

VHA URGENT CARE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive states policy for Urgent Care.

2. SUMMARY OF CONTENT:

a. Amendment dated March 7, 2025, changes “gender” to “sex,” changes “gender-specific” to sex-specific,” and removed references to VHA Directive 1341 (in paragraphs 16 and 21) comply with EO 14168.

b. As published March 20, 2023, this was a new directive that states policy, responsibilities and standards for Urgent Care including minimum criteria for Urgent Care Levels I, II and III in Appendix B. As published, this directive reflected the change in terminology from “Urgent Care Centers” to Urgent Care. Policy governing Department of Veterans Affairs (VA) Emergency Departments is located in VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Specialty Care Services Program Office (11SPEC) is responsible for the content of this directive. Questions may be referred to the VHA Emergency Medicine Program at vhaemx@va.gov.

5. RESCISSIONS: None.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of March 2028. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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CONTENTS

VHA URGENT CARE

1. PURPOSE..... 1

2. BACKGROUND..... 1

3. DEFINITIONS 2

4. POLICY 4

5. RESPONSIBILITIES 4

6. URGENT CARE STAFFING 12

7. TELEHEALTH 15

8. URGENT CARE REQUIREMENTS 15

9. GENERAL OPERATIONS REQUIREMENTS 18

10. AIRWAY MANAGEMENT 22

11. USE OF ANESTHETIC AGENTS FOR MODERATE SEDATION IN URGENT CARE
..... 22

12. URGENT CARE MANAGEMENT OF PATIENTS WHOSE PRESENTATION
INCLUDES MENTAL HEALTH CONCERNS 22

13. INFORMED CONSENT..... 26

14. URGENT CARE OF THE OLDER ADULT 26

15. URGENT CARE OF PEDIATRIC PATIENTS..... 27

16. OBSTETRIC AND GYNECOLOGIC CARE AND URGENT CARE 27

17. INTIMATE PARTNER VIOLENCE 29

18. URGENT CARE MANAGEMENT OF ACUTE SEXUAL ASSAULT 29

19. TRAINING 30

20. RECORDS MANAGEMENT..... 31

21. REFERENCES..... 32

APPENDIX A

URGENT CARE INTERPROFESSIONAL TEAM AND STAFFING CRITERIA.....A-1

APPENDIX B

MINIMUM SERVICES FOR URGENT CARE LEVELSB-1

APPENDIX C

URGENT CARE INTERDISCIPLINARY SUPPORT SERVICES C-1

VHA URGENT CARE

1. PURPOSE

This Veterans Health Administration (VHA) directive states the minimum requirements that Department of Veterans Affairs (VA) medical facilities with an Urgent Care need to meet to ensure Veterans have access to high-quality urgent care services. The new Urgent Care levels outlined in Appendix B must be designated and operational within 6 months of publication of this directive. In addition to the requirements stated in the body of this directive, Appendix B defines only the minimum services that must be available during all hours of operation to establish the criterion of Urgent Care Level of I, II or III. **AUTHORITY:** 38 U.S.C. §§ 1710, 7301(b).

2. BACKGROUND

VHA is committed to providing timely and high-quality urgent care services to patients as described below.

a. This directive describes standards required to provide access to appropriate urgent care services in VA medical facilities with an Urgent Care. The provision of urgent care services includes planning for the management of VA patients whose care needs may exceed the capabilities of both the Urgent Care or VA medical facility (e.g., acute myocardial infarction needing emergent cardiac catheterization, major trauma, obstetric and gynecologic emergencies, pediatric emergencies or surgical subspecialty care).

b. Urgent care practice at VHA includes:

(1) Unrestricted access to appropriate and timely urgent care services during operational hours at VA medical facilities (VA Hospital, Health Care Center (HCC) or community-based outpatient clinic (CBOC)) with an Urgent Care. **NOTE:** See VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, dated July 7, 2017, for a definition of HCC.

(2) Urgent Care locations do not accept community emergent 911 ambulances.

(3) Supervision, teaching and evaluation of the performance of health professions trainees consistent with requirements of national accrediting bodies and with the policies of the VHA Office of Academic Affiliations listed at <https://dvagov.sharepoint.com/sites/VHAOAA/public/SitePages/OAA-Policies.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

(4) Use of medical services to provide a more integrated approach to patient care, as appropriate. Roles may include, but not limited to, Physician Assistants (PAs), Nurse Practitioners (NPs), Physical Therapists (PTs) and Clinical Pharmacy Specialists (CPS). **NOTE:** See paragraph 6 and Appendix A for more information.

(5) Procedures and protocols that allow for a smooth transition from Urgent Care to a VA hospital for needed inpatient care, or else, post-discharge, to the appropriate outpatient setting for needed follow-up by that service line.

c. The VA Emergency Medicine Improvement (EMI) Initiative is intended to provide a structured method for monitoring, communicating and managing the operational efficiency, quality and safety of care delivered in VA EDs and Urgent Care sites. **NOTE:** For more information on EMI, see the Emergency Medicine (EM) SharePoint: <https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>. This is an internal VA website that is not available to the public.

d. **Urgent Care Levels.** Urgent Care provides outpatient acute medical care for patients without a scheduled appointment who need prompt attention for an acute medical or mental health illness or minor injuries that are significant but not life threatening. Urgent Care does not function with the same capability as an ED. Urgent Care does not exist in VA medical facilities with an ED on a contiguous campus. In general, Urgent Care does not operate 24 hours a day, 7 days a week. There are three Urgent Care levels (minimum standards per level are outlined in Appendix B):

(1) **Urgent Care Level I.** Ability to address the highest acute patient needs during all hours of operation and does not accept 911 ambulances. Urgent Care Level I must be co-located at a VA hospital with acute care inpatient medical beds.

(2) **Urgent Care Level II.** Ability to be freestanding or co-located at a Multi-Specialty CBOC, HCC or VA hospital. For Urgent Care Level II with no co-located acute care inpatient medical beds, Urgent Care patients requiring admission may be transferred to an inpatient unit at a VA or community hospital via existing practice or written process (e.g., standard operating procedure (SOP), memorandum of agreement or understanding).

(3) **Urgent Care Level III.** Ability to be freestanding or co-located at a Primary Care CBOC; provides treatment for low acute minor illnesses and injuries.

3. DEFINITIONS

a. **Acute Care Inpatient Medical Bed.** Acute care inpatient medical beds are beds associated with acute inpatient medical care defined by the treating specialty. Examples of bed sections considered to be acute care inpatient medical beds include a VA hospital's inpatient ward, step-down care, observation unit, acute hospital medicine, or general medical inpatient care.

b. **Boarding.** Boarding is defined by The Joint Commission as the practice of holding VA patients in the ED or another temporary location (i.e., Urgent Care) under the control of Urgent Care after a decision to admit or transfer has been made. **NOTE:** Urgent Care does not routinely board patients. If temporary boarding is utilized, a

patient boarded in Urgent Care does not constitute or take the place of an acute care inpatient bed. The care of the boarding patient is accommodated in the temporary location until an appropriate bed for their intended level of inpatient care is available. For further details regarding boarding, see paragraph 9.h.

c. **Direct Line-of-Sight Observation.** Direct line-of-sight observation is the continuous observation by staff of a patient in a mental health intervention room, in lieu of one-to-one observation due to the safety features of mental health intervention rooms. See paragraph 12.g.(1) for further information.

d. **Emergency Escalation of Care.** Emergency escalation of care is a situation in which a patient presents to an Urgent Care with a condition, or develops a condition while in Urgent Care, that is beyond the capabilities of the Urgent Care to safely evaluate or treat and who requires 911 emergent transfer to a higher level of care. See paragraph 9.k. for further information.

e. **Encounter.** An encounter is a professional contact between a patient and a VA provider vested with responsibility for diagnosing, evaluating and treating the patient's condition. **NOTE:** See VHA Directive 1230, *Outpatient Scheduling Management*, dated June 1, 2022, for further information.

f. **Mental Health Intervention Room.** A mental health intervention room is a room where patients who may be at high risk for harm to self or others may be taken immediately on arrival. The purpose of this room is to provide an environment suitable for the rapid medical and mental health evaluation of dangerously unstable situations and the capacity to safely manage and treat the patient. When possible, it should be away from the waiting area and near the nursing station. The mental health intervention room should meet the standards outlined in the Mental Health Environment of Care Checklist (MHEOCC) found at: <http://vaww.ncps.med.va.gov/guidelines.html#mhc>. **NOTE:** This is an internal VA website that is not available to the public. To request a copy of the MHEOCC, email the National Center for Patient Safety at ncps@va.gov with subject: MHEOCC Request. For further details regarding provision of mental health services in Urgent Care, see paragraph 12.

g. **One-to-One Observation.** One-to-one observation is the constant monitoring of one patient by one staff member who will not have other responsibilities to ensure the patient is provided constant observation and never left unattended. See paragraph 12.g.(2).

h. **Safety Planning in the Emergency Department.** Safety Planning in the ED (SPED) is an evidence-based intervention for individuals who present to the Emergency Department or Urgent Care and are identified to be at elevated risk for suicide. This intervention includes safety planning and follow up contact. See paragraphs 5.l. and 12.b. for details.

i. **Urgent Care Provider.** For purposes of this directive, Urgent Care providers are appropriately credentialed and privileged physicians, PAs and NPs who provide patient care in Urgent Care. See paragraph 6.

j. **Urgent Care Observation.** Urgent Care Observation is a status that Urgent Care providers assign to patients receiving extended evaluation and care prior to disposition. For more information, please see VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020. **NOTE:** *The use of Observation status is not appropriate in Urgent Care Level III.*

4. POLICY

It is VHA policy to provide quality urgent care to patients who present to a VA medical facility that has an Urgent Care or to a freestanding VA Urgent Care located in the community.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services.** The Assistant Under Secretary for Health for Clinical Services is responsible for supporting the VHA Emergency Medicine Program with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

d. **National Program Director, VHA Emergency Medicine.** The National Program Director, VHA Emergency Medicine is responsible for:

(1) Providing national leadership, advice and consultation to all VA urgent care programs and working with each VISN Director and VISN Chief Medical Officer (CMO) to identify a VISN EM Consultant.

(2) Collaborating with VISN and VA medical facility executive leadership to ensure that high-quality urgent care services are made available, immediately accessible by and efficiently provided to all Urgent Care patients as clinically appropriate.

(3) Acting as the principal advisor to the Under Secretary for Health on urgent care policies and procedures.

(4) Collaborating with professional organizations and provider groups in affiliated institutions, and with other public and private organizations concerned with the delivery of urgent care medicine in VHA.

(5) Leading the development of clinical practice guidelines, protocols and best practices to be used in the analysis and management of urgent care services and programs.

(6) Developing enterprise-wide planning guidelines to support planning strategies for Urgent Care sites and contributing to VHA strategic-operational planning processes consistent with VHA Directive 1075, Strategic-Operational Planning Process, dated July 27, 2020.

(7) Writing all VHA directives and notices related to urgent care medicine consistent with VHA Directive 0999, VHA Policy Management, dated March 29, 2022.

(8) Consulting on clinical restructuring requests or other proposed changes in urgent care services from VA medical facilities.

(9) Approving or denying waivers submitted by the VA medical facility Director or VISN Director, in accordance VHA Notice 2022-01, Waivers to VHA National Policy, dated February 10, 2022.

