



DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
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SECNAVINST 1754.7A
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SECNAV INSTRUCTION 1754.7A

From: Secretary of the Navy

Subj: CREDENTIALS REVIEW AND CLINICAL PRIVILEGING OF CLINICAL PRACTITIONERS/PROVIDERS IN DEPARTMENT OF THE NAVY FLEET AND FAMILY SUPPORT PROGRAM AND MARINE CORPS COMMUNITY SERVICES

Ref: (a) SECNAVINST 1754.1A
(b) BUMEDINST 6320.66D
(c) SECNAVINST 6320.23
(d) SECNAVINST 6401.2A
(e) SECNAVINST 1752.3A
(f) MCO P1700.24B
(g) BUMEDINST 6320.67A

Encl: (1) Definitions
(2) Process of Credentials Review and Privileging
(3) Core Privileges and Scope of Practice for Clinical Care Providers in DON FFSP and MCCS Centers
(4) Clinical Functions Associated with Practitioners and Providers
(5) Peer Review Panel (PRP) Procedures

1. Purpose

a. To revise and update guidance concerning the provision of counseling services and the credentials review and privileging of clinical providers within Navy Fleet and Family Support Program (FFSP) and Marine Corps Community Services (MCCS) per reference (a). This instruction is a complete revision and should be reviewed in its entirety.

b. To provide minimum standards for credentials review and clinical privileging of FFSP clinical providers (clinical counselors) as described in reference (b).

2. Cancellation. SECNAVINST 1754.7.

3. Applicability. This instruction applies to all military (active duty and Reserve) and civilian clinical providers/practitioners, as defined in enclosure (1), who are assigned to, employed by, contracted to, or under partnership agreement with the Department of the Navy (DON) FFSP or MCCS Centers. The provisions of this instruction apply to all clinical providers working as part of the Navy FFSP, including when the Family Advocacy Program (FAP) operates from a separate facility or MCCS. This instruction does not apply to chaplains unless they are providing clinical counseling as a clinical provider/practitioner. This instruction also does not apply to those health care practitioners and clinical support staff covered by reference (c).

4. Background

a. Provision of clinical counseling services for active duty members and their families has been a core function of Navy and Marine Corps family support programs since inception. Reference (a) described such services under the title of Family Assistance.

b. References (b) and (c) require all health care providers to be either credentialed, if they are clinical support staff, or both credentialed and privileged if they are health care practitioners. Health care providers include clinical providers who provide clinical counseling in FFSP/MCCS Centers, and per reference (c), all clinical providers must be either clinically privileged or under the supervision of a clinically privileged practitioner. References (b) through (d) issue policy applying to licensure, certification, and clinical privileging of DON health care providers. Enclosure (1) provides definitions of key terms including clinical practitioner and clinical privileging.

5. Policy

a. FFSP/MCCS clinical counseling is, by design, multi-disciplinary. Counseling services offered by FFSP and FAPs meet a basic need for clinical counseling and reduce the costs associated with referrals to private social service providers. In order to achieve quality standards of clinical services,

clinical providers will function within a three-tier system of professional qualifications in the provision of clinical services. (Enclosure (2) describes this three-tier system). The provision of clinical services provided will be consistent with staff resources, scope of practice, quality assurance procedures, and guidance contained herein. Clinical counseling shall be conducted per references (e) and (f).

b. Clinical counseling is intended to be problem-focused and brief. Brief treatment is not specifically defined in terms of an absolute number of sessions or for a finite time period. The intent is to focus counseling on well-defined problem areas amenable to relatively brief intervention/treatment. Clinical providers shall possess the expertise to assess disorders contained in the standard nomenclature of the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for the purposes of appropriate referral and quality client service.

c. DON policy (references (a), (b), (c), and (e)) requires as a condition of employment, that all health care practitioners be granted written clinical privileges by a Designated Privileging Authority (DPA) prior to providing independent clinical care. Credentialing review and privileging responsibilities for clinical counselors include:

(1) DPAs must define, profile, evaluate, and periodically reassess (at intervals not to exceed 2 years) the clinical performance and conduct of all assigned clinical practitioners following guidance contained in this instruction.

(2) DPAs must maintain an Individual Credentials File (ICF) on all clinical privileged practitioners. Designated credentialing authorities must maintain an Individual Professional File (IPF) on all clinical non-privileged providers. Contractors will maintain a current ICF/IPF for their employees working within DON and will provide a copy to the DPA. The ICF/IPF will contain documentation related to the clinical provider's current and past licensure/certification status, education and training, professional experience, current competence, and other items listed in reference (c) per Service specific guidance. Commanding officers (COs) must ensure the information contained in the ICFs/IPFs is monitored, continually

updated, and reported quarterly. COs must also ensure full compliance with all requirements relating to Quality Assurance (QA) and 10 U.S.C. 1102. The ICF/IPF will be transferred with the providers through their course of DON employment or archived upon their departure.

