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DEPARTMENT OF THE NAVY  
Office of the Secretary  
Washington, DC 20350-1000

SECNAVINST 6320.23  
BUMED-35  
7 February 1990

**SECNAV INSTRUCTION 6320.23**

**From:** Secretary of the Navy  
**To:** All Ships and Stations

**Subj:** CREDENTIALS REVIEW AND  
CLINICAL PRIVILEGING OF  
HEALTH CARE PROVIDERS

- Ref:**
- (a) DoD Directive 6025.11 of 20 May 88 (NOTAL)
  - (b) DoD Directive 6025.13 of 17 Nov 88 (NOTAL)
  - (c) SECNAVINST 6401.2A
  - (d) SECNAVINST 5212.5C
  - (e) SECNAVINST 1920.6A
  - (f) CPI 752 (NOTAL)
  - (g) CPI 432 (NOTAL)
  - (h) 29 CFR 1613.701 *et seq* (NOTAL)
  - (i) SECNAVINST 1850.4B (NOTAL)
  - (j) SECNAVINST 5310.16
  - (k) Title 10, United States Code, Section 1102 (NOTAL)
  - (l) SECNAVINST 5720.42D
  - (m) SECNAVINST 5211.5C
  - (n) SECNAVINST 1120.6B (NOTAL)
  - (o) SECNAVINST 1120.8B (NOTAL)
  - (p) SECNAVINST 1120.12A (NOTAL)
  - (q) SECNAVINST 1120.13A (NOTAL)

- Encl:**
- (1) Definitions
  - (2) Reportable Misconduct
  - (3) Peer Review Panel Procedures
  - (4) Individual Credentials File Contents for New Accessions, Employees Entering Civil Service, and Contractors and Others Entering Under an Initial Contract or Agreement
  - (5) Instruction Sheet, Health Care Provider Adverse Clinical Privileges Action Report, (RCS-DD-HA(AR)1611)

**1. Purpose.** To establish policy and procedures and implement reference (a), and paragraphs

F3b(1) and (2), and F3c(1) through (4) of reference (b) on review of credentials, clinical privileging and utilization of health care providers, as defined in enclosure (l).

**2. Applicability.** This instruction applies to all military (active duty and Reserve) and civilian health care practitioners and clinical support staff (as defined in enclosure (l)), who are assigned to, employed by, contracted to, or under partnership agreement with Department of the Navy (DON) activities or are enrolled in a Navy sponsored training program.

**3. Definitions.** Terms used in this instruction are defined in enclosure (l).

**4. Policy.** Department of the Navy policy is that all health care practitioners who are to be responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care will be subject to credentials review and will be granted a professional staff appointment with delineated clinical privileges by a designated privileging authority prior to providing care independently. Practitioners must possess a current, valid license or certification, a licensure or certification waiver, or be specifically authorized to practice independently without a license or certification or waiver of same, as prescribed in reference (c), to be eligible for a professional staff appointment and clinical privileges.

a. Privileging authorities shall define, profile, evaluate, and periodically reassess (at intervals not to exceed 2 years) the clinical performance and conduct of all assigned health care providers following the guidelines of this instruction.

b. Privileging authorities shall maintain an individual credentials file (ICF) on all health care practitioners and an individual professional file (IPF) on all clinical support staff as specified in this instruction. Additionally, commanding officers of fixed medical treatment facilities (MTFs) and dental treatment facilities (DTFs)

will maintain ICFs and IPFs on health care providers who are assigned to other activities, as designated by the Chief, Bureau of Medicine and Surgery (BUMED). Disposition of ICFs and IPFs will follow reference (d).

c. Privileging authorities will maintain clinical performance profiles (CPP) documenting applicable activities, as specified in paragraph 13b of this instruction, for all health care practitioners providing direct patient care services.

d. Privileging authorities will grant clinical privileges to health care practitioners using standardized, specialty specific privilege sheets which reflect the currently recognized scope of care appropriate to each health care specialty. Commanding officers are to ensure that health care practitioners provide services and treatments consistent with their approved clinical privileges.

e. Eligible health care practitioners shall be required, upon reporting for clinical duty, to request a professional staff appointment and the broadest scope of core and supplemental privileges commensurate with their level of professional qualification, current competence, the support level available, and the health care demands placed on the treatment facility. Those who fail to maintain required qualifications or those who do not request such privileges are subject to processing for separation for cause under reference (e) for military personnel or administrative action including termination of employment under references (f) or (g) for civilian employees. Commanding officers will ensure the practitioners conform to this guidance and will initiate the required administrative action in a timely manner when practitioners fail to do so. Commanding officers have a duty to provide practitioners the resources and training necessary to enable them to meet their prescribed responsibilities.

f. Commanding officers will assign clinical support staff clinical responsibilities commensurate with their health status, licensure or certification, education and training, and current

competence. Clinical support staff who do not maintain required qualifications or current competence are subject to processing for separation for cause under reference (e) for military personnel or administrative action including termination of employment under references (f) or (g) for civilian employees.

g. Interns may not be granted clinical privileges during their internship. Health care practitioners enrolled in residency or fellowship training programs may not be granted clinical privileges in their training specialty, but may apply for and be granted clinical privileges in the health care specialty for which they are already fully qualified. The practice of granting professional staff appointments and clinical privileges to residents and fellows should be the exception rather than the rule, should impact upon the training program as little as possible, and should only be considered to meet the operational needs of the DON. DON treatment facilities may employ and grant staff appointments and clinical privileges to civilian practitioners who are currently enrolled in graduate medical education (GME) programs only if the practitioner meets all the following criteria:

(1) They have completed all the clinical requirements of their current program.

(2) Their current training program responsibilities are limited to research activities.

(3) They are seeking employment to maintain their clinical skills.

(4) They have the written approval of their training program director to be employed.

h. Commanding officers will assign nontrainee practitioners, who fail to qualify for clinical privileges and are required to practice under supervision, duties commensurate with their licensure or certification, education and training, and current competence as specified in paragraphs 4f through 4h.

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i. Military and civil service practitioners who fail to qualify for clinical privileges within 1 year of reporting for clinical duty are to be processed for separation for cause under reference (c) for military personnel or administrative action including termination of employment under references (f) and (g) for civilian employees, or under the terms of their contract or agreement for contract or partnership practitioners.

j. Health care providers whose professional impairment or misconduct may adversely affect their ability to provide safe, quality care will be immediately removed from direct patient care activities. This is not only a regulatory requirement but a moral and ethical responsibility of the officials involved.

k. With respect to civilian employees, the requirements for reasonable accommodation under reference (h) must be observed when actions are undertaken in compliance with this instruction on the basis of physical or mental impairment.

#### 5. Authority to Grant Professional Staff Appointments and Clinical Privileges.

The Chief, Bureau of Medicine and Surgery (CHBUMED), serving as the governing body, required by the Joint Commission on Accreditation of Health Care Organizations standards, is designated the corporate privileging authority for all DON practitioners. The following are designated representatives of CHBUMED and are hereby authorized to grant professional staff appointments and clinical privileges.

a. The designated privileging authority for practitioners assigned to fixed MTFs or DTFs is the commanding officer of the treatment facility. The Assistant Chief for Health Care Operations and the Assistant Chief for Dentistry, BUMED are designated as the privileging authorities for practitioners who are commanding officers of fixed MTFs or DTFs respectively.

b. The designated privileging authority for practitioners assigned to the fleet, excluding the Fleet Marine Force (FMF), is the fleet type commander or fleet dental officer for dentists. ( R

c. The designated privileging authority for all practitioners, except dentists, assigned to the FMF is the commanding general of the Marine Division (MARDIV), Marine Air Wing (MAW), or Force Service Support Group (FSSG) to which the practitioner is assigned.

d. The designated privileging authority for dental officers assigned to the FMF is the commanding officer of the dental battalion to which the dental officer is assigned. The designated privileging authority for a dentist who is a commanding officer of a dental battalion is his or her commanding general.

