

Veterans Health Care System of the Ozarks (VHSO)

VHSO Memorandum Number 2012-00-55

June 15, 2012

Disruptive Behavior Management Program

1. Purpose

To assure that a safe and healthful workplace is maintained, to minimize or eliminate disruptive behavior (e.g., verbal or physical aggression), to minimize the severity of injuries resulting from disruptive behavior, and to assure that employees exposed to disruptive behavior are provided appropriate medical care and counseling.

2. Background

a. Disruptive behavior at the Fayetteville Veterans Health Care System of the Ozarks and the CBOCs where facility employees are required to perform their duties is an occupational health hazard. Workplace violence is preventable, and most acts of violence in the workplace have warning signs (verbal and non-verbal). Prevention of violence in the workplace greatly enhances services provided by allowing staff to safely interact with patients, beneficiaries, visitors, volunteers, and other employees. Additionally, preventive measures reduce costs associated with work related injuries.

b. Federal law (Public Law 91-596 and Executive Order 12196) and Department policy (VA Directive 7700 and VHA Handbook 7701.1) require the Veterans Health Care System of the Ozarks to provide a place of employment free from recognized hazards that may cause death or serious injury. The Occupational Safety and Health Administration (OSHA) has cited federal facilities for failing to protect its workers from disruptive behavior in accordance with Executive Order 12196, "Occupational Safety and Health Programs for Federal Employees," paragraph 1-201a.

3. Policy

Disruptive behavior will not be tolerated at this facility. Persons (patients, beneficiaries, volunteers, visitors, employees) committing acts of violence will be reported to the appropriate authorities and prosecuted to the fullest extent of the law. Appropriate disciplinary action will be instituted against employees that are verbally or physically aggressive. Following are definitions of different types of violence:

a. *Physical contact* is unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, or the throwing of objects.

b. *Threat (verbal or written)* is the expression of a present or future intent to cause physical or mental harm. An expression constitutes a threat without regard to whether

the party communicating it has the present ability to do harm, and without regard to whether the expression is contingent, conditional, or future.

c. *Harassment/Verbal Abuse* is behavior or communication designed or intended to intimidate, menace, or frighten another employee.

d. *Property Damage* is behavior or acts that contribute to the destruction or damage of private or government property.

e. *Patient Abuse* is unkind, rudeness, verbally inappropriate comments, and rough treatment in responding to a patient's disturbed or disruptive behavior with violence.

f. *Criminal Assault* is when a person unlawfully and intentionally causes bodily harm to another person or places another person in fear of imminent bodily harm. Inappropriate, unwanted touching of a sexual manner may also be included in criminal assault.

g. *Domestic Violence* occurs when persons who cohabitate become involved in physical or verbal aggression and/or property destructions. When a person presents for treatment and reports that domestic violence has occurred, the Arkansas State Laws pertaining to Domestic Violence intervention will be followed. Those regulations are kept on file in the Police Service Office.

h. *Disruptive Behavior* is behavior that is dangerous to self and/or others.

4. Responsibilities

a. **Facility Director** is responsible to:

(1) Assure that patients, employees, volunteers and visitors are provided a safe and healthful environment; and

(2) Notify appropriate law enforcement agencies when a VA patient, staff, volunteer or visitor is assaulted in the workplace.

(3) Initiate Boards of Investigation when deemed appropriate.

(4) See that National Patient Record Flag Program (PRF) is instituted. (See Appendix E)

b. **The Chief, Human Resources Management Service** will serve as the facility Disruptive Behavior Management Program Coordinator and is a member of the Disruptive Behavior Committee. (See appendix D for Membership)

c. **The Disruptive Behavior Prevention Coordinator along with the Facility Safety Officer** are responsible to:

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- (1) Coordinate the facility Disruptive Behavior Management Program for employees;
- (2) Assure that all employees and volunteers are provided disruptive behavior prevention training; also insure that those areas/employees identified as High Risk Areas/High Risk Occupations are trained in accordance with the Prevention and Management of Disruptive Behavior (PMDB) Educational Guidelines;
- (3) Review the facility's Disruptive Behavior Management Program annually to assure that the Program is current and addresses the facility's needs;
- (4) Review incident investigation reports prepared by supervisors, to coordinate informal reviews and recommend further investigations, if deemed appropriate, and to identify corrective actions to preclude incidents of violence at the facility; and
- (5) Provide periodic reports semi-annually (March and September) concerning program effectiveness to the Environment of Care Committee.

d. **Chief, Psychiatry Service (or designee)** is responsible to:

- (1) Assure that patient-related incidents are reported and addressed as part of the facility's Disruptive Behavior Management Program;
- (2) Develop recommendations and implement corrective action(s) intended to preclude recurrence of disruptive behavior incidents by individual patients in coordination with the requirements of the program;
- (3) Assist and support the Disruptive Behavior Management Coordinator to implement an effective Disruptive Behavior Management Program throughout the facility; and
- (4) Assist with counseling of employees who have been exposed to disruptive behavior in the workplace or at home, as appropriate

e. **The Chief, Police Service** is responsible to:

- (1) Assure that incidents involving violence at the facility or at off-site work areas are reported and addressed as part of the facility's Disruptive Behavior Management Program;
- (2) Develop recommendations and implement corrective action(s) intended to preclude recurrence of violence at the facility in coordination with the requirements of this program;
- (3) Assist and support the coordinator and the Environment of Care Committee to implement an effective Disruptive Behavior Management Program throughout the facility and CBOCs.

(4) Conduct Code Red drills, one per shift per quarter with critiques to be sent to the Mental Health Council and the Disruptive Behavior Committee. **Note: An actual Code Red with critique can be substituted for a Code Red Drill on the appropriate shift.**

f. The **Facility Safety Officer** is responsible to:

(1) Assure that incidents of violence involving employees or volunteers (either as the victim or the perpetrator) are reported and addressed as part of the facility's Disruptive Behavior Management Program;

(2) Develop recommendations and implement corrective actions(s) intended to preclude recurrence of disruptive behavior incidents involving employees in coordination with the requirements of this program);

(3) Assist in the presentation of disruptive behavior prevention training for employees and volunteers; and

(4) Assist and support the coordination and the Environment of Care committee to implement an effective Disruptive Behavior Management Program throughout the facility and the off-site work areas.

g. **Education Coordinator** is responsible to:

(1) Ensure that PMDB material is available for staff to review on-line;

(2) Update changes to the on-line content as necessary;

(3) Provide deficiency and attendance reports to track compliance.

h. **Service Chiefs and Supervisors** at all levels are responsible to:

(1) Enforce VA safety rules, regulations, and standards, including those concerning disruptive behavior. Instruct employees and volunteers under their supervision in safe work practices and correct employees or volunteers that do not follow safe work practices;

(2) Identify unsafe conditions and practices in their area(s) of responsibility and take prompt corrective action, as appropriate;

(3) Investigate injuries or illnesses that occur to employees or volunteers under their supervision using the Automated Safety Incident Surveillance Tracking System (ASISTS) program to document within 24 hours. Institute or recommend corrective actions intended to preclude recurrence of similar injuries;

(4) Notify appropriate personnel of work-related injuries that occur to employees or volunteers under their supervision;

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- (5) Assure that employees and volunteers under their supervision receive prompt and appropriate medical attention in the event of injury;
- (6) Complete compensation forms, when appropriate;
- (7) Assure that employees or volunteers who are: Verbally or physically assaulted, who witness disruptive behavior in the workplace, or who have demonstrated warning signs associated with potential disruptive behavior are provided support and referral, as appropriate, to the Employee Assistance Program;
- (8) Initiate disciplinary action, as appropriate, against employees or volunteers who assault beneficiaries, volunteers, visitors, or other employees;
- (9) Assure that all employees or volunteers assigned to them complete appropriate disruptive behavior prevention training;
- (10) To complete the "Workplace Incident Documentation Form", appendix C after any violence incident on staff, volunteers, or patients.

i. **Employees and Volunteers** are responsible to:

- (1) Follow safe work practice (those that minimize the potential for violent behavior);
- (2) Recognize unsafe conditions and immediately take corrective action to eliminate those unsafe conditions under the control of the employee;
- (3) Report unsafe conditions to supervisory personnel;
- (4) Attend training related to disruptive behavior prevention;
- (5) Attend counseling and support meetings, as appropriate;
- (6) Report in a timely manner (same day) work related injuries or verbal or physical abuse to supervisor or other management official;
- (7) Wear identification badges at all times, with their picture, name and department identification on the badge. The badge will be worn so that others may easily read the name;
- (8) Employees, volunteers and visitors are to sign in at the front door when entering the Fayetteville Campus from 9 pm to 5 am.

j. **Environment of Care Committee** is responsible to:

- (1) Provide assistance and support for the facility Disruptive Behavior Management Program and serve as the focal point for the Disruptive Behavior Management Program and its related activities;

- (2) Assist the development and revision of policies, programs, and procedures related to Disruptive Behavior Prevention, recommend approval, and evaluate the effectiveness of these policies, programs and procedures;
- (3) Provide technical support and assistance for the facility's Disruptive Behavior Prevention Program;
- (4) Recommend and monitor resource allocations required for the facility Disruptive Behavior Management Program;
- (5) Review and comment on assessments and annual assessment updates (including corrective actions and interim corrective actions) conducted to identify potential sources of disruptive behavior at the facility or other worksites where VA employees or volunteers are assigned;
- (6) Identify trends and develop strategies annually to reduce or eliminate risks associated with disruptive behavior at the facility; and
- (7) Promote disruptive behavior prevention throughout the facility.

5. Identification of Potential Sources of Disruptive Behavior

a. **Assessment:** An assessment of potential sources of disruptive behavior at this facility has been conducted by the Chief, Police Service with input from the Safety Officer and representatives of the Disruptive Behavior Committee. It has been determined that potential sources of disruptive behavior exist in the Emergency Department, which is accessible to the public 24 hours per day; the Mental Health Building; the Canteen and cafeteria, the cashiers office (which handles money); the pharmacy booth that deals with dispensing medication; the Primary Care reception areas where individuals access the various clinics; and security posts.

b. **Annual Assessment:** The Chief of Police will provide an annual assessment of the potential sources of disruptive behavior at the facility, and after any significant incident involving disruptive behavior, and prior to any changes to the use or function of an area that could impact the potential for disruptive behavior. A report of this annual assessment will be provided to Executive Leadership Team through the Environment of Care Committee. Corrective Actions will be developed as appropriate.