(3) A centralized credentials database will be maintained at Commander, Navy Installations (CNI) and Deputy Commandant, Manpower and Reserve Affairs (CMC (MR)). Primary source verification and periodic credentials review will be performed by CNI/CMC (MR). Contractors are responsible for primary source verification and periodic review of their employees, the results of which will be provided to CNI.

(4) DPAs will grant clinical privileges to clinical practitioners using the standardized privilege sheet contained in enclosure (3). The privilege sheet reflects the currently recognized scope of care. Regional commanders are to ensure that clinical practitioners provide services and treatments consistent with their approved clinical privileges.

(5) Eligible clinical providers are required, upon reporting for clinical duty, to request clinical privileging and the broadest scope privileges commensurate with their level of professional qualification, current competence, and the support level available at the facility. Privileges will be consistent with the needs and mission of the facility.

d. Clinical providers are responsible for ensuring the accuracy and currency of all credentials and privileging information reflected in their ICF/IPF. Providers must immediately inform the holder of their ICF/IPF of any change in status of any professional qualification which could impair their ability to provide safe, competent, and authorized clinical care services.

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

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f. FFSP counseling services may use graduate student interns for limited clinical services. Such interns can only provide services under the supervision of a clinically privileged practitioner. Interns cannot function in supervisory level positions and shall not comprise more than one third of the FFSP counseling staff.

6. Authority to Grant Clinical Privileges

a. CNI shall serve as the corporate privileging authority for Navy FFSP clinical practitioners.

b. CMC (MR) shall serve as the corporate privileging authority for Marine Corps FFSP clinical practitioners.

c. CNI/CMC (MR) shall each be responsible for primary source verification, ongoing credentials review, and evaluation of degree equivalencies for their respective personnel. DON contractors will be responsible for primary source verification and ongoing credentials review of employees working within DON FFSPs and will provide that information to CNI/CMC (MR), who maintains corporate privileging authority. Regional commanders may be the DPA for CNI/CMC (MR) and grant privileges to their respective FFSP clinical practitioners when such appropriate privileges have been recommended and approved by CNI/CMC (MR).

7. Investigation and Disposition of Allegations of Health Care Provider Impairment. Regional COs must investigate, without delay, allegations of clinical provider impairment (mental or professional) or misconduct, substandard performance, and moral or professional dereliction, including reportable misconduct, by clinical providers. Per reference (c), regional/installation COs will initiate administrative, judicial, nonjudicial, or adverse privileging actions upon receipt of allegations of clinical provider misconduct. Prompt action is required to safeguard client care, to protect the rights of the parties involved, and to preserve the integrity and effectiveness of the commands involved.

a. Acts of misconduct by clinical providers are incidents for which separation for cause may be appropriate and will be reported to CNI/CMC (MR).

b. COs will notify the CNI/CMC (MR) within 3 working days of initiation of an investigation and within 3 working days after the final verdict, adjudication, privilege action, or administrative disposition has been determined.

c. Allegations of criminal misconduct by clinical providers will be referred to the Naval Criminal Investigative Service (NAVCRIMINVSVC) and other authorities holding jurisdiction over the alleged offenses. Allegations of criminal misconduct by military clinical providers will be referred to Commander, Navy Personnel Command (COMNAVPERSCOM) (PERS-483), Conduct and Separations Branch.

d. In those cases where there is a reasonable belief that clinical practitioners are unable to safely execute their responsibilities in the practice of their clinical specialty, the regional COs will immediately initiate the following actions:

(1) Privileged practitioners whose professional impairment or misconduct may adversely affect their ability to provide safe, quality care will be immediately removed from direct clinical activities by having their clinical privileges suspended or held in abeyance.

(2) Upon receiving allegations of professional impairment or misconduct by a clinical practitioner, the privileging authority may, at their discretion, impose a privilege abeyance. The privilege abeyance period provides an opportunity to conduct an investigation into the allegations while ensuring client safety and protecting the practitioner from an unwarranted adverse privileging action. Such privilege abeyance will terminate upon completion of the investigation or at the end of 28 days, whichever occurs sooner. A privilege abeyance is not adverse and is non-punitive. Any record or notation of a privilege abeyance that results in the practitioner being returned to full clinical duties will be expunged from the practitioner's ICF at the time the privilege abeyance is terminated.

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

procedure per enclosure (5). Additional guidance for PRP can be found in reference (g).

(4) The PRP process shall be an unbiased evaluation by a panel of clinically privileged clinicians of a provider's ability to provide competent client care. Although it is not intended to be an adversarial legal proceeding, due to the implications an adverse action may have, the respondent is entitled to be represented by an attorney or other personal representative at the panel proceedings.

e. Final authority for all appeals action is CNI/CMC (MR).

