

SLEEP MEDICINE CLINICAL PRIVILEGES

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| 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 SLEEP MEDICINE

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

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 Sleep Medicine, or department-approved equivalent training and experience.

AND

2. Documentation of current subspecialty certification or Board eligibility (with achievement of certification within the required time frame set forth by the respective Boards) leading to subspecialty certification in Sleep Medicine by the relevant American Board of Medical Specialties or the American Osteopathic Board.

AND

3. Required current experience: Has demonstrated competence in Sleep Medicine with appropriate workup and management of sleep related disorders (minimum 500 patients), reflective of the scope of privileges requested, within the past 24 months, or successful completion of an ACGME- or AOA-accredited residency, or clinical fellowship within the past 24 months. Please provide a clinical activity/procedure log.

Renewal of Privileges: To be eligible to renew privileges in Sleep Medicine, 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 (minimum 500 patients with sleep disorders) 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: Sleep Medicine

- Requested:** Admit, evaluate, diagnose, and provide consultation and treatment to adult patients (>/ 18 years old) presenting with conditions or disorders of sleep, including sleep-related breathing disorders (such as obstructive sleep apnea), circadian rhythm disorders, insomnia, parasomnias, disorders of excessive sleepiness (e.g., narcolepsy), sleep-related movement disorders, and other conditions pertaining to the sleep-wake cycle. May provide care to patients in the intensive care setting.

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, based on lack of competency, please strike through the procedures that you do not wish to request, and then initial and date.

Sleep Medicine

- Performance of history and physical exam
- Actigraphy
- Home/ambulatory testing
- Maintenance of wakefulness testing (MWT)
- Multiple sleep latency testing (MSLT)
- Oximetry
- Polysomnography (including sleep-stage scoring) - PSG
- PSG titration (CPAP/ BIPAP)
- Sleep log interpretation
- Oral appliance titration

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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 9 patients with Sleep Medicine related disorders in the care of whom the applicant significantly participated. FPPE/proctoring has to 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 performed in the department. FPPE/proctoring has to be representative of the provider’s scope of practice.
3. FPPE should be concluded as soon as possible (i.e. within the first 3-4 months after starting work at CCRMC).
4. Completed FPPE forms have to be submitted to the Credentialing Office.
5. 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.
6. **For low volume providers: please see separate FPPE/proctoring guidelines.**
7. **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:**
- Do Not Recommend the Following Requested Privileges:**

| Privilege | Condition/Modification/Explanation |
|-----------|------------------------------------|
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Notes:

[Department Chair] Signature: _____ **Date:** _____

FOR MEDICAL STAFF SERVICES DEPARTMENT USE ONLY

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|---|------------|
| Credentials Committee Approval | Date _____ |
| Temporary Privileges | Date _____ |
| Medical Executive Committee Approval | Date _____ |
| Board of Supervisors Approval | Date _____ |