
DATA LINK

Your link to the Centralized Credentials Database

To keep you knowledgeable about current and emerging developments within your areas of expertise for the purpose of enhancing your professional development

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THANKS TO THE NAVY PAC FAMILY AND MEDICAL STAFF LEADERS FOR MAKING THE PAC CONFERENCE A SUCCESS

Thank you PAC Family, who together with the Medical Staff leaders attending the 2001 PAC Conference, *2001 A Privileging Odyssey*, contributed to the success of the conference.

This conference was BIGGER and BETTER with over 20 speakers, 23 presentations presented by individuals assigned to the Bureau of Naval Personnel (BUPERS), Naval Dental Centers, Military Treatment Facilities, operational green and blue, and BUMED. The attendees represented worldwide participation, both CONUS, and OCONUS. They came prepared to overcome the vast challenges of "air-travel."

The climate of the conference was one of challenge; an interactive learning environment. PAC and Medical Staff participation was HIGH; the Medical Staff was very involved with the issues presented, and supportive of the PAC community.

The case presentations were professionally discussed, addressing each issue. Each case presentation assisted the PAC community, and Medical Staff leaders, with future decision-making processes. The gain in confidence will assist the PAC and Medical Staff to offer advice and guidance in the management of difficult

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Editor: CDR (Ret) G. Irvine, Code O71

issues, often revolving around impairment, misconduct, or adverse privileging processes.

Consider what topics, speakers, type of conference, agenda items, etc., you want to see next year. Sandy and I are standing by ready for any and all recommendations.



**QUESTIONS...QUESTIONS...
QUESTIONS???**

There are several questions time did not permit us to discuss from the conference. Therefore, this section of the DATALINK is devoted to the discussion of questions not covered at the conference.

**1. Teleradiologist:
Mammography
Interpretation-Do the FDA
requirements need to be
gathered on the receiving
end should the FDA come to
review the receiving
command?**

No, it is not necessary to maintain two sets of FDA documents for physicians who interpret mammograms via the Teleradiology process.

The FDA mandates specific requirements for all physicians interpreting mammograms. The FDA, and the American College of Radiologists (ACR), websites have further information as to specific requirement.

The Diagnostic Radiologist Specialty Leader states it is inherent in the Navy's radiological process, any Radiologist interpreting mammograms must meet the FDA requirements.

Therefore, it is not required the ICTB address the FDA mammography requirements. Should a FDA or a JCAHO surveyor ask for specific documentation on a Teleradiology physician providing mammography interpretation, this information can be faxed to the receiving command for the surveyor to review.

**2. Is there going to be a
mechanism in the future to
answer inquiries adequately
meeting Navy standard?**

The Navy does not have a "standard" for the completion of inquiry letters. Whether the command uses the form provided, or in a letter, is the command's decision.

Some medical boards, e.g., Pennsylvania, will only allow you to use their form; the board will return the letter

with an explanation stating to complete the PA form.

The Naval Healthcare Support Office is not a "primary source" for education and training information. We will answer the inquiry, but for legal reasons we must state we are not the primary source for this information.

Current competency/Quality Assurance questions are answered as long as the PAR is in the credentials file.

NPDB questions are answered; if there is information about an adverse privileging action, medical malpractice payment, or something in the HIPDB, we will state there is something noted, the date of the NPDB, and tell the inquiring organization to seek additional information from the practitioner.

The above information is included in the answer back to the inquiry organization for every command the practitioner was assigned, as long as the PAR is complete and present in the ICF, and endorsement pages with clinical privileges noted are included.

If adverse privileging action was taken, this will be noted in the letter (it is a fact, objective--not hearsay). Remember, files with adverse action, malpractice claims, are forwarded to BUMED, MED-00L when the practitioner separates from the Navy. The organization is told to seek additional information from the

practitioner, or if appropriate to contact us.

The HSO cannot answer inquiries with subjective observations, or hearsay issues...facts only noted on the PAR, endorsement page, clinical privileging list, application, NPDB/HIPDB, etc. If the ICF does not address any legal issues, the organization is advised to contact BUMED MED-00L, and we supply the address.