#### 6. Investigation and Disposition of Allegations of Health Care Provider Impairment.

Commanding officers will investigate, without delay, allegations of health care provider impairment (physical, mental, or professional) or misconduct, substandard performance, and moral or professional dereliction, including reportable misconduct listed in enclosure (2), by health care providers. Allegations of substandard performance by health care providers received up to 1 year following separation, termination, or retirement also shall be investigated. Commanding officers will initiate administrative, judicial, nonjudicial, or adverse privileging action as applicable upon receipt of allegations of health care provider misconduct listed in enclosure (2). Prompt action is required to safeguard patient care, to protect the rights of the parties involved and to preserve the integrity and effectiveness of the commands involved.

a. Allegations of criminal misconduct by health care providers will be referred to the Naval Criminal Investigative Service and other authorities holding jurisdiction over the alleged offenses. ( R

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b. Acts of misconduct by military health care providers are incidents for which separation for cause may be appropriate and will be reported to the Chief of Naval Personnel as required by enclosure (4) to reference (c).

c. Commanding officers will notify the CHBUMED within 3 working days of initiation of an investigation and within 3 working days after the final verdict, adjudication, privilege action, or administrative disposition has been determined.

d. In those cases where there is a reasonable belief that a health care practitioner is unable to safely execute his or her responsibilities in the practice of his or her health care specialty, the commanding officer will immediately initiate one of the following actions:

(1) Practitioners who have a potentially infectious disease or are undergoing treatment for a temporary medical condition that would not require the convening of a medical board for military personnel under reference (i) will be temporarily reassigned to nondirect patient care activities. This reassignment is not an adverse action and does not require suspension of privileges.

(2) Privileged practitioners whose professional impairment or misconduct may adversely affect their ability to provide safe, quality care will be immediately removed from direct patient care activities by having their clinical privileges suspended or held in abeyance as defined by enclosure (1). This is not only a regulatory requirement but a moral and ethical responsibility as well.

(a) Upon receiving allegations of professional impairment or misconduct by a practitioner, the privileging authority may, at his or her discretion, impose a privilege abeyance. The privilege abeyance period provides an opportunity to conduct an investigation into the allegations while ensuring patient safety and protecting the practitioner from an unwarranted adverse privileging action. Such privilege abeyance will terminate upon completion of the investigation or at

the end of 28 days, whichever occurs sooner. A privilege abeyance is not adverse and is nonpunitive. Any record or notation of a privilege abeyance that results in the practitioner being returned to full clinical duties will be expunged from the practitioner's ICF at the time the privilege abeyance is terminated.

(b) As soon as evidence is identified that supports the allegations, or the investigation substantiates the allegations, the privileging authority will suspend the practitioner's clinical privileges and initiate the Peer Review Panel procedure prescribed in enclosure (3).

(c) Adverse privileging actions are incidents for which separation of military personnel for cause may be appropriate and will be reported to the Chief of Naval Personnel as required by enclosure (4) to reference (c).

(d) The scope of practice of privileged health care practitioners will not be suspended except under the guidelines in this instruction. When privileging authorities suspend clinical privileges, they will initiate the Peer Review Panel procedure prescribed in enclosure (3).

(3) Nonprivileged practitioners, including practitioner trainees in inservice training programs, whose professional impairment or misconduct may adversely affect their ability to provide safe, quality care must be immediately removed from direct patient care activities. Such cases will be investigated, reviewed, and resolved in the same manner as prescribed in this instruction for privileged practitioners with the following exception. Cases that deal solely with the issues of failure to make satisfactory progress in GME programs, including both inservice and outservice programs, will be addressed under procedures established by the CHBUMED.

e. Health care practitioners who have had their privileges suspended or clinical support staff who have been removed from direct patient care activities under this instruction will have their permission, granted under reference (j), to

engage in off-duty employment withdrawn pending final resolution of the problem. The commanding officer will promptly notify known civilian facilities employing the provider that permission for off-duty employment has been rescinded.

#### 7. Actions to be Reported

a. Per paragraph F2b of reference (a), CHBUMED will report within 5 working days the following directly to applicable State or national licensing and certification agencies, applicable professional clearing houses, the National Practitioner Data Bank (when in operation), the Assistant Secretary for Manpower and Reserve Affairs (ASN(M&RA)), and the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

(1) Adverse privileging actions resulting, after completion of any appeal, in denial, limitation, or revocation of clinical privileges or termination of professional staff appointment, as defined in enclosure (1).

(2) Health care providers (both active duty and civilian) who, due to disability, are released from active duty, retired, or have their employment terminated.

(3) Health care providers found to have committed acts of misconduct listed in paragraph 1 of enclosure (2). Agreements governing DON sponsored full-time outservice (FTOS) training programs will contain provisions requiring the participating educational institutions to report to the CHBUMED all allegations and final dispositions involving acts of misconduct by Navy members participating in these programs.

(4) Health care providers referred for courts-martial or indicted by a civilian court for acts of misconduct listed in paragraph 2 of enclosure (2). A followup report will be sent confirming the final verdict, adjudication, or administrative disposition.

b. Director, Naval Council of Personnel Boards will notify the CHBUMED within 3 working days when naval health care providers are approved by ASD(HA) for disability separation (discharge or temporary or permanent retirement).

c. The servicing civilian personnel office will notify the CHBUMED within 3 working days when civilian health care providers are approved by the Office of Personnel Management (OPM) for medical termination or retirement.

#### 8. Confidentiality

a. Documents and records created pursuant to this instruction are medical quality assurance materials within the meaning of reference (k) and are therefore exempt from the requirements of the Freedom of Information Act, reference (l). Such records may not be disclosed to any person or entity and testimony from any person who reviews, creates, or participates in any proceeding that reviews or creates such records may not be required or permitted, with respect to such record, proceeding, or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as follows:

(1) To a Federal executive agency or private organization if the record or testimony is needed to perform licensing or accreditation functions related to Department of Defense (DOD) health care facilities or to perform monitoring of DOD health care facilities required by law.

(2) To an administrative or judicial proceeding commenced by a present or former DOD health care practitioner concerning the termination, suspension, limitation, or revocation of clinical privileges of such health care practitioner.

(3) To a governmental board or agency or to a professional health care society or organization which needs the record or testimony

to perform licensing, privileging, credentialing, or the monitoring of professional standards concerning any health care provider who is or was a member or employee of the DOD.

(4) To any institution that provides health care services and requires the record or testimony to assess the professional qualifications of a health care provider who is or was a member or employee of the DOD and has applied for or been granted authority or employment to provide health care services for such institution.

(5) To an officer, employee, or contractor of the DOD who has a need for such record or testimony to perform official duties.

(6) To a criminal or civil law enforcement agency or instrumentality charged with the protection of public health or safety, if a qualified representative of the agency makes a written request for the record or testimony for a purpose authorized by law or in an administrative or judicial proceeding commenced by such an agency, but only with respect to the subject of such proceeding.

(7) To an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency referred to in paragraph 8a(6), but only with respect to the subject of such proceedings.

(8) To an individual who makes an appropriate Privacy Act request under reference (m).

b. Credentials and privileging files may appropriately contain documents that are not medical quality assurance records such as, criminal investigative reports, indictments, court-martial records, or nonjudicial punishment records. When considering written requests from regulatory or licensing agencies for copies of records which contain such documents, the procedures set forth in reference (m) shall be followed in determining the releasability of

documents that are not medical quality assurance records.

c. In all disclosures, care shall be taken to protect the privacy interests of other providers and patients following the procedures set forth in reference (l).

d. Requests by regulatory or licensing agencies for information regarding permanent adverse privileging actions or reportable misconduct will be referred to CHBUMED.

## 9. Individual Credentials Files

a. The ICF will contain documentation related to the health care practitioner's current and past licensure/certification status, education and training, health status, professional experience, current competence, and other items as listed in enclosure (4). ICFs of privileged practitioners will also contain documentation of past and current clinical privileges.

b. All items listed in enclosure (4) will be collected, verified, and evaluated prior to the individual being selected for naval service, employed by or contracted to the DON, or granted clinical privileges and professional staff appointment by a privileging authority of a Navy MTF or DTF.

c. Responsibility for collection and verification of the items listed in enclosure (4) is as follows:

(1) For direct accessions, recalls to active duty, and interservice transfers to naval service: The Commander, Navy Recruiting Command is responsible, following the documentation guidelines in references (n) through (q). The applicable professional review board appointed under references (n) through (q) will confirm the authenticity of the documents comprising the entering credentials information.