6. Procedures: Disruptive behavior as defined in paragraph 2.a of this policy shall be reported.

a. When a person (employee, volunteer, patient or visitor) has been threatened or assaulted, or becomes aware of threats or assaults to another person, the facility Police shall be notified.

b. The Police and the affected Service Chief will investigate all incidents of disruptive behavior. **The following forms will be completed as appropriate: The Workplace Incident Documentation Form (Appendix 1), Code Red/Code**

Grey/Code 6 Critique (Appendix 3), VA Form 2162 (through the ASISTS program), and VA Form 10-2633.

c. The completed forms will be forwarded to the Chief, Psychiatry Service (116A), Chairman of Disruptive Behavior Committee (116A), Safety Officer (005) and/or the Patient Safety Manager (010) for review and coordination of further investigation and reporting to VISN, if deemed appropriate.

d. Discovery of any weapon or object that can be used as a weapon, hidden in an area that suggests intent for its use as a weapon will be immediately reported to the Police and a Workplace Incident Documentation Form completed.

e. Evaluation and intervention for the offender: The management of disruptive behavior stemming from actions recommended by the **Disruptive Behavior Committee** range from least to the most restrictive behavioral limit-setting tools:

(1) **Counseling** a disruptive Veteran by a VA employee (i.e. DBC Chair, VA Police, Chief of Staff); then

(2) A **Letter of Concern** (known locally as a Warning Letter) written to a Veteran outlining the specific disruptive behavior and **officially** admonishing the Veteran and encouraging them to behave appropriately in the future. Additionally, articulating the progression of further **limit setting interventions** if disruptive behaviors continue are also clarified in the Letter of Concern. And finally

(3) The most restrictive form of **therapeutic limit-setting** is the **Orders for Behavioral Restriction (OBR)**.

f. OBRs may include, but are not limited to

(1) Specifying the hours in which non-emergent Veteran patient care will be provided;

(2) Arranging for medical and any other services to be provided in a particular patient care area (e.g., private exam room near an exit);

(3) Arranging for medical and any other services to be provided at a specific site of care;

(4) Specifying the health care provider, and related personnel, who will be involved with the patient's care, i.e. male only or two providers at once;

(5) Requiring police escort, check-in, stand-by, or walk through;

(6) Authorizing VA providers to terminate an encounter immediately if certain behaviors occur [38 CFR, Part 17.106].

g. The OBR will contain

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(1) A summary of the pertinent facts and the bases for the Chief of Staff's (COS) determination regarding the need for restrictions;

(2) The effective date. Unless otherwise stated, the restrictions imposed by an order will take effect upon issuance by the COS;

(3) The duration of the restrictions

(4) The criteria, if any, for termination of restrictions

(5) Description of the process for appealing the OBR to the Network Director;

h. Documenting the OBR

(1) Once an OBR is approved by the COS, the COS or designee will document the OBR in the form of a certified letter over the COS's or designee's signature. The letter will advise the patient of the reasons for the restrictions, the nature and duration of restrictions, and the patient's rights to appeal the restrictions. Whenever possible, the letter will be sent to the patient by the US Postal Service-certified mail.

(2) A Category I Patient Record Flag (PRF) will also be entered into the patient's record in accordance with the Directive 2010-053, "Patient Record Flags." The flag narrative itself should conform to Directive 2010-053 and should be a brief statement of the "Problem" and the "Plan."

(3) The Patient Record Flag Directive also requires that a Text Integration Utility (TIU) Progress Note be entered for each PRF. A copy of the OBR letter serves as the TIU Progress Note. The title of the Progress Note for an OBR will be:

(a) **"Patient Record Flag Category I, Order of Behavioral Restriction"**

(4) The signed OBR letter should also be scanned into CPRS Vista Imaging to serve as an official record of the OBR

i. The procedure for appealing the OBR is as follows:

(1) The patient must submit a written appeal to the Network Director through the COS within 30 days of the effective date of the OBR.

(2) As soon as possible, the COS shall forward the OBR and the patient's written appeal to the Network Director for a review and a final decision.

(3) The network Director shall issue a final decision on this appeal within 30 days of receipt of the request by the COS.

(4) VA will enforce the OBR while it is under review by the Network Director.

(5) The COS will provide written notice of the Network Director's final decision to the patient as soon as possible

j. When the patient fails to comply with an OBR, that day's episode of care will be terminated once he/she is medically stable. If necessary, the patient will be escorted from facility grounds by VA Police. The patient may resume his/her access to care the following day. Repeated failure to abide by an OBR may result in progressive restrictions up to but, **short of denying access** to the full range of VA care.

(1) When an OBR requires that a disruptive patient is to seek care at another nearby VA Medical Center or at a nearby non-VA facility at VA expense. Regulation 38 CFR, Part 17.106 requires that any order is "narrowly tailored to address the patient's disruptive behavior and avoid undue interference with the patient's care." When an OBR directs that care be offered at a different facility, the following should be documented in the patient's medical record.

(2) Appropriate VA consents for release of information (when referred to a non-VA facility), signed by the patient, and must be scanned into the medical record.

(3) The veteran must have the ability to travel to appointments at the receiving facility (to require that the veteran must travel more than a few hours to another facility will not meet the requirement of 38 CFR, Part 17.106 that restrictions "avoid undue interference with the patient's care"). Appropriate modes of transportation must be accessible to the patient. In some cases, it may be necessary for the costs of the patient's transportation to be arranged and born by the facility that is imposing the OBR.

(4) The COS ordering the OBR should transact a Memorandum of Understanding (MOU) with the COS of the receiving facility. The MOU should include complete information from the OBR.

(a) Any relevant health conditions that might be exacerbated by travel to the receiving facility must be considered and accommodated by the sending facility.

(b) The patient under an OBR should be provided with information about assigned providers and appointments at the receiving facility prior to his/her first visit there.

(c) He/she should also be provided with sufficient prescription refills by the sending facility to bridge any delays before his/her first appointments at the receiving facility.

(d) The disruptive patient should be provided all of this transfer information in writing prior to his/her first visit to the receiving facility.

(e) Copies of all records pertaining to the reasons for the first facility's establishment of an OBR must be sent in a secure manner to the receiving facility. The COS of the receiving facility should consider whether an OBR should be crafted and communicated to the veteran before his/her first appointments.

(5) **Flagging medical records:** A computerized warning of disruptive behavior on patients who have been involved in episodes of disruptive behavior may be identified in the computer as having the potential for disruptive behavior per Guidelines established in the National Patient Record Flag Directive VHA Directive 2010-053 (See Appendix E for National Patient Record Flags.)

(6) **Employee or Volunteer Offender:** If an incident is committed by someone in either of these categories, the Police and the offender's Service Chief/supervisor are to be notified immediately. The responding officer will determine the proper course of action to ensure the immediate safety of the individual(s) involved. Dependent on the severity of the incident, Executive Leadership may also need to be notified.

(7) The fugitive felon program requirements can be found in Appendix F.

k. **Legal Intervention**

(1) Any victim of a threat, assault, or other violent act may pursue criminal or other legal action against the offender. The Police Service will be the point of contact for the U.S. Attorney's Office for all matters regarding criminal complaints that initiate from this facility.

(2) All employees who apply for or obtain a protective restraining order which lists this facility as being a protected area, must notify their Service Chief and provide the Police Service with a copy of the order and declarations used to seek the order. The Police Service will take necessary measures to protect the employee and any sensitive information

7. Training

a. **Initial Training:** The primary PMDB training will be presented during the new-hire orientation week on two separate occasions

(1) **First:** On Wednesday of orientation week all new-hires will be presented a 45 minute orientation to PMDB training focusing on a discussion of workplace violence, appropriate reporting procedures, and the agenda for the expanded PMBD training presented on Friday of orientation week

(2) **Second:** On Friday afternoon new-hires will be presented the full 4 hour PMDB class. Class topics include: understanding medical settings and the violence potential; assessing risk from others, self, and the environment; predisposing individual factors, i.e. understanding body language and verbal behavior; discussion and practice of de-escalation techniques for managing tension and anger, i.e. active listening and limit setting; VA reporting procedures; and, Personal Safety Skills

b. **Refresher training:** PMDB Annual training is required of all employees via the TMS on-line training system. This three hour refresher course provides an overview of the PMDB program and a discussion of workplace violence, assessing risk, appropriate assessment, and reporting procedures. Additionally, a slide presentation of the

Personal Safety Skills is presented. Employees are required to achieve an 80% passing grade. Employee training for PMDB will be based on the information below:

(1) **High Risk Areas:**

- (a) Emergency Department
- (b) Primary Care
- (c) Mental Health Opt Clinic
- (d) Inpatient Psychiatry Ward
- (e) Pharmacy Counseling Booths
- (f) Police

(2) **High Risk Occupations:**

- (a) Primary Care Clerks
- (b) Emergency Department Clerks/Administrative Officers on Duty (AODs)
- (c) Primary Care/Emergency Department
- (d) Nursing Staff
- (e) Pharmacists
- (f) Outpatient Mental Health Unit Staff
- (g) Evening/Night Nursing Coordinators
- (h) Emergency Department Physicians
- (i) Police
- (j) Wards - Nursing Staff
- (k) Nursing Staff Specialty Clinics
- (l) Physicians
- (m) Patient Advocate

8. Prevention and Monitoring:

a. **Personal Conduct to Minimize Violence:**

- (1) **Do:**

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- (a) Project calmness: Move and speak slowly, quietly and confidently.
- (b) Be a good listener: Encourage the person to talk and listen patiently.
- (c) Focus your attention on the other person to let them know you are interested in what they have to say.
- (d) Maintain a relaxed yet attentive posture and position yourself at a right angle rather than directly in front of the other person.
- (e) Acknowledge the person's feelings. Indicate that you can see he/she is upset.
- (f) Ask for small specific favors such as asking the person to move to a quieter area.
- (g) Establish ground rules if unreasonable behavior persists. Calmly describe the consequences of any disruptive behavior.
- (h) Use delaying tactics, which will give the person time to calm down. For example, offer a drink of water (in a disposable cup).
- (i) Be reassuring and point out choices. Break big problems into smaller, more manageable problems.
- (j) Accept criticism in a positive way. When a complaint might be true, use statements like "You're probably right" or "It was my fault". If the criticism seems unwarranted, ask clarifying questions.
- (k) Ask for his/her recommendation. Repeat back what you feel he/she is requesting of you.
- (l) Arrange yourself so that he/she is not blocking you access to an exit.
- (2) **Do not:**
 - (a) Use styles of communication, which generate hostility such as apathy, brush off, coldness, and condescension, going strictly by the rules or giving the run-around.
 - (b) Reject all of the person's demands from the start.
 - (c) Pose in challenging stances such as standing directly in front of someone, hands on hips or crossing your arms. Avoid any physical contact, finger pointing, or long periods of fixed eye contact.
 - (d) Make sudden movements, which can be seen as threatening. Notice the tone, volume and rate of your speech.

(e) Challenge, threaten or dare the person. Never belittle the person or make him/her feel foolish.

(f) Criticize act or impatiently move toward the agitated individual.

(g) Attempt to bargain with a threatening individual.

(h) Try to make the situation seem less serious than it is.

(i) Make false statements or promises you cannot keep.

(j) Try to impart a lot of technical or complicated information when emotions are high.

(k) Take sides or agree with exaggerations.

(l) Invade the individual's personal space. Make sure there is a space of 3-6 feet between you and the person.

b. Warning signs of potentially violent individuals:

(1) Externalization of blame.

(2) Un-reciprocated romantic obsession.

(3) Taking up much of supervisor's time with behavior or performance problems.

(4) Fear reaction among coworkers/clients.

(5) Drastic change in belief systems.

(6) Displays of unwarranted anger.

(7) New or increased source of stress at home or work.

(8) Inability to take criticism.

(9) Feelings of being victimized.

(10) Intoxication from alcohol or other substances.

(11) Expressions of hopelessness or heightened anxiety.

