
DATA LINK

Your link to the Centralized Credentials Database

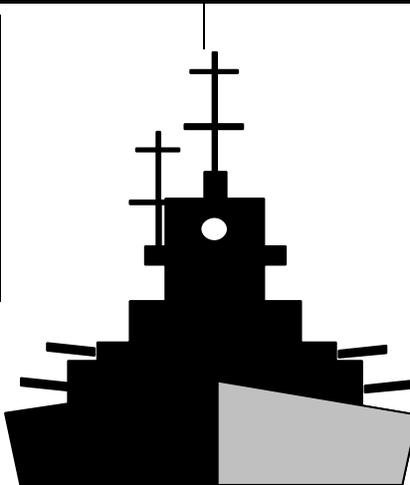
To keep you knowledgeable about current and emerging developments within your areas of expertise for the purpose of enhancing your professional development

Volume 2 Issue 2

Jul 1998

**CREDENTIALS &
PRIVILEGING
ISSUES LEAD THE
JCAHO TYPE 1
LIST** CDR G. Irvine

**Pay Attention to the
Area of Credentials
and Privileging:**
.....



Ambulatory Care Findings

According to the *Briefings* article, the area causing the most problem for ambulatory care last year, was the standard intended to ensure that practitioners and clinical support staff are appropriately skilled and trained, and those skills are maintained.

Take a moment to consider your facility. How would you prove to a surveyor all the providers at your command had the appropriate education and training for the requested skills, whether those skills are reflected in privileges or a position description (PD)? How do you document those skills are being maintained? Showing a surveyor the number of CME/CEU hours, on a recent PAR, may not be enough. The key is appropriate education and training, and the maintenance of current competency for those skills (privileges) requested.

*Briefings on JCAHO/AAAHC:
Ambulatory Care, April 1998,*
published by Opus
Communications, Inc., recently
ran an article addressing the
top 40 Type 1 recommendations
JCAHO surveyors gave out in
1997.

What follows is a synopsis of
the article. Whether you are a
PAC at a free standing
Ambulatory Care Center, a Naval
Hospital, or a branch clinic,
this article is for you!

FOR OFFICIAL USE ONLY
Copies authorized for internal distribution
Editor: CDR G. Irvine, Code OOA
Published by HSO, Jacksonville, FL.
32212-0140

It is interesting to note, the most troublesome standard was HR.7.1, which requires facilities to uniformly apply credentials criteria to licensed independent practitioners. For 1997, the JCAHO awarded over one-fifth of the 226 ambulatory care facilities surveyed with a Type I recommendation for failure of this standard.

Whether you are in a MTF/DTF or a branch clinic, an Ambulatory Care Clinic, or an operational unit, consider how you would prove this to either a JCAHO/MED IG/or an HSO surveyor.

The Top 40 JCAHO Type I Findings in Ambulatory Care

Briefings presented the top 40 Type I recommendations during 1997 for the 226 ambulatory care facilities surveyed.

These facilities are under the *Comprehensive Accreditation Manual for Ambulatory Care* and the standards reflected in this section are from that manual.

Each grid element standard will have a percentage (%) number reflecting the percentage of facilities receiving scores of 3,4, or 5 (Type I's).

Only the standards addressing credentials/privileging or medical staff issues will be presented here.

STANDARDS

GRID ELEMENT

Credentialing and Privileging of Licensed Independent Practitioners.

STANDARD AREA AND % OF FACILITIES RECEIVING TYPE I RECOMMENDATIONS:

HR.7.1: Credentialing criteria are uniformly applied to independent practitioners. 20.9%

HR.7.2: Each licensed independent practitioner provides care in accordance with delineated clinical privileges. 17.9%

HR.7.2.1: Clinical Privileges are granted based on the practitioner's qualifications. 17.2%

HR.7.2.2: clinical privileges are reviewed or revised every two years. 8.8%

HR.7: All individuals permitted by law and the organization to practice independently are appointed through a defined process. 8.3%

As evidenced above, the three top Type I recommendations were within the credentials process arena. Are you ready in your facility to address each of the above issues with a surveyor?

The bulk of the Type I recommendations, after the credentials issues, were regarding competence assessment for clinical support staff members, and other related performance improvement issues.

The top Type I's are used by the JCAHO to determine surveyor elements to focus on during the random unannounced surveys. The credentials process was at the top of the list.

