

# Integration of an Academic Medical Center and a Community Hospital: The Brigham and Women's/Faulkner Hospital Experience

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## Abstract

Brigham and Women's Hospital (BWH), a major academic tertiary medical center, and Faulkner Hospital (Faulkner), a nearby community teaching hospital, both in the Boston, Massachusetts area, have established a close affiliation relationship under a common corporate parent that achieves a variety of synergistic benefits. Formed under the pressures of limited capacity at BWH and excess capacity at Faulkner, and the need for lower-cost clinical space in an era of provider risk-sharing, BWH and Faulkner entered into a comprehensive affiliation agreement. Over the past seven years,

the relationship has enhanced overall volume, broadened training programs, lowered the cost of resources for secondary care, and improved financial performance for both institutions. The lessons of this relationship, both in terms of success factors and ongoing challenges for the hospitals, medical staffs, and a large multispecialty referring physician group, are reviewed. The key factors for success of the relationship have been integration of training programs and some clinical services, provision of complementary clinical capabilities, geographic proximity, clear

role definition of each institution, commitment and flexibility of leadership and medical staff, active and responsive communication, and the support of a large referring physician group that embraced the affiliation concept. Principal challenges have been maintaining the community hospital's cost structure, addressing cultural differences, avoiding competition among professional staff, anticipating the pace of patient migration, choosing a name for the new affiliation, and adapting to a changing payer environment.

Over the past seven years the clinical services of two hospitals, Brigham and Women's Hospital (BWH) in Boston, Massachusetts, and Faulkner Hospital (Faulkner) in Jamaica Plain, Massachusetts, have established a close affiliation. BWH is a major academic tertiary teaching institution with a strong research base, while Faulkner is a nearby community secondary-care teaching institution with a long tradition of clinical excellence. In 1997, the leadership of both institutions began to explore ways to collaborate, and in 1998 formally developed a highly integrated affiliation under a common corporate parent. This new relationship allowed for development of complementary services, and for care of patients to be directed to the most appropriate hospital, based on the relative intensity of clinical needs. The philosophy of the affiliation at the time of inception and today is that the tertiary and secondary care programs of both institutions supplement one another, enabling success in an increasingly competitive, cost-sensitive environment.<sup>1</sup> This clinical affiliation has been embraced by Harvard Vanguard

Medical Associates (HVMA), a large multispecialty medical group that previously admitted their patients to BWH nearly exclusively. The teaching programs of both BWH and Faulkner have also been consolidated in the affiliation.

This intricate relationship has experienced several successes and a number of significant obstacles in the process of sharing care across two institutions. The issues that were encountered should be considered by other institutions contemplating a similar relationship. Attention must be given to the historical mission and roles of the institutions, payer environment, institutional receptivity to integration of teaching programs and clinical services, flexibility of medical staff, cost structure, and other key relationship factors and obstacles (e.g., naming, budgeting), all of which were encountered by BWH and Faulkner.

## The New Relationship

### Historical context

In 1995, managed care was ascendant in eastern Massachusetts. Prompted by the hopes and fears created by the Clinton health plan, most observers believed that health care was moving toward a system

in which primary care-based global risk capitation was the prevalent mode of reimbursement. Under this payment scheme, a large primary care base was thought to be necessary to ensure the health of a hospital.<sup>2</sup>

This was especially true for a tertiary teaching institution like BWH. Large tertiary care academic medical centers often have higher costs-per-patient discharge than do community hospitals.<sup>3</sup> Primary care physicians based in the community were becoming more cost-conscious when making referrals in the capitated environment and were shifting their capitated patients to less costly hospitals to decrease patient care expenses and thereby increase their own reimbursements. Cost-effective secondary care was in rising demand. At BWH, the situation with managed care was particularly acute. For the previous decade BWH had been the principal hospital for over half of the practice centers of the HVMA, a multispecialty group descendent of a staff model health maintenance organization (Harvard Community Health Plan). For most of the 1990s, HVMA used BWH for both inpatient tertiary and secondary care. HVMA, with over 250,000 members,

received most of its reimbursement at that time in the form of full risk capitation payments. Cost pressures created by capitation reimbursement would continue to keep pressure on the BWH cost per discharge.<sup>4</sup> HVMA gained great marketing strength from its close association with BWH. However, by the late 1990s, it was clear that BWH could not continue to afford offering HVMA secondary care hospital rates that would be acceptable. In addition to managed-care-related strains, BWH was exhausting available inpatient bed capacity, particularly for secondary type care. Despite predictions in the early part of the decade of excess bed capacity, occupancy levels at BWH were frequently above 90%, and limitations on operating room access were seriously stalling growth. Ambulatory space was similarly overutilized and in short supply.

