From Entrepreneur to Employee: Part 2. The Devil's in the Details, So Don't Forget to Ask About Them

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"From Entrepreneur to Employee: Part 1. Ambiguity in Attitudes About Hospital Employment" appeared in the June issue.

For many years, a small group of physicians had worked together in a high-volume orthopedic practice and enjoyed a solid reputation and referral stream in the marketplace. When the group was approached by a hospital, the partners decided the deal was "too sweet" to pass up.

Employees were told very little about the deal, and nothing about whether they would keep their jobs. They received no training in the hospital's procedures or computer system and no explanation of the new clinic's workflow or operations. On the morning of day 1, staff trained on the hospital registration system for 2 hours. Patients began arriving at 1:00 p.m. No one thought ahead to schedule patients at half the usual volume for the first week or two. Chaos ensued.

Meanwhile, the physicians were given unionized clinical staff from the hospital. None of the staff had training or experience in orthopedics, and all were supervised by an interim manager from another department. Hospital employees were also provided for the front desk. For months, because of the complexities of processes and forms and the differences between the physicians' check-in preferences, wait times averaged an hour or more. In the reception room, lemonade and cookies pacified a few patients.

The result of no transition planning and no consideration of workflow was that 6 different computer software systems were being used to input patient information, and these systems did not interface with one another. Paper encounter forms had to be sent to the hospital billing office and, through daily courier pickup, to an outside billing service the physicians had engaged. In addition, the hospital billing office began charging a facility fee for office visits. The tripled charges shocked even the most hardy of established patients.

Charts were everywhere, including a storage unit outside the hospital and the chart room at the old office. Finding an established patient's chart sometimes took days. One of the physicians' family members was asked, in an act of desperation, to help locate charts after hours.

Think this couldn't happen to your practice? Think again. These well-respected, well-liked physicians had an excellent reputation. Before signing on with the hospital, they had met with attorneys and administrators several times and thought they were getting a good deal. They had seen integration with the hospital as a win–win situation. But after only a few months, several of the surgeons were considering exercising their contract's out-clause.

What went wrong? Like many physicians, these surgeons had focused almost entirely on their contract and compensation. They hadn't discussed operational and process integration, information systems, transition timelines, authority over practice management, or the hierarchy and politics of a unionized staff. Used to just telling their manager or staff what they wanted done, and having it handled, they were ill-equipped to deal with employees who were no longer "theirs." Even the staff and manager who had been brought from the old office were now hospital employees.

Although contracts and compensation are important, if you fail to address critical operational and cultural details, your expectations about life within the hospital walls will be very different than the reality. And you'll probably end up miserable.

Don't Forget: The Doctor's in the Driver's Seat

In a recent survey, "Hospitals Employing Specialists," KarenZupko & Associates, Inc., collected feedback from 787 orthopedic surgeons about their experience with this trend. "What would you change?" was asked of the already employed surgeons. One hand surgeon said, "Put everything down on paper so you get what you are told you are getting. Do not be afraid to negotiate. Be a little pushy."

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Am J Orthop. 2010;39(7):347-349.

Take this advice to heart. You *can* be a little pushy, and insist on getting everything in writing, because the hospital has a lot to gain from your joining its ranks.

According to a 2010 Merritt Hawkins survey,[1] hospitals typically earn 5 to 10 times more revenue from employed physicians than what they pay them in salaries—which are limited by Stark and anti-kickback laws and Internal Revenue Service requirements. On an average salary of $481,000, orthopedic surgeons earn a hospital, on average, $2.11 million a year in admissions, procedures, diagnostics, and other services.

So, take the kid gloves off and address the key details of employment head-on. Get your attorney involved early in the process and insist on written timelines and specific answers before you agree to move forward.

First, Order an Employment-Reality Sandwich

According to the experience of your surveyed colleagues, "Steady, reliable income," "Paid vacation," and "Better retirement" must be balanced with the many realities of giving up autonomy and private practice. Don't let anyone sugar-coat things for you. Employed orthopedists say that you should expect to:

•Work for administrators who probably have no practice management skills or experience, let alone in orthopedics, and over whom you have no control to hire and fire.

•Have little (or more likely no) authority to hire, discipline, or fire the administrative or clinical staff, particularly in a unionized hospital.

