Multispecialty Clinic Practice

David A. Margolin, M.D.[1,2] and David E. Beck, M.D.[1,2]

ABSTRACT

A multispecialty clinic practice is a common practice arrangement for colorectal surgeons. This type of practice has a variety of features, both positive and negative. The authors explore location, practice patterns, lifestyles, compensation, and academic opportunities associated with a multispecialty clinic practice. This information can assist younger surgeons in choosing a practice opportunity and guide experienced surgeons through their career progression.

KEYWORDS: Colon and rectal surgery practice, clinic, practice patterns, compensation

Objectives: Upon completion of this article, the reader should be familiar with the characteristics of a multispecialty clinic practice.

A multispecialty clinic group practice (MSP) is a common practice pattern for colorectal surgeons. This type of practice has both positive and negative features, depending on the surgeon's perspective and needs. In general, there are six to seven large clinic practices (e.g., Cleveland, Henry Ford, Lahey, Mayo, and Ochsner) and several medium or smaller clinics. These have many similarities, but also some specific differences, here we will describe the characteristics of a MSP and explore some of the variations including location, practice patterns, lifestyles, compensation, and academic opportunities. Descriptions of these characteristics have some overlap, and several of the topics discussed will have an emphasis on the authors' home institution, the Ochsner Clinic Foundation, New Orleans, Louisiana (DEB, DAM), and previous places of employment (Henry Ford Health System, Detroit: DAM), or training (Cleveland Clinic: DEB).

LOCATION

The majority of MSPs were initially located on the periphery of major urban centers. Historically, these clinics were urban institutions developed from a variety of ideas: a multispecialty surgical group could provide a higher quality of patient care (Ochsner), the average man and worker deserved the best possible medical and surgical care (Henry Ford), desire for a practice close to favorite hunting spots (Mayo), and even discord with the local medical school (Cleveland Clinic).[1,2] With changing populations, these institutions have often maintained their core location while developing health-care systems that broadened their outreach to match population shifts and bring tertiary care closer to the patients. As such, a MSP usually serves a large local patient population and has a wide geographic referral base. Since the 1930s, the formative years of MSPs, these institutions have developed and flourished in all regions of the country, giving practicing physicians the

[1]Ochsner Clinical School, The University of Queensland School of Medicine, Brisbane, Australia; [2]Department of Colon and Rectal Surgery, Ochsner Clinic Foundation, New Orleans, Louisiana.

Address for correspondence and reprint requests: David A. Margolin, M.D., Department of Colon and Rectal Surgery, Ochsner Clinic Foundation, 1514 Jefferson Hwy., New Orleans, LA 70121 (e-mail: damargolin@ochsner.org).

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opportunity to locate in regions of their choice. Furthermore, as these institutions have developed into tertiary care centers, they have created affiliations with institutions of higher learning (from medical schools to universities).

PRACTICE PATTERNS

While we are emphasizing MSPs, all colorectal clinics, both large and small, are some form of group practice. Most of the large ones are MSPs while some of the smaller ones are single-specialty groups. In MSP, the colon and rectal surgeons are usually grouped into a separate department or as a section in the department of surgery. As in any academic institution, a separate department of colon and rectal surgery carries more influence. They are better able to structure their practice to meet their patient's needs as well as their own goals. A section within a general surgery department may have less influence in determining both the structure and function of the group, as well as the possibility of taking general surgery call. The number of colorectal surgeons in an MSP varies depending on the work available. Nonetheless, for the department or section to continue to grow and perpetuate itself there needs to be a spectrum of ages and experience levels. This requires an influx of younger surgeons who contribute new ideas from their training while benefiting from the experience of their senior partners. As the senior partners' practice matures, they may decrease their call and change their practice dynamics. For example, older colorectal surgeons may increase the percentage of anorectal surgery and endoscopy practices while decreasing the amount of major abdominal surgery funneling larger more physically demanding cases to their younger partners. Often this practice shift can be accomplished with minimal alterations in their production numbers thus maintaining a stable income.

Regardless of the practice demographics, physicians in a MSP are either partners (actually own a part of the practice) or are employees of the parent institution. In most of the larger groups, the employee pattern is more common. As a partner (owner), depending on the organizational structure of the group, you may have more decision-making authority as well as having a direct financial stake in the profit or loss. As an employee, you have less authority, but have some employee rights (e.g., due process, labor law) and a lower liability for institutional issues.

