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SYMPOSIUM: ALIGNING PHYSICIAN AND HOSPITAL INCENTIVES

Orthopaedist-Hospital Alignment in a Community Setting

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Abstract

Background Physician-hospital alignments are becoming more common in today's healthcare environment. In the community setting, these relationships can impact quality of care as well as physician and hospital bottom lines. Alignment strategies take many different forms and can be advantageous to both the community orthopaedist and the community hospital, but certain key factors must be present to prevent a failed effort. Both the physician and hospital must be clear about their goals and expectations to overcome barriers and ensure success.

Questions/purposes We outline alignment strategies, goals, expectations, and implementation of a community-based, hospital alignment program and key factors that must be present to prevent a failed effort.

Search Strategy We queried PubMed and the AAOS web site for the terms "physician hospital alignment", "hospital physician alignment", and "clinical integration". We initially identified 65 articles and identified 19 that described the formation, evaluation, and examples of community hospital alliances.

Results In 2012, multiple business arrangements have been developed to deal with this vision for our healthcare future. One of these strategies known as alignment is generally considered to be a relationship among patients, orthopaedic surgeons, and stakeholders to fulfill these quality benchmarks and deliver improved quality care. Community practices have unique developmental barriers that must be negotiated for this process to be successful.

Conclusions The majority of hospital-based, orthopaedic care is practiced in the community settings far away from large, urban medical centers. Despite the relatively rural nature of these orthopaedic practices, patients, physicians, and all other orthopaedic stakeholders share a common goal of providing safe, quality health care at an affordable price.

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Introduction

Partnerships in medicine represent one of the fundamental tenets in providing effective and high-quality care. Physicians have always known that they must have trusting working relationships with their patients and their physician colleagues. For decades, orthopaedic practices in community settings have enjoyed independence in clinical decision-making and engaging in entrepreneurial opportunities. Orthopaedic surgeons have treated their patients without regard to government oversight, national benchmarking, or community stewardship. In accordance with the American Academy of Orthopaedic Surgeons' (AAOS) mission, a patient-first philosophy has always been at the forefront of community orthopaedic care and continues to prevail despite economic and political pressures to the contrary [1]. In the recent AAOS demographic survey, 72% of orthopaedic surgeons consider themselves in some type of private practice [17]. A strong physician-hospital relationship is also crucial to providing good care. In today's

healthcare environment, these alliances are becoming more common and likely soon to be mandated by the federal government.

Many factors are driving the trend of clinical integration. The federal government's push for integrated health networks, the development of accountable care organizations, and focus of reimbursement based on episodes of care are among these influences. Changes in private payor reimbursements, competition, and efforts to improve quality are additional factors prompting these alignments [2, 5]. Unfortunately, the historically adversarial relationship between physicians and local hospitals has created major barriers for timely movement forward. The days of orthopaedists providing surgical services and simply submitting a charge for reimbursement (fee for service) are rapidly coming to an end and being replaced with hospital-based programs that stress quality, accountability, cost-containment, and benchmarking (pay for performance) [6]. Orthopaedists and hospital administrators will be required to work together for the common good.

In many community practice environments, the hospitals own the health plans and are looking for opportunities to improve use based on quality measures. Orthopaedists have found implementation of office-based quality measures and technology to be time-consuming and costly, usually instituted without outside financial support. Concerns exist in the private community that, despite private practice commitments to accommodate constructive change, payors perceive it inadequate. Routine denial of payments by government regulators, without a reasonable appeal process, further burdens private medicine small businesses with increased overhead and barriers for constructive improvement.

Alignment between community orthopaedic surgeons and community hospitals can be a mutually beneficial relationship. These integration efforts can also have a meaningful impact on healthcare spending because 13% of healthcare dollars is spent on musculoskeletal care (Table 1) [7, 14].

This article basically explores the barriers to implementation of an alignment strategy in a community hospital environment. We specifically explore the types of alliances that exist to the benefit of the patient, hospital system, and physician; the expectations of all parties involved; and provides some specific examples and strategies of developing and implementing these collaborative alignments.

