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Physician/Hospital Alignment Models: Strategies for Success

By James Burns

The interactions between physicians and hospitals have always been complex, dynamic, and at times, maybe even a little contentious. For a number of years, relationships were guided by the most basic principle that hospitals need physicians in order to provide patient care, while physicians need hospitals as the space in which to deliver that care. During the past few decades, however, this traditional scenario has drastically changed, as many practitioners have no hospital presence or no established relationship with a particular organization, and instead have developed their own facilities in which to perform diagnostic care and outpatient procedures.

This new dynamic has left hospital leaders with few options in terms of their medical staff relationships, basically limited to:

1. Cede the services offered by physicians in their private facilities to them and instead focus on the business that remains at the hospital;
2. Rally for payor and governmental support to limit what can be performed outside of hospital facilities; or
3. Collaborate with physicians in order to understand the reasons for bypassing hospitals. In conjunction, hospitals can employ strategies that may help to make providing certain clinical services outside of the hospital setting a less-attractive option.

While a number of healthcare facilities and systems have settled for the first and second option listed above, or have too quickly jumped into an ill-conceived concept to try and accomplish the third option, there are success stories. In fact, Corazon has worked with many organizations to not only plan, but also implement physician/hospital alignment strategies of all types that are successful due to the focused efforts put forth on the overall structure.

From the simplest arrangements to complex leadership models and financial contracts, the options are varied depending upon a hospital or service line's unique situation; but, all successful arrangements have one thing in common — they invest both time and energy in creating an arrangement that has real value to all participants … and one that is adaptable enough to remain relevant well into the future.

Following are the critical steps that all of these success stories have in common. Corazon believes that these elements have allowed our client organizations to create meaningful and lasting alignment agreements that not only stand the test of time in our changing healthcare landscape, but also provide mutual clinical, financial, and operational benefit to all stakeholders:

1. **Project Leadership –** A key misstep that many organizations make when preparing to launch or maintain any type of alignment model is the failure to charge someone with leading and managing the arrangement. Because of the complex nature of even the most basic agreements, hospitals must dedicate the appropriate resources during the negotiation, execution, data management, and ongoing maintenance phases in order to obtain the best outcomes. Consideration should be given to the existing workload of this leader, their experience and aptitude in managing contracts, and their skills at establishing and maintaining relationships. These agreements are, at their core, mechanisms to more closely align the goals of the organization and its invaluable physicians.

2. **Adequate Time for Planning and Execution –** More often than not, these arrangements are subject to real and implied time constraints. Organizational inertia could delay action and create pressure when certain factors, such as competitive responses or financial limitations, prevent active vetting and instead force action before all parties are ready. One of the basic, yet often overlooked, components of this phase is fact-finding to determine the motivations and desired outcomes of all parties, and then understanding how these diverse goals can best be achieved. Corazon has been witness to a number of instances where assumptions are made regarding expectations that do not end up meeting the needs of either party, which often leads to distrust and disillusionment with the entire process, as well as between negotiating partners.

3. **Creating Value for Each Party –** As mentioned previously, perceived and real value must exist within these agreements, and it may not necessarily be monetary. Physicians sometimes seek greater overall control and efficiency, or program add-ons that could lead to improved clinical outcomes, or even research/publishing opportunities. Some physicians, who may not be ready to sell their private practices and become hospital employees, could need a partner to help them navigate new regulatory requirements around outcomes, quality, and IT infrastructure that are being imposed on their businesses. These are all sound avenues to explore in terms of value-creation for a formal arrangement.

4. **Clear and Attainable Timelines and Milestones –** Because of the time involved in the development/ negotiation component, as well as the actual contract development, momentum and enthusiasm for these arrangements can be lost, causing the entire project to be derailed and stalled, or at worst, called off completely. This is where strong project leadership is essential in keeping all parties engaged and invested in the agreement, despite the lengthy process. Milestones are also important for marking progress achievements and signaling when contracts need to be evaluated and updated, as well as when new goals and objectives should be assigned. Frequent and detailed communication is essential in all phases as well.

5. **Obtain External Expertise in a Timely Manner –** Stark laws and anti-kickback statutes are very complex, and at times, vague. This is why any agreement involving an exchange of money or services of value between hospitals and physicians needs to be thoroughly evaluated by a legal team well versed in these regulations. Optimally, legal expertise should be secured during the development phases of the agreement to help prevent any missteps in terms of what is promised and what can be legally delivered. Additionally, projects where external expertise is secured to help maintain the development timeline and to aid in negotiations often produce better, longer lasting agreements than those developed completely via internal means and resources.

