

Orthopedic Practice Management

Strategies for Growth
and Success

Eric C. Makhni

Melvin C. Makhni

Eric F. Swart

Charles A. Bush-Joseph

Editors

 Springer

Orthopedic Practice Management

Eric C. Makhni • Melvin C. Makhni
Eric F. Swart • Charles A. Bush-Joseph
Editors

Orthopedic Practice Management

Strategies for Growth and Success

 Springer

Editors

Eric C. Makhni
Department of Orthopedic Surgery
Henry Ford Hospital
Detroit, MI
USA

Eric F. Swart
Department of Orthopedic Surgery
UMass Memorial Health Care
Worcester, MA
USA

Melvin C. Makhni
Brigham and Women's Hospital
Harvard Medical School
Department of Orthopedic Surgery
Boston, MA
USA

Charles A. Bush-Joseph
Department of Orthopedic Surgery
Rush University Medical Center
Chicago, IL
USA

ISBN 978-3-319-96937-4 ISBN 978-3-319-96938-1 (eBook)
<https://doi.org/10.1007/978-3-319-96938-1>

Library of Congress Control Number: 2018962531

© Springer Nature Switzerland AG 2019

This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.

The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.

The publisher, the authors, and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, express or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Foreword

These are exciting times in medicine. Our health care delivery and payment systems are undergoing fundamental transformation from a system focused on the provision of health care services, to one that is focused on improvements in health. These changes create unique opportunities and challenges for orthopedic surgeons. In addition to being skilled technicians and excellent communicators, orthopedic surgeons entering practice today must be adept at using information about their outcomes and costs of delivering care in continuous performance improvement efforts; facile with ever growing and rapidly changing health information technology; and familiar with a variety of different contracting and integration strategies.

From understanding what type of practice environment is right for you, to learning effective strategies for building and growing a practice, to gaining insights into tools and technologies that can be used to measure and improve patient outcomes, and identifying and evaluating professional and leadership development activities outside of clinical practice, this book will serve as a valuable reference guide for young orthopedic surgeons as they enter practice.

Practicing orthopedic surgery is both a great privilege and a grave responsibility; I hope you will find the insights provided on the pages herein by those who have come before you to be helpful on your journey to what I am certain will be a long, productive, and rewarding career.

Austin, TX, USA
November 2017

Kevin J. Bozic, MD, MBA

Preface

One of the most common questions I get by my colleagues and residents is, “How do you use your MBA in your medical practice?” And of course, without fail, my only response is, “I use it all the time!” I was very fortunate to have had the opportunity to seamlessly pursue my Masters of Business Administration (MBA) during medical school. However, due to a variety of reasons, most of my colleagues did not have this opportunity.

While many may believe that a formal coursework is required to learn the “business” fundamentals of clinical orthopedics, our hope is that this book may serve as a useful guide and even alternative to that coursework. In fact, most of the best, business-savvy orthopedic surgeons I know never took a course in management, or finance, or marketing, and instead became proficient through self-education and trial-and-error. Moreover, most of what I “wish” I knew when I started my clinical practice was not taught in business school. So – for those of you who do not have an MBA – rest assured that you can be a pro in practice management without ever paying a dollar of tuition (except maybe, for this book and others!).

Our main goal in this book is to provide readers with a brief introduction to many of the fundamental aspects of practice management. While this is written from an orthopedic focus, our hope is that practitioners in other specialties may find useful information within the chapters ahead. On the other hand, we realize that it is impossible to cover every topic relevant to practice management in one book. Therefore, we hope that we can continue to publish and review this guide so that we not only stay current in the subject matter, but also continue to comprehensively cover all the salient topics that matter most to practitioners.

As you progress through the chapters of this book, please remember a few core principles. First, and foremost, this book is meant to be an introduction. There is a *wealth* of information out there that augments and enhances the text ahead. There are several resources from the business world that are very powerful to practicing orthopedics. For those of you who have daily commutes, I recommend you download any of the several management-oriented podcasts (most of them are free). Some of these include Career Tools, Manager Tools, and reviews from the *Harvard Business Review*. There is no shortage of helpful textbooks as well that you can

similarly listen to in the car or train in audio-book format or in text/Kindle format as well. The ones that I have found most helpful have been those focused on effective management strategies as well as those focused on communication and leading teams. Make sure to explore the business section of your local bookstore (brick and mortar or online) to see what other books are out there that will help you become a successful practitioner.