(10) Collaborating with the VISN Director to determine each VA medical facility's appropriate designation and Urgent Care level within 6 months of publication of this directive. **NOTE:** *Appendix B outlines the minimum standards for each Urgent Care level. An Urgent Care may operate at a higher level, but the level is assigned based on their minimum operating capacity during any operating hour.*

e. **Veterans Integrated Services Network Director.** The VISN Director or designee appointed by the VISN Director (e.g., the VISN CMO) is responsible for:

(1) Ensuring that Urgent Care sites within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring that the VISN EM Consultant has at least 10% dedicated administrative time to accomplish their responsibilities.

(3) Collaborating with the National Program Director, VHA Emergency Medicine on selecting and appointing a VISN EM Consultant and determining each VA medical facility's appropriate designation and level within 6 months of publication of this directive.

(4) Reviewing Urgent Care data regarding operational vulnerability and data reliability for VA medical facilities within their purview. **NOTE:** *For more information*

regarding operational vulnerability metrics, see the Emergency Medicine Management Tool User Manual at

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEmergency%20Medicine%20Management%20Tool%20%28EMMT%29>. This is an internal VA website that is not available to the public.

(5) Ensuring compliance with VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016, by reviewing and evaluating clinical restructuring proposals and submitting each approved proposal with the associated Business Plan accordingly. **NOTE:** *Clinical restructuring proposals should be developed in consultation with the VISN EM Consultant.*

(6) Submitting waiver requests to the National Program Director of VHA Emergency Medicine on behalf of the VISN or, by request, on behalf of a VA medical facility within the VISN, in accordance with VHA Notice 2022-01. The VISN Director must notify the individuals specified in VHA Notice 2022-01 using the waiver request template located at:

<https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx>. **NOTE:** *This is an internal VA website that is not available to the public.*

f. **Veterans Integrated Services Network Emergency Medicine Consultant.** The VISN EM Consultant serves as the Point of Contact (POC) for issues pertaining to urgent care practice in the VISN. This individual must be clinically active in EM or urgent care medicine. The VISN EM Consultant is responsible for:

(1) Providing leadership, expertise and guidance to VA medical facilities with EDs and Urgent Care sites in the VISN.

(2) Supporting urgent care medicine research and educational activities.

(3) Consulting, when requested, on evaluation and facilitation of quality improvement processes within Urgent Care sites within the VISN; development and implementation of strategic plans for urgent care services within the VISN, including virtual urgent care services; and oversight of clinical outcomes, standards of care, and best practices for urgent care medicine at VA medical facilities within the VISN, with the ability to immediately evaluate critical events.

(4) Assisting with operational process improvement efforts at Urgent Care sites in alignment with the EMI Initiative.

(5) Disseminating information from the VHA Emergency Medicine Program to each of the VA medical facilities within the VISN.

(6) Promoting communication between VA medical facilities with an Urgent Care within the VISN.

(7) Notifying the National Program Director, VHA Emergency Medicine when a new VA medical facility Urgent Care Medical Director is selected.

(8) Serving as an advisor to the VA medical facility Chief of Staff (COS) and the Urgent Care Medical Director, if questions arise regarding scheduling Urgent Care provider shifts greater than 12 hours of clinical time, in accordance with paragraph 6.c.

(9) Notifying the National Program Director, VHA Emergency Medicine of unanticipated changes to Urgent Care operating hours, for awareness.

(10) Working with VA medical facility executive leadership to develop clinical restructuring proposals and initiate waiver applications.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive.

(2) Working with the VHA Emergency Medicine Program through VISN leadership to finalize Urgent Care level designation. **NOTE:** *A Level I Urgent Care that operates 24 hours a day, 7 days a week and is attached to an acute inpatient care facility should consider redesignation as an ED if it would more appropriately meet the needs of the patient population and VA medical facility.*

(3) Working with the VA medical facility COS to determine placement of an Urgent Care within the organizational framework of the VA medical facility that provides processes for quality and safety oversight and reporting to VA medical facility executive leadership.

(4) Ensuring the VA medical facility COS notifies the VISN EM Consultant when a new Urgent Care Medical Director is selected.

(5) Submitting clinical restructuring proposals to the VISN Director.

(6) In conjunction with the VISN EM Consultant, submitting waiver requests to the National Program Director of VHA Emergency Medicine (either directly or through the VISN Director) in accordance with VHA Notice 2022-01. The VA medical facility Director must notify the individuals specified in VHA Notice 2022-01 using the waiver request template located at:

<https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx>. **NOTE:** *This is an internal VA website that is not available to the public. Initiating a waiver may require a clinical restructuring proposal.*

(7) Collaborating with the VA medical facility Chief of Police to provide a safe environment for patients seeking urgent care for all Urgent Care levels. See VA Directive 0730, Security and Law Enforcement, dated December 12, 2012.

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

(1) Working with the VA medical facility Associate Director for Patient Care Services (ADPCS) to develop written processes for boarding of patients in an Urgent Care or area under the control of Urgent Care while awaiting admission to a VA inpatient bed.

NOTE: *Urgent Care does not routinely board patients. For further details regarding boarding, see paragraph 9.h.*

(2) Working with the VA medical facility Director to determine the structure of an Urgent Care within the organizational framework of the VA medical facility.

(3) Determining the final clinical disposition of an Urgent Care patient when responsible Urgent Care providers and inpatient providers cannot agree. See paragraph 9.g.

(4) Appointing the VA medical facility Urgent Care Medical Director and notifying the VISN EM Consultant of the selection. **NOTE:** *The VA medical facility EM Chief may be appointed as the Urgent Care Medical Director for Level II or III provided that the ED is located within the same health care system as the Urgent Care site.*

(5) Ensuring that an Urgent Care has access to any needed consult services in accordance with paragraph 9.f.

(6) Approving routinely scheduled provider shifts greater than 12 hours of clinical time for all Urgent Care levels, in accordance with paragraph 6.c.

(7) Notifying the VISN EM Consultant of unanticipated changes to operating hours for all Urgent Care levels.

(8) Working with the VA medical facility Urgent Care Medical Director to develop a Provider Staffing Contingency Plan SOP or written plan to ensure adequate provider coverage during all times of operation of the Urgent Care. See paragraph 6.c.

(9) Ensuring that all Urgent Care staff receive ongoing education and training and that provider competencies are up to date to ensure the full range of health care services, including mental health services, are provided at all times either on-site or on-call.

(10) Working with the VA medical facility Urgent Care Nurse Manager, ADPCS and Urgent Care Medical Director to create a written surge plan.

(11) Working with the VA medical facility Director to develop waiver requests in accordance with VHA Notice 2022-01.

(12) Conducting an evaluation, as needed, when Urgent Care physicians are repeatedly asked to respond to emergencies that arise outside of an Urgent Care. See

paragraph 6.c.(2). **NOTE:** *The VA medical facility COS may appoint a designee to perform this investigation.*

(13) Working with the VA medical facility Director to support implementation of the SPED intervention by identifying a Facility Champion and ensuring the VA medical facility has an SOP for SPED management that aligns with Urgent Care SOPs. **NOTE:** *The VA medical facility may create a separate SOP or include content within an existing SOP.*

i. VA Medical Facility Associate Director for Patient Care Services/Nurse Executive. The ADPCS/Nurse Executive (referred to as ADPCS) is responsible for:

(1) Appointing a qualified VA medical facility Urgent Care Nurse Manager.

(2) Working with the VA medical facility Urgent Care Nurse Manager, COS and Urgent Care Medical Director to create a written surge plan.

(3) Working with the VA medical facility COS to develop written processes for boarding of patients in an Urgent Care or area under the control of Urgent Care while awaiting inpatient admission (see paragraph 9.h.) and evaluate the delivery of urgent care services as appropriate.

(4) Working with the VA medical facility Urgent Care Nurse Manager to ensure that nursing competency is maintained for the level appropriate for the Urgent Care, develop nursing staffing contingency plans and ensure adequate nursing coverage. **NOTE:** *Nursing staffing contingency plans may be incorporated into the provider staffing contingency plan. See paragraph 6.*

(5) Working with the VA medical facility Director to develop waiver requests in accordance with VHA Notice 2022-01.

j. VA Medical Facility Urgent Care Medical Director. **NOTE:** *This individual should have active clinical privileges in Urgent Care or an ED. For Urgent Care Medical Director staffing criteria, see Appendix A.* The VA medical facility Urgent Care Medical Director is responsible for:

(1) Ensuring that Urgent Care staff have appropriate experience (see Appendix A) and are appropriately credentialed and privileged as outlined in VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021, and VHA Directive 1100.21, Privileging, dated March 2, 2023.

(2) Continually monitoring and evaluating the quality, safety and appropriateness of urgent care services.

(3) Working collaboratively with the VA medical facility Urgent Care Nurse Manager to establish guidelines, policies and procedures relevant to Urgent Care operations, as needed, including sexual assault procedures described in paragraph 18.a. **NOTE:** *Standardized local document templates are located at*

<https://dvagov.sharepoint.com/sites/VACOVHACOS/10B4/PIRP/10B4/SitePages/Document%20Templates.aspx>. This is an internal VA website that is not available to the public.

(4) Ensuring all relevant staff receive appropriate training on the correct use of the Emergency Department Integration Software (EDIS) package or electronic health record (EHR) system, in coordination with the VA medical facility Urgent Care Nurse Manager. See paragraphs 9.c. and 19.

(5) Providing opportunities for health professions education; establishing clinical rotations in Urgent Care, as needed, through collaboration with the VA medical facility Designated Education Officer, appropriate affiliate program directors and VA Residency Site Directors. **NOTE:** *In VA medical facilities with academic activities, the Urgent Care Medical Director should provide academic and research opportunities to Urgent Care physicians qualified to teach and participate in other academic activities.*

(6) Developing schedules that optimize provider presence during high volume times and effectively managing patient flow to identify and reduce operational risk and ensure high quality care.

(7) Collaborating with local Emergency Medical Services (EMS) officials in conjunction with the VA medical facility Urgent Care Nurse Manager to ensure timely emergency transport services when needed.

(8) Collaborating with the VA medical facility Urgent Care Nurse Manager and clinical pharmacy services to evaluate and determine medication needs and appropriate storage options for medications within the Urgent Care. **NOTE:** *For further information, see Appendix C and VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022.*

(9) Reviewing cases of delay of care resulting in potential patient harm pertaining to boarding and ancillary services such as radiology, laboratory and pharmacy or awaiting consultation with VA medical facility executive leadership.

(10) Serving on or appointing a designee to serve on the VA medical facility Peer Review Committee when appropriate to assess Urgent Care practice and standards. For further information on the peer review process see VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.

(11) Creating a written Provider Staffing Contingency Plan SOP, in conjunction with the VA medical facility COS, to ensure adequate provider coverage during all times of operation in the Urgent Care. See paragraph 6.c.(3). **NOTE:** *This is applicable to Urgent Care Levels I and II only.*

(12) Creating a written surge plan to address situations in which patient demand exceeds Urgent Care capacity, in conjunction with the VA medical facility Urgent Care Nurse Manager, ADPCS and COS. **NOTE:** *This plan must be easily available to all staff and address situations where provider resources must be quickly mobilized. These*

plans must authorize Urgent Care nursing personnel to contact the Urgent Care Medical Director or designee appointed by the Urgent Care Medical Director for implementation of the plan when provider staffing is deemed insufficient to handle patient demands.

