
DATA LINK

Your link to the Centralized Credentials Database

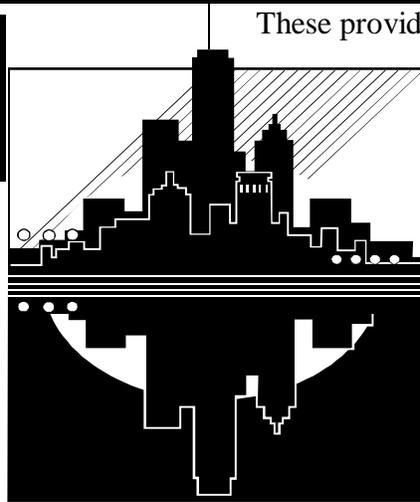
To keep you knowledgeable about current and emerging developments within your areas of expertise for the purpose of enhancing your professional development

Volume 1 Issue 2

July 1997

CCQAS ENTRIES

We initiated an ad-hoc report on Registered Dental Hygienists (RDH) to extrapolate some specific data. Upon review of the report, several individual names were noted who should not have been placed in CCQAS, e.g. medical operative assistants, dental assistants, etc. These individuals have credentials; but, they are not licensed, and they are not considered "clinical support staff." Only licensed health care providers, or providers whose certifications equate to independent practice, are placed in the CCQAS database. There is an exception, Navy enlisted DTs' (DT 8708) who have graduated from a Dental Hygienist program. When you think it through, these individuals are not really an exception, because their national certification equates to independent practice as a RDH. Who comprises the Navy's "clinical support staff?" Only 3 categories exist: pharmacist, registered nurse, and RDH.



These providers receive Individual Professional Files (IPF), and are tracked by the Professional Affairs Coordinator (PAC), and are placed in CCQAS. Your facility will have many additional providers who are "credentialed"; but, they are not placed into CCQAS and they do not have an IPF, and the PAC is not responsible for them (as a rule). These "credentialed" providers are considered to be employees of the hospital, clinic, or dental clinic. As employees at your

command, they come under the usual performance improvement and competency requirements called for in the JCAHO manual. Under the Leadership JCAHO standards (LD.2.5), it is the Department Head or Director of the Department who determines the qualifications and competence of department personnel who provide patient care services and who are not licensed independent practitioners (LIPS). These individuals do not come under the medical staff standards, so there is no medical staff standard requiring the same type of primary source verification (PSV) you do for your LIPS. It is up to your organization to decide what constitutes competency, and proof thereof, for these providers. They do not have an IPF and are not placed in CCQAS. It is up to the facility how they will track and trend these providers. If they want to develop a separate database to contain these providers, OK; but,

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Editor: CDR G. Irvine, Code OOA

Published by HSO, Jacksonville, FL.

32212-0140

they are not to be input into CCQAS. Additionally, these providers should have a PI file, but not an IPF and are not to be included with the PACs credentials files. When these providers are added to CCQAS, they skew the data. This means headquarters decisions will be based on wrong and/or misleading data. If you have specific questions and/or problems please call me at (904) 542-7200 Ext 8111.

NPDB QUERY MISSING? Don Riggs

Skipped NPDB Queries?!

You've probably had a provider in CCQAS, that was skipped when the NPDB queries were performed. This is possible, if key information is missing in the providers CCQAS record, at the time you send in your CCQAS Quarterly Report. The required (key) fields are Lastname (LNAME), Firstname (FNAME), Date of birth (DOB), School of qualifying degree (PR_SC_AT), Graduation date (CPLT_DTE1), License number (L1_NUM), State of license (L1), Field of license (F_LIC1). If these fields all contain correct, and valid information, then the NPDB query should be successful. If not, then a query on that provider will not even be attempted. Make yourself up an AD-HOC report, containing these fields, and give them a looking over - before you submit your next CCQAS Quarterly Report.