Second, never forget that formal education is more accessible than ever. You do not have to find a 2-year break in your education or practice to go and pursue a formal MBA. There are numerous alternatives to such an education. Many business schools offer online curricula that can be completed on nights and weekends. Other schools – including the top schools in the country – offer “Executive Education” programs that can be focused on a specific subject matter or broad and inclusive of a typical (but condensed) MBA coursework. Finally, there are numerous non-MBA degrees that are tailored to professionals in healthcare. Examples include Master of Healthcare Administration, Master of Public Health, and many others.

Ultimately, you are reading these pages because you have an interest and desire to understand how the “nonclinical” world works. We thank you for taking the time to explore the contents of this book, and we welcome any and all feedback that you might have. Please feel free to reach out to us (orthopedicpracticemanagement@gmail.com) and share your thoughts and comments with us so that we can work to implement this feedback into future versions of the book.

West Bloomfield, MI, USA

Eric C. Makhni

Contents

Part I Starting and Building a Practice

- 1 What to Look For In a New Job Opportunity: Strategic, Personal, and Legal Considerations 3**
Eric F. Swart
- 2 Partnership, Ancillaries, and Other Considerations 11**
Michael J. McCaslin and Nicholas B. Frisch
- 3 Setting up your Clinical Practice – Keys for Growth and Success 33**
Eric C. Makhni and Brian Forsythe
- 4 Recruiting and Incorporating Mid-Level Providers 43**
Peter Borowsky, Jacob Blanchett, Kyle Pilz, and Eric C. Makhni
- 5 Social Media Use in the Field of Orthopedic Surgery 61**
Mohsin S. Fidai, Joseph S. Tramer, Toufic R. Jildeh, Sasha Stine, Fabien Meta, and Eric C. Makhni

Part II Leadership and Management

- 6 Building and Managing a Successful Private Practice 73**
Joseph M. Lombardi, Melvin C. Makhni, and Joseph S. Lombardi
- 7 Leading a Privademic Medical Center: Experience Running the Rothman Institute 85**
Hamadi A. Murphy, Arjun J. Sebastian, Weilong J. Shi, Christie Stawicki, Gregory D. Schroeder, Mike West, and Alexander R. Vaccaro
- 8 Recruitment and Department Expansion 93**
William N. Levine
- 9 Implementing Outcomes Collection in Clinical Practice 99**
Fabien Meta, Vincent A. Lizzio, and Eric C. Makhni

10 Pursuing a Dual Degree 115
Eric C. Makhni

11 Healthcare Policy 121
Ramin M. Lalezari and Christopher J. Dy

Part III Additional Topics

12 Surgical Training and Education 151
Daniel J. Miller and Vasilios (Bill) Moutzouros

13 Independent Medical Examinations and Legal Depositions 161
Fady Y. Hijji, Ankur S. Narain, Krishna T. Kudravalli, Kelly H. Yom, Edward Goldberg, and Kern Singh

14 Board Certification and Maintenance in Orthopedic Surgery 171
Kenneth R. Gundle

15 Principles of Clinical Research 187
Richard N. Puzitiello, Avinesh Agarwalla, Brian Forsythe, and Natalie L. Leong

16 Innovation for Surgeon Inventors 213
Stephen Bartol

Index 235

Contributors

Avinesh Agarwalla, BS Rush University Medical Center, Midwest Orthopedics at Rush, Chicago, IL, USA

Rush University Medical Center, Department of Orthopedic Surgery, Chicago, IL, USA

Stephen Bartol, MD, MBA, FRCSC CMO for Henry Ford Innovations, Henry Ford Health System, Department of Orthopedic Surgery, Detroit, MI, USA

Jacob Blanchett, BS Division of Sports Medicine, Department of Orthopedic Surgery, Henry Ford Health System, West Bloomfield, MI, USA

Peter Borowsky, BS Division of Sports Medicine, Department of Orthopedic Surgery, Henry Ford Health System, West Bloomfield, MI, USA

Kevin J. Bozic, MD, MBA Dell Medical School at The University of Texas at Austin, Department of Surgery and Perioperative Care, Austin, TX, USA

Charles A. Bush-Joseph, MD Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Christopher J. Dy, MD, MPH Washington University School of Medicine, Department of Orthopedic Surgery, Division of Hand and Upper Extremity Surgery, Department of Surgery, Division of Public Health Sciences, St. Louis, MO, USA

Mohsin S. Fidai, MD Henry Ford Health System, Department of Orthopedic Surgery, Detroit, MI, USA

