

UNMH Pediatric Pulmonology 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.

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Qualifications for Pediatric Pulmonology

Initial privileges - *To be eligible to apply for core privileges in pediatric pulmonology, 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 accredited fellowship in pediatric pulmonology.

AND/OR

Current subspecialty certification or active participation in the examination process leading to subspecialty certification in pediatric pulmonology by the American Board of Pediatrics or the American Osteopathic 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 pulmonology, the applicant must meet the following maintenance of privilege criteria:*

Current demonstrated competence and an acceptable 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 Pulmonology*

Admit, evaluate, diagnose, treat and provide care to infants, children and young adults with all types of conditions, disorders and diseases of the respiratory system and the lungs utilizing a variety of invasive and noninvasive diagnostic and therapeutic techniques. 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.

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Pediatric Pulmonology 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. CPAP
3. Diagnostic and therapeutic procedures, including related procedures
4. Examination and interpretation of sputum, bronchopulmonary secretions, pleural fluid, and lung tissue.
5. Flexible fiber-optic bronchoscopy procedures
6. Inhalation challenge studies;
7. Pulmonary function tests to assess respiratory mechanics and gas exchange, to include spirometry, flow volume studies, lung volumes, diffusing capacity, arterial blood gas analysis, and exercise studies;
8. Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen humidifiers, nebulizers, and incentive spirometry
9. Use of positive pressure ventilatory modes, to include initiation:
 - ventilatory support to include BiPAP;
 - weaning, and respiratory care techniques; and
 - maintenance and withdrawal of mechanical ventilatory support.

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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 Diagnostic Thoracoscopy Including Biopsy

Criteria: Successful completion of an accredited ACGME or AOA post graduate training program that included training in thoracoscopy and evidence of the performance of at least 5 thoracoscopy procedures during training or under the supervision of a qualified surgeon. Optimally, the applicant should demonstrate completion of a thoracoscopy course that confirms to the guidelines of the AATS/STS Joint Committee on Thoracoscopy and Video Assisted Thoracic Surgery.

Required Previous Experience: Demonstrated current competence and evidence of the performance of an acceptable volume of thoracoscopy procedures during 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 thoracoscopy procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

NON-CORE PRIVILEGES: *Diagnostic Thoracoscopy Including Biopsy*

Requested

Qualifications for Endobronchial Ultrasound (EBUS)

Criteria: Successful completion of an accredited ACGME or AOA post graduate training program that included training in EBUS or completion of a hands on CME. At least 50 procedures should be performed in training in a supervised setting.

Required Previous Experience: Demonstrated current competence and evidence of the performance of an acceptable volume of EBUS procedures during 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 EBUS procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

NON-CORE PRIVILEGES: *Endobronchial Ultrasound (EBUS)*

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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:

Division Chief Signature _____ Date _____

Print Name _____ Title _____

Department Chair Signature _____ Date _____

Print Name _____

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