CCQAS v2.0 Conversion

Here is a heads up on the CCQAS v1.0 to CCQAS v2.0 conversion. (a) Only one license per state, per field of license, will be allowed - you can not have two licenses in one state under the same field of license. So, if you have put Certifications up in the Licenses area, and you have the same state and field of license - then the second (third, forth, etc.) will be rejected (not

added to the CCQAS v2.0 record). You need to move those Certs down to the Certification fields. (b) Only one Professional Affiliation per hospital, under the Other Affiliations section. Subsequent entries for the same hospital, will be rejected (not added to the CCQAS v2.0 record).

SELRES EXTENSIONS LCDR S. O'Connor

The JCAHO has approved extension of clinical privileges up to two (2) ninety (90) day periods.

Refer to attachments 1, 2, and 3.

CRITERIA FOR CREDENTIALING ACTIVE DUTY DENTAL HYGIENISTS (DT 8708) AND INPUT INTO CCQAS

CDR G. Irvine, Don Riggs

Now that our commands are starting to receive graduates from this program, the Dental Hygienist, DT 8708, Navy Enlisted Classification and Training Program, several questions have been asked. By the time these individuals arrive at your facility, they will be Registered Dental Hygienists (RDH); but, they may or may not have state licensure. These individuals are clinical support staff and require an IPF.

I have included a listing of the credentials each RDH must have requiring primary source verification (PSV):

- a. Dental Hygiene National Board Certification.
- b. Associate of Science Degree in Dental Hygiene...a certification.

c. clinical Board Certification to be called a RDH.

State licensure is desired, but not a mandatory standard; therefore, if someone arrives at your command and has failed an attempt at state licensure, this will not affect their status as an enlisted dental RDH. State licensure is not required. If state licensure is desired, the individual must pay for the state licensure themselves.

CCQAS INPUT OF NAVY ENLISTED RDH INDIVIDUALS

Currently, there is no consistency in the way we input these individuals (Navy enlisted DTs who are RDHs) into CCQAS. This makes it very time-consuming and difficult to do any ad-hoc reporting in a timely manner. Please input the data into CCQAS in the following manner:

- a. Screen 1 - SERVICE = N11
- b. Screen 1 - RANK = DT 1-2 or 3 (Pull down pick-list)
- c. Screen 1 - CORPS = OTH (Pull down pick-list)
- d. Screen 1 - AOC = leave blank
- e. Screen 2 - SPECIALTY = 9999 goes here. Now, when you input the last 9, the screen will come up "empty", just hit the "cancel" button and CCQAS will take the 9999. DO NOT PUSH "OK" BUTTON! The program will throw you out.
- f. Screen 5 - FIELD = 609 This 609 goes in either the licensure or certification field. The DTs will not have licensure, just certifications.

Don Riggs will be sending you a file which you can install which will enable you to input the

data as noted in a through f. The pick list will look like this:

Here is a list of ranks that will be added to the CCQAS picklist:

- DR - DENTALMAN RECRUIT
- DA - DENTALMAN APPRENTICE
- DN - DENTALMAN
- DT3 - DENTAL TECHNICIAN 3RD CLASS
- DT2 - DENTAL TECHNICIAN 2ND CLASS
- DT1 - DENTAL TECHNICIAN 1ST CLASS
- DTC - CHIEF DENTAL TECHNICIAN
- DTCS - SENIOR CHIEF DENTAL TECHNICIAN
- DTMC - MASTER CHIEF DENTAL TECHNICIAN

----- Don Riggs (904) 542-7200
x8158 / DSN 942-7200 x8158

**MEDICAL STAFF:
PI ACTIVITIES CDR G. Irvine**

At our smaller commands, our PACs do double duty...they function as PACs, but may also function as the PI Coordinator. Several questions have been asked regarding the nexus between organizational PI activities and the medical staff's responsibility regarding PI activities. So...here goes...hang on, it maybe a long trip!