8. Actions to be Reported

a. CNI/CMC (MR) will report the following information, within 5 working days, directly to applicable State or National licensing and certification agencies, applicable professional clearing houses, the Assistant Secretary of the Navy (Manpower and Reserve Affairs (ASN(M&RA))), and the Assistant Secretary of Defense for Health Affairs (ASD(HA)):

(1) Adverse privileging actions, after completion of any appeal, resulting in denial, limitation, or revocation of clinical privileges.

(2) Clinical providers (e.g., active duty, civilian and contracted personnel) who, due to disability, are released from active duty, retired, or have their employment terminated.

(3) Clinical providers found to have committed acts of misconduct listed in reference (c).

(4) Clinical providers referred for courts-martial or indicted by a civilian court for acts of misconduct. A follow-up report will be sent confirming the final verdict, adjudication, or administrative disposition.

b. The servicing civilian personnel office will notify CNI/CMC (MR) within 3 working days when civilian clinical providers are approved by the Office of Personnel Management (OPM) for medical termination or retirement.

9. Procedures and Responsibilities

a. Credentials Review and Clinical Privileging

(1) Clinical practitioners include, but are not limited to, privileged psychologists, social workers, and marriage and family therapists. Practice groups eligible for independent privileging are consistent with the current Federal regulation (e.g., 32 CFR 199.6 and 42 CFR 5, appendix C). All providers who are not independent practitioners shall practice under the supervision of a clinically privileged independent clinical practitioner, as defined in reference (c). Guidance expressed in reference (b) for credentials review and privileging procedures applies to FFSP clinical providers. Service specific instructions will issue guidance for a centralized Credentials Review and Clinical Privileging Committee (CRCPC) and will address compliance with credentials review and clinical privileging in FFSP. Enclosure (3) lists core privileges for clinical practitioners in Navy and Marine Corps FFSP.

(2) FFSP Site Managers shall ensure that eligible practitioners, upon reporting for clinical duty, request a credentials review and the granting of clinical privileges commensurate with the practitioner's level of professional qualification.

(3) Under exceptional circumstances, an FFSP or an individual provider, including those other than psychologists, social workers, and marriage and family therapists, may request a waiver of specific requirements for clinical privileging. Waiver requests must include full documentation of the rationale for such a request, including a discussion of the education, clinical training, and State licensure/certification requirements that are met, or a detailed plan to rectify the situation so as to obtain compliance with privileging regulations. CNI and CMC (MR) may grant such waivers. Waiver requests shall be submitted via the chain of command.

(4) Achieving the appropriate expertise and educational requirements to be clinically privileged to practice independently is the responsibility of the individual.

b. Continuing Education. FFSP will ensure all clinical providers have an opportunity to obtain a minimum of 16 hours of continuing education per annum.

c. Quality Assurance (QA). FFSP will have a written QA Plan to ensure client welfare, promote safety, and improve service delivery. This plan will encompass:

(1) Record review

(a) Records Audit. The FFSP Regional Director or Deputy Director is responsible for ensuring the audit of counseling records. Audits will include review of case files to ensure all required documentation is present, complete, and conducted in a timely manner. Audits shall not involve the reading or critique of clinical assessments, case notes, or treatment plans. Records will be selected randomly and audits conducted on a quarterly basis. Results and follow-up actions will be documented in the "Records Audit" section of the QA file.

(b) Clinical Care Review. Only clinically privileged practitioners shall perform clinical care review of counseling records. The review will consist of an audit of clinical records to ensure the appropriateness of initial assessment, case notes, treatment plans, referrals, and recommendations for the termination of treatment. Clinical care reviews will be conducted on a quarterly basis. A random sample of 10 percent of cases opened that quarter and 5 percent of records closed that quarter will be reviewed. Ongoing assessment of practitioner performance will be conducted per Service specific guidance.

(2) Supervision/Consultation. All FFSP providers/practitioners will participate in clinical supervision or consultation depending upon their privileging status.

(3) Client Satisfaction. Clients and their commands will be surveyed to evaluate the quality of FFSP care. Using locally determined methods, results will be analyzed on at least a semiannual basis and incorporated into QA files.

(4) Critical Incident Review. The regional commander or designee will convene a locally established critical incident review committee to review any allegations of unethical behavior, life endangering incidents, and/or allegations of deviance from accepted practices. If a critical incident review committee recommends a change in a clinical provider's privileges or a termination of professional staff appointment, procedures for convening a PRP are outlined in enclosure (5).

d. Confidentiality. FFSP and commands shall ensure compliance with the Privacy Act of 1974 and 10 U.S.C. 1102 with respect to client records and provider/practitioner records.

e. Referrals to Outside Resources. Individual family members seen at FFS Centers may be referred to community resources for counseling and/or other assistance. In such cases, adequacy of care provided by the referral source must be evaluated per Service specific guidance and local protocols.

f. The FFSP has a major role in the installation-level FAP, described in reference (e), which addresses prevention, identification, evaluation, treatment, rehabilitation, follow-up, and reporting of intra-familial violence or neglect. In areas where related clinical services (e.g., case management and counseling) are provided under the purview of the FFSP or in a freestanding FAP facility, such counseling services are covered by this instruction.

