

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

PEDIATRIC GASTROENTEROLOGY 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: 09022015

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 PEDIATRIC GASTROENTEROLOGY

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

Current subspecialty certification in pediatric gastroenterology by the American Board of Pediatrics.

OR

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 gastroenterology and active participation in the examination process with achievement of certification within 5 years of completion of formal training leading to subspecialty certification in pediatric gastroenterology by the American Board of Pediatrics.

Required Previous Experience: Applicants for initial appointment must demonstrate the provision of inpatient or consultative services, reflective of the scope of privileges requested, for a sufficient volume of patients during 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 Pediatric Gastroenterology, the applicant must meet the following Maintenance of Privilege Criteria:

Current demonstrated competence and a sufficient volume of experience, 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 pediatric gastroenterology 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. 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

PEDIATRIC GASTROENTEROLOGY CORE PRIVILEGES

- ☐ **Requested** Admit, evaluate, diagnose, consult and provide care to infants, children, adolescents and young adults with acute and chronic diseases of the digestive system (esophagus, stomach, intestines, liver and pancreas) and nutritional disorders. 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.

ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHIES (ERCP)

☐ **Requested**

Criteria: Successful completion of an ACGME or AOA accredited program in gastroenterology that included training in ERCP in the past 12 months OR evidence of the performance of a sufficient volume of ERCP procedures in the past 24 months. Applicants who do not meet these criteria within the past 12/24 months but have previous training and/or experience in ERCP will be proctored for their first 10 cases.

Maintenance of Privilege: Demonstrated current competence and evidence of the performance of a sufficient volume of ERCP procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

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BALLOON ENTEROSCOPY

☐ **Requested**

Criteria: Successful completion of an ASGE course in Balloon enteroscopy in the past 12 months OR evidence of the performance of a sufficient volume of Balloon enteroscopy procedures in the past 24 months. Applicants who do not meet these criteria within the past 12/24 months but have previous training and/or experience in Balloon Enteroscopy will be proctored for their first 10 cases. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of ERCP procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

CAPSULE ENDOSCOPY

☐ **Requested**

Criteria: Successful completion of 8 hours of didactic training AND expert review of 10 capsule endoscopy cases. Applicants who do not meet these criteria within the past 12/24 months but have previous training and/or experience in Capsule Endoscopy will be proctored for their first 10 cases. **Maintenance of Privilege:** Demonstrated current competence and evidence of the performance of a sufficient volume of Capsule Endoscopy procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

FLUOROSCOPY USE

☐ **Requested**

Criteria:

- ☐ Current board certification in Radiology, Diagnostic Radiology or Radiation Oncology by the American Board of Radiology or the American Osteopathic Board of Radiology
OR

- ☐ Successful completion of a residency/fellowship program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) that included 6 months of training in fluoroscopic imaging procedures and documentation of the successful completion of didactic course lectures and laboratory instruction in radiation physics, radiobiology, radiation safety, and radiation management applicable to the use of fluoroscopy, including passing a written examination in these areas.
OR

- ☐ Participation in a preceptorship that requires at least 10 procedures be performed under the direction of a qualified physician who has met these standards and who certifies that the trainee meets minimum fluoroscopy safety standards. (Applicable to physicians whose residency/fellowship did not include radiation physics, radiobiology, radiation safety, and radiation management)
OR

- ☐ Good faith estimate of volume of procedures performed utilizing fluoroscopy in the last 24 months.

Examples of procedures performed: _____

Number of procedures performed in the last 24 months: _____

Percentage of cases with fluoroscopic time >120 minutes, dose > 3 Gy, or equivalent: _____

AND (all applicants)

- ☐ Successful completion of a fluoroscopy safety course provided by the UMMC Radiation Safety Officer

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Maintenance of Privilege: A practitioner must document that procedures have been performed over the past 24 months utilizing fluoroscopy (with acceptable outcomes) in order to maintain active privileges for use. In addition, completion of a fluoroscopy safety refresher course provided by the Radiation Safety Officer is required for maintenance of the privilege.

RADIOLOGY CHAIR APPROVAL:

I have reviewed the above requested privileges and I attest that this practitioner is competent to perform the privileges requested based on the information provided.

Signature, Chair—Department of Radiology

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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,

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neurocritical care or pediatric critical care, as well as active clinical practice in the provision of procedural sedation.

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.*

- Breath hydrogen analysis
- Cecostomy in conjunction with urology
- Diagnostic and therapeutic lower gastrointestinal colonoscopy
- Design, implementation, and monitoring of TPN regimens
- Diagnostic and therapeutic upper gastrointestinal endoscopy
- Diagnostic motility studies for functional bowel disorders (includes manometry)
- Esophageal dilation
- Esophageal pH monitoring and impedance monitoring
- Establishment and maintenance of parenteral and enteral nutrition
- Gastrostomy tube (change of)
- Interpretation of gastric, pancreatic, and biliary secretory tests
- Interpretation of metabolic cart
- Interpretation of percutaneous cholangiography
- Management of renal and hepatic failure, poisoning
- Manual removal of fecal impactions
- Nonvariceal hemostasis (upper and lower)
- Order respiratory services
- Order rehab services
- Pancreatic stimulation test
- Paracentesis
- Percutaneous endoscopic gastrostomy tube placement, PEG removal with or without G-tube (button) replacement
- Percutaneous liver biopsy
- Perform history and physical exam
- Perform routine medical procedures (Venipuncture, skin biopsy, bladder catheterization, fluid and electrolyte management, foreign body removal from nose or ear, manage and maintain indwelling venous access catheter, administer medications and special diets through all therapeutic routes, basic cardiopulmonary resuscitation, superficial burns, evaluation of oliguria, I & D abscess, interpretation of antibiotic levels and sensitivities, interpretation of EKG (for therapeutic purposes), lumbar puncture, arterial puncture and blood sampling, management of anaphylaxis and acute allergic reactions, management of the immunosuppressed patient, monitoring and assessment of metabolism and nutrition, pharmacokinetics, use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen, humidifiers, nebulizers, and incentive spirometry)
- Perform waived laboratory testing not requiring an instrument, including but not limited to fecal occult blood, urine dipstick, and vaginal pH by paper methods
- Push Enteroscopy
- Suction rectal biopsy
- Variceal hemostasis

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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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CREDENTIALS COMMITTEE REPRESENTATIVE'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

Credentials Representative's 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, 6/2/2010, 9/7/2011, 12/16/2011, 2/1/2012, 6/6/2012, 04/03/2013, 08/25/2015, 09/02/2015