NEUROLOGY 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 NEUROLOGY

Initial Applicants: To be eligible to apply for privileges in Neurology, the applicant must meet the following criteria:

EITHER

Pathway A:

1. Documentation of successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited postgraduate training program in the relevant medical specialty and successful completion of an accredited fellowship in Neurology

AND

2. Documentation of current certification or Board eligibility leading to certification (with achievement of certification within the required time frame set forth by the respective Boards) in Neurology by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry

OR

Pathway B:

1. Documentation of successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited postgraduate training program in Internal Medicine or Family Medicine, and Department-approved experience in Neurology

AND

2. Documentation of Board Certification or Board Eligibility in Internal Medicine or Family Medicine (with achievement of certification within the required time frame set forth by the respective Boards) by the American Board of Internal Medicine (ABIM) or Family Medicine (ABFM) , or American Osteopathic Board of Internal Medicine (AOBIM) or Family Medicine (AOBFM)

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

AND

(The following are required for both pathways.)

1. Documentation of current experience: Inpatient/ outpatient care of least 500 patients with neurological disorders, reflective of the scope of privileges requested, within the past 24 months, or successful completion of an ACGME- or AOA-accredited residency within the past 24 months. Please provide a clinical activity/procedure log.

Renewal of Privileges: To be eligible to renew privileges in Neurology, the applicant must meet the following criteria:

1. Maintenance of Certification or Osteopathic Ongoing Certification is required.

AND

2. Current documented competence and an adequate volume of experience (500 patients with neurological disorders) 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.

Core Privileges: Neurology – Adult

☐ ***Requested****:* Admit, evaluate, diagnose, treat, and provide consultation to adult patients with diseases, disorders, or impaired function of the brain, spinal cord, peripheral nerves, muscles, autonomic nervous system, and the blood vessels that relate to these structures. 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, please strike through the procedures that you do not wish to request, and then initial and date.

Adolescent and Adult Neurology

- Autonomic testing
- Botulinum toxin injection
- Evoked potentials
- Interpretation of electroencephalogram (EEG)
- Lumbar puncture
- Performance of history and physical exam
- Tensilon® testing

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

Non-Core Privileges: Performance and Interpretation of Electromyography Evaluation (EMG) and Nerve Conduction Studies

☐ ***Requested****:* Performance and Interpretation of Electromyography Evaluation (EMG) and Nerve Conduction Studies

Criteria for Initial Request:

1. Successful completion of an ACGME– or AOA–accredited postgraduate training program in physical medicine and rehabilitation or neurology that included training in EMG and nerve conduction studies, or successful completion of an accredited ACGME fellowship program in clinical neurophysiology or neuromuscular medicine, or an

ACGME-accredited electrodiagnostic medicine preceptorship, or certification by the American Board of Electrodiagnostic Medicine, or department approved extra training and experience

AND

2. Demonstrated current competence and evidence of the performance and interpretation of at least 100 EMGs within the past 24 months or completion of training within the past 24 months.

Criteria for Renewal of Privileges:

1. Demonstrated current competence and evidence of the performance and interpretation of 100 EMGs within the past 24 months, based on results of ongoing professional practice evaluation and outcomes.

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 ACGME– or AOA–accredited 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.

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 neurological disorders in the care of whom the applicant significantly participated. FPPE/proctoring must be representative of the provider's scope of practice.
2. Concurrent proctoring (direct observation) of at least 3 different procedures that are representative of procedures regularly preformed in the department. FPPE/proctoring must be representative of the provider's scope of practice.
3. FPPE/Proctoring is also required for at least one (1) procedure/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 _____

DEPARTMENT / DIVISION CHAIR'S RECOMMENDATION

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

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 _____**