRICT DISCLOSURE

VA employees will not enter into any formal or implied agreement that would prohibit the reporting of a separated licensed health care professional to a State licensing board, or destroy or remove any information needed in the disclosing process, in return for a personnel action such as resignation, retirement, or reassignment. Entrance into such an agreement forms the basis for administrative and/or disciplinary action.

34.06 RESPONSIBILITY

a. The health care facility Director has overall responsibility for the program for releasing information to State licensing boards and to prospective employers.

b. The Chief of Staff has administrative, programmatic and operational responsibility for the program including the required interface with various clinical and administrative hospital services.

**34.07 REPORTING TO STATE LICENSING BOARDS QUARTERLY REPORT
RCS 10-0849**

a. **Uses.** The VA Form 10-0134, Reporting to State Licensing Boards Quarterly Report RCS 10-0849 (see App. 34D), to be reproduced locally, provides quantitative and qualitative data relative to State Licensing Board reporting activities; and serves as a self-appraisal tool for health care facilities. The report supplies the Chief Network Officer (10N) through the Veterans Integrated Service Network (VISN) (10N__), information needed to monitor facility compliance with policy and procedures contained in this chapter.

b. **Who Is to Prepare Report.** Reporting to State Licensing Boards, Quarterly Report, RCS 10-0849, is the responsibility of the Chief of Staff in cooperation with the Chief, Human Resources Management Service.

c. **When and where submitted.** Each health care facility will submit an original and two copies of the completed VA Form 10-0134 to the appropriate VISN Director (10N__) within 10 working days after the end of the quarter. Negative reports are required. Upon receipt, the VISN Director will forward copies to the Chief Network Officer (10N), and the Office of the Medical Inspector (105B).

**SECTION II. VA INITIATED REPORTING OF SEPARATED HEALTH CARE
PROFESSIONALS TO STATE LICENSING BOARDS****34.08 POLICY**

a. VHA health care facilities will report on their own initiative each separated licensed health care professional whose clinical practice so significantly failed to meet generally acceptable standards of clinical practice as to raise reasonable concern for the safety of patients. The following are examples of actions to be reported:

(1) Significant deficiencies in clinical practice, for example: lack of diagnostic or treatment capability; multiple errors in transcribing, administering or documenting medications; inability to perform clinical procedures considered basic to the performance of one's occupation; or performing procedures not included in one's clinical privileges in other than emergency situations.

(2) Patient neglect or abandonment.

(3) Mental health impairment sufficient to cause the individual to behave inappropriately in the patient care environment, or to provide unsafe patient care.

(4) Physical health impairment sufficient to cause the individual to provide unsafe patient care.

(5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provider or in the patient care environment.

(6) Falsification of credentials.

(7) Falsification of medical records or prescriptions.

(8) Theft of drugs.

(9) Inappropriate dispensing of drugs.

(10) Unethical behavior; e.g., sexual misconduct toward a patient.

(11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including any action or behavior that conflicts with a patient's rights identified in Title 38 Code of Federal Regulations (CFR) Section 17.34a; intentional omission of care; willful violations of a patient's privacy; willful physical injury; or intimidation, harassment or ridicule of a patient.

(12) Falsification of research findings.

b. In the event there has been a court conviction, the public documents related to that conviction may be provided directly to the appropriate State Licensing Board (s) by the facility Director without further review.

c. Special procedures, involving an alert to State Licensing Boards, are required when a statistically significant association links a separated licensed health care professional to a series of unexpected events that have resulted in patient injuries or death.

(1) In those extraordinary circumstances, VA facilities shall provide to each State Licensing Board where the professional is licensed an expeditious alert of the statistical association. Statistical significance shall be established at the .05 level, using generally accepted statistical methods.

(2) The alert will:

(a) Identify the occupational title of the employee;

(b) Describe the unexpected events that are statistically linked to that employee;

(c) Disclose that an accelerated investigation is being conducted to determine if there is a non-statistical connection between the employee and the unexpected events;

(d) Notify the Board that upon completion of the investigation, it will be advised whether substantial evidence does or does not exist to indicate that the former employee so significantly

failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients; and

(e) Assure the Board that while the employee will be reported by name, consistent with Privacy Act requirements, to each State Licensing Board(s) where the employee is licensed if substantial evidence exists to establish a linkage, it may nevertheless at any time during the investigation consistent with subsection (b)(7) of the Privacy Act request the name of the former employee and further information.

(3) Any information disclosed under a (b)(7) of the Privacy Act request that identifies a specific employee will also be provided to that employee. Additionally, the facility Director will immediately, as soon as the association is established:

(a) Commence an investigation as outlined in this Chapter on an expedited basis, and

(b) Notify the VISN (10N__), the Office of the Medical Inspector (105B), and General Counsel (02), of the alert sent to the State Licensing board and provide a copy to both offices. The alert shall be prepared in substantially the same format as shown in Appendix 34J (see Sample Alert Letter to State Licensing Board).

34.09 REQUIRED PROCEDURES AND TIME STANDARDS FOR A VA INITIATED REPORTING

a. The facility Director, with assistance from the Chief of Staff, (and Associate Director as appropriate), will ensure that within 30 days of the date a separated licensed health care professional leaves VA employment, a professional review of the individual's clinical practice is conducted to determine if it appears that, during VA employment, the individual so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. *NOTE: If an employee has appealed the separation action under the provisions of MP-5, Part II, Chapter 8 and its VHA supplement, the 30 day timeframe for initiation of the clinical practice review begins after the final VA administrative decision on the appeal has been executed.*

b. When there is a basis for concluding that the separated licensed health care professional may have so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, the Director is responsible for:

(1) Creating an evidence file with the assistance of the appropriate clinical service chief.

