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Physician Clinical Alignment and Integration: A Community–Academic Hospital Approach

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EXECUTIVE SUMMARY

An overwhelming need for change in the U.S. healthcare delivery system, coupled with the need to improve clinical and financial outcomes, has prompted hospitals to direct renewed efforts toward achieving high quality and cost-effectiveness. Additionally, with the dawn of accountable care organizations and increasing focus on patient expectations, hospitals have begun to seek physician partners through clinical alignment. Contrary to the unsuccessful alignment strategies of the 1990s, today's efforts are more mutually beneficial, driven by the need to achieve better care coordination, increased access to infrastructure, improved quality, and lower costs.

In this article, we describe a large, academic, tertiary care hospital's approach to developing and implementing alignment and integration models with its collaboration-ready physicians and physician groups. We developed four models—short of physicians' employment with the organization—tailored to meet the needs of both the physician group and the hospital: (1) medical directorship (group physicians are appointed to serve as medical directors of a clinical area), (2) professional services agreement (specific clinical services, such as overnight admissions help, are contracted), (3) co-management services agreement (one specialty group co-manages all services within the specialty service lines), and (4) lease arrangement (closest in scope to employment, in which the hospital pays all expenses and receives all revenue).

Successful hospital–physician alignment requires careful planning and the early engagement of legal counsel to ensure compliance with federal statutes. Establishing an integrated system with mutually identified goals better positions hospitals to deliver cost-effective and high-quality care under the new paradigm of healthcare reform.

For more information about the concepts in this article, contact Dr. Salas-Lopez at debbie.salas-lopez@lvhn.org.

BACKGROUND

There is an overwhelming need for change in the U.S. healthcare delivery system. Declining revenues and thinning operating margins are driving hospitals to further concentrate their focus on quality, costs, volume, and growth. Both hospitals and physicians are feeling the pressures of heightened patient expectations and the need to improve clinical and financial outcomes. To properly address these concerns, the way in which hospitals and physicians view each other must change.

This pressure to change is nothing new. In the past, hospitals viewed physicians primarily as customers, providing unnecessary frills and unchecked autonomy. Then, in recent years, as more inpatient services shifted to the ambulatory setting, hospitals began to view physicians as competitors. Presently, with the dawn of accountable care organizations (ACOs) and an increasing focus on patient expectations, hospitals have begun to align with physicians as partners (HFMA, 2011). With the healthcare cost crisis looming, hospitals must seek methods of alignment that control costs without sacrificing quality of care (Kellis & Rumberger, 2010). An aligned physician medical staff committed to mutual goals and shared accountability helps ensure continued high-quality healthcare delivery in the ACO climate.

The physician-hospital alignment model gaining the most momentum is the employment model, in which hospitals acquire physician practices and hire physicians in the community. This practice is similar to the large-scale physician employment and

consolidation trend that hospitals experienced in the 1990s—a strategy designed to increase admissions in an attempt to protect themselves from the threat of reduced payments. The impetus for integration in the 1990s was purely economic; the strategy, based simply on acquisition, was largely unsuccessful (Harbeck, 2011). Today, alignment models are more mutually beneficial, driven by the need to establish collaborative relationships that focus on patient-centered care to improve quality and reduce costs. Additionally, physicians today are more inclined to pursue employment. Payment cuts and redesign, infrastructure costs, and the complexity of operating a physician practice have steered physicians toward the hospital employment model (Harbeck, 2011).

In response, hospitals are taking inventory—of the physician practices in their markets, the needs of their community populations, their market shares, and their competitors (Harbeck, 2011). The new ACO environment challenges hospitals and physicians to join forces, focusing on strategies that are outcomes driven and that increase value to patients. To that end, hospitals need to develop and maintain strong relationships with their physicians. As not all physician practices are interested in being acquired (i.e., employed), hospitals must offer alternate strategies to align physicians on their medical staffs. Equally important, progressive hospital systems are seeking out physicians and physician groups with proven records of excellence and thus capable of authentic collaboration. The formula for successful integration requires

prioritizing cultural compatibility and setting clear expectations for achieving shared goals and ideals.