Three miles away from BWH, Faulkner had a long tradition of success as a community hospital. Founded in 1900, Faulkner was supported by a loyal private staff and a long-term relationship with Tufts University School of Medicine and the New England Medical Center (NEMC) teaching programs. Faulkner was deeply committed to both teaching and to community practice. However, the pressures that had been brought to bear on small- and intermediate-size community hospitals throughout eastern Massachusetts had also visited Faulkner. With continued downward pressure on reimbursement for hospitalization, and striking reductions in both the length of stay and number of hospital beds across the state, many community hospitals were either closing or searching for partners.<sup>4</sup> In the mid-1990s, nearly every hospital in Massachusetts was considering joining an integrated delivery network.<sup>5</sup>

At Faulkner the number of admissions was steadily declining, and the hospital was facing a small, but increasing operating deficit. It considered formal relationships with a variety of competing integrated delivery networks to provide managed care contract participation, enhanced volume for clinical services, and to maintain its commitment to the teaching programs at the institution. However, offers of a full merger, and potential loss of institutional identity and relative autonomy, were not viewed as favorably as those that permitted

Faulkner to maintain its existing identity as an independent community teaching hospital.

A high-level group of representatives from the administrations and the medical staffs of both BWH and Faulkner, including CEOs, medical staff presidents, and key administrative and board members, began to meet in 1997. They reached an agreement whereby Faulkner would become a closely integrated affiliate of BWH, with a common parent entity, Brigham and Women's/Faulkner Hospital (BW/F). BW/F would itself be a subsidiary of Partners Health care System, the largest integrated delivery network in Massachusetts, of which BWH was already a founding member. Each hospital would retain its own board, administration, medical staff, and financial reporting systems; however, financial statements would all combine to BW/F. The president of BWH also serves as president of BW/F, the holding company of the two hospitals. Although a full-scale merger of assets and leadership was considered, the need to maintain the identity of Faulkner as a distinct community hospital was perceived both by patients (in focus groups) and staff to be essential. BW/F was developed as the parent organization, to which the hospitals and the Brigham and Women's Physicians Organization would report. The large private practice staff at Faulkner would remain independent.

The objectives of the affiliation were to enhance the utilization of both institutions, at Faulkner with incremental secondary care from BWH, and at BWH with additional tertiary cases in new capacity created by the move of secondary care to Faulkner. The tactics to accomplish this integration were to integrate the teaching programs, establish some common clinical systems that might facilitate care on both campuses regardless of physician location (e.g., a hospitalist program), and provide referring physician groups, such as HVMA, with alternative sites of care based on intensity of clinical need. These transitions were to be monitored closely in terms of their potential impact on patient satisfaction, quality of care, and financial performance of the BW/F and its members.

A critical element of the BW/F affiliation would be efforts by BWH faculty to move

community-level secondary care to Faulkner, thus permitting BWH to open capacity for incremental tertiary care cases. Prospective financial analyses suggested the move of approximately 3,000 cases from BWH to Faulkner, as well as associated growth at Faulkner, could be worth \$13–15 million in net contribution margin to BW/F. These funds would then be available for reinvestment by BW/F to help achieve its collective mission. Faulkner agreed to certain limitations on its corporate decision making as part of BW/F, but asserted that the overall nature of the community hospital could not be changed, and that its separate private practice staff would retain its independence and prerogatives within the medical staff. The agreement met the volume needs of both organizations, while also respecting the underlying practice models at both institutions. From the patients' perspective, care could be obtained at either institution, depending on complexity of medical problems and patient/physician preference, thereby enhancing access to services.

### Teaching programs

Leaders from both BWH and Faulkner believed the first measured steps forward in the affiliation should be the integration of training programs. The Faulkner teaching programs had previously been for residents from NEMC, in both medicine and surgery. Medical students from Tufts University School of Medicine also rotated through Faulkner. At the time of the BW/F affiliation, it was estimated that as much as 35% of the training time for a typical NEMC medical resident was occurring at Faulkner.