(2) Preparing and sending a notice letter to the separated licensed health care professional. This is to be done, after preparing the evidence file, with the assistance of the Chief, Human Resource Management Service, and the facility Privacy Act Officer. *NOTE: The time required to create the evidence file and send the notice letter will not exceed 30 days.*

Chapter 34**Change 3**

(3) Reviewing and determining, in consultation with the appropriate clinical service chief, if the separated licensed health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. This determination will be made considering evidence file data and information submitted by the former employee in response to the notice letter. This review and determination will be done within 10 days after the 14-day period for submitting a reply has expired.

(4) Within 10 days of determining that the separated health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, submit required information, through specified channels (see par. 34.13 b.), for the General Counsel (024) to review and give opinion regarding the requirements of information disclosure laws. The file to be submitted to General Counsel shall consist of the complete evidence file with a cover memorandum that summarizes the facts, lists the charges, explains the rationale for reporting on each charge (including the resolution of any conflicts raised by the evidence, the reply to the notice letter, or otherwise). It will also include the proposed summary statement to be reported to the State licensing board. The evidence supporting each charge should be indexed in the evidence file and specifically referenced in the cover memorandum. It is anticipated that once the complete case is received by the General Counsel (024), the time required for the legal review should be not more than 60 days.

(5) Within 10 days of receiving the General Counsel (024) opinion, send a letter to the appropriate State licensing board(s) disclosing information indicated by General Counsel (024) to be appropriate for initial release.

34.10 EFFECT OF DEADLINES

It is noted that this chapter provides for a number of deadlines; for example, a period of time to reply to a notice letter and time limits for the Administration to take action. It is the intent of the chapter to make determinations based on all information available. It is not intended that time limits be utilized to abbreviate this process. Thus, it is intended that the Administration would consider a late reply to a notice letter. Similarly, late action by the Administration would not be a bar to further processing or to reporting.

34.11 EVIDENCE FILE

a. An Evidence File Will Be Created When

Based on the initial professional review, it appears that during VA employment the separated health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

b. An Evidence File Will Be Used

(1) To provide to the separated health care professional, should the individual request such in response to the notice letter, a copy of the evidence being used to make a determination to report. (All patient identifiers will be deleted from evidence provided the separated health care professional.)

(2) To make an informed determination concerning whether the separated health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

(3) To obtain from General Counsel a legal opinion of whether the requirements of information disclosure laws have been met.

c. Contents and Organization

(1) The evidence file will contain, at a minimum, the following information and documents in the order presented:

(a) Facility Director's letter to General Counsel (024) through the appropriate Regional Director (13_) and AsCMD for Operations (13) requesting legal review and opinion by General Counsel, regarding the requirements of information disclosure laws, that includes:

1. Information about the individual to be reported including full name, occupation, Social Security number, known last address, date separated, states in which individual is or has ever been licensed and the corresponding license numbers.

2. Date on which the individual was notified of possible reporting and date of response, if any.

3. Systems of records in which evidence is contained (see app. 34A).

4. Specific basis for reporting including a listing of each instance of failure to meet generally accepted standards of clinical practice indicating exactly what the individual did or did not do and statement(s) identifying the correct or accepted clinical practice standard for each instance of failure. (See sample language in app. 34C.)

5. If received, separated employee's response to specific issues with facility Director's consideration of the response as it relates to reporting. (See par. 34.12 f.)

6. Statement(s) summarizing the determination to report and the basis for the determination.

7. Proposed statement for release to the State licensing board(s) (see sample letter, app. 34G).

(2) Notice letter to separated employee (see par. 34.12 and app. 34E).

(3) Evidence of separated employee's receipt of notice letter, if other than a written response from the individual. This could include such things as a response from the individual's attorney or copy of a signed receipt for acceptance of the letter. In the absence of evidence of receipt, documentation should be presented that demonstrates effort made to notify the separated employee. (See par. 34.12 e.)

(4) All relevant documentation for each instance of failure to meet generally accepted standards of clinical practice. This could include, but is not limited to such items as, administrative boards of investigation; reports of contact; Security Police reports; patient record information (including, in cases involving controlled substances, all relevant prescription and administration control records); copies of facility policies and procedures that identify standards or requirements; signed statements from staff or patients; separated employee acknowledgement of incident(s) VA Form 10-2633, Report of Special Incident Involving a Beneficiary; and, health information specific to the separated employee. (See app. 34B.) The evidence regarding each charge will be organized according to individual charges. Each instance(s) of failure to meet generally accepted standards of clinical practice which is to be reported will be listed. Documentation which proves that the failure is valid will be attached and indexed to each specific failure. If evidence applies to more than one failure, it should be indexed to each. The evidence file should not be composed of a summary of charges attached to an unindexed file of evidence.

d. An Evidence File Will NOT Contain

Medical quality assurance records that are confidential and privileged under the provisions of 38 U.S.C. § 5705 (formerly § 3305).

34.12 NOTICE LETTER

a. A notice letter serves the purpose of satisfying information law requirements for release of information that must be met in order for the VA health care facility to release information to State licensing board(s). Each separated licensed health care professional being considered for reporting to State licensing board(s) will be provided a notice letter that conforms to the sample letter (see app. 34E). Any charge, allegation, or performance deficiency not contained in the notice letter may not be disclosed to State licensing board(s). Patient identifiers must not be included.

b. A Notice Letter Will Contain

(1) A statement indicating that VA is considering notifying appropriate State licensing board(s) that the former employee has so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, and the legal authority that allows VA to report.

(2) A listing of incident(s) from the evidence file demonstrating each failure to meet generally accepted standards of clinical practice that VA intends to disclose to the State licensing board. Incidents must be listed individually and specifically with patient identifiers excluded. As example, "You saw patient Mr. X on six occasions over a 3-month period from July to September 1991. On each visit the patient complained of a sore throat, inability to swallow and significant weight loss. You failed to order indicated tests and procedures to diagnose Mr. X's cancer of the throat." In this case, the statement, "You committed a number of diagnostic and treatment errors," would be too general.

