

**DEPARTMENT OF THE ARMY**  
**WOMACK ARMY MEDICAL CENTER**  
Fort Bragg, North Carolina 28310

MEDCEN SUPPLEMENT  
NO. 43-01

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**GOVERNING BODY AND MEDICAL STAFF BYLAWS**

- 1. PURPOSE.** To establish Governing Body and Medical Staff Bylaws
- 2. APPLICABILITY.** This regulation applies to all personnel assigned or attached to Womack Army Medical Center.

**3. REFERENCES.**

a. Federal laws; Department of Defense regulations, directives and instructions; Department of the Army regulations, directives, and policies; and MEDCOM regulations and policies serve as the adopted bylaws of the Governing Body.

b. The primary federal and DOD directives and regulations, Army Regulations (AR), and local memoranda and regulations, incorporating the requirements of the Governing Body and Medical Staff bylaws are:

- (1) MEDCEN Cir 40-66, Medical Abbreviations
- (2) MEDCEN Memo 40-4, Use of Physical Restraints
- (3) MEDCEN Memo 40-11, Risk Management Program
- (4) MEDCEN Memo 40-16, Advance Directives, Do Not Resuscitate/Do Not Intubate and Withdrawal of Care
- (5) MEDCEN Memo 40-18, Patient Rights and Organization Ethics
- (6) MEDCEN Memo 40-19, Guidelines for Sedation and Anesthesia of Patients Undergoing Diagnostic or Therapeutic Procedures
- (7) MEDCEN Memo 40-20, Organ and Tissue Donation
- (8) MEDCEN Memo 40-21, Impaired Personnel Committee (IPC)
- (9) MEDCEN Memo 40-22, Ambulatory Procedure Visits (APV)
- (10) MEDCEN Memo 40-30, Patient Disposition Against Medical Advice
- (11) MEDCEN Memo 40-33, Pain Management
- (12) MEDCEN Memo 40-35, Medication Management
- (13) MEDCEN Memo 40-40, Disease Reporting and Control
- (14) MEDCEN Memo 40-43, Policy for Reporting and Billing of Observation Bed Patients
- (15) MEDCEN Memo 40-65, Performance Improvement Plan
- (16) MEDCEN Memo 40-350, Transfer of Patients
- (17) MEDCEN Memo 608-18a, Management of Alleged Child Abuse Cases
- (18) MEDCEN Memo 608-18b, Management of Spouse Abuse Cases

- (19) MEDCEN Memo 608-18c, Abuse of the Elder or disabled
- (20) MEDCEN SUPP 1 to MEDCOM Reg 10-1, Org and Function Policy
- (21) MEDCEN Reg 15-1, Committees, Boards, and Teams
- (23) MEDCEN Memo 40-93 Pediatric Sexual Assault
- (24) MEDCEN Memo 40-94 Medical Facility Management of Sexual Assault
- (24) MEDCEN Reg 40-36, Credentials Policy
- (25) WAMC Infection Control Manual
- (26) MEDCOM Cir 40-54, Surgical/Procedural Site Verification
- (27) MEDCOM Memo 40-87, The Patient Safety Program
- (28) AR 1-1, Planning, Programming, Budgeting and Execution System
- (29) AR 5-1, Total Army Quality Management
- (30) AR 15-1, Boards, Commissions, and Committees – Committee Mgt
- (31) AR 40-1, Composition, Mission, and Functions of the AMEDD
- (32) AR 40-3, Medical, Dental and Veterinary Care
- (33) AR 40-4, Army Medical Department Facilities/Activities
- (34) AR 40-66, Med Rec Administration and Health Care Documentation
- (35) AR 40-68, Medical Staff Services Clinical Quality Management
- (36) AR 40-400, Patient Administration
- (37) AR 40-501, Standards of Medical Fitness
- (38) AR 351-3, Professional Education & Tng Programs of the AMEDD
- (39) AR 600-20, Army Command Policy
- (40) AR 600-85, Army Substance Abuse Program (ASAP)
- (41) AR 608-1, Army Community Service Center
- (42) AR 614-100, Officer Assignment, Policies, Details and Transfers
- (43) AR 930-5, American Nat'l Red Cross Svc Program & Army Utilization
- (44) DoD 5500.7-R, Joint Ethics Regulation (JER)
- (45) DoD 6025.18-R, DoD Health Information Privacy Regulation
- (46) DOD Directive 6025.13, Clinical Quality Management Program
- (47) DoD Directive 6490.1, Mental Health Evaluations of Members of the Armed Forces
- (48) 45 Code of Federal Regulations Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule
- (49) Comprehension Accreditation Manual for Hospitals; Joint Commission on Accreditation for Healthcare Organizations, Current Edition

#### **4. GOVERNING BODY.**

a. The Surgeon General (TSG) is the senior medical officer in the Department of the Army and is responsible for the delivery of health care by the Army. He/she is selected by a senior officer board appointed by the Secretary of the Army, nominated to his position by the President, and confirmed by the Senate IAW provisions of Title 10, United States Code.

b. The Office of the Surgeon General (OTSG) is comprised of the six Army Medical Department (AMEDD) Corps Chiefs: Medical, Army Nurse, Medical Service,

Army Medical Specialist, Dental, and Veterinary Corps. The Surgeon General and these representatives of the disciplines involved in the provision of Army health care form the Governing Body of the AMEDD.

c. The OTSG performs Governing Body functions for all Army Medical Department hospitals worldwide.

d. In the OTSG, medical specialty consultants selected by TSG serve as medical staff representatives to the Governing Body. These representatives participate with other members of the Governing Body in the development of Army Regulations (ARs) and other policy statements governing the provisions of health care. The extensive staffing process used in the development of ARs provides many opportunities for other members of the medical staff to have input into the development process as well.

e. The commander of each local Army hospital is the individual delegated authority to represent the Governing Body at the local level. Hospital commanders are selected by Department of the Army command selection boards and are assigned to hospitals based on the needs of the Army, their individual experience level, and their assignment preference. The hospital commander's assignment orders and assumption of command documents provide written evidence of the legitimacy of this position. AR 600-20, Army Command Policy and Procedure, governs the authority of the hospital commander.

f. As the Governing Body representative, the hospital commander discharges the Governing Body's responsibilities through staff members, appointed by AR or as deemed necessary by the hospital commander.

g. The hospital commander appoints staff members to committees required by ARs and to any other committees deemed necessary to conduct hospital business and to properly discharge the Governing Body's responsibilities. MEDCEN Regulation 15-1 (Committees, Boards, and Teams) defines the hospital committee structure.

h. The hospital Executive Committee (EXCOM), which includes the Deputy Commander for Clinical Services (DCCS), Deputy Commander for Administration (DCA), Deputy Commander for Patient Services (DCPS), the Command Sergeant Major (CSM) and Chief QSD, formally integrates medical and administrative functions. It serves as the local Governing Body, of which the hospital commander is the Chief.

**5. PLANNING AND BUDGETING.** Planning and budgeting for AMEDD hospitals is governed by the Army's Planning, Programming, Budgeting, and Execution System (PPBES). The PPBES's six-year planning cycle provides opportunities for AMEDD organizations to participate at various points in the process.

a. Planning. WAMC periodically conducts a series of strategic planning meetings, involving department, division, separate service chiefs, and other staff members, in the planning process. These meetings clarify the hospital's mission statement and future

vision, develop long range hospital plans, and identify specific objectives for the current fiscal year (FY).

b. Budgeting

(1) WAMC budgeting is based on historical funding; the previous year's number of authorized beneficiaries within the Ft. Bragg community, and on an inflated three-year trend.

(2) WAMC funds are internally distributed based on projected workload and assigned missions as voted in the PBAC (Program and Budget Advisory Committee ) and approved by the EXCOM. WAMC's five major funding programs are: Civilian pay, contracts, supplies, travel and equipment. Position Management Review Committee (PMRC) meetings, chaired by the Chief of Staff, are periodically held for the Deputies and Command Sergeant Major to make recommendations on staffing levels for Commander approval.

**6. MEDICAL STAFF.**

a. Selection and Appointment

(1) The hospital commander does not select the active duty officers assigned to the hospital. AR 614-100 (Officer Assignments, Policies, Details and Transfers) and the officer assignment policies of the OTSG govern the selection and assignment process. However, the hospital commander is typically consulted before the assignment of key staff members, and has some latitude in the utilization of the officers who are assigned to the hospital.

(2) The hospital commander has latitude in the establishment and filling of civilian positions on the medical staff. Based on the needs of the hospital and budgetary constraints, the commander may establish civil service positions, establish contractual relationships with providers, establish TRICARE Resource Sharing Agreements (RSAs) with providers, or appoint individuals as consultants. The appointment of individuals to these positions is based on the individual's qualifications.

(3) Privileging, appointing and adverse action procedures are delineated in AR 40-68, (Clinical Quality Management) and MEDCEN Reg 40-36,( Credentials Policy). "Active" medical staff appointment is granted to a provider exercising regular privileges and meeting all qualifications for medical staff membership after successful completion of the initial appointment period. "Affiliate" medical staff appointment is granted to a provider exercising regular privileges and meeting all qualifications for medical staff membership who, due to conditions of employment, is neither assigned organizational responsibilities of the medical staff nor expected to fully participate in activities of the medical staff. In general, contracted staff, visiting consultants, visiting staff in a TDY status, resource-sharing personnel, part-time staff, USAR & ARNG

providers performing individual duty for training (for example, monthly drills), and individual mobilization augmentees (IMAs) have affiliate appointments.

b. Organization. MEDCEN SUPP. 1 to MEDCOM Reg 10-1 (Organization and Function Policy) provides policy and guidance for the organization and functions of WAMC. Formal lines of authority and communication are clearly defined. It also delineates the various functions that the hospital staff membership are expected to fulfill. The regulation identifies the various clinical departments and services and the responsibilities of each. The DCCS must be a privileged member of the medical staff. He/she is the Chief and only specified member of the Medical Staff. The hospital commander may remove the DCCS from this position.

c. Executive Committee of the Medical Center Staff (ECMCS). All members of the organized medical staff, any discipline or specialty, are eligible for membership on the ECMS. The majority (at least 51 percent) of voting ECMS members will be licensed physicians with current privileges and medical staff appointments. Voting membership will include the DCCS (chairperson), the DCN, directors and chiefs of clinical departments and three at-large members. Non-voting members include senior privileged providers from garrison-level units and chiefs of patient administration division (PAD) and CQM).