(13) Working collaboratively with the VA medical facility Urgent Care Nurse Manager to establish procedures relevant to Urgent Care operations, as needed.

(14) Developing written procedures or an SOP for Managing High Risk Mental Health Presentations in Urgent Care, in collaboration with the VA medical facility Urgent Care Nurse Manager. See paragraph 12.g.

(15) Working with the VA medical facility Chief, Pathology and Laboratory Medicine Service to develop guidelines for availability and timeliness of laboratory services in Urgent Care. See Appendix C.

(16) Assisting VA medical facility executive leadership with development of waiver requests.

(17) In collaboration with the VA medical facility COS, approving routinely scheduled Urgent Care provider shifts greater than 12 hours of clinical time in accordance with paragraph 6.c.

(18) In collaboration with the VA medical facility Urgent Care Nurse Manager, updating key contacts and characteristics about Urgent Care operations quarterly in the EM Electronic Site Directory (see paragraph 9.m.).

(19) Representing Urgent Care, as needed, on the VA medical facility's Executive Committee of the Medical Staff or equivalent committee.

k. **VA Medical Facility Urgent Care Nurse Manager.** For Urgent Care Nurse Manager staffing criteria, see Appendix A. The VA medical facility Urgent Care Nurse Manager is responsible for:

(1) Conducting a full unit nursing staffing methodology process with the VA medical facility nursing expert panel and reevaluating unit staffing in conjunction with the VA medical facility executive leadership consistent with VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023. **NOTE:** See *paragraph 6.b. for further information regarding nursing staffing.*

(2) Working with the VA medical facility ADPCS to ensure that nursing competency is maintained for Urgent Care, develop nursing staffing contingency plans and ensure adequate nursing coverage.

(3) Ensuring that employees using EDIS or an equivalent EHR patient tracking system receive appropriate training on the correct use of the EDIS package or EHR tracking system, in coordination with the VA medical facility Urgent Care Medical Director. See paragraphs 9.c. and 19.

(4) Working collaboratively with the VA medical facility Urgent Care Medical Director to establish procedures relevant to Urgent Care operations, as needed.

(5) Collaborating regularly with the VA medical facility Chief of Mental Health Services and Urgent Care Medical Director to develop a Managing High Risk Mental Health Presentations SOP for Urgent Care. See paragraph 12.g.

(6) Collaborating with local EMS officials in conjunction with the VA medical facility Urgent Care Medical Director in order to ensure timely emergency transport services when needed.

(7) Collaborating with the VA medical facility Urgent Care Medical Director and pharmacy administration to evaluate and determine medication needs and appropriate storage options for medications within Urgent Care. **NOTE:** *For further information, see Appendix C and VHA Directive 1108.07.*

(8) Creating a written surge plan for situations in which patient demand exceeds Urgent Care capacity, in conjunction with the VA medical facility Urgent Care Medical Director and COS. **NOTE:** *This plan must be easily available to all staff and address situations where provider resources must be quickly mobilized. These plans must authorize Urgent Care nursing personnel to contact the Urgent Care Medical Director or designee appointed by the Medical Director for implementation of the plan when provider staffing is deemed insufficient to handle patient demands.*

(9) Updating key contacts and characteristics about Urgent Care operations quarterly in the EM Electronic Site Directory, in collaboration with the VA medical facility Urgent Care Medical Director.

I. **VA Medical Facility Staff.** VA medical facility staff are responsible for administering safety planning and assisting with coordination of follow up contact post-discharge from Urgent Care for SPED interventions as described on the Suicide Risk Identification and Management/SPED SharePoint (SPED Resource tab) at: <https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx>.

NOTE: *This is an internal VA website that is not available to the public.*

6. URGENT CARE STAFFING

a. **Administrative Staff.** Appropriately trained administrative staff should be available to support the administrative needs of the Urgent Care at all times, including but not limited to patient check-in, registration, communications, arranging transfers and follow up appointments and admissions.

b. **Nursing.** Appropriately educated and qualified nursing professionals must be present and able to staff the Urgent Care during all hours of operation based on the nursing staffing methodology plan (see paragraph 5.k. for related responsibilities for the VA medical facility Urgent Care Nurse Manager).

(1) Urgent Care volume, complexity, resources and flow based on patient intake are necessary pieces of information to determine the appropriate number of staff members required. Urgent Care nurse staffing should take into consideration the need for additional staff members for triage in addition to the minimum nursing requirements.

NOTE: For minimum required nursing staffing levels and other criteria by Urgent Care level, see Appendices A and B.

(2) All VA medical facilities with an Urgent Care should have written nursing staffing contingency plans. **NOTE:** This may be incorporated into the provider staffing contingency plan.

(3) A dedicated charge nurse is strongly recommended for Urgent Care Level I to assist with flow and communication needs between the Urgent Care Nurse Manager, physicians, Urgent Care Medical Director, and other VA medical facility executive leadership. The Urgent Care charge nurse should have no other clinical assignments to allow for a focus on patient throughput and daily shift operations.

c. **Physicians.** Appropriately credentialed and privileged physicians (or NPs or PAs in Urgent Care Level III) must be physically present and immediately available in the defined space of Urgent Care during all hours of operation (see minimum staffing by level in Appendix B). Shift schedules must be completed and published in advance to all providers working in the Urgent Care. Shift lengths more than 12 hours may occasionally be scheduled. If shifts greater than 12 hours of clinical time are routinely scheduled or needed, the VA medical facility Urgent Care Medical Director will discuss approval with the VA medical facility COS; the Urgent Care Medical Director may contact the VISN EM Consultant for advice, if necessary. An Urgent Care utilizing shifts greater than 12-hours must monitor this practice closely to be sure the staff members working these extended hours are performing their duties at the highest level. Providers working more than a 12-hour shift must be provided available space to rest if the situation allows. Shift length may be affected by a family emergency or an illness. In this temporary situation an extended shift may be approved by the VA medical facility Urgent Care Medical Director or designee appointed by the Urgent Care Medical Director. **NOTE:** For physician staffing criteria by Urgent Care level, see Appendices A and B.

(1) The recommended number of patients per hour for Urgent Care providers depends on the acuity mix and the practice environment. Decisions on staffing should be based on patient flow data with the objective of reducing delays in provider evaluation and care.

(2) The Urgent Care provider is not responsible for any inpatient activities outside of Urgent Care except under the following conditions: the provider may respond to emergencies that arise outside of Urgent Care if the emergency is beyond the capabilities of the normal response team, the provider is the most knowledgeable or experienced provider available to manage the emergency and the response will not jeopardize the care of patients in Urgent Care. For repeated instances that require the Urgent Care provider to respond, the VA medical facility COS, or designee appointed by

the COS, must evaluate the reason and develop an effective solution that does not risk leaving Urgent Care without a provider physically present in Urgent Care during all hours of operation.

(3) All Urgent Care levels must have a written Provider Staffing Contingency Plan SOP or written plan to ensure adequate coverage during all hours of operation. The SOP template for the contingency plan is available at <https://dva.gov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>.
NOTE: This is an internal VA website that is not available to the public.

(4) Resident physicians working in Urgent Care must be supervised in accordance with VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019. In addition, other health professions trainees must be supervised in accordance with VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

d. **Physician Assistants.** PAs can work within their scope of practice with a collaborating physician available for real-time consultation (in-person or remote). See VHA Directive 1063(1), Utilization of Physician Assistants (PAs), dated December 24, 2013.

e. **Nurse Practitioners.** NPs can work within their scope of practice or credentials and privileges, as applicable, in Urgent Care. For further information regarding full practice authority for NPs, see VHA Directive 1350, Advanced Practice Registered Nurse Full Practice Authority, dated September 13, 2017.

f. **Physical Therapists.** A PT provides comprehensive conservative management services in accordance with their individualized scope of practice, based on local credentialing and within VHA Directive 1170.05, VHA Physical Therapy Practice, dated May 11, 2020. It is recommended that dedicated PT coverage be available during the peak times of the day, or as determined appropriate to individual Urgent Care needs.

g. **Clinical Pharmacy Specialists.** CPS are medication experts who are credentialed in accordance with VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015, and provide comprehensive medication management services to support the Urgent Care team. The CPS provides coordination of pharmacy services in conjunction with Clinical Pharmacists and Pharmacy Technicians within the inpatient and outpatient pharmacy.

h. **Social Workers.** Social workers provide comprehensive psychosocial support services to patients focused on evaluation of key social determinants of health domains including access to care, economics, housing, psychological status, cognitive status and social support. See VHA Directive 1110.02, Social Work Professional Practice, dated

July 26, 2019. **NOTE:** During all hours of operation, Urgent Care must have on-site or on-call access to social work services for Urgent Care patients.

i. **Unlicensed Assistive Personnel.** Unlicensed assistive personnel (UAP) including intermediate care technicians (ICTs) may staff Urgent Care sites depending on local needs. UAPs include individuals who are trained to perform certain health care-related tasks under the supervision of licensed health care professionals. **NOTE:** See Appendix A for more information regarding ICTs.

7. TELEHEALTH

a. Video telehealth, using VA Video Connect (VVC) for telehealth or other approved video technologies for clinical care, is encouraged to provide a virtual access point of care for patients in lieu of their presentation to a VA Urgent Care. Telehealth clinics are supported as a mechanism for the delivery of urgent care based on the needs of the patient and the state of technology and should be used to facilitate convenient and effective access to care when appropriate.

b. With a focus on providing basic urgent care services, tele-capable Urgent Care sites should collaborate with other VA medical facilities to offer specialty consultation services such as mental health, geriatrics, Tele-Intensive Care Unit, Tele-Stroke, Clinical Resource Hubs, Clinical Contact Centers and other specialty services as deemed clinically appropriate to accommodate their urgent care patients' clinical needs.

c. **Tele Emergency Care.** Tele Emergency Care (Tele-EC) can be established in VA Urgent Care to enhance access to urgent care for patients to deliver urgent, acuity-appropriate episodic care. Services should be integrated with current VISN and VA medical facility pathways available for patients to obtain telehealth services. Appropriate stop codes or encounter-based billing mechanisms must be used when establishing or providing Tele-EC.

8. URGENT CARE REQUIREMENTS

a. **Urgent Care Administration.** Urgent Care falls under the leadership of a VA medical facility Urgent Care Medical Director and Nurse Manager or EM Chief. The Emergency Medicine Field Advisory Board (EMFAB) and the VISN EM Consultant serve as a resource to VA medical facilities as they develop and evolve the practice of urgent care medicine. **NOTE:** EMFAB is the principal VA advisory body for urgent care medicine. The role of EMFAB is to support and provide guidance in the practice of emergency medicine (EM) and urgent care medicine. For further information regarding EMFAB, visit the EM SharePoint:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>

This is an internal VA website that is not available to the public.

b. **Stop Codes.** All patients receiving face-to-face evaluation in Urgent Care for treatment, regardless of the severity of their illness or triage level, must be coded under a primary stop code of 131.

c. **Urgent Care Safety.**

(1) VA recognizes the urgent care environment as a high-risk area for staff safety and VA Police or security must be available during all hours of operation to provide standby assistance when requested by Urgent Care staff to address public safety incidents. It is strongly recommended that police officers or security be stationed within or in very close proximity to Urgent Care as a visible security presence can deter significant events from happening and offer the police the ability to witness firsthand events from inception. See paragraph 19 for information regarding required training in Prevention and Management of Disruptive Behavior (PMDB).