Brian Forsythe, MD Rush University Medical Center, Midwest Orthopedics at Rush, Chicago, IL, USA

Rush University Medical Center, Department of Orthopedic Surgery, Chicago, IL, USA

Nicholas B. Frisch, MD, MBA Ascension Crittenton Hospital, Rochester Hills, MI, USA

Edward Goldberg, MD Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Kenneth R. Gundle, MD Orthopedic Oncology, Oregon Health and Science University, Department of Orthopedics and Rehabilitation, Portland VA Medical Center, Operative Care Division, Portland, OR, USA

Fady Y. Hijji, MD Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Toufic R. Jildeh, MD Henry Ford Health System, Department of Orthopedic Surgery, Detroit, MI, USA

Krishna T. Kudaravalli, BS Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Ramin M. Lalezari, BA Washington University School of Medicine, Department of Orthopedic Surgery, St. Louis, MO, USA

Natalie L. Leong, MD Rush University Medical Center, Midwest Orthopedics at Rush, Chicago, IL, USA

Rush University Medical Center, Department of Orthopedic Surgery, Chicago, IL, USA

William N. Levine, MD New York Presbyterian/Columbia University Medical Center, Department of Orthopedic Surgery, New York, NY, USA

Vincent A. Lizzio, BS Wayne State University School of Medicine, Henry Ford Hospital, Department of Orthopedic Surgery, Detroit, MI, USA

Joseph M. Lombardi, MD Orthopedic Surgery, Columbia University Medical Center, Department of Orthopedic Surgery, New York, NY, USA

Joseph S. Lombardi, MD JFK Medical Center, Edison Surgical Center, Department of Orthopedic Surgery, Edison, NJ, USA

Eric C. Makhni, MD, MBA Division of Sports Medicine, Department of Orthopedic Surgery, Henry Ford Health System, West Bloomfield, MI, USA

Melvin C. Makhni, MD, MBA Brigham and Women's Hospital, Harvard Medical School, Department of Orthopedic Surgery, Boston, MA, USA

Michael J. McCaslin, CPA Somerset CPAs and Advisors, Indianapolis, IN, USA

Fabien Meta, BS Wayne State University School of Medicine, Henry Ford Hospital, Department of Orthopedic Surgery, Detroit, MI, USA

Daniel J. Miller, MD Gillette Children's Specialty Healthcare, St. Paul, MN, USA

Vasilios (Bill) Moutzouros, MD Division of Sports Medicine, Henry Ford Health System, Department of Orthopedic Surgery, Detroit, MI, USA

Hamadi A. Murphy, MD, MS The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Ankur S. Narain, BA Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Kyle Pilz, MMS, PA-C RUSH University Medical Center, Department of Sports Medicine, Midwest Orthopedics at RUSH, Chicago, IL, USA

Richard N. Puzitiello, BS Rush University Medical Center, Midwest Orthopedics at Rush, Chicago, IL, USA

Rush University Medical Center, Department of Orthopedic Surgery, Chicago, IL, USA

Gregory D. Schroeder, MD The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Arjun J. Sebastian, MD The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Weilong J. Shi, MD The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Kern Singh, MD Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Christie Stawicki, BS The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Sasha Stine, MS Wayne State University School of Medicine, Henry Ford Hospital, Department of Orthopedic Surgery, Detroit, MI, USA

Eric F. Swart, MD Department of Orthopedic Surgery, UMass Memorial Healthcare, Worcester, MA, USA

Joseph S. Tramer, MD Henry Ford Hospital, Department of Orthopedic Surgery, Detroit, MI, USA

Alexander R. Vaccaro, MD, PhD, MBA The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Mike West, MBA, CPA The Rothman Institute at Thomas Jefferson University, Department of Orthopedic Surgery, Philadelphia, PA, USA

Kelly H. Yom, BA Department of Orthopedic Surgery, Rush University Medical Center, Chicago, IL, USA

Part I
Starting and Building a Practice

Chapter 1

What to Look For In a New Job Opportunity: Strategic, Personal, and Legal Considerations



Eric F. Swart

If This Is Your First Job

If this is the first time you are applying for a job outside of the standard training “pipeline” of college, medical school, and residency, there are a few crucial differences in this process that are worth considering.