(3) Statements indicating that within 14 days from the date of receipt of the notice letter the former employee may voluntarily submit information for consideration by VA, that information submitted would become part of a system of records and subject to release under provisions of The Privacy Act, and that if information is not submitted, VA will make a determination about reporting based on the available information.

c. Determining Correct Current Address

Considerable effort must be made to determine the correct current address of the separated health care professional if it is unknown or if there is question. This may include contacting State licensing board(s), professional organizations, prospective employers and references. The VA health care facility will document efforts made to obtain the current address when the same have been unsuccessful and this information will be included with information submitted for the General Counsel (024) review.

d. Notice Letter Sent Certified or Registered Mail

The notice letter must be sent certified or registered mail, return receipt requested.

e. Nonacceptance of Certified or Registered Letter

In the absence of validation that an initial notice letter was received, a second notice letter will be sent certified or registered mail, return receipt requested. If the second notice letter is not received or accepted, and it has been verified (see, for example, par. c.) that the address is correct, the VA health care facility should carefully document efforts made to ensure receipt and include this information with material submitted for the General Counsel (024) review.

f. Processing Former Employee's Response to Notice Letter

(1) Should the former employee ask for the evidence being used to make the determination, the evidence will be provided registered mail, "Return Receipt Requested," after patient identifiers have been redacted. The former employee will have an additional 14 days from the date of receipt to respond.

(2) Should the former employee respond to the charges, any information the separated health care professional provided will be considered when determining whether the separated employee so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. If it is determined that the individual significantly failed to meet clinical standards, information submitted for the General Counsel (024) review must state why each of the points raised by the individual did not alter the decision to report. For example, if physical abuse is alleged, and the individual responded that the patient provoked the situation by striking first, the cover memorandum analysis would address this fact. The information to be reported would be stated followed by the former employee's rebuttal and a statement to effect that there is no acceptable reason to strike a patient.

34.13 REVIEW PROCESS

a. Chief of Staff and Facility Director

The evidence file and the separated licensed health care professional's response to the notice letter will be reviewed by the Chief of Staff who in consultation with the appropriate clinical service chief and Associate Director, as indicated, will determine if the separated licensed health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. A memorandum indicating the determination along with the individual's response and the evidence file will be prepared for the facility Director's approval. In a case where the facility Director disagrees with the determination of the Chief of Staff, the Director will forward the case to the Regional Director (13_) for resolution. The Regional Director (13_) will appoint a minimum of two reviewers to review the file and make recommendations. The two reviewers must be of the same profession as the separated health care professional, and from VA facilities other than where the individual was employed. Based on the recommendation of these reviewers, The Regional Director (13_) will make a final determination of whether the separated health care professional so significantly failed to meet generally accepted standards of clinical practice as to cause reasonable concern for the safety of patients.

b. Requesting General Counsel Review and Opinion

When it is determined that the separated licensed health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise

reasonable concern for the safety of patients, the health care facility Director (00) will submit the case for legal review and opinion by the General Counsel (024) regarding the requirements of information disclosure laws. Submission will be through the Regional Director (13_) and Office of the AsCMD for Operations (13) to the General Counsel (024). The package of material submitted by the health care facility Director (00) will conform to the requirements set forth in paragraphs 34.9 and 34.11.

c. Regional Director and AsCMD Review and Processing

(1) Upon receiving the package prepared by the health care facility for review and opinion of the General Counsel (024), the Regional Director (13_) will, within 10 days of receipt, review the package to assure that:

- (a) The Director's letter conforms to the requirements of this chapter.
- (b) Evidence file is complete as required by this chapter.
- (c) Evidence file provides adequate documentary support for charges made including information regarding standards breached and consideration of the separated employee's response, if any.
- (d) Information inappropriate for consideration is NOT included; for example, such things as 38 U.S.C. 5705 protected quality assurance information, legal charges that are dropped when an individual enters a substance abuse treatment program.

(2) Packages that do not conform to the requirements of this chapter may be held at the Regional Office for additional information or returned to the facility for revision and resubmission. If it is determined that the evidence is complete and that it does not demonstrate that the individual so significantly failed to meet acceptable standards as to raise concern for the safety of patients, it will be returned to the facility without forwarding to General Counsel for review.

(3) When packages are forwarded to General Counsel for review, the Regional Director (13_), will attach a cover memorandum that identifies by name, position, and FTS number, the staff person at the Regional Office responsible for ensuring completeness, accuracy, and timeliness of information submitted by the health care facility prior to it being forwarded to VA Central Office. This person will serve as a contact person for any General Counsel (024) questions regarding the case. To help ensure consistency and efficiency, the Regional staff person assigned responsibility for review and liaison regarding State licensing board reporting should be the same for all cases.

d. General Counsel Response

(1) The General Counsel (024) opinion regarding the case will be returned to the health care facility Director (00), by the Office of the AsCMD for Operations (13) through the Regional Director (13_). A copy of the opinion and the evidence file upon which the opinion was based will be forwarded to Employment and Training Service, Title 38 Employment Division (054D), for consideration for placement on the Cautionary List.

(2) In any written opinion stating that the requirements of information disclosure laws have been met, it is anticipated that the General Counsel (024), will indicate what information may be initially released to State licensing board(s) and what information

may subsequently be released by the health care facility should the State licensing board(s) request follow-up information (see par. 34.14).

34.14 REPORTING LETTER TO STATE LICENSING BOARD(S)

As appropriate, the VA health care facility will send a letter (see app. 34G) to appropriate State licensing board(s) within 10 working days of receipt of the written opinion of the General Counsel concerning authority to report. The statement to be released to the appropriate State licensing board(s) by the VA health care facility must conform explicitly to the language provided in the General Counsel opinion. A letter from the State licensing board requesting follow-up information (see app. 34H) received by the facility must meet The Privacy Act, 5 U.S.C. 552a, requirements identified in paragraph 34.20. All information to be released to the State licensing board(s) will be released only after patient identifiers have been deleted.