(2) Any Urgent Care staff member can alert VA Police to the existence of a potential or actual public safety incident or violation of security/conduct requirements occurring on the premises.

(3) Patients who are being clinically evaluated in the Urgent Care for an acute mental health emergency, to determine the appropriateness of implementing an involuntary mental health hold or detention under applicable State law and procedures, or those who have already been placed on an involuntary hold under applicable State law provisions and are awaiting transfer, may pose a serious safety risk to the patient themselves or to others. VA Police may provide assistance in preventing patients from departing prior to an involuntary mental health evaluation being completed, or subsequent to an involuntary mental health hold being implemented.

(4) While clinical staff are determining whether an involuntary hold/detention is clinically warranted under applicable State law and procedures, or, in cases where positive determinations have already been made and Urgent Care is awaiting transfer of the patient for involuntary inpatient admission, the patient is to be placed in an environmentally safe room with one-to-one observation or in a designated mental health intervention room under direct line-of-sight observation by a trained staff member. If a mental health intervention room does not exist, is in use or not available, Urgent Care staff will place the patient in an exam/treatment room with a safety attendant and will remove all objects that could pose a risk of harm to self or others, provided they can be easily removed without adversely affecting the ability to deliver medical care. An Urgent Care without an available dedicated mental health intervention room must also place the patient on one-to-one observation by a trained staff member. For reasons of patient and staff safety, the patient's belongings must be removed, secured and screened for hazardous items; valuables must be inventoried. Belongings are not to be returned to the patient until a medical or mental health provider determines it is safe to do so.

(5) VA medical facilities may consider using metal detectors (magnetometers) to screen all patients and visitors for weapons upon entering Urgent Care. If metal detectors are in use, they must be used for all patients and visitors entering Urgent

Care. **NOTE:** See VA Handbook 0730, *Security and Law Enforcement*, dated August 11, 2000, which addresses specific requirements for the use of metal detectors.

(6) Persons found to be in possession of weapons or other hazardous items during screening are subject to arrest and prosecution. See 18 U.S.C. § 930; 38 U.S.C. § 902; 38 C.F.R. § 1.218(a)(13); VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022; and VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021, which addresses workplace violence prevention at VA medical facilities.

d. **Environment of Care.** An Urgent Care must provide a safe environment for patients and staff, make access convenient and protect visual and auditory privacy to the greatest practical extent possible. Appropriate signage indicating convenient access for all individuals presenting for care must be placed at major points of entrance into the VA medical facility and must clearly indicate directions to access Urgent Care during operational hours. In general, ingress to Urgent Care should be limited via PIV badge entry, key code or similar security measure. **NOTE:** See VHA Directive 1608, *Comprehensive Environment of Care Program*, dated June 21, 2021, for additional information.

e. **Safety, Comfort and Mobility Design.** Environmental features that promote visual contrast and accessibility and reduce fall risk include handrails and non-slip, non-skid floors and ramps. See VHA PG 18-9 for specific National Safety Foundation requirements (<https://www.cfm.va.gov/til/space.asp>). Restrooms dedicated for use by mental health patients should be ligature free and follow Mental Health Environment of Care Checklist (MHEOCC) guidance. VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017, provides national policy on the use of the MHEOCC in designing spaces used to evaluate patients presenting to an Urgent Care with mental health concerns.

f. **Equipment, Devices and Supplies.** Urgent Care equipment and supplies must be readily available in the VA medical facility with an Urgent Care during all hours of operation; this includes critical and semi-critical reusable medical devices. See VHA Directive 1761, Supply Chain Management Operations, dated December 30, 2020, and VHA Directive 1116(2), Sterile Processing Services (SPS), dated March 23, 2016, for further information. A process for inspection and documentation of the proper functioning of all equipment must be in force; see VHA Directive 1860, Biomedical Engineering Performance Monitoring and Improvement, dated March 22, 2019. **NOTE:** Recommended equipment for Urgent Care can be found on the EM SharePoint: <https://dva.gov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>. This is an internal VA website that is not available to the public.

g. **Interdisciplinary Support Services.** Standard procedures must allow access to support services during operating hours. See Appendix C for details.

9. GENERAL OPERATIONS REQUIREMENTS

a. **Urgent Care Services.** Urgent Care provides non-emergent outpatient care on an unscheduled basis to patients seeking urgent care. Patient preference for Urgent Care staff sex is to be accommodated to the extent feasible.

b. **Patient Sign In.** All VA medical facilities registering patients in Urgent Care must comply with VHA Directive 1230. All outpatient appointments meeting the definition of an encounter must be made in count clinics using EHR scheduling software. During non-operational hours for all Urgent Care levels, signage and telephone messages must indicate that there are no urgent care services available, must direct patients to the nearest ED that can provide medical or mental health services, and must include the phone number to the Veterans Crisis Line.

c. **Patient Tracking System.** Urgent Care must utilize either the EDIS tracking system or EHR platform to monitor patient quality and flow metrics for both VA medical facility and national reporting and flow management. Urgent Care sites operating at VA medical facilities with acute care inpatient medical beds should refer to VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.

d. **Triage.**

(1) **Emergency Severity Index.** Triage in Urgent Care should be consistent with the Emergency Nurses Association (ENA) position statement dated May 2017, Triage Qualifications and Competency, and the use of the Emergency Severity Index (ESI) as the sole triage tool. Triage Nurses must have demonstrated competency in use of the five tier ESI triage system, to be assessed as part of regular competency validations. The ENA position statement can be found at:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive.>

NOTE: This is an internal VA website that is not available to the public.

(2) All Urgent Care sites must use the most recent triage template approved by the VHA Emergency Medicine Program in the EHR. VA medical facility-specific screening questions necessary for triaging patients safely may be added to the template, provided that such additions do not unnecessarily delay Urgent Care provider evaluation and treatment of the patient.

e. **Nurse First Process.** The Quick Look Nurse or Nurse First position is located at the check-in area of Urgent Care and must be staffed by a Registered Nurse (RN). The primary responsibility of this position is to quickly sort incoming patients into two categories: emergent or non-emergent. This position relies on rapid assessments and

requires experienced and knowledgeable nurses trained in triage to perform the job successfully. Quick Look Nurse or Nurse First nurses do not typically assign patients an ESI priority unless the patient's condition warrants them to assist with the full triage, stabilization, and the emergency escalation of care process (see paragraph 9.k.). This position may also be responsible for monitoring the patients in the waiting area for recognition of changes in their condition, should be without additional clinical assignments and is strongly recommended for all Urgent Care sites especially during identified queuing times. For Urgent Care, Nurse First is a recommended best practice but is not mandated by this directive.

f. **Consult Services.** Urgent Care must follow VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016. The VA medical facility COS must ensure access to all necessary consult services during all hours of operation. Each consult service must provide Urgent Care with an accurate schedule and contact information of on-call staff. The expectation for a return call from an on-call consultant is no longer than 30 minutes, with an on-site or telehealth evaluation, as clinically indicated, within 60 minutes under normal circumstances. No STAT consult may be declined. See Appendix B for criteria by Urgent Care level.

g. **Admissions.** The decision to admit a patient is made when there is adequate clinical information to determine the admitting service, the level of care and the suspected diagnosis. **NOTE:** See paragraph 12 and VHA Handbook 1160.06, *Inpatient Mental Health Services*, dated September 16, 2013, for information regarding admission for mental health patients.

(1) A verbal handoff from Urgent Care to VA inpatient provider(s) occurs concurrently with the decision to admit to the hospital and generally within 30 minutes, independent of whether there are open inpatient beds. If Urgent Care providers cannot reach the admitting team within 30 minutes, Urgent Care providers may escalate the call to the appropriate service chief. The goal is to transfer primary responsibility to the admitting team as soon as can be safely accomplished and typically at the time of verbal handoff.

(2) In Urgent Care Level I, appropriately qualified inpatient providers must be available during all hours of operation and must be identified in advance to manage the care and activities of Urgent Care patients requiring admission.

(3) If after an in-person evaluation, the proposed admitting attending disagrees on the appropriate treating service or level of care, the final disposition will be determined by escalation, which may include respective section or service chiefs with involvement of the VA medical facility COS, or designee appointed by the COS, if necessary.

(4) Urgent Care providers may place initial bed requests and may place additional transition orders to expedite patient movement to the inpatient ward. If transition orders are used to facilitate patient movement, the Urgent Care provider should collaborate with the admitting provider to formulate brief, time-limited transition orders specific to clinical care of the patient. Transition orders do not require bedside evaluation of the

patient by the inpatient provider prior to being placed. Such limited orders will typically include information regarding the intended bed type, admitting service, activity, safety precautions, diet and general monitoring orders.

(5) The Urgent Care provider must not write any detailed orders that extend care and responsibility for the patient beyond the treatment given in the Urgent Care. Once the patient is in admitted status, the Urgent Care provider will direct Urgent Care and inpatient nursing staff to contact the admitting provider with specific questions regarding future VA inpatient care.

(6) Once the patient's care has been transitioned to the admitting team, the admitting team will not extend Urgent Care length of stay for completion of an inpatient history and physical, non-emergent labs, testing, medications or interventions.

(7) Once the admitting team assumes primary responsibility of the patient, they are generally responsible for all care, including while the patient is still located in Urgent Care. If the patient's medical status changes to require immediate medical treatment, such as for acute pain or shortness of breath and the admitting team is not present, Urgent Care providers must provide interventions as appropriate, including re-evaluation of the patient for changes in level of care or admitting service and communicate these actions to the admitting team.

(8) Admitted patients who remain in Urgent Care after the decision to admit will receive care that is consistent with their admission level of care. This is achieved by Urgent Care nursing, inpatient nursing, or a combination of the two based on VA medical facility resources.

(9) Inpatient providers who determine that the patient's condition does not warrant admission may be permitted to officially discharge the patient from Urgent Care according to the VA medical facility's SOPs. In such cases, the Urgent Care provider and inpatient provider must work together to ensure that all VA documentation requirements and procedures are followed.

h. Urgent Care Boarding and High Census Plans or Surge Plan. Urgent Care does not routinely board patients. If temporary boarding is utilized, all VA medical facilities must have written processes that address the boarding of Urgent Care patients to ensure that optimal care is uniformly and expediently delivered when patients must be boarded in Urgent Care due to lack of bed availability on the destination unit. **NOTE:** *Urgent Care sites with no inpatient units cannot board. Urgent Care Level III will not have the ability to board patients.* These processes include:

(1) According to the Urgent Care level and associated inpatient services that are available, implementation of a VA medical facility high census/surge plan through a collaboration between the Urgent Care Attending and Nurse Manager, Bed Flow Coordinator (BFC) or Flow Coordination Center (FCC), and Nurse on Duty (NOD) or Admitting Department for high census/surge plan initiation and execution.

(2) Identification of locations for overflow patients (i.e., Post Anesthesia Care Unit, Inpatient Rehabilitation Unit, Short Stay) outside of Urgent Care.

(3) Deferring transfers into Urgent Care from other VA medical facilities, including off-site VA clinics or Community-Based Outpatient Clinics (CBOCs), during times the high census/surge plan is activated.

