

PODIATRIC MEDICAL AND SURGICAL SERVICES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive establishes policy for podiatric medical and surgical services for eligible Veterans.

2. SUMMARY OF MAJOR CHANGES:

a. Compliance with the requirements of VHA Directive 6330 and integration of VHA Handbook 1122.01.

b. Updating various roles, responsibilities, and duties regarding the provision of foot and ankle care.

c. Reorganization of identifying guidelines, standard operating procedures and clinical standards to a separate document: Podiatry Service Guidelines and Standard Operating Procedures and Podiatry Service and Graduate and Post-Graduate Education and Training Guideline for Podiatry Service.

3. RELATED ISSUES: VHA Directive 1410, dated March 31, 2017, or subsequent policy.

4. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the contents of this directive. Questions may be addressed to the National Program Director of Podiatry Service at 202-461-7120.

5. RESCISSION: VHA Directive 2009-030, dated June 16, 2009 and VHA Handbook 1122.01, date November 25, 2009, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2023. This directive will continue to serve as national VHA policy until it is recertified or rescinded.

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PODIATRIC MEDICAL AND SURGICAL SERVICES

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for the management of foot and ankle care programs at VHA facilities. Podiatric medical and surgical services are included in the medical benefits package provided to all Veterans who are enrolled in VA health care. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b); and Title 38 Code of Federal Regulations (CFR) 17.38.

2. BACKGROUND

a. Veterans often have health care needs which are more complex than those of the general population. Concurrent systemic diseases, such as diabetes, peripheral vascular disease, end stage renal disease, and arthritis, place Veteran patients at increased risk for limb-threatening consequences, such as the inability to walk. The ability of patients to walk has a profound influence on their physical and psychological condition including quality of life.

b. Nationally, there are approximately 350 full and part-time podiatric physicians comprising the Podiatric Medical and Surgical Service. One hundred and thirty-seven VHA medical centers (exclusive of Community Based Out-patient Clinics) have dedicated Podiatric Medical and Surgical Services; the remaining medical centers use consultant staff. Additionally, there are 235 podiatric residency trainee positions in 34 VHA podiatric residency training programs, representing approximately 20% of all entry level podiatric residency positions in the United States.

c. A growing number of patients are presenting to VHA for basic foot care and management of painful conditions of their feet. Common ailments include mechanically induced keratosis (corns and calluses) and a variety of toenail disorders. Medicare may not cover treatment for these conditions because its guidelines define medical necessity using a set of restrictive clinical criteria (class findings) that determine eligibility for treatment. Typically, only those patients considered to be at high risk for developing serious foot complications (ulcers or amputation) are covered by Medicare for ongoing, regularly scheduled preventive services. **NOTE:** See *VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE)*, dated March 31, 2017, or subsequent policy, and Appendix A of this directive.

d. VHA has taken an expanded view of medical necessity, to include those patients who are visually, cognitively, or physically impaired, Veterans who may have severe hand deformity and arthritis, and those on chronic anticoagulation therapy; thus, compromising their ability to maintain proper foot care. It is well established that aging adds a degree of peripheral vascular compromise and a reduction in immune response. Wounds may take longer to heal in elderly patients. This cohort of "at risk" Veterans should not be using sharp instruments on their own feet as the potential for self-inflicted injury is high. However, the resources of the Department of Veterans Affairs (VA) are

limited and eligibility criteria must be developed to differentiate routine basic hygiene from limb preservation.

e. The implications of an aging Veteran population as well as an influx of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn Veterans suggests an increased need for basic foot care as well as care for more complex medical and surgical conditions of the foot.

3. POLICY

It is VHA policy that each VA medical facility is responsible for providing podiatric medical and surgical services to all eligible Veterans, and that such services may be provided either at the facility or in the community.

4. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for ensuring compliance with this directive.

b. **Deputy Under Secretary of Health for Operations and Management (10N).** The Deputy Under Secretary of Health for Operations and Management (10N), or designee, is responsible for:

(1) Communicating the contents of this directive to each of the VISN Directors;

(2) Ensuring that each VISN Director has the resources required to support the fulfillment of the terms of this directive in all VA medical facilities within that VISN; and

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Chief Consultant, Specialty Care Services (SCS).** The Chief Consultant, Specialty Care Services (SCS), or designee, is responsible for:

(1) Providing programmatic oversight for specialty care services, including podiatry services;

(2) Concurring on the Director of Podiatry Services nominations appointments of Field Advisory Committee (FAC) Chairperson and Vice Chairperson; and

(3) Appointing a national Podiatry Service representative to serve on the Surgery Advisory Board (SAB).

d. **Director, Podiatry Services, Office of Specialty Care Services.** The Director, Podiatry Services, or designee, is responsible for:

(1) The overall administration of a system-wide podiatry health care service, including the development and oversight of program policy.

