



DEPARTMENT OF THE NAVY

OFFICE OF THE SECRETARY

1000 NAVY PENTAGON

WASHINGTON, D. C. 20350-1000

SECNAVINST 1754.7

ASN(MRA) (FSF)

1 February 1999

SECNAV INSTRUCTION 1754.7

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

Subj: CREDENTIALS REVIEW AND CLINICAL PRIVILEGING OF CLINICAL PRACTITIONERS/PROVIDERS IN DEPARTMENT OF THE NAVY (DON) FAMILY SERVICE CENTERS

Ref: (a) SECNAVINST 1754.1
(b) BUMEDINST 6320.66 (NOTAL)
(c) SECNAVINST 6320.23
(d) SECNAVINST 6401.2A
(e) DOD Directive 6025.13 (NOTAL)
(f) SECNAVINST 1752.3A
(g) Family Service Center Desk Guide, Vol. 5, (Counseling) (NOTAL)
(h) Quality Standards Accreditation Checklist (NOTAL)
(i) MCO 1752.3B (NOTAL)
(j) DOD 6400.1-M of Aug 92 (NOTAL)
(k) BUMEDINST 6320.67

Encl: (1) Definitions
(2) Process of Credentials Review and Privileging
(3) Core Privileges and Scope of Practice for Clinical Care Providers in DON FSCs and FAP Centers
(4) Clinical Functions Associated with Practitioners and Providers
(5) Peer Review Panel 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 and Marine Corps Family Service Centers (FSCs) and Family Advocacy Program Centers (FAP Centers) in accordance with reference (a).

b. To establish minimum standards for credentials review and clinical privileging of FSC and FAP Center clinical providers (clinical counselors) as described in reference (b).

2. 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 within DON FSCs and FAP Centers. The provisions of this instruction apply to all FSC clinical providers including

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those working as part of the Navy and Marine Corps FAP. 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).

3. Background

a. Provision of clinical counseling services for active duty members and their families has been a core function of Navy and Marine Corps FSCs and FAP Centers 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 FSCs and FAP Centers, and in accordance with reference (c), all clinical providers in FSCs and FAP Centers must be either clinically privileged or under the supervision of a clinically privileged practitioner. References (b) through (e) issue recent 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."

4. Policy

a. FSC and FAP Center clinical counseling is by design multidisciplinary. Counseling services offered by FSCs and FAP Centers 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 in DON FSCs and FAP Centers, 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 at FSCs and FAP Centers will be consistent with staff resources, scope of practice, quality assurance procedures and guidance contained herein. Clinical counseling shall be conducted in accordance with references (g) through (i).

b. Clinical counseling provided in DON FSCs and FAP Centers is intended to be problem focused and "brief." "Brief treatment" is not specifically defined in terms of an absolute number of sessions nor 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 clinical expertise to assess disorders contained in the standard nomenclature of the 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 prior to providing independent clinical care. Credentialing review and privileging responsibilities for clinical counselors in DON FSCs and FAP Centers include:

(1) Designated privileging authorities 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) Designated privileging authorities 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 FSCs and FAP Centers and will provide a copy to the designated privileging authority. 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) in accordance with service specific guidance. Commanding officers must ensure the information contained in the ICFs/IPF is monitored, continually updated, and reported quarterly. Commanding officers must also ensure full compliance with all requirements relating to Quality Assurance 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 from DON employment.

(3) A centralized credentials database (CCDB) will be maintained at Bureau of Naval Personnel (BUPERS) (Pers-66) and Commandant of the Marine Corps (Manpower and Reserve Affairs). Primary source verification and periodic credentials review will be done by personnel of the CCDB. Contractors are responsible for primary source verification and periodic review of their employees, the results of which will be provided to the CCDB.

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

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(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. In positions for which privileging is required, those clinical providers who do not request such privileges, those clinical providers who do not maintain required qualifications or those clinical providers who do not qualify for clinical privileges within 36 months are subject to processing for separation for cause under SECNAVINST 1920.6A for military personnel or administrative action under CPI 752 (NOTAL) or CPI 432 (NOTAL) for civilian employees or under the terms of their contract or agreement for contract for partnership providers.

e. Clinical providers are responsible for ensuring the accuracy and currency of all credentials and privileging information reflected in his or her 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.

f. 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.

g. FSC and FAP Center 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 as Deputy Director, Chief of Counseling (or equivalent position), or in Level II Family Advocacy positions (as defined in reference (j)). Interns shall not comprise more than one third of an FSC/FAP Center counseling staff.