(4) Direction of on-site clinic admissions to Urgent Care only for Urgent Care patients who are critical or unstable. Urgent Care is not to be used to hold patients because of the lack of needed inpatient beds.

(5) Direction to decompress Urgent Care patients to avoid inpatient boarding at the Urgent Care or to divert cases if needed to maintain urgent care treatment capacity.

(6) Development of workflows for appropriate care when boarding patients in the Urgent Care or in an area controlled by the Urgent Care, including providing a similar level of care for a patient admitted to an inpatient service in all temporary bed locations.

(7) Transferring care responsibility from the Urgent Care provider to the admitting provider, which generally occurs after direct verbal communication between the Urgent Care provider and the admitting provider, assuring this can be accomplished safely. See paragraph 9.g.

i. **Transfer Process.** All VA medical facilities with an Urgent Care must comply with VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017, for patients transferring to VA or outside facilities.

j. **Discharge Instructions.** All patients discharged from Urgent Care are given specific follow-up care instructions. These instructions must be legible and be reviewed with the patient or caregiver prior to discharge. Documentation of this must be reflected in the patient chart. Additionally, instructions must include relevant updated medication information and education/counseling to ensure effective self-care and follow-up.

k. **Emergency Escalation of Care.** Emergency escalation of care is a situation in which a patient presents to an Urgent Care with a condition, or develops a condition while in Urgent Care, that is beyond the capabilities of Urgent Care to safely evaluate or treat and who requires 911 emergent transfer to a higher level of care. All measures should be taken to provide an expedited medical evaluation or treatment within the capabilities of Urgent Care while awaiting transport but must not unnecessarily delay transfer of a patient with a potentially life- or limb-threatening condition. A provider must document the emergency escalation of care in the EHR.

l. **Urgent Care Observation.** All VA medical facilities with an Urgent Care must follow VHA Directive 1036. In accordance with VHA Directive 1036, patients assigned to Urgent Care Observation status must be limited to a stay of 23 hours and 59 minutes in Urgent Care itself or an observation unit operated by the Urgent Care site. Patients who cannot be discharged in this time frame must be admitted or placed in Observation status on an inpatient unit at a location outside of Urgent Care.

m. **Emergency Medicine Electronic Site Directory.** The EM Electronic Site Directory provides information about VA ED and Urgent Care sites, including key operational characteristics and contact information for ED/Urgent Care leadership. The information in the EM Electronic Site Directory must be updated on a quarterly basis by the VA medical facility Urgent Care Medical Director and the Urgent Care Nurse Manager. Access to the EM Electronic Site Directory is provided by emailing VHA EMX (vhaemx@va.gov). **NOTE:** *The EM Electronic Site Directory can be found here: https://vaww.pbi.cdw.va.gov/PBI_RS/report/GPE/QSV_HSIPC/EM/DIR_SUM. This is an internal VA website that is not available to the public.*

10. AIRWAY MANAGEMENT

a. **Out of Operating Room Airway Management.** VA medical facilities must not utilize the sole Urgent Care physician for primary response to cardiopulmonary emergencies that arise outside of Urgent Care in lieu of a rapid response team or similar emergent out-of-operating room airway team (see VHA Directive 1101.04, Medical Officer of the Day, dated February 6, 2019). The Urgent Care physician may respond to such cases if the emergency is beyond the capabilities of the normal response team, the Urgent Care physician is the most knowledgeable or experienced physician available to manage the emergency and the response will not jeopardize the care of patients in Urgent Care.

b. **Intubation/Airway Management.** Providers in Urgent Care Level I may use anesthetic agents for intubation, with approved privileges and documentation, in accordance with VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018. See VHA Directive 1157(1) for standards and requirements.

11. USE OF ANESTHETIC AGENTS FOR MODERATE SEDATION IN URGENT CARE

Urgent Care providers in Urgent Care Level I ordering, administering or supervising the performance of moderate sedation in support of patient care must be qualified and have appropriate credentials, privileges or scope of practice to perform sedation. (See VHA Directive 1073(1), Moderate Sedation by Non-Anesthesia Providers, dated December 20, 2022.)

a. Moderate sedation may be performed in Urgent Care Level I; Urgent Care Level II sites interested in performing moderate sedation should collaborate with their VISN EM Consultant to ensure it can be performed safely.

b. Urgent Care Level III may not perform moderate sedation.

12. URGENT CARE MANAGEMENT OF PATIENTS WHOSE PRESENTATION INCLUDES MENTAL HEALTH CONCERNS

a. All VA medical facilities with an Urgent Care must be able to assess the need for the full range of health care services, including mental health services during all hours of operation either on-site, or on-call. This coverage is to be provided by an

appropriately credentialed licensed independent practitioner (LIP) or as may be required by VA medical facility requirements. **NOTE:** For a definition of LIP, see VHA Directive 1100.20. VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, defines minimum administrative and clinical requirements for VHA mental health services provided at all VHA medical points of service.

b. Suicide screening is administered to all patients presenting to an Urgent Care via the National Emergency Department/Urgent Care Triage note in the EHR. All patients presenting with suicidal or homicidal ideation must be formally assessed using current screening and evaluation tools. Immediate triage and identification of emergency medical conditions will take precedence over this screening process.

(1) Risk Identification (Risk ID) requirements in Urgent Care can be accessed by visiting <https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx> and choosing "Setting Specific Guidance." **NOTE:** This is an internal VA website that is not available to the public.

(2) SPED requirements and procedures can be accessed by visiting the SPED SharePoint site at: <https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx>. **NOTE:** This is an internal VA website that is not available to the public.

c. A medical assessment from an Urgent Care provider will occur, including appropriate physical exams and laboratory testing, to identify and rule out medical conditions that could be responsible for the presenting mental health condition.

d. When Urgent Care has on-call coverage for mental health, the provider should acknowledge receipt through locally agreed upon processes within 30 minutes of request and begin the telehealth or face-to-face evaluation within 60 minutes of acknowledged receipt. A tele-visit is acceptable for mental health evaluation by an appropriately telehealth-trained and credentialed mental health provider. **NOTE:** Use of tele-mental health (TMH) to support the delivery of services is appropriate and encouraged for meeting Urgent Care mental health coverage requirements. The use of TMH should be clinically determined based on the needs and preferences of the patient and the state of technology and evidence-based practice to facilitate convenient and effective access to care.

e. A face-to-face assessment by on-site mental health LIPs within 60 minutes of a consultation request is preferred whenever possible. In situations where face-to-face evaluations cannot occur, TMH is acceptable.

f. As addressed in paragraph 8, if an individual in Urgent Care is being evaluated for risk of suicidal or homicidal thoughts, they must be immediately placed and maintained in a safe environment until a more in-depth assessment occurs. The in-depth assessment is needed to determine whether the patient qualifies for placement of an involuntary hold or detention consistent with the requirements and procedures

established by applicable State law. Until that in-depth assessment can be made, the patient should be placed in an environmentally safe room with one-to-one observation or in a designated mental health intervention room under direct line-of-sight observation by a trained staff member. Staff must follow their mental health SOPs regarding safe patient care and handling. An Urgent Care with an available mental health intervention room is to use direct line-of-sight observation for patients and must follow their mental health SOPs regarding safe patient care and handling. If a mental health intervention room does not exist, is in use, or is not available, Urgent Care staff will place the patient in an exam/treatment room with a safety attendant and will remove all objects that could pose a risk for harm to self or others, provided they can be easily removed without adversely affecting the ability to deliver medical care. The patient is to be put on one-to-one observation by a trained staff member. If restraints are used, their use must be consistent with 38 C.F.R. § 17.33(d); The Joint Commission guidance; and VA medical facility procedures. The Mental Health Intervention Room and Mental Health Bathroom environment of care must be reviewed every 6 months by the VA medical facility Interdisciplinary Safety Inspection Team as outlined in VHA Directive 1167.

g. The VA medical facility Urgent Care Medical Director, Chief of Mental Health Services and Urgent Care Nurse Manager collaborate to establish local procedures or a Managing High Risk Mental Health Presentations SOP to coordinate the intake, assessment, treatment and, if necessary, inpatient admission of patients who are determined by the VA medical facility to be patients with high risk mental health preventions (e.g., imminent risk for suicide or homicide and for whom an involuntary hold is authorized), consistent with applicable State law terms and procedures. For patients who do not qualify for such holds but who are still considered to have violent, disruptive or self-injurious behaviors, the Urgent Care must employ appropriate patient monitoring strategies to maintain patient and staff safety while the patient remains in Urgent Care. If using an SOP, the VA medical facility must use the standardized SOP template available at

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>

NOTE: This is an internal VA website that is not available to the public.

(1) **Direct Line-of-Sight Observation.** Direct line-of-sight observation of patients is only allowable if the patient is in a mental health intervention room. Staff can observe multiple patients, but must remain in the area with patients, such that if a patient needs immediate intervention, the staff member can immediately intervene and call other staff to help as needed. Observation by cameras may not necessarily substitute for direct line-of-sight observation unless it is determined for clinical reasons to provide a necessary alternative means of observation (e.g., a patient who is currently COVID-19 positive, or who has escalated with aggression to staff). Use of cameras must comply with VHA Directive 1078, Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings, dated November 29, 2021. For further information on observation levels, see Guide of Various Safety Observation Levels Available for Use; please also see VHA Guidance for VA Inpatient Mental Health Units. Both documents

are located at

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>

NOTE: This is an internal VA website that is not available to the public.

(2) **One-to-One Observation.** Patients on one-to-one observation must be continuously observed and monitored at all times by a trained staff member. For Urgent Care without an available mental health intervention room, patients must remain on one-to-one observation. The availability and use of a mental health intervention room does not remove the requirement for (at a minimum) direct line-of-sight observations for patients with suicidal ideation. During one-to-one observation, staff members must remain in close proximity to the patient so that they are able to react immediately to an adverse situation. Any Urgent Care staff member can initiate one-to-one observation. While under one-to-one observation, the patient is not to be allowed to leave the room for any reason (e.g., snacks, phone call), and any restroom visit requires a staff person who can continue to visibly monitor the patient for suicidal behavior, provided that such restrictions on the patient's freedom are consistent with statutory and regulatory authority. Use of a MHEOCC-compliant bathroom does not remove the requirement to visibly monitor the patient for suicidal behavior. Patients who may require one-to-one observation include those who are at risk for causing imminent harm to themselves or to others. Observation by cameras cannot substitute for one-to-one observation unless it is determined for clinical reasons to provide appropriate alternative means of observation (e.g., a patient who is currently COVID-19 positive, or who has escalated with aggression to others). If the patient is agitated or has a potential for violence, the staff member should consider observation at two to three arm's lengths away or observation by camera and patient behaviors should be immediately discussed with the treatment team.

(3) In addition, steps must be taken to ensure visitors do not bring objects into the mental health intervention room that patients could use to harm themselves or others. Staff will be sensitive to the dignity and privacy of the patient while maintaining safety and observation; as such, the patient should be asked what sex staff they prefer to have in attendance during the one-to-one observation. Urgent Care staffing should account for these potential situations and while every effort is made to address the patient's preference, there may be situations where staffing may not permit the one-to-one observation sex preference to occur. However, during restroom breaks or while the patient is undressing, it is imperative the patient's preference is respected to ensure that patient-centered care is given. A patient is never left unattended while using the restroom, even if that restroom meets MHEOCC standards.