•Have little or no authority to make decisions regarding practice operations, billing, and management.

•Give up making autonomous decisions about practice management, marketing, and finances. These decisions will have to be approved by an administrator, a committee, or the chief financial officer.

•Give up being compensated for your full production—which you may come to resent over time.

•Be required to attend many more meetings than you'd like.

•Be forced in most cases to use the centralized billing office and scheduling department, in which the staff do not interact with your patients, and few or none know how to bill for orthopedic services.

•See your accounts receivable increase because of lack of efficiency and expertise in the hospital billing office.

Make sure you can accept these rules of the employment game. If you can't, remaining in private practice may be a better option.

Clarify Expectations

Most surgeons follow the "Get it in writing" rule when negotiating their employment contract and compensation, but typically they don't follow it with respect to management and decision-making authority, information technology, and operational processes.

For these questions, you need granular responses, not "Yes, someone in billing worked for an orthopedic group" or "Our financial policy provides financial assistance to those who need it." Such vague statements ensure only that no one will be clear about anything. Because they'd never asked, those 3 surgeons whose implementation failed were surprised to learn that someone from oncology would be their interim manager, and that no one in billing understood how to submit their office visits correctly.

Start with the management of your new practice setting, and your authority therein. Do you have to report to someone? About what? Is there an approval process for buying, say, a new fax machine, or can you order it yourself?

Most survey respondents said that, once employed, they were not able to keep their manager. So, who will be your new manager, and what does he or she know about orthopedics? What responsibilities are in the job description, and can you provide input? Is the manager able to develop a marketing plan and analyze reports, or is he or she a unit secretary who just got a promotion to manage your practice?

Do you have a say in hiring or firing? If not, what's the course of action when you and the new medical assistant are like oil and water? Insist on being able to oversee nurses and clinical staff, and ensure that you have at least some input regarding oversight of the staff who work directly with patients.

What about governance and decision making? Can you establish policies or continue your current referral-building activities, or is there now an approval process for that?

Where will your paper charts be stored, retrieved, and archived? Does the hospital require a new chart for all your patients? If so, you'll end up with duplicate charts—a not uncommon occurrence. Make sure you and the staff walk through all possible scenarios—new patient, established patient seen 1 year ago, established patient seen 7 years ago, and so forth—and nail down a plan. If you skip this step, as those 3 newly employed surgeons did, you'll find yourself trying to evaluate your longtime patients without the benefit of their charts, because no one will be able to find them.

And how is billing going to be done? Who codes? Who follows up on claims? Does anyone in the billing office know how to distinguish a hand code from a joint code? Is this person sent to annual American Academy of Orthopaedic Surgeons coding courses to learn the latest and ensure your claims are paid correctly? If not, negotiate this into your deal.

Beware the Tech Carrot

Many hospitals bait physicians to become employees with the promise of an electronic medical records (EMR) system. And most physicians quickly take the bait, without

knowing all the facts. Best advice: Don't take the job just for a free EMR system.

But if the system is part of the deal, be clear about what it will and won't do for orthopedics. Use it to code and document a few of your chart notes. Ask to be walked through customization of a visit template for a rotator cuff injury or hammer toe.

And, if you'll be expected to move from paper charts to an EMR system, who will be in charge of the transition to digital? If it'll be your manager, be prepared for him or her to do little else during the migration.

Finally, what of the billing system in which you've invested tens of thousands of dollars over the years? Do you get to keep it? If the information technology staff at the hospital say they can integrate your system with the hospital's, who pays for that?

And what of your existing patient data? Must staff now enter all that information into the hospital system? If so, all established patients will be registered or preregistered as if they were new patients the first time they come to see you in the new clinic.

Hospital employment can provide consistent income, reduce the number of managerial headaches, and allow you to focus on patient care. But there are two sides to every coin. Understanding the details ensures that you enter life as an employee with your eyes wide open.

Authors' Disclosure Statement

The authors report no actual or potential conflict of interest in relation to this article.

Reference

1. 2010 Physician Inpatient/Outpatient Revenue Survey. Merritt Hawkins Web site. http://www.merritthawkins.com/pdf/2010revenuesurvey.pdf. Accessed May 12, 2010.