SECTION III. RESPONDING TO INQUIRIES FROM STATE LICENSING BOARDS AND PROSPECTIVE EMPLOYERS

34.15 POLICY

VA health care facilities will provide accurate, timely, and relevant information to State licensing boards and prospective employers in response to inquiries.

34.16 SIGNED RELEASE FORM

a. Is not required to disclose information about a current or separated VA health care professional in response to an inquiry from another VA health care facility. The inquiring VA facility will be informed of the individual's strengths and weaknesses.

b. Is required to disclose information, covered by the Privacy Act, about a current or separated VA health care professional in response to an inquiry from a non-VA employer unless data to be disclosed comes from files covered by a Privacy Act routine use which authorizes such a disclosure.

c. Is not required in order to disclose information in response to an inquiry from a State licensing board providing the Board's request satisfies requirements of The Privacy Act (see par. 34.20).

d. When relying on the signed release form, rather than a Privacy Act routine use, the form must have been signed within the last 6 months prior to the date of the response. It must state the individual or organization to whom the information may be released and the type of information that may be released. Clarification should be received from the District Counsel in cases such as when receiving a signed release form that specifies that VA may release any information other than information that is derogatory, or one that does not specify the type of information that VA may release.

34.17 SUBPOENA

Information will not be released in response to a State licensing board subpoena for information concerning a current or separated VA health care professional without determination of appropriateness through consultation with District Counsel.

34.18 NON-PRACTITIONER SPECIFIC REQUEST FROM STATE LICENSING BOARD

A State licensing board request for information that is non-practitioner specific, such as a request for information to be provided each time there is a clinical practice concern, will not be honored.

34.19 INTERIM RESPONSE TO A STATE LICENSING BOARD INQUIRY WHEN VA IS CONSIDERING REPORTING ON OWN INITIATIVE

When a request for information concerning a separated health care professional is received from a State licensing board while the VA health care facility is considering reporting the individual, the facility should respond to the initial inquiry by stating that the Board's request is considered a serious matter; that an inquiry into this matter has been initiated; and that the request is being processed. The facility should expeditiously create the evidence file, send the notice letter, complete the clinical review and determination, and forward required information for General Counsel review and opinion. The VA health care facility will not provide information to the State licensing board concerning the individual until after all procedures required for VA reporting have been met.

34.20 STATE LICENSING BOARD'S REQUEST MUST MEET PRIVACY ACT REQUIREMENTS

a. Information will be released only when a State licensing board's request for information concerning a current or former employee meets requirements of The Privacy Act, 5 U.S.C. 552a, that follow:

- (1) Is in writing on letterhead stationary.
- (2) Cites the law giving the State licensing board authority to take action against licenses.
- (3) Identifies the civil or criminal law enforcement activity for which the information is sought. This would usually indicate protection of the health and welfare of the State's citizens.
- (4) Specifically identifies the individual about whom information is sought, the portion of the records desired, and the reason(s) for which the Board seeks the information.
- (5) Is signed by the head of the Board or a person who has been designated to act for the head of the Board. A designee must be an official of sufficient rank to ensure that the request for records has been the subject of a high level evaluation of the need for the information. If the request is signed by a designee, a copy of the designation of authority, specifically citing (b)(7) of the Privacy Act, must be enclosed (see app. 34I).

b. The Chief of Staff, or designee, should consult with the facility Privacy Act Officer, and as needed, the District Counsel, to ensure that the State licensing board request complies with The Privacy Act requirements.

c. These requirements do not apply if a signed release form is received, and the facility is relying on the release form rather than routine use provisions of The Privacy Act when releasing information to a State licensing board in response to the board's request.

34.21 DETERMINING INFORMATION TO BE DISCLOSED IN RESPONSE TO STATE LICENSING BOARD INQUIRY

The Chief of Staff, or the appropriate clinical service chief, will assist the facility Director to determine information to be disclosed in response to a State licensing board's (or prospective employer's) inquiry. The facility Privacy Act Officer, or District Counsel, should be consulted as needed, to ensure that information proposed to be released to the requesting State licensing board meets requirements of The Privacy Act.

SYSTEMS OF RECORDS

The following identifies the Systems of Records in which evidence is most frequently maintained.

- (1) OPM/GOVT-1. "**General Personnel Records.**" This file contains the Official Personnel Records for title 5 personnel.
- (2) OPM/GOVT-2. "**Employee Performance File System Records.**" This file contains the performance records for title 5 personnel. Records in this file may include annual summary performance appraisals, written recommendations for removals, demotions, reassignment, denials of in-grade increases; records needed to support removal for unsatisfactory performance.
- (3) OPM/GOVT-3. "**Records of Adverse Actions and Actions Based on Unacceptable Performance.**" This file contains records and documents on the processing of adverse actions and actions based on unacceptable performance for title 5 personnel. Records in this file may include notice of proposed action and materials relied upon to support the reasons in the notice, replies by the employee, statements of witnesses, hearing notices, reports and agency decisions.
- (4) OPM/GOVT-5. "**Recruiting, Examining, and Placement Records.**" This file contains records related to applications and processing of applications for title 5 employment.
- (5) 02VA135. "**Applicants for Employment Under Title 38, U.S.C. - VA.**" This file contains records related to applications and processing of applications for title 38 employment.
- (6) 76VA05. "**General Personnel Records (Title 38)-VA.**" This file contains the Official Personnel Records for title 38 personnel.
- (7) 32VA00. "**Veteran, Employee and Citizen Health Care Facility Investigation Records-VA.**" This file pertains to both title 38 and title 5 employees and contains copies of reports of investigations, findings, and follow-up concerning matters such as veterans who have died as a result of reaction to anesthesia or drugs, blood transfusion incompatibility, error in treatment; patients who allege physical abuse on the part of health care providers; employees who have been involved in the sale of drugs on VA premises, employees who have been accused of improper or unethical conduct.
- (8) 24VA136. "**Patient Medical Records - VA.**" This file contains a cumulative account of health care provided.
- (9) 77VA11. "**Health Care Provider Credentialing and Privileging Records - VA.**" This file contains records related to the credentialing and privileging of VA health care professionals.
- (10) 29VA11. "**Physician, Dentist and Supervisory Nurse Professional Standards Board Action File - VA.**" This file contains personnel forms and correspondence pertaining to such matters as promotions, reassignments, transfers, proficiency ratings, and physical examinations.