While this process may seem lofty, and perhaps a little overly complex, the following two case studies show the value of extensive planning and then adhering to the well-developed plan, in addition to fastidious attention to detail during the implantation phases.

Case Study A:

Facility – Large, urban system in the northeastern United States.

Situation – Cardiologists were struggling to keep practices solvent while facing increased pressure from employed physicians at competitor hospitals. These physicians approached the potential hospital partner for some type of alignment agreement to aid in their dilemma and to allow them to remain practicing in the market.

Reaction – Hospital entered into negotiations with one outcome in mind: employment with productivity incentives.

Outcome – Contracts were developed, valued, and executed within 60 days. Outside entities, primarily private accounting and law firms, engaged by physicians after agreements were signed, determined that the contracts were undervalued. Several key physicians accepted out-of-market offers due to feeling lowballed by the hospital. Remaining physicians could not reach RVU (relative value unit) incentive thresholds because consideration was not given to maintaining outpatient testing. Eventually, the hospital's satisfaction rating and overall reputation in the market suffered due to the lack of incentives or plans for quality improvement. The remaining physicians also faced difficulty with maintaining service levels and meeting the demands of service for the local population. Furthermore, the planned integration of these specialists into the existing employed physician group, which\ primarily consisted of family practice doctors, was not successful, due to many billing and scheduling issues.

Lessons Learned – The reactionary response of the hospital, coupled with the limited options embraced by its leadership, doomed this agreement from the start. Eventually, most physicians left the market or were released into private practice. Significant market share was ceded to the competitor, most of which has not yet been recovered. Unfortunately, this outcome is more of the norm than the exception. As is the case in this example, poor planning, inflated egos, and historically adversarial relationships set the dynamics that would remain constant through the process. This situation, in particular, is more troubling than most because the hospital system did invest in outside resources to support the program, but ultimately responded to pressures created by certain physicians and impatient administrators, and began working outside of the agreed-upon process. The results speak for themselves.

Case Study B:

Facility – Multi-site system in the mid-Atlantic United States.

Situation – New interventional suites were being built at the system's anchor hospital. Hospital leadership wanted new space (and excess capacity) to serve as the foundation for a Vascular Center of Excellence. The hospital approached cardiology, interventional radiology, and vascular surgery groups about cooperating to form a vascular institute.

Reaction – Groups were hesitant and pessimistic at first, but became more engaged as each step progressed. Physicians voiced appreciation at being included in all planning and decision making steps, even those related to the hospital component of the services. New cooperation among these specialists, especially in terms of care and diagnostic standards, was welcomed by all medical staff, which translated into an 11% increase in vascular care referrals in just the first year of operation of the branded vascular center.

Outcome – The formalized arrangement for the vascular institute remained successful for many years and was replicated at outlying community hospital sites that were part of the system. Some challenges were experienced when physicians left the center due to retirement and relocation. Difficulties also arose when new physicians, who were not part of the original process and therefore not as invested in the project, were brought into system, which required new contracts for services separate from the vascular institute. Although not the exact same agreement or structure, some iteration of the original contract remains intact and successful today.

Lessons Learned – Planning that included physicians from the beginning of the process, as well as engaging legal and project leadership support in the early phases, assured buy-in from all of the key members of the team from the outset. This led to eventual success that all parties felt a part of. This cooperation resulted in an agreement that could be, and was, replicated at multiple sites, and one that has withstood industry and practice changes for over a decade. Though these are real-world examples, some minor details have been changed to maintain client anonymity. And while both case studies focus on cardiac and vascular services, the concepts and structures of planning successful arrangements hold true across all specialties. The key takeaway lessons are clear, and could mean the difference between success and failure for a physician/hospital alignment effort:

- Invest in the time and resource support needed to plan a meaningful and mutually beneficial arrangement;
- Complete the research and due diligence needed to create value for the program in terms of what the arrangement will accomplish; and,
- Develop and adhere to a realistic timeline and work plan, holding responsible parties accountable for progress.

While there are many other factors to consider when developing a successful alignment agreement, these strategies definitely start the process on the right path.

James is a Vice President at Corazon, Inc., a national leader in strategic program development for the heart, vascular, neuroscience, spine, and orthopedic specialties. Corazon offers a full continuum of consulting, software solution, recruitment, and interim management services for hospitals, health systems, and practices of all sizes across the country and in Canada. To learn more, visit www.corazoninc.com or call 412-364-8200. To reach the author, email jburns@corazoninc.com.