

**UNIVERSITY HOSPITAL AND HEALTH SYSTEM
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 North State Street, Jackson MS 39216**

OPHTHALMOLOGY CLINICAL PRIVILEGES

Name: _____

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- Initial Appointment
- Reappointment

All new applicants must meet the following requirements as approved by the governing body effective: 5/23/2013.

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

- Note that privileges granted may only be exercised at the site(s) and/or setting(s) 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 and/or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional governance (MS Bylaws, Rules and Regulations) organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR OPHTHALMOLOGY

To be eligible to apply for core privileges in ophthalmology, the initial applicant must meet the following criteria:

Current specialty certification in ophthalmology by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology.

OR

Successful completion of an Accreditation Council for Graduate Medicine Education (ACGME) or American Osteopathic Association (AOA) accredited residency in ophthalmology and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to specialty certification in ophthalmology by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology.

Required Previous Experience: Applicants for initial appointment must be able to demonstrate performance of a sufficient volume of ophthalmologic procedures, reflective of the scope of privileges requested, in the past 24 months or demonstrate successful completion of an ACGME or AOA accredited residency, clinical fellowship, or research in a clinical setting within the past 12 months.

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Reappointment Requirements: To be eligible to renew core privileges in ophthalmology, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and a sufficient volume of ophthalmologic procedures, with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on 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. Medical Staff members whose board certificates in ophthalmology bear an expiration date shall successfully complete recertification no later than three (3) years following such date. For members whose certifying board requires maintenance of certification in lieu of renewal, maintenance of certification requirements must be met, with a lapse in continuous maintenance of no greater than three (3) years.

CORE PRIVILEGES

OPHTHALMOLOGY CORE PRIVILEGES

- Requested** Admit, evaluate, diagnose, treat and provide consultation, order diagnostic studies and procedures and perform surgical and non-surgical procedures on patients of all ages, with ocular and visual disorders, the eyelid and orbit affecting the eye and the visual pathways. May provide care to patients in the intensive care setting in conformance with unit policies. 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.

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 previous experience, and for maintenance of clinical competence.

PHOTOREFRACTIVE KERATECTOMY

- Requested**

Criteria: Successful completion of an ACGME or AOA accredited residency program in ophthalmology with experience in corneal refractive surgery and certification in the use of eximer laser. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of photorefractive keratectomy procedures in the past 12 months or first 4 cases proctored by a physician who currently holds the privileges or an appropriate proctor as approved by the Department Chairman and Credentials Committee. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of photorefractive keratectomy procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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CORNEAL RING IMPLANTS

Requested

Criteria: Successful completion of an accredited residency in ophthalmology; and an approved course in corneal ring implant procedures and performance of a sufficient volume of corneal ring implants, a sufficient volume of which were performed under the supervision of an experienced surgeon. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of corneal ring implants in the past 24 months. **Maintenance of Privilege:** Performance of a sufficient volume of corneal ring implant in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

CORNEAL TRANSPLANTS (PENETRATING KERATOPLASTY)

Requested

Criteria: Successful completion of an ACGME or AOA accredited residency in ophthalmology and successful completion of a fellowship which included training in corneal transplants. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of corneal transplant procedures in the past 24 months. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of corneal transplant procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

RETINA AND VITREOUS SURGERY

- Requested** Closed system vitrectomy including peeling epiretinal or subretinal membranes
- Requested** Pneumatic retinopexy
- Requested** Scleral buckle procedures
- Requested** Macular photocoagulation for choroidal neovascular membrane
- Requested** Photodynamic therapy
- Requested** Brachytherapy
- Requested** Cryoretinopexy

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Criteria: Successful completion of an ACGME or AOA accredited residency in ophthalmology followed by successful completion of a fellowship in vitreo retinal surgery. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of retina and vitreous surgery procedures, reflective of the scope of privileges requested, in the past 24 months.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of a sufficient volume of retina and vitreous surgery procedures, reflective of the scope of privileges requested, in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

USE OF LASER

Requested

Criteria:

- 1) Completion of an acceptable laser safety course provided by the UMMC Laser Safety Officer
AND
- 2) Successful completion of an approved residency in a specialty or subspecialty which included training in lasers
OR
Successful completion of a hands-on CME course which included training in laser principles and observation and hands-on experience with lasers
OR
Evidence of sufficient volume of procedures performed utilizing lasers (with acceptable outcomes) within the past 24 months
AND
- 3) Practitioner agrees to limit practice to only the specific laser types for which they have documentation of training and/or experience

Maintenance of Privilege:

A practitioner must document that procedures have been performed over the past 24 months utilizing lasers (with acceptable outcomes) in order to maintain active privileges for laser use. In addition, completion of a laser safety refresher course provided by the Laser Safety Officer is required for maintenance of the privilege. Practitioner agrees to limit practice to only the specific laser types for which they have documentation of training and/or experience.