The full charter for the ECMCS is in MEDCEN REG 15-1. In general, the ECMCS oversees MEDCEN policy approval, credentials, risk management, and quality assessment activities, forwarding recommendations to the Executive Committee.

d. Performance Improvement Activities. Army Regulation 40-68 (Clinical Quality Management) specifies the authority and responsibilities of each level of the organization with respect to performance improvement. Specific duties, responsibilities, procedures, and processes for accomplishing these functions at WAMC are included in MEDCEN Memo 40-65 (Performance Improvement Plan). Pathways of routine communication flow among the hospital staff, ECMCS, and EXCOM, and are described in this memo. Each established structure's membership, organization, responsibilities, and reporting mechanisms are defined in MEDCEN Reg 15-1 (Committees, Boards, and Teams). Membership attendance at all assigned meetings is expected.

e. Patient Safety and Risk Management. AR 40-68 (Clinical Quality Management), MEDCOM Reg 40-41 (The Patient Safety Program), MEDCEN Memo 40-11 (Patient Safety/Risk Management Program, DoDD 6025-13 (Clinical Quality Management Program) and TJC Comprehensive Accreditation Manual for Hospitals (CAMH) govern WAMC patient safety and risk management policies. The Patient Safety Program promotes safe activities for the efficient delivery of high quality care. It identifies innovative practices, as well as systems that would benefit from redesign. The Risk Management Program focuses on the medical claims process, and proactively examines Potentially Compensable Events. All providers will participate and support the Patient Safety and Risk Management Programs.

f. Clinical Privileges. Army Regulation 40-68 (Clinical Quality Management) and DOD Directive 6025.13 (Clinical Quality Management Program) (with OTSG implementing memorandum dated 10 March 1997), and MEDCEN Regulation 40-36 specify the authority and responsibilities of individual health care providers and each level of the organization for the initial granting, periodic renewal, modification, or removal of clinical privileges and medical staff appointments. These documents also include fair hearing and appellate review procedures for all privileged providers, mechanisms for record corrections, and descriptions of medical staff membership categories.

(1) The hospital commander, considering the recommendations of the Credentials Committee and ECMCS, grants all health care provider privileges.

(2) Once clinical privileges have been granted, providers may not exceed the scope of their privileges, except in the case of an emergency as specified in AR 40-68 and MEDCEN Regulation 40-36.

(3) All health care providers will have current privileges at WAMC before providing any patient care at Ft. Bragg. Providers are required to maintain a current, valid, unrestricted license (or other authorizing document, for some non-physicians) for these privileges to be valid.

(4) AR 40-68 and MEDCEN Reg 40-36 define causes for adverse privileging action, specific reportable actions of misconduct, and potential outcomes of such.

g. Continuing Medical Education (CME). WAMC-sponsored CME is offered by several departments, and is open to all staff members. Providers will be responsible for obtaining minimum CME requirements as defined by MEDCEN Reg 40-36. These requirements vary by provider type, and may differ from that required by state licensing boards. It is the provider's responsibility to ensure that all CME documentation is included in his/her credentials file. Inadequate CME documentation may result in adverse privileging actions.

h. Conflict of Interest. Requirements concerning conflict of interest and other standards of conduct applying to active duty members and other government employees or contracted health care providers are specified in the DoD Joint Ethics Regulation (JER). In general, this regulation provides that AMEDD members, civilian employees, and contract physicians may not suggest to anyone authorized to receive health care services at Army expense that they should receive health services from the member when he is not on duty or from a civilian associated in practice with the member. Active duty members and full-time civilian employees may not be personally reimbursed for health care provided to anyone authorized health care from any federal program. Additionally, leadership and key supervisors are required to file annual financial declaration statements that are reviewed by their supervisors and the hospital

ethics counselor. Lastly, AMEDD officers in a transitional leave status may not work for contractors doing business with the U.S. government.

i. Confidentiality of Medical Information. DoD, DA, and WAMC policies ensure that medical information confidentiality will be maintained for all patients to the maximum extent possible. Protected health information (PHI) will be released IAW 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information; Final Rule) and DoD 6025.18-R, (DoD Health Information Privacy Regulation). Reasons for PHI release include the delivery of health care, public health purposes, performance of other official duties, or conducting medical research (with approval of the Clinical Investigation Committee). Authority to access medical information and specific procedures for releasing medical information are specified in AR 40-66 (Medical Records Administration). Quality assurance documents and information, which may include patient medical information, are protected from disclosure by 10 U.S.C. § 1102. Army Regulation 40-68 (Clinical Quality Management) governs release of any quality assurance information.

j. Conflict resolution among individuals with hospital leadership will be done IAW AR 600-20 (Army Command Policy). Simply stated, military organizations have a chain of command that has inherent decisional authority. WAMC's committee structure and the rules and regulations governing civilian personnel grievances also provide avenues of conflict resolution. Conflicts involving critical aspects of patient care and treatment are referred to the hospital Bioethics Committee for resolution.

k. An annual medical staff meeting, chaired by the DCCS, will be held for all medical staff staff at which time the medical staff bylaws will be updated. An interim meeting may be called at the discretion of the Commander and/or the DCCS. Officer's Calls (Officer Professional Development) also serve as medical staff meetings. All healthcare providers, whether civilian or military, are invited to attend these medical staff meetings and are responsible for knowing any healthcare-related information provided during these meetings. When meetings are determined to have essential information, attendance may be made mandatory.

**7. Medical Practice Standards.** All health care providers will provide medical care IAW Army, MEDCOM, and WAMC regulations, policies, and memoranda, the National Patient Safety Goals and Universal Protocols, as well as community standards of practice for their specialty. Appendix A (Medical Practice Standards) provides a summary of the most important information regarding day-to-day practice with which all providers must comply. Revisions of this appendix will be approved by the ECMCS and Executive Committee, but do not require the vote of the full medical staff membership. The respective department chiefs represent members at the ECMCS meetings. Significant changes will be made available to the medical staff.

**8. Directors.** Directorships, predominately along care-lines, were formed in 2013 to promote interdepartmental collaboration and facilitate governing-body management of the MEDCEN. Directors will be appointed by the Commander after consultation with

the appropriate Deputy Commander. The directors will maintain oversight of their departments and will serve to integrate departments within their directorate and between directorates. They are responsible for oversight of the clinical and administrative aspects of departments within their directorship

**9. Department Chiefs.** . Physicians or other privileged providers will be appointed as chiefs of medical departments/services by the commander. Selection will be based on qualifications including clinical and leadership experience and ability.

a. In instances where a non-physician serves as the chief of a department/service, a physician will be selected as the medical director. For department of nursing as well as ancillary services such as occupational therapy, physical therapy, pharmacy, and clinical dietetics, a medical director is not required. The medical director will advise the chief and be responsible for practice issues outside the clinical scope of the non-physician chief. The medical director will be responsible for peer review and the credentialing and privileging of physicians and other privileged providers. The chief will represent the department/service at the ECMS and other required meetings.

b. Rating schemes will reflect the administrative command and control regardless of the Corps (discipline) of the department/service chief. The chiefs (or medical director if the chief is not a physician) will be board certified by a relevant, recognized medical board, or have equivalent competence. All clinical department chiefs are responsible for managing the clinical and administrative aspects of their departments. These include, but are not limited to:

- a. Determining the type and scope of services that will be offered
- b. Recommending the number of qualified and competent staff required providing care, treatment, and service
- c. Developing, maintaining, and implementing policies and procedures that guide and support the departmental services
- d. Determining departmental criteria for granting clinical privileges
- e. Recommending clinical privileges for departmental healthcare providers and others who request privileges generally overseen by that department
- f. Monitoring the departmental providers' performance, to include peer-review
- g. Assessing and improving departmental quality of care and services
- h. Assessing and recommending to the DCCS off-site sources for needed patient care, treatment, and services not provided by WAMC



- i. Integrating their departments into the primary functions of the MEDCEN
- j. Coordinating and integrating inter- and intradepartmental services
- k. Determining the qualifications and competence of department personnel who are not licensed independent practitioners (LIPs) and who provide patient care, treatment, and services
- l. Ensuring that all persons in their department are oriented to the department and to the MTF, and that they receive continuing education
- m. Identifying departmental space and other resource requirements
- n. Managing the departmental budget

**9. Bylaws Modification.** The Governing Body and Medical Staff Bylaws will be adopted and amended by a vote of the medical staff with active appointments, with approval of the EXCOM. Review of the medical staff bylaws will occur at a minimum annually by ECMCS and at the annual medical staff meeting. Recommendations for modifications should be presented to the medical staff at least 7 days prior to the annual medical staff meeting; Any amendment recommended by the medical staff shall become effective only after approval by the EXCOM. A simple majority of the votes for each group is needed for approval. Neither group may unilaterally adopt or amend the MEDCEN bylaws. The hospital commander is the final approving authority. After final amendment approval, a copy of the modified bylaws will be made available to all medical staff.

