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JCAHO COMMISSION MEDICAL STAFF 2001 STANDARDS

The JCAHO Medical Staff standards for 2001 are published. As of 1 Jan 01, the Professional Affairs Coordinator (PAC) and Medical Staff at each accredited facility will be responsible for compliance with these new standards.

This DATA LINK is not a policy-setting document. Each new standard will be presented, and discussed. When local action can be taken immediately, or where corporate Navy policy is required, this will be stated.

CDR (Ret) G. Irvine will be discussing these standards with the Medical Staff leadership at the HSO and BUMED.

Each command Professional Affairs Coordinator will be immediately informed of policy changes/approvals. The PAC will immediately inform the command's Medical Staff leadership of the new policy, including processes to demonstrate compliance to the policy.

Each Medical Staff Leader, Executive Committee of the Medical Staff Chair, and PAC must work together to implement these standards within the facility.

These standards apply to all Navy health care treatment facilities, e.g., hospitals, Ambulatory Care Centers, and Branch Clinics. As corporate

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policy is written and approved, Navy Dental Clinics, ECODS, and Branch Dental Clinics will need to be in compliance with corporate policy.



ELEMENTS OF LICENSED INDEPENDENT PRACTITIONER (LIP) COMPETENCY ASSESSMENT

Many questions are asked regarding just what does each facility need to monitor during a licensed independent practitioner's appointment period to ascertain current competency for privileges requested?

The following data will demonstrate an applicant is competent and worthy of appointment and/or reappointment at your command. The results of this data should be given to each Department Head, Director, and Senior Medical Officer to develop a valid opinion of an applicant's current competency. These data represent not only individual data, but aggregate data as well:

(1) Operations and procedures that place patients at risk. Medical Staff must define what procedures these are, and monitor outcomes.

(2) Blood and blood products usage.

(3) Mortality rates.

(4) Utilization Review, e.g., length of stays (LOS), both individual and aggregate across departments.

(5) Risk Management; occurrence screens, MVR, incident reports.

(6) Significant departures from established standards of practice, e.g., clinical practice guidelines (CPG), policies and procedures.

(7) Participation in education of patients and families.

(8) Coordination of patients care with others.

(9) Good clinical judgment and technical skills.

(10) How do peers think of the applicant? Team player?

(11) Medication use. e.g., how LIP uses medications, for example coumadin, and newer expensive drugs.

(12) Medical Record Review (admin review, e.g., legibility)

(13) Medical assessment and treatment (peer review-medical record)

(14) Restraint and seclusion review; must be 100% review. The JCAHO requires a 100% review of all restraint and seclusion events.

(15) Care of patients in high-risk populations, defined by Medical Staff, e.g., HIV.

(16) Commendations and complaints from patients.

(17) Compliance with Medical Staff Bylaws, policies & procedures, meeting attendance (citizenship issues).

(18) Role as a leader.

(19) Results of Performance Improvement (PI) activities and competency.

As you can see, at the time of Performance Appraisal Report (PAR) completion and reappointment, the above information presents a complete picture of an applicant's role as a Medical Staff citizen, his/her interpersonal relationships, clinical judgment, and technical skills.

This information may be kept in a variety of places within the command, e.g., CAF, in a computer database like CHCS, in the Department Head's files, etc. Wherever it is maintained this information must be available to the individual completing the PAR, and the Department Head prior to appointment, reappointment, or the granting/renewal of privileges.



2001 Revision to Intent of MS.5.4 Through MS.5.4.3
(2) Procedures Rule for Reappointment

There appears to be confusion within the "Halls of the JCAHO" regarding this issue.

During a recent JCAHO Medical Staff conference Sandy and I attended, the JCAHO surveyor physician presenters explained the new standard requiring, at minimum, two procedures to assess ability to perform a privilege.

At NH Yokosuka and NH Guam, a JCAHO surveyor stated the same, and told the Medical Staff the JCAHO expects to see at least two procedures of each skill contained within the Core set, to be practiced to assess the ability to perform.

