OR Manager Inc

OR Manager
Vol. 30 No. 11
November 2014

OR Business Performance

Co-management agreements thrive in a culture of responsibility

Most hospitals are experimenting with ways to collaborate better with physicians. An alignment model that is particularly relevant for hospital ORs is the surgical services co-management agreement (CMA).

Under a CMA, surgeons receive compensation for helping to manage a service line. Several leading ORs have used CMAs to engage surgeons in efforts to improve quality, increase efficiency, reduce costs, and achieve strategic goals. However, establishing a successful CMA requires careful planning and ongoing management attention.

We talked to several OR experts who have helped establish and run CMAs.

Goals and targets

Clearly defining the objectives of the agreement is critical for creating organizational focus and is necessary for legal compliance.

According to Dana Regnier, MHA, RN, vice president of ambulatory services at the University of Arizona Health Network in Tucson, CMA goals can run the gamut of OR quality, efficiency, and safety objectives. From 2010 to 2012, Regnier was executive director of a cardiovascular services CMA at MacNeal Hospital in Berwyn, Illinois. The agreement encompassed several service lines with participation from cardiovascular surgeons, vascular surgeons, and cardiologists.

"Goals and performance metrics should be based on the specialties represented," Regnier says. "Our metrics focused on outcomes such as ventilator times, pulmonary complications, primary PCI [percutaneous coronary intervention] within 90 minutes of arrival, and patient satisfaction." Other performance metrics addressed readmission rates, block time utilization, compliance with care pathways, and cost reduction. "We also had program development metrics because one of our top goals was to develop an arrhythmia center."

Other CMAs have targeted improvement in on-time starts, turnover time, preference card costs, and other hot-button issues. As much as possible, CMA goals should be formulated in terms of concrete performance targets. For example, instead of just "improve surgical safety," specify "increase Surgical Care Improvement Project compliance to 98% or above."

Another common CMA objective is care standardization. Lynette Wilkos-Prostran, MSN, RN, is executive director of the musculoskeletal service line at Loyola University Health System in Maywood, Illinois. From 2009 to 2013, she served as service line director of orthopedics and then as vice president of perioperative services at Weiss Memorial Hospital in Chicago, where she helped launch and lead an orthopedic service line CMA. "One of the major goals of the Chicago Center for Orthopedics was to improve clinical outcomes by standardizing care pathways and order sets," she says.

Activities and valuation

Once the goals of the CMA are established, the next step is to determine physician duties under the agreement and the value of these services.

"Required management activities could include things like board participation and traditional medical director responsibilities," Regnier says. All activities should

be defined in terms of the specific time contribution and performance objectives. For example, an agreement might require surgeons to devote 6 hours per month to work on a process standardization goal, including committee work and preparation.

The next step is to determine the valuation of the services. According to Tina Brinton, executive vice president/chief operating officer of Dynafios, a healthcare consulting firm in Issaquah, Washington, the most common approach to CMA valuation is the market approach.

"In the market approach, you take the set of physician management duties and compare it with standard remuneration in the local market," she says. The less common approach is cost-based valuation. "Under the cost approach, you would use medical group or physician executive cost benchmarks to establish a value for services."

Fees and incentives

The CMA valuation drives physician compensation. Most CMA compensation structures have two components—a base management fee and an incentive payment. The base management fee is often distributed as a monthly stipend. "Typically, this base fee is about 20% to 30% of the total potential compensation amount," Brinton says.

Incentive payments represent the bulk of CMA compensation, and they are usually paid at year-end. The final distribution amount depends on surgeons' achievement of performance goals. Under many agreements, surgeons will have basic "level I" goals and "level II" stretch goals. If participants achieve level I performance, they receive 75% of the incentive dollars. Meeting the level II performance threshold secures the final 25% of the incentive.