(12) Productivity and/or attendance problems.

(13) Violence toward inanimate objects.

(14) Steals or sabotages projects or equipment.

- (15) Lack of concern for the safety of others.

c. **Recognizing Inappropriate Behavior:** Inappropriate behavior is often a warning sign of potential hostility or violence. When left unchecked it can escalate to higher levels. Employees who exhibit the following behaviors should be reported to your supervisor.

- (1) Unwelcome name-calling, obscene language, and other abusive behavior.
- (2) Intimidation through direct or veiled verbal threats.
- (3) Throwing objects in the workplace regardless of the size or type of object being thrown or whether a person is the target of a thrown object.
- (4) Physically touching another employee in an intimidating, malicious, or sexually harassing manner. This includes such acts as hitting, slapping, poking, kicking, pinching, grabbing and pushing.
- (5) Physically intimidating other, including obscene gestures.

9. Response Teams

a. VHSO Fayetteville

(1) Code Red Team

(a) Between the hours of 8 a.m. to 4:30 p.m. (Monday- Friday) the Code Red Team will consist of the Chief, Psychiatry or designee, Psychiatry Physician Assistant (PA), 1A Nursing Coordinator, Nursing Bed Control, Social Worker, VA Police Officer(s), and all available Nursing and Medical Service Staff in the area. The Nurse Coordinator or designee will assume responsibility for coordinating the response and communicating with other team members and complete the Code Red Critique Form, Appendix B.

(b) Implement "Personal conduct to minimize violence" (See under paragraph #7).

(c) Between the hours of 4:30 p.m. and 8 a.m., weekends, and holidays, the following staff will respond to the Code Red alarms: the Medical Officer of the Day (MOD), Nursing Coordinator on Duty, VA Police Officer(s), and all available medical staff.

(2) Communication

(a) 7 a.m. - 8 p.m. (Switchboard Operating Hours):

1) Telephone operator will be notified via voice or panic button to announce Code Red, giving the location of the crisis.

2) For voice notification of the telephone operator a phone line, extension 65911 should be used. Callers should specifically state "Code Red" and the location.

3) The telephone operator will call the VA police on the radio giving the CODE RED and location of the crisis and they will report immediately to the scene.

4) The telephone operator will page the Code Red Beeper Group on pager 555.

5) At the sound of the announcement, nursing coordinators on each unit are to designate available nursing staff on each unit to report to the affected area.

6) If the crisis occurs in an area other than the nursing units (i.e., basement, main lobby), any member of the hospital staff is to notify the telephone operator to announce CODE RED giving the location of the crisis.

(b) 8 p.m. - 7 a.m. (Non-functioning Switchboard Hours)

1) The area in which the crisis is located will telephone the Administrative Officer of the Day (AOD) (extension 0) to announce over the medical center's paging system Code Red and give the location of the crisis.

2) The AOD will page the Code Red Beeper Group on pager 555.

3) The AOD will then radio the VA police giving the code red signal, the location of the crisis and they will report immediately to the scene. The AOD will notify the Medical Officer of the Day giving the code red signal and location of the crisis and he will respond immediately to the scene.

4) The Nursing Care Coordinator will immediately respond by reporting to the area of the crisis. At the sound of the announcement, charge nurses from each unit are to designate available nursing staff to report to the crisis area.

(c) At all times:

1) Staff can also be alerted using the code red call buttons.

2) Button locations are:

a) Emergency Room Nurses (3 Buttons)

b) Employee Health Office

c) Patient Advocate's Office (2-09)

d) Ward 1A, Nurses Station, Rooms 1-115, 1-116, 1-118A, 1-120, 1-121

e) Release of Information (1-45)

- f) Pharmacy Booth – Main Pharmacy
- g) 3B Clinic Nurse's Station
- h) AOD Front Desk (rings at ED Nurse's desk)
- i) Director's Suite Bldg 4 (1 Ea Secretary's desk)
- 3) The alarm is sounded in the following locations:
 - a) Telephone Switchboard Operator's Room, Monday through Friday, between the hours of 7 a.m. and 8 p.m., and on weekends and holidays from 10 a.m. to 6 p.m.
 - b) Admissions area, and Ward 1A, Monday through Friday, from 8 p.m. to 7 a.m. and on weekends and holidays from 6 p.m. to 10 a.m.

(d) **Police Support:**

- 1) The senior or responsible patient care staff person at the scene should always clearly signal to the police when to assist.
- 2) Hospital police are not to be utilized as a disciplinary force responding to minor disorders, which are within the capabilities of the direct care staff to manage. When police are summoned, if appropriate, the senior or responsible patient care staff person should provide the police with the following information:
 - a) Is the patient a danger to self or others?
 - b) Pepper Spray contraindicated?
 - c) Physical Limitations or Injuries?
 - d) History of violence/assault by the patient?
- 3) It is considered appropriate that hospital police be used to assist in escorting violent-prone patients between wards and clinics when the attending physician believes such precautions are necessary.

(3) **Direct Emergency Admissions to Psychiatry Service**

- (a) Step 1: The patient will be escorted directly to the psychiatric unit. The nurse manager or the charge nurse should be contacted as soon as possible. The patient may be placed in the quiet room until further assessment is complete.
- (b) Step 2: The provider will write admission orders as soon as possible and alert the clinic RN to call bed control. The provider may alternatively accompany the patient to the ward to provide any needed direction to nursing staff.

(c) Step 3: Police will remain with the psychiatric nursing staff until staff can inspect and inventory all the patient's belongings.

(d) Step 4: The patient's belongings will be locked in a closet on the ward or in the clothing room as indicated.

(e) Step 5: The nurse will sign a statement of inspection and list any potentially hazardous objects removed.

(f) Step 6: If patient refuses to cooperate, the patient will be either discharged for failure to comply with VHSO policy and/or rules and regulations, or the commitment process will commence if homicidal, suicidal, or gravely disabled due to mental illness.

b. **Gene Taylor Community Based Outpatient Clinic (GTCBOC):** The management of a violent patient at the GTCBOC at Mt. Vernon will be accomplished as follows:

(1) Dial 480 to get the operator who will overhead announce a Code Grey.

(2) The staff psychiatrist or a medical physician in the absence of the psychiatrist will assess the patient to determine need.

(3) The MRC Security Officer will determine whether or not local law enforcement officers are required to manage the patient in the interim, and they will also be responsible for making the necessary contact.

(4) If the Missouri Rehabilitation Center (MRC) Security Officer is not immediately available, or a weapon is displayed, the communications center personnel will be so advised and immediately call the MRC Operator to call the Mt. Vernon Police. The MRC operator will also be advised if a weapon is displayed.

(5) The Code Grey Team of the GTCBOC will consist of the following:

(a) Staff Psychiatrist

(b) Staff physician

(c) Team Nurse

(d) Staff Nurse

(e) Social Worker

(f) Pharmacist

d. **Ft. Smith (Code 6), Harrison, Branson, Jay and Ozark CBOCs and Sunbridge and Township Clinics** will call 911 in response to the physician's verbal

request. Team will consist of the lead physician, team nurse, and medical clerk/receptionist, a staff nurse and at Fort Smith the Psychiatrist and Psychiatry PA.

9. Incident Follow-up/Counseling:

a. Responses to the Code Red (VHSO), Code Grey (GTCBOC), Code 6 (Ft. Smith CBOC) and Harrison, Branson, Jay, Ozark CBOCs and Sunbridge and Township clinics (Call 911) will be critiqued using Appendixs A and B to this memorandum. The nursing coordinator/manager will be responsible for the critique. Upon completion, it will be routed for review to the Mental Health Council and Disruptive Behavior Committee thru the Chief, Psychiatry.

b. VA volunteers and staff, who are assaulted, experience the feelings and reactions typical of other victims and may need help in dealing with emotional trauma.

c. Emotionally disturbed beneficiaries, patients, or applicants for medical care who become assaultive require special understanding and compassion. Medical staff, involved employees, VA police officers, and management officials must assess the intent of the person committing an assault and the existence of 'mitigating circumstances.' Mental health clinicians determine the degree to which a patient's mental state was responsible for a particular incident of assaultive behavior.

d. Ordinarily, assaultive behavior that results in the injury of another or in property damage constitutes a criminal offense. Presence of a mental disorder does not always absolve a person of criminal responsibility. Medical personnel are responsible to provide care to the patient and attempt to bring misbehavior related to mental disorder under control. The physical arrest and detention of a beneficiary or patient must occur when the act committed constitutes a felony and the person will possibly run from the authorities.

10. National Patient Record Flags PRFs: See Appendix E for process implementing National PRFs.

11. References: IL 10-2010-002, Intimidating and Disruptive Behaviors that Undermine a Culture of Patient Safety, dated January 13, 2010, VA Directive 7700, Occupational Safety and Health, dated February 11, 2009, VHA Handbook 7701.01, Occupational Safety and Health (OSH) Program Procedures, dated August 24, 2010, VHA Handbook 100.2, VHA Fugitive Felon Program, dated December 2, 2004 and VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010.

12. Rescissions: Medical Center Memorandum 07-00-55, dated August 3, 2011.

13. Rescission: This Medical Center Memorandum will expire June 15, 2015.

Mark A. Enderle, MD
Medical Center Director

MCM #12-00-55, Disruptive Behavior Management Program

Appendixes: A, B, C, D, E, F, G, H, I, J

Distribution: Via Intranet

Code Red */ Code Grey /Code 6 *****

Critique

1. Purpose: To provide a method for ongoing monitoring and evaluation of Code Red/Grey/Code 6 situations.

2. Actions:

a. A Code Red/Grey/Code 6 Critique will be initiated, completed and appropriately routed by the nursing coordinator/manager or PC Nurse Supervisor. Members of the team following the Code Red/Grey/Code 6 will give input.

b. The critiques will be reviewed by the Mental Health Council and the Disruptive Behavior Committee. Formal recommendations will be developed and implemented by the Chairperson or will be referred to the Environment of Care Committee and the CEB, as appropriate.

c. Code Red/Grey/Code 6 Critique Tool. (See Appendix B)

*The term 'Code Red' is used at VHSO, Fayetteville, Arkansas to designate a violent or potentially violent situation. Code Red would be used at the Sunbridge Clinic (internally) with staff calling 911 for assistance.

** The term 'Code Grey' is used at the Gene Taylor Community Based Outpatient Clinic in Mt. Vernon to designate a violent or potentially violent situation.

*** The term 'Code 6' is used at the Ft. Smith Community Based Outpatient Clinic to designate a violent or potentially violent situation.