First, as an attending orthopedic surgeon, **you have a lot of value**. You are highly trained, and will be billing and collecting hundreds of thousands (or millions) of dollars annually, and will generate profit for both your practice and the healthcare system you practice in. This will stand in stark contrast to what life has been like in training thus far, and one of the most common mistakes for young surgeons is to underestimate their own value and contributions.

Further, unlike medical school, residency, and fellowship, the search for a job *really is a two-way fit*. You are not one of hundreds of applicants applying for multiple training “spots,” where most qualified applicants could satisfactorily accomplish the job requirements. You are looking to join a practice where your individual contributions will be significant, and you will be entering into a long-term, complex relationship with the group you join. The importance of understanding what you want out of that relationship from the group, and what the group expects out of that relationship from you is crucial.

Along those lines, *the job description for a practicing orthopedic surgeon is relatively flexible*. As opposed to the role of a junior resident which has very concrete and well-defined requirements and obligations, recognize that as a practicing physician you have significantly more control over how you spend your time and what you want to choose to focus on. This is an opportunity to define your professional life and center it around your personal priorities and interests.

E. F. Swart

Department of Orthopedic Surgery, UMass Memorial Healthcare, Worcester, MA, USA

Define What Matters to You

Before even communicating with any prospective employers, the first step in looking for a new job opportunity is to define what your personal and professional priorities are. This should be as explicit and formally stated as possible, in order to force concrete description and prioritization, which will make decision-making more straightforward at later stages.

One commonly utilized method is to start by listing all of the attributes that you will take into account when considering a potential position. At this stage, just list any factor that you think you will be considering. Do not worry about assigning value or importance yet. A potential list of factors might be:

- *Clinical Practice Type*: Private practice, academics, or something in between? You may want to consider and evaluate multiple different types of positions, but this is a core distinction you should consider early in the process.
- *Geography*: Where you are willing to live and practice plays a central role in this process. For some, this will be a primary factor, while for others it may be relatively flexible.
- *Salary/Reimbursement*: How much you are paid, and how that pay is structured are critical factors. Some may want a more reliable, guaranteed income, while others may be more interested in positions with higher potential pay but less income stability.
- *Mentorship Opportunities*: The availability of senior partners in the practice to act as mentors and provide guidance may be a crucial factor for some, especially those earlier in their careers. It is important to evaluate not only the presence of mentors, but their availability and interest in mentoring as well.
- *Research Potential*: Some applicants will make research a primary consideration, while others will have minimal interest in research. No matter what your situation, you should clearly identify the expectations and requirements for research in any potential position, and make sure it is compatible with your goals and interests.
- *Stability*: Is this a well-established position with multiple partners who have been present for many years, or is this a new/expanded position where the prospects for success are less reliable? How much recent turnover has there been in the practice, both at entry-level positions and leadership positions? The importance of stability of a position will be a function of your current life and family situation, and your short- and long-term goals.
- *Growth Potential*: Is there a clear path for growth and advancement within the practice? How dedicated is the group to your success? Are your personal goals aligned with their strategic growth plans?
- *Teaching Role*: Will you work with residents? Physician assistants or nurse practitioners? Virtually all positions have at least some teaching component, although the amount and importance of that component can be highly variable, and should match your level of interest.

- *Administrative Role:* What responsibilities will you have outside of clinical and academic duties? Are you interested in being involved in process and quality improvement, or financial management? Making sure your interests match with expectations is crucial.
- *Work-Life Balance:* Finally, what will your life be like outside work? How much flexibility is there, and how important is that to you? At different stages of life, people may have very different priorities about balance between work responsibilities and life outside the hospital. Even the best work environment can be unsustainable if there is not room for meaningful life outside of work.

Once you have thought through and defined the aspects of job opportunities that you will be considering, *define what matters most to you*. The simplest way to do this is to rank the factors you identified from “most important” to “least important.” For some, geography and work-life balance will be their major considerations, while for others it may be salary and growth potential. *If you have family members centrally involved in your life, involve them heavily in this process*. Clearly identifying what is most important to you and your family will make decision-making less daunting when you are evaluating multiple opportunities by providing a structure through which to compare them, and by reminding you of what you have decided is the most important.