(2) For new civil service employees: The servicing civilian personnel office will collect

and verify the required credentials information prior to hiring the individual.

(3) For new contract practitioners: In the case of individuals contracted directly to the treatment facility, the privileging authority is responsible. If the contract involves an intermediate contracting agency, the contracting agency may be held responsible.

(4) For practitioners reporting for duty following completion of Navy Active Duty Delay for Specialists (NADDS), Armed Forces Health Professions Scholarship Program (AFHPSP), and Uniformed Services University of the Health Sciences (USUHS) programs, the CHBUMED is responsible.

d. The items listed in enclosure (4), plus any related new or updated information, summaries of the Manual of the Judge Advocate General (JAGMAN) investigations or liability claims in which the individual was a principal party, must be maintained in the individual's ICF for the duration of the individual's naval service or employment.

e. Performance appraisal reports (PAR) will be inserted into the individual's ICF and maintained for the duration of the individual's naval service or employment.

f. The information contained in the credentials file must be monitored, continually updated, and reported to the DON centralized credentials database (CCDB) as prescribed by the CHBUMED.

#### 10. Disposition of Individual Credentials Files

a. When an individual is transferred for duty to another DOD treatment facility, the ICF will be forwarded to the gaining facility. The ICFs of health care practitioners transferred to nonclinical assignments will be forwarded to the MTF or DTF designated by the CHBUMED.

b. ICFs of health care practitioners except as specified below, who have separated from the service or terminated employment will be

retained for at least 5 years at the facility where the ICF was last maintained, as required by reference (d). At the time of separation from naval service or termination of employment of Navy health care practitioners, privileging authorities will forward to the CHBUMED the original ICFs of any health care practitioners with permanent adverse privileging actions or investigations of misconduct involving reportable events as listed in enclosure (2) retaining a copy of the ICF in the local file for 5 years. The CHBUMED will place the ICFs in the permanent archives at the Naval Record Center following the guidelines in reference (d).

**11. Granting Professional Staff Appointments and Clinical Privileges to Health Care Practitioners.** To meet the procedural standards of the Joint Commission on Accreditation of Health Care Organizations, health care practitioners will be authorized to provide medical or dental care only through issuance of a written professional staff appointment. The professional appointment will require the practitioner to adhere to the bylaws, rules and regulations of the facility, and the code of professional ethics of their profession, and be accompanied by delineated clinical privileges defining the scope and limits of practice authorized for the practitioner. Commanding officers may not permit practitioners to independently diagnose, initiate, alter, or terminate health care treatment regimens except through staff appointments with accompanying delineation of authorized clinical privileges issued by a privileging authority following this instruction.

a. CHBUMED will prescribe standard, specialty specific clinical privilege sheets providing for two categories of privileges:

(1) Core privileges which, as a group, constitute the expected baseline scope of care and level of expertise for a fully trained and currently competent practitioner of a specific health care specialty. Core privileges will be requested and granted as a single entity.

(2) Supplemental privileges which are itemized, facility specific privileges that are relevant to the specific health care specialty but lie outside the baseline scope of care due to their level of risk, requirements for unique facility support staff or equipment, or are too technically sophisticated or new to yet be included in the core scope of care. Supplemental privileges will be requested and granted on an item-by-item basis.

b. Eligible health care practitioners will apply for a professional staff appointment and delineated clinical privileges from the designated privileging authority upon reporting for clinical duty at a treatment facility. Privileging authorities will grant staff appointment and clinical privileges to practitioners based upon consideration of information documenting the practitioner's past professional performance; verified licensure status and education and training; current health status; current competence, the ability of the treatment facility to support the clinical privileges requested, and the health care demands placed on the treatment facility.

c. The initial professional staff appointment in the Navy health care system will be "provisional", granted for a period not to exceed 12 months. The provisional staff appointment period is intended to provide an opportunity for the practitioner to demonstrate to the privileging authority an understanding of and compliance with the facility's bylaws, rules and regulations, and to demonstrate current clinical competence in the requested clinical privileges as compared against predetermined, command approved evaluation criteria. The command will assign a proctor who will monitor the professional conduct and clinical performance of each practitioner with a provisional appointment. However, the provisional staff appointment is a period of independent practice, not a period of practice under supervision. The intensity and degree of surveillance, monitoring, and oversight required during the provisional staff appointment period is that required to ensure patient safety while evaluating the practitioner's current clinical

competence and is not to be construed as an adverse privileging action.

d. Following satisfactory compliance with facility bylaws, adherence to rules and regulations, and demonstration of current competence as supported by peer recommendations during the provisional staff appointment, the privileging authority will grant the practitioner an active staff appointment with delineated clinical privileges. It is not mandatory to require the practitioner to complete the provisional staff appointment period if demonstrated competence justifies an earlier active staff appointment. Active staff appointments will not exceed 2 years. During the active staff appointment period the practitioner continues to practice independently but is to be monitored and evaluated in clinical performance through the facility's quality assurance program.

e. Privileging authorities must reappraise active staff appointments and associated delineated clinical privileges at least every 2 years. Reappointments will be based upon reappraisal of the practitioner's verified licensure, education and training, current health status, and demonstrated current clinical competence as documented through the command's quality assurance program and as compared against the command approved, department specific criteria for reappointment to the professional staff. Reappointments will be for a period not to exceed 2 years.

f. Professional staff appointments terminate upon detachment from the command incident to permanent change of station (PCS), completion of temporary additional duty (TAD), retirement, or termination of employment, contract, or agreement.

g. Privileging authorities will normally accept current active staff appointments with delineated clinical privileges granted by other DON privileging authorities, allowing the practitioner to exercise those privileges on a nonpermanent basis.

h. Practitioners reporting for clinical duty at a treatment facility on PCS orders who held an active staff appointment with delineated clinical privileges at another command during the 2 years immediately preceding their current reporting date are eligible for direct appointment to the gaining commands' active staff upon their arrival. Provisional appointments are not required.

## 12. Eligibility for Scopes of Care for Health Care Practitioners

a. **Health Care Practitioners.** Facility and specialty specific criteria regarding scope of care will be developed, approved by the privileging authority, and used throughout the credentials review and privileging process.

b. **Trainees.** Facility, program, and year level specific criteria regarding scope of care will be developed, approved by the commanding officer, and used throughout the credentials review process.

c. **Nontrainee Practitioners Requiring Supervision.** The provision of patient care by nonprivileged practitioners (other than trainees) will be defined by a command approved written plan of supervision, specific to the practitioner, that contains the following elements:

- (1) Scope of care permitted.
- (2) Level of supervision required.
- (3) Identification of supervisor.
- (4) Required evaluation criteria.
- (5) Frequency of evaluations.

## 13. Ongoing Assessment of Practitioner Performance

a. Privileging authorities will establish and maintain Clinical Activity Files (CAF), separate and distinct from the ICF, on all health care practitioners, providing direct patient care services. The CAF will contain practitioner specific results from the command's quality

assurance monitoring and evaluation program. In addition, the CAF must include data reflecting workload (productivity), peer review, outcome indicators, and performance assessment. CHBUMED will prescribe the detailed documents to meet the requirements in this paragraph.

b. Information in the CAF will be summarized at 6-month intervals to develop a Clinical Performance Profile (CPP) on each practitioner providing direct patient care services. The CPP must be maintained in the CAF until reflected in a Performance Appraisal Report (PAR) included in the ICF. Summaries of the following elements contained in the CAF, as applicable to the practitioner are required in the CPP:

- (1) Workload indicators relevant to the individual's clinical assignment, e.g., admissions, outpatient encounters, major surgical procedures.
- (2) Occurrence screens (both facility wide and department specific). Occurrence screens are predetermined events or outcomes which if noted to occur are subjected to further review.
- (3) Medical or dental staff monitors.
- (4) Facility wide monitors (utilization review, infection control, external civilian peer review, and patient contact program).
- (5) Number of liability claims, JAGMAN investigations, and risk management reviews in which the practitioner was the principal focus.
- (6) Number of continuing professional education hours and number of professional papers or presentations.
- (7) Positive clinical achievements, e.g., letters of appreciation and other recognition of clinical performance.
- (8) In addition to the items listed in this paragraph, the CPP for practitioners in training programs will contain an academic performance

assessment at 6-month intervals plus an annual recommendation from the program director for or against promotion to the next year's training level.

c. Privileging authorities will complete at intervals not to exceed 2 years, a PAR, as developed by the CHBUMED, on practitioners providing direct patient care services.