In a study of 11,000 physicians in 69 medical groups, Budetti et al. (2002) found that many health systems did not align well with physicians. Even with a clear commitment to alignment, the hospitals did not pay adequate attention to the issues of importance to physicians, resulting in missed opportunities. The present article describes several models of clinical alignment and integration—short of physicians' employment with the organization—that were implemented at our large, community/academic health network with success for both parties. The stakeholders involved became interconnected parts of a hospital system that shared a common strategy, culture, and vision.

ALIGNMENT CONSIDERATIONS

Defining Clinical Alignment and Integration

Hospital-physician alignment can be very complex and requires a well-thought-out strategy prior to implementation. For many physicians, especially those who have been practicing for several years, participation in an alignment initiative requires a change in the way they perceive themselves and their practices (HFMA, 2011). A balance, precarious at times, of independence and interdependence between the hospital and physicians must be maintained. In the past, quality healthcare could be provided by a single physician operating independently; however, as healthcare has become more advanced

and specialized, physicians must collaborate in order to provide high-quality care (HFMA, 2011). Likewise, hospitals need to engage physicians as new models of care delivery evolve that focus on quality and efficiency (Kellis & Rurnberger, 2010).

Clinical alignment and integration agreements are refreshing alternatives to employment. They appeal to the many physician groups that prefer to retain moderate autonomy but are willing to dedicate themselves to one hospital to improve care and contain costs. The essence of clinical alignment and integration is an agreement between a hospital and physicians (or physician practices) to commit to delivering evidence-based care and improving quality, efficiency, and coordination of care while paying attention to costs. Metrics and targets that are designed to influence the clinical practice of all physicians and improve value for patients are supported by data-driven mechanisms and processes by which to monitor and manage utilization of healthcare services. Such agreements are tailored to the scope of the physician practice and the needs of the hospital while offering financial incentives to physicians to achieve mutually agreed-on goals.

We describe the efforts of a large, academic, tertiary care hospital in Pennsylvania that serves more than 800,000 people living in three area cities and their surrounding communities. Three campuses comprise the hospital, totaling nearly 1,000 beds, with 70,000 admissions and 175,000 emergency department visits in 2012. The hospital retains a physician medical staff of

1,200 plus 530 advanced practice clinicians (nurse practitioners and physician assistants). Of these, 900 are employed and an additional 172 are clinically aligned with and integrated into the hospital.

In response to organizational and physician practice needs, a team of senior leaders developed several different alignment and integration models to determine the most mutually beneficial agreement between physicians or practices and the hospital. Four agreement options were defined: medical directorships, professional services agreements, agreements for direct contract services and co-management of service lines, and a physician/practice lease arrangement.

Physician-Partner Attributes

Deciding which physicians with whom to align is as critical as the model chosen (Thomas, 2009). Prior to determining which model best suited a particular physician group, the

leadership team assessed the group’s level of readiness for alignment and integration. Key attributes, identified as being requisite for success (Table 1), had to be in place before discussions began. As conversations evolved, we found that successful alignment required commitment to and patience with the process, a common vision, and a robust relationship between the hospital and the physician group. A key aspect of identifying and resolving any differences between hospital and physician group strategies was selecting strong, respected hospital clinical leaders to drive these discussions. Once core attributes were identified and cultural fit ascertained, the next step was to choose the right model for the physician partner.

Because our hospital has a long-standing culture of collaboration with physicians, we were able to establish trust early by listening to the physician groups, identifying the most capable group leaders, and selecting groups known by reputation for their clinical

TABLE 1
Core Attributes Necessary for Clinical Integration and Alignment

Physician-Partner Attributes	Description
Commitment	Demonstrated loyalty to each other Commitment to achieve mutual goals that address community needs
Cultural Fit	Complementary characteristics Compatibility for future goals
Engagement	Shared urgency to achieve greater access, improve care, and lower costs
Relationship	Strong relationship predicated on trust Collective strengths as a framework on which to build Mutual values for the future

quality of care and practice performance. Discussions focused on how best to provide high-value care to our mutual patients and, equally important, needed to progress over time so that a formal plan could be thoughtfully developed and executed. It was crucial to not allow hospital politics to stall or inhibit the plan of action; to that end, we strived to repair hospital-physician relationships when necessary and took ownership of past failures.

