The concept of “alignment” between physicians and hospitals is a popular buzzword in the age of health care reform. Despite their often tumultuous histories, physicians and hospitals find themselves under increasing pressures to work together toward common goals. However, effective alignment is more than just simple cooperation between parties. The process of achieving alignment does not have simple, universal steps. Alignment will differ based on individual situational factors and the type of specialty involved. Ultimately, however, there are principles that underlie the concept of alignment and should be a part of any physician–hospital alignment efforts. In orthopedic surgery, alignment involves the clinical, administrative, financial, and even personal aspects of a surgeon’s practice. It must be based on the principles of financial interest, clinical authority, administrative participation, transparency, focus on the patient, and mutual necessity. Alignment can take on various forms as well, with popular models consisting of shared governance and comanagement, gainsharing, bundled payments, accountable care organizations, and other methods. As regulatory and financial pressures continue to motivate physicians and hospitals to develop alignment relationships, new and innovative methods of alignment will also appear. Existing models will mature and evolve, with individual variability based on local factors. However, certain trends seem to be appearing as time progresses and alignment relationships deepen, including regional and national collaboration, population management, and changes in the legal system. This article explores the history, principles, and specific methods of physician–hospital alignment and its critical importance for the future of health care delivery. [Orthopedics. 2015; 38(9):e806-e812.]
The historical relationship between orthopedic surgeons and hospitals has been one of begrudging symbiotic mutual necessity. Stated most simply, the surgeon needed a hospital and the hospital needed a surgeon, but the 2 parties often did not really like each other. Both sides have tried to gain the upper hand in the ongoing relationship, with surgeons moving cases to the office or ambulatory centers and hospitals using both “sticks and carrots” to protect their own interests. As health care reform lumbers forward, however, surgeons and hospitals are each recognizing the need for true cooperation and productive collaboration to replace the traditional culture of suspicion and self-protection.

**History**

Physicians and hospitals have always had complicated relationships. Physicians and their healing arts have their heritage in ancient times, with Hippocrates and Galen as examples of famous forebears. Hospitals trace their roots to antiquity as well—with the temples of ancient Egypt and Greece serving as the first centers of medical attention. As history progressed, religious institutions—particularly the Christian churches—played a major role in the development of the concept of the modern hospital. During the Age of Enlightenment and the Industrial Revolution, hospitals became targets for increasing involvement with government, educational, military, and commercial power players—forming the early stages of the complex web of interactive forces that exists in hospitals today. Throughout this long history, the interaction of physicians and hospitals has been characterized by the dynamic interplay of conflicting individual and mutual interests.

Against this background, orthopedic surgery has played a prominent role in the history of physician–hospital relationships. The first type of private health insurance ever offered in America was “bodily injury coverage” for railroad and steamboat workers in Massachusetts in 1850. Almost a century ago, the “father of American shoulder surgery,” Dr. E. A. Codman, argued for surgeon–hospital collaboration in an “end-result system” and his principles echo even today—but, ironically, he was fired from his hospital because of his ideas. Orthopedic surgery laid the foundation for the concept of “specialty hospitals” with institutions like the Hospital for the Ruptured and Crippled (later the Hospital for Special Surgery) and the Shriners’ Hospitals for Children.

As time progressed into the 1990s and the era of managed care, many hospitals engaged in significant purchasing of physician practices as a means of controlling their markets. Many of these practice-purchase transactions were done without complete mutual agreement—functioning almost like “hostile takeovers” at times. Once purchased and converted to salaried employees, physicians in many practices lost motivation and decreased productivity. Ultimately, many hospitals ended up selling the practices they had purchased, creating a significant sense of betrayal and suspicion on both sides in communities across the nation.

This lack of trust created or exacerbated during the managed-care boom remains a major obstacle in many situations today. Many physicians believe that hospital administrative teams will not stay the course on initiatives with longer-term event horizons, and they worry that they will be abandoned at a critical point in the process.

