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Practice Models: From Those Who Have Changed Practices

My first position was at a major academic institution. It was and remains a great academic institution. However, as the healthcare environment changed, I switched from an employed academic position that was essentially an academic private practice (collection based), to a salaried hospital-based position, and then to an incentivized hospital-based position, and currently to an “enterprise” practice model as an independent contractor/owner.

The “climate” of healthcare had a great impact on our choices of practice models since compensation, regulation, and supply and demand economics affected the types of practices available to orthopaedic trauma surgeons. Back when trauma surgeons were scarce, we were paid little, worked harder than our colleagues and often lacked resources to do what we do. In the 1990s the OTA membership was only a few hundred persons. There were several seminal events that changed the sub-specialty of orthopaedic trauma.

First, was the malpractice problem and call crisis of the turn of the century. Nevada and West Virginia had issues with orthopaedic call coverage that resulted in hospitals diverting trauma and suffering great financial and reputational harm. There were very few true orthopaedic traumatologists and general orthopaedic surgeons were loathe to provide call coverage as orthopaedic trauma experience a surge in complexity and technology (until the late 1990s a small frag and large frag and a simple nail and external fixator was most of our armamentarium). As a result of this “shortage” of labor across the country, resources and pay were improved for orthopaedic surgeons because hospitals realized they had to provide orthopaedic care or lose their trauma center verification. Suddenly, orthopaedic traumatologists were in high demand and able to negotiate competitive incomes and obtain the resources needed to perform their work (access to an operating room during daylight hours being the most important).

Second, because our pay and lifestyle improved, there was a dramatic increase of interest in orthopaedic trauma and the number of fellowships available in the US went from around 20 positions to over 90 positions. The membership in the OTA reflects this surge as does the number of candidates sitting for ABOS part II exams. Since trauma centers expansion had not yet occurred, the simple law of supply and demand economics began to impact our sub-specialty and thus our economic models of employment. The demand continued to exist, and even grow, but the supply out paced the demand and there was no longer a “shortage” of traumatologists. In fact, there became and remains a glut of providers, albeit, not all equally skilled or trained. This is reflected by the market demand and ABOS experience.

As a result of the initial shortage and needs of trauma centers, in the early to mid-2000s, the wRVU model became the benchmark of compensation, where orthopaedic traumatologist was fairly compensated for the “work” they did. They were not penalized for unfunded patients or for doing multiple procedures on one patient when it was good patient care. Hospitals realized that by providing OR access, a fair compensation model, and ancillary support (PA, office etc.), they were able to retain their orthopaedic trauma service line and thus maintain the lucrative status of being ACS verified for trauma. Irrespective of what any hospital may have told the provider, they made money off of orthopaedic trauma as a system, even though the provider may not have financially support their income. In business terms, this was called being a “loss leader” for the enterprise. Several economic articles, of which ours was one of the first (resf), demonstrated the “value” of orthopaedic trauma and the market began to swell with more stable and sustainable orthopaedic trauma programs.

As the market of surgeons grew, the “over-supply” of orthopaedic traumatologists had the impact one would expect, which was a trend towards “commoditizing” the value of their service. There were more providers than positions available and thus the economics and leverage of the provider shifted. Institutions began to use “Fair Market Value” analysis to reign in their compensation models and reduce their professional side expenses. As such, the current market employment models are regional and based on the economics of that local market. There remains a wide variation of compensation and employment conditions, many of which are not sustainable in the long run. Below, I outline my perspective of various pros and cons of employment and practice models in the current healthcare environment.

Academic: This model uses established compensation models that are not “collection based”. Income is often below “market” rates. There is an advantage of having residents and volume. Resources for academic activity vary which may present challenges for those who aspire to be academically productive. One of the biggest disadvantages is bureaucratic regulations and the limits of participation with outside ventures with industry and the ownership of intellectual property. This is a huge detractor for those with entrepreneurial aspiration. There are no opportunities for ancillary income from surgery centers, imaging, DME, etc since they are all institutionally owned. All outside medical consulting is usually vetted through the institution and department and the surgeon is a w-2 employee with little to no tax benefits.