The Stages of a Job Search

The process of finding, applying for, and evaluating different job opportunities is more fluid and open-ended than most of the preceding stages of medical training (in medical school, residency, fellowship, etc.), which generally have clear, concrete timelines, and a set of well-defined steps required to obtain a position. In contrast, evaluating orthopedic positions is much more dynamic and flexible, so staying organized, being a clear communicator, and having a solid plan is essential. In general, the process can be broken down into a few stages:

- *Early Communication:* Prior to any formal communication about a specific position, contact with potential future employers occurs on a more informal basis. Word-of-mouth, referrals, and networking are crucial for identifying and staying in touch with potential future employers. Cast a broad net early by using academic meetings, courses, and other venues to make connections. Keep track of communications, as they often end with vague plans to retouch base in a set period of time when things may become more definite. Following up reliably is a way to demonstrate sustained interest and commitment, and show a potential employer that you are serious about taking the discussion further.
- *The Interview Process:* At some point, informal conversations will transition into plans to formally interview for a position. The interview process itself is highly variable, may involve multiple rounds, and sometimes even formal presentations. This is usually a “feeling out” process where you determine how closely your

interests match their needs, and if your skills and personality are a good fit for the group.

- *Negotiation*: In truth, the negotiation process starts the first time you contact a potential employer, but it typically becomes more formal and concrete during the interview process and in follow-up communication after the process. It is important during this process to have a strong position on what you can bring to the practice, and to know what your “asks” are. The clearer a sense you have at the onset of what your “musts” or “deal breakers” are vs. what your “wants” are, the more straightforward these conversations can be. An important negotiation principle is, whenever possible, to have a strong alternative available (sometimes described as Best Alternative to Negotiated Agreement, or BATNA). If this is your first job, it means trying to align the timeline so you are discussing multiple offers concurrently, to give you a direct basis for comparison and a stronger bargaining position. If you are already employed, it means understanding how any offer compares to your current position, and having a clear sense for what additional benefits it would take to get you to switch positions.
- *Finalization and Contract Signing*: Until you have a formal, written offer letter or a job contract, you do not have a job. See the section below about important details of the contract itself, but this phase is an important part of the process of transitioning the negotiation process above into an explicit, mutually agreed-upon plan. The more concrete you can be in terms of goals, objectives, deliverables, and requirements, the easier things will be in the future if there are any disagreements or concerns.

The Job Contract

The prospect of reading, interpreting, and negotiating over the fine legal details in a job contract can be harrowing to physicians, usually due to unfamiliarity with the terminology and a lack of formal training in both the meaning and the importance of several items commonly found in orthopedic contracts. However, in addition to verbally negotiating over the circumstances of a new job opportunity, it is critical that the contract also be carefully negotiated over to make sure it accurately reflects the position as defined by both groups. Below are some key tips and terms in the contract negotiation process:

- *Read the Contract!* This may seem obvious, but many surgeons never formally read through the contract themselves due to unfamiliarity with the terms and the misperception that the language in the contract will always reflect the content of the conversations that have happened. You should read the whole contract, in entirety, and understand precisely what you (and your employer) are agreeing to.

- Likewise, *if something is important to you about your job, make sure it is written down*. Prospective employers willing to verbally agree to conditions but unwilling to put it in writing should be a red flag in the negotiation process. In some circumstances (like many large academic centers), the formal employment contract is standardized, and you may be told that there is no room for negotiation of the contract language. If that is the case, you can still have a separate, formal written agreement between you and your employers about the things you are agreeing to outside of the standard physician contract.
- *If you are going to use a contract lawyer*: Having your contract reviewed by an attorney representing your interests is generally recommended under most circumstances. *Strongly consider using an attorney with specific experience in healthcare contracts*. Physician employment contracts have nuances and unique circumstances that not all attorneys may be familiar with. Make sure any attorney you use has the experience and skill set to best advocate for you. Additionally, *get them involved early*. If you plan on involving a lawyer of your own, tell your employer as early in the contract process as possible that you plan on doing so. If the contract has already undergone several rounds of negotiation and is in the finalization process, and then the process halts when an additional lawyer is brought in by you, it can be frustrating to your potential employer and sour negotiations.

Terms to be familiar with and specific items to look for in the contract:

- *Terms of contract and renewal terms*: Carefully examine the timing of the contract and renewal terms, to know how long the contract is valid for, and when it will be re-negotiated. Some contracts will renew automatically if both parties are happy, and others have conditions that necessarily expire after a certain time. Of note, pay attention to the termination conditions (see below). You may have a “3-year contract,” but if either party can terminate without cause with a 90-day notice, it is effectively only a 3-month contract. This can affect the stability of your position and other personal life choices you may make.
- *Partnership conditions and buy-in options*: In private practices, you may have the option to buy-in to the practice after a certain period of time (typically about 3–5 years). Read this carefully to understand what the financial commitment for a buy-in requires, and what assets and revenue streams are associated with the practice.
- *Malpractice insurance and tail coverage*: The structure of malpractice coverage is generally one of two kinds:
 - *Claims Made*: Claims-made coverage means that you are covered by the policy only if the claim is made while you are in the practice.
 - *Occurrence*: Occurrence coverage means that you are covered as long as the issue involved the lawsuit happened while you were in the practice.