(4) Qualified staff must be available to accompany and remain with such patients from one area of Urgent Care to another.

(5) Requirements for mental health intervention rooms vary according to Urgent Care level; see Appendix B. Urgent Care Levels I and II must have at least one

dedicated mental health intervention room or a treatment space that can be immediately converted to a mental health exam/treatment room. **NOTE:** *The MHEOCC (<http://vaww.ncps.med.va.gov/guidelines.html>) provides the environmental criteria for the mental health intervention room and mental health bathroom in Urgent Care. This is an internal VA website that is not available to the public. If an Urgent Care Level I or II site does not have a mental health intervention room, one should be added during the next planned remodel or redesign of the Urgent Care.*

13. INFORMED CONSENT

a. **Signature Informed Consent.** Consistent with VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009, the following minor bedside procedures commonly performed in the Urgent Care setting generally do not require signature consent, but do require an informed consent discussion with the patient (or surrogate, if the patient lacks decision-making capacity) and documentation of such discussion in the patient's EHR:

(1) Laceration repairs that are not expected to have significant cosmetic or functional impact to the patient and are at low risk of post-repair complication (infection, dehiscence, etc.).

(2) Simple abscess incision and drainage that is at low risk of damaging underlying neurovascular structures.

(3) Simple intradermal foreign body removal that is at low risk of adverse cosmetic or functional impact or damage to underlying neurovascular structures.

(4) If one of the above procedures is likely to be high risk for a particular patient, signature consent is required. A decision tool for determining if signature consent is required is available at:

https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Informed_Consent.aspx.

NOTE: *This is an internal VA website that is not available to the public.*

b. **Consent to Obtain and Disclose Evidentiary/Forensic Evidence.** For information regarding consent for release of evidentiary information and material, see VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

14. URGENT CARE OF THE OLDER ADULT

VA medical facilities with an Urgent Care are encouraged to have systems in place for providing age-friendly urgent care. Effective urgent care of older patients can result in more cost-effective care and better patient outcomes. VA medical facility Urgent Care Medical Directors are encouraged to work with other services to provide age-friendly urgent care. This includes:

a. Staffing protocols should include geriatric-trained providers, when possible, to provide geriatric education and training opportunities for all Urgent Care staff members.

b. Procedures and protocols supporting age-friendly care of the elderly, including interdisciplinary collaboration, screening of risk for adverse outcomes, additional needs assessments and specific geriatric consultations or interventions. **NOTE:** See VHA Directive 1199(1), *Reporting Cases of Abuse and Neglect*, dated November 28, 2017, for policy related to the reporting of known and suspected cases of abuse and neglect.

c. Geriatric EM resources may be helpful for some sites depending on services offered. For more information see <https://dvagov.sharepoint.com/sites/VAEMGeriatrics/SitePages/VA%20EM%20GERI%20HOME%20PAGE%20.aspx?OR=Teams-HL&CT=1633721530335>. **NOTE:** This is an internal VA website that is not available to the public.

15. URGENT CARE OF PEDIATRIC PATIENTS

a. All VA medical facilities with an Urgent Care must have pediatric/neonatal Basic Life Support (BLS) equipment available for pediatric/neonatal emergencies, and all Urgent Care clinical staff must have current BLS training; in addition, Advanced Cardiac Life Support (ACLS) training is required in Urgent Care Level I and II. EM board-certified physicians are strongly encouraged, but not required, to have current BLS and ACLS certification. See VHA Directive 1177, *Cardiopulmonary Resuscitation*, dated January 4, 2021, for additional information.

b. For sites that routinely see pediatric patients, full pediatric resuscitation equipment as well as Pediatric Advanced Life Support (PALS) training is required for all clinical staff.

16. OBSTETRIC AND GYNECOLOGIC CARE AND URGENT CARE

a. VHA Directive 1330.01(6), *Health Care Services for Women Veterans*, dated February 15, 2017, provides policy for all VHA sites of care, including Urgent Care, to ensure delivery of quality care to female Veterans, including sex-specific medical services, when accessing VA health care services.

(1) Emergency contraception must be available when clinically appropriate either at the time of the Urgent Care visit or by a prescription that can be filled in time to be effective.

(2) Urgent Care caring for pregnant patients onsite must have the following (**NOTE:** *Capabilities apply primarily to Urgent Care Level I*):

(a) Appropriate medications, supplies and processes to assure the temporizing treatment of an ectopic pregnancy, miscarriage or post-partum hemorrhage. **NOTE:** *Recommended obstetric and gynecologic medications and equipment for Urgent Care can be found on EM SharePoint at:*

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2F>

[VHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive.](#)
This is an internal VA website that is not available to the public.

(b) A plan for performing and interpreting pelvic ultrasound (including transvaginal), either on-site or by transfer agreement. (This does not apply to Urgent Care Level III.)

(c) Rh testing and availability of Rho (D) Immunoglobulin (RhoGAM) (see paragraph 16.e.).

(d) Access to specialty care providers (i.e., Ob/Gyn) (on-site, off-site, through transfer to another facility, or via tele-gynecology consultation).

(e) Ability to recognize and provide initial care (including emergent transfer to the nearest ED for higher level of care) for cases such as severe pre-eclampsia and eclampsia. **NOTE:** See the EM SharePoint for additional information on Care of the Pregnant Patient:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>
This is an internal VA website that is not available to the public.

b. As stated in VHA Directive 1330.01(6), all VA medical facilities must develop SOPs for managing obstetric and gynecologic emergencies. These SOPs must clearly describe on-site capabilities and processes/protocols for emergent patient transfer which are consistent with VHA Directive 1094 and must include processes for addressing obstetric and gynecologic emergencies which will differ by VA medical facility depending on the availability of the following:

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

(2) On-site diagnostic and treatment resources (e.g., pelvic ultrasound not available at Urgent Care Level II or III, operating room capacity). Type and screen for Rhogam for Urgent Care Level I.

c. Clinical staff providing urgent care treatment to Veterans must have sufficient training and expertise to care for Veterans presenting with obstetric and gynecologic issues, regardless of the VA medical facility's ability to provide labor and delivery services, as described in VHA Directive 1330.01(6).

d. Pregnancy Testing.

(1) As stated in VHA Directive 1330.01(6), all Veterans of child-bearing age (age ≤ 52 years) triaged in Urgent Care should be asked about pregnancy status and last menstrual period, if deemed appropriate based on information provided by the Veteran. Nursing triage documentation should include this information.

(2) An Urgent Care must have the ability to test and confirm pregnancy. Urgent Care Level I must have STAT qualitative pregnancy testing (urine or serum) with results available to the patient's Urgent Care clinician within 1 hour of order and a plan for obtaining urgent quantitative serum results if indicated. Immediate access to point of care qualitative urine pregnancy testing at triage is ideal for initial assessment in Veterans of child-bearing age (≤ 52 years), if deemed appropriate based on information provided by the Veteran, as pregnancy status may impact the evaluation and treatment options. Quantitative serum pregnancy testing is critical for evaluating and managing certain cases (e.g., possible ectopic pregnancy at Urgent Care Level I, not required for Urgent Care Level II or III).

e. **Blood Type Evaluation (Type and Screen- Urgent Care Level I Only)**. Blood type and antibody screen must be part of the evaluation of every pregnant Veteran who presents to an Urgent Care with vaginal bleeding. Urgent Care Level I must develop a process to ensure availability of Rho (D) Immunoglobulin to prevent Rh isoimmunization in Rh negative patients who are pregnant, in the appropriate clinical context.

17. INTIMATE PARTNER VIOLENCE

Every VA medical facility must implement and maintain an Intimate Partner Violence Assistance Program (IPVAP) in accordance with VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019. Veterans, intimate partners and employees impacted by intimate partner violence will have access to services including resources, assessment intervention and referrals to VA or community agencies as deemed appropriate and clinically indicated. Contact information for the IPVAP Coordinator and program is posted and distributed in prominent locations throughout the VA medical facility (e.g., main entrance(s), Urgent Care, Women's Health Clinics, websites, directories). VA medical facilities must develop and implement local protocols for screening at-risk populations for IPV in accordance with the national IPVAP Screening Toolkit located at <https://dvagov.sharepoint.com/sites/VHACMSWS/IPV/IPVAP%20Directive%20Draft/Forms/AllItems.aspx?id=%2Fsites%2FVHACMSWS%2FIPV%2FIPVAP%20Directive%20Draft%2F2%20Operating%20Guide%20and%20Toolkits>. **NOTE:** This is an internal VA website that is not available to the public.

18. URGENT CARE MANAGEMENT OF ACUTE SEXUAL ASSAULT

a. Acute sexual assault is defined as unwanted sexual contact by an alleged perpetrator. Urgent Care must have procedures in place to evaluate, support and treat patients of reported sexual assault consistent with consent requirements in VHA Handbook 1004.01(5), to include the following elements:

(1) Screening for injuries requiring emergent treatment or stabilization;

(2) Preserving evidence collection for forensic examination in consideration of regional law enforcement;

(3) Performing or referring for forensic examination, preferably by a Sexual Assault Nurse Examiner (SANE), if desired by the patient; and

(4) Ensuring access to prophylaxis for sexually transmitted disease and pregnancy when clinically indicated. Follow-up care may include screening and treatment of sexually transmitted diseases, treatment of injuries or access to law-enforcement and patient services such as a Rape Crisis Center based on regional availability and mental health services. Acceptable procedures must consider regional law-enforcement requirements. Evaluation for collection of forensic evidence should occur within 72 hours after the assault. Individual State guidelines may authorize collection at a later time.

(5) If the forensic examination is being performed in a VA medical facility, the forensic provider must first obtain the individual's informed consent for forensic examination and also be trained in conducting forensic evidentiary examinations. **NOTE:** *Acute sexual assault patients must, as part of the informed consent discussion, be made aware of the applicable limits to confidentiality in the relevant State(s).*

b. The patient has the right to accept or refuse any aspect of the medical evaluation and treatment or forensic evidentiary examination. Refusal of the forensic examination for evidence of sexual assault is not a ground for denial of treatment for injuries or possible pregnancy and sexually transmitted diseases. Refusal of any recommended treatment or procedure must be documented in the HER and respected. **NOTE:** *Patients have the option to have forensic evidence collected anonymously in the event they choose to pursue prosecution at a later date. District Counsel should be consulted regarding State laws.*

(1) **Collection and Safeguarding of Evidence.**

(a) Urgent Care staff must consult with VA Police regarding the proper collection, sealing and labeling of the evidence.

(b) When the patient has consented to the examination and collection of evidence of sexual assault, VA Police must be notified to safeguard and secure the evidence collected. **NOTE:** *The collection and safeguarding of evidence must be done in accordance with VA Handbook 0730.*

(2) **Report of Incident.** See VHA Directive 5019.02(1) and VA Directive 0321, Serious Incident Reports, dated June 6, 2012, for requirements for reporting incidents of harassment or sexual assault.