10. Action

a. The Chief of Naval Operations (CNO) and CMC shall:

(1) Carry out the program prescribed here and ensure implementation of its policies.

(2) Notify ASN(M&RA) of substantive changes to Service policies no later than 30 days prior to implementation.

b. CNI/CMC (MR) are responsible for technical and professional evaluation of clinical providers. They shall establish a credentials review process and standardized criteria for the selection and clinical privileging of clinical care within the guidelines of this instruction. They will establish

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a committee to perform primary source verification of clinical practitioner's credentials, ongoing credentials review, and to evaluate degree equivalency.

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DEFINITIONS

Clinical Counseling. Services provided to individuals, couples, or families to monitor or treat mental health-related problems. Such services include assessment, diagnosis, and treatment planning, as well as the initiation, alteration, or termination of a course of clinical care.

Clinical Practitioner. Military (active duty and Reserve) and Department of the Navy (DON) civilian providers (Federal civil service, foreign national hire, contract, or partnership) who are required by Navy and Department of Defense (DOD) policy to be granted clinical privileges to independently diagnose, initiate, alter, or terminate clinical treatment.

Clinical Privileging. The process whereby a Fleet and Family Support Program (FFSP) clinical practitioner is granted permission and responsibility to independently provide specified clinical care within the scope of the practitioner's license, certification, or registration.

Clinical Provider. A generic term indicating clinical practitioners and non-privileged clinical providers.

Clinical Record Review. The review of clinical records to ensure the appropriateness of initial assessment, progress notes, treatment plans, termination, and referrals. Reviews may be accomplished by such means as record review, individual case review, group case conferences, peer review, and staff supervision.

Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification, experience, and expertise of clinical care providers.

Credentials Review. The application and screening process whereby clinical providers have their credentials verified before being selected for naval service, employed by DON, granted clinical privileges, or assigned client care responsibilities.

Individual Credentials File (ICF). A file that contains documentation relating to clinical practitioner's current and

past licensure (certification status, education, and training), professional experience, and health status.

Individual Professional File (IPF). A file that contains documentation relating to clinical non-privileged providers current and past education, training, and health status.

Non-Clinical Functions. Functions which do not require professional licensure, but may require specialized education and/or experience. Such functions include teaching, facilitating educationally-based groups or programs (where no clinical interpretation of behavior is made), administrative functions, or providing generally available information to groups or individuals.

Supervision. The process of reviewing, observing, and accepting responsibility for the healthcare services provided by clinical care providers.

PROCESS OF CREDENTIALS REVIEW AND PRIVILEGING

1. The potential consequences of unqualified or impaired clinical providers or the misconduct of providers are so significant that complete verification of credentials and adequate control of clinical privileges are imperative. Reference (d) requires that all health care practitioners who are responsible for making independent decisions to diagnose, initiate, alter, or terminate a regimen of clinical care will be subject to credentials review and will be granted a professional staff appointment with delineated clinical privileges by a DPA before providing independent health care.

2. In order to achieve quality standards of clinical services in FFSP, clinical care provider's function within a three-tier system of professional qualifications in the provision of services. This three-tier model is designed to ensure quality clinical care delivery of services and to serve as a career path for FFSP clinical counselors.

a. Tier I includes entry-level providers who are collecting their supervised clinical hours to be applied toward licensure. Licensure/certification shall be completed within a 36 month period. Exceptions to this policy must be approved by CNI/CMC (MR). Providers who are not State licensed or State certified or whose license/certificate was not granted by a U.S. territory, must perform all clinical duties under the supervision of a licensed practitioner and under no circumstances can provide independent clinical care. Enclosure (4) provides details concerning the limits of practice for non-privileged providers.

b. Tier II includes providers who are State licensed or State certified or were granted a license or a certificate by a U.S. territory to provide independent clinical care. These providers are eligible to apply for clinical privileges to function as an independent practitioner.

c. Tier III includes providers who are State licensed or State certified or were granted a license or a certificate by a U.S. territory, have been granted clinical privileges to function as an independent practitioner, and have attained specified additional clinical experience. Clinical supervision

of other FFSP providers and the ability to function as a sole provider, often in remote locations, is restricted to providers who are qualified in Tier III.

d. Practitioners functioning in Tiers II and III must possess a current, valid, unrestricted license or certification that grants independent status, per reference (d), to be eligible for professional staff appointment with clinical privileges.

