DETROIT MEDICAL CENTER
DEPARTMENT OF MEDICINE

DELINEATION OF PRIVILEGES IN CARDIOVASCULAR MEDICINE

APPLICANT NAME: _____

PLEASE PRINT

QUALIFICATIONS:

*** You must complete a General Internal Medicine delineation of privileges along with this delineation.**

Effective July 1, 2009, all new applicants to the DMC will be required to be board certified, or in the active certification process, in their practice specialty. See Board Certification addendum for complete requirements.

Core Privileges in Cardiovascular Medicine

1. Current certification or active participation in the examination process leading to certification in Cardiovascular Disease through the American Board of Internal Medicine, or the American Osteopathic Board of Internal Medicine, AND/OR successful completion of an accredited ACGME or AOA fellowship program in Cardiovascular Diseases with current certification or active participation in the examination process leading to certification in Cardiovascular Diseases by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, within 5 years.

2. Documented clinical experience in the practice of Cardiovascular Disease:
   A. If the applicant is within 2 years of completion of an accredited ACGME or AOA fellowship program in Cardiovascular Diseases, a letter from the fellowship director (or **designee**) must be supplied.

   B. If the applicant completed training in Cardiovascular Diseases at an accredited ACGME or AOA residency program more than 2 years before the application, documentation of activity in the practice of Cardiovascular Medicine **must** be demonstrated by:

      1) Demonstration of sufficient inpatient activity to allow ongoing professional performance evaluation on delivery of care meeting accepted standards and guidelines, and without variance from standards as recommended by the Chief of Medicine.

         a. Patients hospitalized at a DMC owned/operated facility within the past 2 years for which the applicant has been the attending of record, **or**
         b. **Submission** of documentation of hospital admissions at a JCAHO approved hospital and demonstration of certification at that hospital.

      2) Proof of sufficient ambulatory activity to demonstrate delivery of care meeting acceptable standards and guidelines for clinical care and without demonstrated variance. The ambulatory practice review may be accomplished by the Specialist-in-Chief, or designee. Upon request the applicant may be requested to gather additional letters of reference or other information to support the application and to determine quality of care.

Proof of successful completion of an approved, recognized course when such exists, or acceptable supervised training in residency, fellowship or other acceptable program; and demonstration of indications for the procedures/test/ therapy, and documentation of the competence to obtain and retain clinical privileges. Where nationally recognized certification agencies have established specific criteria for minimal clinical experience, the criteria will be cited and followed. Current Board certification or active participation in the examination process leading to certification within established Board requirements.

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APPLICANT NAME: _____

PLEASE PRINT

Special Privileges in Cardiovascular Medicine

Transcatheter Aortic Valve Replacement (TAVR)

1. Must be credentialed at the DMC as an Interventional Cardiologist.
2. Board certified/qualified in Interventional Cardiology.
3. Must have ≥100 career structural heart procedures
   OR
   ≥30 left-sided structural procedures per year
4. Completion of device-specific formal training and certification by the sponsor (Edwards or Core Valve Medtronic).
5. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
6. Reappointment: Applicants must be able to demonstrate that they have maintained competence in Transcatheter Aortic Valve Replacement (TAVR) procedures of at least 10 cases in the previous year, including continuing education relevant to the material.

Transcatheter Mitral Valve Repair (MitraClip) (TMVR)

1. Must be credentialed at the DMC as an Interventional Cardiologist.
2. Board certified/qualified in Interventional Cardiology.
3. Must have ≥50 structural procedures per year including atrial septal defects (ASD), patent foramen ovale (PFO) and trans-septal punctures.
4. Completion of device-specific formal training and certification by the sponsor/manufacturer (Abbott Vascular).
5. Experience with catheter-based management of potential complications including, but not limited to, pericardiocentesis.
6. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
7. Reappointment: Applicants must be able to demonstrate that they have maintained competence in Transcatheter Mitral Valve Repair (TMVR) procedures over the reappointment cycle, including continuing education relevant to the material and continues to perform ≥25 procedures involving transseptal punctures through an intact septum, with at least 12 being TMVR over a 24-month period.

