

Comanagement as an Alignment Tool

A proven pathway to improved performance given the anticipated changes to payment models.

BY SUZETTE JASKIE

Comanagement is a proven tool for managing and improving the performance of the cardiovascular service line; progressive programs have been working with their hospital partners to comanage the cardiovascular services for more than a decade. Today, because of incentives and payment models concordant with health care reform, combined with the employment trend in cardiology, the comanagement approach is becoming more prevalent as an alignment tool and physician compensation component.

The goals of the comanagement contract are straightforward: To create alignment between hospitals and their physicians to support the goals of the hospital system. This joint approach is also a tremendous physician engagement tool, because it creates clarity in organizational objectives and requires all parties to acknowledge the value of physician input in a strategic and meaningful way. The rationale for a comanagement approach was perhaps best articulated by Dr. Arnold Relman, the former editor of *The New England Journal of Medicine*, who stated that in the United States, physician expenses account for only about 20% of the health care expenditures, but in treating patients, physicians influence and often control 100% of the expenditures.¹ This truth led the savvy service line leaders to construct a systematic methodology for alignment.

The comanagement agreement is typically a contractual relationship between a hospital or hospital system and its physicians. The agreement can be a stand-alone contract, or it can be a component of the physician employment agreement. Comanagement contracts can include employed physicians, independent physicians, or both. The agreement specifies how the physician participants and the hospital will together manage the

service line. Typical components of a comanagement agreement include an organizational or governance structure, leadership and management roles within the structure, management services, and improvement services (see the *Six Keys to Comanagement Agreement Success* sidebar).

COMANAGEMENT AGREEMENT COMPONENTS

The organizational structure serves as the decision-making mechanism for the comanagement agreement. A leadership or executive board or committee with subsidiary business and clinical subcommittees is often utilized to oversee comanagement. The size of the structure is typically related to the size of the program and the number of physicians involved. Governance can be as simple as the designated hospital administrators and physician leaders meeting monthly to manage the performance of the cardiovascular program and the progress in achieving the predetermined goals.

Another key component of the organizational structure is management of the structure itself. Successful comanagement agreements have adopted a dyad leadership model in which administrators and physicians are paired at every level of the decision-making structure. Each comanager's role is distinct. For example, leading the clinical program, establishing clinical standards, and managing physicians is typically the primary responsibility of the physician side of the dyad. Leading operations and staffing is typically the primary responsibility of the administrator. Together, the dyad makes financial and strategic decisions and is responsible for the enterprise's overall performance. The dyad leadership model not only leverages the knowledge and skill sets of both leaders, it also works to create a new collaborative culture.

TABLE 1. MANAGEMENT SERVICES

Physician chair	Annual stipend with job description
Coronary interventionist	Hourly compensation: 10 hours per month budgeted
Peripheral vascular interventionist	Hourly compensation: 10 hours per month budgeted
Emergency department physician	Hourly compensation: 10 hours per month budgeted

TABLE 2. IMPROVEMENT SERVICES

Operations goals	• Physician catheterization lab on-time start 85% of the time • Develop and implement block physician scheduling by June 30, 2015 • Establish same-day discharge program by December 31, 2015
Financial goals	• Standardization of catheterization lab supplies
Quality goals	• Reduction of door-to-balloon time below 90 min 98% of the time • Reduction in mortality • Establish and implement robust catheterization lab quality conference and peer development function by August 1, 2015
Clinical goals	• Increase use of radial access approach by 25%

COMANAGEMENT SCOPE

Comanagement agreements vary in the scope of their activities. Some comanagement agreements are focused on a very specific clinical service, such as a catheterization lab or other hospital department, the heart failure program, or an ambulatory site. More commonly, the agreements are the basis for a more comprehensive approach to the provision of cardiovascular services—often referred to as the *service line model*—and are far reaching, including multiple departments, sites, and services. Whether focused or broad, the core elements of the comanagement agreement are the same—mainly, physicians are compensated for providing management services and improvement services within the defined structure and scope to meet specific organizational goals.

Management services are those provided by the physicians in operationalizing the decision-making structure. Management services, or time spent performing non-clinical tasks, is compensable usually on an hourly basis. Physicians in leadership roles, as well as those participating in the infrastructure as committee members or project participants, are all integral members of the management services. Although physician time is compensable, as long as several legal requirements are satisfied, there is tremendous compensation variability for nonclinical time. Most commonly, existing medical director agreements are folding into the management services description. Management services are fixed components of the comanagement agreement; time spent in providing the nonclinical work is compensated at a fixed rate and not at risk for performance.

Improvement services are at risk for performance; if established goals and metrics are not achieved, the services are not compensated. Improvement services are composed of several metrics, each of which has an associated payment if the goal is achieved. Many programs use a balanced scorecard approach to the provision of metrics, including leading and lagging success indicators and goals directed toward operations, clinical quality, and financial metrics.

COMANAGEMENT IN THE CATH LAB

The following matrix overview (Tables 1 and 2) is a simple comanagement model related to a catheterization lab that illustrates the components of a comanagement agreement. In this example, the program has 14 cardiologists, eight of whom are active in the catheterization lab. The comanagement agreement will provide oversight for the operations and performance of two labs at one hospital location and covers all aspects of the lab, including operations, financial performance, and quality performance. The decision-making structure is a catheterization lab operating committee composed of a physician cochair (who is currently the medical director of the lab), two interventionists (one focusing on coronary and the other on peripheral vascular work), and an emergency department physician for the emergent component. As most hospitals participate in the NCDR quality registry for the catheterization lab (NCDR-Cath PCI), the person responsible to populate the registry is an important committee mem-

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SIX KEYS TO COMANAGEMENT AGREEMENT SUCCESS

1. The hospital and the physicians pursuing a comanagement agreement must have a shared vision of success.
2. Physician leadership and collaborating administrators will make or break the program.
3. Diligence is required to determine meaningful performance factors and the most impactful improvement opportunities.
4. A defined structure in which a regular and frequent dialog between physicians and administrators takes place and a collaborative culture is developed.
5. Goals that are clear and have been tested to ensure that performance can be measured accurately.
6. Assessment by appropriate legal and valuation third parties to ensure compliance with laws concerning hospital and physician relationships.

ber; usually that person is part of the hospital quality department.

CONCLUSION

Comanagement provides hospitals and physicians the opportunity to align cardiovascular services and the pursuit of excellence. The comanagement approach to the provision of services facilitates collaboration between hospitals and physicians and provides a runway to improved performance given the anticipated changes to payment models. The comanagement agreement is a win-win proposition in which achievement of the goals results in improved performance that is aligned with the strategic and operations goals of the program. ■

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1. Relman A. Health care: the disquieting truth. The New York Review of Books. September 30, 2010. <http://www.nybooks.com/articles/archives/2010/sep/30/health-care-disquieting-truth>. Accessed January 14, 2015.