PHAKIC INTRAOCULAR LENS IMPLANT SURGERY

Requested

Criteria: Successful completion of an ACGME or AOA accredited residency in ophthalmology. In addition, applicants must complete a certification course in phakic IOL implant surgery. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of a sufficient volume of phakic IOL surgery procedures in the past 24 months. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of phakic IOL implant surgery procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes. In addition, continuing education related to phakic IOL implant surgery should be required.

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ADMINISTRATION OF SEDATION AND ANALGESIA

- Requested** See Hospital Policy for Procedural Sedation by Non-Anesthesiologists for additional information.

Section One--INITIAL REQUESTS ONLY:

- Completion of residency or fellowship in anesthesiology, emergency medicine or critical care **-OR-**
- Completion of residency or fellowship within the past year in a clinical subspecialty that provides training in procedural sedation training **-OR-**
- Demonstration of prior clinical privileges to perform procedural sedation along with a good-faith estimate of at least 20 such sedations performed during the previous year (the estimate should include information about each type of procedure where sedation was administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:
- _____

-OR-

- Successful completion (within six months of application for privileges) of a UMHC-approved procedural sedation training and examination course that includes practical training and examination under simulation conditions.

Section Two--INITIAL AND RE-PRIVILEGING REQUESTS:

- Successful completion of the UMHC web based Procedural Sedation Course/Exam initially and at least once every two years **-AND-**

Provision of a good-faith estimate of the number of instances of each type of procedure where sedation is administered with a list of any adverse events related to the sedation during those cases, including causal analysis, treatment, and outcome:

-AND-

- ACLS, PALS and/or NRP, as appropriate to the patient population. **(Current)**

-OR-

- Maintenance of board certification or eligibility in anesthesiology, emergency medicine, pediatric emergency medicine, cardiovascular disease, advanced heart failure and transplant cardiology, clinical cardiac electrophysiology, interventional cardiology, pediatric cardiology, critical care medicine, surgical critical care, neurocritical care or pediatric critical care, as well as active clinical practice in the provision of procedural sedation.

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Section Three--PRIVILEGES FOR DEEP SEDATION:

- I am requesting privileges to administer/manage deep sedation as part of these procedural sedation privileges.

Deep Sedation/Anesthetic Agents used: _____

APPLICABLE TO REQUESTS FOR DEEP SEDATION ONLY:

I have reviewed and approve the above requested privileges based on the provider's critical care, emergency medicine or anesthesia training and/or background.

Signature of Anesthesiology Chair

Date

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CORE PROCEDURE LIST

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

- A and B mode ultrasound examination
- Anterior limbal approach or pars plana automated vitrectomy
- Conjunctiva surgery, including grafts, flaps, tumors, pterygium, pinguecula
- Corneal surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy and refractive surgery
- Cryotherapy for ciliary body for uncontrolled painful glaucoma
- Glaucoma surgery with intraoperative/postoperative antimetabolite therapy, primary trabeculectomy surgery, trabeculotomy
- Glaucoma, reoperation, Seton/Tube surgery
- Injection of intravitreal medications
- Intra and extracapsular cataract extraction with or without lens implant, or phacoemulsification
- Laser peripheral iridotomy, trabeculoplasty, pupilo/gonioplasty, suture lysis. Pan-retinal photocoagulation, repair of retinal tears, capsulotomy, cyclophotocoagulation, sclerostomy, lysis
- Lid and ocular adnexal surgery, including plastic procedures, chalazion, ptosis, repair of malposition, repair of laceration, blepharospasm repair, tumors, flaps, enucleation, evisceration
- Nasolacrimal surgery including dacryocystectomy, dacryocystorhinostomy, excision of lacrimal sac mass, probing and irrigation with or w/o placement of tube stent, balloon dacryoplasty
- Orbit surgery, including removal of the globe and contents of the orbit, exploration by lateral orbitotomy, exenteration, blowouts, rim repairs, tumor and foreign body removal
- Order respiratory services
- Order rehab services
- Perform history and physical exam
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Periocular or facial injection of Botox
- Removal of anterior and/or posterior segment foreign body
- Retrobulbar or peribulbar injections for medical delivery or chemical denervation for pain control
- Strabismus surgery
- Reparative operations for diseases or trauma of the globus oculi including: conjunctiva, Tenon's capsule procedures, cornea, sclera, uveal tract, lens, vitreous, retina

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ACKNOWLEDGEMENT 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 University Hospital and Health System, University of Mississippi Medical Center, 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** _____

DIVISION CHIEF'S RECOMMENDATION (AS APPLICABLE)

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- Recommend all requested privileges.
- Recommend privileges with the following conditions/modifications:
- Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

Division Chief Signature _____ **Date** _____

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DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant. To the best of my knowledge, this practitioner's health status is such that he/she may fully perform with safety the clinical activities for which he/she is being recommended. I make the following recommendation(s):

- Recommend all requested privileges.
- Recommend privileges with the following conditions/modifications:
- Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

Department Chair Signature _____ **Date** _____

Reviewed:

Revised:
2/3/2010, 7/19/2010, 6/2/2010, 6/1/2011, 10/5/2011, 11/2/2011, 12/16/2011, 9/05/2012, 4/3/2013,
5/23/2013