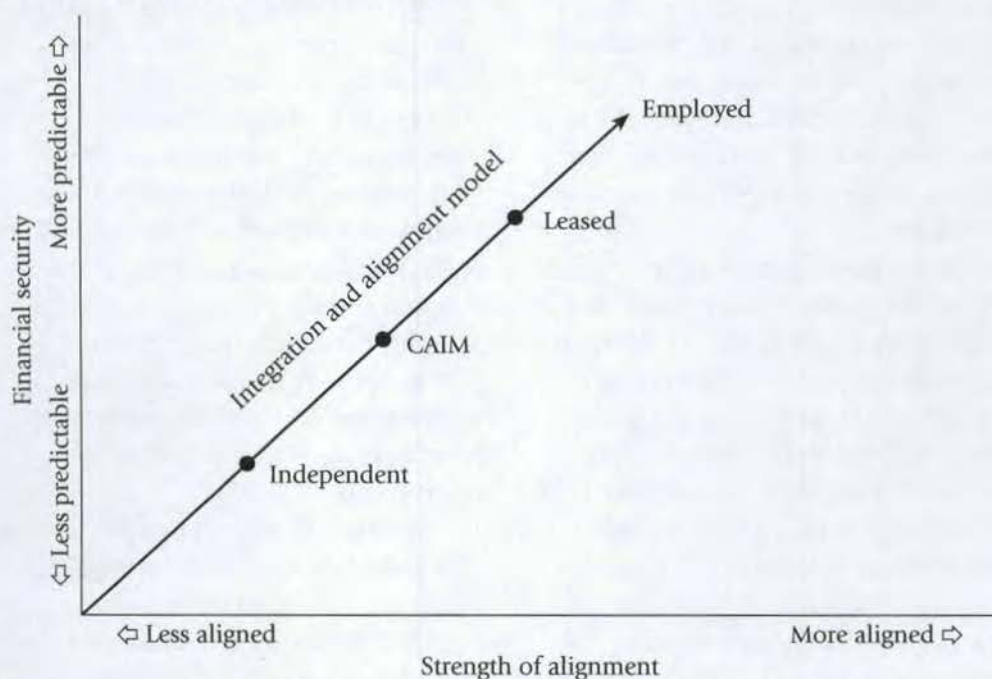
To assure physicians of its commitment to reaching a mutually beneficial agreement, the hospital invited its potential collaborating physicians to a seat at the alignment discussion table. Reinforcing its message of partnership in the organization and the importance of collaboration, the hospital actively and

publicly addressed those physicians who were not yet on board. Making tough decisions to not engage reluctant physicians built true enthusiasm for new and varied terms of partnership for those physician groups that were ready to engage with the hospital.

MODEL SELECTION PROCESS

Comprehensive clinical alignment and integration can be achieved in several ways, using different models that are tailored to meet the needs of both the physician group and the hospital. As each model confers differing degrees of commitment for alignment and integration and financial security (short of employment), the model chosen should be based on the readiness and willingness of the physician group (Figure 1).

FIGURE 1
Model and Strength of Alignment and Integration



Note. CAIM = clinically aligned and integrated models.

In the following paragraphs, we describe our application of the four models.