Both the medicine and surgery departments at BWH and Faulkner (whose chiefs were integrated to serve as vice-chairs of the corresponding BWH department) agreed that Faulkner would be an excellent place to undertake training of their residents, and immediately began to negotiate with NEMC for a gradual transition. Over the course of three years, NEMC medical residents were replaced by BW/F residents, who now perform a portion of their training at Faulkner approximately equal to that of their NEMC predecessors. In surgery, the transition was just as rapid. The training program directors at BWH and Faulkner were very

supportive. Faulkner provided different learning experiences for BWH trainees, enhancing their exposure to community hospital care. The program directors were also quite committed to the institutional goals of integration. NEMC residents assumed positions at other Massachusetts teaching hospitals. This transition occurred smoothly, in a graded fashion, with no appreciable change in the quality of care.

The private staff physicians in the Faulkner departments of medicine and surgery were supportive of this teaching program integration, as evidenced by their enthusiastic participation in teaching residents. A few of these Faulkner staff also began teaching responsibilities at BWH. Faulkner has a long and deep commitment to teaching, and since the affiliation, Faulkner attending physicians (including the chief of medicine) have received several of the most highly regarded teaching awards from BWH housestaff. Faulkner attending physicians are now integrated into the BWH resident selection process. Performance on the resident Match, such as in internal medicine, has remained outstanding. The only freestanding Faulkner fellowship, in gastroenterology, was merged with the BWH program, creating a more clinically diverse program.

**Clinical integration**

The next step in achieving the affiliation objectives, especially related to the move of volume from BWH to Faulkner, was to achieve key areas of clinical integration. These developments lagged slightly behind the teaching integration. One of the factors in this delay was the underlying commitment to put in place key infrastructure components—such as access to information systems and

communication pathways—prior to carrying out major patient care moves. The affected services were surgery, orthopedics, and medicine, including primary care and subspecialties. Although BWH has a large obstetrics and women’s health service, the decision was made not to move these patients to Faulkner, which did not have a history of obstetrics care. The BWH Department of Surgery promptly began to move patients to Faulkner, especially for ambulatory surgical care. This was driven by a lack of surgical operating room time at BWH. Over the late 1990s, BWH achieved extremely rapid throughput and high occupancy rates. During much of this period of time, surgeons found that there was very limited available operating room times or beds in which to care for postoperative patients. Reducing this high-capacity utilization at BWH to more efficient levels was a clear BWH objective of the affiliation. Making operating rooms that were only partially filled at Faulkner available to the BWH surgeons immediately caused the migration of surgical patients. Orthopedics was an especially important part of this process and began to take steps towards setting up an ambulatory center in vacant space in the Faulkner medical office building. In 2000, BWH moved its entire foot and ankle center to Faulkner, where the practice has expanded successfully.

A similar migration occurred in cardiology. The catheterization lab at Faulkner had seen a dwindling number of cases over the course of the mid-1990s. Once the affiliation occurred, the cardiology staff at BWH assumed the directorship of the Faulkner catheterization lab with the agreement of the Faulkner staff. While offering only diagnostic catheterizations, the

laboratory was nonetheless a welcome place to refer patients from BWH practitioners as well as from the Faulkner staff. As cardiac procedure volume grew, laboratory resources were added. The cardiology divisions of the two hospitals began to work more closely together, and a new cardiologist was hired through BWH to be part of the BW/F team at Faulkner. BWH also moved one of its senior office-based cardiologists to Faulkner with the goal of integrating services and sharing diagnostic rotations.

Similar joint programs have since developed in pulmonary, oncology and neurology. An infusion and dialysis center has been established at Faulkner with the support of both institutions. Overall growth of specialty care was encouraged, which resulted in increases in cardiac procedures, echocardiography, radiologic imaging, and gastrointestinal procedures at Faulkner (see Table 1).

