Forum on Economic Credentialing (E. C.)

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What is economic credentialing? The California Medical Association defines economic credentialing as follows: "The use of economic criteria that do not apply to quality for granting or renewing medical staff privileges."[1] The American Medical Association defines economic credentialing as "...the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualification for initial or continuing hospital medical staff membership or privileges."[1] The Florida Medical Association defines economic credentialing as "...any practice that denies access to hospitals based on economic criteria unrelated to the clinical qualifications or professional responsibilities of the physician." It also defines economic credentialing as "...fiscal responsibility in practicing quality healthcare," and specifically notes that the governing body of a hospital has the right to discipline physicians (and presumably, exclude them) on the basis of resource utilization.

What does economic credentialing mean? Among the many responsibilities of the hospital governing board, there are two major obligations that affect physicians: (1) appointing and reappointing physicians; (2) granting and modifying physician privileges.

Economic viability of a hospital (in the current reimbursement climate) is a primary consideration in the deliberations of the hospital board. Therefore, efficiency of care (which could be regarded as desired outcome, divided by cost of the outcome) has become a major driving force in changing delivery of care in a hospital. A

physician's appointment or reappointment to the medical staff may involve scrutiny of that given physician's practice profile that could adversely affect the economic well being of a hospital. In other words, if there were two practitioners achieving the same outcomes, but one of them was using fewer resources to achieve them, then a hospital may revoke or modify the privileges of the more expensive physician.

Many hospitals are obtaining data elements that enable them to compare physicians by producing physician specific data. Periodically, these data are given to the medical staff with an intention of modifying (provider) physician behavior. Hospitals may refer to this process as physician profiling rather than economic credentialing.

Physician influences over utilization of hospital resources can be measured. Managed competition utilizing physicians to control costs, thereby making hospitals competitive, is fast becoming a reality. The various national data benchmarks on physician performance (e.g., cardiovascular surgery) have pushed economic credentialing to the forefront. When continuous quality improvement process stalls (i.e., where there is no change in the physician's practices) after profiling data are distributed, the process may move into the realm of economic credentialing. The most important part of this process should be that the patient conditions and outcomes are comparable and that the norms set are properly set by national and international standards. Also, these processes should be controlled by physicians.

ECONOMIC CREDENTIALING – A DEPARTMENTAL CHAIRMAN'S VIEW
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We have been told that reducing costs by increasing efficiency is imperative for survival of both hospitals and physicians. Physicians have accepted this and become the primary agents in cost reduction. As a chairman of surgery at a large suburban Chicago hospital, I have been asked to consolidate and tighten patterns of practice among surgeons.

As an example of the kinds of cooperative efforts made by hospitals and physicians together, a laparoscopic cholecystectomy antibiotic study was carried out to check how many different types of prophylactic antibiotic coverage were being used. Infection rates, effectiveness and cost of both the antibiotics and their delivery were charted over a 1-year period. Considering the information extracted from this study, recommendations were made to all staff surgeons performing a laparoscopic cholecystectomy surgery for the most cost-effective prophylactic antibiotic. This was a recommendation and not a demand.

The staff response was good and a number of antibiotics were dropped from the hospital formulary. This created a sizable savings for the hospital. It also resulted in savings for patients. This is known as provider behavior modification.

A second cooperative effort was undertaken. This was considerably more difficult to achieve. The operating room was stocking two completely different lines of surgical staplers. This became extremely costly as sometimes it led to the mistaken opening of packages for surgeons using different systems with the complete loss of the opened product. Carrying two complete lines also reduced volume discounts available to larger single manufacturer orders. Stocking two lines of products was expensive.

There were, however, feelings on the part of excellent surgeons for one system over the other. All aspects of the system offering the better prices were reviewed. A consensus was developed regarding a majority of instruments that everyone agreed to use. There were, however, a few instruments that some surgeons refused to part with; therefore these few were stocked as special items. All other staplers were ordered from a supplier who offered the best discount. The hospital got better prices, much larger discount, and significant savings; at the same time the quality of care was protected for the patient. All instruments thought to be absolutely necessary were still available in both lines.

The Role of Insurers

We should understand that in a very real sense, hospitals are being economically credentialed by the selection or deselection process of insurers. Hospitals are being chosen based heavily on cost of care and secondarily on location. Quality of care unfortunately is not a first concern of the insurance companies despite protests to the contrary. For insurers good enough has replaced best, and hospitals were forced to tow the line.

The ability of hospitals to reduce cost depends almost entirely on the efforts of physicians. In a great many ways, this is a good process. It forces each of us as practitioners, to review our practice routines and to examine the efficacy and cost effectiveness of our routines.

The Role of Healthcare Manufacturers

For many years, the costs of providing medical care were not scrutinized at all. As a result, manufacturers enjoyed huge profits and felt they could charge whatever the market would bear. Unfortunately, physicians and hospitals went along with the costs and passed them along to the patients.

