

PEDIATRIC PULMONOLOGY CLINICAL PRIVILEGES

Name: _____

Effective From ____/____/____ To ____/____/____

- Initial Appointment (initial privileges)
- Reappointment (renewal of privileges)

- Privileges granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.
- The core procedure list (if applicable) is not intended to be an all-encompassing procedure list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques. Applicants wishing to exclude any procedures, should strike through those procedures which they do not wish to request, initial, and date.

QUALIFICATIONS FOR PEDIATRIC PULMONOLOGY

<i>Education and training</i>	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.
<i>Certification</i>	Current subspecialty certification or board eligible (with achievement of certification within seven (7) years of post-graduate training) leading to subspecialty certification in pediatric pulmonology by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.
<i>Required current experience – initial</i>	Demonstrated current competence and evidence of the provision of Pediatric Pulmonary Medicine services, 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.
<i>Required current experience – renewal</i>	Demonstrated current competence and an adequate 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 peer review outcomes as per the Medical Staff Bylaws.
<i>Ability to perform (health status)</i>	Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges.

BHMC = Broward Health Medical Center; BHCS = Broward Health Coral Springs;
BHIP = Broward Health Imperial Point; BH North = Broward Health North

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Approved by MEC = May 11th, 2021

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CORE PRIVILEGES – PEDIATRIC PULMONOLOGY

Requested **BHMC** **BHCS**

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. 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 below and such other procedures that are extensions of the same techniques and skills.

1. Perform history and physical exam
2. Airway management
3. CPAP
4. Diagnostic and therapeutic procedures, including thoracentesis, endotracheal intubation, and related procedures;
5. Examination and interpretation of sputum, bronchopulmonary secretions, pleural fluid, and lung tissue.
6. 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;
7. Use of reservoir masks and continuous positive airway pressure masks for delivery of supplemental oxygen humidifiers, nebulizers, and incentive spirometry
8. 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.
9. Flexible Fiber-Optic Bronchoscopy

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SPECIAL NON-CORE PRIVILEGES (SEE SPECIFIC CRITERIA)

Non-Core Privileges are requested individually in addition to requesting the core. Each individual requesting Non-Core Privileges must meet the specific threshold criteria as applicable to the initial applicant or reapplicant.

ENDOBROCHIAL ULTRASOUND (EBUS)

Requested **BHMC** **BHCS**

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 at least **5** ~~20~~ EBUS procedures during the past 12 months or completion of training in the past **10** ~~12~~ months. **Renewal of Privilege:** Demonstrated current competence and evidence of the performance of at least 40 EBUS procedures in the past 24 months based on results of ongoing professional practice evaluation and peer review outcomes.

Moved to Core – please review Dr Swerdloff and Dr. Rodriguez-Cortez

FLEXIBLE FIBER-OPTIC BRONCHOSCOPY

Requested **BHMC** **BHCS**

~~**Criteria:** Successful completion of an accredited ACGME or AOA post graduate training program that included training in flexible fiber-optic bronchoscopy or completion of a hands-on CME. **Required Previous Experience:** Demonstrated current competence and evidence of the performance of at least **[n]** procedures during the past 12 months or completion of training in the past 12 months. **Renewal of Privilege:** Demonstrated current competence and evidence of the performance of at least **[n]** procedures in the past 24 months based on results of ongoing professional practice evaluation and peer review outcomes.~~

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ACKNOWLEDGEMENT OF PRACTITIONER

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.

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 Broward Corporate, 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 CHAIRPERSON'S RECOMMENDATION

Check the appropriate box for recommendation.

If recommended with conditions or not recommended, provide explanation. *I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and 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. _____	_____

Notes

Department Chairperson Signature _____ **Date** _____

FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY

Credentials Committee Action _____ **Date** _____

Medical Executive Committee Action _____ **Date** _____

Board of Commissioners Action _____ **Date** _____

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