BWH next moved a limited member of primary care practices to Faulkner. At BWH, ambulatory office space is just as constrained as operating room time. Space in the Faulkner ambulatory care area has long been occupied by private primary care practitioners associated with the Faulkner staff. The primary care practices that moved from BWH to Faulkner are mainly mature practices that are fully populated by patients, to minimize concerns about competition with local Faulkner practices. Over time, other subspecialties will move from BWH to Faulkner as the clinical integration continues. The hospital and departmental leaderships of both institutions convene a monthly meeting of subspecialists from both campuses to determine opportunities to collaborate on clinical roles, coverage issues, and teaching responsibilities. The outcome has resulted in increased value for the system due to better capacity utilization, subspecialty care growth, and coordination of resources.

**Harvard Vanguard Medical Associates**

In early 2000, BWH and HVMA began to renegotiate their long-term hospital rate agreement. The agreement historically had a seven-year term, and the previous seven-year term was to end in 2001. However, HVMA wished to begin the negotiations early, as it had been offered attractive terms by one of the competing academic medical centers in Boston. In

**Table 1**  
**Total Patient Visits to Selected Clinical Areas at Faulkner Hospital, FY1999–2002**

Area	FY1999	FY2000	FY2001	FY2002
Cardiac catheterization and related procedures	217	177	288	306
Echocardiography	1,593	1,743	2,172	2,726
Cardiac stress testing	1,282	1,289	1,538	1,942
Cardiac rehab	2,518	2,150	2,667	2,964
CT	5,468	5,733	7,805	10,340
MRI	1,810	1,840	2,239	2,975
Ultrasound	3,326	3,234	3,916	4,648
GI procedures	3,181	3,824	4,810	6,341

addition, HVMA had just hired a new chief executive officer with a great deal of experience in managed care and oversight of physician practices. He wanted to be innovative in the way care was being offered for HVMA patients.

In this setting, BWH and HVMA focused on the idea of potentially treating more of the community-hospital-level admissions from HVMA at Faulkner and reserving the higher-cost BWH site for the high-intensity cases. In this arrangement BW/F could provide reduced rates for HVMA at Faulkner, while increasing the rates at BWH. This would result in overall reduced hospitalization costs for the HVMA group, but appropriate reimbursement at both BW/F sites. HVMA decided that the BW/F solution was the best long-term alternative. The HVMA leadership became convinced that the presence of the BWH specialists and housestaff, overall better parking and access to Faulkner, availability of private rooms at Faulkner, and branding of Faulkner on the part of BW/F were sufficient reasons to convince their staff and patients that BW/F was really one hospital care experience. The HVMA relationship, and its extension to both campuses, serves as a tremendous driver of the BW/F strategy and embodies the principles of the overall affiliation.

The agreement also focused on a number of medical management initiatives, to be arranged across both campuses, to help provide more cost-effective care. BW/F

was willing to fund some of the transition costs and interim service duplications required to move HVMA infrastructure to Faulkner. HVMA is a leader in the use of hospitalists, advanced case management, electronic medical records, and disease management. BW/F assisted with the move of these services to facilitate reestablishment of a successful medical management model at Faulkner, critical to successful performance in joint risk-sharing arrangements undertaken by HVMA and BW/F. Information systems at Faulkner were enhanced to incorporate access portals to all three electronic patient databases (at HVMA, Faulkner, and BWH).

In the spring of 2000, a contract was completed that entailed moving as many as 2,500 medical/surgical HVMA patients annually from BWH to Faulkner. Table 2 demonstrates the progress of the migration of these patients, who were sent by both HVMA and BWH referring physicians. While the growth in Faulkner admissions and procedures has been significant, continued demand has kept corresponding BWH volume declines slight and within anticipated parameters. In some areas BWH has seen growth in spite of the move of similar services to Faulkner.

The overall impact on Faulkner in terms of total volume of inpatient discharges, observations, outpatient visits, outpatient surgery, emergency department visits, and financial operating performance has

been substantial and continues to improve (see Table 3, top panel). Prior to the affiliation, these volumes were flat or declining. Meanwhile, BWH continues to have strong performance in these measures, and operating gains continue (see Table 3, bottom panel).

Satisfaction for HVMA patients is high. One indication of this are the high satisfaction ratings obtained in a postdischarge Press Ganey mail survey carried out in April, 2002 (40% response rate). A total of 86% of the responding patients who had been previously hospitalized at both BWH and Faulkner felt that Faulkner was equally or more satisfying than BWH. Also, 92% said they would recommend Faulkner to family and friends. On most measures of satisfaction, there was little difference reported between the two institutions for both HVMA and non-HVMA patients.