Our patients have now demanded that we, the physicians, take the lead in reducing costs and as a result, we have seen our workloads increase and our incomes decrease. The efforts from this point on to control costs should be a cooperative effort with heavy physician involvement, with an intent to protect the best interests of physicians, and protect quality of care for our patients.

Comment

While all of this is important, I want to add a word of warning. When we create uniformity in an effort to reduce costs and ask physicians to practice along guidelines, we limit innovation and its special spark of genius. When everyone is brought to a median of practice, it may raise the lowest levels, but it will inevitably bring down the highest. This is the greatest danger of uniformity for the sake of cost reduction, the suppression of the innovator. Innovators have been the main source of breakthroughs in medicine.

We, as physicians, should actively be involved in cost control, but we should try to establish voluntary and not mandatory guidelines. We must insist that the best patient care should not be compromised and that hospitals and suppliers share monetary sacrifices with physicians. The innovators must be given the opportunity to innovate. We must never lose sight of the fact that the right care may not be the cheapest.

A CARDIOVASCULAR SURGEON'S PERSONAL EXPERIENCE IN ILLINOIS
RAJ B. LAL, M.D.

I am a cardiovascular and thoracic surgeon whose 20-year relationship with Gottlieb Hospital in Melrose Park became a casualty of these ECs the day before New Year's Eve, 1992. That is when our private practice was informed that as of January 1, 1993, we would no longer have cardiac surgery privileges because the hospital had created an exclusive contract for heart

surgery with another group of cardiovascular surgeons. Let me detail the broad issues our case raises.

First: Administrative business decisions can have a powerful impact on our ability to practice the art and science to which we have devoted our lives. When all the cardiovascular surgeons who had previously had privileges at Gottlieb were told the new exclusive contract would preclude our practicing cardiac surgery there, we were assured this decision was not a negative reflection on the quality of our medical care. Yet how could we not be negatively affected by having to tell long-time patients that if they needed our help, they would have to choose between having us perform the procedure elsewhere or having someone else perform it at the hospital which is most convenient and most comfortable for them? How could we not be affected by the marketing slogan the hospital adopted for its new surgical groups—calling it "one of the ten best surgical teams in the country"? How can this not affect the professional reputation each of us has worked so hard to establish? And how could it not affect us when in future credentialing applications and reapplications, we may be called upon to report this "administrative" termination of cardiac surgery privileges? The mere fact of such a reduction of privilege carries adverse inference, even though the decision had nothing to do with quality of care; so how could this not reflect on our capabilities as physicians?

Second: Don't count on fair and honorable treatment by hospital administrators or trustees. Illinois State Medical Society President Arthur R. Traugott, M.D., testified against economic credentialing before the Illinois Health Facilities Planning Board, and it is the American Medical Association's policy that "AMA does not believe that economic productivity should be a factor in medical staff reappointment." Yet the reality beyond this policy is that just as we had been given no previous notice that an exclusive contract might be in the works at Gottlieb, once it was a fait accompli, we were given no information about the provisions of that contract, other than its exclusivity. There was no due process, and we were never told the criteria used for judging the selection of surgeons who can now perform cardiac surgery at Gottlieb. I have now lost my practice partner, a promising young surgeon whom I had recently brought into my solo practice in good faith. He had worked with me to show our loyalty to one hospital by focusing the majority of our cardiac surgical caseload at Gottlieb. What happened to me and my partner should give all other surgeons pause about trying to be loyal to a particular hospital.

Third: Our hospital medical staff organization and our medical societies must develop more clout. When the Evangelical Hospital Associated at Good Samaritan Hospital in Downers Grove entered into an exclusive contract for cardiac surgery services, the medical staff condemned exclusive contractual arrangements, but the administration ignored the physician organization. The same happened at Gottlieb. Meanwhile, our state medical society is on record against economic credentialing, but when the ISMS introduced a bill on this subject to the state legislature, the Illinois Hospital Association lobby was successful in blocking it. Such events make a mockery of any power or autonomy physicians may think they have.

So what can we do? We need medical staff bylaws that carry powers equal to those of the administration; we need the legal power to require that all exclusive contracts be reviewed by the medical staff; and we need due process as the cornerstone of medical staff bylaws. Further, we must commit our full energy and support to the American College of Surgeons and our local chapters so these organizations can oppose ECs effectively. I hope my experience with ECs sounds a warning bell for all physicians who protest they are "too busy being doctors to waste time on hospital or medical society politics."

Fourth: We must alert the public that when economics is put above patient welfare, rationing is inevitable. Most lay people do not understand the implications of physicians being penalized for treating patients whose age or overall poor health makes it likely they will not enhance that doctor's economic efficiency ratings. As the process of national healthcare policy reform is played out, we physicians are the only ones who can educate the public about such subtle forms of rationing.

Fifth: Hospitals operate under a public trust, but they act as if the bottom line is what matters most. Most hospitals are designated as non-profit entities and enjoy tax exempt status, but administrators and governing boards too often pay first allegiance to the profit and loss statements. Further, all hospitals need government approvals, but this does not always ensure that the people—both patients and physicians—are their first concern.