5. Authority to Grant Clinical Privileges

a. The Chief of Naval Personnel (CHNAVPERS) shall serve as the corporate privileging authority for Navy FSCs and FAP Center clinical practitioners.

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b. The Commandant of the Marine Corps (CMC) shall serve as the corporate privileging authority for Marine Corps FSC clinical practitioners.

c. CHNAVPERS/CMC 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 their employees working within DON FSCs and FAP Centers and will provide that information to the CHNAVPERS/CMC, who maintain corporate privileging authority. Installation commanders may be the designated representatives of CHNAVPERS/CMC and grant privileges to their respective FSC and FAP Center clinical practitioners when such appropriate privileges have been recommended and approved by CHNAVPERS/CMC.

d. For all other non-FSC and non-FAP Center clinical privileging refer to reference (c).

6. Investigation and Disposition of Allegations of Health Care Provider Impairment. Installation commanding officers 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. Installation commanding officers will initiate administrative, judicial, non-judicial, or adverse privileging actions, in accordance with reference (c), upon receipt of allegations of clinical provider misconduct listed in reference (c). 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 the CHNAVPERS (Pers-66)/CMC-MR.

b. Commanding officers will notify the CHNAVPERS (Pers-66)/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 and other authorities holding jurisdiction over the alleged offenses. Allegations of criminal misconduct by military clinical providers will be referred to Pers-8.

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

(1) Upon receiving allegations of professional impairment or misconduct by a clinical practitioner, the privileging authority may, at his or her discretion, impose a privilege abeyance. The privilege abeyance period provides an opportunity to conduct an investigation into the allegations while ensuring 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.

(2) As soon as evidence is identified that supports the allegations, or the investigation substantiates the allegations, the privileging authority will suspend the practitioner's clinical privileges and initiate the Peer Review Panel procedure in accordance with enclosure(5).

e. Final authority for all appeals actions is CHNAVPERS/CMC-MR.

7. Actions to be Reported

a. Per enclosure (4) of reference (e), CHNAVPERS/CMC-MR will report within 5 working days the following directly to applicable State or national licensing and certification agencies, applicable professional clearing houses, the National Practitioner Data Bank, 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 resulting, after completion of any appeal, in denial, limitation, or revocation of clinical privileges.

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(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 (k).

(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 the CHNAVPERS/CMC-MR within 3 working days when civilian clinical providers are approved by the Office of Personnel Management (OPM) for medical termination or retirement.

8. Procedures and FSC and FAP Center Responsibilities

a. Credentials Review and Clinical Privileging

(1) In DON FSCs and FAP Centers, clinical practitioners include, but are not limited to: privileged psychologists, social workers, marriage and family therapists. Practice groups eligible for independent privileging are consistent with the current federal regulation (e.g., 32CFR199.6 and 42CFR5, 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 FSC and FAP Center clinical providers. Service specific instructions will issue guidance for a centralized credentials review committee, and will address compliance with credentials review and clinical privileging in FSCs and FAP Centers. Enclosure (3) lists core privileges for clinical practitioners in Navy and Marine Corps FSCs and FAP Centers.

(2) FSC and FAP Center Directors shall ensure that eligible practitioners, upon reporting to an FSC/FAP Center 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 FSC/FAP Center 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. CHNAVPERS 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. FSCs and FAP Centers will ensure all clinical providers have an opportunity to obtain a minimum of 16 hours of continuing education per annum.

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

(1) Record review

(a) Records Audit. The FSC/FAP Center Director or Deputy Director is responsible for ensuring the audit of FSC/FAP Center 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 Quality Assurance file.

(b) Clinical Care Review. Clinical care review of FSC/FAP Center counseling records shall be done only by a clinically privileged practitioner. The clinical care review will consist of a review 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 in accordance with service specific guidance.

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

(3) Client Satisfaction. Surveys will be conducted to evaluate the quality of FSC and FAP Center care. Both clients and the clients' command will be surveyed. Using locally

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determined methods, results will be analyzed on at least a semiannual basis and incorporated into the FSC/FAP Center QA files.

(4) Critical Incident Review. The installation 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, the procedures for convening a Peer Review Panel are outlined in enclosure (5).

d. Confidentiality. FSCs, FAP Centers 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 FSCs and FAP 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 in accordance with service specific guidance and local protocols.

f. FAP. The FSC has a major role in the installation-level FAP, described in reference (f), which addresses prevention, identification, evaluation, treatment, rehabilitation, follow-up, and reporting of intra-familial violence or neglect. In areas where FAP related counseling is provided under the purview of the FSC or in a Family Advocacy Center, such counseling services are covered by this instruction.