The HVMA medical staff has a presence at both hospitals and has been coordinating care with both BWH specialists and Faulkner private medical staff specialists. Triage mechanisms between BWH and Faulkner have been well developed, including significant coordination between the two emergency departments and the HVMA community health centers. Patients seen at one hospital (either BWH or Faulkner) are triaged from its emergency department to the other depending on the clinical circumstances. This occurs for all patients, whether referred by HVMA or by BW/F primary and specialty physicians. The HVMA health center urgent care units are active participants in these triage patterns, and play a critical role in directing patients to the best setting depending on clinical circumstances. HVMA is also moving more ambulatory specialty clinics to Faulkner, to concentrate its clinical care in this site.

### Relationship Factors

The integrated affiliation model of an academic medical center and a community teaching hospital is dependent on several key relationship factors as well as the overall marketplace and payer environment. Most important are the geography and size of the affiliated institutions, receptivity of clinical staff, cautious capital investment, commitment of senior leadership,

Table 2

#### Admissions and Ambulatory Procedures at Faulkner Hospital for Patients Referred by HVMA and BWH Physicians, FY1998–2002\*

	FY1999	FY2000	FY2001	FY2002
<b>Care at Faulkner Hospital: patients referred by HVMA and BWH physicians</b>				
Medical/surgical admissions and observations	–	491	2,216	3,241
Ambulatory procedures	720	1,270	1,983	2,338
<b>Care at BWH: patients referred by all referring physician groups</b>				
Medical/surgical admissions and observations	35,762	36,227	35,290	35,410
Ambulatory procedures	11,808	12,179	11,796	13,651

\* In the spring of 2000, a contract was completed that entailed moving annually as many as 2,500 medical/surgical patients, referred by HVMA, from BWH to Faulkner Hospital. The table shows the progress of the migration of these patients, who were sent by both HVMA and BWH referring physicians. (HVMA = Harvard Vanguard Medical Associates; BWH = Brigham and Women's Hospital.)

Table 3

**Comparison of the Institutional Volumes and Other Measures at Brigham and Women's Hospital and Faulkner Hospital, FY1999–2002**

Hospital	FY1999	FY2000	FY2001	FY2002
<b>Faulkner Hospital volume, staffing, and financial performance</b>				
Discharges	6,007	5,765	7,267	8,079
Observation cases	724	720	1,177	1,302
Outpatient visits	146,682	151,054	157,328	175,707
Outpatient surgery	4,866	4,961	5,858	6,362
ED visits	20,000	22,000	24,697	26,834
FTEs	771	757	836	895
Operating (loss) gain	(\$6.3M)	(\$7.1M)	(\$4.2M)	0
<b>Brigham and Women's Hospital volume, staffing, and financial performance</b>				
Discharges	49,566	50,930	50,038	49,742
Observations	6,393	6,574	5,974	6,205
Outpatient visits	605,368	635,699	644,753	650,992
Outpatient surgery	9,599	10,101	9,745	10,121
ED visits	49,077	54,139	51,214	50,760
FTEs	4,851	5,083	5,384	5,676
Operating (loss) gain	(\$1.5M)	\$4.6M	\$20.2M	\$46.3M

complementary nature of clinical services, and presence of a large, well-managed referring physician group that is sensitive to the cost of care and fully engaged in the strategy.

In terms of geography, the two hospitals described are approximately three miles apart. While a specific distance would not seem essential to success, we believe this degree of geographic separation is optimal. The closeness permits the move of patients and clinicians with relative ease. However, the hospitals are not so close as to promote confusion as to exactly which institution provides particular services, as we have seen in several other hospital relationships in our region. Similarly, the hospitals are not so far apart as to promote total autonomy and complete duplication of all clinical services and capabilities. We believe this geographic distance between the institutions, approximately a 15-minute drive (in Boston traffic), places them at the “sweet spot” of separation between academic medical center and community hospital affiliate.

