

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

- Initial privileges (initial appointment)
- Renewal of privileges (reappointment)
- Expansion of privileges (modification)

*All new applicants must meet the following requirements as approved by the UNMH Board of Trustees effective: 09/27/2013*

### **INSTRUCTIONS**

**Applicant:** Check off the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

**Department Chair:** Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

### **OTHER REQUIREMENTS**

1. Note that privileges granted may only be exercised at UNM Hospitals and clinics that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.
2. This document defines qualifications to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### ***Qualifications for Pediatric Cardiology***

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***Initial privileges*** - To be eligible to apply for core privileges in pediatric cardiology, the initial applicant must meet the following criteria:

Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency in pediatrics followed by successful completion of an ACGME accredited fellowship in pediatric cardiology

AND/OR

Current subspecialty certification or active participation in the examination process leading to subspecialty certification in pediatric cardiology by the American Board of Pediatrics

AND

***Required previous experience:*** Inpatient or consultative services for an acceptable volume of patients, reflective of the scope of privileges requested, during the past 12 months or successful completion of an ACGME or AOA accredited residency or clinical fellowship within the past 12 months.

***Reappointment requirements:*** To be eligible to renew core privileges in pediatric cardiology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

### ***Core Privileges: Pediatric Cardiology***

Admit, evaluate, diagnose, consult and provide comprehensive care to newborns, infants, children and adolescents presenting with congenital or acquired cardiovascular disease and disorders of the heart and blood vessels. Care may also include adult patients with congenital heart disease or pregnant mothers with fetal diagnosis of congenital heart disease. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

**Requested**

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### *Pediatric Cardiology Core Procedures List*

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

**To the applicant:** If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, then initial and date.

1. Perform history and physical exam
2. Ambulatory ECG monitoring studies
3. Cardioversion
4. Diagnostic right and left heart cardiac catheterization
5. Echocardiography interpretation; fetal, transthoracic and transesophageal (excluding intracardiac)
6. Electrocardiography; ambulatory monitoring and exercise testing (with ECG monitoring)
7. Intra-cardiac electrophysiologic studies
8. Pericardiocentesis and thoracentesis
9. Programming and management of automatic implantable cardiac defibrillators and pacemakers in collaboration with industry representatives
10. Transthoracic echocardiography
11. Rhythm issues (excluding intracardiac procedures)

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### ***Qualifications for Pediatric Interventional Cardiology***

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***Initial privileges*** - *To be eligible to apply for core privileges in pediatric interventional cardiology, the initial applicant must meet the following criteria:*

Be granted core privileges in pediatric cardiology and successful completion of an accredited fellowship in pediatric cardiology that included at least 12 months advanced training in pediatric cardiac catheterization.

AND/OR

***Required previous experience:*** An acceptable volume of diagnostic and therapeutic catheter/interventional procedures, reflective of the scope of privileges requested, in the past 12 months or successful completion of an accredited residency or clinical fellowship within the past 12 months.

***Reappointment requirements:*** *To be eligible to renew core privileges in pediatric interventional cardiology, the applicant must meet the following maintenance of privilege criteria:*

Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

### ***Core Privileges: Pediatric Interventional Cardiology***

Admit, evaluate, treat and provide consultation to newborns, infants, children and adolescent patients with congenital or acquired cardiovascular disease and disorders of the heart and blood vessels. Privileges include percutaneous non-coronary intervention. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

**Requested**

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### *Pediatric Interventional Core Procedures List*

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

**To the applicant:** If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, then initial and date.

1. Aortic valve dilation
2. Balloon septostomy
3. Coarctation dilation
4. Coarctation stent
5. Collateral occlusion
6. Diagnostic right and left heart cardiac catheterization
7. Ductus arteriosus occlusion
8. Endomyocardial biopsy
9. Intra-cardiac echocardiography
10. Intra-cardiac foreign body removal
11. Management of mechanical complications of percutaneous intervention
12. Pulmonary valve dilation
13. Pulmonary artery dilation
14. Pulmonary artery stent
15. Selective angiocardiology
16. Transseptal puncture

## UNMH Pediatric Cardiology Clinical Privileges

Name: \_\_\_\_\_  
Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### ***Qualifications for Pediatric Clinical Cardiac Electrophysiology (CCEP)***

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***Initial privileges*** - To be eligible to apply for core privileges in pediatric clinical cardiac electrophysiology, the initial applicant must meet the following criteria:

Successful completion of an accredited advanced fellowship in pediatric intracardiac procedures which included training in pediatric clinical cardiac electrophysiology

AND

***Required previous experience:*** An acceptable volume of intracardiac procedures, reflective of the scope of privileges requested, in the past 12 months or successful completion of an accredited residency or clinical fellowship within the past 12 months.