In the established MSP, there is a significant patient base in addition to a well-developed referral pattern. In most situations, a new surgeon should expect to be busy from the start. Because a MSP serves the role of a tertiary care referral center and sees a large number of complicated and interesting cases, over time a surgeon can develop a challenging specialty practice based on individual interests. However, as the MSP grows and expands to new locations, a physician may need to develop a satellite practice in an area where the MSP's footprint is not welcome. One advantage of being in a MSP is having the backing of a large institution with all its resources. This should give the practitioner not only salary support, but also patient referrals from the MSP primary care physicians in that region.

Most MSPs have office space immediately adjacent or in close proximity to a hospital, which is owned or closely affiliated with the MSP. Initially most MSPs used one or two hospitals, minimizing time spent traveling between hospitals. However, as a MSP develops health care networks, surgeons are often required to practice at these outlying institutions thus limiting the relations with department /division at the main facility. Most MSPs utilize a closed staff model (i.e., all or almost all of the physician staff at the hospital are MSP physicians). Because all providers are members of the MSP, the staff often shares a commitment toward the institution's vision resulting in a quality of patient care that is usually consistent and uniformly high. As most MSP use a closed physician staff model, the MSP administration can control access to its facilities as well as have a direct impact on recourse utilization. Obtainment of new equipment or supplies must usually go through some committee process.

As MSPs have expanded their footprint in their regional market, they have purchased surrounding hospitals. These new additions are an open-staffed hospital with non-MSP physicians obtaining privileges through the standard credentialing process. This can be problematic as the MSP is often not welcome. They are perceived—whether correctly or not—as acting in a predatory manner to drive out the original non-MSP physicians. Furthermore, as the hospital organizational structure changes and equipment and supplies become standardized across the system a fair amount of push-back is seen. This can initially impact negatively on the practicing physician who is seen as a surrogate for the new administration. Initially, there may also be a difference in the quality of care provided. Weeks et al recently found significantly less costly, improved utilization of evidence-based care and an overall increase in the quality of care between 22 multispecialty clinics and patients not affiliated with MSPs.[3] Over time, as the health system matures, both of these issues should not be a problem.

The daily work schedule varies among MSPs, and somewhat among colorectal surgeons in each institution. A surgeon's time is divided between the operating room, clinic, and endoscopy facility. As physicians mature, there is often opportunity to engage in administrative activities. As the MSP grows and patient populations shift, physicians are being asked to travel more and more to satellite clinics and hospitals. Here the practice pattern is similar with a mix of clinic, endoscopy, and

surgery. One difference is that now with MSPs building new hospitals they expect inpatient surgery to be performed there. This is one of the strengths of a MSP. While you are operating some days at a second hospital, a member of the department can be counted on to see your patients at the main hospital—ensuring continuity and quality care. In addition, physician extenders, advanced clinical practice nurses, can be utilized to achieve the same endpoints.

Physicians interested in a clinic practice should contact the chair or section head at each institution and inquire about available positions. Postings on the American Society of Colon and Rectal Surgeons' (ASCRS) Website can also serve as a good though often outdated resource.[4] Qualities often sought for in applicants for staff positions at the larger clinics include quality of training, experience, and ability to operate, care for patients, teach, and conduct research. Newer staff is often recruited to bolster or expand certain capabilities at the institution (e.g., laparoscopic surgery, endoscopy, physiologic testing, research). Diversity of background and training is important. The applicant's personality also must mesh with other staff members and the culture of the institution.

LIFESTYLE

As MSPs are group practices, the call schedule is distributed. Larger clinics have less frequent call, but each physician must cover more patients when on call. If a training program is present, the residents and fellows spare the staff many duties such as emergency room evaluations, fever workups, history and physicals, and discharge summaries. Surgeons often work hard while at work, but have sufficient time to spend with family and pursue outside activities. There are respected colleagues with whom to discuss difficult cases, and resources to cover patients when the physician is spending time with family, on vacation, participating in educational activities or becoming involved in organized medicine such as the ASCRS and the American Board of Colon and Rectal Surgery. Most institutions have delineated vacation and sick leave policies.

ACADEMIC OPPORTUNITIES

The larger MSPs have associated training programs. These may be general surgery or colon and rectal surgery residencies or both. Trainees are a mixed blessing. They perform many of the less desirable components of patient care such as histories and physicals, discharge summaries, daily rounds, and orders for diagnostic studies. The price for shifting some of these patient care activities is having to relinquish the performance of procedures or evaluations to others. In this form of practice, the physician often needs to supervise and instruct rather than do it himself or herself. This takes a different skill set and personality that must be understood and embraced if a physician is to be happy and successful. For individuals who like to teach, an MSP is extremely rewarding. It can be especially gratifying to see former trainees achieve professional and personal success.

