DEVELOPMENTAL-BEHAVIORAL PEDIATRICS 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.

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

QUALIFICATIONS FOR DEVELOPMENTAL-BEHAVIORAL PEDIATRICS

Initial Applicants: To be eligible to apply for privileges in Developmental-Behavioral Pediatrics, the applicant must meet the following criteria:

1. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited residency in Pediatrics, followed by a fellowship in Developmental - Behavioral Pediatrics.

AND

2. Current certification or Board eligibility (with achievement of certification within the required time frame set forth by the Board) leading to certification by the Sub-Board of Developmental-Behavioral Pediatrics administered by the American Board of Pediatrics. Board certification in General Pediatrics is required prior to Sub-Board Certification.

AND

3. Required current experience: Documentation of developmental/behavioral pediatric services for at least 150 patients, reflective of the scope of privileges requested, within the past 24 months, or successful completion of fellowship within the past 24 months. Please provide clinical activity log.

Renewal of Privileges: To be eligible to renew privileges in Developmental-Behavioral Pediatrics, the applicant must meet the following criteria:

1. Documentation of Maintenance of Certification is required.

AND

2. Current documented competence and an adequate volume of experience (150 patients) 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.

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

Core Privileges: Developmental-Behavioral Pediatrics

☐ ***Requested:***

Evaluate, diagnose, consult, and provide care to patients from infancy through adolescence with developmental difficulties and problematic behaviors.
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 PROCEDURE/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.

Developmental-Behavioral Pediatrics

- Performance of history and physical exam
- Assessment of behavioral adjustment and temperament
- Behavioral screening and surveillance techniques
- Developmental screening and surveillance techniques
- Interviewing and assessment of family history and functioning
- Neurodevelopmental assessment
- Psychiatric interviewing and diagnosis
- Patient management skills, including but not limited to the following:
    - Anticipatory guidance
    - Behavioral treatment methods
    - Developmental interventions
    - Individual and family counseling
    - Psychopharmacotherapy

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

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) for initial applicants

1. Retrospective or concurrent proctoring (chart review or direct observation) of at least 9 patients with developmental-behavioral problems in the care of whom the applicant significantly participated. FPPE/proctoring must be representative of the provider's scope of practice.
2. FPPE should be concluded as soon as possible (i.e. within the first 3-4 months after starting work at CCRMC).
3. Completed FPPE forms must be submitted to the Credentialing Office.
4. 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.
5. **For low volume providers: please see separate FPPE/proctoring guidelines.**
6. **For more detailed information, please see separate FPPE/proctoring guidelines.**
7. **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** ____________________

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

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** ____________________