Evolution of Physician-Hospital Alignment Models: A Case Study of Comanagement

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Abstract

Background Recently, quality, financial, and regulatory demands have driven physicians to seek alignment opportunities with hospitals. The motivation for alignment on the part of physicians and hospitals is now accelerating because the new paradigm under healthcare reform requires an increased focus on improving quality, cost, and efficiency.

Questions/purposes We (1) identify the key drivers for physician-hospital alignment models; (2) summarize comanagement as a physician-hospital alignment model; and (3) explore a detailed case study of comanagement as an option to better align physicians with hospital goals on quality, safety, and outcomes.

Methods A Medline abstract review was performed that identified 45 references that discuss options for physician-

hospital alignment. None of the articles identified provide a detailed example of successful alignment structures. A detailed case study of a successful comanagement alignment program is reviewed.

Results The key drivers for alignment are inpatient growth rates, declining reimbursements, and the opportunity to improve quality, decrease costs, and increase efficiency. Two general strategies of alignment involve noneconomic and/or economic integration. In our example, comanagement with economic integration was chosen as the preferred structure for physician-hospital alignment.

Conclusions The choice of structure will vary depending on the existing relationships and governance of the hospital and the physicians in the targeted area of focus. The measure of success in building physician-hospital alignment is measured in improvements in care for the patient, reduced cost of care delivery, and improved relations between physicians and hospital leadership.

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Introduction

The national dialogue about healthcare and payer reform has expedited the transformation of organizational structures and governance models to align with the critical success factors defined by this new environment. New payment models such as pay-for-performance and bundled payments are just a few of the examples within reform that are driving closer alignment between physicians and hospitals. Continued payment reform will shift the risk from consumers and payers to providers. Payment reductions to primary care and specialists along with the economic challenges in this country have created compounding factors that further create the key drivers for different alignment models. These new alignment strategies will require us to look beyond the

historical structure and governance models and create forums for providers and healthcare leaders to define common goals around quality, cost, and efficient care delivery that will lead to improved patient care.

The historical physician-hospital relationship was characterized by unique, symbiotic interdependence in which two parties had compatible incentives to increase the volume of care using the latest and most expensive technology while maximizing the professional autonomy of the physician [10]. The professional autonomy was reinforced by a reimbursement system that ignored the interrelatedness of the actions of physician and hospitals and the costs incurred. A difference in the alignment strategies from prior decades requires leaders to focus on defining performance metrics that are related to the payer models that much more closely align with quality, cost, and efficiency.

Prior studies on traditional forms of physician-hospital interaction such as shared decision-making have documented effects on patient outcomes. In 2000 Kohn [8] found that although some physician-hospital organizations accepted full risk and played a major role in hospital quality improvement activities, other organizations have been less aggressive in setting up alignment models to address quality improvement. Cueller and Gertler [2] took data from three states from 1994 through 1998 to examine the effects of affiliations on cost, utilization, and outcomes. They found fully integrated organizations were associated with lower levels of surgical complications. Kohn [8] stated a differing view that it is unclear whether affiliations are formed to manage financial incentives or to combat them by forming larger and more complex organizations resistant to change.

In this article we (1) identify the key drivers for physician-hospital alignment models; (2) summarize comanagement as a physician-hospital alignment model; and (3) explore a detailed case study of comanagement as an option to better align physicians with hospital goals on quality, safety, and outcomes.

Search Strategy and Criteria

A search of PubMed was performed using the search terms “physician-hospital” and “physician-hospital alignment”. A total of 363 references were identified. A detailed review of these references identified 45 references that discuss options for physician-hospital alignment that seeks to improve one or more of three key areas: improving patient care, reduce costs, and improving quality in care delivery. A majority of the articles that discuss these key areas were published after 2005. None of the articles identified provide a detailed example of successful alignment structures.

Key Drivers for Physician-Hospital Alignment

Many factors for physicians and hospitals influence the development of alignment programs or advanced stages of integration rather than the traditional medical staff relationship model. Flatter inpatient growth rates, declining professional and hospital reimbursement, and the opportunity to redesign care to improve quality, decrease costs, and positively impact efficiency are some of the reasons for alignment within health care. There is also a generational shift among new physician goals and values that has been a catalyst for the change from the current-state model of the physician-hospital relationship. Physicians joining the work force increasingly value maintenance of lifestyle and time for nonwork-related activities [6]. National trends indicate that specialty groups are increasing their hospital affiliations on par with primary care [7].