The institutions are substantially different in size (BWH is much larger than Faulkner), and this difference has also helped to minimize confusion of roles and unnecessary duplication of services. Complementary services are

provided that are appropriate for the clearly different patient populations. For example, interventional cardiac procedures (such as PTCA) are provided exclusively at BWH, while diagnostic cardiac catheterization is available at Faulkner. These distinct differences in size, patient population, and clinical expertise have allowed the affiliation to avoid some of the inefficiency and political complexity that relationships of highly similar hospitals often endure.

Both institutions were receptive to limited clinical service integration, a key to such an affiliation. An important aspect of this receptivity was expanding to Faulkner those BWH services that do not directly compete for patients with Faulkner physicians. For example, the BWH hospitalist program has been fully integrated into the Faulkner medical service. The local private staff at Faulkner, many of whom continue to care for their own patients without the aid of a hospitalist, were reassured that the objective was not to take away inpatient care and associated revenue from Faulkner primary care physicians and specialists who desire to care for their own hospitalized inpatients. Rather, the objective was to provide efficient and coordinated attending physician coverage for patients referred by those BWH

physicians who are logistically unable to care for inpatients at both hospitals. The voluntary use of the hospitalist program has been popular at Faulkner. Some private referring physicians outside of BWH now also use hospitalists to care for the majority of their inpatients at Faulkner.

Some investment in infrastructure, limited in scope, was necessary to accommodate the affiliation. All parties using Faulkner have benefited from the affiliation's associated upgrade in ancillary services and physical plant. However, capital was invested cautiously so as not to duplicate the cost structure of the academic medical center.

Joint planning and performance monitoring is a shared activity, designed to promote the smooth flow of information. For example, there is an ongoing collaborative effort to assure that volume targets at both institutions are achieved and that care is provided appropriately. This is reviewed in a monthly BW/F Steering Committee meeting attended by leaders from both hospital organizations and HVMA. In terms of quality, there is ongoing quality-assurance review of cases transferred between institutions, with regular feedback provided to appropriate physicians in the emergency departments, hospitalist programs, and HVMA urgent care centers. It has been important to educate the staff of both institutions and HVMA about the affiliation and the gradual steps that have evolved in its development. This has taken the form of staff meeting presentations, written and electronic communication with faculty, and other departmental updates.

The most important relationship factor has been the provision of complementary services between the two institutions. Doing this has enhanced the value of the health care provided by the system.<sup>1</sup> The system has the capability of triaging patients to the most appropriate setting based on clinical need and cost-effectiveness. This carefully evolved relationship developed at a time of relative financial stability for both organizations, albeit with some concerning trends, rather than in an atmosphere of impending financial collapse. Institutional roles have been defined within the BW/F system with

clarity and caution, and continue to develop gradually as opportunities to leverage mutual benefits arise. For example, where there is a need to have additional secondary-type care for BWH patients, such as routine dialysis or cardiac rehabilitation, consideration is first given to establishing or expanding that service at Faulkner.

### Transitional Challenges

The affiliation of the two institutions has not been without problems. Some observers have likened hospital mergers “more to a divorce than a marriage, introducing vulnerabilities, sensitivities, suspicion and redirection, that often seem inappropriate.”<sup>6,7</sup> While the BW/F relationship is not a complete hospital merger, the affiliation between BWH and Faulkner did engender some of the same feelings, especially early in the relationship. Leadership of both entities recognized from the beginning that while the institutions had shared values, and somewhat overlapping missions, they also had distinct cultures. Many of these issues have been faced by other institutions, both within health care and in other industries, attempting to launch similar integration.

**Maintaining the community hospital’s cost structure.** The most significant problem has been maintaining the cost structure of the community hospital.<sup>2</sup> The impulse in this tight affiliation relationship is to attempt to make the two institutions completely seamless from an administrative viewpoint. This might entail developing clinical information and management control systems that are quite comparable or fully integrated, such that clinical and administrative information can travel easily from one institution to the other. However, the costs associated with extension of a single information system platform from BWH could not be easily borne by a community hospital. For example, immediate extension of the BWH-developed electronic order-entry system from BWH to Faulkner would have been prohibitively expensive. Instead, the BWH order-entry module is being extended to Faulkner’s existing system over a three-year period. Similarly, a small community hospital like Faulkner has not been able to afford the high cost of fully integrated electronic systems for human resources, finance,

and cost accounting. Finally, in a community hospital setting, albeit a community hospital with a long history of teaching programs, physicians from BWH and HVMA had to become accustomed to less clinical-fellow support than was the case at BWH. Unlike the extensive fellowship programs at BWH, there is only a single postresidency clinical fellow assigned to Faulkner.