3. A thorough description of the minimum qualifications and capabilities of providers functioning within this three-tier system is described below:

a. Tier I (Clinical Provider). All individuals providing clinical services must meet basic qualifications in order to be hired. The following qualifications are required for clinical providers:

(1) A masters or doctoral degree in one of the following disciplines or in an allied clinical field:

(a) Counseling from a program accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or an equivalent degree.

(b) Marriage and Family Therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or an equivalent degree.

(c) Social Work from a school accredited by the Council on Social Work Education (CSWE) or an equivalent degree.

(d) Psychology from a doctoral program approved by the American Psychological Association (APA) or an equivalent degree; an Allied Clinical field from a regionally accredited graduate program leading to a State license or State certification to practice independently in a clinical field; or a masters degree in psychology from a graduate program accredited by the Inter-organizational Board for Accreditation of Masters in Psychology Accreditation Counsel (MPAC) or an equivalent degree.

(2) Clinical providers will be supervised by a Tier III clinical practitioner and will be involved in a professional development plan as directed by the site/regional FFSP Counseling and Advocacy Coordinator.

b. Tier II (Clinical Practitioner). The clinical practitioner must meet the following requirements:

(1) State or U.S. territory license or certification that provides legal authority to provide clinical services as an independent practitioner.

(2) When the State or U.S. territory licensing or certification requirements include a written examination, candidates for privileging must have achieved a passing score on that examination.

(3) Possess at least a masters degree in one of following clinical fields:

(a) Marriage and Family Therapy from a program accredited by COAMFTE or an equivalent degree.

(b) Social Work from an accredited school or an equivalent degree.

(c) Psychology from a doctoral program approved by APA or an equivalent degree.

(4) Must have engaged in 2 years, that includes at least 2,000 hours, full-time, post-masters supervised clinical experience.

c. Tier III (Clinical Practitioner, supervisor eligible). The clinical practitioner who is eligible to provide clinical supervision shall meet the following requirements:

(1) All criteria required for clinical practitioner.

(2) Two years post licensure, that includes at least 2,000 hours post licensure or 4,000 hours post graduate degree, full-time clinical experience in a clinical setting.

**CORE PRIVILEGES AND SCOPE OF PRACTICE FOR CLINICAL CARE
PROVIDERS IN DON FFSP AND MCCS CENTERS**

The following privileging sheets represent the full range of skills and functional areas providers should be able to perform within the scope of their discipline. That individual's position description and the scope of services offered by the facility shall dictate the actual clinical services any individual provider performs.

Clinical Psychology - Core Privileges

Consultation, differential diagnosis, and treatment planning for all disorders defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM):

- Organic mental disorders
- Psychotic disorders
- Schizophrenia
- Delusional disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders
- Psychoactive substance use disorders
- Sleep disorders
- Factitious disorders
- Impulse control disorders
- Psychological factors affecting physical condition
- Disorders usually first evident in infancy, childhood or adolescence now manifest in an adult patient such as eating disorders and gender-identity disorders
- Conditions not attributable to a mental disorder that are a focus of attention or treatment
- Sexual disorders
- Adjustment disorders
- Personality disorders
- Dissociative disorders
- Combat stress disorder

Diagnostic and therapeutic procedures include:

- Interviewing
- Psychosocial history taking

- Mental status examination
- Major types of psychotherapy including short term, long term, psychodynamic, family, marital, group, individual, and behavior therapy
- Crisis intervention
- Community outreach (e.g., health promotion and command consultation)
- Special psychological examinations (e.g., incapacitation determinations and Rules for Courts-Martial examinations (sanity boards))
- Evaluations for suitability and fitness for duty
- Administration and interpretation of psychological tests (intellectual and cognitive, clinical objective and inventory, clinical projective, achievement, vocational and aptitude, and questionnaire and survey instruments)

Clinical Psychology - Supplemental Privileges:

- Neuropsychological assessment (requires subspecialty code 1842)
- Prescribe and dispense psychotropic medications as delineated by the Pharmacy & Therapeutics Committee
- Admit patients to the hospital included in the psychologist's scope of care and be responsible for patient histories and physical findings respective to their areas of expertise.

Other:

Treatment Facility:
Practitioner Name:

Date Requested:
Date Approved:

Clinical Social Work - Core Privileges

Consultation, differential diagnosis, and treatment planning for all disorders defined by the DSM:

- Organic mental disorders
- Psychotic disorders
- Schizophrenia
- Delusional disorders
- Mood disorders
- Anxiety disorders
- Somatoform disorders

- Psychoactive substance use disorders
- Sleep disorders
- Factitious disorders
- Impulse control disorders
- Psychological factors affecting physical condition
- Gender-identity disorders
- Conditions not attributable to a mental disorder that are a focus of attention or treatment
- Sexual disorders
- Adjustment disorders
- Personality disorders
- Dissociative disorders
- Combat stress disorder

Diagnostic and therapeutic procedures include:

- Interviewing
- Major types of psychotherapy including short term, long term, psychodynamic, family, marital, group, individual, and behavior therapy
- Community outreach (e.g., health promotion and command consultation)
- Mental status examination
- Crisis intervention
- Case management
- Medical discharge planning
- Psychosocial history taking

Clinical Social Work - Supplemental Privileges:

Other:

Treatment Facility:
Practitioner Name:

Date Requested:
Date Approved:

Marriage and Family Therapy - Core Privileges

Consultation, differential diagnosis, and treatment planning within the context of family systems for all disorders defined by the DSM:

- Organic mental disorders
- Psychotic disorders

- Schizophrenia
- Delusional disorders
- Anxiety disorders
- Somatoform disorders
- Psychoactive substance use disorders
- Sleep disorders
- Factitious disorders
- Impulse control disorders
- Psychological factors affecting physical condition
- Disorders usually first evident in infancy, childhood, or adolescence now manifest in an adult patient such as eating disorders and gender-identity disorders
- Conditions not attributable to a mental disorder that are a focus of attention or treatment
- Sexual disorders
- Adjustment disorders
- Personality disorders
- Dissociative disorders
- Combat stress disorder

Diagnostic and therapeutic procedures:

- Interviewing
- Psychosocial and family history taking
- Mental status evaluation
- Major types of therapy including short and long term psychotherapy, psychodynamic, family systems, marital, group individual, and behavioral therapy
- Crisis intervention
- Community outreach
- Family and individual case management
- Community and systemic consultation (e.g., health promotion, prevention services, and command systems consultation)
- Discharge planning

Marriage and Family Therapy - Supplemental Privileges:

Other:

Treatment Facility:
Practitioner Name:

Date Requested:
Date Approved:

CLINICAL FUNCTIONS ASSOCIATED WITH PRACTITIONERS AND PROVIDERS

1. Clinical Provider (Non-privileged):

a. This term includes all health care providers who do not have a State or U.S. territory license or certificate that enables them to practice independently. State or U.S. territory license or certificate in and of itself does not necessarily authorize independent practice (e.g., master's level psychology licenses). Therefore, it is important to determine any limits to practice imposed in the specific license or certification issued. In FFSP, such non-privileged providers would include Licensed Professional Counselors (LPCs), entry-level marriage and family therapists, social workers, and psychologists who have completed their masters/doctoral degree but have not yet accumulated sufficient supervised clinical experience to enable them to obtain a State or U.S. territory license or certificate to practice independently.

b. Non-privileged clinical providers must perform all clinical duties under the supervision of a clinical practitioner who has been privileged to function independently (i.e., the privileged practitioner has a State or U.S. territory license or certificate to provide independent health care services). The non-privileged provider works under the license of a privileged independent practitioner.

c. Non-privileged clinical providers may interview, assess, diagnose, and counsel clients. However, their work must be reviewed and supervised by a privileged practitioner who signs or counter signs all of their clinical work. Additionally, non-privileged providers may function as co-facilitator in a group therapy situation with a facilitator who is a privileged practitioner. A non-privileged provider should normally not be assigned unusual, complex, or difficult cases unless there is close and ongoing supervisory consultation, which must be well documented.

d. A non-privileged clinical provider may not, under any circumstances, provide independent clinical care. In practice, therefore, a non-privileged provider cannot be the only clinical counselor in a given location.

e. A non-privileged provider may perform a variety of non-clinical functions including teaching, facilitating educationally based groups or programs, or providing information to groups or individuals.

f. When performing non-clinical duties, the non-privileged provider requires general supervision only and need not work under the license of a privileged practitioner.

2. Clinical Practitioners (Privileged):

a. This term includes all health care providers who have a State or U.S. territory license or certificate and who have been granted clinical privileges to practice independently. In FFSP, clinical practitioners might include marriage and family therapists, social workers, and doctoral-level psychologists.

b. Privileged practitioners may perform clinical functions independently, i.e., they may independently diagnose, initiate, alter, or terminate clinical treatment. Privileged practitioners work under their own license/certificate, sign their own work, and have sole responsibility for the clinical services which they provide.

c. Privileged practitioners may perform a variety of clinical functions. They may interview, assess, diagnose, refer, counsel, or provide consultation. They may provide individual, family, or group therapy. Privileged practitioners, as a matter of sound practice, normally seek peer consultation for unusual, complex and/or difficult cases.

d. Privileged practitioners may practice independently, with sufficient experience (Tier III), may be the only counselor in a given location, and may provide clinical supervision to others.

PEER REVIEW PANEL (PRP) PROCEDURES

1. Purpose. The Peer Review Panel (PRP) provides a process whereby a respondent is afforded a fair and impartial hearing at which time the allegations that form the basis for a potential denial, limitation, or revocation of clinical privileges, or termination of professional staff appointment may be responded to or rebutted. The PRP process shall be an unbiased evaluation, by a panel of clinicians, of a provider's ability to provide competent client care. When the clinical privileges of a respondent are suspended, the action will be reviewed through the PRP procedure.