GUIDELINES FOR COLLECTING EVIDENCE ON CLINICAL PRACTICE

In order to meet the legal requirements for reporting a separated licensed health care professional to State licensing board(s), adequate and accurate documentation must be gathered to establish the clinical practice failures committed by the separated licensed health care professional. When a clinical performance problem becomes serious to the point of raising concern for the safety of patients, it is unacceptable not to report the separated licensed health care professional because only undocumented observation was available. To help ensure that health care managers collect and collate complete, accurate and timely documentation, rather than relying on undocumented observation, the following information is provided:

a. Signed Statements from Staff or Patient Witnesses

(1) Whenever possible, documentation should be first hand such as signed statements from staff or patient witnesses written in first person specifically describing what, when and where an event happened, and who was present, e.g., "On June 19, 1991, I saw Nurse "A" slap Mr. Johnson in front of Mr. Nelson, Mr. Johnson's roommate." The statement, "I observed Dr. "Y" for 10 months and he was incapable of handling an emergency," is not sufficient evidence. In this case, specifics of each emergency and how the separated licensed health care professional failed to provide appropriate intervention should be documented by as many staff as possible. Hearsay, "Someone told me that Dr. "W" frequently missed patient appointments," or an imprecise statement, "I don't remember exactly when, but Dr. X. fell asleep during a procedure," generally will not suffice as evidence.

(2) Reasonable effort should be made to obtain a signed statement from a patient when the patient can provide relevant information, such as when a patient states a medication was not received and it is documented that it was administered, or when a patient witnessed or was recipient of abuse.

b. Separated Licensed Health Care Professional Incident Acknowledgement

If the separated health care professional acknowledges the incident(s), effort should be made to obtain a signed statement with specific details. Witnesses to the acknowledgement should provide, on separate sheets of paper, signed statements of what they heard and observed.

c. Case Record Developed For An Administrative Proceeding Such As A Disciplinary Board, Probationary Review Board, or Physical Standards Board

(1) In an administrative proceeding where the decision regarding involuntary separation is made in VA Central Office, a copy of the administrative proceeding case record will be returned to the VA health care facility. The facility will proceed to create an evidence file using relevant portions of the administrative proceeding case record when it appears that the individual so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

(2) Only portions of the administrative case record relevant to the charge(s) and individual failure(s) should be included in the evidence file. However, if part of a testimony is used as evidence, and from this part the person testifying can be identified, then the entire testimony of that individual should be included in the evidence file even if

the entire testimony is not relevant to the alleged failures. Otherwise, testimony not relevant to the alleged failures should not be included.

d. VA Form 10-2633, Report of Special Incident Involving a Beneficiary

In most cases, the completed VA Form 10-2633 is not, in and of itself, sufficient evidence. Additional documentation should include statements from witnesses and, as relevant, copies of appropriate parts of the medical record.

e. Patient's Medical Record

If the patient's medical record provides evidence for determining that the separated licensed health care professional so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, then a copy of the portion of the medical record proving the failure(s) should be obtained and included as part of the evidence file. Medical Record data should not be highlighted since this may cause it to photocopy black. Medical record documents should include the name and other patient identifiers when placed in the evidence file and when submitted for the General Counsel (024) legal review. Patient identifiers must be removed; however, if these data are provided to the separated health care professional upon request after receiving the notice letter, and if provided to a State licensing board.

f. Other Evidence

(1) Relevant portions of an Administrative Board of Investigation conducted by the VA health care facility should be included as part of the evidence file.

(2) If the former employee retired or was separated due to a medical disability and the disability causes the concern for ability to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, a copy of the medical documentation related to the former employee's health would be included as a part of the evidence file.

EXAMPLES

LISTING OF FAILURE TO MEET GENERALLY ACCEPTED STANDARDS

1. Case alleging deficiencies in clinical practice of a registered nurse:

For purposes of this example, only one of several failures concerning this fictional individual's clinical practice is described. The failure listed would state that Jane Doe, R.N., made medication transcription errors on July 21, 1991, by failing to transcribe orders for Digoxin and Lasix from VA Form 10-1158, Doctor's Orders, to VA Form 10-2970, Continuing Medication Record, for patient Z (patient's name should be identified). The correct clinical practice standard, which is to transcribe all medication orders, would be identified. Relevant documentation for this failure would include a signed and dated memorandum written by an individual with knowledge that the subject R.N. was responsible for transcribing doctor's orders on patient Z on said date, the VA Form 10-1158 for said date and the VA Form 10-2970 for said date. This procedure would be followed for each failure to be reported.

2. Case alleging deficiencies in clinical practice of a physician:

There were several instances of failure in this fictional physician's clinical practice. One is described for purposes of this example. The failure listed would state that John Doe, M.D., failed to conduct a proper workup on patient Z (patient's name should be identified) on June 18, 1991, when responsible for medical care delivered in Admissions. It would indicate that patient Z presented with chest pain radiating to jaw area, diaphoresis, and nausea. It would indicate that after looking at the vital signs and performing a cursory physical examination, Dr. Doe diagnosed indigestion, ordered mylanta, and sent the patient home. It would indicate that 3 hours later the patient returned to Admissions via ambulance and died of cardiac arrest before staff could admit the patient. This would be followed by a statement defining what constitutes a proper workup in this case. Documentation for this failure would include a copy of the completed VA Forms such as VA Form 10-10M, Medical Certificate, for the first visit; SF 509, Progress Notes; HRA-162-1, Certificate of Death; any examination or treatment records created and any other relevant documentation. This procedure would be followed for each failure.