Appendix A to the bylaws and all other WAMC regulations, memos, policies, or other guiding documents may be adopted, revised, or amended by the ECMCS, with approval of the EXCOM. The EXCOM may establish policies as needed. Departments and divisions may develop internal policies and procedures with the approval of their respective chief.

**10. Reference Availability.** All publications referenced in this memorandum are made available for review to providers at the time of initial application for medical staff privileges. Providers may obtain copies through the Army publications ordering system at the Distribution Center or via the Internet, including the WAMC intranet site at <https://www1.wamc.amedd.army.mil/>.

**The proponent for this publication is the Deputy Commander for Clinical Services (Chief of the Medical Staff). Any questions regarding the information presented in this publication should be addressed to this individual.**

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## APPENDIX A

### MEDICAL PRACTICE STANDARDS

**1. General.** These standards define the roles and responsibilities of licensed independent practitioners (LIPs) providing care for hospitalized and ambulatory WAMC patients. Policies of individual services or sections will not conflict with these standards. These standards follow relevant Army, MEDCOM, and WAMC regulations and policies. Address questions to the appropriate department chief, director or the DCCS.

a. All staff members should read their Outlook and AKO e-mail at least once per duty day. All WAMC credentialed LIPs will provide their department chief their contact information. This data will be consolidated and posted so that results of any test, radiologic exam, medical study or prescription determined to be aberrant, contain Panic/Critical Values or are erroneous can be reported immediately to the LIP telephonically. The LIP will provide their department chief their office phone number; military provided cell phone (if authorized) or carry a WAMC provided pager. LIPs are responsible for providing their chief changes to contact information immediately.

b. Staff members who choose not to participate in an aspect of care or treatment, due to culture or religious beliefs, will discuss their decision with their department chief or the DCCS as directed in WAMC regulations (WAMC Memo 40-18, Patient/Staff Rights and Organizational Ethics).

c. All hospital staff, patients, and visitors will be treated with dignity, respect, and courtesy. Disruptive behavior will not be tolerated within this organization. This includes but is not limited to: shouting or rude/demeaning behavior; profanity; throwing objects; destruction of hospital property; or pushing, shoving, or engaging in acts of overt intimidation. Disruptive behavior is unprofessional and may be grounds for adverse privileging actions and/or other administrative actions.

**2. Patient Rights and Responsibilities:** Patient Rights are outlined in MEDCEN Memo 40-18 and are published in the Patients Rights and Advance Directive trifold distributed throughout the hospital. Command involvement in the health care decisions of active-duty patients is outlined in Army Regulation 600-20. All competent adult patients have a moral and legal right to participate in their medical care and to refuse medical treatment even in life-saving or life-sustaining situations.

a. A patient who is incapable of understanding health care choices and the risks, benefits and complications associated with such choices may be deemed incompetent to make health care decisions. The staff physician responsible for the patient will document the clinical basis for incapacity and the name of the patient's surrogate decision maker—either the legal next-of-kin or a health care agent designated by a validly executed health care power of attorney.

b. The parent or legal guardian of an unemancipated minor has the legal right and responsibility to make health care decisions for the minor patient, with the exception of decisions which the minor patient has the right to make without parental involvement, including the prevention, diagnosis, and treatment of pregnancy, sexually-transmitted disease, substance abuse and emotional disturbance. Treatment of minors is further addressed in MEDCEN Memo 40-18 and North Carolina General Statutes, Chapter 90, Article 1A.

c. All patients have the right to appropriate assessment and management of pain as outlined in MEDCEN MEMO 40-33 (Pain Management). All healthcare providers will use the standardized screening tools described in this memo. Providers will treat patients' pain with consult to other services, if necessary.

d. All health care workers are responsible for identification and reporting of possible victims of abuse or neglect. MEDCEN regulations provide detailed instructions regarding reporting, evaluation, and management of these patients (e.g., MEDCEN Memo 608-18a, Management of Alleged Child Abuse Cases; 608-18b, Management of Spouse Abuse Cases; 608-18c, Abuse of the Elder or disabled, MEDCEN Memo 40-93 Pediatric Sexual Assault; MEDCEN Memo 40-94 Medical Facility Management of Sexual Assault

**3. Patient Abuse, Patient Safety and Risk Management.** MEDCEN Memo 40-11 (Risk Management Program), MEDCEN Memo 40-87, (Patient Safety Program) and Policy Memo #103 (National Patient Safety Goals) specifies WAMC staff members' roles and responsibilities with respect to patient safety and risk management. Specific LIP roles and responsibilities include:

a. Identify any occurrence or risk, including safety hazards or procedural problems, observed patient safety violation or potential thereof. Personally correct potential safety hazards whenever possible. After providing any immediate patient care needed, verbally report the identified issue to his/her supervisor. Providers are encouraged to utilize the electronic Patient Safety Reporting (PSR) system.

b. Secure medical material, equipment, or medication involved in an incident. If medical material or equipment is involved in an incident, the individual identifying the incident must secure the material or equipment immediately. The individual must complete an electronic Patient Safety Report, and take the equipment to logistics for further action.

c. Use OSHA approved safety devices when available. Only rarely will a non-safety device be used (i.e. after multiple unsuccessful attempts with a safety device). The reason for use of the non-safety device must be documented.

d. The Joint Commission (TJC) requires that hospitals promote implementation of National Patient Safety Goals (NPSG) by their provider components and LIPs. Requirements for each LIP include but are not limited to:

(1) Comply with current CDC hand hygiene guidelines 1A, 1B, and 1C CDC Recommendations. (<http://www.cdc.gov/handhygiene/>).

(2) Use at least 2 patient identifiers (neither to be the patient's room number) normally the patient's full name and date of birth prior to any specimen collection, medication administration, transfusion or treatment. The hospital actively involves the patient and, as needed, the family in the identification and matching process. Use two identifiers to label sample collection containers in the presence of the patient.

(3) Thoroughly complete laboratory, radiology, and other consultation requests forms and include contact information to facilitate critical value reporting. If any provider receives critical lab or radiology test results, the person receiving the test result must verify by "read back" those results. Simply repeating back the test result is not sufficient. Whenever possible, the receiver of the test result should write down the critical test result, then read it back, and receive confirmation from the individual who reported the telephonic result. When the responsible licensed caregiver is not available, the LIP on call for that service will be notified of critical results. If that LIP is not available the service or Department Chief will be notified of the critical lab value. Providers receiving critical results on a patient for whom they have no regular responsibility, must act in the best interest of the patient to initiate appropriate clinical care.

(4) Comply with the pre-procedure verification process, marking the procedure site, and conducting a final pre-procedural "time out."

(a) The final verification process confirms the correct patient, procedure, Site, and availability and completeness of appropriate documents (including all consent forms). This verification process uses active—not passive—communication techniques. For outpatient procedures, providers may use one of 3 mechanisms to confirm procedure and site verification: Use the most recent form 741-R, a Universal Protocol Stamp (which can be on the back of the informed consent form) or an electronic note, with the following minimum required information present:

- Correct patient identity
- Correct side and site are marked
- Consent Form
- Agreement on the procedure to be done
- Correct patient position
- Relevant images/results labeled and available
- IV fluid or antibiotics
- Safety precautions identified and met

(b) A "time out" or immediate preoperative/pre-procedural pause must occur in the exact location where the procedure is to be done prior to starting procedure. The "time out" should involve the entire procedural team which, at a minimum, includes the LIP doing the procedure, the anesthesia LIP (if any), and the

circulating nurse or other assistant. In addition, there should be no barrier to anyone speaking up if there is concern about a possible error.

(5) All healthcare workers are responsible to label medications (including sterile water) and medication containers (syringes, medicine cups, basins) on and off the sterile field in perioperative and other procedural settings.

(6) When patient care is transferred from one provider to another, there is an effective 'hand-off' which includes communicating the essential information required for safe and effective patient care and allows time for questions. Specific communication should be made when moving those with defined advanced directive and at high fall risk or when prescribing medications for patients who are pregnant or lactating.

(7) Using a process that involves the patient or their surrogate, ensure that a complete list of medications and supplements (medication reconciliation) be effectively communicated whenever the patient is admitted for hospitalization, referred or transferred to different setting, service practitioner, or level of care either within or outside the organization. Medication reconciliation can be accomplished by either completing a Medicine Reconciliation Form (508e) or by using the Medication reconciliation module in ESSENTRIS.

**4. Impaired Personnel Committee.** The facility acknowledges its responsibility to the potentially or actually impaired health care personnel. Early recognition and intervention is encouraged to optimize rapid recovery and minimize any patient or staff injury. When concerns arise, they should be presented to the chain of command. Appropriate treatment referrals will be accomplished within the scope of Department of the Army guidance. Actions involving impaired health care personnel will be handled by the WAMC Impaired Personnel Committee, as outlined in MEDCEN Memo 40-21.

**5. Drug/Alcohol Screening/Forensic Evidence Collection.** The medical center will collect samples from individuals pursuant to valid legal (state, federal, and UCMJ) requirements. This will be done according to established policies and procedures. At no time will an individual be restrained or physically forced to submit to the collection of a specimen. The hospital SJA is readily available to assist in these cases.

**6. Training.** All healthcare workers will attend newcomers' orientation as soon as possible, but not later than 45 days after arrival at facility. Further, they will fulfill all annual hospital training requirements (HIPAA, etc).

**7. Infection Control.** All healthcare workers will adhere to standard isolation procedures and universal precautions and ensure that all reportable conditions are reported IAW MEDCEN Memo 40-40 to the infection control office, preventive medicine, and/or the appropriate state or federal agency.

**8. Conduct of Care.** All health care providers will have current privileges at WAMC (or be enrolled in an appropriate GME program) before providing any patient care at Ft.

