DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6010.31
BUMED-M00J
15 Apr 2016

BUMED INSTRUCTION 6010.31

From: Chief, Bureau of Medicine and Surgery

Subj: MANAGEMENT AND REPORTING OF CLINICAL ADVERSE ACTIONS AND PROFESSIONAL MISCONDUCT FOR PRIVILEGED HEALTH CARE PROVIDERS AND NON-PRIVILEGED CLINICAL SUPPORT STAFF

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) The Joint Commission Hospital Accreditation Standards Manual
(c) BUMEDINST 6010.30
(d) SECNAVINST 1754.7A
(e) BUMEDINST 1524.1B
(f) SECNAVINST 1850.4E
(g) OPNAVINST 7220.17
(h) SECNAVINST 1920.6C
(i) DON Civilian Human Resources Manual, Subchapter 752
(j) 10 U.S.C. §1102
(k) DoD Instruction 6490.04 of 4 March 2013

Encl: (1) Definitions
(2) Reportable Professional Misconduct
(3) Preliminary Matters
(4) Investigation and Evaluation
(5) Procedures for Privileged Health care Providers
(6) Procedures for Non-Privileged Clinical Support Staff
(7) Administrative Hearing Guide
(8) Appeal Process
(9) Sample Letters

1. Purpose. To update and establish policy, assign responsibility, and prescribe procedures for the management and reporting of clinical adverse actions and professional misconduct for privileged health care providers and non-privileged clinical support staff for the Department of the Navy (DON), per references (a) through (c).

2. Cancellation. BUMEDINST 6320.67A.

3. Scope and Applicability. This instruction applies to all military (active duty and reserve), and civilian health care providers, including non-privileged clinical support staff, who are assigned to, employed by, contracted to, or employed within DON activities. This instruction

does not apply to health care providers credentialed and privileged through Commander, Navy Installations Command per reference (d). Trainees in Navy Graduate Medical Education Programs per reference (e) are subject only to the reporting of professional misconduct as described in this instruction.

4. Definitions. See enclosure (1).

5. Policy

a. General

(1) Navy Medicine provides quality health care by ensuring its practitioners are properly qualified, trained, and competent. Privileged providers and clinical support staff who cannot deliver safe, quality, competent patient care, must not be permitted to engage in patient care activities. In these instances, clinical adverse actions are appropriate when there is evidence of clinical incompetence, professional misconduct, or impairment that could create a risk/harm, or has created a risk/harm, to patient(s), or staff safety. The procedures set forth in this instruction provide a mechanism to promptly assess such cases and afford individuals appropriate due process.

(2) Only conduct that is detrimental to the delivery of safe, competent patient care may be the basis for a clinical adverse action. Examples of professional misconduct that may be detrimental to the delivery of safe, competent patient care are provided in enclosure (2). The clinical adverse action process may not be used as a disciplinary tool. Conduct that may be the basis for a clinical adverse action may also violate local, state or federal law, the Uniform Code of Military Justice (UCMJ), or other military regulations. In those instances, it may be appropriate to pursue a clinical adverse action, as well as disciplinary action. Where disciplinary action is contemplated, consultation with a staff judge advocate (SJA) or health law attorney is required to ensure proper military and or civilian procedures are followed.

(3) Providers and support staff who are undergoing treatment or evaluation for a temporary medical or mental health condition not requiring a medical board per reference (f), or who have a potentially infectious disease, may be reassigned to non-direct patient care activities. Reassignment is temporary and the prognosis of the medical or mental health condition must be evaluated at regular intervals to assess the provider's ability to safely resume patient care activities. Administrative reassignment is a non-adverse, non-reportable action.

(a) The limitation on practice or need for special equipment due to a medical condition requiring an accommodation is considered administrative and is not a clinical adverse action when the provider is able to provide safe, competent care. (Examples: a provider with back problems sees fewer patients as he or she is unable to stand for more than a few hours or a provider with a hearing impairment requires a special stethoscope).

(b) The limitation of privileges (for providers) or clinical practice (for non-privileged clinical support staff) infected with hepatitis B virus (HBV), hepatitis C virus (HCV), and or the human immunodeficiency virus (HIV), solely based upon a risk of disease transmission to a patient, is considered administrative and is not a clinical adverse action. (Example: an HIV infected surgeon who is outwardly healthy, but who is restricted from performing invasive surgical procedures due to a risk of provider-to-patient HIV transmission).

(c) The limitation or revocation of privileges (for providers) or clinical practice (for non-privileged clinical support staff) infected with HBV, HCV, or HIV as a result of impairment caused by severe illness is considered a clinical adverse action. (Example: an HIV infected provider who has become physically debilitated to the point he or she can no longer safely practice).

(d) Additional guidance on obtaining authorization to allow providers and support staff infected with HBV, HCV, or HIV to perform certain procedures can be found in reference (c).

(4) If warranted, a clinical adverse action must be taken regardless of the individual's affiliation with the organization (i.e., contract employee, provider from another military Service, or volunteer) or duty status within the medical treatment facility (MTF). Severing the employment, relationship (e.g., transfer, separation, retirement, or resignation) or negotiating a contractual or employment settlement (e.g., voluntary relinquishment of some or all privileges/clinical practice) in lieu of taking a clinical adverse action that is indicated, is not permitted.

(5) Individuals are informed in writing at the initiation of an abeyance or removal action that if they end affiliation with the Navy through separation, resignation, or retirement they have a right to request that the due process procedures be continued. He or she must submit a written request to the privileging authority within 5 calendar days after learning of the change in their affiliation status. No adverse reports will be made until the due process procedures are complete. However, if the individual waives this right or fails to submit a request, the process will continue through the convening of a peer review panel to the issuance of a decision by the privileging authority based on the panel's recommendations. Such decision by the privileging authority will be final as the right to a formal hearing (if the decision is adverse) and appeal of a final adverse decision has been waived.

(6) Military providers who are the subject of a final clinical adverse action must have their special pays re-evaluated per reference (g).

(7) Final clinical adverse actions may warrant separation for cause for military officers per reference (h) and personnel actions for Federal civilian employees per reference (i).

(8) Time lines are in calendar days and are established to allow individuals adequate time to prepare for, sufficiently participate in the proceedings, and to facilitate timely resolution of a clinical adverse action. Although it is important that time limits in this instruction are met, no additional rights accrue to the benefit of an affected individual, in an otherwise proper action, based solely on the command's failure to meet such time limits.

b. Clinical Adverse Action Process. The process for affecting the privileges of providers or the clinical practice of support staff requires the same basic steps: notification, quality assurance (QA) investigation, peer review, hearing, and appeal. These procedures provide a framework to balance the interest of patient safety and quality of care along with the competing interests of due process, fundamental fairness, and equal treatment. Details explaining these steps and sample letters can be found in enclosures (3) through (9).

c. Basic Principles. The following basic principles apply in all phases of the clinical adverse action process:

(1) Regular monitoring and evaluation (M&E) of an individual's clinical practice provide an opportunity to discover deficits that should initially be addressed through non-adverse methods such as Ongoing Professional Practice Evaluations, Focused Professional Practice Evaluations (FPPE), monitoring, mentoring, training, and education. In all but extreme cases when there is an immediate concern for patient safety, remediation should first be attempted and documented prior to initiating a clinical adverse action.

(2) Patient safety and the furtherance of quality health care are the primary factors affecting decisions and actions.

(3) Criminal or other misconduct that is not consistent with acceptable ethical, medical, or professional standards may also be detrimental to patient safety and the delivery of quality patient care. It may also have a negative effect on the medical staff, patient communities, and the integrity of Navy Medicine.

(4) Prior to proceeding with any clinical adverse action, consultation with a SJA or health law attorney for the MTF and/or appropriate Navy Medicine Region is required. The SJA and/or health law attorney will ensure that appropriate due process and legal rights are afforded from the outset of any action that may be taken.

(5) All final decisions and actions must be warranted by the facts and comply with the procedures in this instruction.

6. Responsibilities

a. Privileging Authorities must:

(1) Inquire into and, when necessary, investigate, without delay, allegations of health care provider or support staff clinical incompetence, impairment, or professional misconduct. Prompt action is necessary to safeguard patient care, to protect individual rights, to preserve the effectiveness and integrity of Navy Medicine, and to initiate judicial, non-judicial, clinical adverse action, or other administrative action as appropriate.

(2) Be designated as a privileging authority as defined in reference (c), in order to initiate the procedures in this instruction; this authority cannot be further delegated. When a clinical adverse action is initiated, the privileging authority must be actively involved in the entire process. It is strongly recommended that an acting commanding officer (CO) only initiate these procedures in those instances where the privileging authority is absent and circumstances require immediate action. Every effort should be made to notify and consult with an absent privileging authority prior to initiating action.

(3) Withdraw any permission for the privileged provider and non-privileged support staff to engage in clinically-related employment outside Navy Medicine from the initiation of an abeyance (for privileged providers) or initiation of the removal from patient care duties (for non-privileged clinical support staff) until all due process procedures are completed. Notification letters must be given to any military or civilian health facility where the provider is currently practicing.

(4) Ensure appropriate consultation with either the Civilian Human Resources office (HRO) or contracting officer when a clinical adverse action is initiated against a Federal civil service employee or contract employee. Such consultation ensures that appropriate employee guidelines or contract provisions are also followed.

(5) Ensure that due process, notification procedures, and clinical adverse action decisions comply with this instruction.

(6) Forward results of completed disciplinary actions involving professional misconduct of privileged providers and non-privileged clinical support staff to Special Assistant for Medical-Legal Affairs/Staff Judge Advocate, Bureau of Medicine and Surgery (BUMED-M00J) with recommendation for reporting as appropriate.

b. Medical Staff Professionals must:

(1) Manage the command's clinical adverse action process in consultation with the command's SJA or health law attorney. Any correspondence related to this process must be reviewed and cleared by the SJA or health law attorney.

(2) Assist appointed investigating officers (IO) in the collection of records or documents required for review and inclusion in the investigative report.

(3) Provide copies of documents under review to appointed members of a peer review panel and to the subject provider or individual.

(4) Assist appointed recorders in the preparation of materials for formal hearings.

(5) Ensure delivery and receipt of all notification letters to the subject provider or individual.

(6) Notify BUMED-M00J within 5 calendar days of issuance and provide copies of documentation regarding an abeyance, the temporary removal from patient care (non-privileged clinical support staff), the notice of peer review panel, the summary suspension of clinical privileges, the report of the peer review panel, a proposed adverse decision, a notice of hearing, the report of the hearing panel, and the final decision in all clinical adverse action cases.

(7) In cases resulting in a clinical adverse action, the medical staff professional is also responsible for forwarding to BUMED-M00J the complete case file (notification letters, investigations, reports, transcripts, exhibits, attorney communications, etc.) within 14 calendar days of the privileging authority's final decision letter or the first endorsement on an appeal of a clinical adverse action.

c. SJA and Civilian Health Law Attorneys must:

(1) Provide advice to privileging authorities, Chairs of the Credentials Review Committees (CRC) and Medical/Nurse Executive Committees (MEC/NEC), medical staff professionals, and other staff regarding legal aspects of clinical adverse actions.

(2) Provide guidance to IOs assigned to conduct peer review QA investigations and review reports of QA investigations for legal sufficiency.

(3) Ensure legal requirements and timelines are met regarding due process procedures. Review all documents related to this process prior to signature by the privileging authority.

d. Special Assistant for Medical-Legal Affairs/Staff Judge Advocate (BUMED-M00J) must:

(1) Provide direct oversight of Navy Medicine's Clinical Adverse Action Program.

(2) Develop and maintain instructions implementing Navy Medicine's Clinical Adverse Action Program.

(3) Provide policy support and technical assistance regarding clinical adverse actions.

(4) Review all final clinical adverse actions for due process requirements and legal sufficiency. In appeal cases, coordinate the formal appeal committee process and prepare a recommendation to Chief, BUMED.

(5) Report all clinical adverse actions to the appropriate reporting entity (National Practitioner Data Bank (NPDB), state(s) of licensure, regulatory agencies, professional organizations, and the Defense Practitioner Data Bank/Centralized Credentials and Quality Assurance System database) within 30 calendar days of Chief, BUMED's decision.

(6) Respond to queries from employers or regulatory agencies on current or former DON health care providers who have been the subject of a final clinical adverse action or reportable professional misconduct.

7. Confidentiality. All documents generated for the clinical adverse action process are privileged and protected per reference (j) and should be marked accordingly. These documents must not be released without proper authority.

8. Records. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV M-5210.1 of January 2012.

9. Reports. The reports required in paragraph 6c(5) are exempt from reports control per SECNAV M-5214.1 of December 2005, part IV, paragraph 7p.

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DEFINITIONS

1. Abeyance. The temporary reassignment away from clinical duties while a QA investigation is conducted. A period of abeyance cannot exceed 30 calendar days from the date of notification to the provider. At the end of an abeyance, if privileges are not reinstated the action will automatically become a summary suspension. An abeyance is non-adverse and is not reportable.

2. Adverse Practice Action. A limitation on the scope of practice of the non-privileged clinical support staff, including removal from patient care, based upon lack of clinical competence, impairment, or professional misconduct adversely affecting the delivery of health care.

3. Adverse Privileging Action. The denial, suspension, restriction, reduction, or revocation of a health care provider's clinical privileges based upon lack of clinical competence, impairment, or professional misconduct adversely affecting the delivery of health care.