(2) Providing reports to the Chief Consultant, Specialty Care Services (SCS), as requested.

(3) Serving as VHA's liaison to the American Podiatric Medical Association (APMA), American Association of Colleges of Podiatric Medicine (AACPM), and the Council of Teaching Hospitals (COTH).

(4) Serving as the Field Advisory Committee (FAC) manager.

(5) Appointing the FAC Chairperson and Vice Chairperson with the concurrence of the Chief Consultant SCS or his/her designee/

(6) Serving as the Chair oversight of Prevention of Amputations in Veterans Everywhere program. **NOTE:** See VHA Directive 1410 or subsequent policy.

e. **Field Advisory Committee (FAC), Podiatry Service.** The structure and responsibilities of the FAC are described in Appendix G. The FAC, Podiatry Service is responsible for:

(1) **Education and Training.** The FAC assesses the education and training needs of the service, reviews requirements for training program approval, and evaluates any other data that are considered appropriate for this purpose. Such assessments will be ongoing by the Committee and an annual report of findings and recommendations will be submitted to the FAC manager (Director, Podiatry Services, Office of Specialty Care Services).

(2) **Research Advisory.** The FAC assesses the research needs of the Podiatric Medical and Surgical Service, reviews requirements for research funding, and evaluates any other data that are considered appropriate for this purpose. These assessments are to be ongoing, and an annual report of findings and recommendations will be submitted to the FAC manager.

(3) **Professional Development.** The FAC assesses the professional development needs of the Podiatric Medical and Surgical Service, post-program surveys, reviews for approval the requirements for sponsors of podiatric continuing medical education, and evaluates any other data that are considered appropriate for this purpose. **NOTE:** *Such assessments should be ongoing by this group and an annual planning session for upcoming programs will be held.* To accomplish this, the FAC will:

(a) Plan for educational activities based on needs assessments and available resources;

(b) Assist in the development of learning goals and objectives of educational activities;

(c) Recommend the most effective methods of information delivery. Interactive methods will be preferred over passive methods;

(d) Develop post-program surveys when appropriate; and

(e) Approve content assessment methods (i.e., pre-tests, post-tests, and module examinations which are to be designed by the faculty) to provide outcome data concerning the effectiveness of the program.

(4) Quality Assurance. The FAC assesses the needs of the service through peer review, examination of VHA policies pertaining to quality assurance, The Joint Commission (TJC) requirements, health equity and cultural competency, patient safety, and root cause analysis database information pertaining to patient safety within podiatry. Assessments are to be ongoing, and an annual report of findings, and recommendations must be submitted to the FAC manager.

(5) Podiatric Practice. The FAC assesses the practice needs of the service through VHA policies which relate to credentialing and privileging, and analyzes any other data that are considered appropriate for this purpose. Assessments are to be ongoing by the Committee and any report of findings and recommendations will be submitted to the FAC manager.

f. Veterans Integrated Service Network (VISN) Director. The VISN Director, or designee, is responsible for ensuring compliance with this directive at every facility in the VISN.

g. VA Medical Facility Director. The VA medical facility Director, or designee, is responsible for:

(1) Determining appropriate organizational placement of podiatric physicians.

(2) Ensuring that vulnerable Veterans in risk groups are identified based on existing VA policy, VHA Directive 1410, or subsequent policy, and Appendix A of this directive.

h. Chief, Podiatric Medical and Surgical Service; Lead Podiatrist. The Chief, Podiatric Medical and Surgical Service, Lead Podiatrist, or designee, is responsible for:

(1) Serving as a liaison to professional organizations, Colleges of Podiatric Medicine, and in some cases, Veterans Integrated Service Networks (VISNs).

(2) Ensuring that interpretation of policy or procedures is communicated through appropriate channels to the Podiatry Service, VHA Central Office, for clarification, when indicated.

(3) Ensuring quality care is delivered to patients by:

(a) Actively participating in system-wide efforts to ensure prompt access to quality care;

(b) Critically reviewing and continuously improving all operations within Podiatric Medical and Surgical Services to enhance quality of services and outcomes of services provided;

(c) Integrating contingency plans for:

1. Short and long-term loss of supply (including staffing resources);
2. Variations of demand for Podiatric Medical and Surgical Services; and
3. Unusual, but predictable events.