Table 1. Healthcare expenditures [7, 14]

18% of the US' gross domestic product is composed of healthcare costs, which represents the largest sector of the economy
The US government pays for 46% of all healthcare expenditures
Medicare costs have been growing at a rate twice as fast as the US economy
13% of all healthcare dollars go toward musculoskeletal care

Search Strategy and Criteria

Using PubMed, we queried the terms "physician hospital alignment", "hospital physician alignment", and "clinical integration". Additionally, the AAOS web site was queried using these same terms. Using these sources we initially identified 65 articles. We included all references that described the formation, evaluation, and examples of community hospital alliances. Of these sources, the references listed in each article were reviewed to locate additional literature. Using the inclusion criteria noted, we excluded 46 of the original 65 articles. This left 19 articles for review. The majority of the healthcare management literature reviewed consisted of expert opinion and case examples, representing a low level of evidence. However, this topic is not one that lends itself well to the levels of evidence established for orthopaedic literature.

Types of Alliances

The recent AAOS survey data [2] suggest orthopaedic group practices are the dominant provider model and have had some success in maintaining autonomy from aggressive hospital acquisition programs. Depending on the regional demographics, many of these group-type practices have been able to successfully compete with hospitals for orthopaedic services by diversifying their business models to incorporate profit centers (outpatient surgery centers, imaging, physical and occupational therapy centers, sports performance centers). Powerful hospital lobbyists have challenged these creative business models. However, we suspect quality, efficiency, and stewardship usually favor the physician leadership models. Payors are much more inclined to favor satisfied patients, treated by familiar community physicians, with cost-effective implants and with outcomes exceeding national benchmarks.

Today, orthopaedists and their administrative staff have much stronger business acumens than previously recognized. They work together to strategically outmaneuver antiquated, expensive full-service hospitals that are now populated with costly, disincentivized, employed physicians. In general, motivated, high-quality orthopaedic group practices bring value, leadership, reputation, and choice to the marketplace. It is in the best interest of the hospital to engage these orthopaedic practices, especially in competitive healthcare marketplaces. Most newly trained hospital administrators now recognize the importance of operating room volume, collaborative working

relationships, surgeon leadership, and the experience of operational performance. They favor situations in which physician-hospital alignments exist. Once the hospital administration recognizes the value these groups bring to the table, constructive planning can occur.

Alignment Expectations

Many different opportunities exist for community orthopaedic group practices to establish an alignment with their local hospital. Many incentives for improving care delivery exist and exceed personal financial rewards. More efficient and higher quality care leads to better outcomes. Excellent results and collegiality promote more referrals. Efficient care delivery leads to cost savings for both the physician's practice and the hospital. It may also allow greater throughput, which can directly have an impact on both the quality of life and revenue stream for physicians. When cost savings occur, these dollars can be directed toward patient-oriented initiatives (eg, decreasing staff-to-patient ratios, increasing the number of physical therapists, investing in operating room technology). Other physician benefits include practice access to financial management, business development, and information technology support through management service organizations [7]. Collaborative efforts may also open the doors to physician-hospital partnership in other ventures including: service line comanagement, clinical integration, gain-sharing, participation in savings from bundled payments, or development of educational programs [2]. Before beginning these relationships, physicians must be aware of the hospital's objectives.

Hospital Expectations

When forming these alliances, the hospital's goal is to support both its mission statement and bottom line. Hospitals want patients to receive high-quality care in an efficient manner with successful outcomes and a limited number of complications. The three As (availability, affability, and ability) will always be central to the relationship. In modern medicine, two more As, accountability and advocacy, are integral to physician and hospital alliances. Physicians who exhibit these characteristics will not only provide excellent care, but will be good partners in alignment efforts.

Hospitals expect prompt, high-quality, evidence-based, and cost-conscious care for all individuals regardless of financial status. Hospitals need physicians to fulfill their coverage needs, support service lines, and drive elective cases to their institutions [9]. Hospitals value physician self-governance and accountability and welcome participation in quality assurance committees, medical directorships, and other leadership roles. Physicians are expected to provide direct care to patients, but they are also asked to indirectly influence care delivery through the education of hospital clinical and medical staff, hospital administrators, and legislators. Medical staff members are expected to maintain compliance with Centers for Medicare & Medicaid Services guidelines as well as uphold patient confidentiality. Hospitals look to physicians to spearhead and participate in cost-savings initiatives. They seek support for quality outcome measures such as deep vein thrombosis prophylaxis, reduction in iatrogenic and hospital-acquired complications, reduction of readmission and never events, participation in Surgical Care Improvement Project protocols, and striving for patient satisfaction to bolster Hospital Consumer Assessment of Healthcare Providers and Systems survey results. Physicians are also sought after as advocates for health policy and reform. Communication with legislators, hosting political events, and testifying at hearings will benefit patients, physicians, and the hospital system.