I contacted the JCAHO Standards Department, and discussed the issue with Mr. John Harringer, JCAHO surveyor.

He stated the following: "No, this is not correct. The JCAHO has not set the number of procedures, per privilege requested, to two to assess ability to perform. It is a Medical Staff decision, at each facility, to decide how many of each privilege is required to assess competency for that privilege. The (2) procedures is a misunderstanding from the website. The website states the following:

For renewing or revising clinical privileges...could be based on pertinent results of review of operative and other procedures(s) (2), medication usage, blood usage...

This (2) does not indicate number of procedures, but it is a footnote, found at the end of

the article, explaining what operative and other procedures include.

When I read the JCAHO website, I concur, the (2) is a footnote indicating what the terms operative and other procedures includes, found at the end of the article.

It is interesting to note that both the JCAHO physician conference presenters, and the NH Yokosuka/Guam surveyor thought it meant two procedures to assess ability to perform, yet the JCAHO Standards Department states it does not.

Do not get excited over this standard yet, or start changing policies. The important language in this standard focuses on the requirement for Departmental Specific Criteria from which the Department Head, Directorate, and ECOMS uses in the decision making process.

As new information is published, it will be immediately forwarded to the PAC.



**NEW MS STANDARD FOR
2001: MS.5.16 & MS.5.16.1
TELEMEDICINE**

- **Standard:** Practitioners who diagnose or treat without clinical supervision (LIPS) or direction, via telemedicine link, are subject to the

credentialing processes of the organization that receives the telemedicine service.

- The medical staff recommends the clinical services to be provided by telemedicine.

If a telemedicine practitioner prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient, the telemedicine practitioner is credentialed and privileged by the organization receiving the telemedicine service.

Within the Navy this need not be an onerous process. We can accomplish this by using the Interfacility Credentials Transfer Brief (ICTB), coupled with the Appendix Q process. Easy.

If telemedicine services is from a civilian institution, and the civilian physician is prescribing, rendering a diagnosis, or otherwise providing clinical treatment to the Navy patient, the process may be more difficult requiring cooperation from the civilian institution.

The Navy may use the credentialing information from another Joint Commission accredited facility, so long as the decision to **delineate privileges** is made at the Navy facility receiving the telemedicine service.

Civilian hospitals do not have a similar ICTB process, stand alone in the credentialing process, and do not share information readily.

The policy will either be in the BUMED Credentials Process instruction or in the Medical Staff Bylaws in the future; on 1 Jan 01, the Medical Staff must be knowledgeable of this process and have it in place.

More will be forwarded to each PAC as policy is approved.



**NEW MS STANDARD FOR
2001: MS.2.6
PHYSICIAN HEALTH**

- **Standard:** The Medical Staff implements a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function.
- **Intent:** Health Care Organizations have an obligation to protect patients from harm.

Medical Staff leaders must design a process that provides for education about physician (LIP) health, emotional illness, addictive behavior and rehabilitation.

This standard needs to be addressed at the organizational level, BUMED, and included in the Bylaws. The adverse privileging instruction, BUMED 6320.67A, addresses selected practitioner illness issues, but the Navy does not have an identified process for practitioner education and training containing seven (7) specific educational elements the JCAHO requires per Bylaws. This will need to be discussed, written, approved, and disseminated.

Upon review of Navy standard, we are meeting the new physician standard in that we recognize temporary vice permanent illness; however, we do not have the physician (LIP) JCAHO required educational piece in place.

The JCAHO surveyor will ask the Medical Staff members these two questions:

-Has the Medical Staff implemented a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function?

-Does the process design include the seven items listed in the intent statement?