4. Clinical Adverse Action. Action invoked against a health care provider or the non-privileged clinical support staff with the result that the authority to practice clinically is adversely affected. A clinical adverse action is taken in response to a provider's acts or omissions (e.g., clinical incompetence, impairment, or professional misconduct) that creates or may create a risk to patient safety, quality of health care, or the integrity of the military health system (MHS).

5. Clinical Incompetence. Any deficits in medical knowledge, expertise, or judgment that creates or may create a risk to patient safety or adversely affects or may adversely affect the ability to render quality care.

6. Clinical Privileges. Permission by the privileging authority to independently and without supervision provide medical and other patient care services within defined limits based on the provider's education, training, professional license, experience, competence, ability, health, and judgment.

7. Credentials. The documents that constitute evidence of appropriate education, training, licensure or certification, experience, and expertise of a health care provider.

8. Denial of Clinical Privileges. The refusal to grant requested privileges to a provider, upon application for initial, active, renewal, or modification of privileges application due to clinical incompetence, impairment, or professional misconduct. A denial of privileges is an adverse privileging action that is reportable to the NPDB. Denial of privileges due to facility-related limitations is not adverse and is not reportable to the NPDB.

9. FPPE. A process that requires M&E of an individual's professional performance and competence to identify performance deficiencies that may impact quality of care and patient safety. Criteria and methods for a FPPE can be found in reference (c). Practice under a FPPE is not adverse and is not reportable.

10. Impairment. A physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs, including alcohol, that results in an individual being unable to practice clinically with reasonable skill and safety.

11. M&E. A well-defined, time-limited, well documented plan of intensified peer review to confirm a provider or non-privileged clinical support staff possesses the skill, knowledge, and ability to render safe and effective health care.

12. NPDB. The national data repository of actions against health care providers and reports of malpractice payments managed by the Department of Health and Human Services per 42 U.S.C. §1101.

13. Peer Review. Any assessment of the quality of medical care carried out by a health care professional (privileged provider or non-privileged clinical support staff), including an individual's clinical performance, impairment, and professional misconduct.

14. Peer Review Panel. The convening of at least three clinical peers to determine the merits of allegations involving clinical incompetence, impairment, or professional misconduct and to recommend actions involving clinical privileges or practice. The clinical peers must be of similar clinical specialty, education, and training as the health care provider or non-privileged clinical support staff under review.

15. Professional Misconduct. Unprofessional, unethical, or criminal conduct that creates or may create a risk to patient safety, quality of health care, or the integrity of the MHS.

16. Reduction in Clinical Practice. The permanent removal of a portion of the non-privileged support staff's clinical practice after due process procedures are completed. Reduction of clinical practice is reportable to the appropriate licensing or regulatory agencies.

17. Reduction of Clinical Privileges. The permanent removal of a portion of a health care provider's clinical privileges after due process procedures are completed. Reduction in clinical privileges is reportable to the NPDB.

18. Reinstatement of Clinical Practice. The return of non-privileged clinical support staff to regular clinical activities.

19. Reinstatement of Clinical Privileges. The return of all regular clinical privileges. Reinstatement of privileges after a reported adverse privileging action requires a revision of that report to the NPDB.

20. Removal from Clinical Practice. The permanent removal of all of the non-privileged support staff's clinical practice and patient care activities after due process procedures are completed. Removal from clinical practice is reportable to the appropriate licensing or regulatory agencies.

21. Restriction of Clinical Practice. The temporary or permanent limit placed on all or a portion of the non-privileged support staff's clinical practice after due process procedures are completed. A restriction requires some form of supervision. Restriction of clinical practice is reportable to the appropriate licensing or regulatory agencies.

22. Restriction of Clinical Privileges. The temporary or permanent limit placed on all or a portion of a health care provider's clinical privileges after due process procedures are completed. The provider may perform those affected privileges under supervision if authorized by the privileging authority. Restriction of clinical privileges is reportable to the NPDB.

23. Revocation of Clinical Privileges. The permanent removal of all of a health care provider's clinical privileges and the permanent removal from all patient care activities after due process procedures are completed. Revocation of clinical privileges is reportable to the NPDB.

24. Standard of Care. Health care diagnostic or treatment judgments and actions of a provider generally accepted in the health care discipline or specialty involved as reasonable and appropriate.

25. Summary Suspension of Clinical Privileges. The temporary removal of all or part of a health care provider's clinical privileges taken prior to the completion of due process procedures. A summary suspension is valid for 6 months and continues until due process procedures are completed. Extensions beyond 6 months require approval from BUMED-M00J. A summary suspension of privileges is not reportable unless the final action is reportable.

26. Suspension of Clinical Practice. The temporary removal of the non-privileged support staff from clinical practice and patient care activities after due process procedures are completed. Suspension of clinical practice is reportable to the appropriate licensing and regulatory agencies.

27. Suspension of Clinical Privileges. The temporary removal of all or part of a health care provider's clinical privileges or the temporary removal of the provider from all patient care duties after due process procedures are completed. Suspension of clinical privileges is reportable to the NPDB.

REPORTABLE PROFESSIONAL MISCONDUCT

1. Disciplinary actions involving acts of professional misconduct or similarly unprofessional incidents by health care providers or suppliers will be reported to the NPDB in cases where the conduct had or could have adversely affected the delivery of a health care item or service. Personnel (active duty, civil service, and personal service contractors) in any position or assignment providing health care services, whether in direct patient care or in support of the delivery of health care, are subject to reporting. Reporting of health care providers and suppliers is not exclusive to those individuals who are licensed, certified, registered, or privileged.

2. With the advice and recommendation of the SJA or civilian health law attorney, the following acts of misconduct must be investigated and a determination made whether to pursue disciplinary action. Each of the listed acts may also be cause for initiation of processing for separation from naval service for active duty members, adverse personnel actions for civilian employees, and other actions for contract employees.

3. Misconduct which must be reported to BUMED-M00J after all command action, including appeals, is complete:

a. Fraud or misrepresentation involving application for initial, active, modification, or renewal of credentials, staff appointment, and privileges. This includes, but is not limited to, failure to disclose any sanction issued by a licensing or regulatory agency in a timely manner (within 7 calendar days), any ongoing investigations by a licensing or regulatory agency, falsifying credentials, forging signatures on peer reference letters, and other intentional acts or omissions meant to deceive the credentialing and privileging process.

b. Theft of government or personal property committed in a clinical setting.

c. Drug offenses to include illegal use, possession, or distribution of controlled substances; diversion of narcotics; self-prescribing; or other improper prescribing of controlled medications.

d. Reporting to or performing clinical duties while under the influence of alcohol or drugs.

e. Alcohol or drug abuse.

f. Acts of sexual abuse or exploitation related to patient care.

g. Engaging in a sexual or other inappropriate relationship with a patient that violates professional boundaries.

h. Assaulting patients or staff or engaging in threatening behavior while performing clinical duties.

i. Other acts or omissions for which the provider is formally disciplined that can be considered related to the delivery of a health care item or service that had or could have negatively affected the provision of health care.

4. Chief, BUMED is responsible for reporting to the NPDB administrative and disciplinary actions involving health care providers (privileged, non-privileged, and those who are licensed or certified to perform health care services) and suppliers (individuals who furnish, whether directly or indirectly, health care services, supplies, items, or ancillary services regardless of licensure, certification, or registration status) who deliver health care services to Department of Defense (DoD) beneficiaries. Chief, BUMED reports to the NPDB the following adverse actions:

a. UCMJ actions resulting in convictions by courts-martial (once approved by the courts-martial convening authority) or non-judicial punishment (once finalized) when the acts or omissions for which the member was convicted or punished are found to be related to the delivery of a health care item or service that had or could have negatively affected the provision or delivery of health care. Examples include, but are not limited to, fraud, drug or alcohol-related incidents, assault, homicide, sexual misconduct, and theft.

b. Other final adjudicated administrative personnel actions resulting in:

(1) Separation, reduction in grade, involuntary military occupational specialty reclassification, or other administrative actions when such action is found to be related to the delivery of a health care item or service that had or could have negatively affected the provision or delivery of health care.

(2) Adverse personnel actions involving civilian employees based on acts or omissions that are found to be related the delivery of a health care item or service that had or could have negatively affected the provision or delivery of health care. Examples include, but are not limited to: fraud, drug or alcohol-related incidents, assault, homicide, sexual misconduct, and theft. Adverse disciplinary actions include suspension of more than 14 calendar days, removal from Federal employment, and change to lower grade based on disciplinary procedures. Actions such as furlough without pay, and reduction in grade, or removal based on performance are not reportable, unless related to the delivery of health care.

c. Reportable actions involving contract personnel include contract termination for default taken by an MTF or military command against a personal or non-personal services contractor providing medical services.

5. COs of Navy Medicine health care providers and suppliers are responsible for identifying administrative or disciplinary actions that meet the criteria in paragraph 2 of this enclosure, and forwarding such actions to BUMED-M00J with a recommendation to report the case to the NPDB. Medical program managers (e.g., respective Corps Chiefs and Independent Duty Hospital Corpsman Program management) should also be notified of these actions.

a. The CO will notify the individual in writing of the adverse effect the misconduct had or could have had on the provision of a health care item or service and that the case will be forwarded to Chief, BUMED for final determination and reporting to the NPDB as appropriate. The individual will also be notified that he or she may submit a statement within 14 calendar days regarding the recommended reporting of the misconduct. If submitted, this statement will be commented on, and attached to, the forwarding letter to Chief, BUMED.

b. The requirement to report these actions to BUMED-M00J applies to all Navy health care providers and suppliers including military members (officers and enlisted), Federal civilian employees, and contractors regardless of privileging status or possession of state licenses, certifications, or registrations.

6. Professional misconduct recommended for a potential clinical adverse action will follow the procedures in enclosures (3) through (8). It is possible that acts or omissions by a provider may result in multiple reports to the NPDB (i.e., adverse privileging action and adverse administrative/discipline action).

PRELIMINARY MATTERS

1. Upon discovery or notification of possible provider or support staff clinical incompetence, impairment, or professional misconduct. The privileging authority must:

a. Follow the procedures of this instruction. The procedures remain unchanged regardless of whether the individual later separates from military Service or otherwise terminates employment with DoD. Voluntary offers to resign or limit privileges in lieu of adverse privileging action will not be accepted.

b. Consult with the MTF SJA or other health law attorney for guidance on the procedures in this instruction.

c. Determine if the circumstances leading to the allegation require immediate action to protect patient safety and, if warranted, temporarily remove the individual from clinical practice by invoking an abeyance or a temporary removal from patient care (non-privileged provider). An abeyance/temporary removal is not an adverse action; however, the individual is notified in writing that a review of his/her practice has begun which may result in a clinical adverse action. An abeyance can last up to 30 calendar days; temporary removals are not time specific. Any permission for the individual to engage in clinically-related outside employment must be withdrawn from the initiation of an abeyance/temporary removal until all due process procedures are completed.

d. Appoint an IO to conduct a QA investigation into the allegations. If the individual under review is a military member, the IO should be of the same or senior rank. The IO must be an impartial peer of the provider under investigation with similar education, training, clinical specialty, and experience and who does not have a personal or professional conflict of interest related to the investigation. The IO can be selected from another command or military Service if appropriate.

2. Allegations involving individuals who have separated from military Service, government employment, or no longer providing contract services prior to discovery of the acts or omissions giving rise to the allegations cannot result in a clinical adverse action affecting privileges or clinical duties. However, if allegations are received within 1 year of the individual's separation, the privileging authority must:

a. Appoint an IO to conduct a QA investigation into the allegations.

b. Refer the completed QA investigation to the MEC/NEC or CRC for recommendation on what action would have been taken if the provider were still working for the Navy. If the privileging authority decides that a clinical adverse action would not be appropriate, the matter is closed.

c. In cases where the privileging authority decides a peer review panel would have been convened and a clinical adverse action would have been appropriate, forward the QA investigation to BUMED-M00J. In addition, the privileging authority will also send a redacted copy of the QA investigation per the Privacy Act of 1974 to the former member, employee, or contractor advising him or her of the investigation and affording an opportunity to submit comments on the investigation to be sent directly to BUMED-M00J within 30 calendar days from receipt of the notification. Chief, BUMED will review the case, the individual's comments (if submitted), and determine if the results of the QA investigation should be reported to the provider's state(s) of licensure, certification, or registration.

INVESTIGATION AND EVALUATION

1. QA Investigation

a. The purpose of the QA investigation is to determine whether allegations of clinical incompetence, impairment, or professional misconduct involving a provider or support staff can be substantiated.

b. The IO is appointed in writing. The IO must be an impartial peer of the individual under investigation (i.e., with similar education, training, clinical specialty, and experience). The IO must not have a personal or professional conflict of interest related to the investigation. If appropriate, an IO can be appointed from outside the command.

c. The IO should consult with the MTF SJA or other health law attorney before beginning his or her investigation in order to receive instruction on how to conduct the investigation and guidance on the format of the investigative report.

d. The IO must collect relevant facts, review and preserve documentation and other evidence, and make findings as to whether the allegations are substantiated or not.

e. The IO may testify at any hearing conducted following the investigation and may be required to provide clarifying information or respond to questions by reviewing committees as appropriate. Requests for the IO to provide additional information or investigation will be submitted in writing to the privileging authority and, along with any responses from the IO, will be made an addendum to the QA investigation.