Changes in healthcare delivery have prompted many physicians to seek hospital employment. Between 2004 and 2008, orthopaedist hospital employment increased by 70% [14]. Hospitals recognize the leadership capability of orthopaedic surgeons and hope that employment models increase market share and precipitate quality initiatives [9]. Both factors would place hospitals and practices in better negotiating positions with health plans. However, these models have met with varying degrees of success and assessment of objective improvement has been difficult.

Although employment models do offer certain advantages, this change has major drawbacks for the community physician. The loss of autonomy, risk of being fired, selling an established business with community rapport, and lessening patient choice are personal and professional hazards. Feelings of dissatisfaction, stress, despair, and personal failure can arise when a midcareer surgeon with a home, children in school, and deep community ties is uprooted professionally. Community orthopaedists have a stake in the success of their local economy and the well-being of their friends and neighbors. Furthermore, physician-hospital relationships are not permanent. Community hospital ownership frequently changes as a result of economic failure. Out-of-state hospital systems that purchase community hospitals as potential profit centers can be ill-informed about local politics, referral patterns, and community business relationships. Strategic plans of the new administration may not include the orthopaedist's vision of care in their community. Physician communication of this vision is crucial to success.

Physician Expectations

Physician goals for alignment often fall into three broad categories: improve customer service, enhance clinical performance, and define innovative products and services [8]. These objectives can take many forms and require hospital commitment to achieve. Surgeons expect to have access to the operating room and its staff to perform elective and emergent cases. The requested equipment must be available and in good condition and cases should start on time. An adequate number of amiable and well-trained support staff (eg, social workers, therapists, nurses, nursing assistants, emergency room technicians, traction technicians, transport technicians, physician extenders, etc) should be employed by the hospital to facilitate prompt and high-quality care delivery. Hospitals must also provide the appropriate ancillary resources (eg, MRI, CT, therapy) that are of high quality and are accessible in a timely manner. Nonorthopaedic specialties should be supported to ensure that physicians have access to well-trained consultants when patient condition demands their involvement. The infrastructure and technology must be in place to facilitate care delivery in the hospital and when the physician is off campus (eg, electronic medical record and picture archiving and communication system [PACS] and off-site access with adequate technical support).

Physicians should also look to the institution to provide indigent care to the community and employ clinical care coordinators who can facilitate appropriate discharge dispositions as well as medication assistance. Hospitals should support physician education during local and national continuing medical education (CME) opportunities. For physicians taking call, a lounge and call room should be available. Most importantly, care providers must be included in decisions regarding hospital initiatives, support staff, and capital investments in technology (eg, PACS, navigation). When cost savings or successes arise from these collaborative efforts, the monies should be directed toward service reinvestment.

A shared vision increases the likelihood of the initiative's success. The goal of satisfying all of these expectations is to ensure high levels of patient satisfaction and care outcomes while minimizing the number of complications. The patient-physician relationship continues even after the hospital stay is complete, but the patient's hospital experience can play a major role in the perception of their overall care and recovery.

Implementation of Successful Alignments

Physician-hospital relationships must be symbiotic; care suffers when stakeholders neglect the partner's needs. Both parties must also hold each other mutually accountable. Successful physician-hospital alignments are centered on common clinical, financial, and operational goals that are sustainable over time (Table 2) [5, 15]. Mutual trust and objectives built around value and performance are required to promote the relationship [8, 11, 14, 15]. Failures and triumphs are critically evaluated and the latter are rewarded. Focus is placed on identifying physician and hospital leaders and developing their career paths [12, 14]. Finally, metrics are created and assessed to ensure that the return on investment continues to meet the targeted mission, quality outcomes, and profitability [14]. Like in all relationships, communication is the key. Both physicians and hospitals frequently hold their cards close to their chests unwilling to express their true objectives. If these wants are not made clear at the start of the relationship, when they remain unfulfilled because of misdirected aims, both parties will be unsatisfied.