During the same timeframe that hospitals were purchasing practices, orthopedic surgeons were developing their own methods of empowerment: ambulatory surgery and independent ancillary services. Because more orthopedic procedures could be performed on an outpatient basis due to improved technology and techniques, surgeons were able to break hospitals’ monopoly on the operating room by shifting the cases to ambulatory surgery centers (ASCs). Some orthopedic surgeons even pursued outright ownership of ASCs because declining reimbursements from surgical fees drove surgeons to seek additional income streams. Physician-owned ancillary services became another target for increasing income, with physicians offering physical therapy, laboratory, durable medical equipment, advanced imaging, and other services that had traditionally been the purview of the hospital. These ASCs and ancillary services were able to carve out significant profits from hospitals, leading to increased competition and animosity.

In the modern era of reform after the passage of the Affordable Care Act, the landscape has begun to shift yet again. Both government and private payors are seeking better outcomes at a lower cost—a market pressure that is forcing physicians and hospitals to work together in new and creative ways. “Alignment” is now a popular buzzword used to describe the general concept of mutually empowering and mutually beneficial collaboration. Alignment projects involve the adaptation and application of some of the principles and practices of business success to the complex entity of health care.

**Principles of Alignment**

The process of achieving alignment does not have simple, universal steps. Alignment will differ based on individual situational factors, such as local history, personalities, geography, facilities, and many other influences. Alignment will also differ among specialties—alignment in orthopedics will look different than alignment in psychiatry or pediatrics. Ultimately, however, there are principles that underlie the concept of alignment and should be a part of any physician–hospital alignment efforts.

**Financial Interest**

The profit motive is at the heart of any physician–hospital relationship. Un-
Clinical Authority

One of the most common complaints often voiced by physicians is the loss of their clinical authority under the various situational changes in modern health care. Programs or policies that simply tell doctors how to do their jobs will fail because few physicians will readily abdicate their hard-earned knowledge and experience at the feet of an institutional mandate. On the other hand, physicians need to recognize that many policies that may appear to challenge or limit their clinical authority are actually driven by benign motives or even outright financial necessity.

In seeking alignment, surgeons and hospitals must work to keep clinical authority in the hands of the doctors as much as possible while simultaneously educating physicians about the non-clinical forces that drive various policies. Doctors may perceive more of a sharing of authority rather than a loss of authority if they participate in alignment projects that allow them to help design or manipulate the framework that affects their clinical practice.

Administrative Participation

Physicians’ financial interests and clinical authority may be the 2 most important principles of alignment, but they can only be developed and protected if the physicians themselves participate in the administrative processes at the hospital. Physicians must be given the opportunity to participate in a meaningful way and be appropriately compensated for their efforts, but they must also be appropriately prepared for the role. Both sides should pursue options for physician administrative or leadership training and should develop methods of reward and reimbursement that can offset the time lost from clinical practice or personal and family activities.

Transparency

Transparency of information, especially about financial data and costs, is a major theme of health care reform affecting all players—from surgeons and hospitals to insurers and patients. Given the long history of suspicion and lack of trust between physicians and hospitals, even the perception of a hidden agenda could prove fatal to alignment relationships. Trust must be earned through mutual respect, proper communication, and, most importantly, transparency. Clear declaration of all goals, even ones that may not necessarily be mutually beneficial, should characterize any common efforts or projects. Transparency also offers physicians and hospitals the chance to discover additional, perhaps unexpected, ways of further collaboration.

Patient Advocacy

If alignment can be simplified as looking in the same direction at the common goals, then no more obvious common goal exists than patient care, which is the fundamental mission of both physicians and hospitals; even the most historically disagreeable parties can agree to work together if this common goal is involved. Too often, the interests of the patient are not adequately represented or communicated, so alignment projects must focus on this critical element.

Mutual Necessity

Physicians and hospitals are usually acutely aware of the negative aspects of their relationships, and both sides can likely quickly generate reasons why they do not need or want to depend on one another. For successful alignment, both parties should focus on the positive aspects of their relationships and the potential ways that these aspects can be nurtured and grown. For example, hospitals may want to emphasize their vast primary care referral networks or large state-of-the-art operating suites, whereas surgeons might emphasize the potential profitability of their service lines and their community reputation and goodwill that can be shared. Indeed, alignment is easier if each side recognizes their need for the other.