For instance, recently hospitals have sought to acquire status and public approval via affiliation with university medical schools. In the Chicago area, Good Samaritan, Hinsdale Hospital and Alexian Brothers Hospital in Elk Grove Village received approval for development of open heart programs under the umbrella of Loyola University's surgeons and then made exclusive contract arrangements for cardiac surgery with a group affiliated with Loyola. LaGrange Memorial Hospital and Weiss Memorial Hospital in Chicago have joined under the banner of the University of Chicago with exclusive contracts, as Oak Park's West Suburban Hospital has with Northwestern University surgeons. Central DuPage Hospital affiliated itself with Rush-Presbyterian St. Luke's Medical Center cardiac surgeons through the Glen Ellyn Clinic, in effect doing an end run around another surgeon with whom the clinic had a contract. Yet who is to say that the public is necessarily better served by university-affiliated specialists than by physicians who may have more professional experience and community loyalty?

Worse, none of these "deals" shows real concern for the patients in the area these hospitals serve. In many cases, hospitals have severed individual patient relationships with surgeons whom they knew and trusted for many years, or have blunted physicians' ability to refer their patients to the specialist they know and trust. When an institution violates the rights of its medical staff and makes economic decisions that limit patients' choice of physicians, how can it be trusted to protect the health and rights of its patients?

At the close of the spring of 1993 legislative sessions, Illinois physicians convinced state lawmakers of the need for a study on economic credentialing by the Illinois Health Facilities Planning Board.

We physicians are our patients' advocates, first and foremost, and that role is one we must never surrender to the dealmakers of the world.

LEGAL MATTERS

Denial of Hospital Privileges—Based on Purely Economic Criteria

Florida case—Rosenblum v Tallahassee Memorial Regional Medical Center (TMRMC):[1] Dr. Rosenblum, a cardiac surgeon, was denied admitting privileges at TMRMC. He had open heart privileges at TMRMC but he was also the director of the Heart Program at a rival HCA

Tallahassee Community Hospital. The quality of the work performed by Dr. Rosenblum was not an issue—he was deemed to be a competent and capable surgeon. TMRMC Board of Trustees terminated Dr. Rosenblum's admitting privileges at TMRMC because they felt his activities constituted an economic threat to their hospital. The Florida circuit court upheld the action of TMRMC. Exclusive contracts by hospitals with selected (providers) physicians have survived legal challenges in the past.

ILLINOIS SENATE BILL 398

Amends the Hospital Licensing Act effective January 1, 1995.[4]

a. Requires hospitals and hospital based providers to explain to individual providers the reasons, including economic factors, for credentialing decisions, allow an opportunity for a fair hearing, and report economic credentialing to the Hospital Licensing Board for further study.

b. By-laws of hospital except county hospitals shall include:

1. Minimum procedures for initial applicants for medical staff privileges shall include:

- Written procedures relating to acceptance and processing of initial applicants.
- Written procedures to be followed in determining an applicant's qualifications.
- Written criteria for evaluating applicant's qualifications.
- Evaluation of applicant's current health-status and current license status.
- Written response to each applicant explaining reason(s) for any adverse decision including economic factors.

2. Minimum procedures with respect to medical staff and clinical privileges determinations concerning current members.

- Written notice of an adverse decision.
- Explanation of all reasons for adverse-decision
- Statement of medical staff member's right to request a fair hearing on the adverse decision.
- Statement of member's right to inspect all pertinent information in the hospital's possession with respect to the decision.
- Statement of member's right to present witnesses and other evidence.
- Written notice and explanation of decision resulting from hearing.
- Notice given 15 days before implementation of an adverse staff membership or clinical privileges decision.

3. Every adverse decision based substantially on economic factors shall be reported to the Hospital Licensing Board before the decision takes effect.

CONCLUSION

Economic credentialing is here to stay. Physicians should understand the implications of physician profiling data and actively get involved in the process. Active physician involvement will limit and modify the adverse impact of economic credentialing. Active physician involvement in the Illinois political scene has resulted in positive pro-physician, patient-protecting legislation.

As long as medical staff members cooperate with hospital administration in using economic criteria as one of the many criteria in evaluating physicians, antitrust litigation will not be a reality. Physicians should actively get involved in state politics and seek to change laws with an intent to protect patient and physician rights. The motives of third party insurers and insurance companies should be analyzed and active political steps undertaken to counteract adverse monetary issues.

It is preferable to have physician input into economic credentialing rather than input from other sources which may affect the well being of physician practices. Physicians involved in the process should insist on the highest quality of care when evaluating economic performance of physicians. Decisions based on pure economic business criteria without taking quality issues into consideration should be avoided. We should try to be the ombudsman for the patient.

Managed care, managed competition, marketplace-regulated healthcare—these concepts originating from the fertile imagination of Dr. Paul Ellwood resulted in uncontrolled changes in the delivery of healthcare—can only be defeated by an informed American public. This is our challenge, responsibility, and calling. **STI**

REFERENCES

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