The HSO cannot answer "employment" questions, because employment in the Navy is a personnel, administrative, issue, not a credentials/privileging issue. The commands where privileges were granted, and the dates of the appointment, can be given, it is on the endorsement pages, and on the PAR. However, when the practitioner actually raised his/her hand, and was sworn into the Navy, we do not keep these dates. A practitioner may be employed in the Navy several years, before ever seeking an appointment and/or clinical privileges.

An additional issue: It is difficult to provide an adequate inquiry response when the ICF is fragmented, or there are large gaps of information. The HSO Archive Section noted many incomplete ICFs, fragmented ICFs with whole years missing, and according to the PPIS privileges were granted. When this happens the HSO cannot provide an adequate response. Perhaps this information still exists at the

command, but it does not exist within the ICF.

3. Can CAPT Bryner's presentation be filmed and sent out to all command CO's?

It would be WONDERFUL if the HSO could answer "yes," but we cannot at this time. This is a very expensive, and time consuming process.

All Navy-wide videos must be approved by the Navy Media Center in Bethesda, Maryland. A request must be made, a script written by a scriptwriter, time scheduled to film, then review and modification of the video if needed. It is a year to two-year process.

Hopefully next year the conference can be filmed, and placed on the web for viewing.

4. Can the CCPD make the "Q" a part of the credentialing package for Reservists?

LCDR B. Hart, Head, CCPD states this is a situation where centralization of this process would not improve the process, and would add a significant amount of workload to CCPD staff. From the PAC point of view it is easy to understand why sending out dozens of Qs

might make sense, but multiplied across the Navy, it becomes a high undertaking for the following reasons:

- a) While the addition of an additional piece of paper to the CCPD application package is possible, it may not be feasible. Given the fact the CCPD has a difficult time just getting the PPIS and other information in a timely manner, expectations for the Q to be returned are low;
- b) Please consider the following scenario: Q is returned, checked for a signature and filed in ICF. When/if SNO requests an AT etc, the PAC requests an ICTB. This places the additional burden on the ICTB staff to locate the record, find the Q, fax it and the ICTB to the PAC, return the Q to the file, re-file the record. You have now added multiple steps onto the ICTB process, which will only slow it down. Multiply the delay if extra time is needed to find the record and/or Q.
- c) How long would the Q be good for? Many reservists don't do an AT every year, or do non-clinical ATs not requiring an ICTB. The Q could sit in the ICF for years without use.
- d) 2nd scenario - SNO does not return the Q with the

package. Now, would CCPD staff be forced to "hound" the reservist to return it? Would failure to return the Q result in 2nd notice/non compliance? At what point do we say, sorry, we've spent too much time trying to get a piece of paper that we don't require anyway?

A better suggestion, at least from my viewpoint, is for the RLO to send a Q out when they issue the BCN. It would be given to the reservist by the RESCEN cutting the orders, and could be faxed back immediately to the MTF.

5. Next year please place microphones with stands in the room for attendees to ask questions.

We will try; obtaining the service depends on availability of equipment. For this years conference we could get the microphones, but the amplifiers were unavailable. The lapel microphone works well, because it is attached to its own amplifier. We will work on this next year: keep your fingers crossed!

6. Perhaps a separate conference for Chair ECOMS

and Credentials Committee in the future?

This is a priority for the HSO. Unfortunately due to funding issues, a Medical Staff Leadership conference addressing credentials/privileging/adverse action is on hold.

We considered a VTC conference with the Medical Staff Leaders, but it is very difficult to have an intense dialogue among several participants at once during a VTC.

A phone conference would not provide increased value. It would be very difficult to discuss the completion of the PAR, using examples, unless the exact examples were forwarded to all attendees.

Adults take in knowledge via the visual, hearing, and/or tactile route. During a phone conference, visual people go crazy (nothing to see to use as a reference point); hearing people love phone conversations. When the conference is given either in person, or via a VTC, the needs of the visual, hearing, and tactile (surrounded by fellow professionals increases the knowledge intake...more discussion, more examples, immediate feed-back) individuals.