Code Red/Code Grey/Code 6 Critique:

Patient Name:	
Patient Social Security Number:	
Location:	
Date of Occurrence:	
Diagnosis:	
Initiation Was Code Red/Grey/6 signal initiated correctly?	
Response Time Was response time within two minutes?	
Leadership Present	Physician: Nurse:
Number of Participants:	
Interventions(s):	
Of those responding, number trained in PMDB:	
Problems Identified:	Initiation and Response: Injuries to staff, visitors or patients: Equipment failure: Inadequate Supplies: Obstacles: Other:
Recommendations:	
Reviewer Signature:	
Date:	

Return completed form to Christina Williamson RN-BC, MSN, Q&P Specialist
Quality and Performance Service, Mail route 002

1. Today's Date:

2. Your Name:

3. Your title/position:

4. Your work phone number:

5. Who reported it to you?

Name	
Status	
Ward or Phone Number	
Name	
Status	
Ward or Phone Number	

6. Is this a Completed Act/Behavior or a Threat?

7. Who is/are the victim(s) or target of act/threat?

Name	
Status	

Ward or Phone Number	
Name	
Status	
Ward or Phone Number	
Name	
Status	
Ward or Phone Number	

8. If this is a threat not yet to have occurred, has/have the target(s) or recipient(s) of the threat been notified?

--

9. If this is a threat, is it a:

Direct Threat	
Conditional Threat	
Veiled Threat	

10. Who is the alleged perpetrator?

Name	
Status	

11. When did the incident/threat happen? (Date and time, if known)

--

12. Describe what happened in as much detail as possible.

--

13. Were there any witnesses?

Name	
Status	
Ward or Phone Number	
Name	
Status	
Ward or Phone Number	
Name	
Status	
Ward or Phone Number	

14. Forward completed form to the Chairman, Disruptive Behavior Committee; Safety Officer and Patient Safety Manager

(Add blank sheet for additional information, if necessary)

Membership – Disruptive Behavior Committee (DBC)

Chairperson: Chief, Psychiatry Service or Designee

Members: Chief, Police Service

Patient Safety Manager

Patient Advocate

Administrative Assistant, Chief of Staff

Education Coordinator

Safety Officer

Chief, Social Work Service

Primary Care Administrator or designee

Chief, Nursing Service or Designee

Chief, Human Resources Management Service (Disruptive

Behavior Program Coordinator) or Designee

American Federation of Government Employees (AFGE) Safety Representative

Primary Care Patient Service Assistant Supervisor

Chief, Health Information Management Section (Ad Hoc)

Regional Counsel (Ad Hoc)

National Patient Record Flags (PRFs)

1. **Purpose:** The purpose of Appendix E of this medical center memorandum is to outline policy and guidance for the proper use of (PRFs)
2. **Policy:** This medical center and its Community Based Outpatient Clinics (CBOCs) are committed to a safety program that is systems based and focused on prevention, not on punishment or retribution. Preventative methods that target root causes are favored
 - a. A PRF alerts employees to patients whose behavior, medical status, or characteristics may pose an **immediate** threat either to that patient's safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter. PRF enhances both the right of all patients to receive confidential, safe, and appropriate health care, as well as the right of employees to a safe work environment. PRF permit employees to develop strategies for offering health care to even the most behaviorally challenging patients who, in an earlier era, might have been excluded from receiving VHA health care.
 - b. PRF was originally developed for the specific purpose of improving safety in providing health care to patients who are identified as posing an unusual risk for violence. The use of PRF has expanded to address a limited number of additional safety vulnerabilities that present in the initial moments of a patient encounter. These PRFs are to be used very judiciously and approved either by the medical center Director based on recommendations from the medical center Disruptive Behavior Committee (DBC).
 - c. The effectiveness of PRF is paradoxically based upon the degree to which their appearance on the computer screen is so unusual that it captures the attention of the user. Inappropriate use of any PRF reduces the effectiveness of all PRFs.
 - d. For ethical reasons, it is inappropriate to use a PRF in the absence of a clear risk to safety. The use of PRF can be ethically problematic for two reasons. First, a PRF stigmatizes patients, labeling them as difficult, whether for clinical or behavioral reasons. Second, a PRF compromises privacy because it reveals private patient information to anyone who opens the patient's chart, regardless of whether that person has the need to know that would normally justify revealing such information. Accordingly, a PRF must only be used for a compelling safety reason which outweighs these ethical concerns.
 - e. The use of PRF is limited to addressing immediate clinical safety issues. However, PRF are not an appropriate tool with which to alert employees to every potential safety issue. For example, a patient's human immunodeficiency virus status is not an immediate threat to the safety of the patient or staff and thus is not appropriate as a PRF and additionally, would be in violation of the patient's privacy as all users of the Computerized Patient Record System (CPRS) would see the PRF. With the practice of universal precautions, such flags may be redundant.

f. The use of PRF for administrative or law enforcement purposes is strictly prohibited. Signaling a Veteran's theatre or era of service, unresolved felony warrants, or fee-basis eligibility would be examples of prohibited uses of PRF. Only safety issues of an immediate clinical nature (e.g., recurring violence, high risk for suicide, missing patient) are permitted.

g. A PRF is not the only tool available that may function as an alert for selected problems. Within CPRS some alert alternatives are: the patient problem list; Crisis Warning Allergies and Directives (CWAD) notes; and Veterans Health Information Systems and Technology Architecture (VistA). However, only Category I PRF is to be used to signal high risk for seriously disruptive, threatening, or disruptive behavior.

h. Blanket program or facility-level access restrictions, based upon the mere presence of a Category I PRF, are prohibited. Category I PRF is intended to make it possible for VHA to offer clinical services even to patients who present significant clinical (risk of danger to others) safety challenges. The presence of a Category I PRF on a patient's health record shall not, by itself, be grounds for refusing admission or services to a patient seeking care in a VHA facility or program. Nor should any PRF be automatic grounds for discharging a patient from a program to which the patient is entitled, and for which the patient is clinically appropriate. Each patient with a PRF is to be evaluated individually for appropriateness for any VHA service. The presence of any PRF should only be one factor in that calculation. Program managers or admission screeners may wish to seek consultation in assessing the suitability of a patient with a Category I PRF for entry into a program or use of a Department of Veterans Affairs (VA) service from the Disruptive Behavior Committee (DBC).

i. **Category I PRF—Violent or Disruptive Behavior.** Category I PRF is nationally approved and is shared across all known treating facilities for a given patient. Use of Category I PRF is not optional. Individual Category I PRF is assigned locally in accordance with standards developed nationally for the Category I PRF type in question. Category I PRF become national information as part of the Master Patient Index and is displayed at all VHA facilities where the patient is registered. As a result, patients with a Category I PRF who present an immediate safety risk for seriously disruptive, threatening, or disruptive behavior, may be safely treated within VHA wherever they are registered and seek care. A Text Integrated Utility (TIU) Progress Note in the CPRS describing the rationale for the PRF assignment must accompany all Category I PRF.

j. **Category II Local PRF—Patient at Risk**

(1) Category II PRF may be established by the medical center. Category II PRF is used for a range of purposes. Appropriate uses include:

(a) Flagging patients who are enrolled in research trials involving potentially risky investigatory pharmaceuticals;

(b) Flagging patients with a documented history of narcotics diversion or theft;

- (c) Flagging patients at high risk for suicidal behavior;
 - (d) Flagging patients with spinal cord injuries;
 - (e) Flagging homeless Veterans who have urgent medical test results pending; and
 - (f) Flagging missing and wandering patients.
- (2) The use of Category II PRF, like Category I PRF, must be strictly limited to information that is immediately needed for the delivery of safe and appropriate health care. A TIU Progress Note in the CPRS describing the rationale for the PRF assignment must also accompany all Category II PRFs.

(3) **Inappropriate Use of PRF.** PRF must never be used for law enforcement or administrative purposes.

(a) An inappropriate use of PRF for law enforcement might include flagging of fugitive felon status.

(b) An inappropriate use of PRF for administrative purposes might include name changes, Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF) status, etc.

3. Responsibilities

a. Medical Center Director. The Medical Center Director, or designee, is responsible for:

(1) Ensuring that Category I PRF is originated and accessible, and whether optional Category II PRF is to be used. *NOTE: Appendix B, Standards for PRF, defines the standards for the origination of, and access to, both Category I and Category II PRF.*

(2) Establishing a process for requesting, assigning, reviewing, and evaluating PRF.

(3) Establishing a plan to transition previous VistA, CPRS, local Class III Advisories, and any other behavioral alerts or warnings system in use, to VHA's nationally released PRF software. *Note: As of September 25, 2003, only PRF computerized advisories as described in Appendix B are approved for use in the identification of patients who are at significant risk for violence.*

(4) Ensuring that each Category I PRF assigned to a patient is reviewed at least once a year; however, reviews may be appropriate anytime a patient's violence risk factors change significantly, the patient requests a review, or for other appropriate reasons.

(5) Training appropriate staff in determining when a PRF is to be entered, how PRFs are entered, and how PRF and PRF-related documents are to be maintained and reviewed.

(6) Evaluating the facility process to ensure that PRF is assigned appropriately.

(7) Ensuring that each PRF in a patient's record is accompanied by a TIU Progress Note. The TIU titles utilized must be:

(a) PRF Category I, or

(b) PRF Category II.

b. **Clinical Executives: Chief of Staff (COS).** The COS is responsible for:

(1) Instituting procedures to ensure that the utilization of PRF and the associated processes for recommending PRF are ethical, clinically appropriate, supported by adequate resources, and used in accordance with this Directive.

(2) Ensuring that patients are notified that a PRF has been placed in their health record and that they are informed of its contents.

(3) Establishing a DBC.

(a) The DBC or DBB is responsible for:

1) Coordinating, when possible and appropriate, with the clinicians responsible for the patient's medical care, and recommending amendments to the treatment plan that may address factors that may reduce the patient's risk of violence.

2) Implementing the standards in Appendixes A and B.

3) Collecting and analyzing incidents of patient disruptive, threatening, or disruptive behavior.

4) Assessing the risk of violence in individual patients.

5) Informing patients they have a right to request amendment to the contents of a PRF, and providing the information for contacting the facility privacy officer in the event the patient wants to pursue an amendment.

6) Identifying system problems.

7) Identifying training needs relating to the prevention and management of disruptive behavior.

8) Recommending to the COS other actions related to the problem of patient violence.

(b) The DBC must be comprised of:

- 1) A senior clinician chair that has knowledge of, and experience in, assessment of violence;
- 2) A representative of the Prevention Management of Disruptive Behavior Program in the facility (see subpar. 5i);
- 3) VA Police;
- 4) Health Information Management Service and/or Privacy Officer (ad hoc);
- 5) Patient Safety and/or Risk Management official;
- 6) Regional Counsel (ad hoc);
- 7) Patient Advocate;
- 8) Other members as needed, with special attention to representatives of facility areas that are at high risk for violence, (e.g., emergency department, nursing home, inpatient psychiatry, and community-based outpatient clinics).
- 9) Representative of the Union Safety Committee; and
- 10) Clerical and administrative support staff to accomplish the required tasks.
- 11) The DBC or DBB, whose primary focus is upon reducing the risk of patient violence toward employees and others, will offer technical advice to other PRF software users as appropriate.
- 12) Identifying a Suicide Prevention Coordinator who will be responsible for entering, maintaining, and deactivating Category II Suicide PRFs in accordance with VHA policy regarding the use of PRFs to identify patients at high risk for suicide.
- 13) Identifying an employee or employees who will be responsible for entering, reviewing, maintaining, and deactivating Category II PRFs for missing or wandering patients in accordance with VHA policy regarding management of wandering and missing patient events.

(c) **Facility Privacy Officer.** The facility privacy officer is responsible for:

- 1) Receiving requests from patients regarding an amendment to a PRF that has been placed in the patient's health record.
- 2) Amending the health record, as appropriate, according to VHA Handbook 1907.01.