Practically, this means that occurrence is more desirable than claims made. For example, if you had a claims-made policy, then left the practice, and the next year were sued for a patient care event that happened while you were in the practice, you would not be covered by a strict claims-made policy. In that instance, coverage after you left the practice for incidents that occurred while in that practice must be purchased, which is called a “tail”. The issue of who pays for the tail coverage in the event of contract termination can be essential (and expensive), and should be clearly delineated.

- *Restrictive Covenants*: Restrictive covenants broadly govern the ability of a physician to compete with a practice after leaving it. They take various forms including non-compete, non-solicitation, and confidentiality agreements. These are not permitted in some states, and the where they are allowed, the rules governing their application can be complex. If there is a restrictive covenant in the contract you are evaluating, this should be reviewed by your attorney to ensure your interests are protected, and that you understand what the consequences of leaving the group would be on your career and future practice.
- *Termination Conditions*: Be sure to understand the conditions for which either group can terminate the contract. The grounds for early termination can be “for cause” or “at will” (without a cause). If the contract can be terminated without cause, check what the repercussions of that termination mean: Do restrictive covenants still apply? Who will pay for the tails on malpractice insurance? Failure to closely evaluate this possibility can leave you financially and legally exposed if it is not clearly defined.

The Final Decision

Before making any final decisions, make sure to do due diligence and research the practice beyond the information they provide: Call former practice members who have recently left, get access to publicly available financial records, call members of other practices in the area to find out their reputation, and use whatever means you can to confirm (or change) the information you have available to make your decision.

Once you have gathered as much information as you can, go back to your original priorities, and explicitly work through how the new position will affect you (and your family). Remember that no job opportunity is ever perfect, but you can evaluate the important changes: Are you improving the areas that are important to you? Are there drawbacks or issues with the new opportunity areas where you are willing to sacrifice? By advocating for yourself during the negotiation process, gathering and corroborating detailed information about the practice, and evaluating the opportunity against your predefined list of priorities, you can maximize the chance that you will make the best decision and put yourself in a position for future success.

Recommended Reading

1. Grewal S. CareerMedicine.com's Mini Guide to physician job search: CreateSpace Independent Publishing; Feb 2009.
2. Harbin T. The business side of medicine: what medical schools don't teach you: Mill City Press; Dec 2012.
3. Higgins NB. Transition 2 practice: 21 things every doctor must know in contract negotiations and the job search: Two Harbors Press; Oct 2015.
4. Shaw K. The ultimate guide to finding the right job after residency. McGraw-Hill; Dec 2005.

Chapter 2

Partnership, Ancillaries, and Other Considerations



Michael J. McCaslin and Nicholas B. Frisch

Introduction

Healthcare is a continually changing environment, which impacts the formation and ongoing succession planning for an orthopedic group practice. Generational changes coupled with a dynamic healthcare environment create many challenges for orthopedic group practices. A succession plan is the structure which enables the addition of new physicians, facilitating the retirement and related buy-out of the senior physicians. Ultimately, appropriate succession planning leads to the continued growth and prosperity of the practice.

Understanding the importance of healthcare policy changes as well as the impact of generational shifts is critical to helping your practice successfully navigate forward. Partnership, income distribution formulas, buy-in and buy-out values and structures, and the viability of long-term practice successes are often intricately tied to policy and generational shifts. The passage of the Affordable Care Act (ACA) and the introduction of the Generation X (Gen X) and Millennials into the orthopedic group practice workforce have left a permanent impact on orthopedic group practice succession planning. The ACA pushed hospitals to become health systems, which resulted in hospitals hiring physicians across all specialties including primary care, cardiology, and orthopedics. Ultimately, there is great uncertainty today regarding the state of the ACA as new healthcare legislation continues to be debated among lawmakers. Data from the American Medical Association Physician Masterfile showed that in 2001, 47.5% of all surgeons were self-employed, but by 2009 that

M. J. McCaslin (✉)
Somerset CPAs and Advisors, Indianapolis, IN, USA
e-mail: mmccaslin@somersetcpas.com

N. B. Frisch
Ascension Crittenton Hospital, Rochester Hills, MI, USA
e-mail: nick@gafrisch.com

number decreased by 15.4% [1]. Between 2006 and 2011, there was a 32% increase in the number of surgeons employed full-time by hospitals.