Bragg. Privileged providers who practice without supervision are required to maintain a current, valid, unrestricted license (or other authorizing document, for some non-physicians) for these privileges to be valid.

a. All health care providers will render care appropriate to community standards of practice for their profession and specialty, within the scope of the privileges granted by WAMC.

b. Although WAMC providers are licensed/certified in various other states, as a Federal Institution in the State of North Carolina, State Medical Board practice standards should be considered when appropriate. These can be found as the "Position Statements of the North Carolina Medical Board" at [www.ncmedboard.org/nc/pos2.htm](http://www.ncmedboard.org/nc/pos2.htm).

c. Students may work within WAMC within their appropriate scopes and with supervision if approved through the Graduate Medical Education (GME) Office under a DoD sponsored program or via a Memorandum of Understanding between WAMC and the student's school. This includes, but is not limited to, medical, nursing, physician assistant, and 68W students. Resident physicians and interns may also practice within their scope of practice in WAMC with approval through the GME office. Refer to AR 40-66 for the requirement of countersignature as it pertains to all students.

**9. Role of Non-physician Health Care Providers:** All non-physician providers will perform only the duties for which they have been trained and privileged. Army and MEDCEN regulations (e.g. AR 40-66, and AR 40-68, MEDCEN Reg 40-36) include the policies on privileging, duties, expanded role functions, and supervision of these providers. All non-physician health care providers must be familiar with appropriate sections in Chapter 7 of AR 40-68 governing the specific professional requirements for their category of privileged provider.

a. **Admitting Privileges:** Admitting privileges are granted according to Army regulations and the MEDCEN Credentials policies. Audiologists, certified nurse anesthetists, clinical pharmacists, community health nurses, dentists (excluding oral/maxillofacial surgeons and specialty dentists), dietitians, chiropractors, occupational therapists, optometrists, physical therapists, psychiatric clinical nurse specialists, social workers, physicians assistants, nurse practitioners and speech pathologists may not be granted admitting privileges. The scope of admitting privileges for other non-physician providers will be granted individually, and in accordance with AR 40-68 chapter 7.

b. Each provider must assure timely, adequate professional care for his/her hospitalized patients by being available, or having another member of his/her service, with at least equivalent clinical privileges, available by prior arrangement.

c. Discharge planning, with identification of the patient's post hospital needs and coordination of resources to meet those needs, begins at patient admission.

d. Orders: Non-physician healthcare providers may write orders for medications and tests as outlined in Army and MEDCEN regulations and their individually delineated privileges. These orders do not require countersignature. Physician assistants may write routine orders on inpatients. Inpatient record documents requiring physician countersignature (H&P, pre-op counseling, narrative summaries, and inpatient treatment record cover sheet), must be signed, dated, and timed by the staff physician within 24 hours. Physician assistants' outpatient records do not require physician countersignature.

**10. Supervision of non-physician health care providers includes the following:** A supervising physician for each privileged physician assistant is designated in writing. The credentials committee has the option to request the designation of supervisors for other mid-level providers as well. Providers with a designated supervisor must be oriented to their duties and responsibilities by the supervisor and the process reviewed by the Service/ Department Chief. The credentials office, supervisor, any alternate supervisor, and the individual will be given a copy of the supervisor letter. A designated physician will always be readily available and easily accessible for consultation/collaboration in person, telephonically or in other means that facilitate person-person exchange. The supervised individual will inform their supervisor of any state-license related supervision requirements. The supervisor will coordinate to meet these requirements as long as meeting them does not create an undue organizational burden. The supervisor of a PA must be in that PA's rating chain. Physician Assistants and their supervisors must comply with all requirements as delineated in paragraph 7-16 in AR 40-68.

a. Activities of non-physician health care providers will be monitored through record review, peer reviews, use of clinical guidelines, and drug utilization evaluations, etc. All providers will deliver the same level of patient care regardless of where and to whom the services are provided. Care is based upon the clinical condition and needs of the patient.

**11. On-Call: When** providers are "on call" they are to be available by telephone or pager. They are to respond telephonically or in person within 10 minutes. When needed for emergency patient evaluation or care, they will be present in the hospital within 30 minutes, or sooner as is appropriate for the patient care.

**12. Ethics:** A Bioethics Committee consultation may be requested by any patient, patient family member, or staff with ethical issues or concerns regarding patient care. The chair of the Bioethics Committee may be contacted through the DCCS. If convened, the Bioethics Committee will not make a binding decision, but will determine the ethically acceptable options and assist in decision-making based upon medical ethical principles.

**13. Protective Security, Restraint and Seclusion:** Any use of protective security, restraints, or seclusion will follow Army and MEDCEN policies and procedures (e.g.



MEDCEN Memo 40-4). Restraints will only be used when less restrictive methods are not sufficient to protect the patient or others from injury or to safeguard property or the therapeutic milieu. The decision to restrain requires adequate and appropriate clinical justification. Restraint is to be applied for no longer than it is clearly needed and any doubts about the need for restraint should be resolved in favor of an alternative to restraint. WAMC does not permit the use of restraints for punishment or staff convenience. Physicians will write orders authorizing restraints using WAMC OP 638 (soft restraints) or WAMC OP 637 (locking restraints) orders. Restraint indication, type, location, and duration will be written in the orders, with appropriate annotation included in a progress note. Under NO CIRCUMSTANCE will restraint orders be written as “PRN,” “continuous” or “as needed.” Such orders are NEVER authorized for restraints of any type.

**14. Do-not-resuscitate and Withhold/Withdraw Orders (also known as “abatement” orders):** AR 40-3 (Medical, Dental, and Veterinary Care) Chapter 2 and MEDCEN Memo 40-16, Advance Directives, Do Not Resuscitate/Do Not Intubate and Withdrawal of Care will be followed for all such orders. Key points from these regulations and local implementation guidance are below. Additional details are available in MEDCEN Memo 40-16 and should be reviewed by all physicians writing abatement orders. North Carolina General Statutes 90-320 through 90-322 (Right to a natural death) also provides helpful information <http://www.ncleg.net/statutes/statutes.asp>.

a. The staff physician primarily responsible for the patient’s care is ultimately responsible for ensuring that the patient has adequate information on which to base his/her decision and that the patient’s wishes are honored so far as possible.

b. At the time the abatement order is written, documentation of the rationale for the abatement order will be made in the progress notes by the attending staff physician or PGY-2 or higher level GME physician. GME physicians must document discussion with an agreement by a specific staff physician. A staff physician must countersign the progress note (with date/time) within 24 hours. The note must show the patient’s decision-making capacity and concurrence of the patient or surrogate. Any related ethics committee review/consultations will also be included, if applicable.

c. Only privileged staff physicians may write an abatement order. Physicians in GME status, at least PGY-2 level or higher, may transcribe a verbal abatement order from a privileged staff physician (e.g. “DNR per Dr John Doe”, then stamped/signed/dated/timed by the GME physician). No other staff (e.g. nurses) may take a verbal abatement order. A staff physician must countersign the verbal order (with date/time) within 24 hours.

**d. Orders for comfort care and orders to withdraw or withhold treatment other than resuscitative efforts must be written separately.**

e. All who are responsible for the patient's care should clearly understand the order, its scope, its rationale, and its implications. Abatement orders will be reviewed routinely on rounds and whenever there is a significant change in the patient's condition. The staff physician may rescind abatement orders. A patient may rescind his/her abatement order at any time. Rescission of the orders must be documented.

f. Advance Medical Directives (AMD) and Living Wills: The WAMC program for AMD and living wills is outlined in Army and MEDCEN regulations (e.g. AR 40-3 and MEDCEN Memo 40-16). Ultimately, it is the responsibility of the attending physician to assist the patient in understanding Advance Medical Directives/ Living Wills and/or refer patients to the Corps or Division Office of the Staff Judge Advocate for information/preparation. The WAMC Office of the Center Judge Advocate (CJA) will not routinely be used for AMD's and living wills because the WAMC (CJA) represents the hospital rather than the patient (a potential conflict of interest). However, in an emergency, the WAMC (CJA) may be consulted. Advance Directives and Living Wills will be honored in accordance with state law and federal law and regulations.

**15. Organ Donation.** Providers must ensure that a call is placed to the Carolina Donor Service (CDS) (1-800-252-2672) within one hour of the time of death. This requirement includes all fetuses > 20 weeks. All "imminent" deaths must be called in to CDS within one hour of determination of imminent death. Only the Carolina Donor Service will approach the family regarding donation. The responsibility for determining donor suitability and eligibility falls on the CDS. Pertinent references are AR 40-3 chapter 9 and MEDCEN Memo 40-20.

**16. Autopsies:** Both medical and forensic autopsies are performed at WAMC. Preliminary and final autopsy reports will be generated within two and thirty working days of routine autopsies, respectively. These reports will be kept on file in the Patient Administration Division (PAD).

a. Medical autopsies may be performed on decedents who die while in the hospital due to presumed natural disease processes or in the course of treatment. Each member of the Medical Staff is expected to participate actively in obtaining autopsy consent from the next of kin in the following situations:

- (1) To establish the cause of death in sudden, unexpected, or unexplained deaths which are apparently natural in cause
- (2) To assess the effects or complications of therapy; to confirm or refute iatrogenic complications
- (3) To evaluate an unusual event or course in a known disease
- (4) To enhance medical education in unusual processes
- (5) Stillborn and fetal deaths
- (6) All obstetric, neonatal, and pediatric deaths

b. Autopsies will be performed only with the written consent of the deceased/next of kin, unless directed by lawful authority. If permission is denied, the attending

physician will make a progress note annotation. To document authorization for autopsy, SF Form 523 must be completed in full.

c. The pathologist will communicate the preliminary results to the ordering physician. The ordering physician is responsible for ensuring that the next of kin are counseled on the preliminary autopsy findings.

d. Forensic autopsies will be performed by formally trained and pathologist as directed by the Armed Forces Medical Examiner and in coordination with the C, Pathology in accordance with 10 U.S. Code, Section 1471. Such cases are authorized by the Armed Forces Medical Examiner and does not require consent from the next of kin.