Transcatheter Left Atrial Appendage Closure (LAAC)

1. Must be credentialed at the DMC as an Interventional Cardiologist or Electrophysiologist.
2. Interventionalist:
   Board certified/qualified in Interventional Cardiology.
   ≥25 Interventional cardiac procedures involving transseptal punctures through an intact septum
   ≥50 Lifetime structural heart procedures (TAVR, MitraClip)
3. Electrophysiologist:
   Board certified/qualified in Electrophysiology.
   ≥25 Electrophysiology procedures involving transseptal punctures through an intact septum
   ≥50 Lifetime left-sided catheter ablation procedures.
4. All operators must complete formal training and certification by the sponsor/manufacturer.
5. Clinical knowledge that includes comprehensive understanding of stroke and bleeding risk in atrial fibrillation and appropriate treatment strategies.
6. Experience with catheter-based management of potential complications including, but not limited to, pericardiocentesis and embolized device retrieval.
7. Understanding of left atrial appendage anatomy and imaging.
8. Suitable training on the devices to be used.
9. Documentation of self-certification (completion of training prescribed by the manufacturer on the safe and effective use of the device prior to performing LAAC).

10. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
11. Reappointment: Applicants must be able to demonstrate that they have maintained competence in Left Atrial Appendage Closure (LAAC) procedures over the reappointment cycle, including continuing education relevant to the material and continues to perform ≥25 procedures involving transseptal punctures through an intact septum, with at least 12 being LAAC over a 24-month period.

Transcatheter Left Atrial Appendage Closure (LAAC)

1. Must be credentialed at the DMC as an Interventional Cardiologist or Electrophysiologist.
2. Interventionalist:
   Board certified/qualified in Interventional Cardiology.
   ≥25 Interventional cardiac procedures involving transseptal punctures through an intact septum
   ≥50 Lifetime structural heart procedures (TAVR, MitraClip)
3. Electrophysiologist:
   Board certified/qualified in Electrophysiology.
   ≥25 Electrophysiology procedures involving transseptal punctures through an intact septum
   ≥50 Lifetime left-sided catheter ablation procedures.
4. All operators must complete formal training and certification by the sponsor/manufacturer.
5. Clinical knowledge that includes comprehensive understanding of stroke and bleeding risk in atrial fibrillation and appropriate treatment strategies.
6. Experience with catheter-based management of potential complications including, but not limited to, pericardiocentesis and embolized device retrieval.
7. Understanding of left atrial appendage anatomy and imaging.
8. Suitable training on the devices to be used.
9. Documentation of self-certification (completion of training prescribed by the manufacturer on the safe and effective use of the device prior to performing LAAC).
10. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
11. Reappointment: Applicants must be able to demonstrate that they have maintained competence in Left Atrial Appendage Closure (LAAC) procedures over the reappointment cycle, including continuing education relevant to the material and continues to perform ≥25 procedures involving transseptal punctures through an intact septum, with at least 12 being LAAC over a 24-month period.

MICRA Transcatheter Leadless Pacing System (Medtronic)

1. Must be credentialed at the DMC as an Electrophysiologist.
2. Board certified/qualified in Electrophysiology.
3. To successfully implant the MICRA system, physicians must demonstrate the appropriate formal experience/training:
   a. Gaining access via the femoral vein and navigation of fixed and deflectable delivery catheters to the right ventricle. This is similar to electrophysiology procedures training.
   b. Deliver the device: requires correlation of RV anatomy and the use of biplane fluoroscopy specifically lateral image to insure septal position to reduce perforations.
   c. Appropriately ensure fixation of device and/or recapture device if necessary.
   d. Free device from delivery system.
   e. Management of device interrogation and patient follow up: ABIM Electrophysiology certification / IBHRE Certification
   f. Manage end of device life and subsequent implant considerations

DELINEATION OF PRIVILEGES IN CARDIOVASCULAR MEDICINE

APPLICANT NAME: _____

PLEASE PRINT

4. All operators must complete formal training and certification by the sponsor/manufacturer (Medtronic).
5. Documentation of self-certification (completion of training prescribed by the manufacturer on the safe and effective use of the device prior to performing MICRA).
6. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
7. Reappointment: Applicants must be able to demonstrate that they have maintained competence in performing MICRA. Reappointment will be based on objective results of care according to the DMC's existing quality assurance criteria.