This issue remains high on our "To-Do" list.

7. Does the OMR replace the Risk Management Screen for Navy Hospital Jacksonville?

Mrs. Judy Stapleton, Quality Manager, NH Jacksonville, states it depends upon what the Risk Management Screen covers at the command.

At NH Jacksonville, the OMR is used strictly for clinical issues. However, the OMR could relate to a Risk Management (RM) issue, if so, the OMR is forwarded to RM for further investigation.

The MVR is used for non-clinical issues, and is coordinated through RM.

In the future, NH Jacksonville wants to consolidate both forms into one form appropriate for any incident: QM would route the consolidated form.

8. What does a practitioner do when he/she does not want to perform a Core privilege?

Ok...the answer is it depends on "why" the practitioner does not want to perform either a whole Core or a skill out of the Core.

WHOLE CORE

The BUMEDINST 6320.66C, main body of instruction, para 10.e., states eligible health care practitioners are required to request a professional staff appointment, and the **broadest scope of core and supplemental privileges** commensurate with their level of **professional qualification (e.g., education & training)**, current competence, etc.

This means a Family Practitioner, residency trained, may or may not be board certified, **cannot** request PCMO (GMO) privileges. That would not be within Navy standard. The FP must be granted FP privileges as the basic set of Core privileges.

WITHDRAWAL OF WHOLE/MAJORITY/PART CORE

BUMEDINST 6320.66C, Section 2, para 7.c, states a practitioner **cannot withdraw** a core privilege(s) if the practitioner is the subject of allegations of substandard care or misconduct, or for any other reason (does not want the Core (or a part of the Core) anymore), except to correct administrative errors, e.g., the Medical/Dental Staff granted the wrong set of privileges.

Practitioners who do not maintain required qualifications, or do not request such privileges are

subject to processing for separation for cause for military personnel, or for administrative action including termination of employment for civilian employees.

SUPPLEMENTAL PRIVILEGES

Supplemental privileges come and go without any untoward adverse action outcome.

However, if there is an issue of substandard care, or unsafe care, the practitioner should be given the opportunity of remedial education/training/experience to improve the ability to practice this skill. Perhaps the practitioner just requires additional cases with oversight provided.

COMMANDING OFFICERS

Commanding Officers due to the nature of their administrative duties may have difficulty maintaining current competency in a requested specialty. Should a CO desire to remain clinically active, the CO can request PCMO privileges regardless of specialty.

However, if a CO is granted a specialty Core, the CO cannot withdraw that Core due to substandard, or unsafe patient practices. Once a Core is granted, all of the credentials and privileging

processes/policies are in place and must be adhered to.

What happens if a specialty is granted to a CO, and the CO does not have the clinical time to see enough patients (volume), with the appropriate Core (patient case mix), to equate to a majority of the Core? The Core cannot be withdrawn. The CO would keep the Core until the Core expires. The PAR would state something like, "Did not see patients," or "Did not see the volume of patients to equate to a majority of the Core." In both of these cases, the Medical/Dental Staff would state, "Cannot attest to the current competency of this practitioner."



IF A PROVIDER IS ON AN OPERATIONAL EXEMPTION, DOESN'T OBTAIN A LICENSE PRIOR TO DEPLOYMENT, AND THE EXEMPTION EXPIRES THE MONTH AFTER HE/SHE ARRIVES OVERSEAS:

-
1. Do you allow him to deploy?
 2. Plan of Supervision?

This individual probably should not deploy if not licensed; **however**, there are several variables to this question:

1. The minute the operational exemption expires; this provider will be placed under a Plan of Supervision.
2. The provider who has **not** passed either USMLE I, II, or III is **not** eligible for an operational exemption.
3. If this individual has not passed either I, II or III, should not deploy, patients will be at risk if this is a single billet (one-holer) assignment.
4. If this is a deployed one-holer assignment, the Medical/Dental staff needs to consider supervision issues, e.g., is the supervisor close within personal reach (reach out and touch); is the supervisor within phone contact; is there another health care treatment facility nearby to provide supervision; in an emergency what physician can rescue, etc. Again, the PA or IDC community does not count...we are discussing physician issues.
5. If this individual deploys with another

physician (or a group of physicians—not IDCs or PAs), that physician can be the supervisor. In this case deployment would probably not be a problem.