9. Action

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

(1) Carry out the program prescribed here and implement its policies.

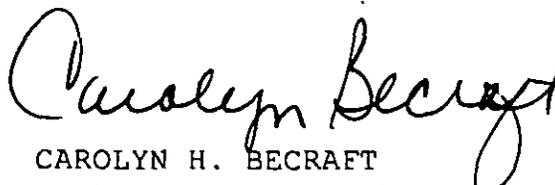
(2) Notify ASN(M&RA) of substantive changes to Service policies no later than 30 days prior to implementation.

b. CHNAVPERS/CMC-MR are responsible for technical professional evaluation of clinical providers. They shall establish a credentials review process and standardize criteria for the selection and clinical privileging of clinical care in FSCs and FAP Centers within the guidelines of this instruction. They will establish a committee to perform primary source

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verification of clinical practitioners' credentials, ongoing credentials review, and to evaluate degree equivalency.



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DEFINITIONS

1. 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.
2. Clinical Privileging. The process whereby a DON FSC/FAP Center clinical practitioner is granted the permission and responsibility to independently provide specified clinical care within the scope of the practitioner's license, certification or registration.
3. Clinical Record Review. The review of clinical records to ensure the appropriateness of initial assessment, progress notes, treatment plans, termination and referrals. Such reviews may be accomplished by such means as record review, individual case review, group case conferences, peer review, staff supervision.
4. Clinical Practitioner. Military (active duty and Reserve) and DON civilian providers (Federal civil service, foreign national hire, contract, or partnership) who are required by Navy and DoD policy to be granted clinical privileges to independently diagnose, initiate, alter, or terminate clinical treatment.
5. Clinical Provider. A generic term indicating clinical practitioners and non-privileged clinical providers.
6. Credentials. Documents that constitute evidence of qualifying education, training, licensure, certification, experience, and expertise of clinical care providers.
7. Credentials Review. The application and screening process whereby clinical providers have their credentials verified before being selected for Naval Service, employed by the DON, granted clinical privileges, or assigned client care responsibilities.
8. 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.
9. Individual Professional File (IPF). A file that contains documentation relating to clinical non-privileged providers current and past education, training, and health status.
10. Non-clinical functions. Functions which do not require professional licensure, but may require specialized education and/or experience. Such functions include teaching, facilitating

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educationally based groups or programs (where no clinical interpretation of behavior is made) administrative functions, or providing generally available information to groups or individuals.

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

Enclosure (1)

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PROCESS OF CREDENTIALS REVIEW AND PRIVILEGING

1. The DON recognizes the quality of clinical services is largely dependent on the quality of clinical and administrative processes. Implementation of continuous quality improvement/total quality leadership in DON is a primary means for ensuring quality of clinical care. 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. DON policy, reference (d), requires 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 designated privileging authority before providing independent health care.

2. In order to achieve quality standards of clinical services in DON FSCs and FAP Centers, clinical care providers function within a three-tier system of professional qualifications in the provision of services.

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 CHNAVPERS/CMC-MR. These providers, who are not state licensed or state certified or whose license or 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.

Enclosure (2)

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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 FSC or FAP Center providers and the ability to function as a sole provider (often in remote locations) is restricted to providers who are qualified in Tier III. This three-tier model is designed to ensure quality clinical care delivery of services and to serve as a career path for Family Service Center and Family Advocacy Center clinical counselors.

d. Practitioners functioning in Tiers II and III must possess a current, valid, unrestricted license or certification which 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 in an FSC 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:

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

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

- Social Work from a school accredited by the Council on Social Work Education (CSEE) or an equivalent degree, or

Enclosure (2)

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- Psychology from a doctoral program approved by the American Psychological Association (APA) or an equivalent degree or 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 Program (IBAMPP) 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 Chief of Clinical Services.

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

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

(2) When the state 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:

- Marriage and Family Therapy from a program accredited by Commission on Accreditation for Marriage and Family Therapy Education or an equivalent degree or

- Social Work from a school accredited by CSEE or an equivalent degree or

- Psychology from a doctoral program approved by APA or an equivalent degree or

(4) Have engaged in 2 years (which includes at least 2000 hours) full-time, post-masters supervised clinical experience.

Enclosure (2)

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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 a clinical practitioner,
and

(2) Two years post licensure (which includes at least 2000 hours post licensure or 4000 hours post graduate degree), full-time clinical experience in a clinical setting.