Standards for Category I and Category II

Patient Record Flags

1. **Background:** A diverse group of patients present with certain behavioral or clinical risk factors that place special demands upon the health care system. It is both a privilege and a challenge for the Department of Veterans Affairs (VA) health care employees and facilities to offer safe and appropriate care to all patients. The safety of patients and the safety of staff who treat them, can be enhanced when carefully designed Patient Record Flags (PRF) immediately alert care providers to the presence of risk factors *that must be made known in the initial moments of a patient encounter.*

a. Because some of the most challenging patients may be nomadic, and because a patient's electronic health record is increasingly available to other facilities, it is essential that conventions for creating, supporting, and maintaining computerized advisories be made uniform throughout VA's health care system.

b. PRFs should never be used to punish or to discriminate against patients, nor should they be constructed merely for staff convenience. The effectiveness of PRFs depends upon limiting their use to those unusual risks that threaten the safe delivery of health care. Threats to the effective use of PRFs are their misuse and overuse.

c. Providing an environment that is safe for patients, visitors, and employees is a critical factor in health care. The safety of patients and staff, as well as the effectiveness of care and patients' right to privacy and dignity, need not be compromised by threats of violence or other clinical safety risk factors. Risks associated with a history of violence or other risk factors can be limited when those risks are recognized and reported. Risks need to be addressed by an interdisciplinary group under senior clinical leadership and documented, when appropriate, in the patient's treatment plan. They must also be communicated in a standardized manner to those most at risk in an encounter with a "flagged" patient.

2. **Procedures:** Each facility must demonstrate its readiness to use PRF in a manner which is consistent with the standards and protocols outlined in this Directive.

a. As part of the patient health record, all PRFs are entered under the authority of the Chief of Staff (COS) or designee at each facility. **Note:** *PRF must be accorded the same confidentiality and security as any other part of the health record.*

b. The COS, or designee, at each facility is responsible for identifying those employees authorized to initiate, enter, and access PRF. The COS, or designee, must ensure that only those employees with a demonstrated need to know are permitted access to PRF menu options.

c. Access to viewing PRFs is recommended for employees who are likely to be the first to encounter a "flagged" patient, prior to or at the time of the patient's visit. Access includes viewing the type of PRF and the narrative associated with it. Those who access a PRF are responsible for communicating the PRF advisory to doctors,

nurses, and others who have a need to know. The following are examples of medical center staff who have direct patient contact needing to view, or be made aware of PRF:

- (1) Emergency room clerks and receptionists;
- (2) Administrative Officer of the Day;
- (3) Pharmacists and pharmacy technicians;
- (4) VA police officers;
- (5) Enrollment clerks;
- (6) Social Work staff;
- (7) Triage and telephone care staff;
- (8) Ward and clinic clerks;
- (9) Insurance and billing staff;
- (10) Receptionists;
- (11) Travel clerks;
- (12) Laboratory clerks and technicians;
- (13) All medical staff;
- (14) Patient advocates;
- (15) All Nursing staff;
- (16) Decedent Affairs Clerk;
- (17) Scheduling staff;
- (18) Fee clerks; and

d. Release of Information Clerks. PRF software is in place. Although facilities may respond appropriately to PRF transmitted from other facilities, only facilities that employ the criteria in this Directive may enter new Category I PRFs.

e. A Text Integration Utility (TIU) Progress Note must be entered at the same time as the entry of any PRF. This note must provide general guidance to PRF users, and should include a brief summary of the rationale for the existence of the specific PRF. The progress note, however, is not the same narrative as the PRF itself.

f. A process exists for the review of each flag for risk of disruptive behavior at least every year. A review may be appropriate when: the risk factors change significantly; a patient with a PRF requests a review; or for other appropriate reasons as determined by the facility that established the flag. A reminder for an upcoming review must be generated 60 days prior to the one year anniversary date of each PRF.

g. PRFs serve only to preserve and enhance the safety and appropriateness of patient care.

h. PRFs alert staff to a potential risk only; they are advisories. At each patient encounter, the examining physician or other clinician remains responsible for making appropriate clinical decisions.

i. Each facility must have clearly written definitions and entry criteria (that are consistent with this VHA Directive) for all Category I and Category II PRFs.

j. PRF should be entered, only by employees who have been trained in the technical aspects of entry, with the appropriate criteria, and in the conventions for security, format, and terminology.

k. PRF must be free of redundant language, slanderous or inflammatory labels, and must provide sufficient information or guidance for action. PRF narratives must be written in language sufficiently specific as to inform readers of the nature of the risk and recommended actions to reduce that risk. The PRF narrative should also avoid alluding to site-specific persons, acronyms, abbreviations, processes, buildings, or other descriptors unique to the originating site that would have no meaning for other sites where the Veteran may appear.

l. In order for PRFs to be effective, they must be used only when necessary. PRFs should be deactivated when their usefulness has passed. Overuse dilutes the importance of a PRF. Each facility must exercise great care in establishing optional Category II PRFs. Only when there is a compelling immediate clinical safety issue should additional PRF types be utilized. PRF is not to be used for staff convenience, or to address administrative or law enforcement concerns. Category II PRF types must adhere to the standards as spelled out in this appendix.

m. Patients may request an amendment to the presence or content of a PRF advisory through the facility privacy officer.

n. The Deputy Under Secretary for Health for Operations and Management (10N) provides oversight to the Veterans Integrated Service Networks (VISN) to ensure that PRFs are appropriately implemented by the facilities.

o. All VHA staff must respond appropriately to the appearance of PRF.

p. All VISNs must establish processes for the origination and appropriate use of Category I PRFs.

(1) All facilities are required to implement and respond to Category I PRFs, regardless of which facility originated the flag.

(2) All facilities must participate in utilization of PRF, regardless of the originating facility for any individual advisory or type of PRF advisory. Only the nationally developed PRF is to be utilized.

q. The responsibility for ensuring the quality, timeliness, routine review, and documentation in support of a PRF advisory belongs to the originating facility.

(1) The advisory itself will reference the authorizing facility and the COS or designee who can provide additional information about a specific PRF advisory. A facility that, in the course of providing care to a patient who was “flagged” by another facility, discovers new information that could influence the status of that advisory should not amend the original advisory, but instead should contact the originating facility with the new information.

(2) The responsibility for ownership and maintenance of PRF needs to be transferred when it appears that a flagged patient has relocated to a new facility. The originating facility should make available to the new facility, copies of all documents and records in support of the advisory.

r. PRF Training.

(1) Training must provide instruction on how to utilize PRF software on the assignment, continuation, inactivation, and review of flags.

(2) Training content must address:

(3) Various types of PRF;

(4) Appropriate responses;

(5) PRF confidentiality; and

(6) Compliance with Public Law 105-220 Section 508 (see subpars. 5h and 5i).

Category I Patient Record Flags (PRFs)**Special Requirements**

- a. Category I **Violent and Disruptive Behavior** are currently the only implemented types of Category I PRFs that are designed to appear in all Department of Veterans Affairs (VA) facilities where a Veteran is registered to receive care. All Category I PRFs require a Text Integrated Utility (TIU) Progress Note in the Computerized Patient Record System (CPRS).
- b. Category I **Violent and Disruptive Behavior** PRF describe patient risk factors that may pose an immediate threat to the safety of other patients, visitors, or employees. Category I **Violent and Disruptive Behavior** PRF also recommend specific behavioral limit settings or treatment-planning actions designed to reduce violence risk.
- c. Health care workers experience one of the highest rates of nonfatal injuries from workplace assault of any occupation in the United States (U.S.). Health care is one of only two industries that have merited special attention from the U.S. Occupational Safety and Health Administration (OSHA) (see subpars. 5a and 5b). When compared to employees of other health care systems, Veterans Health Administration (VHA) employees are two and a half times more likely to suffer injuries in violent incidents involving patients (United States Postal Commission, 2000; Hodgson et al, 2004). In recognition, VHA has initiated a broad-based program of violence prevention, including performance monitors through the Office of the Deputy Under Secretary for Operations and Management. Efforts have included the redesign of the basic course for all employees, "Prevention and Management of Disruptive Behaviors," and the development of new courses for geriatrics and other disciplines.
- d. The Joint Commission recently made patient violence and its prevention, a focus of the Environment of Care Standards (see subpar. 5c).
- e. VA's Office of Inspector General (OIG) in its report "Evaluation of VHA's Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients" (6HI-A28-038, dated March 28, 1996) recommended that facilities communicate among themselves so that staff are aware of high risk patients regardless of where in VHA's system they may seek health care (see subpar. 5f).
- f. For PRF to assist in the prevention of adverse events when high risk patients travel between facilities, all facilities must follow uniform processes as described in current VHA policy on inter-facility transfer. This would include noting any existing Patient Record Flag. The effectiveness of PRFs depends upon limiting their use to those unusual clinical risks that immediately threaten health care safety, and quality in the initial moments of a patient encounter.
- g. The safety of patients and employees, the effectiveness of care, and the patient's right to privacy need not be compromised by threats of violence. Risk of

h. violence can be mitigated by reporting, assessing, documenting, communicating, and developing treatment plans that specifically make violence reduction a treatment objective.

i. The decision to enter a Category I **Violent and Disruptive Behavior** PRF must be made by the Disruptive Behavior Committee (DBC) or the Disruptive Behavior Board only after completion of an evidence-based, multidisciplinary, and multi-dimensional threat assessment, which considers static and dynamic violence risk factors present in the patient, violence risk mitigators, and violence risk factors associated with the setting where the incident occurred (see subpar. 5o). Appendix C describes a threat assessment protocol that meets these requirements. There may be other protocols or instruments that are suitable, but the burden is on any DBC to use a threat assessment protocol that is evidence-based.

j. Competent prediction of violence is always multi-dimensional, and a thorough assessment of violence risk should consider factors relating not only to the patient but also to the training and behavior of the Department of Veterans Affairs (VA) employees, and to aspects of the situation in which the patient is treated.

k. The facility must develop a systematic approach for collecting reports involving incidents of disruptive, threatening, or disruptive behavior.

l. Interdisciplinary review and threat assessment of patient behavior is documented, and the documentation of this review and of all associated incident reports are kept in a secure location. In many cases, a summary of the threat assessment should be shared with the patient's care providers in an effort to address the problem of violence risk in the patient's treatment plan.

m. Appropriate training of staff, who in the course of their duties, must assess and document violence risk, as well as implement or recommend behavioral limits and treatment plans, will be documented. All DBC members should avail themselves of ongoing training opportunities available through the Employee Education System and VA's [Office of Occupational Safety and Health](#). **Note:** *This is an internal VA Web site not available to the public.*