Patient safety is the guiding principle the Medical/Dental staff must discuss and use in their decision making process.

1. A PRACTITIONER DOES NOT SHOW CURRENT COMPETENCE FOR A CORE PRIVILEGE, DO YOU NEED A PLAN OF SUPERVISION?
2. WHAT IF THEY NEVER HAD TEACHING/TRAINING IN THE CORE PRIVILEGE?

This frequently happens especially since the whole Core is granted, and the Navy's policy does not expect the practitioner to be currently competent in the whole Core.

A Plan of Supervision (POS) **CANNOT** be used if the privileges are granted. A POS for a privileged practitioner in the granted specialty would be an adverse action.

The above holds true whether or not the practitioner had education/training/experience in that one privilege (skill) out of the whole Core.

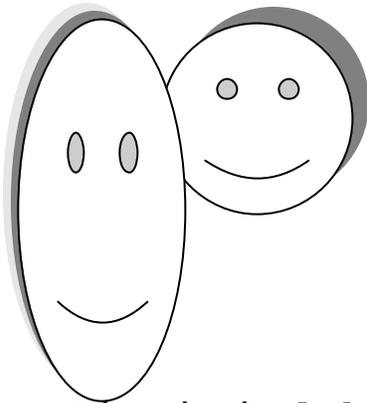
Therefore, how does the Medical/Dental Staff manage this issue? The following questions need to be considered:

1. Is this one skill required by the command?
2. If so, assess the reason for the apparent lack of current competency in that one skill. It may be as simple as the practitioner has not practiced that skill in the last two years.
3. Is it a lack of education, training, experience, unfamiliarity with the procedure, and/or lack of desire to do this skill?
4. Education and Training are **never** considered adverse. Therefore, if there is a lack of education/training/experience, place the practitioner under a formal Performance Improvement (PI) Training Plan. State in the plan who will provide the oversight, education/training/and/or experience for this individual, and where this will occur. State how many cases must be completed before

current competency can be ascertained? If a formal classroom type of environment is required, e.g., additional AEGD courses, GME courses with clinical application, get this individual to those classes.

5. If the skill is not practiced within your facility, and the practitioner wants to gain or maintain current competency, TAD may be the answer, but this is a command decision.
6. If this skill is facility restricted at your command (your command cannot support this skill), the Medical Staff can either TAD the individual to another command who supports this skill; or, do nothing. Remember, the Navy policy does not require our practitioners to be currently competent in 100% of the skills.
7. At a future command where this skill is required, the Medical/Dental staff will bring the practitioner "up-to-standard" for this skill prior to letting this practitioner practice this skill, independently.





The question is included in the answers below.

Yes, the SG is the Corporate Privileging Authority (PA) for Navy Medicine.

Yes, Chief, BUPERS, is the PA for the Family Service Centers (FSC).

Yes, the Navy recognizes only the 24 medical boards recognized by the American Board of Medical Specialties (ABMS). No others!

Yes, the Navy recognizes only the osteopathic physician boards recognized by the American Osteopathic Association (AOA).

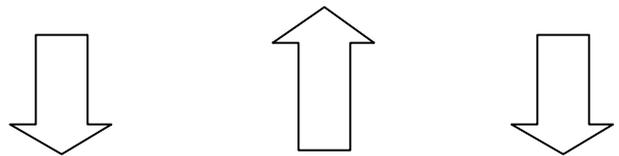


DO WE NEED TO PSV CERTIFICATES FROM CREDENTIALING INSTITUTION SUCH AS ANCC?

Definitely. It is the American Nurses Credentialing Center's

(ANCC) or the certification from the specialty professional organization's board that make the Advanced Practice Nurse (APN) an APN. It is not the nurse's license that allows independent practice.