**REPORTING TO STATE LICENSING BOARDS
QUARTERLY REPORT RCS 10-0849**

VA Facility _____ Facility Number _____

Designated Contact Person _____

Title _____ FTS Telephone Number _____

Quarter (check one) 1st ___ 2nd ___ 3rd ___ 4th ___ Fiscal Year: 19 ___

1. Provide the following information regarding the number of licensed health care professionals separated this quarter, and the number of licensed health care professionals reported to SLBs this quarter.

OCCUPATION	SLB REPORTING		
	# SEPARATED THIS QRTR.	# REPORTED THIS QRTR.	TOTAL # REPORTED THIS FY
Registered Nurses	_____	_____	_____
Practical/Vocational Nurses	_____	_____	_____
Physicians	_____	_____	_____
Dentists	_____	_____	_____
Podiatrists	_____	_____	_____
Pharmacists	_____	_____	_____
Physical Therapists	_____	_____	_____
Occupational Therapists	_____	_____	_____
Physicians Assistants	_____	_____	_____
Optometrists	_____	_____	_____
Psychologists	_____	_____	_____
Other (specify):	_____	_____	_____

2. Attach copy of the letter sent to State Licensing board(s) for each licensed health care professional reported during this quarter whose clinical practice significantly failed to meet generally accepted standards of clinical practice.

Chapter 34
Change 1
APPENDIX 34D

3. Provide information regarding each separated licensed health care professional whose clinical practice so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients OR who left VA service after questions of professional competence or professional conduct were raised and not resolved, and who, it has been determined this quarter, will not be reported:

The following format is suggested:

Name _____ Profession/Occupation _____

Date of Separation _____

Charges/failure/concerns: _____

Explanation of why a report is not to be sent to
SLB(s): _____

(attach additional sheets as necessary for each practitioner)

I certify that the information provided in this document is complete and accurate and that the clinical practice of each licensed health care professional who separated from this facility during this reporting period was reviewed and an appropriate determination was made regarding whether their clinical practice so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

Signature of Facility Director _____ Date _____

Send original and 2 copies to:
AsCMD for Operations (13) through
Regional Director (13_)

VA Form 10-0134
Oct 1994 (RS)

TO BE REPRODUCED LOCALLY

SAMPLE NOTICE LETTER TO SEPARATED HEALTH CARE PROFESSIONAL

(Return Receipt Requested)

Dear _____:

Consistent with the mandate in the Veterans' Administration Health Care Amendments Act of 1985, Public Law 99-166, it is the policy of the VA (Department of Veterans Affairs) to report to State licensing boards those terminated (voluntary or otherwise) health care professionals whose clinical practice appears to have significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

Based upon the following, we are considering whether, under these criteria, you should be reported to State licensing board(s).

Our records indicate that you were terminated (or resigned) from the VA on (date) .

Our records also indicate (State specific concerns. The following are examples.):

a. On December 14, 1990, and December 17, 1990, you incorrectly diagnosed a patient with a brain tumor as having a sinus headache, even though you had observed on December 14, 1990, that the patient had "unsteady gait and slow speech."

b. On March 9, 1991, you admitted a patient for the purpose of determining whether the veteran had a subdural hematoma. You did not order the necessary diagnostic tests until March 12, 1991.

c. On March 20, 1991, you failed to prescribe an antihypertensive medication for a patient admitted by you for pneumonia, even though the patient's medical record stated that the veteran was taking Diazide and Aldomet for hypertension.

d. On March 27, 1991, you prescribed ampicillin to a patient even though the patient's medical records stated that the patient is allergic to penicillin.

If you have information that you believe should be considered regarding whether VA should report you concerning these matters, please submit such information to the above address within 14 calendar days from the date of receipt of this letter.

Providing information in response to this letter is voluntary. If you do not provide information, a decision concerning whether to report you to State licensing board(s) will be made based on available information. Information you submit will be kept in the appropriate Systems of Records and in accordance with provisions of The Privacy Act, could be made available to Federal, State or local authorities.

(Director's Signature)

SAMPLE COVER LETTER FROM VAMC DIRECTOR (00) TO GENERAL COUNSEL (024)

(Date)

From: Director, VAMC _____

To: General Counsel (024)

Thru: Regional Director (13_)
Associate CMD for Operations (13)

Subj: Disclosure to State Licensing Board - John Doe, M.D.

1. In accordance with VHA M-2, part I, chapter 34, documentation is submitted for your review to determine if requirements of information disclosure laws have been met that would allow reporting John Doe, M.D., to the appropriate State licensing board(s) for so significantly failing to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, when during his clinical performance as a general staff surgeon he made multiple diagnostic and treatment errors. Relevant information follows:

a. Name: John Doe, M.D.
Occupation: Physician
SSN: 000-00-0000
Last Know Address: 13 Earl Place, Washington, DC 20906
Date Separated: March 22, 1991
Licensure: New York #0000000
Maine #00000

b. Dr. Doe was notified of this review in a letter of May 30, 1991, sent certified mail (Enclosure A). He responded in a letter dated June 10, 1991 (Enclosure B).