Degrees of physician-hospital alignment can range from tactical to transformational with varying degrees of integration and risks (Fig. 1). Examples of tactical alignment include volunteer medical staff and medical director agreements. In these agreements, the hospital purchases physician administrative time through medical directorships to provide an array of management and administrative services to hospitals. As organizations and physicians have become more strategic in their approaches to alignment, other tactical agreements have taken the form of joint ventures, comanagement agreements, institute models, or individual provider employment contracts. Transformational alignment requires a focus on new organizational governance and structure models that will support clinical integration across a healthcare organization reflective of an enterprise that is poised to manage populations of patients and financial risks within their community.

Conflicting incentives between physicians and hospitals are often cited as a major obstacle that affects collaboration and alignment [4, 9]. These conflicts are often driven by the

Fig. 1 Varying degrees of physician-hospital alignment (tactical, strategic, and transformational) with their respective levels of integration (independent, comanagement, employment) are shown.

opposing reimbursement incentives of physicians and hospitals. The physicians are incented to provide the best care for each individual patient, to provide more procedures, and often to use the newest implants or technology. The hospital, on the other hand, is incented to standardize care delivery, encourage use of lower cost implants, and provide nursing and ancillary support that matches the clinical demand to provide care for the patients. The goal and outcome of alignment should be clinical integration, defined by the physicians' and hospital's ability to share the same mission, vision, and strategies to improve organizational performance. The strategy to achieve this goal will depend on organizational culture readiness, trust, the catalyst for change, and leadership alignment within the physician practice and hospital.

The literature identifies two strategies for alignment between physicians and hospitals [11]. The first approach is noneconomic integration, emphasizing the cooperative nature of the relationship between both parties. The second approach is economic integration, in which alignment is achieved through financial means. The noneconomic integration is the foundation for true clinical integration and often the most challenging component in achieving alignment [1, 3]. Shared planning, decision-making, and development of improvement strategies that drive organizational performance will allow for physicians and hospitals to operate more effectively in a complex and ever-changing payer environment. The 1990s alignment models were focused primarily on economic integration. Today's reform agenda is driving alignment that will incorporate both the economic and noneconomic variables in the evolution of the models.

Physician-hospital alignment models are further complicated when clinical programs cross the historical specialty departments and/or divisional structures. For instance, a successful oncology program requires alignment among the hospital, surgical oncologists, medical oncologists, and radiation oncologists. Defining governance, performance metrics and accountability expectations in these types of structures will be critical to the long-term success and outcomes of these models. We describe a comanagement model designed to create further alignment among neurosurgeons, orthopaedic surgeons, anesthesiologists, and physiatrists in the development of a spine center.

Comanagement as a Construct for Physician and Hospital Alignment

Comanagement of a service line is one of many tools that hospitals are using to create tighter alignment around improving organizational performance in quality and

safety. Pay-for-performance methodologies are often key drivers for these types of arrangements, which in some respects are to joint ventures and/or employment models. Development of a comanagement arrangement typically involves focusing on developing a governance model, capturing the physician's work efforts in rendering the comanagement services, establishing performance metrics to achieve superior quality, understanding historical performance and setting appropriate attainment targets, creating a fee structure for fixed duties and a performance-based component, and assuring that the agreement meets all legal requirements. The terms of the agreements are typically for 1 year and require a resetting or establishment of new performance targets in the following years. Hospitals and physicians should continue annual adjustments to comanagement agreements to assure continued alignment and performance improvement and overall value.

Establishing the governance model requires the hospital leadership and physician leaders to work through issues of trust, mutual understanding, and accountability. Operating the clinical service line becomes a shared responsibility of the two parties. It requires a partnership in developing and executing on operational improvement strategies. The physicians typically form a limited liability company (LLC) for contracting with the hospital to manage the identified clinical service line.

The participating physicians (or in most cases the management entity formed by physicians) are paid by the hospital to provide a comprehensive set of services based on fixed duties established in advance. The payment of the involved physicians is critical for the implementation of comanagement. However, this can be disruptive to standard compensation plans within a physician practice or an academic department. The fixed-fee structure is directly aligned with defined administrative duties that physicians will perform to improve the quality, patient safety, and operations of the service line. Once the duties and performance metrics for the contract are established, the leaders must define the effort (typically expressed in hours) required to complete the fixed duties.