2. Notice of Privilege Suspension and Advice of Rights. Within 7 days of suspension of privileges, the privileging authority shall notify the respondent in writing (enclosure (5), appendix A) of the following matters:

- a. Effective date of the suspension.
- b. Scope of the suspension, total or partial, and if a partial suspension, the specific clinical privileges affected.
- c. That in cases of partial suspension, all clinical privileges could be revoked based upon additional investigative findings or peer review recommendations.
- d. That their staff appointment could be terminated.
- e. The grounds for the suspension, including the specific misconduct, substandard performance, or professional or personal impairment.
- f. The right to a reasonable opportunity, normally within 7 days, to consult with counsel or other advisor prior to electing or waiving any of the rights in this paragraph.
- g. The right to have the case heard at a PRP hearing and to be present at the hearing.
- h. The right to representation by counsel or other representative at the hearing.

- i. The right to present evidence at the hearing.
- j. The right to waive the rights in paragraphs 2f through 2i.

k. If the final action after completion of all appeal procedures is to deny, limit, or revoke clinical privileges or terminate staff appointment, that fact will be reported to the applicable State, U.S. territory, or National licensing and certification agencies; applicable professional clearing house; Assistant Secretary of the Navy (Manpower & Reserve Affairs) (ASN(M&RA)); Assistant Secretary of Defense (Health Affairs) (ASD(HA)); and other organizations or agencies required by this instruction.

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

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

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

4. Rights of Respondent. The respondent has the following rights at a PRP hearing:

- a. The right to be present at the PRP hearing.
- b. The right to be represented by an attorney or other personal representative at the hearing. The attorney or representative shall have the right to address the panel or witnesses directly.
- c. The right to present evidence.
- d. The right to make a statement to the PRP.
- e. The right to waive any of the above hearing rights, including the right to a PRP hearing. In such a case, the provider may submit written matters for the panel's consideration.

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f. Failure to respond to the letter of notification within 7 days constitutes a waiver of the right to appear at the peer review hearing. An extension of the 7-day period may be granted by the DPA for good cause.

g. Failure to appear at the hearing, after receiving notice about the time, date, and location of the hearing, constitutes a waiver of the right to appear unless the DPA grants a continuation of the hearing date.

h. The right to have reasonable opportunity to consult with counsel or other advisor before electing or waiving hearing rights. Absent unusual circumstance, 7 days will normally be considered a reasonable opportunity.

5. Counsel

a. Member of the Armed Forces Respondent. Respondent may be represented by an attorney or other person of their choice.

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

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

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

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

6. Panel Hearing. If the respondent elects a hearing, privileging authority shall convene a PRP within 30 days of issuing the Notice of Clinical Privileges Summary Suspension and Advice of Rights. The panel hearing must begin not less than 30 days after the respondent received actual notice of their rights as provided in paragraph 2.

7. Pre-hearing Disclosure of Information

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

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

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

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

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

(1) Any documentary evidence they wish to be considered at the hearing.

(2) Written notice of the names of witnesses to be called to testify on the respondent's behalf, and the matters their testimony will cover. Local authority will determine the production of any witness that may require expenditure of funds by the convening authority.

8. Panel Membership, Recorder, and Legal Advisor. The PRP will consist of three to five members of the professional staff of

the FFSP who are well qualified by reason of experience and judicious temperament, one of whom will be the credentials committee chairperson who will serve as the PRP chairperson. Persons expected to be called as witnesses shall not be appointed to the panel.

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

b. When the respondent is a civilian, (e.g., a Federal civilian employee or contractor) at least one member of the panel will be a civilian of the same discipline as the respondent, if available.

c. The opportunity to serve on a PRP should be given to women and minorities; however, the lack of such membership does not constitute a basis for challenging the proceedings.

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

e. The convening authority may appoint a non-voting legal advisor to assist the panel. The convening authority may request the Regional Legal Service Office, the local Trial Service Office, or another command in the area with a Staff Judge Advocate to provide a judge advocate to act as the legal advisor for the panel. The requested CO may assign a judge advocate, subject to reasonable availability. The legal advisor shall not participate in closed sessions of the panel and shall either be available in person or by telephone during the panel hearing. The role of the legal advisor is to be neutral.

9. Hearing Procedures

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

b. Challenge for Cause. The respondent or respondent's representative may challenge members of the PRP for cause only.