Table 2. Characteristics of successful alignments [11–15]

Mutual trust
Defined, mutual goals
Performance initiatives
Incentivizing participants to bring value back to the hospital
Critical evaluation of successes and failures
Identifying physician and hospital leaders
Career path development
Return of investment metrics

Barriers to Implementation

Although attention to these elements increases the likelihood of success, the involved parties must also be prepared to address the following barriers to alignment (Table 3) [5, 14]. As all physicians are aware, health care is in turmoil. Whether or not a national healthcare system is legislated, changing public policy will influence alignment efforts. Each party also has differences in priority. The key stakeholders in orthopaedics include physicians, hospitals, suppliers, payors, patients, and policymakers [19]. Physicians desire good patient outcomes, autonomy, efficiency, and fair compensation [19]. Hospitals want to manage their risk while providing high-quality, cost-effective care [19]. Suppliers seek to foster loyalty and product sales. Payors want to add value, cover lives, and generate profits [19]. Patients desire good outcomes, transparency, and trust, whereas policymakers hope to maximize health benefits with waning resources [19].

Additional hurdles include hospital ignorance of physician concerns and failure to incorporate them as leaders

Table 3. Barriers to alignment [11, 12, 14]

Changing public policy
Differences in priority
Lack of focus on physician issues
Conflicting payment incentives
Divisive production incentives
Lack of physician leadership

Table 4. Markers of failed alignments [13, 14]

Cost-containment measures are neglected
Efforts to deliver value and increased performance are neglected
Strong leadership is not developed and nurtured
Career development, performance improvement, and longevity are not addressed
Organizational cultural differences are ignored (eg, treatment of patients and referring physicians and employees, level of formalities and controls, performance rewards, risk tolerance, quality, and cost orientation)

[11]. Conflicting payment incentives and divisive production incentives can also hurt relationships [11]. Likewise, several key elements predict the failure of alignment efforts (Table 4) [11–14]. Neglect of cost-containment, value, and performance efforts; organizational cultural differences; and the development and cultivation of strong leadership and longevity ensure collapse.

Implementation Strategies for Physician-Community Hospital Alignment

Physician-hospital alignments can take many forms. Effective partnership efforts have surrounded the development of orthopaedic trauma call panels, quality assurance panels, implant selection committees, or the development of a center of excellence (eg, joint replacement or trauma) also known as a hospital within a hospital. Other collaborative efforts may arise in the development of order sets for hip fractures, fragility fracture programs, or participating in educational ventures (eg, lectures within the institution or in the community, development of graduate medical education programs). The broad goals of these partnerships are to improve patient experience, decrease length of stay, educate and promote high-quality outcomes, and judicious resource use.

The experience in Reno represents only one of many avenues of community physician-community hospital alignment. In 1992, the orthopaedic surgeons of Reno, NV, USA, successfully participated in the design and development of a community-based, orthopaedic trauma panel to provide quality orthopaedic trauma care to injured patients of northern Nevada, northern California, southeastern Oregon, and southwestern Idaho [3]. A fellowship-trained traumatologist directed the panel comprised of several independent private practice surgeons. Each member was committed to the care of the trauma patient in the community. This program is of historical importance because it probably represents the first published experiences with community-based physician-hospital alignment [3, 4].

At the outset, the mission was to provide trauma patients with quality care, measured outcomes, hospital stewardship, quality improvement programs (morbidity and mortality conferences), and community educational opportunities for general orthopaedic surgeons committed to participation on the trauma panel. This vision, nearly 20 years ago, is surprisingly similar to many of the benchmarks insurers use today. Initially, the hospital agreed to reimburse physicians with a stipend for their commitment to the program. The financial arrangement was based on office overhead reimbursement to assist with the burden of an increased underinsured patient population and the negative impact on developing subspecialty practices.