(d) Developing and updating processes that improve access to quality care and that are based on best practices that may be published by organizations such as VHA, The Joint Commission (TJC), American Podiatric Medical Association, American College of Foot and Ankle Surgeons, and the American College of Foot and Ankle Orthopedics and Medicine, all of which have documented standards of care applicable to the practice of Podiatric Medical and Surgical Services;

(e) Ensuring that resources to meet clinical demands, which may vary at each medical facility, are met; both physical and human resources are deployed and used as efficiently as possible; and

(f) Assessing the quality of health care delivery within the service, as delegated by or through the VISN Director, facility Director, or the Chief of Staff. All minutes and items brought forth that pertain to the Quality Improvement program activities must remain confidential to the extent required by 38 U.S.C. 5705. Physician confidentiality is to be maintained using provider identification numbers. **NOTE:** *The Director, Podiatry Service VA Central Office Service, Office of Specialty Care Services, provides general guidance and nationwide coordination of the Podiatric Medical and Surgical Strategic Plan.*

1. Ensuring the quality of the overall affiliated education and residency training program, if applicable;
2. Ensuring that the program is in compliance with the policies of the respective accrediting and the certifying body, i.e., the Council on Podiatric Medical Education (CPME), if applicable;
3. Ensuring that staff podiatric physicians are familiar with the content and provisions of this directive and implementing local policies and procedures; and
4. Ensuring that staff podiatric physicians maintain licensure, certification, and privileging requirements as applicable in VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, or subsequent policy.

5. MANAGEMENT OF PEDAL KERATOSES, ONYCHOMYCOSIS, AND OTHER NAIL DISORDERS

a. **Veterans in risk groups are identified.** To define eligibility criteria for basic foot care (i.e. pedal keratosis, onychomycosis and other common nail conditions) a classification system to identify high, moderate, and lower risk patients to guide podiatry referrals has been established. **NOTE:** *See Appendix A for Risk Group Chart.*

(1) **High Risk.** Patients with a documented history of peripheral arterial disease and sensory neuropathy are in the high-risk category (see Appendix A).

(2) **Moderate Risk.** Those with systemic conditions that place them at increased risk for injury are at moderate risk. **NOTE:** *High risk and some moderate risk patients, depending on the judgment of the podiatric physician or foot care specialist, are recommended for ongoing or regularly scheduled basic nail care (see Appendix A).*

(3) **Lower Risk.** Patients who are otherwise healthy but who cannot physically maintain their foot hygiene are at lower risk. In this group, the decision to provide ongoing care needs to be made at the provider level as circumstances may or may not warrant regularly scheduled care (see appendix A). **NOTE:** *The diagnosis of diabetes in and of itself does not confer a level of risk and subsequent inclusion in a particular risk group; however, individuals with diabetes require annual foot screening examinations to identify progression of their lower extremity disease. Determination of risk category for patients with diabetes depends on vascular and neurologic status, presence of foot deformity, and prior history of ulceration and or amputation. NOTE: See VHA Directive 1410, or subsequent policy.*

b. **Staffing resources.** Staffing resources must be adequate to address foot care needs. For example, the addition of the foot hygienist or health technician as part of the podiatric clinical team helps address the increased need for basic foot care under the direction of the Chief of Podiatry allowing the podiatric physician to treat more complex foot and ankle conditions.

c. **Education.** Education on foot care is utilized for individual patients as a part of a total interdisciplinary approach to preventive care.

d. **Podiatric Surgical Care.** Podiatric surgical care is provided in accordance with individual delineation, local facility admitting privileges, and performed in the appropriate setting utilizing suitable anesthesia services for patient care when required for nail conditions requiring surgical intervention. **NOTE:** *Admitting privileges should be determined based upon the scope of practice permitted by the individual physician's licensing body.*

6. OTHER PODIATRIC HEALTH CARE COMPONENTS

a. **Preventive Health Services.** Preventive health services, to include podiatric services, are available as part of the medical benefits package in 38 CFR 17.38. Each VA medical facility must have a program which is consistent with this directive, to

educate Veterans with respect to podiatric health promotion and disease prevention and provide screening and other clinical services for podiatric conditions.

b. **VA and Department of Defense (DoD) Sharing Agreements.** VA and DoD may enter into sharing agreements to provide a broad spectrum of health-related activities, including podiatric medical and surgical services. **NOTE:** See *VHA Handbook 1660.04, VA-DoD Health Care Resources Sharing Agreements, dated July 29, 2015, or subsequent policy.*

7. VHA SPECIAL EMPHASIS PROGRAM

VA's mission is to serve the needs of America's Veterans. VA does this by providing specialized care, primary care, and related medical and support services. Special Emphasis Programs are an essential and critical part of VA, and are assessed utilizing performance measures to ensure the ongoing successful functioning of these programs.