(1) The purpose of the PAR is to periodically summarize and evaluate the data contained on the CPPs to ensure that health care practitioners warrant continued assignment of their clinical duties. Additionally, the PARs contained in the ICFs should be reviewed at the time of fitness report preparation.

(2) The PAR will be completed on health care practitioners during the latter portion of the initial provisional professional staff appointment period or prior to the completion of an inservice graduate professional training program to support the granting of an active staff appointment; at the time of separation, termination, or retirement at which time it will be retained with the ICF; upon completion of temporary duty at which time it will be forwarded to the practitioner's privileging authority for inclusion in the practitioner's ICF; prior to transfer to another command for permanent duty at which time the PAR will be forwarded with the ICF to the gaining command; and when 2 years has passed since the last PAR was completed.

**14. Management of Clinical Support Staff.** Commanding officers will ensure that assignments to patient care activities of clinical support staff are based on consideration of the staff member's verified qualifying degrees and licenses, past professional experience and performance, education and training, health status, and current competence as compared to facility, specialty specific criteria regarding eligibility for defined scopes of direct patient care services. Commands will develop eligibility criteria using procedures established by the CHBUMED in coordination with the chiefs of the appropriate corps.

a. Commanding officers of fixed treatment facilities will maintain an IPF on clinical support staff assigned to their facilities. For nonfixed treatment facilities, the designated privileging authority for health care practitioners assigned to the treatment facility will also maintain an IPF on all clinical support staff assigned to those facilities. The IPF will contain documentation of the staff member's experience, professional training, current competence, and verified qualifying degrees and licenses and certifications.

b. The items delineated in paragraph 14a must be collected prior to the individual being selected for naval service, employed by or contracted to the DON, or assigned clinical duties other than under direct supervision as defined in this instruction.

c. Responsibility for initial collection and verification of the items listed in paragraph 14a is as follows:

(1) For direct accessions, recalls to active duty, and interservice transfers to naval service: The Commander, Navy Recruiting Command is responsible, following the documentation guidelines in references (n) through (q). The applicable professional review board appointed under references (n) and (q) will confirm the authenticity of the documents comprising the entering IPF.

(2) For new civil service employees: The servicing civilian personnel office will collect and verify the required credentials information prior to hiring the individual.

(3) For new contract clinical support staff: In the case of individuals contracted directly to the treatment facility, the privileging authority is responsible. If the contract involves an intermediate contracting agency, the contracting agency may be held responsible.

d. The items listed in paragraph 14a plus any related, new, or updated information, summaries of JAGMAN investigations or liability claims in which the individual was a principal party, and performance appraisals will be

maintained in the individual's IPF for the duration of the individual's naval service or employment.

e. The information contained in the IPF must be monitored, continually updated, and reported to the DON CCDB as prescribed by the CHBUMED.

f. The disposition of IPFs will follow the guidelines for disposition of ICFs as described in paragraph 10 of this instruction.

g. The ongoing assessment of the clinical performance of clinical support staff will be through the command's quality assurance program. Upon transfer, separation, termination, resignation, or retirement, and at intervals not to exceed 2 years, an appraisal of each clinical support staff member's clinical performance and conduct will be completed with documentation of same placed in the member's IPF. The appraisal must address at a minimum the member's clinical department assignments, the scope of patient care activities provided by the member, indicators of workload, and results of ongoing monitoring and evaluation of individual performance as determined through the command's quality assurance program.

**15. Assistance with Program Requirements.** For commands which cannot meet the requirements of this instruction due to a lack of adequate numbers of assigned professional staff or expertise within the command, CHBUMED will designate the fixed MTF or DTF to provide the technical support and assistance necessary to achieve compliance with program requirements.

**16. Annual Management Assessment.** The CHBUMED will provide by 30 October each year an annual management assessment of compliance with credentials review, privileging, performance documentation, adverse privileging actions, and health care provider misconduct requirements of this instruction to the ASN(M&RA) via the Chief of Naval Operations (CNO). The assessment will address fixed and nonfixed facilities, headquarters functions, and supporting activities. Emerging trends will be

identified with recommendations to correct or reverse any adverse trends. The CHBUMED will submit to the ASD(HA) an annual QA summary with brief review of major milestones, goals, impact on care, and any other specific subjects as directed by ASD(HA). The report will be provided to ASD(HA) no later than 120 days after the end of each calendar year, per reference (b).

## 17. Responsibilities

a. ASN(M&RA) is responsible for overall policy control and oversight of the program for control of credentials review and clinical privileging of health care providers.

b. The Chief of Naval Operations and the Commandant of the Marine Corps are responsible for carrying out the program prescribed in this instruction.

c. The CHBUMED, under the Chief of Naval Operations, is responsible for technical professional evaluation and execution of the credentials review and privileging program within the guidelines of this instruction. The CHBUMED will:

(1) Issue technical implementation guidelines within 120 days of the date of this instruction, applicable to all DON activities with health care providers, with a copy to ASN (M&RA).

(2) Ensure that the certifications of professional qualifications required by references (n) through (q) are based on verified credentials documents, so identified in the ICF or IPF.

(3) Submit reports, required in paragraph 7, of professional misconduct, convictions, adverse privileging actions, and separations to the appropriate agencies.

(4) Establish in coordination with the chiefs of the appropriate corps, standardized clinical privilege sheets which prescribe both core

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and supplement privileges reflecting currently recognized scopes of care for each health care specialty.

(5) Represent the DON in professional practice and credentials review and privileging matters with the DOD and with other governmental and civilian agencies within DON policy guidelines. CHBUMED will keep the ASN(M&RA) advised in a timely manner of any matter considered by such groups that could impact upon or modify DON policy or programs.

(6) Ensure that privileging authorities, when granting clinical privileges, confirm that the practitioners requesting clinical privileges possess the required qualifying credentials and are currently competent to provide the privileges granted.

(7) Comply with reference (1) by providing applicable Privacy Act statements and ensuring system notices are published in the Federal Registry.

d. The Commander, Naval Recruiting Command will ensure that the requirements of this instruction are met by all commands under his or her cognizance.

e. The Commander, Naval Reserve Force will ensure that the requirements of this instruction are met by drilling health care providers in the Selected Reserve and the Individual Ready Reserve.

f. The Commanding Officer, Naval Reserve Personnel Center will ensure that the requirements of this instruction are met by nondrilling providers in the Individual Ready Reserve.

## 18. Report and Form

a. **Report.** The report to ASD(HA) cited in paragraph 7 is the Health Care Provider Adverse Clinical Privileges Action Report, enclosure (5),

and is assigned report control symbol DD-HA(AR)1611 is approved for 3 years from the date of Change Transmittal 1. The Performance Appraisal Report (PAR) required by paragraph 13c is exempt from reports control by SECNAVINST 5214.2B.

(R)

b. **Form.** The DD 2499 (Oct 92), Health Care Provider Adverse Clinical Privileges Action Report, is available from BUMED, MED-35.