2. Cases Involving Naval Criminal Investigative Service (NCIS) and Command Investigations

a. Allegations involving professional misconduct may also become the subject of a NCIS or command criminal investigation. The QA investigation should not conflict or interfere with these investigations; this may result in the QA investigation being delayed pending the completion of such investigations. The privileging authority, or IO, should coordinate through the MTF SJA with the assigned NCIS agent or command IO to determine when the criminal investigation is completed and the QA investigation can resume.

b. It is permissible to delay the processing of a clinical adverse action pending the completion of a criminal case. When the criminal investigation and disposition of the charges are completed, those documents may be included in the initial QA investigation or as a subsequent addendum.

3. Investigative Report

a. There is no specific format for the written QA report of investigation; however, the content of the report must contain the following:

(1) A preliminary statement describing the education, training, clinical specialty, and experience of the IO; the scope of the investigation (i.e., what evidence was reviewed); and any difficulties in completing the investigation or obtaining information.

(2) A summary of the education, training, clinical specialty, and experience of the individual under investigation. Specific detail should include when he or she began working in the current assignment, results of performance evaluations, and origin of the allegations under investigation.

(3) A separate statement for each allegation with a recitation of relevant facts and an analysis of the evidence related to that allegation. Based on the evidence discovered during the investigation, an IO may amend or add allegations to his or her report.

(4) All relevant documents attached to the investigation. If documents or other exhibits are not appended to the report, a complete list of those items and their location must be stated. Documents or other exhibits not appended to the report must be safeguarded to ensure their availability during the peer review process.

(5) Summarized written witness statements prepared by the IO and attached to the report. In addition, a list of the names and contact information for all witnesses must also be included.

(6) A statement that the individual under investigation was offered an opportunity to be interviewed for the investigation. In cases involving allegations of clinical incompetence, the provider should also be given an opportunity to review only relevant medical record entries under review in the presence of the IO and to provide comments or explanations. If the individual declines these opportunities, it shall be noted in the report of investigation. The individual may consult with legal counsel and have counsel available for the interview; however, the investigation will not be unreasonably delayed (more than 2 weeks) due to requests by, or the availability of, the individual's counsel. The individual should be informed that participation in the investigation will apprise him or her of the evidence that will be relied upon in making decisions on whether to continue the peer review process.

(7) Conclusions for each allegation as to whether the allegation is substantiated or not. The standard for reaching these conclusions is preponderance of the evidence; that is, based upon the evidence, it is more likely than not the allegation is true or untrue.

(8) A recommendation, based on the findings, whether the individual should be returned to clinical practice, with or without M&E, or that the matters under review should be referred to a peer review panel for consideration of a clinical adverse action.

(9) The following statement at the bottom of every page of the report, "This is a quality assurance document as defined in 10 U.S.C. §1102. It may only be released as permitted by law."

b. The IO will have a draft of his or her report reviewed by the MTF SJA or other health law attorney to ensure the requirements stated above have been met and that the evidence in the report supports the IO's findings and recommendations.

c. The QA investigation should be completed within 30 calendar days; extensions may be granted by the privileging authority.

4. Evaluation

a. In addition to the investigation, the privileging authority may elect to have the individual evaluated to determine clinical competence or impairment. This may involve a period of monitoring (if privileged) or supervision (if non-privileged clinical support staff) for competency issues or medical evaluations for impairments involving medical health concerns or suspected substance abuse, to include alcohol. The evaluation may be accomplished at another MTF. For mental health concerns involving active duty Service members, the procedures in reference (k) apply.

b. If the individual is on active duty, he or she may be ordered to participate in the period of evaluation. If the individual is a civilian employee or contractor, the period of evaluation may be offered by the privileging authority, but not directed.

c. At the end of an evaluation period, a written report must be provided to the privileging authority. The report should contain an opinion by the evaluator regarding the extent of clinical competence and or impairment and provide a basis for that opinion.

d. The individual may request a period of evaluation, but he or she is not entitled to one as a matter of right.

PROCEDURES FOR PRIVILEGED HEALTH CARE PROVIDERS

1. Abeyance

a. The privileging authority will place a provider's privileges in abeyance when his or her conduct, condition, or clinical performance requires immediate action to protect the safety of patients while a thorough and impartial investigation is conducted. The fact-finding period allows time to gather and carefully evaluate additional information regarding the situation prior to initiation of an adverse privileging action.

b. An abeyance is valid for 30 calendar days. If the investigation is not complete and/or a decision to reinstate privileges has not been issued in writing within the 30 days, the abeyance automatically becomes a summary suspension. The written notice of summary suspension is delayed until a decision has been made to convene a peer review panel.

c. The provider must be notified in writing that his or her privileges have been placed in abeyance. The notice will include: the basis for the action (i.e., allegations of clinical incompetence, impairment, or professional misconduct); that a QA investigation is being conducted; that the results of the QA investigation will be reviewed by the credentials review committee; and that if the abeyance is not resolved within 30 calendar days, or if the provider ends his or her relationship with the MTF/command and has not requested a continuation of due process, the abeyance will become a summary suspension. See enclosure (9) for a sample notification letter.

d. If only a portion of the provider's privileges are being placed in abeyance, the notification letter must state which privileges are affected. During the period of abeyance, the provider shall not engage in patient care duties under the privileges affected.

e. If the provider's privileges are due to expire during the period of abeyance, the affected privileges do not lapse. Therefore, no renewal action will be taken on the affected privileges; those privileges are considered static (i.e., frozen in place) during this period.

f. An abeyance is non-adverse and is not reportable, nor is it an adverse action the provider must self-report or disclose. An abeyance is not to be mentioned in performance appraisals.

g. The medical staff professional will notify BUMED-M00J within 5 calendar days of an abeyance. If the provider is a Federal civilian employee, a copy of the abeyance letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the abeyance letter will be provided by the medical staff professional to the contracting officer.

2 Credentials Review Committee Action

a. The report of the QA investigation will be forwarded for review to the Chair, MEC or Chair, CRC as appropriate, within 14 calendar days of completion. The review will be conducted by an ad hoc sub-committee of at least three privileged providers, one of which shall be a peer with similar privileges/clinical specialty, level of training, and experience as the provider under review. If needed, members of the ad hoc sub-committee may come from outside the MTF/command and participate via video teleconferencing, audio, or in person to meet this requirement or add objectivity to the review.

b. Personnel participating in the ad hoc sub-committee must be able to impartially review the case. The following personnel will not participate: direct supervisor or subordinates of the provider under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the provider under review; and any person who is reviewing, or has reviewed, the provider's actions under consideration.

c. The role of the ad hoc sub-committee is to examine information obtained from the QA investigation and to make recommendations to the privileging authority regarding further action on the provider's clinical privileges. If additional information is required, they may refer the case back to the IO for further response or inquiry by making a written request to the privileging authority.

d. The provider under review does not have the right to attend the meeting of the ad hoc sub-committee; however, he or she may provide a written statement for consideration by the members. The provider is afforded the opportunity to be interviewed and allowed to review only relevant medical record entries evaluated as part of the QA investigation.

e. The provider may consult with legal counsel at any step in this process, but the ad hoc sub-committee meeting is not a legal proceeding and no rights are afforded outside of this instruction. As such, the release of copies of any documentation under consideration by the ad hoc sub-committee to the provider is not required.

f. The chair of the ad hoc sub-committee will forward to the privileging authority within 10 calendar days of review completion a written action recommendation with supporting comments and analysis that will include one of the following:

(1) Reinstatement of privileges (the return of the provider's regular clinical privileges without further action).

(2) Reinstatement of privileges with M&E/FPPE. M&E/FPPE is a defined, time-limited, and well documented plan to confirm that the provider possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. The plan

must include the areas of concern or procedures to be evaluated with clear expectations and measures of success. Further guidance can be found in reference (c). M&E/FPPE is distinct from supervised practice as there is no restriction or control placed on the provider's clinical practice; it is a period of monitoring and providing feedback. It is non-adverse and is not reportable.

(3) Convene a peer review panel. This action considers a potential clinical adverse action relating to the provider.

3. Privileging Authority Action

a. The privileging authority has 10 calendar days from receipt of the recommendations from the MEC/CRC to make a determination on what action to take; reinstate, reinstate with M&E/FPPE, or convene a peer review panel. The privileging authority is not bound by the recommendation(s) of the MEC/CRC.

b. The privileging authority will provide written notification to the provider of this decision. See enclosure (9) for a sample decision letter.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the written decision. If the provider is a Federal civilian employee, a copy of the decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the decision letter will be provided by the medical staff professional to the contracting officer.

4. Notice of Peer Review Panel/Summary Suspension of Clinical Privileges

a. When the privileging authority decides to convene a peer review panel, the provider will be notified in writing of the allegations under review, the date of the peer review, and his/her rights regarding participation in the peer review proceedings, which are limited to receiving a complete copy of all documents to be examined by the peer review panel and the opportunity to provide a written statement regarding the events under review for the panel's consideration. See enclosure (9) for a sample notification letter.

b. At the time the provider is notified of the peer review panel, the privileging authority will separately notify the provider in writing that his/her privileges are in summary suspension and the allegations supporting the action. The allegations must provide adequate notice to the provider and should be based upon the evidence presented in the QA investigation along with the recommendations of the MEC/CRC. Generic statements alleging clinical incompetence, impairment or professional misconduct do not meet this requirement. The stated allegations for the notice of summary suspension must be the same as the stated allegations in the notice of peer review panel. See enclosure (9) for a sample notification letter.

(1) If only a portion of the provider's privileges are being placed in summary suspension, the notification letter must state which privileges are affected. During the period of summary suspension, the provider must not be engaged in patient care duties under the privileges affected.

(2) If the provider's privileges are due to expire during the summary suspension, the affected privileges do not lapse. Therefore, no renewal action will be taken on the affected privileges; those privileges are considered static (i.e., frozen in place) during this period.

(3) A summary suspension remains in effect until the privileging authority issues a final decision in the case and is valid for up to 6 months. If an extension is required after 6 months in order that the action proceed through completion, the privileging authority, or his or her designee, must request BUMED approval to extend the summary suspension at 6 month intervals. Requests should be forward to BUMED-M00J.

(4) A summary suspension of privileges within DoD is not reportable to the NPDB unless the final action is reportable.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the written notifications of peer review panel and summary suspension of clinical privileges. If the provider is a Federal civilian employee, copies of the notification letters will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, copies of the notification letters will be provided by the medical staff professional to the contracting officer.

5. Peer Review Panel

a. The privileging authority will appoint a peer review panel in writing. The peer review panel will be comprised of at least three clinical peers of the involved provider with similar clinical specialty, education, and training; peers will be of the same paygrade or higher. If the MTF/command does not have three peers available to conduct the review, it may be accomplished using peers from another MTF/command, who can participate via video teleconferencing, audio, or in person.

b. Personnel participating in the peer review panel must be able to impartially review the case. The following personnel will not participate: direct supervisor or subordinates of the provider under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the provider under review; and any person who is reviewing, or has reviewed, the provider's actions under consideration.

c. The role of the peer review panel is to evaluate the provider's clinical practice, condition, or conduct based on the information from the QA investigation and any other evidence submitted for its consideration.

d. The provider under review may submit written comments to the peer review panel for consideration, but does not have the right to attend this meeting. It is recommended that the provider consult with legal counsel to review the evidence forwarded to the peer review panel and to assist in the preparation of any written comments.

e. The peer review panel should convene within 14 calendar days after receipt of the privileging authority's determination, the QA investigation, and any other evidence.

f. The chair of the peer review panel will forward within 14 calendar days of review completion a written report (see enclosure (9) for a sample report) to the privileging authority via the MEC/CRC. The report will include findings on each allegation and a recommendation on the provider's clinical privileges that will include one of the following:

(1) Reinstatement of privileges (the return of the provider's regular clinical privileges without further action).

(2) Reinstatement of privileges with M&E/FPPE. M&E/FPPE is a defined, time-limited, and well documented plan to confirm that the provider possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. The plan must include the areas of concern/procedures to be evaluated with clear expectations and measures of success. Further guidance can be found in reference (c). M&E/FPPE is distinct from supervised practice as there is no restriction or control placed on the provider's clinical practice; it is a period of monitoring and providing feedback. It is non-adverse and is not reportable.

(3) Restriction of privileges. The temporary or permanent limit placed on all or a portion of the provider's clinical privileges; the provider may perform those affected privileges under supervision with approval of the privileging authority. Restriction of clinical privileges is reportable to the NPDB and to licensing and professional agencies.

(4) Reduction in privileges. The permanent removal of a portion of the provider's clinical privileges. Reduction in privileges is reportable to the NPDB and to licensing and professional agencies.

(5) Suspension of privileges. The temporary removal of all or part of a provider's privileges or the temporary removal of the provider from all patient care duties. Suspension of privileges is reportable to the NPDB and to licensing and professional agencies.

(6) Revocation of privileges. The permanent removal of all of the provider's clinical privileges and the permanent removal of the provider from all patient care duties. Revocation of privileges is reportable to the NPDB and to licensing and professional agencies.