a. **Prevention of Amputation in Veterans Everywhere (PAVE).** VHA's PAVE program (see VHA Directive 1410 or subsequent policy) was designed to meet the changing needs of the Veteran population, i.e., to prevent, to the greatest extent possible, amputations due to either trauma or neuropathic and vascular conditions. It represents a model of care developed to prevent or delay amputation through proactive early identification of patients that are at risk of limb loss.

b. **Geriatric and Long-term Care Program.** Podiatric Medical and Surgical services provide medical and surgical management of foot pathology seeking to improve the functional capacity of geriatric patients by keeping them ambulatory longer, reducing pain and discomfort, and thereby improving the quality of life. **NOTE:** *VA Medical Facilities that have established Geriatric Research Education and Clinical Centers (GRECC) may offer education and training in the care of elderly Veterans by co-sponsoring Podiatric-Geriatric residency fellowships.*

c. **Spinal Cord Consultation.** Podiatric Medical and Surgical services provide medical and surgical management of foot, ankle, and lower extremity related pathology to achieve the highest possible functional capacity for spinal cord injury patients and thereby improve quality of life.

8. RESEARCH AND DEVELOPMENT

Research and development is an essential component of the Podiatric Medical and Surgical Service. It has been estimated that 90 percent of Veterans over the age of 65 suffer from some type of painful foot condition, severe enough to limit ambulation. This Veteran population represents a special cohort of patients with increased needs as compared to the general population. Podiatric research must consider the epidemiological characteristics of foot conditions and those related to chronic disease and aging. For those facilities that have an active research program, an Institutional Review Board (IRB) is necessary for oversight of clinical trials.

9. TRAINING REQUIREMENTS

There are no formal training requirements associated with this directive.

10. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the facility Records Manager or Records Liaison.

11. REFERENCES

- a. 5 U.S.C. App 2, 3(2)(C).
- b. 38 U.S.C. 5705, 7301(b), 7401-7412, 7405.
- c. 38 CFR 17.38.
- d. 41 CFR 102-3.40(h).
- e. VA Handbook 5005, Staffing, or subsequent policy.
- f. VA Handbook 5021, Employee/Management Relations, or subsequent policy.
- g. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, or subsequent policy.
- h. VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012, or subsequent policy.
- i. VHA Directive 1410, Prevention of Amputation in Veterans Everywhere (PAVE) Program, dated March 31, 2017, or subsequent policy.
- j. VHA Handbook 1660.04, VA-DoD Health Care Resources Sharing Agreements, dated July 29, 2015, or subsequent policy.

FOOT CARE RISK CATEGORIES

Risk Group	Description	Care Level by Podiatry Service once referred by Primary Care.
High Risk	Documented Peripheral Arterial Disease Documented Sensory Neuropathy Prior history of foot ulcer or amputation	Ongoing regularly scheduled care at prevention intervals determined by podiatric physician
Moderate Risk	Visually impaired Physically impaired Neuromuscular diseases, Severe arthritis Cognitive dysfunction Chronic anticoagulation therapy	Ongoing care as needed determined by podiatric physician
Lower Risk	>70 years old without other risk factors Diabetes without foot complications Obesity	Initial care and discharge or care as necessary and as determined by a Podiatric physician.

WORKLOAD STANDARDS

a. **Workload Projections.** The maximum number of patients a podiatry clinic is capable of treating in a quality manner depends on several factors. These factors include the number of physicians, complexity of care, treatment space, equipment, (e.g. examination tables, instruments) number of resident trainees, and support staff (appointment clerk, non-physician providers such as physician assistants, nurse practitioners, and other technicians). For workload projection, the following is the minimum standard to ensure quality health care for veterans:

(1) **Podiatric Physician.** Assuming minimum staffing with two treatment areas (per provider), appointment clerk, and clinician/independent licensed provider; an estimated minimum number of 14 – 16 patients in an 8-hour period.

(2) **Resident.** The addition of a resident provider, with additional treatment area(s) should increase estimated total capacity to between 18-20 patients in an 8-hour period. Additional space and additional resident providers would create even more capacity.

(3) **Non-Physician provider.** The addition of a basic foot care provider (e.g. Non Doctor of Podiatric Medicine providing foot and ankle care) would provide for a level greater than that of a resident; but somewhat less than the clinician.

(4) **Administrative Support Staff.** Each clinic should have administrative support to provide care coordination, scheduling, and other administrative functions for the efficient and effective operation of the clinical practice.