(R)

  
John H. Dalton

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## DEFINITIONS

1. Abeyance. The temporary removal of a privileged practitioner from clinical duties while an inquiry into allegations of practitioner misconduct or professional impairment is conducted. Abeyances shall not exceed 28 days. A privilege abeyance is nonpunitive and is not an adverse privilege action.
2. Adverse Privileging Action. The denial, suspension, limitation, or revocation of clinical privileges based upon privileged practitioner misconduct, professional impairment, or lack of professional competence. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership is also an adverse privileging action.
3. Alcohol or Drug Abuse. The use of alcohol or other drugs to an extent that it has an adverse effect on performance, conduct, specialty, mission effectiveness, or the user's health, behavior, family, or community. The wrongful or illegal possession or use of drugs in any amount also constitutes drug abuse.
4. Clinical Privileging. The process whereby a healthcare practitioner is granted the permission and responsibility to independently provide specified medical or dental care. Clinical privileges define the scope and limits of practice for individual practitioners.
5. Clinical Support Staff. Personnel who are required to be licensed under reference (c) but are not included in the definition of healthcare practitioners. This category includes pharmacists, dental hygienists, and nonprivileged nurses.
6. Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification, experience, and expertise of healthcare providers.
7. Credentials Review. The application and screening process whereby healthcare providers have their credentials evaluated prior to being selected for naval service, employed by the DON, granted clinical privileges, or assigned to patient care responsibilities.
8. Denial of Privileges. An adverse privileging action taken by a privileging authority which denies privileges requested by a practitioner when those privileges are of a nature which would normally be granted at the facility to a practitioner of similar education, training, and experience occupying the same billet. A denial may only be imposed by a privileging authority after the opportunity for a peer review hearing has been afforded to the practitioner.

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9. Disability (physical). Any impairment of function due to disease or injury, regardless of the degree, which reduces or precludes an individual's actual or presumed ability to engage in gainful or normal activity. The term "physical disability" includes mental disease but not such inherent defects as personality disorders and primary mental deficiency, although they may render a member unsuitable for military duty.

10. Healthcare Providers. Healthcare practitioners and clinical support staff collectively.

11. Healthcare Practitioners. Military (active duty and Reserve) and DON civilian providers (Federal civil service, foreign national hire, contract, consultant, or partnership) required by reference (a) to be granted clinical privileges to independently diagnose, initiate, alter, or terminate healthcare treatment regimens. This includes physicians, dentists, nurse practitioners, nurse midwives, nurse anesthetists, clinical psychologists, optometrists, clinical dieticians, podiatrists, clinical social workers, clinical pharmacists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants. Individuals enrolled in training programs leading to qualification for clinical privileges are also considered healthcare practitioners, for purposes of this instruction.

12. Limitation of Privileges. An adverse privileging action taken by the privileging authority which permanently removes a portion of a practitioner's clinical privileges. A limitation may only be imposed by a privileging authority after the opportunity for a peer review hearing has been afforded to the practitioner.

13. Professional Impairment. A personal characteristic which may adversely affect the ability of a practitioner or clinical support staff to render quality care. Professional impairment includes deficits in medical knowledge, expertise, or judgement; unprofessional, unethical, or criminal conduct; and any medical condition requiring the convening of a medical board under reference (i).

14. Professional Staff Appointment. Formal, written authorization to perform patient care. It is accompanied by a delineation of authorized clinical privileges.

a. Active Staff Appointment. Staff appointments granted to practitioners who successfully complete the provisional staff appointment period.

b. Provisional Staff Appointment. The initial naval Medical Department professional staff appointment, granted for a period not to exceed 12 months, to give the practitioner the opportunity to demonstrate to the privileging authority current clinical competence and the ability to comply with the facility's bylaws, rules, and regulations, and the code of professional ethics.

15. Quality Healthcare. That healthcare that in any given situation:

a. Is thought by knowledgeable, responsible clinicians to be in consonance with practice of the applicable professional community.

b. Is associated with a high probability for good clinical results.

c. Is consistent with policies, guidance, and general requirements of authorized accrediting organizations.

d. Is perceived by beneficiaries to be caring, competent, and effective.

16. Revocation of Privileges. An adverse privileging action taken by a privileging authority which permanently removes all of a practitioner's clinical privileges. A revocation may only be imposed by a privileging authority after the opportunity for a peer review hearing has been afforded to the practitioner.

17. Supervision. The process of reviewing, observing, and accepting responsibility for the healthcare services provided by healthcare providers. Levels of supervision are defined as:

a. Indirect. The supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the member not exceeding the authorized scope of care.

b. Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows:

(1) Verbal. The supervisor is contacted by phone or informal consultation before implementing or changing a regimen of care.

(2) Physically Present. The supervisor is physically present through all or a portion of care.

18. Suspension. An initial adverse privileging action which temporarily removes all or a portion of a privileged practitioner's clinical privileges. If only a portion of the practitioner's privileges are removed, it is a partial suspension. This summary action is imposed prior to the initiation of the peer review process.

19. Verification. Confirmation of the authenticity of credentials documents through contact with the issuing agency, (the primary source) or use of a secondary source as authorized by the Deputy Chief of Naval Operations (Manpower, Personnel, and Training) (DCNO(MP&T)) under references (n) through (q). Verification must be documented.

REPORTABLE MISCONDUCT

The following misconduct actions shall be reported, at the times prescribed, to the civilian and military authorities in paragraph 6 of the basic instruction. Each of the actions listed shall be cause for initiation of processing for separation for cause under reference (e) for military personnel or administrative action including termination of employment under references (f) or (g) for civilian employees.

1. Misconduct to be Reported After All Command Action, Including Appeal When Made, is Complete

a. Fraud or misrepresentation involving application for enlistment or commission into naval service that results in discharge from the Navy.

b. Fraud or misrepresentation involving any application for any contract for professional employment, clinical privileges, or extension of service obligation.

c. Proof of cheating on a professional qualifying examination.

d. Abrogation of professional responsibility through any of the following actions:

(1) Deliberately making false or misleading statements to patients as regards clinical skills or clinical privileges.

(2) Willfully or negligently violating the confidentiality between the practitioner and patient except as required by civilian or military law.

(3) Drug abuse.

(4) Being found impaired by reason of alcohol abuse or alcoholism.

(5) Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

(6) Commission of an act of sexual abuse or exploitation related to clinical activities, and such acts not related to clinical activities when, in the judgement of the privileging body, such acts impair the provider's overall effectiveness and credibility within the healthcare system, or within his or her professional or patient communities.

(7) Possessing or using any drug legally classified as a controlled substance, as defined by 21 USC 811 et seq as updated and republished under the provisions of that section in the Code of Federal Regulations, for other than acceptable therapeutic purposes.

Enclosure (2)

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e. Prescribing, selling, administering, or providing Schedule II substances as defined by 21 USC 811 et seq, as updated and republished under the provisions of that section in the Code of Federal Regulations, for use by the practitioner or a family member of the practitioner without prior waiver of policy.

f. Failure to report to the privileging authority any disciplinary action taken by professional or governmental organization reportable under this instruction.

g. Failure to report to the privileging authority malpractice awards, judgments, or settlements occurring outside of DON facilities.

h. Failure to report to the privileging authority any professional sanction taken by a civilian licensing agency or healthcare facility.

i. Commission of any misdemeanor that is punished by actual fine of over \$1,000.00 or confinement for over 30 days.

2. Misconduct to be Reported Upon Referral for Trial by Courts-martial or Indictment in a Civilian Court and Upon Final Verdict, Adjudication, or Administrative Disposition

a. Offenses designated as felonies by the jurisdictions in which the alleged offense occurred.

b. Offenses punishable by confinement or imprisonment for more than 365 days under 10 U.S.C. 801 through 940.

c. Entry of a guilty or nolo contendere plea, or request for discharge in lieu of courts-martial while charged with an offense designated in paragraph 2a or b above.

d. Commission of an act or acts of sexual abuse or exploitation related to the practice of medicine or dentistry.

e. Receiving compensation for treatment of patients eligible for care in DoD hospitals.

f. Prescribing, selling, administering, giving, possessing, or using any Schedule II substances, as defined by 21 USC 811 et seq as updated and republished under the provisions of that section in the Code of Federal Regulations, for other than medically acceptable therapeutic purposes.