The seven (7) process design elements are the following:

-Education of the Medical Staff and other organization staff about illness and impairment recognition

issues specific to physicians;

- Self-referral by a physician and referral by other organization staff;
 - Referral of the affected physician to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
 - Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened;
 - Evaluation of the credibility of a complaint, allegation, or concern;
 - Monitoring of the affected physician and the safety of patients until the rehabilitation or any disciplinary process is complete; and,
 - Reporting to the Medical Staff leadership instances in which a physician is providing unsafe treatment.
- Each PAC will be informed of new policies and processes connected with physician health issues.



**NEW MS STANDARD FOR
2001: MS.5.1.1**

EXPEDITED CREDENTIALING

This standard does not apply to the Navy process, as it is currently written by the JCAHO. This article is to give you information regarding this new standard.

Standard: The governing body, pursuant to its Bylaws, may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decision to a committee of the governing body.

Intent: To expedite appointment, reappointment, or renewal or modification of clinical privileges, the governing body may delegate the authority to render those decisions to a committee consisting of at least two governing body members (**not ECOMS**) members.

(Please remember, Navy Commanding Officers represent the Navy's governing body, the SG. There cannot be a committee of two if one CO represents the governing body.)

How the process would work:

1. Following a positive recommendation from the **ECOMS**, the committee of the governing body reviews and evaluates the application, and renders its decision.
2. When the full governing body meets it still must consider

and ratify all positive committee decisions.

3. If the committee's decision is adverse to the applicant, the matter is referred back to the ECOMS for further evaluation.

This would be possible if a governing body committee, as in the civilian community, managed each Navy hospital/clinic/branch clinic, but our Navy health care treatment facilities are under the authority of a single individual, the Commanding Officer. Therefore, expedited credentialing, as per the JCAHO standard, does not seem appropriate at this time.



PAC ALERT

**NAVY PAC INFORMATION:
VERIFICATION OF
CURRENT LICENSURE &
ABILITY TO PERFORM**

**NEW STANDARDS FOR VERIFYING
CREDENTIALS**

Current Licensure

Licensure is verified with the primary source at:

1. Time of Initial Appointment and initial granting of clinical privileges;
2. Time of reappointment, renewal, revision, modification of clinical privileges; and,

3. Time of license **expiration** by a letter or computer printout obtained from the appropriate state licensing board. Internet or telephone documentation is acceptable if per Navy standard.

Number three (3) above means, if the license does not expire, and is renewed prior to expiration, the license does not require verification, **but** if the license expires, when the license is received by the physician, it is as if it is a completely new license regardless of State, and you **must** verify it again.

This is why each PAC should complete their monthly license expiration adhoc CCQAS report, and advise the physicians to renew ASAP, and not to allow the license to expire.

Medical Staff Alert

**Ability to Perform
Privileges Requested:**

Currently, the Department Head upon review of each appointment application (Appendix K) does not sign the application attesting to the fact he/she has reviewed the information contained therein.

Question 3.d., states "I have no current mental or physical impairment that could limit my clinical abilities." This statement checked by the applicant represents the applicant's attestation of his/her ability to perform privileges requested.

Per JCAHO standards, the ability to perform must be evaluated, and documented in the applicant's ICF. The Navy statement located on the application is acceptable; **however, this statement must be confirmed** via the following methods:

1. For an applicant for Initial Appointment or initial clinical privileges, the statement is confirmed by the director of a training program, by the chief of services, or chief of staff at another hospital at which the applicant holds privileges, or by a **currently licensed physician designated by the hospital**, e.g., Department Head.

2. For an applicant for reappointment or renewal or revision (modification) of clinical privileges, the statement is confirmed by at least a **countersignature** on the applicant's statement by a department director (Department Head) in a departmentalized hospital, or by the chief of staff in a nondepartmentalized hospital.

Active Duty Process to Meet This Standard:

Follow this process:

(1) Appendix K Application: The heading of the application lists the usual From, To, and the very important, **Via** line.