Over time, this physician-hospital alignment has morphed into a nationally recognized orthopaedic trauma program and fellowship. It has demonstrated benefits to the community, indigent and insured patients, the physician, and the hospital based on quality outcomes, performance metrics, cost-containment, and the development of a strong working relationship with the hospital administration. The benefits of a trauma program to the community relate to improved 24/7 access to emergency orthopaedic services, referral access to a major trauma center despite insurance status, and care being provided by fellowship-trained orthopaedic traumatologists. The benefits to the physician are some reimbursement for underinsured care, sharing in call, midlevel trauma team support, and the ability for generalists to transfer patients to fellowship-trained traumatologists. Finally, the benefits to the hospital are having quality physicians on their staff, committee activities working on cost-containment, and quality assurance [4]. Physician participants received generous call reimbursement, physician assistant on-call support, a trauma room, trauma fellowship-trained backup for difficult referral cases, trauma fellowship educational exposure, and trauma CME reimbursement. Hospital advantages included cost-containment programs documented to have saved several million dollars, quality outcomes and program development, market share, national recognition, high-quality orthopaedic trauma fellowship education, hospital committee leadership, and the halo effect of surgeons bringing elective cases to the same hospital where they take trauma call. The hospital infrastructure, employment opportunities, influence in the region, and community competiveness have grown as a

result of the hospital's vision to partner with local physicians in the care of the orthopaedic trauma patient.

Despite this alignment, the Reno orthopaedists have retained their autonomy through private practice models. They continue to direct patient care decisions and maintain an entrepreneurial spirit with continued control over ancillary ventures, insurance plan negotiations, and staff hiring and firing. The surgeons are able to tailor billing negotiations with insurance companies. They retain the ability to shape their professional and personal environments and maintain their quality of life.

This early program development has been beneficial for the next phase of the business relationship. Attending meetings together, sharing stewardship ideas, and quality improvement have set the stage for developing a more sophisticated relationship in the future such as comanagement, hospital within a hospital, or even some sort of shared employment arrangement. It has also prevented the hospital administration from looking elsewhere to fulfill its need for orthopaedic trauma care by hiring locums or outside trauma groups employed by the hospital. Orthopaedic trauma programs that have a history of productive negotiations with their hospital systems clearly have an advantage in any future discussions and should use these relationships to move forward.

Developing a formal trauma system is only one way in which these alliances can be created. Another strategy of alignment is the development of comanagement agreements. Comanagement, in orthopaedic terms, is a legal relationship between orthopaedic surgeons and their hospitals that recognizes the expertise of the surgeon in the design, development, and management of orthopaedic programs that are committed to quality care, improvement, and operational efficiency [14, 16]. These win-win alignments create opportunities for financial return for both parties yet allow each business to remain independent. Usually the compensation agreement has two revenue streams: one related to a base payment to the group or individual orthopaedic surgeon relative to fair market value and the second is a quality incentive bonus based on performance metrics [2, 9]. There must be shared ownership in the agreement with regard to the risk and the potential return; both businesses must be legally protected and equally willing to share in the success. Because the concept of comanagement is discussed elsewhere in this symposium, this discussion regarding comanagement is directed to issues involving large group practices with the majority market share practicing in smaller community environments and the potential effects on community orthopaedic surgeon colleagues.

Our experience suggests large, successful community group practices can withstand the first years of economic turmoil by developing strategic plans built on growth, quality, and commitment to patient care. Practices frequently have recruited high-quality administrative support, hired subspecialty-trained physicians, developed ancillary income streams, created employee loyalty, and maintained a reputation as patient and community advocates and for providing quality care. Physician members often have experience in business and community leadership. Most of these physicians have outlasted multiple hospital administrative changes or hospital buyouts, giving them an advantageous position to create sustainable business opportunities. To put it simply, community group practices are perfectly positioned to plan and execute comanagement agreements that benefit the hospital, patients, community, and the orthopaedic group, yet allow the private business of orthopaedic practice to maintain its autonomy. By aligning the largest, most qualified orthopaedic group with the largest, most respected community hospital, both businesses can create a win-win relationship and position themselves for the inevitable future changes in healthcare reimbursement.

The relationship that the Hospital for Special Surgery has with its orthopaedists serves as another alignment example. The department of orthopaedics is composed of over 90 private practice orthopaedists. Efforts to align the physicians and hospital have centered around four initiatives [18]. Three of these can be directly applied to all community settings: improve management efficiency by developing service lines, promote practice growth, and contain costs. Service lines are broken down into each subspecialty. Processes, implants, and soft goods management are streamlined. Staff are trained and held accountable to reach efficient and high-quality outcomes. Practice growth efforts look at ways to increase surgeon demand through marketing and increased efficiency in the clinic and operating room. Implant costs are controlled through incentivized gain-sharing plans.