PEER REVIEW PANEL PROCEDURES

1. Purpose. The Peer Review Panel procedure is established to provide a process whereby a respondent is afforded a fair and impartial hearing at which time the allegations that form the basis for a potential denial, limitation, or revocation of clinical privileges or termination of professional staff appointment may be responded to or rebutted. When the clinical privileges of a respondent are suspended, the action will be reviewed through the Peer Review Panel procedure.
2. Notice of Privilege Suspension and Advice of Rights. Within 7 days of suspension of privileges, the privileging authority shall notify the respondent in writing of the following matters:
  - a. The date the suspension became effective.
  - b. The scope of the suspension (total or partial) and if a partial suspension, the specific clinical privileges affected.
  - c. That in cases of partial suspension, all clinical privileges could be revoked based upon additional investigative findings or peer review recommendations.
  - d. That his or her staff appointment could be terminated.
  - e. The grounds for the suspension, including the specific misconduct, substandard performance, or professional or personal impairment.
  - f. The right to a reasonable opportunity (normally within 5 days) to consult with counsel or other advisor prior to electing or waiving any of the rights in this paragraph.
  - g. The right to have the case heard at a Peer Review Panel Hearing and to be present at the hearing.
  - h. The right to representation by counsel or other representative at the hearing.
  - i. The right to present evidence at the hearing.
  - j. The right to waive the rights in paragraphs f through i.
  - k. If the final action after completion of all appeal procedures is to deny, limit, or revoke clinical privileges, or terminate staff appointment, that fact will be reported to the Federation of State Medical Boards, States of licensure, National Practitioner Data Bank or other professional clearing house as applicable, the Office of the Secretary of Defense (Health Affairs), and the other organizations or agencies required by this instruction.

Enclosure (3)

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1. That failure to respond after a reasonable opportunity to consult with counsel constitutes a waiver of the rights in paragraphs 2f through i above.

m. That failure to appear without good cause at the hearing constitutes waiver of the right to be present at the hearing.

3. Response to Notice. The respondent will be given 7 days, from the receipt of notice of suspension and advice of rights, to respond in writing. Failure to respond constitutes a waiver of the rights provided in paragraphs 2f through i above. An extension may be granted only upon a timely showing of good cause.

4. Counsel

a. Members of the Armed Forces. Respondent may be represented by an attorney or other person of his or her choice.

(1) Respondent may be represented by civilian counsel or other person at his or her own expense.

(2) Respondent may request military counsel, certified per article 27(b), Uniform Code of Military Justice. Military counsel will be provided by the privileging authority's servicing naval legal service office or law center if reasonably available at the scheduled time of the hearing. Determination of reasonable availability is within the sole discretion of the commanding officer of the servicing office or center.

(3) Respondent may alternatively request military counsel of his or her choice. Requested alternative counsel of choice will be provided if attached to the servicing office or center or assigned duties aboard a Navy or Marine Corps installation at or nearest the site of the hearing, provided such installation is within 100 miles of the proceeding (using the Official Table of Distances) and if reasonably available at the scheduled time of the hearing. Determination of reasonable availability is within the sole discretion of the requested counsel's commanding officer or reporting senior, as applicable.

b. Civilian Respondent. Respondent may be represented by a civilian lawyer or other civilian representative at no expense to the Government.

5. Panel Hearing. If the respondent elects a hearing, the privileging authority shall convene a Peer Review Panel within 30 days of issuing the Notice of Privilege Suspension and Advice of Rights. The panel hearing must begin not less than 30 days after the respondent received actual notice of his or her rights as provided in paragraph 2.

6. Prehearing Disclosure of Information

a. Ten days prior to the hearing, the chairperson shall cause the following information to be provided to all members of the panel, the respondent, and the recorder:

(1) Written notice of the specific time, date, and place of the hearing. The respondent will be reminded that failure to appear before the panel without good cause constitutes waiver of the right to be present at the hearing.

(2) Any documentary evidence supporting the allegations against the respondent to be considered at the hearing. Documentary evidence provided should include reports of investigations, case reviews, medical charts, and journal articles.

(3) The names of witnesses to be called to testify at the hearing and the matters their testimony will cover.

b. Seven days prior to the hearing, the respondent must present to the chairperson, each member of the panel, and the recorder:

(1) Any documentary evidence he or she wishes to be considered at the hearing.

(2) Written notice of the names of witnesses which will be called to testify on the respondent's behalf and the matters their testimony will cover. If the production of any witness would require expenditure of funds by the convening authority, the requirements of paragraphs 8d(5) through (9) apply.

7. Panel Membership, Recorder, and Legal Advisor. The Peer Review Panel will consist of: Three but no more than five members of the professional staff of the facility who are well qualified by reason of experience and judicious temperament, one of whom will be the chairperson of the credentials committee. The chairperson of the credentials committee will serve as chairperson of the Peer Review Panel. Persons expected to be called as witnesses shall not be appointed to the panel.

a. When the respondent is an officer, at least one member of the panel will be of the same competitive category (corps) as the respondent.

b. When the respondent is a civilian, a civilian who meets the qualifications of paragraph 7 shall also be appointed a panel member, if available.

c. The opportunity to serve on a Peer Review Panel should be given to women and minorities. The lack of such a member does not constitute a basis for challenging the proceedings.

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d. The convening authority shall appoint a nonvoting recorder to perform such duties as are appropriate. The recorder shall not participate in closed sessions of the panel.

e. The convening authority may appoint a nonvoting legal advisor to perform such duties as the panel desires. The convening authority may request the servicing naval legal service office or law center to assign a judge advocate as legal advisor for the panel. The commanding officer of the office or center may so assign a judge advocate subject to reasonable availability. The legal advisor shall not participate in closed sessions of the panel.

## 8. Hearing Procedures

a. Presiding Officer. The chairperson shall preside and shall rule finally on all matters of procedure and evidence, except that a challenge for cause against the chairperson shall be decided by the convening authority.

b. Challenge for Cause. The respondent may challenge members of the panel or the legal advisor. Cause for removal of a member exists if a member has a predisposed attitude towards the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. If challenge is made, the respondent must state the grounds. Except for challenges for cause against the chairperson, the remaining members of the panel, in the absence of the challenged member, will determine the validity of challenge by majority vote. The convening authority will determine the validity of the challenge to the chairperson or legal advisor.

### c. Presentation of Evidence

(1) The rules of evidence for courts-martial and other judicial proceedings shall not apply. Oral or written matter not admissible in a court of law may be accepted by a hearing panel. Oral and written matter presented may be subject to reasonable restrictions as to relevance, materiality, competence, and cumulativeness of evidence.

(2) All testimony shall be given under oath or affirmation.

(3) The chairperson may, upon a showing of good cause, allow the introduction of material or information not previously disclosed per paragraph 6. However, if information not previously disclosed per paragraph 6 is to be considered, requests for reasonable delay in the hearing by the adversely affected party should be liberally considered.

d. Witnesses

(1) Witnesses whose testimony will add materially to the issues before the panel shall be invited to appear to offer testimony before the panel if such witnesses are reasonably available.

(2) Panel members shall not be called as witnesses.

(3) Witnesses not within the immediate geographical area of the panel are considered not being reasonably available, except as provided for in paragraph (5).

(4) Statements or depositions shall be admitted and considered by panels from witnesses not reasonably available to testify during a panel proceeding.

(5) The convening authority shall request the commanding officer or activity head to make available for a personal appearance active duty or DON civilian employee witnesses whose personal appearance is essential to a fair determination, but who:

(a) Is not reasonably available to testify, or;

(b) Declines an invitation to testify before a panel.

(6) Respondent will specify in his or her request for witnesses to the convening authority the type of information the witness is expected to provide. Such a request shall contain the following matter:

(a) A synopsis of the testimony that the witness is expected to give.

(b) An explanation of the relevance of such testimony to the issues to be reviewed by the panel.

(c) An explanation as to why written or recorded testimony would not be sufficient to provide for a fair determination.

(7) Requests for witnesses may be denied if not requested in a timely manner.

(8) Witnesses not on active duty or employed by the DON must appear voluntarily and at no expense to the Government, except as provided for by paragraph (10).

(9) The determination of the convening authority concerning whether the personal appearance of a witness is necessary will be final.

(10) If the convening authority determines that the personal appearance of a witness is necessary, the expenditure of funds for production of the witness shall be authorized. In determining whether the personal appearance of a witness is necessary, the convening authority should consider whether:

(a) The testimony of a witness is cumulative.

(b) The personal appearance of the witness is essential to fair determination on the issues.

(c) Written or recorded testimony will not accomplish adequately the same objective.