JCAHO Focal Points for 1998 Random Unannounced surveys

1. Credentials and privileging of LIPS.
2. Environment of care - implementation.
3. Medication use.
4. Improving performance.
5. Improving organizational performance - assessment.

For any survey focus on the following credentials/privileging/medical staff areas:

- **NO** unlicensed providers. Each provider should be either a student, LIP, clinical support staff member, under a POS or an operational exemption. Physicians licensed with a ME Oregon license, and, dentists licensed with a ME Tennessee license should be under a POS and be in the process of obtaining a license. Check your files against the CCQAS database to make sure the information is correct.
- Check every ICF/IPF for the appropriate PSV of credentials. If missing, complete the PSV. If you need a checklist, contact either CDR Irvine or Sandy Banning.
- Check every application for involuntary/voluntary status of licensure/appointment and privilege relinquishment. Make sure you have the current update for the PPIS forms in the BUMEDINST 6320.66B.
- No gaps in appointments unless accounted for.

- Read and know the Medical Staff Bylaws...discuss appropriate elements within the Bylaws with your Chairs of ECOMS/ECODS.
- Read and know the JCAHO Medical Staff standards, and associated standards appropriate to the Medical Staff. Teach and train your Medical Staff what questions will be asked and what they will need to show proof of during a survey.
- Make sure your Medical Staff knows the responsibilities of a Medical Staff Department Head/Director.
- Make sure the non-LIP Department Head/Directors know their responsibilities. The reason I mention the non-LIP Department Head is because at many of our facilities, RNs are designated as the Department Head of a clinical department. There are many questions that arise when a non-LIP is Department Head and has physicians within that department. Remember, a RN can be the administrative Department Head of a clinical areas, but cannot be the medical director of that department...only a physician can direct medical care and physician clinical issues.
- This is a time for teamwork with your Performance Improvement Coordinator...know how PI information is collected on your providers and where this information is maintained.
- Be familiar with the restraint & seclusion guidelines within

your facility...make sure your Medical Staff are aware of these guidelines...they are located within the Medical Staff Bylaws.

- Be familiar with the IV conscious sedation guidelines within your facility.

.....

DENTAL CORNER
CHAIN OF COMMAND IN
OPERATIONAL ARENA

CDR G. Irvine

An interesting question was forwarded from the operational arena: Explain the chain of command, in the operational arena, for the administrative management of unlicensed officers...in this case, dental officers.

Generally within the Navy, the privileging authority (PA) and the commanding officer (CO) are the same person. Within the operational arena the demarcation line between PA and CO can get confusing: Is the PA the provider's ship CO or the unit Commanding General (CG), is it the Dental Department Head, Force Dental Officer, or the Fleet Dental Officer who manages the credentials process?

What is the correct chain of correspondence for BUMED notification of administrative procedures, e.g., separation of unlicensed providers, etc?

MED-32 Clinical Management, BUMED, recommends the following: When the practitioner's PA is different from their CO, the

explanatory letter should go via the CO to the PA. When the PA/CO or PA and CO decide(s), hopefully with a recommendation from the ECODS, that it is time to separate the practitioner (or any administrative action), notification is to BUPERS via Chief, Dental Corps. BUPERS only requests to be notified when we have decided to separate the practitioner.

Remember, the management responsibility for unlicensed physicians and dentists rests with the PA/CO and the ECOMS/ECODS. The PA/CO, medical/dental staff, is closest to the action and needs to make the call whether keeping an unlicensed practitioner, under a POS, is helping or hindering mission accomplishment. Detailers must be kept in the loop also. There will be a point in time when the unlicensed practitioner will not be eligible for orders.

CCQAS CORNER
INPUT OF MEDICAL
READINESS TRAINING
DATA

Ms. Stazy Godlewski

Located on the Medical Readiness Training screen are five pieces of mobilization information requiring input for our physicians and dentists.

Our operational and OCONUS activities have been asking questions regarding the input of information into these fields.

I contacted Stazy Godlewski and she gave the following guidance:

- For OCONUS activities: If they have no mobilization billets (platforms) assigned, they should consider themselves already at their mob site.
- In this case, they enter the facility UIC in the UIC field for Current Mobilization Platform UIC.
- They enter the date the member arrived at their command, in the Sustained Medical Readiness Training Certification date field.
- The idea being they are already where they would be in the event a war (or whatever broke out), and because they are doing the same job they would be required to do in the event of a war (they are already fully qualified). We realize they are not operational in the same sense as the Marines or line activities, but the bottom line is they are outside CONUS...they are doing the job they were ordered to...and, they are not going to be sent to another site (mob platform).