(2) This "Via" line should have the following typed in it for departmentalized hospitals/clinics: "Department

Head." Nondepartmentalized hospitals/clinics must have the title of the individual who fulfills the role of the Department Head. This individual must be a currently licensed physician designated by the Medical Staff for all physicians. If applicant is a non-physician the appropriate specialty applies. The "Via" line must include the specialty designator, e.g., MC, DC, NC, MSC.

The standard actually states the "chief of staff" must confirm the ability to perform statement. In the Navy the chief of staff is represented by the Department Head or Director, who fulfill the credentialing role of the chief of staff, e.g., recommending applicants to the ECOMS committee based on Departmental Specific Criteria.

Therefore, it would be appropriate for the Department Head or Directorate to confirm, by signature, the ability to perform on the application.

(3) Since the application contains the statement addressing the ability to perform, the Department Head shall sign the "Via" line on the application as a confirmation of number 3.d., ability to perform privileges requested.

Navy Reserves

The Reserve health care practitioner is under the same policies as the active duty member.

During the Reserves ECOMS meeting, each ICF is scrutinized to assure the Reserve practitioner meets the 4-Pillars of credentials and privileging.

Each ECOMS member reviews files for applicants within the ECOMS member's specialty. At this time, not only are current credentials, PI outcomes, and peer review discussed, but the ability to perform is also assessed.

When the ECOMS committee member (who is fulfilling the credentials role of the Department Head) is assured the applicant meets the Navy standard, he/she recommends to the ECOMS Chair that the applicant should be recommended to the Privileging Authority for appointment and clinical privileges.

Reserve Process to Meet This Standard:

(1) Each application will be stamped with the following statement: "Confirmed the SNO's (Subject Named Officer) ability to perform statement."

(2) This statement, along with the recommendation/not recommended, comments and date section, will be signed (confirmed) by the ECOMS committee member.

This process will meet the intent of the JCAHO standard.

Not only is the applicant's ability to perform privileges requested evaluated, but the applicant's statement that no health problems exist that could affect his or her practice (has ability to perform), is confirmed.



REVISION TO CURRENT
STANDARD:
MS.5.12
REAPPRAISAL FOR
REAPPOINTMENT

Intent Statement Now

Includes: Relevant practitioner-specific information from organization P.I. activities is considered and compared to aggregate information when evaluating professional performance.



MEDICAL STAFF ALERT

REVISIONS TO
ANESTHESIA CARE
STANDARDS

FOR SEDATION AND ANESTHESIA CARE

To better reflect the latest safe anesthesia and sedation practices, new definitions of "sedation" and "anesthesia" and new and revised standards on sedation and anesthesia go into effect on 1 Jan 2001.

These changes reflect the continuum of anesthesia, including conscious sedation (moderate sedation).

These standard revisions were driven by the changing definitions of anesthesia based on changes in technology, medications, and practices in anesthesia care services.

The previous iteration of the definition of anesthesia, to which the standards applied, focused on the loss of protective reflexes, or an inability to maintain a patent airway independently.

Today, this is not considered a comprehensive indicator of patient safety, since loss of protective reflexes is often a late indication a patient receiving conscious sedation (moderate sedation) could be in trouble.

The JCAHO also considered the anecdotal evidence from the field indicating adult and pediatric patients were experiencing negative outcomes, even death, as a result of conscious sedation. Conscious sedation, itself, was not

addressed in previous standards, or in the survey process as an entity. This is changed with the 2001 anesthesia and sedation standards.

In October 1999, the American Society of Anesthesiologists (ASA) drafted and adopted revised definitions of sedation and anesthesia. The JCAHO for the 2001 standards followed the ASA lead.

These definitions identify levels of sedation and anesthesia allowing for the entire continuum of sedation and anesthesia to be surveyed.

REVISED DEFINITIONS

1. **Minimal sedation (anxiolysis):** A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular (CV) functions are unaffected;
2. **Moderate sedation/analgesia (conscious sedation):** A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous

ventilation is adequate. CV function is usually maintained;

3. **Deep sedation/analgesia:** A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function maybe impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. CV function is usually maintained; and,
4. **Anesthesia:** Consists of general, spinal, or major regional anesthesia. Does not include local anesthesia. General anesthesia patients are not arousable, even with painful stimuli. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required. CV function may be impaired.