**17. Consultations:** If appropriate, the primary provider will initiate an electronic consult (CHCS) or SF 513 "Request for Consultation." It is the responsibility of the requesting provider to indicate the urgency of the consultation and to indicate if ongoing management of the patient is requested after the initial consultation.

a. Seventy-two hour or less consults (Stat, ASAP, and urgent) must be made by direct provider to provider communication. "Routine" consults may be reviewed by the specialty service consulted and scheduled by individual service policy.

b. Each specialty service must clearly define its policy regarding which patients within their clinical scope of practice should be seen as routine or urgent. This information will be available in the specialty referral guidelines.

c. A consultation response is to reflect an evaluation adequate to support the assessment. Providers qualified within their specialty will perform the consultations. All consultations will be completed on a standard form, which will indicate review of the patient's record, pertinent findings on physical examination, and the signed opinion and recommendations of the LIP consultant. Findings/recommendations should be communicated back to the requesting provider within the appropriate time frame as indicated in the initial consultative request. AHLTA documents automatically available in electronic medical record.

d. Consults performed in the Emergency Department: A note should be written for all consultations performed in the Emergency Department. The consultant's response may be recorded on an admission H & P (ESSENTRIS), electronic medical record (AHLTA) with a copy printed for the ED and admissions charts, or SF 513 consultation sheet, as dictated by the disposition of the patient. When an Emergency Department (ED) LIP is seeking consultation, it is his/her responsibility to indicate whether he/she is requesting telephone advice, arrangements for follow-up, or clinical evaluation of the ED patient. In the latter case, the consultant service will personally evaluate the patient and provide recommendations for ongoing patient care.

e. Patient flow in the ED is directly dependent on the timely disposition of patients. The goal is evaluation, treatment, and disposition within 2 hours of being in the ED bed. DEM providers should avoid lengthy evaluations of the patients who clearly require admission, and consultants should expedite the admission of ED patients requiring inpatient care, to include the completion of histories and physicals and diagnostic evaluations on the inpatient ward.

f. Consultants are expected to respond promptly to consultation requests from the ED. When providers are "on call" they are to be available by telephone or pager. They are to respond telephonically or in person within 10 minutes. When needed for emergency patient evaluation or care, they will be present in the hospital within 30 minutes, or sooner as is appropriate for the patient care situation. If the consultant is already occupied with urgent care, his/her back up should be called to respond to the ED's needs. The on-call provider must coordinate closely with the ED provider if this goal cannot be met.

g. If additional evaluation or treatment in the Emergency Department is necessary prior to admission, the consultant will coordinate with the ED LIP. In cases where the patient will be admitted regardless of the outcome of additional evaluation or treatment, the patient should be admitted in a timely fashion with the evaluation or treatment continuing as an inpatient. When consulted to admit a patient, the consulting service should have admission orders written within 1 hour from the time of the initial consult. For services with providers in training, an additional 30 minutes (90 minutes total) may be allowed to enhance training opportunities. Attending staff should be readily available to aid providers in training with their response to patients in the Emergency Department, particularly with multiple simultaneous consultations.

h. In an emergency, if any provider is called to evaluate a patient for whom they have no regular responsibility, he/she should initiate appropriate clinical care for the patient, personally contact the responsible provider, and document the encounter.

Intra-operative consultation will be documented in a progress note in the inpatient electronic record (ESSENTRIS).

j. Inpatient consultation: Formal inpatient consultations require a brief clinical note in the electronic medical record and telephonic or face-to-face contact with the assigned consultant. Consultants must evaluate the patient and make recommendations in a timely fashion, generally within 24 hours of the initial request or sooner as the clinical situation dictates. Recommendations should be annotated in a clinical note in the electronic medical record.

k. Informal consultations (advice only), where appropriate may also be obtained. Informal consultations do not require a clinical note from the consultant; however, the role and extent of the consulting service should be clearly delineated in the inpatient records. In general, if the consultant has not personally evaluated the patient, his name should not appear in the patient chart and he/she does not assume responsibility for the

patient's care. If the primary service desires ongoing recommendations and advice, a formal inpatient consult should be requested.

## **18. Medical/Surgical Admissions:**

a. Admitting privileges are granted as part of the privileging process as outlined in Army and MEDCEN regulations (e.g. AR 40-68 and MEDCEN Reg 40-36). Any privileged medical staff member may apply for admitting privileges under the provisions of these regulations. The preferred method of medical documentation is the electronic inpatient record (ESSENTRIS). All patients admitted to WAMC will receive timely evaluations by a qualified Medical Staff member who is responsible for:

(1) Full patient assessment and all medical care and treatment

(2) An admission note made at the time of initial evaluation. This note must acknowledge and confirm the patient's wishes if it has been annotated that the patient has advanced directives. If the patient does not have advanced directives, a frank discussion of contingency plans in the event of an adverse outcome must be discussed with the patient, family, or surrogate and be documented in the chart.

b. Daily progress note that includes assessment of pain level and plan to mitigate and relieve the pain. The follow-up note should document that the treatment used to relieve the pain was successful or that another modality is being used.

c. Prompt completion and accuracy of medical records during hospitalization and at discharge. This includes but is not limited to:

(1) A thorough History and Physical (H & P) appropriate to the clinical presentation. The H & P must be on the chart within 24 hours of admission. See other details in section 24B (3).

(2) Orders written will include a complete list of admission medications and indication for the medication (unless there is only one indication for the medicine). See Section 5, Medical Orders. The LIP of record will be identified in the orders. The LIP of record is responsible to ensure that abbreviations from the hospital-wide "Do Not Use Abbreviation" list are not used.

(3) A brief operative note must be written in the chart immediately after the procedure or operation. An operative report must be dictated within 24 hours of a procedure. See Operative Note 6.3.9.10.

(4) Use of moderate sedation should be appropriately monitored and documented on WAMC Form 2300.

(5) Verbal orders are to be discouraged but on occasion will be accepted in emergent situations. Refer to Section 5.3, Verbal Orders.

d. Transmissions of reports of patient's condition to other involved providers, family members, and government agencies when requested to do so in accordance with the Privacy Act and other applicable regulations. Transmission of reports of patient's condition to a provider temporarily assuming responsibility when the attending provider is not on call or otherwise available

e. Documentation if there is a change in the patient's condition that requires evaluation. Reevaluation of monitoring, treatment, and care after a major change in the patient's status. Assuring that all admitted patients have a complete in-patient record as outlined in section 24B.

f. For planned admissions for procedures, the history & physical, orders, or other documentation may be completed before admission. These must be done within the 30 days before the procedure. If the procedure is delayed beyond the 30-day window, the H&P, pre-operative diagnosis, assessment, treatment plan, consent form, and orders must be rewritten, confirmed, corrected, re-signed, and re-dated. If there is a 24 hour lapse from the time that the H & P is written and admission, a progress note addendum is required that annotates what changes if any are present in the patient. The addendum to the H & P must specifically state if there are no changes in the patient's status in the intervening period if indeed this is the case. A statement such as, "The H&P has been reviewed, and there are no changes to the patient's condition" will suffice.

**19. Behavioral Health Admissions:** Adults requiring inpatient psychiatric care will be medically cleared prior to admission on Ward 6S. Voluntary civilians requiring inpatient care will be admitted as space permits after being informed about the ward environment and signing a *Voluntary Consent for Psychiatric Admission* form. Civilians will not be admitted involuntarily. Medically unstable patients will be admitted to the appropriate medical/surgical service until medically cleared, then transferred to 6S upon the recommendation of the Psychiatric Consult Liaison team. Intoxicated patients with a BAL exceeding 200 or a history of complicated alcohol withdrawal are considered medically unstable. Substance detoxification and rehabilitation activities are routinely performed on Ward 6S, but the need for such services does not normally justify inpatient psychiatric care. Children and adolescents requiring inpatient psychiatric care will be transferred to a Tri-Care network hospital with appropriate facilities. Federal Regulations, including Department of Defense Directive 6490.04 (Mental Health Evaluations of Members of the Military Services) will be followed at all times.

**20. Transfers:** Army regulations and MEDCEN Memo 40-350, Transfer of Patients, will guide all transfers. For inter-facility transfers, priority should be given to transferring patients to facilities included in the WAMC managed care network when appropriate care is available within the medically needed timeframe for the individual patient's needs. Non-network facilities may be used to expedite care due to the patient's medical condition. DCCS notification is required for non-network patient transfers.

a. For inter-facility transfer, the transferring physician will ensure that all pertinent information, including the accepting physician's name, accompanies the patient. Transferring clinician will determine the most appropriate means of transport and level of monitoring, and will coordinate with WAMC EMS and PAD for transport. Use of the DoD AirEvac system will be coordinated through the Patient Administration Division. The Ambulance Section will coordinate air and ground transfers in the local (NC) and nearby states.