Accountability

One of the biggest problems throughout the history of physician–hospital relationships has been accountability. Both sides have been at fault on this issue. Hospital leadership may not always keep critical promises and may frequently show reluctance for complete transparency. Physicians may not always follow practice guidelines or meet cost-reduction goals. For alignment initiatives to succeed, both sides must be able to hold the other accountable.

Accountability must apply at all levels of the organization—from the chief executives and physicians to the clerks and medical assistants—or distrust will come back into the picture. Accountability must also be meaningful and consequential—offenders must know that they will receive more than a proverbial slap on the wrist if they do not uphold their part of the agreement.

Models and Methods of Alignment

Depending on local and regional factors, physician–hospital alignment may take on numerous different forms, and
some situations may be better suited for it than others. The needs of private community practice surgeons will differ from those at major academic medical centers.\textsuperscript{8-11} Some markets may see physicians align with more than 1 hospital and hospitals align with various groups of physicians. Some relationships may involve several different alignment projects occurring at once, whereas other participants may choose to focus only on a single collaboration at a time. Some situations may require systemic level change to meet the needs of physicians, whereas others may involve changing physician behavior or expectations to meet the demands of a system.\textsuperscript{12}

**Employment**

At first glance, physician employment might seem like the simplest form of alignment. Over the past few years, significantly more orthopedic surgeons have sought hospital employment over private practice opportunities when starting their career or changing jobs.\textsuperscript{13,14} However, employment and alignment are anything but synonyms,\textsuperscript{5} and direct employment may be one of the worst ways to attempt to achieve alignment.

As an employee, a surgeon can essentially be *commanded* by the hospital and may have no voice in administrative matters. Unless the contract involves production incentives, employed surgeons may have no financial interest in things that can dramatically affect the hospital. There may be no transparency, and no work to maintain mutual dependence beyond the initial recruitment. In short, employment situations can actually violate many of the principles of alignment and thus should not be considered true alignment relationships in their own right.

Indirect employment is another option that may follow alignment principles more than direct employment. Under indirect employment, the hospital or health system enters into a contract with a separate business entity that provides physician services. This entity may be a distinct physician services company, a medical foundation,\textsuperscript{15} or even a wholly owned subsidiary of the hospital.

Although indirect employment creates more legal complexity, it does give the participating physicians more opportunity to protect their own interests and gives the hospital potential tax benefits and other features—potentially improving overall alignment. Although indirect employment has been a common means of providing internal medicine “hospitalist” services, a new but similar paradigm of “orthopedic surgicalists” has recently gained popularity in certain markets.\textsuperscript{16}

**Pay-for-Performance**

The phrase pay-for-performance has numerous meanings in the era of health care reform. Various pay-for-performance programs have been proposed by government and private payors to reward physicians for meeting certain specified quality measures. However, in the sense of physician–hospital alignment, the hospital itself (not the payors) designs the details of the pay-for-performance program. Essentially, the hospital sets various goals for process efficiency, clinical outcome, patient satisfaction, cost minimization, or other targets. Physicians who reach these goals are rewarded financially.

These programs may apply both to employed and nonemployed physicians, and they may or may not involve true physician administrative input. These programs may have complex performance metrics or they may involve simple changes, such as moving from a salary to compensation based on relative value units.\textsuperscript{17} Despite their differences, pay-for-performance programs share the common theme of using the principle of financial interest to align physician incentives with hospital goals.

**Gainsharing**

Gainsharing is an arrangement between hospitals and physicians to share the financial rewards of the cost savings that result from specific efforts to improve efficiency of care delivery processes.\textsuperscript{18} This model differs from pay-for-performance in 2 major ways—the administrative participation of physicians and transparency. Rather than simply receiving goals to meet, physicians are charged with creating their own goals and managing the initiatives and programs to reach them. Therefore, physicians must assume administrative roles, whereas pay-for-performance may only require them to be better or more efficient clinicians.

In addition, the financial gains under a gainsharing model must be real. Physicians are rewarded for actually saving money, not just meeting a nonfinancial target, such as clinical outcomes or patient satisfaction. Gainsharing thus cannot function without complete transparency because surgeons must be able to see and manage all relevant data to know whether the program is working. In pay-for-performance models, physicians may only see the final result data but not the composite information that led to it.