Other alignment trends have included bundling payments or creating episodes of care [19]. Typically, these programs center on arthroplasty or spine procedures. By consolidating products and streamlining processes, both the hospital and physician are motivated to decrease costs and thus increase profit margins. However, Wilson et al. [19] suggested that most bundled payment arrangements exclude high-risk patients to ensure their viability.

In an era in which hospitals have been accustomed to purchasing physician practices and treating physicians like any other employee, or profit center, this equal, comanagement partnership model can be a challenge for the hospital to accept. Orthopaedists must continue to introduce the concept of partnership with their hospital administration whenever they meet together to discuss mutually beneficial opportunities. Physicians no longer have to agree to programs that solely benefit the hospital at their time and expense.

In smaller communities where one large group can maintain a majority market share, the natural alignment is an exclusive agreement with the hospital, thereby excluding smaller orthopaedic groups or the individual practitioner. The history and commitment of all community orthopaedic surgeons to the trauma program deserve to be included in any future hospital business relationships. Exclusion of small numbers of community surgeons in these business relationships by large groups creates animosity, ill will, and increases the chances of failure for advancement of patient care in community-based practice models. Orthopaedic surgeons in these communities belong to the same professional organizations; their children attend the same churches and schools and physicians participate in like recreational activities together. Unintended alignment consequences have the potential to impact professional relationships with other community orthopaedists not involved in the negotiations. These exclusive agreements could have a devastating impact on the businesses these practices support. With this in mind, these historically strong personal and professional community relationships need to be coveted and a plan must include a mechanism to allow other community surgeons the opportunity to participate if they meet established criteria and support the program.

Confidential proceedings during the due diligence process prevent the parties involved from sharing their plan with other orthopaedists in the community. However, efforts to openly outline the intended development of the program without breeching confidentiality should occur. In the ideal setting, representatives from the management committee of the orthopaedic practice and hospital administrators involved in the alliance should meet with the other community surgeons to inform them and address their concerns. The more transparent the process, the less likely the political fallout will negatively affect the program.

Nonmember surgeons should be able to participate in a comanagement agreement by adhering to the quality measures, outcome data collection, and established protocols that will result in the alignment's success. Although it may be difficult for a nongroup partner to participate in the financial rewards, their patients will benefit from the anticipated improvement in the processes used to better meet quality measures. One such example might be the patient undergoing arthroplasty. A nongroup surgeon who admits a patient to the new arthroplasty program and adheres to the pre- and postoperative protocols and advanced intraoperative techniques creates more predictable outcomes with fewer complications and greater patient satisfaction. The alignment benefits from another successful arthroplasty, and the nonmember surgeon has a more streamlined arthroplasty experience with a satisfied patient. The patient, the surgeon, and the surgeon's business benefit from the program.

Community orthopaedic surgeons not directly involved in the arrangement can provide support to trauma call programs and assist in the hospital administrative structure. They can support other local hospitals financially by driving cases to their operating room and running businesses that support employed families. Their value as partners in any alignment program cannot be minimized. Despite pressure from hospital administrators and consultants to exclusively direct these alignment programs, the integrity of professional orthopaedic community relationships and our mutual commitment to excellence in patient care must take precedence over any unilateral business decision.

Creating a Hospital Within a Hospital

The hospital within a hospital is a relatively new concept in the hospital industry in which the huge, everything-to-everybody hospital is replaced by a small, updated, homestyle structure catering to the demands of a specialized patient population. Some refer to these programs as centers of excellence. Despite the label chosen, orthopaedic care lends itself perfectly to this type of program development. These institutes within large community hospitals can fulfill the needs of patients in an updated, congenial fashion.

New programs, ideally developed and run by comanagement relationships, should allow the building design to be shared by physicians, administrators, and architects alike to create a modern, functional, and cost-effective structure to best fit the needs of the patient. With modern waiting rooms, examination facilities, and operative and recovery room alignment, the hospital within a hospital creates abundant opportunities for education, growth, and attraction of new physicians as well as creates futuristic operating efficiencies to quickly adapt to the changing healthcare environment.