(7) Denial of privileges. The refusal to grant requested privileges to the provider at the time of initial application or renewal. A denial of privileges is reportable to the NPDB and to licensing and professional agencies.

g. The MEC/CRC will reconvene within 10 calendar days of receipt of the peer review panel report to review the findings and recommendations and forward its final recommendation to the privileging authority.

h. The medical staff professional will notify BUMED-M00J within 5 calendar days of the report of the peer review panel and the MEC/CRC final recommendation.

6. Privileging Authority Proposed Decision

a. The privileging authority has 10 calendar days from receipt of the MEC/CRC final recommendation to give written notification to the provider of his or her proposed decision and to address all specified allegations (see enclosure (9) for a sample letter). The privileging authority is not bound by the recommendations of the MEC/CRC or the peer review panel.

b. If the proposed decision is to restrict, reduce, suspend, revoke, or deny the provider's privileges, the privileging authority must advise the provider in writing of his or her right to a hearing and to appeal a clinical adverse action. The provider must have access to and have previously received copies of all information considered by the privileging authority that resulted in the basis for the proposed decision.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the privileging authority's written proposed decision. If the provider is a Federal civilian employee, a copy of the proposed decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the proposed decision letter will be provided by the medical staff professional to the contracting officer.

7. Provider Hearing Rights

a. If the privileging authority's proposed decision is an adverse privileging action, the provider may elect a formal hearing; an election must be made in writing within 30 calendar days after receipt of the proposed adverse decision. The privileging authority may extend this time period as appropriate.

b. If the provider waives his or her right to a hearing, the right to appeal is also waived. If no written request from the provider is received within the allotted time, the hearing and appeal rights are waived. In both situations, the proposed decision will then become final. The privileging authority will issue a written final decision to the provider indicating the waiver of his or her rights. The case file will then be forwarded to BUMED-M00J for review and recommendation to Chief, BUMED on reporting the action to the NPDB and appropriate agencies. See enclosure (9) for a sample final decision letter.

(1) For Navy active duty providers working in other military Services' MTFs, the adverse action process follows the Service chain of command of the involved MTF. That Service will provide information throughout the process and notification of a final action to Chief, BUMED.

(2) For active duty providers from other military Services working in a Navy MTF, the procedures in this instruction will be followed. BUMED-M00J will provide information throughout the process and notification of a final action to the provider's Service Surgeon General's office.

c. If the provider requested a hearing but fails to appear for the scheduled hearing, the privileging authority may choose to proceed with the hearing or consider the hearing waived and act on the provider's privileges as intended in the written notice of the proposed decision. The appeal rights are also considered waived.

8. Hearing Panel Procedures

a. If elected, the provider must receive written notification of hearing procedures (see enclosure (9) for a sample hearing notification letter) within 10 calendar days of receipt of his or her request. The written notification must include:

(1) The date, time, and location of the hearing, which must be no sooner than 30 calendar days from the date of the notification, but should be scheduled within 60 calendar days.

(2) A statement of the provider's right to be represented by counsel at their expense or to have another representative present. For active duty members, military counsel may be appointed. The legal or other representative may actively participate in the hearing, address the hearing panel, and question witnesses.

(3) A statement of the provider's right to attend the hearing, to present evidence, to call witnesses, and to cross-examine witnesses. The provider must arrange for the presence of his or her witnesses. However, assistance may be requested from the privileging authority in obtaining the appearance of any witness; requests must be made no later than 15 calendar days before the

scheduled hearing. Witnesses may testify in person, by teleconferencing, or via a written statement. The provider must disclose the names and contact information for all witnesses testifying on his or her behalf and copies of any documents to be presented at the hearing no later than 15 calendar days before the scheduled hearing.

(4) The names and contact information of the privileging authority's witnesses to be called to testify at the hearing and a copy of the documents to be presented to the hearing panel.

(5) The provider may request a delay of the hearing for good cause. However, if the scheduled hearing is within 5 calendar days, no postponement will be granted by the privileging authority unless there are extenuating circumstances.

b. The privileging authority will appoint a hearing panel in writing. The panel will include a minimum of three privileged providers; at least one of the members will be a professional peer (similar clinical specialty, education, and training). Panel members will be of the same paygrade or higher as the provider under review.

(1) To facilitate an impartial review, members who participated in the MEC/CRC review or peer review panel will not be appointed to the hearing panel.

(2) Personnel participating in the hearing panel must be able to impartially review the case. The following personnel will not be panel members: direct supervisor or subordinates of the provider under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the provider under review; and any person who is reviewing, or has reviewed, the provider's actions under consideration.

(3) For civilian providers under review, one member should be a civilian, if available.

(4) For active duty providers under review who belong to a different military Service, one member should be from that military Service, if available.

(5) The members of the panel must appear in person for the hearing.

(6) The chairperson of the hearing panel presides at the hearing and rules on all matters of procedure and evidence.

c. A non-voting legal advisor will be appointed in writing to provide procedural and evidentiary guidance to the chairperson of the hearing panel. The advisor may participate via video teleconferencing, audio, or in person. The legal advisor supports the panel chairperson and any consultations are permitted to be off the record and outside the presence of respondent's

counsel and the recorder. The advisor may be a MTF SJA, civilian health law attorney, or other Judge Advocate General Corps (JAGC) officer and should be appointed from a command different from the privileging authority.

d. The privileging authority will appoint a non-voting recorder to present evidence to the hearing panel and administer oaths or affirmation to witnesses called to testify. The medical staff professional will assist the recorder in preparing evidentiary packets and exhibits for the hearing panel and the provider's counsel. The recorder can be any military officer in the grade of O-4 and above. The recorder assists the hearing panel in obtaining factual information related to the allegations under review. As such, the recorder may address the hearing panel, respond to comments made by provider's counsel, and question witnesses; however, the recorder should not advocate for a particular outcome.

e. The privileging authority will arrange for a recording and verbatim transcript of the hearing procedures. Normally, a verbatim transcript (and recording services) is obtained via a private local company at a cost to the command. Court reporting services costs vary, but can be expensive and the command comptroller should be notified as soon as possible to ensure funds are available. The hearing transcript must be authenticated by the chairperson of the hearing panel. The transcript will be given to the provider within 30 calendar days of hearing completion.

f. The hearing is administrative and the rules of evidence for courts-martial and other judicial proceedings do not apply to the hearing proceedings. Oral and written matter that is not admissible in a court of law may be considered by the hearing panel subject only to reasonable restrictions on relevance, materiality, competence, and cumulativeness. The hearing panel cannot on its own seek additional evidence which is not presented at the hearing.

g. The provider may challenge any voting hearing panel member for cause; that is, by showing a member cannot render a fair, impartial decision. Cause for removal of a member exists if a member has a predisposed attitude toward the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. The chairperson of the hearing panel rules on a challenge to a hearing member; the privileging authority rules on a challenge to the chairperson.

h. Any witness who is reasonably available and whose testimony will add materially to the issues before the hearing panel should be invited to appear in person.

(1) Witnesses not within the immediate geographic area of the site of the hearing are not reasonably available. Written statements or telephonic testimony may be used in the alternative.

(2) The privileging authority may request a CO or activity head to make available military or DON civilian employees whose appearance at the hearing is considered material to the proceedings. The CO or activity head of an active duty military or DON civilian witness determines whether the witness will be permitted to attend the hearing.

(3) Witnesses not on active duty or not employed by the DON (i.e., contract employees) cannot be directed to appear; they must appear voluntarily and at no expense to the government.

i. The standard of proof at the hearing is a preponderance of the evidence, meaning that the greater weight of credible evidence supports a finding that an allegation is either more likely than not true or untrue. There is no requirement to prove any allegation by clear and convincing evidence or beyond a reasonable doubt.

j. An administrative hearing guide is provided per enclosure (7) to serve as an aid in conducting the hearing panel proceedings.

k. At the end of the hearing, only the panel members will deliberate in a closed session. They are required to make findings on each allegation as listed in the notice of hearing letter; they cannot deviate from the wording of the stated allegations or propose additional allegations with findings. The panel members must make a recommendation, by majority vote, to the privileging authority regarding the provider's clinical privileges. They are not restricted by the privileging authority's proposed adverse decision; they are permitted to make any recommendation on clinical privileges to include: reinstatement (with or without M&E/FPPE), restriction, reduction, suspension, revocation, or denial. If the panel members recommend a temporary adverse privileging action (restriction, reduction, or suspension), they may suggest corrective actions or other remediation a provider might take to accomplish reinstatement of privileges. Any proposed limitation, supervision, or restriction on clinical practice is inconsistent with a recommendation to reinstate clinical privileges.

l. The hearing panel will provide a report of their findings on each allegation and their recommendation(s) for action to the privileging authority within 30 calendar days of completion. Substantiated allegations must be supported by sufficient credible evidence. The report will reference any pertinent section of the hearing record or exhibits as needed to support the findings. Any panel member who dissents from an aspect of the report may attach a statement explaining their dissent. Hearing panel members shall not verbally brief their recommendations or discuss the case with the privileging authority. The verbatim transcript and all exhibits considered by the hearing panel must be appended to the report. See enclosure (9) for a sample report.

m. A copy of the hearing panel report will be given to the provider within 30 calendar days of hearing completion. The provider will have 10 calendar days from receipt of the report to submit a written statement of exceptions, corrections, or other comments to the privileging authority. The privileging authority may approve requests for an extension of time if made before the time limit has expired.

n. The medical staff professional will notify BUMED-M00J within 5 calendar days of the issuance of the hearing panel report.

9. Privileging Authority Final Decision

a. The privileging authority will make a final decision within 10 calendar days of receipt of the hearing panel's report and the provider's written statement.

(1) The privileging authority is not bound by the hearing panel's findings and recommendation(s); however, he or she must provide rationale for taking a different action and cite to specific evidence in the case file that was relied upon in reaching his or her decision.

(2) The privileging authority will provide written notification to the provider of the final decision and will include the final action, basis for the action, and rationale if the decision is different from the hearing panel recommendations. If the decision is adverse (restriction, reduction, suspension, revocation, or denial), the notice will state the action is reportable to the NPDB and other regulatory agencies. The provider will also be informed of his or her right to appeal the adverse decision to Chief, BUMED. See enclosure (9) for a sample final decision letter.

(3) If a provider waives his or her right to appeal the final decision, either in writing or by failing to appeal in a timely manner, the privileging authority will prepare an endorsement to Chief, BUMED stating that the appeal was waived along with a recommendation that the final adverse action be reported to the NPDB and appropriate agencies. Along with the endorsement, the entire case file will be sent (either certified mail or express mail) to BUMED-M00J for review and recommendation to Chief, BUMED on reporting the case to the NPDB and appropriate agencies.

b. The medical staff professional will notify BUMED-M00J within 5 calendar days of the privileging authority's written final decision. If the provider is a Federal civilian employee, a copy of the final decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the final decision letter will be provided by the medical staff professional to the contracting officer.

PROCEDURES FOR NON-PRIVILEGED CLINICAL SUPPORT STAFF

1. Removal (Temporary) From Patient Care Duties

a. Non-privileged clinical support staff by definition practice under supervision. As such, there is more supervisor flexibility in addressing identified deficits in knowledge, skill, or judgment that do not require a formal clinical adverse action. However, when an individual's conduct, condition, or clinical performance requires immediate action to protect the safety of patients, the privileging authority, as defined in reference (c), will temporarily remove such staff member from all or a portion of patient care duties while a thorough and impartial investigation is conducted. The fact-finding period allows time to gather and carefully evaluate additional information regarding the situation prior to initiation of an adverse practice action. These procedures are only applicable to those non-privileged clinical support staff that are licensed, certified, or registered in a United States' jurisdiction.

b. The individual must be notified in writing that he or she is being removed from patient care activities. The notice will include: the basis for the action (i.e., allegations of clinical incompetence, impairment, or professional misconduct); that a QA investigation is being conducted; and that the results of the QA investigation will be reviewed by the NEC or CRC. See enclosure (9) for a sample notification letter.

c. If only a portion of the individual's patient care activities are removed, the notification letter must state which patient activities are affected. During the period of temporary removal, the individual shall not engage in the affected patient care activities.

d. The temporary removal from patient care activities is non-adverse and is not reportable, nor is it an adverse action the provider must self-report or disclose.

e. The medical staff professional will notify BUMED-M00J within 5 calendar days of a temporary removal. If the individual is a Federal civilian employee, a copy of the notification letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the notification letter will be provided by the medical staff professional to the contracting officer.

2. CRC Action

a. The report of the QA investigation will be forwarded for review to the NEC/CRC, as appropriate, within 14 calendar days of completion. The review will be conducted by an ad hoc sub-committee with at least one member as the same clinical profession as the individual under review. If needed, members of the ad hoc sub-committee may come from outside the MTF and participate via video teleconferencing, audio, or in person to meet this requirement or to add objectivity to the review.

b. Personnel participating in the ad hoc sub-committee must be able to impartially review the case. The following personnel will not participate: direct supervisor or subordinates of the individual under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the individual under review; and any person who is reviewing, or has reviewed, the individual's actions under consideration.

c. The role of the ad hoc sub-committee is to examine information obtained from the QA investigation and to make recommendations to the privileging authority regarding further action on the individual's clinical practice. If additional information is required, they may refer the case back to the IO for further response or inquiry by making a written request to the privileging authority.

d. The individual under review does not have the right to attend the meeting of the ad hoc sub-committee; however, he or she may provide a written statement for consideration by the members. The individual is afforded the opportunity to be interviewed and allowed to review only relevant medical record entries evaluated as part of the QA investigation.

e. The individual may consult with legal counsel at any step in this process, but the ad hoc sub-committee meeting is not a legal proceeding and no rights are afforded outside this instruction. As such, the release of copies of any documentation under consideration by the ad hoc sub-committee to the individual is not required.

f. The chair of the ad hoc sub-committee will forward to the privileging authority within 10 calendar days of review completion a written action recommendation with supporting comments and analysis that will include one of the following:

(1) Reinstatement of clinical practice (the return to clinical activities without further action).