(5) **Appointment time periods.** The amount of time it takes to see a patient for either routine visits or out-patient procedures will vary depending on the resources available to support the care. The steps that take up time involved in each patient encounter must be considered when estimating clinic capacity and appointment time intervals. These steps include:

- (a) Transport from waiting room to treatment room;
- (b) Preparing patient for care;
- (c) Providing care;
- (d) Preparing patient for transport back to waiting room;
- (e) Charting;
- (f) Room clean up;
- (g) Restocking; and

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(h) Other considerations that may increase visit time intervals include initial history and physical examination, wound care, and office based surgical procedures.

NOTE: *These are guidelines defining ideal practice environments and are not mandates. As such they need to be interpreted based on local needs and resources.*

GRADUATE AND POST-GRADUATE EDUCATION AND TRAINING

VHA conducts the largest coordinated education and training effort for health care professionals in the Nation. The Office of Academic Affiliation (OAA) leads VHA's health professions education mission that enables VHA to provide excellent care to Veterans; to attract and retain high quality professional staff; and to enhance the learning environment. VHA partners with academic and professional communities to educate the next generation of health care professionals for the benefit of VA and the Nation. **NOTE:** See VHA Handbook 1400.01, *Resident Supervision*, dated December 19, 2012, or subsequent policy.

a. **Podiatry Student.** Clinical experience may be offered to podiatric medical students in doctoral programs approved by the Council on Podiatric Medical Education (CPME). Training provides students with exposure to the podiatric and non-podiatric clinical practice in a patient care setting under the direct supervision of supervising practitioners.

b. **Podiatric Medical and Surgical Resident.** Residents are individuals who are engaged in an approved graduate training program in podiatric medicine and surgery, and participate in patient care under the direct supervision of supervising practitioners. Such training is usually provided for a minimum of 3 years in a program approved by CPME.

c. **Podiatric Medical and Surgical Fellows.** Fellows are individuals that have completed an approved specialty residency program. Podiatric fellowship education is a component in the continuum of the educational process.

d. **Types of Post-Doctoral Residency Programs.** The CPME is an autonomous accrediting agency for podiatric medical education and sets the standards for podiatric training programs which are reissued periodically. VHA recognized the CPME as the official accrediting agency and complies with its training policies. In the latest version from July 2013, the CPME approved a new residency training format that VHA follows:

(1) Podiatric Medicine and Surgery Residency (PMSR) without or with an added credential of Reconstructive Rear Foot/Ankle (RRA) Surgery for programs with those clinical exposures. These programs are a minimum of 3 years in duration and are resource-based, competency-driven, and assessment-validated that consists of post graduate training in inpatient and outpatient medical and surgical management. The program provides training resources that facilitate the resident's sequential and progressive achievement of specific competencies.

(a) Resident completion of a PMSR leads to the foot surgery certification pathway of the American Board of Foot and Ankle Surgery (ABFAS) and the certification pathway of the American Board of Podiatric Medicine (ABPM). The completion of the added RRA credential of reconstructive rear foot and ankle surgery, if offered by the program, leads to RRA added certification pathways of the ABFAS. Either pathway leads to the ABPM certification; and

(b) The curriculum of a PMSR must be completed within 36 months. Additional educational experiences may be added to the curriculum allowing up to 48 months. Programs that extend the residency beyond 36 months must present a clear educational rationale consistent with program requirements and secure sponsoring institution and OAA permission.

(2) A podiatric medical and surgical fellowship is a post-residency educational program that provides advanced knowledge, experience, and training in a specific content area within podiatric practice. Fellowships, by nature of their specific content concentration, seek to add to the body of knowledge through research and other collaborative scholarly activities.

e. **Approval of Post-Doctoral Residency Programs.**

(1) **Council on Podiatric Medical Education.** The CPME has been authorized by the APMA to approve institutions that sponsor residency training programs that demonstrate and maintain compliance with the standards and requirements of the CPME. The Council has final authority for the accreditation of colleges of podiatric medicine and the recognition of specialty certifying boards for podiatric medical practice. The Council is recognized by the Council on Higher Education Accreditation (CHEA) and the United States Secretary of Education as the accrediting agency for first professional degree programs in podiatric medicine.