2. The evidence in this case is contained in systems of records 24VA136, 76VA05, and 32VA00 and reveals the following:

a. On June 20, 1990, Dr. Doe performed an exploratory laparotomy for small bowel obstruction on a 76 year old, Frank Leach. On the sixth post-operative day Mr. Leach had an evisceration of the wound. Had retention sutures been used, it is felt that the evisceration would not have occurred (Enclosure C).

b. On July 22, 1990, 32 year old patient, Bob Jones, was operated on by Dr. Doe for gallstones. Post-operatively Mr. Jones developed an incisional infection and an internal abscess. Although the infection was noted by Dr. Doe in the progress notes on July 6, 1991, he did not institute antibiotic treatment until July 11, 1991. Antibiotic treatment should have been started earlier (Enclosure D).

c. Dr. Doe was counseled on August 4, 1990, for inappropriately annotating on August 3, 1990, a change in the strength of a medication on a previously written order. The proper procedure on August 11, 1990, would have been to rewrite the order for Digoxin for patient, Connie Nelson (Enclosure E).

Chapter 34
APPENDIX 34F

d. Also in August 1990, Dr. Doe admitted patient Paul Parker who had a history of pneumothorax and emphysematous lung disease. On August 7, 1990, Dr. Doe inappropriately prescribed IPPB therapy and ordered too high a dose of metaproteranol (Enclosure F).

e. Dr. Doe was observed cutting secretion soaked bandages on patient Charlie Bjornson on September 14, 1990, and then using the same scissors to clip the penrose drain advanced on patient Joe Higgins. The proper standard would have been to observe sterile technique (Enclosure G).

f. On November 22, 1990, Dr. Doe mismanaged the fluid balance of patient George Hellinger resulting in Mr. Hellinger having the complication of post-operative fluid overload. An administrative board of investigation supported this conclusion (Enclosure H).

g. On December 4, 1990, patient James Drix was admitted with severe abdominal pain. During the night, Mr. Drix continued to suffer severe abdominal pain and he was seen by Dr. Doe at 6:30 a.m. Dr. Doe examined the patient and noted a normal abdomen. Five hours later, when he was examined again, Mr. Drix was found to have significant abdominal problems and was taken to surgery. During the exploratory laporatomy, massive gangrene of the bowel was found. The Chief of Surgery, and the Chief of Staff, identify that the clinical judgment of "normal abdomen" was inaccurate, and that an emergency exploratory laporatomy should have been done at 6:30 a.m. (Enclosure I).

h. Roy Lura had a below the knee (BK) amputation done on December 22, 1990. He had previously had his left leg amputated. Review of the case reveals that an inadequate preoperative workup was done. The peripheral vascular exam does not indicate the temperature, color, or sensation of the right lower extremity. Presence or absence of foot/leg pulses is not indicated. Arterial studies such as doppler ankle pressure and an arteriogram should have been completed prior to surgery (Enclosure J).

3. In his response to the notice letter, Dr. Doe stated that the allegations made are "unfounded", are a part of a "professional and personal attack", and reflects "VA management using VA policy to pursue age discrimination". In essence, Dr. Doe chose to not respond to the specific allegations. The file contains substantial evidence to support the charges. The following statement is proposed for release to the State licensing board(s): "Dr. Doe significantly failed to meet generally accepted standards of clinical practice in that he made diagnostic and treatment errors that placed patients at risk."

Signature
VA health care facility Director

Enclosures

cc: Regional Director (13_)
AsCMD for Operations (13)

SAMPLE REPORTING LETTER TO STATE LICENSING BOARD

(Copy of letter to be forwarded with Quarterly Report, RCS 10-0849)

(Date)

(Address of State Licensing Board)

Dear _____:

In compliance with Federal regulatory requirements, be advised that Jane Doe, R.N., so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients by (Example: physically abusing a patient).

The following identifying data are submitted:

Date of Birth:	March 20, 1957
Social security Number:	000-00-0000
Home Address:	5555 Twin Valley Road
Massachusetts License Number:	000000, Expires 3-20-91

Questions in this regard may be referred to _____, title, on (Telephone number).

If you wish to obtain the relevant information contained in the evidence file in this case, please submit a letter to us which meets subsection (b)(7) of the Privacy Act. Instruction and a sample letter are enclosed.

(Signature)
Medical Center Director

**SAMPLE FOLLOW-UP LETTER FROM STATE LICENSING BOARD
REQUESTING EVIDENCE FILE**

(Official Letterhead Stationery)

(State) Board of Medical Examiners
Executive Office
Suite 000
0000 University Avenue
(City, State, Zip)
(Telephone No.)

(Date)

Director
VA Medical Center
One Veterans Drive
Minneapolis, MN 55417

RE: John Doe, M.D.

Dear Sir:

Thank you for your recent correspondence of December 1, 1990. The Board requests that you submit the evidence file to support the conclusion that Dr. Doe failed to conform to generally accepted standards of professional clinical practice.

Under (State) Statues Section _____, a copy of which is attached, the Board has law enforcement authority to take disciplinary action against Dr. Doe in order to protect the public health and welfare.

A copy of the written delegation of authority for me to make this request for information is attached. The delegation of authority specifically cites subsection (b) (7) of the Privacy Act, Title 5, United States Code, Section 552a (see note below for directions as to when this paragraph should be used).

Thank you for your cooperation.

Sincerely,

(Signature)
Deputy Executive Director

NOTE: For the VA to have Privacy Act disclosure authority the letter must be signed by the head of the Board or a person who has been designated to act for the head of the Board. A designee must be an official of sufficient rank to ensure that the request for records has been the subject of high level evaluation of the need for the information. If the request is signed by a designee, a copy of the designation of authority, specifically citing (b)(7) of the Privacy Act, must be enclosed.

SAMPLE LETTER OF INQUIRY FROM STATE LICENSING BOARD

(Copy of letter to be forwarded with Quarterly Report, RCS 10-0849)

(Official Letterhead Stationery)

(State) Board of Medical Examiners
Executive Office, Suite 000
0000 University Avenue
(City, State, Zip)
(Telephone No.)

