ORAL AND MAXILLOFACIAL SURGERY CLINICAL PRIVILEGES

Name: _____
Effective from _____/_____/_____ to _____/_____/_____ (for MSO staff use only)

All new applicants must meet the following requirements as approved by the governing body.
Effective: _____/_____/_____.

☐ **Initial Privileges (Initial Appointment)**

☐ **Renewal of Privileges (Reappointment)**

Applicant: Please check the ***"Requested"*** box for each privilege requested.
Applicants have the burden of producing information and documentation 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 not recommended, provide the condition or explanation on the last page of this form.

Other Requirements

- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
- Note that privileges granted may only be exercised at the site(s) designated by CCRMC and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the privilege.

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QUALIFICATIONS FOR ORAL AND MAXILLOFACIAL SURGERY

Initial Applicants: To be eligible to apply for privileges in oral and maxillofacial surgery, the applicant must meet the following criteria:

1. Documentation of successful completion of a Commission on Dental Accreditation–accredited residency in oral and maxillofacial surgery that included training for procedures of the soft and hard tissues as well as history and physicals.

AND

2. Documentation of current certification or Board eligibility (with achievement of certification within the required time frame set forth by the respective Boards) leading to certification in oral and maxillofacial surgery by the American Board of Oral and Maxillofacial Surgery.

AND

3. Documented current experience of at least six (6) cases within the past 24 months in each of the major surgery categories (dento-alveolar surgery, "pathology," reconstructive/cosmetic surgery, and trauma – see procedure/treatment list) for which privileges are requested; ***or*** successful completion of a Commission on Dental Accreditation –accredited residency within the past 24 months. Please provide clinical activity/procedure log.

Renewal of Privileges: To be eligible to renew privileges in Oral and Maxillofacial Surgery, the applicant must meet the following criteria:

1. Maintenance of Certification by the American Board of Oral and Maxillofacial Surgery is required.

AND

2. Current documented competence and an adequate volume of experience (six (6) cases in each of the major surgery categories: (dento-alveolar surgery, "pathology," reconstructive/cosmetic surgery, and trauma – see procedure/treatment list) with acceptable results, reflective of the scope of privileges requested, within the past 24 months, based on results of ongoing professional practice evaluation and outcomes.

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Core Privileges: Oral and Maxillofacial Surgery

☐ ***Requested****:* Admit, evaluate, diagnose, treat, and provide consultation to patients of all ages with pathology, injuries, and disorders of both the functional and aesthetic aspects of the hard and soft tissues of the head, mouth, teeth, gums, jaws, and neck, and perform surgical procedures and postoperative management. May provide care to patients in the intensive care setting. Assess, stabilize, and determine the disposition of patients with emergent conditions regarding emergency and consultative call services.
The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills, as determined by the department chair.

CORE PROCEDURES/TREATMENT LIST

This is not intended to be an all-encompassing procedures 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, as determined by the department chair.

To the Applicant: If you wish to exclude any procedures, due to lack of current competency, please strike through the procedures that you do not wish to request, and then initial and date.

- Performance of history and physical exam
- **Dento-alveolar surgery**, including management of odontogenic infections, and erupted, unerupted, and impacted teeth, including third-molar extractions and defects and deformities of the dento-alveolar complex
- **Pathology**, including major maxillary sinus procedures, treatment of temporomandibular joint pathology, salivary gland/duct surgery, management of head and neck infection, including incision and drainage procedures, and surgical management of benign and malignant neoplasms and cysts
- **Reconstructive surgery**, including bone grafting and soft tissue grafting procedures (distant bone graft sites may include but are not limited to the calvaria, rib, ilium, fibula, and tibia; distant soft tissue grafts include but are not limited to cartilage, skin,

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fat, nerve, and fascia); reconstructive surgery procedures include vestibuloplasties, augmentation procedures, temporomandibular joint reconstruction, management of continuity defects.