CCQAS 1.5 cannot distinguish between operational and non-operational (OCONUS) operational billets. Since we need to be able to track and manage all of these providers, continue to follow the above guidance for the input of mobilization data into CCQAS, if you are in an OCONUS activity.

CCPD CORNER

LCDR S. O'Connor

Clinical Support Staff

Reservist Competency

How does the facility manage the Clinical Support Staff reservist, RN, who does not have appropriate current competency documentation?

LCDR O'Connor states, "Basically, the CCPD is notifying the facilities if the Naval Reservist does not have adequate documentation to support current competency. The facilities need to decide whether they are willing to accept the SELRES for drills, annual training, etc., or if they want to put them under supervision.

The Clinical Support Staff (nurses) issue is that we notify the commands on the CTBs IAW what was dictated to us by BUMED 00NCBR. This is the language that we place on the CTB:

'<Naval Reserve> Member meets basic requirements for professional nursing'.

CCPD recommends competency be evaluated by the command with the generation of a PAR. Please forward the PAR to CCPD."

As billets become tight and as we continue to work with the BUMED RCOGs and RESFOR, billets should only be filled with a direct match.

If any additional guidance is required, please contact LCDR O'Connor.

Desk Top Guide

Supplemental Privileges

Officer in Charge, Naval Healthcare Support Office has been delegated the authority by the Chief, Bureau of Medicine and Surgery to grant core privileges for Naval Reserve independent practitioners. Supplemental privileges are facility-specific, non-transferable, and are granted by Privileging Authorities at respective Medical/Dental Treatment Facilities (MTFs/DTFs) where they may be supported.

The Naval Reservist, who meets the criteria for supplemental privileges, may request those supplemental privileges at the respective Medical/Dental Treatment facility where they are assigned. This may also include those facilities where the Naval Reservist plans to perform annual training. The Naval Reservist should contact the Professional Affairs office at the MTF/DTF to initiate their request for supplemental privileges so that appropriate paperwork can be completed.

Supplemental privileges for Naval Reservists may be temporarily granted, using the modification process, for a specific time frame to accommodate the annual training period (not to exceed thirty days) or may be granted for the same time frame as the core privileges were granted for by the Naval Healthcare Support Office with the same ending date (gaining sites where the Naval Reserve member drills. This information is reflected on the

credentials transfer brief that the gaining site receives from the CCPD.

CDR Irvine's comment:

The granting of supplemental privileges to the Naval Reservist by the individual MTF/DTF requires a modification of privileges. Using the modification of privileges process, there is a paper trail at the command which documents the provider meets the facility criteria for the requested supplemental. There is a request for the modification (addition of privileges), and an endorsement page documenting the appropriate credentials process.

Please refer to BUMEDINST 6320.66B, Section 2, para 11a(1)(c), page 2-17...it states if a practitioner is TAD, drilling, or during an annual training, etc. (temporary duty at your command), and the practitioner requests to perform supplemental privileges **not currently held**, but for which the practitioner meets the facility's departmental specific criteria, the practitioner may apply and be granted the privilege(s) at the gaining facility. The gaining command may grant the privileges, and inform the practitioner's privileging authority (CCPD) of the action taken.

This is how the process should work at your command:

- (1) The Naval Reservist will complete the Appendix K and request modification of clinical privileges, number 1(e). Please note this sentence states clinical

privileges, not core privileges. Therefore, since your command is adding supplemental privileges to the Naval Reservist's core privileges, this is a modification to his/her clinical privileges.

- (2) The Endorsement Page-Modification of Clinical Privileges will be completed for the supplemental privileges being granted. You will note the endorsement page states clinical privileges, not core privileges, so this is appropriate for supplemental privileges.
- (3) The endorsement page expiration date will reflect the Core expiration date for those Naval Reservists who drill at your command. This date is located on the CTB.
- (4) The endorsement page expiration date will reflect the ending annual training date for those Naval Reservists who are on annual training at your command not to exceed a 1-month period.
- (5) All original paperwork will be forwarded to the CCPD for inclusion in the practitioner's ICF. I would recommend your facility keep a copy of this paperwork in the provider's PI file (or whatever local file you maintain on your Naval Reserve practitioners).

I am sure you all will agree this process is consistent with the modification process we all use for our active duty practitioners when they request the addition of supplemental privileges.

If you have any additional questions please do not hesitate to contact either LCDR O'Connor or me on this issue.