At most clinic practices, there is abundant opportunity for scholarly activities. Large patient bases and institutional support provide the means for research and publication. Most MSPs have affiliations with medical and graduate schools that allow for basic science collaborations. Senior staff often serves as mentors, providing guidance and assistance with academic pursuits and participation in professional organizations. The prestige of clinic affiliation often leads to invitations to participate in meetings and symposiums as well as to submit manuscripts. Many institutions encourage these activities through compensation methods described later and by providing protected time.

COMPENSATION

One potential drawback of a MSP is that physician compensation is ultimately based on income generated (revenue) minus overhead expenses. By definition, an MSP has a mixture of both specialists and generalists, each producing revenue and utilizing resources at different levels. Although this may lead to an optimal environment in which to practice medicine, it can often be an inefficient model of health care delivery. As MSPs grow, they lose the benefit of economy of scale, have a more difficult time controlling resource utilization, and often have a higher percentage of managed care patients than the solo practitioner.[5,6] Furthermore, it is imperative that the MSP administration develops a compensation plan that the physicians perceive as fair, equitable, and understandable, which at the same time protects the financial viability of the institution.

Individual compensation includes several components such as salary, retirement, malpractice, health, dental insurance, and other monetary and nonmonetary support. Salaries are usually guaranteed for the first year or two in practice. After this period, there is some form of increasing salary over several years ("ramping up time" or "buy in") until one reaches a "parity" level. During this period, the surgeon's productivity should also increase. At the parity point, each physician's salary is established by an institutional method. At some institutions, a salary level is determined by specialty and some method of seniority or experience. Such factors as historical salaries, market forces, and production are also taken into account. In addition, external benchmarks such as the surveys published by the Association of American Medical Colleges (AAMC), the American Medical Group

Association (AMGA), McGladrey and Pullen, or the Hay Management Group can serve as a comparison.[7]

More institutions are currently implementing some form of performance-based compensation system. Current measurements of production used today include gross charges, net charges, or Relative Value Units (RVU). Gross production (what you bill as professional fees) is easy to measure, but has limited relationship to actual money collected. Most institutions set their gross charges at some multiple of Medicare reimbursement (i.e., 200–300% of Medicare allowable). Updating or changing charges (which all practices should do periodically) will affect the total credit assigned to providers despite their putting forth the same amount of effort. Net charges correspond to actual cash received. However, in a MSP these charges are extremely difficult to determine accurately. Net collections are dependent on payor mix and efficiency of billing and collections. Thus, problems in the billing department or poor contracting could result in the physicians receiving less credit for similar work. At larger institutions, the billing function is often standardized and centralized. While this limits the time a surgeon must devote to this function, the limited physician involvement can lead to uncertainty concerning the adequacy and accuracy of this critical activity. Few institutions are willing to share their net collections data, so it is difficult to compare net production between institutions.

Due to the difficulties in using billing or collection data to determine physician production, many MSP are turning to RVU-based compensation systems. RVUs are based on the Resources Based Relative Value Scale (RBRVS).[8] This scale attempts to value the resource used to provide a specific physician service (CPT code) relative to other services. All CPT codes receive a value relative to other CPT codes based on the work necessary to perform the service. Total work is broken down into three periods: preservice, intraservice, and postservice work. Work is more than the time used to perform the service; it includes the complexity of the service, mental effort, knowledge, judgment and diagnostic acumen, technical skill, physical skill, psychological stress and potential iatrogenic risk. Total RVUs are composed of Work RVU (RVUw), practice expenses RVUs, and malpractice RVUs.[7–9] For compensation purposes, most institutions use RVUw. The RVUw produced by a provider can be used as a measure to compare the work of different providers or different specialties. This also allows the institution to benchmark against other institutions of similar size. There are limitations to work RVUs. Newer procedures can take 2 to 3 years to receive a CPT code, and thus an RVU value. In addition, the work involved in codes can change over time. These value discrepancies and changes in physician work are adjusted, by federal statute, every 5 years.