Medical directorship. In this model—the simplest in terms of structure and the easiest to execute—our hospital contracted with one specialty group to appoint group physicians to serve as medical directors of a clinical area and as leaders of that clinical service line. The medical directors' duties and functions specific to the service line were outlined, and the requisite skills were sought within the group. Clear roles and responsibilities were mutually agreed on. These responsibilities were framed around the five pillars of the organization—people, service, quality, cost, and growth (Table 2)—with an estimated minimum time requirement of 1–4 hours per week to oversee each defined area. Medical directors met with their respective teams monthly and with network leadership on a quarterly basis to track progress and address any challenges. In addition, ongoing periodic reviews were conducted to ensure that all deliverables were being met. All payments for the medical director services were based on fair market value.

Professional services agreement. This model proved useful when a specific clinical service was needed. As an example, our hospital contracted a primary care group to cover the hospital admissions at night to help ambulatory primary care physicians with their overnight admissions. Metrics (shown in Table 3) were set for quality, including physician and patient satisfaction with quality of care; in addition, ongoing monthly meetings were held to gauge progress on meeting established deliverables.

Co-management services agreement. In this model, our hospital contracted with one specialty group to help the hospital co-manage all services within the specialty service line. A management committee, consisting of hospital administrators and physician leaders, retains oversight of the agreement and established quality goals (see Table 3), educational efforts, research goals, and service goals. The selection of physician leaders was mutually agreed on, clear roles and responsibilities were outlined, and metrics were set for measuring success. Ongoing monthly meetings were held to ensure that all agreed-on deliverables were being met. All payments under the agreement were based on fair market value.

Lease arrangement. This model, the closest to employment in scope and function of those we developed, has proven to be the most complex and difficult to execute and sustain. A large primary care group's physicians, staff, and offices were leased, and the hospital paid for all expenses of the practice, including salaries of physicians and staff, and received all revenue. Operations were managed by the hospital, and leadership was appointed from both the hospital and the physician group. Monthly meetings ensured that the operations were meeting the needs of both parties. All payments under the lease agreement were based on fair market value.

The practice lease option is a reasonable consideration when the physician group wants to grow closer to the hospital but desires an interim solution and "dating period" before making a final commitment to employment. This

TABLE 2
Medical Director Functions

Duties	Description	Metrics
People: Team development	Develop the service line team members in areas such as quality improvement, patient satisfaction, leadership, scholarship, teaching, and research.	People enrolled in network leadership activities; people enrolled in external programs such as the Institute for Healthcare Improvement Learning Modules, faculty development, and other teaching scholarship activities
Service: Patient-centered experience	Lead efforts to enhance patient satisfaction and the patient experience within the service line.	Patient satisfaction scores for the unit; number of service excellence patient complaints; number of initiatives implemented to improve satisfaction with care
Quality: Quality improvement and quality assurance leadership	Lead efforts to improve quality of care, implement evidence-based and standard practices, and review quality assurance protocols.	Number of quality improvement initiatives developed and implemented; number of quality assurance cases reviewed and corrected Process and outcome measures and scores for unit, including Core Measures, morbidity and mortality, readmission rates, and infection rates
Cost: Value-based care	Ensure service line participation in optimizing care and value-based care for patients.	Expense per adjusted admission; evidence of value-added cost control measures; number of cost control initiatives developed and implemented, such as on-time start and appropriate documentation
Growth: Strategies for growth	Work collaboratively with network leaders on unmet community needs, growth opportunities, and innovative strategies for the future.	Number of initiatives developed and implemented in the community

TABLE 3
Quality Goals and Metrics

Quality Goal	Metrics
Patient satisfaction	Press Ganey scores HCAHPS scores
Core Measures (percentile rank)	Ventilator-associated pneumonia Surgical site infections Catheter-associated urinary tract infections Central line-associated bloodstream infections Glycemic control
Patient readmissions	Readmission rate
Care coordination	Attainment of patient-centered medical home status or equivalent initiative to improve care coordination and greater access to care
Clinical care pathways	Use of clinical care pathways and evidence-based guidelines to provide care
Emergency department diversions	Number of hours the emergency department must divert ambulances to another hospital due to long wait times
Quality improvement	Active participation in quality improvement initiatives

Note. HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems.

alternative provides revenue stabilization to the physicians in the form of a dollar per work relative value unit (\$/wRVU) payment, as well as downside shelter from rising practice expenses. For this model to work economically for the hospital, the negotiated fair market value payment rate should be less than the \$/wRVU rate used in the full employment model. The lease arrangement model requires substantial effort; to avoid expending even more energy on executing this model, a joint vision for the next step in the relationship—full employment—should be created as early as possible in the lease term.