The following standards remain unchanged: A pre-sedation or preanesthesia assessment before beginning moderate sedation and before anesthesia induction; patient's moderate or deep

sedation and anesthesia care is planned; sedation and anesthesia options and risks are discussed with patient and family prior to administration; each patient's physiological status is monitored during sedation or anesthesia; patient's postprocedure status is assessed on admission to and before discharge from post-sedation or postanesthesia recovery area; patient's discharge from recovery area by a qualified LIP, or according to criteria approved by the Medical Staff.

The old standard was really a pharmacologic standard; but now since patient's care may involve reversing agents dealing with patient problems slipping into a lower level of sedation/anesthesia, these standards now involve performance improvement, Medical Staff clinical standards.

It is an assumption a patient can drop one-level inadvertently. The risk is how far the patient drops, depending upon what the practitioner's level of competency is, and on additional variables.

These revised standards will be found across four manuals (Ambulatory, Behavioral Health, Hospital, and Long Term Care-Subacute only).

Please note the following changes:

1. **Qualified Staff**

- Perform the procedure
- Provide moderate or deep sedation
- Monitor the patient/individual/resident
- Ability to "rescue" from unintentional deeper levels of sedation

2. **Appropriate Equipment**

- Monitor Vital Signs
 - HR & RR
 - Oxygenation using pulse oximetry
 - Respiratory frequency and adequacy of pulmonary ventilation monitored continuously
- Blood pressure in all
- ECG in those at risk.

WHAT MEDICAL STAFF ACTION IS APPROPRIATE UNTIL OFFICIAL NAVY POLICY IS APPROVED AND SIGNED:

BUMED will need to approve policy regarding these issues; however, approval, and signature, of this policy will take awhile.

Therefore, each Medical Staff needs to be cognizant of the following, and start to formulate the local moderate sedation (conscious sedation) policy, which may be included in the overall organization's sedation and anesthesia policy. I would recommend this, but in this DATALINK I will focus on

moderate sedation (conscious sedation):

1. Medical Staff leaders discuss the new sedation and anesthesia standards with the Medical Staff.
2. I recommend the Medical Staff leaders and members read the following articles before discussion:
 - a. JCAHO website: Standards and Intents for Sedation and Anesthesia Care at: <http://www.jcaho.org/standard/aneschap.html>; and,
 - b. ASA website: Practice Guidelines for Sedation and Anesthesia by Non-Anesthesiologists at: <http://www.asahq.org/practice/sedation/sedation.html>.
3. Start to formulate overall sedation and anesthesia policy addressing major standards found in TX.2 through TX.2.4.1 and PE.1.8.1, PE.1.8.2, PE.1.8.3, and PE.1.8.4 addressing pre and post sedation and anesthesia assessment, evaluation, re-evaluation, and discharge from recovery services.
4. Address the organization's policy and processes for what criteria is used to evaluate who is the qualified individual to perform, provide sedation, monitor patient, "rescue" patient, and discharge patient from recovery services.

5. Address the organization's policy and procedures for the education, training, evaluation, and monitoring of the qualified individuals, including LIPs, clinical support staff (non-privileged nurses), and corps staff.
6. Address the organization's policy and procedures for appropriate equipment, locations where moderate sedation will be practiced, where the recovery services for those patients not recovered in the OR recovery room will be located, and who the qualified individuals will be providing recovery services. *Remember* standard of care for the whole continuum of moderate sedation/analgesia and anesthesia must be the same throughout the organization. For example, if moderate sedation is practiced in the Otolaryngology Department, the JCAHO surveyor would expect recovery services to provide the same standard of monitoring care, e.g., pulse oximetry, etc., as one would find wherever else moderate sedation was practiced within the organization. The JCAHO surveyor would expect to find the same appropriate equipment, including crash carts, reversal medications, etc. Again, same standard of care.