(d) The need for live testimony is substantial, material, and necessary for a proper disposition of the case.

(e) The significance of the personal appearance of the witness, when balanced against the practical difficulties in producing the witness, favors production of the witness. Factors to be considered in relation to the balancing test include, but are not limited to, the cost of producing the witness, the timing of the request for production of the witness, the potential delay in the proceeding that may be caused by producing the witness or the likelihood of significant interference with military operational deployment, mission accomplishment, or essential training.

(11) If it is determined that the personal testimony of a witness is required, the hearing will be postponed or continued, if necessary, to permit the attendance of the witness.

(12) The hearing shall be postponed or continued to provide the respondent with a reasonable opportunity to obtain a written statement from the witness if a witness requested by the respondent is unavailable in the following circumstances:

(a) When the convening authority determines that the personal testimony of the witness is not required.

(b) When the commanding officer or activity head of a witness determines that military necessity precludes the witness' attendance at the hearing.

(c) When a non-DON employee civilian witness declines to attend the hearing.

e. Rights of the Respondent. Subject to the limitations of paragraphs 6, 8b, and 8d, the respondent has the following rights:

(1) The respondent may testify in his or her own behalf.

(2) The respondent or respondent's counsel may submit written or recorded matter for consideration by the panel.

(3) The respondent or respondent's counsel may call witnesses on behalf of the respondent.

(4) The respondent or respondent's counsel may question any witness who appears before the panel.

(5) The respondent or respondent's counsel may present argument prior to the panel's closing the hearing for deliberation on findings and recommendations.

(6) The respondent or respondent's counsel may challenge a member of the panel or the legal advisor, if any, for cause only. See paragraph 8b above.

f. Deliberations. The panel shall determine its findings and recommendations in closed session, with only the voting members present. A majority vote is required to decide an issue.

g. Record of the Hearing. The record of the hearing shall be kept in summarized form unless the convening authority directs that a verbatim record be kept. If a member has a dissenting opinion, it will be filed with the report.

h. Findings. The panel shall state the findings of fact related to each allegation and the specific evidence it considered as supporting each of the findings as made.

i. Recommendation. The panel will make recommendations to the privileging authority for each allegation supported by a preponderance of the evidence. With regard to respondent's clinical privileges, the panel may recommend:

- (1) Reinstatement or initial granting.
- (2) Denial.
- (3) Limitations.
- (4) Revocation.

With regard to the professional staff appointment, the panel may recommend that it be continued or terminated. A recommendation to terminate the professional staff appointment is inconsistent with a recommendation that would leave any clinical privileges intact. A recommendation to grant or continue a professional staff appointment is inconsistent with a recommendation to deny or revoke privileges.

9. Respondent's Comments on the Panel Report. A copy of the report will be given to the respondent at the time it is submitted to the privileging authority. The respondent may

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submit written comments to the privileging authority within 7 days identifying errors, misstatements, or omissions in the report and stating any disagreements or agreement with the findings of fact or recommendations.

10. Privileging Authority's Action. The privileging authority will advise the respondent of his or her decision on the case and the right to appeal the decision within 7 days of receipt of the panel report or within 7 days of the expiration of the time allowed for the respondent's comments. The privileging authority's decision must be based upon the information contained in the peer review panel report. However, the recommendations of the peer review panel are not binding upon the privileging authority. He or she has the authority and responsibility, as the official granting clinical privileges and staff appointment within the facility, to make an independent decision. If the privileging authority's decision departs from the findings and the recommendations of the panel, the decision must state the basis for that departure.

11. Appeal. A respondent may appeal a decision to deny, limit, or revoke clinical privileges or terminate staff appointment. The appeal must be submitted in writing to the CHBUMED via the privileging authority within 14 days of the privileging authority's decision and must state the specific grounds for appeal. The decision of the privileging authority shall remain in effect during the appeal.

a. Appeal decisions will ordinarily be limited to review of the stated grounds for appeal. For new evidence to be considered, the appeal must show that the information was not available at the time of the hearing and with reasonable diligence could not have been discovered by the respondent.

b. The CHBUMED will review the stated grounds for the appeal, the evidence of record, and any new information included under the provisions of paragraph 11a. The standard for decision on appeal is whether the privileging authority abused his or her discretion. After consultation with the chief of the appropriate corps on substantive professional issues, and legal review, the CHBUMED will grant or deny the respondent's appeal. The decision of the CHBUMED is final.

INDIVIDUAL CREDENTIALS FILE CONTENTS FOR NEW ACCESSIONS, EMPLOYEES  
ENTERING CIVIL SERVICE, AND CONTRACTORS AND OTHERS ENTERING  
UNDER AN INITIAL CONTRACT OR AGREEMENT

1. Evidence of qualifying degrees needed for the performance of clinical privileges, e.g., MD, DO, DDS, DMD, PhD., MSW, etc., and independent verification of these documents.
2. Evidence of postgraduate training, e.g., internship, residency, fellowship, nurse anesthesia, and independent verification of these documents.
3. Evidence of all current State licenses. A listing of all healthcare licenses held within the last 10 years, including an explanation for any license that is not current or that was terminated or lapsed, voluntarily or involuntarily. The current status of all licenses held within the last 10 years must be independently verified.
4. For physician graduates of foreign medical schools. Evidence of passing either the Foreign Medical Graduate Examination of the Medical Sciences (FMGEMS) or the examination of the Educational Commission on Foreign Medical Graduates (ECFMG) and independent verification of same.
5. Evidence of specialty board certifications, if applicable, and independent verification of these documents.
6. A listing of practice experience to account for all periods of time following graduation from medical school, dental school, nursing school, etc.
7. Evidence of current competence (letters of reference and a recent description of clinical privileges as concurred with by the directors of the facility in which the practitioner is or was practicing). The performance appraisal reports (PARs) contained in practitioners' ICFs will serve as letters of reference for practitioners coming from Navy treatment facilities.
8. Documentation of any medical malpractice claims, settlements, or judicial or administrative adjudications with a brief description of the facts of each case.
9. History of any disciplinary action by hospital, licensure/certification board, or other civilian agency. This shall include any resolved or open charges of misconduct, unethical practice, or substandard care.
10. Statement on physical and mental health to include any history of drug or alcohol abuse.

Enclosure (4)

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11. Interview summary by at least one Navy Medical Department officer of the same or similar specialty.

12. When activated, a report from the National Practitioner Data Bank (NPDB). Until such time as the NPDB is active, a report from the Federation of State Medical Boards, or equivalent professional clearing house for nonphysicians will be included. For providers in the Navy healthcare system on the effective date of this instruction, reports from the Federation of State Medical Boards, or equivalent, will be obtained at the time of the next privilege renewal.

INSTRUCTION SHEET  
HEALTH CARE PROVIDER ADVERSE CLINICAL PRIVILEGES ACTION REPORT  
(RCS-DD-HA-(AR)1611)

The attached form is to be used for case reporting to ASD(HA) actions on the limitation, suspension, revocation, or reinstatement of clinical privileges of DoD military and civilian healthcare providers with independent clinical privileges. Check the applicable boxes for each numbered item on initial or first-time actions. When updating an action, as a minimum, respond to items 1 through 7 and 10 through 14.

Item 1. Reporting Period. Enter the fiscal year and the date of the report.

Items 2. and 3. Enter the service filing the report. If the provider is on active duty at the time of the clinical privileges action, indicate the service; otherwise check civilian.

Items 4. and 5. Indicate whether this is an initial report or an update of a previously filed report. The date requested is the date of the action being reported.

Item 6a. Self-explanatory.

Item 6b. Enter the Health Affairs Defense Medical Information System (DMIS) code for the facility responsible for maintaining and reviewing the PCF of the provider. The DMIS number is available from AQCESS or the Patient Administrative Division of the facility.

Item 8. Enter the profession of the provider. If the provider is a physician or a dentist, enter the highest level of education (specialization) and the primary specialty.

Item 9. Self-explanatory.

Item 10a. Clinical Privileges Adverse Action. Enter a brief description of the type of action taken. Examples: Required to have consultation on all inpatients, operative surgery only with supervision, no emergency call, may not prescribe third generation cephalosporins, and American Society of Anesthesiology Class I patients only.