(2) Reinstatement of clinical practice with M&E. M&E is a defined, time-limited, and well documented plan to confirm that the individual possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. The plan must include the areas of concern and procedures to be evaluated with clear expectations and measures of success. M&E is non-adverse and is not reportable.

(3) Convene a peer review panel. This action considers a potential clinical adverse action relating to the individual.

3. Privileging Authority Action

a. The privileging authority has 10 calendar days from receipt of the recommendations from the NEC/CRC to make a determination on what action to take; reinstate, reinstate with M&E, or convene a peer review panel. The privileging authority is not bound by the recommendation(s) of the NEC/CRC.

b. The privileging authority will provide written notification to the individual of this decision. See enclosure (9) for a sample decision letter.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the written action decision. If the individual is a Federal civilian employee, a copy of the action decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the action decision letter will be provided by the medical staff professional to the contracting officer.

4. Notice of Peer Review Panel

a. When the privileging authority decides to convene a peer review panel, the individual will be notified in writing of the allegations under review, the date of the peer review, and his/her rights regarding participation in the peer review proceedings, which are limited to receiving a complete copy of all documents to be examined by the peer review panel and the opportunity to provide a written statement regarding the events under review for the panel's consideration. See enclosure (9) for a sample notification letter.

b. The stated allegations must provide adequate notice to the individual and should reflect the evidence presented in the QA investigation along with the recommendations of the NEC/CRC. Generic statements alleging clinical incompetence, impairment, or professional misconduct do not meet this requirement.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the written notification of a peer review panel. If the individual is a Federal civilian employee, a copy of the notification letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the notification letter will be provided by the medical staff professional to the contracting officer.

5. Peer Review Panel

a. The privileging authority will appoint a peer review panel in writing. The peer review panel will be comprised of at least three clinical peers of the involved individual with similar clinical specialty, education, and training; peers will be of the same paygrade or higher. If the

MTF does not have three peers available to conduct the review, it may be accomplished using peers from another MTF/command, who can participate via video teleconferencing, audio, or in person.

b. Personnel participating in the peer review panel must be able to impartially review the case. The following personnel will not participate: direct supervisor or subordinates of the individual under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the individual under review; and any person who is reviewing, or has reviewed, the individual's actions under consideration.

c. The role of the peer review panel is to evaluate the individual's clinical practice, condition, or conduct based on the information from the QA investigation and any other evidence submitted for its consideration.

d. The individual under review may submit written comments to the peer review panel for consideration, but does not have the right to attend this meeting. It is recommended that the individual consult with legal counsel to review the evidence forwarded to the peer review panel and to assist in the preparation of any written comments.

e. The peer review panel should convene within 14 calendar days after receipt of the privileging authority's determination, the QA investigation, and other evidence.

f. The Chair of the peer review panel will forward within 14 calendar days of review completion a written report (see enclosure (9) for a sample report) to the privileging authority via the NEC/CRC. The report will include findings on each allegation and a recommendation on the individual's clinical practice that will include one of the following:

(1) Reinstatement of clinical practice (the return to regular clinical activities without further action).

(2) Reinstatement of Clinical Practice with M&E. M&E is a defined, time-limited, and well documented plan to confirm that the individual possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. The plan must include the areas of concern and procedures to be evaluated with clear expectations and measures of success. M&E is non-adverse and is not reportable.

(3) Restriction of Clinical Practice. The temporary or permanent limit placed on all or a portion of the individual's clinical practice; affected clinical activities may be performed if under supervision. Restriction of clinical practice is reportable to the appropriate licensing, professional, and regulatory agencies.

(4) Reduction in Clinical Practice. The permanent removal of a portion of clinical practice. Reduction in clinical practice is reportable to the appropriate licensing, professional, and regulatory agencies.

(5) Suspension of Clinical Practice. The temporary removal of all clinical practice and the temporary removal from all patient care duties. Suspension of clinical practice is reportable to the appropriate licensing, professional, and regulatory agencies.

(6) Removal from Clinical Practice. The permanent removal from clinical practice and from all patient care activities. Removal from clinical practice is reportable to the appropriate licensing, professional, and regulatory agencies.

g. The NEC/CRC will reconvene within 10 calendar days of receipt of the peer review panel report to review the findings and recommendations and forward its final recommendation to the privileging authority.

h. The medical staff professional will notify BUMED-M00J within 5 calendar days of the report of the peer review panel and the NEC/CRC final recommendation.

6. Privileging Authority Proposed Decision

a. The privileging authority has 10 calendar days from receipt of the NEC/CRC final recommendation to give written notification to the individual of his or her proposed decision and to address all specified allegations (see enclosure (9) for a sample letter). The privileging authority is not bound by the recommendations of the NEC/CRC or the peer review panel.

b. If the proposed decision is to restrict, reduce, suspend, or remove the individual's clinical practice, the privileging authority must advise him or her in writing of the right to a hearing and to appeal a clinical adverse action. The individual must have access to and have previously received copies of all information considered by the privileging authority that resulted in the basis for the proposed decision.

c. The medical staff professional will notify BUMED-M00J within 5 calendar days of the privileging authority's written proposed decision. If the individual is a Federal civilian employee, a copy of the proposed decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the proposed decision letter will be provided by the medical staff professional to the contracting officer.

7. Provider Hearing Rights

a. If the privileging authority's proposed decision is an adverse practice action, the individual may elect a formal hearing; an election must be made in writing within 30 calendar days after receipt of the proposed adverse decision. The privileging authority may extend this time period as appropriate.

b. If the individual waives his or her right to a hearing, the right to appeal is also waived. If no written request is received within the allotted time, the hearing and appeal rights are waived. In both situations, the proposed decision will then become final. The privileging authority will issue a written final decision indicating the waiver of the individual's rights. The case file will then be forwarded to BUMED-M00J to review and await Chief, BUMED direction on reporting to appropriate licensing, professional, and regulatory agencies. See enclosure (9) for a sample final decision letter.

(1) For Navy active duty members working in other military Services MTFs, the adverse action process follows the Service chain of command of the involved MTF. That Service will provide information throughout the process and notification of a final action to Chief, BUMED.

(2) For active duty members from other military Services working in a Navy MTF, the procedures in this instruction will be followed. BUMED-M00J will provide information throughout the process and notification of a final action to the member's Service Surgeon General's office.

c. If the individual requested a hearing but fails to appear for the scheduled hearing, the privileging authority may choose to proceed with the hearing or consider the hearing waived and act on the individual's clinical practice as intended in the written notice of the proposed decision. The appeal rights are also considered waived.

8. Hearing Panel Procedures

a. If elected, the individual must receive written notification of hearing procedures (see enclosure (9) for a sample hearing notification letter) within 10 calendar days of receipt of his or her request. The written notification must include:

(1) The date, time, and location of the hearing, which must be no sooner than 30 calendar days from the date of the notification, but should be scheduled within 60 calendar days.

(2) A statement of the individual's right to be represented by counsel at their expense or to have another representative present. For active duty members, military counsel may be appointed. The legal or other representative may actively participate in the hearing. The counsel or representative may address the hearing panel and question witnesses.

(3) A statement of the right to attend the hearing, to present evidence, to call witnesses, and to cross-examine witnesses. The individual must arrange for the presence of his or her witnesses. However, assistance may be requested from the privileging authority in obtaining the appearance of any witness; requests must be made no later than 15 calendar days before the scheduled hearing. Witnesses may testify in person, by teleconferencing, or via a written statement. The individual must disclosure of the names and contact information for all witnesses testifying on his or her behalf and copies of any documents to be presented at the hearing no later than 15 calendar days before the scheduled hearing.

(4) The names and contact information of the privileging authority's witnesses to be called to testify at the hearing and a copy of the documents to be presented to the hearing panel.

(5) A request for delay of the hearing may be made for good cause. However, if the scheduled hearing is within 5 calendar days, no postponement will be granted by the privileging authority unless there are extenuating circumstances.

b. The privileging authority will appoint a hearing panel in writing. The panel will include a minimum of three providers; at least one of the members will be a professional peer (similar clinical specialty, education, and training). Panel members will be of the same paygrade or higher as the provider under review.

(1) To facilitate an impartial review, members who participated in the NEC/CRC review or peer review panel will not be appointed to the hearing panel.

(2) Personnel participating in the hearing panel must be able to impartially review the case. The following personnel will not be panel members: direct supervisor or subordinates of the individual under review; any IOs; any person whose testimony is relevant to the case; any officer/provider who is or has participated in other proceedings (courts-martial or administrative review boards) involving the individual under review; and any person who is reviewing, or has reviewed, the individual's actions under consideration.

(3) For civilian employees under review, one member should also be a civilian, if available.

(4) For active duty members under review who belong to a different military Service, one hearing member should be from that military Service, if available.

(5) The members of the hearing panel must appear in person for the hearing.

(6) The chairperson of the hearing panel presides at the hearing and rules on all matters of procedure and evidence.

c. A non-voting legal advisor will be appointed in writing to provide procedural and evidentiary guidance to the chairperson of the hearing panel. The advisor may participate via video teleconferencing, audio, or in person. The legal advisor supports the panel chairperson and any consultations are permitted to be off the record and outside the presence of respondent's counsel and the recorder. The advisor may be an MTF SJA, civilian health law attorney, or other JAGC officer and should be appointed from a command different from the privileging authority.

d. The privileging authority will appoint a non-voting recorder to present evidence to the hearing panel and administer oaths or affirmation to witnesses called to testify. The medical staff professional will assist the recorder in preparing evidentiary packets and exhibits for the hearing panel and the individual's counsel. The recorder can be any military officer in the grade of O-4 and above. The recorder assists the hearing panel in obtaining factual information related to the allegations under review. As such, the recorder may address the hearing panel, respond to comments made by the individual's counsel, and question witnesses; however, the recorder should not advocate for a particular outcome.

e. The privileging authority will arrange for a recording and verbatim transcript of the hearing procedures. Normally, a verbatim transcript (and recording services) is obtained via a private local company at a cost to the command. Court reporting services costs vary, but can be expensive and the command comptroller should be notified as soon as possible to ensure funds are available. The hearing transcript must be authenticated by the chairperson of the hearing panel. The transcript will be given to the provider within 30 calendar days of hearing completion.

f. The hearing is administrative and the rules of evidence for courts-martial and other judicial proceedings do not apply to the hearing proceedings. Oral and written matter that is not admissible in a court of law may be considered by the hearing panel subject only to reasonable restrictions on relevance, materiality, competence, and cumulativeness. The hearing panel cannot on its own seek additional evidence which is not presented at the hearing.

g. Hearing panel members may be challenged for cause; that is, by showing a member cannot render a fair, impartial decision. Cause for removal of a member exists if a member has a predisposed attitude toward the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. The chairperson of the hearing panel rules on a challenge to a hearing member; the privileging authority rules on a challenge to the chairperson.

h. Any witness who is reasonably available and whose testimony will add materially to the issues before the hearing panel should be invited to appear in person.

(1) Witnesses not within the immediate geographic area of the site of the hearing are not reasonably available. Written statements or telephonic testimony may be used in the alternative.

(2) The privileging authority may request a CO or activity head to make available military or DON civilian employees whose appearance at the hearing is considered material to the proceedings. The CO or activity head of an active duty military or DON civilian witness determines whether the witness will be permitted to attend the hearing.

(3) Witnesses not on active duty or not employed by the DON (i.e., contract employees) cannot be directed to appear; they must appear voluntarily and at no expense to the government.

i. The standard of proof at the hearing is a preponderance of the evidence, meaning that the greater weight of credible evidence supports a finding that an allegation is either more likely than not true or untrue. There is no requirement to prove any allegation by clear and convincing evidence or beyond a reasonable doubt.

j. An administrative hearing guide is provided in enclosure (7) to serve as an aid in conducting the hearing panel proceedings.

k. At the end of the hearing, only the panel members will deliberate in a closed session. They are required to make findings on each allegation as listed in the notice of hearing letter; they cannot deviate from the wording of the stated allegations or propose additional allegations with findings. The panel members must make a recommendation, by majority vote, to the privileging authority regarding the individual's clinical practice. They are not restricted by the privileging authority's proposed adverse decision; they are permitted to make any recommendation on clinical practice to include: reinstatement (with or without M&E), restriction, reduction, suspension, or removal. If the panel members recommend a temporary adverse privileging action (restriction, reduction, or suspension), they may suggest corrective actions or other remediation an individual might take to accomplish reinstatement of clinical practice.

l. The hearing panel will provide a report of their findings on each allegation and their recommendation(s) for action to the privileging authority within 30 calendar days of completion. Substantiated allegations must be supported by sufficient credible evidence. The report will reference any pertinent section of the hearing record or exhibits as needed to support the findings. Any panel member who dissents from an aspect of the report may attach a statement explaining their dissent. Hearing panel members shall not verbally brief their recommendations or discuss the case with the privileging authority. The verbatim transcript and all exhibits considered by the hearing panel must be appended to the report. See enclosure (9) for a sample report.

m. A copy of the hearing panel report will be given to the individual within 30 calendar days of hearing completion. He or she will have 10 calendar days from receipt of the report to submit a written statement of exceptions, corrections, or other comments to the privileging authority. The privileging authority may approve requests for an extension of time if made before the time limit has expired.

n. The medical staff professional will notify BUMED-M00J within 5 calendar days of the issuance of the hearing panel report.