7. The policy should be very explicit the same standard of care is provided within the organization wherever moderate sedation is provided.
8. The policy should also address all of the unchanged standards as well.


MEDICAL STAFF ALERT

**REVISIONS TO
RESTRAINT AND SECLUSION
STANDARDS**

The old restraint and seclusion standards were site specific. Not so for the new revised standards.

The revised restraint and seclusion standards are based on the **reason(s) for the behavior** requiring the application of restraint and/or seclusion.

The JCAHO defines the reasons for the application of restraint and/or seclusion to be either a **behavioral health reason (TX.7.1 through TX.7.1.16)**, or a **non-behavioral health reason (TX.7.1.4.1, TX.7.1.5, TX.7.1.6 through TX.7.1.8 and TX.7.1.10 and TX.7.1.11)**.

**Behavioral health reason
defined:**

An unanticipated action/behavior based on a psychiatric/psychological behavioral diagnosis; overt destructive, aggressive behavior, or a demented patient.

Usually found within mental health settings, psychiatric health hospital settings.

Non-behavioral health reason defined:

To promote medical healing; to maintain focus of medical care.

Usually found in general medical/surgical settings in which patient is interfering with medical treatment.

The Medical Staff will need to determine if the actions/behavior is behavioral health related, or non-behavioral health related, and then apply the appropriate JCAHO standards. Is the reason for the restraint and/or seclusion to promote healing, or for a behavioral health reason, e.g., overt destructive behavior?

The concern is for the safe care of patients in restraint and/or seclusion situations.

Do not box your organization into laborious behavioral standards if this is not necessary.

These new standards will become policy in the revised Medical Staff Bylaws. Until revised Bylaws are approved and signed, each Medical Staff must be aware and discuss these new standards, and start

formulating local organization policies and procedures to meet these new standards.

Major Change in Behavioral Health Standards - One-Hour Rule:

In Navy hospitals seeking (or possessing) JCAHO "deemed status," a new standard applies regarding when a LIP must evaluate patients placed in restraint and/or seclusion.

TX.7.1.6 states the LIP who is primarily responsible for the individual's ongoing care, or his/her designee, or other LIP conducts an in-person evaluation of the individual **within 4 hours** of the initiation of restraint or seclusion for individuals ages 18 or older, and **within 2 hours** for ages 17 and under.

The Health Care Financing Agency (HCFA) has set a more stringent standard for those behavioral health institutions that come under the HCFA/Medicare standards—this will include those Navy organizations that possess, or are seeking, deemed status with the JCAHO. This standard requires the LIP to conduct an in-person evaluation of the individual **within one hour** of the initiation of restraint.

For a more in-depth discussion of the current JCAHO restraint and seclusion standards, click onto:

http://www.jcaho.org/standard/restraint/restraint_stds.html

These new requirements will be included in the revised Medical Staff Bylaws, BUMEDINST 6010.17B.



PAC & MEDICAL STAFF

THE QUESTION BEGS:
WHAT ACTIONS CAN THE
PAC AND MEDICAL STAFF
TAKE UNTIL WE HAVE A
SIGNED BUMED POLICY?

Each organization's PAC and Medical Staff can be proactive in meeting the 2001 JCAHO standards. Work in coordination with the Performance Improvement Coordinator at each command.

Do not wait for a signed policy from which to start formulating your actions and local Medical Staff policies and procedures. The JCAHO does not wait for the Navy to sign a policy to survey; come 1 Jan 2001 each accredited command will be expected to either be in compliance, or have these standards in a "working-process" form.

Remember, the JCAHO surveys for the previous 12 months, so if your survey is early in the year, you will be surveyed under the 2000 standards. However, some of these standards were being surveyed as early as September 2000...I do not know how stringent the new

standards were surveyed, perhaps the surveyor just questioned the Commanding Officer and Medical Staff leadership and members as to their knowledge of these standards, and what actions the command was taking to meet these standards.