AGREEMENT IMPLEMENTATION

Metrics

The most challenging part of the alignment agreement, irrespective of the model, is deciding with the physician partner on appropriate metrics. The metrics chosen should be important to both parties; must be trackable; and, most importantly, must adhere to all regulatory guidelines in the development, monitoring, and reporting of performance.

Initial discussions should focus on goal setting and metrics as high priorities and shared responsibilities. In

addition, it is important to address expectations surrounding the established goals and metrics: determining how often to review roles and responsibilities, gauging the successful maturation of the relationship, and measuring deliverables to ensure that goals are met. Furthermore, metrics around quality must be agreed on, must be meaningful to both parties, and must focus on excellent patient care. Quality goals should be evidence based and seen as essential to improving quality and lowering costs.

As a first step in defining benchmarks for our alignment agreement, we conducted a thorough review of our opportunities as a hospital system. We obtained baseline metrics for the agreed-on quality goals and determined what data to collect in order to track the group's performance. Of equal importance, we explored the degree of experience that our physicians had with performance metrics and ascertained their desire to learn more about quality improvement. Choosing metrics, including prevention and management of chronic diseases and patient satisfaction with care, that appealed to the physician group was a major consideration.

The traditional metrics of the Physician Quality Reporting System (CMS, 2011), Healthcare Effectiveness Data and Information Set (HEDIS) (NCQA, 2011), and the Centers for Medicare & Medicaid Services Core Measures were included as part of the selected metrics; however, these alone were not sufficient. Our hospital also strived to raise the quality bar by developing specialty-specific quality initiatives and identifying other quality

metrics needed to ultimately improve outcomes, lower costs, and transform care delivery in our hospital system.

Legal Oversight

Hospital-physician alignment strategies are highly complex and, as such, require careful scrutiny to be sure they comply with the Stark and anti-kickback statutes (HHS, 1991, 2004) and do not violate antitrust or tax exemption regulations. Legal counsel must have an understanding of and experience in healthcare law as well as the skills and passion for developing solutions and models to facilitate a healthy hospital-physician dialogue. The legal team should be involved in early discussions, communicate to all participants the legal requirements affecting the proposed alignment strategy, and quickly identify and resolve issues on any elements of the proposed agreement that may not comply with applicable laws.

Clay and Bruton (2012) name several indicators to evaluate when exploring affiliation. Building on their key points, we identified the most critical issues to consider when laying the groundwork for our clinical alignment and integration agreements. Generally, we have found that the agreement is not acceptable to one or both parties (and therefore not entered into) unless the following key issues have been addressed.

Structure. The structure of the clinical alignment and integration can take several forms: (1) direct contract between the hospital and one or more physicians or physician groups, (2) lease of the physicians and offices, or (3) formation of a joint venture

management company owned by both the hospital and the physician group. A decision must be made as to whether a management board, composed of both hospital and physician group representatives, will be established. If so, the board's duties, areas of authority (budgets, business and strategic plans, marketing, staffing, equipment and supplies selection, managed care contracting, licensure/accreditation, quality review), and matters requiring supermajority board approval need to be determined.

Scope of services. It is important to define early on what clinical services are covered by the agreement, including inpatient, outpatient, ancillary, and multisite services.

Term. The hospital and physician group need to establish whether the clinical alignment and integration strategy will be a long-term arrangement with limited exit rights (for cause) or a trial arrangement that might include termination rights, either without cause or following an initial trial term. If the hospital has outstanding tax-exempt bond financing of its physical plant or equipment under the independent physician group management, the term of any management agreement with the physician group could be limited, based on Internal Revenue Service Management Contract standards (IRS, 1997).

