It is well known in the industry that the historical relationship between radiologists and cardiologists has been strained around the area of cardiovascular imaging, with both specialties vying for ‘control’ of that clinical and business platform. Many Chief Executives and Chief Medical Officers can tell tales of vehement turf battles and sometimes relentless political posturing between the two specialty groups. But, the relationship doesn’t necessarily have to play out that way. In fact, Corazon believes that a truly collaborative working arrangement can be developed, beginning with a strong foundation of trust and shared goals between the two ‘sides’ of this proverbial fence.

If, over the years, internal solutions have been unable to bring these two parties together, external factors may have, to some degree, saved the day in recent years. Radiologists and cardiologists now face the same (or similar) regulatory changes, which will demand a level of cooperation between these physicians far beyond that which currently exists.

Indeed, throughout the country, healthcare reform, declining reimbursements and increasing scrutiny around appropriate utilization has helped drive the development of “real time” clinical and business alliances between the two specialties. Evidence exists that today’s healthcare leaders, radiologists, and cardiologists are now experiencing dramatic changes in their traditional thinking around cardiovascular imaging…political barriers are collapsing and true collaborations are taking shape. It is now possible to attain what has long been thought impossible! Mostly through focused planning efforts, clear and direct communication, and dedicated focus to creating a model that works for all involved, especially for the patient.

With the leveling of the playing fields, the benefits of the new collaborations are undeniable:

- More efficient testing for smoother through-put
- Improved communications among practitioners
- More effective clinical decision-making
- Better utilization of resources for cost-savings
- Better overall patient care “experience”

Even more specifically for the patient, the new collaborations can render less radiation exposure, less risk, and less expense.

Still, achieving true collaborative practice brings with it a myriad of challenges. So, how have hospitals, health systems, and the key physician specialists accomplished this dynamic change?

Collaboration, of course, is much easier said than done. In order for the collaboration to be successful, radiologists and cardiologists must be willing rethink their training and both traditional and current practice behaviors. In essence, physicians must be asked to shed their ‘egos’ in the interest of the greater good.

Sometimes it’s just a matter of bringing the parties together and outlining the fair and reasonable benefit logic of the proposed collaboration juxtaposed against the “rules of the game” in today’s new and competitive healthcare environment. Bringing the parties together to face the inevitabilities of accountable care organizations (ACOs), vertical integration, global billing, and new payment paradigms can sometimes lead to that Oprah-esque “Ah ha” moment! Often times, however, it takes a bit more effort…

Building a Foundation – The Clinical Institute Model

Radiologists and cardiologists need a solid clinical and business structure that allows them to join forces relative to the design, development, and deployment of a collaborative practice model, with imaging as a starting point.

As the transition to a collaborative model moves from initial planning phases towards more of a reality, expert consulting and legal services may in order. Multiple, viable physician collaboration options do exist, but more than often, that model comes to fruition in the form of a hospital-sponsored Clinical Institute with a Co-Management Agreement – the model Corazon most recommends for such a scenario.

As a service line-driven structure, the Clinical Institute Model serves to blur the distinction between specialists, and patients are referred to a program rather than an individual physician. The model encourages evidenced-based best practice, and physicians benefit from monitoring patient care from a more global perspective, both clinically and financially, preparing them to compete in the new outcome-driven healthcare economy where quality is king.

The Institute model also allows the sponsoring hospital to create an economic model in which physicians benefit from joint efforts that enhance quality and efficiency, which likewise leads to a focus on streamlined care delivery. In essence, the sponsoring hospital encourages collaboration by minimizing the financial competition between the radiologists and cardiologists – better clinical care can lead to better financial outcomes for both the hospital and the physicians.

In the traditional Institute model, the hospital and physicians create a charter or bylaws for the model, detailing the Institute’s organizational and membership structure, as seen in the diagram on the following page.
The new Institute and the physicians enter into individual membership agreements, detailing the rights and obligations of membership. Usually, to be eligible for membership, physicians must hold active hospital medical staff membership and unrestricted clinical privileges in one of the Institute’s subspecialties.