Therefore, whenever an APN, or an Allied Health Specialists has a "credential" from a specialty professional organization, this must be PSV'd. It must be PSV'd at the time of renewal also.



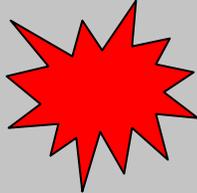
TO DO A MODIFICATION OF THE NEW INSTUCTION CORE AND SUPPLEMENTALS FOR ALL OUR PROVIDERS, DO WE FOLLOW MR. J. FENNEWALD'S PROCESS?

Yes, Jeff's process is in accordance with Navy standard:

1. Do a modification to add or delete privileges, or an entire core.
2. Use the Appendix K, specialty privilege sheet, endorsement page, letter or PAR attesting to current competency for privilege(s) requested, and the additional education/training and/or experience.

3. Modifications do not alter the expiration date of the current staff appointment.
4. Forward request to modify using the same process as your renewal of active staff.

**SECURITY OF
RECORDS (COMPUTER
ACCESS-EMAIL). ADP
DEPT HAS ACCESS TO
CREDENTIALS FILES
ON PC**



to the computer and assorted systems; **however**, ADP MUST NOT have access to the **practitioner information** contained within CCQAS.

You, the PAC, need to restrict access of this **practitioner information**, and set specific securities in CCQAS.

Contact Don Riggs to do this at (904) 542-7200 X8158 DSN 942

ARE PA'S LIPS OR NOT; I AM STILL CONFUSED. WE SAID THEY PRACTICE UNDER A LICENSED PHYSICIAN'S

CREDENTIALS – THUS HOW CAN THEY BE “LIPS”

It is confusing is it not? The facts are the following:

- At the national level, the community of U.S. PA's does not desire to reach independent status.
- No, in the strictest sense the PA is not a LIP, because the PA is not an independent practitioner.
- While we do “privilege” the PA, the PA is not truly an “independent” practitioner; the PA practices under the supervision of the physician supervisor.
- In the Navy, many of our PA's are assigned to a one-holer assignment, e.g., ship. While the PA may be practicing “independently”, meaning without any direct supervision, the PA is not an “independent” practitioner. Somewhere there is a physician who is the supervisor of the PA who is practicing at a one-holer assignment.

IS SUMMARY SUSPENSION ADVERSE?

Summary Suspension is an adverse action, but it is not

reported to the NPDB. A Fair Hearing is required when anyone is placed into a Summary Suspension.

What is reported is the Fair Hearing final decision. Therefore, if the Fair Hearing decision is adverse, this is reported to the NPDB. If the Fair Hearing decision is to reinstate privileges (non-adverse), then nothing is reported to the NPDB.

WHY ARE RESIDENTS NOT PRIVILEGED?

The resident is a student/trainee. The resident is not a licensed independent practitioner (LIP) while in training. The resident may be licensed while in residency training, but is not an independent practitioner while in training for a specific specialty.

Only LIPs are granted privileges. Not students, even if licensed. Students are under different standards, policies, and procedures.

Training institutions do not privilege residents for the skills they are learning in training (the student has not completed the education/training, or has he/she successfully completed the course of instruction).

However, a licensed resident, who may also be in training, may be privileged for PCMO privileges. During the time of

residency specialty training, the resident is not in training for PCMO skills; therefore, during training may be privileged for PCMO privileges.

These privileges have nothing to do with the training program. This is why the Navy states a letter from the Program Director is required prior to the privileging of any resident/fellow so as not to interfere with the training.

WHAT IS THE PROCESS FOR AN ACTIVE DUTY ENLISTED DENTAL HYGIENIST GOING TAD?

The Dental Hygienist, civilian or active duty is not a LIP, is not granted privileges. TAD is TAD. The sending command would forward an ICTB to the gaining command, noting education, training, and current competency. The Active Duty hygienist is considered a Clinical Support Staff member. When a RN goes TAD, an ICTB is forwarded; when an RDH goes TAD an ICTB is forwarded.

DO WE SEND OCCURRENCE REPORTS ON RESERVISTS TO THE CCPD?