Institutions can assign compensation value to work RVUs in several ways. As institutions receive a specific payment for each RVU (standardized Medicare reimbursement or contracted value), providers can be assigned an institutional value for each RVU they produce. With this method, work is valued in a consistent manner and all providers receive the same compensation for each RVU they produce. This maintains the spirit behind RVUw that work equals work: one RVU of a surgeon's work is equal to one RVU of an internist's work is equal to one RVU of a psychiatrist's work. However, market forces and payor mix issues (some providers get mostly Medicare reimbursement while others may get more fee-for-service patients or lucrative contracts, etc.) make a salary based on this type of formula noncompetitive for some specialties. To compensate their providers competitively, the institution must make some modification to the calculated amount to bring the salary in line with market values. To avoid making this kind of modification (which may be politically uncomfortable for some institutions), most institutions use a specialty-specific RVUw compensation value. This value is calculated by dividing compensation received by a specific specialty by the RVUw performed. In this type of system, an internal medicine provider may receive $60 per RVUw, while a colorectal surgeon may get only $46 per RVUw. Typically, proceduralists generate larger numbers of RVUw than do nonproceduralists. In addition, to come up with the appropriate compensation overhead costs must be taken into account. Here proceduralists or high-profit-margin practices are often charged a disproportionate amount. This is the unspoken cost of practicing in a MSP. Unfortunately, while the RVUw data generated allow the institution some external comparisons and limit the problems associated with charges, these specialty-specific RVUw payments are in many ways just a surrogate for the charges /collections model.

Several management firms or associations have collected compensation and production data from groups or institutions and make it available to members of the organization (e.g., AMGA) or offer it for sale.[10] Administrators of most large institutions use one or more of these surveys to set or compare their compensation plan to national benchmarks. Data from one survey are presented in Table 1. Each of these compensation or financial surveys has limitations. The data compiled are only as good as the data received. The data are submitted by the institutions and their accuracy varies. The groups sampled (large versus small, academic versus clinical) and the sample size affects the usefulness of the data. Colon and rectal surgery is a small specialty, and the number of respondents in typical surveys has ranged from 20 to 60. With this small sample size, activity or changes by a few institutions (such as hiring several younger surgeons or

Table 1 Compensation Data for Colon and Rectal Surgeons

Category	No. of Groups	No. of Responses	20th Percentile	Median	Mean	80th Percentile	Standard Deviation
Compensation	29	101	302,000	394,723	395,320	483,142	118,888
Gross production	25	77	1,217,706	1,613,149	1,777,461	2,254,889	709,018
Work RVUs	25	74	6,334	8,340	8,386	10,554	2,550
Ratios: Compensation to gross production	25	77	15.2%	23.0%	24.5%	33.0%	
Compensation to work RVU	25	74	$35.71	$45.46	$46.38	$57.52	

From American Medical Group Association Compensation & Financial Survey, 2010 report based on 2009 data. Available for purchase at www.AMGA.com.

reporting incorrect data on a few individuals) can significantly alter the data. In contrast, specialties such as general surgery with hundreds of respondents have better statistical sampling. Most organizations have some type of administrative committee that sets the salaries (using some or all of the criteria described previously) on an annual or semiannual basis. Negotiation by the chair, section head, or physician with the committee is often a significant factor in determining final value of compensation.

At almost all clinics, malpractice coverage and health and dental coverage are included in the compensation package. Retirement options vary from defined compensation plans to opportunities for 401K, 403B, or 457 plans. However due to changes in the tax laws and the capitol requirements for viability, defined benefit plans are becoming obsolete. Thus, institutions to attract quality surgeons usually provide some form of match to the employee's participation in other retirement plans.

As discussed previously, most of the larger institutions provide support and encouragement for participation in activities outside the clinical practice. These include the society (ASCRS), board, American Medical Association, American College of Surgeons, regional and state societies, and socioeconomic entities. Support may include time away from work, stipends for dues, or production credit.

THE FUTURE

Although there are many positives with the MSP model the current U.S. health care environment raises significant questions as to its future. In March of 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act were signed into law. The scope and impact of this legislation is too broad to be covered here. However, the development of accountable care organizations (ACO) may foster the further growth of MSPs. An ACO is a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population. The goal of the ACO is to deliver coordinated and efficient care. ACOs that achieve quality and cost targets will receive some sort of financial bonus, and under some approaches, those that fail will be subject to a financial penalty. As you can imagine MSP's are well positioned to provide the quality and coordination of care necessary to take advantage of the statues and reap its benefits.

SUMMARY

A multispecialty clinic practice can be very rewarding. It has characteristics of both an academic and a private practice. The exact balance varies among institutions. If the features match the desires of the individual surgeon, a multispecialty clinic practice will be a good career choice. It is hoped that the material included in this article will aid the reader in career choice and provide guidance in career progression.

DISCLOSURE

The authors are employees of the Ochsner Clinic Foundation, a large multispecialty clinic.

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