**Building trust.** Second, there was a need to build trust between the two medical staffs.<sup>8</sup> The practitioners at Faulkner were concerned from the start of the affiliation discussions that the relationship between the two hospitals might be an aggressive attempt at establishing control by BWH. The community hospital staff were concerned that they would lose autonomy over their clinical practices. As a result, language in the final affiliation documents made it clear that an independent private practice staff was to be valued and would be continued at Faulkner.

The medical professional staffs of all three affected groups (BWH, Faulkner, and HVMA) practice under quite different organizational and financial models. Indeed, most of the Faulkner staff hew to a private practice model. They maintain admitting privileges at Faulkner, but are not otherwise financially related to the hospital. While the chiefs of medicine, surgery, and of a number of the hospital-based specialties such as radiology, anesthesia, and pathology have employment contracts with Faulkner, the overwhelming majority of the staff members do not.

At BWH, nearly all the physicians are employed by the Brigham and Women’s Physicians Organization (BWPO). This is a separate, nonprofit organization but it has the same corporate parent as BWH and Faulkner do, the BW/F. Most of the physicians are salaried, although almost all physicians also have financial incentives for productivity that are based on private practice models. Nonetheless, the mindset and culture of the two institutions’ physician staffs are quite a bit different.<sup>9</sup> The third major set of physicians, from HVMA, practice substantially under global capitation, and bring incentives focused primarily on cost-effectiveness of care. Despite these differences, primary care practitioners and surgical subspecialists from all three entities have practiced peacefully together

at Faulkner. All three groups of physicians bring their own cases to Faulkner, and there has not been a significant sense of competition or a disruption of existing loyalties.

However, the export of cases from BWH to Faulkner Hospital put pressure on the hospital-based practices in the BWPO. In particular, the radiology, anesthesia and pathology departments had cases, and potential clinical revenue travel to Faulkner. While replacement cases at BWH have offset some of this loss, some pressure continues on the professional side. At Faulkner, the hospital-based physicians are private practitioners on contract with the hospital. This created a great deal of tension and resulted in continued negotiation between, for example, the Department of Radiology in the BWPO and the Faulkner radiologists. Ultimately the Faulkner radiologists became employees of the BWPO under terms that addressed many of the concerns of both entities.

These types of clashes between hospital-based specialties are not uncommon. In at least one other example, at Santa Monica Hospital in southern California, the relationship with the teaching institution led to significant pressure on the relationship with the hospital-based specialists at the community hospital.<sup>10</sup> Such conflicts can be resolved only to the degree that the physicians in both the community and the teaching hospital are willing to accommodate one another and to make compromises.<sup>11</sup> A single financial platform for the physicians of both institutions makes the movement of cases from one hospital to the other much more seamless. Without a unified platform each party must give much more attention to recognizing the value added by the overall relationship and respecting cultural differences as they seek to resolve these matters.<sup>11</sup>

Issues with the medical staffs have merited continuous monitoring by the collective BW/F and HVMA leadership to ensure that those issues are addressed in a timely and constructive fashion. Full resolution of these issues is still incomplete, and worries about second class citizenship, and special privileges for certain physicians employed in one group or the other, persist. There have been numerous joint meetings of leadership to swiftly address concerns as they arise, and

in general the situation has improved greatly over the past seven years, with greater trust and cooperation. Thoughtful consideration, respect, and commitment to a robust overall enterprise that benefits the whole, are required to overcome these staff issues.

#### **Anticipating the pace of patient flow.**

The third challenge in an affiliation of this type is anticipating the pace of the flow of patients from the academic center to the community hospital. This makes budgeting difficult both in terms of the volume of cases anticipated to move and resources required to care for these patients. Factors that are difficult to predict include individual patient and physician willingness to move care to the community hospital setting, impact of differential rates on the behavior of referring physicians who use capitated and other risk-sharing approaches, and market-based resource constraints such as nursing supply. In our own situation, although the flow of patients is bidirectional, the major new stream of patients since the affiliation has been the flow from BWH to Faulkner. Budgeting for BW/F has become increasingly more accurate as the affiliation has proceeded.

