Life After Fellowship - A riddle, wrapped in a mystery, inside an enigma – How to begin your search...

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Overview

• How to prepare for life after fellowship

• The search – how to begin....

• A helpful approach to finding the right opportunity – the three “Ps”

• Private practice vs. Academics– Details, details, details.

• Private Practice Models
Ways to prepare for life after fellowship

• Become the best physician you can be
  • See more patients
  • Observe and perform more procedures
  • Observe different clinical approaches
  • Form your own clinical style
  • Find a niche
  • Develop Non-Clinical Skills (EMR, QI, Finances, Marketing, Research)
Additional Ways to prepare...

• Learn about the business of medicine (MACRA/MIPS/APM)

• Learn about billing and coding

• Learn about the nuances of local healthcare climate

• Ask questions about everyday challenges faced in clinical practice – **Ask “What am I not thinking about?”**
A good approach....

• Start early

• Have a plan
Gather your resources...

– Chief of division
– Program director
– Previous fellows
– Word of mouth
– Journals
– Meetings (ACG, DDW, AASLD)
– Recruiting services
Think about the Three “Ps”

- Professional goals
- Practice goals
- Personal goals
Professional Goals:

• What kinds of patients do you want to see?
• What kind of procedures do you enjoy?
• Is marketing or practice administration of interest?
• Is research of interest to you?
• Is teaching of interest to you?
• Are you interested in becoming involved in physician advocacy within local/national committees or societies?
Practice Goals:

- What type of practice/dept?
- What facilities/technology would be available to effectively utilize your skills?
- What is the economic philosophy of the practice?
- Does the practice employ other practitioners (NPs/PAs)?
- How are clinical responsibilities distributed?
- How is the practice/dept. handling the changing healthcare landscape?
- What types of innovative endeavors are being undertaken?
Personal goals:

• Where do you want to live?
• Do you need to be close to family?
• How much do you want to work?
• Commute to work?
• Financial planning/goals?
• Is this your initial plan? Do you have plans for additional education/training?

• Are you putting the necessary constantly in front of the important?
What to look for in a private practice...

- Leadership
- Management style
- Mission statement / strategic plan
- Patient base
- Relationship between practice and Hospitals/PCPs
- Competition
More specifics to look at:

- Atmosphere in practice – do people enjoy working there?
- Relationship b/w physicians
- Relationship b/w physicians and support staff
- Mentoring program
- Attrition rate

- *Will the practice satisfy you professional, practice, and personal goals?*
What a practice looks for....

• Professionalism

• Clinical acuity/Technical skills

• Work Ethic

• “Team player”

• Innovation/Engagement

• Problem Solver
What is life like in private practice?
Typical patients

- GERD
- IBD
- Hepatitis C
- Dysphagia
- Bloating/IBS
- Abdominal pain/Dyspepsia
- Abnormal Imaging
- Rectal bleeding
- Pregnancy and GI complications
Typical Day-Endoscopy Session

- Screening colonoscopy
- EMR
- IBD Surveillance
- Esophageal Dilation
- APC/RFA
- ERCP
- Deep Enteroscopy
- Capsule Endoscopy/Placement
A Day in Private Practice

- Hospital Rounds
- Endoscopy Center
- Office Hours
- Teaching opportunities
Professional Relationships of Private Practice

• Patients
• Partners
• Office Employees
• Referring Physicians
Patients

- **Communicate**: return all of their calls in a timely fashion to alleviate their fears
- **LISTEN**
- **EMPATHIZE**
- **Opportunity, not a burden**: talk to family
Partners

• Seek mutual respect
• Practice culture contributes to work satisfaction
• Partnership is a professional marriage
• Income distribution and call distribution can destroy groups
• Make sure to recognize each individual’s strength and weaknesses
Employees

- Face of the practice
- Bad employees hamper a practice culture
- High turnover of support staff is a red flag
- Strong practice administrator leadership is priceless
  - Insurance contracts, HR, expenses, payroll, attorney and accountant interface, billing, AR
Referring Physicians

• Never complain about too much work

• There are no stupid consults
  • They are seeking your help!

• Be a resource – Make their life easier

• Never criticize a doctor’s care of a patient
Networking...
Networking

• Working and collaborating together
• Creating connections
• Mutually beneficial relationship building
• Revealing of yourself
• Learning from others
• Resource problem solving in a reciprocal way

• NOT SELF PROMOTION
Why Do Physicians Change Jobs?

- What was promised was not delivered
- Lack of autonomy/appreciation
- Underutilized medical skills
- Poor relations with administration or partners
- Long hours, busy call schedule
- Family uncomfortable in community
- Need for higher salary
- Desire for another climate
- Another opportunity presents itself unexpectedly – Medicine has become more fluid

*NEED TO ASK ABOUT PHYSICIAN DEPARTURES!*
Private Practice is **HETEROGENEOUS**
Private Practice Models

- Single Specialty Groups
- Multi-specialty Groups
- Hospital or System Employee

Physician Owned
Physician Owned Practices

Single Specialty and Multi-Specialty

• Initial Employee Contract

• PARTNERSHIP CONTRACT and STRUCTURE
Initial Employee Contract

- Length of Contract: ie how long to partnership contract
- Guaranteed salary; any productivity incentive?
- Benefits
- Vacation/Scheduled Days Off
- Expense reimbursements
- Meeting attendance
- Sign on Bonus/Relocation expense
- Loan repayment program
- Work with health care employment attorney
Employee Issues to consider

- Teaching Opportunities/Medical School Affiliations
- Call schedule distribution
- Needs of practice which are to be fulfilled
- Flexibility of schedule
- ERCP/EUS coverage
- Sub specialty GI services: manometry, capsule, breath tests, etc.
- Secretarial/MA support
- How can you provide feedback? Receive feedback?
- Mentoring/Marketing
Employment → Partnership
What Does Partner Status Mean?