9. Privileging Authority Final Decision

a. The privileging authority will make a final decision within 10 calendar days of receipt of the hearing panel's report and the individual's written statement.

(1) The privileging authority is not bound by the hearing panel's findings and recommendation(s); however, he or she must provide rationale for taking a different action and cite to specific evidence in the case file that was relied upon in reaching his or her decision.

(2) The privileging authority will provide written notification of the final decision and will include the final action, basis for the action, and rationale if the decision is different from the hearing panel recommendations. If the decision is adverse (restriction, reduction, suspension, or removal), the notice will state the action is reportable to the appropriate licensing, professional, and regulatory agencies. The individual will also be informed of his or her right to appeal the adverse decision to Chief, BUMED. See enclosure (9) for a sample final decision letter.

(3) If the individual waives his or her right to appeal the final decision, either in writing or by failing to appeal in a timely manner, the privileging authority will prepare an endorsement to Chief, BUMED stating that the appeal was waived along with a recommendation that the final adverse action be reported to the appropriate licensing, professional, and regulatory agencies. Along with the endorsement, the entire case file will be sent (either certified mail or express mail) to BUMED-M00J for review and recommendation to Chief, BUMED on reporting the case to the appropriate licensing, professional, and regulatory agencies.

b. The medical staff professional will notify BUMED-M00J within 5 calendar days of the privileging authority's written final decision. If the individual is a Federal civilian employee, a copy of the final decision letter will be provided by the medical staff professional to the civilian HRO. If the provider is a contract employee, a copy of the final decision letter will be provided by the medical staff professional to the contracting officer.

ADMINISTRATIVE HEARING GUIDE

The following abbreviations are used throughout this guide:

CHRP: Chairperson
REC: Recorder
CR: Counsel for Respondent
RESP: Respondent (Provider or Individual)
WIT: Witness

CHRP: This meeting of Naval (Hospital or Health/Dental Clinic), (location) Hearing Panel will come to order. The recorder will note the time, date, and place of this hearing.

[**Note:** The REC should record the time and date of the opening and closing of each session of the panel and the presence (or absence) of all parties (panel members, REC, RESP, CR, or other representative.]

CHRP: This hearing has been convened by CO, Naval (Hospital or Health/Dental Clinic), (location), letter of (date), a copy of which has previously been provided to all parties who are present. A copy of the hearing appointing letter will be entered as exhibit 1.

CHRP: The following persons are present:

_____, Chairperson

_____, Member

_____, Member

_____, Recorder

_____, Respondent

_____, Counsel for Respondent

CHRP: This hearing has been convened for the purpose of considering written documentation and testimony in order to make findings and recommendations as to whether the clinical Privileges/Practice of Rank/Title _____ should be reinstated, restricted, reduced, suspended, revoked/removed, or denied (if applicable). The allegations under review are stated in the Notice of Hearing letter, dated _____. A copy of this letter will be entered as exhibit 2.

CHRP: Rank/Title _____, I will now discuss with you your rights in connection with this hearing. If you have any questions about any of these rights, do not hesitate to ask me. If you wish, you may discuss your questions with your (counsel or representative).

Exhibit 2: CO, Naval (Hospital or Health/Dental Clinic), letter of (date) provided you notice of this hearing and your advice of rights. BUMEDINST 6010.31 provides that 30 calendar days must elapse between the time you received hearing notification and when the hearing starts, unless you agree to an earlier date. This is to ensure you have ample opportunity to prepare your case to respond to the allegations. (As applicable: (You were given a copy of exhibit 2 more than 30 days ago. The hearing may proceed.) or (You were given a copy of exhibit 2 less than 30 days ago. The hearing may not start before (date) unless you agree. Do you wish to waive your right to the full 30-day period and proceed now, or do you prefer to reschedule the hearing to start (date)?)

First, you have the right to be present at this hearing with or without counsel or personal representative. If you are represented, your counsel or personal representative may actively participate in the hearing and directly address this panel on your behalf.

Second, you may challenge any voting member of this panel for cause; that is, by showing a member cannot render a fair, impartial decision. Cause for removal of a member exists if a member has a predisposed attitude toward the outcome of the hearing. Mere knowledge of the facts of a case is not sufficient cause for removal. You or your representative may question any panel member to determine whether a basis for challenge exists.

Third, you may examine any and all documentary evidence available to the panel that has a bearing on any matter relevant to this hearing. In this regard, I want to advise you the instructions establishing the hearing process state you will be provided the following at least 30 calendar days before the hearing date:

1. Written notice of the specific date, time, and place of the hearing.

2. Any documentary evidence concerning the allegations against you to be considered at the hearing.

3. Names of witnesses to be called to testify at the hearing.

Did you receive this information at least 30 calendar days before the hearing?

[**Note**: If respondent did not, the reason for the delay in providing the information should be stated for the record and the following stated: Since you did not receive all of the above information in a timely manner, you have a right to request delay of the hearing until (date). Do you wish to proceed with the hearing today or wish to instead start the hearing on (date)? Any information not previously made available to you will now be provided.]

Fourth, you may choose to testify under oath, to make an unsworn statement, and/or to remain silent. If you choose to testify under oath, you will be subject to questioning by the recorder and the hearing members. If you choose not to testify, that fact cannot and will not be held against you in any way.

Fifth, you may call witnesses to testify on your behalf, and to ask questions, either by yourself or through your representative, of any witnesses appearing before the hearing.

Sixth, you may submit documentary evidence you wish the hearing members to consider. This includes, but is not limited to, depositions, sworn or unsworn statements, affidavits, and stipulations. This also includes depositions of witnesses not reasonably available to appear at the hearing and other witnesses unwilling to appear voluntarily. BUMEDINST 6010.31 required you to disclose the names and contact information for all witnesses testifying on your behalf and any documentary evidence you wanted the hearing panel to consider at least 15 calendar days before the hearing. I may, upon a showing of good cause, allow you to introduce information to this panel you did not previously disclose; however, I will also consider granting reasonable delay to allow other documents or witnesses to be located and made available to the hearing members if relevant to address issues or matters your evidence raises.

Finally, your failure to invoke any of these rights is not a bar to the hearing proceedings or to its findings and recommendations.

Rank/Title _____, do you understand the purpose of this hearing and your rights before it?

RESP/CR: (Questions or the respondent has no questions)

CHRP: There are some procedural rules in connection with this hearing I will now explain to you.

First, these proceedings are administrative in nature. The rules of evidence do not apply. The hearing members may consider information that might not be admissible in a court of law, so long as the information is relevant to matters before this panel. Members of the hearing panel may ask for additional evidence, summon additional witnesses to testify, and question any witness who testifies at this hearing.

Second, if you have any objections to any matters introduced, or to any of the proceedings of this panel, you may state your objection and the reasons for it. I will consult with (name of attorney), the legal advisor appointed to this hearing, as needed prior to ruling on any objections. As chairperson, I will make the final ruling regarding the relevance and admissibility of substantive clinical matters and I will defer to the legal advisor on procedural matters and issues implicating due process. By the term "relevant evidence", I mean testimony and evidence which will help the hearing members make findings and recommendations on the allegations contained in exhibit 2, the notice of hearing letter.

Third, the recorder will administer oaths or affirmations to the witnesses.

Fourth, the hearing panel's findings must be supported by a preponderance of the evidence. The term "preponderance of the evidence" simply means the greater weight of credible evidence or that the factual allegation is either more likely than not true or untrue. There is no requirement to prove any allegation by clear and convincing evidence or beyond a reasonable doubt. The members of the committee will use their best judgment, experience and common sense in resolving disputed and conflicting evidence. The hearing panel's recommendations must be supported by the findings and any recommended action will be made by a majority vote and in good faith.

Fifth, if you desire a postponement or continuance of this hearing, you must submit your request to the privileging authority via this panel. Your request may be granted only upon a showing of good cause.

Do you have any questions concerning the procedures before this panel?

RESP/CR: ((Questions) or (The respondent has no questions.))

REC: I will now swear in the members of the hearing panel. Please stand and raise your right hand:

"Do you swear that you will answer truthfully the questions concerning whether you should serve as a member in this hearing and that you will faithfully and impartially make findings and recommendations according to the evidence and the stated procedures?"

(Panel members' responses)

REC: Hearing members, I will now ask you a few questions that will help determine whether you can be fair and impartial at this hearing. Please respond to my questions by stating yes or no.

1. Is any member the supervisor, reporting official, or endorsing official on performance evaluations for any member of the Hearing Committee, for any witnesses expected to testify, or for Rank/Title _____?

2. Has any member been asked for or given advice on the allegations being considered in this case or is a principal witness in these allegations?

3. Has any member participated in any other judicial or administrative proceedings regarding Rank/Title _____?

4. Is any member aware of any matter which would prevent him or her from rendering an objective, independent, fair, and impartial decision based only on the evidence presented at this hearing?

(Panel members' response(s))

CHRP: At this time, do you or your representative wish to question any voting member of this hearing panel in relation to any matter that may constitute grounds for challenging the member?

RESP/CR: ((Questions) or (The respondent has no questions.))

CHRP: Do you or your representative have any challenge to any voting member of the hearing panel?

RESP/CR: ((Challenge(s)) or (The respondent has no challenge(s).))

[**Note**: The chairman rules on any challenges to a voting member; if the chairman is challenged, the privileging authority must be informed and rule on whether the chairman can remain on the hearing panel.]

CHRP: At this point, we will hear from the recorder who will provide a brief statement of the allegations that require this hearing.

REC: (The recorder should make a brief statement reviewing the facts and circumstances that led to the hearing, including a recitation of the proposed adverse privileging/practice decision by the privileging authority in the subject case.)

CHRP: Does respondent or respondent’s representative desire to make an opening statement?

RESP/CR: (Opening statement).

[**Note**: The opening statement may be made now or before presentation of respondent's case.]

CHRP: At this time, the panel will receive such documents as are pertinent to this hearing.

[**Note**: Recorder’s exhibits are marked by numbers and respondent’s exhibits are marked by letters.]

(Exhibit 1 is the hearing appointment letter, exhibit 2 is the notice of hearing letter, exhibit 3 is the notification of proposed adverse decision; the remaining recorder exhibits will include the notice of summary suspension of clinical privileges (if applicable), the peer review panel recommendation report and its enclosures, the notice of peer review panel letter, any credentials committee reports/recommendations in the case, any correspondence concerning requests for

delays in hearing dates, QA investigation with enclosures, and any waiver of any rights by the respondent. Exhibits should also include copies of relevant information from the provider's clinical activity file and individual credentials file. The last exhibit will be the findings and recommendation worksheet for the hearing panel to use during deliberations).

REC: The following documents are submitted for the panel's consideration.

Exhibit 1 is the appointing order for this hearing.

Exhibit 2 is the notice of hearing letter from the CO to the respondent notifying him/her of this hearing and their rights at the hearing.

Exhibit 3 ... etc.

Exhibit __ is the hearing panel findings and recommendations worksheet.

CHRP: Are there any objections to the panel's consideration of these exhibits?

RESP/CR: ((Objection) or (There is no objection.))

CHRP: Does respondent have any documents he or she wishes the panel to consider?

RESP/CR: The following documents are submitted for the panel's consideration:

Exhibit A is ...

Exhibit B is ... etc.

CHRP: Exhibits 1 through __and A through _ are accepted and made a part of the hearing record.

[**Note**: The panel may wish to recess at this point to allow all members the opportunity to review the documentary evidence.]

CHRP: Recorder will call the first witness.

REC: The first witness is _____.

[**Note**: The chairperson is required to order all oral evidence at the hearing be taken under oath or affirmation, with the exception of any unsworn statement offered by the respondent.]

REC: (Administering oath or affirmation.) Do you swear (or affirm) the evidence you give in the case now in hearing will be the truth, the whole truth, and nothing but the truth?

WIT: I do.

REC: Would you state your grade/rate/title, name, corps, armed force, and current duty station?

WIT: (Answer).

[**Note**: The recorder should conduct the initial introductory questioning of each witness. Detailed questioning on the medical aspects of the allegations should be done by the panel members. Thereafter, respondent will have an opportunity to question the witness.]

CHRP: (After questioning is completed.) Thank you for your testimony. You are not to discuss your testimony except with a member of the panel, recorder, respondent, or his or her counsel.

[Note: After all witnesses desired by the recorder and panel members have testified, respondent should be permitted to present testimony of witnesses he or she calls. Recorder should administer the oath. Initial questioning will be conducted by the RESP/CR, followed by questions from the panel members and recorder.]

RESP/CR: (At conclusion of witness testimony.) I have nothing further to present.