No. The actual occurrence screen cannot be copied, nor sent out of a command. If the occurrence resulted in

counseling and/or an informal investigation or JAGMAN, this will be noted on the PAR. If the occurrence was outside of the standard of care, but not noted on the PAR, an email may be forwarded to LCDR Hart, Head, CCPD, with a synopsis of the occurrence.

ARE PARS REQUIRED ON WEEKEND DRILLER WHEN OUR STAFF IS NOT THERE TO OBSERVE THEIR PRACTICE?

Yes. It is the responsibility of the Medical/Dental staff to ensure patients coming into their command are receiving the standard of care as set forth by the Medical/Dental staff.

It does not matter what the status of the patient is, e.g., active duty, reservist, humanitarian, beneficiary, etc., when the patient enters your facility or branch clinics, etc., this patient is yours. It does not matter if a reservist physician is attending to a reservist patient; this reservist is yours, and the patient is yours.

The Medical/Dental Staff must initiate a process to guarantee appropriate peer review for any LIPs within the command during working hours, after hours, week-ends, holidays, full moon, rainy season, etc.

WHY KEEP COPIES OF APPLICATION & STATEMENT OF UNDERSTANDING AFTER THE DEA CERTIFICATE IS RECEIVED?

Maintaining copies documents the whole process in case any questions should arise. It is not probably necessary to keep copies of the application & statement of understanding in the ICF (only the certification); but, these documents should be kept (not thrown-away), and follow the practitioner to each duty station.

Let us look at the following situation. A physician/dentist prescribes medications for a non-beneficiary who dies from the wrong medication. There is an investigation. The physician/dentist states, "This command did not tell me there were restrictions as to who I could prescribe for." Your command can show documented proof the physician did receive the appropriate information by showing the investigator the signed Statement of Understanding. If you threw this documentation away...there goes the case.

IS THERE A COMPLETE PACKET OF INFORMATION ON THE DENTAL HYGIENIST

**E.G., EVERYTHING
NECESSARY TO GET THE
RDH CHAIR-SIDE?**

No. Network. Contact the PAC at one of our NDCs. Our NDC PACs are eager to provide any assistance needed to help you initiate the best process around for your RDH community (even if it is a community of one).

**AN MTF RECEIVED A TYPE I
FOR FAILING TO OBTAIN AN
NPDB ON A NURSE
PRACTITIONER. WHAT IS
THE REQUIREMENT FOR
THE NP NPDB?**

All LIPS are required to have a NPDB query prior to hiring, employment, and every two years.

To be queried, the practitioner must possess a license. If unlicensed, the query is cancelled by the NPDB software before the query is run.

In the Navy some of our LIP communities are not licensed, including many of our Nurse Practitioners. The Navy standard does not require a NP license, because not all States license the NP within the State.

We cannot query on the national, or professional

specialty certification, e.g., ANCC or PA certification.

BUMED is working on this issue. Until a decision is made at the DoD level, we cannot query the unlicensed LIP.

**CAN WE JUST DECIDE ON
ONE REASONABLE & LEGAL
& PRACTICAL METHOD TO
DO PAPERWORK ON ALL
GRADUATING INTERNS?**

I am sorry, but I do not know what the issue is. Please review the following:

1. If the intern is unlicensed upon graduation, the paperwork is a Plan of Supervision.
2. If the intern is licensed, upon graduation the paperwork is the application package. You will probably only have the MD certificate, the intern certificate, and if licensed, a copy of the license to verify. If the intern arrives from a civilian training institution, you will also need a letter from the Program Director attesting to current competency for privileges requested (in the inquiry letter to the Program Director it is best to include the PCMO privileges). Ask the Director to check off

those privileges the graduated student was proficient in during training.

3. If the intern has some prior medical experience as a physician, then you would also need current competency documentation on that experience.

If there are additional questions, please do not hesitate to contact me, Georgi Irvine.

Where do I find the requirements for the non-DOD trainee coming into the facility to practice?

Please refer to 6320.66C, Section 2, para 18, Health Care Services Provided by Non-DoD Trainees.