**21. Ambulatory Procedure Visits (APVs):** An APV is a surgical or invasive medical care provided to outpatients with the expectation that the patients will be recovered sufficiently to be released within 24 hours. All providers performing APVs must be familiar with MEDCEN MEMO 40-22 that contains a list of the only APVs authorized to be performed in the MTF. Anesthesia selection is by the appropriately credentialed provider and should be appropriate for the clinical setting. Anesthetics that allow for patient recovery and release in less than 24 hours should be chosen.

a. At a minimum, the documentation in the medical record will include the appropriate forms (or equivalent ESSENTRIS notes) documenting: Procedure, and Site Verification Record (MEDCOM FORM 741-R), History and Physical Exam (DD Form 2770 which may reference an attached AHLTA note), Provider Orders (MEDCOM Form 688-R), Advance Directives (WAMC OP 504), Privacy Act Statement (DD 2005), and evidence of on-going, interdisciplinary assessment of patient needs and plan of care, to include, but not limited to, pre-procedure and post-procedure patient instructions and a physician's summary of care provided (for example, SF 509 or DD Form 2770, etc.). Providers performing APVs should update the patient's AHLTA Problem List at the earliest opportunity for the procedure performed and findings.

b. If applicable the record will also include (or the appropriate ESSENTRIS equivalent): Operation Report, Medical Record – Anesthesia (DA Form 7389), Tissue Exam Form (SF 515), Informed Consent (OF 522), Progress Note/Brief Op Note (SF 509), and all appropriate therapeutic documentation such as post-procedure follow-up telephone call (DA Form 5008), emergency treatment record (SF 558), and diagnostic reports such as laboratory, radiology, or ECG tracings.

**22. Observation services** are those services furnished on the hospital premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine a possible admission to the hospital as an inpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient. Most observation services do not exceed 23 hours. In some instances, depending on medical necessity, up to 48 hours of observation services may be justified. Only in rare and exceptional cases do observation services span more than two calendar days. The period of observation begins the moment the patient is placed in observation status.

a. The following services are not covered as outpatient observation services: Observation concurrent with treatments such as chemotherapy, services for postoperative monitoring, and services associated with ambulatory procedure visits.

b. All documentation related to an observation stay will be filed in a separate observation record (or equivalent ESSENTRIS notes) and will comply with the requirements listed in section 4.1 above.

### **23. Medical Orders:**

a. Doctor's Orders. Whenever possible, doctor's orders should be entered via the hospital computer system for inpatient and outpatient orders. There must also be a corresponding medical record entry documenting the reason for the order within the inpatient or outpatient treatment record. Electronic medical record entries (such as T-cons or consultations) are also appropriate sites for documentation. All physicians, including all physicians in graduate medical education (GME) programs (residents and interns) may write doctor's orders. Countersignature of GME physicians' orders is not routinely required. Non-physician health care providers' order writing privileges are outlined in section 9.

b. Medical orders written for patient care will be dated, timed, and signed by the provider issuing the order before the instructions are executed. The preferred method for writing medical orders is in ESSENTRIS. Medical Staff members may write orders only within the authority of their clinical privileges. To expedite routine admission of healthy newborns from labor & delivery, standing admission orders for healthy newborns may be accepted and executed while the admitting healthcare provider's signature is pending. The admitting healthcare provider must sign, date, and time the admission orders within 24 hours of admission. Nursing personnel who accept and execute these orders must follow the existing protocols regarding healthcare provider notification.

c. "Orders" for radiological procedures and anatomic pathology specimens are in reality consultation requests to the radiologist/pathologist and will be treated as consults. That is, a relevant history, description of physical findings, and clinical question to be answered should be included with each request.

d. Blanket orders, such as "resume/continue previous orders" or other non-specific orders are not authorized. All orders must be written/rewritten such that the orders are complete and independent of any other documents or previous orders. New orders must be written each time a patient is transferred to a new level of care.

e. PRN orders must be written to include the symptom or indication for use (example: PRN pain, PRN fever) unless there is only one possible use for the medication (e.g., docusate for constipation).



f. Orders that allow a range of options should have very clear parameters for implementation (i.e. Morphine IV 1-2 mg q4 hours prn pain is INCORRECT, whereas Morphine IV q4 hours 1 mg for pain 1-4/10, 2 mg for pain 5-10/10 is CORRECT).

**24. Medication Orders:** Army and MEDCEN Regulations (e.g. MEDCEN Memo 40-35, Outpatient Medication Management, MEDCEN SOP 40-2, Hospitalized Patient Medication Management) and the WAMC Formulary contain information pertaining to the availability of medications within WAMC, policies concerning prescribing and medication reconciliation.

a. Providers who practice in an area where CHCS or another electronic entry platform is accessible are to enter prescriptions electronically. Whenever possible, the patient is provided with a copy of their medication profile which can be generated from this electronic platform by the provider or any pharmacist. The WAMC main pharmacy and outlying clinics will also accept prescriptions written on a DoD or MEDCEN prescription form (e.g. DD1289 or MEDCEN form 1679) from WAMC providers who do not have access to CHCS or AHLTA. Written prescriptions, for our beneficiaries, from providers outside the WAMC health system are also honored.

b. Disposition of drugs collected from patients:

(1) Turn-in of medications. In the majority of situations, the use of a patient's own medications is discouraged because it is not known how they were stored or handled prior to the patient's admission. Hence, nursing personnel will collect all medications patients bring into the hospital under their care and inform the patients that use is not permitted. Whenever possible, the hospital staff will give all medications brought into WAMC by an inpatient to a responsible family member for safekeeping. If this is not possible, hospital personnel will turn in all medications to the Inpatient Pharmacy as described below. Pharmacy personnel will assist in the receipt, identification, storage, and coordination of the disposition of all medications brought into the hospital.

(2) Turned-in medications dispensed from a military pharmacy will be returned to the patient upon discharge if approved by the attending physician. Turned-in medications dispensed from a civilian pharmacy (i.e., the patient purchases) are considered personal property. These medications will be returned to the patient upon patient request at discharge.

(3) Except as noted, drugs collected from patients will not be used to treat a WAMC inpatient. To the maximum extent possible, drugs used to treat inpatients will be from pharmacy stocks. However, providers may permit patients to use their personal medications when alternative drugs stocked in the pharmacy are not therapeutically acceptable or available in a timely manner. If used, the medical staff will write an appropriate medication order, an inpatient pharmacist will identify the medication and evaluate its integrity, and when possible, the Inpatient Pharmacy will dispense the medication as part of its unit dose drug delivery system.

c. Automatic Stop Orders for hospitalized patient medications are outlined in Army and MEDCEN regulations (e.g. MEDCEN Memo 40-35, Medication Management). Additionally, providers must rewrite all orders upon patient transfer to a different level of care.

d. Orders written on inpatients will include a complete list of admission medications and indication for each medication (unless there is only one indication for the medicine). The LIP of record will be identified in the orders. The LIP of record is responsible to ensure that abbreviations from the hospital-wide "Do Not Use Abbreviation" list are not used.

**25. Verbal Orders:** Verbal orders. Verbal orders will be used only for emergency STAT orders. The RN who accepts the order must write it on DA Form 4256 and enter after it "Verbal order (doctor's/nurse's name, rank, Army Nurse Corps, or RN)." The prescriber must countersign the order as soon as possible, but no later than 24 hours after the emergency.

a. Telephone orders. Telephone orders will be held to the minimum and accepted only by an RN; they must be countersigned by the prescriber within 24 hours. The RN accepting the order(s) must record the order(s) on the DA Form 4256 followed by the notation "Telephone Order(s)"; the physician's name; and the RN's name, rank, and title. If the prescribing physician is unable to countersign the telephone order, he or she may contact the covering physician and discuss the order. The covering physician may then countersign the telephone order for the prescribing physician.

b. A verbal abatement order (Do not resuscitate or withdraw/withhold orders; see section 12) may be dictated by a privileged staff physician only to a GME physician who is PGY-2 level or higher. The GME physician will record the order and include with it the name and title of the staff physician. The GME physician will then write the order in ESSENTRIS. A staff physician must properly countersign the order within 24 hours. No other staff members may receive a verbal abatement order.

## **26. Medical Records:**

### a. Basic Administrative Requirements:

(1) The preferred method of medical documentation is by electronic medical record (AHLTA or ESSENTRIS). Nevertheless, hand written records may be appropriate in certain circumstances (i.e. computer system failure, mass casualty situation). If hand written medical documentation is performed, records will be legible, dated, timed, and authenticated by affixing a signature (or initials) and a stamped or neatly printed name. The author of the records must be easily identified by the signature and printed/stamped name. It is the responsibility of the provider to ensure authentication of the portions of the record for which they are responsible in a timely manner. All records must be completed within 30 days of patient discharge.

(2) Use of Approved Abbreviations and Symbols: Only those abbreviations identified in Army or MEDCEN Regulations (e.g. AR 40-66 and MEDCEN Circular 40-66) are to be used. Abbreviations that are listed in the “Do Not Use” list (MEDCEN Circular 40-66) will not be used in any handwritten orders or medication-related documents. The provider must know what abbreviations are not be used. If any abbreviation from the “Do Not Use” list is used when writing medications orders, the nurse transcribing the order will contact the ordering provider for clarification. Similarly, orders with “Do Not Use Abbreviations” that make it to the pharmacy will require clarification from the ordering provider or surrogate. “Do Not Use” abbreviations will not be used on any hospital preprinted forms.

(3) All providers with inpatient and APV responsibilities must make regular visits (typically weekly) to the medical record room to ensure timely completion of medical records. Members of the medical staff with admitting privileges and providers in training are expected to sign in at the inpatient chart room weekly. Their signature attests that all chart responsibilities have been fulfilled for the week. Providers who will be deploying or on leave or TDY should note this on the sign in sheet during the week preceding his/her absence. The expectation is that charts placed in individual LIP slots will be completed within 7 days. Providers with delinquent charts (incomplete after 30 days from patient discharge) that are attributable to the provider will be reported to the Department Chiefs and ultimately the DCCS. Failure to meet in-patient record closure requirements may result in an adverse credentialing action. An exception is autopsy reports.

(4) Reports of diagnostic and therapeutic imaging procedures will be completed promptly and will be immediately incorporated into the patient’s medical record.

(5) Release of Information:

(a) Release of information will only be accomplished IAW existing Department of the Army (DA) regulations, Department of Defense Privacy Regulations and the Health Insurance Portability and Accountability Act (HIPAA).