• No longer an employee with a guaranteed set salary
• Access to the practice’s collections and revenues
• *Involved in decision making*
• “Perks”: call schedule, vacation time, expense card, days off, pension plan
• Opportunity to buy – in
• “Partner by day, OWNER by night.”
What Does a partner own?
How Do I Buy It?
What You “OWN”

- Patient visits and Procedure Fees
- Surgery Center (ASC) facility fee
- Pathology and Anesthesia And Research

Total Revenue stream
What You “Buy”

Partner Buy In Component

- Office Practice
- Surgery Center (ASC) Buy In
Office Practice Buy In

- Office visit and hospital income
- Physician procedure fees
- Hard assets
- Anesthesia and path
- “Sweat Equity” or Money
- Healthcare Accountant and Attorney
Partner Buy In Component

- Office Practice
- Surgery Center (ASC) Buy In
Ambulatory Surgery Center

- Physician owned center with multiple OR’s
- Control of staff and scheduling
- Efficient
- Facility Fee
- Anesthesia and Pathology
- National surgery center organizations
Income Based on Site of Procedure

Hospital

Physician Procedure Fee

Surgery Center

• Physician Fee
• Facility Fee
• Anesthesia/Pathology
ASC Buy-In

• How many current owners
• Limited to practice or open to outside physicians?
• What percentage ownership is available to new partner?
• Methodology of buy-in: all at once or gradual ownership?
• Calculation of buy-in
• Obtaining funds for buy-in
  • Buy-in based on multiple of annual earned income EBITDA
Private Practice Models

- Single Specialty Groups
- Multi-specialty Groups
- Hospital or System Employee

Physician Owned
Multi Specialty GI Group

• Advantages of multi specialty
  – Referral source
  – Ancillary services
  – Economies of scale

• Employment contract to partnership

• How is income from other specialties shared?
Distribution of Partner Income

• Equal distribution of all revenue

• Purely productivity based

• Hybrid models: set base and remainder productivity based
Productivity Based

- Will there be appropriate opportunity to earn
- Payor mix
- SCHEDULE
- What is the measure of productivity?
- RVU vs Collections
- Access to ancillary services incomes
- Possibility of internal competition
Hybrid Models of Income Distribution

• Set base for all partners
• What percentage beyond is productivity
• Division of ancillary service income
Private Practice Models

Single Specialty Groups

Multi-specialty Groups

Hospital or System Employee

Physician Owned
Hospital Employee

- **Employee** Contract with Hospital or System

- No responsibility of managing staff, contracts, ASC, etc: No ownership

- Guaranteed income for three years

- RVU used as measure of productivity
• **Relative Value Unit**

• Reflects the level of time, skill, training, and intensity required for physician to provide given service

• Related to the monetary compensation for a service by insurance company

• Each CPT code has RVU assigned to it
  
  • Colonoscopy with lesion removal (45385) -4.57
RVU

• Physician work component: time, skill training, and intensity to provide service

• Practice Expense component: cost of maintaining a practice including rent, equipment, supplies, and non physician costs

• Malpractice component; payment for professional liability expenses
Hospital Employee Contract

- Productivity measured by **number of RVU’s generated by your services**
- Paid x dollars per RVU generated
- Can generate 8,000-12,000 RVU per year
- Average pay per RVU can be $55-$65
Hospital Employee Contract

• What happens if you fall short of RVU needed for salary?
• Is there a salary cap?
• What if you generate RVU beyond your income?
Academic Medicine

What is FTE?

Understanding Academic Rank

Path to Promotion
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**FTE= Full-Time Equivalent**

1.0 FTE = 100% time worked
Effects of Working Part-Time

• If you plan to work part-time:
  – Talk to others to decide best FTE for you
  – Find out ability to change FTE later
  – Investigate the effects on your benefits
    • Salary
    • Vacation and trip days
    • Pension fund
    • Health insurance
Levels of Academic Rank

- Instructor of Medicine
- Assistant Professor of Medicine
- Associate Professor of Medicine
- Professor of Medicine
Academic Rank: What You Need to Know

• Do you have tenure, and is it linked to academic rank? If so, find out details.
  – Time to reach the rank?
  – Adjusted if part-time?
  – Annual reviews to check progress?

• What are institutional differences with each rank?
  – Salary, benefits
  – Future leadership roles

• Realize academic rank differs place to place.
Academic Rank

- With Associate and Professor levels:
  - Notable # of papers (the commodity!)
  - National/international presence
  - Support/letters from others:
    - Cannot have worked with them
    - Cannot have collaborated with them
    - This is where networking is KEY!!!
Promotion Tracks

• Institution may have both:
  – Traditional promotion track
  – Educational promotion track

• **Traditional track:**
  – Papers, funding, mentoring, recognition

• **Educational track:**
  – Papers, curriculum, talks, running a course/clerkship, roles, mentoring, recognition
Academics and private practice
They CAN Co-exist!

- Make sure the practice values research and teaching
- Take initiative
- Be creative with scheduling
- Be willing to work hard
- Do what you love and love what you do!!!!
Don’t wait to implement a plan
• YOU MAKE A LIVING FROM WHAT YOU GET, BUT YOU MAKE A LIFE OUT OF WHAT YOU GIVE.

- Anonymous
Questions?

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