***Reappointment requirements:*** To be eligible to renew core privileges in pediatric clinical cardiac electrophysiology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and an adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on the results of ongoing professional practice evaluation and outcomes. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

### ***Core Privileges: Pediatric Clinical Cardiac Electrophysiology***

Admit, evaluate, treat and provide consultation to newborns, infants, children and adolescents patients with heart rhythm disorders; including the performance of invasive diagnostic and therapeutic cardiac electrophysiology procedures. Assess, stabilize, and determine disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

#### **□ Requested**

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

**To the applicant:** If you wish to exclude any procedures, please strike through those procedures which you do not wish to request, then initial and date.

1. Intracardiac electrophysiology studies
2. Performance of therapeutic catheter ablation procedures

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### **Special Non-Core Privileges (See Specific Criteria)**

If desired, non-core privileges are requested individually in addition to requesting the core. Each individual requesting non-core privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required experience, and maintenance of clinical competence.

### **Qualifications for Percutaneous Atrial Septal Defect (ASD)/ Patent Foramen Ovale (PFO) Closure**

**Criteria:** Successful completion of an ACGME or AOA accredited post-graduate training program in interventional cardiology or pediatric cardiology that included the performance of at least 10 ASD/PFO procedures, 3 to 5 of which were proctored, or demonstrate equivalent practice experience. In addition, applicants must have successfully completed a training course in the ASD or PFO device for which privileges are requested and will agree to restrict their practice to the device(s) type(s).

**Required Current Experience:** Demonstrated current competence and evidence of the successful performance of an acceptable volume of percutaneous ASD or PFO closure procedures in the past 12 months or completion of training in the past 12 months.

**Maintenance of Privilege:** Demonstrated current competence and evidence of the successful performance of an acceptable volume of percutaneous ASD or PFO closure procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes. In addition, continuing education related to percutaneous ASD/PFO closure should be required.

### **Non-Core Privilege: Percutaneous Atrial Septal Defect (ASD)/ Patent Foramen Ovale (PFO) Closure**

**Requested**

## UNMH Pediatric Cardiology Clinical Privileges

Name:

Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

### ***Qualifications for Percutaneous Atrial Septal Defect (ASD)/ Transcatheter Device Closure (TDC)***

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**Criteria:** Successful completion of an ACGME or AOA accredited post-graduate training program in interventional cardiology or pediatric cardiology that included the performance of at least 10 ASD/TDC procedures, 3 to 5 of which were proctored, or demonstrate equivalent practice experience. In addition, applicants must have successfully completed a training course in the ASD or TDC device for which privileges are requested and will agree to restrict their practice to the device(s) type(s).

**Required Current Experience:** Demonstrated current competence and evidence of the successful performance of an acceptable volume of percutaneous ASD or PFO closure procedures in the past 12 months or completion of training in the past 12 months.

**Maintenance of Privilege:** Demonstrated current competence and evidence of the successful performance of an acceptable volume of percutaneous ASD or PFO closure procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes. In addition, continuing education related to percutaneous ASD/PFO closure should be required.

### ***Non-Core Privilege: Percutaneous Atrial Septal Defect (ASD)/ Transcatheter Device Closure (TDC)***

**Requested**

### ***Qualifications for Transesophageal Echocardiography (TEE)***

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**Criteria:** Successful completion of an accredited residency in cardiology, anesthesiology, radiology, or cardiothoracic surgery that included education and direct experience in transthoracic echocardiography and TEE with performance and interpretation of an acceptable volume of supervised TEE cases, or National Board of Echocardiography certification in TEE.

**Required Current Experience:** Demonstrated current competence and evidence of the performance of an acceptable volume of TEE procedures in the past 12 months or successful completion of training or NBE certification in the past 12 months.

**Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of an acceptable volume of TEE procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

### ***Non-Core Privilege: Transesophageal Echocardiography (TEE)***

**Requested**

## UNMH Pediatric Cardiology Clinical Privileges

Name:

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### *Qualifications for Valvuloplasty*

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**Criteria:** Successful completion of an ACGME or AOA accredited fellowship in interventional cardiology. If valvuloplasty training was not included in the fellowship program, the applicant must have completed training with a physician who has these privileges and training must have included 5 proctored procedures.

**Required Current Experience:** Demonstrated current competence and evidence of the performance of an acceptable volume of cases in the past 12 months or completion of training in the past 12 months.

**Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of an acceptable volume of cases in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

### *Non-Core Privilege: Valvuloplasty*

**Requested**

**UNMH Pediatric Cardiology Clinical Privileges**

Name: \_\_\_\_\_  
Effective Dates: \_\_\_\_\_ To: \_\_\_\_\_

**Acknowledgment of practitioner**

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at UNM Hospitals and clinics, and I understand that:

- a. In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Department recommendation(s)**

I have reviewed the requested clinical privileges with the applicant and the supporting documentation for the above-named applicant and:

- Recommend all requested privileges with the standard professional practice plan
- Recommend privileges with the standard professional practice plan and the following conditions/modifications:
- Do not recommend the following requested privileges:

Privilege Condition/Modification/Explanation

Notes:

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Division Chief Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Title \_\_\_\_\_

Department Chair Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Criteria approved by UNMH Board of Trustees on 09/27/2013