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Credentialing and Privileging in Emergency Ultrasound:

How to Win Hospital Turf Battles With a Minimum of Controversy

by Erik Ness

Since ultrasound began working its way into emergency medicine in the 1980s the enthusiasm of physicians over its potential has been somewhat dampened by the political battles over getting permission to use it. Despite the obvious benefits to patients, other hospital departments with imaging capability may resist autonomous ultrasound in the ED.

"We have made inroads in working with other specialties to advance the cause of emergency ultrasound, but the fight isn't over and we still have a long way to go," said Robert Jones, DO, the Director of Emergency Ultrasound at MetroHealth Medical Center in Cleveland, OH, and chair of the ACEP Emergency Ultrasound Section. If you're getting ready to bring your ED into the ultrasound age, he warns, "chances are better than not that you're going to experience a turf battle of some kind--usually with radiology, usually involving the credentialing and privileging process."

You do have the right to use ultrasound in the emergency department; the trick is making it happen with a minimum of controversy. "The best way to guarantee never losing a privileging conflict is to never have one in the first place," said Dr. Jones.

The first step is becoming students of hospital governance. Physician credentialing is the process of gathering information regarding a physician's qualifications for appointment to the medical staff, while clinical privileging is how the hospital determines which procedures may be performed by which practitioners in the hospital. The Joint Commission, formerly called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), sets credentialing standards, and it mandates that individuals permitted by law and by the hospital to provide patient care must have delineated clinical privileges. Hospital bylaws set the local playing field, where each department is overseen by its chair. (Because of the Joint Commission's deference to department chairs, if your ED is a division you should consider seeking department status as a first step.)

In 1999 the AMA House of Delegates recommended that hospital credentialing committees follow specialty-specific guidelines for hospital credentialing decisions. "This resolution should allow emergency departments to grant privileges using the 2001 ACEP guidelines and forward them directly to the credentials committee--without seeking approval from other departments," said Dr. Jones. The ACEP policy, which was revised in 2006, states that "the exercise of clinical

privileges in the emergency department is governed by the rules and regulations of the department."

But hospital bylaws aren't always current, and each hospital works a little differently, so the first principle of getting approval for ED ultrasound is to know your hospital bylaws so that that you can see the twists and turns ahead. Bylaws, many written decades ago, are often filled with deadwood, said Dr. Jones. In the 1960s it was not unreasonable to give radiology control over all imaging. The proliferation of imaging technology has likely made this rule obsolete, but if it's still on the books it's a potential roadblock that needs to be cleared, preferably before you make your case.

Once you understand the bureaucratic landscape, an ED needs to define why it needs ultrasound, and how having ultrasound will benefit patient care. Review your practice and decide what emergency ultrasound applications make sense. "Once you can define those things it makes it easier to present your case to the hospital," said Dr. Jones.

Before you get to the official hearing, a little politicking is in order. Make sure you know the members of the committee and have talked through the issues with them and answered any questions they may have. Identify potential opponents and recruit allies. Departmental allies could include trauma surgery, vascular surgery, ob-gyn, or cardiology. One or more of these departments may be particularly interested in emergency ultrasound simply because it will put less stress on their staff and resources. For example, if off-hours ob/gyn is a particular weakness in your hospital, they should support ED ultrasound.

Control the debate, and make sure that the bottom line is standard of care. "There has never been a study that says emergency physicians do harm as a result of using ultrasound in the ED," said John Kendall, MD, past chair of the ACEP Emergency Ultrasound Section. "What it shows is that we decrease complications, we decrease the amount of time the patients are in the department, that our diagnoses are accurate, and that it improves mortality as well as morbidity. Just put it on the table: This is our literature." If you can back up the literature with cases from your ED where the availability of emergency ultrasound could have made a difference, your case will be that much stronger.

In a straightforward clinical privileging process the chronology looks like this:

1. Decision to develop an emergency ultrasound program.
2. Select an ultrasound coordinator.
3. Decide scope of practice.
4. Follow ACEP guidelines to design ultrasound program.
5. Meet all qualification before you apply.
6. Review the medical staff bylaws for bias and recruit allies.
7. Department chair presents application to hospital credentialing committee.
8. On approval, specific ultrasound studies are added to ED credentialing checklist.

That's the best case scenario. If you are denied, things get more complicated. Ask for a written explanation of the denial. Review the bylaws again, and familiarize yourself with the appeals process. Did the hospital follow its own bylaws? "Denials frequently happen because the hospital has deviated from JCAHO's guidelines," said Dr. Jones. "All hospital privileging processes must

be fair and awarded or denied solely on documented training, experience and current clinical competence. Privileging based on any other factor is contrary to the written standards of JCAHO. When privileging battles go to court, they are won principally because the privileging process deviated from this standard."

With the letter of denial and the bylaws in hand, review your case. Begin by double-checking that your staff meets the 2001 ACEP guidelines. If your denial is based on not meeting these guidelines, your appeal won't go far. But if you clear that bar, redouble your outreach. In a particularly energetic fight, you may need to cast a wider net. Lobby the administration, educate them about the value of emergency ultrasound. Mobilize your state ACEP chapter. Finally, with all your support marshaled and your case iron-clad, bring it the committee again (the hospital must offer an appeals process).

Vivek Tayal, MD, ultrasound director at Carolinas Medical Center in Charlotte, and past chair of the ACEP Emergency Ultrasound Section, adds a few more tips about the bargaining process. He suggests you should never bargain away billing or other rights to other departments, and give yourself room to maneuver and grow by using more general language in credentialing documents.

Some credentialing disputes are finally resolved by a mediator, and a few go to court, but Drs. Tayal and Jones both counsel that legal action should only be considered as a last resort.

Somewhere in all of this you're likely to get frustrated, but don't let it get personal. The very idea of a physician simultaneously performing and interpreting a bedside diagnostic ultrasound is a paradigm shift that's often unfamiliar to other physicians, other departments, hospital administrators, and payors. "Be ready to explain this difference many times over-and use it to your advantage," concludes Dr. Tayal.