*MEDICAL STAFF INVOLVEMENT
WHAT IS CLINICAL PERTINENCE?*

CDR G. Irvine

Clinical pertinence review (CPR) (no, not the resuscitation type) is a form of peer review. CPR is very important in determining not only

individual clinical competence, but as a part of the overall quality management plan for your facility, as an indicator of the quality of care your providers, as a whole, are providing. Since the medical staff governs itself, they are responsible for setting the standards/criteria for CPR. CPR can be done on inpatient, outpatient care; on specialty clinic concerns; on procedures or any particular treatments your facility does. The following are *examples* of CPR criteria: Appropriate medical history; summary of patient's psychosocial needs; relevant physical examination; appropriate conclusions or impressions drawn from admission H&P; correct treatment plan; correct therapeutic orders; appropriate informed consent; clinical observations including results of therapy noted; appropriate progress notes made by medical staff and other authorized staff; correct final diagnosis, appropriate discharge summary; results of autopsies; appropriate follow-up of patient problems, etc. These indicators should be written and understood by all members of the medical staff. Each department/clinic/unit may have their own set of CPR indicators or these may be included in the organizational medical staff indicators. There are a set of indicators *specifically* for the *medical staff* to monitor on every provider (as appropriate): Operative, other invasive and noninvasive procedure review; medication review with monitoring of adverse medication reactions; blood and blood component review; and, medical records review (CPR) indicators. The medical staff performance improvement program may wish to include the following data: Predetermined indicators; incident reports/MVRs/etc.; RM information; quality control measures; utilization measures; specific clinical outcome measures; trended information from organizational performance improvement activities, e.g. infection control outcome monitors; comparison to standards of care or practice parameters per either individual providers and/or departments doing the same treatments or procedures.

The medical staff may decide to do a "focused", PI, peer review on a provider (this is not an adverse action). Example: A Family Practitioner (FP) who has not practiced OB or Neonatal medicine in several years. No problem. ..adverse privileging action is *not* required here. The medical staff may assign the FP provider to the OB/GYN Dept to work directly with the OB/GYN practitioners for a specific period of time. At the end of that time an evaluation (PAR) is completed, and the practitioner is considered currently competent. This does not require a Plan of Supervision or any privileging action, your command is doing all of this under the Performance Improvement (PI) umbrella.

*PEER REVIEW OR FAIR HEARING?
IS THERE A DIFFERENCE?*

This question comes up often because the language in the 6320.67 uses these terms interchangeably. I see these two terms as two distinct terms with different provider outcomes.

PERFORMANCE IMPROVEMENT
PEER REVIEW

In the process of PI activities, the term "peer review" is the process by which practitioners of the same discipline evaluate the outcomes of PI related monitoring activities. Medical staff PI activities assure that when the findings of the assessment process are relevant to an individual's performance, the medical staff determines their use in peer review or the ongoing evaluation of a LIP's competence in accordance with the standards related to clinical privileges as defined by that command's medical staff and the JCAHO standards. This is not an adverse privileging action, in itself. In fact, one of the goals of the PI monitoring process is to maintain patient safety by keeping our providers out of the adverse privileging arena. As discussed previously, when a provider has a

problem or needs additional training, the provider can be placed under a focused PI review (not a Plan of Supervision), where additional education and training are given and the providers care is monitored closely until he/she achieves current competency.

FAIR HEARING PROCEDURES

The Peer Review Panel Procedure is the Fair Hearing process. The Fair Hearing (adverse privileging action) process *includes* medical staff peer review activities. So when we say we are taking a provider to Fair Hearing, this can result in an adverse privileging action. I hope this helps to clarify the definition of these terms and explain potential outcomes from their different processes.

Let us know if you need a flow chart or an outline of the Fair Hearing process to keep on hand as a reference.