Membership duties and responsibilities are detailed in written agreements that also include statements on benefits of membership, any non-compete covenants and conflict-of-interest statements, and statements regarding how the Institute will be marketed to the community and referring physicians. The agreement should also detail the fair market hourly compensation that physician members will be paid for any administrative services they provide to the Institute, any research-related compensation, and/or compensation for rural outreach activities.

With an embedded Co-Management Services Agreement in the model, physician members of the Institute may also be eligible for fair market value incentive compensation based on meeting and/or exceeding pre-determined goals for clinical delivery and patient outcomes. A Co-Management Institute Model is depicted in the diagram below.

In creating a co-management Institute, the sponsoring hospital must be willing to implement and maintain the Institute business structure, create a transparent culture for information sharing, and commit to a capital and operating budget to support the Institute’s infrastructure. The hospital should also provide corporate services such as: payor contracting, expert marketing, and information systems and decision support systems. As the hospital and physicians evolve, adherence to clinical, operational, and service protocols and standards may become more complex – setting the standards up-front and in the early phases works well to establish the foundation of basic operating rules, which is not to say the terms cannot be adjusted as the Institute matures.

In fact, a collaborative model between cardiologists and radiologists can and should be flexible, changing as needed as time passes. The model chosen between these or many other viable options should be structured in a way that allows for reasonable changes with agreement from all parties. In fact, the best arrangement contracts are the ones that have the structure necessary to be sound, but the fluidity necessary to remain relevant as the program evolves and matures.

For their part, the physicians are expected to evolve their relationships and meet participation criteria; be active members in good standing with the hospital medical staff; perform a minimum number of cases as necessary to measure quality and outcomes; attend meetings; achieve performance metrics; assist in the development of Institute programs and services; and participate in philanthropic, research and educational initiatives. Physicians will also be expected to evolve and adhere to clinical, operational, and service protocols and standards such as:

- Standardized clinical protocols
- Utilization management initiatives
- Outcome management and reporting
- Guidelines for outcome reporting, inclusive of documentation requirements (ACC, STS, CCORP)
- Program development
- Cost management
- Patient satisfaction goals
- CMS-mandated requirements and professional association best-practice standards

Many Institutes are comprised of physicians representing all major cardiac, radiology, vascular, and electrophysiology services with the aim of optimizing the patient experience. Ultimately, most Institutes move beyond cardiovascular imaging and move to create clinical platforms whereby interventional radiologists, cardiologists, and surgeons jointly develop best-practice protocols, policies, procedures, and credentialing criteria for all CV services, inclusive of all interventional suites.

This is an unavoidable trend, driven by the current healthcare environment and by the fact that no one specialty has the needed composite skills to clinically build and financially support the hospitals Institute infrastructure. The future is sure to produce even more challenges as the blurring of roles continues. For example, cardiovascular specialists may seek to do renal angioplasty and endovascular procedures in the extremities. Vascular surgeons and cardiologists may be performing procedures that once fell almost exclusively to the interventional radiologist. On the other hand, radiologists may see their practices evolve to more direct patient care through their engagement in vascular clinics and outreach and also through cardiology and vascular surgery clinical rotations.

No doubt the payors will begin to demand a higher level of integrated service and physicians and hospitals will have to find a way to provide them. Likewise, patients, who are increasingly savvy about choosing healthcare in this internet age, will no doubt
demand a more positive overall care experience. Hospitals and physicians working together – regardless of the model chosen – to achieve a myriad of goals, whether clinical, financial, or operational, is a hallmark of top-tier, high-performing programs.

And just as the key components of healthcare reform begin to roll-out, the industry focus on quality and outcomes, along with tightening reimbursement across many service lines, is not likely to end any time soon. Indeed, the delivery of high-quality, low-cost healthcare will be a shared responsibility between the hospital and physicians AND among physicians in multiple specialties for decades to come.

Bruce is a Vice President at Corazon, Inc., a national leader in strategic program development for the heart, vascular, neuro, and orthopedic specialties. Corazon offers a full continuum of consulting, recruitment, interim management, and physician practice and alignment services for hospitals and health systems across the country and in Canada. To learn more, visit www.corazoninc.com or call 412-364-8200. To reach the author, email bpayton@corazoninc.com.