The respondent or respondent's representative must state specifically the grounds for any challenge(s) issued. Cause for removal of a member of the PRP exists if a member has a predisposed attitude towards the outcome of the hearing or has acted as a preliminary inquiry officer, investigating officer, or advisor to the DPA in the matter under review. Mere knowledge of the facts of a case is not sufficient cause for removal.

c. Standard of Proof. The standard of proof is a preponderance of the evidence.

d. Presentation of Evidence

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

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

(3) The chairperson may, upon a showing of good cause, allow the introduction of material or information not previously disclosed per paragraph 7. However, if information not previously disclosed per paragraph 7 is to be considered, requests for reasonable delay in the hearing by the adversely affected party should be liberally considered.

e. Witnesses

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

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

(3) Witnesses not within the geographical commuting area of the panel are considered not reasonably available; however,

such witnesses are welcome to appear at no expense to the government.

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

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

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

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

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

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

(7) Witnesses not on active duty or employed by the DON must appear voluntarily and at no expense to the government, except as provided for by paragraph 9f(9) below.

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

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

(a) The testimony of a witness is cumulative.

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

(c) Signed statements, telephonic testimony, or depositions will not accomplish adequately the same objective.

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

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

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

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

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

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

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

f. Rights of the Respondent. The respondent has the following rights:

(1) The respondent may testify on their own behalf. If the respondent elects to make such a statement, members of the PRP may question them.

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

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

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

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

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

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

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

i. Recommendations. The panel will make recommendations to the privileging authority for each allegation supported by a preponderance of the evidence.

(1) With regard to respondent's clinical privileges, the panel may recommend:

(a) Reinstatement or initial granting.

(b) Denial.

(c) Limitations.

(d) Revocation.

(2) With regard to the professional staff appointment, the panel may recommend that it be continued or terminated. A recommendation to terminate the professional staff appointment is inconsistent with a recommendation that would leave any

clinical privileges intact. A recommendation to grant or continue a professional staff appointment is inconsistent with a recommendation to deny or revoke privileges.

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

10. Respondent's Comments on the Panel Report. A copy of the report will be given to the respondent at the time it is submitted to the privileging authority. The respondent may submit written comments to the privileging authority within 7 days identifying errors, misstatements, or omissions in the report, and stating any disagreement or agreement with the findings of fact or recommendations.

11. Privileging Authority's Action. After the respondent has been provided 7 days to submit comment, the privileging authority will advise the respondent of their decision on the case and explain the respondents right to appeal the decision as outlined in paragraph 12 below. The privileging authority's decision must be based upon the information contained in the PRP report. However, the recommendations of the PRP are not binding upon the privileging authority. They have the authority and responsibility, as the official granting clinical privileges and staff appointment within the facility, to make an independent decision. If the privileging authority's decision departs from the findings and the recommendations of the panel, the decision must state the basis for that departure.

12. Appeal. A respondent may appeal a decision to deny, limit, or revoke clinical privileges, or terminate staff appointment. The appeal must be submitted in writing to CNI via the privileging authority within 14 days of the date of privileging

authority's decision and must state the specific grounds for appeal. The decision of the privileging authority shall remain in effect during the appeal.

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

b. CNI/CMC (MR) will review the stated grounds for the appeal, the evidence of record, and any new information included under the above provisions. The standard for review on appeal is whether the privileging authority abused their discretion. After consultation with the chief of the appropriate corps on substantive professional issues, and legal review, the CNI/CMC (MR) will grant or deny the respondent's appeal. The decision of CNI/CMC (MR) is final.

APPENDIX A

**SAMPLE NOTICE OF CLINICAL PRIVILEGES SUMMARY SUSPENSION AND
ADVICE OF RIGHTS LETTER**

From: Commanding Officer,
To:

Subj: NOTICE OF CLINICAL PRIVILEGES SUMMARY SUSPENSION AND
ADVICE OF RIGHTS

Ref: (a) SECNAVINST 1754.1A
(b) BUMEDINST 6320.67A

1. I have determined that there is sufficient evidence to indicate you may (have committed an act of misconduct/be impaired). Accordingly, per references (a) and (b), all of your clinical privileges for the Fleet & Family Support Program are summarily suspended, effective immediately. (If only a partial suspension is invoked, the specific clinical privileges affected must be identified.)

2. The grounds of the summary (or partial) suspension are as follows:

(Include the specific misconduct or impairment upon which the suspension is based. These should be specific allegations that clearly identify the misconduct or impairment.)

3. A Peer Review Panel (PRP) will be convened to conduct a hearing concerning the above allegations and provide me with findings of fact and recommendations concerning this matter.

4. In cases of partial summary suspension, all clinical privileges could be revoked based upon PRP recommendations. Your staff appointment could also be terminated.

5. Per references (a) and (b), you have the right to:

- a. Appear at a PRP hearing.
- b. Be represented by counsel or any other personal representative at the PRP hearing.
- c. Present evidence at the PRP hearing.
- d. Make a statement at the PRP hearing.

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e. Appeal any permanent adverse privileging action taken against you as a result of the peer review hearing.

Signature