CONTENTS OF PROVIDER'S PROFILES AND/OR CLINICAL ACTIVITY FILES (CAF)

The CAF is no longer required in the BUMEDINST 6320.66B; *however*, commands still need to maintain some type of provider reappraisal profile or files. In this day of increased technology, your command can decide upon the form of these files, and can decide who will be responsible for tracking and maintaining the information. Just be sure, at time of survey, everyone knows your process for retrieval of provider reappraisal information. It is easier if it is kept in one file (*not the ICF!*) in one designated place at your facility.

Provider reappraisal profiles (files) should contain the following information regarding:

a. Number and type of clinical services performed, patients seen (inpatient/outpatient).

b. Number and type of surgical/invasive/noninvasive procedures performed.

c. Rates of desirable and/or undesirable outcomes.

d. Relevant trended information from medical staff PI activities.

e. Relevant trended information from organizational PI activities.

f. Comparison of rates with others in either the facility or at the Department level.

g. Results of any peer review activities.

h. Educational activities, CMEs (include *type of educational offering - a JCAHO standard and they may be checking on this one during your next survey*).

Remember, the PAR is the Navy's statement regarding the providers competency; therefore, the PAR should contain a written statement as to the competency of the provider for the privileges requested. Unless the competency statement specifically includes all supplemental(s) privileges, there should be an additional statement regarding the competency for the supplemental(s) requested.

ORGANIZATIONAL REENGINEERING

OR

WHERE OH WHERE HAS MY MEDICAL STAFF GONE?

This is an issue civilian institutions are dealing with right now. You will find this is happening

in many Navy facilities as well. For you all as PACs there is one danger you need to be alert to: Be sure the medical staff does not “reengineer” themselves out of their medical staff leadership roles and responsibilities. The policies and procedures in the Medical Staff Bylaws cannot be modified, changed, and/or ignored. This can cost your facility its’ accreditation.

WHAT IS REENGINEERING?

Reengineering is learning to work differently. It is not task based thinking, but a shift to process-based thinking. The essence of the reengineering approach is to manage businesses around their processes. Reengineering is based on the premise the “design of processes”--how work is done--is of essential importance. Reengineering is not restructuring, downsizing, or TQL.

HOW DOES REENGINEERING AFFECT OUR MEDICAL STAFF?

What exactly is the business of our Navy medical staff? Or, put another way...what are the “business processes” of our medical staff?

(a) Credentialing: Appointment, privileging, reappointment/reappraisal, and reprivileging. The medical staff must carefully assess candidates for appointment, privileges granted, and renewal of membership and privileges based on clinical competency. (b) Peer Review and the Committee Structure: Care is evaluated *continuously* by the medical staff performing such functions as: Surgical Case Review; blood and blood component usage review; drug usage review; medical records review; pharmacy and therapeutics review; utilization review; and infection control. These functions do not need separate committee to perform them. The JCAHO Accreditation Manuals require only ONE committee--THE MEDICAL EXECUTIVE COMMITTEE OR

ECOMS/ECODS. The Navy Medical Staff Bylaws contain the necessary procedures and safeguards to provide for substantive and procedural due process. This CANNOT be aborted by any reengineering/restructuring process. Additionally, this process SHOULD NOT be demoted to a "procedures manual" concept within your facility: This violates the JCAHO standards. Also, it would cause the medical staff to lose two other important protections: (i) many courts have held that bylaws, not policy documents, are a contract; therefore, any items moved out of the bylaws will not be protected per contract theory; and, (ii) the JCAHO standards prohibit unilateral amendment of the medical staff bylaws; therefore, items not in the bylaws are not protected against unilateral amendment. Very important, since the bylaws are the vehicle by which our medical staff governs themselves.

DEPARTMENTAL RESTRUCTURING

Diminishing the number of departments is restructuring, not true reengineering. This can take many forms:

(a) A Primary Care, Acute Medical/Surgical, and Specialized Services form; or, (b) A Medical, Surgical, Maternal/Child form, or (c) Dept of Medical Services, Dept of Surgical Services. There are many different forms for restructuring our organizations.