First check to see if there is a MOU/ISSA between your facility, and the local civilian training institution, e.g., college, university, etc.

The MOU should state the requirements for oversight (supervision); type of evaluation required during the training--how often the student is evaluated--type of form to be used, who the supervisor(s) will be; type of supervision; who is responsible in case of an adverse outcome or untoward event (indemnification); what type of information the Navy command requires from the

training institution on each student, e.g., demographics, scope of practice, year in training, training institution contact for any student problems, etc.

The Navy command should have an official letter from the training institution verifying the name and credentials of each student; point of contact at the institution; length-hours-dates of training, etc. A copy of this letter should be placed in the student's file.

It is the command's decision who will maintain the student files, e.g., the PAC or GME. Since these are students, these individuals do not come under the Medical Staff standards of the JCAHO, except the standard regarding supervision of students, or "house staff."

Several PACs asked for a copy of the CCPD Telephone Verification form: It is located below

NH504XINST 6310 1F
12 Mar 95

NAVAL HEALTHCARE SUPPORT ACTIVITY
CENTRALIZED CREDENTIALS REVIEW & PRIVILEGING DEPARTMENT
BOX 540 (CODE 07)
JACKSONVILLE, FL 32213-0140
PHONE (800) 555-5494 - FAX (904) 542-7210

TELEPHONE CREDENTIALS VERIFICATION

AUTHORITY: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
PURPOSE: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff provider competence.
ROUTINE USE: Information may be released to government boards or agencies or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
DISCLOSURE IS VOLUNTARY. However, failure to provide information may result in limitation or termination of clinical privileges.

NAME:

SSN: CORPS:

EDUCATION and TRAINING

Document:

Institution:

From: To:

BOARD/PROFESSIONAL AGENCY

Document: Number:

Institution:

Issued: Expired:

LICENSURE **CURRENT STATUS**

State: Number: ACTIVE

Institution: INACTIVE

Issued: Expires: Good Standing? YES NO EXPIRED

VERIFICATION COMPLETED

Verifying Official - Institution	Verifying Official - HSO JAX
Name: <input type="text"/>	Name: <input type="text"/>
Position: <input type="text"/>	Rate/Rank: <input type="text"/>
Institution: <input type="text"/>	Date: <input type="text"/>
Telephone #: <input type="text"/>	Signature: <input type="text"/>

FEE REQUIRED/FORWARDED **WRITTEN REQUEST/SENT**

NHSO4XINST 6310 (0007)

P.S. If you want a blown up version: contact me via email.

What follows is the NDC
Great Lakes' policy
authorizing provision of RDH
clinical services. Jan gave
permission to disseminate
this policy to the PAC Family

NDCGLAKESINST 6320.2F

***Clinical Support Staff:
Authorization to Provide
Clinical Services***

1. **Background.** Dental Hygienists are in the category

of Clinical Support Staff. Per BUMEDINST 6320.66C these personnel are included in the definition of health care providers, but are not included in the definition of health care practitioners, and are required to be licensed. Only health care practitioners are granted staff appointments with clinical privileges. Whether Contract, Government Service (GS), or Military, dental hygienists, by virtue of their credentials, are allowed to practice within their scope of care as authorized by the Privileging Authority.

Although contract and GS dental hygienists working in a military DTF are required to have at least one active license in any state, military dental hygienists are not required to maintain an active license while working in a military DTF. Military dental hygienists are most strongly encouraged to acquire a current state license as soon as possible after

completing their dental hygiene education.

2. **Dental Hygienist Credentials.** Requirements are discussed in the text of this instruction.

3. **Plan of Supervision.** Per BUMEDINST 6320.66C the following elements of supervision are established:

a. The **Scope of Care** permitted is specified by the following duties and responsibilities enumerated.

b. The **Evaluation Criteria** are specified in the text of this instruction and comprise the information utilized to complete the periodic PAR generated for each dental hygienist.

c. The **Frequency of Evaluation** occurs during ECODS review of the two year periodic PAR generated for each dental hygienist.