- **Maxillofacial Trauma,** including open and closed reductions of fractures of the mandible, maxilla, zygomatico-maxillary, nose, naso-frontal-orbital-ethmoidal and midface region, and repair of facial, oral, and soft-tissue injuries and injuries to specialized structures

Special Non-Core Privileges (See Specific Criteria)
Non-core privileges are requested individually in addition to requesting the core. Each provider requesting non-core privileges must meet the specific threshold criteria as applicable to the applicant or re-applicant.

Non-Core Privileges: Oral and Maxillofacial Oncology

☐ **Oral and Maxillofacial Oncology**
This privilege includes major soft tissue excision for benign tumors (e.g., hemiglossectomy, excision of the floor of the mouth, jaw excision for benign and malignant disease (e.g., marginal or segmental mandibulectomy and partial maxillectomy).

Criteria for Initial Request:

1. Successful completion of a Commission on Dental Accreditation -accredited fellowship in oral and maxillofacial oncology or the equivalent in training and experience.

AND

2. Documented current competence and evidence of the performance of at least 10 oral and maxillofacial oncology procedures within the past 24 months, or completion of training within the past 24 months.

Criteria for Renewal of Privileges:

1. Documented current competence and evidence of 10 oral and maxillofacial oncology procedures within the past 24 months based on ongoing professional practice evaluation and outcomes.

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Non-Core Privileges: Administration of Sedation and Analgesia

Administration of Sedation and Analgesia:

- ☐ **Conscious Sedation** (e.g. versed, morphine, fentanyl) – DOES NOT INCLUDE USE OF KETAMINE OR PROPOFOL
- ☐ **Ketamine** (test required every 2 years)
- ☐ **Propofol** (test required every 2 years)

Criteria for Initial Request:

1. Successful completion of an appropriate post graduate training program which included training in administration of sedation and analgesia, including the necessary airway management skills, or department-approved extra training and experience.

AND

2. Documented current competence and evidence of the performance of at least 5 cases (can be any combination) within the past 24 months, or completion of training within the past 24 months. Please provide clinical activity/procedure log.

Criteria for Renewal of Privileges:

1. Documented current competence and evidence of the performance of at least 5 cases (can be any combination) within the past 24 months.

Non-Core Privileges: Oral and Maxillofacial Oncology

- ☐ **Fluoroscopy**

Privilege to operate and/or supervise operation of fluoroscopy equipment.
Requirement: Current Fluoroscopy or Radiology X-Ray Supervisor and Operator Permit from CDPH

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FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) for initial applicants

1. Retrospective or concurrent proctoring (chart review or direct observation) of at least nine (9) hospitalized patients in the care of whom the applicant significantly participated. FPPE/proctoring must be representative of the provider's scope of practice.

2. FPPE/proctoring must be representative of the provider's scope of practice. Concurrent proctoring (direct observation) of at least three (3) procedures. FPPE/proctoring has to be representative of the provider's scope of practice.

3. FPPE/proctoring is also required for at least one (1) case of each of the requested non-core privileges.

4. FPPE should be concluded as soon as possible (i.e. within the first 3-4 months after starting work at CCRMC).
5. Completed FPPE forms must be submitted to the Credentialing Office.
6. It is the applicant's ultimate responsibility to make sure that FPPE and submission of all required paperwork to the Credentialing Office takes place in a timely manner. Failure to do so may result in loss or limitation of privileges.
7. **For low volume providers: please see separate FPPE/proctoring guidelines.**
8. **For more detailed information, please see separate FPPE/proctoring guidelines.**

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I will adhere 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 _____

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DEPARTMENT / DIVISION CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**

☐ **Recommend Privileges with the Following Conditions/Modifications:**

☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:

_____
_____
_____
_____

[Department Chair] Signature: _____ Date: _____

FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY

Credentials Committee Approval **Date: _____**

Temporary Privileges **Date: _____**

Medical Executive Committee Approval **Date: _____**

Board of Supervisors Approval **Date: _____**