Threat Assessment

a. The purpose of Disruptive Behavior Committees (DBC) or Disruptive Behavior Boards (DBB) is to evaluate the risk of violence in a given setting or situation, with a given patient and to recommend measures that may be taken to mitigate that violence risk. This is often called “threat assessment.” In their 2007 guide entitled, WAVR-21, A Structure Professional guide for the Workplace Assessment of Violence Risk, White and Meloy describe the purpose of groups like DBCs:

b. *“They will gather information concerning the context and critical aspects of the behavior in question, and about the employee or third party whose behavior has generated concern. The risk assessment professional will then synthesize and evaluate the data and apply careful professional judgment to answer the ultimate questions: Does the person whose conduct has generated concern pose a threat? And if so, what is the general level of threat? What steps can be taken to mitigate any risk, and what actions might exacerbate it?”*

c. Examples of common sentinel events that should lead to a violence risk assessment by the DBC or DBB include, but are not limited to: a report of physical violence against patients or staff at a medical center or clinic; documented acts of repeated violence against others; credible reports verbal threats of harm against specific individuals, patients, staff, or the Department of Veterans Affairs’ (VA) property; reports of possession of weapons or objects used as weapons in a health care facility; a documented history of repeated nuisance, disruptive or larcenous behavior that disrupts the environment of care; or a documented history of repeated sexual harassment toward patients or staff.

d. However, the mere occurrence of a sentinel event should not be cause to initiate a Category I **Violent and Disruptive Behavior** PRF. DBCs or DBBs are not “Flagging ommittees.” Patients are not “flagged” because they have demonstrated disruptive behavior or because their Primary Care Provider or other provider, having been verbally abused or threatened, is upset and demands that the patient be flagged. DBCs apply a Category I **Violent and Disruptive Behavior** PRF to a patient’s record only when the DBC concludes in a review of violence risks and mitigators that to do so will likely reduce violence risk.

e. All members of DBCs or DBBs should take advantage of training offered by VA Employee Education System (EES), and when possible, by outside vendors. The references in this Directive provide suggested resources for training and information on violence prediction and threat management.

f. The following is one evidence-based threat assessment protocol suggested for use by DBCs or DBBs (adapted from Meloy, 2000 see subpar. 5o):

(1) **Patient Risk Factors:** (list of factors is not exhaustive and factors not equally weighted)

(2) **Static Risk Factors:** (Include additional detail for each item checked)

_____ Male Gender (10X risk for females).

_____ Veteran's history of violence in and outside of health care facilities.
Consider frequency and recency of violence, and severity of injury to victims, if any.

Additional Comments:

_____ Veteran's self-report of arrests and convictions for violent crimes.

(Criminal background investigation data may be available in selected cases, if VA

Police conclude that there is probable cause for obtaining and sharing this
information on

need-to-know basis.)

Additional Comments:

_____ Documented credible threats toward VA employees or patients.

Additional Comments:

_____ Prior supervision/treatment plan failures, (e.g., probation, mandated Drug
and Alcohol treatment.

Additional Comments:

_____ Presence of serious psychiatric disorder, especially psychopathy or
paranoia.

Additional Comments:

_____ Head injury with Loss of Consciousness by history.

Additional Comments:

Dynamic Risk Factors: (Include additional detail for each item checked)

_____ Recent incidents of disruptions, threats, or violence in or out of health care
settings.

Additional Comments:

_____ Recent (past 6 mos) abuse of Central Nervous System (CNS) stimulants,
including
Cocaine and Methamphetamines.

Additional Comments:

_____ Recent abuse of ETOH or other CNS disinhibitors.

Additional Comments:

_____ Presence of situational stressors and destabilizing events, such as recent incarceration, death of loved ones, financial problems, estrangement from his or her family, homelessness, onset of acute medical problems, and other destabilizing events.

Additional Comments:

_____ Chronic pain or narcotics seeking behavior.

Additional Comments:

_____ Documented impulsivity (e.g., financial, sexual, or other decision making).

Additional Comments:

_____ Veteran's claims of weapons in his possession, especially new acquisition or relocation of firearms.

Additional Comments:

Risk Mitigation Factors: (Include additional detail for each item checked)

_____ Numerous visits to Medical Center without incidents.

Additional Comments:

_____ Positive recommendation of Veteran's health care providers.

Additional Comments:

_____ Documentation of successful participation in substance abuse recovery program with a significant (60 days or more) period of sobriety.

Additional Comments:

_____ Documented resolution of destabilizing events or factors.

Additional Comments:

_____ Patient's acknowledgement of his previous disruptive behavior with plans for preventing recurrence.

Additional Comments:

_____ Changes in patient's health status or mobility that would mitigate any threat the patient previously posed.

Additional Comments:

Setting Risk Factors

_____ Staffing issues (please describe):

_____ Training deficits (please describe):

_____ Supervisory issues (please describe):

Fugitive Felon Program

1. Purpose: The Veterans Health Administration (VHA) Handbook 1000.2, "VHA Fugitive Felon Program," establishes procedures for ensuring compliance with the Fugitive Felon portion of Public Law (Pub. L.) 107-103 § 505, "The veterans Education and Benefits Expansion Act (VEBEA) of 2001," codified at Title 38 United States Code (U.S.C.) § 5313B. In addition, the handbook provides guidance to medical centers and community based outpatient clinics (CBOCs) on meeting their responsibilities in implementing VHA's Fugitive Felon Program (FFP) for patients and beneficiaries.

2. Policy: It is the policy of this medical center and its CBOCs to assure that: we comply with guidelines established in VHA Handbook 1000.2. The VEBEA of 2001 requires that the Department of Veterans Affairs (VA) withhold specified benefits (including health care) from veterans and from dependents of veterans who are fugitive felons. The VEBEA requires VA, upon request to furnish law enforcement personnel with the most current address of the veteran or dependent of a veteran who is a fugitive felon.

3. Definitions: A fugitive felon is defined as a person who is:

4. Fleeing to avoid custody or confinement after conviction for an offense which is a felony under the laws of the place from which the person is fleeing, or for an attempt to commit such an offense; and/or

5. Fleeing to avoid prosecution for an offense or an attempt to commit an offense which is a felony; and/or

6. Violating a condition of probation or parole imposed for committing a felony under Federal or State law.

7. Note: *The preceding definition includes high misdemeanors under any State law that treats felony offenses as high misdemeanors*

8. Responsibilities:

a. The Medical Center Director is responsible for:

(1) Implementing the procedures described in paragraphs 3 through 10, as applicable.

(2) Notifying law enforcement officers of possible harm to a patient or beneficiary if subjected to questioning or removal from a program of health care.

(3) Submitting tracking information as requested to the appropriate Network Office.

(4) Ensuring that Category I and II FFP flags are originated and accessible in the patient's record.

- (5) Following established guidelines in support of VHA Handbook 1000.2.
- (6) Training appropriate staff
- (7) Ensuring that each FFP flag in a patient's record is accompanied by a template progress note. The template titles utilized will be:
 - (a) FFP Category I - non-VA Care Medically Acceptable, and
 - (b) FFP Category II - non-VA Care Medically Unacceptable.
- b. The Chief of Staff (COS) is responsible for:
 - (1) Instituting procedures to ensure that the FFP and associated processes are ethical, effective, and reviewed as noted in this directive.
 - (2) Identifying a Fugitive Felon Program Committee which reports to the COS. The Fugitive Felon Program Committee needs to be comprised of:
 - (a) A senior clinical chairperson.
 - (b) A member (s) of the VA Police.
 - (c) A member (s) of Health Information Management System.
 - (d) A member (s) of Patient Safety and/or Risk Management Program.
 - (e) A Regional Counsel (ad hoc).
 - (f) A Patient Advocate.
 - (g) Other members, as needed.
 - (h) Clerical and administrative support to accomplish the required tasks.
 - (i) A physician internist to complete a medical review.

Note: The Fugitive Felon Program Committee for Veterans Health Care System of the Ozarks, Fayetteville Arkansas will consists of the same members as the Disruptive Behavior Committee with the addition of the Chief, Business Office – See Appendix D of the MCM

- c. The Fugitive Felon Program Committee is responsible for:
 - (1) Conducting the clinical reviews prescribed by VHA Handbook 100.2.
 - (2) Providing the written documentation of their reviews to the facility director.
 - (3) Identifying system problems.

(4) Identifying training needs relating to the implementation and management of the FFP.

9. Procedures to follow when a patient is identified as a fugitive felon:

Note: Appendix G provides a flowchart of procedures that should occur at Veterans Health Care System of the Ozarks.

a. **Facility Director:** Facility Director must ensure that the following occurs:

(1) **Warrant Validation:** Veterans Health Care System of the Ozarks Police must contact the issuing agency to verify the validity of the fugitive felon warrant.

(2) **Searching Veterans Information Systems and Technology Architecture (VistA):** The facility's VistA System must be searched immediately to determine if the fugitive felon:

(a) Is currently an inpatient at a VHA facility or in a community facility at VA expense.

(b) Is scheduled for an outpatient clinic appointment, or an ambulatory procedure, or for elective admission.

(c) Is currently a non-VA Fee Identification (ID) card holder or on a non-VA short-term authorization.

(3) **Flagging the Patient's Electronic Medical Record:** The patient's record must be flagged and identified a sensitive record using a software patch in VistA. The flagging action is required to indicate that the clinical review has been conducted and that the determination of the appropriateness of "no-VA care" has been made. No indications are to be placed on or in patients' paper records, such as a sticker on the outside front of a file jacket. Information Security must perform appropriate monitoring to ensure only those who have a legitimate need to know are able to access flagged records.

(4) **Notification to the Health Eligibility Center (HEC):** Appropriate documentation (e.g., FFP-3, OIG letter, or other) must be faxed to (404) 235-1355. The HEC then ensures an Ineligible Enrollment status is appropriately transmitted to affected sites.

(5) **Issuing a Letter:** Issuing a letter to the fugitive felon notifying the fugitive felon that care can no longer be provided by VA (see App. B).

(6) **Reviewing Medical Record:** Reviewing the fugitive felon's medical record to determine if the fugitive felon veteran is currently receiving care through VHA.

(a) The fugitive felon's medical record and other information, as needed, must be reviewed within 5 days to:

- 1) Assess the patient's or beneficiary's medical status and treatment needs;
- 2) Establish plans for transition of care (should a specific treatment protocol need to continue, health care treatment would have to be continued on a humanitarian basis pursuant to 38 U.S.C. 1784 at the veteran's expense).

(b) Results of the clinical review and/or transition plan must be documented in the patient's or beneficiary's medical record. Documentation in the medical record should not cite the status as a fugitive felon. It should state that eligibility for VA benefits has been terminated by the Agency and a clinical review has been completed. Documentation needs to include whether or not a care transition plan is required and who is responsible for ensuring the care transition plan is accomplished. "No further action required," or similar statement, needs to be included in the documentation, as medically appropriate. The plan and any needed background information are to be communicated as promptly as possible to VA Police and to staff members directly involved in the patient's care, as well as the necessary action(s) authorized by the facility Director.

(c) In cases where the notification letter has been sent to a patient or beneficiary identified as a fugitive felon, and the veteran or beneficiary presents for either scheduled care or unscheduled care **before the clinical review** and resulting plan have been completed:

- 1) Staff may contact VA Police to determine a plan for notifying the patient of the fugitive felon status identification; and.
- 2) VA police must respond to the general location of the patient or beneficiary to ensure the safety of all individuals involved.

(7) **Notifying Non-VA Health Care Facilities When Appropriate:** When specific non-VA health care facilities, programs, and/or providers are identified to assume the care of a fugitive felon patient, they need to be notified by confidential letter (see App. E).