Hospital employed: Mature systems have realized they are not good at managing physicians and typically the provider is a direct employee answering to a mid-level administrator (service line director or VP) or part of a hospital affiliated practice group (usually multi-specialty). Compensation is typically RVU based and resources for the provider have to be pre-negotiated. The hospital “owns” the provider and thus the surgeon is subject to the whims of the current administration. Often, what we hear is that after the “honeymoon” period is over (typically 2 years), there can be a change in how the physician is “managed”. Sometimes the relationship flourishes, but other times it sours and becomes onerous. I had a C suite administrator tell me point blank the following sentiment: “we know that once you move your family and get rooted for a few years, it is very hard to uproot and move, so that’s when we start to make the changes we want and extract what we want from you, we push and push to get what we can until your limit of tolerance to uproot your family”. Currently, many institutions and systems that have been in the business of employing providers are looking to get away from this model and remove the provider part of the business “off their books”. This is especially true of publicly traded healthcare systems. One big disadvantage is that the provider cannot benefit from any ancillary income from surgery centers, imaging, DME etc due to their employed status. Intellectual property often remains with the surgeon but outside medically related income usually goes through a disclosure and vetting process. The surgeon is a w-2 employee with little to no tax benefits.

Private practice: This is a collection-based model where you make money if you get paid. Unless the demographic is good and your partners do not “dump” on you, there is a big chance that you will work more and get paid less. If there isn’t a good demographic (most common scenario for trauma centers), what ends up happening is that the surgeon begins to “cherry-pick” their cases or shift towards a more elective practice (hip, sports, etc.). Such a shift may create a problem amongst the partners who may not be able to divert the “unfunded” trauma case. Alternatively, the trauma surgeon moves towards and elective practice creating the need to hire a new, young, and naïve surgeon out of training, with a continuation of the cycle or “revolving door”. On the other hand, if the demographic is favorable (rare in trauma), the surgeon can form management and administrative arrangements with the institution and have a sustainable career and thriving practice. Those situations are rare. One advantage is the ability to benefit from ancillary income such as surgery centers, imaging, DME, etc but the regulatory obstacles for such benefits are increasing from governmental sources. Intellectual property and outside medical ventures belong to the surgeon and there are excellent tax benefits to being a proprietor of one’s own “business”.

Locums: This is mercenary work. It pays reasonably and has the advantage of being able to travel and have a very flexible schedule. There is little need for clinic and long-term patient relationships and is not for everyone. It may be difficult to endure at institutions with very “austere” resources. The surgeon may feel like a resident or fellow. There are no ancillary benefits and little negotiating power on the part of the surgeon. The main benefit is flexible hours and mobility.

Enterprise/Co-management model: This is a new model for orthopaedic trauma but not in healthcare. In the 1990s neonatologists provided services to hospitals based on agreed upon contractual arrangements where the provider group was a “partner” of the hospital. Currently, many anesthesia and ED groups fall into this category and company names such as Emcare, Envision, Apollo, Delphi, Synergy, Team Health, and others abound. In most of these practice models, the providers were either employed by or contracted with the enterprise that had an administrative arm that interacted with the “client” institution. Hospitals benefited because they were able to demand performance-based metrics and services they required for their agenda, and providers benefited because they had their own administrative team to negotiate what they felt necessary to provide their service.

A newer version of this concept is an enterprise owner model, where the provider is not only a contracted provider but can also become a shareholder/owner of the enterprise. By being an owner, the provider is incentivized differently and aligns their agenda with that of both the enterprise and client institution. A huge advantage of this model are the opportunity for “ownership” equity on the part of the provider. Intellectual property and outside ventures belong to the surgeon and if the provider is a “contractor” with the enterprise, there are significant tax benefits. My current practice is that of a contractor and owner of Hughston Orthopaedic Trauma. Our compensation model is FMV based with specified metrics and responsibilities. We have the latitude of pursuing any outside interest and ownership allows for enterprise based ancillary revenue in the form of a company wide distribution model. We believe it to be the best practice model of the current healthcare market. Our executive and administrative team takes care of most administrative tasks such as credentialing, regulatory and compliance burdens, malpractice and benefits. Most advantageous is the fact that that same administrative team which is comprised of seasoned C suite executives (CEO, COO, CIO, CFO, etc) represents the interests of the orthopaedic trauma providers and interfaces effectively with the client institutions. As such, all parties are equally and fairly represented and the model is sustainable and productive.