

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

PLASTIC SURGERY 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: 11/04/2015

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 PLASTIC SURGERY

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

Current specialty certification in plastic surgery by the American Board of Plastic Surgery or the American Osteopathic Board of Surgery.

OR

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

Required Previous Experience: Applicants for initial appointment must be able to demonstrate the performance of a sufficient volume of plastic surgery procedures, reflective of the scope of privileges requested, 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 plastic surgery, the applicant must meet the following maintenance of privilege criteria:

Current demonstrated competence and performance of a sufficient volume of plastic and reconstructive surgery procedures) that are reflective of the scope of privileges requested, with acceptable results, 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 plastic surgery 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

PLASTIC SURGERY CORE PRIVILEGES

- Requested** Admit, evaluate, diagnose, provide consultation to patients of all ages, presenting with congenital and/or acquired defects of the body's musculoskeletal system, craniomaxillofacial structures, hand, extremities, breast and trunk and external genitalia and soft tissue including the aesthetic management. 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.

REPLANTATION SURGERY

- Requested**

Criteria: Successful completion of an ACGME or AOA accredited Surgery of the Hand fellowship.

Required Previous Experience: Demonstrated current competence and evidence of a sufficient volume of reconstructive microsurgery procedures in the past 24 months. **Maintenance of Privilege:**

Demonstrated current competence and evidence of the performance of a sufficient volume of reconstructive microsurgery procedures, with acceptable outcomes, 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

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- 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.

JOINT REPLACEMENT FOR ARTHRITIS OF THE HAND

Requested

Criteria: Successful completion of an ACGME or AOA accredited Surgery of the Hand fellowship.

Required Previous Experience: Demonstrated current competence and evidence of the performance of a sufficient volume of joint replacement for arthritis of the hand procedures in the past 24 months.

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

ARTHROSCOPY OF THE HAND

Requested

Criteria: Successful completion of an ACGME or AOA accredited Surgery of the Hand fellowship.

Required Previous Experience: Demonstrated current competence and evidence of the performance of a sufficient volume of hand arthroscopies in the past 24 months. **Maintenance of Privilege:**

Demonstrated current competence and evidence of the performance of a sufficient volume of hand arthroscopies 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

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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

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

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

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(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.

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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ULTRASOUND-GUIDED CENTRAL LINE INSERTION

- Requested** See Medical Staff Policy for Ultrasound-Guided Central Line Insertion for additional information.

Initial Privileging:

As for core privileges plus:

- Performance of at least 10 ultrasound-guided central line insertions in the past 24 months; and
- Completion of a UMMC ultrasound-guided central line insertion Healthstream learning module

Maintenance of Privilege:

As for core privileges plus:

- Performance of at least 10 ultrasound-guided central line insertions in the past 24 months; and
- Completion of a UMMC ultrasound-guided central line insertion Healthstream learning module

If volume requirements are not met, the following may substitute:

- Completion of ultrasound-guided central line insertion simulation training in the UMMC Simulation and Interprofessional Education Center; and
- Focused professional practice evaluation to include proctoring of the ultrasound-guided insertion of at least 5 central lines (femoral or internal jugular) within the first 6 months of re-appointment

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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.

Plastic Surgery

- Amputation
- Areola and nipple repigmentation (tattooing)
- Arthroplasty of large and small joints, wrist or hand, including implants
- Basic hand surgery
- Below knee amputation
- Bone graft pertaining to the hand
- Botulinum toxin injection
- Carpal tunnel decompression
- Chemical face peels
- Dermal filler injection
- Facial plastic surgery to include cosmetic surgery on the face, nose, external ear, eyelids and lips
- Fasciotomy and fasciectomy
- Fracture fixation with compression plates or wires
- Free tissue transfer flap with microvascular anastomosis
- Liposuction or lipo-injection procedure for contour restoration, head and neck; trunk and extremities
- Major head and neck radical cancer surgery and reconstruction.
- Management of all forms of facial or maxillofacial trauma including fractures
- Management of frontal sinus fractures
- Management of patients with burns, including plastic procedures on the extremities
- Microdermabrasion
- Microvascular procedures excluding replantation
- Nerve graft
- Neurorrhaphy
- Open and closed reductions of fractures
- 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
- Plastic procedures of external and internal male and female genitalia excluding gender dysphoria or hypospadias
- Plastic procedures on the female and male breast, including augmentation and reduction mammoplasties, post-mastectomy reconstruction
- Plastic reconstruction of all forms of congenital and acquired soft tissue anomalies, including those requiring the use of skin grafting procedures, the use of pedicle flaps, or tissue fillers
- Plastic reconstruction of soft tissue disfigurement or scarring, for cosmetic or functional reasons
- Polydactyly and syndactyly repair
- Removal of benign and malignant tumors of the skin
- Removal of soft tissue mass, ganglion palm or wrist, flexor sheath, etc
- Repair of lacerations
- Repair of rheumatoid arthritis deformity

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- Resection of intra oral tumors, oral cavity, palate
- Skin grafts
- Surgery of congenital anomalies, including revision of cleft lip and cleft palate
- Tendon reconstruction (free graft, staged)
- Tendon release, repair and fixation
- Tendon transfers
- Tracheostomy
- Treatment of infections
- Ultrasound assisted liposuction

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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** _____

Revisions:

6/2/2010, 12/01/2010, 10/5/2011, 11/2/2011, 12/16/2011, 06/06/2012, 12/27/2012, 4/3/2013, 12/3/2014, 8/05/2015, 11/04/2015