[**Note**: If the panel now desires additional witnesses, they may be called or recalled at this point.]

CHRP: Does the recorder or respondent want to make a brief closing statement?

REC/RESP/CR: Yes/No (sir or ma'am). (Closing statements).

CHRP: Has the recorder or respondent anything further to offer?

REC/RESP/CR: No, (sir or ma'am).

CHRP: The panel will close for deliberations. You will be provided a copy of the hearing panel's report and transcripts when forwarded to the CO. The hearing is adjourned.

APPEAL PROCESS

1. Appeal of Clinical Adverse Actions

a. Every health care provider and non-privileged clinical support staff has the right to appeal a clinical adverse action to Chief, BUMED.

(1) A written request must be submitted to the privileging authority within 10 calendar days of receipt of the final adverse decision asking for reconsideration of the decision stating the grounds for the request. An extension of time to submit the request may be made for good cause.

(2) The privileging authority will review and consider the request.

b. The privileging authority will forward within 14 calendar days any denial (partial or complete) of a request for reconsideration as an appeal to Chief, BUMED. Any delays encountered by the privileging authority must be noted in the forwarding endorsement.

(1) In the forwarding endorsement of the appeal, the privileging authority will respond to or rebut evidence to any issues raised in the appeal.

(2) The endorsement will also provide information on the current military or employment status of the provider and identify any associated administrative actions. This may include information related to special pays, pending administrative discharge/retirement, physical evaluation board, or other employment/contract status.

(3) The endorsement and complete case file will be forwarded to BUMED-M00J for coordination of appellate review.

c. The clinical adverse action decision remains in effect during the appeal process.

2. BUMED Appellate Process

a. Appellate review is based on sufficiency of due process, evidentiary support for the findings, and whether the decision by the privileging authority was an abuse of discretion.

b. BUMED-M00J will coordinate the appeal process to include:

(1) Legal review of the due process procedures.

(2) Clinical peer review coordinated through the appropriate staff corps (Medical Corps, Dental Corps, Nurse Corps, Medical Service Corps, or Hospital Corps).

(3) An appeal committee to examine the appeal, legal, and clinical peer review in order to make a recommendation on the appeal to Chief, BUMED. Committee members may participate via video teleconferencing, audio, or in person.

(a) The committee will be comprised of at least three members, one of which will be of a similar specialty to the provider under review.

(b) The individual under review does not have a right to attend the meeting of the appeal committee.

(c) If the individual under review is an active duty member of a different Service, a representative from the member's Service should be appointed, if available. Copies of all adverse action documents will be sent to the member's Surgeon General's office for review and comment prior to consideration of the case by the appeal committee.

3. Appellate Decision

a. Chief, BUMED will make the final decision on whether to grant or deny an appeal. The decision may direct corrective action if a procedural error not raised on appeal is identified during the appellate review and affects the fundamental fairness of the peer review process.

b. The individual will be notified in writing of the final decision on his or her appeal and the rationale for that decision. If the individual is an active duty member of a different Service, the member's Surgeon General's office will be notified of the final decision.

c. The decision by Chief, BUMED is final.

d. All final clinical adverse actions will be reported by BUMED-M00J as follows:

(1) Adverse privileging actions will be reported to the NPDB, state(s) of licensure, professional entities, and the Defense Practitioner Data Bank.

(2) Adverse practice actions will be reported to the appropriate licensing, certifying or registration agency, and the Defense Practitioner Data Bank.

SAMPLE LETTERS

NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31

1. You are hereby notified that, effective immediately and per references (a) and (b), (all)/(a portion) of your (state the type) clinical privileges at (name of the MTF or duty location) are in abeyance. This action is being taken in response to allegations of (list as appropriate: lack of clinical competence, impairment, professional misconduct) as evidenced by (give a brief statement of the facts). These issues (have had) (could potentially have) an adverse effect on patient safety and the delivery of quality medical care.

2. During this period of privilege abeyance, you are relieved of all clinical duties; you may not see any patient nor engage in any other activity directly involving patient care. Any previous permission to engage in off-duty employment involving direct patient care is hereby withdrawn. Notification of this abeyance will also be given to any other military and/or civilian medical treatment facilities where you are practicing. [Note: If the provider is a contractor substitute with following language: It is your responsibility to notify other medical facilities where you hold clinical privileges that your privileges at this facility are in abeyance.]

3. A quality assurance (QA) investigation will be conducted into the allegations specified above. The results of the QA investigation will be reviewed and if the allegations are substantiated, a peer review panel may be convened to review the evidence and make a recommendation regarding your clinical privileges to the privileging authority. If a peer review panel is convened, you will be notified in writing.

4. This period of abeyance will not exceed 30 calendar days from the date of notification. If at the end of the 30-day abeyance your privileges are not reinstated in writing, the action will automatically become a summary suspension.

Subj: NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES

5. Providers who separate, resign, retire, are discharged, or their employment with the Navy is terminated while an adverse action review is taking place may be reported to the National Practitioner Data Bank, Defense Practitioner Data Bank, and state licensing agencies. However, you may request the review of your clinical privileges to continue and any report, if warranted, will not be made until completion of the due process. Such a request must be made in writing within 5 calendar days following your knowledge of the change in your employment status.

6. An abeyance is neither punitive nor adverse. It will not be reported to any regulatory agency and it does not mandate disclosure in future official applications for state licensure or clinical privileges. Likewise, if this abeyance becomes a summary suspension, the summary suspension is not adverse and is not reportable unless the final action is reportable.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the Notice of Abeyance of Clinical Privileges.

_____ _____

Signature of Provider Date

BUMEDINST 6010.31
15 Apr 2016

FINAL DECISION FINAL DECISION IN CLINICAL ADVERSE ACTION (REINSTATEMENT)

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31
(c) (Select as appropriate: Credential Review Committee action recommendation/ peer review panel recommendation/hearing panel report)

1. As required by references (a) and (b), I have reviewed the findings and recommendations in reference (c). I concur with the recommendation to (reinstate/reinstate with monitoring and evaluation) your clinical (privileges/practice). The reinstatement of your clinical (privileges/practice) is hereby effective this date.

2. [If privileges were in summary suspension include the following: The summary suspension of your clinical privileges is not reportable to the National Practitioner Data Bank as the resultant action reinstated your clinical privileges.]

3. [If monitoring and evaluation or placement on a focused professional practice evaluation was a condition of reinstatement include the following: Details concerning the scope and duration of monitoring and evaluation or a focused professional practice evaluation will be provided by separate correspondence.]

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

I acknowledge receipt of the letter of Notification of Final Decision in Clinical Adverse Action.

_____ _____

Signature of Provider Date

FINAL CLINICAL ADVERSE ACTION DECISION LETTER (WITH HEARING)

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31
(c) Hearing Panel Report
(d) Provider's comments

1. Per references (a) and (b), a hearing panel was convened to review the relevant evidence in your case and to make findings on the allegations and to provide a recommendation to me on your clinical (privileges/practice). The hearing was held on (date) and the hearing panel submitted a report, reference (c). A copy of the panel's report and transcript of the hearing were provided to you. You were afforded 10 calendar days to submit comments on the report. I have received your comments, reference (d) and have considered them in my final decision in your case. [Note: if no comments are submitted use the following: You have not submitted any comments within the allotted time or requested an extension of time to provide comments.]

2. You are hereby notified that based on the hearing panel's recommendation, my final decision is to (restrict; reduce; suspend; revoke/remove; deny) your clinical (privileges/practice). This action is being taken in response to the following findings that were substantiated by the [select all that apply: Quality assurance investigation, peer review panel, Credentials Review Committee and hearing panel review]:

(List each allegation as stated in the hearing panel report.

[Provide privileging authority comments regarding the findings and how it affects the provider's ability to practice clinically. If decision is different from hearing panel's recommendation, cite to specific evidence in case file that was relied upon in reaching the decision]

3. Per references (a) and (b), this action is reportable to the National Practitioner Data Bank (for privileged providers), the Defense Practitioner Data Bank, state licensing boards, and other professional regulatory entities as appropriate.

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

4. You are advised that you have a right to appeal this decision to Chief, Bureau of Medicine and Surgery (BUMED-M00J), in writing, via the privileging authority within 10 calendar days from receipt of this letter. The grounds for the appeal must be stated. My decision will remain in effect during the appeal.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the Notification of the Final Decision in Clinical Adverse Action.

_____ _____

Signature of Provider Date

FINAL CLINICAL ADVERSE ACTION DECISION (WITHOUT HEARING)

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

Ref: (a) Proposed Adverse Action
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31

1. I have not received a written request for a hearing within the 30 calendar days of your receipt of reference (a), my proposed (restriction; reduction; suspension; revocation/removal; denial) your clinical (privileges/practice). As you have elected not to proceed with a hearing on this matter, and consistent with the procedures in references (b) and (c), you have waived your right to a hearing and to appeal the proposed adverse action.

2. This notice is to communicate my final action on your clinical privileges. You are hereby notified that my final decision is to (restrict; reduce; suspend; revoke/remove; deny) your clinical (privileges/practice). This action is being taken in response the following substantiated findings by the quality assurance investigation, Credential Review Committee, and peer review panel as follows:

(List each allegation as stated in the peer review panel report.)

3. Per references (b) and (c), this action is reportable to the National Practitioner Data Bank (for privileged providers), the Defense Practitioner Data Bank, state licensing boards, and other professional regulatory entities as appropriate. This action will be forwarded to Chief, Bureau of Medicine and Surgery (BUMED-M00JB) for review of your case and direct reporting.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

Subj: FINAL DECISION IN CLINICAL ADVERSE ACTION

I acknowledge receipt of the letter of Notification of Final Decision in Clinical Adverse Action.

_____ _____

Signature of Provider Date

HEARING PANEL REPORT

Date

From: Chair, Hearing Panel
To: Privileging Authority

Subj: HEARING PANEL REPORT IN CASE OF (Provider's Name)

Ref: (a) Notice of Peer Review Panel
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31

Encl: (1) Verbatim Transcript
(2) Hearing Exhibits

1. As required by references (a) through (c), a hearing panel convened on (date) to make findings and recommendations regarding allegations which may adversely affect the clinical (privileges/practice) of (provider's name). [Note: the report can provide a preliminary statement if necessary to inform the privileging authority of any difficulties encountered during the hearing].

2. Based on the evidence in enclosures (1) and (2), we find the following allegations are substantiated or unsubstantiated as follows:

a. **Allegation**: (list each allegation separately as stated in the notice of hearing letter).

Findings: (state if the allegation is substantiated or unsubstantiated).

Reasons for findings; provide an analysis for the findings and include reference to specific information/testimony relied upon in the panel's determination.

b. **Allegation**:

Findings:

3. Based on the aforementioned findings, the hearing panel by unanimous/majority vote recommends (pick one): (name of provider's) (specialty) clinical (privileges/practice) be (reinstated; reinstated with monitoring and evaluation/ focused professional practice evaluations; restricted; reduced; suspended; revoked/removed; or denied). [If decision is not unanimous, indicate whether a minority opinion is submitted].

Provide an analysis/explanation of what factors/information was relied upon in making this recommendation.

Subj: HEARING PANEL REPORT IN CASE OF (Provider's Name)

_____
Rank, Name, Corps, USN
Chair
Concur

_____
Rank, Name, Corps, USN
Member
Concur

_____
Rank, Name, Corps, USN
Member
Concur

Date received by privileging authority/medical treatment facility commanding officer:_____

NOTICE OF HEARING

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTICE OF HEARING

Ref: (a) Provider Request for Hearing
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31
(d) Notice of Proposed Adverse Action

Encl: (1) List of witnesses to be called
(2) (Documents to be considered by the hearing panel)

1. In response to your request in reference (a), and per references (b) and (c), you are notified that a hearing panel will meet to review allegations that may adversely affect your clinical (privileges/practice). The following allegations will be reviewed (list the allegations as stated in the notice of proposed adverse action):

a.

b.

c.

2. The hearing will be held on (date and time) at (location).

3. At the hearing, you have the right to attend, to present evidence, call witnesses on your behalf, and to cross-examine witnesses called by the hearing panel. While it is your responsibility to arrange for the presence of any witnesses you desire to participate in the hearing, you may request assistance in obtaining the appearance of any witness no later than 15 calendar days before the scheduled hearing. In your request, you must provide a synopsis of the witness' expected testimony with an explanation why a written statement or availability by telephone is not an adequate substitute for the witness' personal appearance.

Subj: NOTICE OF HEARING

4. You have the right to consult with and be represented by legal counsel at your own expense or to have another representative present at the hearing. The legal or other representative may actively participate in the hearing, address the hearing panel, and question witnesses. (If the provider is military, add the following: As a military provider, you may request military legal counsel be appointed to represent you by submitting a request to the privileging authority within 7 calendar days of receipt of this notification).

5. The witnesses expected to be called to testify at the hearing and their contact information are listed in enclosure (1). The documents attached in enclosure (2) will be presented at the hearing. You are required to disclose the names and contact information for all witnesses testifying on your behalf and copies of all documents you intend to present at the hearing no later than 15 calendar days before the scheduled hearing.

6. You may request, in writing, a delay of the hearing for good cause; however, absent compelling circumstances (i.e., severe illness or death of a family member) delays will not be granted if the request is made less than 5 calendar days prior to the scheduled hearing. If you fail to appear at the scheduled hearing, the hearing may proceed, or the privileging authority may consider the hearing waived and act on your privileges as stated in the written notice of proposed adverse action, per reference (d).