Your **Performance Improvement Coordinator** will be a critical resource in JCAHO matters.

Proactive Actions

1. Provide a copy of this DATALINK to each CO, Medical Staff leader, and member of ECOMS.
2. Invite the PAC and the Performance Improvement Coordinator to the next ECOMS to include them in discussions regarding these new Medical Staff standards.
3. It will take time for policy to be written, approved, and signed at the BUMED level regarding the new, and revised, 2001 standards. Even so, each Medical Staff can take proactive steps to formulating the command's local Medical Staff and/or organizational policies and procedures.
4. Thoughts for your consideration:
 - a) **Telemedicine:** (1) The policy will consistent with JCAHO policy which states: Practitioners who diagnose or treat without clinical supervision (Navy LIPS) or direction, via telemedicine link, are subject to the

credentialing processes of the organization that receives the telemedicine services. If you are the recipient command, you know you will require an Intra-facility Credentials Transfer Brief (ICTB) from the command providing the telemedicine services, on the specific LIP providing the service to your facility. If you are the command providing the telemedicine service, you know the receiving command will request an ICTB on the LIP providing the service. We already do this for our TAD and Reserve practitioners. Each PAC will maintain a separate "Telemedicine" file containing the ICTB's and the Appendix Q's that have been approved by the Commanding Officer.

(2) Per JCAHO standards your Medical Staff will need to recommend the clinical services to be provided by telemedicine.

BUMED will guide the field if these services are to be designated at the BUMED level for each command. CDR (Ret) G. Irvine will be checking with BUMED regarding this issue of policy.

b. Physician Health: This is a more complicated issue requiring both credentials and legal coordination. Given this each Medical Staff knows

the following must be done at the local level: (1) The Medical Staff must implement a **process** to identify and manage matters of individual physician (LIP) health. BUMED Legal will address the issue of separation from the disciplinary action. (2) Each command must have a **process** that provides for education about physician (LIP) health, emotional illness, and rehabilitation. The JCAHO surveyor stated civilian hospitals are initiating Physician Health Committees to address these issues. (3) There are seven (7) distinct items that must be included in your process design. These seven items are delineated in this DATALINK. Any policy written must address each item, and how it is met by the command.

c. Restraint & Seclusion:

(1) Any policy must include processes for both behavioral health and non-behavioral health restraint and seclusion standards. This is because it is not the location of the incident upon which the decision to use what standard is based, it is **why** the restraint and seclusion is being instituted, either for behavioral reasons, or to promote medical healing. For example, if

the patient was on a Med-Surg unit, experienced a hallucination, and evidenced overt behavior that was destructive to him/herself and the staff, and restraints were warranted, the **behavioral health** standards would apply, even though this is a Med-Surg unit and not a Psychiatric unit. (2) The **one-hour** rule applies if your command is, or is seeking, JCAHO "deemed-status."

d. PAC ALERT: (1) On 1 Jan 2001 initiate the new standards for the verification of current license and ability to perform discussed in this DATALINK.

e. Medical Staff start to think about gathering aggregate data, which is used to improve patient care services.

f. Sedation & Anesthesia: Review the new 2001 standards. Any revised policy regarding moderate sedation (conscious sedation) will be based on these new standards and definitions. The policy should address what constitutes a "qualified staff" in the command to perform the procedure, provide the moderate sedation, monitor the patient, and provide "rescue" from unintentional deeper levels of sedation.

The policy should address what constitutes "appropriate equipment" in the command, where moderate sedation is practiced, and what recovery services are available and where.

Read the articles presented in this DATALINK and discuss.

As new policy is initiated, each PAC will be advised.

If there are questions/concerns, please do not hesitate to contact CDR (Ret) Georgi Irvine at (904) 542-7200 Ext 8111 or DSN 942-7200 Ext 8111, or Ms. Sandra Banning at the same prefix with Ext 8142.