#### **Controversy over naming the new entity.**

Fourth, the naming of the affiliated entity was controversial. There were many in the BWH community who felt that the name of the new entity should more exclusively reflect BWH's brand identity. Similarly, on the Faulkner side there was a desire to maintain some autonomy regarding the new name. After extensive market studies evaluating patient reaction, it was determined that a joint name, Brigham and Women's/Faulkner Hospitals, resonated best with those to whom the system was most trying to appeal, its mutual patients. At Faulkner, the Faulkner Hospital name remains prominent though there are Brigham and Women's/Faulkner signs in obvious view. Similarly, at BWH, the original BWH name remains most prominent. While the BW/F name has struck a reasonable balance with various constituents, the system continues to reexamine naming issues as its identity evolves.

**Clinical overlap issues.** Fifth, while much of the early specialty care provided by BWPO physicians at Faulkner did not overlap clinically with the work of

Faulkner specialists, over time there have been areas of common practice that may lead to concern. For example, secondary specialty care such as medical test interpretation is an area that will need to be better defined between the staffs. Other similar areas of overlap, such as secondary care medical or surgical consultation, will also need to be resolved without creating undue stress and competition.

#### **Need for balance in financial reporting and accountability.**

Sixth, in terms of financial performance, while the overall bottom line is common between the BW/F family, each hospital maintains a separate profit and loss statement, which is reviewed by the senior leadership of the integrated BW/F system. Distinct income statements can create internal hurdles to "system thinking." For example, in one particular contract, payer rates for secondary care at Faulkner were higher than at BWH. While an internal adjustment of the rates makes sense from the standpoint of the system to encourage the flow of patients, particularly managed care risk patients, such a rate adjustment needs to be seen from a system perspective. If each entity hospital were evaluated solely based on its own revenue and expense performance, they might overlook the system benefit of rationalizing hospital rates within the affiliation. It is critical to establish balance between systemic and local financial reporting and accountability.

#### **The changing payer environment.**

Finally, the payer environment is continually changing. As an organization, BW/F hospitals and physicians are committed to providing the most appropriate care in the most appropriate setting. Although the affiliation structure was originally developed in the context of rising provider risk-sharing and global capitation, these full-risk arrangements are waning in our region. While cost pressures under capitation persist for the HVMA population, even HVMA has begun to accept a growing segment of nonrisk patients. Nonetheless, it is possible that the current backlash against substantial provider risk sharing will be short lived. Even without dramatic provider risk, maintaining and enhancing a low-cost model of care will remain highly desirable. Furthermore, recently developed insurance plans that present patients with differential co-payments

and co-insurance depending on the site of service, as well as high-deductible plans, will motivate patients to seek low-cost settings for secondary care. Regardless of the specific incentives, a focus on cost-effectiveness remains a fundamental part of the overall strategy.

#### **The Always-Evolving Affiliation**

In full consideration of the BW/F affiliation, it is an important caveat that relationships of this sort are never truly completed. Other significant hospital affiliations, some of which had some early success, later collapsed.<sup>12</sup> There are clearly still substantial challenges to complete the vision of a single integrated entity that is capable of rationalizing the provision of high-quality services.

The organizing principle for BW/F has been to provide the right care in the right place at the right time. Even as global capitation risk-sharing fades in our region, there are substitute pressures presented by health plans with enhanced patient cost sensitivity. Many patients are cared for in the community setting quite appropriately. Other patients' clinical conditions require that they be cared for in a tertiary facility. Focusing on a single, rationalized standard of care for all patients that encompasses a range of acuity levels simplifies the mechanics of the relationship between hospitals and promotes a successful affiliation in the best interest of patients, faculty, and institutions.

Seven years into the relationship, patient satisfaction remains high. Also, although there are some flash points, the medical staffs at both hospitals and HVMA report satisfaction with the evolving relationship. Finally, the payers are extremely pleased to have patients referred to a community hospital, with a lower cost structure, when clinically appropriate. The same is true for risk-sharing primary care physicians, who can take advantage of the lower cost of care at Faulkner. Various relationship issues and problems remain challenges, but the results thus far are very encouraging about the future prospects for Brigham and Women's/Faulkner Hospitals.

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