(2) **The Residency Review Committee.** The Residency Review Committee (RRC) is responsible for determining candidate status of new training programs and authorization of requests for additional trainee positions, and recommending approval of postgraduate training programs to CPME. Membership of the RRC is comprised of trained residency evaluators nominated to the CPME by the following organizations that are recognized by VHA:

(a) American Board of Podiatric Medicine (ABPM);

(b) American Board of Foot and Ankle Surgery (ABFAS);

(c) A representative from CPME; and

(d) A representative from American Association of Colleges of Podiatric Medicine (AACPM)/Council of Teaching Hospitals (COTH).

f. **Appointment of Podiatric Residents Fellows and Students.**

(1) Podiatric residents and fellows may be appointed on a not-to-exceed 3-year basis; or on a without compensation (WOC) basis;

(2) Podiatry students are only appointed on a WOC basis;

(3) Residents and fellows must meet the requirements that are stated within the scope of the training program; and

(4) VHA Podiatric Medical and Surgical Training Programs will not receive trainee stipend support unless they are approved by CPME. Those VHA facilities with training programs must document to VHA OAA appropriate and timely plans to seek approval and re-approval.

g. **Supervision of Podiatry Residents and Determination of Levels of Responsibility.** See VHA Handbook 1400.01, or subsequent policy.

h. **Podiatry Residents Dispute Resolution Process: Due Process and Mechanism of Appeal.** *NOTE: Due process for residents will be provided in accordance with VA Handbook 5021 and local policies and procedures.*

(1) The podiatry resident is a temporary employee of the Department of Veterans Affairs (VA) appointed pursuant to 38 U.S.C. 7405. As such, the podiatry resident is not entitled to appeal or otherwise dispute the termination of their employment. However, the VA will adhere to the process detailed in paragraph (4) below for resolving disputes relating to the termination of a podiatry resident's participation in the podiatry residency program;

(2) VA reserves the right to terminate a podiatry resident's participation in the podiatry residency program for lack of or poor performance deemed consistently substandard by the director of podiatric medical education. Such actions may include the failure to follow program requirements as identified by the Council on Podiatric Medical Education and specific objectives stated by resident policy. This may include but is not limited to the following:

(a) Incompletion, failure to attend and/or complete the minimum requirements for goals and objectives of any of the rotations and/or the program in general;

(b) Consistently poor performance as reflected on official assessments and after remediation attempts;

(c) Gross incompetence where the resident is deemed dangerous to patients as defined and documented by podiatric and or medical staff;

(d) Failure to keep medical/surgical logs and diary current (i.e. within 30 days of encounters);

(e) Failure to conduct inpatient rounds in a timely manner (i.e. within 24 hours of notification or as specifically directed by attending);

(f) Failure to fulfill on call duties satisfactorily by not responding to on call pager messages and requests in a timely manner, by not being within vicinity allowing a reasonable response time to the hospital when on call, and failure to assure hospital coverage when on call;

(g) Failure to stay well informed and remain prepared with medical and surgical status of both inpatients and outpatients;

(h) Poor attitude and/or disrespect towards patients, students and/or staff members;

(i) Failure to complete dictations and progress notes as prescribed in VA and Training program policies (i.e. medical facility policy usually requires note to be completed within 24 hours of the encounter);

(j) Failure to be prepared for grand rounds and journal club duties;

(k) Consistent tardiness to clinic, OR and/other meetings; and

(l) Breach of ethical behavior.

(3) If the director of podiatric medical education considers the infractions minor, the resident will be reprimanded verbally and resolution may be developed to mitigate the deficiency or problem. The programs established remediation process for this program will guide all academic and training related deficiencies. However, if consistent infractions are noted and/or the director of podiatric medical education considers an infraction significant, VA will notify the resident of its intent to terminate their participation in the Training program. In most cases, the resident's employment will also be terminated at this time. While, as noted above, the resident may not challenge termination of their employment, they may dispute the termination of their participation in the Training program pursuant to the process detailed in paragraph 4 below;

(4) Residency Program Termination Dispute Resolution Process. If it is determined that a resident should be terminated from the program, the resident's participation in the program will be immediately suspended and the resident will be placed on administrative absence with pay until a decision is made regarding his program status; and

(a) A certified letter indicating intent to terminate will be issued by the director of podiatric medical education to the resident with a list of the act(s) of misconduct and/or infraction(s) which has led to this action;

(b) The resident is given 7 days from the date of receipt of the intent to terminate letter to file a written request to respond with the director of podiatric medical education. If the resident does not file a timely written request to respond, the director of podiatric medical education will issue to the resident, within 10 days of the end of the request-to-respond period, a letter terminating their participation in the Training program (with carbon copy to Chief of Staff, Chief of Service, and Chief, Human Resources) with an effective termination date. If the resident does file a timely written request to respond, the following resolution process will be initiated; and

(c) A three-person ad hoc committee will be formed consisting of one or more of the following: a podiatry staff member(s), the chief of service (surgery, medicine, or as appropriate) and a non-podiatry member(s) of the surgical or medical staff, for the purpose of hearing the resident's dispute.