Orthopedic surgery is an area absolutely ripe for multiple gainsharing arrangements, with significant focus in recent years on programs in total joint replacement and trauma surgery. Because orthopedic surgery involves substantial costs due to the technologies and implants involved, ample opportunity exists for surgeons to have a profound influence by making clinically appropriate but financially favorable alterations in their surgical techniques, implant selections, and other areas. By giving surgeons financial incentives to find innovative ways to reduce costs, gainsharing programs follow many of the basic principles of alignment and have seen great success. However, one major drawback to gainsharing is that these projects may prove short-lived because continually smaller financial gains will occur each year as the processes reach maximum efficiency.\textsuperscript{7}
Co-management

Although gainsharing initiatives may focus only on a single surgery (such as knee replacement) or an area of surgery (such as trauma), co-management takes the collaboration to the next level—an entire service line at the hospital. Co-management projects may also prove more sustainable than gainsharing. Following the alignment principle of increasing physicians’ administrative roles, many physician–hospital partnerships have instituted successful co-management models for the orthopedic surgery service line.19 These co-management agreements usually involve a base management fee plus incentive pay for meeting various goals of cost reduction, clinical outcomes, patient satisfaction, process improvement, or other targets.20

The orthopedic service line in most hospitals represents a potential bumper crop for the hospital’s financial harvest, but the involvement of surgeons in the management of the entire service line can drive those institutional margins even higher.21 These arrangements are also predicated on transparency because both sides must share information with one another to function effectively.

Co-management agreements must be carefully arranged to avoid legal entanglement with Stark and federal anti-kickback laws, and many agreements pass through a separate entity such as a Limited Liability Company (LLC) set up for the sole purpose of supporting the alignment venture.20,21 The LLC will have representatives from both sides, with surgeons and hospital officials working together. Through involvement in such administrative structures, physicians can maintain clinical authority while also protecting their financial interests and yet still promote mutual dependence and patient advocacy. Indeed, co-management agreements seem to encompass all of the fundamental principles of alignment.

Joint Ventures

Joint ventures are agreements between physicians and hospitals to form and operate a distinct common enterprise. These ventures typically focus on freestanding facilities, such as surgery centers, endoscopy suites, urgent care clinics, diagnostic centers, durable medical equipment vendors, and other mutually beneficial arrangements. Because of the outpatient nature of many orthopedic procedures and the acute nature of many orthopedic injuries, orthopedic ambulatory surgery centers and orthopedic urgent care clinics have been extremely popular forms of joint ventures.22 Like co-management arrangements, joint ventures typically involve the formation of an independent company or other distinct legal entity, so they must be carefully structured and reviewed by legal counsel to avoid problems. Successful joint ventures may help promote further alignment between the physicians and hospitals involved.

Bundled Payments

The concept of a bundled payment involves a single price for a discrete “episode of care,” such as a total shoulder arthroplasty.23 This price includes all of the various individual component products and services involved, which now have their own individual prices under the current fee-for-service model. The ability to set the bundled price depends on all participants in the episode of care working together—an obvious opportunity to pursue alignment. From the perspective of the payor, bundling is attractive because it makes costs more predictable and shifts a good deal of financial risk to the provider. The federal government has focused on bundled payments as one of its top targets for new reimbursement models under reform. Private insurance companies have also pursued bundled payment pilot programs, often partnering with various major medical centers around the country. Orthopedic surgery, a natural fit for such initiatives, has led the way in many of these projects. Bundled payment initiatives expand the players in the alignment game beyond the physicians and hospitals to include other medical service providers, payors, and even patients.

Accountable Care Organizations

The ACO may be the most complex current model of physician–hospital alignment. The precise definition of an ACO remains somewhat in flux, and it depends most directly on who is making the definition. The federal government defines an ACO as a group of “doctors, hospitals, or other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients.”24 Private insurers have laid out similar definitions as a means of alternative payment and cost-containment based on regional markets. Providers may define their organizations as ACOs for marketing purposes or in hopes of becoming an official ACO in the eyes of certain payors. Regardless of its precise definition, an ACO requires significant interaction and cooperation between the physicians and hospitals involved, forcing them to follow the principles of alignment if they hope to achieve any success.