19. TRAINING

The following training is **required** for employees working in Urgent Care, including but not limited to RNs, physicians, intermediate care technicians (ICTs), health technicians and licensed practical nurses, with a brief description of training requirements below:

a. **Basic Life Support.** BLS training must be provided to and maintained by all Urgent Care staff members as noted in VHA Directive 1177. **NOTE:** *EM board-certified physicians are strongly encouraged, but not required, to have current BLS certification unless required by the VA medical facility. See VHA Directive 1177 for more information.*

b. **Advanced Cardiac Life Support.** ACLS training must be provided to and maintained by all licensed staff members working in Urgent Care Level I and II. **NOTE:** *EM board-certified physicians are strongly encouraged, but not required, to have current ACLS certification unless required by the VA medical facility. See VHA Directive 1177 for more information.*

c. **Pediatric Advanced Life Support.** PALS training is required of all Urgent Care clinical staff who routinely see pediatric patients.

d. **Suicide Prevention.** Suicide prevention training requirements for clinical and non-clinical employees are located in VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

e. **Prevention and Management of Disruptive Behavior.** Employees must receive training in PMDB at the appropriate level as determined by the VA medical facility. **NOTE:** *For further information about PMDB training, see VHA Directive 1160.08(1). PMDB is VHA's accepted training in verbal de-escalation, personal defense and safety/physical containment for managing disruptive and potentially violent patients.*

f. **Emergency Department Integrated Software Training.** Employees using EDIS or an equivalent HER patient tracking system must be trained on system requirements during local orientation and training must be documented locally. EDIS training varies based on the local configuration. The EDIS User Guide can be used as a supplement to local training. The EDIS User Guide is located at <https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?ga=1&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEDIS%202%2E2>. **NOTE:** *This is an internal VA website that is not available to the public.*

g. **Documentation of Training.** Training must be documented for each individual Urgent Care staff member and documentation must be readily available for inspection and review.

20. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Officer.

21. REFERENCES

- a. 38 U.S.C. §§ 902, 1710, 7301(b).
- b. 18 U.S.C. § 930.
- c. 38 C.F.R. §§ 1.218, 17.33.
- d. VA Directive 0321, Serious Incident Reports, dated June 6, 2012.
- e. VA Directive 0730, Security and Law Enforcement, dated December 12, 2012.
- f. VA Handbook 0730, Security and Law Enforcement, dated August 11, 2000.
- g. VA Handbook 5005, Staffing, dated February 4, 2022.
- h. VHA Directive 0999, VHA Policy Management, dated March 29, 2022.
- i. VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017.
- j. VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020.
- k. VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.
- l. VHA Directive 1063(1), Utilization of Physician Assistants (PAs), dated December 24, 2013.
- m. VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.
- n. VHA Directive 1073(1), Moderate Sedation by Non-Anesthesia Providers, dated December 20, 2022.
- o. VHA Directive 1075, Strategic-Operational Planning Process, dated July 27, 2020.
- p. VHA Directive 1078, Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings, dated November 29, 2021.
- q. VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated October 7, 2015.
- r. VHA Directive 1094, Inter-Facility Transfer, dated January 11, 2017.
- s. VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021.

- t. VHA Directive 1100.21, Privileging, dated March 2, 2023.
- u. VHA Directive 1101.04, Medical Officer of the Day, dated February 6, 2019.
- v. VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023.
- w. VHA Directive 1106, Pathology and Laboratory Medicine Service, dated July 27, 2018.
- x. VHA Directive 1108.07, General Pharmacy Service Requirements, dated November 28, 2022.
- y. VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.
- z. VHA Directive 1116(2), Sterile Processing Services (SPS), dated March 23, 2016.
- aa. VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018.
- bb. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.
- cc. VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients, dated May 12, 2017.
- dd. VHA Directive 1170.05, VHA Physical Therapy Practice, dated May 11, 2020.
- ee. VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021.
- ff. VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018.
- gg. VHA Directive 1198, Intimate Partner Violence Assistance Program, dated January 24, 2019.
- hh. VHA Directive 1199(1), Reporting Cases of Abuse and Neglect, dated November 28, 2017.
- ii. VHA Directive 1229(1), Planning and Operating Outpatient Sites of Care, dated July 7, 2017.
- jj. VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.
- kk. VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.
- ll. VHA Directive 1330.01(6), Health Care Services for Women Veterans, dated February 15, 2017.

mm. VHA Directive 1350, Advanced Practice Registered Nurse Full Practice Authority, dated September 13, 2017.

nn. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

oo. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

pp. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

qq. VHA Directive 1608, Comprehensive Environment of Care Program, dated June 21, 2021.

rr. VHA Directive 1761, Supply Chain Management Operations, dated December 30, 2020.

ss. VHA Directive 1860, Biomedical Engineering Performance Monitoring and Improvement, dated March 22, 2019.

tt. VHA Directive 5019.02(1), Harassment, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration, dated September 12, 2022.

uu. VHA Notice 2022-01, Waivers to VHA National Policy, dated February 10, 2022.

vv. VHA Handbook 1004.01(5), Informed Consent for Clinical Treatments and Procedures, dated August 14, 2009.

ww. VHA Handbook 1108.11(1), Clinical Pharmacy Services, dated July 1, 2015.

xx. VHA Handbook 1160.01(1), Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.

yy. VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013.

zz. VHA Handbook 1400.04, Supervision of Associated Health Trainees, dated March 19, 2015.

aaa. Emergency Medicine Management Tool User Manual.

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEmergency%20Medicine%20Management%20Tool%20%28EMMT%29>. **NOTE:** This is an internal VA website that is not available to the public.

bbb. Mental Health Environment of Care Checklist.
<http://vaww.ncps.med.va.gov/guidelines.html>. **NOTE:** This is an internal VA website that is not available to the public.

ccc. Risk ID SharePoint site.
<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx>.
NOTE: This is an internal VA website that is not available to the public.

ddd. Signature Informed Consent Decision Tool.
https://dvagov.sharepoint.com/sites/VHAethics/SitePages/Informed_Consent.aspx.
NOTE: This is an internal VA website that is not available to the public.

eee. Suicide Risk Identification and Management/SPED SharePoint site.
<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/SPED-Resources.aspx>.
NOTE: This is an internal VA website that is not available to the public.

fff. VA EM SharePoint. Care of the Pregnant Patient.
<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>.
NOTE: This is an internal VA website that is not available to the public.

ggg. VA EM SharePoint. EDIS User Guide.
<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?ga=1&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FResource%20Library%2FEDIS%202%2E2>. **NOTE:** This is an internal VA website that is not available to the public.

hhh. VA EM SharePoint. Guidance for VA Inpatient Mental Health Units. April 13, 2020.
<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>.
NOTE: This is an internal VA website that is not available to the public.

iii. VA EM SharePoint. Guide of Various Safety Observation Levels Available for Use. December 31, 2019.
<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>.
NOTE: This is an internal VA website that is not available to the public.

jjj. VA EM SharePoint. Recommended Medical, Pharmacy and Laboratory Equipment Supplies for Urgent Care.
<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/F>

[orms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%20Directive.](https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/General%20Directive)

NOTE: *This is an internal VA website that is not available to the public.*

kkk. VA SharePoint website. Communication of Test Results.

[https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/CTR/SitePages/Home.aspx.](https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/CTR/SitePages/Home.aspx)

NOTE: *This is an internal VA website that is not available to the public.*

III. Waivers to VHA National Policy.

[https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx.](https://dvagov.sharepoint.com/sites/VACOVHACBI/CBI%20Front%20Door/SitePages/Waivers-to-VHA-National-Policy.aspx)

NOTE: *This is an internal VA website that is not available to the public.*

mmm. Emergency Nurses Association (ENA). Position Statement -Triage Qualifications and Competency. May 2017:

[https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%20Directive.](https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%20Directive)

NOTE: *This is an internal VA website that is not available to the public.*

URGENT CARE INTERPROFESSIONAL TEAM AND STAFFING CRITERIA

This appendix states preferred staffing criteria for the Urgent Care interprofessional team. The appendices in Part II of VA Handbook 5005, Staffing, dated February 4, 2022, state underlying qualification standards for physicians, nurses and physician assistants (PAs). **NOTE:** For additional information regarding credentialing and privileging requirements, see VHA Directive 1100.20, Credentialing of Health Care Providers, dated September 15, 2021, and VHA Directive 1100.21, Privileging, dated March 2, 2023.

1. URGENT CARE MEDICAL DIRECTOR

The VA medical facility Urgent Care Medical Director should meet the following criteria:

- a. Board-certified or board-eligible by the American Board of Emergency Medicine (preferred), the American Osteopathic Board of Emergency Medicine (preferred) or possess another board certification/eligibility, experience and a knowledge base of urgent care medicine with comparable qualifications, training and experience.
- b. Active clinical privileges in their Urgent Care or a VA Emergency Department (ED).
- c. For Urgent Care Level III, a Nurse Practitioner (NP) may serve as the Urgent Care Medical Director.

2. PHYSICIANS

Urgent Care physicians should meet the following criteria:

a. **Urgent Care Level I.** A minimum of one licensed physician credentialed and privileged to work in the Urgent Care during all hours of operation. Physicians are recommended to be board-certified or board-eligible in Emergency Medicine (EM) but may be board-certified or board-eligible in Internal Medicine (IM) or Family Medicine (FM) with documented ED or urgent care experience as deemed appropriate by the VA medical facility Urgent Care Medical Director.

b. **Urgent Care Level II.** A minimum of one licensed physician credentialed and privileged to work in the Urgent Care during all hours of operation. Physicians are recommended to be board-certified or board-eligible in either EM, IM or FM with documented ED or urgent care experience as deemed appropriate by the VA medical facility Urgent Care Medical Director.

c. **Urgent Care Level III.** If staffed with a physician, the physician must be credentialed and privileged to work in the Urgent Care. Physicians are recommended to be board-certified or board-eligible in either EM, IM or FM with documented acute care

experience as deemed appropriate by the VA medical facility Urgent Care Medical Director. **NOTE:** See Appendix B for minimum required staffing in Urgent Care Level III. A physician, NP or PA must staff Urgent Care Level III during all hours of operation. There must be a qualified licensed independent practitioner (LIP) in the Urgent Care during all hours of operation.

3. URGENT CARE NURSE MANAGER

The VA medical facility Urgent Care Nurse Manager should meet the following criteria:

- a. Hold a current, full and unrestricted RN license in any State, Territory, or Commonwealth (i.e., Puerto Rico) of the U.S. or in the District of Columbia.
- b. Graduate of a school of professional nursing approved by the appropriate State-accrediting agency and accredited by one of the following accrediting bodies at the time the program was completed by the applicant: The Accreditation Commission for Education in Nursing or The Commission on Collegiate Nursing Education.
- c. Preferred education of either a Bachelor of Science in Nursing or Master of Science in Nursing or a related field.

4. NURSING

Nursing staff in any Urgent Care level should have documented experience deemed appropriate by the VA medical facility Urgent Care Nurse Manager. All nurses working in Urgent Care must hold a current, full and unrestricted license to practice in any U.S. State or territory.

5. NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

NPs and PAs provide patient care either under a scope of practice or through credentials and privileges. A PA provides patient care under a scope of practice that includes physician collaboration. NPs and PAs practicing in any Urgent Care level should have documented clinical skills and credentials deemed appropriate by the VA medical facility Urgent Care Medical Director.

6. INTERMEDIATE CARE TECHNICIANS

Intermediate care technicians (ICTs) work under the supervision of licensed healthcare professionals to provide direct patient care within Urgent Care. Through demonstrated and documented evidence of education, training, and competencies, ICTs may assist or perform technical health care procedures including obtaining a patient's health history, assisting in evaluating the presenting condition, and performing any necessary interventions based on symptoms and established protocols and standards of care. Additional information regarding ICTs is available at <https://dvagov.sharepoint.com/sites/VHAOPCIandI/ICT/SitePages/Home.aspx>. **NOTE:**

March 20, 2023

**VHA DIRECTIVE 1101.13(1)
APPENDIX A**

This is an internal Department of Veterans Affairs (VA) website that is not available to the public.

