Hospital and MDs form company for managing surgical services

On-time starts for the first case of the day, which had been running at 38%, shot up to 94% within 1 year. Physicians started to participate in decisions about the block schedule. And when capital budget time came, the physicians sat around the table and decided among themselves on spending priorities.

Sound like a dream? It’s among changes 355-bed Bloomington Hospital in Bloomington, Indiana, saw after it set up a separate limited liability company (LLC) with physicians to manage surgical services. Through a management contract with the company, physicians have the opportunity to manage the hospital’s 14 ORs and related departments.

The hospital pays the company a monthly fee for its services plus rewards for achieving performance goals based on quality, efficiency, and patient satisfaction (sidebar).

“The collaboration has really been remarkable,” says Sharon Ormstedt, RN, BS, CAPA, administrative director of surgical services.

“We now have physicians who see the whole picture. They are taking an active role in scheduling processes and making some difficult decisions about who gets block time, and what release time should be required.” They’ve also helped make some difficult decisions about capital equipment and supplies.

The physician comanagement arrangement is one of a few that have started cropping up in the past few years.

Faced with more pay-for-performance initiatives that require a close working relationship, “it’s imperative that hospitals and physicians find a way to cooperate more effectively,” says Steve Thomas of Health Evolutions (www.healthevolutions.com), Indianapolis, who consulted with Bloomington on the model.

Ron Schmidt, principal with DMI Transitions (www.dmitransitions.com), Cleveland, Ohio-based consultants, says his firm has been developing comanagement arrangements for about 3 years.

Comanagement may be a good option when there is a need to develop collaboration within a short time frame and address issues in a particular service line or area, he suggests.

Comanagement has advantages because it allows physicians to participate with a minimal upfront investment and engages them directly in quality and operational issues, he notes. On the down side, physicians’ return on investment is less than with other alignment models, such as joint ventures, and the contract has a life span of typically 1 to 2 years but is renewable.

“When you have a comanagement agreement with the surgeons, and you agree on the quality and operational indicators, now you have a white coat talking to a white coat,” says Schmidt, meaning physicians begin working directly with one another on these initiatives.

Launching BORMA

Bloomington decided to try the arrangement when it learned of plans to set up a specialty hospital in the area. The hospital’s executives began looking for ways to increase physician collaboration. They developed the comanagement model over several months, working with a task force of surgeons and Thomas as the consultant.

All surgeons, anesthesiologists, podiatrists, and gastroenterologists who did not
have a conflict of interest, such as ownership in a competing surgery center, were invited to join. About 59% of the physicians are participating.

The management company, named Bloomington Operating Room Management Associates (BORMA), has a board of directors that includes the hospital’s CEO and CNO, a medical director, Ormstedt as the administrative director, and 7 other physicians. The chairman, a practicing physician, is appointed by the BORMA board and approved by the hospital. Ormstedt and the medical director and administrative director are paid by BORMA. The nursing staff continues to be hospital employees.

BORMA has committees for cost, efficiency, improvements, management, and employee relations. Each committee includes staff as well as physicians. Performance measures include:

- for quality, the measures of the national Surgical Care Improvement Project (SCIP)
- for patient satisfaction, the hospital’s results from NRC+Picker and the government’s HCAHPS surveys
- for OR efficiency, the hospital’s benchmark results from an OR collaborative led by VHA Inc’s central region.

Source: DMI Transitions. Reprinted with permission.
A shift in collaboration

Ormstedt, who has a dual role as BORMA administrator and a hospital manager, says she has seen a shift in physician collaboration since BORMA was launched in June 2006. “The largest impact is that physicians are arriving on time. They are part of the process now,” she says. “They know they have some control, and I think that’s what’s been so successful.”

The medical director, Charles McKeen, MD, a surgeon, plays an active role. “He’s respected, and he’s here every day,” she notes. “People can talk to him, and they know he’s watching what’s going on, so that’s helping.”

To improve on-time starts, Ormstedt says, “We did a lot of education on what happens before physicians get there and how they could help us get a case started on time.” The team began posting arrival and start times, which helped boost timeliness.

They celebrated incremental improvements. One day, breakfast was served with omelets.

Data is an important tool, Ormstedt notes. “When you have data and you can put it in front of them, it speaks volumes,” she adds. “We were able to identify specific rooms, specific team members, and specific physicians.” Once the data was presented, she says, “everyone took responsibility for it.”

This year, for the first time, at the staff’s request, physicians are participating in staff performance appraisals. Physicians use a written tool to rate the staff on measures such as clinical practice, accountability, decision making, delegation, and communication.

Ormstedt admits she was unsure about the arrangement at first. “But I think my role has been enhanced,” she says. She also finds the physicians have a better sense of her role. “They’re amazed at some of the things I field on a daily basis,” she says.

Legal aspects

Any physician comanagement arrangement must be accompanied by legal safeguards to make sure it doesn’t violate Stark rules and the Anti-Kickback Statute. Thomas advises that the arrangement be reviewed by independent legal counsel. There should also be an independent assessment to make sure physician compensation is based on “fair market value.” The program’s incentives must be based on improvements in service and quality, not on physician referrals or the amount of business a physician brings in.

For example, BORMA physicians are not prohibited from practicing at competing facilities, though they may not have a management or ownership interest in competing entities. Also, the physician compensation method was reviewed by an independent valuation firm to make sure it was based on fair market value. The program’s incentives must be based on improvements in service and quality, not on the value or volume of physician referrals.

Carrie Fairfield, business development manager for DMI Transitions, says such arrangements can be created to fit within the Stark personal services exception and the personal services safe harbor under the Anti-Kickback Statute. Both have specific requirements that must be met.

Recently, the Centers for Medicare and Medicaid Services (CMS) proposed severe limits on many Stark exceptions. The proposal is part of the proposed 2008 Medicare physician fee schedule published July 12.

But the changes as proposed probably wouldn’t affect this type of physician comanagement, says Nora Liggett, JD, a partner with the law firm of Waller Lansden Dortch & Davis, Nashville, Tennessee.

Though the arrangements have to be structured correctly, Schmidt says they can be an effective way of forging collaboration. “If you can get your key surgeons in a comanagement agreement working with you, they see that you have established goals, and they get paid for their time, they are going to come to the table, especially when they see the benefit of it,” he says.
Models for hospital-MD collaboration

Are there ways for hospitals and physicians to work together more closely? MedPAC—the Medicare Payment Advisory Commission, which advises Congress—is discussing what policy changes might be needed to encourage collaboration. Some current models:

• Hospitals paying community physicians for clinically related services, such as serving as medical director of a service line, coming to committee meetings, or taking emergency room call
• Hospitals and physicians forming comanagement arrangements
• Hiring physicians as full- or part-time employees, such as hospitalists
• Joint ventures such as imaging centers, ambulatory surgery centers, or specialty hospitals
• Gainsharing, carefully structured arrangements where hospitals and physicians share savings from projects that reduce costs and improve quality
• “Virtual” gainsharing, more informal projects in which hospitals and physicians collaborate to streamline care and reduce costs, but any savings go to indirect benefits for the physicians, such as capital equipment, rather than direct payments.