Brinton discourages any attempt to assign different weights to different performance goals. "Dividing the incentive equally over all the indicators sends the message that all the goals are equally important," she says. "What you don't want is for people to start arguing over which objectives are more or less valuable. When you put barriers in the way in terms of nuances, it wastes valuable time."

Organizational structure

A CMA can be structured as either a joint venture company or an all-party management services contract. According to Brinton, the contract model is simpler and produces the same results as a more complex joint venture. "The trend is toward eliminating the joint venture structure," she says. "Once physicians hear about the contractual model, they usually don't see a need to create a separate joint venture entity."

A CMA "org chart" typically includes a leadership board and an array of operational teams. Within an operational team, surgeons and hospital personnel work together to achieve the CMA's specific performance goals. One operational team might focus on quality, another on efficiency improvement, a third on pharmacy costs, etc.

The CMA leadership board monitors and directs all activities under the agreement. This group should hold monthly meetings to review current performance metrics, receive operational team updates, discuss problems, and establish priorities.

Successful CMA enterprises are typically managed by a hospital-employed administrator, often the director of the surgical service line. Administrator responsibilities include coordinating surgeon meetings, assisting with data capture and analysis, and ensuring that participating surgeons maintain progress toward goals.

As executive director of the MacNeal cardiovascular CMA, Regnier actively managed the agreement down to the operational team level. "It's important to be engaged with the physicians," she says. "As administrator, it was my responsibility to set agendas for operational team meetings, attend all sessions, and report back to the leadership board on team progress and metrics."

Challenges

"For a co-management agreement to be successful, hospital executives need to be engaged and visible," Regnier says. "The governing board of our cardiovascular services CMA included the CEO, COO, CFO, and CNO of the hospital. They took the initiative very seriously, and I think it made a difference for the physicians to know that executives were very invested."

Another problem is surgeon commitment. "Not all physicians will have the same level of commitment to the agreement," Wilkos-Prostran says. The solution is ongoing attention and communication. "If physicians are struggling or there is no movement on performance indicators, you need to initiate a discussion about the obstacles and what support or resources are needed to achieve the goal."

Even among committed participants, maintaining focus over the long term can be difficult. "During the first year of the agreement, participants received a sizable bonus for achieving the stretch goals. But during the second year, performance becomes more difficult as you need to sustain the goals of the first year and develop goals for the second year," Wilkos-Prostran says.

Strong CMAs are able to sustain progress because they create a culture of responsibility. "Surgeons hold each other as well as leadership and staff responsible," Wilkos-Prostran says.

A good tool

Surgical services CMAs offer several benefits to OR leaders, the most important of which is improving surgery department performance.

The Weiss CMA, for instance, reduced length of stay (LOS), cost per case, and readmission rates for orthopedic patients.

At MacNeal Hospital, the cardiovascular services CMA reduced LOS, cut postoperative infections, and improved protocol compliance. It also decreased costs. "Our direct costs decreased by about 9% overall for the service line, so profitability increased," Regnier says.

Wilkos-Prostran believes that CMAs help keep physicians loyal to the hospital. "Surgeons gain satisfaction in improving their time management to grow their practices and, more importantly, happy patients who are satisfied with their care," she says. "In addition, the surgeons understand that if they want to make things better in the OR, they need to be present there on a regular basis to work with the multidisciplinary teams on improving outcomes."

Surgical services co-management can be an important part of a comprehensive effort to engage physicians in OR leadership. "Co-management agreements are a good tool for achieving initial alignment between surgeons and the OR," says Bob Dahl, chief operating officer of Surgical Directions. "Getting surgeons involved in this range of issues can set the stage for more robust collaboration through a surgical services executive committee."

Dahl also believes that co-management can be a good way to introduce surgeons to value-based payment. "CMAs provide a platform for getting surgeons focused on performance metrics and allowing them to self-organize to hit performance targets, all within an incentive structure." ❖

This column is written by the perioperative services experts at Surgical Directions (www.surgicaldirections.com) to offer advice on how to grow revenue, control costs, and increase department profitability.