Cal Ortho On-Line

Orthopaedic Legal/Practice Management News

EMERGING TRENDS IN ORTHOPAEDIC PRACTICE MANAGEMENT, DELIVERY MODELS, AND LEGAL ISSUES

REPORT II—2013—SPECIAL EDITION

Cal Ortho On-Line provides COA members with timely and relevant information on emerging issues affecting orthopaedic practice.

*T*opics will range from new health delivery models, strategies to make your practice successful, the use of physician extenders, and updates on recent legal/regulatory developments.

This publication is only available to COA Members.

Advance Calendaring . . .

COA's 2014 Annual Meeting/ QME Course

May 29—June 1, 2014

Portola Hotel & Spa
Monterey, CA

Information regarding the meeting will be posted at www.coa.org as it becomes available.

This meeting will be accredited for:

- Category I CME hours
- QME CME hours
- Radiology CME hours
- ABOS MOC Self Assessment hours

CALIFORNIA ORTHOPAEDIC ASSOCIATION

1246 P STREET
SACRAMENTO, CA 95814

P:(916) 454-9884
F:(916) 454-9882
COA1@PACBELL.NET

IN THIS ISSUE

Cal Ortho On-Line

Orthopaedic Legal News

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Did you know.....

ORTHOPEDIC SURGEON SALARY VS. HOSPITAL REVENUE GENERATED: HOW ORTHOPEDICS STACK UP

Written by Laura Miller - Becker's Orthopedic Review—May 17, 2013

Annually, orthopedic surgery generates the most revenue for hospitals—$2.68 million on average, according to the "2013 Physician Inpatient/Outpatient Revenue Survey" from Merritt Hawkins.

The survey cited statistics on physician-generated hospital revenue, hospital salaries for physician and their corresponding revenue-to-compensation ratios based on data from the survey, comparing orthopedics to other key specialties.

Orthopedic surgeons
Median 2013 revenue: $2,683,510
Median 2012 hospital compensation: $519,000
Revenue-to-compensation ratio: 5.17:1

Cardiologists (invasive)
Median 2013 revenue: $2,169,643
Median 2012 hospital compensation: $512,000
Revenue-to-compensation ratio: 4.24:1

Neurosurgeons
Median 2013 revenue: 1,684,523
Median 2012 hospital compensation: $669,000
Revenue-to-compensation ratio: 2.52:1

Family practice physicians
Median 2013 revenue: $2,067,567
Median 2012 hospital compensation: $189,000
Revenue-to-compensation ratio: 10.94:1

General surgeons
Median 2013 revenue: $1,860,655
Median 2012 hospital compensation: $343,000
Revenue-to-compensation ratio: 5.42:1

White Paper on the Role of Mid-Level Providers in Emerging Health Care Delivery Systems

SUMMARY

A number of recent reports have emphasized the fact that there is an impending U.S. physician shortage. It is also clear that a significant increase in demand is also anticipated. This demand will be driven by a number of factors:

- U.S. population growth of 13% by 2025.
- Aging of the population, with 70 million U.S. residents over the age of 65 by 2030. Utilization of resources for this group is approximately twice that of persons under age 65. In 2004, the Center for Health Statistics anticipated an 82% increase in annual physician visits by 2030.
- A growth in the incidence of patients with chronic disease states. It is anticipated that 50% of the U.S. population will have one or more chronic conditions by 2030.
- The addition of approximately 30 million newly insured into the health care system with the advent of health care reform.

During this same time period, the expectation is for a deficit in the number of health care professionals available to meet those needs. For physicians alone, recent data from the American Association of Medical Colleges predict the following physician deficits by 2025:

Primary Care Physicians	46,000
Surgeons	41,000
Medical Specialists	8,000
Other Specialists	29,000
Impact from reform	31,000
Total Physician Deficit	155,000

A number of factors are affecting these calculations, and are likely to make the shortfall difficult to address in the next decade. These include:

- An aging physician workforce, with one third of physicians expected to retire within the next 10 years. 50% of physicians in California are over age 55.
- Insufficient ability to increase medical school class sizes to meet the anticipated need.
- Declining interest in primary care as a specialty.

- Job dissatisfaction resulting in early retirement or part-time practice.
- A static number of residency slots for physicians completing their medical education.
- Regional disparity in physician distribution, with only one in four physicians electing to practice in an underserved area.

For all of the reasons noted above, there is impetus to increase the utilization of mid-level providers in the provision of medical care. As this trend accelerates, all physicians will experience increased interaction with these providers. This may be especially true with respect to the emphasis for improved care coordination. For orthopaedic surgeons, this will mean increased interaction with those who will be providing initial primary musculoskeletal care. The White Paper discusses the scope of practice and training of mid-level providers commonly utilized in an orthopaedic practice.

Read the entire White Paper.

Patient-Reported Outcomes:
An Overview of the Validated Reporting Tools and Implementation Strategies

Patient-Reported Outcomes: An Overview of the Validated Reporting Tools Implementation Strategies

Summary

The goal of this COA-commissioned White Paper is to provide recommendations on practical, cost-effective processes and standards to encourage more widespread and consistent, use of patient-reported outcome (PRO) instruments by COA members.