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the Notice of Hearing.

_____ _____
Signature of Provider Date

NOTICE OF PEER REVIEW PANEL

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTICE OF PEER REVIEW PANEL

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31

Encl: (1) Quality Assurance Investigation
(2) Provider statement (if applicable)
(3) List all other documents that were reviewed

1. Per references (a) and (b), you are notified that a peer review panel will be conducted to review the following allegations:

(List each allegation separately by stating one of the following: lack of clinical competence, impairment, or professional misconduct) as evidenced by (give a brief statement of the facts))

2. The peer review panel will review enclosures (1) through (3) and determine the validity of the allegations. The panel will then make a recommendation to the privileging authority via the Credentials Review Committee. The recommendations may include: [for privileged providers: reinstatement of privileges; reinstatement of privileges with monitoring and evaluation (M&E) or focused professional practice evaluation; restriction of privileges; suspension of privileges; reduction in privileges; revocation of privileges; or denial of privileges] [for non-privileged providers: reinstatement of clinical practice; reinstatement of clinical practice with M&E; restriction of clinical practice; reduction in clinical practice; suspension of clinical practice; or removal from clinical practice].

3. You do not have the right to be present for the panel's proceedings; however, you may submit a written statement regarding the allegations under review.

4. You will receive written notification of any proposed adverse action against your clinical (privileges/practice).

Subj: NOTICE OF PEER REVIEW PANEL

5. If you separate, retire or are discharged, or end employment with the Navy while an adverse privileging action is taking place, you have the right to request that full due process procedures be continued. You must submit a written request to the privileging authority within 5 calendar days after learning of the change in your affiliation status. If you waive this right or fail to submit a request, the process will only continue through the convening of a peer review panel to the issuance of a decision by the privileging authority based on the panel's recommendations. Such decision by the privileging authority will be final. If the decision is adverse, your right to a hearing and to appeal is considered waived. In addition, any final adverse action will be reported to the National Practitioner Data Bank (privileged providers only), state licensing boards, regulatory agencies, and the Defense Practitioner Data Bank.

6. If you have any questions, please contact _____ by telephone at _____ or e-mail at _____.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the notice that a Peer Review Panel will convene to review the allegations noted above.

_____ _____
Signature of Provider Date

NOTICE OF PROPOSED (RESTRICTION / REDUCTION / SUSPENSION / REVOCATION / REMOVAL / DENIAL) OF CLINICAL (PRIVILEGES / PRACTICE) (ADVERSE ACTION)

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTICE OF PROPOSED (RESTRICTION / REDUCTION / SUSPENSION / REVOCATION / REMOVAL / DENIAL) OF CLINICAL (PRIVILEGES / PRACTICE)

Ref: (a) Notice of Peer Review Panel
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31
(d) Peer Review Panel Recommendation

1. Per references (a) through (c), a peer review panel was convened to review the relevant evidence in your case and to make a recommendation on your clinical (privileges/practice). The panel met on (date) and submitted a report, reference (d).

2. You are hereby notified that based on the panel's recommendations, I propose to (restrict; reduce; suspend; revoke/remove; deny) your clinical (privileges/practice) as follows: (state the scope of the action, i.e.,what privileges/practices are affected). This action is being taken in response to the following substantiated findings by the peer review panel:

(List each substantiated allegation from the panel report)

These (deficiencies/impairment/misconduct) had (or could have) the following adverse effects on patient care and safety as (provide details).

3. You are advised that you have a right to have a formal hearing review this action. To invoke this right, you must make a written request to me within 30 calendar days from the date you receive this notification. Failure to make a written request within this time period, or if you fail to appear for the scheduled hearing, will result in a waiver of your right to a hearing and the right to appeal this adverse (privileging/practice) action to Chief, Bureau of Medicine and Surgery (BUMED). In addition, if no written hearing request is received within the allotted time, my proposed decision will become final and this adverse action will be forwarded to Chief, BUMED for reporting to the National Practitioner Data Bank (for privileged providers), the Defense Practitioner Data Bank, states of licensure, and appropriate professional organizations.

Subj: NOTICE OF PROPOSED (RESTRICTION / REDUCTION / SUSPENSION / REVOCATION / REMOVAL / DENIAL) OF CLINICAL (PRIVILEGES / PRACTICE)

4. During this time while due process procedures are ongoing and until a final decision on your privileges is reached, your clinical privileges will remain in summary suspension.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the Notice of the Proposed (Restriction/Reduction /Suspension/ Revocation/Removal/Denial) of my clinical (privileges/practice).

_____ _____

Signature of Provider Date

NOTICE OF SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTICE OF SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Ref: (a) Abeyance letter
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31

1. Your clinical privileges were placed in abeyance per reference (a). As your privileges were not reinstated after 30 days, your privileges were automatically suspended on (date). This letter provides written notification, per references (a) and (b), that all of your (type) clinical privileges at (medical treatment facility/command) are in summary suspension.

2. This action is based on the following allegations:

(State the allegations as listed in the notice of peer review panel.)

3. During this period of summary suspension, you may not see any patient nor engage in any other clinical activity related to your affected privileges. Any previous permission to engage in off-duty employment involving direct patient care is hereby withdrawn. Notification of this summary suspension will also be given to any other military and/or civilian medical treatment facilities where you are practicing. [**Note**: If the provider is a contractor substitute with the following language: It is your responsibility to notify other medical facilities where you hold clinical privileges that your privileges at this facility are in summary suspension].

4. This period of summary suspension will not exceed 6 months from the date of this notification; however, it may be extended if necessary. [**Note**: If the provider is a federal civilian employee, include the following language: "A copy of this letter will be forwarded to the Human Resource Office." If the provider is a contractor, include the following language: "A copy of this letter will be forwarded to the contracting office."]

5. If you separate, retire or are discharged, or end employment with the Navy while an adverse privileging action is taking place, you have the right to request that full due process procedures be continued. You must submit a written request to the privileging authority within 5 calendar days after learning of the change in your affiliation status. If you waive this right or fail to

submit a request, the process will only continue through the convening of a peer review panel to the issuance of a decision by the privileging authority based on the panel's recommendations. Such decision by the privileging authority will be final. If the decision is adverse, your right to a hearing and to appeal is considered waived. In addition, any final adverse action will be reported to the National Practitioner Data Bank (privileged providers only), state licensing boards, regulatory agencies, and the Defense Practitioner Data Bank.

6. Per references (a) and (b), a summary suspension is not reportable to the NPDB unless the final action is reportable.

(Signature)

Copy to:
Medical Staff Professional
BUMED-M00J

I acknowledge receipt of the Notice of Summary Suspension of Clinical Privileges.

_____ _____

Signature of Provider Date

PEER REVIEW PANEL APPOINTMENT

6010
Code
Date

From: Privileging Authority
To: (Panel Chair)

Subj: PEER REVIEW PANEL APPOINTMENT

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31
(c) 10 U.S.C. §1102

Encl: (1) Notice of Peer Review Panel
(2) Quality Assurance Investigation
(3) Provider statement (if applicable)
(4) [Any other documentation as appropriate]
(5) Sample Peer Review Panel Report

1. Per references (a) and (b), you are hereby appointed as Chair of a peer review panel. You and the other two appointed members listed below will each review all documentation provided in enclosures (1) through (4) related to the clinical (privileges/practice) of (name of provider). The following additional members are appointed to the peer review panel:

_____, Member

_____, Member

2. The panel should convene within 14 days after receiving this appointment. The peer review meeting may be conducted in person, via video, or teleconferencing. After examining all available evidence, the panel will submit a written report to me, via the Credentials Review Committee, using the format in enclosure (5) within 14 calendar days from the close of the peer review meeting. The report shall include separate findings on each of the allegations as listed in enclosure (1) and a recommendation regarding (name of provider)'s clinical (privileges/practice) as follows:

a. Reinstatement; the return of all clinical (privileges/practice) without further action.

Subj: PEER REVIEW PANEL APPOINTMENT

b. Reinstatement with Monitoring and Evaluation (M&E)/Focused Professional Practice Evaluations (FPPE). The documented plan of M&E/FPPE must include clear expectations and measures of success that will be routinely reviewed throughout the set period.

c. Restriction; a temporary or permanent limit on all or portion of clinical (privileges/practice).

d. Reduction; the permanent removal of a portion of clinical (privileges/practice).

e. Suspension; the temporary removal of all or a portion of clinical (privileges/privileges) and the temporary removal of the provider from all patient care duties.

f. Revocation of privileges (privileged provider)/removal from clinical practice (non-privileged clinical support staff); the permanent removal of all clinical (privileges/practice) and the permanent removal of the provider from all patient care duties.

g. Denial of privileges (privileged provider); refusal to grant requested privileges to the provider at the time of initial, active, renewal, or modification of privileges application.

3. The peer review panel meeting is not a legal proceeding. (Name of provider) does not have the right to attend the meeting; however, he/she may provide written comments.

4. The panel's efforts and all generated documentation are for use as part of Navy Medicine's Quality Assurance Program; therefore, per reference (c) they are confidential and privileged. As such, no part of these records may be disclosed to a person or entity, subject to discovery, or admitted into evidence in any judicial or administrative proceeding, except as provided with the statute. Your report must be labeled "**FOR OFFICIAL USE ONLY – 10 U.S.C. §1102**" and you must take appropriate measures to safeguard it.

5. You may seek advice from _____, by phone at _____ or e-mail at _____.

(Signature)

Copy to:
Panel Members
Provider
Medical Staff Professional

PEER REVIEW PANEL RECOMMENDATION

Date

From: Chair, Peer Review Panel
To: Privileging Authority
Via: Chair, Executive Committee of the Medical/Nursing Staff

Subj: PEER REVIEW PANEL RECOMMENDATION IN CASE OF (PROVIDER'S NAME)

Ref: (a) Notice of Peer Review Panel
(b) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(c) BUMEDINST 6010.31

1. As required by references (a) through (c), a peer review panel convened on (date). The panel consisted of the following three (specialty) members, considered clinical peers of (provider name):

a.

b.

c.

2. Based on review of the available documentation, the panel makes the following findings:

a. **Allegation**: (state each allegation separately, i.e., clinical incompetence, impairment or professional misconduct). Each allegation must be addressed as listed in the notice of peer review panel.

Panel may also identify other allegations/grounds to support an adverse privileging action that were not stated in the summary suspension letter, if applicable.

Findings: (state if the allegation is substantiated or unsubstantiated).

Reasons for findings; provide an analysis of what information was relied upon in the panel's determination.

b. **Allegation**:

Findings:

Subj: PEER REVIEW PANEL RECOMMENDATION IN CASE OF (PROVIDER'S NAME)

3. Based on the aforementioned findings, the panel by unanimous/majority vote recommends (pick one): (name of provider's) (specialty) clinical (privileges/practice) be (reinstated; reinstated with Monitoring and Evaluation/Focused Professional Practice Evaluations; restricted; reduced; suspended; revoked/removed; or denied).

Provide an analysis of what factors/information was relied upon in making this recommendation.

(Signature)

Date received by privileging authority: _____

NOTICE OF REMOVAL FROM PATIENT CARE DUTIES

6010
Code
Date

From: Privileging Authority
To: Provider

Subj: NOTICE OF REMOVAL FROM PATIENT CARE DUTIES

Ref: (a) DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) of 29 October 2013
(b) BUMEDINST 6010.31

1. You are hereby notified that effective immediately and per references (a) and (b), you are being temporarily removed from all (a portion) of your patient care activities. This action is being taken in response to (list as appropriate: lack of clinical competence, impairment, professional misconduct) as evidenced by (give a brief statement of the facts). These issues have had (or could potentially have) an adverse effect on patient safety and the delivery of safe, quality care.

2. During the period of removal, any previous permission to engage in clinically related outside employment is hereby withdrawn until all due process procedures are completed.

3. A quality assurance (QA) investigation will be conducted into the allegations specified above. The results of the QA investigation will be reviewed and if the allegations are substantiated, a peer review panel may be convened to review the evidence and make a recommendation regarding your clinical practice and patient care activities to the privileging authority. If a peer review panel is convened, you will be notified in writing.

4. If you separate, retire or are discharged, or end employment with the Navy while an adverse practice action is taking place, you have the right to request that full due process procedures be continued. You must submit a written request to the privileging authority within 5 calendar days after learning of the change in your affiliation status. If you waive this right or fail to submit a request, the process will only continue through the convening of a peer review panel to the issuance of a decision by the privileging authority based on the panel's recommendations. Such decision by the privileging authority will be final. If the decision is adverse, your right to a hearing and to appeal is considered waived. In addition, any final adverse action will be reported to the National Practitioner Data Bank (privileged providers only), state licensing boards, regulatory agencies, and the Defense Practitioner Data Bank.

Subj: NOTICE OF REMOVAL FROM PATIENT CARE DUTIES

5. A temporary removal is neither punitive nor adverse. It will not be reported to any regulatory agency and it does not mandate disclosure in future official applications for state licensure or clinical appointments.

(Signature)

Copy to:
Medical Staff Personnel
BUMED-M00J

I acknowledge receipt of the Notice of Removal from Patient Care Duties.

_____ _____
Signature of Provider Date