Item 10b. Duration of Action. Self-explanatory.

Item 10c. Other Actions Taken. Enter all applicable actions.

Item 11. Reasons for Action. Enter all applicable reasons. Circle the primary reason in cases involving more than one reason.

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Item 12. Licensing Information. List the States in which the provider is known to be licensed.

Item 13. Notification. Gives a checklist of notifications required by this directive and requires that those agencies notified be listed.

Item 14. Remarks. Self-explanatory.

HEALTH CARE PROVIDER ADVERSE CLINICAL PRIVILEGES ACTION REPORT			REPORT CONTROL SYMBOL DD-HA(AA)1611		
<b>1. REPORTING PERIOD</b>		<b>2. SERVICE REPORTING (X one)</b>			
a FISCAL YEAR	b DATE OF REPORT (YYMMDD)	<input type="checkbox"/> a ARMY	<input type="checkbox"/> b NAVY	<input type="checkbox"/> c AIR FORCE	
<b>4. TYPE OF ACTION (X one)</b>		<b>3. STATUS OF PROVIDER (X one)</b>			
<input type="checkbox"/> a INITIAL	<input type="checkbox"/> b UPDATE	<input type="checkbox"/> a ARMY	<input type="checkbox"/> b NAVY	<input type="checkbox"/> c AIR FORCE <input type="checkbox"/> d CIVILIAN	
<b>5. EFFECTIVE DATE OF ACTION (YYMMDD)</b>		<b>6. MEDICAL TREATMENT FACILITY</b>		<b>7. PROVIDER SSN</b>	
		a NAME		b. DMIS CODE	
<b>B. TYPE OF PROVIDER AND SPECIALTY (X all that apply)</b>					
<b>a. PHYSICIAN</b>					
(1) Highest Level of Specialization					
<input type="checkbox"/> (a) Board Certified	<input type="checkbox"/> (b) Residency Completed	<input type="checkbox"/> (c) In Residency	<input type="checkbox"/> (d) No Residency		
(2) Primary Specialty					
<input type="checkbox"/> (a) In Training	<input type="checkbox"/> (g) Family Practice	<input type="checkbox"/> (m) Orthopedics	<input type="checkbox"/> (s) Radiology		
<input type="checkbox"/> (b) General Medical Officer	<input type="checkbox"/> (h) Internal Medicine	<input type="checkbox"/> (n) Pathology	<input type="checkbox"/> (t) Surgery		
<input type="checkbox"/> (c) Anesthesiology	<input type="checkbox"/> (i) Neurology	<input type="checkbox"/> (o) Pediatrics	<input type="checkbox"/> (u) Underseas Medicine		
<input type="checkbox"/> (d) Aviation Medicine	<input type="checkbox"/> (j) Obstetrics/Gynecology	<input type="checkbox"/> (p) Physical Medicine	<input type="checkbox"/> (v) Urology		
<input type="checkbox"/> (e) Dermatology	<input type="checkbox"/> (k) Ophthalmology	<input type="checkbox"/> (q) Preventive Medicine	<input type="checkbox"/> (w) Other (Specify)		
<input type="checkbox"/> (f) Emergency Medicine	<input type="checkbox"/> (l) Otorhinolaryngology	<input type="checkbox"/> (r) Psychiatry			
(3) Highest Level of Education					
<b>b. DENTIST</b>					
(1) Highest Level of Specialization					
<input type="checkbox"/> (a) Board Certified	<input type="checkbox"/> (b) Residency Completed	<input type="checkbox"/> (c) In Residency	<input type="checkbox"/> (d) No Residency		
(2) Primary Specialty					
<input type="checkbox"/> (a) General Dental Officer	<input type="checkbox"/> (b) Oral Surgeon	<input type="checkbox"/> (c) Other (Specify)			
(3) Highest Level of Education					
<b>c. OTHER PROVIDERS</b>					
<input type="checkbox"/> (1) Audiologist	<input type="checkbox"/> (4) Clinical Psychologist	<input type="checkbox"/> (8) Nurse Practitioner	<input type="checkbox"/> (12) Physician Assistant		
<input type="checkbox"/> (2) Clinical Dietician	<input type="checkbox"/> (5) Clinical Social Worker	<input type="checkbox"/> (9) Occupational Therapist	<input type="checkbox"/> (13) Podiatrist		
<input type="checkbox"/> (3) Clinical Pharmacist	<input type="checkbox"/> (6) Nurse Anesthetist	<input type="checkbox"/> (10) Optometrist	<input type="checkbox"/> (14) Speech Pathologist		
	<input type="checkbox"/> (7) Nurse Midwife	<input type="checkbox"/> (11) Physical Therapist			
<b>9. EMPLOYEE INFORMATION</b>					
<b>a. SOURCE OF ACCESSION (X all that apply)</b>					
(1) Military			(2) Civilian		
<input type="checkbox"/> (a) Volunteer	<input type="checkbox"/> (b) Armed Forces Health Professional Scholarship Program	<input type="checkbox"/> (c) Uniformed Services University of Health Sciences	<input type="checkbox"/> (a) Civil Service	<input type="checkbox"/> (b) Contracted	
<input type="checkbox"/> (d) Ready Reserve of the National Guard or Reserve Components	<input type="checkbox"/> (e) Other (Specify)		<input type="checkbox"/> (c) Consultant	<input type="checkbox"/> (d) Foreign National (Local hire)	
			<input type="checkbox"/> (e) Other (Specify)		
<b>b. PAY GRADE</b>		<b>c. YEARS OF FEDERAL SERVICE</b>		<b>d. MEDICAL SCHOOL TRAINING (X one)</b>	
				<input type="checkbox"/> (1) United States <input type="checkbox"/> (2) Foreign	
<b>10. CLINICAL PRIVILEGES ADVERSE ACTION</b>					
<b>a. PRIVILEGES AFFECTED BY THE ACTION</b>			<b>c. OTHER ACTIONS TAKEN (X all that apply) (If more than one reason, circle primary reason.)</b>		
			Pending	Completed	
			(1) Investigation / Review		
			(2) Rehabilitation		
			(3) Retraining		
			(4) On-the-Job Training		
			(5) Full Reinstatement of Privileges		
			(6) Partial Reinstatement of Privileges		
			(7) Separated for Cause		
			(8) Fired		
			(9) Separated / Resigned		
			(10) Retired		
(11) Other (Specify)					
<b>b. DURATION OF ACTION (X one)</b>					
<input type="checkbox"/> (1) Suspension (Pending Investigation) (Enter length of time)	<input type="checkbox"/> (2) Permanent (X (a) or (b))				
	<input type="checkbox"/> (a) Limited	<input type="checkbox"/> (b) Revoked			

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11. REASON FOR ACTION (X all that apply)			12. LICENSING INFORMATION		
<input type="checkbox"/>	a. UNPROFESSIONAL/FRAUDULENT BEHAVIOR		a. STATE OF LICENSE	b. LICENSE IS (X one)	
<input type="checkbox"/>	b. DRUG ABUSE			Active	Inactive
<input type="checkbox"/>	c. MEDICAL DISABILITY				
<input type="checkbox"/>	d. PSYCHIATRIC				
<input type="checkbox"/>	e. INCOMPETENT SKILLS				
<input type="checkbox"/>	f. OTHER (Specify)				
<b>13. NOTIFICATION</b>					
a. MANDATORY NOTIFICATION IS REQUIRED FOR THE FOLLOWING:		State(s) of License	Clearing House	b. DOCUMENTATION OF NOTIFICATION	
(1) Incompetence	Yes	Yes		(1) Name of State(s) and Clearing House	(2) Date Notified (YYMMDD)
(2) Privilege Restrictions	Yes	Yes			
(3) Privilege Revocation	Yes	Yes			
(4) Formal Criminal Charge	Yes	No			
(5) Resolution of Charges					
(a) Innocent	Yes	No			
(b) Guilty Plea	Yes	Yes			
(c) Nolo Contendere	Yes	Yes			
(d) Separation in Lieu of Court-Martial	Yes	Yes			
14. REMARKS					