(8) **Discontinuing VA Health Care and Services:** It is understood that discontinuing health care and services provided by VA due to loss of eligibility is potentially uncomfortable territory for VHA staff. However, 38 U.S.C, Section 5313B, provides that a veteran and/or dependent that is otherwise eligible for certain benefits, including medical care, may not be paid or otherwise provided such benefits **for any period of time during which the veteran is in a fugitive felon status**. Fugitive felony warrants are typically resolved by the felon surrendering or being arrested, or by the Originating Agency, canceling the warrant due to error in issuance (i.e., mistaken identity), or by choice if/as allowed by law.

Note: Two sample notification letters to veterans are included in Appendix H and Appendix I.

(9) **Canceling Remaining Scheduled Health Care and Debarment:** Once the clinical review has been completed and the Director has approved the action plan, staff must coordinate cancellation of any remaining scheduled health care admissions or appointments and terminating provision of all services and products, including but not limited to provision of pharmaceuticals, supplies, prosthetics, etc. It may be necessary to coordinate with a Consolidated Mail-Out Pharmacy (CMOP). If the fugitive felon has not been extradited and continues to present for care after receiving notice that she or he is no longer eligible for VHA benefits, a Letter of Debarment (see App. C) may be issued.

(10) **Billing for Services Rendered:** The Business Office will take action within 60 days of fugitive status notification to bill for services rendered while the veteran was in a verified fugitive felon status. The billing rate will be the humanitarian rate.

(11) **Guidance for Withholding Services:** Guidance on the contents of VHA Handbook 1000.2 will be provided to all potentially impacted staff. If the veteran or beneficiary continues to present for care or services after receiving a Letter of Debarment, it will be considered trespassing and VA Police must initiate established arrest procedures.

b. **VHA Health Administration Center (HAC):** VHA's HAC is responsible for:

- (1) Flagging records using internal processes.
- (2) Taking action within 60 days of fugitive felon status notification to bill beneficiaries for VA services rendered while the beneficiary and/or veteran sponsor is in a fugitive felon status.
- (3) Using two letters for the veteran's spouse and CHAMPVA Beneficiaries. Appendix J6 is a Sample Letter to a CHAMPVA Beneficiary When the Veteran's Sponsor is a Fugitive Felon. Appendix J7 is a Sample Letter to a CHAMPVA Beneficiary Identified as a Fugitive Felon.

c. **Arrests:**

(1) **If an Arrest is to Occur:** If the Patient or Beneficiary is to be arrested at a VHA Facility, established procedures must be adhered to.

(2) **If No Arrest is to Occur:** If no arrest will occur, but health care, services, and products must be withheld in accordance with Pub. L. 107-103, medically appropriate transfer and other transitioning of care to a non-VHA facility or program of care must be determined and enacted by VHA. VA cannot cover any costs of non-VA care, regardless of service connected status, "Millennium Bill" or other eligibilities during the time in which the patient or beneficiary is ineligible for VHA benefits due to fugitive felon status. If a veteran or beneficiary restores eligibility for care by resolving the

warrant with the Originating Agency, VA cannot retro-actively cover any costs of non-VA care. The exception to this is if evidence is provided to the facility Director that the Originating Agency made an error and the patient or beneficiary was actually not in a fugitive felon status at the time the patient's or beneficiary's care was transitioned to non-VA.

d. Decisions Regarding Patients or Beneficiaries Identified as Fugitive Felons who are Medically Assessed as not Competent:

(1) The facility Director may authorize staff to work with the Originating Agency to determine an appropriate course of action that would resolve the warrant for fugitive felon patients or beneficiaries medically assessed as not competent to handle their own affairs, or patients for whom withholding care could result in critical medical complications, such as complications arising from discontinuation of dialysis or anti-psychotic medication, regardless of whether an arrest is planned, or only withholding of VHA care as must occur by law.

(2) Extensions will be authorized for fugitive felon patients or beneficiaries who could be critically harmed by withholding of benefits, such as, but not limited to dialysis, anti-psychotic medications, or medication for controlling blood pressure.

(3) VA is required to bill the veteran or guardian for all care provided at VA expense during any extension, including for humanitarian or medical risk.

(4) **Evidence of Warrant Satisfaction:** Upon the presentation of evidence that the warrant has been satisfied, appropriate action must be taken to deactivate pertinent flags. This includes faxing this notification to the HEC at (404) 235-1355. Staff must remove the 'Ineligible' enrollment status which is then automatically transmitted to all affected sites. The HEC notifies the OIG that the veteran has provided proof that the warrant is cleared.

e. Removal of Veterans from the OIG Fugitive Felon List: Upon receipt of proof from the HEC, the veteran's name must be removed from the fugitive felon listing.

6. References:

a. Pub. L. 107-103 § 505, "The Veterans Education and Benefits Expansion Act of 2001," codified at 38 U.S.C. § 5313B, effective December 27, 2001.

b. VA Handbook 0730.

c. VHA Handbook 1000.2.

**Flowchart of the Veterans Health Administration (VHA) Fugitive Felon Program
and Procedures for Facilities**

The Office of Inspector General (OIG) searches databases monthly by name, Social Security Number, and date of birth, from Fugitive Felon (FF) Warrants in the National Crime Information Center (NCIC), State, and local law enforcement agencies' files to Veterans Health Administration (VHA) databases.

OIG

**10N (Directors of Network Support and Health Systems Specialists)
Network Director
Medical Center Director**

1. Department of Veterans Affairs (VA) Police must confirm with warrant holder that the warrant is valid.
2. Search the Veterans Health Information System and Technology Architecture (VistA) for any future scheduled admission, Outpatient appointment, Ambulatory Procedure appointment or non-VA Fee authorization. If an admission or appointment is imminent, expedite the Clinical Review.
3. Flag patient's VistA medical record. Make sure the flag doesn't identify future appointments or scheduled admissions.
4. Fax notification to the Health Eligibility Center (HEC) at (404) 235-1355.
5. Issue letter to patient notifying of FF match.
6. Clinical Review performed within 5 business days of the facility Director's receipt of FF notice (if applicable).
7. Develop a transition plan and notify non-VA health care provider, if appropriate, and terminate care by canceling any remaining appointments.
8. Within 60 days of notification, begin billing for VA services provided the patient while the patient in FF status.
9. Complete data entry in Fugitive Felon Program (FFP) Feedback Report (FFP-3) (a spreadsheet to the Network Office).
10. Notify the Network Director , via email, that FFP-3 has been completed.
11. If the patient provides evidence that the FF warrant has been satisfied, have VA Police confirm; fax notification to the HEC at (404) 235-1355; restore eligibility, remove flag and schedule return to care. Amend the FFP-3, and notify the Network Director.

Sample Letter from the Department of Veterans Affairs (VA) to Current Patients Identified as a Fugitive Felon

(Date)

Ref. (Facility #)

Veterans Name
Veterans Address

Dear (Veterans Name):

Under Public Law 107-103, "The Veterans Education and Benefits Expansion Act of 2001," VA is prohibited from providing or continuing to provide certain benefits to veterans and dependents identified as fugitive felons. The prohibition includes health care and services, including medications and any care provided in the community at VA expense. The Act also requires VA to provide law enforcement personnel, upon request, the most current address of a veteran or dependent whose identity was matched in a fugitive felon database.

This letter notifies you that your name has been matched in the database searches as having a felony warrant against you in an open status. Your identity matched on all three criteria: name, social security number, and date of birth. As required by law, the Office of Inspector General contacted the law enforcement agency that issued the warrant against you. This agency is referred to as the "Originating Agency." If the Originating Agency has local jurisdiction, it may choose to arrest you. If the Originating Agency does not have local jurisdiction, it may choose to extradite you to its area of jurisdiction and then arrest you.

You have been identified as a fugitive felon, and VA must terminate the health care it has been providing to you, effective 60 days from the date of this letter. Under the law, this applies even to those veterans who are service-connected or have other eligibilities, such as those for VA coverage of emergency care in communities. This applies to other beneficiaries, such as veterans' family members who qualify as eligible dependents and includes: clinic appointments, scheduled admissions, scheduled ambulatory procedures, medication, dental care, prosthetic devices and care, supplies, and other health care services. Your computerized medical record or other health record has been flagged so that VA staff can take appropriate steps to plan transition and/or termination of your health care in VA programs or other programs at VA expense. In addition, VA will bill you and/or your beneficiaries for all VA provided care received while in this fugitive felon status.

Because you are an active outpatient, we will perform a confidential Clinical Review of your medical or health record and other relevant data and information. The purpose of this review is to assess your treatment needs and to assist you, if desired or needed, in locating alternative care outside the VA health care system. Under the law, VA cannot pay for any of this alternative care. (Or, as an inpatient, we are notifying you that VA can no longer provide care at our expense. We will work with you to transition your care.) If you or a beneficiary comes to a VA health care facility for a medical emergency, VA will provide emergency care on a humanitarian basis at the expense of the person receiving the care. This will be provided to stabilize the medical condition. Afterward, you or beneficiary will be discharged or transferred to an appropriate non-VA health care facility and will be billed for any health care provided by VA on

an emergency humanitarian basis. If a non-VA health care facility provides care to you or the beneficiary, VA will not be financially or otherwise responsible for that care.

We must ensure that the Veterans Health Care System of the Ozarks, and all its community clinics and other activity sites, provide a safe environment where health care and administrative business can be provided in an orderly fashion and that we are in compliance with the law. Therefore, in addition to notifying you of your match to a fugitive felon warrant, this letter also notifies you that at any time you are on VA property or at a VA site, whether owned or leased, you must abide by all prevailing laws, regulations, and policies. Failure to do so may result in arrest by VA Police and/or local law enforcement officials. Also, you may be subject to arrest by Federal or State law enforcement agencies for the fugitive felony warrant itself. If you have any questions about this notification letter and how it applies to your legal status as far as VA is concerned, please contact our VA Police at ____ (telephone number) ____.

Fugitive felon status is a self-inflicted status that you may resolve by contacting the Originating Agency for the felony warrant. You must contact the Originating Agency that issued a felony warrant against you, not the VA Police, if you believe:

- a. An error was made, such as mistaken identity.
- b. The warrant should be cancelled.
- c. The warrant has been satisfied by your arrest or surrender.
- d. There are other reasons, which would resolve the warrant.

If you have evidence now that the warrant has been satisfied, or you obtain such evidence, you need to provide this evidence to my office immediately. You may provide this evidence by mail or fax, or you may ask someone you trust to deliver the evidence. If the Originating Agency (warrant holder) does not have local jurisdiction, it may choose to have you arrested by local authorities, and have you extradited back to the jurisdiction responsible for the warrant.

Thank you for your cooperation. Sincerely,

Signature block for the Director, Veterans Health Care System of the Ozarks XXXXXXXX

Name: First MI Last

SSN: 000-00-0000

DOB: 00/00/0000

VA Treatment Location: VAMC XXXXXXXXXXXX, NY

Law Enforcement Agency: Law Enforcement Agency Name

Address: Law Enforcement Agency Address

Telephone Number: 000-000-0000

Date of Warrant: 00/00/0000

Offense: Offense Name

Sample Letter to a Veteran not Currently Receiving Care of as a Debarment from the Department of Veterans Affairs (VA) to a Fugitive Felon

(Date)

Ref. (Facility #)

Veterans Name
Veterans Address

Dear (Veterans Name):

Under Public Law 107-103, "The Veterans Education and Benefits Expansion Act of 2001," VA is prohibited from providing or continuing to provide certain benefits to veterans and dependents identified as fugitive felons. The prohibition includes health care and services, including medications and any care provided in the community at VA expense.