**MAINTAINING DATA
CURRENT WITHIN THE
IPF** CDR G. Irvine

**The Data/Information Contained
Within the IPF Requires the Same
Diligence as That Contained
Within the ICF**

**FOREIGN PHYSICIANS
PRACTICING WITHIN THE
BOUNDARIES OF OUR
MTF/DTFs** CDR G. Irvine

This issue came to my attention after completing an ad-hoc CCQAS report. In several facilities, Canadian and/or British health care providers had been granted privileges to practice within our MTF/DTFs.

Perhaps this situation has happened to you?

Picture This: It is indeed a fine Navy day...and you are strolling down the hallway of your MTF/DTF, humming a little ditty as you go. You happen to look in a room and see a provider, in a strange uniform, treating patients. You stop, your eyes roll up as you think about what you have seen...hum...you continue on your way...quickly, and stop in to see the Chairman, ECOMS. She states, "Oh, yes...these Canadian/British providers have been here for awhile...but they only treat their beneficiaries. No need to worry about them! We already granted them privileges!" You wonder (quickly) back to your office and think...oh boy!

Is this a problem?

Yes, can be a problem.

The Who?

We are not discussing the foreign national local hire (FNLH) providers...they are covered under the status of forces agreement (SOFA). Nor, are we discussing foreign students in our GME/AEGD programs...they are covered under training standards.

We are discussing the health care providers, usually Canadian or British, who request to treat their beneficiaries in your MTF/DTF.

The Situation

These providers may be part of a small contingent of Canadian or British military operational forces located close to your MTF/DTF. While they have their own physician/dentist, they do not have the appropriate space

or equipment to meet their troop's medical/dental needs. They request of your CO to use a small space within the MTF/DTF to provide health care to their military troops, using your facility's equipment and ancillary services, e.g., lab or xray.

Your CO, and rightly so, wants to assist these health care providers to meet their operational health care needs by providing the space requested.

The Problem

While it may be appropriate to assist Canada and the United Kingdom to meet their operational health care needs, Canadian and British providers do not meet the Navy licensure standard. These providers, licensed in Canada or the United Kingdom, cannot practice independently within our MTF/DTFs and cannot be members of our Medical/Dental staff.

The Navy Medical Staff sets the standard for medical/dental care within each facility. Canadian/British health care providers practice under a different set of standards. They may not be delivering the same level of care (refer to MS.6.8) throughout your facility as our providers. The standard states, "Comparable level of care for same condition regardless of which department, discipline, specialty, or setting, in which the care, treatment, or procedure is provided. This comparability is evaluated through PI activity monitoring and by the clinical privilege process." Since Canadian and British providers do not possess

U.S. licensure, they cannot be granted privileges; therefore, they cannot practice independently within a facility.

The Solution

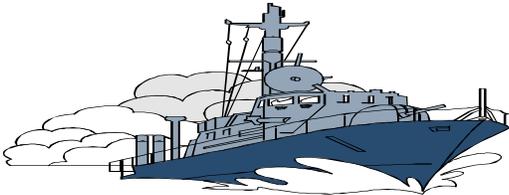
If deemed appropriate to offer assistance to Canadian and British physicians/dentists to meet their operational health care needs within a Navy MTF/DTF, the following must be followed per JAGC, BUMED, MED-03L:

Each case must be considered individually based on many different factors.

Send a written inquiry to MED-03L containing the pertinent information requesting assistance and guidance.

**PRIVILEGING
COAST GUARD
PRACTITIONERS**

When a Coast Guard provider



comes to your command requesting privileges, your command may grant this provider privileges based on his credentials and current competency for privileges requested.

**Answers to Commonly Asked
Questions Re:**

Coast Guard Providers

- Coast Guard (CG) providers are covered by the Federal Torts Claims Act (FTCA).
- They are subject to the UCMJ.
- No additional malpractice coverage is required.
- Coast Guard HQ maintains credentials files on Coast Guard providers' (202) 267-0801.
- Working within a DoD facility is considered to be within the scope of a CG provider's scope of employment.
- There is no interagency agreement directing the exchange of providers between the Navy and the Coast Guard.

If you have any additional questions, contact CDR G. Irvine.



**EVER WONDER WHO USES
CCQAS?**

Ms. Stazy Godlewski

Ever wonder who uses the CCQAS data?

BUMED AND DoD use the data to make decisions on funding, staffing, effectiveness of care being delivered, mobilization status, etc.