Dispute resolution process. The parties must decide on an internal dispute resolution process and whether arbitration/mediation or litigation follows a failure of the internal process to resolve the dispute.

Exclusivity. The hospital and physician group need to determine if the

physician group will be the exclusive provider of the applicable medical director, professional, and service line management services or if other physicians or physician groups on the medical staff might be allowed to provide some of these services as well.

Noncompete terms. The hospital must decide if the aligned physician group may provide similar medical director or service line management services at other hospitals or medical facilities and, if so, outline the geographic scope and terms of compliance (duration of the clinical alignment and integration agreement or 1–2 years posttermination).

Compensation. There are typically two levels of compensation under a clinical alignment and integration agreement. The first level is a fixed annual fee that is based on the fair market value of the time and effort of the participating physicians to manage and oversee the service line. Services represented in this first level might include medical director services, budget services, strategic planning, community relations and education, development of clinical protocols, ongoing assessment of work-flow processes, physician staffing, patient scheduling, staff supervision, case management activities, medical staff-related activities, and committee participation.

The second level of compensation is typically a bonus or an incentive fee for shared savings or quality performance, that is, predetermined payment amounts contingent on the achievement of specified, mutually agreed-on, and objectively measurable service line

quality improvement and efficiency goals, such as patient satisfaction scores, turnaround times, room utilization, return-to-operating room rates, or mortality rates.

Both the base fee and the shared savings/quality performance fee must be fixed, fair market value amounts.

Because of the regulatory issues posed by clinical alignment and integration agreements, it is strongly recommended that the parties obtain an independent fair market value appraisal of these fees before the agreement is finalized.

Current regulatory guidance on shared savings and quality performance programs is available through Office of Inspector General (OIG) advisory opinions on specific gain-sharing arrangements as well as in a CMS proposed exception to the Stark laws for incentive payment and shared savings programs (GPO, 2008). The CMS exception and 14 separate advisory bulletins, ranging from 2001 (OIG, 2001) through 2009 (OIG, 2009), included the following safeguards:

1. Document the quality or cost savings measures and targets with specificity.
2. Identify independent medical evidence that incentives do not adversely affect patient care; conduct independent medical reviews to ascertain impact on quality.
3. Impose no limitation on the physician's ability to order tests, treatments, or specific supplies.
4. Apply the program to all patients.
5. Apply reasonable caps on incentives, establish floors on cost savings, and

rebase all targets in subsequent years to reward only new savings.

6. Pay incentives to participating physicians on a per capita basis.
7. Set the term of the incentives to between 1 and 3 years.
8. Disclose the payment of incentives to patients.

Although neither the OIG opinions nor the CMS exception contains specific approved performance measures, the following incentives, if properly structured, could meet regulatory concerns: (a) increases in patient satisfaction scores; (b) decreases in turnaround times; (c) increases in on-time starts; (d) increases in room utilization, if not tied to "quicker-sicker" discharges; (e) decreases in supply costs per case, if not tied to limiting physicians' choices; (f) decreases in infection rates; (g) decreases in readmissions; or (h) decreases in mortality rates.

The OIG and CMS consider compensation on the following measures suspect: (a) increases in utilization, (b) increases in revenues or margins of the service line, (c) changes in case mix, (d) changes in acuity, or (e) decreases in length of stay. Because there is little regulatory guidance on incentive programs, the parties may want to obtain an advisory opinion from the OIG on the acceptability of the specific shared savings/quality performance measures selected.

Tracking the Work

For our alignment initiative, each clinical alignment and integration agreement was formally signed and

celebrated in the office of the hospital's president/CEO with members of the collaborating physician group. This formal observance not only gave all participants the opportunity to reflect on and share their thoughts and hopes for the future but also created a sense of collegial ownership of the process.

Monthly meetings were convened with a predetermined group of stakeholders to ensure that the work started and stayed on schedule. Stakeholders included individuals capable of tracking and interpreting data who were also skilled in using information technology to help automate the metrics where possible. Meetings included sharing and discussing goals with the potential to result in cost savings.