MINIMUM SERVICES FOR URGENT CARE LEVELS

1. MINIMUM SERVICES FOR ALL URGENT CARE LEVELS

a. All Urgent Care sites must have a designated Urgent Care Medical Director.

NOTE: A Department of Veterans Affairs (VA) medical facility Emergency Medicine (EM) Chief may be appointed as the Urgent Care Medical Director for Urgent Care Level II or III provided that the Emergency Department (ED) is located within the same healthcare system as the Urgent Care site.

b. No Urgent Care accepts emergent 911 ambulance services.

2. MINIMUM CRITERIA BY URGENT CARE LEVEL

In addition to the requirements stated in the body of this directive, the tables below define only the minimum services that must be available during all hours of operation to establish the criterion of Urgent Care Level of I, II or III. Urgent Care sites may elect to offer additional services based on local patient needs. An Urgent Care site may operate at a higher level during certain times, but their level will be assigned based on their minimum operating capacity.

OPERATIONS

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
Ability to address the highest acute patient needs during all hours of operation and does not accept 911 ambulances.	Can be free-standing or co-located clinic at a Multi-Specialty Community-based Outpatient Clinic (CBOC) Health Care Center or VA hospital.	Ability to be a stand-alone clinic in a Primary Care CBOC; provides treatment for low acute minor illnesses and injuries. See VHA Directive 1043.
Must be co-located at a VA hospital with acute care inpatient medical beds due to acute nature of patients and need for consultants.	Urgent Care patients requiring hospital admission may be transferred to an inpatient unit at a VA or community hospital via existing practice or written process.	
May operate 24 hours a day, 7 days a week. NOTE: Urgent Care Level I changing to operating on a 24/7 basis must initiate a clinical restructuring request per VHA Directive		

<p>1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.</p>		
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RADIOLOGY/IMAGING

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
<p>Plain Film Plain Film X-ray available in-house.</p>	<p>Plain Film Plain Film X-ray available in-house (preferred) or within 1 hour via either an on-call process or by transfer to a community facility.</p>	
<p>Computed Tomography Computed tomography (CT) Scan (Enhanced/Unenhanced).</p>	<p>Computed Tomography CT Scan (Enhanced/Unenhanced).</p>	
<p>Ultrasound Ultrasound available on-site, on-call or by transfer. <i>NOTE: STAT Ultrasound and STAT MRI should go to an ED unless the Urgent Care site has ability to provide specialist support or referral.</i></p>	<p>Ultrasound Ultrasound available on-site, on-call or by transfer (e.g., minimum ultrasound procedures include evaluation of lower extremities for deep vein thrombosis and limited abdominal ultrasonography to detect acute biliary pathology).</p>	
<p>Interpretation Interpretation of STAT imaging studies available generally within 1 hour of study completion.</p>	<p>Interpretation Interpretation of STAT imaging studies available generally within 1 hour of study completion.</p>	

LABORATORY

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
<p>Minimum Mandatory Minimum mandatory: Complete blood count (CBC), Chemistry (Chem), troponin (Trop), urinalysis (UA), urine drug screen (UDS), human chorionic gonadotropin (HCG), acute vaginitis probe, coagulation studies, prothrombin time or partial thromboplastin time, lactate and arterial blood gases (ABGs)/venous blood gases (VBGs) (may use i-point of care). Type and screen.</p>	<p>Minimum Mandatory CBC, Chem, Trop, UA, UDS, HCG, acute vaginitis probe, coagulation studies, lactate.</p>	<p>Minimum Mandatory CBC, Chem, UA, HCG, acute vaginitis probe, coagulation studies. <i>NOTE: Laboratory studies can be available as point of care testing.</i></p>
<p>STAT prioritization with turn-around time from collection to result of 1 hour (standard or point of care).</p>	<p>STAT prioritization with turn-around time from collection to result of 1 hour (standard or point of care).</p>	

PHARMACY

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
<p>Preferred to have pharmacist within hospital during all hours of operation. Must have capability to provide the below.</p>	<p>Preferred to have pharmacist accessible (on-site or on call) during all hours of operation for consult.</p>	<p>Preferred to have pharmacist accessible for consult during all hours of operation.</p>
<p>Capabilities Intravenous (IV) Therapy including fluids, antibiotics, antiemetics, Proton pump inhibitors (PPIs) and medications as listed at: https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive. NOTE: This is an internal VA website that is not available to the public.</p>	<p>Capabilities IV Therapy including fluids, antibiotics, antiemetics, PPI and medications as listed on the EM SharePoint website (see Level I).</p>	

SPACE AND EQUIPMENT CAPABILITIES

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
At least one dedicated mental health intervention room or a treatment space that can be immediately converted to a mental health intervention room in Urgent Care. See paragraph 12.g. in the body of this directive.	At least one dedicated mental health intervention room or a treatment space that can be immediately converted to a mental health intervention room.	Access to a treatment space that can be immediately converted to a mental health intervention room.
Electrocardiography (EKG) machine in Urgent Care.	EKG machine in Urgent Care.	EKG machine in Urgent Care.
A dedicated department Advanced Cardiac Life Support (ACLS) crash cart in Urgent Care.	A dedicated department ACLS crash cart in Urgent Care.	
A negative pressure isolation room in Urgent Care.	Access to a negative pressure isolation room within the VA medical facility.	
Telemetry monitoring in Urgent Care.	Telemetry monitoring in Urgent Care.	
Ability to accept patients from outpatient clinics and provide care or determine admission or transfers.		

STAFFING

Refer to Appendix A for details on preferred qualifications.

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
All Clinical Staff: Basic Life Support (BLS) and ACLS certifications.	All Clinical Staff: BLS and ACLS certifications.	All Clinical Staff: BLS certification.
Nursing Minimum of two registered nurses (RNs) physically present and immediately available within the Urgent Care.	Nursing Minimum of two RNs physically present and immediately available within the Urgent Care.	Nursing Minimum of one RN physically present and immediately available within the Urgent Care.
Physician Minimum of one licensed physician credentialed and privileged to work in Urgent Care during all hours of operation. Must be physically present and immediately available within the Urgent Care.	Physician Minimum of one licensed physician credentialed and privileged to work in Urgent Care during all hours of operation. Must be physically present and immediately available within the Urgent Care.	Physician Must have one of the following in Urgent Care during all hours of operation (Must be physically present and immediately available within the Urgent Care): - Licensed physician credentialed and privileged to work in Urgent Care. - Qualified Nurse Practitioner. - Physician Assistant with collaborating physician available for real-time consultation (in-person or remote).

CONSULTATIVE SERVICES AVAILABILITY

LEVEL I SERVICES	LEVEL II SERVICES	LEVEL III SERVICES
<p>Mental Health Mental Health licensed independent practitioner (LIP) in house or by telehealth.</p>	<p>Mental Health Mental Health LIP in house or by telehealth.</p>	<p>Mental Health Mental Health LIP in house or by telehealth.</p>
<p>Medical and Surgical Cardiology, Gastroenterology, Surgery and Hospitalist available for Veterans Health Administration (VHA) or community phone consult. Neurology in house or by telehealth.</p>	<p>Medical and Surgical Cardiology, Gastroenterology, Surgery and Hospitalist available for VHA or community phone consult.</p>	

URGENT CARE INTERDISCIPLINARY SUPPORT SERVICES**1. RADIOLOGY/IMAGING**

Radiology support staff (i.e., radiology technician) must be available during all hours of operation of Urgent Care Level I and II. All STAT and Urgent/ASAP studies ordered by Urgent Care should have prioritization. Time-sensitive/critical imaging turnaround time should reflect national radiology standards. Standard radiological studies vary according to Urgent Care level. All Department of Veterans Affairs (VA) medical facilities should have standardized processes for following up regarding critical or incidental findings, as well as the management of preliminary vs. final imaging interpretations. The minimum mandatory radiology/imaging services are determined by Urgent Care level (see Appendix B).

2. LABORATORY

Laboratory testing must be available during all hours of Urgent Care operation. STAT tests from Urgent Care Level I and II should generally have prioritization with 1-hour turn-around time for results. On-site staff must be capable of performing standard laboratory testing or point of care critical tests. The minimum mandatory laboratory tests are determined by Urgent Care level. For minimum mandatory laboratory services by Urgent Care level, see Appendix B. For suggested laboratory capabilities by Urgent Care level, visit the Emergency Medicine (EM) SharePoint:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>

NOTE: This is an internal VA website that is not available to the public.

a. VHA Directive 1106, Pathology and Laboratory Medicine Service, dated July 27, 2018, outlines the requirements that must be met to perform Clinical Laboratory Improvement Amendments (CLIA) Waived Laboratory Testing in Urgent Care.

b. These tests must be performed under the purview of the VA medical facility laboratory, the VA medical facility Chief, Pathology and Laboratory Medicine Service and the ancillary testing coordinator to ensure the processes comply with all regulatory requirements. Urgent Care sites must not apply for their own CLIA certificates. All testing performed is under the direct or indirect oversight of the Chief or Director of Pathology and Laboratory Medicine at the VA medical facility even if that VA medical facility has its own CLIA certificate. See VHA Directive 1106 for additional requirements for CLIA testing.

c. For outpatient laboratories, Urgent Care must not serve as the default location for off-tour reporting. Appropriate mechanisms must be in place to allow notification to the ordering provider or their respective surrogate. If the ordering provider or their surrogate

cannot be reached, clear processes must be in place to provide timely action on critical results and escalation of notification. Refer to the Communication of Test Results website for related resources:

<https://dvagov.sharepoint.com/sites/VHAOPCOps/Policy/CTR/SitePages/Home.aspx>.

NOTE: *This is an internal VA website that is not available to the public.*

d. Mechanisms must be in-place to provide notification of test results for patients receiving care in Urgent Care, in accordance with VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated October 7, 2015.

3. PHARMACY

Medications need to be available during hours of operation at Urgent Care sites. Medications must be made available to Urgent Care patients through clearly defined process ownership via inpatient and outpatient pharmacies. Urgent Care Level I and II must have an appropriately stocked code cart and the ability to provide Advanced Cardiac Life Support (ACLS) with ACLS-certified staff. The use of automated dispensing cabinets is encouraged to expedite administration of commonly used medications. VA medical facility Urgent Care Medical Directors, along with the Urgent Care Nurse Manager, must work closely with pharmacy administration to evaluate and determine medication needs and appropriate storage options for medications within Urgent Care. The minimum mandatory pharmacy services are determined by Urgent Care level (see Appendix B). For a recommended list of medications for Urgent Care, visit the EM SharePoint:

<https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/Shared%20Documents/Forms/AllItems.aspx?FolderCTID=0x012000E4F9E3CFC6444E4D9F4C8CDEE51F7FB0&viewid=e073063f%2D9b34%2D47ab%2D8d1e%2D67cd7d51b89b&id=%2Fsites%2FVHAEmergencyMedicine%2FShared%20Documents%2FGeneral%2FUC%20Directive>.

NOTE: *This is an internal VA website that is not available to the public.*