(Date)

Director
VA Medical Center
One Veterans Drive
Minneapolis,
Minnesota 55417

RE: John Doe, M.D.

Dear (VA Medical Center Director):

We have a complaint about the surgical care that Dr. Doe provided John Q. Veteran. Please submit to us any information you have concerning this case.

The (State) Statutes provide law enforcement authority under Section _____, a copy which is attached, for the Board to take disciplinary action against Dr. Doe in order to protect the public health and welfare.

A copy of the written delegation of authority for me to make this request for information is attached. The delegation of authority specifically cites Subsection (b) (7) of the Privacy Act, Title 5, United States Code, Section 552a. (See NOTE for directions as to when this paragraph should be used.)

Thank you for your corporation.

Sincerely,

(Signature)
State Licensing Board Deputy Executive Director

NOTE: For the VA to have Privacy Act disclosure authority the letter must be signed by the head of the Board or a person who has been designated to act for the head of the Board. A designee must be an official of sufficient rank to ensure that the request for records has been the subject of high level evaluation of the need for the information. If the request is signed by a designee, a copy of the designation of authority, specifically citing (b)(7) of the Privacy Act, must be enclosed.

SAMPLE ALERT LETTER TO STATE LICENSING BOARD
(For alerting a State board of a statistical association by occupational title)

NOTE: Copy of letter to be forwarded with Quarterly Report, RCS 10-0849

(Date)

(Address of State Licensing Board in the State where the professional is licensed)

Dear _____:

In compliance with Department of Veterans Affairs (VA) policy, be advised that a (occupational title of the employee), who was a former employee of this facility, has been statistically linked with a series of unexpected patient events. (Describe the unexpected events that are statistically linked to that employee.)

The VA initiates a report to State Licensing boards when there is substantial evidence that the former employee so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Statistical association alone does not constitute substantial evidence since it fails to show what clinical standard was breached, how it was breached, when and where it was breached and who breached the standard. Such association, however, creates a duty to investigate further to determine whether the reporting standards has been met.

An accelerated investigation is being conducted to determine if there is a non-statistical connection between the employee and the unexpected events. Upon completion of the investigation, you will be advised whether substantial evidence does or does not exist to indicate that the former employee breached a care standard which would raise reasonable concern for the safety of patients. If such evidence exists, the employee will be reported by name consistent with Privacy Act requirements to each State Licensing Board where the employee is licensed.

Notwithstanding the above, you may at any time request the former employee's name and further information by submitting a letter consistent with subsection (b)(7) of the Privacy Act, Title 5 United States Code §552a(b)(7). Questions may be addressed to _____, title, at (telephone number).

(Signature)

Medical Facility Director

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-2, Part I
Chapter 34

November 5, 1991

1. Transmitted is a new chapter to Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part I, "General," Chapter 34, "Release of Information Concerning Health Care Professionals to State Licensing Boards and to Prospective Employers."

2. The purpose of chapter 34 is to:

a. Provide policy and procedures for releasing information to State licensing board(s) concerning a separated health care professional as a VA (Department of Veteran Affairs) initiative in the absence of an inquiry from the State licensing boards.

b. Provide policy and procedures for releasing information to State licensing board(s) and prospective employers in response to an inquiry.

3. Filing Instructions

Insert pages

34-i through 34-14

Appendices 34A-1 through 34I-1

4. Rescission: VHA Circular 10-87-42, dated May 12, 1987.

JAMES W. HOLSINGER, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1036 is assigned
FD

Printing Date: 11/91

Department of Veterans Affairs
Part I
Veterans Health Administration
Chapter 34
Washington, DC 20420
Change 1

M-2,

October 4, 1994

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part I, "General," Chapter 34, "Release of Information Concerning Health Care Professionals to State Licensing Boards and to Prospective Employers." Brackets have not been used to identify changes.

2. The purpose of the change is to:

- a. Provide a revised reporting form that is easier to use.
- b. Eliminate one distribution point for the report.

3. **Filing instructions**

Remove pages

34-3 through 34-4
34D-1 through 34D-2

Insert pages

34-3 through 34-4
34D-1 through 34D-2

4. **RESCISSION:** None.

John T. Farrar, M.D.
Acting Under Secretary for

Health

Distribution: **RPC: 1036**
FD
Printing Date: 10/94

December 16, 1994

1. Transmitted is a change to the Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part I, "General," Chapter 34, "Release of Information Concerning Health Care Professionals to State Licensing Boards and to Prospective Employers."

2. The purpose of the change is the deletion of the phrase "and National Practitioner Data Bank."

3. **Filing instructions**

Remove pages

3-iii
34-3 through 34-4

Insert pages

3-iii
34-3 through 34-4

4. **RESCISSION:** M-2, Part I, Chapter 34, Change 1, pages 34-3 and 34-4, dated October 4, 1994.

Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Distribution: **RPC: 1036**
FD

Printing Date: 1/95

1. Transmitted is a change to the Department of Veterans Affairs, Veterans Health Administration Manual M-2, "Clinical Affairs," Part 1, "General," Chapter 34, "Release of Information Concerning Health Care Professionals to State Licensing Boards and to Prospective Employers."

2. The purpose of the change is to :

a. **Subparagraph 34.08c:** Address the issue of providing an alert to State Licensing Boards of statistically significant associations which link a separated employee with unexpected patient injury or death.

b. **Appendix 34J:** Provide a sample letter for alerting a State Licensing Board of a statistical association by occupational title.

3. **Filing Instructions:**

Remove Page

34-i through 34-iii
34-3 through 34-4

Insert Pages

34-i through 34-iii
34-3 through 34-4b
34J-1

4. **RESCISSION:** M-2, Part 1, Chapter 34, Change 2, pages 34-3 and 34-4, dated December 16, 1994.

S/ by Thomas Garthwaithe, M.D. for
Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Distribution: **RPC: 1036**
FD

Printing Date: 6/96