Substantial focused discussion should take place in choosing the appropriate performance metrics to achieve superior quality and service line efficiency. The agreement should clearly outline the performance metrics and targets that must be attained for the physicians to receive incentive compensation. Performance metrics are data-driven measures to facilitate improvement in targeted areas with a goal of improving quality, patient safety, operational efficiency, and/or the patient experience within the clinical service line. Examples of metrics may include items related to clinical processes (develop care maps), patient safety (readmissions within 30 days), efficiency (on-time operating room starts), and satisfaction (percent compliance with referring

physician communication). The performance metrics cannot incent referrals nor should they be based on gain-sharing type arrangements. The hospital should assure that there are clearly understood objective bases for measuring the achievement or failure to achieve metrics. The hospital should review historical performance levels benchmarked against nationally recognized performance standards as part of its analysis in establishing performance metrics. University Healthsystem Consortium, Press Ganey, Centers for Medicare & Medicaid Services, the Agency for Healthcare Research and Quality, and The Joint Commission are examples of organizations that provide performance standards to benchmark against. Many state and local hospital associations also publish peer benchmark data to support performance improvement efforts. The hospital should understand its current performance compared with what is seen as average/median and top decile performance levels for similar institutions. This is an important step to establish what it will mean to achieve superior outcomes in the comanagement agreement. If performance metrics are not achieved, no payment will take place for that specific metric. The goal is to set up a compensation model that will reward superior outcomes in quality and safety.

Like with any physician alignment strategy, hospital leaders must be cognizant of federal regulations mandating that all payments to physicians be consistent with fair market value, provided only for services deemed necessary and actually performed and not based in any way on the volume or value of anticipated or actual referrals. The agreement must also be compliant with the Stark Law [5], Anti-Kickback Statute [5], and (as to nonprofit hospitals) applicable IRS laws and regulations. Accordingly, it is important to ensure that a firm with expertise in compensation evaluation is engaged to perform a fair market value analysis of the overall fee structure.

Case Study: Comanagement Agreement for Spine Center

This case study describes the process of implementing a comanagement agreement as a model for creating tighter physician and hospital alignment for a spine center in an academic quaternary care hospital. The hospital engaged an outside consultant and legal counsel, as neutral parties, to assist in understanding the pros and cons of different models. Once the comanagement model was chosen as the strategy for alignment, the external groups were used to educate all parties on how to properly structure a compliant comanagement agreement.

The purpose of the comanagement alignment model was for the hospital to contract with neurosurgeons and orthopaedic surgeons, anesthesiologists, and physiatrists for

administrative management services with the spine center inclusive of fixed duties and performance objectives. The following were the guiding principles for that alignment: enhance the quality of patient care, improve patient safety and satisfaction, develop a strategic plan for creating an environment to support best practices, and create value through improving efficiencies. This alignment strategy also created an opportunity to provide further clarity to the physician leadership expectations and accountability model for operational improvement.

The first step in the process was to obtain buy-in from all the key stakeholders around the proposed comanagement model as a construct for creating greater alignment, fixed duties, performance-based expectations, and a decision-making structure for the spine center. The next steps required the leadership of the hospital to define the number of administrative hours that would be required to support the defined fixed duties, in other words, to capture the necessary work effort of the physicians. The establishment of performance metrics was also required to develop the overall compensation model for that agreement. The final phase of the creation of the comanagement agreement was establishing leadership roles and committee structures to support the work defined by both parties as the critical success factors that would create further clinical program alignment. On regular occasions, it was imperative to have legal counsel participate and advise on the legal structure, proposed compensation models for the comanagement services, how performance metrics are defined, and other issues relevant to ensuring regulatory compliance.

In this instance, the multispecialty practice group created an LLC to provide the physicians to perform the comanagement services. The hospital then contracted with the LLC for comanagement services, and the hospital paid the LLC and not the individual physicians. The LLC is responsible for compensating the participating physicians.

The comanagement agreement should clarify in detail the scope of what is included. In this example all hospital inpatient admissions, hospital-based clinic visits, preoperative, operating rooms, postoperative, patient access, and triage systems for spine patients being cared for by the providers within the defined spine center were included. A total of seven surgeons, three physiatrists, and two anesthesiologists were included in the agreement. The fixed duties and performance metrics are established on an annual basis. The parties recognized the importance of maintaining documentation of the performance of the specified comanagement services and have built documentation and effort verification processes into the implementation of the comanagement agreement.

The fixed duties within this agreement included focused physician leadership time in the following areas among others: strategic plan development, day-to-day operational

Table 1. Sample performance metrics and improvement from baseline

Performance metrics	Measurement	Improvement (+) from baseline
Clinical process metrics		
Patient satisfaction: Press Ganey how well your pain was controlled	Percent	+
Complications and patient safety metrics		
Reduced readmissions within 30 days—related	Percent	+
Reduce inpatient mortality index	Percent	+
Process and efficiency/operational metrics		
Improve on-time starts—first case	Percent on-time	+
Improve OR TAT compliance with goal	Minutes	+
Percent compliance of e-signatures within required timeframe (outpatient)	Percent	+
Reduce days to third appointment	Days	+
Increase Press Ganey: patient satisfaction of provider section, OP	Mean score	+
Satisfaction metrics		
Percent compliance of autofaxed discharge summaries sent to referring physicians (inpatient)	Percent	+
Percent compliance of autofaxed notes sent to referring physicians (outpatient)	Percent	+
Patient satisfaction: Press Ganey Physician kept you informed	Percent	—
Patient satisfaction: Press Ganey likelihood recommending hospital	Percent	—

management of those areas included within the scope of services, clinical management oversight, staffing oversight, supply and materials management, physician/community relations, coordination of spine services within the hospital, performance metric management, financial and capital planning, and information system implementation.