Specifically, the objectives are to:

1) Educate COA members about the importance of beginning to collect PRO data from their patients;
2) Identify the most appropriate, standardized, validated instruments for assessing PROs in patients with musculoskeletal conditions within the named subspecialties;
3) Identify processes and software tools by which these instruments can be administered routinely in clinical practice settings, both pre- and post-procedures;
4) Identify PRO data flow issues – i.e., compatibility, integration with Electronic Medical Record/Electronic Health Record (EMR/EHR) systems; and,
5) Educate COA members about issues surrounding interpretation and analysis of PRO data in a risk-adjusted manner.

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Orthopaedic Legal News

Did you know.....

10 Statistics on Orthopedic-Driven Surgery Center Operating Expenses

Written by Laura Miller - Becker's Orthopedic Review | May 16, 2013

10 statistics on orthopedics-driven ambulatory surgery center operating expenses based on the 2011 VMG Multispecialty ASC Intellimarker report on ASCs with more than 50 percent orthopedics.

1. Occupancy costs per square foot were reported as $39.85 on average.
2. General and administrative costs per square foot were reported as $11.30.
3. Employee salary and wages per case were $489.05 on average.
4. Taxes and benefits per case were $55.96 on average.
5. Medical and surgical costs per operating room were around $500,000.
6. Other medical cots per operating room were on average $17,000.
7. Insurance per case was on average $13.16.
8. General and administrative costs were around $55.96 per case.
9. On average, employee salary and wages represented 20.1 percent of the net revenue.
10. Total operating expenses represented 68.6 percent of net revenue.

Adoption of these processes is important for improving physician patient management, CQI monitoring of interventions, and more generally as the field moves towards more patient-centered care. It also is advisable for COA and the profession to take a lead in defining quality processes and models before payors make their own determinations and mandates.

For individual practices: We recommend beginning to put processes in place for collecting PRO data in the office setting. In general, this will involve the following steps:

1. Selecting a general and disease-specific PRO instrument(s) (Tables 1-5; e.g., SF-12, UCLA Activity Index) already available on one of the PRO-specific software tools (Tables 6-7; e.g., OBERD, SOCRATES, SOS).
2. Checking for instrument licensure requirements (most software tools expect the user to do so).
3. Developing data collection/tracking protocols that include: when instruments should be administered (e.g., pre-operative, 1-month post operative), and their mode of administration (e.g., Ipad; smartphone application; online survey).
4. Preparing a data management and storage plan.
5. Preparing a data analysis plan.
6. Preparing a data reporting plan.

This can be a complicated process and should be tailored for each practice. ETR is an agency in northern California that has the capacity and expertise to act as a consultant in this process. Clinicians also should consider the possibility of participating in a demonstration project to establish a base of California orthopaedic PRO data for risk adjustment model development (see Section IX of the White Paper).

For the COA and sub-specialty fields: We recommend:

1. Working with a consulting organization to identify a small set of general and disease-specific PRO instruments to recommend as region-specific standards for use across California; and,
2. Collaborating with an organization to establish a data center in which early adopters of PRO integration into clinical practice can pool their data for a demonstration project. Such a demonstration project would serve to: (a) provide data for beginning to establish normative values and risk adjustment models; and, (b) demonstrate to non-early adopters the value of collecting PRO data, including the identification of effective clinical practices and ability to show patient-centered value to payors.

These recommendations encourage the staged implementation of PRO integration across the state and would enable COA to set standards and determine normative values/risk adjustment models rather than waiting for government agencies and payors to do so.

Read the entire White Paper.

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California Health Care Foundation California Health Plans and Insurers: A Shifting Landscape

Summary

The insurance market in California is set to undergo enormous changes when the Affordable Care Act takes full effect in 2014 and millions of residents become eligible for public insurance or subsidies for private insurance.

This report provides a performance baseline for health plans and insurers before the law begins to influence the marketplace. Data primarily from the state's two insurance regulators, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), were used to examine market share, enrollment, financial performance, share of premiums devoted to medical care, and consumer satisfaction.

Key findings are:

- Six insurance carriers account for three-fourths of the $111 billion health insurance revenues in California in 2011.
- Commercial enrollment remained essentially flat. Individual enrollment declined 9.1% from 2010 levels and group enrollment grew by less than 1%.
- Enrollment grew in the public sector, mainly due to increased sign-ups for managed care Medi-Cal.
- DMHC-regulated companies insure the largest share of consumers, with the exception of the individual market, where CDI-regulated carriers insured two of every three enrollees.
- Most of the largest carriers, both under DMHC and CDI, reported positive net income.
- ACA requires insurers to spend a minimum share of premium dollars on medical care or pay a rebate to consumers. In 2012, the first rebates were paid: $74 million was returned to approximately 1.1 million California policyholders.

Covered CA

(California's Health Benefit Exchange)

- **Covered California Announces Plans and Rates for 2014**
  - Press Release
  - Health Plans Booklet
  - Frequently Asked Questions

Read the entire report.

An interactive graphic shows the largest private insurance carriers in California and their enrollment and revenue figures.

Comments or ideas for future topics?

Contact the COA office at 916-454-9884 or coa1@pacbell.net