4. Dental Hygiene Duties and Responsibilities. The following duties and responsibilities are enumerated from the Statement of Work (SOW) section of the Individual Set Aside (ISA) contract type utilized by the Healthcare Services Support Directorate of the NA VMEDLOGCOM at Fort Detrick. There is no other reference from BUMED on the so listed duties and responsibilities. Actual health care worker clinical activity will be a function of the Commanding Officer's credentialing process and the overall demand for hygienist services. Health care worker productivity is expected to be comparable to other dental hygienists assigned to the same facility and authorized the same scope of practice.

a. The health care worker shall be clean and maintain their work area to meet the clinic's standards and may be assigned other duties as directed by the Commanding Officer, consistent with the normal duties of a dental hygienist.

b. Review patient's medical and dental history for evidence of past and present conditions such as medical illnesses and use of drugs that may complicate or modify dental hygiene treatment.

c. Obtain blood pressure on patients presenting for treatment.

d. Inspect head and neck, examine mouth, throat and pharynx for evidence of disease such as oral cancer and/or soft tissue pathosis.

e. Review and complete preliminary dental health screening for periodontal recall patients. Oversee and manage periodontal recall programs.

f. Examine teeth and surrounding tissues for evidence of caries, periodontal disease and then record findings.

g. Expose, develop and interpret radiographs to identify tooth structure, periodontal support and other abnormalities such as periodontal bone loss, periapical pathosis, caries, defective restorations, improper tooth contours and contact relationships.

h. Refer suspected medical conditions, hard and soft tissue abnormalities caries, periapical and periodontal pathosis and traumatic or suspicious lesions to the dental officer for evaluation.

i. Develop dental hygiene treatment plans for patients including assessment of the problem, type and extent of treatment required and sequence of appointments to complete treatment.

j. Perform complete oral prophylaxis and non-surgical periodontal treatment on ambulatory patients using ultrasonic and hand instruments.

k. Provide oral prophylaxis, preventive dentistry procedures and non-surgical periodontal therapy to active duty military personnel and eligible beneficiaries.

l. Perform pit and fissure sealant applications.

m. Perform subgingival scaling, root planing and curettage under local anesthesia administered by dental officer; if the appropriate background training and credentials exist administer local infiltration and/or block anesthesia.

n. Polish teeth and apply disclosing solutions, fluorides, desensitizing agents and other topical medications to the teeth for the purpose of controlling caries and dentinal hypersensitivity. Apply prescribed topical medications.

o. Clean and polish removable dental appliances worn by patients.

p. Comply with applicable quality assurance standards for preventive dentistry.

q. Instruct patients, individually and in group seminars, in proper oral hygiene using a variety of aids such as models of teeth, slides, toothbrushes, floss, disclosing tablets, mirrors, interproximal brushes and rubber tips.

r. Plan and adapt oral home care techniques to the specific need of the individual patient.

s. Explain causes and periodontal disease to patients and the importance of nutrition in maintaining dental and systemic health.

t. Monitor, supervise and assist in training dental technicians involved in direct patient care to perform scaling, prophylaxes, polishing procedures, fluoride applications and oral home care instructions.

u. Record condition of teeth and supporting tissues, type of therapy provided and progress notes.

v. Clean and maintain instruments and insure their sterility.

w. Treat acute necrotizing ulcerative gingivitis.

x. Maintain a record of patient treatment and number of patients treated.

5. Expanded Functions. Administration of local infiltration and/or block anesthesia is not a required qualification; however, if the appropriate- background training and credentials exist,

the Privileging Authority may grant this expanded function.

a. This expanded function must be within the scope of current expected duties.

b. Completion of minimum requirements as listed below:

Expanded Function

Local Anesthesia

Authorization

Evidence of completion of training

Renewal

Evidence of 2 Cases and ongoing completion of clinical supervision every two years.

6. ECODS ensure all Clinic Directors, appropriate Department Heads, and all dental hygienists thoroughly review and become familiar with this Authorization. Implement this Authorization for Clinical Support Staff to Provide Clinical Services effective immediately.

REMINDER

Quarterly Report Due

1 Jul 01