1. Any member may chair the committee and will cause a summary of the hearing to be made;

2. The hearing will be scheduled within 14 days of the director of podiatric medical education's receipt of the residents request to respond;

3. The resident may appear at this hearing alone or have an attorney/representative present who may provide advice but cannot participate in the hearing;

4. The VA may also have an attorney/ representative present who may provide advice but cannot participate in the hearing;

5. At this hearing the resident may present his argument of dispute and have the case considered by the committee members;

6. After the completion of the hearing and the resident and/or his attorney/representative has left the hearing room, a decision of the committee will be brought to vote. All committee members maintain one equal vote and no abstentions will be allowed;

7. The committee's findings/action will be sent to the Chief of Staff (or Acting Chief of Staff) who may concur with the committee's findings/action, request additional information if necessary before proceeding with a decision, or decide to take a different action; and

8. The Chief of Staff's decision will be final. The resident will be notified of the Chief of Staff's decision within 10 days after the Chief of Staff makes his decision. To the extent that any of the foregoing Podiatry Residents Dispute Resolution Process conflicts with VA Handbook 5021, Part VI, paragraph 15, or federal regulation or statute, the VA Handbook procedures, federal regulation or statute shall be controlling. **NOTE:** *Any individual possessing a conflict of interest related to the dispute, including the director of podiatric medical education must be excluded from all levels of the appeal process.*

(5) Each resident or fellow is given the opportunity to complete a confidential written evaluation of staff practitioners and the quality of the resident or fellow's training. Such evaluations are to include the adequacy of clinical supervision by the staff practitioner; and

(6) All written evaluations of residents, fellows and staff practitioners must be kept on file in a location in accordance with local facility policy.

RECRUITMENT APPOINTMENT AND PROMOTION

a. **Recruitment.** Podiatric physicians are recruited in accordance with the stated strategies and sources suggested in VA Handbook 5005, Part I, and Chapter 1. When individual VHA medical facilities have been unsuccessful in recruiting for funded positions, they may request assistance from the Director, Podiatry Service and VA Central Office (VACO). Requests should contain all pertinent information on the vacant position, including specialty, required qualifications, and intended assignment. Contact information on the Director, Podiatry Services can be found on the Podiatry Services Web Page: <http://vaww.medicalsurgical.va.gov/podiatry>.

b. **National Podiatry Professional Standards Board.** The Podiatry Professional Standards Board is composed of the Chairperson and two additional podiatric physicians. A representative from Human Resource Management will serve as the technical representative to the Podiatry Professional Standards Board. The primary functions of this board are to:

(1) Review and act on employment applications to determine whether the applicant meets the requirements set forth in VHA qualification standards;

(2) Review all applicant qualifications for advancement by examining the Official Personnel Folder, proficiency reports, and other pertinent documentation, and to make appropriate recommendations based on findings;

(3) Execute VA Form 10-2543, Board Action; and

(4) Establishes, reviews, and updates VHA qualification standards.

c. **Appointment.** 38 U.S.C. 7401-7412 control appointment of VHA personnel, including podiatric physicians. Qualification standards and procedures for appointing podiatric physicians are further defined in VA Handbook 5005 (Part II Appendix G4).

CREDENTIALING, PRIVILEGING, AND ONGOING PRACTICE EVALUATION

a. **Clinical Privileging.** Clinical privileging is defined as the process by which a licensed practitioner is permitted by law and the facility to practice independently, to provide specified medical or other patient care services within the scope of the individual's license, based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training and licensure. Clinical privileges must be facility-specific, provider-specific, and within available resources. **NOTE:** See *VHA Handbook 1100.19 Credentialing and Privileging, dated October 15, 2012, or subsequent policy.*

b. **Professional Practice Evaluation.** Professional Practice Evaluation (PPE) is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. At the time of initial granting of a privilege(s), a time-limited Focused Professional Practice Evaluation (FPPE) is implemented during which the medical staff leadership evaluates and determines the practitioner's professional performance. Subsequent to the FPPE, on-going monitoring of privileges allows the facility to monitor the quality of care delivered by the practitioner, and identify professional practice trends that impact positively or negatively the quality of care and patient safety.

d. **Chief, Podiatric Medical and Surgical Service.** The Chief, Podiatric Medical and Surgical Service, refers to the podiatric physician(s) at the facility level with primary responsibility for the operations of the Podiatric Medical and Surgical Service and the management of related professional and administrative activities. The Chief must have the qualifications, responsibilities, and authority of the Chief clearly defined in writing.