(b) Removal of medical records will only be made IAW DA rules and regulations. Medical records may be removed from the organizations’ jurisdiction only by court order, subpoena, or statute after documented legal review by the Center Judge Advocate (CJA), or at the time of a soldier’s permanent change of station or expiration of term of service.

b. Inpatient Medical Records will include:

(1) Basic patient identification including name, register number, social security number of sponsor, address, date of birth, and an emergency contact.

(2) MEDCEN Form 687-R Interdisciplinary Plan of Care (or the ESSENTRIS equivalent Interdisciplinary Plan of care), will be initiated at admission and will list all active problems related to the admission. All disciplines will maintain and update on an as needed basis.

(3) History and Physical Examination (H&P) / SF 504, SF 505 and SF 506 or the equivalent ESSENTRIS H&P which:

(a) Is signed by a staff physician, staff oral/maxillofacial surgeon, certified midwife, resident physician, or resident oral/maxillofacial surgeon at least PGY-2 level. If a PA, PGY-1 physician, PGY-1 oral/maxillofacial surgeon, or student completes the H&P, it must be countersigned within 24 hours and before any surgical procedure. All providers who may sign H&Ps are also authorized to countersign for trainees. Hand written History and Physical Examinations must be legible, dated, timed and signed and meet the same requirements for countersignature as outlined above including all sections of the H&P.

(b) Is completed or dictated within 24 hours of admission, (if dictated, a comprehensive admission note is required) When a patient is readmitted within 30 days for the same condition or if the H&P was performed in an ambulatory setting within 30 days of the date of admission an interval history and physical can be written in the progress notes (SF 509) or ESSENTRIS equivalent with pertinent changes recorded at the time of admission. If the H&P was completed more than 24 hours prior to surgery, a progress note must be written indicating if there are any changes to the patient's status. An addendum noting that "the H&P has been reviewed, and there are no changes to the patient's condition" is sufficient if this is indeed the clinical situation.

(4) The service specific H&P in ESSENTRIS is the documentation of choice. In the event that a handwritten documentation is required, a "short form" H&P-(Abbreviated medical record; e.g. DD Form 2770)) may be used for the following hospitalizations:

(a) Cases of a minor nature when the anticipated hospitalization will be less than 48 hours (including APVs). If surgery is planned, the patient may be ASA class I or II only. The abbreviated medical record may never be used for ASA class III patients. If use of general anesthesia is planned, the physical examination must fully describe the cardiopulmonary findings. Terms such as "normal", "WNL", and "negative" will not be used.

(b) Any hospitalization (regardless of expected length of stay) for military members with uncomplicated conditions not normally requiring hospitalization in the civilian sector (e.g. measles, respiratory infection).

(c) Any hospitalization for delivery that is expected to be an uncomplicated vaginal delivery (even if length of stay may exceed 48 hours). Healthy newborns may also be admitted using this form.

(d) Short forms are not acceptable for patients admitted for major surgical procedures or medical conditions in which the expected length of stay is over 48 hours.

(e) In the event that a short admission unexpectedly exceeds 48 hours, an electronic H&P should be produced in ESSENTRIS at the earliest available opportunity.

(f) Is completed and available before surgery; includes a planned course of action. Includes a history of present illness with a pertinent summary of previous treatments/interventions and the results of those treatments or interventions that may have led to the present admission. Includes a history with relevant age specific past history, psychosocial status, family history, pertinent occupational history, and appropriate inventory of body systems.

(5) Attending physicians will document progress notes in the medical record at least daily on all inpatients, more often if clinical condition warrants additional documentation. The problem-oriented medical record approach utilizing SOAP (Subjective, Objective, Assessment, and Plan) format is the preferred documentation style. Progress notes may be made by anyone needing to document patient care or patient interactions (this includes, but is not limited to, physician and non-physician healthcare providers, nurses, chaplains, and ancillary personnel). The preceptor or the preceptor's representative will countersign notes made by students. When graduate medical education (GME) physicians are involved a patient's care, a progress note by the staff physician or staff countersignature of the GME physician's note must be made as often as needed to substantiate active participation in and supervision of the patient's care. A staff note is required at the time of admission and for all abatement (do not resuscitate/do not intubate) orders.

(6) Discharge plan: Initiated upon admission by discharge planners or any member of the health care team and determined by the patient's needs. Discharge planning will provide for continuity of care, will be documented in the medical record in the appropriate section, and will provide for timely post discharge care.

(7) In the event of death, a death note including the date, time, and cause of death will be recorded. In the event an autopsy is performed, a preliminary anatomic gross diagnosis will be documented within 2 working days, and a complete report will appear in the record within 60 days. (Specimen sent to AFIP may take longer).

(8) In the event that a patient leaves Against Medical Advice (AMA), the provider must comply with procedure as delineated in MEDCEN Memo 40-30, Patient Disposition Against Medical Advice, including completion of DA 5009-R and DA 4106.

#### c. Operating Room Medical Record:

(1) A history and physical examination, results of diagnostic tests, and the preoperative diagnosis will be completed and recorded in the medical record prior to

surgery. In unusual emergency situations where there is inadequate time to record the history and physical examination, a brief note, including the preoperative diagnosis, will be recorded before surgery.

The provider performing procedures or treatments has the responsibility for informing the patient and for obtaining consent. The consent will include the risks, benefits, and alternatives/options to the procedure, and risks benefits to the alternatives. A statement will be included that all patient questions were answered.

(a) Army and MEDCEN regulations (e.g. AR 40-66, AR 40-400 and MEDCEN Memo 40-18) establish policies and procedures regarding informed consent. This policy will be followed for all diagnostic and therapeutic procedures that require sedation, local, regional, or general anesthesia; that might cause patients to lose protective reflexes; that produce significant discomfort; or that pose risk of significant complications.

(b) Written consent may be obtained by any privileged provider or any provider enrolled in an approved GME program.

(2) The surgical site will be definitively identified and documentation completed as required in MEDCOM Circular 40-54 Surgical/Procedural Site Verification). Wrong site, wrong procedure, and wrong patient errors can be prevented by using a three-pronged approach—using a pre-procedure verification process, marking the procedure site, and conducting a final pre-procedural “time out.” Use MEDCEN Form 741-R or ESSENTRIS equivalent, Procedure and Site Verification Record as a checklist to avoid wrong site, wrong procedure, and wrong patient errors.

(3) Providers who administer sedation to patients will comply with MEDCEN Reg 40-19 Guidelines for Sedation and Anesthesia of Patients Undergoing Diagnostic or Therapeutic Procedures). There will be a pre-anesthetic assessment of each patient for whom anesthesia is contemplated. This evaluation will include an assessment and documentation of the patient’s airway. Before induction of anesthesia, there will be a determination by a provider with specific delineated anesthesia privileges that the patient is an appropriate candidate to undergo the planned anesthesia. Immediately before the induction of anesthesia, the patient will be reevaluated and this will be documented on the Anesthesia Record Form.

(4) The postoperative status of the patient is assessed on admission to, and discharge from, the post-anesthesia recovery area. Immediately after release from recovery room, a post-anesthesia note will be made by the anesthesiologist/anesthetist describing the presence or absence of anesthesia related problems or complications. This note will be documented on the reverse of Anesthesia Record Form. In addition, at least one note will be written after the patient’s complete recovery from anesthesia on the same form. All post anesthesia notes will be annotated with the date and time.

(a) Post-operative documentation will include: vital signs and level of consciousness; medications, IV fluids, and blood/blood components; unusual events/complications and how managed; names of direct care nurses (or supervisor, if direct care not by registered nurse); and discharge from post-anesthesia care (by provider or by discharge criteria).

(b) A Brief Op Note: An operative progress note will be immediately written on all cases (the preferred method is in ESSENTRIS). The operative note will name the procedure, provide operative findings, technical procedures used, specimen removed, post-operative diagnosis and estimated blood loss. This note will include the name of the responsible staff surgeon for each surgical procedure performed and will be written immediately following the surgical procedure before the patient is moved to the next level of care.

(c) The Operative note should be dictated promptly after a procedure but must in all cases be finished within 24 hours. It will contain: A description of the procedure and the date it was performed, the name(s) and title(s) of the primary surgeon and assistants, preoperative and postoperative diagnosis, relevant details regarding performance of the procedure including a description of the specimens removed, major findings and conclusions, a discussion of complications including plans for following up on any complications, the condition of the patient following the procedure, and the name and title of the author of the Operative Report. If a GME provider dictates the operative report, the resident should sign the report, and the staff surgeon must co-sign the report (with printed name or stamp).

d. Discharge Summary: A discharge summary will be completed on the day of discharge. This may either be dictated or completed in ESSENTRIS. Discharge instructions and orders, as well as other pertinent information, are expected in a timely fashion to ensure appropriate continuity of care for transfers or follow-up in an ambulatory care setting. The final narrative summary (SF 502) must be signed by the attending LIP. A final progress note (SF 509)/ESSENTRIS equivalent may be used in lieu of a narrative summary for certain situations, as indicated in section 24D (2).

(1) The discharge summary and instructions should include the following as appropriate: Employment status; Assertion of Competency; Activity limitations/profiles; A list of medications and indication for each medication at the time of discharge; Reason for hospitalization; Significant findings; Procedures performed and treatment rendered; Instructions to the patient and family; Final diagnoses (as specific as possible, listing all major problems).

(2) A progress note (SF 509) or ESSENTRIS equivalent summarizing the case may be substituted for the narrative summary (SF 502)/when:

(a) A transfer or discharge occurs within 48 hours after admission.

(b) An obstetrical case has a normal, uncomplicated delivery. If the hospital length of stay (mother and newborn) lasts more than 48 hours with no complications, a narrative summary is not required. Instead a progress note can be substituted for a narrative summary; the progress note will include the patient's condition at discharge, discharge instructions, and required follow-up care.