Since you are currently not receiving care through VA, this letter is to confirm that you are no longer eligible or entitled to receive health care and services at or through (Veterans Health Care System of the Ozarks Anywhere) while you have any felony warrant against you. You may not receive health care and services at any other Veterans Health Administration (VHA) facility or through a Department of Veterans Affairs (VA)-paid program, effective immediately. In addition, VA will bill you and/or your beneficiaries for all VA-provided care received while in this fugitive felon status.

You have been identified as a fugitive felon, VA must terminate your eligibility to receive health care, effective 60 days from the date of this letter. We realize that you are not currently receiving care from VA. If you or a beneficiary comes to a VA health care facility 60 days from the date of this letter for a medical emergency, VA will provide emergency care on a humanitarian basis at the expense of the person receiving the care. This emergency care will be provided to stabilize the person's medical condition. Afterward, you or the beneficiary will be discharged or transferred to an appropriate non-VA health care facility and will be billed for any health care provided by VA on an emergency humanitarian basis. If a non-VA health care facility provides care to you or the beneficiary, you or the beneficiary will also be billed for that care. These billings will occur even if you are service connected, if you previously qualified for VA coverage of emergency care in your local or nearby community under other treatment authorities, or if you have any other eligibility as a veteran or beneficiary.

(only if applicable) This letter serves as official debarment from entering VA property. Failure to comply with this debarment will result in your arrest by VA Police for trespassing. If you have any questions about this Letter of Debarment, please call our VA Police at (telephone number).

Please contact the law enforcement agency that issued the felony warrant against you to try to resolve this issue (see attached). If you have evidence now that the warrant has been satisfied, or you obtain such evidence, your eligibility for VHA health care and services may be reinstated.

You may provide my office with this evidence by mail or you may fax the VA Police at (fax number) (if this is applicable). You may also ask someone you trust to deliver that evidence to our VA Police. It is important that you not come to this facility in person while this Letter of Debarment is in force. If you come to this facility you will be arrested by VA Police for trespassing.

Thank you for your cooperation. Sincerely,

Signature block for the Director, Veterans Health Care System of the Ozarks XXXXXXXX

Name: First MI Last

SSN: 000-00-0000

DOB: 00/00/0000

VA Treatment Location: VAMC XXXXXXXXXX, NY

Law Enforcement Agency: Law Enforcement Agency Name

Address: Law Enforcement Agency Address

Telephone Number: 000-000-0000

Date of Warrant: 00/00/0000

Offense: Offense Name

Questioning and the Arrest Authority of Local Law Enforcement Officers

1. A law enforcement officer acting officially for an agency having local, State, or Federal law enforcement jurisdiction may not be denied access to the facility or a patient.
 - a. At facilities on property in which the Federal Government exercises concurrent or proprietary jurisdiction, local and State officers may affect patient arrests.
 - b. At facilities on property in which the Federal Government exercises exclusive jurisdiction, only Federal officers [including Department of Veterans Affairs (VA) police] may arrest without a warrant.
 - c. Local or State officers may only arrest with a warrant on property under exclusive Federal jurisdiction when the State act of cession reserves the right of the State to serve or execute State civil and criminal process on the property.
2. All non-VA law enforcement officials entering the VA health care facility need to be directed to the Office of the Director or Chief, Police and Security unit for a formal presentation of the purpose of the visit.
3. Facility Directors must cooperate to the fullest extent possible with law enforcement authorities carrying out official investigations or the orders of a judicial official given the Federal Government's jurisdiction over the facility.
4. The Director and members of the facility staff have no legal authority to prevent the lawful questioning, arrest, or serving of process on a patient.
5. When the purpose of the visit is to question or arrest a patient, the responsible medical staff member, preferably the attending physician will be immediately consulted for a determination of the effect that questioning or arrest and removal from a treatment program would have on the patient.
 - a. Directors and health care professionals have a responsibility to warn law enforcement officers of the possibilities of harm to a patient if the patient is subjected to questioning or removal from a program of health care.
 - b. A written record must be made when a medical staff member's opinion is that the intended action would have a clearly adverse effect on the patient.
 - c. During the conference between the law enforcement officer and the medical staff member, no information may be disclosed except as authorized by law.
 - d. When the seriousness of a charge against a patient causes the law enforcement officer to insist on taking the patient into custody against medical advice, every effort needs to be made to influence the law enforcement officials to seek a postponement of orders from their superiors or to arrange for the patient's transfer to a custodial health care facility capable of continuing needed treatment.

e. If the law enforcement official requires a detailed statement of the patient's condition to achieve either a postponement or to effect continued treatment in a custodial facility, the law enforcement official must be advised to submit a written request for the information, which meets the requirements of the Privacy Act and Title 38 United States Code §§ 5701 and 7332. Any such written request received will be forwarded to the appropriate release of information officials for consideration.

f. Agreements reached by the Director and law enforcement officials to retain a patient, against whom criminal or civil charges are pending, will not include the stationing of an armed police officer, guard, or a VA police officer to guard the patient.

**Sample of a Department of Veterans Affairs (VA) Facility Director's Letter to a
Non-VA Health Care Entity Assuming a Veteran's Care**

CONFIDENTIAL Information Accompanying Transition of Health Care for Mr. First MI
Last

Mr. First MI Last, Social Security Number 000-00-0000, has been declared ineligible to continue receiving benefits from the Department of Veterans Affairs (VA). This includes health care, services, and products provided to him by the Veterans Health Administration (VHA).

Thank you for your assistance with this complex and sensitive matter. If you have any questions, please call me at (telephone number).

Sincerely,

Signature block for the Director, Veterans Health Care System of the Ozarks XXXXXXXX

Letter to Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Beneficiary when the Veterans Sponsor is a Fugitive Felon

March 25, 2003

Veterans Name
Veterans Address

Subject: Notification of Non-entitlement to Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Benefits

Dear (Veterans Name):

This office has been informed that your spouse has been identified as a fugitive felon. Under Public Law 107-103, "The Veterans Education and Benefits Expansion Act of 2001," VA is prohibited from providing or continuing to provide certain benefits to veterans and dependents identified as fugitive felons. The prohibition includes health care and services, including medications and any care provided in the community at VA expense.

The Act also requires VA to provide law enforcement personnel, upon request, the most current address of a veteran or dependent whose identity was matched in a fugitive felon database. This will assist law enforcement personnel in apprehending fugitive felons. The Health Administration Center is a participant in the Fugitive Felon Program.

This letter notifies you that the veteran sponsor for your Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) benefits has been matched in database searches as having a felony warrant in an open status. The identity of the veteran matched all three criteria - name, social security number, and date of birth. As required by law, the Office of Inspector General contacted the Health Administration Center regarding the outstanding warrant.

Because the veteran sponsor for your CHAMPVA benefits has been identified as a fugitive felon, the VA must terminate CHAMPVA benefits provided to you and any other dependents. Your record has been flagged so that our staff can take appropriate steps to terminate your CHAMPVA health care benefits. In addition, VA will bill you and/or beneficiaries for all VA provided care received while your veteran sponsor is in this fugitive felon status.

Fugitive felon status is a self-inflicted status that may be resolved if the veteran contacts the Origination Agency that issued the felony warrant. The veteran may contact the Origination Agency that issued the felony warrant, if:

- a. An error was made, such as mistaken identity.
- b. The warrant should be canceled.

- c. The warrant has been satisfied by the veteran's arrest or surrender.
- d. Other reasons that may resolve the warrant.

If you have evidence now that the veteran's warrant has been satisfied, or you obtain such evidence, you should provide this evidence to my attention immediately. You may provide this evidence by mail, fax at (303) 331-7800, or you may ask someone you trust to deliver the evidence. You may also make an appointment by calling (303) 331-7500 to provide this evidence.

Thank you for your cooperation in this matter. Sincerely,

Ralph Charlip, FACHE, FAAMA Director, Health Administration Center

Name: First MI Last

SSN: 000-00-0000

DOB: 00/00/0000

VA Treatment Location: VAMC XXXXXXXXXX, NY

Law Enforcement Agency: Law Enforcement Agency Name

Address: Law Enforcement Agency Address

Telephone Number: 000-000-0000

Date of Warrant: 00/00/0000

Offense: Offense Name

Letter to Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Beneficiary Identified as a Fugitive Felon

April 8, 2003

Veterans Name

Veterans Address

Subject: Beneficiary Matched in Fugitive Felon Database(s)

Dear (Veterans Name)

This office has been informed that you have been identified as a fugitive felon. Under Public Law 107-103, "The Veterans Education and Benefits Expansion Act of 2001," VA is prohibited from providing or continuing certain benefits to veterans and dependents identified as fugitive felons. The prohibition includes health care and services, including medications and any care provided in the community at VA expense.

The Act also requires VA to provide law enforcement personnel, upon request, the most current address for a veteran dependent whose identity was matched in a fugitive felon database. This will assist law enforcement personnel in apprehending fugitive felons. The Health Administration Center is a participant in the Fugitive Felon Program.

This letter notifies you that your name has been matched in database searches as having a felon warrant against you in an open status. Your identity matched on all three criteria - name, social security number and date of birth. As required by law, the Office of Inspector General contacted the law enforcement agency that issued the warrant against you. This agency is referred to as the "Origination Agency." If the Originating Agency has local jurisdiction, it may choose to extradite you. If the Originating Agency does not have local jurisdiction, it may choose to extradite you to its area of jurisdiction and then arrest you. The Originating Agency may choose not to extradite you.

Because you have been identified as a fugitive felon, VA must terminate your Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) benefits. Your record has been flagged so that our staff can take appropriate steps to terminate these benefits. In addition, VA will bill you and/or beneficiaries for all VA provided care received while in this fugitive felon status.

Fugitive felon status is a self-inflicted status that you may resolve by contacting the Origination Agency for the felony warrant. You must contact the Originating Agency that issued a felony warrant against you, if you believe:

- a. An error was made, such as mistaken identity.
- b. The warrant should be canceled.
- c. The warrant has been satisfied by your arrest or surrender.
- d. There are other reasons that may resolve the warrant. Appendix J7 (Continued)

If you have evidence now that the warrant has been satisfied, or you obtain such evidence, you should provide this evidence to my office immediately. You may provide this evidence by mail, fax at (303) 331-7800, or you may ask someone you trust to deliver the evidence. You may also make an appointment by calling (303) 331-7500 to provide this evidence.

Thank you for your cooperation in this matter.

Ralph Charlip, FACHE, FAAMA Director, Health Administration Center

Name: First MI Last

SSN: 000-00-0000

DOB: 00/00/0000

VA Treatment Location: VAMC XXXXXXXXXX, NY

Law Enforcement Agency: Law Enforcement Agency Name

Address: Law Enforcement Agency Address

Telephone Number: 000-000-0000

Date of Warrant: 00/00/0000

Offense: Offense Name