e. **Staff Podiatric Physicians and Non-Physician Providers.** Providers of foot and ankle care must be qualified and individually competent to deliver appropriate services. To be coded, those clinics that use non-physician providers for the provision of routine foot care must have appropriate staff supervision by physicians or podiatric physicians with foot and ankle privileges. These non-physician providers must take the TMS Basic Foot Care (TMS ID 16262) course and received a certificate of completion. **NOTE:** *Other licensed non-physician providers can provide care remotely with appropriate telehealth supervision technologies in place (e.g. telephone consultation, store and forward photographs and/or clinical video teleconferences) (see [VHA TelePodiatry Specialist Clinical Video Telehealth Supplement 2013](#)).*

FACILITY RESOURCES

As the demand for podiatric medical and surgical services increases the process for managing patient needs must be based on sound medical decisions. Resources to meet those demands may vary at each medical facility; therefore, each facility must use both physical and human resources as efficiently as possible.

a. **Optimization of Space and Equipment.** Common equipment must be stored, utilized and supplied in an efficient and prudent manner, including the following:

(1) Treatment chair designed for the positioning of patients for foot and ankle treatment;

(2) Treatment cabinet with a lock for the storage of commonly used instruments, supplies, and medications;

(3) Access to an orthotic grinder for the adjustment of orthotic devices;

(4) Access to a hood for ventilation of areas where flammable chemicals exist (for example, orthotic lab);

(5) A provider stool;

(6) A desk with computer workstation that has access to the Veterans Health Information System and Technology Architecture (VistA) patient database & Computerized Patient Record System (CPRS) and IMED consent signature pad;

(7) A supply of podiatric instruments that is individually wrapped and sterilized for use with each patient. This supply of instruments needs to serve the patient population that is being treated, with a surplus to accommodate an extra clinic day in reserve;

(8) A “sharps” container and biohazard waste containers;

(9) A sink for hand washing;

(10) Available Safety (“PPE” Personal Protective) equipment such as gloves, masks, eye shields or face guards, gowns etc.;

(11) Barrier and drapes;

(12) Access to a handheld Doppler;

(13) Access to blood pressure cuff;

(14) Access to an emergency “crash cart”;

(15) Other equipment required by Occupational Safety and Health Administration (OSHA) and the Joint Commission; and

(16) Lockable cabinet for storage of flammable supplies (for example, Phenol).

b. **Space Recommendations.** Space recommendations include:

(1) **Standardized Examination Rooms.**

(a) Instruments and supplies need to be available in the same locations in all examination rooms to ensure providers can move from one room to another with efficiency.

(b) Examination rooms must be a minimum size of 10' x 12' room, be wheelchair and gurney accessible, and have adequate ventilation. **NOTE:** *The number of examination rooms needs to be determined by a review of needs and functions.*

(2) **Administrative Space.**

(a) An office for the full-time Chief Podiatrist must be provided.

(b) Although dependent on facility resources, staff podiatric physicians and residents need to have individual or shared office space.

(c) An office for the Training Program Director, should that individual be someone other than the Chief, Podiatric Medical and Surgical Service, must be provided.

(3) **Utility Room.** Access to a utility room with ventilation hood for orthotic grinding and handling volatile reagents, if used, must be provided.

FIELD ADVISORY COMMITTEE, PODIATRY SERVICE

a. **Scope.** The Field Advisory Committee (FAC), Podiatry Services provides independent advice to VHA on clinical policy and program development (e.g. IMedConsent™ consent form review, My Health eVet). The FAC assists VA Central Office in program oversight, forward field concerns, assist in distributing information to the field, serves as a resource to other VACO program offices.

b. **Chair.** The FAC Chairperson will be appointed from the committee members and may serve for an additional three years. The FAC Chairperson and the Director Podiatry Service are jointly responsible for selecting and appointing the general committee membership.

c. **Membership.**

(1) FAC, Podiatry Services is composed of 4 to 8 field-based VHA Podiatry Services employees, recommended to serve for 3 years. The FAC is composed solely of VHA employees and therefore is exempt from Federal Advisory Committee Act (FACA) requirements (5 U.S.C. App. 2, 3(2)(C), 41 CFR 102-3.40(h)).

(2) FAC membership will approximate the diversity among VHA professionals. The appointments of FAC members may be terminated and replacements added by the FAC manager (Director, Podiatry Service, Office of Specialty Care Services);, Chief Consultant, SCS or their designee at any time. FAC members serve one term (3 years) and may, at the discretion of the Chief Consultant, SCS, be renewed for a second term provided the re-appointee's FAC has a succession plan in place, approved (by the Chief Consultant, SCS or designee, for maintaining diversity in gender, ethnicity, and geography during the second 3-year term.