The governance structure of these types of programs must be shared to allow the business acumen of the hospital administration and the clinical excellence of the orthopaedic surgeons to develop financially successful programs. Arrangements center around the management of the operating rooms, outpatient surgery centers, hospital data collection, marketing, contracting, research, education, and community philanthropy. Most subspecialty areas of orthopaedic practice could be created as destination centers. These quality hospital-within-a-hospital programs will enhance the reputation of the community orthopaedic practices as the hospital's performance, quality, outcomes, and patient satisfaction improve. Appropriate marketing and program branding are a critical part of the strategy to attract referrals as a quality destination orthopaedic care center.

The success of these agreements is predicated on improving clinical quality, cost-containment, mutual profitability, and improved patient experience. Potential program development in the areas of trauma, implant inventory, hip fracture protocols, joint arthroplasty, spine care, sports performance, outpatient surgery, and operating room efficiency could create sound, economic opportunities for both parties. For these relationships to survive, well-defined goals, performance metrics, careful consideration of the legal aspects of the partnership, indemnification, dispute resolution, and exit strategies all need to be considered carefully [2].

In some cases, the relationship will not succeed and both parties must move on to explore other options. Time is of the essence in developing these programs. The longer negotiations carry on, the more likely the chance for failure. Everyone should focus on the outcome rather than the painful process of strategy.

Discussion

This article explores the concept of orthopaedic surgeons developing professional relationships that establish as its goals improved outcomes, high-quality practice standards, and stewardship of the healthcare dollar while attempting to maintain a private practice delivery model.

We recognize limitations to our review. First, we found limited literature regarding alignment strategies and research to show how they affected hospital and physician practices. Second, from our experience it seems that hospitals are interested and experienced in the ownership model, ie, hospitalists, radiology, emergency medicine, etc; however, they are uncomfortable with any relationship that has a shared governance despite data that suggest physician leadership business models provide more cost-effective, higher quality patient outcomes. The investment in time, consulting resources, attorney's fees, and professional management is nearly prohibitive to the private practice business models in the attempt to create hospital alignment programs. The hospitals seem to have time and resources on their side and have little to gain from time-efficient negotiations to finalize these business relationships. Any negotiation with local hospital administration must be time-sensitive and should be reasonably easy to complete or simply walk away to negotiate another day.

For decades, orthopaedic surgeons have had the unique opportunity of practicing our profession without few, if any, external controls. Surgeons cared for their patients, used implants of their choice, and were reimbursed fairly for procedures through a fee-for-service program. Declining reimbursements, federally unfunded mandates requiring changes in office and surgical practices, and hospital-based practice metrics have increasingly applied pressure on the private practice of medicine. Surgeons have migrated to hospital employment, thus abandoning their communities, business and employee relationships, and lessening patient choice for their orthopaedic care.

Although not frequently thought of as alignment, many communities have established orthopaedic trauma programs with a history of physician-hospital alignment. Historically, hospitals have become accustomed to reimbursing physicians for participation in a trauma program to cover call and provide quality trauma care. This relationship can serve as the core for the development of values in creating a more complex business relationship. Other orthopaedic specialties have not had the hospital-based negotiating experience traumatologists have in the past and should be able to learn from these experiences.

Consulting firms hired by hospitals or orthopaedic groups are famous for expensive site-visits, personnel interviews, drafting an overview of vision, and then recommending an action plan, always from their home offices out of town. The members of these firms do not live or practice in smaller communities where personal and professional orthopaedic relationships are still viewed with great trust and dignity despite the changing economics of orthopaedic practice. Therefore, we believe hiring out-of-state consultants should be undertaken with great care; performance clauses should be added to the consultant agreement that prevents payment for services without implementation or alignment results.

Orthopaedic surgeons have a unique opportunity to create community alignment models that benefit both their business practices and the quality of care within their local hospitals. Comanagement agreements are one option that align the business acumen of the hospital administrators with the clinical expertise of the orthopaedic surgeon to design and develop win-win programs within the walls of their existing hospitals. Successful group practices have the expertise and leverage to create opportunities to protect the private practice of medicine for themselves and their community colleagues. These programs will invest in patient quality outcomes by appropriately collecting and reviewing hospital data, participating in cost-containment programs, and, thus, position themselves to adapt to future changes in healthcare reform.

Many private practice models have the experience and current business acumen to establish comanagement agreements. By timely negotiations, proper use of consulting services, and commitment to the goals of excellence in patient care, cost-effective programs that benefit patients, physicians, and hospital partners can successfully become a cooperative model for the future.

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