Gen X and Millennials did not go into medicine necessarily dreaming of owning their own medical practice and all of the management and financial issues that accompany this. There remains little to no formal business or management training in traditional medical school education. The increasing desire for hospitals to recruit and support employed physicians offers an appealing option and alleviates much of the administrative burden associated with running a successful practice [2]. Add to this, that senior physicians have an incentive to consider hospital employment so private practice survival is at risk. While we are witnessing a shift from volume- to value-based reimbursement, senior physicians and often their existing practices are not necessarily geared toward profitability under these new payment models. Furthermore, future compensation is potentially at risk due to a number of factors including healthcare regulatory and reimbursement changes, plus increased competition with hospital-employed physicians.

Putting this all together, the path to partnership, buy-in and buy-out, ancillaries, and related practice entities has changed dramatically. We believe there is still great value to the private practice model and if set up correctly, an incredible opportunity for personal and professional growth with long-term financial sustainability. The theme in this environment is ease of practice entry, affordability, and proper exit strategy. Ease of entry and affordability is the current path to recruit and retain the current new generation of physicians. This chapter will address the current state and environment for these issues as we see it in 2018 and beyond.

Qualifications for Partnership/Partnership

There are many different legal structures in which a medical practice operates. This includes a Sub-Chapter C corporation, a Sub-Chapter S corporation, a Limited Liability Company (LLC), a Limited Liability Partnership (LLP), and a Partnership or a sole proprietorship (schedule C on the individual tax return). These different entities result in different names for the partners such as shareholder, partner, member, etc. We will reference all as “partners” for purposes of this discussion.

For a long period of time, the track to partnership inside the orthopedic private group practice industry had a pretty standard set of criteria which was utilized by most orthopedic group practices. We acknowledge that there are many variations on this model and it may not apply to every group. A newly recruited physician was required to work 2 years as an “Associate Physician,” meet all Board Certification requirements (passing the written and oral Board requirements), and be in the black (producing net income when considering the Associate Physician’s compensation) in terms of financial performance. Barring any personality or behavior issues, the Associate Physician was invited to become a partner, execute the buy-in in accordance with the buy-in formulas, and execute the appropriate legal documents.

Even with the competition of hospital employment, there are still a significant number of private practice groups and partnership opportunities for the orthopedic surgeon. Many groups have general unwritten guidelines as to what it takes to become a partner in a practice. Groups that have written guidelines generally have a list that is flexible due to the challenges in recruitment in the current environment (i.e., now competing with hospitals to hire orthopedic surgeons and not just competing with other orthopedic groups). It is advisable to obtain a clear list of qualifications for partnership in advance, which could include the following:

- Patient and bedside manner reputation
- In office and personal communication style and demeanor
- Fellow physician communication style and demeanor
- Board eligible and certified by the completion of the second year of employment
- Being in the black (producing net income) under the associate physician income distribution formula
- Regular attendance at group practice meetings, marketing functions, and social functions
- Adherence to medical records group practice documentation requirements
- Adherence to quality of care group practice required data submissions
- Adherence to group practice patient-reported outcome forms completed (HOOS JR, KOOS JR, SF-12, etc.)
- Adherence to group practice mandated number of patient satisfaction surveys completed
- Participation in group practice call coverage and emergency department group practice call coverage requirements (unless a special deal has been negotiated)
- Generally contributing in a positive way to the group practice culture

This represents a general list, and not all groups may have all items on their list or even have a list. Some of these criteria are objective, and some of these criteria are subjective. These criteria are the starting point for the group to consider whether to offer partnership. Typically, meeting these requirements does not guarantee partnership will be offered, but usually is a starting point for the partnership discussion. Group practices do not want to be boxed in in terms of having to offer partnership. If the group decides it is going to offer partnership to a physician and this is communicated to the physician, there is a substantial amount of work to be done by the physician and the group to address all the partnership issues. This includes legal requirements, buy-in issues related to what could be a number of medical practice-related entities, and a number of other related financial issues (loan guarantees).