The performance metrics categories included: clinical process, complications and patient safety, operational process and efficiency, and patient satisfaction (Table 1). Financial performance of the service line was not included as a performance. Each of the metrics had established baseline performance before the start of the agreement and attainment improvement targets were set for any incentive payouts to occur at the end of the first year of the contract. Each performance metric had established definitions and was weighted so that complete transparency was established before the start of the agreement regarding how incentive payments could be achieved.

The comanagement governance structure required a partnership between the hospital leadership and the physicians to monitor the fixed duties and attempt to achieve the objectives reflected in the performance metrics. An executive committee was established that consists of a physician spine program leader from neurosurgery and orthopaedics, the surgical and anesthesia director, the physician leader responsible for quality and compliance, service line administrator, and the president of the hospital. The executive committee continues to meet monthly to provide overall management and assess performance of the spine center.

This comanagement agreement created a win-win for the hospital and physicians that benefits the patients through improved care delivery. The model supported the alignment of incentives around quality, safety, and efficiency. It created an explicit decision-making authority for the spine center and also supported fair market compensation for physician management services. This alignment strategy also provided an environment for a collaborative relationship across departments to build a multidisciplinary spine program.

Within the first quarter of the implementation of this agreement in 2012, meaningful discussions and activity around quality and safety, service line performance, and strategic direction have occurred between physician and hospital leadership. The hospital has seen incremental improvements month over month under the established performance metrics.

Discussion

Transformational alignment requires a focus on new organizational governance and structure models that will drive integration of improvements in care delivery across a healthcare organization that is poised to manage populations of patients and financial risks within their community. In our example, comanagement was chosen as the preferred structure for physician-hospital alignment. The choice of structure will vary depending on the existing relationships and governance of the hospital and the physicians in the

targeted area of focus. The measure of success of efforts at building physician-hospital alignment is measured in improvements in care for the patient, reduced cost of care delivery, and improved relations between physicians and hospital leadership.

Our review is subject to some limitations. First the literature in the area of physician-hospital alignment is limited. The majority of articles are written from the perspective of healthcare administrators. There is a paucity of work reviewing successful implementation strategies in this area. Second, this article provided a deeper analysis of only one type of physician-hospital structure: comanagement. There are other structures that have been described. However, comanagement is considered a medium- or midrange level of alignment. It is perhaps of more value to those healthcare organizations and physician groups who do not have experience with alignment structures. Third, this work describes one situation of alignment. Each situation is unique and we cannot cover all potential situations.

Many factors must be considered when choosing to enter a comanagement alignment structure. Although the goals of alignment are laudable, a driving factor for the hospital in choosing comanagement is the opportunity for improved patient outcomes and margin improvement by having the targeted physician groups actively engaged in the process of care delivery. Examples of such margin improvements are reductions in cost with more efficient and cost-effective care delivery or from increased revenue resulting from more focused attention to coding of comorbidities to ensure appropriate coding, which may adjust the case mix indices. Clinical service lines without such margin opportunities may not be suitable for a comanagement structure. The ultimate goal of comanagement is to engage the physicians in managing and improving the processes of care delivery with a goal of improving patient care.

Physician practices are increasingly interested in opportunities to share in technical revenue generated by the care they provide to patients. Comanagement is such a structure. However, physician groups are often seeking sources of revenue to support activities in addition to care delivery. This is particularly common in the academic setting. Comanagement represents a specific contractual agreement between a hospital or healthcare organization and a group of physicians specifically dealing a focused area of healthcare delivery. This type of alignment is not intended as a means to support the academic mission of a group physician.

The changing environment in health care and payer reform will require physicians and hospitals to continue to define new strategies for greater alignment to improve quality, safety, and overall performance of the hospital. These partnerships are critical to continue to improve clinical services to the patients and families within our service regions and will require leaders to explore opportunities and organizational structures that are very different from our past. We have outlined a variety of alignment structures and provided a detailed case example of one specific alignment structure. Organizations will need to continue to study new models and the short- and long-term impacts on performance, defined outcomes, and patient care.

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