Early successes were celebrated, with every effort made to include other staff members (e.g., unit nurses, directors of service lines) who were involved in accomplishing project goals. Thus, we created a halo effect for others who might be considering alignment and integration while also raising awareness of the importance of improving quality and lowering costs. Successes were defined as achievement of quality goals, higher patient and physician satisfaction scores, improved readmission rates and transitions of care, and other patient-centric metrics.

Setbacks were dealt with swiftly and expeditiously. One challenge we faced was a particular physician group's loss of interest in continuing to provide the agreed-on services and work. In this instance, under the terms of the agreement, the group was notified of the hospital's intention to terminate the agreement. This timely and decisive

action allowed both the hospital and the physician group to reconsider their choices. We continue to assess the success of each alignment model for ongoing process improvements and readjustments. A future article will focus on the measurable outcomes and lessons learned from each model.

Lastly, any agreement is predicated on the continued strength of the relationships; trust between the parties; and, despite the inevitable challenges, a commitment to work toward common goals. If these basic foundations are compromised, it becomes difficult to accomplish the objectives of the agreement, thwarting the integration effort.

CONCLUSION

We are living in a time of uncertain economics characterized by the increased use of healthcare by baby boomers, a new physician philosophy of work-life balance, and an unprecedented mandate for healthcare reform. Together, these factors have created a "perfect storm," and hospitals and physicians must explore mutually beneficial ways in which to work together in order to weather that storm.

Some observers believe that the voluntary (independent) medical staff model will continue to decline and is not suited to improving quality or controlling the costs of medical care (Casalino, November, Berenson, & Pham 2008). The Healthcare Financial Management Association (2011) suggests that hospitals take into consideration "market analysis, goal setting, physician leaders/champions, data sharing, compensation incentives, engagement/cultural blending, technology, and

process improvement" when weighing in on an integration strategy.

While some hospitals have begun to employ and acquire more physician practices, alternate alignment models also have value. Hunter and Baum (2013), in their article on "employment lite" as an alternative to full employment, present four variations on the professional service agreement model. The clinical institute model offers a single service to deliver best-practice, evidence-based care (May, 2011). One integrated delivery system in Louisville, Kentucky, chose to implement a "soft integration" model: a matrix structure in which service lines cut across hospitals. While acknowledging matrix system challenges, which can impede swiftness of change, participants affirm that it drives "true collaboration and . . . higher-quality decisions" (Kreindler et al., 2012).

Successful alignment and integration of hospitals and physicians requires careful planning, a comprehensive strategy, mutually identified goals, and an intentional approach to create a truly integrated delivery system that is well poised to deliver high-quality, cost-effective care under the new paradigm of healthcare reform. It also must be aided by policy makers, who need to reconsider current policy restrictions on physicians' and hospitals' ability to work together (Berenson, Ginsburg, & May 2007). It is imperative that healthcare leaders take a fresh look at how hospitals and physicians align themselves to contain costs and continue to achieve financial success in today's environment. Clinical alignment and integration efforts are gaining momentum, but they

must be executed within the framework of our regulatory boundaries.

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PRACTITIONER APPLICATION

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The time has never been more critical to rethink the physician-hospital relationship, as the system profiled in this article has done. Shrinking inpatient volumes, the advent of multiple competitors in the outpatient arena, and the need to reduce cost and utilization require hospitals and physicians to collaborate as never before for mutual benefit.

While health systems may say they learned from the mistakes of the 1990s, many are going down the same path and are destined for the same result. Competition for volume often drives systems to rush to align with physicians so as not to lose them or their patients. In fact, many organizations in our particular market are "collecting" physicians to create scale and mass without considering goals, fit, and performance. This trend will only lead to dissatisfied partners trying to figure out how to unravel their relationship.

Of importance are several of the well-articulated priorities noted by the authors' health system:

- Establishing clearly defined and measurable hospital/health system goals.

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