Performance/Interpretation of Cardiac MRI

1. Must have at a minimum level II training in cardiac MRI at an accredited program
2. At least 50 hour of CMR related coursework
3. Maintenance of skill
   a.. CME in CMR at least 20 hours every 2 years
   b. Primary interpretation of at least 50 cases in 2 years

Performance/Interpretation of Cardiac CTA

1. Must have at a minimum level II training in cardiac CT at an accredited program
2. 20 hours of lectures related to cardiac CT
3. Maintenance of certification:
   a. Interpretation of 50 contrast cases every 2 years
   b. CME in cardiac CT at least 20 hours every 36 months

Performance/interpretation of exercise and pharmacologic nuclear stress tests including MUGA scans

1. Must have at least level II training in nuclear cardiology
2. Maintenance of certification
   a. Interpretation of 50 cases over 2 years

Alcohol Septal Ablation for Hypertrophic Cardiomyopathy (HOCM)

1. Must be credentialed at the DMC as an Interventional Cardiologist.
2. Board certified in Interventional Cardiology.
3. Must have ≥100 career alcohol ablation cases for HOCM
4. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.

Percutaneous closure of secundum ASD and PFO shunts

1. Must be credentialed at the DMC as an Interventional Cardiologist.
2. Board certified in Interventional Cardiology
3. Must have ≥25 career PFO/ASD closure procedures, and 5 proctored cases
4. Completion of device-specific formal training and certification by the sponsor
5. Temporary privileges to be granted to the applicant under the supervision of a proctor/preceptor with a minimum of five (5) cases brought back to the Credentials Committee and Medical Executive Committee upon completion in order to finalize privileges.
6. Reappointment: Applicants must be able to demonstrate that they have maintained competence in Secundum ASD and PFO Closure procedures of at least 10 cases in the previous year, including continuing education relevant to the material.

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Reappointment Requirements

Maintenance of all core and special privilege qualifications and current demonstrated competence and experience in the practice of Cardiovascular Medicine, through ongoing professional practice evaluation without demonstrated variance from accepted standards and guidelines for clinical care as recommended by the Specialist-in-Chief of the Department of Medicine.

DMC Affiliation for No Volume or Referring Physicians

Requesting **"Affiliate Status, Membership Only (No clinical privileges)"** status is for those practitioners that wish to obtain or maintain a DMC affiliation but do not meet the minimum qualifications as defined by the DMC and/or their clinical department.

PRIVILEGES REQUESTED:

(R)-Requested (A)-Recommend Approval as Requested (C)-Recommend with Conditions (N)-Not Recommended

Note**: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason must be stated below or on the last page of this form **and discussed with the applicant.

Applicant: Please place a check mark in the (R) column for each privilege requested.

(R) (A) (C) (N)
☐ ☐ ☐ ☐ **AFFILIATE STATUS, MEMBERSHIP ONLY, NO CLNICAL PRIVILEGES**

Check 'R' box and do not complete the remainder of the form, go directly to Page 4, sign and date.

(R) (A) (C) (N)
☐ ☐ ☐ ☐ **CORE PRIVILEGES IN CARDIOVASCULAR MEDICINE**

Admission, work up, diagnose and provide treatment or consultative services to patients of all ages in need of cardiovascular care. ***Core privileges may include the following high volume procedures which are commonly performed by specialists in cardiovascular medicine:***

1. ECG interpretation and report
2. Electrical (DC) cardioversion
3. Placement of arterial and central venous catheters
4. Placement of temporary pacemaker
5. Calibration and operation of hemodynamic recording systems
6. Evaluation and/or consultation of appropriate diagnostic radiographs and hemodynamic recordings.
7. Placement of pulmonary artery balloon flotation catheters
8. Pericardiocentesis
9. Interpretation of electrocardiographic rhythms, including ambulatory ECG recordings
10. Performance/interpretation of exercise cardiac treadmill stress test
11. Echocardiography:
    a. Interpretation and performance of transthoracic two dimensional Echo and Doppler (spectral and color flow) recordings.