What must NOT be done is: The organization (facility) cannot organize themselves out of a medical staff! Civilian facilities are having this problem. The medical staff structure must be maintained and Headed by the medical staff leadership. A clinical support staff RN cannot Head a medical staff function. A clinical support staff RN can be an administrative Head of a Dept, Unit, or Service, but cannot Head any part of the medical staff function in that Dept, Unit, or Service. In advising your medical staff...the

medical staff must maintain the medical staff leadership structure to carry out the business of the medical staff, e.g., credentialing, privileging and peer review. Also remember, "peer review" means just that, review by a peer. A RN is not the peer of an MD. If a RN peer reviews physicians, the physicians could lose protection under the Health Care Quality Improvement Act of 1986, because in essence, there is no peer review if an RN evaluates the competency of a physician. Since the PAR is the Navy's competency statement for our providers; and, since a RN cannot evaluate the quality of medical care a physician renders, a RN cannot complete the PAR. A civilian institution in the West was using RNs to evaluate (via the peer review process) the medical staff...No can do!

AS THE PAC, WHAT IS MY RESPONSIBILITY AT THIS FACILITY?

If you hear rumors of an reorganization\restructuring\reengineering going on, or being contemplated in your facility, contact your Chairman of ECOMS/ECODS and discuss what this means as far as your medical staff. Make sure the medical staff leadership structure remains in place. ECOMS\ECODS must remain in place (remember, if your command is thinking about changing the name of the ECOMS/ECODS, the bylaws call for it to be called ECOMS/ECODS. Anyway, it must be very CLEAR this committee is the MEDICAL EXECUTIVE COMMITTEE, not a professional staff committee. The ECOMS/ECODS is there to carry out the business of your medical staff, NOT to carry out the business of all of your professional staff. In small commands the whole medical staff maybe the ECOMS/ECODS. Call me if you have any questions. The other medical staff leaders cannot abort their own peer review activities...your facility must maintain a structured mechanism for the business of the

medical staff at all levels. As the PAC, you may need to give a class to your medical staff regarding their duties and responsibilities as members of the Navy's Medical Staff and include medical staff leadership responsibilities as well. I know if faced with this issue, all of you will figure out the best way for your command to meet the medical staff needs of both Navy and JCAHO standards, and communicate this to your medical staff leadership.

WOMEN'S HEALTH NURSE PRACTITIONER

Name Change Alert: The OB/GYN Nurse Practitioners have changed their title to Women's Health Nurse Practitioner. If you need the new Women's Health Nurse Practitioner Core Privileging sheet, let me know and I will fax it to you. It is in the BUMEDINST 6320.66B.



**3rd QUARTER
UPDATES
DUE
TO DON RIGGS
30 JUN 97**

**CREDENTIALING AND
PRIVILEGING
CONFERENCE 4-7
NOVEMBER 1997**

S. Banning

The Credentialing and Privileging Conference is coming along. Some of you have been contacted to give a presentation and truly want to make this YOUR conference. If there is some particular item that you would like to present, let

**NEW PAC
TELEPHONE
DIRECTORY**

me know. This year, with your help, we will be awarded CEUs for the conference. To do this, I must have your presentation overheads (Power point, xerox handouts, etc.), CV, goals and objectives and a copy of your course content in time to present to the CEU Coordinator. She has requested all information 8 weeks prior to conference, so that will make it around the 1st of September. I need your information about 3 weeks before that so that I can arrange the program. I have set the cutoff for submission as 15 August. You would be surprised how the

creative juices start flowing once you get into it. A nice letter will go back to your command and would look great on your Fitrep or Appraisal.