(3) A patient can only be pronounced dead by a physician. Following notation in the medical record of the date, time and circumstances of the death, the body will be released to the hospital morgue. All deaths require a dictated Death Summary.

e. Outpatient/Emergency Services Medical Records:

(1) All encounter notes should be complete and consistent with standard medical practice.

(2) All encounters will be closed in ADM within 72 hours of the visit.

(3) The recognized master problem list will be maintained in the AHLTA Electronic Health Record (EHR) database.

(4) Clinicians must be familiar with service and departments standard operating procedures and scope of practice.

(5) All outpatient ambulatory surgical procedures require a procedure note written immediately after the surgical procedure outlining: All procedures performed; Pre and postoperative diagnoses; Detailed account of surgical findings; Specimens removed and sent to the laboratory; Providers involved in the procedure; Anesthetics and sedatives used.

**27. Medical Profiles:** The intent of physical profiling is to ensure qualified medical and behavioral health personnel determine functional activities and limitations/restrictions related to medical and behavioral health conditions and prescription medications. The e-Profile is the approved method to communicate duty limiting medical conditions to the chain of command. While additional methods to communicate with the patient's Commander exist, such as phone calls or encrypted messages, these forms of communication must supplement and not replace use of the e-Profile. In all circumstances, when a Soldier is identified with a duty limiting medical condition that will persist for greater than 7 days, it is the standard of medical care at Fort Bragg, NC that credentialed providers ensure an e-Profile is immediately entered for the Soldier.

a. Profiling providers at Fort Bragg, NC will use the most current versions of AR 40-



501 and CENTCOM medical deployability guidelines to communicate medical fitness and deployability.

b. A complete list of all possible diagnoses and/or medications that require an e-Profile is impractical for this publication. The medical professional must consider the Soldier's duty position, physical job requirements, training requirements, work environment, ability to perform mandatory basic Soldier tasks including firing weapons, wearing personal protective equipment/helmet/body armor, ability to receive immunizations and worldwide deployability. For selected medical conditions and selected medications that require a profile see Annex A.

c. The diagnosis on profiles should be presented in laymen's terms and might be vague, generalized or tentative. However, the restrictions and limitations must be specific, detailed and helpful to the unit commander in assigning training and tasks to the individual Soldier. It is often more helpful for a profile to list what a Soldier may do rather than list what he/she may not do, particularly for complex diagnoses.

d. Profiles should not be written for longer than absolutely needed. In general, it is preferable to see patients more frequently to evaluate the need for continuing profile rather than default to a larger number simply for patient convenience.

e. Soldiers receiving medical or surgical care or recovering from illness, injury, or surgery will be managed with temporary physical profiles until they reach the point in their evaluation, recovery, or rehabilitation where the profiling officer determines that the Medical Retention Determination Point (MRDP) has been achieved but no longer than 12 months.

(1) MRDP is when the Soldier's progress appears to have stabilized medically, the course of further recovery is relatively predictable, and where it can be reasonably determined that the Soldier is most likely not capable of performing the duties of the Soldier's MOS, grade, or rank.

(2) This MRDP and referral to the Integrated Disability Evaluation System (IDES) for Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) will be made within one year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards IAW AR 40-501, chapter 3, but the referral may be earlier if the provider determines that the Soldier will not be capable of returning to duty within one year.

f. Soldiers with a temporary profile will be medically evaluated at least once every three months, at which time the profile may be extended for a maximum of six months from the initial profile start date by the profiling officer.

g. Temporary profiles exceeding six months duration, for the same medical condition, will be referred to a specialist (for that medical condition) for management and consideration for one of the following actions:

- (1) Continuation of a temporary profile for a maximum of 12 months from the initial profile start date.
- (2) Change the temporary profile to a permanent profile.
- (3) Determination of whether the Soldier meets the medical retention standards of AR 40-501, chapter 3, and, if not, referral to the IDES for MEB/PEB.

h. Clinical peer review will routinely include a determination of appropriate initiation of medical profiles as well as their quality. The standard is generation of an e-Profile on the same day as the clinical visit.

## ANNEX A

Selected medical conditions that require a profile:

1. Asthma that has a Forced Expiratory Volume-1 <50% of predicted despite Appropriate therapy that has required hospitalization in the past 12 months, or that requires daily systemic (not inhaled) steroids.
2. Seizure disorder, either within the last year or currently on anticonvulsant Medication for prior seizure disorder/activity.
3. Diabetes Mellitus, Type 1 or 2, on pharmacotherapy or with HgA1C > 7.0.
  - a. Type 1 diabetes or insulin-requiring Type 2 diabetes.
  - b. Type 2 diabetes, on oral agents only, with a change in medication within the last 90 days and/or a HgA1C > 7.0.
4. History of heat stroke.
5. Meniere's disease or other vertiginous/motion sickness disorder.
6. Recurrent syncope for any reason.
7. Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.
8. Renolithiasis, recurrent or currently symptomatic.
9. Pregnancy.
10. Moderate or worse obstructive sleep apnea.
11. BMI >35 with serious co-morbidities such as diabetes, sleep apnea, obesity-related cardiomyopathy, or severe joint disease.
12. Symptomatic coronary artery disease.
13. Myocardial infarction within one year.
14. Coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair.
15. Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medications, electro-physiologic control, or automatic implantable cardiac defibrillator.
16. Uncontrolled hypertension.

17. Heart failure or history of heart failure.
18. Uncontrolled Hyperlipidemia (Total Cholesterol >240, LDL >160, Triglycerides >500).
19. Blood-borne disease (Hepatitis B, Hepatitis C, HTLV, HIV) that may be transmitted to others in a deployed environment.
20. Latent tuberculosis, including those who are untreated or who are currently under treatment.
21. Active tuberculosis.
22. Cancer for which the individual is receiving continuing treatment or requiring frequent subspecialist examination and/or laboratory testing during the anticipated duration of the deployment.
23. Precancerous lesions that have not been treated and/or evaluated and that require treatment and evaluation during the anticipated duration of the deployment.
24. Any medical condition that requires surgery (e.g., unrepaired hernia) or for which surgery has been performed and the patient requires ongoing treatment, rehabilitation or additional surgery to remove devices (e.g., external fixator placement).
25. Individuals who have had surgery requiring followup during the deployment period or who have not been cleared/released by their surgeon (excludes minor procedures).
26. Individuals who have had surgery (open or laparoscopic) within 6 weeks of deployment.
27. Psychotic and Bipolar Disorders.
28. Clinical psychiatric disorders with residual symptoms, or medication side effects, which impair social and/or occupational performance.
29. Psychiatric disorders with fewer than three months of demonstrated stability from the last change in treatment regimen (medication, either new or discontinued, or dose changes).
30. Mental health conditions that pose a substantial risk for deterioration and/or reoccurrence of impairing symptoms in the deployed environment.
31. Chronic insomnia that requires the use of sedative hypnotics/amnestics, benzodiazepines, and antipsychotics for greater than three months.

32. Psychiatric hospitalization, suicide attempt, or enrollment in a substance abuse program within the last 12 months.

Selected medications that require a profile:

1. Blood modifiers:
  - a. Therapeutic Anticoagulants: warfarin (Coumadin®).
  - b. Platelet Aggregation Inhibitors or Reducing Agents: clopidogrel (Plavix®), Anagrelide (Agrylin®), Diabgatan (Pradaxa®)
  - c. Hematopoetics: filgrastim (Neupogen®), sargramostim (Leukine®), Erythropin (Epogen®, Procrit ®).
  - d. Antihemophilics: Factor VIII, Factor IX.
2. Antineoplastics (oncologic or non-oncologics use): e.g. antimetabolites (methotrexate, hydroxyurea, mercaptopurine, etc.), aromatase inhibitors (anastrozole, exemestane, etc.), medroxyprogesterone (except use for contraception), interferons, etoposide, bicalutamide, bexarotene, oral tretinoin (Vesanoid®).
3. Immunosuppressants; e.g. chronic systemic steroids).
4. Biologic Response Modifiers (immunomodulators) e.g., abatacept (Orencia®), adalimumab (Humira®), anakinra (Kineret®), etanercept (Enbrel®), infliximab (remicade®), leflunomide (Arava®), etc.
5. Antipsychotics, including atypical antipsychotic medication (
6. Antimanic (bipolar) agents; e.g. lithium, valproic acid, carbamazepine, lamictal
7. Anticonvulsants, used for seizure control or psychiatric diagnoses.
  - a. Anticonvulsants (except those listed below) which are used for *non-Psychiatric* diagnoses, such as migraine, chronic pain, neuropathic pain, and post-herpetic neuralgia, are not deployment limiting as long as those conditions themselves are not disqualifying.
  - b. Valproic acid (Depakote®, Depakote ER®, Depacon®, etc.)
  - c. Carbamazepine (Tegretol®, Tegretol XR®, etc.).
8. Varenicline (Chantix®).
9. Benzodiazepines: Chronic use or newly prescribed: lorazepam (Ativan) alprazolam (Xanax), diazepam (Valium), clonazepam (Klonopin), etc.

10. CII Stimulants taken for treatment of ADHD/ADD: Ritalin, Concerta, Adderall, Dexedrine, Focalin XR, Vyvanse, etc.

11. Sedative Hypnotics/Amnestics: Taken for greater than three months for treatment of chronic insomnia: zolpidem (Ambien, Ambien CR), eszopiclone (Lunesta), zaleplon (Sonata) estazolam (ProSom), triazolam (Halcion), temazepam (Restoril), Flurazepam (Dalmane), etc.

12. Opioids, opioid combination drugs, or tramadol (Ultram®), chronic use (>90days).

13 Insulin and exenatide (Byetta®)