These core privileges do not include any of the following special procedures.

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PLEASE PRINT

(R)	(A)	(C)	(N)	**SPECIAL PRIVILEGES**
☐	☐	☐	☐	1. Echocardiography: a. Interpretation of exercise and pharmacologic stress Echocardiography b. Performance and interpretation of Trans-esophageal Echocardiogram
☐	☐	☐	☐	2. Diagnostic heart catheterization including coronary angiography
☐	☐	☐	☐	3. Performance/Interpretation of Cardiac MRI
☐	☐	☐	☐	4. Performance/Interpretation of Cardiac CTA
☐	☐	☐	☐	5. Performance/interpretation of exercise and pharmacologic nuclear stress tests including MUGA scans
☐	☐	☐	☐	6. Alcohol Septal Ablation for Hypertrophic Cardiomyopathy (HOCM)
☐	☐	☐	☐	7. Percutaneous aortic valvuloplasty
☐	☐	☐	☐	8. Percutaneous mitral valvuloplasty
☐	☐	☐	☐	9. Endomyocardial biopsy by catheter techniques
☐	☐	☐	☐	10. Percutaneous intra-aortic balloon insertion and management
				11. Transluminal coronary angioplasty:
☐	☐	☐	☐	a.. with or without stent placement
☐	☐	☐	☐	b. use of rotablator
☐	☐	☐	☐	c. transluminal extraction catheter (TEC)
				12. Transluminal peripheral arterial and venous angioplasty with and without intravascular stent placement:
☐	☐	☐	☐	a. extremities and renal vessels
☐	☐	☐	☐	b. carotid artery
☐	☐	☐	☐	c. endovascular prosthesis for aortic aneurysm
☐	☐	☐	☐	13. Atrial transseptal catheterization
☐	☐	☐	☐	14. Percutaneous closure of secundum ASD and PFO shunts
				15. Electrophysiological Procedures:
☐	☐	☐	☐	a. Diagnosis and management of cardiac rhythm disorders using intracardiac electrical monitoring and stimulation, with or without simultaneous administration of diagnostic and therapeutic agents.
☐	☐	☐	☐	b. Ablation of cardiac rhythm disorders
☐	☐	☐	☐	c. Implantation and follow up of permanent atrial and right ventricular pacemakers
☐	☐	☐	☐	d. Implantation and follow up of biventricular pacing devices
☐	☐	☐	☐	e. Pacemaker lead extraction
☐	☐	☐	☐	f. Insertion, testing and follow up of intra-cardiac defibrillators (IDC's)
☐	☐	☐	☐	g. Implantation, testing and removal of implantable rhythm recording devices
☐	☐	☐	☐	h. Tilt table testing, with and without pharmacological agents
☐	☐	☐	☐	i. Coronary sinus balloon angioplasty and stenting for purpose of CRT LV lead implant and stabilization
☐	☐	☐	☐	j. Subclavian vein/SVC balloon angioplasty and stenting to assist at the time of lead extraction and or implantation of pacemaker or defibrillator leads
☐	☐	☐	☐	16. Transcatheter aortic valve replacement (TAVR)
☐	☐	☐	☐	17. Transcatheter mitral valve repair (MitraClip) (TMVR)

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PLEASE PRINT

☐ ☐ ☐ ☐
☐ ☐ ☐ ☐
☐ ☐ ☐ ☐

18. Transcatheter left atrial appendage closure (LAAC)
19. MICRA Transcatheter Leadless Pacing System
20. **Moderate Sedation**
    This category requires knowledge of the DMC Moderate Sedation Tier 1 Policy (and Tier 3 Children's Hospital policy for Pediatrics), acknowledgement to observe the policies and complete the LearnShare Modules on Moderate Sedation. My initials attest that I will comply with the policy and have completed the module. _____ Initial

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Acknowledgement of Practitioner

By my signature below, I acknowledge that I have read and understand this privilege delineation form and applicable standards and criteria for privileges.

_____ _____
Applicant Signature Date

Specialist-in-Chief/Chief of Service (or designee) Recommendations:
By my signature below, I certify that I have reviewed and evaluated the applicant's request for clinical privileges, credentials and other supporting information, and the recommendations that has been made takes all pertinent factors into consideration.