In short the data is used to project a picture of your facility's personnel resources. If this information isn't correct for whatever reason, then the conclusions drawn may also be flawed. This is why it is so important that you **double-check** the information before you forward it each quarter.

DOUBLE CHECK REPORT

Creating and saving a report that looks at the following fields can double-check your data very quickly:

CORPS, DESIG, PROV_TYPE, SUBSP1, C_APPOINT, COREPRIV1, PRIVCAT, CSSPROV, F_LIC1, C1_FLD, STCER_1, STLIC_1. (Note you should also include LNAME or SSN so you can identify who needs corrections.)

This allows you to see conflicting provider data. An example would be a NUR (that's the corps (CORPS) for a civilian nurse) with a designator (DESIG) of 2305 (MSC designator), a subspecialty (SUBSP1) of 1900 (General nursing specialty and a field of license (F_LIC1) of 140 (LPN License) and a field of certification (C1_FLD) of 642 (NCCPA certification). In case you thought I made that up, there were approximately 50 such "providers" in the last data run I did to project what it would cost to query the NPDB if we had to query on all providers. I "counted" them as LPN's which

may make the funding off if they really are Physician Assistants.

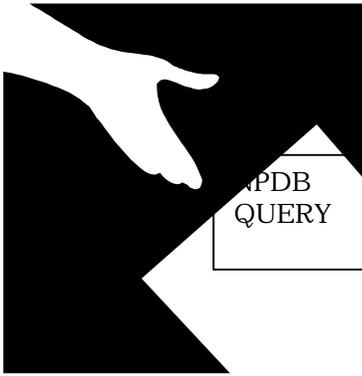
During the past month, CDR Irvine and Sandy have had to check every physician in CCQAS against a BUPERS (personnel) database report to ascertain their current licensure status. Don would bring up reports containing clinical support staff nurses. When corresponding reports were ran on nurses, physicians would be included...all because of errors in the input of information. Unfortunately, we are finding CCQAS 1.5 does not "catch" all input errors (finger-slips).

Don Riggs, Sandy Banning and CDR Irvine are very good at catching errors, but these errors cannot be corrected at the headquarters level...they must be corrected at your level and forwarded to the headquarters CCQAS quarterly. This is why Navy PACs have been receiving calls regarding their data input...it is to alert you to the fact that there is a discrepancy in the data and it requires clarification at your level. Additionally, it is easier to see errors when you are not looking at 20,000 plus records.

Therefore, prior to forwarding every quarter report, please run the Double Check Report.

If you have any additional questions please do not hesitate to contact (202) 762-3194.

NPDB QUERIES



Mr. Don Riggs

Due to a recent upgrade in NPDB query software, it is now required to include "gender" in each provider's CCQAS record. If gender is not present (blank), then the provider will not be selected by the NPDB query software. That is, unless I go in manually, and update the provider's gender field myself! And there really is not the time to do that.

So please, fill in those gender fields.

While you are at it, here are the other fields required by the NPDB query software. You might want to run yourself a CCQAS adhoc report containing these fields, and perform a final check - before you send me your quarterly report. That will help insure that you get the queries you need.

NPDB QUERY FIELDS

Be sure these fields have good data in them!!!

LNAME, FNAME, MI, DOB (birthdate), PR_SC_AT (primary school), CLPT_DTE1 (school grad date), L1 (license state), F_LIC1 (field of license), ST_LIC1 (status of license), L1_NUM (license number). Also,

status of license must be 'C', field of license must be 030 or less (e.g. 020, 010), and license state must be one of the 50 States, Commonwealth of Puerto Rico, US Virgin Islands, Guam, or District of Columbia.

CCQAS 2.0 UPDATE

Development of the CCQAS 2.0 software has been **delayed** due to a change in software development companies (contractor). Currently, there is not an 'official' estimated deployment date. I will update you on the status as I learn more from the new software company.

In July 98 a pre-deployment survey will be sent to all of the Navy's privileging entities. This survey will be addressed to respective Information Systems (IS) departments (MID). The IS departments will need to contact each Professional Affairs Department, to get an inventory of currently installed computer hardware/software. Also, a list of CCQAS 2.0 users and contacts will be compiled. Professional Affairs Coordinators (PACs), Risk Managers, Readiness Officer (POMI), and the Reserve Liaison Officer, will be connected to CCQAS 2.0 at each site. Each will have a user ID with limited access to their respective area of responsibility.

Please respond promptly to any inquiries regarding the CCQAS pre-deployment survey.