Although the main goal of many ACOs has more of a primary care focus, orthopedic specialty care is still an important aspect of the model. Patients receiving care from an ACO will still need care for fractures, arthritis, sports injuries, and other common orthopedic problems. These clinical issues represent a large part of the potential costs under an ACO model because surgical care may be expensive but is seen by patients as extremely necessary. As such, orthopedic surgeons will have significant negotiating power in the structure of the ACO. For some orthopedic surgeons, participation in multiple ACOs may be an option, depending on the size and dynamics of the local market.

Future Directions

As regulatory and financial pressures continue to motivate physicians and hospitals to develop alignment relationships, new and innovative methods of alignment
will appear. Existing models will also mature and evolve, with individual variability based on local factors. However, certain trends seem to be appearing as time progresses and alignment relationships deepen.

Regional Collaboration

Despite growing regional competition among hospitals and health systems, pressure and precedent also exist for regional collaboration. The Virginia Cardiac Surgery Quality Initiative has several years’ experience with a regional effort to improve outcomes and contain costs through data sharing and analysis, decision support and modeling, and the promotion of best practices.25

Over the past 10 years, several regional orthopedic forums have been established to promote collaboration between orthopedic groups on issues of clinical care, practice management, and financial viability.26,27 These networks enable more efficient communication and transfer of viable physician–hospital alignment programs within the region and potentially beyond it.

In Arizona, a statewide electronic health information system has been proposed as a means of “improving clinical efficiency and safety, improved health outcomes and consumer ownership and involvement in their own health care.”28 Ideas such as these will continue to appear and flourish as the culture of alignment grows.

National Collaboration

Most developed industrial countries have a national joint replacement registry that tracks data about arthroplasty procedures. Many powerful studies have emerged out of analysis of data from these registries, and these studies have altered clinical practice across the world. Historically, the United States lacked a national registry until the founding of the American Joint Replacement Registry (AJRR)—a private, not-for-profit entity supported by multiple stakeholders across the country.29 Participation in the AJRR demands a certain level of collaboration and alignment from both surgeons and hospitals, and each party stands to benefit immensely from the clinical, operational, and financial knowledge that will emerge as the AJRR produces high-level, multicenter studies based on its data. The AJRR provides an example of success for other national-level initiatives that promote physician–hospital alignment.

Population Management

A spectrum of alignment models exists as described above—moving from pay-for-performance through ACOs. The next level of alignment involves the ability to care for an entire population. Population management may necessitate the cooperation of multiple ACOs or multiple hospitals and health care systems, depending on the size of the target population. Regional- and national-level collaboration will be required, and the complexity of such an endeavor is immense. In addition to high-volume administrative and clinical considerations, population management involves higher levels of strategic facility development, information technology, revenue management, materials management, leadership training, operational issues, and other factors. Data management will prove critical in such projects, and participants will assume much greater financial risks. However, the potential for reward is also great because successful initiatives can result in the ability to corner a significant market and ensure financial stability.

Legal System Changes

As surgeons and hospitals push the envelope into more intertwined relationships, they will inevitably run up against legal problems on both the state and federal levels.31,28 Many of these laws seek to address aspects of physician–hospital relationships that result in increased costs to the government, but now, ironically, they may stand squarely in the way of innovations meant to decrease those costs. Outdated and problematic portions of these laws have a better probability of being changed as physicians and hospitals work together.30

Both physicians and hospitals may also benefit from efforts to achieve meaningful tort reform.30 Indeed, the next level of collaboration and alignment may even be in the realm of the lobbyists representing both physicians and hospitals together as they seek to improve the legal landscape. Orthopedic surgery plays a major leadership role in this area, as the political action committee of the American Academy of Orthopaedic Surgeons is one of the best-funded and most-influential medical specialty political action committees in the country.18,31

Conclusion

Alignment is the current concept in physician–hospital interactions that promises the most effective means of ensuring mutual benefit to 2 parties with a long and tumultuous past. As American health care moves away from a fee-for-service model characterized by an “everyone for themselves” mentality, alignment will be a critical pillar in the coming age of value-based reimbursement and accountable care characterized by more of a team approach. Although the exact models and methods of physician–hospital alignment will continue to evolve, the principles of alignment outlined herein will continue to guide both parties as they write the new history of their relationship.

References

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