Enclosure (2)

SECNAVINST 17547

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**CORE PRIVILEGES AND SCOPE OF PRACTICE FOR CLINICAL CARE
PROVIDERS IN DEPARTMENT OF NAVY FSC'S AND FAP CENTERS**

The following privileging sheets represent the full range of skills and functional areas each provider should be able to perform within the scope of his/her 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.

Enclosure (3)

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DEPARTMENT OF THE NAVY
Clinical Psychology - Core Privileges

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

- * 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 reaction

Diagnostic and therapeutic procedures:

- * 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 706 examinations (sanity boards))

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- * 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:

Enclosure (3)

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DEPARTMENT OF THE NAVY
Clinical Social Work - Core Privileges

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

- * 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 reaction

Diagnostic and therapeutic procedures:

- * 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

Enclosure (3)

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Clinical Social Work - Supplemental Privileges

Other:

* None

Treatment Facility:

Practitioner Name:

Date Requested:

Date Approved:

Enclosure (3)

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DEPARTMENT OF THE NAVY
Marriage and Family Therapy - Core Privileges

Consultation, differential diagnosis, and treatment planning within the context of family systems for all disorders defined by the Diagnostic and Statistical Manual for Mental Disorders:

- * 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 reactions

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

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Marriage and Family Therapy - Supplemental Privileges

Other:

* None

Treatment Facility:

Practitioner Name:

Date Requested:

Date Approved:

Enclosure (3)

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**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 license or certificate which enables them to practice independently. State 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 a DON Family Service Center (FSC), such non-privileged providers would include Licensed Professional Counselors (LPCs) and 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 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 license or certificate to provide independent health care services). The non-privileged provider works under the license of the 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.

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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 Practitioner (privileged)

a. This term includes all health care providers who have a state license or certificate and who have been granted clinical privileges to practice independently. In a DON Family Service Center, 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, and, with sufficient experience (Tier III), may be the only counselor in a given location and may provide clinical supervision to others.

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PEER REVIEW PANEL PROCEDURES

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

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terminate staff appointment, that fact will be reported to the Federation of State Medical Boards, States of licensure, National Practitioner Data Bank or other professional clearing house as applicable, the Office of the Secretary of Defense (Health Affairs), and the other organizations or agencies required by this instruction.

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

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

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

4. Counsel

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

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

(2) Respondent may request military counsel, certified per article 27(b), Uniform Code of Military Justice. Military counsel will be provided by the privileging authority's servicing Naval Legal Service Office (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 commanding officer of the servicing office or center.

(3) Respondent may alternatively request military counsel of his or her choice. Requested alternative counsel of choice will be provided if attached to the servicing office or center or assigned duties aboard a Navy or Marine Corps installation at or nearest the site of the hearing, provided such installation is within 100 miles of the proceeding (using the official Table of Distances) and if reasonably available at the scheduled time of

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the hearing. Determination of reasonable availability is within the sole discretion of the requested counsels commanding officer or reporting senior, as applicable.

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

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

6. 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 or witnesses to be called to testify at the hearing and the matters their testimony will cover.

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

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

(2) Written notice of the names of witnesses which will be called to testify on the respondent's behalf and the matters their testimony will cover. If the production of any witness

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would require expenditure of funds by the convening authority, the requirements of paragraphs 8d(5) through (9) apply.

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

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

b. When the respondent is a civilian, (e.g. a Federal civilian employee or contractor) a civilian who meets the qualifications of paragraph 7 above shall also be appointed a panel member, if available.

c. The opportunity to serve on a Peer Review Panel should be given to women and minorities. However, the lack of such a member 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 perform such duties as the panel desires. The convening authority may request the servicing NLSO or law center to assign a judge advocate as legal advisor for the panel. The commanding officer of the office or center may so assign a judge advocate subject to reasonable availability. The legal advisor shall not participate in closed sessions of the panel.

8. Hearing Procedures

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

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

c. Presentation of Evidence

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

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

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

d. Witnesses

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(a) The testimony of a witness is cumulative.

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

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

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

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

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

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

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

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

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

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

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- (1) The respondent may testify in his or her own behalf.
- (2) The respondent or respondent's counsel may submit written or recorded matter for consideration by the panel.
- (3) The respondent or respondents counsel may call witnesses an behalf of the respondent.
- (4) The respondent or respondents counsel may question any witness who appears before the panel.
- (5) The respondent or respondent's counsel may present argument prior to the panel's closing the hearing for deliberation on findings and recommendations.
- (6) The respondent or respondent's counsel may challenge a member of the panel or the legal advisor, if any, for cause only. See paragraph 8b above.

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

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

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

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

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

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

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

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

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

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

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

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