REGISTRATION will begin on 15 July and close on 15 October. ALL registration will be done in writing this year. You can either fax me your registration at (904) 542-7209 (DSN-942-7209) or e-mail me at jax0slb@jax10.med.navy.mil. On your request for a seat, please include your *name, position, command, address, social security number and daytime phone number*. You will be given a confirmation number by return e-mail or fax. You should have this number at the time of the conference. Last year, many people were turned away due to lack of space, and many came that were not registered. To avoid this same problem this year, confirmation numbers will be issued and used for admission to the conference. The BOQ is filling up fast. I would suggest that if you have not already made arrangements, you do so immediately. The BOQ phone number is (904) 542-3427. Tell them you are registering for the NHSO conference. I have already reserved the rooms, but they must put a name to the room. All enlisted personnel should request a room at the BEQ. The billeting office number for the BEQ is (904) 542-4050. Look for an update and agenda in the next DATALINK. I am looking forward to seeing each of you again this year.

Ms. Sandy Banning has been working non-stop to get our PAC Directory finished before all of the numbers change again! The Directory was written both in MS Word and WordPerfect. Detailed below is how to access the Directory from email:

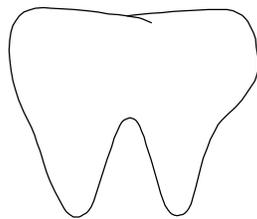
If you have EUDORA, then chances are that your attachments go into C:\EUDORA\ATTACH\ file. First, open up your File Manager (Explorer for NT or WIN95), then

open up the C:\EUDORA\ATTACH directory. Next, double-click the CCQASDIR.EXE file. This will expand-out the DIRECTRY.DOC file. So, to access the new CCCQAS Directory, open up WORD or WORDPERFECT. Click FILE, then OPEN. Change the drive and directory to: C:\EUDORA\ATTACH. If you are using WORD, then you should be able to see the DIRECTRY.DOC file. Double click it. For those of you that are using WORDPERFECT, you must go one step farther in the file section, and change file types to ALL*.* Now you should be

**CCPD: TIMELY
RETURN
OF THE
ICF TO THE CCPD
LCDR O'Connor**

able to see DIRECTRY.DOC. Double click it!

If you have problems expanding these files, call Don Riggs at (904) 542-7200 Ext 8158 for assistance.



Purpose: The above instruction is to provide policy to dental treatment facilities (DTF) for the administration of outpatient anesthesia services in IV sedation to dental patients.

DTF Defined: A freestanding DTF. This instruction does not pertain to dental care provided by a hospital.

Fully read the instruction. There is one item I want to bring to the PACs attention...What credentials are needed to perform IV sedation at a freestanding DTF:

✓ All privileged providers of outpatient sedation for dental patients need to be currently certified in:

- a. BLS
- b. ACLS

If your providers are not BLS and ACLS certified, the Dental Staff cannot approve the supplemental privilege of IV conscious sedation at the freestanding DTF.

If you do not have a copy of BUMEDINST 6710.67A, have your command get one for you. Read it fully for any additional particulars you need to be familiar with.

Within six months of the expiration of the initial appointment, the original ICF must be forwarded back to the CCPD to begin the re-appointment process for an Active Staff Appointment. Include in the original ICF the endorsement page with core privileges sheets, and the completed PAR stating initial appointment was satisfied. If

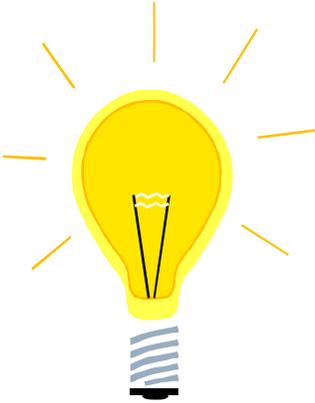
**OUTPATIENT IV
SEDATION FOR DENTAL
PATIENTS**

the privileging authority has determined the

BUMEDINST 6710.67A OF 15 FEB 96

provider has not met the standards of care to be granted an initial appointment for the provisional period, documentation supporting the decision must be forwarded with the original ICF back to the CCPD.

REMEMBER!!!!



Until CDR Irvine figures out how to remove the extra pages in this DATALINK template, set your printer to print 10 pages! I will figure it out sooner or later. If anyone has any ideas.....