☐ Recommend as requested ☐ Do not recommend

☐ Recommend with conditions/modification as listed _____

_____ _____
Chief of Service (or designee) Signature Date

_____ _____
Specialist-in-Chief (or designee) Signature Date

Joint Conference Committee Approval: _____
JCC Approved 10.27.09:03.27.2020:06.25.2021:0930.2022
Date

DETROIT MEDICAL CENTER
DELINEATION OF PRIVILEGES IN CARDIOVASCULAR MEDICINE
ADDENDUM*

APPLICANT NAME: _____
PLEASE PRINT

☐ **Clinical Privileges in Carotid Artery Angioplasty and Stent Placement**

Criteria: These procedures should be performed on patients meeting appropriate clinical criteria or through specified protocols by physicians with training and expertise in cerebrovascular angiography, pathophysiology, hemodynamics, and vascular interventions, and anticipated risks and complications.

Qualifications: Current Certification or active participation in the examination process for certification in Vascular Surgery, Neurosurgery, Interventional Cardiology, or Interventional Radiology and Neurology. Physicians with other specialty board certification may be eligible if they can demonstrate the number of procedures performed which would make them eligible by criteria for any of the above Boards.

Required Previous Experience/Training:

A. Demonstration of previous performance of requisite procedures to obtain certification in primary Board. Beyond these, the performance of diagnostic cerebral/carotid angiograms in a minimum of 30 patients, and 25 interventional carotid cases, with 15 of these as the supervised primary operator, are required. No more than two interventional procedures per case may be counted to meet these criteria.

B. Demonstration of Radiation Safety training

Observation and Monitoring Requirements: Ongoing monitoring of inclusion criteria met (e.g. SAPPHIRE or similar trial), satisfactory outcomes, stroke rates, restenosis rates, and mortality will be performed through Multidisciplinary Endovascular Quality Assessment and Improvement activities

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_____ _____
Applicant signature Date

_____ _____
Signature, Service and/or Department Chief Date

_____ _____
Signature, Specialist-in-Chief, or designee Date

***Addendum to the following Department Delineation of Privileges:**

- **Medicine(Cardiology only)**
- Neurology
- Neurosurgery
- Interventional Radiology
- Surgery (Vascular and cardiothoracic)

BOARD CERTIFICATION REQUIREMENTS

- Beginning July 1, 2009, all applicants to the DMC Medical Staff shall be Board Certified, or shall achieve Board Certification within five (5) years of completion of formal training. Relative to eligibility for board certification, completion of formal training (residency versus fellowship) is defined by the primary certification body for that specialty.

- Individual clinical department Board certification may be more stringent. If so, the department's requirements supersede the DMC minimum Board certification requirement.

- The Board certification must be in the specialty and specific practice which clinical privileges are requested.

- Board certification must be in a specialty recognized by the American Board of Medical Specialties, American Osteopathic Association, American Dental Association or the American Board of Foot and Ankle Surgery.

- If Board certification is time-limited, the applicant will have a maximum of three (3) years to achieve re-certification, beginning with the expiration date of his/her current Board Certification, or will be voluntarily resigned from the Medical Staff. DMC medical staff members on staff prior to July 1, 2009 with time-limited certifications will not be required to recertify.

- DMC medical staff members who obtain certification in specialty and subspecialty categories will be required to recertify in the area(s) of certification required by the certification body.

- An extension of the Board certification or re-certification requirement may be granted by the Medical Executive Committee to the applicant who has obtained an extension from the requisite Board for reasons of significant health issues or military service.

- DMC medical staff members on staff prior **to July 1, 2009,** who are not Board certified will not be required to achieve Board certification**.** Eligibility for the Board certification waiver requires uninterrupted DMC Medical Staff membership since July 1, 2009.

- Under special circumstances, some outstanding applicants brought to the DMC may be ineligible for Board certification. These members will be considered by their departments on an individual case-by-case basis, and review by a subcommittee of the SICs, may be granted privileges without Board certification with a majority vote of the Medical Executive Committee and the Joint Conference Committee.