The orthopedic group medical practice could have a number of entities that represent the overall interest of the practice. This could include the medical practice legal entity (where the professional services and ancillary services are rendered), a real estate entity or multiple real estate entities tied to the medical office buildings the group may own, a surgery center entity that houses an ambulatory surgery center owned by the group, or an entity holding the physicians partnership interest in the ambulatory surgery centers (ASC) owned by the group and another entity and

potentially skilled nursing facilities. Each of these entities becomes a part of the partnership process and could be structured differently in each group. Knowing what your groups' entities are and how they are structured is a critical part of the decision-making process before formally entering any practice.

Medical Practice Entity

The Core Orthopedic Medical Practice

The medical practice entity is the core entity for the orthopedic group practice. This is where the professional services are delivered as well as any group practice ancillary services. The orthopedic group medical practice entity typically includes some combination of the following:

- Professional practices services
- Imaging: X-ray, magnetic resonance imaging (MRI) and computed tomography (CT)
- Physical therapy (PT) and/or occupational therapy (OT)
- Durable medical equipment (DME)
- Pharmacy

Other, less commonly available ancillary services include ambulatory surgery centers (ASC) and urgent care facilities. Additionally, some practices have the ability to perform a variety of other services that derive revenue which may include platelet-rich plasma (PRP) and stem cell injections. These are the exception rather than the rule and will not be discussed as part of this chapter.

These ancillary service lines represent potential revenue streams that a partner could buy-in to selectively, or gain access to as a whole upon reaching partner status in the group.

Inside the medical practice entity, the driver of the practice entity is the provision of physician's professional services. Generally, these services are supported by staff (medical/clinical, administrative/executive) and fixed assets (furniture, fixtures, and equipment) required to provide core professional services. When the patients arrive for the provision of services, at the time of service, the patient will make their co-payment and then the patient and the practice will wait for the processing of the insurance claim before billing the patient for the balance of the patient's payment obligation (amount owed by patient when the patient deductible has not been met). The medical practice entity bills for the physicians' services, the claim is processed, and the insurance company remits to the practice the contractual amount they are obligated to pay the practice based on the contract negotiated with the practice. This payment by the insurance company takes into account the co-payment and deductible obligation for each patient. This process results in the medical practice entity having an "accounts receivable" asset.

Accounts receivable at any point in time in the life cycle of the practice represents the claims that have not yet been processed by the insurance company and the outstanding balance payable by patients related to their co-payment and unmet deductible. As professional service fee accounts receivables are collected, they make their way through the income distribution formula of the orthopedic group practice. Each physician within the practice has their own identified accounts receivable, and the partners of the practice have their accounts receivable flow through to their compensation.

The physician who is not yet a partner but working toward partner status typically would not have a legal claim to the accounts receivable. They are an “Associate Physician” with a claim only to the base compensation and incentive compensation they would have negotiated as part of their Associate Physician Employment Agreement. This employed physician is typically on some type of guaranteed salary with a potential amount of incentive compensation that such incentive compensation will vary by group in terms of how the incentive compensation is determined.

Every orthopedic group practice that hires a new physician out of a residency or fellowship program takes the risk of whether the physician will work out and make their way to partnership. This risk could be related to work ethic, patient satisfaction, the group’s satisfaction with the clinical expertise of the physician, or just personality match. If the employment relationship does not work to the point of leading to partnership status, then typically the physician and the practice part ways. At this point, the practice is left with the departed employed non-partner physician’s accounts receivable and any remaining overhead issues, legal issues, or simply the cost to find a replacement physician.

An Associate Physician who does not become a partner generally does not have a legal claim to the accounts receivable they generated and walks away from it on departure. Because there is no legal claim on departure, if the physician is offered the opportunity to become a partner, the historical industry approach was receivables generated before the physician became a partner belong to the “partners” and the new physician partner must start over in the generation of their accounts receivable. This approach was in essence deemed part of the physician’s medical practice buy-in. In some groups, the physician was required to write a check for a calculated amount of the estimated receivables to be collected on behalf of the new partner physician. This clearly creates a financial burden for the new partner and must be understood and negotiated prior to making any formal commitments. In other practices, the receivables buy-in was simply handled through a compensation reduction structure with such reduction occurring over a 12–24–36-month period. The result of this was the collection of the new partners “Associate-related receivables” and allocation to the partners either as they were collected or in some ratable amount over the number of months noted. The 12–24–36-month reduced salary approach made the accounts receivable buy-in much more affordable for the new partner physician as it spreads the compensation reduction impact over a longer period of time.